

# When Medi-Cal Recedes: Section 17000 and California's County Health Care Backstop

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## Abstract

California counties retain legal responsibility for indigent residents under Welfare and Institutions Code Section 17000, yet that backstop faded from view after the Affordable Care Act, Medi-Cal expansion, and AB 85 redirected local indigent-care financing. That history is newly relevant because California Department of Health Care Services and Legislative Analyst's Office documents indicate that federal policy changes taking effect on October 1, 2026, and January 1, 2027, could increase county exposure to adults losing Medi-Cal, including some noncitizens and others affected by new disenrollment pressures. Using legal and budget materials plus a county-by-county review of official county program and health-system documents, this paper maps California's current indigent-care landscape and the institutional pathways through which counties may absorb coverage loss. Thirty-five counties participate in the shared County Medical Services Program. Among the twenty-three self-administered counties, nineteen maintain visible county-branded indigent-care or uninsured-adult access programs, while four rely on county hospitals, behavioral-health systems, FQHCs, and payment-assistance structures rather than a single named program. County roles also differ qualitatively: Sacramento separates a traditional last-resort program from a distinct undocumented-adult pathway; San Diego and Riverside retain explicit indigent programs; Kern and San Joaquin tie current operations directly to Section 17000 or county mandate; and Los Angeles illustrates how county-built models can recede after statewide expansion. Section 17000 was submerged, not superseded. As federal retrenchment reduces Medi-Cal continuity, county variation in the backstop is likely to shape equity, affordability, and local fiscal strain. California's response to federal coverage losses will therefore depend not only on state policy choices, but also on county institutional capacity.

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## I. Introduction

California's safety net has long rested on more than Medi-Cal. Long before the Affordable Care Act, counties carried legal responsibility for indigent residents under Welfare and Institutions Code Section 17000. Counties financed hospital systems, maintained medically indigent programs, and absorbed adults who were ineligible for categorical coverage. Yet after Medi-Cal expansion and subsequent fiscal realignment, that county backstop largely disappeared from mainstream policy discussion. The disappearance was political and institutional, not legal.

That submerged backstop matters again. California policy documents now indicate that federal changes taking effect on October 1, 2026, and January 1, 2027, could push some adults out of Medi-Cal or create new renewal friction. That pressure will not fall evenly across the state. It will be mediated through county systems that look very different from one another: a 35-county regional program in some places, named county indigent programs in others, and county hospital or clinic-based safety-net structures elsewhere.

This paper asks a descriptive but policy-relevant question: what county backstop infrastructure still exists in California, and through what institutional forms would counties likely absorb renewed coverage loss? The paper does not estimate a causal treatment effect. Instead, it reconstructs a statewide institutional map at a moment when that map may soon become operationally important again.

The contribution is threefold. First, the paper recenters Section 17000 as the organizing institution rather than treating county programs as scattered local anecdotes. Second, it links the fading visibility of county indigent responsibility to ACA-era expansion and AB 85's redirection of county financing rather than implying that county obligations simply vanished. Third, it provides a current statewide county typology built specifically for the 2026-2027 federal retrenchment moment.

The strongest claim is not that counties vary in generosity. The stronger claim is that counties vary in the institutional form of the backstop itself. Some counties retain named last-resort indigent programs. Some separate undocumented-adult pathways from the general backstop. Others preserve county responsibility through county hospitals, behavioral-health systems, FQHCs, and payment-assistance architecture. That institutional variation is the paper's central finding.

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## II. Background and Literature

The historical literature consistently treats counties as California's provider and payer of last resort for uninsured indigent adults. Older Legislative Analyst's Office materials describe county indigent programs as highly variable in eligibility rules, benefits, and financing. Haeder's work on California public hospitals helps explain why county responsibility changed form over time rather than disappearing outright. CHCF reports by Deborah Reidy Kelch similarly show that counties remained central to California's health infrastructure even as the ACA shifted coverage responsibility upward to state and federal programs.

The ACA transition and AB 85 are the key bridge to the current paper. ACA expansion did not replace counties overnight; it reorganized their role. Counties served as bridge institutions through Low Income Health Programs and other local mechanisms. AB 85 then redirected county health realignment funds on

the logic that Medi-Cal expansion had reduced county indigent burden. That sequence helps explain why Section 17000 faded from view. The duty remained, but coverage expansion and fiscal redirection altered who was visible, who paid, and which level of government appeared to matter most.

The closest peer-reviewed literatures are adjacent rather than duplicative. One strand studies county or local access programs such as Healthy San Francisco and My Health LA. Another examines California immigrant coverage expansions and shows that local county infrastructure shaped the timing and reach of statewide expansions. A third looks at county hospitals and local safety-net architecture more broadly. These papers are useful context, but they do not provide a statewide Section 17000 paper organized around AB 85, county heterogeneity, and the current federal retrenchment window.

That gap matters because the legal story is sharper than a general “coverage gap” narrative. Counties may have a clearer obligation toward indigent residents than toward undocumented adults, yet several counties built undocumented-adult pathways on top of their broader safety-net infrastructure. Sacramento is especially useful for that distinction because it maintains both a general last-resort program and a separate undocumented-adult pathway. Los Angeles is useful for the opposite reason: its county-built My Health LA model receded after statewide expansion. Taken together, these counties show that county responsibility was submerged, not superseded.

The current policy moment gives the paper its urgency. DHCS and LAO materials indicate that 2026-2027 federal changes may increase county exposure to disenrollment among populations affected by immigration-status changes, work requirements, and renewal burden. The paper therefore contributes not only institutional history but also a concrete planning framework for California counties and state policymakers.

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### III. Data and Approach

The paper combines three source layers. The first is legal and fiscal history, including Section 17000, ACA transition materials, and LAO and DHCS documents related to realignment and current federal policy changes. The second is a statewide county source inventory based on official county program pages, county health-system pages, CMSP materials, and county hospital or behavioral-health documents. The third is a structured comparison set for counties that best illustrate distinct backstop models.

The unit of analysis is the county as an institutional case rather than a person, encounter, or claim. The goal is to classify county backstop form and document which organizational pathways are visible in public materials. Each county is assigned to a first-level bucket:

1. CMSP county

2. self-administered county with a visible county-branded indigent or uninsured-adult program
3. self-administered county with a fragmented but still visible provider-side safety-net structure

This is a descriptive classification strategy, not a causal design. The project is intentionally transparent about what the source inventory can and cannot establish. It can identify first-order institutional form. It cannot yet fully standardize benefit scope, budget exposure, or the precise population rules for every county.

The statewide inventory resolves all 58 counties at that first level. Thirty-five counties participate in the County Medical Services Program. Among the twenty-three self-administered counties, nineteen maintain visible county-branded access or indigent programs, while four rely on county hospitals, behavioral-health systems, FQHCs, or payment-assistance structures instead of a single named countywide program.

The manuscript then uses a high-value comparison set to move from statewide mapping to policy interpretation. Sacramento, San Diego, Riverside, Kern, Fresno, San Joaquin, San Bernardino, and Ventura are the most useful counties because they clarify how county obligations persist through different institutional forms.

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## IV. Statewide County Landscape

### A. The 35-County CMSP Backbone

The largest portion of the state still sits inside a regional county backstop structure. Thirty-five counties participate in CMSP, which remains the clearest statewide institutional expression of pooled county indigent responsibility. For those counties, the county backstop is not best understood as a local branded program; it is better understood as participation in a shared regional architecture.

This matters for the paper’s core argument. Section 17000 did not collapse into a patchwork of isolated county experiments. In most counties, the backstop remains visible through a multi-county structure. That is analytically important because it means the state does not divide cleanly into “counties with programs” and “counties without programs.” A large set of counties instead operate through a common regional framework.

### B. Nineteen Self-Administered Counties With Visible County-Branded Programs

The most striking descriptive result is how many self-administered counties still maintain explicit county-branded access or indigent programs. Nineteen coun-

ties fall into that category: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Merced, Orange, Placer, Riverside, Sacramento, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Stanislaus, and Tulare.

These counties are the paper’s strongest evidence that Section 17000’s practical relevance did not disappear after Medi-Cal expansion. The specific program names differ, but the common pattern is visible county infrastructure for uninsured or medically indigent adults. Some of these programs explicitly describe themselves as last-resort mechanisms. Others are framed as local access programs. Some remain broad; others are more bounded and facility-linked.

Los Angeles is analytically useful because it captures the “submerged by expansion” story in a single county. My Health LA was an important county-built model, yet the county now illustrates how explicit county-branded coverage infrastructure can recede after broader statewide expansion. That is not evidence that the county role ended; it is evidence that the visible form of that role changed.

### **C. Four Self-Administered Counties With Fragmented Provider-Side Backstops**

A smaller but important set of counties lacks a single branded indigent program while still showing evidence of a county backstop through provider-side infrastructure. Monterey, San Bernardino, Santa Cruz, and Ventura fit this category.

These counties matter because they prevent an overly narrow reading of the statewide landscape. A county should not be coded as having “no backstop” simply because it lacks a neatly branded insurance-style program. In Ventura, the county health system explicitly describes itself as serving patients regardless of ability to pay or immigration status through financial-assistance and access structures. In San Bernardino, the visible backstop appears to run through county hospital financial assistance and county behavioral-health access. These are not identical to MISP or CMISP, but they are still county backstop institutions.

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## **V. County Comparison Set**

### **A. Sacramento: Dual-Track County Design**

Sacramento is the clearest county for distinguishing general indigent responsibility from more discretionary undocumented-adult coverage. CMISP is framed as a last-resort health care program for low-income adults not eligible for other health care programs. Healthy Partners is distinct and explicitly serves low-income undocumented adults. That split shows why the paper should not treat all county coverage pathways as legally equivalent.

### **B. San Diego, Riverside, and Fresno: Legible Last-Resort Programs**

San Diego, Riverside, and Fresno illustrate a highly legible county backstop form: a named county indigent program with explicit last-resort or medically indigent language. San Diego’s County Medical Services materials are especially useful because they describe the program as a last resort for uninsured indigent adult residents. Riverside’s RUHS materials emphasize historical continuity. Fresno provides a useful hospital and FQHC-linked example of short-term assistance for adults with medical need and no available coverage.

### **C. Kern and San Joaquin: Explicit Section 17000 or Mandate Language**

Kern and San Joaquin are among the strongest counties in the paper because official materials tie current operations directly to Section 17000 or county mandate. Kern’s audited financial statements identify the Medically Indigent Adult program as the mechanism through which the county fulfills its Section 17000 duty. San Joaquin’s Medical Financial Assistance materials explicitly say that the program fulfills the county mandate under Welfare and Institutions Code 17000. These counties show that the legal obligation remains operationally visible in at least some current public materials.

### **D. San Bernardino and Ventura: Fragmented but Real Backstops**

San Bernardino and Ventura illustrate a different model. Neither county presents a single countywide indigent insurance-style program comparable to CMISP or MISP. Yet both preserve access through county provider systems and payment-assistance architecture. Ventura is particularly important because the county health system openly frames itself as a safety-net provider regardless of ability to pay or immigration status. These cases show that institutional fragmentation is not the same as disappearance.

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## **VI. Why Section 17000 Matters Again**

The paper’s policy relevance comes from timing. Current DHCS and LAO documents indicate that 2026-2027 federal policy changes may increase county exposure to adults losing Medi-Cal through several channels. Some of those channels involve immigration-related changes. Others involve work requirements or other disenrollment pressures. The exact scale remains uncertain, but the direction of strain is clear enough for a planning paper.

The key point is that California’s response will not depend only on statewide coverage policy. It will also depend on county institutional capacity. Counties with clear county-branded programs may absorb coverage losses differently from counties that rely on fragmented provider-side arrangements. CMSP counties may face different operational pressures from large self-administered counties.

Counties that maintain a separate undocumented-adult pathway, such as Sacramento, may be positioned differently from counties that maintain only a general indigent backstop.

This county heterogeneity has direct implications for equity and affordability. If adults losing Medi-Cal encounter sharply different local backstops depending on county residence, then federal retrenchment may widen substate disparities in access and financial strain. That implication is important even in the absence of a causal design because it identifies where California’s next coverage stresses are likely to surface.

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## VII. Discussion

This paper makes a narrow but original contribution. It does not claim that counties will necessarily experience identical fiscal shocks or that every county-branded program is equally generous. It claims something more defensible and more useful: California still has a county backstop, but that backstop is institutionally heterogeneous and newly relevant.

That framing helps reconcile several otherwise disconnected literatures. County indigent obligations, public hospital history, local undocumented-adult access programs, ACA transition mechanisms, and AB 85 realignment are usually discussed separately. Organizing the paper around Section 17000 shows how they fit together. Section 17000 explains why county obligation persisted. ACA expansion explains why the visible need for county programs temporarily receded. AB 85 explains why the fiscal and political salience of county indigent care diminished. The 2026-2027 federal policy window explains why those county institutions matter again.

The paper also has immediate planning value. County and state policymakers need a statewide map of existing county backstop forms before federal retrenchment pressures fully materialize. A county typology cannot answer every budget or coverage question, but it can identify where the institutional pathways already exist and where they appear thinner or more fragmented.

Two limitations are important. First, the source inventory is strongest at the first typology level, not at the full benefit-design level. The paper can establish whether a county has a visible program or provider-side backstop, but not yet the complete scope of benefits, budgets, or provider networks in every county. Second, this is a noncausal policy analysis. It does not estimate the effect of county backstop variation on access, spending, or health outcomes. Those are appropriate next-step questions once the institutional map is established.

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## VIII. Conclusion

Section 17000 did not disappear after ACA expansion. It was submerged by broader coverage gains and by fiscal and administrative shifts that made county responsibility less visible. The statewide county scan presented here shows that the backstop remains active through three institutional forms: CMSP, visible county-branded indigent or uninsured-adult programs, and fragmented provider-side county safety-net systems.

That finding matters because California is entering a new period of potential Medi-Cal retrenchment. If coverage losses rise in 2026 and 2027, county variation in the form of the backstop is likely to shape who gets help, through what channel, and with what degree of administrative friction. California's response to federal coverage loss will therefore depend not only on state policy choices but also on county institutional capacity. The right question is not whether Section 17000 still exists. It does. The right question is what form it now takes and how unevenly that form is distributed across the state.

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## Figures

### Figure 1. California County Backstop Typology

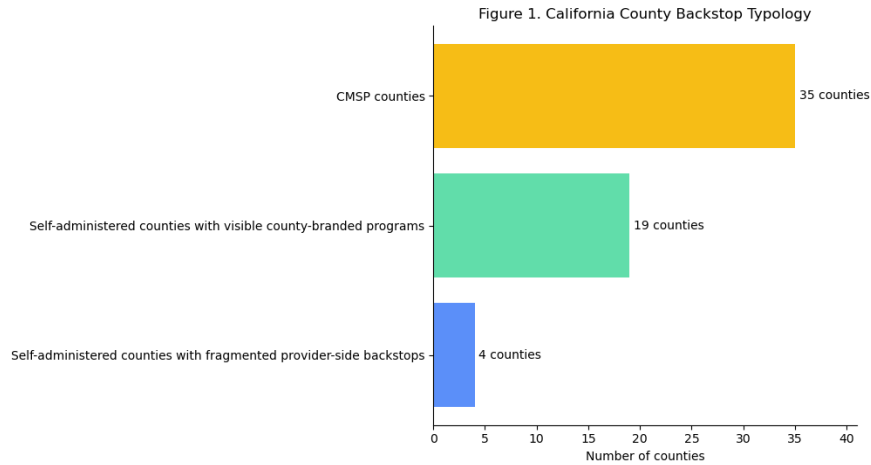
Generated from the statewide county source inventory at `figure1_county_typology.png`. The figure makes the paper's main descriptive point visible at a glance: most counties sit inside CMSP, a smaller but still substantial set of self-administered counties retains visible county-branded programs, and only a small set appears to rely on more fragmented provider-side structures.

### Figure 2. High-Value County Comparison Matrix

Generated from the structured county comparison file at `figure2_high_value_county_matrix.png`. The matrix highlights why Sacramento, San Diego, Riverside, Kern, Fresno, San Joaquin, San Bernardino, and Ventura anchor the manuscript: they differentiate explicit Section 17000 or mandate language, last-resort framing, undocumented-adult pathways, and fragmented provider-side backstop models.

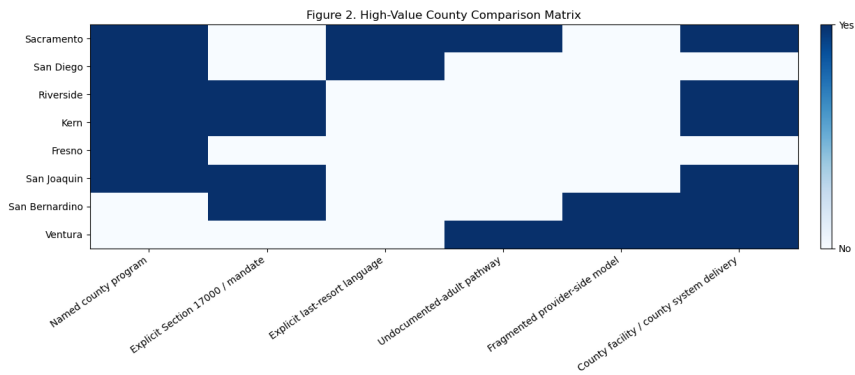
### Figure 3. Section 17000, Expansion, AB 85, and the 2026-2027 Retrenchment Window

Generated from the manuscript-supporting chronology at `figure3_policy_timeline.png`. The figure makes the paper's core historical argument visible in one line: county indigent responsibility was not repealed, but submerged first by expansion-era bridge financing and then by AB 85's fiscal redirection, before reemerging as a practical planning issue under the January 1, 2026, October 1, 2026, and January 1, 2027 retrenchment dates.



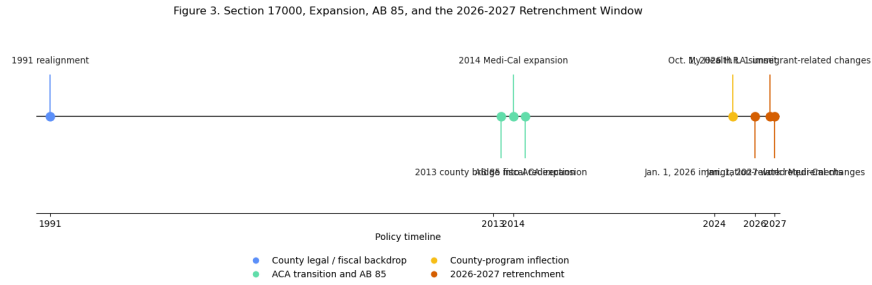
**Figure 1:** Figure1 County Typology

*Note:* This figure presents the county Typology. It is included to make the empirical design, sample structure, or headline result easier to read alongside the surrounding text.



**Figure 2:** Figure2 High Value County Matrix

*Note:* This figure provides contextual structure for the high Value County Matrix. It summarizes the policy setting, mechanism, or empirical workflow used to interpret the estimates.



**Figure 3:** Figure3 Policy Timeline

*Note:* This figure provides contextual structure for the policy Timeline. It summarizes the policy setting, mechanism, or empirical workflow used to interpret the estimates.

## Tables

**Table 1. Statewide County Backstop Typology**

Reproducible source table: `table_county_typology.csv`

County group	Count	Interpretation
CMSP counties	35	Shared regional county backstop structure
Self-administered counties with visible county-branded programs	19	Explicit county indigent or uninsured-adult access infrastructure
Self-administered counties with fragmented provider-side backstops	4	County responsibility preserved through hospitals, clinics, behavioral health, or financial-assistance systems

*Notes:* This table documents the source files, scripts, variables, or data inputs used in the analysis. It is included to make the construction of the analytic evidence reproducible.

**Table 2. High-Value County Comparison Set**

Reproducible source table: `table_high_value_county_comparison.csv`

County	Backstop form	Why it matters
Sacramento	Named indigent program plus separate undocumented-adult pathway	Cleanest distinction between general county obligation and undocumented-adult county discretion
San Diego	Named last-resort indigent program	Strong example of explicit last-resort county language
Riverside	Named indigent program through county health system	Illustrates historical continuity of a visible county program
Kern	Hospital-based indigent program tied to Section 17000	One of the clearest current links between county operations and Section 17000
Fresno	Named short-term medically indigent program	Useful hospital/FQHC-linked inland county comparator
San Joaquin	County facility program tied to Section 17000 mandate	Strong official statement that the county mandate remains active
San Bernardino	Fragmented county hospital and behavioral-health backstop	Shows county responsibility can persist without a single named program
Ventura	Fragmented provider-side safety-net architecture	Shows an explicit county safety-net role without an

The full county-by-county inventory used to build the manuscript is available at `table_county_landscape.csv`.

### **Table 3. Policy Timeline Anchors**

Reproducible source table: `table_policy_timeline.csv`

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## **References**

Full citations are maintained in `bibliography.bib`.

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# **Appendix: California’s County Health Care Backstop**

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## **Appendix A. County Classification Rules**

Counties were classified using official county program pages, county health-system pages, CMSP materials, county hospital financial-assistance materials, and county behavioral-health pages. The classification goal was intentionally limited to first-order backstop form.

### **Classification buckets**

1. `CMSP county` Counties participating in the County Medical Services Program.
2. `self-administered county with visible county-branded program` Counties with an identifiable county-branded indigent-care, uninsured-adult, or county medical access program.
3. `self-administered county with fragmented provider-side backstop` Counties where the backstop is visible through county hospitals, clinics, behavioral-health systems, or payment-assistance structures rather than one named countywide program.

This appendix does not claim that all counties in the same bucket offer identical benefits, budgets, or eligibility rules. The bucket captures institutional form, not generosity.

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## Appendix B. CMSP Counties

The following 35 counties participate in CMSP:

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.

The central implication is that most California counties still sit inside a shared county indigent-care structure rather than an isolated local program.

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## Appendix C. Self-Administered Counties With Visible County-Branded Programs

County	Program or structure	Status	Notes
Alameda	HealthPAC	Active	County page explicitly states citizenship is not required.
Contra Costa	Basic Health Care	Active	County materials state the program is available regardless of documentation status.
Fresno	Medically Indigent Services Program	Active	Short-term assistance for adults with medical need and no available coverage.
Kern	Medically Indigent Adult Program plus Kern Medical Wellness Program	Active	County financial statements explicitly tie operations to Section 17000.
Los Angeles	My Health LA	Historical, sunset 2024	Important example of a county-built model that receded after statewide expansion.
Merced	Medical Assistance Program	Active	County criteria and FAQs identify a medically indigent assistance pathway.
Orange	Medical Safety Net	Active	County SSA materials identify a county safety-net program for adults ages 21-64.
Placer	Medical Care Services Program	Active	County-based medical access program for adults not eligible for Medi-Cal.
Riverside	Medically Indigent Services Program	Active	County health-system materials link the program to longstanding indigent-care operations.

County	Program or structure	Status	Notes
Sacramento	CMISP plus Healthy Partners	Active	Strong dual-track county with both general indigent and undocumented-adult pathways.
San Diego	County Medical Services	Active	Program of last resort for uninsured indigent adults.
San Francisco	Healthy San Francisco	Active	Long-running local access program that remains in place.
San Joaquin	Medical Financial Assistance / Medical Assistance Program	Active	Official materials explicitly tie the program to Section 17000.
San Luis Obispo	Medically Indigent Services Program	Active	Short-term assistance for immediate medical need and no source of coverage.
San Mateo	ACE	Active	Locally funded access program for low-income adults outside other insurance pathways.
Santa Barbara	Indigent Care Program plus Benefits and Referral Center	Active	County health-program structure visibly preserves an indigent-care pathway.
Santa Clara	PCAP	Active	Local low-cost coverage pathway for uninsured adults.
Stanislaus	IHCP / Medically Indigent Adult component	Active	County clinic-based indigent health structure remains visible in HSA materials.
Tulare	TCMS	Active	Program helps pay for care for low-income uninsured residents who do not qualify for Medi-Cal.

*Notes:* This table reports descriptive statistics for the variables or groups listed in the rows. Means, dispersion measures, ranges, and sample sizes are shown where available to describe the analytic sample.

## Appendix D. Self-Administered Counties With Fragmented Provider-Side Backstops

County	Structure	Why it matters
Monterey	County clinic system plus Medi-Cal navigator and low-income referral infrastructure	Shows a county backstop embedded in clinics and navigation rather than a single program name.
San Bernardino	County hospital financial assistance plus county behavioral-health access	Illustrates a county where the backstop appears real but institutionally fragmented.
Santa Cruz	County FQHC and homeless-health access structure	Shows targeted county access without a countywide coverage-style program.
Ventura	County self-pay discount, charity care, sliding-fee programs, and behavioral-health access	Strong example of a visible county safety-net role without a single insurance-style indigent program.

*Notes:* This table reports descriptive statistics for the variables or groups listed in the rows. Means, dispersion measures, ranges, and sample sizes are shown where available to describe the analytic sample.

## Appendix E. High-Value County Comparison Notes

### Sacramento

Sacramento is the strongest county for separating the traditional county indigent backstop from a distinct undocumented-adult pathway. CMISP is framed as a last-resort program for adults not eligible for other coverage. Healthy Partners is explicitly for low-income undocumented adults. This distinction is central to the manuscript’s argument that counties may have a clearer obligation toward indigent residents than toward undocumented adults, even when they choose to do both.

### San Diego and Riverside

San Diego and Riverside are high-value comparators because both retain legible named indigent programs with current county-facing materials. They show that county indigent responsibility remains visible in some large counties even after Medi-Cal expansion.

### Kern and San Joaquin

Kern and San Joaquin are especially valuable because official materials explicitly reference Section 17000 or county mandate. These counties provide the strongest current operational evidence that Section 17000 remains more than dormant legal text.

## San Bernardino and Ventura

San Bernardino and Ventura illustrate the fragmented model. Their importance is conceptual: they show why the paper should not define county backstops only by the existence of a branded county indigent program.

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## Appendix F. Current Figure and Table Build

The current analysis layer now includes the following manuscript-supporting outputs:

1. A statewide typology table at `table_county_typology.csv`.
2. A county-by-county landscape table at `table_county_landscape.csv`.
3. A cleaned high-value comparison table at `table_high_value_county_comparison.csv`.
4. A statewide county typology figure at `figure1_county_typology.png`.
5. A high-value county comparison matrix at `figure2_high_value_county_matrix.png`.
6. A policy timeline table at `table_policy_timeline.csv`.
7. A policy timeline figure at `figure3_policy_timeline.png`.

The current exhibit layer now covers the paper's three core descriptive needs: statewide county typology, high-value county comparison, and the chronology connecting Section 17000 to the 2026-2027 retrenchment window.

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## Appendix G. Limitations of the County Scan

This source inventory is strongest at identifying institutional form. It is weaker at fully standardizing:

- exact benefit scope
- budget size
- provider-network breadth
- post-2024 operational changes in every county
- the practical interaction between county programs and new federal restrictions once implementation begins

Those remaining gaps do not undercut the paper's central descriptive contribution. They define the next research step.