Towards Mental Health Equity in Medi-Cal:

An Updated Analysis of AB 470 Data

California Pan-Ethnic
HEALTH NETWORK

Table of Contents

1 Executive Summary

4 The Medi-Cal Mental Health Care System

7 History of AB 470: The Mental Health Equity Act

8 About the Data

9 Defining Terms

10 Key Findings

- Access and Continued Engagement Rates: Over Time
- Access and Continued Engagement Rates: Demographic Disparities
- Race and Ethnicity: Access and Continued Engagement 2022
- Race and Ethnicity: Eligible Population
- Race and Ethnicity: Top ICD-10 Diagnosis Categories
- Preferred Written Language: Access and Continued Engagement
- Preferred Written Language: Eligible Population
- Sex: Access and Continued Engagement
- Sex: Eligible Population
- Age: Access and Continued Engagement

31 Recommendations

35 Acknowledgements

36 Appendix

37 Endnotes

Executive Summary

In 2017, the California Pan-Ethnic Health Network (CPEHN) sponsored Assembly Bill (AB) 470, known as the Mental Health Equity Act, because we recognized disparities in mental health care but lacked the data to address them. Now, seven years after AB 470 was passed, we have seen important progress in data collection to unveil gaps in access and equity.

A few years ago, the AB 470 dataset was updated to include data from 2021 and 2022, along with county-level data for each managed care plan (MCP) and county mental health plan (MHP). The inclusion of this 2021 and 2022 data provides an important snapshot of access to Medi-Cal's behavioral health services immediately after the COVID-19 pandemic, a period that exacerbated disparities and the need for mental health support, but before full implementation of many of the more recent health system delivery changes under the California Advancing and Innovating Medi-Cal (CalAIM) initiative and other significant behavioral health policies. This report can then serve as a baseline from which to measure the extent to which Cal-AIM policies and interventions have resulted in significant improvements in health outcomes.

CPEHN and other advocates were eager for plan-specific county-level data to assess regional performance and identify mental health service delivery gaps. However, upon analyzing the updated data, we noticed significant coding revisions, with non-specialty mental health service codes expanding from 48 to 201 by 2021. After unsuccessful attempts to clarify and better understand these changes with the Department of Health Care Services (DHCS), we made the difficult decision to postpone a county-level analysis until more is understood. Additionally, recent changes in MCP contracting, including new plans entering and other plans exiting counties, highlight the need to revisit this data in future reports once the MCP landscape stabilizes.

Summary of Key Findings

The data in this report highlights ongoing disparities in access and continued engagement across demographic groups within Medi-Cal's mental health services from 2019-2022, with a primary focus on 2022 data. Statewide access and continued engagement rates for both non-specialty mental health services (NSMHS) and specialty mental health services (SMHS) remained low and relatively stable from 2019 to 2022, with a slight decline in SMHS rates in 2022.

- **Race and ethnicity:** Disparities across racial and ethnic groups are notable. White beneficiaries consistently had the highest rates of access and continued engagement in NSMHS, whereas Asian and Pacific Islander (API) beneficiaries had the lowest rate across both NSMHS and SMHS, possibly due to factors such as cultural stigma around mental health and limited availability of culturally and linguistically appropriate services. Black beneficiaries showed the highest rates for SMHS, which may

reflect a greater need for intensive mental health support possibly driven by factors such as chronic stress and systemic inequities, as well as unmet needs in early intervention settings. Conversely, Hispanic and API beneficiaries had low access and continued engagement rates in SMHS, highlighting possible barriers to higher levels of care and the ongoing need for culturally and linguistically tailored support within this setting.

- **Language:** Language barriers play a significant role in mental health service access. Beneficiaries who prefer English generally have higher access and continued engagement rates in NSMHS and SMHS, while those preferring other languages, like Spanish or Vietnamese, often have lower rates, indicating potential gaps in linguistically relevant services. For languages with fewer speakers, data is often limited, making it challenging to assess access and continued engagement rates fully. Their access rates are likely even lower, highlighting the need for targeted support to ensure equitable access for all non-English-speaking communities.

- **Sex:** Female beneficiaries had higher access and continued engagement rates for NSMHS than male beneficiaries, reflecting broader trends of lower mental health service utilization among males due to societal stigma and reluctance to seek help. This analysis, however, was limited to binary categories, emphasizing the need for data collection that includes a broader range of gender identities.

- **Age:** Adults aged 33-44 showed the highest access and continued engagement rates for NSMHS, while older adults aged 45-68 accessed SMHS more frequently. This suggests distinct age-related patterns and barriers in the types of mental health services utilized across age groups.

Together, these findings emphasize the need for targeted policies that address the specific access barriers faced by various demographic groups.

Summary of Recommendations

To address observed disparities and enhance mental health service accessibility and engagement across Medi-Cal populations, we recommend the following:

1. **Conduct Targeted Mental Health Outreach for Communities of Color:** Establish culturally and linguistically relevant outreach initiatives, particularly for communities of color facing the highest barriers in mental health access. While SB 1019 mandates outreach for NSMHS, we recommend extending similar outreach efforts to SMHS to ensure comprehensive awareness across the entire mental health service continuum.

2. **Improve Early Access and Engagement for Non-Specialty Mental Health Services:** Invest in initiatives to improve early access and engagement in NSMHS for communities of color, especially Black, Hispanic, and API communities. Strategies should include expanding screenings in community settings, integrating mental health services into primary care, and addressing barriers related to cost, transportation, and language.

3. **Support Community-Based Organizations in Providing Culturally Appropriate Mental Health Care:** Increase funding for community-based organizations (CBOs) that deliver mental health services in culturally appropri-

ate and linguistically accessible formats. This type of support will help CBOs continue to not only recruit, but also retain professionals from within communities to provide trusted, culturally relevant care for populations with limited English proficiency.

4. **Ensure Equitable Implementation of Diagnosis-Based Behavioral Health Policies:** Implement equity-focused frameworks for diagnosis-driven programs, like CARE Court, to ensure they do not reinforce disparities or lead to disproportionate treatment of communities of color. This includes addressing the issue of overdiagnosis, particularly for Black individuals and other communities at risk of receiving more severe diagnoses. Emphasize culturally sensitive diagnostic practices, minimize the risk of overdiagnosis, and prioritize voluntary, informed treatment options to prevent unnecessary or restrictive interventions.

5. **Further Disaggregate Race and Ethnicity Data and Support Cross-Tabulation with Other Demographics:** Further disaggregate race and ethnicity data, especially for diverse subgroups within Asian, Latino, and Middle East and North African (MENA) communities. Enabling cross – tabulation with other demographic factors will also allow for a nuanced understanding of intersectional disparities and targeted interventions.

6. **Implement SOGI Data Collection Across Medi-Cal:** Introduce sexual orientation and gender identity (SOGI) data collection across Medi-Cal to better understand and address disparities affecting queer and trans populations, allowing for more inclusive and effective mental health services.

7. **Align Age Categories Between Medi-Cal and Medicare:** Standardize age groupings in Medi-Cal reporting to allow for meaningful comparisons with Medicare, improving service continuity and supporting targeted mental health interventions for older adults.

8. **Expand AB 470 Data to Include Quality of Care and Enrollee Experience Measures:** Broader AB 470 data collection to include quality of care and enrollee experience measures, providing a comprehensive view of service equity and effectiveness within Medi-Cal mental health services.

These recommendations aim to create a more equitable and responsive mental health care system within Medi-Cal – one that prioritizes culturally competent care, addresses systemic barriers, and uses comprehensive data to inform interventions. As you continue reading, you'll find detailed insights into the data, analyses, and findings that shape each recommendation.

The Medi-Cal Mental Health Care System

This report focuses on adult Medi-Cal enrollees from 2019 to 2022, with particular emphasis on the most recent data from 2022. Before the Affordable Care Act (ACA), adult enrollees with milder mental health conditions had limited options for accessing care. Many of these individuals received mental health care solely through their primary care providers or through referrals to fee-for-service mental health providers. The ACA changed this by expanding Medi-Cal's coverage to include mental health as an essential health benefit. This expansion enabled California to increase access to mental health services, especially for adults with mild-to-moderate need, through Medi-Cal managed care plans. Despite this progress, the state maintains two distinct pathways for delivering mental health care, creating unique challenges in continuity and access.

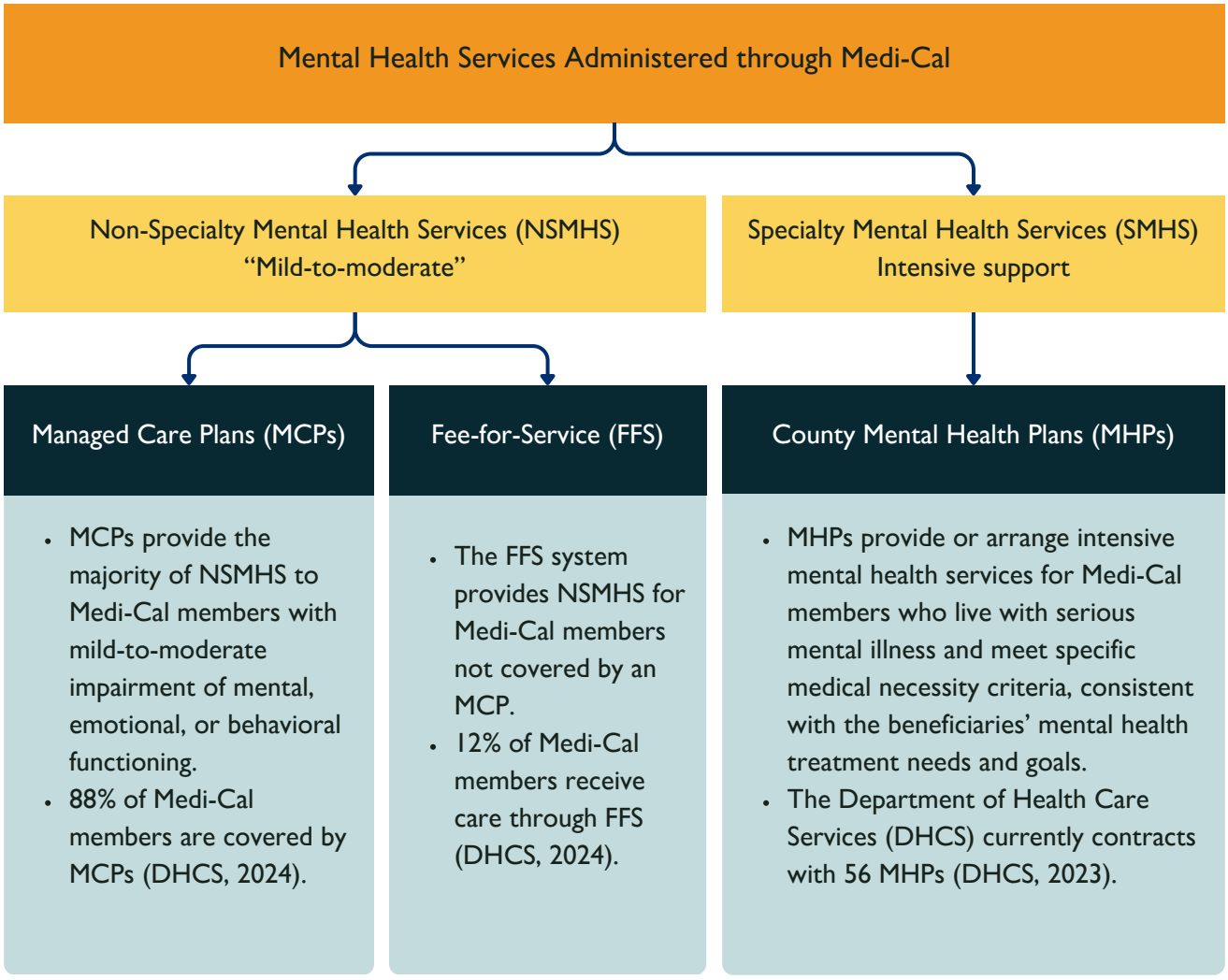
Today, California's Medi-Cal mental health services for adults are delivered through two distinct service categories, each responsible for different levels of care:

- **Non-specialty mental health services** are delivered by **managed care plans (MCPs)**, or **fee-for-service (FFS) providers** in some cases, and focus on mild-to-moderate mental health conditions.

- **Specialty mental health services** are delivered by **county mental health plans (MHPs)** and address more serious mental health conditions.

Medi-Cal beneficiaries can access services depending on the level of care needed, with coordination of care ideally occurring across the MCP, FFS, and MHP delivery systems. Reducing the burden on beneficiaries to navigate these mental health systems on their own is critical to improving timely and uninterrupted access to a comprehensive spectrum of services.

By focusing on adult data in this report, we aim to address the disparities specific to the adult Medi-Cal population across both of these systems. Understanding the unique barriers to accessing both non-specialty and specialty mental health services is essential for developing strategies that support continuity of care and equity within California's complex mental health landscape for adults.



No Wrong Door Policy

Through the California Advancing and Innovating Medi-Cal (CalAIM) initiative's No Wrong Door Policy, effective July 1, 2022, Medi-Cal members can access timely mental health services across delivery systems without delay or interruption in care, allowing them to receive both non-specialty and specialty mental health services when the services are "clinically appropriate, coordinated, and not duplicative." MCPs and MHPs are required to coordinate care for individuals receiving both NSMHS and SMHS or seeking to transition from one service type to another (NHeLP, 2022).

Sources: California Department of Health Care Services (DHCS), Medi-Cal Enrollment and Renewal. 2024.; DHCS, Contracts and Medicaid State Plan. 2023.; Liban et al., *An Advocate's Guide to Medi-Cal Services, Chapter III: Mental Health Services*. National Health Law Program (NHeLP), December 2022.

What do non-specialty and specialty mental health services look like?

Non-specialty mental health services through MCPs and FFS include [1]:

- Mental health evaluation and treatment, including individual, group and family psychotherapy, and dyadic behavioral health services
- Psychological and neuropsychological testing
- Outpatient drug therapy monitoring
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies, and supplements
- Eating disorders (physical components and comprehensive medical case management services)
- Psychotherapeutic medications

Specialty mental health services through county MHPs include [2,3]:

- Rehabilitative services
  - Individual or group therapy
  - Psychiatric medication support
  - Community-based therapy programs providing day rehabilitation and intensive day treatment
  - Crisis intervention and crisis stabilization for a faster response, such as those provided through hospitals or clinics, or community-based mobile crisis
  - Residential treatment services and crisis residential treatment services
- Psychiatric inpatient hospital services
- Targeted case management
- Treatment and diagnosis services provided by licensed psychiatrists and psychologists
- Eating disorders (inpatient and outpatients SMHS components)
- Psychotherapeutic medications

History of AB 470: The Mental Health Equity Act

AB 470 (Arambula) was signed into law in 2017 to improve transparency and accountability in the delivery of Medi-Cal mental health services. Its primary goal was to ensure Medi-Cal members receive timely access to quality mental health services, ultimately working to reduce mental health disparities across California.

A central component of AB 470 is the mandate for data collection and reporting to uncover and analyze disparities in access, engagement, and outcomes. The legislation requires this data to be stratified by key demographics, such as age, sex, gender identity, race, ethnicity, primary language, and sexual orientation. This detailed stratification enables a deeper examination of performance outcomes across different populations.

The data collected under AB 470 is intended to provide DHCS with the insights needed to identify inequities in care delivery and design targeted interventions that address these disparities effectively.

Timeline

2017 AB 470 is signed into law to improve transparency and accountability in Medi-Cal mental health services.

2019 DHCS publishes its first set of data under AB 470, providing enrollment and access information for Medi-Cal enrollees receiving specialty mental health services through county mental health plans. This data was disaggregated by race/ethnicity and primary language.

2020 DHCS expands its reporting to included Medi-Cal managed care plan data on non-specialty mental health services.

2022 DHCS updates the data set to include additional years of data through fiscal year 2021 and introduces the option to filter data by county and health plan.

2023 DHCS updates the data set to include additional years of data through fiscal year 2022.

About the Data

Years

The data in this report is from 2019-2022, with a primary focus on data from fiscal year 2022 (July 2021-June 2022), which is the most recent year of available data.

Population of focus

The analysis is limited to adults aged 21 and older. All adults age 21+ who were eligible for mental health services through non-specialty mental health services (N=7,687,748) or specialty mental health services (N=9,541,784) in 2022 were included in this analysis.

Descriptive statistics

This report analyzes California mental health service data and provides descriptive statistics by race and ethnicity, preferred written language, sex, and age group.

Primary data sources

- The Mental Health Service Dashboard Adult Demographic Datasets available on the California Health and Human Services (CalHHS) Open Data Portal.
- The Adult Mental Health Services Demographic Dashboard (AB 470) available on the DHCS Behavioral Health Reporting Data Hub, where data on the top ICD-10 diagnosis categories are most recently updated.

Notable limitations

- Racial and ethnic categories in this analysis are defined as: Asian or Pacific Islander (API), African American or Black, American Indian or Alaskan Native (AI/AN), Hispanic, White, Other and Unknown. These categories lack data on subgroups which would allow us to further stratify variables for this analysis, and could mask important differences within each population.
- This data lacks both a gender identity and sexual orientation variable. There is a critical need to understand the experiences of Medi-Cal beneficiaries beyond the binary "sex" variable provided (male or female).

Defining Terms

- **Non-Specialty Mental Health Services (NSMHS):** NSMHS are administered through **managed care plans (MCPs)**. These services are primarily intended for "mild-to-moderate" mental health concerns. While MCPs are the main providers for NSMHS, Medi-Cal members that do not have coverage through an MCP can also access these services through **fee-for-service (FFS) providers**.

- **Specialty Mental Health Services (SMHS):** SMHS are administered through **county mental health plans (MHPs).** These services provide more intensive support for mental health concerns causing an individual significant impairment, distress, or disability [4]. Specialty mental health services in this data include the total eligible beneficiaries in both MCPs and FFS. This broader inclusion is due to SMHS being delivered through MHPs, which encompass individuals from both MCPs and FFS, identified by their county of residence.

- **Access Rate:** The percentage of eligible Medi-Cal beneficiaries that received at least one (1) or more services. The access rate is also referred to as the penetration rate.

- **Continued Engagement Rate:** The percentage of eligible Medi-Cal beneficiaries that received at least five (5) or more services. This is a measure of ongoing access to care.

Key Findings

Access and Continued Engagement Rates: Over Time

All Beneficiaries

Statewide access and continued engagement rates are relatively low among both service types. Rates have remained relatively steady between 2019-2022, but rates for specialty mental health services were their lowest in 2022.

Across 2019-2022, statewide access and continued engagement rates held steady for non-specialty mental health services received through MCPs (Figure 1). While the difference is slight, access and continued engagement rates of SMHS were lowest in 2022 compared to 2019-2021 (Figure 2).

With several behavioral health policies introduced in recent years to prioritize care for individuals with serious mental illness, future data will reveal whether these measures lead to improvements in access and engagement rates.

Figure 1. Access and Continued Engagement Rates, ***Non-Specialty Mental Health Services****, California, 2019-2022*

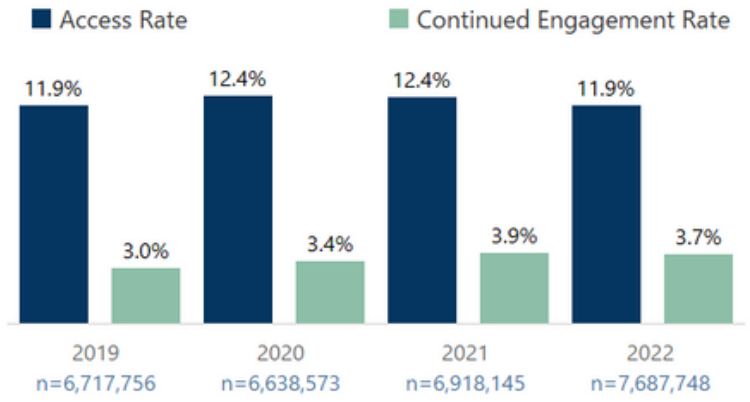
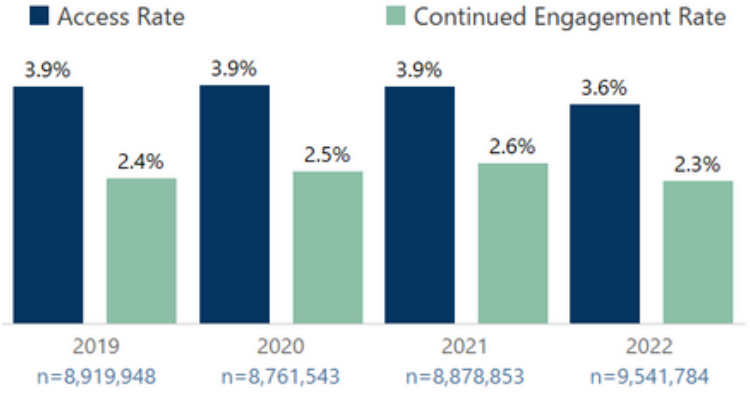


Figure 2. Access and Continued Engagement Rates, ***Specialty Mental Health Services****, California, 2019-2022*



Source: "Adult Demographics by Sex (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.
Note: The access rate refers to the percent of eligible beneficiaries that received at least one (1) service, while the continued engagement rate refers to the percent of eligible beneficiaries that received at least five (5) services.

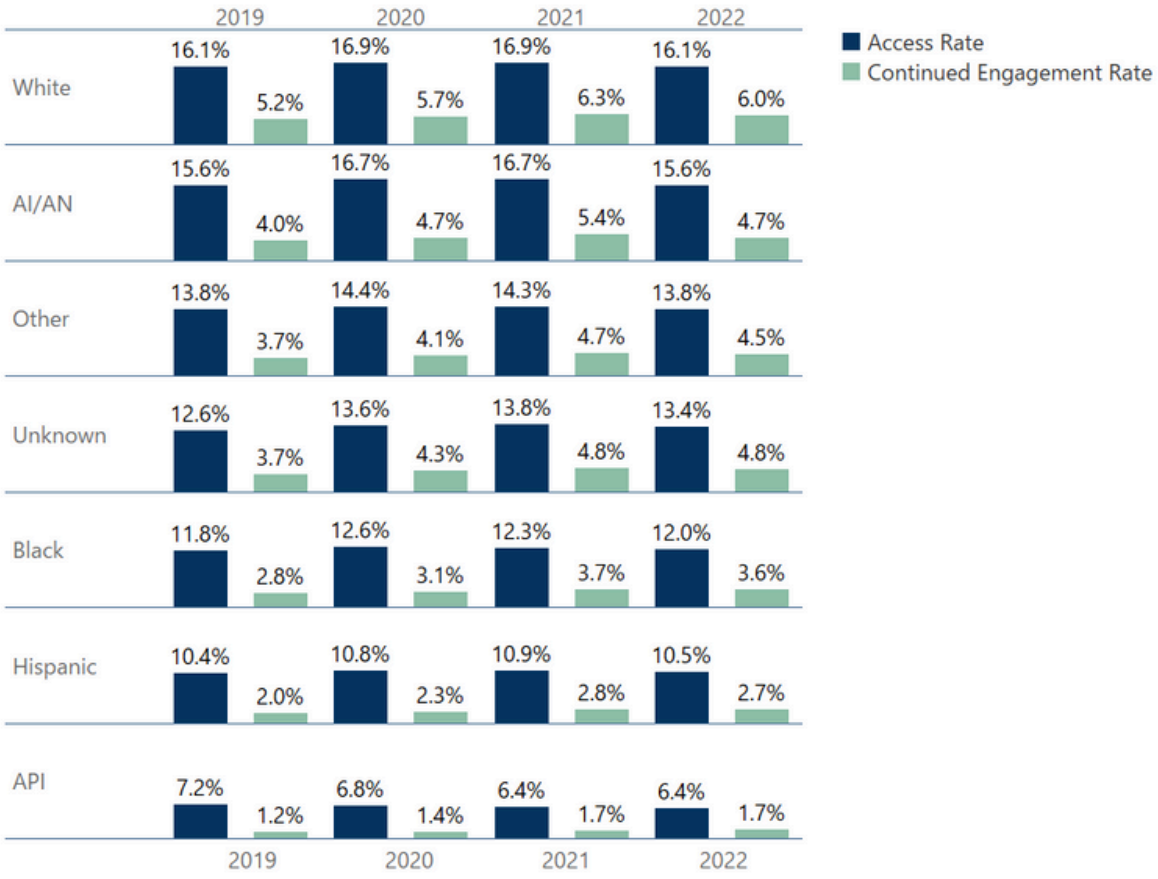
Access and Continued Engagement Rates: Demographic Disparities

Access and continued engagement rates of non-specialty and specialty mental health services were relatively stagnant from 2019 to 2022 across all racial and ethnic groups, with rates overall being low.

Figures 3 and 4, which are ordered from overall highest to lowest rates among racial and ethnic groups, display relatively steady rates of both NSMHS and SMHS use across all groups. Across all four years, White beneficiaries had the highest access and continued engagement rates of NSMHS, while Asian and Pacific Islanders (API) had the lowest, with Hispanic and Black beneficiaries having the second and third lowest rates, respectively.

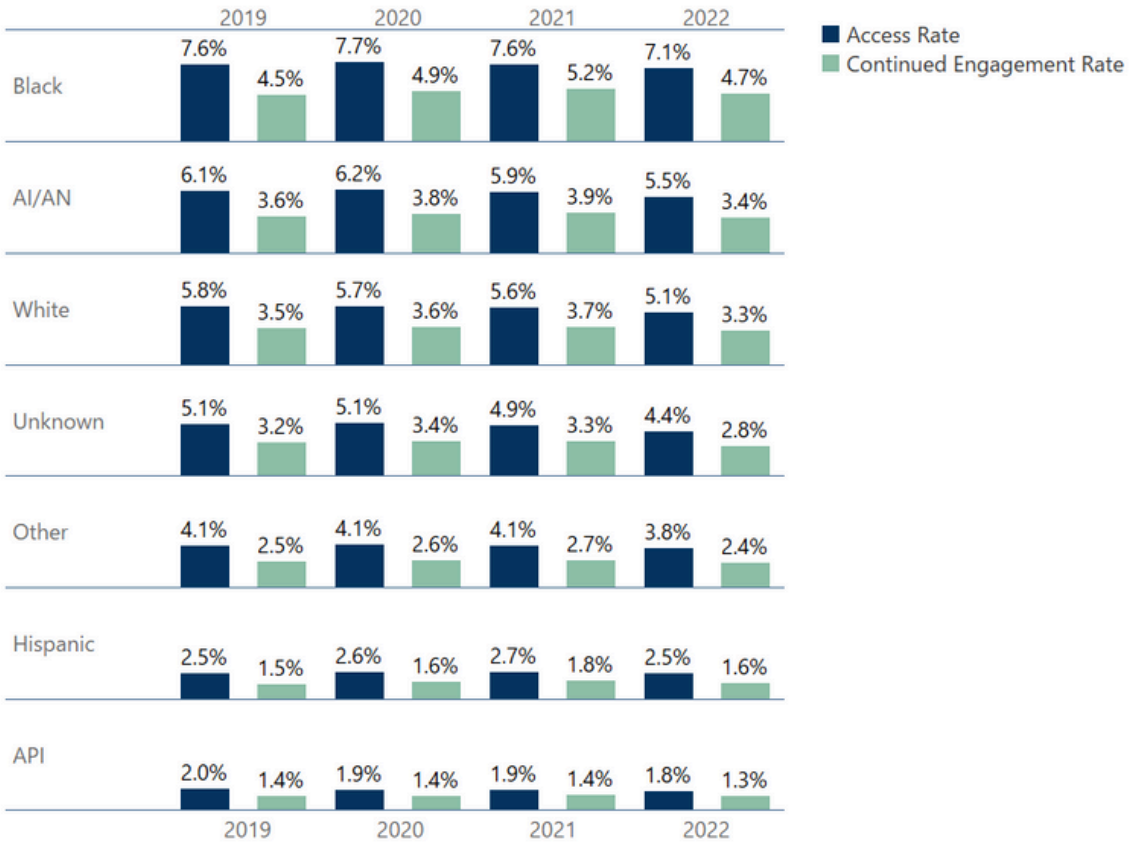
In Figure 3, Black beneficiaries had the third lowest rates for NSMHS, while in Figure 4, they have the highest access and continued engagement rates of SMHS. Similar to NSMHS, API had the lowest rates of SMHS across all four years.

Figure 3. Access and Continued Engagement rates by race and ethnicity over time, ***Non-Specialty Mental Health Services****, California, 2019-2022*



Source: "Adult Demographics by Race (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.

Figure 4. Access and Continued Engagement rates by race and ethnicity over time, ***Specialty Mental Health Services****, California, 2019-2022*



Source: "Adult Demographics by Race (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.

Despite various efforts by the state to address mental health disparities, these rates have shown little change, indicating that interventions may not be fully effective in closing racial and ethnic disparities in mental health service access and engagement. The lack of improvement highlights the need for the state to intensify its focus on leveraging data to drive meaningful changes in health equity over the next several years.

Since 2022, additional policies have been introduced to further improve mental health access and equity within Medi-Cal, and future data will be crucial to assess the impact of these changes. We hope that future iterations of this report, which will include post-2022 data, will reveal positive trends and reductions in disparities resulting from these policy efforts.

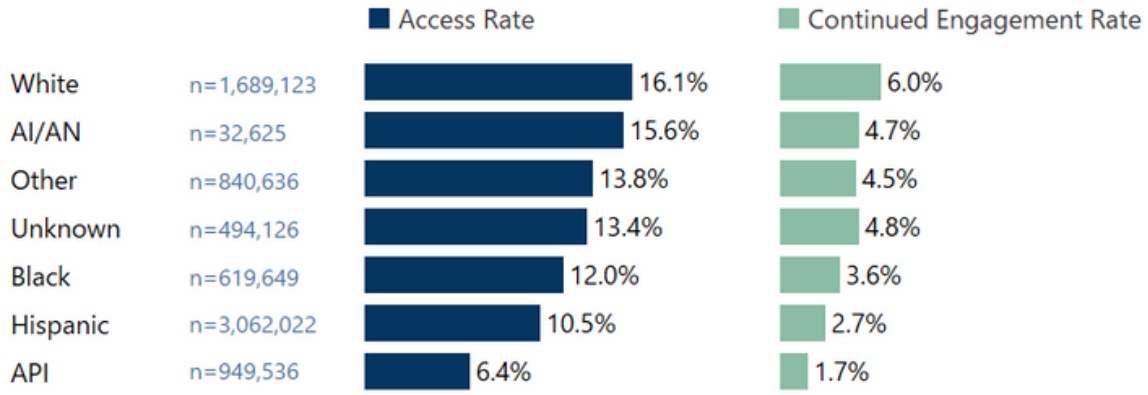
Throughout the rest of this report, we focus on just 2022 data to get additional insight into how usage of services compares across groups.

Race and Ethnicity: Access and Continued Engagement 2022

In 2022 Black beneficiaries had the highest access and continued engagement rates for specialty mental health services, while API and Hispanic beneficiaries had the lowest access and continued engagement rates for both non-specialty and specialty mental health services.

White beneficiaries had the highest access (16.1%) and continued engagement (6.0%) rates in 2022 for non-specialty mental health services through a managed care plan. American Indian/Alaskan Native (AI/AN) beneficiaries had the second highest access and continued engagement rates at 15.6% and 4.7%, respectively. API had the lowest access (6.4%) and continued engagement (1.7%) rates (see Figure 5).

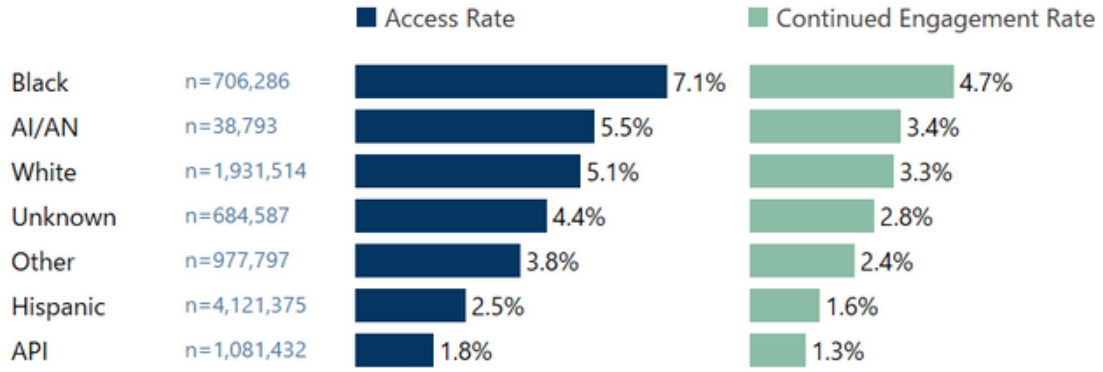
Figure 5. Access and Continued Engagement rates by race and ethnicity, ***Non-Specialty Mental Health Services****, California, 2022*



Source: "Adult Demographics by Race (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.

For specialty mental health services, Black beneficiaries had the highest access and continued engagement rates in 2022 at 7.1% and 4.7%, respectively compared to lower access and continued engagement rates for non-specialty mental health services (see Figure 5 and 6). AI/AN beneficiaries again had the second highest access (5.5%) and continued engagement (3.4%) rates. Access and continued engagement of SMHS among Hispanic beneficiaries were the second lowest overall at 2.5% and 1.6%, respectively. API had the lowest access (1.8%) and continued engagement rates (1.3%).

Figure 6. Access and Continued Engagement rates by race and ethnicity, ***Specialty Mental Health Services****, California, 2022*



Source: "Adult Demographics by Race (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.

Interpreting Visuals:

Access and Continued Engagement Rates vs. Share of Eligible Beneficiaries

- Access & Continued Engagement rates (Figures 5 & 6): These visuals show the **percentage of people within each racial/ethnic group** who are accessing or continuing mental health services. For example, for the API group, this visual intends to answer, "What percentage of people in the API group accessed or continued using services?" The denominator here is only within the specific racial/ethnic group.

- Share of beneficiaries eligible for services (Figures 7 & 8): These visuals show the **proportion each racial/ethnic group represents within the total eligible population of beneficiaries** who are accessing or continuing mental health services. For example, for the API group, this visual intends to answer, "What share of all eligible beneficiaries who accessed or continued using services are API?" The denominator here is across all groups combined.

- In a system where different groups utilized services according to their expected shares, each racial/ethnic group would access services proportional to their share of the overall eligible population. For example, if API individuals make up 12.4% of all Medi-Cal beneficiaries eligible for NSMHS, they would also represent about 12.4% of those accessing at least one service and 12.4% of those accessing five or more services in NSMHS (Figures 7). As Figures 7 and 8 demonstrate, however, disparities persist with some groups accessing services at rates below their proportional representation. In an ideal, equitable system, groups with historically lower access and who face unique barriers may even make up larger shares of service users in order to address unmet needs.

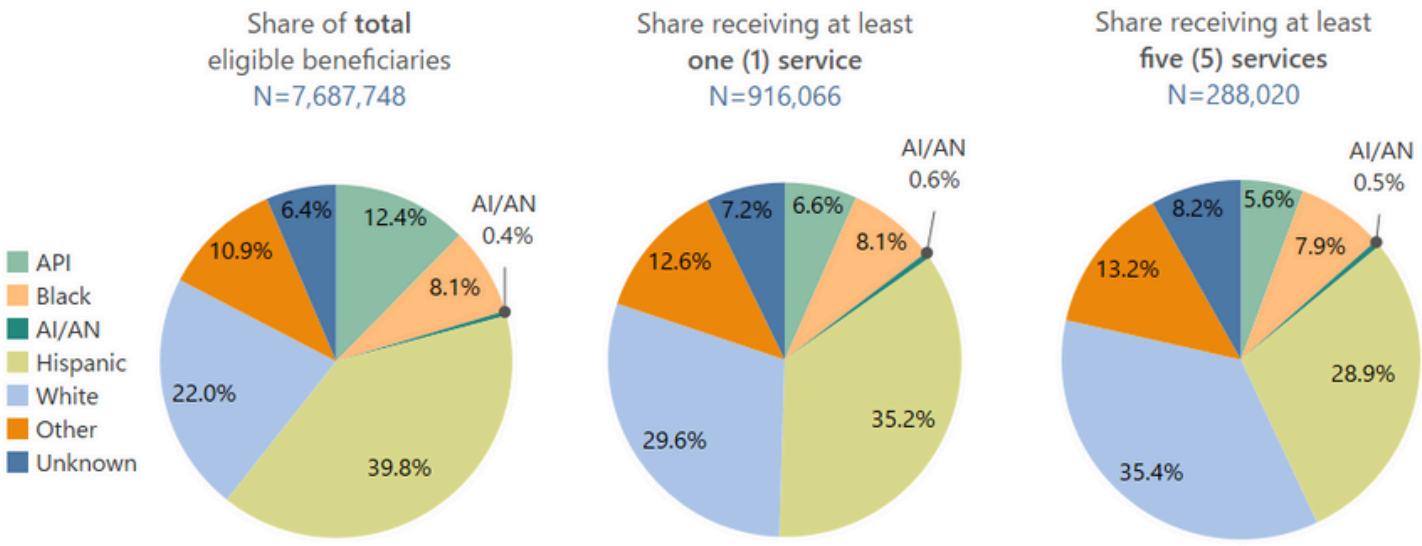
Race and Ethnicity: Eligible Population

Asian and Pacific Islanders make up smaller shares of the beneficiaries receiving at least one and at least five non-specialty mental health services compared to their share of the total eligible population.

Below are the shares of all individuals eligible for non-specialty mental health services, all individuals receiving at least one service, and all individuals receiving at least five services in FY 2022 by race and ethnicity.

Compared to their share of the total eligible population (39.8%), Hispanic individuals had smaller shares of beneficiaries receiving at least one service (35.2%) and those receiving at least five services (28.9%). API composed 12.4% of all eligible MCP beneficiaries, but made up only 6.6% and 5.6% of beneficiaries receiving at least one and five services, respectively. White beneficiaries, however, composed higher shares of beneficiaries receiving at least one (29.6%) and at least five services (35.4%) compared to their share of the total eligible population (22.0%). These assessments are consistent with the earlier figures above, where API and Hispanic beneficiaries had the lowest access and continued engagement rates for NSMHS, while White beneficiaries had the highest. These low levels of access and continued engagement among API individuals may be attributed to barriers such as stigma and a lack of linguistically and culturally appropriate services. However, further analysis would be necessary to confirm if these factors significantly contribute to the observed disparities.

*Figure 7. Share of beneficiaries eligible for **Non-Specialty Mental Health Services** by race and ethnicity, California, 2022*



Source: "Adult Demographics by Race (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.

*Table 1. Share of beneficiaries eligible for **Non-Specialty Mental Health Services** by race and ethnicity, California, 2022*

Race and Ethnicity	All eligible beneficiaries	Share of all eligible beneficiaries (%)	Number receiving at least one service	Share receiving at least one service (%)	Number receiving at least five services	Share receiving at least five services (%)
AI/AN	32,625	0.4%	5,094	0.6%	1,549	0.5%
API	949,536	12.4%	60,447	6.6%	16,207	5.6%
Black	619,649	8.1%	74,049	8.1%*	22,615	7.9%
Hispanic	3,062,022	39.8%	322,902	35.2%	83,287	28.9%
Other	840,636	10.9%	115,743	12.6%	38,122	13.2%
Unknown	494,126	6.4%	66,001	7.2%	23,501	8.2%
White	1,689,123	22.0%	271,557	29.6%	102,057	35.4%
Missing	31		273		682	
Total	7,687,717	100.0%	915,793	100.0%	287,338	99.8%

Source: "Adult Demographics By Race (Suppressed)." CalHHS Open Data Portal, accessed July 8 2024.
Note: Proportions may not add up to 100.0% due to missing race/ethnicity data from county-level cell suppression of cell counts less than 11.
**Value not found to be statistically significant, indicating that any observed difference in this group is not significantly different than the expected value based on the share of the total eligible population. Differences in all other proportions for those receiving at least one and at least five services were found to be statistically significant.*

These disparities may be shaped by factors such as differences in awareness of available services, trust in the healthcare system, and the presence of culturally relevant outreach and support. For Hispanic and API populations, limited access could stem from barriers like language, cultural stigma around mental health, and the availability of providers who can offer linguistically and culturally tailored services. For White beneficiaries, comparatively higher engagement may reflect fewer structural or cultural barriers to accessing and continuing care.

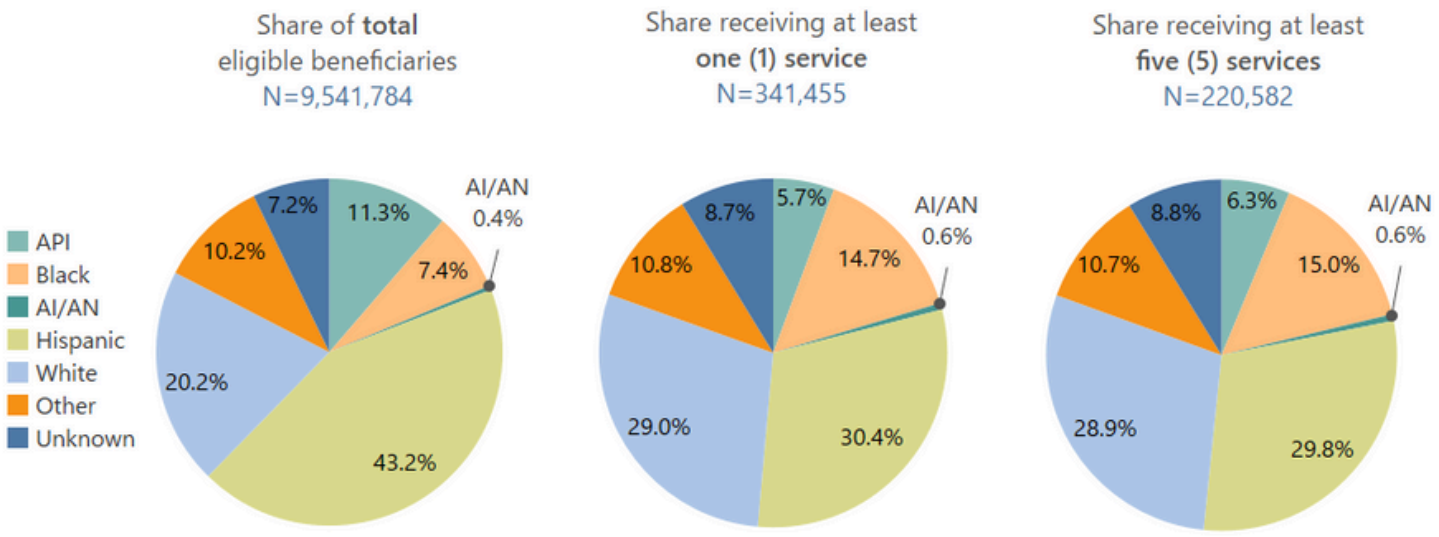
Addressing these disparities is crucial for advancing equitable access to mental health services and ensuring that all populations receive the support they need. Policies that expand culturally and linguistically relevant mental health services, improve outreach to underutilizing communities, and build trust in the healthcare system are key steps toward reducing these gaps. Further analysis is necessary to fully understand the impact of these factors on service engagement across racial and ethnic groups and to inform targeted policy interventions that promote inclusivity in mental health care.

Hispanic and API beneficiaries make up smaller shares of those receiving specialty mental health services compared to their share of the total eligible population, while Black beneficiaries comprised higher shares of those receiving services compared to their share of the total eligible population, nearly double their proportion.

Below are the shares of all individuals eligible for specialty mental health services, all individuals receiving at least one service, and all individuals receiving at least five services in FY 2022 by race and ethnicity.

Compared to their share of the total eligible population (43.2%), Hispanic individuals had smaller shares of those receiving at least one service (30.4%) and those receiving at least five services (29.8%). API composed 11.3% of all beneficiaries eligible for SMHS, but made up only 5.7% and 6.3% of those receiving at least one and five services, respectively. Black beneficiaries comprised 7.4% of the total eligible population for SMHS in 2022, but comprised higher shares of those receiving at least one (14.7%) at least five services (15.0%) respectively. Similarly, white beneficiaries were 20.2% of the total eligibles, but had larger shares receiving at least one (29.0%) and at least five (28.9%) services. These assessments are again consistent with earlier figures displaying low access and continued engagement rates of SMHS among Hispanic and API beneficiaries, and the highest rates for Black beneficiaries.

*Figure 8. Share of eligible beneficiaries eligible for **Specialty Mental Health Services** by race and ethnicity, California, 2022*



Source: "Adult Demographics by Race (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.

*Table 2. Share of eligible beneficiaries eligible for **Specialty Mental Health Services** by race and ethnicity, California, 2022*

Race and Ethnicity	All eligible beneficiaries	Share of all eligible beneficiaries (%)	Number receiving at least one service	Share receiving at least one service (%)	Number receiving at least five services	Share receiving at least five services (%)
AI/AN	38,793	0.4%	2,120	0.6%	1,332	0.6%
API	1,081,432	11.3%	19,359	5.7%	13,882	6.3%
Black	706,286	7.4%	50,250	14.7%	33,013	15.0%
Hispanic	4,121,375	43.2%	103,886	30.4%	65,671	29.8%
Other	977,797	10.2%	36,914	10.8%	23,538	10.7%
Unknown	684,587	7.2%	29,827	8.7%	19,391	8.8%
White	1,931,514	20.2%	99,099	29.0%	63,755	28.9%
Missing	-		-		-	
Total	9,541,784	100.0%	341,455	100.0%	220,582	100.0%

Source: "Adult Demographics By Race (Suppressed)." CalHHS Open Data Portal, accessed July 8 2024.
Note: Differences in all proportions for those receiving at least one and at least five services were found to be statistically significant.

The significantly higher rates of Black beneficiaries accessing specialty mental health services, compared to their share of the population, may indicate a greater need for mental health support within this community – potentially due to chronic stress, systemic inequities, and adverse social determinants of health – as well as unmet needs within early intervention settings due to factors like service quality, cultural competency, or continuity of care. Further research is necessary to confirm if these factors significantly influence service utilization and to guide policies that promote equity in mental health care access and outcomes.

As new behavioral health benefits are implemented across the continuum of care, such as the Medi-Cal mobile crisis benefit for those experiencing a behavioral health crisis, it is essential to ensure that these services are both culturally responsive and consider the specific needs of diverse communities. Given that Black beneficiaries are accessing specialty mental health services at higher rates – despite the underlying reasons remaining unclear – these services should be designed with particular attention to safety and accessibility. This includes implementing safety measures, such as avoiding police presence in crisis interventions, due to the historical and ongoing trauma Black individuals have faced in interactions with law enforcement, which has, in many cases, led to harm or even death. Prioritizing cultural responsiveness and safety within these services is crucial to promoting equitable, effective care for Black Medi-Cal members and all communities served.

Race and Ethnicity: Top ICD-10 Diagnosis Categories

In 2022, the top mental health diagnosis categories across both service types included anxiety and major depressive, bipolar, schizoaffective, or attention-deficit hyperactivity disorders. Other top diagnoses included those for psychosis due to a substance or known physiological condition, reactions to severe stress, and schizophrenia. For a list of the top ICD-10 diagnosis categories for both NSMHS and SMHS and their prevalence among all Medi-Cal beneficiaries, see Appendix A.

Research has shown that Black individuals are often over-diagnosed with schizophrenia and related disorders, which raises concerns about the impact of diagnosis-based behavioral health policies on these communities [5]. As California introduces new policies that rely on specific diagnoses to determine eligibility for services and interventions, it is essential to assess how these policies may affect different racial and ethnic groups. Policies like CARE Court, which mandates court-ordered treatment for individuals diagnosed with certain severe mental health conditions, use these diagnoses as criteria for implementing treatment plans. Our data indicates that schizoaffective disorders and schizophrenia are among the top diagnoses for AI/AN, Black, and API beneficiaries, raising concerns that these communities may be disproportionately impacted by policies targeting these conditions.

*Table 2. Share of eligible beneficiaries eligible for **Specialty Mental Health Services** by race and ethnicity, California, 2022*

	Non-Specialty Mental Health Services*		Specialty Mental Health Services	
Race and Ethnicity	**Diagnosis Category**	**% of those receiving at least one service**	**Diagnosis Category**	**% of those receiving at least one service**
AI/AN	Other Diagnosis	62.4%	Major depressive disorder, recurrent	21.2%
	Other anxiety disorders	39.6%	Reaction to severe stress, and adjustment disorders	21.1%
	Reaction to severe stress, and adjustment disorders	26.2%	Schizoaffective disorders	16.6%
	Major depressive disorder, recurrent	18.7%	Bipolar disorder	15.1%
	Major depressive disorder, single episode	16.4%	Other Diagnosis	15.1%
	Bipolar disorder	10.1%	Schizophrenia	12.7%
	Alcohol related disorders	5.1%	Unspecified psychosis not due to a substance or known physiological condition	12.7%
	Schizophrenia	4.6%	Major depressive disorder, single episode	11.0%
	Schizoaffective disorders	4.1%	Other anxiety disorders	10.7%
	Attention-deficit hyperactivity disorders	3.9%	Unspecified mood [affective] disorder	6.9%

Race and Ethnicity	Non-Specialty Mental Health Services		Specialty Mental Health Services	
	Diagnosis Category	% of those receiving at least one service	Diagnosis Category	% of those receiving at least one service
API	Other Diagnosis	69.3%	Major depressive disorder, recurrent	23.0%
	Other anxiety disorders	28.3%	Schizophrenia	22.3%
	Major depressive disorder, recurrent	17.9%	Schizoaffective disorders	15.9%
	Reaction to severe stress, and adjustment disorders	14.1%	Reaction to severe stress, and adjustment disorders	10.9%
	Major depressive disorder, single episode	14.0%	Unspecified psychosis not due to a substance or known physiological condition	10.9%
	Schizophrenia	5.2%	Major depressive disorder, single episode	10.7%
	Bipolar disorder	4.1%	Bipolar disorder	10.1%
	Attention-deficit hyperactivity disorders	3.5%	Other Diagnosis	9.3%
	Schizoaffective disorders	2.9%	Other anxiety disorders	8.8%
	Sleep disorders not due to a substance or known physiological condition	2.7%	Unspecified mood [affective] disorder	4.6%
Black	Other Diagnosis	65.0%	Major depressive disorder, recurrent	21.8%
	Other anxiety disorders	31.4%	Schizoaffective disorders	19.1%
	Major depressive disorder, recurrent	19.2%	Schizophrenia	17.4%
	Reaction to severe stress, and adjustment disorders	18.2%	Unspecified psychosis not due to a substance or known physiological condition	15.8%
	Major depressive disorder, single episode	14.3%	Reaction to severe stress, and adjustment disorders	13.7%
	Schizophrenia	8.9%	Bipolar disorder	13.3%
	Bipolar disorder	8.3%	Major depressive disorder, single episode	11.3%
	Schizoaffective disorders	5.8%	Other Diagnosis	11.0%
	Unspecified psychosis not due to a substance or known physiological condition	4.9%	Unspecified mood [affective] disorder	8.0%
	Unspecified mood [affective] disorder	2.9%	Other anxiety disorders	7.8%

Race and Ethnicity	Non-Specialty Mental Health Services		Specialty Mental Health Services	
	Diagnosis Category	% of those receiving at least one service	Diagnosis Category	% of those receiving at least one service
Hispanic	Other Diagnosis	71.4%	Major depressive disorder, recurrent	25.0%
	Other anxiety disorders	40.2%	Other anxiety disorders	16.1%
	Major depressive disorder, recurrent	17.9%	Major depressive disorder, single episode	14.3%
	Major depressive disorder, single episode	15.9%	Reaction to severe stress, and adjustment disorders	14.1%
	Reaction to severe stress, and adjustment disorders	15.2%	Schizoaffective disorders	12.8%
	Bipolar disorder	4.3%	Other Diagnosis	12.7%
	Schizophrenia	2.9%	Schizophrenia	12.6%
	Attention-deficit hyperactivity disorders	2.5%	Bipolar disorder	12.4%
	Schizoaffective disorders	2.0%	Unspecified psychosis not due to a substance or known physiological condition	12.2%
	Unspecified psychosis not due to a substance or known physiological condition	1.9%	Unspecified mood [affective] disorder	7.8%
White	Other Diagnosis	60.3%	Major depressive disorder, recurrent	23.3%
	Other anxiety disorders	43.9%	Bipolar disorder	20.0%
	Major depressive disorder, recurrent	22.8%	Reaction to severe stress, and adjustment disorders	16.1%
	Reaction to severe stress, and adjustment disorders	18.3%	Schizoaffective disorders	14.5%
	Major depressive disorder, single episode	16.4%	Other anxiety disorders	14.4%
	Bipolar disorder	11.1%	Other Diagnosis	12.4%
	Attention-deficit hyperactivity disorders	6.5%	Schizophrenia	12.1%
	Schizophrenia	4.3%	Major depressive disorder, single episode	11.0%
	Schizoaffective disorders	3.9%	Unspecified psychosis not due to a substance or known physiological condition	9.6%
	Unspecified mood [affective] disorder	3.4%	Unspecified mood [affective] disorder	7.3%

Race and Ethnicity	Non-Specialty Mental Health Services		Specialty Mental Health Services	
	Diagnosis Category	% of those receiving at least one service	Diagnosis Category	% of those receiving at least one service
Other	Other Diagnosis	66.3%	Major depressive disorder, recurrent	24.8%
	Other anxiety disorders	41.7%	Reaction to severe stress, and adjustment disorders	19.1%
	Major depressive disorder, recurrent	21.0%	Bipolar disorder	16.9%
	Reaction to severe stress, and adjustment disorders	20.5%	Schizoaffective disorders	14.3%
	Major depressive disorder, single episode	18.5%	Unspecified psychosis not due to a substance or known physiological condition	13.5%
	Bipolar disorder	7.7%	Schizophrenia	13.4%
	Attention-deficit hyperactivity disorders	5.7%	Other Diagnosis	12.9%
	Schizophrenia	3.5%	Other anxiety disorders	12.1%
	Unspecified mood [affective] disorder	3.0%	Major depressive disorder, single episode	10.8%
	Schizoaffective disorders	2.9%	Unspecified mood [affective] disorder	7.3%
Unknown	Other Diagnosis	63.1%	Schizophrenia	22.2%
	Other anxiety disorders	36.9%	Schizoaffective disorders	20.9%
	Major depressive disorder, recurrent	19.2%	Major depressive disorder, recurrent	18.3%
	Reaction to severe stress, and adjustment disorders	15.5%	Other Diagnosis	15.8%
	Major depressive disorder, single episode	15.0%	Unspecified psychosis not due to a substance or known physiological condition	15.2%
	Bipolar disorder	8.7%	Bipolar disorder	15.0%
	Schizophrenia	8.2%	Reaction to severe stress, and adjustment disorders	12.3%
	Schizoaffective disorders	5.8%	Other anxiety disorders	10.8%
	Attention-deficit hyperactivity disorders	4.9%	Major depressive disorder, single episode	9.7%
	Unspecified psychosis not due to a substance or known physiological condition	4.4%	Unspecified mood [affective] disorder	7.4%

Source: Adults Age 21 and Over Mental Health Services Demographic Dashboards (AB470) Dashboard: Diagnosis Data, California Department of Health Care Services, accessed July 8, 2024.

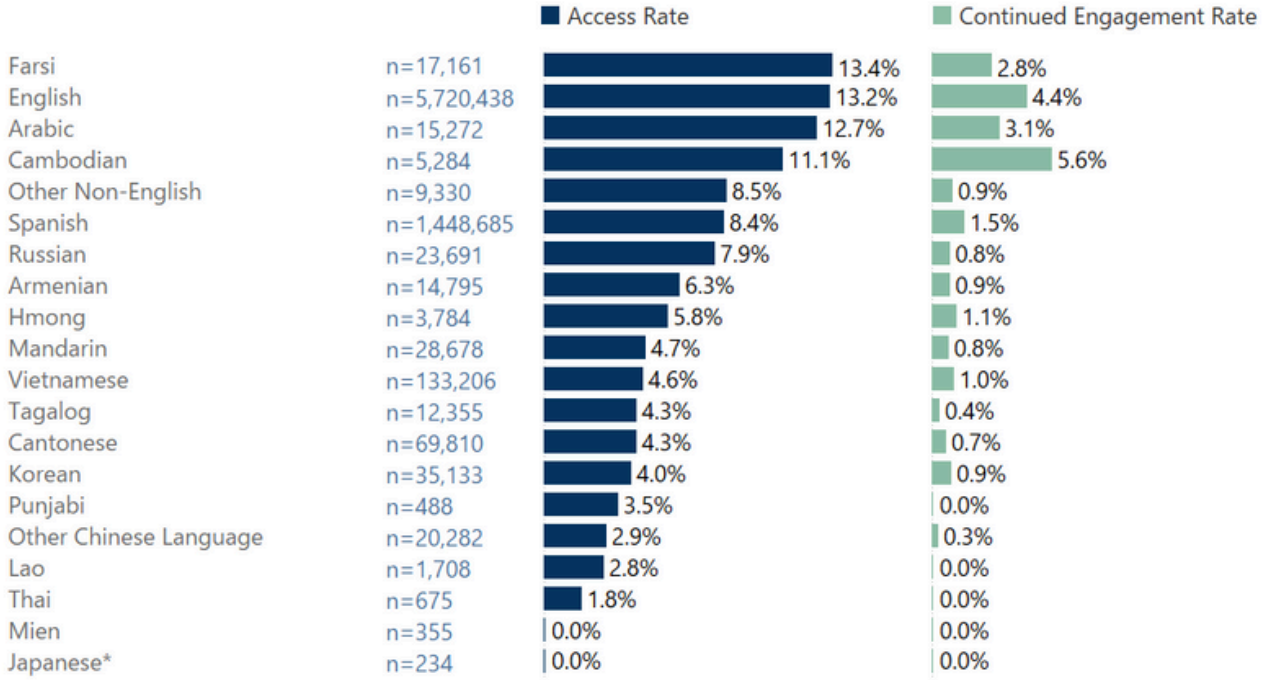
**Non-Specialty Mental Health Services includes both the managed care plan and fee-for-service systems.*

Preferred Written Language: Access and Continued Engagement

Medi-Cal beneficiaries whose preferred written language was either Farsi, English, Arabic, or Cambodian had the highest access rates of non-specialty mental health services, with beneficiaries who preferred Cambodian also having the highest continued engagement rate.

Beneficiaries whose preferred written language was Farsi had the highest access rate (13.4%), but a lower continued engagement rate (2.8%) of non-specialty mental health services in 2022. Beneficiaries who preferred English had the second highest access rate (13.2%) and continued engagement rate (4.4%). Those whose preferred written language was Cambodian had the highest continued engagement rate at 5.6%, but fell slightly lower among other languages in access rates at 11.1%.

Figure 9. Access and continued engagement rates by preferred written language, ***Non-Specialty Mental Health Services****, California, 2022*

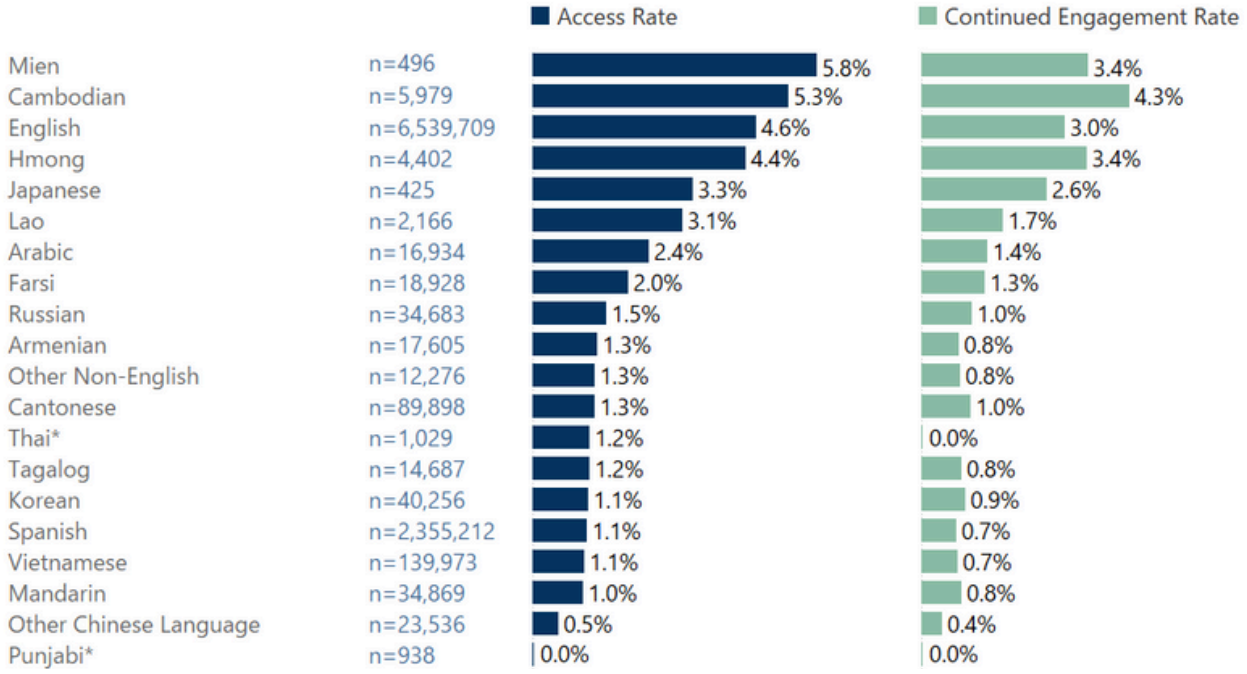


Source: "Adult Demographics by Written Language (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.
Notes: Beneficiaries in the "Unknown" category had an access rate of 11.6% and continued engagement rate of 4.4%. French, Hebrew, Hindi, Ilocano, Italian, Polish, Portuguese, Samoan, and Turkish are excluded from this figure due to having either true zeros or suppressed cells for those that received at least one and at least five services across both non-specialty and specialty mental health services.
**Cell suppressed for a cell count of less than <11 for the access rate.*

Medi-Cal beneficiaries whose preferred written language was Mien, Cambodian, English, or Hmong had the highest access and continued engagement rates of specialty mental health services.

Beneficiaries that preferred Mien had the highest access rate of SMHS at 5.8% (Figure 10), but had one of the lowest rates of NSMHS in Figure 9. Those whose preferred written language was Cambodian had the second highest access rate at 5.3% and the highest continued engagement rate at 4.3% for SMHS. Following Tagalog at an access rate of 1.2%, beneficiaries whose preferred written language was Korean, Spanish, Vietnamese, Mandarin, Other Chinese Language, or Punjabi had the lowest access rates at 1.1% or lower.

*Figure 10. Access and continued engagement rates by preferred written language, **Specialty Mental Health Services**, California, 2022*



Source: "Adult Demographics by Written Language (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.
Notes: Beneficiaries in the "Unknown" category had an access rate of 5.3% and continued engagement rate of 4.0%. French, Hebrew, Hindi, Ilocano, Italian, Polish, Portuguese, Samoan, and Turkish are excluded from this figure due to having either true zeros or suppressed cells for those that received at least one and at least five services across both non-specialty and specialty mental health services.
**Cell suppressed for continued engagement for Thai and in both access and continued engagement for Punjabi.*

Preferred Written Language: Eligible Population

Medi-Cal beneficiaries whose preferred language was English constituted the majority of those who accessed non-specialty and specialty mental health services.

Out of 30 preferred written languages, English comprised the highest share at 74.4% but comprised even higher shares of beneficiaries receiving at least one (82.7%) and at least five (88.3%) non-specialty mental health services in 2022. Beneficiaries whose preferred written language was Spanish were 18.8% of the total eligible population for NSMHS, but composed smaller shares of those receiving at least one (13.3%) and at least five services (7.7%). This is consistent with what we see in Figure 9, where Spanish had low access and continued engagement rates compared to other groups.

*Table 4. Share of beneficiaries eligible for **Non-Specialty Mental Health Services** by preferred written language, California, 2022*

Preferred Written Language	All eligible beneficiaries	Share of all eligible beneficiaries (%)	Number receiving at least one service	Share receiving at least one service (%)	Number receiving at least five services	Share receiving at least five services (%)
English	5,720,438	74.41%	757,564	82.70%	254,251	88.28%
Spanish	1,448,685	18.84%	121,415	13.25%	22,164	7.70%
Vietnamese	133,206	1.73%	6,156	0.67%	1,396	0.48%
Unknown	113,950	1.48%	13,191	1.44%	4,995	1.73%
Cantonese	69,810	0.91%	3,004	0.33%	474	0.16%
Korean	35,133	0.46%	1,418	0.15%	313	0.11%
Mandarin	28,678	0.37%	1,362	0.15%	223	0.08%
Russian	23,691	0.31%	1,882	0.21%	200	0.07%
Other Chinese Language	20,282	0.26%	592	0.06%	65	0.02%
Farsi	17,161	0.22%	2,300	0.25%	482	0.17%
Arabic	15,272	0.20%	1,932	0.21%	480	0.17%
Armenian	14,795	0.19%	931	0.10%	126	0.04%
Tagalog	12,355	0.16%	532	0.06%	46	0.02%
Other Non-English	9,330	0.12%	790	0.09%	88	0.03%
Cambodian	5,284	0.07%	586	0.06%*	295	0.10%
Hmong	3,784	0.05%	219	0.02%	43	0.01%
Lao	1,708	0.02%	48	0.01%	0	0.00%
Thai	675	0.01%	12	0.00%	0	0.00%
Punjabi	488	0.01%	17	0.00%	0	0.00%
Mien	355	0.00%	0	0.00%	0	0.00%
Japanese	234	0.00%	**	0.00%	0	0.00%
All Other Languages* **	863	0.01%	-	-	-	-
Missing	11,571		2,115		2,379	
Total	7,676,177	99.85%	913,951	99.77%	285,641	99.17%

Source: "Adult Demographics by Written Language (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.
Notes:
1. *Missing includes the number of beneficiaries that did not have any preferred written language data and invalid values.*
2. *Proportions may not add up to 100.0% due to missing preferred written language data from county-level cell suppression of cell counts less than 11.*

**Value not found to be statistically significant, indicating that any observed difference in this group is not significantly different than the expected value based on the share of the total eligible population. Differences in all other proportions for those receiving at least one and at least five services were found to be statistically significant.*
*** Suppressed cell for count less than 11.*
**** "All Other Languages" includes French, Hebrew, Hindi, Ilocano, Italian, Polish, Portuguese, Samoan, and Turkish, which contain either true zeros or suppressed cells for those that received at least one and at least five services across both non-specialty and specialty mental health services.*

*Table 5. Share of beneficiaries eligible for **Specialty Mental Health Services** by preferred written language, California, 2022*

Preferred Written Language	All eligible beneficiaries	Share of all eligible beneficiaries (%)	Number receiving at least one service	Share receiving at least one service (%)	Number receiving at least five services	Share receiving at least five services (%)
English	6,539,709	68.54%	299,863	87.82%	192,933	87.47%
Spanish	2,355,212	24.68%	26,523	7.77%	16,663	7.55%
Unknown	153,083	1.60%	8,075	2.36%	6,179	2.80%
Vietnamese	139,973	1.47%	1,470	0.43%	1,044	0.47%
Cantonese	89,898	0.94%	1,140	0.33%	897	0.41%
Korean	40,256	0.42%	456	0.13%	365	0.17%
Mandarin	34,869	0.37%	366	0.11%	289	0.13%
Russian	34,683	0.36%	524	0.15%	359	0.16%
Other Chinese Language	23,536	0.25%	123	0.04%	97	0.04%
Farsi	18,928	0.20%	371	0.11%	248	0.11%
Armenian	17,605	0.18%	235	0.07%	136	0.06%
Arabic	16,934	0.18%	405	0.12%	229	0.10%
Tagalog	14,687	0.15%	171	0.05%	121	0.05%
Other Non-English	12,276	0.13%	158	0.05%	99	0.04%
Cambodian	5,979	0.06%	314	0.09%	256	0.12%
Hmong	4,402	0.05%	193	0.06%	150	0.07%
Lao	2,166	0.02%	67	0.02%*	36	0.02%
Thai	1,029	0.01%	12	0.00%	**	0.00%
Punjabi	938	0.01%	**	0.00%	**	0.00%
Mien	496	0.01%	29	0.01%	17	0.01%*
Japanese	425	0.00%	14	0.00%*	11	0.00%*
All Other Languages* **	2,324	0.02%	-	-	-	-
Missing	34,700	-	946	-	453	-
Total	9,507,084	99.64%	340,509	99.72%	220,129	99.79%

Source: "Adult Demographics by Written Language (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.Notes:

1. *Missing includes the number of beneficiaries that did not have any preferred written language data and invalid values.*
2. *Proportions may not add up to 100.0% due to missing preferred written language data from county-level cell suppression of cell counts less than 11.*

**Value not found to be statistically significant, indicating that any observed difference in this group is not significantly different than the expected value based on the share of the total eligible population. Differences in all other proportions for those receiving at least one and at least five services were found to be statistically significant.*

*** Suppressed cell for count less than 11.*

**** "All Other Languages" includes French, Hebrew, Hindi, Ilocano, Italian, Polish, Portuguese, Samoan, and Turkish, which contain either true zeros or suppressed cells for both those that received at least one and at least five services across both non-specialty and specialty mental health services.*

For specialty mental health services, beneficiaries whose preferred written language was English in 2022 composed a larger share of eligible beneficiaries (68.5%) and composed higher shares of those receiving at least one (87.8%) and at least five (87.5%) services. Despite making up 24.7% of eligible beneficiaries, beneficiaries whose preferred written language was Spanish composed 7.7% and 7.6% of those receiving at least one and at least five services, respectively. This assessment is consistent with the lower access and continued engagement rates of SMHS among beneficiaries who preferred Spanish. Of beneficiaries that chose other languages (as listed in Table 5), most comprised lower shares of those receiving at least one and five SMHS than their share of the total underlying eligible population except for those who preferred Cambodian as their written language. Beneficiaries who preferred Cambodian comprised 0.06% of eligible beneficiaries, but comprised 0.09% and 0.12% of beneficiaries receiving at least one and five SMHS, respectively.

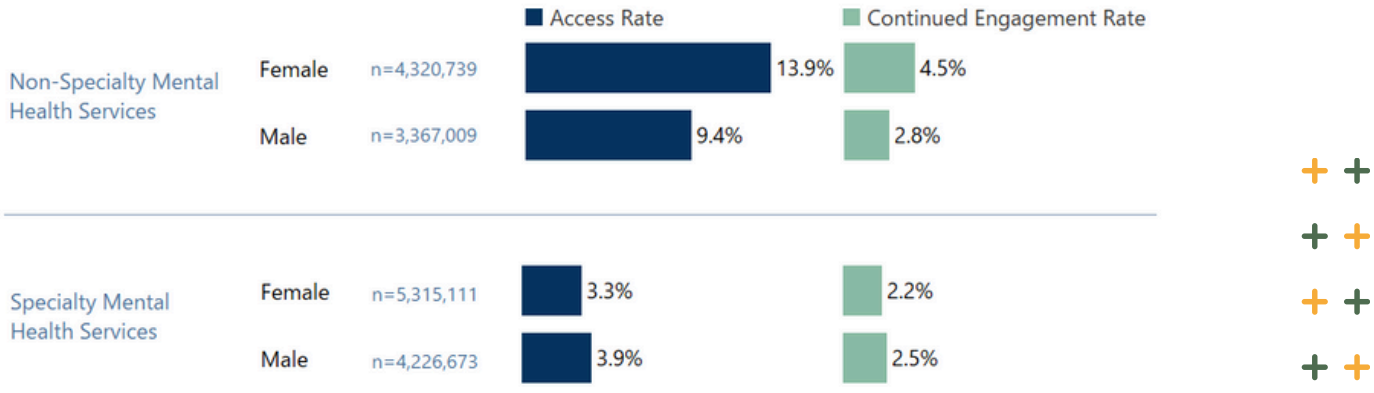
This underutilization among non-English speakers may indicate challenges such as limited availability of in-language providers, fewer in-language resources, and possible cultural or logistical barriers that discourage service use. These disparities highlight the importance of increasing language accessibility and culturally relevant outreach for non-English-speaking populations to ensure equitable access across all Medi-Cal mental health benefits, programs, and initiatives. Further analysis could explore specific barriers faced by these language groups and identify targeted strategies to improve their access to mental health services.

Sex: Access and Continued Engagement

Male beneficiaries access specialty mental health services at higher rates than their female counterparts, but access non-specialty mental health services at lower rates.

Under non-specialty mental health services, female beneficiaries had higher access and continued engagement rates than male beneficiaries in 2022 at 13.9% and 4.5%, respectively. Male beneficiaries had an access rate of 9.4% and continued engagement rate of 2.8%. Male beneficiaries had a slightly higher access (3.9%) and continued engagement (2.5%) rate of specialty mental health services than female beneficiaries in 2022.

Figure 11. Access and Continued Engagement Rates by sex and Medi-Cal Service Type, California, 2022



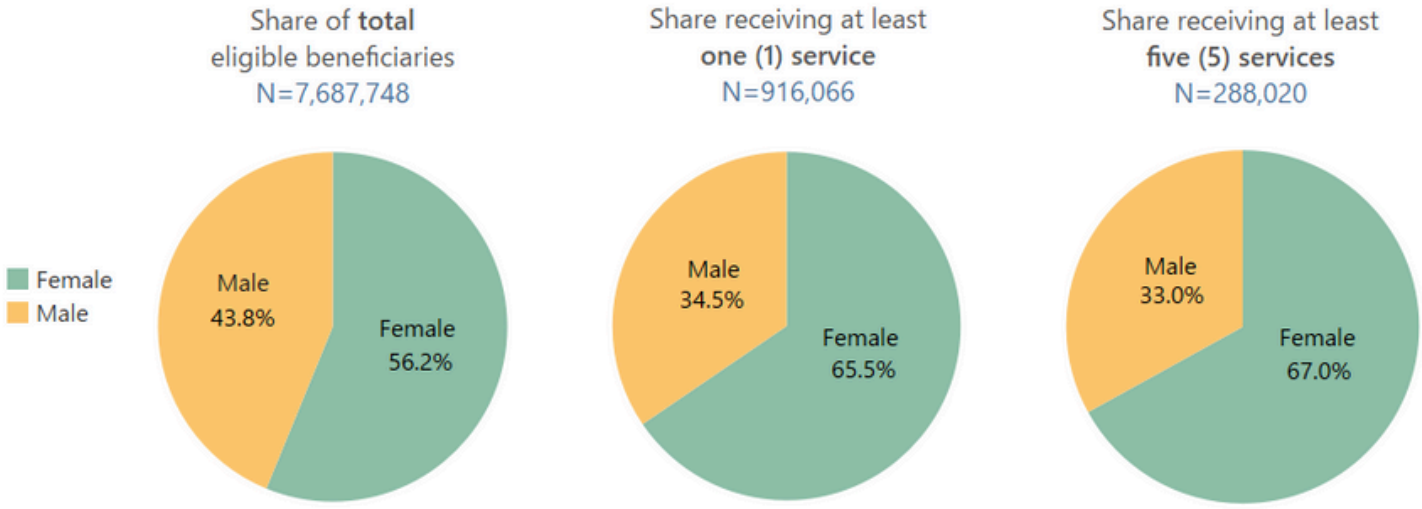
Source: "Adult Demographics by Sex (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.

Sex: Eligible Population

Compared to their shares of the total population eligible for non-specialty mental health services, female beneficiaries comprise higher shares of beneficiaries receiving at least one or five services than male beneficiaries.

Female beneficiaries comprised higher shares of the beneficiaries receiving at least one and five non-specialty mental health services than their male counterparts in 2022 at 65.5% and 67.0%, respectively (Figure 12).

*Figure 12. Share of beneficiaries eligible for **Non-Specialty Mental Health Services** by sex, California, 2022*

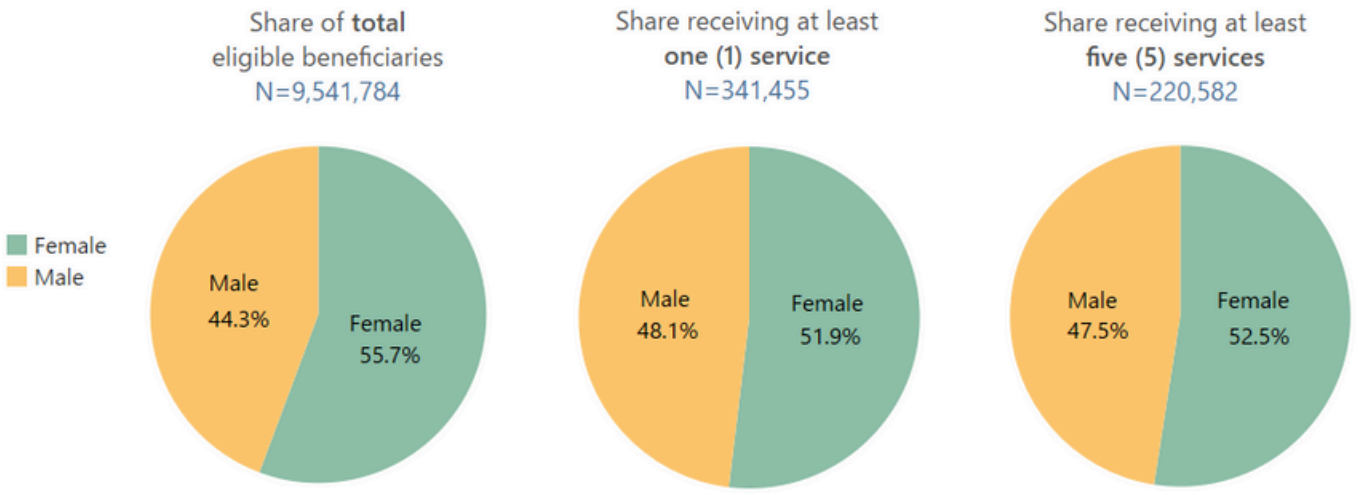


Source: "Adult Demographics by Sex (Suppressed)." CalHHS Open Data Portal, accessed July 8 2024.

This reflects broader trends in mental health utilization, as research shows that men tend to access mental health services at lower rates than women [6]. Contributing factors include societal stigma surrounding male mental health, a reluctance to seek help, and traditional norms that may discourage men from addressing mental health concerns. This analysis is however limited by the inability to cross-tabulate with race, which would provide a more detailed view of how access and engagement rates may vary across racial and ethnic groups within each sex category. This additional layer of data could help identify more targeted areas for intervention and support.

The differences by sex in the shares of beneficiaries varied less for specialty mental health services, but female beneficiaries still had larger shares of those receiving at least one (51.9%) and at least five services (52.5%) than their male counterparts (Figure 13).

*Figure 13. Share of beneficiaries eligible for **Specialty Mental Health Services** by sex, California, 2022*



Source: "Adult Demographics by Sex (Suppressed)." CalHHS Open Data Portal, accessed July 8 2024.

Table 5. Share of beneficiaries eligible for mental health services by sex and Medi-Cal Service Type, California, 2022

Sex	All eligible beneficiaries	Share of all eligible beneficiaries (%)	Number receiving at least one service	Share receiving at least one service (%)	Number receiving at least five services	Share receiving at least five services (%)
Non-Specialty Mental Health Services						
Female	4,320,739	56.2%	600,039	65.5%	192,932	67.0%
Male	3,367,009	43.8%	316,027	34.5%	95,088	33.0%
Total	7,687,748	100.0%	916,066	100.0%	288,020	100.0%
Specialty Mental Health Services						
Female	5,315,111	55.7%	177,253	51.9%	115,756	52.5%
Male	4,226,673	44.3%	164,202	48.1%	104,826	47.5%
Total	9,541,784	100.0%	341,455	100.0%	220,582	100.0%

Source: "Adult Demographics by Sex (Suppressed)." CalHHS Open Data Portal, accessed July 8, 2024.

The male and female binary categories used in this dataset do not reflect the full spectrum of gender identities, which limits our understanding of access and engagement patterns for non-binary and gender-diverse individuals. Expanding data collection to include a broader range of gender identities is essential to capturing the unique challenges faced by all Medi-Cal beneficiaries in accessing mental health care.

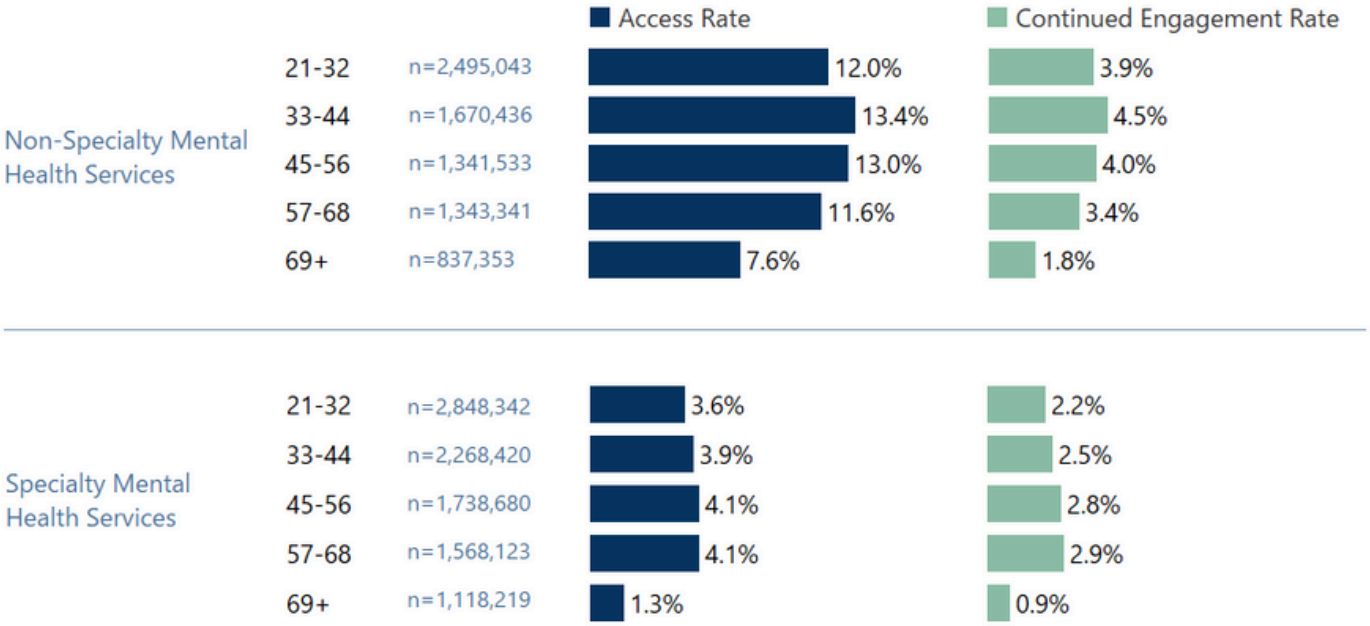
Age Group: Access and Continued Engagement

Non-specialty mental health services have higher access and continued engagement rates from a younger age group compared to specialty mental health services.

Beneficiaries in the age group of 33-44 had the highest access and continued engagement rate of non-specialty mental health services at 13.4% and 4.5%, respectively.

For specialty mental health services, beneficiaries in the age groups of 45-56 years and 57-68 years had the highest access rates at 4.1% and the highest continued engagement rates at 2.8% and 2.9%, respectively.

Figure 14. Access and continued engagement rates by age group and Medi-Cal Service Type, California, 2022



Source: "Adult Demographics by Age Group (Suppressed)." CalHHS Open Data Portal, accessed July 8 2024.

Recommendations

1. Conduct Targeted Mental Health Outreach for Communities of Color

The data reveals disparities in both access and continued engagement rates for communities of color, particularly among American Indian/Alaskan Native populations, Asian and Pacific Islander populations, and Black populations. To help address these gaps, CPEHN co-sponsored legislation SB 1019 (Gonzalez), which mandates health plans to develop and implement culturally and linguistically relevant outreach and education materials to improve utilization of non-specialty mental health services. However, similar targeted outreach is equally necessary for specialty mental health services to ensure comprehensive awareness and access across all mental health services.

Outreach efforts should align with the goals of SB 1019 (Gonzalez) by leveraging trusted messengers within each community to create materials that resonate with the unique needs and concerns of these populations. Effective outreach plans should also include measurable goals, such as tracking improvements in initial access, sustained engagement rates, and community awareness of available mental health services. While SB 1019 (Gonzalez) sets these requirements for non-specialty mental health services, we recommend extending such outreach to specialty mental health services to fully support communities in accessing mental health care available to them across the continuum.

2. Improve Early Access and Engagement for Non-Specialty Mental Health Services

Access and continued engagement rates for non-specialty mental health services should ideally be higher than those for specialty mental health services, as NSMHS provides early, preventive care to address mental health concerns before they escalate. While this is generally true across racial and ethnic groups in the data for access rates, Black individuals show a different pattern – they have the highest rates overall for SMHS, with their continued engagement rates in SMHS higher than in NSMHS (Figures 5 & 6).

Notably, Black individuals' shares of all eligible beneficiaries receiving at least one and at least five SMHS are almost double their representation in the eligible population (Figure 8). This discrepancy suggests that Black individuals may not be receiving early, preventive care that is sufficient through NSMHS, leading to more intensive mental health needs over time. In this case, SMHS access rates may reflect a higher demand for care, indicating an unmet need for earlier intervention within NSMHS for the Black population. Similarly, Hispanic and API populations experience lower access and engagement rates in NSMHS compared to other groups, with API beneficiaries showing the lowest rates overall (Figure 5).

These disparities highlight an urgent need for DHCS to invest in initiatives aimed at improving early access and continued engagement in non-specialty mental health services, particularly for Black, Hispanic, and API Medi-Cal members. Potential strategies include increasing mental health screenings in community settings, integrating mentalhealth services into primary care, and reducing barriers to non-

specialty mental health services, such as cost, transportation, trust in providers, and language limitations. By strengthening early access and engagement in non-specialty mental health care, DHCS can help prevent the progression of untreated mental health needs and reduce reliance on more intense levels of care for these communities.

3. Support Community-Based Organizations in Providing Culturally Appropriate Mental Health Care

The data highlights significant disparities in access and continued engagement among populations with limited English proficiency or who primarily speak non-English languages. To address these gaps, DHCS should provide targeted funding to community-based organizations (CBOs) that offer mental health services in culturally and linguistically resonant ways for these communities. Many CBOs already recruit and train professionals from within their communities who speak the relevant languages but face challenges retaining these staff members due to limited funding. By increasing financial support, DHCS can help CBOs retain culturally competent professionals, making mental health services more accessible and relevant for populations with limited English proficiency.

This approach is particularly needed for languages with high unmet needs, such as those spoken by Southeast Asian communities, where data shows that, on average, only about 1 in 75 individuals (1.3%) access at least one mental health service, with even fewer engaging in ongoing care (Table 5). Additionally, special attention should be given to the "All Other Languages" category in the data, where languages are grouped due to small sample sizes. This highlights the need for targeted support for these smaller linguistic communities to ensure equitable access for all populations (Table 5).

Supporting CBOs enables the provision of trusted, culturally relevant, and accessible care, helping to reduce stigma, encourage earlier engagement with mental health services, and lower barriers for communities of color, ultimately improving mental health outcomes.

4. Ensure Equitable Implementation of Diagnosis-Based Behavioral Health Policies

Policies such as CARE Court, which tie eligibility and interventions to specific mental health diagnoses, require careful implementation to prevent potential inequities. Data reveals that diagnoses such as schizoaffective disorders and schizophrenia are disproportionately assigned to Black, AI/AN, and API communities, raising concerns that these diagnosis-based interventions could lead individuals to higher levels of treatment – potentially involuntary – than necessary. Overdiagnosis of conditions like schizophrenia among Black individuals further compounds this issue, potentially disproportionately subjecting them to restrictive or forced treatment options.

To address these concerns, DHCS should implement equity-focused monitoring and evaluation frameworks for policies like CARE Court to ensure they are culturally and clinically appropriate for diverse populations. This includes conducting regular equity audits on diagnosis-driven programs to

assess their impact on BIPOC communities, with a focus on those disproportionately diagnosed with conditions like schizophrenia. It also involves increasing provider training on culturally responsive and accurate diagnostic practices to minimize overdiagnosis and misdiagnosis, especially for Black individuals, who face a higher risk of inaccurate diagnoses. Additionally, DHCS should prioritize voluntary and culturally informed treatment options within these programs, ensuring that individuals retain autonomy and have access to care that aligns with their cultural needs and values. By adopting an equity-focused implementation framework, DHCS can help ensure that diagnosis-based interventions like CARE Court provide necessary support without reinforcing systemic inequities in mental health care or leading individuals into unnecessary or involuntary treatment.

5. Further Disaggregate Race and Ethnicity Data and Support Cross-Tabulation with Other Demographics

The current race and ethnicity categories used by DHCS are overly broad, particularly for Asian, Hispanic/Latine, and Middle Eastern/North African (MENA) groups, which masks important differences within these populations. For example, there is no specific category for MENA populations, effectively erasing these communities from the data and making it difficult to identify their unique needs. Additionally, the Asian and Hispanic/Latino categories encompass highly diverse subgroups, each with distinct access barriers and health needs that are obscured within broader groupings. These categories should be further disaggregated into specific subgroups, such as Chinese, Filipino, Cambodian, Vietnamese, etc., within the Asian category, and similarly specific subgroups within the Latine population.

While this disaggregation is a critical first step, further insights would be possible with the ability to link our race and ethnicity data with other demographic factors for multiple levels of stratification. A deeper analysis could, for example, reveal unique disparities among Hispanic populations who speak Spanish, Indigenous languages, or English as their primary language, highlighting the complex intersections within these identities. Current DHCS datasets do not allow for this level of analysis, limiting our ability to pinpoint intersecting needs. Moving forward, DHCS should consider structuring datasets to support these types of cross-tabulations and enable more targeted interventions.

By starting with further disaggregation of race and ethnicity data, we can begin to accurately identify which subgroups face the greatest barriers, making visible disparities that are hidden within existing categories. This approach is essential to ensuring that these communities receive equitable access to resources and support, allowing for targeted interventions that can reduce disparities and ultimately improve mental health outcomes across California's diverse populations.

6. Implement SOGI Data Collection Across Medi-Cal

The absence of sexual orientation and gender identity (SOGI) data limits Medi-Cal's ability to understand and address mental health disparities among queer and trans populations. Research in California has shown that LGBT adults had significantly higher rates of serious psychological distress

distress when compared to straight and cisgender adults [7], indicating a critical need to understand the experiences of Medi-Cal beneficiaries beyond the binary "sex" variable provided (male or female). Implementing SOGI data collection will enable a clearer analysis of service gaps and support more targeted interventions, helping to reduce inequities in access and care for these communities. Collecting this data will also provide foundational insights into the needs of queer and trans communities, guiding Medi-Cal in developing and funding initiatives that more effectively address the unique barriers these populations face.

7. Align Age Categories Between Medi-Cal and Medicare

The current age groupings for adults in Medi-Cal's AB 470 data reporting are as follows: 21-32, 33-44, 45-56, 57-68, and 69+. These groupings do not align with Medicare's age requirement, which limits the ability to make meaningful comparisons of services, access, and outcomes between the two programs. This misalignment particularly impacts the 65 and older age group, obscuring insights into the mental health needs and service utilization patterns of older adults, including those transitioning from Medi-Cal to Medicare or dual-enrolled in both programs (Medi-Medi). By aligning age categories to include an older adult segment starting at age 65, Medi-Cal can enable a more accurate analysis of mental health needs across age groups and enhance coordination between Medi-Cal and Medicare. This alignment would facilitate smoother care transitions, help identify service gaps and disparities affecting older adults, and support the development of targeted interventions to improve mental health outcomes for California's aging population.

8. Expand AB 470 Data to Include Quality of Care and Enrollee Experience Measures

The current AB 470 data sets focus primarily on process measures, such as visit types and service counts, which are useful for evaluating system performance and identifying access disparities. However, these metrics do not capture potential inequities in care quality, treatment outcomes, or enrollees' experiences within the mental health system, such as whether care is delivered respectfully and equitably. To provide a more comprehensive view of enrollee experiences, future AB 470 data releases should include additional measures related to timely access to care, quality of care, and treatment outcomes. These enhancements would support more meaningful analyses across both managed care and county specialty mental health systems, providing critical insights to address disparities and improve overall care quality for Medi-Cal enrollees.

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About the California Pan-Ethnic Health Network

The California Pan-Ethnic Health Network (CPEHN) is a BIPOC-led, multicultural, state policy organization, which seeks to advance health equity by dismantling structural racism and ensuring opportunity and health for all Californians. For 30 years, CPEHN has worked with a diverse network of community-based organizations across the state to identify and elevate community priorities to state policymakers. CPEHN is dedicated to building power with communities of color through policy advocacy, research, network and leadership building, and storytelling.

Appendix

Appendix A. Top ICD-10 Diagnosis Categories for Specialty and Non-Specialty Mental Health Services, Statewide, 2022

These tables display the top ten ICD-10 diagnosis categories by Medi-Cal service type.

- While this report has exclusively examined non-specialty mental health services administered through managed care plans, "Non-Specialty Mental Health Services" in this diagnosis data includes services administered through both managed care plans and the fee-for-service system.
- The percentage displayed is the percent of individuals that received at least one service.
- For a more granular look at demographic-specific counts and rankings of diagnosis categories, visit the California Department of Health Care Services' AB470 Dashboard.

Top ICD-10 Diagnosis Categories for Non-Specialty Mental Health Services, 2022		Top ICD-10 Diagnosis Categories for Specialty Mental Health Services, 2022	
Diagnosis Category	**% of those receiving at least one service**	**Diagnosis Category**	**% of those receiving at least one service**
Other Diagnosis	66.1%	Major depressive disorder, recurrent	23.3%
Other anxiety disorders	39.7%	Bipolar disorder	15.3%
Major depressive disorder, recurrent	20.0%	Schizoaffective disorders	15.3%
Reaction to severe stress, and adjustment disorders	17.0%	Reaction to severe stress, and adjustment disorders	14.9%
Major depressive disorder, single episode	16.0%	Schizophrenia	14.7%
Bipolar disorder	7.4%	Other anxiety disorders	13.0%
Unspecified psychosis not due to a substance or known physiological condition	4.5%	Other Diagnosis	12.5%
Schizophrenia	4.4%	Unspecified psychosis not due to a substance or known physiological condition	12.3%
Attention-deficit hyperactivity disorders	4.3%	Major depressive disorder, single episode	11.9%
Schizoaffective disorders	3.3%	Unspecified mood [affective] disorder	7.4%

Endnotes

[1] Liban et al., *An Advocate's Guide to Medi-Cal Services, Chapter III: Mental Health Services*. National Health Law Program (NHeLP), December 2022.

[2] Ibid.

[3] *Medi-Cal Specialty Mental Health Services Covered by County Mental Health Plans – Adults Ages 21 and Older.* Disability Rights California. August, 2022.

[4] Liban et al., *An Advocate's Guide to Medi-Cal Services, Chapter III: Mental Health Services*. National Health Law Program (NHeLP), December 2022.

[5] Faber et al., *The weaponization of medicine: Early psychosis in the Black community and the need for racially informed mental healthcare*. February, 2023.

[6] Griffith, Ogunbiyi, & Jaeger, *Men and mental health: What are we missing?* Association of American Medical Colleges. April, 2024.

[7] Lopes et al., *California Health Interview Survey (2023) Making an Impact*. December, 2023.