Health and Human Services Policy Committee
125th CSAC Annual Meeting
Tuesday, December 3, 2019 · 2:30 p.m. – 4:00 p.m.
Hilton San Francisco Union Square · Imperial A
333 O'Farrell Street · San Francisco, California

Supervisor Das Williams, Santa Barbara County, Chair
Supervisor Jeff Griffiths, Inyo County, Vice Chair

Note: This policy committee meeting is an in-person meeting only and is being held as part of the CSAC 2019 Annual Conference.

2:30 p.m. I. **Welcome and Introductions**
Supervisor Das Williams, Santa Barbara County, Chair
Supervisor Jeff Griffiths, Inyo County, Vice Chair

2:35 p.m. II. **State and County Coordinated Approach to Serving Children and Youth Who Have Experienced Trauma**
Michelle Baass, Undersecretary, California Health and Human Services Agency

2:50 p.m. III. **County Behavioral Health: Looking to 2020 and Beyond**
Michelle Doty Cabrera, Executive Director, County Behavioral Health Directors Association of California

3:10 p.m. IV. **Counties and the 2020 Waiver: Funding, Flexibility, and Feasibility**
Michelle Doty Cabrera, Executive Director, County Behavioral Health Directors Association of California
Michelle Gibbons, Executive Director, County Health Executives Association of California
Sarah Hesketh, Senior Vice President of External Affairs, California Association of Public Hospitals and Health Systems
Cathy Senderling-McDonald, Deputy Executive Director, County Welfare Directors Association of California

3:40 p.m. V. **2019 IHSS Success and Next Steps**
Supervisor John Peters, IHSS Working Group Co-Chair, Mono County
Supervisor Belia Ramos, IHSS Working Group Co-Chair, Napa County

3:50 p.m. VI. **ACTION ITEM: Health and Human Services 2019 Year in Review and 2020 Priorities**
Farrah McDaid Ting, Legislative Representative, CSAC
Justin Garrett, Legislative Representative, CSAC
Roshena Duree, Legislative Analyst, CSAC

4:00 p.m. VII. **Closing Comments and Adjournment**
Supervisor Das Williams, Santa Barbara County, Chair
Supervisor Jeff Griffiths, Inyo County, Vice Chair

ATTACHMENTS

II. State and County Coordinated Approach to Serving Children and Youth Who Have Experienced Trauma

Attachment One ..... CSAC Memo: State and County Coordinated Approach to Serving Children and Youth Who Have Experienced Trauma

III. County Behavioral Health – Looking to 2020 and Beyond

Attachment Two ..... CSAC Memo: County Behavioral Health – Looking to 2020 and Beyond

IV. Counties and the 2020 Waiver: Funding, Flexibility, and Feasibility

Attachment Three ..... CSAC Memo: Counties and the 2020 Waiver: Funding, Flexibility, and Feasibility

Attachment Four: ..... Department of Health Care Services CalAIM High Level Summary

Attachment Five ..... Department of Health Care Services CalAIM Timeline

V. 2019 IHSS Success and Next Steps

Attachment Six ..... CSAC Memo: 2019 IHSS Success and Next Steps

Attachment Seven ..... Overview of 2019-20 County IHSS MOE

Attachment Eight ..... IHSS Wages and Bargaining Brief

Attachment Nine ..... 2019-20 IHSS MOE County Amounts Methodology Brief

VI. Health and Human Services 2019 Year in Review and 2020 Priorities

Attachment Ten ..... Health and Human Services 2019 Year in Review and 2020 Priorities

State and County Coordinated Approach to Serving Children and Youth Who Have Experienced Trauma

Attachment One

CSAC Memo: State and County Coordinated Approach to Serving Children and Youth Who Have Experienced Trauma

December 3, 2019

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To: Members of the Health and Human Services Policy Committee

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

RE: State and County Coordinated Approach to Serving Children and Youth Who Have Experienced Trauma

Background. Foster youth who have experienced severe trauma face increased challenges that can impact all aspects of their lives. Severe trauma in youth can be linked to negative health and behavioral health outcomes which can lead to placement disruptions, disconnection to the education system, and law enforcement/juvenile justice involvement.

Assembly Bill 2083. During the 2018 legislative session, the County Welfare Directors Association (CWDA) sponsored and successfully secured passage of AB 2083 (Chapter 815, Statutes of 2018). CSAC supported this bill that was authored by Assembly Member Ken Cooley. AB 2083 requires counties to work with local agencies, entities, and stakeholder groups to develop Memorandums of Understanding (MOUs) to ensure coordination of trauma-informed services. It also requires the state to establish an interagency placement resolution team with representatives from the relevant state departments to provide guidance and technical assistance to counties and other entities on establishing MOUs to identify and secure the appropriate services for youth who have experienced severe trauma.

California Health and Human Services Agency Coordination. In August 2018, the California Health and Human Services Agency (CHHS) convened numerous state departments, county associations, counties, and other local partners to discuss coordination of services for high-needs children and youth. The purpose of this meeting was to begin a partnership between state, regional center, and county experts to identify best practices, explore new strategies, and improve positive outcomes for children and youth who are served by multiple public programs and have often experienced trauma. Once AB 2083 was signed into law, CHHS broadened the scope of this process to also include developing the required guidance to counties and other entities on establishing MOUs to ensure that youth who have experienced severe trauma effectively receive the appropriate services.

Over the course of a year, CHSS convened numerous meetings and opportunities for input in the development of this MOU implementation guidance. These local MOUs must include specific components including an interagency leadership team, information and data sharing, and alignment and coordination of services. For each of these components, the MOU implementation guidance will provide guiding questions, information on the required elements, and practices for success. The drafting of the MOU implementation guidance is nearly complete and CHSS will then work with partners to distribute and provide training opportunities. Michelle Baass, Undersecretary of the California Health and Human Services Agency, has been leading these collaborative efforts for CHHS and will provide the latest updates at the HHS Policy Committee meeting.

Resources

- CHHS System of Care website – www.chhs.ca.gov/home/system-of-care/

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To: Members of the Health and Human Services Policy Committee

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

RE: County Behavioral Health – Looking to 2020 and Beyond

Introduction. Counties are pleased to welcome Michelle Doty Cabrera as Executive Director of the County Behavioral Health Directors Association of California (CBHDA).

The CBHDA Executive Director Search Committee, which included CSAC Executive Director Graham Knaus, announced Ms. Cabrera's acceptance of the positon as the leader of California's county behavioral health directors in March.

Ms. Cabrera is excited to join CBHDA during these times of change and opportunity. "Behavioral Health is an issue that is near and dear to my heart and I am excited to bring my passion to work with counties and stakeholders in advancing mental health and substance use disorder care in our communities," she said.

Ms. Cabrera has a wealth of experience as a policy and budget consultant and lobbyist, most recently for California Service Employees International Union, where she handled health and behavioral health policy as Director of Research. She also served as a Senior Consultant for the Assembly Human Services Committee and a Program Officer for California HealthCare Foundation.

Ms. Cabrera also serves on the California Pan-Ethnic Health Network Board of Directors, the National Quality Forum Disparities Standing Committee, and as a Board member for Health Access California.

She joins CBHDA at a critical juncture for behavioral health services. The mental health and substance use disorder realms are a hot topic in policy and budget circles, and county behavioral health and CBHDA are at the forefront of the conversation. Specific topics include:

CalAIM – the ambitious proposal from the Department of Health Care Services to streamline and reform the state's Medi-Cal system has significant implications for county behavioral health, including changing the reimbursement system, broadening the definition of medical necessity, implementing behavioral health integration, and a focus on behavioral health services for special populations, such as foster children.

MHSA – the Mental Health Services Act, passed by voters as Proposition 63 in 2004, is under the microscope as the Governor, legislators, county partners, and stakeholders eye this critical county funding stream for other uses, such as homelessness or for those involved in the criminal justice system.

Network Adequacy – County Mental Health Plans (MHPs) continue to grapple with new DHCS requirements, regulations, and legislation related to Network Adequacy.

Counties are working to clarify the requirements and meet the new standards, but are also raising questions about the efficacy and basis for the DHCS ratios. This issue will continue to evolve in 2020, as more than half of counties are supposed to meet a Network Adequacy deadline by mid-January.

Mental Health Conservatorships – the Lanterman-Petris-Short Act of 1964 (LPS Act) sets forth the statutory framework for mental health conservatorships in California. Handled exclusively by county Public Guardians, Conservators, and Administrators offices, LPS conservatorships are also of high interest among those who are seeking solutions to homelessness. However, the role of counties, including county behavioral health, and the fiscal implications of any changes to the LPS Act raise significant concerns at the county level.

Please welcome Ms. Cabrera to the county family! She can be contacted at:

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Counties and the 2020 Waiver: Funding, Flexibility, and Feasibility

Attachment Three

CSAC Memo: Counties and the 2020 Waiver: Funding, Flexibility, and Feasibility

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Roshena Duree, CSAC Legislative Analyst, Health and Human Services

RE: Counties and the 2020 Waiver: Funding, Flexibility, and Feasibility

Background. On October 29, the Department of Health Care Services (DHCS) released a sweeping proposal to reform the state's massive Medi-Cal program, which provides health, behavioral health, and oral health care to nearly 13 million beneficiaries – a third of the state's population.

Dubbed "California Advancing and Innovating Medi-Cal," or CalAIM, the package consists of multiple proposals at the state and federal levels to simplify and streamline the Medi-Cal program, including county specialty mental health services, county social services eligibility functions, and special initiatives focused on children, foster youth, and those who are homeless or incarcerated. You can read the 181-page proposal here: DHCS CalAIM.

The state developed CalAIM as a package to respond to the upcoming renewal of the federal Medicaid Section 1115 and 1915(b) waivers in 2020. The CalAIM framework can be divided into four "buckets" from the county perspective. Below is a description of the key considerations for counties and some details on each of the buckets.

The Department is also kicking off an extensive public stakeholder process through February 2020 to gather input on the proposals. CSAC and a number of county affiliates and county staff will participate in the stakeholder subcommittees to ensure that county needs and concerns are communicated and addressed.

CalAIM is ambitious, and some early barriers include recent leadership changes at DHCS and a new proposal from the Centers for Medicare and Medicaid Services (CMS) to restrict how states can draw down federal matching funds. And, as always, financing for the proposals – which is unclear at best – remains a top priority for CSAC and counties.

CalAIM "Buckets."

1. **Behavioral Health Payment Reform**
   DHCS proposes moving the county specialty mental health and Drug Medi-Cal systems from a cost-based reimbursement model to an Intergovernmental Transfer (IGT) model, where counties pay for the service as well as provide the non-federal share to the department, and then receive federal matching dollars, usually within 30 days. The amount of the IGTs, and potential federal financial participation, would be based on rates developed by the department.

Pros:

- Rapid reimbursement structure is far better than the current seven-year final cost reconciliations;
- Opportunity to develop rates that exceed actual costs;
- Relieve administrative burden of cost reports, multiple reconciliations, and reimbursement lag;
- Clearer, more timely picture of overall revenues, which can assist in operation and planning for the mental health plans;
- Timeliness and frequency of ratesetting is imperative to ensure rates are capturing full costs.

Cons:

- Ratesetting process is opaque and must be approached cautiously;
- Potential for a gap between old cost-based methodology and new IGT reimbursement which may require a state general fund contribution to affected counties;
- Audits and streamlined cost reporting will still be necessary;
- Requires intensive training and technical assistance for all counties.

2. **<u>Benefit Changes & Funding Flexibility (Whole Person Care 2.0)</u>**

DHCS proposes to shift the Whole Person Care (WPC) program to the Medi-Cal managed care plans by creating new "bundles" of special care for patients that include higher rates for this level of care statewide. Bundles could include housing and rental assistance, medically tailored meals, and intensive case management. This could be achieved through Enhanced Care Management (ECM) and In Lieu of Services (ILOS) rates for **health plans** (not counties).

Pros:

- Could focus on special target populations of mutual concern to counties: homeless, foster kids, those transitioning from jails or institutions;
- Opportunity to contract with plans to continue county WPC services – but this model is unclear and requires close examination.

Cons:

- Plans may pass on contracting with counties to offer these services even though many of the proposed CalAIM services are currently offered by counties under WPC;
- Counties may have to dismantle WPC staffing and infrastructure;
- Offering these services statewide will be difficult, especially for those areas that do not have WPC now;
- DHCS proposed to limit some of these special benefits, like housing assistance, to once-in-a-lifetime. Counties know from our WPC experience that one intervention is not effective;
- Who will outreach to and engage these special populations?;
- How will the special populations be defined?

3. **Medi-Cal Eligibility and Oversight**

   DHCS proposes to increase oversight and accountability for Medi-Cal eligibility functions by county social services. Proposals include mandating Medi-Cal eligibility services in county jails before release, developing new statutory standards and timelines for county eligibility activities, and improving the accuracy and collection of Medi-Cal eligibility data, including contact and demographic information.

   Pros:

   - Counties would welcome state funding to develop jail "inreach" activities, along with flexibility;
   - Jointly developing or updating statutory requirements for Medi-Cal eligibility activities is an acknowledged need.

   Cons:

   - Jail inreach will require intra-county coordination between social services and Sheriff;
   - New statutory requirements for eligibility activities could be overly burdensome or unrealistic;
   - Improving data collection is acknowledged to be a heavy technical lift and may include significant costs and worktime.

4. **Behavioral Health Integration**

   DHCS proposes to expand the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver statewide and refine the definition of Medical Necessity for county behavioral health services. The state is also interested in allowing MHPs to work regionally in service delivery or administration, or both.

   Pros:

   - The DMC-ODS waiver has almost revolutionized drug and alcohol service delivery in participating counties, increasing access to and the continuum of treatment;
   - Refining or updating Medical Necessity criteria is a shared goal.

   Cons:

   - Significant expansion of services if DMC-ODS goes statewide could create potential fiscal concerns;
   - Implementation will be slow and difficult for non-DMC-ODS counties/regions;
   - If Medical Necessity criteria is loosened/expanded, more people will qualify for county behavioral health services, thereby potentially placing additional fiscal pressure on the system;
   - Changes to Medical Necessity should be covered by Prop 30 (changes to service levels or overall costs) – this requires legal review;
   - Regional models should be opt-in and developed based on need and costs, not just geographic proximity.

CSAC will continue to update counties as this process moves forward.

Attachments and Resources

DHCS High-Level CalAIM Summary (attached)
DHCS CalAIM Webpage: www.dhcs.ca.gov/calaim
DHCS Implementation Timelines (attached)

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Counties and the 2020 Waiver: Funding, Flexibility, and Feasibility

Attachment Four

Department of Health Care Services CalAIM High Level Summary

California Advancing and Innovating Medi-Cal (CalAIM)
High Level Summary

The Department of Health Care Services (DHCS) has developed a framework for the upcoming waiver renewals that encompasses broader delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population. This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduce health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on an individual's health and quality of life, and through iterative system transformation, ultimately reduce the per-capita cost over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are initial proposals whose implementation will ultimately depend on whether funding is available.

Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations as well as state-level statutory and policy changes. During this time, the DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on the needs of the beneficiary, some may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.). As one would expect, need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and

align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

To achieve such outcome, CalAIM proposals offer the solutions to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as Whole Person Care, the Coordinated Care Initiative, public hospital system delivery transformation, and the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees. CalAIM seeks to build upon past successes and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time through a comprehensive array of health and social services spanning all levels of intensity of care, from birth to end of life. To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and make system changes necessary to close the gap in transitions between delivery systems, opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

Key Goals

CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

The reforms of CalAIM are comprehensive and critical to the success of the delivery system transformation necessary to improve the quality of life for Medi-Cal members as well as long-term cost savings/avoidance that will not be possible to achieve absent these initiatives. Furthermore, these reforms are interdependent and build off one another; without one, the others are not either possible or powerful. Below is an overview of the various proposals and recommendations that make up CalAIM.

Identify and Manage Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

- Require plans to submit local population health mangement plans.
- Implement new statewide enhanced care management benefit.
- Implement in lieu of services (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement incentive payments to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
- Evaluate participation in Institutions for Mental Disease Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver.
- Require screening and enrollment for Medi-Cal prior to release from county jail.

- Pilot full integration of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for foster care children and youth.

Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance accredited
- Implement annual Medi-Cal health plan open enrollment
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults
- Administrative behavioral health integration statewide
- Regional contracting
- Substance use disorder managed care program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle and Silver Diamine Fluoride for young children
- Pay for Performance for adult and children preventive services and continuity of care through a Dental Home

County Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contract and demographic information

For detailed descriptions of the CalAIM proposals please refer to the full CalAIM document located on CalAIM page of the DHCS website.

Advancing Key Priorities

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medicaid can easily integrate, complement and catalyze the Administration's plan to impact the State's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more

integrated systems of care and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission. Furthermore, CalAIM will advance a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for kids, proliferating the use of value-based payments across our system, including in behavioral health and long-term care. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services including specialty mental health and substance use disorder services, Medi-Cal eligibility, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if enacted and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal, ensuring the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal. CalAIM proposes enhanced care management and in lieu of services benefits (such as housing transitions, respite and sobering centers) that address the clinical and non-clinical needs of high-cost Medi-Cal beneficiaries, through a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how Californians (adults and children) will access specialty mental health and substance use disorder services. It aligns the financing structure of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, eligibility for, and access to integrated behavioral health care.

Vulnerable Children: CalAIM would provide access to enhanced care management for medically complex children to ensure they get their physical, behavioral, developmental and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children including identifying the complex impacts of trauma, toxic stress and adverse childhood experiences by, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to clinically linked housing continuum via in lieu of services for our homeless population, including housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.

Justice Involved: The Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral

health and non-clinical social services for justice-involved individuals prior to and upon release from county jails. These efforts will support scaling of diversion and reentry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for felons incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services would allow the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide by 2026. MLTSS will provide appropriate services and infrastructure for home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and should be a critical component on the State's Master Plan on Aging.

Counties and the 2020 Waiver: Funding, Flexibility, and Feasibility

Attachment Five

Department of Health Care Services CalAIM Timeline

6. Appendices

Appendix A: CalAIM Implementation Timeline

Date	Implementation Activity
2019	
November-December 2019	**Stakeholder Engagement Process:** • Population health management/ Annual enrollment • Enhanced care management/ In lieu of services • Behavioral health proposals
2020	
January 2020	**Stakeholder Engagement Process:** • Population health management/Annual open enrollment • Enhanced care management/In lieu of services • Behavioral health proposals • Full Integration Plans • NCQA **Regional Rates:** Develop rate setting methodologies and seek managed care plan input **County Oversight:** DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide **Benefit standardization:** Fabrication of optical lenses carve-out effective **Long-Term Plan for Foster Care:** Internal planning and selection of workgroup members
February 2020	**Stakeholder Engagement Process:** • Population health management/Annual open enrollment • Enhanced care management/In lieu of services • Behavioral health proposals • Full Integration Plans • NCQA
March 2020	**County Inmate Pre-Release Application Process:** Establish workgroup
April 2020	**County Oversight:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards
July 2020	**County Inmate Pre-Release Application Process:** Develop guidance • **County Oversight (CCS, CHDP):** Review of current standards, policies, and guidelines, and development of goals, performance measures, and metrics • **Global Payment Program:** Extended through December 31, 2025 • **Long Term Plan for Foster Care:** Workgroup meetings to inform policy recommendation (implementation timeline will be determined through stakeholder process)
October 2020	**County Inmate Pre-Release Application Process:** Stakeholder process

Date	Implementation Activity
December 31, 2020	**Medi-Cal 2020 1115 waiver expires along with**: Whole Person Care, PRIME, the Health Homes Program, California Children's Services pilot, designated state health programs, safety-net care pool, tribal uncompensated care
2021	
January 1, 2021	**Managed Care Authority:** Shifts to 1915(b) authority **Implementation of the following CalAIM proposals:** • Population health management • Enhanced care management/In lieu of services • Shared savings and incentive payments • PRIME transitions to Quality Improvement Program • Dental benefits and pay for performance • Managed care benefit standardization • Non-dual managed care enrollment standardization** • Long-term care integration • Regional rates Phase I • Behavioral health payment reform (at the earliest for HCPCS Level I code implementation) • Substance use disorder managed care renewal and policy improvements • Changes to behavioral health medical necessity **Behavioral Health Administrative Integration:** Begin in 2021 and continue over the five years of the waiver **County Inmate Pre-Release Application Process:** Begin technical Assistance (through December 2021) **Full Integration Plans:** Begin building managed care contract and request for proposal **County Oversight:** Begin assessing County Performance Standards **Long-Term Plan for Foster Care:** Policy work based on workgroup recommendations
April 2021	**County oversight:** Implementation of the "county performance monitoring dashboard" **County oversight (CCS, CHDP):** Development of auditing tools
July 2021	**County oversight:** Publication of the county performance monitoring dashboard on the CHHS Open Data Portal.
November-December 2021	First Medi-Cal managed care plan open enrollment period
2022	
January 1, 2022	**County Inmate Pre-Release Application Process:** Implementation **Full Integration Plan:** Post RFP (6 months) **Annual Open Enrollment:** Effective date of enrollment into Medi-Cal plans selected during first open enrollment period

Date	Implementation Activity
April 2022	**County Oversight (CCS, CHDP):** Evaluate and analyze findings and trends, identify gaps and vulnerabilities
July 2022	**Full Integration Plans:** Contracts awarded; establish readiness (18 months)
October 2022	**County oversight (CCS, CHDP):** Initiate Memorandum of Understanding between State and counties, shift to an automated PFG submission
December 31, 2022	**Cal MediConnect:** End of program
2023	
January 2023	**Duals:** • Require statewide mandatory enrollment of dual eligibles in a Medi-Cal managed care** • All Medi-Cal health plans required to operate Dual Eligible Special Needs plans in all service areas they operate as an Medi-Cal managed care plan **Regional Rates:** Implement Phase II regional rates statewide (at the earliest)
2024	
January 2024	**Full Integration Plan:** Go Live
2025	
January 2025	**NCQA:** All Medi-Cal managed care plans required to be NCQA accredited
2026	
January 2026	**Long-Term Services and Supports, Long-Term Care, Dual Eligible Special Needs Plans:** Full implementation **Behavioral Health Managed Care:** submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the 1915(b) waiver

*TBD: IMD SMI/SED waiver, regional contracting (will vary), improving beneficiary contact and demographic information

**Mandatory Managed Care enrollment: See Appendix G

2019 IHSS Success and Next Steps

Attachment Six

CSAC Memo: 2019 IHSS Success and Next Steps

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December 3, 2019

To: Members of the Health and Human Services Policy Committee

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

RE: 2019 In-Home Supportive Services Success and Next Steps

Throughout the 2019-20 budget process, CSAC continued to strongly advocate in support of the Governor's proposal to revise the County In-Home Supportive Services (IHSS) Maintenance of Effort (MOE), which was enacted into law in Senate Bill 80 (Chapter 27, Statutes of 2019). The enactment of the new County IHSS MOE was the culmination of two years of effort by CSAC, in partnership with counties, county affiliates, and other stakeholders, to advocate for a more sustainable fiscal structure for counties to manage IHSS costs and continue to deliver vital services on behalf of the state. SB 80 accomplishes those goals and CSAC is grateful to the Governor and the Legislature for this outcome.

County IHSS MOE Details. The major provisions of the County IHSS MOE established by SB 80 include:

- Lowering the County IHSS MOE base in 2019-20 from $2.06 billion to $1.56 billion,
- Reducing the MOE annual inflation factor from seven percent to four percent,
- Stopping the redirection of vehicle license fee (VLF) growth funds from Health, Mental Health, and County Medical Services Program to Social Services,
- Ending the State General Fund IHSS mitigation,
- Returning to the original method for calculating IHSS caseload and no longer utilizing accelerated caseload growth, and
- Funding IHSS administrative costs through a General Fund allocation.

The new MOE is made possible by a significantly increased and ongoing State General Fund commitment for IHSS. The state is contributing nearly $300 million more for IHSS costs in 2019-20, which grows to more than $600 million in 2022-23. Over the first four years of this new structure, the state's commitment has grown by $1.86 billion from what it would have been under prior legislation. Please see CSAC's *Overview of 2019-20 County IHSS MOE* for the full details on the major provisions of the new IHSS MOE.

There are also numerous IHSS wages, benefits, and collective bargaining provisions, which include:

- Maintaining the existing wage supplement tool,
- Maintaining the existing tool to allow limited state participation in local wage and health benefit increases above the state participation cap,
- Increasing the county share of costs and reducing the state share of costs for locally negotiated wage and benefit increases starting on January 1, 2022 when state minimum wage reaches $15.00 per hour,
- Eliminating the state participation cap when state minimum wage reaches $15.00 per hour, and
- Requiring MOE adjustments for future increases in the costs of health benefit premiums.

In addition, SB 80 creates a one-time 1991 Realignment withholding related to IHSS collective bargaining that could potentially apply to counties without a collective bargaining agreement in place. A county would be subject to the withholding only if all of the following four conditions are met: (1) A county and provider union have completed the full IHSS mediation and factfinding process; (2) the factfinding panel has issued recommended settlement terms that are more favorable to the union; (3) the county has an expired IHSS collective bargaining agreement; and (4) the county and union have not reached an agreement within 90 days after the release of the factfinding recommendations. CSAC worked tirelessly to achieve the best possible outcome for counties related to IHSS collective bargaining and the final provision is significantly improved from earlier proposals.

Finally, SB 80 requires the Administration to report to the Legislature on the status of IHSS collective bargaining contracts in every county. These reports must be submitted to the fiscal committees of the Legislature by January 10, 2020 and May 14, 2020. The Administration must consult with both CSAC and IHSS provider unions when determining the status of bargaining in each county. CSAC has surveyed counties to be able to share accurate and updated information with the Administration. Please see *IHSS Wages and Bargaining Provisions Brief*, which CSAC produced jointly with the County Welfare Directors Association and the California Association of Public Authorities, for full details about all of the provisions of SB 80 that relate to wages, benefits, and collective bargaining.

County MOE Amounts. One of the first tasks to implement the rebased IHSS MOE was to determine the individual county MOE amounts. CSAC formed an IHSS MOE Subcommittee of the existing CSAC IHSS Working Group to secure county input in developing the recommended MOE amounts. The Subcommittee was co-chaired Mono County Supervisor John Peters and Napa County Supervisor Belia Ramos, who co-chair CSAC's IHSS Working Group, and included County Administrative Officers (CAOs) from rural, suburban, and urban counties, as well as county technical experts. Once the Subcommittee developed the recommendations, all CAOs were briefed and CSAC's officers gave their approval for moving forward with the methodology. The Department of Finance and Department of Social Services have confirmed that they are moving forward with implementing the recommended amounts.

The IHSS MOE methodology takes a two-step approach to distribute the nearly $500 million decrease to get from the $2.06 billion MOE prior to the rebase to the rebased MOE of $1.56 billion. For the first step, the $330 million increase that would result from the end of the State General Fund mitigation and the $134.8 million increase that would result from the seven percent inflation factor were removed in the same county-by-county manner that they were added to establish a starting point. For the second step, the methodology provides every county with the same 2.01 percent decrease from the starting point to the individual county final MOE amounts. Please see CSAC's *2019-20 IHSS MOE County Amounts Methodology Brief* for complete details.

IHSS Training. On November 20, CSAC hosted an IHSS Training in partnership with the County Welfare Directors Association and the California Association of Public Authorities. Approximately 200 county staff from nearly every county gathered in Sacramento for a full day of training and discussion on IHSS. The training provided an overview of the new County MOE and collective bargaining provisions, information about the latest implementation updates, and an opportunity to engage with other counties about IHSS.

Next Steps. CSAC will continue to partner with counties, the Department of Finance, and the California Department of Social Services (CDSS) on implementation efforts related to the new County IHSS MOE.

This includes collaborating with CDSS on their official guidance for the 2019-20 MOE amounts and the IHSS MOE wage and benefit provisions.

CSAC is also engaged on IHSS as it relates to the state's Master Plan for Aging. In response to the Governor's Executive Order, the California Health and Human Services Agency is moving forward with developing a Master Plan for Aging by October 2020. The Executive Order establishes a Long-Term Services and Supports (LTSS) Subcommittee of the full Stakeholder Advisory Committee. The LTSS Subcommittee is required to issue a report by March 2020 that examines the growth and sustainability of LTSS programs, including IHSS, access to and financing of long-term care, impacts on the LTSS workforce, and includes recommendations to stabilize LTSS programs.

The LTSS Subcommittee includes three county and county affiliate representatives – Los Angeles County Supervisor Kathryn Barger, Sonoma County Human Services Director Karen Fies, and California Association of Public Authorities Executive Director Karen Keeslar. To help inform the work of the LTSS Subcommittee, the California Department of Social Services is hosting a series of IHSS listening sessions around the state. The purpose of these listening sessions is to provide recipients, providers, and other stakeholders the opportunity to provide input on sustainability strategies and IHSS program enhancements. CSAC will remain engaged on the Master Plan for Aging, including working closely with the county representatives on the LTSS Subcommittee to ensure county priorities are considered in the LTSS report.

Attachments

- Overview of 2019-20 County IHSS MOE
- IHSS Wages and Bargaining Brief
- 2019-20 IHSS MOE County Amounts Methodology Brief

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2019 IHSS Success and Next Steps

Attachment Seven

Overview of 2019-20 County IHSS MOE

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Overview of 2019-20 County IHSS MOE

November 2019

The Governor's proposal to revise the County In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) was enacted into law in Senate Bill 80 (Chapter 27, Statutes of 2019). The new IHSS MOE creates a more sustainable fiscal structure for counties to manage IHSS costs and continue to deliver vital services on behalf of the state. This resource provides a high level overview of the major provisions in SB 80 related to the IHSS MOE. Please see CSAC's *2019-20 IHSS MOE County Amounts Methodology Brief* for specific details about how the county amounts of the rebased MOE were determined. Please see *IHSS Wages and Bargaining Provisions Brief*, which CSAC produced jointly with the County Welfare Directors Association and the California Association of Public Authorities, for full details about all of the provisions of SB 80 that relate to wages, benefits, MOE adjustments, and collective bargaining.

Advocacy for Sustainable IHSS Structure

As part of the legislation that established the 2017 IHSS MOE, CSAC advocated for a provision that required the Department of Finance to reexamine the IHSS fiscal structure during the development of the 2019-20 budget. Specifically, the Department of Finance was required to submit findings and recommendations to the Legislature by January 2019 on several elements including the availability of 1991 Realignment funds to cover program costs, the growth of IHSS, the impact of the IHSS MOE on health and mental health programs, and the status of collective bargaining. The Department of Finance's Senate Bill 90: 1991 Realignment Report contains the recommendations that were included in the Governor's IHSS MOE proposal and enacted into law in SB 80.

CSAC partnered with counties, county affiliates, and other stakeholders for nearly two years to advocate for a more sustainable fiscal structure for counties to manage IHSS costs and continue to deliver other important health and behavioral health services on behalf of the state. SB 80 accomplishes those goals and CSAC is grateful to the Governor and the Legislature for this outcome.

2019-20 Statewide IHSS MOE

Senate Bill 80 establishes a new 2019-20 County IHSS MOE with a statewide amount of $1.56 billion. The Department of Finance determined this new amount by fully following through existing law at the time through the end of 2018-19 to develop a 2019-20 MOE prior to the rebased amount. That MOE total was $2.06 billion and results from the 2018-19 MOE, MOE adjustments for local wage and benefit increases in 2018-19, and the seven percent inflation factor. Once that amount was determined, the Department of Finance calculated the incremental increase over 2018-19, incorporated the available 1991 Realignment revenues, and determined a new lowered MOE base that would fit within the Realignment revenues available to counties.

In addition to lowering the MOE, SB 80 also lowers the annual inflation factor from seven percent to four percent. The County IHSS MOE will only increase by the annual inflation factor and the county share of any locally negotiated wage and benefit increases. The new MOE contains only one MOE component for services, and does not have the four separate MOE components (Services, County Administration, Public Authority Administration, Case Management Information and Payrolling System) that were included in the 2017 MOE. The State will fund IHSS administrative costs through a General Fund allocation. Counties will be responsible for any administrative costs above the State General Fund allocation for administrative costs.

State General Fund Commitment
The new MOE is made possible by a significantly increased and ongoing State General Fund commitment for IHSS. The state is contributing nearly $300 million more for IHSS costs in 2019-20, which grows to more than $600 million in 2022-23. Over the first four years of this new structure, the state's commitment has grown by $1.86 billion from what it would have been under prior legislation.

IHSS Mitigations
With the lowered MOE and the increased State General Fund commitment, the new IHSS MOE is nearly $500 million lower in 2019-20 than it would have been under prior legislation and fits within available 1991 Realignment revenues. Therefore, the IHSS mitigations, or offsetting revenue, that existed under the 2017 IHSS MOE are not included with the new MOE. The State General Fund offset ended as the state is now covering an increased share of IHSS costs rather than providing an offset to counties. The redirection of vehicle license fee (VLF) growth funds from Health, Mental Health, and County Medical Services Program to Social Services ends earlier than outlined under prior legislation. The final year for the redirection of this VLF growth was the 2018-19 Realignment year. The process of accelerated caseload growth for IHSS is also discontinued after the 2018-19 Realignment year. IHSS caseload growth costs will now be included within the overall Social Services caseload growth calculation and two-year cycle. This is the same process that existed prior to the 2017 IHSS MOE.

2019 IHSS Success and Next Steps

Attachment Eight

IHSS Wages and Bargaining Brief

IHSS Wages and Bargaining Provisions Brief
November 2019

A new County In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) was established by SB 80 (Chapter 27, Statutes of 2019). The new IHSS MOE creates a more sustainable fiscal structure for counties to manage IHSS costs and continue to deliver vital services on behalf of the state. Please see CSAC's *Overview of 2019-20 County IHSS MOE* for the full details on the major provisions of the new IHSS MOE including the new MOE amount, inflation factor, and State General Fund commitment. SB 80 also contained several significant provisions related to MOE adjustments for locally negotiated wage and benefit increases, as well as impasse procedures for collective bargaining between counties and IHSS provider unions. This resource provides an overview of these tools and procedures, some of which continue from the 2017 IHSS MOE legislation and others that change. CSAC, CWDA, and CAPA will continue working with the Department of Finance and the California Department of Social Services (CDSS) on implementation and guidance related to these provisions.

Overview of Changes under SB 80
SB 80 continues many of the new collective bargaining tools and MOE adjustment provisions that were established by the 2017 IHSS MOE legislation. However, there are some notable differences. Below is a table providing brief highlights of the key consistencies and changes. The full details about all of the below items can be found throughout this document.

Consistent with 2017 IHSS MOE legislation	• State approval of rate increases • Wage supplement tool • MOE adjustment calculations
Changes in 2019	• MOE adjustments for increases in health benefit premiums • Impasse procedures/Realignment withholding
No immediate changes, but changes in 2022	• State/County share of costs in local wage/benefit increases • State participation cap • State participation above the cap tool

State Approval for Changes in IHSS Provider Wages and Benefits
All counties must meet the requirements of Welfare and Institutions Code § 12302.25 to act as or establish an employer of record for IHSS and to meet and confer pursuant to the Meyers-Milias-Brown Act. Most counties have established a Public Authority to fulfill these requirements. The state must review and approve the Public Authority rate for wages, health benefits, and other economic terms of a local bargaining agreement before the changes can take effect. The same procedures and funding requirements apply for any wage or benefit change that is locally negotiated, mediated, imposed, or adopted by ordinance. The state does not have the authority to approve or deny locally negotiated wages and benefits, but can review the rate change

request for compliance with state and federal law. It is important to note that the state has never denied a rate increase. Counties must provide CDSS with documentation of the County Board of Supervisors' approval of the proposed public authority or nonprofit consortium rate.

Increases to the hourly wage and benefits will not take effect until both CDSS and the Department of Health Care Services have determined that the increase is consistent with federal law to ensure federal financial participation and CDSS has reviewed for compliance with state law. The rate increases will go into effect on the first day of the month after the month that final approval by the state is granted. A request to change the Public Authority rate must be made at least 60 calendar days, but not more than 90 calendar days, prior to the requested effective date of the change.

State Financial Participation in Wages and Benefits

Currently, the state will participate in 65 percent of the non-federal share of costs of wages and health benefits up to $13.10 per hour, which is the current state participation cap. As the state minimum wage continues to increase, the cap on state participation will continue to rise to $1.10 above the increased state minimum wage. The sum of the hourly wage plus the amount of the hourly rate for health benefits establishes the total amount that determines the level of state financial participation. For example, if a county has a provider wage of $12.60 per hour and provides health benefits of $0.50 per hour, then the county would be at the state participation cap. Counties will pay the entire non-federal share of costs for any wage or health benefit increase that is above this cap. However, there is a provision that will allow limited state participation above this cap and that is detailed in the *State Participation Above the Cap* section.

Starting January 1, 2022

On the date that state minimum wage reaches $15.00 per hour, currently scheduled for January 1, 2022, there will be changes to the state participation level. The state participation in the non-federal share of a wage, health benefit, or non-health benefit increase will decrease to 35 percent and the county will then be responsible for 65 percent of the non-federal share of costs. Also on this date, the state participation cap will be eliminated. The state will participate in all approved wage and health benefit increases, no matter how far above the state minimum wage. However, state participation will be at the reduced level of 35 percent of the non-federal share of costs. This change in state participation applies to all increases in wages or benefits that go into effect on or after January 1, 2022. Increases that are negotiated prior to January 1, 2022, but that go into effect on that date or later will be subject to the new reduced state participation level. Below is a table that shows the state minimum wage and state sharing through 2022.

Year	State Minimum Wage	State Participation Cap	State Share of Non-Federal Costs Under the Cap
January 1, 2019	$12.00 per hour	$13.10	65%
January 1, 2020	$13.00 per hour	$14.10	65%
January 1, 2021	$14.00 per hour	$15.10	65%
January 1, 2022	$15.00 per hour	No cap	35%

MOE Adjustments for Wage Increases

The County IHSS MOE will be adjusted for the annualized cost of increases in provider wages that are locally negotiated, mediated or imposed on or after July 1, 2019, including those increases that result from being adopted by a local ordinance. The MOE adjustment shall reflect

the County's share of costs for the wage increase. The annualized MOE adjustment will be calculated based on the county's 2019-20 paid IHSS hours, any inflation factors that have occurred to that point, and the appropriate cost-sharing ratio. The annual four percent inflation factor will apply to any MOE adjustments. CSAC, CWDA, and CAPA are engaged in ongoing discussions with the Administration related to guidance on MOE adjustments for wage increases.

Wage Supplement

Counties have the ability to negotiate a wage increase as a wage supplement, which is a specified amount that is in addition to the county provider wage and is subsequently applied on future dates. Consistent with the 2017 IHSS MOE legislation, SB 80 does not make any changes to a counties' ability to negotiate a wage supplement, how the wage supplement works, or create an end date for use or applications of the wage supplement. All counties, whether at minimum wage, above minimum wage, or above the state participation cap can use the wage supplement tool. The wage supplement can also be used in conjunction with the state participation above the cap tool. When submitting a rate increase for approval, counties must specify in both the collective bargaining agreement and in the rate change request that the wage increase is a wage supplement.

When a wage supplement is first negotiated and applied, there is an adjustment to the County IHSS MOE for the county share of the wage supplement. A wage supplement will be subsequently applied when the state minimum wage equals or exceeds the county provider wage absent the wage supplement amount. For subsequent applications of the wage supplement, there is no new adjustment to the County IHSS MOE. The state participation level in the non-federal costs of the wage supplement depends on if the county is below the state participation cap, if the county is using a tool to garner state participation above the cap, and if the wage supplement goes into effect prior to January 1, 2022 (when the state participation level changes).

<u>Example of Wage Supplement</u>

In 2020, if a county's provider wage is $13.10 per hour and the county negotiates a $0.50 wage supplement, the amount the IHSS provider is paid would increase to $13.60 per hour ($13.10 provider wage plus $0.50 supplement) and there would be an MOE adjustment for the county share of the $0.50 increase. When the state minimum wage increases to $14.00 per hour in 2021, it passes the provider wage absent the wage supplement of $13.10 per hour and the wage supplement would be subsequently applied, bringing the total wage to $14.50 per hour ($14.00 provider wage from new minimum wage plus $0.50 supplement). There would be no new MOE adjustment for this subsequent application of the $0.50 wage supplement. Below is a table that demonstrates how this example would work.

	1/1/2020	**1/1/2021**	**1/1/2022**
State minimum wage	$13.00	$14.00	$15.00
County provider wage	$13.10	$14.00	$15.00
Wage supplement	$0.50	$0.50	$0.50
Total amount IHSS provider is paid	$13.60	$14.50	$15.50

State Participation Above the Cap (10 Percent Over Three Years)
The tool that was established by the 2017 IHSS MOE legislation and allows the county to secure state participation in the non-federal share of costs of a wage or health benefit increase for counties that are above the state participation cap continues under SB 80. Under the 2017 IHSS MOE legislation, there was already a requirement that a three year period must be started prior to January 1, 2022. The 2019 IHSS MOE legislation continues that requirement, but the SB 80 provision that changes the state participation level on January 1, 2022 does have implications for the use of this tool, which are discussed further in this section.

All counties that have individual provider wages and health benefits currently equal to or above the state participation cap or that will increase to an amount equal to or above the cap, are eligible to utilize the 10 percent over three years state participation provision. Counties are able to utilize this tool in conjunction with the wage supplement to secure state participation in part or all of a wage supplement that is above the cap. When submitting a rate increase for approval, counties must specify and select that they are utilizing this tool to secure state participation above the cap.

The state will participate in a cumulative total of up to a 10 percent increase in the sum of the combined total of changes in wages or health benefits, or both over a three-year period. The state will participate in the non-federal costs of provider wage and/or health benefit increases for no more than two three-year periods. The second three-year period must begin after the first three-year period has ended. Counties that utilized a three-year period starting under the 2017 MOE must wait for the entire three-year period to end before commencing a second three-year period. The county will be responsible for the entire non-federal costs of any increases above the ten percent amount in a three-year period prior to January 1, 2022. If the first three-year period ends prior to January 1, 2022 and no second three-year period is utilized, the county will pay the entire non-federal share of costs of provider wage and/or health benefit increases above the state participation cap that take effect after the end of the three-year period and prior to January 1, 2022.

<u>Example of State Participation Above the Cap for County not yet at Cap</u>
In 2020, the state participation cap is $14.10. If a county's provider wage is $13.00 per hour and health benefits are $0.75 per hour, the total wages and benefits are $13.75 per hour. Prior to utilizing this tool, the county could secure state participation up to a $0.35 increase in wages or health benefits. At that point, the county would be at the state participation cap of $14.10 and the county would then be eligible to use this tool to secure state participation up to an additional $1.41 of an increase in wages or health benefits over three years. Below is a table demonstrating this example.

State Participation Cap in 2020	$14.10
County Wage in 2020	$13.00
County Health Benefits in 2020	$0.75
County Total	$13.75
Amount Available for State Participation from Being Under Cap	$0.35
Amount Available for State Participation from 10 Percent Over Three Years Provision	$1.41

Example of State Participation Above the Cap for County Already Above the Cap

The ten percent amount is not ten percent of the state participation cap, but rather ten percent of the total county wages and health benefits at the time the tool is used. This is relevant for a county that is already above the state participation cap. In 2020, if a county's provider wage is $14.50 per hour and health benefits are $0.50 per hour, the total wages and benefits are $15.00 per hour, which is above the $14.10 state participation cap. This means the county could secure state participation in up to a $1.50 increase (10 percent of $15.00) over three years. Below is a table demonstrating this example.

State Participation Cap in 2020	$14.10
County Wage in 2020	$14.50
County Health Benefits in 2020	$0.50
County Total	$15.00
Amount Available for State Participation from 10 Percent Over Three Years Provision	$1.50

Starting January 1, 2022

On this date, assuming the state minimum wage reaches $15.00 per hour, the state participation cap is eliminated meaning there will no longer be a limit on wage and health benefit increases that the state participates in. The practical effect of this is that any three-year period that is started under the 2019-20 MOE will not be a full three years, but rather will go from the implementation date of the increase that initiates the use of the tool until December 31, 2021. This also means that for any increases that go into effect on January 1, 2022 or later, whether they were negotiated to use the ten percent over three years tool or not, the state participation will be 35 percent of the non-federal share and the county share will be 65 percent of the non-federal share.

MOE Adjustments for Health Benefits

The County IHSS MOE will be adjusted for the annualized cost of increases in health benefits that are locally negotiated, mediated or imposed on or after July 1, 2019, including those increases that result from being adopted by a local ordinance. The hourly rate for health benefits is included in the calculation for the state participation cap. For a county to secure state participation in 65 percent of the non-federal share of a health benefit increase, the increase must be under the state participation cap or the county must utilize the ten percent over three years tool that is detailed above. Consistent with the change on wages, the state participation in a locally negotiated health benefit increase will decrease to 35 percent of the non-federal share on January 1, 2022 and there will be no state participation cap on that date.

Under the prior MOEs, there was an MOE adjustment each time there was an increase in either the fixed total amount or fixed hourly rate for health benefits. There was no MOE adjustment when the cost of health benefits went up due to an increase in the capitated amount paid to a health plan. SB 80 contained language that requires MOE adjustments for the county share of costs for any future cost increases in health benefit premiums. When the cost of health benefits that are included in a collective bargaining agreement increase and the county submits a rate increase to reflect that increase, there will be an MOE adjustment for the county share of these increased health benefit costs. For any collective bargaining agreement that was submitted to CDSS for approval prior to July 1, 2019, this provision does not apply and there will not be a county MOE adjustment for increases in the cost of health benefit premiums through the end

date of the collective bargaining agreement. CSAC, CWDA, and CAPA are engaged in ongoing discussions with the Administration related to MOE adjustments for health benefits.

MOE Adjustments for Non-Health Benefits
The County IHSS MOE will be adjusted for the annualized cost of increases in certain non-health benefits that are locally negotiated, mediated or imposed on or after July 1, 2019, including those increases that result from being adopted by a local ordinance. Non-health benefits are not included in the state participation cap. The state will participate in 65 percent of the non-federal share of the increase in non-health benefits. On January 1, 2022, consistent with the change for wages and health benefits, the state participation in non-health benefits will be reduced to 35 percent of the non-federal share.

Typically, non-health benefits have included transportation passes, training stipends, and safety equipment. SB 80 outlines that CDSS can determine that the state does not participate in certain non-health benefits, but must do so in consultation with CSAC. CSAC, CWDA, and CAPA are engaged in ongoing discussions with the Administration on MOE adjustments and state financial participation for non-health benefits.

Procedures to Resolve Differences in Collective Bargaining
SB 80 continues the procedures that were created under the 2017 IHSS MOE legislation to help the county and provider union reach agreement on a new Memorandum of Understanding (MOU). Either the Public Authority or the union representing IHSS workers may request mediation to be conducted by State Mediation & Conciliation Services, which is a division of the Public Employment Relations Board (PERB). Mediators have no authority to impose a settlement, but can be useful in helping the parties look at the problem from a new perspective and find common ground. Unlike the Meyers-Milias-Brown Act, mediation is required if only one party initiates the request; neither the employer nor the union can block mediation. State Mediation & Conciliation Services will designate a pool of no more than five qualified individuals with relevant subject matter expertise, priority given to IHSS expertise, to serve as mediators or on a factfinding panel. The mediation shall take place within 15 business days from when it was requested. If there is no agreement on a mediator, State Mediation & Conciliation Services will appoint one from the pool.

If no agreement is reached through mediation, then the parties will move to factfinding. It is also possible to bypass mediation and move directly to factfinding if both parties agree. With the assistance of State Mediation & Conciliation Services, a factfinding panel is appointed which reviews both parties' proposals, holds hearings and ultimately recommends a settlement. The factfinding panel must recommend advisory terms of settlement within 30 days after being appointed by State Mediation & Conciliation Services. Either party may then request post-factfinding mediation, which shall take place within 15 days. When the services of a mediator or factfinding panel are utilized, the costs will be split equally between the parties. Timelines can be extended if there are no individuals available to serve as mediators or on a factfinding panel. The findings of fact and recommended settlement terms will not be made public until mediation has finished. The County Board of Supervisors is required to hold a public hearing within 30 days after the public release of the factfinding panel's recommended settlement terms.

Realignment Withholding
SB 80 creates a one-time 1991 Realignment withholding related to IHSS collective bargaining that could potentially apply to counties without a collective bargaining agreement in place. A county would be subject to the withholding only if all of the following four conditions are met: (1) A county and provider union have completed the full IHSS mediation and factfinding process

described in the previous section; (2) the factfinding panel has issued recommended settlement terms that are more favorable to the union; (3) the county has an expired IHSS collective bargaining agreement; and (4) the county and union have not reached an agreement within 90 days after the release of the factfinding recommendations.

The language that authorizes the withholding went into effect on October 1, 2019 and will become inoperative on January 1, 2021. For any county that has already gone through mediation and factfinding with recommended settlement terms issued prior to June 30, 2019, the county will have 90 days to reach an agreement or the withholding will occur on October 1, 2019. The withholding will be equivalent to one percent of a county's 2018-19 IHSS MOE amount prior to any of the offsets that were received. The withholding will occur through an adjustment to the county's Social Services Realignment base. The Social Services Realignment base will be restored by the amount of the withholding in the next fiscal year. The Public Employment Relations Board is required to notify the county, the provider union, the Department of Finance, and the State Controller of any withholding.

Reports on the Status of Collective Bargaining
SB 80 also requires CDSS to report to the Legislature on the status of IHSS collective bargaining contracts in every county. These reports must be submitted to the fiscal committees of the Legislature by January 10, 2020 and May 14, 2020. CDSS must consult with both CSAC and IHSS provider unions when determining the status of bargaining in each county.

2019 IHSS Success and Next Steps

Attachment Nine

2019-20 IHSS MOE County Amounts Methodology Brief

2019-20 IHSS MOE County Amounts Methodology Brief

August 2019

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One of the first tasks to implement the rebased MOE is to determine the individual county MOE amounts. The Department of Finance is required to consult with CSAC on making these determinations. This document outlines the methodology that was utilized to determine the individual county amounts of the rebased 2019-20 IHSS MOE.

Process for Developing Methodology

CSAC formed an IHSS MOE Subcommittee of the existing CSAC IHSS Working Group to secure county input in developing the recommended MOE amounts. The Subcommittee was co-chaired Mono County Supervisor John Peters and Napa County Supervisor Belia Ramos, who co-chair CSAC's IHSS Working Group, and included County Administrative Officers (CAOs) from rural, suburban, and urban counties, as well as county technical experts. Once the Subcommittee developed the recommendations, all CAOs were briefed and CSAC's officers gave their approval for moving forward with the methodology. The recommended MOE amounts were then shared with the Administration for their consideration. The Department of Finance and Department of Social Services have confirmed that they are moving forward with implementing the recommended amounts.

2019-20 Statewide IHSS MOE

Senate Bill 80 establishes the statewide 2019-20 County IHSS MOE at $1.563 billion. The Department of Finance determined this new amount by fully following through existing law at the time through the end of 2018-19 to develop a 2019-20 MOE prior to the rebased amount. That MOE total was $2.06 billion and results from the 2018-19 MOE, MOE adjustments for local wage and benefit increases in 2018-19, and the seven percent inflation factor.

Once that amount was determined, the Department of Finance calculated the incremental increase over 2018-19, incorporated the available 1991 Realignment revenues, and determined a new lowered MOE base that would fit within the Realignment revenues available to counties. This $1.563 billion amount becomes the new County MOE in 2019-20 and only increases from there by a lowered annual four percent inflation factor and adjustments for local wage and benefit increases. The lowered County MOE is made possible by an increased State General Fund commitment for IHSS costs that is ongoing and that totals nearly $2 billion in the first four years of this new structure. The State General Fund offset, redirected vehicle license fee (VLF) growth, and accelerated caseload growth mitigations that existed under the prior 2017 MOE end under the new MOE. The 2019-20 MOE contains only one MOE component for services, and does not have the four separate MOE components that were previously included.

IHSS MOE Methodology

The IHSS MOE methodology distributes the nearly $500 million decrease to get from the $2.06 billion MOE prior to the rebase to the final rebased MOE of $1.563 billion.

Step One: Remove County Specific Increases from End of State General Fund Mitigation and Seven Percent Inflation Factor in the Same Manner they were Added

For the first step, a starting point was established that incorporated the existing county MOE and how the increased costs were added prior to the rebase. While the MOE is being lowered by nearly $500 million from what it would have been, the increased amount over the final 2018-19 MOE after MOE adjustments for local wage and benefit increases were added directly results from specific individual county amounts. The methodology reflects that these amounts needed to be removed in the exact same manner. The $330 million increase that would result from the end of the State General Fund mitigation and the $134.8 million increase that would result from the seven percent inflation factor were removed from the $2.06 billion total MOE amount prior to the rebase in the same county-by-county manner that they were added.

The result of this is a statewide starting point of $1.595 billion with corresponding individual county starting points that add to this total. This starting point is only $32.1 million higher than the final rebased 2019-20 MOE amount of $1.563 billion. Below is a table that demonstrates this statewide starting point.

2019-20 IHSS MOE

2018-19 County MOE after General Fund Mitigation	$1.523 billion
2018-19 Annualized MOE Adjustments	$72.4 million
Increase to MOE from End of General Fund Mitigation	$330 million
Increase to MOE from Seven Percent Inflation Factor	$134.8 million
Total 2019-20 Prior to Rebase	$2.06 billion
Remove General Fund Mitigation Increase	-$330 million
Remove Inflation Factor Increase	-$134.8 million
Starting Point for Determining Rebased County Amounts	$1.595 billion
Difference from Starting Point to Rebased 2019-20 MOE	-$32.1 million
Rebased 2019-20 MOE	$1.563 billion

Step Two: Provide Equal Percent Decline for Every County for Remaining MOE Decrease

Once this starting point was established, the next task was to determine how to distribute the remaining $32.1 million decrease among the 58 counties. This calculates to a statewide decrease of 2.01 percent from the starting point to the final MOE amount. The methodology will provide every county with this same 2.01 percent decrease from the individual county starting point amounts to the individual county final MOE amounts.

In addition to the results described above, this methodology also accomplishes the following outcomes:

- The full annualized MOE adjustment amount was added to the MOE for any county that increased wages or benefits in 2017-18 or 2018-19.
- Any county that did not increase wages or benefits in 2018-19 will have a 2019-20 MOE amount that is lower than the county's 2018-19 MOE after General Fund offset.
- Any county that did increase wages or benefits in 2018-19 will have a 2019-20 MOE amount that is lower than the sum of the county's 2018-19 MOE after General Fund offset and the annualized MOE adjustment for that wage or benefit increase.

Health and Human Services 2019 Year in Review and 2020 Priorities

Attachment Ten

CSAC Memo: Health and Human Services 2019 Year in Review and 2020 Priorities

December 3, 2019

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

RE: 2019 Legislative Review and 2020 HHS Priorities: ACTION ITEM

Outcomes of Health and Human Services Issues for 2019.

There were several significant issues that dominated the focus of the HHS team in 2019 – homelessness, In-Home Supportive Services, Continuum of Care Reform enhancements, child support funding, and behavioral health services. We also engaged on numerous other key legislative issues. This section describes the outcomes for the most significant HHS issues in 2019.

Homelessness

Securing funding in the state budget to address the local homelessness crisis was a top priority across multiple CSAC policy teams this year. The Budget package approved by the Legislature and sent to the Governor included more than $650 million in funding to assist local governments in addressing homelessness for a spectrum of housing options, from short-term shelters to new affordable housing units to permanent supportive housing units for those living with severe mental illness.

- $275 million will be available to cities or a city and county that has a population of more than 300,000.
- $175 million will be available directly to counties.
- $190 million will be available to local Continuums of Care.

The package also included funding for several health human services programs, such as additional funding for the Bringing Families Home program and Whole Person Care. The nine major programs funded in the 2019-20 Budget Act include:

- $120 million for county Whole Person Care to help provide housing options for participants and to expand to more counties
- $25 million for the Bringing Families Home program
- $14.6 million ongoing for the CalWORKs Homeless Assistance Program and trailer bill language to allow the use of assistance for up to 16 cumulative days
- $8 million to provide housing support for older foster youth
- $5 million to support housing navigators to help young adults aged 18 to 21 secure and maintain housing, with priority given to foster youth
- $5.6 million for the Los Angeles Homeless Service Authority's work in Service Project Area 3
- $5 million for grants to limit barriers for homeless individuals with pets
- $1 million to fund Encinitas, Carlsbad, Oceanside, and Vista with $250,000 each for homelessness prevention and intervention services in partnership with the Community Resource Center

In addition to the budget package, CSAC also supported AB 728 (Chapter 337, Statutes of 2019) by Assembly Member Miguel Santiago, which was signed by the Governor. This measure expands the current authority of county homeless adult and family multidisciplinary personnel teams (MDT) in seven counties to allow for data sharing regarding individuals who are at risk of homelessness, and expands who can be included on the MDT.

In-Home Supportive Services (IHSS)

For the past two years, CSAC led a sustained push to secure a more stable fiscal structure for counties to manage In-Home Supportive Services (IHSS) costs and deliver other services on behalf of the state. These efforts included a County IHSS Working Group that was co-chaired by two Supervisors and included county administrative officers and county affiliate partners. This dedication paid off in 2019 with the Governor proposing in January to revise the County IHSS Maintenance of Effort (MOE). CSAC strongly supported this proposal and worked to successfully enact it into law.

With this new MOE, the state is contributing nearly $2 billion more in State General Fund for IHSS costs over the first four years of this new and ongoing structure. The major provisions of the County IHSS MOE established by SB 80 include:

- Lowering the County IHSS MOE base in 2019-20 from $2.06 billion to $1.56 billion,
- Reducing the MOE annual inflation factor from seven percent to four percent,
- Stopping the redirection of vehicle license fee (VLF) growth funds from Health, Mental Health, and County Medical Services Program to Social Services,
- Ending the State General Fund IHSS mitigation,
- Returning to the original method for calculating IHSS caseload and no longer utilizing accelerated caseload growth, and
- Funding IHSS administrative costs through a General Fund allocation.

For more information on the IHSS MOE, collective bargaining provisions, and implementation efforts, please see the *IHSS Success and Next Steps* memo in this agenda packet.

CSAC also engaged on several bills that would impact the IHSS program including AB 426 (Chapter 424, Statutes of 2019), authored by Assembly Member Brian Maienschein. This bill will prohibit an individual from being charged by a licensed health care professional for the completion of the IHSS medical certification form. CSAC and the County Welfare Directors Association of California collaborated closely with the author, sponsors, the Legislature, and the Administration to negotiate AB 426 language that wouldn't negatively impact county IHSS eligibility determination processes.

Aging: SB 228 (Jackson)

California's aging population is projected to grow significantly in the coming years. As California begins to determine how to manage the aging population, members of the Legislature authored several measures to assist with the upcoming challenges and opportunities, including SB 228 (Chapter 742, Statutes of 2019) by Senator Hannah-Beth Jackson. This bill requires the Secretary of the California Health and Human Services (CHHS) Agency to coordinate with the Director of the Department of Aging to lead the implementation process for the Master Plan for Aging established by Executive Order N-14-19 and identify policy changes needed to prepare for California's aging population. The Master Plan for Aging Stakeholder Advisory Committee includes representatives from a wide range of systems including

local government. CSAC supported the bill through the legislative process and was pleased to have Governor Newsom sign SB 228.

Child Welfare: Family Urgent Response System, AB 826 (Reyes) & AB 1301 (Cooley)

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

AB 826, authored by Eloise Gómez Reyes, was related to the provision of behavioral health services to children placed out of their home counties by child welfare agencies and probation departments. In partnership with the County Welfare Directors Association of California, County Behavioral Health Directors Association of California, and the Chief Probation Officers of California, CSAC worked with the author's office on a series of amendments. AB 826 has become a two-year bill and CSAC will continue to engage with the authors and stakeholders in 2020.

For two years CSAC has supported establishing the Family Urgent Response System to provide immediate response to foster youth and their caregivers in a crisis. This system will help prevent the unnecessary separation of youth from their caregiver and ensure access to needed services in a time of crisis. The program was enacted and funded in the 2019-20 Budget with $15 million for 2019-20 and $30 million in the following year.

CSAC additionally supported AB 1301 (Chapter 827, Statutes of 2019) by Assembly Member Ken Cooley. This bill will transfer the administration of the Private Adoption Agency Reimbursement Program (PAARP) from the California Department of Social Services (CDSS) to county child welfare departments. Funding will be provided to counties to reimburse PAARP expenses and allow counties more flexibility for the use of funds. The Legislature approved the bill which was signed by Governor Newsom.

Social Services Program Eligibility: AB 1377 (Wicks) & AB 1403 (Carrillo)

CSAC actively engaged on AB 1403, authored by Assembly Member Wendy Carrillo. The bill would have required counties to alter their locally-established General Assistance (GA) or General Relief (GR) eligibility levels to provide additional county-funded assistance to certain parents who are no longer eligible for the California Work Opportunity and Responsibility to Kids program. CSAC and county affiliates were successful in negotiating language that would remove our opposition, but the bill was ultimately held in the Senate Appropriations Committee prior to being amended. The agreed upon language represents a positive outcome that recognizes that an expansion of GA benefits needs to be accompanied by a funding source and prioritized in the annual state budget negotiations.

Assembly Member Buffy Wicks authored AB 1377 (Chapter 461, Statutes of 2019), a bill requiring the California Department of Social Services, the Department of Health Care Services, the Department of Education, and stakeholders to examine ways to increase enrollment for free and reduced meals program participants into the CalFresh nutrition benefit program. CSAC supported this bill, which was sponsored by CWDA, as a step towards increasing the CalFresh utilization rate throughout the state.

Funding for Child Support Programs

The Budget included an increase of $56 million General Fund ($19.1 million General Fund and $36.9 million federal funds) for local child support agencies (LCSAs) in 2019-20. The trailer bill language approved funding through an interim methodology for 2019-20. The Department of Child Support Services is required to work with stakeholders, including the Child Support Directors Association, to propose updates to this methodology by February 1, 2020, and also to work toward the implementation of an ongoing methodology in 2020-21. CSAC has supported efforts to increase funding for LCSAs and will be active on the stakeholder workgroup enacted by the 2019-20 Budget.

Behavioral Health: AB 1642 (Wood), SB 10 & SB 11(Beall)

CSAC continues to work on a range of behavioral health proposals, bills, and issues which look to change how funding sources are used by counties, assist with the workforce shortage, clarify mental health parity standards, and enforce network adequacy standards.

AB 1642 (Chapter 465, Statutes of 2019), authored by Assembly Member Jim Wood, began as an overly broad measure that provided the Department of Health Care Services (DHCS) additional authority to place sanctions on health plans, including county-administered mental health plans, that could reduce or negatively impact patient services. CSAC and county affiliates proposed several amendments to the language which identified the Department's current sanctioning authority and requested state accountability and transparency. Through negotiations, CSAC was able to eliminate our opposition and ultimately remain neutral on the measure, which was approved by the Legislature and signed by Governor Newsom.

CSAC continues to prioritize behavioral health enhancement legislation. Senator Beall authored two bills that were supported by CSAC. SB 10 would have established a statewide behavioral health peer support specialist certification program for individuals with lived behavioral health experience. The use of peer support specialists has gained support in the wake of the behavioral health workforce shortage. Counties supported this certification program, but Governor Newsom ultimately vetoed the bill. Senator Beall's SB 11 would require the Department of Managed Health Care and the Department of Insurance annually to report to the Legislature on the steps taken to enforce mental health parity laws. Senator Beall made SB 11 a two-year bill after continued discussion.

Substance Use Disorder: AB 1031 (Nazarian) & SB 445 (Portantino)

CSAC continues to advocate and support legislation that will expand the quality and access to substance use disorder prevention and treatment. AB 1031, introduced by Assembly Member Adrin Nazarian, and SB 445, authored by Senator Anthony Portantino, both would have addressed the lack of statewide standards for youth substance use disorder treatment. Counties have identified the need for this guidance for the youth SUD comprehensive continuum. AB 1031 has become a two-year bill and SB 445 passed the Legislature, but was subsequently vetoed by Governor Newsom.

Emergency Medical Services: AB 1544 (Gipson) & SB 438 (Hertzberg)

CSAC partnered with county affiliates to negotiate amendments to two bills that would have altered community paramedicine pilots and eroded the medical authority of local emergency medical service agencies. AB 1544, authored by Assembly Member Mike Gipson, and SB 438 (Chapter 389, Statutes of 2019), authored by Senator Robert Hertzberg, were similar to bills authored by the same legislators in

2018. In 2018, CSAC and county affiliates were successful in their advocacy efforts, which ultimately resulted in a Governor Brown vetoing the paramedicine bill. In 2019, CSAC and county affiliates tirelessly worked with the bill's sponsors to negotiate provisions to clarify that local emergency medical service agencies retain medical control and which public agencies are granted first right of refusal. The willingness of the bill sponsors to negotiate, and advocacy efforts by CSAC and affiliates, ultimately led to satisfactory amendments on both bills and the removal of most of the problematic provisions. AB 1544 has become a two-year bill and is eligible for continued work, and Governor Newsom signed SB 438.

Top Health and Human Services Priorities for 2020.

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

Each policy committee is then tasked with examining and discussing the proposed priorities in their issue area and voting to approve draft priorities. Once approved by the policy committee, these draft priorities will be forwarded to the CSAC Board of Directors for final approval in early 2020.

The proposed 2020 HHS priorities were developed with the current state and federal political landscapes in mind. Please review these draft 2020 priorities and prepare for a discussion and action during the December 3 meeting of the policy committee.

The below section briefly describes the highest-level potential 2020 HHS Priorities. In addition to our highest-level priorities described below, there are myriad HHS issues that we have identified for counties to consider in 2020.

California Advancing and Innovating Medi-Cal (CalAIM)

Dubbed "California Advancing and Innovating Medi-Cal," or CalAIM, this ambitious package consists of state and federal proposals to simplify and streamline the Medi-Cal program. CalAIM has significant implications for many county health and human services functions, including behavioral health services, social services eligibility, county public hospitals, and cross-sector initiatives for foster youth and those who are homeless or incarcerated. Counties must focus on the federal, state, and local finance implications, as well as the impacts on county operations, successful programs, and the people and families we serve.

Behavioral Health Issues

County behavioral health services and funding will continue to dominate health and homelessness policy conversations in 2020. CSAC will work to gain additional flexibility within the Mental Health Services Act (MHSA, or Proposition 63 of 2004) and protect county fiscal stability and successful services through the state's CalAIM Medi-Cal proposal. CSAC will also focus on cross-sector collaboration and efforts to build robust and responsive services with schools, the criminal justice system, and other stakeholders.

Homelessness and Poverty Issues

Homelessness remains a top Association priority in 2020 and county health and human services programs remain a critical focus, including general relief/general assistance, federal welfare programs such as CalWORKs and CalFresh, conservatorships and changes to the Lanterman-Petris-Short Act, data sharing between county departments, child support changes, extended foster care, safe parking and other shelter programs, and behavioral health. Funding, flexibility, and facilitation of homeless solutions will be sought at all levels to help counties combat homelessness.

In-Home Supportive Services (IHSS)

CSAC will continue to prioritize the fiscal sustainability of the IHSS program. In 2019, CSAC supported the Governor's IHSS proposal which lead to the enactment of a lowered County IHSS Maintenance of Effort (MOE). In 2020, CSAC will work closely with the Administration and counties to continue implementing the new MOE and to engage on the IHSS collective bargaining provisions, including the required reports to the Legislature. In addition, the state is moving forward with the development of a Master Plan for Aging by October 2020 as required by the Governor's Executive Order. CSAC will remain engaged on the overall Master Plan for Aging and specifically any IHSS-related elements.

Child Welfare/Foster Care Funding and Implementation

CSAC will continue to partner with counties and county affiliates on implementing and securing adequate funding for efforts to improve outcomes for foster youth. AB 12 (Chapter 559, Statutes of 2010) extended foster care to youth up to age 21 and has shown significant positive results. The Continuum of Care Reform (CCR) is working to reduce the use of group homes and increase the availability of trauma-informed services. Counties are fully engaged on expanding these services and achieving the goals of extended foster care and CCR. CSAC will seek additional state funding for these important reforms related to increased costs that counties are experiencing above a cap on county expenditures and the funding level that has been provided.

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