Health and Human Services Policy Committee

Tuesday, November 19, 2013 • 2:30 p.m. – 4:30 p.m.
CSAC 119th Annual Meeting • Santa Clara County
San Jose Convention Center • Room A 1
150 West San Carlos Street, San Jose, CA 95113

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

2:30 p.m.	I.	**Welcome and Introductions** *Supervisor Kathy Long, Ventura County*
2:35 – 2:40	II.	**Scope of the HHS Policy Committee** *Farrah McDaid Ting, CSAC Associate Legislative Representative*
2:40 – 3:15	III.	**The ACA and AB 85: Looking Back and Looking Forward** *Farrah McDaid Ting, CSAC Associate Legislative Representative* *Judith Reigel, County Health Executives Association of California* *Assmaa Elayyat, County Welfare Directors Association*
3:15 – 3:45	IV.	**Expansion of Benefits: County Mental Health and Substance Use Disorder Services** *Robert Oakes, Executive Director, California Mental Health Executives Association*
3:45 – 4:05	V.	**Practical Tips for Healthier Workplaces and Communities** *Tom Carter, Vice President, Consulting and Customer Support, Kaiser Permanente*
4:05 – 4:25	VI.	**The Children's Movement of California** *Former Assembly Member Ted Lempert, President, Children Now*
4:30	VII.	**Adjournment**

PLEASE NOTE:
This policy committee meeting is an in-person meeting held in conjunction with the CSAC 119th Annual Meeting; no conference line is available. Materials will be posted at www.csac.counties.org.

ATTACHMENTS

Attachment One

CSAC Memo: Scope of the Health and Human Services Policy Committee

CSAC Health and Human Services Overview

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November 5, 2013

To: CSAC Health and Human Services Policy Committee

From: Farrah McDaid Ting, Associate Legislative Representative

Re: Scope of the Health and Human Services Policy Committee and Member Engagement

Background. CSAC staff is working to ensure increased member engagement in the policy committee process. CSAC policy committees are the key policy-making bodies for the Association and supervisor and affiliate participation is critical to meeting the needs and goals of counties.

To that end, staff has produced a series of documents outlining the scope and issues assigned to each policy committee. CSAC staff reads and categorizes more than 1500 legislative measures each year, and, with the exception of most education-related bills, weighs in every measure that may impact counties. Each of the five CSAC Policy Committees provides the foundational policy platform for CSAC staff in determining and lobbying a position on these measures.

The attached document outlines the scope of issues for the Health and Human Services Policy Committee, but it is by no means exhaustive. For example, HHS issues are increasingly intertwined with Administration of Justice issues, especially in the wake of AB 109 and 2011 Criminal Justice Realignment. Further, many "smaller" issues, such as mandated reporting for suspected child abuse, are included in the broader Child Welfare Services area.

CSAC has posted similar documents for each issue area on the CSAC website at www.csac.counties.org/Advocacy. We invite Supervisors to peruse the lists and contact CSAC staff with any questions.

Speaker

Farrah McDaid Ting
Associate Legislative Representative
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Health and Human Services

The Health and Human Services (HHS) Policy Committee has responsibility for the development of policies and proposals relating but not limited to local, state and federal statutes and regulatory activities. Counties are both providers and employers in the health and mental health care systems and are responsible for a wide range of eligibility and enrollment activates related to social services programs. Significant efforts are also made during the state budget process, as many health and human services programs are funded through federal, state, and local dollars.

CHAIR:

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Ventura County

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Supervisor Ken Yeager,
Santa Clara County

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Primary Legislative Policy Committees

Senate and Assembly Health Committees
Senate and Assembly Human Services Committees
Senate and Assembly Appropriations Committees
Assembly Aging and Long-Term Care Committee

Primary Budget Committees/Subcommittees

Senate Budget and Fiscal Review Committee
Senate Budget and Fiscal Review Subcommittee No. 1 on Health and Human Services
Assembly Budget Committee
Assembly Budget Subcommittee No. 3 on Health and Human Services

Key State Agencies

Department of Finance
Covered California
California Health and Human Services Agency
Department of Health Care Services
Department of Social Services
Department of State Hospitals
Department of Public Health
Department of Education
Department of Managed Health Care
State Controller's Office
California Emergency Medical Services Authority
Office of Statewide Health Planning and Development
California Managed Risk Medical Insurance Board

Key CSAC Affiliates

California Association of Areas Agencies on Aging
California Association of Public Hospitals and Health Systems
California Mental Health Directors Association
California Mental Health Services Authority
California State Association of Public Administrators, Public Guardians, and Public Conservators
County Alcohol and Drug Program Administrators Association of California
County Health Executives Association of California
County Welfare Directors Association
First 5 Association of California
California Association of Public Authorities
Health Officers Association of California

Legislative Responsibilities

- State Budget
- 1991 Realignment
- 2011 Realignment (HHS)
- Aging & Long-Term Care
- Long-Term Care
- Adult Day Health Care/CBAS
- Alcohol & Drug Programs
- Drug Medi-Cal
- Affordable Care Act
- Child Welfare Services/Foster Care
- AB 12
- KIN/GAP
- Children's Health Care/SCHIP
- Public Health
- Medically Indigent Services Program (MISP)
- County Medical Services Program (CMSP)
- Public Hospitals
- Disproportionate Share Hospitals (DSH)
- Proposition 99
- Proposition 10
- Health Plans and Medical Care
- Health Insurance Portability and Accountability Act (HIPAA)
- Mental Health
- Short-Doyle System
- Lanterman-Petris-Short Act
- Dual Diagnosis
- State Hospitals
- Managed Care/Expansion
- Medi-Cal
- Eligibility
- Benefits
- Reimbursements
- County Administration
- The Uninsured
- Child Support
- Child Support Automation
- Welfare/Social Services Programs
- Adult Protective Services
- General Assistance
- Homeless Assistance
- CalWORKS/Food Stamps (SNAP)
- In-Home Supportive Services (IHSS)
- Coordinated Care Initiative/Duals Demonstration Project
- Developmental Disabilities/Regional Centers
- Emergency Medical Services (EMS)
- Tobacco
- Family Violence
- Federal Waivers

Attachment Two

CSAC Memo: The ACA and AB 85: Looking Back and Looking Forward

CSAC Memo: The ACA and County Operational Challenges

CSAC AB 85 Reader's Guide (September 2013

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November 5, 2013

To: CSAC Health and Human Services Policy Committee

From: Farrah McDaid Ting, Associate Legislative Representative
Judith Reigel, Executive Director, CHEAC

Re: The ACA and AB 85: Looking Back and Looking Forward

Background. The Affordable Care Act (ACA) is upon us, with the health benefit exchange (Covered California) opening October 1 and the Medicaid expansion slated for January 1, 2014. But these components of federal law are just the tip of the iceberg for California's counties, which play a critical role in everything from the provision of health care to eligibility and enrollment to actually financing health services to indigent adults.

It is this last role – using 1991 health realignment funds to provide medical care to indigent adults, a responsibility delegated to counties under Section 17000 of the state Welfare and Institutions Code – that drew the most interest from the Brown Administration and Legislature in 2013. Governor Brown announced in his proposed budget in January that he intended to either realign the county responsibility to include providing care to Medicaid eligible adults, or recoup as much of the 1991 health realignment funding from the counties as possible.

CSAC, with significant help from a range of county affiliates (CHEAC, CWDA, CAPH), key county staff, CSAC officers, and Chair of this committee Kathy Long, successfully redirected the realignment effort and instead negotiated a complex fiscal transaction that reflects the shift of indigent adults to the state's Medi-Cal program.

After months of intense negotiations, the Governor signed AB 85 (Chapter 24, Statutes of 2013) in June and a second technical cleanup measure, SB 98 (Chapter 358, Statutes of 2013), in September. Both measures are the result of the State's intent to capture 1991 health realignment and potential county General Fund "savings" from the Medi-Cal expansion and Covered California. However, significant unknowns remain, including questions about the actual impact of the ACA coverage expansions on counties, including how many uninsured individuals to whom counties will still need to provide services. Counties will also retain the Section 17000 responsibility despite the above measures, and there will be significant variations in the impact of both the ACA and AB 85 for the different types of counties: county hospital, payor/clinic and County Medical Services Program (CMSP) counties. Further, we anticipate significant implementation issues related to the fiscal transaction that will need to be resolved in the coming months and years.

Current (2013/14) Fiscal Year Impacts. Specifically, AB 85 and SB 98 provide the framework for the fiscal transaction. In the current (2013/14) fiscal year, the key points include:

- A total of $300 million will be will be redirected in FY 13/14, which is approximately 22% of the estimated total 1991 health realignment revenues for the year.

- The redirection of health realignment funds will start January 2014, and will be spread over five or six months, according to a schedule to be developed by the Department of Finance (DOF), in consultation with CSAC.

- For counties that chose the savings formula option there will be a true-up process (see below). At that time, a county's FY 13/14 contribution could be adjusted down; however, a county's contribution will never be higher than originally redirected for FY 13/14.

County Options. Options that reflect the priorities of the abovementioned three types of counties are also included in the framework.

COUNTIES THAT OWN AND OPERATE HOSPITAL SYSTEMS (12)

Alameda	San Bernardino
Contra Costa	San Joaquin
Kern	San Francisco
Los Angeles	San Mateo
Monterey	Santa Clara
Riverside	Ventura

For counties with public hospitals, the following options apply:

1. 60/40 with Maintenance of Effort (MOE) Split Option: Counties may elect to have 60% of the amount of their 1991 health realignment funds (base and growth) plus the amount of their statutory MOE redirected. Counties with an MOE that is greater than the average for this group of counties (approximately 25.9%), when compared to their total health realignment funds, may instead choose to use that average MOE to determine the amount to be redirected.

2. "Article 12" Savings Formula Option: Alternatively, these counties may elect to use a "savings formula" which calculates costs and assumed available revenues for uninsured and Medi-Cal patients. Any "savings" would be shared with the state on an 80/20 split, with 20% retained by the county. In addition, the amount of redirected realignment funds for a county cannot be greater than the historical percentage used by the county to provide services to indigent individuals enrolled in the county indigent program.

NON-CMSP, NON-HOSPITAL PAYOR/CLINIC COUNTIES (12)

Contract-only counties	Counties that operate a clinic(s)
Fresno	Placer
Merced	Sacramento
Orange	Santa Barbara
San Diego	Santa Cruz
San Luis Obispo	Stanislaus
Yolo	Tulare

For counties which operate clinics (clinic) and/or contract with providers (payor), the following options apply:

1. 60/40 with MOE Split Option: Counties may elect to have 60% of the amount of their health realignment funds (base and growth) plus the amount of their statutory MOE redirected. Counties with an MOE that is greater than the average for this group of counties (approximately 14.6%) when compared to their total health realignment funds may instead choose to use that average MOE to determine the amount to be redirected.

2. "Article 13" Savings Formula Option: These counties may instead elect to use a "savings formula" which calculates costs and assumed available revenues for serving medically indigent individuals. Again, counties would retain 20% of any determined "savings", and would be capped at redirecting no more than the percentage of Health Realignment historically spent on care to the indigent.

CMSP COUNTIES (34)

Alpine	Lake	Shasta
Amador	Lassen	Sierra
Butte	Madera	Siskiyou
Calaveras	Marin	Solano
Colusa	Mariposa	Sonoma
Del Norte	Mendocino	Sutter
El Dorado	Modoc	Tehama
Glenn	Mono	Trinity
Humboldt	Napa	Tuolumne
Imperial	Nevada	Yuba
Inyo	Plumas	
Kings	San Benito	

CMSP Counties, because of the way they have historically provided care to the

indigent as a group, have only the 60/40 with MOE option. This calculation is done in aggregate for all 34 counties, and results in a split of approximately 62%/38% of total funds. However, the redirected funds will all be drawn from only those funds that previously went to the CMSP program and the CMSP Governing Board.

Key Dates. There are number of key dates and deadlines for counties under AB 85/SB 98. They include:

A. January 22: All Boards of Supervisors must adopt a resolution by this date indicating which option the county is choosing. For non-CMSP counties, if Boards do not meet this deadline, their contribution will be calculated at 62.5% of their health realignment plus MOE.

B. May of each year: The state determines the estimated amount of redirected health realignment for each county for the following fiscal year. This is the amount that the State Controller's Office (SCO) will use when distributing funds.

True-up Process. For counties choosing either the "Article 12" or "Article 13" savings formula options, a "true-up" process will occur. The timelines for that process are as follows:

December 1: Counties must submit initial cost and revenue data to the Department of Health Care Services (DHCS) for the prior fiscal year (e.g. for FY 13/14, interim data must be submitted by 12/1/14).

June 30: Counties must submit final cost and revenue data to DHCS for the prior fiscal year (e.g. for FY 13/14, final data must be submitted by 6/30/15).

December 15: DHCS must provide final calculations to the counties (eg. For FY 13/14, DHCS must make a final determination of the redirected amount by 12/15/15).

June 30: The Director of Finance makes a final decision about each county's redirected amount for the fiscal year two years prior (eg. A final decision for FY 13/14 will be made by DOF in June of 2016). Based on whether this final determination is above or below the estimated amount originally redirected, the state will either reimburse the county, or the county will owe the state additional funds.

For counties choosing the 60/40 with MOE option:

By January 10 of each year: After growth distributions are made, the Department of Finance will determine the final amount owed for the previous Fiscal year.

Changes to 1991 Realignment Growth Distribution: AB 85 changes the distribution of realignment growth funds in two fundamental ways:

A. First, the method/formula for redirecting health realignment funds for each county (i.e. savings formula or 60/40) will also apply to that county's 1991 realignment growth funds. So whichever option a county has chosen, the total amount of their health realignment funds (base plus growth) will be included in the calculation to determine the amount of funds to be redirected.

B. Second, the formulas for determining how growth funds are distributed will be changed to the following:

   1. Social Services caseload growth will still get first call on Sales Tax growth

   2. After caseload growth is fully paid, the next draw on growth remains CMSP (*now shared with the state*).

   3. Next in line is General Growth, which is changed to the following.

      - The Mental Health Account will continue to receive growth based on its historic resource base formula, which has usually amounted to about 40% of General Growth.

      - The Health Account will now receive a flat 18.45% (*Note: Historically, Health has received about 50% of General Growth.)*

      - The remainder of General Growth funds (approximately 42%) will now be used to fund CalWORKs grant increases.

      - The Social Services Account will no longer receive General Growth.

Mechanics of 1991 Realignment Changes.

Two new realignment accounts have been created to implement the redirection of health realignment funds:

1. The Family Support Subaccount is created at the state and county levels, and will be used to receive the redirected health realignment funds, and to pay a new county "contribution" for CalWORKs. This new county "contribution" is limited to the amount of redirected health realignment funds, and is simply a fiscal transaction to off-set current state costs.

2. There is also a new Child Poverty and Family Supplemental Support Subaccount created at the state level, which will be used for the CalWORKs grant increases.

Sales Tax/Vehicle License Fee (VLF) Swap:

Since VLF revenues cannot be used to fund the new "county contribution" to CalWORKs, AB 85 moves up to $300 million in FY 13/14 and up to $1 billion in future years in sales tax revenues from the Social Services Account to the Health Account, and moves the same amount of VLF from Health to Social Services.

Safety Valves for Counties. It is clear that a fiscal transaction of this magnitude presents unprecedented challenges for counties as they work to cope with the changing ACA landscape. In recognition of this, CSAC negotiated several provisions to recognize any unique circumstances that may come up in the following years, including:

Cash Flow Issues for formula counties pending true-up:

For counties choosing the savings formula option, there may be a cash flow issue pending the final true up. Remember that counties will still have the Section 17000 obligation and be required to fund public health programs in our communities. Under AB 85, the amount of health realignment redirected each year for these counties will be based on state estimates of each county's likely savings. If the estimated savings are significantly greater that what is actually realized, there will be a three year period between the start of each fiscal year and the final true-up for that year. Counties may also consult with CSAC and DoF on individual cash flow concerns.

Appeals Processes:

1. A County Health Care Funding Resolution Committee (comprised of one person selected by DHCS, one person selected by DOF and one person selected by CSAC) is created to hear county appeals on specific issues, including disagreements between counties and DHCS on historical data or if a county wishes to change from the 60/40 to the savings formula option for specified reasons.

2. An expedited Administrative Appeals Process will also be established by the state to hear county appeals of the state's decisions on the formula true-up. The timeline for this process should be no more than 18 months.

Implementation Stage. At this time, counties that are considering opting for the savings formula have all submitted their historical expenditure data for FY 08/09 through FY 11/12 to DHCS. The Department is currently in the process of reviewing

this data and meeting with counties, and must notify each county by December 15 if they disagree with the county's data.

CSAC, CHEAC and CWDA are also working with the Department of Finance and the State Controller's Office on myriad technical issues related to the structural changes to 1991realignment, including:

- Mechanics of the sales tax/VLF Swap
- Mechanics of the diversion of health realignment funds to the Family Support Subaccount
- Preparation of the many schedules DOF must provide to SCO for distribution of funds.
- Family Support Account Distributions
- Child Poverty and Family Supplemental Support Subaccount Distributions

Conclusion. While significant issues with implementation remain, counties now have a framework for determining the remaining amount of 1991 realignment health funding. Concerns about the technical complexity of the deal, the unique position of some counties, and the overall effectiveness of the ACA and who will remain uncovered continue to be a part of the conversation. CSAC, along with this policy committee, will continue to play a key role as these issues evolve.

Speakers:

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November 5, 2013

To: CSAC Health and Human Services Policy Committee

From: Farrah McDaid Ting, Associate Legislative Representative

Re: ACA Implementation Overview: County Operational Challenges

Background. Health Care Reform implementation has allowed county Human Services departments the opportunity to offer local residents and communities with an avenue to apply for and obtain information on the additional health insurance programs and services which were created by the Affordable Care Act (ACA).

ACA implementation in counties is an extension of the Medi-Cal services already provided by Human Services departments statewide. Serving as the primary local application pathway for ACA, county departments have undertaken tremendous efforts in preparing for the integration of current and new programs and services. Some of these efforts include:

- Hiring new staff
- Training current staff
- Opening up new call centers
- Expanding existing call centers
- Working with community partners on various outreach efforts

Governance. The governance structure for the Medi-Cal program under the ACA has changed. Different entities newly created by ACA now play vital roles in program and technology administration of health insurance programs. County Human Services departments continue to have their own policies and IT systems, collectively known as the Statewide Automated Welfare System or SAWS, in place while working with local and state agencies, but also rely on key information from the following entities to ensure proper implementation of Health Care Reform:

- California Department of Health Care Services (DHCS) – oversees Medi-Cal.
- Covered California – the newly established healthcare exchange in the state of California – oversees subsidized and unsubsidized coverage for individuals whose incomes are above the Medi-Cal limits.
- California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) – the newly built IT system for ACA enrollment and eligibility, co-owned by Covered California and DHCS.
- Centers for Medicare and Medicaid Services (CMS) – overseeing federal agency

California has chosen to implement its health insurance exchange, Covered California, independent of the Federal Exchange used by many states. This has allowed California many opportunities for flexibility, but also posed several challenges as counties statewide work to streamline processes with both Covered California and CalHEERS.

Transition. With the implementation of ACA, the state has taken the "all paths lead to coverage approach" where all individuals seeking out health insurance coverage or information can be serviced by their local county. In addition to existing programs and application pathways, counties have streamlined their processes to facilitate Health Care Reform implementation by implementing the following transitional changes:

- Continuing to take applications via mail, online, in-person, and by phone in addition to accepting applications from Covered California by:
  - "Warm hand-off" transfers for phone applications
  - Finalizing eligibility and enrollment for Medi-Cal applications entered online through CalHEERS
- Conducting eligibility and enrollment processes for all health insurance applications received directly by the county for all programs including coverage through Covered California's subsidy programs:
  - Advanced Premium Tax Credits (APTC)
  - Cost Sharing Reductions (CSR)
- Assisting applicants with healthcare plan selection
- Participating in department-wide organizational change management efforts to fully integrate Health Care Reform into current practices and develop business processes to enhance customer service and deal with culture change
- Implementing "horizontal integration" strategies that allow counties the opportunity to use Health Care Reform as a doorway to provide comprehensive services for those seeking them (for example, CalWORKs and CalFresh)
- Enhancing current IT systems (SAWS) to allow for full integration and effective communication with CalHEERS and Covered California

(continued on next page)

Challenges

Policy	Technical
• Several policy questions surrounding current and future programs remain pending both at the state and federal levels • Key guidance materials or decisions received from CMS beyond feasible dates to ensure proper guidance and system readiness • Reviewing system programming to ensure it follows policy	• The CalHEERS system is not fully integrated with current county systems, thus resulting in additional manual work by county staff • The initial delay in the CalHEERS interface with county systems has resulted in this lack of integration and is scheduled to be integrated in January 2014 • Delays in policy clarification have resulted in delays in essential system functionality • Counties continue to experience system slowness and other technical issues within CalHEERS

Speaker:

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California State Association of Counties
Reader's Guide to AB 85 (as modified by SB 98)
Last Updated September 2013

Section, page	Topic	Description
1, p. 4-6 Welfare & Institutions Code §11450.025	CalWORKs grant increases	This section effectuates the CalWORKs grant increases through a newly created Child Poverty and Family Supplemental Support Subaccount of the 1991 Local Revenue Fund. Deposits in the Child Poverty and Family Supplemental Support Subaccount may results in CalWORKs grant increases. Includes a process and calculation for determining grant increases. If funds in the Child Poverty and Family Supplemental Support Subaccount in a fiscal year are insufficient to fully fund any grant increases, the remaining costs for that fiscal year will be addressed through existing authority in the Budget Act. Clarifies that there is no county share of cost for the grant increases.
2, p. 6-11 Welfare & Institutions Code §14199.1 and 14199.2	Medicaid Expansion Under the Affordable Care – provisions related to county hospitals	§14199.1 Specifies Medi-Cal assignment to plans and primary care providers in county hospital counties. From 12/31/13 through 12/31/16: 75% of default members to a primary care provider within county hospital system until hospital meets its target 1/1/17: 50% of default members to a primary care provider within county hospital system until hospital meets its target Doesn't apply when a county hospital meets or exceeds its target Medi-Cal managed care plans shall first assign a primary care provider within a county hospital system to those default members who have accessed care within the county hospital system two to three times in the past 12 months. Penalties for health plans that don't comply. Beneficiaries still able to modify or change their primary care providers. §14199.2 Provides that the plans shall pay the county hospital systems rates for the newly eligible at the cost of providing services. Provides for penalties on health plans that do not comply. Allows for voluntary Intergovernmental Transfers (IGTs) for the non-federal share of a capitated rate.
3, p. 11-12 Welfare & Institutions Code §14301.5	Medi-Cal managed care plan rate range increases	Allows Department of Health Care Services (DHCS) to pay rate range increase for Medi-Cal managed care plans at a minimum level of 75% of rate range for the newly eligible beneficiaries. If a non-federal share is required, a county hospital system may provide it voluntarily through an IGT. The increased payments to Medi-Cal managed care plans shall not be reduced as a consequence of

Section, page	Topic	Description
		payment under this section. The Medi-Cal managed care plan shall pay all of the rate range increases provided under this section as additional payments to county hospital systems. Provides for penalties on health plans that do not comply.
4, p. 12-13 Welfare and Institutions Code §17600	1991 Realignment Accounts and Subaccounts	Sunsets the existing 1991 Local Revenue Fund section that creates all the accounts and subaccounts on July 1, 2013 to effectuate changes to the 1991 Local Revenue Fund (see next section).
5, p.13-14 Welfare and Institutions Code §17600	1991 Realignment Accounts and Subaccounts	As of July 1, 2013, recreates the 1991 Local Revenue Fund section that creates all the accounts and subaccounts, as follows: <u>Accounts</u>: Sales Tax Account Vehicle License Fee Account Vehicle License Collection Account Sales Tax Growth Account Vehicle License Fee Growth Account <u>Subaccounts of the Sales Tax Account</u>: Mental Health Subaccount Social Services Subaccount Health Subaccount CalWORKs MOE Subaccount Family Support Subaccount – NEW Child Poverty and Family Supplemental Support Subaccount – NEW <u>Subaccounts of the Sales Tax Growth Account</u>: Caseload Subaccount County Medical Services Subaccount General Growth Subaccount Note that the following subaccounts are eliminated: Base Restoration, Indigent Health Equity, Community Health Equity, Mental Health Equity, State Hospital Mental Health Equity
6, pp. 14	Family Support	Adds the Family Support Account to the list of accounts each county and city and county are required

Section, page	Topic	Description
Welfare and Institutions Code §17600.10	Account	to establish as part of 1991 Realignment.
7, p. 14-17 Welfare and Institutions Code §17600.15	Sales Tax Distributions	Ends the current distribution of sales tax funds within 1991 Realignment at the end of 2012-13. In 2013-14, swaps **up to $300 million** in sales tax funds between the Social Services Subaccount and the Health Subaccount at the state level. The swap is intended to only replace the source of funds for each account – not the underlying distribution of revenues via existing formulas. The disbursements to the Mental Health Subaccount do not change. Sales tax growth continues to be allocated based on existing law. In 2014-15 and beyond, **up to $ 1 billion is swapped annually, based on actual VLF monthly receipts, between the Social Services Subaccount and the Health Subaccount.** Adds that the Child Poverty and Family Supplemental Support Subaccount will receive sales tax and sales tax growth in 2014-15 and beyond. The disbursements to the Mental Health Subaccount do not change. Sales tax growth continues to be allocated based on existing law.
8, p. 17-18 Welfare and Institutions Code §17600.20	1991 County Transfer Provisions	Clarifies that the provisions in existing law that allow counties to transfer up to 10 percent between local accounts applies to the health, mental health and social services accounts and NOT to the CalWORKs MOE or Family Support accounts.
9, p. 18-21 Welfare and Institutions Code §17600.50	County Selection of Formula	Details the election into the 60/40 formula for the County Medical Services Program and 34 CMSP counties participating in CMSP as of 2011-12. The 60% is calculated based on 1991 health realignment funds and the health realignment MOE. Details the options for the non-CMSP, non-hospital counties (Fresno, Merced, Orange, Placer, Sacramento, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Stanislaus, Tulare and Yolo). Each county shall make a tentative decision by **Nov. 1, 2013** with a final resolution adopted by the board of supervisors on or before **January 22, 2014**. A county may choose: ▪ A savings calculation of costs and revenues detailed in Article 13 (p.66) ▪ A 60/40 calculation. The 60% is calculated based on 1991 health realignment funds and 60% of the health realignment MOE. If a county's MOE is greater than 14.6% of total value of the

Section, page	Topic	Description
		county's 2010-11 health realignment allocation, the value of the MOE is limited to 14.6%. Details the options for the hospital counties (Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura). Each county shall make a tentative decision by **Nov. 1, 2013** with a final resolution adopted by the board of supervisors on or before **January 22, 2014**. A county may choose: ▪ A savings calculation of costs and revenues detailed in Article 12 (p.39) ▪ A 60/40 calculation. The 60% is calculated based on 1991 health realignment funds and 60% of the health realignment MOE. If a county's MOE is greater than 25.9% of total value of the county's 2010-11 health realignment allocation, the value of the MOE is limited to 25.9%. If a county fails to elect or inform the DHCS by **January 22, 2014**, then the following calculation shall be used: 62.5% of the 1991 health realignment funds and 62.5% of the health realignment MOE. Revenues shall be transferred to the Family Support Subaccount. **SB 98 clarifies that the calculation of the growth portion of the diverted funds under either option is based on the amount the Health Subaccount will receive under the new growth formulas.**
10, p. 21-23 Welfare and Institutions Code §17600.60	County Health Care Funding Resolution Committee	Creates the County Health Care Funding Resolution Committee to do all of the following: ▪ Hear and determine disputes over the data submitted to DHCS for the historical percentages of health realignment amount, imputed (credited) county low-income health amount, and indigent program costs **(SB 98 clarifies that this applies to both Article 12 and Article 13 counties).** ▪ Hear and determine petitions from counties that want to change the selection of the 60/40 formula to the savings calculation based on costs and revenues. A county must demonstrate and provide sufficient evidence that there have been changes in expenditures related to state and federal law changes, regulations and rulemaking or court decisions that impact health care services to indigent adults. Additionally, a county must submit all of the data necessary to participate in Article 12 or 13. ▪ Hear and determine petitions for an alternative cost calculation to the per person calculation for non-hospital counties. A county must document extraordinary circumstances, including circumstances related to the local health care marketplace, provider and provider contracts and submit all necessary data. The committee is comprised of representatives from: 1) CSAC, 2) DOF and 3) DHCS. The committee is exempt from the Bagley-Keene Open Meeting Act and the Administrative Procedures Act for purposes of drafting regulations. The committee shall determine the form of petition by **January 31,**

Section, page	Topic	Description
		2014. The committee shall make decisions within 45 days of hearing any petition. NOTE: This is an administrative process and, as such, counties can seek judicial review upon completion of that process.
11, pp. 23	Family Support Allocations	Adds a new heading to Article 2.5 (commencing with Section 17601.25) to Chapter 6 of part 5 of Division 9 of the Welfare and Institutions Code – Article 2.5, Family Support Allocations.
12, p. 23-24 Welfare and Institutions Code §17601.25	Family Support Allocations	Clarifies that the allocations from Family Support Subaccount and CalWORKs MOE are a contribution, **not** a share of cost.
13, pp. 24 Welfare and Institutions Code §17601.50	Directing funds from state level to county level: Child Poverty & Family Supplemental Support Subaccount	Directs funds from the Child Poverty & Family Supplemental Support Subaccount at the state level to the family support account at the local level. Clarifies that all the funds are to be used for CalWORKs grant increases.
14, pp. 24 Welfare and Institutions Code §17601.75	Allocation of family support funds	Allocates fund to the family support account per a schedule developed by DOF in consultation with CSAC. Clarifies counties **do not** have a new share of cost for CalWORKs grants. Clarifies that funds in the family support account are not subject to the transferability provisions within the 1991 realignment structure at the local level.
15, p. 24-28 Welfare and Institutions Code §17603	Sales tax & sales tax growth disbursements: 2013-14 and 2014-15 and beyond	Clarifies existing disbursements of sales tax and sales tax growth ends at the end of the 2012-13 fiscal year. For 2013-14, disburses up to $300 million from the Health Subaccount to the Family Support Subaccount. The funds will be withheld via a schedule developed by DOF in consultation with CSAC. CMSP counties transfer no more than the $89 million statutory CMSP payment that counties are obligated to remit to the CMSP governing board. If there is a difference, it will be paid by the CMSP Governing Board. Clarifies that the city allocations (there are 3 cities receiving health realignment funds for their public health departments) do not change. For 2014-15 and beyond, DOF, in consultation with CSAC, shall calculate each county's contribution

Section, page	Topic	Description
		for each year. Clarifies that the city allocations do not change.
16, p.28-32 Welfare and Institutions Code §17604	Vehicle License Fees	Adjusts the VLF disbursements to effectuate the sales tax and VLF swaps between the health and social services subaccounts. Social Services will now be the recipient of VLF, while Health will receive sales tax. **SB 98 clarifies that the swap will occur monthly, based on a schedule prepared by DOF.**
17, p. 32-36 Welfare and Institutions Code §17606.10	General Growth	General growth disbursements as part of 1991 realignment continue through 2012-13. In 2013-14 and beyond, General Growth is calculated as follows: ▪ The mental health calculation remains the same ▪ The Health Account receives 18.4545 percent ▪ The rest of the general growth funds go the Child Poverty and Family Supplemental Support Subaccount. Please note that the new disbursement eliminates general growth for social services and changes the calculation for health from a calculated amount to a flat percentage.
18, p. 36 Welfare and Institutions Code §17609.02	Family Support Account	Clarifies that the funds in the Family Support Account can only be used to pay for CalWORKs.
19, p. 37-39 Welfare and Institutions Code §17610-17611 Article 11	True-up and Reconciliation process	§17610. True-up process for the Family Support Subaccount for counties that choose the savings calculation based on costs and revenues: June 2016 final true-up (for 2013-14). Final true up every June thereafter for the fiscal year two years prior. If county overpaid, the state shall deposit the difference in the health account. If the county underpaid, the county shall pay the difference to the family support account at the local level. If the county does not pay within 3 months, the state will have 1.5 times that amount withheld from the county's health subaccount and transferred to the Family Support Subaccount at the next allocation. **For FY 13/14 only, the final true up will not exceed the amount the county paid under the original FY 13/14 schedule.** §17610.5. Creates a 2013-14 Special Holding Account in the Family Support Subaccount. Funds will

Section, page	Topic	Description
		stay in the Special Holding Account until May Revise. The funds will be transferred to the Family Support Subaccount by **the end of the 13/14 fiscal year**. If a county's revised savings is lower than the amount transferred, the balance is returned to the county. §17611. True-up process/reconciliation for counties that choose the 60/40 formula: By January 10 of the following fiscal year, DOF will make a final determination of the allocation attributable to each county that chooses the 60/40 formula. DOF and the Controller will make adjustments based on the health realignment deposits. DOF shall notify every county and the Joint Legislative Budget Committee of its determinations.
20, p. 39-65 Welfare and Institutions Code §17612.1-17612.8 Article 12	Hospital County Savings Formula	Details the process to redirect realignment funds. Defines technical terms associated with the calculation. Defines costs. Defines the cost containment limit and provides exceptions to that limit. Defines revenues. **SB 98 includes an allocation methodology for other sources of funding that include unrestricted special local health funds (tobacco settlement or special assessment), one-time funds or carry-over funds, and county general purpose revenues.** Total revenues and other funds payable for a fiscal year: Medi-Cal revenues + Uninsured revenues + Medicaid demonstration revenues + Hospital fee direct grants + Special local health funds + County indigent health care realignment amount + Imputed county low-income health amount + Imputed gains from other payers + The amount by which the public hospital system county's cost exceed the cost containment limit (expressed as a negative number) multiplied by .50 MINUS Medi-Cal costs, uninsured costs, other entity IGTs, new mandatory other entity IGTs = Resulting amount shall be multiplied by by .70 in 2013-14 and .80 in 2014-15 and beyond.

Section, page	Topic	Description
		If the amount is positive, then that amount shall be redirected. If the amount is negative, then the amount shall be zero. The amount to be redirected shall not exceed the county indigent care health realignment amount for that FY. The calculation stays in effect until whichever is later: June 30, 2023 OR the beginning of a FY following two consecutive years when the interim calculation is within 10 percent of the final calculation and the final reconciled amounts are within 5% of each other. Data submission to DHCS for the historical percentages of health realignment amount, county general fund contribution for Medi-Cal and uninsured, imputed gains from other payers and special local health funds: ▪ **October 31, 2013** – county determines amount or percentage and provides DHCS with the calculation and supporting data ▪ If DHCS disagrees, the state will confer with the county by **Dec 15, 2013. DHCS must issue a final determination by January 31, 2014.** ▪ If agreement is not reached by **January 31, 2014**, DHCS shall apply the county's calculation until a decision is issued A county can submit a petition to the County Health Care Funding Resolution committee over the data submitted to DHCS for the historical percentages of health realignment amount, county general fund contribution for Medi-Cal and uninsured, imputed gains from other payers and special local health funds. The County Health Care Funding Resolution Committee shall issue a decision within 45 days of the decision. A county can contest the determination. While the county is contesting, the Committee's decision will apply for purposes of an interim calculation. DHCS shall establish an expedited formal appeal process for counties to contest either the Committee's decision on the historical data or the Department's final determination in the true-up process each year: ▪ The county shall have 30 calendar days to file an appeal with the DHCS director. Appeals shall be in writing. ▪ A formal hearing before an Office of Administrative Hearings and Appeals Administrative Law Judge shall begin within **60 days** of filing the appeal requesting a formal hearing.

Section, page	Topic	Description
		▪ A final decision **shall be adopted no later than 6 months** following the issuance of the appeal. ▪ If a county does not file an appeal within 30 days, the determination of the Committee shall be final. If a final decision is not issued by DHCS within two years, the county shall be deemed to have exhausted its administrative remedies and can purse judicial review. The time period can be extended by either undue delay caused by the county or an extension of time granted to a county at its request. §17612.5. Los Angeles specific formula. §17612.7. Allows DHCS to implement without creating regulations. §17612.8. Requires DHCS to apply for another Medicaid demonstration project to replace the current Medicaid Bridge to Reform waiver.
21, p. 65-75	Non-Hospital County Savings Formula	Details the process to redirect realignment funds. Defines technical terms associated with the calculation. Defines costs. Defines the cost containment limit and provides exceptions to that limit. Defines revenues. Total revenues and other funds payable for a fiscal year: Indigent program revenues + Special local health funds + County indigent health care realignment amount + Imputed county low-income health amount MINUS Indigent program costs (not to exceed the cost containment limit) = Resulting amount shall be multiplied by by .70 in 2013-14 and.80 in 2014-15 and beyond. If the amount is positive, then that amount shall be redirected. If the amount is negative, then the amount shall be zero. The amount to be redirected shall not exceed the county indigent care health realignment amount for that FY.

Section, page	Topic	Description
		The calculation stays in effect until whichever is later: June 30, 2023 OR the beginning of a FY following two consecutive years when the interim calculation is within 10 percent of the final calculation and the final reconciled amounts are within 5% of each other. Data submission to DHCS for the historical percentages of health realignment amount, imputed county low-income health amount, and indigent program costs: ▪ **October 31, 2013** – county determines amount or percentage and provides DHCS with the calculation and supporting data ▪ If DHCS disagrees, the state will confer with the county by **Dec. 15, 2013. DHCS must issue a final determination by January 31, 2014.** ▪ If agreement is not reached by **January 31, 2014**, DHCS shall apply the county's calculation until a decision is issued A county may submit a petition to the County Health Care Funding Resolution committee regarding the data submitted to DHCS for the historical percentages of health realignment amount, imputed county low-income health amount, and indigent program costs. The County Health Care Funding Resolution committee shall issue a decision within 45 days of the decision. A county can contest the determination. While the county is contesting, the Committee's decision will apply for purposes of an interim calculation. DHCS shall establish an expedited formal appeal process for counties to contest either the Committee's decision on the historical data or the Department's final determination in the true-up process each year: ▪ The county shall have 30 calendar days to file an appeal with the DHCS director. Appeals shall be in writing. ▪ A formal hearing before and Office of Administrative Hearings and Appeals Administrative Law Judge shall begin within **60 days** of filing the appeal requesting a formal hearing. ▪ A final decision shall be adopted **no later than 6 months** following the issuance of the appeal. ▪ If a county does not file an appeal within 30 days the determination of the Committee shall be final. If a final decision is not issued by DHCS in two years, the county shall be deemed to have exhausted its administrative remedies and can purse judicial review. The time period can be extended by either undue delay caused by the county or an extension of time granted to a county at its request.
22, pp. 75	General	Requires DOF, DHCS, Department of Social Services, and the Controller, in consultation with CSAC, to

Section, page	Topic	Description
Uncodified	implementation	work on technical implementation of the measure. DOF, in consultation with CSAC, will work with any county that has cash flow issues stemming from allocations in the Health Subaccount.
23, p. 75-76 Uncodified	Federal Immigration Reform	States legislative intent to review the formulas (60/40 and cost/revenue formulas) if the federal government enacts immigration reform. Additionally requires DHCS to report to the Legislature on the potential impacts of federal immigration reform on county health care expenditures.
24, pp. 76 Uncodified	Mandates	If the measure contains a mandate per the Commission on State Mandates, reimbursements shall be made to local agencies.
25, pp. 76 Uncodified	Budget bill	Clarifies the measure provides for appropriations related to the Budget Bill.

Attachment Three

CSAC Memo: Expansion of Benefits: County Mental Health and Substance Use Disorder Services

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November 5, 2013

To: CSAC Health and Human Services Policy Committee

From: Farrah McDaid Ting, Associate Legislative Representative

Re: Expansion of Benefits: County Mental Health and Substance Use Disorder Services

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Background. California opted to participate in the Medicaid expansion under the federal Affordable Care Act (ACA) in June. This historic move will provide Medicaid coverage – called Medi-Cal in California – to more than a million uninsured citizens up to 138 percent of the Federal Poverty Level ($15,415 annual income for an individual, $31,810 for a family of four) beginning January 1, 2014.

Benefits. As part of the expansion, California committed to a standard package of Medicaid benefits, called the Essential Health Benefits. But the state also opted to include the following additional mental health and Substance Use Disorder (SUD) benefits:

Mental Health

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

S.U.D.

- Intensive outpatient treatment (no longer limited to pregnant/postpartum/under 21 population)
- Residentially-based substance use disorder services (no longer limited to pregnant/postpartum population)
- Medically necessary inpatient detoxification

Providers. Counties will provide the S.U.D. benefits through the realigned Drug Medi-Cal program, while Medi-Cal Managed Care plans will provide the mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver.

2014 and Beyond. Many issues associated with the expansion and the role of counties in financing benefits and providing the services remain unresolved. The California Mental Health Directors Association and the California Alcohol and Drug

Program Administrators Association of California are working to combine their efforts to ensure a smooth rollout for these benefits within all 58 counties.

Speaker:

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Speaker:

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Attachment Four

CSAC Memo: Practical Tips for Healthier Workplaces and Communities

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November 5, 2013

To: CSAC Health and Human Services Policy Committee

From: Farrah McDaid Ting, Associate Legislative Representative

Re: Practical Tips for Healthier Workplaces and Communities

Background. The Affordable Care Act includes funding and incentives for health prevention activities in workplaces and communities. By focusing on health and prevention, the drafters of the Act hoped to reduce health care costs overall.

In the public and private sectors, this has often translated into programs and incentives for changing behavior, such as those seen with smoking cessation or weight loss. And while basic behavior change is necessary in most cases, entities that attempt to tackle health issues by focusing solely on individual behavior change have made less progress than expected.

In the new age of wellness, the emphasis is shifting to one of culture change. Kaiser Permanente has been a leader in this area, striving to change its own workplace and member culture. The workplace efforts by Kaiser – installing walking paths, creating walking clubs and walking meetings, revamping work and break areas – may seem like small changes, but they are steps toward creating a culture where wellness and health are achievable and normal. Kaiser also offers consulting and grant services to local governments and private organizations on the healthy culture concept, with an emphasis on sustainability.

Clearly there are a number of other significant areas in which a more healthy culture can be promulgated – the built environment, policymaking, the food industry, etc. – but Kaiser has demonstrated that any size organization, be it a small family, a local government, or a large private company, can make small changes to promote health and wellness – and enjoy the fruits of that labor.

Speaker:

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Attachment Five

CSAC Memo: The Children's Movement of California

2013-14 Pro-Kid Policy Agenda for California

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November 5, 2013

To: CSAC Health and Human Services Policy Committee

From: Farrah McDaid Ting, Associate Legislative Representative

Re: The Children's Movement of California

Background. CSAC President David Finigan declared 2013 "The Year of the Child" for the Association. In the related resolution adopted by the CSAC Board of Directors and individual counties, members pledge to "...prioritize California's children and consider the impact of each decision they make on all of our children today, tomorrow, and in the future..." and "...share this dedication to the good health, school readiness, and general well-being of our children."

To that end, CSAC has invited former Assembly Member and current President of the nonprofit children's advocacy group Children Now to speak to policy committee members about The Children's Movement of California.

Mission. The Movement, founded by Children Now, connects more than 700 organizations and individuals with the shared goal of improving children's health and education in California. What is different about this effort is the collaborative, inclusive nature of the coalition, whose individual members possessed varying priorities and a diffuse influence on the policy making process.

The Movement focuses each member's efforts to improve the lives of children by providing timely tools and information on children's issues and legislative measures. The Movement realized significant success this past legislative session with the enactment of the school Local Control Funding Formula, measures to protect foster youth and a major bill to protect the online privacy of children (SB 568).

Children Now is a non-partisan, multi-issue research, policy development, and advocacy organization dedicated to promoting children's health and education in California and creating national media policies that support child development. Children Now is the founder and leader of The Children's Movement of California.

Speaker:

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THE 2013-14 PRO-KID POLICY AGENDA FOR CALIFORNIA

Introduction & Table of Contents

A GUIDE TO PRO-KID POLICYMAKING

The *2013-14 Pro-Kid Policy Agenda for California* provides a single source of guidance needed to better understand and reflect the full scope of what it means to be Pro-Kid in the state's approach to policymaking. Included are the top policy priorities for children in the foundational areas of Education, Health, Integrated Services, and Child Welfare, with a consistent emphasis on equity, access, quality, and accountability. The *Agenda* is the roadmap for the state's policymakers, stakeholders, and others who want all children to have the opportunity to reach their full potential, and it addresses the disproportionate impacts of poverty and race on a child's chances of success.

We have no expectation that everyone will endorse all of the items included in the *Agenda*, though many may. Rather, the *Agenda's* value to anyone supporting any topic in it lies in the overarching Pro-Kid framework it establishes. This framework addresses the longstanding problem of too many uncoordinated, single-issue efforts for kids overwhelming policymakers, marginalizing one another, and limiting results. Others have used similar frameworks very effectively, like the Pro-/Anti-Business framework used by the Chamber of Commerce.

There is no lack of evidence that a Pro-Kid approach to policymaking will improve the economic and civic prosperity of our state. There also is no lack of public support for children. In fact, few if any issues are so broadly backed. Furthermore, while California's state and local tax revenues rank among the highest in the nation on both per capita and percentage of personal income bases, the state ranks 41st nationally on children's well-being overall and near the bottom on school funding. Cleary we can do better for California's kids.

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The *Agenda* was compiled by Children Now, the leading, nonpartisan, multi-issue research, policy development, and advocacy organization dedicated to promoting children's health and education in California, and leader of The Children's Movement of California. It reflects the knowledge of the many children's health and education coalitions in which the organization is involved.

If you have any questions or comments regarding the *Agenda*, please email them to agenda@childrennow.org

THE 2013-14 PRO-KID POLICY AGENDA FOR CALIFORNIA

Summary Version

EDUCATION

Early Education

(1) Provide greater access to quality early care and education programs starting at birth.

(2) Support a high quality standard for all programs by maintaining Department of Education oversight, supporting quality rating and improvement systems, building workforce capacity, and promoting family involvement.

(3) Increase the frequency of licensing visits to early care and education facilities.

(4) Establish stronger links among preschool, transitional kindergarten, and kindergarten.

(5) Enhance economic and educational opportunity, including introducing a savings account program beginning in infancy.

K-12 Education

(1) Implement a rational, student-centered, and transparent school finance system.

(2) Implement stronger, up-to-date curriculum standards with an aligned assessment and accountability system, including a greater emphasis on Science, Technology, Engineering, and Math.

(3) Support teaching effectiveness with improved training and a more meaningful evaluation system.

(4) Foster innovation in approaches to the traditional school day and expanded learning time (i.e., afterschool and summer programs) to extend proven programs, such as Linked Learning.

(5) Leverage technology more fully and appropriately to advance academic achievement by revamping the education infrastructure, taking successful blended learning models to scale, and supporting professional development.

(6) Address inequitable suspension and expulsion policies and chronic absence.

HEALTH

(1) Expand and strengthen preventive services for at-risk infants and toddlers, including developmental screenings, early intervention, and home visitation.

(2) Provide every child with affordable and comprehensive health insurance coverage.

(3) Promote children's timely access to the complete range of critical health care services they need, including preventive screenings, immunizations, dental, mental, vision, and hearing care.

(4) Establish a tech-savvy "health home" for every child, and expand the number of school-based health centers.

(5) Institute a comprehensive approach to combating childhood obesity, focusing on healthy food and beverage choices, increased physical activity, and nutrition education.

INTEGRATED SERVICES

(1) Institute a Children's Coordinating Council.

(2) Establish a comprehensive, longitudinal interagency data system.

(3) Develop eligibility and enrollment standards and outcome measures to be used across agencies.

CHILD WELFARE

(1) Hold local governments accountable for child welfare realignment outcomes.

(2) Strengthen and expand prevention, early intervention, and at-home services.

(3) Prioritize stability and permanence.

(4) Ensure foster youth aging out of the system have access to education, health care, and other services.

THE 2013-14 PRO-KID POLICY AGENDA FOR CALIFORNIA
Detailed Version

EDUCATION

Early Education

(1) Provide greater access to quality early care and education programs starting at birth.

The state should begin working to restore access to early care and education (i.e., child care and preschool) programs cut in recent years, including the 100,000 spaces for low-income children eliminated since 2008. Funding should begin to be restored through the 2013-14 state budget and additional steps taken to ensure that more young children have access to quality early care and education programs. For example, only 8% of California's infants and toddlers from income-eligible families are attending any type of subsidized early care and education program, and the state is losing many of its high-quality Title 5 infant/toddler early care and education spaces. To help remedy this, the state should explore ways to increase the level of reimbursement received by child care providers who accept infants and toddlers whose enrollment fees are subsidized.

(2) Support a high quality standard for all programs by maintaining Department of Education oversight, supporting quality rating and improvement systems, building workforce capacity, and promoting family involvement.

- Keep early learning programs within the Department of Education:
  California should continue to administer state-funded early learning programs through the Department of Education and focus on aligning these programs with the state's K-12 and higher education investments. Disconnecting early learning from the state's education system would limit student achievement by hindering the creation of more consistent and aligned teaching practices and learning environments from birth to 3rd grade, when key social-emotional milestones like self-regulation are taking shape as well as foundational learning milestones like reading must be reached.

- Improve program quality through Quality Rating and Improvement Systems:
  The state should continue to support the implementation of the federal Race to the Top-Early Leaning Challenge grant, which will roll-out new and improved local Quality Rating and Improvement Systems (QRIS) in 16 counties over the next three years, in collaboration with the Department of Education and other state agencies. These systems will collect information on early learning programs that will be analyzed and shared to improve program quality.

- Enhance training and professional development for teachers and administrators:
  The Department of Education should encourage shared professional development opportunities for early care and education and elementary teachers with a focus on aligning their approaches to teaching and learning. The California Preschool Instructional Network provides an existing platform for doing this on which the state can build. The state should also provide (a) aggregated school readiness data, and guidance on how to use it to preschool directors and teachers about the young children who attended their preschools to inform and improve their efforts and (b) similarly, coaching and on-line resources to help kindergarten teachers analyze kindergarten readiness information and better support young children's academic and social-emotional development.

- Promote family involvement and strengthen language and literacy services:
  The state should promote family engagement in their children's early learning to foster stronger family connections to and support for children's literacy. Furthermore, the state should expand professional development opportunities for non-English speaking and bilingual early care and education providers – including family relative and neighborhood caregivers – that focus on creating language- and literacy-rich experiences for children in their first three years.

(3) Increase the frequency of licensing visits to early care and education facilities.

California ranks among the bottom five states on early care and education licensing standards and oversight. The state should better ensure the health and safety of children in early learning programs by increasing the frequency of inspections of licensed early care and education facilities from once every five years to annually.

(4) Establish stronger links among preschool, transitional kindergarten, and kindergarten.

California already is a national leader in aligning early learning and education program and early elementary school standards. This is an important first step toward ensuring what is taught each year in every classroom builds on the previous year and supports all children reading by third grade. The state should continue to take steps to more tightly align preschool, transitional kindergarten, and kindergarten through third grade with regards to curriculum, developmentally-appropriate assessments, data geared to improving instruction, and professional development.

More specifically, California should launch a statewide kindergarten readiness observation and assessment tool that (a) helps parents better support their children's development, (b) informs the instructional practices of preschool, transitional kindergarten, and kindergarten teachers, and (c) provides policymakers a statewide snapshot of overall kindergarten readiness. Currently, the California Department of Education is working on making such a tool, the Desired Results Developmental Profile-School Readiness (DRDP-SR) tool, freely available to school districts statewide by 2014.

(5) Enhance economic and educational opportunity, including introducing a savings account program beginning in infancy.

Children's Savings Accounts are a promising approach to promoting equity in higher education opportunities and breaking the cycle of poverty. Mirroring the best practices of successful local and state Children's Savings Account programs, the money saved from infancy through adulthood could be used to pay for college or vocational training, put a down payment on a home, or provide seed money for self-employment and entrepreneurship. By establishing a Children's Savings Account program, the state would encourage savings, create a pathway to economic self-sufficiency for more children, defray some of the high and increasing cost of college attendance, and increase the college-going rate of California's at-risk children.

K-12 Education

(1) Implement a rational, student-centered, and transparent school finance system.

The distribution of funding for schools through the state's current education finance system is incomprehensible, irrational, and not based on the actual needs of students. The state should reform this system to set a base funding amount for each student and provide additional resources for high-need students. The current categorical system should be dismantled, shifting decision-making locally to encourage innovation, accountability, and the allocation of dollars based on distinct local needs. This could be achieved by greatly simplifying and clarifying how funding is allocated by the state while shifting decision-making to the local level along with robust oversight tools to monitor fiscal and program decisions and outcomes locally, including online access to actual school-level expenditures.

(2) Implement stronger, up-to-date curriculum standards with an aligned assessment and accountability system, including a greater emphasis on Science, Technology, Engineering, and Math.

California has adopted the Common Core State Standards in English language arts and mathematics, which will allow for more accurate state-by-state comparisons of students' knowledge and skills, and the state should also adopt the Next Generation Science Standards in 2013. To further implement these standards and ensure California's testing system is aligned to adequately measure the skills and knowledge necessary for success, the state should reauthorize its assessment program (STAR) in 2013. The reauthorized assessment system should provide school staff with data that can be used to improve instruction, inform parents about their child's progress, and more effectively measure student's problem-solving and complex thinking skills.

With the passage of Senate Bill 1458 (Steinberg, 2012), the state should broaden the definition of accountability, consider ways to incorporate other school climate measures, and move quickly to integrate accurate drop-out and graduation data, as well as other significant college and career indicators into the accountability system. In addition, greater emphasis should be placed on science, which will require the implementation of additional science assessments to ensure appropriate sample sizes for accountability purposes.

(3) Support teaching effectiveness with improved training and a more meaningful evaluation system.

Existing teaching preparation and induction programs must be updated, and substantial new professional development opportunities made available to support teachers and prepare schools for the implementation of Common Core and Next Generation Science Standards. In addition, state policy must be revised to ensure that evaluations are meaningful, objective, support professional development, and contribute to personnel decisions that benefit the state's most disadvantaged and struggling schools and students.

(4) Foster innovation in approaches to the traditional school day and expanded learning time (i.e., afterschool and summer programs) to extend proven programs, such as Linked Learning.

Proven innovations that advance effective teaching and learning should be brought to scale across California. As such, the state should do more to promote the expansion of successful Linked Learning and Expanded Learning approaches.

High-quality Expanded Learning approaches, including afterschool and summer programs, offer students hands-on, inquiry-based, and collaborative learning experiences, and reinforce the knowledge and skills they gain in the classroom with real-world applications. Schools and community partners should work collaboratively to develop a shared vision for expanding learning opportunities for children. In addition, the state should implement policies to support more meaningful integration of community partners in school improvement planning, the implementation of complementary curriculum and instructional strategies, and, where appropriate, professional development and joint data reflection.

Similarly, Linked Learning approaches can enrich the high school experience and make it more relevant by bringing together strong academics, demanding technical education, and real-world experience in industry-themed pathways to better prepare students for college and career. Innovative pilot programs are also working to integrate both Expanded Learning and Linked Learning on high school campuses throughout the state for the benefit of students.

(5) Leverage technology more fully and appropriately to advance academic achievement by revamping the education infrastructure, taking successful blended learning models to scale, and supporting professional development.

California should eliminate the existing policy and regulatory barriers to more broadly applying proven education technology solutions that improve instruction and learning. The state should also build out the 21st century infrastructure needed to fully integrate technology into all educational environments, facilitate learning for today's advanced student assessments and international economy, and support professional development and training in this area.

(6) Address inequitable suspension and expulsion policies and chronic absence.

The state should address inequitable suspension and expulsion policies that result in disproportionate out-of-school suspensions and missed learning time. It should also address chronic absence, which itself is an early predictor of academic distress and dropout. To support districts and communities in addressing these factors, policymakers should reexamine policies in these areas, revising those that needlessly result in the loss of instruction time, elevating the importance of school climate and attendance monitoring, and encouraging the use of "early warning systems" to identify and support struggling students before it is too late.

HEALTH

(1) Expand and strengthen preventive services for at-risk infants and toddlers, including developmental screenings, early intervention, and home visitation.

- Provide developmental screenings for all young children:
  California should promote universal developmental and behavioral screening of infants and toddlers to get more pediatricians, community clinics, and child care centers to work with families to evaluate the developmental progress of young children and provide any necessary follow-up referral, diagnosis, or treatment as early in a child's life as possible.

- Expand evidence-based, voluntary home visiting programs:
  The state should expand the federally-funded California Home Visitation Program, currently underway in 20 counties, so that more vulnerable young children, pregnant mothers, and new parents receive regular visits by a trained professional who provides culturally competent child development information and learning activities, and serves as a general resource for family needs.

- Sustain early intervention programs:
  California should maintain funding for early intervention programs, such as Early Start, and keep out-of-pocket costs low so that families with developmentally-delayed infants and toddlers can get the services and supports their children need.

(2) Provide every child with affordable and comprehensive health insurance coverage.

- Maximize the number of eligible children enrolled in state health insurance programs:
  Roughly 700,000 of the nearly 1.1 million uninsured children in California are currently eligible for Medi-Cal or Healthy Families coverage. The state should answer the national challenge issued by the Obama administration to enroll all eligible children in a health insurance program. To meet this challenge, the state needs to (a) streamline the eligibility and enrollment system for children, (b) reduce "churn" in health coverage programs by making it easier for children to stay covered (e.g., by better automating coverage renewals), and (c) support efforts by providers and community-based organizations to educate families about new coverage opportunities provided by the federal Affordable Care Act and connect children to them.

- Prioritize funding for existing children's health coverage programs:
  The state needs to prioritize the funding of public health insurance programs to ensure that it can support adequate provider networks and timely access to services, so children can get the care these programs are intended to deliver.

- Carefully consolidate coverage programs:
  The state decided to transition all children in the Healthy Families program to Medi-Cal coverage. As this process moves forward in 2013, state administrators must wait to transition children until all Medi-Cal systems are adequately prepared to accept the new children, clearly communicate with families about the changes, improve access to care in the Medi-Cal program, and ensure that no child loses coverage during the transition.

(3) Promote children's timely access to the complete range of critical health care services they need, including preventive screenings, immunizations, dental, mental, vision, and hearing care.

- Improve children's access to oral health care:
  California should pursue all available federal funding opportunities to strengthen existing programs and create new ones to improve the oral health of the state's children, such as Affordable Care Act grant opportunities focused on addressing dental disease prevention, expanding the dental workforce, investing in state infrastructure, and improving dental data collection. The state should also align Medi-Cal dentist reimbursement rates more closely with private dental coverage to improve children's access to pediatric dental care.

  Of all the barriers to children accessing the dental services they need, the greatest may well be a lack of education. If the state incentivized pediatricians to explain the importance of routine pediatric dental care to parents, there likely would be much greater utilization of cost-effective, preventive dental services for children. The state should also expand the use of tele-dentistry to reach underserved child populations, especially those in rural areas, and expand the oral health care workforce so dentists' time can be used more efficiently and more children can access needed services.

- Increase access to preventive screenings and services:
  California should leverage federal dollars from the Affordable Care Act's prevention and public health fund to increase the availability of preventive health care services, such as screenings. In addition, the state should educate the public about the Affordable Care Act section that provides no-cost preventive services.

- Improve the delivery of mental health services to children:
  To help fight the growing, costly, and potentially tragic epidemic of poor mental health among children, the state should require that improvements be made in the delivery, coordination with primary care networks and providers, and follow-up for mental health services provided by the health plans that contract with the state. California should also work expeditiously with counties to effectively leverage all newly available funds generated by the Mental Health Services Act of 2004, emphasizing early intervention programs.

- Increase the percentage of children who receive evidence-based immunizations:
  The state should bolster its immunization programs, including developing an outreach campaign to educate and inform parents about the importance, recommended timing, and availability of immunizations and screenings. The state also should apply for federal grants available through the Affordable Care Act to improve its immunization rates and better support public health.

(4) Establish a tech-savvy "health home" for every child, and expand the number of school-based health centers.

- Leverage available federal funding for health homes:
  A health home is a model for delivering health care in a more accessible, coordinated, and prevention-focused fashion. Its cross-sector approach is particularly effective for children as it supports successful early management of chronic childhood conditions with complex roots, such as diabetes, asthma, attention deficit disorder, and obesity. Health homes show strong potential to create cost-savings for the state and limit children's suffering over a lifetime. The federal Affordable Care Act provides an opportunity for California to develop health homes using 90% federal matching funds. The state has

evaluated this option and now should move forward quickly toward implementing of a child-centered model.

- Utilize the latest technology to make health care more efficient:
  California should ensure all health care systems, including health homes, incorporate technological advances such as electronic health records to deliver the best care to patients and use doctors' time most efficiently.

- Expand the number of school-based health centers:
  Critical social and health services screenings, including dental, vision, and mental health, should occur at schools, including early care and education facilities, where children already spend the majority of their time. The state should implement this common sense reform to dramatically improve children's access and deliver services more efficiently and effectively.

(5) Institute a comprehensive approach to combating childhood obesity, focusing on healthy food and beverage choices, increased physical activity, and nutrition education.

- Centralize the creation of a public policy agenda to address the multitude of factors underlying childhood obesity:
  The factors contributing to childhood obesity – everything from lack of access to healthy food to unhealthy food advertising and unsafe walking routes to school – are numerous and interrelated in complex ways. Informed prioritization of the broad range of variables contributing to childhood obesity is needed at the state level to determine where and how policymakers should direct their focus.

- Support a state tax on sweetened beverages:
  Taxing sweetened beverages would help reduce dental decay and obesity by reducing consumption, and would create a significant amount of revenue dedicated to funding prevention and treatment efforts for California's children.

- Offer students healthy food and beverage choices:
  All school districts should comply with existing federal rules for school lunch nutrition and advocate for stronger standards. They should also implement recent legislation to provide students access to free, fresh drinking water during meal times in school food service areas to promote water consumption. Nutrition could also be improved through school-based community gardens and enrollment in free or reduced-price meal programs in school or community venues.

- Increase physical activity during and after school:
  California should implement policies to ensure students will spend at least 50% of physical education class time engaged in moderate to vigorous physical activity. Additionally, the federal Affordable Care Act includes funding for community-based childhood obesity prevention projects that could be used to promote increased physical activity in these and other ways.

- Better educate students about healthy eating:
  The state should immediately restart the adoption process for the health curriculum framework and ensure the inclusion of research-based nutrition education.

INTEGRATED SERVICES

(1) Institute a Children's Coordinating Council.

A state-level Children's Coordinating Council should be established, comprised of the heads of each agency and department that serves children's well-being, including the Superintendent of Public Instruction. The Council should be charged with prioritizing the health, education, and overall well-being of all children and promoting information sharing, collaboration, increased efficiency, and improved service delivery among the state's child-serving agencies and organizations.

(2) Establish a comprehensive, longitudinal interagency data system.

The state should connect and make use of data covering early learning and development through higher education, health, juvenile justice, child welfare, and workforce indicators in order to better track, address, and improve the health, education, and overall well-being of children throughout their lives.

(3) Develop eligibility and enrollment standards and outcome measures to be used across agencies.

The state should develop eligibility and enrollment standards across all income-based children's programs and facilitate more effective inter-agency cooperation. The state should also identify benchmark goals for the many interrelated aspects of children's well-being from cradle to career. Using these goals, agencies that provide services to children should work together more closely to report on children's outcomes in a manner that is accessible and informative to the public and policymakers.

CHILD WELFARE

(1) Hold local governments accountable for child welfare realignment outcomes.

While the state's decision to shift more control over certain public services to the local level, which is known as "realignment," has the potential to improve child welfare outcomes by giving distinct communities needed flexibility in tuning their approaches, it also includes substantial risks associated with funding, equity among counties, and accountability for outcomes. To address these risks, the state should closely monitor and evaluate the impact of child welfare realignment to ensure sufficient funding, high standards of care, and parity for all children across California.

(2) Strengthen and expand prevention, early intervention, and at-home services.

California should support a statewide prevention program for children and families at risk. This program would promote prevention, early intervention, and at-home services, with the goals of keeping children safe, supporting families as they learn to care for their children successfully, and saving children from the trauma of being removed from their homes and families when possible. The state should streamline court practices when

children are at risk of removal from their homes/families and allow more coordination between dependency courts and other agencies to ensure families with multiple contributing issues, such as substance abuse and mental health, are receiving well-coordinated services and interventions.

(3) Prioritize stability and permanence.

The state should support policies that encourage successful family reunification. Youth who enter the foster care system have been exposed to abuse or neglect, are traumatized by being removed from their homes, and often end up being moved to multiple placements, thus losing the chance to form meaningful connections. Providing the resources and supports necessary to ensure that these vulnerable children can heal and thrive within their communities should be a top priority. The state should prioritize sibling placements and family maintenance services after reunification.

(4) Ensure foster youth aging out of the system have access to education, health care, and other services.

The state should ensure that foster youth have access to health care, employment, and quality education upon leaving the child welfare system. The state should apply for a federal waiver and enact legislation to allow former foster care youth to receive healthcare benefits until the age of 26 in order to mirror provisions in the Affordable Care Act that allow young adults to stay on their parents' policies until that age.