



Health and Human Services Policy Committee
Wednesday, April 13, 2016 — 12:00 – 1:00 p.m.
CSAC 1st Floor Peterson/Wall Conference Room
1100 K Street, Suite 101, Sacramento, CA 95814
Call-in: 1-800-867-2581; Passcode 7500559#

Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair

- 12:00 p.m. I. **Welcome and Introductions**
Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair
- 12:05 p.m. II. **Legislative Update: Soda Tax and Tobacco Legislation**
Farrah McDaid Ting, Legislative Representative, CSAC
Elizabeth Marsolais, Legislative Analyst, CSAC
- 12:20 p.m. III. **2020 Medicaid Waiver Update & Opportunities**
Kelly Brooks-Lindsey, Partner, HBE Advocacy
- 12:35 p.m. IV. **Budget Update: Maximum Family Grant, AB 403, Others**
Farrah McDaid Ting, Legislative Representative, CSAC
Elizabeth Marsolais, Legislative Analyst, CSAC
- 12:50 p.m. V. **Homelessness Issues Update**
Farrah McDaid Ting, Legislative Representative, CSAC
Elizabeth Marsolais, Legislative Analyst, CSAC
- 1:00 p.m. VI. **Closing Comments and Adjournment**
Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair

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



April 7, 2016

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To: Members of the Health and Human Services Policy Committee

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

RE: Legislative Update: Tobacco Legislation Update and More

Tobacco Legislation Still in Limbo

The CSAC Policy Committee adopted a SUPPORT position on a raft of tobacco control measures heard in the Second Extraordinary Session on Health Care (Special Session) over the past nine months. All of the bills have now cleared both the Senate and Assembly, and the special session has adjourned.

However, these bills have not yet been transmitted to the Governor's desk, pending a direct threat from the tobacco industry of mounting a statewide initiative campaign to overturn the proposed measures. So they are parked in enrollment, a little-used purgatory of sorts between the Legislature and the Governor, to stall any move by the industry to overturn them. As of this writing, all of the measures remain in enrollment and the feasible date to introduce and gather signatures for a new statewide ballot measure has essentially passed. The deadline for all measures to qualify for the fall 2016 ballot is June 30.

Tobacco Legislation Update		As of April 8, 2016		
Bill Number	Author	Description	CSAC Position	Location
SBX2 5	Senator Mark Leno	Adds e-cigarettes and vaping products to the existing definitions of tobacco products.	Support	Enrolled; not yet transmitted to Governor
SBX2 7	Senator Ed Hernandez	Increases the age of sale for tobacco products from 18 years of age to 21.	Support	Enrolled; not yet transmitted to Governor
ABX2 7	Assembly Member Mark Stone	Closes loopholes in smoke-free workplace laws. CSAC sought amendments clarifying that the requirements of the bill would only apply to owner-operated business where there is interaction with the public.	Support if Amended	Enrolled; not yet transmitted to Governor
ABX2 9	Assembly Member Tony Thurmond	Closes existing school tobacco regulation loopholes and expands eligibility for Tobacco Use Prevention and Education program funding to charter schools.	Support	Enrolled; not yet transmitted to Governor
ABX2 10	Assembly Member Richard Bloom	Allows a county to impose a tax on the privilege of distributing cigarettes and tobacco products.	Support	Enrolled; not yet transmitted to Governor
ABX2 11	Assembly Member Adrin Nazarian	Establishes an annual Board of Equalization tobacco licensing fee program, similar to how alcohol is licensed.	Support	Enrolled; not yet transmitted to Governor

Other Legislative Items of Interest

CSAC is tracking more than 500 Health and Human Services-related bills this session. Below is a sampling of some of the bills that are causing concern and on which CSAC staff is diligently working. You will see many "PENDING" positions on these bills – this simply means that CSAC staff is engaged with the authors, sponsors, policy committee consultants, stakeholders, and CSAC affiliates concerned with the bill.

AB 1997 (Stone) – SUPPORT IN CONCEPT

As Amended on April 5, 2016

AB 1997 is the follow-up legislation to last year's landmark AB 403, the Continuum of Care Reform (CCR) bill to abolish the current group foster home landscape in favor of more family placements for foster youth, decreased stays in congregate care, and providing the right care and service supports to child and probation foster youth in family-based settings.

Sponsored by the California Department of Social Services, AB 1997 promises to be lengthy. CSAC, along with several CSAC Affiliates – including the County Welfare Directors Association, the County Behavioral Health Directors Association and the Chief Probation Officers Association – is engaged with the Department on technical changes and cleanup in an effort to smooth implementation, only eight short months away (January 1, 2017).

AB 403 funding issues are being handled in the state budget process. CSAC will continue to work collaboratively to help implement this landmark reform. AB 1997 will be heard by the Assembly Human Services Committee on April 12.

AB 1836 (Maienschein) – OPPOSE

As Amended on March 31, 2016

AB 1836 is a redux of last year's AB 197, also by Assembly Member Maienschein and that was vetoed by the Governor last fall. It would increase county costs by authorizing a Probate Court to recommend a Lanterman-Petris-Short Act (LPS) conservatorship to a county conservatorship officer and compel that officer to conduct an investigation and submit a report to the Probate Court.

CSAC is concerned that the bill compels the conservatorship officer to conduct a conservatorship investigation and report back to the Probate Court on its findings, which will increase the number of LPS conservatorship referrals and significantly increase county general fund costs. AB 1836 also bypasses the established mental health system and gives probate judges the same authority over mental health evaluations as mental health practitioners.

AB 1836 was placed on the Assembly Appropriations Committee Suspense File last week. The Author continues to engage with CSAC in the hopes of developing a solution that addresses his real concern for those who may be slipping through the cracks of the Probate Court system. For now, CSAC is working closely with him but continues to oppose this version of the bill.

AB 1737 (McCarty) Child Death and Review Teams – NEUTRAL
As Introduced on February 1, 2016

AB 1737, by new Assembly Member Kevin McCarty, would require all counties to establish an interagency child death review team (CDRT) to assist local agencies in identifying and reviewing suspicious child deaths.

Currently, counties may establish CDRTs, but are not required to do so. CSAC is NEUTRAL on AB 1737, as we support the investigation, and especially the prevention, of child injuries or deaths, but is also gathering more information on the potential cost for counties that do not currently have a child death review team.

Should AB 1737 become law, it will be a new mandate and all counties – including ones that do not currently have a CDRT as well as those that have operated them voluntarily – that incur at least \$1000 in new costs will be eligible to submit a mandate claim under the existing SB 90 process. AB 1737 was passed by the Assembly Local Government Committee, and has not yet been set for a hearing by the Assembly Appropriations Committee.

AB 1300 (Ridley-Thomas) – OPPOSE
As Amended on March 15, 2016

CSAC, along with the County Behavioral Health Directors Association and the National Alliance for Mental Illness – who represent the family members of those suffering from mental illness – strongly opposed AB 1300 last year.

AB 1300 would have made over 80 technical changes to the Lanterman Petris-Short (LPS) Act – commonly referred to as the 5150 process– concerning the involuntary commitment to a mental health institution in California. The California Hospital Association has pushed changes to involuntary commitment over the past several years, and while counties acknowledge that persons can be waiting for long periods of time in emergency rooms to receive treatment, we did not believe the bill includes solutions to that problem and instead would have the effect of releasing people without providing treatment.

The bill was amended last month, and CSAC staff is engaged with the Author and California Hospital Association on the new version, with meetings scheduled on April 15. The bill will likely be heard by the Senate Health Committee in June.

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April 8, 2016

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To: Members of the Health and Human Services Policy Committee

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

RE: Legislative Update: Details Emerge on Soda Tax Bill

Since the March 9, 2016, HHS Policy Committee meeting, details on the proposed soda tax bill, AB 2782, have emerged. This bill reintroduces last year's proposed soda tax (AB 1357, also by Assembly Member Bloom), which failed to pass out of the Assembly Health Committee, where AB 2782 is scheduled to be heard on Tuesday, April 12. CSAC will be prepared with an update for the April 13 HHS Policy Committee meeting on the outcome of the Assembly Health Committee. Due to timing, CSAC is recommending a support position if the bill is passed out of the Assembly Health Committee.

Overview. AB 2782 would propose a 2-cent per ounce "health impact fee" on bottled sweetened beverages at the distributor level. Revenues from the fee would go into the Healthy California Fund, which would then distribute the funding to the Department of Public Health (DPH), the Department of Education, the Department of Food and Agriculture, and the Department of Health Care Services (DHCS). The departments would then use regular and competitive grant processes to provide funding to counties, cities, nonprofits, community-based organizations, and licensed clinics. The grant funding would be used to invest in childhood obesity and diabetes prevention activities, safe drinking water, and oral health programs.

Allocation of the Fund. The money in the Healthy California Fund will be distributed in the following manner:

- 51% of the funds are allocated to DPH:
 - 27% of these funds are to be used to develop and administer a regular grant program to all county and city health departments, or their nonprofit designee, seeking to invest in obesity diabetes, and dental disease prevention activities. Funds from this source will be distributed in a reasonable proportion for prevention activities across the three chronic diseases and pursuant to existing Target Population Funding Criteria.
 - 28% of these funds are to be used to develop and administer a competitive grant program for nonprofit and community based organizations seeking to invest in obesity, diabetes, and dental disease prevention activities.
 - Between 15-20% of these funds are to be used to support nonprofit organizations working statewide.
 - At least 8% of the funds are to be used for statewide priority population leadership networks, including African American, Hispanic, American Indian and Alaska Native, Asian American, Native Hawaiian and Pacific Islander and low socioeconomic status populations.
 - 28% of these funds are to be used to develop and administer a competitive grant program for clinics. Funds are to be used for direct services and supporting programs that use culturally and linguistically appropriate educational and other public health approaches that raise awareness of the importance of nutrition and physical activity in preventing childhood obesity, diabetes, and dental disease.
 - 7% of these funds are to go to DPH or its nonprofit partners for statewide advertising and media campaigns.

- 10% of these funds are to go to DPH to include technical assistance to potential grantees and its prevention activities.
 - No more than 3% of these funds may be used for administering the Healthy California Fund.
 - A minimum of 3% of these funds are to be used for independent evaluation.
 - 1% of these funds are to be subgranted to California-based public universities or nonprofits to strengthen chronic disease surveillance.
 - 3% of these funds go to DPH's Oral Health Program.
- 4% of these funds are allocated to DHCS for the Expanded Access to Primary Care, Rural Health Services Development, Health of Seasonal Agricultural Migratory Workers, and Indian Health Programs to support culturally and linguistically appropriate clinic-based obesity and diabetes prevention and related disease management.
 - No more than 3% may be used for department administrative costs.
- 25% to the Department of Education
 - No more than 3% may be used for department administrative costs.
 - 28% to administer a competitive grant program for school districts for promoting physical activity.
 - 31% to administer a competitive grant program for school districts for promoting improved nutrition and access to healthy food and beverages.
 - 14% to the California Farm to School Program, administered by the Department of Education.
 - 24% to administer a competitive grant program for school districts for ensuring access to clean drinking water throughout the schoolday.
- 20% to the Department of Food and Agriculture
 - No more than 3% may be used for department administrative costs.
 - The Office of Farm to Fork to administer a competitive grant program to aide community food producers or socially disadvantaged, beginning, military veteran, or limited resource specialty crop producers that improve the health and resilience of their communities by increasing access to any variety line of fresh, canned, dried, or frozen whole or cut fruits and vegetables without added sugars, fats or oils, and salt.

Board Composition. The Healthy California Fund Oversight Committee would be established to advise DPH, DHCS, the Department of Education, and the Department of Food and Agriculture regarding policy development, integration, and evaluations of the program funded by the Healthy California Fund. The Committee will also develop a master plan for the future implementation of diabetes, obesity, and dental disease prevention programs. Committee members will serve for a term of three years, with up to two consecutive terms. The Committee will be composed of:

- Two members representing nonprofit public health organizations
- One member representing an organization that represents the health center community
- One member of a professional education association, such as an association of teachers
- One representative of a professional dental organization, a nonprofit dental health organization, or representing an organization dedicated to dental disease prevention
- One member of a university faculty with expertise in programs intended to promote healthy eating, active living, and diabetes and obesity prevention
- Two representatives of a target population group
- One representative of DPH
- One representative of DHCS
- One representative of the Department of Food and Agriculture
- One representative of the Department of Education

- One representative of local health departments

Sponsors. AB 2782 has multiple sponsors, listed below:

- American Diabetes Association
- American Heart Association
- Asian Pacific Partners for Empowerment, Advocacy & Leadership
- California Black Health Network
- California Dental Association
- California Primary Care Association
- California Rural Indian Health Board
- California School-Based Health Alliance
- Latino Coalition for a Healthy California
- Public Health Institute
- Roots of Change

Support. An expansive list of supporters can be found in the attached fact sheet. Notably, a few CSAC affiliates are in support of the bill, such as the County Health Executives Association of California (CHEAC).

Relevant CSAC Policy. Excerpted from the CSAC Platform 2015-16, Chapter Six: Health Services

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...Furthermore, counties play an integral role in chronic disease prevention through policy, system and environmental changes promoting healthier communities."

Attachments:

Fact Sheet. AB 2782 (Bloom). April 6, 2016 version.
AB 2782 Bill Text, as amended on March 30, 2016.

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AB 2782 (Bloom)
Sugar Sweetened Beverage Health Impact Fee
Fact Sheet

PURPOSE

To create the Healthy California Fund and provide funding for childhood obesity and diabetes prevention activities as well as oral health programs. The fund will also provide funding to improve access to physical education and clean drinking water in schools.

SUMMARY

AB 2782 would establish a \$0.02 per fluid ounce health impact fee on sugar sweetened beverages at the distributor level. The revenues from this fee would be collected in the Healthy California Fund, which would distribute the funding to the Department of Public Health, Department of Education, the Department of Food and Agriculture, and the Department of Health Care Services. These departments will use both regular and competitive grant processes to provide funding to counties, cities, nonprofit organizations, community-based organizations, and licensed clinics to invest in childhood obesity and diabetes prevention activities, safe drinking water and oral health programs.

EXISTING LAW

Currently, there are no state funds reserved for diabetes prevention. The California Department of Public Health (DPH) is responsible for administering the State's diabetes prevention programs. DPH's diabetes prevention efforts are funded through grants from the federal Centers for Disease Control and Prevention. Although the number of Californians with diabetes has increased significantly over the past decade, DPH received 22% less federal funding for diabetes prevention in fiscal year 2013-14. At a funding level of 3 cents per capita, California has the lowest per capita funding for diabetes prevention in the nation.

BACKGROUND

Soda and other sugar sweetened beverages are the number one source of added sugar in the American diet, and are linked to increased risk of diabetes as well as diseases such as heart and liver disease, obesity, and tooth decay. Studies have shown that the number of people diagnosed with diabetes in California has jumped 50 percent between 2001 and 2012. Unless the trend is reversed, one in three of

our children born after 2000 – and half of Latino and African American children – will go on to develop Type 2 Diabetes in their lifetimes. Moreover, the California obesity rate has skyrocketed from nine percent in 1984 to over 25 percent today and is projected to increase to 47 percent by 2030. Diabetes alone adds an extra 1.6 billion dollars every year to state hospitalization costs – money which would be better invested in preventive health and education.

Scientific studies have concluded that a major contributor to the dramatic increase in diabetes and obesity rate is increased consumption of sugar sweetened beverages. Americans today consume nearly 300 more calories per day than 30 years ago and up to 43% of that caloric increase comes from the consumption of sugar-sweetened beverages.

AB 2782 confronts these negative health impacts head on by creating a revenue source to fund programs that educate communities on the dangers of over consumption of sugar-sweetened beverages and provide tools and resources for healthy alternatives. The fund will be used to award grants to counties, cities, nonprofit organizations, community-based organizations, and licensed clinics that seek to invest in obesity and diabetes prevention activities and oral health programs.

SUPPORT

American Diabetes Association (sponsor)
American Heart Association (sponsor)
Asian Pacific Partners for Empowerment, Advocacy & Leadership (sponsor)
California Black Health Network (sponsor)
California Dental Association (sponsor)
California Primary Care Association (sponsor)

California Rural Indian Health Board (sponsor)
California School-Based Health Alliance (sponsor)
Latino Coalition for a Healthy California (sponsor)
Public Health Institute (sponsor)
Roots of Change (sponsor)

AFSCME, District Council 36
United Food & Commercial Workers Union
SEIU California
Alchemist Community Development Corporation
American Academy of Pediatrics
Agriculture and Land-Based Training Association
Asian Pacific Islander Obesity Prevention Alliance
Children Now
California Chronic Care Coalition
CA Food Access Coalition
CA Food Policy Advocates
Ecology Center
Farmers Guild
Health Trust
Long Beach Fresh
Los Angeles Trust for Children's Health
National Hmong American Farmers
Public Health Institute
CA School Nurses Organization
California Pan-Ethnic Health Network
Mathiesen Memorial Health Clinic
Southeast Asia Resource Action Center
Street Level Health Project
CA Rural Legal Assistance Foundation
Community Clinic Consortium
Mountain Valleys Health Centers
Alliance for Rural Community health
North East Medical Services
Health and Life Organization
Vision y Compromiso
Sonoma County Indian Health Project
ACT for Women and Girls
Sacramento Native American Health Center
Altamed
North Coast Clinics Network
Kheir Center
San Ysidro Health Center
Dignity health
Tiburcio Vasquez Health Center

Version: 4/6/2016

AMENDED IN ASSEMBLY MARCH 30, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2782

**Introduced by Assembly Member Bloom
(Coauthors: Assembly Members Chiu and Wood)**

February 19, 2016

~~An act to amend Section 104655 of the Health and Safety Code, relating to nutrition. An act to add Chapter 5 (commencing with Section 104895.50) to Part 3 of Division 103 of the Health and Safety Code, relating to public health.~~

LEGISLATIVE COUNSEL'S DIGEST

AB 2782, as amended, Bloom. ~~Healthy food.~~ *Healthy California Fund.*

Existing law provides for various programs that prevent disease and promote health.

This bill, subject to specified exemptions, would impose a fee on every distributor, as defined, for the privilege of distributing in this state bottled sweetened beverages, at a rate of \$0.02 per fluid ounce and for the privilege of distributing concentrate in this state, either as concentrate or as sweetened beverages derived from that concentrate, at the rate of \$0.02 per fluid ounce of sweetened beverage to be produced from concentrate. The Board of Equalization would be responsible for administering and collecting the fee and registering the distributors upon whom the fee is imposed. These amounts would be deposited into the Healthy California Fund, created by the bill. The bill would require moneys in the fund, upon appropriation by the Legislature, to be allocated to the State Department of Public Health, the State Department of Health Care Services, the Department of

Education, and the Department of Food and Agriculture, as specified, for various purposes related to statewide diabetes and childhood obesity treatment and prevention activities and programs, including awarding competitive grants to local governments, nonprofit organizations, school districts, and other entities for activities in support of the bill's objectives. This bill would also authorize the State Public Health Officer, the Director of Health Care Services, the Superintendent of Public Instruction, and the Secretary of Food and Agriculture to establish regulations and provide procedural measures to bring into effect those purposes.

The bill would create the Healthy California Fund Oversight Committee, to advise the affected state departments in implementing the bill's requirements. Among other requirements, the committee would evaluate programs and interventions funded under the bill and report to the Legislature annually regarding programs funded by the Healthy California Fund. The committee would produce a comprehensive master plan for implementing diabetes and obesity prevention programs throughout the state, increase healthy eating and active living, reduce food insecurity, and promote sustainable, healthy, resilient communities.

This bill would require the State Department of Public Health, in consultation with the other participating departments, to prepare and adopt an annual program budget, as specified. The bill would establish the Children and Family Health Promotion Administration Account within the fund, to be used, upon appropriation by the Legislature, to reimburse expenditures by the State Department of Public Health in administering and implementing the activities required by the bill, and to repay specified loans from other funds.

This bill would make legislative findings and declarations relating to the consumption of sweetened beverages, diabetes, childhood obesity, and dental disease.

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $\frac{2}{3}$ of the membership of each house of the Legislature.

~~Existing law requires the State Department of Public Health to establish and implement the 5 A Day—For Better Health program to promote public awareness of the need to eat more fruits and vegetables in order to improve health and prevent major chronic diseases. Existing law provides that nothing shall operate to prohibit contributions to the~~

program by certain marketing organizations and commissions subject to specified provisions:

~~This bill would make technical, nonsubstantive changes to this provision:~~

Vote: ~~majority~~^{2/3}. Appropriation: no. Fiscal committee: ~~no~~^{yes}. State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 **SECTION 1.** *The Legislature finds and declares as follows:*
2 *(a) Over 2.3 million California adults report have been*
3 *diagnosed with diabetes, representing one out of every 12 adult*
4 *Californians. The vast majority of diabetes cases in California are*
5 *type II, affecting 1.9 million adults.*
6 *(b) According to the State Department of Public Health, diabetes*
7 *is the seventh leading cause of death in California and has been*
8 *determined to be the underlying cause of death for almost 8,000*
9 *people each year.*
10 *(c) Adults with type II diabetes more often have other health*
11 *problems. Half of adults with type II diabetes also have*
12 *hypertension. This rate of occurrence is twice as high as for those*
13 *without diabetes. Adults with diabetes are also twice as likely to*
14 *have cardiovascular disease than adults without diabetes.*
15 *(d) Adults with diabetes are 50 percent more likely to have*
16 *arthritis than adults without diabetes. Over 40 percent of new*
17 *cases of kidney failure are attributed to diabetes. New cases of*
18 *kidney failure declined slightly from 2001 to 2007, but began to*
19 *increase again after 2007.*
20 *(e) Hispanics, African Americans, American Indians, Alaska*
21 *Natives, Asian Americans, Native Hawaiians, and Pacific Islanders*
22 *have a higher prevalence of type II diabetes than non-Hispanic*
23 *whites. Hispanics and African Americans have two times higher*
24 *prevalence: 7 percent of non-Hispanic Whites have type II diabetes,*
25 *compared with 12 percent of Latinos, 9 percent of Asian*
26 *Americans, 14 percent of Pacific Islander Americans, 13 percent*
27 *of African Americans, and 17.5 percent of American Indian and*
28 *Alaska Native populations. In some populations, type II diabetes*
29 *remains undiagnosed. For example, more than half of Asian*
30 *Americans with type II diabetes, and even more Asian Americans*
31 *with prediabetes, are undiagnosed. Nationally, the lifetime risk of*

1 *developing diabetes is now 40 percent, or 2 of every 5 adults, and*
2 *exceeds 50 percent for Hispanic men and women and non-Hispanic*
3 *black women. If trends are not reversed, it is predicted that 40*
4 *percent of Americans and nearly half of Latino and African*
5 *American children born in the year 2000 will develop type II*
6 *diabetes in their lifetime.*

7 *(f) The prevalence of obesity in the United States has increased*
8 *dramatically over the past 30 years. In California, obesity rates*
9 *have increased even more, rising from 8.9 percent in 1984 to 23.8*
10 *percent in 2011. Although no group has escaped the epidemic,*
11 *low-income populations and communities of color are*
12 *disproportionately affected.*

13 *(g) The rate of children who are overweight has also increased*
14 *dramatically in recent decades. In 2010, 38 percent of California*
15 *children in grades 5, 7, and 9 were overweight or obese. Thirty-one*
16 *of California's 58 counties experienced an increase in childhood*
17 *obesity from 2005 to 2010.*

18 *(h) In 2006, overweight and obesity-related health costs in*
19 *California were estimated at almost \$21 billion. The cost of health*
20 *care alone for diabetes in California in 2010 is estimated to have*
21 *been \$13 billion.*

22 *(i) There is overwhelming evidence of the link between obesity,*
23 *diabetes, and heart disease and with the consumption of sweetened*
24 *beverages, including soft drinks, energy drinks, sweet teas, and*
25 *sports drinks. California adults who drink one or more per day*
26 *are 27 percent more likely to be overweight or obese, regardless*
27 *of income or ethnicity.*

28 *(j) According to nutritional experts, sweetened beverages, such*
29 *as soft drinks, energy drinks, sweet teas, and sports drinks, offer*
30 *little or no nutritional value, but massive quantities of added*
31 *sugars. A 20-ounce bottle of soda contains the equivalent of*
32 *approximately 16 teaspoons of sugar, yet the American Heart*
33 *Association recommends that Americans consume no more than*
34 *five to nine teaspoons of sugar per day.*

35 *(k) Research shows that almost half of the extra calories*
36 *Americans consume in their diet comes from sugar-sweetened*
37 *beverages, with the average American drinking nearly 50 gallons*
38 *of sugar-sweetened beverages a year, the equivalent of 39 pounds*
39 *of extra sugar every year.*

1 *(l) Research shows that 41 percent of California children from*
2 *2 to 11 years of age, inclusive, and 62 percent of California teens*
3 *from 12 to 17 years of age, inclusive, drink soda daily, and for*
4 *every additional serving of sweetened beverage that a child*
5 *consumes per day, the likelihood of the child becoming obese*
6 *increases by 60 percent.*

7 *(m) Sugary drinks are a unique contributor to excess caloric*
8 *consumption. A large body of research shows that calories from*
9 *sugary drinks do not satisfy hunger the way calories from solid*
10 *food or beverages containing fat or protein do, such as those*
11 *containing milk and plant-based proteins. As a result, sugary*
12 *beverages tend to add to the calories people consume rather than*
13 *replace them.*

14 *(n) Dental caries, commonly referred to as tooth decay, is the*
15 *most common chronic childhood disease, and by third grade tooth*
16 *decay affects almost two-thirds of the children in California.*
17 *Twenty-eight percent of elementary school children— some*
18 *750,000— have untreated tooth decay. Dental disease caused by*
19 *tooth decay is linked to broader health problems, including*
20 *cardiovascular disease, strokes and diabetes. It can lead to serious*
21 *health, developmental, and social concerns, as well as significantly*
22 *increased cost of restorative care and reliance on high-cost health*
23 *care settings like hospital emergency departments.*

24 *(o) Research shows that low income and minority populations*
25 *disproportionately feel the burden of tooth decay, as low-income*
26 *children suffer twice as much from dental disease as those from*
27 *higher income families, and their disease is more likely to be*
28 *untreated. Nationally, 32 percent of Latino children and 28 percent*
29 *of African American children have untreated tooth decay,*
30 *compared to only 18 percent of white children. Pain and infection*
31 *from untreated tooth decay impairs concentration and learning in*
32 *students and leads to missed schooldays.*

33 *(p) Sugar is the primary and necessary factor in the development*
34 *of tooth decay. In addition to sugar, the acids found in beverages*
35 *like soda, energy drinks, and juice erode tooth enamel, making*
36 *sweetened beverage consumption one of the most significant*
37 *contributors to dental caries in children. Children from families*
38 *of low socioeconomic status have a significantly higher*
39 *consumption of soda and other types of sugary beverages.*

1 (g) *It is the intent of the Legislature in creating the Healthy*
2 *California Fund to diminish the human and economic costs of*
3 *diabetes, obesity, heart disease, and dental disease in California.*
4 *The fund is intended to create a dedicated revenue source for*
5 *health, education, and wellness programs designed to prevent and*
6 *treat obesity, diabetes, and heart and dental disease and to reduce*
7 *the burden of attendant health conditions that result from the*
8 *overconsumption of sugar-sweetened beverages.*

9 SEC. 2. *Chapter 5 (commencing with Section 104895.50) is*
10 *added to Part 3 of Division 103 of the Health and Safety Code, to*
11 *read:*

12
13 *CHAPTER 5. HEALTHY CALIFORNIA FUND*
14

15 *104895.50. The following definitions shall apply for purposes*
16 *of this chapter:*

17 (a) (1) *“Beverage for medical use” means a beverage suitable*
18 *for human consumption and manufactured for use as an oral*
19 *nutritional therapy for persons who cannot absorb or metabolize*
20 *dietary nutrients from food or beverages, or for use as an oral*
21 *rehydration electrolyte solution for infants and children formulated*
22 *to prevent or treat dehydration due to illness.*

23 (2) *“Beverage for medical use” includes a “medical food.”*
24 *Consistent with Section 5(b)(3) of the Orphan Drug Act (Public*
25 *Law 97-414; at 21 U.S.C. 360ee(b)(3)), “medical food” means a*
26 *food that is formulated to be consumed or administered enterally*
27 *under the supervision of a physician and that is intended for the*
28 *specific dietary management of a disease or condition for which*
29 *distinctive nutritional requirements, based on recognized scientific*
30 *principles, are established by medical evaluation.*

31 (3) *“Beverage for medical use” does not include drinks*
32 *commonly referred to as “sports drinks,” or any other derivative*
33 *or similar terms.*

34 (b) *“Board” means the State Board of Equalization.*

35 (c) *“Bottle” means any closed or sealed container, regardless*
36 *of size or shape, including, without limitation, those made of glass,*
37 *metal, paper, plastic, or any other material or combination of*
38 *materials.*

39 (d) *“Bottled sugar-sweetened beverage” means any*
40 *sugar-sweetened beverage contained in a bottle that is ready for*

1 consumption without further processing, such as dilution or
2 carbonation.

3 (e) "Caloric sweetener" means any caloric substance suitable
4 for human consumption that humans perceive as sweet, including,
5 but not limited to, sucrose, fructose, glucose, fruit juice
6 concentrate, or other sugars. "Caloric sweetener" excludes
7 noncaloric sweeteners. For purposes of this definition, "caloric"
8 means a substance that adds calories to the diet of a person who
9 consumes that substance.

10 (f) "Consumer" means a person who purchases a
11 sugar-sweetened beverage for consumption and not for sale to
12 another.

13 (g) "Distributor" means any person, including a manufacturer
14 or wholesale dealer, who receives, stores, manufactures, bottles,
15 or distributes bottled sugar-sweetened beverages, syrups, or
16 powders for sale to retailers doing business in the state, or any
17 combination of these activities, whether or not that person also
18 sells those products to consumers.

19 (h) "Fund" means the Healthy California Fund.

20 (i) "Milk" means natural liquid milk, regardless of animal or
21 plant source or butterfat content, natural milk concentrate, whether
22 or not reconstituted, or dehydrated natural milk, whether or not
23 reconstituted.

24 (j) "Natural fruit juice" means the original liquid resulting
25 from the pressing of fruits, or the liquid resulting from the dilution
26 with water of dehydrated natural fruit juice.

27 (k) "Natural vegetable juice" means the original liquid resulting
28 from the pressing of vegetables, or the liquid resulting from the
29 dilution with water of dehydrated natural vegetable juice.

30 (l) "Noncaloric sweetener" means any noncaloric substance
31 suitable for human consumption that humans perceive as sweet,
32 including, but not limited to, aspartame, acesulfame-K, neotame,
33 saccharin, sucralose, and stevia. "Noncaloric sweetener" excludes
34 caloric sweeteners. For purposes of this definition, "noncaloric"
35 means a substance that contains fewer than five calories per
36 serving.

37 (m) "Person" means a natural person, partnership, cooperative
38 association, limited liability company, corporation, personal
39 representative, receiver, trustee, assignee, or other legal entity.

1 (n) "Place of business" means any place where sugar-sweetened
2 beverages, syrups, or powders are manufactured or received for
3 sale in the state.

4 (o) "Powder" means any solid mixture of ingredients used in
5 making, mixing, or compounding sugar-sweetened beverages by
6 mixing the powder with one or more other ingredients, including,
7 but not limited to, water, ice, syrup, simple syrup, fruits, vegetables,
8 fruit juice, vegetable juice, or carbonation or other gas.

9 (p) "Retailer" means any person who sells or otherwise
10 dispenses in the state a sugar-sweetened beverage to a consumer
11 whether or not that person is also a distributor.

12 (q) "Sale" means the transfer of title or possession for valuable
13 consideration, regardless of the manner by which the transfer is
14 completed.

15 (r) "State" means the State of California.

16 (s) (1) "Sugar-sweetened beverage" means any nonalcoholic
17 beverage, carbonated or noncarbonated, that is sold for human
18 consumption and contains added caloric sweetener. As used in
19 this subdivision, "nonalcoholic beverage" means any beverage
20 that contains less than one-half of 1 percent alcohol per volume.

21 (2) "Sugar-sweetened beverage" does not include any of the
22 following:

23 (A) Bottled sugar-sweetened beverages, syrups, and powders
24 sold to the United States government and American Indian tribal
25 governments.

26 (B) Bottled sugar-sweetened beverages, syrups, and powders
27 sold by a distributor to another distributor that is registered
28 pursuant to Section 104895.58 if the sales invoice clearly indicates
29 that the sale is exempt. If the sale is to a person who is both a
30 distributor and a retailer, the sale shall also be fee-exempt and
31 the fee shall be paid when the purchasing distributor or retailer
32 resells the product to a retailer or a consumer. This exemption
33 does not apply to any other sale to a retailer.

34 (C) Beverages sweetened solely with noncaloric sweeteners.

35 (D) Beverages consisting of 100 percent natural fruit or
36 vegetable juice, with no added caloric sweetener.

37 (E) Beverages in which milk, or soy, rice, or similar milk
38 substitute, is the primary ingredient or the first listed ingredient
39 on the label of the beverage.

1 (F) Beverages with fewer than five grams of added sugar or
2 other caloric sweeteners per 12 ounces.

3 (G) Coffee or tea without added caloric sweetener.

4 (H) Infant formula.

5 (I) Beverages for medical use.

6 (J) Water without any caloric sweetener.

7 (t) "Syrup" means a liquid mixture of ingredients used in
8 making, mixing, or compounding sugar-sweetened beverages using
9 one or more other ingredients, including, but not limited to, water,
10 ice, powder, simple syrup, fruits, vegetables, fruit juice, vegetable
11 juice, carbonation, or other gas.

12 (u) "Water" includes nonflavored water, or water flavored with
13 noncaloric "natural fruit essence" or "natural flavor." The source
14 of the water may be artesian, mineral, spring, or well. The type of
15 water may also include carbonated, such as sparkling, club, or
16 seltzer, and still, distilled, or purified, such as demineralized,
17 deionized, or reverse osmosis.

18 (v) "Culturally and linguistically appropriate" means meeting
19 the requirements of paragraphs (1) and (2) of subdivision (c) of
20 Section 2190.1 of the Business and Professions Code.

21 104895.51. (a) (1) The Healthy California Fund is hereby
22 established in the State Treasury with the purpose of diminishing
23 the human and economic costs of diabetes, obesity, heart disease,
24 and dental disease in California. The fund shall support culturally
25 and linguistically appropriate programs and interventions that
26 use educational, environmental, policy, and systems change, and
27 other public health approaches to improve access to, and
28 consumption of, healthy and affordable foods and beverages,
29 reduce access to, and consumption of, calorie-dense and
30 nutrient-poor foods, encourage physical activity and decrease
31 sedentary behavior, improve oral health literacy, raise awareness
32 about the importance of nutrition and physical activity in the
33 prevention of obesity and diabetes, and raise awareness of the
34 impact of nutrition and oral health habits on dental disease.

35 (2) The majority of expenditures shall be directed to support
36 comprehensive policy, systems, and environmental change
37 approaches that promote healthy eating, active living, and
38 improved oral health, including, but not limited to, those
39 recommended by the Institute of Medicine and the federal Centers
40 of Disease Control and Prevention. The fund shall consist of all

1 *fees, interest, penalties, and other amounts collected pursuant to*
2 *this chapter, less refunds and reimbursement for expenses incurred*
3 *in the administration and collection of the fees.*

4 *(b) Fifty-one percent of the moneys in the fund shall be allocated*
5 *to the State Department of Public Health and distributed for the*
6 *following purposes:*

7 *(1) Twenty-seven percent to develop and administer a regular*
8 *grant program to all county and city health departments, or their*
9 *nonprofit designee, seeking to invest in obesity, diabetes, and*
10 *dental disease prevention activities. Funds shall be distributed in*
11 *a reasonable proportion for prevention activities across the three*
12 *chronic diseases and pursuant to the Target Population Funding*
13 *Criteria under Section 104895.52.*

14 *(2) Twenty-eight percent to develop and administer a competitive*
15 *grant program for nonprofit and community based organizations*
16 *seeking to invest in obesity, diabetes, and dental disease prevention*
17 *activities. At least 15 percent and up to 20 percent of these funds*
18 *shall be used to support nonprofit organizations working statewide,*
19 *including those that provide capacity building and technical*
20 *assistance services. At least 8 percent of these funds shall be used*
21 *for statewide priority population leadership networks, including*
22 *African American, Hispanic, American Indian and Alaska Native,*
23 *Asian American, Native Hawaiian and Pacific Islander and low*
24 *socioeconomic status populations. Grants to community-based*
25 *organizations shall be distributed in a reasonable proportion for*
26 *prevention activities across the three chronic diseases and shall*
27 *meet the Target Population Funding Criteria pursuant to Section*
28 *104895.52.*

29 *(3) Twenty-eight percent to develop and administer a competitive*
30 *grant program for clinics licensed under subdivision (a) of Section*
31 *1204 to invest in a comprehensive approach to obesity, diabetes,*
32 *and dental disease prevention and treatment activities. In addition*
33 *to direct services, funding shall support programs that use*
34 *culturally and linguistically appropriate educational and other*
35 *public health approaches that raise awareness about the*
36 *importance of nutrition and physical activity in the prevention of*
37 *childhood obesity, diabetes, and dental disease. Funds shall be*
38 *distributed in a reasonable proportion for prevention activities*
39 *across the three chronic diseases and pursuant to the target*
40 *population funding criteria specified in Section 10895.52.*

1 (4) *Seven percent to the department or its nonprofit partners*
2 *for statewide advertising and media campaigns, including social*
3 *media initiatives, to change social and cultural norms around risk*
4 *factors for chronic diseases, including diet and physical activity,*
5 *and dental disease prevention. The statewide advertising and media*
6 *campaigns shall be guided by a subcommittee of the Oversight*
7 *Committee pursuant to Section 104895.53 and ensure that*
8 *advertising and media campaigns are tailored for the populations*
9 *most affected, as listed in subdivision (a) of Section 104895.52.*

10 (5) *Ten percent to the department, of which no more than 3*
11 *percent may be used for administration of the Fund to include*
12 *technical assistance to potential grantees and its prevention*
13 *activities; a minimum of 3 percent for independent evaluation; 1*
14 *percent subgranted to California-based public universities or*
15 *nonprofits to strengthen chronic disease surveillance, including*
16 *measures to track economic, racial, and ethnic disparities and*
17 *health inequities; and 3 percent to the department's Oral Health*
18 *Program to support statewide coordination and delivery of*
19 *preventive dental health programs and to ensure that funding is*
20 *directed to programs in accordance with the implementation of*
21 *the Oral Health Program.*

22 (c) *Four percent to the Expanded Access to Primary Care, Rural*
23 *Health Services Development, Health of Seasonal Agricultural*
24 *Migratory Workers, and Indian Health programs in the State*
25 *Department of Health Care Services. Funds shall be used to*
26 *support culturally and linguistically appropriate clinic-based*
27 *obesity and diabetes prevention and related disease management*
28 *pursuant to subdivision (v) of Section 104895.50 with no more*
29 *than 3 percent going towards department administrative costs.*

30 (d) *Twenty-five percent to the Department of Education and*
31 *distributed for the following purposes and pursuant to the Target*
32 *Population Funding Criteria, under Section 104895.52, with no*
33 *more than three percent to be used for department administrative*
34 *costs:*

35 (1) *Twenty-eight percent to administer a competitive grant*
36 *program for school districts for educational, environmental, policy,*
37 *and other public health approaches that promote physical activity.*
38 *The approaches funded pursuant to this paragraph may include*
39 *improving or constructing school recreational facilities that are*
40 *used for recess and physical education, joint-use activities during*

- 1 *after hours, providing continuing education training for physical*
2 *education teachers, hiring qualified physical education teachers,*
3 *and implementing Safe Routes to School programs.*
- 4 *(2) Thirty-one percent to administer a competitive grant*
5 *program for school districts for educational, environmental, policy,*
6 *and other public health approaches that promote improved*
7 *nutrition and access to healthy foods and beverages. The*
8 *approaches funded pursuant to this paragraph may include*
9 *improving the quality and nutrition of school breakfasts, lunches,*
10 *and snacks, increasing access to federal meal programs for*
11 *underserved populations, and incorporating practical nutrition*
12 *education into the curriculum.*
- 13 *(3) Fourteen percent to the California Farm to School Program*
14 *administered by the department.*
- 15 *(4) Twenty-four percent to administer a competitive grant*
16 *program for school districts for ensuring access to clean drinking*
17 *water throughout the schoolday, including, but not limited to,*
18 *drinking fountains and water bottle refilling stations.*
- 19 *(e) Twenty percent to the Department of Food and Agriculture,*
20 *to be distributed equally for the following purposes, with no more*
21 *than 3 percent going towards department administrative costs:*
- 22 *(1) To the Office of Farm to Fork, including, but not limited to,*
23 *consumer incentive programs, pursuant to Section 49001 of the*
24 *Food and Agricultural Code.*
- 25 *(2) To the Office of Farm to Fork, Chapter 12 (commencing*
26 *with Section 49001) of Division 17 of the Food and Agricultural*
27 *Code, to administer a competitive grant program to aide*
28 *community food producers, as defined under Section 113752, or*
29 *socially disadvantaged, beginning, military veteran, or limited*
30 *resource specialty crop producers that improve the health and*
31 *resilience of their communities by increasing access to any variety*
32 *of fresh, canned, dried, or frozen whole or cut fruits and vegetables*
33 *without added sugars, fats or oils, and salt.*
- 34 *104895.52. (a) The target populations described in paragraphs*
35 *(1) to (5), inclusive, at a minimum, shall be the focus of the*
36 *campaign implemented pursuant to this chapter, and all moneys*
37 *in the fund, including those designated for statewide activities,*
38 *shall be allocated with no less than 60 percent priority given to*
39 *communities located in zip codes with the highest 30 percentile of*
40 *type II diabetes, as reported by the California Health Interview*

1 Survey (CHIS) conducted by the University of California, Los
2 Angeles Center for Health Policy Research. Departments shall
3 use the most current survey data available in identifying the
4 following populations:

5 (1) African American, Hispanic, American Indian and Alaska
6 Native, Asian American, Native Hawaiian, and Pacific Islander.

7 (2) Low socioeconomic status populations.

8 (3) Zip codes with the top 30th percentile of rates of type II
9 diabetes.

10 (4) Communities identified as dentally underserved or with high
11 rates of dental disease.

12 (5) At-risk populations, as determined by the California Health
13 Interview Survey (CHIS) and other data sources.

14 (b) Pursuant to this chapter, the State Department of Public
15 Health and the State Department of Education shall use the most
16 current survey data available to target all moneys in the fund to
17 address the needs of the identified target populations using the
18 following criteria and methodologies:

19 (1) For funding to the California Department of Public Health:

20 (A) (i) Pursuant to the county and local government funding
21 criteria, funding shall be focused and primarily expended on
22 programs and activities with a priority and focus on directly
23 serving communities identified in paragraph (1) of subdivision
24 (a), and where consumption of bottled sugar-sweetened beverages
25 is the highest, in neighborhoods with schools with a high
26 concentration of students who qualify for supplemental and
27 concentration grants, pursuant to Section 2574 of the Education
28 Code, and in neighborhoods with a demonstrated need for services,
29 including a high concentration of Medi-Cal eligible residents.

30 (ii) The department shall develop a funding formula to provide
31 a minimum base level to all county and city health departments
32 with the additional amount weighted to reflect the number of
33 residents in each jurisdiction living below 150 percent of the
34 federal poverty level. Funding shall be dependent on each local
35 health department submitting an approved implementation plan
36 and maintaining a community coalition to support the objectives
37 of the funding. At least one third of each jurisdiction's funds shall
38 be subgranted to community partners selected through a
39 competitive process with a priority and focus on directly serving

1 communities and populations described in paragraph (1) of
2 subdivision (a).

3 (B) Grants for nonprofit and community-based organizations,
4 pursuant to paragraph (2) of subdivision (b) of Section 104895.51,
5 shall be reserved for providing activities in communities described
6 in paragraph (1) of subdivision (a) and assisting populations that
7 are no more than 150 percent above the poverty level. Priority
8 shall be given to culturally and linguistically appropriate activities,
9 pursuant to subdivision (v) of Section 104895.50. Those activities
10 shall directly serve communities with a demonstrated need for
11 health care services, including those with high levels of
12 limited-English-Proficient residents.

13 (2) Funding to the State Department of Education shall be
14 focused and primarily expended on campuses located in
15 neighborhoods and serving children, pursuant to paragraph (1)
16 of subdivision (a), with a high density of students who qualify for
17 the National School Lunch Program or the federal School
18 Breakfast Program, more than 50 percent of students who would
19 qualify for supplemental or concentration grants, pursuant to
20 Section 2574 of the Education Code, and a demonstrated need
21 that may include showing that access to fresh fruits and vegetables
22 is limited in the neighborhood surrounding the school.

23 104895.53. (a) Upon appropriation by the Legislature, all
24 moneys in the fund shall be expended only for the purposes
25 expressed in this chapter and shall be used only to supplement
26 existing levels of service. Moneys in the fund shall not supplant
27 any federal, state, or local funding for existing levels of service.

28 (b) The State Public Health Officer, the Secretary of the
29 Department of Food and Agriculture, the Director of Health Care
30 Services, and the Superintendent of Public Instruction may
31 coordinate to establish regulations and procedural measures
32 necessary to effectuate the purposes of this chapter. The regulations
33 may provide for specific programs to be funded consistent with
34 the allocation of funds as set forth in this chapter. In establishing
35 these regulations, the departments shall give particular
36 consideration to reducing the prevalence of diabetes, as identified
37 by data from the CHIS and other data sources.

38 (c) The California State Auditor's office shall conduct periodic
39 audits to ensure that the annual allocation to individual programs
40 is awarded by the fund in a timely fashion consistent with the

1 requirements of this chapter. The first audit shall be conducted no
2 later than 24 months after the effective date of this section.

3 104895.54. (a) The Healthy California Fund Oversight
4 Committee is hereby created in state government. The committee
5 shall advise the State Department of Public Health, the State
6 Department of Health Care Services, the Department of Food and
7 Agriculture, and the State Department of Education with respect
8 to policy development, integration, and evaluation of the state and
9 local programs funded under this chapter, and shall develop a
10 master plan for the future implementation of diabetes, obesity, and
11 dental disease prevention programs.

12 (b) The committee shall be composed of 13 members to be
13 appointed as follows, with specific consideration to address the
14 needs of the target populations described in Section 104895.52:

15 (1) Two members representing nonprofit public health
16 organizations dedicated to healthy eating, active living, and
17 diabetes and obesity prevention, appointed by the Speaker of the
18 Assembly.

19 (2) One member representing an organization that represents
20 the health center community, appointed by the Senate Rules
21 Committee.

22 (3) One member of a professional education association, such
23 as an association of teachers, appointed by the Senate Rules
24 Committee.

25 (4) One representative of a professional dental organization, a
26 nonprofit dental health organization, or representing an
27 organization dedicated to dental disease prevention, appointed by
28 Governor.

29 (5) One member of a university facility with expertise in
30 programs intended to promote healthy eating, active living, and
31 diabetes and obesity prevention, appointed by the Governor.

32 (6) Two representatives of a target population group, appointed
33 by the Governor.

34 (7) One representative of the State Department of Public Health,
35 appointed by the Governor.

36 (8) One representative of the State Department of Health Care
37 Services, appointed by the Governor.

38 (9) One representative of the Department of Food and
39 Agriculture, appointed by the Governor.

1 (10) *One representative of the State Department of Education,*
2 *appointed by the Superintendent of Public Instruction.*

3 (11) *One representative of local health departments, appointed*
4 *by the Governor.*

5 (c) *Members shall serve for a term of three years, renewable*
6 *at the option of the appointing authority, with up to two consecutive*
7 *terms. The initial appointments of members shall be for two or*
8 *three years, to be drawn by random lot at the first meeting. The*
9 *committee shall be staffed by the coordinator of the State*
10 *Department of Public Health programs created pursuant to*
11 *subdivision (b) of Section 104895.51.*

12 (d) *The committee shall meet as often as it deems necessary,*
13 *but not fewer than four times per year.*

14 (e) *The members of the committee shall serve without*
15 *compensation, but shall be reimbursed for necessary travel*
16 *expenses incurred in the performance of the duties of the*
17 *committee.*

18 (f) *An equity subcommittee shall be established as part of the*
19 *Oversight Committee to ensure progress on advancing health*
20 *equity.*

21 104895.55. *The committee shall be advisory to the State*
22 *Department of Public Health, the State Department of Health Care*
23 *Services, the Department of Food and Agriculture, and the State*
24 *Department of Education, for the following purposes:*

25 (a) *Evaluating programs and interventions funded under this*
26 *chapter as necessary in order to assess the overall effectiveness*
27 *of efforts made by the program to promote healthy eating and*
28 *active living and to prevent diabetes and obesity. In order to*
29 *evaluate programs, the committee shall seek the cooperation and*
30 *assistance of the State Department of Public Health, the State*
31 *Department of Health Care Services, the Department of Food and*
32 *Agriculture, the State Department of Education, the University of*
33 *California, local health departments, local education agencies,*
34 *administrative representatives, target populations, school officials,*
35 *nongovernmental organizations, and researchers. A principal*
36 *measurement of effectiveness shall be the reduction of diabetes*
37 *and obesity and the increased consumption of healthy foods and*
38 *levels of physical activity among a given target population.*

39 (b) *Facilitating programs directed at promoting healthy eating*
40 *and active living and preventing diabetes and obesity that are*

1 *operated jointly by more than one agency or entity. The committee*
2 *shall propose strategies for the coordination of proposed programs*
3 *administered by the State Department of Public Health, the State*
4 *Department of Health Care Services, the Department of Food and*
5 *Agriculture, and the State Department of Education, and local*
6 *lead agencies, in order to avoid the duplication of services and to*
7 *maximize the public benefit of the programs.*

8 *(c) Making recommendations to the Department of Public*
9 *Health, the Department of Health Care Services, the Department*
10 *of Food and Agriculture, and State Department of Education*
11 *regarding the most appropriate selection criteria for, and*
12 *standards of, the operation and the types of programs to be funded*
13 *under this chapter.*

14 *(d) (1) Notwithstanding Section 10231.5 of the Government*
15 *Code, reporting to the Legislature on or before January 1 of each*
16 *year on the number and scope of programs funded by the Healthy*
17 *California Fund created by Section 104895.51, the amount of*
18 *money in the fund, any moneys previously appropriated to the*
19 *State Department of Public Health, the State Department of Health*
20 *Care Services, the Department of Food and Agriculture, and the*
21 *State Department of Education, but unspent by the departments,*
22 *a description and assessment of all programs funded under this*
23 *chapter, and recommendations for any necessary policy changes*
24 *or improvements for program interventions and strategies.*

25 *(2) A report submitted pursuant to paragraph (1) shall be*
26 *submitted in compliance with Section 9795 of the Government*
27 *Code.*

28 *(e) Ensuring that the most current research findings regarding*
29 *diabetes and obesity prevention are applied in designing the*
30 *programs administered by the State Department of Public Health,*
31 *the State Department of Health Care Services, the Department of*
32 *Food and Agriculture, and the State Department of Education.*
33 *The departments shall apply the most current findings and*
34 *recommendations of research and best practice.*

35 *(f) Based on the results of programs supported by this chapter*
36 *and any other proven methodologies available to the committee,*
37 *producing a comprehensive master plan for implementing diabetes*
38 *and obesity prevention programs throughout the state to increase*
39 *healthy eating and active living, reduce food insecurity, and*
40 *promote sustainable, healthy, resilient communities. The master*

1 plan shall include longitudinal data on obesity prevalence and
2 incidence rates, data on diabetes prevalence and incidence rates,
3 and longitudinal information on sweetened beverage consumption
4 rates across the state population. The master plan shall also
5 include implementation strategies for programs to address the
6 needs of underserved and at-risk target populations throughout
7 this state. The Healthy California Fund Oversight Committee shall
8 submit the master plan to the Legislature biennially, in compliance
9 with Section 9795 of the Government Code. The master plan and
10 its revisions shall include recommendations for administrative
11 arrangements, funding priorities and integration and coordination
12 of approaches by the Department of Public Health, the Department
13 of Health Care Services, the Department of Food and Agriculture,
14 and State Department of Education and their support systems,
15 local lead agencies, and nongovernmental organizations, as well
16 as progress reports relating to the needs of specific target
17 populations.

18 104895.56. (a) A health impact fee is hereby imposed on every
19 distributor for the privilege of distributing bottled sweetened
20 beverages and concentrate in the state, for deposit into the fund.
21 The fees shall be calculated as follows:

22 (1) The fee on bottled sweetened beverages distributed in this
23 state shall be two cents (\$0.02) per fluid ounce.

24 (2) The fee on concentrates distributed in the state either as
25 concentrate or as a sweetened beverage derived from that
26 concentrate shall be equal to two cents (\$0.02) per fluid ounce of
27 sweetened beverage produced from that concentrate. For purposes
28 of calculating the fee for concentrate, the volume of sweetened
29 beverage to be produced from concentrate shall be the largest
30 volume resulting from use of the concentrate according to any
31 manufacturer's instructions.

32 (b) In each transaction described in subdivision (a), the
33 distributor shall include the following information on each receipt,
34 invoice, or other form of accounting for the distribution of bottled
35 sweetened beverages or concentrate:

36 (1) The name and address of the distributor.

37 (2) The name and address of the purchaser.

38 (3) The date of sale and invoice number.

39 (4) The kind, quantity, size, and capacity of packages of bottled
40 sweetened beverages, sweetened beverages, or concentrate sold.

1 (5) *The amount of fees due from the distributor on the sale of*
2 *the bottled sweetened beverages, sweetened beverages, or*
3 *concentrate.*

4 (6) *Any other information, as required by the board.*

5 (c) *The program shall develop reimbursement criteria to enable*
6 *participating departments to recover administrative costs*
7 *associated with collecting the charge.*

8 (d) *This section shall not preempt a city or county from enacting*
9 *or enforcing an ordinance related to taxation of sugar-sweetened*
10 *beverages if the ordinance is more stringent than this section.*

11 104895.57. (a) (1) *No later than July 1, 2017, and annually*
12 *thereafter, the State Department of Public Health, the State*
13 *Department of Health Care Services, the Department of Food and*
14 *Agriculture, and the State Department of Education shall*
15 *commence preparation of a program budget for the following*
16 *calendar year. The budgets shall include all of the following*
17 *information:*

18 (A) *Anticipated revenues and costs of implementing the program,*
19 *including related programs, projects, contracts, and administrative*
20 *expenses.*

21 (B) *A recommended funding level sufficient to cover the*
22 *program's budgeted costs and to operate the program over a*
23 *multiyear period in a prudent and responsible manner.*

24 (C) *The amount of the health impact fees, as described in Section*
25 *104895.56, and itemization of costs that the fees cover.*

26 (2) *The State Department of Public Health, the State Department*
27 *of Health Care Services, the Department of Food and Agriculture,*
28 *and the State Department of Education shall solicit feedback on*
29 *their proposed budgets from the Healthy California Fund Oversight*
30 *Committee before adopting a final budget.*

31 (3) *The departments shall adopt final program budgets for*
32 *purposes of this chapter by October 1 of each year.*

33 (b) *The fund shall reimburse the State Department of Public*
34 *Health, the State Department of Health Care Services, the*
35 *Department of Food and Agriculture, and the State Department*
36 *of Education for administration and implementation costs the*
37 *departments incur pursuant to this chapter, as provided in*
38 *subdivision (c). The reimbursement shall not exceed the*
39 *departments' direct costs to implement and enforce this chapter.*

1 (c) *The State Department of Public Health, the State Department*
2 *of Health Care Services, the Department of Food and Agriculture,*
3 *and the State Department of Education shall deposit all moneys*
4 *submitted for reimbursement costs by the program into the Healthy*
5 *California Fund Administration Account, which is hereby*
6 *established within the fund. Upon appropriation by the Legislature,*
7 *moneys in the account shall be expended by the departments to*
8 *administer and enforce this chapter and to repay any outstanding*
9 *loans made from other funds used to finance startup costs of the*
10 *department's activities pursuant to this chapter.*

11 104895.58. (a) *The board shall administer and collect the*
12 *charges imposed by this chapter pursuant to the Fee Collection*
13 *Procedures Law (Part 30 (commencing with Section 55001) of*
14 *Division 2 of the Revenue and Taxation Code). The board may use*
15 *no more than 3 percent of the revenues generated to cover its*
16 *administrative costs in collecting the fees imposed under this*
17 *chapter.*

18 (b) *The board may prescribe, adopt, and enforce regulations*
19 *relating to the administration and enforcement of this chapter,*
20 *including, but not limited to, collections, reporting, refunds, and*
21 *appeals.*

22 (c) *The board may adopt regulations to implement this chapter.*
23 *The adoption, amendment, repeal, or readoption of a regulation*
24 *authorized by this section is deemed to address an emergency, for*
25 *purposes of Sections 11346.1 and 11349.6 of the Government*
26 *Code, and the board is hereby exempted for this purpose from the*
27 *requirements of subdivision (b) of Section 11346.1 of the*
28 *Government Code.*

29 104895.59. *The fees imposed by this chapter are due and*
30 *payable to the board on or before the last day of the first month*
31 *following each calendar quarter.*

32 104895.60. (a) *On or before the last day of the first month*
33 *following each calendar quarter, a return for the preceding*
34 *calendar quarter shall be filed with the board using electronic*
35 *media.*

36 (b) *The board may prescribe those forms and reporting*
37 *requirements as are necessary to implement the fees, including,*
38 *but not limited to, information regarding the total amount of bottled*
39 *sweetened beverages and concentrate sold and the amount due.*

1 (c) Returns shall be authenticated in a form or pursuant to
2 methods prescribed by the board.

3 104895.61. A distributor required to pay the fees imposed
4 under this chapter shall register with the board. An application
5 for registration shall be made upon a form prescribed by the board
6 and shall set forth the name under which the applicant transacts
7 or intends to transact business, the location or locations of each
8 place of business, and any other information required by the board.
9 An application for an account under this section shall be
10 authenticated in a form, or pursuant to methods, prescribed by the
11 board.

12 104895.62. The distribution of bottled sweetened beverages
13 or concentrate by a distributor to either of the following persons
14 shall be exempt from the fees imposed by this chapter:

15 (a) A person when, pursuant to the contract of sale, the bottled
16 sweetened beverages or concentrate shall be shipped, and are
17 shipped, to a point outside of this state by the distributor by means
18 of either of the following:

19 (1) Facilities operated by the distributor.

20 (2) Delivery by the distributor to a carrier, customs broker, or
21 forwarding agent, whether hired by the purchaser or not, for
22 shipment to the out-of-state point.

23 (b) A person who is otherwise exempt from the taxation of that
24 sale, use, or consumption under the Constitution of the United
25 States, federal law or regulation, or the California Constitution.

26 104895.63. A distributor who has paid a fee, either directly to
27 the state or to another distributor registered under this chapter
28 and makes a subsequent distribution of bottled sweetened
29 beverages or concentrate may claim a credit on the distributor's
30 return for the period in which the subsequent sale or distribution
31 occurs.

32 ~~SECTION 1. Section 104655 of the Health and Safety Code~~
33 ~~is amended to read:~~

34 ~~104655. Notwithstanding any other law, nothing shall operate~~
35 ~~to prohibit contributions to the program created pursuant to this~~
36 ~~article by organizations and commissions subject to Division 22~~
37 ~~(commencing with Section 63901) of the Food and Agricultural~~
38 ~~Code.~~

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HURST+BROOKS+ESPINOSA

April 7, 2016

TO: Members, CSAC Health and Human Services Policy Committee
FROM: Kelly Brooks-Lindsey, Partner, Hurst Brooks Espinosa
Re: Medi-Cal 2020 Waiver Summary

On December 30, 2015 the California Department of Health Care Services and the Centers for Medicare and Medicaid Services (CMS) announced agreement on California's Medicaid Section 1115 waiver, titled Medi-Cal 2020. The Special Terms and Conditions (STCs) provide a framework for the programs funded by the waiver. DHCS continues to work with DHCS on finalizing the attachments – which will provide additional details to accompany the STCs. The attachments for the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) and Global Payment Program (GPP) are complete. The Whole Person Care attachments are anticipated to be finalized this month. DHCS is working on an aggressive timeline to get the projects funded by the waiver operational as quickly as possible.

Below is a summary of some of the recent state activities:

- PRIME proposals were due to DHCS on April 4
- A Whole Person Care Frequently Asked Question (FAQ) document was released by DHCS in March. The document will be updated as stakeholders continue to submit questions to the department.
- DHCS is planning to release a draft Request for Application (RFA) and draft selection criteria for Whole Person Care in April. DHCS will be asking for public comments on the draft documents.
- DHCS has tentatively planned to release the RFA on May 16 with applications due July 1 for Whole Person Care pilots.

Waiver Implementing Legislation

The waiver implementation bills – AB 1568 (Bonta) and SB 815 (Hernandez) – are set for hearing the week of April 18 in Assembly and Senate Health Committees. The bills are in spot form as of the writing of this memo; however, amendments are anticipated shortly.

Attached is a detailed summary of the waiver, based on STCs.

MEDI-CAL 2020

OVERVIEW OF CALIFORNIA'S MEDICAID SECTION 1115 WAIVER

The Centers for Medicare and Medicaid Services (CMS) announced renewal of California's Medicaid Section 1115 Waiver on December 30, 2015. California's new waiver is titled, "Medi-Cal 2020." The Special Terms and Conditions (STCs), the legal document governing the waiver, includes important details about the major elements of the waiver.

Medi-Cal 2020 includes \$6.2 billion in federal funds over five years. Major elements include:

- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME):** a successor to the Delivery System Reform Incentive Program that will provide \$3.27 billion for designated public hospitals and \$466.5 million for district and municipal hospitals.
- **Global Payment Program:** intended to incentivize primary and preventive care to the remaining uninsured through a value-based payment structure.
- **Whole Person Care:** up to \$300 million per year for five years for county-based pilots to coordinate health, behavioral health and social services to improve beneficiary health and well-being.
- **Dental Transformation Initiative:** up to \$750 million total over five years to improve preventive care and continuity of care. These incentive funds do not have a local match requirement.

The following document provides an overview of each of these elements. Additionally, this document includes a summary of the demonstration and program years and a list of the attachments to the STCs.

Public Hospital Redesign and Incentives in Medi-Cal

The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) is a successor to the Delivery System Reform Incentive Program (DSRIP) from the 2010-15 waiver that will provide \$3.27 billion for designated public hospitals and \$466.5 million for district and municipal hospitals.

PRIME is designed to support efforts to accelerate changes to care delivery to maximize health care value and strengthen the ability of public hospitals to successfully perform under risk-based alternative payment models (APMs) in the long term.

Details on PRIME can be found STC Paragraphs 70-101. DHCS and CMS will be developing PRIME attachments, including: PRIME Projects and Metrics (Attachment Q), Alternative Payment Methodologies (Attachment R), PRIME Evaluation and Monitoring (Attachment S), and PRIME Program Funding and Mechanics (Attachment II).

PRIME Funding

Demonstration Year (DY)	Designated Public Hospitals	District or Municipal Hospitals	Total
DY 11	\$700 million	\$100 million	\$800 million
DY 12	\$700 million	\$100 million	\$800 million
DY 13	\$700 million	\$100 million	\$800 million
DY 14	\$630 million	\$90 million	\$720 million
DY 15	\$535.5 million	\$76.5 million	\$612 million
5-Year Total	\$3.2655 billion	\$466.5 million	\$3.732 billion

In addition to the funding outlined above, the STCs include 5% penalties if the state fails to meet APMs targets in demonstration years 14 and 15.

PRIME includes three project domains. Designated Public Hospitals (DPHs) are required to address Domains 1, 2 and 3 (with some required projects). District or municipal hospitals will be required to address one domain at a minimum. District or municipal hospitals can choose to partner on PRIME.

Domain 1: Outpatient Delivery System Transformation and Prevention. The menu of projects include:

- Integration of Physical and Behavioral Health (required for DPHs)
- Ambulatory Care Redesign: Primary Care (required for DPHs)
- Ambulatory Care Redesign: Specialty Care (required for DPHs)
- Patient Safety in the Ambulatory Setting
- Million Hearts Initiative
- Cancer Screening and Follow-up
- Obesity Prevention and Healthier Foods Initiative

Domain 2: Targeted High-Risk or High-Cost Populations. The menu of projects include:

- Improved Perinatal Care (required for DPHs)
- Care Transitions: Integration of Post-Acute Care (required for DPHs)
- Complex Care Management for High Risk Medical Populations (required for DPHs)

- Integrated Health Homes for Foster Children
- Transition to Integrated Care: Post Incarceration
- Chronic Non-Malignant Pain Management
- Comprehensive Advanced Illness Planning and Care

Domain 3: Resource Utilization Efficiency. DPHs must select at least one of the following projects:

- Antibiotic Stewardship
- Resource Stewardship: High Cost Imaging
- Resource Stewardship: Therapies Involving High Cost Pharmaceuticals
- Resource Stewardship: Blood Products

Alternative Payment Models (APMs). Under APMs, managed care systems will shift risks for costs and/or outcomes to participating hospital systems. Contracts between managed care plans and participating DPHs will be required to include language requiring the hospital system to report on a broad range of metrics. PRIME funding will also support direct incentives to participating DPHs to support better integration of physical and behavioral health services in inpatient and outpatient settings, improved health outcomes, and increased access to health care services.

PRIME includes requirements to implement APMs: 50 percent of all Medi-Cal managed care beneficiaries assigned to DPHs will receive all or a portion of their care under a contracted APM by January 2018; 55 percent by January 2019; and 60 percent by the end of 2020. Four tiers of capitated payments would exist: 1) partial (primary care only); 2) partial-plus (primary care and some specialty care); 3) global (primary, specialty, ancillary and/or hospital care; and 4) additional payment methodologies approved by the state and CMS.

PRIME Timeline

Key Dates	PRIME Deadline
February 1, 2016 or 30 days after approval of PRIME protocols (whichever is later)	Submit a 5-year PRIME project plan to DHCS for review.
March 15, 2016 or 45 days after approval of PRIME protocols (whichever is later)	DHCS will complete its review and respond to PRIME applicants.
	PRIME entities will respond to DHCS questions in writing within 3 business days of notification by DHCS.
April 1, 2016 or 60 days after approval of PRIME protocols (whichever is later).	DHCS will approve (or disapprove) of each PRIME plan.

Global Payment Program

The Global Payment Program (GPP) is a new element in the Medi-Cal 2020 waiver. The GPP is intended to promote the delivery of more cost-effective and higher-value care to the uninsured. The payment structure will reward the provision of care in more appropriate settings, rather than through the emergency department or through inpatient settings.

Medi-Cal 2020 includes \$236 million for the GPP in Year 1. Specifically, GPP combines two funding sources – Disproportionate Share Hospital (DSH) and former Safety Net Care Pool funds – into a global payment for the remaining uninsured. The non-DSH funding in years 2 through 5 will be determined following an independent assessment of uncompensated care due to be completed in the spring of 2016.

The GPP details can be found in STC Paragraphs 162 – 177. Additionally there are two attachments, Attachment EE and FF, related to GPP yet to be developed.

Participating designated public hospitals will receive payments that will be calculated using a value-based point methodology that incorporates factors that shift the overall delivery of services for the uninsured to more appropriate settings. GPP payments will be to designated public hospitals and the DPH's affiliated and contracted providers.

Each public hospital system's annual threshold amount will be determined through a baseline analysis that accounts for factors such as its historic and projected volume, cost and mix of services to the uninsured and estimated need. Care for the uninsured is defined as care to individuals for whom there is no sources of third party coverage for the specific services furnished by the public hospital system. Elements of this new global payment include:

- Each individual public hospital system will have its own “global payment” from within the pool of overall federal funding. Individual payments will allow each hospital system more certainty about its budget and how much federal funds would be available.
- Funding will be claimed quarterly with the public hospital providing the necessary Intergovernmental Transfer (IGT), which moves away from the prior cost-based methodology.
- A public hospital system will achieve “points” for threshold service targets, with a base level of points required for each system to earn their full global budget.
- Partial funding will be available for partial achievement of points.
- Points will allow for the continuation of traditional services but encourage more appropriate and innovative care. Additionally, point values will be developed for innovative or alternative services where there is currently little to no reimbursement.

The state will establish baseline threshold point targets for services currently provided today. Below is an overview of the categories and types of services that will be assigned points. The full description of each category will be included in the forthcoming Attachment FF, which is currently under development.

The state shall redistribute unexpended GPP payments to hospitals that exceeded their respective threshold in a given year.

Category 1. Traditional Outpatient. Includes traditional outpatient services provided by a public hospital system facility. Specifics include:

<i>Non-physician practitioner</i>	<i>Mental health visit</i>
<i>Dental</i>	<i>Public health visits (TB clinic, STC screening);</i>
<i>Emergency room/urgent care</i>	<i>Post-hospital discharge</i>
<i>Traditional, provider-based primary care or specialty care visit</i>	<i>Outpatient providers/surgery, provider performed diagnostic procedures</i>

Category 2. Non-Traditional Outpatient. Outpatient encounters where care is provided by nontraditional providers or in nontraditional or virtual settings. Specifics include:

<i>Community health worker encounters</i>	<i>Health coach encounters</i>
<i>Care navigation</i>	<i>Health education & community wellness encounters</i>

Category 3. Technology-Based Outpatient. Technology-based outpatient encounters that rely mainly on technology to provide care. Examples include:

<i>Call line encounters (nurse advice line)</i>	<i>Texting</i>
<i>Telemedicine</i>	<i>Provider-to-provider eConsults for specialty care</i>
<i>Telephone and email consultations between provider and patient</i>	

Category 4. Inpatient and Facility Stays. Includes traditional inpatient and facility stays by patients. Specifics include:

<i>Recuperative/respite care days</i>	<i>Sober center days</i>
<i>Sub-acute care days</i>	<i>Skilled nursing facility days</i>

Evaluation and Accountability. The STCs include two evaluations of provider expenditures and activities under the global payment methodology. The evaluations will monitor the implementation and impact of the demonstration to inform how improvements to the GPP can be made following the expiration of the waiver. Both evaluations will examine the purpose and aggregate impact of the GPP, care provided by public hospitals, and patients' experience, with a focus on understanding the benefits and challenges of this payment approach.

The second evaluation will also examine the extent to which the GPP encouraged or improved:

- Care in more appropriate settings, to ensure that patients are seen in the right place and given the right care at the right time
- Changes in resource allocation
- Improvements in workforce involvement and care team transformation

Disproportionate Share Hospital (DSH) Funding Background. DSH payments were not part of the 2010 waiver. DSH funds currently provide reimbursement for hospital-based services. DSH payments are federal payments that provide additional reimbursement to those hospitals that serve a significantly disproportionate number of low-income patients (both Medicaid and uninsured). States receive an annual federal DSH allotment to pay for a portion of the uncompensated care costs. California's allotment is approximately \$1.188 billion, with designated public hospitals receiving approximately \$1.176 billion (federal funds).

Federal health care reform included provisions to reduce DSH; those reductions, which have been extended, are slated to begin in 2018-19. The DSH reductions increase each year until 2024 when they stabilize. Nationally, the DSH cut is over 50 percent of the current DSH total. It is not yet clear how the DSH reduction formula will work in the context of state Medicaid expansions v. non-expansion state.

Whole Person Care

The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health and social services to improve beneficiary health and well-being through more efficient and effective use of resources. Details about the WPC Pilots are included in STC Paragraphs 110-126. DHCS and CMS are required to develop additional attachments to the STCs, including: WPC Pilot Requirements and Metrics (Attachment MM), WPC Pilot Requirements and Application Process (Attachment HH), and WPC Reporting and Evaluation (Attachment GG).

What are the WPC Pilots expected to do? Through collaborative leadership and coordination among public and private entities, the pilots will: 1) identify the target population, 2) share data between systems, 3) coordinate care in real time, and 4) evaluate individual and population progress.

Who is the target population(s)? WPC Pilots will identify high-risk, high utilizing Medi-Cal beneficiaries and assess their unmet need. The target population shall be identified through a collaborative data approach to identify common patients who frequently access urgent and emergent services. The target population may include but are not limited to individuals:

- With repeated incidents of avoidable emergency use, hospital admission, or nursing facility placement
- With two or more chronic conditions
- With mental health and/or substance use disorders
- Who are currently experiencing homelessness; and/or
- Individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (such as hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail, state prison or other).

WPC Pilot Strategies:

- Increase integration among county agencies, health plans and providers
- Increase coordination and appropriate access to care
- Reduce inappropriate emergency and inpatient utilization
- Improve data collection and sharing amongst local entities
- Achieve targeted quality and administrative improvement benchmarks
- Increase access to housing and supportive service (optional)
- Improve health outcomes for the WPC population

Who can apply for a WPC Pilot? A county, a city and county, a health or hospital authority, or a consortium of any of those entities. Each application shall designate a “Lead Entity” that will either be a county agency, designated public hospital or district or municipal public hospital. The Lead Entity will be the single point of contact for the Department of Health Care Services (DHCS).

Who should potential WPC Pilots sites be collaborating with? The WPC Pilot application must identify other entities participating in the WPC Pilot, including:

- At a minimum one Medi-Cal managed care plan
- At least three county departments: both county health services and county mental health and one other public agency or department – which may include county alcohol and substance use disorder, county human services, public health, criminal justice/probation, or housing authorities

- At least two other key community partners that have significant experience serving the target population, such as physician groups, clinics, hospitals, and community-based organizations

If a lead entity cannot reach agreement with a required participant, it may request an exception to the requirement.

Housing and supportive services are an optional strategy. What partners should a WPC pilot focusing on homelessness include? If a WPC Pilot chooses to focus on individuals at risk of or who are experiencing homelessness who have a demonstrated medical need for housing or supportive services, WPC pilots would include as participating entities:

- Local housing authorities
- Local Continuum of Care (CoCs) programs
- Community based organizations
- Others serving the homeless population

What are WPC Pilot payments for? Payments will support:

- Infrastructure to integrate services among local entities that serve the target population
- Services not otherwise covered or directly reimbursed by Medi-Cal, such as housing components
- Other strategies to improve integration, reduce unnecessary utilization of health care services and improve outcomes

Participation/Eligibility. Services are voluntary. Eligible beneficiaries must opt-in. Individuals may opt out at time. WPC Pilot sites may include individuals who are not Medi-Cal beneficiaries but federal financial participation will not be available for funding in support of services provided.

Enrollment caps. Lead entities may identify an enrollment cap in the application. A lead entity must notify the state within 90 days prior to imposing an enrollment cap and obtain approval prior to implementing. If enrollment caps are approved, wait lists must be developed.

Funding. Medi-Cal 2020 includes \$300 million each year for five years. No pilot shall be awarded more than 30 percent of the total funding. Lead entities will provide the non-federal share of payment through an Intergovernmental Transfer (IGT).

Key Dates for Whole Person Care

Date	Activity
<u>April 1, 2016</u> or 90 days after CMS approval of WPC Attachments	DHCS will publish via a Request for Application (RFA) the application process, detailed timelines, and selection criteria.
<u>May 15, 2016</u> or 45 days after DHCS issues the RFA	Lead entities submit WPC Pilot applications to DHCS
<u>July 15, 2016</u> or 60 days after submission of WPC applications	DHCS review and response to WPC Pilot applications in writing
5 business days	Lead entity will respond to DHCS questions and concerns in writing
30 days	DHCS will take action on applications

Dental Transformation Incentive

The STCs contain significantly more detail about the dental initiative than had previously been available. The Medi-Cal 2020 Waiver contains up to \$148 million annually or \$740 million total over five years to improve preventive care and continuity of care. These incentive funds do not have a local match requirement. The STCs detail four projects under the Dental Transformation Incentive (DTI). More specificity on DTI can be found in STC Paragraphs 104-109 and Attachment JJ.

Project 1: Increase Preventive Service Utilization for Children (required)

Goals:

- Increase the statewide proportion of children ages one through 20 and enrolled in the Medi-Cal Dental Program and who receive a preventive dental services by 10 percentage points over a five year period
- Maintain preventive oral care for children who previously received this service

This project will provide semi-annual incentive payments to dental provider service office locations that provide preventive services. DHCS will determine the baseline for measurement purposes and a set pre-determined number of beneficiaries that a service office location must see in order to qualify for payments. Providers who meet or exceed DHCS's pre-determined number of beneficiaries would qualify for payments. **Federally qualified health centers/rural health centers and Tribal Health Centers are eligible for incentives;** the dental payments would be separate and apart from their Prospective Payment System (PPS) or Memorandum of Agreement (MOA) rates.

Project 2: Caries Risk Assessment and Disease Management Project (required)

Goals:

- Diagnose early childhood caries and treat it as a chronic diseases
- Introduce a model that proactively prevents and mitigates oral disease through the delivery of preventative services in lieu of more invasive and costly procedures
- Track the target population's utilization of preventive and restorative services

This project is only available initially to dentists in select pilot counties that elect and are approved to participate in the program. This project will begin as a pilot in select counties; DHCS will seek to implement on a statewide basis if the pilot is determined to be successful and there are sufficient funds available in the DTI pool.

Medi-Cal dentists voluntarily participating in these pilots will be eligible to receive incentive payments for performing pre-identified treatment plans for children age 6 and under based upon the beneficiary's risk level as determined by a dentist via a caries risk assessment. Treatment plans will include motivational interviewing and use of antimicrobials, as indicated by the assessment. Pilot counties will be identified and selected by DHCS through an analysis of counties with a high percentage of restorative services, a low percentage of preventive services, and indication of likely enrolled service office locations participation.

Project 3: Increase Continuity of Care (required)

Goals:

- Increase dental continuity of care among Medi-Cal children enrolled in the Medi-Cal Dental Program. This will also be a pilot in select counties. DHCS will seek to implement on a statewide basis if the pilot is determined to be successful and there are sufficient funds available in the DTI pool. Project 3 will include incentive payments paid to dental provider service office locations who have maintained continuity of care through providing examinations for their enrolled child beneficiaries, age 20 and under and for 2-, 3-, 4-, 5-, and 6-year continuous periods.

Project 4: Local Dental Pilot Programs (optional)

DHCS will be soliciting proposals for a maximum of 15 Local Dental Pilot Programs (LDPPs). LDPPs are intended to target individuals in need of dental services and are to be designed to include specific strategies to meet one or more of the three DTI domains: 1) increase preventive services utilization for children; 2) increase caries risk assessment and disease managements; and 3) increase continuity of care. The STCs specify that no more than 25 percent of the DTI will be available for LDPPs.

The STCs allow counties to receive funds for LDPPs. **A county, a city and county, a consortium of counties, a Tribe, an Indian health program, UC or CSU campus can apply to be a pilot site.** The Local Dental Pilot Program is intended to use strategies focused on rural areas including, local case management initiatives and education partnerships. Lead entities may submit applications to DHCS 60 days after the applicable protocols are approved by CMS (if the protocols are approved by March 1, applications would be due May 1, 2016).

LDPP applications must include:

- Identification of LDPP lead entity
- Collaboration plan that includes local partners and details how decisions will be made
- Description of the needs assessment that was conducted to identify the target population(s), including the data used
- Description of how the lead entity and participating providers will be accountable for ensuring that the patient's receive timely, medically necessary care
- Detail of the specific interventions, including how a process improvement plan will be incorporated to modify and learn from interventions
- Description of how data sharing will occur between the entities
- Description of other strategies and outreach efforts that will be implemented
- Plan for the lead entity to conduct ongoing monitoring of the LDPP and make subsequent adjustments
- Letters of support from participating providers and other relevant stakeholders
- Financing structure, including how and to whom LDPP payments will be distributed
- Total requested annual dollar amount, which shall be based on budgeted costs for infrastructure and overall a LDPP support and the expected value or impacts of the LDPP. Budgets shall exclude costs for services reimbursable with Medi-Cal Dental or other federal funding sources.

Medi-Cal 2020: Demonstration & Programs Years

<i>Demonstration Year (DY)</i>	<i>Dates</i>
DY 11	January 1, 2016 – June 30, 2016
DY 12	July 1, 2016 – June 30, 2017
DY 13	July 1, 2017 – June 30, 2018
DY 14	July 1, 2018 – June 30, 2019
DY 15	July 1, 2019 – June 30, 2020
DY 16	July 1, 2020 – December 30, 2020

Public Hospital Redesign and Incentives in Medi-Cal (PRIME)

<i>Demonstration Year (DY)</i>	<i>Dates</i>
DY 11	July 1, 2015 – June 30, 2016
DY 12	July 1, 2016 – June 30, 2017
DY 13	July 1, 2017 – June 30, 2018
DY 14	July 1, 2018 – June 30, 2019
DY 15	July 1, 2019 – June 30, 2020

Global Payment Program

<i>Program Year (PY)</i>	<i>Dates</i>
PY 1	July 1, 2015 – June 30, 2016
PY 2	July 1, 2016 – June 30, 2017
PY 3	July 1, 2017 – June 30, 2018
PY 4	July 1, 2018 – June 30, 2019
PY 5	July 1, 2019 – June 30, 2020

Whole Person Care Pilots

<i>Program Year (PY)</i>	<i>Dates</i>
PY 1	January 1, 2016 – December 31, 2016
PY 2	January 1, 2017 – December 31, 2017
PY 3	January 1, 2018 – December 31, 2018
PY 4	January 1, 2019 – December 31, 2019
PY 5	January 1, 2020 – December 31, 2020

Dental Transformation Initiative

<i>Program Year (PY)</i>	<i>Dates</i>
PY 1	January 1, 2016 – December 31, 2016
PY 2	January 1, 2017 – December 31, 2017
PY 3	January 1, 2018 – December 31, 2018
PY 4	January 1, 2019 – December 31, 2019
PY 5	January 1, 2020 – December 31, 2020

Attachments to the Medi-Cal 2020 Special Terms and Conditions

There are 42 attachments to the STCs; 28 are complete (**bold**) and 14 pending (*italics*).

Attachments	Title
A	<i>Reserved (untitled)</i>
B	<i>Reserved for "SPD Discharge Planning Checklist" Form</i>
C	Global Payment Program Participating Public Health Care Systems
D	Designated Public Hospital Systems and District/Municipal Public Hospitals that are Participating PRIME Entities
E	<i>Reserved (untitled)</i>
F	Funding and Reimbursement Protocol: Determination of Allowable Costs to Uninsured Individuals in Designated State Health Programs
G	<i>Reserved (untitled)</i>
H	Accounting Procedures
I	Quarterly Report Guidelines
J	<i>Reserved (untitled)</i>
K	Budget Neutrality Projections and Allotment Neutrality Requirements
L	Managed Care Enrollment Requirements
M	Geographic Distribution and Delivery System Model
N	Capitated Benefits Provided in Managed Care
O	County Listing for SPD Enrollment
P	Demonstration and Program Years
Q	Reserved for PRIME Projects and Metrics
R	Reserved for Alternative Payment Methodologies
S	Reserved for PRIME Evaluation and Monitoring
T	2013 Managed Care Expansion Monitoring Elements
U	CCI Enrollment Timeline by Population and County
V	MLTSS Monitoring Items
W	Community-Based Adult Services (CBAS) Provider Standards of Participation
X	Drug Medi-Cal Organized Delivery System (DMC-ODS) Operational Protocol
Y	DMC-ODS DHCS Appeals Process
Z	DMC-ODS County Implementation Plans
AA	<i>Reserved for DMC-ODS County Certified Public Expenditure Protocol</i>
BB	DMC-ODS Tribal Delivery System
CC	DMC-ODS Financing and Availability of Medication Assisted Treatment (MAT) Services
DD	DMC-ODS UCLA Evaluation
EE	Reserved for Global Payment Program Funding and Mechanics
FF	Reserved for Global Payment Program Valuation
GG	<i>Reserved for Whole Person Care Reporting and Evaluation</i>
HH	<i>Reserved for Whole Person Care Requirement and Application</i>
II	Reserved for PRIME Program Funding and Mechanics
JJ	Medi-Cal 2020: Dental Transformation Incentive Program
KK	<i>Reserved for California Children's Services Pilot Protocol</i>
LL	<i>Reserved for Historical Information – Budget Neutrality Test</i>
MM	<i>Reserved for Whole Person Care Pilot Requirements and Metrics</i>
NN	<i>Reserved for DSH Coordination Methodology</i>
OO	<i>Reserved for CBAS Program Integrity</i>
PP	<i>Reserved for Negative Balance Payment Schedule</i>



March 7, 2016

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To: Members of the Health and Human Services Policy Committee

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

RE: HHS Budget Update – Halfway Through Budget Hearing Season

We are about halfway through the state budget hearing season, with budget subcommittees taking the lead to hear each of the Governor's January budget proposals as well as other ideas presented by members, advocates, and stakeholders.

Budget hearings will continue right up to the Governor's release of the May Revision Budget on or around May 15. The budget subcommittees will then reconvene to hear previous and new issues. The Legislature must pass the 2016-17 budget act no later than June 15.

CSAC is lobbying several HHS-related budget issues up to, and through, the Governor's May Revision. They include:

AB 403 Continuum of Care Reform – The Governor signed AB 403, the Continuum of Care Reform legislation to abolish the group home system for all but the most high-need foster youth, last fall. AB 403 will require, at a minimum, funding for capacity building and new practice requirements in county child welfare services, probation, and mental health agencies.

The Governor has proposed \$96 million for foster family recruitment and probation services in his 2016-17 January budget. While the funding is welcome, it falls far short of what is needed for implementation and ongoing activities associated with AB 403— especially since the bill requires a reformed group home system just 8 short months from now.

CSAC is working with the County Welfare Directors Association, the Chief Probation Officers of California and the County Behavioral Health Directors Association to determine county funding needs for AB 403 implementation. CSAC is also working on ongoing Proposition 30 questions surrounding AB 403 costs to affected county departments, which were realigned to counties in 2011.

Please see attached joint CSAC, CWDA, CBHDA, and CPOC letter to the Assembly Budget Subcommittee on AB 403 issues.

County Medi-Cal Administration Funding – It is a CSAC 2016 priority to ensure that counties have enough administrative funding to handle the activities and workload of conducting Medi-Cal eligibility on behalf of the state.

The incredibly rapid growth in Medi-Cal caseload, coupled with technical difficulties, continues to create significant workload at the local level. The Governor's January Budget proposal for 2016-17 includes \$169 million (\$57 million General Fund) over 2015-16 levels for both 2016-17 and 2017-18 for ongoing ACA implementation at the local level. The Governor's two-year proposal will allow counties to retain and hire caseworkers and keep up with the unprecedented demand.

Further, CSAC also supports the Governor's proposal to conduct a time study to gather data on the amount of time and work county eligibility staff is contributing. This data would then be used to inform a new Medi-Cal county administration budgeting methodology.

CSAC strongly supports these proposals. Both the Senate and Assembly subcommittees have heard this item and have not yet taken action pending the May Revision. Please see attached budget letter.

Other Issues. The budget process is just underway, so materials for specific issues are being developed. A few of the other budget issues that CSAC expects to weigh in on include:

Adult Protective Services: CSAC will join the County Welfare Directors Association to advocate for \$5 million (State General Fund) for statewide training of social work staff in the APS program.

In-Home Supportive Services Maintenance of Effort: CSAC has joined with the County Welfare Directors Association and the California Association of Public Authorities to oppose proposed trailer bill language that would raise the IHSS MOE for counties that provide IHSS services through what is known as "contract mode." Currently, only two counties are in contract mode, but the associations are opposing the precedent that the trailer bill language might set if enacted. See attached letter for more details.

In-Home Supportive Services Overtime Implementation (FLSA): CSAC has joined with a large coalition of IHSS stakeholders in asking for regulatory cleanup to assist counties with implementing new federal and state IHSS overtime rules. Asks include changing IHSS task hours from a monthly to a weekly authorization, allowing 26 equal pay periods, and paying for certain travel and wait time services in arrears to ensure the IHSS recipient is properly cared for. See attached letter for more details.

Please also note that the implementation and cost of the new federal Fair Labor and Standards Act (FLSA) overtime regulations remain a state cost.

Attachments:

Joint CSAC, CWDA, CBHDA, and CPOC Budget Letter (April 2016)

CSAC Medi-Cal Administration Budget Letter (March 2, 2016)

Adult Protective Services Coalition Budget Letter (April 2016)

IHSS MOE Contract Mode Issue (March 8, 2016)

IHSS Overtime Issues (February 29, 2016)

CSAC Staff Contacts:

Farrah McDaid Ting, CSAC Legislative Representative: fmcdaid@counties.org, (916) 650-8110
Elizabeth Marsolais, CSAC Legislative Analyst: emarsolais@counties.org, (916) 327-7500 Ext. 524



**CALIFORNIA STATE
ASSOCIATION OF
COUNTIES**

April 5, 2016

The Honorable Tony Thurmond, Chair
Assembly Budget Subcommittee No. 1 on Health and Human Services
State Capitol Building, Room 5150
Sacramento, CA 95814



**COUNTY WELFARE
DIRECTORS
ASSOCIATION**

Re: AB 403 – Continuum of Care Reform (CCR)

Dear Assembly Member Thurmond,

The California State Association of Counties (CSAC), the County Welfare Directors Association (CWDA), the County Behavioral Health Directors Association (CBHDA), and the Chief Probation Officers of California (CPOC) are writing to you today to support the implementation of last year's AB 403, the landmark Continuum of Care Reform (CCR) measure.



**COUNTY BEHAVIORAL
HEALTH DIRECTORS
ASSOCIATION OF
CALIFORNIA**

The CCR reflects a much-needed foundational change in how California cares for its most vulnerable children who have been removed from their homes and are served by county child welfare, mental health, and probation agencies. By reforming the group home system from the ground up, CCR will help provide better, more appropriate care and services for children and youth in home-based settings, and reduce the time a child might spend in congregate care settings.



**CHIEF PROBATION
OFFICERS OF
CALIFORNIA**

Our organizations and the county supervisors, human services directors, behavioral health directors, and probation chiefs that we represent, support the state's effort to make these important and timely changes to improve the care and outcomes for our child welfare and probation foster youth. However, a massive reform effort like CCR requires thoughtful and comprehensive planning and coordination, as well as adequate fiscal support.

In the midst of these efforts, we are striving to not lose sight of the fact that CCR implementation will have concrete effects on the lives of each of the children and families we serve. The stakes are high and we haven't much time between now and the January 1, 2017 implementation date – only 8 short months away.

Our associations have been working collaboratively to identify areas in which we must work with our state counterparts at the Department of Social Services, the Department of Health Care Services, and the Department of Finance to shepherd AB 403's CCR from concept to reality.

Our task is complicated by the very design of the CCR – informed by evidence and supported by foster youth – which is intended to drive collaboration across all systems and professionals that serve child welfare and probation foster youth. This adds complexity to the efforts of our four associations to ascertain the costs, workload, and other considerations needed for successful implementation in advance.

Clearly county social workers, mental health professionals, and probation officers will either build on existing duties or be required to participate in entirely new innovations to implement CCR. Examples include the Child and Family

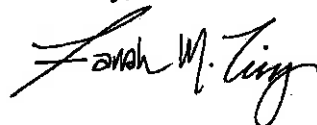
Team (CFT) model, which has shown encouraging outcomes for the children served in the *Katie A.* subclass.

Also, mental health departments will be responsible for expanded Medi-Cal certification duties and oversight of agencies implementing Short-Term Residential Therapeutic Programs (STRTPs) and Therapeutic Foster Care, while social workers and probation officers will spend significantly more time recruiting, certifying, retaining, and training foster families to build the capacity to best serve each child. While the additional staff time alone will certainly contribute to the cost of AB 403 implementation, we recognize that it is also a necessary component of the CCR.

We are grateful to the Governor for acknowledging that up-front investment is needed to support AB 403 implementation, and for including funding in his January Budget Proposal for probation and child welfare services costs. We continue to work with the Administration to develop more accurate estimates on county costs that will lead to the successful implementation of CCR statewide. Without adequate funding for the casework, the recruitment and support of family-based providers, and certification of new providers that are required by AB 403, CCR simply will not work. It is also important to develop a plan now for measuring county-incurred costs and local savings, so that counties, the state administration, the legislature, and stakeholders can accurately quantify the cost-benefit of this reform effort in the longer term.

Despite these large issues, counties remain committed to working with department staff, child welfare and probation foster youth, and advocates to create the best, safest placements with the required array of services and supports to create better outcomes for our most vulnerable children and youth.

Sincerely,



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cc: Honorable Members, Assembly Budget Subcommittee No. 1
The Honorable Mark Stone, Member, California State Assembly
The Honorable Anthony Rendon, Speaker of the Assembly
Will Lightbourne, Director, California Department of Social Services
Jennifer Kent, Director, California Department of Health Care Services
Michael Cohen, Director, California Department of Finance
Gail Gronert, Consultant, Office of Assembly Speaker Rendon
Mike Wilkening, Undersecretary, California Health and Human Services
Agency
Sara Rogers, California Department of Social Services
Nicole Vazquez, Consultant, Assembly Budget Subcommittee No. 1
Cyndi Hillery, Consultant, Assembly Republican Caucus



March 2, 2016

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The Honorable Tony Thurmond, Chair
California Assembly Budget Subcommittee No. 1
State Capitol Building, Room 5150
Sacramento, CA 95814

Re: County Medi-Cal Administration Funding

Dear Assembly Member Thurmond:

The California State Association of Counties (CSAC) appreciates the Administration's and Legislature's commitment to providing adequate funding for county administration of the Medi-Cal program. Counties have been working hard to ensure the successful implementation of the Affordable Care Act (ACA) and provide efficient and timely eligibility determinations for both new and existing Medi-Cal beneficiaries. The Governor's January Budget proposal for 2016-17 includes an increase for counties to administer the state's Medi-Cal program. CSAC strongly supports this proposal.

CSAC is grateful for the inclusion of \$169 million (\$57 million General Fund) over 2015-16 levels for both 2016-17 and 2017-18 for ongoing ACA implementation in the Governor's January budget proposal. The incredibly rapid growth in Medi-Cal caseload, coupled with technical difficulties, continues to create significant workload at the local level. The Governor's two-year proposal will allow counties to retain and hire caseworkers and keep up with the unprecedented demand.

Further, CSAC also supports the Governor's proposal to conduct a time study to gather data on the amount of time and work county eligibility staff is contributing. This data would then be used to inform a new Medi-Cal county administration budgeting methodology. County stakeholders would be included in the development of this new methodology. CSAC supports the time study proposal to provide better data on actual county costs associated with Medi-Cal eligibility. Once developed, a new budgeting methodology will stabilize the state's annual appropriations for these services and afford counties some predictability in year-to-year funding levels. For a program as important as Medi-Cal, this is a worthy effort.

Counties wish to again thank the Administration for providing additional funding for ACA implementation in the January Budget proposal and respectfully ask that your committee approve the Governor's request for \$169 million in 2016-17 and 2017-18. An "aye" vote would signal your committee's commitment to keeping California on the cutting edge of ACA implementation.

If you have additional questions about the county position on this topic, I can be reached at fmcdaid@counties.org or (916) 650-8110. Thank you.

Sincerely,

A handwritten signature in cursive script that reads "Sarah M. Ting".

Farrah McDaid Ting
CSAC Legislative Representative

cc: Honorable Members, Assembly Budget Subcommittee No. 1
Agnes Lee, Office of the Assembly Speaker
Chris Woods, Office of the Assembly Speaker
Andrea Margolis, Assembly Budget Subcommittee No. 1
Cyndi Hillery, Assembly Republican Fiscal Office
Jennifer Kent, Director, Department of Health Care Services
Matt Paulin, Department of Finance
Mark Newton, Legislative Analyst's Office
Amber Didier, Legislative Analyst's Office
Frank Mecca, County Welfare Directors Association



April 4, 2016

The Honorable Tony Thurmond, Chair
Assembly Budget Subcommittee No. 1



Honorable Members
Assembly Budget Subcommittee No. 1
State Capitol Building, Room 6026
Sacramento, CA 95814



California Alliance
OF CHILD AND FAMILY SERVICES

RE: SUPPORT TO CHILD WELFARE AGENCIES TO SERVE CHILD VICTIMS OF COMMERCIAL SEXUAL EXPLOITATION (CSEC)

CHILDREN NOW

Dear Chairman Thurmond and Members:



Our broad coalition of agencies and organizations urges your support to provide \$19.7 million General Funds to expand services provided to child victims of commercial sexual exploitation through California's child welfare services programs. This funding is needed to meet new federal and state mandates that require the child protective services system to identify and serve this unique population.



CAST
COALITION TO ABOLISH
SLAVERY & TRAFFICKING

The commercial sexual exploitation of children (CSEC) is a national and statewide epidemic that deserves our highest attention. Various studies have pointed to the fact that many CSEC victims have had prior involvement with CWS, and some have been recruited while being in the foster care system. In addition, three of the top ten highest trafficking areas in the nation are right here in California: San Francisco, Los Angeles and San Diego metropolitan areas. In many respects, these victims are like other children that counties serve in the child welfare services system, but also have unique needs due to their experiences of extreme trauma and abuse that cannot be fully met with current resources.



We greatly appreciated the Legislature's investment of \$14 million into the CSEC Program in the 2014-15 State Budget. During the first year of ramp up, a total of \$5 million was allocated, with a portion dedicated for training of social workers, probation officers, group home staff, family-based foster care providers and youth, and the remainder provided to counties to begin developing local multi-disciplinary response protocols. Last year, the full \$14 million was allocated to counties, of which \$3.25 million was redirected to meet the new mandates of the federal Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183), which requires that child welfare agencies develop procedures and protocols for finding runaway youth and screening to determine if youth are victims of commercial sexual exploitation. The remaining \$10.75 million was allocated to counties opting into the CSEC State Program: eighteen counties received grants for continued development of their local CSEC protocols, and twenty-two counties received funding to implement local protocols, in coordination with local law enforcement, probation agencies, public health, behavioral health, and community-based organizations serving youth.



WESTCOAST CHILDREN'S CLINIC



Children's Law Center
of California
Excellence in Advocacy

The investment of \$14 million included a clarification in state law (SB 855, Statutes of 2014) that child victims of commercial sexual exploitation must come under the protection of the child welfare system. This was followed by federal law (P.L. 113-183) that requires child welfare agencies implement locally-established protocols, provide case management and secure other services and supports to meet unique needs of CSEC youth, beginning September 2016. Data indicates that counties served over 400 victims of commercial sexual exploitation between July 2015 and September 2015 and anticipate serving over 800 in this fiscal year. However, the need is likely far greater, given the prevalence of commercial sexual exploitation in California and the fact that counties and community partners are just beginning to identify CSEC youth as a result of efforts to increase awareness through education and implementation of local screening tools.

Additional funding is needed to ensure that all counties and their community partners can implement local protocols and meet both federal and state mandates. We know from local experience that CSEC victims need intensive services and support to protect them from further victimization and help them overcome severe physical and emotional abuse. These victims require immediate assistance to keep them safe from their perpetrators, including emergency housing and supplies, and case coordination across service providers to assist in their recovery. Successful interventions requires specialized training and close collaboration across public and private agencies and service providers, led by child welfare agencies.

For these reasons, we support the request for \$19.7 million in additional funding to serve CSEC victims, of which \$3.5 million would be utilized for federally-mandated training, and \$16.2 million will provide direct services to CSEC victims.

We thank you for your attention to this important matter on behalf of child victims of commercial sexual exploitation.

Sincerely,

Frank J. Mecca, Executive Director
County Welfare Directors Association of CA

Stephanie Richard, Policy/Legal Services Dir.
Coalition to Abolish Slavery

Carroll Schroeder, Executive Director
California Alliance of Child and Family Services

Amy Lemley, Policy Director
John Burton Foundation for Children without Homes

Farrah McDaid-Ting, Senior Legislative Rep.
California State Association of Counties

Liberty Sanchez, Legislative Representative
LIUNA Local 777 and 792

John J. Bauters, Policy Director
Californians for Safety and Justice

Claire Lipschultz, Esq., State Policy Advocate
National Council of Jewish Women

Leslie Heimov, Executive Director
Children's Law Center of California

Tia Orr, Senior Government Advocate
Service Employees Union International (SEIU)

Susanna Kniffen, Associate Director,
Child Welfare Policy, Children NOW

Stacey Katz, Executive Director
WestCoast Children's Clinic

Budget Memo – CSEC
April 4, 2016
Page 3

cc: Gail Gronert, Office of the Assembly Speaker
Chris Woods, Office of the Assembly Speaker
Nicole Vazquez, Assembly Budget Subcommittee No. 1
Cyndi Hillery, Assembly Republican Fiscal
Will Lightbourne, Department of Social Services
Robert Smith, Department of Social Services
Michael Wilkening, Health and Human Services Agency
Matt Paulin, Department of Finance
Jay Kapoor, Department of Finance
Mark Newton, Legislative Analyst's Office
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March 3, 2016

To: The Honorable Holly Mitchell
Chair, Senate Budget Subcommittee No. 3

Honorable Members, Senate Budget Subcommittee No. 3

From: Farrah McDaid Ting, Legislative Advocate, California State Association of Counties
Frank J. Mecca, Executive Director, County Welfare Directors Association
Karen Keesler, Executive Director, California Association of Public Authorities for IHSS

Re: **Contract Mode Adjustments to IHSS MOE Trailer Bill Language – OPPOSE**

The California State Association of Counties (CSAC), the County Welfare Directors Association (CWDA), and the California Association of Public Authorities for IHSS (CAPA) are opposed to the Administration's proposed trailer bill language (TBL) that would adjust the county In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) for all increased costs of contracts in counties in the contract mode. This TBL would inappropriately shift to counties additional costs that are already covered by the IHSS MOE adjustment formula. We respectfully request that you reject or adopt a modified version of this TBL.

The IHSS MOE took effect in the 2012-13 fiscal year and changed the county contribution for IHSS Program costs. Prior to 2012-13, counties were statutorily required to cover a specified share of all nonfederal costs of the IHSS program. The IHSS MOE replaced that statutory state/county sharing ratio. It capped each county's contribution to the nonfederal costs of the IHSS program at the county's 2011-12 expenditure level and requires that the new county contribution grow annually in two ways:

- For counties that locally negotiate a wage or health benefit increase for their providers in any fiscal year, those counties' IHSS MOEs are permanently increased beginning in the fiscal year that the wage or health benefit increase takes effect for the county's share of those costs based on the previously-existing statutory state/county sharing ratios.
- Beginning in 2014-15, all counties' IHSS MOEs increase by 3.5 percent each year, except in any fiscal year in which 1991 Realignment revenues to counties declines.

The increase in the IHSS MOE for locally negotiated wage and health benefit increases ensures that counties continue to share in IHSS Program costs that are specific to IHSS and over which the county has direct control. The annual 3.5 percent inflation factor ensures that counties continue to have a share of all other IHSS costs, such as for caseload increases, increases in the costs per case, other programmatic

changes that increase costs, or other administrative costs to the IHSS Program over which the county has little or no control. The IHSS MOE does not permit the county IHSS MOE to decline in any fiscal year from the prior year.

The IHSS MOE was established in conjunction with the Coordinated of Care Initiative (CCI) and the shift of collective bargaining in the IHSS Program from counties that have fully implemented the CCI to the state. The IHSS MOE ensures that the costs resulting from any state-negotiated changes to the wage or health benefits of IHSS providers, over which counties have no control, are not shifted to the counties. The IHSS MOE was applied to all counties, and not just the original eight counties in the CCI, because eventually all counties are intended to participate in the CCI and shift IHSS collective bargaining to the Statewide Public Authority. . It is also administratively very difficult, if not impossible with our current systems, to maintain different state/county cost sharing ratios for different counties within the same program.

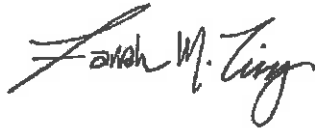
The IHSS statutes allow counties to contract with another agency to make available IHSS providers to ensure that the county can fulfill the statutory mandate that all authorized services are provided to every eligible IHSS participant. This is called "contract mode," and statute is specific about what costs can be covered by these contracts. IHSS providers employed by the contractor are required to be paid consistently with other non-contract IHSS providers in the county. The contract costs also cover costs of the contractor over which the county, and the contractor itself in many cases, have no control, such as taxes, insurance costs, and the costs of state and federal changes to the program. The statute permits the contract to cover the actual, documented expenditures of the contractor and any reasonable costs over which the contractor has no control.

There are currently only two counties that participate in this "contract mode," San Francisco and San Mateo, and in even in those counties, contract providers are used to provide services to only a minority of consumers. The use of non-contract IHSS providers is the vastly preferred method of providing IHSS services to consumers, as it provides consumers more choice and control in who their providers are. However, for some high need, difficult-to-serve consumers or consumers with no provider choices, contract providers are the only means to keep these IHSS consumers living safely in their own homes and out of more costly institutional care.

The Administration's proposed TBL would adjust a "contract mode" county's IHSS MOE for ALL increases in the cost of the contract, not just those cost increases associated with locally negotiated provider wage or health benefit increases. The contract costs that are not associated with provider wages and health benefits are comparable to other IHSS costs that are already covered by the 3.5 percent inflation factor and do not result in the calculation of a separate IHSS MOE adjustment in addition to that 3.5 percent. The proposed TBL is inconsistent with the existing statutory framework for how counties' IHSS MOEs are to grow over time. That framework for growth was part of the original IHSS MOE agreement between the Administration and counties when the IHSS MOE was put into place. The proposed TBL would, in effect, result in a county being charged twice for those contract cost increases that are beyond provider wages and health benefits, once as a part of the 3.5 percent inflation adjustment and again in the separately calculated IHSS MOE adjustment.

CSAC and CWDA are not opposed to TBL that would clarify that county IHSS MOEs should be increased for the county's share of contract provider wage or health benefit increases resulting from local negotiations, consistent with the IHSS MOE adjustment made for locally negotiated wage or health benefit increases for all other IHSS providers. The proposed TBL is currently much broader than that. Therefore, we respectfully request that you either reject the proposed TBL or adopt a modified version that is consistent with current law.

CSAC-CWDA-CAPA Budget Letter:
Contract Mode Adjustments to IHSS MOE Trailer Bill Language – OPPOSE
March 3, 2016



Sincerely,
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cc: Jennifer Troia, Office of the Senate President Pro Tempore
Craig Cornett, Office of the Senate President Pro Tempore
Theresa Pena, Senate Budget Subcommittee No. 3
Chantele Denny, Senate Republican Fiscal
Will Lightbourne, Department of Social Services
Robert Smith, Department of Social Services
Michael Wilkening, Health and Human Services Agency
Matt Paulin, Department of Finance
Jay Kapoor, Department of Finance
Mark Newton, Legislative Analyst's Office
Ginni Bella Navarre, Legislative Analyst's Office
Callie Freitag, Legislative Analyst's Office
County Caucus



March 1, 2016

The Honorable Tony Thurmond, Chair
Assembly Committee on Human Services

Honorable Members
Assembly Budget Subcommittee No. 1

RE: Making FLSA Work in IHSS: Improving Outcomes for All

The undersigned organizations respectfully request your consideration of necessary statutory changes to support the implementation of the Fair Labor Standards Act (FLSA) as it applies to the In-Home Support Services (IHSS) Program. These changes are needed to enable IHSS consumers and providers to comply with the new mandates and reduce possible harm that may result absent these changes.

We have serious concerns with the current policy, which places undue pressure on IHSS consumers and providers to navigate a complex myriad of new rules and procedures for overtime and travel time. Despite our collective efforts to educate IHSS consumers and providers on the new rules, we believe the current rules are unmanageable and a set up for failure. Several aspects of implementation are simply too cumbersome to properly implement. This places IHSS consumers in jeopardy of losing their providers and worse, potentially risks their health and safety.

To prevent unintended and undesired harmful consequences to IHSS consumers, we have identified several changes necessary to enable both IHSS consumers and providers to comply with FLSA requirements. Below we identify specific areas of needed changes and these changes are presented in order of what we believe are the priority areas to be addressed:

- 1. Extend the Grace Prior to September 1, 2016 before Violations Begin to Toll:** The current grace period for providers, before violations begin to toll, begins May 1, 2016. Given the significant changes in the program and challenges in recruiting additional IHSS providers, this grace period should be extended, to September 1, 2016, before consequences for violating overtime and travel time limits become effective. This will give additional time to make programmatic changes necessary to comply with FLSA.
- 2. Ensure that consumers can continue to receive services to remain safely at home:** A small number of IHSS providers care for more than one consumer with highly specialized needs. The overtime limit means that they cannot continue to provide that care if the consumers' combined hours exceed 66 per week. These providers are parents with more than one child with disabilities, an adult caring for two parents with dementia, an adult caring for a spouse and a child, both with disabilities. There may not be a suitable additional provider available to avoid an overtime situation. When no other provider is available, the consumer cannot receive the services which were authorized as needed for safety in their homes.

The California Department of Social Services (CDSS) has recognized this issue and is attempting to address this administratively. However, statutory protections are needed to allow for situations when a provider can work above the CDSS cap of 66 hours/week in certain, limited situations, including:

- Providers who are the parent, step-parent, grandparent or legal guardian of two or more children (including providers approved after Jan 31, 2016);
- Spouses, domestic partners, adult children caring for parents, adult siblings, and adult grandchildren, when no other suitable provider is available; and
- Individual consumer situations when there is no other suitable provider is available, the recipient would be at risk of out-of-home placement, or the recipient's health (including physical, psychiatric or emotional) or safety would be at risk.

In addition, statute should allow some providers to work over 90 hours/week in limited situations based on individual consumer needs when there is no other suitable provider is available, the recipient would be at risk of out-of-home placement, or the recipient's health (including physical, psychiatric or emotional) or safety would be at risk.

3. **Align IHSS Authorized Hours with FLSA Policy:** Current law requires a monthly authorization of hours, yet FLSA requires consumers and providers to track their hours by the week. When counties perform assessments, the majority of tasks are assessed at a weekly amount, then converted to a monthly amount. By overlaying FLSA requirements, consumers now have to take an *additional* step of converting back to a weekly amount. These extra steps are not only unnecessary, but can easily lead to errors in the calculation, which may result in a provider working more than s/he is permitted. This can increase costs to the IHSS program and could result in violations, and eventual termination, of the provider. The following changes are needed to align FLSA implementation with the IHSS Program:

- **Pay Providers on a bi-weekly basis in 26 equal pay periods:** Currently the IHSS program pays providers twice per month (1-15th and 16-30/31st day of each month). SB 855 now requires recipients/providers to track hours worked per week (Saturday through Sunday). Because a workweek can break across two different months, this makes tracking time worked and overtime difficult and inconsistent with SB 855. Aligning the pay period to the SB 855 workweek will require a one-time programming change to the CMIPS Payrolling System and align the IHSS pay schedule with the FLSA work week.
- **Create equitable caps in overtime for IHSS Providers:** CDSS has created two different caps for providers: providers serving one consumer may be compensated for hours worked up to 70.75 hours per week, while providers serving multiple consumers may be compensated at 66 hours per week. This is unfair to consumers and creates new challenges to Public Authorities to recruit additional registry providers for clients. This policy should be revised to allow providers with multiple consumers to receive compensation up to the 70.75 hour weekly cap.
- **Authorize all IHSS tasks by the week:** Most tasks are already assessed according to a workweek except for Domestic Services, which is assessed up to 6 hours per month, and under this proposal, would be assessed up to 1.5 hours per week to align with all other IHSS tasks.

- **Retain current flexibility in the IHSS program:** Consumers have fluctuating needs for services based on their health needs, and the IHSS program has always provided flexibility to adjust hours to the consumer's needs, so long as the total hours remained within their monthly authorization. Consumers should be able to retain this flexibility to move hours without having to contact the county to seek permission.
4. **Pay for Certain Services in Arrears to Align with FLSA:** FLSA requires payment for travel time between consumers on the same day and SB 855 allows travel time to be paid in arrears after the travel is incurred, up to 7 hours per week. The travel time is not taken from the consumers' authorized hours, it is an addition. FLSA also now requires payment for wait time at medical appointments. However, wait time is deducted from authorized hours. Therefore, consumers with the highest need, who are already at or near the 195/238 monthly authorization cap are prevented from actually claiming this new service. This puts them in jeopardy of either not having their provider to assist them at medical appointments, or if the provider claims those wait time hours, they do so at the cost of not providing other needed services. It is also difficult to accurately predict wait time since doctor's appointments can vary.

In addition, other services occur infrequently, at irregular intervals, or cannot be easily assessed for time until after the tasks are rendered. For example: yard hazard abatement, ice/snow removal, heavy cleaning and teaching and demonstration, are services that occur infrequently but are often critical in maintaining the safety of the recipient in their home and community, and should be paid in arrears.

5. **Permit Waiver Clients to Access Public Authority Registry Services:** Currently Public Authorities are only allowed to provide access to registry services to IHSS consumers. Yet, consumers of Waiver Personal Care Services (WPCS) are excluded from registry services, even though WPCS consumers use IHSS-like services (and often use both IHSS and WPCS services) and are also subject to the new FLSA rules. This proposal would simply allow WPCS consumers to also contact the registry to help them identify in-home providers.

We anticipate these changes will reduce confusion to IHSS consumers and providers as they try to comply with the new overtime rules. While we are still developing a fiscal estimate for these changes, but ultimately, we believe these changes will result in marginal new costs for additional overtime paid during the grace period and expansion of service hours. There are one-time costs associated with changes to the CMIPS system to convert to a bi-weekly pay period. We believe there will also be offsetting savings as a result of reduced county workload to address provider violations and helping consumers to find new providers and back-up providers, and potential savings in hospitalizations and other institutional care settings by avoiding unintentional harm to consumers and providers. Once we have additional information regarding the overall fiscal impact we will provide that to the Committee and staff.

The attached analysis provides additional background on each of the aforementioned proposals.

Thank you for your consideration of our request.

Sincerely,

Karen Keeslar, Executive Director
California Association of Public Authorities for IHSS (CAPA)

Farah McDaid-Ting, Legislative Representative
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Attachment

cc: Gail Gronert, Office of the Assembly Speaker
Myesha Jackson, Office of the Assembly Speaker
Chris Woods, Office of the Assembly Speaker
Nicole Vazquez, Assembly Budget Subcommittee No. 1
Cyndi Hillery, Assembly Republican Fiscal
Tyrone McGraw, Office of Assemblymember Tony Thumond
Will Lightbourne, Department of Social Services
Robert Smith, Department of Social Services
Michael Wilkening, Health and Human Services Agency
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To: Members of the Health and Human Services Policy Committee

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

RE: Homelessness Issues Update

Homeless issues are heating up at both the state and local levels. However, California's counties have been grappling with the issues for decades.

Overview. From urban to rural, each of California's 58 counties provide essential services for people experiencing homelessness, including poverty-reduction programs, physical and behavioral health services, public safety and affordable housing.

- **Poverty:** Counties are key partners with the state in administering many of the critical poverty-reduction programs, such as CalWORKs and CalFresh benefits and Medi-Cal health eligibility. These poverty programs provide essential support to people experiencing homelessness while they work towards self-sufficiency.
- **Behavioral Health Services:** Counties operate the county mental health plans and provide substance use disorder services. These services help to stabilize individuals as they exit homelessness, and help increase the likelihood that they will remain housed.
- **Public Safety:** County and city public safety systems have an intimate knowledge of their local homeless population due to frequent contacts, and often act as valuable partners in the effort to identify and assist homeless individuals.
- **Zoning and Siting:** Counties are also responsible for appropriate zoning and general planning, and have an important role in creating and supporting affordable housing options. Counties are also often providers of temporary housing solutions for the homeless, especially those struggling with mental health or substance use disorder issues and people recently released from state prison or local jails.

The Senate "No Place Like Home" Proposal. In January, Senate leaders released their "No Place Like Home" proposal. Senate President pro Tempore Kevin de León and former Senator Darrell Steinberg crafted the plan to redirect a portion of Mental Health Services Act (MHSA, or Proposition 63) funding from counties to help securitize up to \$2 billion in affordable housing bonds. Under the proposal, only counties would compete with each other for the housing bond funds. The proposal also urges an increase in the state's Supplemental Security Income/State Supplementary Payment (SSI/SSP) rates, which provide monthly funding to those who are aged, blind, or disabled. Further, the proposal affirms support for the existing Housing Support Program, which is administered by counties within the CalWORKs program, and a new "Bringing Families Home" program to provide family housing.

CSAC has not yet developed a position on the "No Place Like Home" proposal, as details beyond what is attached to this memo – three pages in all – are not yet available.

CSAC Efforts. CSAC is undertaking a number of efforts on the issue, including:

- **Collaboration:** Because homelessness is a local issue that crosses county and city boundaries, CSAC will be forming a joint task force on Homeless Issues with the League of California Cities. The task force is in the initial planning stages, and more information will be released as it becomes available.

CSAC is also working with the County Behavioral Health Directors (CBHDA) and the County Welfare Directors Association (CWDA) on developing a position on the No Place Like Home proposal. While the proposed diversion of MHSA funding is worrisome, the human services-related elements of the plan (more support for the Housing Support Program, etc.) have significant potential and are supported by human services directors. Please also see CBHDA's Housing Principles document for more detail on their concerns, attached.

- **Education:** The CSAC Institute for Excellence in County Government will present an Emerging Issues course on homelessness on April 14 in Sacramento.

CSAC will also organize a workshop on homeless issues during the 2016 CSAC Legislative Conference, May 18-19 in Sacramento. Details on the workshop will be provided as they become available.

- **Engagement:** CSAC will continue to engage with the Senate and other stakeholders to ensure the county voice is part of the process and any final package. The Senate Budget and Fiscal Review Committee held an informational hearing titled "Challenges and Opportunities: Homelessness in California's Local Communities" on February 25, hearing testimony from a variety of state and national experts on the issue, including Yolo County Supervisor Oscar Villegas on behalf of CSAC.

CSAC will continue to work with the League of California Cities on the joint task force and issues of mutual interest.

Attachments:

Senate's No Place Like Home Proposal (January 4, 2016)

CBHDA's Housing Principles (February 11, 2016)

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Senate President pro Tempore Kevin de León Press Release:

Senate Announces “No Place Like Home” Initiative To Tackle Homelessness in California

Monday, January 4, 2016

California Senate Legislative Package to Prevent and Address Homelessness in our Local Communities

LOS ANGELES — To assist local communities in preventing and addressing homelessness, a bipartisan coalition of members from the California State Senate introduced a strategic and first-of-its kind “No Place like Home” initiative at a press conference at The Star Apartments on Skid Row in Los Angeles on Monday. This unprecedented policy framework amounting to over \$2 billion in support builds on years of research and best practices and is guided by the core belief that no individual or family in California should ever experience the uncertainty and pain of living without a home.

“This bipartisan legislative package will help secure progress in tackling homelessness and provide a key to health and hope for many Californians who have no place to go.” said Senate President pro Tempore Kevin de León (D-Los Angeles). “Coming off the holiday season, I can think of no better way to start the legislative session than in Skid Row focused on lifting those without voices in our political process.”

“This is a tipping-point moment for mental health, homelessness, and Proposition 63 in California.” Said former Senate leader Darrell Steinberg, co-author of Proposition 63 (2004) – The Mental Health Services Act – and founder The Steinberg Institute. “Thanks to the leadership of this Senate, we have a historic opportunity to help local communities forge systemic long-term solutions, making a real difference in the lives of thousands of forgotten Californians.”

The Senate proposal is crafted with the understanding that fighting modern homelessness – with long-term solutions, not short-term Band-Aids – requires a localized approach sustained by a strategic statewide commitment.

The proposals will empower local governments with additional resources and flexibility to better serve homeless individuals and families, increase access to affordable housing, address the effects of income inequality and, and extend proven programs for homeless who are either disabled or in need of mental-health assistance.

California has the nation’s largest homeless population while ranking as the seventh largest economy of the world at the same time. The 114,000 total homeless people who live across our state make up 22 percent of the nation’s homeless population, with Los Angeles holding the dubious ranking of the homeless capital of the country with nearly 42,000 homeless residents.

The Senate legislative package on homelessness re-purposes Proposition 63 (2004) – The Mental Health Services Act – bond money and creatively leverages billions of additional dollars from other local, state, and federal funding to achieve the following goals:

Housing:

- 2 billion bond to construct permanent supportive housing for chronically homeless persons with mental illness.
- \$200 million, over 4 years, to provide supportive housing in the shorter-term, rent subsidies, while the permanent housing is constructed or rehabilitated.
- Support for two special housing programs that will assist families:

The “Bringing Families Home” pilot project, a county matching grant program to reduce homelessness among families that are part of the child welfare system.

The CalWORKs Housing Support Program, which provides housing and support services for CalWORKs families in danger of homelessness.

Income support and outreach:

- An increase in Supplemental Security Income/State Supplementary Payment (SSI/SSP) program grants which provide income support for the aged, blind, and disabled poor who cannot work.

Rates of homelessness are higher for persons with disabilities who cannot work; SSI/SSP is intended to help them make ends meet, and a large portion of grants usually goes toward rent.

These increases will assist about 1.3 million low-income Californians (72% with disabilities and 28% who are elderly).

- A one-time investment to incentivize local governments to boost outreach efforts and advocacy to get more eligible poor people enrolled in the SSI/SSP program.

The federal government covers 72% of the total costs of the SSI/SSP program, so state and local benefits are multiplied significantly for each newly eligible recipient.

California has more than one third of the nation’s chronically homeless – those with mental illness or other significant problems, and an even higher percentage among homeless women. Of the 28,200 chronically homeless in California, nearly 85 percent are unsheltered with this group absorbing the greatest amount of taxpayers’ resources, often toping \$100,000 annually per person in public costs for emergency room visits, hospital stays, law enforcement, and other social services.

The Senate proposal supports a “housing first” strategy which many homeless advocates and social service experts across the state prefer because it provides safe, secure housing creates an environment that allows for wrap-around services, such as mental health treatment, to take hold. Studies show homelessness aggravates mental illness, making it more difficult to reach and house those with the greatest need of shelter and treatment.

There are local programs, such as Project 25 in San Diego, which are successfully housing, treating, and transitioning chronically homeless clients back into society. Project 25 is a 3-year-pilot program funded by the United Way of San Diego and led by St. Vincent de Paul which uses the housing first model as a means of intensive case management and delivery of psychiatric and medical care to several dozen clients. Project 25 is paying dividends for the taxpayers. In two years the annual public costs related to participants of Project 25 were reduced nearly 63 percent, to \$1.6 million from \$4.3 million.

- See more at: <http://sd24.senate.ca.gov/news/2016-01-04-senate-announces-%E2%80%9Cno-place-home%E2%80%9D-initiative-tackle-homelessness-california#sthash.X0BxC95o.dpuf>

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CBHDA Housing Principles **Adopted February 11, 2016**

Expanding safe and affordable housing is a key priority for the County Behavioral Health Directors Association (CBHDA). County behavioral health departments are essential partners in any effort to reduce and prevent homelessness when mental illness and/or substance use are key contributing factors. A safe place to call home is essential for personal recovery and wellness, and behavioral health services are critical in preventing homelessness. Based on our experiences, we strongly believe the following principles must be considered in designing new efforts and targeting new investments:

1. Utilize the Public Behavioral Health Target Population Definition for Homelessness Prevention and Reduction Efforts

In public behavioral health, Mental Health Services Act (MHSA) funded supportive housing is targeted for people who are low-income and who are homeless or at risk of being homeless. A person who lives on the streets or lacks a fixed and regular night time residence is considered homeless. The target population is further defined as adults, older adults, transition-age youth with serious mental illness, children with severe emotional disorders and their families, who at the time of assessment for housing services meet the criteria for MHSA programming. Use of MHSA funding must be consistent with the voter mandate.

2. Utilize Proven Models To Respond to Homelessness

Housing First is an approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible – while providing supportive services. This approach posits that having a roof over one's head is an essential step in reducing homelessness while acknowledging the many mental health and substance use challenges that prevent the homeless from accepting assistance. Rapid Re-housing rapidly connects families and individuals experiencing homelessness to permanent housing. Efforts should also be made to ensure that individuals in temporary and bridge housing are targeted for permanent, supportive housing (i.e., not just those individuals who are homeless). A variety of proven strategies should be considered in any investment to end homelessness.

3. Invest in Supportive Services and Break the Cycle of Long-Term Homelessness

Supportive services, for people with behavioral health challenges, are essential to housing stability and to maximizing each individual's ability to live independently. County Behavioral health departments are uniquely positioned to identify and intervene, in collaboration with community partners, to address the dual, interwoven, public health crises of substance use and mental illness that complicate homelessness. A successful strategy to combat homelessness will build on local and statewide collaborations and include essential mental health and substance use services.

4. Fund Construction, Operating Subsidies, and Supportive Services

Construction is only one of the *three* major costs to permanent supportive housing. Equally important is funding to make up the difference between what it costs to operate the housing – such as paying for maintenance, property management and other employees, or a new roof -- and what residents can afford to pay. Most homeless individuals lack income beyond a monthly check provided under federal Social Security programs for people with disabilities and could not afford the rent of an apartment without a subsidy. Therefore, in order to make the units affordable for the tenants, the units must be subsidized through a capitalized operating reserve or some other form of subsidy. And finally – supportive services including mental health and substance use are essential.

5. Ensure Residents of All Counties Can Benefit from Additional Housing Investments

Homelessness impacts all counties. Therefore, any MHSAs set aside for the purpose of expanding housing capacity should be available, through a noncompetitive process, to all counties to invest in additional housing and supportive services.

6. Balance Investment

Counties and providers are working diligently to achieve the goals of the MHSAs which calls for more expansive, inclusive, effective, innovative, and an accountable mental health system. Every dollar devoted to a statewide approach to housing is a dollar that will not be spent providing direct mental health and substance use services at a time of overwhelming need. There needs to be a balance between investing in affordable housing and investing in other critical mental health and substance use services.

7. Consider MHSAs Revenue Volatility

MHSA funding allocations are not consistent each year. The annual amount of MHSAs funding diverted for housing needs to be adjusted and matched with the volatility of the revenue source and each county should be able to determine what funding is used to pay back any bond debt (e.g. Prevention and Early Intervention (PEI), Innovation, Community Services and Supports (CSS), funds at risk of reversion or new funding). In addition, there needs to be a consideration given to fund services *in the long term* to people living in permanent supportive housing created by any statewide program as well as funding for long term operating costs of maintaining housing.

8. Ensure Flexibility to Address Local Needs

There is not a “one size fits all” approach to housing across the State; there are a number of housing models for supportive housing. The housing setting can vary and is based on a range of factors including the resident’s preference, the type of housing available, affordability, and the history of a local community’s real estate market. For example, in cities, large apartment buildings are typical while in suburban and rural communities; single-family homes are more common. Programs need flexibility with regard to the utilization of housing such as options for Master Lease agreements and housing rehabilitation, in addition to capital investments.

9. Address “Not in My Backyard” (NIMBY) and Siting Challenges

Organizations that provide housing and supportive services to people with mental health and substance use disorders have tremendous challenges including identifying housing sites, obtaining necessary funding, arranging for services, navigating complex administrative systems, and securing scarce funding sources even when neighbors and local government support the project. The process becomes far more difficult when neighbors protest about housing “those people” in “our” neighborhood. Any statewide

housing initiative should support efforts to reduce stigma and housing discrimination against people with mental health and substance use challenges.

10. Leverage and Increase the Impact of Existing and Emerging State Housing and Services

The MHSAs Housing Program developed in August 2007 set aside \$400 million in funds to provide capital development loans and critical funding for long term operating subsidies for the development of affordable rental housing for MHSAs individuals. Each county's Department of Mental Health provides MHSAs residents with an *individualized array of supportive services* needed for recovery and the opportunity to become fully functioning community members. These program funds are administered for counties by the California Housing Finance Agency (CalHFA) and the California Department of Health Care Services (DHCS). The funds from the MHSAs Housing Program will ultimately house approximately 2,600 MHSAs residents. Several counties plan to continue the partnership and assign additional MHSAs dollars to CalHFA to administer under a new statewide program. Additionally, as authorized under the Affordable Care Act, States can create "Health Homes" to serve individuals with chronic conditions including mental health and substance use. One of the primary goals of the Health Home Program in California is to link individuals to housing and services. This is another opportunity to address the needs of the homeless. Aligning with initiatives such as these is imperative.