

Health Services

Section 1: GENERAL PRINCIPLES

Counties serve as the front line defense against threat of widespread disease and illness and to promote health and wellness among all Californians. This chapter deals specifically with health services and covers the major segments of counties' functions in health services. Health services in each county shall relate to the needs of residents within that county in a systematic manner without limitation to availability of hospital(s) or other specific methods of service delivery. The board of supervisors in each county sets the standards of care for its residents.

Local health needs vary greatly from county to county. Counties support and encourage the use of multi-jurisdictional approaches to health care. Counties support efforts to make cost-saving partnerships between the state and the counties in order to achieve better fiscal outcomes for both entities. Therefore, counties should have the maximum amount of flexibility in managing programs. Counties should have the ability to expand or consolidate facilities and services to provide a comprehensive level of services and achieve maximum cost effectiveness. Additionally, as new federal and state programs are designed in the health care field, the state needs to work with counties to encourage maximum program flexibility and to minimize disruptions in county funding from the transition to new reimbursement mechanisms.

A. Public Health

The county public health departments and agencies are the only health agencies with direct day-to-day responsibility for protecting the health of every person. The average person does not have the means to protect him or herself against contagious and infectious diseases. Government must assume the role of health protection against contagious and infectious diseases. It must also provide services to prevent disease and disability and encourage the community to do likewise. These services and the authority to carry them out become especially important in times of disaster and public emergency. To effectively respond to these needs, counties must be provided with full funding for local public health communicable disease control and surveillance activities.

B. Health Services Planning

Counties believe strongly in comprehensive health services planning. Planning must be done through locally elected officials both directly and by the appointment of quality individuals to serve in policy and decision-making positions for health services planning.

C. Mental Health

Counties support community-based treatment of mental illness. They also accept responsibility for providing treatment and administration of such programs. It is believed that the greatest progress in treating mental illness can be achieved by continuing the counties' role in supporting and assisting the state in administering its programs. Programs that treat mental illness should be designed to

meet local requirements within statewide criteria and standards to ensure appropriate treatment of mentally ill persons. However, counties are concerned about the erosion of state funding and support for mental health services. Although the adoption of Proposition 63, Mental Health Services Act, will assist counties in service delivery it does not add funding to existing programs, but rather provides for new programs which expand the capacity of existing services. We strongly oppose additional reductions in state funding for mental health services that will result in the state shifting its costs to counties. These costs shifts result in reduced services available at the local level.

The realignment of health and social services programs in 1991 restructured California's public mental health system. Realignment required local responsibility for program design and delivery within statewide standards of eligibility and scope of services, and designated revenues to support those programs. Counties are committed to service delivery that manages and coordinates services to mentally ill persons and which operates within a system of performance outcomes that assure funds are spent in a manner that provides the highest quality of care.

California law consolidated the two Medi-Cal mental health systems, one operated by county mental health departments and the other operated by the state Department of Health Services on a fee-for-service basis, effective in fiscal year 1997-98. Counties supported these actions to consolidate these two systems and to operate Medi-Cal Mental Health services as a managed care program. Counties were offered the first opportunity to provide managed mental health systems, and every county chose to operate as a Medi-Cal mental health plan. This consolidated program provides for a negotiated sharing of risk for services between the state and counties. However, counties oppose a managed care model in which the state abdicates its funding responsibility to counties. Counties are paying for an increasing share of the Medi-Cal Mental Health program. As state funding declines, counties will reconsider providing managed mental health systems.

County mental health agencies provide necessary, child and family-centered high quality services to special education pupils. This program is known as AB 3632 (Statutes of 1984). The State provided inadequate funding for this mandate from fiscal year 2002-03 through 2004-05. Counties cannot continue to assume the legal and financial risk for this federal special education entitlement program. Counties urge the State to fully fund counties for their costs of providing the state mandated services under AB 3632 and to develop a reasonable plan for repaying past due SB 90 claims. Alternatively, counties would also support repealing the AB 3632 mandate on counties, recognizing that accountability for ensuring the provision of mental health related services under the IDEA rests with education – not local government. If school districts become fiscally responsible for this mandate, the program must be restructured so that schools are legally responsible for ensuring that mental health-related services are provided to special education students pursuant to the federal IDEA. Under such a restructured system, county mental health departments would remain committed to maintaining and enhancing their effective collaborative partnerships with education, and to working with all interested stakeholders in developing a system that continues to meet the mental health needs of special education pupils.

In response to county concerns, state law also provides funds to county programs to provide specialty mental health services to CalWORKs' recipients who need treatment in order to get and keep employment. Similar law requires county mental health programs to provide specialty mental health services to seriously emotionally disturbed children insured under the Health Families Program. Counties have developed a range of locally designed programs to serve California's diverse population.

Adequate mental health services can reduce criminal justice costs and utilization. Appropriate diagnosis and treatment services will result in positive outcomes for mentally ill offenders. Ultimately, appropriate mental health services will benefit the public safety system. Counties continue to work across disciplines to achieve good outcomes for persons with mental illness and/or co-occurring substance abuse issues.

D. Substance Abuse Prevention And Treatment

Counties have been, and will continue to be actively involved in substance abuse prevention and treatment. Counties believe the best opportunity for solutions are at the local level. Counties continue to provide a wide range of substance abuse treatment services. However, counties are concerned that treatment capacity cannot accommodate all persons needing substance abuse treatment services.

Counties continue to support state and federal efforts to provide substance abuse benefits under the same terms and conditions as other health services. Under current practice, insurance policies routinely treat alcohol and other drug abuse or dependency differently than other illnesses.

With the enactment of Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, substance abuse treatment demands on counties continue to increase. Counties are concerned that the dedicated funding for Proposition 36 will expire on June 30, 2006. However, the mandate to provide services under Proposition 36 does not expire; counties will be unable to provide services without adequate dedicated funding.

Adequate substance abuse prevention and treatment services can reduce criminal justice costs and utilization. Appropriate diagnosis and treatment services will result in positive outcomes for offenders with substance abuse problems. Ultimately, appropriate substance abuse treatment services will benefit the public safety system. Counties continue to work across disciplines to achieve good outcomes for persons with substance abuse issues and/or mental illness.

E. Medi-Cal, California's Medicaid Program

State officials began discussing reforming Medi-Cal, California's Medicaid program, in 2004. Currently federal officials are also looking to change the federal rules for how Medicaid functions. Undoubtedly, changes to the Medi-Cal program will affect counties. Counties are concerned about state and federal proposals that would decrease access to health care and that would shift costs or risk to counties.

California counties have a unique perspective on the reform of the state's Medicaid program. Counties are charged with preserving the public health and safety of communities. As the local public health authority, counties are vitally concerned about health outcomes.

Counties are the foundation of California's safety net system. Under California law, counties are required to provide services to the medically indigent. To meet this mandate, some counties own and operate county hospitals and clinics. These hospitals and clinics also provide care for Medi-Cal patients and rely heavily on Medicaid reimbursements. Medi-Cal reform that results in decreased funding to county hospitals and health systems will be devastating to the safety net. The loss of Medi-Cal funds translates into fewer dollars to help pay for remaining uninsured persons served by county facilities. In recent years, county hospitals are serving more uninsured as a percentage of the

total patients. Counties are not in a position to absorb or backfill the loss of additional state and federal funds. Rural counties already have particular difficulty developing and maintaining health care infrastructure and ensuring access to services.

Additionally, county welfare departments determine eligibility for the Medi-Cal program. County mental health departments are the health plan for Medi-Cal Managed Care for public mental health services.

Changes to the Medi-Cal program will undoubtedly affect the day-to-day business of California counties. Counties recognize that the state and federal governments have budget deficits, not unlike our own. Because of our unique role with the Medi-Cal program, counties believe we can offer cost-effective solutions. As such, counties must be involved in the development of Medi-Cal reform proposals.

Counties have agreed that any reform of the Medi-Cal program should be subject to the following principles:

Safety Net: It is vital that reform efforts preserve the viability of the safety net and not shift costs to the county safety net.

Managed Care: Expansion of managed care must not adversely affect the safety net and must be tailored to each county's needs.

- Movement of the aged, blind, and disabled into managed care is a major policy shift and the state must recognize the full impact of such a change, including the loss of funds to public hospitals. In counties with public hospitals currently receiving these payments, the loss of these funds would destabilize the public health care safety net.
- Adequate funding levels must be developed for public hospitals and those qualified safety net hospitals operating within a county organized health system (COHS) managed care framework.
- Due to unique characteristics of the health care delivery system in each county and variations in health care accessibility and demographics of client population, counties believe that managed care systems must be tailored to each county's needs.
- The state should continue to provide options for counties to implement managed care systems that meet local needs. The state should work openly with counties as primary partners in this endeavor.
- The state needs to recognize county experience with geographic managed care and make strong efforts to ensure the sustainability of county organized health systems.
- The Medi-Cal program should offer a reasonable reimbursement mechanism for managed care.

Special Populations Served by Counties – Mental Health, Drug Treatment Services, and California Children's Services (CCS): Reform efforts must preserve access to medically necessary mental health care, drug treatment services, and California Children's Services.

- The carve-out of specialty mental health services within the Medi-Cal program must be preserved, if adequately funded, in ways that maximize federal funds and minimize county risks.
- Early and Periodic Screening Diagnosis and Treatment (EPSDT) services for children must be preserved.
- Maximum federal matching funds for CCS program services must continue in order to avoid cost shifting to counties.

- Counties are open to reforming the Drug Medi-Cal program in ways that maximize federal funds and minimize county risks. Any reform effort should recognize the importance of substance abuse services in the health care continuum.

Maximizing Funds: Other states have received waivers for unique program elements not used in California. The State should pursue all possible options for securing additional federal funds.

- Counties will not accept a share of cost for the Medi-Cal program.
- Reform efforts must allow county health systems to maintain essential funding through Medi-Cal Administrative Activities (MAA), Targeted Case Management (TCM) or other programs that allow counties to maximize federal Medi-Cal funding.

Simplification: Reform efforts must simplify Medi-Cal eligibility requirements without jeopardizing eligibility. Reform should not add to the complexity of the Medi-Cal Program.

- Complexities of rules and requirements should be minimized or reduced so that enrollment, retention and documentation and reporting requirements are not unnecessarily burdensome to recipients, providers, and administrators and are no more restrictive or duplicative than required by federal law.
- Simplification should include removing barriers that unnecessarily discourage beneficiary or provider participation.
- Counties support simplifying the eligibility process for administrators of the Medi-Cal program.

Continuity: Reform efforts must preserve continuity of care and coverage.

- The Medi-Cal program must retain categorical linkages to full benefits.

Maintaining Access and Eligibility

- Any reform proposal must uphold Congress' clearly stated objectives of the Medicaid Act to: 1) furnish medical assistance to limited income families with dependent children and the aged, blind, and disabled, and 2) furnish rehabilitation and other services to help them attain/retain independence or self care.

Individuals currently eligible for Medi-Cal should remain eligible.

Benefits for eligible individuals must remain available in order to preserve meaningful access to medically necessary care and should not create differences in access based on levels of poverty.

- True reform must streamline eligibility requirements, expand access to care, preserve the safety net, and improve quality, cost effectiveness and program efficiency, as well as encouraging preventative care and healthy outcomes for all served.
 - ❑ Policies that (in effect) result in a lapse or loss of coverage for those eligible for Medi-Cal or other public health programs should be eliminated.

- Policies that restrict access to care or make access more cumbersome or difficult should be rejected.
 - A functional Medi-Cal program should provide access to qualified providers and ensuring that services are culturally and linguistically appropriate.
 - Any reform efforts should preserve safety net services and must not shift the burden of providing uncompensated care to safety net providers, especially county health systems.
- Reform efforts should ensure that costs imposed upon eligible individuals do not make care inaccessible or unaffordable.
 - Increased cost-sharing requirements for those individuals who can least afford it should be rejected, as current studies and data consistently indicate that cost-sharing impedes their access to medically necessary services or causes them to access care at more expensive entry points, such as emergency departments.
 - Reform should offer a range of reimbursement to providers that reflect local economies, both for managed care plans and fee for service.
- Reform efforts must not be at the expense of vulnerable and special needs populations. Coverage of immigrants, elderly, pregnant women and persons with disabilities must be maintained, including full implementation of the *Olmstead* decision.

Due Process: Reform efforts must not undermine existing due process rights and protections of beneficiaries.

E. Medicare Part D

In 2003, Congress approved a new prescription drug benefit for Medicare effective January 1, 2006. The new benefit will be available for those persons entitled to Medicare Part A and/or Part B and for those dually eligible for Medicare and Medi-Cal.

Beginning in the fall of 2005, all Medicare beneficiaries can start to choose a Medicare Prescription Drug Plan. While most beneficiaries must choose and enroll in a drug plan to get coverage, different rules apply for different groups. Some beneficiaries will be automatically enrolled in a plan.

The new drug coverage plan eliminates state matching funds under the Medicaid program and shifts those funds to the new Medicare program. Beginning December 31, 2005, Medicare will stop paying for prescription drug coverage. The plan requires beneficiaries to pay a co payment and for some, Medi-Cal will assist in the cost.

For counties, this change will lead to increased workloads for case management across many levels of county medical, social welfare, criminal justice, and mental health systems. The potential for the use of county realignment funds to assist in the share of cost for co-payments exists. Counties strongly oppose any change to realignment funding that may result and would oppose any reduction or shifting of costs associated with this benefit that would require a greater mandate on the counties.

Section 2: HEALTH CARE COVERAGE PRINCIPLES

Counties support universal health care coverage in California, with the goal of a health care system that is fully integrated and offers access to all Californians. Universal health care coverage will ultimately allow the state to realize cost savings in publicly funded health care programs. However, the foundation of the publicly funded health care system needs immediate attention. The State of California must preserve and adequately fund existing publicly funded health care programs before expanding services. Counties resources are limited and are not in a position to increase our expenditures to pay for expanded health care coverage and access.

A. Access And Quality

- Counties support access to quality and comprehensive health care through universal coverage.
- Any universal health care program should provide a truly comprehensive package of health care services.
- Counties support a health care system that includes a component of health care services to prisoners and offenders, detainees, and undocumented immigrants.
- Reforms should address access to health care in rural communities and other underserved areas.

B. Role Of Counties As Health Care Providers

- Counties strongly support maintaining a stable and viable health care safety net. An adequate safety net is needed to care for persons who remain uninsured as California transition's to universal coverage and for those who may have difficulty accessing care through a traditional insurance-based system.
- The current safety net is grossly underfunded. Any diversion of funds away from existing safety net services will lead to the dismantling of the health care safety net and will hurt access to care for all Californians.
- Counties believe that delivery systems that meet the needs of vulnerable populations and provide specialty care, such as emergency and trauma care and training of medical residents and other health care professionals, must be supported in any universal health coverage plan.
- Counties strongly support adequate funding for the public health system as part of a plan to achieve universal health coverage. Counties recognize the linkage between public health and health care. A strong public health system will reduce medical care costs, contain or mitigate disease, and address disaster preparedness and response.

C. Financing And Administration

- Counties support increased access to health coverage through a combination of mechanisms that may include improvements in and expansion of the publicly funded health programs, increased employer-based and individual coverage through purchasing pools, tax incentives, and system restructuring. The costs of universal health care shall be shared among all sectors: government, labor, and business.

- Efforts to achieve universal health care should simplify the health care system – for recipients, providers, and administration.
- The federal government has an obligation and responsibility to assist in the provision of health care coverage.
- Counties encourage the state to pursue ways to maximize federal financial participation in health care expansion efforts, and to take full advantage of opportunities to simplify Medi-Cal, the Healthy Families Program, and other publicly funded programs with the goal of achieving maximum enrollment and provider participation.
- County financial resources are currently overburdened; counties are not in a position to contribute additional resources to expand health care coverage.
- A universal health care system should include prudent utilization control mechanisms that are appropriate and are not a barrier to necessary care.
- Access to health education, preventive care, and early diagnosis and treatment will assist in controlling costs through improved health outcomes.

D. Role Of Employers

- Counties believe that every employer has an obligation to contribute to health care coverage. Counties are sensitive to the economic concerns of employers, especially small employers, and employer-based solutions should reflect the nature of competitive industries and job creation and retention. Therefore, counties advocate that such an employer policy should also be pursued at the federal level.
- Reforms should offer opportunities for self-employed individuals, temporary workers, and contract workers to obtain health coverage.

E. Implementation

Counties recognize that California will not achieve full universal health care system immediately, and implementation may necessitate an incremental approach. As such, counties believe that incremental efforts must be consistent with the goal and the framework for universal health care coverage, and include counties in all aspects of planning and implementation.

Section 3: CALIFORNIA HEALTH SERVICES FINANCING

Those eligible for Temporary Assistance for Needy Families (TANF)/California Work Opportunity and Responsibility to Kids (CalWORKs), should retain their categorical linkage to Medi-Cal as provided prior to the enactment of the federal Personal Responsibility Work Opportunity Reconciliation Act of 1996.

Counties are concerned over the erosion of state program funding and the inability of counties to sustain current program levels. As a result, we strongly oppose additional cuts in county administrative programs we administer, as well as any cost shifts from the state for these programs.

Counties support legislation to permit commensurate reductions at the local level to avoid any cost shifts to local government.

With respect to the County Medical Services Program (CMSP), counties support efforts to improve program cost effectiveness and oppose state efforts to shift costs to participating counties, including administrative costs and elimination of other state contributions to the program.

Counties believe that enrollment of Medi-Cal patients in managed care systems may create opportunities to reduce program costs and enhance access. Due to unique characteristics of each county's delivery system and health care accessibility and demographics of client population, counties believe that managed care systems must be tailored to each county's needs. The state should continue to provide options for counties to implement managed care systems that meet local needs. Because of the significant volume of Medi-Cal clients that are served by the counties, the state should work openly with counties as primary partners.

Where cost-effective, the state should provide non-emergency health services to undocumented immigrants. The State should seek federal reimbursement for medical services provided to undocumented immigrants.

Counties oppose any shift of funding responsibility from accounts within the Proposition 99 framework that will negatively impact counties. Any funding responsibilities shifted to the Unallocated Account would disproportionately impact the California Healthcare for Indigents Program/Rural Health Services (CHIP/RHS) thereby potentially producing severe negative fiscal impacts to counties.

Counties support increased funding for trauma and emergency room services. Trauma centers and emergency rooms play a vital role in California's health care delivery system. Trauma services address the most serious, life-threatening emergencies. Financial pressures in the late 1980s led to the closure of several trauma centers and emergency rooms. The financial crisis in the trauma and emergency systems is due to a significant reduction in Proposition 99 tobacco tax revenues, increasing number of uninsured patients, and the rising cost of medical care, including specialized equipment that is used daily by trauma centers. Although reducing the number of uninsured through expanded health care coverage will help reduce the financial losses to trauma centers and emergency rooms, critical safety-net services must be supported while incremental progress is made on the uninsured.

A. Realignment

In 1991, the state and counties entered into a new fiscal relationship known as realignment. Realignment affects health, mental health, and social services programs and funding. The state transferred control of programs to counties, altered program cost-sharing ratios, and provided counties with dedicated tax revenues from the sales tax and vehicle license fee to pay for these changes.

Counties support the concept of state and local program realignment and the principles adopted by CSAC and the Legislature in forming realignment. Thus, counties believe the integrity of realignment should be protected. However, counties strongly oppose any change to realignment funding that would negatively impact counties. Counties remain concerned and will resist any reduction of dedicated realignment revenues or the shifting of new costs from the state and further

mandates of new and greater fiscal responsibilities in this partnership program.

B. Hospital Financing

In 2005, 15 counties own and operate 21 hospitals statewide, including Alameda, Contra Costa, Kern, Los Angeles, Modoc, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, Trinity, Tuolumne, and Ventura Counties. These hospitals are vital to maintaining health access to low-income populations.

County hospitals could not survive without Medicaid funds. CSAC has been firm that any proposal to change hospital financing must guarantee that county hospitals do not receive less funding than they currently do, and are able to receive more federal funding in the future, as needs grow. California's new federal Medicaid hospital financing waiver (implemented in SB 1100, Chapter 560) provides a baseline hold harmless for county hospitals for five years. Some serious concerns still remain about both the viability of the waiver and the fiscal and practical impacts reflected in SB 1100, the counties believe implementation of the waiver is necessary to ensure that county hospitals to be paid for the care they provide to Medi-Cal and uninsured patients.

Counties remain concerned about the huge ramifications associated with the changes to the new financing structure under the certified public expenditure (CPE) model. We are concerned that individual hospitals and county health systems may be negatively impacted. It is not clear that hospitals will be able to access all of the federal funds available. Additionally, the audit structure provides an opportunity for the federal government to further reduce the level of federal funding for county hospitals, without clear advance guidelines and rules as to allowable expenditures. CSAC continues to work with the California Association of Public Hospitals and Health Systems on county hospital issues.

Counties are supportive of opportunities to reduce costs for county hospitals, particularly for mandates such as the seismic safety requirements and nurse-staffing ratios. Therefore, counties support infrastructure bonds that will provide funds to county hospitals for seismic safety upgrades, including construction, replacement, renovation, and retrofit.

Section 4: FAMILY VIOLENCE

In 2000, the CSAC Family Violence Task Force was established to raise awareness among county supervisors and staff regarding family violence and to highlight efforts that can assist counties in addressing family violence prevention, intervention, and treatment. Bridging health and human services and administration of justice policy issues the task force seeks to: (1) develop a continuum of services and treatment, focusing on early intervention; (2) support strong partnerships and collaboration with governmental and non-governmental agencies; and (3) establish best practices with an emphasis on reducing children's exposure to violence. The newly created task force has been instrumental in informing counties on the issue of domestic violence and implementing coordinated strategies between first responders – law enforcement officers and human service workers to provide strategies for county-wide domestic violence prevention efforts. Specific strategies for success should be developed through cooperation between state and local governments, as well as community and private organizations addressing family violence issues.