DISPROPORTIONATE FUNDING DENIES SPECIALTY MENTAL HEALTH CARE TO HUNDREDS OF THOUSANDS OF CALIFORNIA YOUTH

Discretionary funding allocations constrain SMHS performance in counties with the highest proportion of Medi-Cal eligible youth

Young Minds Advocacy

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Disproportionate Funding Denies Specialty Mental Health Care To Hundreds Of Thousands Of California Youths

Executive Summary

Motivation

Unmet mental health needs contribute to juvenile delinquency, family stress and disruption, entry into foster care, homelessness, failure in school, unemployment, hopelessness, and suicide. Access to appropriate mental health treatment reduces pain and suffering, strengthens families and communities, and assists young people in reaching their full potential as independent, productive adults. While one may expect that access to public mental health services for children and youth are based on program eligibility and need, this report shows that funding allocations devised by the Departments of Finance (DOF) and Health Care Services (DHCS) have largely determined who gets care and whose needs go unmet in California.

California funds its children and youth Specialty Mental Health Services (SMHS) program primarily with dedicated state sales tax and vehicle licensing fees, and federal Medicaid matching funds. Allocation of the sales tax and licensing fees among the counties is determined by DOF and DHCS, largely based on prior county mental health spending patterns. This funding formula results in a disproportionate allocation of resources favoring counties that historically spent more on mental health care for children and youth.

The data show that funding allocations dating back to at least 2011 Realignment have constrained mental health service performance in counties that received proportionately less state funding. As a result, hundreds of thousands of youths have not received *any* services simply because they resided in counties that have proportionately more Medi-Cal eligible youths than mental health funding. Moreover, these "underwater" counties have been less able to engage youth who touched their SMHS systems, and have provided far fewer average hours of treatment and for shorter time-periods to those who do get care. Compared with reasonable standards of access and care, youths in these counties went unserved or underserved, contrary to government's promise of equal access to care and the mandates of state and federal Medicaid law.

Analysis

Young Minds Advocacy's study focusses on Medi-Cal-funded SMHS for children and youths in the largest 28 Mental Health Plans (MHPs) that serve 29 counties and account for roughly 95% of the number of youths served and amount of dollars spent on SMHS.

The study uses annual data from a) the State Controller's Office (SCO Realignment and appropriations reports); b) the DHCS Performance Outcome System (POS); and c) DHCS Cost Summary Reports for State Fiscal Years (FY) 2012-13 through 2019-20. The data was analyzed through the lens of two county-level metrics—the Equity Ratio (ER) and the Access Index (AI). The ER reflects each county's proportion of behavioral health funding relative to the number of Medi-Cal eligible youth in the county. The Access Index (AI) is a ratio of the supply of mental health services measured in minutes of treatment to an estimated demand for those services. These metrics allowed us to compare SMHS funding with spending and performance among counties and to reasonable access and intensity standards.

Findings

State funding for youth SMHS steadily increased under 2011 Realignment from $924 million in FY 2012-13 to $1.38 billion in FY 2019-20 for the largest 28 MHPs. Over that time, the number of unduplicated youths receiving SMHS from these MHPs fluctuated between 229,773 and 257,472, annually.

2011 Realignment changed the way California funds youth SMHS. One change was to designate DOF, in consultation with DHCS, with responsibility for allocating youth SMHS funding among the counties. DOF and DHCS' funding decisions, relying primarily on past spending, have resulted in wide disparities in relative funding per eligible youths among counties, measured here as ERs. For example, in FY 2019-20, Kings County received 0.24% of total statewide 2011 Realignment behavioral health funds to serve 0.57% of California's total statewide Medi-Cal eligible youth, and had an Equity Ratio of 0.42. Twelve MHPs had ERs below 0.75 in FY 2019-20. We refer to these as "deep-underwater" MHPs. Seven MHPs had ERs above 1.25, including Los Angeles County with an ER of 1.35. We refer to these as "high-surplus" MHPs.

Inequity in funding has increased since 2011 Realignment. More than three-fifths of all eligible youths—about 3.3 million—lived in counties where inequity grew during the study period.

In order to adequately measure access to care, we developed an Access Index (AI) that compares the combined total of mental health services provided at the county level to a standard of performance for both a) the number of youths in need and b) the level of needed care measured in treatment units. Thus, the AI is essentially the county-level ratio of supply to demand measured in minutes of treatment. The AI provides a sense of how much of the expected mental healthcare need or demand is met, county-by-county.

For example, Santa Clara and Butte counties, each with an AI of 0.86, may be understood to have provided 86% of the estimated total need for minutes of care in FY 2019-20. San Joaquin (AI= 0.16) and Madera (AI=0.17) counties provided 16% and 17% of the total need for care, respectively. Our results show significant variability in access to care for families and youths across California.

Combining ER and AI we compared funding and performance among counties and determined that greater relative funding (ER) strongly corresponds to better access to care (AI). Alternatively, insufficient relative funding was shown to impair access to care. This pattern has been consistent for every year post-2011 Realignment.

The data show that California's discretionary funding allocations dating back to at least 2011 Realignment have constrained mental health service performance in counties that received proportionately less state funding. Hundreds of thousands of youths have not received services simply because they resided in counties with more Medi-Cal eligible youths than mental health funding provided under the 2011 Realignment.

Moreover,

- Underwater counties have been less able to engage youth who touched their SMHS systems, and have provided far fewer average hours of treatment, for shorter durations to those who did get care.

- Counties with more youths, in terms of the proportion of the state total and the proportion of the county population, received fewer 2011 Realignment mental health dollars for youth.

- Sixteen medium and large counties, serving more than a third of California's youth, missed out on an estimated $3 billion in mental health funds and failed to serve about one-half million eligible youths since FY 2012-13. In FY 2019-20 alone, at least 46,000 youths failed to receive any SMHS due to disproportionate 2011 Realignment funding.

- Underwater counties generally received proportionately less funds in other key mental health programs, including Mental Health Service Act, Medicaid Federal Funding Participation, 1991 Realignment adult funding, and Non-Specialty Mental Health Services.

The additional annual funding for underwater counties required to achieve 75% of the expected mental health services need for eligible youth was estimated to be $690 million for FY 2019-20. The data suggest that federal Medicaid cost-share match might provide an estimated 60% or more of the funding to meet this need.

Conclusion

Discretionary funding allocations dating back to at least Realignment 2011 have constrained performance in counties that received disproportionately less state funding. Indeed, hundreds of thousands of youths did not receive *any* services simply because they resided in underwater counties—those that have proportionately more Medi-Cal eligible youths and proportionately less 2011 Realignment funding due to the State's funding scheme. Additionally, deep-underwater counties with more kids and less money were also markedly less able to engage youth who touched their SMHS systems, and provided far fewer hours of service for shorter lengths of time on average to youths who did get care.

According to a reasonable standard of access to care, in FY 2019-20 every underwater county failed to provide adequate care, both in terms of number of youths served and intensity of services provided. One can only imagine how many tens of thousands of youths would have succeeded in school, remained in their homes with their biological parents, avoided delinquency and detention, or survived to become adults, had mental health funding afforded them fair access to treatment for their serious mental health needs.

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About the Author

This report was written by Patrick Gardner, President of Young Minds Advocacy. A public interest lawyer for more than 35 years, he specializes in children's mental health law and policy involving child welfare, juvenile justice, special education, and behavioral health systems. A University of Virginia Law graduate, he has served as counsel or advisor in numerous statewide class actions to strengthen children's rights to behavioral health care, and works with legislative bodies and administrative agencies to improve access to individualized, high-quality treatment. Prior to founding Young Minds Advocacy, Patrick was deputy director of the National Center for Youth Law, and previously, Hawaii County managing attorney with the Legal Aid Society of Hawaii.

> *"Decades of experience advocating for low-income and at-risk people has taught me to be creative, outspoken, persistent—but never patient. Children and youths with serious mental health needs deserve access to quality treatment now."*

Acknowledgement

Identifying, gathering and analyzing billions of bytes of data, and then turning what was learned into this report, required many hundreds of hours, and couldn't have been completed without considerable help. Many, many thanks to Amed Prado, Kevin Clark, Patty Gish, Rob Waring, Margaret Mangan, and Eren Manavoglu for their unstinting help with research, editing, design, and production. Their creative, insightful, patient, and persistent assistance was essential. Thanks also to the folks at California Children's Trust for financial and production support, and to the leaders at the Department of Health Care Services for sharing their data and feedback. Finally, I greatly appreciated the constructive conversations with Nathan Israel, Alex Briscoe, and Margaret Mangan that helped sharpen my thinking and presentation. Although I am indebted to many for their help in completing this report, the views expressed herein are my own, and I am responsible for any errors or omissions. Finally, the data sets underpinning this research are numerous and large, and are not included herein. Individuals interested in the original data should contact me.

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Disproportionate Funding Denies Specialty Mental Health Care To Hundreds Of Thousands Of California Youths

I. Introduction

Unmet mental health needs contribute to juvenile delinquency, family stress and disruption, entry into foster care, homelessness, failure in school, unemployment, hopelessness, and suicide. Access to appropriate mental health treatment reduces pain and suffering, strengthens families and communities, and assists young people in reaching their full potential as independent, productive adults. This paper shows how public mental health funding mechanisms devised by the Departments of Finance and Health Care Services have largely determined who gets care and whose needs go unmet in California.

We reviewed the Department of Health Care Services' (DHCS) Performance Outcomes System (POS) and other statewide administrative data to assess the impacts of 2011 Realignment on Specialty Mental Health Services (SMHS) access and performance for Medi-Cal beneficiaries under age 21 from fiscal year 2012-13 through 2019-20. Medi-Cal funded SMHS are the cornerstone of California's public mental health system for children and youths, providing services to one-quarter million young people annually.

California funds its children and youth SMHS program primarily with dedicated state sales tax and vehicle licensing fees, and federal Medicaid matching funds. Allocation of the state sales tax and licensing fees among the counties is determined by the Department of Finance (DOF), largely based on prior county mental health spending patterns. This results in a disproportionate allocation of resources favoring counties that historically spent more on mental health care for children and youth.

The data we analyzed show that funding allocations dating back to at least 2011 Realignment have constrained mental health service performance in counties that received proportionately less state funding. Indeed, hundreds of thousands of youths have not received *any* services simply because they resided in counties that have proportionately more Medi-Cal eligible youths than mental health funding provided under the 2011 Realignment funding allocation methodology.

Moreover, these "underwater" counties have been less able to engage youth who touched their SMHS systems, and have provided far fewer average hours of treatment to those who did get care. Compared with reasonable standards of access and care, youths in these counties went unserved or underserved, contrary to government's promise of equal access to care and the mandates of state and federal Medicaid law.

II. Background

California, along with every other state, participates in the federal Medicaid program. In return for federal funding, Medicaid programs (known as Medi-Cal in California) must arrange for, or provide, health care for all eligible beneficiaries. For children and youth up to age 21, the entitlement to care is broad and deep and includes the healthcare services and supports needed to correct or ameliorate mental health conditions. This youth entitlement, called Early and Periodic Screening, Diagnostic and Treatment (EPSDT), mandates care for every Medicaid coverable service or support that is medically necessary regardless of whether the service or support is listed in the State Medicaid Plan.[i] Services and supports provided may include: screening, assessment, case management and care coordination, outpatient mental health services, intensive home-and community-based services, medication management, day treatment and residential care, inpatient treatment, transition services, and more.[ii] Treatment must be available statewide and provided with reasonable promptness.[iii]

California's EPSDT mental health program is split into two primary service delivery systems: specialty mental health services[iv] provided by county-run Mental Health Plans (MHPs)[v,vi] and non-specialty mental health services[vii] provided by Managed Care Plans (MCPs).[viii] MHPs are financed using dedicated state sales tax and vehicle licensing fees.[ix] MCPs are financed by state General Fund annual appropriations.[x] This paper addresses the MHP service system involving specialty mental health services (SMHS).

III. Data Sources and Procedures

Our study uses annual data from a) the State Controller's Office (SCO Realignment and appropriations reports[xi]; b) the DHCS Performance Outcome System (POS)[xii]; and c) DHCS Cost Summary Reports,[xiii] for State Fiscal Years (FY) 2012-13 through 2019-20. We also gathered

funding data on Special Education Assistance, non-specialty mental health services, and the Mental Health Services Act (MHSA). Our primary focus, however, is on Medi-Cal-funded EPSDT SMHS for children and youths.

Challenges arose in aggregating and combining data sets this large and varied. To reduce the size of the databases we limited our study to the largest 28 MHPs (29 counties[xiv]), which account for roughly 95% of the number of youths served and the amount of dollars spent on SMHS. The data were stratified by county MHP and year for FY 2012-13 through FY 2019-20.[xv] Adjustments were made to address issues including spending that combined youth and adult information; varied fiscal years; and unreported, erroneous, and suppressed data. Additionally, we focused on major funding sources, excluding some smaller and local mental health programs. Altogether, these data provide the most comprehensive and detailed publicly available county-level funding, spending, and performance information regarding California's Specialty Mental Health Services program for youth.

IV. Analysis

In FY 2019-20, California's EPSDT SMHS program served (i.e., provided at least one unit of care) 246,726 unduplicated youths at a total cost of $1.82 billion. Average spending per SMHS youth recipient was $7,365. In FY 2019-20 almost 5.5 million youth in California were eligible for Medi-Cal. That means that just 4.5% of eligible youth "touched" the SMHS system during the year. This "touch" rate is called the SMHS penetration rate. The number of youths served, EPSDT funding or spending amounts, and penetration rates are the most commonly reported data for California's EPSDT SMHS program. Table 1 shows these data for the largest 28 MHPs for fiscal years 2012-13 through 2019-20. State funding for EPSDT SMHS increased under 2011 Realignment from $924 million in FY 2012-13 to $1.38 billion in FY 2019-20 for the largest 28 MHPs.

TABLE 1. Specialty Mental Health Services System Data for the 28 Largest MHPs from FY 2012/13 to FY 2019/20

Fiscal Year	Youths Receiving SMHS	Total 2011 Realignment BH Funding	Total EPSDT SMHS Spending	Mean SMHS Spending per Youth	Medi-Cal Eligible Youths	Penetration Rate
2012-13	229,773	$923,979,766	$1,451,426,250	$6,317	5,151,578	4.5%
2013-14	243,377	$984,353,763	$1,572,340,841	$6,461	5,548,909	4.4%
2014-15	245,239	$1,093,934,917	$1,593,464,663	$6,498	5,768,010	4.3%
2015-16	245,024	$1,154,912,854	$1,603,717,817	$6,545	5,954,122	4.1%
2016-17	247,080	$1,254,636,324	$1,888,716,511	$7,644	6,003,094	4.1%
2017-18	254,814	$1,336,572,509	$1,963,212,374	$7,704	5,815,645	4.4%
2018-19	257,473	$1,400,297,844	$1,828,695,404	$7,102	5,672,629	4.5%
2019-20	246,726	$1,380,721,528	$1,817,043,767	$7,365	5,495,655	4.5%

Aggregate data for 28 largest MHPs show system trends since 2011 Realignment.

Prior to 2011 Realignment, EPSDT SMHS were funded primarily using state and federal reimbursements for certified public expenditures incurred by MHPs for providing treatment to Medi-Cal eligible youths.[xvi] The federal government reimbursed counties for at least half of their total EPSDT mental health expenditures and the State matched county expenditures with an additional 40-50%, varying over time. In 2011, California shifted its share of EPSDT behavioral health funding from annual General Fund appropriations to dedicated taxes and fees with 2011 Realignment legislation.[xvii] This mirrored an earlier change, known as 1991 Realignment, that shifted adult mental health funding from General Fund annual appropriations to dedicated taxes and fees.[xviii] Under 2011 Realignment, the State Controller's Office would distribute state mental health funding based on an allocation schedule created by DOF in consultation with DHCS and the California State Association of Counties.[xix] Total annual funding was now based on taxes and fees received rather than on annual General Fund appropriations based on SMHS expenditures. Federal cost-sharing continued as before, reimbursing counties for approved spending.[xx]

Initially, the funding allocation formula continued to be based primarily on prior county spending.[xxi] The formula was adjusted each year until 2019, when the "rolling base" methodology was formally adopted.[xxii] Beginning with FY 2018-19, each county's allocation has been based on the sum of its 2011 Realignment behavioral health accounts' allocation from the previous year. If additional 2011 Realignment behavioral health funds remain after distributing the base allocations, MHPs were awarded growth funds based on a formula that includes both spending and population components. The net result of these law and funding changes is total state funding increased for much of the period, but each MHP's share of total state funding remained much the same as it was before 2011 Realignment.

A. Distribution of Funding Is Unequal Among Counties

In order to evaluate the impact of DOF's funding allocations, we first determined the behavioral health funding share each county received from the State under 2011 Realignment. 2011 Realignment behavioral health funding is comprised of two funds: the Behavioral Health Subaccount and the Behavioral Health Special Growth Account. These accounts may be used to fund five services, including EPSDT SMHS.[xxiii] We also calculated the share of total statewide Medi-Cal eligible youth that resided in each MHP's jurisdiction. In order to compare relative funding among counties, we developed an Equity Ratio (ER) using the county proportion of total statewide 2011 Realignment behavioral health funding as the numerator and the county proportion of total statewide Medi-Cal eligible youths as the denominator.

$$ER = \frac{\text{County Percent of Total 28 MHP 2011 Behavioral Health Funding}}{\text{County Percent of Total 28 MHP EPSDT Eligible Youths}}$$

With this Equity Ratio, we mapped 2011 Realignment behavioral health funds and eligible youths for 28 Mental Health Plans (MHPs) over time. See Figure 1. An ER of 1.0 means a county received the same share of total Realignment 2011 funding as their share of total eligible Medi-Cal youths. An ER significantly greater or less than 1.0 indicates the share of funding is disproportionate to the county's SMHS-eligible population.

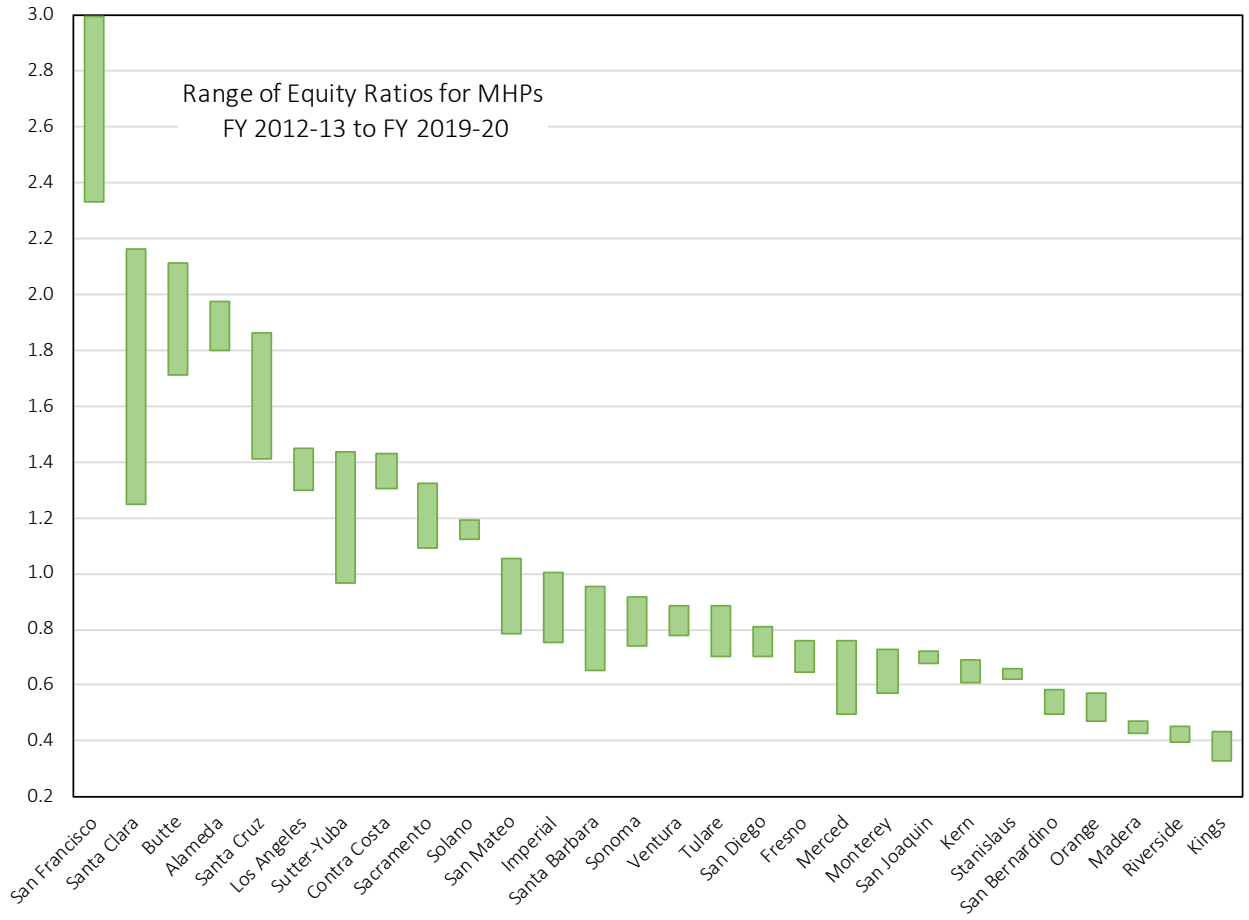

Figure 1. 2011 Realignment funding per Medi-Cal eligible youth varies widely amongst the largest MHPs. See Appendix for data.

Of particular interest are those counties with an ER substantially less than 1.0, i.e., those receiving proportionately less total funding than the proportion of the total number of Medi-Cal eligible youths residing in the county. For example, in FY 2019-20, Kings County received 0.24% of total statewide 2011 Realignment behavioral health funds to serve 0.57% of California's total statewide Medi-Cal eligible youth, and had an Equity Ratio of about 0.42. Twelve counties had an ER below 0.75 in FY 2019-20. For this analysis, we refer to these as "deep-underwater" counties or MHPs. See Figure 2. Seven counties had ERs above 1.25, including Los Angeles County with an ER of 1.35 (data in Appendix). We refer to these as "high-surplus" counties.

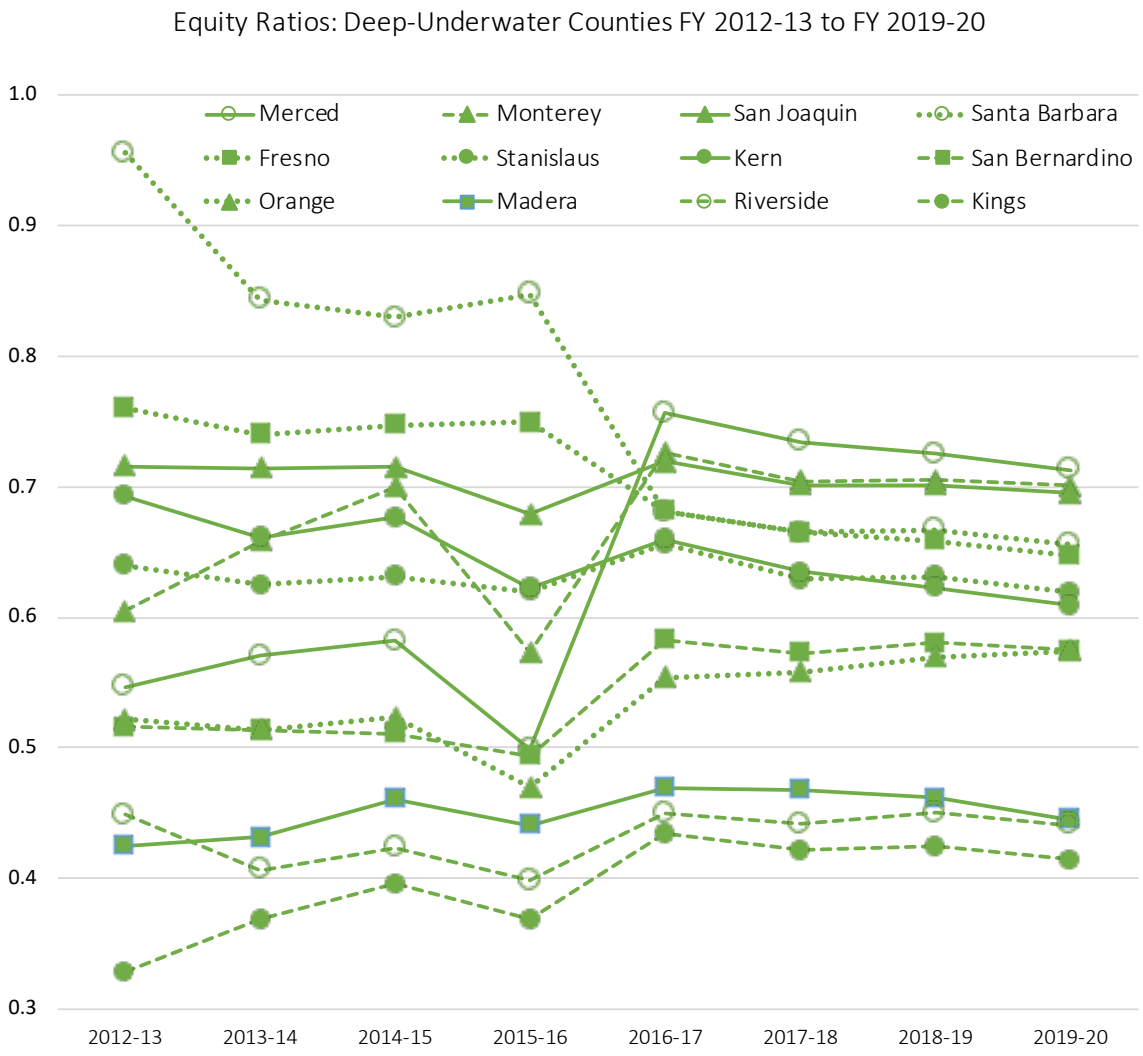

Figure 2. Twelve deep-underwater counties (ER < 0.75) receive disproportionately less 2011 Realignment funding for Medi-Cal eligible youth.

Looking at Equity Ratios over time we see that inequity in the system has increased since 2011 Realignment. Figure 3 groups surplus and underwater counties into quadrants showing surplus counties on the left, underwater counties on the right, and counties whose ER increased above and whose ER decreased below. Counties where inequity grew are displayed in the top left and bottom right quadrants. Counties where inequity declined are listed in the bottom left and top right quadrants. More than 3.3 million eligible youths lived in counties where inequity grew during the study period. Moreover, in six counties that showed improvement, the ER nevertheless remained much lower than 0.75 (Kings, Madera, Merced, Monterey, Orange and San Bernardino).

Mean Equity Ratio and Percent Change FY 2012-13 to 2019-20

	Equity Ratio Above 1			Equity Ratio Below 1		
					Mean ER	Change
Increasing ER		Mean ER	Change	Imperial	0.94	+1.1%
	Contra Costa	1.36	+0.2%	Kings	0.40	+2.9%
	Los Angeles	1.35	+0.1%	Madera	0.45	+0.6%
	San Francisco	2.68	+2.2%	Merced	0.64	+3.4%
	Santa Clara	1.74	+7.1%	Monterey	0.67	+1.9%
				Orange	0.54	+1.2%
				San Bernardino	0.54	+1.4%
				San Diego	0.77	+0.5%
				San Mateo	0.94	+2.2%
				Tulare	0.84	+2.3%
	1,895,998 eligible youth FY 2019-20			1,661,174 eligible youth FY 2019-20		
Decreasing ER				Fresno	0.71	-2.0%
	Alameda	1.87	- 0.1%	Kern	0.65	-1.6%
	Butte	1.90	- 1.8%	Riverside	0.43	-0.2%
	Sacramento	1.18	- 2.4%	San Joaquin	0.71	-0.4%
	Santa Cruz	1.61	- 2.8%	Santa Barbara	0.77	-4.6%
	Solano	1.17	- 0.3%	Sonoma	0.80	-2.3%
	Sutter-Yuba	1.11	- 4.8%	Stanislaus	0.63	-0.4%
				Ventura	0.80	-1.4%
	555,539 eligible youth FY 2019-20			1,382,944 eligible youth FY 2019-20		

Figure 3. Funding inequities increased since 2011 Realignment, worsening (upper left and lower right quadrants) in counties with almost 3.3 million youths.

B. Measuring Access to Care

Access to care is typically reported as "number served" or "penetration rate," metrics that do not present a complete picture of service delivery, and therefore, access to care. In order to adequately measure access to care, we compared the number of youths served and the treatment provided to them with the population of youths in need, and the units of care needed for their treatment.

To do this, we developed an Access Index (AI) that compares the combined total of mental health services provided at the county level to a standard of performance for both a) the number of youths in need and b) the level of needed care measured in treatment units. Thus, the AI is essentially the county-level ratio of supply to demand measured in minutes of treatment. The AI measures the total number of minutes of services provided divided by a total number of Minutes Needed Standard described below.

$$AI = \frac{\text{Total Minutes Provided}}{(\text{EPSDT Eligible Youths} \times \text{Youths in Need Standard}) \times \text{Minutes Needed Standard}}$$

The supply of treatment units was calculated using the total combined minutes of services for the seven POS-reported SMHS "minute" services provided by MHPs: Intensive Home and Community-Based Services (IHBS), Intensive Care Coordination (ICC), Therapeutic Behavioral Services (TBS), Crisis Intervention, Mental Health Services, Case Management/Brokerage, and Medication Support.

Demand for treatment minutes was calculated using the estimated number of youths needing services multiplied by the estimated average need for minutes of treatment per youth. We estimated the number of youths needing services by multiplying the EPSDT eligible population by the Serious Emotional Disturbance (SED) penetration rate of 7.56% used by DHCS for determining SMHS network adequacy.[xxiv] This "Youths in Need Standard" estimates the percent of the Medi-Cal eligible population who would likely have SED and, therefore, need SMHS. The average minutes of care needed, "Minutes Needed Standard," was calculated using the mean total minutes provided per youth by the top quartile of counties as measured by their ERs.[1] The average minutes of treatment for the top quartile of the 28 MHPs for FY 2012-13 through FY 2019-20 was 2,670, or 44.5 hours.[xxv] The Access Index allows us to combine number served with units of service into an access-to-care distribution chart. See Figure 4. An AI of 1.0 means a county is providing services to an average of 7.56% of Medi-Cal eligible youth with 2,670 minutes of treatment. By incorporating standards for number served and service units, the AI provides a sense of how much of the expected mental healthcare need or demand is met, county-by-county.

[1] This approach is intended to reflect a standard of care that is consistent with current mental healthcare eligibility and practice that is least constrained by funding.

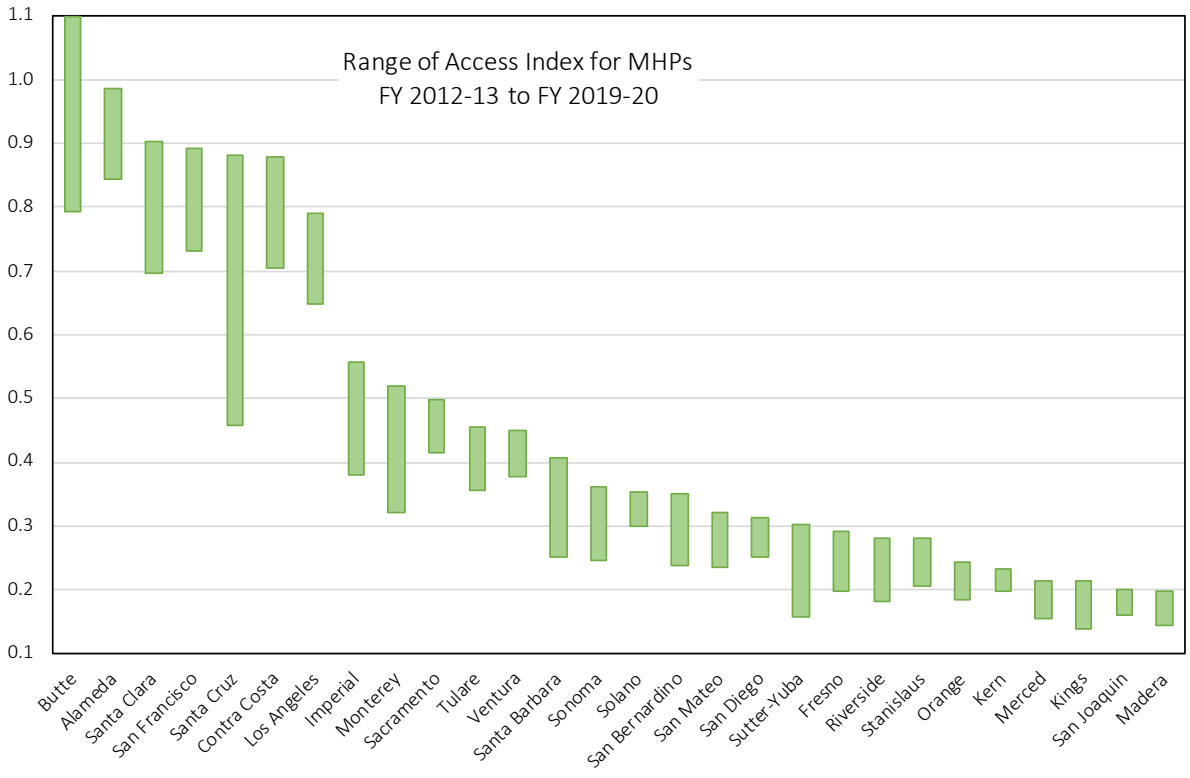

Figure 4. Access to SMHS varies considerably across counties. Many counties meet less than half of the expected treatment need. See Appendix for data.

For example, Santa Clara and Butte counties, each with an AI of 0.86 may be understood to have provided 86% of the estimated total need for care by eligible youths in FY 2019-20 (data in Appendix). San Joaquin (AI = 0.16) and Madera (AI = 0.17) counties provided 16% and 17% of the total need for care in FY 2019-20, respectively. Our results indicate that families and youths across California experienced significant variability of access to care.

We also looked more closely at the relationship between the number of youths receiving care and the intensity of care. See Figure 5. Judging by the number of counties that exceeded 0.75 of either standard (10 counties for Service Intensity, four counties for Number Served), the data suggest that *gaining entry into care* is more challenging than *getting sufficient treatment* once in care. Notably, measures that are generally used to evaluate access to care—including penetration rates, the total number of youths served, and total spending per youth—cannot afford such insights.

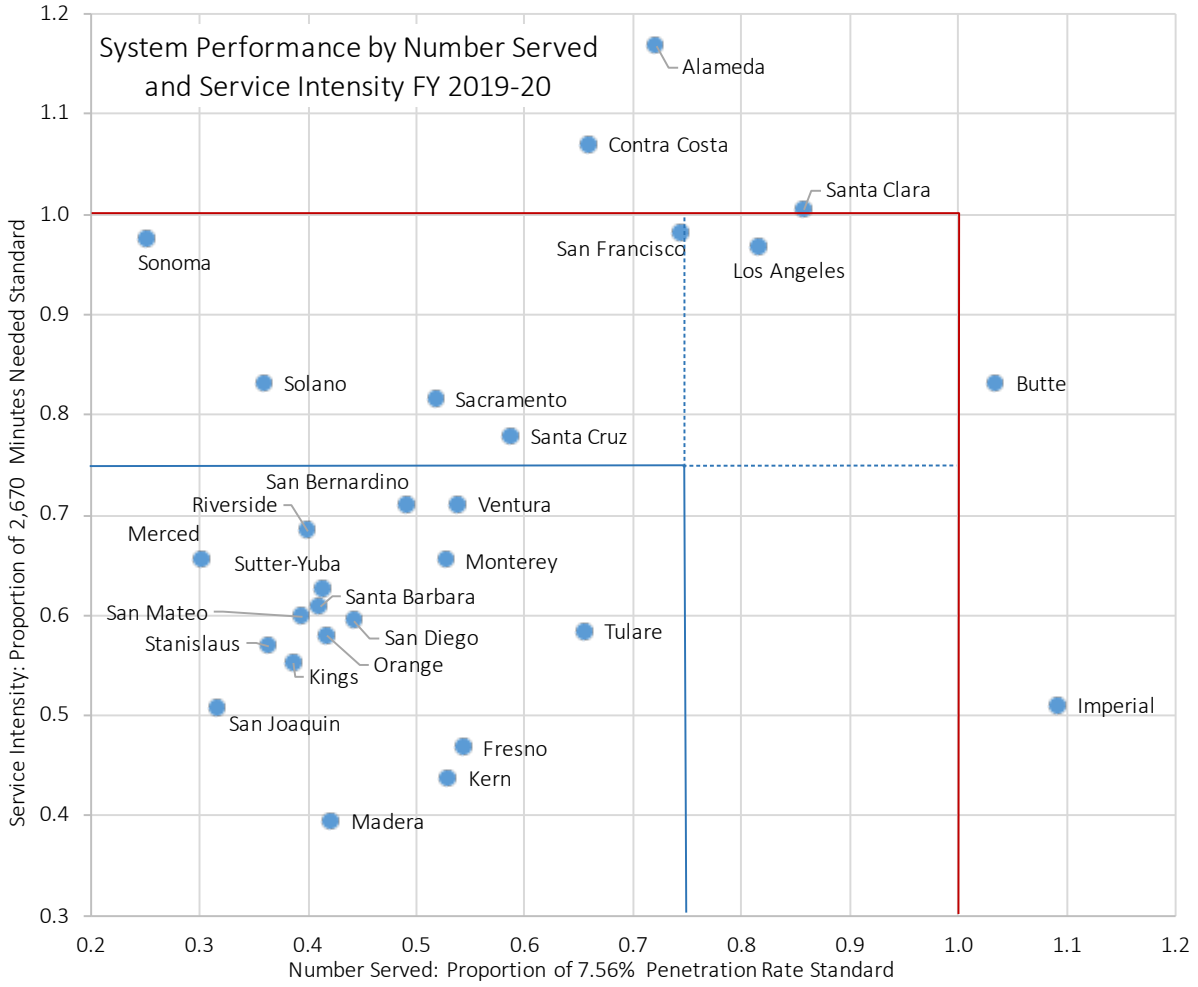

Figure 5. The number served and service intensity data suggest that gaining access to care is more challenging than receiving sufficient treatment once in care.

C. <u>Underwater Counties Perform Poorly Compared to Surplus Counties</u>

Plotting the Equity Ratio as a function of the Access Index compares funding with performance at the county level. See Figure 6. In FY 2019-20, the data indicate a strong, positive correlation between increased relative funding (ER) and better access to care (AI). Alternatively, insufficient relative funding was shown to impair access to care. This pattern has been consistent for every year post-2011 Realignment.

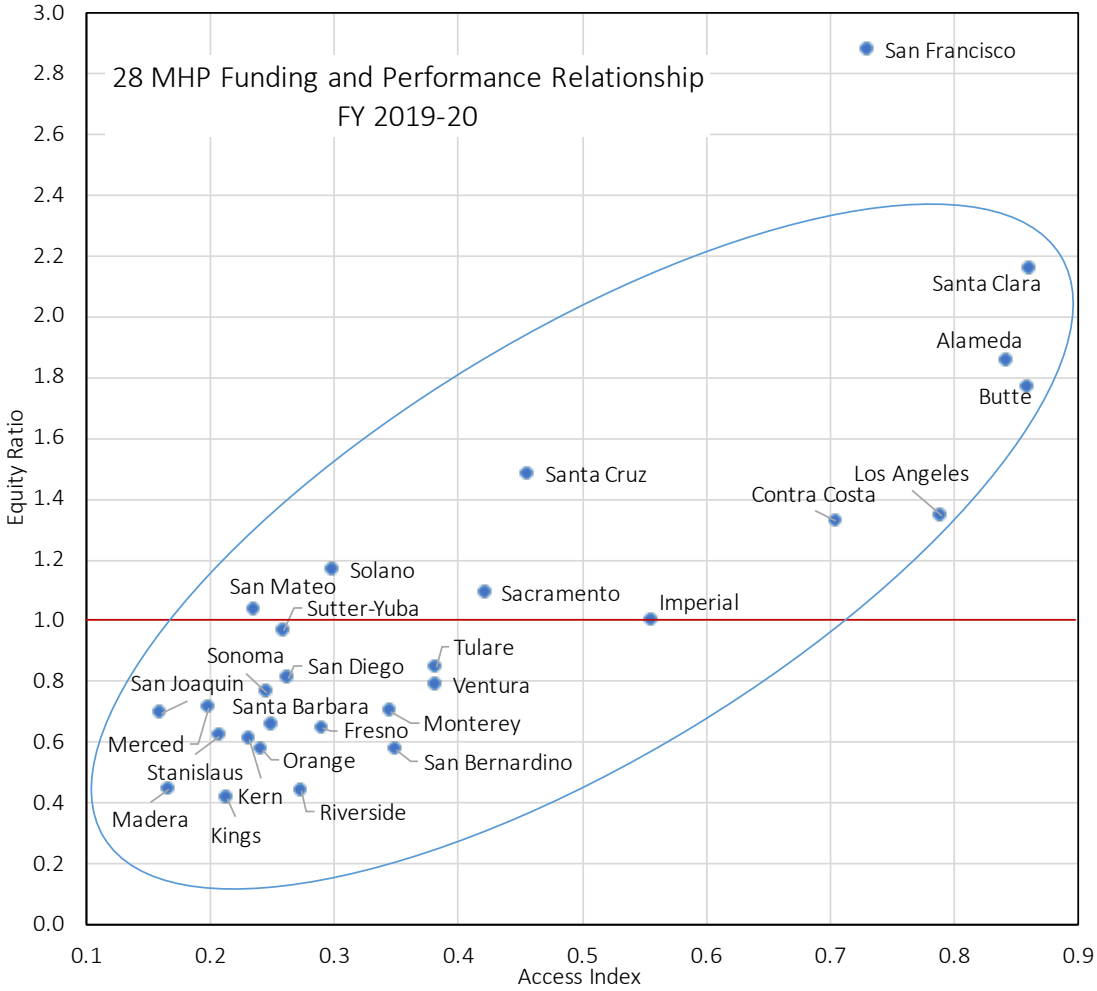

Figure 6. Counties that receive relatively less 2011 Realignment funding systematically serve fewer youth with less treatment than those with more 2011 Realignment funding.

The data also allow for a deeper dive into county-level comparisons of relative funding with eligibility, spending, and performance. With each comparison, the data show a strong relationship to relative 2011 Realignment behavioral health funding. This is especially true for high-surplus (ER > 1.25) and deep-underwater (ER < 0.75) counties.

Looking first at eligibility, the data demonstrate a strong relationship among a county's relative amount of 2011 Realignment behavioral health funding and a) the county proportion of Medi-Cal eligible youths to adults and b) the proportion of county youths who are Medi-Cal eligible.

TABLE 2. FY 2019-20 County Proportions of 2011 Realignment Behavioral Health Funding, Medi-Cal Eligible Youth to Adults, and Medi-Cal Eligible Youth to Total Youth

County MHP	2011 Realignment BH Funds per Medi-Cal Eligible Youth	Youth Percent of Total Medi-Cal Eligible Population	Percent of Youths that are Medi-Cal Eligible
San Francisco	$723	25%	44%
Santa Clara	$542	36%	38%
Alameda	$466	34%	47%
Butte	$444	36%	74%
Santa Cruz	$372	38%	56%
Los Angeles	$338	37%	71%
Contra Costa	$334	39%	48%
Merced	$179	48%	88%
Monterey	$176	48%	84%
San Joaquin	$175	45%	73%
Santa Barbara	$165	46%	75%
Fresno	$163	45%	84%
Stanislaus	$156	43%	79%
Kern	$153	46%	86%
San Bernardino	$144	44%	75%
Orange	$144	39%	54%
Madera	$112	52%	94%
Riverside	$111	45%	72%
Kings	$104	47%	67%
Median	**$201**	**42%**	**72%**
Mean	**$255**	**42%**	**67%**

Counties with more youth, in both the proportion of the state total and the proportion of the county population, received fewer 2011 Realignment BH dollars to spend on EPSDT.

See Table 2.[2] These data indicate that counties with proportionately more youths to adults in their Medi-Cal eligible population receive proportionately less 2011 Realignment behavioral health funding. The data also show that counties with greater expected demand—those with proportionately more Medi-Cal eligible youth—receive proportionately less 2011 Realignment behavioral health funding. In other words, counties with relatively larger youth poverty populations get proportionately less youth SMHS funds.

Turning to county funding and spending comparisons, the data show a strong relationship among Equity Ratios and county SMHS spending. With the rare exception, high-surplus counties spent more per youth SMHS recipient than deep-underwater counties. In FY 2019-20, five of seven high-surplus counties spent more than $10,000 per SMHS recipient, whereas 10 of 12 deep-underwater counties spent less than $7,000. Two counties spent less than $5,000 per youth recipient. See Table 3.

Because Federal Financial Participation (FFP) is determined by SMHS spending, greater spending correlates with higher federal funding, which, in turn, leads to higher SMHS spending. Accordingly, surplus counties received far more FFP funds per SMHS recipient than underwater counties did. The importance of this relationship cannot be

[2] The remaining Tables are presented as heat maps to assist in identifying patterns among the many columns and rows of numbers. The relational colors (green is high, white is low) are calculated independently for each column using its median value.

TABLE 3. FY 2019-20 Equity Ratios and County Spending

County MHP	Equity Ratio	SMHS Spending per Youth Served	Youth FFP per Youth Served
San Francisco	2.88	$16,782	$8,930
Santa Clara	2.16	$10,817	$5,417
Alameda	1.85	$11,386	$11,460
Butte	1.77	$7,108	$4,905
Santa Cruz	1.48	$10,643	$6,495
Los Angeles	1.35	$7,558	$5,855
Contra Costa	1.33	$11,452	$8,614
Merced	0.71	$6,990	$4,880
Monterey	0.70	$8,073	$1,357
San Joaquin	0.70	$6,022	$3,577
Santa Barbara	0.66	$6,853	$5,332
Fresno	0.65	$6,414	$2,175
Stanislaus	0.62	$6,474	$4,708
Kern	0.61	$4,946	$2,931
San Bernardino	0.57	$5,995	$4,193
Orange	0.57	$5,264	$3,602
Madera	0.45	$4,952	$3,271
Riverside	0.44	$5,322	$4,860
Kings	0.41	$7,199	$4,290

High-surplus counties spend more on SMHS and are awarded greater federal cost share than deep-underwater counties.

overstated as FFP provides a larger share of total funding for SMHS services than any other single funding source. Leveraged federal matching funds magnify the disparity of state funding.

The strong relationship among county ERs and eligibility and spending holds true for performance measures as well. Based on POS data,[xxvi] high-surplus counties substantially out-performed deep-underwater counties on average SMHS minutes provided per youth, length of stay,[3] and engagement rates.[4] See Table 4. Estimated county SMHS relative system capacity[5] also corresponds positively to county ERs.

One performance metric we studied ran contrary to the pattern of high ER coupled with high performance and low ER corresponding to modest or low performance. Provision of *Katie A*. services, including Intensive Care Coordination (ICC) and Intensive Home- and Community-Based Services (IHBS), was greater for the group of deep-underwater counties, in terms of both relative spending and proportion of youths served, than it was for the group of high-surplus counties. See Table 5. *Katie A*. services are higher intensity treatment services provided to children with serious mental health needs who are at risk for out-of-home placement. Los Angeles County was the sole high-surplus county that devoted greater than 15% of its SMHS spending on *Katie A.* services, whereas three-

[3] Length of stay was calculated by comparing the number of youths served by the system capacity or number of treatment "placements" available in each county. (See endnote xxviii.)

[4] POS "snapshot" data are reported for youth who had at least one billing event, as well as youths with five or more days of service, during the year. Comparing the percent of youths who touched the system with those that received at least five days of service provided county-level evidence of relative sustained engagement with the SMHS system.

[5] Using the census of youths in care during the final month of the fiscal year, we estimated the number of treatment "placements," or system capacity, each county maintains.

quarters of deep-underwater counties devoted more than 15%, and one-quarter spent more than 25% of their SMHS funds on *Katie A*. services. Nevertheless, although underwater counties outperformed the surplus counites on delivering *Katie A*. services, the strong relationship between county ERs and county performance persisted: In this case, high-surplus counties *as a group* spent markedly less and served fewer youths, while deep-underwater counties *as a group* spent more and served more SMHS youths.

TABLE 4. FY 2019-20 Equity Ratios and SMHS Performance

County MHP	Equity Ratio	Mean Minutes per Youth Served	Mean Months of Stay	Engagement Rate	Eligible Youths per Service Space
San Francisco	2.88	2618	5.4	81%	40
Santa Clara	2.16	2682	5.3	81%	35
Alameda	1.85	3118	5.8	84%	38
Butte	1.77	2219	5.3	77%	29
Santa Cruz	1.48	2078	5.4	82%	51
Los Angeles	1.35	2581	5.4	81%	36
Contra Costa	1.33	2852	5.5	79%	44
Merced	0.71	1750	3.9	56%	135
Monterey	0.70	1747	4.5	66%	67
San Joaquin	0.70	1355	4.1	62%	124
Santa Barbara	0.66	1625	4.2	64%	92
Fresno	0.65	1370	5.3	66%	53
Stanislaus	0.62	1519	4.0	65%	109
Kern	0.61	1165	5.1	72%	59
San Bernardino	0.57	1898	3.8	70%	86
Orange	0.57	1548	5.1	73%	75
Madera	0.45	1052	3.4	52%	111
Riverside	0.44	1826	4.4	71%	89
Kings	0.41	1475	4.0	54%	102
Median	**0.80**	**1749**	**5.1**	**72%**	**71**
Mean	**1.00**	**1898**	**4.9**	**71%**	**72**

As a group, deep-underwater counties perform worse on average treatment minutes, duration of services, engagement rate, and system capacity. Note: Relational colors reversed in last column.

TABLE 5. Proportions of *Katie A.* Spending and Numbers Served Relative to Youth SMHS Totals

County MHP	Equity Ratio	*Katie A.* Spending	*Katie A.* Number Served
San Francisco	2.88	14.6%	10.8%
Santa Clara	2.16	10.1%	9.5%
Alameda	1.85	5.9%	5.3%
Butte	1.77	10.7%	15.6%
Santa Cruz	1.48	3.8%	3.6%
Los Angeles	1.35	19.3%	12.2%
Contra Costa	1.33	14.7%	6.2%
Merced	0.71	19.3%	20.6%
Monterey	0.70	2.7%	5.0%
San Joaquin	0.70	22.8%	37.2%
Santa Barbara	0.66	19.0%	26.3%
Fresno	0.65	13.2%	7.0%
Stanislaus	0.62	26.8%	14.6%
Kern	0.61	11.5%	8.7%
San Bernardino	0.57	28.8%	24.0%
Orange	0.57	20.2%	26.6%
Madera	0.45	25.4%	22.9%
Riverside	0.44	18.9%	28.3%
Kings	0.41	22.9%	9.2%
Median	**0.80**	**15%**	**14%**
Mean	**1.00**	**15%**	**15%**

As a group, deep-underwater counties provide more home and community-based intensive (Katie A.) services than do high-surplus counties.

V. Discussion

The data we analyzed amply demonstrate the close relationship between state and federal SMHS funding and statewide access to care at the county level. Indeed, our analysis provides clear evidence that prior spending, aggravated by 2011 Realignment funding allocations, is a more powerful determinant of who gets what services than are the mental health needs of children and youths or their Medi-Cal eligibility status. In these circumstances, the DOF's allocation formula for distributing behavioral health SMHS dollars has an outsized impact on access to care, at least since Realignment 2011.

The net result of DOF's allocation methodology is that hundreds of thousands of California's youths go unserved or under-served. The data show that children in underwater counties are less frequently treated for mental health needs and get fewer hours of services, on average, when they do receive care. The adverse impact of this disproportionate allocation of resources is especially alarming because underwater counties have proportionately greater youth behavioral health needs than do surplus counties because they have relatively more youths who are Medi-Cal eligible and because they have higher ratios of youths to adults receiving SMHS. Additionally, children and youths in underwater counties are less likely to become engaged with the SMHS system and they have a shorter average length of stay. Underwater counties as a group also have proportionately less system capacity, and spend far fewer dollars per youth, on average.

In what appears to be a bright spot in system performance by underwater counties as a group, *Katie A*. intensive services are proportionately more available than in surplus counties. On the face of it, providing more *Katie A.* services is a good thing, but further research is needed to determine

whether providing more ICC and IHBS is a reflection of a higher acuity of need for youth who are served due to otherwise inadequate access to care. A similar analysis of out-of-home mental health care could shed further light on this important question.

Had underwater counties received 2011 Realignment funding equal in proportion to their proportion of EPSDT eligible youth, they would have received an estimated $3.05 billion in additional state and federal funding since 2011 Realignment.[6] See Figure 7. Using actual SMHS spending per youth over that time period, we estimated that more than one-half million youths went unserved in underwater counties since 2011 Realignment due to under-funding. In FY 2019-20 alone, we estimate that at least 46,000 youths in underwater counties failed to receive any SMHS due to disproportionate 2011 Realignment funding. The additional annual funding for underwater counties needed to achieve 75% of the Youth in Need and Minutes Needed standards detailed above was estimated to be $690 million for FY 2019-20. The data suggest that federal Medicaid cost-share match might provide an estimated 60% or more of the funding to meet this need.

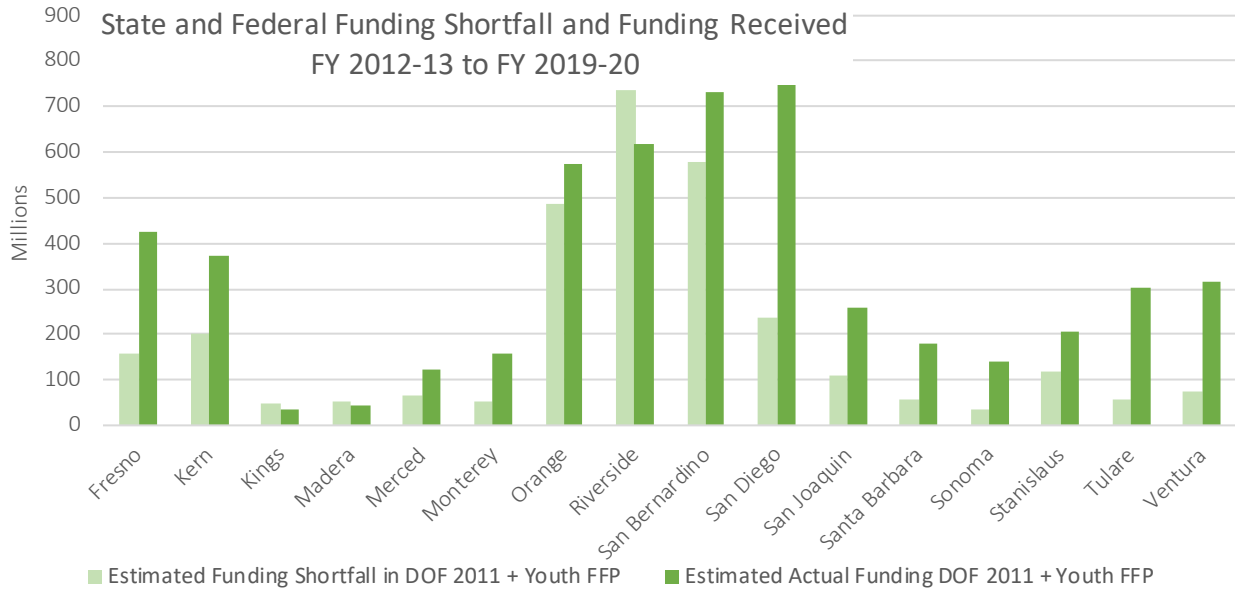

Figure 7. Deep-underwater counties lost out on billions of dollars in 2011 Realignment funding due to the allocation methodology set by the State.

[6] EPSDT mental health services are a federal entitlement that does not allow reductions in medically necessary services to eligible youths, so we assumed level-up, additional funding, rather than reallocating historic 2011 Realignment funding. Thus, the funding challenge involves insufficient resources, not just unfair allocation.

TABLE 6. Average Funding Per Medi-Cal Eligibile Youth and Estimated Per Minute Cost for SMHS Minute Services FY 2012-13 to 2019-20		
San Francisco	$568	$4.20
Butte	$395	$2.20
Alameda	$391	$2.14
Santa Clara	$375	$3.61
Santa Cruz	$333	$2.55
Contra Costa	$284	$2.31
Los Angeles	$283	$2.37
Sacramento	$245	$1.78
Solano	$245	$3.45
Sutter-Yuba	$230	$3.65
San Mateo	$199	$3.69
Imperial	$199	$4.43
Tulare	$176	$2.41
Sonoma	$167	$2.57
Ventura	$167	$2.12
San Diego	$162	$2.53
Santa Barbara	$158	$2.44
San Joaquin	$148	$2.66
Fresno	$147	$3.09
Monterey	$142	$2.49
Merced	$136	$2.63
Kern	$135	$2.96
Stanislaus	$132	$2.83
San Bernardino	$115	$2.37
Orange	$113	$2.57
Madera	$95	$2.29
Riverside	$91	$1.80
Kings	$83	$3.19

Estimated unit costs did not track relative funding under 2011 Realignment, unlike SMHS spending and access to care.

Countervailing Considerations

It might be assumed that the relationships detailed above are driven primarily by the varying costs of services across the state. While allocating greater funds to counties with higher costs could be a rational policy intended to ensure access to care in more expensive locales, the data we reviewed do not support this hypothesis. Comparing relative 2011 Realignment funding to estimated county SMHS unit costs[7] does not produce a consistent relationship of higher costs for surplus counties and lower costs for underwater counties. Indeed, some of the high-surplus counties with expensive metro areas (Sacramento, Los Angeles, and Alameda) maintained some of the lowest costs per minute of service over the study period. See Table 6.

It might also be supposed that the SMHS services California does not fund with 2011 Realignment dollars are provided using alternative resources. That supposition is not supported by the data. First, the performance data reviewed here do not indicate that deep-underwater counties were able to improve access to care using other funding. Second, we calculated Equity Ratios for other key statewide mental health funding sources using Medi-Cal eligibility as the ER denominator. Figure 8 compares funding of deep-underwater MHPs for six primary mental health programs: 2011 Realignment, 1991 Realignment, FFP, Mental Health Services Act, non-specialty mental health services, and All Others. The ER values are represented by the length of the horizontal bars. The width of the bars reflects each funding program's percentage of county total funding.

[7] County costs were estimated as the average rate of SMHS expenditures for minute services divided by the total of provided POS-reported minute services.

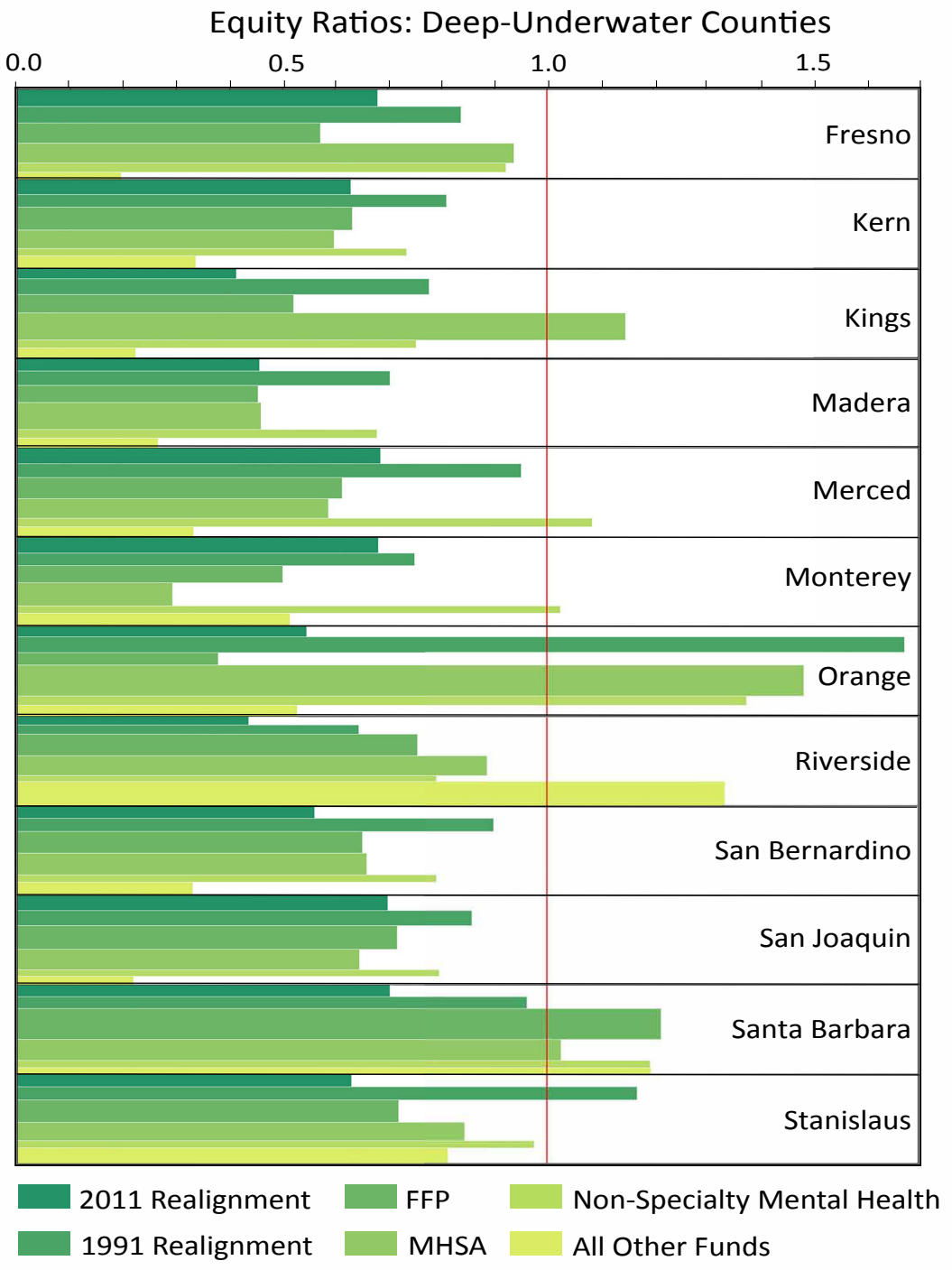

Figure 8. Deep-underwater counties generally received proportionately less funding (ER<1) from other major funding sources, and were not made whole by the addition of these resources.

Only rarely were surplus funds available to underwater counties that might offset a shortfall in 2011 Realignment funds. In most cases, underwater counties had ERs less than 1.0 for other funding sources. Five counties had ERs of less than 1.0 in every funding category. Five had just one funding source out of six with an ER greater than 1.0. Only two deep-underwater counties had more than one funding source with ERs greater than 1.0. Even where the ER for other funds is greater than 1.0, the overall mental health funding gain is limited because the funding surpluses—where there are any—are mostly small. For the seven counties that had any surplus funding, one can visualize in the figure how the size of the surplus funding (the area in the green bar(s) to the right of the dashed line of ER=1) compares to the deficit funding (the area not in the green bars to the left of the dashed line). Only Orange and Santa Barbara MHPs have significant surpluses that could have possibly mitigated their inadequate 2011 Realignment funding. For 10 of the 12 deep-underwater counties, serving 30% percent of California's youth with SED, there was no alternative funding sufficient to make up the substantial shortfalls resulting from the State's 2011 Realignment funding allocations.

VI. Conclusion

California is required by law to arrange for or provide SMHS sufficient to correct or ameliorate mental illness or conditions for all Medi-Cal eligible youths. Administrative data tell a great deal about how the State and counties seek to fulfill this obligation. These data show that discretionary funding allocations have constrained performance in counties that receive disproportionately less state funding. Indeed, hundreds of thousands of youths did not receive *any* services simply because they reside in underwater counties—those that have proportionately more Medi-Cal eligible youths and proportionately less 2011 Realignment funding due to discretionary funding decisions by DOF, in consultation with DHCS. Additionally, deep-underwater counties with more kids and less money were markedly less able to engage youths who touched their SMHS systems, and provided far fewer hours of service on average to youths who did get care.

In FY 2019-20, according to a reasonable standard of access to care, every underwater county failed to provide adequate care, both in terms of number of youths served and intensity of services provided, contrary to state and federal promises of equal access to mental health care, and in violation of state and federal laws that require prompt, adequate treatment statewide. One can only imagine how many tens of thousands of youths would have succeeded in school, remained in their homes with their biological parents, avoided delinquency and detention, or survived to become adults, had California's mental health funding allocations afforded fair access to treatment for their serious mental health needs.

End Notes

[i] 42 USC §§1396a (a)(10)(A), 1396a (a)(43), 1396d (a)(4)(B) and 1396d (r)(5); 42 CFR §§ 441.50 et seq.
[ii] DHCS All Plan Letter 17-018 (Oct. 17, 2017), p. 10.
[iii] 42 U.S.C. §1396a(a)(1); 42 CFR § 431.50; and 42 U.S.C. § 1396a(a)(8).
[iv] 9 CCR § 1810.247.
[v] Mental Health Plans are county-operated prepaid inpatient health plans that provide specialty mental health services to Medi-Cal eligible beneficiaries. These plans are authorized by Welfare and Institutions Code § 14680, and more broadly by the Social Security Act § 1915(b) waiver program. Legislation to implement the 1915(b) waiver is set forth at Welfare and Institutions Code, §§ 14680 et. seq., and 14700-14727.
[vi] In discussing individual MHPs, we use the terms "MHP" and "County" interchangeably. For the one MHP in our study that serves multiple counties, we combined the data and use the label "Sutter-Yuba."
[vii] Welfare and Institutes Code § 14132.03.
[viii] Welfare and Institutions Code § 14189.
[ix] Welfare and Institutions Code § 14705.
[x] DHCS funds these services through the Medi-Cal Local Assistance Estimates Process. Initial estimates for the upcoming fiscal year are provided in the Governor's Proposed Budget, released in January of each fiscal year. Initial estimates are then updated during the May Revise process in spring of each fiscal year.
[xi] The State Controller maintains public access to these data dating back to Fiscal Year 2015-16 at https://sco.ca.gov/ard_payments_realign.html.
[xii] DHCS maintains public access to these data dating back to Fiscal Year 2015-16 at https://data.chhs.ca.gov/dataset/early-and-periodic-screening-diagnosis-and-treatment-of-children-and-youth-performance-dashboard.
[xiii] Cost Summary Reports provide county-level mental health revenue and expenditure data. These reports identify how much federal funding a particular county is entitled to receive, what sources of revenues fund specific SMHS services, and how much funding is allocated to particular providers in the county. *See* Welfare and Institutions Code § 14705(d).
[xiv] Counties studied include: Alameda, Butte, Contra Costa, Fresno, Imperial, Kern, Los Angeles, Madera, Merced, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, and Yuba.
[xv] Combining administrative data from multiple sources can tell a detailed story about the funding, spending, and performance of California's children and youth SMHS delivery system. Still, it is only a ten-thousand-foot view. While we are able to present county-level data for a far more informative perspective than state-level analyses, our analysis still masks significant variability *within* counties. Breaking this information down further by stratifying Los Angeles County data by Service Planning Area, for example, would improve the utility of the analysis for tens of thousands of youths.
[xvi] DHCS Mental Health Services Division Medi-Cal Billing Manual (September 2019), pg. 74; *See Also,* Sarah Arnquist and Peter Harbage, "A Complex Case: Public Mental Health Delivery and Financing in California" (July 2013), Chapter II.
[xvii] 2011 realignment consisted of a patchwork of legislative amendments during the 2011-12 budget and policy cycle. Statutory authority to use dedicated sales tax revenues and vehicle license fee revenues is authorized under Chapter 40, Statutes of 2011 (AB 118), and Chapter 35, Statutes of 2011 (SB 89), respectively.
[xviii] Chapter 89, Statutes of 1991, Bronzan-McCorquodale Act (Welfare and Institutions Code Sections 5600-5772) provided the statutory authority to use state sales tax and vehicle license fee revenues for Medi-Cal mental health services. *See Also*, "Rethinking the 1991 Realignment," LAO (October 2018).
[xix] Government Code § 30029.6.
[xx] The Federal Financial Participation rate for EPSDT mental health expenditures is 50% or more, depending on the eligibility and spending category.
[xxi] MHSUDS Information Notice 12-08.
[xxii] DHCS ACL 19-027 and Enclosure 1.

[xxiii] Government Code § 30025(f)(16)(B).
[xxiv] In its 2019 Annual Network Certification SMHS, pages 10-11, DHCS established the "estimated need" for SMHS based on the SED prevalence estimate for youths 0-17 that had been developed for the state's Bridge to Reform 1115 Waiver, at page 67.
[xxv] The annual averages varied between 834 minutes (Sutter-Yuba) and 3,557 minutes (Contra Costa).
[xxvi] Combining POS "children and youth specialty mental health services utilization" and "performance dashboard children and youth snapshot report" data provides information on annual entries and exits into the SMHS system and service intensity. Using these data, we calculated the means for several performance measures to compare with relative funding—including engagement rate, minutes of service provided, and duration or length of stay in months.

Appendix: Equity Ratios and Access Indices FY 2012-13 to 2019-20

Equity Ratios for Fiscal Years 2012-13 to 2019-20								
County	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Alameda	1.87	1.94	1.89	1.97	1.80	1.81	1.82	1.85
Butte	2.05	2.07	2.00	2.11	1.75	1.71	1.74	1.77
Contra Costa	1.31	1.43	1.41	1.34	1.35	1.36	1.34	1.33
Fresno	0.76	0.74	0.75	0.75	0.68	0.66	0.66	0.65
Imperial	0.92	0.76	0.91	0.93	1.01	0.99	1.01	1.00
Kern	0.69	0.66	0.68	0.62	0.66	0.63	0.62	0.61
Kings	0.33	0.37	0.40	0.37	0.43	0.42	0.42	0.41
Los Angeles	1.33	1.37	1.38	1.45	1.30	1.33	1.32	1.35
Madera	0.42	0.43	0.46	0.44	0.47	0.47	0.46	0.45
Merced	0.55	0.57	0.58	0.50	0.76	0.73	0.72	0.71
Monterey	0.60	0.66	0.70	0.57	0.73	0.70	0.71	0.70
Orange	0.52	0.51	0.52	0.47	0.55	0.56	0.57	0.57
Riverside	0.45	0.41	0.42	0.40	0.45	0.44	0.45	0.44
Sacramento	1.32	1.23	1.19	1.24	1.12	1.11	1.11	1.09
San Bernardino	0.52	0.51	0.51	0.49	0.58	0.57	0.58	0.57
San Diego	0.78	0.79	0.74	0.70	0.78	0.78	0.79	0.81
San Francisco	2.42	2.34	2.33	2.57	2.94	2.95	3.00	2.88
San Joaquin	0.72	0.71	0.72	0.68	0.72	0.70	0.70	0.70
San Mateo	0.87	0.87	0.85	0.78	1.02	1.03	1.05	1.04
Santa Barbara	0.96	0.84	0.83	0.85	0.68	0.66	0.67	0.66
Santa Clara	1.25	1.35	1.50	1.26	2.09	2.15	2.16	2.16
Santa Cruz	1.86	1.73	1.69	1.77	1.41	1.44	1.47	1.48
Solano	1.19	1.16	1.12	1.14	1.18	1.19	1.18	1.17
Sonoma	0.92	0.84	0.83	0.84	0.74	0.74	0.76	0.76
Stanislaus	0.64	0.62	0.63	0.62	0.66	0.63	0.63	0.62
Sutter-Yuba	1.44	1.19	1.16	1.18	1.01	0.99	0.99	0.97
Tulare	0.70	0.88	0.83	0.82	0.88	0.87	0.86	0.85
Ventura	0.88	0.79	0.78	0.80	0.78	0.78	0.80	0.79

Access Indices for Fiscal Years 2012-13 to 2019-20								
County	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Alameda	0.91	0.99	0.98	0.93	0.91	0.90	0.93	0.84
Butte	1.10	0.96	0.86	0.79	0.86	0.91	0.90	0.86
Contra Costa	0.85	0.87	0.88	0.79	0.79	0.81	0.73	0.70
Fresno	0.21	0.20	0.21	0.22	0.23	0.25	0.27	0.29
Imperial	0.42	0.38	0.38	0.39	0.45	0.51	0.56	0.56
Kern	0.22	0.21	0.22	0.20	0.21	0.21	0.20	0.23
Kings	0.14	0.15	0.16	0.15	0.16	0.17	0.18	0.21
Los Angeles	0.72	0.70	0.66	0.65	0.67	0.76	0.76	0.79
Madera	0.15	0.14	0.16	0.17	0.20	0.19	0.18	0.17
Merced	0.16	0.17	0.18	0.18	0.19	0.20	0.21	0.20
Monterey	0.32	0.37	0.52	0.36	0.37	0.37	0.37	0.35
Orange	0.24	0.23	0.21	0.18	0.19	0.21	0.22	0.24
Riverside	0.18	0.19	0.20	0.21	0.22	0.25	0.28	0.27
Sacramento	0.49	0.50	0.49	0.46	0.41	0.43	0.44	0.42
San Bernardino	0.24	0.24	0.25	0.24	0.27	0.30	0.33	0.35
San Diego	0.31	0.30	0.28	0.26	0.25	0.27	0.27	0.26
San Francisco	0.81	0.82	0.89	0.88	0.89	0.80	0.83	0.73
San Joaquin	0.18	0.19	0.20	0.17	0.18	0.17	0.16	0.16
San Mateo	0.32	0.27	0.26	0.26	0.26	0.27	0.26	0.24
Santa Barbara	0.41	0.38	0.34	0.33	0.27	0.29	0.27	0.25
Santa Clara	0.70	0.77	0.85	0.82	0.80	0.88	0.90	0.86
Santa Cruz	0.88	0.82	0.82	0.65	0.60	0.50	0.49	0.46
Solano	0.35	0.33	0.34	0.32	0.31	0.32	0.33	0.30
Sonoma	0.36	0.36	0.35	0.32	0.28	0.25	0.26	0.25
Stanislaus	0.28	0.28	0.28	0.26	0.27	0.26	0.23	0.21
Sutter-Yuba	0.17	0.16	0.27	0.27	0.30	0.26	0.29	0.26
Tulare	0.38	0.45	0.45	0.38	0.36	0.38	0.39	0.38
Ventura	0.41	0.40	0.38	0.42	0.42	0.44	0.45	0.38