



## The California County Platform | Chapter 6 Health Services

*Adopted by the CSAC Board of Directors November 2020*

### **SECTION 1: GENERAL PRINCIPLES**

Counties are mandated to protect Californians against threats of widespread disease and illness and are tasked with promoting health and wellness equitably across all populations in California. This chapter deals specifically with health services and covers the major segments of counties' functions in health services. Health services in each county shall relate to the needs of residents within that county in a systematic manner without limitation to availability of hospital(s) or other specific methods of service delivery. The board of supervisors in each county sets the standards of care for its residents.

Local health needs vary greatly from county to county. Counties support and encourage the use of multi-jurisdictional approaches to health care. Counties support efforts to create cost-saving partnerships between the state and the counties, and other organizations to achieve better health outcomes and health equity. Therefore, counties should have the maximum amount of flexibility in managing programs. Counties should have the ability to expand or consolidate facilities, services, and program contracts to provide a comprehensive level of service and accountability, access for all populations, and maximum cost effectiveness. Additionally, as new federal and state programs are designed in the health care field, the state must work with counties to encourage maximum program flexibility and minimize disruptions in county funding, from the transition phase to new reimbursement mechanisms and outcome development and assessment.

Counties also support a continuum of preventative health efforts – communicable disease control and chronic disease prevention – and the inclusion of public health in the design and planning of healthy communities. Counties also support efforts to prevent and treat substance use and mental health disorders. Preventative health efforts have proven to be cost effective and provide a benefit to all residents.

Federal health reform efforts, including the Patient Protection and Affordable Care Act (ACA) of 2010, provide new challenges, as well as opportunities, for counties. Counties, as providers, administrators, and employers, are deeply involved with health care at all levels and must be full partners with the state and federal governments to expand Medicaid and provide health insurance and access to care. Counties believe in maximizing the allowable coverage for their residents in accordance with eligibility criteria, while also preserving access to local health services for the residual uninsured. Counties remain committed to serving as an integral part of any effort to improve or reform California's health system.

At the federal level, counties also support economic stimulus efforts that help maintain service

levels and access for the state’s neediest residents, regardless of an extenuating circumstance such as an emergency or disaster. Counties strongly urge that any federal stimulus funding, enhanced matching funds, or innovation grants that include a county share of cost be allocated directly to each county that qualifies.

## **SECTION 2: PUBLIC HEALTH**

County health departments and agencies are responsible for protecting, assessing and assuring individual, community and environmental health. Public health agencies are tasked with controlling the spread of infectious diseases through immunizations, surveillance, disease investigations, laboratory testing and planning, preparedness, and response activities. Furthermore, county health agencies are tasked with evaluating the health needs of their communities and play a vital role in chronic disease and injury prevention through education, policy, system, and environmental changes promoting healthier communities.

County health departments are also charged with responding to public health emergencies, ranging from terrorist and biomedical attacks to natural disasters and emerging infectious diseases, including maintaining the necessary infrastructure – such as laboratories, medical supply, and prescription drug caches, as well as trained personnel – needed to protect our residents. Currently, counties are concerned about the lack of funding, planning, and ongoing support for critical public health infrastructure. The state and federal governments must work with counties and provide funding to ensure adequate planning, medical supplies, access to laboratory testing services, workforce and alternative care capacity to appropriately respond to any local, state, or global health emergency.

County health departments are also working to reduce health inequities with efforts to eliminate barriers to good health and supporting the equitable distribution of resources necessary for the health of California’s diverse population, including underserved communities. Strategies addressing the social determinants of health by working with other sectors to maintain and expand affordable, safe, and stable housing; ensuring a health equity lens is applied to economic and social policies to identify and address unintended consequences and potential effects on vulnerable populations; and collecting, analyzing, and sharing information to understand and address the health impacts of racism, discrimination and bias.

- 1) To effectively respond to these local needs, counties must have adequate, sustained funding for local public health communicable disease control, epidemiological surveillance, chronic disease and injury prevention, emergency preparedness, planning and response activities and other core public health functions. Counties must also have state and federal support in growing and retaining a highly skilled public health workforce.
- 2) Counties support the preservation of the federal Prevention and Public Health Fund for public health activities, and oppose any efforts to decrease its funding. Counties support

efforts to secure direct funding for counties to meet the goals of the Fund.

- 3) Counties believe strongly in comprehensive health services planning. Planning must be done through locally elected officials, both directly and by the appointment of quality individuals to serve in policy and decision-making positions for health services planning efforts. Counties must also have the flexibility to make health policy and fiscal decisions at the local level to meet the needs of their communities.

### **SECTION 3: BEHAVIORAL HEALTH**

Counties provide a full continuum of community-based prevention and treatment services for individuals living with severe mental illness and with substance use disorders (SUD). Counties have responsibility for providing treatment and administration of mental health and substance use disorder programs for individuals across all payors, including the uninsured, and specifically for Medi-Cal beneficiaries. Counties must have the flexibility to design and implement behavioral health services that best meet the needs of their local communities. The appropriate treatment of people living with substance use and severe mental health disorders should be provided equitably and within the framework of local, state, and federal criteria. Counties have developed a range of locally designed programs to serve California's diverse population, and must retain the local authority and flexibility. At the same time, the state must ensure that counties have adequate funding to continue such services.

Behavioral health services may also reduce criminal justice costs and recidivism through prevention, diversion and reentry services. The state and counties must partner to ensure adequate resources for addressing the complex needs of individuals involved in or at risk of being involved in the criminal justice system who also live with serious mental illness and substance use disorders.

The state must acknowledge the critical role of counties in responding to natural disasters and local emergencies and the need for disaster response trauma-related behavioral health services.

#### Proposition 63: Mental Health Services Act

The adoption of Proposition 63, the Mental Health Services Act of 2004 (MHSA), assists counties in mental health service delivery to the public. The Act is intended to provide new funding that expands and improves the capacity of county behavioral health systems of care and provides opportunities to fund initiatives not otherwise funded via Medicaid, such as infrastructure, workforce, prevention, the "whatever it takes" model of care, and community-led innovations. MHSA funding is also dedicated to meeting the needs of each community via robust stakeholder input to determine spending priorities. The Act is crucial to the stability of the Medi-Cal behavioral health safety net as counties expertly leverage MHSA funding to provide more than \$1 billion in Medi-Cal services annually.

- 1) Counties oppose additional reductions in state funding for behavioral health services that will result in the shifting of state or federal costs to counties, or require counties to use MHSAs for that purpose. These cost shifts result in reduced services available at the local level and disrupt treatment options for behavioral health clients. Any shift in responsibility or funding must hold counties fiscally harmless and provide the authority to tailor behavioral health programs to individual community needs consistent with the Act.
- 2) Counties also strongly oppose any effort to redirect MHSAs funding to existing state services instead of the local services for which it was designated by the voters. The realignment of health and social services programs in 1991 restructured California's public behavioral health system. Realignment required local responsibility for program design and delivery within statewide standards of eligibility and scope of services, and designated revenues to support those programs to the extent that resources are available.
- 3) MHSAs funds have been diverted in the past due to economic challenges and the establishment of the No Place Like Home Program in 2016. Any further diversions of MHSAs funding will require robust county engagement, keeping the needs of local communities at the forefront without disruption to current programming at the local level.
- 4) Counties support timely and clear reporting standards, including reversion timelines, for MHSAs expenditures and seek guidance from the Department of Health Care Services on all reporting standards, deadlines, and formats. Any development or update to reporting should be clearly established with county stakeholder involvement. Further, updates should be data-driven and measurable.
- 5) Counties support the fiscal integrity of the MHSAs and transparency in stakeholder input, distributions, spending, reporting, and reversions.
- 6) Counties support the continued evaluation of MHSAs funding silos to allow for greater funding flexibility, accountability for outcomes, and its usage for individuals living with a substance use disorder or co-occurring disorders, provided counties are central to the development of reforms and any shift to accountability for outcomes is grounded in sound data science and client and community input.

#### County Specialty Behavioral Health Plans

Counties are committed to service delivery that manages and coordinates services to persons with behavioral health needs and that operates within a system of performance outcomes which assures funds are spent in a manner that provides access to the highest quality of care for all residents. County specialty behavioral health plans must to adapt to new models, lead collaborative efforts, and receive adequate and sustainable resources for the next era of behavioral health care.

Counties assumed the role of Medi-Cal specialty plans for behavioral health when they supported the consolidation of what were then two distinct Medi-Cal behavioral health systems one operated by county behavioral health departments and the other operated by the state Department of Health Services into a single Medi-Cal Mental Health services managed care plan at the local level that operates separately, or is “carved-out,” of Medi-Cal managed care. California counties subsequently developed the first in the nation 1115 Medicaid waiver to deliver substance use disorder services through a managed care model under the Drug Medi-Cal Organized Delivery System waiver program. There is a negotiated sharing of risk for services between the state and counties, particularly because counties became solely responsible for managing the nonfederal share of cost for all Medicaid specialty behavioral health services under 2011 Realignment.

- 1) Counties recognize that access to high quality prevention and treatment services for adolescents and young adults with behavioral health needs can be improved, and support fiscally viable strategies for building a more comprehensive continuum of care including residential treatment services, for this vulnerable age group.
- 2) Counties support technical assistance for counties and providers to ensure timely and accurate billing, as well as compliance with quality and service requirements. Responsibility for billing errors, code errors, or other billing oversights must be shared by the state, counties and any applicable providers.
- 3) The State must ensure that Medi-Cal specialty behavioral health plans are adequately resourced.
- 4) Counties continue to support state and federal efforts to provide behavioral health benefits under the same terms and conditions as other health services and welcome collaboration with public and private partners to achieve behavioral health parity.
- 5) Counties support and seek additional housing options for people with mental health and substance use disorders, including recovery and treatment housing options within the community, as well as residential treatment services.
- 6) Counties support cross-sector, multi-jurisdictional collaboration to promote education on substance use disorders, and mental health conditions, and to prevent suicide, overdoses and disparities in mortality for individuals with behavioral health conditions.
- 7) The courts may still refer individuals to counties for treatment under Proposition 36 or by court order, but counties are increasingly unable to provide these voter and judge-mandated services without adequate dedicated state funding.
- 8) Counties urge the state to prioritize coordination and alignment with county based systems of care when funding new mental health and substance use disorder initiatives, and to include counties in opportunities for supplemental or flexible funding for

behavioral health services. Funding behavioral health services in a fragmented or siloed manner is unlikely to promote access or quality.

#### **SECTION 4: PUBLIC GUARDIANS/ADMINISTRATORS/CONSERVATORS**

Public Administrators, Public Guardians and Public Conservators act under the authority granted by the California Superior Court, but are solely a county function and funded with county General Funds. The recent rise in interest in conservatorships as vehicles to help manage justice involved and homeless populations also places significant fiscal and workload pressure on county guardians and conservators.

- 1) CSAC supports the acquisition of additional and sustainable non-county resources for public guardians, conservators, and administrators to ensure quality safety-net services for all who qualify. Any proposal from the Legislature to expand the responsibility of county public conservators of LPS “gravely disabled” conservatees must come with additional funding and time for the system to treat and manage the expanded population.
- 2) CSAC opposes additional duties, mandates, and requirements for public guardians, conservators, and administrators without the provision of adequate funding to carry out these services.
- 3) CSAC will work to support placement capacity for public guardians, conservators, and administrators as California severely lacks safe and secure housing for the majority of residents under conservatorship. This includes supporting efforts to acquire additional resources for licensed adult residential facilities and residential care facilities for the elderly.

#### **SECTION 5: CHILDREN’S HEALTH**

##### California Children’s Services

Counties administer the California Children’s Services programs on behalf of the State. With the implementation of the Whole Child Model within County Organized Health Systems (COHS), counties moved service authorization and case management services to local managed care plans. Under the Whole Child Model, counties also are still responsible for determination of residential, medical, and financial eligibility for the program. Counties also provide Medical Therapy Program services for California Children’s Services children, and retain a share of cost for services to non-Medi-Cal children.

- 1) Maximum federal and state matching funds for The California Children’s Services program must continue to avoid the shifting of costs to counties. Counties cannot continue to bear the rapidly increasing costs associated with both program growth and

eroding state support.

- 2) Counties also support efforts to test alternative models of care under pilot programs.
- 3) Counties seek to ensure these high-need patients continue to receive timely access to quality care, and there are no disruptions in care. In addition, counties must be adequately resourced to provide services to children that remain the county's responsibility.

#### State Children's Health Insurance Program

- 1) CSAC supports sustained funding for the federal Children's Health Insurance Program (CHIP/Healthy Families). In 2018, the CHIP program was reauthorized through 2023. However, the federal match rate decreases over time during this period and limits the requirement to provide coverage for children in families with income at or below 300% of the federal poverty level. Without federal funding, some families risk losing coverage for their children if their income is too high to qualify for Medicaid/Medi-Cal and too low to purchase family coverage.

#### Proposition 10: The First 5 Children and Families Commissions

In November 1998, California voters passed Proposition 10, the "Children and Families Act of 1998" initiative, which created the 58 First 5 county commissions across the state. The act levies a tax on cigarettes and other tobacco products and provides funding for early childhood development programs and mandates that commissions work across systems to integrate service delivery and promote optimal childhood development.

First 5 Children and Families Commissions believe that every child deserves to be healthy, safe, and ready to succeed in school and life. Based on extensive research, First 5 promotes the importance of collective impact to support children and families from the earliest moments possible. This prevention framework leads to improved child health and development outcomes, increased school success, and over time increases economic benefit across all public systems.

- 1) Counties recognize the importance of policies that advance whole child, whole
- 2) family approaches, increase racial equity, build integrated systems and focus on prevention to enhance critical services for children and families. As such, counties support strengthening early care, comprehensive health and development, and learning programs and systems, with a focus on programs that counties administer, facilitate participation in, or that enhance the ability of First 5 commissions to serve communities and families. Counties will also give consideration to how improved early childhood outcomes can have positive impacts related to potential interaction between children and families with other programs that counties administer.
- 3) Counties support efforts that improve system coordination and encourage leveraging of resources within counties and between local and state agencies to enhance critical

services for children and families.

- 4) Counties oppose any effort to diminish First 5 funding, lower or eliminate state support for county programs with the expectation that the state or local First 5 commissions will backfill the loss with Proposition 10 revenues. Due to the declining nature of tobacco tax revenues, counties support the inclusion of existing tobacco taxes, including Proposition 10, in any subsequent tobacco tax proposal.
- 5) Counties oppose any effort to restrict local First 5 expenditure authority. First 5 commissions must maintain the necessary flexibility to direct these resources address the greatest needs of communities surrounding family resiliency, comprehensive health and development, quality early learning, and systems sustainability and scale.

## **SECTION 6: MEDI-CAL: CALIFORNIA'S MEDICAID PROGRAM**

California counties have a unique perspective on the state's Medicaid program, Medi-Cal. Counties are charged with preserving the health and safety of communities; they also operate health plans, provide direct services, specialize in care for patients with complex social needs, conduct eligibility for benefits, and bear a significant amount of risk for financing the program. As the local public health authority, counties are vitally concerned about health outcomes. Undoubtedly, changes to the Medi-Cal program, including efforts to integrate and coordinate care for Medi-Cal enrollees, will affect all counties.

- 1) Counties remain concerned about state, federal and local partner proposals that would decrease access to health care or shift costs and risk for Medicaid services to counties.
- 2) Any Medi-Cal reform that results in decreased access to or funding of county hospitals and health systems will be devastating to the safety net and the patients we serve. The loss of Medi-Cal funds translates into fewer dollars to operate our facilities and deliver care to all persons served by county facilities. Counties are not in a position to absorb or backfill the loss of state and federal funds. Rural counties already have particular difficulty developing and maintaining health care infrastructure and ensuring access to services.
- 3) Counties support the continued role of county welfare departments in Medi-Cal eligibility, enrollment, outreach, and retention functions. The state should fully fund county costs for the administration of the Medi-Cal program, and consult with counties on all policy, operational, and technological changes in the administration of the program. Further, enhanced data matching and case management of these enrollees must include adequate funding and be administered at the local level.
- 4) County behavioral health departments provide Medi-Cal Managed Care Specialty Mental health services, and must receive adequate funding for these critical services

and new sustainable funding for additional responsibilities. Changes to the Medi-Cal program, including the move toward integrated care, will undoubtedly affect the day-to-day business and fiscal viability of California counties as well as the people we serve.

- 5) It is vital that changes to Medi-Cal preserve the viability and innovations of the local safety net and not shift additional costs to counties. Counties support examining payment reform within the county specialty mental health plans as long as efficiencies and administrative workload are simplified and counties do not shoulder additional costs.
- 6) Counties oppose any efforts to decrease funding for or reverse expansions to the Medi-Cal program, which will eliminate coverage for consumers and shift the responsibility of these individuals with healthcare from the Medi-Cal program to counties, which are required to provide services to the medically indigent.
- 7) The state should continue to provide options for counties to implement managed care systems that meet local needs. The state should work openly with counties as primary partners in this endeavor and allow counties a role in managed care plan selection.
- 8) The state needs to recognize county experience with geographic managed care and make strong efforts to ensure the sustainability of county organized health systems. The Medi-Cal program must offer a reasonable reimbursement and rate mechanism for local managed care systems.
- 9) Changes to Medi-Cal must preserve access to medically necessary behavioral health care and drug treatment services. Counties also support proposals, such as the CalAIM proposal of 2019, to modify the state's definition of medically necessary to include services provided before a clinical diagnosis is made. This modification will increase timely access to critical services for children, those with substance use disorders, and all mental health plan clients. These changes must be accompanied by the ability to claim federal Medicaid funding for pre-diagnosis services
- 10) The carve-out of specialty behavioral health services within the Medi-Cal program must be examined in the era of integrated care, but any change must preserve federal funding available to counties and minimize county risks to continue the effective delivery of rehabilitative community-based mental health services to local Medi-Cal enrollees.
- 11) Counties recognize the need to continue to innovate under the Drug Medi-Cal Organized Delivery System Waiver program in ways that maximize federal funds, ensure access to medically necessary evidence-based practices, allow counties to retain authority and choice in contracting with accredited providers, and minimize county fiscal risks.

- 12) Any Medi-Cal reform effort must recognize the importance of substance use disorder treatment and services in the local health care continuum, as well as the evidence of good outcomes under integrated care models.
- 13) Counties will not accept a share of cost to locally support the Medi-Cal program. Counties also believe that Medi-Cal long-term care must remain a state-funded program and oppose any cost shifts or attempts to increase county responsibility through block grants or other means.
- 14) The state should fully fund county costs associated with the local administration of the Medi-Cal program.
- 15) Complexities of rules and requirements should be minimized or reduced so that enrollment, retention and documentation and reporting requirements are not unnecessarily burdensome to recipients, providers, and administrators and are no more restrictive or duplicative than required by federal law.
- 16) The State should consider counties as full partners in the administration of Medi-Cal, and consult with counties in formulating and implementing all policy, operational and technological changes.

#### Medicare Part D

Medicare Part D led to an increase in workload for case management across many levels of county medical, social welfare, criminal justice, and behavioral health systems.

- 1) Counties strongly oppose any change to realignment funding that may result and would oppose any reduction or shifting of costs associated with this benefit that would require a greater mandate on counties.

#### Medicaid and Aging Issues

- 1) Counties support reliable funding for programs that affect older and dependent adults, such as Adult Protective Services and In-Home Supportive Services, and oppose any funding cuts, or shifts of costs to counties without revenue, from either the state or federal governments. Please see the Human Services Chapter of the CSAC Platform for more details on IHSS and APS.
- 2) Counties support efforts to prevent, identify, and prosecute instances of elder abuse.
- 3) Counties support investments of new state and federal resources to support the APS workforce and enhance the direct services available to victims of abuse and neglect.
- 4) Counties are committed to addressing the unique needs of older and dependent adults in their communities, and support collaborative efforts to build a continuum of services as part of a long-term system of care for this vulnerable but vibrant population.

- 5) Counties support federal and state funding to support Alzheimer’s disease and dementia research, community education and outreach, and resources for caregivers, family members and those afflicted with Alzheimer’s disease and dementia.
- 6) Counties support legislative efforts to prevent homelessness among at-risk older adults and people with disabilities.
- 7) Counties support funding for the full range of aging programs that provide services to older adults including services provided by Area Agencies on Aging (AAAs), senior nutrition programs, caregiver supports, resource centers, ombudsman programs, and home and community-based supports.

## **SECTION 7: HEALTH REFORM EFFORTS**

Counties support affordable, comprehensive health care coverage for all persons living in the state. The sequence of changes and implementation of federal or state healthcare reform efforts must be carefully planned, and the state must work in partnership with counties to successfully realize any gains in health care and possible cost increases or decreases.

Under AB 85, Counties must also retain sufficient health realignment revenues for residual responsibilities, including existing Medi-Cal non-federal share responsibilities to care for the remaining uninsured, and public health. Any changes to AB 85 must also allow counties to retain sufficient health realignment revenues for these residual responsibilities and future needs.

- 1) Counties support offering a truly comprehensive package of health services that includes mental health and substance use disorder treatment services at parity levels and a strong prevention component and incentives.
- 2) Counties support the integration of health care services for inmates and offenders of county and state correctional institutions, detainees, and undocumented immigrants into the larger health care service model.
- 3) Health reform efforts must address access to health care in rural communities and other underserved areas and include incentives and remedies to meet these needs as quickly as possible.
- 4) Counties strongly support maintaining a stable and viable health care safety net with adequate funding.
- 5) The current safety net is grossly underfunded. Any diversion of funds away from existing safety net services will lead to the dismantling of the health care safety net and will hurt access to care for all Californians.

- 6) Counties believe that delivery systems that meet the needs of vulnerable populations and provide extensive primary, specialty and tertiary care –are essential providers. Their education, training and ongoing work must be supported in any health care reform effort.
- 7) Counties strongly support adequate funding for the local public health system as part of a plan to reform health care and achieve universal health coverage. A strong local public health system can help reduce medical care costs, assist patients in managing chronic disease, reduce health inequities, and address disaster preparedness and response.
- 8) Counties support access to affordable, comprehensive health coverage through a combination of mechanisms that may include improvements in and expansion of the publicly funded health programs, increased employer-based and individual coverage through purchasing pools, tax incentives, and system restructuring. The costs of universal health care and health care reform shall be shared among all sectors: government, labor, and business.
- 9) Health reform efforts, including efforts to achieve universal health care, should simplify the health care system – for consumers, providers, and overall administration. Any efforts to reform the health care system should include prudent utilization control mechanisms that are appropriate and do not create barriers to necessary care.
- 10) The federal government has an obligation and responsibility to assist in the provision funding of health care coverage.
- 11) Counties encourage the state to pursue ways to maximize federal financial participation in health care expansion efforts, and to take full advantage of opportunities to simplify Medi-Cal, and other publicly funded programs with the goal of achieving maximum enrollment and provider participation.
- 12) County financial resources are currently overburdened; counties are not in a position to contribute permanent additional resources to expand or integrate health care coverage.
- 13) Counties strongly encourage public health and equity as key components to any health care coverage expansion. Public health prevention activities in addition to access to health education, preventive care, and early diagnosis and treatment will assist in controlling costs through improved health outcomes. Health equity efforts will increase access to health care for underserved populations and improve the overall health of our communities.
- 14) Counties, as both employers and administrators of health care programs, recognize that, under the current system in the United States every employer has an obligation to contribute to health care coverage, and counties advocate that such an employer policy

should also be pursued at the federal level and be consistent with the goals and principles of local control at the county government level.

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

## **SECTION 8: CALIFORNIA HEALTH SERVICES FINANCING**

- 1) Those eligible for Temporary Assistance for Needy Families (TANF)/California Work Opportunity and Responsibility to Kids (CalWORKs), should retain their categorical linkage to Medi-Cal.
- 2) Counties are concerned about the erosion of state program funding and the inability of counties to sustain current program levels. As a result, we strongly oppose additional cuts in county administrative programs as well as any attempts by the state to shift the costs for these programs to counties. With respect to the County Medical Services Program (CMSP), counties support efforts to improve program cost effectiveness and oppose state efforts to shift costs to participating counties, including administrative costs and elimination of other state contributions to the program. Due to the unique characteristics of each county's delivery system, health care accessibility, and demographics of client population, counties believe that managed care systems must be tailored to each county's needs, and that counties should have the opportunity to choose providers that best meet the needs of their populations. Where cost-effective, the state and counties should provide non-emergency health services to undocumented immigrants and together seek federal and other reimbursement for medical services provided to undocumented immigrants.
- 3) Counties support the continued use of federal Medicaid funds for emergency services for undocumented immigrants. Counties support increased funding for trauma and emergency room services overall.
- 4) Although reducing the number of uninsured through expanded health care coverage will help reduce the financial losses to trauma centers and emergency rooms, critical health care safety-net services must be supported to ensure their long-term viability.

### Realignment

- 1) Counties believe the integrity of realignment should be protected. Counties also strongly oppose any change to realignment funding that would negatively impact counties fiscal or administratively.
- 2) Counties remain concerned and will resist any reduction of dedicated realignment revenues or the shifting of new costs from the state and further mandates of new and

greater fiscal responsibilities to counties in this partnership program.

- 3) Any effort to realign additional programs must occur in the context of Proposition 1A constitutional provisions and must guarantee that counties have sufficient revenues for residual responsibilities, including public health programs.
- 4) In 2011, counties assumed fiscal responsibility for Medi-Cal Specialty Mental Health Services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); Drug Medi-Cal; drug courts; perinatal treatment programs; and women's and children's residential treatment services as part of the 2011 Public Safety Realignment. Please see the Realignment Chapter of the CSAC Platform and accompanying principles.
- 5) Counties bear significant responsibility for financing the non-federal share of Medi-Cal services in county public health systems. They also continue to have responsibility for uninsured services.

#### Hospital Financing

Public hospitals are a vital piece of the local safety net, and serve as indispensable components of a robust health system, providing primary, specialty, and acute health services, as well as physician training, trauma centers, and burn care. California's public hospitals provide a significant portion of the state's non-federal share in the Medi-Cal program, and these local expenditures are made at the sole discretion of the county Supervisors.

- 1) Counties have been firm that any proposal to change hospital Medicaid financing must guarantee that county hospitals do not receive less funding than they currently do, and are eligible for more federal funding in the future as needs grow and challenges arise.
- 2) Counties strongly support the continuation of robust and innovative Medicaid Section 1115 and 1915(b) waivers to ensure that county hospitals are paid for the safety net care they provide to Medi-Cal recipients and uninsured patients and have the ability to innovate and improve access to care.
- 3) As California moves away from large Medicaid waivers that county public hospitals have relied on for critical funding, funding levels must be preserved and strengthened through other vehicles.
- 4) Counties also support opportunities for county public hospitals and health systems to make delivery system improvements, including improving care coordination, which will help ensure the provision of high quality, accessible care to all patients they serve.
- 5) Counties support proposals to preserve supplemental payments to public and private hospitals. Any loss of federal funds through changes to waiver agreements or federal regulations must identify other fiscal opportunities and support to ensure the continued

viability of the safety net.

## **SECTION 9: FAMILY VIOLENCE**

CSAC remains committed to raising awareness of the toll of family violence on families and communities by supporting efforts that target family violence prevention, intervention, and treatment. Specific strategies for early intervention and success should be developed through cooperation between state and local governments, as well as community and private organizations addressing family violence issues, taking into account that violence adversely impacts Californians, particularly those in disadvantaged communities, at disproportionate rates and that these impacts have long ranging health and economic consequences for these individuals and the state as a whole.

## **SECTION 10: HEALTHY COMMUNITIES**

Built and social environments significantly impact the health of communities. Counties support public policies and programs that aid in development of healthy communities including food and beverage policies that increase access to healthier food in county-operated no/low cost food programs (e.g., USDA Summer Lunch, inmate programs, and senior meals) or concession and vending operations. Counties support the concept of joint use of facilities and partnerships, mixed-use developments and walkable and safe developments, to promote healthy community events and activities.

## **SECTION 11: VETERANS**

Specific strategies for intervention and service delivery to veterans should be developed through cooperation between federal, state and local governments, as well as community and private organizations serving veterans.

Counties support coordination of services for veterans among all entities that serve this population, especially in housing, treatment, and employment training.

## **SECTION 12: EMERGENCY MEDICAL SERVICES**

- 1) Counties do not intend to infringe upon the service areas of other levels of government who provide similar services, but will continue to discharge our statutory duties to ensure that all county residents have access to the appropriate level and quality of emergency services, including medically indigent adults.
- 2) Counties support ensuring the continuity and integrity of the current emergency medical services system, including county authority related to medical control, trauma

planning, and alternative destination efforts.

- 3) Counties recognize that effective administration and oversight of local emergency medical services systems includes input from key stakeholders, such as other local governments, private providers, state officials, local boards and commissions, and the people in our communities who depend on these critical services.
- 4) Counties support maintaining the authority and governing role of counties and their local emergency medical services agencies to plan, implement, and evaluate all aspects and components of the local Emergency Medical Services system.
- 5) Counties oppose efforts that would weaken the local authority of local medical services agencies or lead to system fragmentation and safety issues.

### **SECTION 13: COURT-INVOLVED POPULATION**

Counties recognize the importance of enrolling the court-involved population into Medi-Cal and other public programs. Medi-Cal enrollment provides access to important behavioral health, substance use, and primary care services that will improve health outcomes and may reduce recidivism. CSAC continues to look for partnership opportunities with the Department of Health Care Services, foundations, and other stakeholders on enrollment, eligibility, quality, and improving outcomes for this population. Counties are supportive of obtaining federal Medicaid funds for inpatient hospitalizations, including psychiatric hospitalizations, for adults and juveniles while they are incarcerated.

### **SECTION 14: INCOMPETENT TO STAND TRIAL**

Counties affirm the authority of County Public Guardians under current law to conduct conservatorship investigations and are mindful of the potential costs and ramifications of additional mandates or duties in this area.

Counties support collaboration among the California Department of State Hospitals, county Public Guardians, Behavioral Health Departments, and County Sheriffs to find secure placements for individuals originating from DSH facilities, county jails, or who are under conservatorship. Counties support a shared funding and service delivery model for complex placements, such as the Enhanced Treatment Program.

Counties recognize the need for additional secure placement options for adults and juveniles who are conserved or involved in the local or state criminal justice systems, including juveniles.