California HealthCare Foundation

Locally Sourced:
The Crucial Role of Counties in the Health of Californians

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About the Author

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About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Introduction

For decades, California's 58 counties have been core providers of health care services and public health programs in local communities. The state relies on the counties to support and administer an array of state and federal health care programs. In partnership with the state, counties have important responsibilities related to medical care, behavioral health (mental health and substance use disorder treatment), and public health. (See *California and Its Counties Under the ACA: A Leadership Framework*, available at www.chcf.org.)

This report provides an overview of county health services and programs across the traditional silos of medical care, behavioral health, and public health. Given the shifting landscape of health care delivery now underway, the report emphasizes the core health responsibilities counties assume and the arrangements counties typically use to meet those responsibilities. The report also highlights many state and federal policies affecting county programs, including some that are pending or in process, to provide a context for monitoring the ongoing changes counties and county health programs are likely to experience in the months and years ahead. This report provides a snapshot of county health services with program and policy details subject to change as the health care landscape in the state continues to evolve. Information in this report is current as of July 2015, except as noted.

Under state law, counties establish and operate health programs and services for low-income individuals who have no other form of health coverage. Some counties own and operate hospitals and clinics offering a comprehensive array of services for low-income and uninsured people, as well as publicly and privately insured patients, and contribute a significant portion of the nonfederal share of funding for the Medi-Cal program. Counties organize and oversee local mental health and substance use disorder programs, primarily for Medi-Cal and uninsured patients, and match federal and state funds for these programs. County public health departments operate public health laboratories and administer programs focused on population health, including communicable disease control, disease prevention and management, health and nutrition education, maternal and child health promotion, and disease surveillance.

To administer and support this wide array of health programs and services, counties must navigate a complex and frequently changing set of federal, state, and local funding streams and requirements. One significant, complicating aspect of the state-county partnership on health has been a recurring back-and-forth shifting of responsibility for program administration, funding, and decisionmaking between the state and counties.

With the unprecedented changes in health care delivery following passage of the Affordable Care Act (ACA), county health programs are in a period of flux and instability as new state and federal policies are implemented, revised, and reframed. In the coming years, the role of counties in providing health care and public health programs will continue to evolve as public and private health care markets mature under the ACA's framework of expanded health coverage and delivery system reform. Even in a changed health care environment, counties will continue to be core providers of health care and public health services for Californians.

Medical Care

California county governments have long assumed a central role in the delivery of medical care services for their residents. Counties provide health care for uninsured indigent people; participate in and help to administer the Medi-Cal program, including the California Children's Services (CCS) program; and organize other state and local medical care programs.

County Indigent Health Care Programs: The Basics

Under California law, dating back to the early 1900s, counties are responsible for the care and support of low-income residents who have no other source of care. This responsibility is often referred to as counties serving as "providers of last resort." In 1933, Section 17000 of the California Welfare and Institutions Code codified this basic county obligation: "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." Subsequent legislation and related court decisions have reaffirmed the duty of counties to provide health care to indigent, uninsured legal residents.

Although counties maintain the basic Section 17000 obligation to serve indigent individuals, over time, responsibility for specific populations and services has shifted between the state and the counties. For example, between 1971 and 1982, the state administered a coverage program for medically indigent adults (MIAs) through Medi-Cal using only state and local funds. In 1982, the state returned responsibility for medical care of MIAs to counties. Beginning in 2014, however, most MIAs again became eligible for federally supported Medi-Cal coverage under the federal ACA Medicaid expansion. (See Table 1.)

Table 1. Major Milestones: Medically Indigent Adult (MIA) Programs in California, by Year

	EVENT
1901	**California Pauper Act of 1901.** The 1901 Pauper Act adds a comprehensive mandate for counties to "relieve and support" all incompetent poor persons, which was interpreted to include medical care services.
1933	**Welfare & Institutions Code Section 17000 obligation.** California enacts legislation to clarify county obligation to be the caretakers of last resort for indigent health care and income support.
1966	**Federal Medicaid and Medicare.** In 1965, the federal government enacts Medicaid and Medicare. California's new Medicaid program, Medi-Cal, includes a requirement that counties provide 10% matching funds for the program.
1971	**Medically Indigent Adults program.** California creates a new state/county-funded Medi-Cal eligibility category for adults 21-64, not linked to a federal aid program and not eligible for federal funding.
1978	**Proposition 13.** California voters pass a ballot measure to cut property taxes, which reduces the primary source of general purpose revenues for counties and intensifies competition among local funding priorities, including health care.
1979	**State funding for county health services.** In the aftermath of Proposition 13, with reduced local revenues, the Legislature passes Assembly Bill (AB) 8 (Chapter 282 of 1979), which allocates new state revenues to counties for local public health programs such as public health nursing, epidemiology, health education, and public health laboratories, and establishes a county maintenance of effort (minimum county spending level). The AB 8 allocation formulas and process, and the county maintenance of effort for those programs, later become components of state and local realignment of health and social service programs. AB 8 repeals the county share of cost for Medi-Cal and allows counties to use the revenues not only for public health but also for indigent health care and health services in county correctional facilities.
1983	**Medically Indigent Adult "transfer."** California eliminates Medi-Cal coverage for MIAs age 21-64, which essentially returns responsibility for this population to the counties (under Welfare and Institutions Code §17000). Counties receive funding estimated to equal 70% of state costs for MIA health care. Small counties have the option to contract back with the state through the County Medical Services Program (CMSP).
1988	**Proposition 99.** California voters pass Proposition 99 to increase tobacco taxes and dedicate the revenues to tobacco prevention and health care programs. Enabling legislation allocates $350 million in Proposition 99 funds to county medical services through the California Healthcare for Indigents Program for large counties and the Rural Health Services program for smaller counties. A county maintenance of effort is set at 1988-89 county spending levels for health services. Proposition 99 revenues decline over time so that by 2003-04, Proposition 99 funding for these programs declines to $27 million. The Legislature terminates Proposition 99 county indigent care funding effective July 1, 2009.
1991	**State and county program realignment.** Realignment transfers to counties responsibility for specified mental health, social services, and health programs, and provides counties with dedicated revenues from sales tax and vehicle license fees to fund the realigned programs.
2004	**Proposition 1A.** California voters pass a legislatively referred amendment to the state constitution that shifts $2.6 billion of local property tax revenues to the state in exchange for constitutional protections of future local revenues. The proposition limits the state's ability to impose new unfunded local mandates. The reduction in county revenues increases pressure on local funds and competition among programs, including health care, but also offers greater stability to county revenues going forward.

Table 1. Major Milestones: Medically Indigent Adult (MIA) Programs in California, by Year, *continued*

	EVENT
2005	**Hospital Financing Medicaid waiver.** California secures a federal Section 1115 Medicaid waiver to provide funding for the uncompensated care costs of uninsured patients and to pilot a coverage initiative for low-income childless adults. Medicaid financing modifications focus primarily on how the state provides the Medicaid "match" (nonfederal share) for inpatient services for Medi-Cal and for Medicaid Disproportionate Share Hospital (DSH) payments for Medi-Cal and uninsured hospital services.
2010	**"Bridge to Reform" Medicaid waiver.** This successor waiver to the hospital financing waiver provides significant federal funding and support for the state's ACA implementation preparations. Among other things, the 2010 waiver: (1) supports county-operated and county-financed transition coverage, collectively known as Low Income Health Programs (LIHP), for county indigent patients until they become eligible for Medi-Cal in 2014 and (2) provides public health care systems (county and UC) with additional resources (matched by the systems) to make health care delivery changes in anticipation of reform.
2011	**Public Safety Realignment.** As part of the transfer to counties of responsibility for various criminal justice activities, counties assume increased responsibility for the nonfederal share of specialty mental health services for Medi-Cal and indigent people, as well as for specific substance use disorder programs. This realignment eliminates state general funds for core community mental health and substance use disorder services but provides counties with additional dedicated sales tax and vehicle license fee revenues to support the realigned programs.
2013	**Realignment: Health redirection.** The state revises realignment formulas and redirects to the state a portion of health realignment revenues that counties historically spent on indigent care. This 2013 health redirection recognizes increased state costs, and county savings, related to the ACA coverage expansions anticipated for 2014.
2014	**ACA coverage expansions.** California expands Medi-Cal coverage for low-income residents, including single adults, and establishes its ACA exchange, Covered California, to administer federal subsidies for low- and moderate-income families. Many Californians previously served by county indigent medical care programs have new public or private coverage, excluding low-income undocumented people who are only eligible for emergency Medi-Cal and may otherwise remain uninsured.

Counties have discretion to determine the manner and method by which they meet their Section 17000 obligations, including the relative emphasis on indigent health care compared to other local funding priorities. Counties determine eligibility requirements, services they will provide, and participating providers, including whether to serve undocumented people. County indigent health care programs are generally not subject to state requirements or minimum standards for eligibility and scope of services, although court decisions over the years have affected the programs and services counties must offer. The wide discretion afforded counties results in tremendous variation among county programs and in spending for indigent health care.[1]

All counties maintain at least a basic program to provide health care services for low-income county residents, subject to local variations and discretion. In addition, many counties — especially those with county-administered health care systems — support and administer broader coverage programs for individuals with unmet health care needs.

Counties use one of two broad approaches to provide health care for low-income and uninsured individuals. The 35 smaller, mostly rural counties offer indigent health care services through the County Medical Services Program (CMSP), which administers a defined program at the state level and contracts with local providers on behalf of participating counties. The 23 larger counties, historically referred to as medically indigent service program (MISP) counties, individually provide, organize, and/or pay for indigent medical care using a variety of service delivery strategies.

CMSP counties contract with the independent CMSP Governing Board, which uses realignment funds plus contributions from member counties to provide limited-term health coverage for eligible uninsured low-income adults who have no other health coverage. Traditionally, the CMSP program served citizens and other legal residents age 21-64 who were not eligible for Medi-Cal and who had incomes up to 200% of federal poverty level (FPL). The Governing Board, composed of 11 members, sets program eligibility requirements, determines the

scope of covered health services, and sets the payment rates for participating providers.

MISP counties differ significantly from one another in eligibility requirements, benefits provided, and service delivery methods. Most MISP counties serve adults age 21-64, but some have no age restriction. Some MISP counties define the indigent care obligation narrowly, offering eligibility of six months or less and limited benefits. Some county programs focus on assisting uninsured people with high-cost medical trauma or emergency medical care needs, while others emphasize limited primary and specialty care and do not cover emergencies. Some counties administer coverage programs that provide access and payment for defined benefits to eligible residents, while other counties provide low-cost services when residents access county hospitals and/or clinics through charity care or discount programs. Some programs limit services to very low-income legal resident adults (e.g., prior to the ACA, seven counties had maximum income eligibility levels of less than 200% of FPL, including one county at 63% of FPL), while the majority of MISP counties have supported health care services for individuals up to 200% of FPL, at a minimum.[2] Prior to the ACA, 14 counties covered some services for low-income undocumented adults.[3]

For decades, researchers, policymakers, and stakeholders have distinguished MISP counties based on the model the county chooses for indigent care: provider counties, payer counties, or hybrid counties. (The CMSP serves as the fourth model of county indigent care.) See sidebar for model descriptions and counties using each model.

Evolution of County Indigent Care Under the ACA

Under the ACA, counties are seeing reduced indigent care program costs because many low-income individuals have become eligible for expanded Medi-Cal coverage or for enrollment in subsidized coverage through California's Health Benefit Exchange, Covered California. Generally, citizens and legal resident adults with incomes below 133% of FPL, many who previously were eligible for one or more county medical care programs, are now eligible for Medi-Cal. (A 5% "income disregard" essentially expands eligibility to 138% of FPL.) Undocumented people with incomes up to 138% of FPL are eligible for emergency-only Medi-Cal services. People with incomes of 139%-400% of FPL are eligible for subsidized coverage in Covered California.

Four Models of County Indigent Care

County indigent health care delivery systems are often categorized into four general types:

- **Provider counties** operate public hospitals and clinics that provide county-sponsored indigent care, and participate in Medi-Cal and other publicly and privately funded health care programs.

  Provider counties: Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura

- **Payer counties** contract with University of California (UC) hospitals, and/or private hospitals and clinics, to provide indigent medical care services.

  Payer counties: Fresno, Merced, Orange, San Diego, and San Luis Obispo

- **Hybrid counties** operate public outpatient clinics but not public hospitals, and contract with UC and/or private hospitals to provide inpatient care.

  Hybrid counties: Placer, Sacramento, Santa Barbara, Santa Cruz, Stanislaus, and Tulare

- **County Medical Services Program counties** contract with the CMSP Governing Board to administer health care services for eligible beneficiaries. CMSP administers the program through contracts with Advanced Medical Management for medical benefits and with MedImpact Health System for pharmacy benefits.

  CMSP participating counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba

Since January 1, 2014, more than 5 million Californians have obtained health insurance in Covered California or Medi-Cal. Total Medi-Cal enrollment is now projected to be 12.4 million in 2015-16, or nearly one-third of California's total population.[4] As of March 2015, 1.4 million were enrolled in Covered California.[5]

The diversity of county indigent care programs continues post-ACA. Most counties did not immediately make significant changes to local indigent care programs in response to the ACA, though some counties reduced the length of eligibility or limited the number of participating providers. County indigent care programs historically restricted enrollment to those ineligible for other programs, but post-ACA most counties now explicitly require prospective enrollees to apply for Medi-Cal or Covered California coverage and to show denial of eligibility in order to enroll in the county program. Los Angeles County, however, allows those with existing coverage to enroll in the county's low-income program and to use the program to cover deductibles for private insurance. (See Appendix A for a county-by-county breakdown of post-ACA county indigent care programs.)

CMSP continues to cover adults age 21-64 with incomes of 139%-200% of FPL who are not eligible for other publicly funded health coverage, but limits eligibility to three months. Like many of the individual county programs, CMSP requires members to apply for other public coverage, including Medi-Cal and private insurance through Covered California. Enrollees may have to pay a monthly share of cost, depending on income. In June 2015, the CMSP Governing Board adopted program changes scheduled for early 2016 to reach more of the remaining uninsured. The changes include increasing the CMSP eligibility income threshold to 300% of FPL, increasing the amount of assets applicants may keep, reducing the share of costs that participants must pay, and establishing a basic primary care benefit for CMSP share-of-cost participants and newly eligible undocumented people currently only eligible for emergency services.

Undocumented people are not eligible for most county indigent coverage programs. However, some counties that do not generally cover undocumented people do cover emergency-only care for them, similar to Medi-Cal. Other counties do not cover undocumented uninsured people in their core indigent care program but do have other programs serving those who are undocumented. For example, Fresno County does not cover undocumented people through its indigent care program but does reimburse Community Medical Centers health system for specialty care services, and administers contracts with local federally qualified and rural health centers to serve undocumented people.[6] Similarly, in May 2015 Sacramento County adopted a limited public-private partnership to make primary and specialty care services available for an estimated 3,000 undocumented people.

Counties with public health care systems provide and administer services for uninsured individuals, including those who are undocumented, either explicitly through specific programs or as discounts and charity care in county facilities. Under state and federal law, all hospitals — private, nonprofit, and county-operated facilities alike — must assess, treat, and stabilize anyone who accesses emergency care, regardless of ability to pay or immigration status.[7] California hospitals must also have payment discount policies for financially qualified patients, including, at a minimum, patients with incomes up to 350% of FPL.[8] Hospital discount policies must limit expected payments to what the hospital would expect to receive from Medicare, Medi-Cal, or other government-funded programs. For example, Ventura County uses a self-pay discount program at Ventura County Medical Center as its primary approach to indigent care, providing discounts to those with incomes up to 700% of FPL, and charity care for eligible county residents with incomes below 100% of FPL.

Although there is still no statewide data on enrollment or participation in county indigent care programs, anecdotal information and research for this report suggests that many counties have seen a dramatic drop in applications and participation in indigent care programs. In recent months, following ACA implementation, some counties, similar to CMSP, increased the number of people potentially eligible by raising the income standard or made other changes to expand the programs. As the ACA coverage expansions provide more people access to comprehensive health coverage, counties are likely to continue adjusting eligibility requirements and the type of services they offer through their programs.

County Children's Health Initiative Programs

Prior to the ACA, some counties administered local coverage programs specifically for low-income uninsured children ineligible for Medi-Cal or the Healthy Families Program because of family income or immigration status. These coverage programs became known collectively as Children's Health Initiatives (CHIs). The first such Healthy Kids program was established in Santa Clara County in 2001.

CHIs operated as county-based public-private partnerships and generally provided low-cost insurance products for children, regardless of immigration status, in families with incomes up to 300% of FPL. Financing models, eligibility requirements, and funding levels differed by community, but generally included county funds, in-kind contributions, and in some instances, Proposition 10 Children and Families Program funding (also known as First 5 funding).[9] By 2006-07, there were 25 CHIs operating in 30 counties; as of November 2014, 12 counties had active CHI programs.[10] Counties scaled back or eliminated CHI programs because historic funders reduced support in anticipation of the ACA and as more children became eligible for Medi-Cal or subsidized coverage in Covered California. Post-ACA, most of the children served in the remaining CHIs are undocumented. As ACA implementation unfolds, many CHIs have implemented eligibility, outreach, and screening initiatives that encourage and support families to apply for coverage if their children are eligible for Medi-Cal or Covered California. Some CHIs have formally pursued certification and funding as enrollment and outreach entities or navigators through Covered California.

For more information about coverage programs for children prior to the ACA, see *Covering Kids: Children's Health Insurance in California*, available at www.chcf.org.

Structure and Financing of County Medical Care Programs

Limited statewide data exist on MISP county funding and expenditures for indigent care in the years preceding the ACA. Historically, the primary sources of funding for county indigent care in both MISP and CMSP counties were county general funds plus revenues the state allocated to the counties under the terms of the 1991 realignment of health and social services programs. Counties operating public health care systems also receive state and federal matching funds — to help defray expenditures they make on behalf of individuals who are uninsured or enrolled in Medi-Cal — and provide billions in local match dollars each year to access federal funds, including DSH funding.

State and Local Program Realignment

As noted earlier, responsibility and financing for health care and public health programs has shifted, over time, back and forth between the state and the 58 counties. These changes are usually brought about through state legislation, often as part of the annual budget process, including through wide-ranging state and local program realignments. When realignment involves a shift in responsibility from the state to the counties, the state estimates what it would have spent on the realigned programs and dedicates a similar amount of revenues (such as sales tax and vehicle license fees) to counties for support of the realigned programs. The state distributes realignment funds to counties annually, including year-to-year revenue growth. The realignment programs, and subsequent changes to realignment funding or program parameters, directly affect county health programs and may affect them indirectly as well. Given the level of discretion counties have in funding and administering local health programs, big changes in available funds and state mandates can reshape these programs.

In 1991, California enacted the first state and county program realignment. This program transferred responsibility from the state to the counties for county indigent care, public health services, and community mental health services, and funding responsibility for specified social services, with dedicated revenues to support the realigned programs. (For details about the 1991 realignment, see *The Crucial Role of Counties in the Health of Californians: An Overview*, available at www.chcf.org.)

In the period leading up to ACA implementation, California enacted two additional realignment changes, with significant impacts on county revenues and health program responsibilities.

- **2011 Public Safety Realignment.** In 2011, California enacted "public safety realignment" to address court-ordered reductions in the state prison population and the growing costs of state prisons. This realignment transferred programmatic and financial responsibility from the state to the counties for various criminal justice activities and provided counties with dedicated sales tax and vehicle license fee revenues to defray the associated costs.

  In the realm of health care, the 2011 realignment eliminated state general funds for community mental health and substance use disorder services such that, by July 1, 2012, counties had assumed full responsibility for the nonfederal share of specialty mental health services for Medi-Cal and indigent individuals, as well as for specific substance use disorder (SUD) treatment programs. (Counties had specific responsibilities for mental health programs and funding prior to this realignment. See the section on behavioral health for additional details and historical context for the state-county roles in mental health and SUD services in the lead-up to the 2011 changes.)

- **2013 Health Redirection (AB 85).** The 2013-14 budget redirected a portion of health realignment funds from the counties to the state to reflect the expansion of coverage under the ACA and potential county savings.[11] County costs and responsibilities for indigent health care are decreasing as more people gain health coverage through Medi-Cal and private insurance. At the same time, state costs for Medi-Cal are increasing as enrollment in the program grows. Public health care systems that provide the nonfederal share for Medi-Cal may also see a growth in Medi-Cal costs.

  The 2013 health redirection established a process for estimating county savings related to decreased indigent care costs and redirected a portion of the estimated savings to the state. Counties could choose one of two options for calculating county savings and redirected amounts. MISP counties could choose either a 60/40 (state/county) split based on historic health realignment allocations to the county, or an 80/20 (state/county) shared savings formula, based on historic (and actual) reported applicable health care costs.

All 12 counties with public health care systems chose the public hospital 80/20 shared savings formula because of financial uncertainty related to the dual responsibilities of providing the nonfederal Medi-Cal match and providing services to the remaining uninsured. The public hospital formula considers costs and revenues for Medi-Cal and uninsured patients. Of the 12 MISP counties without public health care systems, 7 chose the non-county hospital 80/20 formula, which considers costs and revenues for uninsured patients only, and 5 chose the 60/40 split. The 35 CMSP counties are subject to a version of the 60/40 split.

The state budgeted the redirected health realignment funds to defray state costs for the expansion of Medi-Cal and an increase in CalWORKs grants. From a total of approximately $1.6 billion in realignment revenues previously allocated to counties for health services (including indigent medical care and public health), AB 85 redirected $300 million to the state in 2013-14, and the 2015-16 state budget redirects approximately $742 million to the state. The interim redirection amounts to more than half of health realignment funds, though the exact amount will not be known until after the reconciliation process. (AB 85 provides for reconciliation to actual data within two years after every fiscal year. The first annual reconciliation will occur in July 2016 for the 2013-14 budget year. For 2013-14, the redirection is capped at $300 million but can decrease if data show that any counties had less savings than estimated.)

Table 2 compares the provisions of the three realignment programs. (See page 10.)

Table 2. Overview and Comparison of State and County Program Realignments Affecting County Health Programs

	1991 REALIGNMENT	2011 PUBLIC SAFETY REALIGNMENT	2013 HEALTH REDIRECTION
Overview	Transfers specific health and human services programs to counties, along with dedicated revenues, and adjusts the county share of costs for specific human services programs.	Transfers specific court and criminal justice programs to counties, as well as financing for mental health services, with dedicated revenues to support increased county costs for affected programs.	Redirects from counties to the state "savings" in county indigent care costs expected with ACA coverage expansions for low-income residents. Amount redirected is based on each county's choice of a savings formula.
Affected Programs	*Health:* public health, medically indigent services, CMSP, and local health services *Mental health:* community-based mental health, institutes for mental disease, state hospitals *Social services:* aid payments, county welfare administration, foster care, child welfare, adoptions, in-home supportive services, GAIN (pre-CalWORKs), county services block grant, juvenile justice, and California Children's Services	*Justice system:* trial court security, local community corrections, local law enforcement, district attorney, public defender, and juvenile justice *Mental health:* same programs as 1991 realignment — community-based mental health, institutes for mental disease, and state hospitals	*Health:* public health, medically indigent services, CMSP, and local health services
Details	For county health, mental health, and social services programs: ▶ Provides counties with dedicated revenues to fund health and mental health programs. Counties determine local program and service levels. ▶ Increases county share of cost for social services programs, funded with a portion of the dedicated revenues. ▶ Establishes specified accounts and allocation formulas, and permits limited fund transfers among program areas.	For county justice system: ▶ Shifts from state prisons to local jails all sentenced nonviolent, nonserious, non-sex offenders. ▶ Modifies parole statutes and creates the Post Release Community Supervision program. ▶ Shifts parole revocations to counties gradually. ▶ Establishes Community Corrections Partnerships and requires counties to prepare local plans. For county mental health: ▶ Requires counties to assume responsibility for nonfederal share of community mental health services and certain SUD services; updates 1991 realignment funding and shifts funding for mental health to new sales taxes. ▶ Increases funding for community mental health.	For county health services: ▶ Redirects a portion of total 1991 health realignment funding provided to counties to the state, effective 2014-15 ($300 million in 2013-14). ▶ Establishes county options for estimating savings: (1) 60/40 (state/county) split of historic health realignment funds or (2) a "shared savings" formula, with an 80/20 (state/county) split based on actual county costs for indigent care (and Medi-Cal for public health care systems). ▶ Maintains 1991 realignment provisions, as modified by 2011 realignment, but redirects realignment growth funds for public health to fund CalWORKs grant increases. ▶ Establishes a "true-up" to reconcile actual county costs under the "shared savings" approach; first true-up is scheduled for 2016.
Primary Revenues	*Sales tax:* 0.005% (½ cent) *Vehicle license fee (VLF):* 74.9% of revenues	*Sales tax:* 1.0625% of existing tax *VLF:* portion of VLF rate	*Sales tax and VLF:* portions of each allocated under 1991 realignment (varies by county)

Counties and Medi-Cal

As of December 2014, California's Medicaid program, Medi-Cal, had 11.9 million enrollees, an increase of 2.8 million since October 2013. Even though Medi-Cal is a state-administered program, counties — especially those with county-owned and -operated health facilities — are integral partners with the state in the Medi-Cal program. The partnership has many aspects:

- County-operated clinics and hospitals are core Medi-Cal providers, and county (and UC) hospitals fund the majority of the nonfederal match for Medi-Cal patients they serve.
- Some counties establish and administer Medi-Cal managed care plans (described below).
- County social services agencies are responsible for Medi-Cal eligibility determinations for the majority of beneficiaries (with the exception of aged, blind, and disabled recipients on Supplemental Security Income/State Supplemental Payment [SSI/SSP], who are determined eligible and enrolled by the Social Security Administration).

Medi-Cal beneficiaries can have very different experiences with the program depending on their county of residence. The differences may be due to any of the following factors:

- The wide variation in the number and type of providers participating in Medi-Cal, including whether there are county hospitals and clinics available
- The delivery system through which an individual receives care — managed care or fee-for-service
- The type of managed care program that operates in the county

Managed care has become the dominant delivery system in Medi-Cal. As of December 2014, Medi-Cal managed care plans enrolled 8.9 million Medi-Cal beneficiaries, 75% of all those covered by the program. The remaining 25% of beneficiaries receive services through fee-for-service (FFS) Medi-Cal, in which health care professionals and facilities meet state licensing and certification requirements, provide services to beneficiaries, and bill the state, with the state reimbursing for the services at state-established rates.

As California expanded enrollment of Medi-Cal beneficiaries into managed care in recent years, the state's Department of Health Care Services (DHCS) developed multiple managed care approaches. DHCS currently recognizes four managed care models (for the distribution of these four models across the state, see Figure 1 on page 12):

- **County Organized Health System (COHS).** In each COHS county, DHCS contracts with one health plan established and administered by the county, with input from local government, health care providers, community groups, and beneficiaries. All Medi-Cal beneficiaries in the county are required to enroll in the COHS. Some COHS plans have grown to serve beneficiaries in multiple counties. As of December 2014, 1.9 million beneficiaries in 22 counties were enrolled in one of six COHS plans.[12]
- **Geographic Managed Care (GMC).** In the two GMC counties, Sacramento and San Diego, DHCS contracts with several commercial health plans and offers these choices to beneficiaries. As of December 2014, 942,642 beneficiaries were enrolled in the two GMC counties.
- **Two-Plan Model.** In two-plan counties, DHCS contracts with a county-organized local initiative plan and with a commercial plan, allowing beneficiaries to choose between the two. Local initiative plans are locally organized health plans created by counties that operate independent of the county. As of December 2014, there were 5.7 million beneficiaries in 14 two-plan counties.
- **Regional and county-specific.** In the remaining 20 primarily rural counties, DHCS contracts with commercial plans. In 18 of these counties, DHCS contracts with two commercial health plans. In Amador, El Dorado, and Placer Counties, Kaiser Health Plan has some Medi-Cal members in addition to the two other commercial plans. As Figure 1 illustrates, the state separately classifies Imperial and San Benito Counties as distinct model types, based on when the counties' expansion to managed care occurred. Imperial has two commercial plans, while San Benito County allows beneficiaries to choose either Anthem Blue Cross or FFS Medi-Cal. As of December 2014, there were 302,304 Medi-Cal beneficiaries in these 20 counties.

Figure 1. Medi-Cal Managed Care Models, by County

Source: California Department of Health Care Services.

California Children's Services

California Children's Services (CCS) is a statewide program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to eligible children under age 21. To receive CCS services, children must be state residents and have a CCS-eligible medical condition. The CCS program only provides treatment and services related to the specific CCS qualifying conditions, which include certain injuries, physical limitations, and chronic health conditions or diseases, such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, and infectious diseases. CCS also supports medical therapy services delivered at public schools. Most CCS children are also enrolled in Medi-Cal, though families with incomes too high to qualify for Medi-Cal can participate in CCS if the child's medical expenses in a year exceed certain thresholds.

Counties administer key components of the CCS program in partnership with the state. In the 31 counties with populations greater than 200,000 (known as independent counties for CCS program purposes), county staff perform all case management activities for eligible children residing within the county. This includes determining all phases of program eligibility, evaluating need for specific services, determining the appropriate provider(s), and authorizing medically necessary care.

For the 27 counties with populations under 200,000 (referred to as dependent counties), DHCS provides

certain CCS management services through its regional offices located in Los Angeles, Sacramento, and San Francisco.[13] The dependent counties themselves make decisions on financial and residential eligibility, while the DHCS regional offices are responsible for case management and benefit determinations. Some dependent counties also opt to participate in the program's Case Management Improvement Project, which facilitates county collaboration with DHCS regional offices in determining medical eligibility and service authorization. The regional offices provide consultation, technical assistance, and oversight to these counties and to individual CCS-participating providers, hospitals, and specialty care centers in the region. In addition to program administration and cost sharing, most counties serve as direct providers of CCS medical therapy services.

By state law, CCS services are not included in Medi-Cal managed care contracts, so the state administers CCS as an FFS program. This approach is often referred to as a carve-out and also applies to other Medi-Cal services not included in managed care contracts, such as specialty mental health services. County CCS program funding includes a combination of county realignment funds, state general funds, and federal Medicaid and Children's Health Insurance Program funds.

Federal and State Policies Affecting County Medical Care Programs

County medical care programs operate in the broader environment of state and federal rules, programs, and funding streams available to support the services that counties administer. State policy and funding decisions affecting county programs must comply with detailed federal requirements, many of which changed substantially under the ACA. This section highlights new federal ACA requirements, as well as other state and federal programs and policies that affect county medical care programs.

ACA Coverage Expansions

The ACA expanded coverage to low- and moderate-income individuals and families through Medi-Cal and premium subsidies in Covered California. Millions more who were previously excluded from coverage or charged very high premiums because of health status or pre-existing conditions became eligible to purchase private coverage through the exchange or through the non-exchange private individual market.

The population newly eligible for coverage under the ACA overlaps with the population previously served in county indigent care programs, to varying degrees, depending on the pre-ACA eligibility rules in each county. Thus, as the ACA's coverage expansions reduce the number of uninsured people in the state, the expansions also reduce the number eligible for county indigent care programs or charity care in county-operated facilities.

Despite coverage increases, however, many Californians remain uninsured, because they are either not eligible for or not enrolled in public or private health coverage. Prior to ACA implementation, an estimated 6.3 million Californians were uninsured. Analysts suggest that this number will drop to 3-4 million in 2015 and to 2-3 million by 2019.[14]

Medi-Cal. Under the ACA, California retained its existing Medi-Cal eligibility categories and also implemented the optional Medi-Cal expansion (individual states choose whether to implement this expansion). The optional expansion extends coverage to adults at or below 138% of FPL (largely childless adults), excluding undocumented immigrants. Undocumented people who otherwise would qualify can enroll in Medi-Cal coverage for emergency and pregnancy-related services, and, when needed, state-funded long term care services. For the Medi-Cal expansion population, the federal government pays 100% of the costs through 2016, declining gradually to 90% in 2020 and subsequent years. As part of the AB 85 redirection, when the federal share is reduced to 90%, counties with public health care systems will provide the nonfederal share for newly eligible patients served in those systems. Low-income childless adults in this category were eligible for coverage in most pre-ACA county programs, so their enrollment in Medi-Cal will reduce enrollment in county programs.

The so-called mandatory expansion of Medi-Cal refers to individuals eligible under pre-ACA Medi-Cal rules but who, absent the ACA, were not or would not have enrolled in Medi-Cal. Many of these people are expected to enroll because of ACA features such as enrollment simplifications, enhanced outreach, and the individual coverage requirement. Generally, the state continues to pay 50% of the costs, known as the federal medical assistance percentage in Medicaid, for individuals who enroll in pre-ACA Medi-Cal eligibility categories. Counties with public health care systems pay the nonfederal match for

Medi-Cal services they provide for seniors and people with disabilities in managed care plans.

In 2013, nearly 800,000 children in the Healthy Families Program (HFP), California's version of the federal Children's Health Insurance Program (CHIP), transitioned into Medi-Cal. CHIP programs provide health coverage for low- and moderate-income children with 65% federal and 35% state matching funds. Until the transition, the Managed Risk Medical Insurance Board administered HFP as a separate, freestanding program. The Medi-Cal Optional Targeted Low Income Children's Program (OTLICP), which covers those children formerly eligible for HFP (with family incomes up to and including 250% of FPL), provides comprehensive medical, dental, mental health, and substance use disorder services. The HFP transition coincided with the Medi-Cal managed care expansion, including expansion into rural and smaller counties, so that by the conclusion of the phased transition, all children in OTLICP were in Medi-Cal managed care plans.

Additional expansions to Medi-Cal eligibility are planned or in process. The 2015-16 state budget allocates $40 million ($132 million per year when fully implemented) to enroll undocumented low-income children in full-scope Medi-Cal starting in May 2016. An estimated 170,000 children otherwise eligible for Medi-Cal except for their immigration status will be able to enroll. The budget requires DHCS to seek federal matching funds for this expansion if federal funds are not available to develop a state-only program. The state is also seeking federal approval to expand income eligibility for pregnant women from 60% of FPL to the same level as other adults, 138% of FPL.[15] Finally, in 2016, California is scheduled to implement a new state-funded program for certain low-income documented immigrants (subject to a federal waiting period of five years for Medicaid eligibility), linking them to premium and cost-sharing assistance (wraparound coverage) if they purchase coverage through Covered California.[16]

State health benefit exchange. Some low-income and uninsured individuals previously served by county indigent care programs are now eligible for subsidized coverage in Covered California. Covered California offers health coverage for individuals and small employers with fewer than 50 employees through contracts with commercial health plans. Federal premium assistance is available for individuals with incomes up to 400% of FPL if they are not eligible for Medi-Cal or other qualifying coverage. In addition, individuals with incomes between 138% and 250% of FPL are eligible for reductions in their copayments and deductibles. Individuals not eligible for subsidies can also purchase coverage in the exchange. Undocumented individuals cannot purchase coverage in the exchange or receive premium assistance. Undocumented people who remain uninsured may seek services in county facilities or enroll in those county programs that cover the undocumented. As of May 2015, Covered California reported that 1.4 million individuals have enrolled in the individual exchange.

The remaining uninsured. A major factor in the future of county indigent health care is the number and the profile of people remaining without health coverage despite the ACA coverage reforms. These people are sometimes referred to as the remaining uninsured, or the residual uninsured. This group includes those who are not required to have coverage under the ACA (including undocumented individuals, who are ineligible for non-emergency Medi-Cal or exchange subsidies), and those who are required to have health insurance but do not purchase coverage or enroll.

As of January 2014, the ACA requires most individuals to maintain either public (Medi-Cal, Medicare, or other) or private health coverage or to pay a federal tax penalty. However, certain individuals are exempt from what is called the individual responsibility or individual mandate provision. An exemption may be based on religion, incarceration, immigration status, or financial hardship. Federal law generally defines financial hardship as cases where families have incomes that are below tax filing levels, and their insurance premiums, or the employee share of employer-provided coverage, would exceed 8% of household income.

Some people who are not exempt still will remain uninsured. Some may choose to pay a federal penalty rather than get coverage. Others have financial challenges in paying their share of premiums, or copayments and deductibles, or both, whether or not they are receiving premium subsidies. Among those remaining uninsured are some low-income families with employer coverage who fall into what is known as the "family glitch." These are families whose monthly premium costs (for the employee and dependents) exceed 8% of income but who are nonetheless ineligible for federal premium assistance in the exchange because the *employee-only*

premium for the job-based coverage remains below the 8% cut-off. As a result, family coverage is unaffordable, and family members remain uninsured. Finally, because enrollment in Covered California is available only during specific open and special enrollment periods, some individuals and families are uninsured during gap periods if they did not enroll within the specified timeframes.

According to the UC Berkeley-UCLA California Simulation of Insurance Markets (CalSIM, version 1.91),[17] the majority (62%) of the remaining uninsured will be exempt from federal tax penalties associated with not having coverage. CalSIM estimates that in 2015 the remaining uninsured includes 1.4 to 1.6 million undocumented individuals and as many as 1.3 to 1.8 million people eligible for Medi-Cal or Covered California subsidies but not enrolled.

Medi-Cal Waivers Affecting County Health

Since 2005, California secured and implemented two five-year federal Medicaid demonstration waivers under Section 1115 of the Social Security Act with significant implications for county health services. The current waiver expires in October 2015, and a waiver renewal request is pending with the federal Centers for Medicare & Medicaid Services. (See sidebar.) The 2005 Hospital Financing Waiver restructured state reimbursement for public health care systems, including county health care systems, serving Medi-Cal and uninsured individuals, and altered the mechanism by which California matches federal Medicaid funds.

The 2005 financing structure allowed designated public health care systems to obtain 50% federal matching funds for the costs of providing inpatient health services to Medi-Cal patients. The waiver shifted the nonfederal share of Medi-Cal for 22 county and UC hospitals (designated public hospitals) from state general funds to certified public expenditures (CPEs). In the 2005 waiver, CPEs include costs counties (and UC) incur to provide services to Medi-Cal patients for inpatient fee-for-service stays; the state draws down and returns to the public health care systems federal Medicaid matching funds equivalent to approximately 50% of the CPEs.

The waiver ended the use of intergovernmental transfers (IGTs) by public health care systems to support the DSH program for private hospitals serving Medi-Cal and uninsured patients. The vast majority of the state's DSH allotment was allocated to public health care systems that provided the nonfederal match through CPEs and to district hospitals with the match provided by state general funds. Private hospitals received DSH replacement funds paid for with state general funds. The change in DSH funding distribution between public and private hospitals is known as the DSH swap.

The 2005 waiver also established a Safety Net Care Pool of federal funds to similarly reimburse designated public

California's Next Medicaid Waiver: Medi-Cal 2020

In the lead-up to the ACA, public programs and health systems in California operated under the terms of federal Medicaid Section 1115 waivers. The current Bridge to Reform waiver expires in 2015, and on March 27, 2015, the California Department of Health Care Services (DHCS) submitted a five-year waiver renewal application, dubbed Medi-Cal 2020, to the federal Centers for Medicare & Medicaid Services (CMS). The state's proposal seeks approximately $17 billion in federal investment for three primary strategies:

- **Delivery System Transformation and Alignment Programs.** Building on the 2010 DSRIP program, this focuses on six areas for transformation and improvement: managed care, fee-for-service, public safety net, workforce development, access to housing and supportive services, and whole person care pilots.
- **Public Safety Net Global Payments for the Uninsured.** Unifies Disproportionate Share Hospital (DSH) and safety net care pool funding streams into a global payment system for public health systems to care for the remaining uninsured.
- **Shared Savings.** Proposes a new federal-state shared savings model that allows the state to share in a portion of the federal savings from the waiver initiatives, if savings accrue. The state could use the savings for other investments in Medi-Cal delivery system improvements.

As of this writing, DHCS is in discussion with CMS about the waiver proposal. California legislation is pending to enact the final waiver provisions approved by CMS.

For more information and updates, see the DHCS webpage on the 2015 waiver renewal at www.dhcs.ca.gov.

hospitals, including county hospitals, for care provided to the uninsured at the applicable federal matching rate, generally 50%.

California's successor 1115 waiver, the 2010 Bridge to Reform waiver, includes specific initiatives to prepare California's health system for ACA reforms. Among these initiatives are:

- **Low Income Health Program.** The Low Income Health Program (LIHP) was a transitional coverage program for individuals who became eligible for ACA coverage in 2014. Participating counties administered and financed local coverage programs starting in 2011 (some counties started later) through the end of 2013, for low-income adults scheduled to become newly eligible for Medi-Cal (adults with incomes below 133% of FPL) and, in some counties, individuals scheduled to become eligible for subsidized coverage through Covered California in 2014 (133%-200% of FPL). Counties provided matching funds for the coverage to draw down federal Medicaid funds.

  Eventually, 53 of California's 58 counties participated; Fresno, Merced, San Luis Obispo, Santa Barbara, and Stanislaus Counties did not. CMSP operated a single program for its 35 participating counties, known as Path2Health. Ultimately, the participating counties enrolled more than 650,000 people in LIHP. LIHP county programs tested a variety of approaches to improve county care systems, including assigning enrollees to a medical home and testing strategies to improve care coordination for high-risk target populations. The state automatically enrolled eligible LIHP participants in Medi-Cal on January 1, 2014, and notified those eligible for Covered California of the option to apply for subsidized coverage. The state assigned LIHP enrollees who enrolled in Medi-Cal managed care to the county systems that had been serving them.

- **Uncompensated care.** The 2010 waiver continues the Safety Net Care Pool established under the 2005 waiver, which partially reimburses public health care systems for uncompensated care costs. In addition, the waiver provides federal matching funds up to $400 million for the state to recoup costs for designated state health programs serving low-income and uninsured populations, such as the Every Woman Counts breast cancer screening and treatment program, Family Planning Access and Treatment, and the IMPACT Prostate Cancer Treatment Program.

- **Delivery System Reform Incentive Pool (DSRIP).** The waiver provides up to $3.4 billion in federal funds for public health care systems, including county hospitals, contingent upon achievement of specific milestones and deliverables related to infrastructure development, innovation and redesign, and population-focused improvements. The DSRIP supports the efforts of public health care systems to implement reforms under the ACA, including managing the LIHP. To qualify for DSRIP incentive payments, hospitals need to demonstrate achievement on measurable benchmarks. Public systems must also provide local matching dollars for the incentive payments. (For more information, see the California Association of Public Hospitals and Health Systems webpage on DSRIP at www.caph.org.)

- **Managed care expansion.** The waiver calls for mandatory Medi-Cal managed care enrollment for most seniors and people with disabilities (SPDs) in counties that already had mandatory managed care for Medi-Cal families and children. DHCS implemented the transition beginning in June 2011. Public health care systems provide the nonfederal match for SPDs in managed care for services provided in public hospitals and clinics.

- **California Children's Services (CCS).** The 2010 waiver allows CCS pilot programs to test up to four health care delivery models to improve care coordination, health outcomes, and patient satisfaction in the CCS program. As of this writing, DHCS has not implemented CCS pilots, but several are in planning stages. Statutory authority for the existing CCS carve-out from Medi-Cal managed care plans sunsets in December 2015, and DHCS is currently engaging stakeholders to consider the options for CCS program improvements.

In addition to the original elements of the 2010 waiver, during the five-year period of the waiver, California submitted and received approval for certain amendments, as outlined in Table 3 on page 17. (For details on the waivers, see *A Bridge to Reform: California's Section 1115 Waiver*, available at www.chcf.org.)

Table 3. Amendments to the 2010 Bridge to Reform Waiver, by Date

	PROGRAM	PURPOSE
April 2012	Community-Based Adult Services Centers	Outpatient day programs with comprehensive medical and social supports for eligible frail elderly and disabled Medi-Cal beneficiaries
January 2013	Optional Targeted Low Income Children's Program (OTLICP)	Transition of children up to 250% of FPL from Healthy Families Program to Medi-Cal
April 2013	Indian Health Services uncompensated care	Payments to Indian Health Services and tribal facilities for primary care visits for uninsured individuals up to 133% of FPL
August 2013	Medi-Cal managed care expansion	Expansion of Medi-Cal managed care into 28 additional, primarily rural, counties
January 2014	LIHP enrollees transfer	Addition of LIHP enrollees up to 133% of FPL to Medi-Cal managed care
	Outpatient mental health	Expansion of Medi-Cal managed care benefits to include outpatient mental health services
March 2014	Coordinated Care Initiative	Integration of health and long-term support services to rebalance service delivery away from institutional care to home and community in seven counties

Source: *Medi-Cal 2020: Key Concepts for Renewal,* California Department of Health Care Services, March 27, 2015.

Policies Affecting County Health Care Systems

This section highlights policies and programs that specifically affect what are known as provider counties — those that own and operate a health care system with one or more public hospitals and affiliated clinics. The number of county health systems has declined significantly over the last 50 years: from 50 counties with 66 hospitals in 1964 to 12 counties with 16 county-operated hospitals in 2012.[18] However, provider counties still account for approximately 60% of the state population.

Counties with public health care systems have a unique set of challenges and responsibilities. A county's role as a direct provider influences its administration of the local health services described in this report — health care, behavioral health, and public health services. Public health care systems typically provide a range of health care services, including primary care, outpatient specialty care, emergency, and inpatient services. Public health care systems may also provide long term care services or offer specialty tertiary services for the regions they serve, such as trauma or burn and disaster-response services.

County public health care systems serve as central players in the health care safety net for Medi-Cal and uninsured populations. As such, county hospitals and health systems navigate a complicated array of funding streams and targeted programs that support and stabilize public and private safety-net providers.

- **Disproportionate Share Hospital (DSH) funding.** The federal DSH program provides supplemental reimbursement to hospitals, including county hospitals, that serve significant numbers of low-income uninsured and Medi-Cal patients. States receive an annual DSH allotment to reimburse qualifying hospitals up to their actual uncompensated care costs for uninsured and Medicaid patients.

  Although subject to complex formulas, transfers, and requirements, the DSH program in California generally requires public health care systems (county and UC) to provide the state's DSH match for Medi-Cal through a combination of CPEs and IGTs. The state provides the DSH match for eligible district and private hospitals. In addition, the state's 2010 Bridge to Reform waiver allows public health care systems to draw down additional federal funds (from the waiver's Safety Net Care Pool) based on CPEs for services to the uninsured, including services otherwise not eligible for DSH payments such as nonhospital clinics and physician services. The state uses a formula to allocate any remaining Safety Net Care Pool funds among the public health care systems. DSH funds are subject to federal limits requiring public health care systems to account for all other sources of matched reimbursement, including the system's own matching contribution, before claiming DSH funds for uncompensated care.

Anticipating fewer uninsured people thanks to expanded public and private coverage provisions, the ACA reduced DSH funding nationwide. The ACA originally scheduled this reduction for October 2013, but subsequent federal legislation delayed it until October 2017 (federal fiscal year 2018). For 2018, the anticipated nationwide DSH reduction is set at $2 billion, gradually increasing to $8 billion in federal fiscal year 2025; the Centers for Medicare & Medicaid Services (CMS) has not yet released specific state reductions. For 2015, California's federal DSH allocation was approximately $1.19 billion: $1.18 billion for public health care systems (matched by public hospitals) and $12.5 million for district hospitals matched by state general funds. Private hospitals are eligible to receive a small share ($80 million) of the federal DSH allotment but have declined it in recent years. They separately receive approximately $550 million in a Medicaid supplemental payment referred to in California as "DSH replacement" or "virtual DSH" funds (federal and state funds).

- **AB 85: Priority managed care assignment.** Under the terms of the 2013 health redirection legislation, county health care systems have priority for assignment of Medi-Cal managed care beneficiaries who do not choose a plan or provider. The goal is to help county systems maintain a sufficient number of Medi-Cal patients to remain financially viable and to promote continuity of care for county health system patients. In 2014, the state transferred LIHP participants eligible for Medi-Cal to managed care and kept them with the county primary care systems where they had been receiving services. Going forward, managed care plans must assign 75% of enrollees who do not choose a provider to county primary care providers, until the county reaches an enrollment target based on the number of uninsured individuals and LIHP enrollees previously served by the county. In 2014, of the 454,430 people eligible to be placed in county systems by default, Medi-Cal managed care plans assigned 405,748, or an average of 89.3% statewide, to the county systems.[19] The default rate among individual health plans ranged from a low of 35% in Monterey County, where the county hospital reached assignment capacity, to 100% in the counties of Riverside, San Bernardino, and San Mateo.

- **Hospital Presumptive Eligibility for Medi-Cal.** Prior to ACA implementation, certain Medi-Cal providers could grant temporary presumptive eligibility to patients meeting certain criteria, including children and pregnant women. Effective January 2014, California implemented an ACA presumptive eligibility program, specifically for hospitals, that provides temporary Medi-Cal eligibility for up to 60 days for people the hospital determines may qualify for Medi-Cal based on their self-reported income, household size, and state residency as reported at the point of care. To participate in the presumptive eligibility programs, qualified hospitals register with DHCS and agree to meet specified terms and conditions, including training requirements for hospital staff. Hospitals can submit online applications for the following groups:

  - Income-eligible children up to age 18
  - Parents and caretaker relatives of children
  - Pregnant women
  - Former foster youth age 18 to 26 who were in foster care on their 18th birthday
  - Adults age 19 to 64 who are not eligible for Medicare or in any of the other eligible groups

  DHCS approved all of California's county hospitals for the presumptive eligibility program. Presumptive eligibility ensures hospitals that qualifying individuals are eligible for Medi-Cal coverage for at least a temporary period and thus reduces the financial risk of providing uncompensated care. For county hospitals, it also means they can transfer stabilized Medi-Cal patients to other facilities, and providers that participate in the local Medi-Cal delivery system may provide services not available at the public hospital. The 2014 November Medi-Cal estimate assumed a monthly caseload of 34,000-36,000 individuals made eligible for Medi-Cal through hospital presumptive eligibility at all the state's hospitals (not just county hospitals).[20] According to DHCS, as of May 9, 2015, hospitals had enrolled 268,029 beneficiaries in the PE program, with 132,806 individuals, approximately half of the statewide total, enrolled via county hospitals.

- **Hospital quality assurance fee.** California's hospital quality assurance fee program (hospital fee), established through state legislation in 2009, imposes fees on private hospitals serving Medi-Cal and uninsured patients.[21] The revenues from the fees match federal Medicaid funds and support supplemental payments to participating private hospitals. The hospital fee revenues also provide funding for direct grants to designated public (county and UC) and nondesignated public (district) hospitals, defray state costs for children's health care coverage, and reimburse DHCS for the direct costs of administering the program. The most recent state legislation imposing the fee for the period January 1, 2014, to December 31, 2016, estimated a net benefit to California hospitals of $10 billion over three years.[22]

Behavioral Health

Counties have significant responsibilities related to the provision of mental health and substance use disorder (SUD) services, collectively referred to as behavioral health services.

Counties administer an array of federal, state, and local funding streams for behavioral health, much as they do for indigent medical care. In contrast to county indigent medical care programs, however, behavioral health services are financed and managed through a shared state-county model. Also, counties have greater discretion to design and administer indigent medical care programs, while county behavioral health services are subject to state and federal standards affecting eligibility and benefits. But all counties, whether or not they operate county health care systems, must use county revenues, including realignment funds, to provide the nonfederal Medicaid match for specified behavioral health services.

In 2012, California eliminated the state Department of Mental Health and the Department of Alcohol and Drug programs and transferred these program responsibilities to DHCS, with the goal of improving both state and local coordination and integration of the services. Toward this end, all but four counties (Los Angeles, Napa, Plumas, and Tehama) have established a single county behavioral health agency to manage mental health and SUD programs. However, coordinating and integrating these two very different program and service areas is still a work in progress at the state and local levels.

This section outlines the role of counties in each program area — mental health and SUD — and highlights key policies affecting county behavioral health services.

County Mental Health Programs

California's public mental health system is decentralized. Historically, counties have been the primary providers of public mental health services for Medi-Cal and non-Medi-Cal clients. Mental health service delivery and specific mandated programs are described in both state and federal law, but over the last several decades California has transferred most financial and administrative responsibility for mental health service delivery to the counties.[23]

Prior to the 1991 realignment, county mental health programs competed for limited funding in the annual state budget process. To address this, the 1991 realignment moved the funding and program decisions to the counties; the realignment required counties to provide mental health services for specified target uninsured populations — seriously mentally ill adults, seriously emotionally disturbed children, and people in acute psychiatric crisis — but only to the extent that available resources allowed.

As California expanded managed care approaches for Medi-Cal medical care services in the early 1990s, the state pursued a similar path for Medi-Cal specialty mental health services. In 1995, under the terms of a federal Medicaid 1915(b) Freedom-of-Choice waiver (also known as the Specialty Mental Health Services Consolidation waiver), California consolidated inpatient and outpatient mental health services into one program of specialty mental health services at the county level. Counties administer these services through a county mental health plan (MHP) and provide the nonfederal match for Medicaid specialty mental health services using county revenues, including realignment funds.

Under the Freedom-of-Choice waiver terms, all Medi-Cal beneficiaries must receive what the state defines as specialty mental health services through the local MHP — the state carves out specialty mental health services from Medi-Cal managed care plan contracts. These specialty mental health services include psychiatric hospital services, residential treatment services, crisis intervention, and targeted case management, among other services, along with medication support services and individual and group therapy. Each county MHP directly provides

or contracts for specialty mental health services for Medi-Cal patients who meet diagnostic and impairment criteria outlined in state regulations.[24]

As of 2014, Medi-Cal managed care plans are responsible for providing mental health services for Medi-Cal enrollees with "mild to moderate" levels of impairment who do not meet the diagnostic and functional criteria for specialty mental health services. Managed care plans provide individual and group therapy, psychological testing, medication management, and psychiatric consultation, in many cases through contracts with behavioral health managed care organizations. Similar services are available for individuals enrolled in Medi-Cal on a fee-for-service basis. (See Table 4 for details.)

The 1991 realignment also required counties to establish a community mental health program for non-Medi-Cal clients and a local mental health advisory board. Counties have discretion to determine local funding levels, eligibility, and services for non-Medi-Cal mental health services, consistent with the priority target groups outlined in state law and based on the funds available.

Funding for County Mental Health

Public mental health services are financed through a variety of sources, which include realignment and other county revenues; Mental Health Services Act (MHSA) funds; categorical state funds (allocated for specific programs or services); and federal funds, including Medicaid and CHIP federal matching funds, and Substance Abuse

Table 4. Mental Health and Substance Use Disorder Benefits in Medi-Cal (2015): Services and Populations, by Coordinating Entity

	COUNTY MENTAL HEALTH PLANS (MHP)	COUNTY SUBSTANCE USE DISORDER (SUD) SERVICES	MEDI-CAL MANAGED CARE PLANS (MCP)
Target Population	Children and adults who meet medical necessity or EPSDT* criteria for Medi-Cal specialty mental health services	Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal substance use disorder services	Children and adults in managed care plans who meet "mild to moderate" medical necessity criteria or EPSDT criteria for mental health services
Outpatient Services	▶ Mental Health Services (assessments plan development, therapy, rehabilitation, and collateral) ▶ Medication Support ▶ Day Treatment Services and Day Rehabilitation ▶ Crises Intervention and Crises Stabilization ▶ Targeted Case Management ▶ Therapeutic Behavior Services	▶ Outpatient Drug Free ▶ Intensive Outpatient (newly expanded to additional populations) ▶ Residential Services (expansion to additional populations on hold) ▶ Medication-Assisted Treatment, including methadone, buprenorphine, disulfiram, naloxone, and naltrexone	Services carved-in effective 1/1/2014: ▶ Individual/group mental health evaluation and treatment (psychotherapy) ▶ Psychological testing when clinically indicated to evaluate a mental health condition ▶ Outpatient services for monitoring medication treatment ▶ Psychiatric consultation ▶ Outpatient laboratory, medications, supplies, and supplements ▶ Screening Brief Intervention and Referral for Treatment (SBIRT), for people with, or at risk of developing, alcohol use disorders
Inpatient Services	▶ Acute Psychiatric Inpatient Hospital Services ▶ Psychiatric Inpatient Hospital Professional Services ▶ Psychiatric Health Facility Services		
Residential Services	▶ Adult Residential Treatment Services ▶ Crises Residential Treatment Services		
New Services		▶ Inpatient Detoxification Services (limited to general acute care hospitals, pending expansion to other settings)	

*The EPSDT program is the child health component of federal Medicaid for eligible children under age 21.

Note: Does not include provisions of DMC-ODS waiver (see page 24).

Source: California Department of Health Care Services, 2014 (edited), updated here for 2015.

and Mental Health Services Administration (SAMHSA) grant funds. Following the 2011 public safety realignment changes to mental health funding, counties now administer about 90% of the revenue dedicated to public mental health services in the state.[25] Combined federal, state, and local funding for community mental health services in California totaled approximately $6 billion in 2014-15.[26]

Counties use realignment, MHSA, and other local funds to draw down federal Medicaid matching funds for the specialty mental health services they administer for Medi-Cal clients. The county incurs and certifies expenditures to be matched with federal financial participation at the established federal matching assistance percentage for the relevant Medi-Cal eligibility group.

Mental Health Services Act. The MHSA, passed by California voters as Proposition 63 in 2004, expanded mental health services and funding through a 1% state tax on personal income in excess of $1 million. The MHSA expanded community mental health services for state residents who have severe mental illness and whose needs are not met by other programs. The MHSA established a maintenance-of-effort obligation (baseline level of funding that counties must maintain) for community mental health services to ensure that MHSA funds supplement but do not supplant resources in existence at the time of its passage. The state allocates the majority of MHSA funds to counties consistent with approved county plans. MHSA funding supports five program areas: (1) community services and supports, (2) prevention and early intervention, (3) innovation, (4) workforce education and training, and (5) capital facilities and technology. The state Mental Health Services Oversight and Accountability Commission oversees implementation of the MHSA and allocation of funds to counties.

Realignment and mental health. Under the 1991 realignment, each county's previous funding levels determined the base allocations for all of the realigned programs.[27] Realignment also set the priority and allocation formulas for any revenues above the base allocations, referred to as growth revenues. Generally speaking, caseload increases for in-home supportive services and child welfare programs have first priority for 1991 realignment growth revenues, and, over time, mental health realignment funds failed to keep pace with demand for mental health services. Counties also used increasing proportions of realignment funds as the mandatory Medicaid match for mental health services, and to pay the costs of mental health services for Medi-Cal enrollees for non-Medicaid services, such as involuntary psychiatric inpatient and long term care services. County costs for Medi-Cal enrollees gradually reduced the available revenues for mental health services for uninsured and other populations with unmet mental health needs.

The 2011 public safety realignment provides additional revenue for community mental health services (via sales taxes), including a set 5% annual growth in mental health funding, as long as certain social services funding levels are attained. In 2012, voters passed Proposition 30, which provides state constitutional protection for the 2011 realignment structure and funding and prohibits the state from passing laws that increase county costs unless it also provides additional funding.

As a result of the combined 1991 and 2011 realignment programs, counties assume full financial responsibility for the nonfederal share of costs for community mental health services for Medi-Cal beneficiaries, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services for children, and services for the uninsured. There are no remaining state general funds supporting core community mental health services.

Policies Affecting County Mental Health

This section highlights federal ACA requirements, California laws and regulations implementing the federal law, and other state policies that affect county mental health programs. As the primary providers of public mental health services in California, counties directly implement state and federal policy changes affecting mental health services.

ACA benefit expansion in Medi-Cal. In implementing the ACA, California expanded coverage for mental health services for all Medi-Cal beneficiaries (and for SUD treatment services, discussed in more detail below). Prior to the benefit expansion, which took effect January 1, 2014, Medi-Cal beneficiaries with mental health conditions not meeting criteria for county specialty mental health services had very limited psychology and psychiatry services in FFS Medi-Cal and limited outpatient mental health services provided by primary care providers.

The mental health benefit expansion requires Medi-Cal managed care plans to cover mental health services other than the specialty mental health services administered

by counties. This benefit expansion is generally meant to serve individuals with mild to moderate impairments who would not qualify for specialty mental health services. (The ACA benefit expansion made no change to the specialty mental health benefit.)

Federal rules allow states to choose the model or "benchmark plan" for essential health benefits from a specified list of existing public and private employer coverage plans in the state. The state selected the Kaiser Small Group Health Plan as California's benchmark for ACA essential health benefits.

The expanded Medi-Cal managed care services are primarily outpatient services that are typically provided in office settings. Medi-Cal managed care plans are also obligated to cover mental health assessments by licensed mental health professionals. (See Table 4 for an overview of mental health and SUD services in Medi-Cal and the entities responsible for each.)

As part of the implementation process, Medi-Cal managed care plans are required to revise existing memoranda of understanding (MOUs) with county mental health plans. The MOUs serve as the primary vehicles for outlining how the health plans and the counties will coordinate and oversee mental health services, engage in shared oversight, and resolve any disputes or conflicts. The state continues to work with counties, health plans, and other stakeholders toward common standards and approaches for implementing the new mental health benefits.

EPSDT mental health services. 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 that may not otherwise be part of the state's Medicaid program. California counties administer the mental health component of EPSDT, subject to state and federal eligibility and scope-of-services requirements that are broader than the criteria for adults. Under the terms of the 2011 public safety realignment, counties must use realignment funds to support the nonfederal share for EPSDT services.[28]

In July 2014, CMS issued guidance clarifying that states must cover Applied Behavioral Analysis (ABA) as an EPSDT benefit for Medicaid-eligible children diagnosed with autism spectrum disorder. Effective September 15, 2014, Medi-Cal managed care plans are required to cover medically necessary ABA services. DHCS is in the process of developing revised managed care rates to reflect the new requirement; the rates will be retroactive once developed.[29]

Services for involuntarily committed individuals. Under the Lanterman-Petris Short (LPS) Act,[30] counties are responsible for arranging and financing a number of services for people subject to involuntary detention because of mental illness. For example, California law authorizes local law enforcement and people designated by the county to take into custody, involuntarily hold for evaluation, and admit for treatment for up to 72 hours, people with mental disorders who are a danger to themselves or to others, or who are gravely disabled. Counties designate and the state approves the facilities that can admit people being involuntarily committed. State law includes detailed procedures for local law enforcement, county mental health programs, and treating facilities. An involuntary hold of this type is known as the 5150 process, a reference to the section of the state Welfare and Institutions Code that governs the procedure. Other areas of county responsibility include LPS conservatorships, assisted outpatient treatment, and short- and long-term involuntary inpatient treatment.

Mental Health Wellness grants. California's Investment in Mental Health Wellness Act of 2013 (MHWA) provided $150 million (state general fund, MHSA, and federal Medicaid match) for grants to counties, or their public or private designee, to expand and develop mental health crisis support programs.[31] The goal of this act is to support programs focused on "wellness, resiliency, and recovery in the least restrictive setting possible." Specifically, grant funds are available to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. The grants, administered by the California Health Facilities Financing Authority (CHFFA), are available to support program capital improvement, expansion, and limited start-up costs. CHFFA awarded two rounds of grants in 2014, and a third is in process for 2015. As part of the 2013 MHWA, the Mental Health Services Oversight and Accountability Commission also administers a $54 million grant program (federal and MHSA funds) for mental health triage personnel in selected rural, suburban, and urban areas.

Specialty mental health waiver. In 2013, CMS approved the federal waiver renewal for the 1915(b) freedom-of-choice waiver that underlies the system of county MHPs, as described above. In June 2015, California received federal approval for a new five-year 1915(b) Specialty Mental Health Services freedom-of-choice waiver. The new federal waiver terms and conditions include enhanced performance measurement of county MHPs and require the state to develop a process for public reporting of county MHP performance dashboards. CMS had previously expressed concerns about the scope, frequency, and intensity of monitoring and oversight of MHPs by DHCS.

County Substance Use Disorder Programs

DHCS oversees the public system of care for the prevention and treatment of substance use disorders (SUD), but counties administer that system on the local level. While the state-county division of responsibility for SUD has some parallels to that for mental health services, the two systems have historically been financed and administered separately, and are still quite different. Unlike county mental health services, there is no local organized delivery system similar to county MHPs and significantly more limited provider capacity for SUD services in many regions of the state.

Public treatment of SUD predominantly has been provided in separate specialty service programs, some of which are based on social-model recovery (e.g., 12-step), and others that offer medication-assisted treatment (MAT) (e.g., methadone, buprenorphine). County SUD program types vary significantly and range from emergency counseling and initial assessment to detoxification services and residential or long-term outpatient treatment. As with other county health services, the delivery system and services available vary widely county to county.

Medi-Cal SUD Services

Most SUD services for Medi-Cal beneficiaries are provided through Drug Medi-Cal (DMC). In addition, managed care plans have new responsibilities to provide limited SUD services, and some specific services are available through FFS Medi-Cal.

Drug Medi-Cal services. Like mental health services, DMC services are generally carved out of Medi-Cal managed care and offered through county-administered SUD programs. The DMC program will be transformed over the next few years via the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver, described below.

Under the current system, the Medi-Cal program contracts with county governments for the administration and delivery of DMC services. Counties have the option to administer DMC, but they must meet state and federal requirements and standards if they choose to do so.[32]

Counties administering DMC may only contract with SUD providers, generally SUD clinics, that have been certified by DHCS. However, even if a county decides not to contract with a certified DMC provider, DHCS is required, as a result of a 1994 lawsuit, to contract directly with any willing DMC provider in that county that meets minimum DMC requirements. In addition, DHCS contracts directly with providers in counties that do not participate in the DMC program.

The range of services offered by county DMC programs varies substantially. Services reimbursed by DMC must be medically necessary and provided by or under the direction of a physician. DMC only covers services provided at a treatment site certified by DHCS, and these include MAT services, outpatient treatment services, and perinatal residential services in facilities with fewer than 16 beds. Prior to the ACA expansion of mental health and SUD services, DMC residential and intensive outpatient services were generally limited to pregnant and postpartum women and youth under 21. State legislation implementing the ACA expansion of mental health and SUD services, however, expands intensive outpatient services to all Medi-Cal beneficiaries as outlined outlined in Table 4 and described in more detail below.[33]

Screening, Brief Intervention, and Referral to Treatment (SBIRT). Starting in 2014, under the ACA benefit expansion, Medi-Cal covers SBIRT for alcohol use disorders, though not yet for other substance use disorders. SBIRT, a comprehensive health promotion approach for delivering early intervention and treatment services to people with, or at risk of developing, substance use disorders, is covered through Medi-Cal managed care plans or Medi-Cal fee-for-service, depending on the delivery system of the patient.

Other Medi-Cal SUD benefits through managed care or fee-for-service. Medi-Cal also provides limited MAT in outpatient settings, covered by Medi-Cal managed care

or FFS, depending on the medication. (Some medications are included and some are carved out of managed care contracts.) Medically necessary voluntary inpatient detoxification in general acute care hospitals is also available to all beneficiaries, if medically necessary, through FFS Medi-Cal.

Funding for County SUD Programs

Counties use realignment funds, county funds, federal Medicaid matching funds, and federal SAMHSA grants, including the Substance Abuse Prevention and Treatment (SAPT) block grant, to support county SUD treatment programs. While not all counties provide DMC services, there are SUD services in all counties funded with SAPT grant funds. SUD services are provided by county-contracted providers, state-direct contracted providers, or by county SUD program providers. The state does not track county funds used to support non-Medi-Cal local SUD programs.

Federal and State Policies Affecting County SUD Programs

This section discusses federal and state policies that affect county SUD treatment programs.

2011 Public Safety Realignment. Under the terms of the 2011 realignment, the state retains the responsibility to certify and monitor SUD services, while counties must use realignment funds to pay for those services, including providing the state's match to federal Medicaid funds. Even in counties where DHCS directly contracts with providers for DMC, counties retain financial responsibility for the services because the state accesses county realignment allocations to make the provider payments.

Medi-Cal benefit expansion. Effective January 1, 2014, the Medi-Cal expansion made DMC benefits available to all Medi-Cal beneficiaries for whom treatment is medically necessary. However, CMS did not approve the expansion of *residential* treatment to all populations, and it limited coverage for inpatient detoxification services to general acute care hospitals. The expansion of SUD services under Medi-Cal, and the new requirement that Medi-Cal managed care plans cover SBIRT, present coordination and implementation challenges similar to those posed by the expansion of mental health services. Collaboration, communication, and care coordination between Medi-Cal managed care plans and counties is essential to ensure that Medi-Cal enrollees receive appropriate services in appropriate settings. County MHPs, county SUD programs, and Medi-Cal managed care plans need to coordinate screening and assessments, referrals, and case management.

Drug Medi-Cal Organized Delivery System waiver. In August 2015, the federal government approved California's amendment to the 2010 Bridge to Reform waiver to implement an organized DMC delivery system. Counties that opt in to the SUD waiver demonstration project will be required to create a single point of entry for beneficiaries seeking SUD services, implement selective provider contracting, and provide or arrange for all DMC benefits for individuals meeting medical necessity criteria. The new system will be implemented in a phased regional approach over several years. The waiver creates a continuum of reimbursable DMC services including outpatient treatment, case management, MAT, recovery services and recovery residences, withdrawal management, residential treatment, and physician consultation.

In addition, the waiver permits short-term residential SUD treatment in facilities of any size. Traditionally, federal Medicaid financing for mental health and SUD residential treatment has been limited to treatment in smaller facilities — those with 16 or fewer beds. This is called the Institutions for Mental Diseases (IMD) exclusion. (Exceptions were made for pregnant or postpartum women.) This has significantly limited access to residential care: According to DHCS, as of February 2014, there were 783 licensed SUD treatment facilities in California, with a total of 18,155 beds, but only 1,825 of those beds were in the smaller facilities eligible for Medicaid SUD reimbursement.[34]

California is the first state in the country to receive federal approval of an Organized Delivery System waiver, which will be effective for five years.

Drug Medi-Cal provider enrollment. There is a severe shortage of Medi-Cal SUD service providers throughout the state, and in some counties, there are no available providers. SUD provider shortages are exacerbated by delays in DHCS provider certification and recertification. When DHCS assumed responsibility for SUD programs, it conducted a review that turned up allegations of fraud in the DMC program.[35] DHCS then required all DMC providers to apply for recertification using a revised certification application and process. As a consequence, there is a continuing backlog of providers seeking certification,

and some providers report it can take a year or more to complete the application process.[36]

Services for prisoners and released prisoners. The ACA Medi-Cal expansion and the 2011 public safety realignment increased the demand for mental health and SUD services to treat prison and jail populations. The ACA expansion of Medicaid eligibility means that many who have been incarcerated will qualify for Medicaid coverage when released in the community. (Medicaid coverage is suspended or terminated when an individual is in jail or prison.) Due to the ACA behavioral health benefit expansions, these individuals will be eligible for continuing care for their mental illnesses and/or substance use disorders, in many cases for the first time. This new demand increases county costs for the nonfederal share of the services and places pressure on the mental health and SUD delivery systems.

The 2014-15 state budget establishes several programs to fund mental health and substance use services for inmates and parolees, including competitive grants to adult and juvenile authorities for mentally ill offenders, additional funds for SUD treatment in prisons, and community-based reentry programs focused on mentally ill offenders that include transitional housing programs.

Public Health

Public health services are distinct from other county health services because their focus is not on the provision of services to individuals but on population-based strategies to protect the overall health of the community. Core public health functions include preventive medicine, health education, control of communicable diseases, application of sanitation standards, and monitoring of environmental hazards.

California law requires local health departments to provide the following basic public health services: data collection and analysis, health education, public health nursing, communicable disease control activities, environmental health, public health laboratory services, maternal and child health promotion, chronic disease prevention, and nutrition education programs.[37] Local health departments also have primary responsibility to respond to local emergencies such as floods and other natural disasters, disease outbreaks, or bioterrorism attacks.

Structure and Functions of Local Public Health Systems

For public health purposes, California has 61 local health jurisdictions (LHJs): the 58 counties and the cities of Berkeley, Long Beach, and Pasadena. All LHJs are led by a physician health officer appointed by city and county authorities. Most counties also have a health administrator to manage and oversee the array of public health programs. Smaller counties have the option to contract with the state for environmental specialists and public health nurses who work in and for the county but who are state employees. California's public health system historically has worked cooperatively between the state and local levels.

Public health officers have broad and far-reaching authority and responsibility under the law.[38] For example, public health officers have the authority to order testing of individuals and communities, to quarantine individuals and groups, and to close beaches, restaurants, and other facilities for public safety reasons. The state Department of Public Health (DPH) works with and monitors local public health jurisdictions, and county health departments must submit regular public health and program reports to DPH and to other state agencies such as the Emergency Medical Services Authority.

How different LHJs meet their legal requirements and conduct specific public health programs varies substantially in administrative structure, scope, funding levels, staffing, and specific services and programs offered. Yet despite the breadth, variety, and importance of their functions, no statewide resource regularly profiles county public health programs or funding.

Communicable Disease Control

Under California law, communicable disease control activities include prevention, epidemiological services, public health laboratory identification, surveillance, immunizations, follow-up care for sexually transmitted diseases, and tuberculosis control and support services. Local public health officers accept and evaluate mandated reports from health providers on more than 80 statutorily reported diseases.[39] Some counties offer tuberculosis and STD immunizations and treatment at county-operated health clinics and/or in partnership with community providers. Counties may also combine these services with public health nursing and offer treatment

through their primary care delivery systems. As one illustration of this important LHJ function, state and local public health departments tracked and monitored the 2014-15 measles outbreak.

Categorical Programs

Local public health departments administer an array of state and federal public health categorical programs, which are programs for specific populations or for particular, limited purposes. Categorical programs are generally funded by separate federal or state allocations or grants and have specific program requirements or guidelines associated with the funding. The programs offered and the scope of services can vary significantly between counties.

Among the largest of these categorical programs is Maternal, Child, and Adolescent Health (MCAH). Local MCAH programs provide services to at-risk pregnant women and new mothers, connecting them with services to improve their health outcomes and those of their children. County public health nurses make home visits to at-risk mothers and new babies to help new families get a healthy start. MCAH activities include assessment of maternal and child health indicators, community health education programs, and outreach with emphasis on Medi-Cal enrollees. Local MCAH programs may include, among others, Adolescent Family Life, Black Infant Health, Comprehensive Perinatal Services, Fetal and Infant Mortality Review, Childhood Injury and Prevention, and Perinatal Outreach and Education. A related program administered by local public health departments is WIC (Special Supplemental Nutrition Program for Women, Infants, and Children). LHJs are also local lead agencies in tobacco education and prevention programs.

Counties also have specific responsibilities related to reporting and tracking HIV infection as part of their responsibilities for communicable disease control. In addition, some counties receive state and federal funding for HIV/AIDS prevention, care, and treatment. Counties often subcontract with local providers and community-based agencies for these programs. The DPH Office of AIDS administers and allocates state and federal HIV/AIDS funds to LHJs (but may also contract directly with providers and agencies on the local level). Only LHJs deemed by DPH to be "highest burden" at any point in time receive funds for prevention, including counseling, testing, and targeted prevention for high-risk groups. Some counties administer federal Ryan White Comprehensive AIDS Resources Emergency (CARE) funds for primary and medical care and support services for HIV-infected people. Counties may also help to enroll individuals in the AIDS Drug Assistance Program, which provides financial assistance for those who may not otherwise be able to afford the full costs of HIV/AIDS medications.

Emergency Preparedness

Local health departments have the lead local role in early detection of and response to emergency public health crises, disasters, or bioterrorism events. Local health departments are required to initiate expanded surveillance and to lead the local response to the public health effects of emergencies and disasters. Counties contract with the state for these responsibilities and manage federal funds for specific emergencies.

Environmental Health

County environmental health inspectors monitor, inspect, and control permits for restaurants and food establishments, multifamily housing, hazardous materials storage facilities, wells, septic tanks, and community swimming pools. Environmental health programs are generally fee-supported and receive oversight from various state agencies in areas such as solid waste, small public water systems, underground storage tanks, and hazardous materials.

Funding for County Public Health

Counties rely on a range of funding sources for public health services, including realignment funds, county general funds, and state and federal categorical program funding. During the decade prior to implementation of the ACA, California substantially reduced or eliminated state funds for many public health programs and services. For example, in 2009-10, California eliminated all state general funds for maternal and child health and local immunization programs. As a result, local public health departments increasingly rely on the combination of local revenues and categorical federal funds, including federal funds for Title V Maternal and Child Health, Ryan White CARE funds, and emergency preparedness grants and funding.

Federal and State Policies Affecting County Public Health

This section focuses on state and federal policies and programs affecting local public health departments.

State and Local Program Realignment

In the wake of Proposition 13 (California's landmark 1979 property tax reduction initiative) the Legislature enacted programs to make up for local revenue losses in many areas, including providing direct state funding for county health services, local public health services, and indigent care programs. Assembly Bill 8 in 1979 established funding distribution formulas and county maintenance of effort for county health programs.

As described earlier, the state's 1991 realignment transferred responsibility for specific health and social services, including public health, to counties, along with dedicated revenues for health, mental health, and social services. Counties generally must use each revenue fund for the defined category of services, with some limited transfer authority, and thus must fund both indigent care and public health mostly from the health revenue account. Since 1991 realignment, counties determine locally how much of that fund to allocate to indigent care and how much to public health — meaning that public health programs compete with indigent health care for health revenue funds, and with other realigned programs for revenue growth funds year-to-year. The local flexibility that counties gained from this realignment structure is reflected in widely varying public health programs and funding levels county-to-county, with no state-level tracking of county public health spending.

AB 85 of 2013 redirects to the state certain funds that counties historically spent for indigent medical care; this is in recognition of the shift of individuals, primarily single, low-income adults, from county indigent programs to Medi-Cal. The health redirection established formulas and a tracking process to identify the appropriate levels of funds for redirection, including attempting to separate historic county indigent care spending from historic county spending on public health services. The intent was to ensure that counties retain the relative level of funding historically allocated to public health services. Under the new realignment formulas, the state will also allocate a fixed 18.5% of any revenue growth to the health account. This means that county realignment funds available for public health going forward will be limited by historic funding levels for the programs in each county and by the fixed allocation of growth funds. (For more information on the redirection, see the DHCS AB 85 page at www.dhcs.ca.gov.)

ACA Impacts on County Public Health

The ACA emphasizes increased access to health coverage through public and private insurance expansion and program reforms. At the same time, the ACA highlights prevention and population health through a variety of policies, programs, and investments. For example, the ACA encourages providers and private insurers to adopt a population health approach through payment reforms and new models of care and financing such as medical homes and accountable care organizations. The ACA coverage expansions and the focus on prevention and population health combine to provide both opportunities and challenges for county public health programs.

The ACA requires coverage for specific clinical preventive services in Medicare and private insurance at no cost to patients and offers higher federal matching rates for states that enact prevention programs within their state Medicaid systems. This means that many people now have insurance coverage for screening and prevention programs traditionally offered by county public health departments, such as adult and childhood immunizations, screening for sexually transmitted diseases, and HIV testing. This expansion of insurance coverage for prevention may reduce the need for screenings typically offered by county public health departments and even for entire public health clinics, many of which had already seen significant funding reductions in the years prior to passage of the ACA. However, it may also allow the programs to refocus their limited resources on specific target groups and on those who remain uninsured.

The ACA established the federal Prevention and Public Health Fund (Prevention Fund) to promote health across all programs, and the National Prevention Council to develop a national strategy aimed at health in all policies. "Health in all policies" is a collaborative approach to improving population health by considering the health impacts of decisionmaking across sectors and policy areas. The Prevention Fund supports prevention and other public health activities, including community-based preventive health programs (e.g., tobacco cessation, obesity prevention, and chronic disease management programs). The federal Administration for Community Living, the Centers for Disease Control and Prevention

(CDC), and SAMHSA administer targeted programs under the Prevention Fund, including grants to state and local public health agencies. Since passage of the ACA, Congress has significantly reduced amounts in the fund.

California has received two Community Transformation Grants from the CDC to engage in capacity building related to health improvement and chronic disease management. Fresno, Kern, Los Angeles, San Diego, San Francisco, Stanislaus, and Ventura Counties have also received targeted CDC grants since program inception. A collaboration between the Public Health Institute and the California Department of Public Health received a five-year, $5.9 million CDC grant to provide local agencies in 42 low-density California counties (populations of 500,000 or less) with tools, training, and guidance to make their communities healthier. The program, known as CA4Health, focuses on four strategies: reducing consumption of sugary beverages, increasing availability of smoke-free housing, creating safe routes to schools, and providing people who have chronic disease with skills and resources to manage their illness. (For more information about CA4Health, see www.ca4health.org.)

ACA Home Visiting Program. Another example of an ACA initiative directly affecting many county public health departments in California is the nurse home-visiting program serving pregnant women and children up to age 5. Under the California Home Visiting Program, 22 sites in 21 LHJs receive federal funds to provide comprehensive, coordinated in-home services focused on supporting positive parenting and improving outcomes for families residing in identified at-risk communities. The number of programs is limited to 22 because the state did not receive enough funding to support programs in all counties. (For more information, see the DPH page about the California Home Visiting Program at www.cdph.ca.gov.)

Conclusion

California counties historically have been core providers and administrators of health, behavioral health, and public health services. Despite the passage of landmark federal health care reform, this review finds that the basic county roles and responsibilities for health and health care remain as they have for decades.

Nonetheless, the ACA, and state policy initiatives enacted to prepare for and implement its provisions, are reshaping county services and programs. Core county health programs remain, but the services, delivery systems, and populations served are evolving. Many low-income residents previously eligible for county programs are eligible for and enrolled in comprehensive coverage under the ACA. The level and types of funding available to support county health programs, and county funding responsibilities for those programs, have shifted. Counties provide the nonfederal Medicaid match for key health programs, such as mental health and SUD programs, and in counties with public health care systems, for Medi-Cal health care services, even as the programs expand enrollment and benefits.

California's implementation of delivery system changes and coverage expansions, begun following passage of the ACA in 2010, is still very much a work in progress. Table 5 lists major pending actions and policies that will continue to affect county programs in the coming years.

Most observers agree it is too soon to know how the ACA will ultimately transform public and private health care markets and programs. Counties are providing and administering health programs in the context of unprecedented changes in health care delivery, which invites and necessitates new partnerships, innovations, and quality improvement imperatives. This report offers an updated overview of the programs that counties offer, and the varied approaches they use to deliver county health services, as background for policymakers and stakeholders monitoring the progress of health care reform.

Table 5. Pending Policies Affecting County Health Programs, by Date

	EVENT
March 27, 2015	California submitted federal 1115 waiver proposal, successor to the Bridge to Reform waiver, for CMS review.
October 31, 2015	Bridge to Reform waiver expires.
December 31, 2015	Existing "carve-out" of CCS from Medi-Cal managed care sunsets.
2016	The state and counties first reconcile estimates and costs for indigent care savings under health redirection formulas.
2018	Federal reductions in DSH payments scheduled to take effect.

Appendix A. County Medically Indigent Care Programs: Key Characteristics (as of July 1, 2015)

Provider counties (operating county hospitals and clinics)

COUNTY / PROGRAM NAME	ELIGIBILITY (FPL)	ELIGIBLE AGES	COVER UNDOCUMENTED	COPAYS/SHARE OF COST (SOC)	ELIGIBILITY PERIOD	DELIVERY SYSTEM
Alameda *Health Program of Alameda County (HealthPAC)*	<200%	19-64	Yes	SOC	12 months	County hospitals – Alameda Health System; contracts with network of 9 community clinics
Contra Costa *Basic Health Care*	<300%	19+	No	SOC varies by income and age	12 months	County hospital – Contra Costa Regional Medical Center and 12 affiliated clinics
Fresno *Fresno County Medically Indigent Services Program (MISP)*	≤138% FPL 138%-224% FPL	21-65	No Contracts with CMC for specialty care and local FQHC clinics	≤138% FPL: No SOC 138-224% FPL: SOC	1 month or 3 months, depending on individual circumstances	Contracts with private hospital, Community Medical Centers (CMC), and Central California Faculty Medical Group
Kern *Kern Medical Center Health Plan*	138%-200%	19-64	No	Copayments	12 months	County hospital – Kern Medical Center (KMC) and KMC clinics
Los Angeles *My Health LA* *Ability-to-Pay Plan (ATP)*	≤138% No FPL cap	6+	Yes	≤138% FPL: No SOC >138% FPL: SOC	12 months	Community clinic partners under contract with the county; county hospitals 5 county hospitals and affiliated county clinics; contracted nonprofit community clinics
Merced *Merced County Medical Assistance Program (MAP)*	<100%	21-64	No	No	30-180 days	Local providers and by referral to specialty providers outside the county if necessary
Monterey *Monterey County Medical Services Program*	<250%	21-64	No Pilot program in process for 2016	SOC	Month-to-month eligibility	County hospital and clinics – Natividad Medical Center; Specialty care may be authorized outside of county facilities
Orange *Orange County Medical Safety Net Program (MSN)*	138%-200%	19–64	No	Copayments	12 months	Partnership between the Orange County and the private medical community, including community clinics
Placer *Medical Care Services Program (MCSP)*	<185%	21-64	No	>138% FPL: SOC	3 months	Placer County Medical Clinic and contracts with local hospitals
Riverside *Riverside County Medically Indigent Services Program (MISP)*	<200%	21-64	Yes	Copayments and SOC	12 months	County hospital – Riverside County Regional Medical Center; Riverside County health centers; contracted community clinics

County Medically Indigent Care Programs: Key Characteristics, *continued*

Provider counties (operating county hospitals and clinics)

COUNTY / PROGRAM NAME	ELIGIBILITY (FPL)	ELIGIBLE AGES	COVER UNDOCUMENTED	COPAYS/SHARE OF COST (SOC)	ELIGIBILITY PERIOD	DELIVERY SYSTEM
Sacramento *County Medically Indigent Services Program (CMISP)*	No FPL cap	21-64	No New separate limited benefit program	SOC (begins at 63% FPL)	12 months	County clinics for primary care, pharmacy, and labs; contracted specialty, emergency and hospital providers (Dignity Health and Sutter Health)
San Bernardino *San Bernardino County Medical Services Plan (CMSP)*	≤100%	19-64	No	No	12 months	County hospital and clinics — ArrowHead Regional Medical Center
San Diego *San Diego County Medical Services (CMS)*	<165% Hardship program for incomes up to 350%	21-64	No	>165% FPL: SOC	6 months	Network of community health centers; private physicians and hospitals
San Francisco *Healthy San Francisco*	≤400%	18-64	Yes	>100% FPL: Participation fee and copayments	12 months	County hospital and clinics; San Francisco Community Clinic Consortium clinics; private community providers
San Joaquin *San Joaquin Medical Assistance Program (MAP)*	<300%	19-64	No	Yes	6-12 months	County hospital and clinics – San Joaquin General Hospital
San Luis Obispo *San Luis Obispo Medically Indigent Services Program (SLO-MISP)*	139%-250%	19-64	No	SOC	3 or 6 months	Community Health Centers of the Central Coast (CHC) clinics; Limited local specialists; All local hospitals accept SLO MISP patients
San Mateo *San Mateo Access and Care for Everyone (ACE)*	<225%	19+	Yes	Enrollment fee: $360/year	12 months	County hospitals and clinics – San Mateo Medical Center
Santa Barbara *Indigent Care Program (ICP)*	138%-200%	21–64	No Eligible for sliding scale services at county health centers; tobacco settlement funds cover services outside of health centers for low income uninsured including undocumented	SOC	3 months with option to reapply	Santa Barbara County Public Health Department (PHD) Health Care Centers Services outside of PHD county health care centers must be pre-authorized. Many local providers accept ICP including all hospitals in the county.
Santa Clara *Ability-to-Pay Program*	138%-250%	19-64	Yes, if resident of county for 5 years	Copayments	12 months	County hospital – Santa Clara Valley Medical Center and its affiliated clinics

County Medically Indigent Care Programs: Key Characteristics, *continued*

Provider counties (operating county hospitals and clinics)

COUNTY / PROGRAM NAME	ELIGIBILITY (FPL)	ELIGIBLE AGES	COVER UNDOCUMENTED	COPAYS/SHARE OF COST (SOC)	ELIGIBILITY PERIOD	DELIVERY SYSTEM
Santa Cruz *MediCruz Program*	<100%	21–64	Yes	Copayments and SOC	2-3 months	County clinics for primary care; other nonemergency services outside of county clinics require pre-authorization
Stanislaus *Medically Indigent Adult Program (MIA)*	Varies in increments by age: <144% (21-29) to <175% (60-64)	21–65	No	SOC	3–12 months	County-based physicians and family practice residents at county clinics; Doctor's Medical Center of Modesto
Tulare *Sliding fee scale discount at county clinics*	<175%	21–64	Yes	Copayments and sliding scale SOC	12 months	County-operated clinics
Ventura *Self-pay discount program*	<700% Eligible county residents <100% FPL may be eligible for a charity care adjustment	19–64	No	SOC (discounted payment for services at VCMC)	12 months	Ventura County Medical Center (VCMC) facilities and clinics
CMSP Counties (35) *County Medical Services Program (joint program)*	139%-300%	21–64	Yes	SOC	3 months	Contracts with local providers organized by contracted administrator

Notes: FPL is the federal poverty level. Information on this chart was obtained directly from counties and through online research but subject to change as counties update and revise programs and services. Eligibility for most county indigent care programs requires applicants to have no other source of health coverage and to apply for Medi-Cal / Covered California before seeking assistance through the county. Some county programs retain eligibility at very low income levels, although most individuals with incomes 0%-138% FPL are eligible for Medi-Cal, except for undocumented people who are only eligible for emergency Medi-Cal. Share of cost for the programs typically varies based on income. Counties with hospitals may have discount and charity care programs for low-income uninsured individuals, including undocumented people, in addition to the specific indigent care programs profiled here. AB 774, Chapter 755, Statutes of 2006 requires all hospitals in the state, not only county hospitals, to administer a discount payment and charity care policy for financially qualified patients. Fresno, Monterey, Santa Barbara, and Sacramento Counties have or are developing limited programs for undocumented people, but those counties report they have not revised the eligibility rules to make undocumented individuals eligible for the core county indigent care programs.

Endnotes

1. For more details about the evolution and characteristics of pre-ACA county indigent care programs, see Deborah Kelch, *The Crucial Role of Counties in the Health of Californians: An Overview,* California HealthCare Foundation, March 2011, www.chcf.org.
2. Trisha McMahon and Matthew Newman, *County Programs for the Medically Indigent in California,* California HealthCare Foundation, October 2009, www.chcf.org.
3. Ibid.
4. Governor's May Revision of the 2015-16 Budget, www.ebudget.ca.gov (PDF).
5. Executive Director's Report to the Board, Covered California, May 21, 2015, board.coveredca.com (PDF).
6. The California Legislature passed special legislation (AB 2731, Chapter 743, Statutes of 2014) permitting Fresno County to delay until 2020 its maintenance of effort payments to the local Road Fund, as long as the county continues to provide medical services to indigent and undocumented people consistent with eligibility and benefits in effect in the 2013-14 fiscal year. The county is using $5.5 million from the Road Fund to pay for the indigent care services.
7. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) and implementing state laws require anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay. Under EMTALA, "any patient arriving at an Emergency Department (ED) in a hospital that participates in the Medicare program must be given an initial screening, and if found to be in need of emergency treatment (or in active labor), must be treated until the patient is stable. EMTALA is also referred to as the "anti-patient dumping" requirement.
8. AB 774, Ch. 755, Statutes of 2006. Hospital Fair Pricing Policies, HSC Sections 127400-127446.
9. In November 1998, California voters passed Proposition 10, the "Children and Families Act of 1998" initiative. The act levies a tax on cigarettes and other tobacco products to provide funding for early childhood development programs. Revenues generated from the tobacco tax must be used to enhance the early growth experiences of children, enabling them to be more successful in school and ultimately to give them an equal opportunity to succeed in life.
10. "Mission, Vision, and History," California Coverage and Health Initiatives, cchi4families.org.
11. AB 85, Chapter 24, Statutes of 2013.
12. *Medi-Cal Managed Care Enrollment Report,* Department of Health Care Services, December 2014.
13. Dependent CCS counties are Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Imperial, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Modoc, Mono, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.
14. *CalSIM version 1.91 Statewide Data Book, 2015-2019* (Table 1), UCLA Center for Health Policy Research and UC Berkeley Labor Center, May 2014, healthpolicy.ucla.edu (PDF).
15. SB 75, Chapter 18, Statutes of 2015.
16. SB 1 X1, Chapter 4, Statutes of 2013-14 of the First Extraordinary Session.
17. CalSIM is a micro-simulation model jointly developed by the UCLA Center for Health Policy Research and the UC Berkeley Center for Labor Research and Education. CalSIM estimates the impact of various features of the ACA using a wide range of official data sources, including the California Health Interview Survey, healthpolicy.ucla.edu.
18. Orange, Sacramento, and San Diego Counties contract for indigent care services with UC hospitals, which have access to similar but not identical funding sources as county-operated facilities. Together, county and UC hospitals are considered "designated public hospitals" for purposes of federal indigent care funding, the federal Medicaid 1115 waiver, and the state's hospital provider fee.
19. Department of Health Care Services, email message to author, "Percent Default Population Assigned to the County Public Hospitals and Health Systems, January-June 2014 and July-December 2014."
20. *November 2014 Medi-Cal Local Assistance Estimate,* Department of Health Care Services, www.dhcs.ca.gov.
21. AB 1383, Chapter 627, Statutes of 2009.
22. *Analysis of Senate Bill 239, Chapter 657, Statutes of 2013,* Senate Committee on Health, September 12, 2013.
23. *A Complex Case: Public Mental Health Delivery and Financing in California,* California HealthCare Foundation, July 2013, www.chcf.org.
24. Specialty mental health services administered by county MHPs are subject to medical necessity criteria depending on whether the determination is for inpatient, outpatient, or outpatient services for beneficiaries under 21. Regulations governing medical necessity can be found at Title 9, California Code of Regulations, Section 1820.205 (inpatient), 1830.205 (outpatient) and 1830.210 (outpatient for beneficiaries under 21). Beneficiaries must have one or more mental health diagnoses outlined in the regulations, have one or more impairments as a result of the diagnoses (e.g., a significant impairment in life functioning), and the proposed intervention must be focused on the impairment from the diagnosis with the expectation that the intervention will diminish the impairment or, in the case of a child under 21, allow them to progress developmentally.
25. CHCF, *A Complex Case.*

26. "Subcommittee #3, Part A Health and Mental Health Oversight, CHFFA, DHCS" (budget hearing agenda), Senate Budget and Fiscal Review Committee, April 9, 2015, sbud.senate.ca.gov.
27. CHCF, *A Complex Case*.
28. For information on EPSDT services in Medi-Cal managed care, see "All Plan Letter 14-017," Department of Health Care Services, December 12, 2014, www.dhcs.ca.gov (PDF).
29. For information on BHT services in Medi-Cal managed care, see "All Plan Letter 14-011," Department of Health Care Services, September 15, 2014, www.dhcs.ca.gov (PDF).
30. California WIC Section 5000 et seq.
31. SB 82, Chapter 34, Statutes of 2013.
32. See WIC Division 9, Part 3, Chapter 7, Sections 14124.20-14124.29.
33. SB 1 X1, Chapter 4, Statutes of 2013-14 of the First Extraordinary Session.
34. Senate Budget and Fiscal Review Committee, "Subcommittee #3."
35. *Drug Medi-Cal Limited Scope Review,* California Department of Health Care Services, November 2013, www.dhcs.ca.gov (PDF).
36. Senate Budget and Fiscal Review Committee, "Subcommittee #3."
37. See California HSC, Division 101, Part 3, Section 101000 et seq.
38. Ibid.
39. California HSC, Division 105, Part 1, Section 120100 et seq.