CHCF

The Crucial Role of Counties in the **Health Care and Public Health of Californians**

JANUARY 2026

AUTHORS
Meredith Wurden, MPH, MPP
Alexandra Kanemaru, MPH
Olivia Brown, MGPS

About the Authors

Meredith Wurden, MPH, MPP, is senior strategic adviser at Sellers Dorsey. Alexandra Kanemaru, MPH, is director at Sellers Dorsey. Olivia Brown, MGPS, is senior consultant at Sellers Dorsey.

This is an update to the 2015 publication, *The Crucial Role of Counties in the Health of Californians*.

About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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.

Contents

Introduction

California is composed of 58 counties that each have a critical role in administering health care, behavioral health services, and public health services in local communities. To support policymakers' and other stakeholders' understandings of counties' roles in administering health care and public health, this report provides an overview of the county landscape as it relates to health services and programs, and it highlights many state and federal policies affecting counties.

Background

California counties administer and implement state policies, programs, and services at the local level while exercising a degree of autonomy through certain program flexibilities and allowances. These measures enable counties to tailor programs to local needs. While counties have long been providers and administrators of health care, changes in Medi-Cal — California's Medicaid program — have altered the way counties perform these functions. Over the past decade, the ACA; coverage expansions; and ongoing Medi-Cal transformation efforts, including CalAIM (California Advancing and Innovating Medi-Cal), have continually reshaped the services and programs counties administer to their populations.

In addition, counties are mandated to protect the health of communities and do so through administering public health programs and services. County public health departments operate public health laboratories and administer programs focused on population health, including communicable and chronic disease prevention and management initiatives, programs to address social determinants of health (SDOH), and disaster relief. In recent years, county public health departments have prioritized emergency preparedness, pandemic response, and health equity initiatives to address disparities exacerbated by COVID-19 and other public health crises.

Counties also play pivotal roles in administering mental health and substance use disorder (SUD) services, collectively referred to as behavioral health services. Jointly with the state, counties administer Medi-Cal specialty behavioral health services and programs. In recent years, counties have faced new responsibilities, opportunities, and challenges driven by behavioral health transformation and an unprecedented number of related initiatives. Figure 1 shows California's 58 counties. For additional details, see this paper's companion report, *The Crucial Role of Counties in the Behavioral Health of Californians*.

Figure 1. California, by County

Source: "California Counties," California State Association of Counties, accessed January 5, 2026.

Terms Used in this Report

This report includes the following concepts and terms that are similar but denote different meanings:

- **Indigent care:** Health care provided to individuals who lack financial resources to pay for services.
- **Medical care:** Health care professionals' diagnosis, treatment, and prevention of illness or injury.
- **Public health:** A whole-population approach to protect and improve the health of people and their communities, guided by government policy and community efforts.
- **Public health care:** Government-funded health care services aimed at ensuring the well-being of the public.
- **Public hospital:** A government-owned and/or -operated hospital that provides medical care to the public, often with a focus on serving low-income or vulnerable populations.
- **Designated public hospital (DPH):** A specific subset of public hospitals part of systems that include its affiliated government entity clinics, practices, and other providers formally designated by the state for purposes of program eligibility, funding, and reporting. These hospital systems are operated by a county, a city and county, the University of California, or a special hospital authority. DPHs are explicitly named in state statute and recognized by the California Department of Health Care Services policy and program authorities. DPH systems may also be generally called Public Hospital and Health Systems or Public Health Care Systems.
- **Behavioral health services:** Mental health and substance use disorder services.
- **Social services:** Public services designed to support individuals and families in need.

Source: Authors review of multiple sources.

County Governance and Structure

The structures of counties' health, human services, public health, and behavioral health departments vary and change over time in response to shifts in policy and county priorities. A county may have stand-alone departments or departments that fall under a combined health and human services agency, for example. Additionally, counties provide other services — including the oversight of jails, housing, and child welfare — through departments that coordinate with the core health departments.

Typically, the directors of these departments and agencies report to a County Administrative Officer (CAO) or County CEO, who then reports to a county's elected Board of Supervisors (BOS). One exception to this typical structure can be found in Los Angeles County, where the County CEO will be an elected political position beginning in 2029.[1] The specific structures, reporting relationships, and responsibilities of these positions can vary depending on a county's size, organizational structure, and BOS preferences.

Because county health departments operate within a governance structure that is accountable to locally elected BOSs — which retain decisionmaking authority over program direction, contracting, funding, and expenditures — balancing local priorities and goals with state and federal program requirements and expectations can be challenging. This is especially true for balancing responsibilities for Medi-Cal entitlement services for eligible residents.

Health Care

County Roles and Responsibilities

Dating back to the early 1900s, California counties have acted as providers of last resort, providing indigent care for those who cannot afford it and lack another source of support. Section 17000 of the Welfare and Institutions Code codifies this obligation, stating: "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."

With the implementation of the ACA and Medi-Cal coverage expansions, the role of California counties has evolved as it relates to the following safety-net programs:

1. **Medically Indigent Adult (MIA) programs.** Counties have discretion in shaping their MIA programs to meet their Section 17000 obligations. Therefore, operations, eligibility criteria (e.g., immigration status, age, and income), and scopes of service (ranging from primary care only to broad sets of services) vary.[2]

2. **Medi-Cal.** Counties administer components of the Medi-Cal program on behalf of the California Department of Health Care Services (DHCS), the state Medicaid agency, and contract and have agreements with Medi-Cal managed care plans (MCPs).

While many counties still operate their MIA programs, the ACA and Medi-Cal expansions have led several to close or restructure their programs (see the "Medi-Cal Coverage Expansion" section on page 8 for details).

Some counties also play direct roles as service providers by owning and operating hospitals and clinics targeting underserved Californians, as well as Medi-Cal members and privately insured people; contracting with MCPs to provide services; and contributing a portion of the non-federal share of funding to Medi-Cal.

The abbreviated "Federal and State Health Care and Coverage Milestones" timeline highlights many of the key events described throughout this report. For additional details, see Appendix A on page 24.

Federal and State Health Care and Coverage Milestones

1901. The California State Pauper Act enacted

1965. Federal Medicare and Medicaid Act passed

1965. Welfare and Institutions Code Section 17000 enacted in its current form

1966. Medi-Cal implemented

1991. State and county realignment shifts responsibility to counties for certain health, social services, and mental health programs

2010. Bridge to Reform Section 1115 demonstration waiver and Low Income Health Program begins

2011. Public safety realignment further expands counties' responsibility in behavioral health and other areas

2014. Medi-Cal expanded under the ACA alongside other ACA-related expansions

2016. Medicaid and CHIP Managed Care Final Rule issued

2016. Medi-Cal expanded for children age 19 and under, regardless of immigration status

2020. Medi-Cal expanded for young adults age 19 through 26, regardless of immigration status

2021. CalAIM waiver approved

2022. Medi-Cal expanded for older adults age 50 and older, regardless of immigration status

2024. Medi-Cal expanded for adults age 26 through 49, regardless of immigration status

2025. Federal H.R. 1, commonly known as the One Big Beautiful Bill Act, passed

2026. Medi-Cal enrollment moratorium effective for UIS adults age 19 and older

Notes: *CHIP* is Children's Health Insurance Program; *CalAIM* is California Advancing and Innovating Medi-Cal; *UIS* is unsatisfactory immigration status.

Source: Authors' analysis of resources.

Funding Health Care Through Realignment

Counties finance their health care program obligations using a mix of state, federal, special, and county funds. Over time, responsibility and financing for health programs have shifted back and forth between the state and counties. These changes are usually brought about through state legislation, often as part of the annual budget process 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 revenue to counties to support the realigned programs. Otherwise, the state must reimburse counties for these new responsibilities — known as state mandates — under California's Constitution.[3]

Over the past 35 years, the state has undertaken two major state-to-county realignments in response to state budget deficits and one major funding redirection from the counties to the state after ACA expansions reduced the population without health care coverage.[4] As described in Appendix B, these major shifts are as follows:

- 1991 Realignment
- 2011 Public Safety Realignment
- 2013 Health Realignment Redirection[5]

For the 2025–26 state fiscal year, counties are projected to receive an estimated $1.2 billion in realignment funds to support indigent health care and public health, plus $2.9 billion annually for 1991 social services realignment, including the In-Home Supportive Services (IHSS) program and the California Children's Services (CCS) program.[6] Realigned Medi-Cal programs and services are a major county cost driver, including IHSS, which is mainly a Medi-Cal benefit. For realigned Medi-Cal programs, counties are responsible for a portion of the non-federal share of cost. Realignment is not subject to the annual state budget process and is funded through dedicated sales taxes and vehicle license fees (VLFs). The California State Controller's Office apportions realignment funds to counties monthly.

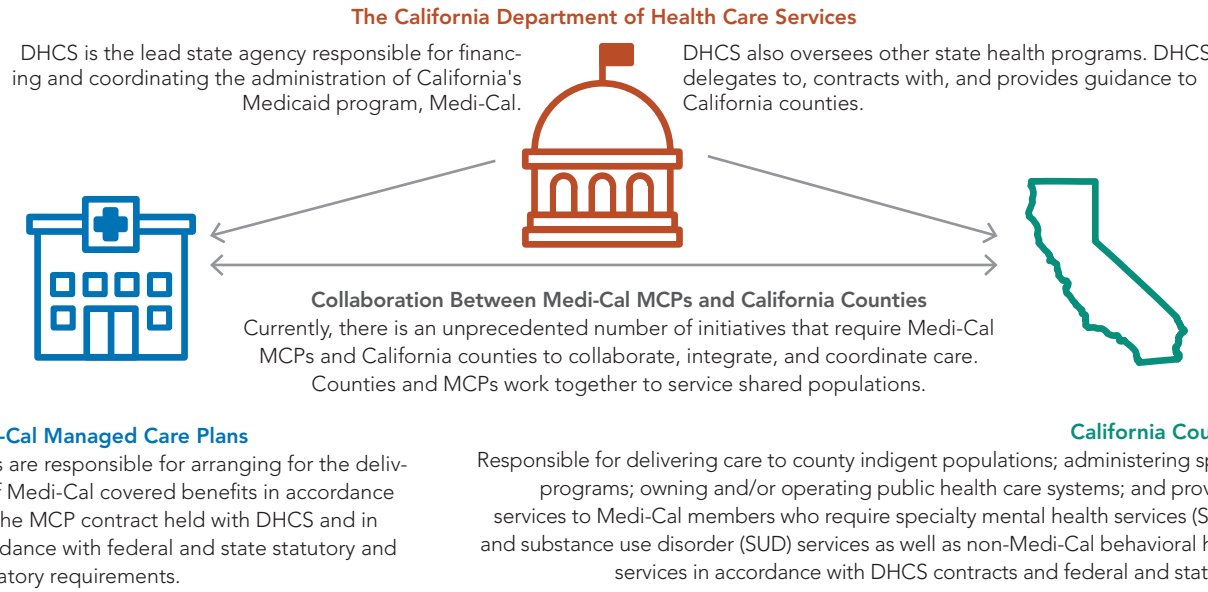
Managing these dollars can be challenging for counties because the funding established under realignment may not align or keep up with changes in program demand and costs. IHSS is somewhat of an exception as legislative changes have adjusted to better align IHSS program costs with revenues. Counties must balance wide-ranging community needs with program requirements, including Medi-Cal entitlements. Further, counties have limited ability to modify core Medi-Cal realigned programs and services to contain costs despite being at financial risk for some of the non-federal share. While realignment rules allow for some shifting of funds between programs, counties must make difficult trade-offs to support local priorities and obligations.

For more historical background on realignment, see CHCF's 2015 *Locally Sourced: The Crucial Role of Counties in the Health of Californians*.

County Medi-Cal Responsibilities

With a budget over $200 billion, Medi-Cal provides health care coverage to around 14.8 million low-income families and individuals, seniors, people with disabilities, children in foster care, and undocumented individuals across the state.[7] Covered

Figure 2. Relationship Between State and County Health Care Delivery Systems



Notes: *DHCS* is California Department of Health Care Services; *MCP* is managed care plan.
Source: Authors' analysis of DHCS resources.

Medi-Cal services include but are not limited to primary and preventive care, hospital and emergency services, maternity and newborn care, and access to prescription drugs. In addition, Medi-Cal covers non-traditional health services like Community Supports (most are federally authorized as In Lieu of Services) as well as services provided by doulas and community health workers.[8]

While DHCS, primarily through MCPs, administers the statewide Medi-Cal program, it also delegates functions and programs to counties. Counties provide support for administering the following Medi-Cal funded programs, services, and activities:

- Medi-Cal eligibility and enrollment
- Specific programs and services, such as IHSS and CCS
- Specialty behavioral health services, including Medi-Cal SMHS and SUD services covered through Drug Medi-Cal (DMC)-only or the Drug Medi-Cal Organized Delivery System (DMC-ODS)

The relationships between county health and human services, behavioral health, MCPs, and DHCS are illustrated in Figure 2.

Although Medi-Cal is a statewide program, members can have different experiences with the program depending on their county of residence due to any of the following factors:

- **Mix of Medi-Cal MCPs.** The type of MCPs available in that county and the services and programs they offer.
- **Differences in Access to Providers.** The wide variation in the numbers and types of providers participating in Medi-Cal as well as whether there are county hospitals and clinics available.
- **Variance in Delivery Systems.** The delivery systems through which an individual receives care such as managed care or fee-for-service.
- **County Choice with Initiative Implementation.** The priorities, ability, and resources a county can leverage to take on new opportunities and/or

initiatives, such as the Whole Person Care (WPC) program or behavioral health transformation and other initiatives.

Medi-Cal Coverage Expansion

Coverage expansions under the ACA in 2014, along with subsequent Medi-Cal expansions, significantly affected the counties' roles in administering indigent care programs. The post-ACA maturation of health care markets and continued Medi-Cal coverage expansions increased the number of residents insured through Covered California, the state's health insurance exchange, and covered by Medi-Cal. Many of these people may have previously been served by county indigent care programs.

Between 2016 and 2024, the state further expanded Medi-Cal coverage to individuals regardless of immigration status.[9] Under these expansions, Medi-Cal became available for the following populations:

- Children age 19 and under (2016)
- Young adults age 19 to 26 (2020)
- Older adults age 50 and older (2022)
- Adults age 26 to 49 (2024)

While the Section 17000 obligation still exists today, counties have a diminished practical role in providing health care services to indigent residents, as far fewer Californians lack health care coverage. In 2023, only 6.4% of Californians were without health insurance compared to 17.2% in 2013.[10] Several counties have closed their indigent care programs or modified their scope to offer services to Californians who do not qualify for Medi-Cal based on income.[11] Concurrently, counties have increasingly focused on supporting Medi-Cal administration and coordinating with MCPs.

However, following a decade of progress in expanding health care coverage and bringing the state's uninsured rate to a historic low, California risks an estimated 3.4 million Medi-Cal members, especially individuals with unsatisfactory immigration status (UIS), losing coverage due to federal policy changes.[12] Additionally, the state faces budget shortfalls and, in the most recent budget cycle, took action to limit future enrollment and scale back benefits for individuals with UIS. These uncertainties require counties to reconsider their roles once again in providing indigent care.

County Public Health Care Systems (PHSs)

Twelve counties own and/or operate public health care systems comprising designated public hospitals as well as medical centers, clinics, and/or affiliated physician practices that serve as key safety-net providers in their local communities. These systems generally serve a disproportionate share of low-income Medi-Cal and uninsured residents who are at higher risk of poor health outcomes and health disparities. County PHSs vary in size and complexity and are primarily located in urban areas throughout the state (see Table 1).

Over the last decade, these systems have adapted to changing population needs by focusing more on outpatient care, directly managing assigned Medi-Cal populations, and addressing disparities in care delivery and quality through key Medi-Cal initiatives. County PHSs use realignment and other public funds as the non-federal share for Medi-Cal by transferring these dollars — through what is known as an intergovernmental transfer (IGT) — to DHCS. The dollars are then matched by the federal government.

Counties have also responded to local needs by stepping in to preserve critical health care services when systems risk closure. For example, in 2019, Santa Clara County acquired O'Connor Hospital, St. Louise Regional Hospital, and De Paul Health Center to preserve access to care.[13]

Table 1. California County Public Health Care Systems

Alameda	Alameda Health System: Alameda Hospital Fairmont Rehabilitation and Wellness John George Psychiatric Hospital Park Bridge Rehabilitation and Wellness San Leandro Hospital South Shore Rehabilitation and Wellness Wilma Chan Highland Hospital
Contra Costa	Contra Costa Health Services: Contra Costa Regional Medical Center
Kern	Kern Medical
Los Angeles	Los Angeles County Department of Health Services: Harbor/UCLA Medical Center Los Angeles General Medical Center Olive View/UCLA Medical Center Rancho Los Amigos National Rehabilitation Center
Monterey	Natividad Medical Center
Riverside	Riverside University Health System
San Bernardino	Arrowhead Regional Medical Center
San Francisco	San Francisco Department of Public Health: Zuckerberg San Francisco General Hospital and Trauma Center Laguna Honda Hospital and Rehabilitation Center
San Joaquin	San Joaquin County Health Care Services: San Joaquin General Hospital
San Mateo	San Mateo Medical Center
Santa Clara	County of Santa Clara Health System: Santa Clara Valley Medical Center O'Connor Hospital St. Louise Regional Hospital Regional Medical Center
Ventura	Ventura County Health Care Agency: Ventura County Medical Center Santa Paula Hospital

Source: "Members," California Association of Public Hospitals and Health Systems, accessed December 28, 2025.

Note: Most county public health care systems have clinics (not listed in table).

Medi-Cal Transformation Initiatives and Partnerships with Medi-Cal Managed Care

California has used statewide Medicaid Section 1115 demonstration and 1915(b) waivers for over two decades to drive Medi-Cal system changes that have shifted counties' roles in care delivery and coordination.[14] Through these waivers, counties have become key partners in integrated care models, WPC programs, and behavioral health care, with increased responsibilities for coordination and reporting. Section 1115 waivers allow states to waive certain Medicaid rules to test and implement new delivery system changes to further the program.[15] 1915(b) waivers allow states to implement managed care delivery systems.

Historically, the state's Section 1115 waivers focused on financing for public hospital systems to strengthen delivery for uninsured and underinsured Californians. For example, a 2005 waiver focused primarily on restructuring hospital financing in California, with major changes to both public and private hospital financing for Medi-Cal and the uninsured. The waiver was also intended to prevent loss of federal funding, add potential for funding growth, and improve quality of care. Over time, the primary focus of these waivers has expanded to include broader reforms affecting all parts of the Medi-Cal delivery system, including hospitals, to drive improvement. Over the last decade, several waiver-related initiatives laid the groundwork for future statewide Medi-Cal coverage and benefit expansions via county pilots and other programs.

Since their origin, Section 1115 waivers have focused on supporting counties and expanding access by giving flexibility and funding to innovate and address local needs. The following Section 1115 waivers have played important roles in how California counties engage with Medi-Cal:

- **Medi-Cal Hospital/Uninsured Care Waiver** (2005–2010)
- **Bridge to Reform** (BTR; 2010–2015)
- **Medi-Cal 2020** (2015–2021)
- **CalAIM** (2022–2026)
- **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Initiative and Demonstration (BH-CONNECT)** (2025-2029)

Bridge to Reform. In 2010, California received federal US Centers for Medicare & Medicaid Services (CMS) approval for the BTR Section 1115 demonstration waiver, effective through October 2015. Focusing on expanding health care coverage to low-income uninsured adults in anticipation of the ACA coverage expansion, public hospital transformation and support for hospital uncompensated care costs, this waiver brought approximately $10 billion in federal funding to California.[16] The BTR waiver's impact on counties is described in Table 1.

Medi-Cal 2020. In 2015, DHCS submitted a new five-year Section 1115 waiver application to CMS seeking approximately $17 billion in federal investments, later extended to run through 2021. This new waiver built upon the BTR waiver and added new programs impacting counties (see Table 3).

CalAIM. DHCS leveraged a combination of waivers and State Plan Amendments (SPAs) to operationalize CalAIM, including new Section 1115 demonstration and 1915(b) waivers effective through December 2026.[17] CalAIM is a multiyear Medi-Cal transformation initiative that began in 2022 with an overarching goal of improving the quality of care and reducing disparities within Medi-Cal. CalAIM seeks to standardize the delivery system, make services more consistent across programs and counties, and enhance state oversight and monitoring of counties for specific programs and functions. Under CalAIM, DHCS strengthened county monitoring

Table 2. Bridge to Reform Initiatives Impacting Counties

INITIATIVE	DESCRIPTION
Low Income Health Program (LIHP)	▸ Expanded California counties' roles in the administration and delivery of health care to low-income populations who were not covered by Medi-Cal through the LIHP, and leveraged counties' long-standing experiences serving this population through indigent care programs. ▸ Allowed counties to tailor programs to meet local needs and create infrastructure for Medicaid expansion under the ACA.
Delivery System Reform Incentive Pool (DSRIP)	▸ Established first-in-the-nation funding for public health care systems, including county hospitals, for infrastructure development, innovation and redesign, and population-focused improvements.
California Children's Services (CCS) Demonstration Project	▸ Tested the efficiency of transitioning county CCS programs from fee-for-service to an organized health care delivery model with capitated payments. ▸ Produced outcomes that led to S.B. 586 (Cal. 2016) authorizing the California Department of Health Care Services to carve CCS services into Medi-Cal managed care, shifting responsibilities away from counties to managed care plans.

Source: Authors' analysis of California Department of Health Care Services resources and implementation plans.

Table 3. Medi-Cal 2020 Initiatives Impacting Counties

INITIATIVE	DESCRIPTION
Whole Person Care (WPC)	▸ Counties (lead entities) and local partners collaborated to implement the WPC pilot, which sought to coordinate health care, behavioral health, and social services in a person-centered manner to improve members' health and quality of life and to address social determinants of health (SDOH). ▸ Counties opted in and county dollars were leveraged for federal matching funds.
Global Payment Program (GPP)	▸ Established a statewide funding pool for the remaining uninsured that combines uncompensated care funding and Disproportionate Share Hospital (DSH) funding. ▸ Impacted select designated public hospital systems, allowing them to achieve their "global budget" by meeting a service threshold that incentivizes primary care, preventive care, and other services.
Public Hospital Redesign and Incentives in Medi-Cal (PRIME)	▸ Builds on the Delivery System Reform Incentive Pool (DSRIP) program for designated public hospital systems to implement pay-for-performance initiatives for improvements in three domain areas: ▸ Transformation of outpatient delivery systems and prevention efforts ▸ Care for targeted high-cost or high-risk populations ▸ Resource utilization efficiency through specific projects

Source: Authors' analysis of DHCS resources and implementation plans.

and oversight related to county eligibility functions and the CCS program. While CalAIM initiatives are largely administered by MCPs, the programs require increased integration, investment, and collaboration with delivery system partners, including counties, to administer whole-person care for members in new ways. Major initiatives impacting the provision of care at the county level are outlined in Table 4.

During the 2021 and 2022 budget surplus years, the state invested significantly in Medi-Cal programs including those operated in partnership with counties and other entities. This includes CalAIM, which provides counties with opportunities to assess their local needs in partnership with MCPs and other entities to provide better, more coordinated care for Medi-Cal members. Many CalAIM initiatives impacting counties, such as Enhanced Care Management (ECM) and Community Supports, are contingent on MCPs opting to contract with and leverage the expertise of counties. Thus, counties have had varying degrees of success in collaborating with MCPs to leverage CalAIM opportunities depending on resources and capacity, existing relationships, and experience working with managed care. As of March 2025, 20 counties provide ECM and 25 counties provide at least one Community Support service.[18]

CalAIM brings in several billion new federal dollars annually in Medi-Cal matching funds and state General Fund investments. Some of this funding can go toward county initiatives, incentives, and collaborations with managed care depending on the specific activity and eligibility. Presently, it is difficult to know the amount and overall impact of CalAIM funding for counties.

For additional details on CalAIM, visit CHCF's website for a comprehensive overview: see CHCF's CalAIM in Focus series.

Table 4. Major CalAIM Initiatives Impacting Counties

INITIATIVE	DESCRIPTION
Enhanced Care Management (ECM)	▸ Builds on county-administered Whole Person Care (WPC) pilots that ended in 2021. ▸ Managed care plan (MCP)-administered statewide benefit focusing on comprehensive care management for certain members with complex needs, termed "populations of focus." ▸ MCPs are responsible for overall ECM administration, including identifying enrollees and assigning members to providers, which include counties, local health departments, and county behavioral health providers.
Community Supports (previously In Lieu of Services, or ILOS)	▸ Voluntary medically appropriate services, such as housing transition navigation services and medically tailored meals, offered by MCPs as cost-effective alternatives to traditional health care services or settings. ▸ MCPs contract with a variety of health and social service entities, including counties, local health departments, and county behavioral health providers, to deliver Community Supports.
Global Payment Program (GPP)	▸ Continues GPP originally established under Medi-Cal 2020.
Population Health Management (PHM)	▸ Offers a comprehensive suite of services to MCP members to improve overall health outcomes. ▸ Required joint community planning between MCPs and local health jurisdictions (LHJs), leveraging community health assessments and Community Health Improvement Plan processes.
Justice-Involved Reentry Initiative*	▸ A first-in-the-nation program providing targeted Medi-Cal services to youth and eligible adults in state prisons, county jails, and youth correctional facilities for a maximum of 90 days prior to release to enable continuity of care. ▸ Requires county entities, such as correctional facilities and behavioral health agencies, to coordinate pre- and post-release services with other parties.

Notes: Table does not capture all CalAIM initiatives. Items listed in this table include but are not limited to CalAIM initiatives authorized through the 1115 waiver.

* For additional details, see: *CalAIM in Focus: Reentry*, CHCF, July 2023.

Source: Authors' analysis of DHCS resources and implementation plans.

More on CalAIM behavioral health-specific initiatives and BH-CONNECT are discussed in *The Crucial Role of Counties in the Behavioral Health of Californians.*

Medi-Cal Managed Care

Most Medi-Cal members receive care via the managed care delivery system through health plans that contract with DHCS to administer and arrange covered benefits. Over the past decade, Medi-Cal managed care has become the dominant delivery system in California. As of April 2025, 95% of Medi-Cal members were enrolled in managed care, up from 77% in 2016.[19]

MCPs contract for health care services through established networks of care with providers that focus on primary care, preventive services, and specialty care.[20] CalAIM and other recent initiatives have expanded managed care in a way that emphasizes integrated and coordinated care between counties and MCPs and requires deeper collaboration to administer person-centered health care services, with the outlook that alignment between counties and MCPs fosters more comprehensive care. Through CalAIM, traditional service roles are shifting. For example, some county agencies are

becoming ECM and Community Supports providers, including those that led the county WPC programs that laid the foundation for these new services. Several Community Supports, such as housing supports, offer non-traditional Medi-Cal services that require collaboration with other county entities, such as housing authorities, social services, and Sheriff's departments.

Counties are also adjusting to impacts on long-standing programs like Targeted Case Management (TCM), which provides Medi-Cal case management services to specific populations.[21] Furthermore, counties are having to evaluate their current programs and work closely with MCPs to ensure services are not duplicated, since these new programs have overlapping target populations and services with legacy programs. For example, a Medi-Cal member eligible for ECM may not receive TCM as of June 30, 2025.

California's Medi-Cal managed care system operates under several delivery models, with counties playing a role in some of these models. Under certain circumstances, a county can establish a local MCP, known as a County Organized Health System (COHS), through actions taken by its BOS and with approval from DHCS. Several local MCPs in California have been established by counties and are run by a county government entity.[22] Initially established in the 1980s, COHS plans enable counties to have direct control and oversight of the delivery of health services that are tailored to address local health care needs. In the 1990s, local initiatives (LI) were developed based on the COHS model to protect the safety net, promote cost savings, and give local communities some control and flexibility in managed care.

Medi-Cal Managed Care Model Types

As of January 2024, the California Department of Health Care Services (DHCS) oversees five delivery models across the state:*

1. **County Organized Health System** (COHS) Model. In COHS counties, DHCS contracts with one plan that is established by the county and administered by a county government entity, with input from local government, health care providers, and members. All Medi-Cal members in a COHS county are required to enroll in that plan, except for members who are eligible for and choose to enroll in Kaiser. In 2021, 12 counties opted to change their managed care model to a COHS. These model changes went into effect in 2024, bringing the total number of COHS counties to 34.† As of July 2025, 2.9 million Medi-Cal members in 34 counties are enrolled in one of six COHS plans.
2. **Single Plan Model.** Under this model, DHCS contracts with plans that operate under the authorization and sponsorship of a county or local authority. In the Single Plan Model, plans operate like a COHS. As of July 2025, about 773,000 Medi-Cal members are enrolled to receive services from Alameda Alliance for Health, Contra Costa Health Plan, and Community Health Plan of Imperial Valley as part of those counties' Single Plan Models. Alameda and Contra Costa Counties were previously Two-Plan Model counties, in which the local initiatives (LIs) became the single plan for those counties.
3. **Two-Plan Model.** In Two-Plan Model counties, DHCS contracts with an LI and commercial plan, giving Medi-Cal members a choice for enrollment. LI plans are locally organized health plans authorized by counties that operate independently. As of July 2025, 7.75 million members were enrolled to receive services in 14 Two-Plan counties (5.7 million in LI and 2.05 million in commercial).‡

4. **Geographic Managed Care (GMC) Model.** Sacramento and San Diego Counties operate GMC models, whereby DHCS contracts with four commercial health plans in each county. In San Diego County, Community Health Group operates in addition to the commercial plans. As of July 2025, about 950,000 members were enrolled to receive services through commercial health plans in Sacramento and San Diego counties, and Community Health Group covered another 370,000 members.
5. **Regional Model.** In counties that do not operate as a COHS, Single Plan, Two-Plan, or GMC Model, DHCS contracts with commercial plans in two or more contiguous counties. The Regional Model was originally developed to expand Medi-Cal managed care into largely rural parts of California. This model is currently limited to Amador, Calaveras, Inyo, Mono, and Tuolumne Counties. As of July 2025, around 43,000 Medi-Cal members were enrolled to receive services in one of those five counties.

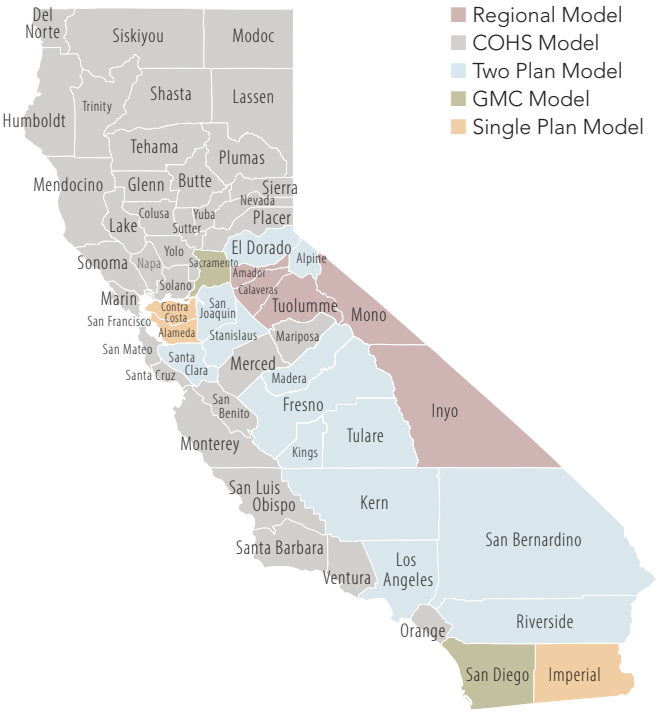
* Enrollment data do not include Kaiser. As of July 2025, Kaiser enrollment statewide was around 1.2 million across all five managed care model types.

† Mariposa and San Benito Counties (2) opted to join Central California Alliance for Health; Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba Counties (10) joined Partnership HealthPlan.

‡ LI count includes member enrollment for Anthem Blue Cross in Tulare County. Although Anthem Blue Cross is not a designated LI, it was appointed by Tulare County to operate there due to the absence of an LI.

Sources: "Medi-Cal Managed Care Performance Dashboard," DHCS, accessed September 2025; "Medi-Cal Managed Care Enrollment Report," California Health and Human Services Agency, last modified August 19, 2025; *Medicaid Section 1115 Demonstration Amendment Request: CalAIM Medi-Cal Managed Care Model Changes* (PDF), DHCS, August 12, 2022; and *Medi-Cal Managed Care Plan Model Fact Sheet* (PDF), DHCS, January 1, 2024.

Figure 3. Medi-Cal Managed Care Model Type, by County



Source: "Medi-Cal Managed Care Models" (PDF), California Department of Health Care Services, January 1, 2024.

Note: *DMC-ODS* is Drug Medi-Cal Organized Delivery System.

State Managed Care Structure and Recent Changes

2024 MCP Overhaul. In 2024, DHCS changed its managed care contracting relationships in four important ways:[23]

1. **County Managed Care Model Changes.** DHCS approved managed care model changes in 17 counties, 15 of which sought to have only one plan either via a COHS or Single Plan model.[24] These models provide counties with a more expansive role in the health care their community receives. Changes in MCP model type exemplify a push by counties to have a greater role in managed care delivery and move away from large national commercial health plans.

2. **Commercial Contracting.** In December 2022, DHCS announced that 21 counties with

commercial MCPs would implement new state contracts, changing how counties collaborate, contract, and coordinate with MCPs, as well as how many and which MCPs counties engage with.[25] For example, only four commercial MCPs now operate in San Diego County, down from six previously. In Los Angeles County, Health Net holds the commercial Medi-Cal managed care contract but agreed to delegate 50% of their membership to Molina Healthcare, thereby allowing Molina to administer plan services on Health Net's behalf for those members.

3. **Kaiser in the Medi-Cal Landscape.** The state has a direct MCP contract with Kaiser in 32 counties, adding another layer of coordination and complexity.[26]

4. **State-MCP Contract Updates.** DHCS implemented a sweeping update of the state-MCP contract to incorporate relevant components of new state policy.[27] Ultimately, these updates increase MCP responsibilities; shift how plans address local health priorities; and require county engagement, local planning efforts, and contributions to the community. Due to new or expanded MCP requirements, the following key changes demand extensive resource and coordination efforts on behalf of counties and MCPs:

   - **Community Investment.** Developing annual community reinvestment plans and contributing MCP income to local communities.[28]
   - **Strengthening and Clarifying Local Relationships.** Executing expanded Memorandum of Understanding with local partners, including county health, social services, and behavioral health departments, for specific programs and services.[29]
   - **Local Emergency Preparedness and Response.** Creating a local emergency preparedness and response plan, coordinating with city and county programs, and attempting to establish cooperative arrangements with other local health care organizations for assistance and mutual aid.
   - **Population Health and Data Exchange.** Population health requirements making MCPs work with counties for population needs assessments, related data exchange, and other activities.

These changes represent an unprecedented shift in MCP models and operations, altering the commercial payer mix by significantly expanding the role of local health plans and introducing MCP competition for COHSs for the first time. In total, about 1.2 million members transitioned to a new MCP on January 1, 2024. Still, far more Medi-Cal managed care members are served by COHSs and LIs (66%) compared to those served by commercial MCPs (34%).[30] Additionally, DHCS' direct contract with Kaiser makes existing managed care delivery models somewhat of a misnomer in practice. For instance, Kern County operates a Two-Plan Model (Kern Health Systems and Anthem Blue Cross Partnership Plan), but since Kaiser operates in this county, there are three MCPs directly contracting with the state.

Managed Care Directed Payments for PHSs. County PHSs historically received supplemental Medi-Cal funding through certain Medi-Cal waiver initiatives and other state programs. To comply with federal Medicaid managed care rules issued in 2016, several supplemental payments needed to be restructured and transitioned to a new managed care financing mechanism known as state directed payment. Beginning in 2017, PHSs began receiving funds tied to service utilization or quality from contracted MCPs, changing their relationships with MCPs.

Adjusting to this new payment relationship presented both opportunities and challenges under these new structures and program rules. In 2023,

Managed Care Final Rules

The US Centers for Medicare & Medicaid Services (CMS) released several federal Medicaid managed care rules over the past decade that have directly impacted counties and hospital financing:

- The **2016 Medicaid and CHIP Managed Care Final Rule** (hereafter the 2016 Final Rule) overhauled managed care regulations, including provisions requiring managed care plans (MCPs) to comply with rules related to network adequacy, member protections, and managed care payments, thereby increasing county responsibilities. It impacted county public hospital financing for services administered to MCP members.
- The **2020 Medicaid and CHIP Managed Care Final Rule** aimed to strike a better balance between federal oversight and state and local flexibility while reducing the administrative burden the 2016 Final Rule placed on counties.
- The **2024 Medicaid and CHIP Managed Care Final Rule** focused on managed care access, finance, and quality.

Source: "Medicaid and CHIP Managed Care Final Rules," CMS, accessed August 27, 2025.

approximately $3.4 billion (including the non-federal share contributed by county PHSs) was directed through MCPs to county PHSs for both the Enhanced Payment Program (EPP) and the Quality Incentive Pool (QIP). New managed care federal rules issued in 2024 paired with 2025 federal budget legislation passed in H.R. 1 affect how these directed payments operate and require redesign that could introduce more fiscal risk for these systems.

In-Home Supportive Services

In-Home Supportive Services (IHSS) provides eligible individuals with personal care services in their homes and is administered through a shared state-county model outside the Medi-Cal managed care delivery system. While IHSS existed in some form before Medi-Cal (e.g., the Attendant Care Program), now that it is primarily a Medi-Cal benefit, the state can leverage significant federal matching funds to support the program. Counties are financially responsible for part of the non-federal share, which they primarily pay using realignment funds.

Historically, counties paid a specific percentage share of cost for the non-federal portion, however, as program costs outpaced available realignment revenues, counties pushed for change. In 2017, a new financing mechanism was put in place requiring counties to maintain a certain level of spending to receive IHSS funding. For the 2025–26 budget, California counties are required to spend about $2.3 billion of program costs (an amount that is adjusted annually by an inflation factor of 4% according to state law).[31] Today, IHSS is one of the costliest and fastest-growing realigned Medi-Cal programs, with an estimated total budget of $29 billion and a projected reach of nearly 800,000 individuals in 2025–26.[32]

California Children's Services

Established in 1927, the CCS program is one of the nation's oldest health coverage programs. CCS is a statewide program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to eligible members under age 21. Counties administer key components of the CCS program in partnership with the state.[33] The program serves approximately 190,000 children today.[34]

Whole Child Model (WCM). Based on findings from the BTR waiver's CCS Demonstration Project and in alignment with broader trends, there has been a push to move CCS care coordination and case management into managed care, requiring county programs to interface with MCPs to coordinate care for CCS members. In 2016, S.B. 586 authorized DHCS to "carve" CCS services into Medi-Cal managed care via the WCM program,

which shifted responsibilities away from county CCS programs to MCPs.[35] As a result, in WCM counties, CCS beneficiaries enrolled in an MCP began receiving CCS-specific services through the MCP instead of the county CCS program, including medical case management.

Between July 2018 and July 2019, CCS services were carved into managed care in 21 COHS counties.[36] Effective January 1, 2025, A.B. 118 expanded the CCS WCM program to serve Medi-Cal eligible CCS beneficiaries enrolled in an MCP served by a COHS, Regional Health Authority, or Kaiser in 12 additional counties. The changes to the CCS program have caused WCM counties to work more closely with MCPs while maintaining responsibility for select county functions (see Figure 4).[37]

Figure 4. Whole Child Model Counties

Source: "California Children's Services Whole Child Model," California Department of Health Care Services, accessed December 12, 2025.

Behavioral Health Delivery System

Counties have significant responsibilities related to the administration and delivery of Medi-Cal specialty behavioral health services as well as non-Medi-Cal safety-net behavioral health services and programs. For Medi-Cal, DHCS contracts with 56 county mental health plans (MHPs) to administer SMHS in all 58 counties.[38] Medi-Cal specialty mental health and SUD services are overseen by DHCS and administered through county-operated MHPs and DMC-only or DMC-ODS programs. Counties also administer non-Medi-Cal community behavioral health services and programs, including but not limited to behavioral health services funded through the Behavioral Health Services Act (BHSA). For additional details on the administration, funding, policy changes, and other relevant aspects of county behavioral health, refer to *The Crucial Role of Counties in the Behavioral Health Care of Californians*.

Public Health

Role of Counties in Public Health

Public health services are distinct from other county health services due to their focus on protecting the overall health of the community, rather than that of the individual. Core public health functions include prevention and control of communicable and chronic diseases; injury prevention; advancing maternal, child, and adolescent health; assessing for and responding to environmental health concerns; responding to local disasters, including public health emergencies (PHEs); supporting linkages to health care; and addressing underlying social determinants of health that impact public health and health outcomes.

California statutes and regulations require 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.[39]

Structure and Function of County Public Health. The California Department of Public Health (CDPH) works with and monitors local health jurisdictions (LHJs), the legal entities that are responsible for public health functions in California and are required to submit regular public health and program reports to the state.[40] All LHJs must have a physician health officer (local health officer, or LHO) appointed by the city or county BOS, and most counties have a health administrator who manages and oversees public health programs. Depending on the county, LHOs may be included in the LHJ leadership team. LHOs from all 61 LHJs serve on the California Conference of Local Health Officers, a technical and policy-oriented advisory body to CDPH, boards, commissions, and other agencies.

The structure of each LHJ includes divisions or units that focus on functional areas, such as communicable disease control; epidemiology; health education and promotion; environmental health; emergency preparedness; maternal, child, and adolescent health; and administration. Each LHJ has a unique organizational setup based on local needs, priorities, funding levels, and programs. LHOs have broad and far-reaching authority and responsibility under the law to take action to prevent disease, including requiring isolation and quarantine.

Other Public Health Responsibilities. Over time, public health has evolved and expanded focus on SDOH and health equity. Increasingly, it is also being called on to address complex societal challenges, including climate change, violence prevention, and homelessness. Some counties have established specific offices dedicated to addressing these issues while others have services that cross county departments. Counties also collaborate with various agencies and community organizations to address SDOH — such as housing insecurity, education, and economic development — and improve the lives of their residents.

Terminology: Local Health Jurisdiction and Public Health Department

The terms local health jurisdiction (LHJ) and public health department are often used interchangeably in California. However, LHJ is broader than the term public health department and encompasses governmental entities responsible for the administration of public health services within a geographic area; in California, there are 61 LHJs consisting of 58 counties and three cities – Berkeley, Pasadena, and Long Beach. Public health departments or local health departments typically refers to a specific county and/or city department/agency that implements and administers public health programs and services in the LHJ.

Communicable and Chronic Disease Prevention and Control

California statutes and regulations task LHJs with preserving and protecting public health, including but not limited to communicable disease control activities. These functions include prevention, epidemiological services, public health laboratory testing, surveillance, immunizations, follow-up care for sexually transmitted infections, and tuberculosis control and support services, among others. In response to the COVID-19 PHE, many local health departments collaborated with their local health care delivery systems — including with health plans, providers, hospitals, and community-based organizations to implement coordinated testing and vaccination programs and provide their communities with education and prevention strategies.

Chronic disease and injury prevention also fall within the purview of LHJs. Services vary but may

The COVID-19 Public Health Emergency

The COVID-19 public health emergency (PHE) exemplified the actions local health officers (LHOs) are authorized to take in the interest of the community, observed through the ways social distancing and stay-at-home orders varied by county. The COVID-19 PHE laid bare gaps in county public health infrastructure, public health funding, and health care delivery systems. By most metrics, the COVID-19 PHE was the most significant public health threat of the past century. With little warning, counties had to activate and utilize local public health delivery systems in unprecedented ways, forcing public health officials to exercise the full reach of their authority. As county staff were redirected to the front lines of vaccination and contact-tracing efforts, LHJs were overwhelmed by the workloads before them.

The COVID-19 PHE catalyzed and expedited some significant policy changes, both temporary (e.g., continuous enrollment for Medi-Cal members to avoid loss of coverage) and permanent (e.g., more permissive guidelines governing the ongoing use of telehealth). Further, the PHE shed light on the limits of local public health infrastructure, leading to critical investments. Counties received federal funds to address health disparities that required LHJs to establish a health equity lead staff position. Some counties have leveraged additional federal and other funds to maintain these positions, expand their health equity activities, and address social determinants of health.

Emergency Medical Services (EMS)

Under California law, the Emergency Medical Services Authority (EMSA) was established as one of the departments within California Health and Human Services and is overseen by the California Commission on Emergency Medical Services. EMSA is responsible for establishing standards, orchestrating training for emergency response professionals, and ensuring quality of care prior to arriving at the hospital.

According to California Health and Safety Code, each county may develop an emergency medical services program to oversee the day-to-day operations of EMS. Each county developing an EMS program must designate a local EMS agency (LEMSA) to administer emergency medical services. This can be a county health department, an agency established and operated by the county, an entity with which the county contracts, or a joint powers agency between counties or cities and counties. LEMSAs are responsible for planning, implementing, and evaluating EMS at the local level. These agencies develop local EMS plans in accordance with state regulations, coordinate ambulance services, manage trauma and specialty care systems, and oversee pre-hospital care within their jurisdictions.

Sources: *Local EMS Agencies in California* (PDF), California Emergency Medical Services Authority, accessed September 26, 2025; and California Health & Safety Code §§ 2.5.1797-1797.120, 1797.200, and 1797.94.

cover asthma and obesity prevention, tobacco control, harm reduction, and other programs. Local public health officers accept and evaluate mandated reports from health providers on more than 80 statutorily reported diseases.[41]

Categorical Programs

LHJs administer an array of state and federal public health categorical programs, which serve specific, limited purposes. The programs offered and the scope of services vary significantly between counties. Among the largest of these categorical programs administered is the Maternal, Child, and Adolescent Health (MCAH) program. Local MCAH Programs, which may include the Black Infant Health program and the California Home Visiting Program, provide services to at-risk pregnant women and new mothers to improve their health outcomes and those of their children. See Appendix C on page 30 for a list of major categorical programs administered by LHJs.

Like counties, LHJs are experiencing a shift in their role as programs historically administered by public health are becoming the responsibility of MCPs. Two examples of this include:

1. **Child Health and Disability Prevention (CHDP) Program.** CHDP was a county-run, preventive care program responsible for delivering periodic health assessments and services to low-income children and youth in California. In 2022, S.B. 184 authorized CHDP's transition into Medi-Cal managed care effective July 1, 2024, to create program efficiencies.[42]

2. **Comprehensive Perinatal Services Program (CPSP).** CPSP allows Medi-Cal members to receive maternal health services from conception to 60 days postpartum and is jointly managed by CDPH and DHCS. As more individuals have moved to Medi-Cal managed care, the volume of services administered by county CPSP programs (which focus on non-managed care Medi-Cal individuals) has lessened.[43]

Environmental Health

California's counties play a significant role in monitoring and maintaining environmental health and responding to PHEs. LHJs are responsible for addressing water quality, lead control, food safety, and other vectors for disease. The organizational structure of local environmental health departments throughout the state varies, and there is a mix of how local departments operate, including under LHJs, county public health departments, standalone departments, or local building or planning agencies.

Disaster Response

In recent years, California has faced numerous natural disasters like wildfires and floods. To prepare for such events, LHJ activities include but are not limited to community outreach, communication, and education. During emergencies, LHJs play critical roles in disaster response by actively surveilling the threat; coordinating with relevant local partners, such as hospitals, long-term care facilities, and other entities; allocating public health and medical resources; and communicating accurate and timely information to their communities. In the aftermath of a disaster, communities look to LHJs to address their immediate and long-term health-related needs.

Public Health Accreditation

In 2014, CDPH became the first state public health agency to receive voluntary public health accreditation through the Public Health Accreditation Board (PHAB), supported by the US Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation. Since then, agencies in 38 states and the District of Columbia have received accreditation, including New York Department of Health, Oregon Health Authority Public Health Division, and Georgia Department of Health. As of August 2025, 24 counties and 2 cities (Long Beach and Pasadena) have received this accreditation. Accreditation demonstrates commitment to quality improvement, accountability, and transparency.[44] To become PHAB-accredited, an LHJ must view public health through a health equity lens and share data to promote collaboration.

Public Health Funding

Counties rely on several funding sources for local public health, which include local, state, special, and federal funds. The largest source of support — totaling about $1.7 billion — comes in the form of local assistance from CDPH-administered federal grant programs. Most of CDPH's approximately $5 billion budget is for local assistance including funding for counties. Because these funds are mostly categorical grants — meaning dollars must be spent on specific activities, issues, or diseases — counties have limited discretion over spending.

Counties do have some discretion over funds from 1991 realignment and use them to support public health activities. However, counties often must make decisions about how to spend these realignment dollars between competing priorities, including health services, indigent care, and public health. Counties may supplement other funding with county General Fund dollars. Since there is no statewide tracking of local public health spending, it is unclear how much counties are spending on public health.

Prior to the COVID-19 PHE, CDPH funding was relatively flat.[45] With more recent state investments, CDPH local assistance now totals over $3 billion annually, with a significant portion going to counties.[46] In March 2025, the CDC announced the withdrawal of $11.4 billion in nationwide funding that had previously been allocated to state and local public health agencies during the COVID-19 PHE. CDPH estimates that the termination of these federal grants will result in a total loss of at least $840 million to California, with more than $330 million of these funds intended to support local public health efforts.[47] Subsequently, the passage of H.R. 1[48] impacted local health departments with a loss of funding around $50 million for the SNAP-Ed (Supplemental Nutrition Assistance Program Education) program. However, the overall impact remains uncertain, as the federal funding cuts are being challenged in court. This uncertainty makes it challenging for counties to meet current and emerging needs, respond to changing conditions, and quickly address public health threats.[49]

Future of Public Health Initiative

Since 2022, the Future of Public Health (FoPH) Initiative has worked to modernize California's public health infrastructure and workforce to better serve Californians, both in general and during public health threats. Coming out of the COVID-19 PHE, state and legislative leaders recognized the need to shore up and overhaul the existing public

California Data Exchange Framework (DxF)

Signed into law in 2021, the goal of the DxF is to enable every Californian to walk into a provider office, county social service agency, or emergency room knowing health and human services providers can access the information needed to provide safe, effective, whole-person care. As of February 2025, nearly 4,500 health care organizations had signed the state's first-ever statewide data sharing agreement, including more than 400 hospitals and acute care providers, nearly 2,000 ambulatory care providers, and more than 400 community-based organizations. Entities that are required to participate in the DxF include hospitals, physician organizations and medical groups, skilled nursing facilities, health plans and disability insurers, clinical laboratories, and acute psychiatric hospitals. DxF includes over $250 million in multiyear funding to support infrastructure and technical assistance for counties and other impacted entities. As of August 1, 2025, the California Department of Health Care Access and Information oversees DxF implementation.

Additionally, the California Department of Health Care Services has released the CalAIM Data Sharing Authorization Guidance for a wide range of entities, including county and other public agencies, which provide or oversee the delivery of health or social services to Medi-Cal members. In alignment with A.B. 133 (Cal. 2021), CalAIM created new expectations for data sharing related to disclosure of personal information in accordance with federal law. The guidance is limited to Medi-Cal members enrolled in a managed care plan,, those receiving any form of behavioral health services, and justice-involved populations that qualify for pre-release Medi-Cal benefits.

For additional details on California's data exchange efforts and infrastructure visit CHCF's website.

Sources: California Health & Safety Code § 130290(f); Center for Data Insights and Innovation (CDII), "Health and Social Services Entities Begin Statewide, Secure, Real-Time Exchange of Electronic Health Records to Support a Healthier California," press release, January 31, 2024; "The Big Health Care Wins in California's State Budget," CHCF, August 8, 2022; *CalAIM Data Sharing Authorization Guidance* (PDF), DHCS, October 2023; *Strengthening California's Health Data Exchange: The Need for Enduring Leadership*, CHCF, April 2025.

health system, resulting in the largest-ever flexible and ongoing state General Fund investment in local public health.[50] Due to the budget deficit, the 2024–25 budget eliminated some ongoing funding for FoPH, reducing General Fund investments from $300 million to $276.1 million, with about $188.1 million for LHJs, down from what was originally $200 million.[51]

California counties play a critical role in implementing FoPH, and each county's response is dependent on available resources and priorities. One of the foundational services of FoPH is focused on workforce development, recruitment, and training to strengthen capacity at the state and county levels. In March 2023, CDPH established the Regional Public Health Office to bolster county and state partnerships and strengthen the public health capacity in all regions.[52]

Conclusion

Changes in the state and federal landscape raise important questions about the future of California counties' roles in health care and public health. While it is too soon to know exactly how changes to the state, federal, and county delivery systems will transform counties' roles, there are several key topics to monitor:

- Evolving federal policy, regulatory changes, and funding shifts demand the attention of California state departments, counties, and local governments to navigate the administration of the Medi-Cal program, manage counties' roles in indigent care, and address uncertainties in public health funding to ensure California communities receive essential services. Most recently, the signing of the federal budget reconciliation H.R. 1, imposes Medicaid cuts and changes to funding and eligibility that are anticipated to impact California county systems.[53]
- The combination of California's projected budget shortfalls with shifting federal funding policies raises questions about how the state will close future budget gaps. Fiscal pressures could require counties and local governments to reassess priorities and reallocate resources to maintain core services for communities.
- The future of CalAIM — including a potential extension, expansion, or renewal — and collaboration between counties and MCPs to implement services and supports remain uncertain.

The state, federal, and county delivery system changes outlined throughout this report will continue to impact California counties' roles in health care and public health delivery. Counties are administering health care programs in the context of unprecedented changes and new policy guidance, challenging traditional and existing boundaries with the state, local partners, and the communities they serve to bolster innovation and quality improvement.

Appendix A. Major Milestones in County Health Care and Coverage

YEAR	EVENT
1901	**California Pauper Act.** 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.
1937	**WIC 17000 codified.**
1965	**WIC Section 17000 reorganized into the current format.**
1966	**Medicare and Medicaid Act.** 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	**Medi-Cal Managed Care Pilot.** California becomes the first state in the country to pilot Medicaid managed care via authorization of capitated prepaid health plans.
1971	**Medically Indigent Adults (MIA) program.** California creates a new state/county-funded Medi-Cal eligibility category for adults age 21–64 that is neither linked to a federal aid program nor eligible for federal funding. This program shifted responsibility for providing health care for the established population from counties to the state. Counties were required to assume a share of cost for the Medi-Cal program.
1978	**Proposition 13.** California voters passed a ballot measure to cut property taxes, reducing the primary source of general-purpose revenues for counties and intensifying competition among local funding priorities, including health care.
1979	**State funding for county health services (A.B. 8).** With reduced local revenues following passage of Proposition 13, the legislature passed A.B. 8 (Chapter 282 of 1979), which allocated new state revenues to counties for local public health programs, such as public health nursing, epidemiology, health education, and public health laboratories, and established a minimum county spending level (maintenance of effort, or MOE). Later, the allocation formulas, process, and county MOE became components of state and local health and social service program realignment. A.B. 8 repealed the county share of cost for Medi-Cal and allowed counties to use revenues not only for public health but also for indigent care and health services in county correctional facilities.
1983	**Medically Indigent Adult "transfer."** California eliminated Medi-Cal coverage for MIAs age 21–64, returning responsibility for this population to the counties under WIC § 17000.
1988	**Proposition 99.** California voters passed Proposition 99 to increase tobacco taxes and dedicate the revenues to tobacco prevention and health care programs. Legislation allocated $350 million 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 MOE is set at 1988–89 county spending levels for health services. Proposition 99 revenues declined over time so that by 2003–04, funding for these programs declined to $27 million. The legislature terminated Proposition 99 county uninsured or underinsured care funding in July 2009.
1991	**1991 realignment.** California enacted its first state and county program realignment, transferring responsibility to counties for specified mental health services, social services, and health programs and providing counties with dedicated revenues from sales tax and vehicle license fees to fund the realigned programs.
1993	**Personal Care Services Program.** California established the Personal Care Services Program as a Medi-Cal benefit that allowed for federal funding for the In-Home Supportive Services (IHSS) program, for which counties have a share of cost.

YEAR	EVENT
1993	**Medi-Cal managed care enrollment.** The department released a strategic plan to move Medi-Cal toward a managed care approach. Legislation accompanying the 1992 Budget Act gave the department broad authority to expand managed care in California.
2004	**Proposition 1A.** California voters passed a legislatively referred amendment to the state constitution that shifted $2.6 billion of local property tax revenues to the state in exchange for constitutional protections of future local revenues. The proposition limited the state's ability to impose new unfunded local mandates. Reduced county revenues increased pressure on local funds and competition among programs, including health care, but offered greater financial stability going forward.
2005	**Medi-Cal Hospital/Uninsured Care waiver.** California secured a federal US Centers for Medicare & Medicaid Services (CMS) approval of a Section 1115 waiver to provide funding for the uncompensated care costs of uninsured members and to pilot a coverage initiative for childless adults with low incomes. Medicaid financing modifications focused primarily on how the state provides the Medicaid match (non-federal share) for inpatient Medi-Cal services and for Medicaid Disproportionate Share Hospital or DSH payments.
2010	**Bridge to Reform Medicaid waiver.** This successor waiver to the Medi-Cal Hospital/Uninsured Care waiver provided significant federal funding and support for the state's ACA implementation preparations via the Low Income Health Program (LIHP). The LIHP allowed counties to tailor their programs to meet local needs and created the infrastructure for Medicaid expansion under the ACA.
2011	**Public safety realignment.** As part of the transfer to counties of responsibility for various criminal justice activities, counties assumed increased fiscal responsibility for the non-federal share of specialty mental health services for Medi-Cal enrollees, as well as for specific substance use disorder (SUD) programs. This realignment eliminated state General Fund dollars for core community mental health and SUD services but provided counties with additional dedicated sales tax and vehicle license fee revenues to support the realigned programs.
2013	**Medi-Cal managed care statewide expansion.** Medi-Cal managed care expanded statewide to rural California counties and added a regional rural model of managed care.
2013	**Coordinated Care Initiative (CCI).** This reform effort was aimed at improving health care delivery quality and efficiency. Initial CCI efforts sought to improve care coordination, address social determinants of health, reduce health care spending, and promote population health.
2013	**Health redirection (A.B. 85).** The state revised realignment formulas and redirected to the state a portion of health realignment revenues that counties historically spent on indigent care. This recognized increased state costs and county savings related to anticipated 2014 ACA coverage expansions.
2014	**ACA coverage expansions.** California expanded Medi-Cal coverage for residents with low incomes, including single adults, and established its ACA exchange, Covered California, to administer federal subsidies for families with low and moderate incomes. Many Californians previously served by county indigent medical care programs acquired new public or private coverage. The expansions excluded undocumented people with low incomes, who remained eligible only for emergency Medi-Cal.
2015	**Medi-Cal 2020 waiver.** This waiver aimed to continue to improve the quality and value of care initiated in the Bridge to Reform waiver. Most significantly, the waiver included: (1) a Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, (2) A Global Payment Program to fund sources of care for California's remaining uninsured populations, and (3) A Whole Person Care (WPC) program to support local and regional efforts to integrate care for high-needs Medi-Cal members. Counties could choose whether to implement the waiver.

YEAR	EVENT
2016	**Proposition 56.** California voters passed the proposition, increasing tobacco taxes from $0.87 to $2.87 per pack, including for electronic cigarette cartridges. Revenues are distributed among state agencies; the California Department of Health Care Services (DHCS) uses its portion to improve payments for Medi-Cal health care treatment and services.
2016	**Medicaid and Children's Health Insurance Program (CHIP) Managed Care 2016 Final Rule.** This overhauled managed care regulations, including provisions requiring Medi-Cal managed care plans (MCPs) to comply with rules related to network adequacy, member protections, and managed care payments, and thereby increasing county responsibilities. It impacted county public hospital financing for services administered to managed care members.
2016	**Medi-Cal child expansion.** California expanded Medi-Cal coverage for residents with low incomes to include children age 19 and under, regardless of immigration status.
2017	**IHSS Maintenance of Effort (S.B. 90).** This bill changed county IHSS MOE from a county share-of-cost model (35% of non-federal share) to a fixed-dollar MOE base with annual adjustments.
2020	**Medicaid and CHIP Managed Care Final Rule.** CMS sought to streamline the regulatory provisions outlined in the 2016 Final Rule, which many felt to be administratively burdensome.
2020	**Medi-Cal young adult expansion.** California expanded Medi-Cal coverage for residents with low incomes to include young adults age 19 through 26, regardless of immigration status.
2022	**CalAIM (California Advancing and Innovating Medi-Cal) implementation begins.** To operationalize CalAIM, DHCS leveraged a combination of Section 1115 waiver authority, a 1915(b) waiver, and contractual Medi-Cal state plan amendments SPAs to provide person-centered, integrated care across physical health, behavioral health, and local service providers. With the implementation of CalAIM, managed care authority transitioned from a Section 1115 waiver to a 1915(b) waiver authority. The program now includes major health initiatives, such as the Enhanced Care Management (ECM) and Community Supports benefits, a global payment program for public health systems, population health management, justice-involved initiatives, housing and homelessness initiatives, the Providing Access and Transforming Health PATH program, county oversight and administration, and incentive funding.
2022	**Medi-Cal older adult expansion.** California expanded Medi-Cal coverage for residents with low incomes to include older adults age 50 and above, regardless of immigration status.
2022	**Community Health Worker benefit.** Beginning July 2022, CMS approved the provision of the Community Health Worker (CHW) benefit to support MCP implementation of CalAIM's ECM and Community Supports. CHW services are broad and preventive in nature.
2023	**Doula services benefit.** In January 2023, DHCS made doula services a covered benefit in both fee-for-service and managed care. The intent of this benefit is to prevent perinatal complications and improve health outcomes for birthing people and infants through emotional and physical support leading up to, during, and following birth.
2024	**Medi-Cal managed care model changes.** In 2021, counties were given the option to change their MCP model. DHCS approved managed care model changes in 17 counties, 15 of which sought to have only one plan, either via a County Organized Health System (COHS) or Single Plan. These changes became effective on January 1, 2024, in alignment with the new MCP contract.
2024	**Medi-Cal adult expansion.** California expanded Medi-Cal coverage for residents with low incomes to include adults age 26 through 49, regardless of immigration status.

YEAR	EVENT
2024	**Proposition 1.** Proposition 1 authorized $6.38 billion in bonds to build treatment facilities and provide housing for Californians experiencing or at risk of homelessness who have mental health and/or substance use challenges. It also amended the Mental Health Services Act (MHSA) to add substance use disorder treatment, changed funding allocations, and renamed the MHSA to the Behavioral Health Services Act (BHSA).
2024	**Medicaid and CHIP Managed Care Final Rule.** Broadly focused on access, finance, and quality, the impact of this most recent final rule on counties will continue to unfold as implementation progresses.
2025	**One Big Beautiful Bill Act (H.R. 1).** This federal reconciliation bill, signed into law in July 2025, includes provisions that may significantly affect California's Medi-Cal program, shift administrative costs to counties, and put essential health and behavioral health resources at risk.
2026	**Medi-Cal enrollment moratorium.** The moratorium became effective for UIS adults age 19 and older.

Source: Deborah Reidy Kelch, *Locally Sourced: The Crucial Role of Counties in the Health of Californians* (PDF), CHCF, October 2015.

Appendix B. Overview and Comparison of State and County Program Realignments Affecting County Health Programs

	1991 REALIGNMENT	2011 PUBLIC SAFETY REALIGNMENT	2013 HEALTH REALIGNMENT REDIRECTION
Statute	A.B. 1288 (Cal. 1991)	A.B. 109 (Cal. 2011)	A.B. 85 (Cal. 2013)
Overview	Transfers specific health and human services programs and dedicated revenues to counties and adjusts the county share of cost for specific human services programs.	Transfers specific court and criminal justice programs and financing for behavioral health services to counties, with dedicated revenues to support increased county costs for affected programs.	Redirects from counties to the state the savings in county indigent care costs expected with ACA coverage expansions for residents with low incomes. Amount redirected is based on each county's choice of a savings formula.
Affected Programs	**Health:** public health, medically indigent services, County Medical Services Program (CMSP), local health services **Mental health:** community-based mental health, short-term inpatient psychiatric care (referred to federally as Institutes for Mental Disease), state hospitals **Social services:** aid payments, county welfare administration, foster care, child welfare, adoptions, In-Home Supportive Services (IHSS), Greater Avenues for Independence (GAIN, pre-CalWORKs), county services block grant, juvenile justice, California Children's Services (CCS)	**Justice system:** trial court security, local community corrections, local law enforcement, district attorney, public defender, juvenile justice **Behavioral health:** same programs as 1991 realignment (community-based mental health, short-term inpatient psychiatric care, and state hospital), Medi-Cal specialty mental health services, and substance use disorder (SUD) services (e.g., Drug Medi-Cal program)	**Health:** public health, medically indigent services, CMSP, local health services

	1991 REALIGNMENT	2011 PUBLIC SAFETY REALIGNMENT	2013 HEALTH REALIGNMENT REDIRECTION
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 dedicated revenues ▸ Establishes specified accounts and allocation formulas and permits limited fund transfers among program areas	For county justice systems: ▸ 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 behavioral health: ▸ Requires counties to assume responsibility for non-federal 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	Impact to county health funding: ▸ Redirects a portion of total 1991 realignment funding provided to counties to the state, effective 2014–15 ▸ 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 CalWORKs grant increases ▸ Establishes a "true-up" to reconcile actual county costs under the shared savings approach
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)

Source: Deborah Reidy Kelch, *Locally Sourced: The Crucial Role of Counties in the Health of Californians* (PDF), CHCF, October 2015.

Appendix C. Major County Public Health Programs

PROGRAMMATIC AREA OF FOCUS	PROGRAM NAME
Healthy Communities	Tobacco Control Program
	Lead Poisoning Prevention Program
	Chronic Disease and Violence Prevention Programs (including oral health, nutrition, and physical activity promotion)
	Emergency Preparedness Response Program
Environmental Health	Food Safety Program
	Toxicology and Outbreak Program
	Climate Change and Health Programs
Infectious Disease	Ryan White HIV/AIDS Program
	Communicable Disease Control Programs (including tuberculosis and sexually transmitted disease control)
	Immunization Programs
Family and Maternal Health	Maternal, Child, and Adolescent Health Programs, including: ▸ Black Infant Health Program ▸ Adolescent Health Programs ▸ Newborn Screening Program ▸ Women, Infants, and Children

Notes: This is not a comprehensive list of county public health programs. Many counties may use alternative names for public health programs and/or not administer listed programs.

Source: Authors' analysis of county-administered public health programs.

Endnotes

1. *General Election, November 5, 2024: Measures Appearing on the Ballot* (PDF), Los Angeles County Registrar-Recorder/ County Clerk, June 6, 2024.
2. Len Finocchio, *Covering the Uninsured: Considerations for California as It Prepares for Coverage Losses*, CHCF, September 2025.
3. *Rethinking the 1991 Realignment*, Legislative Analyst's Office (LAO), October 15, 2018.
4. For historical background on realignment, see: Deborah Reidy Kelch, *Locally Sourced: The Crucial Role of Counties in the Health of Californians* (PDF), CHCF, October 2015.
5. A.B. 85, 2013–2014 Leg., Reg. Sess. (Cal. 2013).
6. Scott Graves and Nishi Nair, *Understanding Realignment: California's Shifts in State and County Responsibilities*, California Budget & Policy Center (CBPC), July 2025.
7. Data for state fiscal year 2024-2025. "Fast Facts," California Department of Health Care Services (DHCS), last modified August 2025; and *2025-26 Budget Act* (PDF), DHCS, July 1, 2025.
8. California's Community Supports include: Housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care (medical respite), respite services, day habilitation programs, nursing facility transition/ diversion to assisted living facilities, community transition services/ nursing facility transition to a home, personal care and homemaker services, environmental accessibility adaptations (home modifications), medically supportive food/ medically tailored meals, sobering centers, asthma remediation. Short-term post hospitalization housing and recuperative care (medical respite) are not "in-lieu of services" and are authorized under the CalAIM Section 1115 waiver.
9. Finocchio, *Covering the Uninsured*, Appendix A.
10. Ramos Yamamoto, A. Universal Health Coverage in California: Progress and Key Policy Actions, November 2024.
11. Finocchio, *Covering the Uninsured*.
12. Finocchio, *Covering the Uninsured*; and *Stakeholder Advisory Committee and Behavioral Health Stakeholder Advisory Committee* (PDF), DHCS, July 23 2025.
13. County of Santa Clara, "County of Santa Clara to Assume Responsibility for Operating O'Connor and St. Louise Hospitals on March 1," press release, March 1, 2019.
14. "Section 1115 Medicaid Waiver Resources," DHCS, accessed December 23, 2024; and *Medi-Cal Waivers and State Plan Amendments*, CHCF, March 2025.
15. States have options to make changes to their Medicaid programs through waivers and State Plan Amendments (SPAs). There are several types of waivers that permit waiving certain program requirements, such as requirements to provide services statewide, to do research and. These demonstration waivers, commonly known as 1115 waivers, bring in new federal funds and are typically approved for a 5-year period. SPAs allow for changes to a state's Medicaid plan within existing federal Medicaid program rules and are not time limited.
16. *California Bridge to Reform A Section 1115 Waiver Fact Sheet* (PDF), DHCS, November 2010.
17. Kate Johnson, Catherin Gekas-Steevy, and Liz Stein, *Medi-Cal Explained: CalAIM Authorities Chart* (PDF), CHCF, March 2025.
18. "Executive Summary - A Section of the ECM and Community Supports Quarterly Implementation Report," DHCS, last updated October 2025. Count of ECM and Community Supports provided by county does not include county behavioral health.
19. *Medi-Cal Monthly Eligible Fast Facts* (PDF), DHCS, August 2025; and "Managed Care Enrollment Summary," US Centers for Medicare & Medicaid Services (CMS), accessed September 30, 2024.
20. Medi-Cal includes other managed care delivery systems, including county-run mental health plans for specialty mental health services and substance use services through the Drug Medi-Cal Organized Delivery System in certain counties. Dental services are also available through private dental managed care plans in Sacramento (mandatory enrollment) and Los Angeles (members may opt-in) counties.
21. Children Under the Age of 21, Medically Fragile Individuals, Individuals at Risk of Institutionalization, Individuals in Jeopardy of Negative Health or Psycho-Social Outcomes, and Individuals with a Communicable Disease.
22. *Medi-Cal Managed Care Plan Model Fact Sheet* (PDF), DHCS, January 2, 2024.
23. "2024 Medi-Cal Managed Care Plan (MCP) Transition" (PDF), DHCS, November 2, 2023.
24. "Managed Care Plan County Model Change Update" (PDF), DHCS, December 7, 2021.
25. DHCS, "*Joint Statement on the 2024 Medi-Cal Managed Care Plan Contracts*", News Release, December 30, 2022.
26. *Memorandum of Understanding Between DHCS and Kaiser Foundation Health Plan, Inc., for Standards and Requirements Applicable to the Alternate Health Care Service Plan as a Direct Medi-Cal Managed Care Plan* (PDF), DHCS, accessed November 12, 2025.
27. 2024 Managed Care Plan Boilerplate Contract (PDF), DHCS, accessed April 24, 2024.

28. MCPs and their fully delegated subcontractors must annually submit to DHCS a community reinvestment plan outlining activities for planned reinvestments into the community and a community reinvestment report on the outcomes of those activities. MCPs and their fully delegated subcontractors with positive net income will be required to allocate 5 to 7.5% of these profits (depending on the level of their profit) to local community activities identified in the plan.
29. Michelle Baass (director, DHCS) to all Medi-Cal managed care plans, "Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities" (PDF), All Plan Letter 23-029, October 11, 2023.
30. "Medi-Cal Managed Care Enrollment Report," California Health and Human Services Agency (CalHHS), last modified August 19, 2025.
31. S.B. 80, 2019–2020 Leg., Reg. Sess. (Cal. 2019); *Local Assistance: Detail Tables* (PDF), California Department of Social Services (CDSS), revised May 2025.
32. *Local Assistance: Caseload Projections* (PDF), CDSS, revised May 2025; *Local Assistance 2025-26 Appropriation* (PDF), CDSS, accessed August 12, 2025.
33. In 31 independent counties (populations greater than 200,000), county staff perform all case management activities for eligible children. Dependent counties (populations less than 200,000) determine financial and residential eligibility, while DHCS regional offices perform medical case management and benefit determinations.
34. *California Children's Services Enrollment by Financial Indicator* (PDF), DHCS, July 2024.
35. The Bridge to Reform waiver included California Children's Services (CCS) pilots that were a precursor to the Whole Child Model (WCM).
36. A.B. 2724 (Cal. 2022) authorized DHCS to enter into a comprehensive risk contract with Kaiser Permanente as the alternate health care service plan (AHCSP) to implement the WCM program in Marin, Napa, Orange, San Mateo, Santa Cruz, Solano, Sonoma, and Yolo counties.
37. S.B. 586 (Cal. 2016) required DHCS to contract with an independent entity to evaluate the WCM program as compared to the CCS program in counties where CCS services are not incorporated into managed care. This evaluation was published in 2022 and concluded that "WCM was able to maintain access to specialty care and primary care services for clients." Beginning July 2025, as part of CalAIM, A.B. 133 (Cal. 2021) establishes the CCS Compliance, Monitoring, and Oversight program to set a statewide standard for the county administration of CCS, signifying a shift towards standardized operations across California counties. *California Senate Bill 586, The Whole Child Model program: Final Evaluation Report*, UCSF Institute for Health Policy Studies, December 2022.
38. This includes two joint-county arrangements in Sutter/Yuba Counties and Placer/Sierra Counties.
39. California Health & Safety Code § 101.3.101000.
40. California Health & Safety Code § 101185.
41. California Health & Safety Code § 105.1.120100.
42. S.B. 184, 2021–2022 Leg., Reg. Sess. (Cal. 2022).
43. Tomás J. Aragón (state public health officer & director, California Department of Public Health [CDPH]), "RE: Transition of the Perinatal Services Coordinators (PSCs) activities supporting Provider Enrollment, Technical Assistance/Training, and ensuring Monitoring/Oversight of the Comprehensive Perinatal Services Program (CPSP)," May 16, 2023.
44. "Accreditation Activity," Public Health Accreditation Board, accessed September 17, 2024.
45. *The Intersection and Coordination of Public Health and Health Care in California: Learning from Covid-19 and Innovating for the Future* (PDF), Insure the Uninsured Project, January 2022.
46. *May Revision Highlights: Fiscal Year 2024-25* (PDF), CDPH, May 10, 2024.
47. The US Centers for Disease Control and Prevention (CDC) specified the following grant programs for elimination: 1) epidemiology laboratory capacity, 2) immunization and vaccines for children, 3) health disparities. Assembly Budget Agenda: *Assembly Budget Subcommittee No. 1 on Health*, California State Assembly, April 21, 2025.
48. H.R. 1 - One Big Beautiful Bill Act, 119th Congress (2025-2026)
49. Will Owens, *The 2024-25 Budget: Future of Public Health Budget Solution*, LAO, May 21, 2024.
50. The 2022 state budget included $300 million ongoing general fund to support public health infrastructure development. Of this amount, $200 million was earmarked for local assistance for Local Health Jurisdictions or LHJs across the state. Future of Public Health Work Group, *Investments and Capabilities Needed for the Future Public Health System* (PDF), CDPH, September 2021.
51. "Health and Human Services" (PDF), California State Budget: 2024-25, accessed September 18, 2024.
52. "Regional Public Health Office," CDPH, accessed September 18, 2024.
53. H.R. 1 - One Big Beautiful Bill Act, 119th Congress (2025-2026)