



California and Its Counties Under the ACA: A Leadership Framework

The history of health care in California is, in many respects, the story of how the state and its 58 counties have managed and shared responsibility for the health of Californians over time. Since counties were first created in 1850, the state and county partnership in health has seen shifting responsibility for funding, program administration, and decisionmaking. In recent decades, state policy shifts most often stemmed from California's "boom and bust" economic cycles and resulting budget crises. The story of this partnership has also been shaped by the wide diversity of California counties in terms of local resources, priorities, and political climates.

As California moves to carry out the federal Affordable Care Act (ACA), it is implementing major health program, policy, and fiscal changes that will once again transform the state-county partnership. As a prelude to state monitoring and oversight of these sweeping changes, this issue brief offers policymakers and stakeholders:

- ▶ A leadership framework to assess potential impacts of shifting responsibility for health programs and services between the state and local level.

- ▶ Highlights of state policy and ACA implementation activities most likely to affect counties.
- ▶ Application of the leadership framework to state and county roles in 2014.
- ▶ Things to watch for in California counties as ACA implementation unfolds.

Who Is Taking the Lead?

This section offers a new way to think about the state-county partnership in health — an analytical framework focused on the relative leadership responsibility of the state and the counties. For some health program and policy areas, the state assumes lead responsibility to design, finance, and administer the services, but for other programs counties assume the lead.

Historical Role of Counties in Health

See Appendix A for a summary of the historical twists and turns affecting publicly funded health care for low-income adults in California.

At different points in history, the relative responsibility of the state and counties has yielded different results. In general, where the state has taken the lead, policies developed at the state level produced greater operational consistency across counties. Alternatively, where counties assumed lead responsibility, the level and type of services that county residents received reflected the diversity of California counties in terms of resources, capacity, and political orientation.

Importantly, the lead is never absolute — throughout history both the state and counties retained some role or responsibility in each health program area. Still, for policymakers and stakeholders, recognizing that health services will be similar or vary widely depending on the relative leadership responsibility of counties is one critical factor in deciding how to structure and monitor programmatic and fiscal responsibility in these areas.

Using this framework, health programs can be organized into three categories: (1) those where the state takes the lead; (2) those where the counties take the lead; and (3) those where the state and the counties share responsibility. Table 1 outlines potential advantages and disadvantages of the three leadership categories.

Table 1. Leadership Framework for Health Programs in California: Advantages and Disadvantages

STATE HAS LEAD RESPONSIBILITY	STATE AND COUNTY SHARED RESPONSIBILITY	COUNTY HAS LEAD RESPONSIBILITY
Advantages		
<ul style="list-style-type: none"> ▶ Centralized policymaking in the executive and legislative branches ▶ Consistency in program administration, financing, and service levels county to county (covered benefits, eligibility, etc.) ▶ State-level accountability subject to legislative oversight ▶ Efficiency through minimizing administrative duplication and centralized program oversight ▶ Enhanced control over program integrity 	<ul style="list-style-type: none"> ▶ Policymaking inclusive of local input but also consistent statewide ▶ Enhanced consistency in program administration, financing, and service levels county to county (covered benefits, eligibility, etc.) with some local flexibility (delivery system) ▶ Shared accountability ▶ Financing responsibility and risk can be shared by state and counties ▶ Care delivery tailored to local needs and provider expertise with state-level monitoring ▶ Encourages local innovation and best practices 	<ul style="list-style-type: none"> ▶ Policymaking responsive to local needs and priorities ▶ Supports county-specific program administration, financing, and service delivery ▶ Local accountability with opportunity for local public input ▶ More manageable size and scale of administration and program operations ▶ Maximizes the opportunity for local innovation and experimentation
Disadvantages		
<ul style="list-style-type: none"> ▶ Less county input into policy decisions and less responsive to local needs and priorities ▶ Can be bureaucratic and cumbersome due to size and scale of the state ▶ State bears the financial risk, and program funding is subject to state budget fluctuations and limits ▶ May disregard nuanced local infrastructure and delivery system differences ▶ Potential to minimize or discourage local innovation 	<ul style="list-style-type: none"> ▶ Policy decisionmaking becomes more complex to reflect both state and local input ▶ Potential for some variation and uneven service delivery across counties ▶ Leadership nexus and accountability may be blurred and less clear for stakeholders (e.g., consumers, advocates, providers) ▶ Depending on which level of government bears the financial risk, program funding is subject to state and/or local budget fluctuations and limits ▶ Requires greater coordination and mutual agreement between the state and counties to achieve program goals 	<ul style="list-style-type: none"> ▶ Inconsistent program administration, financing, and service levels across counties ▶ Diffuse accountability and program oversight ▶ Counties bear the financial risk, and program funding is subject to local budget fluctuations and limits

Applying the Leadership Framework: Indigent Health Care

This section applies the framework to medical care for low-income adults in the state as one example of how lead responsibility has shifted between the state and the counties over time.

- ▶ In the late 1800s, some counties independently established the first local health facilities and almshouses to care for indigent individuals. In the 1930s, legal responsibility for the counties to serve as “providers of last resort” was enacted in state law (*county lead*).
- ▶ In the early days of the Medi-Cal program in the late 1960s, California permitted — but did not require — counties to have “non-linked” adults (the unemployed, single adults, and the working poor) served through Medi-Cal, if counties transferred 100% of what they had been spending, with the state covering costs above that (*state and county shared responsibility*).
- ▶ In the early 1970s, the state adjusted the county contribution to Medi-Cal, made it mandatory, and created a state-only program (no federal Medicaid funds) to serve “medically indigent persons (MIPs)” using state and county funds (*state and county shared responsibility*).
- ▶ In 1982, facing a serious state budget deficit, California eliminated the MIP Medi-Cal program and transferred responsibility for medically indigent adults (MIAs) to counties along with 70% of

historic state funding for the program. Funding and program responsibility for county indigent care was later incorporated into the 1991 State and Local Program Realignment (*county lead*).

- ▶ In 2013, California adopted the ACA Medi-Cal expansion for low-income childless adults living at or below 139% of the federal poverty level (FPL), assuming responsibility for MIA medical care (*state lead*).

At each of these transitions, the nature of the programs, financing, and eligibility for MIA medical care varied significantly depending on whether the state or the counties were in the lead. For example, benefits and eligibility rules were consistent in a state-administered MIA program but inconsistent and varied county-to-county when counties had the lead responsibility and discretion to design the program. (See Appendix A for more detail on the evolution of medical care for low-income adults in California).

Gearing Up for ACA: Coverage Expansion and Program Redesign

To set the stage for applying the leadership framework to health programs in 2014, this section summarizes several state initiatives and changes affecting county health programs in the lead-up to full ACA implementation. California not only adopted specific ACA implementing provisions, such as expanded coverage for new categories of low-income individuals, but seized the opportunity presented by the ACA to modify and restructure

state and county health programs and financing. Important changes include:

- ▶ **“Bridge to Reform” Medicaid waiver.** Following passage of the ACA, California requested and received a five-year federal Medicaid Section 1115 waiver, which replaced the state’s 2005 Hospital Financing waiver. The 2010 waiver includes: (1) authority and funding for early expansion of Medi-Cal to eligible low-income adults (see box); (2) funding support and

Low-Income Health Program (LIHP)

The “Bridge to Reform” waiver and implementing state legislation authorized California counties to voluntarily establish LIHPs for uninsured adults age 19 to 64. LIHP programs could have two components:

- ▶ Medicaid Coverage Expansion (MCE) for those with incomes below 138% FPL (essentially MIAs) who in 2014 are newly eligible for Medi-Cal under the ACA.
- ▶ Counties offering the MCE could also implement a Health Care Coverage Initiative (HCCI) for those with incomes above 138% FPL.

LIHP programs were funded with 50% federal Medicaid funds as a match to 50% county funds. Between 2011 and 2013, 53 counties established LIHP programs and enrolled over 650,000 eligible members. The MCE enrollees automatically transferred to Medi-Cal effective January 1, 2014, and approximately 24,000 HCCI enrollees were eligible to apply for subsidized coverage through Covered California.¹

quality improvement incentives for safety-net hospitals, including county-operated facilities; and (3) promotion of coordinated systems of care in Medi-Cal, including mandatory managed care for seniors and persons with disabilities and pilot projects to improve the California Children's Services program serving children with special health care needs.¹

- ▶ **Medi-Cal Expansion.** In 2013, California expanded eligibility for Medi-Cal consistent with new program requirements and options available to states under the ACA. In 2014, most childless adults at or below 138% FPL, other than undocumented immigrants, are newly eligible for Medi-Cal, the costs of which will be paid with 100% federal funds through 2017. By 2019, the number of people enrolled in Medi-Cal is projected to increase by 1 million or more due to ACA coverage expansions and program changes.² California also expanded state-only Medi-Cal coverage of emergency services for undocumented persons up to 138% FPL and established a new linkage program permitting legal immigrants enrolled in state-only Medi-Cal (those pending a 5-year Medicaid bar under federal law) to receive assistance with coverage through Covered California.³
- ▶ **State and County Program Realignment.** In 1991, California enacted the State and County Program Realignment (1991 realignment) transferring program and financial responsibility from the state to the counties in the following program areas: county indigent care, public health services, community mental health and social services, along with dedicated revenues

to support the realigned programs. Twenty years later, the state enacted two additional program realignments, which affected county health programs as outlined below.

- ▶ **Public Safety Realignment.** In 2011, California enacted a new Public Safety Realignment (2011 realignment) to address court-ordered reductions in the state prison population and the growing costs of state prison obligations. The 2011 realignment transferred programmatic and financial responsibility to counties for various criminal justice activities and provided counties with dedicated new sales and vehicle license fee revenues. It also eliminated state general funds for community mental health services so that by July 1, 2012, counties assumed responsibility for the non-federal share of specialty mental health services for Medi-Cal and indigent individuals, as well as for various substance use programs.⁴
- ▶ **Health Realignment.** The 2013 health realignment redirected a portion of county funds for indigent medical care to the state, in recognition that counties could expect savings in those programs because uninsured people will get other coverage under the ACA. It established methods to estimate the realignment savings leading up to a "true up" in 2015. Counties with public hospitals (*provider counties*) and counties that contract for hospital care but may operate county clinics (*payer/hybrid counties*) choose from either a 60/40 (*state/county*) split based on historical health realignment funds or the "shared savings" formula, 80/20 (*state/county*), calculated

on historic costs and savings for indigent care. The 34 counties in the County Medical Services Program (CMSP), a pooled coverage program, are subject to a version of the 60/40 split.⁵ (See box, page 5 for more on county indigent care models.) Of approximately \$1.6 billion in health realignment revenue previously allocated to counties, the 2013 health realignment redirected \$300 million to the state in 2013–14 and approximately \$900 million to the state in 2014–15. The county savings captured by the state will help defray the state costs of an increase in CalWORKs grants and the expansion of Medi-Cal.

- ▶ **State-Based Health Insurance Exchange.** In 2010, California enacted the first legislation establishing a state-based health insurance exchange under the ACA.⁶ The state exchange offers health coverage options to individuals and small employers through contracted commercial health plans. Individuals with income up to 400% FPL are eligible for federal premium tax credits to help pay the costs of coverage. From its inception, Covered California actively partnered with the state Department of Health Care Services (DHCS) and with counties to develop a shared eligibility and enrollment system for ACA coverage, the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). An estimated 1.9 million people will enroll in Covered California by 2015–16.
- ▶ **Expanded Mental Health and Substance Use Disorder (SUD) Services.** California added new coverage for mental health and SUD treatment to the Medi-Cal benefit package for existing and

Four County Indigent Care Models

The 2013 health realignment categorized county indigent health care delivery systems into four general types, based on the existing structure of county programs:

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

PROVIDER COUNTIES: Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura.

- ▶ **Payer counties** contract with private hospitals and clinics to provide services.

PAYER COUNTIES: Fresno, Merced, Orange, San Diego, and San Luis Obispo.

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

HYBRID COUNTIES: Placer, Sacramento, Santa Barbara, Santa Cruz, Stanislaus, and Tulare.

- ▶ **County Medical Services Program counties** contract with the CMSP Governing Board, which administers health care services through contracts with Anthem Blue Cross for medical benefits and with MedImpact Health System for pharmacy benefits.

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

expansion Medi-Cal beneficiaries; it is consistent with the Kaiser Small Group Health Plan, which California adopted as its benchmark for ACA essential health benefits. Starting in 2014, Medi-Cal managed care plans are required to cover new mental health services for Medi-Cal enrollees (primarily short-term outpatient assessment and counseling services). County mental health plans (MHPs) will continue to provide specialty mental health services (inpatient, residential, and intensive outpatient services) for individuals with serious mental illness meeting medical necessity criteria. The expanded SUD benefits (intensive day rehabilitation, residential treatment, and inpatient detox) are expected to be provided through the existing county-based delivery system.⁷

In addition, the 2013-14 state budget allocated \$182 million in new state resources (\$143 million general fund) to build mental health service capacity and improve access to care. The additional funding will support grants for treatment capacity, crisis stabilization units, mobile crisis teams, additional triage personnel, and peer support programs.⁸

Table 2 on page 6 applies the leadership framework presented in Table 1 to health programs as of January 2014, taking into account the recent state policy changes described above.

What to Watch for in 2014

Given the ACA and state policy changes over the last five years, state and local activities are under way, and outstanding issues will arise, as California moves toward full implementation. This section highlights what policymakers and stakeholders will particularly want to watch for in key program areas affecting county health services.

- ▶ **County indigent care programs.** Most low-income individuals who previously relied on county LIHP and indigent care programs will be eligible for Medi-Cal or subsidized coverage in Covered California, except for undocumented persons and individuals who are not subject to the ACA individual mandate. However, most observers acknowledge that even some of those who are eligible may not actually enroll in coverage right away. Those who remain uninsured are often referred to as the “residual uninsured” population. Counties will have local decisions to make regarding the level and type of indigent care programs they will continue to administer for residually uninsured individuals.

What to Watch for:

- ▶ What will be the size and composition of the “residual uninsured” population?
- ▶ What decisions will counties make about local indigent care programs and services they offer for this population?

Table 2. Applying the Leadership Framework in 2014: Relative State and County Responsibility for Health Programs in California

STATE HAS LEAD RESPONSIBILITY	STATE AND COUNTY SHARE RESPONSIBILITY	COUNTY HAS LEAD RESPONSIBILITY
<p>Medi-Cal State sets policy, program rules, eligibility and funding levels, and provides/manages majority of federal matching funds. Counties conduct eligibility determinations, provide match funding through certified public expenditures for specific populations or services, and county facilities/providers may participate as providers.</p> <p>Covered California State sets policy, program rules, and organizes coverage offerings consistent with state and federal law. Counties may conduct eligibility determinations, and county facilities or local health plans may participate as health plan or provider offerings.</p>	<p>Behavioral Health Mental health and substance use disorder treatment State sets eligibility, benefits, and program rules for Medi-Cal enrollees; oversees state funding streams such as Mental Health Services Act (Proposition 63) and state general funds; and oversees the distribution of federal Medicaid and other categorical funding streams, such as federal Substance Abuse and Mental Health Services Administration funding. Counties determine service delivery methods and provide or arrange for services for all individuals eligible for specialty mental health services (Medi-Cal and uninsured), fund the nonfederal match for Medi-Cal specialty mental health services and some SUD treatment services, and set local eligibility, service, and funding levels for non-Medi-Cal eligible individuals.</p>	<p>Indigent Health Care – Section 17000 Obligation Counties determine eligibility, services, funding levels, and delivery models for low-income individuals not eligible for Medi-Cal, and administer any services or programs established. State oversees federal Medicaid waiver and match funding for county facilities and programs serving uninsured individuals.</p> <p>Public Health Counties define and administer programs and funding levels consistent with local priorities. State establishes minimum local public health program requirements and authority and oversees the pass-through of categorical federal funds, such as Maternal Child and Adolescent Health funds and emergency preparedness grants.</p>

- ▶ How will these county program and funding decisions affect county health system costs and capacity?
- ▶ How and to what extent will counties leverage their former LIHP infrastructure to organize and deliver care for the residual uninsured?

▶ **County delivery systems.** Counties operating public hospitals, clinics, and provider delivery systems have invested in new approaches, capacity, and programs through the Bridge to Reform waiver and LIHP. The long-term sustainability of county health systems ultimately depends on counties being able to maintain and grow their enrolled patient populations as health reform unfolds. Health realignment made county health delivery systems the default when Medi-Cal enrollees do not choose a plan or provider, but beneficiaries can choose or change to a non-county provider.

What to Watch for:

- ▶ How effectively will county health systems compete for both existing and newly covered patients?
- ▶ To what extent will county health system providers gain patients through participation in Covered California and other commercial insurance networks?
- ▶ What impacts will the multiple changes in funding streams, such as the health realignment savings and proposed federal reductions in disproportionate share hospital (DSH) funds, have on the long-term viability of county health systems?

- ▶ What will be the state and local fallout if county systems cannot compete or remain financially viable?

- ▶ **Medicaid expansion.** The ACA changes to Medicaid included coverage expansions for new groups of low-income persons (primarily childless adults) as well as eligibility and enrollment simplifications. Counties and the state will be challenged to successfully navigate the new Medi-Cal eligibility rules. In addition, the state will receive different levels of federal matching funds depending on the category of eligibility (100% for the new populations and 50% for existing eligibility categories).

What to Watch for:

- ▶ What challenges will emerge as the state and counties implement the new program rules for Medi-Cal eligibility and enrollment simplification?
- ▶ How much of the additional costs for increased Medi-Cal enrollment will ultimately be borne by the state versus federal Medicaid funds?
- ▶ **County realignment impacts.** Under the 2013 realignment, counties will provide savings to the state from revenues previously allocated to indigent health care. In the first quarter of 2014, counties made decisions about which methods they will be using to determine realignment savings: the shared savings formula or the 60/40 split. All of the counties with public hospitals chose the shared savings formula, and of the 12 payer/hybrid counties, seven chose the formula

and five chose the 60/40 split.⁴ CMSP counties will implement a version of the 60/40 split.

What to Watch for:

- ▶ What will be the impact for individual counties from the methodologies chosen to estimate health realignment savings?
- ▶ How will the estimates of county savings and state costs compare with actual experience?
- ▶ **Behavioral health expansions.** As a result of changes affecting mental health and SUD services, including the 2011 realignment and expansion of Medi-Cal behavioral health benefits, counties will continue to be the primary providers and funders of public specialty mental health and SUD services. Counties will face new opportunities and challenges in how the services are funded and delivered, and will need to develop and enhance state and local partnerships to ensure the delivery of appropriate services to eligible individuals. Implementation of these changes will require enhanced collaboration, communication, and care coordination between the state, Medi-Cal managed care plans, and counties to ensure Medi-Cal enrollees receive appropriate services in the appropriate setting.

What to Watch for:

- ▶ How will Medi-Cal managed care plans implement the additional Medi-Cal mental health services, and will there be sufficient capacity to meet the increased demand?
- ▶ Will the new responsibilities of Medi-Cal

managed care plans relating to mental health screening and assessment identify more individuals in need of county MHP specialty mental health services? Will there be sufficient capacity and funding to meet the demand?

- ▶ What new openings and potential barriers will emerge from the imperative for counties, health plans, and providers to collaborate in the delivery and financing of mental health services?
- ▶ **Public health impacts.** Counties have a broad statutory mandate to provide local services and programs to “protect the public health of the county,”¹⁰ and they have significant discretion to establish local program priorities, funding levels, and approaches. To support local public health programs and services, counties use realignment funds, county general funds, and federal and state categorical program funds. Under the coverage expansions, more people will have access through public and private coverage for primary and preventive care services historically provided by many county public health programs. These often include immunizations, chronic disease prevention and care management, treatment for sexually transmitted diseases, and family planning. Counties may need to reexamine their program priorities as sweeping changes to the system of health care delivery and financing unfold.

What to Watch for:

- ▶ How and to what extent will counties reshape local public health programs and services in the context of the new culture of coverage?

- ▶ What impact will the multiple changes in county funding streams and funding levels have on county public health programs and funding?
- ▶ How will public health programs that focus on the health of the community, versus the delivery of services to individual people, change or evolve?

Conclusion

This is a time of dynamic change for state and local health service delivery. In the short run, the scope of the changes in California is likely to complicate evaluation of the ACA's effects on state and county health programs. To effectively monitor and understand the full impact of ACA implementation will require not only state program oversight but also ongoing state-level review and analysis of what is happening in counties across the state. Given the diversity of California counties, there will not be one set of common outcomes but many locally influenced variations, innovations, and lessons learned.

This issue brief offers a framework for policymakers and stakeholders to view and consider the leadership roles of the state and counties. It is intended to help decisionmakers identify the policy levers and options for monitoring and improving programs as they evolve. The "what to watch for" section offers a starting point for focusing needed state-level oversight on county health programs during this early stage of ACA implementation.

About the Author

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About the Foundation

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

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Endnotes

1. For more information on the "Bridge to Reform" waiver, see *A Bridge to Reform: California's Section 1115 Medicaid Waiver*, at www.chcf.org.
2. UCLA Center for Health Policy and UC Berkeley Labor Center, *Medi-Cal Expansion Under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State*, January 2013, laborcenter.berkeley.edu.
3. SB x1 1, Chapter 4, Statutes of 2013–14 First Extraordinary Session.
4. While nearly all 2011 realigned programs were transferred to counties in fiscal year (FY) 2011–12, Medi-Cal Specialty Mental Health Services was not realigned until FY 2012–13 because the Legislature diverted Mental Health Services Act funds to support those programs in FY 2011–12. SB 1020, Chapter 40, Statutes of 2012, a 2012–13 budget trailer bill, establishes the permanent financial and account structure for 2011 Realignment.
5. AB 85, Chapter 24, Statutes of 2013.
6. AB 1602, Chapter 655, Statutes of 2010.
7. SB x1 1, Chapter 4, Statutes of 2013–14 First Extraordinary Session.
8. For a more in-depth look at mental health service delivery in California, see *A Complex Case: Public Mental Health Delivery and Financing in California*, prepared for CHCF by Sarah Arnquist and Peter Harbage of Harbage Consulting, at www.chcf.org.
9. Legislative Analyst, *The 2014–15 Budget: Analysis of the Health Budget*, February 20, 2014, www.lao.ca.gov.
10. California Health and Safety Code §101025.

Appendix A: Shaping County Health Services: Proposition 13 to Realignment 2011

In 1978, passage of the tax-cutting ballot measure Proposition 13 set in motion a concentration of decisionmaking at the state level affecting most state and local programs. In the immediate aftermath, Governor Jerry Brown, during his first term, approved AB 8, the so-called “county health bailout,” which backfilled funding for local health and public health programs facing devastating reductions in county property tax revenues.

In 1982, as California grappled with a severe economic downturn, Governor Brown approved transfer to the counties of responsibility for medically indigent adults (MIAs) who were eligible for state-only Medi-Cal. The MIA transfer essentially relied on the county obligation in state law since the 1930s (Welfare and Institutions Code Section 17000) to provide aid and care to the indigent poor. Under the 1982 transfer, the state provided counties 70% of the state funds spent on the population in the prior fiscal year and booked an immediate savings of \$300 million. Larger counties, which came to be known as medically indigent services program (MISP) counties, were required to administer their own indigent care programs. Smaller counties, in recognition that many did not have capacity to administer the programs, had the option to participate in the County Medical Services Program (CMSP), a pooled coverage program.

In the years that followed the MIA transfer, state General Fund appropriations to counties for indigent health care were reduced, driven in part by economic conditions and enactment of Proposition 99 in 1989, which created a new tax on tobacco and dedicated some of the revenue to indigent health care.

By 1991, with California facing yet another severe economic downturn, California enacted “State and Local Program Realignment” (1991 realignment) as a means for achieving two objectives — protecting funding for public health, indigent health, and mental health and social services programs by removing them from near-certain reductions in the state budget and moving responsibility for the programs to counties with a dedicated source of revenue to provide more predictable funding going forward.

The 1991 realignment transferred from the state to the counties program and financial responsibility for indigent health care, public health, community mental health and social services, along with revenues to support the realigned programs (a half-cent sales tax and a dedicated portion of vehicle license fees). While the 1991 realignment started in a declining revenue period, the years that followed saw the programs experience more revenue predictability than when they were subject to the annual state budget process.

In 2011, California enacted a new “Public Safety Realignment” (2011 realignment) primarily designed to address court-ordered reductions to the state prison population and the continuing costs associated with state prison obligations. The 2011 realignment also eliminated state general funds for community mental health services so that by July 1, 2012, counties assumed full funding for the non-federal share of specialty mental health services for Medi-Cal and indigent individuals with severe mental illness and seriously emotionally disturbed children (Early and Periodic Screening, Diagnosis, and Treatment program) as well as various drug

and alcohol treatment programs, including Drug Medi-Cal.

After years of fiscal belt-tightening that dramatically affected state and local funding for health services, voters approved Proposition 30 in 2012 to temporarily raise revenues and get the state’s budget on an even keel. In 2013, the Office of the Legislative Analyst forecast even higher revenues than had been predicted when the 2013–14 state budget was finalized and estimated that, absent any changes to current laws and policies, the state would end 2014–15 with a multibillion-dollar reserve.