Health and Human Services Policy Committee

Tuesday, November 18, 2014 ▪ 2:30 p.m. – 4:30 p.m.
Magic Kingdom Room 1▪ The Disneyland Hotel
1150 West Magic Way ▪ Anaheim, CA

Supervisor Kathy Long, Ventura County, Chair
Supervisor Ken Yeager, Santa Clara County, Vice Chair

Note: This policy committee meeting is an in-person meeting only
and is being held as part of the CSAC 2014 Annual Meeting

2:30 p.m.	**I.**	**Welcome and Introductions** *Supervisor Kathy Long, Ventura County*
2:35 – 2:55	**II.**	**myHealthOC: Eat. Play. Breathe** *David Souleles, Deputy Agency Director, Orange County Health Care Agency*
2:55 – 3:50	**III.**	**Federal Waivers in 2015** *Kelly Brooks-Lindsey, CSAC Senior Legislative Representative* *Toby Douglas, Director, Department of Health Care Services (invited)* *Sarah Muller, Director of Government Affairs, California Association of Public Hospitals and Health Systems* *Representative, County Behavioral Health Directors Association of California*
3:50 – 4:25	**IV.**	**Human Services Update: Medi-Cal Eligibility, In-Home Supportive Services, and Relative Caregivers** *Cathy Senderling-McDonald, Deputy Executive Director, County Welfare Directors Association of California*
4:25 – 4:30	**V.**	**Health and Human Services Platform Review** *Farrah McDaid Ting, CSAC Legislative Representative*
4:30	**VI.**	**Adjournment**

ATTACHMENTS

Attachment One............................... CSAC Memo: MyHealthOC.org – Eat. Play. Breathe

Orange County PowerPoint Presentation: Public Health Planning: A Platform for Action

Attachment Two............................... CSAC Memo: Federal Waiver Opportunities in 2015

DHCS 1115 Waiver Renewal Concept Paper

DHCS PowerPoint Presentation: Section 1115 Waiver Renewal Concept Development

DHCS Dates and Locations for 1115 Waiver Renewal Stakeholder Workgroups

Providing Whole-Person Care to Medicaid High-Utilizers in California: Opportunities for County-Based Pilots in California's 1115 Waiver Renewal

DHCS PowerPoint Presentation: Drug Medi-Cal Organized Delivery System Waiver

Attachment Three............................CSAC Memo: Human Services Update: Medi-Cal Eligibility, In-Home Supportive Services, and Relative Caregivers

Attachment Four............................... CSAC Memo: 2015-16 Health and Human Services Platform Documents

CSAC Health Platform (Draft)

CSAC Human Services Platform (Draft)

Attachment One

CSAC Memo: MyHealthOC.org – Eat. Play. Breathe

Orange County PowerPoint Presentation – Public Health Planning: A Platform for Action

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California
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Facsimile
916.441.5507

November 5, 2014

TO: CSAC Health and Human Services Policy Committee

FROM: Kelly Brooks-Lindsey, Senior Legislative Representative
Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: MyHealthOC.org – Eat. Play. Breathe.

Background: In July 2014, the Orange County Health Care Agency launched the "Eat. Play. Breathe" Campaign. The campaign encourages Orange County residents to make three simple lifestyle changes – eat fresh, play some way, breathe smoke-free, everyday – that have significant impacts on overall health and quality of life.

In Orange County, 60 percent of preventable deaths are due to a chronic disease that can be linked to three behaviors: poor nutrition, physical inactivity and smoking. The campaign's website provides access to simple tools and information to help people live healthier lifestyles. The website offers:

- Information and tips for healthy eating;
- Fun physical activity ideas and local active events and places; and
- Information and local support for smokers wanting to quit.

Invited Speaker:

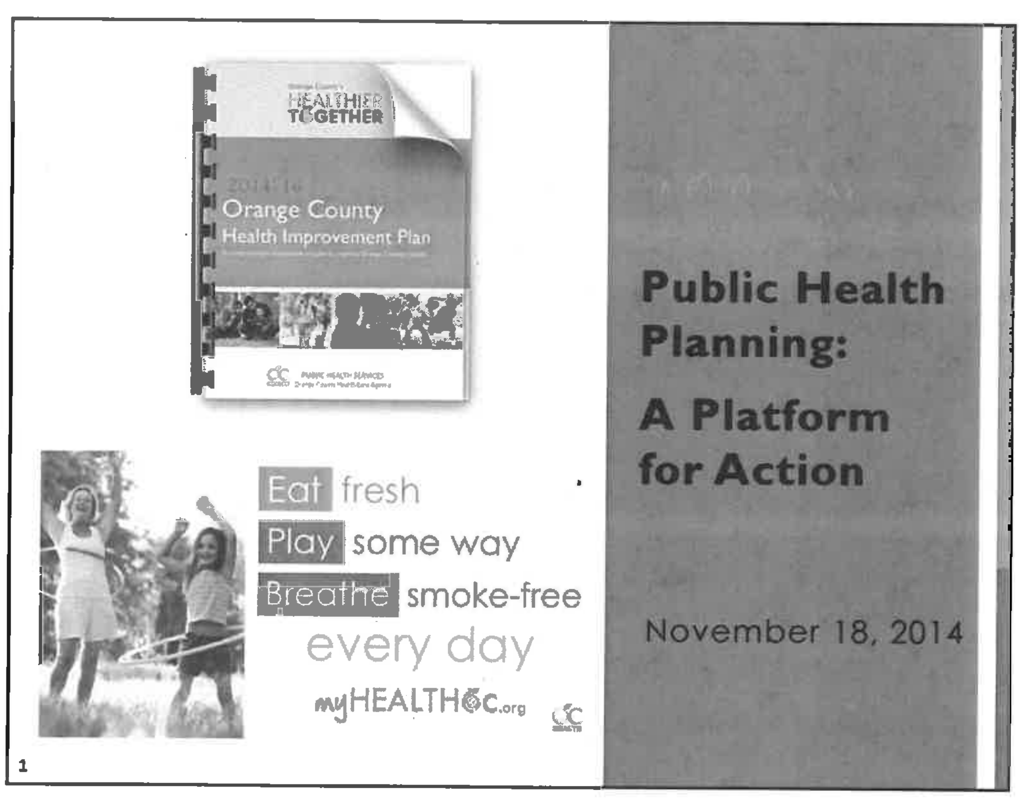
David Souleles, Deputy Agency Director of Public Health for the Orange County Health Care Agency, will be providing the policy committee with an overview of the "Eat. Play. Breathe." Campaign.

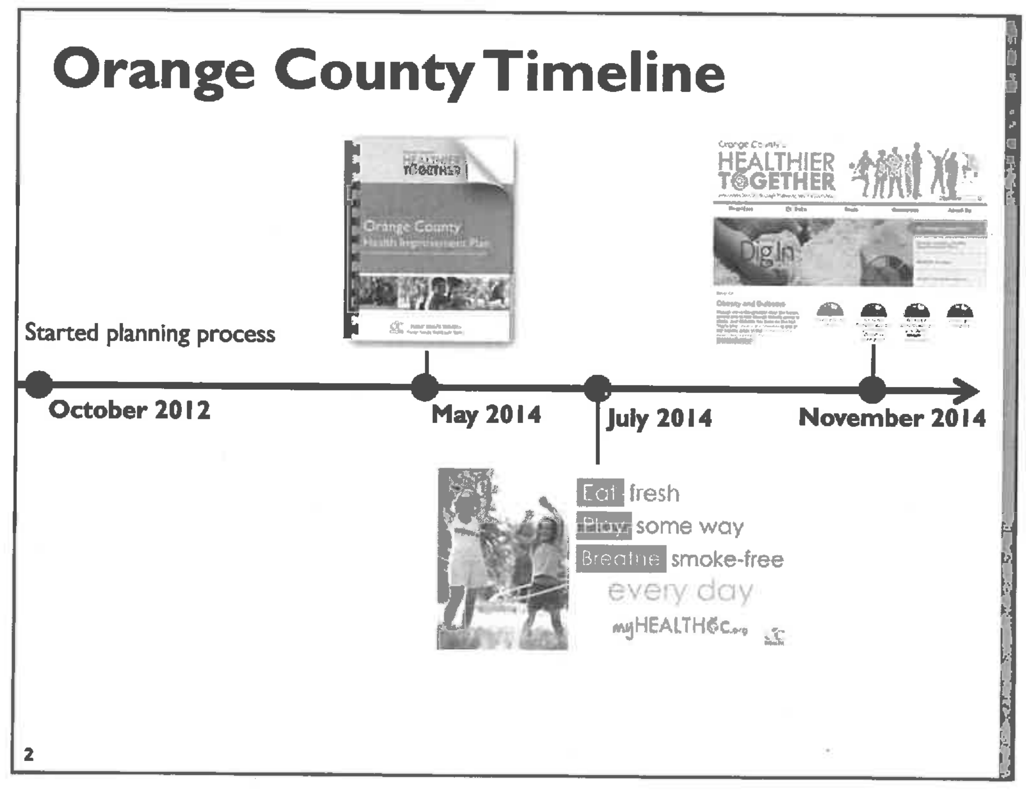
Attachments and Information:

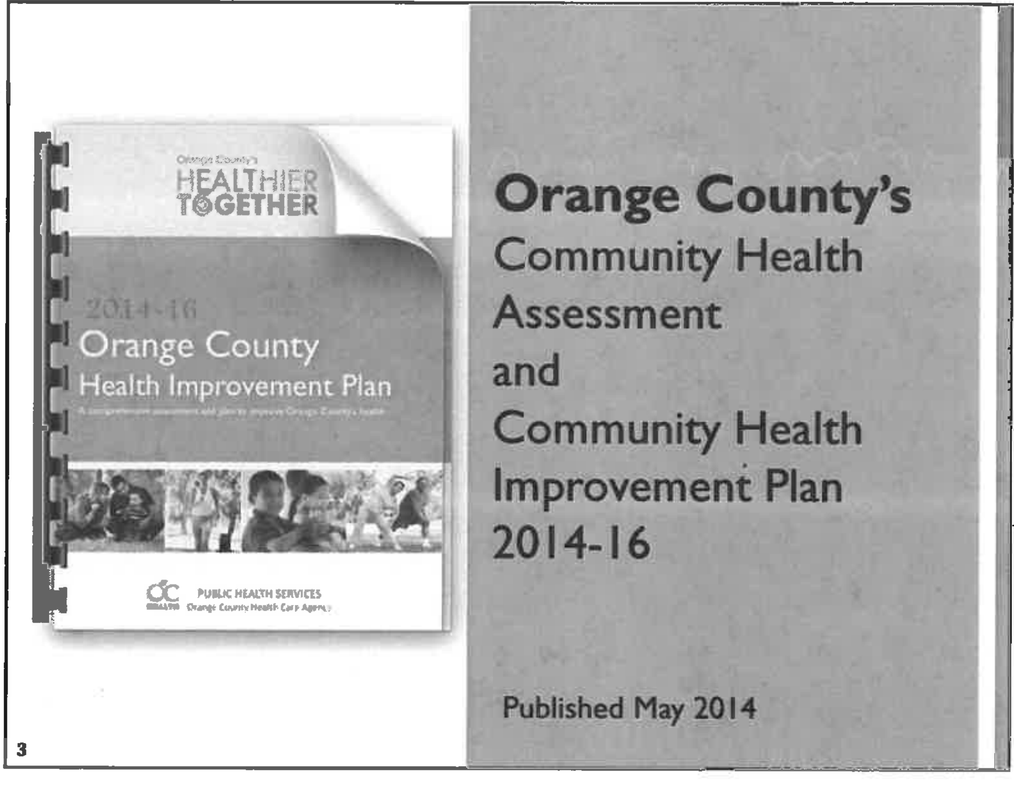
Eat. Play. Breathe. Campaign Website:
www.myHealthOC.org

Staff Contact:

Kelly Brooks-Lindsey can be reached at (916) 327-7500 Ext. 531 or kbrooks@counties.org.
Farrah McDaid Ting can be reached at (916) 327-7500 Ext. 559 or fmcdaid@counties.org.
Michelle Gibbons can be reached at (916) 327-7500 Ext. 524 or mgibbons@counties.org.


HEALTHIER TOGETHER
Orange County
Health Improvement Plan
Eat fresh
Play some way
Breathe smoke-free
every day
myHEALTHOC.org
Public Health Planning:
A Platform for Action
November 18, 2014
1

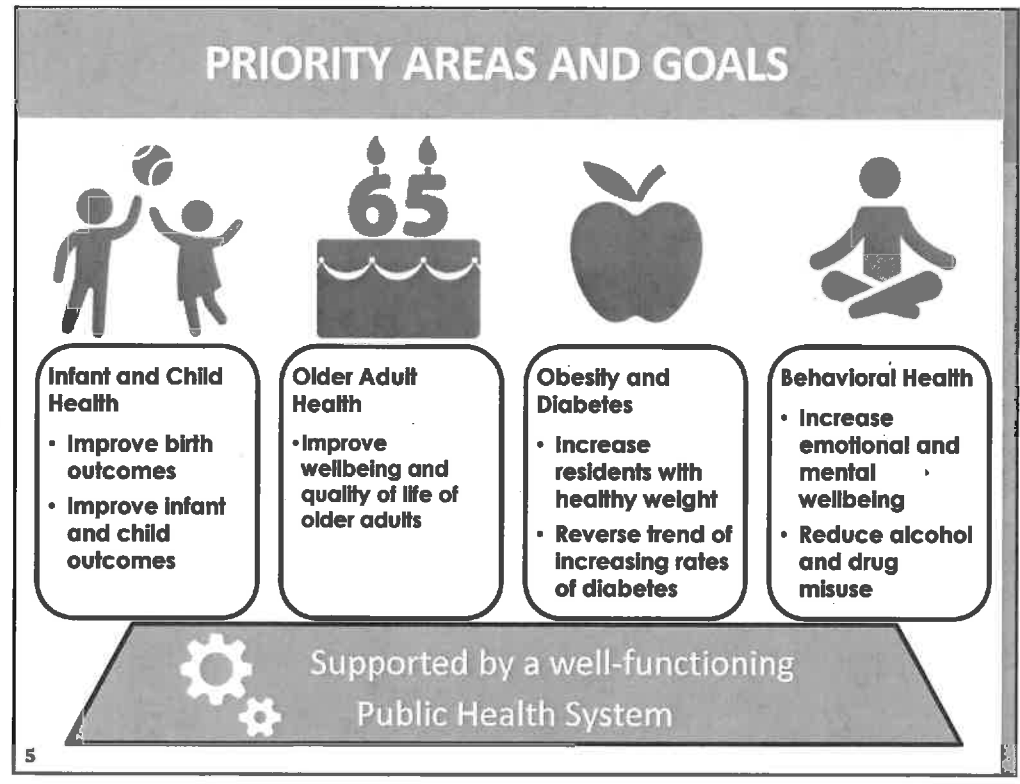

Orange County Timeline
Started planning process
October 2012
May 2014
July 2014
November 2014
HEALTHIER TOGETHER
Orange County
Health Improvement Plan
Dig In
Eat fresh
Play some way
Breathe smoke-free
every day
myHEALTHOC.org
2



Community Planning Objectives

1. Conduct a comprehensive assessment of Orange County's health-related needs
2. Develop and publish "standardized" health indicators
3. Establish a county-wide Community Health Improvement Plan (CHIP)
4. Create a plan for sustaining coordinated and collaborative efforts

4



OBESITY AND DIABETES

6 of 10 preventable deaths in Orange County are due to chronic diseases, which can be linked to three behaviors:

1. **poor nutrition**
2. **physical inactivity**
3. **smoking**

6

OBESITY AND DIABETES

Highlighted Strategies

Promote and expand community efforts **involving parents and families such as *Walk to School Day, Champion Moms,* and youth engagement programs.**

Coordinate consistent messages **about ways to prevent and manage diabetes**

(e.g. proper nutrition, physical activity, smoking cessation**).**

7

Eat fresh
Play some way
Breathe smoke-free
every day
myHEALTHOC.org

8

Eat. Play. Breathe.

- 113,278 users have seen ad
- 1,462 users clicked on ad
- $1,000 on advertising
- Cost per click: Less than $1

- 17+ million impressions
- 70 kings (side of bus)
- 107 interiors

- 1,337,167 people visited fair in 23 days

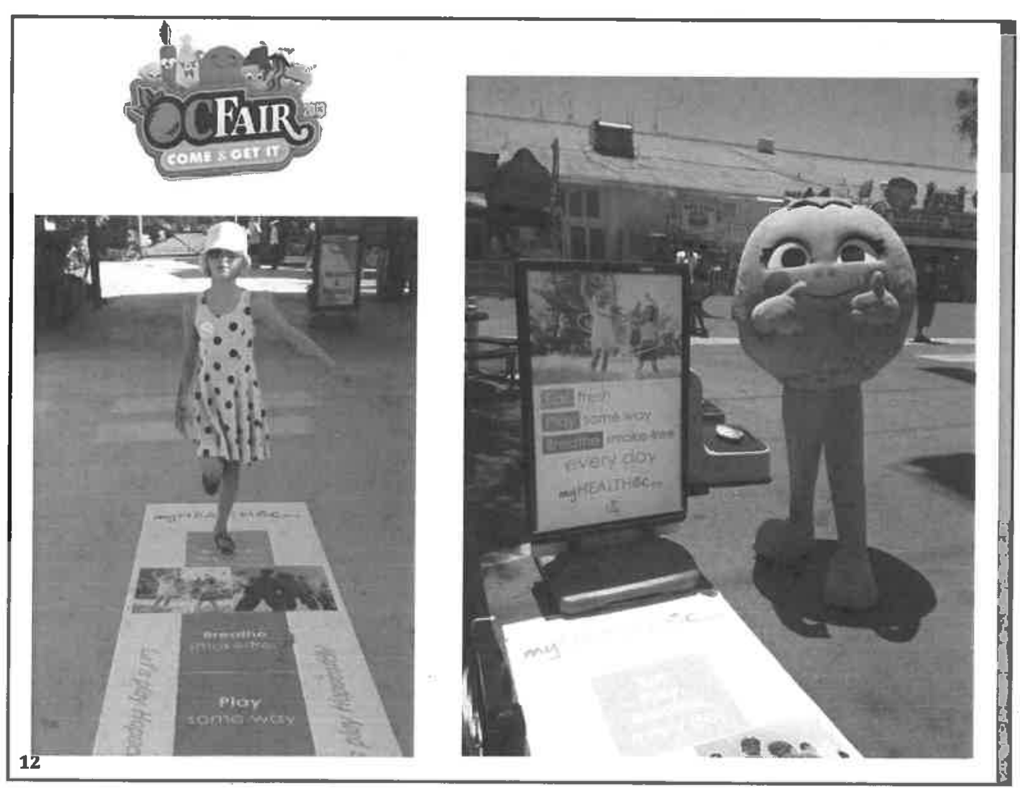
- Daily Traffic: 484,000 vehicles

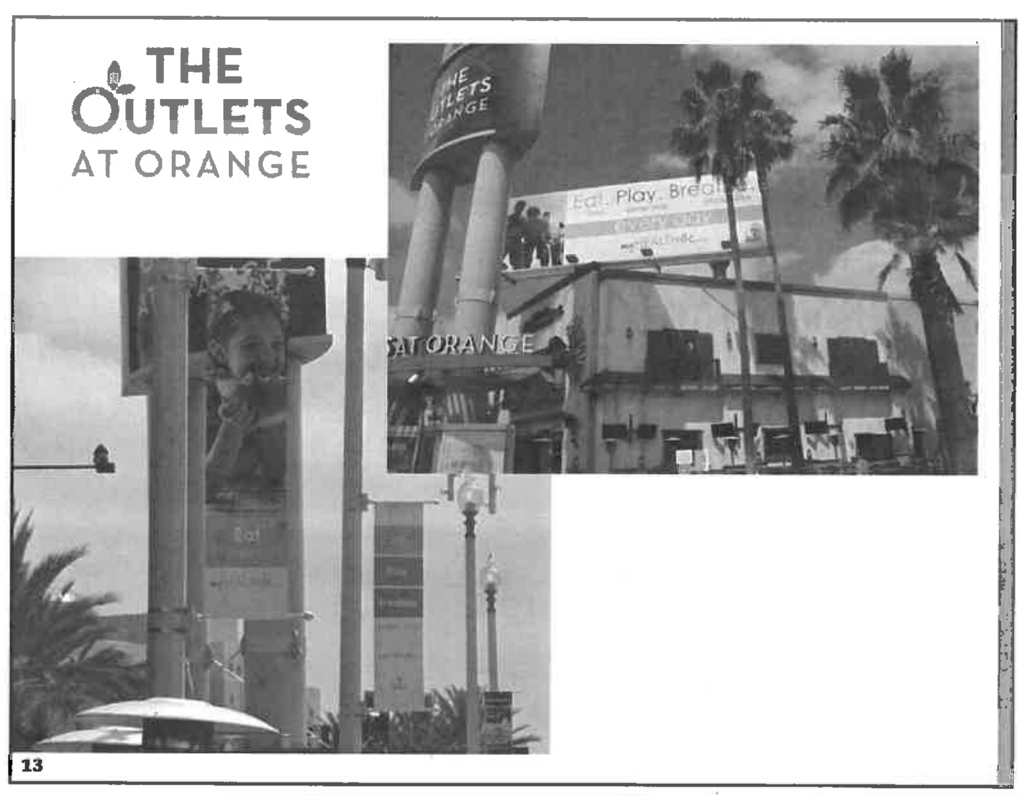
- ~2 million visitors during campaign
- 12 million shoppers annually

9

10

5510
Orange County Transportation Authority
octa
11


OCFAIR
COME & GET IT
Play
some way
12


THE
OUTLETS
AT ORANGE
AT ORANGE
13

ochealth
Just now
Like Page
Easy Ways to Eat Fresh and Play Every Day!
EAT. PLAY. BREATHE.
MYHEALTHOC.ORG
Learn More
EAT. PLAY. BREATHE.
myhealthoc.org
Easy Ways to Eat Fresh and Play Every Day!
14

myHEALTHOC.org
Home Eat Play Breathe Blog Contact Us
Caring For Yourself Doesn't Have To Be Difficult
Join with others in the Orange County area and together we will be healthy.
EAT.
PLAY.
BREATHE.
15

myHEALTHOC.org
Home Eat Play Breathe Blog Contact Us
Caring For Yourself Doesn't Have To Be Difficult
Join with others in the Orange County area and together we will be healthy.
EAT.
PLAY.
BREATHE.
16

myHEALTHOC.org
Search
Home
Eat
Play
Breathe
Blog
Contact Us
Eat
CONGRATULATIONS!
Let's Start Eating Healthy!
Eating healthy isn't always easy, and if you have clicked on this page, you probably already know that healthy eating matters. With so much information to sort through, it is not always easy to know which choices are the healthiest or that it is easy to do. To get started, click on a question to the right that interests you, and you will discover some tips and resources to help you get started today!
What Are Some Easy Ways to Eat Healthy?
How Can I Avoid Piling On Extra Calories When I Eat Out?
What Are Some Ways I Can Help My Kids Eat Healthy?
How Can I Track My Calories For Free?
17

myHEALTHOC.org
Search
Home
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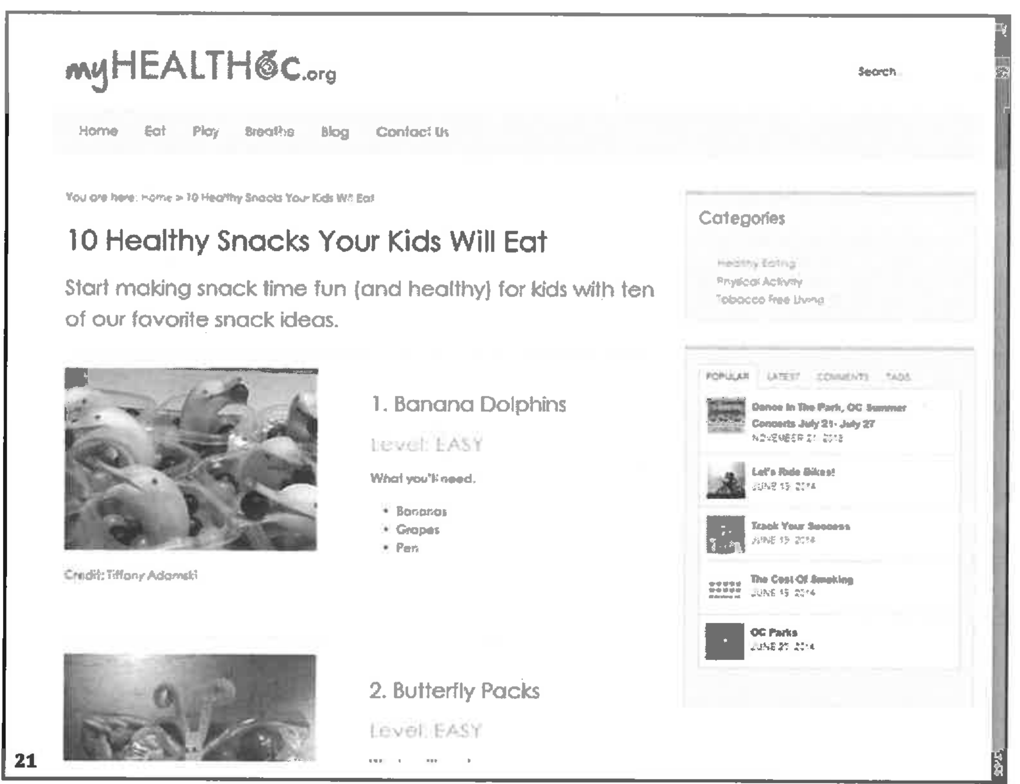
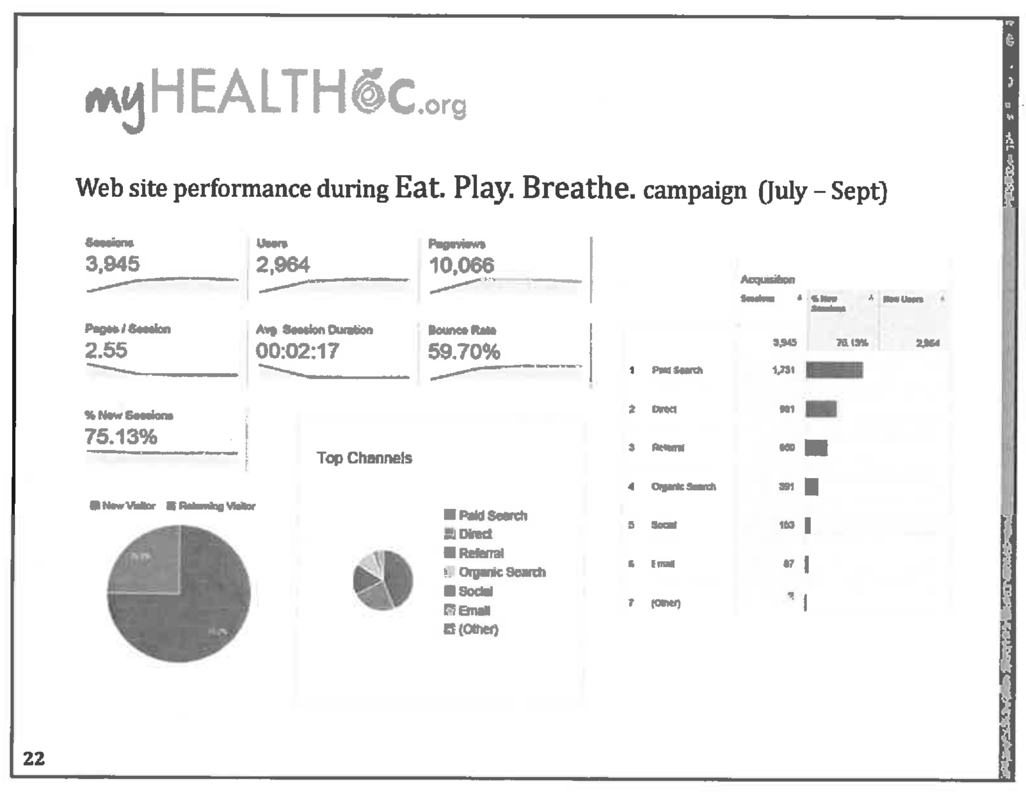
Breathe
Blog
Contact Us
Play.
CONGRATULATIONS!
Let's Play 30 Minutes Every Day!
Physical activity is a great way to improve your health. Being physically active helps you to manage your weight, help you to avoid some types of cancer, help you to feel better, and strengthen your bones. With all these great benefits, who wouldn't want to be healthy? If we were honest, lots of us because it can be so boring. Don't fear, we have some great ideas to make physical activity fun. To get started, click on a question to the right that interests you, and you will discover some tips and resources to help you play!
PHYSICAL ACTIVITY FINDER
How Can I Fit Physical Activity Into My Work Day?
How Can I Get My Kids Moving?
How Can I Track My Success?
18

myHEALTHOC.org
Search
Home
Eat
Play
Breathe
Blog
Contact Us
Breathe.
CONGRATULATIONS!
It's Time to Breathe Smoke-Free Every Day!
If you are a smoker, or someone you love smokes, you have taken the first step in finding out more about resources that can help. You should be commended! Life is made up of small choices, and the choice to quit smoking can literally extend life. Tobacco is the leading cause of preventable death in the United States. Most adults who smoke, started as teens. Smoking harms the body in many ways.
To take the next step, click a question on the right that you find helpful, and discover resources, support and tips to help.
Want Help Quitting?
Would You Like To Hear Some Success Stories?
How Can I Keep My Teen From Smoking?
Are You Supporting A Family Member Who Is Quitting?
What's the Big Deal With Vaping?
19

Caring For Yourself
Doesn't Have To
Be Difficult
Join with others in the Orange County area and together we will be healthy
EAT
PLAY
BREATHE
Get the full decade back!
20


myHEALTHOC.org
Search
Home
Eat
Play
Breathe
Blog
Contact Us
10 Healthy Snacks Your Kids Will Eat
Start making snack time fun (and healthy) for kids with ten of our favorite snack ideas.
1. Banana Dolphins
Level: EASY
What you'll need.
Bananas
Grapes
Pen
Credit: Tiffany Adamski
2. Butterfly Packs
Level: EASY
Categories
Healthy Eating
Physical Activity
Tobacco Free Living
Dance In The Park, OC Summer Concerts July 21 - July 27
Let's Ride Bikes!
Track Your Success
The Cost Of Smoking
OC Parks
21


myHEALTHOC.org
Web site performance during Eat. Play. Breathe. campaign (July – Sept)
Sessions
3,945
Users
2,964
Pageviews
10,066
Pages / Session
2.55
Avg. Session Duration
00:02:17
Bounce Rate
59.70%
% New Sessions
75.13%
New Visitor
Returning Visitor
Top Channels
Paid Search
Direct
Referral
Organic Search
Social
Email
(Other)
Acquisition
3,945
2,964
1 Paid Search 1,731
2 Direct
3 Referral
4 Organic Search
5 Social
6 Email
7 (Other)
22

myHEALTHOC.org

NEXT STEPS

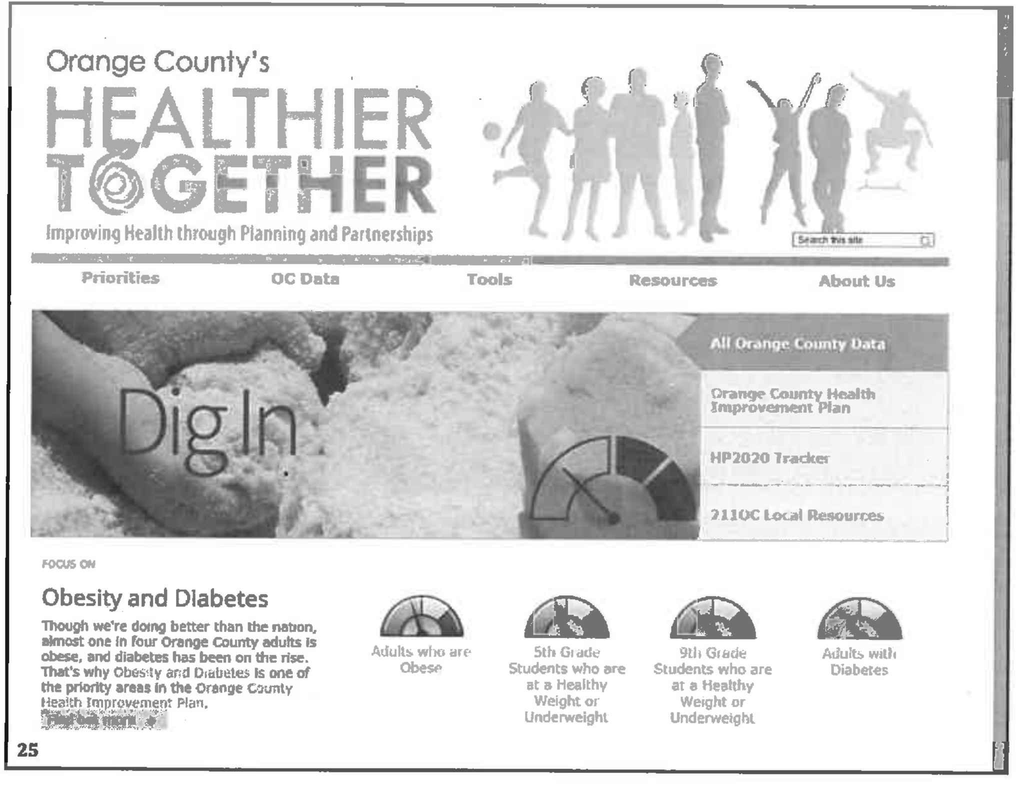
- Continually update and refresh website content
- Additional promotion and targeting (online, pay-per-click)
- Cross promotion with other websites

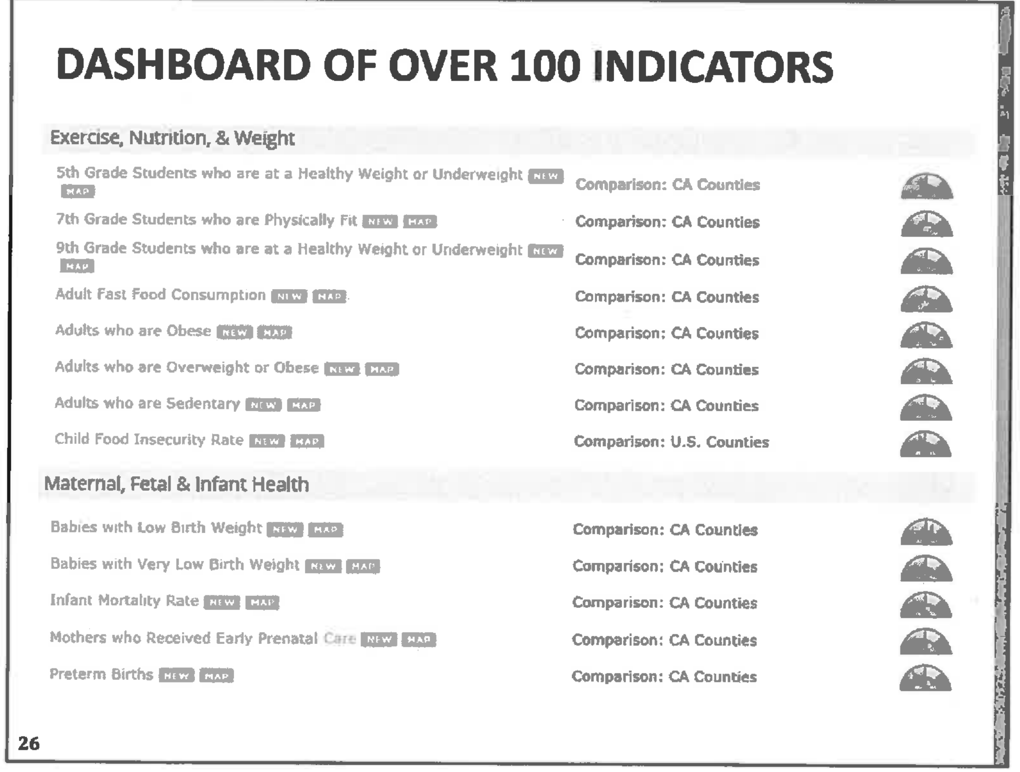
23

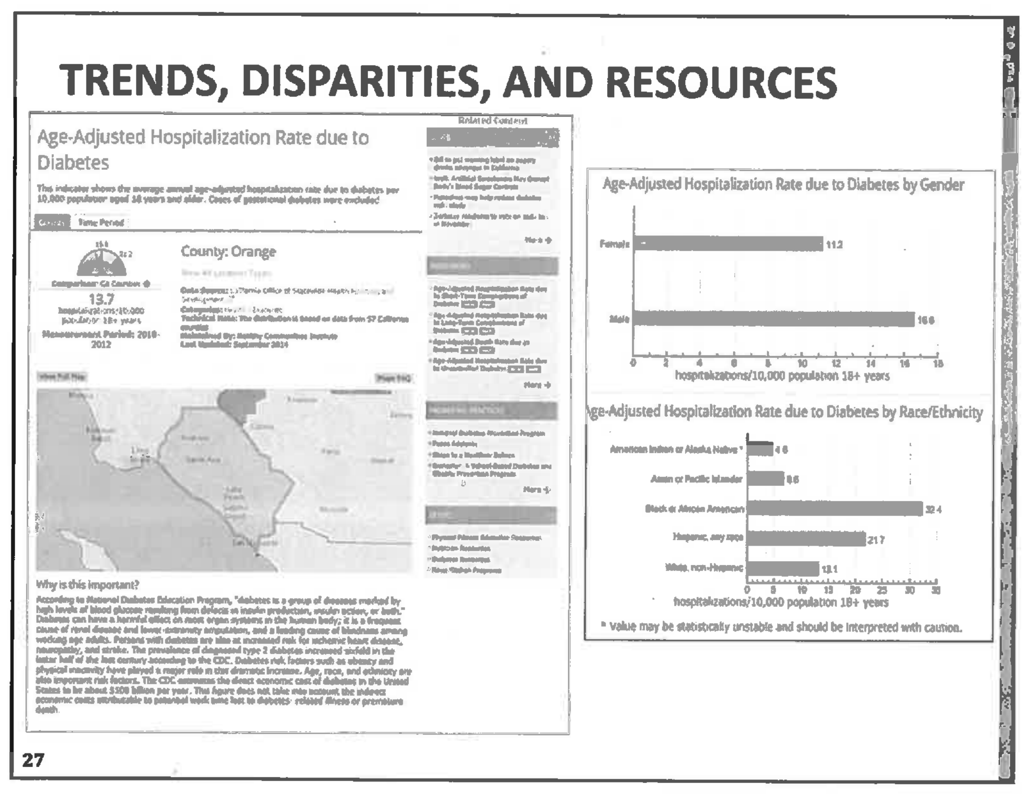
- A fully configured and **hosted website** tailored to any sized region or community
- **Dashboard** of over 100 health and quality-of-life indicators
- **Promising Practices** (2,000+) database of evidence-based programs
- Links to **Local Resources**
- **Community engagement** and collaboration tools: Event Calendar, News, Polls, etc.
- **Literature** and education materials

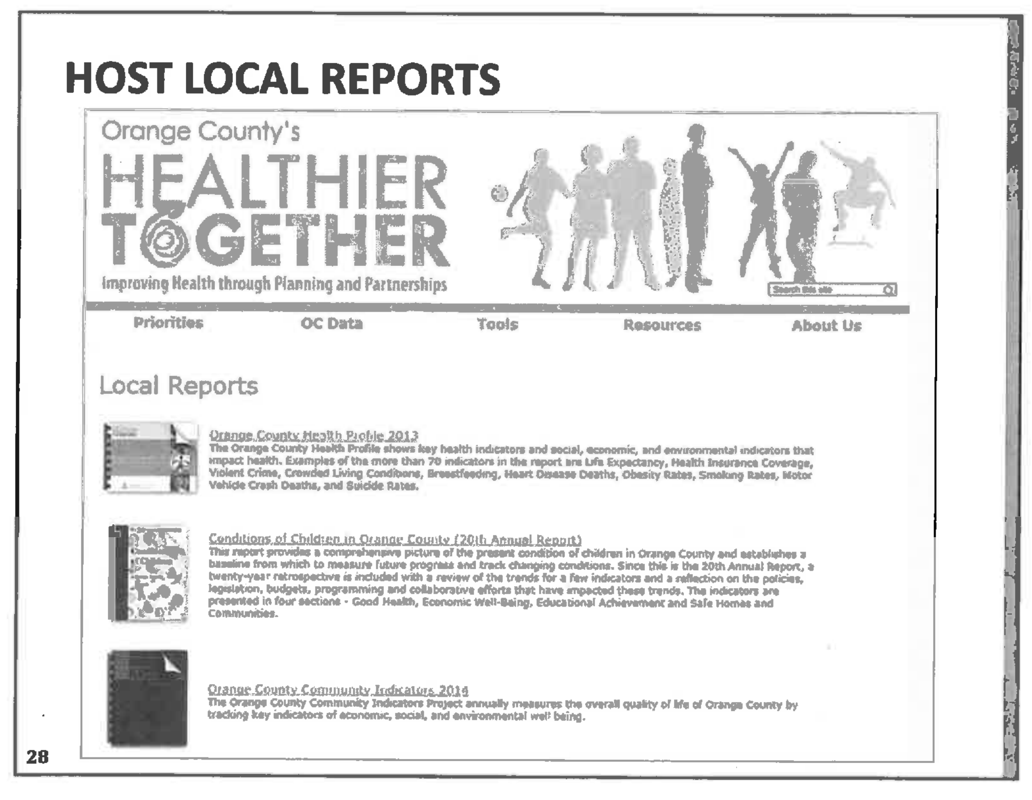
Orange County's HEALTHIER TOGETHER

24

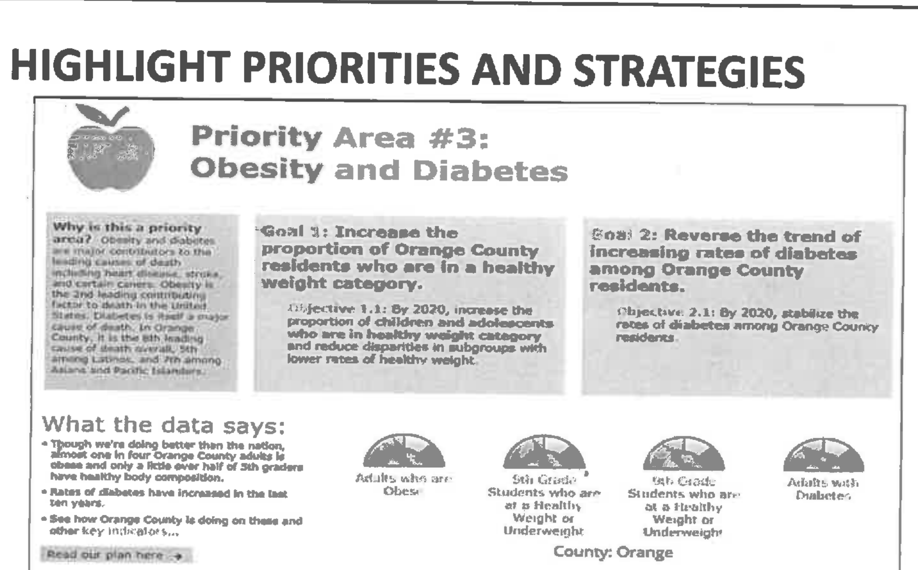

Orange County's
HEALTHIER TOGETHER
Improving Health through Planning and Partnerships
Priorities
OC Data
Tools
Resources
About Us
Dig In
All Orange County Data
Orange County Health Improvement Plan
HP2020 Tracker
211OC Local Resources
FOCUS ON
Obesity and Diabetes
Though we're doing better than the nation, almost one in four Orange County adults is obese, and diabetes has been on the rise. That's why Obesity and Diabetes is one of the priority areas in the Orange County Health Improvement Plan.
Adults who are Obese
5th Grade Students who are at a Healthy Weight or Underweight
9th Grade Students who are at a Healthy Weight or Underweight
Adults with Diabetes
25


DASHBOARD OF OVER 100 INDICATORS
Exercise, Nutrition, & Weight
5th Grade Students who are at a Healthy Weight or Underweight NEW MAP Comparison: CA Counties
7th Grade Students who are Physically Fit NEW MAP Comparison: CA Counties
9th Grade Students who are at a Healthy Weight or Underweight NEW MAP Comparison: CA Counties
Adult Fast Food Consumption NEW MAP Comparison: CA Counties
Adults who are Obese NEW MAP Comparison: CA Counties
Adults who are Overweight or Obese NEW MAP Comparison: CA Counties
Adults who are Sedentary NEW MAP Comparison: CA Counties
Child Food Insecurity Rate NEW MAP Comparison: U.S. Counties
Maternal, Fetal & Infant Health
Babies with Low Birth Weight NEW MAP Comparison: CA Counties
Babies with Very Low Birth Weight NEW MAP Comparison: CA Counties
Infant Mortality Rate NEW MAP Comparison: CA Counties
Mothers who Received Early Prenatal Care NEW MAP Comparison: CA Counties
Preterm Births NEW MAP Comparison: CA Counties
26


TRENDS, DISPARITIES, AND RESOURCES
Age-Adjusted Hospitalization Rate due to Diabetes
County: Orange
13.7
Why is this important?
Age-Adjusted Hospitalization Rate due to Diabetes by Gender
Female
11.2
Male
16.6
hospitalizations/10,000 population 18+ years
Age-Adjusted Hospitalization Rate due to Diabetes by Race/Ethnicity
American Indian or Alaska Native *
4.6
Asian or Pacific Islander
8.6
Black or African American
32.4
Hispanic, any race
21.7
White, non-Hispanic
13.1
hospitalizations/10,000 population 18+ years
* Value may be statistically unstable and should be interpreted with caution.
27


HOST LOCAL REPORTS
Orange County's
HEALTHIER TOGETHER
Improving Health through Planning and Partnerships
Priorities
OC Data
Tools
Resources
About Us
Local Reports
Orange County Health Profile 2013
The Orange County Health Profile shows key health indicators and social, economic, and environmental indicators that impact health. Examples of the more than 70 indicators in the report are Life Expectancy, Health Insurance Coverage, Violent Crime, Crowded Living Conditions, Breastfeeding, Heart Disease Deaths, Obesity Rates, Smoking Rates, Motor Vehicle Crash Deaths, and Suicide Rates.
Conditions of Children in Orange County (20th Annual Report)
This report provides a comprehensive picture of the present condition of children in Orange County and establishes a baseline from which to measure future progress and track changing conditions. Since this is the 20th Annual Report, a twenty-year retrospective is included with a review of the trends for a few indicators and a reflection on the policies, legislation, budgets, programming and collaborative efforts that have impacted these trends. The indicators are presented in four sections - Good Health, Economic Well-Being, Educational Achievement and Safe Homes and Communities.
Orange County Community Indicators 2014
The Orange County Community Indicators Project annually measures the overall quality of life of Orange County by tracking key indicators of economic, social, and environmental well being.
28

HIGHLIGHT PRIORITIES AND STRATEGIES



Updates

Eat. Play. Breathe. on MyHealthOC.org: Coordinating consistent messages about ways to prevent obesity and diabetes are strategies in our plan. MyHealthOC.org was launched in summer 2014 and is a great place for Orange County residents to find resources to eat fresh, play some way, and breathe smoke-free every day.

29

THANK YOU

David M. Souleles, MPH
Deputy Agency Director
Orange County Health Care Agency
(714) 834-3882
dsouleles@ochca.com

Orange County's
HEALTHIER
TOGETHER

30

Attachment Two

CSAC Memo: Federal Waiver Opportunities in 2015

DHCS 1115 Waiver Renewal Concept Paper

DHCS PowerPoint Presentation: Section 1115 Waiver Renewal Concept Development

DHCS Dates and Locations for 1115 Waiver Renewal Stakeholder Workgroups

Providing Whole-Person Care to Medicaid High-Utilizers in California: Opportunities for County-Based Pilots in California's 1115 Waiver Renewal

DHCS PowerPoint Presentation: Drug Medi-Cal Organized Delivery System Waiver

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November 5, 2014

To: Kathy Long, Chair, CSAC Health & Human Services Policy Committee
Ken Yeager, Vice Chair, CSAC Health & Human Services Policy Committee
Members, CSAC Health & Human Services Policy Committee

From: Kelly Brooks-Lindsey, Senior Legislative Representative
Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: Federal Medicaid Waiver Opportunities in 2015

California's existing Medicaid Section 1115 "Bridge to Reform" Waiver expires in October 2015. The Department of Health Care Services (DHCS) has begun work on developing a five year extension to the Bridge to Reform Waiver. Additionally on a separate but parallel track, DHCS is drafting an amendment to the existing waiver to change the way that Drug Medi-Cal (DMC) services are delivered in California.

The policy committee will hear from a panel of state and county representatives discussing the latest issues associated both with the Medicaid Section 1115 Waiver renewal and the waiver amendment for Drug Medi-Cal.

Federal Section 1115 Waiver Background

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to waive provisions of major health and wealth welfare programs, including Medicaid, and allows a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. For example, the federal government could waive statewideness to allow a state to experiment with an alternative delivery system for health services.

Section 1115 waivers are approved at the discretion of the Secretary of Health and Human Services through negotiations between a state and the Centers for Medicare and Medicaid Services (CMS).

In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the federal government, which means that during the course of the demonstration federal Medicaid expenditures will not be more than federal spending without the waiver.

The existing waiver provides California with approximately $10 billion in federal funds over five years for investment in California's health care delivery system to prepare for national health care reform and to sustain the Medi-Cal program. The Bridge to Reform waiver includes the following key elements:

- Coverage Expansion (Low Income Health Program)
- Delivery System Reform Incentive Pool: $3.3 billion over 5 years

- Safety Net Care Pool: $7.1 billion over 5 years
- Care Coordination. The waiver requires mandatory enrollment of seniors and persons with disabilities into Medi-Cal managed care.

The Drug Medi-Cal waiver is being submitted to CMS as an amendment to the existing Medicaid Section 1115 "Bridge to Reform" Waiver, which is effective from November 1, 2010 to October 31, 2015. The Brown Administration is hoping to incorporate the Drug Medi-Cal changes into the waiver renewal, which would mean the changes to Drug Medi-Cal would be in effect until 2020.

Medicaid Section 1115 "Bridge to Reform" Waiver Renewal

DHCS released a concept paper in July of this year outlining their approach to renewing the existing Medicaid Section 1115 Waiver. The paper (which is included in the material packet) includes the following concepts:

- **Federal/State shared savings initiative.** California will be seeking federal support to promote cost efficiency and access through a shared savings initiative. California would establish per beneficiary payments per year for the Medi-Cal beneficiaries covered under the waiver. California would receive these pre-established per beneficiary payments to deliver whole-person, coordinated care. Periodically the state and federal governments would perform reconciliation of these payments to actual expenditures. If California's actual expenditures were below the pre-established per beneficiary amounts, the state would retain the federal funding for the difference.

- **Payment/Delivery Reform Incentive Payment Programs.** DHCS is interested in reforming payment and delivery systems to encourage increased care coordination, case management, and initiatives that will reduce the overall cost trend, impact the total cost of care and improve overall health care outcomes.

- **Safety Net Payment Reforms.** California wants to explore innovative payment reforms that more appropriately align incentives for these safety net providers to better coordinate the care for the uninsured providers. Specifically, they are interested in a global payment that provides flexibility to integrate Medicaid Disproportionate Share Hospital and Safety Net Care Pool funding.

- **Federal Qualified Health Center (FQHC) Payment/Delivery Reform.** DHCS views the waiver as an opportunity to further support or expand efforts to transform FQHC payment/delivery away from a volume based model to a risk-based model that provides FQHCs the incentives and flexibilities to provide care in the most cost-effective and patient-centered manner possible.

- **Successor Delivery System Reform Incentive Payment Program.** Building on the lessons learned with the 2010 Delivery System Reform Incentive Payment (DSRIP) Program, California would seek to create a successor program that would be more outcomes- and value-oriented, particularly with respect to population health, and would seek to demonstrate advancement of Triple Aim goals more consistently across California's 21 public hospitals.

- **California Children's Services (CCS) Program Improvements.** DHCS is also interested in options to improve care delivery, quality and cost in the CCS program.

- **Medicaid Funded Shelter for Vulnerable Populations.** DHCS would like to explore demonstration options for testing how funding for shelter through Medicaid can also contribute to increased quality, ensure continuity of care, deliver better health outcomes, and reduce total cost of care.

- **Workforce Development.** DHCS is interested in confronting the issues associated with attracting new Medi-Cal providers and the market factors affecting payors across different systems. California could offer subsidies for malpractice insurance premiums of doctors who are willing to devote significant portions of their practices to low-income patients.

In order to further refine these concepts, DHCS – in partnership with the California Endowment, the California HealthCare Foundation and the Blue Shield of California Foundation – is convening a stakeholder workgroup process. The schedule for each of the workgroups is attached. University of California Los Angeles is providing assistance to the CCS workgroup. Workgroups include: 1) DSRIP 2.0, 2) Housing/Shelter, 3) Workforce, 4) Safety Net Financing, 5) MCO/Provider Incentives, 6) Federal/State shared savings, and 7) CCS. CSAC is a member of the housing/shelter and the safety net financing workgroups.

The workgroup process wraps up in January 2015. The Administration is anticipating drafting a document in February to share with the federal CMS. CSAC anticipates working closely with the state, county affiliate organizations, public hospitals, health plans and other stakeholders on the waiver renewal process. Typically, waiver negotiations between states and the federal government may last several months.

In anticipation of the waiver renewal, CSAC has been meeting with county affiliate organizations – the County Behavioral Health Directors Association, the County Health Executives Association, the County Welfare Directors Association, and the California Association of Public Hospitals and Health Systems – to explore including a whole person care pilot that would include a shelter/housing component. A copy of the concept paper is included in the agenda material.

DMC-ODS Waiver Proposal

DHCS is also working on developing a federal Medicaid waiver to change the delivery of Drug Medi-Cal (DMC) services in California. DHCS convened several stakeholder meetings in the spring to discuss the current DMC delivery system and ways to improve it. DHCS released a draft paper in mid-July that focuses on programmatic and policy changes; the Administration released details on the financing provisions on November 3.

The Administration is proposing to organize the delivery of Drug Medi-Cal services. The waiver would be an opt-in – counties would have the option of participating. For counties that do not participate, the existing Drug Medi-Cal delivery system and responsibilities would remain unchanged.

Key elements of the DMC Organized Delivery System (ODS) Waiver include:

- Creates a continuum of care for substance use disorder treatment services, including early intervention, physician consultation, outpatient treatment, case management, medication assisted treatment, recovery services, recovery residence, withdrawal management and residential treatment.
- Directs the use of an assessment tool (the American Society of Addiction Medicine, ASAM) to determine the most appropriate level of care.
- Provides for case management services to ensure that the client is moving through the continuum of care and that counties coordinate care for those residing in the county.
- Gives counties more authority to select providers, through selective provider contracting.
- Establishment of relationships between county substance use programs and managed care plans and criminal justice partners. The draft requires counties to enter into MOUs with managed care health plans for referrals and coordination, and also includes language that county substance abuse programs coordinate with criminal justice partners.

DHCS is proposing that counties operate pre-paid ambulatory plans under Medicaid law. Essentially counties would act as specialty health plans for the delivery of substance use disorder treatment. This would be a parallel to the existing arrangement where counties operate pre-paid inpatient plans for the delivery of specialty mental health services.

Financial Details
In a presentation to stakeholders on November 3, the DHCS provided additional about the financing components of the DMC waiver.

DHCS recognizes the need to address the following financing components:

- Switching from the current allocation of DMC based on county of service to a county of residence model. DHCS recognizes the need to consider how that will impact funding for individual counties.
- Variability among counties in historical expenditures and service levels.
- Variability among counties in population and number of users vs. number of DMC beneficiaries overall.
- Need to develop a methodology that would account for new services and new populations.
- Need to develop a methodology that would maintain state and county funding responsibilities but also provides flexibility for counties to develop rates to ensure provider participation AND ensure that neither the state nor counties had financial incentives to influence service use or type.

DHCS is utilizing a per user per month methodology as the basis for developing a financing model. DHCS looked at five years of historic cost data and trended it forwarded for two years for each of the 58 counties. The department is willing to work with any county that is interested in looking at the specific per user per month data. The historic data would be used in conjunction with a model to forecast utilization and costs of the new services. An interested county and DHCS would work together to develop a state/county sharing ratio for non-federal costs that takes into account historic expenditures and projections of future utilization and costs. The sharing ratio would be based on what percentage of non-federal funding would have been either the state's or the county's absent the waiver. For example, if a county's historic costs trended forwarded would have been $25 million absent the waiver, but with the addition of new services and populations costs are projected to be $50 million, the state and county would share in DMC waiver costs at a rate of 50/50.

A county that opts to participate in the waiver would have the ability to set provider rates. The rates would be subject to DHCS approval. DHCS believes the per user per month provides a target for counties to consider in developing rates, and service and utilization projections.

The per user per month model would also be used to develop the budget neutrality component of the waiver.

Next Steps

CSAC is an active participant in the Medicaid Section 1115 Waiver renewal workgroups. Staff anticipates the Administration will develop a draft in February 2015. Stakeholders will have an opportunity to comment on the draft prior to submission to CMS.

CSAC anticipates that the Drug Medi-Cal waiver amendment will be submitted to CMS sometime this month. DHCS began informal conversations with CMS earlier this year and has received positive feedback on a number of components, including expanding residential treatment services.

Staff will be providing regular updates to the CSAC Health and Human Services Policy Committee, the Executive Committee and Board of Directors over the coming months.

Attachments

- Concepts for California's Next Medicaid Waiver Renewal (July 2014)
- Section 1115 Waiver Renewal Concept Development PowerPoint (September 11, 2014)
- Dates and Locations for Expert Stakeholder Workgroups 1115 Waiver Renewal
- Providing Whole-Person Care to Medicaid High-Utilizers in California: Opportunities for County-Based Pilots in California's 1115 Medicaid Waiver Renewal (Fall 2014)
- Drug Medi-Cal Organized Delivery System Waiver (November 3, 2014)

Concepts for California's Next Medicaid Waiver Renewal
July 2014

Background – California's 2010 Medicaid Waiver

California's existing section 1115 "Bridge to Reform" Waiver is a five-year demonstration of health care reform initiatives that invest in the state's health care delivery system to prepare for the significant changes spurred on by the Affordable Care Act (ACA). California is currently in the fourth year of its 1115 Waiver. With the flexibilities and federal support afforded by the Waiver, the state was able to prepare for successful implementation of health care reform through an early expansion of Medicaid, test innovations in health care delivery and financing, and support safety net providers who are critical to the Medicaid program. Through this Waiver, California has amassed a valuable set of experiences and lessons learned that can be built upon in future years to help ensure success of the Affordable Care Act (ACA) throughout the state.

The Bridge to Reform Waiver enabled California to engage in delivery system reform and expand our Medi-Cal managed care program aimed at improving health care delivery and reducing the cost growth of our Medicaid program. Through the Waiver, California successfully enrolled 650,000 individuals in an early expansion of the ACA provision to expand Medicaid eligibility to adults under 138% of the poverty level. This early coverage expansion will be a critical component of CA's success in 2014 and beyond. In addition, the Waiver provided CA's safety net with critical funding to support its continued viability as well as its transformational efforts to improve care delivery at a lower cost with higher quality.

California's Medicaid Waiver Renewal

California's 1115 Waiver embodies the shared commitment between the state and the federal government to support the successful realization of some of the ACA's most critical objectives. As California continues to be a leader in implementing health care reform, our state requires additional support to ensure that strides made towards delivery of quality, cost effective care can be further expanded and sustained over time. A Medicaid Waiver Renewal is a fundamental component to California's ability to continue to successfully implement the ACA beyond the primary step of coverage expansion. To that end, California is seeking a Waiver Renewal that will build on the approaches and successes of the existing 2010 Waiver as we move forward with expanding and improving our Medi-Cal program through delivery and payment system transformation. Current Waiver initiatives such as the delivery of care for Seniors and Persons with Disabilities through managed care and the state's Coordinated Care Initiative, would continue through Waiver Renewal.

Because of the successes of the Bridge to Reform Waiver, California is in a position where we are primed to focus our efforts on other critical components to the success of health care reform such as expanding access, improving quality and outcomes, and controlling the cost of care. Continuance of the federal government's commitment to the implementation of the ACA in CA through a successor 1115 Waiver will allow the state to move to the next phase in health care reform and better care for the lives served by our Medicaid program.

California is also pursuing a grant opportunity through Center for Medicare & Medicaid Innovation for multi-payor health care reform initiatives through California's State Innovation Model (CalSIM). The

1115 Waiver could serve as a vehicle to support the goals of the CalSIM in the Medicaid delivery system with the potential to positively impact other sectors.

The focus of the Waiver Renewal will be on improving and reforming our Medi-Cal payment and delivery systems and ensuring ongoing support for the safety net. These objectives are essential to improve the quality of care provided to beneficiaries and reduce the cost trend in the Medi-Cal program, which will help ensure the long-term viability of the program and the Medi-Cal expansion.

The Waiver Renewal will also need to be innovative in developing sources of non-federal share as CA has done in prior years through partnerships at the local level with counties and public hospital systems.

The Department has developed several concepts for consideration as part of the Waiver Renewal to achieve the goals identified above. This paper provides a brief overview of the concepts that have been developed thus far:

Federal/State shared savings initiative
California has been a leader is ensuring cost efficiency in the Medicaid program. A critical component to the success of the Affordable Care Act will be the ability for states to slow the cost growth of the Medicaid program while also ensuring access to high quality health care. Absent flexibilities and innovations California is seeking under this 2015 Waiver, we expect that costs would not only continue to grow but would grow at an increasing trend, in part due to the significant expansion of coverage in both Medicaid and through the health insurance exchange that puts significant pressure on access and provider rates. Under a new Medicaid Waiver, California would seek federal support to promote cost efficiency and access through a shared savings initiative.

Under this approach, California would establish per beneficiary payments per year for the Medi-Cal beneficiary categories covered under the Waiver. These per beneficiary amounts would be developed in a manner consistent with the 2010 Waiver budget neutrality and would include cost trend factors intended to incentivize the state to slow the cost trend in California's Medicaid program relative to the cost trend the state would face absent the Waiver. California would receive these pre-established per beneficiary payments to deliver whole-person, coordinated care for these beneficiaries. Periodically, and at the end of the waiver period, the state and federal government would perform reconciliation of these per-beneficiary-per-year payments to California's actual expenditures under the Waiver. If California's actual expenditures were below the pre-established per beneficiary amounts, the state would retain the federal funding for the difference between the actual expenditures and the pre-established beneficiary amounts.

This shared savings initiative would provide California with the incentive to slow the growth of cost in the Medicaid program while also enabling the state to use the shared savings to invest in our delivery system to help ensure access and quality for California's Medicaid beneficiaries, such as in the potential initiatives outlined below.

Payment/Delivery Reform Incentive Payment Programs

California is interested in reforming our payment and delivery systems to encourage increased care coordination, case management, and initiatives such as patient centered medical homes, readmission/ED visit reductions that will reduce the overall cost trend and impact the total cost of care as well as improve overall health care outcomes.

Incentive payment programs for our managed care plans and/or Medi-Cal providers could be developed that would measure the total cost of care and quality for Medi-Cal beneficiaries enrolled in accountable care-like programs or risk-based delegated health home models wherein primary care, specialty care, hospital care, etc, are all coordinated under a single entity. Incentive payments would be available to the accountable care group (whether that be a health plan or providers within a health plan) if quality and outcome measures are achieved and the actual total cost of care of the beneficiaries was lower than the projected total cost of care.

Similarly, the State is interested in developing incentive payment programs aimed at better integrating behavioral health care provided through our County mental health and substance use disorder treatment plans with the medical care provided by our Medi-Cal managed care plans. Again, incentive payments based on total cost of care reductions and performance on quality and outcome measures could be provided to help drive better alignment and care coordination between the mental health and the physical health care delivery systems. Incentive Payments could target specific initiatives such as reducing ED visits and overdose prevention.

Safety net payment reforms that support coordinated and cost effective care for the remaining uninsured

California's 21 public hospital and clinic systems are critical to the state's safety net for all Californians, but particularly those who will remain uninsured post-ACA implementation. For the last two Medicaid Waivers, these systems have receive partial reimbursement for their care to uninsured through California's Safety Net Care Pool as well as nearly all of the state's DSH funding. These systems have claimed reimbursement under these two funding sources through a cost-based system that has not necessarily provided the best levers to drive coordinated or cost effective care.

Under a Waiver Renewal, California seeks to explore innovative payment reforms that more appropriately align incentives for these safety net providers to better coordinate the care for the uninsured populations. We are interested in a global payment approach that provides federal flexibility to integrate Medicaid DSH and Safety Net Care Pool funding for these systems. The funding pool could be structured as a bundled payment for an episode of care. The global payment approach would support the public hospital systems' efforts to integrate care for the remaining uninsured by supporting comprehensive care that includes primary care in lower cost outpatient settings. This could ultimately help achieve reduced emergency and inpatient services, and lower costs. This more flexible payment structure would improve access and quality for the uninsured who seek services in California's public hospital systems by moving away from traditional cost-based reimbursement. The structure allows for more efficient use of funds that would otherwise pay for emergency and inpatient services by redirecting some of these monies to outpatient primary and specialty care.

FQHC Payment/Delivery Reform

Efforts and discussion are already underway on the topic of FQHC payment and delivery reform. The Waiver Renewal could be an opportunity to further support or expand the efforts to transform FQHC payment/delivery away from a volume based model to a risk-based model that provides FQHCs the incentives and flexibilities to provide care in the most cost-effective and patient-centered manner possible. FQHCs serve a high volume of Medicaid members and are essential to ensuring and expanding access in California's safety net. Payment and delivery system reforms at the clinics have the potential to control the rising cost trends in the Medi-Cal program and incent more efficient and coordinated care. The inclusion of these efforts under the Waiver would be intended as further support of the goals of reducing overall costs, California would not be seeking to waive the requirements of PPS or Alternative Payment Methodology requirements.

Successor Delivery System Reform Incentive Payment program

The 2010 DSRIP has been critical in supporting the public hospital and clinic system safety net in anticipation of health care reform. Under this program, the 21 public hospital systems have built a strong foundation of delivery system transformation that will help ensure access to quality healthcare for California's Medicaid beneficiaries. Building on the lessons learned from the 2010 DSRIP, a successor program would be more outcomes- and value-oriented, particularly with respect to population health, and would seek to demonstrate advancement of Triple Aim goals more consistently across the 21 public hospital systems. This successor program is a critical component in ensuring that the growing Medicaid population in California will continue to have access to high quality, cost-effective care. Key areas of interest to the Department include patient safety, complex patients and prevention.

The successes and lessons learned from the current DSRIP could also be built upon to create a DSRIP program for the state's Non-Designated Public Hospitals (NDPHs). These hospitals are already embarking on transformation to their payment systems by moving away from cost-based or per-diem payments to a Diagnosis Related Group (DRG) payment methodology. An NDPH DSRIP would further support delivery system transformation through quality improvement projects that meet the goals of the Triple Aim.

California Children's Services (CCS) Program Improvements

As part of the Waiver Renewal, the Department would also like to explore options at improving care delivery, quality and cost in the CCS program. Similar to other initiatives described above, the Waiver could include pay for performance programs, efforts to move toward a more coordinated and organized delivery system. Any such efforts would be aimed at improving the CCS program while still recognizing the important value of the specialized care these beneficiaries require and the certified providers that provide this care.

Medicaid funded Shelter for Vulnerable Populations

Shelter is an integral component of ensuring the success of the state's efforts to coordinate whole-person care for particularly vulnerable populations, such as those in our Coordinated Care Initiative and beneficiaries with behavioral health issues. The Department would like to explore demonstration options for testing how funding for shelter through Medicaid can also contribute to increased quality, ensure continuity of care, deliver better health outcomes, and reduced total cost of care.

Workforce Development
The Medicaid expansion now underway is likely to add over 2 million people to the Medi-Cal program. Many of the additions are people who have never had access to reliable primary care, and have tended to seek medical attention when they need it in hospital emergency rooms. If the system contemplated by the ACA is to work, the primary care delivery system will need to be substantially transformed and expanded to meet the needs of these new Medicaid enrollees and change the way they seek care.

At the same time that this new demand for primary care emerges, there will be enhanced competition for the time and resources of the health care provider community from other payor sources--primarily the commercial sector. Commercial payors have tended to be significantly higher payers than the Medicaid program, which means that doctors and other providers are likely to be more resistant to caring for Medicaid patients, since they can be fully occupied serving insured patients at a higher level of compensation. The state must be able to attract new providers into the Medi-Cal programs given the market factors across payors. At the same time, California must also seek incentives to retain existing providers in an environment where a greater volume of patients with potentially higher acuity and pent up demand are presenting need for services.

Under this Waiver, California could offer subsidies for malpractice insurance premiums of doctors who are willing to devote significant portions of their practices to low income patients. The malpractice insurance premium subsidy program will provide subsidies that are related to the percentage of the doctors' practices devoted to low income populations. The subsidies will be provided as capitation supplements paid to Medicaid managed care organizations based on their reports of the level of business done with doctors in their health plans. The MCOs would be required to pass the supplements through to the doctors. The federal matching portion would be a blend of the regular and the enhanced FMAP rate based on the proportions of the overall capitation payments matched at each rate.

Section 1115 Waiver Renewal Concept Development

Mari Cantwell

Chief Deputy Director, Health Care Programs

Department of Health Care Services

September 11, 2014

1115 Waivers

Allow states flexibility to design demonstration projects that promote the objectives of the Medicaid program

Demonstrations are typically approved for five years; states may submit request for renewal for 3 - 5 years

Must be budget neutral

2010-2015 Bridge to Reform

"Bridge to Reform" Waiver 2010-2015

Current Waiver demonstration sunsets October 31, 2015

Waiver renewal request must be submitted to the Centers for Medicare and Medicaid Services (CMS) at lest 6 months before the end of the current Demonstration

"Bridge to Reform" Waiver 2010 - 2015

Six Primary Goals

- Strengthen California's health care safety net
- Maximize opportunities to reduce the number of uninsured individuals
- Optimize opportunities to increase federal financial participation and maximize financial resources to address uncompensated care
- Promote long-term, efficient, and effective use of state and local funds
- Improve health care quality and outcomes
- Promote home-and community-based care

Successes of "Bridge to Reform"

- Low Income Health Program (LIHP)
- Delivery System Reform Incentive Pool (DSRIP) + Category 5 HIV Transition Projects
- Transition of Seniors and Persons with Disabilities (SPDs) into Mandatory Managed Care
- California Children's Services (CCS) Pilots
- Health Families Program (HFP) Transition
- Rural Managed Care Expansion
- Indian Health Services Uncompensated Care claiming
- ACA Optional Medi-Cal Expansion
- Community-Based Adult Services (CBAS)
- Integration of Outpatient Mental Health Services
- Safety Net Care Pool / Designated State Health Programs
- Coordinated Care Initiative (CCI)
- Organized Delivery System Waiver for the Drug Medi-Cal (DMC) Program (pending)
- Full Scope Medi-Cal for Pregnant Women 109-138% FPL (pending)

2015 Waiver Renewal Initial Concepts

Purpose of 1115 Waiver Renewal

Shared Goals with CMS	
	To further delivery of high quality and cost efficient care for our beneficiaries
	To ensure long-term viability of the delivery system post-ACA expansion
	To continue California's momentum and successes in innovation achieved under the "Bridge to Reform" Waiver

Objectives

- Strengthen primary care delivery and access
- Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Address social determinants of health
- Use California's sophisticated Medicaid program as an incubator to test innovative approaches to whole-person care

Strategy to Achieve Objectives

Implement innovative healthcare financing and delivery system transformation strategies through the flexibilities of the 1115 Waiver to tailored to California Medicaid's unique needs

Additional consideration: Finding areas of synergy with CalSIM and other state initiatives

Initial Waiver Concepts

- Federal/State Shared Savings
- Payment/Delivery Reform Incentive Payments
- Safety Net Payment Reforms
- FQHC Payment/Delivery Reform
- Successor DSRIP
- CCS Program Redesign
- Shelter for Vulnerable Populations
- Workforce Development

Federal/State Shared Savings

- Under the Waiver, a per-beneficiary-per-year cost amount would be established based on predicted costs for those beneficiaries absent the waiver
- The state would retain federal funding for the difference between actual expenditures and pre-established per beneficiary amounts
- The savings serve as key component that will allow CA to implement many of the other waiver initiatives
- Concept is not a per-capita cap that limits entitlement spending; any excess spending over the anticipated per-beneficiary cost would count against budget neutrality margin

Related Objective: Use California's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care

Payment/Delivery Reform
Incentive payments

- CA would seek Waiver authority to create one or more incentive programs to achieve goals of the Triple Aim
- Focus on integration of behavioral health and substance abuse disorder services with medical care, as well as coordination between delivery systems
- Incentive payments would target total cost of care and allow for shared savings when an accountable entity meets specified quality and outcome measures
- Payments could be targeted at both managed care plans and Medi-Cal providers

Related Objective: Strengthen primary care delivery and access

Related Objective: Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency

Related Objective: Use California's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care

Safety Net Payment Reforms

- Aim for innovation in aligning incentives for safety net providers by transforming the traditional Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) reimbursement structures
- Explore concept of a global or bundled payment approach that provides federal flexibility to integrate DSH and SNCP funding and serve as level to drive coordinated care
- Support safety net providers in their efforts to provide comprehensive care for the remaining uninsured that includes primary care, in lower costs outpatient and clinic settings

Related Objective: Strengthen primary care delivery and access

Related Objective: Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency

Related Objective: Use California's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care

FQHC Payment/Delivery Reform

DHCS

- Discussions on FQHC payment and delivery system reform occurring in separate workgroup efforts; under the waiver, the reforms will further support the goal of reducing overall costs in Medi-Cal
- Not seeking Waiver authority to waive PPS or Alternative Payment Methodology requirements
- Goal is to transform care at FQHCs from a volume-based model to a risk-based model and provide FQHCs with incentives and flexibilities to provide cost-effective, patient-centered care

Related Objective: Strengthen primary care delivery and access

Related Objective: Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency

Related Objective: Use California's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care

Successor DSRIP

- Would build on lessons learned from 2010 DSRIP and other states' DSRIPs
- Lessons learned from the BTR DSRIP could inform program design for Non-Designated Public Hospitals (NDPHs)
- Successor DSRIP would be more outcomes and value-oriented and seek to demonstrate advancement of the Triple Aim more consistently across the public hospital systems

Related Objective: Strengthen primary care delivery and access

Related Objective: Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency

Related Objective: Use California's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care

California Children Services (CCS)

Pilot Sites under "Bridge to Reform" Waiver

Health Plan of San Mateo	Rady Children's Hospital (San Diego)
• Operational on April 1, 2013 • All CCS county population covered • All health conditions covered • COHS model • Population size ~1600	• Operational date expected in late 2014 • Includes 5 CCS health Conditions • Hemophilia, Cystic Fibrosis, Sickle Cell, Leukemia, Diabetes • ACO-like model • Population size ~600

2015 Waiver Renewal and CCS

- Existing demonstration pilots will continue (HPSM, Rady Children's Hospital)
- Separate stakeholder process to begin in late September/early October
- No predetermined delivery system identified, all options to be considered
- Key program principals will be maintained (e.g.: provider standards, whole child approach, maintaining regional provider network)
- UCLA Center for Health Policy Research will administer the stakeholder process
- Will include workgroups in key subject matter areas (e.g.: funding simplification, provider network, care coordination, patient centered medical care)

Related Objective: Use California's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care

Medicaid-Funded Shelter

- Potential to test ways in which Medicaid-funded shelter can contribute to better health outcomes and reduced total cost of care for beneficiaries

- Ideas, such as subsidized housing, can support the goal of a whole-person approach to care for vulnerable populations

Related Objective: Address social determinants of health

Related Objective: Use California's sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care

Workforce Development

- Pressing need to transform and expand primary care delivery systems to serve the Medi-Cal population, given increased competition for providers post-ACA

- One concept is to support primary care providers' capacity to serve Medi-Cal populations by offering malpractice insurance premiums for physicians who serve a significant portion of Medi-Cal patients

Related Objective: Strengthen primary care delivery and access

Stakeholder Process

Proposed Stakeholder Concept Development

In developing the approach to stakeholder involvement, DHCS considered:

- Best practices from 2010 Waiver Renewal efforts
- Timing constraints leading up to CMS submission
- Ensuring an efficient and meaningful process with participation from impacted stakeholders

The Department is considering a targeted workgroup structure of subject matter experts, in a format specific to each major Waiver concept

Behavioral/physical health integration strategies will be a sub-topic of several of the workgroups

Meetings will be open to the public with time allotted to public comment

Stakeholder Engagement

Federal-State Shared Savings

- One all-day stakeholder meeting for the Department to present the savings model and solicit input from a broad, impacted stakeholder group

Stakeholder Engagement (Cont.)

Safety Net Payment Reform / DSH & SNCP Bundled Payment

- Two targeted workgroup sessions with public hospitals, county health agencies and safety net providers on payment reforms for the safety net/uninsured

DSRIP II

- 2-5 targeted workgroup sessions of impacted hospital associations and affiliated stakeholders

MCO and provider incentive programs

- Two targeted workgroup sessions on incentive programs for managed care delivery system

Stakeholder Engagement (Cont.)

Medicaid-Funded Shelter

- Four targeted workgroup sessions
- Meeting 1: Kick-off to establish evidence, best practices, other states' experiences
- Meetings 2-4: identify demonstration options potentially focusing on different target populations

Workforce Development

- Three targeted workgroup sessions
  - One meeting on malpractice subsidies
  - Two meetings on other incentive ideas

Foundation Support

The Blue Shield of California Foundation, the California Endowment, and the California Health Care Foundation will provide funding and technical support to aid in:

- Stakeholder workgroup efforts
- Technical assistance on concept development including linkage to subject matter experts
- Development of Special Terms and Conditions (STCs)

Stakeholder Process: Timing

Summer 2014

- July 25, 2014: Webinar on initial DHCS concept paper
- Solicit input on Waiver concepts and stakeholder process

Fall/ Winter 2014

- Stakeholder discussions and concept development
- Targeted Workgroups anticipated to begin mid-October 2014

Winter / Spring 2015

- Submission of Waiver renewal to CMS anticipated for February 2015

Spring/ Fall 2015

- Development of Special Terms and Conditions (CMS)

Questions / Comments:

WaiverRenewal@dhcs.ca.gov

DATES AND LOCATIONS FOR EXPERT STAKEHOLDER WORKGROUPS
1115 WAIVER RENEWAL

Workgroup Name	Date	Time	Location
DSRIP 2.0	November 13, 2014	TBD	TBD
	December 19, 2014	TBD	TBD
	January 13, 2015	TBD	USC State Capitol Center
	January 26, 2015	TBD	DHCS – Training Rooms A, B, & C
	February 3, 2015	TBD	Sacramento Convention Center - Room TBD
Housing / Shelter	November 4, 2014	10:00 AM – 3:00 PM	Sacramento Convention Center - Room 203
	December 16, 2014	TBD	TBD
	January 14, 2015	TBD	USC State Capitol Center
	January 28, 2015	TBD	USC State Capitol Center
Workforce	November 20, 2014	TBD	TBD
	December 11, 2014	TBD	TBD
	January 7, 2015	TBD	Sacramento Convention Center - Room TBD
Safety Net Financing (DSH/SNCP Bundled Payments)	December 9, 2014	TBD	TBD
	January 12, 2015	TBD	USC State Capitol Center
	January 29, 2015	TBD	DHCS – Training Rooms A, B, & C
MCO/Provider Incentives	November 12, 2014	TBD	Sacramento Convention Center - Room TBD
	December 15, 2014	TBD	USC State Capitol Center
	January 23, 2015	TBD	DHCS – Training Rooms A, B, & C
Federal/State Shared Savings	January 30, 2015	TBD	DHCS - Auditorium

Location Addresses

Department of Health Care Services Training Rooms A, B, & C 1500 Capitol Avenue Sacramento, CA 95814	Department of Health Care Services DHCS Auditorium 1500 Capitol Avenue Sacramento, CA 95814	Sacramento Convention Center 1200 J Street Sacramento, CA 95814	USC State Capitol Center Room E 1800 I Street Sacramento, CA 95811-3004

California Association of
Public Hospitals and Health Systems

Providing Whole-Person Care to Medicaid High-Utilizers in California: Opportunities for County-Based Pilots in California's 1115 Medicaid Waiver Renewal

A New Opportunity for California

The recent expansion of health care coverage to low-income Californians through the Affordable Care Act has provided unprecedented opportunities both for access to coverage and for enhanced collaboration among providers of historically siloed services to Medi-Cal eligible clients. At the same time, many California counties are taking on increased responsibilities for the provision of services that touch many of our most vulnerable Medi-Cal eligible residents, including those needing behavioral health, social services supports, and those involved with the criminal justice system. Within this context, there is a new opportunity to advance local efforts to improve the health outcomes of some of our most vulnerable populations, to use resources more effectively through a coordinated and more holistic approach across sectors, and to better aligns services for low-income populations.

Meaningful local collaboration is already happening today. For example, efforts are now underway to coordinate the delivery of mental health and substance use benefits between Medi-Cal Plans, Specialty Mental Health Plans, and county systems. Other local efforts are focused on enrolling vulnerable populations, such as individuals who are being released from county jails, into Medi-Cal coverage and linking them to a health home. To develop systematic approaches that link service delivery across separate systems of care, focus systems on improving health outcomes while using resources more effectively, and take current local efforts to scale, a programmatic and financing structure for Whole-Person Care is needed. The absence of a systematic Whole-Person Care approach today results in poorer health outcomes for many low-income residents, continued utilization of high-cost services (e.g. emergency room, hospitalization, and incarceration), and a less efficient use of Medicaid funds and other critical resources. **With the upcoming renewal of California's 1115 Medicaid waiver, California can build upon and expand current county efforts to test a systematic framework for Whole-Person Care and align payment incentives to ensure effectively coordinated care across multiple local agencies for the highest need patients.**

Whole Person Care Working Definition

The coordination of health, behavioral health and social services in a patient-centered manner with the goals of improved health and well-being for individual and family outcomes and more efficient and effective use of resources.

Vision and Framework

Our vision is for counties and local agencies to provide Whole-Person Care as described in the definition for the highest need patients – their "high users of multiple systems" that have historically been served by county systems – through collaborative leadership and systematic coordination with other public and private entities identified by the county. County agencies will identify these clients with shared data, coordinate their care in real time, and evaluate individual and population progress. Clients will have an individualized care plan and a single accountable, trusted care manager that supports them getting them needed services. Financial flexibility will permit providers across partnering sectors to do what is right for the client and will align incentives for providers to collaborate. These components describe a framework for providing Whole-Person Care.

Whole-Person Care County Pilots in California's 1115 Medicaid Waiver Renewal

As a centerpiece of California's 1115 Medicaid waiver renewal demonstrating payment reform and delivery system transformation, California should propose authority for development of County Whole-Person Care Pilots that incorporate the Whole-Person Care framework described above. These pilots would test innovative care coordination and collaboration strategies for the targeted Medi-Cal populations, and would allow participating counties additional flexibility in how they allocate resources to best address the issues contributing to the target population's health conditions and current utilization of services across sectors. A key component envisioned to be authorized through the waiver is the ability to use waiver funds for services not traditionally covered in the Medicaid program, such as targeted housing assistance. While counties would have flexibility to test approaches for identifying the target population and range of services and supports provided, all participating counties would be measured against a uniform set of identified outcomes focused on overall improvements in health, well-being, and efficiency.

Drug Medi-Cal (DMC) Organized Delivery System Wavier

November 3, 2014

1

DMC Organized Delivery System Waiver

Agenda

- Waiver Amendment Submission Requirements
- Waiver Finance Planning Process
- Proposed Shared Financing Model
- Budget Neutrality
- Readiness Assessment
- Implementation Plan
- Next Steps

2

DMC Organized Delivery System Waiver

Waiver Amendment Submission Requirements

- Tribal Notice
- Expenditure Authority
- Special Terms and Conditions
- Budget Neutrality

3

DMC Organized Delivery System Waiver

Waiver Finance Planning Process

- DHCS began discussions regarding the financial considerations of an organized delivery system for Drug Medi-Cal (DMC) with the counties
- Counties almost universally voiced similar concerns:
  - Services vary from county-to-county
  - Lack ability to contract with quality providers
  - Counties and providers have minimal ability to adjust costs to reflect specific needs of communities

4

DMC Organized Delivery System Waiver

Waiver Finance Planning Process

- Counties also indicated common priorities:
  - Ability to draw down federal financial participation for a wider set of services
  - Chance to increase access to residential treatment options
  - Foster coordination between delivery systems

5

DMC Organized Delivery System Waiver

Key Issues to Address in Financing Components

- Need to switch to county of residence; consider impact to county funding
- Variability among counties in historical expenditures and service levels
- Variability among counties in population and number of users vs. number of Medi-Cal beneficiaries overall

6

DMC Organized Delivery System Waiver

- **Key Issues to Address in Financing Components**

- Need to develop a methodology that would account for new services and new populations
- Need to develop a methodology that would maintain State and county funding responsibilities but also:
  - provide flexibility for counties to develop rates to ensure provider participation
  - ensure neither counties nor the State had financial incentives to influence services use or type

7

DMC Organized Delivery System Waiver

Overall Financing Structure

- Based on the key issues, first decision was to utilize a concept of an overall per user per month (PUPM) methodology:
  - County specific to account for county variability
  - Per user selected vs. per member given variability on number of service users vs. overall population
  - Overall PUPM vs service-specific PUPM to allow flexibility in county rate development as well as to provide incentive for appropriate service utilization

8

DMC Organized Delivery System Waiver

- Overall Financing Structure

- PUPM development incorporates both county historical spending and assumptions regarding projecting future trends as well as impact of new services and expanded populations
- Table on next slide shows example of PUPM calculation's based on historical date for four counties (note: given data issues for FY09-10, data for that year needed to be simulated)

9

DMC Organized Delivery System Waiver

——PAST FIVE YEARS OF DATA —— | FUTURE YEARS → grew rate by 1%

County Name	Category	State Fiscal Year 08-09 [Actuals]	State Fiscal Year 09/10 [Simulated]	State Fiscal Year 10/11 [Actuals]	State Fiscal Year 11/12 [Actuals]	State Fiscal Year 12/13 [Actuals]	State Fiscal Year 13/14 [Estimate]	State Fiscal Year 14/15 [Estimate]
County X	IOT Annual Expenditures	$952,450	$750,224	$552,858	$787,025	$552,988	$538,650	$551,778
County X	IOT User Months	1,283	1,024	764	1,099	686	693	700
County X	IOT PUPM	$742.36	$733.00	$723.64	$716.13	$806.10	$777.43	$788.49
County X	NTP Annual Expenditures	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
County X	NTP User Months	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
County X	NTP PUPM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
County X	ODF Annual Expenditures	$1,113,108	$1,288,502	$1,475,444	$3,182,868	$1,808,222	$2,080,816	$2,257,194
County X	ODF User Months	5,299	5,835	6,370	10,189	6,365	6,429	6,491
County X	ODF PUPM	$210.06	$220.84	$231.62	$312.38	$284.09	$323.68	$347.64
County X	Residential Annual Expenditures	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
County X	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
County X	Residential PUPM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
County X	Total Annual Expenditures	$4,380,883	$4,271,924	$4,153,455	$6,285,709	$4,697,511	$4,698,890	$4,814,239
County X	Total Unduplicated User Months	11,477	11,743	12,008	16,086	11,847	11,965	12,085
County X	Total PUPM	$381.71	$363.80	$345.89	$390.76	$396.51	$392.70	$398.36

——COUNTY BASE FOR EXPENDITURES——

10

DMC Organized Delivery System Waiver

Waiver Finance Planning Process

- DHCS collaborated with the four county staff to discuss the PUPM model and determine if the waiver was viable
- Department anticipates between eight to twelve counties may opt-in initially

small
medium
large

11

DMC Organized Delivery System Waiver

Key Next Steps

- Refinement of county PUPMs for counties interested in participating
- Refinement and consensus on assumptions utilized for new services and expanded populations
- Use of PUPM structure for both development of county/State funding relationship and development of budget neutrality

12

DMC Organized Delivery System Waiver

Proposed Shared Financing Model

- Designed to be flexible enough to address different county needs
- Wavier allows counties ability to propose rates independent of current DMC process, with DHCS approval
- Funding of actual PUPM costs to be based on State/county sharing ratio for non-federal share

13

DMC Organized Delivery System Waiver

- Ratio developed based on what percentage of non-federal funding would have been State and county absent the waiver
- Helps ensure there is no financial incentive to encourage utilization of one service over another
- PUPM provides target amount for counties to use in rate, service and utilization development

Note: in non-Waiver counties, obligation for funding of services remains as it is today

14

DMC Organized Delivery System Waiver

Budget Neutrality

- The requirement for overall 1115 budget neutrality is that the spending for the entire programs under the Waiver (Medi-Cal managed care program, incentive payment programs, uncompensated care pool, etc) must not exceed what the spending on the program would have been overall without the Waiver
- Any "savings" incurred by having implemented the Waiver programs allows States to claim federal funds for "costs not otherwise matchable" (CNOM), an example from the current Waiver is the Safety Net Care Pool

15

DMC Organized Delivery System Waiver

- Overall the current budget neutrality is composed of many components:
  - Projected costs of Medi-Cal program absent managed care
  - Projected costs of designated public hospitals if reimbursed and the upper payment limit
  - Projected costs trends absent managed care
  - State projection for future costs
- The current budget neutrality needs to be adjusted to add in the proposed DMC spending

16

DMC Organized Delivery System Waiver

- The adjustments include:
  - Projections of what DMC spending would be absent the Waiver, using the PUPM methodology for counties opting-in
  - Projections of what DMC spending will be under the Waiver, including the spending only allowed under the Waiver (e.g. residential treatment services in facilities with more than 16 beds, for counties opting-in). *Note: this will be adjusted in future to be the actual PUPM spending incurred*
- If DMC spending under the Waiver costs more than it would have absent the Waiver, savings from other elements of the Waiver will ensure ability of FFP for DMC Waiver spending

17

DMC Organized Delivery System Waiver

<u>Readiness Assessment</u>

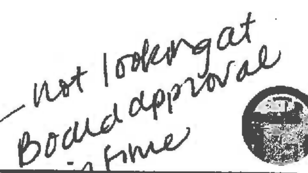
- Counties will need to demonstrate readiness
- Counties will commit to opting in to waiver

18

DMC Organized Delivery System Waiver

Implementation Plan

- Sections in the Plan
  - Narrative
  - Assurances
  - Projected Beneficiaries
  - Projected Services
  - Proposed Rates
  - Board of Supervisors Approval



19

DMC Organized Delivery System Waiver

Implementation Plan

- Narrative
  - Service Delivery System
  - Assure Access
  - Quality Assurance Activities
  - Integration of Services
- Assurances

20

DMC Organized Delivery System Waiver

- Projected Beneficiaries
  - Projections for each service modality
  - Projections for each level of service
- Proposed Rates
  - Proposed rates for each service modality
  - Rates would correlate with utilization projections
  - Brief narrative would justify the rates

21

DMC Organized Delivery System Waiver

Next Steps

- DHCS will continue to accept feedback on all components of the Waiver
- DHCS will look at submitting the formal waiver once all components are complete

22

DMC Organized Delivery System Waiver

		------PAST FIVE YEARS OF DATA -----					FUTURE YEARS	
County Name	Category	State Fiscal Year 08-09 [Actuals-]	State Fiscal Year 09/10 [Simulated]	State Fiscal Year 10/11 [Actuals-]	State Fiscal Year 11/12 [Actuals-]	State Fiscal Year 12/13 [Actuals-]	State Fiscal Year 13/14 [Estimate-]	State Fiscal Year 14/15 [Estimate]
County X	IOT Annual Expenditures	$952,450	$750,224	$552,858	$787,025	$552,988	$538,650	$551,778
County X	IOT User Months	1,283	1,024	764	1,099	686	693	700
County X	IOT PUPM	$742.36	$733.00	$723.64	$716.13	$806.10	$777.43	$788.49
County X	NTP Annual Expenditures	$2,232,675	$2,146,261	$2,060,183	$2,240,833	$2,324,996	$2,321,307	$2,382,724
County X	NTP User Months	4,873	4,863	4,853	4,793	4,803	4,851	4,900
County X	NTP PUPM	$458.17	$441.34	$424.52	$467.52	$484.07	$478.52	$486.32
County X	ODF Annual Expenditures	$1,113,108	$1,288,502	$1,475,444	$3,182,869	$1,808,222	$2,080,816	$2,257,194
County X	ODF User Months	5,299	5,835	6,370	10,189	6,365	6,429	6,493
County X	ODF PUPM	$210.06	$220.84	$231.62	$312.38	$284.09	$323.68	$347.64
County X	Residential Annual Expenditures	$82,650	$73,621	$64,970	$74,977	$11,305	$9,892	$10,387
County X	Residential User Months	37	36	35	41	4	4	4
County X	Residential PUPM	$2,233.78	$2,045.03	$1,856.29	$1,828.71	$2,826.30	$2,448.63	$2,545.50
County X	Total Annual Expenditures	$4,380,883	$4,271,924	$4,153,455	$6,285,703	$4,697,511	$4,698,890	$4,814,239
County X	Total Unduplicated User Months	11,477	11,743	12,008	16,086	11,847	11,965	12,085
County X	Total PUPM	$381.71	$363.80	$345.89	$390.76	$396.51	$392.70	$398.36

------COUNTY BASE FOR EXPENDITURES-----

Attachment Three

CSAC Memo: Human Services Update: Medi-Cal Eligibility, In-Home Supportive Services, and Relative Caregivers

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November 5, 2014

TO: CSAC Health and Human Services Policy Committee

FROM: Kelly Brooks-Lindsey, Senior Legislative Representative
Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: **Human Services Update: Medi-Cal Eligibility, In-Home Supportive Services, and Relative Caregivers**

Counties are facing a number of pressing human services issues in the 2015 legislative session that involve funding, administration, and complex fiscal transactions. Some are the result of federal law, others involve changes in state policy, and all three present fiscal ramifications for counties. We have invited Cathy Senderling-McDonald, Deputy Executive Director for the County Welfare Directors Association, to outline three of the issues we expect to grapple win the coming year.

Funding for Medi-Cal Eligibility. The implementation of the Affordable Care Act (ACA) in California has triggered a massive increase in workload for county eligibility workers. Governor Brown recognized the key role of county eligibility workers when he opted to participate in the ACA's Medicaid expansion and provided a small boost in eligibility administration funding in 2013-14. However, as we approach year two of the expansion, the state's health care benefit exchange, Covered California, is still working to process applications it received from year one. Covered California has turned to county eligibility workers to help reduce this backlog, and we anticipate that a similar situation will occur in year two as recipients are required to renew their applications at the same time that new enrollees are expected to spike.

With this in mind, counties will be seeking additional funding for Medi-Cal administration costs at the local level. The request that has been made for the current year (2014-15) is in the $100 million to $150 million total funds range. We hope to hear from the Administration no later than the January 10 budget (and possibly earlier) what level of funding is being included in the January budget. Additional funds beyond the current year number will be sought in the budget year (2015-16), with the total to be determined in discussion with the Administration and (ideally) also included in the January budget.

In-Home Supportive Services. There are a number of issues with the In-Home Supportive Services program (IHSS) that will need to be addressed in 2015. Counties will face significant challenges in implementing new policies for overtime and travel pay necessary to comply with changes to the federal Fair Labor Standards Act (FLSA) changes.

The Administration and Legislature implemented these changes in Trailer Bill 855, but capped the overtime hours that can be paid per provider to 61 hours per week and capped travel time to 7 hours per week. The law also requires consumers to make requests to counties for an exception when a recipient has a need for their provider to work more than 40 hours in a week. The policy also required new timesheets and travel claim forms to process and assist consumers and providers.

The new rule goes into effect on January 1, 2015 and includes a three-month grace period that allows providers to work overtime and receive pay for travel without penalty. The grace period will also enable consumers and providers to receive training on the new rules and timesheets. The grace period provides some limited relief to counties to establish local procedures and hire the necessary staffing necessary.

In the short term, starting November, counties are responding to consumer and provider questions, organizing training sessions for consumers and providers, and preparing to receive and process new forms as required by CDSS. In addition, counties will need to assist some consumers in finding additional providers, provide timely response to consumer requests for changes in their weekly service hours, review travel claims, and enforce violations to any provider who fails to comply with the new policy. Additional staffing and facility space will be needed to implement these changes locally. However, counties bear no additional share of cost because of the IHSS MOE, which effectively means the State will bear 100% of the cost for counties to administer these changes.

Implementing the New Approved Relative Caregiver Funding Option Program. The Legislature created the Approved Relative Caregiver Funding Option Program (ARC) and provided for $30 million in the 2014-15 budget. This new program operates as a county opt-in, and would pay an approved relative caregiver a "per child, per month" rate equal to the base rate paid to foster care providers for a federally eligible AFDC-FC child. CSAC supported the creation of ARC and the dedicated annual funding, but significant technical details have emerged that will almost certainly delay the January 1, 2015 statutory start date for the program.

The technical details center on how the state will determine each county's caseload and base rate, outstanding administrative implementation questions (such as around the application and payment processes), and whether the initial $30 million investment is enough to cover the number of cases for the counties that opt in.

If there is insufficient funding, counties have the ability opt out of the program by providing 120 days' notice to the Department of Social Services and at least 90 days' prior written notice to the approved relative caregiver or caregivers, informing them that his or her payment will be reduced on a certain date.

In addition, the new program is run on a calendar-year basis and the annual $30 million appropriation will be adjusted by the California Necessities Index annually.

If this appropriation is insufficient to fully fund the base caseload of approved relative caregivers, the legislation provided for the appropriation of additional funds to fully fund that base caseload.

The combination of the technical difficulties in determining base caseloads and base funding amounts and the other implementation uncertainties, have already delayed the October 2014 deadline for counties to opt into the program.

Invited Speaker:

Cathy Senderling-McDonald, Deputy Executive Director, County Welfare Directors Association

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Michelle Gibbons can be reached at (916) 327-7500 Ext. 524 or mgibbons@counties.org.

Attachment Four

CSAC Memo: 2015-16 Health and Human Services Platform Documents

CSAC Health Platform (Draft)

CSAC Human Services Platform (Draft)

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November 5, 2014

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Senior Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst
Michelle Gibbons, Legislative Analyst

Re: 2015-16 Health and Human Services Platform Documents

Background. The policy committees of the California State Association of Counties (CSAC) review and, if appropriate, revise their respective planks of the Association's policy platform on a biannual basis. Attached you will find the initial proposed drafts of the CSAC Health and Human Services (HHS) chapters. The proposed texts will serve as the guiding policy documents for 2015-16.

Process. The attached platform chapters represent the proposed draft of policy for 2015-16. The CSAC HHS policy committee must review and discuss the proposed changes, and, if appropriate, vote to adopt the chapters. CSAC HHS Policy Committee staff will also solicit comments from all interested parties on proposed changes and/or suggestions for additions. The CSAC HHS policy committee's recommendations will then be forwarded to the CSAC Board of Directors. The full Board will review the proposed chapters at their first scheduled meeting of the 2015 calendar year. Should the Board of Directors modify or seek clarification on the policy committee's recommendations, the policy committee will meet again via conference call to examine the inquiries or suggested modifications.

Staff Comments. The attached draft version of proposed changes to the CSAC Health and Human Services chapters is intended only as a notification of proposed changes; a full HHS Policy Committee meeting will be convened in early December to discuss the documents and vote on whether to forward them to the Board of Directors. Many of the changes reflect updates to programs and policy. However, for 2015-16, we have proposed some significant changes related to new issues and policies, including:

Federal Waivers: We anticipate work on two major federal waivers in 2015 – the renewal of the Section 1115 Medicaid Waiver and the creation of a new Organized Delivery System waiver for the Drug Medi-Cal program. We have updated the federal waiver section of the attached draft in anticipation of the major issues surrounding these efforts.

Intersection of Health and Human Services with the Court Involved Population: In the wake of 2011 Realignment and the implementation of the Affordable Care Act, counties have worked to enroll the court-involved population into Medi-Cal and other health and human services programs. Counties are supportive of obtaining federal funds to assist in these efforts, including Medicaid funds for inpatient hospitalizations – including psychiatric hospitalizations – and any state funding available to reduce recidivism.

Homelessness and Poverty Issues: The CSAC Executive Committee has indicated an interest in appointing a taskforce in 2015 to examine homelessness and poverty issues from the county perspective. We expect to add language to the policy platform as a result of the proposed taskforce's work.

Commercial Sexual Exploitation of Children (CSEC): We have added policy on the special needs and services required for the population of children and youth who have been sexually abused for commercial profit. This population is increasing and county child welfare services systems are working to create an array of supports to meet the special needs of this traumatized and often hard-to-reach population.

There are additional changes and corrections throughout the attached draft platform documents. We encourage members and county staff to review the proposed changes and contact CSAC HHS staff with questions and comments.

Recommendation. No action is required at this time. The CSAC Health and Human Services Policy Committee will meet via phone in December to discuss and approve the proposed changes.

Attachments:

CSAC Health Platform (DRAFT)

CSAC Human Services Platform (DRAFT)

Staff Contacts:
Kelly Brooks-Lindsey can be reached at (916) 327-7500 Ext. 531 or kbrooks@counties.org.
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Chapter Six

DRAFT November 2014

Health Services

Section 1: GENERAL PRINCIPLES

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

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

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

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

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

A. Public Health

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

County health departments are also charged with responding to terrorist and biomedical attacks, including maintaining the necessary infrastructure – such as laboratories, hospitals, medical supply and prescription drug caches, as well as trained personnel – needed to protect our residents. Counties welcome collaboration with the federal and state governments on the development of infrastructure for bioterrorism and other disasters. Currently, counties are concerned about the lack of funding, planning, and ongoing support for critical public health infrastructure.

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

B. Health Services Planning

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

C. Mental Health

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

The adoption of Proposition 63, the Mental Health Services Act of 2004, assists counties in service delivery. However, it is intended to provide new funding that expands and improves the capacity of existing systems of care and provides an opportunity to integrate funding at the local level. We strongly oppose additional reductions in state funding for mental health services that will result in the shifting of state or federal costs to counties. These cost shifts result in reduced services available at the local level and disrupt treatment options for mental health clients. Any shift in responsibility or funding must hold counties fiscally harmless and provide the authority to tailor mental health programs to individual community needs. We also strongly oppose any effort to redirect the Proposition 63 funding to existing state services instead of the local services for which it was originally intended.

The realignment of health and social services programs in 1991 restructured California's public mental 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. Counties are committed to service delivery that manages and coordinates services to persons with mental illness and that operates within a system of performance outcomes that assure funds are spent in a manner that provides the highest quality of care. The 2011 Realignment once again restructured financing for the provision of Med-Cal services for children and adults.

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

In 2011, Counties became solely responsible for managing the nonfederal share of cost for these mental health services.

In response to county concerns, state law also provides funds to county programs to provide specialty mental health services to CalWORKs recipients who need treatment in order to get and keep employment. Counties have developed a range of locally designed programs to serve California's diverse population, and must retain the local authority, flexibility, and funding to continue such services. Similar law requires county mental health programs to provide specialty mental health services to seriously emotionally disturbed children insured under the Healthy Families Program. The Healthy Families Program was dissolved in the 2012-13 Budget Act, and counties will continue to provide specialty mental health services to this population under Medi-Cal. However, counties anticipate increased demand for these services under Medi-Cal, and must have adequate revenues to meet the federal standards and needs of these children.

Adequate mental health services can reduce criminal justice costs and utilization. Appropriate diagnosis and treatment services will result in positive outcomes for offenders with mental illness and their families. Ultimately, appropriate mental health services will benefit the public safety system. Counties continue to work across disciplines and within the 2011 Realignment structure to achieve good outcomes for persons with mental illness and/or co-occurring substance abuse issues to help prevent incarceration and to treat those who are about to be incarcerated or are newly released from incarceration and their families.

D. Children's Health

California Children's Services

Counties provide diagnosis and case management services to the ~~approximately~~ over ~~175~~200,000 children enrolled in the California Children's Services (CCS) program, whether they are in Medi-Cal ~~, Healthy Families~~ or the CCS-Only program. Counties also are responsible for determination of medical and financial eligibility for the program. Counties also provide Medical Therapy Program (MTP) services for both CCS children and special education students, and have a share of cost for services to non-Medi-Cal children.

Maximum federal and state matching funds for CCS program services must continue in order to avoid the shifting of costs to counties. Counties cannot continue to bear the rapidly increasing costs associated with both program growth and eroding state support. Counties support efforts to redesign or realign the program with the goal of continuing to provide the timely care and services for these most critically ill children. Counties also support efforts to test alternative models of care under CCS pilots in the 2010 Medicaid Waiver and subsequent waivers.

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) is a federally funded program that allows states to provide low- or no-cost health insurance to children up to 250 percent of the Federal Poverty Level (FPL). ~~California's SCHIP program is called the Healthy Families Program. CSAC supports federal reauthorization of the SCHIP program, including an eligibility increase of up to 300 percent of the FPL for the state's children. Many of these children will be Medi-Cal eligible under the ACA.~~ CSAC supports a four-year extension of funding for the federal Children's Health Insurance Program (CHIP/Healthy Families). As a block grant, the appropriation for the program expires on September 30, 2015. Without federal funding, some families risk losing coverage for their children if their income is too high to qualify for Medicaid/Medi-Cal and too low to purchase family coverage through Covered California.

T~~T~~he 2012-13 Budget Act authorized the transfer of Healthy Families Program children into Medi-Cal. The transfer will begin in 2013 and consist of several phases. CSAC supports the transfer of all Healthy Families Program enrollees into Medi-Cal. The state must work to ensure network adequacy and access, as well as timely transitions on the technological systems that support eligibility, enrollment, and case management. Further, the state must work in partnership with counties to ensure a seamless transition for these children regardless of arbitrary timelines.

Proposition 10

Proposition 10, the California Children and Families Initiative of 1998, provides significant resources to enhance and strengthen early childhood development. Local children and families commissions (First 5 Commissions), established as a result of the passage of Proposition 10, must maintain the full discretion to determine the use of their share of funds generated by Proposition 10. Further, local First 5 commissions must maintain the necessary flexibility to direct these resources to the most appropriate needs of their communities, including childhood health, childhood development, nutrition, school readiness, child care and other critical community-based programs. Counties oppose any effort to diminish Proposition 10 funds or to impose restrictions on their local expenditure.

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

E. Substance Use Disorder Prevention and Treatment

Counties have been, and will continue to be, actively involved in substance use disorder prevention and treatment, especially under the 2011 Realignment rubric, where counties were given responsibility for

substance abuse treatment and Drug Medi-Cal services. Counties believe the best opportunity for solutions reside at the local level. Counties continue to provide a wide range of substance use disorder treatment services, but remain concerned about evidence-based treatment capacity for all persons requiring substance abuse treatment services.

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

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

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

F. Medi-Cal, California's Medicaid Program

California counties have a unique perspective on the state's Medicaid program. Counties are charged with preserving the public health and safety of communities. As the local public health authority, counties are vitally concerned about health outcomes. Undoubtedly, changes to the Medi-Cal program will affect counties. Even as the Affordable Care Act is implemented, counties remain concerned about state and federal proposals that would decrease access to health care or shift costs and risk to counties.

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

Additionally, county welfare departments determine eligibility for the Medi-Cal program. County mental health departments are the health plan for Medi-Cal Managed Care for public mental health services. Changes to the Medi-Cal program will undoubtedly affect the day-to-day business of California counties.

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

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

2. –**Managed Care.** Expansion of managed care must not adversely affect the safety net and must be tailored to each county's medical and geographical needs. Due to the unique characteristics of the health care delivery system in each county, the variations in health care accessibility and the demographics of the client population, counties believe that managed care systems must be tailored to each county's needs. The state should continue to provide options for counties to implement managed care systems that meet local needs. –The state should work openly with counties as primary partners in this endeavor. The state needs to recognize county experience with geographic managed care and make strong efforts to ensure the sustainability of county organized health systems. The Medi-Cal program should offer a reasonable reimbursement mechanism for managed care.

3.
Special Populations Served by Counties – Mental Health, Substance Use Disorder Treatment Services, and California Children's Services (CCS). Changes to Medi-Cal must preserve access to medically necessary mental health care, drug treatment services, and California Children's Services. The carve-out of specialty mental health services within the Medi-Cal program must be preserved, if adequately funded, in ways that maximize federal funds and minimize county risks. Maximum federal matching funds for CCS program services must continue in order to avoid the shifting of costs to counties. Counties recognize the need to reform the Drug Medi-Cal program in ways that maximize federal funds, ensure access to medically necessary evidence-based practices, –allow counties to retain authority and choice in contracting with accredited providers, and minimize county risks. Any reform effort should recognize the importance of substance use disorder treatment and services in the local health care continuum.

4. –**Financing.** Counties will not accept a share of cost for the Medi-Cal program. Counties also believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost shifts or attempts to increase county responsibility through block grants or other means. The state should fully fund county costs associated with the administration of the Medi-Cal program.

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

G. Medicare Part D

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

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

The Medicare Part D drug coverage plan eliminated state matching funds under the Medicaid program and shifted those funds to the new Medicare program. The plan requires beneficiaries to pay a copayment and for some, Medi-Cal will assist in the cost.

For counties, this change led to an increase in workload for case management across many levels of county medical, social welfare, criminal justice, and mental health systems. Counties strongly oppose any

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

H. Medicaid and Aging Issues

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

Counties support the continuation of federal and state funding for the In-Home Supportive Services (IHSS) program, and oppose any efforts to shift additional IHSS costs to counties. Counties support the IHSS Maintenance of Effort (MOE) as negotiated in the 2012-13 Budget Act.

Section 2: AFFORDABLE CARE ACT (ACA) IMPLEMENTATION

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

Counties also caution that increased coverage for low-income individuals may not translate into savings to all county health systems. Counties cannot contribute to a state expansion of health care before health reform is fully implemented, and any moves in this direction would destabilize the county health care safety net. Counties must also retain sufficient health revenues for residual responsibilities, including public health.

A. Access and Quality

- Counties support offering a truly comprehensive package of health care services that includes mental health and substance use disorder treatment services at parity levels and a strong prevention component and incentives.
- Counties support the integration of health care services for prisoners and offenders, detainees, and undocumented immigrants into the larger health care service model.
- Health care expansion must address access to health care in rural communities and other underserved areas and include incentives and remedies to meet these needs as quickly as possible.

B. Role of Counties as Health Care Providers

- Counties strongly support maintaining a stable and viable health care safety net. An adequate safety net is needed to care for persons who remain uninsured as California transitions to universal coverage and for those who may have difficulty accessing care through a traditional insurance-based system.

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

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

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

C. Financing and Administration

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

- Efforts to achieve universal health care should simplify the health care system – for recipients, providers, and administration.

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

- 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, ~~the Healthy Families Program,~~ and other publicly funded programs with the goal of achieving maximum enrollment and provider participation.

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

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

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

D. Role of Employers

- Counties, as both employers and administrators of health care programs, believe that every employer has an obligation to contribute to health care coverage. Counties are sensitive to the economic concerns of employers, especially small employers, and employer-based solutions should reflect the nature of competitive industries and job creation and retention. Therefore, 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.

- Reforms should offer opportunities for self-employed individuals, temporary workers, and

contract workers to obtain affordable health coverage.

E. Implementation

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

Section 3: CALIFORNIA HEALTH SERVICES FINANCING

Those eligible for Temporary Assistance for Needy Families (TANF)/California Work Opportunity and Responsibility to Kids (CalWORKs), should retain their categorical linkage to Medi-Cal as provided prior to the enactment of the federal Personal Responsibility Work Opportunity Reconciliation Act of 1996.

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

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

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

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

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

emergency rooms, critical safety-net services must be supported to ensure their long-term viability.

A. Realignment

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

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

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. Further, any effort to realign programs or resources must guarantee that counties have sufficient revenues for residual responsibilities, including public health programs.

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

B. Hospital Financing

In 20142, 12 counties own and operate 16 hospitals statewide, including Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura Counties. These hospitals are a vital piece of the local safety net, but also serve as indispensable components of a robust health system, providing both primary and specialized health services to health consumers in our communities, as well as physician training, trauma centers, and burn care.

County hospitals could not survive without federal Medicaid funds. CSAC has been firm that any proposal to change hospital financing must guarantee that county hospitals do not receive less funding than they currently do, and are eligible for more federal funding in the future~~,~~ as needs grow. California's current federal Section 1115 Medicaid waiver (implemented in SB 208 and AB 342, Chapter 714 and 723, respectively, Statutes of 2010) provides county hospitals with funding for five years. Counties believe implementation of the waiver is necessary to ensure that county hospitals are paid for the care they provide to Medi-Cal recipients and uninsured patients and to prepare counties for federal health care reform implementation in 2014.

California's existing Section 1115 "Bridge to Reform" Medicaid Waiver expires in October 2015. The Waiver is a five-year demonstration of health care reform initiatives that invested in the state's health care delivery system to prepare for the significant changes spurred on by the Affordable Care Act (ACA). Continuance of the federal government's commitment to the implementation of the ACA through a successor Waiver will allow the state and counties to further improve care delivery and quality. Through the Waiver, counties seeks federal and state support to promote and improve health outcomes, access to care and cost efficiency, building upon the system of care delivery models developed under the 2010 Waiver. Counties support a five-year state Medicaid Waiver that provides funding to counties at current levels. The successor waiver should: 1) support a public integrated safety net delivery system; 2) build on previous delivery system improvement efforts for public health care systems so that they can continue to transform care delivery; 3) allow for the creation of a new county pilot effort to advance improvements through coordinated care, integrated physical and behavioral health services and provide robust coordination with social, housing and other services critical to improve care of targeted high-risk patients.; 4) improve access to share and integrate health data and systems; 5) and provide flexibility for counties/public health care systems to more provide more coordinated care and effectively serve individuals who will remain uninsured.

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

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

Section 4: FAMILY VIOLENCE

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

Section 5: HEALTHY COMMUNITIES

Counties support policies and programs that aid in the development of healthy communities which are designed to provide opportunities for people of all ages and abilities to engage in routine physical activity or other health-related activities. To this end, Counties support the concept of joint use of facilities and partnerships, mixed-use developments and walkable developments, where feasible, to promote healthy community events and activities.

Section 6: VETERANS

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

Section 7: EMERGENCY MEDICAL SERVICES

Counties are tasked with providing critical health, safety, and emergency services to all residents, regardless of geography, income, or population. Because of this responsibility and our statutory authority to oversee pre-hospital emergency medical services, including ambulance transport service, counties are forced to operate a balancing act between funding, services, and appropriate medical and administrative oversight of the local emergency medical services system. Counties 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. Reductions in authority for counties in this area will be opposed. 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.—

Section 8: Court-involved population

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

Section 9 placeholder poverty

Section 10. –Incompetent to Stand Trial

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

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

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

Chapter Twelve
DRAFT November 2014

Human Services

Section 1: GENERAL PRINCIPLES

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

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

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

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

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

Prior to Proposition 13 in 1978, property taxes represented a stable and growing source of funding for county-administered human services programs. Until SB 154 (1978) and AB 8 (1979), there was a gradual erosion of local control in the administration of human services due to legislation and regulations

promulgated by the state, which included dictating standards, service levels and administrative constraints.

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

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

Section 2: HUMAN SERVICES FUNDING DEFICIT

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

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

Section 3: CHILD WELFARE SERVICES/FOSTER CARE

A child deserves to grow up in an environment that is healthy, safe, and nurturing. To meet this goal, families and caregivers should have access to public and private services that are comprehensive and collaborative.

The existing approach to budgeting and funding child welfare services was established in the mid1980's. Since that time, dramatic changes in child welfare policy have occurred, as well as significant demographic and societal changes, impacting the workload demands of the current system. 2011 Realignment provides a mechanism that will help meet the some of the current needs of the child welfare services system, but existing workload demands and regulations remain a concern.

Counties support efforts to reform the congregate care – or youth group home – system and strongly support efforts to recruit, support, and retain foster family homes to address the decline of foster family home placements in California today. Any reform efforts must consider issues related to collaboration, capacity and funding. Additionally, reform efforts must take into account the needs of juveniles who are wards of the court.

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

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

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

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

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

When parental rights must be terminated, counties support a permanency planning process that quickly places children in the most stable environments, with adoption being the permanent placement of choice. Counties support efforts to accelerate the judicial process for terminating parental rights in cases where there has been serious abuse and where it is clear that the family cannot be reunified. Counties also support adequate state funding for adoption services.

Furthermore, 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 2~~5~~6. Counties also support such ongoing services for former and emancipated foster youth up to age 26~~5~~, and pledge to help implement the Fostering Connections to Success Act of 2010 to help ensure the future success of this vulnerable population.

With regards to caseload~~-~~ and workload standards in child welfare, counties remain concerned about increasing workloads and fluctuations in funding, both of which threaten the ability of county child welfare agencies to meet their federal and state mandates in serving children and families impacted by abuse and neglect.

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

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. The Temporary Assistance for Needy Families (TANF) and California Work Opportunity and Responsibility to Kids (CalWORKs) programs allow counties to take care of children regardless of the status of parents.

Section 4: EMPLOYMENT AND SELF- SUFFICIENCY PROGRAMS

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

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

A welfare system that includes shrinking time limits for assistance should also recognize the importance of and provide sufficient federal and state funding for education, job training, child care, and support services that are necessary to move recipients to self-sufficiency. There should also be sufficient federal and state funding for retention services, such as childcare and additional training, to assist former recipients in maintaining employment. Any state savings from the welfare system should be directed to counties to provide assistance to the affected population for programs at the counties' discretion, such as General Assistance, indigent health care, job training, child care, mental health, alcohol and drug services, and other services required to accomplish welfare-to-work goals. In addition, federal and state programs should include services that accommodate the special needs of people who relocate to the state after an emergency or natural disaster. It is only with adequate and reliable resources and flexibility that counties can truly address the fundamental barriers that many families have to self-sufficiency.

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

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

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

Finally, counties support efforts to address housing supports and housing assistance efforts at the state and local levels. Long-term planning, creative funding, and accurate data on homelessness are essential to

addressing housing security and homelessness issues.

Section 5: CHILD SUPPORT ENFORCEMENT PROGRAM

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

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

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

Section 6: PROPOSITION 10: THE FIRST FIVE COMMISSIONS

Proposition 10, the California Children and Families Initiative of 1998, provides significant resources to enhance and strengthen early childhood development. Local children and families commissions (First 5 Commissions), established as a result of the passage of Proposition 10, must maintain the full discretion to determine the use of their share of funds generated by Proposition 10. Further, local First 5 commissions must maintain the necessary flexibility to direct these resources to the most appropriate needs of their communities, including childhood health, childhood development, nutrition, school readiness, child care and other critical community-based programs. Counties oppose any effort to diminish local Proposition 10 funds or to impose restrictions on their local expenditure authority.

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

Section 7: REALIGNMENT

In 1991, the state and counties entered into a new fiscal relationship known as 1991 R~~r~~ealignment. 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~~the~~ sales tax and vehicle license fees to pay for these changes.

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

protected. However, counties 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.

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.

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

Section 8: FAMILY VIOLENCE

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

Section 9: AGING AND DEPENDENT ADULTS

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

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

Adult Protective Services

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

In-Home Supportive Services

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

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

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

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

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

Section 10: VETERANS

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