2025 California Quality Collaborative Network Convening Burbank, CA

Catalyzing Integrated Care in California

March 4, 2025

PBGH California Quality Collaborative

Panelists

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Chief Executive Officer, Collaborative Family Healthcare Association

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Moderator:
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Director,
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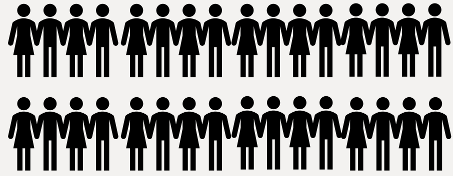
Integration Taking Root in California



8 participating orgs provide care to over **730,000 Californians** across all major payers (commercial, Medicare, Medi-Cal)

BHI Models Implemented

5 PCBH

2 CoCM

1 PCBH CoCM

CHINESE HOSPITAL — CoCM

San Francisco Health Network — SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH — CoCM, PCBH

Community Memorial HEALTHCARE — PCBH

SHARP — PCBH

Scripps — CoCM *Via external vendor*

perlmanclinic++ — PCBH

Riverside Family Physicians — PCBH

PVHMC — PCBH

San Francisco

Los Angeles

San Diego

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Performance Improved Significantly in 9 months!

CalHIVE BHI impact to date:

10,000 additional patient screenings

1,000 patients diagnosed with depression

500 patients connected to BH services

3.2% increase in depression screening and follow-up (DSF-E)

75%

of follow-up care provided at pilot sites

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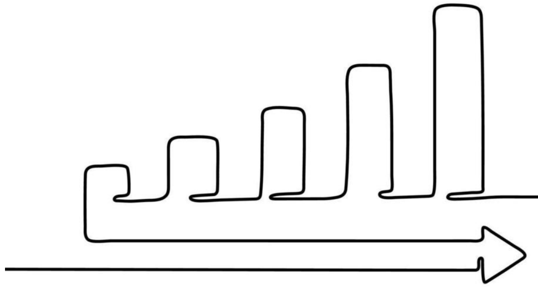
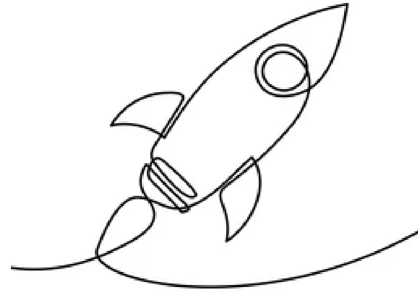
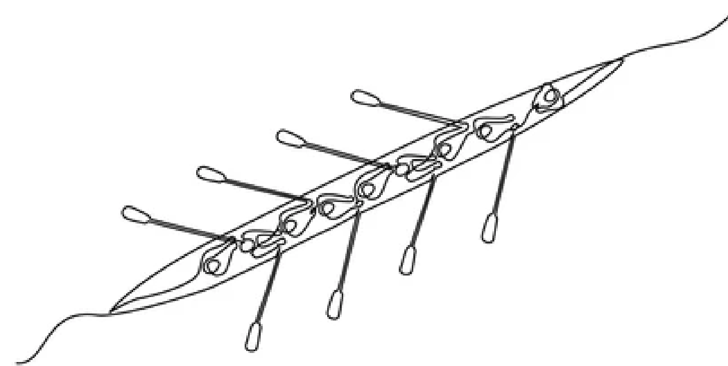
Catalyzing Integrated Care – Q&A

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LEVERAGING BEHAVIORAL HEALTH DATA FOR EXCELLENCE: MEETING AND EXCEEDING COVERED CALIFORNIA'S REQUIREMENTS

Charles Raya, DrPHc, MHA

Equity and Quality Specialist

Health Equity and Quality Transformation (EQT)

COVERED CALIFORNIA

Strategic Pillars

The **Pillars** are the ways we achieve our mission and vision.

Affordable Choices

We connect consumers to financial assistance and a choice of affordable plans and providers that give them the best value.

Quality Care

We ensure consumers consistently receive accessible, equitable, high-quality care.

Organizational Excellence

We foster a nimble culture of continuous improvement that empowers and motivates our team to deliver on our mission with high standards.

Reaching Californians

We are unwavering in our pursuit to reach Californians and connect them to comprehensive and affordable coverage.

Catalyst for Change

We pioneer new ideas and disseminate our learnings to drive improvement in health care in California and nationally.

Exceptional Service

We provide the highest level of service and exceed our consumers' expectations.

DIVERSITY, EQUITY, INCLUSION

We apply this lens in all our work to improve the health and experience of our consumers and to create and support a workforce reflective of our core values and the people we serve.

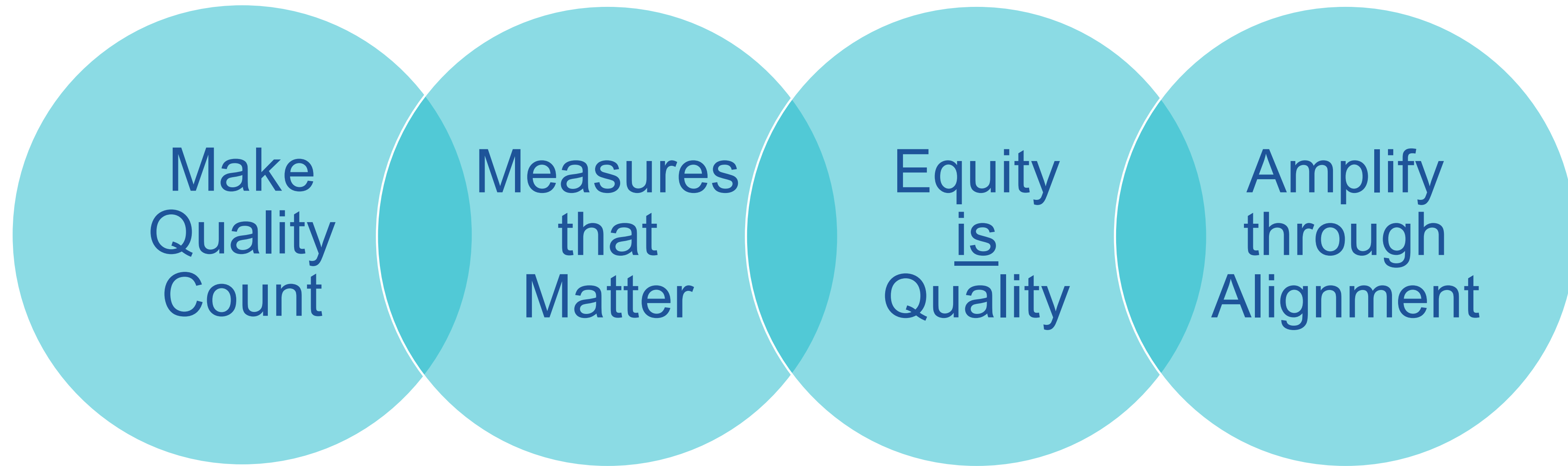
QUALITY CARE

Quality Care

We ensure consumers consistently receive accessible, equitable, high-quality care.

1. Produce **measurable**, equitable improvements in health outcomes.
2. Hold Qualified Health Plan (QHP) and Qualified Dental Plan (QDP) issuers **accountable** for consistent, standard levels of quality.
3. Increase access to and support of **high quality, diverse providers** who practice with cultural humility.
4. Make demonstrable progress in addressing health disparities and increasing **health equity**.
5. Increase access to and quality of **behavioral health** care.

AND BELIEVE THERE IS NO QUALITY WITHOUT EQUITY



Delivering on Covered California's vision to improve the health of all Californians, this proposed methodology aligns with efforts occurring at DMHC, DHCS/Medi-Cal, and CalPERS

CONTRACT DEVELOPMENT GUIDING PRINCIPLES

Principles	Framework
Equity is quality	Build on the strong foundation of 2023-2025 contract
Center the member	Prioritize alignment with DHCS, CalPERS, & OHCA
Make it easy to do right	Emphasize outcomes
Amplify through alignment	Pursue administrative simplification
Focused scope for high impact	

Stakeholder Engagement

- Contract workgroup open to all Issuers, Public Purchasers, and Consumer Advocate Groups
- Provided feedback on proposed contracts and language

Contract Workgroup

- 9 public meetings from March – August 2024
- 18 unique organizations commented with 341 total comments

Public Comment Period

- Cycle 1 - 14 unique organizations with 236 total comments
- Cycle 2 - 7 unique organizations with 50 total comments

PROPOSED 2026-28 ARTICLE 2 REQUIREMENTS

- **Article 2: Behavioral Health**
- Issuers must submit NCQA BH network or equivalent reports with current network data if older than two years, and demonstrate enhanced access to behavioral health services, including telehealth, via website evidence
- Monitor behavioral and virtual behavioral health quality through utilization analysis and vendor criteria submission, and oversee delegated entities to ensure quality behavioral health care, including submission of a detailed delegation report
- Provide staff with cultural humility training, deploy culturally specific materials for marginalized groups, and implement and report on disparity reduction in behavioral health utilization using data-driven strategies and community engagement
- Promote harm reduction for opioid use, support Tobacco Treatment, and track health metrics per Smart Care California guidelines
- Annually report on behavioral health spending by product according to OHCA guidelines, collaborate with other QHP Issuers, engage in community initiatives, and encourage suggestions for activities that align with Covered California's methodologies
- Support integration of behavioral health with medical services

PLD

Depression Screening and Follow-Up Measure (DSF-E)

Measurement Year 2023	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5 – Type 1	Plan 6	Plan 7 – Type 2	Plan 8 – Type 1	Plan 9	Plan 7 – Type 1	Plan 10 – Type 1	Plan 8 – Type 2	Plan 10 – Type 3	Plan 11
DSF % Screening Rate	13.3%	10.6%	10.6%	4.4%	3.8%	3.2%	2.1%	2.1%	0.9%	0.5%	0.4%	0.4%	0.2%	0%
DSF % Follow-Up Rate	84.6%	75%	85.5%	73.5%	51%	96.3%	59.2%	67.4%	100%	65%	68.8%	40%	62.5%	0%

- DSF-E will be introduced as first-year QRS measure starting in Measurement Year 2024
- Extensive screening population – including all members aged 12+ without a history of depression or bi-polar disorder, indicating a broad denominator for screening
- MY2023 Preliminary Findings
    - 11 out of 14 plans screened less than 5% of eligible members
    - Only 3 achieved screening rates of over 10% of eligible members
    - Follow-up percentage is drastically higher
- Challenges
    - Initial scoring set to begin in MY2024, though there may be hesitancy in public reporting of early results due to expected low scores
    - QRS does not currently plan to calculate DSF-E benchmarks at the measure indicator level

PROPOSED 2026-28 ARTICLE 4 REQUIREMENTS

Article 4: Delivery System and Payment Strategies to Drive Quality

Use of Virtual Care

- Issuers must report all virtual care solutions and vendors in place and disclose vendors' NCQA Virtual Care Accreditation status
- Issuers must collect quality monitoring measures from virtual care vendors and annually report summary findings to Covered California
- Issuers must provide member support for navigating virtual services, ensuring solutions are culturally and linguistically tailored, and share relevant tools and resources with Covered California
- Issuers must report on reimbursement policies for both network and third-party providers, ensuring payment parity for virtual services
- Issuers must collaborate with Covered California to review virtual care service utilization, address disparities using HEI, submit improvement plans for outliers, and participate in best practice collaboratives, including digital literacy support

HEALTHCARE EVIDENCE INITIATIVE (HEI) MEASURES BACKGROUND AND METHODOLOGY

Measures List

- Using HEI data, we pulled administrative measures for 2019-2023.
- The stratified measures that we include in this report cover several domains, including preventive care services, utilization patterns, and behavioral health.

Measure Sections	Page
All Population Performance	9
QHP Performance	67

PERFORMANCE MEASURE	Domain
Breast Cancer Screening Rates with Stratifications	Preventive Care
Child and Adolescent Well Care Visits with Stratifications	Preventive Care
No Utilization of Care with Stratifications	Utilization
Primary Care Visits / 1000 members with Stratifications	Utilization
Primary Care Telehealth Visits / 1000 Members with Stratifications	Utilization
Adult Preventive Visits / 1000 members with Stratifications	Utilization
Ambulatory ER Visits / 1000 members with Stratifications	Utilization
Behavioral Health Visits / 1000 members with Stratifications	Behavioral Health
Behavioral Health Telehealth Visits / 1000 members with Stratifications	Behavioral Health
Concurrent Use of Benzodiazepines (COB) with Stratifications	Behavioral Health
Use of High Dose Opioids (HDO) with Stratifications	Behavioral Health
Pharmacotherapy for Opioid Use Disorder (PLD Measure)	Behavioral Health

ALL POPULATION PERFORMANCE

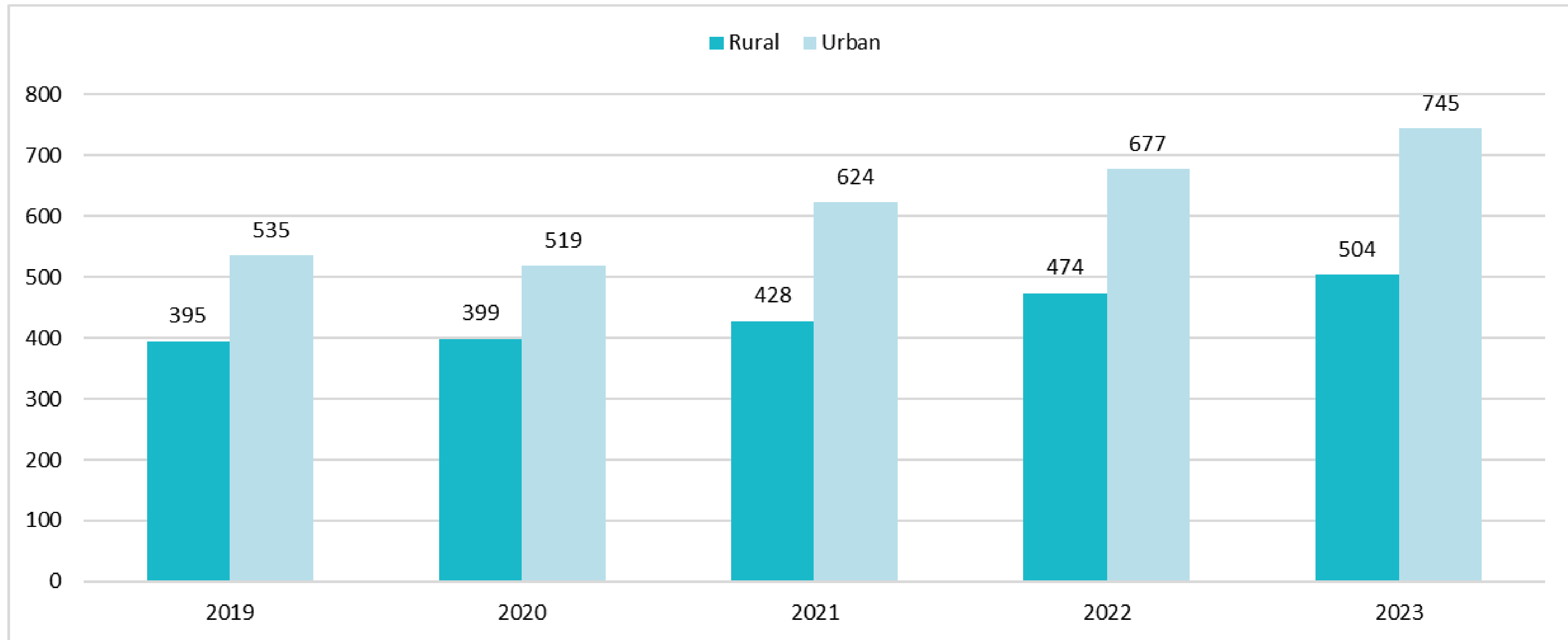
Behavioral Health Visits per 1,000 Members Summary

- **Definition**: The Behavioral Health Visits measure is the annual number of behavioral health visits per 1,000 enrolled members at age 18 and older. Behavioral health (BH) clinicians include counselors, psychologists, psychiatrists, social workers and other therapists. Most visits are for individual patient therapy though other visits may involve group therapy or various behavioral health treatments occurring in the outpatient setting.
- **Key Findings**:
  - Overall rates of behavioral health visits have increased since the start of the COVID-19 pandemic in 2020, and they continue to increase year-over-year and persist well above pre-pandemic levels in 2023.
  - From 2019-2023, members living in rural zip codes had significantly fewer behavioral health visits per 1,000 members each year compared to those in urban zip codes beyond the level of expected distribution.
  - Additional differences* in the rates of behavioral health utilization by race/ethnicity include:
    - Members who identify as Asian American or Native Hawaiian/Pacific Islander have lower behavioral health visit rates than members identifying as other race/ethnicities, but these differences are not statistically significant.
      - Among members identifying as Asian American, members who identify as Hmong had very low rates of behavioral health utilization and members identifying as multiple Asian American races had statistically significant higher rates of BH use in 2021 - 2023.
    - Members identifying as American Indian/Alaska Native, Multiple races, or White have higher rates of behavioral health utilization than members identifying as other race/ethnicities, but these differences are not statistically significant.
    - Among members identifying as Hispanic/Latino, members identifying as Puerto Rican and members identifying as Cuban had high rates of behavioral health utilization compared to members identifying as other ethnicities. These differences are notable but not statistically significant.

*For this measure, BH visits per 1000 members stratified by race/ethnicity have a wide distribution, which means that we may see large overall differences between groups but cannot assert statistical significance. These differences likely need additional exploration to understand if they represent differences that warrant intervention.

ALL POPULATION PERFORMANCE

Behavioral Health Visits per 1,000 Members by Rural / Urban



COVERED CALIFORNIA

HEI

ALL POPULATION PERFORMANCE

Behavioral Health Visits per 1,000 Members by Race/Ethnicity

Race/Ethnicity	2019	2020	2021	2022	2023
All Population	**528**	**514**	**614**	**667**	**732**
American Indian / Alaska Native	939	902	906	1032	1128
Asian American	144	143	200	220	238
Black or African American	525	538	725	778	874
Hispanic or Latino	301	325	432	484	538
Multi-racial	790	843	1037	1133	1219
Native Hawaiian / Pacific Islander	333	249	402	321	422
Non-Respondent	581	559	637	696	778
Other	544	518	613	634	696
White	903	876	1010	1084	1182

COVERED CALIFORNIA

Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.

ALL POPULATION PERFORMANCE

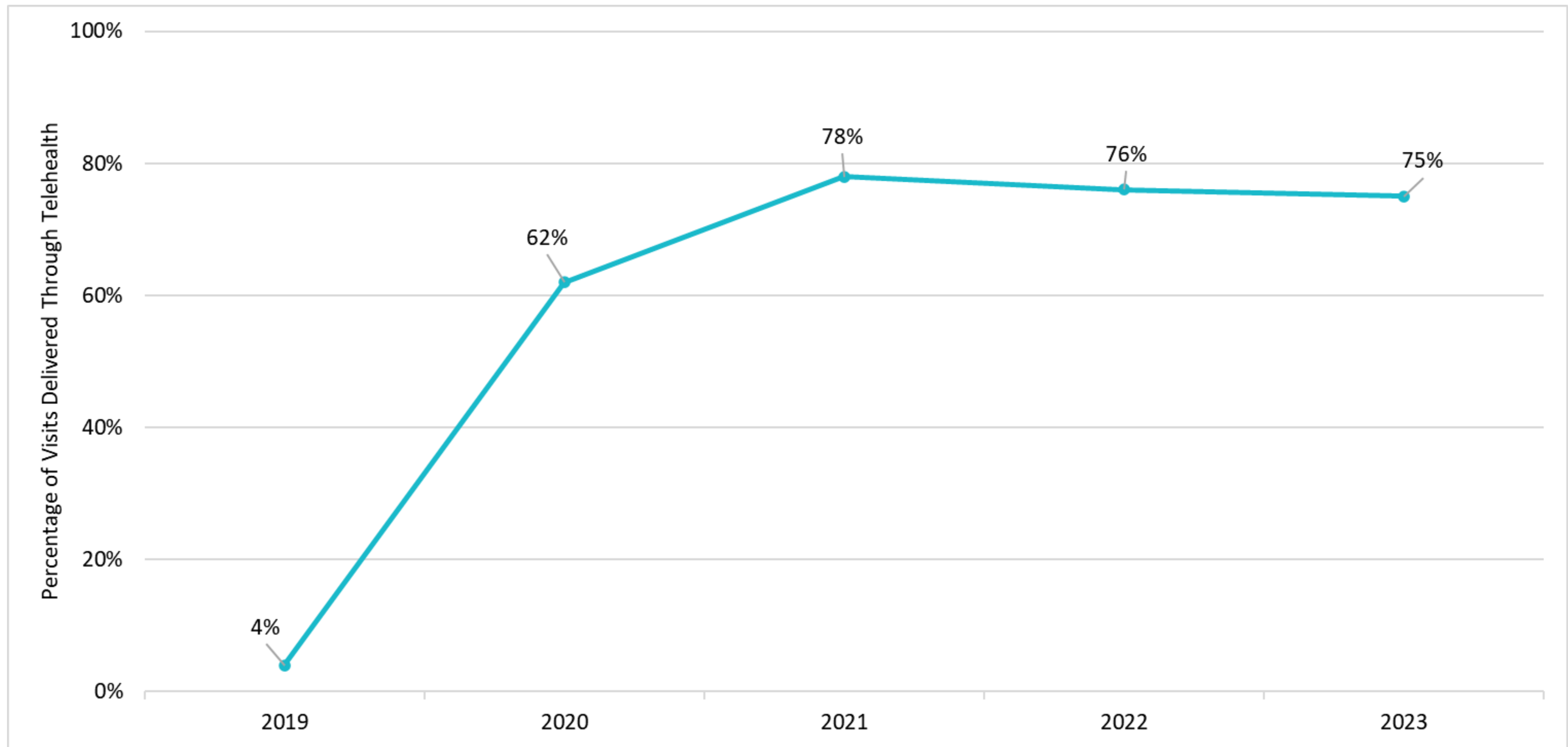
Behavioral Health Care Through Telehealth Summary

- **Definition**: The Behavioral Health Care Through Telehealth measure is the portion of ambulatory behavioral health visits that were delivered via telehealth for adults aged 18 and older. The remaining portion of behavioral health visits were done in-person. Typically, telehealth occurs by phone and can include real time video communications between a patient and clinician. Patients consistently report high satisfaction when getting care by telehealth[3,4], and value its convenience and the ability to get care at home. However, some patients, especially those with lower incomes, may face barriers to using telehealth due to its availability or technologic barriers.[5]
- **Key Findings**:
  - The overall portion of behavioral health visits delivered via telehealth increased from 2019 to 2020, catalyzed by the COVID-19 pandemic. Telehealth has been the predominant form of delivery of behavioral health care since 2020, and in 2023 we see 75% of all behavioral health visits delivered via telehealth. This is in stark contrast to the trend we see with primary care, where less than a quarter of all visits in 2023 are delivered via telehealth.
  - When stratifying by race/ethnicity, members identifying as American Indian/Alaska Native had statistically significant lower rates of accessing behavioral health via telehealth than members identifying as other races/ethnicities in 2021, 2022, and 2023. However, as previously noted, members identifying as American Indian/Alaska Native have higher rates of BH visits overall.
  - When stratifying by income, members in the unsubsidized group had statistically significant lower rates for 2021-2022 of accessing behavioral health via telehealth than members in all other FPL ranges. The 'Unsubsidized' category within the income/FPL stratification encompasses a diverse set of members and a multitude of factors may contribute to the reduced rates of telehealth utilization.
  - In 2021-2023, members in rural zip codes have significant 10% - 11% lower rates of accessing behavioral health via telehealth as compared to members living in urban zip codes. This indicates that telehealth is a way to expand access in rural settings may not be effectively reaching those who live there.

HEI

ALL POPULATION PERFORMANCE

Behavioral Health Care Through Telehealth Over Time



COVERED CALIFORNIA

HEI

ALL POPULATION PERFORMANCE

Behavioral Health Care Through Telehealth with Other Stratifications

Language	2019	2020	2021	2022	2023
All Population	**4%**	**62%**	**78%**	**76%**	**75%**
Arabic		75%	74%	70%	87%
Armenian		72%	92%	62%	86%
Cambodian		50%		57%	64%
Cantonese	5%	70%	78%	67%	72%
English	4%	62%	78%	76%	75%
Farsi	4%	62%	69%	63%	64%
Hindi					93%
Hmong					
Korean	3%	51%	73%	65%	84%
Mandarin	3%	66%	79%	70%	68%
Punjabi			84%	87%	92%
Russian		60%	81%	82%	80%
Spanish	4%	65%	80%	74%	71%
Tagalog		76%	89%	78%	88%
Vietnamese	5%	58%	82%	77%	75%

Income	2019	2020	2021	2022	2023
All Population	**4%**	**62%**	**78%**	**76%**	**75%**
0 to ≤138	4%	58%	80%	79%	77%
>138 to <150	3%	60%	78%	75%	74%
≥150 to <200	4%	63%	80%	78%	77%
≥200 to <250	5%	64%	79%	78%	76%
≥250 to <400	4%	65%	79%	77%	77%
≥400	5%	62%	77%	75%	74%
Unsubsidized	4%	57%	74%	70%	72%

Geography	2019	2020	2021	2022	2023
All Population	**4%**	**62%**	**78%**	**76%**	**75%**
Rural	5%	58%	69%	66%	65%
Urban	4%	62%	79%	77%	76%

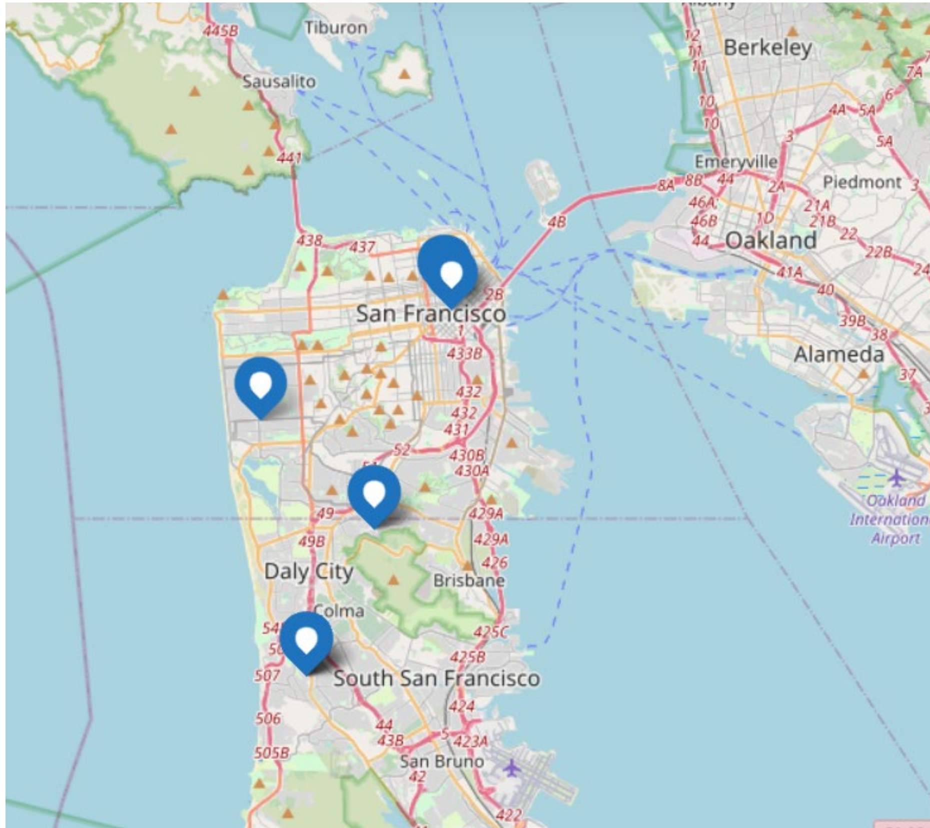
Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.

Chinese Hospital
BHI Implementation & Payment

Jiami Wu, MPH, Director of Clinics

March 4th, 2025

Chinese Hospital



- Community-owned, not-for-profit organization
- Mission: deliver quality health care in a cost effective way, responsive to the community's ethnic and cultural uniqueness, providing access to health care and acceptability to all socioeconomic levels

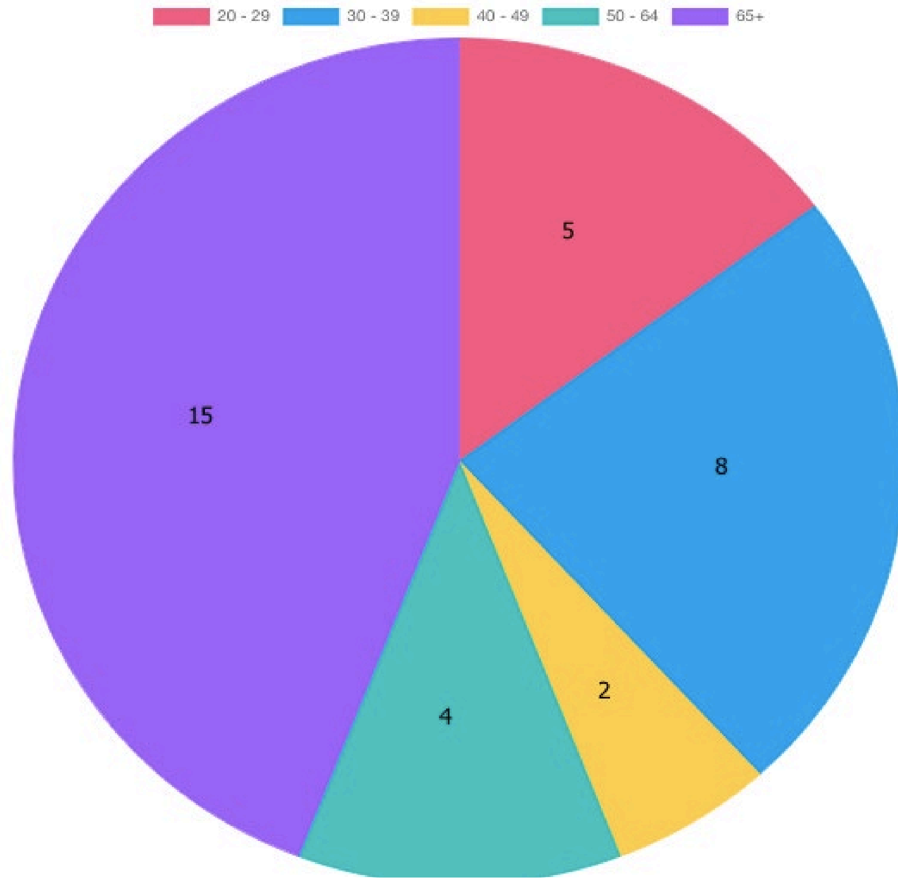
Behavioral Health Integration Implementation Overview

- **BHI Program Timeline**
  - 2023: Decided on internal Collaborative Care (CoCM) program
  - June 2024: Launched pilot
  - July 2024: Started billing
- **PHQ9 scores:** 0 – 27
- **Diagnoses:**
  - Mild/moderate depression
    - Few severe cases
  - Anxiety
  - Few schizophrenia and bipolar cases
- 1/3 of patients currently seeing a behavioral health provider

CoCM Referrals

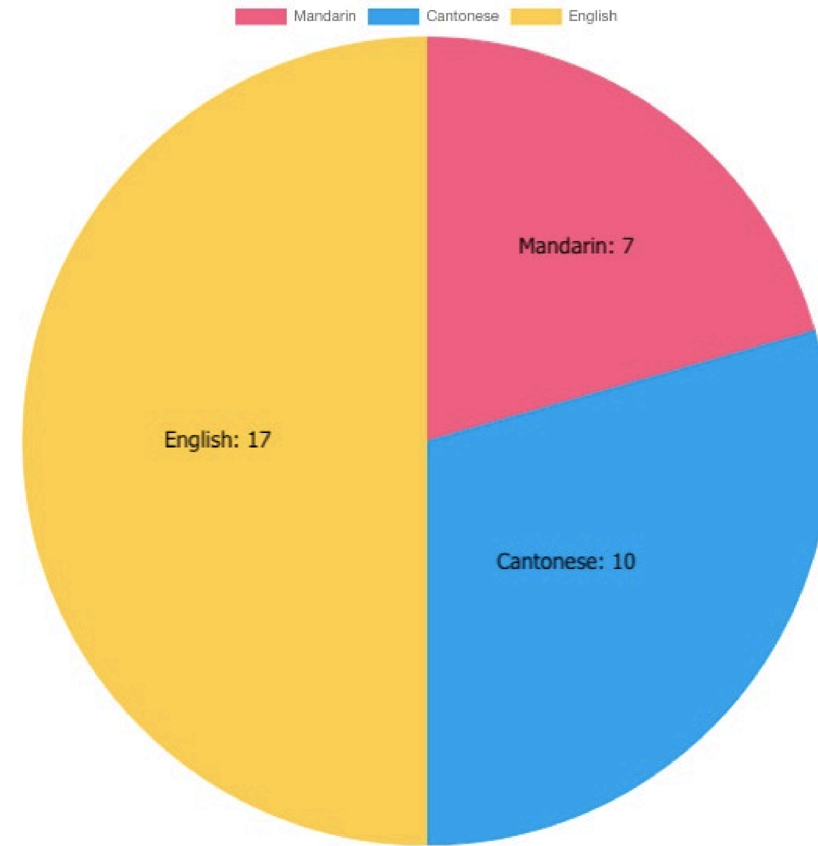
- Slow referral rate first 3 months of program
- In-person all clinic team meeting in October which increased referral rates by 50%
- ~5 to 10 referrals per month
- 9 out of 11 PCPs have at least 1 patient in CoCM
- From LMFT Dr. Poon and dietitian (!)
- 60% successful referral/consent to participate rate
  - Even if patient declines program, we will still help look for behavioral health services

CoCM Patient Demographics



Age

- 40% of participants are 65+

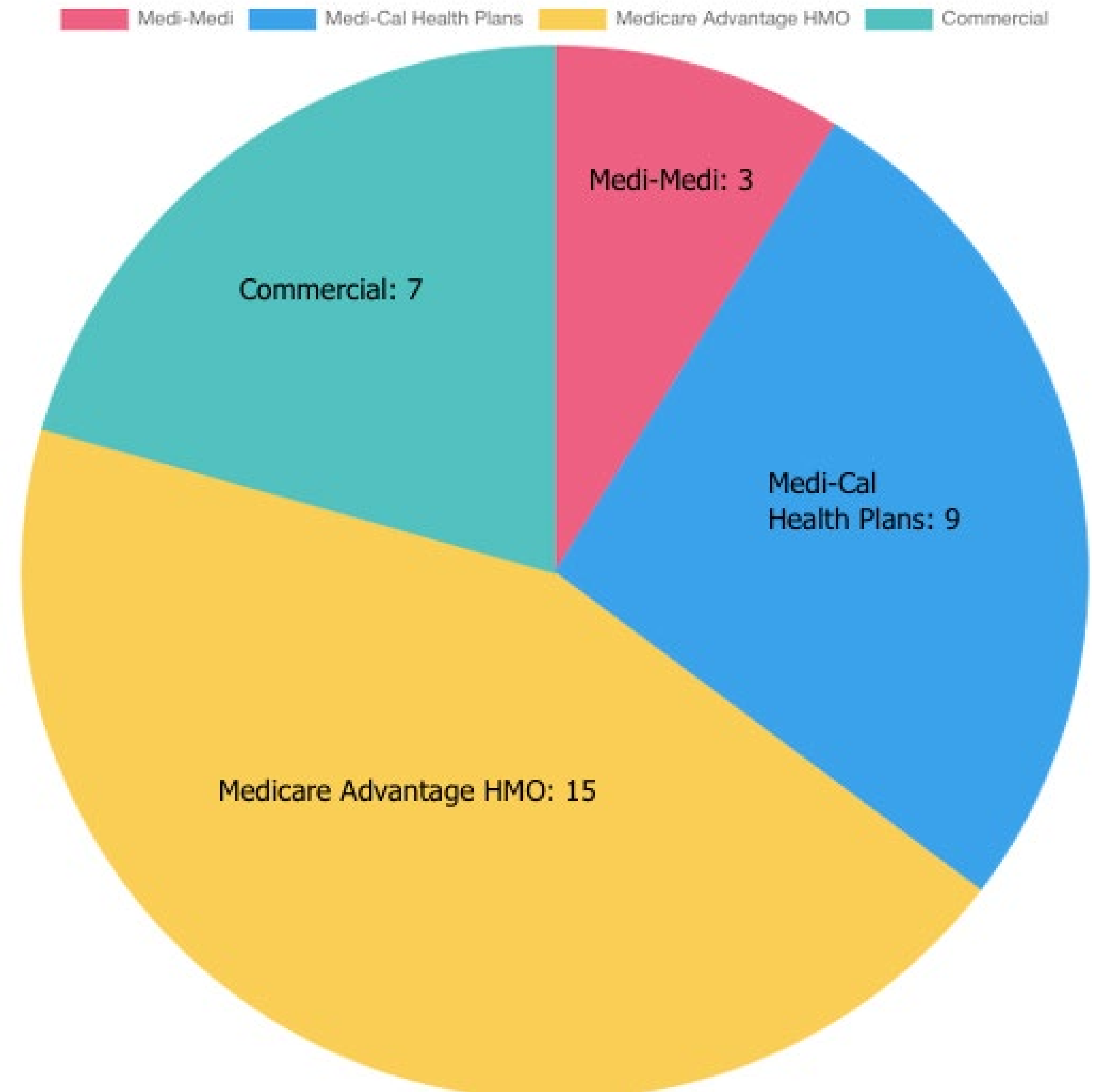


Language

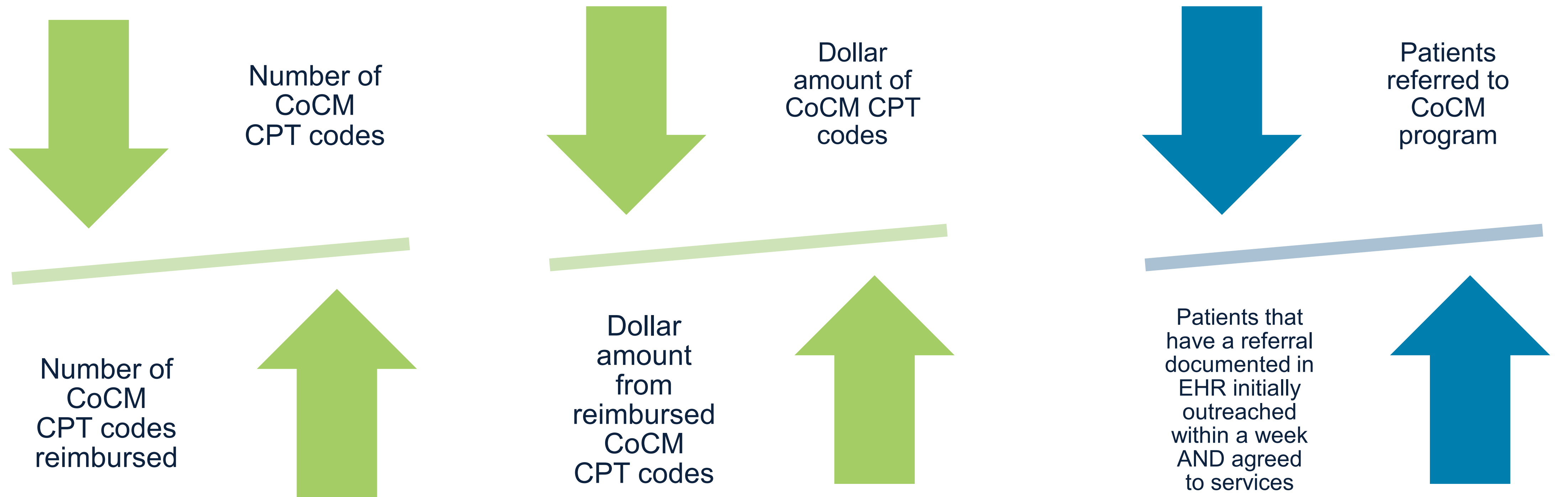
- 50% English

CoCM Payer Mix

- Medi-Medi: 3
- Commercial: 7
- Medi-Cal Health Plans: 9
- Medicare Advantage HMO: 15



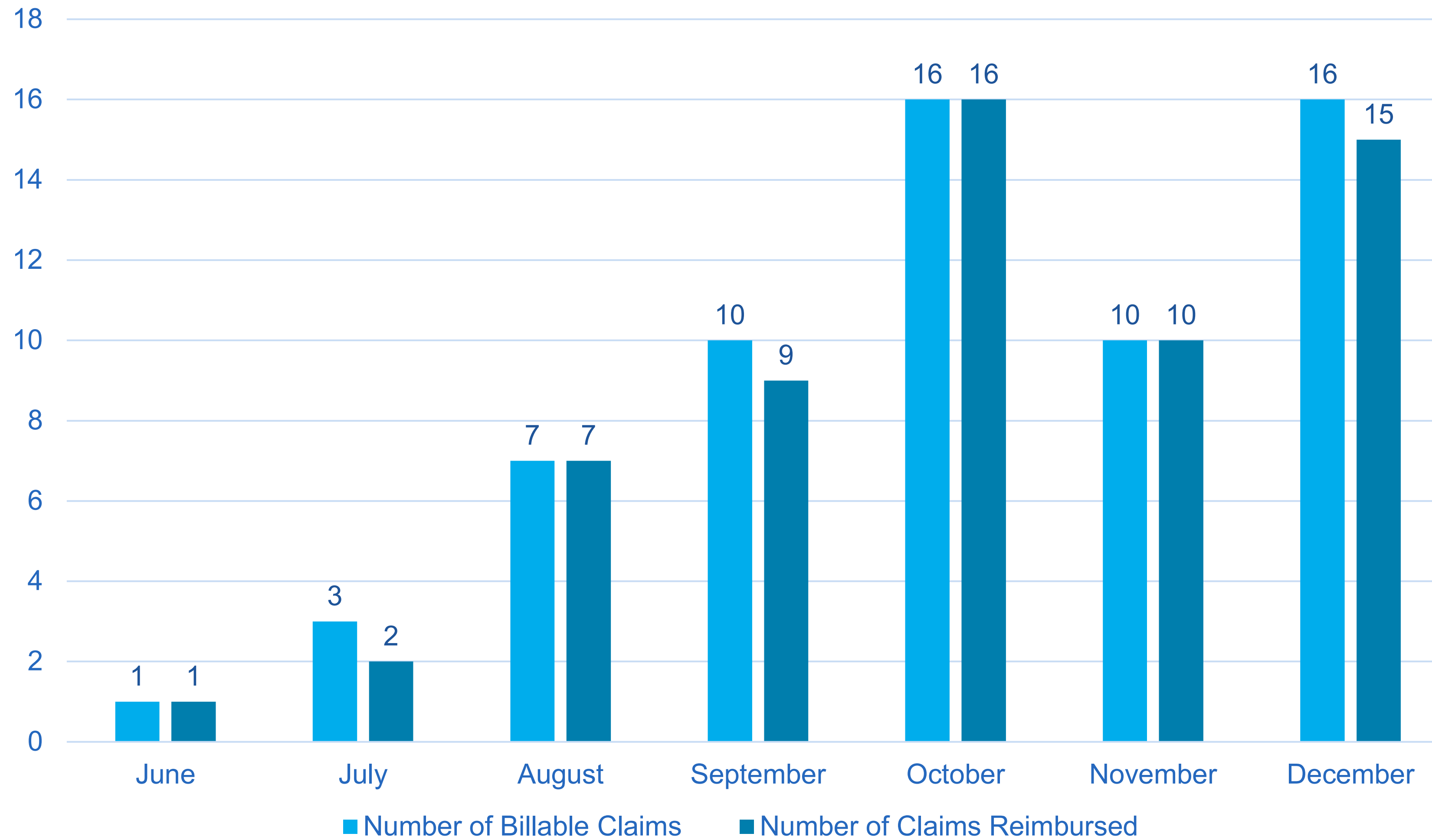
Pilot Site Measures



Financial Measures

Process Measure

Reimbursements



Reimbursement Challenges - Themes

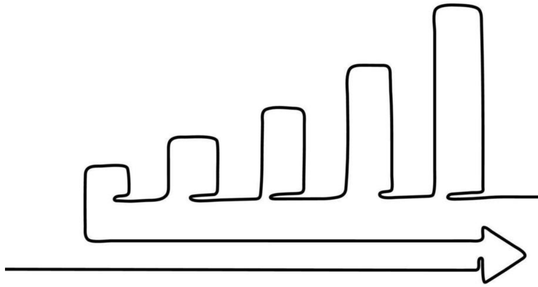
Denial Reasons (from IPAs)

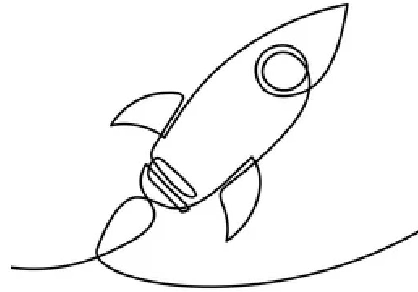
- Patient has been undergoing psychiatry treatment with Chinese Hospital; why is CoCM needed?
- CoCM CPT code (99494 x 3) exceeded the allowed frequency
- Requested medical records review for all CoCM claims
- Requesting Prior Authorization for each CoCM claim
  - Later denied all claims and withdrew previous 3 payments, informed us that it’s not their Division of Financial Responsibility (DOFR), and directed us to submit the claims to health plans

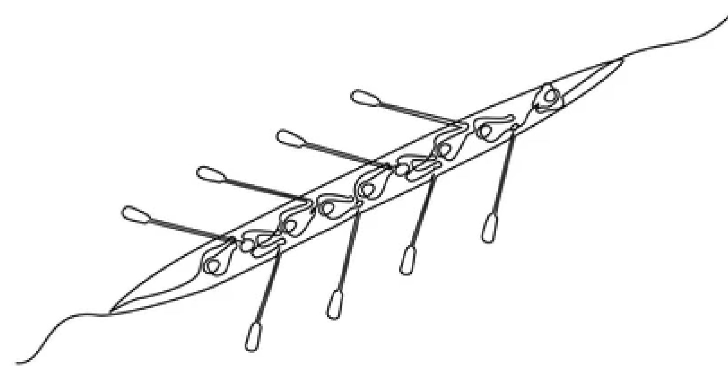
Payment Themes (from Plans)

- Reimbursement range: from 1 week, 1 month, still pending

Catalyzing Integrated Care – Q&A







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Appendix

HEALTHCARE EVIDENCE INITIATIVE (HEI) MEASURES BACKGROUND AND METHODOLOGY

Interpreting the HEI-Sourced Measure Set

- Member race and ethnicity is sourced from the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS).
- Health Evidence Initiative (HEI) data excludes Covered California for Small Business (CCSB) and includes only Qualified Health Plan (QHP) submitted claims.
- Measure results from HEI data may differ slightly from Quality Rating System (QRS) measure results due to allowable adjustments in specifications and different denominators as small business members are included in QRS scores. HEI-sourced rates are subject to a quality assurance process including assessing year-over-year results, comparison to QRS publicly reported results where applicable and other industry norms.
- This report was produced using the 3m24b HEI database. This means that data replacements and specification updates may cause slight variation between PPR reports.
- Rates with fewer than 11 cases in the numerator have been suppressed to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard.
- Rates with fewer than 30 cases in the denominator have been suppressed as small denominators may be unreliable.
- Covered California acknowledges that some rates calculated using HEI data may not precisely match other data sources due to updates and improvements over time. These small variations are felt to be acceptable.

HEI Race and Ethnicity Stratification Background

- Since its inception, addressing health equity and disparities in health outcomes has been integral to the mission of Covered California and central to the organization's marketing, benefit design and health plan accountability efforts.
- Covered California has several contractual requirements of its Qualified Health Plans (QHPs) directly related to health equity and disparities reduction, including:
  - QHP issuers must achieve an 80%-member self-reported response rate for race and ethnicity tied to a performance guarantee.
  - QHP issuers must also meet member self-reported language data collection requirements.
  - Quality of care disparities reduction interventions are required of all health plans and are tied to performance guarantees.
  - NCQA Health Equity Accreditation (previously Multicultural Health Care Distinction) must be obtained.
- This report includes administrative quality measures stratified by race and ethnicity at the QHP level.
- Additionally, this report contains administrative quality measures reported at the Covered California all-population level and stratified by more granular race and ethnicity categories.

Race and Ethnicity Stratification Mapping

Covered California Race and Ethnicity Categories	Office of Management and Budget	Enrollee Selection [CalHEERS]	Covered California Plan Performance Report Cohort
Responses for ethnicity	Hispanic or Latino	*Hispanic or Latino Indicator* – Yes Cuban Guatemalan Mexican/Mexican American/Chicano Other Hispanic, Latino, or Spanish Origin Puerto Rican Salvadoran	Hispanic or Latino
Responses for race	American Indian or Alaska Native	American Indian or Alaska Native	American Indian or Alaska Native
	Asian American	Asian American Indian Cambodian Chinese Filipino Hmong Japanese Korean Laotian Other Asian American Vietnamese	Asian American
	Black or African American	Black or African American	Black or African American
	Native Hawaiian or Other Pacific Islander (NHOPI)	Native Hawaiian Samoan Guamanian or Chamorro Other Pacific Islander	Native Hawaiian or Other Pacific Islander (NHOPI)
	White	White	White
	Other	Other	Other
Multiple responses for race		Multiple (more than one race selected)	Multi-Racial
No response for race [or ethnicity]		Null (no response)	Non-Respondent

Additional Stratifications Background

- Covered California collects information on members' income level, geographic location, language preference, and race/ethnicity as part of the member enrollment application whose data is stored in CalHEERS.
- This report uses information to perform additional stratifications at the All-Population level by:
  - Race/ethnicity
  - Asian American subpopulation and Hispanic/Latino subpopulation
  - Income / Federal Poverty Level (FPL)
  - Preferred spoken language
  - Rural versus urban location
- Race and ethnicity stratification was analyzed at OMB categories, with further disaggregation for Asian American and Hispanic groups.
- To stratify members by Income/FPL range, population-level scores are stratified into seven FPL ranges plus an unsubsidized category based on reported income and FPL percentage.
- Members were stratified by their reported preferred spoken language into 15 categories.
- To stratify members by rural versus urban, we used members' zip code as mapped by CMS.[1]

Outliers Assessment

- Throughout this report, we have highlighted outliers in performance across various metrics and stratifications.
- We performed statistical analysis using the following methodologies:
  - Z score: For measures and stratifications that contained large and normally distributed data, Z scores were calculated to identify outliers more than 3 standard deviations from the mean.
  - Interquartile Range: For all other metrics, outliers were detected using the IQR, marking values beyond 1.5*IQR from the quartiles. IQR is a statistical method that accounts for low volumes.
- In each measure summary slide, we've noted statistically significant outliers across stratifications. In slides featuring data tables, we use bold red boxes to highlight significantly poor-performing data points, and a blue oval to indicate high performance. For measures where lower performance is preferable, red still signifies poor performance. Examples of these markings are provided in the slide deck below.

67%
63%
70%
68%

- For measures stratified into two groups (urban and rural), we applied a different methodology due to limitations of Z score and IQR unable to detect differences between only two groups. To flag disparities between urban and rural measure rates, we note where the percentage rate differences exceed 5% and instances where per 1000 rates diverged by more than 69 visits, thresholds were determined by identifying a clear gap, or discontinuity, in the distributions of the data, indicating extreme values.

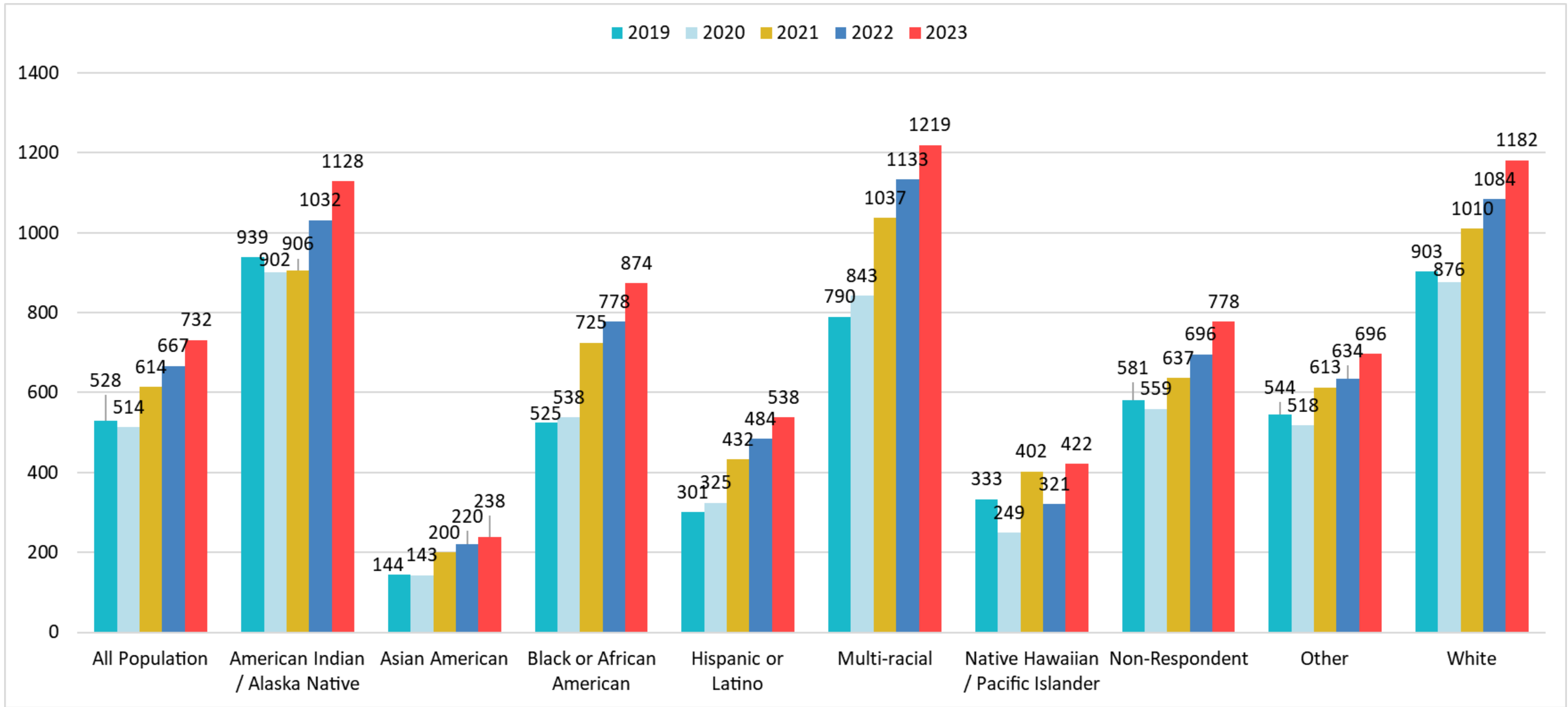
Using the Report

- This report is divided into two sections:
  - The first section contains results at the All-Covered California population level.
  - The second section contains results specific to Qualified Health Plan performance on each measure.
- The first section of this report, at the All-Covered California population level, features administrative measures with multiple stratifications as described in previous slides, including by race/ethnicity, Asian American and Hispanic/Latino subpopulations, spoken language, income/FPL ranges, and rural vs urban.
  - Note: The 'Unsubsidized' category within the income/FPL stratification encompasses a diverse set of members and a multitude of factors contribute to this category's rates for each measure.
- The second section of this report, at the QHP level, features administrative measures, some of which are stratified by race/ethnicity.
- Each section of the report contains:
  - A summary slide(s) with Key Findings described.
  - A set of visuals that highlight measures of interest or notable trends over time.
  - Several slides thereafter with data tables. Throughout these slides, there is additional description as well as notation of where statistically significant outliers were detected using the methods described previously.
- Citation sources throughout the report may be found on the final slide of this report.

HEI

ALL POPULATION PERFORMANCE

Behavioral Health Visits per 1,000 Members by Race/Ethnicity



COVERED CALIFORNIA

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ALL POPULATION PERFORMANCE

Behavioral Health Visits per 1,000 Members by Subpopulation

Race	2019	2020	2021	2022	2023
All Asian American Population	**144**	**143**	**200**	**220**	**238**
Asian Indian	184	189	249	243	281
Cambodian	86	99	178	236	188
Chinese	128	122	156	167	174
Filipino	185	197	292	344	406
Hmong	83	92	155	95	120
Japanese	266	245	378	421	462
Korean	161	147	206	244	250
Laotian	81	92	151	161	150
Mixed Race	287	307	450	581	690
Other Asian American	134	161	231	273	293
Vietnamese	78	85	140	152	164

Ethnicity	2019	2020	2021	2022	2023
All Hispanic/Latino Population	**301**	**325**	**432**	**484**	**538**
Guatemalan	215	250	379	457	500
Mexican/Mexican American/Chicano	258	273	377	433	489
Other	370	421	542	583	633
Puerto Rican	606	725	925	1108	1172
Salvadorian	199	268	335	356	421
Cuban	625	978	942	1269	1225

COVERED CALIFORNIA

Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.

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ALL POPULATION PERFORMANCE

Behavioral Health Visits per 1,000 Members with Other Stratifications

Language	2019	2020	2021	2022	2023
All Population	**528**	**514**	**614**	**667**	**732**
Arabic	45	30	80	115	176
Armenian	137	78	87	87	154
Cambodian	53	47	17	57	65
Cantonese	47	50	63	65	54
English	650	628	742	800	877
Hindi					70
Farsi	298	352	374	496	439
Hmong					65
Korean	44	43	55	62	43
Mandarin	48	41	56	57	55
Punjabi			200	298	131
Russian	143	133	131	114	110
Spanish	88	88	102	106	108
Tagalog	31	38	48	85	90
Vietnamese	24	23	46	47	39

Income	2019	2020	2021	2022	2023
All Population	**528**	**514**	**614**	**667**	**732**
0 to ≤138	743	707	813	773	773
>138 to <150	688	643	739	777	871
≥150 to <200	525	532	635	698	730
≥200 to <250	403	409	481	539	589
≥250 to <400	410	401	484	550	628
≥400	4268	534	622	711	799
Unsubsidized	677	691	843	973	1053

Geography	2019	2020	2021	2022	2023
All Population	**528**	**514**	**614**	**667**	**732**
Rural	395	399	428	474	504
Urban	535	519	624	677	745

Values marked as low rate outliers, based on z-scores or Interquartile Range, are identified with a red box. High rate outliers are identified with a blue circle.
Blank cells are suppressed data due to counts too low to report.
Some notably high values were not highlighted due to a low denominator, affecting their reliability.

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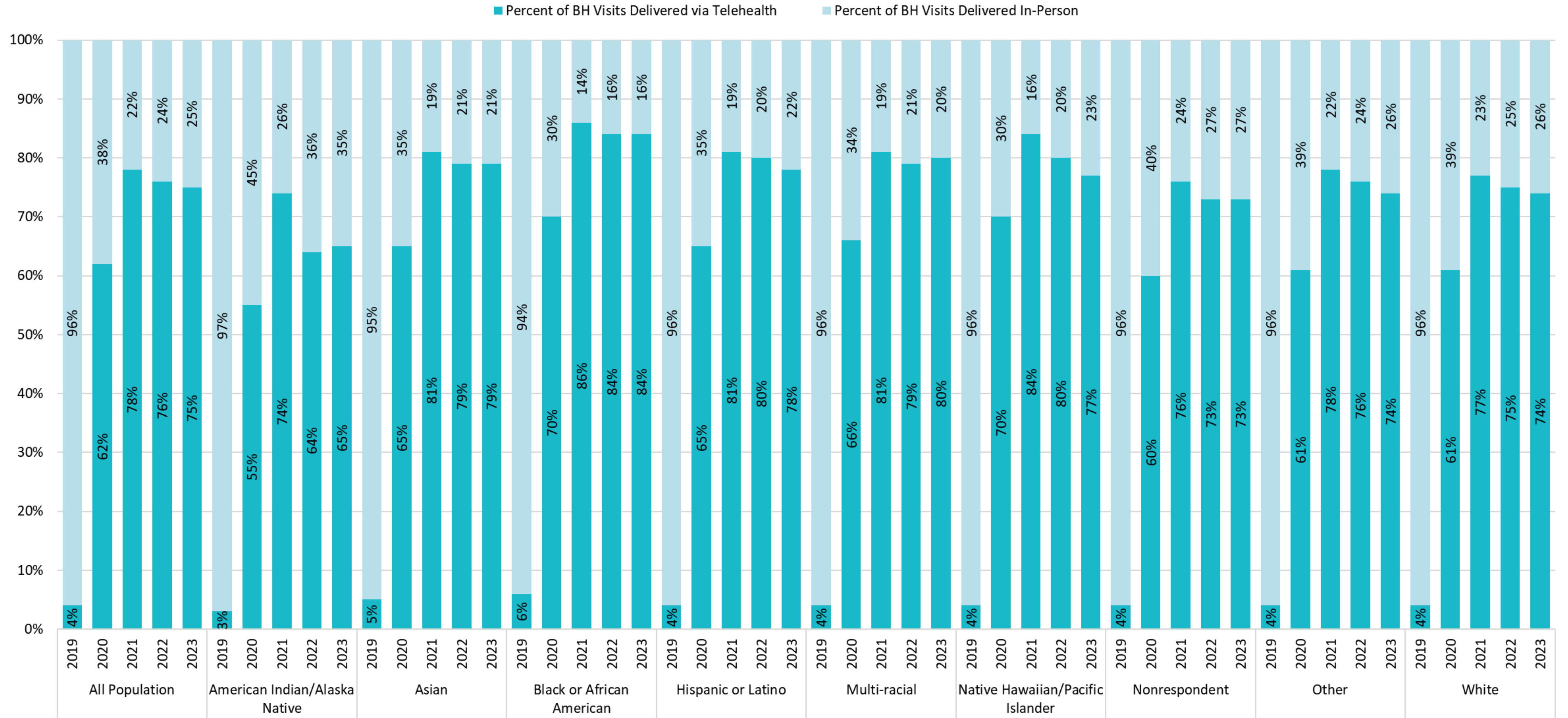
ALL POPULATION PERFORMANCE

Behavioral Health Care Through Telehealth by Race/Ethnicity



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ALL POPULATION PERFORMANCE

Behavioral Health Care Through Telehealth by Race/Ethnicity

Race/Ethnicity	2019	2020	2021	2022	2023
All Population	**4%**	**62%**	**78%**	**76%**	**75%**
American Indian / Alaska Native	3%	55%	74%	64%	65%
Asian American	5%	65%	81%	79%	79%
Black or African American	6%	70%	86%	84%	84%
Hispanic or Latino	4%	65%	81%	80%	78%
Multi-racial	4%	66%	81%	79%	80%
Native Hawaiian / Pacific Islander	4%	70%	84%	80%	77%
Non-Respondent	4%	60%	76%	73%	73%
Other	4%	61%	78%	76%	74%
White	4%	61%	77%	75%	74%

COVERED CALIFORNIA

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