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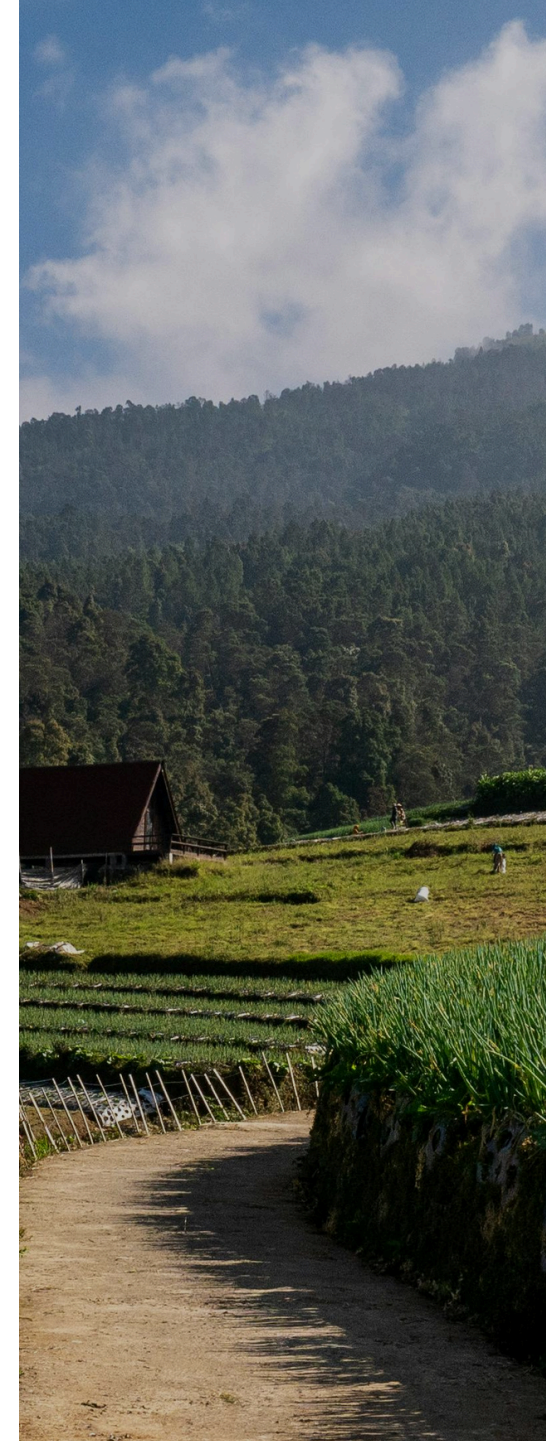
Mental Health Disparities in Medi-Cal



California Pan-Ethnic
HEALTH NETWORK

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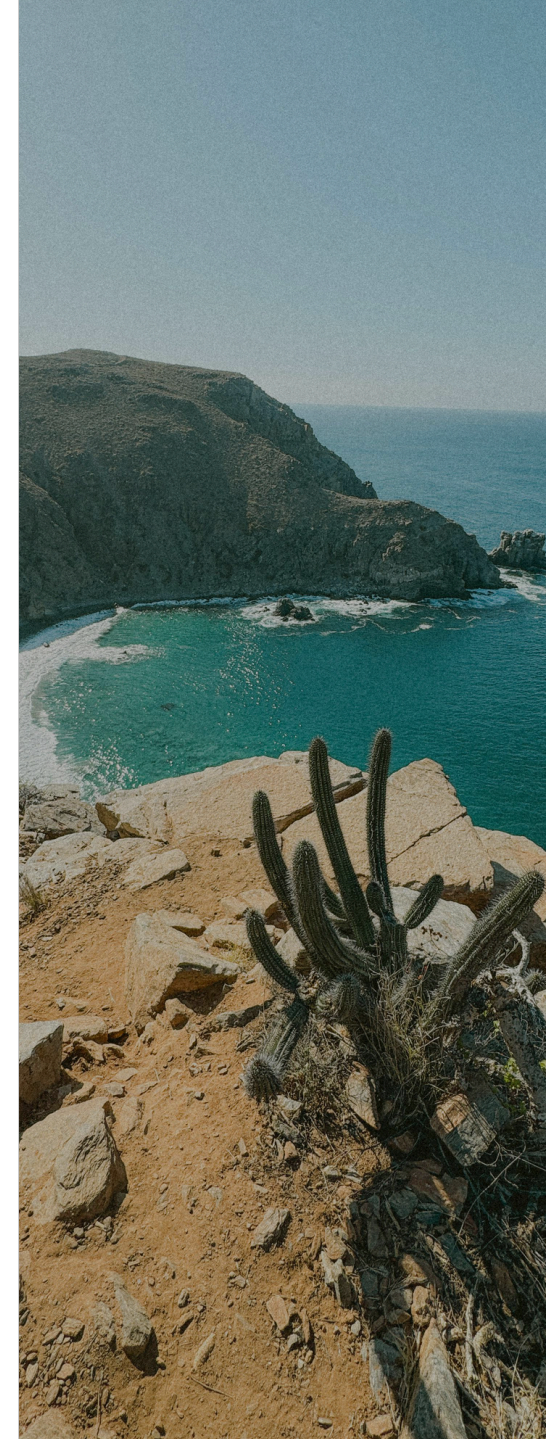
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Executive Summary

In 2017, the California Pan-Ethnic Health Network (CPEHN) sponsored Assembly Bill (AB) 470, the Mental Health Equity Act, to improve data transparency in monitoring behavioral health service delivery through Medi-Cal. This report analyzes recently updated AB 470 data for fiscal year 2023, focusing on racial, ethnic, and language disparities with a snapshot of utilization by race and ethnicity at the county and managed care plan (MCP) levels. In addition to AB 470 data, this report presents data on other quality measures and the peer support specialist workforce to more comprehensively understand the broader behavioral health landscape within Medi-Cal.

California has recently implemented several policy reforms and investments in behavioral health transformation, including CalAIM's No Wrong Door policy, the optional Medi-Cal Peer Support Specialist benefit, and the Behavioral Health Services Act (BHSA). Disaggregated data collection and reporting remain critical to evaluating the effectiveness and progress of these reforms in reducing disparities, improving access and continuity of care, and advancing behavioral health equity. As these reforms are still in early stages of implementation, this report provides important context for understanding existing disparities and tracking future progress.



Data analyzed by CPEHN for this report shows ongoing disparities in the landscape of access to Medi-Cal behavioral health services.

This report highlights ongoing disparities in Medi-Cal behavioral health service utilization across demographic groups and examines the composition of the peer support specialist workforce within Medi-Cal. Analysis of updated AB 470 data indicates statewide utilization of non-specialty and specialty mental health services among adult Medi-Cal members has not meaningfully improved over time, with disparities persisting in how groups are utilizing mental health services across delivery systems. Other behavioral health quality measures further indicate disparities not only exist among racial and ethnic groups, but also potentially between health plans. Additional years of data are necessary to determine if these disparities are trends that persist over the years. These findings further support the need for investment in culturally and linguistically responsive behavioral health care, particularly as the state navigates recently implemented policy reforms.

Executive Summary (continued)

Key Findings

- **Overall statewide access and continued engagement rates of non-specialty and specialty mental health services have remained low and have not meaningfully improved from 2020 to 2023.**
- **Across both non-specialty mental health services and specialty mental health services, Asian and Pacific Islander (API) members had the lowest access and continued engagement rates**, which highlights the importance of targeted outreach, language access efforts, partnerships with community-based organizations that have trusted relationships with these communities, and sustained investments in culturally responsive services.
- **Black and American Indian or Alaska Native (AI/AN) members had the highest access and continued engagement rates of specialty mental health services.**
- **Access rates of non-specialty mental health services among AI/AN members decreased from 2020 to 2023.** This decrease may reflect unmet needs within prevention and early intervention settings, as well as the impacts of systemic inequities and adverse social determinants of health that contribute to more acute behavioral health needs. This also highlights opportunities to strengthen early intervention and culturally responsive community-based services.
- **Members whose preferred written languages were an API language generally had the lowest access rates of non-specialty mental health services, but higher rates of specialty mental health services.** This may be due to barriers to accessing care earlier in the care continuum and highlights the importance of investing in culturally and linguistically responsive outreach and multilingual providers to support engagement before mental health needs become more severe.
- **Out of the ten largest Medi-Cal managed care plans, Community Health Group, which serves San Diego County, had the highest access rates of non-specialty mental health services.**
- **Nearly half of inpatient specialty mental health visits did not have a documented step down service within one week of discharge**, which raises questions about continuity of care and the effectiveness of transitions following intensive treatment.
- **The peer support specialist workforce within Medi-Cal increased significantly from fiscal years 2023 to 2025, with growing representation of communities of color and the majority of them working full time as peers.** However, California's behavioral health workforce is still not completely representative of the state's diverse population, particularly for Latine and API communities.

The Medi-Cal Mental Healthcare System

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 (NSMHS) 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**. Some of the non-specialty mental health services delivered by managed care plans include [1]:

- Mental health evaluation and treatment, including psychotherapy and dyadic behavioral health services
- Psychological and neuropsychological testing
- Outpatient services and drug therapy monitoring
- Psychiatric consultation
- Comprehensive case management for eating disorders
- Psychotherapeutic medications

Specialty mental health services (SMHS) are delivered by **county mental health plans (MHPs)** and address more **serious mental health conditions**. Some of the specialty mental health services delivered by county mental health plans include [2,3]:

- Rehabilitative services, including crisis intervention and stabilization
- Psychiatric inpatient hospital services
- Targeted case management
- Treatment and diagnosis services from licensed psychiatrists and psychologists
- Inpatient and outpatient treatment of eating disorders
- Psychotherapeutic medications

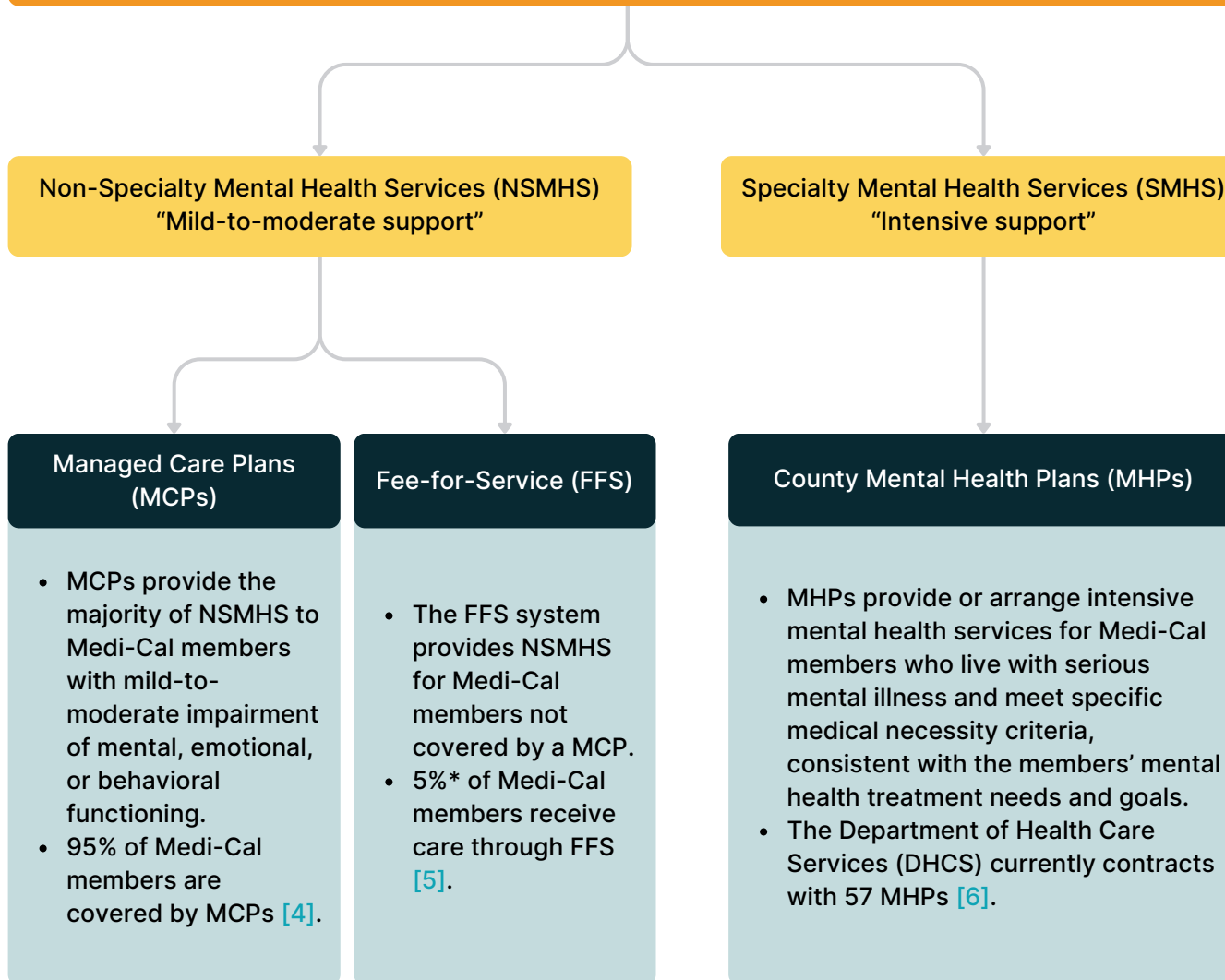
Defining Terms

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



MENTAL HEALTH SERVICES ADMINISTERED THROUGH MEDI-CAL



*While currently 5% of Medi-Cal members receive care through FFS, this number is expected to increase as 2 million members with unsatisfactory immigration status transition from MCPs to FFS due to new federal requirements [7].

Coordinating Behavioral Health Care

Because Medi-Cal members may move between levels of care over time, coordination between MCPs, FFS Medi-Cal providers, and MHPs is critical to ensuring continuity of services and preventing disruptions in care.

Differences in access, engagement, and outcomes across these delivery systems can provide insight into behavioral health equity. Because MCPs and MHPs operate separately, disparities may emerge at different points in the behavioral health continuum. Understanding who can access services, remain engaged in care, and successfully transition between levels of care is essential in evaluating whether the state's behavioral health system is meeting the needs of historically underserved communities.



AB 470: The Mental Health Equity Act

CPEHN sponsored AB 470 (Arambula), which 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 and to ultimately reduce mental health disparities across California.

A core component of AB 470 mandates disaggregated data collection and reporting to monitor disparities in access, engagement, and outcomes. The law requires data to be stratified by key demographic variables, such as age, sex, gender identity, race and ethnicity, primary language, and sexual orientation. By making disparities visible, AB 470 enables policymakers, health plans, counties, advocates, and community members to better understand who is accessing care, who is not, and where inequities persist.

Since leading the passage and implementation of AB 470, CPEHN has analyzed available data to assess trends in mental health access and engagement across Medi-Cal. Over time, the data available through AB 470 has expanded to provide more insights into differences across racial and ethnic groups, languages, counties, and health plans. As the state implements major behavioral health reforms (described in the next section), AB 470 continues to be an essential tool to evaluate whether these efforts are producing meaningful improvements for communities of color. Yet the value of AB 470's transparency depends on timely reporting. At the time of this report's publication in 2026, the most recent available data reflects only through fiscal year 2023. This lag limits advocates' and other stakeholders' ability to identify disparities and respond to emerging needs as reforms are implemented.

Accountability Framework for Behavioral Health

AB 470 established a framework for accountability, which allows the state to measure progress toward mental health equity and identify where targeted interventions and investments are needed.

As California continues to invest in behavioral health transformation, disaggregated data remains essential for evaluating whether reforms are reaching historically underserved communities and reducing longstanding disparities.



Understanding the Behavioral Health Landscape

This report builds on previous analyses. AB 470 data demonstrates who can access mental health care and remain engaged in care, but not what happens to members once they enter the system, or who their care is delivered by. For the first time, this report pairs AB 470 access and engagement data with additional measures such as follow up care members receive, the continuity of their transitions between levels of care, and the growth and composition of the peer support workforce. Together, these sources move beyond the question of who gets in the door, toward a fuller picture of behavioral health equity. This report presents a clearer view of where the system continues to fall short for communities of color to help identify opportunities to strengthen the behavioral health system.

Recent Behavioral Health Reforms

Over the past several years, California has launched a set of significant behavioral health reforms. Initiatives including CalAIM's No Wrong Door policy and the optional Medi-Cal Peer Support Services benefit were designed to improve access to care, strengthen coordination across delivery systems, and expand culturally responsive behavioral health services. More recently, the Behavioral Health Services Act (BHSA) established a new framework for county behavioral health planning and accountability. As counties prepare to implement BHSA, community-based organizations and advocates have raised questions about how funding and planning changes may affect investments in culturally responsive services.

Because many of these reforms are still in the early stages of implementation, and because data analyzed in this report primarily reflects the period through fiscal year 2023, it is too early to fully assess their impact on behavioral health equity. Instead, this report provides a snapshot of access, engagement, continuity of care, quality, and workforce indicators during a period of significant systems change. These findings establish a baseline against which future progress can be measured, and against which persistent disparities the state must continue to address become visible.

CalAIM's No Wrong Door Policy

Through California Advancing and Innovating Medi-Cal (CalAIM), the state sought to improve coordination across behavioral health delivery systems and reduce barriers to accessing care. A central component of this effort was the implementation of the No Wrong Door policy in July 2022. Under this policy, Medi-Cal members should be able to access timely mental health services wherever they initially seek care across delivery systems (either managed care plans or county mental health plans), without experiencing delays or gaps in care. Managed care plans and county mental health plans are expected to coordinate services for members receiving both non-specialty mental health services and specialty mental health services, or transitioning from one service type to another as their needs change over time [8].

Because individuals may move between specialty and non-specialty mental health services, successful implementation depends on strong coordination across delivery systems. This report analyzes measures related to access, engagement, and continuity of care to better understand how members are navigating the mental health system during the early stages of CalAIM implementation.

Medi-Cal Peer Support Services

In July 2022, California established Peer Support Services as an optional Medi-Cal behavioral health benefit and added Peer Support Specialists as a provider type. Counties may opt in to cover Peer Support Services through their Specialty Mental Health Services program. Where implemented, the benefit is intended to expand access to behavioral health services delivered by individuals with lived experience of mental health conditions, substance use disorders, or caregiving [9]. Peer support specialists can play an important role in helping individuals engage in services, navigate behavioral health systems, and build trust with providers.

The establishment of the optional benefit was also intended to diversify and strengthen California's behavioral health workforce at a time when many communities continue to face barriers to culturally and linguistically responsive care. This report analyzes the growth, diversity, and employment of the certified peer workforce across fiscal years 2023-2025. Because the certified workforce and Medi-Cal benefit are relatively new, and county implementation remains optional, these findings show an early picture of who is entering the field and how certified Peer Support Specialists are being employed, rather than a full assessment of the optional benefit's implementation.

Behavioral Health Services Act (BHSA)

With implementation going into effect in July 2026, California's Behavioral Health Services Act (BHSA) will reshape county behavioral health planning, as counties are responsible for developing Integrated Plans that outline local priorities and investments for improving behavioral health outcomes.

BHSA implementation has generated questions among community-based organizations, advocates, and other stakeholders regarding how changes in funding priorities may affect investments in culturally responsive services. As counties prepare to implement BHSA, understanding existing disparities and local patterns of access is important.

Because BHSA places a greater emphasis on county planning, accountability, and outcomes, county-level performance will play an important role in advancing behavioral health equity. The county-level analyses included in this report show how access and engagement vary across local behavioral health systems, and where disparities exist. Because the data in this report predates BHSA implementation, it does not measure the impact of BHSA itself. Instead, this report helps identify disparities that future county planning and implementation efforts will need to address. The ten counties included in this analysis were selected based on several factors, including representation of major regions, county size, demographic diversity, community advocacy infrastructure, and ongoing behavioral health planning and engagement efforts with our local partners.

About the Data

AB 470 Data

This report analyzes Behavioral Health Program Performance Data available on the [Mental Health Performance Dashboard](#) published by DHCS. This analysis utilizes data from fiscal years 2020-2023, with single year analysis focused on 2023 (July 2022-June 2023). Adults aged 21 and older who were eligible for non-specialty mental health services (N=8,926,047 in FY 2023) and specialty mental health services (N=10,327,652 in FY 2023) through Medi-Cal were included in this report. This report provides descriptive statistics for race and ethnicity and preferred written language, with prevalence ratios conducted for race and ethnicity in R (version 4.4.1) using RStudio (version 2026.4.0).

Medi-Cal Peer Support Specialists Data

This report also presents data extracted from the [Certified Medi-Cal Peer Support Specialists \(CMPSS\) Dashboard](#) published by the California Mental Health Services Authority (CalMHSA). The dashboard displays data on the demographics of CMPSS, their specializations, and issue-specific experience. The data in this report cover fiscal years 2023-2025, and provides descriptive statistics for race and ethnicity, employment status, and peers with personal recovery or family/caregiver experience with mental health conditions or substance use disorders.

Additional Data Sources

The External Quality Review Organization (EQRO) annually conducts studies on Medi-Cal managed care plans, including analysis of Managed Care Accountability Set (MCAS) measures reported by the plans. This report presents descriptive statistics extracted from an [EQRO report](#) containing performance measures by race and ethnicity for contract year 2024-2025, with a focus on behavioral health outcomes including follow-up after emergency department visits for mental illness or substance use and depression screening.

Limitations

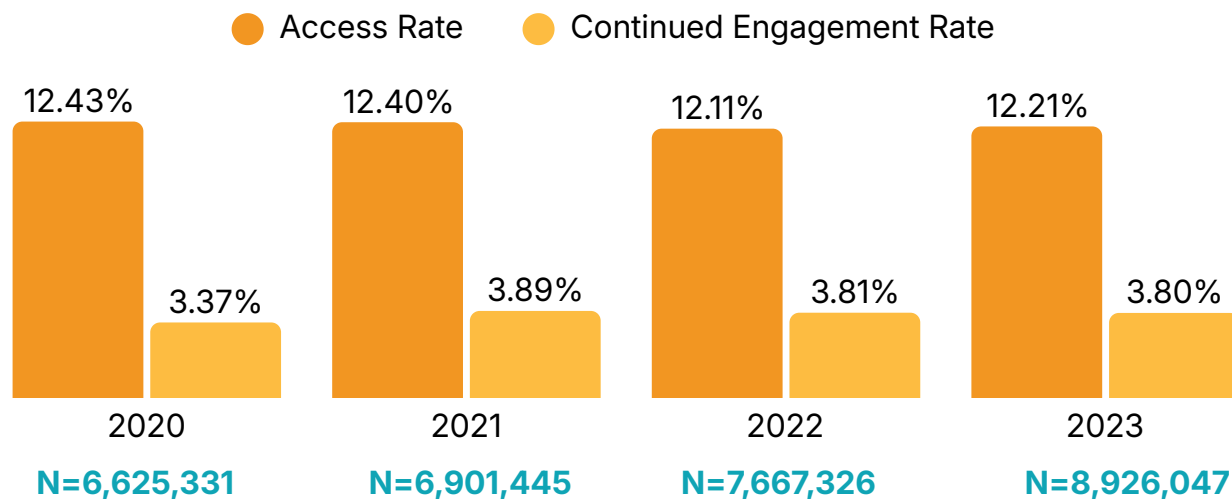
AB 470 and Certified Medi-Cal Peer Support Specialists data do not further stratify racial and ethnic categories into subgroups. Current categories include Asian or Pacific Islander (API), African American or Black, American Indian or Alaska Native (AI/AN), Hispanic, White, Other, and Unknown. Limited disaggregation could mask potentially important disparities within these groups. Additionally, the AB 470 data analyzed in this report does not include young adults and children aged 20 and younger. The behavioral health outcomes data in this report covers up to fiscal years 2023 and 2024. Many behavioral health reforms were either in the process of being implemented or implemented after these years. Data presented therefore do not capture the impacts of these recent reforms.



AB 470 Data Update

Statewide Access and Continued Engagement Rates Over Time, Non-Specialty Mental Health Services

Figure 1: Statewide Access and Continued Engagement Rates, Non-Specialty Mental Health Services, FY 2020-2023



Tracking Behavioral Health Progress

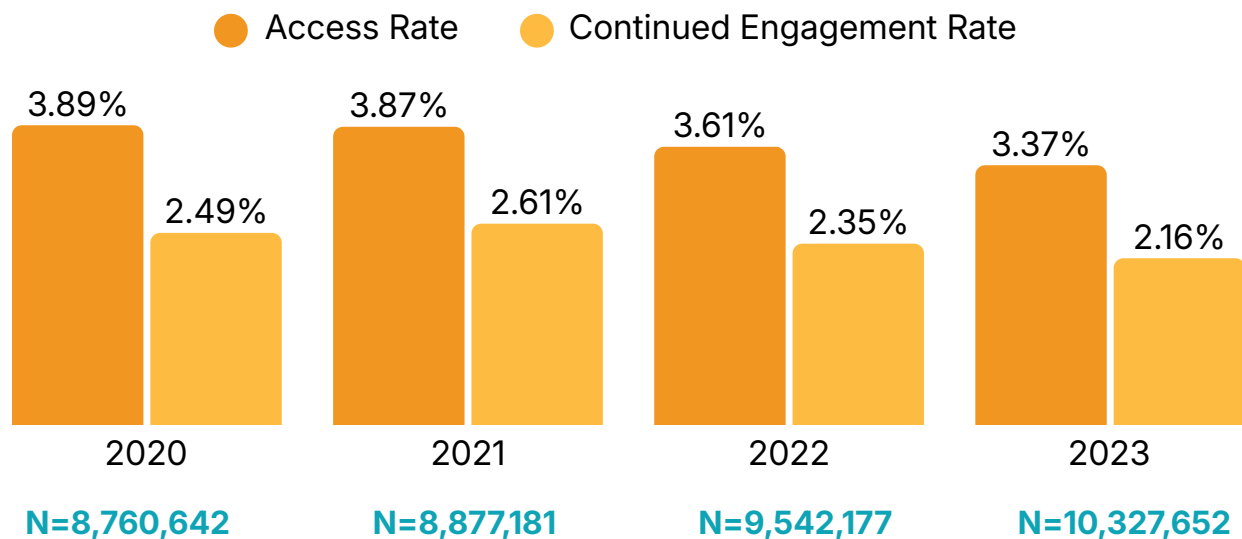
Access and continued engagement rates of non-specialty mental health services remained relatively unchanged from 2020-2023.

During this period, Medi-Cal enrollment increased substantially due to eligibility and continuous coverage flexibilities implemented during the COVID-19 pandemic. The pandemic also accelerated the expansion of telehealth, which had the potential to improve access to services by reducing geographic and transportation barriers.

Despite these changes, NSMHS access rates remained relatively stable. This may suggest that managed care plans were able to maintain service utilization as enrollment grew, although telehealth and other access efforts may not have been sufficient to produce an overall increase in utilization. Telehealth may have helped prevent even greater declines, but this data does not allow us to determine its specific impact.

Statewide Access and Continued Engagement Rates Over Time, Specialty Mental Health Services

Figure 2: Statewide Access and Continued Engagement Rates, Specialty Mental Health Services, FY 2020-2023



Access rates for specialty mental health services (SMHS) have decreased slightly across the years, with continued engagement rates remaining relatively unchanged.

Despite the growing number of eligible individuals through both delivery systems, utilization of specialty services across the state remained low.

SMHS access rates declined slightly, which may indicate that county specialty mental health systems faced greater challenges of expanding access as the eligible population grew.

As California continues implementing major behavioral health reforms, access and continued engagement rates should increase over time if reforms successfully address longstanding barriers to care. Special attention must be paid to improve awareness of available services for members by strengthening outreach and engagement and addressing workforce shortages. Monitoring these rates will be critical to assessing whether recent reforms translate into meaningful increases in mental health service utilization in future years.

Statewide Access and Continued Engagement Rates of Non-Specialty Mental Health Services by Race & Ethnicity

Figure 3: Statewide Access and Continued Engagement Rates, Non-Specialty Mental Health Services, by Race & Ethnicity, FY 2023

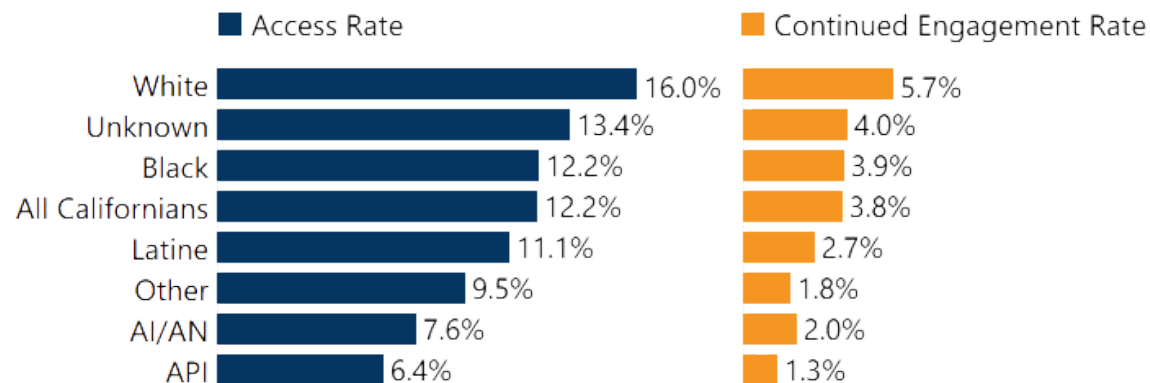
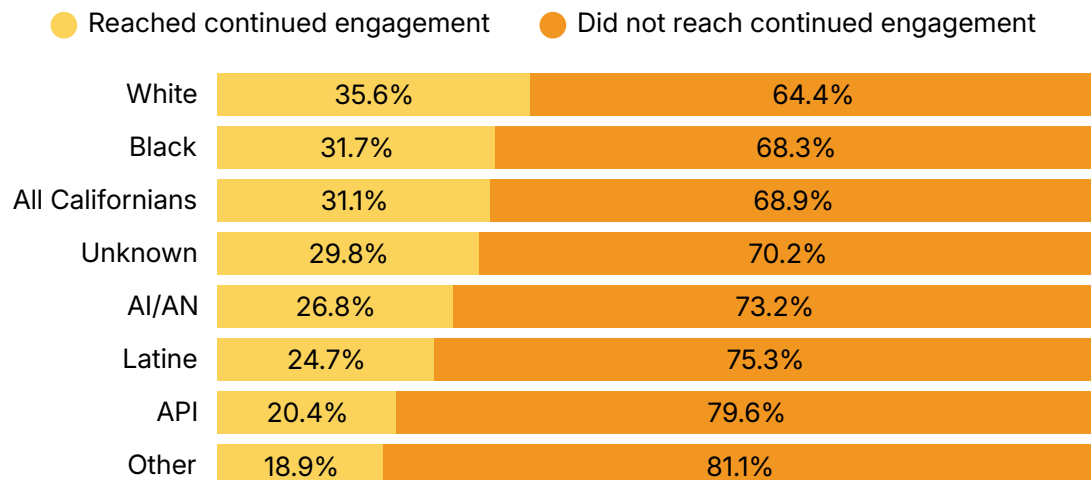


Figure 4: Percent of Medi-Cal members who accessed services but did not receive 5 or more services, Non-Specialty Mental Health Services, by Race & Ethnicity, FY 2023*



*This percentage is calculated by dividing the number of people who received 5 or more services by the number of members who received at least 1 service. Reaching continued engagement is defined as receiving 5 or more services

In 2023, disparities persist in how groups are accessing non-specialty mental health services with API members having the lowest access and continued engagement rates.

In 2023, White Medi-Cal members had the highest access and continued engagement rates for non-specialty mental health services. API members had substantially lower NSMHS utilization, with access and continued engagement rates being 60% and 77% lower, respectively, than those of White members. AI/AN members' access and continued engagement rates of NSMHS were 53% and 64% lower, respectively, than the rates of White members.

Figure 4 displays the percent of Medi-Cal members who accessed services but did not reach continued engagement (i.e., received 5 or more services). API members were 24% more likely than White members to not reach continued engagement. Latine and AI/AN members were 17% and 14% more likely to not reach continued engagement, respectively.

Note: This report uses the term "Latine" when referring to Hispanic or Latino members.

Statewide Access and Continued Engagement Rates of Specialty Mental Health Services by Race & Ethnicity

Figure 5: Statewide Access and Continued Engagement Rates, **Specialty Mental Health Services**, by Race & Ethnicity, FY 2023

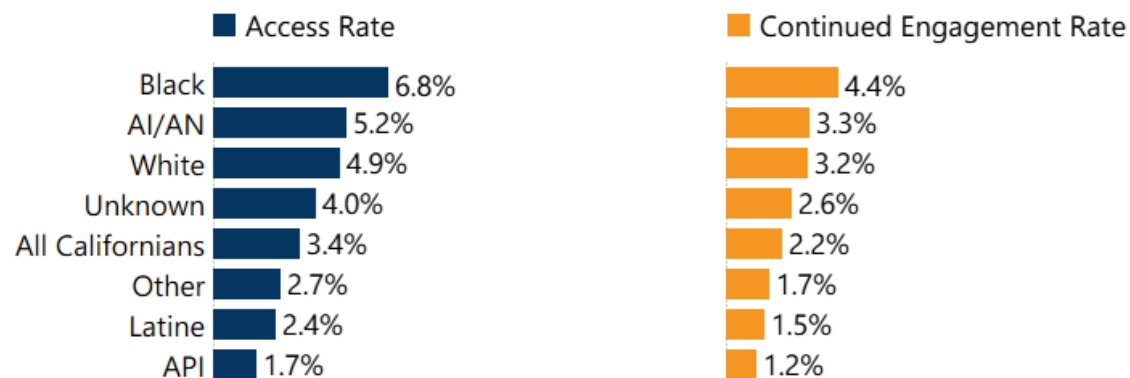
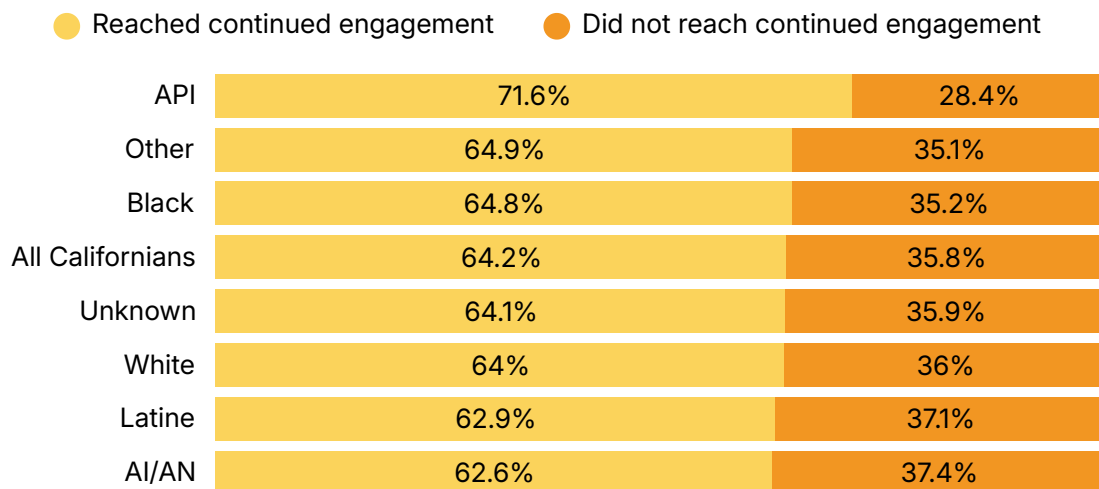


Figure 6: Percent of Medi-Cal members who accessed services that did not receive 5 or more services, **Specialty Mental Health Services**, by Race & Ethnicity, FY 2023*



*This percentage is calculated by dividing the number of people who received 5 or more services by the number of members who received at least 1 service. Reaching continued engagement is defined as receiving 5 or more services

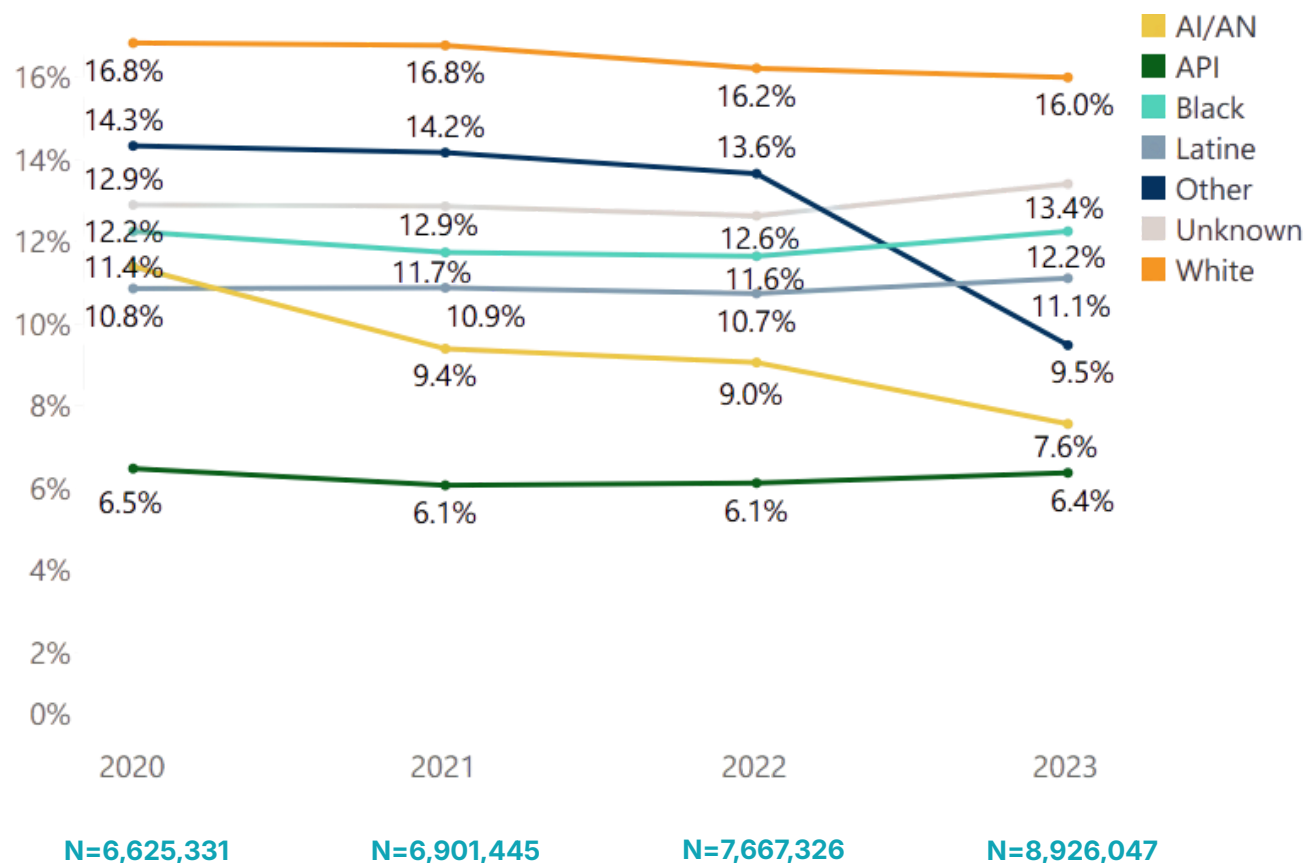
Black and American Indian or Alaska Native members had the highest access rates of specialty mental health services.

Black Medi-Cal members had the highest access and continued engagement rates of specialty mental health services. Black Medi-Cal members' access and continued engagement rates were 38% and 39% higher than rates for White Medi-Cal members. AI/AN members had the second lowest access rate of non-specialty mental health services, but the second highest access rate of specialty mental health services. Similar to non-specialty mental health services, API members had the lowest access and continued engagement rates of SMHS.

Figure 6 shows that the percent of members that accessed services but did not reach continued engagement varied less between groups. Notably, API had a higher rate of not reaching continued engagement for non-specialty mental health services compared to other groups. With SMHS, however, API had the lowest percentage (28%) of those not reaching continued engagement. Overall, the majority of members in each group who accessed services received 5 or more.

Statewide Access and Continued Engagement Rates of Non-Specialty and Specialty Mental Health Services by Race & Ethnicity Over Time

Figure 7: Statewide Access Rates, *Non-Specialty Mental Health Services*, by Race & Ethnicity, FY 2020-2023



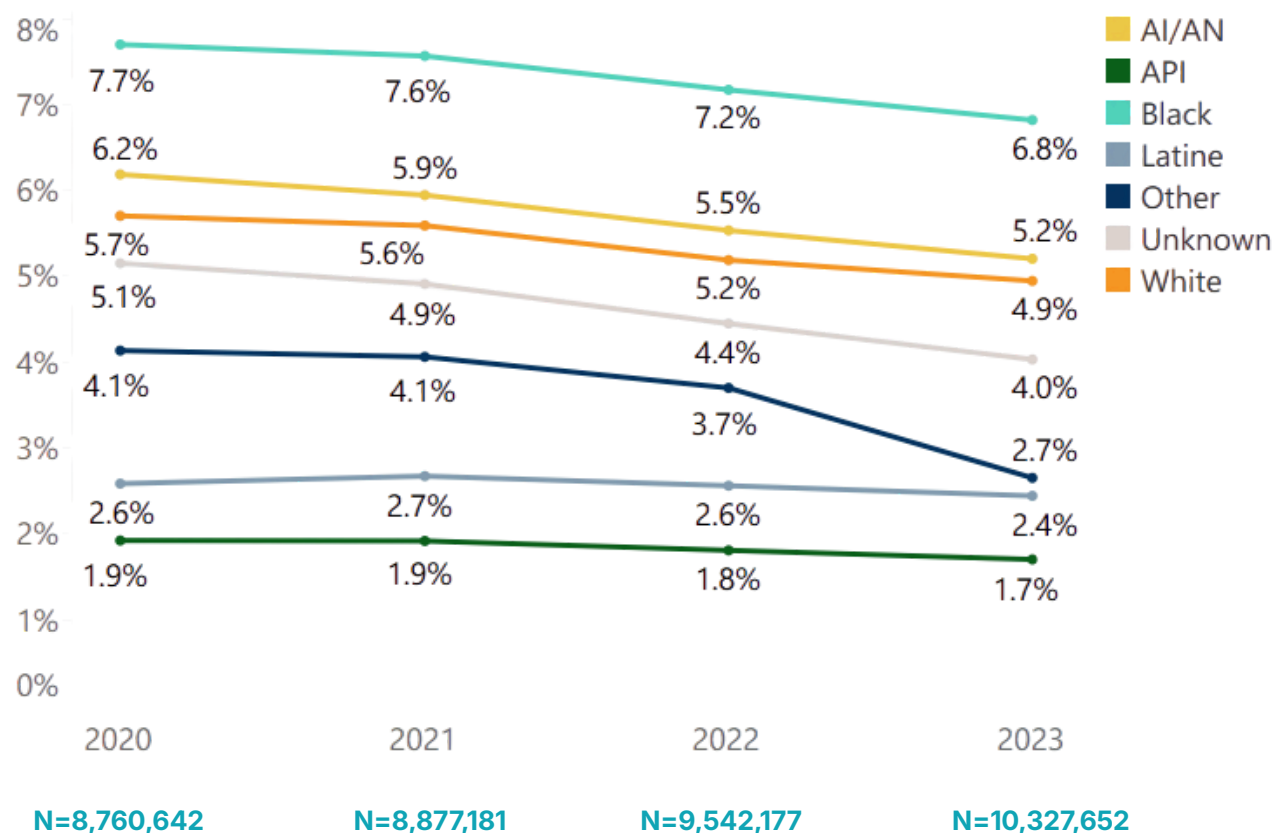
Across the four years of data, access rates for NSMHS declined among AI/AN members but minimally changed for other racial and ethnic groups.

Notably, the access rate among AI/AN Medi-Cal members decreased by nearly 4 percentage points from 2020 to 2023. This decline highlights the need for services that are responsive to the unique historical and cultural contexts of AI/AN communities.

Investments in culturally responsive mental health services that reflect the traditions and healing practices of Native communities are essential to improving access and engagement rates. Community-defined evidence practices (CDEPs), including culturally grounded healing approaches and services deployed by and for AI/AN communities can play an important role in improving trust and engagement in behavioral health systems. Sustained funding for Native-led organizations and culturally responsive behavioral health programs may help reduce barriers to care and improve access to services among AI/AN communities.

As for Medi-Cal members identifying as “Other”, we cannot determine from the data the reasoning behind the decrease in access rates for NSMHS from 2022 to 2023.

Figure 8: Statewide Access Rates, *Specialty Mental Health Services*, by Race & Ethnicity, FY 2020-2023



Access rates for specialty mental health services decreased slightly or remained stagnant for some groups over the years.

With the number of eligibles increasing over fiscal years 2020-2023, access rates of SMHS have not improved. Access rates for SMHS decreased slightly over time for Black, AI/AN, and White members. Across all four years, Black Medi-Cal members had the highest access rates of specialty mental health services. Notably, non-specialty mental health services access rates did not increase substantially, suggesting that the decrease in specialty mental health services is not driven by an increased utilization of more preventative measures.

Like NSMHS, it cannot be determined what is driving the steeper downward trend among members identifying as "Other" from 2022 to 2023.



Unveiling Deeper Disparities with Data Disaggregation Among Asian and Native Hawaiian or Pacific Islanders

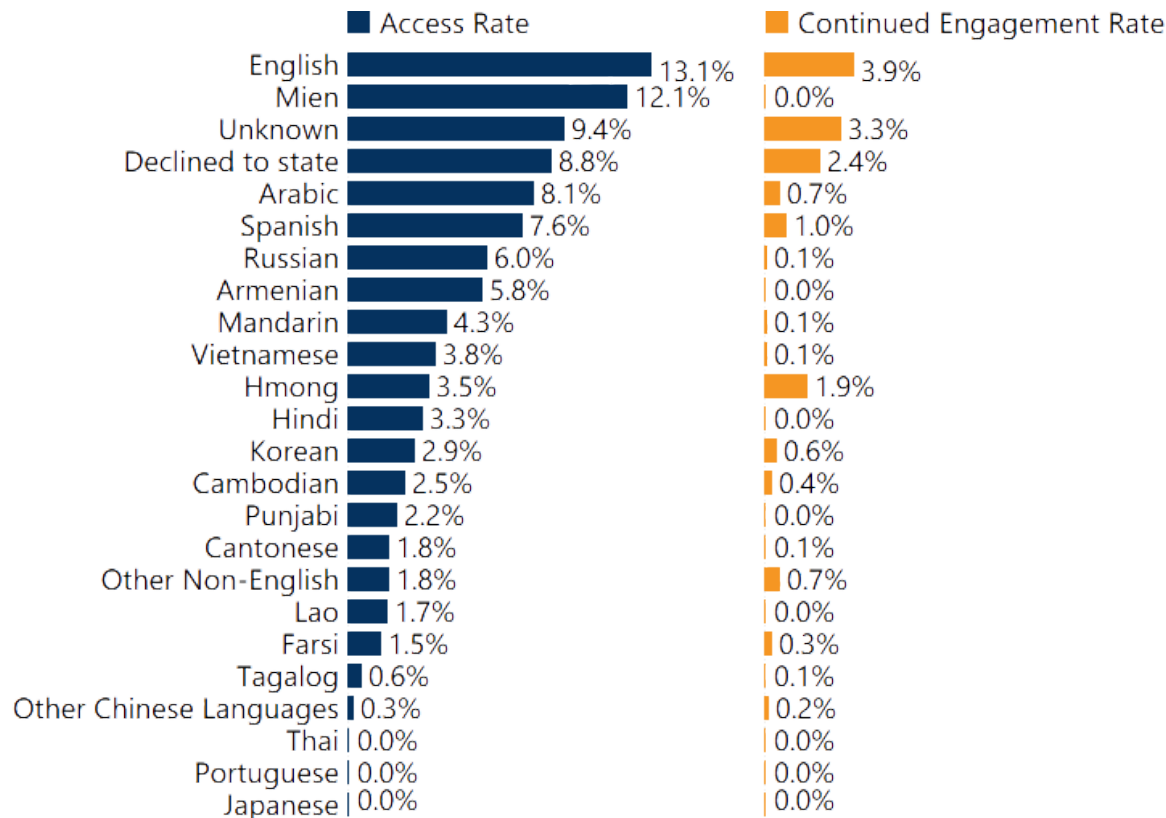
Across both NSMHS and SMHS, API had the lowest access rates across all four years. Notably, current AB 470 data does not further disaggregate API groups, which potentially masks any deeper disparities among Native Hawaiian or Pacific Islander (NHPI) communities. Across the U.S., NHPI adults were 60% less likely and Asian adults were 45% less likely than adults overall to receive any mental health treatment in 2024 [10, 11]. In California, according to a report from the UCLA Center for Health Policy Research, only 1 in 4 (26.8%) NHPI adults reported accessing mental health treatment in their lifetime [12].

Statewide Access and Continued Engagement Rates of Non-Specialty and Specialty Mental Health Services by Preferred Written Language

Access rates of non-specialty mental health services remain considerably low among most Asian languages when compared to Medi-Cal members whose preferred written language is English.

Members whose preferred written language was English had the highest access (13%) and continued engagement (4%) rates of non-specialty mental health services in fiscal year 2023, with members whose preferred written language was Mien having the second highest access rate (12%). Members whose preferred written language was Other Chinese Languages (0.3%) or Tagalog (0.6%) had the lowest access rates.

Figure 9: Statewide Access and Continued Engagement Rates, Non-Specialty Mental Health Services, by Preferred Written Language, FY 2023



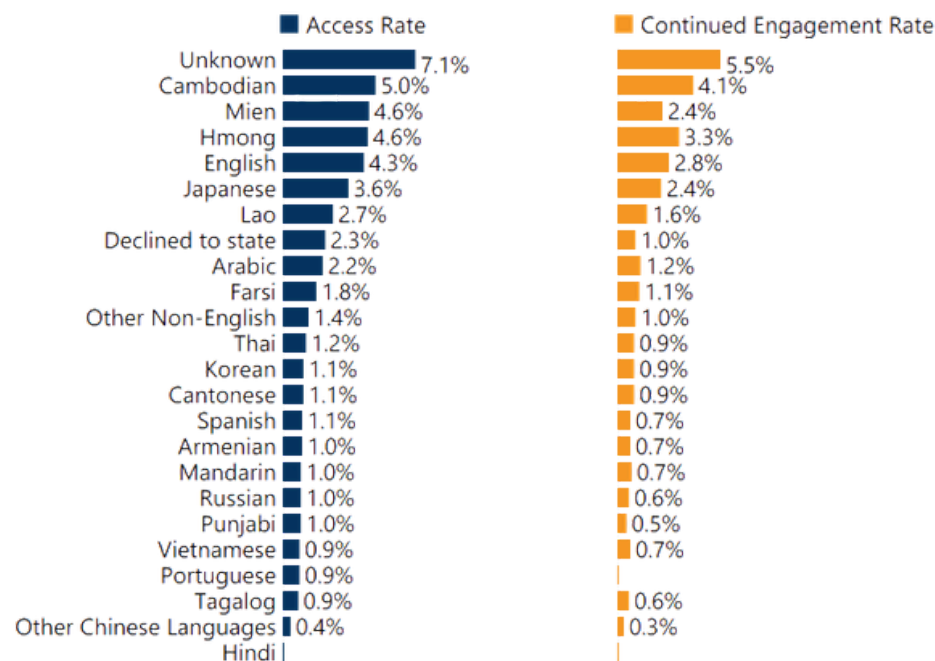
Members whose preferred written language was something other than English overall had lower rates of access and continued engagement.

These findings highlight the importance of language access as a core component of mental health equity. Lower access and continued engagement rates among many non-English language groups may reflect barriers such as insufficient translated materials, limited in-language and culturally responsive outreach, challenges navigating services, and limited availability of providers who speak members' preferred languages, among other things.

DHCS reports these measures as recorded in Medi-Cal eligibility data [13]. Preferred written language may provide insight into members' ability to access and understand written health information, including notices, forms, instructions, and prescriptions. However, the measure does not necessarily reflect a member's preferred spoken language, the language a member uses to communicate with providers, or the language in which services were delivered.

Note: French, Hebrew, Ilocano, Italian, Polish, Samoan, Turkish, Ukrainian, and "No Valid Data Reported" are excluded due to having either true zeros or suppressed cells for counts of those that received at least one and at least five services across both non-specialty and specialty mental health services.

Figure 10: Statewide Access and Continued Engagement Rates, Specialty Mental Health Services, by Preferred Written Language, FY 2023



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

Aside from those whose preferred written language was unknown, members whose preferred written language was Cambodian had the highest access and continued engagement rates for specialty mental health services. Notably, members whose preferred written language was Cambodian had a low access rate (2.5%) of non-specialty mental health services. Across both non-specialty and specialty mental health services, those whose preferred written language was Tagalog or “Other Chinese Languages” had the lowest access and continued engagement rates.

As the state implements behavioral health reforms, investments toward workforce development and improving reimbursement structures and funding mechanisms that support the recruitment, retention, and sustainability of multilingual providers and culturally specific community-based services should be prioritized. Without these investments, communities with limited English proficiency may continue to face barriers to accessing and remaining engaged in care, even as broader behavioral health reforms are implemented.

Note: French, Hebrew, Ilocano, Italian, Polish, Samoan, Turkish, Ukrainian, and “No Valid Data Reported” are excluded due to having either true zeros or suppressed cells for counts of those that received at least one and at least five services across both non-specialty and specialty mental health services.

According to the California Department of Health Care Access and Information, among California’s behavioral health workforce, only 20.8% speak Spanish and 4.1% speak an Asian or Pacific Islander language [14]. Medi-Cal members whose preferred written language was Spanish or a Chinese language, which are the most commonly spoken languages in the state, had low access and continued engagement rates of SMHS.

Interpreter services are essential for helping members access care and navigate services, but interpretation alone is not sufficient to support meaningful engagement in mental health treatment. Mental health care often requires individuals to discuss deeply personal and sensitive experiences and having an interpreter in the room may not always create the trust or comfort needed for effective care.

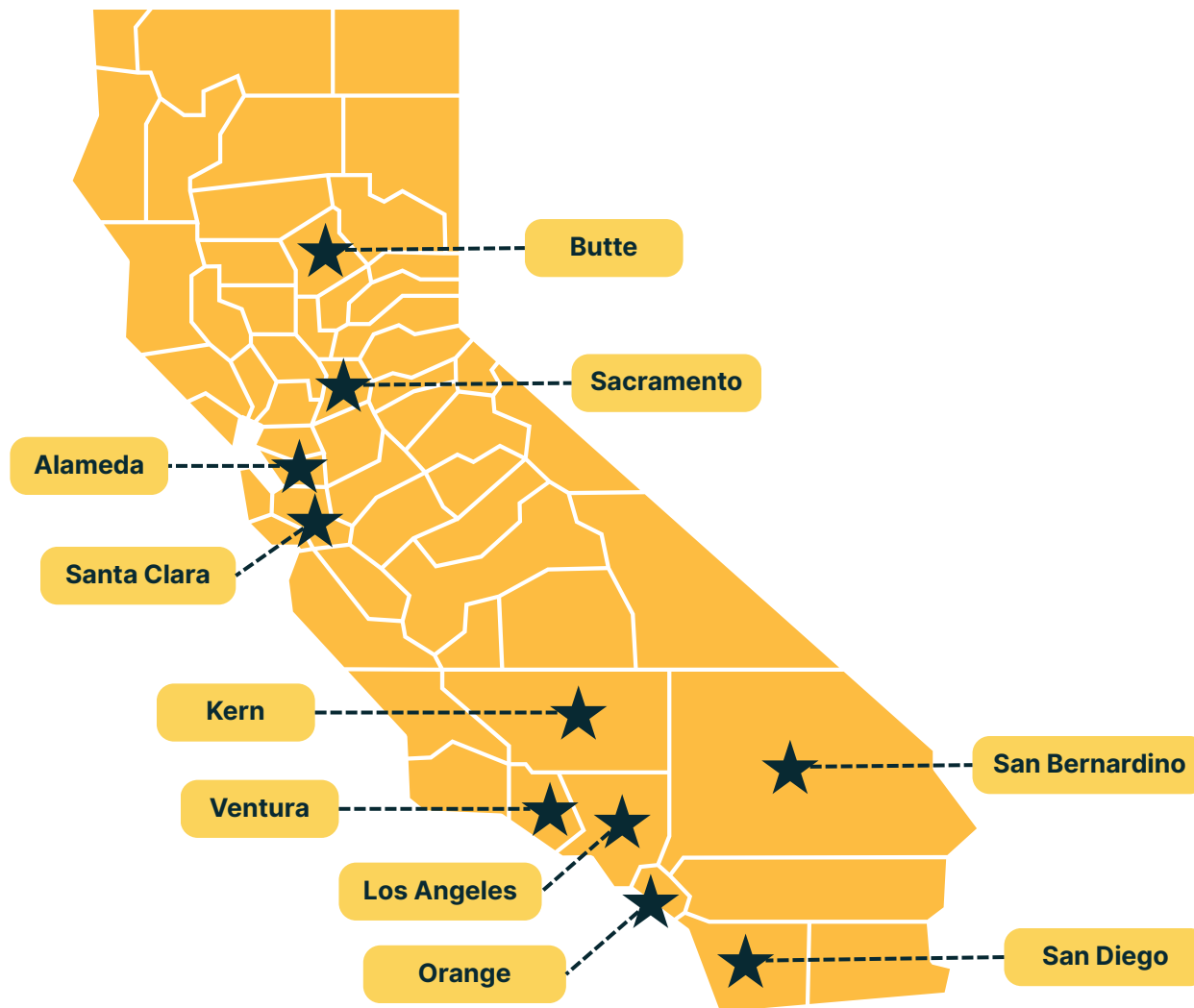
Improving access and continued engagement will require sustainable investment in linguistically and culturally responsive services and multilingual behavioral health providers. Many community-based organizations already have trusted relationships with the communities they serve and employ providers who speak their communities’ languages and understand their cultural contexts, but they need stable funding to deliver these services sustainably without any interruptions due to insufficient funding.



AB 470 Data by County and Managed Care Plan

Access and Continued Engagement Rates of Non-Specialty and Specialty Mental Health Services by Select California Counties

Figure 11: California Counties Selected for Analysis of AB 470 Data



The following county figures focus on access and continued engagement rates in ten selected California counties.

This county-level analysis was conducted to better understand local variation in mental health access and engagement across diverse regions, populations, and delivery systems. Because counties play a central role in planning and delivering behavioral health services, especially as California prepares to implement the Behavioral Health Services Act (BHSA), county-level data can help identify local disparities and opportunities to strengthen equity-focused planning and accountability.

The counties included in this analysis were selected based on several factors, including representation of major regions, county size, demographic diversity, community advocacy infrastructure, and ongoing behavioral health planning and engagement efforts with our local partners. While this data does not evaluate BHSA implementation, as it predates implementation, it does provide an important baseline for understanding access and engagement patterns that future county planning efforts will need to address.

Access and Continued Engagement Rates of Non-Specialty and Specialty Mental Health Services by Select California Counties

Figure 12: Access and Continued Engagement Rates, Non-Specialty Mental Health Services, by County, FY 2023

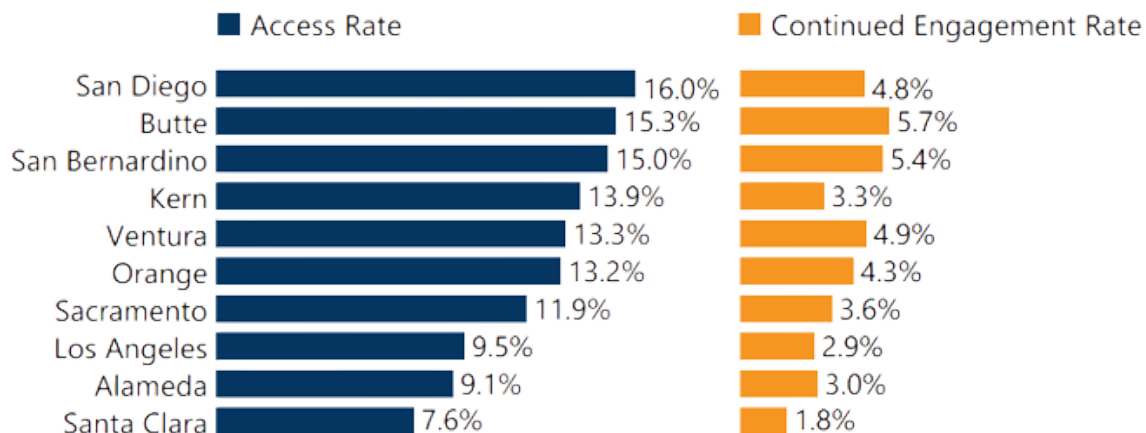
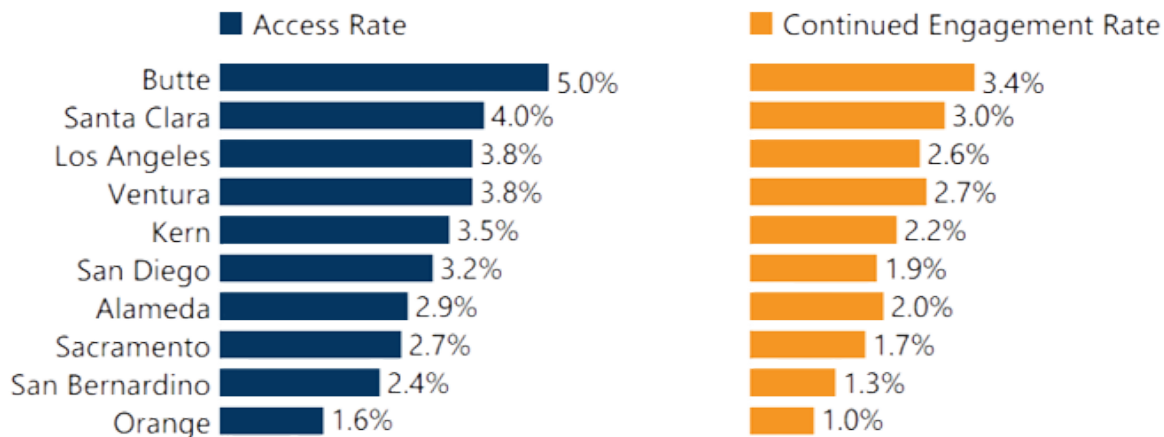


Figure 13: Access and Continued Engagement Rates, Specialty Mental Health Services, by County, FY 2023



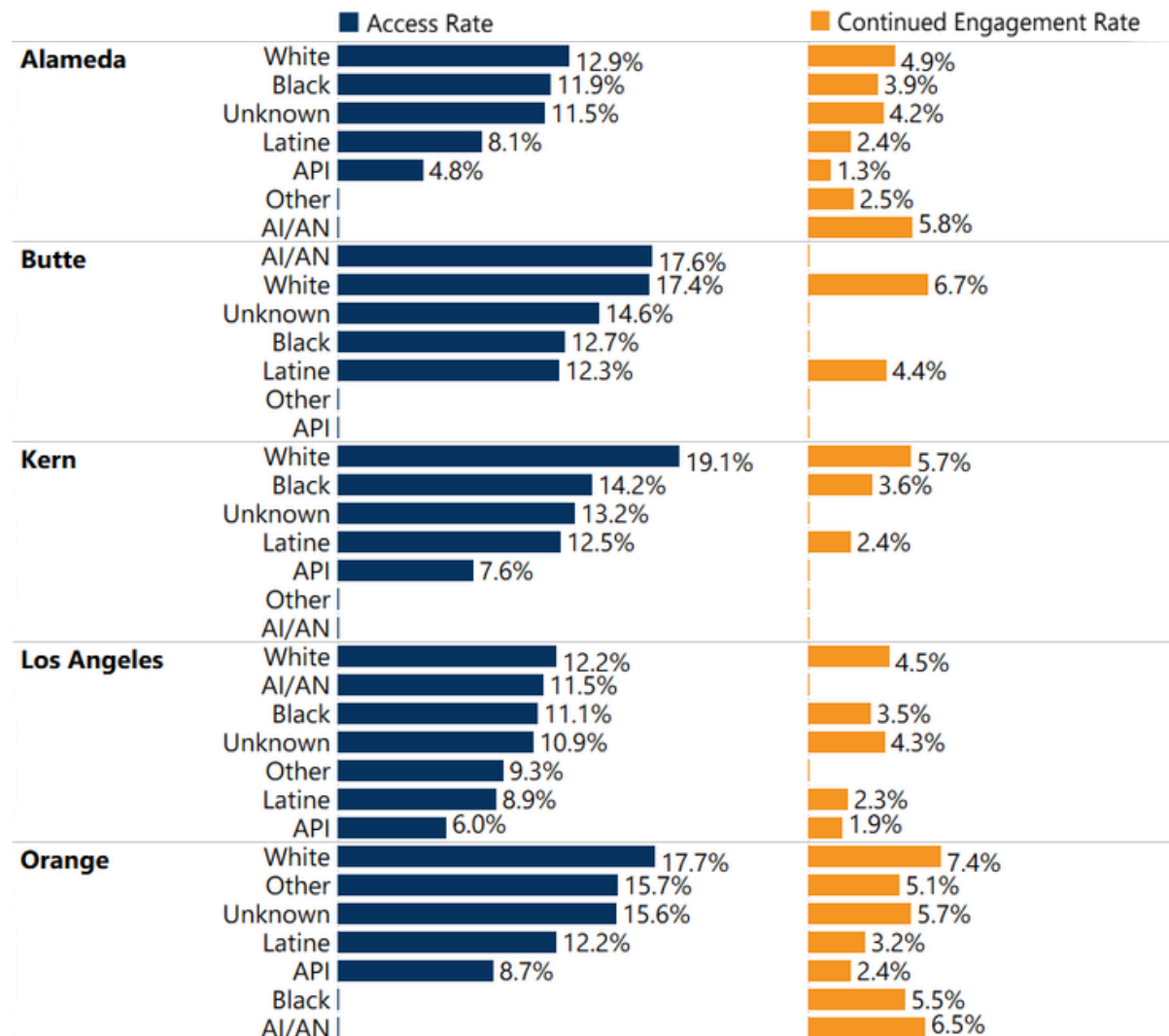
Access and continued engagement rates varied across the ten selected counties, but San Diego and Butte Counties had the highest rates for non-specialty mental health services. Some counties with lower rates of NSMHS had higher access rates of SMHS.

Butte County had the second highest access rate of NSMHS, and the highest access and continued engagement rates of SMHS. Santa Clara and Los Angeles Counties overall had lower access and continued engagement rates of NSMHS, but a higher access rate of SMHS.



Access and Continued Engagement Rates of Non-Specialty Mental Health Services by County and Race & Ethnicity

Figure 14: Access and Continued Engagement Rates, **Non-Specialty Mental Health Services**, by County and Race & Ethnicity, FY 2023



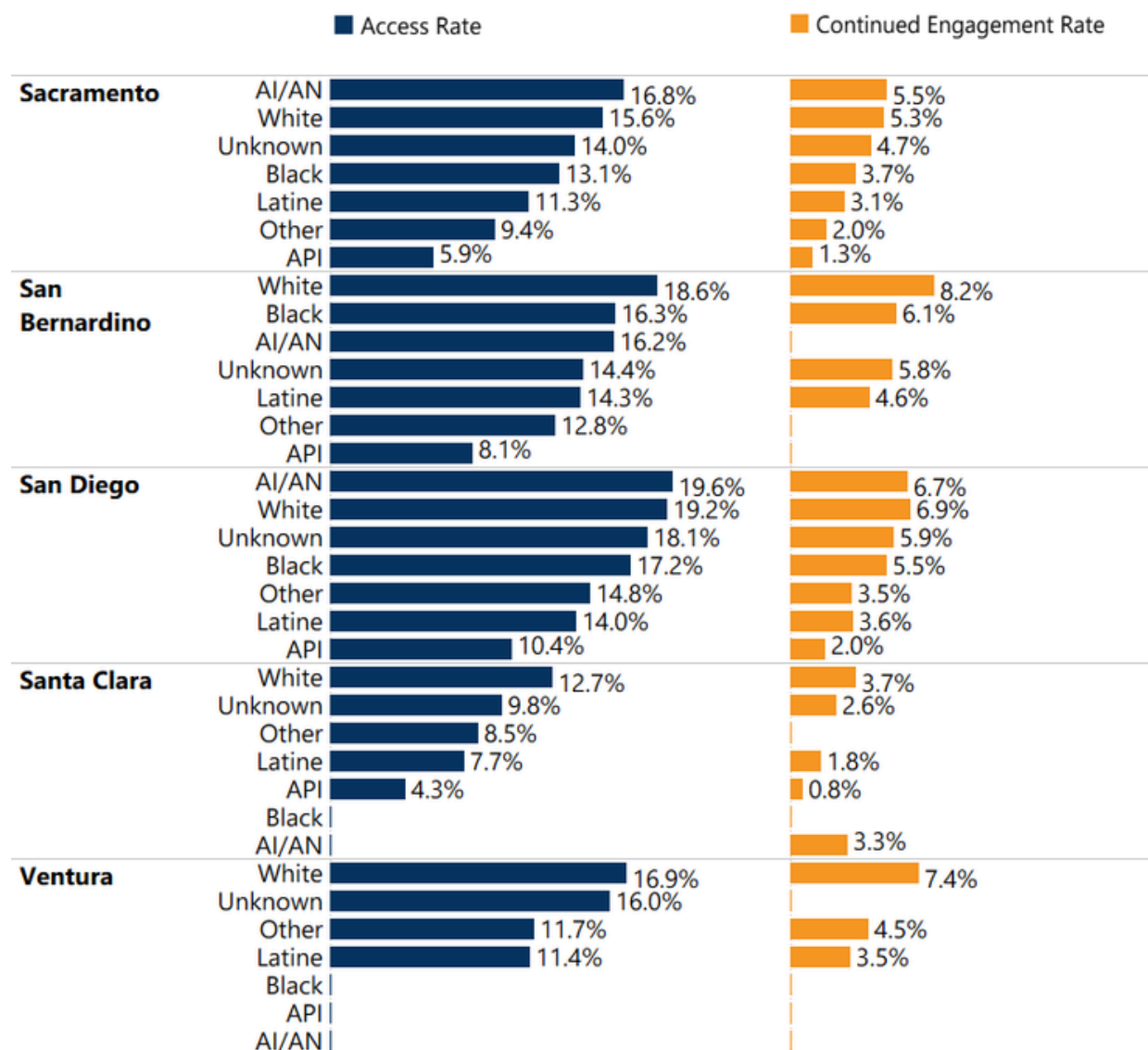
Similar to statewide trends, API and Latine members had some of the lowest access and continued engagement rates of non-specialty mental health services.

When broken down by race and ethnicity, White and AI/AN members had the highest access and continued engagement rates of NSMHS in most of the ten counties selected for this report. Where data was available, API and Latine members had some of the lowest access and continued engagement rates. Access rates among API members were nearly half that of the group with the highest rates in each county. In several counties, more than 70% of API and Latine members who received at least one service did not go on to reach continued engagement status ([Appendix B](#)).

Several counties had suppressed values. Though continued engagement numbers are a subset of the access population, suppression can occur in the access rates and not in continued engagement rates. In these instances, suppression occurred frequently for Black, AI/AN, and API members.

Note: A bar with no number indicates where data suppression has occurred due to small numbers.

Figure 14 (continued): Access and Continued Engagement Rates, Non-Specialty Mental Health Services, by County and Race & Ethnicity, FY 2023

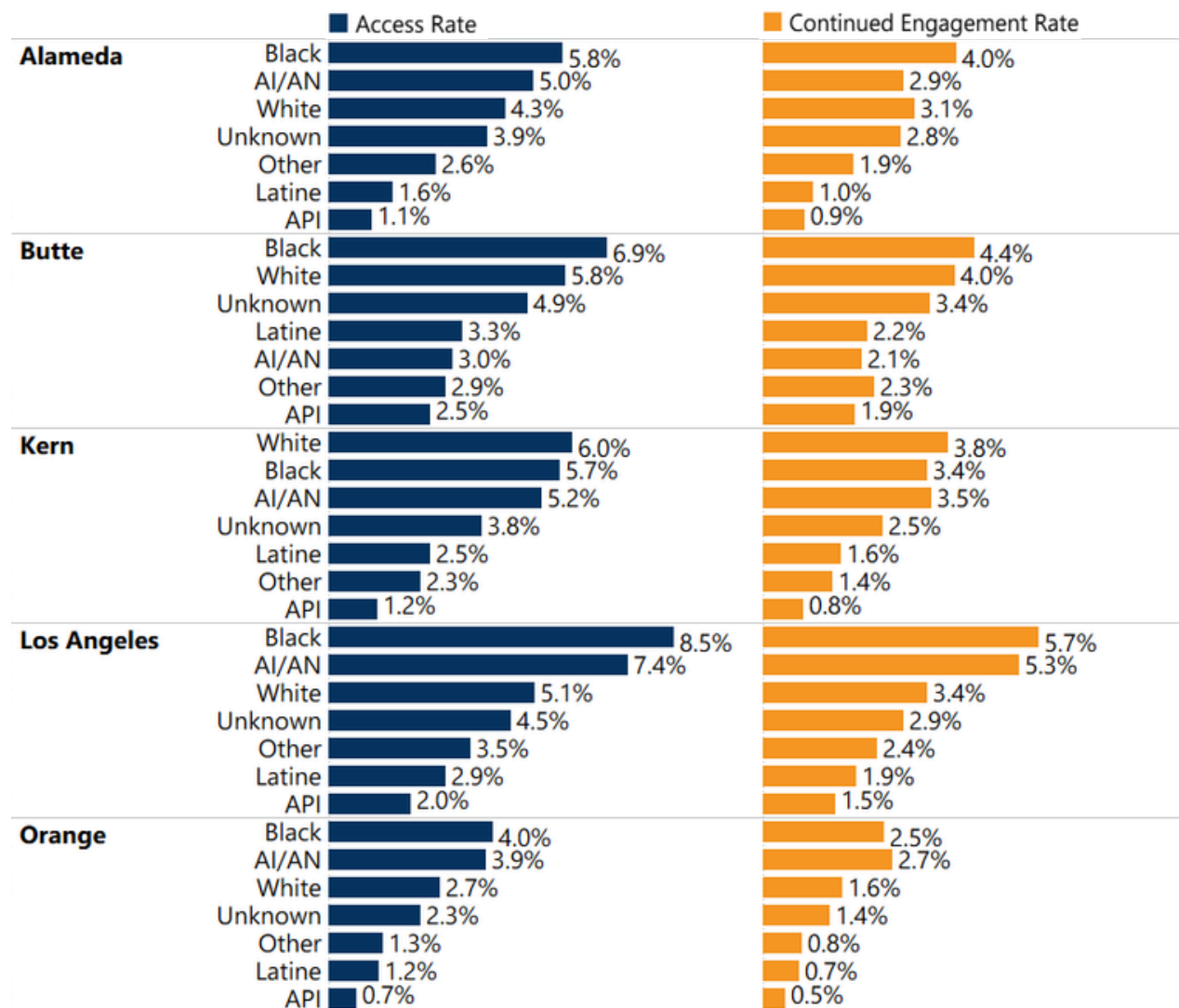


Note: A bar with no number indicates where data suppression has occurred due to small numbers.



Access and Continued Engagement Rates of Specialty Mental Health Services by County and Race & Ethnicity

Figure 15: Access and Continued Engagement Rates, **Specialty Mental Health Services**, by County and Race & Ethnicity, FY 2023



Similar to statewide trends, in the ten selected counties, Black members had the highest or second highest access rates of specialty mental health services, with the highest rates in Los Angeles and Santa Clara Counties.

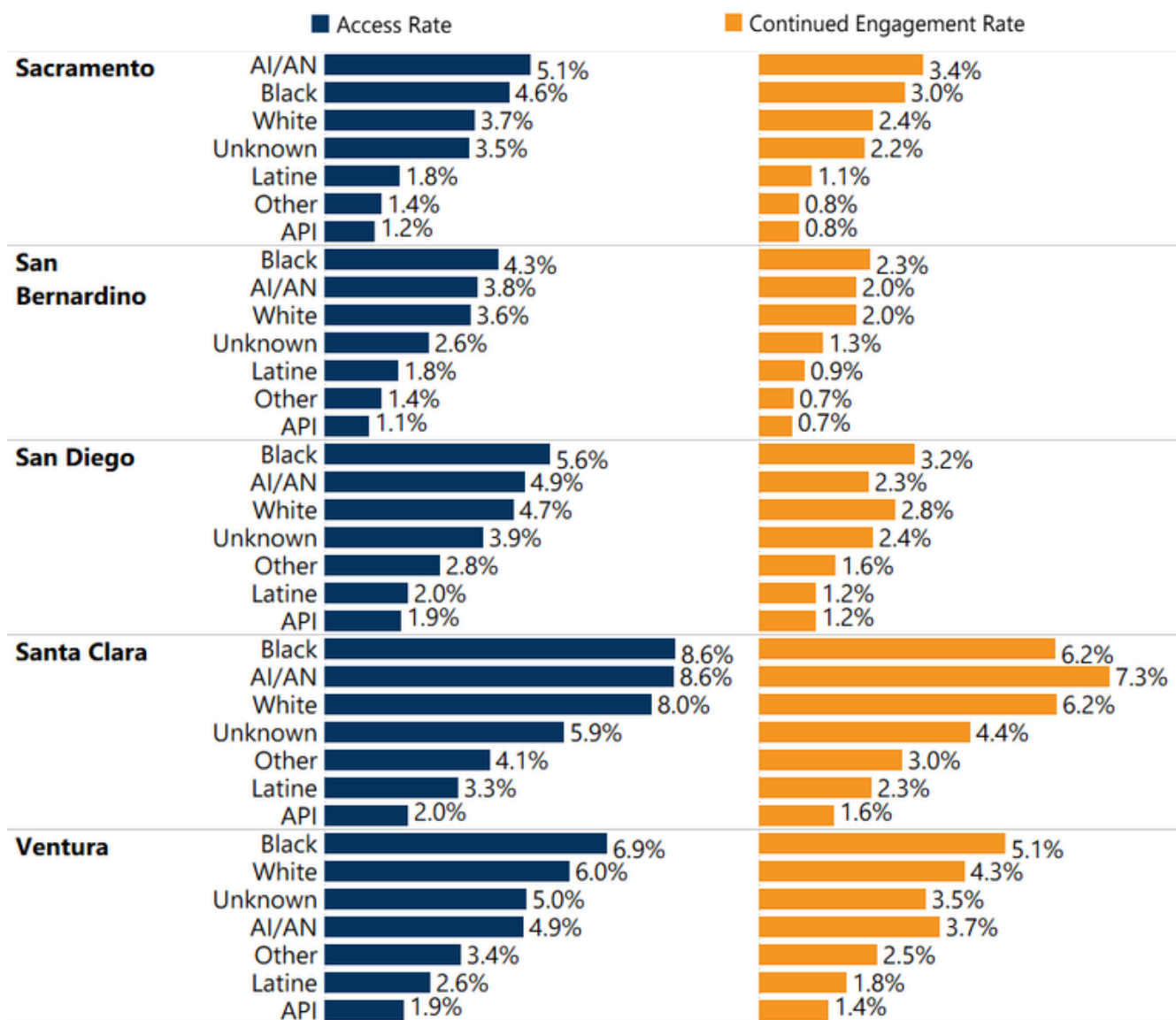
Aside from Butte County, Latine members had among the lowest utilization for the counties displayed. API members had the lowest access rate in all ten counties.

Among those who accessed at least one service, over a third of members in the majority of groups in Orange, Sacramento, San Bernardino, and San Diego Counties did not go on to receive five or more services ([Appendix B](#)).



Note: A bar with no number indicates where data suppression has occurred due to small numbers.

Figure 15 (continued): Access and Continued Engagement Rates, Specialty Mental Health Services, by County and Race & Ethnicity, FY 2023



Note: A bar with no number indicates where data suppression has occurred due to small numbers.

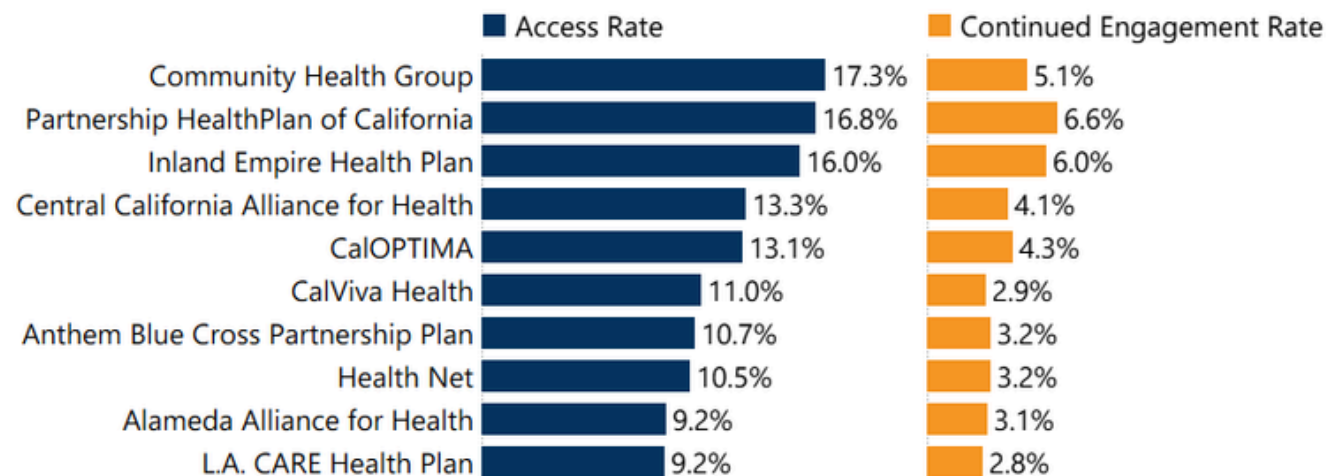
Higher overall county access did not necessarily translate into equitable access across racial and ethnic groups.

Santa Clara and Los Angeles had among the highest overall SMHS access rates yet also had some of the widest racial and ethnic disparities, with large gaps between the groups with the highest and lowest access rates. Racial and ethnic disparities were also present in counties with lower overall access. Together, these findings highlight how countywide aggregate estimates can mask inequities. Regular collection and public reporting of data disaggregated by race and ethnicity are essential for identifying which communities are being left behind and where resources and interventions are most needed.

This data does not explain the reasons for county-level variation. Differences may reflect variation in population needs, behavioral health system capacity, provider availability, outreach and referral practices, community-based infrastructure, and access to services earlier in the continuum of care. Additional analysis of county spending, provider networks, service availability, and population characteristics would be needed to understand what contributes to higher SMHS access and continued engagement rates.

Access and Continued Engagement Rates by Largest Managed Care Plans

Figure 16: Access and Continued Engagement Rates, Non-Specialty Mental Health Services, by largest Managed Care Plans, FY 2023



Note: Refer to Appendix A for eligible counts and counties where these managed care plans operate.

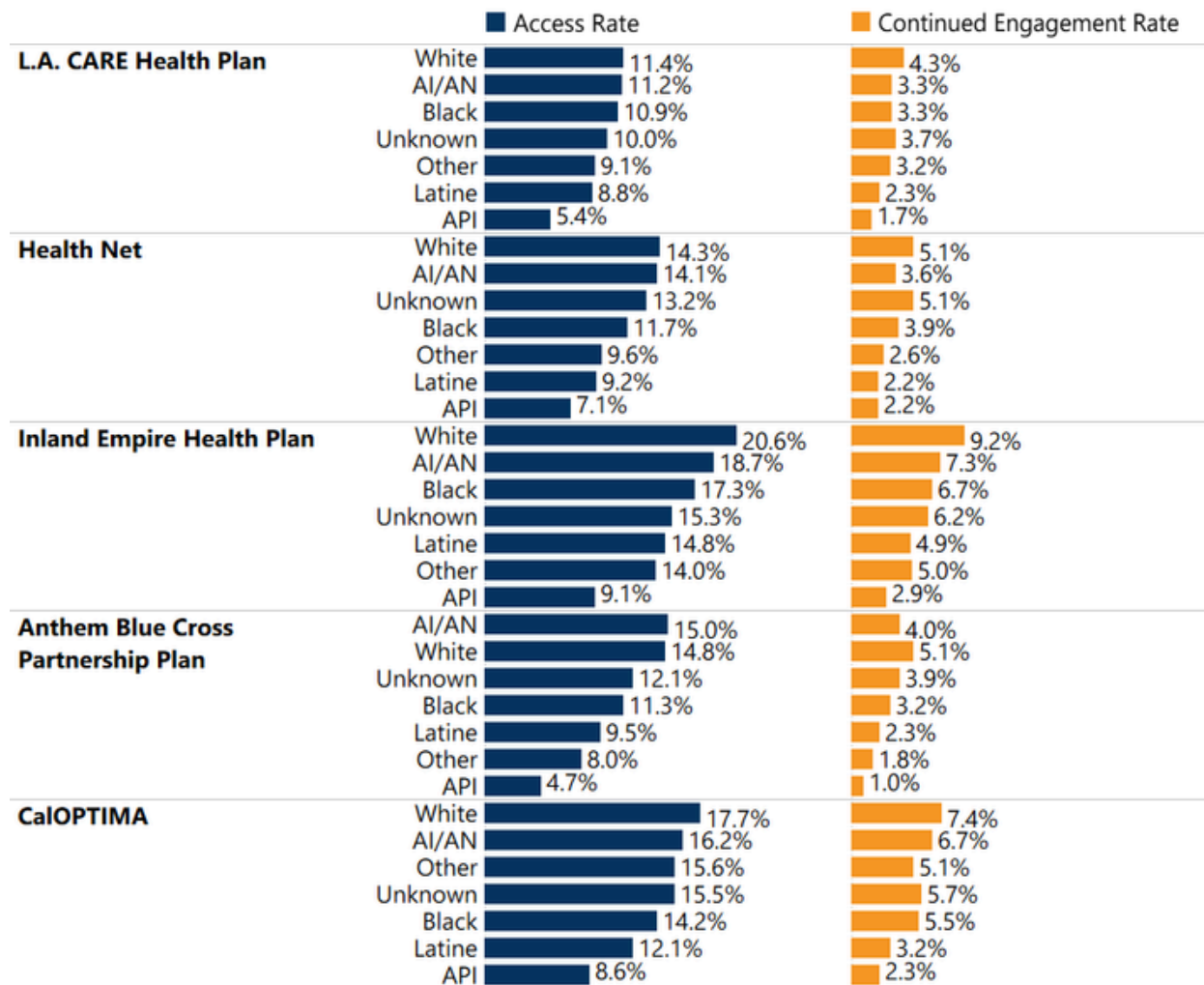
Out of the ten largest MCPs, Community Health Group, Partnership HealthPlan of California, and Inland Empire Health Plan had the highest access and continued engagement rates.

Figure 16 displays access and continued engagement rates for non-specialty mental health services for the top ten managed care plans (MCPs) with the highest numbers of eligibles across the state. Community Health Group, which serves San Diego County, had the highest access rate in fiscal year 2023. Across the ten counties in Figure 12, San Diego had the highest overall utilization of non-specialty mental health services. Partnership Health Plan, which serves northern California counties, and Inland Empire Health Plan (IEHP), which covers Riverside and San Bernardino counties, also had higher access and continued engagement rates than the rest of the top ten MCPs. L.A. CARE Health Plan, which serves the largest number of eligibles, and Alameda Alliance for Health had the lowest access and continued engagement rates.

Across these ten MCPs, the majority of members who received at least 1 service did not go on to receive 5 or more services, with CalViva Health having the highest percent (74%) of individuals not reaching continued engagement ([Appendix C](#)).

Access and Continued Engagement Rates by Largest Managed Care Plans and Race & Ethnicity

Figure 17: Access and Continued Engagement Rates, **Non-Specialty Mental Health Services**, by Largest Managed Care Plans and Race & Ethnicity, FY 2023



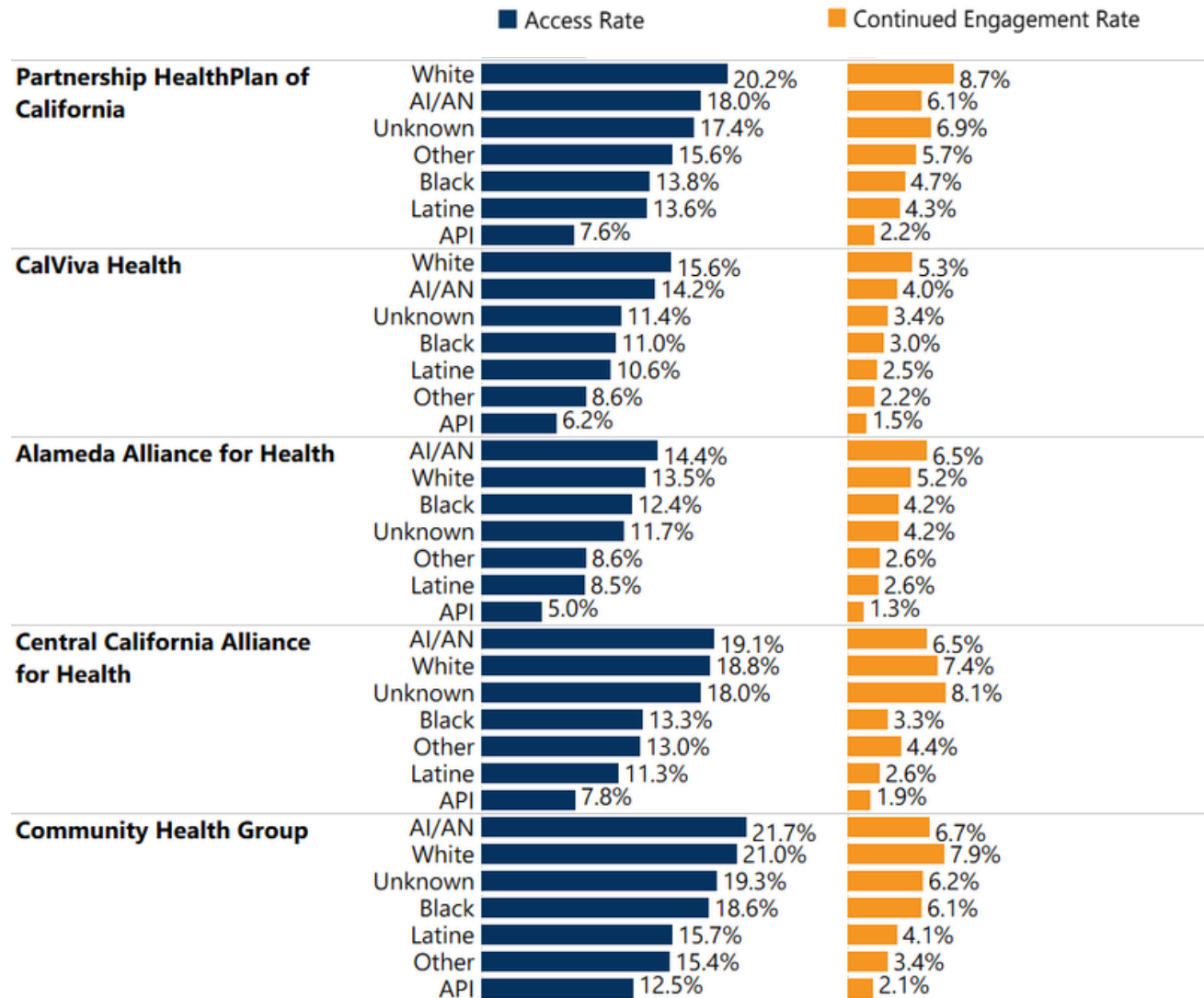
API and Latine members have the lowest overall utilization of non-specialty mental health services across the ten largest managed care plans.

White and AI/AN members had the highest access rates of non-specialty mental health services across the ten MCPs with the largest eligible populations in this data. In each of these ten MCPs, API members had the lowest access and continued engagement rates, with Latine members having the second lowest rates in the majority of MCPs shown here.

Under most of these ten MCPs, API and Latine members who received at least 1 service did not go on to receive 5 or more services at higher percentages than other groups ([Appendix C](#)).



Figure 17 (continued): Access and Continued Engagement Rates, **Non-Specialty Mental Health Services, by Largest Managed Care Plans and Race & Ethnicity, FY 2023**





Continuity of Behavioral Health Care

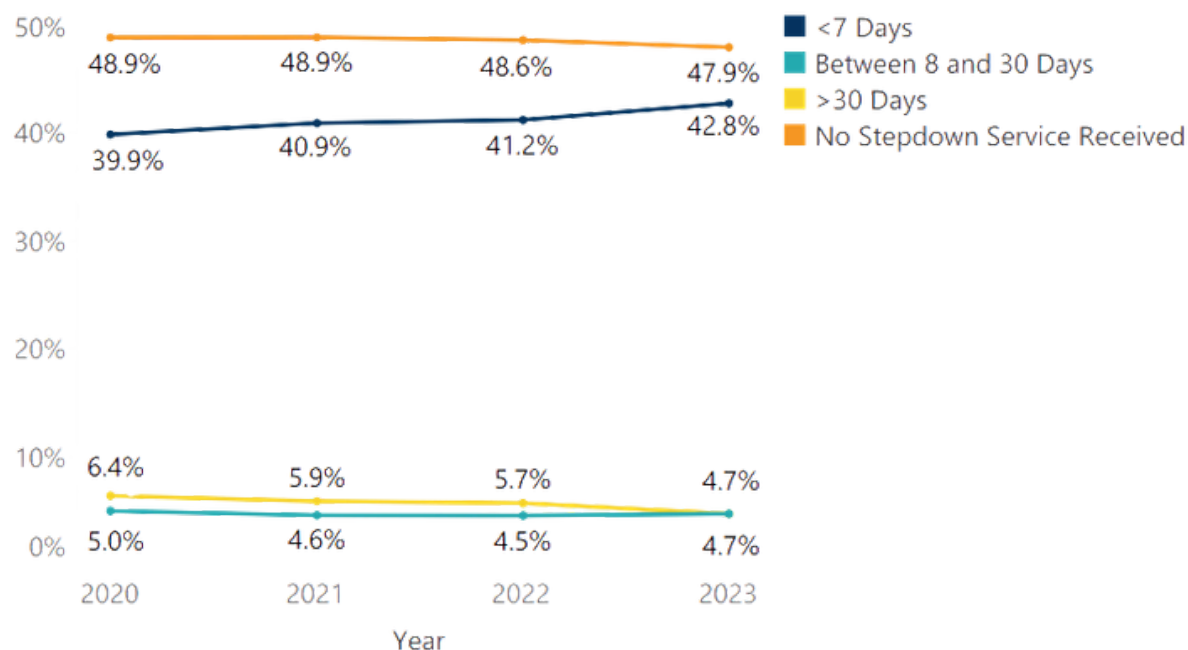
Time to Step Down After Inpatient Services

Mental health needs can change over time, requiring individuals to move between different levels of care. Individuals discharged from inpatient SMHS continue to need mental health support as they transition back to their communities. Timely follow up access to outpatient mental health services following discharge from an inpatient SMHS can help ensure continuity of care, can support recovery, and can reduce the risk of worsening mental health conditions. Additionally, this access to outpatient mental health services following discharge from an inpatient SMHS can help avoid future crises and avoid rehospitalizations.

For this analysis, a **step down** service refers to an outpatient mental health service received within a specified number of days following discharge from an inpatient specialty mental health stay. Measuring the timeliness of these follow up services provides insight into how effectively behavioral health systems are connecting individuals to ongoing care after a period of intensive treatment.

Monitoring step down services can help identify gaps in follow up care and opportunities to strengthen transitions between inpatient and outpatient settings. Ensuring that members remain connected to appropriate services after discharge is an important component of promoting positive behavioral health outcomes and reducing fragmentation across the behavioral health system.

Figure 18: Time to Step Down, Statewide, FY 2020-2023



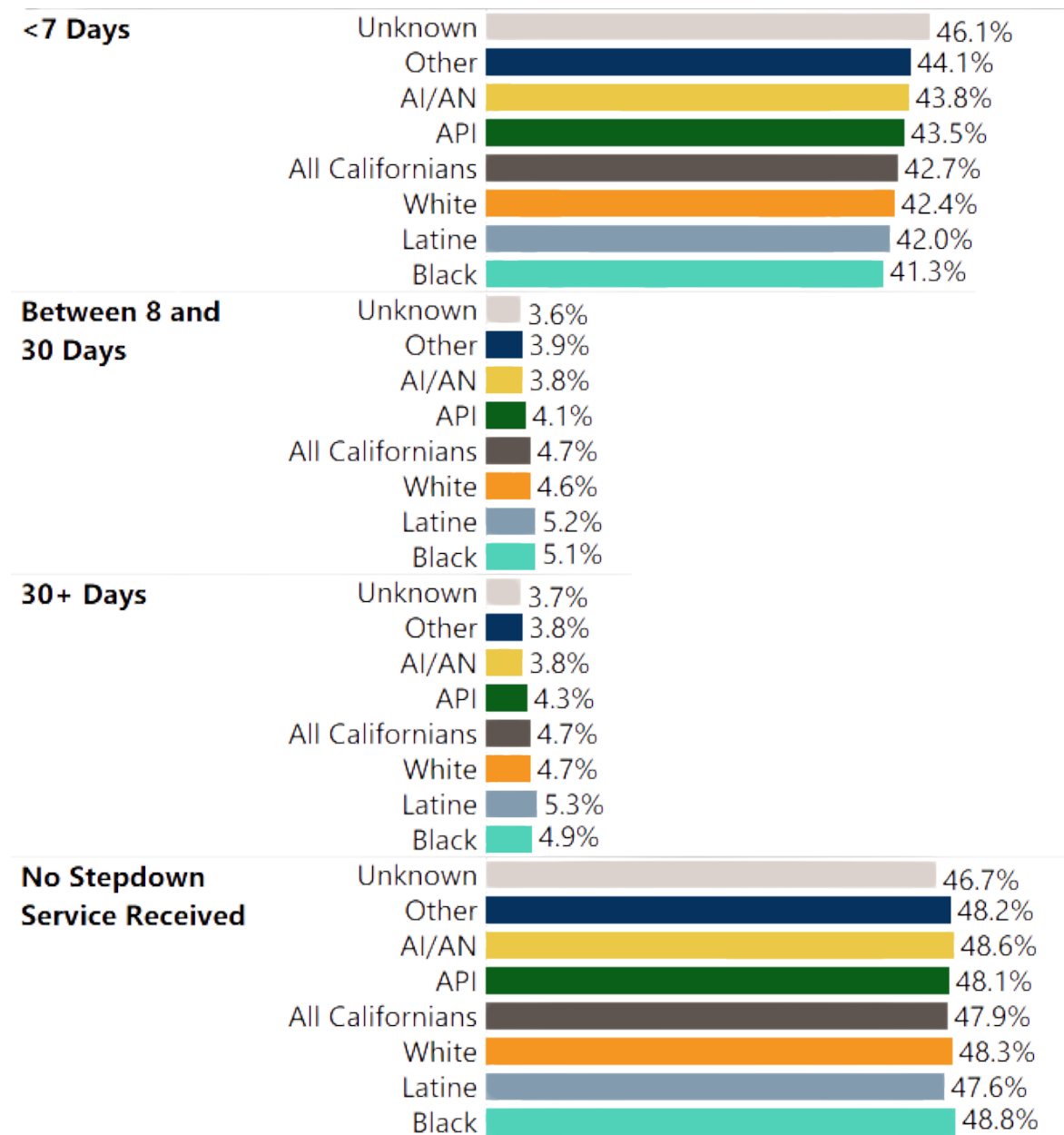
Overall, the percentage of specialty mental health inpatient stays receiving a step down mental health service did not vary widely from fiscal years 2020 to 2023.

In 2023, 43% of specialty mental health inpatient stays received a step down service within a week, while 48% of stays received no step down service. The percentage of inpatient stays receiving a step down service within 7 days only slightly improved over time.

This finding highlights the importance of care coordination and continuity of care following discharge for inpatient SMHS and raises questions about how effectively Medi-Cal members are being connected to ongoing outpatient care after a period of intensive treatment.



Figure 19: Time to Step Down, Statewide by Race & Ethnicity, FY 2023



Rates of receiving step down services did not vary widely across racial and ethnic groups, but the majority of each group either received a step down service within a week of an inpatient stay or received no step down service at all.

In 2023, the percentage of inpatient specialty mental health stays followed up by a step down service within 7 days was lowest among Black individuals, only slightly lower than groups with the highest percentages.

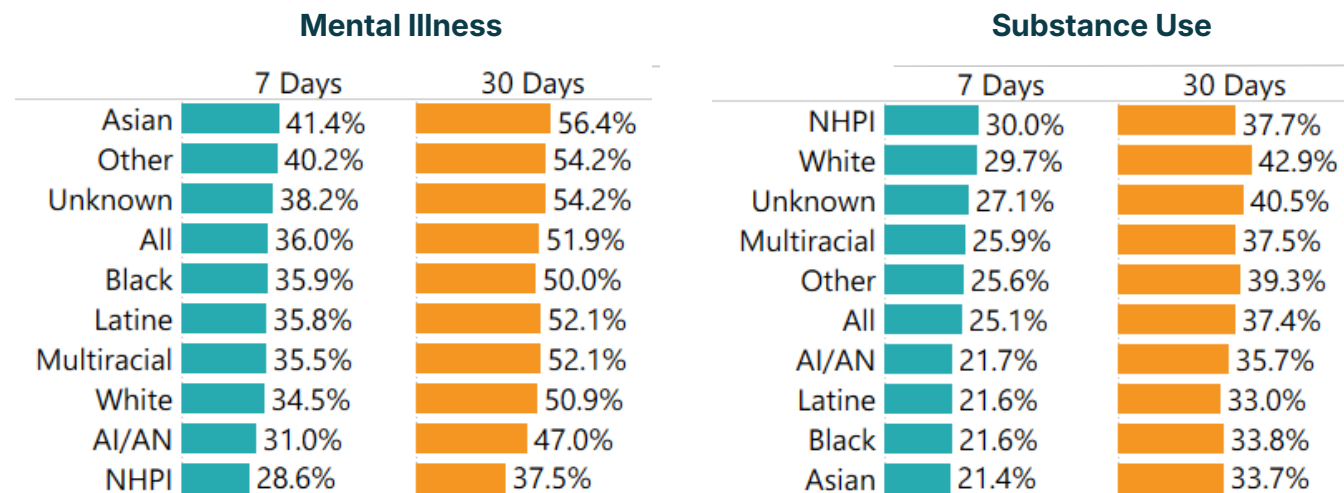
As the state continues to implement policy changes aimed at ensuring Medi-Cal members are connected to appropriate care as their needs change over time, improvements in timely follow up services after inpatient discharge could serve as one indicator of stronger continuity of care across the behavioral health system.



Medi-Cal Managed Care Accountability Sets: Follow-Up After an Emergency Department Visits for Mental Illness or Substance Use

Medi-Cal managed care plans are required by DHCS to annually report on select quality measures also known as the Medi-Cal Managed Care Accountability Sets (MCAS). These measures are used in studies conducted by the External Quality Review Organization (EQRO). The following figures display data for three indicators in the behavioral health domain: follow-up within 7 days and 30 days after an emergency department visit for mental illness, follow-up within 7 and 30 days after an emergency department visit for substance use, and depression screening and follow-up on a positive screen for adolescents and adults. For plan-specific data, this report focuses on the three managed care plans with the highest Medi-Cal enrollment for contract year 2024-2025.

Figure 20: Follow-Up After Emergency Department Visit for Mental Illness or Substance Use Across Managed Care Plans, Statewide Aggregate, by Race & Ethnicity, 2024



Note: A bar with no number indicates where data suppression has occurred due to small numbers. Groups are shown in descending order of rates of follow-up within 7 days.

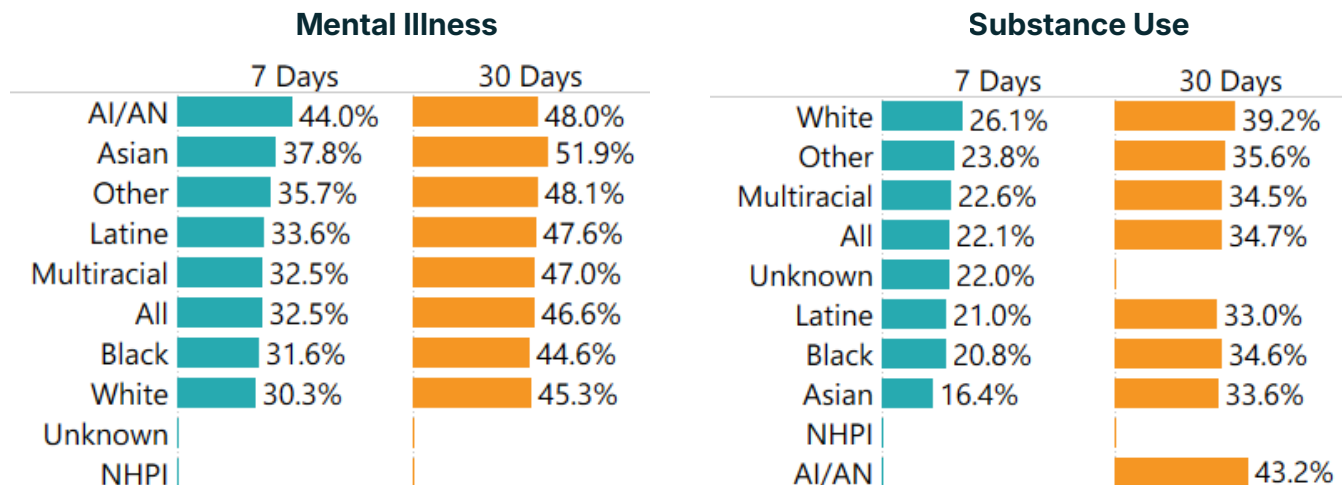
Across Medi-Cal managed care plans statewide, NHPI and AI/AN members received follow-ups to an emergency department visit for mental illness at the lowest rates compared to other groups. Asian, Black, Latine, and AI/AN Medi-Cal members had the lowest rates of follow up for ED visits for substance use.

NHPI members had the lowest follow-up rates for an ED visit for mental illness, but some of the highest follow-up rates for an ED visit for substance use. Asian members had the highest follow-up rates for an ED visit for mental illness, but the lowest rates of follow-up for substance use. Black, Latine, and AI/AN members also had among the lowest rates of follow-up for substance use visits.

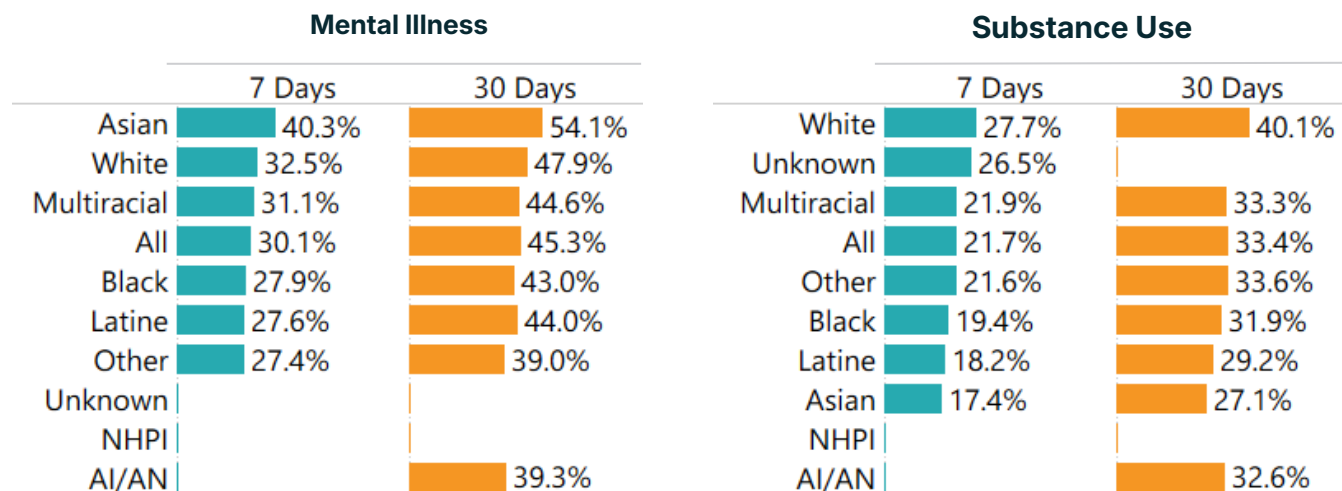
Notably, in the AB 470 data presented earlier in this report, API had the lowest overall utilization of non-specialty and specialty mental health services. In this figure, NHPI and Asian members have vastly differing rates of follow-up. These differences among Asian and NHPI members could indicate further data disaggregation of the broader API category used in other behavioral health datasets is necessary to evaluate more granular disparities for more targeted interventions.

Figure 21: Follow-Up After Emergency Department Visit for Mental Illness or Substance Use Across Managed Care Plans, by Race & Ethnicity, 2024

L.A. CARE Health Plan



Health Net Community Solutions, Inc.



Note: A bar with no number indicates where data suppression has occurred due to small numbers. Groups are shown in descending order of rates of follow-up within 7 days.

Across the three largest MCPs in the data, Asian members had some of the highest rates of follow-up within 7 days of an emergency department visit for mental illness, but the lowest rates of follow-up within 7 days for visits for substance use.

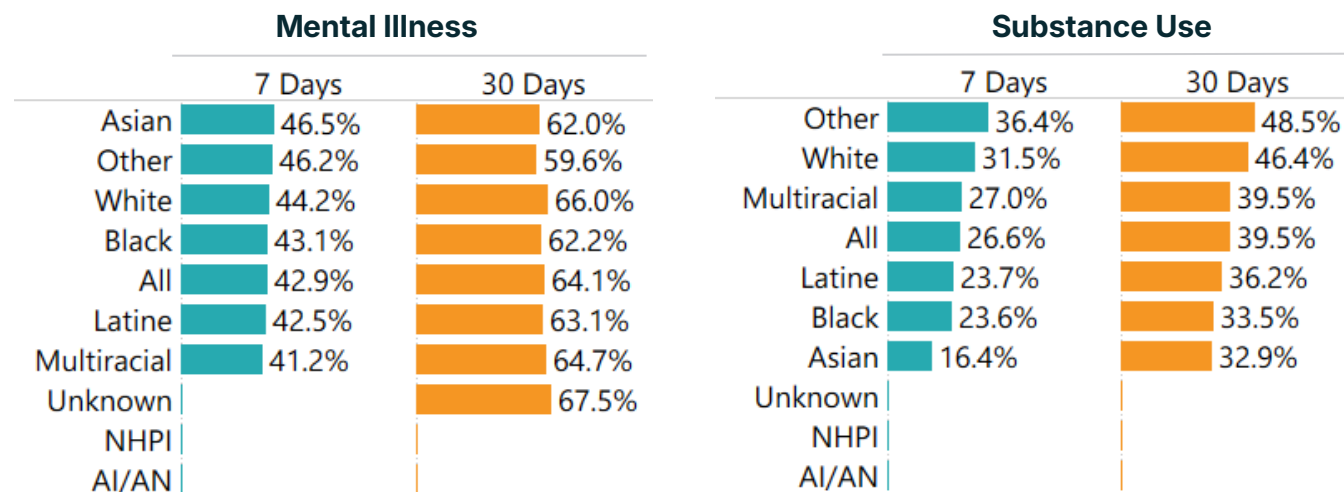
Out of the ten largest Medi-Cal managed care plans, Inland Empire Health Plan had the third highest overall access rate for non-specialty mental health services (see Figure 17). This figure displays that among the three largest MCPs, IEHP also had the highest overall follow-up for emergency department visits for mental illness or substance use in 2024.

AI/AN members of L.A. CARE Health Plan had the highest rate of follow-up within 7 days for an ED visit for mental illness compared to other groups. Data for AI/AN was suppressed for both Health Net and IEHP, and data was suppressed across all three plans for NHPI.

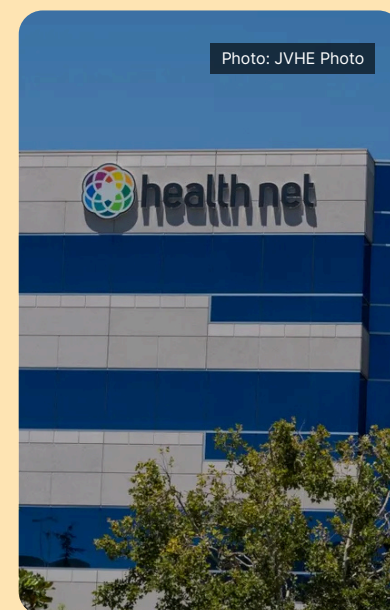
LA County composes a significant portion of Health Net's population served, while L.A. CARE solely serves the county. As two of the largest managed care plans serving the county, differences in how groups are receiving follow-ups across plans could indicate notable differences in how managed care plans are administering care.

Figure 21 (continued): Follow-Up After Emergency Department Visit for Mental Illness or Substance Use Across Managed Care Plans, by Race & Ethnicity, 2024

Inland Empire Health Plan



In this most recent MCAS report, racial and ethnic categories were defined according to the updated U.S. Office of Management and Budget (OMB) race and ethnicity standards. Additional years of data using consistent racial and ethnic definitions will be necessary to determine if the differences in rates among groups in 2024 persist and reflect ongoing disparities.



Note: A bar with no number indicates where data suppression has occurred due to small numbers. Groups are shown in descending order of rates of follow-up within 7 days.

Medi-Cal Managed Care Accountability Sets: Depression Screening Among Adolescents and Adults

Figure 22: Depression Screening and Follow-Up for Adolescents and Adults Across Managed Care Plans, Statewide Aggregate, by Race & Ethnicity, 2024

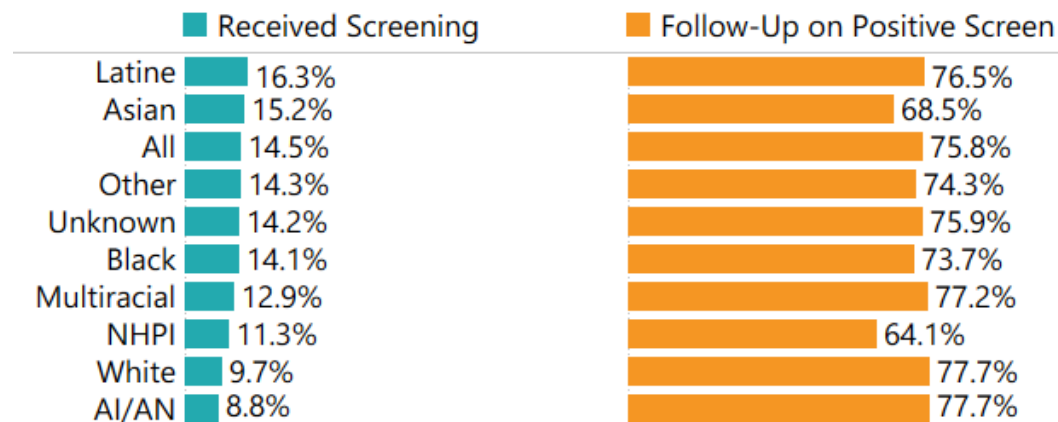
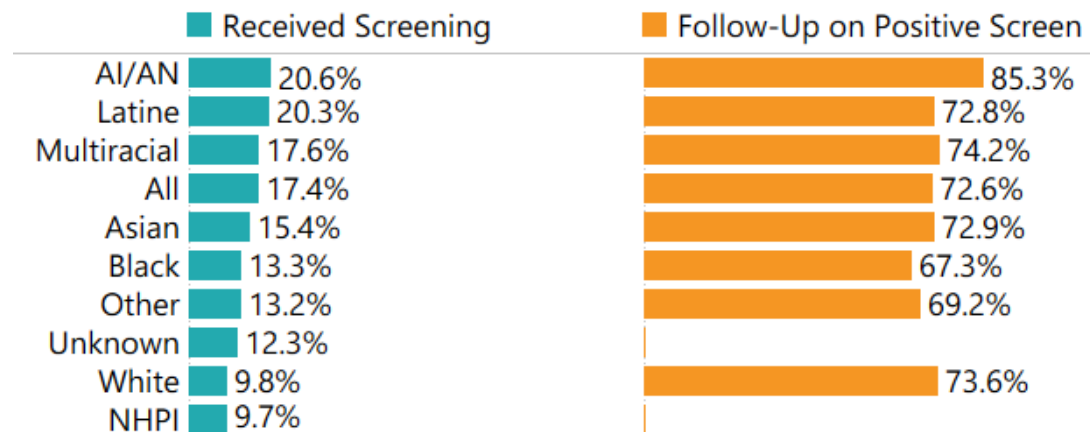


Figure 23: Depression Screening and Follow-Up for Adolescents and Adults across Managed Care Plans by Race & Ethnicity, 2024

L.A. CARE Health Plan



Statewide rates of receiving depression screening and a follow-up after a positive screen varied across racial and ethnic groups, with Latine members having the highest rate of screening.

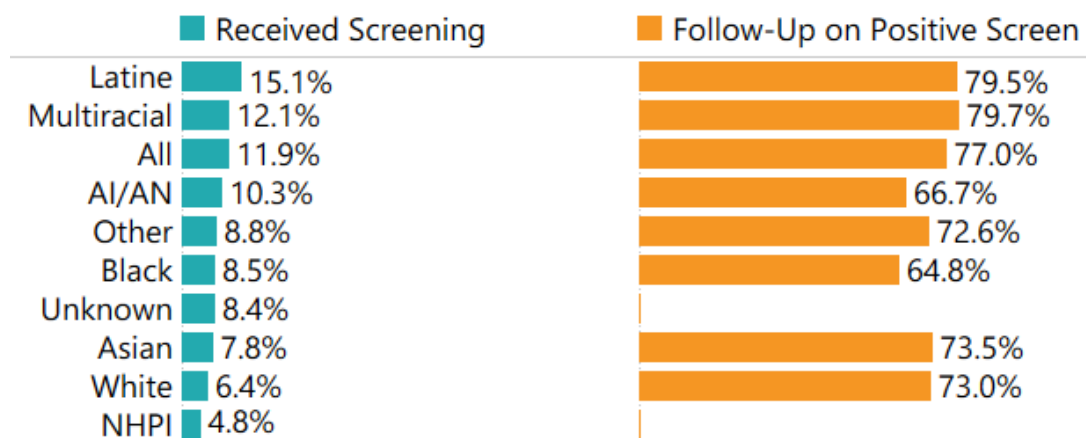
Across the state, AI/AN and White Medi-Cal members received depression screenings at the lowest rates but had the highest rates of follow-up on a positive screen. Latine and Asian members received screening at the highest rates at 16% and 15%, respectively. NHPI members had the lowest rate of follow-up on a positive screen, followed by Asian members. Overall, the majority of adolescents and adults enrolled in a Medi-Cal MCP who are screened for depression receive a follow-up on a positive screen.



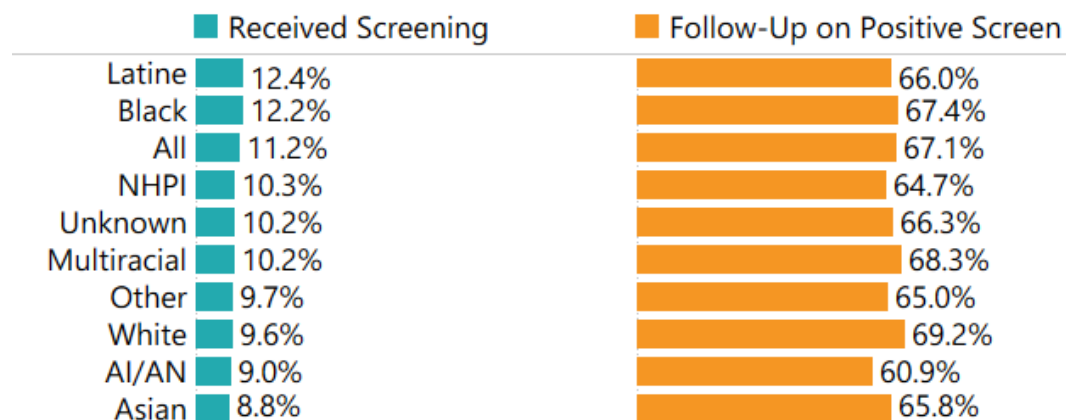
Note: A bar with no number indicates where data suppression has occurred due to small numbers. Groups are shown in descending order of rates of follow-up within 7 days.

Figure 23 (continued): Depression Screening and Follow-Up for Adolescents and Adults Across Managed Care Plans by Race & Ethnicity, 2024

Health Net Community Solutions, Inc.



Inland Empire Health Plan



Rates of depression screening among racial and ethnic groups varied across the three largest Medi-Cal managed care plans.

Latine members had the highest rates of receiving depression screening under Health Net and IEHP and the second highest under L.A. CARE. AI/AN had the highest screening rate under L.A. CARE but much lower rates under Health Net and IEHP. Asian members had lower rates compared to other groups, but the lowest rate of receiving screening under IEHP. NHPI received screening at the lowest rates under L.A. CARE and Health Net, but had a higher rate of screening under IEHP. It cannot be determined how many NHPI members received a follow-up due to data suppression under L.A. CARE and Health Net.

IEHP overall had a lower follow-up rate on a positive screen than the other two plans. Broadly, the majority of screenings across all three plans where data was not suppressed received a follow-up under all three plans.

Notes: A bar with no number indicates where data suppression has occurred due to small numbers. Groups are shown in descending order of rates of follow-up within 7 days.



Medi-Cal Certified Peer Support Specialists

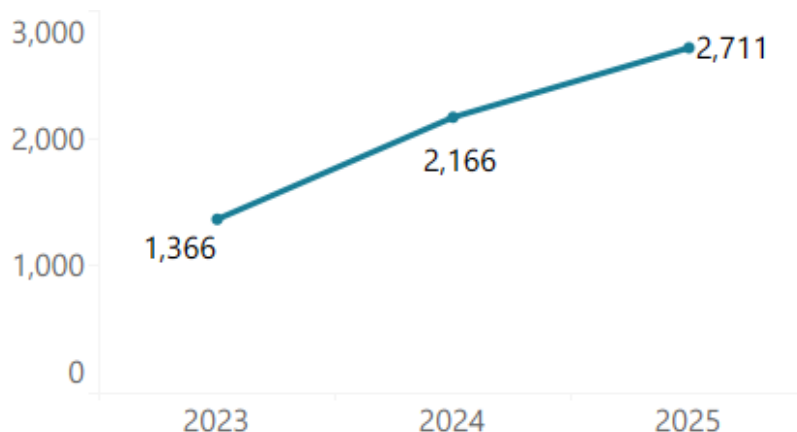
Expanding the Medi-Cal Behavioral Health Workforce: Peer Support Specialists

A Peer Support Specialist (PSS) is an individual with lived experience of mental health conditions and substance use disorders, who is trained to use that experience to support others navigating behavioral health services and recovery. PSS provide mentorship, resource navigation, and other recovery-oriented services that complement traditional behavioral health treatment.

Peer support is an important component of behavioral health care, allowing individuals to receive support from someone who has faced similar challenges and can use their own lived experience to support individuals seeking care. Peers can help reduce stigma, build trust, support recovery, and help individuals navigate complex behavioral health systems. Peer support can be especially meaningful when peers share similar cultural backgrounds or languages with the communities they serve, which helps to make behavioral health services feel more accessible and culturally responsive.

Recognizing the value of peer support, California established Medi-Cal Peer Support Services as a covered benefit in 2022, adding certified Medi-Cal Peer Support Specialists as a unique provider type eligible to deliver certain reimbursable behavioral health services [15]. However, the benefit is not automatically available statewide. Counties must voluntarily opt in to offer Medi-Cal Peer Support Services through their behavioral health delivery systems. Currently, 54 out of 58 counties include the benefit in their delivery systems, with Alpine, San Benito, Tehama, and Tuolumne Counties not offering the benefit [16]. This section examines the growth and makeup of California's certified Medi-Cal Peer Support Specialist workforce to better understand whether this workforce reflects the diversity of the communities it is intended to serve.

Figure 24: Count of Certified Medi-Cal Peer Support Specialists, Statewide, FY 2023-2025



The number of certified Medi-Cal peer support specialists nearly doubled from 2023 to 2025.

This increase in certified Medi-Cal Peer Support Specialists shows a clear expansion of the peer workforce within Medi-Cal. While peer support roles and community-based peer services existed before the Medi-Cal benefit, Medi-Cal certification creates a pathway for peers to be recognized as a distinct provider type and for their services to be reimbursed through Medi-Cal.



Figure 25: Certified Medi-Cal Peer Support Specialists With Personal Recovery Experience, Statewide, FY 2025

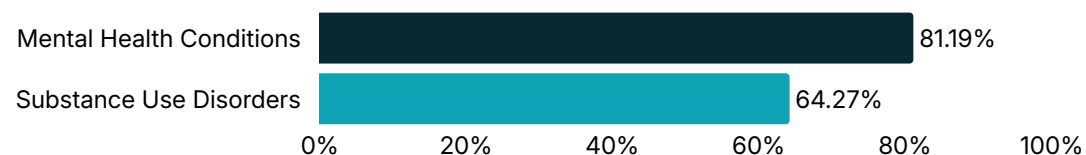


Figure 26: Certified Medi-Cal Peer Support Specialists With Family or Caregiver Experience, Statewide, FY 2025

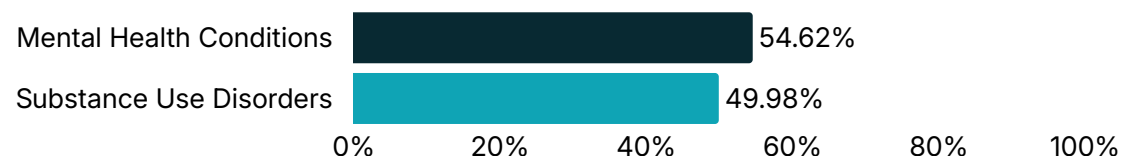
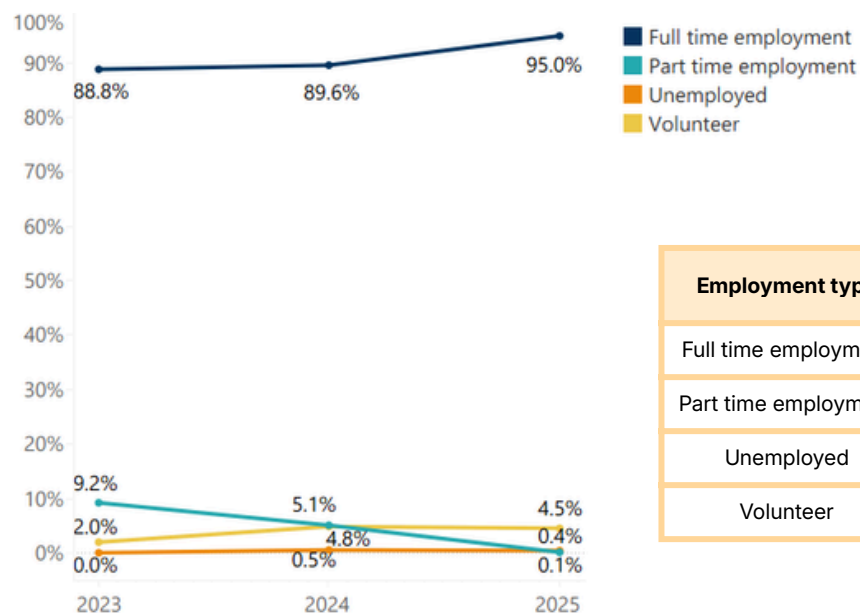


Table 1 and Figure 27: Employment Status of Medi-Cal Certified Peer Support Specialists, Statewide, FY 2023-2025



Employment type	2023	2024	2025
Full time employment	1,215	1,941	2,576
Part time employment	126	110	3
Unemployed	0	11	11
Volunteer	27	105	122

Most certified Medi-Cal peer support specialists have personal experience with mental health conditions (81%) and substance use disorders (64%). The majority also have family or caregiver experience dealing with mental health conditions (55%) and substance use disorders (50%).

From 2023 to 2025, the percentage of Medi-Cal certified peer support specialists with full-time employment status increased from 89% to 95%. Part time employment decreased from 9% to less than 1%, while the share of volunteer peers increased.



Note: Figures have been adapted from the Certified Medi-Cal Peer Support Specialists dashboard for this report.

Diversifying the Behavioral Health Workforce

Because peers can help build trust, reduce stigma, and support members in navigating behavioral health services, a diverse peer workforce is important for improving access to care. Peers who share similar racial, ethnic, cultural, or linguistic backgrounds with the communities they serve can be well positioned to support engagement among communities that face barriers to care. Continued investment in recruitment, certification, hiring, and retention of peers from underrepresented communities can help strengthen access to care and ensure the peer workforce truly reflects the diversity of Medi-Cal members.

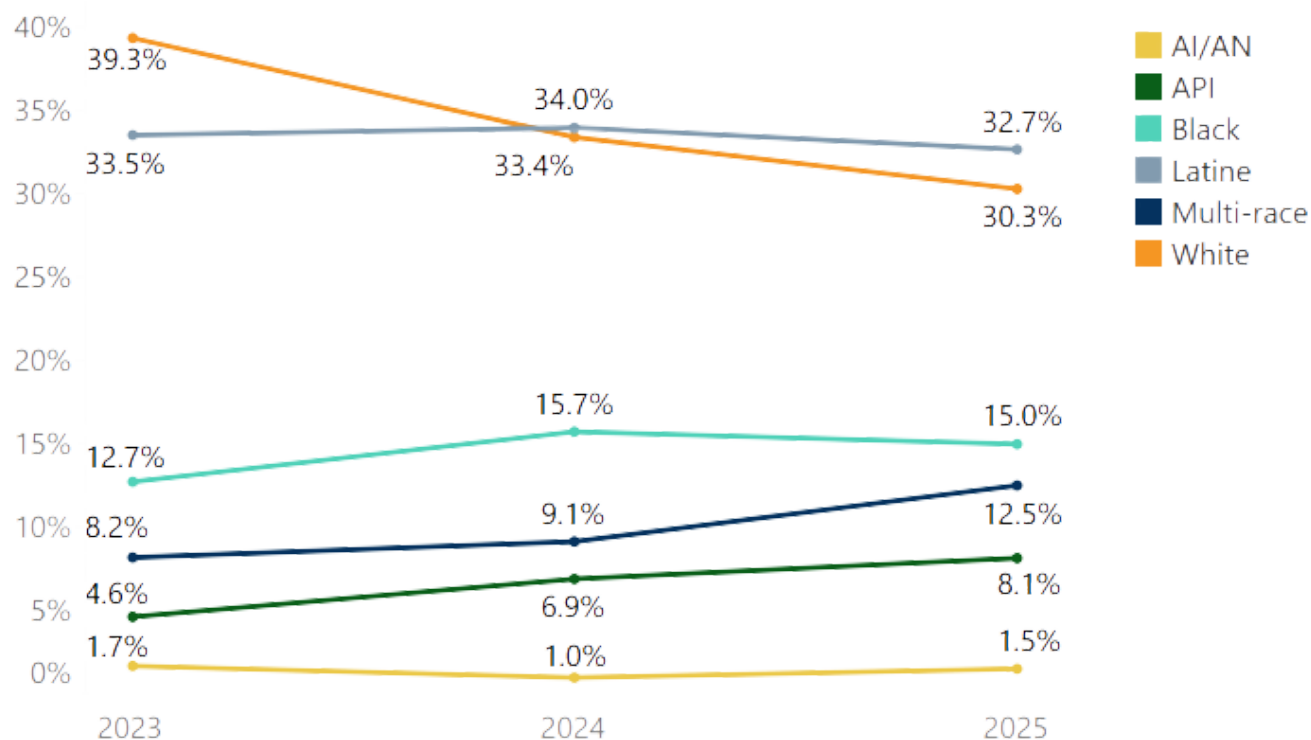
Table 2: Race & Ethnicity of Certified Medi-Cal Eligibles as of February 2026

Race or Ethnicity	Number of Certified Eligibles	Percentage of Total
Black	960,844	6.8%
AI/AN	47,128	0.3%
API	1,382,618	9.7%
Latine	7,320,459	51.6%
White	2,233,286	15.7%
Not Reported	2,240,235	15.8%
Total	14,184,570	100.0%

Note: This table has been adapted from the California Department of Health Care Services' [Medi-Cal Monthly Eligible Fast Facts](#) published in May 2026.



Figure 28: Certified Medi-Cal Peer Support Specialists by Race & Ethnicity, Statewide, FY 2023-2025



Over half of Medi-Cal members identified as Latine in early 2026. From 2023 to 2025, only a third of Medi-Cal certified peer support specialists identified as Latine.

As identified in the earlier data of this report, API communities have the lowest overall utilization of non-specialty and specialty mental health services. The increase in Medi-Cal certified peer support specialists identifying as API from 5% to 8% is a modest increase. According to 2024 data from the California Department of Health Care Access and Information (HCAI), despite Asians and Native Hawaiians or Pacific Islanders composing over 15% of the state's population, only 9.6% of California's behavioral health workforce identified as Asian and 0.3% identified as Native Hawaiian or Pacific Islander [17]. While the Medi-Cal PSS workforce is more diverse than the licensed behavioral health provider workforce, it is still not entirely reflective of the Medi-Cal population.



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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.



References

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Appendix

Appendix A: Ten Largest Medi-Cal Managed Care Plans by Number of Eligibles and Counties Served, FY 2023

Managed Care Plan	Number of Medi-Cal Eligibles*	Counties Reporting AB470 Data for this MCP*
L.A. CARE Health Plan	1,823,881	Los Angeles
Health Net	1,092,036	Los Angeles, Kern, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare
Inland Empire Health Plan	973,835	Riverside, San Bernardino
Anthem Blue Cross Partnership Plan	698,402	Alameda, Alpine, Amador, Butte, Calaveras, Contra Costa, Colusa, El Dorado, Fresno, Glenn, Inyo, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, Santa Clara, Santa Cruz, San Francisco, Sierra, Sutter, Tehama, Tulare, Tuolumne, Yuba
CalOPTIMA	634,900	Orange
Partnership HealthPlan of California	448,671	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Shasta, Siskiyou, Sonoma, Trinity, Yolo, Napa, Solano
CalViva Health	244,866	Kings, Madera, Fresno
Alameda Alliance for Health	244,314	Alameda
Central California Alliance for Health	240,081	Merced, Monterey, Santa Cruz
Community Health Group	222,193	San Diego

*Lists only capture counties reporting AB470 data for an MCP, and are therefore not comprehensive of all counties an MCP operates in and the complete number of eligibles.

Appendix

Appendix B: Percent of Medi-Cal Members Who Accessed Services That Did or Did Not Reach Continued Engagement, **Non-Specialty and Specialty Mental Health Services**, by Race & Ethnicity and County, FY2023

County	Race or Ethnicity	Non-Specialty Mental Health Services		Specialty Mental Health Services	
		Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
Alameda	All	67.2%	32.8%	28.8%	71.2%
	AI/AN	--	--	42.5%	57.5%
	API	73.8%	26.2%	19.9%	80.1%
	Black	67.2%	32.8%	30.2%	69.8%
	Latine	70.1%	29.9%	35.4%	64.6%
	Other	--	--	29.0%	71.0%
	Unknown	63.6%	36.4%	27.0%	73.0%
	White	62.5%	37.5%	27.9%	72.1%
Butte	All	62.6%	37.4%	31.6%	68.4%
	AI/AN	--	--	32.3%	67.7%
	API	--	--	24.7%	75.3%
	Black	--	--	35.8%	64.2%
	Latine	64.7%	35.3%	34.3%	65.7%
	Other	--	--	20.0%	80.0%
	Unknown	--	--	29.6%	70.4%
	White	61.4%	38.6%	31.5%	68.5%

*Continued engagement is defined as receiving 5 or more services in a year.

Note: Empty cells indicate an invalid value due to underlying cell suppression.

Appendix

Appendix B (continued): Percent of Medi-Cal Members Who Accessed Services That Did or Did Not Reach Continued Engagement, **Non-Specialty and Specialty Mental Health Services**, by Race & Ethnicity and County, FY2023

County	Race or Ethnicity	Non-Specialty Mental Health Services		Specialty Mental Health Services	
		Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
Kern	All	76.6%	23.4%	35.9%	64.1%
	AI/AN	--	--	33.3%	66.7%
	API	--	--	29.6%	70.4%
	Black	74.9%	25.1%	39.9%	60.1%
	Latine	80.8%	19.2%	35.1%	64.9%
	Other	--	--	36.3%	63.8%
	Unknown	--	--	34.6%	65.4%
	White	70.0%	30.0%	36.1%	63.9%
Los Angeles	All	69.6%	30.4%	32.5%	67.5%
	AI/AN	--	--	27.8%	72.2%
	API	68.3%	31.7%	25.2%	74.8%
	Black	68.6%	31.4%	32.8%	67.2%
	Latine	74.5%	25.5%	32.8%	67.2%
	Other	--	--	32.2%	67.8%
	Unknown	60.8%	39.2%	35.0%	65.0%
	White	62.9%	37.1%	32.9%	67.1%

*Continued engagement is defined as receiving 5 or more services in a year.

Note: Empty cells indicate an invalid value due to underlying cell suppression.

Appendix

Appendix B (continued): Percent of Medi-Cal Members Who Accessed Services That Did or Did Not Reach Continued Engagement, **Non-Specialty and Specialty Mental Health Services**, by Race & Ethnicity and County, FY2023

County	Race or Ethnicity	Non-Specialty Mental Health Services		Specialty Mental Health Services	
		Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
Orange	All	67.1%	32.9%	38.8%	61.2%
	AI/AN	--	--	31.1%	68.9%
	API	72.9%	27.1%	32.8%	67.2%
	Black	--	--	37.9%	62.1%
	Latine	73.8%	26.2%	39.2%	60.8%
	Other	67.3%	32.7%	39.0%	61.0%
	Unknown	63.1%	36.9%	39.3%	60.7%
	White	58.1%	41.9%	40.0%	60.0%
Sacramento	All	70.0%	30.0%	36.3%	63.7%
	AI/AN	67.0%	33.0%	32.8%	67.2%
	API	77.7%	22.3%	30.8%	69.2%
	Black	71.4%	28.6%	33.4%	66.6%
	Latine	72.2%	27.8%	40.0%	60.0%
	Other	78.3%	21.7%	39.4%	60.6%
	Unknown	66.7%	33.3%	38.0%	62.0%
	White	65.7%	34.3%	35.9%	64.1%

*Continued engagement is defined as receiving 5 or more services in a year.

Note: Empty cells indicate an invalid value due to underlying cell suppression.

Appendix

Appendix B (continued): Percent of Medi-Cal Members Who Accessed Services That Did or Did Not Reach Continued Engagement, **Non-Specialty and Specialty Mental Health Services**, by Race & Ethnicity and County, FY2023

County	Race or Ethnicity	Non-Specialty Mental Health Services		Specialty Mental Health Services	
		Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
San Bernardino	All	63.7%	36.3%	46.1%	53.9%
	AI/AN	--	--	46.8%	53.2%
	API	--	--	36.0%	64.0%
	Black	62.7%	37.3%	45.8%	54.2%
	Latine	67.9%	32.1%	47.8%	52.2%
	Other	--	--	47.8%	52.2%
	Unknown	59.4%	40.6%	48.6%	51.4%
	White	56.0%	44.0%	43.8%	56.2%
San Diego	All	70.1%	29.9%	40.5%	59.5%
	AI/AN	65.7%	34.3%	53.8%	46.2%
	API	80.9%	19.1%	37.9%	62.1%
	Black	67.9%	32.1%	42.0%	58.0%
	Latine	74.4%	25.6%	42.3%	57.7%
	Other	76.6%	23.4%	43.8%	56.2%
	Unknown	67.2%	32.8%	39.2%	60.8%
	White	64.2%	35.8%	39.5%	60.5%

*Continued engagement is defined as receiving 5 or more services in a year.

Note: Empty cells indicate an invalid value due to underlying cell suppression.

Appendix

Appendix B (continued): Percent of Medi-Cal Members Who Accessed Services That Did or Did Not Reach Continued Engagement, **Non-Specialty and Specialty Mental Health Services**, by Race & Ethnicity and County, FY2023

County	Race or Ethnicity	Non-Specialty Mental Health Services		Specialty Mental Health Services	
		Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
Santa Clara	All	75.9%	24.1%	26.0%	74.0%
	AI/AN	--	--	15.3%	84.7%
	API	82.4%	17.6%	23.2%	76.8%
	Black	--	--	28.8%	71.2%
	Latine	77.0%	23.0%	28.9%	71.1%
	Other	--	--	27.2%	72.8%
	Unknown	73.5%	26.5%	25.7%	74.3%
	White	70.7%	29.3%	23.3%	76.7%
Ventura	All	63.6%	36.4%	29.7%	70.3%
	AI/AN	53.8%	46.2%	23.5%	76.5%
	API	--	--	26.0%	74.0%
	Black	--	--	26.6%	73.4%
	Latine	69.8%	30.2%	30.4%	69.6%
	Other	61.8%	38.2%	26.8%	73.2%
	Unknown	--	--	30.3%	69.7%
	White	56.6%	43.4%	29.1%	70.9%

*Continued engagement is defined as receiving 5 or more services in a year.

Note: Empty cells indicate an invalid value due to underlying cell suppression.

Appendix

Appendix C: Percent of Medi-Cal Members Who Accessed Services That Did or Did Not Reach Continued Engagement, **Non-Specialty Mental Health Services**, by Race & Ethnicity and Managed Care Plan, FY2023

Managed Care Plan	Race or Ethnicity	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
Alameda Alliance for Health	All	67.0%	33.0%
	AI/AN	54.8%	45.2%
	API	74.1%	25.9%
	Black	66.1%	33.9%
	Latine	69.7%	30.3%
	Other	69.7%	30.3%
	Unknown	63.7%	36.3%
	White	61.8%	38.2%
Anthem Blue Cross Partnership Plan	All	70.1%	29.9%
	AI/AN	73.4%	26.6%
	API	79.3%	20.7%
	Black	71.6%	28.4%
	Latine	75.5%	24.5%
	Other	77.9%	22.1%
	Unknown	67.5%	32.5%
	White	65.5%	34.5%

Managed Care Plan	Race or Ethnicity	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
CalOPTIMA	All	67.1%	32.9%
	AI/AN	58.8%	41.2%
	API	72.8%	27.2%
	Black	61.4%	38.6%
	Latine	73.8%	26.2%
	Other	67.2%	32.8%
	Unknown	63.1%	36.9%
	White	58.2%	41.8%
CalViva Health	All	73.5%	26.5%
	AI/AN	71.6%	28.4%
	API	75.2%	24.8%
	Black	73.2%	26.8%
	Latine	76.9%	23.1%
	Other	74.2%	25.8%
	Unknown	70.6%	29.4%
	White	66.1%	33.9%

*Continued engagement is defined as receiving 5 or more services in a year.

Appendix

Appendix C (continued): Percent of Medi-Cal Members Who Accessed Services That Did or Did Not Reach Continued Engagement, **Non-Specialty Mental Health Services**, by Race & Ethnicity and Managed Care Plan, FY2023

Managed Care Plan	Race or Ethnicity	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
Central California Alliance for Health	All	69.0%	31.0%
	AI/AN	65.8%	34.2%
	API	75.8%	24.2%
	Black	75.2%	24.8%
	Latine	76.6%	23.4%
	Other	66.5%	33.5%
	Unknown	55.0%	45.0%
	White	60.7%	39.3%
Community Health Group	All	70.7%	29.3%
	AI/AN	68.9%	31.1%
	API	83.4%	16.6%
	Black	67.3%	32.7%
	Latine	74.1%	25.9%
	Other	78.2%	21.8%
	Unknown	68.1%	31.9%
	White	62.3%	37.7%

Managed Care Plan	Race or Ethnicity	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
Health Net Community Solutions, Inc.	All	69.7%	30.3%
	AI/AN	74.1%	25.9%
	API	69.5%	30.5%
	Black	67.1%	32.9%
	Latine	75.8%	24.2%
	Other	72.5%	27.5%
	Unknown	61.4%	38.6%
	White	64.2%	35.8%
Inland Empire Health Plan	All	62.5%	37.5%
	AI/AN	61.3%	38.7%
	API	68.4%	31.6%
	Black	61.3%	38.7%
	Latine	66.9%	33.1%
	Other	64.6%	35.4%
	Unknown	59.3%	40.7%
	White	55.2%	44.8%

*Continued engagement is defined as receiving 5 or more services in a year.

Appendix

Appendix C (continued): Percent of Medi-Cal Members Who Accessed Services That Did or Did Not Reach Continued Engagement, **Non-Specialty Mental Health Services**, by Race & Ethnicity and Managed Care Plan, FY2023

Managed Care Plan	Race or Ethnicity	Percent receiving at least 1 service that did not reach continued engagement*	Percent receiving at least 1 service that did reach continued engagement*
L.A. CARE Health Plan	All	69.9%	30.1%
	AI/AN	70.5%	29.5%
	API	69.4%	30.6%
	Black	69.9%	30.1%
	Latine	74.0%	26.0%
	Other	65.1%	34.9%
	Unknown	63.4%	36.6%
	White	62.6%	37.4%
Partnership HealthPlan of California	All	61.0%	39.0%
	AI/AN	66.3%	33.7%
	API	71.0%	29.0%
	Black	65.9%	34.1%
	Latine	68.4%	31.6%
	Other	63.7%	36.3%
	Unknown	60.4%	39.6%
	White	57.1%	42.9%

*Continued engagement is defined as receiving 5 or more services in a year.