What We Will Discuss

- Programs and Services
- Federal/State Mandates
- Funding
- Policy Issues
- County Role

Health and Human Services

What We Do

- Health
  - Indigent Health Care
  - Public Health

- Behavioral Health
  - Mental Health
  - Alcohol and Other Drugs

- Child Welfare Services
  - Indigent Health Care
  - Public Health

- Senior and Adult Services
  - Indigent Health Care
  - Public Health

- Public Assistance
  - CalWORKs
  - Medi-Cal Eligibility
  - CalFresh (food stamps)
  - General Assistance
Welfare and Institutions Code: Section 17000

Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.

California Mandates

Health and Safety Code 101025
• “...take measures as may be necessary to preserve and protect public health...of the county...”

CA Code of Regulations title 17, Chapter 3
• Data collection and analysis
• Communicable disease control
• Environmental Health
• Laboratory services
• Maternal Child Health Services
• Nutrition services
• Chronic disease prevention services
• Public health nursing services

Health Programs

Indigent Health Care
• Counties mandated as providers of last resort
• Includes minimum primary, emergency, and dental care
• Most indigents now covered by Expanded Medi-Cal under Affordable Care Act

Medi-Cal
• Managed Care
• Scope of services

Public Health
• Communicable Disease
• Emergency Preparedness – Pandemic Flu or other outbreak
• Immunizations
• Vital Statistics – birth/death records
• Population based health improvement
Health Programs - Fiscal

Indigent Health Care
- 100% County share

Medi-Cal
- 50% County share services
- 0% County share eligibility

Public Health
- Realignment
- State funds
- Federal funding - EPO

Behavioral Health Programs

Mental Health
- Mental Health Managed Care
- EPSDT
- Education Related Mental Health Services
- Mental Health Services Act (Prop. 63)

Alcohol & Other Drug Treatment
- Proposition 36
- Drug Medi-Cal
- Drug Court
- Proposition 47

Behavioral Health Programs - Fiscal

Mental Health
- Realignment
- SGF for Medi-Cal Managed Care
- EPSDT AB 3635 services to children
- MHSA
- Federal matching funds

Alcohol & Other Drugs
- Realignment: Drug Medi-Cal
- SAPT Block Grant
- CalWorks
- * AB 109
Health and Behavioral Health Policy

Health Care Reform and AB 85 - redirection of 1991 Health realignment

• 34 County Medical Services Program (CMSP) Counties
• 12 Article 13 Counties
• 11 Public Hospital Counties
• Los Angeles County

Revenues decrease and services demands increase:
• Property Tax, Sales Tax, Vehicle License Fees, State Budget Cuts
• Economy downturn results in re-basing service levels

Traditional relationships no longer exist:
• Elimination of entire state departments such as DMH and ADP
• Integration into agencies that may lack program expertise or vision
• Counties in Control: California Mental Health Services Authority (CalMHSA)

New partnerships emerging:
• Managed Care: Public systems under private plans?
• Health Care Reform: Partnership = Savings = Revenue

Health and Behavioral Health Policy Issues

• 2 Million newly eligible Medi-Cal
• 1/3 have MH or SUD conditions
• MH and SUD benefits are part of Essential Health Benefits
• More Americans with access to quality health care that includes coverage for mental health and substance use disorder services

How will county infrastructure and service delivery systems adapt?

ACA: Is It Over?

• On the cusp of major changes in health system – health care, and the county role, will be dramatically different at the end of the decade
• The nation is beginning to recognize and address the multiple determinants of health and the importance of access to care through coverage
• The county challenge: bring it to scale at the local level with changes in state policy (AB 720, AB 82)
ACA: County Considerations

- Inextricable links between health outcomes, socioeconomic status, educational attainment, employment, housing, substance abuse, mental health, crime
- Leveraging current programs and infrastructure, regardless of organizational model
- Financing strategies: historical, categorical, and options, intergovernmental transfers, CMAA/TCM
- Improved public/private partnerships to extend the reach and effectiveness of County HHS

Child Welfare Programs

- Children's Protective Services
  - Emergency Response
  - Role of Social Workers
  - Role of Law Enforcement
  - Role of Juvenile Court
- Foster Care
  - Court Process
  - Placements
  - Reunification
  - Extended Foster Care
- Permanency and Adoptions
  - Parental Rights
  - Role of County
  - Ongoing Support

Child Welfare Policy Issues

Continuum of Care Reform
- Better outcomes for foster children
- Full scope of support services
- Improved assessment and placement matching
- Reduced placement in group homes
- Provider accountability

Katie A. Implementation
- Expanding and increasing mental health services to foster children
**Health & Human Services**

**Adult Service Programs**

- **Adult Protective Services**
  - Scope
  - Local Discretion
  - Challenges

- **In-Home Supportive Services**
  - Client and Caregivers
  - County Assessment
  - Public Authority – Employer of Record

- **Coordinated Care Initiative**
  - 7-county demonstration project
  - Integrates medical, behavioral, and long-term care services
  - Roadmap to integrate MediCal and Medicare

**Adult Service Policy Issues**

- **Coordinated Care Initiative**
  - Ongoing funding

- **IHSS Overtime**
  - Federal law exemption for caregiver agencies
  - Federal regulatory requirement to pay OT
  - Judicial overturn of federal regulation

- **IHSS Public Authority Bargaining**
  - County responsibility until 2016
  - County MOE after state assumption of collective bargaining

**Public Assistance Programs**

- **CalWORKs**
  - Counties determine eligibility and process payments
  - Work Requirements
  - Subsidized Employment
  - Family Stabilization
  - Housing Support
  - Child Care

- **Medi-Cal**
  - Counties determine eligibility
  - State pays for services

- **CalFresh**
  - State version of SNAP (a.k.a., food stamps)
  - Counties determine eligibility and issue benefits
  - Outreach
  - Restaurant Program
Public Assistance Programs

- 100% County Program
- Welfare and Institutions Code 17000 Obligation
- Grant levels
- Time limit flexibility

Public Assistance Policy Issues

- Self-sufficiency
- Addressing Poverty

Health and Human Services “Realignment”

1991
- Transferred financial responsibility of state’s Mental Health, Public Health, and some Social Services (CWS, Foster Care, CalWORKs) to counties
- ½ cent Sales Tax
- Vehicle License Fee

2011
- Public Safety Realignment
- Funded by 1.0625 cent sales tax
- Includes HHS Programs: CWS, Foster Care, APS, MH Managed Care, EFSC, SUD services

AB 85 and Prop 30
- Redirect 1991 Realignment
- Impacts on Growth payments
- Protections to 2011
1991 Realignment: the Motivators

- State budget crisis
- Stable, relatively predictable (until recently) funding source has allowed counties to plan across fiscal years
- Flexibility has allowed local health departments to target resources as needed to address local community health needs
- Realignment funds have been used to supplement categorical grant funding that has not kept up with need

1991 Realignment: Issues for Counties

- No Sales Tax growth from FY 05/06 – 12/13
- No VLF growth from FY 06/07 – 12/13
- VLF has been extremely volatile
- Demand for local services has increased at same time revenues have decreased

2011 Realignment: the Motivators

- Federal panel: Reduce prison overcrowding
- $26 Billion budget gap and expiring taxes
- Interconnected programs with more flexibility
2011 Realignment: Issues for Counties

• Makes low level offenders ineligible for prison
• Burden placed on county jails, with limited space and not equipped to hold inmates for long periods of time
• True reform? Or are low level offenders now packed into county jails instead of prison?
• Community Corrections Partnerships – Counties are keys to success.
• Collaborations must focus on alternatives to incarceration, as well prevention, treatment to reduce recidivism

AB 85: Redirection of County Health Realignment Funds

• Created in 2013 as part of the State Budget Process
• Based on premise that Medi-Cal expansion in January 2014 would result in county savings to indigent health programs
• State wanted to reclaim these county savings in order to help fund increase state Medi-Cal costs
• Redirected Health Realignment funds are used to off-set state General Fund obligations for CalWORKS

Changes to Realignment Growth Distribution

• Health Account previously received approximately 50% of General Growth
  • Starting with FY 13/14 Growth will receive 18.45%
• Mental Health still receives approximately 40% of General Growth
• Social Services no longer receives General Growth
• Remainder of General Growth (approximately 42%) now goes to fund CalWORKS grant increases
Prop 30 Impact on Counties

- Realignment funding is constitutionally protected
- Any new costs imposed on 2011 Realignment programs by the federal government will be shared 50/50 between the State and local government.
- The State will not request optional changes from the federal government that increase local costs – unless the State funds those increased costs.
- Any new costs imposed by federal courts on 2011 Realignment programs must be funded 50/50 between the State and local governments.
- Realigned programs are not reimbursable mandates
- Counties must understand what was realigned

HHS Organizational Models

Health & Human Services Umbrella Agency/Depart.
- Consolidated Model
- Integrated Model

Separate Departments Based on Function

Organization by County Size
- 10 of 31 Rural Counties: Agency v. separate departments.
- 5 of 15 Suburban Counties: Agency v. separate departments.
- 1 of 12 Urban Counties: Agency v. separate departments.

Counties and California’s Health

Role
- Local health services
- Coverage for low income, uninsured, underinsured
- Protective services and safety net programs
- Public health prevention, policy and data analysis
- Environmental health
- Mental health and substance use disorder treatment

Revenue
- Complex shifting patchwork of local, state and federal funds

Challenges
- Economic and fiscal challenges
- Shifting policy and political landscape
- At all levels of government.
The Changing Landscape

Local Control Versus State Control:
- 1991 Realignment increased county responsibilities irrespective of funding
- Realignment shortfalls, depleted local reserves, ability to fund reserves
- 2011 realignment different than 1991: transfers, reserves, more accounts
- State actively manages some 2011 realignment accounts
- November 2012 Election: Prop. 30 Constitutional Guarantee

Revenues decrease and services demands increase:
- Property Tax, Sales Tax, Vehicle License Fees, State Budget Cuts
- Economy downturn results in re-basing service levels
- Elimination of entire state departments such as DMH and ADP
- Integration of agencies that may lack program expertise or vision
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New partnerships emerging:
- Managed Care: Public systems under private plans?
- Health Care Reform: Partnership = Savings = Revenue

Looking Forward...
- The role of counties in the health and welfare of Californians is on the threshold of major change and restructuring
- State and county policymakers prepare to redefine county health and human services in the context of federal health care reform and long-term structural budget deficits.
- Counties have responded to federal and state program and funding shifts by reshaping and restructuring their delivery systems and the nature and types of programs they offer and administer.

Roles to Achieve HHS goals
- CSAC and Affiliates
  - Support and technical assistance
  - Advocacy and expertise
  - Network of colleagues
- County Supervisor
  - Provide policy direction
  - Make budget decisions
- County Administrators and Staff
  - Provide recommendations on policies and budget issues
  - Implement policies, programs and services
County Social Services Departments are given the responsibility to help our communities’ children and women to be free from abuse, and to help low-income working families to be free from dependence on public aid. With rapidly changing rules, increasing caseloads and increased oversight from Washington D.C., counties have had to develop effective and efficient approaches to meeting these responsibilities.

Who provides these services for the State and Federal government, working to ensure that families and communities are protected and strengthened? **Counties do.**

The strength, health, and safety of our communities depend on county human services. Please support our efforts as we work to protect children and the elderly, and to provide support to low-income working families.

If you would like to learn more about county human services and how to support them, please contact your local human services agency, or contact CWDA at (916) 443-1749. You may also visit our website at www.cwda.org.

The County Welfare Directors Association of California (CWDA) is a non-profit association representing the human service directors from each of California’s 58 counties. The Association’s mission is to promote a human services system that encourages self-sufficiency of families and communities, and protects vulnerable children and adults from abuse and neglect.

Who empowers vulnerable seniors? protects abused and neglected children? helps families escape welfare and discover self-sufficiency? **Counties do!**

The Association’s goals are:

- **Advocates** for policies that will further the mission of the organization.
- **Educates** state and federal policy-makers and the public regarding the impact of human services policies on individuals, communities, and county social services operations.
- **Collaborates** with governmental and community-based organizations to ensure efficient and effective service delivery.
- **Facilitates** effective communication between and among county social service agencies, and state and federal administrative agencies, including the exchange of knowledge and best and promising practices.
Who steps in when children are being abused? Counties do.

Counties do.

Counties Social Services Departments are responsible for providing services to children and their families. They investigate reports of child abuse and neglect, and work with law enforcement and other agencies to protect victims and ensure their safety.

Who helps families achieve independence from welfare, and to find and keep good jobs? Counties do.

California’s Social Services Departments have a dual role of providing services and enacting policies. They provide services to families in need and implement welfare reform policies.

Counties implement programs like CalWORKS, which offers a menu of incentives and supports to help families become self-sufficient. They also provide access to Federal Programs for language services, education, English, and MediCal programs.

Who responds when elderly persons are being abused? Counties do.

Counties do.

California’s Elder Abuse Reporting System was established by state legislation (SB 2199, Lockyer) that became effective January 1999. This law required all residents of the state to report elder abuse; it also required the counties to respond to these reports and to provide case management services to reduce the likelihood of further abuse.

Counties respond to any report alleging abuse in their home, even if the abuse is happening in the same home as the In Home Supportive Services program, also administered by the Social Services Departments. These reports help document the extent of elder abuse in the state, and allow counties to improve their elder abuse response.

The number of counties reporting child abuse or neglect increased by nearly 12% from September 2002 to September 2003. Over the two-year period between July 2000 and June 2002, the number of reports increased by over 60%.

Some of the reasons for the increase in reports of elder abuse may include better training of professionals, increased awareness of the issue, and the implementation of the Elder Abuse Reporting System.

The number of reports by nearly the same percentage. In Fiscal Year 1999/2000, counties supervised the adoption of over 6,500 children. In Fiscal Year 2001/2002, the number of children in foster care is declining.

The number of children who are adopted is increasing and the number of children in foster care is declining. This is due to the implementation of welfare reform policies and increased funding for adoption services.

California now is subject to the Federal Reviews of its performance in Child Welfare, as is every other state. Federal Reviews present opportunity and risk. As the Federal government steps up its review of California’s performance in the Food Stamp program, the state is subject to fiscal sanctions if it fails to meet high performance standards. Proposed changes to the Federal Review process may impact California’s ability to maintain its remarkable progress in reducing dependency on public assistance by securing jobs for low-income families.

The number of families receiving CalWORKs services continues to decline. California’s caseload has declined 46% since December, 1999, when California’s Federal Welfare Reform program began. In July 2002, approximately 870,000 families were receiving CalWORKs benefits from 776,000 in July 1997. The number of families receiving food stamps is rising as families leave CalWORKS. In the two-year period between July 2000 and June 2002, the number of persons receiving food stamp benefits increased by 61%, as the number of families receiving food stamp benefits declined by nearly the same percentage. The number of individuals receiving MediCal benefits declined by 42% since December, 1999, when California’s Federal Welfare Reform program began. In July 2002, approximately 870,000 families were receiving CalWORKs benefits from 776,000 in July 1997.

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Who helps families achieve independence from welfare, and to find and keep good jobs?

California’s County Social Services Departments have done what once was thought impossible. They have helped hundreds of thousands of families to keep their own children, to keep those jobs, to keep their own homes, to keep their own health care, and to keep their own dignity.

Counties have implemented CalWORKS. California’s version of the Federal Welfare Reform law, covering the specific needs of each county’s labor market and population. Unlike the old public assistance programs that merely moved monthly checks and

Who supervises when elderly persons are being abused? Counties do.

The number of reports of abuse of elderly and dependent adults has increased dramatically. In the two-year period between September 2000 and September 2002, the number of In Home Supportive Services clients who supplement the wages of families in need of additional income from welfare and who are working toward independence on public assistance by securing jobs for their dependents declined by nearly 13%, to 84,341.
Who steps in when children are being abused?

Counties do.

County Social Services Departments provide services to children and their families in every county, every city and every neighborhood in California. Some large counties require each county to respond on a 24-hour basis to investigate any report of child abuse or neglect. These reports include: child abuse, neglect, or exploitation of elderly or dependent adults.

The number of reports of abuse of elderly and dependent adults has increased significantly. In the June-August period between September 2001 and August 2002, the number of adults receiving In Home Supportive Services increased by 61%, as the number of persons receiving such services increased by nearly 12%.

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Understanding County Health Services in California: A Brief Overview

Introduction

Counties in California have been providing health services in California for almost 150 years. Since 1933, California law (Welfare and Institutions Code Section 17000) has required counties to provide relief to the poor, including health care services and general assistance. County residents receive these services, regardless of whether they live in the unincorporated area of the county or within city limits.

Summary of County Health Services

The county health department is also the cities' health department. With the exception of the cities of Berkeley, Long Beach, and Pasadena which operate separate health departments for residents, county health services cover residents in both the unincorporated and incorporated areas of the county – that is, within the county and city limits.

Administrative Structure

The county health system is usually an agency or department within the county and is administered by an Administrative Director who is appointed by either the County Administrative Officer and/or the Board of Supervisors. The Board of Supervisors also appoints a Public Health Officer, who is a physician, and who serves as the chief medical officer for the county on public health issues. The organizational structure and programs offered vary from county to county.

The discussion below summarizes the responsibilities and services provided by county health departments.

Alcohol-Drug — Assures necessary substance abuse services are available to the public through a network of public operated and private contracted providers. Services typically include inpatient and outpatient care, residential recovery, detoxification, information, education, prevention, and early intervention.

Detention Facilities — Assures that necessary medical, dental, psychiatric, and substance abuse services are provided to adult and juvenile persons incarcerated in county facilities.

1 The information is adapted from information provided by the California State Association of Counties (www.counties.org).
Environmental Health — Provides all health related approvals and permits relating to land development (well water permits, septic permits, and land use permits), consumer protection (food facility inspections/permits, public pools, small water systems, solid waste, and food borne illness investigation), and hazardous materials [underground storage tanks, medical waste, Proposition 65 reporting (safe drink water enforcement), chemical spills, and incident response].

Emergency Medical Services (EMS) — If designated as the local Emergency Medical Services agency, responsibilities involve ambulance permitting and monitoring, Emergency Medical Technician certification, emergency medical dispatch approvals, and disaster planning.

Hospitals — Currently 13 counties operate hospitals. Most of these hospitals are full service teaching hospitals affiliated with university medical schools. Services vary slightly from hospital to hospital but generally include medical, surgical, emergency, trauma, outpatient, and a wide variety of specialty services. The following counties operate hospitals.

- Alameda
- Kern
- Modoc (until 2011)
- Riverside
- San Francisco
- San Mateo
- Ventura
- Contra Costa
- Los Angeles
- Monterey
- San Bernardino
- San Joaquin
- Santa Clara

Indigent Medical Care — Provides medical care to indigent persons, including Medically Indigent Adults, in a variety of ways including operating a county hospital and/or primary care clinics, or using a wide variety of contracts with providers of care to fulfill their responsibilities. Indigent persons are uninsured, low-income adults who have no other source of health care and are not categorically linked to other public health insurance programs.

Medically Indigent Adults (MIA) — Medically Indigent Adults are those individuals age 21-64 who do not qualify for Medi-Cal. Generally, childless adults are excluded from Medi-Cal. These individuals typically earn too little to purchase either health care or health insurance.

The twenty-four most populous counties administer their own programs for Medically Indigent Adults. Each county sets its own eligibility standards, services, and provider networks.

The other thirty-four counties, primarily rural counties, pool their resources to provide indigent health services; the County Medical Services Program (CMSP) administers this indigent health program.
Mental Health — Provides a wide range of psychiatric services to the public either directly or by contract with private providers. Services typically include acute inpatient care for persons who are a danger to themselves, others, or are gravely disabled, long-term care in facilities that treat mental disease, local crisis services, day treatment, and outpatient care.

Public Health — Services include prevention, early intervention, education, and treatment through a wide range of specific programs and services. These typically include:

- Adult health screening;
- HIV/AIDS testing and counseling;
- Communicable and infectious disease control;
- Immunizations; family planning;
- Children's services, including the Child Health and Disability Prevention program, physical exams, medical, nutrition, etc.;
- Sexually transmitted diseases;
- Home nursing visits; tuberculosis;
- Women, Infants and Children (WIC) nutritional services; and vital statistics registration involving birth/death certificates and burial permits.

Normally an onsite laboratory performs all public health related tests required by the nursing functions of the agency in addition to testing for rabies, water, food, Lyme disease, parasites, bacteria, and microorganisms.

Other Useful Resources for Understanding County Health Services

Several other resources offer information about how counties provide health services to Californians.

- **California State Association of Counties** ([www.counties.org](http://www.counties.org))

  (See especially the “What Counties Do” section under the California’s Counties tab.) The California State Association of Counties’ website includes information about county health services and links to information about other county services.

- **The Crucial Role Counties Play in the Health of Californians**

  “The Crucial Role Counties Play in the Health of Californians”² provides in depth information about the health and health-related services counties provide, including information about how the services are funded. It also discusses challenges faced by

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² “The Crucial Role Counties Play in the Health of Californians” is authored by Deborah Reidy Kelch, M.P.P.A. for the California Health Care Foundation ([www.chcf.org](http://www.chcf.org)).
counties in providing these services. While the document was produced in 2004, it remains relevant.
On March 23, 2010, President Obama signed into law the comprehensive health care reform legislation promising to extend coverage to 33 million Americans – the Patient Protection and Affordable Care Act (ACA). Of note to the behavioral health community, the ACA explicitly includes mental health and substance use disorder services, including behavioral health treatment, as one of ten categories of service that must be covered as essential health benefits. Furthermore, the ACA also mandates that mental health and substance use disorder benchmark coverage must be provided at parity, compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008). Individuals with mental illness and substance use disorders have the opportunity to significantly benefit from the health care law, as insufficient insurance health care coverage for these conditions has traditionally prevented countless people from obtaining needed treatment. If applied correctly, the health care reform law has the opportunity to ensure that clients, families and communities struggling with mental illness and substance use disorders have access to culturally competent prevention and treatment opportunities. Research suggests that without addressing the treatment needs of persons with serious mental health and substance use disorders, it may be very difficult to achieve the three critical healthcare reform objectives articulated by the Institute for Healthcare Improvement’s Triple Aim:

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of total healthcare

The following are some of the opportunities for this population under the ACA:

- Given the low rate of service utilization among uninsured adults with mental health and substance use disorder needs, the expansion of health insurance coverage through health care reform could increase access to and utilization of mental health and substance use disorder services for many uninsured adults in California.
- Half a million uninsured California adults with mental health needs will become eligible for health insurance coverage in 2014.\(^1\)
- Qualified adults will for the first time have access to mental health and substance use disorder services through the Medi-Cal program or subsidized insurance without having a disability.

Given the tremendous opportunities that the ACA affords this population, CMHDA and CADPAAC believe that California’s implementation of the ACA should be grounded in the

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\(^1\) UCLA Center for Health Policy Research (November 2012), Health Policy Fact Sheet, “Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions.”
following principles to ensure access to the highest quality mental health and substance use disorder services for these populations and achieve health care reform objectives:

1) **Health equity must be integrated into all aspects of ACA implementation.** This includes addressing systematic disparities in health status related to race, ethnicity, gender, sexual orientation, income and geography. People of color and people living in rural areas are more likely to be low-income, uninsured, and without access to employer-based health insurance, and therefore have the most to gain from the ACA.

2) **Mental health and substance use disorder systems must be equity partners with physical health care systems.** Parity between mental health and substance use disorder and other medical systems and services must be realized at every level.

3) **Recovery and resiliency-driven services that are culturally and linguistically appropriate must be the standard for covered mental health and substance use benefits available to California’s Medicaid Expansion population.** This includes coverage of consumer/client- and family-directed case management and behavioral health rehabilitation services in the community that reflect the cultural, ethnic and racial diversity of mental health and substance use consumers/clients, and that address each consumer/client’s individual needs.

4) **Access to mental health and substance use disorder services for both the Medicaid Expansion population and the Covered California population should be based upon established medical/clinical necessity criteria for specialty mental health services and substance use services – e.g. Medi-Cal criteria and evidence-based American Society of Addiction Medicine (ASAM) placement criteria.** This is essential to ensure seamless continuity of care and consistent access to services regardless of change in economic status or type of health care coverage. There is also a strong business case supported by research that demonstrates that efficiencies in care and improved outcomes occur when patient needs are well matched with the most appropriate, medically necessary and least restrictive/costly level of care.

5) **Education, prevention and early intervention for mental health and substance use disorders must be fully integrated as part of the spectrum of reimbursable services in any benefit package provided to the Medicaid Expansion population, or individuals insured through Covered California.** The prevention of disease is a central tenet of the ACA; this should apply no less to mental health and substance use disorder services as it does for physical health. Research and experience have proven that education, prevention and early intervention for mental health and substance use disorders play an essential role in population health, client outcomes and cost containment. Such services may include screening in primary care, media and public awareness campaigns, suicide prevention and peer-delivered services.

6) **Specialty mental health and substance use disorder services provided in field, home and community-based settings must be available and reimbursable under all coverage programs and opportunities.** Effectively addressing the rehabilitative needs of children, youth, adults and older adults with serious mental illness and

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2 National Health Law Program (August 21, 2012), 10 Reasons the Medicaid Expansion Helps to Address Health Disparities.
substance use disorders requires assertive, proactive, culturally and linguistically appropriate outreach in a variety of settings by specialty and community providers who have the expertise in engaging individuals at the earliest possible point in an episode of mental illness and/or substance use.

7) Mental health and substance use benefit packages must promote high quality, patient-centered and cost-effective care, and continue to support the existing safety net. This includes, but is not limited to, services not traditionally provided in the medical arena and/or covered by Medicaid, such as many homeless outreach services, mobile response programs, services to children and youth in specialized foster care, supports for housing stability, recovery maintenance homes, field-based services, etc. These services are critical in addressing social determinants of health and are an integral component of California’s specialty mental health and substance use disorder systems.

8) Safety net funding for residually uninsured populations must be preserved. As healthcare reforms take hold and insurance coverage gradually expands, we must ensure that a shifting or reduction in safety net funding does not diminish access to mental health and substance use disorder services for residually uninsured populations. In particular, approximately 11% (58,600) of today’s uninsured Californians with mental health needs will not be eligible under the ACA due to immigration status. This means increasing the efficiency of federal funds reimbursement, preserving realignment revenue and federal block grant funding for County mental health and substance use disorder services and ensuring that the State does not reduce Medi-Cal eligibility or benefits. The size and impact of the residual population, including those ineligible for programs due to placement in an Institute for Mental Disease (IMD), will likely be realized only over time once the ACA policies and programs are fully implemented. Any diversion of funds from these health care delivery systems before a full assessment of the near-term and longer-term impacts of the ACA are determined and analyzed would offer a recipe for undermining the very systems the State will need to rely on to service the expanded Medi-Cal and other publicly sponsored populations. Financing systems may need to be reformed to better align payment policies with care coordination and quality improvement goals and objectives.

9) Support for policies that address the workforce composition, development and expansion to address the needs of the Medicaid expansion and Covered California populations is critical, including pathways to employment, competencies for peer support, etc. This includes the utilization of non-licensed providers and peer support to most effectively and efficiently meet the needs of consumers/clients with mental health and substance use disorders.

10) Coordination of mental health, substance use and primary care is essential to ensuring quality care and realizing cost savings. The aim of the ACA is to ultimately reduce the cost of healthcare delivery to the entire population. In order to more effectively care for the whole person, there must be more seamless coordination between system partners. This includes reducing barriers to the exchange of information necessary to appropriately coordinate care, improve quality, and address confidentiality.

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3 UCLA Center for Health Policy Research (November 2012), Health Policy Fact Sheet, “Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions.”
SUMMARY OF THE AFFORDABLE CARE ACT

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary of the law, and changes made to the law by subsequent legislation, focuses on provisions to expand coverage, control health care costs, and improve health care delivery system.

Patient Protection and Affordable Care Act (P.L. 111-148)

| Overall approach to expanding access to coverage | Require most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the poverty level is $19,530 for a family of three in 2013) and create separate Exchanges through which small businesses can purchase coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level. |
| Requirement to have coverage | • Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual’s income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples). |
| EMPLOYER REQUIREMENTS | • Assess employers with 50 or more full-time employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with 50 or more full-time employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014) • Exempt employers with up to 50 full-time employees from any of the above penalties. |
| Other requirements | • Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage. |
| EXPANSION OF PUBLIC PROGRAMS | • Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income [as under current law undocumented immigrants are not eligible for Medicaid]. All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges. The Supreme Court ruling on the constitutionality of the ACA upheld the Medicaid expansion, but limited the ability of HHS to enforce it, thereby making the decision to expand Medicaid optional for states. To finance the coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those who were enrolled in state-funded programs), states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded... |
**Patient Protection and Affordable Care Act (P.L. 111-148)**

### EXPANSION OF PUBLIC PROGRAMS (continued)

<table>
<thead>
<tr>
<th>Treatment of Medicaid (continued)</th>
<th>Eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. In addition, increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2014)</th>
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<tr>
<th>Treatment of CHIP</th>
<th>• Require states to maintain current income eligibility levels for children in Medicaid and the Children’s Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Provide states with the option to provide CHIP coverage to children of state employees who are eligible for health benefits if certain conditions are met. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.</th>
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### PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>• Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.5% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.</th>
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| Premium credits | • Provide refundable and advanceable premium credits to eligible individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels: 
  - Up to 133% FPL: 2% of income
  - 133-150% FPL: 3 – 4% of income
  - 150-200% FPL: 4 – 6.3% of income
  - 200-250% FPL: 6.3 – 8.05% of income
  - 250-300% FPL: 8.05 – 9.5% of income
  - 300-400% FPL: 9.5% of income
  • Increase the premium contributions for those receiving subsidies annually to reflect the excess of the premium growth over the rate of income growth for 2014-2018. Beginning in 2019, further adjust the premium contributions to reflect the excess of premium growth over CPI if aggregate premiums and cost sharing subsidies exceed .54% of GDP.
  • Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014. |
| --- | --- |

| Cost-sharing subsidies | • Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level:
  - 100-150% FPL: 94%
  - 150-200% FPL: 87%
  - 200-250% FPL: 73%
  - 250-400% FPL: 70% |
| --- | --- |

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<thead>
<tr>
<th>Verification</th>
<th>• Require verification of both income and citizenship status in determining eligibility for the federal premium credits.</th>
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<tr>
<th>Subsidies and abortion coverage</th>
<th>• Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or cases of rape or incest (Hyde amendment). If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.</th>
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Patient Protection and Affordable Care Act (P.L. 111-148)

### PREMIUM SUBSIDIES TO EMPLOYERS

**Small business tax credits**
- Provide small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit.
  - **Phase I:** For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.
  - **Phase II:** For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.

**Reinsurance program**
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $5 billion to finance the program.
  (Effective 90 days following enactment through January 1, 2014)

### TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM

**Tax changes related to health insurance**
- Impose a tax on individuals without qualifying coverage of the greater of $695 per year up to a maximum of three times that amount or 2.5% of household income to be phased-in beginning in 2014.
- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account.  
  (Effective January 1, 2011)
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount.  
  (Effective January 1, 2011)
- Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment.  
  (Effective January 1, 2013)
- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.  
  (Effective January 1, 2013)
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% tax on unearned income for higher-income taxpayers [thresholds are not indexed].  
  (Effective January 1, 2013)
- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage [these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020]. The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage.  
  (Effective January 1, 2018)
- Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.  
  (Effective January 1, 2013)
### Tax changes related to financing health reform

- Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule:
  - $2.8 billion in 2012-2013;
  - $3.0 billion in 2014-2016;
  - $4.0 billion in 2017;
  - $4.1 billion in 2018; and
  - $2.8 billion in 2019 and later.
- Impose an annual fee on the health insurance sector, according to the following schedule:
  - $8 billion in 2014;
  - $11.3 billion in 2015-2016;
  - $13.9 billion in 2017;
  - $14.3 billion in 2018
  - For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth.

For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees’ beneficiary associations (VEBAs) not established by an employer. 

- Impose an excise tax of 2.3% on the sale of any taxable medical device. 
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. 
- Impose a tax of 10% on the amount paid for indoor tanning services. 
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. 
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

### Health Insurance Exchanges

#### Creation and structure of health insurance exchanges

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)

#### Eligibility to purchase in the exchanges

- Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.

#### Multi-state plans

- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.

#### Consumer Operated and Oriented Plan (CO-OP)

- Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate $4.8 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)
### Benefit tiers
- Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets:
  - **Bronze plan** represents minimum creditable coverage and provides the essential health benefits, covers 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);
  - **Silver plan** provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits;
  - **Gold plan** provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits;
  - **Platinum plan** provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits;
- **Catastrophic plan** available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
  - 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);
  - 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);
  - 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,793/family).
These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.

### Insurance market and rating rules
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchange.
- Require risk adjustment in the individual and small group markets and in the Exchange. [Effective January 1, 2014]

### Qualifications of participating health plans
- Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information.
- Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.

### Requirements of the exchanges
- Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges.
- Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.

### Basic health plan
- Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.

### Abortion coverage
- Permit states to prohibit plans participating in the Exchange from providing coverage for abortions.
- Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no
**HEALTH INSURANCE EXCHANGES** (continued)

**Abortion coverage**  
(continued)  
less than $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.  

**Effective dates**  
• Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.

**BENEFIT DESIGN**

**Essential benefits package**  
• Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014)  
• Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)

**Abortion coverage**  
• Prohibit abortion coverage from being required as part of the essential health benefits package.  
(Effective January 1, 2014)

**CHANGES TO PRIVATE INSURANCE**

**Temporary high-risk pool**  
• Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family in 2010). Appropriate $5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)

**Medical loss ratio and premium rate reviews**  
• Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)  
• Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)

**Administrative simplification**  
• Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective dates vary)

**Dependent coverage**  
• Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)

**Insurance market rules**  
• Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. Prohibit pre-existing condition exclusions for children. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary.  
• Grandfather existing individual and group plans with respect to new benefit standards, but require these grandfathered plans to extend dependent coverage to adult children up to age 26 and prohibit rescissions of coverage. Require grandfathered group plans to eliminate lifetime limits on coverage and beginning in 2014, eliminate annual limits on coverage. Prior to 2014, grandfathered group plans may only impose annual limits as determined by the Secretary. Require grandfathered group plans to eliminate pre-existing condition exclusions for children within six months of enactment and by 2014 for adults, and eliminate waiting periods for coverage of greater than 90 days by 2014. (Effective six months following enactment, except where otherwise specified)  
• Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market. (See new rating and market rules in Creation of insurance pooling mechanism.) (Effective January 1, 2014)
### Patient Protection and Affordable Care Act (P.L. 111-148)

#### CHANGES TO PRIVATE INSURANCE (continued)

| Insurance market rules (continued) | • Require all new policies [except stand-alone dental, vision, and long-term care insurance plans], including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. [See description of benefit categories in Creation of insurance pooling mechanism.] [Effective January 1, 2014]  
| Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. [Effective January 1, 2014]  
| Limit any waiting periods for coverage to 90 days. [Effective January 1, 2014]  
| Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Finance the reinsurance program through mandatory contributions by health insurers totaling $25 billion over three years. [Effective January 1, 2014 through December 2016]  
| Allow states the option of merging the individual and small group markets. [Effective January 1, 2014]  

| Consumer protections | • Establish an internet website to help residents identify health coverage options [effective July 1, 2010] and develop a standard format for presenting information on coverage options [effective 60 days following enactment].  
| Develop standards for insurers to use in providing information on benefits and coverage. [Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment]  

| Health care choice compacts and national plans | • Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. [Regulations issued by July 1, 2013, compacts may not take effect before January 1, 2014]  

| Health insurance administration | • Establish the Health Insurance Reform Implementation Fund within the Department of Health and Human Services and allocate $1 billion to implement health reform policies.  

#### STATE ROLE

| State role | • Create an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas.  
| Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 [states have the option to expand enrollment beginning in 2011], coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. A state will be exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year.  
| Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. [Federal grants available beginning fiscal year 2010]  
| Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges. [Effective January 1, 2014] Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. [Effective January 1, 2017]  

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County Supervisors Resource Guide

SUMMARY OF THE AFFORDABLE CARE ACT — Last Modified: April 23, 2013

V2 6-33
### COST Containment

#### Administrative Simplification
- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)

#### Medicare
- Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phase-in revised payments over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas. Provide bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for Medicare Advantage plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modify rebate system with rebates allocated based on a plan’s quality rating. Phase-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7% by 2019. Cap total payments, including bonuses, at current payment levels. Require Medicare Advantage plans to remit partial payments to the Secretary if the plan has a medical loss ratio of less than 85%, beginning 2014. Require the Secretary to suspend plan enrollment for 3 years if the medical loss ratio is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years.
- Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary)
- Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple. (Effective January 1, 2011)
- Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015.
- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. (Effective fiscal year 2014)
- Eliminate the Medicare Improvement Fund. (Effective upon enactment)
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012)
- Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011)
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012)
- Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)
### Patient Protection and Affordable Care Act (P.L. 111-148)

#### COST CONTAINMENT (continued)

**Medicaid**
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price.  
  [Effective upon enactment]
- Reduce aggregate Medicaid DSH allotments by $.5 billion in 2014, $.6 billion in 2015, $.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers.  
  [Effective October 1, 2011]
- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.  
  [Effective July 1, 2011]

**Prescription drugs**
- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.  
  [Effective upon enactment]

**Waste, fraud, and abuse**
- Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities.  
  [Effective dates vary]

#### IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE

**Comparative effectiveness research**
- Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage.  
  [Fund available beginning fiscal year 2010]
- Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act.  
  [Effective upon enactment]

**Medical malpractice**
- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance.  
  [Funding appropriated for five years beginning in fiscal year 2011]

**Medicare**
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program.  
  [Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016]
- Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction.  
  [Effective January 1, 2012]
- Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010.  
  [Effective October 1, 2012]
- Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.  
  [Reports to Congress due January 1, 2011]

**Dual eligibles**
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles.  
  [Effective March 1, 2010]
### Patient Protection and Affordable Care Act (P.L. 111-148)

#### Improving Quality/Health System Performance (continued)

| Medicaid | Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion. [Effective January 1, 2011]  
Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations [effective January 1, 2012 through December 31, 2016]; to make global capitated payments to safety net hospital systems [effective fiscal years 2010 through 2012]; to allow pediatric medical providers organized as accountable care organizations to share in cost-savings [effective January 1, 2012 through December 31, 2016]; and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition [effective October 1, 2011 through December 31, 2015].  
Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). [$11 million in additional funds appropriated for fiscal year 2010] |
| Primary care | Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. [Effective January 1, 2013]  
Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015. [Effective for five years beginning January 1, 2011] |
| National quality strategy | Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. [National strategy due to Congress by January 1, 2011]  
Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. [Funds appropriated for five years beginning in FY 2011] |
| Financial disclosure | Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. [Report due to Congress April 1, 2013] |
| Disparities | Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. [Effective two years following enactment] |

#### Prevention/Wellness

| National strategy | Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation’s health. [Strategy due one year following enactment]  
Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. [Initial appropriation in fiscal year 2010]  
Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. [Effective upon enactment]  
Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings, the Education and Outreach Campaign for preventive benefits, and immunization programs. Appropriate $7 billion in funding for fiscal years 2010 through 2015 and $2 billion for each fiscal year after 2015. [Effective fiscal year 2010]  
Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. [Funds appropriated for five years beginning in FY 2010] |
| Coverage of preventive services | Eliminate cost-sharing for Medicare covered preventive services that are recommended [rated A or B] by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the Secretary to modify or eliminate Medicare coverage of preventive services, based on recommendations of the U.S. Preventive Services Task Force. [Effective January 1, 2011] |
### PREVENTION/WELLNESS (continued)

#### Coverage of preventive services (continued)
- Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) for these services. [Effective January 1, 2013]
- Authorize Medicare coverage of personalized prevention plan services, including a comprehensive health risk assessment, annually. Require the Secretary to publish guidelines for the health risk assessment no later than March 23, 2011, and a health risk assessment model by no later than September 29, 2011. Reimburse providers 100% of the physician fee schedule amount with no adjustment for deductible or coinsurance for personalized prevention plan services when these services are provided in an outpatient setting. [Effective January 1, 2011]
- Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. [Effective January 1, 2011 or when program criteria is developed, whichever is first] Require Medicaid coverage for tobacco cessation services for pregnant women. [Effective October 1, 2010]
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. [Effective six months following enactment]

#### Wellness programs
- Provide grants for up to five years to small employers that establish wellness programs. [Funds appropriated for five years beginning in fiscal year 2011]
- Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. [Conduct study within two years following enactment]
- Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. [Effective January 1, 2014] Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. [Report due three years following enactment]

#### Nutritional information
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. [Proposed regulations issued within one year of enactment]

### LONG-TERM CARE

#### CLASS Act
- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. This provision was repealed by the American Taxpayer Relief Act of 2012.

#### Medicaid
- Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014).
- Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. [Effective October 1, 2010]
- Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. [Effective October 1, 2011]
- Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. [Effective October 1, 2011 through September 30, 2015]
### Patient Protection and Affordable Care Act (P.L. 111-148)

**LONG-TERM CARE (continued)**

<table>
<thead>
<tr>
<th>Skilled nursing facility requirements</th>
<th>• Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)</th>
</tr>
</thead>
</table>

**OTHER INVESTMENTS**

| Medicare | • Make improvements to the Medicare program:  
- Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 [Effective January 1, 2010];  
- Phase down gradually the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100% to 25% by 2020:  
  - For brand-name drugs, require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013)  
  - For generic drugs, provide federal subsidies of 75% of the generic drug cost by 2020 for prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011);  
- Between 2014 and 2019, reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage;  
- Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012);  
- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result [Effective upon enactment];  
- Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and  
- Provide payments totaling $400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties with the lowest quartile Medicare spending; and  
- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011) |

| Workforce | • Improve workforce training and development:  
- Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010)  
- Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for payments for the expenses associated with operating primary care residency programs. (Funds appropriated for five years beginning fiscal year 2011)  
- Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010)  
- Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011) |
### OTHER INVESTMENTS (continued)

<table>
<thead>
<tr>
<th>Workforce (continued)</th>
<th>Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health centers and school-based health centers</td>
<td>Improve access to care by increasing funding by $11 billion for community health centers and by $1.5 billion for National Health Service Corps over five years (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2010) and nurse-managed health clinics (effective fiscal year 2010).</td>
</tr>
<tr>
<td>Trauma care</td>
<td>Establish a new trauma center program to strengthen emergency department and trauma center capacity. Fund research on emergency medicine, including pediatric emergency medical research, and develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated beginning in fiscal year 2011)</td>
</tr>
<tr>
<td>Public health and disaster preparedness</td>
<td>Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. (Funds appropriated for five years beginning in fiscal year 2010)</td>
</tr>
<tr>
<td>Requirements for non-profit hospitals</td>
<td>Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)</td>
</tr>
<tr>
<td>American Indians</td>
<td>Reauthorize and amend the Indian Health Care Improvement Act. (Effective upon enactment)</td>
</tr>
</tbody>
</table>

This publication (#8061-02) is available on the Kaiser Family Foundation’s website at www.kff.org.
The Critical Role for County* Public Health  
in the Era of Health Care Reform

The Affordable Care Act (ACA) is landmark legislation which promises to improve the health of every American. While most public attention is being paid to the critically important coverage expansions, the ACA also makes a commitment to prevention, as evidenced by the inclusion of a National Prevention Strategy establishing a national health agenda that states, “Preventing disease and injuries is key to improving America’s health.” As California implements the ACA, maintaining a robust local public health system is critical for meeting these health improvement goals.

What Does County Public Health Do?

Public Health saves lives and creates healthier communities. Never has a government function been more a victim of its own success. County health departments are on the front lines of this public health effort – you may not always see the work they do, but our communities are safer and healthier because of it.

When the United States Public Health Service first started collecting disease data from state health authorities in 1912, the most common diseases reported were diphtheria, measles, polio, scarlet fever, tuberculosis, typhoid and small pox. Among the top ten causes of death that same year in the United States were tuberculosis, diarrhea and enteritis, and premature birth. The reason these are largely consigned to the history books is because public health works.

For decades, the United States has set goals and objectives for health promotion and disease prevention. In the December 2010 launch of Healthy People 2020, U.S. Health and Human Services Secretary Kathleen Sebelius stated, “Our challenge and opportunity is to avoid preventable diseases from occurring in the first place.” Secretary Sebelius went on to note that “Chronic disease, cancer and diabetes are responsible for seven out of every ten deaths among Americans each year and account for 75 percent of the nation’s health spending. Many of the risk factors that contribute to the development of these diseases are preventable.”

Local public health departments work toward reducing these preventable diseases and making our communities healthier through many activities, including:

- Monitoring, investigating and containing communicable and food-borne disease outbreaks;
- Planning for and responding to local disasters, such as pandemic influenza, fires, earthquakes and floods;
- Ensuring our water supplies are safe;
- Enforcing local and state health and safety codes;
- Educating the public about emerging health risks and prevention measures;
- Tracking the health status of our communities in order to develop community based responses.

By statute, code and policy, California’s local governments are required to assure the population’s health. Every Californian is touched by these critical local public health services every day.

* The cities of Berkeley, Long Beach and Pasadena also provide these essential public health services.
California Mandates for Local Public Health

Under Health and Safety Code Section 101025, counties have a broad mandate to “…take measures as may be necessary to preserve and protect the public health...of the county…” Furthermore, the California Code of Regulations Title 17, Chapter 3, Local Health Services, requires that each local health department “shall offer at least the following basic services to the health jurisdiction it serves”:

- Data Collection and Analysis
- Health Education Programs
- Communicable Disease Control
- Environmental Health
- Laboratory Services
- Services Promoting Maternal and Child Health
- Nutrition Services
- Chronic Disease Prevention Services
- Public Health Nursing Services

Counties are also required to respond to emergencies and disasters, including floods, fires and earthquakes with local public health staff as an integral part of the local government response to these life-threatening events.

Moreover, local public health departments provide varied additional services and their staff engage in a broad array of activities addressing the local needs of their communities.

Funding

Counties provide these services through a broad range of funding sources, including Health Realignment, county general funds, and state and federal categorical program funding. Most of these funding sources have been declining in recent years, and as a result, staffing levels in local public health departments have also declined. Findings from a recent survey conducted by the County Health Executives Association of California (CHEAC) found that between FY 07/08 and FY 10/11 local public health departments lost, on average, 17% of their full-time equivalent employees. Some public health departments saw staff reductions as high as 30% to 40%. That same time period saw a 17% decline in Health Realignment funding for local public health services, largely due to declines in new car sales and the sales tax.

On the state level, the FY 09/10 budget eliminated all state General Fund dollars for maternal and child health and local immunization programs and all but $1 million in state funding for HIV/AIDS programs. The children’s dental disease program was also eliminated that year. Public health departments are increasingly dependent on federal public health funding, which is also under constant threat of cuts. The Public Health Emergency Preparedness (PHEP) grant, which is core funding for local public health emergency preparedness, was reduced by 15% last year.

It is within this constrained fiscal environment that local public health departments must continue to develop strategies to provide core public health services as well as meet new challenges in preventing chronic disease.

The Continued Need for County* Public Health Services

The ACA’s health coverage expansions will not replace the need for local public health services. To the contrary, local public health departments are key partners in assuring that California meets the broad health improvement goals of the ACA. Maintaining current funding for local public health services is essential for meeting the mandated responsibilities of local health departments and keeping our communities healthy.
History and Funding Sources of California's Public Mental Health System
March 2006

In the 1960s California led the nation in community mental health development and civil rights for persons with mental illness, only to lapse into decades of funding instability and program confusion. Since the 1990s, with mental health reform, program and funding realignment, meaningful consumer and family involvement, and strong state and county leadership, California has re-established its pre-eminence in public mental health.

Important principles underlying the mental health system in California include the value of choice and self-determination in treatment for Californians with psychiatric disabilities, children with emotional disturbance, and adults and older adults with mental health issues; the philosophy that recovery is possible and a goal for persons with mental illnesses; prevention, early intervention, education and outreach are effective; treatment works; cultural competence in the delivery of mental health services is essential; consumer and family involvement in policy development is crucial; and stigma and discrimination have no place in our society.

Our system must continue to be based on availability and accessibility of a continuum of quality community-based treatment; focus on meaningful outcomes and quality of life; interface with other components of the health care and human services systems; protection of individuals with mental illness from dangerous environments; and accountability at all levels.

Key Funding Elements/Current Issues in California’s Public Mental Health System

Realignment

In 1991, a major change occurred in the funding of human service programs in the State of California with enactment of the Bronzan-McCorquodale Act, (Chapter 89, Statutes of 1991), referred to as “realignment.” Realignment transferred financial responsibility for most of the state’s mental health and public health programs, and some of the social service programs, from the state to local governments, and provided counties with a dedicated revenue source to pay for these changes. For mental health, realignment transferred the amounts associated with pre-realignment categorical programs, general community mental health funding, state hospital civil commitment funding, and Institutions for Mental Disease (IMD) funding.

In order to fund the program transfers and shifts in cost-sharing ratios, the Legislature enacted two tax increases in 1991, with the increased revenues deposited into a state Local Revenue Fund and dedicated to funding the realigned programs. Each county created three program accounts, one each for mental health, social services, and health. Through a series of accounts and sub-accounts at the state level, counties receive deposits into their three accounts for spending on programs in the respective policy areas. The basic formula, which determines the amount to each county and each sub-account, was included in the statute.
Sales Tax. In 1991, the statewide sales tax rate was increased by a half-cent. The half-cent sales tax generated $1.3 billion in 1991-92 and was expected to generate approximately $2.4 billion in FY 2001-02.

Vehicle License Fee. The VLF, an annual fee on the ownership of registered vehicles in California, is based on the estimated current value of the vehicle.

Annually, realignment revenues are distributed to counties until each county receives funds equal to the previous year’s total. Funds received above that amount are placed into a growth account. The distribution of growth funds is complex. However, it is a fixed amount annually and the first claim on the Sales Tax Growth Account goes to caseload-driven social service programs. Any remaining growth from the Sales Tax Account and all VLF growth are then distributed according to a formula developed in statute.

Realignment represented a new partnership between the state and the counties governing the provision of services. The core principle under realignment was to provide expanded discretion and flexibility to counties to expend state funding. It shifted program and funding responsibilities from the state to counties, adjusted cost-sharing ratios, and provided counties a dedicated revenue stream to pay for these changes in the areas of mental health, social and health services. State oversight was to be increasingly focused on outcome and performance based measures.

Fourteen years later, mental health programs throughout the state have benefited from this dedicated funding source and increased flexibility to develop programs.

Realignment has generally provided counties with many advantages, including:

- A stable funding source for programs, which has made a long-term investment in mental health infrastructure financially practical.
- Greater fiscal flexibility, discretion and control.
- The ability to streamline bureaucracy and reduce overhead costs.
- The ability to use funds to reduce high-cost restrictive placements, and to place clients appropriately.
- Financial incentives for counties to properly manage mental health resources, including the ability to “roll-over” funds from one year to the next, which enables long-term planning and multi-year funding of projects.
- The emphasis on a clear mission and defined target populations under realignment has allowed counties to develop comprehensive community-based systems of care for individuals with severe mental illness and serious emotional disorders. Increased county flexibility has further allowed counties to institute best practices, and to focus on the recovery process for individuals with severe mental illness and serious emotional disturbance.

Medi-Cal

The second largest revenue source for county mental health programs is federal Medicaid dollars. Understanding the changes in California’s Mental Health Medi-Cal program since realignment and the interaction of Medi-Cal revenues with realignment are critical to analyzing the current structure and status of public mental health services in California.
The Medi-Cal program originally consisted of physical health care benefits, with mental health treatment making up only a small part of the program. Mental health services were limited to treatment provided by physicians (psychiatrists), psychologists, hospitals, and nursing facilities, and were reimbursed through the Fee-For-Service Medi-Cal system (FFS/MC).

There was no federal funding of the county Short-Doyle mental health program until the early 1970s, when it was recognized that these programs were treating many Medi-Cal beneficiaries. Short-Doyle/Medi-Cal (SD/MC) started as a pilot project in 1971, and counties were able to obtain federal funds to match their own funding to provide certain mental health services to Medi-Cal eligible individuals. The SD/MC program offered a broader range of mental health services than those provided by the original Medi-Cal program.

A Medicaid State Plan Amendment implemented in July of 1993 added services available under the Rehabilitation Option to the SD/MC scope of benefits, and broadened the range of personnel who could provide services and the locations at which services could be delivered. This change is significant in analyzing the financial status of mental health programs because it enabled counties to greatly increase their claiming of federal Medicaid funds.

The SD/MC program now includes inpatient hospital, psychiatric health facility, adult residential treatment, crisis residential treatment, crisis stabilization, intensive day treatment, day rehabilitation, linkage and brokerage, mental health services, medication support, and crisis intervention.

The two separate Medi-Cal mental health systems -- FFS/MC (the original Medi-Cal mental health system) and SD/MC -- continued as separate programs until Medi-Cal mental health consolidation began in January 1995. From 1995 through 1998, there was a major shift in county obligations within the Medi-Cal program. In order to provide counties more flexibility in the use of state funding, and to enable more integrated and coordinated care, the state developed a plan to consolidate the two Medi-Cal funding streams for mental health services. This strategy was intended to allow a prudent purchaser of services to obtain maximum benefit for its expenditures, and would allow for increased access to specialty mental health services within the same level of funding.

Since research demonstrated that a single integrated system of care is critical for successful treatment of persistent mental illness and emotional disturbance, and that the needs of persons with mental illness do not always receive adequate attention in an all-inclusive health care managed care system, a decision was made to "carve out" specialty mental health services from the rest of Medi-Cal managed care in the mid-1990s. County mental health departments were given the "first right of refusal" in choosing to be the Medi-Cal "Mental Health Plan" for the county. All but two counties in California (including two cities) chose to become the MHP for their beneficiaries, although there are statutory provisions for DMH to choose another entity to be the MHP if the county chooses not to assume that role. Those two counties chose to partner with another county to be the MHP, which makes California’s Medi-Cal mental health program entirely managed by local government.

This program operates under a federal Freedom of Choice waiver. Under this waiver program, each MHP contracts with DMH to provide medically necessary specialty mental health services to the beneficiaries of the county. Medi-Cal beneficiaries must receive Medi-Cal reimbursed specialty mental health services through the MHPs. A distinction is made between specialty mental health care (those services requiring the services of a specialist in mental health) and general mental health care needs (those needs that could be met by a general health care practitioner). General mental health care needs for Medi-Cal beneficiaries remain under the purview of DHS, either through their managed care plans or through the FFS/MC system.

Under consolidation, SGF are appropriated by DHS each year to DMH based upon the estimated amount DHS would have incurred for psychiatric inpatient hospital services and psychiatrist and
psychologist services absent consolidation. In general, each MHP receives, at a minimum, SGF equal to the amount spent in their county prior to consolidation. This SGF allocation is available to be used as Medi-Cal match by MHPs prior to using realignment funds.

**EPSDT**

A lawsuit against the state in 1995 resulted in the expansion of Medi-Cal services to Medi-Cal beneficiaries less than 21 years of age who need specialty mental health services to correct or ameliorate mental illnesses, whether or not such services are covered under the Medicaid State Plan. As a result of the settlement, the state agreed to provide SGF to counties as the match for these expanded specialty mental health services. These services qualify under the EPSDT Medi-Cal benefit and are commonly referred to as EPSDT services. DMH developed an interagency agreement with DHS through which county mental health plans were reimbursed the entire non-federal share of cost for all EPSDT-eligible services in excess of the expenditures made by each county for such services during FY 1994-95. In FY 2002-03, a 10% county share of cost was imposed by the Administration for EPSDT services above a baseline expenditure level. These funds, together with realignment funds, may be used as the state Medicaid match for claiming federal matching funds.

Another lawsuit against the state, filed in 1998, resulted in the approval of a new EPSDT supplemental specialty mental health service for the Medi-Cal program. This new benefit is called Therapeutic Behavioral Services (TBS). Since these services were not included in the original realigned services, new SGF are provided to MHPs as match for these services as well.

**Current Realignment/Medi-Cal Issues**

- Realignment funding was based upon the current funding going to each county at the time of implementation, and did not take into consideration the inadequacy of funding prior to 1991.

- Under the current funding structure, funds appropriated to the counties under realignment have not kept pace with 1991-92 levels when population changes and medical inflation are taken into account. Generally, the percentage increase in medical inflation and client growth combined, along with increased acuity of clients, has been substantially greater than the increase in realignment revenues.

- Due to continued caseload growth in Child Welfare Services and Foster Care, as well as significant (and unanticipated) cost increases in the In Home Supportive Services (IHSS) Program, growth distributions to the Mental Health Subaccount and Health Subaccount have been substantially reduced. This is because the first claim on the Sales Tax Growth Account goes to caseload-driven social services programs. *With current trends, the Mental Health Subaccount will receive no sales tax growth for the foreseeable future.*

- Many counties must use an increasing proportion of their realignment funds to draw the federal Medicaid (Medi-Cal) match, since Medi-Cal is an entitlement program. As such, they have decreased the amount of funds available for their “targeted” indigent clients.

- Since Medi-Cal consolidation, administrative requirements by DMH have grown dramatically.

- Counties have not received COLAs for the Medi-Cal program since 2000. In the FY 03/04 state budget, the Medi-Cal allocation to counties was actually reduced by 5%.
As these trends continue, some counties will have difficulty complying with Medi-Cal requirements, even if devoting as much of their realignment funds as possible toward that population.

The recent failure of the state to fully reimburse counties for their costs in providing state mandated mental health services to Special Education Pupils (see below) have put an additional severe strain on county realignment and other mental health resources.

AB 3632, Mental Health Services to Special Education Pupils

The federal Individuals with Disabilities Education Act (IDEA) entitles all children with disabilities to a free, appropriate public education that prepares them to live and work in the community. IDEA entitlement includes mental health treatment for children and adolescents who are less than twenty-two years of age, have an emotional disturbance, and are in need of mental health services to benefit from a free and appropriate public education. These services are a federal entitlement, and children can receive services irrespective of their parents’ income-level.

Prior to 1984, school districts were responsible for providing all special education services to children. In 1984, the Legislature enacted AB 3632, the Special Education Pupils Program, which, among other things, transferred responsibility for providing mental health services to special education pupils from school districts to county mental health departments. This program (Chapter 26.5 of the Government Code) was intended to build on the counties’ existing responsibilities and expertise in providing mental health treatment, and provide needed collaboration between schools and public mental health in serving students.

While counties are required by state law to provide these services, the services they provide are for the purpose of assisting public education to fulfill its mandate under federal law to provide a free, appropriate education to students with special needs in the least restrictive educational environment. The state Department of Education currently receives over $1 billion annually from the federal government for implementing IDEA throughout the state, and for complying with all IDEA requirements.

Current AB 3632 Issues/Funding Crisis

Prior to enactment of the state’s FY 2002/03 budget, a total of $12 million had been budgeted for counties statewide as categorical funding to pay for the services required under Chapter 26.5. Because the costs incurred by counties in providing those state-mandated services have far exceeded the categorical funding for many years, counties have been reimbursed for their additional costs through the SB 90 local mandate reimbursement process.

In FY 2000/01, the SB 90 claims paid to counties for this program exceeded $100 million. In the FY 2002/03 state budget, the $12 million of categorical funding for counties was eliminated entirely, and counties were told that they could receive all of their funding through the mandate reimbursement process. However, the budget also placed a moratorium on mandate reimbursements for local government. During that year, counties received no funding from the state to pay for this federal education entitlement program.

In the FY 2004-05 budget, the local mandate reimbursement moratorium was extended for an additional year. However, the Governor proposed allocating $69 million in federal IDEA funds to partially pay for the AB 3632 mental health program. The Legislature ultimately approved that funding, which was still not nearly enough to fully fund counties for the costs of providing services under this mandate.

Some counties – particularly small and rural – have no county general funds that can be used to fund this program. That leaves the counties no choice but to use scarce realignment funds, which are meant to serve their “target” low-income and uninsured population of seriously
emotionally disturbed (SED) children, and seriously mentally ill adults (to the extent resources are available). *The state currently owes counties over $300 million for this program alone.*

**Adult Systems of Care/Integrated Services for Homeless Adults (AB 2034)**

It is estimated that there are currently over 50,000 homeless Californians with severe mental illness. Many of these individuals do not have access to needed mental health or other community services, and end up in the criminal justice system for minor crimes, often leading to citations or arrests. This population also experiences frequent high cost inpatient hospitalizations because their mental health needs are addressed only when they reach crisis levels.

The Integrated Services for Homeless Adults (AB 34/2034) program provides outreach and comprehensive services to adults and older adults with severe mental illness who are homeless, or at risk being homeless. It began as a $10 million 3-county pilot in 1999. The data collected from the experiences of those counties in the first year showed clearly that the programs were both successful in getting homeless individuals the services they needed, and extremely cost effective. It has since been expanded to 32-34 counties. This is a categorical program that is funded through the state general fund, with a total current budget of $55 million (following a reduction in 02-03 of $10 million). The program is overseen by the state Department of Mental Health. A basic principle of the program is its flexible funding, which assures that counties may provide whatever services necessary to help the homeless individual access needed resources.

Services offered by local programs include assessment of the individual's needs, providing shelter/housing, establishing identification and legal assistance needs, and providing food, clothing, showers, medical, psychiatric and dental care, alcohol/drug treatment and social rehabilitation.

The data collected from the experiences of those counties in the first year showed clearly that the programs were both successful in getting homeless individuals the services they needed, and extremely cost effective. Outcomes data indicates that those enrolled in the program experienced a 65.6 percent drop in the number of hospital days; an 81.5 percent drop in the number of days spent in jail; and a 79.1 percent drop in the number of days spent homeless. An increase in the level of employment of enrollees was also achieved. The initial success of the pilot programs served as the impetus for strong support from the Administration and the Legislature to provide continued funding for this program and the target population.

**The Mental Health Services Act (Prop. 63)**

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November of 2004 provides the first opportunity in many years for increased funding to support California’s county mental health programs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system, with the purpose of promoting recovery for individuals with serious mental illness.

The MHSA imposes a 1% income tax on personal income in excess of $1 million. Statewide, the Act was projected to generate approximately $254 million in fiscal year 2004-05, $683 million in 2005-06 and increasing amounts thereafter.

According to the Act, no funds may be provided from the state to the counties unless such spending is in accordance with a plan developed in accordance with numerous requirements, including that it must provide for significant local stakeholder input and involvement. The local plans must be approved by the State Department of Mental Health, after review and comment by the Oversight and Accountability Commission.
Each plan is a three-year plan that must be updated annually, and each update must also be submitted to the state for review.

**While these new revenues are an exciting new addition to California’s public mental health system, it is important to note that funds must be used to expand, not supplant, existing services.**

This means that while counties struggle to keep their existing Medi-Cal and realignment-funded programs running with a declining revenue source, they are looking to build new programs. This will inevitably lead to service reductions on the one hand, and limited service expansion on the other. Counties will face increasing challenges as they attempt to make sense of this dynamic while trying to manage their communities’ high expectations for systems improvements through the MHSA.
Fighting Poverty Imperative for Children, Families and Economy

CWDA Commends Governor for ACA Commitment, Urges Policies that Improve Lives of All Californians

SACRAMENTO – The County Welfare Directors Association of California (CWDA) commends Governor Brown for his continued commitment to the Affordable Care Act, reflected in his proposed 2015-16 State Budget, and the critical expansion of Medi-Cal that has brought health care coverage to millions of Californians.

Additionally, after years of budget cuts to county agencies and the families served by our programs, CWDA is pleased to see the continuation of incremental enhancements to the CalWORKs program that serves as a life preserver for families and children across our communities.

While these commitments are important, California policymakers must immediately and systematically tackle the poverty epidemic and growing income inequality that are devastating to millions of adults, children and families across California.

“With nearly 50 percent of California’s children living in poverty or near poverty, and the highest child poverty rate in the country, it is imperative we do more to address this urgent public health crisis,” said Barry Zimmerman, CWDA President and Director of the Ventura County Human Services Agency. “Not only is it shameful to have millions of children going to school hungry and hundreds of thousands of families without stable housing or jobs, we also know the costs are staggering to the public. Our poverty crisis will continue to drag down the economy until this is addressed.”

“There are practical, effective ways we can improve the lives of children and families while also making key investments that would continue to advance California’s long-term economic health,” said Frank Mecca, CWDA Executive Director. “We look forward to working with the Governor and Legislature toward policies that improve the lives of all Californians.”

The County Welfare Directors Association of California (CWDA) is a nonprofit association representing the human service directors from each of California’s 58 counties. The Association’s mission is to promote a human services system that encourages self-sufficiency of families and communities, and protects vulnerable children and adults from abuse and neglect. www.cwda.org

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