Central California Alliance for Health

Year 2024

Quality Improvement (QI) Program Annual Evaluation

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1. Executive Summary

1.1. Overall Effectiveness of the QI Program

1.1.1. 2024 Accomplishments

The 2024 Quality Improvement (QI) Program at CCAH has demonstrated a strong commitment to enhancing the quality of care and achieving health equity. Here's a breakdown of its components and effectiveness:

1.1.2. Achievements and Strategies

- **Effective Work Plan Utilization:** The 2024 QI Work Plan was instrumental in tracking and reporting on organization-wide goals. This comprehensive approach ensured that the quality initiatives were well-defined and impactful across all areas.
- **Leadership and Physician Engagement:** Leadership, along with network physicians, actively participated in relevant committee meetings, offering valuable recommendations and insights. This collaboration was crucial in identifying barriers and finding opportunities for improvement.
- **Provider Grant Program/Provider Partnership program:** The grant program played a significant role in enhancing quality scores. It focused on innovative member engagement and interventions, aiming to deliver high-quality care. Providers were given funding to support member engagement activities.
- **Joint Operation Meetings (JOMs):** Regular JOMs with key provider groups helped to strengthen provider engagement in quality improvement initiatives. These meetings facilitated better collaboration and shared strategies for improvement. Clinic Joint Operation (cJOC) meetings and Joint Operation Committee (JOC) meetings with Hospitals are scheduled quarterly.
- **Advocacy for Increased Commitment:** Leadership advocated for a greater organization-wide focus on quality improvement. This included increasing collaboration with providers and driving member-centric engagement efforts by increasing outreach and incentives for both groups.
- **Continuous Quality Improvement Activities:** In 2024, there were several plans and activities aimed at improving:
    - **Member Access and Engagement:** Ensuring members could easily access and engage with care by maintaining a robust network of practitioners and providers.
    - **Member Experience:** Enhancing the overall experience of members through various initiatives (i.e., Outreach, incentive programs, member education, etc.).
    - **Systems and Reporting Enhancements:** Upgrading existing systems to support better care for members through case management and population health (i.e., use of gap in care reports).
    - **Data Analytics:** Leveraging advanced data analytics to drive improvements.

1.1.2.1. Key functional Areas:

- ***Quality Improvement and Health Equity Transformation Program (QIHETP) and Culturally and Linguistically Appropriate Services (CLAS) Program*** – Both systems reporting requirements under DHCS and NCQA Accreditation are combined into a singular report for evaluation purposes.
- ***Consumer Assessment of Healthcare Providers and Systems (CAHPS)*** – In 2024, CCAH improved to meet 13 goals in either composites or measures compared to 2023 rates. Over 80% of

respondents reported that they received care quickly and over 85% of respondents gave favorable reviews of their doctor.

  - *Double Digit (10% or greater) Increases* - One measure and one composite saw a significant increase from 2022. "Getting Care Quickly" increased from 73.4% (2022) to 82.4% in 2024 as well as the composites submeasure of getting urgent care which improved from 74.5% (2022) to 88.8% in 2024.

- ***Utilization of Language Services*** - Strong utilization of language services across various functions within the organization for individual experiences, and high satisfaction rates among members. Continued monitoring and analysis will be essential in maintaining and improving the effectiveness of language services. Case Management was identified as the primary user of phone interpreting services, indicating a high need for language support in these areas, and the Member Services department, despite having a lower call volume, demonstrated the highest language diversity, highlighting a need for a wide range of linguistic support. Utilization Management showed moderate use, while departments such as Complaints, Grievances and Appeals, Population Health Management and Claims show minimal utilization, indicating potential underuse or lesser need for these services.
- ***Member Experiences of Language Services*** - The survey shows members' high satisfaction with in-person interpreting services among members, with the majority of respondents identified as Hispanic and prefer to communicate in Spanish. All respondents stated they would use the service again, with interpreting services contributing positively to the healthcare experience of the members.
- ***Staff Experiences of Language Services*** – Overall, staff were satisfied with both vendors and found the services helpful.
- ***Healthcare Effectiveness and Data Information Set (HEDIS)*** –CCAH evaluated 18 measures, totaling 54 individual goals across Merced County, Santa Cruz/Monterey County, and All Plan submissions. Out of these measures, 44 met their goals, and 10 did not. All measures submitted for MY2024 for "All Plan" rates to NCQA met their goals.
- ***Care-Based Incentive (CBI) Program*** – Improvement was made for 11 out of 18 measures taking into account Santa Cruz, Monterey, and Merced counties, as well as the total number of CBI groups with four or more measures below the 25th percentile decreased from the prior 2023 program year.
  - *Increased rates:* Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents, Application of Dental Fluoride Varnish, Developmental Screening in the First 3 Years, Breast Cancer Screening, Child and Adolescent Well-Care Visits (3-21), Immunizations: Adolescents, Immunizations: Children (Combo 10), Lead Screening in Children, and Well-Child Visit In The First 15 Months.
  - *Decreased rates:* Ambulatory Care Sensitive Conditions, Preventable Emergency Visits.

  Utilization of the Alliance's Provider Portal Data Submission Tool (DST), also showed positive benefit for providers in supplementing data not received through claims, with the highest submission for depression screening tools and results since the coding cannot be received through claims submissions.

- ***Reporting Stratified Measures***
  - *Member Experience Survey:* Most members of different races and ethnicities are satisfied with our services.
  - *HbA1c:* The hybrid data met the goal for HbA1c <8% and HbA1c >9%, while the admin data did not. The hybrid data successfully met the goal with Not Hispanic/Latino populations. Two or More Races, White and Asian members achieved the highest compliance rates and demonstrated effective diabetes management within these groups. Disparities persist among Hispanic or Latino populations as well as Black or African American and Native American populations who showed lower compliance

rates in the hybrid data. The health disparity analysis by gender also showed a consistent trend of females outperforming males across.

- *W30-6+*: The data shows significant disparities in well-child visit rates across different racial and ethnic groups as well as spoken languages. Spanish-speaking children, especially those identified as Not Hispanic/Latino, achieve the highest compliance rates. In contrast, Hmong-speaking children show the lowest rates across all racial and ethnic categories.
  WCV: Spanish-speaking members had higher well-care visit compliance rates than English-speaking members across all three counties, with Spanish and English as the two primary languages spoken by CCAH members. Compliance rates for Spanish-speaking members were 8 to 13 percentage points higher than those for English-speaking members.

- ***Clinical Safety***
  - *Facility Site Review (FSR):* The FSR program demonstrated operational resilience while navigating staffing transitions and provider-specific challenges. Although internal performance benchmarks were not consistently met across all quarters, the team maintained core functions by onboarding new staff, refining workflows, transitioning to Healthy Data Systems (HDS) for audit documentation, and advancing readiness for Medi-Cal Site Review Portal (MSRP) integration.
  - *Potential Quality Issues (PQI):* The PQI program consistently met its regulatory requirements in 2024 and showed progress in improving internal review workflows. The update to Policy 401-1301 was a key milestone that laid the groundwork for enhanced sustainability.
- ***Member Complaint and Appeal related to Access*** – CCAH met all five categories, including access and the total complaint rate per 1,000 member months. When reviewing trend data, CCAH identified an increase in complaints related to non-behavioral health services. The highest complaint rates were observed in the areas of attitude and service, as well as access to care. Despite this, the rate per 1,000 member months for these issues remains relatively low. CCAH will place further focus on these areas to address the increasing trend in complaints and appeals, which impact overall member satisfaction. This will also ensure that members can access care as quickly as needed.
- ***Access to Care*** – CCAH's assessment found that 98% of urgent care appointments for PCPs are available within 24 hours. This exceeds CCAH's performance target of 80%, which demonstrates that CCAH's network can and does accommodate its members' most pressing healthcare needs. Routine Care also exceeded the target of 80% at 97%, showing overall performance in urgent care and routine care was met for evaluating appointment availability.
- ***Geo-Access to Practitioners –*** CCAH met all geo-access drive and distance standards for all except for the eleven county and provider type combinations below:
  - Monterey County: Allergy/Immunology, Gastroenterology, Hematology, Hospitals, Neurosurgery, Oncology, Primary Care
  - Mariposa County: Hospitals
  - San Benito County: Hospitals, Primary Care
  - Mariposa County: Primary Care

  Attrition of existing providers has led to a shortage of providers in the service area. This has particularly impacted the geographically rural areas within Mariposa, Monterey, and San Benito counties. CCAH's contracting department has done a good job of contracting with a very high percentage of providers in the service area and this has helped the organization meet most of the goals.

- ***DHCS Population Health Management Strategy*** - The annual PHM Strategy submission, work with Local Health Jurisdiction, and NCQA Accreditation standards were met.
- ***Additional Activities: IHA & EPSDT Audits -*** There were many factors affecting various decreases in the IHA audit results for 2024. Due to the decreases, provider outreach was implemented to increase transparency and engagement with providers with a goal to increase better audit outcomes and communication. During the Q2 audit we saw 34% response rate from providers and in the Q4 audit we saw 74% provider engagement. During the outreach periods provider engagement and collaboration went well, resulting in missing elements being submitted, providers implementing new workflows for risk assessment implementation, individualized meetings and working together to fix gaps. Due to the successes of this outreach, this process will remain in place for all future audits.
- ***QIHETP and CLAS Program Initiatives*** – Highlights include expand CCAH's collaboration with Community Based Organizations, Increased member feedback, expanding the provider participation in the Provider Partnership Program, and increasing the focus on health equity and culturally and linguistically appropriate services

1.1.3. 2024 Opportunities

While CCAH is happy with its 2024 QI Program accomplishments, CCAH has a culture of continuous improvement. This requires the organization to self-evaluate and look critically at opportunities to improve (i) internal processes and (ii) quality of services provided to its members. Included below are selected highlights of focus areas for 2025.

- ***QIHETP and CLAS Program*** - CCAH will continue to monitor staffing resources supporting the QI program and may adjust staff as needed throughout 2024.
- ***CAHPS*** – The CAHPS member results reflect some of the ongoing challenges already highlighted in other sections of this document. Although the network has grown, there are still challenges in accessing care, and doctor's communication. In 2024,the Alliance staff worked to address access by expanding telehealth and offering medical grants for specific provider types to aid in recruiting additional practitioners and supporting medical assistants. In 2025, interdepartmental intervention planning will be key as we tackle doctor's communication as an organization through a newly developed Member Experience Committee.
- ***Utilization of Language Services*** - High usage of interpreting services in Spanish shows the need to prioritize the quality Spanish language support, while also ensuring adequate resources for other frequently used languages like Vietnamese and Arabic. Opportunities for targeted interventions were indicated for addressing concerns about wait times and interpreter quality. A significant proportion of calls were categorized under "Unknown Department," highlighting the need for improved data collection practices to ensure accurate and complete departmental data.
- ***Member Experiences of Language Services*** - Although there were 2 members that reported dissatisfaction, they shared in their feedback this was due to specific interpreter staff. The feedback suggests minor improvements in specific interpreters' professionalism and the way they interpreted information during the visit. Feeback was also shared about aligning member needs with interpreters scheduled. For example, when scheduling an ASL interpreter, the member shared it would be nice to have a person that aligns with the member's culture and preferences, as well as in some cases the gender of the interpreter can also have an impact on the comfort level of the member during the doctor visit as opportunities for improvement.
- ***Staff Experiences of Language Services*** – Opportunities included maintaining and potentially expanding Spanish language interpreting services to meet the high demand, addressing a few concerns about interpreter professionalism, and increasing access to Indigenous interpreters. Also identified was to continue engaging both internal and external stakeholders to monitor and identify areas for improvement and implement effective interventions to reduce health care inequities.

- ***HEDIS*** - In MY 2023, reporting year (RY) 2024, the identified priority measures for the Alliance included Childhood Immunization Status-Combination 10 (CIS-10), Immunizations for Adolescents-Combination 2 (IMA-2), Lead Screening in Children (LSC), Well-Child Visits in the First 30 Months of Life-15 to 30 Months—Two or More Well-Child Visits (W30-2), Well-Child Visits in the First 30 Months of Life-0 to 15 Months-Six or More Well-Child Visits (W30-6), and Chlamydia Screening in Women (CHL) in Merced County that were at or below minimum performance levels (MPLs) designated by DHCS. Key provider and member strategies included:
    - *Provider Strategies* - The Workforce Support for Care-Gap Closure grant, equipment reimbursement for point-of-care blood lead screenings, Provider Partnership Pilot Program, new forum for Merced County providers, updating CBI, continued
    - *Member Strategies* - Healthy Start Program promotion, member texting campaign, mobile mammography, health fair, CCAH staff partnering with stakeholders in Merced County on events.
- ***CBI*** – Year over year decreases in measures impacted Initial Health Appointment with the largest percentage loss of 17.06%, followed by minor decreased in Cervical Cancer Screening, Plan All-Cause Readmissions, and Post-Discharge Care, providing opportunities to review trending and opportunities for continued support with Members and Providers. Identified outreach for next year includes reaching out to Mariposa and San Benito providers for additional support.
- ***Reporting Stratified Measures***
    - *Member Experience Survey:* There is lower satisfaction rates specifically related to access to care among minority groups such as Asian, Native Hawaiian or Other Pacific Islander, and American Indian or Alaska Native members. This may be due to language barriers and geographic limitations in accessing care.
    - *HbA1c:* Implement targeted interventions aimed at improving engagement in diabetes management in both males and females, inclusive of community outreach programs, cultural education initiatives to promote health literacy, and support mechanisms to encourage adherence to treatment plans to reduce gender disparities and enhance overall health outcomes for members.
    - *W30-6+*: There are opportunities to develop interventions focusing on the differences across counties for racial and ethnic groups as well as spoken languages, particularly for Hmong-speaking children.
    - *WCV:* Identified opportunities included educating members about OMB category definitions to ensure accurate responses during data collection, and specificity of data for the White population, as well as strategize on ways to collect member information directly. Also identified were promotion of the care gap reports for providers.
- ***Clinical Safety***
    - *Facility Site Review (FSR):* Once fully staffed and the implementation of Healthy Data Systems (HDS) is completed, the team can improve internal performance metrics, expand review capacity, and enhance preparedness for upcoming regulatory audits.
    - *Potential Quality Issues (PQI):* Ongoing evaluation and resource planning will be essential to ensure timely case resolution and compliance, in addition to stabilize staffing. Opportunities exist for enhanced monitoring of audit findings, and alignment with organizational priorities, and balancing pressure on staff with competing expectations,
- ***Complaint and Appeal related to Access*** – CCAH will continue expanding its network by adding non-emergency medical transport vendors and telehealth services to improve access to care. We will enhance scheduling systems, gather patient feedback, and increase network capacity through partnerships with medical schools. CCAH will also offer grants to recruit providers and improve staff training in customer service. Additionally, we will revise policies for flexible scheduling and better communication to reduce confusion and improve member satisfaction.
- ***Access to Care***
    - *High-Volume Specialists (OB/GYN & Cardiology):* CCAH has an opportunity to improve access for urgent and routine care appointments for. CCAH set a goal of 80% for

urgent care appointments to be available within 96 hours of the initial request and for routine care of making appointments available within 15 business days. The OB/GYN specialty care appointment availability met the urgent care and routine care goal with a 100%, and 84% success rate. The Cardiology specialty care appointment availability goal was not met for either urgent care or routine care. The performance rate was relatively low at 43% for urgent care and 51% for routine care.

  - *Specialty Care Practitioner (SCP) Performance – High-Impact Specialists (Oncology):* Performance standards for either urgent care appointments or routine care appointments, indicating a gap in appointment availability for Oncology within the timeframe.
  - *Behavioral Healthcare Practitioner (BCP) Performance – Non-Prescriber: Non-Physician Mental Health (Licensed Clinical Social Worker and Psychologist):* CCAH did not meet the goal of 80% for appointment availability for urgent care and for the first appointment visit for routine care for both LCSWs and Psychologists. The data regarding non-life-threatening emergency appointment availability within 6 hours is NA because members can go to ER without referral or making appointment.

- ***Geo-Access to Practitioners*** – Geo-access standards were mostly met, and the member to provider ratio standards were met except Internists and Allergy/Immunology. CCAH seeks to continuously improve its network to provide more options for members to obtain care. CCAH will continue to recruit new providers, particularly focusing on rural areas, and offer medical capacity grants to fund specific required provider types.
- ***DHCS Population Health Management Strategy*** – The shared goals and objectives identified with the five counties serves as opportunities for focused improvements for the next year, as well as identified improvements in the NCQA population health management standards reports.
- ***Additional Activities: IHA & EPSDT Audits*** – Identified improvements for future audits include improving provider outreach by increasing engagement and updating materials to be more user friendly for providers, and provider news articles that highlight requirements including risk assessments and drug and alcohol screenings.

1.1.4. Conclusion

The 2024 QI Program was successful in aligning its components to support CCAH's mission of improving member health through high-quality care. By focusing on key areas of clinical and non-clinical care, member safety, and experiences, and through active leadership and provider engagement, the program was able to drive meaningful improvements in care quality and health equity.

2. Quality Improvement Health Equity Transformation Program (QIHETP), Inclusive of Culturally and Linguistically Appropriate Services (CLAS) Program

2.1. Evaluation of Core Staff and Resources

The Quality Improvement and Population Health Director has many years of HEDIS and QI experience and oversaw all aspects of the QIHETP and CLAS Program in 2024. CCAH has determined that the Quality Improvement and Population Health Director had the appropriate experience and skills necessary to effectively lead and manage the QIHETP and CLAS Program. Under the direction of the CMO, the QIPH Director is responsible for strategic direction and management of the QIHETP. The Quality Improvement and Population Health Director manages the Alliance's preparations and response to regulatory and

internal medical audits and manages implementation of selected NCQA standards. The Quality Improvement and Population Health Director and the QI Managers are responsible for engagement with internal and external stakeholders in the QIHETP. This role acts at the Performance Improvement Lead or may delegate this role to staff across the organization for the quality and health improvement efforts across the organization, in addition to acting as part of the Regional Quality and Health Equity team.

In 2024, CCAH had four managers comprised of the Quality and Performance Improvement Manager, Quality and Population Health Manager, Clinical Safety Quality Manager, and Quality and Health Programs Manager. Where the QIPH Director focuses on strategy and manages "up" and cross-functionally across the organization, the Quality Improvement and Population Managers focuses on operations and manages "down" to the QIPH team. The QIPH Director and QIPH Managers were able to successfully oversee and manage all aspects of the day-to-day operations of the QIHETP and CLAS Program along with being very hands-on for a number of strategic QI initiatives.

2.2. Evaluation of Reporting Relationships

Throughout 2024, the staff meet frequently, often more than 1x/week, with their direct supervisors. This includes all of the following reporting relationships:

- Nurses reporting to the Clinical Safety Manager,
- 2 Supervisors reporting to the Quality and Health Programs Manager
- QI Managers (Clinical Safety Quality Manager, Quality and Health Programs Manager, Quality and Performance Improvement Manager, and Quality and Population Health Manager) reporting into the Quality Improvement and Population Health Director
- Quality Improvement and Population Health Director reporting to the Health Services Operations Executive Director, who reports to the Chief Medical Officer
- Chief Medical Officer reporting into the Chief Executive Officer

These direct-report meetings occurred in addition to ad hoc meetings, various team meetings, project meetings, interdepartmental meetings, etc. However, the direct-report meetings provided a crucial 1:1 touchpoint for all the various 2024 initiatives, which supported direct and clear accountability throughout the QI Program's chain of command. The quality of these reporting relationships supported and enhanced the execution of the 2024 QI Program activities.

2.3. Evaluation of Funding and Resources for QIHETP Initiatives

Current Activities

CCAH ongoing leverage funding for both member and provider incentives to support various QI initiatives. The key activities included generating gap-in-care reports, executing member incentives coupled with outreach, and conducting member education through newsletters and the website. Provider education was also part of the QI efforts, communicated via newsletters.

Future Plan Enhancements

CCAH also launched the Provider Partnership program. This program provided incentives and staffing support to help local providers close care gaps, including hiring outreach staff and expanding clinic resources.

Additional funding that will be implemented in 2025 is a texting program for member outreach which will be help as a timely reminder. Furthermore, CCAH is transitioning its incentive structure from a claim-based model to a point-of-service model.

2.4. Evaluation of Member, Physician, Community, and Leadership Involvement

In 2024, CCAH made significant improvements to the involvement of physicians within its QI Program. Initially, physician participation was limited to their presence at meetings. However, changes were implemented in 2024 to encourage more active feedback and engagement from physicians. These

adjustments aimed to enhance the quality and effectiveness of the program by ensuring that physician insights were fully integrated into decision-making processes.

Meetings were held as scheduled throughout the year, with a focus on achieving all established goals. These discussions placed a strong emphasis on improving behavioral health representation. The active participation of physicians played a crucial role in aligning the program's initiatives with the plan's objectives.

In addition, CCAH plans to introduce a Member Voice Committee as part of its HealthEquity accreditation efforts. This committee plans to collect member feedback through community meetings held at regular intervals. In order to encourage active involvement, CCAH will offer incentives and schedule meetings at convenient locations and times. These initiatives will further enhance the inclusivity and responsiveness of the QI Program.

In terms of program efficiency, both the QI Director and Chief Medical Officer were directly involved in implementing the 2024 QI Program initiatives. They actively collaborated with other executives and provided continuous guidance and oversight. Their approach to overcoming challenges often involved coordination with multiple departments across CCAH.

Based on the assessment, it can be concluded that the current staffing is sufficient to meet the program's needs.

2.5. Assessment of Systems

For 2024, CCAH has implemented systems to manage and administer its QI programs, including gap-in-care reports, member incentives, and provider incentives. The organization acknowledges both strengths and areas for improvement in these systems.

Current System Capabilities

Gap-in-Care Reports - CCAH currently has systems in place to run gap-in-care reports and summarize relevant data. These systems support the generation of reports necessary for tracking and addressing care gaps.

Incentive Programs - Adequate resources and systems are established to administer member and provider incentive programs. These systems facilitate the management and execution of incentives effectively.

Cultural and Linguistics – CCAH has systems in place to ensure that all Alliance members receive culturally and linguistically appropriate health care services. These systems improve communication between Alliance staff, Alliance health care providers, and Alliance members, and reduce health disparities related to language and cultural barriers.

Future Plan Enhancements

For 2025 CCAH is undertaking a data project aimed at enhancing its data systems to improve the timeliness and accuracy of gap-in-care reports. This initiative seeks to refine the reporting process and provide more precise insights for addressing care gaps.

It can be summarized that CCAH has adequate systems in place to administer its QI programs, including gap-in-care reports, member incentives, provider incentives, and cultural and linguistic services. However, for better performance, CCAH has identified a plan to improve the timeliness and accuracy of gap-in-care reports. This enhancement will further optimize the effectiveness of these programs and ensure more precise outcomes.

2.6. Assessment of Delegated Vendors

In 2024, CCAH maintained a delegation agreement with Carelon, to manage grievances and appeals related to Behavioral Health quality issues. CCAH is committed to ongoing oversight of its delegates to ensure they are performing their functions effectively, particularly in contributing to behavioral health initiatives.

CCAH monitors the performance of its delegated vendors through a structured oversight process. This process includes regular reviews of the delegate's activities and outcomes. It focuses on areas where the delegate provides critical input, such as managing behavioral health issues. Joint operations meetings are held regularly to assess performance. These meetings also address areas for improvement and implement corrective actions when necessary.

For this Annual Evaluation, CCAH has summarized the overall performance of Carelon, emphasizing the vendor's role in managing behavioral health-related grievances and appeals and its contributions to the organization's quality improvement initiatives in sections 12.4.3 Complaints Behavioral Health, and 12.4.4 Appeals Behavioral Health.

3. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

3.1. Introduction

CCAH monitors member satisfaction with health plan functions on an annual basis through the CAHPS survey. CCAH has established key CAHPS measures and quantifiable standards to evaluate member satisfaction. The two main focus areas of this survey were members getting the needed care and members receiving care promptly. This report provides an overview and analysis of CAHPS report for FY 2024.

3.2. Objectives

- Annually evaluate member satisfaction for member population.
- Identify opportunities to improve member satisfaction.
- Develop and implement solutions to improve member satisfaction.

3.3. Methodology

The methodology employed in this survey involves analyzing summary rates based on member responses. In particular, the rates were determined by analyzing the percentage of participants who revealed "Always" or "Usually" in their feedback regarding consistently receiving the care they needed and receiving it in a timely manner. This approach offers a clear measure of satisfaction and allows for year-over-year comparisons to identify trends and guide future improvements in service. By prioritizing these response categories, CCAH can obtain valuable insights into the reliability and accessibility of the care provided to members.

  - Total Completed Surveys: 257
  - Surveys Sent: 2012
  - Response Rate: 12.9%

3.4. Results and Performance Evaluation

CCAH evaluated satisfaction using the following measures and quantifiable standards that represent the percentage of favorable positive responses. The tables below show CCAH's performance against

the goals for 2024 survey. The goals were based on the Press Ganey Book of Business (PG BoB) Data. In 2025, the Alliance will change its goal performance to meet the Quality Compass benchmark

Access to Care

Measure	2021	2022	2023	2024	2024 PG BoB	Goal met
Getting Needed Composite Score	85.30%	82.90%	78.90%	**80.7%**	82.1%	NO
Getting care, tests, or treatment	83.90%	82.50%	82.60%	**84.1%**	85.1%	NO
Getting specialist appointment	86.70%	83.20%	75.30%	**77.3%**	79.1%	NO
Getting Care Quickly Composite Score	84.50%	73.40%	75.90%	**82.4%**	81.2%	YES
Getting urgent care	88.20%	74.50%	82.40%	**88.8%**	82.7%	YES
Getting routine care	80.80%	72.20%	69.40%	**76.0%**	79.7%	NO

Key Findings

- CCAH met the goal for two key measures under "Access to Care."
- CCAH saw improvement across all "Access to Care" measures from 2023 to 2024.
- The highest performing measure in 2023 was "Getting Urgent Care" at 88.8%, which was in the 93rd percentile.
- The lowest performing measure in 2023 was "Getting Routine Care" at 76.0%, which was 3.7% percentage points below the benchmark and a big improvement over the previous year.
- When examining through the composite score. The "Getting Needed Composite Score" we see CCAH is only 1.4 points from the BoB.
- All measures increased year over year.

Care Coordination

Measure	2021	2022	2023	2024	2024 PG BoB	Goal met
Doctors were informed and up to date about care from other health providers	79.40%	83.70%	79.60%	82.8	86.0%	NO

Key Findings

- CCAH did not meet the goal for the key measures under "Care Coordination."
- In 2024, the performance measure of doctors was informed and up to date about care from other health providers was 82.8%. It falls short the goal of 86.0% by 3.2 percentage points.
- The 2024 rate is an improvement of 3.2 percentage points over the previous year.

Customer Service

Measure	2021	2022	2023	2024	2024 PG BoB	Goal met
Customer Service Composite Score	88.90%	91.10%	87.50%	87.8%	89.80%	NO
Provided information or help	83.50%	86.90%	80.30%	80.8%	84.70%	NO

Treated with courtesy and respect	94.30%	95.30%	94.70%	94.8%	94.8%	YES

Key Findings

- When analyzing customer service composite score, CCAH met the goal for "Treated with courtesy and respect" but not for the composite measure or "Provided information or help."
- The lowest performing measure (Customer service staff provided information or help) was 80.80%, which was 3.90 percentage points below the benchmark.
- The highest performing measure in 2023 was "Treated with Courtesy and Respect" at 94.80%, which was at the goal.
- All measures increased year over year.

Global Measures

Measure	2021	2022	2023	2024	2024 PG BoB	Goal met
Rating of Health Plan	79.80%	76.80%	77.10%	78.5%	78.7%	NO
Rating of Health Care	79.10%	75.60%	72.70%	78.2%	75.8%	YES
Rating of Personal Doctor	82.10%	83.10%	80.40%	86.4%	83.9%	YES
Rating of Specialist	77.80%	85.70%	81.50%	84.2%	82.50%	YES

Key Findings

- CCAH did not met 3 of the 4 goals for "Global Measures."
- All measures increased year over year.
- The lowest rate was "Rating of Health Plan" at 78.5%, which was 0.2 percentage points below the benchmark.
- The highest performing measure in 2023 was " Rating of Personal Doctor" at 86.4%, which was 2.5 percentage points above the benchmark.

How Well Doctors Communicate

Measure	2021	2022	2023	2024	2024 PG BoB	Goal met
How Well Doctors Communicate Composite Score	89.30%	91.50%	91.60%	91.8%	93.2%	NO
Doctors explained things in an understandable way	91.60%	90.50%	92.20%	92.6%	93.2%	NO
Doctors listened carefully to you	88.70%	92.70%	92.30%	93.3%	93.3%	YES
Doctors showed respect for what you had to say	90.80%	92.70%	94.30%	94.8%	94.90%	NO
Doctors spent enough time with you	85.80%	89.90%	87.80%	86.6%	91.40%	NO

Key Findings

- CCAH met the goal for one of the key measures under "How Well Doctors Communicate."
- The lowest performing measure (Doctors spent enough time with you) was 4.80% below the goal.

- The highest performing measure (Doctors showed respect for what you had to say) was only 0.10% below the goal.
- There was year over year improvement in all measures except "Doctors spent enough time with you."

CAHPS Trend Analysis

The tables below show a trend analysis of CAHPS ratings from 2021 to 2024.

Measure*	2021	2022	2023	2024	2024 PG BoB	Goal met	Difference from Goal
Rating of Health Plan	79.80%	76.80%	77.10%	78.5%	78.7%	NO	-0.2%
Rating of Health Care	79.10%	75.60%	72.70%	78.2%	75.8%	YES	+2.4%
Rating of Personal Doctor	82.10%	83.10%	80.40%	86.4%	83.90%	YES	+2.50%
Rating of Specialist +	77.80%	85.70%	81.50%	84.2%	82.70%	YES	+1.5%
Getting Needed Care Composite Score	85.30%	82.90%	78.90%	80.7%	82.1%	NO	-1.4%
Getting Care Quickly Composite Score	84.50%	73.40%	75.90%	82.4%	81.2%	YES	+1.2%
Plan Administration Composite Score	88.90%	91.10%	87.50%	87.8%	89.80%	NO	-2.00%
How Well Doctors Communicate Composite Score	89.30%	91.50%	91.60%	91.8%	93.2%%	NO	-1.40%
Coordination of Care Composite Score	79.40%	83.70%	79.60%	82.8%	86.0%	NO	-3.2%
Ease of Filling Out Forms Composite Score	94.50%	93.10%	95.60%	93.6%	94.8%	NO	-1.2%

**Full results of the CHILD and ADULT CAHPS surveys are located in Appendix A.*

Quantitative Analysis

- CCAH received a rating of 78.5% in 2024 which is up 1.4% points over the previous year but below the 2024 PG BoB benchmark by 0.2% points.
- In 2024,78.2% of respondents rated health care positively, which surpassed the 2024 PG BoB benchmark of 72.4%. The goal was met.
- A rating of 86.4% was given to personal doctors in 2024, surpassing the 2024 PG BoB benchmark of 82.4%. The goal was met.
- The rating for specialists was 84.2% in 2024, which surpassed 2024 PG BoB benchmark of 81.5%. The goal was met.
- When investigating CAHPS surveys focused on access to care, CCAH did not meet the benchmark for getting needed care composite score but did surpass the goal for getting care quickly composite score.
- The data showed this is the first increase in member satisfaction with getting needed care between 2021 and 2024.

- The rate for Getting Care Quickly is 6.50 percentage points higher than that in 2023 and 9 percentage points higher than 2022. It indicates a slightly positive trend for members getting care quickly.
- Customer service was rated positively by 87.8% of respondents in 2024, below the 2024 PG BoB benchmark of 89.8%. The goal was not met.
- The communication skills of doctors were rated positively by 91.8% of respondents in 2024, which did not meet the 2024 PG BoB benchmark of 93.2%. The goal was not met.
- Care coordination received a 82.8% positive rating in 2024, underperforming compared to the 2024 PG BoB benchmark of 86.0%. The goal was not met.
- The ease of filling out forms was rated positively by 93.6% of respondents in 2024, below the 2023 PG BoB benchmark of 94.8%

Qualitative Analysis - Opportunities for Improvement

Based on the CAHPS data review, CCAH did not reach its goals for the "getting needed care." This outcome highlights members struggled to access care. CCAH has acknowledged that the "getting needed care" measure is the most essential and is therefore the top priority for Plan improvements. The rate did increase year over year showing improvement.

3.5. Qualitative Barrier Analysis

The SMEs, including Quality Improvement and Population Health Director, Quality and Health Programs Manager, Grievance and Quality Manager, Provider Services Director, Provider Quality and Network Development Manager, Health Services Operations Manager, and Compliance Director, identified the challenges obstructing the transition and quality of health care service.

- *Access to Care*
    - The challenge to increase Access to Care, particularly in the rural communities the Alliance is serves, can be attributed to many factors including member transportation and how to navigate the healthcare system, difficulty recruiting and retaining providers and provider staff. This has been especially challenging in a post-pandemic world where healthcare workers struggle with burnout.
- *Member-Level*
    - Members often expect to receive appointments much sooner than they actually do, which contributes to the low CAHPS ratings. Although appointments are available, the delay in scheduling leads to member dissatisfaction. The gap between the expected and actual appointment times is the primary reason for the low ratings.
    - Members do not know how to navigate the healthcare system as well, and therefore they are not able to get appointments in a timely manner. Some members do not realize that CCAH has appointment assistance for their member services unit that they can call to get the appointment services earlier.
    - Members don't always have transportation or the ability to go to appointment times offered.
- *Provider-Level*
    - Primary Care is getting negatively impacted:
        - Primary care availability was made more challenging due to the limited number of PCPs available for contracting. This is because many medical school graduates are opting for specialist careers, which are more financially rewarding.
    - Providers are not updating their panel status:

        - There are cases when patients contact the clinic to schedule an appointment but find that the office's panel is closed. Members may have the perception that there are fewer appointments available as there were in previous years.
            - Providers may close offices due to high patient volume.
            - Providers may fail to update the CCAH management team on their current panel status due to lack of awareness, time constraints, or staff turnover.
- *Health Plan-Level:*
    - There appears to be an imbalance between the number of patients seeking appointments and the availability of practitioners.
    - Some older recipients may have multiple chronic conditions and may require longer duration of appointments. Practitioner offices often struggle with the availability of longer appointment durations.
    - There was a reduction in the number of providers and medical staff as retention became challenging in the past few years. Many providers and staff left the state due to high costs, a shortage of support staff, and burnout. Several providers faced unsustainable costs related to insurance, taxes, and malpractice, leading to further attrition. Additionally, a major shortage in both practitioners and support staff made it difficult for many providers to run their offices effectively. To address this issue, we instituted a medical assistant grant to help support this critical staffing need.

Opportunities for Improvement

Based on the 2024 CAHPS Survey results, several opportunities have been identified to enhance the timeliness and accessibility of healthcare services for CCAH members. These opportunities target specific areas where performance metrics did not meet the established goals.

- CCAH investigated opportunities to enhance the telehealth solution. Telehealth services will be expanded by increasing the number of telehealth-only providers. Additionally, several clinics offer in-person appointments and provide telehealth options to their patients. This expansion aims to offer members more opportunities to receive care remotely and reduce the need for in-person visits.
- The Plan is using appropriate types of providers (i.e., CHWs, Doulas, and other type of ancillary providers), to cover for shortage PCPs in the service area. These providers can see members and administer the appropriate services instead of PCPs.
- The Plan is also offering grant funding to PCPs to incorporate CHWs in their practices to act as patient navigators.
- CCAH increases network capacity by working with local medical schools, residency programs with University of California Merced and University of California San Francisco to expand the network in remote areas.
- CCAH offers medical capacity grants to fund a portion of the salary for specific provider types to aid in recruiting additional practitioners and supporting medical assistants.
- Implement efficient scheduling systems and inform members about the appointment assistance available through the member services unit, which they can contact to secure earlier appointments.
- CCAH will also enhance awareness of members that they contact Carelon directly to facilitate immediate and comprehensive support. This direct engagement ensures that

members receive timely and coordinated care, enhancing their overall health outcomes and satisfaction with the healthcare system.

- There are incentive programs currently in place for PCPs, SCPs, and hospitals to give more funding to the provider network. CCAH is developing additional incentive programs to provide additional support to the provider network depending on availability of operational revenue. Additional operational revenue is distributed through grant funding or incentive payments to providers.
- CCAH has developed a robust transportation benefit to help members get to appointments.
- CCAH began a grant funding program to PCPs to provide after-hours clinics specifically for preventive care.

By addressing these areas, CCAH can work towards improving the overall healthcare service delivery efficiency and effectiveness, member satisfaction, and Plan goals for timely and accessible care.

Description of Intervention	Barrier Addressed	Timeframe
1. **Continuing to expand the Provider/Practitioner Network** Provider Relations continues to expand the practitioner panel to improve access for CCAH members. The Provider Relations department will focus on growing the specialty network. CCAH is reviewing contract reimbursement amounts requested in specialty areas that have been identified for improvement.	Providers/Practitioners Not Participating with CCAH	Ongoing
2. **Robust Grant Funding Program** In late 2023 and through 2024 the Plan offered Workforce Care Gap Grants to PCP offices which paid PCPs to hire locum providers or pay staff overtime to work additional weekend and evening clinics. The Grants team also continued its Workforce Recruitment Grants for all specialties and expanded it to include CHWs.	Provider Recruitment, After hours availability, Patient Navigators	Ongoing
3. **Continue to educate practitioners on appointment access** standards so they can make necessary arrangements to see patients in a timely manner. The Plan will send newsletters and update its websites to educate practitioners on the appointment access standards. Education distributed annually by Provider Relation Representatives between October – December during in-person office visits.	Practitioners are not aware of appointment availability standards	Ongoing

3.6. Conclusion and Next Steps

CCAH has concluded that there are still some issues related to appointment access. Improving appointment access and making sure members receive the care they need is a key initiative for the Plan in its ongoing effort to improve quality. CCAH is continuing to expand its specialty network in

order to provide better coverage to its members. CCAH will also continue to identify additional health groups and practitioners that can join the Plan in 2025.

4. Utilization of Language Services for Organization Functions

4.1. Provider Phone Utilization of Language Services

This analysis examines different languages used through phone interpreting services from providers to communicate with patients who speak various languages. By assessing the demand for different languages and identifying gaps, CCAH aims to understand the patterns and challenges in provider utilization.

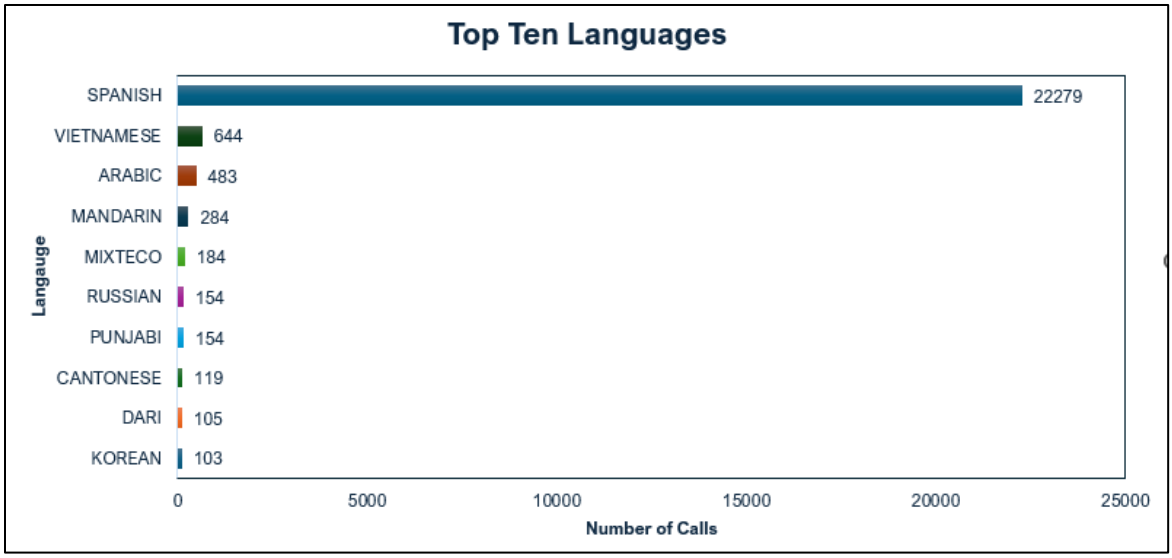
Methodology

- **Data Source:** Data on the utilization of language services was extracted from the phone call service records.

- **Total Calls:** There were **25,187** total calls made to members by providers using phone interpreting services from **January 1 to December 31, 2024.**

Language Usage Distribution

Language	Number of Calls	Percentage
SPANISH	**22,279**	**88.45%**
VIETNAMESE	**644**	**2.56%**
ARABIC	**483**	**1.92%**
MANDARIN	**284**	**1.13%**
MIXTECO	**184**	**0.73%**
PUNJABI	**154**	**0.61%**
RUSSIAN	**154**	**0.61%**
CANTONESE	**119**	**0.47%**
DARI	**105**	**0.42%**
KOREAN	**103**	**0.41%**
OTHER	**678**	**2.69%**



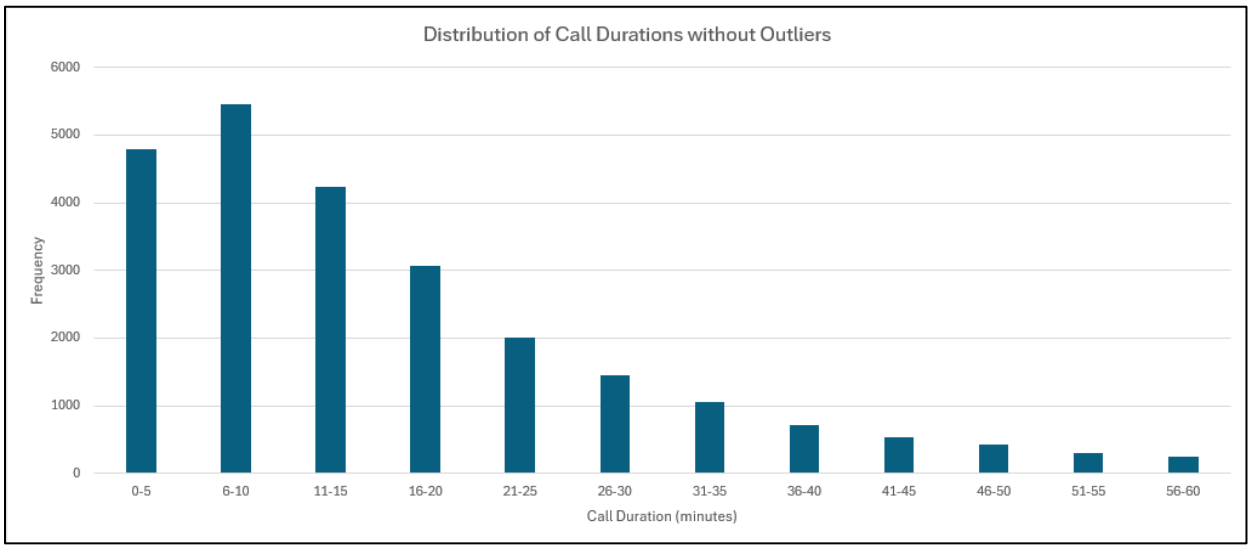
Quantitative Analysis

Language Usage Distribution

- **Total Number of Languages:** 51 unique languages.
- **Most Frequently Used Language:** Spanish (88.45%).
- **Top 3 Languages:** Spanish, Vietnamese (2.56%), Arabic (1.92%).

Spanish is the most frequently used language, with a significantly higher usage compared to other languages. This disparity emphasizes the critical need for high-quality Spanish interpreting services to meet the demands of the majority of users. While Vietnamese and Arabic follow as the next most frequently used languages. This distribution of language usage pointed out the importance of prioritizing Spanish language services while also ensuring adequate resources are available for other languages.

Call Duration Distribution



Quantitative Analysis

Call Duration Distribution

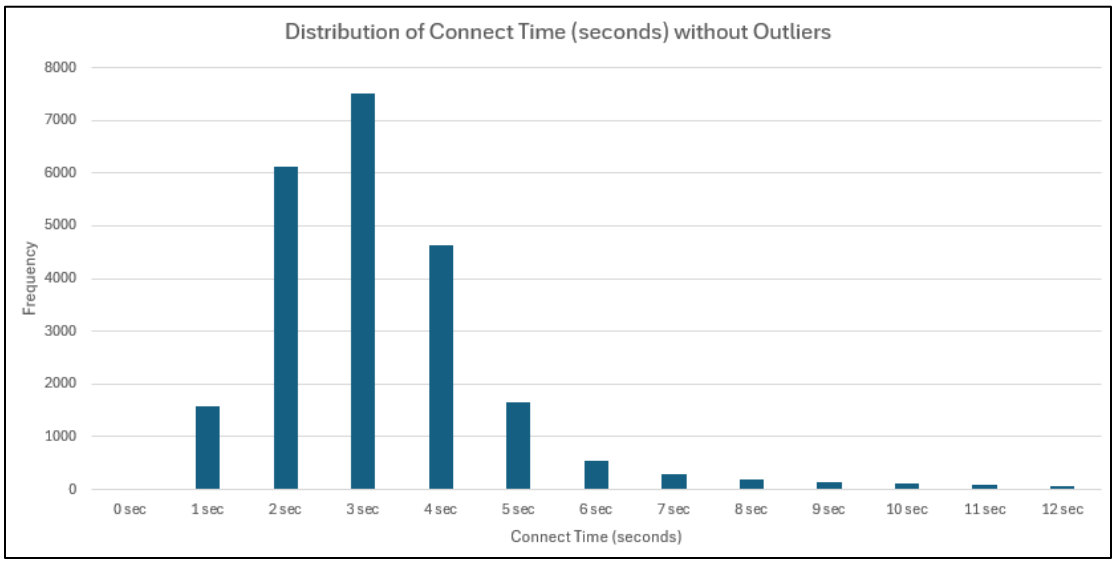
- **Mean Average Duration:** 1.02 minutes
- **Standard Deviation:** 1.015 minutes
- **Minimum Duration:** 1 minute
- **Maximum Duration:** 453 minutes. (outlier)

Quartiles

- **25th Percentile:** 3.5 minutes.
- **50th Percentile (Median):** 9.5 minutes.
- **75th Percentile:** 19.5 minutes.

Most calls last between 1 and 60 minutes, with the majority of calls clustering around 1 to 15 minutes. This range suggests that while many calls are relatively short, however, it reflects diverse and varying communication needs among users.

Connect Time Distribution



Quantitative Analysis

Connect Time Distribution

- **Mean Connect Time:** 2.88 seconds
- **Standard Deviation:** 2.84 seconds
- **Minimum Connect Time:** 0 seconds
- **Maximum Connect Time:** 1699 seconds. (outlier)

Quartiles

- **25th Percentile:** 1.5 seconds
- **50th Percentile (Median):** 2.5 seconds
- **75th Percentile:** 4.5 seconds

Most calls have a connect time of less than 10 seconds, indicating that calls generally connect quickly.

Overall Conclusion Based on Quantitative Analysis

In conclusion, the high usage of interpreting services in Spanish underscores the need to prioritize the quality Spanish language support, while also ensuring adequate resources for other frequently used languages like Vietnamese and Arabic. Additionally, the diverse call durations show varying communication needs among users. However, it should be met with efficient and responsive interpreting services that can connect quickly. The data indicates a strong utilization of language services across various functions within the organization for individual experiences. High satisfaction rates among members underscore the importance of these services, while concerns about wait times and interpreter quality suggest areas for targeted interventions. Continued monitoring and analysis will be essential in maintaining and improving the effectiveness of language services.

Qualitative Analysis

The analysis of provider phone utilization of language services reveals several potential barriers that may impact the effectiveness and efficiency of the services. The high demand for Spanish interpreting services may strain resources and lead to longer wait times for users of other languages. Limited availability of interpreters for less frequently used languages like Vietnamese and Arabic may cause delays and dissatisfaction. The wide range of call durations can create scheduling challenges and may lead to inconsistent service quality.

4.2. Staff Phone Interpreting Utilization of Language Services by Departments

The analysis evaluates how staff across different departments use phone interpreting services. By evaluating the disparities in service utilization among departments, CCAH can pinpoint specific needs and areas for improvement.

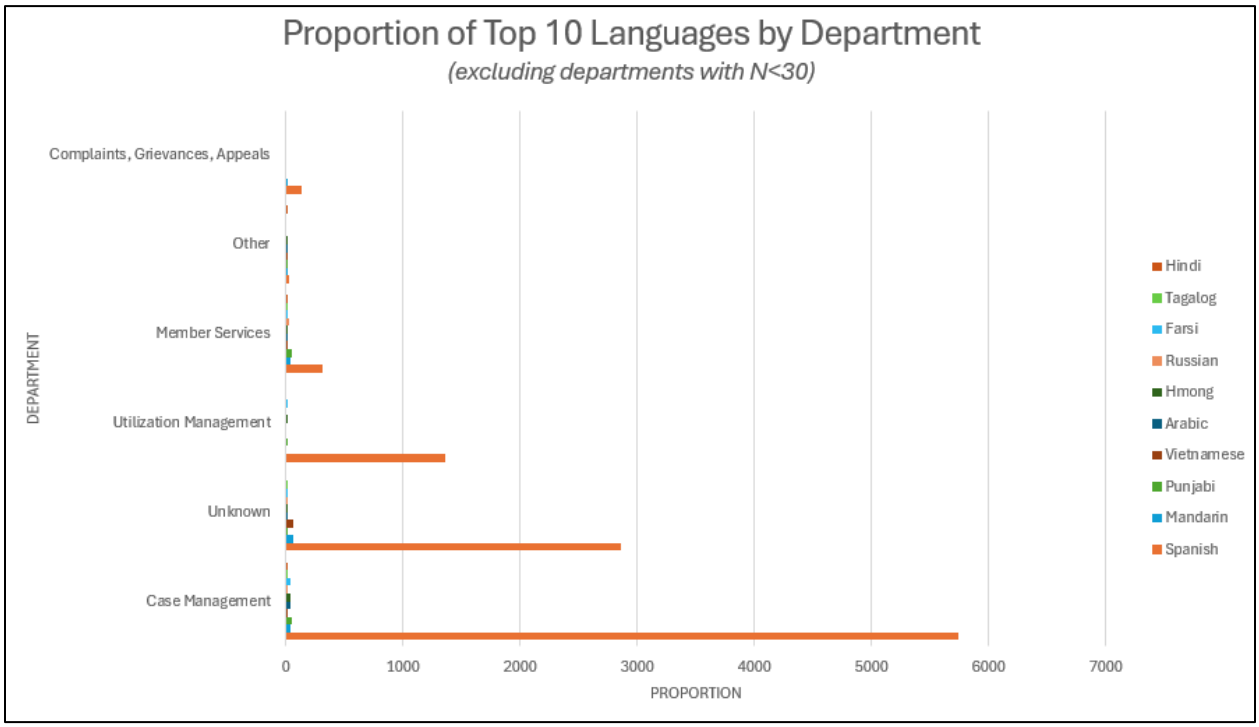
Methodology

- **Data Source**: Data on the utilization of language services was extracted from the phone call service records.
- **Total Calls:** There were 11,198 total calls made from staff of every department using phone interpreting service January 1 to December 31, 2024.

Departmental Utilization Data

Department	Number of Language Service Request	Percentage of Language Service Request
Case Management	6,038	53.92%%
Unknown	3,038	27.13%
Utilization Management	1,370	12.23%
Member Services	555	4.92%
Other / Alliance offices	155	1.38%
Complaints, Grievances, and Appeals	31	0.28%
Population Health Management	11	0.10%

Claims	4	0.036%



Quantitative Analysis

Departmental Utilization Data

- **Case Management:** Highest utilization at 53.92%.
- **Unknown Department:** Second highest at 27.13%.
- **Utilization Management:** 12.23% of total calls.
- **Member Services:** 4.92% of calls, with the most diverse range of languages used. Top languages include Spanish (56.80%), Punjabi (9.62%), Mandarin (5.81%), Russian (3.63%), and Arabic (3.27%).
- **Other Departments:** 1.38% of calls.
- **Complaints, Grievances, and Appeals:** Minimal usage at 0.28%.
- **Population Health Management:** Minimal usage at 0.10%.
- **Claims:** Lowest utilization at 0.036%

Conclusion Based on Quantitative Analysis

Case Management is the primary user of phone interpreting services. It makes up over half of total utilization. This indicates a high need for language support in these areas. The Member Services department, despite having a lower call volume, demonstrates the highest language diversity, highlighting a need for a wide range of linguistic support. Utilization Management shows moderate use, while departments such as Complaints, Grievances and Appeals, Population Health Management and Claims show minimal utilization, indicating potential underuse or lesser need for these services.
Additionally, the significant proportion of calls categorized under "Unknown Department" highlights the need for improved data collection practices to ensure accurate and complete departmental data.

Qualitative Analysis

The analysis of operational unit phone utilization of language services reveals several potential barriers that may impact the effectiveness and efficiency of the services.

- The high demand for interpreting services in Spanish may strain resources and lead to longer wait times for users especially for Case Management department.
- The need for diverse linguistic support in Member Services could strain resources and affect service delivery.
- Issues with unprofessional behavior and lack of word-for-word translation can negatively impact staff experiences and satisfaction.
- Variability in interpreter quality may lead to inconsistent communication outcomes.
- Staff may face difficulties managing call durations that range from very short to exceptionally long. It may impact their workflow and productivity.

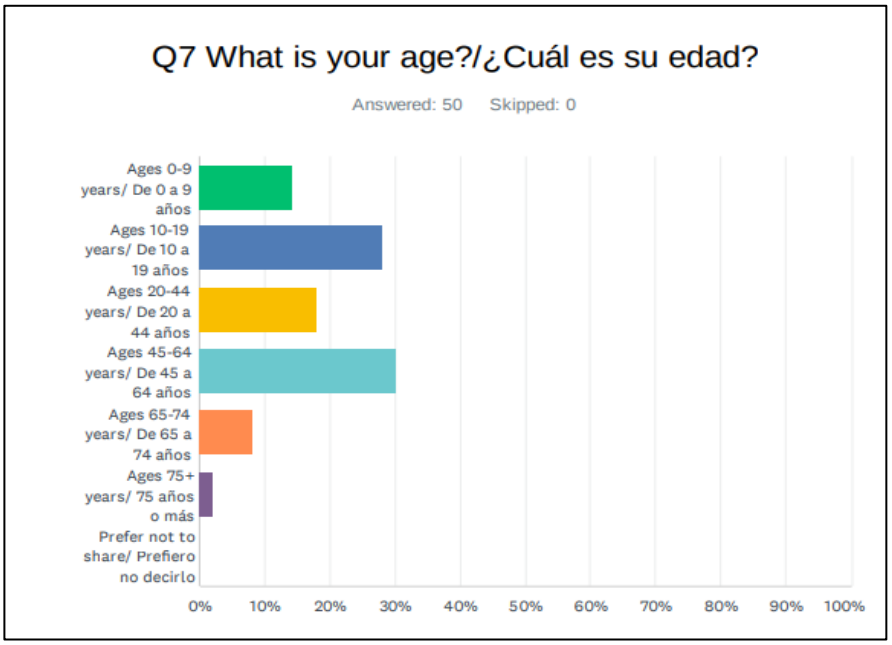
5. Member Experience with Language Services During Health Care Encounters

This report presents the findings from a member survey conducted to evaluate individual experiences with language services during organizational functions. The survey featured 10 questions aimed at assessing member satisfaction and overall experiences with the language services provided. The results provide insights into the effectiveness of these services and highlight areas for improvement. This analysis also identifies key patterns and challenges members face when accessing language support.

Methodology

- **Survey Period:** The member survey was conducted from January 15 to February 19, 2025.
- **Response Rate:** The total number of responses was 50.
- **Data Collection Period:** Members who used interpretation services from January 1, 2024 – December 31, 2024, were surveyed.
- **Survey Instrument:** The survey consisted of 10 questions aimed at assessing the satisfaction and experience of members with the language services provided. For this report, CCAH focused on the relevant questions to provide meaningful insights.

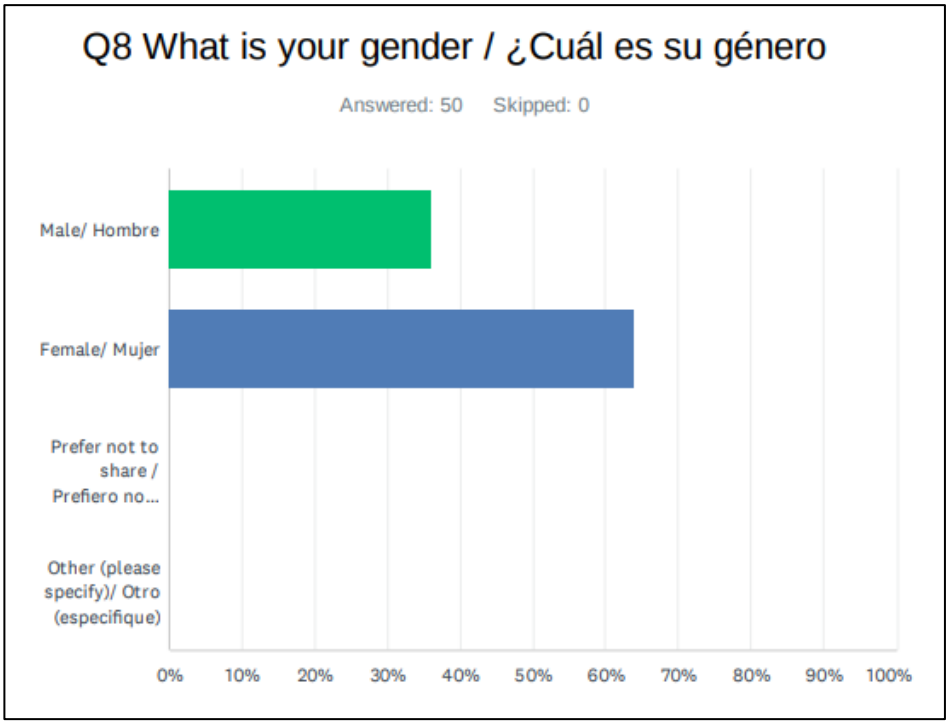
Age Distribution



Key Findings

The age distribution of respondents who have used language services shows a diverse range, with the highest representation in the 10-19 (28%) and 45-64 (30%) age groups. The lowest representation is in the 75+ years age group at 2%.

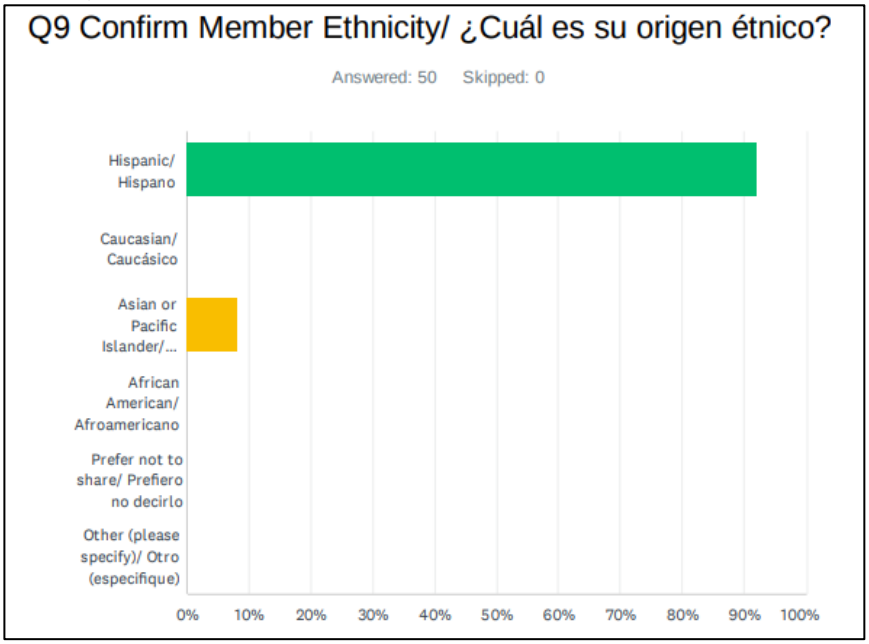
Gender Distribution



Key Findings

The majority of respondents who used language services are female (64%), while 36% are male. No respondents chose not to share or specify another gender.

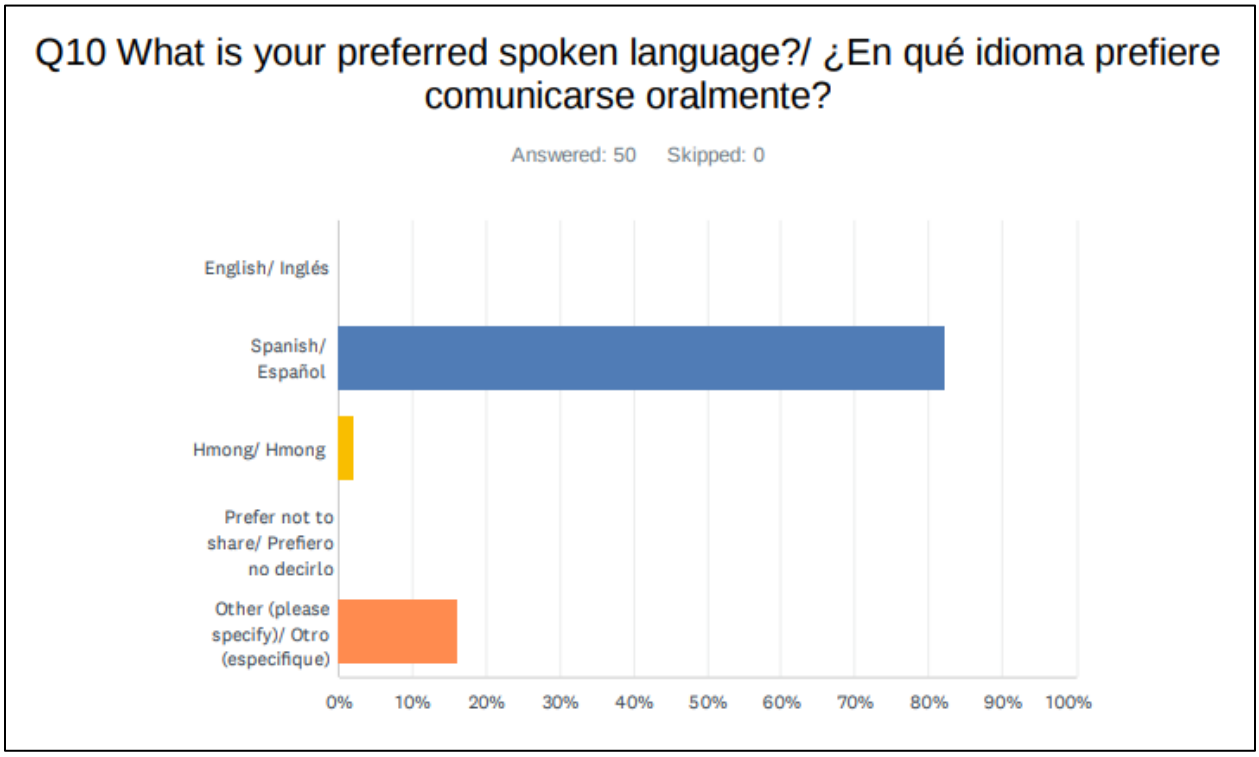
Ethnicity



Key Findings

An overwhelming majority of respondents who used language services identify as Hispanic (92%). Other ethnicities included Asian or Pacific Islander at 8%.

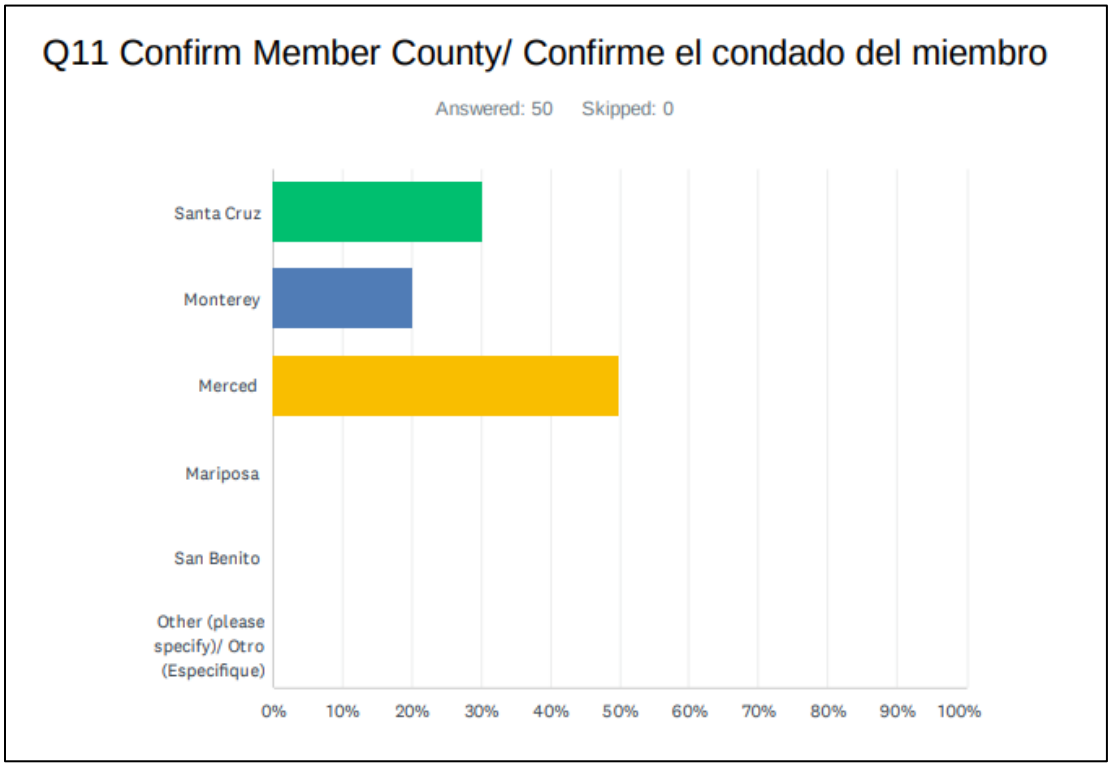
Preferred Spoken Language



Key Findings

The majority of respondents prefer to communicate in Spanish (82%). A small percentage prefers Hmong (2%) or other languages such as American Sign Language, Arabic, Mandarin, and Vietnamese (16%).

County Distribution

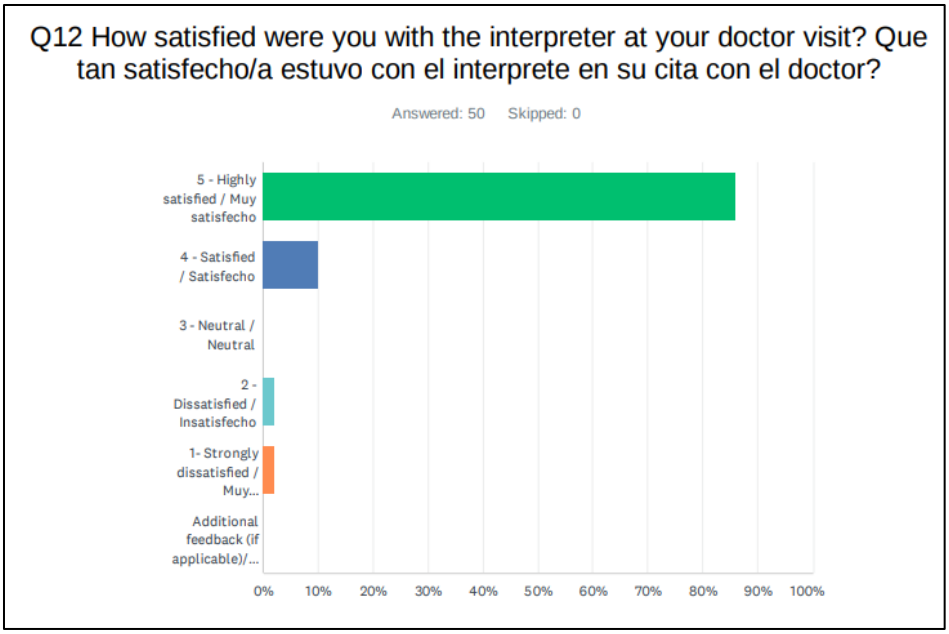


Key Findings

Most respondents are from Merced County (50%), followed by Santa Cruz (30%) and Monterey (20%). No respondents were from Mariposa or San Benito counties.

Quantitative Analysis

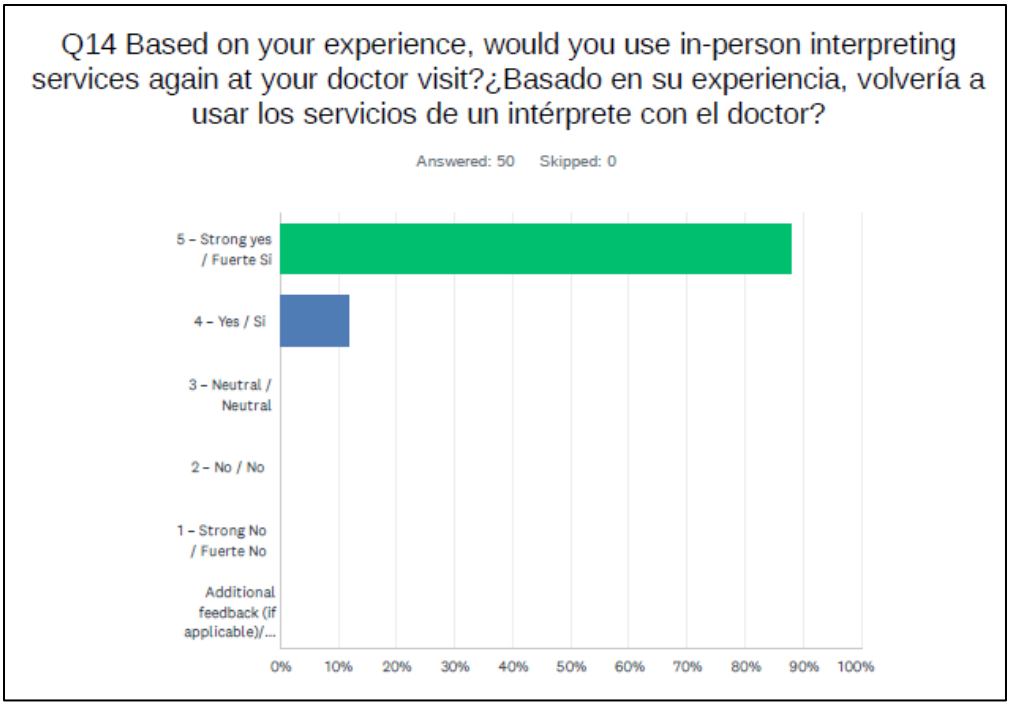
Member Experience Survey Question 12 – How satisfied were you with the interpreter at your doctor visit?



- The chart illustrates the satisfaction levels of 50 respondents regarding interpreter services during their doctor's visits.
- 86% of respondents rated their experience as "Highly satisfied" and 10% as "Satisfied". This indicates a strong positive reception and effectiveness of the interpreter support provided.
- 1 respondent (2%) reported they were dissatisfied, and 1 respondent (2%) was strongly dissatisfied.
- Overall, the data indicates a high level of satisfaction with the interpreter services during doctors' visits, with the vast majority of respondents expressing a positive experience.

Quantitative Analysis

Member Experience Survey Question 14 - Based on your experience, would you use in-person interpreting services again at your doctor visit?



- The chart presents the responses of 50 individuals to the question.
- A strong majority would use in-person interpreting services again, with 88% answering "Strong yes" and 12% answering "Yes". This reflects a positive reception and demonstrates that most of the members found the service satisfactory and would consider using it again.
- There were no respondents that indicated they would not use the services again.

Conclusion Based on Overall Quantitative Analysis

- The survey shows members' high satisfaction with in-person interpreting services among members.
- The majority of respondents identified as Hispanic and prefer to communicate in Spanish.
- The feedback suggests minor improvements in specific interpreters' professionalism and the way they interpreted information during the visit. Although there were 2 members that reported dissatisfaction, they shared in their feedback this was due to specific interpreter staff.
- All respondents stated they would use the service again. Overall, the interpreting services are well received, contributing positively to the healthcare experience of the members.

When comparing respondents feedback in 2023 versus 2024 the pain points shared in the feedback were somewhat different. In 2023 respondents shared that punctuality in appointment times and the way the information was being interpreted were the primary recommended areas for improvement. In 2024 the feedback regarding dissatisfaction and areas for improvement was around 2 specific interpreters. In both 2023 and 2024 the majority of respondents reported positive experiences.

Qualitative Analysis

The results indicate that most members found the service beneficial and are willing to rely on it for future healthcare visits. However, feedback highlights some minor issues related to specific interpreters' professionalism and communication, suggesting there is room for improvement in service delivery. Based on the findings, the SME at CCAH identified the following key barriers to member satisfaction:

- Issues with unprofessional behavior can negatively impact member experiences and satisfaction.
- Members reported high satisfaction with specific interpreters and in 2 cases dissatisfaction with 2 interpreters. This shows that the interpreters' behavior, professionalism, and interactions highly impact the member experience and impact the decision of whether to use the service or not.
- Feeback was also shared about aligning member needs with interpreters scheduled. For example, when scheduling an ASL interpreter the member shared it would be nice to have a person that aligns with the member's culture and preferences. They also shared that in some cases the gender of the interpreter can also have an impact on the comfort level of the member during the doctor visit.

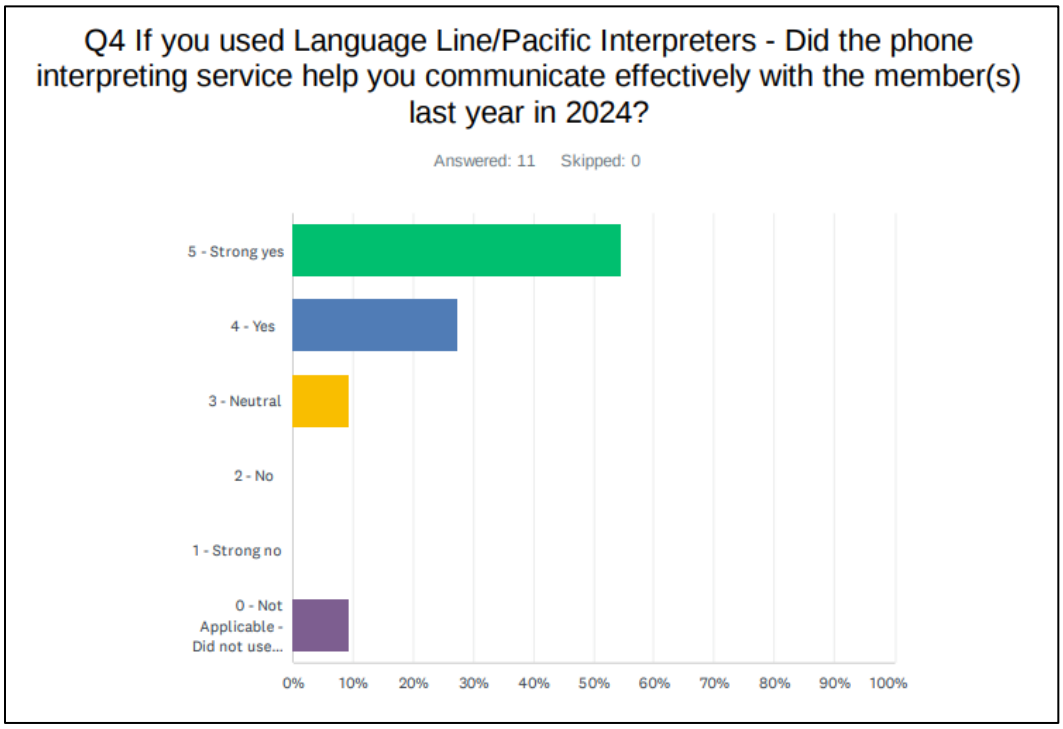
6. Staff Experience with Language Services for Organization Functions

CCAH conducted a frontline staff survey to evaluate experience with language services used for organizational functions. The survey consisted of 5 questions specifically designed to assess the experiences of frontline staff when utilizing these language services. The firsthand insights gained from this survey aim to enhance our understanding of how language services are utilized effectively and identify potential areas for improvement in supporting staff interactions with diverse populations.

Methodology

- **Survey Period:** The staff survey was conducted from September 1 to September 15, 2025.
- **Response Rate:** The total number of responses was 11.
- **Data Collection Period:** Alliance staff who used phone interpretating services from January 1, 2024 – December 31, 2024, were surveyed with a focus on high utilizers.
- **Survey Instrument:** The survey consisted of 5 questions focused on the staff's experience with using language services for organizational functions. In this report, CCAH focused on the relevant questions to provide meaningful insights. Please note there are some questions that are asked for each vender in order to better understand satisfaction with each vendor's services.

Staff Survey Question 4 - Based on your experience, did the phone interpreting service provided by Language Line help you communicate effectively with the member(s)?

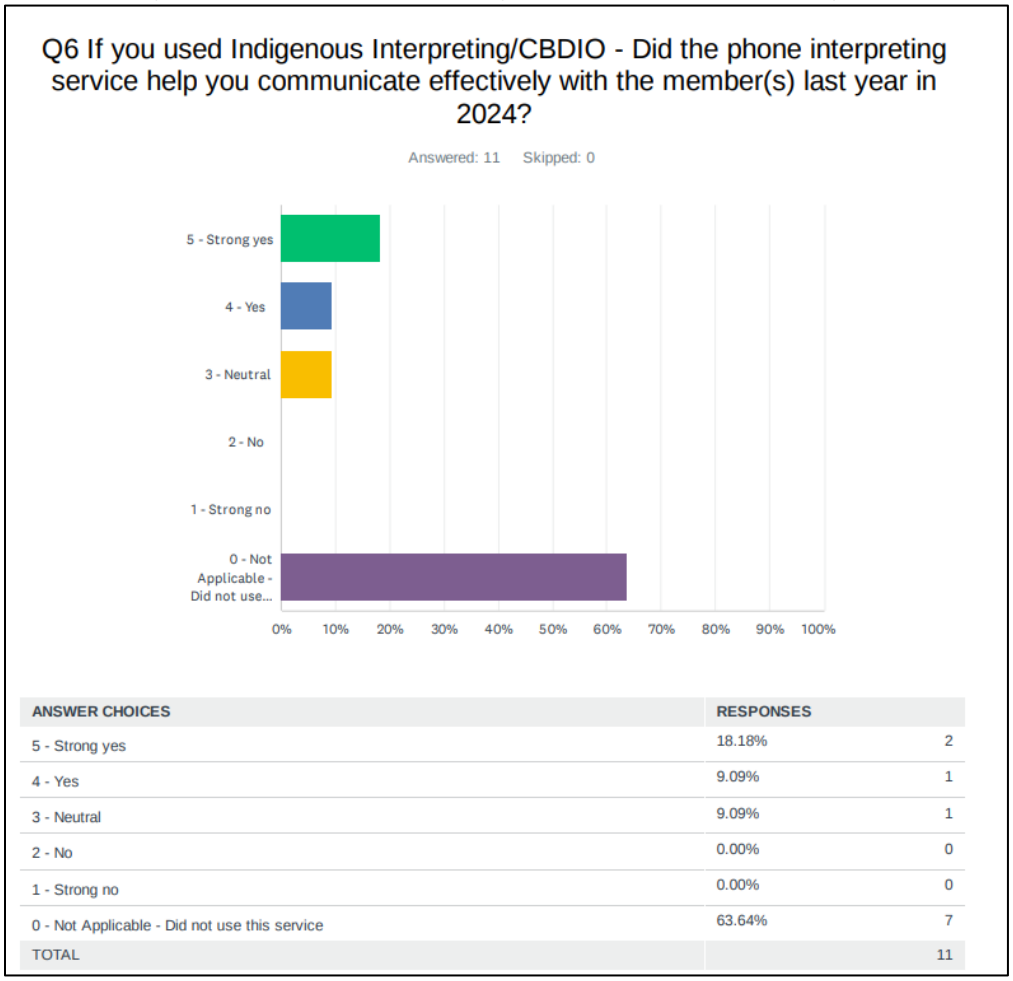


Goal: The interpretation service vendor must maintain a 95% accuracy rate.

Key Findings

- The accuracy rate for the vendor Language Line/Pacific Interpreters was not met. The performance totaled 81.82% against a goal of 95%. The rate was about 13 percentage points below the goal.
- Approximately 54.55% of respondents indicated a “Strong yes.” It suggests that over half of the participants found the phone interpreting service to be highly effective in facilitating communication.
- Most of the remaining respondents, 27.27%, answered "Yes." This suggests a majority of staff had positive experiences with the interpreting service.
- About 9.09% of respondents were neutral.
- None of the respondents chose "No" or “Strong no.”
- There was no additional feedback provided for this question.

Staff Survey Question 6 – If you used Indigenous Interpreting/CBDIO – Did the phone interpreting service help you communicate effectively with the members(s) last year in 2024?



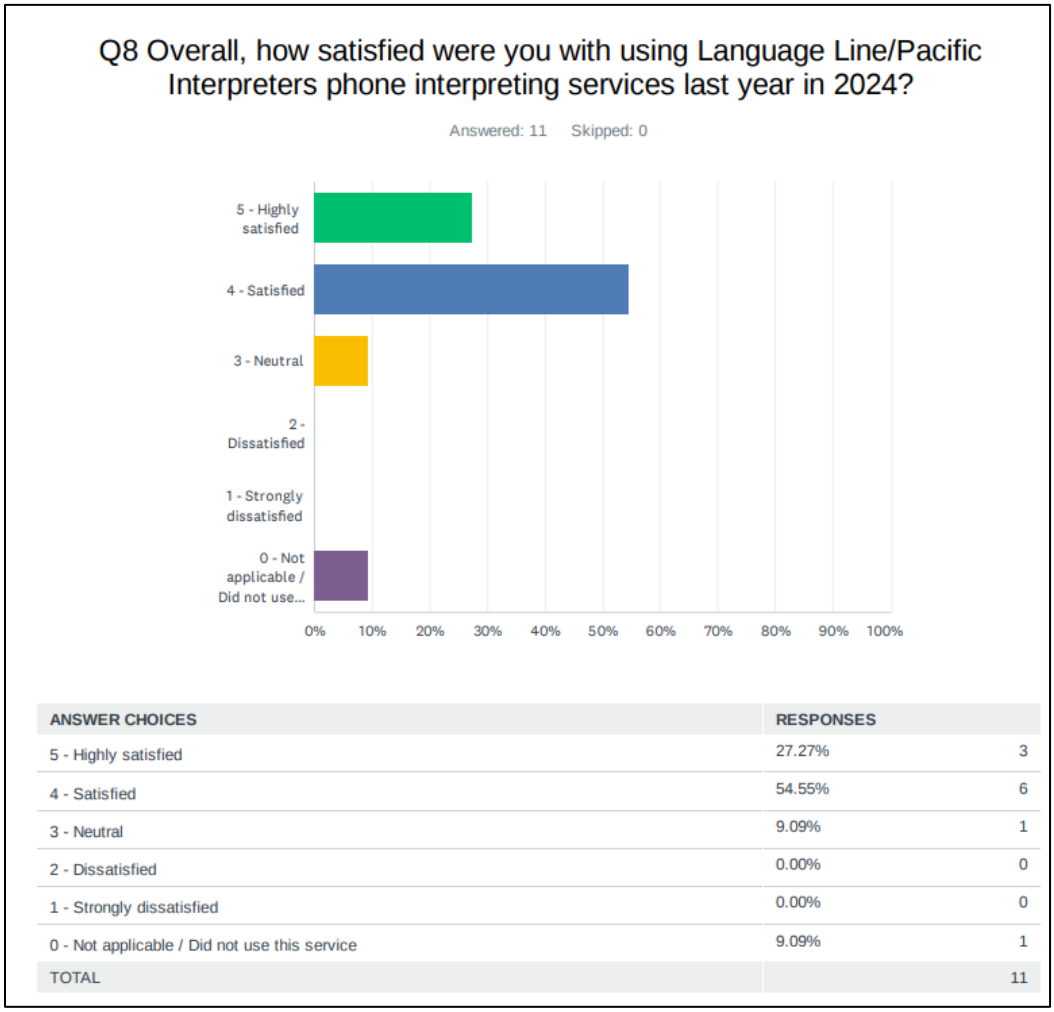
ANSWER CHOICES	RESPONSES	
5 - Strong yes	18.18%	2
4 - Yes	9.09%	1
3 - Neutral	9.09%	1
2 - No	0.00%	0
1 - Strong no	0.00%	0
0 - Not Applicable - Did not use this service	63.64%	7
TOTAL		11

Goal: The interpretation service vendor must maintain a 95% accuracy rate.

Key Findings

- The accuracy rate for the vendor Indigenous Interpreting/CBDIO was not met. There was a total of 4 respondents that used the services. 7 respondents did not use the service and were not counted in calculating the accuracy rate.
- Of the 4 respondents, 3 reported “Strong Yes” and “Yes” which resulted in 75% accuracy rate. 1 respondent reported “neutral”
- The performance totaled 75% against a goal of 95%. The rate was about 20 percentage points below the goal.
- Approximately 50% of respondents indicated a “Strong yes.” It suggests that over half of the participants found the indigenous interpreting service to be highly effective in facilitating communication.
- Most of the remaining respondents, 25%, answered "Yes." This suggests a majority of staff had positive experiences with the interpreting service.
- About 25% of respondents were neutral.
- None of the respondents chose "No" or “Strong no.”
- Additional feedback provided included “Mixteco interpreters not always available. Had to have members call back another time and we would call again the interpreter line to see if they had an interpret for the member.”

Staff Survey Question 8 – Overall, how satisfied were you with using Language Line/Pacific Interpreters phone interpreting services?



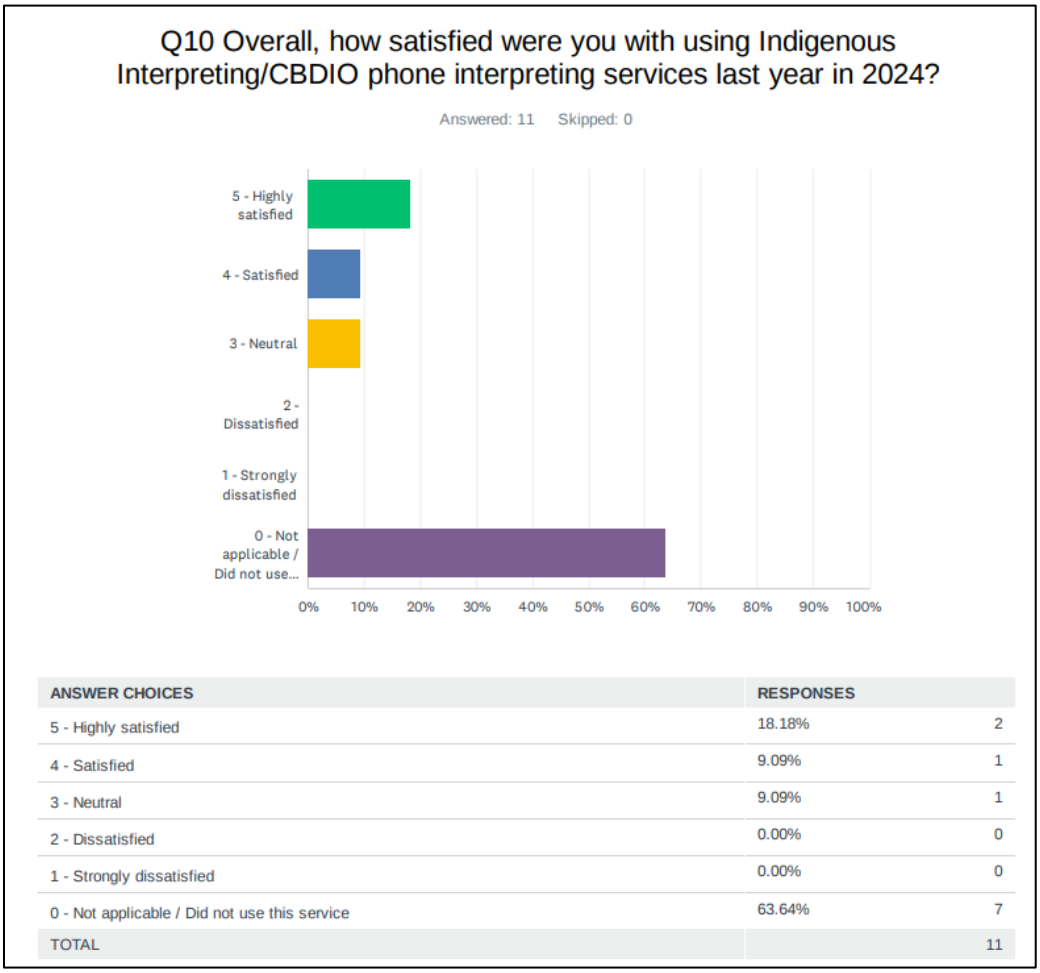
ANSWER CHOICES	RESPONSES	
5 - Highly satisfied	27.27%	3
4 - Satisfied	54.55%	6
3 - Neutral	9.09%	1
2 - Dissatisfied	0.00%	0
1 - Strongly dissatisfied	0.00%	0
0 - Not applicable / Did not use this service	9.09%	1
TOTAL		11

Goal: The interpretation service vendor must maintain a 95% satisfaction rate.

Key Findings

- The overall satisfaction rate for Language Line/Pacific Interpreters was not met. The performance totaled 90% against a goal of 95%. The rate was 5 percentage points below the goal.
- There was a total of 10 respondents that used the service. 1 respondent did not use the service and was not included in the calculation of the rate.
- 30% of respondents reported being highly satisfied with the phone interpreting services.
- A majority, 60%, indicated that they were satisfied with the service. This shows that the service was generally acceptable and met the needs of most users.
- There was 1 respondent (10%) reported “Neutral”.
- There were no respondents that reported “Dissatisfied” or “Strongly Dissatisfied.”
- There was no additional feedback provided for this question.

Staff Survey Question 10 – Overall, how satisfied were you with using Indigenous/CBDIO phone interpreting services last year in 2024?



ANSWER CHOICES	RESPONSES	
5 - Highly satisfied	18.18%	2
4 - Satisfied	9.09%	1
3 - Neutral	9.09%	1
2 - Dissatisfied	0.00%	0
1 - Strongly dissatisfied	0.00%	0
0 - Not applicable / Did not use this service	63.64%	7
TOTAL		11

Goal: The interpretation service vendor must maintain a 95% satisfaction rate.

Key Findings

- The overall satisfaction rate for Indigenous Interpreting/CBDIO was not met. The performance totaled 75% against a goal of 95%. The rate was 20 percentage points below the goal.
- There was a total of 4 respondents that utilized the service. 7 respondents did not use this service and were not included in calculating the rates.
- A majority, 50%, indicated they were highly satisfied with the indigenous interpreting services.
- 25% indicated that they were satisfied with the service. This shows that the service was generally acceptable and met the needs of most users.
- There was 1 respondent (25%) that reported “Neutral”.
- There were no respondents that reported “Dissatisfied” or “Strongly Dissatisfied.”
- There was no additional feedback provided for this question.

6.1. Overall Quantitative Analysis

- Staff were satisfied overall with both vendors and found the services helpful.

- Although interpreter services received high marks from staff and members, there were comments about areas for improvement, including concerns about minor unprofessional behavior by interpreters and need for more access to Indigenous interpreters. These issues have led to some dissatisfaction among users.
- The negative feedback highlights issues with quality control, and the need for better availability for Indigenous languages, which impacts the overall service experience (see attachments 1-4).
- Addressing these concerns could be an opportunity for CCAH to work with vendors to improve quality of services and access to indigenous interpreting to support member needs.

6.1.1. Conclusion Based on Quantitative Analysis

- While staff are generally satisfied with CCAH's interpreting services, there were areas in need of improvement including availability of Indigenous interpreters and overall usefulness.
- For members they were highly satisfied overall but there were concerns are about interpreter professionalism, and some issues with comfort level due to the unprofessional behavior of the interpreter. This indicates opportunities for improvements.

6.1.2. Qualitative Analysis

Barrier Analysis

In recent decades, many major U.S. cities have become more diverse, with an increasing number of residents who have limited English proficiency. Although healthcare systems have tried to accommodate these individuals, their medical interpreter services often fall short, leading to delayed emergency care for children, increased medical errors and costs, and reduced care quality and patient satisfaction.

The healthcare industry faces a significant shortage of in-person medical interpreters, impacting services across all levels of care. Additionally, the lack of support for all languages equally results in uneven access to accurate translation services and a lack of inclusivity for patients.

Even when health plans utilize large teams of professional interpreters from national vendors, their services may still fall short of meeting patients' needs. Effective communication not only requires language proficiency but also professionalism and cultural competence.

Conclusions based on Staff Feedback

- Additional feedback from staff mentions limited availability of Indigenous interpreters.
- This indicates that while the service is satisfactory, there can be challenges with access depending on the language required.

The negative impact of language barriers in healthcare has been well-documented over time. To address this issue, CCAH has established language service policies, standards, and guidelines that mandate the use of interpreter services. These services are regularly promoted to members, and vendors are informed about their expectations. Despite all the current activities, gaps in care still exist and this presents an opportunity for CCAH to implement interventions to improve the overall experience.

6.2. Opportunities for Improvements

- Maintain and potentially expand Spanish language interpreting services to meet the high demand.
- Address a few concerns about interpreter professionalism.

- Address a few concerns about increasing access to Indigenous interpreters.
- Continue engaging both internal and external stakeholders to monitor and identify areas for improvement and implement effective interventions to reduce health care inequities.

6.3. Attachment 1 – Member Survey Question 1

Member Survey Question: Do you have any recommendations to improve this service?

#	RESPONSES
1	It would be nice to have a person that aligns with the member's culture and preferences. Especially with ASL interpreters, there are different spectrums, and so ASL interpreters do not always directly align with the requestor. It would be nice to have a way to see the interpreters' resume, or experience before the appointment to confirm it is a good match. Knowing the gender and having the same gender interpreter would also be nice.
2	If everyone would be equally trained and offer the same quality of service as Sandra at Healthy House.

6.4. Attachment 2– Member Survey Question 2

Member Survey Question: How satisfied were you with the interpreter at your doctor visit? Additional Feedback:

#	RESPONSES
1	James's Hmong was pretty good for being a Hmong American.
2	Member prefers in-person interpreting, would much rather have in-person interpreter rather than a VRI.
3	They did a great job, really nice job. Were there on time, communicated effectively.
4	Interpreter was not professional, not doing her job correctly, and was not dressed appropriately. Waited until the very end to confirm whether or not member's name was being called.
5	Interpreter was great.
6	Interpreter began to get a little too personal. Member felt like interpreter would laugh at what the doctor was telling him - almost in a teasing manner, rather than sticking strictly to the interpretation. Lacked professionalism.
7	Great service!
8	Was very helpful, kind and a great service overall!
9	Punctual, very detailed on the conversation.
10	All interpreters they have gotten have been super friendly and kind.

11	Very good interpreters. By the time the member is called up, the interpreter is ready to start the services.
12	Very polite and kind young man - interpreted very well.
13	In-person is much better compared to VRI.
14	Interpreted very well.
15	Interpreter was very kind. Member did not know what suite her appointment was at, and the interpreter helped her find the correct office location.
16	The interpreter was very kind, professional and heard my concerns well. I felt respected and understood.
17	Attentive, polite, respectful, and overall excellent interpreter.
18	Sandra was great and did her job very well interpreting.
19	Sandra is very concrete and is fast in her interpretation.
20	Thankful for the service and wishes to continue to be helped with the language barrier.

6.5. Attachment 3 – Member Survey Question 3

Member Survey Question: Based on your experience, would you use in-person interpreting services again at your doctor visit? Additional Feedback:

#	RESPONSES
1	I don't speak English, so if an interpreter could always be present in-person that would be really helpful.
2	If it were Rosa interpreting again, absolutely 100%.
3	Would only request to not get the same interpreter.
4	If it's the same interpreter or works in the same manner, then yes. Loved the way the interpreter helped her.
5	Very thankful for the service and would love to continue receiving this service.
6	would only use in the case that there was no bilingual staff available at the doctor's office.
7	Prefers more face-to-face interpreting vs. VRI or audio interpreting.
8	Interpreter was not needed but was of great help regardless.

6.6. Attachment 4 – Member Survey Question 4

Staff Survey: Do you recommend anything that could have improved your experience with the phone interpreting services?

#	RESPONSES
1	Get more Mixteco interpreters to have them available all day.

Acting on Identified Opportunities

CCAH will collaborate and generate a variety of potential interventions to enhance performance on the CLAS programs. CCAH will then select a team to carry out the activities and provide updates on the progress of the work plan. CCAH will engage in a discussion with the Member Advisory Committee to explore the potential opportunities prior to moving forward with implementation.

Prioritize Opportunities to Improve CLAS and Plan to Evaluate Effectiveness of Interventions (HE 6D.2,4,6)

The analysis shows that CCAH has a solid foundation for language assistance services through its partnership with Centro Binacional para el Desarrollo Indígena Oxaqueño (CBDIO). However, feedback from staff identified areas for improvement, particularly in having more Mixteco interpreters available during more hours of the day. Additionally, CCAH received feedback via email from staff and providers in 2024 regarding challenges meeting the high need for Indigenous interpreters.

The C&L Supervisor, Ivonne Munoz, and Care Coordinator, Julia Guerrero reached out to CBDIO to request more details as to hours of availability for indigenous interpreting. CBDIO shared that there are limitations, and unfortunately their service is not available 24 hours a day, 7 days a week due to limited number of Indigenous interpreters available overall. The same barriers exist for Language Line/Pacific Interpreters where they do have Mixteco available as a language, however they also require an appointment to be made with the interpreter due to limited availability of this language.

Conclusion

CCAH has implemented a comprehensive approach for telephonic interpreter requests to ensure that language assistance services are available, robust, and used effectively for medical needs. Providers can request interpreters directly through CBDIO or coordinate with CCAH staff, ensuring members receive the necessary support when they most need it. In cases where members miss scheduled appointments, providers are encouraged to initiate new requests with CBDIO or CCAH. When interpreters are unavailable, CCAH recommends rescheduling the appointment for a time when services can be provided. To address availability challenges, CCAH and CBDIO have worked collaboratively to expand interpreter access, including offering extended hours for appointments. Additionally, CCAH plans to conduct annual training for member-facing staff and collects feedback through surveys to continually assess and improve the quality of services. By fostering collaboration

with CBDIO and prioritizing member needs, CCAH remains committed to delivering effective and accessible language assistance services.

Plan to Evaluate Effectiveness of Interventions

CCAH is committed to enhancing equitable access to healthcare by addressing the linguistic needs of members. The following plan outlines the evaluation of the effectiveness of interventions aimed at improving interpreting services provided through the CLAS program.

The goals of the evaluation are to assess the accessibility and quality of Indigenous language interpretation services, identify any remaining gaps in service availability, and ensure that interventions align with CCAH's mission of equitable healthcare language services access.

CCAH will engage both internal and external stakeholders in this evaluation process. Internally, the organization will collaborate with departments such as Member Services, Provider Relations, and Network Development to identify operational challenges, community impacts, and improvement opportunities.

Externally, CCAH will work with Centro Binacional para el Desarrollo Indígena Oxaqueño (CBDIO) to monitor and gather insights and ensure that interventions are informed by the experiences of both members and providers about language service assistance.

CCAH will use a Plan-Do-Check-Act model to evaluate the effectiveness of changes. The model emphasizes the areas for improvement and the measurement of progress. This approach will be applied to CLAS program measures used to assess the effectiveness of the HE programs. In general, quality improvement initiatives adhere to the following process:

Measure the processes and/or outcomes to improve by identifying areas of deficiency in CLAS program. This involves conducting a thorough quantitative analysis that includes making comparisons of goals to national/regional/internal benchmarks and comparisons to prior performance. When possible, CCAH will also perform tests of statistical significance using relevant tests (e.g., Chi-square, Z-test, T-test, etc.).

The qualitative analysis will cover the following aspects and will be subject to review by a diverse team of professions including the Chief Medical Officer, Case Management Manager, Health Education Manager, Quality Management Manager, Member Services Manager, Provider Relations Manager, Provider Network Development Manager, Medical Director, and the Director of Quality.

- Clarify knowledge about the process.
- Gain a comprehensive understanding and clearly define the crucial factors and characteristics of the process.
- Conduct a robust analysis that includes brainstorming, categorizing and prioritizing barriers, and/or completing a fish-bone analysis.
- Determine the high priority areas that CCAH will concentrate on as a group. Then, prioritize the 4-6 areas according to resource availability.
- Create a plan for enhancing and/or incorporate the necessary documentation into the current Health Equity workplan.
- Develop clear and measurable process indicators to evaluate the impact of improvements.

- Create an interim goal and a schedule for continuous assessment.
- Initiate the process of improvement.
- Continuously analyze the situation to monitor progress at regular periods of time.
- Continue to enhance the process as needed.

7. Healthcare Effectiveness Data and Information Set (HEDIS) Program

7.1. Introduction

CCAH monitors several external and internally developed clinical quality measures that track the quality of health care services provided by the Plan's network of contracted providers. In order to calculate these rates for these measures, CCAH collects data from a variety of different sources that include but are not limited to the following:

- Annual National Committee for Quality Assurance (NCQA) HEDIS submission
- Annual Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) reporting
- Claims and encounter data from contracted primary and specialty care providers
- Claims and encounters from ancillary care providers (e.g., Hospitals, Labs, Radiology centers, etc.)

Measuring and reporting these measures helps CCAH assess the effectiveness of the care members have received. These clinical quality measures are used to evaluate multiple aspects of patient care including:

- Performance with healthcare outcomes and clinical processes.
- Effectiveness of program used to manage chronic conditions.

For the Medi-Cal population, DHCS requires reporting on MCAS, the primary set of performance measures to assess Medi-Cal Managed Care performance. These measures are developed by nationally recognized stewards such as the NCQA, the Centers for Medicare & Medicaid Services (CMS), and the Dental Quality Alliance (DQA), and are primarily reported through the HEDIS. The Alliance monitors and improves performance on MCAS measurement as part of its QIHETP.

Effectiveness of HEDIS Measures

HEDIS is a set of standardized performance measures designed to ensure that healthcare consumers have reliable information for performance comparison amongst health plans. Additionally, it guides the Plan in identifying clinical areas that need ongoing improvements efforts.

7.2. Results and Performance

The table below compares CCAH's performance on some of the key measures to the national percentiles adopted for use by DHCS. In 2025, CCAH will be focusing on improving the measures that did not exceed goals for measurement year (MY) 2023 and MY2024. The Line of Business (LOB) column reflects the reporting populations used in submission of the HEDIS measures to NCQA's Interactive Data Submission System (IDSS). In MY 2022 and 2023, Santa Cruz and Monterey County were combined for reporting "SC/MON," and Merced County was reported separately. Starting in 2025, for MY2024, managed care plans submit a single submission of their county(s) through NCQA IDSS, as well as individual county level reporting to DHCS. Future QIHETP & CLAS evaluations will reflect additional information for county level reporting for Mariposa County, Merced County, Monterey County, San Benito County, and Santa Cruz County.

HEDIS Measures Held to MPL	Measure Acronym	Measurement Year	LOB	Rate		MY22-MY23 Percentage Change	+/- Percentage of Benchmark	Goal 2024 NCQA 50th %ile	Goal Met*
Asthma Medication Ratio	AMR	2022-2023	SC/MON	78.79%	72.00%	-6.79%	6.39%	65.61%	Y
			Merced	79.92%	79.43%	-0.49%	13.82%		Y
		2024	All Plan	69.69%		No Trend	3.45%	66.24%	Y
Breast Cancer Screening	BCS-E	2022-2023	SC/MON	60.39%	63.48%	3.09%	10.88%	52.60%	Y
			Merced	49.65%	56.18%	6.53%	3.58%		Y
		2024	All Plan	62.45%		No Trend	9.77%	52.68%	Y
Cervical Cancer Screening	CCS	2022-2023	SC/MON	65.69%	69.15%	3.46%	12.04%	57.11%	Y
			Merced	61.08%	60.97%	-0.11%	3.86%		Y
		2024	All Plan	67.64%		No Trend	10.46%	57.18%	Y
Child and Adolescent Well-Care Visits	WCV	2022-2023	SC/MON	60.15%	65.68%	5.53%	17.61%	48.07%	Y
			Merced	45.64%	50.49%	4.85%	2.42%		Y
		2024	All Plan	63.32%		No Trend	11.51%	51.81%	Y
Childhood Immunization Status-Combination 10	CIS-10	2022-2023	SC/MON	51.09%	46.72%	-4.37%	15.82%	30.90%	Y
			Merced	16.06%	19.71%	3.65%	-11.19%		N
		2024	All Plan	35.84%		No Trend	8.35%	27.49%	Y

HEDIS Measures Held to MPL	Measure Acronym	Measurement Year	LOB	Rate		MY22-MY23 Percentage Change	+/- Percentage of Benchmark	Goal 2024 NCQA 50th %ile	Goal Met*
Chlamydia Screening in Women	CHL	2022-2023	SC/MON	61.39%	63.23%	1.84%	7.19%	56.04%	Y
			Merced	52.56%	52.62%	0.06%	-3.42%		N
		2024	All Plan	61.38%		No Trend	5.43%	55.95%	Y
Controlling High Blood Pressure	CBP	2022-2023	SC/MON	67.40%	65.45%	-1.95%	4.14%	61.31%	Y
			Merced	59.85%	63.50%	3.65%	2.19%		Y
		2024	All Plan	74.45%		No Trend	9.97%	64.48%	Y
Developmental Screening in the First Three Years of Life	DEV	2022-2023	SC/MON	NA	37.82%	NA	3.12%	34.70%	Y
			Merced	NA	35.29%	NA	0.59%		Y
		2024	All Plan	52.66%		No Trend	16.96%	35.70%	Y
Follow-Up After ED Visit for Mental Illness (FUM) - 30 days	FUM	2022-2023	SC/MON	60.67%	39.37%	-21.30%	-15.50%	54.87%	N
			Merced	70.72%	39.97%	-30.75%	-14.90%		N
		2024	All Plan	63.95%		No Trend	10.13%	53.82%	Y
Follow-Up After ED Visit for Substance Use-30 days	FUA	2022-2023	SC/MON	37.35%	34.55%	-2.80%	-1.79%	36.34%	N
			Merced	22.48%	20.42%	-2.06%	-15.92%		N
		2024	All Plan	44.84%		No Trend	8.66%	36.18%	Y

HEDIS Measures Held to MPL	Measure Acronym	Measurement Year	LOB	Rate		MY22-MY23 Percentage Change	+/- Percentage of Benchmark	Goal 2024 NCQA 50th %ile	Goal Met*
Glycemic Status Assessment for Patients With Diabetes (>9%)	GSD	2022-2023	SC/MON	25.79%	28.22%	2.43%	9.74%	37.96%	Y
			Merced	38.15%	31.63%	-6.52%	6.33%		Y
		2024	All Plan	29.20%		No Trend	4.13%	33.33%	Y
Immunizations for Adolescents—Combination 2	IMA-2	2022-2023	SC/MON	56.48%	60.34%	3.86%	26.03%	34.31%	Y
			Merced	33.09%	32.02%	-1.07%	-2.29%		N
		2024	All Plan	53.35%		No Trend	19.05%	34.30%	Y
Lead Screening in Children	LSC	2022-2023	SC/MON	78.83%	79.51%	0.68%	16.72%	62.79%	Y
			Merced	46.47%	47.01%	0.54%	-15.78%		N
		2024	All Plan	77.13%		No Trend	13.29%	63.84%	Y
Prenatal and Postpartum Care: Postpartum Care	PPC-Pst	2022-2023	SC/MON	95.65%	92.94%	-2.71%	14.84%	78.10%	Y
			Merced	81.02%	85.00%	3.98%	6.90%		Y
		2024	All Plan	88.56%		No Trend	8.33%	80.23%	Y
Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-Pre	2022-2023	SC/MON	91.30%	91.24%	-0.06%	7.01%	84.23%	Y
			Merced	92.21%	93.46%	1.25%	9.23%		Y
		2024	All Plan	92.46%		No Trend	7.91%	84.55%	Y

HEDIS Measures Held to MPL	Measure Acronym	Measurement Year	LOB	Rate		MY22-MY23 Percentage Change	+/- Percentage of Benchmark	Goal 2024 NCQA 50th %ile	Goal Met*
Topical Fluoride for Children	TFL-CH	2022-2023	SC/MON	NA	22.25%	NA	2.95%	19.30%	Y
			Merced	NA	20.25%	NA	0.95%		Y
		2024	All Plan	24.13%		No Trend	5.13%	19.00%	Y
Well-Child Visits in the First 30 Months of Life—15 to 30 Months—Two or More Well-Child Visits	W30-2+	2022-2023	SC/MON	77.78%	80.35%	2.57%	13.59%	66.76%	Y
			Merced	58.09%	61.10%	3.01%	-5.66%		N
		2024	All Plan	80.58%		No Trend	11.15%	69.43%	Y
Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits	W30-6+	2022-2023	SC/MON	62.23%	69.18%	6.95%	10.80%	58.38%	Y
			Merced	36.72%	48.69%	11.97%	-9.69%		N
		2024	All Plan	70.04%		No Trend	9.66%	60.38%	Y

**For the purposes of comparing goals, the most recent MY2023 rate is compared to applicable MPL rates to show goal attainment.*

Quantitative Analysis

- CCAH evaluated 18 measures, totaling 54 individual goals across Merced County, Santa Cruz/Monterey County, and All Plan submissions. Out of these measures, 44 met their goals, and 10 did not.
- The lowest-performing measure in MY23 was Follow-Up After Emergency Department Visit for Mental Illness – 30 days (FUM), in Merced County, with a loss of 29.78% from the previous year. It achieved only 25.09% against a goal of 54.87%, which means it fell short by 29.78 percentage points.
- The highest-performing measure that exceeded the goal the most was Immunizations for Adolescents - Combo 2 in Santa Cruz/Monterey. The rate reached 60.34%. compared to a goal of 34.31% %. The measure exceeded the target by 26.03 percentage points.

Changes in FUM and FUA measures followed payment structure changes for Mental Health Plans (MHPs), that delayed data sharing from DHCS to MCP from reporting.

7.3. MCAS MY2023 Identified Priorities

In MY 2023, reporting year (RY) 2024, the identified priority measures for the Alliance included Childhood Immunization Status-Combination 10 (CIS-10), Immunizations for Adolescents-Combination 2 (IMA-2), Lead Screening in Children (LSC), Well-Child Visits in the First 30 Months of Life-15 to 30 Months—Two or More Well-Child Visits (W30-2), Well-Child Visits in the First 30 Months of Life-0 to 15 Months-Six or More Well-Child Visits (W30-6), and Chlamydia Screening in Women (CHL) in Merced County that were at or below minimum performance levels (MPLs) designated by DHCS. When compared to our more coastal communities in Santa Cruz and Monterey County, Merced County residents face greater sociogeographic health challenges as indicated by the Healthy Places Index score when compared to our more coastal communities in Santa Cruz and Monterey County.

Reporting Unit	Measure Acronym	Domain	Rate	MPL	Trending Difference from MY2022 to MY2023	Population Impacted
Merced	CIS-10	Children's Health	19.71%	30.90%	3.65	1,974
Merced	IMA-2	Children's Health	32.02%	34.31%	-1.07	2,072
Merced	LSC	Children's Health	47.01%	62.79%	0.54	1,303
Merced	W30-2	Children's Health	61.10%	66.76%	3.01	944
Merced	W30-6	Children's Health	48.69%	58.38%	11.97	881

Merced	CHL	Children's Health	52.62%	56.04%	0.06	2,198

When the Alliance expanded to Mariposa and San Benito Counties in 2024, MY23 MCAS performance from the previous health plans was reviewed, however with regional grouping and two model health plan assignment, this made it difficult to fully predict rates for the new counties. Monthly data was tracked and reviewed throughout calendar year 2024 for the new counties, however due to the 12 months of continuous enrollment requirements, the Alliance did not have an accurate assessment of MCAS measure rates for Mariposa and San Benito until December 2024.

7.4. MCAS MY 2023 Interventions in 2024

As part of the MCP's quality strategy, provider and member interventions have been targeted to support challenges like hiring and retaining staff be updated to help achieve improvement, particularly in Merced County, and placed in CY 2025 QI Workplan, as well as and added to the Alliance Strategic Priorities. Interventions identified included

Provider Strategies in Merced County

- The Workforce Support for Care-Gap Closure grant, established in late 2023 for the largest Merced County providers, was expanded in 2024 to pay for locum providers in Merced County with more than 1,000 linked members. These grants supported expanded hours for after-hours and weekend appointments to help school-age children and working parents accessing care, focusing on visits specific to services required for MCAS performance measures.
- As part of the grant, CCAH provided equipment reimbursement for point-of-care blood lead screenings to help increase access and reduce barriers by eliminating time needed to visit another facility for the lab.
- Workforce recruitment grants were expanded to support community health workers and doulas in addition to medical assistants and providers.
- Technology grants offered providers opportunities to communicate with members, including developing texting campaigns for members past due for services, with upcoming appointments, or overdue for specific preventive services (e.g., flu shot, breast cancer screening).
- CCAH launched a new Provider Partnership Pilot Program with five of our largest provider clinics in Merced County to focus on pediatric well-child visits.
- CCAH launched a new forum for Merced County providers to discuss barriers to close care gaps, community culture, and support needed from CCAH, gathering ideas for provider lunch and learn sessions.
- CCAH revised its primary care incentive payment program to include additional payment for performance improvement to support geographically disadvantaged communities in an effort to address disparities present.

Member Strategies

- CCAH began the Healthy Start Program in April 2023 that provides direct incentives (gift cards) for pediatric members for completing immunizations, well-child visits, or well-care visits. In 2024, the strategy was to increase communication efforts to promote the Healthy Start Program to members, network providers, community partners, and internal CCAH departments with staff members who interact with members, and highlighted in the CCAH Member Newsletter, which is distributed quarterly to members.

- CCAH contracted with a vendor to develop new member texting campaigns. The launch in the fall and winter 2024 campaigns included new member welcome text. infant flu incentive reminders, and well-child and adult checkup reminders.
- Strategies under development in Merced County include support for mobile mammography.
- CCAH held the second annual health fair to build trust in the community and provide flu vaccinations in October.
- New point of service member incentive for flu vaccinations for members under 2 years of age and well-child visits for members 12 to 17 years of age.
- CCAH staff partnering with stakeholders in Merced County on events, including backpack immunization events, which encouraged students to prepare for school and receive the recommended vaccinations. Additionally, CCAH partnered with the Merced County Office of Education and Dignity Health to help launch educational campaigns as well as school site immunization clinics.

8. Care-Based Incentive (CBI) Program

8.1. Introduction

The Care-Based Incentive program promotes the Patient-Centered Medical Home, through evidence-based best practice, access, value, and quality of care while rewarding performance and aligning with both the DHCS Quality Strategy and Alliance Strategic Plan. The CBI program is designed in collaboration with Alliance network providers, prioritizing areas that drive high quality of care and reduce healthcare costs in focusing on improvements in MCAS metrics and coordination of care metrics. The program offers rewards to primary care providers for:

- MCAS metrics above the NCQA Medicaid 50th percentile and for improvement on metrics from one program year to the next.
- Care coordination metrics above the CBI Provider's Comparison Group's 2019 Measurement Period median score for the applicable measure, or Alliance defined benchmarks, and improvement from one program year to the next.

The Alliance collects data from the following sources:

- Claims and encounter data from contracted primary and specialty care providers
- Claims and encounters from ancillary care providers (e.g., Hospitals, Labs, Radiology centers, etc.)
- Data Submission Tool (DST) through the Alliance Provider Portal which allows Alliance providers to upload data files via the Provider Portal. This data supplements what cannot be received through claims or labs.

Measuring and reporting these measures helps the Alliance assess the effectiveness of the care members have received. These clinical quality measures are used to evaluate multiple aspects of patient care including:

- Performance with healthcare outcomes and clinical processes.
- Effectiveness of program used to manage chronic conditions.

8.2. Results and Performance

The table below compares the Alliance's performance between 2023 and 2024 CBI Measures.

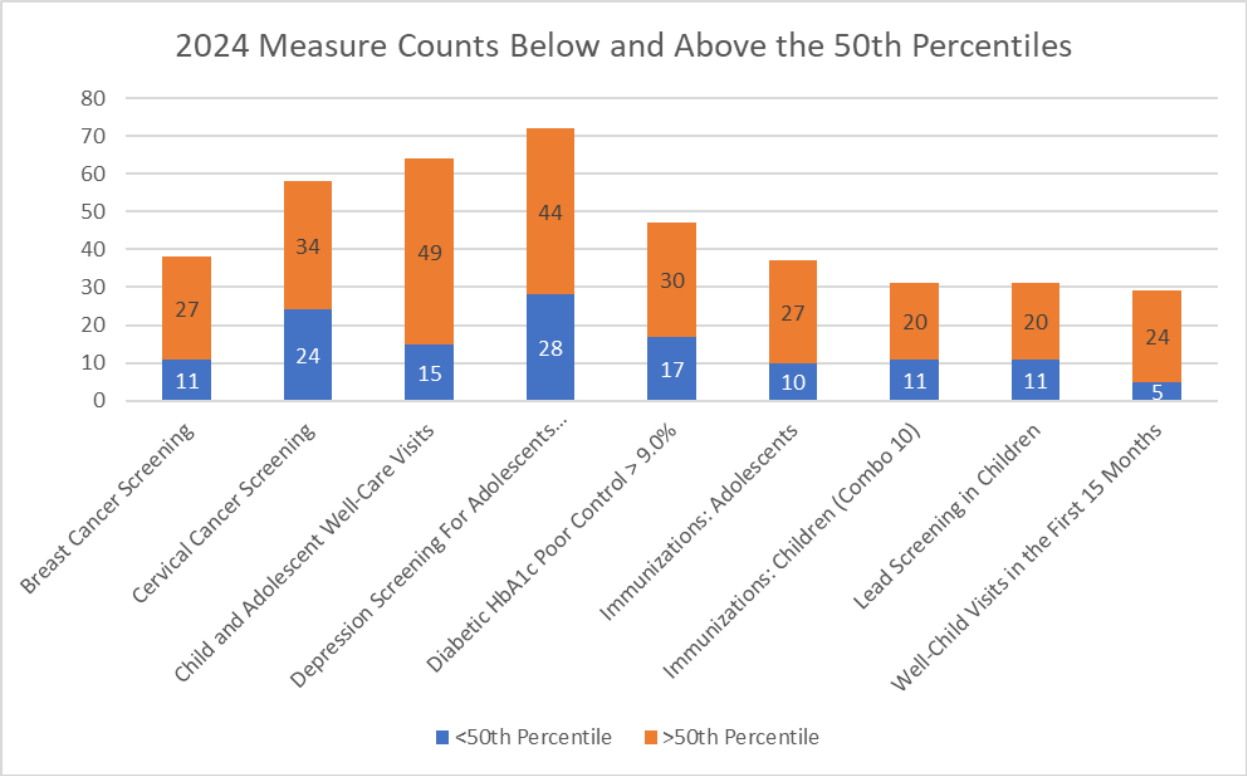
CBI Quality of Care Measures

MEASURE	2023	2024	2023-2024 TREND	% CHANGE
Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents	19.18%	26.60%	↑	7.42%
Application of Dental Fluoride Varnish	21.25%	29.80%	↑	8.55%
Developmental Screening in the First 3 Years	37.02%	53.03%	↑	16.01%
Initial Health Appointment (IHA)	51.78%	34.72%	↓	-17.06%
Post-Discharge Care	37.75%	37.63%	↓	-0.12%
Ambulatory Care Sensitive Conditions	6.60%	6.08%	↓	-0.52%
Plan All-Cause Readmissions	8.06%	8.52%	↑	0.46%
Preventable Emergency Visits	14.38%	13.67%	↓	-0.71%
Breast Cancer Screening	61.41%	62.82%	↑	1.41%
Cervical Cancer Screening	63.52%	60.76%	↓	-2.76%
Child and Adolescent Well-Care Visits (3-21)	60.14%	63.36%	↑	3.22%
Depression Screening for Adolescents and Adults	-	29.97%	-	-
Diabetic HbA1c Poor Control >9.0%	35.51%	36.59%	↑	1.08%
Immunizations: Adolescents	48.26%	53.20%	↑	4.94%
Immunizations: Children (Combo 10)	34.06%	35.88%	↑	1.82%
Lead Screening in Children	65.98%	74.22%	↑	8.24%
Well-Child Visit In The First 15 Months	65.16%	72.58%	↑	7.42%

Improvement was made for 11 out of 18 measures taking into account Santa Cruz, Monterey, and Merced counties. 2024 rates included the newly added counties of Mariposa and San Benito. Of note, all of the pediatric measures improved from 2023 to 2024.

Measure Counts Below and Above the 50th Percentiles

The graph below illustrates performance on all of the Quality-of-Care Measures as they relate to above or below the 50th percentile. All measures had substantially more providers above the 50th percentile, with pediatric measures often having more than twice the number of providers above the fiftieth percentile than below it. Measures with the highest number of providers above the 50th percentile were Child and Adolescent Well-Care Visits and Depression Screening for Adolescents and Adults. The measure with the fewest number of providers below the 50th percentile was Well-Child Visits in the First 15 months. A total of 72 provider groups are included in the graph below. However, not all providers qualify for all measures (e.g., internal medicine groups generally do not qualify for pediatric measures), all providers in the table below qualify at minimum for the Depression Screening for Adolescents and Adults measure.



CBI Tier Summary

In prior years, the Alliance implemented a payment adjustment, with a decrease in CBI payment using a tiered system for those providers that did not meet the 50th percentile on Quality of Care measures. Each provider group is categorized as meeting the requirements of one of the five tiers. The Alliance continues to monitor provider performance through the use of tiers, specifically examining the number of measures between the 25th and 49th percentiles, as well as below the 50th percentile for evaluation purposes. Excluded from the Tier Analysis for 2024 are measures that are new to the 2024 Quality of Care Measures: Depression Screening in Adolescents and Adults and Lead Screening in children. This allows providers one year to improve upon their rates prior to inclusion in the analysis.

The table below takes into account 69 CBI provider groups. The percentage of providers within each tier has remained relatively consistent from Q4 2023 to Q4 2024, but with a slight decrease in Tier 4; indicating that less providers have four or more measures below the 50th percentile. Programmatic year 2023 did not include the counties of San Benito and Mariposa. Due to the continuous enrollment requirements of the HEDIS measures, providers from San Benito and Mariposa counties were only included in the tier analysis in Q4 2024.

Tiers	Q4 2023 Tier	Q1 2024 Tier	Q2 2024 Tier	Q3 2024 Tier	Q4 2024* Tier
All Measures >50th percentile	40.00%	33.90%	38.33%	38.33%	40.58%
Tier 1 : 1-3 Measures between 25th and 49th percentile	13.00%	23.73%	20.00%	18.33%	10.14%
Tier 2 : 4+ Measures between 25th and 49th percentiles	0.00%	0.00%	0.00%	0.00%	0.00%
Tier 3 : 1-3 Measures <250th percentile	43.00%	40.68%	40.00%	43.33%	47.83%
Tier 4 : 4+ Measures <25th percentile	5.00%	1.69%	1.67%	0.00%	1.45%

**Q4 2024 Nine additional providers qualified for HEDIS measures from San Benito and Mariposa counties.*

Supplemental Data Submission Tool

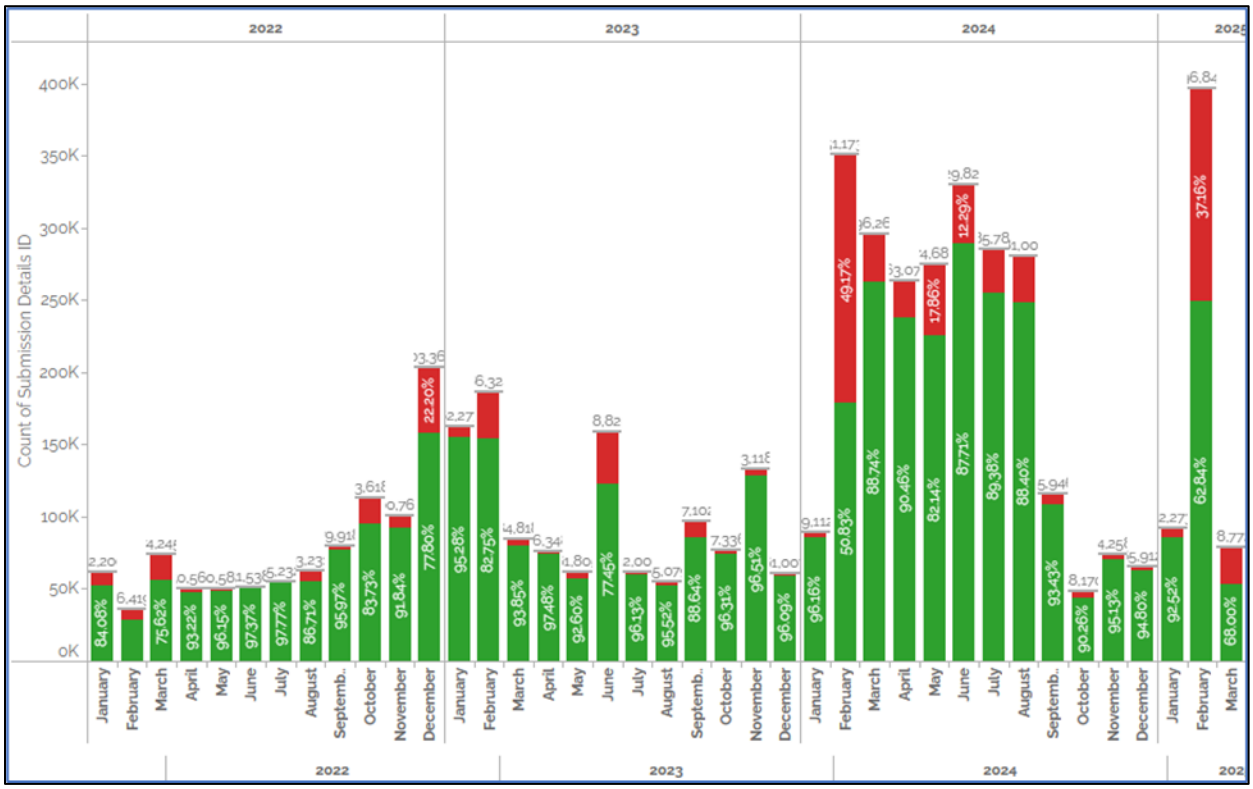
Providers can bridge data gaps as it relates to members receiving care. If there is a discrepancy between Alliance reports and provider records, providers can upload the required information with specified parameters to the Data Submission Tool (DST). Providers upload data to the DST numerous times per day. The table below lists all of the measures for which providers can submit data in order to bridge data gaps.

Measures	
Breast Cancer Screening (Screening and Mastectomies)	Diabetic HbA1c Poor Control >9%
Cervical Cancer Screening	Depression Screening and Follow-Up for Adolescents and Adults
Child and Adolescent Well-Visits	Fluoride Varnish
Chlamydia Screening	Immunizations for Adolescents, Children, and Adults
Controlling Blood Pressure	Initial Health Appointment (IHA)
Colorectal Cancer Screening	Lead Screening in Children
Developmental Screening	Post-Discharge Care

The graph below illustrates the total number and percentage of rows of data submitted through the DST From January 2022 to March 2025: green bars indicate accepted rows; red bars indicate rejected rows. Rows of data can be rejected for several reasons including but not limited to:

- Invalid member id
- Invalid procedure code
- Invalid format for date of service or date of birth, and
- Duplicate row of data within the same file

2024 saw the highest number of submissions per year, substantially more submissions each month than in prior years. The high utilization the DST indicates the usefulness of this tool in order to bridge data gaps for member services.



The table below details the number of submissions for each of the CBI measures for which DST data is accepted. Depression Screening for Adolescents and Adults relies exclusively on DST submissions due to LOINC codes being the only allowable type of code accepted for the measure. As such, it has the highest number of submissions of all measures. Providers also had the most rejected rows for this measure as most of them found it very challenging to extract or crosswalk their existing codes to the required LOINC codes.

Submission Type	Rejected	Accepted	Grand Total
Breast Cancer Screening	1363	6566	7929
Controlling Blood Pressure	775	86687	87462
Cervical Cancer Screening	760	18254	19014

Chlamydia Screening	22	5026	5048
Colorectal Cancer Screening	78	5709	5787
Developmental Screening	5205	15426	20631
Depression Screening	29882	226948	256830
Fluoride Varnish	146	25895	26041
HbA1c	3056	89421	92477
Initial Health Appointment	713	32480	33193
Immunizations (Children, Adolescents, Adults)	12989	50978	63967
Well-Visits (all)	1332	95369	96701
Grand Total	58738	679010	737748

Overall, the DST is a highly used tool for providers in order to submit data and bridge existing data gaps that exist between Alliance reports and provider records. Correct and applicable submissions in turn improve provider rates on the respective measures.

Provider Engagement – CBI Meetings

The table below illustrates the CBI team's high level of provider engagement in 2024. Out of a total of 273 documented encounters or requests, 115 of those were in-person or virtual meetings (CBI Forensics, Meeting (Other), cJOC, and Provider Partnership). The Alliance prides itself on the level of support given to providers in order for providers to be more successful in serving Alliance members. This was also the first year of engagement with Mariposa and San Benito Providers in the CBI program.

Meeting	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
CBI Forensics	3	2	0	2	9	7	3	1	4	3	0	3	**37**
Ad Hoc/Other	1	2	0	0	2	2	3	2	2	0		1	**15**
ACE Attestation	0	0	0	2	3	0	3		5	7	4	4	**28**
Meeting (Other, please specify):	2	3	0	5	3	2	5	1	2	2	2	1	**28**
cJOC	0	1	3	0	1	3	1	0	3	1	2	2	**17**
Provider Question	3	3	0	4	1	2	9	10	12	19	11	11	**85**

Provider Partnership	0	0	0	9	4	2	5	2	2	3	3	3	**33**
Report	0	1	0	5	0	5	5	2		6	1	5	**30**
Total completed	9	12	3	27	23	23	34	18	30	41	23	30	**273**

8.3. Conclusion

The CBI program is a very robust incentive program created to support providers in their efforts to provide quality care for Alliance members. Providers are given many resources including reports, the DST, and many avenues of communication with the CBI team. From 2023 to 2024, providers mostly improved on various measures and primarily achieved above the 50th percentile on the Quality of Care measures.

9. Reporting Stratified Measures

CCAH is committed to reducing health disparities and recognizes that racial and ethnic identity data is pivotal in reviewing population health. The purpose of this continued quality initiative is to improve member health outcomes by providing timely, equitable healthcare.

9.1. Member Experience Survey

Introduction

Central California Alliance for Health (CCAH) conducts the annual Member Experience Survey to evaluate member-reported experiences with healthcare services and identify areas for improvement. For the Measurement Year 2023 survey, CCAH partnered with Press Ganey, a National Committee for Quality Assurance (NCQA) certified HEDIS Survey Vendor, to administer the CAHPS 5.1 Medicaid Adult Survey. This survey is a critical tool for fulfilling NCQA accreditation requirements and aligns with HEDIS standards.

The survey's objective is to capture insights into member experiences and satisfaction, measure the extent to which plans meet members' expectations and needs, and identify opportunities to enhance care quality and member satisfaction. A core focus is identifying disparities in care and supporting efforts to deliver culturally and linguistically appropriate services, ultimately reducing healthcare inequities.

Methodology

The MY 2023 CAHPS® 5.1 Medicaid Adult Survey was conducted by Press Ganey, using a methods approach to ensure comprehensive data collection. The survey timeline included the first questionnaire mailed on April 11, 2023, followed by a second mailing on May 16, 2023. Non-responders were contacted through follow-up calls starting June 6, 2023, and the final day to accept completed surveys was June 2, 2023. The survey assessed key aspects of member experiences, such as access to care, communication, customer service, and experiences of unfair treatment due to race, ethnicity, language, or culture.

A total of 443 surveys were completed from an adjusted sample of 1,976 eligible members, resulting in a 22.4% response rate.

Goal

The goal of the Member Experience Survey is to assess healthcare disparities among diverse demographic groups, including race/ethnicity, language, gender identity, and sexual orientation. CCAH set the member satisfaction standard at 80%.

Result

CCAH selected survey questions related to race/ethnicity data to assess healthcare disparities. This analysis aims to identify areas of inequity and inform targeted quality improvement efforts to enhance culturally and linguistically appropriate services and reduce disparities.

- Equity in Treatment (Questions 1-3)
    - These questions assess members' experiences with fairness and cultural understanding in their healthcare interactions. The summary rates (% Never or Sometimes) indicate the frequency of minimal or no negative experiences.
- Access to Care (Questions 4-6)
    - The composite scores for access to care provide a comprehensive view of members' experiences with obtaining timely and necessary healthcare services. The summary rates (% Always or Usually) reflect the frequency of positive experiences.
- Communication (Question 7)
    - How Well Doctors Communicate Composite Score: This measure evaluates members' satisfaction with their doctors' communication skills, including listening, explaining, showing respect, and spending adequate time during appointments. The summary rates (% Always or Usually) reflect the frequency of positive experiences.

Equity in Treatment	**White**	**Black or African-American**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**American Indian or Alaska Native**	**Other**	**Hispanic**	**Not Hispanic**
1. In the last 6 months, how often were you treated unfairly at your personal doctor's office because you did not speak English very well?								
Numerator	207	14	22	9	18	121	238	156
Denominator	220	15	25	10	18	129	255	169
Rate	98.1%	100.0%	100.0%	100.0%	100.0%	95.3%	96.0%	99.4%
2. In the last 6 months, how often have you been treated unfairly at your personal doctor's office because of your race or ethnicity?								
Numerator	209	13	23	8	15	121	236	162
Denominator	220	15	25	10	18	129	255	169
Rate	99.1%	92.9%	95.8%	88.9%	88.2%	95.3%	96.3%	100.0%
3. In the last 6 months, how often did your personal doctor (or office staff) say or do something that made you feel that they did not understand your culture or language?								
Numerator	211	13	20	8	17	121	242	158
Denominator	220	15	25	10	18	129	255	169
Rate	99.5%	92.9%	90.9%	88.9%	100.0%	96.0%	98.0%	98.8%

**Rate: show the summary rate of % Never or Sometimes*

Quantitative Analysis

Question 1

- When asked about unfair treatment due to language proficiency, all races and ethnicity met the goal of 80% member satisfaction.
- Black or African American, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native achieved 100% satisfaction, making them the top-performing groups. White(98.1%) and Other are follow.
- For Ethnicity Not Hispanic/Latino(99.4%) did better than Hispanic/Latino(96%) 3.4 percentage points

Question 2

- For experiences of unfair treatment due to race or ethnicity, all groups achieved high met the 80% goal.
- White members reported 99.1 % satisfaction, was the top-performing racial group, exceeding the goal by 19.1 percentage points.
- Black or African American members reported a satisfaction rate of 92.9 %, and Native Hawaiian or Other Pacific Islander members reported 88.9 %, showing the lowest rate among racial groups. Hispanic/Latino members achieved 96.3 % satisfaction, which was slightly lower than the 100 % satisfaction rate reported by Not Hispanic/Latino members.
- All racial and ethnic groups met the goal of 80% member satisfaction.
- White (99.1%) was the top-performing racial group, exceeding the goal by 19.1 percentage points. Asian (95.8%) had the second-highest rate, exceeding the goal by 15.8 percentage points, and was 3.3 percentage points lower than the top-performing group.
- Black or African American members reported a satisfaction rate of 92.9 %, and Native Hawaiian or Other Pacific Islander members reported 88.9 %.
- American Indian or Alaska Native had 88.2%, showing the lowest rate among racial groups.
- For ethnicity, Not Hispanic (100%) exceeded the goal by 20 percentage points, while Hispanic (96.3%) exceeded the goal by 16.3 percentage points. The difference between Not Hispanic and Hispanic was 3.7 percentage points.

Question 3

- In terms of whether personal doctors or office staff demonstrated an understanding of culture or language, all groups exceeded the 80% goal.
- American Indian or Alaska Native achieved the highest satisfaction rate at 100%, exceeding the goal by 20 percentage points. White members followed with a satisfaction rate of 99.5%, exceeding the goal by 19.5 percentage points and falling 0.5 percentage points below the top-performing group. The Other group achieved 96%, meeting the goal by 16 percentage points and below the top-performing group by 4 percentage points.
- Black members reported a satisfaction rate of 92.9%, exceeding the goal by 12.9 percentage points but falling 7.1 percentage points below the top-performing group. Asian members reported 90.9% satisfaction, exceeding the goal by 10.9 percentage points and below the top-performing group by 9.1 percentage points.
- Native Hawaiian or Other Pacific Islander had the lowest satisfaction rate at 88.9%. However, the rate met the goal by 8.9 percentage points and was below the top-performing group by 11.1 percentage points.
- For ethnicity, Hispanic/Latino members achieved a satisfaction rate of 98 %, which was slightly lower than the 98.8 % satisfaction rate of Not Hispanic/Latino members.

Access to Care and Communication	White	Black or African-American	Asian	Native Hawaiian or Other Pacific Islander	American Indian or Alaska Native	Other	Hispanic	Not Hispanic
4. Customer Service Composite Score								
Base	61	4	7	2	6	43	80	50
Rate	84.4%	87.5%	71.4%	100.0%	91.7%	89.5%	91.8%	83.0%
5. Getting Needed Care Composite Score								
Base	170	12	16	6	12	80	174	129
Rate	79.1%	80.2%	72.7%	57.5%	60.7%	83.4%	84.7%	73.3%
6. Getting Care Quickly Composite Score								
Base	151	11	18	4	11	72	160	116
Rate	80.9%	75.0%	52.2%	66.7%	64.6%	83.5%	80.6%	71.9%
7. How Well Doctors Communicate Composite Score								
Base	127	6	13	3	4	72	141	98
Rate	93.4%	100.0%	82.7%	75.0%	100.0%	91.2%	93.1%	89.8%

**Rate: show the summary rate of % Always or Usually*

Quantitative Analysis

Question 4: Customer Service Composite Score

- When analyzed customer service composite Score, only Asian did not meet the satisfaction goal of 80% .
- Native Hawaiian or Other Pacific Islander achieved the highest satisfaction rate at 100%, exceeding the goal by 20 percentage points.
- American Indian or Alaska Native (91.7%) had the second-highest rate. It met the goal by 11.7 percentage points and was 8.3 percentage points below the top-performing group.
- The other group(89.5%) was the third followed by Black(87.5%), and White(84.4%). These groups met the goal by approximately 4.4-9.5 percentage points.
- Asian had 71.4% did not meet the goal by 8.6 percentage points. This rate was also below the top-performing group by 28.6 percentage points.
- For ethnicity, Hispanic members achieved a satisfaction rate of 91.8%, exceeding the goal by 11.8 percentage points, while Not Hispanic members had 83.0%, exceeding the goal by 3 percentage points. The difference between the two groups was 8.8 percentage points.

Question 5: Getting Needed Care Composite Score

- When analyzing the getting needed care composite score, White, Asian, Native Hawaiian or Other Pacific Islander, and American Indian or Alaska Native did not meet the satisfaction goal of 80%. Only the other group and the Black population met the goal.
- The Other group achieved the highest satisfaction rate at 83.4%, exceeding the goal by 3.4 percentage points.
- Black or African American (80.2%) had the second-highest rate, meeting the goal by 0.2 percentage points, and was 3.2 percentage points below the top-performing group.
- White (79.1%), Asian (72.7%), Native Hawaiian or Other Pacific Islander (57.5%), and American Indian or Alaska Native (60.7%) did not meet the goal. Their rates were 20.9-22.5 percentage points below the top-performing group.

- For ethnicity, Hispanic members achieved a satisfaction rate of 84.7%, exceeding the goal by 4.7 percentage points. Not Hispanic members had 73.3%, missing the goal by 6.7 percentage points. The difference between the two groups was 11.4 percentage points.

Question 6: Getting Care Quickly Composite Score

- For getting care quickly composite score, all racial groups except White and the Other group did not meet the satisfaction goal of 80%.
- The Other group achieved the highest satisfaction rate at 83.5%, exceeding the goal by 3.5 percentage points.
- White (80.9%) had the second-highest rate, exceeding the goal by 0.9 percentage points and was 2.6 percentage points below the top-performing group.
- Black (75.0%), Asian (52.2%), Native Hawaiian or Other Pacific Islander (66.7%), and American Indian or Alaska Native (64.6%) did not meet the goal. Their rates were 16.8-31.3 percentage points below the top performing group.
- For ethnicity, Hispanic members achieved a satisfaction rate of 80.6%, exceeding the goal by 0.6 percentage points, while Not Hispanic members had 71.9%, missing the goal by 8.1 percentage points. The difference between the two groups was 8.7 percentage points.

Question 7: How Well Doctors Communicate Composite Score

- All racial and ethnic groups met the goal of 80% when analyzed member satisfaction rate of how well doctor communicate.
- Black or African American and American Indian or Alaska Native achieved the highest satisfaction rates at 100%, exceeding the goal by 20 percentage points.
- White (93.4%) had the second-highest rate, exceeding the goal by 13.4 percentage points, and was 6.6 percentage points below the top-performing groups.
- The Other group (91.2%) was third, followed by Asian (82.7%). These groups exceeded the goal by approximately 2.7-11.2 percentage points but were 8.8-17.3 percentage points below the top-performing groups.
- For ethnicity, Hispanic members achieved a satisfaction rate of 93.1%, exceeding the goal by 13.1 percentage points, while Not Hispanic members had 89.8%, met the goal by 9.8 percentage points. The difference between the two groups was 3.3 percentage points.

Qualitative Analysis

The analysis reveals disparities in member satisfaction across racial and ethnic groups, influenced by various factors related to access, communication, and cultural competence in healthcare services.

Language Barriers and Cultural Competence

- Higher satisfaction rates among groups like Black or African American and American Indian or Alaska Native in "How Well Doctors Communicate" scores (100%) suggest that culturally competent care significantly enhances patient experiences. In contrast, groups with lower satisfaction rates, such as Asian members (82.7%), face challenges in cultural understanding and language communication, particularly for those with limited English proficiency (LEP). Asian members who struggle to explain their symptoms because of language barriers visit doctors less often and get less preventive care, resulting in lower satisfaction compared to those who speak English well.

Accessibility to Care

- Lower rates for groups such as Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native in the "Getting Needed Care" and "Getting Care Quickly" composites (57.5% and 64.6%, respectively) shows potential barriers to timely access. These barriers could stem from geographic limitations, understaffed facilities, or a lack of culturally sensitive outreach efforts. Members living in remote areas such as rural Alaska or Pacific islands may face long travel times to the nearest clinic. Coupled with understaffed facilities, this delays care and reduces satisfaction.

Conclusion

There seems to be low disparity in CCAH services because Black and Hispanic member satisfaction rates did not show the lowest rates as typically observed in studies. This indicates that most members of different races and ethnicities are satisfied with our services. However, there are lower satisfaction rates specifically related to access to care among minority groups such as Asian, Native Hawaiian or Other Pacific Islander, and American Indian or Alaska Native members. This may be due to language barriers and geographic limitations in accessing care.

9.2. Hemoglobin A1c (HBD)

The Hemoglobin A1c (HBD) health disparity analysis focuses on assessing blood sugar control among members with diabetes within CCAH population. This analysis uses HEDIS measures to identify healthcare disparities, track progress, and target opportunities for improvement to ensure equitable health outcomes. The goals for this analysis include maintaining HbA1c control below 8% and reducing poor HbA1c control above 9% within the Medicaid HMO population. This assessment will guide interventions that address care disparities across race, ethnicity, and language, ultimately helping to close gaps and improve diabetes management outcomes for all eligible members.

Goal

The goal of this analysis is to review HEDIS healthcare measures to identify opportunities for improvement among CCAH members who have not yet achieved their care objectives. Goals were based on the official HEDIS MY2022 benchmarks at the 50th percentile, which were the latest available benchmarks at the time of the analysis. The goals are as follows:

Product Type	Measure	Goal 50th percentile	Goal Met
Medicaid HMO	HbA1c Control (<8%)	50.9%	**Higher Rate is Better**
Medicaid HMO	Poor HbA1c Control (>9%)	40.3%	**Lower Rate is Better**

Objectives

- Monitor and trend annual HEDIS for health equity gaps:
    - Hemoglobin A1c control for patients with diabetes
        - HBD Measure contains HbA1C <8% and >9%
- Identify potential opportunities for improvement for health disparity projects.
- Identify disparities in care by race/ethnicity or language.

- Identify potential improvement opportunities that can be implemented for members with disparities.
- Develop interventions to reduce disparities in care.

Data Collection

CCAH adheres to NCQA HEDIS reporting methodology by utilizing NCQA certified reporting and audit vendors for our annual data measurement and reporting process. Healthcare disparity measures are included in the NCQA HEDIS measure sets. HEDIS data logic is reported as either:

- **Administrative:** Claims, encounters, or other approved supplemental data feeds received electronically (e.g., lab results).
- **Hybrid:** A combination of administrative data and medical record information.

Methodology for Measurement

Frequency of Data Collection and Review:

- **Quantitative:** Gaps in care (GIC) analysis of healthcare disparity measures are performed monthly. Hybrid HEDIS data analysis for the measure will occur at the end of the measurement year. Administrative analysis occurs on a quarterly basis. Additionally, an assessment of intervention effectiveness will be completed based on final measurement year performance.
- **Qualitative Analysis:** Will be performed on an annual basis.
- A group of Subject Matter Experts (SMEs) at CCAH will review the findings in this report and determine the root cause(s) of the problem.
- **Severity Assessment:**
    - Outcomes and performance on healthcare disparity measures will be analyzed year over year.
- **Opportunities for Improvement:**
    - CCAH will determine the barriers, or opportunities to improve healthcare disparity measures compliance rates through assessing internal processes, patient utilization data, gaps in care, provider performance, and any additional sources of data pertinent to monitoring.
    - When assessing disparities within a measure, members group with 30 or more members will be assessed.
    - Disparities targeted will include known and defined member groups that score lower than the highest performing member groups.

Results

Medi-Cal Merced Population: *Hemoglobin A1c Control for Patients with Diabetes (HBD):*

The data below includes hemoglobin A1c for patients with diabetes (HBD) HbA1C <8%.

MY2023						
Product Line	**Data Type**	**Num/Den**	**HEDIS/GIC Rate**	**Data Type**	**Num/Den**	**HEDIS/ GIC Rate**
Medi-Cal Merced	Admin (HEDIS)	2,773/6,543	42.38%	Hybrid (HEDIS)	232/411	56.45%

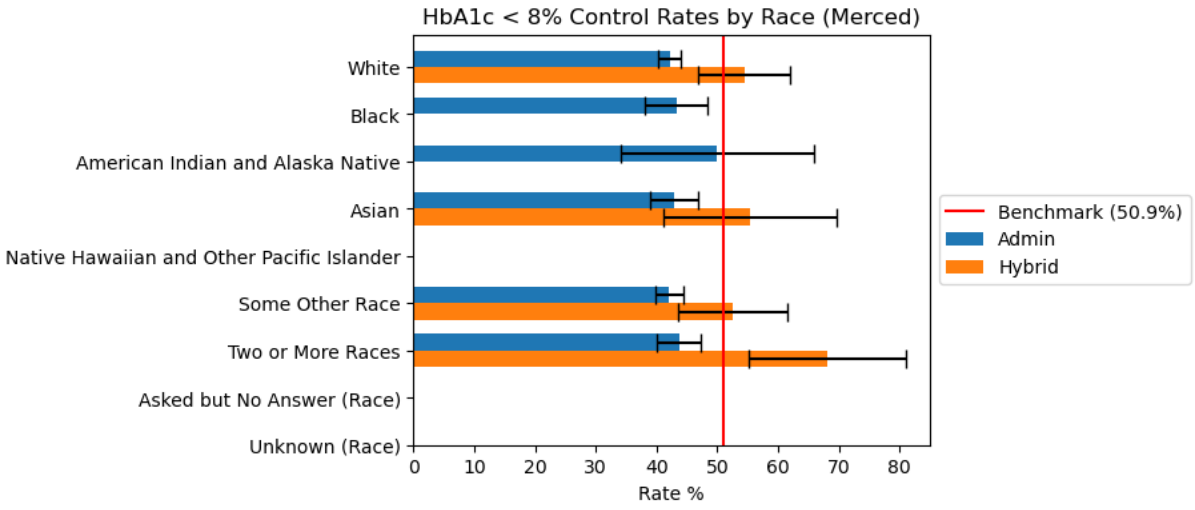
Health Equity performance data by measure: *The data below displays the hemoglobin A1c patient with diabetes disparity data.*

HbA1c 8% Rate by Race for Merced Population

Medi-Cal Merced Population	Race	Universe	Compliant	Compliance Rate %	% Difference between Top Performing Group	Year over Year Trend 2022-2023
MY2023 (HEDIS- Admin**)**	**White**	2,962	1,248	42.13%	-7.87%	N/A
	Black	347	150	43.23%	-6.77%	N/A
	American Indian and Alaska Native	38	19	50.00%	0.00%	N/A
	Asian	613	263	42.90%	-7.10%	N/A
	Native Hawaiian and Other Pacific Islander	22	5	22.73%	*N<30	N/A
	Some Other Race	1,852	779	42.06%	-7.94%	N/A
	Two or More Race	707	309	43.71%	-6.29%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	2	0	0.00%	*N<30	N/A
MY2023 (HEDIS- Hybrid**)**	**White**	169	92	54.44%	-13.56%	N/A
	Black	21	15	71.43%	*N<30	N/A
	American Indian and Alaska Native	4	2	50.00%	*N<30	N/A
	Asian	47	26	55.32%	-12.68%	N/A
	Native Hawaiian and Other Pacific Islander	0	0	0.00%	*N<30	N/A
	Some Other Race	120	63	52.50%	-15.50%	N/A
	Two or More Race	50	34	68.00%	0.00%	N/A

	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	0	0	0.00%	*N<30	N/A

Note: The data combines direct and indirect measurements. The higher the better performance.



Quantitative Analysis

For the Medi-Cal HbA1c <8% measure by race, the benchmark for HbA1c <8% (50.9%) was met by the hybrid data but not by the admin data.

Admin

- American Indian and Alaska Native had the highest compliance rate of 50.00%. This group did not meet the goal, falling short by 0.90 percentage points.
- Among large population sizes, the highest compliance rate was observed in the Two or More Races group, with a rate of 43.71%. This group serves as the referent for comparison. It did not meet the goal of 50.9%, falling short by 7.19 percentage points.
- Black achieved a compliance rate of 43.23%, which is 7.67 percentage points below the benchmark and 0.48 percentage points lower than the top performing Two or More Races group.
- Asian recorded a compliance rate of 42.90%. This is 8.00 percentage points below the benchmark and 0.81 percentage points lower than the Two or More Races group.
- White had a compliance rate of 42.13%, which is 8.77 percentage points below the benchmark and 1.58 percentage points lower than the Two or More Races group.
- Some Other Race showed a compliance rate of 42.06%, which is 8.84 percentage points below the benchmark and 1.65 percentage points lower than the Two or More Races group.

Hybrid

- For the hybrid data, the Two or More Races group had the highest compliance rate of 68.00%. It exceeded the goal by 17.10 percentage points and serves as the top-performing group for comparison.
- The Some Other Race group achieved a compliance rate of 52.50%. This rate is 1.60 percentage points above the goal but 15.50 percentage points lower than the top performing Two or More Races group.
- The White group had a compliance rate of 54.44%, which is 3.54 percentage points above the goal but 13.56 percentage points lower than the Two or More Races group.
- The Asian group achieved a compliance rate of 55.32%, which is 4.42 percentage points above the goal but 12.68 percentage points lower than the top performing Two or More Races group.

Although performance varied across different racial categories, the differences were not statistically significant:

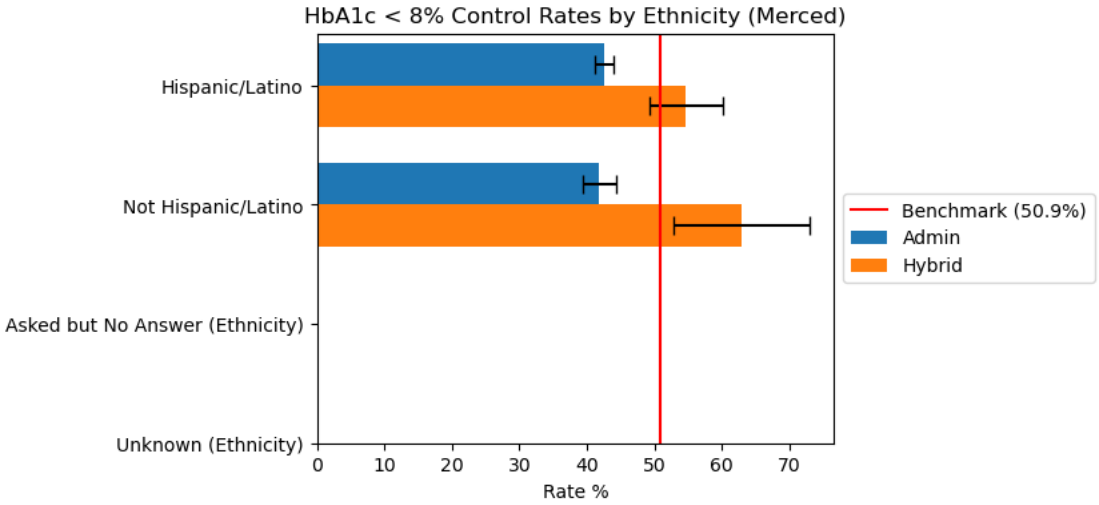
- **Admin Race Data:** $\chi^2 = 1.7153$, $p = 0.8870$
- **Hybrid Race Data:** $\chi^2 = 3.6755$, $p = 0.2987$

**The p-values are greater than 0.05 indicates that the observed differences in compliance rates are not statistically significant.*

HbA1c 8% Rate by Ethnicity for Merced Population

Medi-Cal Merced Population	Ethnicity	Universe	Compliant	Compliance Rate %	% Difference between Top Performing Group	Year over Year Trend 2022-2023
MY2023 (HEDIS- Admin**)**	**Hispanic/Latino**	5,042	2,144	42.53%	0.00%	N/A
	Not Hispanic/Latino	1,499	628	41.89%	-0.63%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	2	1	50.00%	*N<30	N/A
MY2023 (HEDIS- Hybrid**)**	**Hispanic/Latino**	322	176	54.66%	-8.26%	N/A
	Not Hispanic/Latino	89	56	62.92%	0.00%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	0	0	0.00%	*N<30	N/A

Note: The data combines direct and indirect measurements. The higher the better performance.



Quantitative Analysis

For the Medi-Cal HbA1c <8% measure by ethnicity, the benchmark for HbA1c <8% (50.9%) was met by the hybrid data but not by the admin data.

Admin

- The admin rate did not meet the goal of 50.9%.
- The highest compliance rate was observed in the Hispanic/Latino group at 42.53%, which is 8.37 percentage points below the goal and serves as the reference group for comparison.
- The Not Hispanic/Latino group achieved a compliance rate of 41.89%, which is 9.01 percentage points below the goal and 0.64 percentage points lower than the reference group.

Hybrid

- The Not Hispanic/Latino group had the highest compliance rate at 62.92%, which is 12.02 percentage points above the goal and serves as the reference group for comparison.
- The Hispanic/Latino group achieved a compliance rate of 54.66%, which is 3.76 percentage points above the goal but 8.26 percentage points lower than the reference group (Not Hispanic/Latino)

Differences were not statistically significant:

- **Admin Ethnicity Data:** $\chi^2 = 0.1619$, $p = 0.6874$
- **Hybrid Ethnicity Data:** $\chi^2 = 1.6150$, $p = 0.2038$

**The p-values are greater than 0.05 indicates that the observed differences in compliance rates are not statistically significant.*

Overall Conclusion

In conclusion, the hybrid data met the goal for HbA1c <8%, while the admin data did not. The hybrid data successfully met the goal with Not Hispanic/Latino populations. Two or More Races, White and Asian members achieved the highest compliance rates and demonstrated effective diabetes management within these groups. The admin data did not meet the goal. Disparities persist among Hispanic or Latino populations as well as Black or African American and Native American populations who showed lower compliance rates in the hybrid data.

Health Equity Categories	Medi-Cai Merced Product Line in HbA1c <8%
Race	**Top performing:** Members who identified as Two or More Races in hybrid data (68.00%) in MY2023. **Lowest Performing:** Members who identified as Some Other Race in hybrid data (52.50%) in MY 2023. **Disparity Analysis:** The difference in HbA1c <8% compliance rates between the top performing group (Two or More Races) and lowest performing group (Some Other Race) were 15.50%. *Conclusion:* There is a disparity in compliance rates between different racial groups in the hybrid data, with Two or More Races performing the best and Some Other Race performing the worst.
Ethnicity	**Top performing:** Members who identified as Not Hispanic/Latino in hybrid data (62.92%) in MY2023. **Lowest Performing:** Members who identified as Hispanic/Latino in hybrid data (54.66%) in MY2023. **Disparity Analysis:** The difference in HbA1c <8% compliance rates between the top performing group (Not Hispanic/Latino) and lowest performing group (Hispanic/Latino) were 8.26%. *Conclusion:* There is a disparity in compliance rates between different ethnic groups in the hybrid data, with Not Hispanic/Latino performing better than Hispanic/Latino.

Hemoglobin A1c Control for Patients with Diabetes (HBD):*The data below includes hemoglobin A1c for patients with diabetes (HBD) HbA1C >9%.*

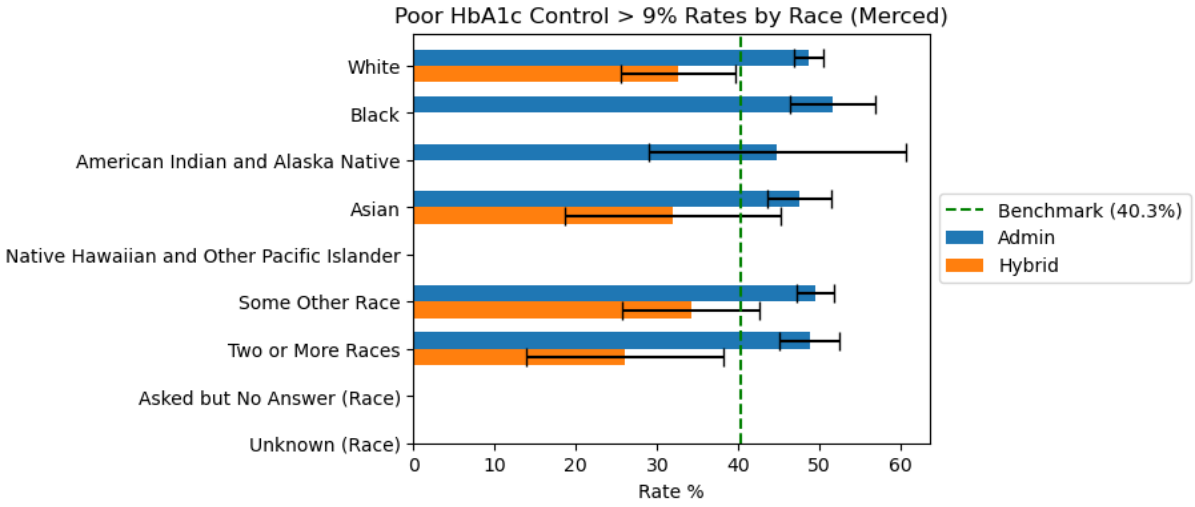
MY2023						
Product Line	***Data Type***	***Num/Den***	***HEDIS/GIC Rate***	***Data Type***	***Num/Den***	***HEDIS/ GIC Rate***
Medi-Cal Merced	Admin (HEDIS)	3,209/6,543	49.04%	Hybrid (HEDIS)	130/411	32.63%

Health Equity performance data by measure: *The data below displays the hemoglobin A1c patient with diabetes disparity data.*

HbA1c >9% Non-Compliance Rate by Race for Merced Population

Medi-Cal Merced Population	Race	Universe	Non-Compliant	Non-Compliance Rate %	% Difference between Top Performing Group	Year over Year Trend 2022-2023
MY2023 (HEDIS-Admin)	White	2,962	1,443	48.72%	3.98%	N/A
	Black	347	179	51.59%	6.85%	N/A
	American Indian and Alaska Native	38	17	44.74%	0.00%	N/A
	Asian	613	291	47.47%	2.73%	N/A
	Native Hawaiian and Other Pacific Islander	22	17	77.27%	*N<30	N/A
	Some Other Race	1,852	915	49.41%	4.67%	N/A
	Two or More Race	707	345	48.80%	4.06%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	2	2	100.00%	*N<30	N/A
MY2023 (HEDIS-Hybrid)	White	169	55	32.54%	6.54%	N/A
	Black	21	4	19.05%	*N<30	N/A
	American Indian and Alaska Native	4	2	50.00%	*N<30	N/A
	Asian	47	15	31.91%	5.91%	N/A
	Native Hawaiian and Other Pacific Islander	0	0	0.00%	*N<30	N/A
	Some Other Race	120	41	34.17%	8.17%	N/A
	Two or More Race	50	13	26.00%	0.00%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	0	0	0.00%	*N<30	N/A

Note: The data combines direct and indirect measurements. The lower the better performance.



Quantitative Analysis

For the Medi-Cal HbA1c >9% measure by race, the benchmark for HbA1c >9% (40.3%) was met by the admin data but not by the hybrid data.

Admin

- The admin rate did not meet the benchmark of 40.3%. The lower the better performance.
- The lowest rate was American Indian and Alaska Native at 44.74%. It met the goal by 4.44 percentage points.
- The highest rate was Black at 51.59%. It did not meet the goal and exceeded it by 11.29 percentage points.
- When analyzing the non-compliance rate by the appropriate population size, Asians perform best among Black, White, Some Other Race, and Two or More Races groups.
- When comparing Black with Asian, Black has a non-compliance rate that is 4.12 percentage points higher than that of Asians.
- When comparing White with Asian, White has a non-compliance rate that is 1.25 percentage points higher than that of Asians.

Hybrid

- Two or More Race had the lowest non-compliance rate at 26.00%. It is in the range of lower 40.3% goal.
- Some Other Race in the hybrid data still showed good non-compliance at 34.17%. It had the highest non-compliance rate but still did not exceed the goal.
- Two The Two or More Races group has the best non-compliance rate among Black, White, Some Other Race, and Asian groups.
- When comparing the best-performing group (Two or More Races) to White, the difference is 6.54 percentage points.
- When comparing Two or More Races to Asian, the difference is 5.91 percentage points.

- When comparing Two or More Races to Some Other Race, the difference is 8.17 percentage points.

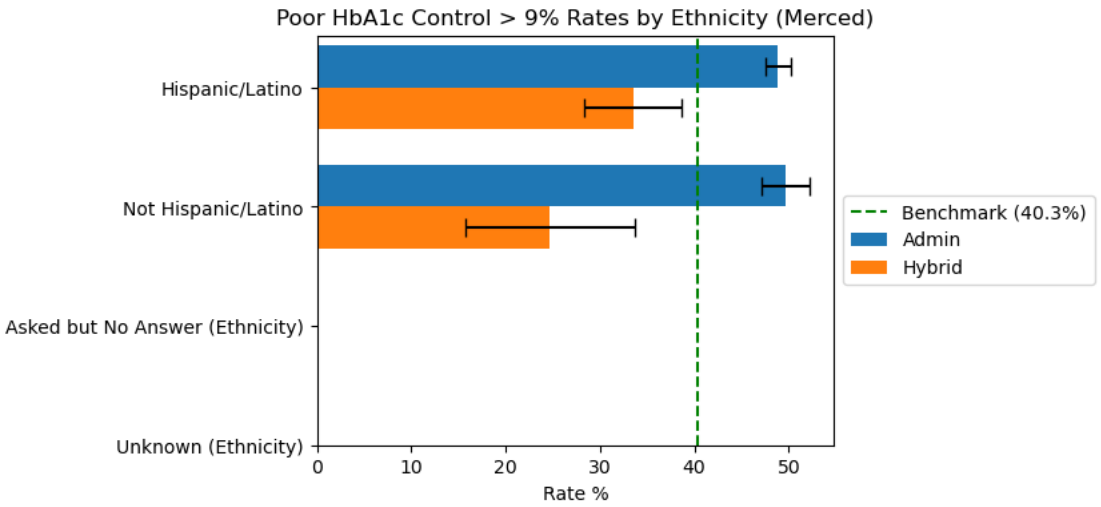
Differences across racial categories were not statistically significant in both the admin data (χ^2 = 1.9947, p = 0.8499) and the hybrid data (χ^2 = 1.1043, p = 0.7760).

**The p-values are greater than 0.05 indicates that the observed differences in compliance rates are not statistically significant.*

HbA1c >9% Non-Compliance Rate by Ethnicity for Merced Population

Medi-Cal Merced Population	Ethnicity	Universe	Non-Compliant	Non-Compliance Rate %	% Difference between Top Performing Group	Year over Year Trend 2022-2023
MY2023 (HEDIS- Admin**)**	**Hispanic/Latino**	5,042	2,464	48.87%	0.00%	N/A
	Not Hispanic/Latino	1,499	744	49.63%	0.76%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	2	1	50.00%	*N<30	N/A
MY2023 (HEDIS- Hybrid**)**	**Hispanic/Latino**	322	108	33.54%	8.82%	N/A
	Not Hispanic/Latino	89	22	24.72%	0.00%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	0	0	0.00%	*N<30	N/A

Note: The data combines direct and indirect measurements. The lower the better performance.



Quantitative Analysis

For the Medi-Cal HbA1c >9% measure by ethnic, the benchmark for HbA1c >9% (40.3%) was met by the admin data but not by the hybrid data.

Admin

- The admin rate did not meet the benchmark of 40.3%. In this HbA1c >9% measure, the lower the better performance.
- Hispanic/Latino was the lowest rate at 48.87% %. It did not meet the goal by 8.57 percentage points exceeding the goal.
- Not Hispanic/Latino showed slightly higher at 49.63%. It also did not meet the goal and far exceeding by 9.33 percentage points.

Hybrid

- The hybrid rate met the goal of 40.3%. In this HbA1c >9% measure, the lower the better performance.
- Not Hispanic/Latino had the lowest non-compliance rate at 24.72%. It is lower than the goal of 40.3% goal.
- Hispanic/Latino still met with the goal non-compliance goal at 33.54%.

Differences across ethnic categories were not statistically significant in both the admin data (χ^2 = 0.2399, p = 0.6243) and the hybrid data (χ^2 = 2.1177, p = 0.1456).

**The p-values are greater than 0.05 indicates that the observed differences in compliance rates are not statistically significant.*

Overall Conclusion

The hybrid data met the benchmark for HbA1c >9%, while the admin data did not. The observed differences in performance across racial categories in the admin data were statistically significant,

indicating potential systematic differences in care or control across these groups. However, differences in the hybrid race data and ethnicity data were not statistically significant, indicating that variations are likely due to random variation rather than systematic differences in care or control across these groups. Overall, the data suggests that members across race and ethnicity are generally maintaining their HbA1c >9% within the hybrid data but not in the admin data.

Health Equity Categories	Medi-Cai Merced Product Line in HbA1c >9%
Race	**Top performing:** Members who identified as Two or More Races in hybrid data (26.00%) in MY2023. **Lowest Performing:** Members who identified as Some Other Race in hybrid data (34.17%) in MY 2023. **Disparity Analysis:** The difference in HbA1c >9% non-compliance rates between the top-performing group (Two or More Races) and the lowest-performing group (Some Other Race) were 8.17%. Conclusion: There is a disparity in non-compliance rates between different racial groups in the hybrid data, with Two or More Races performing the best and Some Other Race performing the worst.
Ethnicity	**Top performing:** Members who identified as Not Hispanic/Latino in hybrid data (24.72%) in MY2023. **Lowest Performing:** Members who identified as Hispanic/Latino in hybrid data (33.54%) in MY 2023. **Disparity Analysis:** The difference in HbA1c >9% non-compliance rates between the top-performing group (Not Hispanic/Latino) and the lowest-performing group (Hispanic/Latino) were 8.82%. *Conclusion:* There is a disparity in non-compliance rates between different ethnic groups in the hybrid data, with Not Hispanic/Latino performing the best and Hispanic/Latino performing the worst.

Medi-Cal Santa Cruz and Monterey Population

Hemoglobin A1c Control for Patients with Diabetes (HBD): *The data below includes hemoglobin A1c for patients with diabetes (HBD) HbA1C <8%.*

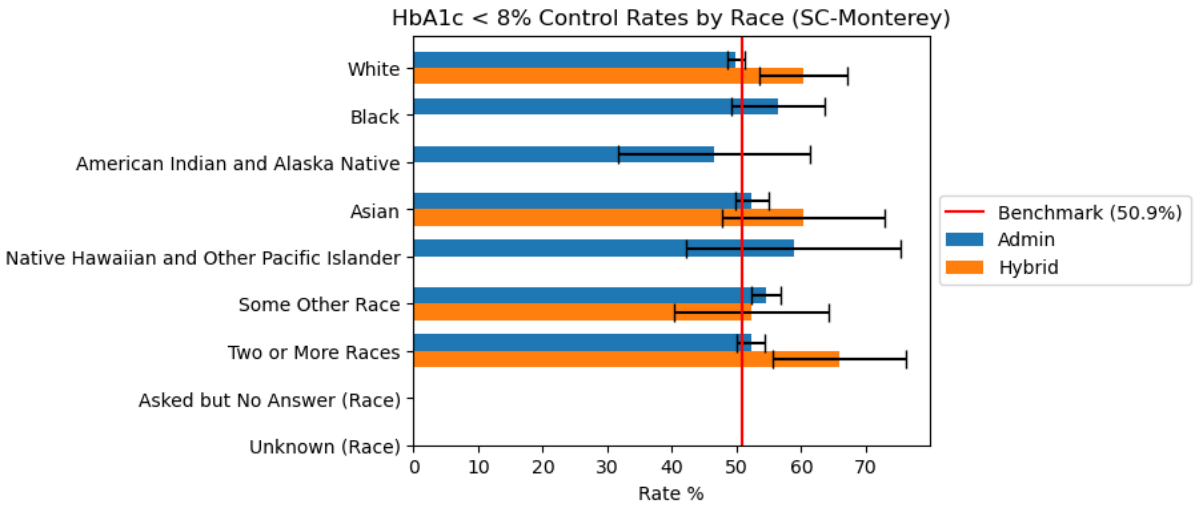
MY2023						
Product Line	***Data Type***	***Num/Den***	***HEDIS/GIC Rate***	***Data Type***	***Num/Den***	***HEDIS/ GIC Rate***
Medi-Cal Santa Cruz and Monterey	Admin (HEDIS)	5,522/ 10,705	51.58%	Hybrid (HEDIS)	244/411	59.37%

Health Equity performance data by measure: *The data below displays the hemoglobin A1c patient with diabetes disparity data.*

HbA1c <8% Rate by Race for Santa Cruz and Monterey Population

Medi-Cal Santa Cruz and Monterey Population	Race	Universe	Compliant	Compliance Rate %	% Difference between Top Performing Group	Year over Year Trend 2022-2023
MY2023 (HEDIS-Admin)	White	5,072	2,529	49.86%	-8.96%	N/A
	Black	179	101	56.42%	-2.4%	N/A
	American Indian and Alaska Native	43	20	46.51%	-12.31%	N/A
	Asian	1,447	757	52.32%	-6.5%	N/A
	Native Hawaiian and Other Pacific Islander	34	20	58.82%	0.00%	N/A
	Some Other Race	1,823	994	54.53%	-4.29%	N/A
	Two or More Race	2,093	1,093	52.22%	-6.6%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	14	8	57.14%	*N<30	N/A
MY2023 (HEDIS-Hybrid)	White	194	117	60.31%	-5.54%	N/A
	Black	7	1	14.29%	*N<30	N/A
	American Indian and Alaska Native	1	0	0.00%	*N<30	N/A
	Asian	58	35	60.34%	-5.51%	N/A
	Native Hawaiian and Other Pacific Islander	1	1	100.0%	*N<30	N/A
	Some Other Race	67	35	52.24%	-13.61%	N/A
	Two or More Race	82	54	65.85%	0.00%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	1	1	100.00%	*N<30	N/A

Note: The data combines direct and indirect measurements. The higher the better performance.



Quantitative Analysis

For the Medi-Cal HbA1c <8% measure by race, the benchmark for HbA1c <8% (50.9%) was met by both admin data and hybrid data.

Admin

- Native Hawaiian and Other Pacific Islander had the highest compliance (58.82%) in the admin data. It surpassed the goal by 7.92 percentage points.
- Black had the second highest compliance and surpassed the goal by 5.52 percentage points.
- Some Other Race, Asian ,and Two or More Race were met the goal by 3.63 percentage points, 1.42 percentage points, and 1.32 percentage points, respectively.
- White and American Indian and Alaska Native had the rate below the goal by 1.04 and 4.39 percentage points, respectively.
- Among the large population groups, Black has the lowest performance rate.
- When compared with the Some Other Race group, the difference is 1.89 percentage points.
- When compared with Asian and Two or More Races groups, the differences are 4.10 percentage points and 4.20 percentage points, respectively.

The largest difference is with the White group, showing a 6.56 percentage point gap, and an even larger gap of 8.96 percentage points when compared with Native Hawaiian and Other Pacific Islander.

Hybrid

- The hybrid data showed that Two or More Races had a compliance rate of 65.85%. It exceeded the benchmark by 14.95 percentage points.
- In addition, Asian and Some Other Race population also met the goal of 50.8%.
- When comparison the best performance(Two or More Race) to the White. The difference is 6.54 percentage points.
- When comparison the best performance(Two or More Race) to the Asian, the different rate is 5.91 percentage points.

- When comparison the best performance(Two or More Race) to the Some Other Race, the different rate is 8.17 percentage points.

Although performance varied across different racial categories, the differences were statistically significant in admin data, but not in hybrid data:

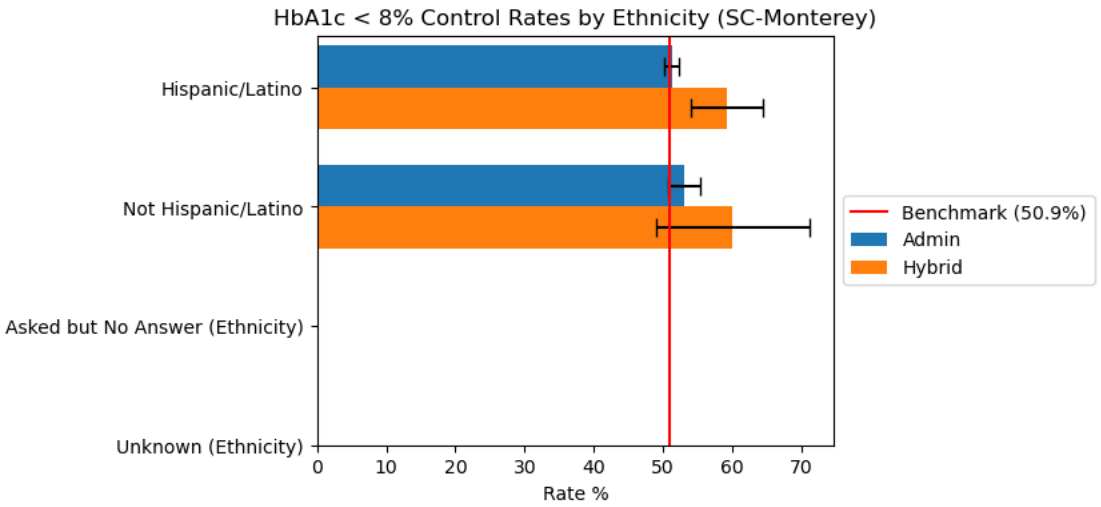
- **Admin Race Data:** χ^2 = 15.8237, p = 0.0147
- **Hybrid Race Data:** χ^2 = 2.8637, p = 0.4131

**The p-values are greater than 0.05 indicates that the observed differences in compliance rates are not statistically significant.*

HbA1c <8% Rate by Ethnicity for Santa Cruz and Monterey Population

Medi-Cal Santa Cruz and Monterey Population	Ethnicity	Universe	Compliant	Compliance Rate %	% Difference between Top Performing Group	Year over Year Trend 2022-2023
MY2023 (HEDIS- Admin**)**	**Hispanic/Latino**	8,895	4,560	51.26%	-1.84%	N/A
	Not Hispanic/Latino	1,806	959	53.1%	0.00%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	4	3	75.00%	*N<30	N/A
MY2023 (HEDIS- Hybrid**)**	**Hispanic/Latino**	336	199	59.23%	-0.77%	N/A
	Not Hispanic/Latino	75	45	60.00%	0.00%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	0	0	0.00%	*N<30	N/A

Note: The data combines direct and indirect measurements. The higher the better performance.



Quantitative Analysis

For the Medi-Cal HbA1c <8% measure by ethnicity, the benchmark for HbA1c <8% (50.9%) was met by both admin data and hybrid data.

Admin

- Not Hispanic/Latino and Hispanic/Latino met the goal for the compliance rate by 2.2 and 0.36 percentage points.
- Not Hispanic/Latino showed the highest compliance rate.

Hybrid

- For, hybrid data, it showed the similar result that both of Not Hispanic/Latino and Hispanic/Latino met the goal for the compliance rate.
- Not Hispanic/Latino showed the highest compliance rate by 9.1 percentage points exceeding the goal.

The differences were not statistically significant:

Admin Ethnicity Data: $\chi^2 = 1.9534$, $p = 0.1622$
Hybrid Ethnicity Data: $\chi^2 = 0.0000$, $p = 1.0000$

**The p-values are greater than 0.05 indicates that the observed differences in compliance rates are not statistically significant.*

Overall Conclusion

The hybrid data met the benchmark for HbA1c <8%, while the admin data did not. The observed differences in performance across racial and ethnic categories were not statistically significant, indicating that variations are likely due to random variation rather than systematic differences in care

or control across these groups. Overall, the data suggests that members across races and ethnicity are generally maintaining their HbA1c <8% within the hybrid data but not in the admin data.

Health Equity Categories	Medi-Cal Santa Cruz and Monterey Product Line in HbA1c <8%
Race	**Top performing**: Members who identified as Two or More Races in hybrid data (65.85%) in MY2023. **Lowest Performing**: Members who identified as Some Other Race in hybrid data (52.24%) in MY2023. **Disparity Analysis**: The difference in HbA1c <8% compliance rates between the top performing group (Two or More Races) and lowest performing group (Some Other Race) were 13.61%. *Conclusion:* There is a disparity in compliance rates between different racial groups in the hybrid data, with Two or More Races performing the best and Some Other Race performing the worst.
Ethnicity	**Top performing**: Members who identified as Not Hispanic/Latino in hybrid data (60.00%) in MY2023. **Lowest Performing**: Members who identified as Hispanic/Latino in hybrid data (59.23%) in MY2023. **Disparity Analysis**: The difference in HbA1c <8% compliance rates between the top performing group (Not Hispanic/Latino) and lowest performing group (Hispanic/Latino) were 0.77%. *Conclusion:* There is a slight disparity in compliance rates between different ethnic groups in the hybrid data, with Not Hispanic/Latino performing slightly better than Hispanic/Latino.

Hemoglobin A1c Control for Patients with Diabetes (HBD): *The data below includes hemoglobin A1c for patients with diabetes (HBD) HbA1C >9%.*

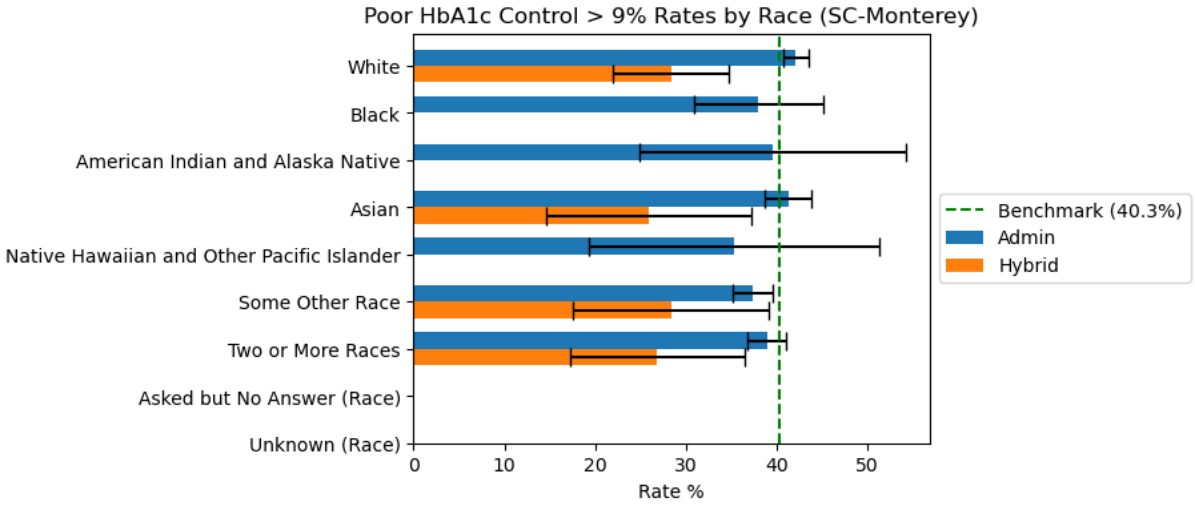
MY2023						
Product Line	*Data Type*	*Num/Den*	*HEDIS/GIC Rate*	*Data Type*	*Num/Den*	*HEDIS/GIC Rate*
Medi-Cal Santa Cruz and Monterey	Admin (HEDIS)	4,329/ 10,705	40.44%	Hybrid (HEDIS)	116/411	28.22%

Health Equity performance data by measure: *The data below displays the hemoglobin A1c patient with diabetes disparity data.*

HbA1c >9% Non-Compliance Rate by Race for Santa Cruz and Monterey Population

Medi-Cal Santa Cruz and Monterey Population	Race	Universe	Non-Compliant	Non-Compliance Rate %	% Difference between Top Performing Group	Year over Year Trend 2022-2023
MY2023 (HEDIS-Admin)	White	5,072	2,135	42.09%	6.80%	N/A
	Black	179	68	37.99%	2.70%	N/A
	American Indian and Alaska Native	43	17	39.53%	4.24%	N/A
	Asian	1,447	597	41.26%	5.97%	N/A
	Native Hawaiian and Other Pacific Islander	34	12	35.29%	0.00%	N/A
	Some Other Race	1,823	681	37.36%	2.07%	N/A
	Two or More Race	2,093	814	38.89%	3.60%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	14	5	35.71%	*N<30	N/A
MY2023 (HEDIS-Hybrid)	White	194	55	28.35%	2.49%	N/A
	Black	7	5	71.43%	*N<30	N/A
	American Indian and Alaska Native	1	0	0.00%	*N<30	N/A
	Asian	58	15	25.86%	0.00%	N/A
	Native Hawaiian and Other Pacific Islander	1	0	0.00%	*N<30	N/A
	Some Other Race	67	19	28.36%	2.50%	N/A
	Two or More Race	82	22	26.83%	0.97%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	1	0	0.00%	*N<30	N/A

Note: The data combines direct and indirect measurements. The lower the better performance.



Quantitative Analysis

Admin

- The admin rate did not meet the benchmark of 40.3%. The lower the better performance.
- Native Hawaiian and Other Pacific Islander had the lowest non-compliance rate at 35.29%.
- Some Other Race, Black, Two or More Race, and American Indian and Alaska Native were also met the goal by keeping the non-compliance rate below 40.3%.
- The races that were not the met and surpassed the goal were Asian and White. They surpassed the goal by 0.96 and 1.79 percentage points, respectively.
- Among the large population size, the Some Other Race group is the top performer with a non-compliance rate of 37.36 percent.
- Black had a non-compliance rate of 37.99 percent, which is 0.63 percentage points higher than the top-performing Some Other Race group.
- The Two or More Races group had a non-compliance rate of 38.89 percent, which is 1.53 percentage points higher than the top-performing group.
- The American Indian and Alaska Native group was excluded due to a universe size lower than 100.
- Asian had a non-compliance rate of 41.26 percent, showing a difference of 3.90 percentage points compared to the top-performing group.
- White had the highest non-compliance rate at 42.09 percent, which is 4.73 percentage points higher than the top-performing group.

Hybrid

- The best performance for Santa Cruz and Monterey Counties hybrid data was Asian. It had the lowest non-compliance rate, showing 25.86%.
- Two or More Race, Some Other Race, and White were also met by showing the rate of non-compliance below 40.3%.
- Two or More Races group demonstrated a non-compliance rate of 26.83 percent, which is only 0.97 percentage points higher than that of the Asian group.

- White exceeded the rate of the top-performing Asian group by 2.49 percentage points.
- The Some Other Race group reflected a 2.50 percentage point difference from the Asian group.

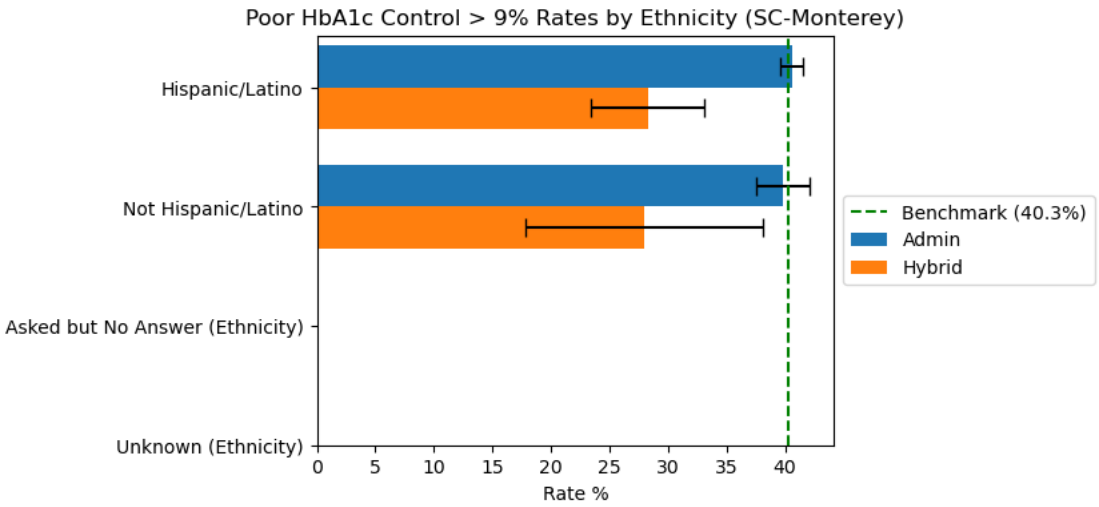
Differences across racial categories were statistically significant in the admin data (χ^2 = 16.2778, p = 0.0123) but not in the hybrid data (χ^2 = 0.1844, p = 0.9801).

**The p-values are greater than 0.05 indicates that the observed differences in compliance rates are not statistically significant.*

HbA1c >9% Non-Compliance Rate by Ethnicity for Santa Cruz and Monterey Population

Medi-Cal Santa Cruz and Monterey Population	Ethnicity	Universe	Non-Compliant	Non-Compliance Rate %	% Difference between Top Performing Group	Year over Year Trend 2022-2023
MY2023 (HEDIS- Admin**)**	**Hispanic/Latino**	8,895	3,609	40.57%	0.76%	N/A
	Not Hispanic/Latino	1,806	719	39.81%	0.00%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	4	1	25.00%	*N<30	N/A
MY2023 (HEDIS- Hybrid**)**	**Hispanic/Latino**	336	95	28.27%	0.27%	N/A
	Not Hispanic/Latino	75	21	28.00%	0.00%	N/A
	Asked but No Answer	0	0	0.00%	*N<30	N/A
	Unknown	0	0	0.00%	*N<30	N/A

Note: The data combines direct and indirect measurements. The lower the better performance.



Quantitative Analysis

Admin

- The admin rate did not meet the benchmark of 40.3%. The lower the better performance.
- Native Hawaiian and Other Pacific Islander had the lowest non-compliance rate at 35.29%.
- Some Other Race, Black, Two or More Race, and American Indian and Alaska Native were also met the goal by keeping the non-compliance rate below 40.3%.
- The races that were not the met and surpassed the goal were Asian and White. They surpassed the goal by 0.96 and 1.79 percentage points, respectively.

Hybrid

- The best performance for Santa Cruz and Monterey Counties hybrid data was Asian. It had the lowest non-compliance rate, showing 25.86%.
- Two or More Race, Some Other Race, and White were also met by showing the rate of non-compliance below 40.3%.

Differences across racial categories were statistically significant in the admin data (χ^2 = 16.2778, p = 0.0123) but not in the hybrid data (χ^2 = 0.1844, p = 0.9801).

**The p-values are greater than 0.05 indicates that the observed differences in compliance rates are not statistically significant.*

Overall Conclusion

The goal for HbA1c >9% was met by the hybrid data (28.22%) but not by the admin data (40.44%). The hybrid data met the benchmark for HbA1c >9%, while the admin data did not. The observed differences in performance across racial categories in the admin data were statistically significant, indicating potential systematic differences in care or control across these groups. However, differences in the hybrid race data and ethnicity data were not statistically significant, indicating that

variations are likely due to random variation rather than systematic differences in care or control across these groups. Overall, the data suggests that members across race and ethnicity are generally maintaining their HbA1c >9% within the hybrid data but not in the admin data.

Health Equity Categories	Medi-Cal Santa Cruz and Monterey Product Line in HbA1c >9%
Race	**Top performing**: Members who identified as Native Hawaiian and Other Pacific Islander in admin data (35.29%) in MY2023. **Lowest Performing**: Members who identified as White in admin data (42.09%) in MY2023. **Disparity Analysis**: The difference in HbA1c >9% compliance rates between the top-performing group (Native Hawaiian and Other Pacific Islander) and the lowest-performing group (White) were 6.80%. *Conclusion:* There is a disparity in compliance rates between different racial groups in the admin data, with Native Hawaiian and Other Pacific Islander performing the best and White performing the worst.
Ethnicity	**Top performing**: Members who identified as Not Hispanic/Latino in hybrid data (28.00%) in MY2023. **Lowest Performing**: Members who identified as Hispanic/Latino in hybrid data (28.27%) in MY2023. **Disparity Analysis**: The difference in HbA1c >9% compliance rates between the top-performing group (Not Hispanic/Latino) and the lowest-performing group (Hispanic/Latino) were 0.27%. *Conclusion:* The disparities in scores between ethnicities were negligible, indicating that Hispanic/Latino and Not Hispanic/Latino members exhibit comparable dedication and commitment to effectively managing their condition

Qualitative Analysis Based on HBD by Race and Ethnicity

CCAH is committed to continuously improving overall HbA1c control rates to enhance diabetes management for its members. The team has been actively identifying disparity barriers that impact care delivery and outcomes. Efforts are focused on collaborative strategies to address these challenges and achieve improved performance.

Disparities Analysis:

The table below provides an analysis of the disparities that exist across ethnicity and race.

Health Equity Categories	Qualitative Analysis (≥ 30 member universe and not known/some other race)
Race	The disparity among different racial categories with regards to healthcare compliance may be due to various factors, including: **Access to Healthcare**: Differences in geographical location and availability of healthcare providers can impact the quality of diabetes management across racial groups, which exacerbates health inequities. o An analysis of appointment availability showed that specialists were often not accessible within the standard timeframe in many areas, leading to disparities among racial and ethnic groups. A major contributing factor is the designation of some service areas as Health Professional Shortage Areas (HPSAs). o It reflects the limited number of healthcare providers in Monterey, Santa Cruz, and Merced that restricts patients' access to timely specialist care. **Socioeconomic Status**: Economic disparities can lead to differences in healthcare access, affordability of medications, and adherence to treatment plans. o As of 2022, Merced County exhibits lower median incomes and higher poverty rates (18.5%) compared to neighboring counties like Santa Cruz(12-14%) and Monterey(14-16%). These socioeconomic factors significantly influence health equity and contribute to disparities among racial and ethnic groups. **Health Literacy**: Variations in education and awareness about diabetes management can result in different levels of adherence to HbA1c control guidelines. o Data shows that Black and Hispanic populations have higher prevalence rates of diabetes compared to White individuals. o Fewer Black members reported having adequate knowledge to manage their diabetes effectively compared to their White members. This gap in knowledge contributes to inadequate self-management practices among some racial groups. Their dietary preferences and lifestyle choices regarding physical activity may impact their A1c level. o Many minority patients are less aware of available resources for managing diabetes, including the coverage they have for diabetic testing supplies and education programs. o They may also not be aware of the community resources that can help them manage their diabetes. **Cultural Factors**: Cultural attitudes towards healthcare, dietary practices, and acceptance of medical interventions can influence diabetes outcomes.
Ethnicity	The disparity among different ethnicity categories with regards to healthcare compliance may be due to various factors, including:

	Access to Healthcare: Not Hispanic/Latino Whites have better access to healthcare facilities and resources that facilitate effective diabetes management. o Racial and ethnic minorities, including Hispanic/Latino individuals, frequently encounter barriers when accessing healthcare services. These barriers may include lack of insurance, transportation issues, and fewer healthcare providers in their communities. Non-Hispanic Whites may have better access to healthcare providers that can result in better A1c control. **Socioeconomic Status**: Differences in income levels, education, and employment can influence healthcare access and health outcomes, potentially explaining the lower compliance rates among Hispanic/Latino individuals. **Health Literacy**: Understanding of diabetes management and the importance of HbA1c control might vary between ethnic groups, affecting compliance rates.

Hemoglobin A1c Analysis by Gender

Medi-Cal Population Merced	Sub measure	Sex	Denominator	Numerator	Rate	Goal	Goal Met
MY2022	Good Control (<8)	F	237	132	55.70%	50.90%	Y
		M	185	79	42.70%	50.90%	N
	Poor Control (>9)	F	237	75	31.65%	40.30%	Y
		M	185	88	47.57%	40.30%	N
MY2023	Good Control (<8)	F	245	152	62.04%	50.90%	Y
		M	185	88	47.57%	50.90%	N
	Poor Control (>9)	F	245	67	27.35%	40.30%	Y
		M	185	73	39.46%	40.30%	Y

**Good Control (<8): A higher rate is better, with the goal being a rate exceeding 50.90%.*
**Poor Control (>9): A lower rate is better, with the goal being a rate below 40.30%.*

Quantitative Analysis

Merced

- When evaluating HBD Good Control (<8) by gender in 2023, females achieved a 62.04% rate. This was the highest performance for this measure and exceeded the goal of 50.90% by 11.14 percentage points. It also showed a 6.34 percentage point improvement from 2022.
- Males achieved a 47.57% rate for HBD Good Control. This was 14.47 percentage points lower than the rate for females and fell short of the goal by 3.33 percentage points. However, this reflected a 4.86 percentage point improvement from 2022.
- For HBD Poor Control (>9), females achieved a 27.35% rate in 2023. This met the goal of keeping rate below 40.30% and marked a 4.30 percentage point improvement from 2022.
- Males achieved a 39.46% rate for HBD Poor Control. This met the goal showing 12.11 percentage points higher than the rate for females and missed the goal by 0.84 percentage points. It also showed an 8.11 percentage point improvement from 2022.

Medi-Cal Population Santa Cruz/Monterey	Sub measure	Sex	Denominator	Numerator	Rate	Goal	Goal Met
MY2022	Good Control (<8)	F	246	165	67.07%	50.90%	Y
		M	184	112	60.87%	50.90%	Y
	Poor Control (>9)	F	246	57	23.17%	40.30%	Y
		M	184	55	29.89%	40.30%	Y
MY2023	Good Control (<8)	F	250	158	63.20%	50.90%	Y
		M	180	96	53.33%	50.90%	Y
	Poor Control (>9)	F	250	66	26.40%	40.30%	Y
		M	180	57	31.67%	40.30%	Y

**Good Control (<8): A higher rate is better, with the goal being a rate exceeding 50.90%.*
**Poor Control (>9): A lower rate is better, with the goal being a rate below 40.30%.*

Quantitative Analysis

Santa Cruz/Monterey

- When assessing HBD Good Control less than eight in 2023 in Santa Cruz and Monterey, females achieved a 63.20% rate. This rate exceeded the goal of 50.90% by 12.30 percentage points but reflected a 3.87 percentage point decline from 2022.
- Males achieved a 53.33% rate for HBD Good Control less than eight in 2023. This was 9.87 percentage points lower than females but exceeded the goal by 2.43 percentage points. However, it showed a 7.54 percentage point decline from 2022.
- Females achieved a 26.40% rate in HBD Poor Control greater than nine in 2023 in Santa Cruz and Monterey. This was met the goal by 13.90 percentage points lower than the goal of 40.30% but reflected a 3.23 percentage point increase from 2022.
- Males had a 31.67% rate in HBD Poor Control greater than nine in 2023. This was 5.27 percentage points higher than females and met the goal by 8.63 percentage points while reflecting a 1.78 percentage point increase from 2022.

Conclusion of HBD Analysis by Gender

- The highest performance overall in both counties for Good Control (<8) was Santa Cruz/Monterey females and Merced females in 2023, with the rate 63.20% and 62.04%. The lowest performing is males in Merced 2023 that show the not met rate by 3.33 percentage points.
- For Poor Control (>9), Santa Cruz/Monterey females in 2023 achieved the best rate at 26.40%, outperforming males and Merced females for this measure. It met the goal by 13.90 percentage points.

Qualitative Analysis

The health disparity analysis by gender of HBD performance shows a consistent trend of females outperforming males across. Several factors may contribute to this disparity in performance:

The analysis reveals key differences and similarities in how men and women with diabetes approach various aspects of disease management, influenced by gender roles and social expectations. Below is a breakdown of the five themes:

1. Disclosure and Identity as a Person Living with Diabetes:

- Women: More open about their diabetes diagnosis, readily disclosing it to friends and family. They seem to integrate diabetes into their identity more easily and manage it as part of their everyday life.

- Men: More reluctant to disclose their condition, possibly due to stigma or perceptions of vulnerability. Their reluctance to share may stem from societal expectations around masculinity, which often prioritize independence and strength.

2. Self-Monitoring of Blood Glucose (SMBG):

- Women: Tend to focus on the emotional and psychological aspects of self-monitoring. Their approach to SMBG may be intertwined with concerns about emotional well-being, including how their blood sugar levels might impact their day-to-day functioning and relationships.
- Men: Focus on the practical aspects of SMBG, using it to experiment with their diabetes management strategies. They are often more goal-oriented, aiming to reduce reliance on medications and optimize their self-management practices through trial and error.

3. Diet Struggles Across Varying Contexts:

- Women: More likely to restrict foods that are perceived as "off-limits" due to their diabetes, possibly as a way of adhering to dietary guidelines and societal expectations of discipline.
- Men: Tend to moderate their food intake based on general guidelines but are more flexible in social situations. This flexibility suggests that men may prioritize social norms or the enjoyment of food in group settings over strict adherence to dietary restrictions.

4. Utilization of Diabetes Resources

- Women: Engage more with socially interactive resources such as educational classes, support groups, and other forms of community or peer support. These social resources likely provide emotional support as well as practical guidance.
- Men: Rely more on self-directed learning, possibly using books, online resources, or other independent methods to manage their diabetes. However, some men express a desire for more structured guidance, particularly regarding how to navigate the healthcare system and make informed decisions about their care.

5. Social Support

- Both: Men and women both express a need for physician support, though this is for different aspects. Women may seek support for the emotional side of self-management (such as reassurance, encouragement, and managing diabetes-related distress), while men may focus more on the practical side, such as advice on treatment options, lifestyle changes, and understanding how to optimize self-management strategies.

Conclusion

The study highlights how gender shapes the experience of living with diabetes, with women more likely to engage in socially supportive behaviors, emphasize emotional aspects of self-care, and integrate their condition into daily life. Men, on the other hand, tend to focus on practical aspects of

self-management, prefer more self-directed resources, and are more hesitant to share their diagnosis. The shared desire for both affective and practical support from healthcare providers suggests that diabetes management requires a holistic approach, tailored to meet the unique needs of both men and women.
This nuanced understanding can inform healthcare interventions, ensuring they are sensitive to gendered differences in diabetes care and support.

Opportunities for Improvement

CCAH will implement targeted interventions aimed at improving engagement in diabetes management in both males and females. These include community outreach programs to raise awareness about the importance of preventive care, cultural education initiatives to promote health literacy, and support mechanisms to encourage adherence to treatment plans. By focusing on these areas, CCAH aims to reduce gender disparities and enhance overall health outcomes for members.

Overall Qualitative Analysis

Limited access to healthcare and health insurance are key factors contributing to differences in glycemic control. While past data showed Hispanic or Latino and non-Hispanic Black individuals faced more challenges, recent findings reveal that White individuals in the Medicaid population now have lower rates of A1C control.
Healthy People 2020 define a health disparity as an unfair health difference between groups. For insured adults with diabetes, financial difficulties can hinder medication adherence and achieving treatment goals. Additional barriers, such as limited access to nutritious food, can further impede the ability to make healthy dietary changes. Factors like advanced disease at diagnosis, influenced by healthcare-related issues such as insurance gaps and screening access disparities, also contribute to poor glycemic control. These other demographic factors may be the explanation for the findings of this report.
Over the last decade, numerous studies have indicated that African Americans and Hispanics have a lower rate of A1C control among members that have diabetes. Plans and National Agencies have been constantly reminding providers to focus on populations with disparities. It is likely that Providers are more aware of the disparities now and hence are more likely to unintentionally pay more attention to A1c Control for members that are Hispanic or African American.
CCAH also conducted gender disparities analysis for Hemoglobin A1c Control in patients with diabetes. The analysis indicates that females consistently outperform males in HBD measures. Females tend to use healthcare services more frequently and benefit from stronger social and familial support systems, which promote better adherence to treatment plans. In contrast, males are less likely to engage in preventive care and routine check-ups. It often leads to delayed detection and management of diabetes-related complications.

Proposed Interventions for Hemoglobin A1c Control for Patients with Diabetes (HBD)

Implementing Interventions

Level	Intervention	Date and Frequency	Barriers Addressed
Patients	Provide an education pamphlet on the importance of A1c Control to White patients. Ensure that materials are focused on the social issues that are affecting white patients and address any unintentional biases that may exist.		The providers may not be discussing screening as commonly with white women for the reasons discussed above. As a result, white women may not understand the importance of getting screened for chlamydia.
Provider	Provider education consistently adhering to nationally recognized guidelines for all ethnic groups.		This will encourage the providers to consistently follow nationally recognized guidelines and therefore ensure members of all groups get equitable care.
Patients	Working with community partners and social workers to promote A1c screening among white members.		Members may not be aware of the getting screened regularly.

Intervention Prioritization

CCAH is determined to address these opportunities through a comprehensive approach.

- Improving language services in healthcare interactions. To enhance our services, CCAH plans to prioritize a communication initiative for all members. This initiative will encourage members to contact our Member Services Department for assistance in finding healthcare providers who speak their preferred language.
- CCAH is committed to addressing disparities in healthcare language services and understands that the most effective way to assist members with limited English proficiency (LEP) and all members is by advocating for the Member Services Department to offer direct support in locating a culturally responsive provider who speaks the member's preferred language.
- CCAH is aware that certain website updates, such as the availability of forms, directory information, and new providers in the online directory, may not effectively accommodate members with limited English proficiency who need to access the site in English.

9.3. Well-Child Visits

The Well-Child Visits health disparity analysis focuses on the Well-Child Visits in the First 15 Months. (W30-6) measure, which tracks the percentage of children who turned 15 months old in the measurement year and received six or more well-child visits with a provider, as well as the Child and

Adolescent Well-Care Visits (WCV-Total), which tracks the percentage of members 3-21 years of age who had at least one comprehensive well-care visits with a PCP or an OB/GYN practitioner during the measurement year. These visits are crucial during early childhood, offering an opportunity to monitor growth, assess developmental milestones, and identify potential health concerns at an early stage.

Despite the clear benefits, well-child visit rates for infants have historically been low. However, recent data shows improvement since 2021. County-specific rates reveal disparities, with Merced County at 36.72%, while Monterey and Santa Cruz counties both achieved a rate of 60.61%. This analysis seeks to explore these variations, identify contributing factors, and guide interventions to enhance access to well-childcare and promote equitable health outcomes for all children in the CCAH service area.

Goal

This analysis aims to review well child rates to uncover health disparities among CCAH members and determine areas for improvement. This assessment supports CCAH's mission to enhance health equity by providing all members access to preventive healthcare services across all races, ethnicities, and languages. The goals are benchmarked against the 50th percentile of MCAS MY20222 administrative data to provide measurable targets for improvement.

Product Type	Measure	Goal 50th percentile
Medicaid HMO	Well Child Visits in the First 15 Months (W30-6+)	54.92
Medicaid HMO	Child and Adolescent Well-Care Visits - Total	45.31

Methodology

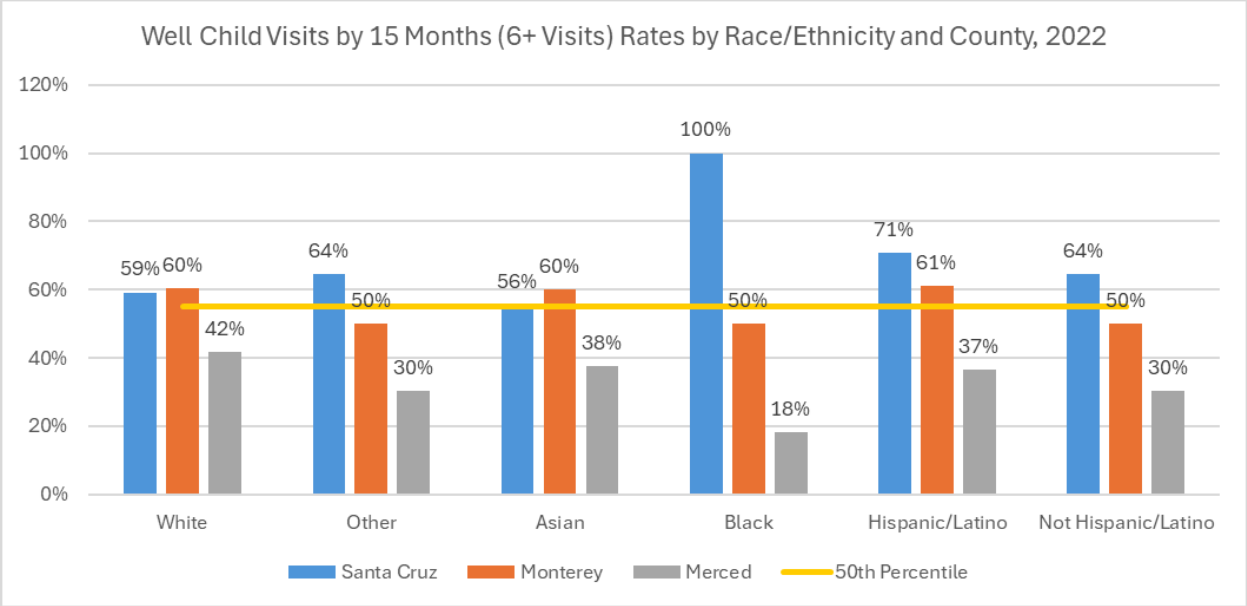
CCAH conducted the well child analysis following NCQA HEDIS standards. The analysis breaks down W30-6+ and WCV-Total data by race/ethnicity and language spoken to identify disparities in care access and emerging trends.

Result

9.3.1. Analysis by Race and Ethnicity: Well Child Visits in the First 15 Months

Figure 1 below displays the percentage of visits stratified by race/ethnicity and county. Black (N=1) infants had the highest rate, followed by Hispanic infants at 70.65%(N=443) in Santa Cruz County, with all but Asian above the 50th percentile. Monterey County's highest rate reports was in members identified as Hispanic, with black (50%, N=6), non-Hispanic (50%, N=16), and other (50%, N=42) below the 50th percentile. All Merced County groups fell well below the 50th percentile for this measure, with their Black population lowest of all at 18% (N=33).

Figure 1. Well Child Visits (6+) by 15 Months by Race/Ethnicity and County/Region, 2022.



Source: MCAS MY2022 administrative data, direct reference only.

Quantitative Analysis

Santa Cruz County

- The chart illustrates the rates of Well Child Visits by 15 months across different ethnic groups and counties for 2022, with the benchmark set at the 50th percentile (54.9%).
- Black children in Santa Cruz County achieved the highest rate at 100%, exceeding the 50th percentile benchmark by 45.1 percentage points. This makes them perform as the reference population group.
- Hispanic/Latino children in Santa Cruz County had a rate of 71%, which is 16.1 percentage points above the goal but 29 percentage points lower than the top-performing Black group.
- Not Hispanic/Latino children in Santa Cruz County reached 64%, which is 9.1 percentage points above the goal but 36 percentage points lower than the Black group.
- Other racial groups in Santa Cruz County had a rate of 64%, which is 9.1 percentage points above the goal but 36 percentage points lower than the Black group.
- White children in Santa Cruz County had a compliance rate of 59%, which is 4.1 percentage points above the goal but 41 percentage points lower than the Black group.
- Asian children in Santa Cruz County had a rate of 56%, which is 1.1 percentage points above the goal but 44 percentage points lower than the Black group.

Monterey County

- In Monterey County, Hispanic/Latino children had the highest rate of well-child visits by 15 months at 61%, making them the reference population for this county. This rate is 6.1 percentage points above the goal but 39 percentage points lower than the top-performing Black children in Santa Cruz County.

- White children, Not Hispanic/Latino children, and Asian children followed closely with a rate of 60%, which is 5.1 percentage points above the goal and 1 percentage point lower than the top-performing Hispanic/Latino group in Monterey.
- Black children, Other ethnic groups, and Not Hispanic/Latino children had a lower rate of 50%, which is 4.9 percentage points below the goal and 11 percentage points lower than the top-performing Hispanic/Latino group in Monterey.

Merced County

- Merced County consistently shows lower rates across all racial/ethnic groups. None of the racial/ethnic groups meets the benchmark set at the 50th percentile(54.9%).
- The highest rate was 42% among White children. This makes them the reference population for this county. This rate is 12.9 percentage points below the goal and 58 percentage points lower than the top-performing Black children in Santa Cruz County.
- Black children in Merced had the lowest rate at 18%, which is 36.9 percentage points below the goal and 24 percentage points lower than the highest rate among White children in Merced.
- Asian children in Merced had a rate of 38%, which is 16.9 percentage points below the goal and 4 percentage points lower than the top-performing White group in Merced.
- Hispanic/Latino children in Merced had a rate of 37%, which is 17.9 percentage points below the goal and 5 percentage points lower than the top-performing White group in Merced.
- Other racial/ethnic groups in Merced had a visit rate of 30%, which is 24.9 percentage points below the goal and 12 percentage points lower than the top-performing White group in Merced.
- Non-Hispanic/Latino children in Merced had a rate of 30%, which is 24.9 percentage points below the goal and 12 percentage points lower than the White group in Merced.

Conclusion

In summary, Black children in Santa Cruz County significantly outperformed other groups, while the other counties, especially Merced, did not meet the 50th percentile benchmark across all race/ethnic groups.

Qualitative Analysis

The qualitative analysis examined well-child visit compliance rates across three counties and pointed out disparities in performance among racial and ethnic groups. The analysis identifies the top-performing and low-performing groups in each county, evaluates overall compliance with benchmarks, and emphasizes gaps that require targeted interventions to improve equitable access to healthcare services.

Santa Cruz County

- **Top-Performing Group:** Black children at 100% compliance, serving as the reference group.
- **Lowest-Performing Group:** Asian children at 56% were 44 percentage points lower than Black children but still exceeded the goal by 1.1 percentage points.

- **Overall Compliance:** All groups met or exceeded the benchmark of 54.9%, demonstrating strong engagement with well-child services across racial/ethnic groups.
- **Disparities:** There is 44% a disparity in compliance rates between different racial groups in the Sanda Cruz County data, with Black performing the best(100%) and Asian performing the worst(56%).

Monterey County

- **Top-Performing Group:** Hispanic/Latino children at 61%, serving as the reference group for Monterey County.
- **Lowest-Performing Group:** Black, Not Hispanic/Latino, and Other racial groups at 50%, which were 11 percentage points lower than the top-performing Hispanic/Latino group but exceeded the goal by 4.9 percentage points.
- **Overall Compliance:** Most groups met or exceeded the benchmark of 54.9%, with Hispanic/Latino groups performing the best.
- **Disparities:** There was a 13% disparity in compliance rates between the highest-performing Hispanic/Latino group (61%) and the lowest-performing Black and Other groups (50%) in Monterey County.

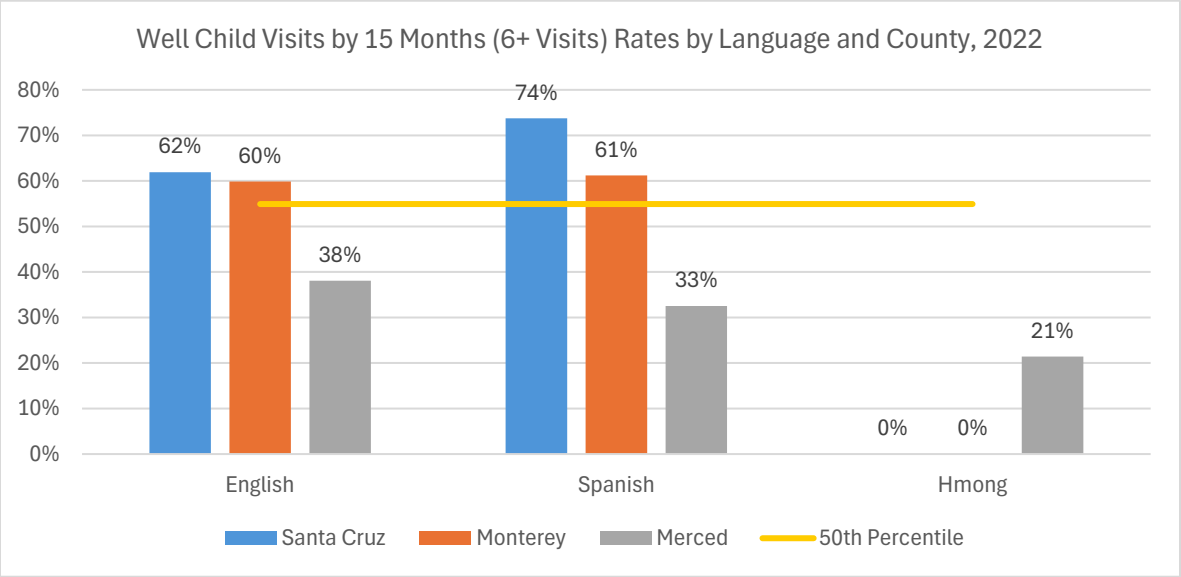
Merced County

- **Top-Performing Group:** White children at 42%, serving as the reference group despite not meeting the goal.
- **Lowest-Performing Group:** Black children at 18%, which were 24 percentage points lower than the top-performing White group and 36.9 percentage points below the goal.
- **Overall Compliance:** No groups in Merced County met the benchmark of 54.9%, indicating widespread underperformance across all racial/ethnic groups.
- **Disparities:** There was a 24% disparity in compliance rates between the top-performing White group (42%) and the lowest-performing Black group (18%) in Merced County.

The analysis reveals disparities in well-child visit compliance across counties. In **Santa Cruz County**, Black children showed the highest compliance, possibly due to effective outreach and culturally tailored programs. However, Black children in Merced County had the lowest compliance rates overall. It reflects differences in access to well-child services between these two counties. Asian children had the lowest compliance in Santa Cruz. In **Monterey County**, Hispanic/Latino children performed the best, likely benefiting from strong community engagement and language-specific resources, while Black and Other groups lagged, potentially due to systemic inequities or limited outreach. Hispanic/Latino children generally performed well across counties but showed significantly below the goal and the reference group in Merced County. **Merced County** faced underperformance, with White children showing the highest compliance and Black children the lowest. This pattern aligns with trends often observed, where White children tend to have comparatively better access to healthcare services. The underperformance in Merced County may result from socioeconomic challenges, healthcare access barriers, and insufficient provider capacity, particularly for Black children and other underserved populations.

9.3.2. Analysis by Spoken Languages: Well Child Visits in the First 15 Months

Figure 2. Well Child Visits by 15 Months (6 Visits) by Spoken Language and County*, 2022



*Source: MCAS MY2022 administrative data. *Spoken language groups included if denominator was >10 members.*

Quantitative Analysis

Santa Cruz County

- Spanish-speaking children had the highest rate in the county at 74%, exceeding the goal by 19.1 percentage points and making them the reference population (top-performing group).
- English-speaking children had a well-child visit rate of 62%, which was 7.1 percentage points above the goal but 12 percentage points lower than the Spanish-speaking top-performing group.
- Hmong-speaking children had a rate of 0% well-child visits, which was 54.9 percentage points below the goal and 74 percentage points lower than the top-performing Spanish-speaking group.

Monterey County

- Spanish-speaking children showed a rate of 61%, 6.1 percentage points above the goal, and were the reference population for this county.
- English-speaking children had a well-child visit rate of 60%, which was 5.1 percentage points above the goal but 1 percentage point lower than the Spanish-speaking top-performing group.
- Hmong-speaking children had a rate of 0% well-child visits, which was 54.9 percentage points below the goal and 61 percentage points lower than the top-performing Spanish-speaking group.

Merced County

- None of the language groups met the 50th percentile goal (54.9%) in Merced County.
- English-speaking children had a well-child visit rate of 38%, which was 16.9 percentage points below the goal but made them the reference population (top-performing group) in Merced County.

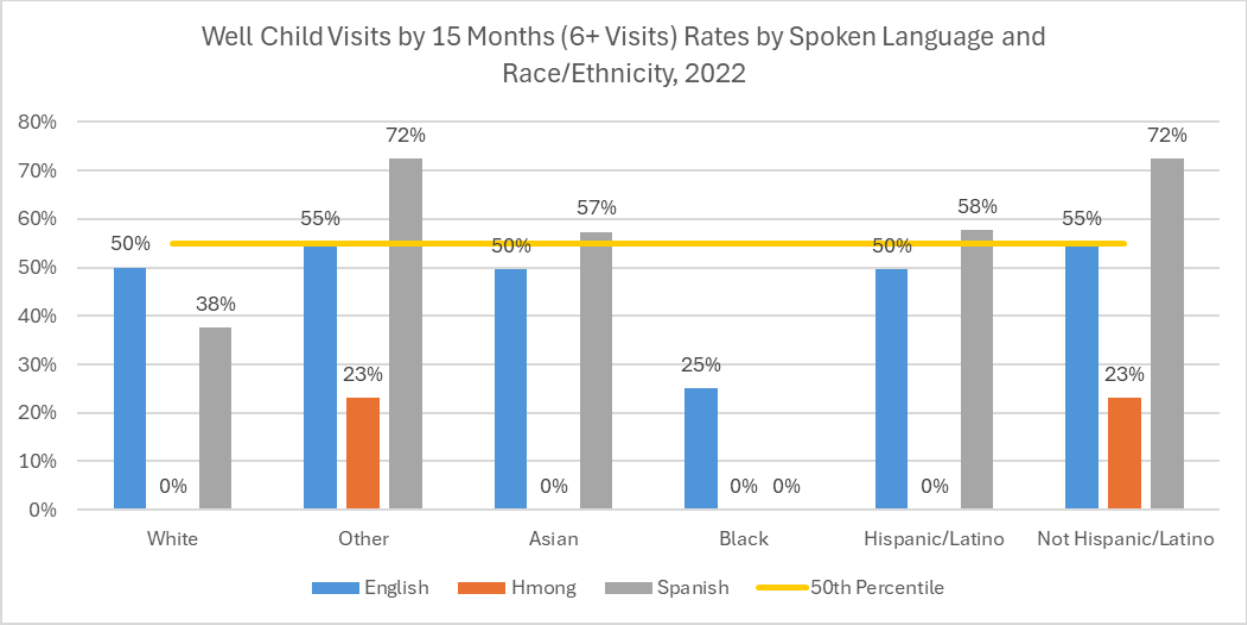
- Spanish-speaking children had a rate of 33%, which was 21.9 percentage points below the goal and 5 percentage points lower than the top-performing English-speaking group.
- Hmong-speaking children had the lowest rate in the county at 21%, which was 33.9 percentage points below the goal and 17 percentage points lower than the top-performing English-speaking group.

Conclusion

Santa Cruz County showed the highest performance for Spanish-speaking children at 74%, while Merced County showed the lowest overall performance, with none of the language groups meeting the 50th percentile benchmark. The Hmong-speaking group showed the most significant gap in all three counties, especially in Santa Cruz and Monterey, where there are no recorded visits.

9.3.3. Analysis by Spoken Language and Race and Ethnicity: Well Child Visits in the First 15 Months

Figure 3. Well Child Visits by 15 Months (6 Visits) by Spoken Language and Race and Ethnicity, 2022



Source: MCAS MY2022 administrative data, direct reference only.

In Figure 3, Spanish speaking families were the highest rates in Other and Not Hispanic/Latino at 72%.

Quantitative Analysis

- For the White population, the most spoken language was English. The rate for English-speaking White children was 50%. This did not meet the goal of the 50th percentile benchmark of 54.9% and was 4.9 percentage points below the goal. When compared to the top-performing group, which was Spanish-speaking children from Other racial groups with a rate of 72%, the rate for English-speaking White children was 22 percentage points lower. Spanish-speaking White children had a rate of 38%. This was 16.9 percentage points below

the goal and 34 percentage points lower than the top performing group. No well-child visits were recorded for Hmong-speaking White children.

- For Other racial groups, the most spoken language was Spanish. Spanish-speaking children from this group achieved a rate of 72%. This rate exceeded the goal by 17.1 percentage points and made them the top-performing group. English-speaking children from Other racial groups had a rate of 55%. This rate was 0.1 percentage points above the goal but 17 percentage points lower than the Spanish-speaking children in the same racial group. Hmong-speaking children from Other racial groups had a rate of 23%. This was 31.9 percentage points below the goal and 49 percentage points lower than the top-performing group.
- Among Asian children, Spanish-speaking children achieved a rate of 57%. This met the goal and exceeded it by 2.1 percentage points. However, this rate was still 15 percentage points lower than the top-performing Spanish-speaking group from Other racial groups. English-speaking Asian children had a rate of 50%. This rate was 4.9 percentage points below the goal and 22 percentage points lower than the top-performing group. No well-child visits were recorded for Hmong-speaking Asian children, resulting in a rate of 0%.
- Black children spoke only English. The rate for Black children was 25%. This was 29.9 percentage points below the goal and 47 percentage points lower than the top-performing Spanish-speaking group from Other racial groups. There were no recorded rates for Hmong-speaking or Spanish-speaking Black children.
- Spanish-speaking Hispanic or Latino children achieved a rate of 58%. This rate exceeded the goal by 3.1 percentage points but was 14 percentage points lower than the top-performing Spanish-speaking group from Other racial groups. English-speaking Hispanic or Latino children had a rate of 50%. This rate was 4.9 percentage points below the goal and 22 percentage points lower than the top-performing group. There was no well-child visits recorded for Hmong-speaking Hispanic or Latino children.
- Spanish-speaking children from the Not Hispanic or Latino population achieved a rate of 72%. This rate exceeded the goal by 17.1 percentage points and made them the top-performing group. English-speaking children from this group had a rate of 55%. This rate was 0.1 percentage points above the goal but 17 percentage points lower than the top-performing Spanish-speaking group. Hmong-speaking children from this group had a rate of 23%. This was 31.9 percentage points below the goal and 49 percentage points lower than the top-performing group.

Conclusion

In summary, the data shows significant disparities in well-child visit rates across different racial and ethnic groups as well as spoken languages. Spanish-speaking children, especially those identified as Not Hispanic/Latino, achieve the highest compliance rates. In contrast, Hmong-speaking children show the lowest rates across all racial and ethnic categories.

9.4. Child and Adolescent Well-Care Visits – Total

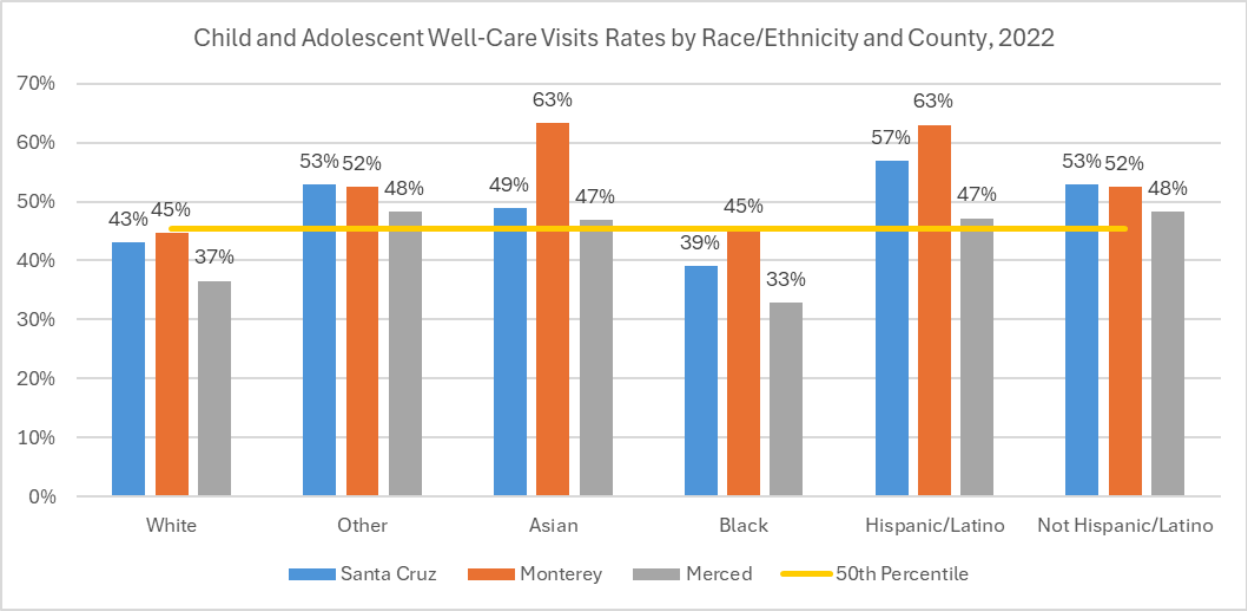
The Child and Adolescent Well-Care Visits – Total (WCV) measure represents the percentage of children ages 3 to 21 years who had at least one comprehensive well-care visit with a PCP or OBGYN practitioner during the measurement year. Overall, 54% of eligible child and adolescent Alliance

members ages 3-21 had at least one well child visit in 2022, with Merced County at 45.64%, Monterey at 45.64%, and 54.22% in Santa Cruz County.

Figure 4 below displays the percentage of WCV visits stratified by race/ethnicity and county. As shown, Asian and Hispanic children and adolescents in Monterey had the highest rates of visits overall (63%, followed by Hispanic and Other in Santa Cruz County. ", "Other" (55%), Asian (51%), Black (47%), Native Hawaiian/Other Pacific Islander (46%), White (44%), and American Indian (42%). In Merced, "Other" race, and Not Hispanic/Latino children and adolescents both had the highest compliance rates. Black (N=1654) and White children (N=6081)and adolescents in Merced County had the lowest rates of compliance overall, at 33% and 37% . Although White children and adolescents in Merced County represent a considerable proportion of members in the denominator and a priority population for preventive care in Merced County, understanding the root cause of these disparities will take time to uncover.

9.4.1.Analysis by Race and Ethnicity: Well-Care Visits – Total

Figure 4. Child and Adolescent Well-Care Visit Rates by Race/Ethnicity and County, 2022



Quantitative Analysis

Santa Cruz County

- Hispanic/Latino children show the highest rate in Santa Cruz County, at 57%. This rate is above the 50th percentile benchmark(45.31%) by 11.69 percentage points, making them the top-performing group within the county.
- Not Hispanic/Latino children other group achieve a rate of 53%, which was 7.69 percentage points above the goal but 4 percentage points lower than the top-performing Hispanic/Latino group.
- Asian children in Santa Cruz County had a rate of 49%, which was 3.69 percentage points above the goal but 8 percentage points lower than the top-performing Hispanic/Latino group.

- White children had a rate of 43%, which was 2.31 percentage points below the goal and 14 percentage points lower than the highest-performing group in the county.
- Black children had the lowest rate in Santa Cruz County at 39%. This rate was 6.31 percentage points below the goal and 18 percentage points lower than the top-performing Hispanic/Latino group.

Monterey County

- Hispanic/Latino children and Asian children in Monterey County had the highest rate of well-care visits at 63%. This rate exceeded the goal by 17.69 percentage points, making them the top-performing groups within the county.
- Not Hispanic/Latino children (Other group) achieved a rate of 52%, which was 6.69 percentage points above the goal but 11 percentage points lower than the top-performing Hispanic/Latino and Asian groups.
- White children and Black children in Monterey County had a rate of 45%, which was 0.31 percentage points below the goal and 18 percentage points lower than the top-performing Hispanic/Latino and Asian groups.

Merced County

- Not Hispanic/Latino children (Other group) achieved a rate of 48%, which was 2.69 percentage points above the goal and made them the top-performing group in Merced County.
- Asian children and Hispanic/Latino children had a rate of 47%, which was 1.69 percentage points above the goal and only 1 percentage point below the top-performing group in Merced County.
- White children had a rate of 37%, which was 8.31 percentage points below the goal and 11 percentage points lower than the top-performing group in the county.
- Black children showed the lowest rate at 33%, which was 12.31 percentage points below the goal and 15 percentage points lower than the highest-performing group in Merced County.

Comparison to National Level Data (Race/Ethnicity)

CCAH is experiencing somewhat of a reverse disparity in comparison to national statistics.

- Average visits decreased from 66.6% in 2018-2019 to 58.6% in 2020, rebounding to 65.1% in 2021.
- The unadjusted disparity in attendance between White non-Hispanic and Black non-Hispanic children widened from 9.6 percentage points in 2018-2019 to 24.8 percentage points in 2020 and 21.4 percentage points in 2021.
- CCAH data shows that the populations do not follow this trend. Hispanic members are doing much better than members that are non-Hispanic white. Hispanic and Asian members are the only groups that performed above the 50th percentile in all three counties. Comparatively, whites did not reach the MPL in any of the counties.

9.4.2. Analysis by Spoken Languages: Child and Adolescent Well-Care Visit – Total

As shown in Figure 5, members in Monterey whose spoken language was listed as Spanish had the highest overall rate of WCV compliance (65%), followed by Spanish speaking members in Santa Cruz at 59% All but English was above the 50th percentile in Merced. In Figure 6, the highest compliance is from Asian Spanish speakers (70%, N= 3231), contrasted with the lowest for Black Spanish speakers (20%, N=5).

Figure 5. Child and Adolescent Well-Care Visit Rates by Spoken Language* and County, 2022

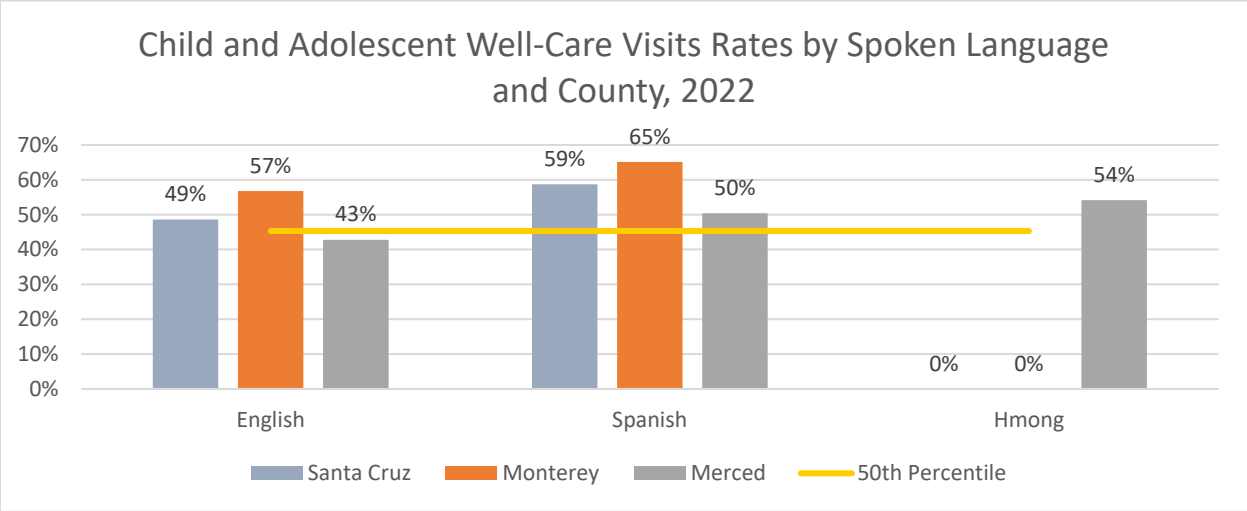
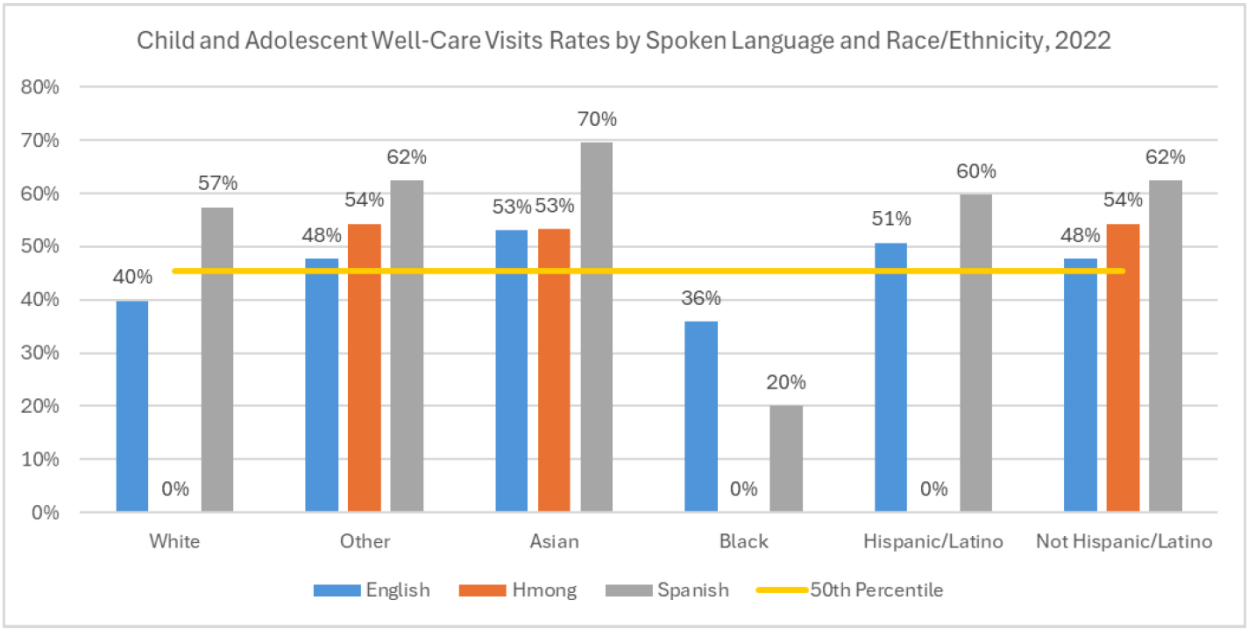


Figure 6. Child and Adolescent Well-Care Visit Rates by Spoken Language and Race/Ethnicity, 2022



Quantitative Analysis

Santa Cruz County

- Spanish-speaking members achieved a compliance rate of 59%, which exceeded the goal of 45.31% by 13.69 percentage points. This group was the top-performing population in the county.
- English-speaking members had a compliance rate of 49%, which was 3.69 percentage points above the goal but 10 percentage points lower than the top-performing Spanish-speaking group.

Monterey County

- Spanish-speaking members achieved a compliance rate of 65%, which exceeded the goal by 19.69 percentage points, making them the top-performing population in the county.
- English-speaking members had a compliance rate of 57%, which was 11.69 percentage points above the goal but 8 percentage points lower than the top-performing Spanish-speaking group.

Merced County

- Hmong-speaking members had a compliance rate of 54%, which met the goal by 8.69 percentage points and was the top-performing group in Merced.
- Spanish-speaking members showed a compliance rate of 50%, which met the goal by 4.69 percentage points.
- English-speaking members had a compliance rate of 43%, which was 2.31 percentage points below the goal and 4 percentage points lower than the top-performing group.

Conclusion

Spanish-speaking members had higher well-care visit compliance rates than English-speaking members across all three counties. Spanish and English remain the two primary languages spoken by CCAH members. Compliance rates for Spanish-speaking members were 8 to 13 percentage points higher than those for English-speaking members. The higher rates among Spanish-speaking members suggest that language-specific outreach and access support for other languages were effectively improved engagement.

Qualitative Analysis by Language and Race/Ethnicity

Member's likelihood of adhering to clinical recommendations is dependent upon their health status, demographic and socioeconomic characteristics, health insurance, and state of residence.
It is very likely that in California, there has been a lot of promotion about healthy behaviors in Spanish and among the Hispanic population. The effects of this are now starting to show in the data as these trends are reversed from any national level statistics.

CCAH scheduled a meeting with the PHM team focused on understanding these reverse disparities in well-child visit rates, particularly the lower performance of the White Medicaid population compared to the Hispanic Medicaid population.
On November 12, 2024, the CCAH members committee met to discuss the reasons for these disparities. Insights from the meeting included:

- According to data from the USDA in 2020, 3.9 million White-only non-Hispanic infants and children were eligible for WIC which is the highest eligible numbers of all race and ethnic. This was followed by 3.2 million Hispanic/Latino children, 2.1 million Black-only non-Hispanic children, and 0.8 million from other races. But Hispanic/Latino children had the highest WIC coverage rate at 62 percent while White-only non-Hispanic children had the lowest at 35 percent. Additionally, most eligible children lived in households with four or more members, and 37 percent were enrolled in Medicaid without receiving SNAP or TANF benefits[1].

[1] https://www.fns.usda.gov/research/wic/eligibility-program-reach-estimates-2020#:~:text=The%20coverage%20rate%20was%20estimated,other%20races%20and%20multiple%20races

    - This data aligns with our findings that Hispanic members and Spanish-speaking members perform better than White or English-speaking members.
- Over time, CCAH has focused numerous health initiatives on the Hispanic population to improve their engagement with healthcare services. This may have contributed to their increased well-child visit rates compared to White populations.
- A key point raised was that Hispanic populations in counties like Merced often participate in programs like WIC and Head Start. These programs provide education on the importance of well-child visits and immunizations. Such participation may contribute to the higher well-child visit rates among Hispanic families.
    - CCAH initiated the Healthy Start Program in April 2023, offering incentives for well-child visits and immunizations. These promotions are available in English, Spanish, and Hmong. We have collaborated with several community-based organizations like WIC and Head Start. Many of these programs serve Latino populations and require vaccines along with discussions about well-child visits.
    - Participation in these programs typically begins early, sometimes during pregnancy, which leads to improved health literacy and healthcare engagement for children in Hispanic families. The CCAH team noted that participation in these programs is widespread in Merced County, which may influence well-child visit rates among Hispanic children in that area.

Opportunities for Improvement

1. Educate members about OMB category definitions to ensure accurate responses during data collection. This will improve the specificity of data for the White population.
    - Clinics will be tasked with educating members using phrases such as, "Please review this definition before answering the question." This effort will address the issue of CCAH relying on second-hand data from the state by promoting direct and accurate data collection at the clinic level.
    - To achieve the most accurate data, CCAH plans to collect member information directly through a new member portal, which will be launched to expand accessibility to all members.
2. Educational Materials for Providers
    - Develop and distribute educational materials targeting providers to address disparities in care delivery. Focus on highlighting existing disparities and emphasizing the need to provide equal opportunities for all members to complete well-child visits. Providers will be encouraged to consider disparities during patient interactions to ensure all members receive equitable care.

3. Utilize gap reports to support providers in prioritizing well-child visits for underperforming populations.
    1. The QIPH team created gap reports in October 2024 to identify children due for well-child visits, specifically targeting White and Black or African American populations.
    2. Updated reports were distributed in November 2024 to five Merced County providers participating in the Alliance's Provider Partnership Program and a major Monterey County provider with a significant number of White and Black members.
    3. These reports included detailed lists of prioritized members and guidance for scheduling visits before the year's end.

As discussed by the CCAH committee on November 12, 2024, we aim to implement the opportunities outlined in items 2 and 3.

Action Taken for Interventions

Intervention	Purpose	Details	Timeline
Educational Materials for Providers	Raise provider awareness about disparities in well-child visits and promote equitable care.	Develop materials to highlight disparities and emphasize equitable care during patient interactions.	Q1-Q2 2025 Planning activities Q3-Q4 2025 Implementation activities
Targeted Gap Reports	Focus on closing care gaps for underperforming populations.	Create PCPs Gap reports targeting White and Black/African American populations prioritizing well-child visits. **Information provided below for details*	Initial reports were shared in October 2024, with updates distributed in November 2024.

Targeted Gap Reports

The California Department of Healthcare Services (DHCS) shared the lowest and second lowest performing race and ethnicity populations for Child and Adolescent Well-Care Visits (WCV) for each Managed Care Plan in August for Measurement Year 2023, Reporting Year 2024, submitted under the Managed Care Accountability Set (MCAS). White and Black or African American members were identified as the priority populations for the Alliance to target in our regions.

Quality Reporting Unit MY 2023	Lowest Performing Population	Second Lowest Performing Population
Monterey/Santa Cruz	White	Black or African American
Merced	Black or African American	White

As an intervention, a gap report was created for PCPs, indicating every child that was due for a well-child visit by the end of 2024, and identified the targeted populations of White and Black or African American. The first report was distributed in early October, and was shared by the Provider Relations team, with an explanation on the cover letter for the health disparity and targeted population. An updated report was shared early November to five Merced County providers participating in the Alliance's Provider Partnership Program, as well as a major Monterey County provider that held a significant number of White and Black members in their linked member population. The goal of this intervention was to educate and share a list of the prioritized members for scheduling well-child visits before the end of the year.

Plan to Evaluate Effectiveness of Interventions for Hemoglobin A1c and Well-Child Visits

CCAH is committed to improving the quality and accessibility of healthcare services for members of all ages. This includes enhancing diabetes management outcomes for patients with Hemoglobin A1c needs and increasing the completion rates of Well-Child Visits. To evaluate the effectiveness of interventions, we will focus on assessing healthcare disparities based on race/ethnicity, language, and other social determinants of health for both measures.

Evaluation Methodology

1. Identify and Prioritize Opportunities

- Utilize data to identify and prioritize opportunities to reduce health care inequities in diabetes management.
- Focus on disparities in Hemoglobin A1c control and Well-Child Visits among different racial, ethnic, and language groups.

2. Implement Interventions

- Implement targeted interventions to address identified inequities in Hemoglobin A1c control rates and well-child visit rates.
- Examples of interventions may include culturally tailored education programs, enhanced language services, and community outreach initiatives.

3. Evaluate Effectiveness

- Utilize the Plan-Do-Check-Act (PDCA) model to evaluate the effectiveness of interventions.
- Measure processes and outcomes to identify areas of deficiency and track improvements over time.

Internal and External Stakeholder Engagement

Internal Collaboration

- Engage with relevant CCAH departments, including Network Development, Member Services, and Provider Relations, to observe operational challenges, community impacts, and opportunities for improvement.

External Collaboration

- Involve external stakeholders to gain insights into the perceived effectiveness of interventions.
- Collaborate with local health organizations, community health partners, and advisory committees to ensure a comprehensive approach.

Evaluation Process

Quantitative Analysis

- Conduct thorough quantitative analysis to compare performance to goals, benchmarks, and prior performance.
- Perform statistical significance tests (e.g., Chi-square, Z-test, T-test) where applicable.

Qualitative Analysis

- Review reports by a diverse team of professionals, including the Chief Medical Officer, Quality Management Manager, and others.
- Conduct brainstorming sessions, categorize and prioritize barriers, and perform root cause analyses.

Continuous Improvement

- Develop clear and measurable process indicators to evaluate the impact of improvements.
- Set interim goals and a schedule for continuous assessment.
- Monitor progress regularly and enhance the process as needed.

Acting on Identified Opportunities

- Generate potential interventions to enhance performance on Hemoglobin A1c control and well-child visits.
- Select a team to carry out activities and provide updates on progress.
- Engage in discussions with the Member Advisory Committee to explore potential opportunities before implementation.

By following this structured approach, CCAH aims to address healthcare inequities, improve clinical management outcomes, and provide high-quality, equitable care for all patients.

9.4.3. Barrier Qualitative Analysis

The team at CCAH performed a detailed barrier analysis. There are two categories of barriers that impact HEDIS measures. These are as follows:

Barrier to Continuity and Coordination of Care

Provider Level Barriers

- PCPs are often unaware when their patients visit the hospital, indicating a collaboration and communication issue between providers and care settings. Hospital staff do not always share information with PCPs after a member's emergency room visit, partly due to not knowing the PCP's identity or failing to complete a release of information form.

- Misinterpretation of HIPAA regulations prevent hospital staff from sharing information with PCPs without a signed release form, which is further complicated by insufficient training on HIPAA requirements.
- Staff turnover in hospitals leads to disruptions in processes, impacting the continuity and coordination of care.
- Infrastructure Challenges:
    - Interoperability between electronic health systems may be suboptimal, impacting the timely exchange of care plans between providers in different settings. Inadequate synchronization of procedures for sharing member discharge plans across settings could delay communication and hinder post-discharge coordination of care.
    - The Hospitals and outpatient practitioners are rarely on the same EMR system which means that they are not able to see the relevant clinical information needed to better manage their patient. There are different kinds of infrastructure established to exchange information between hospitals and PCPs. These include Health information exchanges and ADT feeds. However, due to lack of resources and staffing to set up these systems, several clinics are not able to utilize these systems.
    - Some hospitals may not be connected to the ADT Feed system.
        - PCPs may not be getting sufficient information if they don't have access or did not activate their access to ADT Feed system.
        - Even the clinics that are connected to HIEs and getting ADT feeds have an issue with the providers reviewing these notes once they are received. PCPs who are within those clinics may not be aware that they can get or may not know they are already getting information through the ADT Feeds.

Member Level Barriers

- Communication between healthcare providers and members may be insufficient.
    - Members are not given clear instructions to share the discharge summaries with their outpatient provider. There is limited provider-member interaction time which could lead to unclear instructions for follow-up care once discharged.
    - Members discharged from the hospital without clear guidance on post-discharge follow up care, how and when to schedule an appointment with their PCP, medication management, or other essential information may struggle to adhere to treatment plans, increasing the risk of readmission.
- Members may lack awareness of whom to contact for follow-up care, such as their primary care provider or specialist.
    - This lack of clarity could result in members not seeking necessary post-discharge care, leading to complications and an increased risk of readmission.

- Personal factors, such as limited social support, additional health conditions, and individual circumstances, can hinder members' ability to manage their health effectively post-discharge, contributing to the risk of readmission.

Barrier to Continuity and Coordination Between Medical Care and Behavioral Healthcare

Provider Level Barriers

- PCPs may lack confidence and experience in managing mental health medication compared to BH practitioners.

    - Unfamiliarity with mental health medications, unclear follow-up procedures, and difficulties in advising patients about medication adherence contribute to this issue.
- Access to BH providers is challenging, causing delays in care for members needing ongoing mental health medication management.
- Lack of coordination between PCPs and BH practitioners results in improper management of mental health patients.
    - PCPs may stop prescribing medication without consulting BH practitioners when side effects occur.
- Information exchange systems between providers are suboptimal.
    - Delays in sharing medical history, especially when patients switch providers, impact treatment continuity.
- Misinterpretations of HIPAA regulations hinder information sharing between PCPs and BH practitioners.
- The use of different EMR systems by BH practitioners and medical practitioners hampers effective patient care.

Member Level Barriers

- Members may discontinue mental health medication during summer months due to routine changes, reflecting a lack of awareness about the need for consistent treatment.
- Members might stop taking medication once symptoms improve, not understanding the importance of long-term adherence to prevent relapses.
- Stigma and side effects can lead to treatment discontinuation.
    - Members may choose to stop treatment to avoid judgment or due to bothersome side effects.
- Individuals with other health issues may prioritize physical health over mental health, leading to neglect of psychoactive drugs and non-adherence.

10. Clinical Safety

10.1. Introduction

Clinical safety is a core pillar of health care quality and regulatory accountability. It encompasses the policies, oversight mechanisms, and team structures that detect, investigate, and address safety risks in provider practice and member care experiences. The health plan's Clinical Safety Program consists of multiple components that support the timely identification and remediation of care concerns, enforce site compliance with state standards, and ensure a safe environment for members.

In 2024, the Clinical Safety team carried out oversight efforts through two primary programs: Facility Site Review (FSR) and Potential Quality Issues (PQI). These programs are integrated mechanisms to monitor care quality through structured provider evaluations and investigations of clinical concerns raised via member grievances or internal referrals. The following sections summarize key performance outcomes, highlight operational improvements, and outline strategic priorities to strengthen regulatory alignment and promote member safety.

10.2. Facility Site Review (FSR)

Introduction

The Facility Site Review (FSR) program is a foundational component of the health plan's quality assurance efforts, evaluating primary care provider compliance with state requirements. The

program includes three core review types: Facility Site Review (FSR), Medical Record Review (MRR), and Physical Assessment Review (PAR). Each is designed to assess whether provider sites maintain safe, accessible environments and follow clinical quality and documentation standards. Corrective Action Plans (CAPs) are issued and monitored through resolution when deficiencies are identified. The FSR program operates under the Department of Health Care Services (DHCS) guidelines, including All Plan Letter 22-017.

The following analysis highlights 2024 FSR and MRR site review activities, including review completion performance, CAP management, staffing capacity, and system-level improvements.

Goals and Data Collection

In 2024, the FSR team set ambitious goals to enhance the program's effectiveness further and ensure regulatory compliance. These goals, which form the basis of our annual analysis, include:

- Complete 80 percent or more of primary care provider sites due for FSR or MRR within three years of their prior review.
- Ensure 100 percent of providers with CAPs arising from FSR or MRR submit corrective plans within DHCS-required timeframes.

Performance data was collected and tracked quarterly, based on the number of reviews due and completed, and CAPs issued versus those submitted within required timeframes. Provider communication, review scheduling, and CAP follow-up were coordinated in alignment with regulatory expectations. Site review planning was initiated one quarter in advance to ensure timely completion.

Quantitative Analysis

Quarter	Reviews Due	Reviews Completed	% Completed	CAPs Due	CAPs Received on Time
Q1	13	13	100%	8	8
Q2	13	11	85%	12	11
Q3	16	15	94%	12	5
Q4	6	5	83%	6	6

The Facility Site Review team was responsible for 48 reviews in 2024, of which 44 were completed, resulting in a completion rate of 92 percent. Over the same period, 38 Corrective Action Plans were due, and 34 were submitted on time, yielding a CAP timeliness rate of 89 percent.

Performance Trends

The FSR team maintained a strong overall performance in 2024, consistently exceeding the threshold for review completion while navigating staffing transitions, system changes, and provider-specific challenges. The review completion rate reached 92 percent, surpassing the threshold in all four quarters. Q1 demonstrated full compliance despite lean staffing, driven by strategic scheduling and

an experienced lead reviewer. Q2 and Q4, while slightly below 90 percent, were impacted by onboarding delays and temporary vacancies. Q3 achieved the highest performance outside of Q1, reflecting improved operational coordination.

CAP submission timeliness reached 89 percent overall, with 34 of 38 CAPs submitted on time. Q1 and Q4 met full compliance, while Q3 presented the most significant challenge due to delays across multiple affiliated sites within one provider group. Despite deadline extensions and collaborative efforts, timely CAP closure was not achieved. The team implemented corrective action strategies, and CAP timeliness rebounded in Q4.

The team maintained performance while onboarding new staff, adopting new technology, preparing for Medi-Cal Site Review Portal (MSRP) integration, and managing multiple provider escalations. These efforts reflect the program's ability to remain compliant while adapting to internal and external pressures.

Qualitative Analysis

Staffing Transitions

The year began with the FSR team operating at minimal capacity, supported by one DHCS master-trained nurse. Despite this limitation, the team achieved full compliance with Q1 review and CAP goals. Leadership approved two additional positions and one backfill to expand long-term capacity. One of these positions was filled in Q1, when a second DHCS master-trained nurse was brought on board. This strengthened operational coverage and created the foundation for training incoming staff. However, recruitment and onboarding for the remaining positions extended into Q4, with offers accepted late in the year.

A key constraint emerged. Onboarding and certifying three new nurses will require most of 2025, as DHCS guidelines mandate that a certified DHCS master trainer lead training and validation. With only one certified trainer, onboarding will occur sequentially and under close oversight to ensure inter-rater reliability and compliance with All Plan Letter 22-017.

The departure of an experienced nurse in Q3 added to temporary capacity challenges. To mitigate impact, the team scaled back non-regulatory activities, refined onboarding plans, and worked closely with Human Resources to maintain momentum in recruitment. By year-end, two new hires had accepted offers with early 2025 start dates, while the third remained pending. While this supports future capacity, full readiness will not be achieved until all staff are onboarded and certified.

Conclusion

In 2024, the Facility Site Review (FSR) program demonstrated operational resilience while navigating staffing transitions and provider-specific challenges. Although internal performance benchmarks were not consistently met across all quarters, the team maintained core functions by onboarding new staff, refining workflows, transitioning to Healthy Data Systems (HDS) for audit documentation, and advancing readiness for Medi-Cal Site Review Portal (MSRP) integration. These efforts enhanced reporting accuracy, reduced manual processes, and aligned operations with evolving Department of Health Care Services (DHCS) expectations.

Staffing changes, including the departure of an experienced reviewer and the addition of two new team members, were managed through targeted recruitment, structured training, and strategic

workload distribution. Certification for three additional nurses is expected to continue through 2025, paced by the availability of the team's sole DHCS-certified trainer.

The program enters 2025 with key infrastructure and staffing efforts in motion. With full implementation of Healthy Data Systems (HDS) anticipated by year-end and phased onboarding already underway, the team is positioned to improve internal performance metrics, expand review capacity, and enhance preparedness for upcoming regulatory audits.

10.3. Potential Quality Issues (PQI)

PQI Program Introduction

The Potential Quality Issues (PQI) program serves as a core element of the health plan's clinical oversight infrastructure, supporting identifying, reviewing, and resolving potential deficiencies in the quality of care delivered to members. It functions as a responsive mechanism for evaluating concerns that arise through member grievances, internal referrals, or patterns identified through data analysis.

In calendar year 2024, the program concentrated on managing PQIs associated with grievance-driven regulatory timelines and internal referrals reviewed by the Quality Improvement (QI) team. These activities required close coordination with medical directors, clinical reviewers, and other internal stakeholders to ensure timely resolution and appropriate follow-up. Investigations were guided by internal standards and Department of Health Care Services (DHCS) requirements specific to Long-Term Services and Supports (LTSS) and grievance-related turnaround times.

PQI Quantitative Analysis

Throughout the year, the team resolved high volumes of regulatory PQIs while triaging internal referrals based on known provider trends, CAPs, and member populations such as those enrolled in LTSS.

Regulatory PQI Grievances

- Q1: 112 out of 112 closed on time (100%)
- Q2: 98 out of 98 closed on time (100%)
- Q3: 127 out of 127 closed on time (100%)
- Q4: 112 out of 112 closed on time (100%)

Internal Referral PQIs (90-Day Goal)

- Q1: 25 out of 30 closed on time (83%)
- Q2: 20 out of 30 closed on time (57%)
- Q3: 24 out of 33 closed on time (73%)
- Q4: 24 out of 33 closed on time (73%)

The annual totals included 449 regulatory PQIs, all closed within required timeframes, and 123 internal referrals, with an overall timeliness rate of 76 percent.

PQI Performance Trends

While internal PQI performance did not meet the 80 percent annual target, it revealed meaningful patterns. Strong results in the first quarter led to a second quarter decline due to staffing transitions and the reprioritization of resources toward regulatory obligations. Performance rebounded in the

year's second half, supported by workflow refinements and triaging protocols. Prioritization based on severity, provider history, and Corrective Action Plan (CAP) status contributed to more responsive case handling.

The fourth-quarter revision of Policy 401-1301, Potential Quality Issue, extended the internal referral review window to 120 days beginning in 2025. This policy change is expected to better align expectations with available staffing and create space for more sustainable case resolution in the future.

PQI Qualitative Analysis

The PQI team consistently managed grievance-driven cases while navigating increased volume, staffing changes, and competing departmental priorities. Internal PQIs were more challenging to manage due to workload limitations, a pause in collaborative work, and challenges identifying LTSS members for DHCS Critical Incident reporting.

To address internal case volume, the team implemented referral triaging, prioritized reviews based on provider concerns, and introduced revised turnaround expectations. Staffing adjustments, including the promotion of a nurse to supervisor and backfilling of that position, supported continuity of operations. However, limited resources continued to affect non-regulatory performance throughout the year.

The need to consistently prioritize grievance-related PQIs significantly limited capacity for broader QI activities, such as interdepartmental collaboration and quality studies.

PQI Conclusion

The PQI program consistently met its regulatory requirements in 2024 and showed progress in improving internal review workflows. The update to Policy 401-1301 was a key milestone that laid the groundwork for enhanced sustainability. As the program moves into 2025, success will depend on continued staffing stabilization, monitoring of audit findings, and alignment with organizational priorities.

Anticipated challenges include the potential for new corrective actions, increased audit scrutiny, and pressure on staff to balance competing expectations, including contributions to Long-Term Services and Supports Quality Assurance and Performance Improvement (LTSS QAPI) initiatives and participation in quality studies. Ongoing evaluation and resource planning will be essential to ensure timely case resolution and sustained compliance.

11. Member Complaints and Appeals Related to Access

11.1. Introduction

The Alliance consistently collects data on factors that impact the member experience. The sources concerning complaints (grievances) and appeals challenges in the non-behavioral healthcare and behavioral healthcare (BH) sectors are divided into five NCQA categories. Complaints and appeals are an important source of information about the impact of Alliance services and potential opportunities for improvement. The data is carefully analyzed to assess the effectiveness of the network and to review member concerns. The report summarizes the results of the annual

evaluation of member complaints and appeals, which identify challenges to member satisfaction and propose solutions to address these gaps.

11.2. Methodology

- Complaint and appeal data is analyzed from the universe of complaints, and appeals received by the Alliance during the measurement time period.
- The Alliance Grievance team retrieved complaints and appeals from the database.
- This report includes 2024 data.
- All complaints and appeals are categorized into one of the five NCQA categories:
    - Access
    - Attitude/Service
    - Billing/Financial
    - Quality of Care
    - Quality of Practitioner Office Site
- The rate of complaints per 1,000 member months per month allows the Plan to compare complaint rates with the formula:
    - Annual Rate per 1,000 Member Months = (Total Number of complaints or appeals for the Year / Total Member Months for the Year) x 1,000
    - Total Member Months for the Year = Sum of monthly membership over the course of the Year

11.3. Goal Standards for Member Complaints and Appeals

- Goal for the annual total complaints and appeals per 1,000 member months: **≤5/1,000.**
- Goal for the annual per category of complaints and appeals per 1,000 member months: **≤2/1,000.**

11.4. Key Findings

11.4.1. Complaints Non-Behavioral Health

Category	Previous Year (2023)		Current Measurement Year (2024)			
	Total Member Months 4,851,989		Total Member Months 5,055,088			
	2023 Total Complaints	2023 Complaints per 1,000 Member Months	2024 Total Complaints	2024 Complaints per 1,000 Member Months	Goal (Per 1,000 Members Months)	Goal Met?
Quality of Care	772	0.15	615	0.11	2	YES
Access	1510	0.30	1,033	0.19	2	YES

Attitude/Service	1938	0.38	2166	0.40	2	YES
Billing/Financial	421	0.08	378	0.07	2	YES
Quality of Practitioner Office Site	3	0.0001	1	0.0001	2	YES
Total/Number per 1,000	4644	0.92	4,193	0.78	5	YES

Quantitative Analysis

- The Alliance set the goal for evaluating complaints per category to be below 2 per thousand member months and the overall goal to be below 5 per thousand member months.
- The Alliance met all goals for access, attitude/service, quality of care, billing/financial, and quality of practitioner office site.
- Attitude and service continue to be the most common complaints, with 0.34 complaints per 1,000 member months.
- Access complaints were the second most common category of complaints received in 2024, at 0.19 complaints per thousand member months.
- The quality-of-care rate was 0.11 complaints per thousand member months, which is a decline from prior years.
- There were 0.07 billing and finance-related complaints for every 1,000 member months.
- The quality of the practitioner office site was the lowest complaint category received. It was presented only at 0.0001 complaints per 1,000 member months.
- The total rates of all complaint categories met the goal of less than 5 per 1,000 members. The total was 0.78 per 1,000 member months.
- The overall trend in complaint rates per 1,000 member months showed a slight decrease across most categories in 2024, with the total decreasing by 0.14. Three categories of complaints showed a decreasing trend, including Quality of Care, Access, and Billing/Financial. However, Attitude/Service complaints increased by .02.

Conclusion Based on Quantitative Analysis

The Alliance met all five categories and the total complaints rate per 1,000 member months when evaluating complaints received through the measurement year 2024. When investigating trend data, the Alliance noticed an overall decrease in complaints regarding non-BH services. The grievance data reflects member dissatisfaction with the provider and staff's attitude and service and delays with access to care .

Qualitative Analysis

The analysis of access complaints revealed that the goal of maintaining less than 2 complaints per 1,000 member months was achieved. As most complaints are concentrated in the categories of Access and Attitude/Service, this indicates that members are dissatisfied with service access and the attitude of providers and Alliance staff. The Grievance data shows an opportunity for improved interaction with all member facing teams including the Call Center and Provider Office Staff. Routine

reminders and training opportunities will reinforce the importance of the member experience during interactions. An interdisciplinary team comprised of Subject Matter Experts (SMEs) included Quality Improvement and Population Health Director, Quality and Health Programs Manager, Grievance and Quality Manager, Provider Services Director, Provider Quality and Network Development Manager, Health Services Operations Manager, and Compliance Director explored a detailed examination of the grievances related to access complaints to identify provider availability and timely access issues in specific areas.

Barrier at Member Level:

- Both Monterey and Merced counties have significant rural populations, which face additional barriers to accessing healthcare. Limited transportation options and fewer healthcare facilities contribute to the high number of complaints.
- Members might not be fully aware of the services covered or how to receive care, treatment, tests, and case management, which causes frustrations that inevitably develop into complaints.
- Members do not know how to navigate the healthcare system as well, and therefore they are not able to get appointments in a timely manner. Some members do not realize that providers have same day waitlist appointments, and they can receive appointment assistance with the Alliance care management.
- Members' geographic location, economic status, or educational background might influence their access to healthcare services and their experiences. These factors could hinder their ability to receive timely and quality care. It then contributed to higher complaints in access and attitude/service categories.

Barrier at Provider Level:

- Limited staffing or an imbalance between the number of healthcare providers and the high demand for services can lead to longer wait times and reduced quality of service. As reflected in the increased complaints in the Attitude/Service category, providers and front office staff may lack sufficient training in service or empathy for positive member interactions.
- Limited resources of specialist availability affect the quality of care and access to care. As exploring a detailed examination of the categories related to access complaints, provider availability and timely access are the primary issues in specific areas.

County	Provider Availability	Timely Access	Grand Total
MONTEREY	283	21	304
MERCED	196	10	206173
SANTA CRUZ	165	9	174
Mariposa	17	0	17
San Benito	48	6	54

In conclusion, provider availability and timely access appeared to be the top challenges in access-related complaints. These challenges not only lead to lower levels of member satisfaction but also interfere with the desired outcomes. The table above showed that most complaints are likely to occur in Monterey and Merced counties. The specific types of providers that mostly cause complaints are family practitioners and clinics with mixed specialty types. The potential causes for these complaints in the particular areas are identified as follows:

- There are a limited number of NEMT vendors that are contracted with the Alliance. This limits the ability of members to get transportation to provider offices.
- Monterey and Merced County are designated as health professional shortage areas. These designations are typically made by the Health Resources and Services Administration (HRSA), which assesses regions based on specific criteria to determine shortages of healthcare professionals. It means that there is a limited number of providers in those areas. Because of the shortage, patients have limited access to providers and the plan also does not have much opportunity to contact additional providers in that area.
- Many complaints mention that patients had long wait times to secure an appointment with their PCPs or SCPs. For example, members reported wait times of several months for new patient appointments and delays in scheduling follow-up visits.
- Several providers, clinics, and health centers refused to schedule appointments for new patients or those who had not been seen in a long time. This issue is particularly acute with providers like Alisal Health Center and Federally Qualified Health Centers (FQHCs).
- Provider network shows that practitioners are in-network and/or accepting new patients. However, when members contact the practitioner, they are told that the provider is not accepting new patients.

Barriers at Plan-Level Barriers

- Ineffective communication from providers that may not update their availability or specialty information with the Alliance regularly.
- Inefficiencies in the appointment scheduling systems and inadequate capacity to handle patient preferred times were recurrent themes.
- Policy and procedures regarding appointment scheduling, billing, and eligibility for services can create barriers to accessing care.

Conclusion Based on Qualitative Analysis

In conclusion, the Alliance reported the total complaints per 1,000 members and complaints regarding access met their goals. The data reveal successful performance in keeping the complaints rate low for non-behavioral health services. While ongoing network adequacy steering committee activities will continue to use grievance data as a data insight, no additional barrier analysis is needed to address network adequacy gaps.

Opportunities for Improvement

- The Alliance has been working to expand the network by adding several vendors. These vendors can provide non-emergency medical transport to members so that the member can go to providers that are located far from their residence.
- Implement and expand telehealth clinics to reach remote and underserved areas. The Alliance is in the process of implementing telehealth for both non-behavioral health and behavioral health to expand the number of telehealth only providers. In addition, several of

the clinics offer in-person services. They also offer Telehealth appointments to their patients. This reduces the need for patients to travel long distances and allows providers to see patients virtually which can reduce the pressure on physical clinic spaces.

- The Alliance continues to work with internal front line staff, as well as health partners, to ensure efficient scheduling systems and member communications about available appointment assistance.
- The Alliance continues to increase member feedback monitoring mechanisms to regularly gather and use this data to inform service adjustments. These efforts aim to enhance service quality and member satisfaction while addressing gaps in care.
- The Alliance continues to work towards increasing network capacity by working with local medical schools, residency programs with University of California Merced and University of California San Francisco to expand the network in remote areas.
- The Alliance offers medical capacity grants to fund a portion of the salary for specific provider types to aid in recruiting additional practitioners and supporting medical assistants.
- The Alliance enhanced comprehensive training and staff development programs focused on empathy, customer service, and cultural competence. This approach aims to improve staff interactions with members and reduce complaints related to attitude and service.
- The Alliance continues to develop effective communication methods to help members understand their coverage, how to access services, and how to voice concerns. These ongoing improvements are expected to reduce confusion and dissatisfaction.

11.4.2. Appeals Non-Behavioral Health

Category	Previous Year (2023)		Current Measurement Year (2024)			
	Total Member Months 5,055,088		Total Member Months 5,402,819			
	2023 Total Appeals	2023 Appeals per 1,000 Member Months	2024 Total Appeals	2024 Appeals per 1,000 Member Months	Goal (Per 1,000 Member Months)	Goal Met?
Quality of Care	3	0.0001	7	0.0001	2	YES
Access	186	0.04	209	0.04	2	YES
Attitude/Service	0	0.00	36	0.01	2	YES
Billing/Financial	1	0.0001	3	0.0001	2	YES
Quality of Practitioner Office Site	0	0.00	0	0.00	2	YES

Total/Number per 1,000	190	0.04	255	0.05	5	YES

Quantitative Analysis

- The target for appeal rates per category was set below 2 appeals per 1,000 member months, with an overall organizational goal of less than 5 appeals per 1,000 member months.
- The Alliance successfully met the goals for all categories, including quality of care, access, attitude/service, billing/financial, and quality of practitioner office site.
- The total appeals increased 34% from 190 in 2023 to 255 in 2024, but they remained consistently low at 0.04 per 1,000 member months. This rate met the organization's overall goal of less than 5 appeals per 1,000 member months.
- Appeals related to access was the highest appeal category received in 2024.This rate was stabilized at 0.04 to 0.04 per 1,000 member months. This also achieved the goal of having fewer than two appeals per thousand members.
- Appeals related to Attitude/Service was the second highest appeal category received in 2024. This rate was 0.01 per 1,000 member months. This rate met the set goal.
- Appeals related to Quality of Care maintained a stable appeal rate of 0.001 per 1,000 member months. This rate also met the set goal.
- Appeals related to other categories, including billing/financial, and quality of practitioner office site, were recorded as three appeals. The rates achieved the goal with a successful performance of under 0.001 appeals per 1,000 member months.

Conclusion Based on Quantitative Analysis

The Alliance met all goals for evaluating non-behavioral health appeals for 2024. The report highlights the positive aspect of member satisfaction with the Alliance health services.

Qualitative Analysis

In summary, the Alliance met all goals with appeal categories, at below 2 per 1,000 member months, and there is a zero-complaint rate in the quality of practitioner office site category. Other categories such as billing/financial, quality of care, and attitude/service remain below a .01 rate. This indicates an excellent level of service and care with appeals. The increase of appeal volume during 2024 is attributed to an increase in Community Supports services, such as medically tailored meals and housing services. The recorded appeal rates for access, attitude/service and quality of care were relatively low. This low volume could be attributed to the efforts to improve the accessibility of services. It further suggests that the Alliance has successfully implemented optimized processes to address and resolve benefit issues promptly, preventing them from escalating into appeals.

The Alliance maintained appeal rates below the set goals in every category. This shows the organizational dedication to proactive measures and ongoing development.

Conclusion Based on Qualitative Analysis

Overall, analysis of the 2024 results for complaints and appeals indicate goals were achieved. The low volume of CCAH's members are highly satisfied with non-behavioral health services. This conclusion is supported by the relatively low numbers of complaints and appeals across all service

categories. There is no need to identify opportunities or address network adequacy issues at the moment.

11.4.3. Complaints Behavioral Health

Category	Previous Year (2023)		Current Measurement Year (2024)			
	Total Member Months 5,055,088		Total Member Months 5,402,819			
	2023 Total Complaints	2023 Complaints per 1,000 Member Months	2043 Total Complaints	2024 Complaints per 1,000 Member Months	Goal (Per 1,000 Member Months)	Goal Met?
Quality of Care	19	<0.01	21	<0.01	2	YES
Access	37	<0.01	44	0.01	2	YES
Attitude/Service	53	0.01	65	0.01	2	YES
Billing/Financial	14	<0.01	23	<0.01	2	YES
Quality of Practitioner Office Site	0	0	1	<.01	2	YES
Total/Number per 1,000	123	0.02	154	0.03	5	YES

Quantitative Analysis

- The goals were to maintain complaints per category below 2 per 1,000 member months, with an organizational target of fewer than 5 complaints per 1,000 member months overall.
- The Alliance met all the goals. It demonstrates effective overall management and resolution of member complaints.
- In 2024, the rate of total complaints increased slightly to 0.03 per 1,000 member months. There was a small increase from 0.02 per 1,000 member months in 2023 which still demonstrates a strong performance,
- Complaints related to attitude or service were reported as having the highest number at a rate of 0.01 per 1,000 member months. From 2023 to 2024, the rate rose slightly from 53 to 65 total complaints.
- There were 0.01 access complaints per 1,000 member months. The rate was consistent between 2023 and 2024. This reflects consistent performance in access complaints, demonstrating effective measures taken to enhance access services.

- The complaint Quality of Care in Behavioral Health Care 2024 registered 21 complaints with a rate of less than < 0.001 complaints per 1,000 member months. There was a slight increase from 19 complaints in 2023, indicating a slight increase to monitor, but remains well below the complaint threshold.
- For billing/financial issues in 2024, the volume was 23 complaints and that accounts for less than <.001 per 1,000 member months. This represented a slight increase from the prior year. and still well below the complaint threshold.
- There have been no complaints about the quality of practitioner office site. This indicates the ongoing satisfaction of members with the practitioner office environment.

Conclusion Based on Quantitative Analysis

In conclusion, the Alliance has demonstrated effective complaint management across access and various service categories in 2024. All categories have met the goals set. The overall low rate of complaints, especially in the category of access, underscores the Alliances dedication and effort to enhance member satisfaction to address concerns promptly and efficiently.

Qualitative Analysis

The rates of complaints regarding access and other categories of behavioral health services remained consistently low from 2023 to 2024. This consistent performance suggests the Alliance effective network adequacy, which contributes to heightened member satisfaction. One possible reason for this success is the Alliance's proactive approach to engaging with members, which helps to address issues before they become serious. Implementing strategies such as conducting regular satisfaction surveys, maintaining open and empathetic communication, and deploying a responsive member services team are crucial for success. The Alliance is in a strong position to improve member satisfaction and lower complaint rates in the coming years through proactive issue resolution and continuous monitoring.

Conclusion Based on Qualitative Analysis

In summary, the qualitative analysis reveals a positive trend in member satisfaction regarding behavioral health services. The results showed low complaint frequencies across various categories. In 2024, The objectives concerning service quality, accessibility, and practitioner office site criteria were successfully achieved.

11.4.4. Appeals Behavioral Health

Category	Previous Year (2023)		Current Measurement Year (2024			
	Total Member Months 5,055,088		Total Member Months 5,402,819			
	2022 Total Appeals	2022 Appeals per 1,000 Member Months	2023 Total Appeals	2023 Appeals per 1,000 Member Months	Goal (Per 1,000 Members)	Goal Met?
Quality of Care	0	0.00	0	0.00	2	YES

Access	0	0.00	0	0.00	2	YES
Attitude/Service	0	0.00	0	0.00	2	YES
Billing/Financial	0	0.00	0	0.00	2	YES
Quality of Practitioner Office Site	0	0.00	0	0.00	2	YES
Total/Number per 1,000	0	0.00	0	0.00	5	YES

Quantitative Analysis

- The set goals were to keep complaints per category below 2 per 1,000 member months, with an overall organizational goal of fewer than 5 complaints per 1,000 member months.
- The Alliance met all the goals for investigating appeals rate as there was no appeal reported for behavioral health care service in all five categories. It demonstrates effective overall management and resolution of member complaints.
- There were zero access appeals per 1,000 member months between 2023 and 2024. This reflects the effective ongoing access services of CCAH, leading to the ongoing satisfaction of members.

Conclusion Based on Quantitative Analysis

The Alliance has demonstrated outstanding performance in managing and resolving member complaints and appeals across all service categories. The organization successfully met all goals of maintaining complaints below 2 per 1,000 member months and keeping the overall complaint rate under 5 per 1,000 member months. No appeals were reported for behavioral health care services in all five categories. It underscored the effectiveness of the Alliance management practices and highlights a consistent and positive trend in member satisfaction.

Qualitative Analysis

There has been a consistent and positive trend in the zero number of appeals across all categories in behavioral health appeals for 2023 and 2024. This demonstrates a high level of satisfaction with care and service access. The reason could be that the Alliance has implemented strong systems to ensure that members can easily access services, encounter no billing or financial discrepancies, experience high-quality practitioner office environments, and receive service with a positive attitude. This thorough focus on member experience helps minimize the occurrence of issues in these areas. Furthermore, it suggests that the Alliance has promptly put in place effective procedures to address problems before they become appeals. Continued monitoring and proactive measures will be essential to sustain this positive trend and further improve the quality of care and access provided to Alliance members.

Conclusion Based on Qualitative Analysis

The outcomes reflect a robust framework within the Alliance that ensures ongoing member satisfaction and operational excellence by proactively addressing any potential concerns. There were no barrier and opportunities identified based on the analysis of the 2024 outcomes; however, the Alliance will continue to identify potential barriers and opportunities for improvement to sustain this performance.

Opportunity to Improvement

- Provide healthcare providers with regular training sessions to improve their skills and understanding of delivering quality care.
- Provide members with educational materials to help them better understand their treatment options and expected outcomes.
- Establish standardized treatment plans and policies to ensure reliable, exceptional healthcare.

12. Access To Care

12.1. Introduction

Central California Alliance for Health (CCAH) review the provider appointment availability survey (PAAS) of services standards to measure appointment availability, network service adequacy, and capacity for Primary Care Providers (PCPs), high volume specialists, high impact specialists, and behavioral health specialists to ensure adequate access is provided for members. CCAH conducts a thorough assessment of network adequacy in relation to the state Department of Health Care Services (DHCS) standards, performing this evaluation quarterly and annually. The group in charge of reviewing and analyzing this process consists of Quality Improvement and Population Health Director, Quality and Health Programs Manager, Grievance and Quality Manager, Provider Services Director, Provider Quality and Network Development Manager, Health Services Operations Manager, and Compliance Director.

12.2. Program Goal

The program goal is to ensure that CCAH meets the appointment access standards established to meet the needs of members.

12.3. Program Objectives

The program objectives include the following:

- Determine appropriate access and availability thresholds for the specified areas of care.
- Re-evaluate the appropriateness of network availability standards at least annually.
- Measure the availability of practitioner networks in our geographic area.
- Identify any areas for improving the network to meet the needs of members.
- Develop, prioritize, and implement interventions to improve access for members.

12.4. Methodology

CCAH works with a vendor to complete data collection to monitor appointment availability via PAAS for primary care, high-volume specialty, and high-impact practitioner providers. The survey was conducted via telephone, mail, and web with a contracted survey vendor. The survey included a census of all primary care and specialty care providers to measure appointment availability against access standards. The Timely Access Survey was filed on May 1, 2022. The final data files were received from the vendor on January 30th, 2023.

Performance Standards for Primary Care Practitioners (PCP)

The performance standard for PCPs is that >80% of the appointment types below meet their respective timeframe requirements:

- Urgent care – within 48 hours
- Routine care – within 10 days

Performance Standards for Specialty Care Practitioners (SPC)

The performance standard for SCPs is that >80% of the below appointment types meet their respective timeframe requirements:

- Urgent care – within 96 hours
- Routine care – within 15 days

Performance Standards for Behavioral HealthCare Practitioners (BPC)

The performance standard for SCPs is that >80% of the below appointment types meet their respective timeframe requirements:

- Non-life-threatening emergency– within 6 hours
- Urgent care – within 96 hours
- First Appointment Routine care – within 15 days

12.5. Program Performance

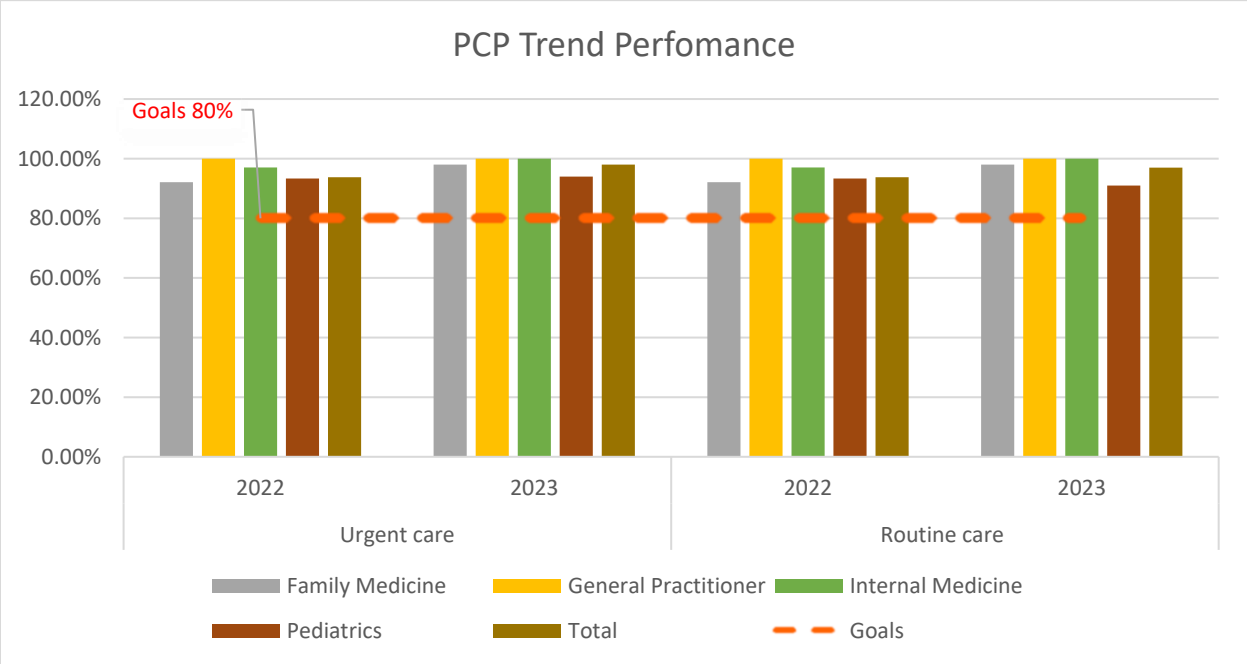
The tables below show the Plan's performance for different types of practitioners over time.

12.5.1. Primary Care Practitioner (PCP) Performance

PCPs include Family Medicine; General Practitioners; Internal Medicine; Pediatrics.

Appointment Type	Performance Standard	PCP Type	2022 Results (Pass/Count)	2023 Results (Pass/Count)	Goal Met (YES/NO)
Urgent care GOAL: 80%	Appointment available within 48 hours of patient will be seen today as a walk in or work in	Family Medicine	92.12% (152/165)	98% (296/301)	YES
		General Practitioner	100% (10/10)	100% (16/16)	YES
		Internal Medicine	97.06% (66/68)	100% (63/63)	YES
		Pediatrics	93.33% (28/30)	94% (66/70)	YES

Appointment Type	Performance Standard	PCP Type	2022 Results (Pass/Count)	2023 Results (Pass/Count)	Goal Met (YES/NO)
		Total	93.77% (256/273)	98% (441/450)	YES
Routine care GOAL: 80%	Appointment available within 10 business days of patient will be seen today as a walk in or work in	Family Medicine	92.12% (152/165)	98% (296/302)	YES
		General Practitioner	100% (10/10)	100% (16/16)	YES
		Internal Medicine	97.06% (66/68)	100% (63/63)	YES
		Pediatrics	93.33% (28/30)	91% (64/70)	YES
		Total	93.77% (256/273)	97% (439/451)	YES



Quantitative Analysis

- CCAH successfully exceeded the 80% benchmark for accessibility to both urgent and routine care across all types of primary care practitioners.
- When assessing urgent care for appointment availability within 48 hours, the overall CCAH result surpassed the goal by 18 percentage points.
- In urgent care, Pediatrics had the lowest service accessibility percentage at 94%, yet it still exceeded the 80% target.
- CCAH exceeded the 80% goal for routine care appointments available within 10 business days by 17 percentage points.
- Achieving a 100% success rate in General Practitioner and Internal Medicine for both urgent care and routine care. This demonstrates CCAH's exceptional performance.

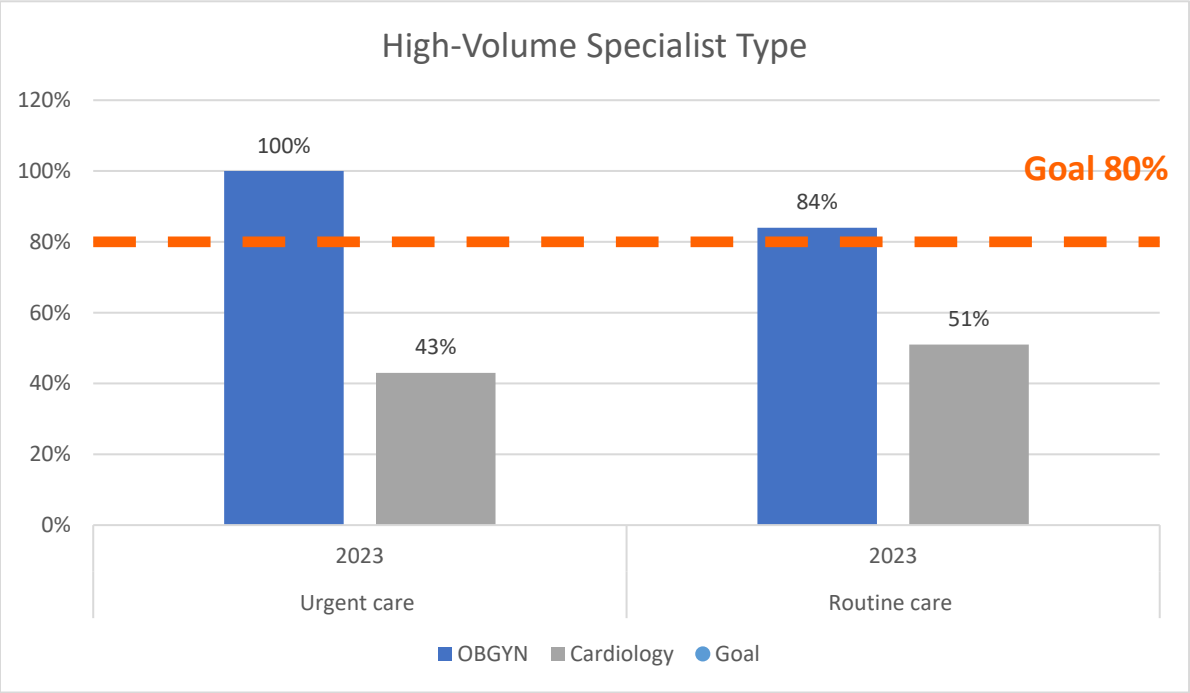
- Overall, the performance in urgent care and routine care was met for evaluating appointment availability.

12.5.2. Specialty Care Practitioner (SCP) Performance – High-Volume Specialists

High-Volume SCPs include OB/GYN and Cardiology

Appointment Type	Performance Standard	High-Volume Specialist Type	2023 Result (Pass/Total Count)	Goal Met (YES/NO)
Urgent care GOAL: 80%	Appointment available within 96 hours of initial request	OB/GYN	100% (42/42)	YES
		Cardiology	43% (27/63)	NO
Routine care GOAL: 80%	Appointment available within 15 business days of initial request	OB/GYN	84% (42/50)	YES
		Cardiology	51% (32/63)	NO

High-Volume SCPs: Urgent Care (w/in 96 hours) and Routine Care (w/in 15 days) Visit Availability



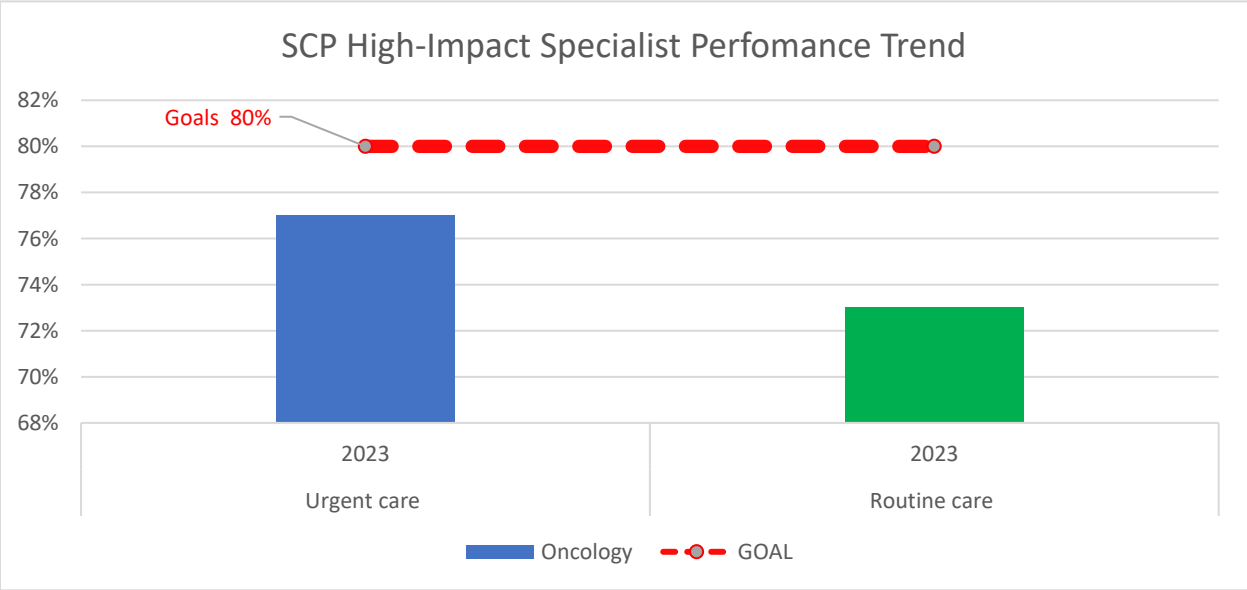
Quantitative Analysis

- CCAH set a goal of 80% for urgent care appointments to be available within 96 hours of the initial request and for routine care of making appointments available within 15 business days.
- The OB/GYN specialty care appointment availability met the urgent care performance goal with a 100% success rate. All 42 appointments requested were scheduled within 48 hours.
- CCAH also met the OB/GYN specialty care appointment availability routine care goals with an 84% success rate, surpassing the goal of 80% by 4 percentage points. Out of 50 appointments, 42 were successfully scheduled within 30 business days.
- The Cardiology specialty care appointment availability goal was not met for either urgent care or routine care. The performance rate was relatively low at 43% for urgent care and 51% for routine care.
- For urgent care, CCAH missed the goal by approximately 37 percentage points. For routine care, CCAH missed the goal by 29 percentage points.

12.5.3. Specialty Care Practitioner (SCP) Performance – High-Impact Specialists

High-Impact SPCs include Oncology

Appointment Type	Performance Standard	High-Impact Specialist Type	2023 Result (Pass/Total Count)	Goal Met (YES/NO)
Urgent care GOAL: 80%	Appointment available within 96 hours of initial request	Oncology	77% (20/26)	NO
Routine care GOAL: 80%	Appointment available within 15 business days of initial request	Oncology	73% (19/26)	NO



Quantitative Analysis

- CCAH set a performance goal for evaluating urgent care appointment availability within 96 hours and routine care appointment availability within 15 business days at an 80% goal.
- CCAH did not meet performance standards for either urgent care appointments or routine care appointments.
- The urgent care performance rate for Oncology was 7 % and fell approximately 3 percentage points short of the 80% target. For routine care, the rate fell short by approximately 7 percentage points.
- This minimal shortfall in the goal indicates a gap in appointment availability for Oncology within the timeframe.

12.5.4. Behavioral Healthcare Practitioner (BCP) Performance – Non-Prescriber: Non-Physician Mental Health

Non-Prescriber BPCs include: Licensed Clinical Social Worker and Psychologist

Appointment Type	Performance Standard	BHCP type	2022 Result (Pass/Total Count)	2023 Result (Pass/Total Count)	Goal Met (YES/NO)
Non-Life Threatening Emergency GOAL:80%	Members are scheduled to be seen within 6 hours of contacting the provider	LCSW	NA	NA	NA
		Psychologists	NA	NA	NA
Urgent Care GOAL: 80%	Appointment available within 96 hours	LCSW	65% (13/20)	79% (15/19)	NO
		Psychologists	50% (4/8)	75% (6/8)	NO
First Appointment Visit For Routine Care GOAL: 80%	Members are scheduled to be seen within 10 business days of contacting the provider	LCSW	62% (13/21)	64% (14/22)	NO
		Psychologists	50% (4/8)	67% (6/9)	NO

Quantitative Analysis

- The data show that CCAH did not meet the goal of 80% for appointment availability for urgent care and for the first appointment visit for routine care.
- The data regarding non-life-threatening emergency appointment availability within 6 hours is NA because members can go to ER without referral or making appointment.
- For urgent care, where members should receive appointment availability within 96 hours, CCAH's Licensed Clinical Social Workers achieved a performance result of 79%, only 1 percentage point short of the target goal. However, for the first appointment visit for routine care within 10 business days, LCSWs missed the goal by 16 percentage points.
- Psychologists failed to achieve the goal by 5 percentage points for urgent care and 13 percentage points for routine care. The rates were 75% and 67%, respectively, compared to the goal of 80%.

12.5.5. Behavioral Healthcare Practitioner (BHCP) Performance – Prescriber

Non-Prescriber BHPCs include Psychiatrists.

Appointment Type	Performance Standard	2022 Results (Pass/Total Count)	2023 Results (Pass/Total Count)	Goal Met (YES/NO)
Non-Life Threatening Emergency GOAL:80%	Members are scheduled to be seen within 6 hours of contacting the provider	NA	NA	NA
Urgent Care GOAL: 80%	Appointment available within 96 hours	75% (6/8)	45% (5/11)	NO
First Appointment Visit For Routine Care GOAL: 80%	Members are scheduled to be seen within 15 business days of contacting the provider	82% (9/11)	36% (4/11)	NO

Quantitative Analysis

- CCAH had a limited number of psychiatrists available. CCAH did not meet the goal for 2023 appointment available.
- The data regarding non-life-threatening emergency appointment availability within 6 hours is NA because members can go to ER without referral or making appointment.
- The performance rate for evaluating appointment accessibility for urgent care did not meet the goal, with a performance result of only 45%. The compliance rate declined from 2022 by 30 percentage points.
- For first-appointment visits, the rate dropped significantly by 46 percentage points from 2022. The 2023 compliance rate of 36% did not reach the goal of 80%.

13. Geo-Access To Practitioners

13.1. Introduction

CCAH has established provider availability standards for the number and geographic distribution of Primary Care Providers (PCPs), high volume Specialists, high impact Specialists, and Behavioral Health providers to ensure adequate access is provided for the Health Plan membership. At least annually CCAH measures performance against its standards.

On August 9, 2024, provider network geo-access was analyzed against the established standards as outlined below. The rows highlighted in red show the geo-access to practitioner standards that were not met and align with the information provided below. This analysis is conducted at least annually.

Santa Cruz County

GEO-ACCESS TO PRACTITIONERS				
Practitioner Type	**Measure**	**Performance Goal**	**Performance**	**Met/Not Met**
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	100%	Met
Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	100%	Met
High-Volume Specialists				
Cardiology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
High-Volume Behavioral Health Providers				
Licensed Clinical Social Workers (LCSW)	LCSW Providers to Members	100%	100%	Met
Psychiatrists	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Psychologists	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
High-Impact Providers				

Oncologists	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Core Specialists				
Dermatology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Ear, Nose, and Throat/Otolaryngology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Endocrinology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Gastroenterology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
General Surgery	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Hematology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
HIV/AIDS Specialists/Infectious Diseases	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Nephrology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Neurology	1 within 60 minutes or 30 miles of member's	100%	100%	Met

	residence or workplace			
Oncology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Ophthalmology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Orthopedic Surgery	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Physical Medicine and Rehabilitation	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Pulmonology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Allergy/Immunology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Neurosurgeons	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met

Monterey County

GEO-ACCESS TO PRACTITIONERS				
Practitioner Type	**Measure**	**Performance Goal**	**Performance**	**Met/Not Met**
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	97%	Not Met

Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	85%	Not Met
High-Volume Specialists				
Cardiology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
High-Volume Behavioral Health Providers				
Licensed Clinical Social Workers (LCSW)	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Psychiatrists	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Psychologists	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
High-Impact Providers				
Oncologists	1 within 75 minutes or 45 miles of their residence or workplace	100%	84%	Not Met
Core Specialists				
Dermatology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Ear, Nose, and Throat/Otolaryngology	1 within 75 minutes or 45 miles of their	100%	100%	Met

	residence or workplace			
Endocrinology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Gastroenterology	1 within 75 minutes or 45 miles of their residence or workplace	100%	92%	Not Met
General Surgery	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Hematology	1 within 75 minutes or 45 miles of their residence or workplace	100%	84%	Not Met
HIV/AIDS Specialists/Infectious Diseases	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Nephrology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Neurology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Oncology	1 within 75 minutes or 45 miles of their residence or workplace	100%	84%	Not Met
Ophthalmology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Orthopedic Surgery	1 within 75 minutes or 45 miles of their	100%	100%	Met

	residence or workplace			
Physical Medicine and Rehabilitation	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Pulmonology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Allergy/Immunology	1 within 75 minutes or 45 miles of their residence or workplace	100%	83%	Not Met
Neurosurgeons	1 within 75 minutes or 45 miles of their residence or workplace	100%	82%	Not Met

Merced County

GEO-ACCESS TO PRACTITIONERS				
Practitioner Type	**Measure**	**Performance Goal**	**Performance**	**Met/Not Met**
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	100%	Met
Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	100%	Met
High-Volume Specialists				
Cardiology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 75 minutes or 45 miles of their	100%	100%	Met

	residence or workplace			
High-Volume Behavioral Health Providers				
Licensed Clinical Social Workers (LCSW)	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Psychiatrists	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Psychologists	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
High-Impact Providers				
Oncologists	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Core Specialists				
Dermatology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Ear, Nose, and Throat/Otolaryngology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Endocrinology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Gastroenterology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
General Surgery	1 within 75 minutes or 45 miles of their	100%	100%	Met

	residence or workplace			
Hematology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
HIV/AIDS Specialists/Infectious Diseases	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Nephrology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Neurology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Oncology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Ophthalmology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Orthopedic Surgery	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Physical Medicine and Rehabilitation	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Pulmonology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Allergy/Immunology	1 within 75 minutes or 45 miles of their	100%	100%	Met

	residence or workplace			
Neurosurgeons	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met

Mariposa County

GEOACCESS TO PRACTITIONERS				
Practitioner Type	**Measure**	**Performance Goal**	**Performance**	**Met/Not Met**
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	99%	Not Met
Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	95%	Not Met
High-Volume Specialists				
Cardiology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
High-Volume Behavioral Health Providers				
Licensed Clinical Social Workers (LCSW)	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Psychiatrists	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met

Psychologists	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
High-Impact Providers				
Oncologists	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Core Specialists				
Dermatology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Ear, Nose, and Throat/Otolaryngology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Endocrinology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Gastroenterology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
General Surgery	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Hematology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
HIV/AIDS Specialists/Infectious Diseases	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met

Nephrology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Neurology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Oncology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Ophthalmology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Orthopedic Surgery	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Physical Medicine and Rehabilitation	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Pulmonology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Allergy/Immunology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Neurosurgeons	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met

San Benito County

GEO-ACCESS TO PRACTITIONERS				
Practitioner Type	**Measure**	**Performance Goal**	**Performance**	**Met/Not Met**
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	91%	Not Met
Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	89%	Not Met
High-Volume Specialists				
Cardiology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
High-Volume Behavioral Health Providers				
Licensed Clinical Social Workers (LCSW)	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Psychiatrists	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Psychologists	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
High-Impact Providers				
Oncologists	1 within 90 minutes or 60 miles of their	100%	100%	Met

	residence or workplace			
Core Specialists				
Dermatology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Ear, Nose, and Throat/Otolaryngology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Endocrinology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Gastroenterology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
General Surgery	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Hematology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
HIV/AIDS Specialists/Infectious Diseases	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Nephrology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Neurology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met

Oncology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Ophthalmology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Orthopedic Surgery	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Physical Medicine and Rehabilitation	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Pulmonology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Allergy/Immunology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Neurosurgeons	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met

Quantitative Analysis

The Geo-Access tables show that goals were met except for the eleven county and provider type combinations listed below. The goals were not met due to a number of reasons discussed in the qualitative analysis.

County Name	Provider Type
Monterey, CA	Allergy/Immunology
Monterey, CA	Gastroenterology

Monterey, CA	Hematology
Mariposa, CA	Hospitals
Monterey, CA	Hospitals
San Benito, CA	Hospitals
Monterey, CA	Neurosurgery
Monterey, CA	Oncology
Mariposa, CA	Primary Care
Monterey, CA	Primary Care
San Benito, CA	Primary Care

Quantitative Analysis

Operations Business Analysis worked with Health Analytics to align the geo-access monitoring report from Quest Analytics to the standards established in Policy 300-5050 – Geographic Accessibility Standards.

Identify reasons why goals are not met for a type of practitioner:

1. Attrition of existing providers has led to a shortage of providers in the service area. This has particularly impacted the geographically rural areas within Mariposa, Monterey, and San Benito counties.
2. Generally, the geo-access analysis shows a trend in that Hospital and Primary Care networks do not meet geo-access standards for Mariposa, San Benito, and Monterey Counties. The other gaps are for specialty care (Allergy/Immunology, Gastroenterology, Hematology, Neurosurgery, and Oncology) in southern Monterey County.

13.2. Provider Ratio Analysis

In June 2024, provider network ratios were analyzed against the established standards as outlined below. This analysis is conducted at least annually.

Practitioner Type	Standard (Requirement) Provider to Member Ratio	Medi-Cal Ratio (RY Actuals) Provider to Member Ratio	Met/Not Met
Total Physicians	1:2,000	1:25	Met
Primary Care Physicians	1:2,000	1:659	Met
General Medicine/Family Practice	1:2,000	1:1,157	Met
Internal Medicine	1:2,000	1:2,503	Not Met
Pediatrics	1:2,000	1:1,053	Met
High Volume Specialists			

Cardiology	1:5,000	1:778	Met
Obstetrics/Gynecology (OB/GYN)	1:3,000	1:368	Met
High Volume Mental Health Providers			
Licensed Clinical Social Workers (LCSW)	1:2,000	1:294	Met
Psychiatrists	1:5,000	1:1,707	Met
Psychologists	1:5,000	1:1,301	Met
High Impact Specialists			
Oncologists	1:10,000	1:964	Met
Other Specialists			
Allergy/Immunology	1:5,000	1:5,368	Not Met
Neurosurgeons	1:10,000	1:2,912	Met

Quantitative Analysis

The ratios table shows that goals were met for all provider types except Internists and Allergy/Immunology. The ratio was above the goals for these practitioner types by 503 members (internists) and 368 members (Allergy/immunology). These goals were not met due to a number of reasons discussed below.

Qualitative Analysis

Operational Business Analysis worked with Health Analytics to align the Provider to Patient Ratio report in Tableau to the NCQA standards.

Identify reasons why goals are not met for a type of practitioner:

1. Attrition of existing providers has led to a shortage of primary care providers in the service area. This has particularly impacted the rural areas included in the Alliance's service area.
2. Increase in membership during the pandemic as members were not being disenrolled. The Alliance then instituted texting reminder processes to ensure that members continued to receive Medi-Cal benefits post pandemic, which was successful in maintaining membership.

13.3. Overall Geographic Analysis

- Numerical standards are met and exceeded for all PCP types except Internal Medicine. Drive distance standards are met and exceeded for all PCP types in Santa Cruz and Merced. but for Monterey, Mariposa, and San Benito the drive distance standards for PCP are not met.
- Numerical standards are met and exceeded for all high-volume specialists and high-impact specialists. Drive distance standards are met and exceeded for all high-volume specialists and high-impact specialists except oncologists in Monterey.
- Numerical standards are met and exceeded for all Behavioral Health provider types. Drive distance standards are met and exceeded for all Behavioral Health provider types.

13.4. Conclusion and Next Steps:

CCAH meets the member to provider ratio standards for most of the provider types. There are only two provider types that don't meet the ratio standards, and this is because several of the areas that CCAH operates in locations that are considered rural and areas designated to have low providers. CCAH's contracting department has done a good job of contracting with a very high percentage of providers in the service area and this has helped the organization meet most of the goals.

14. DHCS Population Health Management Strategy

14.1. Introduction

The Population Health Management Program (PHMP) was launched by DHCS in January 2023, to establish a cohesive statewide framework for Managed Care Plans. Priority was placed on whole-person care, prevention, and responding to Member's medical and social needs and preferences. Documentation and participation transitioned from the prior Population Needs Assessment (PNA) reporting, to annual submissions of a Population and Health Strategy, and meaningful collaboration with the local health jurisdiction (LHJ) partners on their Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs).

14.2. PHMP Program Values and Process

Alliance PHMP values include:

- Focusing on keeping members healthy through health and wellness/prevention.
- Understanding needs and solutions through community outreach.
- Incorporating equity - that members have the same opportunity to live a healthy and thriving life, regardless of race/ethnicity, gender and gender identity, sexual orientation, age, or other demographic drivers – in all programs.
- When possible, building programs upstream to address the social drivers of health.
- Embracing inter-sectoral action and partnerships.
- Patient Centered Medical Home (PCMH) model.

Which are accomplished through:

- Meaningful collaboration with Local Health Jurisdictions (LHJs) and Stakeholders to complete population needs assessments, including participation in Community Health Improvement Plans (CHIPs)/Community Health Assessments (CHAs).
- Population Identification & Data integration.
- Regular Risk Stratification & Risk Tiering of entire member population, including management of members with emerging risk and with multiple chronic illnesses.
- Increasing access to services and support to members, including basic population health management services (BPHM), care management including Complex Case Management (CCM) and Enhanced Care Management (ECM), and Transitions of Care Services (TCS).
- Providing support to the healthcare delivery system and ensuring patient safety and outcomes across settings.
- Addressing health inequities and elimination of health disparities to achieve optimal health outcomes.
- Evaluation and continuous improvement.

14.3. Strategic Alignment

The design of the Alliance PHMP aligns with the following local and State strategic priorities:

- Alliance strategic priorities to advance health equity and person-centered delivery system transformation.1

- DHCS Comprehensive Quality Strategy (CQS) Bold Goals: 50x2025 Initiative focused on children's preventative care, behavioral health integration and maternity outcomes and birth equity.2
- DHCS comprehensive Cal AIM program.
- The Quintuple Aim goals from the Institute for Healthcare Improvement: improve the health of our population, enhance our member's experience of care, reduce per capita cost of healthcare, support wellbeing and joy in the workforce, and advance health equity.3
- Compliance with DHCS4 and NCQA standards for Population Health Management.

14.4. Partnership with Local Health Jurisdiction

As part of the PHMP, CCAH will continue to participate in each County's respective Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs). The completed plans for the most recent assessments below can be found on the Alliance's website: https://thealliance.health/for-communities/community-publications/community-health-assessments-and-community-health-improvement-plans/

- Mariposa County Health & Human Services Agency's 2024 Community Health Assessments (CHAs),
- Merced County Department of Public Health's 2024-2029 Community Health Improvement Plans (CHIPs),
- Monterey County Health Department's 2022 Community Health Assessments (CHAs),
- San Benito County Health & Human Services Agency, Public Health Services Department's 2023/2024 Community Health Assessments (CHAs) and 2023/2024 Community Health Improvement Plans (CHIPs), and
- Santa Cruz County Health Services Agency, Public Health Division's 2024 Community Health Assessments (CHAs).

Shared Goals and Objectives

For the annual PHM Strategy submission, goals and objectives were developed in partnership Mariposa County, Merced County, Monterey County, San Benito County, and Santa Cruz County that will be used to help direct resources and planning for next year.

Mariposa County

Shared Goal

- Mariposa County will increase the well-child visit and immunization rates for adolescents (IMA-2).

SMART Objective

- By December 2025, Mariposa County Public Health Department, Central California Alliance for Health, and Kaiser Permanente, will develop and complete a plan to increase well-child visit and adolescent vaccination rates (IMA-2).

Goals and Objectives

- By March 2025: Will complete a preliminary analysis of well-child visit and adolescent immunization rates and gaps.
- By June 2025: Will finalize analysis of well-child visit and immunization rates and develop strategy to address and finalize data-sharing agreement.

- By December 2025: Will complete one strategy to increase well-child visits and adolescent immunization rates in Mariposa County.

Merced County

Shared Goal

- Merced County will ensure accurate data capture of immunizations in the County.

SMART Objective

- By December 31, 2025, Merced County Department of Public Health, with assistance from the Central California Alliance for Health, will develop a plan to transition the county data from RIDE immunization registry to the statewide CAIR 2 registry, to ensure better quality data for the county and target childhood immunization gaps.

Goals and Objectives

- By June 2025: Will finalize data-sharing agreement.
- By December 2025: Will complete one plan to transition the county data from RIDE immunization registry to the statewide CAIR 2 registry, to ensure better quality data for the county and target childhood immunization gaps.

Monterey County

Shared Goal

- Monterey County will increase maternal and adolescent depression screening in the County.

SMART Objective

- By December 2025, Monterey County Health Department and Central California Alliance for Health will develop and complete a plan to increase maternal and adolescent depression screenings in the County.

Goals and Objectives

- By March 2025: Will complete a preliminary analysis of maternal and adolescent depression screening rates and gaps.
- By June 2025: Will finalize analysis of maternal and adolescent depression screenings and develop strategy to address; and finalize data-sharing agreement.
- By December 2025: Will complete one strategy to increase maternal and adolescent depression screenings in Monterey County.

San Benito County

Shared Goal

- San Benito County Public Health Services Department will increase access to mental health and substance use disorder prevention and treatment programs for individuals and their families residing within the county.

SMART Objective

- By December 2025, San Benito County Public Health Department and Central California Alliance for Health will develop and complete a catalogue of mental health and substance

use disorder providers and programs existing within the county. Both the MCP and LHD will use this catalogue to inform targeted community and MCP-specific intervention alignment and indicated collaborations to increase access to mental health and substance use disorder programs within the respective CHIP and PHM Strategies.

Goals and Objectives

- By March 2025: Will develop a straw model of catalogue.
- By June 2025: Will define targeted community and MCP-specific interventions and indicated collaborations to increase access to mental health and substance use disorder programs; and finalize data-sharing agreements.
- By September 2025: Will finalize catalogue of mental health and substance use disorder providers and programs existing within the county.
- By December 2025: Will develop and launch a countywide stigma reduction campaign; clarify referral pathways for all entry points in the system; identify promising, evidence[1]-based programs (EBPs) that meet local needs and address gaps (e.g., Familia Adelante; youth drug court); identify training and recruitment needs across agencies; make intake and referral materials available in Spanish and indigenous languages; increase collaboration, education, and communication among partners and the community.

Santa Cruz County

Shared Goal

- Santa Cruz County Health Services Agency, Public Health Division will increase fluoride varnish applications in the medical setting from 1989 in 2021 to 2386 in 2027 (20% increase).

SMART Objective

- By December 2025, Santa Cruz County LHJ, the Central California Alliance, and Kaiser Permanente Health Plan will work collaboratively to develop targeted community and MCP-specific interventions that improve the percentage of children who receive topical fluoride application to meet or exceed the DHCS Minimum Performance Level of 19.3%.

Goals and Objectives

- By June 2025: Will develop a straw model of crosswalk identifying existing interventions targeted at improving the percentage of children who receive topical fluoride application in the County; and finalize data-sharing agreements.
- By September 2025: Will finalize crosswalk of existing interventions targeted at improving the percentage of children who receive topical fluoride application in the County.
- By December 2025: Will complete one plan that includes both targeted community and MCP-specific interventions that improve the percentage of children who receive topical fluoride application to meet or exceed the DHCS Minimum Performance Level of 19.3%.

14.5. 2024 Annual PHM Strategy NCQA and Bold Goals Projects

Project 1: Improve the percentage of provider notifications for members with SUD/SMH diagnosis or within 7 days of emergency department (ED) visit.

The current FUA/FUM regulatory DHCS Performance Improvement Project (PIP)'s goal is to improve provider notifications for members with SUD and MH diagnosis within seven (7) days of emergency department (ED) visit. Carelon, who is the Alliance's delegated BH provider, is the PIP provider. Baseline data was from 01/01/2023 to 12/31/2023. Originally, a lack of data timeliness resulted in

members (including those who are frequent utilizers of ED services) being eliminated from ED file data transmitted to the provider's outreach staff. Members with encounter dates greater than 20 business days from the data load date were eliminated from outreach due to the process taking 2-10 business days to complete, missing both 7-day and 30-day outreach windows.

In conjunction with the PIP, the Alliance updated the process to increase member data transmitted to Carelon case management team for outreach by expanding the member focus: from members with < 20-day post-encounter dates to members with > 10 ED visits regardless of encounter date. This change increased the likelihood that members will be contacted for follow-up/coordination of care, ensuring a larger percentage of members are likely to be successfully reached.

This change went live on 09/06/2024. The first lookback period of review was for files received between 09/14/2024-10/15/2024. 64 members were identified for outreach; 10 were successfully contacted. Members who are in need of SUD or SMHS services are referred to the MHP and, if member is NSMHS, Carelon would provide services.

Project 2: Increasing Well-Child Visits (W30-6) in the first 15-months of life for Hispanic members in Merced County.

To assess health equity, the Alliance reviewed data across service areas and identified that Merced County had the lowest W30-6 rate HEDIS MY2022. Analyzing by race/ethnicity, staff found that the Hispanic population in Merced has the largest number of eligible members, a significant gap to the Minimum Performance Level (MPL), and socioeconomic challenges. Overall baseline data for 01/01/2023 - 12/31/2023 is 48.39% (526/1087) for the percentage of Hispanic members who had six (6) or more well-child visits with a PCP on different dates of service on or before the 15-month birthday based on NCQA HEDIS W30-6 measure.

The Alliance developed a related grant opportunity to provide financial support to pilot clinic sites to offer extended hour clinics. These clinics are focused on closing care gaps for well-child visits and potential clients may face access barriers during traditional clinic hours. The pilot clinic site expanded office hours to include one evening per week and two Saturdays per month, offering families more opportunities to attend well-child visits. Recognizing that Hispanic members make up a significant portion of the target population in Merced County, the pilot clinic ensures that care is available in Spanish, effectively removing this language barrier and facilitating access to essential health services for these members.

As of August 2024, the clinic staff outreached to a total of 120 members between 0-15 months of age. Of these members, 61 members (54.17%) scheduled an appointment for the same month, and of those scheduled 47 members (77.05%) completed their appointment.

Project 3: Add LOINC Codes for Depression Screening to the Data Submission Tool.

Annually the Alliance assesses data sources for MCAS reporting for opportunities for improvement. This year the Alliance added depression screening Logical Observation Identifiers Names and Codes (LOINC) codes and the screening results to the Alliance's Provider Portal Data Submission Tool (DST) to allow providers to submit supplemental information for data not received through claims. Baseline data for the Depression Screening and Follow-Up for Adolescents and Adults (DSF) measure was at 0% prior to implementation of the new submission type. Since January 1, 2024, 157,635 member row submissions have been accepted from providers, while 18,282 submissions have been rejected due to incorrect file layout. The rate of depression screenings for the DSF measure for 12-17 years old is 21.69% and for 18-64 year olds is 18.86%.

Because data for electronically received depression screening is very limited across the provider network, the Alliance has been focusing on helping providers share depression screenings for the broader population of 12 years and older that is part of the Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MCAS measure. Once we have more consistent data shared by providers, we can better assess any potential health disparities among adolescent and maternal health populations.

Project 4: Focused Provider Partnerships in Merced County.

The Provider Partnership Program (PPP) is a new initiative launched by the Alliance to provide best practices for improving HEDIS measures. The primary goals of this program include reaching the Minimum Performance Measure (MPL) in two of the lowest performing MCAS measures through CBI practices by the end of the measurement year 2024, improving the delivery of preventive and treatment services to members, and improving the administrative communication between the Alliance and the clinics. Additional elements of the PPP include the participation in Clinical Joint Operations Committee quarterly meetings between the Alliance and practice leadership, and Practice Coaching meetings: monthly brainstorming sessions with clinic staff to review and complete any short-term process improvement projects.

In collaboration with the PPP, an educational Lunch & Learns program was implemented, which brings a one-hour sessions per quarter that is open to all CCAH providers and is focused on one theme that can help raise HEDIS measures. These lunch and learns are structured presentation and include guest presenters.

Under PPP, providers also received Workforce Support for Care Gap Closure grants to hire additional staff or pay for overtime to increase workforce capacity. By increasing staffing, these practices were able to:

- Close care Gaps: Address outstanding care needs for members, particularly in areas like preventive care and chronic disease management.
- Increase Access to Care: Expand appointment availability and reduce wait times.
- Improve Health Outcomes: Enhance overall patient health and well-being.

All participating practices have seen improvement in at least one HEDIS measure.

Project 5: Completion of NCQA Population Health Management Standards.

The Medi-Cal Health Education and Cultural and Linguistic Population Needs Assessment (PNA) 2024 was completed for Santa Cruz, Monterey, & Merced Counties Reporting Areas as part of the Population Health Management Health Plan Accreditation Standards, in addition to other work by Alliance staff in anticipation of NCQA Accreditation submission in 2025.

15. Additional Activities: IHA & EPSDT Audits

15.1. Introduction

The Initial Health Appointment (IHA) and the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) medical record audits occur twice a year, in quarter 2 and quarter 4 to monitor and ensure provider compliance and member access to necessary services. The information collected from these audits is used to capture opportunities to provide educational outreach to providers, improve members' access to services and to evaluate overall performance. Audit results are shared with

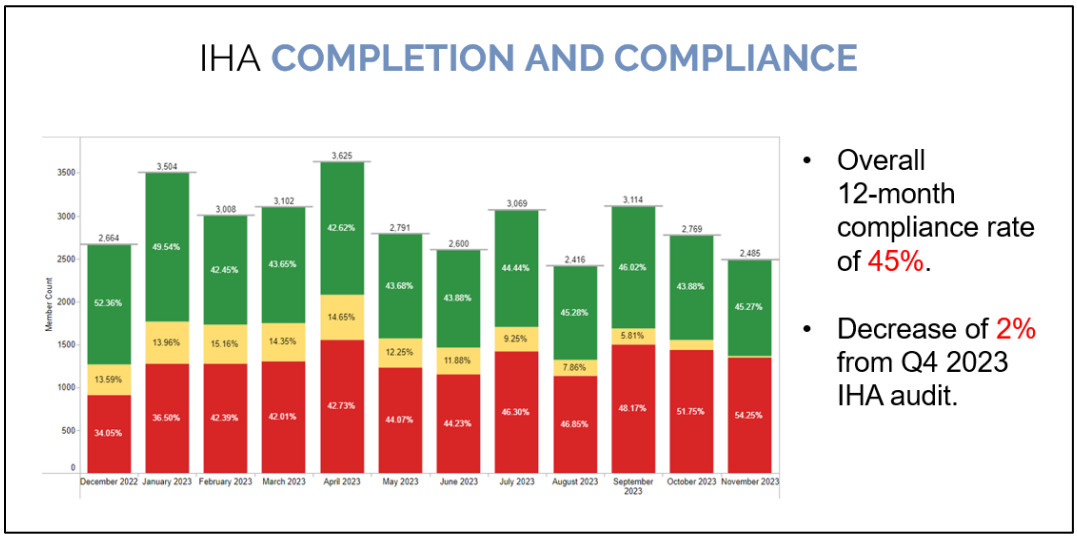
organizational stakeholders, where they are given the opportunity to collaborate on results. Additionally, providers are outreached to after the IHA audit and given an opportunity to provide missing elements. This outreach provides transparency and encourages provider engagement.

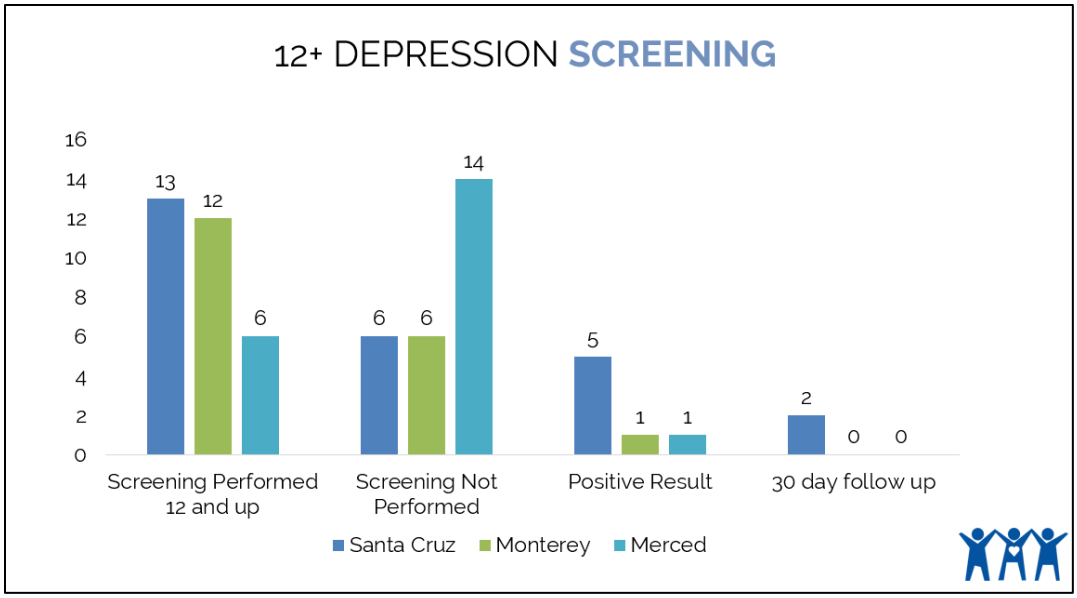
15.2. Methodology

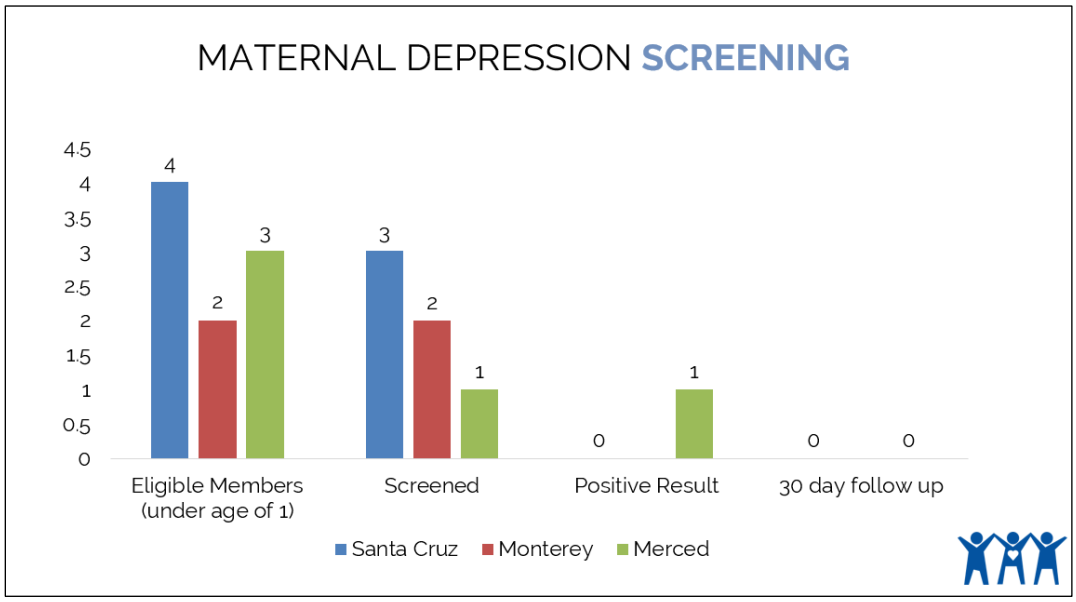
IHA and EPSDT audits begin by pulling in member data through the use of a Tableau report. A 20-member sample will be pulled from each county for each audit. These samples are pulled in using specific encounter types, member demographics, and clinics, as indicated in the audit work instructions. All member information and elements audited will be recorded on a tracking sheet and results presented on a power point.

15.3. Results

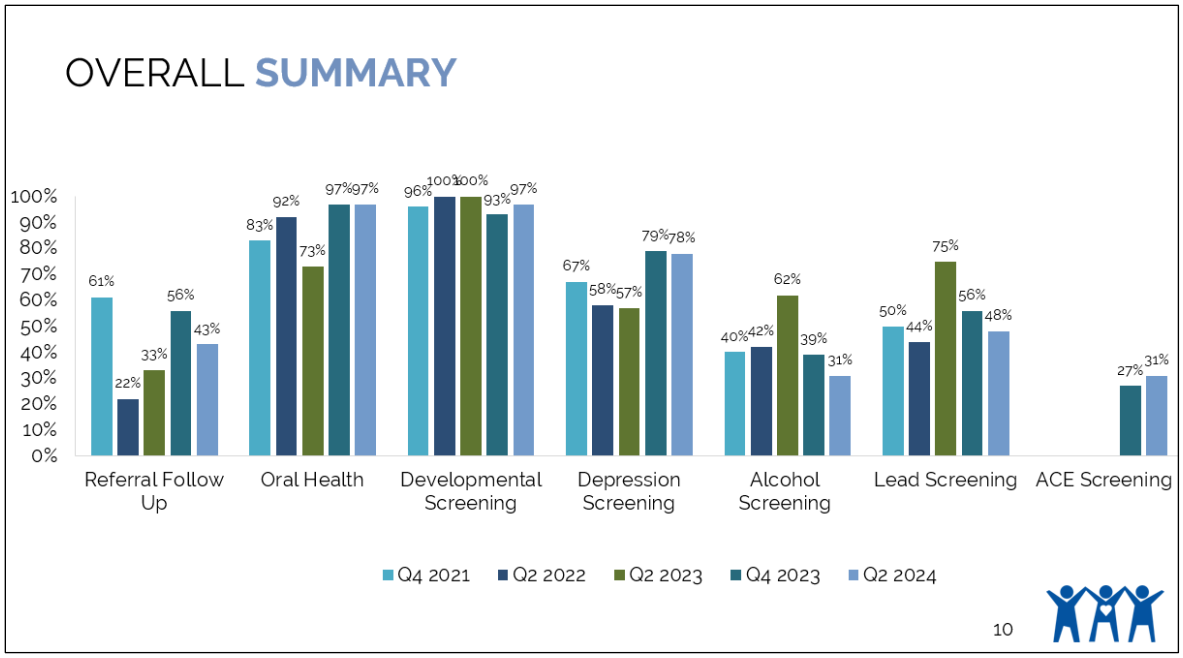
The results of the IHA Q2 audit showed a 2% decrease in completed IHA's within 120-days over a 12-month period, compared to the previous audit, but still above plan goals. Q2 audit saw an increase in members over the age of 12 receiving a depression screening, including pregnant members and postpartum depression screenings. Alcohol screenings continued to see an increase audit over audit, along with lead testing and ACE screenings.



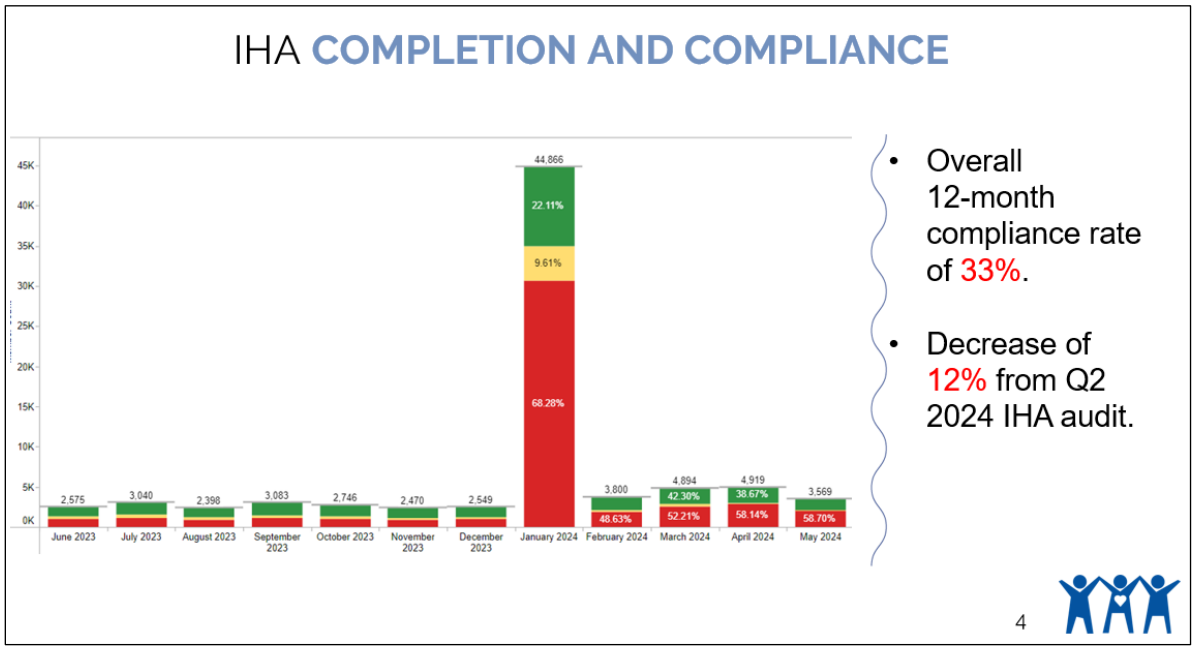


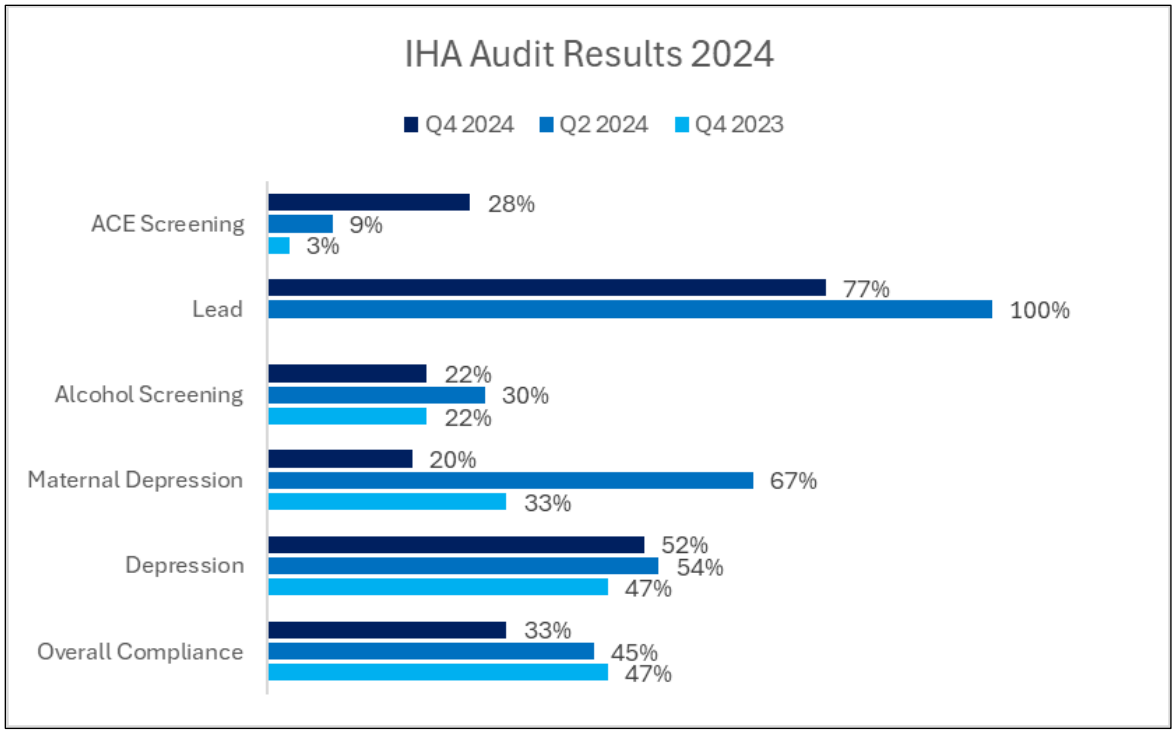


The results of the Q2 EPSDT audit showed consistent results in developmental screenings and oral health, with improvement in members having a dental home and ACE screenings.

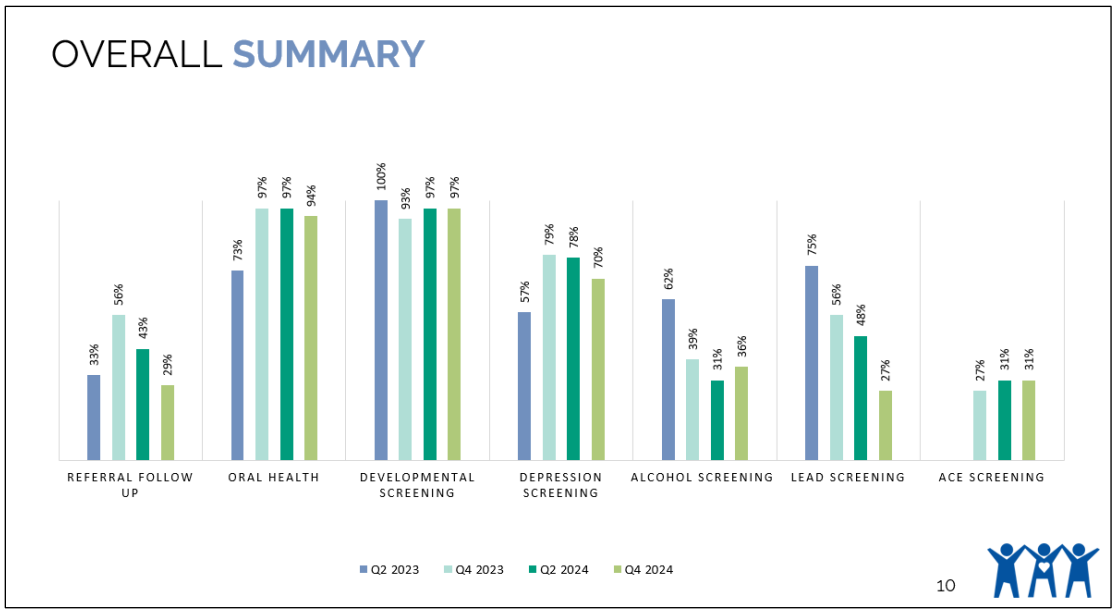


The Q4 IHA audit showed a significant decrease in overall IHA's completed within 120 days. This was due to the older adult expansion that happened in January of 2024, which resulted in 45k new members being added. In the Q4 audit, changes were made to include our newest county additions, Mariposa and San Benito. These factors played a role in the decreases we saw in depression screenings, alcohol misuse screenings, ACE screenings and lead testing.





The Q4 EPSDT audit saw consistent results in developmental screenings, oral health, and ACE screenings, with improvement in alcohol screenings. During the Q4 audit changes were made to include the addition of our new counties, Mariposa and San Benito.



15.4. Key Take Aways and Next Steps

There were many factors affecting various decreases in the IHA audit results for 2024. Due to the decreases, provider outreach was implemented to increase transparency and engagement with providers with a goal to increase better audit outcomes and communication. During the Q2 audit we

saw 34% response rate from providers and in the Q4 audit we saw 74% provider engagement. During the outreach periods provider engagement and collaboration went well, resulting in missing elements being submitted, providers implementing new workflows for risk assessment implementation, individualized meetings and working together to fix gaps. Due to the successes of this outreach, this process will remain in place for all future audits. Additionally, providers will be notified in advance of the audits to allow time to thoughtfully prepare records.

Other Interventions that occurred during the 2024 audits included, provider educational material being created and shared on current IHA requirements, an introduction to coding video for providers, and increased access to providers EMR systems for medical record procurement.

Next steps for future audits include improving provider outreach by increasing engagement and updating materials to be more user friendly for providers, provider news articles that highlight requirements including risk assessments and drug and alcohol screenings.

16. 2024 QIHETP and CLAS Program Initiatives

For 2024, the Quality Improvement Program at CCAH will build upon its previous successes with a renewed focus on innovation and strategic goals. Here's an overview of the key initiatives planned for the year:

1. **Expand CCAH's Collaboration with Community Based Organizations**
    - **Incorporate collaboration with Community Based Organizations:** The program will integrate CCAH's Model into its mission, vision, and values. This model emphasizes addressing the unique needs of members and aims to broaden internal programs and partnerships with Community-Based Organizations (CBOs) to better support members.
2. **Increased member feedback**
    - **Member Feedback** will be introduced to gather direct feedback from members regarding the quality of care and overall satisfaction. This initiative will provide valuable insights to refine and improve services.
3. **Expand Provider Participation in the Provider Partnership Program**
    - **Inclusion of Smaller Providers:** The program will work on increasing participation from smaller network providers in the program. This expansion aims to ensure that quality improvement efforts reach a broader range of providers and benefit a more diverse set of members.
4. **Increase Focus on Health Equity and Culturally and Linguistically Appropriate Services (CLAS)**
    - **Engagement and Feedback:** There will be a heightened emphasis on health equity and CLAS. This includes:
        - **Consumer Advisory Committee (CAC):** Engaging with community and member feedback through the CAC.

The 2024 QIHET Program aims to advance CCAH's mission by integrating its Model of Care, enhancing member feedback mechanisms, expanding provider participation, and focusing on health equity and culturally appropriate services. These initiatives are designed to support continuous improvement in care quality and member outcomes while fostering stronger community and provider engagement.

17. Overall Assessment of QIHETP & CLAS

After reviewing the results of measurement of health care inequities and CLAS Program. CCAH determined that the current and ongoing activities were sufficient to support the Health Equity

initiatives. The CLAS Program will continue collaborating with stakeholders and community representatives to enhance cultural and linguistic services for our members.

17.1. Accomplishments

In 2024, the CLAS Program was able to:

- Address challenges related to several educational materials for providers and members, specifically for Hispanic diabetic members and Hispanic members needing well-child visits.
- Begin expanding the availability of member materials in languages other than English and Spanish.
- Perform outreach to the Hispanic community to further educate members about managing their care.

17.2. Opportunities for Improvement

CCAH was successful in several initiatives in 2024. However, in areas that were not met as the Latino Diabetes goal for 2023, CCAH identified the following opportunities for improvement:

- CCAH enhances language services in healthcare interactions. In 2025, CCAH plans to launch a communication initiative that will encourage all members to contact our Member Services Department for help in finding healthcare providers who speak their preferred language.
- CCAH collaborates with a language services vendor to identify issues such as limited interpreters for indigenous languages, long waiting times for calls, and extended call durations. Steps were taken to resolve these issues by offering training to the language service.
- CCAH is dedicated to addressing disparities in healthcare language services and recognizes that the best way to support members with limited English proficiency (LEP) and all members is by advocating for the Member Services Department to provide direct assistance in finding a culturally responsive provider who speaks the member's preferred language.
- CCAH is aware that some website updates, like the availability of forms, directory information, and new providers in the online directory, may not effectively serve members with limited English proficiency who need to access the site in English.
- CCAH identified that translating the Evidence of Coverage documentation into Vietnamese Characters would benefit members in 2024. This project was completed in 2025.
- CCAH will continue to prioritize translating key member forms and materials into Vietnamese Characters. This remains a focus in 2025.
- CCAH will provide Member Experience Surveys in all threshold languages for Commercial and Medi-Cal products.
- Increase provider education materials in Spanish for diabetic members and well-child visit members.
- Educate providers on the nuances and importance of focusing care on physical education, diet, and medication adherence within the Hispanic population.
- Develop a process to ensure that all Latino diabetic members and well-child visit members are properly accounted for and receive the appropriate materials and care.

17.3. Next Steps

CCAH prioritized the following interventions for 2025:

- **Child Preventive Services:** Efforts to bring all providers in Merced to the MPL on child preventive service measures include:

- Continue Merced Provider Group Meetings
- Continue Provider Partnerships and Care-Based Incentive Program
- Continue to Promote MCP Grant Opportunities
- Leverage Texting Project for Care Gap Closure that launched in September 2024, starting with preventive health measures and expanding to broader care gap closures in the future.
- Planned to launch Facilitate milestones in Equity and Practice Transformation Grant
- Planned to implement Point of Service Incentives-Current pilot.
- Working to address Vaccine Hesitancy and other Social Drivers of Disparities through a coordinated strategy

- **Community Engagement:** To elevate the voices of members and engage the community more effectively, CCAH will:
  - Continue leveraging relationships built by the Community Engagement Team.
  - Continue expanding partnerships with Community-Based Organizations (CBOs).
  - Continue conducting a Population Needs Assessment.
  - Foster feedback from member-facing advisory groups.
  - Utilize Community Health Workers (CHWs) to perform focus groups.
  - Planned to host an Annual Health Fair.
  - Planned to utilize MCP Grant Programs to support pilot initiatives.
- **Reducing Disparities:** CCAH will identify and address political determinants of health inequities in the communities served through targeted interventions and policy support:
  - Analyze stratified MCAS data to develop and complete Performance Improvement Projects (PIPs).
  - Review stratified grievance data to create a Plan of Action to address key issues.
  - Measure access to culturally and linguistically competent care.
  - Review internal policies and procedures to ensure alignment with a Health Equity Lens.
  - Conduct root cause analyses of identified health inequities and link findings to political determinants of health to develop actionable solutions.

17.4. Interventions to be completed in 2024.

Level	Intervention	Timeline and Frequency	Barriers Addressed
Patients	An education pamphlet on the importance of A1c Control to White patients. Ensure that materials are focused on the social issues that are affecting white patients and address any unintentional biases that may exist.	04/01/2025 – 6/30/2025 Planning activities including material development. 7/01/2025 – 11/30/2025 Implementation activities Staff responsible: QIPH	The providers may not be discussing screening as commonly with white women for the reasons discussed above. As a result, white women may not understand the importance of getting screened for chlamydia.
Provider	Provider education consistently adhering to nationally recognized guidelines for all ethnic groups.	04/01/2025 – 6/30/2025 Planning activities including material development. 7/01/2025 – 11/30/2025 Implementation activities	Providers might unintentionally provide inconsistent care to different ethnic groups. This training will encourage the providers to consistently follow nationally recognized guidelines and therefore

		Staff responsible: C&L team	ensure members of all groups get equitable care.
Patients	Working with community partners and social workers to promote A1c screening among white members.	04/01/2025 – 5/31/2025 Planning activities including material development. 6/01/2025 – 11/30/2025 Implementation activities Staff responsible: Health Education team	Members are not aware of the getting screened regularly.
Provider	Educational Materials for Providers to raise provider awareness about disparities in well-child visits and promote equitable care.	02/01/2025 – 4/30/2025 Planning activities including material development. 5/01/2025 – 11/30/2025 Implementation activities Staff responsible: Health Education team	Providers may not be fully aware of existing disparities in well-child visits.
Plan	Conduct PCPs Gap reports targeting White and Black/African American populations prioritizing well-child visits report to close care gaps for underperforming populations.	Initial reports were shared in October 2024, with updates distributed in November 2024.	Care gaps may persist due to limited provider awareness or lack of targeted performance data. Gap reports address this by identifying areas of need and tracking progress.
Plan	Leverage Texting Project for Care Gap Closure, starting with preventive health measures and expanding to broader care gap closures in the future.	Launched in September 2024	Members miss preventive health screenings due to communication challenges or lack of reminders.

Appendices

Appendix A: CAHPS Results

MY 2023 CHILD

Measure	2024 Valid n	2022	2023	2024	2024 PG BoB	2024 QC	Goal Met
Rating Questions (% 9 or 10)							
Q31. Rating of Health Plan	244	75.9%	72.5%	77.5%	72.0%	71.3%	YES
Q8. Rating of Health Care	158	68.3%	58.5%	65.8%	70.5%	69.6%	NO
Q21. Rating of Personal Doctor	188	79.7%	72.1%	72.9%	77.2%	76.5%	NO
Q25. Rating of Specialist +	54	81.6%	77.1%	79.6%	73.7%	72.8%	YES
Rating Questions (% 8, 9 or 10)							
Q31. Rating of Health Plan	244	87.8%	89.0%	91.0%	86.5%	86.3%	YES
Q8. Rating of Health Care	158	88.6%	79.3%	84.2%	87.2%	86.9%	NO
Q21. Rating of Personal Doctor	188	93.4%	87.9%	88.8%	89.9%	89.7%	NO
Q25. Rating of Specialist +	54	93.4%	90.4%	85.2%	86.9%	87.2%	NO
Getting Needed Care Composite Score	110	79.2%	79.4%	81.1%	84.5%	83.3%	NO
Q9. Getting care, tests, or treatment	158	83.7%	82.7%	79.7%	90.3	89.6%	NO
Q23. Getting specialist appointment	63	74.7%	76.1%	82.5%	78.6%	77.7%	YES
Getting Care Quickly Composite Score	109	84.5%	82.3%	83..8%	87.0%	86.3%	NO
Q4. Getting urgent care	63	92.7%	83.3%	88.9%	90.7%	90.5%	NO
Q6. Getting routine care	155	76.2%	81.3%	78.7%	83.3%	82.5%	NO
Q20. Coordination of Care	72	88.4%	87.8%	81.9%	84.3%	83.5%	NO
Customer Service Composite Score	83	92.0%	88.0%	91.0%	88.8%	88.3%	YES
Q27. Provided information or help	83	86.4%	80.0%	88.0%	83.2%	82.7%	YES
Q28. Treated with courtesy and respect	83	97.5%	96.0%	94.0%	94.4%	93.8%	YES

How Well Doctors Communicate Composite Score	144	93.1%	91.7%	91.5%	94.4%	93.8%	NO
Q12. Dr. explained things	146	94.0%	93.0%	92.5%	94.6%	94.3%	NO
Q13. Dr. listened carefully	146	97.0%	94.0%	93.2%	95.6%	95.2%	NO
Q14. Dr. showed respect	145	98.2%	96.0%	96.6%	97.0%	96.7%	NO
Q17. Dr. spent enough time	142	83.4%	83.8%	83.8%	90.2%	89.1%	NO
Q30. Ease of Filling Out Forms Composite Score	239	95.1%	94.1%	96.7%	94.9%	94.9%	YES

MY 2023 ADULT

Measure	2024 Valid n	2022	2023	2024	2024 PG BoB	2024 QC	Goal Met
Rating Questions (% 9 or 10)							
Q28. Rating of Health Plan	246	57.20%	59.30%	63.8%	63.1%	61.5%	YES
Q8. Rating of Health Care	147	51.30%	48.70%	60.5%	57.3%	56.8%	YES
Q18. Rating of Personal Doctor	169	68.40%	68.10%	72.2%	70.3%	69.2%	YES
Q22. Rating of Specialist +	101	72.10%	64.00%	73.3%	68.5%	67.7%	YES
Rating Questions (% 8, 9 or 10)							
Q28. Rating of Health Plan	246	76.80%	77.10%	78.5%	78.7%	77.7%	YES
Q8. Rating of Health Care	147	75.60%	72.70%	78.2%	75.8%	75.8%	YES
Q18. Rating of Personal Doctor	169	83.10%	80.40%	86.4%	83.9%	83.3%	YES
Q22. Rating of Specialist +	101	85.70%	81.50%	84.2%	82.7%	82.5%	YES
Getting Needed Care Composite Score	127	82.90%	78.90%	80.7%	82.1%	81.5%	NO
Q9. Getting care, tests, or treatment	145	82.50%	82.60%	84.1%	85.1%	84.6%	NO
Q20. Getting specialist appointment	110	83.20%	75.30%	77.3%	79.1%	78.8%	NO
Getting Care Quickly Composite Score	117	73.40%	75.90%	82.4%	81.2%	80.4%	YES
Q4. Getting urgent care	89	74.50%	82.40%	88.8%	82.7%	82.8%	YES

Q6. Getting routine care	146	72.20%	69.40%	76.0%	79.7%	78.7%	YES
Effectiveness of Care							
Q33. Advised to Quit Smoking: 2YR	86	69.60%	69.10%	69.8%	73.7%	73.5%	NO
Q34. Discussing Cessation Meds: 2YR +	87	52.20%	53.50%	51.7%	53.4%	52.8%	NO
Q35. Discussing Cessation Strategies: 2YR +	86	43.30%	42.10%	43.0%	47.1%	46.6%	NO
Customer Service Composite Score	77	91.10%	87.50%	87.8%	89.8%	89.1%	NO
Q24. Provided information or help	78	86.90%	80.30%	80.8%	84.7%	83.8%	NO
Q25. Treated with courtesy and respect	77	95.30%	94.70%	94.8%	94.8%	94.3%	YES
How Well Doctors Communicate Composite Score	134	91.50%	91.60%	91.8%	93.2%	93.0%	NO
Q12. Dr. explained things	136	90.50%	92.20%	92.6%	93.2%	92.7%	NO
Q13. Dr. listened carefully	134	92.70%	92.30%	93.3%	93.3%	93.2%	NO
Q14. Dr. showed respect	135	92.70%	94.30%	94.8%	94.9%	94.8%	YES
Q15. Dr. spent enough time	134	89.90%	87.80%	86.6%	91.4%	91.0%	NO
Q17. Coordination of Care Composite Score	93	83.70%	79.60%	82.8%	86.0%	85.6%	NO
Q27. Ease of Filling Out Forms Composite Score	233	93.10%	95.60%	93.6%	94.8%	94.8%	NO