Volume 5 of 5
Medi-Cal Specialty Mental Health Services External Quality Review Technical Report

Contract Year 2024–25

Alternative Access Standards Reporting

California Department of Health Care Services

April 2026

HSAG HEALTH SERVICES ADVISORY GROUP

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Table of Contents

Table of Tables

Mental Health Plan Name Abbreviations

Health Services Advisory Group, Inc. (HSAG) uses the following abbreviated Medi-Cal Mental Health Plan (referred to as "MHP" or "plan") names in this volume.

- **Alameda**—Alameda County Behavioral Health Care Systems
- **Alpine**—Alpine County Behavioral Health Services
- **Amador**—Amador County Behavioral Health
- **Butte**—Butte County Department of Behavioral Health Services
- **Calaveras**—Calaveras County Behavioral Health Services
- **Colusa**—Colusa County Department of Behavioral Health
- **Contra Costa**—Contra Costa County Mental Health
- **Del Norte**—Del Norte County Department of Health and Human Services
- **El Dorado**—El Dorado County Health & Human Services Agency
- **Fresno**—Fresno County Department of Behavioral Health
- **Glenn**—Glenn County Behavioral Health
- **Humboldt**—Humboldt County Health and Human Services
- **Imperial**—Imperial County Behavioral Health Services
- **Inyo**—Inyo County Health & Human Services Behavioral Health
- **Kern**—Kern County Behavioral Health and Recovery Services
- **Kings**—Kings County Behavioral Health
- **Lake**—Lake County Behavioral Health Services Department
- **Lassen**—Lassen County Health and Social Services
- **Los Angeles**—Los Angeles County Department of Mental Health
- **Madera**—Madera County Behavioral Health Services
- **Marin**—Marin County Behavioral Health and Recovery Services
- **Mariposa**—Mariposa County Human Services, Behavioral Health & Recovery Services Division
- **Mendocino**—Mendocino County Mental Health
- **Merced**—Merced County Behavioral Health and Recovery Services
- **Modoc**—Modoc County Behavioral Health Services
- **Mono**—Mono County Behavioral Health
- **Monterey**—Monterey County Behavioral Health
- **Napa**—Napa County Health and Human Services Agency
- **Nevada**—Nevada County Behavioral Health
- **Orange**—Orange County Behavioral Health Services

- **Placer**—County of Placer, Department of Health and Human Services
- **Plumas**—Plumas County Mental Health Services
- **Riverside**—Riverside County Mental Health Services
- **Sacramento**—Sacramento County Behavioral Health Services
- **San Benito**—San Benito County Behavioral Health
- **San Bernardino**—San Bernardino County Department of Behavioral Health
- **San Diego**—San Diego County Behavioral Health Division
- **San Francisco**—San Francisco Community Behavioral Health Services
- **San Joaquin**—San Joaquin Behavioral Health Services
- **San Luis Obispo**—San Luis Obispo County Behavioral Health Department
- **San Mateo**—San Mateo County Behavioral Health and Recovery Services
- **Santa Barbara**—Santa Barbara Department of Behavioral Wellness
- **Santa Clara**—Santa Clara County Behavioral Health Services Department
- **Santa Cruz**—County of Santa Cruz Health Services Agency
- **Shasta**—Shasta County Behavioral Health
- **Siskiyou**—Siskiyou Behavioral Health Division
- **Solano**—Solano County Health & Social Services
- **Sonoma**—County of Sonoma
- **Stanislaus**—Stanislaus County Behavioral Health & Recovery Services
- **Sutter/Yuba**—Sutter-Yuba Behavioral Health Services
- **Tehama**—Tehama County Health Services Agency
- **Trinity**—Trinity County Behavioral Health Services
- **Tulare**—Tulare County Health & Human Services Agency
- **Tuolumne**—Tuolumne County Behavioral Health Department
- **Ventura**—Ventura County Behavioral Health
- **Yolo**—Yolo County Health & Human Services Agency

Commonly Used Abbreviations and Acronyms

Following is a list of abbreviations and acronyms used throughout this volume.

- **AAS**—Alternative Access Standards
- **BHIN**—Behavioral Health Information Notice
- **CalAIM**—California Advancing and Innovating Medi-Cal
- **CAP**—corrective action plan
- **CA WIC**—California Welfare and Institutions Code
- **CMS**—Centers for Medicare & Medicaid Services
- **DHCS**—California Department of Health Care Services
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **HSAG**—Health Services Advisory Group, Inc.
- **MHP**—mental health plan
- **MOUs**—memoranda of understanding
- **NR**—not reported
- **SCA**—single case agreement
- **SFY**—State Fiscal Year

1. Introduction

Overview

The California Department of Health Care Services (DHCS) is responsible for the ongoing monitoring and oversight of its contracted Medi-Cal Mental Health Plans (MHPs), including the assurance that MHPs' provider networks are adequate to deliver services to Medi-Cal members. If an MHP is unable to meet provider network time or distance standards set by the State, the plan may submit an alternative access standards (AAS) request for specified provider scenarios (e.g., provider type, geographic area).

The DHCS Behavioral Health Information Notice (BHIN) 24-020[1] provides DHCS' clarifying guidance regarding network certification requirements, including time or distance AAS requests.

DHCS allows MHPs to offer telehealth services to members to meet time or distance standards, consistent with California Welfare and Institutions Code (CA WIC) section (§)14197(f)(1).[2] If at least 85 percent of members in an area have access to in-person care within usual standards and an MHP has telehealth services available in its network, the MHP may propose to come into compliance utilizing telehealth services. This 15 percent "telehealth allowance" permits MHPs to meet standards without having to submit an AAS request. Although DHCS permits MHPs to use telehealth to meet time or distance standards, these plans must meet the required standards while also facilitating in-person care for members who request it.

CA WIC §14197.05[3] requires DHCS to publish information related to MHPs' AAS requests. DHCS uses its annual external quality review (EQR) technical report to present this information. As such, DHCS requested its external quality review organization (EQRO), HSAG, to process and report on data related to AAS for provider networks. In addition, DHCS has asked HSAG to report on instances wherein MHPs have met time or distance standards using

[1] California Department of Health Care Services. Behavioral Health Information Notice 24-020. Available at: BHIN 2024 Network Certification Requirements for County Mental Health Plans and Drug Medi-Cal Organized Delivery Systems. Accessed on: Jan 14, 2026.

[2] California WIC §14197(f)(1). Available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=6.3. Accessed on: Jan 14, 2026.

[3] California WIC §14197.05. Available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.05. Accessed on: Jan 14, 2026.

a 15 percent telehealth allowance consistent with CA WIC §14197.05 on AAS requests. The measurement period for this study is August 1, 2024, through June 30, 2025.

Reporting Elements

The following reporting elements are defined by CA WIC §14197.05 for inclusion in the annual EQR technical report:

1. The number of requests for AAS in the plan service area for time or distance, categorized by all provider types, including specialists, and by adult and children/youth.[4]
2. The number of allowable exceptions for the appointment time standard, if known, categorized by all provider types, including specialists, and by adult and children/youth.
3. Distance and driving time between the nearest network provider and ZIP Code of the member farthest from that provider for requests for AAS.
4. The approximate number of members impacted by AAS.
5. Percentage of providers in the plan service area by provider and specialty type that are under a contract with a Medi-Cal MHP.
6. The number of requests for AAS approved or denied by ZIP Code and provider and specialty type, and the reasons for the approval or denial of the request for AAS.
7. The process of ensuring out-of-network access.
8. Descriptions of contracting efforts and explanation for why a contract was not executed.
9. Time frame for approval or denial of a request for AAS by DHCS.
10. Consumer complaints, if any.

[4] Adults are persons 21 years of age and over, and children/youth are persons 0–20 years of age.

2. Methodology

Data Sources

To compile information for each reporting element, HSAG used the following datasets and background information supplied by DHCS:

- Extracts from the database used by DHCS to store and organize AAS requests received from MHPs and DHCS' determinations (approvals and denials) regarding the disposition of those requests.
- Grievance data, including MHP name/county name and counts of grievances related to geographic access and other aspects of access to care. MHPs are required to submit appeals and grievances quarterly to DHCS under the terms of an agreement with the Centers for Medicare & Medicaid Services (CMS).[5]

Analysis

HSAG reviewed each data source for completeness and internal consistency. Reporting elements were computed as described under the Reporting Elements heading in Section 1 of this volume ("Introduction"), subject to the analytic considerations described below. A summary of results is presented in Section 4 of this volume ("Results"), detailed tables are presented in Section 5 ("Alternative Access Standards Tables"), and methodological details for each data element are presented in both sections.

Analytic Considerations

DHCS does not currently grant exceptions to the appointment wait time standard for MHPs; therefore, no data are reported for Reporting Element 2 (the number of allowable exceptions for the appointment time standard).

Reporting Element 5, the percentage of providers in the plan service area that are under contract with an MHP, requires a count of all providers practicing in each plan service area. HSAG and DHCS joined efforts but were unable to identify a data source for the denominator of Reporting Element 5, the total number of providers in the service area. DHCS agreed that

[5] California Department of Health Care Services. BHIN 23-062. Available at: BHIN 23-062 1915(b) Quarterly Appeal and Grievance Report Requirements.pdf. Accessed on: Feb 19, 2026.

HSAG would not include Reporting Element 5 in the 2024–25 EQR technical report volume and that DHCS and HSAG will explore data source options for future AAS reporting.

Reporting Element 10 relates to consumer complaints. For this report volume, the terms "consumer complaints" and "member grievances" are used interchangeably. The data used in reporting were member expressions of dissatisfaction with provider or plan services collected by MHPs and submitted quarterly to DHCS on multiple categories of grievances. The category presented in this report is "Access to care/services from plan or provider," which includes "complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues," and is limited to "grievances resolved during the reporting period that were filed for a reason related to access to care." Note that some of the grievances counted may be beyond the scope of this report, including complaints about timely access.

In addition to reporting elements defined in CA WIC §14197.05, HSAG reports on telehealth when it is used in lieu of in-person care to meet network adequacy standards. If any submitted AAS requests had indicated that telehealth coverage would be applied to compensate for deficiencies in the availability of in-person care, those requests would have been presented in this volume. No such requests were submitted in State Fiscal Year (SFY) 2024–25 (i.e., July 1, 2024, through June 30, 2025).

3. Results

This section contains a summary of results. Full details for the quantitative reporting elements (i.e., all available reporting elements except Reasons for Approval or Denial of Alternative Access Standards Requests, Process of Ensuring Out-of-Network Access, and Contracting Efforts) may be found in Section 5 of this volume ("Alternative Access Standards Tables").

Alternative Access Standards Requests, Approvals, and Denials

For this summary of results, HSAG tabulated the number of requests, approvals, and denials for all plans combined.

Alpine submitted four AAS requests in SFY 2024–25. All were denied. No other MHPs submitted requests. All requests were for psychiatry services; two were for adults and two were for children/youth.

A complete tabulation of requests submitted, including approval and denial status, are presented in Section 5 of this volume ("Alternative Access Standards Tables").

Reasons for the Approval or Denial of Alternative Access Standards Requests

DHCS typically requires, as part of the process of developing an AAS request, that MHPs identify the name and location of the nearest in-network provider outside the time/distance standard, as well as the names and locations of the two nearest out-of-network providers.[6] MHPs are also typically required to demonstrate that they have attempted to contract with the identified out-of-network providers if they are closer to affected members than the identified in-network provider. (See additional information under the Contracting Efforts heading in this section of the volume.) DHCS approvals and denials relate to the appropriateness and completeness of AAS requests, the MHPs' selection of providers, and the MHPs' documented

[6] See instructions in BHIN 24-020, Attachment C. Available on request from DHCS; see 2024 Behavioral Health Information Notices. Accessed on: Jan 14, 2026. Additionally, DHCS recognizes certain circumstances where it is unnecessary for an MHP to identify in-network and/or out-of-network providers in an AAS request. For example, if a plan does not have any in-network providers, it can indicate this when submitting AAS requests. Similarly, if a plan has multiple in-network providers that are closer in time or distance than any available out-of-network providers, the plan is not required to report out-of-network providers.

contracting efforts. All MHP AAS requests submitted in SFY 2024–25 were denied; but, according to SFY 2024–25 data and information provided by DHCS, the most common reasons for approval or denial of an AAS request include the following:

- **Approval reasons** (more than one may apply to a single request). The plan:
  - Demonstrated that it was contracted with a provider that resolved the identified network deficiency.
  - Showed that while a network deficiency continued to exist, the plan was contracted with the closest provider.
  - Provided evidence that it had exhausted all in-network and out-of-network options that would have brought the plan into compliance with DHCS standards prior to proposing a new standard.
  - Proposed new time and distance standards that are reasonable for a member to travel.
  - Identified first and second out-of-network providers and agreed to enter into a single case agreement (SCA) with an out-of-network provider.
  - Agreed to coordinate transportation for members requesting in-person appointments.
  - Provided sufficient justification on its inability to contract with out-of-network providers.

- **Denial reasons** (more than one may apply to a single request). The plan did not:
  - Provide sufficient evidence or sufficient details demonstrating why the plan could not meet standards with its current network.
  - Include detailed information in the list of contracted providers regarding the nearest in-network provider named in the plan's AAS request.
  - Submit a complete list of contracted providers including all service types provided and age groups served.
  - Ensure that each in-network provider included in an AAS request was among the providers in the plan’s provider list delivering the service type and/or serving the age group required for the AAS request.
  - Include the name of or other information on a provider the plan proposed to contract with or enter into an SCA with as an AAS.
  - Provide information or sufficient details on what the plan would do when an impacted member presented with a need for services.
  - Identify two out-of-network providers or propose new time and distance standards.
  - Propose time and distance standards that are reasonable for member travel.
  - Provide information on coordination of transportation for in-person service requests.

Distance and Driving Time Between Nearest In-Network Provider and Farthest Member

When an MHP submits an AAS request, it is required to report the distance and drive time between the nearest in-network provider and the member farthest from that provider within the impacted service area (ZIP Code).[7] The distance and drive time are indicators of the hardships faced by impacted members if the network deficiency is not addressed. In addition, DHCS computes the number of members impacted by the network deficiency. For this section, HSAG summarized the reported distances, drive times, and number of members impacted in submitted AAS requests by computing the shortest and longest driving times, distances, and the smallest and largest number of impacted members across all requests.

Across the four requests from Alpine, the shortest driving distance was 42 miles for the two requests submitted for ZIP Code 96120. The longest driving distance was 108 miles for ZIP Code 95223. Only one driving time was submitted across the four requests, which was 116 minutes for the two AAS requests submitted for ZIP Code 95223.

For both adults and youth, ZIP Code 95223 had the smallest number of impacted members, and ZIP Code 96120 had the largest number of members impacted.

Of the four AAS requests submitted by Alpine, two (50.0 percent) of those requests did not have information on driving time.

A complete tabulation of AAS requests submitted, including driving distance, driving time, and number of impacted members is presented in Section 5 of this volume ("Alternative Access Standards Tables").

Time Frame for Approval or Denial of Requests

In accordance with CA WIC §14197(f)(4), DHCS must approve or deny an AAS request within 90 days of submission. DHCS may stop the 90-day review time frame on one or more occasions as necessary if an incomplete MHP submission is received or if additional information is needed from the MHP. Upon submission of the additional information to DHCS, the 90-day time frame would resume at the same point in time it was previously stopped, unless fewer than 30 days remain. In these instances, DHCS must approve or deny the AAS request within 30 days of submission of the additional information.

For each request, HSAG calculated the number of days between the date the MHP submitted the AAS request and the date DHCS made the decision to approve or deny the request. Please note that days when DHCS paused its review awaiting further information from the plan

[7] This is operationalized in the instructions for BHIN 24-020, Attachment C, as the driving distance or time "between the identified nearest in-network provider and the ZIP Code border."

are not excluded from this count, so the number of days can exceed 90 without indicating that DHCS failed to meet the 90-day standard. After calculating the number of days to approve or deny each request, HSAG calculated the median number of days to approve or deny each MHP, the median across MHPs (i.e., the median of the MHP medians), and the range of medians across MHPs.

For Alpine's requests submitted in SFY 2024–25, the median number of days to approval or denial was 69 days. All AAS requests took the same amount of time for a decision from DHCS.

Detailed results for the analysis of the time between an AAS request and approval or denial are presented in Section 5 of this volume ("Alternative Access Standards Tables").

Consumer Complaints

In this report volume, the terms "consumer complaints" and "member grievances" are used interchangeably. DHCS provided HSAG with quarterly counts of grievances related to access to provider and plan services for SFY 2024–25. MHPs are required to collect complaints expressed by members either orally or in writing and submit them to DHCS along with information on how the grievances were addressed.

In total, 426 complaints were received across four quarters by MHPs and reported to DHCS. Among the 36 MHPs that received any complaints, the Calaveras, El Dorado, Glenn, Humboldt, Imperial, Kings, and Solano MHPs received the fewest, while the Kern MHP received the most.

Complete counts of consumer complaints by MHP and quarter are presented in Section 5 of this volume ("Alternative Access Standards Tables").

Process of Ensuring Out-of-Network Access

MHPs must facilitate access to adequate and timely out-of-network care if their network is unable to provide medically necessary covered services with a contracted provider.[8,9] If the nearest out-of-network provider is not within time or distance standards, MHPs may provide the option of telehealth services. If those are not available or the member declines the telehealth option, plans must ensure that transportation is available for access to out-of-network providers. Additionally, MHPs must provide for the completion of covered services by a terminated or out-of-network provider at the request of a member in accordance with the

[8] California Department of Health Care Services. BHIN 24-020. Available at: BHIN 2024 Network Certification Requirements for County Mental Health Plans and Drug Medi-Cal Organized Delivery Systems. Accessed on: Jan 14, 2026.

[9] California Department of Health Care Services. BHIN 21-008. Available at BHIN 21 008 Federal Out-of-Network Requirements for Mental Health Plans. Accessed on: Jan 14, 2026.

continuity of care requirements in the California Health and Safety Code §1373.96. Furthermore, MHPs that fail to meet time or distance standards must ensure subcontractors and delegated entities adhere to the out-of-network access requirements, submit a policy or procedure to ensure there is a consistent process for out-of-network access compliance, and demonstrate their ability to effectively provide information about out-of-network access to members.

Contracting Efforts

Except when the nearest in-network provider is closer to members than any identified out-of-network providers, MHPs submitting AAS requests are required to document their attempts to contract with the two closest out-of-network providers and, when the efforts are unsuccessful, to provide a justification for not contracting.

HSAG reviewed data supplied by Alpine on its contracting efforts for SFY 2024–25. Alpine indicated that it was in the process of negotiating or finalizing memoranda of understanding (MOUs) with one or more providers to provide services to impacted members.

4. Conclusions and a Consideration

Conclusions

Only a single plan—Alpine—submitted AAS requests for SFY 2024–25 to address provider network deficiencies identified by DHCS' time and distance analyses. Findings from the MHP requests and DHCS determinations include the following:

- Alpine submitted four requests, and all were denied. All requests were for psychiatry services; two were for adults and two were for children/youth.
- DHCS indicated that Alpine's AAS requests were denied because the MHP did not provide sufficient details on its network deficiencies and its plans to address the deficiencies.
- Alpine indicated that it was in the process of addressing the deficiencies by negotiating MOUs with one or more providers.
- The median number of days between the submission of an AAS request and the delivery of an approval or denial by DHCS was 69 days. Note that in accordance with CA WIC §14197(f)(4), DHCS must approve or deny an AAS request within 90 days of submission.
- All MHPs were required to report a count of member grievances concerning access-related issues. MHPs received 426 complaints in total.

A Consideration

- DHCS agreed that HSAG would not include Reporting Element 5 (the percentage of providers in the plan service area that are under a contract with a Medi-Cal MHP) in the 2024–25 EQR technical report volume because it requires a count of all providers practicing in each plan service area, and DHCS and HSAG are not currently aware of a suitable source for that information. HSAG suggests that DHCS investigate whether any other State departments or internal DHCS units have access to relevant data.

5. Alternative Access Standards Tables

The tables in this section present key reporting elements defined in CA WIC §14197.05 regarding AAS requests for provider networks.

Table 5.1 and Table 5.2—Reporting Elements 1, 3, 4, and 6

Table 5.1 and Table 5.2 present all submitted AAS requests for the age group served (adults or children/youth, respectively) for plans by plan/county, ZIP Code, and service type. Table 5.1 is limited to AAS requests for providers serving adults. For each request, the table includes the distance in miles and drive time in minutes between the nearest in-network provider and the member farthest from that provider within the specified ZIP Code, as well as the estimated number of members impacted by the network deficiency and the request's approval status. Table 5.2 has the same structure as Table 5.1 but is limited to requests for providers serving children/youth. Requests were submitted to DHCS during the measurement period of August 1, 2024, through June 30, 2025.

Note the following regarding Table 5.1 and Table 5.2:

- Adults are persons 21 years of age and older. Children/youth are persons 0–20 years of age.
- Final dispositions listed as "Approval" in the DHCS data are reported as "Approved"; and final dispositions listed as "Denial" in the DHCS data are reported as "Denied."
- S = HSAG suppressed the Number of Members Impacted to satisfy the DHCS Data De-identification Guidelines (DDG) v3.0 de-identification standard.[10]
- NR = not reported.

[10] Please see the following regarding DHCS statistical disclosure control procedures: California Department of Health Care Services. November 13, 2025. Available at: DHCS Data De-Identification Guidelines (DDG). Accessed on: Mar 16, 2026.

Table 5.1—Driving Distance, Driving Time, Number of Members Impacted, and Final Disposition for Adult Services in Alternative Access Standards Requests by MHP, ZIP Code, and Service Type

Plan/County	ZIP Code	Service Type	Driving Distance (mi)	Driving Time (min)	Number of Members Impacted	Final Disposition (Approved or Denied)
Alpine	95223	Psychiatry	108	116	S	Denied
Alpine	96120	Psychiatry	42	NR	S	Denied

Table 5.2—Driving Distance, Driving Time, Number of Members Impacted, and Final Disposition for Children/Youth Services in Alternative Access Standards Requests by MHP, ZIP Code, and Service Type

Plan/County	ZIP Code	Service Type	Driving Distance (mi)	Driving Time (min)	Number of Members Impacted	Final Disposition (Approved or Denied)
Alpine	95223	Psychiatry	108	116	S	Denied
Alpine	96120	Psychiatry	42	NR	S	Denied

Table 5.3—Reporting Element 9

Table 5.3 presents the number of AAS requests submitted and the median number of days between the submission of an AAS request and the delivery of an approval or denial by DHCS for each MHP that submitted AAS requests between August 1, 2024, and June 30, 2025.

In accordance with CA WIC §14197(e)(3), DHCS must approve or deny an AAS request within 90 days of the initial submission. DHCS may stop the 90-day review time frame on one or more occasions as necessary if an incomplete submission is received or if additional information is needed from the MHP. During this time, the 90-day review window is paused until DHCS receives the updated submission, and these days are not counted as a review day. Upon submission of the additional information to DHCS, the 90-day time frame would resume at the same point in time it was previously stopped, unless fewer than 30 days remain. In these instances, DHCS must approve or deny the AAS request within 30 days of submission of the additional information.

Note the following regarding Table 5.3:

- Days when DHCS paused its review awaiting further information from a plan are not excluded from this count, so the number of days can exceed 90 without indicating that DHCS failed to meet the 90-day standard.

Table 5.3—Time Frame for DHCS Approval or Denial of Alternative Access Standards Requests, by MHP

Plan	Number of Requests	Median Days
Alpine	4	69

Table 5.4—Reporting Element 10—Grievances

Table 5.4 summarizes counts of consumer complaints related to access to providers that were collected in DHCS' quarterly grievance reports from SFY 2024 Quarter 3 through SFY 2025 Quarter 2 (i.e., January 1, 2024, through December 31, 2024). Each MHP is required to collect complaints from members and report them quarterly to DHCS using a standardized grievance reporting tool. Grievance collection methods may include but are not limited to telephone calls, logs, letters, emails, verbal/in person, or complaint forms.

Note the following regarding Table 5.4:

- The table includes grievances submitted by plans in the category "Access to care/services from plan or provider."
- A dash (—) indicates no grievances were reported by the plan.

Table 5.4—Consumer Complaints to MHPs Regarding Access to Care, by MHP and County

		Number of Complaints				
MHP	County	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Total
Alameda	Alameda	—	—	1	1	2
Alpine	Alpine	—	—	—	—	0
Amador	Amador	—	—	—	—	0
Butte	Butte	—	1	1	1	3
Calaveras	Calaveras	—	1	—	—	1
Colusa	Colusa	—	—	—	—	0
Contra Costa	Contra Costa	6	3	1	2	12
Del Norte	Del Norte	—	—	—	—	0
El Dorado	El Dorado	—	1	—	—	1
Fresno	Fresno	2	3	3	1	9
Glenn	Glenn	—	—	1	—	1
Humboldt	Humboldt	—	—	—	1	1
Imperial	Imperial	—	1	—	—	1
Inyo	Inyo	—	—	—	—	0
Kern	Kern	17	21	41	50	129
Kings	Kings	1	—	—	—	1

		Number of Complaints				
MHP	County	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Total
Lake	Lake	4	2	1	1	8
Lassen	Lassen	—	—	—	—	0
Los Angeles	Los Angeles	—	16	30	10	56
Madera	Madera	—	—	—	—	0
Marin	Marin	—	—	—	—	0
Mariposa	Mariposa	1	1	—	2	4
Mendocino	Mendocino	—	—	—	—	0
Merced	Merced	2	—	2	3	7
Modoc	Modoc	—	—	—	—	0
Mono	Mono	—	—	—	—	0
Monterey	Monterey	—	—	3	—	3
Napa	Napa	—	—	—	—	0
Nevada	Nevada	—	—	—	—	0
Orange	Orange	10	8	9	10	37
Placer	Placer/Sierra	—	—	—	—	0
Plumas	Plumas	—	—	—	—	0
Riverside	Riverside	1	1	4	4	10
Sacramento	Sacramento	—	—	2	1	3
San Benito	San Benito	—	—	—	—	0
San Bernardino	San Bernardino	3	3	5	18	29
San Diego	San Diego	2	3	3	5	13
San Francisco	San Francisco	3	2	—	—	5
San Joaquin	San Joaquin	5	1	1	2	9
San Luis Obispo	San Luis Obispo	—	—	1	2	3
San Mateo	San Mateo	2	2	2	2	8
Santa Barbara	Santa Barbara	—	2	1	2	5
Santa Clara	Santa Clara	1	4	6	8	19
Santa Cruz	Santa Cruz	—	—	—	—	0
Shasta	Shasta	1	—	1	2	4

		Number of Complaints				
MHP	County	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Total
Siskiyou	Siskiyou	—	—	—	—	0
Solano	Solano	1	—	—	—	1
Sonoma	Sonoma	—	1	1	2	4
Stanislaus	Stanislaus	1	—	2	—	3
Sutter/Yuba	Sutter/Yuba	1	—	—	1	2
Tehama	Tehama	—	—	—	—	0
Trinity	Trinity	—	—	—	—	0
Tulare	Tulare	—	—	2	5	7
Tuolumne	Tuolumne	—	—	—	2	2
Ventura	Ventura	3	2	—	3	8
Yolo	Yolo	2	2	—	11	15