



Health and Human Services Policy Committee
CSAC Annual Meeting
Tuesday, December 1, 2015 — 2:30 p.m. – 4:30 p.m.
Monterey Marriott, Ferrantes Bay View Room
Monterey County, California

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

- 2:30 p.m. I. **Welcome and Introductions**
Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair
- 2:35 p.m. II. **HHS: Year in Review and 2016 Legislative Priorities**
Farrah McDaid Ting, Legislative Representative, CSAC
Michelle Gibbons, Legislative Analyst, CSAC
- 2:55 p.m. III. **Medi-Cal 2020 Waiver Update**
Kelly Brooks-Lindsey, Partner, Hurst Brooks Espinosa
- 3:20 p.m. IV. **Behavioral Health Priorities in 2016**
Kirsten Barlow, Executive Director,
County Behavioral Health Directors Association of California
- 3:45 p.m. V. **Poverty Working Group Report**
Leticia Perez, Kern County, Poverty Working Group Co-Chair
Lee Adams, Sierra County, Poverty Working Group Co-Chair
- 4:05 p.m. VI. **Special Health Care Session Update**
Farrah McDaid Ting, Legislative Representative, CSAC
Michelle Gibbons, Legislative Analyst, CSAC
- 4:20 p.m. VII. **NACo Committee Opportunities**
Farrah McDaid Ting, Legislative Representative, CSAC
Michelle Gibbons, Legislative Analyst, CSAC
- 4:30 p.m. VIII. **Closing Comments and Adjournment**
Supervisor Ken Yeager, Santa Clara County, Chair
Supervisor Hub Walsh, Merced County, Vice Chair

ATTACHMENTS

HHS: Year in Review and 2016 Legislative Priorities

Attachment One CSAC Memo: HHS Year in Review & 2016
Legislative Priorities

Medi-Cal 2020 Waiver Update

Attachment Two HBE Memo: Medicaid Section 1115 Waiver
Renewal

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HHS: Year in Review and 2016 Legislative Priorities

Attachment One

CSAC Memo: HHS Year in Review and 2016 Legislative Priorities



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November 17, 2015

To: CSAC Health and Human Services Committee

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: **HHS Year in Review and 2016 Legislative Priorities**

2015 Year in Review

Federal Waivers. This year, California submitted an application to the Centers for Medicare and Medicaid Services (CMS) for approval of its third iteration of the Section 1115 Waiver, called the Medi-Cal 2020 Waiver. CSAC has been adamant in advocating for the successor waiver to provide the same level of funding as the prior 2010 Bridge to Reform waiver. CMS has agreed to a roughly \$6.218 billion waiver with the potential for additional funding in the global payment program after the first year. In addition, CSAC has assumed a leadership role in convening county health, hospitals, behavioral health and social services in refining the county-proposed Whole Person Care pilots – to which CMS has agreed in concept.

CSAC also successfully advocated for the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, which will allow counties to operate the Drug Medi-Cal program as an opt-in organized delivery system. In August, CMS approved the DMC-ODS Waiver as an amendment to the Section 1115 Bridge to Reform waiver for a five-year demonstration period.

Continuum of Care Group Home Reform. AB 403 (Stone) is a landmark piece of legislation regarding the Administration's Continuum of Care Reform (CCR) effort to revamp the State's group home system for foster and probation youth. CSAC maintained a Support in Concept position on the bill, which was signed into law by Governor Brown. CSAC worked with county affiliates and the Department of Social Services to add clarity to the bill and – due to the Prop 30 implications of the policy reform – simultaneously worked with legislative staff to secure consensus Prop 30 "boilerplate" language.

Poverty Working Group. The CSAC Executive Committee asked that the Association focus on poverty issues in 2015. In response, CSAC HHS staff formed a Poverty Working Group (PWG), co-chaired by Supervisors representing the Urban, Suburban and Rural perspectives. The PWG established policy within the Association platform allowing staff to advocate for counties on poverty issues, especially as they intersect with other policy areas (such as housing, taxes, and transportation). Additionally, the PWG recommended a support position on the Governor's \$380 million Earned Income Tax Credit proposal, which was adopted in the 2015-16 final budget package. To date,

the PWG has held six meetings in 2015 and will continue to explore ways in which California counties can address poverty in our communities.

Mental Health. CSAC successfully lobbied our concerns – in partnership with county affiliates and advocacy organizations – regarding several related bills that would have adversely impacted the county behavioral health system. CSAC opposed two measures – AB 193 by Assembly Member Brian Maienschein and AB 1300 by Assembly Member Sebastian Ridley-Thomas – which were later vetoed and made a two-year bill respectively. AB 193 sought to change the conservatorship process under the Lanterman-Petris Short (LPS) act and AB 1300 attempted to make detrimental changes to the 5150 process. CSAC will continue to work with stakeholders on AB 1300 issues. CSAC also worked to address our concerns regarding AB 1299 by Assembly Member Ridley-Thomas. The bill would change how foster children placed outside of their county of original jurisdiction are able to access mental health services – hopefully, in a timely manner – and CSAC continues to work with stakeholders to create policy that achieves that goal in the coming session.

Additional Funding. CSAC advocated for additional funding for the county Medi-Cal eligibility administrative workload in 2015-16. The Governor's budget originally proposed \$150 million (\$48.8 million General Fund), which was insufficient to meet the costs that counties were incurring for Medi-Cal eligibility functions. CSAC, with CWDA, was able to secure an additional \$31 million General Fund.

CSAC, also with CWDA, advocated for two additional key budget augmentations: 1) \$15 to \$30 million in 2015-16 for the Approved Relative Caregiver Funding Option Program; and 2) \$15 million for the CalWORKs housing support program, bringing the total of new county human services funding to \$35 million.

Connecting Public Safety Issues with Health and Human Services. CSAC remains engaged and actively working with DHCS on county guidance regarding Medi-Cal claiming when a jail inmate leaves the grounds of the jail for a 24-hour or longer inpatient stay in a community hospital. CSAC has worked with DHCS to ensure that counties will not be harmed by claiming limitations and that sufficient funding has been earmarked for these purposes.

The CSAC Health and Human Services and Administration of Justice teams also continue to work collaboratively together and with CSAC Affiliates to maximize the flexibility and innovation opportunities under 2011 Realignment.

AB 85 Formulas. CSAC continues to work closely with DOF, DHCS and counties to monitor the diversion of 1991 Realignment health funding after the ACA. CSAC staff has worked diligently to inform and influence the diversion and reconciliation process outlined in AB 85.

Eliminating EBT Fees. CSAC has been an active member of a coalition to eliminate CalWORKs and CalFresh Electronic Benefit Transfer (EBT) card fees. It was estimated that roughly \$20 million in bank fees were paid by beneficiaries out of their human services grant funding. The coalition has been able to influence the RFP process for a new EBT vendor for the

State. We are also working collaboratively with the coalition and CDSS to ensure beneficiaries are informed and educated on ways to avoid bank fees.

Public Health. CSAC successfully advocated for SB 277, which Governor Brown signed into law. SB 277 eliminates the personal belief exemption for existing required childhood immunizations for children attending private (K-12) schools and daycare facilities, and further allows physicians to consider family medical history for possible medical exemptions.

2016 Legislative Priorities

IHSS MOE/CCI/MCO Tax. CSAC is mindful of potential impact to counties should the Legislature fail to secure a new managed care organization (MCO) tax – a \$1.1 billion loss in funding – and should the Administration not realize the anticipated savings from the Coordinated Care Initiative (CCI). CSAC will continue to monitor the fate of the CCI and remains committed to the success and eventual expansion of the pilot to all counties. CSAC will also work to protect the county in-home supportive services (IHSS) MOE.

County Medi-Cal Eligibility Administrative Funding. CSAC will continue to advocate for sufficient funding for county costs related to Medi-Cal eligibility workload and will support efforts to undertake a work- and time-study project to better determine funding levels in the future.

Behavioral Health Funding. The 2011 Realignment Behavioral Health Sub and Growth accounts have been of interest to the mental health advocate community and the Administration. CSAC remains engaged in discussions with the County Behavioral Health Directors Association and the Administration to determine equitable distributions and is in the initial stages of discussions related to setting a behavioral health base. CSAC will also continue to oppose any legislation that reduces local flexibility or otherwise adversely impacts the obligations of the county behavioral health systems.

Continuum of Care Group Home Reform. CSAC will continue to advocate for policy and fiscal efforts to ensure that the child welfare services, county behavioral health, and probation systems are adequately resourced to implement this ambitious policy change. CSAC will continue to convene our county affiliates in discussions to ensure we are coordinated in our advocacy efforts and will remain engaged in the Prop 30 implications of the bill.

AB 85 Health Realignment Implementation. 2016 will be the first year the Administration completes its final determinations of the county's 1991 Health Realignment Diversion amounts for a given year. CSAC will engage the Administration to monitor the integrity of the determinations and to establish a payment/recoupment process that is fair for counties.

Medi-Cal 2020 Waiver Implementation. While the Section 1115 Medi-Cal 2020 Waiver has been agreed to in concept by the Centers for Medicare and Medicaid Services (CMS), there is still much work to be done to finalize the Special Terms and Conditions that will be the guiding policy for the Waiver. CSAC will continue to be an active participant in that process.

Drug Medi-Cal Implementation. CSAC will remain engaged as the Drug Medi-Cal Organized Delivery System Waiver continues to be phased into the various regions throughout the state. A key interest for CSAC will be the development of the financing mechanisms and rate development process.

Poverty Working Group. California's poverty rate remains amongst the highest in the nation and will continue to be an issue that affects all Californians including children, adults and seniors. CSAC will continue to convene Poverty Working Group meetings in 2016 to explore policies and serve as a hub for sharing innovative local programs and initiatives addressing poverty.

Federal Priorities

Temporary Assistance for Needy Families 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. The association also supports maintaining the focus on work activities under TANF, while recognizing that "work first" does not mean "work only."

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. The association 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 the 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.

Affordable Care Act Excise Tax. CSAC will monitor legislative proposals, and consider lending support to such efforts, that would eliminate the Affordable Care Act (ACA) excise tax. Effective in 2018, a 40 percent federal excise tax will be imposed on high-cost health insurance plans that have a total cost exceeding a statutory dollar amount. The excise tax is based on the total cost of the employer and employee contribution to the plan, as well as any savings account arrangements such as health reimbursement arrangements and flexible spending accounts.

A number of California counties offer health insurance plans and related programs that will exceed the totals prescribed in the law. Existing labor agreements lock the current plans in place and negotiations of new labor contracts may have to take the tax into consideration.

Medi-Cal 2020 Waiver Update

Attachment Two

HBE Memo: Medicaid Section 1115 Waiver Renewal



HURST+BROOKS+ESPINOSA

November 17, 2015

TO: Matt Cate
Executive Director, CSAC

FROM: Kelly Brooks
Partner, Hurst Brooks Espinosa

Re: Medicaid Section 1115 Waiver Renewal

Work continues to finalize California's renewal of its Medicaid Section 1115 Waiver. The existing "Bridge to Reform" Waiver was extended to December 31, 2015 on October 31 when the state and federal governments came to a conceptual agreement on a waiver renewal, "Medi-Cal 2020."

Currently, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) are developing the Special Terms and Conditions (STCs), the legal document governing the waiver. Both parties are drafting documents and discussing the details of the core elements agreed to in October. CMS and DHCS are anticipated to conclude writing the STCs by December 31, 2015. They have begun exchanging drafts and scheduled meetings to discuss the document.

Core Elements. The conceptual agreement between CMS and DHCS includes the following core elements:

Global Payment Program (GPP). The GPP will provide funding for services to the uninsured in designated public hospital systems (DPH) by combining existing funding streams – Disproportionate Share Hospital (DSH) funds and Safety Net Care Pool (SNCP) funding – into a single global payment system. The global payments are intended to incentivize the provision of primary and preventive care and to move away from the hospital-focused and cost-based structures on which the funding is currently based. The estimated total funds (DSH, SNCP and match) available in the first year is \$2.871 billion, with \$236 million of SNCP funds.

The authority to implement the GPP is contingent upon CMS review and approval of the specific factors and parameters to be used in establishing "points" for the types of services provided to the uninsured. Funding for the GPP in years 2-5 related to the SNCP portion of the funds is undefined and contingent upon a report. CMS is requiring California to submit a report by May 15, 2016 focusing on the providers currently receiving payments through the SMCP and will help the state and CMS to determine the appropriate level of SNCP funding at those providers in Years 2-5.

The report will review the impact of the SNCP on those providers who participate in the SMCP with

respect to:

- Uncompensated care provided
- Medicaid providers payment rates
- Medicaid beneficiary access, and
- Role of managed care plans in managed care

Additionally, CMS is requiring two evaluations of the GPP – the first using 24 months of data and the second at the end of Year 4. Evaluations, at a minimum, will look at the number of uninsured individuals served, the number and types of services provided, the provider expenditures associated with the services provided, and the provide expenditures avoided due to the GPP. CMS is interested in an assessment of the effects of the GPP on care delivery and costs.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME). PRIME will be the successor to the existing Delivery System Reform Incentive Payments (DSRIP) program. California will use the PRIME pool to fund projects that will “change care delivery and strengthen those systems’ ability to revive payment under risk-based alternative payment models. California has committed to adopting alternative payment middles that align with the federal government’s delivery system reform goals where the provider is accountable for quality and cost of care. A required evaluation of PRIME will include metrics and data related to the quality of care and health outcomes of Medicaid beneficiaries.

PRIME funding for delivery system transformation and alignment incentive program will be available for DPHs and district/municipal hospitals (DMPH). The funding will be allocated as follows:

	Designated Public Hospitals	District/Municipal Hospitals	TOTAL
Year 1	\$700 million	\$100 million	\$800 million
Year 2	\$700 million	\$100 million	\$800 million
Year 3	\$700 million	\$100 million	\$800 million
Year 4	\$630 million	\$90 million	\$720 million
Year 5	\$535.5 million	\$76.5 million	\$612 million
5-Year Total	\$3.2655 billion	\$466.5 million	\$3.732 billion

Whole Person Care Pilot (WPC). The WPC program would be a county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations. The funding of this program would be up to \$1.5B in federal funds over 5 years.

Dental Transformation Incentive Program. The funding of this program is \$750M in total funding over 5 years. California proposed to improve dental health for Medi-Cal members, particularly children, by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.

Independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries. California will be comprehensively addressing the question of network adequacy and access to care for Medi-Cal beneficiaries. The assessment will include at a minimum an analysis of compliance with network adequacy and access requirements under California state law that apply to

Medi-Cal as well as commercial plans. The assessment will also include a comparison of Medi-Cal plans with commercial plans in the same geographic services areas.

Independent studies of uncompensated care and hospital financing. This report will examine the following factors with respect to all Medicaid hospital providers in the state:

- Uncompensated care provided
- Medicaid providers payment rates
- Medicaid beneficiary access, and
- Role of managed care plans in managed care

Additionally, the report will include a comparable examination of provider financing for those providers who serve the Medicaid population and the low-income uninsured. This report will include the role of the PRIME program for designated public hospital systems.

Total Funding. The total initial federal funding in the renewal is \$6.218 billion, with the potential for additional federal funding in the global payment program to be determined after the first year. Funding details are summarized in the chart below.

	Year 1	5-Year Total
Global Payment Program	\$236 million	\$236 million*
Public Hospital Redesign and Incentives in Medi-Cal	\$800 million	\$3.732 billion
Whole Person Care	\$300 million	\$1.5 billion
Dental Incentives	\$150 million	\$750 million
TOTAL	1.486 billion	\$6.218 billion

**The Global Payment Program may increase in Years 2-5 based on a study to be completed in 2016.*

Medi-Cal 2020 Waiver Update

Attachment Three

HBE PowerPoint: Medicaid Section 1115 Waiver Renewal



HURST+BROOKS+ESPINOSA

Medicaid Section 1115 Waiver Renewal

Presentation to the CSAC Health & Human Services Policy
Committee

December 1, 2015

Special Terms & Conditions

- Legal document governing the waiver
- Will contain expenditure authorities, claiming details, and other key provisions
- What to watch for:
 - Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
 - Global Payment Program (GPP)
 - Whole Person Care (WPC)

Whole Person Care Pilot

- Opportunity for all counties
- Competitive application process – county is the lead
- Local match requirement
- \$300 million per year for 5 years (\$1.5 billion total)

WPC Vision

- Idea: county and local partners identify high users of multiple county systems using shared data
- Emphasis on building cross-county infrastructure for collaboration
- Shared challenge of improving outcomes for high users of multiple county systems
- Key elements:
 - Collaborative leadership
 - Target Population
 - Coordination of Services Across Sectors
 - Patient-Centered Care
 - Shared Data
 - Financial Flexibility

WPC Planning

- **Data**
 - Identifying partners: county agencies, health plan(s), hospitals, clinics, social services providers
 - Identifying data: are there efforts currently under way to identify data sources and share across systems? What are the needs of individuals (homelessness, substance use disorder treatment, serious mental illness)?
 - Steps to conduct data run or refine data (if there is already process in place)
- **Cross-Sector Care Coordination**
 - Identifying existing care coordination programs or services in the county
 - Opportunities to integrate cross-sector partners – joint strategies? Strengthen existing partnerships?
 - Gaps? Overlap?

Questions?



HURST+BROOKS+ESPINOSA

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Behavioral Health Priorities in 2016

Attachment Four

CSAC Memo: Behavioral Health Priorities in 2016



November 17, 2015

TO: CSAC Health and Human Services Policy Committee

FROM: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: **Behavioral Health Priorities in 2016**

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CSAC is pleased to introduce Kirsten Barlow, MSW, who has returned to the county family as the Executive Director of the County Behavioral Health Directors Association (CBHDA), a CSAC affiliate. Prior to CBHDA, Ms. Barlow – appointed by Governor Brown – served as the Executive Officer of The Council on Mentally Ill Offenders within the California Corrections and Rehabilitation Department.

Between 2009 and 2014, Ms. Barlow was Associate Director at CBHDA, where she directed the Association's legislative and budget advocacy efforts. Ms. Barlow also served as public information officer at the California Department of Mental Health, legislative advocate and information officer for the Los Angeles County Department of Mental Health and Principal Consultant to the California State Assembly Committee on Human Services under the leadership of former Assembly Member Dion Aroner (D-Berkeley). Ms. Barlow earned her Masters of Social Welfare degree in management and planning from the University of California, Berkeley and her Bachelor's degree in psychology from the University of Michigan at Ann Arbor.

Last year, CSAC worked closely with our colleagues at CBHDA to oppose several behavioral health-related measures that would have adversely impacted the county behavioral health system and the patients counties serve. Many of the topics centered on children's behavioral health and the rollout of the Drug Medi-Cal waiver. Other issues, such as potential changes to Proposition 63 and the integration of behavioral health and physical health care, promise to loom large in 2016.

We are pleased and excited to have Ms. Barlow joining us to provide an overview of her members' behavioral health priorities for the upcoming legislative session.

Poverty Working Group Report
Attachment Five
CSAC Memo: Poverty Working Group Report



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November 17, 2015

TO: CSAC Health and Human Services Policy Committee

FROM: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: **Poverty Working Group Report**

Background. Under the direction of the CSAC Executive Committee, CSAC staff convened a Poverty Working Group (PWG) in 2015 to explore ways in which counties could impact poverty in our communities. The PWG operates under the leadership of the PWG co-chairs: Supervisor Kathy Long (Ventura) – who previously served as a CSAC Health and Human Services Policy Committee Chair, Leticia Perez (Kern) and Lee Adams (Sierra) – representing urban, suburban and rural interests, respectively.

2015 Accomplishments. Since its inception, the PWG has convened six meetings exploring a number of efforts – Legislative, county-led and advocate-driven – to address poverty, drafted and adopted a poverty plank for the CSAC Platform and elevated the Governor’s Earned Income Tax proposal for CSAC’s support.

Poverty Plank. At the beginning of each two-year legislative cycle – and as issues require – the CSAC Board of Directors adopts the CSAC Platform, which then guides the Association’s policy work. Prior to 2015, CSAC did not have a unified policy specifically aimed at addressing poverty in our communities. As such, the PWG energetically began creating a poverty plank to be incorporated into the CSAC policy platform. The poverty plank carefully considered the variety of factors that influence poverty and affirmed counties’ role in the delivery of poverty reduction services.

The PWG approved the poverty plank in March 2015. It was then taken to the Health and Human Services Policy Committee in April 2015 for consideration and finally to the CSAC Board of Directors in May 2015 for approval. It received a unanimous vote of approval from the Board. The poverty plank now resides within both the Health and Human Services sections of the CSAC policy platform.

Earned-Income Tax Credit. The PWG explored a number of 2015-16 budget proposals, including child care, a housing support program, and the traffic debt amnesty fee program. While each proposal warranted support, the PWG made an official recommendation to the CSAC Board of Directors to ‘SUPPORT’ the Governor’s Earned Income Tax Credit (EITC) proposal – which was also vetted through the Health and Human Services Policy Committee and supported by the CSAC Women’s Leadership Forum. The proposed EITC set aside \$380 million to assist working Californians on the lowest rungs of the economic ladder and is estimated to assist 2 million residents or 825,000 families. The credit is intended to slide up or down based on the number of dependents in a household. Those with less than \$6,580 in income with no dependents

and up to \$13,870 with three or more dependents will qualify and may receive a tax credit of between \$460 to \$2,653 annually.

The Governor's EITC proposal was adopted in the final budget package. The final budget bill included language indicating the Legislature's intent to increase the allocation amount in the future.

2016 Legislative Outlook. According to new United States Census figures released last month, 16.4 percent of Californians and 22.7 percent of California's children lived in poverty in 2014. And while this is lower than the previous year, it is still far from acceptable for policy leaders.

We expect the dialogue surrounding poverty to continue as a key priority for the Democratic-controlled Legislature, local governments and state and national advocacy organizations in 2016.

State revenues continue to come in strong and above estimates, which will continue to drive conversations about human services program benefit and eligibility levels. For example, California has one of the shortest lifetime eligibility levels for federal Temporary Assistance for Needy Families (TANF) – known as CalWORKs – benefits: only 24 months.

The debate over the Maximum Family Grant rule and Senator Holly Mitchell's SB 23 will also continue.

Homelessness issues are also in the spotlight recently, led by LA County's homelessness initiative, and pressure from affordable housing advocates continues. With a new Speaker in the Assembly, at the time of this writing, it is difficult to judge the potential for action on these issues. But, rest assured that poverty issues will continue to be a priority for the Legislature and CSAC – and this working group – in 2016.

Attachments:

CSAC Poverty Plank adopted by the CSAC Board of Directors, May 2015

References:

Poverty Working Group webpage: <http://www.counties.org/poverty-working-group>

Staff Contacts:

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

Poverty Working Group Report
Attachment Six
CSAC Poverty Plank

POVERTY PLATFORM

(Adopted by the CSAC Board of Directors on May 28, 2015)

The California State Association of Counties affirms that California's counties are the front line of human assistance systems, serving as the community's link between state and federal policies and the delivery of critical poverty reduction services.

Poverty is influenced by a disparate but connected set of factors, including but not limited to: a lack of sufficient income, geographic challenges, employment and economic climate, availability of supports and services, availability of stable and permanent housing, education resources, lack of transportation systems, complex state and federal regulation, access to health care, health disparities, and access to quality child care.

Counties recognize that poverty may be influenced by international, national, and state economic factors outside of local control, but note that any period in which poverty increases results in a pernicious cycle of rising caseloads and needs while revenues at the county level decrease.

Counties must have the local administrative flexibility and resources to meet federal and state standards, while also meeting the unique needs of their residents. Counties recognize that poverty impacts other levels of local government, including schools and cities, and encourage working collaboratively to serve all residents. Counties must also be partners in the design and reform of programs that focus on the whole person/family as the starting point for customizing services in order to address poverty in our communities.

Special Session Update

Attachment Seven

CSAC Memo: Second Extraordinary Session on Health Care



November 17, 2015

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To: CSAC Health and Human Services Policy Committee

From: Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: **Second Extraordinary Session on Health Care**

Topic. The Health Care Special Session convened by Governor Brown in June remains open, but legislators have very little to show for the months-long session.

Special Session legislative committees met and reviewed more than 20 bills (see attached chart), but only one, ABX2 15 (Eggman, Alejo, M. Stone), the “Right to Die” assisted suicide bill, made it to the Governor’s desk. Governor Brown signed ABX2 15 into law on October 6.

The Special Session remains open despite the adjournment of the regular session on September 11, and a conference committee (see below) has been named to continue work on reaching a new Managed Care Organization (MCO) tax deal (see below for more detail on the MCO tax, which is of importance to counties).

The Administration’s main special session goal was to create a workable MCO tax to provide at least \$1.1 billion for Medi-Cal services. While the Governor’s staff and Director of Health Care Services Jennifer Kent worked very hard near the end of the regular session to try to reach a MCO tax deal, they were ultimately unsuccessful due to resistance from health plans and a dearth of Republican votes.

Because of this, the Governor is expected to indicate a \$1.1 billion dollar Medi-Cal hole in his January budget proposal. While it is not clear if the special session conference committee will meet over the interim, efforts to craft a workable MCO tax continue.

Background. Governor Brown opened a second extraordinary special session on health care financing issues on June 16 as part of the 2015-16 budget agreement with Legislative Leaders. The Governor also declared a first extraordinary special session on Transportation issues. Hence, the Health Care Special Session is known as the second extraordinary session.

The Governor’s declaration (attached) explains the goals for the special session: “to consider and act upon legislation necessary to enact permanent and sustainable funding from a new managed care organization tax and/or alternative fund sources...”

The Governor is seeking at least \$1.1 billion in funding to stabilize the state’s General Fund costs for Medi-Cal, but, in conjunction with Legislative Leaders, has also signaled the need for funding for additional priorities, including:

- Funding the 7 percent restoration of In-Home Supportive Services hours beyond the 2015-16 fiscal year (\$266 million)
- Providing funding for Medi-Cal Fee-For-Service provider rate increases (estimated to cost \$250 million annually)
- Providing funding for developmental disability community provider rate increases and services (\$100 million to provide a 10 percent rate increase)

The top priority for the Governor and the Legislature is to authorize a new Managed Care Organization (MCO) tax to provide at least the first \$1.1 billion in funding to the state for Medi-Cal costs. The current MCO tax expires June 30, 2016 and the Brown Administration has proposed a new, flat MCO tax on all health plans providing Medi-Cal services (link attached).

Any funds raised by a new MCO tax above the \$1.1 billion could be used for the additional priorities, which total roughly \$616 million.

Special Session Process and Legislation. Both houses of the Legislature organized new committees for the health special session, which met and considered special session bills ranging from the MCO tax (see below), tobacco legislation, and the “Right to Die” assisted suicide bill for terminally ill patients.

The health special session conference committee, which is a joint committee of the Senate and Assembly, was named in the waning days of the regular session:

SENATE	Assembly
Senator Ed Hernandez, Co-Chair	Assembly Member Rob Bonta, Co-Chair
Senator Mark Leno	Assembly Member Susan Bonilla
Senator Holly Mitchell	Assembly Member James Gallagher
Senator Jim Nielsen	Assembly Member Jim Patterson
Republican Vacancy	Assembly Member Miguel Santiago

The health special session conference committee has yet to convene.

MCO Tax Background

Several MCO tax proposals were introduced during the special session; however they did not make it to the Governor’s desk before the Legislature adjourned the regular session.

ABX2 4 (Levine) would institute a \$7.88 monthly flat tax for each plan enrollee for 45 managed care organizations which cover 21 million Californians, of which 9 million are Medi-Cal patients. The Author has stated that it will raise at least the \$1.1 billion needed to fund existing obligations as well as up to \$1.9 billion to provide funding for the additional stated priorities above (the IHSS 7 percent restorations, Medi-Cal provider rate increases, and disability services rate increases).

ABX2 19 (Bonta) would establish two tax tiers for managed care plans in FY 2016-17. It would further require the Department of Health Care Services and the Department of Managed Health Care to determine the tax methodology in FY 2017-18 and future years.

SBX2 14 (Hernandez) was introduced in the last days of the regular session. The measure would impose a tiered MCO tax on all managed care organizations, in addition to instituting a tobacco tax and a repeal of the 7 percent reduction in in-home supportive services hours. This measure would generate \$1.9 billion per year in MCO tax revenues and \$1.3 billion per year from tobacco tax revenues.

As of this writing, the Administration has not yet formally introduced their MCO tax proposal in the extraordinary session. However, their initial ideas circulated as a draft would impose the new tax on most MCOs, not just those licensed for Medi-Cal Managed Care. It proposes a tiered tax structure based on enrollment size:

For example, according to the Legislative Analyst's Office, a MCO with 1 million taxable member months would pay \$3.50 per unit for the first 125,000 member months, \$25.25 per unit for the next 150,000 member months, and \$13.75 per unit for the remaining 725,000 member months, resulting in a total payment of \$14.2 million. A link to the text of the Administration's original spring MCO proposal is included at the end of this document, however, new models were developed near the end of the regular session in September, so this version is included only as an example of possible models. The Administration's newer models are not in print.

Tobacco Legislation

The six-bill package of tobacco legislation is sponsored by Save Lives California, a coalition comprised of SEIU, CMA, CHA, American Cancer Society, American Lung Association, some health plans and the Dentists (CDA). The coalition's goal is to raise the tax on tobacco by \$2 by 2016 to raise \$1.5 billion annually for unspecified health spending. None of the bills below made it to the Governor's desk, and the Save Lives California coalition has indicated that they intend to place some of this policy as an initiative on the November 2016 ballot.

Please note that CSAC supported two of the introduced tobacco bills, SBX2 5 (Leno)/ ABX2 6 (Cooper) and SBX2 7 (Hernandez)/ ABX2 8 (Wood), both of which the CSAC Health and Human Services Policy Committee voted to support during the regular session.

CSAC presented SBX2 9 (McGuire)/ ABX2 10 (Bloom) to the HHS Policy Committee and the CSAC Executive Committee. Both Committees agreed that pursuing a tobacco tax at the local level would be difficult given the industry and did not recommend that CSAC formally weigh in.

SBX2 9 (McGuire)/ ABX2 10 (Bloom) would have allowed counties to levy taxes on tobacco distributors. Implementation at the county level would have been subject to the usual rules for the adoption of local taxes (two-thirds local vote).

SBX2 7 (Hernandez)/ ABX2 8 (Wood) would have increased the age of sale for tobacco products to 21. The CSAC HHS Policy Committee adopted a support position on Hernandez's SB 151, which was identical to these special session bills. SB 151 died in the Assembly Governmental Organizations Committee last month due to strong opposition from the tobacco industry.

SBX2 5 (Leno)/ ABX2 6 (Cooper) would have added e-cigarettes to existing tobacco products definitions. The CSAC HHS Policy Committee also adopted a support position on Leno's SB 140, which was identical to these special session bills. SB 140 also died in the Assembly Governmental Organizations Committee after committee members added hostile amendments to the bill, forcing author Senator Leno to abandon the bill.

SBX2 10 (Beall) / ABX2 11(Nazarian) would have established an annual Board of Equalization (BOE) tobacco licensing fee program. Funds would have been earmarked for existing tobacco control programs.

SBX2 8 (Liu)/ ABX2 9 (Thurmond and Nazarian) would have required all schools to be tobacco free.

SBX2 6 (Monning)/ ABX2 7 (Stone) would have closed loopholes in smoke-free workplace laws, including hotel lobbies, small businesses, break rooms, and tobacco retailers.

County Impacts of Special Session. The MCO tax issue is of importance to counties because the current MCO tax provides critical implementation funding for the Coordinated Care Initiative (CCI). The continuation of the CCI is tied to the county In-Home Supportive Services (IHSS) Maintenance of Effort (MOE) and the eventual plan to transition collective bargaining for IHSS workers from each county to the state, which was negotiated between the Administration and CSAC in 2012. If the CCI is unsuccessful, or MCO funding for the CCI is not continued, the county IHSS MOE could possibly cease as well.

It is worth noting that the Governor's proclamation calling for the special session does not mention continued funding for the CCI.

CSAC will continue to monitor the health special session.

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Attachments

Special Session Legislation Chart (as of October 13, 2015)

Resources

CSAC has created a Special Session page to gather all materials and resources related to the 2015 special sessions on transportation and health: <http://www.counties.org/special-sessions>

Legislative Analyst's Office: The MCO Tax: A Flat Versus Tiered Structure (August 18, 2015): <http://www.lao.ca.gov/handouts/health/2015/MCO-Tax-081815.pdf>

CSAC Explanation of MCO Tax and CCI Issues (January 2015):
http://www.counties.org/sites/main/files/file-attachments/mco_and_cci_and_the_ihss_moe_june_2015.pdf

The IHSS MOE: Frequently Asked Questions:
http://www.counties.org/sites/main/files/file-attachments/ihss_labor_faq_oct_15_final.pdf

Governor's Proclamation for Extraordinary Session:
http://gov.ca.gov/docs/6.16.15_Health_Care_Special_Session.pdf

Draft Administration Language on MCO Tax (March 2015):
http://www.dof.ca.gov/budgeting/trailer_bill_language/health_and_human_services/documents/647_DHCSManagedCareOrganizationTaxTBL_000.pdf

Special Session Update
Attachment Eight
2015 HHS Special Session Bill Chart

**CALIFORNIA STATE ASSOCIATION OF COUNTIES
HEALTH AND HUMAN SERVICES
2015-16 SPECIAL SESSION BILL CHART**

Tobacco			
ABX 2 6 (Cooper)	Support	Would expand the STAKE Act's definition of tobacco products to include electronic devises that deliver nicotine or vaporized liquids and make it illegal to furnish such products to minors.	Awaiting action on the Assembly Floor.
ABX2 7(Stone)	Watch	Would expand the prohibition on spoking in a place of employment to include owner-operated business.	Awaiting action on the Assembly Floor.
ABX 2 8 (Wood)	Support	Would raise the age for restricted access to tobacco products from 18 to 21.	Awaiting action on the Assembly Floor.
ABX2 9 (Thurmond)	Watch	Would require the Department of Education to require that all school districts, charter schools and county offices of education receiving funding for tobacco use prevention programs adopt and enforce a tobacco-free campus policy.	Awaiting action on the Assembly Floor.
ABX2 10 (Bloom)	Watch	Would authorize a county board of supervisors to impose a tax on distributing cigarettes and tobacco products in a county.	Awaiting action on the Assembly Floor.
ABX2 11 (Nazarian)	Watch	Would require a fee of \$265 to obtain a license for each cigarette and tobacco retail location from the State Board of Equalization.	Awaiting action on the Assembly Floor.
ABX2 16 (Bonta)	Watch	Would expand the definition of tobacco products for purposes of the Cigarette and Tobacco Products Licensing Act to include electronic cigarettes.	Referred to the Assembly Committee on Public Health and Developmental Services
SBX2 5 (Leno)	Support	Would expand the definition of tobacco products in the STAKE Act to include electronic cigarettes.	Held at the Senate desk.
SBX2 6 (Monning)	Watch	Would expand the prohibition on smoking in a place of employment to include an owner-operated business.	Held at the Senate desk.
SBX2 7 (Hernandez)	Support	Would raise the age for restricted access to tobacco products from 18 to 21.	Held at the Assembly desk.
SBX2 9 (McGuire)	Watch	Would authorize a county board of supervisors to impose a tax on distributing cigarettes and tobacco products in a county.	Held at the Assembly desk.
SBX2 10 (Beall)	Watch	Would require a fee of \$265 to obtain a license for each cigarette and tobacco retail location from the State Board of Equalization.	Held at the Assembly desk.

**CALIFORNIA STATE ASSOCIATION OF COUNTIES
HEALTH AND HUMAN SERVICES
2015-16 SPECIAL SESSION BILL CHART**

Managed Care Organization Tax			
ABX2 4 (Levine)	Pending	Would repeal the support services sales tax and establish a new MCO tax to be administered by DHCS in consultation with DMHC.	Awaiting policy committee hearing.
ABX2 19 (Bonta)	Pending	Would establish a new MCO tax and would establish two tax tiers for managed care plans in FY 2016-17. It would further require the Department of Health Care Services and the Department of Managed Health Care to determine the tax methodology in FY 17-18 and future years.	Awaiting policy committee hearing.
SBX2 14 (Hernandez)	Pending	Would: 1) change the definition of tobacco products to include electronic cigarettes; 2) impose a \$2 tobacco tax on cigarettes and an equivalent tax on electronic cigarettes; 3) repeal the 7 percent reduction in in-home supportive services (IHSS) service hours; and 4) impose a tiered MCO tax on all managed care organizations.	Awaiting a vote on the Senate Floor.
Taxation			
ABX2 18 (Bonilla)	Watch	Would impose a surtax on every individual for the purchase of a cocktail at a rate of \$0.05 per cocktail, adjusted annually.	Re-referred to the Assembly Committee on Finance.
Medi-Cal			
ABX2 13 (Gipson)	Watch	Would declare the intent of the Legislature to enact legislation to increase funding for the AIDS Medi-Cal Waiver Program.	Assembly desk.
End of Life			
ABX2 15 (Eggman)	No Position	Would enact the End of Life Option Act would expand the STAKE Act's definition of tobacco products to include electronic devises that deliver nicotine or vaporized liquids and make it illegal to furnish such products to minors.	Signed into law. Chapter 1, Statutes of 2015

NACo Committee Opportunities

Attachment Nine

CSAC Memo: NACo Policy Steering Committee Membership



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November 17, 2015

TO: CSAC Health and Human Services Policy Committee

FROM: Karen Keene, Senior Legislative Representative
Farrah McDaid Ting, Legislative Representative
Michelle Gibbons, Legislative Analyst

Re: NACo Policy Steering Committee Membership

As many of you may already know, NACo's Policy Steering Committees play a crucial role in NACo's advocacy process. Steering Committees annually review and make recommendations on federal policy issues and legislative items that are important to the nation's counties. Through this process, the committees advise the NACo Board of Directors and voting delegates who set NACo policy each year. NACo's policy platform guides the county government message presented to the Administration, Congress, U.S. Courts, and the American public. To ensure that the California's county perspectives are well represented, CSAC encourages you to review the following information and give some thought to joining a NACo Steering Committee.

As a member of a Steering Committee, individuals may introduce policy resolutions and platform changes and vote on other proposed resolutions and platform changes within the jurisdiction of their committee. Throughout the year, committee members participate in regular conference calls and receive email updates from NACo staff to stay up to date on matters relevant to the committee's work.

California county officials wishing to serve on a NACo Policy Steering Committee must apply through CSAC. After receiving a recommendation from CSAC, NACo's president appoints members of each committee. Appointments are made after the NACo Annual Conference in July each year. Policy Steering Committee members serve one-year terms.

Please note that only eight county officials from the same state can be appointed to any one steering committee, and no more than two persons from the same county may serve on any one steering committee. This does not include NACo presidential appointments including steering committee chairs and vice chairs.

NACo maintains ten (10) Policy Steering Committees that cover the full range of county policy issues:

- **Agriculture and Rural Affairs** – Responsible for all matters pertaining to USDA agriculture, rural development programs, rural renewable energy development, food safety, and conservation programs.

- **Community, Economic, and Workforce Development** – Responsible for all matters pertaining to housing, community and economic development, public works, and workforce development.
- **Environment, Energy, and Land Use** – Responsible for all matters pertaining to air, water, energy, and land use, including water resource management, air quality standards, national energy policy, coastal management, oceans, and parks and recreation.
- **Finance, Pensions, and Intergovernmental Affairs** – Responsible for all matters pertaining to the financial resources of counties, fiscal management, municipal borrowing, county revenues, pensions, the federal budget, tax reform, elections, and Native American issues.
- **Health** – Responsible for all matters pertaining to public health and healthy communities, including disease prevention, health insurance, Medicaid, Medicare, and long term care.
- **Human Services and Education** – Responsible for all matters pertaining to children’s issues, public assistance and income support, services to senior citizens and individuals with disabilities, immigration policy, and elementary, secondary, and early childhood education.
- **Justice and Public Safety** – Responsible for all matters pertaining to criminal justice and public safety systems, including law enforcement, courts, corrections, community crime prevention, and emergency management.
- **Public Lands** – Responsible for all matters pertaining to federally-owned public lands, including federal land management programs, natural resource revenue sharing payments, payments in lieu of taxes, and property tax immunity concerns.
- **Telecommunications and Technology** – Responsible for all matters pertaining to telecommunications and technology policy, including the county role as a telecommunications regulator, service provider, and consumer.

For those interested in health and human services issues, we recommend participation on the Health Committee and the Human Services and Education Committee. Because of the significant role that California counties play in these areas as partners with the state and federal governments in the provision of HHS services, we encourage all CSAC HHS Policy Committee members to get involved with the NACo committees.

For those interested in joining a NACo Policy Steering Committee, additional information is available at: <http://www.naco.org/about/committees-state-associations-affiliates/how-join-committee>. You are also welcome to contact CSAC or NACo staff if you have any questions regarding California County participation on the Steering Committees.

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Resources:

NACo Health Platform – <http://www.naco.org/sites/default/files/Health.pdf>

NACo Human Services Platform – <http://www.naco.org/sites/default/files/HSE2014-2015Platform.pdf>