Health and Human Services Policy Committee
Thursday, May 19 • 10:45 a.m. – 12:00 p.m.
Regency Ballroom E&F • Hyatt Regency Sacramento
1209 L Street • Sacramento, CA

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

Note: This policy committee meeting is an in-person meeting only and is being held as part of the CSAC 2016 Legislative Conference.

10:45 a.m.	I.	**Welcome and Introductions** *Supervisor Ken Yeager, Committee Chair, Santa Clara County* *Supervisor Hub Walsh, Committee Vice Chair, Merced County*
10:50 – 11:00 a.m.	II.	**HHS Budget Update** *Farrah McDaid Ting, CSAC Legislative Representative* *Elizabeth Marsolais, CSAC Legislative Analyst*
11:00 – 11:10 a.m.	III.	**Jail Medical Costs Update** *Michelle Gibbons, Executive Director, County Health Executives Association of California*
11:10 – 11:30 a.m.	IV.	**IHSS Issues Update: Minimum Wage, Overtime, and County Administration** *Faith Conley, CSAC Legislative Representative* *Karen Keeslar, Executive Director, California Association of Public Authorities* *Diana Boyer, Senior Policy Analyst, County Welfare Directors Association of California*
11:30 a.m. – 12:00 p.m.	V.	**Presentation: Strategies for Creating Permanency for Older Foster Youth** *Don Nottoli, Supervisor, Sacramento County* *Gail Johnson Vaughan, Director Emerita/Chief Permanency Officer, Families NOW*
12:00 p.m.	VI.	**Adjournment**

ATTACHMENTS

Attachment One: HHS Budget Update

..... CSAC Memo: 2016-17 State Budget Update

Attachment Two: Jail Medical Costs Update

..... CSAC Memo: Jail Medical Costs Update

..... Presentation: Medi-Cal County Inmate Claiming Program

Attachment Three: IHSS Issues Update: Minimum Wage, Overtime, and County Administration

..... CSAC Memo: IHSS Issues Update

..... CSAC Memo: State Minimum Wage Increase (May 5, 2016)

..... CSAC Budget Letter: FLSA County Administration (March 1, 2016)

..... CSAC Budget Letter: IHSS Contract Mode Issue (March 3, 2016)

Attachment Four: Presentation – Strategies for Creating Permanency for Older Foster Youth

..... CSAC Memo: Strategies for Creating Permanency for Older Foster Youth

..... Handout: Permanent Families for Children Who Wait in Foster Care

..... Fact Sheet: AB 1879 (McCarty)

Attachment One

Memo: 2016-17 State Budget Update

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May 5, 2016

To: Members of the Health and Human Services Policy Committee

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

RE: 2016-17 State Budget Update

The Governor's May Revision to the January Budget is anticipated to be released the week of May 9, 2016, prior to the policy committee meeting. Staff will provide the committee with an update on health and human services budget issues, as well as CSAC budget priorities, based on the May Revision. CSAC is lobbying several HHS-related budget issues up to, and through, the Governor's May Revision. They include:

AB 403 Continuum of Care Reform – CSAC is working with the County Welfare Directors Association, the Chief Probation Officers of California and the County Behavioral Health Directors Association to determine county funding needs for AB 403 implementation. CSAC is also working on ongoing Proposition 30 questions surrounding AB 403 costs to affected county departments, including how to measure potential changes in service levels and costs.

County Medi-Cal Administration Funding – It is a CSAC 2016 priority to ensure that counties have enough administrative funding to handle the activities and workload associated with conducting Medi-Cal eligibility on behalf of the state. CSAC also supports the Governor's proposal to conduct a time study to gather data on the amount of time and work county eligibility staff is contributing.

Other Issues. A few of the other budget issues that CSAC has weighed in on include:

Adult Protective Services: CSAC will join the County Welfare Directors Association to advocate for $5 million (State General Fund) for statewide training of social work staff in the APS program.

In-Home Supportive Services Maintenance of Effort: CSAC has joined with the County Welfare Directors Association and the California Association of Public Authorities to oppose proposed trailer bill language that would raise the IHSS MOE for counties that provide IHSS services through what is known as "contract mode." Currently, only two counties are in contract mode, but the associations are opposing the precedent that the trailer bill language might set if enacted.

In-Home Supportive Services Overtime Implementation (FLSA): CSAC has joined with a large coalition of IHSS stakeholders in asking for regulatory cleanup to assist counties with implementing new federal and state IHSS overtime rules. Asks include changing IHSS task hours from a monthly to a weekly authorization, allowing 26 equal pay periods, and paying for certain travel and wait time services in arrears to ensure the IHSS recipient is properly cared for. Please also note that the implementation and cost of the new federal Fair Labor and Standards Act (FLSA) overtime regulations remain a state cost.

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Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524

Attachment Two

Memo: Jail Medical Costs Update
Presentation: Medi-Cal County Inmate Claiming Program

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May 5, 2016

To: Members of the Health and Human Services Policy Committee

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

RE: Jail Medical Costs Update

Background: CSAC and our county affiliate organizations have been working since early 2014 with Department of Health Care Services (DHCS) to develop a framework and guidance for counties seeking Federal Financial Participation (FFP) for county jail inmates who receive medical services outside of the jail for more than 24 hours.

The Medi-Cal County Inmate Program (MCIP) encompasses four subprograms:

1. Medi-Cal Adult County Inmate Program
2. Juvenile County Ward Program
3. County Compassionate Release Program
4. County Medical Probation Program

Major Considerations: As we continue to work on the program framework and guidance, there are a number of issues that require more consideration:

1. Administrative cost methodology
2. Retroactive claiming and eligibility
3. Timing

Next Steps: CSAC will provide counties with updates as additional implementation activities continue. We are finalizing an administrative costs framework and methodology, whereby each participating county will contribute to the state administrative costs of the program. We have also received a target implementation date from DHCS and timeline of activities for erecting the program prospectively, hopefully by this fall. We must also then develop a methodology for claiming costs retroactively as well.

CSAC has worked closely with the California Health Executives Association of California (CHEAC), the California Association of Public Hospitals (CAPH), and the California State Sheriffs Association (CSSA) on this process. We have invited the new executive director of CHEAC, Michelle Gibbons, to provide the policy committee with an informational update on the current issues relating to jail medical costs.

Attachments:

1. Presentation: Medi-Cal County Inmate Claiming Program

CSAC Staff Contacts:

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Medi-Cal County Inmate Claiming Program

Michelle Gibbons, Executive Director
CSAC Legislative Conference
Health and Human Services Policy Committee
May 19, 2016

Background

- Legislation
  - 2010 Budget - AB 1628 (Chapter 729, Statutes of 2010)
  - AB 396 (Chapter 394, Statutes of 2011)
- Authorizes DHCS to allow counties to receive FFP to the extent available for acute inpatient hospital services provided off the grounds of the jail for stays longer than 24 hours for adults and juveniles, respectively.

Jail Medical Costs

- Health Departments
- County Jail
- Probation (Juveniles)

Implementation

- Participation in the program is optional
- Counties that participate will be required to execute contracts with DHCS
- The most recent construct would allow providers to bill Medi-Cal directly as done for non-inmate services
- Counties responsible for reimbursing DHCS for the non-federal share.
  - Excluding services provided by public hospitals
- Participating Counties will be required to pay a portion of DHCS' administrative costs

Outstanding Issues

- Timeline
- Separate process needed for retro period
- Jail Medical Service Contracts
- Process for counties to reimburse the non federal share
- Eligibility guidance
  - Mid-month eligibility changes
  - Retro eligibility

County Collaboration

- California State Association of Counties (CSAC)
- California Association of Public Hospitals and Health Systems (CAPH)
- California State Sheriff's Association
- County Welfare Directors Association (CWDA)
- Chief Probation Officers Association of California (CPOC)
- County Health Executives Association of California (CHEAC)

Contact Information:

Michelle Gibbons, Executive Director
County Health Executives Association of California

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Attachment Three

Memo: IHSS Issues Update
Memo: CSAC Memo on State Minimum Wage Increase (May 5, 2016)
Letter: CSAC Budget Letter – FLSA County Administration (March 1, 2016)
Letter: CSAC Budget Letter – IHSS Contract Mode Issue (March 3, 2016)

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May 5, 2016

To: Members of the Health and Human Services Policy Committee

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

RE: IHSS Issues Update: Minimum Wage, Overtime, County Administration

Background: The In-Home Supportive Services (IHSS) Program provides eligible Californians with an alternative to out-of-home care, such as nursing homes, by providing an in-home care worker. Participants in the program are able to live in their own homes and receive services including personal care services, house cleaning, meal preparation, laundry, grocery shopping, accompaniment to medical appointments, and protective supervision for the mentally impaired. Recent reforms impacting IHSS require careful consideration so as to continue the timely delivery of these critical benefits to the people participating in the program.

Major Considerations: As county public authorities counties continue to work on administering IHSS and the recent reforms that impact it, there are a number of issues that county supervisors should be aware of:

1. Implementation of new minimum wage requirements
2. Implementation of new overtime requirements
3. Overall County Administration of IHSS

The California Association of Public Authorities, CSAC, and the County Welfare Directors Association of California will be providing the policy committee with an informational update on the current issues relating to recent changes affecting the IHSS program.

Attachments:

1. CSAC Memo on State Minimum Wage Increase (May 5, 2016)
2. CSAC Budget Letter: FLSA County Administration (March 1, 2016)
3. CSAC Budget Letter: IHSS Contract Mode Issue (March 3, 2016)

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May 5, 2016

To: Members of the Health and Human Services Policy Committee

From: Faith Conley, CSAC Legislative Representative

RE: State Minimum Wage Increase

Last week, CSAC sent an informational email to counties regarding the recent passage of Senate Bill 3 (Chapter No. 4, Statutes of 2016), which incrementally increases the statewide minimum wage to $15.00/hour by 2022 and provides IHSS workers with three days of paid sick leave per year.

While the increase in the statewide minimum wage will inevitably have an impact on collective bargaining negotiations with your county employees, CSAC wants to clarify that the minimum wage provisions in SB 3 (and any statewide changes to minimum wage) do not apply to counties.

Article 11, Section 1 of the California Constitution states, "*The governing body [of each county] shall provide for the number, compensation, tenure and appointment of employees.*" This express grant of authority to the county necessarily implies that the Legislature does not have that authority.

This application of the home rule provisions for compensation for all counties was confirmed in the Court of Appeal case of *Curcini v. County of Alameda (2008) 164 Cal. App. 4th 629*, which looked at this issue of overtime and meal and rest period claims as applied to a charter county but confirmed that the premise of constitutional home rule provisions for compensation matters applied to all counties:

> *In re Work Uniform Cases (2005) 133 Cal.App.4th 328, 34 Cal.Rptr.3d 635 also recognizes that the "compensation" within the purview of counties (both charter and noncharter) relates to a broader spectrum of activities than merely setting salaries. Plaintiffs in In re Work Uniform Cases alleged that defendants had violated the indemnification provisions of Labor Code section 2802 in failing to compensate them for the actual cost of purchasing, replacing, cleaning and maintaining required work uniforms. (Id. at p. 332, 34 Cal.Rptr.3d 635.) The trial court held with respect to city and county defendants that "article XI of the state Constitution vests the power to prescribe the terms and compensation for employees with the city and county defendants," and that interpreting the Labor Code to require payment for uniform purchase and maintenance "would infringe on that constitutional delegation of power." (Id. at p. 333, 34 Cal.Rptr.3d 635.) The court affirmed, rejecting the plaintiffs' argument that paying for the cost of an employee's uniform was distinct from setting the wages of public employees, as it was not dependent upon performing labor. (Id. at p. 337–338, 345, 34 Cal.Rptr.3d 635.) The court concluded that payment for work uniforms was a "part of the employees' compensation and should be considered like any other payment of wages, compensation or benefits. The impact of this determination is that it places plaintiffs' claim of entitlement to compensation for uniform expenses as indemnification under section 2802 in direct conflict with a public entity's power to provide for compensation of its employees...." (Id. at p. 338, 34 Cal.Rptr.3d 635.) - Curcini, 164 Cal. App. 4th at 644.*

Accordingly, while counties may voluntarily comply with statewide minimum wage laws, the home rule provision within the state Constitution clearly exempts counties from mandatory compliance with SB 3. Please do not hesitate to contact me with any questions.

CSAC Staff Contacts:

Faith Conley, CSAC Legislative Representative, fconley@counties.org, (916) 327-7500 Ext. 522

March 1, 2016

The Honorable Tony Thurmond, Chair
Assembly Committee on Human Services

Honorable Members
Assembly Budget Subcommittee No. 1

RE: Making FLSA Work in IHSS: Improving Outcomes for All

The undersigned organizations respectfully request your consideration of necessary statutory changes to support the implementation of the Fair Labor Standards Act (FLSA) as it applies to the In-Home Support Services (IHSS) Program. These changes are needed to enable IHSS consumers and providers to comply with the new mandates and reduce possible harm that may result absent these changes.

We have serious concerns with the current policy, which places undue pressure on IHSS consumers and providers to navigate a complex myriad of new rules and procedures for overtime and travel time. Despite our collective efforts to educate IHSS consumers and providers on the new rules, we believe the current rules are unmanageable and a set up for failure. Several aspects of implementation are simply too cumbersome to properly implement. This places IHSS consumers in jeopardy of losing their providers and worse, potentially risks their health and safety.

To prevent unintended and undesired harmful consequences to IHSS consumers, we have identified several changes necessary to enable both IHSS consumers and providers to comply with FLSA requirements. Below we identify specific areas of needed changes and these changes are presented in order of what we believe are the priority areas to be addressed:

1. **Extend the Grace Prior to September 1, 2016 before Violations Begin to Toll:** The current grace period for providers, before violations begin to toll, begins May 1, 2016. Given the significant changes in the program and challenges in recruiting additional IHSS providers, this grace period should be extended, to September 1, 2016, before consequences for violating overtime and travel time limits become effective. This will give additional time to make programmatic changes necessary to comply with FLSA.

2. **Ensure that consumers can continue to receive services to remain safely at home:** A small number of IHSS providers care for more than one consumer with highly specialized needs. The overtime limit means that they cannot continue to provide that care if the consumers' combined hours exceed 66 per week. These providers are parents with more than one child with disabilities, an adult caring for two parents with dementia, an adult caring for a spouse and a child, both with disabilities. There may not be a suitable additional provider available to avoid an overtime situation. When no other provider is available, the consumer cannot receive the services which were authorized as needed for safety in their homes.

The California Department of Social Services (CDSS) has recognized this issue and is attempting to address this administratively. However, statutory protections are needed to allow for situations when a provider can work above the CDSS cap of 66 hours/week in certain, limited situations, including:

- Providers who are the parent, step-parent, grandparent or legal guardian of two or more children (including providers approved after Jan 31, 2016);
- Spouses, domestic partners, adult children caring for parents, adult siblings, and adult grandchildren, when no other suitable provider is available; and
- Individual consumer situations when there is no other suitable provider is available, the recipient would be at risk of out-of-home placement, or the recipient's health (including physical, psychiatric or emotional) or safety would be at risk.

In addition, statute should allow some providers to work over 90 hours/week in limited situations based on individual consumer needs when there is no other suitable provider is available, the recipient would be at risk of out-of-home placement, or the recipient's health (including physical, psychiatric or emotional) or safety would be at risk.

3. **Align IHSS Authorized Hours with FLSA Policy:** Current law requires a monthly authorization of hours, yet FLSA requires consumers and providers to track their hours by the week. When counties perform assessments, the majority of tasks are assessed at a weekly amount, then converted to a monthly amount. By overlaying FLSA requirements, consumers now have to take an *additional* step of converting back to a weekly amount. These extra steps are not only unnecessary, but can easily lead to errors in the calculation, which may result in a provider working more than s/he is permitted. This can increase costs to the IHSS program and could result in violations, and eventual termination, of the provider. The following changes are needed to align FLSA implementation with the IHSS Program:

    - **Pay Providers on a bi-weekly basis in 26 equal pay periods:** Currently the IHSS program pays providers twice per month (1-15th and 16-30/31st day of each month). SB 855 now requires recipients/providers to track hours worked per week (Saturday through Sunday). Because a workweek can break across two different months, this makes tracking time worked and overtime difficult and inconsistent with SB 855. Aligning the pay period to the SB 855 workweek will require a one-time programing change to the CMIPS Payrolling System and align the IHSS pay schedule with the FLSA work week.

    - **Create equitable caps in overtime for IHSS Providers:** CDSS has created two different caps for providers: providers serving one consumer may be compensated for hours worked up to 70.75 hours per week, while providers serving multiple consumers may be compensated at 66 hours per week. This is unfair to consumers and creates new challenges to Public Authorities to recruit additional registry providers for clients. This policy should be revised to allow providers with multiple consumers to receive compensation up to the 70.75 hour weekly cap.

    - **Authorize all IHSS tasks by the week:** Most tasks are already assessed according to a workweek except for Domestic Services, which is assessed up to 6 hours per month, and under this proposal, would be assessed up to 1.5 hours per week to align with all other IHSS tasks.

- **Retain current flexibility in the IHSS program:** Consumers have fluctuating needs for services based on their health needs, and the IHSS program has always provided flexibility to adjust hours to the consumer's needs, so long as the total hours remained within their monthly authorization. Consumers should be able to retain this flexibility to move hours without having to contact the county to seek permission.

4. **Pay for Certain Services in Arrears to Align with FLSA:** FLSA requires payment for travel time between consumers on the same day and SB 855 allows travel time to be paid in arrears after the travel is incurred, up to 7 hours per week. The travel time is not taken from the consumers' authorized hours, it is an addition. FLSA also now requires payment for wait time at medical appointments. However, wait time is deducted from authorized hours. Therefore, consumers with the highest need, who are already at or near the 195/238 monthly authorization cap are prevented from actually claiming this new service. This puts them in jeopardy of either not having their provider to assist them at medical appointments, or if the provider claims those wait time hours, they do so at the cost of not providing other needed services. It is also difficult to accurately predict wait time since doctor's appointments can vary.

   In addition, other services occur infrequently, at irregular intervals, or cannot be easily assessed for time until after the tasks are rendered. For example: yard hazard abatement, ice/snow removal, heavy cleaning and teaching and demonstration, are services that occur infrequently but are often critical in maintaining the safety of the recipient in their home and community, and should be paid in arrears.

5. **Permit Waiver Clients to Access Public Authority Registry Services:** Currently Public Authorities are only allowed to provide access to registry services to IHSS consumers. Yet, consumers of Waiver Personal Care Services (WPCS) are excluded from registry services, even though WPCS consumers use IHSS-like services (and often use both IHSS and WCPS services) and are also subject to the new FLSA rules. This proposal would simply allow WPCS consumers to also contact the registry to help them identify in-home providers.

We anticipate these changes will reduce confusion to IHSS consumers and providers as they try to comply with the new overtime rules. While we are still developing a fiscal estimate for these changes, but ultimately, we believe these changes will result in marginal new costs for additional overtime paid during the grace period and expansion of service hours. There are one-time costs associated with changes to the CMIPS system to convert to a bi-weekly pay period. We believe there will also be offsetting savings as a result of reduced county workload to address provider violations and helping consumers to find new providers and back-up providers, and potential savings in hospitalizations and other institutional care settings by avoiding unintentional harm to consumers and providers. Once we have additional information regarding the overall fiscal impact we will provide that to the Committee and staff.

The attached analysis provides additional background on each of the aforementioned proposals.

Thank you for your consideration of our request.

Sincerely,

Karen Keeslar, Executive Director
California Association of Public Authorities for IHSS (CAPA)

Farrah McDaid-Ting, Legislative Representative
California State Association of Counties (CSAC)

Gary Passmore, Executive Director
Congress of California Seniors

Frank J. Mecca, Executive Director
County Welfare Directors Association of CA (CWDA)

Catherine Blakemore, Executive Director
Disability Rights California

Jon Youngdahl, Executive Director
SEIU California

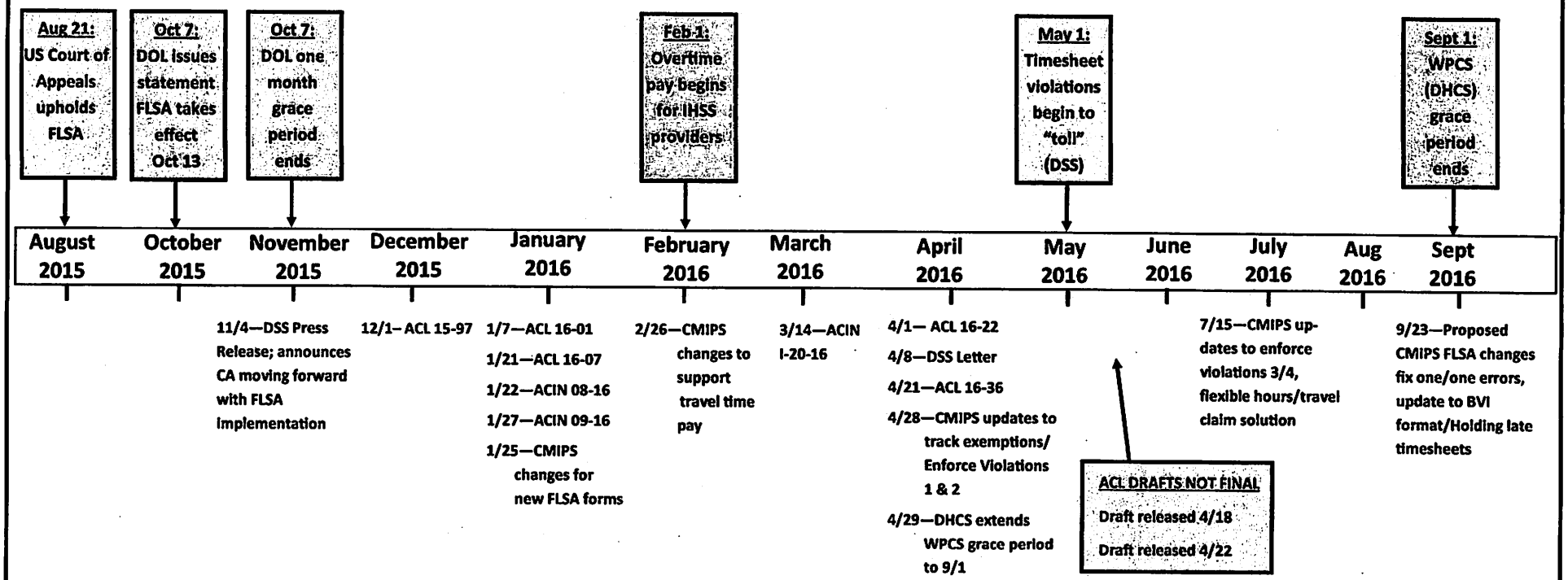
Doug Moore, Executive Director
UDW/AFSME

Attachment

cc: Gail Gronert, Office of the Assembly Speaker
Myesha Jackson, Office of the Assembly Speaker
Chris Woods, Office of the Assembly Speaker
Nicole Vazquez, Assembly Budget Subcommittee No. 1
Cyndi Hillery, Assembly Republican Fiscal
Tyrone McGraw, Office of Assemblymember Tony Thumond
Will Lightbourne, Department of Social Services
Robert Smith, Department of Social Services
Michael Wilkening, Health and Human Services Agency
Matt Paulin, Department of Finance
Jay Kapoor, Department of Finance
Mark Newton, Legislative Analyst's Office
Ginni Bella Navarre, Legislative Analyst's Office
Callie Freitag, Legislative Analyst's Office
County Caucus

Fair Labor Standards Act (FLSA) - Implementation of SB 855 and SB 873 Provisions

Timeline of State Notices and CMIPS Changes



Prepared by CWDA (4/28/16)

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CWDA
Advancing Human Services for the Welfare of *All* Californians

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CAPA

California Association of Public Authorities
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March 3, 2016

To: The Honorable Holly Mitchell
Chair, Senate Budget Subcommittee No. 3

Honorable Members, Senate Budget Subcommittee No. 3

From: Farrah McDaid Ting, Legislative Advocate, California State Association of Counties
Frank J. Mecca, Executive Director, County Welfare Directors Association
Karen Keesler, Executive Director, California Association of Public Authorities for IHSS

Re: Contract Mode Adjustments to IHSS MOE Trailer Bill Language – OPPOSE

The California State Association of Counties (CSAC), the County Welfare Directors Association (CWDA), and the California Association of Public Authorities for IHSS (CAPA) are opposed to the Administration's proposed trailer bill language (TBL) that would adjust the county In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) for all increased costs of contracts in counties in the contract mode. This TBL would inappropriately shift to counties additional costs that are already covered by the IHSS MOE adjustment formula. We respectfully request that you reject or adopt a modified version of this TBL.

The IHSS MOE took effect in the 2012-13 fiscal year and changed the county contribution for IHSS Program costs. Prior to 2012-13, counties were statutorily required to cover a specified share of all nonfederal costs of the IHSS program. The IHSS MOE replaced that statutory state/county sharing ratio. It capped each county's contribution to the nonfederal costs of the IHSS program at the county's 2011-12 expenditure level and requires that the new county contribution grow annually in two ways:

- For counties that locally negotiate a wage or health benefit increase for their providers in any fiscal year, those counties' IHSS MOEs are permanently increased beginning in the fiscal year that the wage or health benefit increase takes effect for the county's share of those costs based on the previously-existing statutory state/county sharing ratios.

- Beginning in 2014-15, all counties' IHSS MOEs increase by 3.5 percent each year, except in any fiscal year in which 1991 Realignment revenues to counties declines.

The increase in the IHSS MOE for locally negotiated wage and health benefit increases ensures that counties continue to share in IHSS Program costs that are specific to IHSS and over which the county has direct control. The annual 3.5 percent inflation factor ensures that counties continue to have a share of all other IHSS costs, such as for caseload increases, increases in the costs per case, other programmatic

changes that increase costs, or other administrative costs to the IHSS Program over which the county has little or no control. The IHSS MOE does not permit the county IHSS MOE to decline in any fiscal year from the prior year.

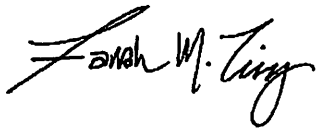
The IHSS MOE was established in conjunction with the Coordinated of Care Initiative (CCI) and the shift of collective bargaining in the IHSS Program from counties that have fully implemented the CCI to the state. The IHSS MOE ensures that the costs resulting from any state-negotiated changes to the wage or health benefits of IHSS providers, over which counties have no control, are not shifted to the counties. The IHSS MOE was applied to all counties, and not just the original eight counties in the CCI, because eventually all counties are intended to participate in the CCI and shift IHSS collective bargaining to the Statewide Public Authority. . It is also administratively very difficult, if not impossible with our current systems, to maintain different state/county cost sharing ratios for different counties within the same program.

The IHSS statutes allow counties to contract with another agency to make available IHSS providers to ensure that the county can fulfill the statutory mandate that all authorized services are provided to every eligible IHSS participant. This is called "contract mode," and statute is specific about what costs can be covered by these contracts. IHSS providers employed by the contractor are required to be paid consistently with other non-contract IHSS providers in the county. The contract costs also cover costs of the contractor over which the county, and the contractor itself in many cases, have no control, such as taxes, insurance costs, and the costs of state and federal changes to the program. The statute permits the contract to cover the actual, documented expenditures of the contractor and any reasonable costs over which the contractor has no control.

There are currently only two counties that participate in this "contract mode," San Francisco and San Mateo, and in even in those counties, contract providers are used to provide services to only a minority of consumers. The use of non-contract IHSS providers is the vastly preferred method of providing IHSS services to consumers, as it provides consumers more choice and control in who their providers are. However, for some high need, difficult-to-serve consumers or consumers with no provider choices, contract providers are the only means to keep these IHSS consumers living safely in their own homes and out of more costly institutional care.

The Administration's proposed TBL would adjust a "contract mode" county's IHSS MOE for ALL increases in the cost of the contract, not just those cost increases associated with locally negotiated provider wage or health benefit increases. The contract costs that are not associated with provider wages and health benefits are comparable to other IHSS costs that are already covered by the 3.5 percent inflation factor and do not result in the calculation of a separate IHSS MOE adjustment in addition to that 3.5 percent. The proposed TBL is inconsistent with the existing statutory framework for how counties' IHSS MOEs are to grow over time. That framework for growth was part of the original IHSS MOE agreement between the Administration and counties when the IHSS MOE was put into place. The proposed TBL would, in effect, result in a county being charged twice for those contract cost increases that are beyond provider wages and health benefits, once as a part of the 3.5 percent inflation adjustment and again in the separately calculated IHSS MOE adjustment.

CSAC and CWDA are not opposed to TBL that would clarify that county IHSS MOEs should be increased for the county's share of contract provider wage or health benefit increases resulting from local negotiations, consistent with the IHSS MOE adjustment made for locally negotiated wage or health benefit increases for all other IHSS providers. The proposed TBL is currently much broader than that. Therefore, we respectfully request that you either reject the proposed TBL or adopt a modified version that is consistent with current law.



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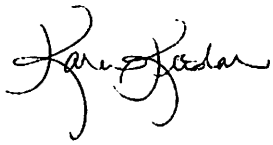

Karen Keeslar
CAPA Executive Director
(916) 492-9111

cc: Jennifer Troia, Office of the Senate President Pro Tempore
Craig Cornett, Office of the Senate President Pro Tempore
Theresa Pena, Senate Budget Subcommittee No. 3
Chantele Denny, Senate Republican Fiscal
Will Lightbourne, Department of Social Services
Robert Smith, Department of Social Services
Michael Wilkening, Health and Human Services Agency
Matt Paulin, Department of Finance
Jay Kapoor, Department of Finance
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Attachment Four

Memo: Strategies for Creating Permanency for Older Foster Youth
Handout: Permanent Families for Children Who Wait in Foster Care
Fact Sheet: AB 1879 (McCarty)

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May 5, 2016

To: Members of the Health and Human Services Policy Committee

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

RE: Presentation: Strategies for Creating Permanency for Older Foster Youth

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

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

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

Issue for Consideration: In this context of significant change in the foster youth system, it is important to remember that permanency is crucial for foster youth, including older foster youth who are preparing to leave the foster care system.

Gail Johnson Vaughan, Director Emerita and Chief Permanency Officer of Families NOW and Sacramento County Supervisor Don Nottoli will be providing the policy committee with an informational update on strategies for creating permanency for older foster youth.

Attachments:

1. Handout: Permanent Families for Children Who Wait in Foster Care
2. Fact Sheet: AB 1879 (McCarty)

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Permanent Families for Children Who Wait in Foster Care

How AB 1879 (McCarty) Helps Counties

Presented to CSAC Policy Committee
May 19, 2016

For More information contact:

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Typical Savings From Youth Permanency for California Counties

Per Child / Per Year

by Placement and Permanency Typ for Youth age 12 to 21
2015-2016 rates

These savings accrue for every year the youth would have remained in care

IV-E Waiver Counties	Total Annual County Savings
Adoption from Foster Family Agency Home	$14,238
Adoption from Group Home Level 10	$77,952
Adoption from Group Home Level 14	$106,560
Kin Guardianship from Foster Family Agency Home	$13,104
Kin Guardianship from Group Home Level 12	$96,012
Reunification from Foster Family Agency Home	$24,312
Reunification from Group Home Level 10	$92,952

Non- Waiver Counties	Total Annual County Savings
Adoption from Foster Family Agency Home	$10,411
Adoption from Group Home Level 10	$57,291
Adoption from Group Home Level 14	$76,852
Kin Guardianship from Foster Family Agency Home	$11,873
Kin Guardianship from Group Home Level 12	$69,864
Reunification from Foster Family Agency Home	$16,411
Reunification from Group Home Level 10	$64,791

Families NOW

www.FamiliesNOW.org

What are Child-Centered Specialized Permanency Services?

AB 1879 proposed amendment to WIC Section 11400(ag):
Child-centered specialized permanency services are designed for and with the child to address the child's history of trauma, separation and loss. These services shall include mental health services as necessary, or other services that are needed to ameliorate impairments in significant areas of life functioning that may reduce the likelihood of the child achieving a permanent family.
These services shall utilize family finding and engagement, including, but not limited to, using search technology and social media to locate family members, and child-specific recruitment, as needed, to assist the child in achieving a permanent family through reunification, adoption, legal guardianship, or other lifelong connections to caring adults, including at least one adult who will provide a permanent, parent-like relationship for that child.

These services include services designed to prepare the identified permanent family to meet the child's needs, set appropriate expectations for before and after permanency is achieved, and stabilize the placement.

Do They Work?

Yes. California led the nation in developing these services. Documentation on pilots across the state show them to be highly effective, both in achieving permanency for children and youth who wait for families, and in significantly reducing child welfare costs.

How Do They Relate to Continuum of Care Reform (CCR)?

The goal of foster care is to provide care until the child can achieve a permanent family. The success of CCR rests heavily on child-centered specialized permanency services. Permanency is a major goal of CCR as evidenced by the design and permanency support core services. Funding for core services are included in the new payment rate being developed as per AB 403.

When Will They Be Required?

When a child in foster care has no viable options for permanency with a family member and no prospective adoptive parents or guardians.

AB 1879 Impact

- Shorter stays in foster care
- Fewer youth age-out of foster care without safe, committed families
- Significantly lower governmental cost costs

Types of Child-Centered Specialized Permanency Practice Models

Child-Centered Permanency Practice

Effective youth permanency practice is youth-specific and requires small caseloads, significant involvement of the youth, and a whatever-it-takes attitude. These practices often include a public/private agency partnership utilizing the unique strengths of each sector.

Typical components of youth permanency practice include:

- In-depth review of case file
- Family-finding / identifying and/or rekindling potential connections -relationship building and mending
- Building a trusting relationship with the youth
- Assessment of youth's strengths, challenges, readiness for adoption or other forms of permanence, etc.
- Network building / engaging caring adults in planning for the teen, both professional and social supports
- Individualized recruitment plan
- Preparation of permanent family to assure they are adequately prepared to meet the needs of the youth

Clinically Enhanced – Child-Centered Permanency Practice

Since many of the permanency needs of youth in foster care are clinical in nature, permanency practices can be enhanced through specialty mental health services reimbursable through Medi-Cal for youth who meet medical necessity criteria. Utilizing this funding stream has both programmatic and fiscal advantages.

Adding enriched clinical components to the permanency services improves permanency outcomes . Clinically-enhanced youth permanency practice utilizes a clinical team to take many of the components of standard youth permanency practice to a deeper clinical treatment level, addressing complex trauma issues and facilitate the development of attachment security including:

- creating safety, self-regulation, and self-reflection,
- traumatic experience integration,
- relational engagement and positive affect enhancement using a family-centered model
- understanding the youth's past, realizing their present situation, and to developing plans for the future
- building sense of empowerment and mastery over their situation and their life by nurturing the youth participation and decision making in their case plan and work
- providing individual, family, collateral and group therapy
- case management and rehabilitation services
- educating and supporting the youth and the families that they live with on the issues of complex trauma and core permanency issues.

Utilizing EPSDT Medi-Cal Funding for the clinical component provides enhanced leverage for County dollars invested in youth permanency

- Federal Financial Participation (FFP) for 100% of children in foster care vs significantly lower FFP for IV-E Foster Care)
- Youth in foster care have federal entitlement for EPSDT medically-necessary services.

Fact Sheet - AB 1879 (McCarty)
Foster Care: Improving Permanency Outcomes

SUMMARY

As of October 1, 2015 there were 66,316 California children living in our foster care system, 25% (16,751) have been in care for over 3 years; 14% (9,469) have been in care for over 5 years. The likelihood of these "long-stayers" growing up in foster care and entering adulthood without the safety net of a permanent family is high unless they receive services proven effective in achieving permanent families for this population.

AB 1879 improves permanency outcomes for children in foster care, enhances the stability of adoptive and guardianship families, and significantly reduces costs by:

1) Defining and requiring child-centered specialized permanency services for children whose reunification services have been terminated, are not placed with a fit and willing relative, and are considered unlikely to achieve a permanent family.

2) Providing prospective adoptive families and guardians with information regarding the importance of working with mental health professionals with specialized training and experience in adoption / permanency clinical issues should the need for clinical services arise.

BACKGROUND

Outcomes are often poor for the children who age-out of foster care without a permanent family. Within two years 50% will be homeless, in prison, victimized or dead.

California led the development of child-centered specialized permanency services for the children and youth likely to age-out of foster care without the safety net of a permanent family. Despite their proven success these services are rarely used in our state, causing hardship to the children and unnecessarily high foster care costs at all governmental levels.

Placement into permanent families through adoption or guardianship is key to the success of our Continuum of Care reform. Permanency can create life-saving changes for these children as their new parents help them overcome their difficult histories including prior trauma and chronic abuse.

Without the support of adoption-competent clinicians children adopted from foster care are at unnecessary risk for disruption from their adoptive family and return to foster care – one more devastating loss in a litany of preventable losses.

SOLUTION

AB 1879 defines and requires, under specified conditions, child-centered specialized permanency services to assist the child in achieving a permanent family through reunification, adoption, legal guardianship, or other lifelong connections to caring adults.

These services are designed for and with the child to address the child's history of trauma, separation and loss. The services include, but are not limited to:

- Mental health services to ameliorate impairments in significant areas of life functioning that may reduce the likelihood of the child achieving a permanent family;
- Family finding and engagement, through search technology and social media to locate family members;
- Child-specific recruitment;
- Services designed to prepare and support the identified permanent family to meet the child's needs.

Further, AB 1879 increases the stability of families adopting children from foster care by requiring information be provided to potential adoptive families and guardians regarding the importance of working with mental health providers who have specialized adoption /permanency clinical training and experience, should the family need clinical support.

SPONSOR

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