

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49

## CHAPTER SIX

# Health Services

### Section 1: GENERAL PRINCIPLES

Counties serve as the front line defense against threats of widespread disease and illness and 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 create 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.

Counties also support a continuum of preventative health efforts – including mental health services, drug and alcohol services, nutrition awareness and disease prevention – and healthy living models for all of our communities, families, and individuals. Preventative health efforts have proven to be cost effective and provide a benefit to all residents.

The State's chronic underfunding of health programs strains the ability of counties to meet accountability standards to provide access to quality health and mental health services. Freezing health program funding also shifts costs to counties and increases the county share of program costs, while at the same time running contrary to the constitutional provisions of Proposition 1A.

At the federal level, counties support economic stimulus efforts that help maintain services levels and access for the state's neediest residents. Counties are straining to provide services to the burgeoning numbers of families in distress. People who have never sought public assistance before are arriving at county health and human services departments. For these reasons, counties strongly urge that any federal stimulus funding must be shared directly with counties for programs that have a county share of cost. **A. Public Health**

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

1 provided with full funding for local public health communicable disease control and surveillance  
2 activities.

3  
4 Counties also support a continuum of preventative health efforts – including mental health services,  
5 drug and alcohol services, nutrition awareness and disease prevention – and healthy living models for  
6 all of our communities, families, and individuals. Preventative health efforts, such as access to  
7 healthy food and opportunities for safe physical activity, have proven to be cost effective and provide  
8 a benefit to all residents.

9  
10 County health departments are also charged with responding to terrorist and biomedical attacks,  
11 including maintaining the necessary infrastructure – such as laboratories, hospitals, medical supply  
12 and prescription drug caches, as well as trained personnel – needed to protect our residents. Counties  
13 welcome collaboration with the federal and state governments on the development of infrastructure  
14 for bioterrorism and other disasters. Currently, counties are concerned about the lack of funding,  
15 planning, and ongoing support for critical infrastructure.

## 16 17 18 **B. Health Services Planning**

19  
20 Counties believe strongly in comprehensive health services planning. Planning must be done  
21 through locally elected officials both directly and by the appointment of quality individuals to serve  
22 in policy and decision-making positions for health services planning efforts.

## 23 24 **C. Mental Health**

25  
26 Counties support community-based treatment of mental illness. Counties also accept responsibility  
27 for providing treatment and administration of such programs. It is believed that the greatest progress  
28 in treating mental illness can be achieved by continuing the counties' role in supporting and assisting  
29 the state in administering its programs. Programs that treat mental illness should be designed to meet  
30 local requirements within statewide criteria and standards to ensure appropriate treatment of persons  
31 with mental illness. However, counties are concerned about the erosion of state funding and support  
32 for mental health services. Although the adoption of Proposition 63, the Mental Health Services Act  
33 of 2004, will assist counties in service delivery, it is intended to provide new funding that expands  
34 and improves the capacity of existing systems of care and provides an opportunity to integrate  
35 funding at the local level. We strongly oppose additional reductions in state funding for mental  
36 health services that will result in the state shifting its costs to counties. These cost shifts result in  
37 reduced services available at the local level. We also strongly oppose any effort to redirect the  
38 Proposition 63 funding to existing state services instead of the local services for which it was  
39 originally intended.

40  
41 The realignment of health and social services programs in 1991 restructured California's public  
42 mental health system. Realignment required local responsibility for program design and delivery  
43 within statewide standards of eligibility and scope of services, and designated revenues to support  
44 those programs to the extent that resources are available. Counties are committed to service delivery  
45 that manages and coordinates services to persons with mental illness and that operates within a  
46 system of performance outcomes that assure funds are spent in a manner that provides the highest  
47 quality of care.

48  
49 California law consolidated the two Medi-Cal mental health systems, one operated by county mental  
50 health departments and the other operated by the state Department of Health Services on a fee-for-

1 service basis, effective in fiscal year 1997-98. Counties supported these actions to consolidate these  
2 two systems and to operate Medi-Cal mental health services as a managed care program. Counties  
3 were offered the first opportunity to provide managed mental health systems, and every county chose  
4 to operate as a Medi-Cal Mental Health Plan. This consolidated program provides for a negotiated  
5 sharing of risk for services between the state and counties. However, counties oppose a managed care  
6 model in which the state abdicates its funding responsibility to counties. Counties are paying for an  
7 increasing share of the Medi-Cal Mental Health program. As state funding declines, counties will  
8 reconsider providing managed mental health systems.

9  
10 County mental health agencies provide necessary, child and family-centered high quality services to  
11 special education pupils. This program is known as AB 3632 (Statutes of 1984). The State provided  
12 inadequate funding for this mandate from fiscal year 2002-03 through 2004-05. Since that time, the  
13 state has provided a combination of federal Individuals with Disabilities Act (IDEA) funds, state  
14 General Fund and mandate reimbursements. Counties cannot assume the legal and financial risk for  
15 this federal special education entitlement program. Counties expect the state to continue to fund  
16 counties for the costs of providing the state mandated services under AB 3632 and to develop a  
17 reasonable plan for repaying past due SB 90 claims. Alternatively, counties would also support  
18 repealing the AB 3632 mandate on counties, recognizing that accountability for ensuring the  
19 provision of mental health-related services under the IDEA rests with education – not local  
20 government. If school districts become fiscally responsible for this mandate, the program must be  
21 restructured so that schools are legally responsible for ensuring that mental health-related services  
22 are provided to special education students pursuant to the federal IDEA. Under such a restructured  
23 system, county mental health departments would remain committed to maintaining and enhancing  
24 their effective collaborative partnerships with education, and to working with all interested  
25 stakeholders in developing a system that continues to meet the mental health needs of special  
26 education pupils.

27  
28 In response to county concerns, state law also provides funds to county programs to provide specialty  
29 mental health services to CalWORKs recipients who need treatment in order to get and keep  
30 employment. Similar law requires county mental health programs to provide specialty mental health  
31 services to seriously emotionally disturbed children insured under the Healthy Families Program.  
32 Counties have developed a range of locally designed programs to serve California's diverse  
33 population.

34  
35 Adequate mental health services can reduce criminal justice costs and utilization. Appropriate  
36 diagnosis and treatment services will result in positive outcomes for offenders with mental illness.  
37 Ultimately, appropriate mental health services will benefit the public safety system. Counties  
38 continue to work across disciplines to achieve good outcomes for persons with mental illness and/or  
39 co-occurring substance abuse issues.

#### 40 41 **D. Children's Health**

##### 42 43 California Children's Services

44  
45 Counties provide diagnosis and case management services to the approximately 175,000 children enrolled  
46 in the California Children's Services (CCS) program, whether they are in Medi-Cal, Healthy Families or  
47 the CCS-Only program. Counties also are responsible for determination of medical and financial  
48 eligibility for the program. Counties also provide Medical Therapy Program (MTP) services for both CCS  
49 children and special education students, and have a share of cost for services to non-Medi-Cal children.

1 Maximum federal matching funds for CCS program services must continue in order to avoid the  
2 shifting of costs to counties.  
3

4 Despite recent actions by the Legislature to lessen proposed cuts to the program, the Department of  
5 Health Care Services has unilaterally implemented reductions to CCS County Administration and also  
6 implemented a radically different methodology for funding both CCS County Administration and MTP.  
7 This action, noticed to counties in November 2008, was taken because the Department had been  
8 overspending their state budget appropriations for both CCS County Administration and MTP for a  
9 number of years. Counties have consistently kept expenditures within their approved budgets and were  
10 unaware that the total amount of the state approved county budgets actually exceeded state budget  
11 appropriation levels. Counties have always operated within individual county budgets approved by the  
12 Department, which allowed for reimbursement of the actual cost of providing services (at matching levels  
13 applicable to each program). The new allocations represent a radically different method of funding  
14 counties for both CCS County Administration and MTP, and threaten the viability of the program as a  
15 whole. Counties cannot continue to bear the rapidly increasing costs associated with both program growth  
16 and eroding state support, and for these reasons endorse a stakeholder process to redesign the program  
17 with the goal of continuing to provide the timely care and services for these most critically ill children.  
18  
19

#### 20 State Children's Health Insurance Program

21  
22 The State Children's Health Insurance Program (SCHIP) is a federally funded program that allows  
23 states to provide low- or no-cost health insurance to children up to 250 percent of the Federal Poverty  
24 Level (FPL). California's SCHIP program is called the Healthy Families Program. CSAC supports a  
25 reauthorization of the SCHIP program, including an eligibility increase of up to 300 percent of the  
26 FPL for the state's children.  
27

#### 28 Proposition 10

29  
30 Proposition 10, the California Children and Families Initiative of 1998, provides significant resources  
31 to enhance and strengthen early childhood development. Local children and families commissions  
32 (First 5 Commissions), established as a result of the passage of Proposition 10, must maintain the full  
33 discretion to determine the use of their share of funds generated by Proposition 10. Further, local  
34 First 5 commissions must maintain the necessary flexibility to direct these resources to the most  
35 appropriate needs of their communities, including childhood health, childhood development,  
36 nutrition, school readiness, child care and other critical community-based programs. Counties  
37 oppose any effort to diminish Proposition 10 funds or to impose restrictions on their local  
38 expenditure.  
39

40 In recognition that Proposition 10 funds are disseminated differently based on a county's First 5  
41 Commission structure and appropriated under the premise that local commissions are in a better  
42 position to identify and address unique local needs, , counties oppose any effort to lower or eliminate  
43 the state's support for county programs with the expectation that the state or local First 5  
44 commissions will backfill the loss with Proposition 10 revenues.  
45

#### 46 AB 3632

47  
48 County mental health agencies provide necessary, child and family-centered high quality services to  
49 special education pupils. This program is known as AB 3632 (Statutes of 1984). The State provided  
50 inadequate funding for this mandate from fiscal year 2002-03 through 2004-05. Since that time, the  
51 state has provided a combination of federal Individuals with Disabilities Act (IDEA) funds, state

1 General Fund and mandate reimbursements. Counties cannot assume the legal and financial risk for  
2 this federal special education entitlement program. Counties expect the state to continue to fund  
3 counties for the costs of providing the state mandated services under AB 3632 and to develop a  
4 reasonable plan for repaying past due SB 90 claims. Alternatively, counties would also support  
5 repealing the AB 3632 mandate on counties, recognizing that accountability for ensuring the  
6 provision of mental health-related services under the IDEA rests with education – not local  
7 government. If school districts become fiscally responsible for this mandate, the program must be  
8 restructured so that schools are legally responsible for ensuring that mental health-related services  
9 are provided to special education students pursuant to the federal IDEA. Under such a restructured  
10 system, county mental health departments would remain committed to maintaining and enhancing  
11 their effective collaborative partnerships with education, and to working with all interested  
12 stakeholders in developing a system that continues to meet the mental health needs of special  
13 education pupils.

#### 14 **E. Substance Abuse Prevention And Treatment**

15  
16 Counties have been, and will continue to be, actively involved in substance abuse prevention and  
17 treatment. Counties believe the best opportunity for solutions are at the local level. Counties  
18 continue to provide a wide range of substance abuse treatment services. However, counties are  
19 concerned that treatment capacity cannot accommodate all persons needing substance abuse  
20 treatment services.

21  
22 Counties continue to support state and federal efforts to provide substance abuse benefits under the  
23 same terms and conditions as other health services. Under current practice, insurance policies  
24 routinely treat alcohol and other drug abuse or dependency differently than other illnesses.

25  
26 With the enactment of Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, the  
27 demand for substance abuse treatment and services on counties continues to increase. Dedicated  
28 funding for Proposition 36 expired in 2006, and since that time, counties have depended on a year-to-  
29 year state budgeting process for funds. However, the mandate to provide services under Proposition  
30 36 does not expire; and counties are increasingly unable to provide these voter-mandated services  
31 without adequate dedicated funding. Due to the state budget deficit, funding for Proposition 36 and  
32 the Offender Treatment Program has declined.

33  
34 Furthermore, even with Proposition 36 funding, state investment in non-offender substance abuse  
35 and treatment services has been static for the last decade. This situation limits the array and amount  
36 of services a county can administer to the non-offender population. Also, adequate early intervention  
37 substance abuse prevention and treatment services have been proven to reduce criminal justice costs  
38 and utilization. Appropriate funding for diagnosis and treatment services will result in positive  
39 outcomes for non-offenders and offenders alike with substance abuse problems. Therefore,  
40 appropriate substance abuse treatment services will benefit the public safety system. Counties will  
41 continue to work across disciplines to achieve good outcomes for persons with substance abuse  
42 issues and/or mental illness.

#### 43 **F. Medi-Cal, California's Medicaid Program**

44  
45 California counties have a unique perspective on the state's Medicaid program. Counties are  
46 charged with preserving the public health and safety of communities. As the local public health  
47 authority, counties are vitally concerned about health outcomes. Undoubtedly, changes to the  
48 Medi-Cal program will affect counties. Counties are concerned about state and federal proposals  
49 that would decrease access to health care and that would shift costs or risk to counties.

1 Counties are the foundation of California’s safety net system. Under California law, counties are  
2 required to provide services to the medically indigent. To meet this mandate, some counties own and  
3 operate county hospitals and clinics. These hospitals and clinics also provide care for Medi-Cal  
4 patients and rely heavily on Medicaid reimbursements. Medi-Cal reform that results in decreased  
5 funding to county hospitals and health systems will be devastating to the safety net. The loss of  
6 Medi-Cal funds translates into fewer dollars to help pay for remaining uninsured persons served by  
7 county facilities. In recent years, county hospitals are serving more uninsured persons as a percentage  
8 of total patients. Counties are not in a position to absorb or backfill the loss of additional state and  
9 federal funds. Rural counties already have particular difficulty developing and maintaining health  
10 care infrastructure and ensuring access to services.

11  
12 Additionally, county welfare departments determine eligibility for the Medi-Cal program. County  
13 mental health departments are the health plan for Medi-Cal Managed Care for public mental health  
14 services.

15  
16 Changes to the Medi-Cal program will undoubtedly affect the day-to-day business of California  
17 counties. Counties recognize that the state and federal governments have budget deficits not unlike  
18 our own. Because of our unique role with the Medi-Cal program, counties believe we can offer cost-  
19 effective solutions. As such, counties must be involved in the development and implementation of  
20 any Medi-Cal reform proposals.

21  
22 Therefore, counties have agreed that any reform of the Medi-Cal program should be subject to the  
23 following principles:

24  
25 **Safety Net: It is vital that reform efforts preserve the viability of the safety net and not shift**  
26 **costs to the county safety net.**

27  
28 **Managed Care: Expansion of managed care must not adversely affect the safety net and must**  
29 **be tailored to each county’s needs.**

- 30
- 31 ▪ Movement of the aged, blind, and disabled into managed care is a major policy shift and the state  
32 must recognize the full impact of such a change, including the loss of funds to public hospitals.  
33 In counties with public hospitals currently receiving these payments, the loss of these funds  
34 would destabilize the public health care safety net.
  - 35 ▪ Adequate funding levels must be developed for public hospitals and qualified safety net hospitals  
36 operating within a county organized health system (COHS) managed care framework.
  - 37 ▪ Due to the unique characteristics of the health care delivery system in each county and variations  
38 in health care accessibility and the demographics of the client population, counties believe that  
39 managed care systems must be tailored to each county’s needs.
  - 40 ▪ The state should continue to provide options for counties to implement managed care systems  
41 that meet local needs. The state should work openly with counties as primary partners in this  
42 endeavor.
  - 43 ▪ The state needs to recognize county experience with geographic managed care and make strong  
44 efforts to ensure the sustainability of county organized health systems.
  - 45 ▪ The Medi-Cal program should offer a reasonable reimbursement mechanism for managed care.
- 46

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

- 1   ▪ The carve-out of specialty mental health services within the Medi-Cal program must be
- 2    preserved, if adequately funded, in ways that maximize federal funds and minimize county risks.
- 3   ▪ Early and Periodic Screening Diagnosis and Treatment (EPSDT) services for children must be
- 4    preserved.
- 5   ▪ Maximum federal matching funds for CCS program services must continue in order to avoid the
- 6    shifting of costs to counties.
- 7   ▪ Counties cannot continue to bear the rapidly increasing costs associated with both CCS program
- 8    growth and eroding state support, and for these reasons endorse a stakeholder process to redesign the
- 9    CCS program in its entirety with the goal of continuing to provide the timely care and services for
- 10   these most critically ill children.
- 11  ▪ Counties are open to reforming the Drug Medi-Cal program in ways that maximize federal funds
- 12   and minimize county risks. Any reform effort should recognize the importance of substance
- 13   abuse treatment and services in the health care continuum.

14  
15 **Maximizing Funds: Other states have received waivers for unique program elements not used**  
16 **in California. The State should pursue all possible options for securing additional federal**  
17 **funds.**

- 18
- 19  ▪ Counties will not accept a share of cost for the Medi-Cal program.
- 20  ▪ Reform efforts must allow county health systems to maintain essential funding through Medi-Cal
- 21   Administrative Activities (MAA), Targeted Case Management (TCM) or other programs that
- 22   allow counties to maximize federal Medi-Cal funding.

23  
24 **Simplification: Reform efforts must simplify Medi-Cal eligibility requirements without**  
25 **jeopardizing eligibility. Reform should not add to the complexity of the Medi-Cal Program.**

- 26
- 27  ▪ Complexities of rules and requirements should be minimized or reduced so that enrollment,
- 28   retention and documentation and reporting requirements are not unnecessarily burdensome to
- 29   recipients, providers, and administrators and are no more restrictive or duplicative than required
- 30   by federal law.
- 31  ▪ Simplification should include removing barriers that unnecessarily discourage beneficiary or
- 32   provider participation.
- 33  ▪ Counties support simplifying the eligibility process for administrators of the Medi-Cal program.

34  
35 **Continuity: Reform efforts must preserve continuity of care and coverage.**

- 36  ▪ .The Medi-Cal program must retain categorical linkages to full benefits.
- 37  ▪ Counties also believe that Medi-Cal long-term care must remain a state-funded program and oppose
- 38   any cost shifts or attempts to increase county responsibility through block grants or other means.

39  
40 **Maintaining Access and Eligibility**

- 41
- 42  ▪ Any reform proposal must uphold Congress' clearly stated objectives of the Medicaid Act to: 1)
- 43   furnish medical assistance to limited income families with dependent children and the aged,
- 44   blind, and disabled, and 2) furnish rehabilitation and other services to help them attain/retain
- 45   independence or self care. Individuals currently eligible for Medi-Cal should remain eligible.
- 46  ▪ Benefits for eligible individuals must remain available in order to preserve meaningful access to
- 47   medically necessary care and should not create differences in access based on levels of poverty.

- 1   ▪ True reform must streamline eligibility requirements, expand access to care, preserve the safety  
2    net, and improve quality, cost effectiveness and program efficiency, as well as encourage  
3    preventative care and healthy outcomes for all served.
- 4   ▪ Policies that (in effect) result in a lapse or loss of coverage for those eligible for Medi-Cal or  
5    other public health programs should be eliminated.
- 6   ▪ Policies that restrict access to care or make access more cumbersome or difficult should be  
7    rejected.
- 8   ▪ A functional Medi-Cal program should provide access to qualified providers and ensure that  
9    services are culturally and linguistically appropriate.
- 10  ▪ Any reform efforts should preserve safety net services and must not shift the burden of providing  
11  uncompensated care to safety net providers, especially county health systems.
- 12  ▪ Reform efforts should ensure that costs imposed upon eligible individuals do not render  
13  appropriate care inaccessible or unaffordable.
- 14  ▪ Increased cost-sharing requirements for those individuals who can least afford it should be  
15  rejected, as current studies and data consistently indicate that cost-sharing impedes access to  
16  medically necessary services or causes individuals to access care at more expensive entry points,  
17  such as emergency departments.
- 18  ▪ Reform should offer a range of reimbursement to providers that reflect local economies, both for  
19  managed care and fee for service plans.
- 20
- 21  ▪ Reform efforts must not come at the expense of vulnerable and special needs populations.  
22  Coverage of immigrants, elderly, pregnant women and persons with disabilities must be  
23  maintained, including full implementation of the *Olmstead* decision.
- 24

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

27

28 G.     Medicare Part D

29

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

33

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

38

39 The Medicare Part D drug coverage plan eliminated state matching funds under the Medicaid  
40 program and shifted those funds to the new Medicare program. The plan requires beneficiaries to pay  
41 a copayment and for some, Medi-Cal will assist in the cost.

42

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

48

49 H.     Medicaid and Aging Issues

50

1 Furthermore, counties are committed to addressing the unique needs of older and dependent  
2 adults in their communities, and support collaborative efforts to build a continuum of services as  
3 part of a long-term system of care for this vulnerable but vibrant population. Counties also  
4 believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost  
5 shifts or attempts to increase county responsibility through block grants or other means.  
6

7 Counties support the continuation of federal and state funding for IHSS, and oppose any efforts  
8 to shift IHSS costs to counties. Counties also strongly support the continuation of services to  
9 clients served through the IHSS Plus Waiver, which was granted by the federal Department of  
10 Health and Human Services in August of 2004. Furthermore, once the IHSS Plus Waiver  
11 expires, counties support working with the appropriate state departments and stakeholders to  
12 draft, submit, and implement a new plan to move the IHSS Plus Waiver population into regular  
13 Medi-Cal, thereby preserving the cost savings associated with the original waiver.  
14  
15

## 16 **Section 2: HEALTH CARE COVERAGE PRINCIPLES**

17

18 Counties support universal health care coverage in California, with the goal of a health care system  
19 that is fully integrated and offers access to all Californians. Universal health care coverage will  
20 ultimately allow the state to realize cost savings in publicly funded health care programs. However,  
21 the foundation of the publicly funded health care system needs immediate attention. The State of  
22 California must preserve and adequately fund existing publicly funded health care programs before  
23 expanding services. Counties' resources are limited and are not in a position to increase expenditures  
24 to pay for expanded health care coverage and access.  
25

### 26 **A. Access And Quality**

27

- 28     ▪ Counties support access to quality and comprehensive health care through universal  
29     coverage.
- 30     ▪ Any universal health care program should provide a truly comprehensive package of  
31     health care services.
- 32     ▪ Counties support a health care system that includes a component of health care services  
33     to prisoners and offenders, detainees, and undocumented immigrants.
- 34     ▪ Reforms should address access to health care in rural communities and other underserved  
35     areas.  
36

### 37 **B. Role Of Counties As Health Care Providers**

38

- 39     ▪ Counties strongly support maintaining a stable and viable health care safety net. An  
40     adequate safety net is needed to care for persons who remain uninsured as California  
41     transitions to universal coverage and for those who may have difficulty accessing care  
42     through a traditional insurance-based system.  
43
- 44     ▪ The current safety net is grossly underfunded. Any diversion of funds away from  
45     existing safety net services will lead to the dismantling of the health care safety net and  
46     will hurt access to care for all Californians.  
47
- 48     ▪ Counties believe that delivery systems that meet the needs of vulnerable populations and  
49     provide specialty care, such as emergency and trauma care and training of medical

1 residents and other health care professionals, must be supported in any universal health  
2 coverage plan.

- 3
- 4 ■ Counties strongly support adequate funding for the public health system as part of a plan  
5 to achieve universal health coverage. Counties recognize the linkage between public  
6 health and health care. A strong public health system will reduce medical care costs,  
7 contain or mitigate disease, and address disaster preparedness and response.  
8

### 9 **C. Financing And Administration**

- 10
- 11 ■ Counties support increased access to health coverage through a combination of  
12 mechanisms that may include improvements in and expansion of the publicly funded  
13 health programs, increased employer-based and individual coverage through purchasing  
14 pools, tax incentives, and system restructuring. The costs of universal health care shall  
15 be shared among all sectors: government, labor, and business.  
16
- 17 ■ Efforts to achieve universal health care should simplify the health care system – for  
18 recipients, providers, and administration.  
19
- 20 ■ The federal government has an obligation and responsibility to assist in the provision of  
21 health care coverage.  
22
- 23 ■ Counties encourage the state to pursue ways to maximize federal financial participation  
24 in health care expansion efforts, and to take full advantage of opportunities to simplify  
25 Medi-Cal, the Healthy Families Program, and other publicly funded programs with the  
26 goal of achieving maximum enrollment and provider participation.  
27
- 28 ■ County financial resources are currently overburdened; counties are not in a position to  
29 contribute additional resources to expand health care coverage.  
30
- 31 ■ A universal health care system should include prudent utilization control mechanisms  
32 that are appropriate and do not create a barrier to necessary care.  
33
- 34 ■ Access to health education, preventive care, and early diagnosis and treatment will assist  
35 in controlling costs through improved health outcomes.  
36
- 37 ■ **D. Role Of Employers** Counties, as both employers and administrators of health care  
38 programs, believe that every employer has an obligation to contribute to health care  
39 coverage. Counties are sensitive to the economic concerns of employers, especially small  
40 employers, and employer-based solutions should reflect the nature of competitive  
41 industries and job creation and retention. Therefore, counties advocate that such an  
42 employer policy should also be pursued at the federal level and be consistent with the  
43 goals and principles of local control at the county government level.  
44
- 45 ■ Reforms should offer opportunities for self-employed individuals, temporary workers,  
46 and contract workers to obtain health coverage.  
47

### 48 **E. Implementation**

49 Counties recognize that California will not achieve a full universal health care system immediately,  
50

1 and implementation may necessitate an incremental approach. As such, counties believe that  
2 incremental efforts must be consistent with the goal and the framework for universal health care  
3 coverage, and also must include counties in all aspects of planning and implementation.  
4

### 5 **Section 3: CALIFORNIA HEALTH SERVICES FINANCING**

6  
7 Those eligible for Temporary Assistance for Needy Families (TANF)/California Work Opportunity  
8 and Responsibility to Kids (CalWORKs), should retain their categorical linkage to Medi-Cal as  
9 provided prior to the enactment of the federal Personal Responsibility Work Opportunity  
10 Reconciliation Act of 1996.  
11

12 Counties are concerned about the erosion of state program funding and the inability of counties to  
13 sustain current program levels. As a result, we strongly oppose additional cuts in county  
14 administrative programs as well as any attempts by the state to shift the costs for these programs to  
15 counties. Counties support legislation to permit commensurate reductions at the local level to avoid  
16 any cost shifts to local government.  
17

18 With respect to the County Medical Services Program (CMSP), counties support efforts to improve  
19 program cost effectiveness and oppose state efforts to shift costs to participating counties, including  
20 administrative costs and elimination of other state contributions to the program.  
21

22 Counties believe that enrollment of Medi-Cal patients in managed care systems may create  
23 opportunities to reduce program costs and enhance access. Due to the unique characteristics of each  
24 county's delivery system, health care accessibility, and demographics of client population, counties  
25 believe that managed care systems must be tailored to each county's needs. The state should  
26 continue to provide options for counties to implement managed care systems that meet local needs.  
27 Because of the significant volume of Medi-Cal clients that are served by the counties, the state  
28 should work openly with counties as primary partners.  
29

30 Where cost-effective, the state should provide non-emergency health services to undocumented  
31 immigrants. The State should seek federal reimbursement for medical services provided to  
32 undocumented immigrants.  
33

34 Counties oppose any shift of funding responsibility from accounts within the Proposition 99  
35 framework that will negatively impact counties. Any funding responsibilities shifted to the  
36 Unallocated Account would disproportionately impact the California Healthcare for Indigents  
37 Program/Rural Health Services (CHIP/RHS), and thereby potentially produce severe negative fiscal  
38 impacts to counties.  
39

40 Counties support increased funding for trauma and emergency room services. Trauma centers and  
41 emergency rooms play a vital role in California's health care delivery system. Trauma services  
42 address the most serious, life-threatening emergencies. Financial pressures in the late 1980s and  
43 even more recently have led to the closure of several trauma centers and emergency rooms. The  
44 financial crisis in the trauma and emergency systems is due to a significant reduction in Proposition  
45 99 tobacco tax revenues, an increasing number of uninsured patients, and the rising cost of medical  
46 care, including specialized equipment that is used daily by trauma centers. Although reducing the  
47 number of uninsured through expanded health care coverage will help reduce the financial losses to  
48 trauma centers and emergency rooms, critical safety-net services must be supported while  
49 incremental progress is made on the uninsured.  
50

1 **A. Realignment**

2  
3 In 1991, the state and counties entered into a new fiscal relationship known as realignment.  
4 Realignment affects health, mental health, and social services programs and funding. The state  
5 transferred control of programs to counties, altered program cost-sharing ratios, and provided  
6 counties with dedicated tax revenues from the sales tax and vehicle license fee to pay for these  
7 changes.

8  
9 Counties support the concept of state and local program realignment and the principles adopted by  
10 CSAC and the Legislature in forming realignment. Thus, counties believe the integrity of  
11 realignment should be protected. However, counties strongly oppose any change to realignment  
12 funding that would negatively impact counties. Counties remain concerned and will resist any  
13 reduction of dedicated realignment revenues or the shifting of new costs from the state and further  
14 mandates of new and greater fiscal responsibilities to counties in this partnership program.

15  
16 **B. Hospital Financing**

17  
18 In 2008, 13 counties own and operate 17 hospitals statewide, including Alameda, Contra Costa,  
19 Kern, Los Angeles, Modoc, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San  
20 Mateo, Santa Clara, and Ventura Counties. These hospitals are vital to maintaining health access to  
21 low-income populations.

22  
23 County hospitals could not survive without federal Medicaid funds. CSAC has been firm that any  
24 proposal to change hospital financing must guarantee that county hospitals do not receive less  
25 funding than they currently do, and are able to receive more federal funding in the future, as needs  
26 grow. California’s new federal Medicaid hospital financing waiver (implemented in SB 1100,  
27 Chapter 560, Statutes of 2005) provides a baseline hold harmless mechanism for county hospitals for  
28 five years. Counties believe implementation of the waiver is necessary to ensure that county hospitals  
29 are paid for the care they provide to Medi-Cal recipients and uninsured patients.

30  
31 Counties remain concerned about the huge ramifications associated with the changes to the new  
32 financing structure under the certified public expenditure (CPE) model. We are concerned that  
33 individual hospitals and county health systems may be negatively impacted. It is not clear that  
34 hospitals will be able to access all of the federal funds available. Additionally, the audit structure  
35 provides an opportunity for the federal government to further reduce the level of federal funding for  
36 county hospitals without clear advance guidelines and rules as to allowable expenditures. CSAC  
37 continues to work with the California Association of Public Hospitals and Health Systems on county  
38 hospital issues.

39  
40 Counties are supportive of opportunities to reduce costs for county hospitals, particularly for  
41 mandates such as seismic safety requirements and nurse-staffing ratios. Therefore, counties support  
42 infrastructure bonds that will provide funds to county hospitals for seismic safety upgrades, including  
43 construction, replacement, renovation, and retrofit.

44  
45 **Section 4: FAMILY VIOLENCE**

46  
47 CSAC remains committed to raising awareness of the toll of family violence on families and  
48 communities by supporting efforts that target family violence prevention, intervention, and treatment.  
49 Specific strategies for early intervention and success should be developed through cooperation  
50 between state and local governments, as well as community, and private organizations addressing

1 family violence issues.