Health and Human Services Policy Committee
Wednesday, January 25, 2017 — 10:30 – 11:30 a.m.
CSAC 1st Floor Peterson/Wall Conference Room
1100 K Street, Suite 101, Sacramento, CA 95814
Call-in: 1-916-246-0723; Passcode: 531199

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

10:30 a.m.	I.	**Welcome and Introductions** *Supervisor Ken Yeager, Santa Clara County, Chair* *Supervisor Candy Carlson, Tehama County, Vice Chair*
10:35 a.m. ***ACTION ITEM***	II.	**Health, Human Services, and Realignment Platform Review** *Farrah McDaid Ting, Legislative Representative, CSAC* *Elizabeth Marsolais, Legislative Analyst, CSAC*
10:55 a.m.	III.	**Budget Update: The Governor's January Budget Proposal** *Farrah McDaid Ting, Legislative Representative, CSAC* *Elizabeth Marsolais, Legislative Analyst, CSAC*
11:15 a.m.	IV.	**Update on the Affordable Care Act** *Farrah McDaid Ting, Legislative Representative, CSAC* *Elizabeth Marsolais, Legislative Analyst, CSAC*
11:30 a.m.	V.	**Closing Comments and Adjournment** *Supervisor Ken Yeager, Santa Clara County, Chair* *Supervisor Candy Carlson, Tehama County, Vice Chair*

*If calling in to the meeting, please place your line on **MUTE** until you wish to speak. Please also **DO NOT PLACE THE LINE ON HOLD**. Thank you.*

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January 13, 2017

To: CSAC Health and Human Services Policy Committee

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

RE: Health, Human Services, and Realignment Platform Review – ACTION ITEM

Background. At the end of each two-year legislative session, CSAC undertakes a policy platform review process. The HHS Policy Committee began this process during its November 29, 2016, Policy Committee Meeting. Following CSAC staff's solicitation of comments from counties and members of the HHS Policy Committee, staff presented an initial draft of the policy platform chapters on health, human services, and realignment to the committee. However, the election of President-Elect Trump required the committee to more closely examine federal portions of the proposed platform, especially the section on the Affordable Care Act.

Based on the HHS Policy Committee's feedback, CSAC staff has undertaken an additional round of edits to better reflect the federal uncertainty regarding the Affordable Care Act (ACA). The attached platform chapters show all changes made since the Policy Platform was last adopted. Edits that were made prior to the Annual Meeting are in purple or flagged with a comment from "CSAC," while edits that have been made since Annual Meeting are in red or flagged with a comment from "EM." The memo from Annual Meeting summarizing the changes made to the platform at that time is attached. Below is a high-level summary of the changes made to each of the chapters in response to comments made at the Annual Meeting.

Health Services
CSAC Staff received direction during the Annual Meeting to make edits to the Health Services Chapter to reflect the potential repeal and replacement of the ACA. These edits include:

- Reframing the platform to include more broad principles about the types of health policy CSAC supports and remove specific references to the ACA. This will allow CSAC Staff to take action regarding both the potential repeal and the potential replacement of the ACA without needing to complete an additional round of platform edits in the event that the ACA is repealed.
- Several edits were made prior to Annual Meeting to reflect that counties have implemented the recent changes to the Medi-Cal program under the ACA. Given the uncertainty at the federal level, this language was reverted to the original text which states that changes to Medi-Cal "will affect" counties.
- Language that had previously been deleted on counties' inability to absorb or backfill the loss of additional state and federal Medi-Cal funds was added back into the platform given the uncertainty at the federal level.
- The language supporting moving collective bargaining for the IHSS program to the Statewide IHSS Authority or another single statewide entity was edited per a comment from Karen Keeslar and to reflect the Governor's January 10 2017-18 Budget.
- Language that had been previously deleted on counties' support for offering a comprehensive package of health care services that includes mental health and substance use disorder treatment services at parity levels was added back into the platform given the uncertainty at the federal level.

- Language that had previously been deleted stating that counties are not in a position to contribute permanent additional resources to expand health care coverage was added back into the platform given the uncertainty at the federal level.
- Edits to clarify which federal waiver is being referenced.
- Previously deleted language referencing emergency medical services for medically indigent adults was added back into the platform.

Human Services
CSAC Staff received direction during the Annual Meeting to make edits to the Human Services Chapter to reflect the potential repeal and replacement of the ACA. These edits include:

- Reframing the platform to include more broad principles about the types of health policy CSAC supports and remove specific references to the ACA. This will allow CSAC Staff to take action regarding both the potential repeal and the potential replacement of the ACA without needing to complete an additional round of platform edits in the event that the ACA is repealed.
- Clarifying edits to the language on Continuum of Care Reform.
- Language was added in response to Yolo County Supervisor Rexroad's comments at Annual Meeting on the issue of supporting transparency related to child fatality and near-fatality incidents so long as it preserves the privacy of the child and additional individuals who may reside in a setting but were not involved or liable for any incidents.
- A duplicative reference to Medicaid was deleted.
- An edit was made in the Realignment section to clarify that the sentence was referring to 1991 Realignment.
- Language on the In-Home Supportive Services Maintenance of Effort and the Coordinated Care Initiative was deleted to reflect the Governor's January 2017-18 Budget.
- The language supporting moving collective bargaining for the IHSS program to the Statewide IHSS Authority or another single statewide entity was edited per a comment from Karen Keeslar and to reflect the Governor's January 10 2017-18 Budget.

Realignment
CSAC staff did not receive any comments on or make any additional edits to the Realignment Chapter following the Annual Meeting.

Process. In response to the comments received at the November 29, HHS Policy Committee and the Governor's January 2017-18 Budget Proposal, staff made changes to the proposed platform chapters, which are attached. If approved by the policy committee, these changes will be submitted to the CSAC Board of Directors for approval during their February 16 meeting. We wish to thank each of the supervisors, county affiliate organizations, and county staff who reviewed the proposed changes and suggested additional clarifications throughout this process.

Attachments:

1. CSAC Memo: Review of the Draft Platform Chapters: Health, Human Services, and Realignment. November 16, 2016.
2. Draft Health Services Platform Chapter
3. Draft Human Services Platform Chapter
4. Draft Realignment Platform Chapter

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November 16, 2016

To: Members of the Health and Human Services Policy Committee

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

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

At the start of each two-year legislative session, CSAC undertakes a policy platform review process. To begin that process of updating the guiding policy document for the Association, we have attached proposed drafts of the Health, Human Services, and Realignment chapters of the CSAC Platform for your review and input. We invited all counties and members of the HHS Policy Committee to review and submit comments, ideas, or questions by 5:00 p.m. on November 2. Following the submission of comments, we have prepared a draft of the platform chapters for review by the Health and Human Services Policy Committee.

This review is intended to serve as the second step in the process of developing the 2017-18 platform. After receiving comments and feedback from the Committee, staff will either make suggested changes or present the draft version to the CSAC Board of Directors for approval.

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

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

Health Services
Edits were made throughout the chapter to remove language that was out-of-date and to streamline the platform. Further edits were made to reformat the chapter in a more reader-friendly manner. Additional substantive changes are noted below:

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

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

Human Services

Edits were made throughout the chapter to remove language that was out-of-date and to streamline the platform. Further edits were made to reformat the chapter and to make it more reader-friendly and concise. Additional substantive changes are noted below:

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

Realignment

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

Comments Received

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

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

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

In response to these comments, staff made changes to the proposed platform chapters, which are attached. We wish to thank each of the supervisors, county affiliate organizations, and county staff who reviewed the proposed changes and suggested additional clarifications.

Attachments.

1. Draft Health Platform Chapter
2. Draft Human Services Platform Chapter
3. Draft Realignment Platform Chapter

CSAC Staff Contacts.

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Chapter Six
DRAFT ~~January 2015~~November~~2016~~ January 2017

Health Services

Section 1: ~~GENERAL PRINCIPLES~~General Principles

Counties serve as the front-line defense against threats of widespread disease and illness and promote health and wellness among all Californians. This chapter deals specifically with health services and covers the major segments of counties' functions in health services. Health services in each county shall relate to the needs of residents within that county in a systematic manner without limitation to availability of hospital(s) or other specific methods of service delivery. The board of supervisors in each county sets the standards of care for its residents.

Local health needs vary greatly from county to county. Counties support and encourage the use of multi-jurisdictional approaches to health care. Counties support efforts to create cost-saving partnerships between the state and the counties in order to achieve better fiscal outcomes for both entities. Therefore, counties should have the maximum amount of flexibility in managing programs. Counties should have the ability to expand or consolidate facilities, services, and program contracts to provide a comprehensive level of service and accountability and achieve maximum cost effectiveness. Additionally, as new federal and state programs are designed in the health care field, the state must work with counties to encourage maximum program flexibility and minimize disruptions in county funding, from the transition phase to new reimbursement mechanisms.

Counties also support a continuum of preventative health efforts – including ~~mental~~ behavioral health services, substance use disorder services, nutrition awareness and disease prevention – and healthy living models for all of our communities, families, and individuals. Preventative health efforts have proven to be cost effective and provide a benefit to all residents.

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

~~The enactment and implementation of the federal Patient Protection and Affordable Care Act (ACA) of 2010 provides~~Federal health care reform efforts, including the Patient Protection and Affordable Care Act (ACA) of 2010, provide new challenges, as well as opportunities, for counties. Counties, as providers, administrators, and employers, are deeply involved with health care at all levels and must be full partners with the state and federal governments in the effort to expand Medicaid and provide health insurance and care to millions of Californians. Counties believe in maximizing the allowable coverage ~~expansion under the ACA~~for their residents in accordance with eligibility criteria, while also preserving access to local health services for the residual uninsured. Counties remain committed to serving as an integral part of ACA implementation, and support initiatives to assist with outreach efforts, access, eligibility and enrollment services, and delivery system improvements.

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

county share of cost must be shared directly with counties.

~~**A.**~~

Public Health

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

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

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

~~**B. Health Services Planning**~~

2) Counties believe strongly in comprehensive health services planning. Planning must be done through locally elected officials, both directly and by the appointment of quality individuals to serve in policy and decision-making positions for health services planning efforts. Counties must also have the flexibility to make health policy and fiscal decisions at the local level to meet the needs of their communities.

~~**C. Mental**~~Behavioral Health

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

Comment [CSAC2]: CHBDA edit.

Proposition 63

The adoption of Proposition 63, the Mental Health Services Act of 2004, assists counties in service delivery. However, it is intended to provide new funding that expands and improves the capacity of existing systems of care and provides an opportunity to integrate funding at the local level. ~~We strongly~~

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

2) Counties also strongly oppose any effort to redirect the Proposition 63 funding to existing state services instead of the local services for which it was originally intended. The realignment of health and social services programs in 1991 restructured California's public ~~mental~~behavioral health system. Realignment required local responsibility for program design and delivery within statewide standards of eligibility and scope of services, and designated revenues to support those programs to the extent that resources are available.

3) Proposition 63 funds have been diverted in the past due to economic challenges and the establishment of the No Place Like Home Program. Any further diversions of Proposition 63 funding will be disruptive to programming at the local level. ~~.~~

Comment [CSAC3]: CBHDA edit.

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

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

Comment [CSAC4]: Santa Clara County edit.

Comment [CSAC5]: CBHDA edit.

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

1) ~~In response to county concerns, state law also provides funds to county programs to provide specialty mental health services to CalWORKs recipients who need treatment in order to get and keep employment.~~ Counties have developed a range of locally designed programs to serve California's diverse population, and must retain the local authority, flexibility, and funding to continue such services. ~~Similar law requires county mental health programs to provide specialty mental health~~

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

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

Comment [CSAC6]: CBHDA edit.

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

Comment [CSAC7]: CBHDA edit.

~~2)~~4) Counties continue to work across disciplines and within the 2011 Realignment structure to achieve good outcomes for persons with mental illness and/or co-occurring substance abuse issues to help prevent incarceration and to treat those who are about to be incarcerated or are newly released from incarceration and their families.

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

~~**D.**~~

Children's Health

California Children's Services

Counties provide diagnosis and some case management services, in conjunction with County Organized Health Systems (COHS) where they exist under the Whole Child Model (WCM), to more than 200,000 children enrolled in the California Children's Services (CCS) program, whether they are in Medi-Cal or the CCS-Only program. Under WCM, c~~C~~ounties also are still responsible for determination of medical and financial eligibility for the program. Counties may also provide Medical Therapy Program (MTP) services for both CCS children and special education students, and ~~have~~retain a share of cost for services to non-Medi-Cal children.~~.~~

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

1) Maximum federal and state matching funds for CCS program services must continue in order to avoid the shifting of costs to counties. Counties cannot continue to bear the rapidly increasing costs associated with both program growth and eroding state support. ~~Counties support efforts to redesign or realign the program with the goal of continuing to provide the timely care and~~

~~services for these most critically ill children.~~

~~1)~~2) Counties also support efforts to test alternative models of care under CCS pilots in the 2010 Medicaid Waiver and subsequent waivers.

3) As counties shift towards the Whole Child Model, counties seek to ensure these high-need patients continue to receive timely access to quality care, there are no disruptions in care, and there is an adequate plan for employee transition.

Comment [CSAC9]: Santa Clara County edit

State Children's Health Insurance Program

1) ~~The State Children's Health Insurance Program (SCHIP) is a federally funded program that allows states to provide low- or no-cost health insurance to children up to 250 percent of the Federal Poverty Level (FPL).~~ CSAC supports a four-year extension of funding for the federal Children's Health Insurance Program (CHIP/Healthy Families). As a block grant, the appropriation for the program ~~expires on September 30, 2015.~~is being considered for reauthorization in 2017. Without federal funding, some families risk losing coverage for their children if their income is too high to qualify for Medicaid/Medi-Cal and too low to purchase family coverage. ~~through Covered California.~~

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

Comment [EM11]: Clarifying edit.

Proposition 10

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

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

~~1)~~2) Local First 5 commissions must maintain the necessary flexibility to direct these resources to the most appropriate needs of their communities, including childhood health, childhood development, nutrition, school readiness, child care, and other critical community-based programs. Counties oppose any effort to diminish Proposition 10 funds or to impose restrictions on ~~their~~ local First 5 Commissions' expenditure authority.

~~2)~~3) ~~In recognition that Proposition 10 funds are disseminated differently based on a county's First 5 Commission structure and appropriated under the premise that local commissions are in a better position to identify and address unique local needs, counties~~Counties oppose any effort to lower or eliminate state support for county programs with the expectation that the state or local First 5 commissions will backfill the loss with Proposition 10 revenues.

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

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

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

~~1)~~2) Adequate early intervention, substance use disorder prevention, and treatment services have been proven to reduce criminal justice costs and utilization~~. Appropriate~~, but appropriate funding for diagnosis and treatment services ~~will result in positive outcomes for non-offenders and offenders alike with substance use disorders. Therefore, appropriate~~ must be available. Appropriate substance use disorder treatment services will benefit the public safety system. Counties will continue to work across disciplines to achieve good outcomes for persons with substance use disorder issues and/or mental illness.

~~2)~~3) Counties continue to support state and federal efforts to provide substance use disorder benefits under the same terms and conditions as other health services and welcome collaboration with public and private partners to achieve substance use disorder services and treatment parity.

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

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

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

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

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

Comment [CSAC12]: Santa Clara County edit

Comment [CSAC13]: Butte County edit.

Comment [EM14]: Clarification of Butte's previous edit based on potential ACA repeal/Medicaid block grant.

~~and clinics also provide care for Medi-Cal patients and serve as the medical safety net for millions of residents. These local systems also rely heavily on Medicaid reimbursements.~~ Any Medi-Cal reform that results in decreased access to or funding of county hospitals and health systems will be devastating to the safety net. The loss of Medi-Cal funds translates into fewer dollars to help pay for safety net services for all persons served by county facilities. Counties are not in a position to absorb or backfill the loss of additional state and federal funds. Rural counties already have particular difficulty developing and maintaining health care infrastructure and ensuring access to services.

Comment [EM15]: Added this language back into the platform given potential ACA repeal and Medicaid block grant.

3) ~~Additionally, county~~ County welfare departments determine eligibility for the Medi-Cal program~~.~~ and must receive adequate funding for these duties.

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

Comment [CSAC16]: Butte County edit.

Comment [EM17]: Clarification of Butte's previous edit based on potential ACA repeal/Medicaid block grant.

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

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

~~4)~~6) Counties oppose any efforts to decrease funding for or reverse expansions to the Medi-Cal program, which will shift the responsibility of providing these individuals with healthcare from the Medi-Cal program to counties, which are required to provide services to the medically indigent.

7) ~~**2. Managed Care.** Expansion of managed care must not adversely affect the safety net and must be tailored to each county's medical and geographical needs. Due to the unique characteristics of the health care delivery system in each county, the variations in health care accessibility and the demographics of the client population, counties believe that managed care systems must be tailored to each county's needs.~~ The state should continue to provide options for counties to implement managed care systems that meet local needs. The state should work openly with counties as primary partners in this endeavor.

~~5)~~8) The state needs to recognize county experience with geographic managed care and make strong efforts to ensure the sustainability of county organized health systems. The Medi-Cal program ~~should~~must offer a reasonable reimbursement and rate mechanism for managed care.

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

10) The carve-out of specialty ~~mental~~behavioral health services within the Medi-Cal

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

Comment [CSAC18]: CBHDA edit.

Comment [CSAC19]: CBHDA edit.

11) Counties recognize the need to reform the Drug Medi-Cal Organized Delevery System Waiver program in ways that maximize federal funds, ensure access to medically necessary evidence-based practices, allow counties to retain authority and choice in contracting with accredited providers, and minimize county risks.

Comment [CSAC20]: CBHDA edit.

~~6)~~12) Any reform effort should recognize the importance of substance use disorder treatment and services in the local health care continuum.

13) ~~**4. Financing.**~~ Counties will not accept a share of cost for the Medi-Cal program. Counties also believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost shifts or attempts to increase county responsibility through block grants or other means.

~~7)~~14) The state should fully fund county costs associated with the administration of the Medi-Cal program.

~~**5. Simplification.**~~ Complexities of rules and requirements should be minimized or reduced so that enrollment, retention and documentation and reporting requirements are not unnecessarily burdensome to recipients, providers, and administrators and are no more restrictive or duplicative than required by federal law. ~~Simplification should include removing barriers that unnecessarily discourage beneficiary or provider participation or billing and timely reimbursements. Counties support simplifying the eligibility process for administrators of the Medi-Cal program.~~

~~8)~~15) The State should consider counties as full partners in the administration of Medi-Cal, including ~~and~~ its expansion under ACA, and consult with counties in formulating and implementing all policy, operational and technological changes.

~~**G.**~~ Medicare Part D

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

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

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

across many levels of county medical, social welfare, criminal justice, and ~~mental~~behavioral health systems.

1) Counties strongly oppose any change to realignment funding that may result and would oppose any reduction or shifting of costs associated with this benefit that would require a greater mandate on counties.

~~H.~~ Medicaid and Aging Issues

1) ~~Furthermore, counties~~Counties are committed to addressing the unique needs of older and dependent adults in their communities, and support collaborative efforts to build a continuum of services as part of a long-term system of care for this vulnerable but vibrant population. ~~Counties also believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost shifts or attempts to increase county responsibility through block grants or other means.~~

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

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

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

5) Counties support moving collective bargaining for the IHSS program to the Statewide IHSS Authority or another single statewide entity.

Comment [EM21]: Edit made per comment from Karen Keeslar – noted at Policy Committee meeting at Annual Meeting.

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

Section 2: ~~AFFORDABLE CARE ACTAffordable Care Act (ACA) IMPLEMENTATION~~Implementation Federal Healthcare Reform Efforts

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

1) ~~Counties also caution that increased coverage for low-income individuals may not translate into~~

~~savings to all county health systems. Counties cannot contribute to a state expansion of health care before health reform is fully implemented, and any moves in this direction would destabilize the county health care safety net.~~Under AB 85, Counties must also retain sufficient health revenues for residual responsibilities, including public health. Any changes to AB 85 must also allow counties to retain sufficient health revenues for these residual responsibilities.

A. Access and Quality

- Counties support offering a truly comprehensive package of health care services that includes mental health and substance use disorder treatment services at parity levels and a strong prevention component and incentives.

Comment [EM22]: Added this language back into the platform given potential ACA repeal and replacement.

2) Counties support the integration of health care services for prisoners and offenders, detainees, and undocumented immigrants into the larger health care service model.

3) Health care ~~expansion~~ reform efforts must address access to health care in rural communities and other underserved areas and include incentives and remedies to meet these needs as quickly as possible.

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

4) Counties strongly support maintaining a stable and viable health care safety net with adequate funding.

5) The current safety net is grossly underfunded. Any diversion of funds away from existing safety net services will lead to the dismantling of the health care safety net and will hurt access to care for all Californians.

6) Counties believe that delivery systems that meet the needs of vulnerable populations and provide specialty care – such as emergency and trauma care and training of medical residents and other health care professionals – must be supported in any health care reform effort~~universal health coverage plan~~.

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

~~**C. Financing and Administration**~~

- Counties support increased access to health coverage through a combination of mechanisms that may include improvements in and expansion of the publicly funded health programs, increased employer-based and individual coverage through purchasing pools, tax incentives, and system restructuring. The costs of universal health care and health care reform shall be shared among all sectors: government, labor, and business.

Comment [CSAC23]: Language kept per Santa Clara County edit.

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

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

10) ~~———~~Counties encourage the state to pursue ways to maximize federal financial participation in health care expansion efforts, and to take full advantage of opportunities to simplify Medi-Cal, and other publicly funded programs with the goal of achieving maximum enrollment and provider participation.

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

Comment [EM24]: Added this language back into the platform given potential ACA repeal and replacement.

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

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

~~**D. Role of Employers**~~

12) ~~———~~Counties, as both employers and administrators of health care programs, believe that every employer has an obligation to contribute to health care coverage~~. Counties are sensitive to the economic concerns of employers, especially small employers, and employer-based solutions should reflect the nature of competitive industries and job creation and retention. Therefore,~~, and counties advocate that such an employer policy should also be pursued at the federal level and be consistent with the goals and principles of local control at the county government level.

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

~~**E. Implementation**~~

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

Section 3: ~~CALIFORNIA HEALTH SERVICES FINANCING~~ California Health Services Financing

1) Those eligible for Temporary Assistance for Needy Families (TANF)/California Work Opportunity

and Responsibility to Kids (CalWORKs), should retain their categorical linkage to Medi-Cal ~~as provided prior to the enactment of the federal Personal Responsibility Work Opportunity Reconciliation Act of 1996.~~.

Counties are concerned about the erosion of state program funding and the inability of counties to sustain current program levels. As a result, we strongly oppose additional cuts in county administrative programs as well as any attempts by the state to shift the costs for these programs to counties. ~~Counties support legislation to permit commensurate reductions at the local level to avoid any cost shifts to local government.~~

2) With respect to the County Medical Services Program (CMSP), counties support efforts to improve program cost effectiveness and oppose state efforts to shift costs to participating counties, including administrative costs and elimination of other state contributions to the program. ~~Counties believe that enrollment of Medi-Cal patients in managed care systems may create opportunities to reduce program costs and enhance access.~~ Due to the unique characteristics of each county's delivery system, health care accessibility, and demographics of client population, counties believe that managed care systems must be tailored to each county's needs, and that counties should have the opportunity to choose providers that best meet the needs of their populations. ~~The state must continue to provide options for counties to implement managed care systems that meet local needs. Because of the significant volume of Medi-Cal clients that are served by the counties, the state should work openly with counties as primary partners.~~Where cost-effective, the state and counties should provide non-emergency health services to undocumented immigrants and together seek federal and other reimbursement for medical services provided to undocumented immigrants.

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

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

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

~~3)~~4) Although reducing the number of uninsured through expanded health care coverage will help reduce the financial losses to trauma centers and emergency rooms, critical safety-net services

must be supported to ensure their long-term viability.

~~A.~~ Realignment

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

1) ~~Counties support the concept of state and local program realignment and the principles adopted by CSAC and the Legislature in forming realignment. Thus, counties~~Counties believe the integrity of realignment should be protected. However, counties strongly oppose any change to realignment funding that would negatively impact counties.

~~1)~~2) Counties remain concerned and will resist any reduction of dedicated realignment revenues or the shifting of new costs from the state and further mandates of new and greater fiscal responsibilities to counties in this partnership program.

~~2)~~3) ~~With the passage of Proposition 1A, the state and counties entered into a new relationship whereby local property taxes, sales and use taxes, and Vehicle License Fees are constitutionally dedicated to local governments. Proposition 1A also provides that the Legislature must fund state-mandated programs; if not, the Legislature must suspend those state-mandated programs.~~ Any effort to realign additional programs must occur in the context of ~~these~~Proposition 1A constitutional provisions~~. Further, any effort to realign programs or resources~~ and must guarantee that counties have sufficient revenues for residual responsibilities, including public health programs.

Comment [CSAC25]: Santa Clara County edit

~~3)~~4) In 2011, counties assumed ~~100 percent~~ fiscal responsibility for Medi-Cal Specialty Mental Health Services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Drug Medi-Cal; drug courts; perinatal treatment programs; and women's and children's residential treatment services as part of the 2011 Public Safety Realignment. Please see the Realignment Chapter of the CSAC Platform and accompanying principles.

Comment [CSAC26]: CBHDA edit.

~~B.~~ Hospital Financing

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

1) ~~County hospitals could not survive without federal Medicaid funds.~~ CSAC has been firm that any proposal to change hospital Medicaid financing must guarantee that county hospitals do not receive less funding than they currently do, and are eligible for more federal funding in the future as needs grow. ~~California's current federal Section 1115~~

~~Medicaid waiver (implemented in SB 208 and AB 342, Chapter 714 and 723, respectively, Statutes of 2010) provides county hospitals with funding for five years.~~

2) Counties believe implementation of the federal Section 15000 waiver is necessary to ensure that county hospitals are paid for the care they provide to Medi-Cal recipients and uninsured patients~~ and to prepare counties for federal health care reform implementation in 2014. California's existing Section 1115 "Bridge to Reform" Medicaid Waiver expires in October 2015. The Waiver is a five-year demonstration of health care reform initiatives that invested in the state's health care delivery system to prepare for the significant changes spurred on by the Affordable Care Act (ACA). Continuance of the federal government's commitment to the implementation of the ACA through a successor Waiver will allow the state and counties to further improve care delivery and quality. Through the Waiver, counties seeks federal and state support to promote and improve health outcomes, access to care and cost efficiency, building upon the system of care delivery models developed under the 2010 Waiver.~~ ..

Comment [EM27]: Edit to specify which federal waiver this section refers to.

3) Counties support a five-year state Medicaid Waiver that provides funding to counties at current levels. The successor waiver should: 1) support a public integrated safety net delivery system; 2) build on previous delivery system improvement efforts for public health care systems so that they can continue to transform care delivery; 3) allow for the creation of a new county pilot effort to advance improvements through coordinated care, integrated physical and behavioral health services and provide robust coordination with social, housing and other services critical to improve care of targeted high-risk patients.; 4) improve access to share and integrate health data and systems; 5) and provide flexibility for counties/public health care systems to provide more coordinated care and effectively serve individuals who will remain uninsured.

~~1)~~4) Counties are supportive of opportunities to reduce costs for county hospitals, particularly for mandates such as seismic safety requirements and nurse-staffing ratios. Therefore, counties support infrastructure bonds that will provide funds to county hospitals for seismic safety upgrades, including construction, replacement, renovation, and retrofit.

~~2)~~5) Counties also support opportunities for county hospitals and health systems to make delivery system improvements and upgrades, which will help these institutions compete in the modern health care marketplace.

6) Counties support proposals to preserve supplemental payments to public and private hospitals as the Federal Medicaid Managed Care rules are implemented in California.

Comment [CSAC28]: Los Angeles County edit.

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

~~CSAC remains committed to raising awareness of the toll of family violence on families and communities by supporting efforts~~Specific strategies for early intervention and success that target family violence prevention, intervention, and treatment~~. Specific strategies for early intervention and success~~ should be developed through cooperation between state and local governments, as well as community and private organizations addressing family violence issues.

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

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

Comment [CSAC29]: Santa Clara County edit

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

~~Counties provide services such as mental health treatment, substance use disorder treatment, and social services that veterans may access.~~ Specific strategies for intervention and service delivery to veterans should be developed through cooperation between federal, state and local governments, as well as community and private organizations serving veterans.

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

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

Section 7: Emergency Medical Services

1) Counties do not intend to infringe upon the service areas of other levels of government who provide similar services, but will continue to discharge our statutory duties to ensure that all county residents have access to the appropriate level and quality of emergency services, including medically indigent adults. .
2) Counties support ensuring the continuity and integrity of the current emergency medical services system~~. Reductions in~~, including county authority ~~for counties in these areas will be opposed.~~ related to medical control.
~~1)~~3) Counties recognize that effective administration and oversight of local emergency medical services systems includes input from key stakeholders, such as other local governments, private providers, state officials, local boards and commissions, and the people in our communities who depend on these critical services.

Comment [EM30]: Added this language back into the platform given potential ACA repeal and replacement.

Section 8: Court-~~**involved population**~~Involved Population

Counties recognize the importance of enrolling the court-involved population into Medi-Cal and

other public programs. Medi-Cal enrollment provides access to important behavioral health and primary care services that will improve health outcomes and may reduce recidivism. CSAC continues to look for partnership opportunities with the Department of Health Care Services, foundations, and other stakeholders on enrollment, eligibility, quality, and improving outcomes for this population. Counties are supportive of obtaining federal Medicaid funds for inpatient hospitalizations, including psychiatric hospitalizations, for adults and juveniles while they are incarcerated.

Section 9~~.~~: Incompetent to Stand Trial

Counties affirm the authority of County Public Guardians under current law to conduct conservatorship investigations and are mindful of the potential costs and ramifications of additional mandates or duties in this area.

Counties support collaboration among the California Department of State Hospitals, county Public Guardians, Behavioral Health Departments, and County Sheriffs to find secure ~~supervised~~ placements for individuals originating from DSH facilities, county jails, or ~~conserved status~~who are under conservatorship. Counties support a shared funding and service delivery model for complex placements, such as the Enhanced Treatment Program.

Comment [CSAC31]: CBHDA edit.

Comment [CSAC32]: CBHDA edit.

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

Comment [CSAC33]: CBHDA edit.

Chapter Twelve
DRAFT ~~January 2015~~~~November~~ January 2017~~2016~~

Human Services

Section 1: ~~GENERAL PRINCIPLES~~ General Principles

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

Inadequate funding for program costs strains the ability of counties to meet accountability standards and avoid penalties, putting the state and counties at risk for hundreds of millions of dollars in federal penalties. Freezing program funding also shifts costs to counties and increases the county share of program costs above statutory sharing ratios, while at the same time running contrary to the constitutional provisions of Proposition 1A.

At the federal level, counties support economic stimulus efforts ~~that~~and additional federal funding to help maintain service levels and access for the state's neediest residents. Counties are straining to provide services to the burgeoning numbers of families in distress. ~~People who have never sought public assistance before are arriving at county health and human services departments. Counties~~With each downturn in the economy, counties report long lines in their welfare departments as increasing numbers of people apply for programs such as Medicaid, Supportive Nutrition Assistance Program (SNAP or Food Stamps), Temporary Assistance to Needy Families (TANF), and General Assistance. For these reasons, counties strongly urge that any federal stimulus funding must be shared directly with counties for programs that have a county share of cost.

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

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

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

Despite state assumption of major welfare program costs after Proposition 13, counties continue to be hampered by state administrative constraints and cost-sharing requirements, which ultimately affect the ability of counties to provide and maintain programs. The state should set minimum standards, allowing counties to enhance and supplement programs according to each county's local needs. If the state implements performance standards, the costs for meeting such requirements must be fully reimbursed.

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

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

Section 2: ~~HUMAN SERVICES FUNDING DEFICIT~~ Human Services Funding Deficit

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

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

Section 3: ~~CHILD WELFARE SERVICES/FOSTER CARE~~ Child Welfare Services/Foster Care

A child deserves to grow up in an environment that is healthy, safe, and nurturing. To meet this goal, families and caregivers should have access to public and private services that are comprehensive and collaborative. Further, recent policy and court-ordered changes, such as those proscribed in the *Katie A.* settlement require collaboration between county child welfare services/foster care and mental health systems.

The existing approach to budgeting and funding child welfare services was established in the mid-

-1980's. Since that time, dramatic changes in child welfare policy have occurred, as well as significant demographic and societal changes, impacting the workload demands of the current system. 2011 Realignment provides a mechanism that will help meet the some of the current needs of the child welfare services system, but existing workload demands and regulations remain a concern.

Further, recent court settlements (Katie A.) and policy changes (AB 12 Fostering Connections to Success Act of 2010 and AB 403, Continuum of Care Reform) require close state/county collaboration with an emphasis on ensuring adequate ongoing funding that adapts to the needs of children who qualify.

1) Counties support efforts to reform the congregate care – or youth group home – system ~~and strongly support efforts to recruit, support, and retain foster family homes to address~~under AB 403, the ~~decline~~Continuum of ~~foster family home placements in California today.~~ Care Reform. Providing stable family homes for all of our foster and probation youth is anticipated to lead to better outcomes for those youth and our communities. However, funding for this massive post-2011 Realignment system change is of paramount importance. Any reform efforts must also consider issues related to collaboration, capacity, and funding. County efforts to recruit, support, and retain foster family homes and , provide pathways to mental health support~~, and incentivize child and family teaming~~ are but some of the challenges under AB 403. Additionally, reform efforts must take into account the needs of juveniles who are wards of the court.

Comment [CSAC1]: CBHDA edit.

Comment [EM2]: Clarifying edit.

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

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

~~2)~~3) When, despite the provision of voluntary services, the family or caregiver is unable to minimally ensure or provide a healthy, safe, and nurturing environment, a range of intervention approaches will be undertaken. When determining the appropriate intervention approach, the best interest of the child should always be the first consideration. ~~These efforts to protect the best interest of children and preserve families may include:~~

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

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

5) When parental rights must be terminated, counties support a permanency planning process that

quickly places children in the most stable environments, with adoption being the permanent placement of choice. Counties support efforts to accelerate the judicial process for terminating parental rights in cases where there has been serious abuse and where it is clear that the family cannot be reunified.

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

~~5)~~7) ~~Furthermore, counties~~Counties seek to obtain additional funding and flexibility at both the state and federal levels to provide robust transitional services to foster youth such as housing, employment services, and increased access to aid up to age 26. Counties also support such ongoing services for former and emancipated foster youth up to age 26, and pledge to help implement the Fostering Connections to Success Act of 2010 to help ensure the future success of this vulnerable population.

~~6)~~8) With regards to caseload and workload standards in child welfare, especially with major policy reforms such as AB 403, counties remain concerned about increasing workloads and fluctuations in funding, both of which threaten the ability of county child welfare agencies to meet their federal and state mandates in serving children and families impacted by abuse and neglect.

~~7)~~9) Counties support a reexamination of reasonable caseload levels at a time when cases are becoming more complex~~;~~, often more than one person is involved in working on a given case, and when extensive records have to be maintained about each case. Counties support ongoing augmentations for Child Welfare Services to partially mitigate workload concerns and the resulting impacts to children and families in crisis. Counties also support efforts to document workload needs and gather data in these areas so that we may ensure adequate funding for this complex system.

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

Comment [EM3]: Edit made per Supervisor Rexroad's comments at the HHS Policy Committee Meeting at Annual Meeting.

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

There is strong support for the simplification of the administration of public assistance programs. The state should continue to take a leadership role in seeking state and federal legislative and regulatory changes to achieve simplification, consolidation, and consistency across all major public assistance programs, including Temporary Assistance for Needy Families (TANF), California Work Opportunity and Responsibility to Kids (CalWORKs), ~~Medicaid,~~ Medi-Cal, and Food Stamps. In addition, electronic technology improvements in welfare administration are an important tool in obtaining a more efficient and accessible system. It is only with adequate and reliable resources and flexibility that counties can

Comment [EM4]: Removed reference to Medicaid for clarity and to avoid duplication with the reference to Medi-Cal.

truly address the fundamental barriers that many families have to self-sufficiency.

1) California counties are far more diverse from county to county than many regions of the United States. The state's welfare structure should recognize this and allow counties flexibility in administering welfare programs. Each county must have the ability to identify differences in the population being served and provide services accordingly, without restraints from federal or state government. There should, however, be as much uniformity as possible in areas such as eligibility requirements, grant levels and benefit structures. To the extent possible, program standards should seek to minimize incentives for public assistance recipients to migrate from county to county within the state.

2) A welfare system that includes shrinking time limits for assistance should also recognize the importance of and provide sufficient federal and state funding for education, job training, child care, and support services that are necessary to move recipients to self-sufficiency. There should also be sufficient federal and state funding for retention services, such as childcare and additional training, to assist former recipients in maintaining employment.

3) Any state savings from the welfare system should be directed to counties to provide assistance to the affected population for programs at the counties' discretion, such as General Assistance, indigent health care, job training, child care, mental health, alcohol and drug services, and other services required to accomplish welfare-to-work goals. ~~In addition, federal~~

~~2)~~4)Federal and state programs should include services that accommodate the special needs of people who relocate to the state after an emergency or natural disaster. ~~It is only with adequate and reliable resources and flexibility that counties can truly address the fundamental barriers that many families have to self-sufficiency.~~

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

~~3)~~6)Welfare-to-work efforts should focus on prevention of the factors that lead to poverty and welfare dependency including unemployment, underemployment, a lack of educational opportunities, food security issues, and housing problems. Prevention efforts should also acknowledge the responsibility of absent parents by improving efforts for absent parent location, paternity establishment, child support award establishment, and the timely collection of child support.

~~4)~~7)California's unique position as the nation's leading agricultural state should be leveraged to increase food security for its residents. ~~Also, with the recent economic crisis, families and individuals are seeking food stamps and food assistance at higher rates.~~ Counties support increased nutritional supplementation efforts at the state and federal levels, including increased aid, longer terms of aid, and increased access for those in need.

~~5)~~8)Counties also recognize safe, dependable, and affordable child care as an integral part of attaining and retaining employment and overall family self-sufficiency, and therefore support efforts to seek additional funding to expand child care eligibility, access, and quality programs.

~~6)~~9)~~Finally, counties~~Counties support efforts to address housing supports and housing assistance

efforts at the state and local levels. Long-term planning, creative funding, and accurate data on homelessness are essential to addressing housing security and homelessness issues.

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

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

1) ~~More recently, the~~The way in which child support enforcement funding is structured prevents many counties from meeting state and federal collection guidelines and forces smaller counties to adopt a regional approach or, more alarmingly, fail outright to meet existing standards. Counties need an adequate and sustainable funding stream and flexibility at the local level to ensure timely and accurate child support enforcement efforts, and must not be held liable for failures to meet guidelines in the face of inadequate and inflexible funding.

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

~~2)~~3)A successful child support enforcement program requires a partnership between the state and counties. Counties must have meaningful and regular input into the development of state policies and guidelines regarding child support enforcement and the local flexibility to organize and structure effective programs.

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

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

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

~~1)~~2)Local First 5 commissions must maintain the necessary flexibility to direct these resources to the most appropriate needs of their communities, including childhood health, childhood development, nutrition, school readiness, child care and other critical community-based programs. Counties oppose any effort to diminish local Proposition 10 funds or to impose restrictions on their local expenditure authority.

~~2)~~3)~~In recognition that Proposition 10 funds are disseminated differently based on a county's First 5~~

~~Commission structure and appropriated under the premise that local commissions are in a better position to identify and address unique local needs, counties~~Counties oppose any effort to lower or eliminate ~~the state's~~state support for county programs with the expectation that the state or local First ~~5commissions~~ 5 commissions will backfill the loss with Proposition 10 revenues. ~~–~~

Section 7: ~~REALIGNMENT~~ Realignment

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

Comment [EM5]: Clarifying edit.

In 2011, counties assumed ~~100 percent~~ fiscal responsibility for Child Welfare Services, adoptions, adoptions assistance, Child Abuse Prevention Intervention and Treatment services, foster care and Adult Protective Services as part of the 2011 Public Safety Realignment. Please see the Realignment chapter of the CSAC Platform and accompanying principles.

Comment [CSAC6]: Edit for consistency with Health Chapter.

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

~~1)~~2) Counties strongly oppose any change to realignment funding that would negatively impact counties. Counties remain concerned and will resist any reduction of dedicated realignment revenues or the shifting of new costs from the state and further mandates of new and greater fiscal responsibilities in this partnership program.

~~2)~~3) ~~With the passage of Proposition 1A the state and counties entered into a new relationship whereby local property taxes, sales and use taxes, and Vehicle License Fees are constitutionally dedicated to local governments. Proposition 1A also provides that the Legislature must fund state-mandated programs; if not, the Legislature must suspend those state-mandated programs.~~ Any effort to realign additional programs must occur ~~in~~within the context of ~~these~~the constitutional provisions~~.~~ of Proposition 1A or Proposition 30 .

~~In 2011, counties assumed 100 percent fiscal responsibility for Child Welfare Services, adoptions, adoptions assistance, Child Abuse Prevention Intervention and Treatment services, foster care and Adult Protective Services as part of the 2011 Public Safety Realignment. Please see the Realignment chapter of the CSAC Platform and accompanying principles.~~

Section 8: ~~FAMILY VIOLENCE~~ Family Violence

CSAC remains committed to raising awareness of the toll of family violence on families and communities by supporting efforts that target family violence prevention, intervention, and treatment. ~~–~~Specific strategies for early intervention and success should be developed through cooperation between state and local governments, as well as community and private organizations addressing family violence issues.

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

California is already home to more older adults than any other state in the nation, and the state's 65 and older population is expected to double ~~over the next 20 years,~~ from 3.5 million in 2000 to 8.2 million in 2030. The huge growth in the number of older Californians will affect how local governments plan for and provide services, running the gamut from housing and health care to transportation and in-home care services. While many counties are addressing the needs of their older and dependent adult populations in unique and innovative ways, all are struggling to maintain basic safety net services in addition to ensuring an array of services needed by this aging population.

1) Counties support reliable funding for programs that affect older and dependent adults, such as Adult Protective Services and In-Home Supportive Services, and oppose any funding cuts, or shifts of costs to counties without revenue, from either the state or federal governments. ~~Furthermore, counties~~

~~1)~~2) Counties are committed to addressing the unique needs of older and dependent adults in their communities, and support collaborative efforts to build a continuum of services as part of a long-term system of care for this vulnerable but vibrant population.

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

Adult Protective Services

The Adult Protective Services (APS) Program is the state's safety net program for abused and neglected adults and is now solely financed and administered at the local level by counties. As such, counties provide around-the-clock critical services to protect the state's most vulnerable seniors and dependent adults from abuse and neglect. ~~Timely~~Counties must retain local flexibility in meeting the needs of our aging population, and timely response by local APS is critical, as studies show that elder abuse victims are 3.1 times more likely to die prematurely than the average senior. ~~Counties must retain local flexibility in meeting the needs of our aging population.~~

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

In-Home Supportive Services

The In-Home Supportive Services (IHSS) program is a federal Medicaid program administered by the state and run by counties that enables program recipients to hire a caregiver to provide services that enable that person to stay in his or her home safely. Individuals eligible for IHSS services are disabled, age 65 or older, or those who are blind and unable to live safely at home without help. ~~All Supplementary Income/ State Supplemental Payment recipients are also eligible for IHSS benefits if they demonstrate an assessed need for such services.~~

County social workers evaluate prospective and ongoing IHSS recipients, who may receive assistance with such tasks as housecleaning, meal preparation, laundry, grocery shopping,

personal care services such as bathing, paramedical services, and accompaniment to medical appointments. Once a recipient is authorized for service hours, the recipient is responsible for hiring his or her provider.

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

~~However, as part of the 2012-13 state budget, the Legislature and Governor approved major policy changes within the Medi-Cal program aimed at improving care coordination, particularly for people on both Medi-Cal and Medicare. Also approved as part of this Coordinated Care Initiative (CCI) are a number of changes to the In-Home Supportive Services (IHSS) program, including state collective bargaining for IHSS, creation of a county IHSS Maintenance of Effort (MOE), and creation of a Statewide Authority. County social workers evaluate prospective and ongoing IHSS recipients, who may receive assistance with such tasks as housecleaning, meal preparation, laundry, grocery shopping, personal care services such as bathing, paramedical services, and accompaniment to medical appointments. Once a recipient is authorized for service hours, the recipient is responsible for hiring his or her provider. Although the recipient is considered the employer for purpose of hiring, supervising, and firing their provider, state law requires counties to establish an "employer of record" for purposes of collective bargaining to set provider wages and benefits. In 2014, the state became the employer of record for the eight Coordinated Care Initiative (CCI) counties.~~

Comment [EM7]: Language deleted to reflect the Governor's January 2017-18 Budget.

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

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

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

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

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

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

Comment [EM8]: Edit made per comment from Karen Keeslar – noted at Policy Committee meeting at Annual Meeting.

Section 10: Veterans

Specific strategies for intervention and service delivery to veterans should be developed through cooperation between federal, state, and local governments, as well as community and private organizations serving veterans.

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

~~1-18-13~~

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

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

~~Proposed Chapter:~~

DRAFT ~~November 2016~~January 2017

Chapter 16

Realignment

In 2011, an array of law enforcement and health and human services programs – grouped under a broad definition of "public safety services" – was transferred to counties along with a defined revenue source. The 2011 Realignment package was a negotiated agreement with the Brown Administration and came with a promise, realized with the November 2012 passage of Proposition 30, of constitutional funding guarantees and protections against costs associated with future programmatic changes, including state and federal law changes as well as court decisions. Counties will oppose proposals to change the constitutional fiscal structure of 2011 Realignment, including proposals to change or redirect growth funding that does not follow the intent of the law.

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

CSAC will oppose efforts that limit county flexibility in implementing programs and services realigned in 2011 or infringe upon our individual and collective ability to innovate locally. Counties resolve to remain accountable to our local constituents in delivering high-quality programs that efficiently and effectively respond to local needs. Further, we support counties' development of appropriate measures of local outcomes and dissemination of best practices.

These statements are intended to be read in conjunction with previously adopted and refined Realignment Principles, already incorporated in the CSAC Platform~~. Those~~ below. These principles, along with the protections enacted under Proposition 1A (2004), ~~would~~will guide ~~counties'~~our response to any future proposal to shift additional state responsibilities to counties.

~~Attachment:~~**2010 CSAC Realignment Principles: Approved by the CSAC Board of Directors**

Facing the most challenging fiscal environment in the California since the 1930s, counties are examining ways in which the state-local relationship can be restructured and improved to ensure safe and healthy communities. This effort, which will emphasize both fiscal adequacy and stability, does not seek to reopen the 1991 state-local Realignment framework. However, that framework will help illustrate and

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guide counties as we embark on a conversation about the risks and opportunities of any state-local realignment.

With the passage of Proposition 1A the state and counties entered into a new relationship whereby local property taxes, sales and use taxes, and Vehicle License Fees are constitutionally dedicated to local governments. Proposition 1A also provides that the Legislature must fund state-mandated programs; if not, the Legislature must suspend those state-mandated programs. Any effort to realign additional programs must occur in the context of these constitutional provisions.

Counties have agreed that any proposed realignment of programs should be subject to the following principles:

1) **Revenue Adequacy.** The revenues provided in the base year for each program must recognize existing levels of funding in relation to program need in light of recent reductions and the Human Services Funding Deficit. Revenues must also be at least as great as the expenditures for each program transferred and as great as expenditures would have been absent realignment. Revenues in the base year and future years must cover both direct and indirect costs. A county's share of costs for a realigned program or for services to a population that is a new county responsibility must not exceed the amount of realigned and federal revenue that it receives for the program or service. The state shall bear the financial responsibility for any costs in excess of realigned and federal revenues into the future. There must be a mechanism to protect against entitlement program costs consuming non-entitlement program funding.

    a. The Human Services Funding Deficit is a result of the state funding its share of social services programs based on 2001 costs instead of the actual costs to counties to provide mandated services on behalf of the state. Realignment must recognize existing and potential future shortfalls in state responsibility that have resulted in an effective increase in the county share of program costs. In doing so, realignment must protect counties from de facto cost shifts from the state's failure to appropriately fund its share of programs.

2) **Revenue Source.** The designated revenue sources provided for program transfers must be levied statewide and allocated on the basis of programs and/or populations transferred; the designated revenue source(s) should not require a local vote. The state must not divert any federal revenue that it currently allocates to realigned programs.
3) **Transfer of Existing Realigned Programs to the State.** Any proposed swap of programs must be revenue neutral. If the state takes responsibility for a realigned program, the revenues transferred cannot be more than the counties received for that program or service in the last year for which the program was a county responsibility.
4) **Mandate Reimbursement.** Counties, the Administration, and the Legislature must work together to improve the process by which mandates are reviewed by the Legislature and its fiscal committees, claims made by local governments, and costs reimbursed by the State. Counties believe a more accurate and timely process is necessary for efficient provision of programs and services at the local level.
5) **Local Control and Flexibility.** For discretionary programs, counties must have the maximum

flexibility to manage the realigned programs and to design services for new populations transferred to county responsibility within the revenue base made available, including flexibility to transfer funds between programs. For entitlement programs, counties must have maximum flexibility over the design of service delivery and administration, to the extent allowable under federal law. Again, there must be a mechanism to protect against entitlement program costs consuming non-entitlement program funding.

6) **Federal Maintenance of Effort and Penalties.** Federal maintenance of effort requirements (the amount of funds the state puts up to receive federal funds, such as IV-E and TANF), as well as federal penalties and sanctions, must remain the responsibility of the state.

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January 13, 2017

To: CSAC Health and Human Services Policy Committee

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

RE: Budget Update: The Governor's January Budget Proposal – Information Only

Background. Governor Jerry Brown echoed familiar themes in the release of his proposed 2017-18 budget with emphasis on prudence and caution due to reduced revenue expectations and a long list of unknowns facing California's fiscal outlook. The proposed budget totals $122 billion in state General Fund expenditures, with just a 0.2% decrease from the last year's January budget.

The Department of Finance (DOF) has reported revenues below forecast from the adopted 2016-17 budget with all of the "big three" general fund sources – income, sales and corporation taxes – showing weakness as part of an economic slowdown. The proposed budget seeks to cover what would be a $1.6 billion dollar deficit in the current budget and future deficits of $1-$2 billion annually. State revenues are still expected to grow by 3% in 2017-18 but this is inadequate to cover spending levels established in last year's adopted budget.

The list of unknowns influencing spending reductions and freezing planned expenditures includes the ever-volatile source of major state funding from personal income taxes and capital gains; the impending sluggish economy following unprecedented growth over the last eight years; and a new Administration in Washington, D.C. that could make significant changes to federal programs and state funding levels.

Many of the questions surrounding possible changes under President-Elect Trump, including those related to repeal of the Affordable Care Act, will not be addressed by DOF until greater certainty and next steps are known. This could be reflected in the Governor's May Revision along with improved revenue returns and revised estimates.

However, a significant program concern for counties is already reflected in the 2017-18 proposal. This includes the unwinding of the Coordinated Care Initiative (CCI) and elimination of the In-Home Supportive Service (IHSS) maintenance of effort (MOE) resulting in approximately $625 million in new county costs statewide for 2017-18 alone and at least $4.4 billion over the next six years. The cost is a result of shifting 35 percent of all costs related to the IHSS program to counties, including newly added costs due to state action to increase in minimum wage and pay sick leave to IHHS workers, as well as, additional cost due to federal action to require overtime pay.

For more detail on the budget as a whole, and other issue areas, please see the CSAC Budget Action Bulletin.

Attachments:
Health and Human Services Section of the CSAC Budget Action Bulletin. January 10, 2017.

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GOVERNOR'S PROPOSED BUDGET FOR 2017-18
JANUARY 10, 2017

January 10, 2017

TO: CSAC Board of Directors
County Administrative Officers
CSAC Corporate Partners

FROM: Matt Cate, CSAC Executive Director
DeAnn Baker, CSAC Deputy Executive Director of Legislative Affairs

RE: **Governor's January Budget Proposal for 2017-18**

Health and Human Services

Governor Dismantles the County IHSS MOE and Returns Collective Bargaining to Counties
Governor Brown's Director of Finance will discontinue the Coordinated Care Initiative (CCI) and dismantle the In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) deal in the 2017-18 budget. Following current statute, Director Cohen has the authority to do so without legislative action. The county IHSS MOE for all counties will expire on June 30 of this year, health plans will lose their enhanced capitation rates for IHSS benefits, and the CCI would end on December 1, 2018. CSAC will oppose the state's efforts to shift new IHSS program costs to counties.

Cost: According to estimates developed by the County Welfare Directors Association, the demise of the county MOE for all 58 counties will result in $625 million in increased county costs for the IHSS program in 2017-18 if statutory sharing ratios for the nonfederal share of the current program costs are used: 65 percent state and 35 percent county. This estimate is based on normal program growth costs and includes new costs recently enacted by the state – the minimum wage increase up to $15 per hour and three paid sick leave days for IHSS workers – and the new federal overtime regulations. The IHSS MOE deal had limited county IHSS costs to a base year calculation of 2011-12 costs plus an annual 3.5 percent inflator.

Collective Bargaining: The January Budget proposal means that IHSS Collective Bargaining from counties participating in the CCI will transfer from the Statewide Public Authority back to the counties. This also means that any future transfer of collective bargaining in the other 51 counties will not occur. To date, only the 7 current CCI counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara) had transferred IHSS Collective Bargaining to the state.

Timeline:

- Jan 10, 2017 - Deadline for Director of Finance to announce that CCI will not generate net General Fund savings and will become inoperative
- July 1, 2017 - County IHSS MOE (WIC §12306.15), including 3.5 percent inflator and state responsibility for collective bargaining, becomes inoperative.
- Jan 1, 2018 - CCI becomes inoperative.

Coordinated Care Initiative: While Director Cohen has decided to repeal the CCI, including the elimination of the enhanced rates for health plans, the eradication of the Statewide Public Authority, and a return to pre-MOE state-county costs sharing (65/35), he does indicate that the budget proposes to continue the Cal Medi-Connect program, continue mandatory enrollment for dual eligibles, and include long-term services and supports – but not IHSS – into managed care. The budget also encourages continued cooperation between plans and counties, but without funding for these activities, it is unclear how the policy directives would be carried out.

Health Care Reform – Affordable Care Act

Governor Brown has steadfastly maintained that the state will operate under the current Affordable Care Act (ACA) statutes and continue to budget accordingly despite the potential for Congress to repeal the Act. He has included language in the budget indicating his willingness to build on what has worked and "play a constructive role" on the issue, but only "within the fiscal constraints facing the state."

MEDI-CAL

Overall

Medi-Cal caseload continues to increase from 7.9 million beneficiaries in 2012-13 to an estimated 14.3 million beneficiaries in 2017-18 for total costs of $20 billion. The state will also assume a 5 percent share of cost for the nearly 4 million ACA Medi-Cal Expansion cases in 2017, contributing $888 million State General Fund in 2017-18 for this population alone.

County Medi-Cal Administration Costs

As part of a budget deal in 2016, the 2017-18 budget maintains the state's commitment to fund county Medi-Cal administration activities with $217.1 million State General Fund ($655.3 all funds). The budget also includes $731,000 ($1.5 million all funds) for the development of a new Medi-Cal Administration budgeting methodology.

MCO Revenues for Medi-Cal

The Managed Care Organization tax passed in 2016 and provides $1.1 billion for Medi-Cal in the current year and is estimated to provide $1.6 billion in 2017-18. This funding is used for the nonfederal portion of managed care rates for services provided to children, adults, seniors, persons with disabilities, and those who are dually eligible for both Medicare and Medicaid. CSAC supported the MCO Fix to assist the state with Medi-Cal and Coordinated Care Initiative costs.

Medi-Cal Error

The State is using $1.8 billion in 2017-18 to repay federal drug rebates and correct a calculation error made in the reimbursement rates for the Coordinated Care Initiative.

Children's Health Insurance Program

Due to the uncertainty in the future of the Children's Health Insurance Program (CHIP) at the federal level – it needs to be reauthorized by Congress by September of this year – the Governor's budget takes a cautious approach and assumes it will be reauthorized, but with a lower federal matching rate (65 percent instead of the enhanced 88 percent) for a total State General Fund cost of $536.1 million in 2017-18.

Medi-Cal Benefits for Undocumented Children and Adults

The Governor's budget proposal maintains state funding for the recent expansion of Medi-Cal benefits to undocumented children (SB 75, Chapter 18, Statutes of 2015) for $279.5 million in 2017-18. It also books $48 million in Medi-Cal savings from the new policy to allow undocumented persons to purchase private insurance from Covered California (SBX1 1m Chapter 4, Statutes of 2016, First Extraordinary Session).

Hospital Quality Assurance Fee (Proposition 52)

Proposition 52 passed in November 2016 and the 2017-18 budget assumes General Fund savings of more than $1 billion due to the fee, which is indefinite. CSAC supported Proposition 52 to assist the state with Medi-Cal costs.

Medicaid Managed Care Regulation

The Governor is dedicating and additional $4.5 million to implement the new federal Medicaid managed care regulations, which require more oversight by the Department of Health Care

Services (DHCS). DHCS will oversee the implementation of the regulation for the state, and it is not yet known how much this new regulation package will cost California and counties.

2011 AND 1991 REALIGNMENT FUNDING

Please refer to the Appendices for more details on the Governor's 2017-18 estimates for 2011 and 1991 Realignment.

Base Set for 2011 Realignment Behavioral Health Subaccount

CSAC and the County Behavioral Health Directors Association worked with the Administration for nearly two years to develop and set a base allocation for the 2011 Realignment Behavioral Health Subaccount. While the base formula was implemented in the current year, beginning with the 2017-18 allocation, the ongoing base allocations will consist of the 2016-17 base allocation plus subsequent growth allocations. This will then serve as a rolling base mechanism for future allocations to the Behavioral Health Subaccount.

PUBLIC HEALTH

AB 85 Health Realignment Redirections

The Governor's budget estimates $585.9 million in county 1991 Realignment Health Subaccount savings for the current year, and $546.2 in 2017-8 – if the Affordable Care Act is still in place. Additionally, the state will complete the "True Up" for the 2014-15 fiscal year, which preliminarily indicates additional county savings of $245.6 million in that fiscal year. Please keep in mind that the True Up is a county-by-county calculation and only those counties that have experienced additional savings in 2014-15 above what was redirected under AB 85 will owe these funds. We also anticipate that some counties will receive reimbursements due to reduced savings under AB 85. These estimates will be updated with audited results in the May Revision Budget. Attached as an appendix to this document are the 2017-18 AB 85 redirections.

PROPOSITION 56: TOBACCO TAX INCREASE

In November 2016, voters passed Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, which increases the excise tax rate on cigarettes and tobacco products, effective April 1, 2017. This tax is now also applicable to electronic cigarettes. The excise tax, which is paid by distributors selling cigarettes in California, increased by $2 – from 87 cents to $2.87 per pack of 20 cigarettes. Proposition 56 requires backfills to Proposition 99, Proposition 10, the Breast Cancer Fund, and to state and local governments to address revenues declines resulting from the additional tax. The specific allocation of Proposition 56 funding in 2017-18 is reflected in the chart on the following page. Because of the April 1, 2017,

effective date of the increased excise tax, the budget includes five quarters of tax revenues for expenditure in 2017-18.

Proposition 56 Allocations
($ in millions)

Investment Category	*Department*	*Program*	*2017-18 Amount*[1/]
Enforcement	Dept. of Justice	Local Law Enforcement Grants	$37.5

		Distribution and Retail Sale Enforcement[2/]	$7.5
	Board of Equalization	Distribution and Retail Sales Tax Enforcement[2/]	$5.8
	Dept. of Public Health	Law Enforcement[2/]	$7.5
Education, Prevention, and Research	University of California	Cigarette and Tobacco Products Surtax Medical Research Program	$80.7
		Graduate Medical Education[2/]	$50.0
	Dept. of Public Health	State Dental Program[2/]	$37.5
		Tobacco Prevention and Control	$178.5
	State Dept. of Education	School Programs	$31.5
Health Care	Dept. of Health Care Services	Health Care Treatment	$1,237.4
Administration and Oversight	State Auditor	Financial Audits	$0.4
	Board of Equalization	Sales and Use Tax	$1.1
Revenue Backfills	Proposition 99, Breast Cancer Research Fund, and Proposition 10		$37.1
Total			**$1,712.5**

1/ "2017-18 Amount" includes one quarter of 2016-17 revenue and four quarters of 2017-18 revenue.
2/ Annual amount specified in statute.

BEHAVIORAL HEALTH

Drug Medi-Cal

The budget includes $3.1 million General Fund ($19.9 million total funds) in 2017-18 for the rollout of the new Drug Medi-Cal Organized Delivery System Waiver, and $141.6 million General Fund in 2018-19. Six counties will participate in 2016-17, and 10 more are expected onboard in the following year.

2011 Behavioral Health Subaccount Base

Please see the Realignment section above for information about the new 2011 Realignment Behavioral Health Subaccount base.

Children's Mental Health Crisis Service Grants

The Budget revokes the $17 million General Fund from the 2016-17 Budget intended for grants to local governments to increase the number of facilities providing mental health crisis services for children and youth under the age of 21. This language was initially included in last year's SB 833 (Committee on Budget and Fiscal Review, Statutes of 2016).

HUMAN SERVICES

Continuum of Care Reform

The Continuum of Care Reform (CCR) of the state's foster and probation youth group homes went live on January 1. The Budget includes $163.2 million General Fund ($217.3 million total funds) to continue the implementation of the Continuum of Care Reform (AB 403, Statutes of 2015). Counties, including Child Welfare Services, Behavioral Health services, and probation services, continue to grapple with implementing CCR. The Budget states that while progress has been made in implementing CCR, assumptions on caseload movement were revised to more accurately reflect the pace of implementation.

CalWORKs

Repeal of the CalWORKs Maximum Family Grant

The 2017-18 proposal includes $224.5 million ($198.2 General Fund) to reflect a full year of increased grant costs that are due to the repeal of the Maximum Family Grant (MFG) rule, effective January 1, 2017. The rule prohibited cash aid for any child born into a CalWORKs household ten or months after initially receiving aid for the purposes of calculating a household's maximum aid payment. It was repealed last year thanks to the work of Senator Holly Mitchell.

Child Welfare Digital Services

The proposed budget includes $88 million General Fund ($175.9 total funds) to support an increase in project activity, including increased funding for county engagement as individual digital services are designed, developed and implemented. The Child Welfare Services New System case management project continues to make progress since adoption in November 2015. The system is a suite of services being developed and integrated to deliver continually improving assistance to state and county workers.

Continue Consolidation of Statewide Automated Welfare Systems

The proposed budget includes $38.5 million ($7.5 million General Fund) for 39 counties using

the Consortium IV system to migrate to the LEADER Replacement System. The first year of funding for these migration activities will be available after the county consortia negotiations are complete and both the Department of Finance and the Department of Technology have reviewed and approved detailed project documents.

SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTAL PAYMENT

As of January 2017, the maximum SSI/SSP grant levels are $895.72 per month for individuals and $1,510.14 per month for couples. For 2017, the current Consumer Price Index growth factor is 0.3 percent, and it is projected to be 2.6 percent for 2018. Additionally, maximum SSI/SSP monthly grant levels will increase by $20 for individuals and $29 for couples as of January 2018.

STATE HOSPITALS

Incompetent to Stand Trial Admissions

Please see the Administration of Justice Section of the Budget Action Bulletin for more details on Incompetent to Stand Trial Admissions.

PUBLIC HEALTH

Licensing and Certification

The proposed budget includes $1.1 million in Licensing and Certification Program Fund in 2017-18 for the Los Angeles County contract to account for several salary increases. Los Angeles County salaries for burse surveyors and other contracted staff are higher than state salaries. These Los Angeles County salaries have increased in each of the past two years and will continue to increase in 2017 and 2018. Because of these ongoing cost pressures, the Department of Public Health is evaluating the most effective way to provide ongoing regulatory oversight of health care facilities in Los Angeles County. The Budget states that any continuation of the current relationship with Los Angeles County will require:

- Regulatory actions be completed in a timely manner and consistent with other areas of the state,
- Consistency in the quality of evaluations ,
- Cost Maintenance and within budgeted amounts.

Elimination of the Health Care Workforce Augmentation

The proposed budget includes the reversion of $33.4 million General Fund from 2016-17 that were intended to fund health care workforce initiatives at the Office of Statewide Health Planning and Development. The Budget does not include additional funding for this purpose in the future.

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January 13, 2017

To: CSAC Health and Human Services Policy Committee

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

RE: Update on the Affordable Care Act – Information Only

Introduction. California's counties have gone to great lengths to implement the federal Affordable Care Act (ACA), which provides billions of federal dollars for indigent health care services, behavioral health services, preventative care, public health grants, and coordinated care**.**

The incoming administration and Congress are certain to make repealing the ACA a top priority. However, without a replacement framework, counties will be forced to reassume the cost of caring for medically indigent adults, our public hospitals will see increases in uninsured patients, and the private insurance market will collapse without the ACA's individual mandate penalty. Further, Medicaid spending totals $20 billion in California, and the state stands to lose up to $18 billion of that funding if the ACA is repealed without a replacement.

While California's counties face tremendous fiscal vulnerabilities if the fiscal structure of the Affordable Care Act is repealed, it is even more imperative that a replacement framework is adopted at the same time so that states, counties, health plans, hospitals, doctors, and health care consumers can plan and prepare for the new landscape.

We don't yet know what shape a replacement policy would look like, but a wide range of county departments will be negatively affected, including health, public health, social services, behavioral, health, Sheriff, probation, as well as the County's General Fund. Below is a sampling of the immediate consequences for counties if the ACA's fiscal provisions are repealed by Congress:

- The contraction or reduction of Medicaid eligibility will increase the number of uninsured adults in our public health systems and the number of medically indigent adults that must be treated by counties.

- Current federal waivers and demonstration projects (Section 1115 Medicaid 2020 Waiver, Whole Person Care Pilot Projects, 1915b Mental Health Waiver, Drug Medi-Cal Organized delivery System Waiver) will need to be recalculated if the underlying fiscal assumptions and federal matching rates are repealed.

- The behavioral health system, especially substance use disorder treatment, will be gutted by reduced reimbursement rates.

- The AB 85 diversion of Health Realignment funding will need to be renegotiated.

- Counties will lose significant Medi-Cal Administration funding with any decrease in eligibility levels.

- Public Hospitals will again serve a disproportionate share of uninsured patients, throwing them again into fiscal uncertainty.

- The loss of more than $250 million annually in public health prevention funds.

- State costs for the CalWORKs program will increase by $1 to $1.5 2 billion annually.

- Counties will lose the ability to leverage Medicaid spending for grant eligibility and other programs.

- Counties must increase existing or create new networks of care for indigent adults who are no longer eligible for Medicaid.

Federal Process. Republican leaders in Congress are using a special legislative procedure known as "reconciliation" to begin the ACA repeal process. Created by the Congressional Budget Act of 1974, reconciliation allows for expedited consideration of certain tax, spending, and debt limit legislation. In the Senate, reconciliation bills aren't subject to filibuster, requires only 51 votes, and the scope of amendments is limited, giving this process advantages for enacting controversial budget and tax measures.

On January 4th, Senate leaders started this process with a procedural vote to open debate on a budget resolution that sets in motion the ACA repeal process. Any changes proposed through the reconciliation process are only fiscal in nature and must impact the federal budget. This would limit changes to the policy portion of the ACA, but would enable Congress to repeal key fiscal provisions in the law, such as the individual mandate penalties, federal subsidies for private coverage, funding for the Medicaid expansion population, and a number of tax credits. While deadlines are subject to change, it is expected that language will be developed by the end of January, with a package presented to the President by mid-to-late February.

CSAC Efforts. CSAC is working with a wide range of organizations on the impacts of the ACA and developing federal, state, and local strategies to build a coalition around maintaining the safety net and a replacement plan that supports county health responsibilities and systems, should repeal occur.

Specifically, CSAC is working with County Affiliates, including the County Health Executives Association of California, the County Behavioral Health Directors Association, the County Welfare Directors Association, the California Association of Public Hospitals and Health Systems, the County Medical Services Program. We are focusing on data and joint advocacy efforts. In addition, CSAC is in contact with key health advocacy organizations, including Health Access and SEIU.

CSAC and our member counties will also be traveling to Washington, D.C. in February for the National Association of Counties (NACo) Legislative Conference and will be advocating on this issue. To further this national effort, our federal lobbyists are coordinating with other state associations to devise a multi-state strategy for urging a timely replacement of the ACA.

CSAC is also drafting a letter to Congress outlining our significant concerns regarding a replacement for the ACA and urging rapid, if not concurrent, adoption of a replacement upon enacting an ACA repeal. We are also drafting issue briefs for a more in-depth look at key impacts on the public hospital, mental health, health, and social services systems.

Attachments:
Joint County Letter on the Affordable Care Act. January 13, 2017.

NACo Letter to U.S. House of Representatives Leadership on Health Care Recommendations. January 6, 2017.

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CALIFORNIA STATE ASSOCIATION OF COUNTIES

CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION

COUNTY HEALTH EXECUTIVES ASSOCIATION OF CALIFORNIA

COUNTY MEDICAL SERVICES PROGRAM

COUNTY WELFARE DIRECTORS ASSOCIATION

January 13, 2017

Dear California Congressional Delegation Member,

The undersigned California county associations are very concerned about the potential dire effects of repealing the Affordable Care Act without a suitable comprehensive replacement that ensures market and delivery system stability and continued coverage for more than 14 million Californians. Our members represent a broad spectrum of California county services, including public safety and law enforcement, public safety net hospitals, public health, human services, and behavioral health (including substance use disorder treatment). Our counties partner with California to provide medical care, behavioral health care, Medicaid, TANF, and SNAP eligibility services, and a number of other key health and human services programs statewide. Many of our largest counties also operate public hospitals. Our broad reach and commitment to the health of our communities – and, increasingly, the close connections and innovations county leadership is developing between public safety efforts and health treatment – provides us with a unique perspective on the Affordable Care Act (ACA) and its effect on our constituents' lives.

Although the outcome is still uncertain, we have illustrated below the potential effects of repealing the ACA without a suitable framework to replace it. California's counties seek the development of such a replacement framework, but we write to share with you the destructive impact the loss of the ACA will have on our members and the 38 million people we serve. California's counties must be included in the development of a comprehensive replacement framework that does not disadvantage enrollees by eliminating coverage or increasing costs.

California's Counties stand to lose billions of dollars if the ACA is repealed without a simultaneous, suitable, comprehensive replacement for providing critical Medicaid services to the more than 14 million Medicaid-eligible people in California. In the absence of an immediate and appropriate replacement plan, our uncompensated care costs will skyrocket, destabilizing our health care systems. Those who lose their Medicaid or Covered California coverage in the absence of the ACA will again have to wait until a health issue becomes an emergency to seek care – care that is the most expensive and with the poorest health outcomes. Important mental health and substance use disorder treatment services will cease to exist, and counties and health providers will be forced to reduce

their workforces by hundreds of workers.

For each of our memberships, the positive impact of the ACA has been unprecedented. It has also incentivized collaboration and innovation to improve health while also delivering high-quality health and behavioral health care more efficiently. Here is a sample of the work our members do and how the ACA impacts our health care and law enforcement responsibilities:

County-Administered Health Care
California's counties are responsible for providing health care to the poorest and sickest adults under Section 17000 of the state Welfare and Institutions Code, as well as critical public health services in our communities. The state's decision to opt into the ACA Medicaid Expansion has significantly reduced the number of uninsured adults by providing health care coverage and access to services.

Since the implementation of the ACA, our health departments have implemented innovative public health programs and services, including outreach to vulnerable populations and targeted health promotion and chronic disease prevention campaigns. Last year, California received roughly $90 million to invest in public health prevention activities through Prevention and Public Health Fund grants, making efficient use of the nation's first dedicated public health funding stream.

The repeal of the ACA without a comprehensive and simultaneous replacement will force counties to rapidly reconstitute indigent health care systems in an uncertain marketplace and fundamentally reduce our capacity to continue prevention strategies and infectious diseases reduction efforts in our communities.

Mental Health and Substance Use Disorder Treatment
Should the ACA be repealed without a suitable comprehensive replacement, millions of Californians will lose access to important behavioral health services. The ACA establishes mental health and substance use disorder benefits as services that must be covered as Essential Health Benefits (EHBs). These EHBs mean that millions of Californians have recently gained access to these critical services. This access will cease if the ACA is repealed without a simultaneous comprehensive replacement.

In California, Medi-Cal enrollees with serious mental illness are eligible for county specialty mental health services. Beneficiaries will lose access to these services if the ACA Medi-Cal expansion is repealed. The loss of mental health services will be especially acute for those individuals being treated within California's county behavioral health system. In addition, county systems will likely see an increase in individuals who are in crisis and seeking specialty mental health services as a result of the loss of commercial coverage through Covered California, our state's ACA heath care exchange.

Further, the loss of the ACA Medicaid Expansion will gut the state's substance use disorder treatment system at a time when more Americans are grappling with opioid and other addictions. It is estimated that approximately 12% (450,000 individuals) of

California's Medicaid expansion population has a substance use disorder. Under California's Drug Medi-Cal Organized Delivery System Waiver, counties may opt into expanded substance use benefits. Those who are able to access substance use disorder treatment include adults transitioning from the jails or state prisons; adults being diverted from the criminal justice system; and individuals who are chronically homeless. These populations, many of whom have a high level of need for health and behavioral health services, have gained health coverage due to the ACA and the Medicaid Expansion. Without the ACA or an immediate, suitable, comprehensive replacement, these adults won't be able to access non-emergency substance use disorder or mental health treatment.

Any repeal without a simultaneous, comprehensive replacement of the ACA will have massive negative fiscal impacts on the county-run specialty mental health services plans and behavioral health system overall. It will roll back the clock on the significant progress made in mental health care and stifle local innovation to reduce recidivism and homelessness in our communities.

Public Hospitals and Health Systems

Coverage expansion through the ACA has transformed how public health care systems provide care in California's communities. The ACA offered an unprecedented expansion of insurance coverage to low-income Californians, with Medi-Cal enrollment increasing from 8.6 million prior to the ACA to more than 14 million in 2016. Public health care systems serve as the primary care medical home for more than 500,000 new Medi-Cal enrollees, and as a result, our medical teams are able to focus more attention on care that promotes better value to patients and improvements in health outcomes. For example, over the last few years public health care systems have enrolled more than 680,000 individuals into "medical homes." The combination of coverage and the medical home model, where care is coordinated, results in the more effective deployment of preventive services, more efficient use of limited resources, and better health outcomes overall.

The risks for California's public health care systems are significant. Our 21 public health care systems (16 county and 5 University of California) serve more than 2.85 million patients annually, despite accounting for just 6 percent of the state's hospitals. More than 70 percent of the patients served by our county-owned and operated health care systems are low-income – either Medi-Cal beneficiaries or uninsured. The expansion of Medi-Cal has generated stability for our health systems and improved the outcomes for the people we serve.

The expansion of coverage has been essential to our systems, and a repeal of the ACA could result in public health care systems losing up to $2 billion annually in federal funding. The loss of funding, coupled with a dramatic increase in the number of uninsured, could destabilize our systems and the life-saving services we provide.

Medicaid Eligibility

California's counties provide Medicaid eligibility services on behalf of the state, enrolling and renewing coverage for the more than 14 million beneficiaries, including

three million new beneficiaries since 2013. We have made great strides in improving the technology of our eligibility systems, streamlined the workload of the overall eligibility process, and worked with the state to direct more funding toward human services and employment programs. The loss of ACA matching and administration funding will impact the county human services workforce, technology systems, and innovative county-based solutions such as the Whole Person Care pilot projects and efforts to combat homelessness.

Public Safety

The ACA has drastically changed the health care landscape in California not only by giving us the tools to improve the health of our residents, but also providing our counties the opportunity to tackle important community issues. California's counties are building on the ACA Medicaid Expansion to address some of the most intractable and expensive social problems in the Golden State: the vicious cycle of criminal justice recidivism and chronic homelessness. Under the ACA, nearly all California counties have established programs to provide enrollment assistance to jail inmates as part of a more comprehensive reentry strategy. This allows former inmates who are eligible under the ACA Medicaid Expansion to access critical medical, behavioral health, and substance use disorder services upon their release and help them comply with post-release requirements (such as attending a drug treatment program). Research shows that interventions that improve access to health-related services go a long way toward reducing recidivism, and the associated cost savings help reduce correctional costs on counties and allow those resources to be directed towards reentry programming.

All counties continue to grapple with the homelessness crisis, and the ACA Medicaid Expansion is also a critical tool in the fight to find shelter and support improved health and mental health for California's most vulnerable populations. Because of the ACA, single childless adults can access mental health and substance use disorder treatment services, which are often a key factor in any successful effort to serve the homeless population. Mental health and health care services are an irreplaceable piece of our homelessness efforts.

Counties are leveraging the ACA Expansion to provide coordinated care and case management services for vulnerable populations. In 18 counties, county departments have implemented local programs to support coordination across numerous county departments and achieve improved health outcomes for those who are homeless and frequent users of the local health, criminal justice, and safety net systems.

Counties are also focused on the "last mile" of providing access to health care, especially for dental services and behavioral health treatment in rural areas, increasing the medical and psychiatric professional workforce, and developing innovative new ways to improve care coordination in all settings.

For California's counties, the ACA has increased our residents' access to health and behavioral health care, given them opportunities to seek primary and preventative care, and avoid costly emergency and hospital stays. For the first time in decades, California's

health care safety net is stabilized. Law enforcement and its partners are reducing recidivism, and those who struggle with addiction can receive evidence-based treatment in their communities. Our members have achieved this progress through collaboration and innovation under the ACA. We can't imagine the health care and public safety landscape without this framework. Repealing the Act without an immediate, suitable, and comprehensive replacement will do irreparable damage to our publicly funded health care systems and those we all serve.

California's County Supervisors, Public Hospital Administrators, Health Directors, Behavioral Health Directors, Human Services Directors, and Rural Health Care Administrators urge you to not move forward with repeal plans unless and until a suitable, comprehensive and simultaneous replacement has been developed that maintains existing levels of Medicaid coverage. The health and stability of California's 58 urban, suburban, and rural counties and the people we serve depends upon your commitment to a comprehensive ACA replacement. We stand ready to assist you as you seek to ensure the stability of our safety net systems.

Sincerely,

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

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

Erica Murray
President and Chief Executive Officer
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Administrative Officer
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January 6, 2017

The Honorable Kevin McCarthy
Majority Leader
United States House of Representatives
U.S. Capitol Building, Room H-107
Washington, D.C. 20515

The Honorable Kevin Brady
Chairman, Committee on Ways and Means
United States House of Representatives
1011 Longworth House Office Building
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The Honorable Greg Walden
Chairman, Committee on Energy and Commerce
United States House of Representatives
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The Honorable Virginia Foxx
Chairwoman, Committee on Education and the Workforce
United States House of Representatives
2262 Rayburn House Office Building
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Dear U.S. House Leadership:

Re: December 2, 2016 Letter to Governors and Insurance Commissioners Seeking Health Care Recommendations

On behalf of the National Association of Counties (NACo) and the 3,069 counties we represent, we thank you for soliciting input on major health reforms to strengthen and improve the health of all Americans. A strong federal-state-local partnership is critical to the success of our local health systems, which serve our most vulnerable citizens. Although each state is different, county governments play an integral role in paying for and providing health services, including financing and delivering Medicaid services. As you consider changes to the nation's health care system, especially Medicaid, we respectfully urge you to consider implications of reforms that would merely shift federal and state Medicaid costs to counties and local taxpayers.

Nationally, counties invest $83 billion annually in community health for more than 300 million residents nationwide. Through 961 county-supported hospitals, 883 county-owned and supported long-term care facilities, 750 county behavioral health authorities and 1,943 county public health departments, counties deliver health services to millions of Americans, including many Medicaid beneficiaries. Our county-supported health systems are the cornerstones of care in our communities.

Counties have always served as a social safety net in our communities, including providing health care for America's low-income populations. Over the past 50 years, the Medicaid program has been crucial in helping counties fulfill this obligation. The majority of states mandate counties to provide some level of health care for low-income, uninsured, or underinsured residents—care that is often not reimbursed. In Harris County, Texas, for example, residents pay more than $500 million per year in property taxes to cover the cost of uncompensated care in the county's public hospitals.

If changes are made to shift additional federal and state health and Medicaid responsibilities and costs to counties, this will create an even more challenging dynamic at the local level as many states already restrict counties' ability to raise revenue. In fact, thirty-eight states impose some limitation on counties' property tax rates and property assessments, which are typically the primary revenue sources for counties. Nonetheless, counties continue to invest in local health systems, even during economic downturns.

In 26 states, counties contribute to the non-federal share of Medicaid. In fact, local governments, including counties, may contribute up to 60 percent of the non-federal share of Medicaid costs in each state. For instance, counties in New York send approximately $140 million per week to the state for Medicaid costs. In Fiscal Year 2012 alone, local governments contributed $28 billion overall to the Medicaid program. Proposals to institute block grants or per capita caps for the Medicaid program would further shift federal and state Medicaid costs to counties and compromise our ability to provide health coverage, especially during economic recessions.

Counties have made the most of Medicaid's flexibility to construct health systems that serve a disproportionate share of low income populations, including the underinsured and uninsured, the homeless and those cycling in and out of county jails. County supported health safety net systems provide specialized care that is often unavailable elsewhere while operating on lower margins than other providers. Already, these health systems are subject to impending federal cuts to the Medicaid disproportionate share hospital (DSH) payments. Without sustained funding, these county hospitals will not be able to keep doors open.

Over 70 percent of America's counties have populations of less than 50,000, and the Medicaid program is especially important to these small and rural counties. Medicaid covers 21 percent of rural residents, compared to only 16 percent of those who reside in urban areas. Rural clinics receive enhanced Medicaid reimbursements and Medicaid payments account for more than 14 percent of rural hospitals' gross revenue. More than 75 rural hospitals have closed since 2010, and further cuts would endanger many more.

Health workforce shortage is also a key challenge, especially in our small and rural counties. The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas. Nearly one-third of rural physicians receive at least 25 percent of patient revenues from Medicaid reimbursements. This revenue is essential to helping these counties retain much needed health professionals, especially as they care for an older population than their urban counterparts.

As drug overdose deaths outpace car accidents as the leading cause of accidental deaths, it must be reinforced that Medicaid is still the largest source of funding for behavioral health services in the U.S. Our county public health departments and behavioral health authorities are engaged in key prevention and treatment initiatives from educating patients and families to expanding access to medication-assisted treatments. As the nation struggles to combat the opioid epidemic, counties are at the frontlines and need a strong federal partner to reverse course.

In addition to being the front door to our nation's health system, counties are also the entry point into the criminal justice system. Counties are required by federal law to provide health care for the 11.4 million individuals who pass through 3,100 local jails each year, 91 percent of which are operated by counties. Unlike in federal or state-operated prisons, the

majority of individuals in local jails are pre-trial and low-risk and the average length of stay is only 23 days.

Federal statute prohibits federal Medicaid matching funds from being used for medical care provided to individuals in jails, even for those who are awaiting trial and presumed innocent until proven otherwise. This population is much sicker than the general population, with 64 percent having a mental illness, 68 percent a history of substance abuse and 40 percent a chronic health condition (e.g., cervical cancer, hepatitis, arthritis, asthma or hypertension). 95 percent of these individuals will return to their communities, bringing their health conditions with them. Our goal is to ensure that they receive appropriate treatment in jail that allows them to successfully integrate back into society and contribute to local economies.

To make matters more challenging, many states terminate, instead of suspend, Medicaid for justice-involved individuals the moment they are booked into jail, even before they are given due process. These individuals then must completely re-enroll in Medicaid after being released from jail, which can take months. Not only does this coverage gap leave health conditions like mental illnesses and substance abuse untreated, it can lead to re-arrests and increased recidivism, putting further strain on law enforcement professionals and other social services. As you consider providing further flexibility in the Medicaid program, we urge you to look at models that improve care coordination and health outcomes for those involved in the justice system.

Counties' multifaceted role in health care extends beyond that of a health payer, provider and administrator; counties also provide health insurance to our workforce. Offering competitive health care benefits is one of the primary ways counties attract and maintain a quality workforce. Counties provide health benefits to an estimated 2.5 million employees and nearly 2.4 million of their dependents. For health insurance premiums alone, counties spend an estimated $20 billion to $24 billion annually. We urge you to fully repeal the Cadillac Tax and protect employer-sponsored health coverage.

As one of the earliest units of local government established in the original thirteen colonies that would become the United States, our counties have always evolved in order to serve our residents in partnership with states and the federal government. We stand ready to work with you to identify new and innovative strategies to strengthen our nation's health system and provide high-quality coverage and access to care for all of our residents while being responsible stewards of local taxpayer dollars.

If you have any questions, please feel free to contact Brian Bowden, NACo's Associate Legislative Director for Health, at bbowden@naco.org or 202.942.4275.

Sincerely,

Matthew D. Chase
Executive Director
National Association of Counties