



NATIONAL

HEALTH

LAW PROGRAM

Foster Youth Access to Medi-Cal Specialty Mental Health Services:

A Review of the Data in California and the Counties with the Largest Foster Care Populations

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Executive Summary

Children and youth involved in child welfare have complex mental health needs, due in part to their compounding experiences with trauma and often inadequate access to appropriate services. In California, the State's Medicaid program (Medi-Cal) provides a critical safety net for foster children and youth. In Medi-Cal, County Mental Health Plans (MHPs) provide Specialty Mental Health Services (SMHS) to beneficiaries with intensive mental health needs.

This report series examines the extent to which foster children and youth in California have meaningful access to Medi-Cal SMHS. Our research focuses on the policies and practices of the five California counties with the largest foster youth populations: Los Angeles, San Bernardino, Riverside, Fresno, and Orange. Our research is presented in three parts: (1) a review of county policies, procedures, and beneficiary-facing materials; (2) a review of the available data in California and the counties; and (3) results from qualitative research studies in the five counties, including a survey of providers and advocates as well as test calls to each county's 24/7 mental health access line.

Taken together, this research seeks to provide a multifaceted picture of foster youth access to Medi-Cal SMHS on the ground. Our analyses suggest that many children and youth are not receiving the services they need to address their mental health conditions and to which they are entitled. In our reports, we make a number of recommendations for improving access to SMHS for foster children and youth, including enhancing State oversight of the counties, implementing greater data transparency, and improving education and training for county staff and providers.

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Introduction

Purpose and Goals

California's children and youth face an escalating mental health crisis. The COVID-19 pandemic has added new and complex stressors, exacerbating mental health challenges while also creating new barriers to accessing care. Thus, more children and youth than ever are experiencing intensive behavioral health needs. This is especially true for children and youth in foster care, who have unique health care needs due to their complex histories of trauma and often poor access to appropriate services prior to entering care. In addition, a disproportionate number of children and youth in foster care are children and youth of color: only 5.4% of children and youth in California are Black, but over 21% of children and youth in foster care in the State are Black; 48% of children and youth in California are Latino, but Latino youth make up 50% of foster youth in California; by contrast, white children, who make up over 28% of children and youth in California, constitute only 22% of youth in foster care.¹ The American Academy of Pediatrics identifies the impact of racism as a “core social determinant of health,” noting that it is linked to chronic stress and disparities in mental health conditions in children and adolescents. It is thus especially important that foster children and youth receive the full array of mental health services that they need and to which they are legally entitled.

Most foster children and youth are eligible for Medicaid. California operates the country's largest Medicaid program, Medi-Cal. Medi-Cal provides a critical safety net to millions of children, youth, and families. In Medi-Cal, County Mental Health Plans (MHPs) are responsible for providing Specialty Mental Health Services (SMHS), which have historically been targeted for beneficiaries with the most serious conditions.² Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions provide Medicaid-eligible children with a broad entitlement to mental health care.³ Effective January 2022, California updated and expanded the Medi-Cal SMHS criteria for access, which makes it easier for foster children and youth to access these services.⁴

This report is one part of a three-part series examining the extent to which foster children and youth in California have access to Medi-Cal SMHS.⁵ This report reviews the data available regarding the use of SMHS by children and youth in Medi-Cal, including children and youth involved in child welfare. Understanding how and to what extent children and youth are accessing these

services is an important component of accountability, especially given the particular need that children and youth in Medi-Cal have for these services. SMHS include a range of outpatient and inpatient services available to beneficiaries who meet medical necessity criteria, as consistent with the beneficiaries' mental health treatment needs and goals.⁶ In addition, we reviewed data regarding access to two specific intensive SMHS for children and youth under age 21: Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS).⁷ These two home-and-community-based services are critical for children and youth with more intensive mental health needs. Our report reviews five years of data (2016–2021), summarizes where this data suggests that children and youth may not have access to the services they need, and makes recommendations for improving the access gaps evidenced in the data in order to improve oversight and accountability for the children and youth who need these critical services.

Methodology

This research focused on Medi-Cal SMHS for children and youth in five counties in California: Los Angeles, San Bernardino, Riverside, Fresno, and Orange. These five counties were selected because they had the largest foster care populations in July 2022.¹⁰ We began our research by examining data reported on the “California Health and Human Services (CalHHS) Open Data Portal” and the “DHCS Behavioral Health Reporting Data Hub,” which are both run by the California Department of Health Care Services (DHCS).¹¹ DHCS publishes several dashboards under its “DHCS Behavioral Health Reporting Data Hub,” which presents claims data aggregated by Fiscal Year at the State and county levels from Short-Doyle/Medi-Cal Phase II, California Medicaid Management Information Systems, Fee-for-Service SMHS inpatient claims, and Medi-Cal Eligibility data.¹²

For this project, we analyzed the “Children and Youth SMHS Performance Dashboard,” which covers children and youth under the age of 21 and the

ICC is “a targeted case management service that facilitates assessment of, care planning for, and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.”⁸

IHBS are “individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth’s functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child or youth’s family’s ability to help the child or youth successfully function in the home and community.”⁹

“Children and Youth in Foster Care SMHS Performance Dashboard,” which covers children and youth under the age of 21 in foster care.¹³ Both Performance Dashboards outline demographic data, snapshot data, utilization data, and time to step down data.¹⁴ The data sets are interactive and allow users to create graphs based on geography, fiscal year, demographic data, and utilization data.¹⁵ We utilized the corresponding data posted on the CalHHS Open Data Portal to create graphs for this report.¹⁶

Our research focused on penetration rates, Intensive Care Coordination (ICC) usage, and Intensive Home Based Services (IHBS) usage for each population, both county and statewide (for comparison purposes).¹⁷ We examined fiscal years 2016 through 2021 because, at the time of our research, 2021 was the most recent year for which data was available on the Dashboard. The Data Hub contains additional data not included in this research because it was beyond the scope of our target population.¹⁸ We utilized data from the California Department of Social Services (CDSS) to identify the foster care population in each county and statewide. CDSS identifies the “foster youth population” as children and youth having an out-of-home-placement (OOHP) in the fiscal year. This population is a subset of the children and youth with Open Child Welfare Cases, which also includes those who are receiving child welfare services while living in their home. CDSS and DHCS count and report this data differently. The CDSS Child Welfare Data is collected as a point-in-time, whereas DHCS uses an annual cumulative total. Finally, we reviewed DHCS’s annual network certification reports and counties’ triennial review system reports from 2016 to 2021, to evaluate the counties’ compliance with timely access and provider ratio rules.¹⁹

Limitations

Our research has several limitations. First, all of the data sources that were crucial to our research came from the publicly available websites run by state agencies, primarily CalHHS and DHCS. Although we were able to obtain additional information about the data directly from DHCS, our data sources and information were still limited to what was publicly available and provided by the State. For example, we recognized that access to health care services can vary greatly within a county (especially in counties such as San Bernardino County, which include both urban and large rural areas). We initially hoped to conduct further county-level analysis. However, because all of the data we had access to was either state or county wide, we could not further investigate how SMHS were utilized within each county. Also, because the datasets that we utilized suppressed values between 1 and 10, we were unable to examine smaller data points and the underlying reasons for these smaller data points. Additionally, since we relied on the State’s data sources and information, our findings were subject to biases and confounding that may have influenced the State’s original data collection and reporting.

During our research, we found that there was data that used to be but is no longer publicly available. In the past, DHCS would publish *Katie A. Specialty Mental Health Reports*, which provided monthly updates on foster youth SMHS utilization rate in each county.²⁰ These reports included critical information such as utilization rate of ICC and IHBS by county, the units (amount) of these services provided, as well as the admission rate to psychiatric health facilities.²¹ Though DHCS continues to publish *Katie A.* monthly and annual reports to the Open Data Portal, these reports are significantly different from the reports published prior to 2020, which included more analysis of the data. The reports on the Open Data Portal still include data related to foster children and youth SMHS. However, the information that used to be published, such as utilization rate and specific ICC and IHBS data, is no longer published as a PDF report with the information visualized into graphs.²² This change in reporting practice, and the lack of detailed information about these services, significantly limits the accessibility of the data, as users must now analyze the data themselves using the *Katie A. (KTA) Report Tool*.

We also experienced challenges in locating the information we needed and navigating the various state-run datasets. Because raw data is not available on the DHCS Behavioral Health Reporting Data Hub, we often had to search for corresponding datasets on the CalHHS Open Data Portal. However, although some of the datasets on CalHHS's Open Data Portal seemed to have the same data sources as the datasets listed on DHCS's website, many of them had different names or contained different filters. For example, upon conducting extensive research on both CalHHS and DHCS's data systems, we thought that DHCS's "Children and Youth Under the Age of 21 Specialty Mental Health Services (SMHS) Performance Dashboard" looked similar to CalHHS's "Children and Youth Specialty Mental Health Services Utilization" dataset.²³ However, because neither dataset had a direct link to each other and the DHCS dashboard only provided selected data, we were unable to confirm their connection. After weeks of engaging in further research and communicating with DHCS, we eventually confirmed that the two datasets contained the same information and that the CalHHS dataset, "Children and Youth Specialty Mental Health Services Utilization," was a part of its "Children and Youth Under the Age of 21 Performance Dashboard."²⁴

Another issue we encountered was that most of the datasets did not clearly list the sources of their data. This information is important, as it helps users understand the reliability of the data sources and any potential biases or limitations. Although some of the data sources can be found in the SMHS Performance Dashboard User Guide, most of the datasets do not include a direct data source. Additionally, not all of the dashboards link to the User Guide, which contain the data sources. Having this information listed on each dashboard page would make the datasets more user friendly.²⁵ A related issue that we encountered was that some of the datasets did not clearly define its

target populations and how the number (or denominator) was arrived at. For example, when examining the “Children and Youth in Foster Care SMHS Performance Dashboard,” we could not locate information on how DHCS defined “in foster care” or what methodology was utilized to calculate the number of children and youth included in that dataset. This information is necessary to enable users to understand the data and its limits, as well as to give users the ability to compare it with other datasets.²⁶

Additionally, during our research, we found that some datasets contain descriptions with invalid links.²⁷ Also, as previously mentioned, per the SMHS Performance Dashboard User Guide, the state run datasets are supposed to be updated “annually around the second quarter of the calendar year.”²⁸ However, when we conducted our research in Spring 2023, we were unable to locate any data for 2022. We decided to focus on fiscal years 2016 to 2021, as they were the most recent years available on the Dashboard.

Findings

1. Foster Care Population in Five Counties by Year from 2016 to 2021²⁹

Figure 1a. Foster care population in five counties by year from 2016 to 2021. This graph represents the population of children and youth under age 21 who had an out of home child welfare placement in each county. This data is drawn from CDSS’s July 1 point-in-time datasets for each year.

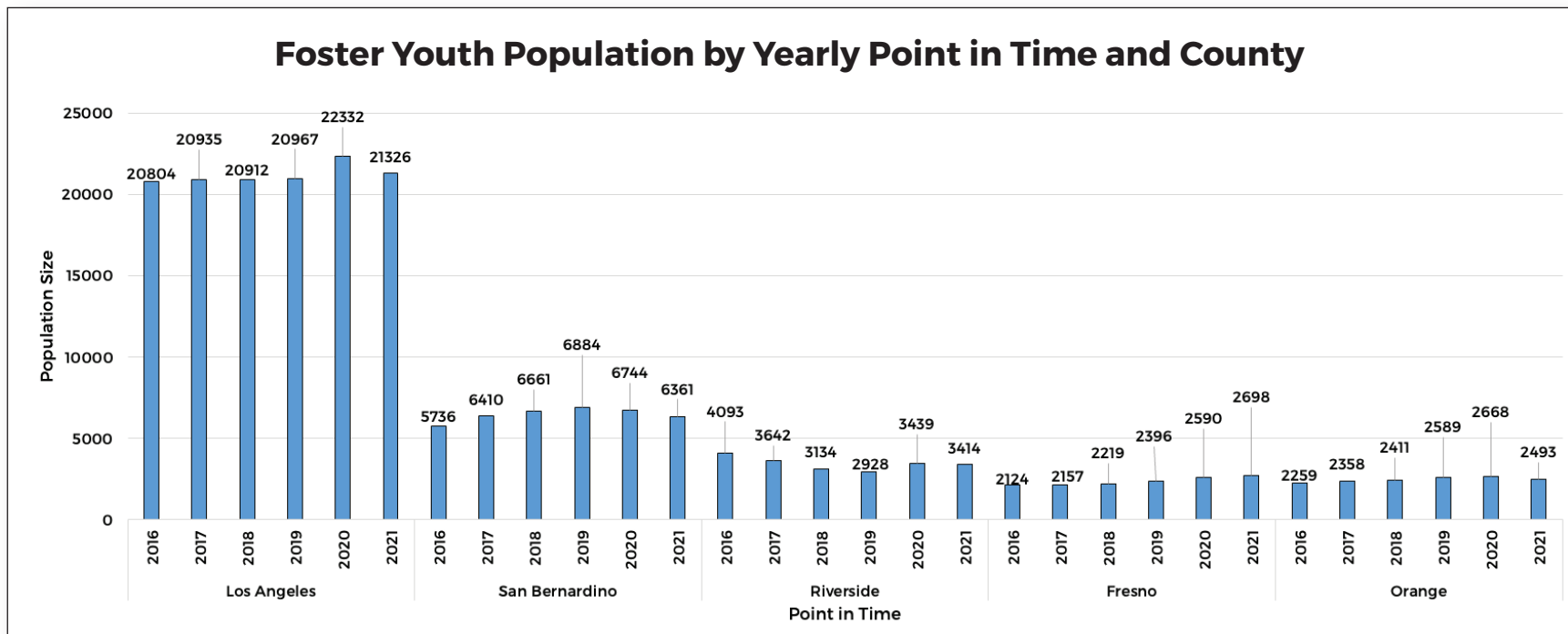
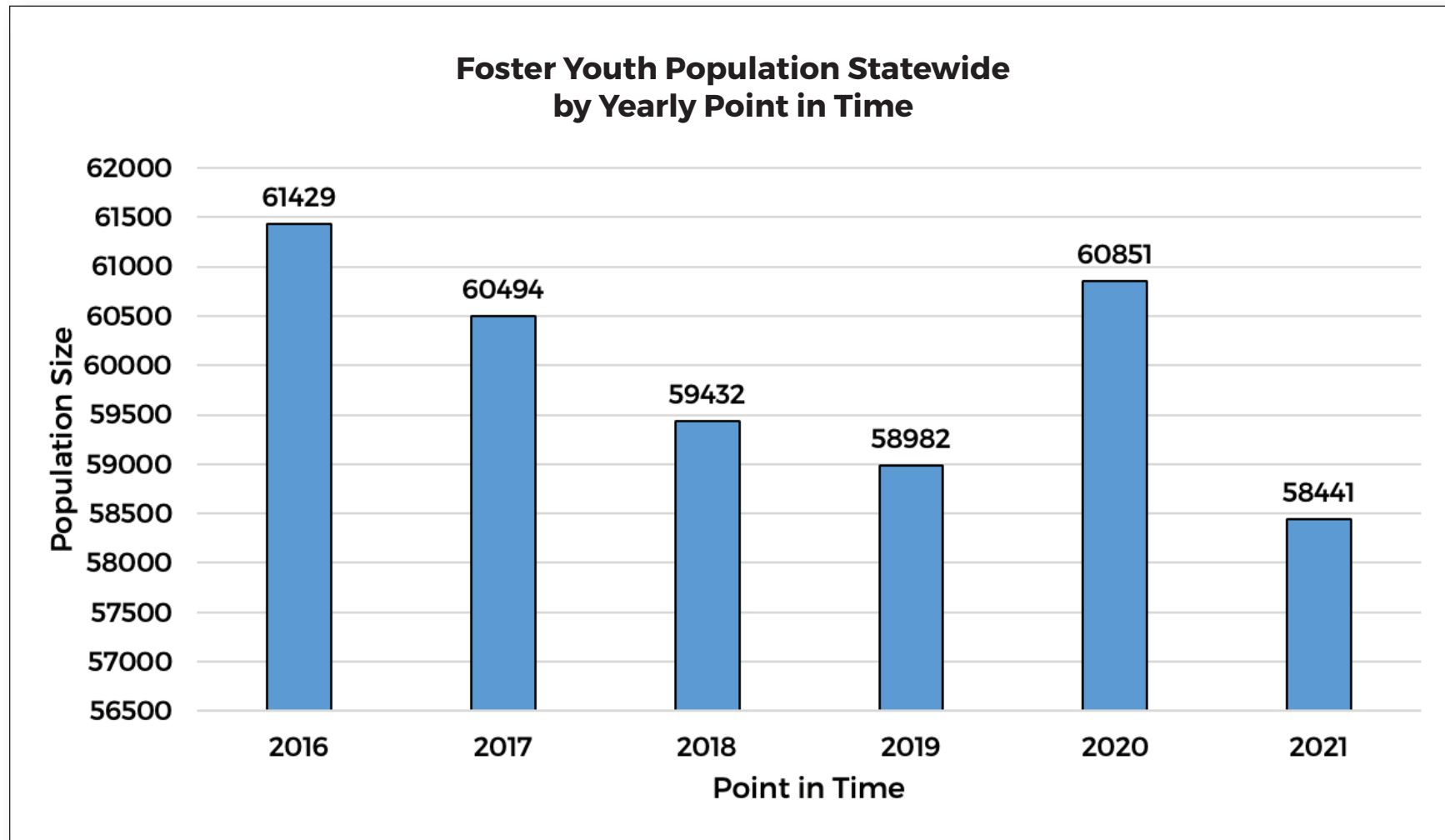


Figure 1b. Statewide foster care population by yearly point in time from 2016 to 2021. This graph represents the population of children and youth under age 21 who had an out of home child welfare placement statewide. This data is drawn from CDSS's July 1 point-in-time datasets for each year.



2. SMHS Penetration Rate

Figure 2a. One or more visits, SMHS penetration rate for all children and youth statewide. This graph represents the percentage of children and youth under the age of 21 on Medi-Cal who received one or more SMHS in a fiscal year statewide. This data is drawn from DHCS's Data Hub Performance Dashboards.

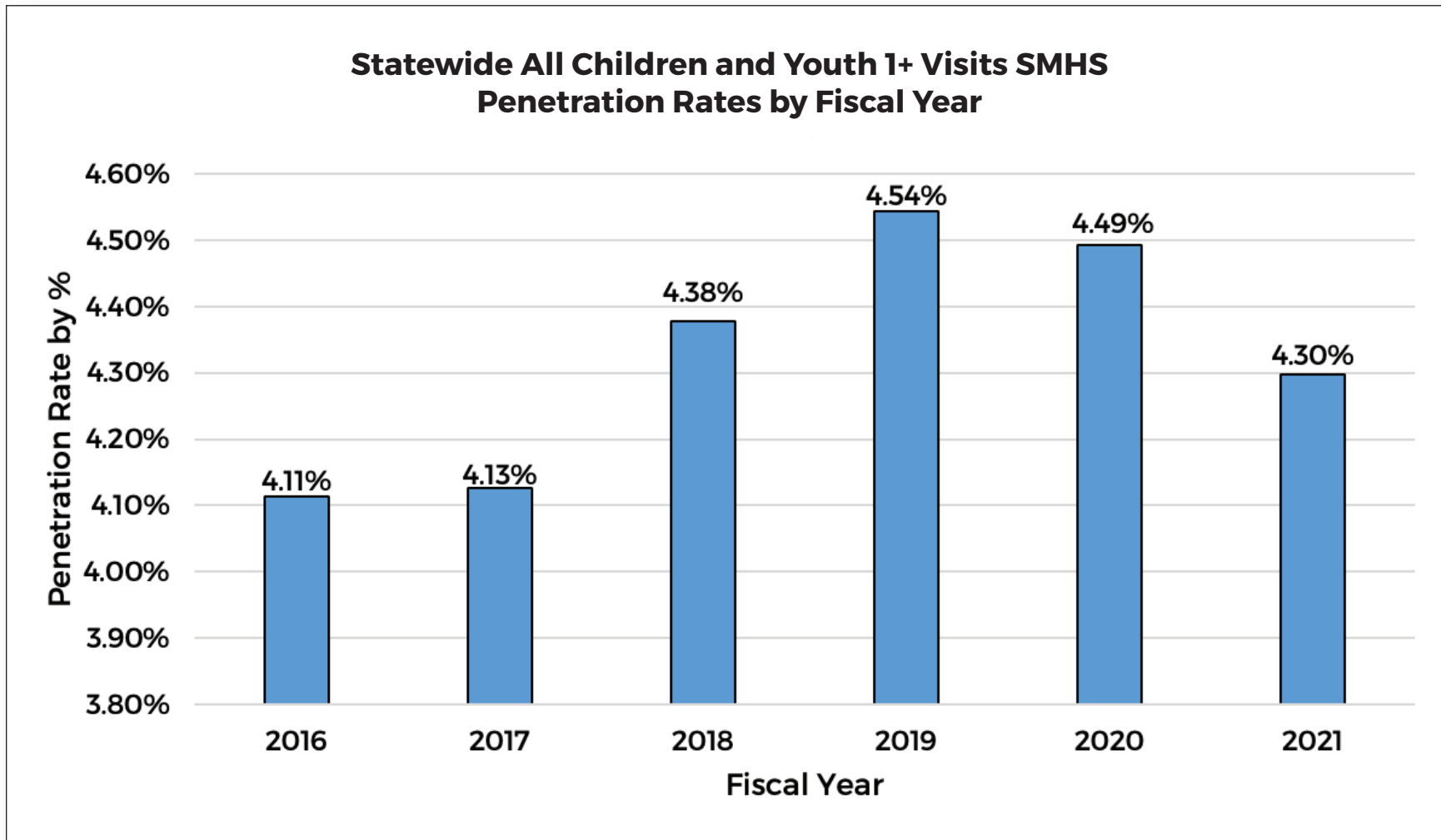


Figure 2b. Five or more visits, SMHS penetration rate for all children and youth statewide. This graph represents the percentage of children and youth under the age of 21 on Medi-Cal who received five or more SMHS in a fiscal year statewide. This data is drawn from DHCS’s Data Hub Performance Dashboards.

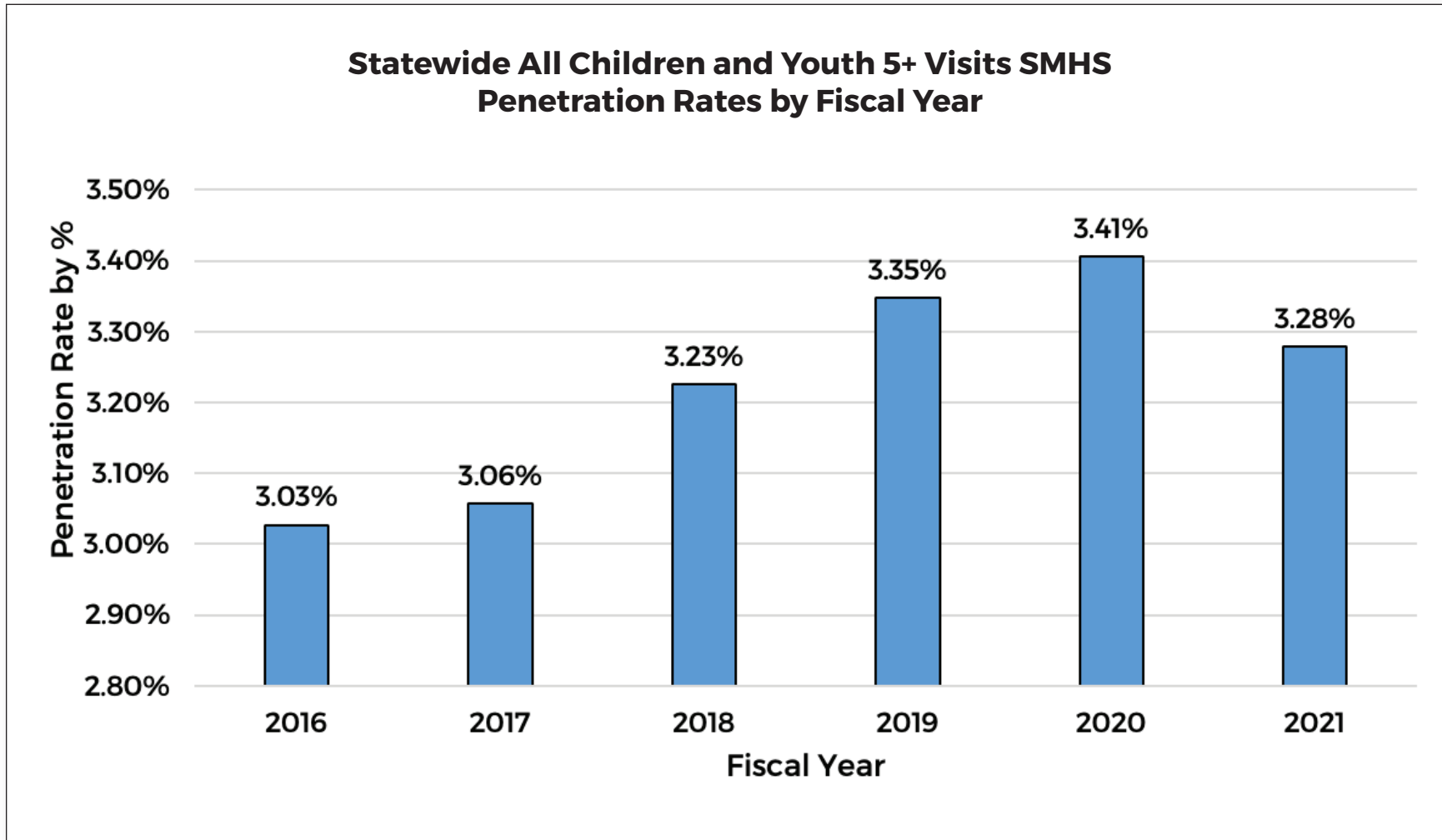


Figure 2c. One or more visits, SMHS penetration rate for foster children and youth statewide. This graph represents the percentage of children and youth in foster care under the age of 21 on Medi-Cal who received one or more SMHS in a fiscal year statewide. This data is drawn from DHCS's Data Hub Performance Dashboards.

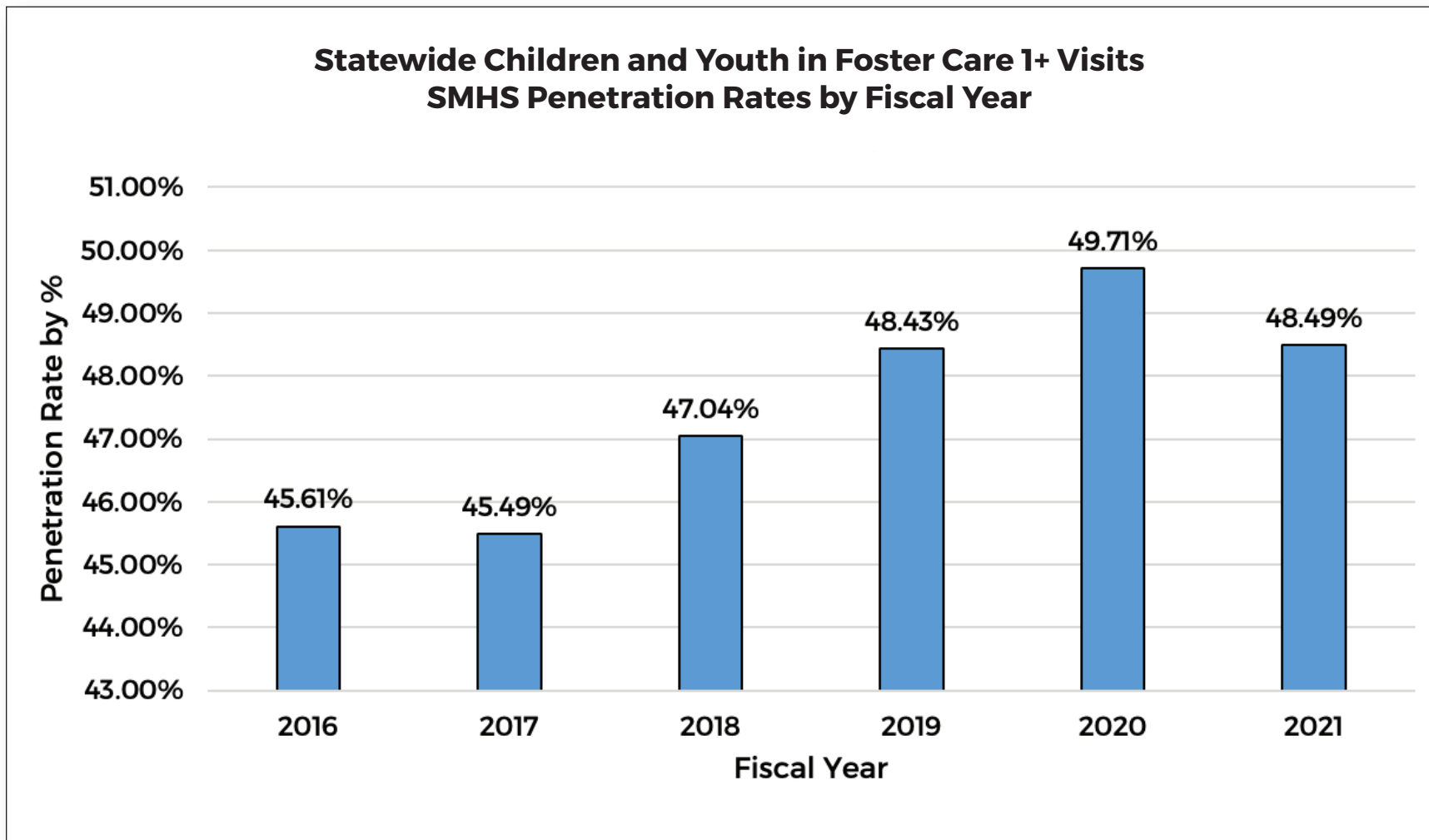


Figure 2d. Five or more visits, SMHS penetration rate for foster children and youth statewide. This graph represents the percentage of children and youth in foster care under the age of 21 on Medi-Cal who received five or more SMHS in a fiscal year statewide. This data is drawn from DHCS’s Data Hub Performance Dashboards.

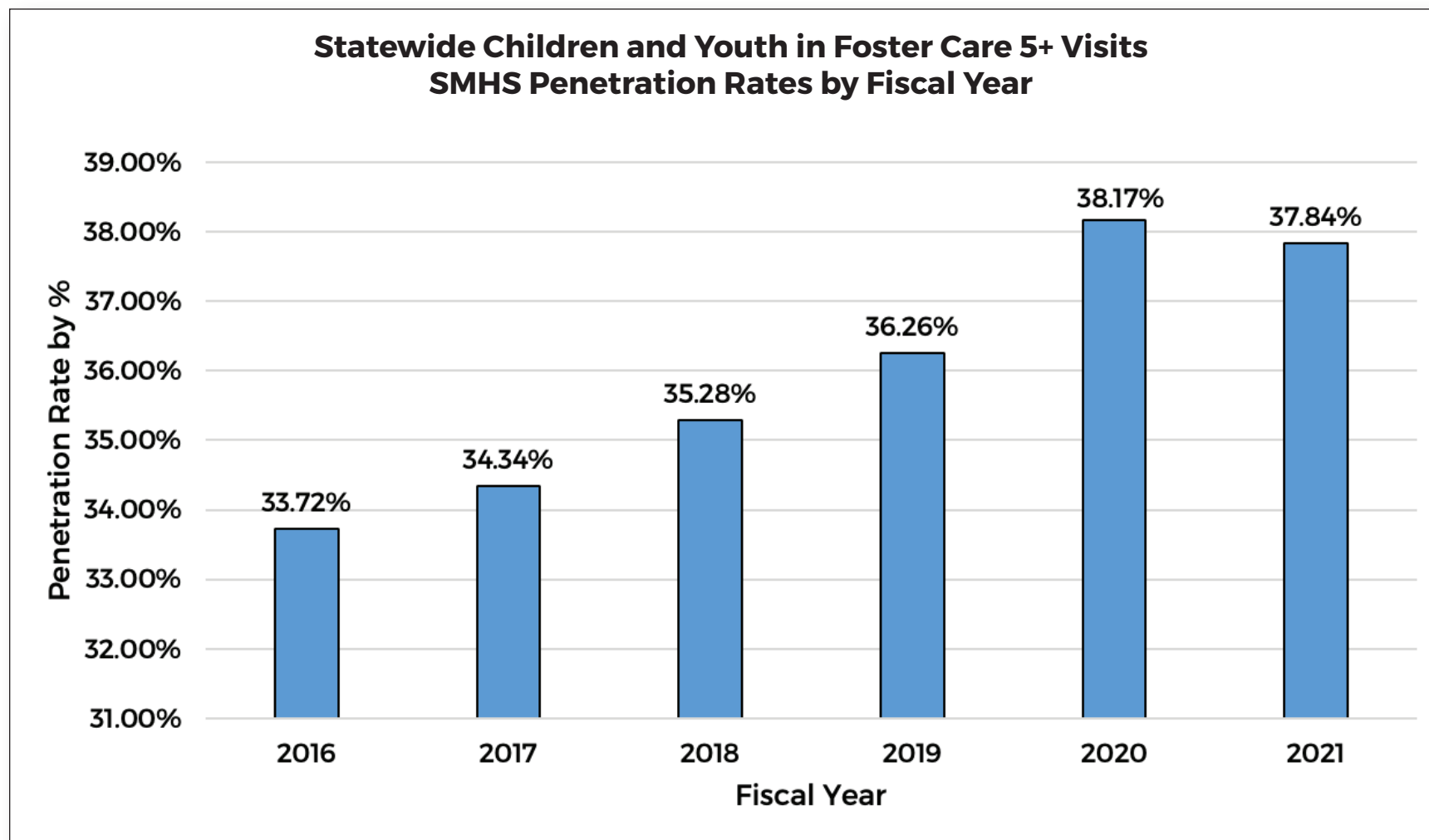


Figure 2e. One or more visits, SMHS penetration rate for all children and youth by county. This graph represents the percentage of children and youth under the age of 21 on Medi-Cal who received one or more SMHS in a fiscal year by county. This data is drawn from DHCS’s Data Hub Performance Dashboards.

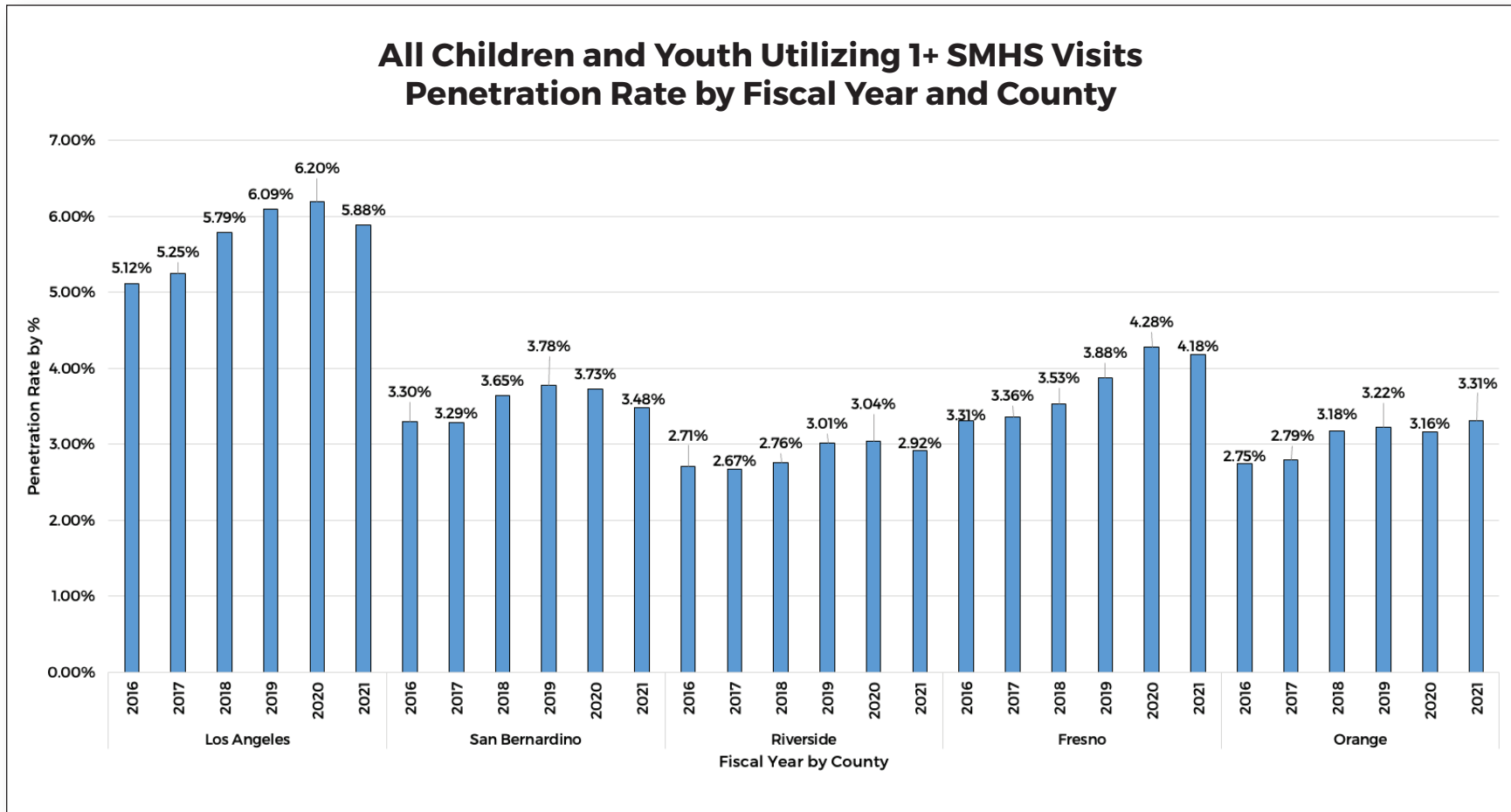


Figure 2f. Five or more visits, SMHS penetration rate for all children and youth by county. This graph represents the percentage of children and youth under the age of 21 on Medi-Cal who received five or more SMHS in a fiscal year by county. This data is drawn from DHCS’s Data Hub Performance Dashboards.

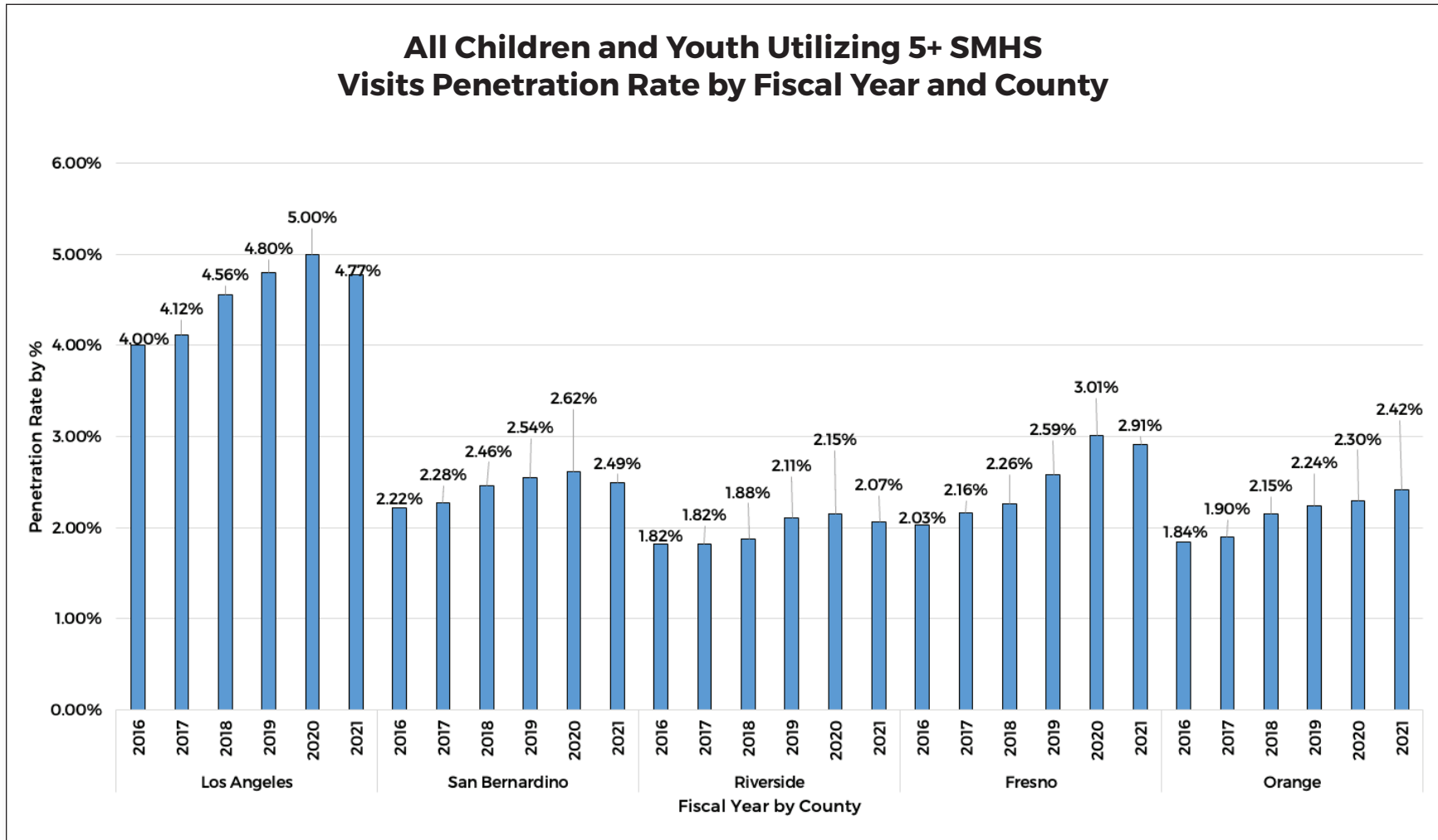


Figure 2g. One or more visits, SMHS penetration for foster children and youth by county. This graph represents the percentage of children and youth in foster care under the age of 21 on Medi-Cal who received one or more SMHS in a fiscal year by county. This data is drawn from DHCS’s Data Hub Performance Dashboards.

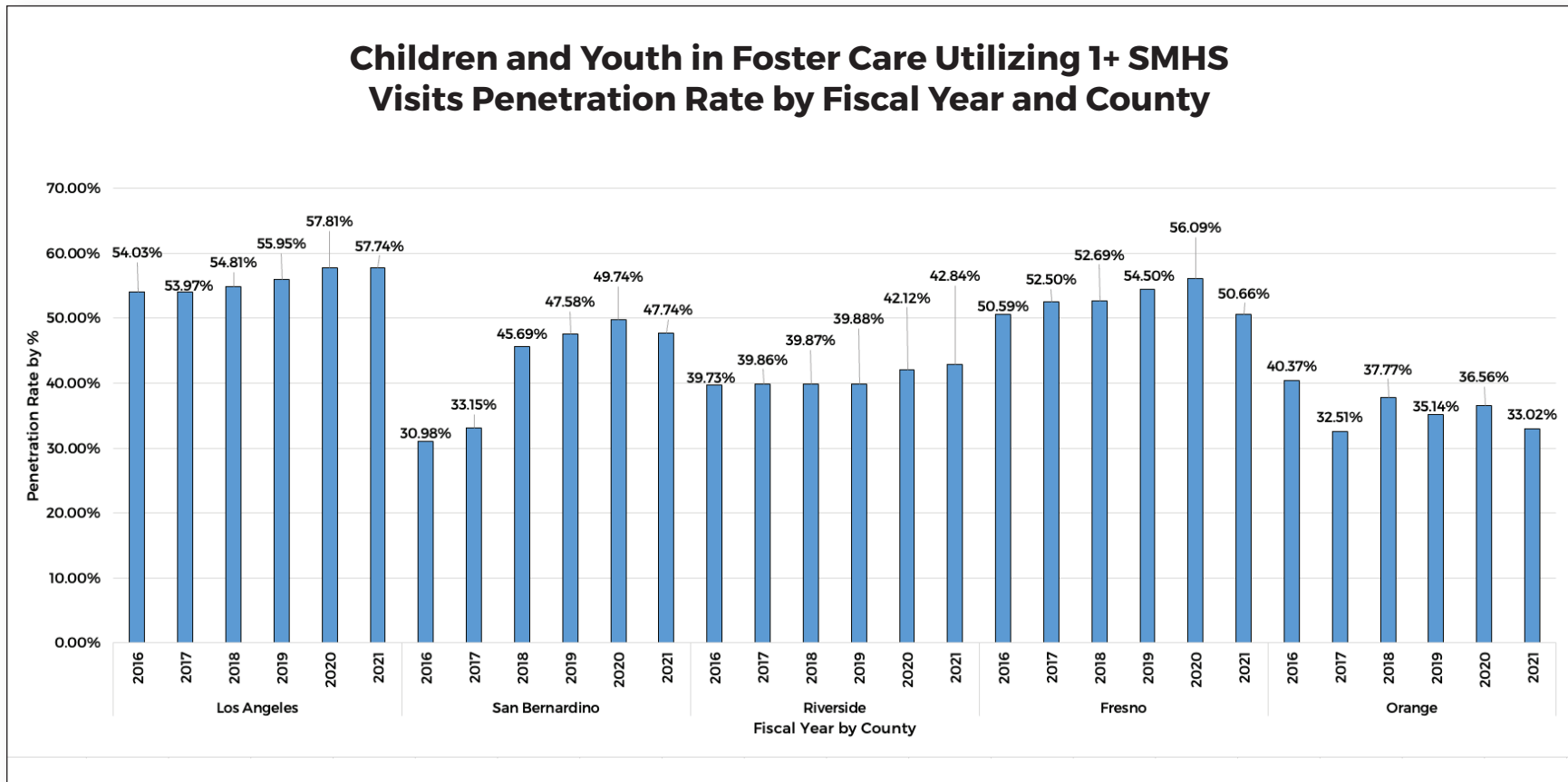
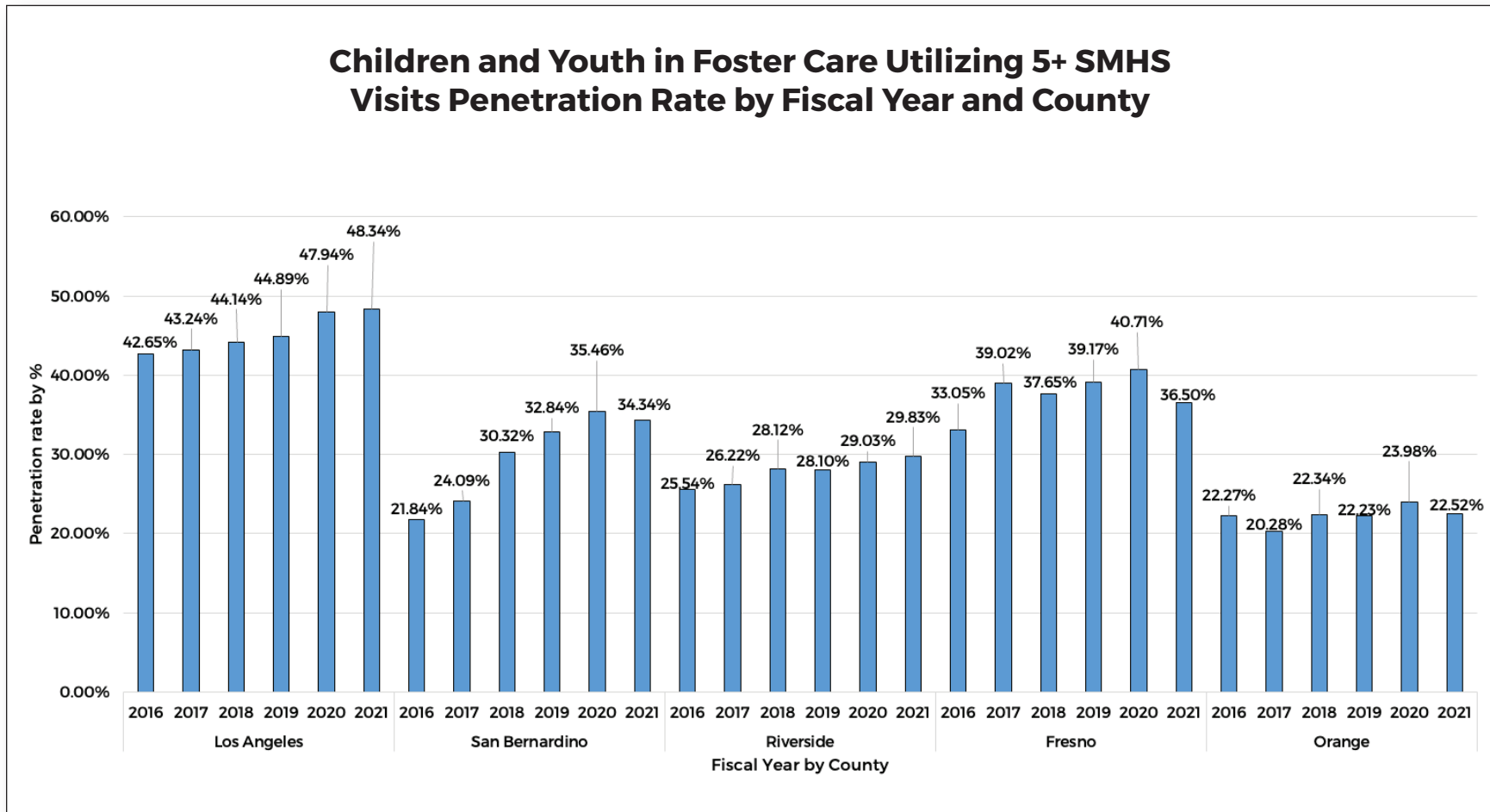


Figure 2h. Five or more visits, SMHS penetration rate for foster children and youth by county. This graph represents the percentage of children and youth in foster care under the age of 21 on Medi-Cal who received five or more SMHS in a fiscal year by county. This data is drawn from DHCS’s Data Hub Performance Dashboards.



Penetration rate is calculated by dividing the number of beneficiaries utilizing SMHS by the number of all eligible individuals.³⁰ Eligible individuals are defined as those who have a certified, full-scope Medi-Cal aid code on their latest eligibility month for the fiscal year.³¹ For comparison, some of these graphs show the penetration rate for youth who received one or more SMHS visits in the fiscal year. In contrast, the other graphs show the number of youth who received five or more SMHS visits in the fiscal year. The penetration rate of youth who received five or more visits in a year is meant to provide an approximation of youth who required intensive services, compared to those who required any level of services (i.e., those who received at least one service in a fiscal year). [Figure 2a](#) demonstrates how the penetration rate for all children and youth statewide for SMHS usage was lowest in 2016 (4.11%) and continued to grow until it peaked in 2019 (4.54%), then lowered in 2021 (4.30%). Throughout 2016–2021, the penetration rate stayed relatively low at about 4%. For children and youth in foster care statewide, as shown in [Figure 2c](#), the penetration rate for SMHS usage followed a similar pattern of growth, with the lowest occurring in 2016 (45.61%), increasing and peaking in 2020 (49.71%), and decreasing in 2021 to 48.49%. The greatest difference between children and youth in foster care and all children and youth statewide was the penetration rate itself. Statewide, children and youth in foster care utilized SMHS at a much higher rate than all children and youth. The SMHS penetration rates for children and youth in foster care ranged from 45.1% to 49.71%, while the penetration rate for all children and youth did not change by more than half of a percentage point (4.11% to 4.59%). [Figure 2e](#) and [Figure 2g](#) show the SMHS penetration rates for all children and youth and for children and youth in foster care utilizing one or more SMHS visits in the five target counties and across the same year range. The penetration rate for all children and youth across the five counties followed a similar pattern to the statewide graph in [Figure 2a](#). However, there was some variation among the counties. Riverside, Orange, and San Bernardino counties had the lowest penetration rates for children and youth SMHS usage with none exceeding 3.78%, which was under the statewide rates. Fresno was also under the statewide rate, but with increases to 4.28% and 4.18% in 2020 and 2021, respectively. Los Angeles County is the largest county of the five and had the highest penetration rate of the five counties and statewide. Los Angeles County ranged from 5.12% in 2016 to a peak of 6.20% in 2020. While the penetration rates for children and youth SMHS usage ranged more within the counties than statewide, the range between the highest and lowest rates did not exceed four percentage points.

Overall, the penetration rates for children and youth in foster care utilizing one or more SMHS visits showed much higher usage at the county level compared to all children and youth. As with the all children and youth population, Orange and Riverside counties had the lowest penetration rates. However, the penetration rates did not follow the same pattern seen in the statewide data. Orange County had the highest penetration rate for SMHS at 40.37% in 2016,

which then fell to its lowest of the six year timeframe at 32.51% in 2017. While Riverside County also had a lower penetration rate, it was at a similar rate to Los Angeles County. Riverside County peaked at 42.84% in 2021 and was at its lowest at 39.73% in 2016. San Bernardino County had the largest change, with the lowest rate of 30.98% in 2016 and an increase to its highest point of 49.74% in 2020. Fresno and Los Angeles counties had the highest penetration rates and were similar to each other, although they changed less over time than the other three counties. Fresno County's lowest penetration rate was 50.59% in 2017 and its highest was 56.09% in 2020. Los Angeles was lowest at 53.97% in 2017 and highest at 57.81% in 2020. Both counties decreased in 2021, although Fresno decreased more dramatically.

The county-level penetration rates for children and youth in foster care were similar to the state-level penetration rates, but more pronounced. [Figure 2h](#) shows the penetration rate for foster youth utilizing five or more SMHS visits. When compared to the penetration rate for foster youth with one or more SMHS visits, foster youth with five or more visits (i.e., our proxy for the use of intensive services) followed the same trend at an overall lower rate. When comparing the penetration rate for foster youth with both one or more visits and five or more visits with the population levels in each county, it is apparent that the use of SMHS is consistent to the proportion of foster youth in each county, or even increasing relative to the changes in the foster care population. This is shown even when the foster youth population in a county decreases. For example, from 2020 to 2021 in Los Angeles County, the foster care population decreased from 22,332 to 21,326; however, the penetration rate decreased by only less than a percentage point for those using one or more visits and increased slightly for those using five or more visits. Similarly, San Bernardino County's foster youth population grew from 5,736 in 2016 to the highest point of 6,884 in 2019; while the penetration rate for one or more visits grew from 30.98% in 2016 to 47.58% in 2019 and for five or more visits grew from 21.84% in 2016 to 32.84% in 2019.

3. SMHS Intensive Care Coordination (ICC) Utilization

Figure 3a. ICC utilization for all children and youth by fiscal year and statewide. This graph represents the total unique beneficiaries (all children and youth under the age of 21 with Medi-Cal) who utilized ICC SMHS statewide and by fiscal year. This data is drawn from DHCS's Data Hub Performance Dashboards.

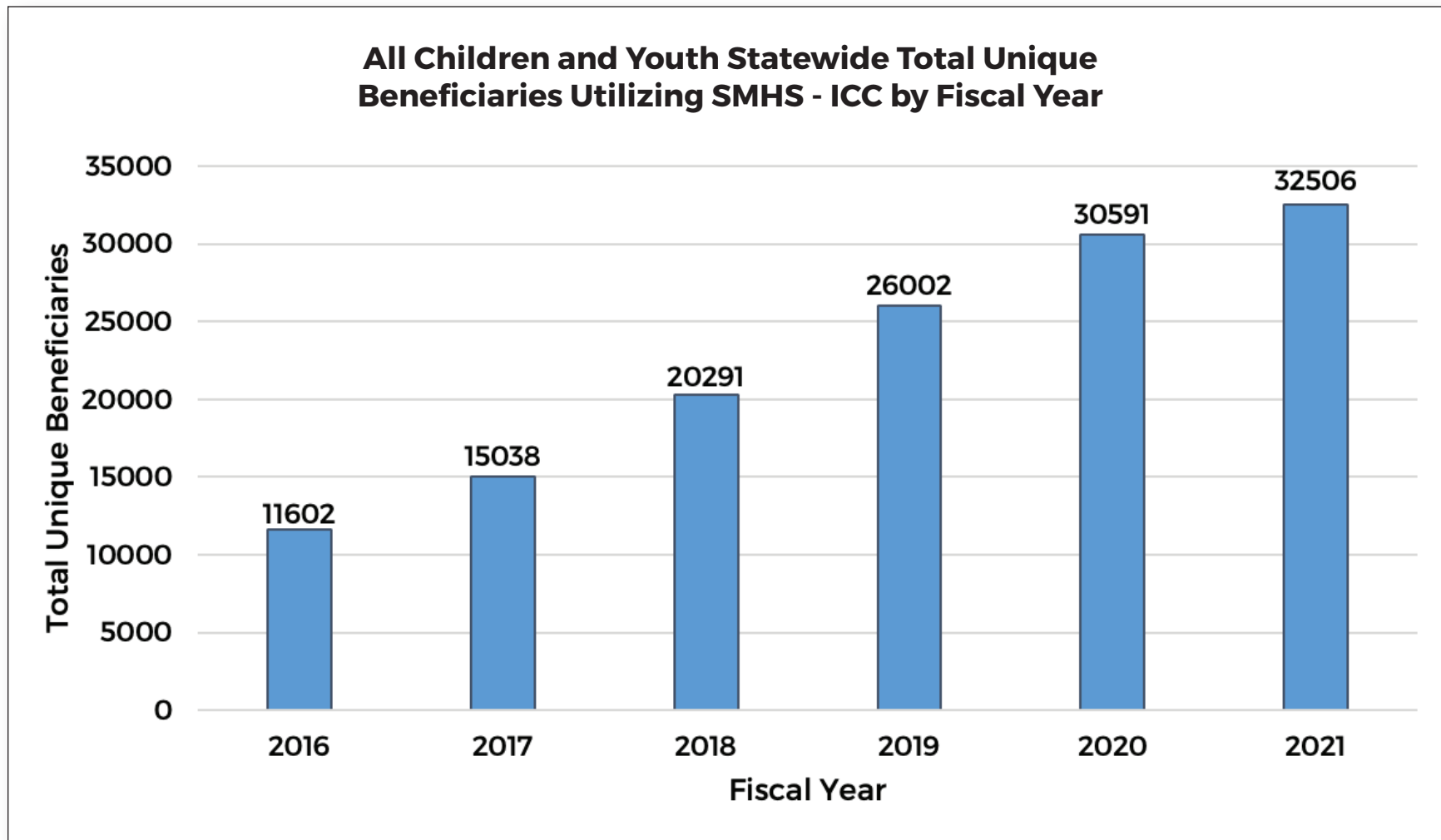


Figure 3b. ICC utilization for children and youth in foster care by fiscal year and statewide. This graph represents the total unique beneficiaries (children and youth in foster care under the age of 21 with Medi-Cal) who utilized ICC SMHS statewide and by fiscal year. The foster youth population is defined as children and youth having an out of home child welfare placement in the fiscal year. This data is drawn from DHCS's Data Hub Performance Dashboards.

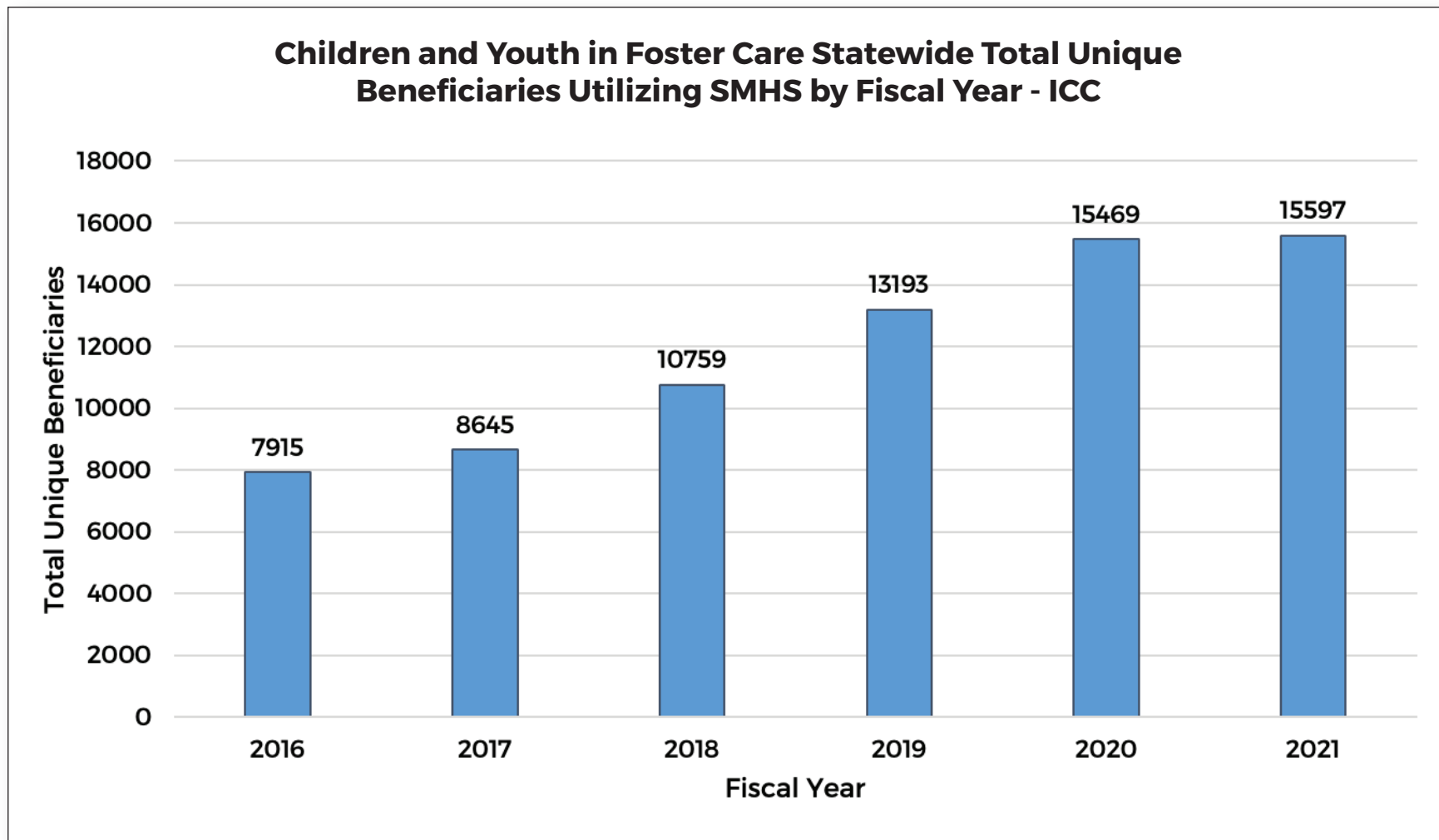


Figure 3c. ICC utilization for all children and youth by fiscal year and county. This graph represents the total unique beneficiaries (all children and youth under the age of 21 with Medi-Cal) who utilized ICC SMHS by county and fiscal year. This data is drawn from DHCS’s Data Hub Performance Dashboards.

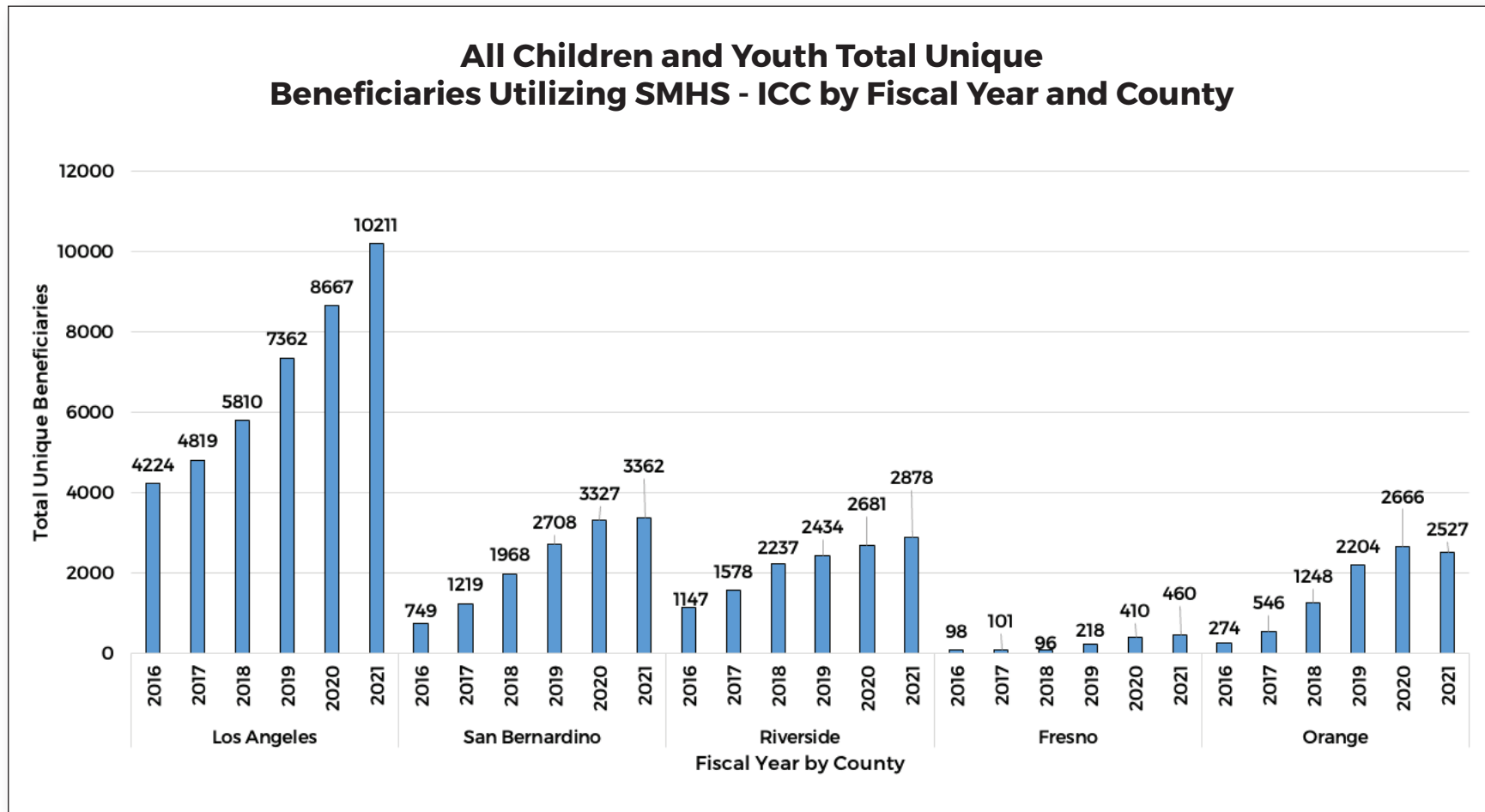


Figure 3d. ICC utilization for children and youth in foster care by fiscal year and county. This graph represents the total unique beneficiaries (children and youth with an out of home child welfare placement in the fiscal year under the age of 21 with Medi-Cal) who utilized ICC SMHS by county and fiscal year. This data is drawn from DHCS’s Data Hub Performance Dashboards.

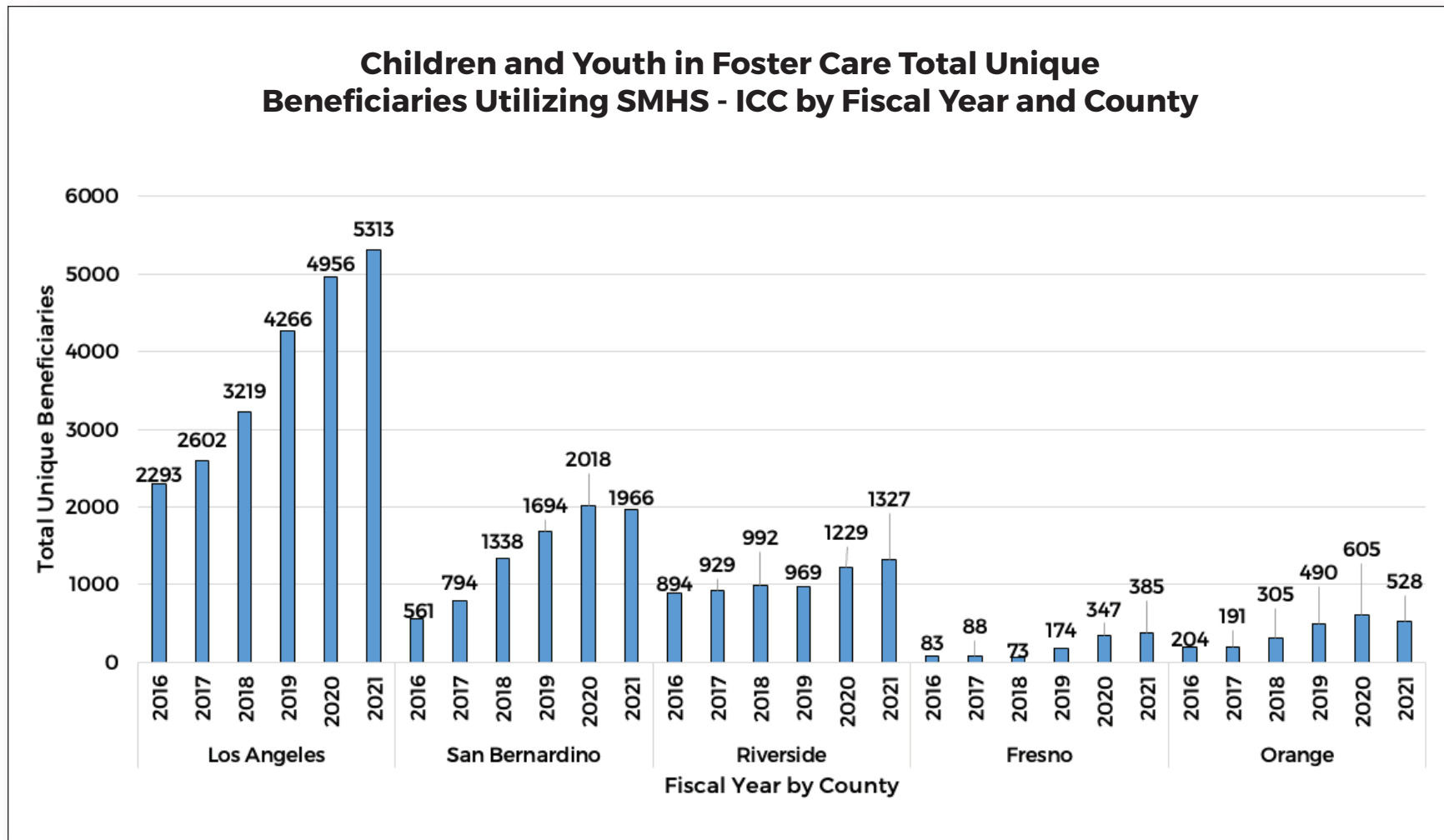
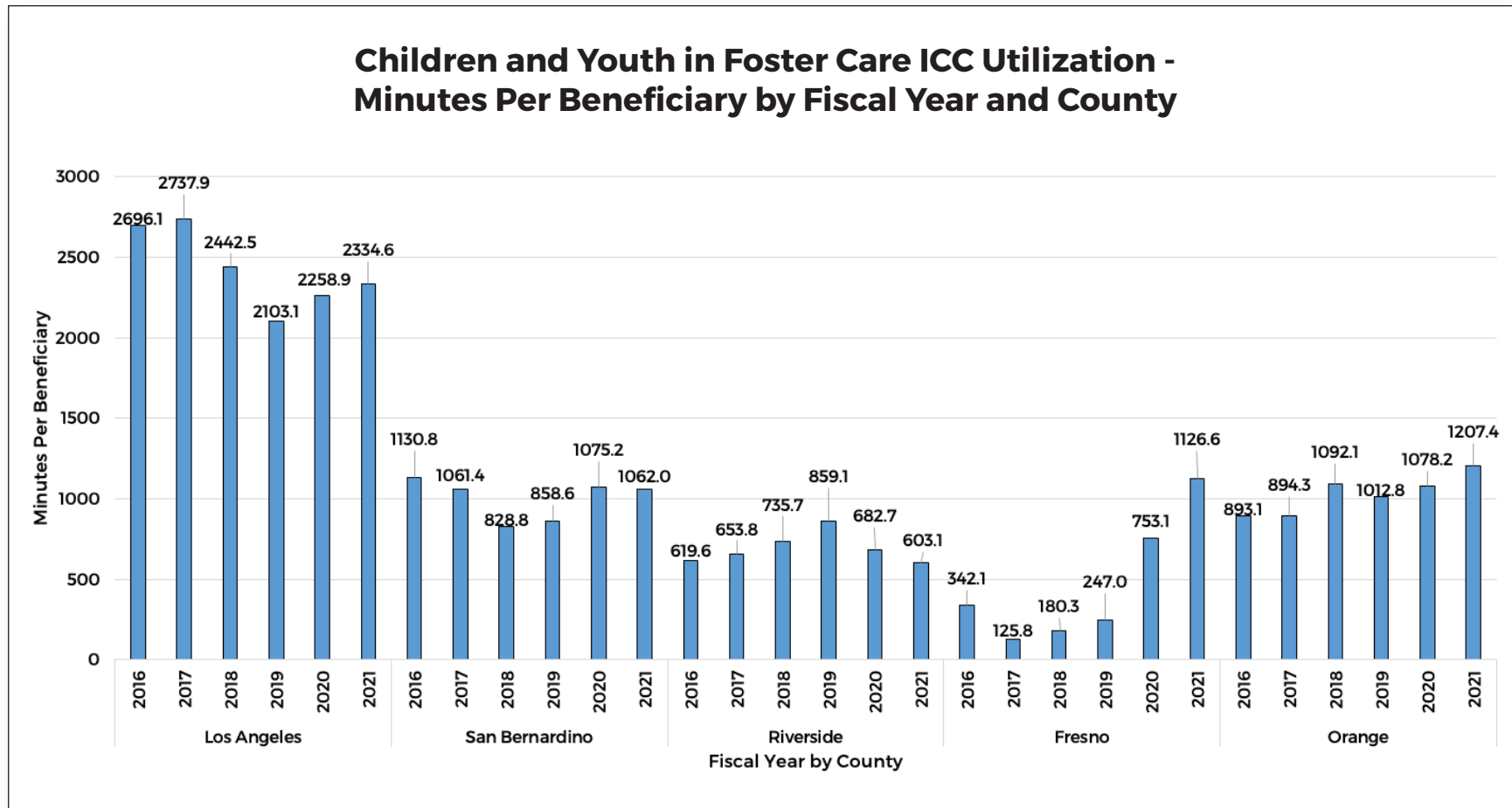


Figure 3e. ICC utilization minutes per beneficiary for children and youth in foster care (those with an out of home child welfare placement in the fiscal year) by fiscal year and county. This graph represents the utilization of ICC SMHS by units used per beneficiary. Units are defined as minutes for ICC SMHS. The population in this graph is children and youth in foster care under the age of 21 with Medi-Cal. This data is drawn from DHCS's Data Hub Performance Dashboards.



Utilization of ICC is captured in [Figure 3a](#), [Figure 3b](#), [Figure 3c](#), and [Figure 3d](#) by total unique beneficiaries that received ICC services statewide, at the county level, across the two populations of focus, and in the year range of 2016–2021. At the statewide level, the total number of all children and youth who utilized ICC increased from 11,602 beneficiaries in 2016 to 32,506 beneficiaries in 2021. Children and youth in foster care statewide showed a similar progression. The total children and youth in foster care using ICC services was 7,915 in 2016 and increased to 15,597 in 2021. This dramatic increase is significant in contrast to the changes of the number of children and youth in foster care, which decreased slightly from 61,429 in 2016 to 58,441 in 2021, as shown in [Figure 1b](#).

At the county level, all children and youth receiving ICC services followed a similar trend of increasing sharply from 2016 to 2021, even as the number of children in foster care in each county stayed relatively flat, as shown in [Figure 1a](#). Fresno County had the lowest total beneficiaries utilizing ICC, with a lowest count of 98 in 2016 and a highest count of 460 in 2021 for all children and youth. Orange County followed, with 274 total beneficiaries using ICC in 2016, a maximum of 2,666 in 2020, and a decrease to 2,527 in 2021 for all children and youth. San Bernardino County had a total of 749 in 2016 and increased to 3,362 in 2021. Riverside increased from 1,147 in 2016 to 2,878 in 2021 for all children and youth. Los Angeles County had the highest total number of beneficiaries receiving ICC across all six years for all children and youth. This high number was expected, as Los Angeles County also had the highest ICC utilization rate per beneficiary overall (see [Figure 3e](#)). Los Angeles County had 4,224 unique beneficiaries using ICC in 2016, which increased to 10,211 in 2021.

By comparison, children and youth in foster care receiving ICC services similarly increased by year. Fresno County was the lowest, with 83 total beneficiaries in foster care using ICC in 2016 and an increase to 385 in 2021. Orange County followed, with 204 total beneficiaries in foster care in 2016 and an increase to a maximum of 605 in 2020, before lowering to 528 in 2021. San Bernardino County had 561 total beneficiaries in foster care using ICC in 2016, peaked at 2,018 in 2020, and lowered to 1,966 in 2021. Riverside County had 894 total beneficiaries in foster care using ICC in 2016 and increased to 1,327 in 2021. Finally, as expected, Los Angeles County had the highest total beneficiaries in foster care receiving ICC across all six years, with 2,293 beneficiaries in 2016 and 5,313 in 2021.

4. SMHS Intensive Home Based Services (IHBS) Utilization

Figure 4a. IHBS utilization for all children and youth by fiscal year and statewide. This graph represents the total unique beneficiaries (all children and youth under the age of 21 with Medi-Cal) who utilized IHBS SMHS statewide and by fiscal year. This data is drawn from DHCS’s Data Hub Performance Dashboards.

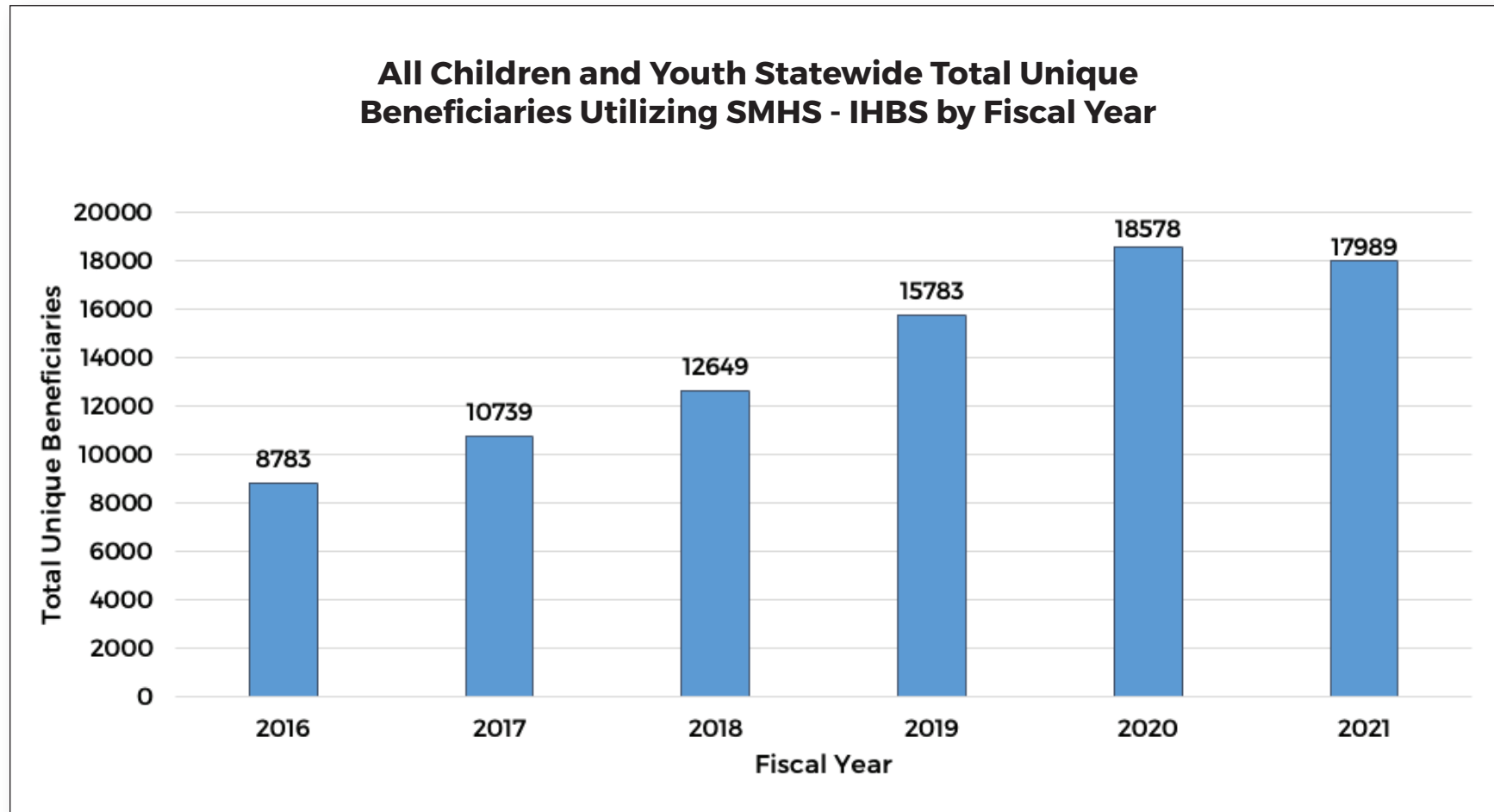


Figure 4b. IHBS utilization for foster children and youth by fiscal year and statewide. This graph represents the total unique beneficiaries (children and youth with an out of home child welfare placement in the fiscal year under the age of 21 with Medi-Cal) who utilized IHBS SMHS statewide and by fiscal year. This data is drawn from DHCS’s Data Hub Performance Dashboards.

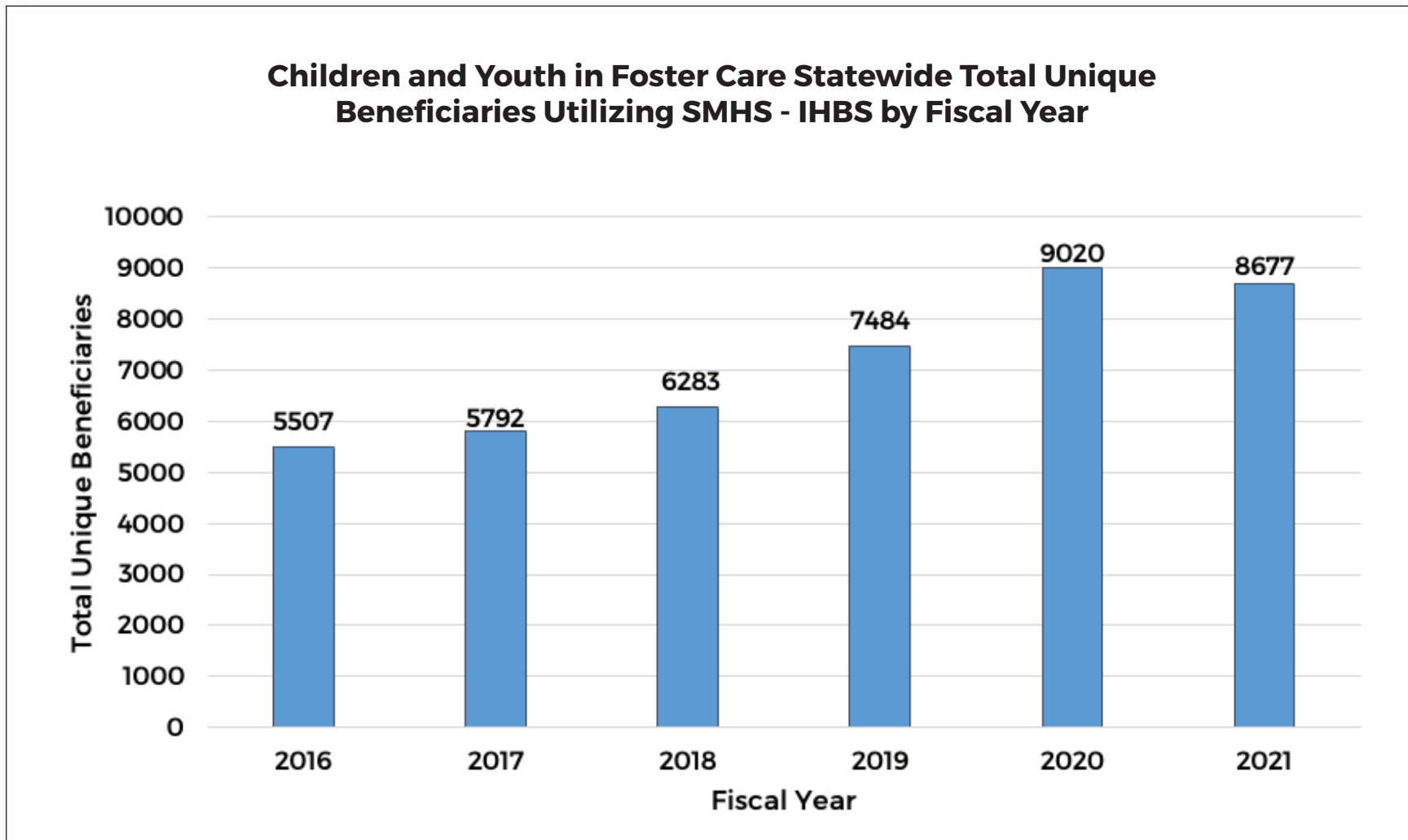


Figure 4c. IHBS utilization for all children and youth by fiscal year and county. This graph represents the total unique beneficiaries (all children and youth under the age of 21 with Medi-Cal) who utilized IHBS SMHS by county and fiscal year. This data is drawn from DHCS’s Data Hub Performance Dashboards.

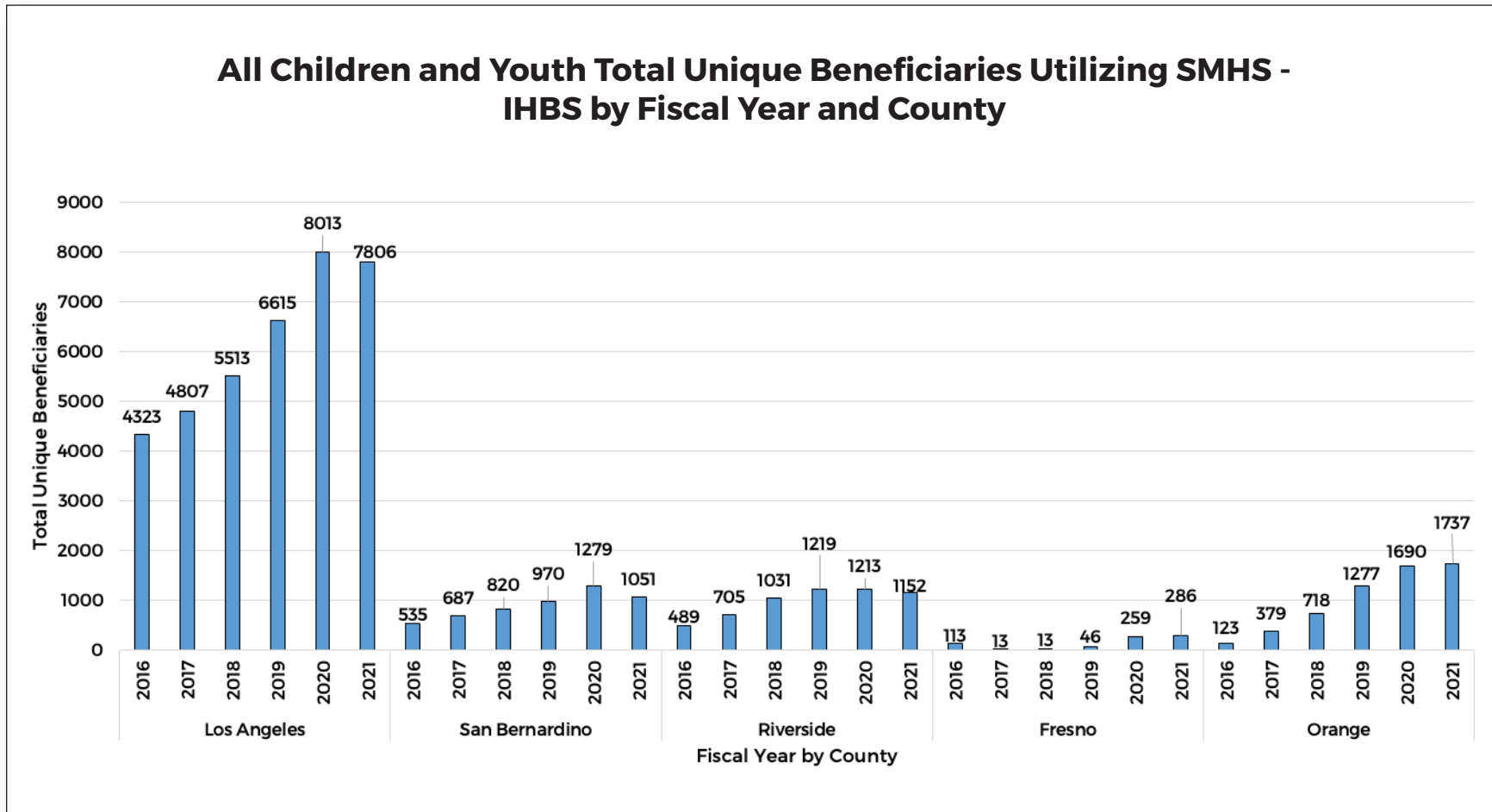


Figure 4d. IHBS utilization for foster children and youth by fiscal year and county. This graph represents the total unique beneficiaries (children and youth with an out of home child welfare placement in the fiscal year under the age of 21 with Medi-Cal) who utilized IHBS SMHS by county and fiscal year. This data is drawn from DHCS's Data Hub Performance Dashboards.³²

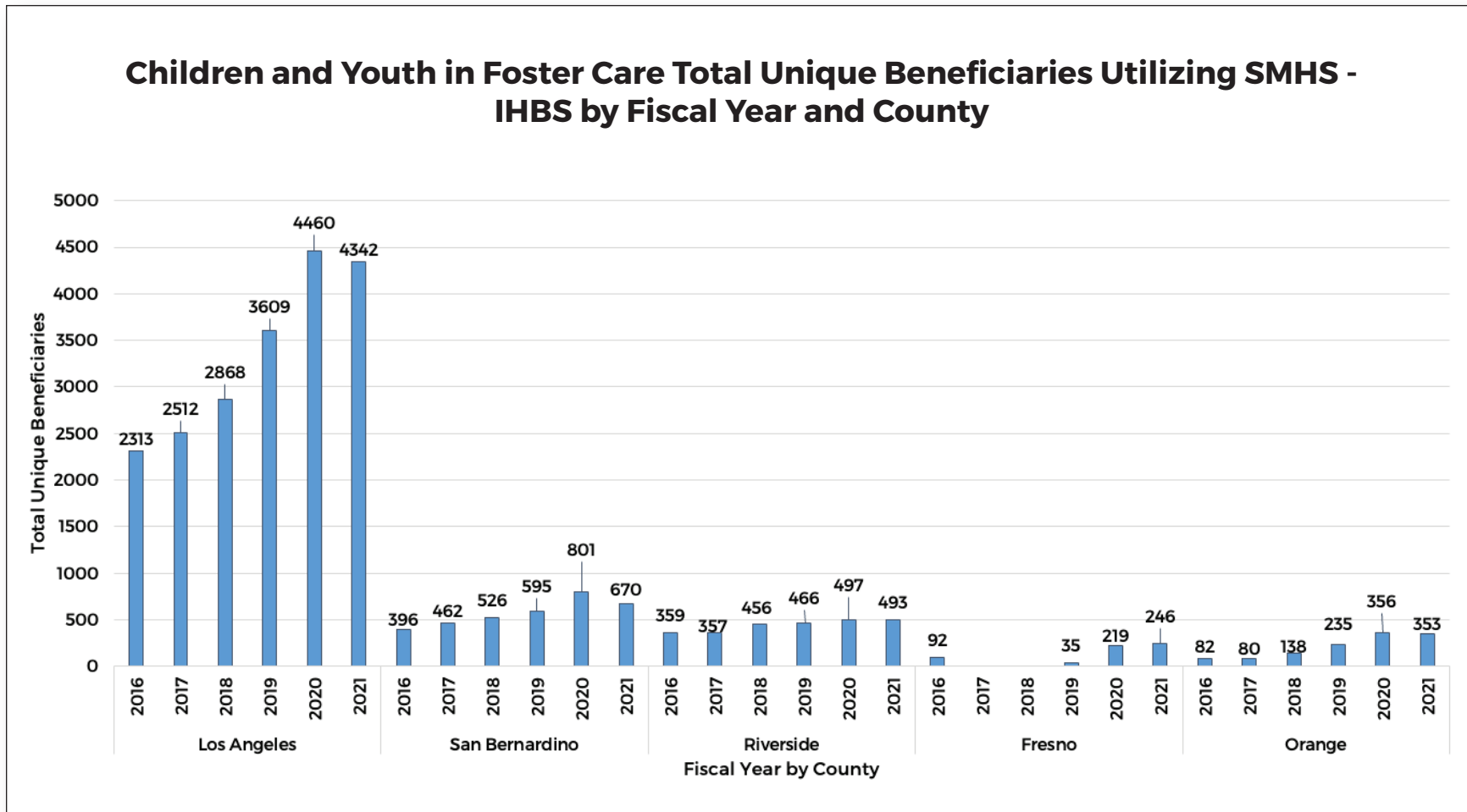
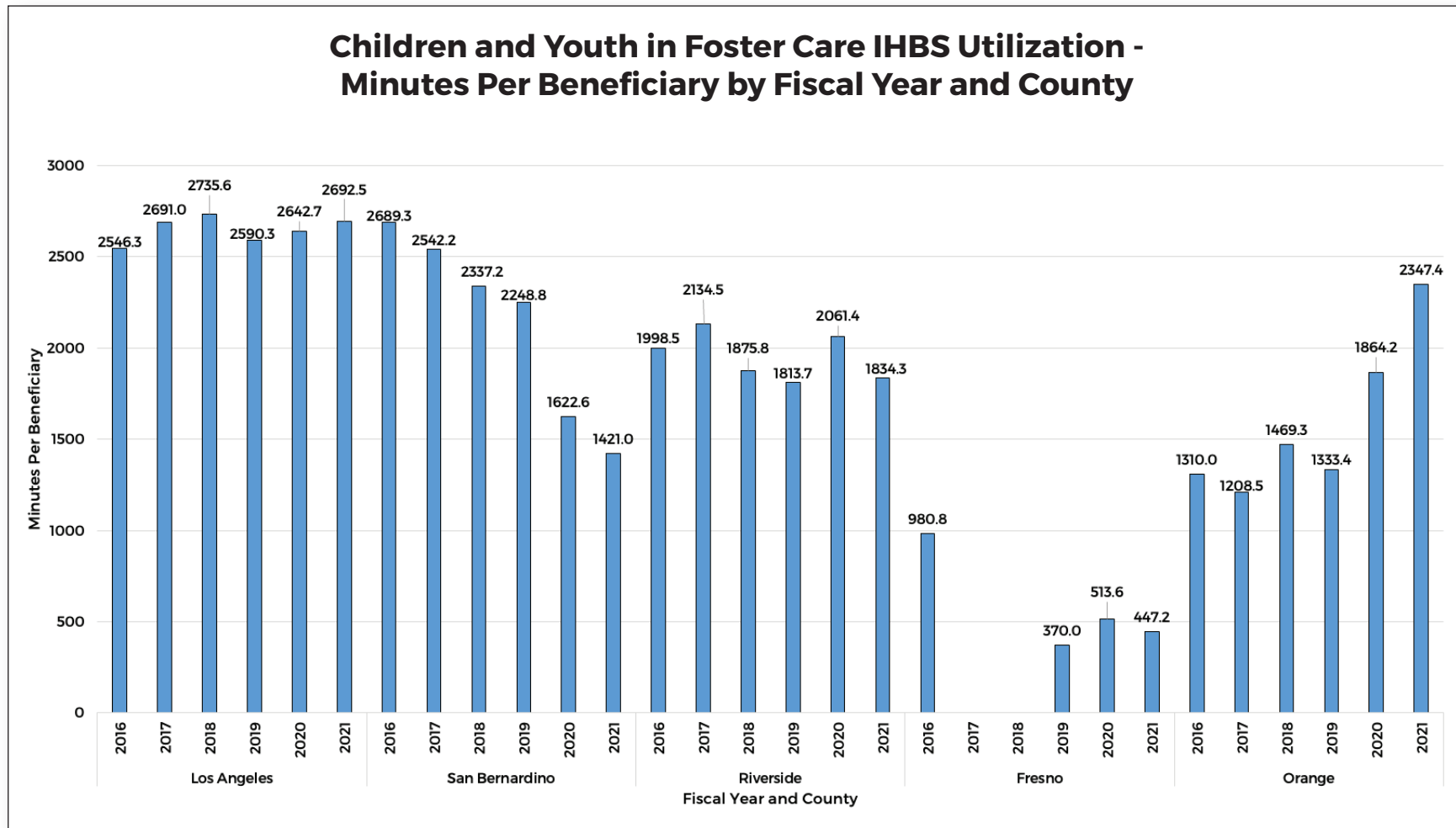


Figure 4e. IHBS utilization minutes per beneficiary by fiscal year and county. This graph represents the utilization of ICC SMHS by units used per beneficiary. Units are defined as minutes for IHBS SMHS. The population in this graph is children and youth in foster care (children and youth with an out of home child welfare placement in the fiscal year under the age of 21 with Medi-Cal). This data is drawn from DHCS's Data Hub Performance Dashboards.³³



As with ICC, IHBS utilization is captured in [Figure 4a](#), [Figure 4b](#), [Figure 4c](#), [Figure 4d](#), and [Figure 4e](#) by total unique beneficiaries that received ICC services statewide, at the county level, across the two populations of focus, and in the year range of 2016–2021. At the statewide level, both all children and youth in Medi-Cal and children and youth in foster care utilized IHBS at a similar rate from 2016 to 2021. For all children and youth utilizing IHBS, the total beneficiaries started at 8,783 in 2016, increased to 18,578 in 2020, and decreased to 17,989 in 2021. For children and youth in foster care, the total beneficiaries using IHBS started at 5,507 in 2016, increased to 9,020 in 2020, and decreased to 8,677 in 2021. Once again, this overall increase is significant in comparison to the changes of the number of children and youth in foster care, which decreased slightly from 61,429 in 2016 to 58,441 in 2021, as shown in [Figure 1b](#).

At the county level, utilization generally increased similarly to the statewide data, even as the number of children in foster care in each county stayed relatively flat, as shown in [Figure 1a](#). For all children and youth, Fresno County is particularly interesting as it started with 113 total beneficiaries using IHBS, decreased to 13 total beneficiaries in 2017 and 2018, increased to 46 in 2019, and then increased to 259 and 286 in 2020 and 2021, respectively. Orange County steadily increased from 123 in 2016 all the way to 1,737 in 2021. Riverside and San Bernardino counties both followed the statewide trend of increasing numbers of total beneficiaries using IHBS, with slight decreases in the most recent year. Riverside County started with 489 total beneficiaries in 2016, increased to 1,213 in 2020, and then decreased slightly to 1,152 in 2021. Similarly, San Bernardino County started with 535 total beneficiaries using IHBS, peaked at 1,279 in 2020, and decreased slightly to 1,051 in 2021. Los Angeles County has the highest total beneficiaries across the five counties and throughout the six years. As shown in [Figure 4e](#), Los Angeles County also consistently provided the most time per beneficiary on IHBS. Los Angeles County started with 4,323 total beneficiaries using IHBS in 2016, peaked at 8,013 in 2020, and then decreased to 7,806 in 2021.

The pattern is similar for children and youth in foster care utilizing IHBS. Fresno County began with 92 total beneficiaries utilizing IHBS in 2016, had under 11 utilizing beneficiaries in 2017 and 2018, increased to 35 in 2019, then to 219 in 2020, and finally to 246 in 2021. Orange County had the next lowest total beneficiaries using IHBS, starting with 82 in 2016, increasing to 356 in 2020, and lowering slightly to 353 in 2021. Riverside County began with 359 total beneficiaries using IHBS in 2016 and reached its highest amount of 497 total beneficiaries in 2020, followed by a decrease in 2021. San Bernardino County began with 396 total beneficiaries in 2016, increased to 801 in 2020, and decreased to 670 in 2021. Finally, Los Angeles County had the highest total and the most growth. Los Angeles County started with 2,313 total beneficiaries in 2016, increased to 4,460 in 2020, and decreased to 4,342 in 2021.

5. Timely Access

Federal laws require all contracted health plans to make covered services available and accessible to enrollees in a timely manner.³⁴ In California, all health plans, including county MHPs, must comply with state-established Timely Access Standards.³⁵ MHPs must make SMHS available 24 hours a day, seven days a week, when it is medically necessary.³⁶ Urgent appointments must be provided within 48 hours or, if prior authorization is required, within 96 hours.³⁷ For non-urgent appointments, MHPs must provide beneficiaries: (i) a non-urgent psychiatric appointment within 15 business days of the request for an appointment; (ii) a non-urgent non-physician mental health (or substance use disorder) appointment within 10 business days of the request for an appointment; and (iii) a non-urgent non-physician mental health (or substance use disorder) follow up appointment within 10 business days of the prior appointment.³⁸

Unfortunately, DHCS reports provide limited information about MHPs' compliance with timely access requirements in its Network Certification Reports, which are submitted annually to the Federal Medicaid Agency, the Centers for Medicare and Medicaid Services (CMS), to document MHPs' compliance with the State's network adequacy requirements. No data is available in these reports for years prior to 2020. For Fiscal Year (FY) 2020–2021, DHCS reported that 13 MHPs were out-of-compliance with the timely access requirements, but it did not list which MHPs were out-of-compliance, except to note that one remained out-of-compliance at the end of the reporting period.³⁹ For FY 2021–2022, DHCS reported that three MHPs were initially found out-of-compliance with the timely access requirements, and one remained out of compliance after taking corrective action.⁴⁰ In any event, DHCS does not explain how or in what respects the MHPs were non-compliant in these reports.

DHCS does provide more detailed information about MHPs' compliance with the timely access requirements in its MHP-specific System Review Findings Reports from its Triennial Reviews⁴¹ (to the extent an MHP was required to enter a Corrective Action Plan based on its review, this information may also be reported in that MHP's Corrective Action Plan Report).⁴² Starting with reviews for FY 2021–2022, DHCS reviews a sample of appointment requests to determine whether MHPs are complying with timely access requirements for physician services and urgent care (previously, DHCS reviewed MHP policies to evaluate compliance). Since those reviews are performed only once every three years, however, the data is not available regularly. For example, three out of the five counties we are reviewed went through the triennial review process in FY 2021–2022. All of them had serious deficiencies with respect to timely access. For example, in Los Angeles County, the triennial review found that six (6) of the 50 physician appointments and 33 of the 50 urgent appointments reviewed did not meet the State timeliness standards.⁴³ In San Bernardino County, the triennial review found that 22 of the 50 physician appointments and 19 of the

50 urgent appointments reviewed did not meet state timeliness standards.⁴⁴ In Riverside County, the triennial review found that nine (9) of the 50 physician appointments and 45 of the 50 urgent appointments reviewed did not meet the State timeliness standards.⁴⁵

While DHCS has made more information about timely access available over the last several years, this is an area where more information would be helpful, including more detailed data about MHP’s performance with respect to timely access.

6. Provider Network Ratios

Federal regulations require all MHPs to maintain a provider network that is sufficient in number and types of providers to provide SMHS to beneficiaries of all ages.⁴⁶ To ensure that MHPs can adequately provide SMHS to all eligible beneficiaries, DHCS has developed a statewide provider-to-beneficiary ratio requirement.⁴⁷ Each MHP must meet the minimum provider-to-beneficiary ratio and proportionately adjust the number of providers to support any anticipated changes in enrollment and utilization of SMHS.⁴⁸

DHCS made MHPs’ compliance with provider-to-beneficiary ratios publicly available starting in 2019.

Compliance with Provider Ratios by Reporting Year (RY)⁴⁹

Psychiatry - Children	RY 2019	RY 2020	RY 2021
Los Angeles	Corrective Action Required*	Corrective Action Required*	Corrective Action Required*
San Bernardino	Compliant	Corrective Action Required*	Compliant
Riverside	Corrective Action Required*	Corrective Action Required*	Corrective Action Required*
Fresno	Compliant	Compliant	Compliant
Orange	Compliant	Compliant	Compliant

Outpatient SMHS - Children	RY 2019	RY 2020	RY 2021
Los Angeles	Corrective Action Required*	Compliant	Compliant
San Bernardino	Compliant	Compliant	Compliant
Riverside	Corrective Action Required*	Compliant	Compliant
Fresno	Corrective Action Required*	Compliant	Compliant
Orange	Corrective Action Required*	Compliant	Compliant

** County added providers after the initial review in order to come into compliance.*

Analysis

As previously mentioned, the five California counties with the largest foster care populations in July 2022 were selected for this research study. Analysis of the five selected counties, Los Angeles, San Bernardino, Riverside, Fresno, and Orange, is listed below by county in descending order of the size of their foster care population.

1. Los Angeles County

Los Angeles County sits in the southern region of the State of California and was established in 1850 as one of the State’s original counties.⁵⁰ Los Angeles means “the angels” in Spanish.⁵¹ Los Angeles County encompasses 4,084 square miles and has the largest population of any county in California and in the United States.⁵² Based on the 2020 U.S. Census, Los Angeles County has a population of 10,014,009, with 14.1% of its residents experiencing poverty and 21.1% under the age of 18.⁵³ 49.1% of residents identified as “Hispanic or Latino,” 25.3% as “White,” 15.6% as “Asian,” 9.0% as “Black or African American,” and 1.5% as “American Indian and Alaska Native.”⁵⁴ In July 2022, 1,497,608 Los Angeles County residents under the age of 21 were enrolled in Medi-Cal.⁵⁵ On July 1, 2022, Los Angeles County had 18,664 children in foster care, which made up more than 35% of the total foster care population in California.⁵⁶ As shown in [Figure 1a](#), the number of children in foster care in Los Angeles County has fluctuated slightly up and down since 2016 with an average population of 21,213 between 2016 and 2021.

Los Angeles County has the largest overall population and the largest foster care population in the State. It also has the highest SMHS penetration rate for all children and youth and the highest foster youth SMHS penetration rate. However, comparing [Figure 2e](#) and [Figure 2g](#) shows that Los Angeles County’s SMHS penetration rate (5+ visits in the fiscal year) for the foster youth population continued to grow incrementally from 2016 to 2021, while the SMHS penetration rate for all children and youth initially increased from 2016 to 2020, before decreasing slightly in 2021.

From 2016 to 2021, Los Angeles County had the highest ICC utilization count among all five counties – both for all children and youth and for foster children

and youth (see [Figure 3c](#) and [Figure 3d](#)). These high numbers are expected, as Los Angeles County has the most children and youth and most foster children and youth in the State. Additionally, as demonstrated in [Figure 3e](#), Los Angeles County consistently had the highest ICC utilization minutes per beneficiary. However, although children and youth in foster care in Los Angeles County increasingly received ICC from 2016 to 2021, the time (minutes) each beneficiary received ICC did not show the same trend. As demonstrated in [Figure 3e](#), ICC utilization minutes per beneficiary in Los Angeles County increased slightly in 2017, dropped in 2018 and 2019, and then increased again in 2020 and 2021. It is worth exploring why there was a significant drop in 2019.

Los Angeles County's IHBS utilization count showed a similar trend as its ICC utilization count, except in 2021. In 2021, 7,806 children and youth under the age of 21 received IHBS, which was 207 beneficiaries less than the previous year. In 2021, 4,342 children and youth in foster care received IHBS, which was 118 beneficiaries less than the previous year (see [Figure 4c](#) and [Figure 4d](#)). The drop in IHBS utilization count (a 2.7% decrease) occurred parallel to a small dip in the foster care population in Los Angeles County during the same time period, from 22,332 in 2020 to 21,326 in 2021 (a 4.5% decrease).

As previously mentioned, information on timely access is not available by county each year. However, based on the triennial review findings, Los Angeles County did not initially comply with the timely access standards in Fiscal Year (FY) 2021–2022.⁵⁷ These reports also show that Los Angeles County has not met the provider network ratio requirement for child psychiatry since Reporting Year (RY) 2019. Starting RY 2020, it shows Los Angeles has complied with the provider network ratio requirement for child outpatient SMHS.

2. San Bernardino County

San Bernardino County is another Inland Empire county that is located in the southern part of the State of California and borders the State of Arizona. San Bernardino County was incorporated in 1853 and given its name in honor of “Saint Bernard,” who was the patron saint of mountain passes.⁵⁸ San Bernardino County covers 20,105 square miles and is the largest county in the United States and one of the largest counties in the world.⁵⁹ Based on the 2020 U.S. Census, San Bernardino County has a population of 2,181,654, with 13.2% of its residents experiencing poverty and 26% under the age of 18.⁶⁰ 55.8% of residents identified as Hispanic or Latino, 25.4% as White, 8.5% as Asian, 9.4% as Black or African American, and 2.2% as American Indian and Alaska Native.⁶¹ In July 2022, 418,251 San Bernardino County residents under the age of 21 were enrolled in Medi-Cal.⁶² On July 1, 2022, San Bernardino County had 5,921 children in foster care, making it the county with the second largest foster care population in California, after its neighbor, Los Angeles County.⁶³ The population of children

and youth in foster care increased slightly between 2016 and 2019 to a peak of 6,884, before decreasing slightly each year starting in 2020, as shown in [Figure 1a](#).

Mirroring the changes in the foster care population in the county, San Bernardino County's SMHS penetration rate (5+ visits in a fiscal year) for all children remained about the same from 2016 to 2017, increased from 2017 to 2019, and declined from 2019 to 2021 (see [Figure 2e](#)). Its SMHS penetration rate (5+ visits in a fiscal year) for foster children, on the other hand, increased steadily from 2016 to 2020 and dropped slightly from 35.46% in 2020 to 34.34% in 2021 (see [Figure 2g](#)).

San Bernardino County's ICC utilization count for all children and youth under the age of 21 increased from 2016 to 2021 (see [Figure 3c](#)). Its ICC utilization count for children and youth in foster care (see [Figure 3d](#)), IHBS utilization count for all children (see [Figure 4c](#)), and IHBS utilization count by foster youth (see [Figure 4d](#)) all showed a similar overall increase. This trend seems to mirror the trends in the total number of children in foster care in the county over the same time period. San Bernardino County's ICC utilization minutes per beneficiary (see [Figure 3e](#)), on the other hand, showed a different pattern. From 2016 to 2018, San Bernardino County provided each beneficiary with less time of ICC (from 1130.8 minutes per beneficiary per year in 2016 to 828.8 minutes per beneficiary per year in 2018). The number increased in 2020 (1075.2 minutes per beneficiary per year) and then dropped again in 2021 (1062 minutes per beneficiary per year). San Bernardino County's IHBS utilization minutes per beneficiary showed a decreasing trend from 2016 to 2021, from 2689.3 minutes per beneficiary to 1421 minutes per beneficiary (see [Figure 4e](#)). These trends are worth exploring further, as a lower number of utilization minutes per beneficiary means each beneficiary received less service time and/or service intensity.

As previously mentioned, information on timely access is not available by county each year. However, based on the triennial review, DHCS found that San Bernardino County did not initially comply with the timely access standards in FY 2021-2022.⁶⁴ San Bernardino County has mostly been meeting the provider network ratio requirement for child psychiatry since RY 2019, except for in RY 2020. The triennial review also found that the county has complied with the provider network ratio requirement for child outpatient SMHS since RY 2019.

3. Riverside County

Riverside County sits in the Inland Empire, a region that is located in the southern part of the State of California and borders the State of Arizona. Riverside County was formed in 1893 and given the name from the City of Riverside, where the Santa Ana River is located.⁶⁵ It covers 7,206 square miles and is the fourth most populous county in California and the tenth most

populous county in the United States.⁶⁶ Based on the 2020 U.S. Census, Riverside County has a population of 2,418,185, with 11.6% of its residents experiencing poverty and 24.6% under the age of 18.⁶⁷ 51.6% of residents identified as Hispanic or Latino, 32.0% as White, 7.5% as Asian, 7.5% as Black or African American, and 2.0% as American Indian and Alaska Native.⁶⁸ In July 2022, 429,337 Riverside County residents under the age of 21 were enrolled in Medi-Cal.⁶⁹ In July 2022, Riverside County had 3,347 children in foster care, making it the county with the third largest foster care population in California.⁷⁰ The population decreased slightly from 2016 to 2019, where it reached a low of 2,928, before increasing slightly starting in 2020, as shown in [Figure 1a](#).

Despite being the fourth most populous county in the State, Riverside County had the lowest SMHS penetration rate (5+ visits in a fiscal year) for all children and youth of all five counties in 2021 (see [Figure 2f](#)). Riverside County also had the second to lowest foster youth SMHS penetration rate (5+ visits in a fiscal year) of the five counties in 2021 (see [Figure 2h](#)). The low SMHS penetration rates indicate that children and youth in Riverside County – overall and those involved in the foster care system – may not be accessing the SMHS they need.

From 2016 to 2021, the number of children and youth under the age of 21 receiving ICC in Riverside County steadily increased (see [Figure 3c](#)). The number of children and youth in foster care receiving ICC in Riverside County showed a similar ascending trend, except in 2019 when 23 fewer foster children received ICC (see [Figure 3d](#)). Riverside County's ICC utilization minutes per beneficiary per year showed a different pattern. From 2016 to 2019, each beneficiary's average ICC time steadily increased – from 619.6 minutes in 2016, to 653.8 minutes in 2017, to 735.7 minutes in 2018, and to 859.1 minutes in 2019 (see [Figure 3e](#)). The number then decreased to 682.7 minutes in 2020 and to 603.1 minutes in 2021 (see [Figure 3e](#)).

Riverside County's IHBS utilization count for all children and youth under the age of 21 increased from 2016 to 2019 but began dropping in 2020 (see [Figure 4c](#)). Its IHBS utilization count for children and youth in foster care remained mostly steady (see [Figure 4d](#)). However, its IHBS utilization minutes per beneficiary by fiscal year changed over the years, with drops in 2018 and 2019, an increase in 2020, and then another drop in 2021 (see [Figure 4e](#)). It is worth exploring further why, from 2016 to 2019, Riverside County had an increased number of children and youth utilizing IHBS while each beneficiary received less time of service. The two patterns (between all children and youth and those in foster care) also elicits concerns of whether foster youth in Riverside County are accessing needed IHBS and in sufficient amounts.

As previously mentioned, information on timely access is not available by county each year. However, based on the triennial review, we found that Riverside County did not initially comply with the timely access standards in FY

2021–2022.⁷¹ Riverside County has not been meeting the provider network ratio requirement for child psychiatry since RY 2019. Starting in RY 2020, it has complied with the provider network ratio requirement for child outpatient SMHS.

4. Fresno County

Fresno County sits in the Central Valley, a region in the central portion of the State of California. Fresno means “ash tree” in Spanish.⁷² Fresno County was incorporated in 1885 and received its name due to the abundance of mountain ash or ash trees in the region.⁷³ It encompasses more than 6,000 square miles and is the sixth largest county in California.⁷⁴ Based on the 2020 U.S. Census, Fresno County has a population of 1,008,654, with 19.4% of its residents experiencing poverty and 28.2% under the age of 18.⁷⁵ 54.7% of residents identified as Hispanic or Latino, 27.2% as White, 11.6% as Asian, 5.9% as Black or African American, and 3.2% as American Indian and Alaska Native.⁷⁶ In July 2022, 235,526 Fresno County residents under the age of 21 were enrolled in Medi-Cal.⁷⁷ On July 1, 2022, Fresno County had 2,685 children in foster care, making it the county with the fourth largest foster care population in California.⁷⁸ The number of children and youth in foster care in the county rose steadily between 2016 and 2021, from 2,124 to 2,698, as shown in [Figure 1a](#).

Fresno County had the second highest percentage of all children and youth utilizing five or more SMHS per year from 2016 to 2021 (see [Figure 2f](#)). With the fourth largest foster care population in the State, Fresno County also had the second highest SMHS penetration rate (5+ visits in a fiscal year) for foster children and youth from 2016 to 2021 (see [Figure 2g](#) and [Figure 2h](#)). These high penetration rates are worth exploring further, as higher penetration rate could be attributed to higher access to SMHS, higher need for SMHS, and/or other reasons. Additionally, in 2021, Fresno County’s SMHS penetration rate (5+ visits in a fiscal year) for foster youth dropped significantly, from 40.71% to 36.5% (see [Figure 2g](#)). This drop in utilization was the most unique and significant among all five counties and worth exploring further.

Fresno County’s ICC utilization count for all children and youth under the age of 21 stayed steady between 96 to 101 beneficiaries from 2016 to 2018, before it increased significantly to 218 beneficiaries in 2019, 410 beneficiaries in 2020, and then to 460 beneficiaries in 2021 (see [Figure 3c](#)). This pattern is consistent with Fresno County’s ICC utilization count for foster children and youth (see [Figure 3d](#)). Fresno County’s ICC utilization minutes per beneficiary for children and youth in foster care showed a sharp decrease from 342.1 minutes in 2016 to 125.8 minutes in 2017, before it slightly increased to 247 minutes in 2019, sharply increased to 753.1 minutes in 2020, and increased again to 1126.6 minutes in 2021 (see [Figure 3e](#)). This growth is significantly higher than the growth of the county’s foster care population.

Among the five counties, Fresno County had the most unique IHBS utilization count pattern. As mentioned earlier, in 2016, Fresno County had 113 total beneficiaries under the age of 21 who received IHBS. The number decreased to 13 in 2017 and 2018, increased to 46 in 2019, and then increased to 259 and 286 in 2020 and 2021, respectively (see [Figure 4c](#)). Similarly, in 2016, Fresno County had 92 foster youth who received IHBS. The number decreased to less than 11 in 2017 and 2018, increased to 35 in 2019, and then increased to 219 and 248 in 2020 and 2021, respectively (see [Figure 4d](#)). The jump in numbers, especially from 2019 to 2020, is worth exploring further. As demonstrated in [Figure 4e](#), the time (minutes) of IHBS each child or youth in foster care received showed a similar trend as the total number of children and youth in foster care who received IHBS in Fresno County (see [Figure 4d](#)).

As previously mentioned, information on timely access is not available by county each year. However, based on the triennial review, Fresno County did not initially comply with the timely access standards in FY 2020–2021.⁷⁹ These same reports show that Fresno County has been meeting the provider network ratio requirement for child psychiatry since RY 2019 and for child outpatient SMHS since RY 2020.

5. Orange County

Orange County sits in the southern region of the State of California and borders the Pacific Ocean, Los Angeles County, San Bernardino County, Riverside County, and San Diego County. Orange County was created in 1889 and given the name of “Orange” to sound like a “semi-tropical paradise” to attract immigrants.⁸⁰ Orange County is the third most populous county in California and the sixth most populous county in the United States.⁸¹ It encompasses 948 square miles and, with an average population density of 4,040 residents per square mile, it is significantly denser than all of its neighboring counties.⁸² Based on the 2020 U.S. Census, Orange County has a population of 3,186,989, with 9.9% of its residents experiencing poverty and 21.4% under the age of 18.⁸³ 38.5% of residents identified as White, 34.1% as Hispanic or Latino, 22.8% as Asian, 2.2% as Black or African American, and 1.1% as American Indian and Alaska Native.⁸⁴ In July 2022, 366,289 Orange County residents under the age of 21 were enrolled in Medi-Cal.⁸⁵ In July 2022, Orange County had 2,517 children in foster care, making it the county with the fifth largest foster care population in California.⁸⁶ The number of children in foster care in the county rose steadily from 2016 to 2020, where the population peaked at 2,668, before declining slightly to 2,493 in 2021, as shown in [Figure 1a](#).

From 2016 to 2021, Orange County had the lowest SMHS penetration rate (5+ visits in a fiscal year) for all children among the five counties (see [Figure 2f](#)). From 2016 to 2020, its SMHS penetration rate (5+ visits in a fiscal year) for all

children and youth grew steadily. In 2021, Orange County was the only county that had an increased SMHS penetration rate (5+ visits in a fiscal year) for all children and youth compared to the previous year (see [Figure 2f](#)). Orange County has the fifth largest foster care population and the lowest SMHS penetration rate (5+ visits in a fiscal year) for foster children and youth among the five counties (see [Figure 2h](#)). In 2021, even though Orange County had an increase in SMHS penetration rate (5+ visits in a fiscal year) for all children and youth, its SMHS penetration rate (5+ visits in a fiscal year) for foster children and youth decreased slightly (see [Figure 2h](#)). The decrease in SMHS penetration for foster youth is worth exploring further, as it could suggest that foster youth in Orange County may be underutilizing or lack access to SMHS.

Orange County's ICC utilization count for all children and youth under the age of 21 increased from 2016 to 2020 and then dropped in 2021 (see [Figure 3c](#)). Its ICC utilization count for children and youth in foster care (see [Figure 3d](#)), IHBS utilization count for all children and youth (see [Figure 4c](#)), as well as IHBS utilization count by foster children and youth (see [Figure 4d](#)) all showed a similar ascending trend. These trends are similar to the trends in the foster care population size in the county (see [Figure 1a](#)). It is worth noting that, despite being the third most populous county in California, Orange County's ICC utilization rates were the second lowest among the five counties. However, it had the overall second highest ICC utilization minutes per beneficiary rate among the five counties, which remained mostly steady, with increases in 2018 and 2021 (see [Figure 3e](#)). The time (minutes) of IHBS each child and youth in foster care received by fiscal year showed an overall ascending trend, with the exception of 2017 and 2019 (see [Figure 4e](#)).

As previously mentioned, information on timely access is not available by county each year. However, based on the triennial review findings, Orange County did not initially comply with the timely access standards in FY 2019–2020.⁸⁷ These reports show that Orange County has been meeting the provider network ratio requirement for child psychiatry since RY 2019 and for child outpatient SMHS since RY 2020.

Conclusion and Recommendations

Taken together, our analysis suggests that many children and youth in Medi-Cal are not receiving the SMHS for which they need to address their mental health conditions and to which they are legally entitled. In the five counties we reviewed, utilization of SMHS among children and youth, including foster children and youth, largely increased over the last five years, but there was substantial variation in utilization rates among the counties, which suggests that some foster children and youth may not have access to the services they need. In addition, several counties struggled to comply with network adequacy standards, which suggests that there may not be sufficient numbers or distributions of providers in those counties to provide children and youth with necessary SMHS.

Given the limitations of the data we analyzed, as described in more detail above, it is difficult to draw more firm conclusions about children and youth in foster care's access to SMHS in Medi-Cal. Thus, we recommend that DHCS take steps to improve the data related to access to SMHS for foster children and youth. Specifically:

- DHCS should make all non-confidential raw data available on their website and make clear which of its datasets correspond to those on the CalHHS Open Data Portal.
- DHCS should ensure that each dataset lists the source(s) of its data. This information is important, as it helps users understand and analyze the reliability of the data and any potential biases or limitations.
- DHCS should coordinate its foster care related data with the California Department of Social Services (CDSS) and jointly publish annual reports that analyze foster youth utilization of SMHS and also account for changes in the number of children and youth in foster care by county by year.
- DHCS should ensure that its datasets are updated regularly and on a consistent schedule. As previously mentioned, per the SMHS Performance Dashboard User Guide, the data is supposed to be updated “annually around the second quarter of the calendar year.”⁸⁸

However, when we conducted our research in Spring 2023, we were unable to locate any data for 2022.

- DHCS should publish detailed timely access and network adequacy data for County Mental Health Plans so that stakeholders can better evaluate their MHP's compliance with timely access and network adequacy requirements. This should include data that is disaggregated by service type, and it should include information about not only timely access, but also geographic access and provider-to-beneficiary ratios for the range of SMHS.
- DHCS should provide additional monitoring and oversight to ensure that children and youth in foster care have access to the specialty mental health services that they need. As described in more detail above, the data we do have suggests that, in many counties, children and youth in foster care are not getting the services they need. More information is needed to understand whether this is the case, and if so, why. Only then can DHCS address barriers to care that these children and youth are experiencing.

Endnotes

- ¹ Compare KidData.org, *Child Population, by Race/Ethnicity* (2018), <https://www.kidsdata.org/topic/33/child-population-race/pie#fmt=144&loc=2&tf=108&ch=7,11,70,10,72,9,73&pdist=73> (last visited Sept. 8, 2023), with KidsData.org, *Children in Foster Care, by Race/Ethnicity* (2018), <https://www.kidsdata.org>. (last visited Sept. 8, 2023).
- ² See CAL. LEGISLATURE, ASSEMBLY & SENATE HEALTH COMMS., *Informational Hearing: The Medi-Cal Mental Health Delivery System: Background* at 2–3 (2019), <https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Final%20February%2026%20Medi-Cal%20Mental%20Health%20Background%202.pdf>.
- ³ EPSDT is also called “Medi-Cal for Kids and Teens” in California. See CAL. DEP’T OF HEALTH CARE SERVS., *Medi-Cal for Kids & Teens*, <https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/home.aspx> (last modified June 20, 2023).
- ⁴ CAL. WELF. & INST. CODE. § 14184.402; see also CAL. DEP’T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 21-073 (Dec. 10, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf> [hereinafter BHIN 21-073].
- ⁵ See also Carly Myers & T. Nancy Lam, NAT’L HEALTH LAW PROGRAM, *Foster Youth Access to Medi-Cal Specialty Mental Health Services: A Review of Policies, Procedures, and Beneficiary-Facing Materials in the California Counties with the Largest Foster Care Populations* (Sept. 2023), <https://healthlaw.org/wp-content/uploads/2023/09/CA-Foster-Youth-SMHS-Document-Review-Report.pdf>; Carly Myers & T. Nancy Lam, NAT’L HEALTH LAW PROGRAM, *Foster Youth Access to Medi-Cal Specialty Mental Health Services: Results from Qualitative Research in the California Counties with the Largest Foster Care Populations* (Sept. 2023), <https://healthlaw.org/wp-content/uploads/2023/09/CA-Foster-Youth-SMHS-Qualitative-Report.pdf>.
- ⁶ See CAL. DEP’T OF HEALTH CARE SERVS., *Specialty Mental Health Services for Children and Youth*, https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx (last modified Feb. 13, 2023). For the medical necessity criteria for children and youth under age 21, see CAL. DEP’T OF HEALTH CARE SERVS., BHIN 21-073, *supra* note 4, at 4–5.
- ⁷ See CAL. DEP’T OF HEALTH CARE SERVS., *Specialty Mental Health Services for Children and Youth*, https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx (last modified Feb. 13, 2023).
- ⁸ *Id.*

⁹ *Id.*

¹⁰ See CAL. DEP'T OF SOC. SERVS. & UNIV. OF CAL. BERKELEY, California Child Welfare Indicators Project, *Children in Foster Care*, <https://ccwip.berkeley.edu/childwelfare/reports/PIT/MTMG/r/ab636/s> (last visited Sept. 7, 2023) [hereinafter CCWIP Data]. “Foster care population” is defined here as “all children who have an open child welfare placement episode in the CWS/CMS system.” *Id.*

¹¹ To access relevant data posted on the “California Health and Human Services Open Data Portal,” see CAL. HEALTH & HUMAN SERVS. AGENCY, *Department of Health Care Services*, <https://data.chhs.ca.gov/organization/department-of-health-care-services> (last visited Sept. 8, 2023). To access relevant data posted on the “DHCS Behavioral Health Reporting Data Hub,” see CAL. DEP'T OF HEALTH CARE SERVS., *DHCS Behavioral Health Reporting*, <https://behavioralhealth-data.dhcs.ca.gov/> (last visited Sept. 8, 2023).

¹² For more information on data sources and claims, see CAL. DEP'T OF HEALTH CARE SERVS., *Performance Outcomes System Measures Catalog*, https://www.dhcs.ca.gov/Documents/CSD_YV/MHSA/MeasuresCatalog-Mar2021.pdf (last modified May 28, 2021).

¹³ To access the “Children and Youth SMHS Performance Dashboard,” see CAL. DEP'T OF HEALTH CARE SERVS., *Children and Youth Under the Age of 21 Specialty Mental Health Services (SMHS) Performance Dashboard*, <https://behavioralhealth-data.dhcs.ca.gov/pages/children-youth-smhs-performance> (last visited Sept. 8, 2023) [hereinafter Children and Youth SMHS Performance Dashboard]. To access the “Children and Youth in Foster Care SMHS Performance Dashboard,” see CAL. DEP'T OF HEALTH CARE SERVS., *Children And Youth In Foster Care Specialty Mental Health Services (SMHS) Performance Dashboard*, <https://behavioralhealth-data.dhcs.ca.gov/pages/f953faa802cf40d5b4d9b5780183fca4> (last visited Sept. 8, 2023).

¹⁴ This dashboard displays the percentage of beneficiaries that received a “step down,” meaning that they received outpatient SMHS within a certain number days after being discharged from an inpatient SMHS. It also displays the mean and median number of days from inpatient discharge to the “step down” of outpatient SMHS. See Kris Dubble, CAL. DEP'T OF HEALTH CARE SERVS., *SMHS Performance Dashboard User Guide* (Oct. 25, 2022), <https://storymaps.arcgis.com/stories/Oa204b8e5b2e47c282bfb2ebe54e8015> [hereinafter SMHS Performance Dashboard User Guide].

¹⁵ Snapshot data includes the count of beneficiaries that arrived, exited, or received continuous services in SMHS. See *id.*

¹⁶ While analyzing this data, we had several questions about the scope and nature of the published data. Some answers were found in the SMHS Performance Dashboard User Guide. See *id.* Other answers were obtained through direct correspondence with DHCS. See Email from Linette Scott, CAL. DEP'T OF HEALTH CARE SERVS., to Kim Lewis, NAT'L HEALTH LAW PROGRAM (June 7, 2023) (on file with author).

- ¹⁷ Penetration rate is defined as “the percentage of SMHS eligible beneficiaries that have been claimed for SMHS via the Short-Doyle/Medi-Cal claiming system.” It is calculated by taking the total number of youth who received one or more SMHS’ in a fiscal year and dividing that by the total number of Medi-Cal eligible youth for that fiscal year. See CAL. DEP’T OF HEALTH CARE SERVS., *Performance Outcomes System Report* at 2, 7 (Feb. 12, 2019), <https://www.dhcs.ca.gov/services/MH/Documents/00-20190304-Statewide-SUP-Final.pdf>.
- ¹⁸ The Data Hub includes two additional Performance Dashboards, “Children and Youth with an Open Child Welfare Case” and “Adult SMHS,” which we did not include in our research because their data included populations beyond those that are the subject of our research (children and youth under age 21 and in foster care). See *id.* at 10. We also chose not to include data from the “Katie A. Specialty Mental Health Datasets” and “Children and Youth MHS Demographic Dashboard (AB 470)” in our research. We did not include the Katie A. Dataset because we found inconsistencies in the data. See CAL. HEALTH & HUMAN SERVS. AGENCY, *Katie A. Specialty Mental Health Datasets*, <https://data.chhs.ca.gov/dataset/katie-a-specialty-mental-health-datasets> (last visited Sept. 8, 2023). We did not include the AB 470 Dashboard because the same information was located in other sources. See CAL. DEP’T OF HEALTH CARE SERVS., *Children and Youth Mental Health Services Demographic Dashboards (AB470)*, <https://behavioralhealth-data.dhcs.ca.gov/pages/46f49ef378e64da6989efd5dd8c6e5e3> (last visited Sept. 8, 2023).
- ¹⁹ To access DHCS’s annual network certification reports, see CAL. DEP’T OF HEALTH CARE SERVS., *Network Adequacy*, <https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx> (last modified July 31, 2023). To access counties’ triennial review system reports, see CAL. DEP’T OF HEALTH CARE SERVS., *Medi-Cal Specialty Mental Health Services Plans of Correction*, https://www.dhcs.ca.gov/services/MH/Pages/County_MHP_POC.aspx (last modified Aug. 24, 2023). To access foster care populations data reported by CDSS, see CAL. DEP’T OF SOC. SERVS. & UNIV. OF CAL. BERKELEY, CCWIP Data, *supra* note 10.
- ²⁰ See CAL. DEP’T OF HEALTH CARE SERVS., *Mental Health Children and Youth Reports: Katie A. Specialty Mental Health Reports*, https://www.dhcs.ca.gov/services/MH/Pages/Mental_Health_Children_and_Youth_Reports.aspx (last modified Feb. 13, 2023).
- ²¹ *Id.*
- ²² See CAL. HEALTH & HUMAN SERVS. AGENCY, *Katie A. Specialty Mental Health Datasets*, *supra* note 18.

- ²³ DHCS’s “Children and Youth Under the Age of 21 Specialty Mental Health Services (SMHS) Performance Dashboard” was introduced in an earlier section of this report as the “Children and Youth SMHS Performance Dashboard.” See CAL. DEP’T OF HEALTH CARE SERVS., Children and Youth SMHS Performance Dashboard, *supra* note 13. To access CalHHS’s “Children and Youth Specialty Mental Health Services Utilization” dataset, see CAL. HEALTH & HUMAN SERVS. AGENCY, *Children and Youth Specialty Mental Health Services Utilization*, <https://data.chhs.ca.gov/dataset/early-and-periodic-screening-diagnosis-and-treatment-of-children-and-youth-performance-dashboard/resource/770ec3e6-2b38-4f6a-a739-6c60273ed09c> (last visited Sept. 8, 2023) [hereinafter Children and Youth SMHS Utilization].
- ²⁴ See CAL. HEALTH & HUMAN SERVS. AGENCY, *Children and Youth Under the Age of 21 Performance Dashboard*, <https://data.chhs.ca.gov/dataset/early-and-periodic-screening-diagnosis-and-treatment-of-children-and-youth-performance-dashboard> (last visited Sept. 8, 2023).
- ²⁵ See CAL. DEP’T OF HEALTH CARE SERVS., SMHS Performance Dashboard User Guide, *supra* note 14.
- ²⁶ See CAL. DEP’T OF HEALTH CARE SERVS., Children and Youth SMHS Performance Dashboard, *supra* note 13.
- ²⁷ For example, the link to the SMHS Billing Manual in DHCS’s Data Dictionary is broken. See CAL. HEALTH & HUMAN SERVS. AGENCY, Children and Youth SMHS Utilization, *supra* note 23.
- ²⁸ See CAL. DEP’T OF HEALTH CARE SERVS., SMHS Performance Dashboard User Guide, *supra* note 14.
- ²⁹ For purposes of this research, we used the California Department of Social Services’ (CDSS’s) definition of “foster youth population:” individuals with a foster care out-of-home placement (OOHP) during their latest eligibility month for the fiscal year. CDSS uses point-in-time data, unlike DHCS, which uses an annual cumulative count. See Email from Linette Scott, CAL. DEP’T OF HEALTH CARE SERVS., to Kim Lewis, NAT’L HEALTH LAW PROGRAM (June 7, 2023) (on file with author).
- ³⁰ Penetration rate is defined as “the percentage of SMHS eligible beneficiaries that have been claimed for SMHS via the Short-Doyle/Medi-Cal claiming system.” It is calculated by taking the total number of youth who received one or more SMHS’ in a fiscal year and dividing that by the total number of Medi-Cal eligible youth for that fiscal year. See CAL. DEP’T OF HEALTH CARE SERVS., *Performance Outcomes System Report*, *supra* note 17 at 2, 7.
- ³¹ To access SMHS, the Medi-Cal enrollee is also required to meet medical necessity criteria.
- ³² Data is not shown for Fresno County in 2017 and 2018 because DHCS suppresses values between 1 and 10.
- ³³ Data is not shown for Fresno County in 2017 and 2018 because DHCS suppresses values between 1 and 10.

³⁴ 42 C.F.R. § 438.206.

³⁵ *Id.*

³⁶ *Id.* § 438.206(c)(1)(iii); CAL. CODE REGS. tit. 9, § 1810.405.

³⁷ CAL. CODE REGS. tit. 28, § 1300.67.2.2(c)(5)(A)–(B).

³⁸ CAL. WELF. & INST. CODE. § 14197(d)(1)(A)–(B) (incorporating requirements in CAL. HEALTH & SAFETY CODE § 1367.03(a)(5)(D)–(F) to apply to all Medi-Cal plans including MHPs); CAL. CODE REGS. tit. 28, § 1300.67.2.2(c)(5)(D), (E); CAL. DEP'T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 21-023 (May 24, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-023-2021-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf>.

³⁹ CAL. DEP'T OF HEALTH CARE SERVS., *2020 Annual Network Certification, Mental Health Plan, Corrective Action Plan Report* at 3 (2021), <https://www.dhcs.ca.gov/Documents/MHP-2020-Annual-Network-Certification-CAP-Report.pdf>. Marin MHP remained out-of-compliance. *See id.*

⁴⁰ CAL. DEP'T OF HEALTH CARE SERVS., *2021 Annual Network Certification, Mental Health Plan, Corrective Action Plan Report* at 7–46 (2022), <https://www.dhcs.ca.gov/Documents/MHP-2021-Annual-Network-Certification-CAP-Report.pdf>. The three counties that were granted a conditional pass were Del Norte, Madera, and Santa Clara. *See id.* Del Norte remained out-of-compliance. *Id.* at 10.

⁴¹ *See* CAL. DEP'T OF HEALTH CARE SERVS., *Medi-Cal Specialty Mental Health Services Plans of Correction*, https://www.dhcs.ca.gov/services/MH/Pages/County_MHP_POC.aspx (last modified August 24, 2023).

⁴² *See id.*

⁴³ CAL. DEP'T OF HEALTH CARE SERVS., *Fiscal Year 2021/2022 Medi-Cal Specialty Mental Health Services Triennial Review of the Los Angeles County Mental Health Plan, Systems Findings Report* at 4–5 (2023), <https://www.dhcs.ca.gov/Documents/Los-Angeles-System-Review-Findings-Report-FY-21-22.pdf> [hereinafter FY 2021/2022 Los Angeles County System Findings Report].

⁴⁴ CAL. DEP'T OF HEALTH CARE SERVS., *Fiscal Year 2021/2022 Medi-Cal Specialty Mental Health Services Triennial Review of the San Bernardino County Mental Health Plan, Systems Findings Report* at 4–5 (2023), <https://www.dhcs.ca.gov/Documents/San-Bernardino-System-Review-Findings-Report-FY-21-22.pdf> [hereinafter FY 2021/2022 San Bernardino County System Findings Report].

⁴⁵ CAL. DEP'T OF HEALTH CARE SERVS., *Fiscal Year 2021/2022 Medi-Cal Specialty Mental Health Services Triennial Review of the Riverside County Mental Health Plan, Systems Findings Report* at 4 (2023), <https://www.dhcs.ca.gov/Documents/Riverside-System-Review-Findings-Report-FY-21-22.pdf> [hereinafter FY 2021/2022 Riverside County System Findings Report].

⁴⁶ 42 C.F.R. § 438.206(b)(1).

- ⁴⁷ For 2021, which was the most recent certification period at the time of this research, the ratio standard for children and youth outpatient SMHS was 1:43, and the ratio standard for adult outpatient SMHS was 1:85. See CAL. DEP'T OF HEALTH CARE SERVS., *Annual Network Certification, Specialty Mental Health Services* at 12 (2021), <https://www.dhcs.ca.gov/Documents/2021-MHP-Network-Certification-Summary-Methodology-and-Findings.pdf> [hereinafter Annual Network Certification]. For more detail about how these ratios are calculated, see CAL. DEP'T OF HEALTH CARE SERVS., Behavioral Health Information Notice No. 22-033 at 7-9 (June 24, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-033-2022-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf> [hereinafter BHIN 22-033].
- ⁴⁸ CAL. DEP'T OF HEALTH CARE SERVS., *Annual Network Certification*, *supra* note 47 at 10-11.
- ⁴⁹ The information contained in this chart was obtained from DHCS's annual network certification corrective action reports. See CAL. DEP'T OF HEALTH CARE SERVS., *Network Adequacy*, <https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx> (last modified July 31, 2023).
- ⁵⁰ CAL. STATE ASS'N OF COUNTIES, *Los Angeles County*, <https://www.counties.org/county-profile/los-angeles-county> (last visited Sept. 11, 2023).
- ⁵¹ *Id.*
- ⁵² LOS ANGELES CNTY., *About LA County*, <https://lacounty.gov/government/about-la-county/about/> (last visited Sept. 11, 2023).
- ⁵³ U.S. CENSUS BUREAU, *Los Angeles County Population: April 1, 2020*, <https://www.census.gov/quickfacts/fact/table/losangelescountycalifornia,US/POP010220> (last visited Sept. 11, 2023). The U.S. Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty. See U.S. CENSUS BUREAU, *How the Census Bureau Measures Poverty*, <https://www.census.gov/topics/income-poverty/poverty/guidance/poverty-measures.html> (last visited Sept. 11, 2023).
- ⁵⁴ *Id.* Please note that we are using the race and ethnicity categories as described by the Census to be accurate with regard to the data, even though the Census's description differs from NHeLP's preferred terminology for talking about Latine, Asian American, and Indigenous people.
- ⁵⁵ CAL. HEALTH & HUMAN SERVS. AGENCY, *Eligible Individuals Under Age 21 Enrolled in Medi-Cal*, <https://data.chhs.ca.gov/dataset/eligible-individuals-under-age-21-enrolled-in-medi-cal-by-county> (last visited Sept. 11, 2023) [hereinafter Medi-Cal Enrollees Under Age 21].
- ⁵⁶ See CAL. DEP'T OF SOC. SERVS. & UNIV. OF CAL. BERKELEY, CCWIP Data, *supra* note 10.
- ⁵⁷ See CAL. DEP'T OF HEALTH CARE SERVS., FY 2021/2022 Los Angeles County System Findings Report, *supra* note 43.

- ⁵⁸ CAL. STATE ASS'N OF COUNTIES, *San Bernardino County*, <https://www.counties.org/county-profile/san-bernardino-county> (last visited Sept. 11, 2023).
- ⁵⁹ *See id.*; U.S. CENSUS BUREAU, *Growth in the Nation's Largest Counties Rebounds in 2022* (Mar. 30, 2023), <https://www.census.gov/newsroom/press-releases/2023/population-estimates-counties.html>.
- ⁶⁰ U.S. CENSUS BUREAU, *San Bernardino County Population: April 1, 2020*, <https://www.census.gov/quickfacts/fact/table/sanbernardinocountycalifornia,US/POP010220> (last visited Sept. 11, 2023).
- ⁶¹ *Id.*
- ⁶² CAL. HEALTH & HUMAN SERVS. AGENCY, *Medi-Cal Enrollees Under Age 21*, *supra* note 55.
- ⁶³ CAL. DEP'T OF SOC. SERVS. & UNIV. OF CAL. BERKELEY, *CCWIP Data*, *supra* note 10.
- ⁶⁴ *See* CAL. DEP'T OF HEALTH CARE SERVS., *FY 2021/2022 San Bernardino County System Findings Report*, *supra* note 44.
- ⁶⁵ CAL. STATE ASS'N OF COUNTIES, *Riverside County*, <https://www.counties.org/county-profile/riverside-county> (last visited Sept. 11, 2023).
- ⁶⁶ *See id.*; U.S. CENSUS BUREAU, *supra* note 48.
- ⁶⁷ U.S. CENSUS BUREAU, *Riverside County Population: April 1, 2020*, <https://www.census.gov/quickfacts/fact/table/riversidecountycalifornia,US/POP010220> (last visited Sept. 11, 2023).
- ⁶⁸ *Id.*
- ⁶⁹ CAL. HEALTH & HUMAN SERVS. AGENCY, *Medi-Cal Enrollees Under Age 21*, *supra* note 55.
- ⁷⁰ CAL. DEP'T OF SOC. SERVS. & UNIV. OF CAL. BERKELEY, *CCWIP Data*, *supra* note 10.
- ⁷¹ *See* CAL. DEP'T OF HEALTH CARE SERVS., *FY 2021/2022 Riverside County System Findings Report*, *supra* note 45.
- ⁷² CAL. STATE ASS'N OF COUNTIES, *Fresno County*, <https://www.counties.org/county-profile/fresno-county> (last visited Sept. 11, 2023).
- ⁷³ *Id.*
- ⁷⁴ CAL. EMP'T DEV. DEP'T, *Fresno County Profile*, <https://labormarketinfo.edd.ca.gov/geography/fresno-county.html> (last visited Sept. 11, 2023).
- ⁷⁵ U.S. CENSUS BUREAU, *Fresno County Population: April 1, 2020*, <https://www.census.gov/quickfacts/fact/table/fresnocountycalifornia,US/POP010220> (last visited Sept. 11, 2023).
- ⁷⁶ *See id.*
- ⁷⁷ CAL. HEALTH & HUMAN SERVS. AGENCY, *Medi-Cal Enrollees Under Age 21*, *supra* note 55.
- ⁷⁸ CAL. DEP'T OF SOC. SERVS. & UNIV. OF CAL. BERKELEY, *CCWIP Data*, *supra* note 10.

- ⁷⁹ See CAL. DEP'T OF HEALTH CARE SERVS., *Fiscal Year 2020-2021 Medi-Cal Specialty Mental Health Services Triennial Review of the Fresno County Mental Health Plan, Systems Findings Report (2021)*, <https://www.dhcs.ca.gov/Documents/Fresno-System-Report-FY-2020-21.pdf>.
- ⁸⁰ CAL. STATE ASS'N OF COUNTIES, *Orange County*, <https://www.counties.org/county-profile/orange-county> (last visited Sept. 11, 2023).
- ⁸¹ ORANGE CNTY. BUS. COUNCIL et al., *OC Community Indicators 2020-2021* at 9 (Sept. 2020), <https://www.ocbc.org/wp-content/uploads/2020/09/2020-Community-Indicators-Report.pdf>.
- ⁸² *Id.*
- ⁸³ U.S. CENSUS BUREAU, *Orange County Population: April 1, 2020*, <https://www.census.gov/quickfacts/fact/table/orangecountycalifornia,US/POP010220> (last visited Sept. 11, 2023).
- ⁸⁴ *Id.*
- ⁸⁵ CAL. HEALTH & HUMAN SERVS. AGENCY, *Medi-Cal Enrollees Under Age 21*, *supra* note 55.
- ⁸⁶ CAL. DEP'T OF SOC. SERVS. & UNIV. OF CAL. BERKELEY, *CCWIP Data*, *supra* note 10.
- ⁸⁷ See CAL. DEP'T OF HEALTH CARE SERVS., *Fiscal Year 2019/2020 Medi-Cal Specialty Mental Health Services Triennial Review of the Orange County Mental Health Plan, System Findings Report (2020)*, <https://www.dhcs.ca.gov/Documents/Orange-County-MHP-FY19-20-System-Findings-Report.pdf>.
- ⁸⁸ See CAL. DEP'T OF HEALTH CARE SERVS., *SMHS Performance Dashboard User Guide*, *supra* note 14.