Health and Human Services Policy Committee

Wednesday, November 28, 2012 · 2:00 – 4:00 p.m.
Room 104B · Long Beach Convention Center
300 E. Ocean Boulevard, Long Beach, CA 90802

Supervisor Liz Kniss, Santa Clara County, Chair
Supervisor Terry Woodrow, Alpine County, Vice Chair

2:00 p.m.	I.	**Welcome and Introductions** *Supervisor Liz Kniss, Santa Clara County*
2:05 – 2:30	II.	**Covered California: News from the Health Benefit Exchange** *David Panush, Director, Government Relations, California Health Benefit Exchange*
2:30 – 3:00	III.	**Medi-Cal in a Changing World** *Toby Douglas, Director, California Department of Health Care Services (via videoconference)*
3:00 – 3:30	IV.	**Special Session on Health Care Reform Implementation in California** *Marjorie Swartz, Consultant, Assembly Health Committee* *Cathy Senderling McDonald, Deputy Executive Director, County Welfare Directors Association* *Sarah Muller, Director of Government Affairs and Communications, California Association of Public Hospitals and Health Systems*
3:30 – 3:55	V.	**Phase Two Realignment?** *Kelly Brooks-Lindsey, CSAC Senior Legislative Representative*
3:55 – 4:00	VI.	**Health, Human Services, and Realignment Chapters of the CSAC Platform: Initial Review** *Farrah McDaid Ting, Senior Legislative Analyst*
4:00	VII.	**Adjourn** *Supervisor Liz Kniss, Santa Clara County*

ATTACHMENTS

Attachment One..... CSAC Memo: Covered California: News from the Health Benefit Exchange

Attachment Two.....CSAC Memo: Medi-Cal in a Changing World

Department of Health Care Services Coordinated Care Initiative Executive Summary

Medi-Cal Managed Care Rural Expansion

Medi-Cal Cal Managed Care Rural Expansion Map

Healthy Families Program Transition to Medi-Cal

Healthy Families Program Transition to Medi-Cal Strategic Plan (partial)

Attachment Three..... CSAC Memo: Special Session on Health Care Reform Implementation in California

Governor Brown's Letter Regarding Special Session on Health Care Reform Implementation

Los Angeles Times: Jerry Brown to Call Special Session on Obama Healthcare Package

Attachment Four.....CSAC Memo: Phase Two Realignment?

PowerPoint Presentation: Anticipated Phase 2 Realignment

Attachment Five.....CSAC Memo: 2013-14 Health, Human Services, and Realignment Platform Documents

Proposed New Platform Chapter/Language: Realignment

2010 CSAC Realignment Principles

DRAFT CSAC Chapter Six: Health Services

DRAFT CSAC Chapter Twelve: Human Services

Attachment One

CSAC Memo: Covered California: News from the Health Benefit Exchange

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500
Facsimile
916.441.5507

November 15, 2012

To: CSAC Health and Human Services Policy Committee

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

Re: Covered California: News from the Health Benefit Exchange

Background. California was the first state in the nation to create a health benefits exchange under the Patient Protection and Affordable Care Act of 2010 (ACA). Since its inception in late 2010 under AB 1602 (Perez, Chapter 655, Statutes of 2010) and SB 900 (Alquist, Chapter 659, Statutes of 2010), the exchange has been known as the California Health Benefits Exchange, or HBEX. In October, HBEX announced a new name: Covered California.

Covered California is governed by a five-member appointed board (the Governor appoints two, the Senate Rules Committee and Assembly Speaker each appoint one, and the Secretary of the Health and Human Services Agency or their designee completes the board). Executive Director Peter V. Lee oversees the organization.

The basic mission of Covered California is to build and operate a website portal by January 1, 2014 that provides standardized comparison information on qualified health plan benefits and options. However, there is a significant amount of work behind the scenes to accomplish this goal, including vetting health plans for quality and standardization, erecting a technological interface to allow consumers to purchase health insurance, establishing eligibility and enrollment pathways for consumers who may qualify for Medi-Cal, and maintaining a robust consumer assistance infrastructure for each of the populations served (Medi-Cal eligible, Medi-Cal expansion population, subsidized consumers, and small businesses).

One significant project undertaken by Covered California is creating, from scratch, the electronic California Healthcare Eligibility, Enrollment, and Retention System (CALHEERS) for the subsidized and small business populations.

Covered California now employs more than 60 people, and has received more than $40 million in federal preliminary planning and innovation grant funding to date. After 2014, federal law requires the state exchanges to be self-supporting from fees paid by health plans and insurers participating in the exchange.

Speaker. We are pleased to welcome David Panush, Director of Government Relations for Covered California. Mr. Panush formerly served as Health Policy Advisor to California Senate President Pro Tempore Darrell Steinberg, and has worked as a key policy consultant for the Office of the Senate President Pro Tempore since 1986.

Materials. Visit the HBEX/Covered California website at www.hbex.ca.gov .

Attachment Two

CSAC Memo: Medi-Cal in a Changing World

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To: CSAC Health and Human Services Policy Committee

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

Re: Medi-Cal in a Changing World

Background. California's Medicaid program, Medi-Cal, is the state's largest health and human services program, adding up to over $30 billion annually ($15 billion dollars in state funds in 2012-13).

The Medi-Cal program is also at the center of major fiscal and policy changes at both the state and federal level. California's fiscal crisis has resulted in significant program cuts, including the elimination of dental services, the institution of beneficiary co-payments for office visits, and constricted provider reimbursements. At the same time, California is preparing for one of the largest expansions of the Medi-Cal program ever undertaken as part of the federal Patient Protection and Affordable Care Act of 2010 (ACA). The ACA will, for the first time, help provide Medicaid coverage for single childless adults. In California, the ACA expansion-eligible population is estimated to comprise 5.8 million people.

California's Department of Health Care Services is responsible for administering the Medi-Cal program, and works with both the federal government and counties on Medi-Cal policy and administration. By state law, counties are required to operate eligibility and enrollment services for Medi-Cal beneficiaries, many counties also serve Medi-Cal clients in their health care system, and most operate Low Income Health Programs (LIHP). For these reasons, counties have a significant policy and fiscal interest in the scope and administration of the Medi-Cal program.

Significant Challenges for the Medi-Cal Program:

Budget Reductions. In the last five years, California has significantly reduced funding for the Medi-Cal program and now ranks last in expenditures per beneficiary. Cuts include reductions to counties' payments that make it more difficult to run eligibility systems at the local level, reductions to the rate paid to Medi-Cal providers that have resulted in California paying one of the lowest reimbursement rates in the nation, and the elimination of key benefits, including dental, podiatry, and vision services. The state is also asking the federal government to allow co-payments for Medi-Cal services to help reduce the state's cost for the program.

LIHP Integration. As part of California's Section 1115 Medicaid Bridge to Reform Waiver, counties have used federal matching funds to expand eligibility for health care services to single childless adults. These Low Income Health Programs (LIHPs) will then be folded into the Medi-Cal program in 2014. Major decisions on creating smooth transition for these enrollees and their eligibility information remain on the table.

Healthy Families Program Shift. The 2012-13 Budget Act directs DHCS to transition 800,000 children in the state's Healthy Families Program (HFP) to Medi-Cal in 2013. The HFP used federal State Children's Health Insurance Program (SCHIP) funding to cover

children in families who made more in income than allowed by Medi-Cal (150 percent is the Medi-Cal cutoff; HFP covered families up to 250 percent). Shifting these children in to Medi-Cal will streamline the delivery of health services in California in advance of ACA implementation in 2014. However, questions regarding network adequacy and provider participation related to the difference in rates paid to see HFP children versus Medi-Cal clients have caused concern about implementing the first part of the HFP shift on January 1, 2013.

Managed Care Shift. The 20120-13 Budget Act also directs DHCS to shift the remaining 28 counties from the Fee-For-Service (FFS) Medi-Cal model to a Medi-Cal Managed Care model. This is also slated for 2013 and the state is currently seeking interested health plans and nonprofits to implement this shift.

Coordinated Care Initiative. The 2012-13 state budget includes a number of major policy changes within the Medi-Cal program aimed at improving care coordination, particularly for people on both Medi-Cal and Medicare. The Administration called the package the Coordinate Care Initiative (CCI). Please recall that the CCI included the following elements:

- Dual Eligible Demonstration Projects: Existing law allows up to 4 demonstration sites to improve care coordination for individuals receiving both Medi-Cal and Medicare – known as dual eligibles. The Administration wanted to expand the number of demonstration sites. The Duals Demonstration Project would expand the managed care benefits to include the In-Home Supportive Services (IHSS) program, as well as Multipurpose Senior Services Programs (MSSP), Community-Based Adult Services, and skilled nursing facility services.
- Long Term Care Services and Supports: The Administration proposed to enroll all Medi-Cal beneficiaries (regardless of whether they are in a duals project) into managed care. The Administration is also proposing to make IHSS a managed care benefit, phasing the implementation to align it with the phase-in of the Duals Demonstration Project.

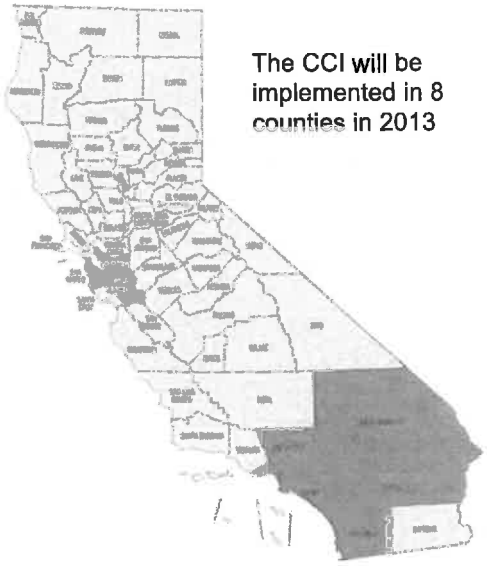
Affordable Care Act Implementation (ACA). The state was the first in the nation to create a health care benefits exchange, but major policy direction is still needed to prepare and implement the ACA. First, the state must determine the size of the expansion – in terms of both cost and lives – by setting the eligibility level for new Medi-Cal enrollees. Decisions regarding streamlining the program, such as eliminating the asset test and mid-year status reports and whether to keep state-only carve outs, must also be made. Efforts to integrate some of California's fiscal choices, such as Medi-Cal co- payments, low provider reimbursement rates, and lagging investment in the technical infrastructure, will also be a priority. Further, the state must conform the program to new federal regulations (some of which have yet to be released) and existing Medi-Cal case law.

Speaker. We have invited Toby Douglas, Director of the California Department of Health Care Services, to speak to the policy committee about the opportunities and challenges facing the Medi-Cal program. Before becoming director of DHCS in early 2011, Mr. Douglas
Had served as chief deputy director since 2009 and held leadership positions in the department since 2005. From 2001 to 2005, Mr. Douglas was a senior manager of activities related to health access, policy and planning at the San Mateo County Health Department. He can be reached at toby.douglas@dhcs.ca.gov.

Materials. Short summaries of the Coordinated Care Initiative, Medi-Cal Managed Care Expansion (including map of counties), and the Healthy Families Program Shift are attached.

Coordinated Care Initiative
Executive Summary

Passage of the Coordinated Care Initiative (CCI) in July 2012 marks an important step toward transforming California's Medi-Cal (Medicaid) care delivery system to better serve the state's low-income seniors and persons with disabilities. Building upon many years of stakeholder discussions, the CCI begins the process of integrating delivery of medical, behavioral, and long-term care services and also provides a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" beneficiaries.



The CCI will be implemented in 8 counties in 2013

Created through a public process involving stakeholders and health care consumers, the CCI was enacted through SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).

Major Components of the Initiative

1. *Duals Demonstration*: A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a single health plan. The CCI provides state authority for the demonstration, which is pending federal approval.
2. *Managed Medi-Cal Long-Term Supports and Services (LTSS)*: All Medi-Cal beneficiaries, including dual eligible beneficiaries, will be required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.

Location and Timing

The CCI will be implemented in eight counties beginning in 2013. The eight counties are Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The participating health plans are part of the state's existing network of Medi-Cal health plans and have experience providing Medicare managed care. Each underwent a rigorous selection process.

Implementation Status

The California Department of Health Care Services (DHCS) is finalizing a Memorandum of Understanding (MOU) with the Centers for Medicare & Medicaid Services (CMS). In fall 2012, the state and federal governments will conduct a comprehensive readiness review of the health plans before signing three-way contracts between the health plans, CMS, and DHCS.

Enrollment will begin no sooner than March 2013. Before any beneficiary is enrolled, the health plans must pass a readiness review process during which the state and federal governments will evaluate each health plan's major systems to ensure they are prepared to provide required continuity of care, seamless access to medically necessary services, care coordination across LTSS, behavioral health and medical care, and beneficiary protections.

Participating Population

The state estimates that about 560,000 dual eligible beneficiaries[1] will be eligible for passive enrollment in the eight counties. An estimated one-third of those beneficiaries already are enrolled in managed care for Medi-Cal, Medicare, or both.

Dual eligible beneficiaries and Medi-Cal seniors and persons with disabilities are among California's highest-need residents. They tend to have many chronic health conditions and need a complex range of medical and social services from many providers. This fragmentation leads to beneficiary confusion, poor care coordination, inappropriate utilization, and unnecessary costs.

Under the CCI, enrolled beneficiaries will have one point of contact for all their covered benefits. They will have one health plan membership card and access to a nurse or social worker whose job is to act as a care coordinator or navigator and help beneficiaries receive the services needed to achieve their personal heath goals and continue living in the setting of their choice. The state is developing care coordination standards that will guide how services are linked.

Counties and Health Plans Implementing the CCI	
County	**Health Plans**
Alameda	Alameda Alliance for Health
	Anthem Blue Cross
Los Angeles	L.A. Care
	Health Net
Orange	CalOptima
San Diego	Care 1st
	Community Health Group
	Health Net
	Molina Health
San Mateo	Health Plan of San Mateo
Riverside	Inland Empire Health Plan
	Molina Health Care
San Bernardino	Inland Empire Health Plan
	Molina Health Care
Santa Clara	Anthem Blue Cross
	Santa Clara Family Health Plan

Coordinated Care Initiative Goals

By consolidating the responsibility for all of these covered services into a single health plan, the CCI expects to achieve the following goals.

1) Improve the quality of care for beneficiaries.
2) Maximize the ability of beneficiaries to remain safely in their homes and communities, with appropriate services and supports, in lieu of institutional care.
3) Coordinate Medi-Cal and Medicare benefits across health care settings and improve continuity of care across acute care, long-term care, behavioral health, and home- and community-based services settings using a person-centered approach.

[1] This number could go down after capitation rates are released and health plans consider their participation options.

4) Promote a system that is both sustainable and person- and family-centered and enables beneficiaries to attain or maintain personal health goals by providing timely access to appropriate, coordinated health care services and community resources, including home- and community-based services and mental health and substance use disorder services.

Financial Alignment Model

Under the CCI, the participating health plans will receive a monthly payment to provide beneficiaries access to all covered, medically necessary services. This is called "capitation." These bundled payments create strong financial incentives for the health plans to ensure beneficiaries receive necessary preventative care and home- and community-based options to avoid unnecessary admissions to the hospital or nursing home.

LTSS Integration

Participating health plans will be responsible for administering all Medi-Cal LTSS that historically have been excluded from managed care. LTSS includes skilled nursing facility care, along with the following home- and community-based services: In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and other services that help beneficiaries stay in their homes and communities, as determined by the health plans.

IHSS will remain an entitlement program. IHSS consumers' will continue being able to self-direct their care by hiring, firing, and managing their IHSS workers. County social workers will continue determining IHSS hours. The current fair hearing process for IHSS will remain in the initial years of the demonstration.

Behavioral Health Coordination

Health plans participating in the duals demonstration will provide beneficiaries all mental health and substance use services currently covered by Medicare and Medi-Cal. County-administered specialty mental health services and Drug Medi-Cal substance use treatment services will not be included in the demonstration health plans' capitation payments. County agencies will continue financing and administering these services, but health plans and county agencies will have written agreements outlining how they will coordinate services.

Better Care Improves Health and Drives Lower Costs

The CCI is expected to produce greater value for the Medicare and Medi-Cal programs by improving health outcomes and containing costs, primarily through rebalancing service delivery into the home and community and away from expensive institutional settings. Better prevention will keep people healthy. Better care coordination will reduce unnecessary tests and medications. Better chronic disease management will help people avoid unnecessary hospital care.

Significant stakeholder feedback informed the beneficiary protections needed to drive success and quality in the CCI's design and implementation. The CCI includes comprehensive protections to ensure beneficiary health and safety and high quality care delivery, which includes medical care, LTSS and behavioral health.

Medi-Cal Managed Care Rural Expansion

Beginning in June 2013, the Governor's Budget expands managed care into rural areas that are now Fee-For-Service (FFS) only. This expansion will provide beneficiaries throughout the state with care through an organized delivery system.

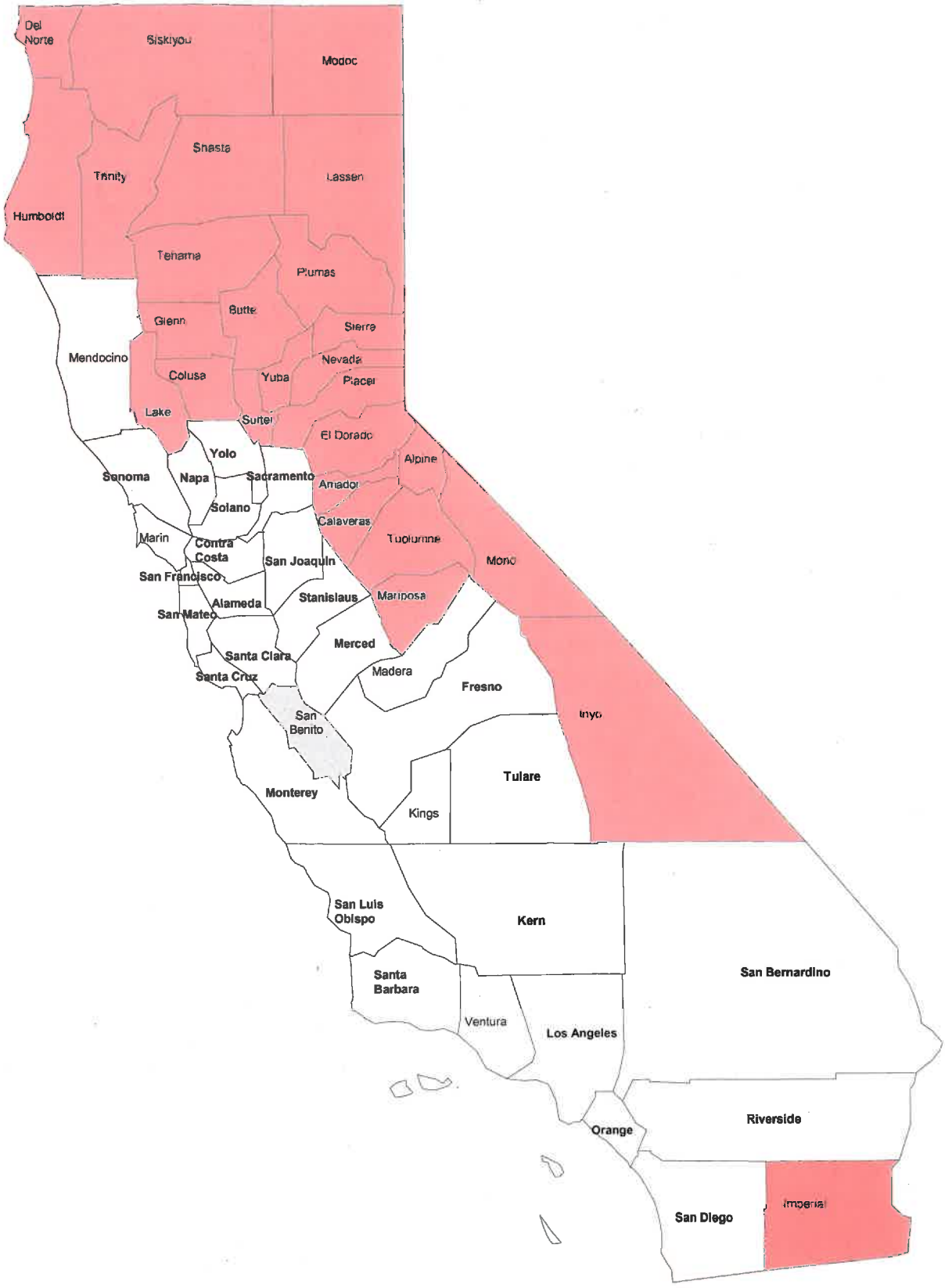
The expansion of managed care includes the following rural Fee-for-Services counties:

Alpine
Amador
Butte
Calaveras
Colusa
Del Norte
El Dorado
Glenn
Humboldt
Imperial
Inyo
Lake
Lassen
Mariposa
Modoc
Mono
Nevada
Placer
Plumas
San Benito
Shasta
Sierra
Siskiyou
Sutter
Tehama
Trinity
Tuolumne
Yuba

For more information, visit
http://www.dhcs.ca.gov/provgovpart/Pages/MMCDRuralExpansion.aspx.

Email questions, comments, or concerns to MMCD.TPGMC@dhcs.ca.gov.

MEDI-CAL MANAGED CARE EXPANSION
26 COUNTY REGION



Healthy Families Program (HFP) Transition to Medi-Cal

Pursuant to Assembly Bill (AB) 1494, (Committee on Budget, Chapter 28, Statutes of 2012), all Healthy Families Program (HFP) enrollees will transition to Medi-Cal as targeted low-income Medicaid children, as allowed under federal law, beginning January 1, 2013.

The transition of approximately 875,000 HFP enrollees will be implemented in four separate phases over the course of one year and in a manner that minimizes disruption in services, maintains adequate provider networks, and ensures access to care. Each Phase will require an implementation plan, including information on health and dental plan network adequacy, continuity of care, eligibility and enrollment requirements, consumer protections, and family notifications.

The state released the list of counties that will comprise Phase A and Phase B of the transition of about 800,000 Healthy Families Program (HFP) children to Medi-Cal in 2013.

The exact date of the transition is pending federal approval, but the 2012-13 Budget Act authorized the state to begin transitioning children as soon as January 1, 2013. The legislation outlined four phases, and the state has divided the first phase into A and B components.

Phase A: Alameda, Riverside, San Bernardino, San Francisco, Santa Clara, Orange, San Mateo, and San Diego. There are 208,376 HFP beneficiaries in these counties.

Phase B: Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Tulare, Sacramento, Napa, Solano, Sonoma, Yolo, Monterey, Santa Cruz, Santa Barbara, and San Luis Obispo. There are 185,714 HFP beneficiaries in these counties.

The transition of HFP enrollees to Medi-Cal is designed to simplify eligibility and coverage for children and families while providing additional benefits and lowering costs for children at certain income levels.

The California Health and Human Services Agency, in collaboration with the Department of Health Care Services, the Managed Risk Medical Insurance Board and the Department of Managed Health Care will collaborate with the Legislature and stakeholder partners over the coming months to ensure a successful plan is created to transition the children from HFP to Medi-Cal. The Administration is convening a stakeholder process for preparation and transition and will have ongoing meetings throughout the transition.

For more information, visit http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspxInquiries. Questions or comments regarding the HFP transition efforts may be directed to: dhcshealthyfamiliestransition@dhcs.ca.gov

A. Proposal Overview, Requirements, and Legislative Oversight

Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012, provides for the transition of Healthy Families Program (HFP) subscribers to the Medi-Cal program commencing no sooner than January 1, 2013. HFP, administered by the Managed Risk Medical Insurance Board (MRMIB), currently serves over 863,000 children with health, dental, and vision coverage. Children enrolled in the HFP will be transitioned into the Medi-Cal program, administered by the Department of Health Care Services (DHCS), where they will continue to receive their health, dental, and vision benefits.

Throughout the transition, DHCS, MRMIB, and the Department of Managed Health Care's (DMHC) main focus will be to work collaboratively to facilitate a smooth transition, ensure minimum disruption in services, maintain existing eligibility gateways, and ensure access to and continuity of care.

This Strategic Plan fulfills the requirements of Welfare and Institutions Code Section 14005.27(d) and (e)--AB 1494 requires the California Health and Human Services Agency (CHHS) to submit a strategic plan by October 1, 2012, and an Implementation Plan for Phase 1 90 days prior to the start of Phase 1. Since there would be significant content overlap between the Strategic Plan and a Phase 1 Implementation Plan, this document will also serve as the Phase 1 Implementation Plan. DHCS will update it to further address Phase 1 readiness based upon the Phase 1 Network Adequacy Assessment due to the Legislature on November 1, 2012.

The Strategic Plan will serve as an overall guide for the transition and the implementation plans for Phases 2 – 4 of this transition, pursuant to Welfare and Institutions Code, Section 14005.27, paragraphs (1) to (8), inclusive, of subdivision (e). It will describe the approach to ensuring continuity of care and primary and specialty care provider network adequacy.

Pursuant to AB 1494, the transition will consist of four phases. Based on significant input received from stakeholders to date, the Administration proposes to separate Phase 1 into two distinct sub-phases. The first group of children will transition to Medi-Cal effective January 2, 2013, given the New Year holiday, and the second group will transition on March 1, 2013. We will work collaboratively with our partner Medi-Cal managed care plans and DMHC to assess plan readiness and network adequacy in order to determine which plans are most ready to proceed with the transition. Throughout the transition, the Administration will continue to request and consider input from consumers, stakeholders, and legislative staff and, based on the outcomes of the pre-implementation analysis of network adequacy and provider capacity, DHCS may consider alternative phasing approaches within each phase.

Phase 1: No sooner than January 1, 2013, children enrolled in a HFP health plan that is also a Medi-Cal managed care health plan in their county of residence shall be enrolled in the same plan. This phase includes approximately 409,000 children.

Phase 2: No sooner than April 1, 2013, children enrolled in a HFP health plan that is also a subcontractor of a Medi-Cal managed health care plan, in their county of residence, to the extent possible, shall be enrolled into a Medi-Cal managed care health plan that includes the child's current plan. This phase includes approximately 259,000 children.

Phase 3: No sooner than August 1, 2013, children enrolled in a HFP health plan that is not a Medi-Cal managed care health plan and does not contract or subcontract with a Medi-Cal managed care health plan shall be enrolled in a Medi-Cal managed care health plan in that county. Enrollment shall include consideration of the child's primary care providers pursuant to the requirements of statute. This phase includes approximately 151,000 children.

Phase 4: No sooner than September 1, 2013, children residing in a county that is not currently a Medi-Cal managed care county shall be transitioned into Medi-Cal managed care health plans, provided the successful completion of efforts to expand Medi-Cal managed care statewide by the State. Pursuant to AB 1467, Chapter 23, Statutes of 2012, DHCS is in the process of expanding Medi-Cal managed care into the 28 counties that do not currently have managed care. The department intends to complete this expansion prior to September 1, 2013. This phase includes approximately 42,000 children.

Each of the four phases will be preceded by scheduled mailings, in the Medi-Cal threshold languages, explaining the transition, describing changes in health, dental, and vision benefit delivery system, where applicable, and giving HFP families an overview of their health and dental plan options and contact information for resources to answer questions and provide any additional assistance.

Dental Coverage

Dental services will transition at the same time as the medical coverage transition. For instance, if a child is being transitioned in Phase 1 for their medical services, they will also have their dental services transitioned. The phase in which the child will receive their dental services relies on their medical transition. A child will only be transitioned into Medi-Cal one time to include all their services. All children, with the exception of children residing in Sacramento and Los Angeles Counties, as described below, will be provided dental services under Denti-Cal, the Medi-Cal Fee-for-Service dental program.

All children residing in Sacramento County will transition into a Medi-Cal Dental Managed Care (DMC) plan during the phase in which their medical benefits transition. If the child's HFP dental plan is a Medi-Cal DMC plan, the child will be

automatically enrolled into that plan. If the child's HFP dental plan is not a Medi-Cal DMC plan, the child will be automatically enrolled into a plan based on where their HFP primary care dentist is an in-network provider. All transitioning children will have the choice to change dental plans once they are transitioned. Additionally, if these children experience difficulty accessing timely dental services after being transitioned into DMC, these children may receive dental services under the Fee-for-Service Denti-Cal program under the Beneficiary Exception Process.

All children residing in Los Angeles County currently enrolled in a Medi-Cal DMC plan will be automatically enrolled into the same dental plan if the HFP plan is also a Medi-Cal DMC plan. If the child's HFP plan is not a Medi-Cal DMC plan, the child will be automatically enrolled into Denti-Cal Fee-For-Service. All transitioning children will have the choice to change dental plans, to enroll into a Medi-Cal DMC plan, or to enroll into Denti-Cal.

Vision Coverage
Vision coverage transition also coincides with the medical coverage transition. As children transition from HFP to Medi-Cal based on the phases outlined above, they will move out of their HFP vision plan and will receive their vision services under the managed health care plan or in Medi-Cal fee-for-service, as applicable. The Medi-Cal managed care plans will coordinate with the Prison Industry Authority for the fabrication of optical lenses.

B. Overview of Operational Steps, Timelines, and Key Milestones

There are many milestones that must be met to ensure a smooth transition across all phases. *Attachment I, Healthy Families Program Transition High-Level Timeline, provides* a high level timeline of critical milestones that must be met across the three departments. Key efforts include the following:

- Strategic Plan Submission to Legislature
- Implementation Plan Submission to the Legislature
- Reports to the Legislature
- State Plan Amendment Submission and Approval
- Waiver Submission and Approval
- Provider Transitions
- MAXIMUS Contract Transition
- Stakeholder Meetings

C. Methods and Processes for Stakeholder Engagement

Effective, ongoing communication is critical to the success of this transition. Such communication must involve the engagement of key partners including the federal Centers for Medicare & Medicaid Services (CMS), other state agencies/ departments, the Legislature, health and dental managed care plans, and advocates. Key state agencies/departments engaged with DHCS are MRMIB, the California Health and Human Services Agency (CHHS), DMHC, and the Department of Finance (DOF).

California Health and Human Services Agency (CHHS)
CHHS has responsibility for convening legislative staff and key stakeholders in the development of the Strategic Plan for the transition. The Strategic Plan will serve as the Phase 1 Implementation Plan and the basis for the subsequent implementation plans for each phase. CHHS is also working closely with DHCS, MRMIB, and DMHC in its planning efforts to ensure a successful transition and has formed a small planning group of legislative staff and advocates familiar with policy and implementation issues who will meet regularly. These meetings are in addition to larger meetings with the broader array of interested stakeholders. The planning group includes children's advocates, health care advocates, physician, pediatric, dental and plan associations, and county representation. The planning group will meet in person and/or via teleconference every few weeks and the larger stakeholder meetings will meet in person and/or via Webinar every four to six weeks during the transition period.

Managed Risk Medical Insurance Board (MRMIB)
MRMIB conducts a public board meeting monthly, with a standing agenda item to discuss the transition of the Healthy Families children to the Medi-Cal Program. The information presented at the meetings includes all updates on coordinated efforts between the DHCS, DMHC, and CHHS, Department of Finance, and CMS. MRMIB staff are also engaged with Maximus to identify the activities and processes necessary to complete the transition and assist DHCS staff in development of its contract with Maximus for on-going activities.

MRMIB will continue participation in technical assistance calls with CMS to assure compliance with federal Title XXI requirements. In addition, MRMIB will continue to conduct quarterly advocate meetings and quarterly HFP Advisory Panel meetings in which DHCS will also participate. MRMIB will also hold monthly meetings with HFP contracted health, dental, and vision plans. MRMIB staff will participate in stakeholder engagement meetings with DHCS, DMHC, and CHHS. MRMIB has created a special section on their website to post relevant information and documents.

DHCS will work collaboratively with MRMIB to develop a plan for transitioning the HFP Advisory Panel to DHCS. Such efforts will include identification of current members, need for replacement of members, roles, and responsibilities for advisory board members, and establishing a timeline for transition. This transition plan will be informed by input from the advisory panel and will be shared publicly.

Additionally, MRMIB has a network of over 4,000 Enrollment Entities (EE) and 24,000 Certified Application Assistants (CAAs) who help families fill out the HFP/Medi-Cal application. Information about the transition will be communicated to the EEs and CAAs through bi-monthly newsletters, e-mail notifications, and postings to the EE and CAA section of the HFP website.

Department of Health Care Services (DHCS)
DHCS has multiple efforts underway in order to reach a variety of stakeholders. These include weekly planning meetings with CHHS, DOF, MRMIB, and DMHC and twice monthly meetings with CMS. The CMS meetings are designed to provide technical assistance on key components of the transition strategy including needed federal approvals via State Plan and waiver amendments, health and dental plan contract approvals, eligibility provisions and cost sharing requirements.

Additionally, DHCS' Divisions of Medi-Cal Managed Care, Eligibility, and Dental Services conduct meetings with key partners who have operational roles in the transition.

Medi-Cal Managed Care Division
- Weekly phone calls with Medi-Cal managed care plans (Every Tuesday)
- Quarterly Meetings with the Medi-Cal managed care plan Advisory Group
- Bi-weekly meetings with DMHC
- Joint review of Medi-Cal managed care provider network with DMHC

Dental Services Division
- Monthly stakeholder meetings with plans and advocates in Los Angeles and Sacramento County
- Monthly all plan meetings
- Monthly stakeholder meetings specific to the transition

Medi-Cal Eligibility Division
- Weekly/bi-weekly meetings with DHCS Information Technology Division staff, counties, county consortia, MAXIMUS, and MRMIB on issues specific to policy and system changes
- Monthly meetings with counties on eligibility policy changes specific to the transition
- Quarterly meetings and more frequent meetings, as necessary, with advocates on eligibility policy changes specific to the transition

Attachment Three

CSAC Memo: Special Session on Health Care Reform Implementation in California

Governor Brown's Letter Regarding Special Session on Health Care Reform Implementation

Los Angeles Times: Jerry Brown to Call Special Session on Obama Healthcare Package

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500

Facsimile
916.441.5507

November 15, 2012

To: CSAC Health and Human Services Policy Committee

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

Re: Special Session on Health Care Reform Implementation in California

Background. In August, with the regular 2011-12 legislative session winding down, Governor Brown signaled his intention to call a special legislative session on Health Care reform. The state has a number of complicated issues to resolve to effectively implement the Patient Protection and Affordable Care Act of 2010 (ACA) by January 1, 2014. We anticipate the special session to convene in January, when legislators return to Sacramento for the 2013-14 regular session.

Major issues for implementing health care reform include:

Eligibility

Defining Modified Adjusted Gross Income (MAGI) levels for the California Covered, the state's version of a health care benefit exchange.

Conforming state Medi-Cal law with federal requirements, such as possibly eliminating the administratively costly Medi-Cal mid-year status report.

Modifying or removing the existing Medi-Cal asset test as allowed by the ACA.

Reviewing and harmonizing previous California case law regarding eligibility with new ACA requirements.

Continuing to define the role of counties in eligibility, enrollment, and retention activities, and ensuring adequate funding for these duties.

Benefits

Setting the benchmark benefits for health plans. The Governor did sign two benchmark benefits measures into law in September (*AB 1453 – Monning and SB 951 - Hernandez)* that established the Kaiser Small Group HMO plan as the state's benchmark health plan, but conversation about adding additional benefits continues to circulate.

Establishment of a Basic Health Program (BHP). Counties supported SB 703, a measure to establish a BHP, which would serve people up to 400 percent of the federal poverty level. We expect this issue to resurface and anticipate supporting it again.

Determining the benefit structure for both the existing Medi-Cal population and the new Medi-Cal MAGI expansion. These structures may differ, particularly regarding substance use disorder treatment and mental health parity services and long term care services.

Examining the state's current Medi-Cal Medically Needy Program (share of cost Medi-Cal).

Individual Programs and Benefits

Will state-only Medi-Cal programs, such as cervical and breast cancer screening for low-income women, continue to exist after 2014?

What will happen to "carve-out" programs, such as the California Children's' Services program? Will these services be available as part of the Covered California?

Speakers. CSAC has invited three knowledgeable speakers to share their thoughts on possible topics for the health care reform special session.

Marjorie Swartz is a consultant with the Assembly Health Committee who specializes in budget coordination and county health services. Ms. Swartz can be reached at Marjorie.swartz@asm.ca.gov.

Cathy Senderling-McDonald is the Deputy Executive Director of the County Welfare Directors Association and is an expert on the state's Medi-Cal program and federal issues related to the ACA. Mrs. Senderling-McDonald can be reached at csend@cwda.org.

Sarah Muller is the Director of Government Affairs and Communications for the California Association of Public Hospitals and Health Systems. Ms. Muller can be reached at smuller@caph.org.

Materials. Attached is Governor Brown's letter to legislative leaders notifying them of his intent to call a special session on health care reform and a short Los Angeles Times article regarding the Governor's plans for the special session.

OFFICE OF THE GOVERNOR

August 16, 2012

The Honorable Darrell Steinberg
President pro Tempore
California State Senate
State Capitol, Room 205
Sacramento, California 95814

The Honorable John A. Pérez
Speaker
California State Assembly
State Capitol, Room 219
Sacramento, California 95814

Dear President pro Tempore Steinberg & Speaker Pérez,

Since the Patient Protection and Affordable Care Act was signed into law in 2010, California has made extraordinary progress implementing many of its provisions, including establishing the Health Benefit Exchange. Several benefits of the Affordable Care Act have already gone into effect, but its most significant provisions, reducing the number of uninsured, encouraging health and wellness, changes to the private health insurance market, and reforming the health care delivery system to lower costs and improve quality, will not begin until 2014.

For almost two years now, we have worked with the legislature and all interested stakeholders to prepare for these changes, many of which require revisions to current law. We will work with you to complete what we can in the current session, but many important issues and questions cannot be addressed or answered without further guidance from the federal government and additional analysis to understand the interrelationship of the decisions we must make.

Therefore, I plan to call a special session at the beginning of the next legislative session to continue this important work of implementing the Affordable Care Act.

We look forward to continuing our work with you, your members and other stakeholders so that California can best position itself to responsibly and effectively implement the federal law's requirements.

Sincerely,

Edmund G. Brown Jr.

cc: The Honorable Bob Huff
The Honorable Connie Conway

Los Angeles Times
August 17, 2012 | 4:15 pm

Jerry Brown to call special session on Obama healthcare package

Gov. Jerry Brown has told legislative leaders he intends to call a special session to deal with issues related to the federal healthcare law signed by President Obama in 2010.

California has been one of the key laboratories for preparations to implement the law. State leaders hope by January 2014 to be able to expand coverage to millions of Californians who currently do not have health insurance.

Brown said a special session, which he plans for December, will allow the state to continue its progress by giving him and lawmakers a way to keep working this year on healthcare proposals that have failed in the current session, which ends Aug. 31. Bills passed in a special session can take effect within 90 days of passage, rather than at the beginning of the next calendar year.

One proposal killed in the Assembly this week would have created a health plan for people who could not afford insurance on the open market but make too much money to qualify for Medi-Cal, the state's health insurance program for the poor.

The option, known as the Basic Health Plan, would provide coverage for individuals with incomes between 133% and 200% of the federal poverty level, or between $15,000 and $21,800 a year.

Many lawmakers wanted to pass that bill, said state Health and Human Services Secretary Diana Dooley, who recommended to the governor that he call a special session.

"I want another crack at that when we have more information," Dooley said.

In a letter to Senate leader Darrell Steinberg (D-Sacramento) and Assembly Speaker John A. Pérez (D-Los Angeles) late Thursday, Brown said a December session would provide an opportunity to work through issues that "cannot be addressed or answered without further guidance from the federal government and additional analysis."

-- Anthony York in Sacramento

Attachment Four

CSAC Memo: Phase Two Realignment?

PowerPoint Presentation: Anticipated Phase 2 Realignment

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500
Facsimile
916.441.5507

November 15, 2012

To: CSAC Health and Human Services Policy Committee

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

Re: Phase Two Realignment?

Background. The Administration alluded to a Phase Two Realignment in January 2011 when Governor Brown proposed the Public Safety Realignment. Generally, the budget documents have discussed a shift in state and county expenditures on health issues. The Administration believes county health expenditures on indigent adults served under Section 17000 requirements will decline as federal health reform is implemented in 2014. The Administration will be seeking to divert or redirect those funds for other purposes.

County Perspective. California counties are in the process of planning for the implementation of the Affordable Care Act (ACA). Counties will be key partners to the State in promoting success of this federal health reform: counties are providers, operating hospitals, health systems and clinics; counties administer the eligibility systems that will enroll people in public programs; and counties provide and fund carved-out Medi-Cal mental health and substance use disorder treatment services.

The fiscal impact of the implementation of the ACA on counties is uncertain and there will be significant county-by-county variation. Counties that contract out entirely for the provision of indigent health care services are positioned quite differently than counties that provide services directly through their existing health care infrastructure. For counties that contract out, a fiscal transaction between counties and the State may, in relative terms, be easier than for counties that own and operate health care delivery systems. Counties that own and operate hospitals, health systems and clinics are essential Medi-Cal providers with large financial commitments to health care safety-net infrastructure. During health reform implementation and beyond, it will be crucial that the State not only retain this existing infrastructure, but build upon it so that access to care for all Medi-Cal beneficiaries is strengthened. Additionally, counties with county hospitals utilize current funding to support the non-federal share of Medi-Cal inpatient days, which would otherwise be paid by the State. Any diversion of funds from these health care delivery systems before a full assessment of the near-term and longer-term impacts are determined and analyzed would offer a recipe for undermining the very systems the State will need to rely on to serve the expanded Medi-Cal and other publicly sponsored populations.

Increased coverage to low-income individuals may not translate to savings to all county health systems. If covered patients are no longer seen at county health care facilities, counties that operate these facilities could lose significant Medi-Cal and federal funds and be left serving the most complex and expensive uninsured patients. Additionally, it is unknown at this time how the federal Disproportionate Share Hospital cuts will impact California's public hospital systems.

Materials. Attached is a Power Point presentation that provides general background on what is known about Phase Two Realignment, county health realignment funding and the 2014 coverage expansion.

CALIFORNIA Counties

Anticipated Phase 2 Realignment

November 28, 2012• Long Beach, CA

CSAC Health & Human Services Policy Committee

CSAC Annual Meeting

Phase 2 Realignment Scenario

What do we know about the Governor's anticipated Phase 2 Realignment proposal for FY 2013-14?

- Comments included in the *A Pages* of the January 2011-12 Budget suggested a Phase 2 realignment focused on revising state and county responsibilities within the context of national health care reform.
- The January 2011-12 *A Pages* said:
  - State would become responsible for costs associated with health care programs, including California Children's Services and In-Home Supportive Services; and,

Phase 2 Realignment Scenario

- The January 2011-12 *A Pages* said (cont.):
  - Counties would assume responsibility for CalWORKs, food stamps administration, child support, and child care.
  - Public health programs would remain at the local level.
- The *A Pages* of the January 2012-13 Budget restated this suggestion but with less specificity: "As the state implements federal health care reform, there will be a natural shift of health care costs from the county indigent health system to Medi-Cal. In the future, it will make sense for the state to assume more responsibility for health care funding, while shifting other programs to the local level."

Phase 2 Realignment Scenario

What do we know about the Governor's anticipated Phase 2 Realignment proposal for FY 2013-14?

- Discussions since Spring 2012 indicate that the Administration is looking at **ALL** indigent health care spending, including county General Funds, Tobacco Settlement, and other funds for a Phase 2 proposal.
- The Administration wants to examine the Local Revenue Fund Indigent Health Care Account (1991 Realignment) and reassess which level of government should provide and pay for health and social services programs.

CALIFORNIA Counties

Phase 2 Realignment Scenario

- Summary:
  - The Administration wants to take advantage of any offsetting health care "savings" or "dividend" at the county level (to any local fund source, not solely 1991 Health Realignment funding) resulting from the shift of indigent populations to Medi-Cal (and Health Exchange)
  - Administration wants to utilize these funds to have counties assume current state costs for certain social services programs while the state assumes certain health care costs.

CALIFORNIA Counties

1991 Realignment

- Three Accounts:
  - Health
  - Mental Health
  - Social Services
- Funded with ½ cent sales tax and Vehicle License Fees (adjusted depreciation schedule)
- Total revenues worth $3.8 billion in 2011-12

CALIFORNIA Counties

Health Account Background

Programs funded by Account:

- County Public Health programs
- County Indigent Health programs

Revenue Stability and Growth:

- Prior to the recession, VLF was a strong, stable funding source.
- VLF revenues since 2006-07 have declined by almost 25%.
- It will take many years for the VLF revenues to return to pre-recession levels.

CALIFORNIA Counties

Mental Health Account: Historical Funding Levels

Fiscal Year	VLF	Sales Tax	Total
2006-07	$375,345,815.34	$841,749,660.94	$1.22 billion
2007-08	$389,160,390.91	$841,749,660.94	$1.23 billion
2008-09	$384,965,860.74	$826,579,816.77	$1.21 billion
2009-10	$353,318,960.92	$719,086,364.25	$1.07 billion
2010-11	$330,468,463.33	$692,552,204.73	$1.02 billion
2011-12	$330,468,463.33	$692,552,204.73	$1.02 billion

CALIFORNIA Counties

Social Services Account: Historical Funding Levels

Fiscal Year	VLF	Sales Tax	Total
2006-07	$62,385,451.16	$1,576,260,903.21	$1.64 billion
2007-08	$65,055,864.10	$1,593,399,055.41	$1.66 billion
2008-09	$64,328,498.45	$1,564,683,136.07	$1.63 billion
2009-10	$58,840,668.54	$1,361,202,251.37	$1.42 billion
2010-11	$54,878,206.35	$131,0974,128.84	$1.37 billion
2011-12	$54,878,206.35	$1,424,860,296.55	$1.48 billion

Health Account: Historical Funding Levels

Fiscal Year	VLF	Sales Tax	Total
2006-07	$1,148,022,173.00	$390,628,954.74	$1.70 billion
CMSP	$124,132,988	$36,858,108	
2007-08	$1,135,186,560.05	$383,589,117.78	$1.68 billion
CMSP	$122,745,103	$36,193,863	
2008-09	$1,038,344,399.78	$333,704,862.46	$1.51 billion
CMSP	$112,273,786	$31,486,994	
2009-10	$968,419,966.03	$321,391,212.12	$1.42 billion
CMSP	$104,713,016	$30,325,131	
2010-11	$968,419,966.03	$321,391,212.12	$1.42 billion
CMSP	$104,713,018	$30,325,128	
2011-12	$898,857,130.20	$321,391,212.12	$1.35 billion
CMSP	$97,191,347	$30,325,129	

CALIFORNIA Counties

Health Account Revenues vs. Total Realignment Revenues

Fiscal Year	Total Health Account & CMSP Funds	Total 1991 Revenues	Percentage of Health Funds of 1991 Revenues
2006-07	$1.70 billion	$4.43 billion	38.38%
2007-08	$1.68 billion	$4.36 billion	38.49%
2008-09	$1.51 billion	$3.86 billion	39.22%
2009-10	$1.42 billion	$3.68 billion	38.73%
2010-11	$1.42 billion	$3.79 billion	37.57%
2011-12	$1.35 billion	$3.70 billion	36.46%

CALIFORNIA Counties

Brief History of Indigent Health & Public Health: 1970s-1990s

- 1971: Creation of MIA state only Medi-Cal category
- 1978-79: Aftermath of Prop. 13 = AB 8
- 1982-83: Transfer MIAs to counties (MISP/CMSP)
- 1991-92: Realignment. Includes:
  - AB 8
  - MISP/CMSP
  - Local Health Services
  - State Legalization Impact Assistance Grants

CALIFORNIA Counties

Federal Health Reform Context

Who is covered?

- Medi-Cal expansion up to 138% FPL
  - 1.4 million newly eligible
  - 1.3 million currently eligible but not enrolled
- Health Exchange – subsidies for 138 – 400 % FPL
  - Approximately 2 million will be eligible

- Source: UC Berkeley Labor Center/UCLA Center for Health Policy Research

CALIFORNIA Counties

Federal Health Reform Context (cont.)

Who remains uninsured?

- Between 3 to 4 million; 1 million due to immigration status
- Undocumented
- Anyone who chooses to pay the penalty rather than purchase insurance (penalty cheaper than premiums)

- Source: UC Berkeley Labor Center/UCLA Center for Health Policy Research

CALIFORNIA Counties

Federal Health Reform: Unknowns

- What issues does California still need to address in legislation and policy decisions?
  - ☐ Benefits for Medicaid expansion population
  - ☐ Carve outs
  - ☐ Medi-Cal share of cost
  - ☐ State-only programs
  - ☐ Eligibility (AB 43/SB 677)
  - ☐ Mental health and substance abuse parity

CALIFORNIA Counties

Federal Health Reform: County Impacts

- Section 17000 Implications
  - Not likely to go away
  - Some advocates may seek revisions to further define county responsibilities in the new federal health reform context
- How quickly will uninsured obtain coverage in 2014 and beyond?
  - What will be the residual populations?
  - How will residual populations present?
- What is the capacity of local health systems to serve new populations, particularly for primary and specialty care?

CALIFORNIA Counties

Federal Health Reform: County Impacts

- How will eligibility system(s) promote linkage to program eligibility for Medi-Cal, Health Exchange, other programs?
- What are the implications for the financing of county health systems?
  - Counties with hospitals have a share of cost in Medi-Cal: ***county hospitals pay the non-federal share of Medi-Cal inpatient days***
  - What resources will support counties in delivering care to residual uninsured, including the undocumented?
- What is the role of public health in the health reform context?

CALIFORNIA Counties

Staff Contact

Kelly Brooks-Lindsey
(kbrooks@counties.org)
916-327-7500, ext. 531

CALIFORNIA Counties

Attachment Five

CSAC Memo: 2013-14 Health, Human Services, and Realignment Platform Documents

Proposed New Platform Chapter/Language: Realignment

2010 CSAC Realignment Principles

DRAFT CSAC Chapter Six: Health Services

DRAFT CSAC Chapter Twelve: Human Services

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500
Facsimile
916.441.5507

November 15, 2012

To: CSAC Health and Human Services Policy Committee

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

Re: 2013-14 Health, Human Services, and Realignment 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 first draft of proposed revisions to the existing CSAC Health and Human Services chapters, as well as new platform chapter dedicated to realignment, for your review. The proposed texts will serve as the guiding policy documents for 2013-14.

Process. The attached platform chapters represent the first draft of proposed policy changes for 2013-14. CSAC is seeking comments from all interested parties on proposed changes and/or suggestions for additions. Input must be submitted to Farrah McDaid Ting in writing at fmcdaid@counties.org by January 11, 2013. The HHS policy committee will then meet via conference call in late January to review and discuss the proposed changes, and, if appropriate, vote to adopt the chapters and forward the recommendations to the CSAC Board of Directors. Both the Administration of Justice and Government Finance and Operations Policy Committees will also review and adopt the Realignment chapter. The full Board will review the proposed chapters at their first scheduled meeting of the 2013 calendar year, usually in March. Should the Board of Directors modify or seek clarification on the Health and Human Services Policy Committee's recommendations, the policy committee will again meet via conference call to comply with any inquiries.

Staff Comments. The attached draft version of proposed changes to the CSAC Health and Human Services chapters, as well as the Realignment platform, represent initial suggestions by staff. Many of the changes reflect updates to programs and policy. However, for 2013-14, we have proposed changes related to new issues and policies, including:

2011 Realignment. CSAC staff has developed a Realignment chapter to define CSAC policy related to 1991, 2011, and any future realignments of programs, funding, or services. We have also included new references related to 2011 Realignment in both the Health and Human Services chapters.

Patient Protection and Affordable Care Act of 2010 (ACA). We have incorporated new references to the ACA and implementation in California. Both the Health and Human Services chapters have been updated to reflect ACA issues.

Emergency Medical Services. We have included a new section on Emergency Medical Services in the Health chapter.

A line-by-line guide to all suggested changes will be provided to the committee for the January conference call (to be scheduled). Again, **please submit suggestions to Farrah McDaid Ting in writing at fmcdaid@counties.org by January 11, 2013.**

PROPOSED NEW PLATFORM CHAPTER/LANGUAGE: REALIGNMENT

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

Proposed Chapter:

In 2011, an array of law enforcement and health and human services programs – grouped under a broad definition of "public safety services" – was transferred to counties along with a defined revenue source. The 2011 Realignment package was a negotiated agreement with the Brown Administration and came with a promise, realized with the November 2012 passage of Proposition 30, of constitutional funding guarantees and protections against costs associated with future programmatic changes, including state and federal law changes as well as court decisions.

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

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

Attachment: Realignment Principles

2010 CSAC Realignment Principles

Approved by the CSAC Board of Directors

1100 K Street
Suite 101
Sacramento
California
95814

Telephone
916.327-7500

Facsimile
916.441.5507

Facing the most challenging fiscal environment in the California since the 1930s, counties are examining ways in which the state-local relationship can be restructured and improved to ensure safe and healthy communities. This effort, which will emphasize both fiscal adequacy and stability, does not seek to reopen the 1991 state-local Realignment framework. However, that framework will help illustrate and guide counties as we embark on a conversation about the risks and opportunities of any state-local realignment.

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

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

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

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

2. **Revenue Source.** The designated revenue sources provided for program transfers must be levied statewide and allocated on the basis of programs and/or populations transferred; the designated revenue source(s) should not require a local vote. The state must not divert any federal revenue that it currently allocates to realigned programs.

3. **Transfer of Existing Realigned Programs to the State.** Any proposed swap of programs must be revenue neutral. If the state takes responsibility for a realigned program, the revenues transferred cannot be more than the counties received for that program or service in the last year for which the program was a county responsibility.

4. **Mandate Reimbursement.** Counties, the Administration, and the Legislature must work together to improve the process by which mandates are reviewed by the Legislature and its fiscal committees, claims made by local governments, and costs reimbursed by the State. Counties believe a more accurate and timely process is necessary for efficient provision of programs and services at the local level.

5. **Local Control and Flexibility.** For discretionary programs, counties must have the maximum flexibility to manage the realigned programs and to design services for new populations transferred to county responsibility within the revenue base made available, including flexibility to transfer funds between programs. For entitlement programs, counties must have maximum flexibility over the design of service delivery and administration, to the extent allowable under federal law. Again, there

must be a mechanism to protect against entitlement program costs consuming non-entitlement program funding.

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

DRAFT PROPOSED CHANGES FOR 2013-14

Version date: 11-15-12

CHAPTER SIX

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, ~~and ss~~services, and program contracts to provide a comprehensive level of service~~s~~ and accountability ~~and~~ achieve maximum cost effectiveness. Additionally, as new federal and state programs are designed in the health care field, the state must ~~needs to~~ work with counties to encourage maximum program flexibility and ~~to~~ minimize disruptions in county funding from the transition phase to ~~to~~ new reimbursement mechanisms.

Counties also support a continuum of preventative health efforts – including mental health services, 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.

~~Counties also support a continuum of preventative health efforts – including mental health services, 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 State's chronic underfunding of health programs strains the ability of counties to meet accountability standards to provide access to quality health and mental health services. Freezing health program funding also shifts costs to counties and increases the county share of program costs, while at the same time running contrary to the constitutional provisions of Proposition 1A.~~

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 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-to-day 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.

~~Counties also support a continuum of preventative health efforts – including mental health services, drug and alcohol services, nutrition awareness and disease prevention – and healthy living models for all of our communities, families, and individuals. Preventative health efforts, such as access to healthy food and opportunities for safe physical activity, have proven to be cost effective and provide a benefit to all residents.~~

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 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. ~~in supporting and assisting the state in administering its programs.~~ 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.

~~However, counties are concerned about the erosion of state funding and support for mental health services.~~ Although tThe adoption of Proposition 63, the Mental Health Services Act of 2004, ~~will~~ 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 ~~state~~ shifting of state or federal ~~its~~ 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 Medi-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. ~~However, counties oppose a managed care model in which the state abdicates its funding responsibility to counties. Counties are paying for an increasing share of the Medi-Cal Mental Health program. As state funding declines, counties will reconsider providing managed mental health systems.~~

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

~~County mental health agencies provide necessary, child and family-centered high quality services to special education pupils. This program is known as AB 3632 (Statutes of 1984). The State provided inadequate funding for this mandate from fiscal year 2002-03 through 2004-05. Since that time, the state has provided a combination of federal Individuals with Disabilities Act (IDEA) funds, state General Fund and mandate reimbursements. Counties cannot assume the legal and financial risk for this federal special education entitlement program. Counties expect the state to continue to fund counties for the costs of providing the state mandated services under AB 3632 and to develop a reasonable plan for repaying past due SB 90 claims. Alternatively, counties would also support repealing the AB 3632 mandate on counties, recognizing that accountability for ensuring the provision of mental health related services under the IDEA rests with education — not local government. If school districts become fiscally responsible for this mandate, the program must be restructured so that schools are legally responsible for ensuring that mental health related services are provided to special education students pursuant to the federal IDEA. Under such a restructured system, county mental health departments would remain committed to maintaining and enhancing their effective collaborative partnerships with education, and to working with all interested stakeholders in developing a system that continues to meet the mental health needs of special education pupils.~~

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. ~~Counties have developed a range of locally designed programs to serve California's diverse population, and must retain the local authority and flexibility to continue such services.~~

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 175,000 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 ~~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.

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 ~~a~~ 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.

The 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 ~~the~~ state~~'s~~ support for county programs with the expectation that the state or local First 5 commissions will backfill the loss with Proposition 10 revenues.

~~AB 3632~~

~~County mental health agencies provide necessary, child and family centered high quality services to~~

~~special education pupils. This program is known as AB 3632 (Statutes of 1984). The State provided inadequate funding for this mandate from fiscal year 2002-03 through 2004-05. Since that time, the state has provided a combination of federal Individuals with Disabilities Act (IDEA) funds, state General Fund and mandate reimbursements. Counties cannot assume the legal and financial risk for this federal special education entitlement program. Counties expect the state to continue to fund counties for the costs of providing the state mandated services under AB 3632 and to develop a reasonable plan for repaying past due SB 90 claims. Alternatively, counties would also support repealing the AB 3632 mandate on counties, recognizing that accountability for ensuring the provision of mental health related services under the IDEA rests with education — not local government. If school districts become fiscally responsible for this mandate, the program must be restructured so that schools are legally responsible for ensuring that mental health related services are provided to special education students pursuant to the federal IDEA. Under such a restructured system, county mental health departments would remain committed to maintaining and enhancing their effective collaborative partnerships with education, and to working with all interested stakeholders in developing a system that continues to meet the mental health needs of special education pupils.~~

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 ~~are~~ at the local level. Counties continue to provide a wide range of substance use disorder treatment services, but remain concerned about ~~. However, counties are concerned that~~ evidence-based treatment capacity for all ~~cannot accommodate all~~ persons requiring ~~needing~~ 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 funding.

~~Furthermore, state investment in non-offender substance use disorder treatment services has been static for the last decade. This situation limits the array and amount of services a county can administer to the non-offender population. Also, 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.~~

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, ~~C~~counties remain ~~are~~ concerned about state and federal proposals that would decrease access to health care or ~~and that would~~ shift costs ~~and~~or 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 ~~and~~ rely heavily on Medicaid reimbursements. Any Medi-Cal reform that results in decreased access to or funding ~~of~~to 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 ~~remaining uninsured persons~~ served by county facilities. ~~In recent years, county hospitals are serving more uninsured persons as a percentage of total patients.~~ 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. ~~safety net.~~

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 ~~and~~ 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 ~~are open to reforming 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.

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 reimbursements. Counties support simplifying the eligibility process for administrators of the Medi-Cal program.

GG~~.~~ 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.

HH~~.~~ 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, ~~IHSS,~~ and oppose any efforts to shift additional IHSS costs to counties.

Section 2: ~~HEALTH CARE COVERAGE PRINCIPLES~~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.

~~Counties support universal health care coverage in California, with the goal of a health care system that is fully integrated and offers access to all Californians. Universal health care coverage will ultimately allow the state to realize cost savings in publicly funded health care programs. However, the foundation of the publicly funded health care system needs immediate attention. The State of California must preserve and adequately fund existing publicly funded health care programs before expanding services. Counties' resources are limited and are not in a position to increase expenditures to pay for expanded health care coverage and access.~~

A. Access and Quality

- ~~Counties support access to quality and comprehensive health care through universal coverage.~~
- Counties support offering a ~~Any universal health care program should provide a t~~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 ~~a health care system that includes a component of~~ health care services for ~~to~~ prisoners and offenders, detainees, and undocumented immigrants into the larger health care service model. ~~.~~
- Health care expansion must ~~Reforms should a~~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 ~~a~~ barrier~~s~~ 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

Counties recognize that California will not achieve a full universal health care system immediately , ~~and implementation may necessitate an incremental approach . As such, counties believe that incremental efforts must be consistent with the goal and the framework for universal health care coverage, and also must include counties in all aspects of planning and 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 ~~should~~ 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.

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. ~~while incremental progress is made on the uninsured.~~

A. Realignment

In 1991, the state and counties entered into a new fiscal relationship known as 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 sales tax and vehicle license fee 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 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Medi-Cal Specialty Mental Health Services; 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 2011~~2~~, 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. ~~to maintaining health access to low-income populations.~~

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 ~~new~~ 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.

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~~ealthy 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.

DRAFT PROPOSED CHANGES FOR
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CHAPTER TWELVE

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 ~~Not~~ 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~~s~~ 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. 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 ~~To the extent the state~~ implements performance ~~standards,~~standards, the costs for meeting ~~it should also fully pay the costs for meeting s~~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~~is~~ frozen at 2001 cost levels. The state's failure to fund actual county cost increases ~~has~~ led to a growing funding gap of nearly $1 billion *annually*. This puts counties in the untenable position of backfilling the gap with their own limited resources or cutting services that the state and county residents expect us to deliver.

~~Not funding 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.~~

~~Counties oppose instituting performance standards and giving counties a share in penalties without first ensuring reasonable and predictable funding reflective of county statutory and programmatic responsibilities.~~

2011 Realignment shifted fiscal responsibility for the Foster Care, Childre Welfare Services, Adoptions and Adult Protective Services programs to the counties.~~C~~ Counties remain committed to the overall principle of ~~call for a solution to this issue that provides~~ fair, predictable and ongoing funding for ~~counties to deliver~~ human services programs that keeps pace with actual costs. ~~on behalf of the state.~~

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 mid-1980's. Since that time, dramatic changes in child welfare policy have occurred, as well as significant demographic and societal changes, impacting the workload demands of the current system. ~~Based on the results of the SB 2030 study which provided an updated social worker workload/yardstick in 2000, California's method of budgeting and financing child welfare services needs to be changed.~~ 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~~The study confirms that the current financing does not meet the actual workload demands. Additionally, these policy changes necessitate a reevaluation of the required county contribution to child welfare services. Counties support state assumption of an additional portion of non-federal child welfare services costs.~~

The ideal focus of children's services is to expand the capacity of families and caregivers to meet the needs of their children. ~~Counties believe that this focus continues to be in jeopardy. While there has been some movement in recent years, the preponderance of spending for child welfare services remains dedicated to court and placement activities, rather than supportive, family based interventions.~~ Counties have and will continue to provide immediate leadership to focus and obtain additional resources for family preservation and support services.

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.

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 25. Counties also support such ongoing services for former and emancipated foster youth up to age 25, 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 case- and workload standards in child welfare, counties remain concerned about increasing workloads and fluctuations in ~~decreasing~~ 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.

~~Existing child welfare budgeting standards, based on 1984 workload considerations, are at best outdated and at worst woefully inadequate. The SB 2030 Child Welfare Workload Study conducted by the University of California at Davis established minimum and optimal caseload standards in 2000, and subsequent legislation required the development of a plan to implement the findings of the SB 2030 Workload Study. This plan was released June 2002; however, budget constraints have since prevented the state from allocating sufficient funding to implement the study's recommendations even to the minimum level recommended.~~ Counties support ~~the implementation of the study's recommendations as well as~~ 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. ~~In the absence of implementation, c~~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. E~~E~~ach 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~~on~~ 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.

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 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 sales tax and vehicle license fee 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 250 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~~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.

~~Unfortunately, the APS program has been underfunded since its inception in 1999, and suffered drastic cuts in each budget since 2007, including a 10 percent cut in 2008-09. The cuts have resulted in fewer social workers and thousands of reports of abuse and neglect going unanswered statewide. These cuts come at a time of rising demand in reported cases of abuse and neglect for this population. Additionally, there are a growing number of seniors being targeted by financial predators. Additionally, the lack of funding adjustments for inflation exacerbates the funding shortfall, resulting in an annual loss of $49.0 million ($31.5 million GF) to APS for direct services to abused and neglected seniors and dependent adults.~~

~~Counties support efforts to increase funding for APS based on caseload and administrative costs and strongly oppose any reductions to an already underfunded program. The consequences of additional~~

~~cuts will threaten the health and financial stability of older adults across the state, and could ultimately result in untimely and undignified deaths. Additionally, cuts to APS will impact other local agencies including local law enforcement and emergency services, such as paramedic response, and may lead to premature placement into nursing home care at an increased cost to taxpayers.~~

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. ~~State law also governs cost-sharing ratios between the state and counties for provider wages and benefits.~~In 2014, the state will become 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.

~~Funding to counties to administer the IHSS program has seriously eroded and threatens service quality. Since 2001, counties have not received any funding to cover increases in the cost of administering the IHSS program. The Governor's veto of $15 million in the 2008-09 budget exacerbated this problem and will result in 100 fewer social workers to assess and serve needy clients. Program cuts, combined with this failure to fund actual county costs to administer the~~

~~program, will result in annual under-funding of IHSS administration by $72.3 million ($30.1 million GF) in 2009-10. In addition, the State's budgeting yardstick for the program, which was inadequate when it was established in 1993, has remained relatively unchanged despite program changes over the years. This yardstick assumes that county workers need only 11.58 hours per client per year to provide a number of services to administer the program, including recipient enrollment into the program, individualized in-home assessments, coordinating with other service providers for care, and enrolling providers and processing provider timesheets. Factoring in the lack of cost increases for the program reduces the funding level of service hours to just over 8 hours per client per year.~~

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 ~~5~~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.