California HealthCare Foundation

The Crucial Role of Counties in the Health of Californians: An Overview

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California HealthCare Foundation

by
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About the Authors

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About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

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I. Introduction

California's 58 counties are core providers of an array of local health services, including medical care for low-income, underserved, and uninsured populations, public and environmental health services, and behavioral health and substance use treatment services. County health programs rely on a historical, complex, and shifting patchwork of federal, state, and local funds. The revenues available to counties, and the expectations of county health programs, are dramatically affected year to year by the economic and fiscal challenges, and the policy and political landscape, at all levels of government.

Implementation of federal health care reform under the provisions of the Patient Protection and Affordable Care Act (ACA) of 2010 creates many new opportunities and challenges for California counties in defining and implementing their health-related programs and responsibilities. At the same time, persistent federal, state, and local fiscal and budget crises will continue to challenge county health programs and systems to maintain core services in the face of continuing budget and program cutbacks. The policy deliberations arising from the ACA, along with fiscal constraints at all levels of government, have the potential to dramatically reshape state and local relationships over the next decade, affecting the provision of public services, including health services.

This report offers an overview of the range of health services and programs that have become the responsibility of California counties, either by statute, practice, or default. It outlines: basic responsibilities currently assigned to counties in the areas of medical care services for low-income populations, public health, mental health, and substance abuse treatment; the funding streams for these services and programs; and the variety of methods counties use to provide the services. The table in the Appendix provides a quick reference summary of the program information.

This snapshot overview is offered as background information for policy discussions about the role California counties will play in the future health of Californians.

II. The Programs and Services

Each of the 58 counties is different in some aspects of their health infrastructure, and tremendous variation exists in program design, administration, and funding. No two counties organize and administer this complex array of health programs in exactly the same way.

COUNTIES HAVE BROAD AUTHORITY AND RESPONSIBILITY relating to the provision of health-related services, as well as wide local discretion in the types of programs offered, the people served, and the methods of service delivery. State law imposes on counties broad and often vague mandates, which are subject to interpretation and vulnerable to changing fiscal environments at all levels of government.

Consequently, there is significant diversity between counties in the level and type of services residents of the county may receive, and in the systems and programs that deliver the services. Each of the 58 counties is different in some aspects of their health infrastructure, and tremendous variation exists in program design, administration, and funding. There is no systematic or unified statewide reporting or tracking of the total revenues and expenditures for the health-related programs that counties administer. Consequently, it can be difficult to get a sense of the total local investment in health, or to assess how effectively each county is meeting the overall health needs of its residents.

There are numerous federal, state, and local agencies involved in allocating the funding, developing program standards and requirements, collecting data, and administering the programs. Even though the variety of health programs counties manage are often administered separately at the state level, some counties combine programs at the local level in the form of one agency or else as coordinated programs, such as: mental health and health, substance abuse treatment and health, medical and mental health care, and mental health and substance abuse treatment.

Indigent Health Care

In California, counties are responsible for the health care of low-income uninsured residents who have no other sources of care. This county obligation is codified in Section 17000 of the California Welfare and Institutions Code, which states:

> *"Every 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 by*

their relatives or friends, by their own means or by state hospitals or other state or private institutions."

This simple language forms the basis for county general relief income support programs and the indigent health care programs administered by California counties. Subsequent code sections confirm the "duty of the counties to provide health care." State law and legal precedents have generally established that the Section 17000 obligation includes, but is not necessarily limited to, responsibility for providing health care services to uninsured low-income adults, often referred to as medically indigent adults (typically low-income adults ages 21 to 64 without other health care coverage). Between 1971 and 1982, California operated a state-funded Medi-Cal program for medically indigent adults, but returned the program and a portion of the funding to the counties in 1982. Generally, the courts have found that counties need to have a standard for the services they provide under Section 17000, but neither law nor legal precedent specifically outlines how counties must meet this obligation. Counties have significant discretion in the level and method of health care they provide.

As a result, tremendous variation exists in county programs and in county spending for health care. Some counties define the Section 17000 obligation narrowly and focus exclusively on serving legal residents who meet the narrow definition of medically indigent adult through a defined and limited indigent care program. Other counties assume broad responsibility for health care services and programs in the county, including programs that serve low-income, undocumented children and adults. Local decision-making allows counties to be responsive to local needs, priorities, and political preferences, but the diversity of county program designs and methods makes comparison of the county programs difficult. The general strategies counties use to fulfill the indigent health care obligation are discussed below.

County Medical Care Programs

When it comes to providing medical care services to low-income and uninsured populations, counties are generally split into two types. The 24 largest counties provide, organize, and/or pay for indigent medical care services directly using a variety of service delivery strategies. These larger counties were historically referred to as Medically Indigent Services Program (MISP) counties. Thirty-four smaller counties voluntarily participate in the centrally administered County Medical Services Program (CMSP), a medical coverage program similar (but not identical) to Medi-Cal, California's Medicaid program.

Whether or not a county is an MISP or CMSP county, and regardless of the system established by the county for delivering services to the medically indigent, in most counties, nonprofit community clinics and health centers (CCHC) and private hospitals also provide health care services to low-income uninsured and underinsured people.

Large Counties: Medically Indigent Services Programs

California's 24 largest counties administer separate, county-specific, medically indigent programs, and each county sets and determines eligibility, services provided, payment methods, providers, and funding levels in the programs. Some MISP counties limit their programs to medically indigent adults who are legal county residents, while others also provide services for undocumented children or adults. Some MISP counties choose to operate public hospitals and/or county outpatient clinics that provide not only indigent care services but also an array of health

and medical care services to individuals with multiple public and private coverage sources.

Counties do not report statewide on the scope of indigent medical care services, eligibility criteria, funding levels, or methods of provider reimbursement. Identifying and characterizing county programs and delivery systems requires county-by-county research on how each one chooses to meet the indigent care obligation.

Characterizing county indigent health care programs and delivery systems in California's 24 largest counties requires county-by-county research on how each one chooses to meet the indigent care obligation.

There are three general methods of county indigent care service delivery, but 24 different indigent care systems.[1] The three methods counties generally use to provide MISP program services are:

- **Provider counties.** Provider counties own and operate county inpatient hospitals, publicly owned clinics, and other facilities that serve both the uninsured and those with other public or private health coverage. As of 2009, 12 counties operated 16 county-owned hospitals (Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura).[2] Modoc Medical Center, a county-operated hospital, is in transition to becoming a district hospital. Of California's 67 designated trauma centers, eight are located at county-owned facilities.[3] Over time, many counties have closed or leased their county hospitals. The current number of county-operated hospitals represents a decrease from 50 counties with 66 facilities in 1964. Provider counties typically have extensive outpatient clinics, including hospital-based outpatient clinics and, in some cases, freestanding clinics. Some counties that are provider counties also contract with or reimburse nonprofit community clinics and health centers (CCHCs), local medical centers operated by the University of California (UC) and private hospitals for services provided to low-income uninsured people.
- **Payer counties.** Payer counties purchase indigent care inpatient services through contracts with one or more private or UC hospitals, and pay for outpatient services through CCHCs, private clinics, and/or private physicians (Fresno, Merced, Orange, San Diego, San Luis Obispo, and Yolo). Two payer counties (Orange and San Diego) contract with local UC hospital medical centers — considered public hospitals for Medicaid funding purposes — to provide some of the county indigent program services.
- **Hybrid counties.** Hybrid counties do not have county-operated hospitals; they contract with private or UC hospitals for inpatient care but also operate some publicly owned outpatient clinics, which may be major providers of primary care services to the uninsured (Placer, Sacramento, Santa Barbara, Santa Cruz, Stanislaus, and Tulare.) Some hybrid counties also have contracts with CCHCs or private physicians to provide services to low-income uninsured people.

The majority of county MISP programs (with some counties having more than one program) serve

adults ages 21 to 64, but nine programs serve any resident regardless of age.[4] Income eligibility for MISP services ranges from 63 percent of the federal poverty level (FPL) to more than 250 percent FPL, with the largest number of counties (17) covering eligible residents with household incomes up to 200 percent FPL. MISP benefits vary widely from county to county. Some MISP counties cover the same services as Medi-Cal, while others have a more limited benefits package. The most commonly excluded services are adult day health care, drug and alcohol treatment, skilled nursing, chiropractic, and psychological services. Twenty counties have integrated indigent medical care programs with other county programs and services such as mental and behavioral health programs.[5]

Smaller Counties: The County Medical Services Program

The 34 smaller counties participate in the CMSP. The CMSP was established in January 1983, when California transferred legal responsibility for providing health services to indigent adults from the state to the counties. This law recognized that many smaller, rural counties were not in a position to operate the program and allowed counties who had 300,000 or fewer residents at that time to contract with the then state Department of Health Services (DHS) to administer the program.

The CMSP was administered by DHS until 1995, when it was transferred to the independent CMSP Governing Board, composed of representatives from participating counties. CMSP provides medical care services to medically indigent adults ages 21 to 64 who are not eligible for Medi-Cal, who are U.S. citizens or legal residents, and who have incomes up to 200 percent FPL ($21,660 for an individual in 2010). Emergency services are provided when immigration status is not known.

Benefits in CMSP are similar but not identical to Medi-Cal. Specific services that are not covered in CMSP include acupuncture, chiropractic, pregnancy-related services, long-term care, skilled nursing facility services, psychological services provided by non-psychiatrist providers, contact lenses that are not medically necessary, methadone maintenance services, and all services provided outside of California and designated border state areas. CMSP does cover adult dental services and offers several other benefits which were eliminated from Medi-Cal coverage in 2009.

CMSP contracts with Anthem Blue Cross and MedImpact Health Systems Inc. (MedImpact) to administer program benefits through contracted providers. Anthem Blue Cross administers medical, dental, and vision benefits, and MedImpact administers pharmacy benefits. County social services agencies (welfare departments) determine eligibility. Most individuals on CMSP have enrollment terms of six months. To continue enrollment, beneficiaries must reapply at the end of their enrollment terms. The average monthly enrollment is 57,000. CMSP is currently funded with realignment funds, county contractual contributions (county general fund revenue), CMSP program reserves, and third-party reimbursements and recoveries. In prior years, CMSP received an allocation of state general and Proposition 99 funds, but there have been no state funds in the program since 2000.

Figure 1. County Programs for Medically Indigent Adults, 2011

DEFINITIONS

Provider counties: Own and operate county inpatient hospitals, publicly owned clinics and other facilities that serve both the uninsured and those with other public or private health coverage. Provider counties may also have contracts with CCHCs or private physicians to provide services to low-income uninsured people.

Payer counties: Purchase indigent care impatient services through contracts with one or more private or UC hospitals for inpatient services and pay for outpatient services through CCHCs, private clinics, and/or private physicians.

Hybrid counties: Do not have county-operated hospitals; they contract with private or UC hospitals for inpatient care but also operate some publicly owned outpatient clinics, which may be major providers of primary care services to the uninsured. Some hybrid counties also have contacts with CCHCs or private physicians to provide services to low-income uninsured people.

CMSP counties: CMSP, administered by the independent CMSP governing board, provides medical care to medically indigent adults in 34 smaller counties which voluntarily participate in the program.

Sources: Insure the Uninsured Project; McMahon, T., and M. Newman. *County Programs for the Medically Indigent in California.* California HealthCare Foundation, October 2009; *County-owned Hospitals in California.* California State Association of Counties, September 2010 (www.csac.counties.org); individual MISP county Web sites.

County Children's Health Initiative Programs

In addition to county-administered programs for medically indigent adults, many counties administer health coverage programs for low-income, uninsured children. The California Children's Health Initiatives (CCHI) are county-based, public-private partnerships that use a variety of programs and funding sources to provide comprehensive health care coverage to low- and moderate-income uninsured children not otherwise eligible for Medi-Cal or the Healthy Families program. These programs are called Healthy Kids in most counties. CCHIs operate in 29 counties and, as of September 2010, provided health coverage for around 55,000 children, a decline from the more than 77,000 children in December 2008.[6]

Healthy Kids programs are funded differently in each community, but typically have some county funding or in-kind contributions and may have a mix of private foundation funding, Proposition 10 Children and Families program funding, or other private funding. In addition, some counties are able to draw down federal Children's Health Insurance Program (CHIP) funding for children who are federally eligible through the County Children's Health Initiative Program (C-CHIP) administered by the Managed Risk Medical Insurance Board (MRMIB). C-CHIP allows counties to use local county funds as a match when they draw down unused federal CHIP funds.

Funding for County Indigent Care

Data about funding and expenditures for county indigent care programs in the 24 largest counties are limited or outdated and there is no one data source for how much MISP counties spend on indigent health care.[7] The CMSP Governing Board tracks funding and expenditures for the program, and the data are generally published in aggregate form on the Board's website. The primary funding sources for indigent health care are health and welfare realignment program funds — dedicated sales tax and motor vehicle license fees (VLF) — and county general funds. In addition, counties that operate public hospitals are able to match county expenditures for Medi-Cal beneficiaries and the uninsured with federal Medicaid funds under the terms of California's federal Medicaid Section 1115 waiver (see page 10).

Many of the revenue sources counties typically rely on to support health services are subject to changing economic trends; dedicated revenues tend to go up when the economy is growing, but decline during a recession. Meeting the obligation to provide care for indigent residents has become more difficult for counties in the wake of the recent economic recession that has both reduced state and local revenues to support safety net programs and increased demand for county health services as people have lost their jobs and health coverage.[8]

Realignment (1991). A principal funding source for county indigent health care (as well as public health and mental health) services continues to be realignment funding. The existing realignment program provides to counties revenues from certain state sales tax and VLFs consistent with the 1991 agreement to shift responsibility for specific health and social services programs, along with specific dedicated revenues, from the state to the counties (see boxed feature on page 9). Under realignment, and with some restrictions, counties may transfer limited funds among the Health, Mental Health, and Social Services accounts.

Since both sales tax and VLF revenues are affected by economic conditions, realignment revenue growth has been inconsistent. Since 2006–07, realignment funds have consistently been a declining source of revenue for county programs. In addition, under the

The 1991 Health and Welfare Realignment

What is realignment?

The health and welfare realignment program was established in 1991 to transfer certain health and mental health programs to the counties and adjust the cost-sharing ratios between the state and the counties for social services and health programs. Realignment also provides counties with dedicated revenues to support their increased financial obligations.

How is realignment funded and allocated?

State funding is provided through two dedicated revenue sources: one half of a cent of the sales tax, and 74.9 percent of VLF revenue. The Local Revenue Fund contains a Sales Tax Account, a Sales Tax Growth Account, a VLF Account, a VLF Growth Account, and several subaccounts. The revenues deposited into these accounts are distributed by the state Controller's Office to all counties and four cities monthly, according to various formulas. Each year an annual allocation base is determined, consisting of the total amount allocated in the previous year, including growth allocations. Revenues in excess of the base are deposited in the growth accounts and are allocated based on different formulas.

Funds allocated by the state controller are deposited into and expended from the Mental Health, Social Services, and Health Trust Funds at the local level. Revenues in these funds must be expended for programs according to state law.

Growth funds are distributed according to complicated formulas in state law. The first claim on sales tax growth goes to entitlement programs, primarily caseload-driven social services programs. The two programs with the greatest cost and caseload increases have been child welfare/foster care and IHSS. The remaining growth in sales tax and VLF revenue is distributed to the counties according to a statutory formula. As a practical matter, over time, the increasing costs of the social services caseloads have significantly reduced the allocations of growth funds to health and mental health services. In addition, there has been no sales tax or VLF growth since 2006–07, and revenues declined during that period.

How are funds allocated and spent?

Generally, realignment funds must be spent for the purposes intended. For example, health realignment funds can be spent only for indigent health care and for the public health programs the state paid for before realignment. However, state law permits counties to reallocate up to 10 percent of the funds in the health, mental health, or social services funds to either one of the other two accounts. If a county has allocated 10 percent of both the health and mental health allocations to social services, counties can shift another 10 percent from health to social services. If counties have extra funds in the social services account, after funding all of the caseload and costs, counties can transfer 10 percent of the social services account to health and mental health. Transfers apply only for the year in which they are made.

What are "poison pill" provisions?

The original realignment legislation included several "poison pill" provisions that would invalidate components of the realignment program. Generally, the poison pill provisions would invalidate elements of realignment or tax increases if the courts or the Commission on State Mandates found state reimbursable mandates, or if the courts found specified constitutional problems with the revenue increases in realignment. A December 2003 court case did trigger one poison pill related to services for medically indigent adults, invalidating the increase in the VLF, but the legislature passed legislation eliminating this poison pill in order to continue the flow of realignment dollars to counties.

realignment formula, counties must pay for the rising costs of social services caseload programs, including foster care and the In-Home Supportive Services (IHSS) program, before allocating any growth that occurs in sales tax revenues to health, mental health, or public health programs.

A combination of historical funding formulas, state and federal program requirements, and local decisions determine the level and extent to which funding for social services programs affects realignment revenues available for health, mental health, and public health programs in a particular county. For example, IHSS programs, which provide county, state- and federally-funded personal assistance services to low-income eligible seniors and people with disabilities, have somewhat different structures and staffing models from county to county. Decisions made by a county to organize services in a specific way and to pay specific wages and benefits to workers affect the costs of the IHSS program in that county. The extent to which counties have over time transferred health or mental health funding to social services also differs significantly from one to the next.[9]

California's Medi-Cal Waiver. Since 2005, California has been operating under the terms of two five-year federally approved Section 1115 Medicaid waivers that include funding for services provided by county indigent health care programs. The waivers were granted pursuant to Section 1115 of the Social Security Act, which allows the federal government to waive certain Medicaid requirements, and allows states to receive matching funds for Medicaid services generally not otherwise allowed as well as coverage expansions to people not typically eligible for Medicaid.

The Medi-Cal Hospital Uninsured Care Waiver: 2005–2010

The purpose of the 2005 Section 1115 waiver was to replace hospital financing arrangements deemed inappropriate by the federal Centers for Medicare and Medicaid Services (CMS), retain federal funding that had been provided under another 1115 waiver for Los Angeles County, and fund initiatives to expand coverage for the uninsured.[10] Sometimes referred to as the "Hospital Financing Waiver," the first phase changed how the state paid hospitals for treating Medi-Cal beneficiaries and people with no insurance. Under the terms of the 2005 waiver, counties with public hospitals received federal Medicaid funds to support services provided to these populations. For county and UC hospitals — "designated public hospitals" — the waiver reduced and limited the use of Intergovernmental Transfers (IGT), transfers of public funds from one level of government (e.g., from a county to a state), or from one state agency to another (e.g., from UC to the state), which had been used by California to fund the non-federal share of payments to hospitals under the Disproportionate Share Hospital program and another supplemental payment program for hospitals with emergency and trauma programs (sometimes referred to as "SB 1255" payments based on the enabling 1989 legislation).[11]

The 2005 waiver replaced a portion of IGTs with certified public expenditures (CPE), costs public hospitals incur in treating Medi-Cal and uninsured patients, to support the non-federal Medicaid match. Under the waiver, state general funds provided to public hospitals were no longer used to fund inpatient, fee-for-service Medi-Cal. Instead, public hospitals spent money on the provision of care and then used the CPEs to draw down federal Medicaid funds from several different funding categories established in the waiver. The waiver included

some limitations on the amount public hospitals could draw down using CPEs. During the course of the waiver, counties spent more in CPEs than they were able to draw down in federal Medicaid funds because of the limits in the waiver, which resulted in significant public hospital costs remaining unreimbursed. The waiver changed the source of the non-federal Medicaid match for private safety net hospitals to state general funds.

In years three, four, and five, the 2005 hospital financing waiver provided $180 million annually in federal reimbursements toward the creation of the Health Care Coverage Initiative (HCCI), demonstration projects expanding coverage to adults at up to 200 percent FPL. The state selected ten counties to implement HCCIs. As with other programs under the waiver, counties and public hospitals provided the non-federal share for the program through the use of CPEs. The HCCIs expanded coverage to more than 100,000 low-income adults.[12] HCCIs assigned each enrollee to a medical home in a public hospital system clinic, a community health center, or a private physician's office for regular primary and preventive care.

The hospital financing waiver expired August 31, 2010 and was extended until October 31, 2010 as the state negotiated the terms of the new five-year waiver.

The Medi-Cal Bridge to Reform Waiver: 2010–2015

On November 2, 2010, the CMS approved California's request for a new Section 1115 waiver, entitled "California's Bridge to Reform," through October 31, 2015.[13] The Bridge to Reform waiver replaces the 2005 Hospital Financing Waiver and is designed to prepare California's health care delivery system for national health care reform as well as to sustain the Medi-Cal program. The 2010 waiver will allow the state to expand coverage to childless adults, promote public hospital delivery system improvements, preserve the safety net, and improve care coordination. Over the five-year waiver period, California could receive $10 billion in federal funds, the majority of which will be used to support indigent care programs administered at the county level, county health care delivery systems, additional coverage expansion, and county health system improvements.

Key elements of the 2010 Bridge to Reform waiver include:

- **Low Income Health Program.** The Low Income Health Program (LIHP) will run through 2013 and could potentially provide coverage to as many as 500,000 uninsured individuals. The new LIHP initiatives are intended to transition individuals to the coverage that will ultimately take effect in 2014 under federal health care reform. There are two program elements to LIHP: the HCCI and the Medicaid Coverage Expansion (MCE). Counties must provide the matching funds for both program elements in order to draw down matching federal Medicaid funds. There will be no state funds available for the LIHP.

  Through the MCE, an LIHP county may opt to cover adults between 19 and 64 years of age with incomes at or below 133 percent FPL. If federal funding is available, an LIHP county may also opt to cover adults between 19 and 64 years of age with incomes between 134 and 200 percent FPL. The new waiver builds on the HCCIs currently operating in ten counties and expands them to all counties that wish to participate, subject to state approval. While federal funding for MCE is not capped because it is considered a Medicaid program, the waiver

limits HCCI funding to $180 million annually for the first three years (through June 30, 2013), and $90 million for the fourth year. Counties participating in LIHP will be required to meet specific financial maintenance of effort (MOE) requirements based on the county's contribution to indigent care. As of this writing, the MOE for counties with existing HCCIs will be based on county expenditures in 2006–07, and for counties newly establishing HCCIs, on county expenditures in 2010–11. LIHPs will also be subject to federal Medicaid rules, unless specifically waived or specified. For example, programs must meet specific network adequacy standards and must also include specific benefits, including mental health services. Like the HCCIs, LIHP enrollees must be assigned to a medical home for primary and preventive care.

- **Uncompensated care.** The waiver continues and expands the Safety Net Care Pool (SNCP) established under the 2005 waiver to partially reimburse public hospitals for uncompensated care costs, and includes up to $400 million annually for the state as a federal match for designated state health programs that serve low-income and uninsured populations.

- **Delivery System Reform Incentive Pool (DSRIP).** A new funding mechanism in the SNCP will be established to improve the public hospital delivery system. Up to $3.3 billion in federal funding will be available to public hospitals over the five-year waiver period, contingent upon their achievement of specific milestones and deliverables related to infrastructure development, innovation and redesign, population-focused improvements, and urgent improvements in care. The DSRIP funding and the new milestones are intended to transform public hospital delivery systems and make them more integrated, efficient, and patient-centered. For example, most public hospital systems are planning to expand the use of medical homes, with the goal of ensuring that patients receive timely and appropriate care in the outpatient setting, rather than in the emergency room.

- **Care coordination.** The new waiver provides for the mandatory enrollment into managed health care plans of approximately 380,000 Medi-Cal-enrolled seniors and people with disabilities in 16 counties. Individuals not enrolled in Medicare or who do not have an unmet share of cost or other health coverage will be eligible. Mandatory enrollment will occur in 14 counties starting June 1, 2011: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Additionally, starting in February 2011, Kings and Madera are expected to begin mandatory enrollment. If projected savings due to this shift are not met, under the terms of the waiver federal funds will be reduced, including DSRIP funds to public hospitals and SNCP funding for the state.

The waiver also allows for the development of a pilot program for the California Children's Services (CCS) program to test up to four health care delivery models.

Proposition 99. One historical source of funds for county indigent and health care programs, Proposition 99 cigarette and tobacco tax revenues, no longer serves as a funding source for county indigent care. The revenues from Proposition 99 had declined steadily since its passage more than 20 years ago, due both in real terms to inflation and to a dramatic decrease in smoking. Starting in

2005–06, the state redirected Proposition 99 funds to two state programs: the Major Risk Medical Insurance Program, which provides subsidized health insurance to those deemed high-risk or uninsurable; and the Access for Infants and Mothers (AIM) program, which provides health care coverage to low-income pregnant and post-partum women. The two Proposition 99 programs that were established based on Proposition 99 revenues, the County Healthcare for Indigents program and the Rural Health Services program, no longer receive Proposition 99 funding and no longer exist. Counties still receive Proposition 99 funds to support tobacco education programs.

One historical source of funds for county indigent and health care programs, Proposition 99 cigarette and tobacco tax revenues, no longer serves as a funding source for county indigent care.

Counties and Other Medical Care Programs

In addition to responsibility for county-administered indigent care programs, counties share responsibilities for other medical care programs with the state, as discussed below.

Medi-Cal

California's Medicaid program, Medi-Cal, provides health care coverage for 7.5 million low-income Californians who lack health insurance and meet state or federal program requirements. Medi-Cal is funded by state (and, in counties with public hospitals, through CPEs, as described earlier) and federal funds and is, for the most part, a state program administered by the Department of Health Care Services (DHCS). The state generally licenses and certifies the providers, and sets benefits, eligibility, and payment levels. Separate delivery systems exist for mental health and treatment for substance abuse under Medi-Cal as discussed later in this section.

County social services agencies are charged with determining Medi-Cal eligibility for all but aged, blind, and disabled recipients of Supplemental Security Income/State Supplemental Payment funds, who are automatically enrolled in Medi-Cal by the Social Security Administration. In addition, counties oversee the Medi-Cal enrollment and recertification application process.

Although Medi-Cal is a state-administered program, people on Medi-Cal might have very different experiences with the program depending on the county in which they live. This is partly because of wide variation in the number and type of participating Medi-Cal providers available in different counties and regions in the state. For example, fewer Medi-Cal providers are typically available in rural communities than in more urban ones. Experiences also vary because counties have

different models of care delivery, as discussed immediately below.

Although Medi-Cal is a state-administered program, people on Medi-Cal might have very different experiences with the program depending on the county in which they live.

Medi-Cal services are delivered through two primary methods: fee-for-service and managed care. In the fee-for-service program, health care professionals and facilities meet state licensing and certification requirements, provide services to beneficiaries, bill the state for the services, and are generally paid at rates set by the state. (As noted previously, county- and UC-owned hospitals, however, finance the non-federal share of the reimbursement they receive for Medi-Cal fee-for-service inpatient services.) As of December 2010, according to Department of Health Care Services, approximately 3.1 million Medi-Cal beneficiaries received care in this manner.

In addition, approximately 4.1 million Medi-Cal beneficiaries received care and services through one of 25 public or private managed care plans. Currently, a greater proportion of Medi-Cal beneficiaries (57 percent) are in managed care delivery systems than in a Medi-Cal fee-for-service (43 percent) system. Managed Medi-Cal has three main models:

- **Two-Plan Model.** The Two-Plan Model serves the greatest number of people and offers beneficiaries a choice of two managed care plans. Generally, one plan is a public plan (a Local Initiative [LI])—and the other is a commercial plan. Children, pregnant women, and non-disabled parents must be enrolled in managed care and can choose one of the two plans offered in their county. Other Medi-Cal beneficiaries—primarily seniors and people with disabilities—may voluntarily enroll. The health plans contract with public and private providers. The Two-Plan Model serves about 2.8 million beneficiaries, in 12 counties (see Figure 2 on page 15).
- **County Organized Health System (COHS).** Under the COHS model, enrollment in a locally administered plan is mandatory and automatic for the county's entire Medi-Cal population (except long-term care residents). COHS counties are paid a fixed monthly fee per person regardless of the services provided (capitation payment). About 9 percent of Medi-Cal beneficiaries statewide are enrolled in a COHS. Federal law limits COHS enrollment to 10 percent of statewide Medi-Cal beneficiaries; additional COHS plans would require specific federal approval. COHS plans serve about 860,000 beneficiaries through five health plans in 11 counties (see Figure 2). Ventura County is in the process of developing its own COHS.
- **Geographic Managed Care (GMC).** Under GMC, currently operating in Sacramento and San Diego counties, the state contracts with a number of private health plans and pays the plans a fixed monthly fee per enrolled person, referred to as a capitation payment. Just as in Two-Plan Model counties, children, pregnant women, and

non-disabled parents must enroll in one of the plans. About 6 percent of Medi-Cal beneficiaries are enrolled in GMC plans. GMC serves about 430,000 beneficiaries in the two counties.

Counties have been actively involved in the development of the various Medi-Cal managed care models in each county. The local initiative (LIs) health plans and the COHS plans were initially

Figure 2. Managed Care Models, by County

*Enrollment numbers are approximations.

Source: California Department of Health Care Services, "Medi-Cal Managed Care Program Fact Sheet," November 2010 (www.dhcs.ca.gov).

organized by charter or resolution adopted by the local county boards of supervisors. LIs are required to include county hospitals in the Medi-Cal provider network in recognition of the importance of Medi-Cal revenues as a funding source for county hospitals. However, counties have no legal risk or financial responsibility for services provided to Medi-Cal beneficiaries through managed care plans operating in the county.

California Children's Services Program

CCS is a statewide program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21. To be eligible for CCS, children must be residents of California, have CCS-eligible conditions—which include certain injuries, physical limitations, and chronic health conditions or diseases—and have a family adjusted gross income of $40,000 or less in the most recent tax year. Children in families with higher incomes may still be eligible for CCS if the estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income or if the child is eligible for and enrolled in Medi-Cal or Healthy Families.

The CCS program is administered as a partnership between county health departments and the DHCS.[14] Counties must use realignment funds according to statutory formulas to meet county match requirements for several program components of CCS. Currently, approximately 70 percent of CCS-eligible children are also Medi-Cal eligible, and Medi-Cal reimburses their care. In counties with Medi-Cal managed care, CCS is carved out of the managed care program and administered as a fee-for-service program. The cost of care for the other 30 percent of children is split equally between CCS-only and CCS/Healthy Families. CCS-only coverage costs are shared equally between the state and counties. The cost of care for CCS-eligible children enrolled in Healthy Families is funded at 65 percent by federal Title XXI CHIP funds, at 17.5 percent by the state, and at 17.5 percent by the county. Services provided to children enrolled in the CCS-only program are funded equally by the state and the child's county of residence. Reimbursement for administrative and operational costs of county CCS programs is shared between the state and counties. In addition to program administration and cost sharing, counties serve as providers of CCS medical therapy services.

The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services.

As of November 2010, CCS had an average quarterly caseload of 185,000 children through a network of CCS-paneled specialty and subspecialty providers and designated special care centers. DHCS oversees the CCS program. Larger counties operate their own CCS programs, and smaller counties share the operation of their programs with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. CCS is funded through the state general fund, and with county and federal funds; parents also pay some of the fees.

Healthy Families Program

The Healthy Families program is administered by the MRMIB and provides health coverage for

uninsured children, not eligible for Medi-Cal, whose families earn up to 250 percent FPL. Healthy Families is California's implementation of CHIP. The federal government pays 65 percent of Healthy Families expenditures. Healthy Families services are delivered through managed care plans under contract with MRMIB, and enrollees share the costs through monthly premiums and co-payments for most services. As of December 2010, nearly 875,000 children were enrolled in Healthy Families.

Healthy Families includes Medi-Cal LIs as health plan choices for enrolled children. County welfare departments may identify children eligible for Healthy Families as part of their responsibilities in Medi-Cal eligibility and enrollment processing. Counties also have a direct role in providing services to Healthy Families subscribers. Seriously emotionally disturbed (SED) children enrolled in Healthy Families are referred to county mental health plans (MHP) that can bill for the federal State Children's Health Insurance Program (SCHIP) matching funds for federally eligible mental health services (excluding pharmacy and laboratory services). Services to SED children are provided by counties to the extent that resources are available under the target population and mental health services provisions of realignment. CCS services are carved out for children enrolled in Healthy Families as they are in Medi-Cal managed care.

Child Health and Disability Prevention Program

The Child Health Disability and Prevention (CHDP) program provides comprehensive health assessments for the early detection and prevention of disease and disabilities in children and youth. Eligible populations for the CHDP program include all Medi-Cal eligible children under age 21, and low-income, non-Medi-Cal eligible children under age 19 with family incomes at or below 200 percent FPL. The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth. Children and youth up to age 19 with family incomes up to 200 percent FPL, and without preventive health care coverage, are temporarily enrolled through the CHDP Gateway process into full scope, no-cost, temporary Medi-Cal for the month of their CHDP health assessment as well as the following month. These services are funded by state general and federal funds under the EPSDT and Healthy Families (Title XXI) programs.

The CHDP program receives state funds and federal funds depending on the program eligibility of children served, but it is operated by the local health departments for each county and three cities. Local CHDP programs are responsible for carrying out community activities, which include: planning, evaluation and monitoring, care coordination, informing, providing health education materials, provider recruitment, quality assurance, and client support services such as assistance with transportation, assistance with medical, dental, and mental health appointment scheduling, and encouragement for completing an application for ongoing health care coverage.

Local CHDP programs are also responsible for oversight of the Health Care Program for Children in Foster Care, which provides public health nursing expertise for meeting the medical, dental, mental, and developmental health needs of children and youth in out-of-home placement or foster care. In these programs, public health nurses work with the social workers or probation officers of children in foster care to ensure that the children receive needed health services.

State and local CHDP programs maximize the use of federal Medicaid funds, matching them with state, county, or city funds. Counties receive funding from the state for CHDP administrative and operational support based on budgets submitted by counties and approved by DHCS. Cities and counties can draw down federal Medicaid matching funds for EPSDT and the Health Care program for Children in Foster Care programs, but not for CHDP services provided to uninsured children ineligible for Medi-Cal. In 2010–11, local CHDP programs were allocated a $7.6 million general fund for CHDP and the Health Care Program for Children in Foster Care.

Public Health

Public health services are distinct from the other health services examined in this paper because the focus is not exclusively on the provision of services to individuals but on population-based strategies for protecting the overall health of the community. Core public health functions, as they are often referred to, include the protection and improvement of the health of the community through preventive medicine, health education, control of communicable diseases, application of sanitation standards, and monitoring of environmental hazards.

The statutory obligations of California counties with regard to public health are not always clear in law and regulation. California counties are required by law to "preserve and protect" the public health and to provide public health services, including public health nursing, communicable disease control activities, and environmental health programs.[15] Public health nursing services and communicable disease control activities are county-mandated functions monitored by the state Department of Public Health (DPH). Local health departments also have primary responsibility to respond during local emergencies such as floods and other natural disasters, disease outbreaks, or bioterrorism attacks. Local governments are mandated to provide environmental programs, which are generally supported by fees and receive oversight from various state agencies in areas such as solid waste, small public water systems, underground storage tanks, and hazardous materials.

For public health purposes, California has 61 local health jurisdictions (LHJ): the 58 counties and the cities of Berkeley, Long Beach, and Pasadena. All local jurisdictions have a legally-appointed physician health officer in charge of protecting public health. Most counties also have a health administrator or director to manage and oversee public health and other related health care programs. Mariposa County is the last remaining county to participate in the Local Public Health Services Program, which provides state-employed environmental specialists and public health nurses to work in and for the county.

Public health officers have broad and far-reaching authority and responsibility under the law. For example, public health officers have the authority to order the testing of individuals and communities, to quarantine individuals or groups, and to close beaches, restaurants, or other facilities for public safety reasons. Public health officers receive reports from health providers and laboratories regarding the incidence of more than 80 statutorily reportable diseases. County health departments must submit monthly, quarterly, or annual public health and program reports to state agencies such as DPH and the Emergency Medical Services Authority.

County public health programs vary substantially in their administrative structures, scope, funding levels, staffing, and specific services and programs offered. Yet no statewide resource regularly compares or reports on the programs or their funding. Local

public health departments additionally administer an array of state and federal categorical programs, that is, programs for specific populations or for limited program purposes. Categorical programs, such as HIV/AIDS and emergency preparedness programs, are generally funded by separate federal or state allocations or grants, and carry specific program requirements and guidelines associated with the funding.

Communicable Disease Control Activities

California law defines communicable disease control activities as communicable disease prevention, epidemiologic services, public health laboratory identification, surveillance, immunizations, follow-up care for sexually transmitted diseases (STD), and tuberculosis control and support services. Public health officers must accept and evaluate mandated reports from health providers on more than 80 statutorily reportable diseases. Implicit in the reporting requirements is the role of public health officers in tracking illnesses, injuries, and deaths so as to identify trends and spot potential epidemics or other public safety concerns. Counties also administer categorical public health programs focused on infectious and communicable disease control, such as TB control, the monitoring and treatment of STDs, and related activities.

Immunizations and treatment for tuberculosis and STDs are often conducted at county public health clinics or community site locations. In many counties, these clinics have very limited hours at each site, such as once-a-month immunization clinics. Counties with public hospitals or primary care clinics may combine public health nursing services such as immunizations and communicable disease follow-up treatment with their primary care service delivery system.

HIV/AIDS

One of the specific areas in which counties receive categorical public health funding is HIV/AIDS. As is the case with other reportable diseases, county health officers have statutory responsibilities related to reporting and tracking of HIV infection. In addition, LHJs receive state and federal program funding for HIV/AIDS prevention, care and treatment, and surveillance. State and federal funds are administered and allocated by formula to LHJs through the DPH Office of AIDS. Local health agencies often subcontract with local providers and community-based agencies for specific programs and services. DPH also directly contracts with or awards grants to local community agencies other than the county.

In 2009–10, DPH restructured Office of AIDS funding for local health departments as a result of funding reductions. LHJs receive funding from the Office of AIDS in three program areas:

- **Prevention.** Only 17 LHJs deemed "highest burden" counties (Alameda, Contra Costa, Fresno, Kern, Long Beach, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, and Sonoma) receive Office of AIDS funds for prevention, which includes HIV counseling and testing, mobile outreach vans in some counties, targeted prevention for high-risk groups, and various special projects (for example needle exchange projects).
- **Surveillance.** Counties also receive funds under the Surveillance Grant Program to develop and implement active AIDS case surveillance programs, including local planning related to AIDS reporting and coordination with local health care providers.

- **Care and treatment.** Counties receive an allocation of federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds for primary medical care and support services for people infected with HIV. Counties conduct enrollment for the AIDS Drug Assistance Program, which provides drugs to those who would otherwise not be able to afford them, and counties receive a small state general fund grant to defray their administrative costs. Other state and federal programs allocated directly to counties include funding for early intervention programs and affordable housing for people infected with HIV.

Funding for HIV/AIDS programs comes primarily from federal funds, including funding from the federal Centers for Disease Control and the Ryan White CARE Act, and a limited remaining amount of general fund dollars for AIDS surveillance.

Emergency Preparedness

According to state law, as part of communicable disease control activities, the local health department also has the lead role in the early detection and identification of a bioterrorist event or other public health emergency or disaster. In the event of a confirmed bioterrorist event or public health disaster, the local health department will be responsible for initiating expanded surveillance. Beginning in 2002, California received an infusion of new federal funding for public health emergency preparedness, bioterrorism, and, more recently, planning and surveillance related to pandemic flu. The federal funds are not available to counties for general public health priorities but are subject to specific federal priorities and restrictions. Counties enter into detailed contracts with the state surrounding the expenditure of the federal funds.

Public Health Nursing and Categorical Public Health Programs

Local public health departments administer an array of public health nursing and categorical programs that are funded by federal or state allocations or grants, including the Maternal, Child, and Adolescent Health (MCAH) program. Not all programs are available in all counties, and the level and type of staffing and funding vary significantly across counties. Although all counties are required to have public health nursing programs, some counties have relatively small programs that concentrate on communicable disease follow-up and immunizations, while other counties have extensive programs that include community health education, home visiting programs, and organized outreach to pregnant women and children.

Maternal, Child, and Adolescent Health Program. DPH funds local health departments through the Maternal and Child Health Branch to carry out the core public health functions of assessment, policy development, and assurance to improve the health of their MCAH populations. MCAH is a federal program (Title V of the Social Security Act) with specific federal requirements, and California receives federal MCAH funds and reallocates most of the funds to counties. All counties and the three city public health departments participate in the MCAH program. Participating cities and counties must have a local MCAH director, either a public health physician or nurse. To receive MCAH funds, local programs are required to conduct a community needs assessment and submit a program plan to the DPH every five years. All counties must operate a toll-free telephone number for access to care and services.

MCAH activities include assessment of health status indicators for maternal and child health populations, community health education

programs, and outreach with a special emphasis on people eligible for Medi-Cal. Specific MCAH categorical programs administered at the county level may include, among others: Adolescent Family Life Program (AFLP); Black Infant Health (BIF) program; Comprehensive Perinatal Services Program; Fetal and Infant Mortality Review program; Childhood Injury Prevention Program; and Perinatal Outreach and Education program.

Funding for Public Health

Funding for public health comes primarily from realignment, county or city general funds, and federal funds, with very limited state general fund dollars. Funding for core public health programs also comes from several narrow categorical public health programs, such as Tuberculosis Control. Environmental health programs are generally supported by fees paid by regulated entities such as restaurants, waste facilities, and public pools. Categorical public health programs have separate categorical funding streams and in recent years state funding for local categorical programs has been dramatically reduced or eliminated.

Funding for MCAH comes from multiple sources, including the federal Title V MCAH block grant, Medicaid federal financial participation, and other grant funds. Virtually all of the state general fund support for MCAH was eliminated in 2009–10. In the 2010–11 budget, the legislature restored the $3 million general fund for the AFLP and the $2 million general fund for the BIF program, but these restorations were vetoed by the governor. The net effect of these actions is that $55.1 million in federal funds are available in 2010–11 for MCAH programs with no state general funds to support the programs.

In 2009–10, general fund support for a number of HIV/AIDS programs was severely reduced in the state budget. In 2010–11, the legislature restored the $52.1 million general fund for Office of AIDS local assistance programs. However, the Governor vetoed the restoration, leaving $55.4 million in funding for HIV/AIDS local assistance, the same funding levels as 2009–10, supplied almost entirely by federal funds.

In 2009–10, $17.9 million in general fund local assistance funding for the Immunization program was eliminated, leaving only federal funds to support the program. The reduction in local assistance for immunizations continues in 2010–11.

Since 2002, California has also received substantial federal funds for bioterrorism and emergency preparedness activities that support core public health functions. The federal funds are subject to specific federal priorities and restrictions, and counties have entered into detailed contracts with the state surrounding the expenditure of the federal funds. In general, local public health departments receive about 70 percent of the federal funds. The state receives the remaining 30 percent. Los Angeles County typically receives a direct allocation of federal emergency preparedness funds.

Mental Health

Counties are the primary providers of public mental health services in California for Medi-Cal and non-Medi-Cal clients. Mental health service delivery and mandated programs are described in both state and federal law. Realignment required counties to serve specified target populations—seriously mentally ill adults, SED children, and people in acute psychiatric crisis—to the extent that resources are available.

County responsibility to provide mental health services to county residents who are not on Medi-Cal or eligible for specific children's programs is limited to the extent that resources are available.

The state "carved out" specialty mental health services from the Medi-Cal fee-for-service and managed health care programs, which had already been implemented. Between 1995 and 1997, California secured and implemented a federal "freedom of choice" Medicaid 1915(b) waiver to consolidate inpatient and outpatient Medi-Cal specialty mental health services into one program at the county level. Pursuant to the waiver terms, California implemented the mental health managed care program, which consolidated the two existing Medi-Cal mental health programs (Short-Doyle and fee-for-service) into one service delivery system, managed by county MHPs. Counties have the first right of refusal to be the MHP, and must provide the required match for federal Medicaid funds using county revenues, including realignment funds. If the county chooses not to be the Medi-Cal MHP, state law permits the state to negotiate with the county on taking some of the realignment funds to provide the match for another entity to act as the MHP.

The 1915(b) waiver covers the expanded mental health services outlined in two Medicaid state plan amendments approved by CMS: the mental health rehabilitation option and targeted case management. The specialty mental health services under the waiver and state plans include: inpatient hospital, psychiatric health facility, adult residential treatment, crisis residential treatment, crisis stabilization, intensive day treatment, day rehabilitation, case management, linkage and brokerage, mental health services, medication support, and crisis intervention.

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), to provide funding for the expansion of mental health services through a 1 percent income tax on personal income in excess of $1 million. The purpose of the MHSA is to expand community mental health services for state residents who have severe mental illnesses and whose service needs are not being met through other funding sources. The MHSA specifies that the new funds are to supplement and not supplant existing resources, and establishes an MOE obligation related to state general fund appropriations for community mental health services.

These are the mental health services and programs administered by counties:

- **Community mental health services.** All counties are required by law under the provisions of realignment to establish a community mental health service program and to establish a local mental health advisory board. Counties must comply with reporting requirements of the state Department of Mental Health (DMH)

and report annual information on performance measures to the state and to the local advisory board. Counties generally have the discretion to determine local funding levels, eligibility, and services provided to non-Medi-Cal-eligible clients, consistent with the target populations outlined in state law and with funds available.

- **Medi-Cal mental health services.** Although counties have the option to operate their local MHPs for Medi-Cal, once they choose to do so they must operate the plans according to state and federal Medi-Cal eligibility, service, and benefit standards as specified in the waiver and the state Medicaid plan. Each local MHP directly provides or contracts for specialty services for Medi-Cal patients if they meet diagnostic and impairment criteria. Medi-Cal beneficiaries must receive their mental health services through the county MHP. Two counties — San Mateo and Solano — administer Medi-Cal mental health through their COHS for general Medi-Cal. Several counties joined together to operate the MHP: Sutter County's plan includes Yuba County, and Placer County's plan includes Sierra County. As of this writing, county MHPs are operational in all 58 counties.
- **Mental Health Services Act.** Most MHSA funding is allocated to county mental health departments for mental health services consistent with approved county plans (three-year plans with annual updates). MHSA funds were initially appropriated on a percentage basis into six different program areas: (1) community planning, (2) community services and supports, (3) prevention and early intervention, (4) innovative programs, (5) capital facilities and technology, and (6) work force education and training. Ongoing annual MHSA funding is provided to support approved county plans for community services and supports, prevention, and early intervention and innovation.
- **Healthy Families mental health services.** Counties provide mental health services to SED children enrolled in Healthy Families under the provisions of memoranda of understanding with the county mental health departments, using realignment revenues to the extent that funds are available. County mental health departments are able to bill for the federal matching SCHIP funds subject to state and federal claiming rules.

Medi-Cal mental health services for children: EPSDT. The federal EPSDT program requires states to provide Medi-Cal recipients under age 21 with medically necessary health and mental health services to correct or ameliorate a defect, physical or mental illness, or condition identified by an assessment, including services not otherwise included in a state's Medicaid (Medi-Cal) Plan. A 1995 lawsuit against the state for non-compliance with EPSDT requirements resulted in the expansion of EPSDT Medi-Cal services. The mental health component of EPSDT has been delegated to county MHPs under the federal waiver and the state Medicaid plan, but the eligibility and scope of services is determined by state and federal policy. As a result of the lawsuit, the state agreed to provide state general fund dollars to defray a portion of the federal Medicaid match for EPSDT services. County MHPs must use a portion of county realignment funds to support the EPSDT program. Specifically, a "baseline" amount was established in 1995, and an additional 10 percent requirement was placed on the counties through an administrative action in 2002.[16] State general funds are budgeted to cover EPSDT costs above the amounts counties must allocate to the program.

- **Services for involuntarily committed individuals.** California law authorizes local law enforcement and individuals designated by the county to take into custody, involuntarily hold for evaluation, and admit for treatment for up to 72 hours any person with a mental disorder who is a danger to himself or others or is gravely disabled. The initial 72 hour detention can be extended through court proceedings for 14 days, and for up to one year in the case of grave disability with the appointment of a public or private guardian to assure access to appropriate mental health treatment. Counties designate and the state DMH approves the facilities that can admit people being involuntarily committed. State law includes specific and detailed procedures to be followed by local law enforcement, county mental health agencies, and the treating facilities. This process of involuntary hold for severely mentally ill people is often referred to as a "5150" process because it is in California Welfare and Institutions Code Section 5150.

Mental Health Services for Special Education Students

Under the provisions of state and federal law, counties have provided mental health services for children who need special education services.

The federal Individuals with Disability Education Act (IDEA) requires that states provide to students in public schools services they need in order to benefit from their "free and appropriate public education." Mental health services are considered related services for purposes of the federal program.

The California Department of Education and local education agencies are responsible for complying with IDEA in identifying students who need special education services, and ensuring they receive those services. Since 1984, and until the 2010–11 state budget year, county mental health departments were mandated by state law to provide mental health-related services to eligible students, based upon an individual education plan (IEP) developed and agreed to jointly by schools, parents, and county mental health. Under the program, often referred to as the "AB 3632" mandate, after the enabling state legislation, eligible students are entitled to services regardless of income if the school district determines they are needed.[1] The Commission on State Mandates has identified the AB 3632 program as a reimbursable state mandate, but the state has not always paid counties for the full costs of the mandate.

In signing the 2010–11 state budget, Governor Schwarzenegger vetoed $132.9 million that the Legislature had allocated to reimburse counties for AB 3632 services provided by counties in prior years, and suspended the mandate in 2010–11. Court challenges followed, and in October 2010 the Superintendent of Public Instruction agreed to use $76 million in federal IDEA funds to continue to pay counties to provide the services for eligible students. There are two pending AB 3632 lawsuits. The California School Boards Association filed a lawsuit in the Los Angeles County Court of Appeal challenging the Governor's authority to suspend the AB 3632 mandate, arguing that only the Legislature can authorize such a suspension. In addition, over thirty counties jointly have filed suit in Sacramento Superior Court asking to be legally relieved of the mandate to provide and pay for mental health services for IEP students given the lack of funding in the 2010–11 state budget.

In his 2011–12 January budget, Governor Jerry Brown proposes to reinstate the AB 3632 mandate, but allocate local MHSA funds to pay counties back for their prior year costs in providing AB 3632 services. Starting in 2012–13, the Governor proposes to make AB 3632 services a county responsibility as part of a proposed realignment of state and local services. Future responsibility for services for children eligible for AB 3632 will likely be determined through the state budget process and the courts.

Funding for Mental Health

Funding for the public mental health system is complex. Funding sources include: county realignment funds, MHSA funds, state general funds for Medi-Cal mental health managed care, budget appropriations for EPSDT and AB 3632 services to children, and federal funds, including Medicaid and CHIP matching funds, and Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds.

As described above, realignment revenues are subject to economic conditions and most recently have been a declining source of revenue for county health and mental health programs. In addition, in previous years, the unpaid amounts for AB 3632 services, provided to students identified by schools as needing mental health services, depleted county resources and further limited realignment funds available for low-income people needing mental health treatment.

Federal Medicaid funds are currently the largest revenue source for county mental health programs. Counties use realignment, MHSA, and other local funds to draw down federal Medicaid matching funds for the services they provide to Medi-Cal clients. Counties are responsible for certifying the claims, consistent with federal CPE requirements, similar to the way counties match Medicaid funds for public hospital and indigent medical care services. Counties vary in their expenditure of local funds and in their rate of capturing federal funds for Medi-Cal mental health services.

MHSA funds have provided an infusion of funding for community mental health services. MHSA local allocations are budgeted at $1.2 billion in 2010–11.[17] MHSA requires a state maintenance of existing funding for mental health programs and prohibits supplanting state or local funding with MHSA funds. However, during this time of sustained state and local fiscal crises, MHSA is at the center of legislative, regulatory, and legal battles related to the continuation of previous mental health services funding levels and uses of the new MHSA revenues.

Counties report that they are increasingly using realignment and MHSA mental health dollars to cover the growing costs of their match for Medi-Cal, leaving less money available for mental health services for people who are not eligible for Medi-Cal.

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The Department of Social Services budget includes some funding for both substance abuse treatment and mental health services for recipients of the California Work Opportunity and Responsibility to Kids (CalWORKS) program for whom substance abuse or mental or emotional difficulties are a barrier to employment. Counties have the flexibility to move funds between the two allocations and to other CalWORKS employment services.

Substance Abuse Treatment Services

California's public system for treatment of substance abuse is administered by county drug and alcohol treatment programs under contract with the state Department of Alcohol and Drug Programs (DADP). All but one of the 58 counties, Plumas County, are currently contracting with the DADP, either individually or jointly, to administer local drug and alcohol treatment programs and to receive an annual allocation of state and federal funds for that purpose. However, counties have no statutory obligation to offer or provide alcohol and drug treatment services, with the exception of services provided to non-violent drug offenders under the terms of a statewide ballot initiative passed in 2000 (Proposition 36—see below). For other substance abuse treatment services, counties could choose not to be the local administrator of the programs and give the state 60 days' notice of their intent to terminate the contract. Local treatment services are also provided by other public entities, including the correctional system and the California Youth Authority.

County alcohol and drug programs must meet state and federal requirements regarding program administration, provider licensing, and use of specific funds. Some counties provide counseling and other treatment services directly, some contract with private treatment programs, and some counties offer both direct and contract services. In general, urban counties are likely to contract for a larger percentage of treatment services than rural counties. Residential treatment providers must be licensed by the DADP. Specific state and federal funding streams establish program and treatment priorities and set-asides for special populations such as perinatal or HIV users, and for special projects such as the Friday Night Live teen prevention program. Counties receive an annual allocation of federal and state funds, a portion of which must be matched with county funds.

Drug Medi-Cal

All but 19 California counties participate in the Drug Medi-Cal program. In counties not participating, the DADP contracts with and reimburses providers directly. The current program, administered through DADP under an interagency agreement with the DHCS, covers limited treatment services: narcotics replacement (methadone detoxification and maintenance programs and naltrexone), restricted outpatient drug-free services, and day care rehabilitative and residential treatment for pregnant and parenting women. The Drug Medi-Cal program covers only services provided at a treatment site certified by DADP.

Proposition 36: The Substance Abuse and Crime Prevention Act of 2000

In November 2000, California voters passed Proposition 36, the Substance Abuse and Crime Prevention Act (SACPA), which requires probation and drug treatment instead of incarceration for individuals convicted of possession, use, transportation for personal use, or being under the influence of controlled substances. Eligible offenders receive up to one year of drug treatment and six months of after-care. Beginning July 1, 2001, SACPA required that $120 million in state funds be set aside each year for the purposes of the act, with funding provided through 2005Â–06. SACPA permanently changed state law to allow first- and second-time non-violent, simple drug possession offenders the opportunity to receive substance use treatment instead of incarceration. By July 2006, when initial funding for the program ran out, over 150,000 people had benefited from treatment under SACPA.

The Offender Treatment Program (OTP) enacted in 2006 serves offenders who qualify for services under SACPA. Under the OTP, DADP distributes available state general funds to counties that demonstrate a commitment of county matching funds at a ratio of $9 for every $1 county match.

In 2008, California voters failed to pass Proposition 5, the Nonviolent Offender Rehabilitation Act, which would have significantly expanded treatment instead of incarceration in the state, including Proposition 36 programs. The Legislature continued to provide state general funds for Proposition 36 treatment programs at a declining rate until 2009–10 when all state funding for Proposition 36 was eliminated. As of this writing, individuals who are convicted and eligible for Proposition 36 treatment are often placed on waiting lists and compete for fewer treatment slots.

Funding for Substance Abuse Treatment Services

The state does not track the extent to which county governments spend money on treatment beyond the annual allocation of state and federal funds. Funding for county substance use treatment programs comes from the federal Substance Abuse Prevention and Treatment (SAPT) block grant through SAMHSA; Drug Medi-Cal (state and federal funds); state general funds; and county funds. Counties may also use the funds set aside in the CalWORKS program for substance use treatment for recipients for whom substance abuse is a barrier to employment.

The state does not track the extent to which county governments spend money on treatment beyond the annual allocation of state and federal funds.

The federal SAPT block grant includes a state MOE obligation. If a state does not meet the requirement, it risks losing part of the federal funding. In addition, states must set aside a portion of the funds in three specific priority areas: primary prevention for people who do not need treatment (20 percent), HIV Early Intervention Services (5 percent minimum and maximum), and services to pregnant women and women with dependent children. ADP allocates SAPT block grant funds to counties in each program area. In 2009–10, California failed to meet the MOE requirement but received a one-year waiver of the requirement from the federal government. As of January 2011, a second waiver of the MOE requirement is pending for 2010–11.

As a result of the state fiscal crisis, county programs have seen a reduction in discretionary state general fund dollars. Cuts in discretionary funds are particularly difficult for smaller counties because many do not have the staff capacity or sufficient numbers of clients in target program areas, such as HIV, to administer and get funding for categorical programs. In addition, budget and program cutbacks to treatment services in the correctional system have dramatically increased the demand for such services in the county programs.

III. Future Considerations

The breadth and character of county health programs and services has been influenced decade to decade by changes in the economic and political environments at the federal, state, and local levels. 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. No two counties have the exact same structure or service system for all of their health programs.

The role of counties in the health of Californians is once again on the threshold of major change and restructuring as state and county policymakers prepare to redefine county health services in the context of federal health care reform and long-term structural budget deficits. This section highlights some of the opportunities and challenges facing county health services in the next decade.

Federal Health Care Reform

The federal Patient Protection and Affordable Care Act (ACA) contemplates a magnitude of change and scope not seen since the creation of Medicaid and Medicare in the 1960s and sets the stage for the reexamination and restructuring of county health services. The ACA expansions of coverage — in particular the movement of millions of low-income uninsured people with incomes up to 133 percent FPL into Medicaid, and new subsidized coverage through the Health Insurance Exchange (Exchange) for those with incomes between 133 to 400 percent FPL — present major opportunities and challenges. The newly Medicaid-eligible populations and those who will be eligible for coverage subsidies in the new Exchange are for the most part the populations now served by county indigent care programs and public delivery systems.

While health care reform offers a more stable source of funding for county health services and the private providers with whom they partner, counties will be challenged to upgrade and expand existing programs and services in the face of increased demand. In nearly all counties, the expansion of coverage will present significant capacity and logistical challenges, while offering the opportunity to improve access to care and move the delivery system toward better-coordinated primary, behavioral, and preventive care. Counties that provide medical care services will be called upon to operate more like private health care providers and health plans, and to compete with private systems for both enrollment and scarce provider resources, but will still maintain their core mission of serving and supporting the poorest and most vulnerable populations. With dramatic increases in the number of covered people, and the creation of the Exchange as a new market, the potential impact on county delivery systems and local markets remains uncertain but will likely be transformational.

Implementing federal reform could also trigger a policy and political discussion surrounding the nature of core county health services and the organization of services at the state and local level, including a reassessment of the Section 17000 indigent care obligation of counties. The rollout of federal reform invites a rethinking of the role and funding of county health services for disenfranchised and special populations, many of whom will gain eligibility for coverage under health reform. County public health services may need to be refocused

to support system-wide efforts to improve health outcomes across the population as contemplated in federal reform. At the same time, program and funding shifts could affect the ability of LHJs to maintain core public health services and activities. Health care reform implementation and federal and state parity requirements will elevate the conversation about the need for better integration of health, mental health, and substance abuse treatment at both the state and local levels. County social services eligibility programs will also be assessed and reshaped so that the state can meet ACA requirements relating to streamlined eligibility and accommodate the increased number of people who will be eligible for Medi-Cal or subsidized coverage under the ACA.

Health care reform also represents a major shift in the incentives and expectations for health care delivery by all providers, with the potential to radically alter existing county delivery systems. Reform not only underscores the need and presents an opportunity for improved "customer service" to ensure that county-operated facilities and programs are desirable from a consumer choice perspective, but also creates new opportunities and imperatives for integration, payment system reform, and expansion of county-level managed care plans. The medical home approach underlying the new federal reform presents an opportunity to get to health problems sooner with improved access to primary care and increased patient satisfaction. The challenge for counties will be in organizing care and services locally, and in developing the relationships and systems needed to create effective medical homes that meet the needs of diverse populations.

Medi-Cal Bridge to Reform Waiver

As California prepares for federal health reform in 2014, in the near term many counties will be focusing on the 1115 waiver, structured as a "bridge" to the implementation of federal reform. The 1115 waiver has the potential for expanded coverage for individuals and creates early incentives for counties to remake the public delivery system (where it exists) more consumer-friendly and competitive. The waiver also offers a unique opportunity for counties to advance innovation in the continuum of services for seniors and people with disabilities. Counties are, however, concerned about their ability to fully match the federal funds that are available under the waiver. In counties where the commitment to and match for indigent health care services has eroded substantially in recent years, participation in the 1115 waiver will be a challenge. Counties of all sizes and service types will, in coming months, be evaluating how to most effectively participate in and take advantage of the funding and system change opportunities in the new Bridge to Reform waiver.

2011–12 Realignment Proposal

As part of his proposed 2011–12 state budget, Governor Jerry Brown proposed a new realignment of government services in California with the goal of finding "the level of government where a service can best and most effectively be delivered."[18] According to the budget document, when fully implemented the realignment proposal would restructure how and where more than $10 billion of government services are delivered. The proposed realignment would unfold in two phases.

Phase one would focus primarily on public safety, fire protection, and juvenile justice programs, but would also, for one year (2011–12), redirect local MHSA funds to three mental health programs: (1) mental health managed care for Medi-Cal

beneficiaries, (2) mental health services for low-income children in the EPSDT program, and (3) state-mandated mental health services for special education students (AB 3632). Beginning in 2012–13, the three programs and community mental health services would be funded through the proposed realignment revenues at the county level. In addition to the use of local MHSA funds, phase one would be financed through a five-year continuation of the 1.15 percent vehicle license fees and the 1 percent sales tax now set to expire. After the five years, the state would provide counties with revenues equal to these two revenue sources.

According to the Governor's budget proposal, phase two of the realignment would link to federal health care reform and the movement of low-income individuals now served in county indigent care programs to Medi-Cal. Phase two assumes that the state will become responsible for costs associated with health care programs, including California Childrens' Services and IHSS, while the counties will assume responsibility for CalWORKS, food stamp administration, child support, and child care. Public health programs would remain at the local level.

Whatever the outcome of the proposed new realignment, the proposal highlights key questions and issues surrounding the future of county health services in the context of continuing state and local fiscal constraints and the pending implementation of federal health care reform.

IV. Conclusion

Counties face many challenges and opportunities in the next decade. To address long-term structural budget deficits, the state has made significant reductions in general fund support and is considering realignment of many county services at the same time that counties and the federal government are experiencing their own serious fiscal challenges and potential program cutbacks. With this backdrop, implementation of the ACA has the potential to transform the role of county health services.

Policymakers at the state and local level will need reliable information to help understand the implications of current and future program, budget and policy choices, and the impact of federal health reform. The significant diversity between counties in the level and type of services residents of the counties receive and the systems and programs that deliver the services adds to the challenges facing policymakers. The limitations of current data systems and the lack of a uniform statewide system for regularly tracking county health programs, services, and funding makes it more difficult for policymakers to evaluate and monitor the impact of budgetary and program changes.

County health services serve as a safety net for people whose financial, social, physical, mental, or geographic conditions limit or complicate their access to mainstream medical care and related supportive services. In this context, counties are the providers of last resort. However, county health services do not only serve the needs of low-income and vulnerable populations but also provide the basic framework for protecting the health, safety, and well-being of the community. At the county level, public health services and the public health infrastructure, have a specific and unique focus on the overall health of the community. County health and behavioral health services reduce the burden of uncompensated medical care on the overall health care system and, in counties with public facilities, support the delivery of trauma and/or emergency medical services for all county residents. The successes and failures of county health programs can have a dramatic effect on access to, affordability of, and availability of health services for everyone. Whatever the future holds for county health services, the outcome will affect the health care landscape for all Californians.

Endnotes

1. The three types of MISP county indigent care models were first described in the manner included in this issue brief by Lucien Wulsin, executive director of the Insure the Uninsured Project.
2. Identification of the county types and the number of county hospitals was developed by compiling information from the following sources: McMahon, T., and M. Newman. *County Programs for the Medically Indigent in California.* California HealthCare Foundation, October 2009; *County-owned Hospitals in California.* California State Association of Counties, September 2010 (www.csac.counties.org); individual MISP county Web sites.
3. *Desginated Trauma Centers.* California Emergency Medical Services Authority, March 2010 (www.emsa.ca.gov).
4. McMahon and Newman. *County Programs.*
5. Ibid.
6. CCHI Enrollment by Counties. California Children's Health Initiatives, September 1, 2010 (www.cchi4kids.org).
7. Until very recently, MISP counties reported to the state demographic, expenditure, and utilization data on county indigent health care programs, which formed the basis for the Medically Indigent Care Reporting System (MICRS). Counties are required to report MICRS data to the extent that the counties receive Proposition 99 revenues for indigent care. Counties no longer receive such funding, and are therefore no longer reporting MICRS data.
8. Felland, L.E., A.B. Katz, and J.R. Lauer. *California's Safety Net: The Role of Counties in Overseeing Care.* California HealthCare Foundation, December 2009.
9. California Legislative Analyst's Office. *Realignment Revisited: An Evaluation of the 1991 Experiment in State-County Relations,* February 6, 2001.
10. Moody, G., and S. Rosenstein. *Medicaid Section 1115 Demonstration Waivers: Comparing California, Massachusetts, and New York.* California HealthCare Foundation, October 2009.
11. SB 1255 (Maddy), Chapter 996, Statutes of 1989.
12. California Association of Public Hospitals. *California's Current Section 1115 Waiver and Its Impact on the Public Hospital Safety Net,* February 2010.
13. The following source materials were reviewed as background for the summary of the new Bridge to Reform Medicaid waiver: *California Bridge to Reform: A Section 1115 Waiver Fact Sheet.* California Department of Health Care Services, November 2010; *Program Requirements and Application Process Low-income Health Program.* California Department of Health Care Services, January 14, 2011; *Medicaid Section 1115 Waiver: California Bridge to Reform Demonstration.* California State Association of Counties, November 10, 2010; *The New Section 1115 Medicaid Waiver: Key Issues for California's Public Hospital Systems.* California Association of Public Hospitals Policy Brief, November 2010.
14. Department of Health Care Services. *Children's Medical Services Plan and Fiscal Guidelines for 2009–10.* September 14, 2009 (www.dhcs.ca.gov).
15. California Health and Safety Code Section 101025.
16. California Senate Budget and Fiscal Review Committee, Subcommittee No. 3, Agenda and Background, March 11, 2010.
17. Mental Health Services Oversight and Accountability Commission. *Mental Health Funding and Financial Report.* January 27, 2011.
18. *Governor's Budget Summary 2011–12: Realignment.*

Appendix: Summary Overview, by Program Area

	COUNTY AUTHORITY/RESPONSIBILITY	PROGRAM TYPES	FUNDING SOURCES
Indigent Health Care	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." (subject to legal and judicial interpretations over decades) • Counties have significant discretion in the method of care delivery, the services provided, the populations served, and the funding for the programs	• Medical care services for low-income persons with no other source of care • Programs offered by the largest counties to provide medical care for uninsured, low-income persons, typically low-income adults with no other health coverage. Program structure, eligibility, services, and program names vary by county. Historically known and Medically Indigent Services Program (MISP) counties • County Medical Services Program (CMSP): Indigent care program offered in 34 smaller counties for eligible, uninsured, low-income adults ages 21 to 64. Administered as one program at the state level by the statutorily created CMSP governing board, composed of ten county officials elected by the counties participating in the program and the Secretary of the California Health and Human Services Agency as an ex-officio member • County-owned and operated inpatient and outpatient facilities and programs • County Children's Health Initiative Programs (CHIs): County-initiated health coverage programs for low- and moderate-income uninsured children not eligible for other public or private health coverage. Counties determine service model, eligibility, and funding	• Realignment revenues • County funds and certified public expenditures (CPEs) of county funds • Federal Medicaid matching funds under the Section 1115 Medicaid Bridge to Reform waiver in counties with county hospitals and/or counties participating in the Low Income Health Program under the federal Medicaid waiver • CHIs: Funding sources vary by county and may include any combination of county funds, private foundation funds, Proposition 10 Children and Families' cigarette and tobacco revenues, or other revenue sources
Public Health	California's 61 local health jurisdictions (LHJs) (58 counties and 3 cities) must administer a local public health program, broadly defined to include public health nursing, communicable disease control, application of sanitation standards, and monitoring of environmental hazards Local public health officers (physicians) have broad authority and responsibility to protect the public's health, which can include ordering communicable disease testing, quarantines, and closures of public and private facilities LHJs: • Respond to local emergencies such as floods or other natural disasters, disease outbreaks, or bioterrorism attacks • Participate in and contribute to local categorical programs, consistent with state and federal requirements, and local discretion (some mandatory, some voluntary, some contractual) • Track and report more than 80 reportable diseases and submit state and federally required surveillance data and statistical reports	• County public health programs vary in structure, scope, funding levels, staffing, and specific services or programs offered • Maternal Child and Adolescent Health (MCAH) programs • Public health clinics, including immunization clinics and tuberculosis testing and treatment programs • Communicable disease control • HIV/AIDS surveillance, care, and treatment • Public health and visiting nurse programs • Environmental health programs, including food and water safety and waste management programs	• Realignment revenues • County funds • Categorical state and federal program funding for specific programs administered in a county, such as MCAH programs. The state General Fund allocated to these programs has declined in the state budget process and many programs now have no state funds available • Federal funds may be available year-to-year for emergency preparedness planning and surveillance, including funding related to bioterrorism and pandemic flu preparedness • Environmental health programs are generally supported by fees

	COUNTY AUTHORITY/RESPONSIBILITY	PROGRAM TYPES	FUNDING SOURCES
Mental Health	• Counties must establish (or join with other counties to establish) community mental health service programs with local mental health advisory boards • Counties have first right of refusal to operate a local mental health plan (MHP) for Medi-Cal. In all counties, Medi-Cal specialty mental health services are "carved out" and Medi-Cal recipients must receive specialty mental health services through the county MHP • Counties must use local revenues as CPEs to provide most of the match for federal funds for Medi-Cal specialty mental health services provided by MHPs • Counties must provide community mental health services for specific target populations outlined in state law, to the extent resources are available • Pursuant to AB 3632, Chapter 1747 (1984), counties are mandated by state law to provide mental health services for special-education students regardless of income. Mandate is suspended in 2010–11	• Treatment for mental disorders and mental health problems for low-income persons, including those eligible for Medi-Cal and those without any public or private coverage • Community mental health services for severely emotionally disturbed children, adults, and older adults (including veterans) with serious mental illness, involuntary services, and services for persons who need brief treatment as a result of a natural disaster or severe local emergency, if resources are available • Federal Mental Health Services Act (MHSA) programs • Medi-Cal specialty mental health services for persons eligible and enrolled in Medi-Cal, and Medi-Cal mental health services for children under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program • AB 3632 program: Services for special education students to support their participation in public education as required under the federal Individuals with Disability Education Act (IDEA). Mandate is suspended in 2010–11 • Services for seriously emotionally disturbed children in the state Healthy Families program, to the extent resources are available	• Realignment revenues • County general funds • Medicaid and Children's Health Insurance Program federal matching funds • MHSA funds • State general funds subject to the state budget process • Federal Substance Abuse and MHSA block grant funds • California Work Opportunity and Responsibility to Kids (CALWORKS) funds may be available depending on annual state budget allocations to serve program recipients for whom mental or emotional difficulties are a barrier to employment
Substance Abuse Treatment	• Administer contractual (but voluntary) substance abuse treatment programs according to state and federal requirements • Option to administer a local Drug Medi-Cal program	• Prevention, early intervention, detoxification, and recovery services to prevent or minimize the effects of addiction and substance abuse • Drug Medi-Cal • Counseling and other treatment services directly or through contracts with private treatment programs • Services for non-violent drug offenders under the terms of Proposition 36 to the extent funds are available	• State and federal Medicaid funds • Federal Substance Abuse and MHSA block grant funds • State general funds subject to the annual budget process • County general funds
Other Health Care Programs	• Counties have program authority and responsibility, and work in partnership with the state, for other health care programs that are state programs • Counties with public hospitals use local revenues as CPEs to match federal funds for Medi-Cal services delivered by county providers • Counties originally chartered or organized public health plans that provide Medi-Cal managed care services—either Local Initiatives (LI) or County Organized Health System (COHS) plans	• Health care services provided by county facilities and providers to Medi-Cal recipients • Child Health and Disability Prevention Program	• State and federal Medicaid funds • County CPEs • Counties are not at legal or financial risk for Medi-Cal services provided by LI or COHS plans

	COUNTY AUTHORITY/RESPONSIBILITY	PROGRAM TYPES	FUNDING SOURCES
California Children's Services	Counties administer and provide a portion of the funding for the California Children's Services (CCS) program, which provides health care services to low- and moderate-income children with specific disabilities or chronic conditions	CCS	• Counties pay a share of the costs for CCS depending on the eligibility category of the child enrolled • The cost of CCS services for children enrolled in Medi-Cal (approximately 70 percent of children in CCS) is share equally by the state and federal government (or consistent with whatever federal Medicaid matching level is set in federal law) • CCS services for children enrolled in Healthy Families are paid for with 65 percent federal CHIP funds, 17.5 percent state funds, and 17.5 percent county funds • The cost of CCS services for children enrolled in CCS only is shared equally between the state and the counties

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