**HEALTH and HUMAN SERVICES**
**Friday March 17, 2017**
**CCI Office**
9 a.m.
(This meeting is recorded)
Teleconference: 1.857.216.6700 Passcode: 171009

## AGENDA

**WELCOME**
Commissioner Nancy Sharpe, Chair
Commissioner Wendy Buxton-Andrade, Vice Chair
Gini Pingenot, CCI
Allison Daley, CCI

**INTRODUCTIONS**

**Federal Update on SSBG, Medicaid and Other Issues of Interest**
Tom Joseph - National Association of County Human Services Administrators (NACHSA)

*Please see both the NACHSA and NACO attachments*

**LEGISLATION**

| CHILD WELFARE | |
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| **Bill #** | **HB17-1052** |
| **Title** | **Child Welfare Allocation Formula Factors** |
| **H-Spon** | S. Beckman |
| **S-Spon** | |
| **Summary** | The bill removes certain data-gathering factors currently required to be taken into consideration in determining a fiscal year's child welfare allocation formula for counties and replaces those with a broader scope of factors that directly affect the population of children in need of child welfare services, as determined by the state department of human services and the child welfare allocations committee. |
| **Position** | Support CCI Bill - Governor Signed |
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| Bill # | HB17-1110 |
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| Title | **Jurisdiction Juvenile Court Parental Responsibilities** |
| H-Spon | S. Beckman |
| S-Spon | |
| Summary | HB 1110 provides procedure for judges to issue an Allocation of Parental Responsibilities (APR) order during a Juvenile Delinquency case when all parties are in agreement. This bill applies to juveniles that are placed in temporary legal custody with a close relative or friend during a juvenile delinquency case. Once the case closes, the temporary legal custody order goes away and the juvenile may return home, but in some cases, the parent declines to take custody of the juvenile again. Without this order, the juvenile delinquency case is sometimes kept open longer than necessary in order to continue the temporary legal custody arrangement. This bill provides faster permanency for some juveniles and ensures they are in a stable environment to work towards self-sufficiency and becoming a productive member of society. |
| Position | Support CCI Bill |
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| **Bill #** | HB17-1111 |
| **Title** | **Dependency & Neglect Civil Protection Orders** |
| **H-Spon** | S. Beckman |
| **S-Spon** | |
| **Summary** | HB 1111 provides procedures for the Juvenile Court to enter civil protection orders in Dependency & Neglect (D&N) actions in the same manner as district and county courts. These protection orders, unlike the "no contact" orders currently used in D&N cases, allow for violators to be arrested and can extend past the closing of the D&N case. This better protects children and families, while ensuring adequate due process for offending parties. |
| **Position** | Support CCI Bill |
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| **Bill #** | HB17-1185 |
| **Title** | **Reports Of Suspected Child Abuse Or Neglect** |
| **H-Spon** | J. Singer |
| **S-Spon** | J. Smallwood |
| **Summary** | Under current law, certain identified persons are mandated to report if they know or suspect that a child has been subject to abuse or neglect (mandatory reporters). The bill adds to the list of mandatory reporters officials and employees of county departments of health, human services, or social services. Current law requires the county department of human or social services to report certain information to mandatory reporters that continue to be involved with a child within 30 days after the filing of a report. The bill extends the period to 60 days. |
| **Position** | Oppose Unless Amended |

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| **Bill #** | HB17-1207 |
| **Title** | **No Detention Facility Requirement Youth Ages 10-12** |
| **H-Spon** | P. Lee |
| **S-Spon** | K. Priola |
| **Summary** | The bill creates provisions that remove the requirements for the department of human services to receive, detain, or provide care for any juvenile who is 10 years of age and older but less than 13 years of age, unless the juvenile has been arrested or adjudicated for a felony or a weapons charge that is a misdemeanor or felony. Provisions remain in statute for other programs and services for the age group that will no longer require placement of the juvenile in a detention facility. |
| **Position** | |
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| **Bill #** | SB17-016 |
| **Title** | **County Choice Child Protection Teams** |
| **H-Spon** | D. Nordberg |
| **S-Spon** | C. Jahn, T. Neville |
| **Summary** | Legislative Audit Committee Bill - Current law requires the creation of a child protection team for any county or group of contiguous counties receiving more than 50 referrals related to child abuse or neglect in a year. Other counties or groups of contiguous counties are encouraged, but not required, to establish a child protection team. The bill makes it optional for all counties and groups of contiguous counties to establish a child protection team. |
| **Position** | Support |
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| **Bill #** | SB17-028 |
| **Title** | **Healthy Families and Military Preparedness Act** |
| **H-Spon** | D. Nordberg |
| **S-Spon** | B. Gardner |
| **Summary** | SB 28 requires the state and county departments of human or social services to provide notice and to collect and share information with the command authority of national military installations regarding any report received of known or suspected instances of child abuse or neglect in which the person having custody or control of the child is a member of the armed forces or a spouse, significant other, or family member of the member of the armed forces assigned to that military installation. The state department and county departments may enter into memorandums of understanding with military installations establishing protocols for the sharing of information and for collaboration on the investigations into child abuse or neglect by a member of the armed forces or a spouse, significant other, or family member of the member of the armed forces. |

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| **Position** | Support |
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| **Bill #** | SB17-177 |
| **Title** | **Children's Code Definition Of Special Respondent** |
| **H-Spon** | P. Rosenthal |
| **S-Spon** | J. Cooke |
| **Summary** | The current definition of special respondent in the Children's Code only allows a party to be involuntarily joined in a dependency or neglect proceeding. The bill amends that definition to allow a party to be voluntarily joined in a dependency or neglect proceeding. |
| **Position** | Support |
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| **HEALTH CARE** | |
| **Bill #** | HB17-1235 |
| **Title** | **Financial Relief Defray Individual Health Plan Cost** |
| **H-Spon** | D. Mitsch Bush, M. Hamner |
| **S-Spon** | D. Coram, L. Crowder |
| **Summary** | The bill creates a financial relief program, available from July 1, 2017, through December 31, 2018, to provide financial assistance to individuals and their families who spend more than 15% of their household income on individual health insurance premiums. The Colorado health benefit exchange (exchange) is to oversee the program, and counties may elect to administer the program in their counties. For any county that opts not to administer the program, the exchange is to administer the program in that county.<br><br>Financial relief is available to individuals and families determined eligible based on the following:<br><br>• The individual or family enrolled in and paid premiums for a bronze, silver, or gold level individual health benefit plan purchased through the exchange;<br>• The individual or family has a household income of more than 400%, but not more than 500%, of the federal poverty line;<br>• The individual or family does not have access to a government-sponsored program, such as Medicaid or Medicare, or an affordable employer-sponsored plan; and<br>• The individual or family pays more than 15% of the household income on premiums for the plan.<br><br>The amount of financial relief is calculated based on the cost of the premium for the lowest-cost bronze health benefit plan available to the individual or family through the exchange, minus an amount equal to 15% of the individual's or family's household income. The general |

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| | assembly is to appropriate money from the general fund to provide financial assistance to individuals who qualify under the program.<br><br>The program repeals on July 1, 2019, unless congress enacts and the president signs legislation repealing the advance premium tax credit authorized under federal law, in which case the program repeals upon the date of the repeal of said tax credit |
| **Position** | |
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| **Bill #** | **HB17-1237** |
| **Title** | **State Employee Group Benefit Plans For Local Government** |
| **H-Spon** | M. Hamner |
| **S-Spon** | D. Coram, L.Crowder |
| **Summary** | Health benefits are offered to state employees through the State Employees Group Benefits Act (act), which is administered by the state personnel director. The bill authorizes the state personnel director, or a designee, to enter into an agreement with any local government to provide health benefits to employees of the local government through the group benefit plans offered to state employees pursuant to the act. The bill specifies that a local government is not required to offer health benefits to its employees through the group benefit plans offered to state employees pursuant to the act. |
| **Position** | |
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| **MISC** | |
| **Bill #** | **HB17-1087** |
| **Title** | **Office Of Public Guardianship Pilot Program** |
| **H-Spon** | D. Young |
| **S-Spon** | |
| **Summary** | The bill creates the office of public guardianship (office) within the judicial department to provide legal guardianship services to indigent and incapacitated adults who:<br>• Have no responsible family members or friends who are available and appropriate to serve as a guardian; and<br>• Lack adequate resources to compensate a private guardian and pay the costs and fees associated with an appointment proceeding.<br>The office is established as a pilot program, to be evaluated and then continued, discontinued, or expanded at the discretion of the general assembly in 2021. On or before January 1, 2021, the director of the office shall submit a report to the judiciary committees of the senate and the house of representatives. The report, at a minimum, must quantify |

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| | Colorado's unmet need and average cost for public guardianship services for indigent and incapacitated adults. The bill creates the public guardianship commission within the judicial department and charges the commission with appointing a director of the office. The work of the office will be supported by gifts, grants, or donations as well as any other money appropriated to the fund by the general assembly. |
| **Position** | Monitor |

## SFY 2017-2018 Budget Update – Human Services

## OTHER BUSINESS

## NACO/FEDERAL UPDATE

## ADJOURN

***In Case You Missed It – News Items from Previous ecountylines publications***

**March 17: Works Allocation Committee (WAC) Meeting**
The next meeting of the Works Allocation Committee (WAC) is set for March 17, 2017 from Noon to 2 pm at the Colorado Department of Human Services (1575 Sherman Street, Denver) in conference room 4A/B. To call in to the meeting, dial 1-857-216-6700 and enter 823617 when prompted. An agenda and handouts will be shared when available. Questions: email Luis Garcia at luism.garcia@state.co.us**.**

**Child Welfare Prevention Steering Committee Has Openings**
CCI is seeking county leaders – a commissioner or a county commission-approved designee – to fill two vacant positions on the Prevention Steering Committee, a subcommittee of the Child Welfare Executive Leadership Council. In early 2016, the Prevention Steering Committee and the Colorado Children's Trust Fund Board agreed to hold joint quarterly meetings to explore alignment of each group's efforts. The Prevention Steering Committee was convened by the Colorado Department of Human Services (CDHS) to provide oversight of the pilot implementation of two programs and an augmentation of an existing program laid out in the Governor's Child Welfare Plan.

The two piloted programs – SafeCare Colorado and Colorado Community Response – have been effectively piloted and are part of ongoing programming at CDHS. The time-limited augmentation of Nurse-Family Partnership has successfully come to a close. The Colorado Children's Trust Fund was created in statute in 1989 to prevent child maltreatment of Colorado children. The Trust Fund Board, whose structure and responsibilities are determined in statute, is governed by nine representatives who oversee the distribution of the fund to the establishment, promotion and maintenance of primary and secondary child maltreatment prevention programs (C.R.S. 19-3.5-104). The two groups have agreed to continue holding joint quarterly meetings through 2017, and will be conducting an asset inventory of existing membership, identifying gaps, and clarifying purpose and needs for a statewide advisory structure around child maltreatment prevention work.

The committee meets quarterly in Denver on the second Thursday from 1 to 4 pm. Future meeting dates for 2017 are **May 5, August 10, and November 19**. Current county representatives on the committee include commissioners Thomas Davidson (Summit), David Weaver (Douglas), Eva Henry (Adams), and Gunnison County Human Services Director Joni Reynolds.

If you would like to serve on this committee, email **Gini Pingenot** or call her at **303.861.4076**. In order to ensure adequate county representation, county staff with the approval of the county's board of county commissioners, may also submit their names for consideration by CCI's Board of Directors.

To: Colorado Counties

From: Tom Joseph, National Association of County Human Services Administrators

Date: March 10, 2017

Subj: Affordable Care Act and SSBG Updates

**Affordable Care Act Repeal & Replace:** The House Ways and Means and Energy and Commerce Committees worked through the night and passed their respective Affordable Care Act (ACA) replacement sections on March 9.

The bill would:

- end the enhanced 95% federal match for Medicaid expansion on January 1, 2020;
- place a per capita cap on federal Medicaid spending on October 1, 2019;
- make a number of administrative changes to Medicaid to make it more difficult to maintain coverage, (e.g., re-determine eligibility for Medicaid expansion enrollees every six months);
- eliminate the enhanced six percentage point increase in the normal federal match Colorado uses under the Community First Choice Option to provide supportive services in the home; and,
- repeal the Prevention and Public Health Fund used by state and local public health departments to reduce infectious disease and respond to other public health issues.

There were no significant amendments to the bill. Republicans did signal, however, that they will likely offer two amendments on the House floor to further restrict Medicaid. They are:

- An amendment to terminate by end of this year (2 years earlier) the 95% enhanced match for any additional enrollees under ACA's Medicaid expansion. Those who remain consistently on the enhanced program would continue to receive the enhanced match but it would sunset by 2023; and,
- An amendment to require certain individuals to work in order to receive Medicaid. (Language is not yet available).

The next steps in the legislative process will unfold in the coming weeks. Early next week, the Congressional Budget Office is expected to release its report estimating the costs of the bill and its impact on the uninsured rate. The House Budget Committee will then combine the respective

sections passed by the two committees. Following that task, the House Rules Committee will then establish what amendments would be considered on the House floor, with a possible vote on the overall bill before month's end.

House leadership is balancing different factions within its 237 member delegation. The conservative 29 member House Freedom Caucus (Colorado Rep. Ken Buck is a member) has stated it wants the ACA repealed completely and has serious concerns with the current bill. Other more moderate members from states which have expanded Medicaid under the ACA have said the measure may have gone too far in cutting Medicaid. The House needs 218 votes to pass the bill.

The Senate intends to bring the House measure straight to the floor, bypassing the Senate Health, Education, Labor and Pensions (HELP) and Finance Committees which have jurisdiction over the ACA. Senator Bennet (D-CO) serves on both committees. Under the reconciliation rules, the ACA replacement bill could be passed by a simple majority vote. With the Senate controlled by 52 GOP members, defections of only three Republicans could defeat the bill. A handful of Senators, including Senator Gardner (R-CO) have expressed concerns with the House bill. Senator Gardner joined three of his GOP colleagues in a letter highlighting problems with the House measure's Medicaid expansion provisions.

**Social Services Block Grant (SSBG):** The National Association of County Human Services Administrators is collaborating with the National Association of Counties, the Child Welfare League of America, Generations United and others to counter efforts to eliminate SSBG. The $1.7 billion flexible block grant is used to meet community-based needs in child and adult protective services, aging services and many other human services programs. Given the flexible nature of the SSBG, some members of Congress have argued that it duplicates other federal programs and should be repealed, generating $17 billion in federal savings over ten years. Past House bills to end SSBG have not survived the legislative process, but here is reason to be concerned that the current focus on finding $54 billion in domestic savings proposed by President Trump will make SSBG a target once again.

According to the latest information from the U.S. Department of Health and Human Services, Colorado spent nearly $26 million in SSBG in fiscal year 2014, with the vast majority of funds targeted to child welfare services.

The SSBG Coalition is visiting with staff in offices of Senate Finance Committee members to make them aware of the program. The Coalition also just released a letter signed by over 70 national groups and entities from all 50 states, including Colorado Counties, Inc. urging that SSBG be protected.

January 6, 2017

The Honorable Kevin McCarthy
Majority Leader
United States House of Representatives
U.S. Capitol Building, Room H-107
Washington, D.C. 20515

The Honorable Kevin Brady
Chairman, Committee on Ways and Means
United States House of Representatives
1011 Longworth House Office Building
Washington, D.C. 20515

The Honorable Greg Walden
Chairman, Committee on Energy and Commerce
United States House of Representatives
2185 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Virginia Foxx
Chairwoman, Committee on Education and the Workforce
United States House of Representatives
2262 Rayburn House Office Building
Washington, D.C. 20515

Dear U.S. House Leadership:

**Re: December 2, 2016 Letter to Governors and Insurance Commissioners Seeking Health Care Recommendations**

On behalf of the National Association of Counties (NACo) and the 3,069 counties we represent, we thank you for soliciting input on major health reforms to strengthen and improve the health of all Americans. A strong federal-state-local partnership is critical to the success of our local health systems, which serve our most vulnerable citizens. Although each state is different, county governments play an integral role in paying for and providing health services, including financing and delivering Medicaid services. As you consider changes to the nation's health care system, especially Medicaid, we respectfully urge you to consider implications of reforms that would merely shift federal and state Medicaid costs to counties and local taxpayers.

Nationally, counties invest $83 billion annually in community health for more than 300 million residents nationwide. Through 961 county-supported hospitals, 883 county-owned and supported long-term care facilities, 750 county behavioral health authorities and 1,943 county public health departments, counties deliver health services to millions of Americans, including many Medicaid beneficiaries. Our county-supported health systems are the cornerstones of care in our communities.

Counties have always served as a social safety net in our communities, including providing health care for America's low-income populations. Over the past 50 years, the Medicaid program has been crucial in helping counties fulfill this obligation. The majority of states mandate counties to provide some level of health care for low-income, uninsured, or underinsured residents—care that is often not reimbursed. In Harris County, Texas, for example, residents pay more than $500 million per year in property taxes to cover the cost of uncompensated care in the county's public hospitals.

If changes are made to shift additional federal and state health and Medicaid responsibilities and costs to counties, this will create an even more challenging dynamic at the local level as many states already restrict counties' ability to raise revenue. In fact, thirty-eight states impose some limitation on counties' property tax rates and property assessments, which are typically the primary revenue sources for counties. Nonetheless, counties continue to invest in local health systems, even during economic downturns.

In 26 states, counties contribute to the non-federal share of Medicaid. In fact, local governments, including counties, may contribute up to 60 percent of the non-federal share of Medicaid costs in each state. For instance, counties in New York send approximately $140 million per week to the state for Medicaid costs. In Fiscal Year 2012 alone, local governments contributed $28 billion overall to the Medicaid program. Proposals to institute block grants or per capita caps for the Medicaid program would further shift federal and state Medicaid costs to counties and compromise our ability to provide health coverage, especially during economic recessions.

Counties have made the most of Medicaid's flexibility to construct health systems that serve a disproportionate share of low income populations, including the underinsured and uninsured, the homeless and those cycling in and out of county jails. County supported health safety net systems provide specialized care that is often unavailable elsewhere while operating on lower margins than other providers. Already, these health systems are subject to impending federal cuts to the Medicaid disproportionate share hospital (DSH) payments. Without sustained funding, these county hospitals will not be able to keep doors open.

Over 70 percent of America's counties have populations of less than 50,000, and the Medicaid program is especially important to these small and rural counties. Medicaid covers 21 percent of rural residents, compared to only 16 percent of those who reside in urban areas. Rural clinics receive enhanced Medicaid reimbursements and Medicaid payments account for more than 14 percent of rural hospitals' gross revenue. More than 75 rural hospitals have closed since 2010, and further cuts would endanger many more.

Health workforce shortage is also a key challenge, especially in our small and rural counties. The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas. Nearly one-third of rural physicians receive at least 25 percent of patient revenues from Medicaid reimbursements. This revenue is essential to helping these counties retain much needed health professionals, especially as they care for an older population than their urban counterparts.

As drug overdose deaths outpace car accidents as the leading cause of accidental deaths, it must be reinforced that Medicaid is still the largest source of funding for behavioral health services in the U.S. Our county public health departments and behavioral health authorities are engaged in key prevention and treatment initiatives from educating patients and families to expanding access to medication-assisted treatments. As the nation struggles to combat the opioid epidemic, counties are at the frontlines and need a strong federal partner to reverse course.

In addition to being the front door to our nation's health system, counties are also the entry point into the criminal justice system. Counties are required by federal law to provide health care for the 11.4 million individuals who pass through 3,100 local jails each year, 91 percent of which are operated by counties. Unlike in federal or state-operated prisons, the

majority of individuals in local jails are pre-trial and low-risk and the average length of stay is only 23 days.

Federal statute prohibits federal Medicaid matching funds from being used for medical care provided to individuals in jails, even for those who are awaiting trial and presumed innocent until proven otherwise. This population is much sicker than the general population, with 64 percent having a mental illness, 68 percent a history of substance abuse and 40 percent a chronic health condition (e.g., cervical cancer, hepatitis, arthritis, asthma or hypertension). 95 percent of these individuals will return to their communities, bringing their health conditions with them. Our goal is to ensure that they receive appropriate treatment in jail that allows them to successfully integrate back into society and contribute to local economies.

To make matters more challenging, many states terminate, instead of suspend, Medicaid for justice-involved individuals the moment they are booked into jail, even before they are given due process. These individuals then must completely re-enroll in Medicaid after being released from jail, which can take months. Not only does this coverage gap leave health conditions like mental illnesses and substance abuse untreated, it can lead to re-arrests and increased recidivism, putting further strain on law enforcement professionals and other social services. As you consider providing further flexibility in the Medicaid program, we urge you to look at models that improve care coordination and health outcomes for those involved in the justice system.

Counties' multifaceted role in health care extends beyond that of a health payer, provider and administrator; counties also provide health insurance to our workforce. Offering competitive health care benefits is one of the primary ways counties attract and maintain a quality workforce. Counties provide health benefits to an estimated 2.5 million employees and nearly 2.4 million of their dependents. For health insurance premiums alone, counties spend an estimated $20 billion to $24 billion annually. We urge you to fully repeal the Cadillac Tax and protect employer-sponsored health coverage.

As one of the earliest units of local government established in the original thirteen colonies that would become the United States, our counties have always evolved in order to serve our residents in partnership with states and the federal government. We stand ready to work with you to identify new and innovative strategies to strengthen our nation's health system and provide high-quality coverage and access to care for all of our residents while being responsible stewards of local taxpayer dollars.

If you have any questions, please feel free to contact Brian Bowden, NACo's Associate Legislative Director for Health, at bbowden@naco.org or 202.942.4275.

Sincerely,

Matthew D. Chase
Executive Director
National Association of Counties