Health and Human Services Policy Committee
Thursday, June 2, 2011 · 10:30 a.m. – Noon
Gardenia Room · Sheraton Grand Hotel
1230 J Street · Sacramento, CA

Supervisor Kniss, Santa Clara County, Chair
Supervisor Woodrow, Alpine County, Vice Chair

This policy committee meeting is an in-person meeting only
and is being held as part of the CSAC 2011 Legislative Conference.

10:30 a.m.	**I.**	**Welcome and Introductions** *Supervisor Liz Kniss, Santa Clara County*
10:35 – 11:00 a.m.	**II.**	**Message From California Department of Social Services** *Will Lightbourne, Director, California Department of Social Services*
11:00 – 11:25 a.m.	**III.**	**The Federal Health Law and California: What's New, What's Next, and What do We Need to Do?** *Anthony Wright, Executive Director, Health Access*
11:25 – 11:50 a.m.	**IV.**	**Parity 101: What Does it Mean for Behavioral Health Services?** *Sandra Naylor Goodwin, PhD, MSW, Executive Director, California Institute for Mental Health*
11:50 – Noon	**V.**	**State & Federal Updates** *Supervisor Liz Kniss, Santa Clara County* *Kelly Brooks, CSAC Legislative Representative*
Noon	**VI.**	**Adjournment** *Supervisor Liz Kniss, Santa Clara County*

ATTACHMENTS

Attachment One..... CSAC Memo: Introducing Will Lightbourne: A Message from the California Department of Social Services

Attachment Two..... CSAC Memo: The Federal Health Law and California: What's New, What's Next, and What Do We Need to Do?

Health Access PowerPoint Presentation: "The Federal Health Law and California: What's New, What's Next, and What Do We Need to Do?"

Attachment Three.....CSAC Memo: Parity 101: What Does it Mean for Behavioral Health?

Attachment Four..... ...CSAC Memo: 2011-12 State Budget Update

CSAC May Revision Budget Action Bulletin (BAB): Health and Human Services Section, May 16, 2011

CSAC Joint Budget Letter: Shift Mental Health Services for Special Education Pupils (AB 3632) to Schools – SUPPORT. May 19, 2011.

CSAC Joint Budget Letter: In-Home Supportive Services: Public Authority and County Administration Cuts – OPPOSE. May 20, 2011.

CSAC Budget Letter: Governor's May Revision Proposal: Shift Health Families Children to Medi-Cal – SUPPORT IN CONCEPT. May 19, 2011.

CSAC Joint Budget Letter: LEADER Replacement System – REJECT SUSPENSION. May 19, 2011.

CSAC Joint Budget Letter: Medi-Cal Waiver: Cuts to Public Hospital Systems – OPPOSE. May 20, 2011.

Attachment Five.....CSAC Memo: Federal Update: Medicaid

Article: "Senators decry Medicaid block-granting," *NACo County News*, May 9, 2011 (Supervisor Kniss appears on the far left in the bottom photo), 2 pages.

Photo Spread: "County officials meet with Obama Administration," *NACo County News*, May 9, 2011, 2 pages.

CSAC Letter to President Obama Opposing Medicaid Changes: May 16, 2011

California Congressional Democrats Letter: May 16, 2011

Attachment One

CSAC Memo: Introducing Will Lightbourne: Message from the California Department of Social Services

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May 25, 2011

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: Introducing Will Lightbourne: A Message from the California Department of Social Services

Background. Governor Jerry Brown appointed Will Lightbourne to serve as the Director of the California Department of Social Services in April.

Director Lightbourne is a familiar face to counties, having served as the Director of Santa Clara County's Social Services Agency since 2000. Before that, he served as Director of the San Francisco City and County Human Services Agency from 1996 to 2000, and also as Director of the Santa Cruz County Human Services Agency from 1990 to 1996.

Director Lightbourne now leads a statewide department that operates under the umbrella of the California Health and Human Services Agency. The California Department of Social Services (CDSS) is responsible for the oversight and administration of programs serving California's most vulnerable residents.

There are several divisions and functions within CDSS, including:

- Adult Programs Division, which includes In-Home Supportive Services (IHSS)
- Children and Family Services Division, which includes Foster Care and Adoptions
- Community Care Licensing Division, which includes child care licensing and adult and elderly facilities
- Welfare to Work Division, which oversees the state's CalWORKs and CalFresh programs
- Disability Determination Service, which determines medical eligibility for Social Security Income/State Supplemental Payments (SSI/SSP)
- Human Rights and Community Services division
- State Hearings Division

CSAC is pleased to welcome Director Lightbourne to the Health and Human Services Policy Committee, and we look forward to working closely with him in the future.

Attachment Two

CSAC Memo: The Federal Health Law and California: What's New, What's Next, and What Do We Need to Do?

Health Access PowerPoint Presentation: "The Federal Health Law and California: What's New, What's Next, and What Do We Need to Do?"

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May 25, 2011

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: The Federal Health Law and California: What's New, What's Next, and What Do We Need to Do?

Background. California is at a critical juncture in providing health care services to the state's neediest residents. The passage of the Patient Protection and Affordable Care Act, (commonly known as federal health care reform or the ACA), the implementation of the state's new Section 1115 "Bridge to Reform" Medicaid Waiver, Congressional efforts to "reform" Medicaid by block-granting the funding to state, and the state's homegrown budget crisis have all impacted the state's ability to continue to provide critical safety net health care services. In turn, these impacts also affect counties, which are tasked with implementing the majority of the above initiatives.

Focus on the ACA. The passage of the Patient Protection and Affordable Care Act in March of 2010 heralded a new era in health care. Provisions of the Act are already in place, and the state and counties are working hard to develop a viable implementation plan for the Act's full implementation by January 1, 2014. In fact, California was the first in the nation to establish a Health Care Exchange. The county Low-Income Health Programs (LIHPs) that are being developed as part of the Medicaid Waiver will serve as the model for ACA implementation in 2014.

Policy Considerations. There are many issues and policy changes that will need to be addressed place in California as the state moves forward with implementing federal law. For example, how will the state and counties transition LIHP enrollees and indigent adults into Medi-Cal in 2014? What will a comprehensive enrollment system look like?

Anthony Wright, Executive Director for Health Access, will be speaking about the opportunities within California between now and 2014 to implement the ACA. Health Access is a statewide health care consumer advocacy coalition. Wright has served as the head of Health Access since 2000, and his background is as a consumer advocate and community organizer. He has been widely quoted in local and national media on a range of issues. He worked for New Jersey Citizen Action, the Center for Media Education, *The Nation* magazine, and in Vice President Gore's office in the White House.

Wright welcomes feedback from county supervisors on ACA implementation and ideas for collaboration.

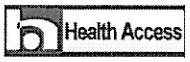
Attachment:

- Health Access PowerPoint Presentation: "The Federal Health Law and California: What's New, What's Next, and What Do We Need to Do?"

The Federal Health Law and California:

What's New, What's Next, and What Do We Need to Do?

Detailed Description * April 2011



www.health-access.org
www.facebook.com/healthaccess
www.twitter.com/healthaccess

Why CA Needed Reform

- **Californians have suffered disproportionately as a result of their coverage not being there when they needed it.**
  - Californians are more likely to be uninsured than most Americans: 8 million Californians are uninsured this year, and live sicker, die younger, and are one emergency away from financial ruin.
  - Californians are less likely to get coverage from an employer, and such coverage is eroding.
  - Californians are more likely, as a result, to have to buy coverage as individuals, and thus more Californians have a lack of affordable coverage options, and more can not get coverage at any price, due to pre-existing conditions.
  - California has a high cost-of-living, and a greater percentage of lower-wage workers, meaning more Californians need help to afford coverage
  - Californians rely on public health insurance programs and the health care safety net, but state budget cuts are making this challenging.
  - Californians need protection from inadequate coverage and discriminatory practices by insurers and employers.

The Worst of Times: The California Budget

A March 2011 budget package cut $12.5 billion, half from health and human services. In Medi-Cal, it would:

- Cap doctor visits to 7/year (with exceptions)
- Impose co-payments, including $5/doctor visit, $50 emergency room, and $100 for a hospital night.
- Reduce provider rates by 10%.
- Eliminate Adult Day Health Care, and replace it with a new program with half the money.
- Eliminate coverage of over-the-counter drugs, and limit coverage to hearing aids & enternal nutrition products.
- Raise Healthy Families premiums and co-payments.

If tax rates aren't extended by a vote of the people, the cuts get much, much worse.

The Biggest Reforms of Our Era

The health reform law doesn't do all that is needed, but it is historic Congressional action in three areas of focus:

1) **Provides new consumer protections** to prevent the worst insurance industry abuses
   - Biggest reform of insurance practices ever: no denials for pre-existing conditions; no rescissions; no lifetime/annual caps on coverage; etc
2) **Ensures security** for those with coverage, and **new and affordable options** for those without coverage
   - Biggest expansion of coverage in 45 years; Would bring US from 85% to 95% coverage.
   - Expansion of Medicaid and a new exchange, with affordability tax credits so premiums are tied to income, not how sick we are.
3) **Begins to control health care costs**, for our families and our government.
   - Multiple efforts to ensure quality & reduce cost
   - Biggest deficit reduction measure in a generation.
   - Big investments in prevention, with unbooked savings

Challenges: Myths Vs. Reality

The new health law has real challenges, but they are not insurmountable.

1) **Repeal:** The House of Representatives passed H.R. 2 on a largely party-line vote, but it failed in the Senate. President Obama has pledged to veto repeal efforts, but has supported specific reforms:
   - 1099 small business tax reporting
   - State flexibility to meet ACA goals moved from 2017 to 2014.
2) **Lawsuits:** Over a dozen legal challenges were thrown out of court. Of the five district court judges,
   - Three ruled the ACA was constitutional
   - One struck down a specific provision requiring individuals to have coverage, but upheld the rest.
   - Only one struck down the entire ACA.

   This is clearly going to Appeals Court and eventually the Supreme Court.
3) **Defunding:** 85% of ACA funding is already appropriated without further Congressional action. Some funds for cost-saving pilot programs and prevention need Congressional approval, and many items will be the subject of budget negotiations.

BOTTOM LINE: California should aggressively take advantage of the new funding, benefits, options, and consumer protections—and help build the momentum to overcome political obstacles.

What's Already in Place: I

Several provisions of the Patient Protection and Affordable Care Act (ACA) are already in effect:

Instilling Confidence in Coverage

- Ending rescissions
- Banning lifetime and annual caps on coverage

Access to Coverage Regardless of Health Status

- Ending discrimination against children with pre-existing conditions
- New, expanded option for adults denied for pre-existing conditions (PCIP)

What's Already in Place: II

Several provisions of the Patient Protection and Affordable Care Act (ACA) are already in effect:

Securing and Expanding Coverage Options

- Young adults can stay on their parent's coverage through age 26
- More security for the 7 million Californians on Medi-Cal and Healthy Families
- More resources for community clinics, prevention efforts, and workforce development
- Better information on health options: www.healthcare.gov

What's Already in Place: III

Several provisions of the Patient Protection and Affordable Care Act (ACA) are already in effect:

Making Health Care More Affordable

- Help ($250 rebate/50% discount) for many seniors to afford prescription drugs, as a first step to closing the Medicare Part D "donut hole"
- Subsidies for early retiree coverage
- Free preventative care (with no-copayments) for those in Medicare & private insurance
- Small business tax credit to help pay for workers' coverage
- More review of insurance rates

How 38 Million Californians Get Coverage Now

- Employer-Based Coverage
  - Around Half, 18-19 Million
- Public Programs: About a Third (10-11 million)
  - Medicare: 4 million
  - Medi-Cal: 7.7 million
  - Healthy Families: Nearly 1 million
- Individual Insurance Market
  - About 5% (around 2 million)
- Uninsured: Around 7 million

Securing On-the-Job Coverage: Subsidies and Standards

- Around half of all Californians (18 million) already have coverage through their employer, and **reform will make on-the-job coverage more secure and reliable**
- **Many small employers of low-wage workers will receive significant subsidies** (tax credits up to 35% of premiums) to help pay for coverage.
- Larger employers (over 50 FTEs) will either cover their workers, or may have to contribute to their care—setting a standard much like the minimum wage does for pay:
  - Provide Health Benefits for Full-Time, Non-Seasonal workers OR
  - Pay a penalty for Full-Time, Non-Seasonal worker in exchange ($2,000/$3,000 depending on coverage offer)
  - Full-Time and Non-Seasonal Defined:
    - Full-Time=Average 30 hours per week in month
    - Non-Seasonal=120 days for one employer in a year

Securing On-the-Job Coverage: A New Floor

- Employers that offer coverage must:
  - Cover 60% of the cost of covered benefits
  - Require an employee contribution of less than 9.5% of taxable income for household
  - Have benefits that satisfy individual mandate
- If an employer covers less than 60% of cost or requires employee to pay more than 9.5% of income, then the employee is eligible for the exchange and the employer pays the fee
- Waiting periods of more than 90 days are banned
- Small employers have other requirements and self-insured plans largely exempt
- Existing employer plans grandfathered in

Improving Public Programs: Medicare

- Nearly a third of Californians (10 million+) get coverage thru Medicare, Medicaid, SCHIP, etc.
- For seniors, **Medicare** will remain intact and be strengthened so it is more stable
  - **No reductions in Medicare benefit package; some improvements:**
  - **Closes "donut hole" gap in prescription drug coverage**
    - Right now, coverage runs out at around $2,830/year; doesn't kick back in until over $4,550.
    - In 2010, impacted seniors will get $250 rebate
    - Annual improvements until drug coverage becomes complete
  - **No cost-sharing for preventative screenings & care**
  - Roots out waste, fraud, and abuse, especially overpayments to insurance companies in Medicare Advantage.
  - Extends solvency of Medicare for nearly a decade

Improving Public Programs: Medicaid

- **Medicaid** (Medi-Cal in CA) will be expanded to cover lowest-income families, including adults without dependent children
  - Expands Medicaid for all under 133% of the federal poverty level (excluding undocumented immigrants)
  - Before reform, adults without kids at home excluded
  - Up to two million additional Californians on Medi-Cal
  - For newly-eligible population, federal government will pay 100% of costs for 2014-2016; By 2020, will pay up to 90% of cost
  - Reduces paperwork and eligibility barriers
    - Example: Removes complicated "asset test" that is barrier to enrollment, and that prevents poor families from saving
  - SCHIP (Healthy Families in CA) intact

Help for Individual Purchasers: New Rules for Insurers

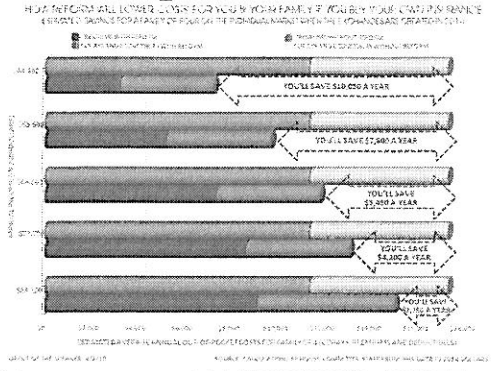
- Unlike current individual market, **no denials or different premiums for pre-existing conditions.**
  - **Modified community rating**
    - No premium difference for health status
    - Age: 3:1 rate band between young and old
    - Family size
    - Tobacco use: 1.5:1
    - Geographic Region
- Minimum essential benefits:
  - Doctors, hospitals, prescription drugs, mental health and substance abuse parity
- Minimum actuarial value: 60%
- Maximum out of pocket costs: $5,950 individual/$11,900 family
- No lifetime limits, no annual limits
- Individuals must have coverage, but availability ensured; affordability subsidies and/or exemptions available

The Exchange: Providing New, Affordable Choices

For those who still must buy coverage as individuals (over 2 million Californians currently) and are now left all alone at mercy of big insurers:

- A new **Health Insurance Exchange** that will offer a number of affordable coverage options.
  - **Affordability credits** will be provided for coverage purchased in the Exchange for families earning up to 400% FPL (~$73K for family of 3).
  - The Exchange will make it **easier to understand** and get a quality, affordable health plan, offering a range of easy-to-compare insurance products, with basic benefits.
  - The Exchange can use its **bargaining power to provide the "group rate"** for individuals and small businesses, to get the best possible price.

Sliding Scale Subsidies



The Exchange in CA

California's first-in-the-nation legislation to establish an Exchange post-reform:

- Provides for "selective contracting," so it can negotiate for individuals and small businesses, who otherwise are left all alone at the mercy of the big insurers.
- Can serve as the HR department for CA, getting a better deal, vetting products, providing neutral and credible information, standardizing benefits, and fixing issues that come up.

- Four of five board members appointed: HHS Secretary Diana Dooley (Gov. Brown); Kim Belshe and Susan Kennedy (Gov. Schwarzenegger); Paul Fearer (Speaker Perez). Still awaiting appointment by Senate Rules Committee.
- First meeting in April; aggressive agenda moving forward
- Initial work: Hire an Executive Director and staff; business plan; apply for federal funds through 2014; eligibility and enrollment systems; IT systems; navigation; stakeholder process; public education and outreach; etc.

Ensuring Affordable Coverage & Essential Benefits

In each of the ways people get coverage today, through
1)an employer
2)a public program, or
3)buying it as an individual
new protections will ensure that coverage includes:

- **Affordability**
  - Premiums not to exceed a percentage of income—sliding scale up to 9.5% of income.
  - No lifetime limits, no annual limits
  - Cap on out-of-pocket costs (co-pays, deductibles) of $5,950 individual/$11,900 family (2010 dollars)
  - No co-pays for preventive services like mammograms and prostate cancer screening.
- **Basic Benefits**
  - Covers doctors, hospitals, prescription drugs, mental health parity.
  - Comparable to most large employers now. (Knox/Keene+Rx)
- **Purchasing Power of Group Coverage**
- **Consumer Protections**
  - Example: Medical Loss Ratio: 85 cents of premiums must be spent on care

Financing Health Reform

- Health reform will cost money upfront, but is **an investment to achieve savings in the long run.**
- Cost is half **Medicaid expansion** and half **affordability subsidies** for low- and moderate-income families.
- Congressional Budget Office estimates that reform will cost $950 billion over 10 years. CBO says **it will be paid for**, and actually **reduce the deficit** by $150 billion in the first ten years, and by a trillion in the 2nd ten years.
- Over half of the financing is **savings in the existing health system** (e.g., reducing the overpayments to insurers in Medicare Advantage program).
- Based on **"shared responsibility"** mandates, sliding-scale contributions for individuals, and an employer requirement.
- **Additional financing** for health reform include: upper-income Medicare tax; an excise tax on high-cost insurance products; and other revenue sources (e.g., a 10% tanning salon tax).

ACA Impacts on Coverage

- **Employer-Based Coverage**
  - Roughly the same (potentially stabilize long-term erosion, some small businesses may join the SHOP Exchange)
- **Medi-Cal**
  - Increases potentially by 2-3 million—for a total of 9-10 million
  - Newly-eligible get much higher than 50-50 matching rate
    - 2014-16: 100% Federally funded
    - 2017: 95%; 2018: 94%; 2019: 93%
    - 2020 and beyond: 90% (still a 9:1 match)
- **Individual Market and the Exchange**
  - Individual market doubles to potentially 4-5 million.
  - Up to 4 million getting subsidies in the Exchange
  - Half (1.7 million) would be newly insured; the rest were getting coverage in the individual market but now getting help to pay for expensive coverage.
  - Exchange Demographics: over half low/moderate-income families of color
- **Uninsured**
  - 4.7 million (2/3 of the uninsured) are eligible for subsidized coverage; more could become covered
  - Some won't be signed up; some will not qualify for help due to income or immigration status; there will be residual population

Alameda County

- *New numbers from UCLA (Two-Thirds of CA's 7 Million... Feb 2011):*
- Almost 1.5 million in Alameda County
- Nearly 1.36 million below 65 years old.
  - Job-based coverage 62.5%
  - Medi-Cal and Healthy Families 11.3%
- 18.8% uninsured (higher than national average, just a bit lower than California average of 21.2%)
- **Over 250,000 uninsured in Alameda County**

Newly-Covered:

- 56,000 newly eligible for Medi-Cal
  - $227 million in federal dollars to Alameda's health system
- 107,000 eligible for subsidies in the Exchange
  - $370.5 million in federal subsidies to Alameda families and health system
- 35,000 newly covered by buying as individual or through employer
- 60,000 remaining uninsured

Los Angeles County

- *Census:* Los Angeles: 9,848,011 (10.6% 65+)
- *New numbers from UCLA (Two-Thirds of CA's 7 Million... Feb 2011):*
- Just over 9 million below 65 years old.
  - Job-based coverage 47.2%
  - Medi-Cal and Healthy Families 19.1%
- 23.7% uninsured (higher than national average, higher than California average of 21.2%)
- **Over 2,154,000 uninsured in LA County**

Newly-Covered (Rough Estimates):

- Over 800,000 newly eligible for Medi-Cal
  - Billions in federal dollars to LA's health system
- Over 900,000 eligible for subsidies in the Exchange (both currently insured and uninsured)
  - Billions in federal subsidies to LA families and health system
- 350,000 newly covered by buying as individual or through employer
- 500,000 remaining uninsured

Securing the Safety-Net

The Need for Transformation

- For hospitals, community clinics, and others, this a challenge and opportunity
- Potential new resources: Direct funds for clinics, newly insured consumers with dollars attached to them.
- Will their consumers stay with them, or go to other providers? Are they ready to compete?
- What is the business plan for safety-net providers?
- **Goal: Not Just Surviving, but Thriving**

Assessing the Entire Community's Capacity

- With many more insured, we need the capacity of the existing safety-net to provide the care.
- The newly-insured will have specific needs, such as language access
- The safety-net will still need strategy and support to provide care to the remaining uninsured.
- How can we provide care better, and more cost-effective? How can a county's health system-public & private-be ready in 2014?
- Overall reforms of delivery systems...

Cost Containment

- **Prevention**: Major investments in prevention and public health; Change delivery system to promote primary and preventative care; no cost-sharing for preventative care to encourage use; other efforts like menu labeling.
- **Bulk Purchasing** through group coverage, and a new exchange, to bargain for better rates.
- **Abolishing Underwriting** and its expense and incentives, getting insurers to compete on cost & quality rather than risk selection.
- **Information Technology** to foster electronic records, reduce bureaucracy, get better data on cost & quality
- **Better Research from Transparency Efforts** on prices and health outcomes; and on **comparative effectiveness** of key treatments.
- **Patient Safety** measures to reduce hospital-acquired infections, reduce hospital re-admissions, etc.
- **Payment Reforms** to reward quality & better health outcomes, including better care coordination and disease management;
- **Coverage for all** both directly (prevention, reduces cost-shift) reduces costs and helps provides policy tools for further efforts.

Prevention

- Outside the health system
  - Beyond no cost-sharing for preventative care, and other delivery system reforms
- **Health In All Policies**
  - Housing, Zoning, Education, Environmental, Transportation, Food Security, Public Safety, and other services all vital.
  - Place matters: Major opportunity for county-based policy interventions
- **Major Investments in Public Health**
- **Community Transformation Grants**
- **Other Policies**
  - Menu labeling, etc.

Health Reform and You

- **IF YOU ARE INSURED**, nothing requires you to change your coverage; but your coverage will be more secure and stable:
  - Makes it more likely your employer continues to offer coverage, set minimum standards for such coverage.
  - Improves Medicare and expands Medicaid.
  - Fixes the "individual market" of coverage in multiple ways.
  - Ensures that even if your life situation changes (job change, divorce, graduation), you have access to affordable coverage.
  - Provides the foundation to bring down the overall costs of health care

Health Reform and You

- **IF YOU ARE UNINSURED**, you will need to get coverage, but there will be new help and new options to ensure coverage is:
  - **AVAILABLE:** No denials or different rates for pre-existing conditions.
  - **AFFORDABLE:** Subsidies/affordability credits for low & mid income families to limit out of pocket costs to a certain percentage of income, plus other efforts to bring down costs.
  - **ADEQUATE**: Minimum benefit standards and a cap on out-of-pocket costs, so no one goes into significant debt or bankruptcy.
  - **ADMINISTRATIVELY SIMPLE:** The Exchange provides choice and convenience, making it easy to compare and sign up for plans.
  - Note that the individual mandate includes **exemptions** for affordability and hardship.

HEALTH REFORM: Next Steps

The Benefits of Health Reform

1. **Near-universal coverage for all,** with expansions of group coverage, both public and private.
2. **New consumer protections**: New rules and oversight on insurers that include the abolition of underwriting and limits on age-based rates and on premiums dollars going to administration and profit.
3. **The biggest expansion of Medicaid** since its creation 40 years ago.
4. **Sliding scale subsidies tied to income**: Consumers will pay for coverage not based on how sick they are, but what they can afford.
5. **The end of most junk insurance** and bankruptcies due to medical bills, with a cap on out-of-pocket costs.
6. **Fair share financing**, including an employer assessment as important in concept as the minimum wage.
7. **Assistance for small business** and their workers to be able to afford coverage.
8. **Improvements for existing public programs**, such as filling donut hole in Medicare & simplifying Medicaid.
9. **The tools for cost containment and quality improvement** in health care generally, from prevention to IT to bulk purchasing.
10. **Momentum to do more** in the future, politically and policy-wise, in health care and beyond

Fulfilling the Promise: A New Federal/State Partnership

- The work continues:
  - To implement and to improve
  - Policy and political; defense and offense
  - State and federal
  - Legislative and regulatory
- Many decisions will be made at the state level with respect to implementing federal health reform provisions. California will determine the outcome of 1/7th of national health reform.
- This creates a responsibility for Californians, but also an opportunity to lead, to improve health reform...
- A legislative agenda that implements; goes early; goes beyond

Fulfilling the Promise: California 2010 Legislation

- **Created an Exchange** that is transparent, consumer-friendly, easy-to-use, fairly governed, and that negotiates with the insurers to provide the best value to consumers: AB1602 (Perez) & SB900 (Alquist/Steinberg)
- **Ensured availability of child-only plans, prohibited children with pre-existing conditions to be denied coverage, and limited higher rates:** AB2244 (Feuer)
- **Made rate hikes (& supporting information) public:** SB1163 (Leno)
- **Conformed state law** to many new federal consumer protections, including rescissions, dependent coverage up to age 26, no cost-sharing for preventative care, etc.

Fulfilling the Promise: The Medi-Cal Waiver

California's "Medicaid waiver" is being negotiated this year, to determine the next five years of the program, which covers 7 million Californians. Some shared goals include:

- Be ready for health reform: through early enrollment and other efforts, have over one million in Medi-Cal on Day 1: January 1, 2014
- Help bring in additional federal funds to California, for the state budget and for our safety-net institutions, especially public hospitals
- Incorporate other delivery system reforms, around coordinated care
- Ensure key consumer protections for seniors and people with disabilities, before any patient is mandatorily shifted

Fulfilling the Promise: (LIHP) Low Income Health Program

A win for the county, the uninsured, and the health system:

- County gets **new federal matching funds**, for dollars they already largely already spend on indigent care, helping their health system and their local economy.
- Up to 500,000 uninsured get **coverage prior to 2014; a medical home** providing primary and preventative care, not just care at the emergency room.
- Since this coverage is grounded in county-based systems of care, these new dollars go to **shore up safety-net institutions**, including public hospitals, community clinics, and other providers.
- This serves as **a bridge to health reform**, ensuring these patients are getting treated and in systems of care before 2014, and ready to get full Medi-Cal (or exchange-based) coverage on day one, maximizing enrollment and federal funds for California.
- This isn't a long-term obligation: In fact, the more people are enrolled in these programs, and thus quickly shifted to Medi-Cal in 2014 with 100% funding by the federal government, the **more county resources can be refocused to better serve the medically indigent who remain uninsured** after 2014.

2011 Agenda:
Consumer Protections & Insurer Oversight

- Watchdog the federal and state government to ensure that **new consumer protections are implemented and enforced.**
  - Focus at the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI)
- Ensure **Californians know about their new rights and options.**
- Start to transition from the "Wild Wild West" insurance market: phasing in benefits, standards, and options.
  - RATE REGULATION: AB 52 (Feuer)
  - MEDICAL LOSS RATIO: SB 51 (Alquist)
  - STANDARDIZING BENEFITS: AB1334 (Feuer)
  - MATERNITY COVERAGE: SB 155 (Evans)
  - MENTAL HEALTH PARITY: AB154 (Beall)
  - SMALL GROUP REFORM: AB1083 (Monning)
- **Fight efforts to weaken, defund, undermine, and repeal** these consumer protections and the rest of reform.

2011 Agenda:
New Public Options

- COUNTY-BASED PLANS:
  - **PUBLIC HEALTH INSURANCE OPTIONS IN THE EXCHANGE?**
  - SB 222 (Alquist) would facilitate joint ventures between county-run health plans, to provide regional provider network and be commercially viable.
  - **THE CORE OF A BASIC HEALTH PLAN?**
  - SB 703 (Hernandez) would establish a Basic Health Plan, for those 133%-200% of the federal poverty level. Under the ACA, it would operate with funds from 95% of Exchange subsidies, and with those dollars possibly could provide better benefits and cost-sharing, and better provider payments than Medi-Cal. Issues include whether it diminishes Exchange's bargaining power, where it lives, etc.

  Also: SB810 (Leno) continues as a vehicle for a single-payer system.

2011 Agenda:
Ensuring Californians Get Coverage

- Eligibility and enrollment legislation:
  - THE 2014 MEDI-CAL EXPANSION: AB43 (Monning) / SB 677 (Hernandez)
  - STREAMLINING ELIGIBILITY AND ENROLLMENT: AB1296 (Bonilla)
  - PRE-ENROLLMENT: AB715 (Atkins)
  - AUTOMATIC ENROLLMENT DURING LIFE CHANGES: AB792 (Bonilla)
  - CONSUMER ASSISTANCE AND NAVIGATION: AB922 (Monning)
- Work to **implement and improve:**
  - Streamline enrollment in Medicaid, Healthy Families, the Exchange and elsewhere; no wrong doors;
  - Get ready so millions of Californians get covered on Day One—January 1, 2014—and California gets all the federal help available.
  - Create integrated system of "navigation"—right now, patchwork of county workers, brokers/agents, community groups, etc.
  - Work at the Legislature and at the Exchange, DHCS, etc.

Fulfilling the Promise:
What a Community Can Do

- Educate the Community about Their New Rights, Options, Benefits, and Consumer Protections
- Engage Communities and Consumers Every Step of the Way
- Find Ways to Maximize Federal Dollars for County and Community
  - Grant opportunities
  - Matching Dollars for Medi-Cal, Healthy Families, LIHP, etc.
- Be Aggressive on the Low-Income Health Program
- Be Ready to Have Community Residents Get Coverage on Day One
  - Set a Goal and Date; Work backwards to Meet That Goal
  - Systems in place for easy enrollment through no wrong door
- Transform the Safety-Net to Survive and Thrive
  - A Business Plan for Safety-net institutions
  - An Assessment and Augmentation of County-wide Capacity
- Use the New Tools in the Law
  - To focus on delivery system reform for cost, quality, safety & equity
  - To build health in all policies, with place-based policy interventions

What it Means to Repeal in CA

LEAVE CONSUMERS AT THE MERCY OF INSURER ABUSES, allowing insurers to:

- **deny almost 400,000 Californians** for "pre-existing conditions";
- **impose arbitrary annual and lifetime caps** on coverage, leaving *insured* patients at risk of medical debt and bankruptcy; and
- **sell "junk" coverage** that does not provide basic benefits.

DENY MILLIONS HELP WITH HEALTH CARE

- Deny **2 million** uninsured Californians access to coverage through Medicaid;
- Deny **3.8 million** uninsured Californians access to new coverage through individual health insurance and prevent improvements to coverage for **21 million** Californians with employer or individual plans.
- Condemn **66,000** more California families a year to bankruptcy due to health care costs.
- Prevent **3.2 million** young adults in California (under age 26) to obtain coverage on their parents' insurance plans.
- Deny all **4.5 million** California seniors with free preventive services

REJECT RESOURCES AND FEDERAL FUNDS FOR CALIFORNIANS

- Deny Californians access to **$106 billion** in tax credits would mean **increased health insurance premium costs for millions of California families**
- **Increase taxes on up to 392,000 California small businesses by $4.3 billion,** by stopping small business tax credit.
- **Increase prescription drug costs for 794,000 California seniors by $9.3 billion,** by leaving the Medicare Donut Hole unfilled.
- **Eliminate $1.4 billion in new funding to California community health centers.**

So Much More To Do:
What Can You Do?

1. **Thank your member of Congress/Tell them not to repeal it:** Call, write, or visit your Congressional Representative and thank them for their yes vote – or attend a public event to thank them!
2. **Share your story** personal stories help others learn how they can benefit from reform – and they are a compelling advocacy tool!
3. **Support state efforts to implement and improve reform** let your local representatives know that you support robust implementation and improvement of reform.
4. **Extra, Extra, Write all about it!** Write a letter to the editor in support of reform and all its benefits.
5. **Join our mailing list** to keep up to date on legislative development and get important action alerts!
   - Sign up at www.health-access.org for E-mail updates
   - Check out our daily blog, at **blog.health-access.org**
   - Check out our **Facebook** and **Twitter** feeds

For more information

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Attachment Three

CSAC Memo: Parity 101: What Does it Mean for Behavioral Health?

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May 25, 2011

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: Parity 101: What Does it Mean for Behavioral Health Services?

Background. Behavioral health parity is a term that is being used more and more in the context of health care. California has existing state statute on behavioral health parity, and two recent and major federal laws also govern behavioral health access and parity for consumers.

California Landscape

Existing Law. California law requires partial behavioral health parity for specified conditions since 1999 (AB 88 [Thomson], Chapter 524, Statutes of 1999). AB 88 requires treatment parity for "serious mental illness," including schizophrenia, autism, and anorexia nervosa. However, a host of clinically less serious mental health issues and substance use disorder treatment remain subject to utilization controls and higher co-payments.

Pending Legislation. In the Legislature, Assembly Member Jim Beall has repeatedly introduced legislation to require health plans and insurers to provide mental health services for conditions included in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV. This would include low-grade depression, anxiety, and substance abuse disorder (SUD). Assembly Member Beall's most recent vehicle is AB 154; the previous bills were all vetoed.

Federal Legislation

Federal Parity Law. Congress passed and President George W. Bush signed the 2008 Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008. The MHPAEA requires group health plans that already provide SUD coverage to do so at the same level as they provide for medical and surgical conditions. The MHPAEA also applies to Medicaid Managed Care plans that provide SUD benefits. Under the MHPAEA, there are six classifications of benefits: (a) inpatient, in-network; (b) inpatient, out-of-network; (c) outpatient, in-network; (d) outpatient, out-of-network; (e) emergency care and (f) prescription drugs.

Federal Health Care Reform. The federal Patient Protection and Affordable Care Act (ACA) of 2010 builds on the MHPAEA in substantial ways. Provisions that are already in effect, such as the prohibition on denying coverage based on pre-existing conditions – including SUD and behavioral health – and coverage for preventive health services such as screening and brief intervention for alcohol misuse and tobacco cessation, offer significant opportunity for behavioral health treatments.

More importantly, the ACA defines behavioral health and SUD services as Essential Health Benefits. Starting in 2014, certain health plans will have to meet a minimum benefit level that contains all Essential Health Benefits as defined in the ACA and implementing regulations. To date, the federal government has not fleshed out the Essential Health Benefit menu, but

is expected to do so by 2013. This provision applies to health plans offered in the Health Care Exchange, all new and individual and small group health plans, and benchmark packages for the newly eligible Medi-Cal population. However, it does not apply to the large group market, and some pre-exiting individual and small group plans may be exempt.

Policy Considerations. The interplay of state and federal law, along with local priorities, makes for a complex policy landscape. The federal government has not issued guidance yet for MHPAEA and Medicaid. In addition, states and counties are awaiting federal guidance on the various provisions of the ACA. As federal health reform implementation proceeds, parity will continue to be a topic of discussion. County supervisors must understand the state and federal requirements, as well as the latest research on the effective delivery of behavioral health and SUD services.

Presenter: CSAC has invited Sandra Naylor Goodwin, Ph.D, MSW, Executive Director of the California Institute for Mental Health (CIMH), to speak on this topic. CIMH was established in 1993 to provide training, technical assistance, research and policy development in behavioral health matters. CIMH staff work closely with both counties and the state to ensure excellence in behavioral health services throughout California.

Attachment Four

CSAC Memo: 2011-12 State Budget Update – Informational

CSAC May Revision Budget Action Bulletin (BAB): Health and Human Services Section, May 16, 2011

CSAC Joint Budget Letter: Shift Mental Health Services for Special Education Pupils (AB 3632) to Schools – SUPPORT. May 19, 2011.

CSAC Joint Budget Letter: In-Home Supportive Services: Public Authority and County Administration Cuts – OPPOSE. May 20, 2011.

CSAC Budget Letter: Governor's May Revision Proposal: Shift Health Families Children to Medi-Cal – SUPPORT IN CONCEPT. May 19, 2011.

CSAC Joint Budget Letter: LEADER Replacement System – REJECT SUSPENSION. May 19, 2011.

CSAC Joint Budget Letter: Medi-Cal Waiver: Cuts to Public Hospital Systems – OPPOSE. May 20, 2011.

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May 25, 2011

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: 2011-12 State Budget Update – INFORMATIONAL

Background. The Governor's May Revision Budget for 2011-12 was released on May 16. Since the Legislature passed and the Governor signed several significant budget bills in March, the Governor's May Revision Budget includes less overall cuts than expected. A full summary of his May Revision proposals is attached, as well as five budget letters sent by CSAC related to specific budget issues (AB 3632, IHSS, Healthy Families Program shift to Medi-Cal, the LEADER project, and Public Hospitals).

Recent Activity. Both houses convened budget hearings last week, and adopted many of the Governor's proposals, with only a few tweaks. Of note is the restoration by both houses of the IHSS Public Authority funding, the one-year suspension of LA County's LEADER computer system, and the elimination of 11 state HHS-related boards and commissions.

Moving Forward. A full vote of the Legislature is expected as early as next week. Legislators are required by the Constitution to pass a full budget by June 15, or they risk permanently losing their pay for each day that the budget is tardy.

Attachments:

- Health and Human Services section of the May 16 CSAC May Revision Budget Action Bulletin (BAB)
- CSAC Joint Budget Letter: Shift Mental Health Services for Special Education Pupils (AB 3632) to Schools – SUPPORT. May 19, 2011.
- CSAC Joint Budget Letter: In-Home Supportive Services: Public Authority and County Administration Cuts – OPPOSE. May 20, 2011.
- CSAC Budget Letter: Governor's May Revision Proposal: Shift Health Families Children to Medi-Cal – SUPPORT IN CONCEPT. May 19, 2011.
- CSAC Joint Budget Letter: LEADER Replacement System – REJECT SUSPENSION. May 19, 2011.
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HEALTH AND HUMAN SERVICES

MEDI-CAL

Major Medi-Cal changes include the following:

- Shift Healthy Families Children to Medi-Cal. The Administration is proposing to transition children currently enrolled in the Healthy Families Program into the Medi-Cal program. The proposal implements the Medicaid expansion for children up to 133 percent of the federal poverty level (FPL) required under federal health reform early and takes the additional step of transitioning all Healthy Families children to Medi-Cal. Under federal law, children up to 150 percent of FPL are exempt from premium cost sharing. Under the Administration's proposal, the new co-pay and premium increases will still be applicable to children with family incomes between 150-250 percent of FPL. The transition will occur from January to June 2012. Of the 890,000 children currently enrolled in Healthy Families, 840,000 live in Managed Care counties. Children will be enrolled in the same plan or a plan that allows them to retain their current provider. For the 50,000 children living in counties without Medi-Cal managed care plans, children will access services through the fee-for-service system. About a third of children enrolled in the Healthy Families Program are below 150 percent FPL. By providing Medi-Cal, children will be entitled to a richer benefit package that includes services such as Early Periodic Screening Diagnosis and Treatment (EPSDT).

  The Administration is estimating the proposal will save $31.2 million General Fund in 2011-12. None of the savings are associated with the loss of health care. Presumably, savings are associated with the different reimbursement rates for Medi-Cal and Healthy Families.

  A statutory change would be required in order to make these changes; the Administration's proposed trailer bill language has not been made available yet. The proposal would maintain a Single Point of Entry (run by Maximus) where applications would be screened and then transmitted electronically to county human services departments for eligibility determinations. County human services departments also would accept applications directly, as under current rules. As proposed, Maximus would be responsible for premium collection for the 150% to 250% FPL cases, with county human services departments conducting eligibility determinations and annual redeterminations for those cases.

- Hospital Fee. The Administration is proposing to extend the existing hospital fee for an additional year, through June 30, 2012, which saves $320 million General Fund.

- Bridge to Reform Medicaid Demonstration Waiver. The Administration believes it may not achieve the full $400 million in state General Fund savings associated with the option to claim federal funds for state-only programs through the "Bridge to Reform" Medicaid Section 1115 Demonstration Waiver. In order to achieve the full $400 million in savings, the state is proposing to use surplus certified public expenditures from public hospitals on a volunteering basis in the current year.

- Intergovernmental Transfers (IGTs). Counties that operate Medi-Cal managed care plans have been utilizing IGTs to increase capitation rates. The state is proposing to assess a fee equal to 20 percent of the transferred funds to offset state General Fund costs by $34.2 million in 2011-12. The remaining 80 percent would be used to match federal funds to provide rate increases.

- Medi-Cal Managed Care Program Changes. The Administration is proposing to limit Medi-Cal beneficiaries from changing managed care plans to once annually, within the first 60 days of enrollment. This would save $1.7 million in 2011-12.

- First 5 (Proposition 10) Funding. The budget restores $1 billion in General Fund for the Medi-Cal program that would have been funded with First 5 funds per AB 99 (Statutes of 2011). A number of county commissions filed lawsuits against the state challenging the fund shift outlined in AB 99. The Administration will continue to defend the legal challenges, but the Administration is electing to take a conservative budget approach and restore General Fund costs.

- Medi-Cal Base Adjustment. The May Revision includes base adjustments to Medi-Cal, primarily due to managed care cost increases of $66.3 million in 2010-11 and $122.2 million in 2011-12.

- Savings Erosions. Due to the one-month delay in implementation of budget solutions previously adopted by the Legislature, the May Revision contains $156.6 million in increased costs for Medi-Cal.

- Federal Funds. The May Revisions includes an additional $170.6 million in federal stimulus funds to offset General Funds.

- Adult Day Health Care (ADHC). The May Revision includes $25 million in 2011-12 to provide funding for ADHC transition assistance as beneficiaries transition to other Medi-Cal services. Please recall the March budget eliminated ADHC. The state has submitted a Medicaid state plan amendment to eliminate ADHC. Once the plan is approved by the Center for Medicare and Medicaid Services, ADHC will end the first day of the month 60 days after federal approval. Please recall that the Legislature included intent language in the March budget trailer bill to provide more narrowly-defined services to be provided under a new program, Keeping Adults Free from

Institutions (KAFI). The Legislature provided $85 million for this purpose. The May Revision does not appear to conform to the Legislature's action.

MENTAL HEALTH

State Hospitals. The Governor proposes a $50 million increase for state hospitals for the current year due to unidentified cost increases. The Governor also increases funding by $9.5 million and 78 positions in 2011-12 to increase safety and security at Napa State Hospital, Metropolitan State Hospital, and Patton State Hospital. Lastly, the Governor's plan includes $1.4 million and eight positions for the planning and activation of the California Health Care Facility. Please note that the California Health Care Facility will be operated by the California Department of Corrections and Rehabilitation and is slated to open in 2013.

The Governor also proposes to create a Department of State Hospitals – please see the State Health and Human Services Government Restructuring portion below.

SOCIAL SERVICES

The Governor proposes no additional cuts in services to the CalWORKs, In-Home Supportive Services (IHSS), and Supplemental Security Income/State Supplemental Payment (SSI/SSP) programs beyond the cuts already signed into law in March of this year. Those cuts included reducing the time limit on CalWORKs aid from 60 to 48 months, reducing monthly CalWORKs grants by 8 percent, requiring a medical certification for all IHSS recipients, and reducing SSI/SSP payments to adults down to the federal minimum.

However, due to caseload adjustments, the Governor proposes to adjust the state's spending in the following ways:

- Increase CalWORKs funding by $14 million in 2010-11 and approximately $80 million in 2011-12 due to a larger-than-forecast number of cases.

- Decrease IHSS funding by $6.9 million in 2010-11 and $7 million in 2011-12 due to projected decrease in caseload. Some of the decline in funding is offset by an increase in the cost per IHHS case.

Foster Care. The Governor proposes to increase Foster Care funding by $10.7 million in 2011-12 in response to the foster care rate lawsuit (*Foster Parent Association, et al vs. John A. Wagner, et al*). This will roll back previous foster care rate cuts, and will affect foster family homes, Adoption Assistance Payments, Kinship Guardianship Assistance Payments, and non-related Legal Guardian payment rates. The May Revision document also notes that $1.6 million of these increased state costs are offset by the elimination of the supplemental clothing allowance for foster family homes.

LEADER and CWS/Web Project Reductions. While not making additional changes to the above social services programs, the Governor seems to have targeted technology projects in this area for reductions. Specifically, he proposes to suspend funding for the CWS/Web Project to save the state $3.1 million in 2011-12. He proposes to suspend funding indefinitely, citing possible upcoming changes to the federal Administration for Children and Families requirements for adopting a statewide automated child welfare information system. As for Los Angeles County's Eligibility, Automated Determination, Evaluation and Reporting Replacement (LEADER Replacement) system, the Governor has proposed to indefinitely suspend funding – a decrease in state costs of $26.2 million in 2011-12. The LEADER Replacement system is supposed to replace the County's existing automated systems for eligibility and benefit determinations for the CalWORKs, CalFresh, Medi-Cal and other social services programs. The Governor also intends to redirect $13.8 million in federal Temporary Assistance to Needy Families (TANF) Block Grant funds that would have gone to the project to Cal Grants instead.

In-Home Supportive Services. The May Revise adjustment for Public Authorities cuts state funding by another $7.5 million on top of the January reduction of $2.5 million – for a total cut of $10 million from the 2010-11 appropriation.

The proposed 2011-12 appropriation for Public Authority administration is $17.2 million (federal, state & county funds) – down from the 2010-11 appropriation of $27.2 million.

PUBLIC HEALTH

AIDS Drug Assistance Program (ADAP). The Governor proposes decreasing funding by $17.3 million General Fund in 2010-11 and $20.2 million in 2011-12 for the ADAP. He would achieve this by modifying the eligibility requirements of the Comprehensive AIDS Resources Emergency/Health Insurance Premium Payment Program (CARE/HIPP), enrolling more clients in the Pre-Existing Condition Insurance Plan through the new California Health Care Exchange, and using an unspecified amount of funds from the Safety Net Care Pool.

Immunization Funding. The Governor proposes to increase spending by $7.3 million General Fund to local health departments for influenza vaccine purchases and immunization programs for elder and at-risk Californians.

Health Care Surge Capacity Funding. The Governor proposes to transition the Department of Public Health's healthcare surge stockpiles and the Emergency Medical Services Authority's mobile field hospitals to "public and private organizations". To do so, he has included $1.8 million GF over two years ($1.3 million in 2011-12 and $560,000 in 2012-13) to support the storage, maintenance, and transportation costs of the transfer. CSAC will provide clarification of this proposal as we receive more information.

Public Health Licensing and Certification. Currently, the state contracts with Los Angeles County to perform licensing and certification of health care facilities. This arrangement is set to expire on June 30 of this year, and under the Governor's May Revision, the state would renew it for one more year (2011-12) and then discuss possibly transferring it to the state in 2012-13. There is not yet a fiscal estimate for this proposed transfer.

California Children's Services (CCS) Program. The Governor's May Revision budget decreases the Family Health Programs Base Estimate by $8.3 million in the current year and $5 million in 2011-12 due to changes in enrollment and benefit treatment costs on the California Children's Services Program, the Child Health and Disability Prevention Program, and the Genetically Handicapped Persons Program.

STATE HEALTH AND HUMAN SERVICES GOVERNMENT RESTRUCTURING

As part of his overall pledge to reign in the deficit and reduce state government costs, Governor Brown has included in his May Revision proposals to eliminate or restructure a bevy of state departments, boards and commissions. The one exception is the creation of a new Department of State Hospitals. We'll begin with the state government changes that are related to the Governor's realignment proposal.

State Government Changes Proposed Due to a Successful Realignment. Should the Governor's proposal to realign some public safety and social services programs to local governments be funded and approved by the voters, he promises to eliminate the Department of Mental Health and the Department of Alcohol and Drug Programs. The state would continue to have federal and oversight responsibilities for these areas, but the departments themselves would be eliminated. The Department of Health Care Services would maintain functions for mental health and substance abuse treatment related to Medi-Cal.

New Department of State Hospitals. Should the Department of Mental Health be eliminated, Governor Brown would also create a new Department of State Hospitals, which would oversee state hospitals. A changing environment in which more patients are committed through the court system, as well as a federal consent judgment to change the state hospital model of treatment, require a continued statewide oversight agency.

Elimination of Boards, Commissions, Task Forces and Offices. The Governor proposes eliminating the following health and human services-related state entities:

- California Privacy Security Advisory Board. The Board develops and recommends privacy and security policies for the new California Health Information Exchange. Instead, committees and task groups will take the place of the Board's 14 members.

- Health Care Quality Improvement and Cost Containment Commission. This Commission, which is inactive, was tasked with researching and recommending changes for promoting high quality care and containing health care costs.

- Commission on Emergency Medical Services. The Commission provides advice to the Emergency Medical Services Authority (EMSA) and approves regulations brought forward by EMSA.

- California Health Policy and Date Advisory Commission. The CHPDAC advised the Office of Statewide Health Planning and Development (OSHPD) on data collection and outcome reporting programs.

- Healthcare Workforce Policy Commission. Designates geographic areas that have a maldistribution of health care services and offers contract advice to the Office of Statewide Health Planning, which will take over its functions.

- Rural Health Policy Council. Serves as an advisory body that examines rural health care policy. The membership is made up of Department Directors in the Health and Human Services Agency, and rural county supervisors sometimes participate.

- Public Health Advisory Committee. Provides advice and makes recommendations on the development of policies to prevent illness and promote public health. The Department of Public Health can obtain this advice from ongoing consultation rather than a formal committee.

- California Medical Assistance Commission. The California Medical Assistance Commission is responsible for negotiating contracts with hospitals, on behalf of the Department of Health Care Services (DHCS) for specific services, under the Medicaid program in California (called Medi-Cal). CMAC would be eliminated on July 1, 2012. Remaining CMAC responsibilities would be transferred to the Department of Health Care Services following implementation of a revised hospital payment structure. The CMAC executive director would report to the Health and Human Services Agency Secretary as of July 1, 2012.

- Rehabilitation Appeals Board. Currently hears appeals from consumers dissatisfied with decisions regarding their eligibility for services. The Board would be eliminated and appeals would be heard by hearing officers.

- Continuing Care Advisory Committee. Advises the Department of Social Services concerning issues related to the continuing care industry. Instead, the Administration recommends DSS convening workgroups as necessary with stakeholder members.

- Managed Risk Medical Insurance Board (MRMIB). Eliminates MRMIB as of July 1, 2012 and the MRMIB executive director would report to the Health and Human Services Agency Secretary as of July 1, 2012. Healthy Families and the Access for Infants and Mothers (AIM) program will transfer to the Department of Health Care Services in 2011-12. In 2012-13, the remaining programs (high risk health insurance purchasing pools and the County Children's Health Initiative Program) would transfer to the Department of Health Care Services.

REALIGNMENT

The Administration has made adjustments to their realignment proposal in the health and human services area.

Mental Health Services for Education Pupils (AB 3632). The May Revision proposes that AB 3632 no longer be realigned to counties, but instead be realigned to school districts.

As such, the Administration is proposing to rebench the Proposition 98 guarantee to reflect the shift in responsibility to schools. This rebenching includes $221.8 million to reflect the shift of responsibility for providing mental health services, including out-of-home residential services, required under federal law from county mental health agencies and county welfare agencies to school districts. The May Revision continues to reflect the $98.6 million in Mental Health Services Act funds (Proposition 63) to county mental health agencies on a one-time basis in 2011-12. School districts will be able to contract with counties to provide services using these Proposition 63 funds but schools will become responsible for any costs exceeding this amount.

Foster Care and Child Welfare Services adjustments include:

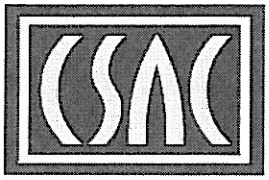
- AB 3632. Reduction of $68 million in Foster Care costs to reflect the fact that AB 3632 residential services will no longer be the responsibility of counties.
- Independent Adoptions. The state will retain responsibility for independent adoptions. Therefore, $1.7 million in realignment funding is being reduced to reflect the ongoing state role. The state does this work in 55 of the 58 counties.
- Agency Adoptions. Realignment will include funding for counties to do agency adoptions. Currently, 28 counties perform this work, with the state doing the work for the balance of counties. $6 million is being provided in realignment for these activities.
- Tribal-State Agreements. The state is retaining $911,000 at the state level to perform Foster Care and Child Welfare Services work for all state-tribal agreements.
- Child Welfare Training activities. The state is retaining $8.2 million to contract for Child Welfare training activities.
- Foster Care Rate Increase. The Foster Care rates reflect an increase of $10.7 million in 2011-12 to increase payment rates for foster family homes as well as prospective Adoption Assistance Payment, Kinship Guardianship Assistance Payments, and Non-

Related Legal payment rates (*Foster Parent Association, et al vs. John A. Wagner, et al* court case).

The Administration is not proposing changes to the remainder of the health and human services elements proposed for realignment. Please recall that the following are included:

- Early Periodic Screening Diagnosis and Treatment (EPSDT) Program
- Mental Health Managed Care (Medi-Cal)
- Drug Medi-Cal
- Drug Courts
- Non Drug Medi-Cal Regular
- Non Drug Medi-Cal Perinatal
- Foster Care
- Child Welfare
- Adoptions
- Adult Protective Services
- Shifting of community mental health funded from 1991 realignment into 2011 realignment
- Funding a higher share of CalWORKs grants with 1991 realignment funds

CWDA



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May 19, 2011

TO: Mark DeSaulnier, Chair, Senate Budget & Fiscal Review Subcommittee No. 3
Members, Senate Budget & Fiscal Review Subcommittee No. 3
Carol Liu, Chair, Senate Budget & Fiscal Review Subcommittee No. 1
Members, Senate Budget & Fiscal Review Subcommittee No. 1

FROM: Kelly Brooks-Lindsey
Legislative Representative, CSAC

Jolena Voorhis
Executive Director, UCC

Frank Mecca
Executive Director, CWDA

Re: Shift Mental Health Services for Special Education Pupils (AB 3632) to Schools – SUPPORT

The California State Association of Counties, Urban Counties Caucus, and the County Welfare Directors Association strongly support Governor Brown's May Revision proposal to shift mental health services for special education pupils (commonly referred to as AB 3632 services) from counties to schools in the 2011-12 fiscal year.

Counties are united in the belief that the Governor's proposal to shift these critical services to schools is a viable, responsible alternative to the recent chaos and uncertainty for students, families, providers, counties and schools that have resulted from former Governor Schwarzenegger's actions. It will also help ensure that the mental health services provided are more closely aligned with educational outcomes. Counties and school districts have already begun the difficult work of transitioning this responsibility from counties to schools since the veto of the funding and it makes sense to build on these efforts. We remain dedicated to continue working with all stakeholders on the transition.

As you know, there have been significant funding issues with the AB 3632 program over the past decade, culminating with Governor Schwarzenegger's veto of the funding in 2010. From 1984 until 2010, counties had been mandated to provide mental health-

related services to public education students, when AB 3632 (W. Brown, Chapter 1747, Statutes of 1984) was enacted. Prior to 1984, school districts were directly responsible for providing all IDEA-required special education services, including mental health-related services, to students with special needs. AB 3632 was subsequently determined to be a reimbursable state mandate, but the state has more often than not failed to fully reimburse counties for their costs in complying with the mandate. When former Governor Schwarzenegger signed the 2010-11 budget, he vetoed the funding for these services and declared the AB 3632 mandate suspended.

Governor Brown's proposal to permanently shift these services to the schools in fiscal year 2011-12 will lead to better outcomes. The proposal will create a stronger connection between the mental health services and student educational outcomes and the school districts will have incentives for cost containment. Further, the Governor's well-thought out proposal includes adequate funding for schools by rebenching the Proposition 98 guarantee to reflect the shift of program responsibilities to schools. The rebenching amount of $221.8 million takes into account the costs of providing mandated mental health educational services as well as out-of-home residential services, which are required under federal law and may be provided by county mental health agencies and county welfare agencies to school districts. The proposal does not alter a student's underlying eligibility for Medi-Cal or a student's ability to access mental health services through the Medi-Cal program.

The May Revision also continues to reflect the $98.6 million in Mental Health Services Act funds (Proposition 63) to county mental health agencies for AB 3632 services. This appropriation is maintained on a one-time basis in 2011-12, and it reflects the state's commitment to the orderly transition of this program from counties to schools.

Over the current fiscal year, school districts have contracted with counties to provide mental health services to students. That model can continue under this budget proposal. Going forward, Governor Brown's proposal will continue to build on the close relationship between county mental health and the schools, and will ultimately ensure that critical services remain available to those students who need them.

For these reasons, our organizations strongly support the Governor's May Revision proposal to shift special mental health education services for pupils to schools in fiscal year 2011-12. Our support includes our commitment to ensure that children with mental health needs in our communities have access to the appropriate high quality mental health and educational services as required by federal law.

Should you have any questions or comments concerning our position, please do not hesitate to contact us. We thank you for your consideration and urge your support.

cc: Diane Van Maren, Consultant, Senate Budget & Fiscal Review Committee
Kim Connor, Consultant, Senate Budget & Fiscal Review Committee
Kirk Feely, Consultant, Senate Republican Caucus
Cheryl Black, Consultant, Senate Republican Caucus
Ana Matosantos, Director, Department of Finance
Diane Cummins, Special Advisor, Department of Finance
Mike Wilkening, Health and Human Services Agency
Cliff Allenby, Interim Director, Department of Mental Health
Marianne O'Malley, Legislative Analyst's Office

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May 20, 2011

The Honorable Mark DeSaulnier
Chair, Senate Budget Subcommittee No. 3
State Capitol, Room 5035
Sacramento, California 95814

SUBJECT: In-Home Supportive Services: Public Authority & County Administration Cuts – OPPOSE

Dear Senator DeSaulnier:

The California State Association of Counties (CSAC) and the Urban Counties Caucus (UCC) oppose Governor Brown's May Revision proposals to reduce funding for the administration of the In-Home Supportive Services (IHSS) program, including a $10 million reduction to public authorities and $5 million for county administration.

The proposals as outlined in the Governor's May Revision Budget would: 1) eliminate more an additional $10 million in funding for the 56 local IHSS Public Authorities statewide, leaving $7.5 million for public authorities statewide and 2) further reduce funding for county administration of IHSS by $5 million General Fund ($12 million total funds).

Public Authorities

As you know, local IHSS Public Authorities were mandated in 1999 with the passage of AB 1682 (Chapter 90, Statutes of 1999) and operational by 2003. Public Authorities now serve as the employer of record for IHSS providers, and perform many of the functions related to the safe and efficient delivery of IHSS at the local level, including providing consumers with the best match of providers. The Public Authorities operate with a mix of state, federal, and county funds, but the state portion of the funding is absolutely necessary to their survival.

The May Revision proposes to reduce Public Authority funding by an additional $10 million, leaving just $7.5 million statewide for Public Authority functions. Three years ago $57 million was provided to Public Authorities statewide. The level of funding is so diminished that some public authorities will have insufficient funds to remain viable.

If a local Public Authority ceases operation due to this proposed budget cut, it raises serious issues about what entity becomes the employer of record for IHSS absent the public authority. CSAC is consulting county counsels about the ramifications of a public authority ceasing operation. One scenario may include a county becoming the employer of record in the absence of the Public Authority. If counties become the employer, there will be direct cost shift to counties. The amount that the state and federal governments will share in for wages and benefits is very different for public authorities than for counties as employers ($12.10 per hour versus minimum wage + 5.31%). It is for these reasons that CSAC and UCC oppose Governor Brown's proposal.

County Administration of IHSS

Counties provide both eligibility determination and assessment for the types and numbers of hours of service for eligible clients. Counties receive funding for a specific number of hours of social worker time. However, the number of hours does not reflect the amount of social worker time needed to determine eligibility and assess the types and numbers of hours of service. Caseload adjustments are funded at 2000-01 costs. The Governor is proposing an additional cut of $5.2 million ($12.6 million all funds). This will further strain county ability to do timely determinations and assessments and meet other workload demands. Counties oppose this reduction.

For the reasons outlined above, CSAC and UCC are opposed to the reductions and urge you to reject them. Should you have any questions or comments concerning our position, please do not hesitate to contact Kelly Brooks-Lindsey of CSAC at 327-7500 Ext. 531 or kbrooks@counties.org, or Jolena Voorhis of UCC at 327-7531 or Jolena@urbancounties.com. Thank you for your consideration.

Sincerely,

Kelly Brooks-Lindsey
CSAC Legislative Representative

Jolena Voorhis
UCC Executive Director

cc: Members, Senate Budget Subcommittee No. 3
Jennifer Troia, Consultant, Senate Budget and Fiscal Review Committee
Chantele Denny, Consultant, Republican Senate Caucus

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May 19, 2011

The Honorable Mark DeSaulnier
Chair, Senate Budget & Fiscal Review Subcommittee No. 3
State Capitol, Room 5035
Sacramento, California 95814

Re: Governor's May Revision Proposal: Shift Healthy Families Children to Medi-Cal – SUPPORT IN CONCEPT

Dear Senator DeSaulnier:

The California State Association of Counties (CSAC) is writing in support of Governor Brown's May Revision proposal to move children currently served by the Healthy Families Program into the Medi-Cal program. Counties are supportive of the policy to move more children into Medi-Cal and consolidate state health programs. The May Revision proposal is the first step in the discussions that need to occur in California about how individual health programs may change or merge prior to implementation of federal health care reform. Counties applaud Governor Brown for beginning this dialogue. Counties know there will be numerous technical issues to work through regarding this proposal and look forward to participating in these discussions.

Counties will be impacted by the shift in a number of ways – as the entities conducting Medi-Cal eligibility determinations, as the county mental health plans providing Early Periodic Screening Diagnosis and Treatment (EPSDT) services, as the entities administering the California Children's Services (CCS) program, and as health care providers.

The Affordable Care Act (ACA) expands Medicaid eligibility for children up to 133 percent of the federal poverty level (FPL) starting in 2014. The Governor's proposal would implement this provision of federal health reform early in California and takes the additional step of transitioning all Healthy Families children to Medi-Cal. Under the proposal, children with family incomes below 150 percent of FPL would be exempt from cost sharing (no premiums or co-pays). Under the Administration's proposal, the March 2011 co-pay and premium increases will still be applicable to children with family incomes between 150-250 percent of FPL. By providing Medi-Cal instead of Healthy Families, children will be entitled to a more comprehensive benefit package that includes services such as Early Periodic Screening Diagnosis and Treatment (EPSDT).

Eligibility. Counties will be critical partners in providing Medi-Cal eligibility determinations and enrolling this group of children in the Medi-Cal program. The Governor's proposal would maintain a Single Point of Entry (run by Maximus) where applications would be transmitted electronically to county human services departments for eligibility determinations. County human services departments also would accept applications directly, as under current rules. As proposed, Maximus would be responsible for premium collection for the 150 to 250 percent FPL cases, with county human services departments conducting eligibility determinations and annual redeterminations for those cases. To the extent that current processes will change, it will be important for counties to provide input, along with other key stakeholders, on issues such as premium deductions, case management, automation needs, and the role of the Single Point of Entry. There may be streamlining and more effective use of technology that can be achieved.

Early Periodic Screening Diagnosis and Treatment (EPSDT). The Governor's proposal will provide EPSDT services to children up to 250 percent of the FPL. These services are more comprehensive than the behavioral health benefits under the Healthy Families Program which are specified under 1991 Realignment and thus provided by counties subject to available

resources. Counties have identified a technical issue with the Administration's proposal. The Administration's 2011-12 appropriation to counties for EPSDT services in AB 100 (Statutes of 2011) does not include funding for the increased caseload related to the shift. Additionally, the Administration's 2011 Realignment proposal does not take into account increased EPSDT caseload due to the shift. Counties will need to work with the Legislature and Administration to be sure funding is providing for this entitlement. Providing an accurate estimate for EPSDT caseload will be especially critical to make the Realignment proposal workable in the long-term. Counties also want to ensure that county mental plans are able to access Title XXI federal matching funds at the enhanced FMAP for services for this group of children.

California Children's Services (CCS). Counties currently share in costs for the California Children's Services. Since trailer bill language is not available, it is not clear what the Administration is proposing. Implementing statute will need to specify that county financial obligations for CCS are not increased beyond the current requirements in Health and Safety Code 123940.

Substance Use Disorder Treatment. There is a limited benefit under Healthy Families for adolescents in need of alcohol or other drug treatment services. Unfortunately, access to these services has been problematic, and out of the thousands of eligible adolescents in California who are in need of substance use disorder treatment, less than 100 annually have been able to access services. Moving these children into the Medi-Cal program should enable them to receive treatment services that are more accessible and comprehensive than the benefits under the Healthy Families Program.

Access. Counties are aware that some children may either lose their current provider or their current health plan with the transition from Healthy Families to Medi-Cal. Some providers accept Healthy Families but not Medi-Cal. Some plans that are offered in Healthy Families may not be offered in Medi-Cal. As a result, there may be continuity of care and access issues, particularly in rural areas. Further discussion and deliberation will be required to mitigate access issues.

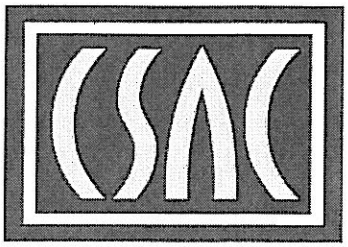
In closing, counties are supportive of the policy of moving children from the Healthy Families Program into Medi-Cal. It is imperative that counties be included in the planning and implementation process for transitioning children into Medi-Cal. Please do not hesitate to hesitate to contact me at 916-327-7500, ext. 531 or kbrooks@counties.org if you have additional questions about our support in concept position. Thank you.

Sincerely,

Kelly Brooks-Lindsey
Legislative Representative

cc: Members, Senate Budget & Fiscal Review Subcommittee No. 3
Diane Van Maren, Consultant, Senate Budget & Fiscal Review
Kirk Feely, Consultant, Senate Republican Fiscal
Diana Dooley, Secretary, California Health & Human Services Agency
Toby Douglas, Director, Department of Health Care Services
Ana Matosantos, Director, Department of Finance
Lisa Mangat, PBM, Department of Finance
Garreth Elliot, Legislative Affairs, Governor's Office

CWDA



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May 19, 2011

To: The Honorable Mark DeSaulnier
Chair, Senate Budget Subcommittee No. 3

Honorable Members
Senate Budget Subcommittee No. 3

From: Kelly Brooks
Legislative Representative
California State Association of Counties

Frank J. Mecca
Executive Director
County Welfare Directors Association of CA

RE: LEADER Replacement System – REJECT SUSPENSION

The California State Association of Counties (CSAC) and the County Welfare Directors Association of California (CWDA) urge you to reject the Governor's May Revision proposal to indefinitely suspend the planning and procurement of the Los Angeles Eligibility, Automated Determination, Evaluation, and Reporting (LEADER) Replacement system. We recognize the magnitude of the State's projected 2011-12 budget deficit and the shared sacrifice required to balance the budget while preserving core state services. However, suspension of this project is short-sighted, more costly over the long term, and will have negative consequences for both the thousands of workers and millions of program beneficiaries in Los Angeles County.

LEADER supports the case management for CalWORKs, CalFresh, Cash Assistance for Program for Immigrants (CAPI), Medi-Cal, General Relief, and associated public assistance programs. There are over one million active public assistance cases (2.4 million beneficiaries) handled by LEADER and over 16,000 users of the system. LEADER processes eight million transactions daily and $3 billion in assistance annually. Original system development began in 1995 and was completed in 2001. The current LEADER technology is over 25 years old, relying on an outdated architecture and unsupported software, and is falling far behind in meeting user and beneficiary needs. LEADER experienced 177 system outages impacting 1,200 users over a three-year period. It is also extremely cumbersome and expensive to modify to meet changing state requirements, relative to the latest, web-based system architecture.

Furthermore, LEADER is a proprietary system, running only on Unisys servers. In 2008, at federal insistence, Los Angeles County attempted to generate competition for maintenance of LEADER, but could not identify any

vendors willing to host the system. The United States Department of Agriculture (USDA) and the Centers for Medicare and Medicaid Services (CMS) have expressly rejected sole source extensions of maintenance of LEADER past 2015.

Based on the overwhelming need for a more responsive, functioning, and competitive system, a request for proposals was released in November 2007 to procure the LEADER Replacement system. After completion of the competitive bid process, a new vendor was selected for having the best solution and greatest overall proposal score. The LEADER Replacement system will use the latest, web-based architecture and will have open standards (i.e., it will not be a proprietary system, allowing for competition in the maintenance of the system). System performance will be vastly improved, there were be far fewer points of system failure, and the system will be more agile and efficient to modify to accommodate changing state requirements. Approximately $6 million has already been spent over the past six years for planning and procurement of the LEADER Replacement system. LEADER Replacement has been consistently supported as necessary by the Legislative Analyst's Office, the Legislature, and until this May Revision, the State.

The indefinite suspension of the LEADER Replacement system effectively cancels the project, wasting years of planning and millions of dollars. Suspension will require extension of the current, expensive sole-source contract for maintenance of the current system with Unisys past 2015, even though federal authorities have indicated that they would not approve such an extension. And continued prolonged use of the current LEADER system substantially risks the timely and accurate delivery of benefits to more than 2.4 million individuals in Los Angeles County. Therefore, CSAC and CWDA respectfully request that you reject the Administration's proposal to indefinitely suspend the LEADER Replacement system.

Thank you for this opportunity to express our concerns. If you have any questions, please contact Frank Mecca at (916) 443-1749 or fmecca@cwda.org, or Kelly Brooks at (916) 327-7500 ext. 531 or kbrooks@counties.org.

cc: Jennifer Troia, Consultant, Senate Budget Committee
Chantele Denny, Consultant, Senate Republican Fiscal Office
Myesha Jackson, Office of The Senate President Pro Tempore
Garreth Elliott, Office of Governor Jerry Brown
Mike Wilkening, Health and Human Services Agency
Lisa Mangat, Department of Finance
Will Lightbourne, Director, Department of Social Services
Patricia Huston, Department of Social Services
Todd Bland, Legislative Analyst's Office
Erika Li, Legislative Analyst's Office
County Caucus

URBAN COUNTIES CAUCUS

California State Association of Counties | **Urban Counties Caucus** | **County Health Executives Association of California**

May 20, 2011

TO: The Honorable Mark DeSaulnier, Chair, Senate Budget SubCommittee No. 3 and Members, Senate Budget SubCommittee No. 3

FROM: Kelly Brooks, Legislative Representative, CSAC
Jolena Voorhis, Executive Director, UCC
Judith Reigel, Executive Director, CHEAC

Re: Medi-Cal Waiver: Cuts to Public Hospital Systems – OPPOSE

The California State Association of Counties (CSAC), the Urban Counties Caucus (UCC) and the County Health Executives Association of California (CHEAC) are opposed to the Governor's May Revision proposals to cut $130 million from public hospital systems.

Specifically, the May Revision proposes two major reductions:

- Cuts $95.2 million in Medi-Cal Waiver funds for public hospital systems. These federal dollars would have been used to help care for the state's uninsured population but under the May Revision these are redirected to the State.

- Redirects $34.2 million that public hospitals have received for the past few years to provide a modest enhancement in reimbursement for Med-Cal services. This funding is critical to meet the demands of those that have lost their jobs and insurance due to the economic crisis.

Both of these cuts reduce the ability of public hospitals to accomplish the goals of the recently approved 1115 Medi-Cal Waiver to expand access to care, improve quality and contain costs. CSAC, UCC and CHEAC participated in the Waiver discussions and we have been clear that federal funds pulled down by county certified public expenditures (CPEs) should be used for county delivery system improvements.

In conclusion, this reduction would have a devastating impact on county hospitals at a critical juncture in the bridge to health care reform. Counties cannot continue to provide these critical services and increase our service delivery when additional cuts and changes are made to the previously negotiated Waiver.

For these reasons, we urge you to reject this proposal. Please do not hesitate to contact us if you have any questions: Kelly at CSAC – 327-7500 Ext. 531, Jolena at UCC – 327-7531, Judith at CHEAC – 327-7540. Thank you.

cc: Jennifer Troia, Consultant, Senate Budget and Fiscal Review Committee
Chantele Denny, Consultant, Republican Senate Caucus
Ana Matosantos, Director, Department of Finance

Attachment Five

CSAC Memo: Federal Update: Medicaid

Article: "Senators decry Medicaid block-granting," *NACo County News*, May 9, 2011 (Supervisor Kniss appears on the far left in the bottom photo), 2 pages.

Photo Spread: "County officials meet with Obama Administration," *NACo County News*, May 9, 2011, 2 pages.

CSAC Letter to President Obama Opposing Medicaid Changes: May 16, 2011

California Congressional Democrats' Letter to President Obama: May 16, 2011

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May 25, 2011

To: CSAC Health and Human Services Policy Committee

From: Kelly Brooks-Lindsey, Legislative Representative
Farrah McDaid Ting, Senior Legislative Analyst

Re: Federal Update: Medicaid

Overview. California county supervisors have been active on a number of federal issues in 2011. Perhaps the single largest issue has been CSAC and NACo's opposition to Congressional efforts to convert Medicaid funding to a block grant-based system to states.

Background. The proposal to convert Medicaid funding to states to a block grant model was first introduced in early April as part of the House Republican Budget Proposal, commonly referred to as Rep. Paul Ryan's budget. Rep. Ryan's plan would convert Medicaid into a block grant to the states that would grow each year based on population growth and inflation. He estimated it would halve federal Medicaid spending by 2030 and save the federal government $771 billion over the next decade. While the proposal would give states full responsibility for their Medicaid costs, it would significantly cut funds for the program, which would result in states cutting provider payments rates and reducing the benefits package.

In California, block granting or capping Medicaid funding would shift significant costs to counties, especially since the state already maintains a lean Medicaid program. According to the California Health Care Foundation, "Overall, Medi-Cal fees were 83% of the Medicaid national average in 2008. California's fees rank 47th overall among states when adjusted for geographic differences in the cost of providing medical care. Among the ten largest state Medicaid programs, California ranks 9th."

On May 20th, Senators Tom Coburn (R-OK), Richard Burr (R-NC), and Saxby Chambliss (R-GA) released a new proposal to reform the Medicaid program. Their proposal would create a block grant for most of Medicaid starting in 2013. Just about all services provided under Medicaid and the Children's Health Insurance Program (Healthy Families Program in California) would be included in these grants, with the exception of acute care for low-income elderly individuals and the disabled, who would be held harmless or enrolled into managed care. The proposal would also repeal the Patient Protection and Affordable Care Act, except for the fraud provisions, and give states incentives to limit medical malpractice costs.

The funding levels for the Medicaid block grant would be based on total Medicaid spending in 2010 (excluding stimulus money), with the allocations to states based on the number of residents who are at or below the Federal Poverty Level. Once the initial block grants are made in 2013, they would be adjusted by changes population and inflation, just like the Proposal.

County Involvement. On May 4, the National Association of Counties sponsored a "Save Medicaid" event at the U.S. Capitol on May 4, in which Santa Clara County Supervisor and CSAC Health and Human Services Policy Committee Chair Liz Kniss participated (see attached photos). California County Supervisors also participated in a special briefing by the

Obama Administration on May 3, including Supervisor Kniss and Sonoma County Supervisor Shirlee Zane (photo attached).

CSAC also sent a letter to President Obama opposing any efforts to block-grant or cap Medicaid funding on May 16.

Additional Federal HHS Issues. Counties also continue to be active on the implementation phase of the state's $10 billion over 5 years "Bridge to Reform" Section 1115 Medicaid waiver, as well as state and federal efforts to plan for the implementation of the Patient Protection and Affordable Care Act.

Attachments:

- Article: "Senators decry Medicaid block-granting," *NACo County News*, May 9, 2011 (Supervisor Kniss appears on the far left in the bottom photo), 2 pages.
- Photo Spread: "County officials meet with Obama Administration," *NACo County News*, May 9, 2011, 2 pages.
- CSAC Letter to President Obama Opposing Medicaid Changes, May 16, 2011

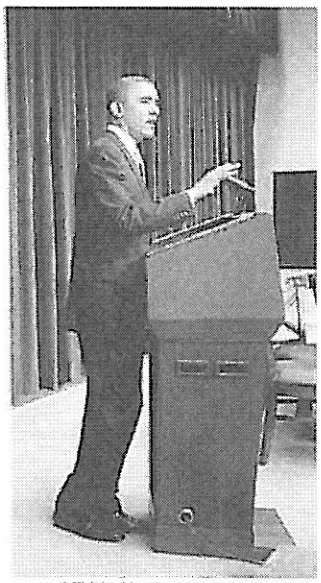
NACo National Association of Counties
County News
The Voice of America's Counties
NATIONAL ASSOCIATION OF COUNTIES ■ WASHINGTON, D.C. VOL. 43, NO. 9 ■ May 9, 2011

Obama meets with county delegation

By Beverly Schlotterbeck
EXECUTIVE EDITOR

A delegation of 90 county leaders, led by NACo President Glen Whitley, heard from President Barack Obama, Vice President Joe Biden and five Cabinet-level officials at a special White House briefing and dialogue on county issues, May 3.

The day ended with an appearance and remarks from President Obama, who opened on a serious note, extending his sympathies to anyone in the delegation whose county had been affected by the devastating outbreak of tornadoes a week earlier. He next acknowledged the tough decisions county officials make everyday and pledged his support to help them balance their budgets in a balanced way.



Official White House Photo by Pete Souza

President Barack Obama delivers remarks at a briefing for the National Association of Counties in the South Court Auditorium in the Eisenhower Executive Office Building, May 3. The audience is reflected in a mirror at left.

He talked about administration efforts to reduce regulatory and administrative burdens so counties can focus on achieving better outcomes at a lower cost. He repeated his support for the Affordable Care Act, noting there will be a need to show some flexibility as the states move forward with their plans.

He said that contrary to rumors he believes that states, and counties and cities can do their jobs, and the administration can help by facilitating best practices and getting resources in the right place.

He ended by referring to his announcement on Sunday, May 1 about the death of Osama bin Laden, noting that many people were moved by what the event symbolized. But what the event also symbolized, he said, is America's ability to accomplish its goals when the country puts it mind to it.

Before he left the stage he took time to sign Coconino County, Ariz. Supervisor Liz Archuleta's copy of "Of Thee I Sing: A Letter to My Daughters," which he co-authored with illustrator Loren Long.

The afternoon meeting at the Eisenhower Executive Office Building was arranged by the White House and featured a high-level lineup of administration experts and leaders who participated in three

See **DELEGATION** *page 8*

QuickTakes

5 Counties with the Highest TPI
(Total Personal Income / 2009)

	Figures in Billions
Los Angeles County, Calif.	$402.46
Cook County, Ill.	$244.06
Harris County, Texas	$196.78
Orange County, Calif.	$148.37
Maricopa County, Ariz.	$142.01

Source: U.S. Bureau of Economic Analysis, 2011

Senators decry Medicaid block-granting

By Charlie Ban
STAFF WRITER

U.S. Sen. Jay Rockefeller (D-W.V.) led six colleagues in voicing opposition to a U.S. House budget bill that would block-grant Medicaid at a rally that topped off a full day of Capitol Hill visits for NACo's Large Urban County Caucus. LUCC leaders were in Washington, D.C for their annual spring fly-in.

Sens. Jeff Bingaman (D-N.M), Jeff Merkley and Ron Wyden (D-Ore.), Al Franken (D-Minn.), Richard Blumenthal (D-Conn.) and Bernie Sanders (I-Vt.) decried the budget proposed by Rep. Paul Ryan (R-Wis.) May 4 at a rally in the Senate Visitors Center.

"All of life can desert you, all

See **MEDICAID** *page 8*

Photo by Jim Philipps

LUCC Chair Ilene Lieberman kicks off the Save Medicaid event at the U.S. Capitol May 4. Pictured left to right: Supervisor Liz Kniss, Santa Clara County, Calif.; NACo Executive Director Larry Naake; Commissioner Sharon Barnes Sutton, DeKalb County, Ga.; NACo Past President Don Stapley, Maricopa County, Ariz.; Sen. Richard Blumenthal (Conn.); Lieberman, Broward County, Fla.; Sen. Jay Rockefeller (W. Va.); LUCC Vice Chair Jim McDonough, Ramsey County, Minn.; Sen. Ron Wyden (Ore.); and Sen. Bernie Sanders (Vt.).

Mark Craft installed as new NACE president

Mark A. Craft was installed as president of the National Association of County Engineers (NACE) at its 2011 Annual Management and Technical Conference in Minneapolis April 17–21. He is engineer manager of the Gratiot County, Mich. Road Commission.

Highlights of the opening ceremonies included remarks from Sen. Amy Klobuchar (D-Minn.) and Mike Opat, chair, Hennepin County, Minn. Board of County Commissioners. Remarks were provided at the General Legislative Session from NACo President Glen Whitley, county judge, Tarrant County, Texas; John Horsley, executive director, American Association of State Highway and Transportation Officials; Tom K. Sorel, commissioner, Minnesota Department of Transportation and Robert J. Fogel, senior legislative director, NACo.

Craft has served in county engineering for the past 23 years. He has been the county engineer and the managing director for all operations of the Gratiot County Road Commission since 2006. He and his staff are responsible for the management of 1,183 miles of roadway and 120 bridges.

Prior to joining the Gratiot County Road Commission, Craft spent 17 years serving the Eaton County Road Commission in Charlotte, Mich. He previously has served as NACE president-elect, secretary-treasurer and Michigan's state director to the NACE Board and is a member of the County Road Association of Michigan.

He holds a B.S. in civil engineering from Michigan State University and earned his Master's in Business Administration from Western Michigan University. He is also a registered professional engineer in the state of Michigan. Active in local community activities, he and his wife Colleen have three children.

Other officers elected or installed included Richie Beyer, county engineer, Elmore County, Ala. as president-elect; Mark K. Servi, highway commissioner, Barron County, Wis. as secretary-treasurer; Ramon D. Gavarrete, county engineer, Highlands County, Fla. as Southeast Region vice president; Duane J. Ratermann, county engineer, Knox County Ill. as North Central Region vice president; Jon F. Rice, managing director, Kent County Road Commission, Mich. as Northeast Region vice president; George A. Johnson, director of transportation and land management Agency, Riverside County, Calif. as Western Region vice president, and Tom Stoner, county engineer, Harrison County, Iowa as South Central Region vice president.

Additionally, Gregory A. Isakson, county engineer, Goodhue County Minn. was selected as Rural County Engineer of the Year, and James W. Piekarczyk, county engineer; Kankakee County Ill. was selected as Urban County Engineer of the Year. Heather Smith, assistant engineer, Barry County, Mich. Road Commission was selected the Project/Program Manager of the Year.

The National Association of County Engineers, with approximately 1,900 members in 50 states and Canada, has a four-fold objective:

- to advance county engineering and management by providing a forum for the exchange of ideas and information,
- to foster and stimulate the growth of individual state organizations of county engineers,
- to improve relations and the spirit of cooperation among county engineers and other agencies in the solution of mutual problems, and
- to monitor national legislation affecting county transportation and public works departments and through NACo, provide NACE legislative opinions.

White House cabinet officials fielded questions

DELEGATION *from page 1*

panel sessions and Q&A sessions.

The day opened with remarks from Ron Sims, former King County, Wash. executive and now HUD deputy secretary. The popular, effervescent Sims drew a large group of well wishers as he mingled with the county officials before his formal introductions of the day's first panelists.

The panel discussions alternated with remarks from DHS Secretary Janet Napolitano, and Heath and Human Services Secretary Kathleen Sebelius. Vice President Biden, who soon abandoned the lectern and the stage in favor of a closer engagement with the audience, followed them.

He worked the room like a popular professor, entertaining but also offering sober reflections on the country's economy, future as a world economic leader and the two visions of America that are driving the current deficit debate.

The three panel sessions explored major domestic issues that critically affect counties. Transportation Secretary Ray LaHood, HUD Secretary Shaun Donovan and EPA Administrator Lisa Jackson handled panelist duties for the Infrastructure and Sustainable Communities session. Assistant Attorney General Laurie Robinson; Pamela Hyde, Substance Abuse and Mental Health Services Administration head; and John Linton, director, Office of Correctional Education, Department of Education fielded questions for the "Breaking the Cycle of Jail And Poverty" panel.

The final panel, "Health Reform Implementation and Medicaid," prompted the most comments and questions from county officials, many of whom expressed concern about the future of Medicaid and public hospitals. Cecilia Munoz, White House Office of Intergovernmental Affairs director, moderated the panel, which included Cindy Mann, deputy administrator, Center for Medicaid, CHIP and Survey and Certification at the Centers for Medicare and Medicaid Services, HHS; and Jeanne Lambrew, deputy assistant to the president for health policy, White House Domestic Policy Council.

Senators frame Medicaid preservation as moral and responsible to counties

MEDICAID *from page 1*

of fortune can desert you, all of opportunity can desert you, but Medicaid does not, as it currently stands," Rockefeller said. "If you turn Medicaid into a block grant, and you force it onto the counties or the states, they will do what they have to do and raise property taxes, and they will do it because they care about these people, because otherwise they are helpless."

Rockefeller, the ranking Democrat on the Senate Finance Committee, pledged his opposition to a budget that block-granted or capped Medicaid, but warned that the Ryan budget was not the worst-case scenario.

"Poor people don't vote, don't organize, and those who don't like them do organize, they're a vulnerable target," he said. "It's a heartless town, and this is a heartless budget, but frankly, some of the amendments that are being offered in the Senate are even worse than the House budget."

Wyden pointed out the illusory nature of the Medicaid proposal.

"These state block grants proposals are not about flexibility, they are a mirage," he said. "They are a back-door cost shift on the local governments that are already walking on an economic tightrope."

Sanders, a staunch single-payer health care supporter, said "What we're talking about when we talk about slashing Medicaid is a death sentence for God-knows how many thousands of Americans."

LUCC Chairwoman Ilene Lieberman, Broward County, Fla. commissioner, pointed out that the health problems of Medicaid-qualified people don't go away just because Medicaid has been capped or block-granted. She mentioned that in 23 states, counties are required to provide health care services to low-income residents.

"This is why we are alarmed by proposals like those in the House-passed Budget Resolution which would turn Medicaid into a block grant — or other proposals to cap Medicaid," she said. "We fear that what looks like helpful Medicaid 'flexibility' in Washington and Tallahassee may be experienced quite differently out in our counties.

"In fact, Medicaid 'savings' for the U.S. Treasury on the scale proposed by the House budget would necessarily require deep cuts to eligibility and benefits, reimbursements to public and private providers — and terrible choices for county officials. Commissioners would be forced to cut local services or to raise property taxes to sustain them. Both options will harm people and put a drag on our fragile economy."

Lieberman was joined at the rally by NACo board of directors member Tim McCormick, commissioner, Ohio County, W. Va. McCormick said for 50 years Medicaid has been the way resources have been deployed to ensure a basic level of health care security for the country's most vulnerable low-income children, seniors and disabled.

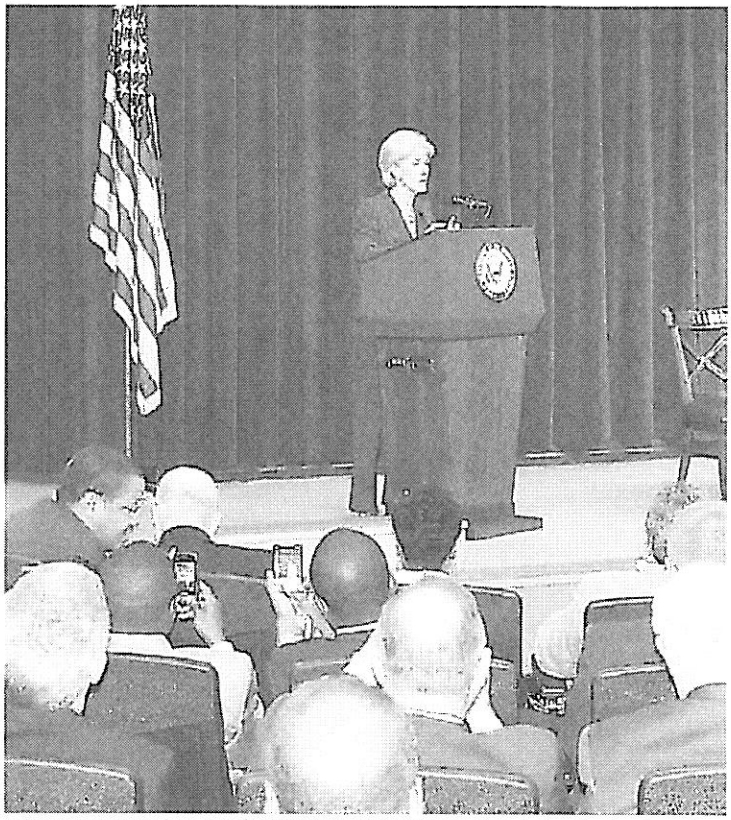
"The deep pockets of persistent poverty in rural America made Medicaid a literal lifeline for many in our communities," McCormick said. "Rural residents—both those under 65 years of age and seniors — are more likely to be enrolled in Medicaid compared to their urban counterparts.

"Rural residents, and especially in Appalachia, face substantial challenges in terms of health outcomes and access to health care," McCormick said. "The deep cuts that would be required to achieve the savings called for in the House-passed budget or in the artificial spending caps under discussion would make an already bad situation much, much worse."

(NACo Media Relations Manager Jim Philipps contributed to this report.)

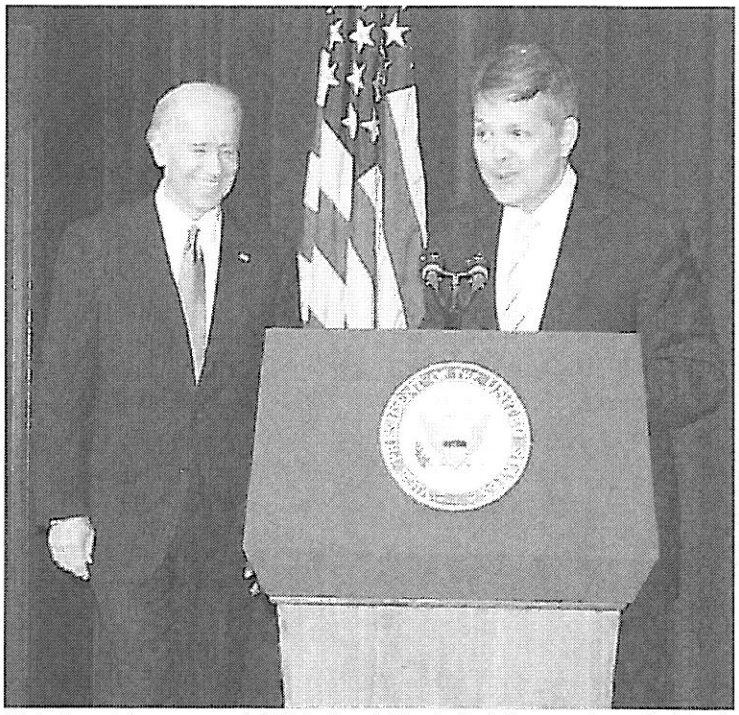
County officials meet with Obama administration

Department of Homeland Security Secretary Janet Napolitano talked about DHS' "See Something. Say Something" campaign, Fusion Centers and FEMA efforts to provide better response at disaster sites through local liaisons.

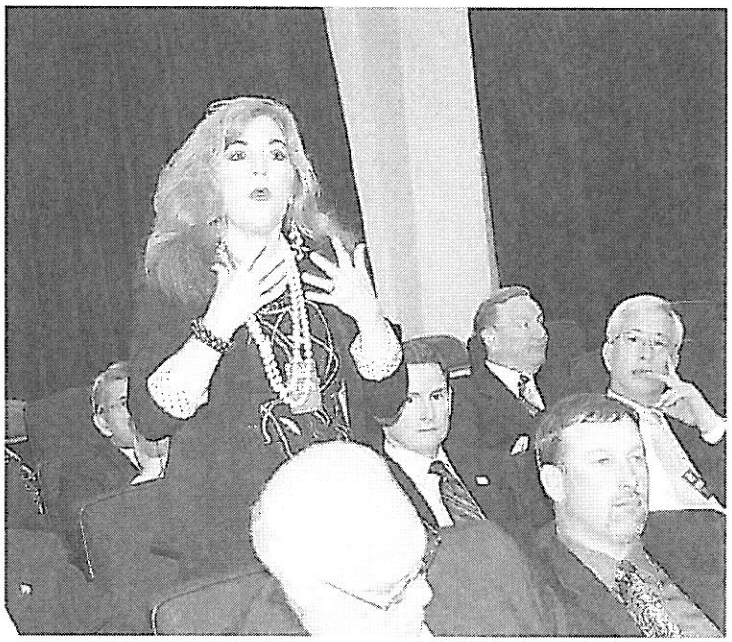


HHS Secretary Kathleen Sebelius takes her turn at the lectern during the five-hour-long meeting with top administration officials.

Cook County, Ill. Board President Toni Preckwinkle engages the health care implementation panel in a discussion about Medicaid.

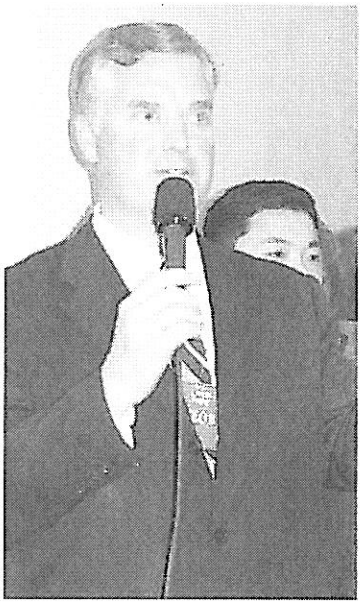


White House Intergovernmental Affairs Deputy Director David Agnew, who worked closely with NACo in organizing the day's events, introduces Vice President Joe Biden.



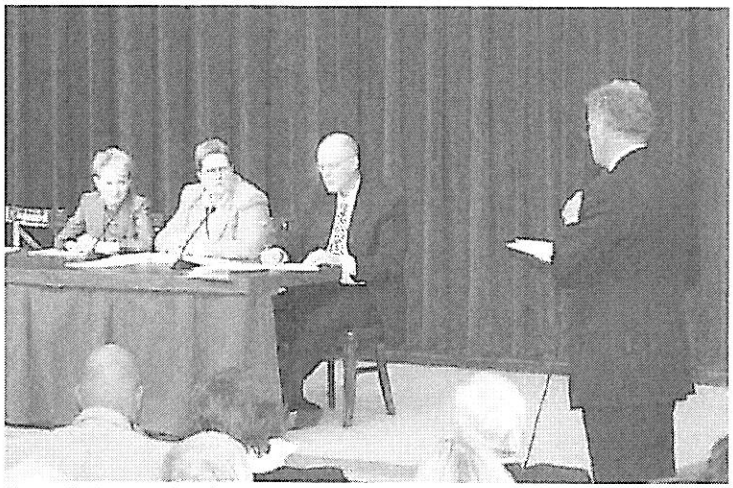
Sonoma County, Calif. Supervisor Shirlee Zane takes a turn at questioning the health reform implementation panel.

County officials meet with Obama administration



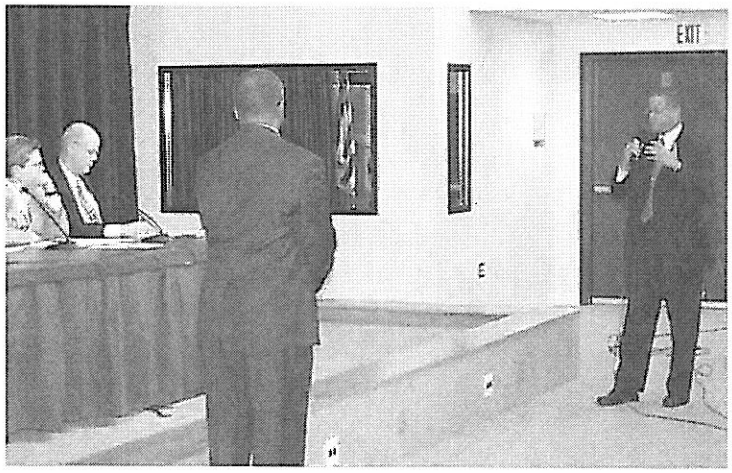
Salt Lake County Mayor Peter Corroon questions the panel on infrastructure and sustainability.

(Above) County officials line up for their turn at the mic. Each panel fielded comments and questions. Over the course of the afternoon, panelists responded to more than 50 questions or comments.



Hennepin County, Minn. Commissioner Peter McLaughlin (r) tells administration officials on the Breaking the Cycle of Jail & Poverty panel that his county is "getting crunched" by rising corrections costs. Panel members included (l-r) Assistant Attorney General Laurie Robinson; Pamela Hyde, Substance Abuse and Mental Health Services Administration head; and John Linton, director, Office of Correctional Education, Department of Education.

Audience members listen to Health and Human Services Secretary Kathleen Sebelius.



Fulton County, Ga. Commission Chair John Eaves suggests to members of the jail and poverty panel that the correctional system is dealing with the shortcomings of educational systems and that there is a need for an "early warning" system to identify, at a very young age, children who are at risk of failing.

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May 16, 2011

President Barack Obama
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear President Obama:

The California State Association of Counties (CSAC) appreciates your steadfast support for the Medicaid program and urges you to continue to oppose Congressional efforts convert it into a block grant. Ranging from Alpine with a little more than 1,200 people, to Los Angeles with more than 10 million, our 58 member counties share many common issues, including serving as the foundation of California's safety net. Under California law, counties are responsible for providing services to the medically indigent. We view Medicaid (known in California as Medi-Cal) as a partnership between the federal, state and local governments.

Given our health delivery responsibilities and financial stake, California's counties support continuous system innovation and reform. Our elected and appointed officials are working closely with the state to implement our five-year, $10 billion "Bridge to Reform" Section 1115 federal Medicaid waiver. Through the waiver, we will be advancing Medi-Cal program changes to help us smoothly launch the Affordable Care Act reforms taking effect in January 2014.

A Medicaid block grant or fixed cap will shift costs to counties. The Congressional Budget Office estimates that federal Medicaid contributions would decrease by 35 percent nationally within ten years. The Kaiser Family Foundation estimates that California would lose 41 percent of its federal support by 2021. Any Medicaid reforms should preserve safety net services and must not shift the burden of providing uncompensated care to safety net providers, especially county health systems. 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.

Cutting the program that drastically cannot occur without denying federal or state-supported care to millions of our state's residents. Medicaid is already a 'lean' program and those losing coverage would have nowhere to turn except to already stressed county and community-based facilities. Moreover, such cuts could have a disproportionate effect on seniors and persons with disabilities. Families USA estimates that Medicaid funds nearly 69,000 seniors in nursing homes and provides home and community-based support to 517,000 seniors and persons with disabilities in our state. While Medicaid is commonly perceived as supporting only low-income families, it is also the foundational health insurance program supporting middle class families whose loved ones are no longer able to afford the intensive health care and community supports they need.

For these reasons, we urge you to continue to reject any efforts to cut or otherwise block grant the program and will continue to support you in that fight.

Sincerely,

Paul McIntosh
Executive Director

Congress of the United States
Washington, DC 20515

May 16, 2011

President Barack Obama
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear President Obama:

We are writing to highlight how important Medicaid is for seniors in nursing homes. Roughly two-thirds of Medicaid funding goes to the frail-elderly who have exhausted their assets and are forced to turn to Medicaid to pay for nursing homes. The Republican budget that passed the House of Representatives on April 15th (Roll No. 277) turns Medicaid into a block grant system. Under a block grant system, Medicaid will no longer be able to support the elderly. Where will the elderly in nursing homes go? We hope that during your negotiations you will continue to fight against block granting or cutting funding for Medicaid. We have also enclosed a letter from the California State Association of Counties that echoes our concerns.

The Medicaid program has been an effective partnership between state and federal governments for our most vulnerable by providing services at the most affordable rate. Although children and parents make up about 75 percent of Medicaid enrollees, **they account for less than a third of the spending.** In contrast, the elderly and individuals with disabilities make up about 25 percent of enrollees **but about two-thirds of spending**. This translates in California, according to a recent Families USA report, to helping fund nearly 69,000 seniors in nursing homes and providing nearly 517,000 seniors and persons with disabilities with Medicaid home and community service support. Additionally, the report showed that 23% of seniors and 50% of persons with disabilities in the state of California receive Medicaid funding.

By converting the current Medicaid system into a block grant indexed to inflation and population growth, Congress would shift the burdens of rising health care costs and an aging population onto the states. Within a decade, according to the Congressional Budget Office, federal contributions to Medicaid would decrease by nearly 35 percent under a block grant system. According to a recent Kaiser Family Foundation report, this would lead to a loss of nearly $122 billion in federal Medicaid funds in California, leading to cuts in benefits and more restrictive eligibility requirements.

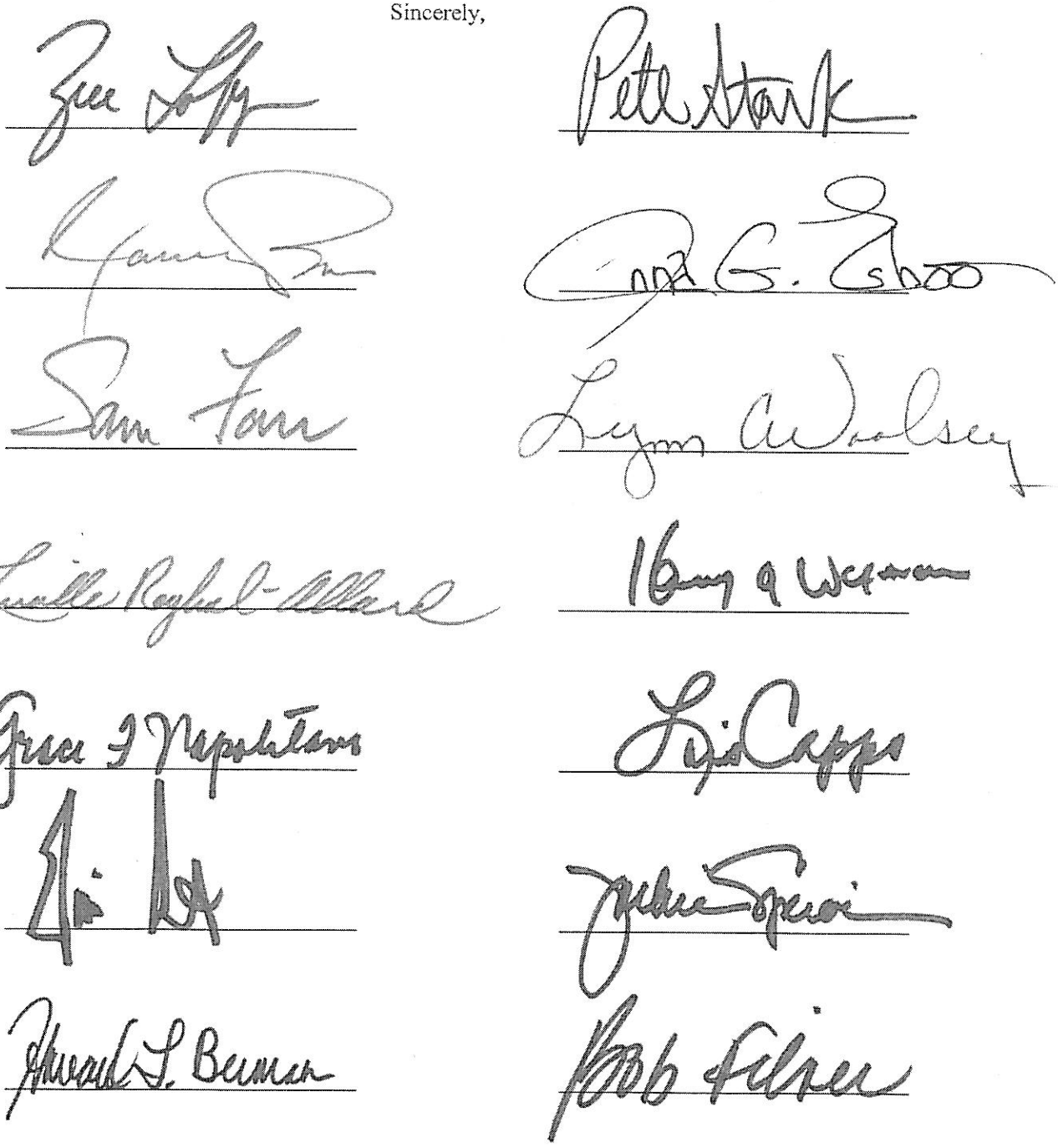
If you sign any such legislation into law, California could see nearly 5 million more uninsured residents by the end of the decade. While we agree on the need to address the nation's long-term deficits, shifting the costs of Medicaid expenditures such as nursing facilities and hospice care onto individuals not only creates excessive hardship on families with aging relatives, it does little to alleviate rising health care costs. According to the Kaiser Family Foundation, Medicaid spending grew significantly slower (4.6 percent) per capita than private insurance premiums (7.7 percent) over the past decade.

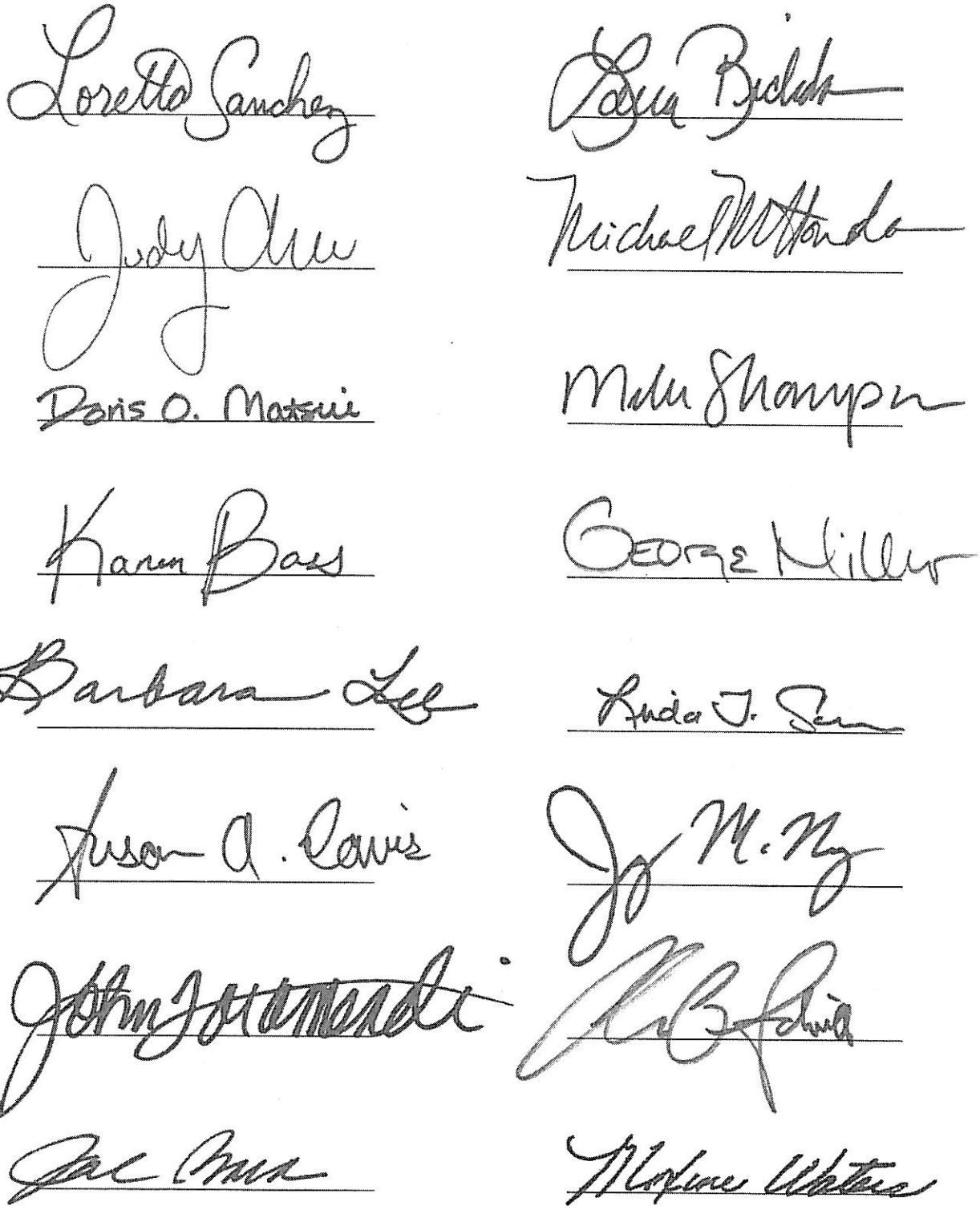
Additionally, changing the Medicaid program now could have negative effects on implementation of health care reform as California counties have been leading the effort in

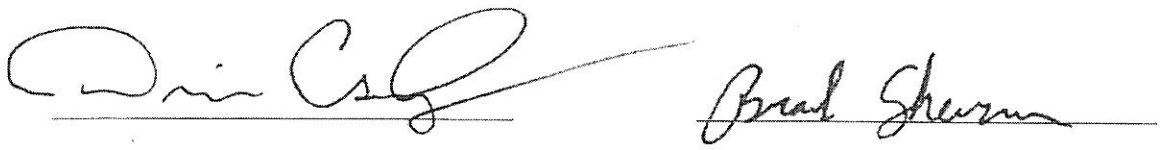
California. In fact, the waiver they received recently from the Administration should not only expand outpatient care and reduce hospital readmissions, but also produce major savings in Medicaid over time due to changes in how health care is provided.

We look forward to working with you as we continue to address our long-term deficit issues and preserve our social safety net for those who need it the most.

Sincerely,







List of Signers in Alphabetical Order

1. Joe Baca
2. Karen Bass
3. Xavier Becerra
4. Howard Berman
5. Lois Capps
6. Dennis Cardoza
7. Jim Costa
8. Judy Chu
9. Susan Davis
10. Anna Eshoo
11. Sam Farr
12. Bob Filner
13. John Garamendi
14. Mike Honda
15. Barbara Lee
16. Zoe Lofgren
17. Doris Matsui
18. Jerry McNerney
19. George Miller
20. Grace Napolitano
21. Laura Richardson
22. Lucille Roybal-Allard
23. Linda Sanchez
24. Loretta Sanchez
25. Adam Schiff
26. Brad Sherman
27. Jackie Speier
28. Pete Stark
29. Mike Thompson
30. Maxine Waters
31. Henry Waxman
32. Lynn Woolsey

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