The California County Platform | Chapter 6
Health Services

Adopted by the CSAC Board of Directors March 2023

Section 1: General Principles

Counties are charged with protecting Californians against threats of widespread disease and illness and are tasked with promoting health and wellness equitably across all populations in California. This chapter deals specifically with health services and covers the major segments of counties' functions in health services. Health services in each county relate to the needs of residents within that county in a systematic manner without limitation to the availability of hospital(s) or other specific methods of service delivery. The board of supervisors in each county generally sets the standards of care for their residents.

Local health needs vary greatly from county to county. Counties support and encourage the use of multi-jurisdictional approaches to health service delivery. Counties support efforts to create cost-saving partnerships between the state and the counties, and other partners to improve health outcomes and health equity. 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, access for all populations, and maximum cost effectiveness. Additionally, as new federal and state programs are designed in the field of health services, 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 and outcome development and assessment. Further, any policy or operational changes at the federal or state level resulting in additional programmatic and/or fiscal pressures on local governments must be accompanied by adequate resources and funding to counties.

Counties also support a continuum of preventative health efforts – including communicable disease control, chronic disease, and injury and violence prevention – and the inclusion of public health in the design and planning of healthy communities. Counties also support efforts to prevent and treat substance use and mental health disorders. Preventative health efforts have proven to be cost effective, avert crisis and suffering, and provide a benefit to all residents. Some counties operate their own public hospitals and clinics, which provide a wide range of services to patients who are uninsured or eligible for Medi-Cal, and also provide training for the physician workforce.

Federal health 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 delivery at all levels and must be full partners with the state and federal governments to expand Medicaid and provide health insurance and access to care. Counties believe in maximizing the allowable coverage for their residents in accordance with eligibility criteria, while also preserving access to local health services for the remaining uninsured. Counties remain committed to serving as an integral part of any effort to improve or reform California's health system.

At the federal level, counties also support economic stimulus efforts that help maintain and improve service levels and access to care for the state's neediest residents, regardless of an extenuating circumstance such as an emergency or disaster. Counties strongly urge that any federal stimulus funding, enhanced matching funds, or innovation grants that include a county share of cost be allocated directly to each county that qualifies.

Section 2: Public Health

County health departments and agencies are responsible for protecting, assessing and assuring individual, community and environmental health. Public health agencies are tasked with preventing and controlling the spread of infectious diseases through immunizations, surveillance, disease investigations, laboratory testing and planning, preparedness, and response activities. Furthermore, county health agencies are tasked with evaluating the health needs of their communities and play a vital role in chronic disease and injury prevention through outreach and education, data collection, policy, system, and environmental changes promoting healthier communities.

Additionally, county health departments are charged with responding to public health emergencies, ranging from terrorist and bioterrorist attacks to natural disasters, emerging infectious diseases, and weather-related incidents, including maintaining and bolstering the necessary infrastructure – such as laboratories, medical supply, and prescription drug caches, as well as trained personnel – needed to protect our residents.

Further, county health departments are also working to reduce health inequities and disparities with efforts to eliminate barriers to good health and health care, and supporting the equitable distribution of resources necessary for the health of California's diverse population, including underserved communities. Strategies include addressing the social determinants of health by working with other sectors to maintain and expand affordable, safe, and stable housing; ensuring a health equity lens is applied to economic and social policies to identify and address unintended consequences and potential effects on vulnerable populations, and disproportionately impacted communities; and collecting, analyzing, and sharing information in a manner that protects privacy to understand and address the health impacts of racism, discrimination, and bias.

While counties are appreciative of recent investments in public health, counties continue to be concerned about the lack of funding, including the lack of flexibility in funding, planning, and ongoing support for critical public health infrastructure. Additionally, counties are currently facing severe workforce capacity challenges as well as staff retention, and challenges to recruit highly skilled, trained public health staff; these challenges become exacerbated when new public health crises emerge. The state and federal governments must work with counties and provide funding and technical assistance in a timely manner to ensure adequate planning, medical supplies, access to laboratory testing services, workforce and alternative care capacity to appropriately respond to any local, state, or global health emergency.

1) To effectively respond to these local needs, counties must have adequate, sustained funding for local public health communicable disease control, epidemiological surveillance, chronic disease and injury prevention, emergency preparedness, planning and response activities and ~~–~~public health infrastructure. Counties must also have state and federal support in growing and retaining a highly skilled public health workforce.

2) Counties support the preservation of the federal Prevention and Public Health Fund for public health activities and oppose any efforts to decrease its funding. Counties support efforts to secure direct funding for counties to meet the goals of the Fund.

3) 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~~retain the authority and flexibility to make health policy and fiscal decisions at the local

level to meet the needs of their communities.

Section 3: Behavioral Health

Counties provide a full continuum of community-based prevention and treatment services for individuals living with mental illness and with substance use disorders (SUD). Counties have the responsibility for providing care, treatment and administration of specialty mental health and substance use disorder programs for low-income Californians as specialty mental health plans under Medi-Cal. In addition, the realignment of health and social services programs in 1991 restructured California's public 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. Under realignment, counties may provide a broad range of behavioral health prevention and treatment services to all Californians across all payors, including the uninsured, provided the county has sufficient resources. Counties must have the flexibility to design and implement behavioral health services that best meet the needs of their local communities. The appropriate treatment of people living with substance use and serious mental health disorders should be provided equitably and within the framework of local, state, and federal criteria.

Counties have developed a range of locally designed programs to serve California's diverse population, and must retain the local authority and flexibility. Counties use dedicated state revenues, including 1991 Realignment, 2011 Realignment, and Mental Health Services Act funds to finance both the non-federal share of Medi-Cal entitlement responsibilities, as well as the broader behavioral health safety net. At the same time, the state must ensure that counties have adequate funding to continue and evaluate such services and are provided with additional funding when new programs are created to ensure existing funds are not redirected, resulting in reduced access or quality of care.

Individuals with behavioral health needs are overrepresented in the justice systemmore likely to become justice involved, and therefore, increased access to behavioral health services may also reduce justice involvement among individuals with behavioral health conditions, as well as lower criminal justice costs and recidivism through prevention, diversion, and reentry services for individuals who have behavioral health conditions. The state, counties, and other organizations must collaborate to ensure adequate resources for addressing the complex needs of individuals involved in or at risk of being involved in the criminal justice system who also live with serious mental illness and substance use disorders.

The state must acknowledge the critical role of counties in responding to emergencies, natural disasters and states of emergencies and the need for disaster response trauma-related behavioral health services.

Proposition 163: MentalBehavioral Health Services Act and the Behavioral Health Infrastructure Bond Act

The approval of Proposition 1 by the voters in March 2024 results in significant policy and system reforms to adoption of Proposition 63, the Mental Health Services Act of 2004 (MHSA), which was approved by the voters in 2004 under Proposition 63 to assists counties in mental health service delivery to the public. The Act isMHSA was intended to provide new funding through a one percent income tax on personal income in excess of $1 million per year thatto expands and improves the capacity of county behavioral health systems of care and provides opportunities to fund initiatives not otherwise funded via Medicaid, such as infrastructure, workforce, prevention, the "whatever it takes" model of care, and community-led innovations. MHSA funding was is also dedicated to meeting the needs of each community via robust stakeholder input to determine

spending priorities.

Proposition 1 consists of two main components that make statutory changes to reform the state's county behavioral health system that redirects a portion of MHSA funds and provides one-time resources to develop supportive housing and establish more state-directed behavioral health treatment resources:

- Among its provisions, Proposition 1 renames the MHSA to the Behavioral Health Services Act (BHSA), revises how counties may spend BHSA revenue by allowing the funds to be used for substance use disorders, and prioritizes funding for housing for those with the most severe needs, including the chronically homeless with significant behavioral health challenges, and establishes additional oversight and accountability measures, including increased state direction of BHSA funds. Notably, the measure shifts funds that currently support county mental health services and adds new funding priorities. Prevention and workforce funding will also be shifted from counties to the state.

- Authorizes $6.38 billion in general obligation bonds to finance the conversion, rehabilitation, and construction of supportive housing and behavioral health housing and treatment settings. Of the total, $1.5 billion is to be awarded through grants exclusively to counties, cities, and tribal entities; and local jurisdictions are not precluded from applying for additional funds.

~~The Act~~Just as under the MHSA, the BHSA continues to be ~~is~~ crucial to the stability of the Medi-Cal behavioral health safety net as counties expertly leverage available ~~M~~BHSA funding to provide critical Medi-Cal specialty mental health services annually. Under the BHSA reforms, counties will be required to increase their focus on Medi-Cal billing with BHSA funds and to seek out contracts with all commercial health plans in the state, as well as leverage funding through the Managed Care Plans. Counties value the partnerships with a broad and diverse set of local community stakeholders that will be integral to implementing changes to the county planning process to develop priorities which address local needs~~,~~. ~~as required by~~ The ~~M~~BHSA~~.~~ requires county integrated plans to be developed every three years with over 20 local stakeholder groups including managed care plans (MCPs), labor representative organizations, and continuums of care, among others.

1) Counties support state funding as statutorily required for all new and ongoing county and county behavioral health agency administrative costs incurred in the implementation of Proposition 1, including but not limited to new and increased planning and reporting activities, aligning county behavioral health plans and managed care plan contract requirements, and increased costs for integrated plan development and improving plan operations.

2) Counties support the partnership with the state in the development of critical policies to implement Proposition 1. Counties support the flexibilities afforded by the statutorily authorized funding transfers and exemptions outlined in Proposition 1. The process and criteria for authorized funding shifts and county exemptions should be as flexible as possible to account for county variability, as well as unknown and unforeseen circumstances. Further, established timelines should be reasonable and

sensitive to county budget cycles, and exemptions should be applied easily and appropriately per the issues/limitations being managed in all counties.

3) Counties support as much flexibility as possible in the policy development of eligible uses of the "Housing Interventions" category of funds to ensure the needs of county behavioral health clients are prioritized and to avoid inadvertently creating new challenges for counties in attempting to house their most vulnerable and medically complex clients.

~~1)~~4) Counties oppose additional reductions in state funding for behavioral health services that will result in the shifting of state or federal costs to counties~~,~~ or require counties to use ~~M~~BHSA funds for that purpose. These cost shifts result in reduced services available at the local level and disrupt treatment capacity and options for behavioral health clients. Any shift in responsibility or funding must hold counties fiscally harmless and provide the authority to tailor behavioral health programs to individual community needs consistent with the Act.

~~2)~~5) Counties also strongly oppose any efforts to redirect B~~M~~HSA funding to new or existing state programs and services, or removing local control over funding decisions as intended by the voters. With the shift of MHSA funding to the state for workforce and prevention initiatives, counties believe that diverted BHSA funding should flow to counties whenever possible to fund prevention and treatment efforts.

~~3)~~6) MHSA funds ~~have been~~ were diverted in the past due to economic challenges and the establishment of the No Place Like Home Program in 2016. Any further diversions of funding under ~~M~~BHSA ~~funding~~ will require robust county engagement, keeping the needs of local communities at the forefront without disruption to current programming at the local level.

~~4)~~7) Counties support timely and clear reporting standards, including reversion timelines, for ~~M~~BHSA expenditures and seek guidance from the Department of Health Care Services through robust county stakeholder engagement on all reporting standards, deadlines, and formats. Any development or update to reporting should be clearly established with county stakeholder involvement. Further, updates should be data-driven, measurable, tied to areas of county behavioral health resourcing and responsibility, and reassessed for effectiveness at specified intervals.

~~5)~~ Counties support the fiscal integrity of the ~~M~~BHSA and transparency in stakeholder input, distributions, spending, reporting, and reversions, and seek collaboration with the state on developing tools that accurately report on B~~M~~HSA programs and expenditures and align with current county budgeting processes.

8) ~~Counties support the continued evaluation of MHSA funding silos to allow for greater funding flexibility, accountability for outcomes, and its usage for individuals living with a substance use disorder or co-occurring disorders, provided counties are central to the development of reforms and any shift to accountability for outcomes is grounded in sound data science and client and community input.~~

9) Counties support the development of recommended solutions to reduce BHSA

revenue volatility and establish appropriate prudent reserve levels to support the sustainability of county programs and services. County participation on the BHSA Revenue Stability Workgroup is critical to assessing revenue volatility and providing county input on the recommendations for the report to be submitted to the Legislature and Governor's Office.

10) Counties support the involvement of local agencies in the planning and implementation of population wide and population specific based prevention and workforce development activities that have been designated as state-administered activities under Proposition 1, and recognize the expertise across county agencies and departments in these areas.

11) Counties support guidance and technical assistance with stakeholder input and community planning as it is expanded to all behavioral health funding sources.

12) Counties oppose the imposition of sanctions, such as corrective action plans, monetary sanctions, or the temporarily withhold of payment to counties for issues/circumstances that are unreasonable or fall outside of a county's control. Any sanctions policy should include a timely appeals process and reasonable time to cure and/or to come into compliance.

13) Counties support the expeditious distribution of bond funds under the BHIBA. Counties support the opportunities BHIBA provides to finance the conversion, rehabilitation, and construction of supportive housing and behavioral health housing and treatment settings that are so critically needed. However, counties also acknowledge concerns regarding the sustainability of maintenance and operations in the absence of ongoing support, as well as the workforce recruitment and retention challenges that will take time to address.

14) Counties support the investment of additional start-up funding to assist with the transition from the MHSA to the BHSA including funding to support the conversion of MHSA only providers to Medi-Cal certified providers, and funding to build out the necessary treatment and other infrastructure needed to realize the vision of the BHSA.

~~6)~~

County Specialty Behavioral Health Plans

Counties are committed to service delivery that manages and coordinates services to persons with behavioral health needs and that operates within a system of performance outcomes which assures funds are spent in a manner that provides access to the highest quality of care for all residents. County specialty behavioral health plans must adapt to new models, lead collaborative efforts, and receive adequate and sustainable resources for the next era of behavioral health care.

Counties assumed the role of Medi-Cal specialty plans for behavioral health when they supported the consolidation of what were then two distinct Medi-Cal behavioral health systems: one operated by county behavioral health departments and the other operated by the state

Department of Health Care Services into a single Medi-Cal Mental Health services managed care plan at the local level that operates separately, or is "carved-out," of Medi-Cal managed care. California counties subsequently developed the first in the nation Section 1115 Medicaid waiver to deliver substance use disorder services through a managed care model under the Drug Medi-Cal Organized Delivery System waiver program. There is a negotiated sharing of risk for services between the state and counties, particularly because counties became solely responsible for managing the nonfederal share of cost for all Medicaid specialty behavioral health services under 2011 Realignment.

1) Counties recognize that access to high quality prevention and treatment services for children, adolescents and young adults with behavioral health needs can be improved, and support fiscally viable strategies for building a more comprehensive continuum of care including inpatient and residential treatment services and placement in facilities preferably within the county of residence, for this vulnerable age group.

2) Counties support technical assistance for counties and providers to ensure timely and accurate coding and billing, as well as compliance with quality and service requirements. Responsibility for billing errors, code errors, or other billing oversights must be shared by the state, counties, and any applicable providers. In addition, counties rely on state and federal audits and urge they be completed in a timely manner to ensure counties have the opportunity to correct errors before subsequent audits.

3) The state must ensure that Medi-Cal specialty behavioral health plans are adequately resourced to meet the Medi-Cal entitlement.

4) Counties seek partnership with the state to seek opportunities to maximize federal financial participation under Medi-Cal for the full array of county behavioral health services necessary to encourage and support voluntary services in the least restrictive setting when possible.

5) Counties continue to support state and federal efforts to provide behavioral health benefits under the same terms and conditions as other health services and welcome collaboration with public and private partners to achieve behavioral health parity.

6) Counties support strengthening the behavioral health system by ensuring substance use disorder services and the workforce are more equitably financed, supported, and recognized.

7) Counties support and seek sustained funding and state investments in the expansion of appropriate and available housing options for people with serious mental illness and substance use disorders along the entire continuum of care, including for board and care facilities, recovery-oriented and treatment housing options within the community, as well as residential treatment services. This includes start-up funding to support the build out of flexible spending pools for housing interventions funded under Medi-Cal.

8) Counties support more robust state funding to expand treatment options for

individuals with substance use disorders.

9) Counties support cross-sector, multi-jurisdictional collaboration to promote prevention and education on substance use disorders, and mental health conditions, and to prevent suicide, overdoses, and disparities in mortality for individuals with behavioral health conditions.

10) Counties support local control and decision-making authority in oversight of local behavioral health crisis services to support the rollout of 988 and the expanded Medi-Cal mobile crisis benefit. Counties support efforts to ensure funding for crisis services which are not reimbursed through Medi-Cal, including services to individuals with private insurance.

11) The courts may refer individuals to counties for treatment by court order, for example under the Community Assistance, Recovery, and Empowerment (CARE) Act, but counties are increasingly unable to provide judge-mandated services without adequate and dedicated state funding.

12) Counties urge the state to prioritize coordination and alignment with county-based systems of care when funding new mental health and substance use disorder initiatives, such as the CARE Act, and to include counties in opportunities for supplemental or flexible funding for behavioral health services. Funding behavioral health services in a fragmented or siloed manner is unlikely to promote access or quality.
~~12)~~

13) Counties support ongoing funding for new ~~mandated~~ and expanded CARE Act requirements imposed on counties, including but not limited to activities not otherwise reimbursable through public or private insurance.

14) Counties support the integration of county behavioral health plans and providers in the state's efforts to promote a health information exchange with adequate funding, including through additional investments in behavioral health provider capacity to effectuate participation.

15) Counties support state funding to implement any new or expanded requirements on county behavioral health agencies imposed through legislative, regulatory, or initiative measures.
~~14)~~

Section 4: Public Guardians/Administrators/Conservators

Public Administrators, Public Guardians and Public Conservators are appointed and act under the authority granted by the California Superior Court, and serve as a safety net for the most vulnerable populations, older and dependent adults, and those with serious and persistent mental health disorders and/or severe substance use disorders, and their estates. These services are solely a county function and funded with local county funds. The recent rise in interest in conservatorships as a vehicle to help manage justice-involved and homeless populations also places significant fiscal and workload pressure on county guardians and conservators.

1) ~~CSAC~~ Counties support~~s~~ the acquisition of additional and sustainable non-county resources for public guardians, conservators, and administrators to ensure quality safety-net services for all who qualify. Any proposal from the Administration or Legislature to expand the responsibility of county public conservators of Lanterman-Petris-Short Act (LPS) "gravely disabled" conservatees or probate conservatees must come with additional funding and time for the system to build the necessary treatment and workforce capacity necessary to safely and effectively treat and manage the expanded population.

2) ~~CSAC~~ Counties oppose~~s~~ additional duties, mandates, and requirements for public guardians, conservators, and administrators, and county behavioral health, without the provision of adequate new funding to carry out these services.

3) Counties urge the state to coordinate with counties to ensure alignment with county-based systems of care when imposing new requirements or providing new funding for local Public Guardian and Public Conservator or related county behavioral health LPS treatment services.

4) CSAC will work to support placement capacity for county behavioral health and public guardians, conservators, and administrators as California severely lacks safe and secure housing for the majority of residents under conservatorship. This includes supporting efforts to acquire additional resources for any new or revised facility licensure standards, as well as licensed adult residential facilities and residential care facilities for the elderly and subacute facilities.

5) Counties support state funding for the development of additional new treatment facility types and capacity to support the needs of individuals who fall under the new grave disability standard related to necessary medical care.
~~4)~~

Section 5: Children's Health

California Children's Services

Counties administer the California Children's Services (CCS) program~~s~~ on behalf of and in partnership with the state, a program providing diagnostic, treatment, therapy, and case management services to children with certain serious and complex medical conditions. Counties also provide Medical Therapy Program (MTP) services for ~~California Children's Services~~CCS children at public school sites~~, and retain a share of cost for services to non-Medi-Cal children~~.

~~With the implementation of the~~ Under the CCS Whole Child Model (WCM) initiative, operating ~~with~~in counties with a County Organized Health Systems (COHS) model, responsibility for ~~counties moved~~ service authorization and case management services transferred from counties to local managed care plans. In 2024, DHCS introduced an alternate health care service plan in multiple counties, requiring county CCS programs to work with a second health plan in administering the CCS program. ~~Under the~~ Whole Child Model~~,~~ counties retain ~~also are still~~ responsibility~~le~~ for case management for the CCS State-Only population, determination of residential, medical, and financial eligibility for the program, and MTP services. As of January 2025, thirty-three counties will operate under the CCS WCM.

DHCS is launching the CCS Couty Monitoring & Oversight Initiative, effective July 2025, to establish statewide performance, quality, and monitoring for county administration of the CCS program. The initiative requires county CCS programs to comply with a series of new requirements, including those related to grievances, training, reporting and surveys, and corrective action and enforcement.

1) Counties support efforts to ensure adequate funding for the CCS program, including for county administration and case management services. Maximum federal and state matching funds for the California Children's Services program must continue 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.

2) Counties ~~also~~ support efforts to test alternative models of care under pilot programs. Counties also support efforts to implement operational and administrative improvements in the CCS program, including those related to budgeting and fiscal activities, state guidance, and program procedures.

3) Counties seek to ensure these high-need patients continue to receive timely access to quality care, and there are no disruptions in care. In addition, counties must be adequately resourced to provide services to children and youth who remain the county's responsibility.

4) Counties seek to ensure new initiatives ~~oversight and monitoring programs~~ imposed by the state on CCS programs accurately reflect the county's role in CCS and that counties are adequately resourced to comply with the policies and standards that are applied.

State Children's Health Insurance Program

1) CSAC supports sustained funding for the federal Children's Health Insurance Program (CHIP/Healthy Families). In 2018, the CHIP program was reauthorized through 2023. However, the federal match rate decreases over time during this period and limits the requirement to provide coverage for children in families with income at or below 300% of the federal poverty level. 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.

Proposition 10: The First 5 Children and Families Commissions

In November 1998, California voters passed Proposition 10, the "Children and Families Act of 1998" initiative, which created the 58 First 5 county commissions across the state. The Act levies a tax on cigarettes and other tobacco products and provides funding for early childhood development programs and mandates that commissions work across systems to integrate service delivery and promote optimal childhood development.

First 5 Children and Families Commissions believe that every child deserves to be healthy, safe, and ready to succeed in school and life. Based on extensive research, First 5 promotes the importance of collective impact to support children and families from the earliest moments possible. This prevention framework leads to improved child health and development outcomes, increased school success, and over time increases economic benefit across all public systems.

1) Counties oppose any effort to diminish First 5 funding, 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. Due to the declining nature of tobacco tax revenues, counties support the inclusion of existing tobacco taxes, including Proposition 10, in any subsequent tobacco tax proposal.

2) Counties support identifying new ongoing and sustainable funding for First 5 programs, as well as prioritizing coordination and alignment with county-based systems of care and existing First 5 services and initiatives for any new funding.
3) Counties oppose any effort to restrict local First 5 expenditure authority. First 5 commissions must maintain the necessary flexibility to direct these resources address the greatest needs of communities surrounding family resiliency, comprehensive health and development, quality early learning, and systems sustainability and scale.

~~*Child Health and Disability Prevention Program*~~

~~Counties administer the Child Health and Disability Prevention Program (CHDP), a preventive program that delivers periodic health assessments and services to low-income children and youth in California. Despite the unique role that CHDP plays, due to increased enrollment into Medi-Cal managed care, the CHDP program is slated to sunset no sooner than July 1, 2024.~~

~~Counties support a robust stakeholder process to inform the transition and the development of a transition plan, defined milestones, and monitoring plan for implementation. Counties also support efforts to ensure programs supported by CHDP are sufficiently funded to support the exploration of new partnerships and roles while leveraging existing county expertise.~~

Health Care Program for Children in Foster Care

Counties administer the Health Care Program for Children in Foster Care (HCPCFC), which operates as a standalone program upon the sunset of the Child Health and Disability Prevention Program as of June 30, 2024. HCPCFC provides public health nurse consultation, oversight, and complex case management services to address the medical, dental, behavioral, and developmental needs of foster children and youth statewide.

Counties support programmatic flexibility to structure and staff their standalone HCPCFC programs to best meet local needs of foster children and youth. Counties also support efforts to ensure standalone HCPCFC programs are sufficiently funded and leverage existing county expertise in providing services and supports to this vulnerable population.

Section 6: 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 health and safety of communities; they also operate health plans, provide direct services, operate public hospitals and clinics, specialize in care for patients with complex social needs, conduct eligibility for benefits, provide indigent medical care, and bear a significant amount of risk

for financing the program. As the safety net and jurisdiction charged with protecting the public's health, counties are vitally concerned about health outcomes. Undoubtedly, changes to the Medi-Cal program, including efforts to integrate and coordinate care for Medi-Cal enrollees, will affect all counties.

1) Counties remain concerned about state, federal and local partner proposals that would decrease access to health care or shift costs and risk for Medicaid services to counties.

2) 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 and the patients counties serve. The loss of Medi-Cal funds translates into fewer dollars to operate our facilities and deliver care to all persons served by county facilities. Counties are not in a position to absorb or backfill the loss of state and federal funds. Rural counties already have particular difficulty developing and maintaining health care infrastructure and ensuring access to services. Counties support Medi-Cal payment reforms that result in increased payments and state General Fund.

3) Counties support the continued role of county welfare departments in Medi-Cal eligibility, enrollment, outreach, 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.

4) County behavioral health departments provide Medi-Cal Managed Care Specialty Mental Health Services, and must receive adequate funding for these critical services and new sustainable funding for additional responsibilities.

5) It is vital that changes to Medi-Cal preserve the viability and innovations of the local safety net and not shift additional costs to counties. Counties support efforts to address unnecessary complexity and risk through behavioral health payment reform with the goal of ensuring additional efficiencies and reducing administrative workload. Counties support state funding to ensure counties do not shoulder additional costs in implementing payment reform.

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

7) The state should continue to provide options for counties to implement managed care systems that meet local needs. The state should work openly and collaboratively with counties as primary partners in this endeavor and allow counties a role in managed care plan selection.

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 must offer a reasonable reimbursement and rate mechanism for local managed care systems which should help ensure sufficient health plan participation and expand the number of providers serving Medi-Cal participants.

9) Changes to Medi-Cal must preserve access to medically necessary behavioral health care and drug treatment services.

10) Efforts to better integrate services in Medi-Cal care delivery must consider the unique role of county behavioral health as specialty plans for beneficiaries with serious mental illness and substance use disorders, and preserve federal funding available to county behavioral health to continue the effective delivery of community-based mental health services to local Medi-Cal enrollees.

11) Counties recognize the need to continue to innovate under the Drug Medi-Cal Organized Delivery 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 fiscal risks. Counties support sustained state investment to ensure statewide implementation of the Drug Medi-Cal Organized Delivery System.

12) Counties support the pursuit of a new Serious Mental Illness/Serious Emotional Disturbance Institutions for Mental Disease (IMD) waiver to allow counties to secure additional federal funding under Medi-Cal for mental health inpatient and residential treatment stays and support maximum local control on how to reinvest savings to improve access to outpatient treatment and reduce the need for inpatient levels of care in the long term.

13) Any Medi-Cal reform effort must recognize the importance of substance use disorder treatment and services in the local health care continuum, as well as the evidence of good outcomes under integrated care models.

14) Counties will not accept a share of cost to locally support the Medi-Cal program for federal or state-only expansion of services. 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.

15) The state should fully fund county costs associated with the local administration of the Medi-Cal program.

16) 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.

17) The state should consider counties as full partners in the administration of Medi-Cal and new Medi-Cal initiatives such as CalAIM. The state should prioritize and fund counties – including through adequate reimbursement rates for CalAIM services – to provide services that leverage our existing expertise and ~~and~~ consult with counties in formulating and implementing all policy, operational, and technological changes.

18) Any statewide efforts at improving and increasing data sharing infrastructure and data integration across platforms must also include robust technical assistance, adequate funding, and consultation with counties and relevant stakeholders.

Medicare Part D

Medicare Part D led to an increase in workload for case management across many levels of county medical, social welfare, criminal justice, and 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.

Medicaid and Aging Issues

1) Counties support reliable funding for programs that affect older and dependent adults, such as Adult Protective Services (APS) and In-Home Supportive Services (IHSS), and oppose any funding cuts, or shifts of costs to counties without revenue, from either the state or federal governments. Please see the Human Services Chapter of the CSAC Platform for more details on APS and IHSS.

2) Counties support efforts to prevent, identify, and prosecute instances of elder and dependent adult abuse.

3) Counties support investments of new state and federal resources to support the APS workforce and enhance the direct services available to victims of abuse and neglect.

4) 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.

5) Counties support federal and state funding to support Alzheimer's disease and dementia research, community education and outreach, respite care, and resources for caregivers, family members and those afflicted with Alzheimer's disease and dementia.

6) Counties support legislative efforts coupled with adequate funding to prevent homelessness among at-risk older adults and people with disabilities.

7) Counties support funding for the full range of aging programs that provide services to older adults including services provided by Area Agencies on Aging (AAAs), senior nutrition programs, meal delivery programs, caregiver supports, resource centers, ombudsman programs, and home and community-based supports.

8) Counties should maintain flexibility and control to determine locally the AAA administrative structure that works best in their communities for delivering aging services.

Section 7: Health Reform Efforts

Counties support affordable, comprehensive health care coverage for all persons living in the state. The sequence of changes and implementation of federal or state healthcare reform efforts must be carefully

planned, and the state must work in partnership with counties to successfully realize any gains in health care access and delivery and possible cost increases or decreases.

Under AB 85 (Chapter 24, Statutes of 2013), counties must also retain sufficient health realignment revenues for residual responsibilities, including existing Medi-Cal non-federal share responsibilities to care for the remaining uninsured, and public health. Any changes to AB 85 must also allow counties to retain sufficient health realignment revenues for these residual responsibilities and future needs.

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

2) Counties support the integration of health care services for justice-involved individuals of county and state correctional institutions, detainees, and undocumented immigrants into the larger health care service model.

3) Health reform efforts must address access to health care in rural communities and other underserved areas and include incentives and remedies, including telehealth and consideration of other innovative access and delivery methods, to meet these needs as quickly as possible.

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

5) The current safety net is grossly underfunded compared to the actual cost of doing business at the local level. 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 extensive primary, specialty and tertiary care –are essential providers. Their education, training and ongoing work must be supported in any health care reform effort.

7) Counties strongly support adequate funding for the local public health infrastructure as part of a plan to reform health care and achieve universal health coverage. A strong local public health infrastructure can help reduce medical care costs, assist patients in managing chronic disease, reduce health inequities, and address disaster preparedness and response.

8) Counties support access to affordable, comprehensive 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.

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

10) The federal government has an obligation and responsibility to assist in the provision of funding of health care coverage.

11) 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.

12) County financial resources are currently overburdened; counties are not in a position to contribute permanent additional resources to expand or integrate health care coverage. Counties support grant and other direct funding opportunities with streamlined application processes, as well as tracking and reporting requirements that are not overly burdensome.

13) Counties strongly encourage public health and equity as key components to any health care coverage expansion. Public health prevention activities in addition to access to health education, preventive care, and early diagnosis and treatment will assist in controlling costs through improved health outcomes. Health equity efforts will increase access to health care for underserved populations and improve the overall health of our communities.

14) Counties, as both employers and administrators of health care programs, recognize that, under the current system in the United States every employer has an obligation to contribute to health care coverage, 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.

15) Reforms of health care coverage should offer opportunities for self-employed individuals, temporary workers, and contract workers to obtain affordable quality health coverage.

Section 8: 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.

2) 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. 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. 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. 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.

3) Counties support the continued use of federal Medicaid funds for emergency services for undocumented immigrants. Counties support increased funding for trauma and emergency room services overall.

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 health care safety-net services must be supported to ensure their long-term viability.

Realignment

1) Counties believe the integrity of realignment should be protected. Counties also strongly oppose any change to realignment funding that would negatively impact counties fiscally or administratively.

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

3) Any effort to realign additional programs must occur in the context of Proposition 1A constitutional provisions and must guarantee that counties have sufficient revenues for residual responsibilities, including public health programs.

4) In 2011, counties assumed 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.

5) Counties bear significant responsibility for financing the non-federal share of Medi-Cal services in county public health and behavioral health systems. They also continue to have responsibility for uninsured services.

Hospital Financing

Public hospitals and health systems are a vital piece of the local safety net, and serve as indispensable components of a robust health system, providing primary, specialty, and acute health services, as well as physician training, trauma centers, and burn care. California's public hospitals provide a significant portion of the state's non-federal share in the Medi-Cal program, and these local expenditures are made at the sole discretion of the county ~~S~~supervisors.

1) Counties have 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 and state funding in the future as needs grow and challenges arise.

2) Counties strongly support the continuation of robust and innovative Medicaid Section 1115 and 1915(b) waivers to ensure that county hospitals are paid for the safety net care they provide to Medi-Cal recipients and uninsured patients and have the ability to innovate and improve access to care.

3) As California moves away from large Medicaid waivers that county public hospitals have relied on for critical funding, funding levels must be preserved and strengthened through

other vehicles.

4) Counties also support opportunities for county public hospitals and health systems to make delivery system improvements, including improving care coordination, which will help ensure the provision of high quality, accessible care to all patients they serve.

5) Counties support proposals to preserve supplemental payments to public and private hospitals. Any loss of federal funds through changes to waiver agreements or federal regulations must identify other fiscal opportunities and support to ensure the continued viability of the safety net.

~~5)~~6) Counties support increased financing for public hospitals and health systems that does not require counties to put up the non-federal share nor result in reductions to other county services or supports.

Section 9: Violence Prevention

CSAC remains committed to raising awareness of the toll of violence – in particular, family violence and cases of ongoing control and abuses of power, hate crimes, and violence against women, children, ~~and~~ the elderly, and other marginalized groups – on families and communities by supporting efforts that target violence prevention, reporting, investigation, intervention, and treatment. Specific strategies for prevention and early intervention should be developed through cooperation between state and local governments, as well as community and private organizations, taking into account that violence adversely impacts all Californians, particularly those in disadvantaged communities at disproportionate rates, and that these impacts have long-term and wide-ranging health and economic consequences. CSAC also supports efforts to build safe communities, use data-informed approaches, pursue trauma-informed care, and work with key partners to implement violence prevention strategies.

Section 10: Healthy Communities

Built and social environments significantly impact the health of communities. Counties support public policies and programs that aid in the development of healthy communities including food and beverage policies that increase access to healthier food in both county-operated and non-county-operated food programs~~–~~. Counties support the concept of joint use of facilities and partnerships, mixed-use developments and walkable and safe developments, to promote healthy community events and activities.

Additionally, counties support efforts and funding to develop climate change mitigation and resiliency strategies, including but not limited to bolstering infrastructure, to help protect against and address potential impacts on human health such as increased respiratory and cardiovascular disease, injuries and premature deaths related to extreme weather events, including catastrophic wildfires, changes in the prevalence and geographic distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health, particularly for disadvantaged communities that are the most vulnerable to the effects of climate change. Please see the Climate Change Chapter of the CSAC Platform for more details.

Section 11: 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.

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

Section 12: 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, including county authority related to medical control, specialty center designations, and alternative destination efforts.

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.

4) Counties support maintaining the authority and governing role of counties and their local emergency medical services agencies to plan, implement, and evaluate all aspects and components of the local Emergency Medical Services system.

5) Counties oppose efforts that would weaken the local authority of local medical services agencies or lead to system fragmentation, inequitable service, and patient safety issues.

Section 13: Justice-Involved Population

Counties recognize the importance of enrolling the justice-involved population into Medi-Cal and other public programs. Medi-Cal enrollment provides access to important behavioral health, substance use, 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 health and behavioral health services, other jail in-reach services received at local detention centers, and inpatient hospitalizations, including psychiatric hospitalizations, for adults and juveniles while they are incarcerated.

Section 14: 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 (DSH), county public guardians, behavioral health departments, and county sheriffs to find secure placements for individuals originating from DSH facilities, county jails, or who are under conservatorship. Counties support a shared funding and service delivery model for complex placements, such as the Enhanced Treatment Program.

Counties oppose efforts to shift financial and other liability and risk for state DSH responsibilities to counties, and support partnering with the state in ensuring that diversion and community-based restoration services are adequately resourced and supported while retaining access to state hospitals for the most high-risk individuals.

Counties recognize the need for state support in establishing additional secure placement options for adults and juveniles who are conserved or involved in the local or state criminal justice systems, both with capital facility investments and by eliminating statutory and administrative barriers to create local flexibility. While existing provisions allow for competency restoration to occur in community settings or in locked sub-acute care facilities (IMDs, mental health rehabilitation centers) the lack of secure placement options across the state and the federal IMD exclusion from Medicaid limit options to provide treatment for IST individuals. Counties support efforts to expand both funding and options to provide treatment and care, including but not limited to seeking a waiver for the IMD exclusion.

Section 15: Homelessness

Given the growing magnitude of California's homelessness crisis, CSAC reinstated the Homelessness Action Team in 2022 to develop guiding principles on homelessness. These *Homelessness Principles* were approved by the CSAC Board of Directors on September 1, 2022, were utilized to develop the AT HOME Plan that was released in March 2023, and will guide advocacy efforts around homelessness policies, investments, and proposals. The principles outline the need for a statewide plan, call for multi-level partnerships and collaboration while recognizing the need for clear lines of responsibility across all levels of government, detail the importance of building enough housing, and highlight how critical sustained and flexible state funding is to making progress.

The California County Platform | Chapter 11

Human Services

Adopted by the CSAC Board of Directors March 2023

Section 1: General Principles

Counties are committed to the delivery of public social services at the local level. However, counties require adequate and ongoing federal and state funding, timely distribution of 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, in some programs, avoid penalties, putting the state and counties at risk for hundreds of millions of dollars in federal disallowances and fiscal 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 and Proposition 30.

At the federal level, counties support 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 individuals and families in distress. With each downturn in the economy, counties experience an increased need of individuals and families seeking assistance through vital safety net programs such as Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and General Assistance. Even in strong economic times, millions of Californians struggle to make ends meet. For these reasons, counties strongly urge that any additional federal or state funding must be shared directly with counties for programs that have a county share of cost.

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

Section 2: Human Services Funding

While counties are legislatively mandated to administer numerous human services programs including Foster Care, Child Welfare Services, CalWORKs, Adoptions, Adult Protective Services, CalFresh, and In-Home Supportive Services, funding for these services has often lagged behind the actual levels needed by counties to administer the programs. The state's failure to fund actual county costs places 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. In the budgeting methodologies for these programs, counties support the inclusion of requirements to provide annual adjustments or revisit funding levels at specific intervals in order to ensure state funding keeps up with actual county costs.

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.

A key area of concern for human services agencies is worker recruitment and retention. Counties support increased investments to strengthen the county workforce, expanding educational and job training pathways, and policies that can help counties more effectively recruit, hire, and retain workers to ensure safety net programs can continue to operate seamlessly, meet increased demands, and serve individuals and families in need.

Section 3: Child Welfare Services/Foster Care

A child deserves to grow up in an environment that is healthy, safe, and nurturing. To meet this goal, families and caregivers should have access to public and private services that are comprehensive and collaborative. Further, recent system reforms and court-ordered changes, such as the Continuum of Care Reform (CCR) effort require collaboration between county child welfare services/foster care and mental health systems as well as other systems.

Since the enactment of 2011 Realignment, 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 some of the current needs of the child welfare services system, but new workload requirements and continued pressure to expand services remain a concern without additional investments by the state and federal government.

Further, court settlements (Katie A.) and policy changes (AB 12 Fostering Connections to Success Act of 2010 and AB 403, CCR) require close state/county collaboration with an emphasis on ensuring adequate ongoing funding that adapts to the needs of children who qualify. Additionally, the specified court settlements and policy changes require close coordination across local county systems to ensure that children and youth receive all medically necessary behavioral health services.

The CCR enacted significant changes in the child welfare program and the county behavioral health delivery system that intended to reduce the use of group homes and improve outcomes for foster youth. In addition, CCR is designed to increase the availability of trauma-informed services and utilize child and family teams to meet the unique needs of foster youth. Counties remain firmly committed to the ongoing implementation of these comprehensive and systematic changes, while seeking the flexibility to create programs and placements to foster success for this unique population.

1) Counties support a comprehensive array of prevention, intervention and post-permanency services for children, youth and families. Both counties and the state have a stake in achieving desired outcomes and as such, these services should be resourced appropriately.

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

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

4) Counties support efforts to reform the congregate care – or youth group home – system under AB 403, the CCR. 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 behavioral health support are but some of the challenges under CCR. Additionally, reform efforts must take into account the needs of juveniles who are wards of the court.

5) When foster children/youth cannot return home, counties support a permanency planning process that matches foster children/youth through adoption and/or guardianship, with a foster caregiver. 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.

6) Counties support adequate state funding for adoption services and post-permanency supportive services.

7) 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 support such ongoing services for former and emancipated foster youth up to age 26. Counties have implemented the Fostering Connections to Success Act of 2010 for non-minor dependents in foster care (aged 18-21) and have assumed hundreds of millions of dollars in costs that have not been reimbursed by the state, an issue that remains unresolved.

8) With regards to caseload and workload standards in child welfare, especially with major policy reforms such as CCR, counties remain concerned about increasing workloads, high staff turnover, and the possibility of reduced Realignment funding in an economic downturn, 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.

9) Counties support a reexamination of reasonable caseload levels given significant recent changes in policy and practice, including CCR and AB 12, and the complex needs of children, youth and families, often requiring cross-system collaboration (i.e., youth with developmental disabilities, behavioral health needs, and special education needs) with youth and families. Counties support ongoing augmentations for Child Welfare Services, including investments in workforce development and workload reduction, to support 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) Commercial sexual exploitation of children (CSEC) is a growing national and statewide issue. Counties believe this complex problem warrants immediate attention, including funding for prevention, intervention, and direct services through county child welfare services agencies. Counties support efforts to build capacity within local child welfare agencies to serve child victims of commercial sexual exploitation. Counties support close cooperation on CSEC issues with law enforcement, the judiciary, and community-based organizations to ensure the best outcomes for child victims.

11) 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.

12) With regard to those foster youth with highly complex care needs, there remain challenges in providing the services and in-state placements that are needed for this population. Counties support further state and county coordination as was started by AB 2083 (2018), increased federal and state investments, and improving the tools and capacity to help meet the needs of these youth.

Section 4: Employment and Self-Sufficiency Programs

Self-sufficiency and employment programs play a critical role in the well-being of county residents and provide needed cash assistance, food assistance, and employment services for eligible individuals. The California Work Opportunity and Responsibility to Kids (CalWORKs) program is California's version of the federal Temporary Assistance for Needy Families (TANF) program, which provides temporary cash assistance to low-income families with children to meet basic needs as well as welfare-to-work services that help families become self-sufficient. CalFresh is California's version of the federal Supplemental Nutrition Assistance Program (SNAP), which provides food assistance benefits to help improve the health of low-income families and individuals.

There is a need for 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, equity, and consistency across all major public assistance programs, including CalWORKs, Medi-Cal, and CalFresh. In addition, electronic technology improvements in human services administration are important tools to obtaining a more efficient and accessible system. It is only with adequate and reliable resources and flexibility that counties can truly address the fundamental barriers that many families have to self-sufficiency.

1) California counties are far more diverse from county to county than many regions of the United States. The state's welfare structure should recognize this diversity and allow counties flexibility in administering welfare programs, while providing overall state-level leadership that draws on the latest understanding of how families in poverty interact with public systems and how to best support them toward self-sufficiency. There should remain 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) The welfare system should also recognize the importance of and provide sufficient federal and state funding for education, job training and job retention, nutrition, subsidized employment, 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 child care and additional training, to assist former recipients in maintaining employment.

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

services required to accomplish welfare-to-work goals.

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

5) Counties 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.

6) Welfare-to-work efforts should focus on prevention of the factors that lead to poverty and welfare dependency including unemployment, underemployment, behavioral health and/or illness, lack of educational opportunities, food security issues, lack of access to child care, violence, and housing problems. Counties support the development of a continuous quality improvement system with agreed upon measures and the consideration of incentives for improvement. Program rules, metrics, and incentives should be aligned to reduce barriers and provide services that best improve the prospects for long-term stability and employment. Prevention efforts should also acknowledge the responsibility of absent parents by improving efforts for absent parent location, paternity establishment, child support award establishment, and the timely collection of child support.

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

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

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

10) The state should fully fund county costs for the administration of the CalWORKs and CalFresh programs, and consult with counties on all policy, operational, and technological changes in the administration of the programs.

Section 5: Medicaid Eligibility

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 county welfare departments in Medi-Cal eligibility, enrollment, outreach, 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.

Section 6: Aging and Dependent Adults

California is home to more older adults than any other state in the nation and this population continues to grow and become more diverse. 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 and dependent adult population.

Adult Protective Services

The Adult Protective Services (APS) Program is the state's safety net program for abused and neglected adults. Counties provide around-the-clock critical services to protect the state's most vulnerable seniors and dependent adults from abuse and neglect. Counties must retain local flexibility in meeting the needs of our aging and dependent adult population, and timely response by local APS is critical.

1) Counties support ~~reliable~~ adequate ~~-~~funding for ~~programs that affect older and dependent adults, such as~~ Adult Protective Services, including for the APS expansion to older adults age 60 and older. ~~and In-Home Supportive Services, and oppose any funding cuts, or shifts of costs to counties without revenue, from either the state or federal governments.~~

2) Counties support efforts to prevent, identify, and prosecute instances of elder and dependent adult abuse.

3) Counties support investments of new state and federal resources to support the APS workforce and enhance the case management and direct services available to victims of abuse and neglect.

Aging Programs

1) 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, support reliable funding for programs that affect older and dependent adults, and oppose any funding cuts, or shifts of costs to counties without revenue, from either the state or federal governments.

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

3) Counties support legislative efforts coupled with adequate funding to prevent homelessness among at-risk older adults and people with disabilities.

4) Counties support adequate funding for the full range of aging programs that provide services to

older adults ~~including services provided by~~through Area Agencies on Aging (AAAs), such as senior nutrition programs, meal delivery programs, caregiver supports, resource centers, ombudsman programs, and home and community-based supports. This includes sufficient funding to meet any newly established performance measurements.

5) Counties should maintain flexibility and control to determine locally the AAA administrative structure that works best in their communities for delivering aging services, including planning service area boundaries, and be consulted on any changes to the intrastate funding formula.

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 their home safely and prevents institutional care, which supports California in meeting federal Olmstead Act requirements. Individuals eligible for IHSS services are disabled, age 65 or older, or those who are blind and unable to live safely at home without help.

County social workers evaluate prospective and ongoing IHSS recipients, who may receive assistance with such tasks as housecleaning, meal preparation, laundry, grocery shopping, personal care services such as bathing, paramedical services, and accompaniment to medical appointments. Once a recipient is authorized for service hours, the recipient is responsible for hiring their 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 California's aging population continues to increase, costs and caseloads for the program continue to grow. In response to the end of the Coordinated Care Initiative and the County IHSS Maintenance of Effort (MOE), a new MOE was negotiated during the 2017-18 state budget process. The 2017-18 MOE included specific offsetting revenue, including a State General Fund contribution, but was not sustainable for county costs. During the 2019-20 state budget process, a new and more sustainable county IHSS MOE was negotiated and enacted.

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

2) The IHSS MOE negotiated in the 2017-18 state budget was not sustainable for counties as the county share of IHSS costs would have significantly outpaced the available revenues in the out years. Counties support changes enacted in the 2019-20 budget that provided additional state funding for IHSS costs and lowered the county share of IHSS costs. Counties support a long-term solution that aligns the county share of IHSS costs with the available revenues, which could occur through a lowered sharing ratio, restructured MOE, or increased State General Fund contribution.

3) The state should fully fund county and public authority costs for the administration of the IHSS program, and consult with counties on all policy, operational, and

technological changes in the administration of the program.

4) Counties support moving collective bargaining for the IHSS program to a single statewide entity. If collective bargaining is moved to the state, it must be done in a manner that works effectively with county funding and programmatic responsibilities. This includes ensuring counties do not have fiscal responsibilities for any increased costs outside of their control, preserving administration funding for counties and public authorities, and including appropriate county representation in bargaining decisions that have a direct impact on county costs or county and public authority administrative responsibilities.

Section 7: Child Support Program

Counties are committed to strengthening the child support program, delivering the best possible services to families participating in the program, and helping to address California's child poverty crisis through implementation of federal mandates and state statutes. Ensuring effective and efficient ongoing operations requires sufficient federal and state funding for each local child support agency. And any federal or state child support policy changes should not result in increased county costs and any increased administrative responsibilities should be fully funded. Counties support maximizing federal funding for child support operations at the county level.

1) The way in which child support funding is structured prevents many counties from efficiently meeting state and federal collection guidelines and occasionally leads smaller counties to adopt a regionalized approach or, more alarmingly, fail to provide needed services as mandated by existing standards. Counties need an adequate and sustainable funding stream for both programmatic and administrative responsibilities, as well as flexibility at the local level to ensure timely and accurate child support efforts, and must not be held liable for failures to meet guidelines in the face of inadequate and inflexible funding.

2) Counties must have the freedom to make local decisions at the local level. While program standards and mandates are codified in state statute and federal mandate, the unique decisions on how to operationalize those mandates in a manner that addresses the unique needs of the families being served by each local child support agency must remain a decision that is made at the local level.

A successful child support 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 the child support program and the local flexibility to organize and structure effective programs.

Section 8: Realignment

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

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

accompanying principles.

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

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

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

Section 9: Early Childhood

Counties recognize the importance of policies that advance whole child, whole family approaches, increase racial equity, build integrated systems and focus on prevention to enhance critical services for children and families. As such, counties support strengthening early care, comprehensive health and development, and learning programs and systems, with a focus on programs that counties administer, facilitate participation in, or that enhance the ability of First 5 commissions to serve communities and families.

Counties will also consider how improved early childhood and family outcomes lead to positive impacts related to other programs and systems that counties administer. Counties support efforts that improve system coordination and encourage leveraging of resources within counties and between local and state agencies to enhance critical services for children and families.For child care, counties support increasing access to early care and education opportunities, promoting efforts to recruit, train, and retain providers, expanding child care availability, and investing in child care facilities and infrastructure.

Proposition 10: The First 5 Children and Families Commissions

In November 1998, California voters passed Proposition 10, the "Children and Families Act of 1998" initiative, which created the 58 First 5 county commissions across the state. The Act levies a tax on cigarettes and other tobacco products and provides funding for early childhood development programs and mandates that commissions work across systems to integrate service delivery and promote optimal childhood development.

First 5 Children and Families Commissions believe that every child deserves to be healthy, safe, and ready to succeed in school and life. Based on extensive research, First 5 promotes the importance of collective impact to support children and families from the earliest moments possible. This prevention framework leads to improved child health and development outcomes, increased school success, and over time increases economic benefit across all public systems.

1) Counties oppose any effort to diminish First 5 funding, 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. Due to the declining nature of tobacco tax revenues, counties support the inclusion of existing tobacco taxes, including Proposition 10, in any subsequent tobacco

proposal.

2) Counties support identifying new ongoing and sustainable funding for First 5 programs, as well as prioritizing coordination and alignment with county-based systems of care and existing First 5 services and initiatives for any new funding.

3) Counties oppose any effort to restrict local First 5 expenditure authority. First 5 commissions must maintain the necessary flexibility to direct these resources to address the greatest needs of communities surrounding family resiliency, comprehensive health and development, quality early learning, and systems sustainability and scale.

Section 10: Violence Prevention

CSAC remains committed to raising awareness of the toll of violence – in particular, family violence and cases of ongoing control and abuses of power, hate crimes, and violence against women, children, ~~and~~ the elderly, and other marginalized groups – on families and communities by supporting efforts that target violence prevention, reporting, investigation, intervention, and treatment. Specific strategies for prevention and early intervention should be developed through cooperation between state and local governments, as well as community and private organizations, taking into account that violence adversely impacts all Californians, particularly those in disadvantaged communities at disproportionate rates, and that these impacts have long-term and wide-ranging health and economic consequences. CSAC also supports efforts to build safe communities, use data-informed approaches, pursue trauma-informed care, and work with key partners to implement violence prevention strategies.

Section 11: 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.

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

Section 12: Homelessness

Given the growing magnitude of California's homelessness crisis, CSAC reinstated the Homelessness Action Team in 2022 to develop guiding principles on homelessness. These *Homelessness Principles* were approved by the CSAC Board of Directors on September 1, 2022, were utilized to develop the AT HOME Plan that was released in March 2023, and will guide advocacy efforts around homelessness policies, investments, and proposals. The principles outline the need for a statewide plan, call for multi-level partnerships and collaboration while recognizing the need for clear lines of responsibility across all levels of government, detail the importance of building enough housing, and highlight how critical sustained and flexible state funding is to making progress.

The California County Platform | Chapter 16

Realignment

Adopted by the CSAC Board of Directors March 2023

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.

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

2010 CSAC Realignment Principles: Approved by the CSAC Board of Directors

Facing the most challenging fiscal environment in 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 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 Title IV-E and TANF), as well as federal penalties and sanctions, must remain the responsibility of the state.