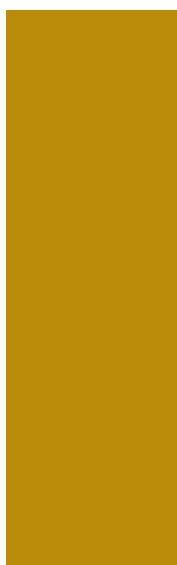




CALIFORNIA  
HEALTHCARE  
FOUNDATION



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

July 2004

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

*Prepared for*

CALIFORNIA HEALTHCARE FOUNDATION

*by*

Deborah Reidy Kelch, M.P.P.A.

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## About the Author

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## About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's healthcare delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality healthcare.

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# I. Introduction

*County services are often referred to as a “safety net” for people whose financial, social, physical, mental, or geographic conditions limit their access to mainstream medical care, however, these systems not only serve the needs of low-income populations, but also provide the basic framework to protect the health of the broader community.*

CALIFORNIA’S 58 COUNTIES ARE CRUCIAL providers of major health services, including health care for the uninsured, public health services, mental health, and substance abuse treatment services. In addition to state and federal funds available to support these programs, many counties allocate money from their general funds to help meet local health care needs.

Given the diversity of California’s counties in size, demographics, income, and culture, tremendous diversity also exists in how the counties organize, fund, and administer these health programs. In addition, these services are generally treated as separate systems for budgeting, policy, and administrative purposes at the state level. However, history has demonstrated that policy and fiscal choices in one program area can have profound unintended or unappreciated consequences for service delivery in other systems. In addition, the specific service needs of clients often overlap the categories of services and programs developed over decades.

These county services are often referred to as a “safety net” for people whose financial, social, physical, mental, or geographic conditions limit or challenge their access to mainstream medical care and related supportive services. In this context, counties are viewed as the providers of last resort. However, these systems do not serve only the needs of low-income and vulnerable populations but also provide the basic framework to protect the health, safety, and well-being of the broader community. Public health services, in particular, and the public health infrastructure at the county level, have a specific and unique focus on population health: the health of the broad community. The successes and failures of these systems can have a dramatic effect on access, affordability, and availability of services for everyone.

For example, having high numbers of people without health insurance or access to health care can overload hospital emergency rooms, raise public and private provider debt, and increase the costs of health care for everyone. Ultimately, the unreimbursed costs of caring for uninsured people threaten the financial viability of important public services such as emergency and trauma care. Untreated mental illness or substance abuse results in a higher use of medical care services, generates

public health and safety challenges, and leads to increased legal and correctional system costs.

Despite their importance, their interrelationship, and the impact these services and programs have on the overall health and well-being of all Californians, policymakers seldom consider the programs or their funding as pieces of a whole. The state's unprecedented fiscal crisis and the dramatic impact it is having, and will continue to have, on county finances and programs provide an important context for this overview of existing programs and services. As policymakers consider potential changes to county funding and program responsibilities, this paper highlights and clarifies for their consideration how counties are involved in health service delivery. The current circumstances make it all the more critical for policymakers to consider the interrelationships of these programs, their funding streams, and the implications of alternative policy options.

This report offers an overview of the range of health services that have over time become the responsibility of California counties, either by statute, by practice, or by default. This paper outlines some of the basic requirements imposed on counties in the areas of health services for the uninsured, public health, mental health, and substance abuse treatment; the funding streams for these services and programs; and the basic structure of how counties provide the services. In addition, the report highlights the issues facing policymakers at the state and local levels that will affect the future of county health programs and services.

## II. The Programs and Systems

*No two counties organize and administer this complex array of health programs exactly the same way.*

THIS SECTION FOCUSES ON THE PROGRAM responsibilities of counties, the funding sources counties receive and use for the programs, and how counties generally meet their responsibilities in four program areas: health, public health, mental health, and substance abuse treatment services.

Counties currently administer local health and mental health programs relying on a historical and deeply complicated patchwork of funding streams. State and federal requirements are constantly shifting in response to political, scientific, and economic changes. State law imposes on the counties broad and often vague mandates, which are subject to interpretation and vulnerable to the changing fiscal environments at all levels of government. The programs are administered by multiple federal, state, and county agencies. At the county level, tremendous variation exists in program design, administration, and funding. Even though the programs are separate at the state level, some counties combine programs: mental health and health, substance abuse and health, medical and mental health care. No two counties organize and administer this complex array of health programs exactly the same way.

### Indigent Health Care

In California, counties are responsible for health care for low-income uninsured residents who have no other sources of care, mostly “medically indigent adults,” ages 21 to 64, without children. This county obligation is outlined in Section 17000 of the California Welfare and Institutions Code, which states:

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

California Welfare and Institutions Code, Section 17000

This simple language forms the basis for county General Relief income support programs and the indigent medical and mental health care programs operated by California counties. Subsequent code sections confirm the “duty of the counties to provide health care.” State law and legal precedents have established that the Section 17000 obligation includes, but is not necessarily limited to, responsibility for providing health care for uninsured low-income adults, often referred to as medically indigent adults. Between 1971 and 1982, California operated a state-funded Medi-Cal program for medically indigent adults but eventually returned the program and a portion of the funding to the counties. Generally, the courts have found that counties need to have a standard for the services they provide under Section 17000, but neither law nor legal precedent specifically outlines how counties must meet this obligation. Counties have significant discretion in the level and method of health care they provide.

As a result, tremendous variation exists in counties’ programs and in their spending for health care for uninsured people. Some counties define the Section 17000 obligation narrowly and focus exclusively on serving legal residents who meet the narrow definition of medically indigent adults, and other counties assume a broad responsibility for health care for all uninsured people, including undocumented children and adults. This flexibility allows counties to be responsive to local needs, priorities, and political preferences. However, the diversity of county program designs and methods makes comparison of the county programs difficult. The general strategies counties use to fulfill their safety net obligations are discussed below.

### **County Medical Care Programs for the Uninsured**

When it comes to medical care services for the uninsured, counties are generally split into two categories. The 24 largest counties provide,

organize, or pay for indigent medical care services directly using a variety of service delivery strategies. Large counties have historically been referred to as Medically Indigent Services Program (MISP) counties. Thirty-four smaller counties voluntarily participate in the centrally administered County Medical Services Program (CMSP), a medical coverage program similar (but not identical) to Medi-Cal, California’s Medicaid program.

Large counties have broad discretion to set and determine eligibility, services provided, payment methods, and providers in the program. Some limit their programs to medically indigent adults who are legal county residents, and others also provide services for undocumented children or adults. Many large counties have also developed delivery systems to enhance access to health services for both indigent and non-indigent patients by operating public hospitals and outpatient clinics.

Counties do not report the scope of services, eligibility criteria, or methods of provider reimbursements for their indigent care programs. One variable that affects the scope of county programs is the service delivery model in each county. The Insure the Uninsured Project (ITUP), a California-based project of the Center for Governmental Studies, focuses on increasing health coverage for California’s uninsured and conducts ongoing analysis and research of programs serving the uninsured including county health systems.

ITUP has identified three main county service delivery models:

- **Provider counties.** These counties own and operate county inpatient hospitals, and, in most cases, publicly owned clinics, that serve the uninsured, as well as individuals with other public or private health coverage.

Currently, 15 counties operate 22 county-owned hospitals, and four counties contract with local University of California hospital

medical centers to serve as public hospitals. Provider counties typically have extensive outpatient clinics, including hospital-based outpatient clinics and, in some cases, free-standing clinics. Over time, many counties have closed or leased their county hospitals. The number of county-operated hospitals has decreased from 50 counties with 66 facilities in 1964. In addition, some counties operating public hospitals have recently instituted new rules and co-payments for indigent care because of county budget constraints.

- **Payer counties.** Payer counties purchase indigent care services through contracts with one or more private hospitals for inpatient services and through community clinics or private physicians for outpatient services.
- **Hybrid counties.** Hybrid counties do not have public hospitals; they contract with private hospitals for inpatient care but also operate some publicly owned outpatient clinics, which may be the primary providers of services to indigent people. Some hybrid counties also have contracts with nonprofit community clinics or private physicians.

### County Medical Services Program

Smaller counties participate in the County Medical Services Program (CMSP). The CMSP was established in January 1983, when California law transferred responsibility for providing health services to indigent adults from the state to the counties. This law recognized that many smaller, rural counties were not in a position to operate the program and allowed counties with 300,000 or fewer inhabitants to contract back with the state Department of Health Services (DHS) for the program. Thirty-four counties currently participate in CMSP.

The program was administered by DHS until 1995, when the program was transferred to the independent CMSP Governing Board, composed of representatives of participating counties. The

CMSP provides medical care services to medically indigent adults ages 18 to 64 who are not eligible for Medi-Cal and who are U.S. citizens or legal residents. Emergency services are provided when immigration status is not known. CMSP is organized as a traditional fee-for-service program similar to Medi-Cal but with fewer benefits. County welfare departments determine eligibility. Most individuals on CMSP are on the program for only three to seven months; the average monthly enrollment is about 40,000.

### Funding for Indigent Care

The primary funding sources for indigent health care are health and welfare realignment program funds—dedicated sales tax and motor vehicle license fees—(see p. 17 sidebar on realignment for more details) and county general funds (see Appendix A: County General Purpose Revenues). In addition, counties that operate public hospitals receive Disproportionate Share Hospital funds, which are Medi-Cal funds provided to public and private hospitals serving high numbers of Medi-Cal patients. In many counties, realignment funds allocated to both health and mental health programs have been transferred to pay for the rising costs of social services programs, especially foster care and In-Home Supportive Services (IHSS). Caseload growth in child welfare/foster care and IHSS has also limited the realignment funds that are available for growth in both health and mental health programs.

Large counties and two small rural counties also receive a relatively small allocation of Proposition 99 tobacco tax revenue for indigent care (see Appendix B: Proposition 99). The large county program is called the California Healthcare for Indigents Program (CHIP), and the smaller county program is the Rural Health Services (RHS) program. Proposition 99 funds have been dramatically and steadily declining, dropping by 85 percent since the program began. Funding for indigent care has declined from \$343 million in 1989–90 to just over \$27 million in 2003–04.

Counties receive funding based on a formula and, in return, agree to submit data about their indigent care programs and to provide follow-up treatment identified as necessary through a Child Health and Disability Prevention Program screening. Partly as a result of the decline in Proposition 99 revenue for indigent care, counties report that an increasing share of realignment health funds and county general fund revenue has been allocated to indigent health care.

Data about funding and expenditures for county indigent care programs are limited. Data available through the Medically Indigent Care Reporting System (MICRS) are based on information that Proposition 99-funded counties report to DHS and are typically several years old. Because programmatic arrangements vary substantially between counties, comparing the MICRS data across counties can be problematic and, at times, controversial.

Although some revenue sources for indigent care, such as Proposition 99, have declined, county expenditures for indigent health care, as reported through MICRS, have grown. In 2001–02, with 23 of the 25 counties participating in MICRS reporting, counties reported expenditures of \$1.5 billion total funds to serve about 1.4 million indigent patients. In 1997–98, 27 counties reported total expenditures of \$1.3 billion for 1.3 million patients. Counties report that indigent care costs represent an increasing share of health realignment funds and county general funds.

ITUP reviewed MICRS data in conjunction with its assessment of county programs, funding, and spending for the uninsured. Although ITUP found significant data inconsistencies in the information that counties report to DHS, the project was able to draw some general conclusions. ITUP found that the average funding that counties receive per uninsured person is dramatically less than the costs of coverage in either private commercial health plans or health plans participating in Medi-Cal.

In addition, ITUP found the following:

- Funding for the uninsured varies substantially between regions and counties.
- Counties with public hospitals generally had the most funding and provided the most care to the uninsured, followed by CMSP-participating counties.
- Counties with hybrid systems and payer counties had the least funding and provided the least care per uninsured person.

**Funding for CMSP.** The CMSP is currently funded with realignment funds, county contractual contributions (county general fund revenue), and third-party reimbursements and recoveries. In 2002, the CMSP program served about 115,000 people at a cost of \$222 million. When CMSP was transferred to the control of the CMSP Governing Board, state law required an annual general fund contribution of \$20 million. The state has suspended its contribution to CMSP for the past five years, and the Governing Board has relied on CMSP reserves. As a result of the dwindling reserves, over the past two years, CMSP has undertaken provider payment, benefit, and eligibility reductions and is in the process of implementing administrative restructuring to reduce program costs.

### **County Initiatives to Cover the Uninsured**

In recent years, several primarily urban counties with local public health plans for Medi-Cal and the Healthy Families Program have developed county-specific programs to extend health insurance coverage to the uninsured. Eight counties have implemented programs to cover uninsured children not eligible for other programs because of income or legal status. Many more counties are in the planning stages for similar programs. To finance the programs, counties have used different funding strategies combining multiple sources such as county general fund revenue, tobacco settlement funds, program reserves from

Local Initiative plans, Proposition 10 Children and Families funds, and foundation grants.

The County Children’s Health Initiative Program (C-CHIP) is a state program that will provide low-cost health coverage to uninsured children through age 19. The program will allow counties and other entities to use local funds as a match to draw down unused federal State Children’s Health Insurance Program (SCHIP) funds. SCHIP is a federal program to cover uninsured children that reimburses states 66 percent of program costs. SCHIP was implemented in California as the Healthy Families Program through the Managed Risk Medical Insurance Board (MRMIB). In C-CHIP, counties will use the federal funds to provide health insurance to additional children using their locally sponsored health plans. C-CHIP will provide benefits similar to Healthy Families but will serve children between 250 percent and 300 percent of the Federal Poverty Level. California has submitted a state plan amendment for federal approval to implement the program. Four pilot counties have implemented C-CHIP and are waiting federal approval, and another four counties are in the planning stages.

### **Other Health Care Programs and the Counties**

**Medi-Cal.** California’s Medicaid program — Medi-Cal — provides health care coverage for 6.5 million low-income Californians who lack health insurance and meet state or federal program requirements. Medi-Cal is funded by state and federal funds and is, for the most part, a state-administered program. The state generally licenses and certifies the providers, sets benefits, eligibility, and payment levels. Separate delivery systems exist for mental health and drug treatment under Medi-Cal as discussed later in this section.

County social services agencies (welfare departments) are charged with determining Medi-Cal

eligibility for all but those aged, blind, and disabled recipients of Supplemental Security Income/State Supplemental Payment (SSI/SSP) funds, who are automatically enrolled by the Social Security Administration. In addition, counties oversee the enrollment and recertification process. Until recently, eligibility was determined primarily through face-to-face encounters with county welfare eligibility workers. In 1998, coinciding with the implementation of the Healthy Families Program, which is California’s implementation of SCHIP, the state developed a joint mail-in application for Medi-Cal and Healthy Families, and the state is in the process of implementing an Internet-based enrollment application, known as Health-e-App. (Visit [www.healtheapp.org](http://www.healtheapp.org) for more information about Health-e-App.)

People on Medi-Cal might have very different experiences with the program depending on the county in which they live. This is partly because of wide variation in the number and type of participating Medi-Cal providers available in different counties and regions in the state. For example, fewer Medi-Cal providers are typically available in rural communities. Experiences also vary because counties have different models of care delivery.

Medi-Cal service delivery comes through two primary methods: fee-for-service and managed care. In the fee-for-service program, health care professionals and facilities meet state licensing and certification requirements, provide services to beneficiaries, bill the state for the services, and are paid at rates set by the state.

In June 2003, of the 6.5 million Californians on Medi-Cal, 2.4 million beneficiaries in 25 counties were in managed care. Managed Medi-Cal has three main models:

- **Two-Plan Model.** The Two-Plan Model serves the greatest number of people and offers beneficiaries a choice of two managed care

plans. Generally, one plan is a public plan (Local Initiative), and the other is an HMO (commercial plan). Children, pregnant women, and non-disabled parents must be enrolled in managed care and can choose one of the two plans offered in their county. Other Medi-Cal beneficiaries — primarily aged, blind, and disabled people — may voluntarily enroll. The health plans contract with public and private providers. There are 12 Two-Plan Model counties serving 2.4 million enrollees, or 26 percent of all Medi-Cal beneficiaries.

■ ***County Organized Health System (COHS).***

Under the COHS model, enrollment in a county-run plan is mandatory and automatic for the county's entire Medi-Cal population (except long-term care residents). COHS counties are paid a fixed monthly fee per person regardless of the services provided (capitation payment). Five COHSs provide services in eight counties. About 9 percent of Medi-Cal beneficiaries statewide are enrolled in a COHS. Federal law limits COHS enrollment to 10 percent of statewide Medi-Cal beneficiaries; additional COHS plans would require specific federal approval.

- ***Geographic Managed Care (GMC).*** Under GMC, currently operating in Sacramento and San Diego counties, the state contracts with a number of private health plans and pays the plans a fixed monthly fee per enrolled person, referred to as a capitation payment. Just as in Two-Plan Model counties, children, pregnant women, and non-disabled parents must enroll in one of the plans. About 6 percent of Medi-Cal beneficiaries are enrolled in GMC plans.

***Healthy Families Program (HFP).*** Healthy Families is administered by the MRMIB and provides health coverage for uninsured children not eligible for Medi-Cal up to 250 percent of the Federal Poverty Level. Healthy Families is California's program to implement the federal SCHIP. The federal government pays 66 percent

of Healthy Families expenditures, as compared with 50 percent of Medi-Cal expenditures. Services are delivered through managed care plans under contract with MRMIB, and enrollees share the costs through monthly premiums and co-payments for most services. As of December 2003, nearly 700,000 children were enrolled in Healthy Families.

Healthy Families includes Medi-Cal Local Initiative plans as available health plan choices for enrolled children. County welfare departments may identify children eligible for Healthy Families as part of their responsibilities in Medi-Cal eligibility and enrollment processing. Counties also have a direct role in providing services to Healthy Families subscribers. Seriously emotionally disturbed children in Healthy Families are referred to county mental health plans that can bill for the federal matching funds for supplemental services. Counties also provide California Children's Services benefits to both Medi-Cal and Healthy Families-enrolled children (specialty medical services for children with specific physical limitations or chronic illnesses or diseases). (See p. 15 for more information about California Children's Services.)

## **Public Health**

Public health services are distinct from the other health services examined in this paper because the focus is not exclusively on the provision of services to individuals but on population-based strategies to protect the overall health of the community. Public health includes the general responsibility to protect and improve the health of the community through preventive medicine, health education, control of communicable diseases, application of sanitation standards, and monitoring of environmental hazards — often referred to as core public health functions.

The statutory obligations of California counties with regard to public health are not always clear

in law and regulation. California counties are required by law to “preserve and protect” the public health and to provide public health services, including public health nursing, communicable disease control activities, and environmental health programs. Public health nursing services and communicable disease control activities are county-mandated functions monitored by DHS. Local health departments also have primary responsibility to respond during local emergencies such as floods and other natural disasters, disease outbreaks, or bioterrorism attacks. Environmental health programs are mandated to local governments, generally supported by fees, and receive oversight from various state agencies in areas such as solid waste, small public water systems, underground storage tanks, and hazardous materials.

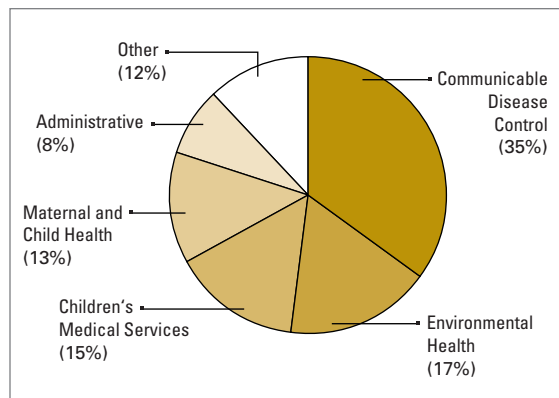
For public health purposes, California has 61 local health jurisdictions (sometimes referred to as LHJs): the 58 counties and the cities of Berkeley, Long Beach, and Pasadena. All local jurisdictions are required by law to have a physician health officer in charge of public health. Larger counties may also have a health administrator to manage and oversee public health and other related health care programs. Eleven small counties participate in the Local Public Health Services Program, which provides state-employed environmental specialists and public health nurses who work in and for those counties.

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

Emergency Medical Services Authority monthly, quarterly, or annually.

County public health programs vary substantially in administrative structure, scope, funding levels, staffing, and specific services and programs offered. However, no statewide resource regularly profiles county public health programs or funding. In 2001, DHS worked with the Health Officers Association of California to survey counties about their public health programs. The survey has significant data limitations because only 34 counties responded and because counties interpreted and responded to the survey questions differently. Still, the survey is illustrative and found that nearly 90 percent of public health expenditures were within five public health categories (see Figure 1).

**Figure 1. Public Health Spending, by Category**



Local public health departments also administer an array of state and federal public health categorical programs, that is, programs for specific populations or limited program purposes. Categorical programs are generally funded by separate federal or state allocations or grants and have specific program requirements or guidelines associated with the funding.

### Communicable Disease Control Activities

California law defines communicable disease control activities as communicable disease prevention, epidemiologic services, public

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

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

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

Local health jurisdictions receive funding from the Office of AIDS in three program areas:

- **Prevention.** Local health jurisdictions receive most of the Office of AIDS funds for prevention, which includes HIV counseling and testing, mobile outreach vans in some counties, targeted prevention for high-risk groups, and various special projects (needle-exchange projects, for example).
- **Surveillance.** Counties also receive funds under the Surveillance Grant Program to develop and implement active AIDS case surveillance programs, including local planning related to AIDS reporting and coordination with local providers in AIDS reporting and tracking.
- **Care and treatment.** Counties receive an allocation of federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds for primary medical care and support services for HIV-infected people. Counties conduct enrollment for the AIDS Drug Assistance Program, which provides drugs to those who would otherwise not be able to afford them, and counties receive a small state grant to defray their administrative costs. Other state and federal programs allocated directly to counties include funding for early intervention programs and affordable housing for people infected with HIV.

Funding for HIV/AIDS programs comes from the state general fund and federal funds, including funding from the federal Centers for Disease Control (CDC) and the Ryan White CARE Act.

**Bioterrorism.** According to state law, as part of communicable disease control activities, the local health department also has the lead role in the early detection and identification of a bioterrorist event. In the event of a confirmed bioterrorist event or other large biologic disaster, the local health department will be responsible for initiating expanded surveillance. Beginning in 2002,

California received new federal funding for public health emergency preparedness and bioterrorism. The federal funds are not available to counties for general public health priorities but are subject to specific federal priorities and restrictions. Counties enter into detailed contracts with the state surrounding the expenditure of the federal funds.

To administer and allocate the new funding, the legislature passed a new allocation formula and expanded the statutorily authorized uses of public health funding. Although the legislation did not create new mandates on counties, by expanding the potential uses of public health funding, it did create a potential future pressure for funding should the federal funds be reduced or eliminated.

### **Public Health Nursing and Categorical Public Health Programs**

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

***Maternal, Child, and Adolescent Health Program.*** DHS funds local health departments through the Maternal and Child Health Branch to carry out the core public health functions of assessment, policy development, and assurance to improve the health of their MCAH populations. MCAH is a federal program (Title V) with specific federal requirements, and California

receives federal MCAH funds and reallocates most of the funds to counties. All counties and the three city public health departments participate in the MCAH program. Participating cities and counties must have a local MCAH director, either public health physicians or nurses. To receive MCAH funds, local programs are required to conduct a community needs assessment and submit a program plan to the DHS every five years. All counties must operate a toll-free telephone number for access to care and services.

MCAH activities include: assessment of health status indicators for maternal and child health populations, community health education programs, and outreach with a special emphasis on people eligible for Medi-Cal. Specific MCAH categorical programs include:

- ***Adolescent Family Life Program (AFLP) (includes Adolescent Sibling Pregnancy Prevention program).*** Public and private contracting agencies conduct outreach to enroll eligible teens, up to the age of 18 for females and age 20 for males, for case management services. About 17,000 teens are served statewide each year. The Adolescent Family Life Program (AFLP) also works to develop community awareness of the problem of adolescent pregnancy and improve services for teen parents.
- ***Black Infant Health (BIH) program.*** Identifies at-risk pregnant and parenting African-American women and helps them use appropriate health care and other family support services. Seventeen local health jurisdictions where 94 percent of black infant births and deaths occur participate in the program.
- ***Comprehensive Perinatal Services Program (CPSP).*** Medi-Cal-eligible women receive a comprehensive prenatal risk assessment and services, including comprehensive prenatal care, health education, nutrition services, and

psychological support for up to 80 days postpartum. More than 1,300 Medi-Cal providers statewide are approved for CPSP. County health departments help local providers meet CPSP certification requirements and offer technical assistance. Most counties also have a similar role in certifying and assisting providers and offering technical assistance for the California Children's Services program and the Child Health and Disability Prevention (CHDP) program.

- ***Fetal and Infant Mortality Review (FIMR) program.*** Case-review teams in 21 counties review selected fetal and infant deaths to identify the factors contributing to the deaths and any system problems that require change.
- ***Perinatal Outreach and Education (POE) program.*** Local health departments and community agencies conduct outreach to women of childbearing age, assess smoking status and exposure to secondhand smoke, and develop an individualized plan to prevent smoking and exposure to tobacco smoke during pregnancy and the postpartum period. The program supports public health nursing case management, tobacco and drug cessation services, including relapse prevention, and child care and transportation to support the above activities.

### **California Children's Services Program and the Counties.**

California Children's Services (CCS) is a state-wide program that treats children with certain injuries, physical limitations, and chronic health conditions or diseases. CCS authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for children with specific conditions. DHS oversees the CCS program. Larger counties operate their own CCS programs, and smaller counties share the operation of their programs with state CCS regional offices in Sacramento, San Francisco,

and Los Angeles. California residents under 21 with covered medical conditions are eligible if their family income is less than \$40,000 or if the family incurs high medical care costs related to the CCS condition. The program is funded with state general fund, county, and federal funds, along with some fees paid by parents.

### **Funding for Public Health**

Funding for public health comes primarily from realignment and county general funds. In addition, counties receive an allocation by formula from a relatively small general fund account (known as the public health subvention), of \$1 million statewide. The funding level in the subvention has generally remained constant, except for a one-time additional augmentation of \$5 million in 2001–02. Other funds for core public health programs come from several narrow categorical public health programs, such as Tuberculosis Control. Environmental health programs are generally supported by fees.

Categorical public health programs have separate categorical funding streams, including Maternal, Child, and Adolescent Health. Funding for MCAH comes from multiple sources, including the federal Title V MCAH block grant, Medicaid federal financial participation, the state general fund, and other grant funds, which may be obtained by the MCAH programs.

Since 2002, California has also received federal funds for bioterrorism and emergency preparedness activities that can be considered core public health functions. The federal funds are subject to specific federal priorities and restrictions, and counties have entered into detailed contracts with the state surrounding the expenditure of the federal funds. In 2004, county public health departments received about 70 percent of California's federal bioterrorism allotment, or about \$38 million. Los Angeles County receives a direct allocation of federal bioterrorism funds.

In many counties, as stated above, realignment funds allocated to both health and mental health programs, including public health, have been transferred by counties to pay for the rising costs of social services programs, especially foster care and IHSS. Caseload growth in child welfare/foster care and IHSS has also limited realignment funds available for both health and mental health programs. In addition, as Proposition 99 revenues have decreased, a greater share of health realignment funds and county general fund revenue has gone to indigent care. Counties report that, as a result, less money has been available for core public health activities (see realignment sidebar on p. 17).

## Mental Health

Counties are the primary providers of public mental health services in California for Medi-Cal and non Medi-Cal clients. The basic Section 17000 safety net responsibility for indigent people generally applies to mental health services, with some statutory and case law limitations specific to mental health. For example, realignment required counties to serve target populations—seriously mentally ill adults, seriously emotionally disturbed children, and people in acute psychiatric crisis—to the extent resources are available. Counties also directly administer the local mental health plans for Medi-Cal, although they are not statutorily required to do so. Counties have the first right of refusal and can choose not to administer the Medi-Cal mental health plan.

In addition, counties have two other significant statutorily mandated responsibilities related to mental health services: 1) provision of services to individuals who are involuntarily committed for 72 hours because they pose a danger to themselves or the community and 2) services to special-education students identified as needing mental health services by their school.

During the 1990s, several major changes occurred in the mental health delivery system in California.

First, in 1991, the enactment of realignment transferred financial and programmatic responsibility for mental health services to the counties. Realignment provided counties with dedicated revenues to pay for these changes. Second, between 1995 and 1997, California secured and implemented a federal Medicaid waiver to consolidate inpatient and outpatient Medi-Cal mental health services into one program at the county level. The mental health managed care program consolidated the two existing Medi-Cal mental health programs (Short-Doyle and Fee-for-Service) into one service delivery system, the county mental health plan. The state “carved out” mental health services from the Medi-Cal managed care program already implemented in 21 counties.

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

- **Community mental health services.** All counties are required by law to establish a community mental health service for the county and to establish a local mental health advisory board. Counties must comply with reporting requirements of the state Department of Mental Health and report annual information on performance measures to the state and to the local advisory board. Counties generally have the discretion to determine local funding levels, eligibility, and services provided to non-Medi-Cal-eligible clients, consistent with the target populations outlined in state law and funds available.
- **Medi-Cal mental health.** Although counties have the option to operate the local mental health plan for Medi-Cal, once they choose to do so, they must operate the plan according to state and federal Medi-Cal eligibility, service, and benefit standards. Each local mental health plan directly provides or contracts for specialty services for Medi-Cal patients if they meet diagnostic and impairment criteria. Medi-Cal patients must receive their mental

## Health and Welfare Realignment

### What is realignment?

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

### How is realignment funded and allocated?

State funding is provided through two dedicated revenue sources: 5 percent of the sales tax and 24.3 percent of vehicle license fee (VLF) revenue. The Local Revenue Fund contains a Sales Tax Account, a Sales Tax Growth Account, a Vehicle License Fee Account, a Vehicle License Fee Growth Account, and several subaccounts. The revenues deposited into these accounts are distributed by the state Controller's Office to all counties and four cities monthly, according to various formulas. Each year an annual allocation base is determined, consisting of the total amount allocated in the previous year, including growth allocations. Revenues in excess of the base are deposited in the growth accounts and are allocated based on different formulas.

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

Growth funds are distributed according to complicated formulas in state law. The first claim on sales tax growth goes to entitlement programs, primarily caseload-driven social services programs. The two programs with the greatest cost and caseload increases have been child welfare/foster care and In-Home Supportive Services. The remaining growth in sales tax and VLF revenue is distributed to the counties according to a statutory formula. As a practical matter, the increasing costs of the social services caseloads have significantly reduced the allocations of growth funds to health and mental health services.

### How are funds allocated and spent?

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

### What are "poison pill" provisions?

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

health services through the county mental health plan. Two counties — San Mateo and Solano — administer Medi-Cal mental health through their COHS for general Medi-Cal. Several counties joined together to operate a managed health plan: Sutter County’s plan includes Yuba County, and Placer County’s plan includes Sierra County. As of this writing, mental health plans are operational in all 58 counties.

■ ***Healthy Families mental health services.***

Counties are also required to provide mental health services to seriously emotionally disturbed children enrolled in the Healthy Families Program. County mental health plans bill for the 66 percent federal matching funds.

■ ***Medi-Cal mental health services for children: EPSDT.***

The federal Early Periodic Screening Diagnosis and Treatment (EPSDT) program requires states to provide Medi-Cal recipients under age 21 with medically necessary health and mental health services. The mental health component of EPSDT has been delegated to the county mental health plans, but the eligibility and scope of services is determined by state and federal policy. Litigation against California in the 1990s required California to expand the mental health services available to children, and the program costs have grown substantially as a result. Counties currently pay 17 percent of the costs of the EPSDT program.

■ ***Services for special-education students.***

Federal law requires that states provide services to children enrolled in special education, as well as related services they need to benefit from their education. Mental health services are considered related services. Since 1984, county mental health departments have been mandated by state law to provide mental health services for these children. Children are entitled to services regardless of income if the school district determines they are needed.

Counties serve about 31,000 students each year. Counties have historically funded the program using realignment, categorical funds provided for that purpose (eliminated in 2002), and mandated claims reimbursement (deferred in 2002 and 2003). In 2003–04, federal special-education funds were made available to defray a portion of the program costs.

■ ***Services for involuntarily committed individuals.***

California law authorizes local law enforcement and county mental health agencies to take into custody and admit for treatment for 72 hours any person with a mental disorder who is a danger to himself or others or is gravely disabled. Counties designate and approve the facility and are obligated to provide mental health evaluation and treatment services to them while they are detained. If the person is not detained but is found to need mental health services, the county must offer available alternative mental health services. After a person’s release, he or she must be offered necessary follow-up services on a voluntary basis. State law includes specific and detailed procedures to be followed by local law enforcement, county mental health agencies, and the treating facilities. This process is often referred to as a “5150” process because it is in California Welfare and Institutions Code Section 5150.

■ ***Optional special programs and services.***

State law authorizes, but does not require, counties to implement specific special projects and grant programs to improve mental health service delivery or to meet the needs of special populations. Participating counties may receive state or federal grants for the programs. The Adult and Children’s System of Care programs are models based on interagency coordination and collaboration, case management, and client- and family-centered services. Counties may choose to implement the program methods whether or not they receive specific state

funding. State funding for the adult program was eliminated in 2003, but limited funding remains through the federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant. Other special projects include: the Early Mental Health Initiative, the Integrated Services for the Homeless Mentally Ill programs, the Supportive Housing Demonstration Projects, and the Projects for Assistance in Transition from Homelessness.

### **Funding for Mental Health**

Funding for the community mental health services provided by counties comes from a variety of sources, including realignment, county funds, state general fund revenue, federal funds, including Medicaid matching funds and Healthy Families matching funds, and patient fees and insurance recoveries. In 2001–02, funding for community mental health statewide was \$2.9 billion from all funds, and about 626,000 clients received services.

Counties use realignment funds, state funds, and county funds to draw down federal Medicaid matching funds for the services they provide to Medi-Cal clients. County mental health plans receive a fixed amount of non-federal funds (primarily realignment and state general fund) based on what the state was spending for Medi-Cal mental health in 1994–95, which is supposed to be adjusted annually for both medical inflation and caseload, subject to the state budget process. In the context of the current state budget crisis, counties have not received the inflation adjustment for several years. California must provide a 50 percent match to receive federal Medicaid funds. In 2001–02, counties contributed 46 percent of the state’s match, and the state contributed 54 percent of the match. Counties vary greatly in their expenditure of county funds and in their rate of capturing federal funds for Medi-Cal mental health services. Many counties report that they are using realignment mental health dollars to

cover the growing costs of their match for Medi-Cal, leaving less money available for mental health services for people who are not eligible for Medi-Cal.

In 2002, the state Department of Mental Health reviewed the impact of the realignment of mental health programs on mental health services and provided a status report as required by legislation. DMH found that realignment had stabilized funding for mental health services by providing dedicated funding and improved access to outpatient services. This is because the counties have additional flexibility regarding the use of mental health funds, financial incentives to properly manage mental health resources, and the ability to use funds to reduce high-cost institutional placements. At the same time, DMH found that realignment funds [for mental health] have not kept pace with 1991 funding levels when population changes and medical inflation are taken into account. In many counties, realignment funds allocated to both health and mental health programs have been transferred by counties to pay for the rising costs of social services programs, especially foster care and IHSS. Caseload growth in child welfare/ foster care and IHSS has also limited the amount of realignment growth funds available for both health and mental health programs.

DMH also reported that counties have had differing experiences with realignment. The extent to which counties have transferred mental health funding to social services programs differs significantly by region. Moreover, there were different levels of funding at the county level before realignment, and these differences were essentially carried forward because realignment was based on historical funding levels. Many observers also believe that realignment carried forward historically low funding levels for community mental health services. Realignment included a complicated formula for improving the equity of mental health funding among

counties, but, to some extent, pre-realignment inequities in county mental health funding continue.

### **Substance Abuse Treatment**

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

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

### **CalWORKS as a Funding Source for Mental Health and Substance Abuse**

In 1997, California enacted the California Work Opportunity and Responsibility to Kids (CalWORKs) program to implement federal welfare reform. As part of the CalWORKs program, the legislature included separate funding for counties to provide substance abuse and mental health treatment services. The purpose of the funds is to provide necessary services for CalWORKs participants to obtain and retain employment. These funds may be transferred between the two services at the discretion of the county welfare director. Counties have substantial flexibility in designing and implementing their CalWORKs programs while meeting specific service requirements.

The CalWORKs treatment funds provided strong incentives for county welfare departments, mental health, and substance abuse agencies to work more closely together. Some county welfare departments co-located treatment staff members with CalWORKs staff members. Some counties implemented multi-disciplinary teams. Although initially counties were not spending all of the funds allocated for mental health and substance abuse, the funds are now fully being spent. In 2003–04, counties received about \$120 million for both mental health and substance abuse treatment in CalWORKs.

Friday Night Live teen prevention program. Counties receive an annual allocation of federal and state funds each year, a portion of which must be matched with county funds.

In 1995, the legislature directed DADP to investigate the feasibility of a managed care model for treatment services. The DADP formed a stakeholder advisory committee, which recommended a "system of care redesign." The current thrust of that effort is to develop and implement a computerized outcome measurement system and collect client data that will help counties and providers choose the most effective treatment for each client.

## Drug Medi-Cal

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

## Proposition 36: The Substance Abuse and Crime Prevention Act of 2000 (SACPA)

In November 2000, California voters passed Proposition 36, which requires that non-violent adults convicted of use or possession of illegal drugs receive drug treatment in the community, rather than incarceration. Beginning July 1, 2001, SACPA required that \$120 million in state funds be set aside each year for the purposes of the act, through 2005–06. Under SACPA, counties must provide eligible offenders with up to one year of drug treatment and six months of after-care. Funds are allocated to local counties based on a formula that differs somewhat from the basic county allocation formula. Counties must develop and submit a collaboratively developed local plan and designate a county lead agency to administer the program.

The initiative is operational in all 58 counties. The primary state agencies involved in the implementation of SACPA are the DADP, the Board of Prison Terms, and the California Department of Corrections (CDC). The primary local entities involved include county alcohol and drug treatment agencies, trial courts, county probation departments, and educational, social, and health services agencies and providers.

Implementation required and continues to require collaboration among many state and local agencies, including the judiciary, law enforcement, health, drug treatment, and social services.

Since its implementation, outpatient treatment programs have increased by 81 percent, and licensure of residential facilities increased by 17 percent, with an overall 42 percent increase in the number of programs licensed and certified to provide drug treatment services. Most clients are using outpatient recovery treatment programs (76 percent), and about 12 percent are using long-term residential recovery programs.

## Funding for Substance Abuse Treatment

The state does not track the extent to which county governments spend money on treatment beyond the annual allocation of state and federal funds. Funding for county substance abuse treatment programs comes from the federal Substance Abuse Prevention and Treatment (SAPT) block grant through SAMHSA; Drug Medi-Cal (state and federal funds); state general fund (including the Proposition 36 set-aside); and county funds. Many counties also employ a variety of special state funds for drug and alcohol treatment, including Proposition 10, tobacco settlement funds, and Juvenile Justice Crime Prevention Act funds.

The 2003–04 state budget for DADP included about \$598 million from all fund sources, (\$233 million state general fund). The largest portion of the funds are for treatment programs (80 percent), with an additional 8 percent specifically dedicated to perinatal treatment services, and the remaining 12 percent for prevention services. In 2003–04, \$557 million was allocated to county alcohol and drug programs (including state and federal Drug Medi-Cal funds and Proposition 36 treatment funds.) The basic county allocation formula provides each county with a base level of funding (\$2,500) and then allocates any remaining funds according to

population. Proposition 36 funding is allocated to counties under a different formula based on population, caseload, and arrest rates.

The federal SAPT block grant includes a state maintenance-of-effort obligation. If a state does not meet the requirement, it risks losing part of the federal funding. In addition, states must set aside a portion of the funds in three specific priority areas: primary prevention for people who do not need treatment (20 percent); HIV Early Intervention Services (5 percent minimum and maximum), and services to pregnant women and women with dependent children (\$15.5 million). To ensure that federal set-aside requirements are met, ADP allocates SAPT block grant funds to counties in each program area.

As a result of the state fiscal crisis, county programs have seen a reduction in discretionary state general fund dollars, and at the same time funding was substantially increased for drug offenders under Proposition 36. Cuts in discretionary funds are particularly difficult for smaller counties because many do not have the staff capacity or sufficient numbers of clients in target program areas, such as HIV, to administer and get funding for categorical programs. There is also some question about whether California might jeopardize a portion of the federal SAPT grant in 2004–05. The legislative analyst reported that the governor’s January budget for substance abuse treatment might place California below the federally required maintenance-of-effort level, which could result in a reduction in the federal allocation.

**Table 1. Funding Streams for County Health Programs and Services**

Indigent Health Care*	Public Health	Mental Health	Substance Abuse Treatment
<ul style="list-style-type: none"> <li>• Realignment               <ul style="list-style-type: none"> <li>• Sales tax</li> <li>• Vehicle license fees</li> </ul> </li> <li>• Proposition 99 revenues</li> <li>• County match and overmatch (county general fund)</li> <li>• <i>Some counties:</i> Federal Disproportionate Share Hospital (DSH) funding for counties operating their own hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Realignment</li> <li>• State Public Health Subvention (\$1 million statewide)</li> <li>• State and federal categorical programs               <ul style="list-style-type: none"> <li>• Proposition 99 revenues</li> <li>• Maternal and Child Health</li> <li>• TB Control</li> <li>• HIV/AIDs</li> <li>• Federal bioterrorism</li> </ul> </li> <li>• County general fund</li> </ul>	<ul style="list-style-type: none"> <li>• Realignment</li> <li>• Medi-Cal (state and federal funds)</li> <li>• State general fund</li> <li>• Federal Mental Health</li> <li>• Block grant (Substance Abuse and Mental Health Services Administration, SAMHSA)</li> <li>• State and federal grants and categorical programs</li> <li>• Other revenues               <ul style="list-style-type: none"> <li>• Patient fees, insurance</li> </ul> </li> <li>• CalWORKs</li> <li>• County general fund</li> </ul>	<ul style="list-style-type: none"> <li>• State general fund</li> <li>• Drug Medi-Cal (state and federal funds)</li> <li>• Substance Abuse Treatment Trust Fund (Proposition 36 set aside \$120 million state general fund)</li> <li>• Federal Substance Abuse Block Grant (SAMHSA)</li> <li>• State and federal categorical programs</li> <li>• CalWORKs</li> <li>• Reimbursements               <ul style="list-style-type: none"> <li>• Corrections</li> <li>• California Youth Authority</li> </ul> </li> <li>• County general fund</li> </ul>

\*Non Medi-Cal

# III. Issues for Consideration

*The combination of state and federal budgetary challenges, and growing pressures on county general purpose revenues, make all of the programs highlighted in this report vulnerable to reductions at the local level.*

THIS SECTION HIGHLIGHTS SOME OF THE POTENTIAL threats and challenges facing the state and counties that could have significant implications for county health programs and suggests some issues for consideration by policymakers.

## Threats and Challenges

Policymakers are faced with multiple funding challenges and with rising demands for health programs and services. The combination of state and federal budgetary challenges, and growing pressures on county general purpose revenues, make all of the programs highlighted in this report vulnerable to reductions at the local level. Several specific, and, in some cases immediate, challenges affect these programs:

***County health systems confront financial and organizational challenges.*** Counties that operate public hospitals, health facilities, and COHSs are experiencing severe fiscal challenges. The San Mateo Health Plan, a COHS for Medi-Cal patients, has been losing money, and the county is considering terminating its contract with the health plan because of the impact on county resources and the financial viability of the county-run hospital. Other COHSs are reporting similar fiscal crises. County-run hospitals are experiencing fiscal problems, and additional public hospital closures could occur, depending on budget choices at the state and county levels. The overall impact of these challenges on the availability and the delivery of county health services could be substantial.

The Los Angeles County health system continues to experience significant fiscal pressure. The county currently has a federal Medicaid 1115 waiver, which brought additional financial resources to the health system, but the waiver will expire on June 30, 2005. The county is struggling to find creative ways to restructure the system and reduce costs while responding to soaring demands for services. Given the size of the county and its health budget challenges, the future of its health system and the financial viability of that system have statewide implications for the funding of health care programs.

***Realignment program faces challenges.*** Realignment is a major source of funding for county health programs. At this juncture, the realignment program is facing significant

challenges and fiscal pressures, including:

- ***Continuing impact of vehicle license fee revenue uncertainty.*** In 2003, the vehicle license fee was first increased and then reduced. The shifting policy actions related to changes in the VLF rates during 2003 created delays in counties receiving anticipated realignment revenue. Counties are still millions of dollars short for 2003–04, and the shortages are estimated in the hundreds of millions of dollars.
- ***No growth in funding for health and mental health.*** Exponential growth in social services program costs and caseload, child welfare, foster care, and particularly IHSS (in-home care services for people with age- or disability-related impairments), continues to reduce funds available for health and mental health programs. County health and mental health programs are facing potentially dramatic program cutbacks as counties build their budgets for 2004–05.
- ***“Poison pill” trigger.*** A December 2003 court ruling in San Diego County held that the 1982 state transfer of responsibility for the Medically Indigent Adult (MIA) program to the counties constituted a reimbursable state mandate. This ruling triggered “poison pill” language in the original realignment statute, repealing the original increase in the vehicle license fee. The repeal was effective March 1, 2004, canceling the distribution of VLF funds into the realignment accounts. The legislature enacted temporary legislation to keep realignment dollars flowing to counties until a more permanent solution can be found.

***State cuts to county general purpose revenues threaten funding for health care programs.***

Health programs are extremely vulnerable to cutbacks when counties have fewer discretionary funds. Most counties contribute significant county general funds (from general purpose

revenue sources) to provide matching funds or to augment funding for health programs.

However, state budgetary actions have reduced county general revenues, threatening funding for county health services. For example, the amount of property tax revenues shifted to education increased from \$2.5 billion in 1993–94 to \$3.9 billion in 2003–04. The governor reached agreement with the counties to cut an additional \$1.3 billion shift in 2004–05 and 2005–06, in exchange for more certain future revenues. The agreement is subject to legislative approval through the budget process.

In 2003–04, some counties reduced funding for health and/or mental health. For example, Alameda County cut county general fund contributions to health care by \$28 million. Many counties currently preparing their 2004–05 budgets are considering new or additional cuts in health and mental health care. As just one example, Orange County is considering eliminating \$50 million in funding to local health care programs, including mental health and substance abuse treatment and family clinics.

***Frequent users challenge systems and resources.***

The evidence increasingly suggests that one of the major cost pressures facing health programs and systems is the cost associated with individuals who have multiple risk factors and complex care needs that can lead to frequent and repeated use of health and mental health resources. For example, DMH reports that 7 percent of the clients in their system account for 50 percent of the costs. Individuals with either substance abuse or mental health disorders, or both, who also lack access to health care, housing, and other basic resources can become frequent users of expensive hospital emergency room care. Their complex care requirements challenge the existing categorical and fragmented nature of programs and services because their service needs do not fit neatly into one program or service category. Despite the fiscal pressures resulting from failure

to meet the complex needs of these clients, policymakers have limited awareness and focus on this issue.

**Counties confront unmet needs and increased demands for services.** In the preparation of this report, county administrators, program officials, and advocates reported substantive needs they are unable to meet at current funding levels. These unmet needs include but are definitely not limited to: the inability of many local jurisdictions to operate full-scope public health and emergency preparedness programs; rising numbers of uninsured and underinsured people; the lack of substance abuse treatment services for youth; and the lack of mental health resources for people who are not eligible for Medi-Cal. The state fiscal crisis, and reductions in county revenues, will put increasing pressure on existing programs. Further funding reductions could lead to greater unmet needs in many areas.

**Proposition 99 revenue has declined 85 percent since 1988.** Revenue generated by Proposition 99 tobacco taxes has declined dramatically since its inception because Californians continue to use fewer tobacco products. Health and public health programs have been hit hard as the legislature grapples with the reduced funding level. For example, Proposition 99 funding for the CHIP program for large county indigent medical care programs declined from \$350 million initially to below \$50 million in 2003–04 (including \$22 million specifically targeted for allocation to physicians). Proposition 99 funding for the CMSP was completely eliminated in 2002–03. At the same time, the legislature has maintained funding for some Proposition 99 funded programs, such as the Access for Infants and Mothers (AIM) program, and established new Proposition 99 programs, such as the Breast Cancer Treatment Program.

**Special-education mandate increases local mental health costs.** County mental health plans are statutorily responsible for providing

federally mandated services to special-education students with mental health needs. Counties have historically funded the program using realignment, categorical funds provided for that purpose (eliminated in 2002), and mandated claims reimbursement (deferred in 2002 and 2003). For 2003–04, \$69 million in federal special-education funds was allocated to counties to partially cover their costs in this program. However, counties estimate that annual costs for the program exceed \$100 million. To the extent that the costs are not fully reimbursed, counties might have fewer funds available for other mental health clients and services.

**Proposition 36 funding set-aside ends, but the mandate remains.** The Proposition 36 requirement of a state general fund set-aside for alcohol and drug treatment programs for drug offenders ends in 2005–06. However, courts will still be legally bound to refer eligible offenders for treatment. Counties would be required to provide the services whether or not specific funding is available. At the same time, some local communities indicate the \$120 million set-aside statewide is already insufficient to meet demand. In addition, while the governor's 2003–04 budget proposed to exclude Proposition 36 funds from the state's federal maintenance-of-effort calculation, the federal SAMHSA disapproved this proposal. This means that SAMHSA will consider the funds allocated for Proposition 36 in calculating the state's future maintenance-of-effort requirement.

**Emerging infectious diseases and bioterrorism.** County public health programs are being asked to prepare for and respond to new threats, including the possibility of bioterrorism attacks, as well as emerging and re-emerging infectious diseases, such as the West Nile virus, severe acute respiratory syndrome (SARS), and outbreaks of tuberculosis. Local preparedness for these challenges requires sufficient resources and public health expertise at both the state and local levels

to ensure adequate training, surveillance, and community education.

## Key Policy Questions

This report highlights the central role that California counties play in the delivery of health services at the local level. Proposals to reorganize government services or funding, or to shift responsibilities between the state and counties, often become part of the larger policy deliberations when the state faces a serious fiscal crisis. This section includes questions policymakers may wish to consider as they review comprehensive proposals that will affect health services at the local level.

***County programs and program administration is at risk under fiscal pressures.*** California has to a large extent avoided requiring counties to administer or to implement specific programs and systems at the local level. The state generally has established program funding streams and attached specific requirements to the funding. For example, counties are not statutorily required to operate a local mental health plan for Medi-Cal or to deliver substance abuse treatment services (beyond those required under Proposition 36). As the available funding is reduced, counties may choose to limit or eliminate their involvement in important programs. This has already occurred with Proposition 99 funding for indigent care. As the funding declined, many smaller rural counties stopped accepting the funds because the related reporting and treatment costs were more expensive than the funding they received. Placer County recently chose to stop accepting its Proposition 99 allocation for the same reason, and other counties report that they are considering similar action. *What would be the impact of counties being unable or unwilling to continue to administer important local health programs? Should the state set minimum standards and priorities to ensure some base level of services throughout the state?*

### ***Fragmented systems are costly and less effective.***

The types of services provided, the clients served, and the goals of all of these programs overlap substantially. However, they are administered at the state and local level by different agencies with different requirements, funding levels, and professional philosophies. The administrative structures at the state and local level increase program costs. Moreover, counties and providers are often seriously challenged to respond to people's real everyday needs, which might extend across the boundaries of multiple programs or agencies, or exist completely outside of any existing categorical program or funding stream. Some counties have implemented local strategies to better coordinate programs and services, but they must overcome significant administrative barriers. *How can county programs be most effectively funded and organized to minimize administrative costs and facilitate coordinated service delivery?*

### ***Financial incentives might be inconsistent with important policy goals and priorities.***

The way that county health programs are administered and funded at the state and federal level determines how programs and services are delivered at the local level. Basically, funding becomes a major driver of programs and policies. However, the resulting financial incentives might be inconsistent with other policy and program goals. Funding for health programs might be tied to the most costly alternatives. For example, Los Angeles County is currently exploring how it might use the Medi-Cal Disproportionate Share Hospital (DSH) payment program in a more flexible way to support outpatient care and services rather than limiting the program to funding for inpatient care, the most expensive level of care. Funding strategies and mandates that apply to other county-administered programs may also influence the delivery of county health services. *What are the financial incentives underlying important funding streams for health programs? What policy goals and priorities do they reinforce?*

***Vague mandates limit accountability.*** In each of these program areas, expected county roles and responsibilities have evolved. The statutory mandates are vague and often unclear. The only way to clearly identify the specific roles and responsibilities of counties in these programs areas is to search volumes of statutes, regulations, state policies, program guidelines, and court cases. Many of the requirements counties must meet are contractual by program. County discretion leads to dramatic differences in access to services for Californians in different regions of the state. This makes it very difficult for policymakers to monitor existing programs effectively, to assess unmet needs in communities, or to identify the potential impact of new legislative ideas or programs. *How can policymakers balance the need for accountability with the goal of ensuring local communities have the flexibility to implement local priorities?*

***Collection of program data and information is burdensome but is not systematic or practical.*** Depending on the health and public health programs that counties administer, some statutory, some contractual, counties might be required to submit more than 100 different reports annually to different divisions of DHS or to other state agencies. And yet, policymakers do not receive regular, usable information about county health programs or services. Requiring counties to report on their programs is an opportunity to improve accountability and to monitor the implementation of legislative strategies and priorities. Collecting boxes of data reports with no clear intended use of the information, and limited ability to analyze and assess the data, is costly but does not accomplish the goal of accountability. *What information do policymakers need in order to assess and monitor programs? What is the most efficient, practical way to obtain the information?*

# V. Methodology and Sources

DATA AND INFORMATION ABOUT COUNTY HEALTH and public health programs, revenues, and expenditures are available from a variety of sources, but no central resource collects and regularly reports, in a user-friendly manner, consistent program and financial information about county health and public health programs. Given the purpose of this report, as well as the tremendous diversity among county health programs and funding, this document should be considered a snapshot of the role of counties in health services, rather than a thorough review and analysis of county health revenues, expenditures, or programs. To the greatest extent possible, data and funding information are from the most recent time period available, although in many instances that information is several years old.

Kelch Associates relied on multiple sources for the information contained in this report, including informant interviews. The report includes data and information that might have known limitations or inconsistencies from county to county or could be obtained primarily only through interviews as long as it contributes to an informed picture of county health programs and services in California. Information sources included state program and financial reports, related statutes and regulations, state budget documents, legislative staff analyses and reports, and the annual analyses of the state budget by the Legislative Analyst's Office. In addition, information from the Insure the Uninsured Project was very helpful in the profile of medical care for the uninsured.

## Appendix A: County General Purpose Revenues

County general fund revenues are the discretionary funds available to counties for local programs and priorities. The primary funding sources are property taxes, vehicle license fees (non-realignment), sales taxes (1 percent) and local taxes, such as utility and hotel taxes. The California Constitution requires voter approval for local agencies to impose or increase local taxes or assessments.

Some of the uses for county general purpose revenues include:

- Matching funds for state-mandated programs such as child welfare services and foster care
- Support for local law enforcement, fire protection, district attorneys, jails, and probation
- Indigent care, public health, mental health, and substance abuse treatment above state and federal funds
- General Relief income support programs for indigent adults
- General local government costs, such as elections, property tax administration and planning
- Debt payments

Most observers report that reductions in county general purpose revenues affect county funding levels for health programs more than any other program area. Some of the most recent changes to county revenues include:

***The ERAF shift.*** Property taxes remains the largest source of county general-purpose revenue, but the percent of property taxes allocated to county general funds has declined in recent years. This is because in 1992 and 1993 the state budget shifted a higher percentage of property taxes to schools and into the Educational Revenue Augmentation Fund (ERAF), resulting in a loss of \$5 billion for counties or about 17 percent of total property tax revenue. The governor proposed an additional \$1.3 billion property tax shift in 2004–05.

***The VLF “gap.”*** Changes in vehicle license fee levels in 2003—first an increase then a reduction—left a “gap” in VLF revenue at the county level from delays in payments, estimated to be more than \$700 million.

## Appendix B: Proposition 99

Proposition 99, the Tobacco Tax and Health Protection Act, was approved by voters in 1988, increasing the tobacco excise tax rate in California and establishing the Proposition 99 Cigarette and Tobacco Products Surtax Fund with very specific funds and funding allocations. Because Californians are now using fewer tobacco products, Proposition 99 revenues have dramatically declined.

The specific Proposition 99 programs and actual allocation of those funds has evolved over the past 12 years through state legislative and budget action and has somewhat complex funding formulas and requirements. Health care programs funded by Proposition 99 include:

**County indigent care.** Under California law, a portion of the tobacco tax funds is allocated to counties for health care services to people who cannot afford to pay all or part of their medical care and are not covered by any other federally reimbursed program. In the larger counties, the allocation is accomplished through the California Healthcare for Indigents Program (CHIP) and in the smaller counties through the Rural Health Services (RHS) program. Funding for these programs dropped from \$350 million in 1989–90 to less than \$50 million in 2003–04.

CHIP and RHS funds come from both the Hospital Services Account and the Physician Services Account. For the Physician Services Account, 50 percent must go to emergency physicians for uncompensated care, and 50 percent goes to private physicians for uncompensated care.

In the hospital services account, 50 percent is formula-driven and goes to hospitals in each county for their uncompensated care, including emergency room and trauma care, based on their report of uncompensated care levels to the Office of Statewide Health Planning and Development (OSHDP). The remaining 50 percent is given to hospitals as determined by the county.

**EAPC.** Proposition 99 resulted in the Expanded Access to Primary Care (EAPC) program, which reimburses non-county clinics per visit for services to the uninsured. EAPC increasingly is funded by state general fund revenue.

**Access for Infants and Mothers (AIM) program.** Provides low-cost health insurance coverage to uninsured, low-income pregnant women and their infants. AIM enrollees receive their care from one of nine health plans participating in the program, and the state supplements the subscriber contribution to cover the full cost of care.

**Proposition 99 contract-back programs.** Over time, smaller CMSP counties found that the combination of the CHDP treatment mandate and declining Proposition 99 revenue made it less attractive to accept Proposition 99 funds. Solano and Sutter are the only CMSP counties still participating in the RHS program. Legislation then allowed DHS to administer two programs in behalf of CMSP counties choosing not to accept Proposition 99 funds:

■ **Physician services contract-back program.**

Reimburses Medi-Cal physicians for uncompensated care. A total of 30 CMSP counties participate.

■ **Children's treatment program.** Reimburses Medi-Cal and Denti-Cal providers for CHDP treatment on a fee-for-service basis.

Other programs that receive small allocations of Proposition 99 funds include the Breast Cancer Early Detection Program, children's hospitals, and Comprehensive Perinatal Outreach.

## Appendix C: Program Overviews

### Indigent Health Care at the County Level

#### Summary

Medical care for low-income people, primarily adults without children, as well as undocumented adults and children, who have no other source of care.

#### Statutory Obligations of Counties

- **Section 17000—provider of last resort.** Since 1933, counties have been legally required to provide “relief and support,” including health care, for “incompetent, poor, indigent persons and those incapacitated by age, disease, or accident, lawfully resident therein” (California Welfare and Institutions Code Section 17000). In the 1970s, California initially assumed responsibility for low-income uninsured adults 21 to 64, as “medically indigent adults” but transferred the program back to counties in 1982.
- **Financial maintenance of effort.** As a condition of receiving Proposition 99 funds for inpatient and outpatient care, counties have a statutory “maintenance of effort” or county match requirement, for indigent care and public health programs and must report expenditures and patient data to the state.
- **CHDP treatment mandate.** Counties that receive Proposition 99 funds for indigent care must provide follow-up treatment identified through a Child Health and Disability Prevention program screening.

#### County Discretion

- Funding levels for indigent care, along with who is eligible for services, what services are provided, and the methods and providers used.
- Some counties also increase access to care locally by establishing county-owned and operated inpatient and outpatient facilities, which serve not only indigent but Medi-Cal and other clients.

#### Programs/Care System

County indigent care programs vary significantly by county and by region, and counties do not report programmatic information such as their scope of services, eligibility criteria, or methods of provider reimbursements. There are four main strategies counties use to arrange for indigent health care:

#### Large Counties (formerly known as County Medically Indigent Services Program counties)

- **Provider counties.** Operate county hospitals and outpatient clinics. Currently, 15 counties operate 19 publicly owned hospitals, and four counties contract with local University of California hospital medical centers to serve as public hospitals.
- **Payer counties.** Contract with one or more private hospitals for inpatient services and with community clinics and private physicians for outpatient services.
- **Hybrid counties.** Pay for hospital services but operate public clinics. May also pay private physicians and clinics.

#### Small Counties (CMSP)

- Thirty-four small counties (population less than 300,000 in 1982) contract with CMSP, a centrally administered health coverage program similar to Medi-Cal.

#### Funding

- Primary funding sources for indigent health care are realignment funds (dedicated sales tax and motor vehicle license fees) and county general fund revenue (county match).
- Large counties and two smaller rural counties receive a relatively small and declining allocation of Proposition 99 tobacco tax revenue for indigent care.
- County owned hospitals receive Disproportionate Share Hospital funds by statutory formula; these are Medi-Cal funds provided to public and private hospitals serving high numbers of Medi-Cal patients.
- In 2001–02, 23 of the 25 counties receiving Proposition 99 funds reported expenditures of \$1.5 billion total funds to serve about 1.4 million indigent patients. In 2002, CMSP served about 115,000 people at a cost of \$222 million.

## County Public Health Services

### Summary

The general responsibility to protect and improve the health of the community through preventive medicine, health education, control of communicable diseases, application of sanitation standards, and monitoring of environmental hazards, often referred to as core public health functions.

### Statutory Obligations of Counties

- Administer a local public health program, including public health nursing, communicable disease control, and environmental health, with a physician health officer in charge of public health.
- Public health officers have broad authority and responsibility to protect the public health and to respond to public health threats, including ordering communicable disease testing, quarantines, and closures of public and private facilities they determine are endangering public health or safety.
- Receive and track reports from health providers on more than 80 reportable diseases.
- Respond to local emergencies such as floods and other natural disasters, disease outbreaks, or bioterrorism attacks.
- Administer local categorical health and public health programs consistent with state and federal requirements (some mandatory, some voluntary and contractual).
- Submit required state and federal public health statistical, surveillance, and program reports.

### County Discretion

- Significant discretion to set funding levels and determine the structure of local public health services.
- Determine levels of service, what services are provided, and the methods and providers used.
- Participate in and contribute county funds to optional categorical programs based on local needs.

### Programs/Care System

- 61 local health jurisdictions in California: the 58 counties and the cities of Berkeley, Long Beach, and Pasadena.

- Large counties may also have a health administrator to manage and oversee public health and other related health care programs.
- Eleven small counties participate in the Local Public Health Services Program, which provides state-employed environmental specialists and public health nurses who work in and for those counties.
- County public health programs vary substantially in structure, scope, funding levels, staffing, and specific services and categorical programs offered. However, no statewide resource exists that regularly profiles county public health programs or funding.
- Some counties have relatively small public health nursing programs that concentrate on communicable disease follow-up and immunizations, and other counties have extensive programs that include community health education, home visiting programs, and outreach to pregnant women and children.
- Some counties operate limited public health clinics for communicable-disease-related control activities, and some combine those services with county-operated primary care clinics and indigent care programs.

### Funding

- Funding sources include realignment, county general fund revenue, and a relatively small state general fund account (known as the public health subvention), of \$1 million allocated by formula to all jurisdictions.
- Other small categorical programs for core public health activities, such as Tuberculosis Control.
- Environmental health programs are generally supported by fees.
- Categorical public health programs, which have separate categorical funding streams, including the Maternal, Child, and Adolescent Health (MCAH) program and the California Children's Services (CCS) program.
- Federal bioterrorism funding available since 2002. Federal bioterrorism funds are subject to federal priorities and restrictions and to the terms of detailed contracts between the state and counties.

## County Mental Health Services

### Summary

Treatment for mental disorders and mental health problems for low-income people, including those eligible for Medi-Cal and those without any public or private coverage.

### Statutory Obligations of Counties

- **County mental health program.** All counties are required to establish (or join with other counties to establish) a community mental health service program for the county and to create a local mental health advisory board.
- **Section 1700—provider of last resort.** Since 1933, counties have been legally required to provide “relief and support,” for “incompetent, poor, indigent persons and those incapacitated by age, disease, or accident, lawfully resident therein” (California Welfare and Institutions Code Section 17000). In the case of mental health, this broad mandate is limited: Counties must provide mental health services for specific target populations to the extent resources are available (enacted as part of realignment in 1991).
- **Services for the involuntarily committed.** Evaluation and treatment of people who are involuntarily detained for 72 hours because they are deemed to be a danger to themselves or others or gravely disabled (often referred to as “5150” detainees).
- **Services for special-education students.** Mental health services for special-education students, regardless of income, identified by the school as needing treatment. (About 31,000 students annually.)
- **State standards and requirements.** Counties choosing to operate the local mental health plan for Medi-Cal must meet state and federal eligibility, benefits, and service standards and must manage the program as a Medi-Cal entitlement. Counties must follow statutory priorities and standards for indigent mental health care to the extent funds are available.

### County Discretion

- Option to administer the local mental health plan for Medi-Cal.
- Selection of providers (certified by the state) for participation in Medi-Cal and indigent care services.
- Service methods, care management and system coordination, consistent with state and federal requirements.
- Funding levels for local mental health services for people who are not eligible for or enrolled in Medi-Cal.

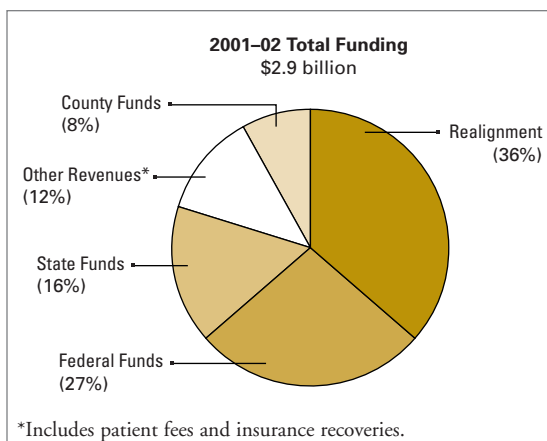
### Program/Care System

- Medi-Cal services are administered at the county level through county-operated mental health plans.
- Counties directly provide or contract for mental health services.
- Counties use state funds, realignment funds, and county funds to draw down federal Medicaid matching funds.
- County mental health departments provide services to indigent people not on Medi-Cal to the extent the county has funds remaining from realignment or other county revenue sources to pay for the services.
- In 2001–02, 626,000 clients received services.

### Funding

Funding for the community mental health services provided by counties comes from a variety of sources. Mental health funding levels and programs vary significantly by county.

**Figure 2. Community Mental Health Funding**



## County Alcohol and Drug Programs

### Summary

Services designed to prevent or minimize the effects of addiction and abuse of alcohol and other drugs. Services include prevention, early intervention, detoxification, and recovery.

### Statutory Obligations of Counties

- Provide treatment services to non-violent drug offenders under the terms of Proposition 36, The Substance Abuse and Crime Prevention Act of 2000. Counties must provide eligible offenders with up to one year of drug treatment and six months of after-care.
- Administer contractual (but voluntary) alcohol and drug treatment programs, including Drug Medi-Cal, according to state and federal requirements.

### County Discretion

- May petition the state for funding for local drug and alcohol treatment services and can terminate the state contract with 60 days' notice.
- Option to administer a local Drug Medi-Cal program.
- Determine local funding levels for treatment programs and services.

### Program/Care System

- Some counties provide counseling and other treatment services directly, some contract with private treatment programs, and some counties offer both direct and contract services.
- All but 19 counties participate in the Drug Medi-Cal program. The state Department of Alcohol and Drug Treatment contracts with and reimburses providers in the non-participating counties. Covers limited treatment services: narcotics replacement (methadone detoxification and maintenance programs and naltrexone), restricted outpatient drug-free services, and day care rehabilitative and residential treatment for pregnant and parenting women. Covers only services provided on a face-to-face basis, if the services are provided at a treatment site certified by DADP.

## Funding

- Funding sources include:
  - Federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grant
  - Drug Medi-Cal (state and federal)
  - State general fund (including the Proposition 36 set-aside of \$117 million)
  - County funds
- Some counties also employ a variety of special state funds for drug and alcohol treatment, including Proposition 10, tobacco settlement funds, and Juvenile Justice Crime Prevention Act funds.
- The largest portion of the funds allocated to DADP in 2003–04 were for treatment programs (67 percent), with an additional 8 percent specifically dedicated to perinatal treatment services, and the remaining 12 percent for prevention services.
- Counties received \$557 million in 2003–04 (including state and federal Drug Medi-Cal funds and Proposition 36 treatment funds).
- The basic county allocation formula provides each county with a base level of funding (\$2,500) and then allocates any remaining funds according to population.
- Proposition 36 funding (\$117 million per year through 2005–06) is allocated to counties under a different formula based on population, caseload, and arrest rates.
- County programs have seen a reduction in discretionary state general fund dollars, and at the same time funding was substantially increased for drug offenders under Proposition 36.



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