Health and Human Services Policy Committee
Tuesday, November 28, 2017 — 2:30 – 4:00 p.m.
Sacramento Convention Center · Room 313
1400 J Street · Sacramento County

Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Candy Carlson, Tehama County, Vice Chair

2:30 p.m.	I.	**Welcome and Introductions** *Supervisor Ken Yeager, Santa Clara County, Chair* *Supervisor Candy Carlson, Tehama County, Vice Chair*
2:35 p.m.	II.	**Presentation: First 5 California – The Future for Critical Services** *Moira Kenney, First 5 Association of California*
2:55 p.m.	III.	**In-Home Supportive Services Update** *Justin Garrett, Legislative Representative, CSAC* *Elizabeth Marsolais, Legislative Analyst, CSAC*
3:10 p.m.	IV.	**Federal Update – Ongoing Uncertainty** *Tom Joseph, Waterman & Associates*
3:20 p.m. ***ACTION ITEM***	V.	**2017 Legislative Review and 2018 HHS Priorities** *Justin Garrett, Legislative Representative, CSAC* *Farrah McDaid Ting, Legislative Representative, CSAC* *Elizabeth Marsolais, Legislative Analyst, CSAC*
3:45 p.m.	VI.	**California's Cannabis Laws – Implementation, Impacts & Resources** *Justin Garrett, Legislative Representative, CSAC* *Farrah McDaid Ting, Legislative Representative, CSAC* *Elizabeth Marsolais, Legislative Analyst, CSAC*
3:55 p.m.	VII.	**Other Items**
4:00 p.m.	VIII.	**Closing Comments and Adjournment** *Supervisor Ken Yeager, Santa Clara County, Chair* *Supervisor Candy Carlson, Tehama County, Vice Chair*

This will be an in-person only meeting. Thank you.

ATTACHMENTS

II. First 5 California – The Future for Critical Services

Attachment One ..... CSAC Memo: First 5 Association of California – The Future for Critical Services

Attachment Two ..... Handout: First 5 Overview

Attachment Three ..... Handout: First 5 2018 Policy Priorities

Attachment Four ..... Handout: First 5 Home Visiting

III. In-Home Supportive Services Update

Attachment Five ..... CSAC Memo: In-Home Supportive Services Update

Attachment Six ..... Handout: County IHSS MOE Methodology Brief

Attachment Seven ..... Handout: Consultation with CSAC on IHSS Implementation

IV. Federal Update – Ongoing Uncertainty

Attachment Eight ..... CSAC Memo: Federal Update – Ongoing Uncertainty

V. 2017 Legislative Review and 2018 HHS Priorities

Attachment Nine ..... CSAC Memo: 2017 Legislative Review and 2018 HHS Priorities

Attachment Ten ..... Handout: CSAC Health and Human Services Draft 2018 Work Plan

VI. California's Cannabis Laws – Implementation, Impacts & Resources

Attachment Eleven ..... CSAC Memo: CSAC Cannabis Policy, Advocacy & Outreach Efforts

First 5 California – The Future for Critical Services

Attachment One

CSAC Memo: First 5 Association of California – The Future for Critical Services

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November 13, 2017

To: CSAC Health and Human Services Policy Committee

From: Farrah McDaid Ting, CSAC Legislative Representative, Health and Behavioral Health
Justin Garrett, CSAC Legislative Representative, Human Services
Elizabeth Marsolais, CSAC Legislative Analyst, Health and Human Services

RE: First 5 Association of California – The Future for Critical Services – Information Only

Introduction. The First 5 Association of California, a CSAC Affiliate, is celebrating the 20th anniversary of Proposition 10 next year. We have invited Moira Kinney, Executive Director of the First 5 Association of California to talk about the successes and challenges for local First 5 Commissions, the Association's policy priorities, and the outlook for funding in the future.

Background. In November 1998, California voters passed Proposition 10, the "Children and Families Act of 1998" initiative. The act levies a tax on cigarettes and electronic tobacco products to provide funding for early childhood development programs. Revenues generated from the tobacco tax must be used to enhance the early growth experiences of children, enabling them to be more successful in school and ultimately to give them an equal opportunity to succeed in life. Revenues must be used for the following specific purposes:

- To create a comprehensive and integrated delivery system of information and services to promote early childhood development;
- Support parenting education, child health and wellness, early child care and education, and family support services; and
- Educate Californians on the importance of early childhood development and smoking cessation.

Tobacco tax revenues are collected at the state level. Eighty percent of these funds are then allocated to the 58 counties according to annual birth rates. The remaining twenty percent of the money is allocated to First 5 California to support statewide programs, research, and media campaigns.

First 5 County Commissions

When voters passed Proposition 10, they launched a new model of responsive public agencies. In each of the 58 counties, the local First 5 Commission is comprised of local community leaders, including county supervisors, as well as experts and advocates who provide oversight for the local First 5's activities.

The State First 5 Commission initiates and funds statewide early childhood development projects, conducts research, and sponsors large media and public education campaigns. Learn more on the website for the First 5 Association of California: www.first5association.org.

Recent Changes Affect Tobacco Funding. Recent legislation has changed the tobacco landscape, including raising the legal age to purchase tobacco products to age 21 and categorizing electronic tobacco products (E-Cigs) the same way as existing tobacco products. This includes subjecting electronic tobacco products to the same state taxation and oversight as existing products.

Despite these changes, revenue is declining statewide. Local First 5 Commissions are grappling with reduced revenue while still working to sustain quality early childhood programs in their communities.

The First 5 Association of California is working to identify critical programs and services, including early childhood health, child care, and education, to assist counties in making targeted investments and building partnerships that will provide the "most bang for their buck."

Policy Priorities. The First 5 Association of California's 2018 policy priorities are grouped in four major areas that are in line with the text of Proposition 10:

- Resilient Families
- Comprehensive Health and Development
- Quality Early Learning
- Sustainability and Scale

Executive Director Kenney will provide an update on the Association's planned efforts in these areas.

Materials.

- First 5 Overview
- First 5 2018 Policy Priorities
- First 5 Home Visiting

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First 5 California – The Future for Critical Services

Attachment Two

Handout: First 5 Overview

FIRST 5'S COMMITMENT TO CHILDREN AND FAMILIES

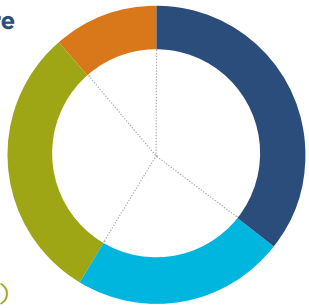
FIRST 5 ASSOCIATION OF CALIFORNIA

The greatest opportunities to improve the trajectory of a child's life happen during pregnancy and the first five years of life.

First 5 leads statewide efforts to champion the complex needs of young children and their families through strong, effective and proven systems of care. Established by California voters through the passage of Proposition 10, First 5 commissions in all 58 counties now have nearly 20 years of on-the-ground experience and work to make kids healthy, safe, and ready to learn.

IN 2016, FIRST 5 COUNTY COMMISSIONS SPENT:

$503M* reaching over 800,000 kids



$179M **Preschool and Quality Child Care** (Preschool, QRIS, Infant and Toddler Care)

$116M **Family Strengthening** (Parent Education, Homeless Services)

$151M **Child Health** (Home Visiting, Early Intervention, Oral Health)

$57M **Systems Building** (Coordinating services between agencies, leveraging resources, advocating for unmet needs)

*includes leveraged funding

CHILDREN AND FAMILIES FACE REAL CHALLENGES

50% Medi-Cal births

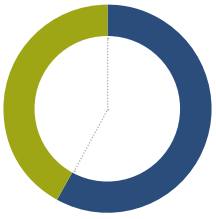
24% living in poverty

14% reported for abuse or neglect at least once

67% are not screened for development delays

91% of eligible infant toddlers are NOT placed in subsided child care

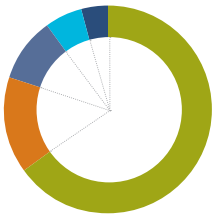
FIRST 5 FUNDING GOES TO:



42% **Community-Based Organizations** (non-profits, including child care providers)

58% **Public Agencies** (Department of Public Health, School Districts, County Offices of Education, Health & Human Services Agencies)

CHILDREN SERVED BY COUNTY COMMISSIONS:



65% Latino

15% White

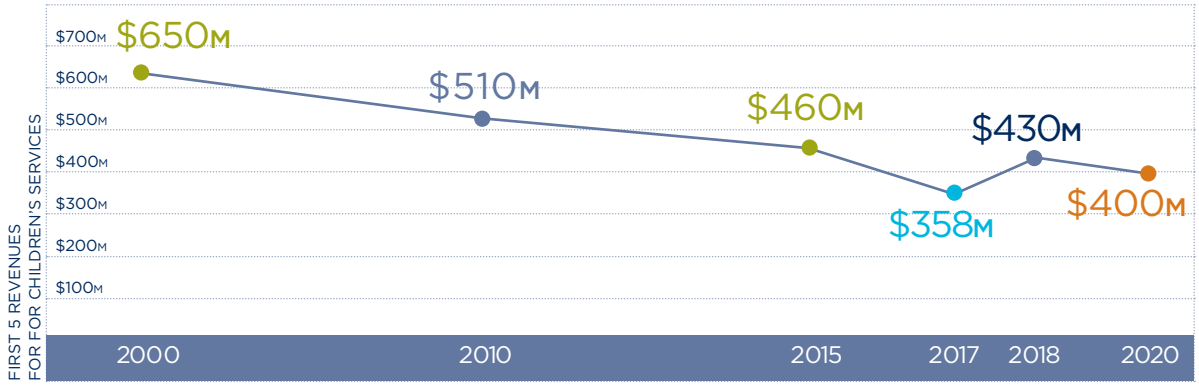
10% Multi-Racial / Other

6% Asian Pacific Islander

4% African-American

BE A CHAMPION FOR CHILDREN

FIRST 5 REVENUES WILL DECLINE BY NEARLY 40 PERCENT BY 2020.



VOLATILE & INADEQUATE FUNDING:

First 5 is solely funded through statewide Tobacco Taxes (Proposition 10, 1998). Fortunately, fewer Californians are smoking. However, California has tied essential services to unstable tobacco taxes.

The cumulative effects of increasing taxes on tobacco products (Prop 56) and increasing the smoking age to 21 (SBx2 5) have further reduced First 5 funding.

The expected declines in tobacco tax revenues will affect programs and services funded by First 5 in your county. We need our state and federal partners to fulfill their responsibilities for the health, education, and care of our youngest children.

EVEN AT ITS PEAK, FIRST 5 FUNDING WAS NEVER ENOUGH TO ADDRESS THE NEEDS OF CHILDREN:

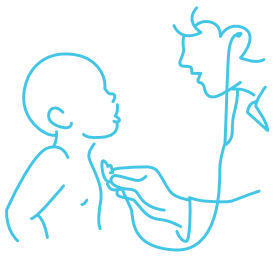
$200 spent per child by First 5 in 2000
$125 spent per child by First 5 by 2020

BY COMPARISON:
$9,500 spent per child enrolled in Head Start programs and services in CA.

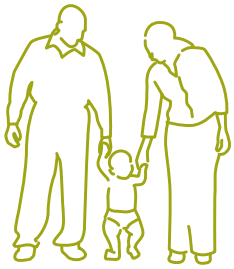
THE TIME TO INVEST IS NOW. *BE A CHAMPION FOR…*

Kindergarten readiness and quality early learning

Developmental screening and early intervention



Preventative health services and oral health care



Supporting resilient families and safe homes

…CALIFORNIA'S YOUNGEST CHILDREN

FIRST 5 ASSOCIATION OF CALIFORNIA

www.first5association.org

First 5 California – The Future for Critical Services

Attachment Three

Handout: First 5 2018 Policy Priorities

First 5: Champions for Children

2018 POLICY AGENDA

FIRST 5 ASSOCIATION OF CALIFORNIA

First 5 builds the early childhood systems and supports needed to ensure California's young children are healthy, safe, and ready to succeed in school. This is accomplished by:

RESILIENT FAMILIES

VISION:
Promote parental resilience, social connections, concrete support in times of crisis, and knowledge of parenting and child development.

POLICY GOALS:

- Expand access to evidence-based family strengthening programs, including home visiting and parent education, to optimize child development and reduce the risk of abuse and neglect.
- Strengthen the social safety net to build family resiliency and promote self-sufficiency.
- Support community hubs for integrated services and crisis supports for children and families.
- Support parent engagement on child brain development, including Talk. Read. Sing.

COMPREHENSIVE HEALTH AND DEVELOPMENT

VISION:
Build a family-centered health system that prioritizes prevention.

POLICY GOALS:

- Ensure all pregnant mothers and children ages 0–5 have affordable and comprehensive health insurance.
- Increase use of essential Medi-Cal services, especially dental, mental health, and vision services.
- Increase coordination across systems of care to connect young children to screening and early intervention, including through the expansion of Help Me Grow.
- Expand availability and geographic spread of health care providers and professionals.

QUALITY EARLY LEARNING

VISION:
Ensure children are healthy and have the social-emotional and cognitive skills to enter kindergarten ready to learn.

POLICY GOALS:

- Increase supply of high-quality early learning programs for children 0–5.
- Embed high-quality standards in all state-funded early learning programs and support state and local efforts to meet them.
- Promote affordability of early learning programs, while ensuring fair workforce compensation.

SUSTAINABILITY AND SCALE

VISION:
Fulfill the voter-approved Proposition 10 mandate: *"To create a comprehensive and integrated delivery system of information and services to promote early childhood development."*

POLICY GOAL:

- Explore and advance alternative revenue sources for children's services.
- Improve and integrate county data systems to track and evaluate children's outcomes.
- Regulate tobacco products.
- Mitigate public health risks that widely affect children's health and wellbeing.

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First 5 California – The Future for Critical Services

Attachment Four

Handout: First 5 Home Visiting

FIRST 5 IS THE LARGEST FUNDER OF HOME VISITING IN CALIFORNIA

FIRST 5 ASSOCIATION OF CALIFORNIA

NUMBER OF CALIFORNIA COUNTIES INVESTING IN HOME VISITING: 44

TOTAL ANNUAL INVESTMENT: $87,500,000

TOTAL LEVERAGED FUNDS: $28,000,000

TOTAL FAMILIES SERVED: 37,000

5 THINGS ABOUT HOME VISITING:

1) Home visiting includes an array of programs and services
There are many different proven, evidenced-based home visiting models that help families and young children. Programs vary to best meet the needs of specific families. For example, certain programs focus on health by using nurse home visitors, while others rely on social workers to refer families to services.

2) Home visiting is voluntary
A family must invite a home visiting professional into their home to receive the services and supports.

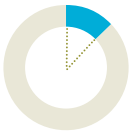
3) Home Visiting has many benefits
Home visiting has immediate and long-term benefits for families and society: improved parenting practices, reduced child maltreatment, family resiliency and self-sufficiency, better birth outcomes, and increased school readiness.

4) First 5 is the largest funder of home visiting
California does not invest General Fund dollars in home visiting programs. Instead, First 5 county commissions are the largest investors in home visiting in the state, many times using matching and leveraged funds to expand programs.

5) Federal home visiting funding is up for re-authorization
Since 2010, California has received over $126 million in federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding. MIECHV is up for reauthorization in September 2017.

CALIFORNIA'S YOUNG CHILDREN:

24% are living in poverty



13% have at least one unemployed parent

57% are covered by Medi-Cal

14% have experienced neglect or abuse

KEY POLICY RECOMMENDATIONS:

INCREASE COORDINATION:
Better state-local coordination across home visiting programs can ensure that programs reach the highest need communities, refer families to services, and share data on program success.

MAXIMIZE RESOURCES:
Home visiting is supported through multiple revenue streams, including First 5 funding. Due to declining funding, First 5 investments in home visiting are not sustainable. Furthermore, federal MIECHV funding is up for reauthorization in September 2017. State investments are needed to sustain home visiting programs throughout the state.

PROMOTE SYSTEMS:
Home visiting works best when families are matched with the program that best addresses their needs and can connect families to other community services and supports. A systems approach ensures that families receive the level of intervention best suited for their needs.

HOME VISITING IS OFFERED IN DIFFERENT LANGUAGES:

HOW IS FIRST 5 SUPPORTING HOME VISITING ACROSS CALIFORNIA?

First 5 programs help parents facing social, economic or health challenges who need additional supports. Home visiting is a proven intervention that strengthens families, helps break the cycle of poverty and ensures children the best possible start in life.

WHAT DO FIRST 5 INVESTMENTS LOOK LIKE IN CALIFORNIA?

CONTRA COSTA

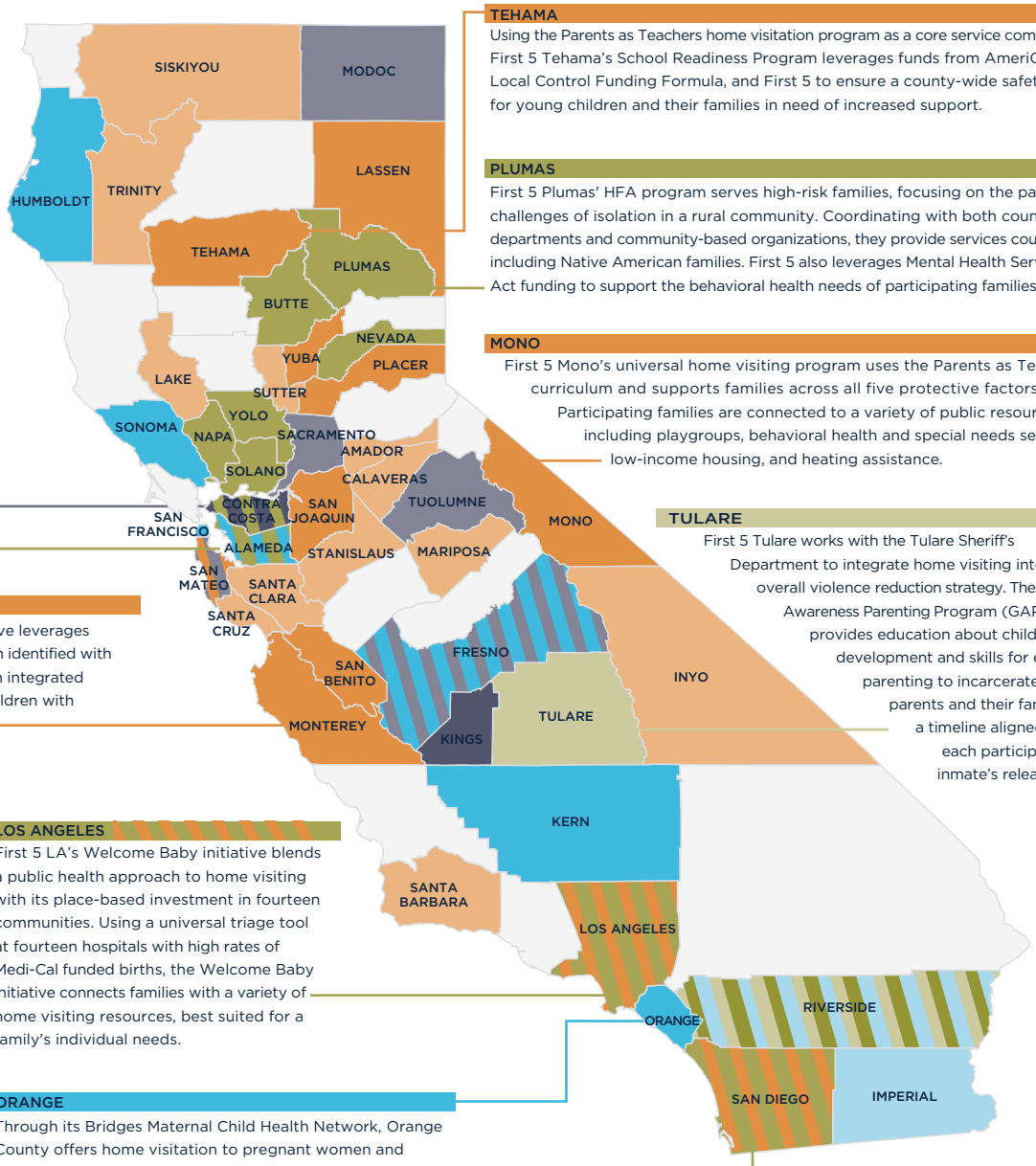
First 5 Contra Costa's HFA program staff includes male home visitors to encourage participation of fathers in their child's early development. In addition to the HFA core curriculum, fathers receive information about employment opportunities, community services, and infant development.

ALAMEDA

First 5 Alameda and the Alameda County Public Health Department have jointly funded a comprehensive home visiting and family support system of care for high-risk families. Central to the effort's success is the integration of programs into a countywide system, use of a common intake and referral process, and common quality standards to maximize resources and outcomes.

MONTEREY

First 5 Monterey's Parents as Teachers initiative leverages Medi-Cal funding to serve families and children identified with a medical necessity. In addition, PAT has been integrated into a comprehensive First 5 effort serving children with special needs living in East Salinas.



TEHAMA

Using the Parents as Teachers home visitation program as a core service component, First 5 Tehama's School Readiness Program leverages funds from AmeriCorps, Local Control Funding Formula, and First 5 to ensure a county-wide safety net for young children and their families in need of increased support.

PLUMAS

First 5 Plumas' HFA program serves high-risk families, focusing on the particular challenges of isolation in a rural community. Coordinating with both county departments and community-based organizations, they provide services countywide, including Native American families. First 5 also leverages Mental Health Services Act funding to support the behavioral health needs of participating families.

MONO

First 5 Mono's universal home visiting program uses the Parents as Teachers curriculum and supports families across all five protective factors. Participating families are connected to a variety of public resources including playgroups, behavioral health and special needs services, low-income housing, and heating assistance.

TULARE

First 5 Tulare works with the Tulare Sheriff's Department to integrate home visiting into its overall violence reduction strategy. The Gang Awareness Parenting Program (GAPP) provides education about child development and skills for effective parenting to incarcerated parents and their families on a timeline aligned with each participating inmate's release plan.

CALIFORNIA HOME VISITING MODELS

- PARENTS AS TEACHERS
- NURSE FAMILY PARTNERSHIP
- HEALTHY FAMILIES AMERICA
- EARLY HEAD START
- SAFECARE
- HIPPY
- NURTURING FAMILIES/ NURTURING PARENTS
- LOCAL MODELS

LOS ANGELES

First 5 LA's Welcome Baby initiative blends a public health approach to home visiting with its place-based investment in fourteen communities. Using a universal triage tool at fourteen hospitals with high rates of Medi-Cal funded births, the Welcome Baby initiative connects families with a variety of home visiting resources, best suited for a family's individual needs.

ORANGE

Through its Bridges Maternal Child Health Network, Orange County offers home visitation to pregnant women and women who deliver at any of 10 high-birth hospitals. Programs offered include Nurse Family Partnership, other public health nursing interventions for high-risk mothers and infants, and the Triple P-Positive Parenting Program. Orange County recently participated in a new one-time Medicaid funding transaction in partnership with CalOptima, the county's Medicaid managed care plan.

SAN DIEGO

San Diego's First 5 First Steps was the recipient of a 2015 Achievement Award by the National Association of Counties. The initiative provides county-wide home visitation services to specific high-risk target populations, including pregnant and parenting teens, military personnel, refugees, immigrants, and low income families.

FIRST 5 ASSOCIATION OF CALIFORNIA

In-Home Supportive Services Update

Attachment Five

CSAC Memo: In-Home Supportive Services Update

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November 13, 2017

To: CSAC Health and Human Services Policy Committee

From: Justin Garrett, CSAC Legislative Representative, Human Services
Elizabeth Marsolais, CSAC Legislative Analyst, Health and Human Services
Graham Knaus, CSAC Deputy Executive Director of Operations & Member Services

RE: In-Home Supportive Services Update – Information Only

Background. The Governor's January budget included the end of the Coordinated Care Initiative (CCI) resulting in the elimination of the In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) and required shift of nearly $600 million in new IHSS costs to counties. CSAC negotiated an IHSS agreement with the Administration that was reflected in the May Revise. The agreement included the establishment of a new County MOE with an annual inflator, State General Fund contributions to partially offset the cost shift including $400 million in 2017-18, additional redirected revenues to offset IHSS costs, and a requirement to reexamine the funding structure during the development of the 2019-20 state budget in consultation with counties. CSAC supported the IHSS agreement and new county IHSS MOE as it will result in significantly reduced overall county contribution for IHSS costs compared to the January budget proposal. The final agreement was reflected in a budget trailer bill SB 90 (Chapter 25, Statutes of 2017) and clean-up provisions were included in the Health and Human Services clean-up trailer bill AB 130 (Chapter 251, Statutes of 2017).

2017-18 County IHSS MOE. SB 90 specifically identified that the Department of Finance will consult with CSAC to implement the County IHSS MOE, including determining each County's IHSS MOE base. CSAC convened an IHSS MOE Workgroup to ensure input from the County Administrative Officers and technical experts and representation from Urban, Suburban, and Rural counties during the development of the County IHSS MOE. On September 7, the CSAC Board of Directors unanimously approved the recommended IHSS MOE methodology, which was also unanimously approved by the CAOs. The Administration is now moving forward with implementing the approved IHSS MOE methodology, including distributing a County Fiscal Letter to counties with the specific MOE amounts and General Fund offset amounts. On our September 27 HHS Policy Committee call, we covered in detail the approved methodology. For further background, please see the *County IHSS MOE Methodology Brief*.

2017-18 Offsetting Revenue. The IHSS MOE methodology was utilized to determine specific percentages for each county of the revenue that is available to offset increased IHSS costs for 2017-18. This includes redirected 2016-17 sales tax growth from Mental Health, Health and County Medical Services Program (CMSP) to Social Services, redirected 2016-17 VLF growth from Mental Health, Health and CMSP to Social Services, and accelerated caseload growth for 2017-18 sales tax. The State Controller distributed the redirected 2016-17 sales tax growth and redirected 2016-17 VLF growth to counties at the end of October. For accelerated caseload growth, we are working with the Department of Finance to determine the final amount and the process for this revenue to be accelerated to counties. It is anticipated that this revenue will be reflected in sales tax payments from the State Controller beginning in November.

Wage and Bargaining Provisions. There are new provisions related to county wage increases and bargaining with IHSS provider unions. These provisions provide additional tools for counties to utilize

when negotiating locally, but also put in place new requirements and timelines. There have been a number of questions regarding how the trailer bill provisions will be implemented. Following discussions with the Administration, we have now received definitive answers on two important points that are consistent with our original understanding and advocacy efforts.

We confirmed that all counties, not just those at minimum wage, are able to negotiate a wage supplement. This is a specified amount that is in addition to the county provider wage. When a wage supplement is first negotiated and applied, there is a one-time adjustment to the County IHSS MOE for the amount of the increase. For subsequent applications of the wage supplement, there is no adjustment to the County IHSS MOE. In addition, we confirmed that it is possible to secure state participation in a wage supplement that exceeds the state participation cap by concurrently utilizing the provision that allows for state participation in a wage increase above the cap, currently at $12.10 per hour. Counties can secure state participation in a cumulative total of up to a 10 percent increase in the sum of the combined total of changes in wages or health benefits, or both over a three-year period.

CSAC will be producing a document that contains detailed explanations of the wage and bargaining provisions. We also will continue to engage in ongoing discussions with the Administration to secure consistent and clear guidance on how these tools will be implemented.

IHSS Administration. There is a separate General Fund amount for counties for IHSS County Administration and Public Authority (PA) Administration. CSAC worked in partnership with the County Welfare Directors Association (CWDA) and the California Association of Public Authorities (CAPA) on the recommended allocation for this General Fund amount and the recommendation has now been shared with the Administration. We are continuing to engage with them on other IHSS administration issues, including how the administration cap will be implemented and the budget methodology for IHSS Administration.

IHSS Training. On November 16, we hosted an IHSS training in Sacramento that included more than 200 county staff and nearly every county represented. The main topics for this training included the IHSS MOE, wage and bargaining provisions, and IHSS Administration.

Next Steps. There are numerous provisions in SB 90 and AB 130 where the Department of Finance is required to consult with CSAC. We have completed some of these, including establishing the County MOE amounts, and continue to engage with them and other departments on other implementation provisions, including the process for MOE adjustments for wage and benefit increases. For additional details on all the provisions that require consultation, see *Consultation with CSAC on IHSS Implementation*. Throughout all of this, we will continue to ensure counties have the information they need through email updates and trainings in order to manage these changes locally. In addition, we will continue to track the impact of the new MOE as we look toward the reopener provision that requires the state to consult with CSAC in the development of the 2019-20 budget and examine the impact on IHSS and other realigned programs.

Attachments.

- County IHSS MOE Methodology Brief
- Consultation with CSAC on IHSS Implementation

CSAC Staff Contacts:

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Elizabeth Marsolais, CSAC Legislative Analyst, Health and Human Services: emarsolais@counties.org, (916) 650-8184
Graham Knaus, CSAC Deputy Executive Director of Operations & Member Services: gknaus@counties.org, (916) 327-7500 Ext. 545

In-Home Supportive Services Update

Attachment Six

Handout: County IHSS MOE Methodology Brief

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County IHSS MOE Methodology Brief

September 2017

On September 7, the CSAC Board of Directors unanimously approved the IHSS MOE methodology. Senate Bill 90, which implemented the May Revise IHSS agreement, specifically identified that the Department of Finance will consult with CSAC to implement the County IHSS MOE, including determining each County's IHSS MOE base. CSAC convened an IHSS MOE Workgroup to ensure input from the County Administrative Officers and technical experts and representation from Urban, Suburban, and Rural counties during the development of the County IHSS MOE. The methodology has been shared with the Administration for their consideration and implementation. This document outlines the approved methodology.

IHSS MOE Methodology

The IHSS MOE Workgroup considered a broad range of factors and data that could be utilized to determine how to distribute the cost shift and offsetting revenue among California's counties. Ultimately, the workgroup selected two factors to combine into an overall methodology.

MOE Base

- Each county has a specific county MOE amount from the Department of Social Services and Department of Finance that forms the 2017-18 starting point before the $592.2 million cost shift is added.
- The county share of the prior MOE period was initially established based on 2011-12 expenditures, essentially what each county spent in 2011-12 on services, IHSS county administration and Public Authority (PA) administration. Changes in local wages and benefits that have occurred over the past five years are reflected in a county's current share of the overall MOE.
- Each county's percent to total of this statewide base number is calculated.
- Utilizing the MOE base provides some stability to each county's current share of the statewide MOE. It also reflects the difference in wages and benefits that each county has negotiated and incorporates that as a factor in determining the share of the cost shift.

Annual Hours Growth

- The amount of annual IHSS provider hours grew by 36.7% statewide over the prior MOE period.
- Data includes the statewide and county specific IHSS provider hours in the most recent year compared to statewide and county specific hours from five years ago.
- Each county's percent to total of this statewide growth number is calculated.
- Utilizing annual hours growth reflects changes that have occurred in the program over the previous MOE period and is responsive to where that growth occurred and may occur in the coming years.

MOE and Offsetting Revenue

- The methodology weights the MOE Base and Annual Hours Growth equally.
- Based on combining 50% from each, a county's overall percent to total is calculated and then applied to determine the county's proportionate share of the cost shift and offsetting General Fund revenue.
- The overall MOE is the sum of four smaller MOE amounts – services, IHSS county administration, PA administration, and Case Management, Information and Payrolling System (CMIPS).
- The MOE Base/Annual Hours Growth methodology is utilized for the services component of the cost shift and General Fund offset, which accounts for 95% of the total cost shift and General Fund offset.

- To determine the IHSS county administration component, each county's percent to total of the most recent 12 months of IHSS county administration expenditures is calculated and then applied to determine the county's proportionate share.
- To determine the PA administration component, each county's percent to total of the most recent 12 months of PA administration expenditures is calculated and then applied to determine the county's proportionate share.
- To determine the CMIPS component, the actual numbers from the Department of Social Services are utilized to determine the county's proportionate share.
- After all four of these components are combined into one overall MOE, each county's percent to total is calculated for the overall cost shift.
- The $400 million State General Fund offset is applied off the top at the state level.
- The new County MOE amount that counties receive is the amount after the cost shift has been added and the General Fund offset has been applied.
- All other offsetting revenue including VLF growth, sales tax growth and accelerated caseload growth is distributed in proportion to a county's share of the overall cost shift.
- County Medical Services Program (CMSP) growth is distributed to the 35 CMSP counties proportional to the county share of the cost shift for just those 35 counties.

In-Home Supportive Services Update

Attachment Seven

Handout: Consultation with CSAC on IHSS Implementation

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Consultation with CSAC on IHSS Implementation

November 2017

The In-Home Supportive Services (IHSS) trailer bill SB 90 (Chapter 25, Statutes of 2017) and the Health and Human Services clean-up trailer bill AB 130 (Chapter 251, Statutes of 2017) contain many references where the Department of Finance (DOF) or Department of Social Services (DSS) is required to consult with the California State Association of Counties to implement specific provisions. This resource describes all of those required consultations as well as the current status of those efforts as of November 2017.

Topic	Code Section	Status
DOF shall consult with CSAC to determine each county's share of the County IHSS MOE base amount	WIC 12306.16 (b)(2)	Completed
DOF shall consult with CSAC to determine each county's share of the General Fund moneys for county administration and public authority administration	WIC 12306.16 (b)(3)(C)	In progress – recommendation shared with DOF/DSS
DSS shall work with CSAC, CWDA, and DOF to examine assumptions related to IHSS administration for 2017-18 and 2018-19 as part of development of 2018-19 budget	WIC 12306.16 (b)(3)(E)	In progress – ongoing discussions with CWDA and DOF/DSS/HHS
DOF shall notify fiscal committees and CSAC by May 14 whether the inflation factor will apply in the following fiscal year based on realignment revenues received	WIC 12306.16 (c)(3)(C)	Await notification
DOF shall consult with CSAC to determine the computations for annualized adjustments for increases in provider wages or health benefits	WIC 12306.16 (d)(8)	In progress – Ongoing discussions with DOF/DSS
DOF shall consult with CSAC to determine distribution of General Fund moneys to offset IHSS costs	WIC 12306.17 (b)	Completed for 2017-18
DOF shall consult with CSAC on schedule for allocation of sales tax revenue	WIC 17600.15 (g)(5)	Completed for 2016-17 growth
DOF shall consult with CSAC and other affected parties to reexamine the funding structure within 1991 Realignment and report findings and recommendations on IHSS MOE by Jan. 10, 2019 to include: (1) extent to which 1991 Realignment funding is available to meet program costs that were realigned; (2) whether IHSS program and administrative costs are growing higher, lower or the same as the MOE and inflation factor; (3) the fiscal and programmatic effects of the	WIC 17600.70 (a)	In progress – tracking of impact is ongoing, but official discussions have not yet started

IHSS MOE on funding available for Health, Mental Health, CMSP and other social services programs included in 1991 Realignment; and (4) the status of collective bargaining for IHSS in each county		
DOF shall consult with appropriate state departments and CSAC on schedule for caseload growth	WIC 17605 (b)(1)(A)	Completed for 2016-17 growth
DOF shall consult with CSAC on the schedule for redirecting CMSP sales tax growth to Social Services	WIC 17605.07 (c)(1)	Completed for 2016-17 growth
DOF shall consult with CSAC on the schedule for redirecting Health and Mental Health sales tax growth to Social Services	WIC 17606.10 (g)(1)	Completed for 2016-17 growth
DOF shall consult with CSAC on schedule for VLF Growth	WIC 17606.20 (b)(5)	Completed for 2016-17 growth
DOF shall consult with CSAC on schedule for redirecting Mental Health, Health and CMSP VLF growth to Social services	WIC 17606.20 (c)	Completed for 2016-17 growth

Federal Update – Ongoing Uncertainty

Attachment Eight

CSAC Memo: Federal Update – Ongoing Uncertainty

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November 13, 2017

To: CSAC Health and Human Services Policy Committee

From: Tom Joseph, Waterman and Associates
Farrah McDaid Ting, CSAC Legislative Representative, Health and Behavioral Health
Justin Garrett, CSAC Legislative Representative, Human Services
Elizabeth Marsolais, CSAC Legislative Analyst, Health and Human Services

RE: Federal Update – Ongoing Uncertainty

Background. The first 10 months of the Trump Administration have been marked by pitched battles on major health and human services issues such as the Affordable Care Act (ACA), the Children's health Insurance Program (CHIP), and the Families First Act.

We have invited CSAC's federal health and human services lobbyist, Tom Joseph of Waterman and Associates, to provide an update on these important federal issues and look ahead to 2018. He has also provided background information on each issue below:

Affordable Care Act

Senate Republicans made two bids to repeal the ACA during the third quarter of 2017. The latter of the two attempts was launched in September after Republican Senators Bill Cassidy (LA), Lindsey Graham (SC), Dean Heller (NV) and Ron Johnson (WI) developed a new repeal and replacement bill that, among other things, would have distributed the current pot of Medicaid expansion funds to all 50 states (instead of the current 30 states, including California, that chose to cover additional individuals under the ACA).

Pursuant to the legislation, Medicaid expansion funding would have ended for all states in the year 2026. Moreover, the Medicaid program would have been transformed into a per-capita block grant program, with each state receiving a fixed amount of funds for each eligible individual. In addition, the nearly $1 billion-a-year Public Health and Prevention Fund used by states and counties to address community health needs would have been terminated.

According to an analysis by the California Department of Health Care Services, the Cassidy-Graham proposal represented the "most devastating repeal bill so far," with the state of California expected to lose over $137 billion in federal Medicaid support over the next decade. Likewise, the nonpartisan Congressional Budget Office (CBO) in a preliminary estimate of the legislation projected that the bill would reduce federal Medicaid spending nationwide by roughly $1 trillion over the next ten years, with millions of enrollees losing health coverage. Additionally, the possible elimination of the Public Health and Prevention Fund translated into a $165 million loss in funding to California and public health entities over the next five years.

Although the vast majority of Senate Republicans signaled their support for the Cassidy-Graham bill, Senators Susan Collins (R-ME), Rand Paul (R-KY) and John McCain (R-AZ) all announced their opposition to the measure.

Faced with certain defeat on the floor of the Senate, Majority Leader Mitch McConnell (R-KY) decided to pull the measure from consideration.

With their latest repeal bill derailed, Senate leaders have begun pivoting to a bipartisan measure that is designed to stabilize some private insurance markets under the ACA. The effort would continue Cost Sharing Reduction payments for insurers to help low-to-moderate income individuals pay their deductibles and co-pays while giving states more flexibility under the ACA to design their programs.

Families First Act

The House has yet to act on the Family First Prevention Services Act (FFPSA, HR 253). Under the legislation, a new federal financial match would be provided for a limited set of prevention services aimed at keeping at-risk children with their families instead of placing them in foster care. The measure also would place stringent new requirements on group homes and other congregate care facilities in order to reduce their use.

While the State of California and its counties support the objectives embodied in HR 253, the legislation would either undo or severely hamper California's ongoing child welfare reform efforts, including implementation of the Continuum of Care Reform bill (AB 403). Accordingly, California's Department of Social Services, CSAC, and CWDA continue to oppose the House bill unless it is amended to allow the state and counties to continue CCR implementation efforts without additional and sometimes conflicting FFPSA mandates. A companion FFPSA bill has not yet been introduced in the Senate.

Children's Health Insurance Program

With GOP congressional leaders devoting much time and attention to ACA repeal and tax reform efforts, the House and Senate have been slow to act on a reauthorization of the Children's Health Insurance Program (CHIP). While program funding technically ended on September 30, the U.S. Department of Health and Human Services projects that most states, including California, generally have sufficient CHIP funds to continue their programs through at least the first quarter of fiscal year 2018.

In the meantime, the House Energy and Commerce Committee and the Senate Finance Committee have adopted five-year CHIP renewal bills that would gradually phase out the ACA's higher federal contribution for CHIP coverage. Under the legislation, the current two-year, 23 percentage point boost in the federal contribution (from 65 percent to 88 percent in California) would continue as planned though fiscal year 2019. The bills would then give states a one-year transition by providing an 11.5-percentage-point increase in the matching rate in 2020, before returning the rate to its regular 65 percent federal match in 2021.

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2017 Legislative Review and 2018 HHS Priorities

Attachment Nine

CSAC Memo: 2017 Legislative Review and 2018 HHS Priorities

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November 13, 2017

To: CSAC Health and Human Services Policy Committee

From: Justin Garrett, CSAC Legislative Representative, Human Services
Farrah McDaid Ting, CSAC Legislative Representative, Health and Behavioral Health
Elizabeth Marsolais, CSAC Legislative Analyst, Health and Human Services

RE: 2017 Legislative Review and 2018 HHS Priorities – Action Item

Outcomes of HHS Measures for 2017.

Three significant issues dominated the focus for the HHS team in 2017 – In-Home Supportive Services (IHSS), AB 1250, and the Affordable Care Act (ACA). We also engaged on several other key legislative issues at both the state and federal level. This section describes the outcomes on the most significant HHS issues in 2017.

IHSS Budget Trailer Bills: SB 90 (Chapter 25, Statutes of 2017) & AB 130 (Chapter 251, Statutes of 2017)

The major HHS legislative accomplishment of the session was negotiating an IHSS agreement with the Administration that will result in significantly reduced county contributions for IHSS costs compared to the January budget. The IHSS agreement was passed in a budget trailer bill (SB 90) in June and included the establishment of a new County IHSS Maintenance of Effort (MOE), State General Fund contributions to partially offset increased IHSS costs, and many other provisions. CSAC continues to work on implementation and the MOE methodology was approved by the CSAC Board of Directors on September 7.

During the last week of session, CSAC also supported AB 130, another trailer bill that included technical clean-up provisions to ensure proper implementation of SB 90. This bill would clarify language around the parties involved with the Public Employment Relations Board process, make technical corrections to ensure caseload growth is calculated correctly, clarify that 2016-17 sales tax growth will be used to offset IHSS costs, and spell out how the wage supplement provision will work. AB 130 was passed by the Legislature on September 15 and signed by the Governor almost immediately on September 16. CSAC continues to partner with the Administration and counties on implementation. For additional details on IHSS, please see Item III in this agenda packet.

Preserving County Contracting Authority: AB 1250

County authority to provide services in the most efficient, effective way to their residents was jeopardized this year by AB 1250 (Jones-Sawyer). The HHS team joined the Association-wide effort to defeat this bill, which quickly rose as a top legislative priority for CSAC.

The bill sought to create a de facto ban on service contracts between counties and nonprofits, community based organizations, and private provider partners in nearly all service areas, including health care, behavioral health, public safety, housing, environmental stewardship, and even basic county administration. However, the impacts of AB 1250 would have been severe in the HHS area, where our health, human services, and behavioral health efforts require collaboration with contractors to conform with state and federal law and provide critical local services.

HHS team advocacy efforts included direct lobbying, grassroots mobilization, establishing partnerships with other organizations, and participation in a robust public affairs campaign that resulted in extensive press, editorial board coverage, and strong social media presence.

While AB 1250 was ultimately held in the Senate Rules Committee, it is eligible as a two-year bill in the 2018 legislative session.

Potential Changes to the Affordable Care Act

CSAC, with Board of Directors approval, dedicated a significant amount of effort at the federal level to oppose efforts to repeal the Affordable Care Act (ACA) and the funding for the ACA Medicaid Expansion.

The Association's opposition is grounded in the significant amount of Medicaid funding that currently flows into California under the ACA and the savings realized by counties since the Medi-Cal expansion began to cover medically indigent adults in 2013. California draws down about $16 billion in federal funds – including a large proportion of dollars associated with the ACA – within a total Medi-Cal budget of $19.1 billion. Further, counties spent between $1.5 and $2 billion annually on medical services for the medically indigent before the ACA expanded Medicaid eligibility – a portion of which has been transferred to the state due to county savings as a result of this population transferring to Medi-Cal.

CSAC worked with all HHS-related county affiliates to generate detailed letters on the House's American Health Care Act and the Senate's Better Care Reconciliation Act. The Association also generated a letter opposing the Cassidy-Graham proposal in early September to redistribute Medicaid spending to all 50 states and cap the amount of funding available per person. As of this writing, CSAC also generated a joint letter opposing President Trump's threats to reduce or eliminate the Cost Sharing Reduction (CSRs) payments to health plans. These payments helped offset the cost of insurance plans offered on the state exchanges. However, President Trump did eliminate these payments via Executive Order in October. In California, the state exchange Covered California was able to modify the premiums offered to consumers to mostly limit the impact of the loss of the CSRs. However, the elimination of the CSR payments are making it increasingly challenging for health plans to operate within the exchanges, and this may reduce the number of plans available to consumers in 2018.

CSAC also worked closely with Waterman and Associates to ensure that California counties were heard in each of the debates. Further, CSAC worked with the National Association of Counties as well as other statewide organizations on analysis and policy. CSAC also reached out to other state associations, such as Colorado and Wisconsin, to strategize on the preservation of Medicaid expansion funding. The work to preserve federal funding for Medicaid will be ongoing in 2018.

General Assistance: Employable Veterans: AB 85 (Rodriguez)

CSAC successfully defeated a bill that would have imposed a significant infringement on counties' statutory authority to set General Relief/General Assistance (GA or GR) funding levels. AB 85 would have required counties to alter their locally-established GA or GR eligibility levels to provide additional county-funded assistance to veterans. This would have imposed a statewide mandate for a specific population without identifying a source of funding. Through our work in partnership with CSAC Affiliates, the bill was held in the Senate Veterans Affairs Committee on July 14.

Local Public Agencies: Meyers-Milias-Brown Act: AB 1603 (Ridley-Thomas)

CSAC was also successful in working with a raft of CSAC Affiliates to stall AB 1603, a measure that would have allowed doctors, psychiatrists, and possibly other licensed medical professionals who contract with counties to join in the collective bargaining process with county union employees.

The measure was opposed by CSAC, CHEAC, CAPH, and CBHDA, as well as psychiatrists and others. AB 1603 is now a two-year bill, which means that the bill did not move forward this session, but could be revived in January. And while AB 1603 was not related to AB 1250 (Jones-Sawyer), it did raise many of the same issues, as county public hospitals, health clinics, and the behavioral health system in each county must retain the authority to contract with clinicians to provide critical safety-net services.

Health & MHSA Funding: SB 97 (Chapter 52, Statutes of 2017)

Senator Jim Beall introduced SB 192, a framework to ensure that unspent Mental Health Services Act (MHSA) funding would revert back to the state as outlined in Proposition 63 passed by voters in 2004. After many discussions, a slightly different framework was included in the Health budget trailer bill in June (SB 97). The measure provides a prospective solution for the reversion of unused MHSA funding that forgives past unused funding and gives small counties up to five years to use MHSA funds. CSAC supported SB 97, which was signed by the Governor on July 10.

Medi-Cal: Medi-Cal managed care plans: SB 171 (Hernandez) & AB 205 (Wood)

The Chairs of both the Senate and Assembly Health Committees introduced a pair of bills to implement critical provisions of the federal Medicaid Managed Care rule related to supplemental Medi-Cal funding for California's public health systems. CSAC supported both SB 171 and AB 205.

In spring 2016, the federal Centers for Medicare and Medicaid Services (CMS) released a final regulation of Medicaid managed care. The regulation included provisions directly related to public health care systems' supplemental payments and placed new restrictions on how these supplemental payments must be directed from the state to Medicaid managed care plans and to providers.

SB 171 outlines important provisions related to the public hospitals, mental health parity, and the Medical Loss Ratio (MLR). It is critical for California to implement the new federal regulations in a way that meets both the needs of all residents and the local county partners who provide the services on the ground, and SB 171 will assure continued federal funding for county public hospitals and health systems.

AB 205 outlines important provisions on the time, distance and access to care, the quality of care, managed care plan grievance provisions, and provisions related to fair hearings. The measure includes language requiring county specialty mental health plans to conform to state Knox-Keene timeliness and access requirements, which could potentially increase state costs. Overall, however, CSAC supported the implementation of the Medicaid managed care regulations through both bills which were signed by the Governor on October 13.

Setting HHS Priorities for 2018.

Each year, CSAC establishes priority advocacy issues for the Association for approval by the Board of Directors. The CSAC advocacy team drafts suggested priorities to conform with the Association's existing platform language.

Each policy committee is tasked with examining and discussing the proposed priorities in their issue area and voting to approve draft priorities. Once approved by the policy committee, these draft priorities will be forwarded to the CSAC Board of Directors for final approval in early 2018.

The proposed 2018 HHS priorities were developed with the current state and federal political landscapes in mind. Please review these draft 2018 priorities and prepare for a discussion and action during the November 28 meeting of the policy committee.

The below section briefly describes the highest level potential 2018 HHS Priorities and references other potential priorities. In addition to the three highest-level priorities described below, there are myriad HHS issues that we have identified to engage on in 2018. These include Continuum of Care Reform, foster youth services, budget methodologies for county administration of human services programs, AB 85 health realignment implementation, behavioral health funding, Drug Medi-Cal implementation, and 2-1-1 referral systems.

A full description of each of these priorities can be found in the attached draft work plan.

Top HHS Priorities for 2018
(please see the attached work plan for a more detailed description of each of the proposed HHS priorities for HHS)

In-Home Supportive Services

In 2018, there will need to be a sustained commitment to continue to implement the new IHSS provisions that were included in SB 90 and AB 130. This will include working with the Administration on MOE adjustments, allocation of offsetting revenue, and other provisions. In addition, we'll continue to partner with counties on implementation and education efforts. Finally, CSAC will need to track the impact of this new MOE and engage with the Administration on reexamining this new structure within overall realignment to ensure long-term sustainability for counties.

Potential Changes to the Affordable Care Act

With the election of President Trump and the current Congressional actions taken to attempt to repeal the Affordable Care Act (ACA), California's counties must continue to engage on any proposals to repeal or alter the ACA. California draws down about $15 billion in federal funds – including a large proportion of dollars associated with the ACA – within a total Medi-Cal budget of $19.1 billion. CSAC will continue to work with our Washington representatives, county affiliates, and the Brown Administration to respond to any county impacts associated with changes to the ACA.

Homelessness and Poverty Issues

Homelessness issues will remain at the top of the Legislature's agenda and CSAC will need to continue to leverage the policy expertise of the health and human services, housing and land use, and

administration of justice policy committees and staff to identify the appropriate opportunities to engage and advocate for counties.

Attachments.
CSAC Health and Human Services Draft 2018 Work Plan

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2017 Legislative Review and 2018 HHS Priorities

Attachment Ten

Handout: CSAC Health and Human Services Draft 2018 Work Plan

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Draft 2018 Health and Human Services Work Plan – Presented November 28, 2017

The HHS team anticipates significant continued effort on several large state and federal fiscal issues in 2018, including In-Home Supportive Services (IHSS) and the Affordable Care Act. Further, California's legislature is expected to maintain their focus on homelessness issues and response to recent disasters. Lastly, the state's revenue receipts are keeping pace with projections, so we anticipate legislative interest in preserving or building on existing health and human services programs through the state budget process.

State

In-Home Supportive Services. Implementation of the IHSS budget trailer bill SB 90 (Chapter 25, Statutes of 2017) will remain a top priority in 2018. SB 90 was a result of CSAC's negotiations with the Administration in response to the Governor's January 2017 budget that shifted nearly $600 million in new IHSS costs to counties. SB 90 included a new County Maintenance of Effort (MOE), state General Fund contributions to offset the increased IHSS costs, and redirected realignment revenue from other accounts to Social Services to further offset costs. There are numerous references in statute to ensure that CSAC is consulted on implementation. A key focus will be to continue to closely work with the Department of Finance and Department of Social Services to ensure all of these provisions are appropriately implemented including MOE adjustments and allocation of offsetting revenue. In addition, CSAC will dedicate resources to educate and train counties on these provisions and their local impact. Finally, there is a requirement for the Administration to consult with CSAC in the development of the 2019-20 budget and submit a report to examine if there is adequate funding for IHSS costs and the impact of the redirected revenue on funding for other realigned programs. In 2018, CSAC will need to track the impact of the new MOE on counties, partner with affiliates on determining the impact of these changes on other realigned programs, and move forward with the conversations and advocacy work on this reopener provision to ensure long-term sustainability for counties.

Potential Changes to the Affordable Care Act & Health Care Delivery. With the election of President Trump, California's counties must continue to engage on any proposals to repeal or alter the Affordable Care Act (ACA). California draws down about $16 billion in federal funds – including a large proportion of dollars associated with the ACA – within a total Medi-Cal budget of $19.1 billion. Further, counties spent between $1.5 and $2 billion annually on medical services for the medically indigent before the ACA expanded Medicaid eligibility – a portion of which has been transferred to the state due to county savings as a result of this population transferring to Medi-Cal. The County response will depend on how President Trump and the Congress proceed in potentially repealing the ACA in its entirety, or retain parts of it, or develop additional proposals to replace it. CSAC will continue to work with our Washington representatives, county affiliates, and the Brown Administration to respond to any county impacts associated with changes to the ACA.

CSAC will also monitor legislative proposals to modify or reform the health care insurance and delivery system in California. The Assembly has formed a Select Committee on Health Care Delivery Systems and Universal Coverage, which met for two days in late October. Co-chaired by Assembly Members Jim Wood and Joaquin Arambula, the committee was formed by Assembly Speaker Rendon in response to his decision to hold SB 562 (Lara and Atkins) this session. The bill, sponsored by the California Nurses Association, sought to erect a single-payer health system in California, but did not include financing details. The select committee is tasked with examining the issue and seeking public comment, and is expected to meet for a series of hearings over the course of the fall Interim period.

Homelessness and Poverty Issues. Homelessness issues will remain at the top of the Legislature's agenda, partly based on the fact that California's poverty and homelessness rates remain among the highest in the nation, affecting all Californians including children, adults, veterans, and seniors. CSAC will continue to leverage the policy expertise of the health and human services, housing, land use, and transportation, and administration of justice policy committees and staff, as well as release a comprehensive report examining issues and solutions for housing and homelessness.

CSAC will also continue to work hand-in-hand with the California Department of Housing and Community Development and the California Health Facilities Financing Authority on the implementation of the No Place Like Home Program, which will provide $2 billion in bond funding to counties for building or refurbishing permanent supportive housing for those who are homeless and living with mental illness.

CSAC will continue working with all counties on communication and education efforts related to homelessness issues, including featuring CSAC issue videos, CSAC Institute for Excellence in County Government courses, workshops, regional meetings, and social and web media to ensure the best outcomes for counties and the people we serve.

Continuum of Care Reform (AB 403) Implementation. CSAC will continue to focus on the wholesale reform of the group home system in California under AB 403, which went "live" in January of 2017. The Department of Social Services and Department of Health Care Services continue to make incremental progress on implementation. Much more work is needed to implement the vision of CCR and Foster Family Agencies (FFA), Resource Family Approval (RFA), and Short-Term Residential Therapeutic Programs (STFTPs). CSAC will continue working closely with county child welfare services, behavioral health, and juvenile probation systems to ensure they are adequately resourced to implement this massive new policy change to improve outcomes for foster and probation youth. CSAC will also continue to convene county affiliates in discussions to ensure coordinated and strategic advocacy efforts and continue the work of quantifying the fiscal implications of the reforms.

Budget Methodologies for County Administration. The state provides critical funding for counties to administer health and human services programs. However, the methodologies that are used to provide this funding do not always align with the actual costs that counties incur. As a follow-up to provisions included in the 2017-18 budget, there are three key efforts underway related to county administration funding.

The California Work Opportunity and Responsibility to Kids (CalWORKs) program Single Allocation is what the state provides to counties to administer the CalWORKs program. The creation of a new methodology to revise the current caseload-driven budget methodology for the Single Allocation is necessary to insulate counties and beneficiaries from experiencing huge swings in year-to-year funding levels for the Single Allocation. The state is also working to develop a new budget methodology for county administration of Medi-Cal. Finally, the budget methodology for administration of the IHSS program also needs to be revised.

In partnership with the County Welfare Directors Association, CSAC will continue to engage in discussions with the Department of Finance, Department of Social Services, and Department of Health Care Services to work towards revising these methodologies and to help counties obtain sufficient resources to effectively deliver these services. Our efforts will examine changes for the 2018-19 budget and long-term proposals for subsequent years.

Foster Youth Services. CSAC will continue to identify opportunities to engage in legislative efforts to support foster youth, who are among the most at-risk populations in California. A significant potential issue relates to the recent state law changes that expanded eligibility for foster care services from age 18 to age 21 and resulted in additional local costs beyond the cap on county expenditures in current statute. CSAC will work with state and county social services, the Department of Finance, and county counsels on this cost issue, as well as working to assess costs within individual counties. Finally, CSAC will also work to ensure transparency within all systems that serve foster youth.

AB 85 Health Realignment Implementation. CSAC continued to work with affiliates and the Department of Finance on current-year AB 85 (Chapter 40, Statutes of 2013) redirections and the second year of the "true up" calculation. CSAC will continue to monitor the integrity of estimated AB 85 redirections and future true up payments, as well as other implementation issues.

Behavioral Health Funding. The 2011 Realignment Behavioral Health Sub- and Growth Accounts have been of keen interest to the mental health advocate community, the Legislature, and Administration in this post-Affordable Care Act world of expanded eligibility for mental health and substance use treatment services. CSAC, with the Administration and the County Behavioral Health Directors Association, was able to build on the establishment of the 2011 Realignment Behavioral Health Base in September of 2016 with a new 1-year growth formula in October of this year. CSAC will continue actively working on a permanent growth funding formula that will ensure the timely distribution of growth funding each year for critical programs.

CSAC will also engage with affiliates and the Department of Health Care Services to increase the efficiency and timeliness of federal specialty mental health reimbursements to counties.

Drug Medi-Cal Implementation. CSAC continues to monitor the implementation of the Drug Medi-Cal Organized Delivery System Waiver, including the development of financing mechanisms and rates, as well as working to ensure expanded access to care and services for beneficiaries under the waiver. Further, CSAC will engage on efforts to erect a residential treatment system for youth, as well as strategies to add additional funding for counties and providers in both the adult and youth systems of care.

2-1-1 Referral Systems. CSAC has actively supported both state and federal legislation to help build and fund a statewide 2-1-1 referral system and will continue to work with counties, the state, and community based organizations to realize the goal of statewide implementation of 2-1-1 services.

Federal

- For more detail, please see the 2018 Draft Federal Priorities Document.

Temporary Assistance for Needy Families (TANF) Reauthorization. CSAC will continue to promote TANF reauthorization legislation that would restore state and county flexibility to tailor work and family stabilization activities to families' individual needs. CSAC also supports maintaining the focus on work activities under TANF, while recognizing that "work first" does not mean "work only." See the 2018 Draft Federal Priorities for more detail.

Child Welfare Services. CSAC will support increased federal funding for services and income support needed by parents seeking to reunify with children who are in foster care. CSAC also supports increased financial support for programs that assist foster youth in the transition to self-sufficiency, including post-emancipation assistance such as secondary education, job training, and access to health care.

In addition, CSAC will work to protect and retain the entitlement nature of the Title IV-E Foster Care and Adoption Assistance programs while seeking the elimination of outdated rules that base a child's eligibility for funds on parental income and circumstances. Finally, CSAC supports federal funding to address the service needs of youth who are victims of commercial sexual exploitation. See the 2018 Draft Federal Priorities for more detail.

Medicaid Funding. At the federal level, CSAC will closely monitor potential efforts to block grant or otherwise provide states per-capita payments based on their historical Medicaid spending patterns in return for increased administrative flexibility in designing and administering the program. California continues to be one of the lowest Medicaid spending states based on a per-capita basis, potentially locking the state in to a very low federal allotment. Moreover, to the extent that state administrative and benefit costs exceed what is covered by the block grant, counties are at risk of assuming the financial liability for those costs. See the 2018 Draft Federal Priorities for more detail.

Children's Health Insurance Program (CHIP). Program funding for CHIP technically ended on September 30, 2017. However, California is projected to have sufficient CHIP funds to continue their program through at least the first quarter of fiscal year 2018. CSAC will continue to engage on CHIP renewal bills and supports full funding of CHIP and continuing the 23 percentage point boost in the federal contribution over the normal 65 percent federal match for CHIP. See the 2018 Draft Federal Priorities for more detail.

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California's Cannabis Laws – Implementation, Impacts & Resources

Attachment Eleven

CSAC Memo: CSAC Cannabis Policy, Advocacy & Outreach Efforts

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November 5, 2017

To: CSAC Health & Human Services Policy Committee
CSAC Administration of Justice Policy Committee
From: Cara Martinson, CSAC Senior Legislative Representative & Federal Affairs Manager

RE: CSAC Cannabis Policy, Advocacy & Outreach Efforts

Background. California has seen an evolution of cannabis policy over the last several years. Along with being the first to decriminalize the use of cannabis for medicinal purposes in 1996 with the passage of Proposition 215, California has now joined seven other states and the District of Columbia in legalizing the adult use of cannabis with passage of Proposition 64 last November. Over the past year, the Legislature and the Regulatory Agencies worked diligently to both integrate our medical and adult use laws into one regulatory framework, and to develop the regulatory program for how the state will license commercial medical and adult use cannabis businesses. Draft Emergency Regulations are expected to be released by the end of the month, with state licensing to begin in January 2018.

Throughout this process, CSAC has been a vocal advocate for protecting the ability of local government to make its own decisions on local cannabis policy and for integrating local regulatory programs within a larger state licensing system. As a result, the regulatory framework in law contains strong local control measures consistent with Proposition 64 and previously chaptered medical laws. These measures allow for broad local regulatory and taxation authority, giving local governments the tools to decide how best to regulate – and impose local taxes on – the retail sale and cultivation of both medicinal and commercial cannabis in their respective communities.

CSAC Advocacy. Counties have a significant stake in shaping the broader statewide landscape of cannabis regulation in California as it will undoubtedly have a significant impact on local government operations. As a result, CSAC has been actively lobbying on cannabis issues for several years, and worked closely with the Administration and the Legislature to ensure county interests were represented in the development of statewide cannabis policy. However, advocacy on cannabis issues is not a new topic for the organization. In 2010, CSAC established a Medical Marijuana Working Group with the purpose of providing input to state agencies and the Legislature as they began to tackle medical marijuana regulation. In addition, the Working Group served as a venue for information exchange as counties began to deal with this complex and challenging policy issue. In 2017, the CSAC Officers established the CSAC Cannabis Working Group, charged with developing comprehensive policy for the organization and to provide input into the regulatory process. Supervisors Nate Miley (Alameda), James Gore (Sonoma), Estelle Fennell (Humboldt) and Judy Morris (Trinity) co-chair this Working Group. The CSAC Board of Directors adopted the Working Group's Cannabis Policy in May 2017, and the Working Group has met several times throughout the year to discuss issues related to cannabis policy implementation.

In addition to statewide advocacy, CSAC is working with our National Association of Counties (NACo) to coordinate with other legalizing states. CSAC organized three national roundtable discussions over the last year, and will continue to coordinate with our partners at the federal level to address the issue of conflicting state and federal cannabis laws.

CSAC Member Education & Outreach. In addition to advocacy, CSAC has been working to provide member education and outreach opportunities to counties. In June, CSAC held a Regional Meeting in Humboldt County to talk about the environmental impacts of cannabis and cultivation issues with

Northern California Counties. In July, CSAC, in cooperation with our other local government partners at RCRC and UCC, held a statewide summit in Sacramento which was attended by over 200 County Supervisors and senior staff and focused on all aspects of cannabis policy, including banking and taxation issues, land use, health impacts, public safety challenges and other impacts to local governments. In addition, the CSAC Communications staff is producing several videos on cannabis impacts. A series of three videos, the first two were released earlier this fall and focused on cultivation, banking and taxation issues. The last video will be released before the end of the year and will highlight public health and safety challenges related to cannabis.

Finally, CSAC staff is working with our Finance Corporation and the State Treasurer's Office to develop solutions to the banking and cash collection issue presented by conflicting state and federal policy on cannabis. Out of this work, CSAC is in the process of developing a Joint Powers Authority (JPA) to develop and manage a statewide data platform that will gather, collect, and analyze information from a myriad of data sources into one resource, to help local governments ensure cannabis regulatory compliance and also provide necessary information to financial institutions that wish to work with the cannabis industry.

Internal Staffing & Contact. While the CSAC Agriculture, Environment & Natural Resources (AENR) Policy team is the lead staff on cannabis issues, we work closely will all other CSAC Policy Committees and staff to ensure that all aspects of county interests are represented. The CSAC Cannabis Working Group is made up of county staff from a number of different departments including County Counsels, Planning & Public Works, Environmental Health, Public Health and local law enforcement. For more information about the Working Group, and CSAC cannabis efforts, please visit the CSAC Cannabis Resource page at: **http://www.counties.org/cannabis.**

For additional information, please contact Cara Martinson, CSAC Senior Legislative Representative & Federal Affairs Manager at 916-327-7500, ext. 504, or cmartinsation@counties.org.