

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, services, and program contracts to provide a comprehensive level of service and accountability and achieve maximum cost effectiveness. Additionally, as new federal and state programs are designed in the health care field, the state must work with counties to encourage maximum program flexibility and minimize disruptions in county funding, from the transition phase 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 enactment and implementation of the federal Patient Protection and Affordable Care Act (ACA) of 2010 provides new challenges, as well as opportunities, for counties. Counties, as providers, administrators, and employers, are deeply involved with health care at all levels and must be full partners with the state and federal governments in the effort to expand Medicaid and provide health insurance and care to millions of Californians. Counties believe in maximizing the allowable coverage expansion under the ACA, while also preserving access to local health services for the residual uninsured. Counties remain committed to serving as an integral part of ACA implementation, and support initiatives to assist with outreach efforts, access, eligibility and enrollment services, and delivery system improvements.

At the federal level, counties also 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, enhanced matching funds, or innovation grants 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 provided with full funding for local public health communicable disease control and surveillance activities.

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

Counties also support the mission of the federal Prevention and Public Health Fund, and support efforts to secure direct funding for counties to meet the goals of the Fund

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 efforts. Counties must also have the flexibility to make health policy and fiscal decisions at the local level to meet the needs of their communities.

C. Mental Health

Counties support community-based treatment of mental illness. Counties 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' current role while providing flexibility for counties to design, implement, and support mental health services that best meet the needs of their community. Programs that treat mental illness should be designed to meet local requirements – within statewide and federal criteria and standards – to ensure appropriate treatment of persons with mental illness.

The adoption of Proposition 63, the Mental Health Services Act of 2004, assists counties in service delivery. However, it is intended to provide new funding that expands and improves the capacity of existing systems of care and provides an opportunity to integrate funding at the local level. We strongly oppose additional reductions in state funding for mental health services that will result in the shifting of state or federal costs to counties. These cost shifts result in reduced services available at the local level and disrupt treatment options for mental health clients. Any shift in responsibility or funding must hold counties fiscally harmless and provide the authority to tailor mental health programs to individual community needs. We also strongly oppose any effort to redirect the Proposition 63 funding to existing state services instead of the local services for which it was

originally intended.

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 to the extent that resources are available. Counties are committed to service delivery that manages and coordinates services to persons with mental illness and that operates within a system of performance outcomes that assure funds are spent in a manner that provides the highest quality of care. The 2011 Realignment once again restructured financing for the provision of Medi-Cal services for children and adults,

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.

In 2011, Counties became solely responsible for managing the nonfederal share of cost for these mental health services.

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. Counties have developed a range of locally designed programs to serve California's diverse population, and must retain the local authority, flexibility, and funding to continue such services. Similar law requires county mental health programs to provide specialty mental health services to seriously emotionally disturbed children insured under the Healthy Families Program. The Healthy Families Program was dissolved in the 2012-13 Budget Act, and counties will continue to provide specialty mental health services to this population under Medi-Cal. However, counties anticipate increased demand for these services under Medi-Cal, and must have adequate revenues to meet the federal standards and needs of these children.

Adequate mental health services can reduce criminal justice costs and utilization. Appropriate diagnosis and treatment services will result in positive outcomes for offenders with mental illness and their families. Ultimately, appropriate mental health services will benefit the public safety system. Counties continue to work across disciplines and within the 2011 Realignment structure to achieve good outcomes for persons with mental illness and/or co-occurring substance abuse issues to help prevent incarceration and to treat those who are about to be incarcerated or are newly released from incarceration and their families.

D. Children's Health

California Children's Services

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

Maximum federal and state matching funds for CCS program services must continue in order to avoid the shifting of costs to counties. Counties cannot continue to bear the rapidly increasing costs associated with both program growth and eroding state support. Counties support efforts to redesign or realign the program with the goal of continuing to provide the timely care and services for these most critically ill children. Counties also support efforts to test alternative models of care under CCS pilots in the 2010 Medicaid Waiver.

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) is a federally funded program that allows states to provide low- or no-cost health insurance to children up to 250 percent of the Federal Poverty Level (FPL). California's SCHIP program is called the Healthy Families Program. CSAC supports federal reauthorization of the SCHIP program, including an eligibility increase of up to 300 percent of the FPL for the state's children. Many of these children will be Medi-Cal eligible under the ACA.

The 2012-13 Budget Act authorized the transfer of Healthy Families Program children into Medi-Cal. The transfer will begin in 2013 and consist of several phases. CSAC supports the transfer of all Healthy Families Program enrollees into Medi-Cal. The state must work to ensure network adequacy and access, as well as timely transitions on the technological systems that support eligibility, enrollment, and case management. Further, the state must work in partnership with counties to ensure a seamless transition for these children regardless of arbitrary timelines.

Proposition 10

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

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

E. Substance Use Disorder Prevention and Treatment

Counties have been, and will continue to be, actively involved in substance use disorder prevention and treatment, especially under the 2011 Realignment rubric, where counties were given responsibility for substance abuse treatment and Drug Medi-Cal services. Counties believe the best opportunity for solutions reside at the local level. Counties continue to provide a wide range of substance use disorder treatment services, but remain concerned about evidence-based treatment capacity for all persons requiring substance abuse treatment services.

Adequate early intervention, substance use disorder prevention and treatment services have been proven to reduce criminal justice costs and utilization. Appropriate funding for diagnosis and treatment services will result in positive outcomes for non-offenders and offenders alike with substance use disorders. Therefore, appropriate substance use disorder treatment services will benefit the public safety system. Counties will continue to work across disciplines to achieve good outcomes for persons with substance use disorder issues and/or mental illness.

Counties continue to support state and federal efforts to provide substance use disorder benefits under the same terms and conditions as other health services and welcome collaboration with public and private partners to achieve substance use disorder services and treatment parity.

With the enactment of Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, the demand for substance use disorder treatment and services on counties continues to increase. Dedicated funding for Proposition 36 expired in 2006, and the 2010-11 state budget eliminated all funding for Proposition 36 and the Offender Treatment Program. However, the courts can still refer individuals to counties for treatment under state law, and counties are increasingly unable to provide these voter-mandated services without adequate dedicated funding.

F. Medi-Cal, California's Medicaid Program

California counties have a unique perspective on 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. Undoubtedly, changes to the Medi-Cal program will affect counties. Even as the Affordable Care Act is implemented, counties remain concerned about state and federal proposals that would decrease access to health care or shift costs and risk to counties.

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 serve as the medical safety net for millions of residents. These local systems also rely heavily on Medicaid reimbursements. Any Medi-Cal reform that results in decreased access to or funding of 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 safety net services for all persons served by county facilities. 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.

In the area of Medi-Cal, counties have developed the following principles:

1. Safety Net. It is vital that changes to Medi-Cal preserve the viability of the safety net and not shift costs to the county.

2. Managed Care. Expansion of managed care must not adversely affect the safety net and must be tailored to each county's medical and geographical needs. Due to the unique characteristics of the health care delivery system in each county, the variations in health care accessibility and the demographics of the 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.

3. Special Populations Served by Counties – Mental Health, Substance Use Disorder Treatment Services, and California Children's Services (CCS): Changes to Medi-Cal 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. Maximum federal matching funds for CCS program services must continue in order to avoid the shifting of costs to counties. Counties recognize the need to reform the Drug Medi-Cal program in ways that maximize federal funds, ensure access to medically necessary evidence-based practices, allow counties to retain authority and choice in contracting with accredited providers, and minimize county risks. Any reform effort should recognize the importance of substance use disorder treatment and services in the local health care continuum.

4. Financing. Counties will not accept a share of cost for the Medi-Cal program. Counties also believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost shifts or attempts to increase county responsibility through block grants or other means.

5. Simplification. 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 or billing and reimbursements. Counties support simplifying the eligibility process for administrators of the Medi-Cal program.

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

For counties, this change led to an increase in workload for case management across many levels of county medical, social welfare, criminal justice, and mental health systems. 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 counties.

H. Medicaid and Aging Issues

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

Counties support the continuation of federal and state funding for the In-Home Supportive Services (IHSS) program, and oppose any efforts to shift additional IHSS costs to counties.

Section 2: AFFORDABLE CARE ACT (ACA) IMPLEMENTATION

The fiscal impact of the federal ACA on counties is uncertain and there will be significant county-by-county variation. However, counties support health care coverage for all persons living in the state. The sequence of changes and implementation of the Act must be carefully planned, and the state must work in partnership with counties to successfully realize the gains in health care and costs envisioned by the ACA.

Counties also caution that increased coverage for low-income individuals may not translate into savings to all county health systems. Counties cannot contribute to a state expansion of health care before health reform is fully implemented, and any moves in this direction would destabilize the county health care safety net. Counties must also retain sufficient health revenues for residual responsibilities, including public health.

A. Access and Quality

- Counties support offering a truly comprehensive package of health care services that includes mental health and substance use disorder treatment services at parity levels and a strong prevention component and incentives.
- Counties support the integration of health care services for prisoners and offenders, detainees, and undocumented immigrants into the larger health care service model.
- Health care expansion must address access to health care in rural communities and other underserved areas and include incentives and remedies to meet these needs as quickly as possible,

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 transitions 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 local 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 local 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 permanent additional resources to expand health care coverage.
- A universal health care system should include prudent utilization control mechanisms that are appropriate and do not create barriers 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, as both employers and administrators of health care programs, 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 and be consistent with the goals and principles of local control at the county government level.

- Reforms should offer opportunities for self-employed individuals, temporary workers, and contract workers to obtain affordable health coverage.

E. Implementation

The sequence of changes and implementation must be carefully planned, and the state must work in partnership with the counties to successfully realize the gains in health and health care envisioned by the ACA.

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 about 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 as well as any attempts by the state to shift the costs for these programs to counties. 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 the unique characteristics of each county's delivery system, health care accessibility, and demographics of client population, counties believe that managed care systems must be tailored to each county's needs, and that counties should have the opportunity to choose providers that best meet the needs of their populations. The state must 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), and thereby potentially produce 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 and even more recently have 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, an 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 to ensure their long-term viability.

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 to counties in this partnership program.

With the passage of Proposition 1A the state and counties entered into a new relationship whereby local property taxes, sales and use taxes, and Vehicle License Fees are constitutionally dedicated to local governments. Proposition 1A also provides that the Legislature must fund state-mandated programs; if not, the Legislature must suspend those state-mandated programs. Any effort to realign additional programs must occur in the context of these constitutional provisions. Further, any effort to realign programs or resources must guarantee that counties have sufficient revenues for residual responsibilities, including public health programs.

In 2011, counties assumed 100 percent fiscal responsibility for Medi-Cal Specialty Mental Health Services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Drug Medi-Cal; drug courts; perinatal treatment programs; and women's and children's residential treatment services as part of the 2011 Public Safety Realignment. Please see the Realignment Chapter of the CSAC Platform and accompanying principles.

B. Hospital Financing

In 2012, 12 counties own and operate 16 hospitals statewide, including Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura Counties. These hospitals are a vital piece of the local safety net, but also serve as indispensable components of a robust health system, providing both primary and specialized health services to health consumers in our communities, as well as physician training, trauma centers, and burn care.

County hospitals could not survive without federal 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 eligible for more federal funding in the future, as needs grow. California's current federal Section 1115 Medicaid waiver (implemented in SB 208 and AB 342, Chapter 714 and 723, respectively, Statutes of 2010) provides county hospitals with funding for five years. Counties believe implementation of the waiver is necessary to ensure that county hospitals are paid for the care they provide to Medi-Cal recipients and uninsured patients and to prepare counties for federal health care reform implementation in 2014.

Counties are supportive of opportunities to reduce costs for county hospitals, particularly for mandates such as 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.

Counties also support opportunities for county hospitals and health systems to make delivery system improvements and upgrades, which will help these institutions compete in the modern health care marketplace.

Section 4: FAMILY VIOLENCE

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

Section 5: HEALTHY COMMUNITIES

Counties support policies and programs that aid in the development of healthy communities which are designed to provide opportunities for people of all ages and abilities to engage in routine physical activity or other health-related activities. To this end, Counties support the concept of joint use of facilities and partnerships, mixed-use developments and walkable developments, where feasible, to promote healthy community events and activities.

Section 6: VETERANS

Counties provide services such as mental health treatment, substance use disorder treatment, and social services that veterans may access. Specific strategies for intervention and service delivery to veterans should be developed through cooperation between federal, state and local governments, as well as community and private organizations serving veterans.

Section 7: EMERGENCY MEDICAL SERVICES

Counties are tasked with providing critical health, safety, and emergency services to all residents, regardless of geography, income, or population. Because of this responsibility and our statutory authority to oversee pre-hospital emergency medical services, including ambulance transport service, counties are forced to operate a balancing act between funding, services, and appropriate medical and administrative oversight of the local emergency medical services system. Counties do not intend to infringe upon the service areas of other levels of government who provide similar services, but will continue to discharge our statutory duties to ensure that all county residents have access to the

appropriate level and quality of emergency services, including medically indigent adults. Reductions in authority for counties in this area will be opposed. Counties recognize that effective administration and oversight of local emergency medical services systems includes input from key stakeholders, such as other local governments, private providers, state officials, local boards and commissions, and the people in our communities who depend on these critical services.