Medi-Cal
Health Education and Cultural and Linguistic Population Needs Assessment (PNA) 2024

Santa Cruz, Monterey, & Merced Counties Reporting Areas

2024

By
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Population Needs Assessment Overview

Central California Alliance for Health (the Alliance) is a regional non-profit managed health care plan established in 1996 in Santa Cruz County. Monterey (1999) and Merced (2009) counties have since been added to comprise the tri-county service area. The Alliance's primary line of business is that of Medi-Cal (99% of members) and provides IHSS services in the county of Monterey to the remaining <1% of members.[1] Using California's County Organized Health System (COHS) model, the Alliance was the sole managed care plan coverage for 335,785 Medi-Cal members in Merced, Monterey and Santa Cruz counties as of 2022 (126,420 in Merced, 148,557 in Monterey and 60,808 in Santa Cruz, see Table 1 below).

The Population Needs Assessment focuses on health disparities, gaps in services, and health status and behaviors of Alliance Medi-Cal members in our tri-county reporting areas. The PNA also emphasizes findings related to the unique needs of Seniors and Persons with Disabilities (SPD), members with children with special health care needs, members with Limited English Proficiency, and members from diverse cultural and ethnic backgrounds. Multiple internal and external data sources were used. Findings from the PNA highlight areas of success, as well as areas of opportunities for improvement in the health plan. The Alliance services several different geographic areas, and through analyzing the needs of its population geographic disparities particularly in Merced County are reflected. With this disparity being reflected in several Populations within the county health initiatives and the Alliance's overall Quality Strategy include resources, and activities aimed at addressing identified health disparities.

To achieve this purpose, PNA will assess:

- The characteristics and needs, including social determinants of health, of its member population.
- The needs of child and adolescent members.
- The needs of members with disabilities.
- The needs of members with serious mental illness or serious emotional disturbance.
- The needs of members of racial or ethnic groups.
- The needs of members with limited English proficiency.
- The needs of relevant member subpopulations.

The 2023 PNA report is being referenced as a comparison throughout this 2024 PNA report as appropriate.

Data Sources and Methods

The 2023 PNA data was collected from numerous reliable primary and secondary data sources. The review of the global Medi-Cal population outlined above is based on data from California Department of Healthcare Services (DHCS) enrollment files and includes all Medi-Cal members only excluding those with other health coverage. Internal sources included queries of claims and encounter data, the most recent Managed Care Accountability Sets (MCAS) (Measurement Year 2022), provider satisfaction survey, 2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for member experience, and member surveys/interviews. Additional external data sources were accessed from 2022 DHCS Preventive Services Data, the California Health Interview Survey (CHIS); the California Department of Public Health (CDPH); and the US Department of Disease Prevention and Health Promotion, Healthy People 2030 (HP2030).

In addition, to further assist in identifying Medi-Cal members' perceptions, preferences, and behaviors as it relates to health education and cultural and linguistic services, the Alliance conducted member and provider surveys.

[1] This report excludes any data using IHSS members and members with Other Health Coverage as primary unless otherwise noted.

The Alliance annual Provider Satisfaction Survey assesses contracted providers' overall satisfaction with core health plan operations. Annual results are used to inform future initiatives and educational opportunities for the provider network, and in conjunction with other health plan data, provide insight into where the Alliance can focus improvement efforts. A total of 217 providers responded to the survey (the 2023 survey was conducted between June and September).

Needs of Its Member Population, Including Social Determinants of Health

Membership Profile

The Alliance serves most Medi-Cal members in the health plan's tri-county area, including the Seniors and Persons with Disabilities (SPD) and the Whole Child Model (WCM), which include children with special health care needs populations. The largest percentage of the plan's Medi-Cal membership for calendar year 2022 is made up of children and teens ages 0-19 (49.49%), followed by adults ages 20-64 (49.26%), and seniors ages 65 and older (1.25%), see Table 1 below. This trend mirrors the data that was reported in the 2022 PNA report (2021 membership data) when adults were the largest population for the plan at 47%. Females make up a higher percentage than males (53% vs. 47%). Members with disabilities make up 4% of the Alliance's Medi-Cal membership. Children with special health care needs who are eligible for the Whole Child Model Program (WCM) make up 2% of the plan's child and teen Medi-Cal membership (A).

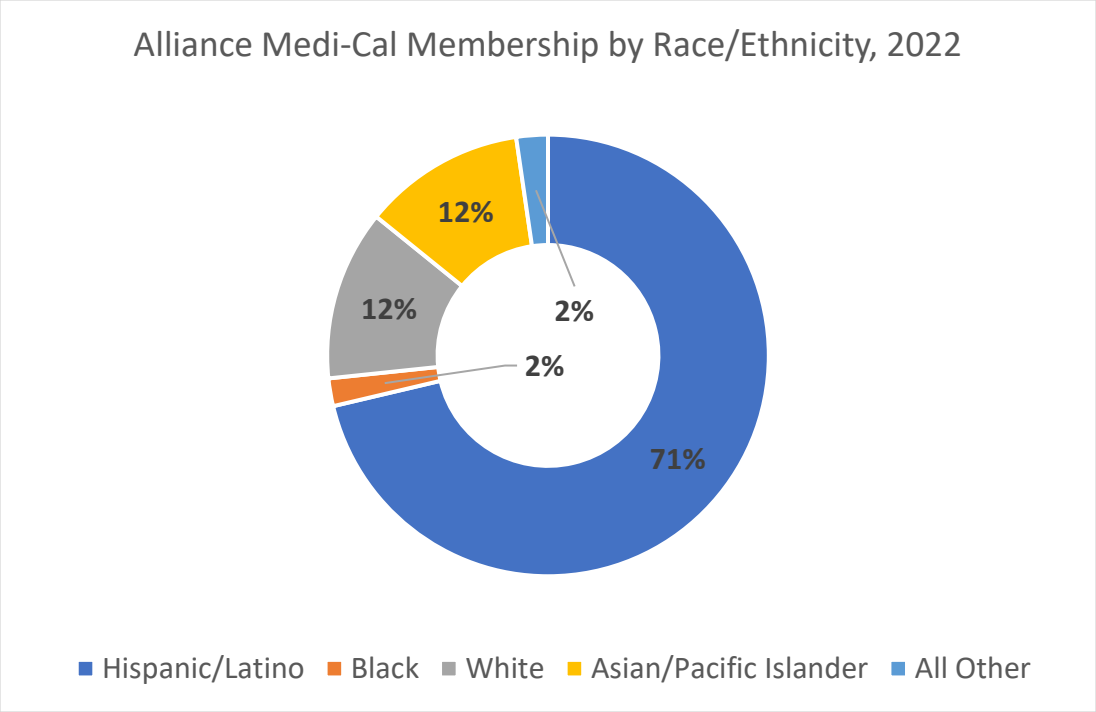
Table 1. Alliance Membership Distribution by County and Age Group, 2023*
*Excludes members with other health coverage as primary coverage.

Age Group	Merced		Monterey		Santa Cruz		Combined	
Under 1	2,359	0.70%	3,375	1.01%	1,094	0.33%	6,828	2.03%
1-9	27,672	8.24%	34,264	10.20%	10,599	3.16%	72,535	21.60%
10-19	32,844	9.78%	40,575	12.08%	13,406	3.99%	86,824	25.86%
20-44	43,719	13.02%	46,681	13.90%	22,183	6.61%	112,583	33.53%
45-64	18,653	5.56%	21,501	6.40%	12,673	3.77%	53,827	15.73%
65-74	712	0.21%	1,295	0.39%	525	0.16%	2,532	0.75%
75-84	338	0.10%	611	0.18%	216	0.06%	1,165	0.35%
85+	123	0.04%	253	0.08%	112	0.03%	488	0.15%
Totals	126,420	37.65%	148,555	44.24%	67,623	18.11%	335,782	100.00 %

Source: Alliance Membership Data, 2022

A large majority of Medi-Cal members self-identify as Hispanic/Latino (71%), followed by White (12%), Asian/Pacific Islander (12%), all others (2%), and Black (2%), see Figure 1 below. There was no significant change in percentages of ethnic populations served compared to the 2022 PNA report. While the Hispanic/Latino population still represents the highest ethnic population served in 2022, the percentage of Medi-Cal members report Spanish as their primary spoken language (42%) remains lower than the percentage of members who prefer English (57%).

Figure 1. Proportions of Membership by Race and Ethnicity, 2022



Source: Alliance Membership Data, 2022

Social Determinants of Health Indicators

In early 2022, DHCS issued an All-Plan Letter to promote the collection of data on Social Determinants of Health using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding. These codes were listed in the document and 25 codes were identified as priority codes for collection. A query of all claims data for all SDOH codes submitted on paid claims for dates of service during the calendar year of 2023 found that 16,773 claims had been submitted with one of the top 25 priority SDOH codes compared to a submission in 2022 of 7,659. The codes in Table 2, show the top 10 highlighted in yellow are the priority codes defined by DHCS, Table 10.

Table 2. Top 10 Social Determinants of Health ICD-10 Codes Reported for All Members, 2023

Code	Code Description	Total
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)	4124
Z59.00	Homelessness unspecified	4085
Z59.89	Other problems related to housing and economic circumstances	2214
Z59.01	Sheltered homelessness	1039
Z59.41	Food insecurity	956
Z59.02	Unsheltered homelessness	605
Z59.811	Housing instability, housed, with risk of homelessness	474
Z59.7	Insufficient social insurance and welfare support	473
Z59.819	Housing instability, housed unspecified	445
Z63.4	Disappearance & death of family member (assumed death, bereavement)	391

Source: Alliance Claims Data, 2023

The most commonly reported SDOH ICD-10 code was "Other specified problems related to psychosocial circumstances (religious or spiritual problem)," surpassing "homelessness unspecified" in 2021 and 2022. Some of the approximate synonyms to that coding are interpersonal problem, codependency; peer problems; religious or spiritual problem; victim of bullying; and victim of teen dating psychosocial violence; or victim of teen psychosocial violence.[i] Homelessness (unspecified, sheltered, unsheltered), and housing instability or problem related to housing and economic circumstance related to 6 of the top 10 SDOH submissions.

The Alliance strategy to address both housing instability, and members struggling with chronic and complex mental, behavioral, and physical health concerns is by linking members to Enhanced Case Management, a wraparound service that addresses not only care coordination, but linkage to a variety of social supports and services (e.g., CalFresh, SSI) including the suite of Community Supports the Alliance offers as benefits including Housing Navigation, Housing Tenancy, and Housing Deposits. The Alliance goal for this time period is to increase enrollment into ECM 5% from 2023 baseline (see Population Health Management Strategy).

The Needs of Child and Adolescent Members - Including analysis by Race/Ethnicity and Limited English Proficiency

MCAS Findings – Children

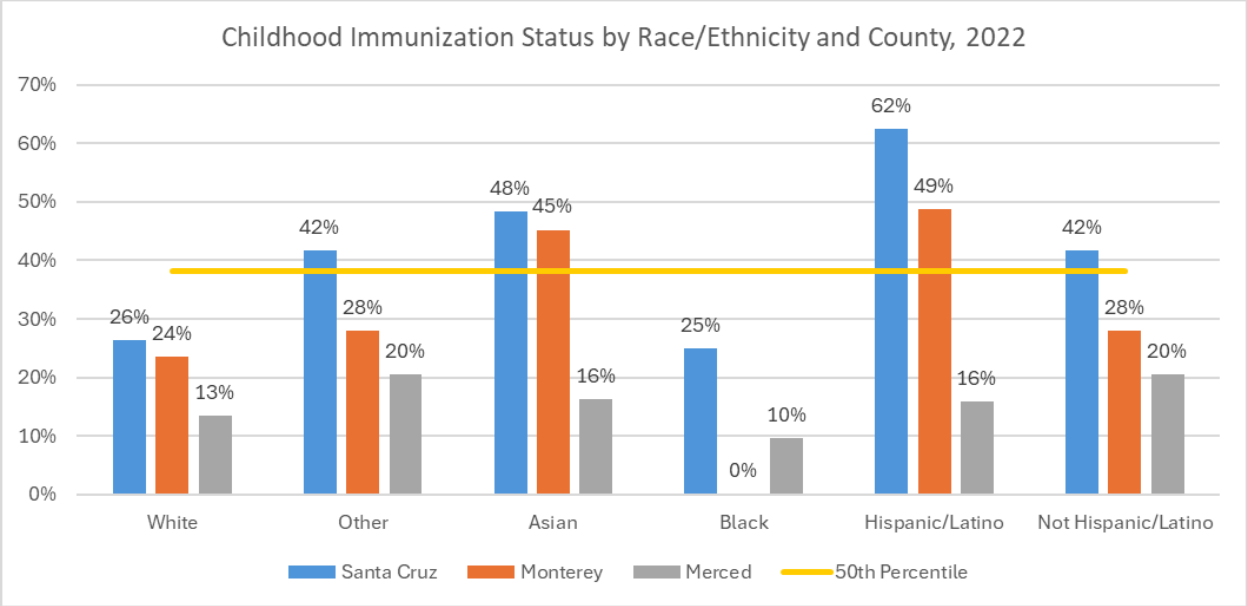
As a health plan we report quality and equity performance measures selected by DHCS through the reporting populations of Santa Cruz and Monterey counties as one unit and Merced County as a separate unit for the Medi-Cal Managed Care Accountability Set (MCAS). MCAS Measurement Year (MY) 2022 (Report Year [RY] 2023) rates were reasonable given the continued impact on primary care services by the COVID-19 pandemic. The Alliance's Santa Cruz-Monterey reporting unit experienced high performance levels (HPLs) in key childhood measures including childhood immunizations, adolescent immunizations, and all measures held to the Minimum Performance Level (MPL) showed improvement, with measures like well-child visits in the first 15 months - six or more well-child visits (W30-6) improving over 10%. More importantly, no measures fell below the minimum performance level (MPL).

In Merced County, Merced showed improvements in eight of the measures, with over 5% improvement in the W30-6 measure. The measures falling below the MPL included childhood immunizations status (CIS-10), Immunizations for adolescents (IMA-2), lead screening in children (LSC), well-child visits for age 15 months to 30 Months—two or more well-child visits (W30-2), well-child visits in the first 15 months—six or more well-child visits (W30-6), and child and adolescent well-care visits (WCV).

Full MCAS MY2022 results are in Appendix B, with select findings on children's measures highlighted in this section. Note that when a racial/ethnic group denominator count falls below 11, it will not be displayed.

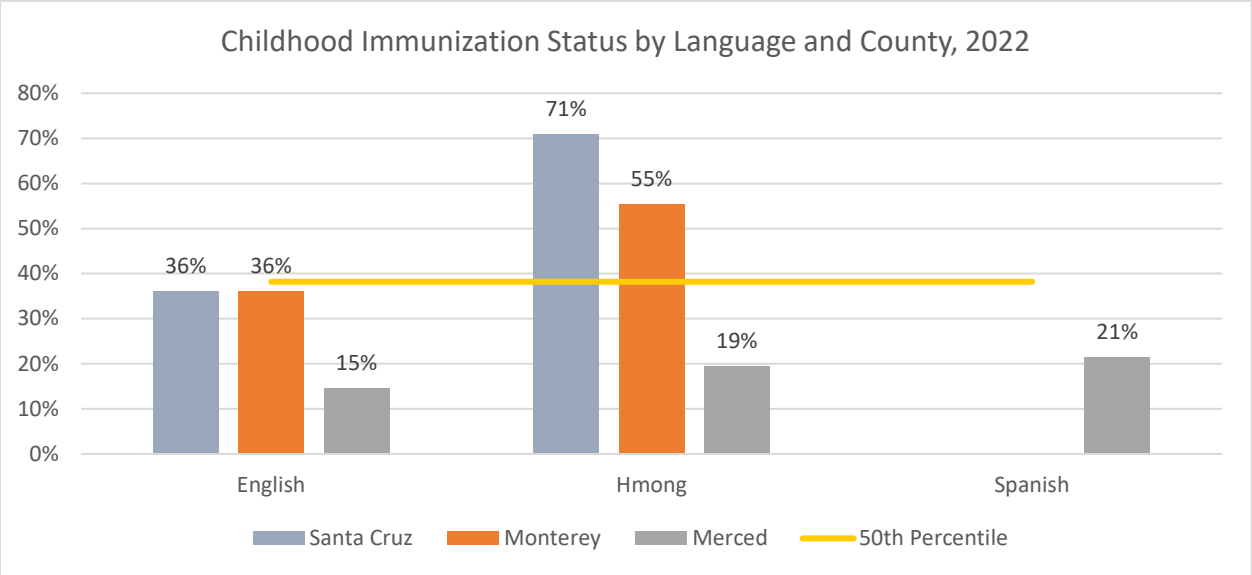
Childhood Immunization Status

Figure 2. Childhood Immunization Status by County and Race/Ethnicity, MY2022



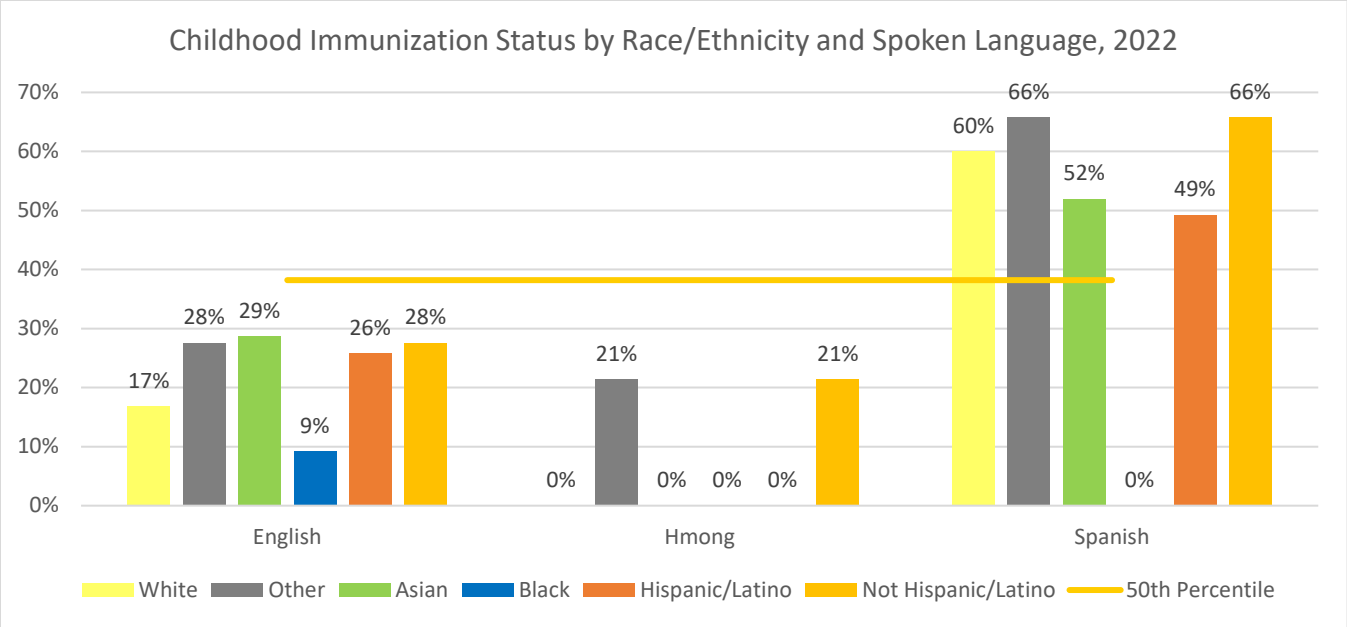
2Source: MCAS MY2022 administrative data, direct reference only.

Figure 3. Childhood Immunization Status by County and Spoken Language, MY2022



Source: MCAS MY2022 administrative data. Hmong was not reported in Santa Cruz and Monterey County.

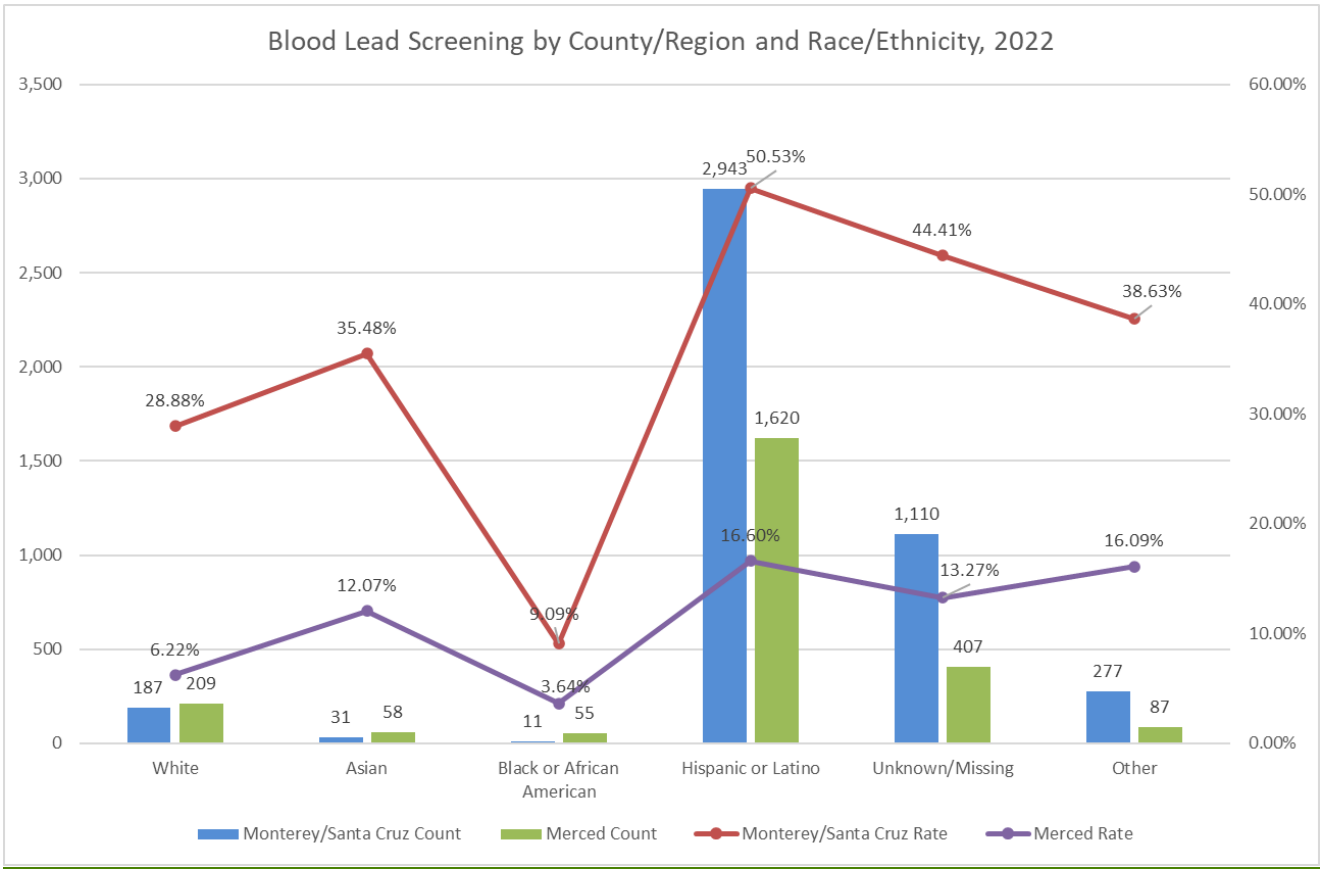
Figure 4. Childhood Immunization Status by Race/Ethnicity and Spoken Language, MY2022



Source: MCAS MY2022 administrative data, direct reference only.

Blood Lead Screening

The Lead Screening in Children (LSC) Measure from MCAS was reported for the first time at 78.83% in Santa Cruz/Monterey and 46.47% for Merced, with Merced below the MPL. In comparison, the figures below from the DHCS Preventive Services Report for 2022 is inclusive of the Medi-Cal requirements for two lead screening tests by 24 months of age. In 2022, the report showed Santa Cruz/Monterey at 47.20%, and Merced County at 14.73%**Figure 5.** Blood Lead Screening in Children by Reporting Unit and Race/Ethnicity, MY2022

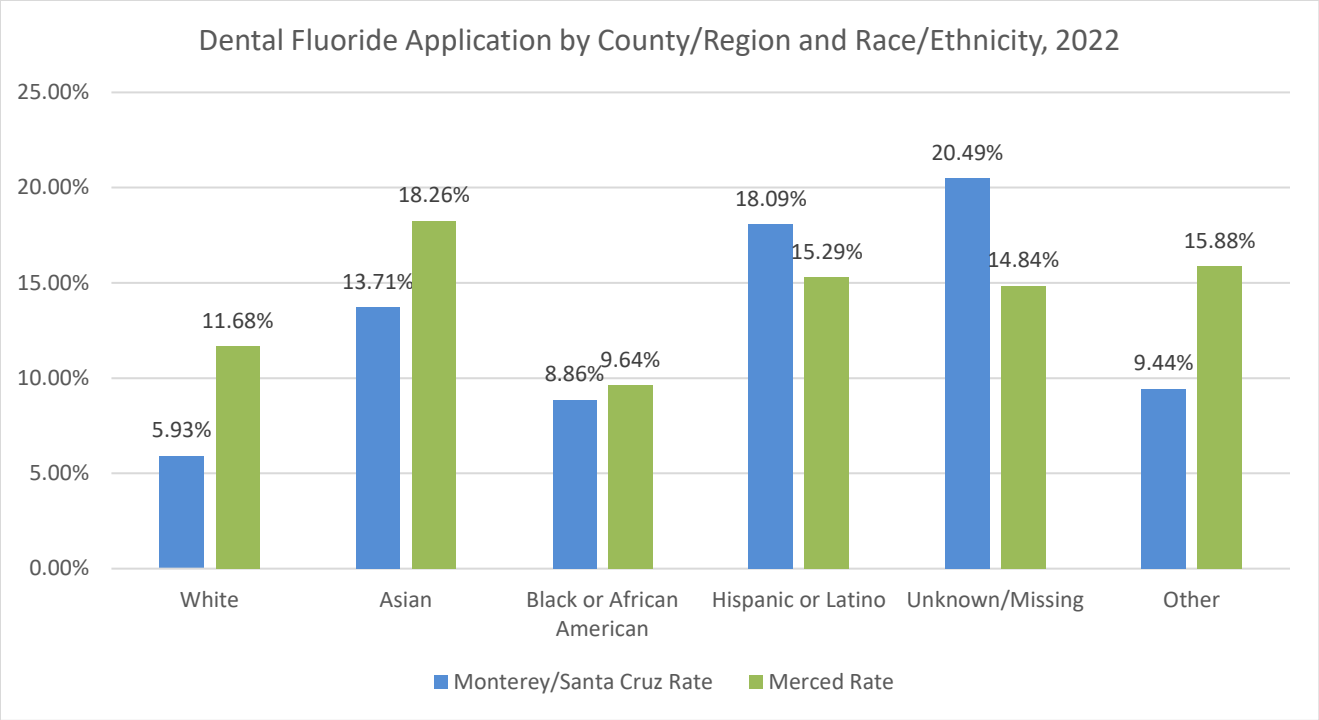


Source: DHCS Preventive Services Report, 2022.

Dental Fluoride Varnish

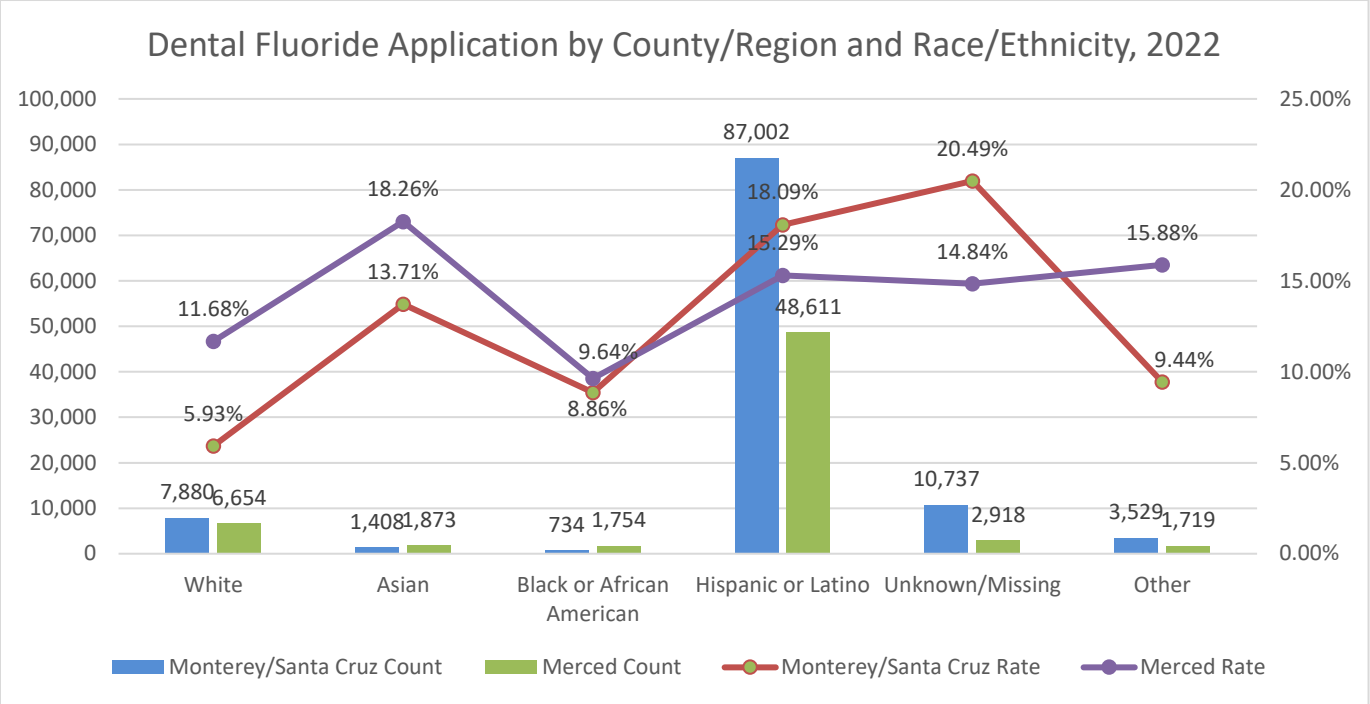
The Topical Fluoride for Children—Dental or Oral Health Services—Total (TFL) MCAS measure was reported in the Preventive Services report for measurement year 2022 at 17.05% for Santa Cruz/Monterey and 14.82% for Merced County.

Figure 6. Dental Fluoride Varnish Application by County and Race/Ethnicity, MY2022



Source: DHCS Preventive Services Report, 2022.

Figure 7. Dental Fluoride Varnish Application by County and Race/Ethnicity, MY2022

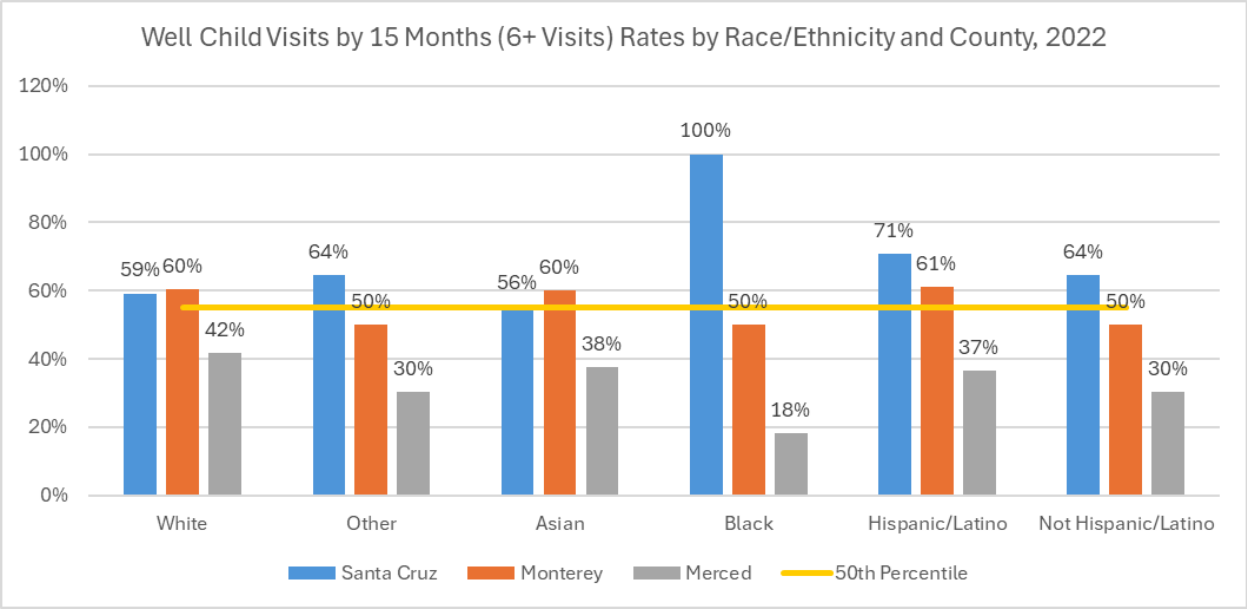


Source: DHCS Preventive Services Report, 2022.

Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6), 2022

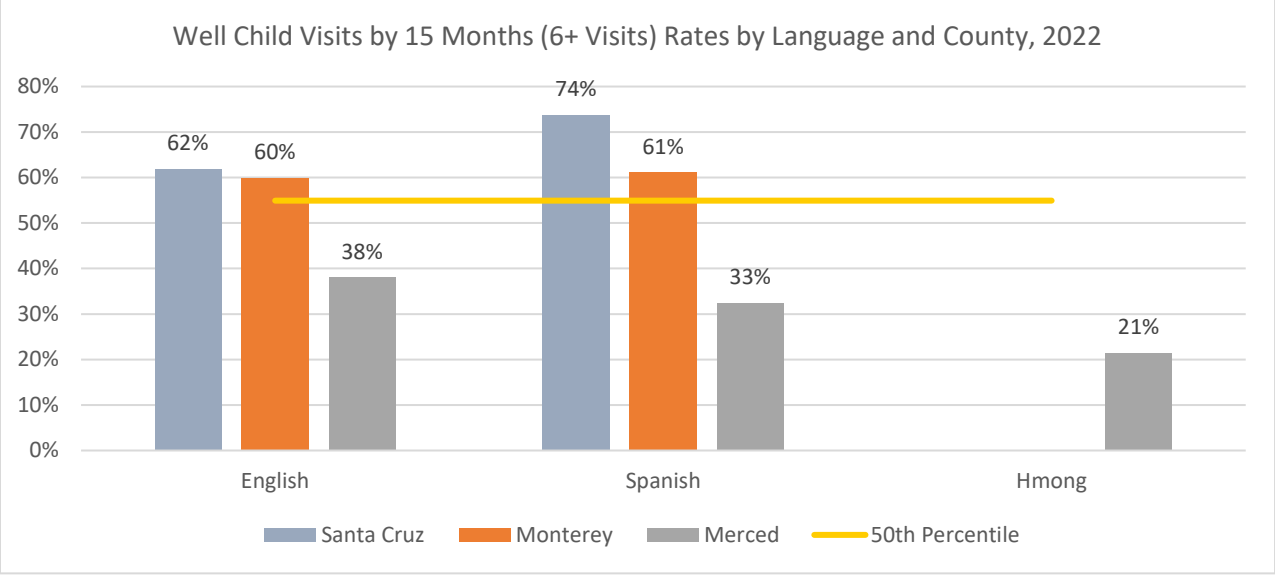
The *W30-6* measure represents the percentage of children who turned 15 months in the measurement year and received six or more well-child visits with a provider. Well-child visits are particularly important during the early months of a child's life to assess growth and development and address problems early. Despite the benefits of visits, rates were low for infants but have improved since 2021. Overall rates by County show Merced County at 36.72%, Monterey at 60.61%, and Santa Cruz at 60.61%.

Figure 8. Well Child Visits (6+) by 15 Months by Race/Ethnicity and County/Region, 2022.



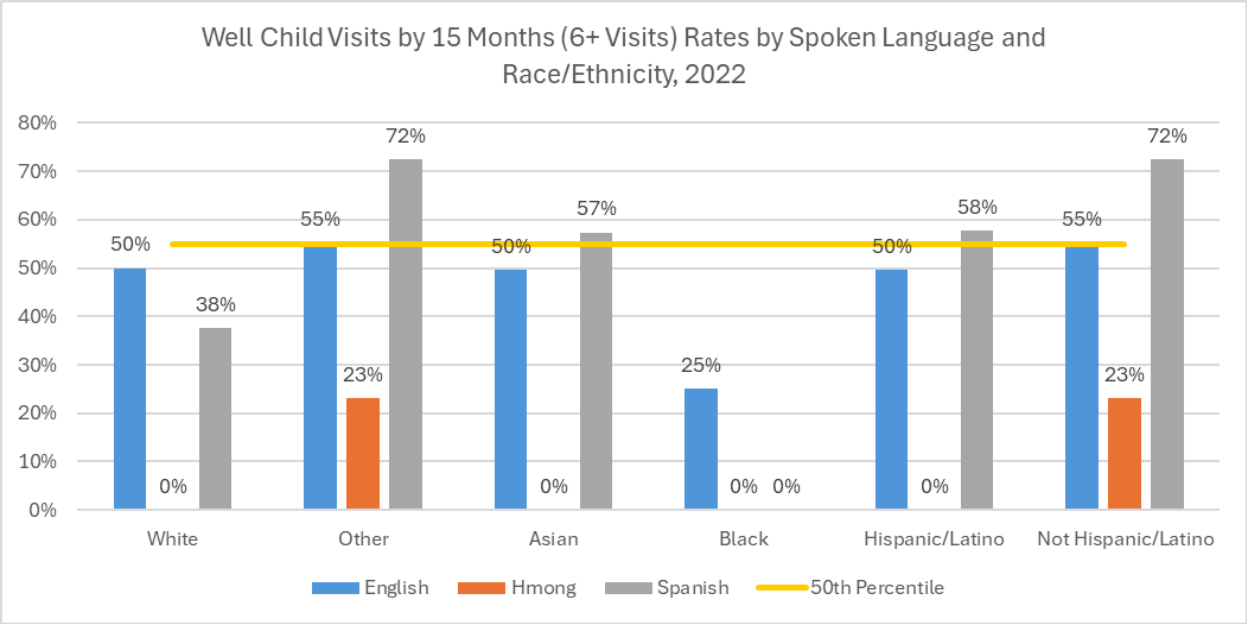
Source: MCAS MY2022 administrative data, direct reference only. Total Black populations in Santa Cruz and Monterey are below 10.

Figure 9. Well Child Visits by 15 Months (6 Visits) by Spoken Language and County*, 2022



Source: MCAS MY2022 administrative data. Hmong was not reported as a spoken language for infant members in Santa Cruz/Monterey.

Figure 10. Well Child Visits by 15 Months (6 Visits) by Spoken Language and Race and Ethnicity, 2022

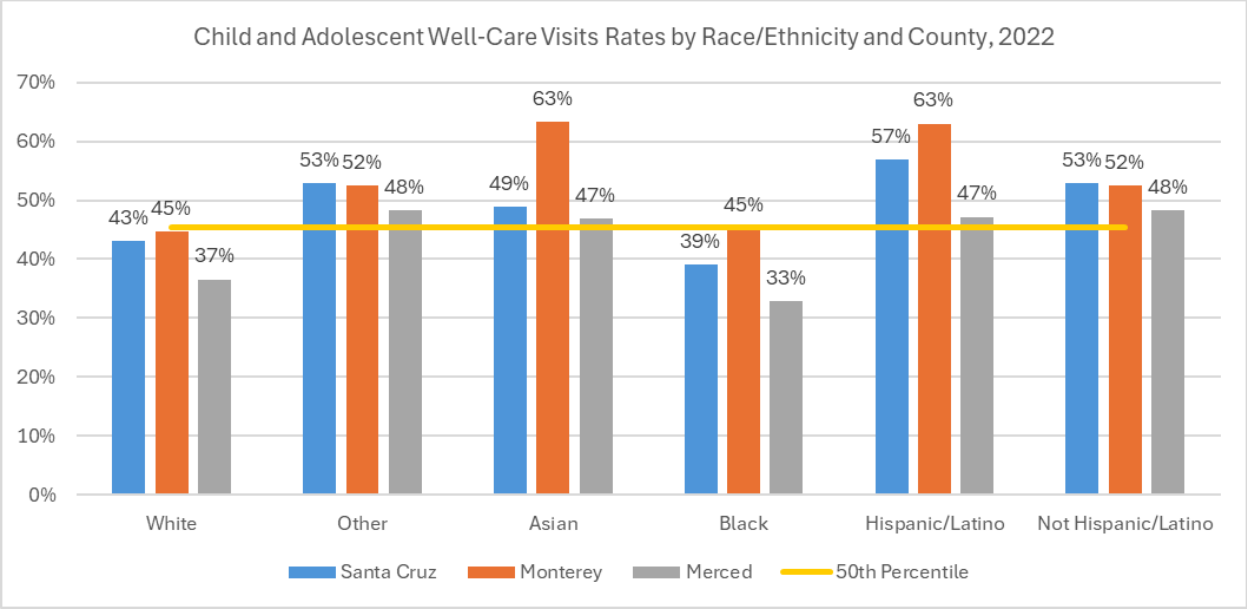


Source: MCAS MY2022 administrative data, direct reference only.

Child and Adolescent Well-Care Visits – Total

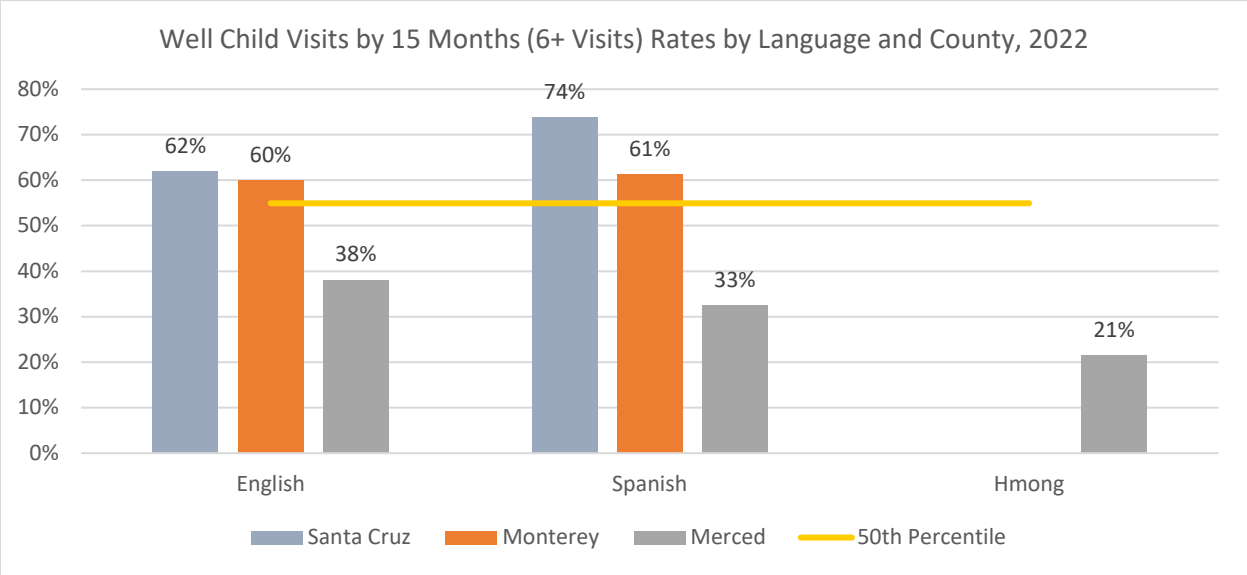
The WCV measure represents the percentage of children ages 3 to 21 years who had at least one comprehensive well-care visit with a PCP or OBGYN practitioner during the measurement year. Overall, 54% of eligible child and adolescent Alliance members ages 3-21 had at least one well child visit in 2022, with 45.64% in Merced County, 45.64% in Monterey County, and 54.22% in Santa Cruz County.

Figure 11. Child and Adolescent Well-Care Visit Rates by Race/Ethnicity and County, 2022



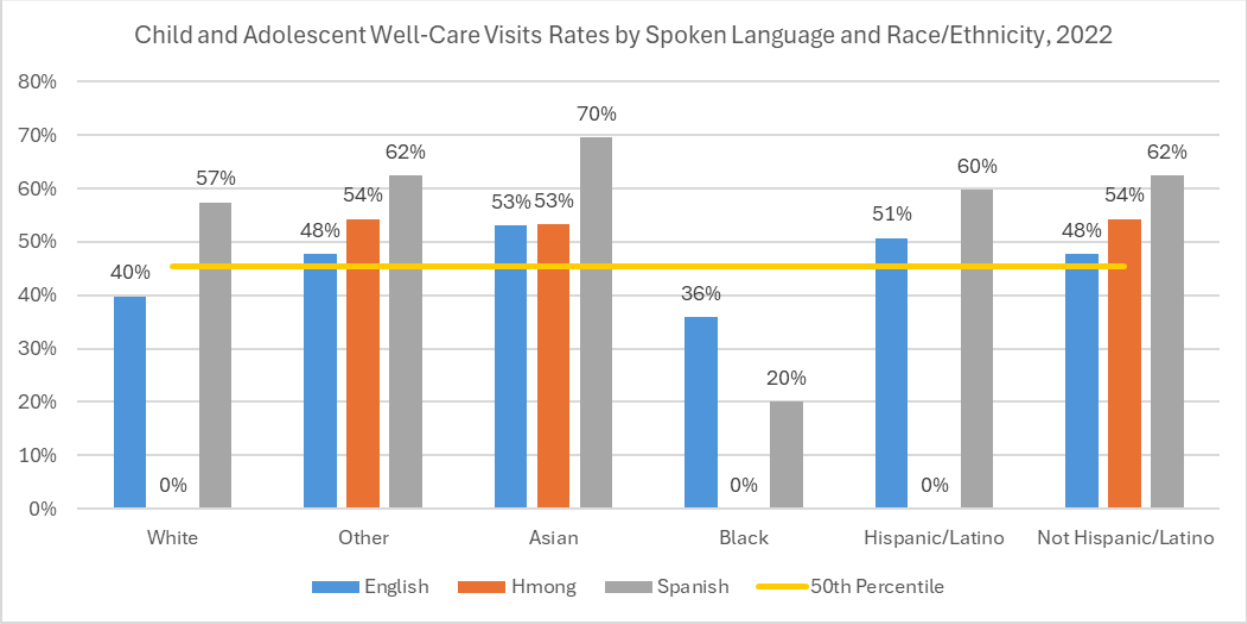
Source: MCAS MY2022 administrative data, direct reference only.

Figure 12. Child and Adolescent Well-Care Visit Rates by Spoken Language and County, 2022



Source: MCAS MY2022 administrative data. Hmong was not reported as a spoken language for children in Santa Cruz and Monterey County.

Figure 13. Child and Adolescent Well-Care Visit Rates by Spoken Language and Race/Ethnicity, 2022



Source: MCAS MY2022 administrative data, direct reference only.

Key Findings of Needs of Child and Adolescent Members

Overall, most of the preventive pediatric measures under review showed geographic disparities between Merced County and its neighboring regions of Santa Cruz and Monterey County.

- Children Immunization Status, Combination 10 (CIS-10) for Two Year Old's rates for MY2022 had a marginal increase increased at 0.11% in Santa Cruz/Monterey but decreased in Merced County by a little over 2% from the prior year, with a reported rate in Santa Cruz-Monterey of 51.09% and Merced County

16.06%. Compared to 2020, with rates at 54% and 22%, vaccinations have still not caught up to pre-pandemic levels. Rates by spoken language in Figure 3 show Spanish-speaking families have the highest rates of vaccination coverage in Santa Cruz and Monterey County, but all threshold languages were below the MPL in Merced County, also consistent with race and ethnicity population in figure 2. The COVID pandemic continues to have an impact on our childhood and adolescent immunization rates, with increases in vaccine hesitancy, and impact on clinic staffing. This regional immunization registries often have challenges with supporting our Providers, particularly when multiple entries of the same member exist that will interfere with matching the member to the correct immunization record. In addition, there may be missed opportunities when the child is present in the clinic yet not given the vaccines that they are behind on.

- Lead Screening in Children (LSC) showed that our Hispanic or Latino population had the highest rates in Figure 5. Notably the Black or African American population has the lowest rate of 9.09% in Monterey-Santa Cruz (N=11) and 3.64% in Merced County (N=55), followed by white at 6.22% in Merced County. A number of providers also shared barriers to care, without access to point of care testing in clinic.
- For Dental Fluoride Varnish Application by County/Region and Race/Ethnicity in Figure 6, the unknown/missing race/ethnicity at 20.49% was highest in Santa Cruz/Monterey compared to Asian in Merced County at 18.26%. Notably the White population has the lowest rate in Monterey-Santa Cruz at 5.93%.
- Well Child Visits in the First 15 Months of Life-6 visits (W30-6+) has improved overall rates at 62.23% for Santa Cruz/Monterey, and 36.72% in Merced as seen in Appendix B. In figure 8, Hispanic/Latino infants had the highest rate at 70.65% (N=443) in Santa Cruz County, with above the 50th percentile. Monterey County's highest rate reports was in members identified as Hispanic/Latino, with 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). As shown in Figure 9, infants in the Spanish speaking group had the highest compliance rate in Santa Cruz (74%) and in Monterey 61%. All three threshold languages in Merced were below MPL. Of note, Hmong was not reported as a spoken language for infant members in Santa Cruz/Monterey. In Figure 10, Spanish speaking families were the highest rates in Other and Not Hispanic/Latino at 72%. Challenges for W30-6, include securing data for the well child visits that occur under the mother's Medi-Cal ID before the child receives their own Medi-Cal ID, as well as potential gaps of coverage for the child moving to their own coverage and PCP. Understanding frequency limitations for billing for well-visits have also been identified as a challenge by providers in the network.
- For Child and Adolescent Well-Care Visits in Figure 11, Asian and Hispanic/Latino children and adolescents in Monterey had the highest rates of visits overall (63%), followed by Hispanic/Latino (57%) and Other (53%) in Santa Cruz County. In Merced, "Other" race (48%) and Not Hispanic/Latino (48%) children and adolescents both had the highest compliance rates. 33% of Black and 37% of White children and adolescents in Merced County had the lowest rates of compliance overall. In Figure 12, members in Monterey whose spoken language was Spanish had the highest overall rate of WCV compliance (65%), followed by Spanish speaking members in Santa Cruz at 59%. All languages but English was above the 50th percentile in Merced.
- Direct race and ethnicity data is limited because the primary data source from Med-Cal enrollment files generate either race or ethnicity, presenting challenges to analyzing the data by race and ethnicity. Supplemental data sources such as adding in direct race or ethnicity data from the immunization registries has been added, but the challenge remains in not having complete information for all members.

Activities and Resources used for Child and Adolescent Members

The Alliance has developed interventions to address the geographic disparities of members living in Merced County. Interventions include the Workforce Support for Care Gap Closure grant funding, which provides monetary support pay for locum providers to expand clinic hours, open or add additional walk in hours, and expand access for working parents with school age children. This support has also provided funding for

purchase of point of care lead testing equipment to better co-locate care opportunities. The Alliance has also prioritized support in Merced County through the Provider Partnership Program, linking quality improvement and population health staff along with medical director support with five provider organizations in Merced County with the largest member linkage to leverage quality improvement activities focusing on pediatric measures below the 50th percentile. The Alliance also launched a project from 2023-2026 aimed at increasing well visits for Hispanic members in the most rural areas in Merced County that showed geographic disparities for W30-6. In an effort for future access, the Alliance is also working to bring mobile units capable of providing immunizations, and well care visits outside of the traditional clinic setting.

The Alliance added the Lead Screening in Children measure to its Primary Care Providers (PCP) Pay for Performance program called the Care-Based Incentive (CBI) Program in 2021 as unpaid "exploratory" measure and has since added it as paid incentive measure for the 2024 CBI program for. Providers have been able access quarterly rosters of their members in the CBI program including gap in care reports of missing services for immunizations, well visits, lead screening, fluoride varnish. There are also monthly gap in care reports available for providers to use for outreach and scheduling, that include status of well-visits, immunizations, and lead screening. The Alliance is also working with our community partners in the Oral Health Access Committee in Santa Cruz County to increase fluoride varnish rates in Santa Cruz County. For providers, additional communication on frequency limitations has been shared in the news articles, and in CBI materials. Data gap closures have also been prioritized to strengthen algorithms in identifying mom-baby relationships to capture the early well visits under the mother's Medi-Cal ID. The Alliance has also prioritized provider education and conversations on pediatric measures.

To help educate members, member branded material updates have been made to the infant wellness map, and updates to the member incentives to trial additional point of care incentives. A well-child visit member texting campaign was completed in October 2024, that included links to one of our website pages for child check-ups/vaccines, as well as member incentive information linked on this page.

The activities and resources are adequate to meet the needs of child and adolescent members, but there are some enhancements planned. To explore vaccine hesitancy and reduced immunization rates, the Alliance is in the process of developing focus groups to explore hesitancy and/or barriers and challenges leading to delayed or uncompleted series that will enhance directed member communication. Also planned is collecting feedback from Community Based Organizations (CBOs) who are trusted community partners to help identify contributing factors of the disparity. Specific to fluoride varnish rates, the Alliance is involved in an Oral Health Access Steering Committee (OHA) in Santa Cruz County, which includes local CBOs or organizations like First 5, Cabrillo Dental Hygiene Program, Community Bridges, Elderday, Meals on Wheels, Community Health Trust of the Pajaro Valley, Grey Bears, Project Smile, Salud Y Carino, Santa Cruz County Office Of Education (SCCOE), Senior Network Services, Seniors Council, United Way of SCC, Ventures, Serving Communities HIO (SCHIO), and is actively working to improve fluoride varnish rates and identify barriers of care. Quarterly the Alliance hosts a Maternal and Child Health Regional Collaborative Meeting with WIC, First 5, and County Health Services and Public Health programs such as Maternal, Child, Adolescent Health (MCAH), Perinatal Services, Oral Health, Lead Poisoning Prevention, Comprehensive Perinatal Services Program (CPSP) which can be used to explore barriers and root causes to the lower rates in children's preventive services.

The Needs of Members with Disabilities – Including Children

Seniors and Persons with Disabilities (SPDs) account for approximately 4% of the Alliance membership in Merced, Monterey and Santa Cruz counties and males make up the marginal majority (52%). Most of the SPD population is between the ages of 20 and 64 (54%), followed by ages 65 or older (25%). Hispanics/Latinos represent 51% of SPDs, followed by White (20%) and Asian/Pacific Islanders (20%). Through the WCM program, children up to age 21 can get the health care and services they need. There were 6,887 Medi-Cal members in 2023 who were receiving services through WCM, 2,594 in Merced County, 3,276 in Monterey County, and 1,017 in Santa Cruz County. Three-quarters (75%) of WCM members are Hispanic, 13% are Asian/Pacific Islander, 9% are White, and 1% are Black. The age distribution of the WCM program members was 4% aged less than 1 year,

followed by 91% ages 1 to 19 years and approximately 4% ages 20-44 years. Additional information is available in Appendix A: Membership Tables.

Table 3.

A. Plan's SPD Members by Gender for December 2023		
Program County	**Member Numbers**	**% of Total Membership**
F	7,137	48.03%
M	7,724	51.97%
Grand Total	**14,861**	**100.00%**

Table 4.

B. Plan's WCM Members by Age Group for December 2023		
Age Group	**Member Numbers**	**% of Total Membership**
<1	286	4.15%
01-09	2,800	40.66%
10-19	3,477	50.49%
20-44	324	4.70%
Grand Total	**6,887**	**100.00%**

Activities and Resources for Patients with Disabilities:

Assessment of Activities and Community Resources:

The majority of the SPD population are eligible for Enhanced Case Management , a wraparound service that addresses not only care coordination, but linkage to a variety of social supports and services (e.g., CalFresh, SSI) including the suite of Community Supports the Alliance offers that specifically addresses SPD needs including Environmental Accessibility Adaptations, intended to modify a member's home to allow them to safely remain in the community; Nursing Facility Diversion, intended to find alternative to Skilled Nursing to house members in the community, Respite Service, Personal Care and Homemaker services, and medically tailored meals.

The Alliance strategy to address SPD needs, especially SPD members struggling with chronic and complex health concerns is by linking members to ECM and appropriate Community Supports. The Alliance goal for this time is to increase enrollment into ECM 5% from 2023 baseline (see Population Health Management Strategy.

The activities and community resources are available are adequate to meet the member needs however it is unclear is all members are fully aware of program offerings.

Enhancement in Resources:

In late 2023 Alliance made the decision to hire a dedicated Director for Enhanced Case Management and Community Supports along with additional program managers. The goal of this dedicated unit is to ensure that all eligible members are identified and receive available services. It is believed that when the program initially launched staffing resources were inadequate however with additional staffing, and dedicated enrollment goals the Alliance will remeasure outcomes to determine if support is not adequate to meet the needs of the population. To meet the needs of increased enrollment the ECM team currently has 3 FTEs and has budgeted an additional 3 FTEs for 2025. Alliance also implemented a robust Care Management System mid 2024 which will help track ECM enrollment, and case management.

The Needs of Members with Serious Mental Illness or Serious Emotional Disturbance - Including analysis by Race/Ethnicity

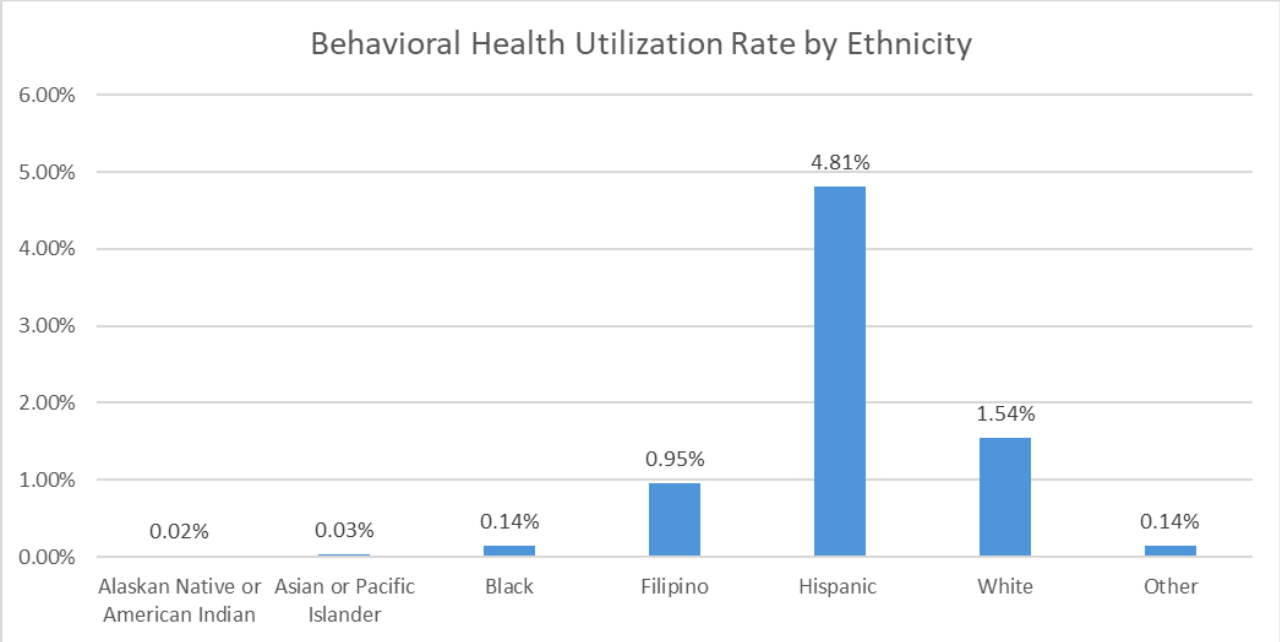
Member utilization of Behavioral Health services is monitored through overall utilization rate, screening and kept appointments. Utilization rate, as described here, is the percentage of members who had at least one mental health visit per year, referred to as the penetration or utilization rate using a combination of Alliance and Carelon Health Options claims. Carelon is contracted with CCAH to provide non-specialty (previously mild to moderate) mental health services. In 2023, 7.69% of Alliance members had at least one mental health visit per year, therefore no change from 2020. Members living in Santa Cruz continue to have the highest rates of utilization of behavioral health services in the both the physical health and behavioral health network settings at 11.89%, Monterey is at 6.20%, and Merced at 6.11% (Table 5). These rates are calculated based on the number of unique utilizers and the average monthly membership by county. Similar methodology is used to calculate utilization by Race/Ethnicity, in Figure 14. Members reporting race as Hispanic proportionally have much higher utilization of services at 4.81%.

Table 5. Behavioral Health Utilization in the Primary Care and Behavioral Health Networks by County, 2023

Program County	Monthly Average Membership	Unique Utilizers	Utilization Rate
Merced	151,636	9,286	6.11%
Monterey	188,485	13,615	6.20%
Santa Cruz	80,434	9,613	11.89%
Total	420,555	32,439	7.69%

Source: Alliance and Carelon Claims Data, 2023

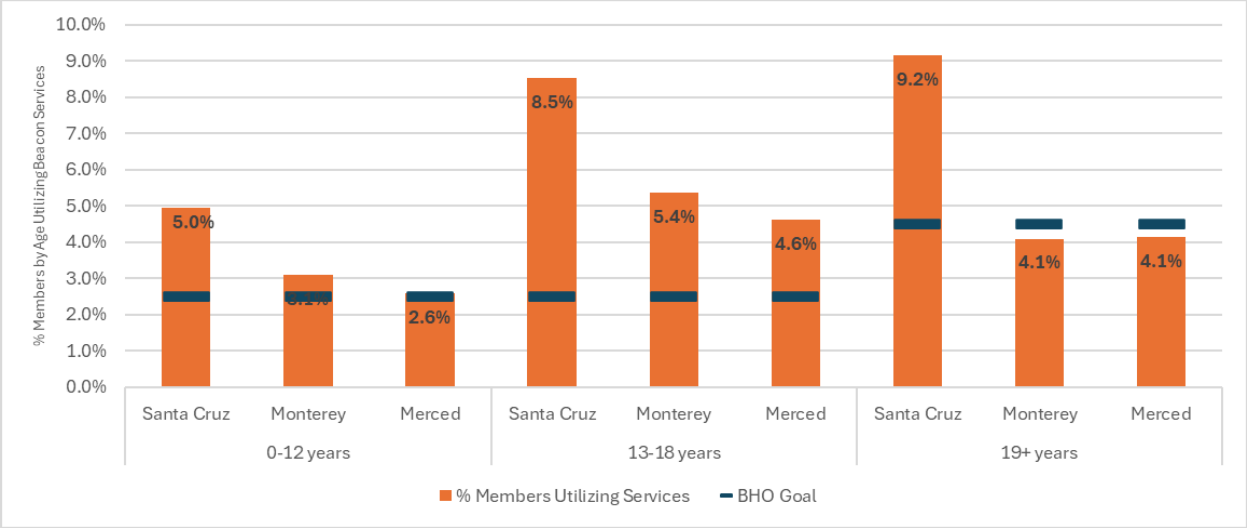
Figure 14. Behavioral Health Utilization Rates (Number of visits per average members per month) by Race/Ethnicity, 2023



Source: Alliance and Claims Data, 2023

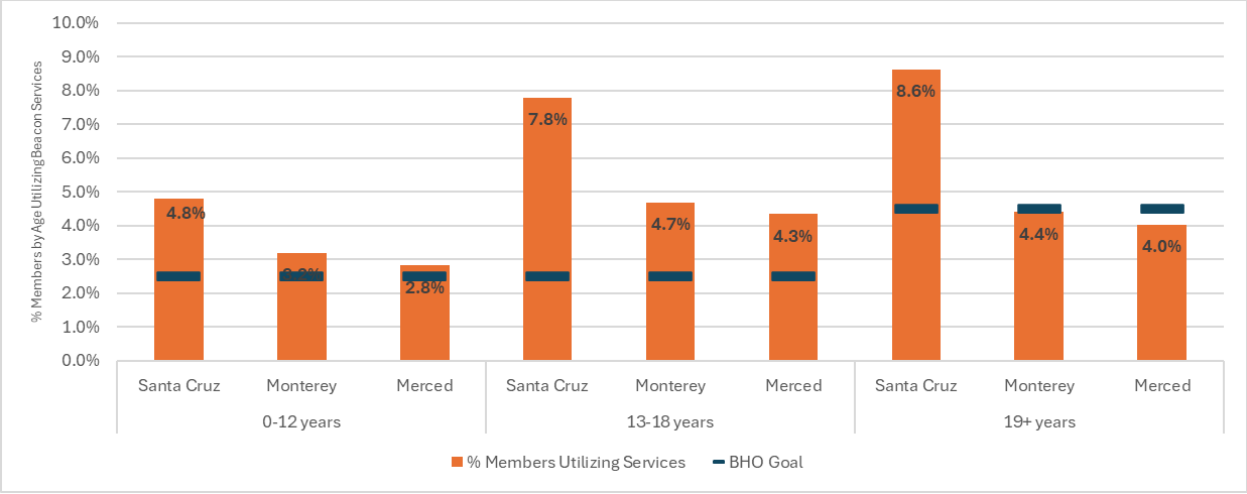
Reviewing Carelon Report there is a similar trend of uptake across the three counties, here displayed by county and age group in Figure 15 for 2022 data and Figure 16 for 2023 data. This data come from the Carelon Report which describes the utilization percentage rates for children and adolescents and for adults are reported by for each county managed by CCAH. Utilization rates reflect a rolling 12-month measurement ending at the Quarter. Utilization percentage is calculated by dividing the number of unique members in each age cohort within each County into the number of members that have received Carelon services from that same County and age cohort within each quarter. Carelon has described the goals for utilization by age group, 2.5-4.0% for 0-12-year-olds and for 13-18-year-olds, and 4.5-6.5% for 19 years and older. The data described in Figure 15 and 16 outlines the percent of members by age and county and indicates (blue bar) the Carelon goal for that age group. Santa Cruz County meets the Carelon goals for all age groups in 2022 and 2023. Monterey and Merced County meets it for the pediatric population but not the adult in 2022 and 2023.

Figure 15. Carelon Health Option Service Utilization by Age Group and County, 2022



Source: Carelon Health Options Reporting, 2022

Figure 16. Carelon Health Option Service Utilization by Age Group and County, 2023



Source: Carelon Health Options Reporting, 2023

While the data is using a five-year period, the demand for services has remained high in Santa Cruz year over year. The actual utilization of services follows the same pattern, highest utilization in Santa Cruz where there is the highest demand, followed by Merced and Monterey with significantly less demand and as our annual report indicates about half the utilization except for the 0–12-year-old population. Regardless, opportunities remain to continue to work towards increased access across all counties and for all age and racial/ethnic groups.

Activities and Resources for Patients with SPMIs

Due to the bifurcated nature of the Mental Health delivery of care system (Specialty Mental Health Services are provided by the county Behavioral Health Departments in which the member lives; non-specialty services are provided by Alliance delegate Carelon), it is easy for these members to fall through the cracks of the system and not get their comprehensive needs met. The primary strategy of the Alliance to support members these members is to connect those members with ECM, under the Severe Mental Illness Population of Focus, or Complex Care Management. ECM/CCM can connect these members to the resources they need including

ongoing Mental Health support, clinical care, and care coordination, as well as other Community Supports and social services they may need (e.g., permanent housing services, short term housing after an inpatient/rehab stay, connection to job opportunities, etc.). The community resources are available are adequate to meet the member needs however it is unclear is all members are fully aware of program offerings. In late 2023 Alliance made the decision to hire a dedicated Director for Enhanced Case Management and Community Supports along with additional program managers. The goal of this dedicated unit is to ensure that all eligible members are identified and receive available services. It is believed that when the program initially launched staffing resources were inadequate however with additional staffing, and dedicated enrollment goals the Alliance will remeasure outcomes to determine if support is not adequate to meet the needs of the population. Additionally due to low utilization, provider, and member feedback the Alliance decided manage Non-Specialty Mental Health, and discontinue its relationship with Carelon effective 7/2025. Services will be integrated within each department however additional staffing resources with Behavioral Health experience will be added. These positions included Behavioral Health Managers in both The Utilization and Care Management Departments as well as dedicated Behavioral Health Medical Director.

While the capacity for ECM service delivery is sufficient across our service area, the issues for utilization and adherence of the program are many. Providers are not always aware of ECM and how to refer their members to the program; in addition, when their member is in the program, providers do not have access to the member care plan. In addition, more stringent data privacy rules around SMI and SUD data make it difficult to share data across the system of care (County Behavioral Health Department, ECM provider, PCP provider, Carelon, and Alliance). The Alliance plans to invest significantly into data sharing systems such as a Qualified Health Information Organization to address this with providers holistically. The Alliance is also working specifically with County Behavioral Health Departments to set up data sharing agreements to ensure these most at risk populations receive appropriate wrap-around services. Lastly, the Alliance is incentivizing PCPs to also participate in Data Sharing and increase education for referral to ECM services

The Needs of Members of Racial or Ethnic Groups

The National Institute of Medicine reviewed the research on the causes of disparities in health care in their report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care[ii]. The report concludes, "Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled." They find that minorities are less likely than whites to receive medically necessary services across a range of health conditions and common procedures. The following are examples compiled by the Office of Minority Health, U.S. Department of Health and Human Services[iii]:

Blacks:

- The death rate for Blacks is generally higher than whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.

Asian Americans:

- Asian Americans contend with numerous factors which may threaten their health. Some negative factors are infrequent medical visits, language and cultural barriers, and lack of health insurance.
- Asian Americans are most at risk for the following health conditions: cancer, heart disease, stroke, unintentional injuries (accidents), and diabetes.

Hispanics:

- Hispanic health is often shaped by factors such as language/cultural barriers, lack of access to preventive care, and the lack of health insurance.
- The Centers for Disease Control and Prevention has cited some of the leading causes of illness and death among Hispanics, which include heart disease, cancer, unintentional injuries (accidents), stroke, and diabetes. Hispanics also have higher rates of obesity than non-Hispanic whites.

The Alliance has done a comparison of Healthy People 2030 goals and targets. The following presents eight Healthy People 2030 (HP2030) objectives which closely match select 2021 Alliance Merced, Santa Cruz, and Monterey counties MCAS measures and the results obtained in survey. Each HP2030 objective is identified, and the target percentage rate given along with the source of information including Alliance 2021 MCAS measure, see results in Table 4. Alliance Merced, Santa Cruz, and Monterey counties measures exceeded HP2030 targets in four of the eight areas reviewed (*). Areas below the HP2030 targets remain the same as previous PNA report and include adolescent health, cervical cancer screening, reduction of an A1c value greater than 9 percent, and timely postpartum care.

Table 6. Select MCAS 2021 Rates Compared to Healthy People 2030 Objectives

Healthy People 2030 Objective	HP2030 Target	Santa Cruz and Monterey Results	Merced County Results
Adolescent Health -AH-01 Increase the proportion of adolescents who have had a wellness checkup in the past 12 months. (Well Child Visits for 12-17-year-olds)	82.6%	**57.3%**	**42.8%**
Cancer -C-09 Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines.	84.3%	**65.6%**	**63.6%**
Diabetes -7 Increase the proportion of persons with diagnosed diabetes whose blood pressure is under control. (MCAS MY 2021)	57.0%	**54.0% ***	**53.3%***
Diabetes – 5 Reduce the proportion of persons with diabetes with an A1c value greater than 9 percent	16.2%	**37.2%**	**43.3%**
Mother, Infant, and Child Health - MICH-08 Increase the proportion of pregnant women who receive early and adequate prenatal care.	80.5%	**93.2%***	**91.7%***
Mother, Infant, and Child Health – 19 Increase the proportion of women giving birth who attend a postpartum care visit with a health care worker	90.8%	**84.9%**	**81.6%**
Nutrition and Weight Status -NWS-05 Increase the proportion of physician office visits made by adult patients who are obese that include counseling or education related to physical activity	32.6%	**79.8%***	**70.6%***
Nutrition and Weight Status -6.3 Increase the proportion of physician visits made by all child or adult patients that include counseling about nutrition or diet	15.2%	**82.5%***	**72.0%***

Sources: Healthy People 2020 (US DHHS, Office of Disease Prevention and Health Promotion) and MCAS measures for MY2021.

MCAS Findings - Adults

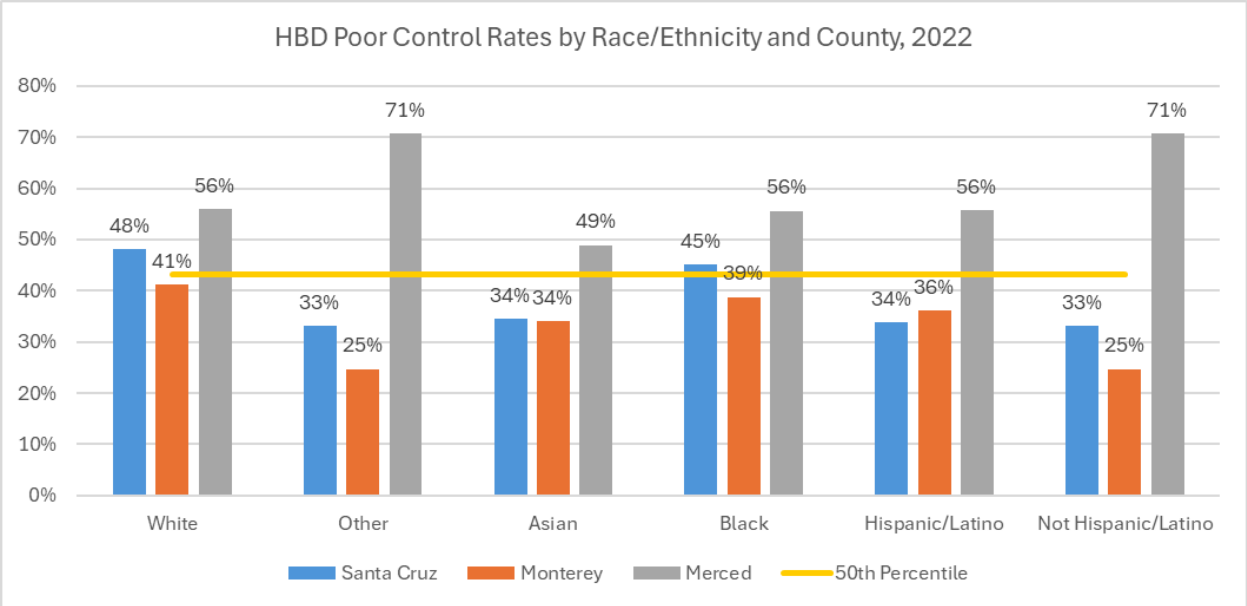
For the adult population, full MCAS MY2022 results are in Appendix B, select findings highlighted in this section for related measures. In 2023, the Alliance's Santa Cruz-Monterey reporting unit for MCAS MY2022 experienced high performance in key measures including HbA1c Poor Control >9% (inverse measure), postpartum care and follow-up after emergency department visit for alcohol and other drug abuse or dependence. The adult population, like the pediatric population, had no measures fell below the minimum performance level. In our Merced reporting unit, we had one high performance level (HPL) in timeliness of prenatal care. Our adult measures falling below the MPL include breast cancer screening and chlamydia screening in women.

In Santa Cruz and Monterey breast cancer screening and postpartum follow-up showed over 5% improvement from the prior year and controlling high blood pressure improved over 10%. The follow-up after emergency department visits for alcohol and other drug abuse or dependence follow-up (FUA), and follow-up after emergency department visit for mental illness (FUM) both showed over a 25% improvement compared to the prior year due to better data exchange from the state on behavioral health carve out data. Merced showed over a 15% improvement for the follow-up after emergency department visit for alcohol and other drug abuse or dependence follow-up, and over 40% improvement for follow-up after emergency department visit for mental illness. For the controlling high blood pressure measure, Santa Cruz/Monterey was able to make a 11% improvement, at 67.40%, with Merced stable at 59.85%, both remaining above the MPL. Data collection continues to be a challenge for the blood pressure readings since most providers have not integrated CPT II codes into their EHRs or have challenges with the billing clearinghouse. We are seeing an increase however, in accepted data through the Provider Portal to supplement provider performance in this measure.

HbA1c Poor Control

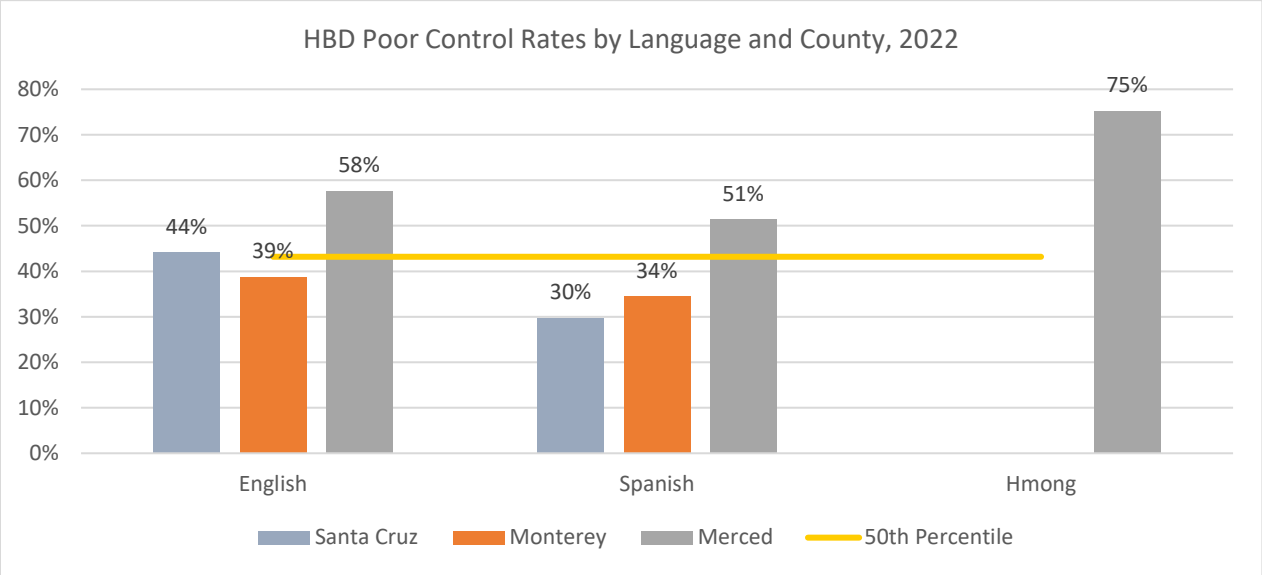
For analysis, the Hemoglobin A1c Control or Patients with Diabetes (HBD) – HbA1c Poor Control (>9%) sub measure was selected due to a high population of members (N=14,877), and impact in overall inpatient stays. Differences across race/ethnicity and county are shown in Figure 17, county and language in Figure 18, and by language and race/ethnicity in Figure 19. To interpret this measure, the lower percentage is the better rate.

Figure 17. Comprehensive Diabetes Care HbA1c: Poor Control >9 (Reverse Measure) By County and Race/Ethnicity, 2022



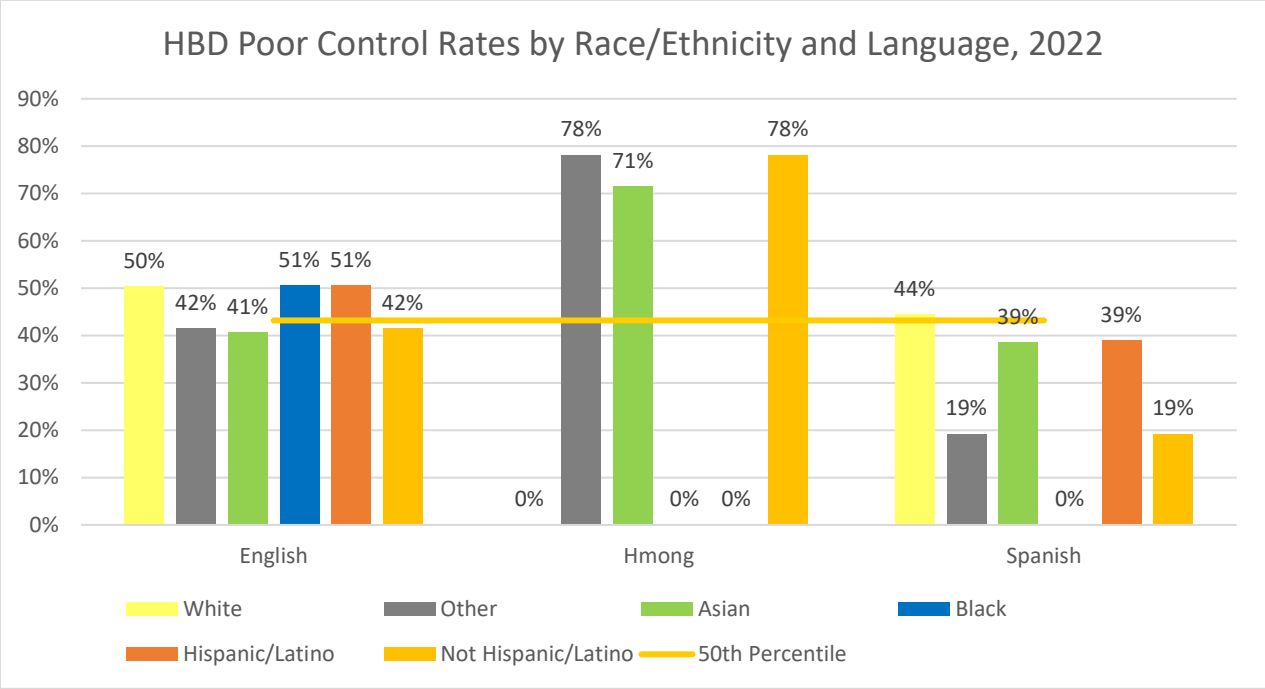
Source: MCAS MY2022 administrative data, direct reference only.

Figure 18. Comprehensive Diabetes Care HbA1c: Poor Control >9 (Reverse Measure) By County and Language, 2022



Source: MCAS MY2022 administrative data. Hmong was not reported as a spoken language for infant members in Santa Cruz/Monterey.

Figure 19. Comprehensive Diabetes Care HbA1c: Poor Control >9 (Reverse Measure) By Language and Race and Ethnicity, 2022



Source: MCAS MY2022 administrative data, direct reference only.
Source: MCAS MY2022 (Administrative data only)

Key Findings of Needs of Racial or Ethnic Groups

Similar to the pediatric assessment, adults in the diabetic HbA1c Poor Control measure showed geographic disparities in Merced County when compared to its neighboring regions of Santa Cruz and Monterey County, with a difference of over 12% across reporting populations, with 38.15% members in poor control in Merced compared to 25.79% in Santa Cruz/Monterey reporting population for MCAS MY2022. We were able to achieve an HPL in Santa Cruz-Monterey for HbA1c poor control with almost a 5% improvement from last year. Looking at the breakdown of administrative data by race and ethnicity, Santa Cruz and Monterey counties had similar rates across most race and ethnicity groups described in Figure 17. Not Hispanic/Latino (25%) and Other (25%) populations in Monterey County have the lowest or best rates of HbA1c Poor Control across the regions. In reverse, the highest rates of poor control were in Not Hispanic/Latino (70%) and Other (70%) populations in Merced County, with White (48%) and Black (45%) members in Santa Cruz County also above the MPL set at 43.19%. In review of the differences by primary language in Figure 18, Spanish speaking members in Santa Cruz had the lowest number of members in poor control at 30%, followed by 34% Spanish speakers in Monterey. Members whose primary language is Hmong had the highest number of members in poor control in Merced County at 75%, with all threshold languages above the MPL in Merced County. Figure 19 shows additional breakdown of Hmong speaking members who identified as Asian (71%), Other (78%) and Not Hispanic/Latino (78%) with the highest poor control rates. In addition to potential health equity concerns among members, this measure may also indicate a lack of the Alliance's access to data as well, as the measure will place anyone without an A1c test or result into the "poor control" category.

As identified in the pediatric population, direct race and ethnicity data is limited because the primary data source from Med-Cal enrollment files generates either race or ethnicity, presenting challenges to analyzing the data by race and ethnicity. Supplemental data sources such as adding in direct race or ethnicity data from the immunization registries has recently been added, but the challenge remains in not having complete information for all members.

Activities and Resources to Assess Disparities in Care

Merced county has 2% or 6,500 Hmong members compared to Monterey, and Santa Cruz has less than 500 members each. In review of the differences by primary language in Figure 18, Spanish speaking members in Santa Cruz had the lowest number of members in poor control at 30%, followed by 34% Spanish speakers in Monterey. Members whose primary language is Hmong had the highest number of members in poor control in Merced County at 75%, with all threshold languages above the MPL in Merced County.

Enhancement in Resources and Activities:

The disparity and clear need of Hmong speaking members was so high, the Alliance intervened specifically with the Hmong population in Merced. Through its grant program the Alliance provided funding to a Hmong-speaking provider with a large population of Hmong-speaking members. The grant funded targeted outreach, and expansion of clinic hours to help target and treat members with poor A1C control. However, this is one single provider who can speak Hmong, and his capacity is limited. CCAH will work with this provider to identify additional barriers that may be impacting the care members are getting to manage their diabetes.

Current activities are not adequate, based on poor control rates of this population. The Alliance needs to focus on development of cultural and linguistically appropriate quality improvement activities to increase care to Hmong speaking members. An activity to enhance resources for the Hmong population will be to work with this grant recipient provider using specific focus groups in 2025, that explore challenges and barriers that the Hmong speaking members face in their diabetes management, which will also provide valuable information to inform the C&L teams on opportunities to increase member awareness of Alliance services including those related to language services. Based on the feedback from the provider, the team will work to identify additional

educational materials and outreach methods (i.e. texting, outreach calls, etc.) that can help member better manage their condition.

Through the community supports initiative, CCAH has adequate community resources to meet the needs of the members. However, the Plan will work to identify potential community partners that can serve as support groups for Hmong speaking members so they can learn how to better manage their diabetes.

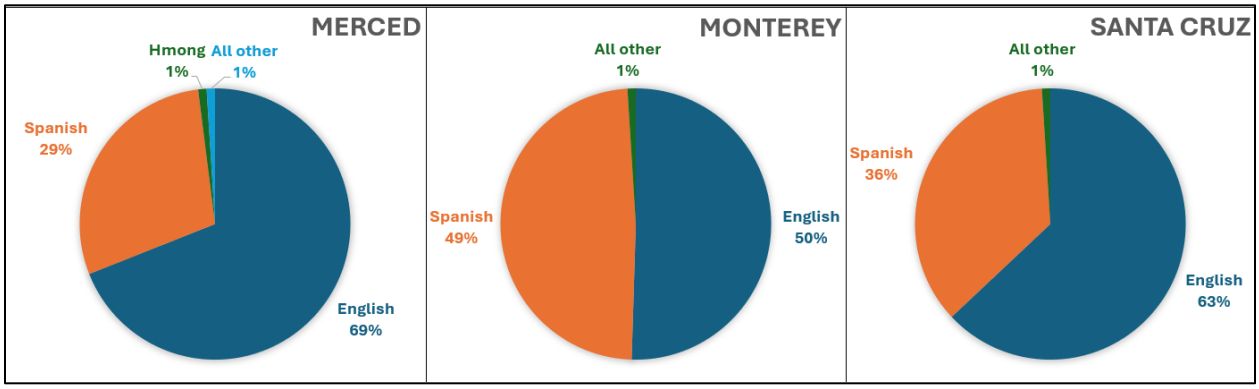
The Needs of Members with Limited English Proficiency

Most Medi-Cal members in Merced, Monterey and Santa Cruz counties identify as Hispanic/Latino (69%), followed by White (14%), Asian/Pacific Islander (13%), Black (2%), and all others (3%). Overall, the number of members who prefer English as their spoken language is 60%, while the percentage of those who'd prefer Spanish 39%, see Figure 20 for county-specific findings. For details about SPD, WCM and Non-SPD populations by spoken language, see Appendix A's tables.

In review of the differences by primary language in Figure 18, Spanish speaking members in Santa Cruz had the lowest number of members in poor control at 30%, followed by 34% Spanish speakers in Monterey. Members whose primary language is Hmong had the highest number of members in poor control in Merced County at 75%, with all threshold languages above the MPL in Merced County.

To identify other potential areas for intervention and needs of our non-English speaking members, further data analysis was completed and is described below.

Figure 20. Alliance Membership Spoken Language by County, 2023



Source: Alliance Membership Data, 2023

In order to assess needs of members with Limited English Proficiency the Alliance Cultural and Linguistic (C&L) team completed Member Experience surveys (N=53) with members who utilized language assistance services with an in-person interpreter during their clinical visits in 2023. This survey allowed members to provide feedback on their experience with the interpreter at their doctor visit and provide recommendations on improvements.

Member feedback was as follows for language assistance services during clinical visits:

- How satisfied were you with the interpreter at your doctor visit?
  - Highly satisfied (75.47%)
  - Satisfied (22.64%)
  - Neutral (1.89%)
- Based on your experience, would you use in-person interpreting services again at your doctor visit?
  - Strong yes (60.38%)

    - Yes (35.85%)
    - Neutral (1.89%)
    - No (1.89%)
- Do you recommend anything that could have improved your experience?
    - 85% shared there were no recommendations.
        - 82% of members that shared no recommendations also commented that the services were excellent.
    - 15% shared recommendations including:
        - Members shared that the interpreters do not always communicate information word for word to the doctors. Some interpreters summarize and member prefers to share information in more detail and not change or shorten it.
        - Member requested the interpreter help with the front office staff upon arrival for the appointment to request updates on appointment wait times.

Assessment of Activities and Resources for Language Services:

Based on survey results overall, members were highly satisfied with the Alliance language assistance services during doctor visits. Member recommendations included ensuring interpreters support all aspects/steps of the visit including check-in at front desk, discussions with the Medical Assistants and discussions with the providers. Additionally, members recommended that interpreters ask the member preferences for example if they would like the interpreter to summarize discussions or interpret all information word for word. The recommendations will be shared with the interpreting services vendors to maintain and support member satisfaction with the services.
The C&L team has incorporated goals to further address needs of members with LEP. Spanish includes increasing utilization of language assistance services by members and providers.

- By June 30, 2025, increase provider utilization of telephonic interpreting services by 5% in comparison to 2024 baseline utilization data.
  By June 30, 2025, increase provider utilization of on-site face-to-face interpreting during medical visits by 5% in comparison to 2024 baseline utilization data.

To achieve utilization goals the C&L team will conduct a minimum of one C&L services training per quarter to ensure that providers and Alliance staff are aware of the Alliance Language Assistance services and how to use them. Additionally, the C&L team will include articles informing members and providers of language assistance services in both the Member Newsletters and the Provider Bulletin. The training will include all the different languages that are covered by the language assistance program. The staff will

The C&L team goals also include gathering consistent member feedback regarding language assistance services.

- By June 30, 2025, member feedback surveys regarding language assistance services will be collected on a quarterly basis.

Member feedback will be collected via phone call surveys in order to support LEP members engagement in the surveys. Phone call surveys will be prioritized in order to ensure that LEP members are able share feedback in their own language over the phone as opposed to writing and mailing a survey. The phone call surveys will be conducted utilizing the Alliance's phone interpreting services so that members that speak languages such as Spanish, Hmong or other languages have an opportunity to provide feedback. The phone interpreting services provides interpreting in over 200 languages.

Activities and resources are adequate to meet the needs of the population. The Plan will, however, conduct additional member outreach will be prioritized to ensure members have the opportunity to provide feedback in their language.

The Plan will also continue reminding members about the availability of language assistance programs through the member newsletters, website, handbook, etc.

The Needs of Relevant Member Subpopulations

One of the most important ways to group data in the Alliance service area is by county – needs are vastly different by county. County specific data is highlighted throughout the above sections. This section will describe other discrepancies between Alliance service area counties. Challenges vary by county however the Alliance has specific interventions made to target underperforming subpopulations throughout its service area.

County Rankings of Population Health

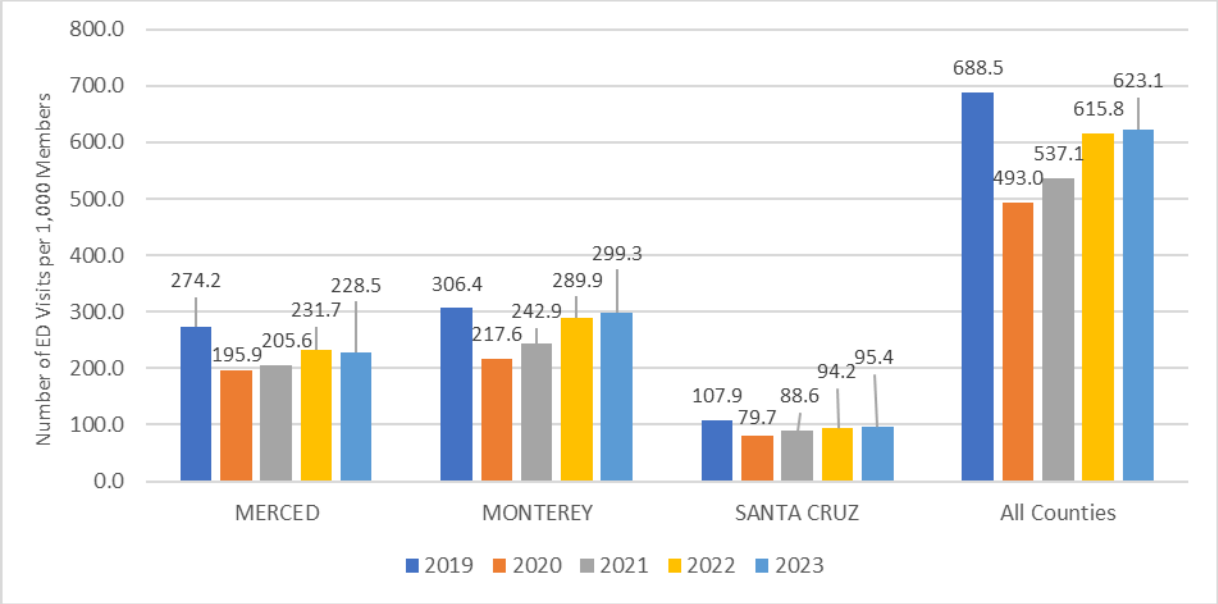
The Robert Wood Johnson Foundation releases an annual report that assesses length of life through rates of premature death as defined as years of potential life lost before the age of 75 (years of potential life lost before age 75 per 100,000 population, age-adjusted to 2000). All geographies have seen an increase in this measure, exacerbated by the pandemic. For this measure, Santa Cruz and Monterey are among the better performers in California (which has a rate of 6,400 years lost), with rates of 5,300 and 5,800 years lost in these counties respectively (years 2019-21 combined), while Merced's rate is significantly higher at 78,500 years lost for the same time period. In terms of overall health rankings, Monterey and Santa Cruz Counties are well above the California age-adjusted death rate, a measure of premature death. Monterey ranks 11th and Santa Cruz ranks 13th in California (out of 58 counties). Merced is 40th, indicating significant differences in death rates and age of death between counties in the Alliance Service Area. We see these general markers of the health of a population also represented in our MCAS and CAHPS results and other data, further supporting a Merced-focused Quality Strategy.

Health factors as measured by the RWJF include health behaviors, clinical care (defined as access to care, quality of care), social and economic factors, and the physical environment, and in this regard, Santa Cruz again ranks above both the state and national average, while Monterey is below the state average, but on par with the national average, and Merced is well below both state and national averages. (Source: RWJ County Rankings, 2024). The County Rankings Population Health model (Figure 4) supports these observations and helps the Alliance align data here; more will be described under Key Findings and Action Plan.

Subpopulation1: Members with Emergency Room Visits

The rate of Emergency Department (ED) utilization among members in this region was 228.5 PKPY in Merced, 299.3 PKPY in Monterey and 95.4 in Santa Cruz (Alliance Claims Data, 2023). Figure 21 includes the PKPY rate of ED visits by County and Year prior, during, and after the pandemic, 2019-2023. All counties had a significant drop in ED utilization that has been increasing to pre-pandemic rates. The increase is less when viewed as a rate given the increase in membership that has occurred over the last three years. By comparison, Figure 5 reports out the rates of total ED visits by quarter in addition to the percent of visits that were considered avoidable or preventable.

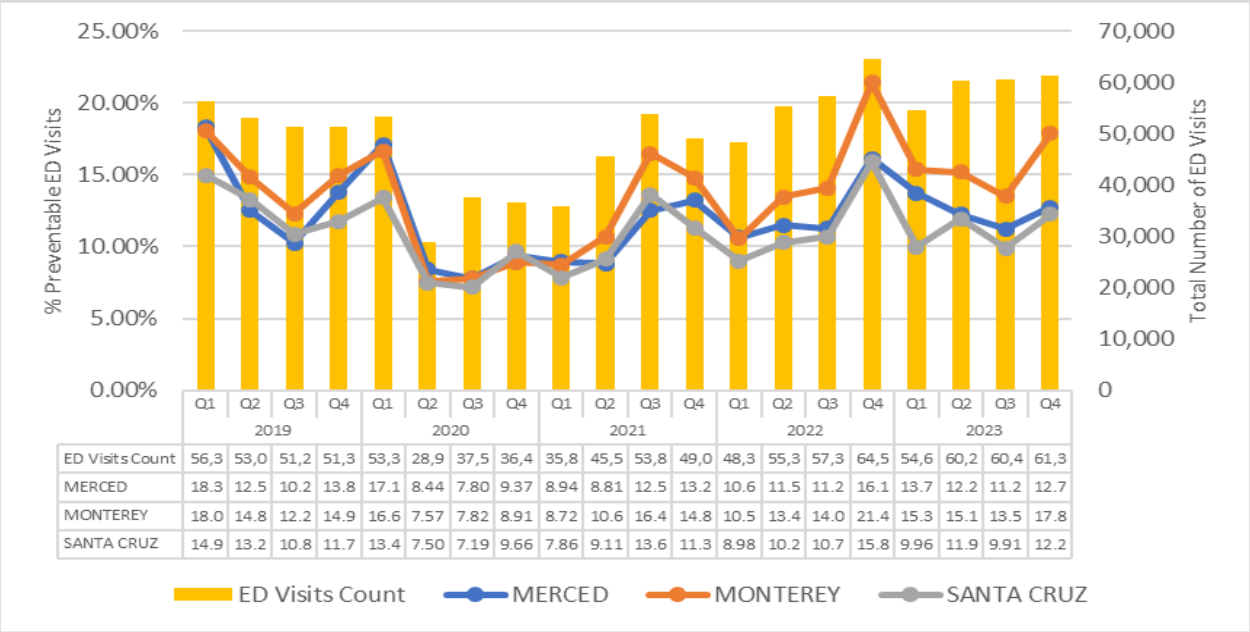
Figure 21. Emergency Department Visit Rates (PKPY) by County and Year, 2019-2023



Source: Alliance Claims Data, 2019-2023

The higher rate in Merced County holds true across most demographics and in the number of visits determined avoidable (1% Merced County, 1% in Monterey, and 1% in Santa Cruz,) based on an algorithm developed by New York University and was further developed by DHCS. The impact from COVID-19 pandemic is visible in 2020, with a slow climb here in Figure 21 with decreased ED utilization across all three counties and is also impacting our avoidable ED rates (Figure 22). Santa Cruz County tended to have the lowest avoidable ED rates throughout the three-year period, with Monterey and Merced counties being more variable from quarter to quarter. The percent of avoidable ED visits in late 2021 have nearly returned to pre-pandemic levels for Monterey and Merced, where they are both above 15%. Our Care Based Incentive (CBI) Program continues to measure the rate of avoidable ED visits and encourages our primary care clinicians to identify members with frequent visits to the ED, especially those with avoidable diagnoses to engage with the primary care medical home and seek care first at the PCP's office, if not available urgent care services are available in many areas if the presenting health concern is appropriate for these settings.

Figure 22. Percent Preventable ED Visits and Total Number ED Visits by County and Year, 2019-2021



	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
ED Visits Count	56,3	53,0	51,2	51,3	53,3	28,9	37,5	36,4	35,8	45,5	53,8	49,0	48,3	55,3	57,3	64,5	54,6	60,2	60,4	61,3
MERCED	18.3	12.5	10.2	13.8	17.1	8.44	7.80	9.37	8.94	8.81	12.5	13.2	10.6	11.5	11.2	16.1	13.7	12.2	11.2	12.7
MONTEREY	18.0	14.8	12.2	14.9	16.6	7.57	7.82	8.91	8.72	10.6	16.4	14.8	10.5	13.4	14.0	21.4	15.3	15.1	13.5	17.8
SANTA CRUZ	14.9	13.2	10.8	11.7	13.4	7.50	7.19	9.66	7.86	9.11	13.6	11.3	8.98	10.2	10.7	15.8	9.96	11.9	9.91	12.2

Source: Claims Data, 2019-2023

The most common ED diagnoses reported for all members during 2023 are shown in Table 7. The primary diagnosis or conditions listed here are less specific and fail to fully illustrate the health conditions of the member. This year COVID-19 diagnoses have left the top ten list compared to 2021, with a doubling of Acute Upper Respiratory Infections of Multiple and Unspecified Sites on the top ten list. This table also displays the use of the ED for common mild acute illnesses that can be addressed by their Primary Care Provider. From this list, there is still an opportunity to create a culture where the PCP is the first point of contact for all mild and moderately acute health issues.

The most common ED diagnoses reported for all members during 2023 are shown in Table 7. Like the diagnosis list from claims data in Table 3, the primary diagnosis or conditions listed here are less specific and fail to fully illustrate the health conditions of the member. This year COVID-19 diagnoses have left the top ten list compared to 2021, with a doubling of Acute Upper Respiratory Infections of Multiple and Unspecified Sites on the top ten list. This table also displays the use of the ED for common mild acute illnesses that can be addressed by their Primary Care Provider. From this list, there is still an opportunity to create a culture where the PCP is the first point of contact for all mild and moderately acute health issues.

Table 7. Top Ten Most Common Primary Emergency Department Visit Diagnoses, 2023

Primary Diagnosis	Count
Acute Upper Respiratory Infections of Multiple and Unspecified Sites	10,092
Abdominal And Pelvic Pain	6827
Other Disorders of Urinary System	4802
Viral Infection of Unspecified Site	4478
Suppurative And Unspecified Otitis Media	4320
Acute Pharyngitis	4009
Dorsalgia	3927
Other Joint Disorder, Not Elsewhere Classified	3747
Abdominal and pelvic pain	3508
Headache	3180

Source: Alliance Claims Data, 2023

Subpopulation 2: Members with Inpatient Admissions

Table 8 provides us with the top ten primary diagnoses for inpatient admissions during Q1 2022-Q2 2023 for our members. In this Table (8), we see mostly maternal child health admissions along with sepsis. These data only reveal the leading diagnosis, not illuminating the complete health status of the member represented by the data. Contrast to the data in 2021, COVID dropped from the second highest inpatient diagnosis to the 9th highest during the time-period, with a drop from diabetes as well as alcohol related disorders previously at 4th and 5th ranking, respectively.

Table 8. Most Common Primary Diagnoses for Inpatient Admissions, All Members, 2022-2023

Diagnosis and Count of Admissions	
Sepsis	4156
Liveborn Infants According to Place of Birth and Type of Delivery	7266
Maternal Care for Abnormality of Pelvic Organs	1163
Other Maternal Diseases Classified Elsewhere but Complicating Pregnancy, Childbirth and the Puerperium	1087
Late Pregnancy	1176
DM	1007
Premature Rupture of Membranes	749
Related Alcohol Disorders	764
COVID-19	719
Hypertensive Heart and Chronic Kidney Disease	717

Source: Alliance Claims Data, Q1 2022-Q2 2023

Inpatient Admissions:

- Data from Table 8 outlines the top ten primary diagnoses for inpatient admissions between Q1 2022 and Q2 2023, predominantly involving maternal child health and sepsis. This data underscores the necessity for enhanced maternal and child health services.
- While COVID-19 admissions have decreased, other conditions like diabetes and alcohol-related disorders still require attention, suggesting a need for continuous monitoring and intervention strategies to support these populations.

Health Issues and Healthcare Utilization:

- According to the California Health Interview Survey (CHIS), prevalent chronic health conditions in the region include:
    - **Asthma**: 13.3% in Merced, 14.2% in Monterey, and 16.3% in Santa Cruz.
    - **Cardiovascular disease**: 7.6% in Merced and Monterey, with 6% in Santa Cruz.
    - **Diabetes**: 12.2% in Merced compared to 7.6% in Monterey and 8.5% in Santa Cruz.
    - **Mental health and substance use**: 23.1% in Merced, 24.5% in Monterey, and 29.7% in Santa Cruz report needing help for emotional or mental health issues or substance use.

Subpopulation 3: Members in Areas with Restricted Access to Care

Each County has one or more Health Professional Shortage Areas (HPSA) as determined by the Health Resources and Services Administration based on geographic area, population characteristics, and/or available facilities (e.g. Federally Qualified Health Centers). HPSA designation indicates a shortage of primary care, mental health, or

dental health providers, which may impact timely access to care. Table 9 shows current HPSA designations within the Alliance Service Area, with the most HPSA designations existing in Merced and Monterey Counties. Both Merced and Monterey are challenged with a shortage of primary care and mental health providers in multiple cities.

	Number of Census Tracts by County			
Service Type, Population and Region	**Merced**	**Monterey**	**Santa Cruz**	**Grand Total**
Dental Health				
LLI – MSSA Ballico	8			8
LI/MFW - MSSA Salinas		32		32
LI – MSSA King City		4		4
ME - MSSA Prunedale		8		8
ME-MSSA Bradley/San Ardo		1		1
Mental Health				
Merced County	63			63
MSSA Big Sur		1		1
MSSA Soledad		8		8
MSSA Santa Cruz			25	25
MSSA Watsonville			8	8
MH MSSA Scotts Valley'			9	9
MSSA King City/San Ardo		4		4
LI/MFW/H/MSSA Marina		13		13
LI/MFW/H/MSSAs/Prunedale/Salinas		40		40
Primary Care				
MSSA Big Sur		1		1
Geographic HPSA Los Banos	8			8
MSSA Atwater	11			11
LI/MFW - MSSA Freedom/Watsonville			8	8
LI/MFW MSSA King City/San Lucas		3		3
LI/MFW - MSSA Ballico/Delhi/Livingston	8			8
LIMSSA Merced/Merced Southwest	25			25
ME – MSSA Soledad		8		8
ME MSSA Le Grand/Planada	2			2
ME-MSSA Salinas		32		32
Grand Total	125	155	50	330

Table 9. HPSA Shortage Areas: Count of Census Tracts by Service Type, County and Population, 2022
Key: MSSA = Medical Service Study Area; LI = Low Income; MFW = Migrant Farm Worker; H=Homeless; ME = Medicaid Eligible Population

Access to healthcare is lower in Monterey and Merced, as indicated by high numbers of medical shortage areas. This led to higher levels of ED utilization, indicating care is not being received at the optimal stage (e.g., Preventative). Alliance strategies to improve this gap are increasing access to providers through workforce recruitment grants, including for paraprofessionals such as Community Health Workers, and care gap closure

clinics for existing providers. In addition, when members are at higher levels of care, the Alliance supports their Transitions of Care from inpatient to community to connect to appropriate support services outside of the inpatient realm.

Issues with Merced Subpopulation

Specifically for our Merced region additional interventions have been developed. Targeted strategies to improve health outcomes in Merced have been prioritized to address the high mortality rates. Monterey (11th) and Santa Cruz (13th) rank well in terms of health outcomes relative to other counties in California, while Merced's rank of 40th highlights systemic challenges. Members in Merced require increased access to quality healthcare services, preventive measures, and community health resources to improve their standing and overall health outcomes. Health factors such as behaviors, clinical care, social and economic determinants, and the physical environment greatly influence population health. Santa Cruz excels in these areas, ranking above both state and national averages. In contrast, Merced falls significantly below these benchmarks, indicating a need for improved healthcare access and quality. Addressing social determinants, such as economic stability and access to healthy environments, is crucial for enhancing health outcomes in Merced.

Assessment of Activities and Resources for All the Subpopulations:

Robust activities have been implemented to address the unique needs of the members of our subpopulations across counties mentioned in the section above. These activities focus on providing outreach, support, and resources to members to increase access, reduce avoidable ed visits, and to improve health outcomes. The programs outlined below specifically target the needs of our identified subpopulations of all counties.

Expansion of Provider Network:
CCAH has a contracting and network development department that continuously works to identify new providers to add to the network. This is an ongoing activity and helps the organization maintain a robust network. In addition, CCAH also offers services through telehealth to members get better access to care.

Care Management Programs

Complex Case Management (CCM) is provided in collaboration with a Primary Care Provider (PCP) to members with high risk or more complex health care needs. CCM member services include comprehensive assessments; promotion of the patient-centered medical home by facilitating a safe connection between our members, their caregivers and their PCPs; care coordination; promotion of health self-management efforts; referrals to community resources; mutually agreed upon, individualized care plans that include targeted interventions; and patient engagement through phone and in-person encounters.[2]

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to care that address the clinical and non-clinical needs of high-cost and/or high-need members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person centered. ECM providers deliver comprehensive care management; care coordination; health promotion; comprehensive transitional care; individual and family support services; and referrals to community social supports. The majority of the SPD population are eligible for Enhanced Case Management , a wraparound service that addresses not only care coordination, but linkage to a variety of social supports and services (e.g., CalFresh, SSI) including the suite of Community Supports the Alliance offers that specifically addresses SPD needs including Environmental Accessibility Adaptations, intended to modify a member's home to allow them to safely remain in the community; Nursing Facility Diversion, intended to find alternative to Skilled Nursing to house members in the community, Respite Service, Personal Care and Homemaker services, and medically tailored meals. The Alliance

strategy to address SPD needs, especially SPD members struggling with chronic and complex health concerns is by linking members to ECM and appropriate Community Supports.

Resources, and staffing are adequate to meet the needs of the members subpopulations however due to the number of members who continue to not access care, utilize services appropriately, and low-quality indicators. In late 2023 Alliance made the decision to hire a dedicated Director for Enhanced Case Management and Community Supports along with additional program managers. The goal of this dedicated unit is to ensure that all eligible members are identified and receive available services. It is believed that when the program initially launched staffing resources were inadequate however with additional staffing, and dedicated enrollment goals the Alliance will remeasure outcomes to determine if support is adequate to meet goals. To help support additional support within Merced County the Quality Department added additional staff to help support grants, and targeted provider partnerships.

Community Resources:

The plan ensures that community resources, such as housing support, SNAP, and WIC services, are integrated into program offerings for eligible members. These resources are adequate to meet the needs of members.

Addressing Gaps in Merced Subpopulation

Targeted health programs addressing chronic conditions, particularly in Merced where the prevalence of diabetes and mental health issues is concerning. Increased access to preventive care and chronic disease management services will be essential for improving the health status of members across these counties. Interventions include a Workforce Support for Care Gap Closure grant funding, which provides monetary support pay for locum providers to expand clinic hours, open or add additional walk in hours, and expand access for working parents with school age children. This support has also provided funding for purchase of point of care lead testing equipment to better co-locate care opportunities. The Alliance has also prioritized support in Merced County through the Provider Partnership Program, linking quality improvement and population health staff along with medical director support with five provider organizations in Merced County with the largest member linkage to leverage quality improvement activities focusing on pediatric measures below the 50th percentile. The Alliance also launched a project from 2023-2026 aimed at increasing well visits for Hispanic members in the most rural areas in Merced County that showed geographic disparities for W30-6. In an effort for future access, the Alliance is also working to bring mobile units capable of providing immunizations, and well care visits outside of the traditional clinic setting.

Appendices

APPENDIX A: Membership Tables

Tables 1 A-D. Non-SPD and Non-WCM Members for December 2023

A. Plan's Non SPD and Non WCM Members by Age Group

Age Group	Member Numbers	% of Total Membership
< 1	6,224	1.79%
01-09	73,664	21.19%
10-19	89,336	25.70%
20-44	124,251	35.75%
45-64	53,286	15.33%
65-74	814	0.23%
75-84	12	0.00%
85+	9	0.00%
Grand Total	**347,596**	100.00%

B. Plan's Non SPD and Non WCM **Members by Age Group and Ethnicity for December 2023**

Ethnicity	Age Group	Member Numbers
Black	<1	47
	01-09	951
	10-19	1,460
	20-44	2,846
	45-64	1,056
-	65-74	13
Black Total		**6,373**
All Others	<1	97
	01-09	1,345
	10-19	1,189
	20-44	2,860
	45-64	1,219
	65-74	40
	75-84	-
	85+	-
All Others Total		**6,750**
Asian or Pacific Islander	<1	2,105
	01-09	13,794
	10-19	5,681

	20-44	14,540
	45-64	6,848
	65-74	140
	75-84	2
	85+	-
Asian or Pacific Islander Total		**43,110**
White	<1	259
	01-09	5,151
	10-19	7,574
	20-44	18,835
	45-64	10,078
	65-74	107
	75-84	1
	85+	2
White Total		**42,007**
Hispanic	<1	3,701
	01-09	52,252
	10-19	73,242
	20-44	84,939
	45-64	34,029
	65-74	513
	75-84	9
	85+	7
Hispanic Total		**248,692**
Not Provided	<1	15
	01-09	171
	10-19	190
	20-44	231
	45-64	56
	65-74	1
Not Provided Total		**664**
Grand Total		**347596**

C. Plan's Non SPD and Non WCM **Members by Age Group and Spoken Language for December 2023**

Spoken Language	Age Group	Member Numbers
English	<1	3,654
	01-09	43,002
	10-19	42,852
	20-44	87,641
	45-64	25,929

	65-74	259
	75-84	4
	85+	2
English Total		**203,343**
Hmong	<1	14
	01-09	192
	10-19	386
	20-44	378
	45-64	208
	65-74	2
	75-84	-
	85+	-
Hmong Total		**1,180**
Other	<1	15
	01-09	189
	10-19	271
	20-44	499
	45-64	648
	65-74	52
	75-84	-
	85+	1
Other Total		**1,675**
Spanish	<1	2,541
	01-09	30,281
	10-19	45,827
	20-44	35,733
	45-64	26,501
	65-74	501
	75-84	8
	85+	6
Spanish Total		**141,398**
Grand Total		**347596**

D. Plan's Non SPD and Non WCM **Members by Age Group and County for December 2023**

County	**Age Group**	**Member Numbers**
MERCED	<1	2,207
	01-09	27,625
	10-19	33,234
	20-44	44,862
	45-64	17,426
	65-74	187
	75-84	6
	85+	3

MERCED Total		**125,550**
MONTEREY	<1	3,111
	01-09	35,280
	10-19	42,298
	20-44	54,242
	45-64	22,971
	65-74	429
	75-84	5
	85+	5
MONTEREY Total		**158,341**
SANTA CRUZ	<1	906
	01-09	10,759
	10-19	13,804
	20-44	25,147
	45-64	12,889
	65-74	198
	75-84	1
	85+	1
SANTA CRUZ Total		**63,705**
Grand Total		**347,596**

Table 2. A-E. SPD Population

A. Plan's SPD Members by Age Group for December 2023		
Age Group	**Member Numbers**	**% of Total Membership**
< 1	10	0.07%
01-09	1,269	8.54%
10-19	1,873	12.60%
20-44	3,928	26.43%
45-64	4,139	27.85%
65-74	2,028	13.65%
75-84	1,120	7.54%
85+	494	3.32%
Grand Total	**14,861**	**100.00%**

B. Plan's SPD Members by Ethnicity for December 2023

Ethnicity	Member Numbers	% of Total Membership
African American	734	4.94%
All Others	477	3.21%
Asian or Pacific Islander	2,995	20.15%
Caucasian	3,010	20.25%
Hispanic	7,633	51.36%
Not Provided	12	0.08%
Grand Total	**14,861**	**100.00%**

C. Plan's SPD Members by Member's Spoken Language for December 2023

Spoken Language	Member Numbers	% of Total Membership
English	9,039	60.82%
Hmong	235	1.58%
Other	710	4.78%
Spanish	4,877	32.82%
Grand Total	**14,861**	**100.00%**

D. Plan's SPD Members by Program County for December 2023

Program County	Member Numbers	% of Total Membership
Merced	6,240	41.99%
Monterey	5,627	37.86%
Santa Cruz	2,994	20.15%
Grand Total	**14,861**	**100.00%**

E. Plan's SPD Members by Gender for December 2023

Program County	Member Numbers	% of Total Membership
F	7,137	48.03%
M	7,724	51.97%

Grand Total	**14,861**	**100.00%**

Tables 3 A-F. Whole Child Model (WCM) Membership

A. Plan's WCM Members by Age Group for December 2023

Age Group	Member Numbers	% of Total Membership
<1	286	4.15%
01-09	2,800	40.66%
10-19	3,477	50.49%
20-44	324	4.70%
Grand Total	**6,887**	**100.00%**

B. Plan's WCM Members by Ethnicity for December 2023

Ethnicity	Member Numbers	% of Total Membership
African American	79	1.15%
All Others	103	1.50%
Asian or Pacific Islander	918	13.33%
Caucasian	587	8.52%
Hispanic	5,194	75.42%
Not Provided	6	0.09%
Grand Total	**6,887**	**100.00%**

C. Plan's WCM Members by Member's Spoken Language for December 2023

Spoken Language	Member Numbers	% of Total Membership
English	3,597	52.23%
Hmong	21	0.30%
Other	23	0.33%
Spanish	3,246	47.13%
Grand Total	**6,887**	**100.00%**

D. Plan's WCM Members by Program County for December 2023

Program County	Member Numbers	% of Total Membership
Merced	2,594	37.67%
Monterey	3,276	47.57%
Santa Cruz	1,017	14.77%
Grand Total	**6,887**	**100.00%**

E. Plan's WCM Members by Gender for December 2023

Program County	Member Numbers	% of Total Membership
F	3,314	48.12%
M	3,573	51.88%
Grand Total	**6,887**	**100.00%**

Tables 4 A-F. Entire Population

A. Plan's Members by Age Group by December 2023

Age Group	Member Numbers	% of Total Membership
<1	6,511	1.60%
01-09	77,312	18.97%
10-19	94,147	23.10%
20-44	131,240	32.21%
45-64	64,748	15.89%
65-74	20,588	5.05%
75-84	9,300	2.28%
85+	3,647	0.89%
Grand Total	**407,493**	100.00%

B. Plan's Members by Ethnicity and Age Group for December 2023

Ethnicity	Age Group	Member Numbers	% of Total Membership
Black	<1	48	0.01%
	01-09	992	0.24%

	10-19	1,555	0.38%
	20-44	3,221	0.79%
	45-64	1,814	0.45%
	65-74	629	0.15%
	75-84	140	0.03%
	85+	48	0.01%
Black Total		**8,447**	**2.07%**
All Others	<1	104	0.03%
	01-09	1,419	0.35%
	10-19	1,258	0.31%
	20-44	3,009	0.74%
	45-64	1,582	0.39%
	65-74	535	0.13%
	75-84	207	0.05%
	85+	62	0.02%
All Others Total		**8,176**	**2.01%**
Asian or Pacific Islander	<1	2,210	0.54%
	01-09	14,492	3.56%
	10-19	6,265	1.54%
	20-44	15,909	3.90%
	45-64	8,596	2.11%
	65-74	3,659	0.90%
	75-84	1,897	0.47%
	85+	746	0.18%
Asian or Pacific Islander Total		**53,774**	**13.20%**
White	<1	276	0.07%
	01-09	5,399	1.32%
	10-19	8,100	1.99%
	20-44	20,577	5.05%
	45-64	13,932	3.42%
	65-74	4,748	1.17%
	75-84	1,753	0.43%
	85+	683	0.17%
White Total		**55,468**	**13.61%**
Hispanic	<1	3,858	0.95%
	01-09	54,835	13.46%
	10-19	76,774	18.84%
	20-44	88,261	21.66%
	45-64	38,605	9.47%
	65-74	10,966	2.69%
	75-84	5,297	1.30%

	85+	**2,106**	**0.52%**
Hispanic Total		**280,702**	**68.89%**
Race Not Provided	<1	15	0.00%
	01-09	175	0.04%
	10-19	195	0.05%
	20-44	263	0.06%
	45-64	219	0.05%
	65-74	51	0.01%
	75-84	6	0.00%
	85+	2	0.00%
Not Provided Total		**926**	**0.23%**
Grand Total		**407,493**	**100.00%**

C. Plan's Members by County and Age Group for December 2023

County	Age Group	Member Numbers	% of Total Membership
MERCED	<1	2,306	0.57%
	01-09	29,071	7.13%
	10-19	35,156	8.63%
	20-44	47,627	11.69%
	45-64	21,937	5.38%
	65-74	6,865	1.68%
	75-84	3,227	0.79%
	85+	1,214	0.30%
MERCED Total		**147,403**	**36.17%**
MONTEREY	<1	3,258	0.80%
	01-09	37,023	9.09%
	10-19	44,378	10.89%
	20-44	56,840	13.95%
	45-64	27,227	6.68%
	65-74	8,642	2.12%
	75-84	3,987	0.98%
	85+	1,667	0.41%
MONTEREY Total		**183,022**	**44.91%**
SANTA CRUZ	<1	947	0.23%
	01-09	11,218	2.75%
	10-19	14,613	3.59%
	20-44	26,773	6.57%
	45-64	15,584	3.82%

	65-74	5,081	1.25%
	75-84	2,086	0.51%
	85+	766	0.19%
SANTA CRUZ Total		**77,068**	**18.91%**
Grand Total		**407,493**	**100.00%**

D. Plan's Members by Spoken Language and Age Group

Spoken Language	**Age Group**	**Member Numbers**	**% of Total Membership**
English	<1	3,831	0.94%
	01-09	45,151	11.08%
	10-19	45,407	11.14%
	20-44	92,973	22.82%
	45-64	34,589	8.49%
	65-74	10,008	2.46%
	75-84	3,614	0.89%
	85+	1,357	0.33%
English Total		**236,930**	**58.14%**
Hmong	<1	14	0.00%
	01-09	203	0.05%
	10-19	407	0.10%
	20-44	446	0.11%
	45-64	397	0.10%
	65-74	188	0.05%
	75-84	96	0.02%
	85+	40	0.01%
Hmong Total		**1,791**	**0.44%**
Other	<1	18	0.00%
	01-09	212	0.05%
	10-19	296	0.07%
	20-44	713	0.17%
	45-64	1,056	0.26%
	65-74	914	0.22%
	75-84	682	0.17%
	85+	368	0.09%
Other Total		**4,259**	**1.05%**
Spanish	<1	2,648	0.65%
	01-09	31,746	7.79%
	10-19	48,037	11.79%

	20-44	37,108	9.11%
	45-64	28,706	7.04%
	65-74	9,478	2.33%
	75-84	4,908	1.20%
	85+	1,882	0.46%
Spanish Total		**164,513**	**40.37%**
Grand Total		**407,493**	**100.00%**

E. Plan's Members by Gender and Age Group for December 2023			
Gender	**Age Group**	**Member Numbers**	**% Total Membership**
F	<1	3,241	0.80%
	01-09	38,092	9.35%
	10-19	46,059	11.30%
	20-44	75,870	18.62%
	45-64	35,096	8.61%
	65-74	11,396	2.80%
	75-84	5,697	1.40%
	85+	2,397	0.59%
F Total		**217,848**	**53.46%**
M	<1	3,270	0.80%
	01-09	39,220	9.62%
	10-19	48,088	11.80%
	20-44	55,370	13.59%
	45-64	29,652	7.28%
	65-74	9,192	2.26%
	75-84	3,603	0.88%
	85+	1,250	0.31%
M Total		**189,645**	**46.54%**
Grand Total		**407,493**	**100.00%**

Table 5: A. Household Language Membership MY2023

Member Spoken Language	# of Members	# of Households
English	225,383	140,994
Spanish	157,863	73,407
Hmong	1,437	704
Panjabi; Punjabi	448	311
Arabic	347	207
Vietnamese	320	223

Other Non-English	246	198
Mandarin	187	130
No Valid Data Reported	186	186
Tagalog	166	135
Russian	107	75
Cantonese	106	82
Farsi	99	63
Mien	87	76
Lao	72	58
Portuguese	71	51
Korean	66	56
American Sign Language	44	43
Cambodian	37	31
Hindi	33	24
Thai	25	23
No response, Client declined t	24	22
Chinese	22	16
Samoan	17	17
Undetermined	14	11
Other Sign Language	8	8
French	7	7
Japanese	4	3
Ilocano	4	4
Ukrainian	3	3
Armenian	3	3
Italian	2	1
Hebrew	2	2
Polish	1	1

Appendix B: MCAS MY2022 Results

Central California Alliance for Health
NCQA HEDIS Measures - MY2022 Rates

				MY2022 Final Hybrid Rates		MY2022 vs. MY2021 %Δ		MY2022 MCAS Benchmarks (Based on MY2021 Results)	
	Measure Acronym	Held to MPL MY2022	Performance Measure	SCMON	MERC	SCMON %Δ	MERCED %Δ	50th Percentile	90th Percentile
Hybrid Measures	CBP	Y	Controlling High Blood Pressure	67.40%	59.85%	11.41% ↗	0.83% ↗	59.85	69.19
	CCS	Y	Cervical Cancer Screening	65.69%	61.08%	3.99% ↗	-1.69% ↘	57.64	66.88
	HBD	Y	HbA1c- Poor >9 *(inverse measure, lower rate better)*	25.79%	38.15%	-4.88% ↘	-3.58% ↘	39.90	30.90
	CIS-10	Y	Childhood Immunizations - Combo 10	51.09%	16.06%	0.11% ↗	-2.19% ↘	34.79	49.76
	IMA-2	Y	Immunizations for Adolescents - Combo 2	56.48%	33.09%	1.96% ↗	-4.62% ↘	35.04	48.42
	PPC-PRE	Y	Timeliness of Prenatal	91.30%	92.21%	2.65% ↗	-0.49% ↘	85.40	91.89
	PPC-PST	Y	Postpartum Follow Up	95.65%	81.02%	5.26% ↗	-3.16% ↘	77.37	84.18
	LSC	Y	Lead Screening in Children	78.83%	46.47%	N/A	N/A	63.99	79.57
			Below 50th percentile benchmark	0	3				
			Above 50th percentile benchmark	4	4				
			Above 90th percentile benchmark	4	1				

				MY2022 Final Admin Rates		%Δ MY2022 - MY2021		MY2022 MCAS Benchmarks (Based on MY2021 Results)	
	Measure Acronym	Held to MPL MY2022	Performance Measure	SCMON	MERC	SCMON %Δ	MERCED %Δ	50th Percentile	90th Percentile
Admnistrative Measures	BCS	Y	Breast Cancer Screening	60.39%	49.65%	6.43% ↗	-0.45% ↘	50.95	61.27
	CHL	Y	Chlamydia Screening in Women	61.39%	52.56%	0.39% ↗	1.77% ↗	55.32	67.84
	FUA - 30 Day	Y	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	37.35%	22.48%	27.68% ↗	16.94% ↗	21.24	32.38
	FUM- 30 Day	Y	Follow-Up After Emergency Department Visit for Mental Illne	60.67%	70.72%	34.15% ↗	40.52% ↗	54.51	72.01
	W30-2+	Y	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits	77.78%	58.09%	4.88% ↗	2.95% ↗	65.83	78.07
	W30-6+	Y	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.23%	36.72%	11.14% ↗	5.66% ↗	55.72	67.56
	WCV	Y	Child and Adolescent Well-Care Visits	60.15%	45.64%	3.86% ↗	4.45% ↗	48.93	62.70
			Count Below 50th	0	5				
			Count Above 50th	6	2				
			Count Above 90th	1	0				
			*(NB) No benchmark for Measurement Year	0	0				

				MY2022 Final Admin Rates		%Δ MY2022 - MY2021		MY2022 MCAS Benchmarks	
	Measure Acronym	Held to MPL?	Performance Measure	SCMON	MERC	SCMON %Δ	MERCED %Δ	50th Percentile	90th Percentile
Administrative Measures	AAP	N	Adults' Access to Preventive/Ambulatory Health Services	68.67%	69.59%	NA	NA	76.50%	84.53%
	ADD-C&M	N	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	40.30%	49.06%	-8.76% ↘	14.06% ↗	51.78%	62.96%
	ADD-Init	N	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	41.14%	41.84%	-3.83% ↘	0.75% ↗	39.78%	50%
	AMB-ED	N	Emergency Department Visits/1000MM	45.59%	42.96%	9.20% ↗	6.47% ↗	45.64%	59.14%
	AMM-Acute	N	Antidepressant Medication Management - Effective Acute Phase Treatment	64.40%	65.05%	3.37% ↗	3.61% ↗	60.44%	71.26%
	AMM-Cont	N	Antidepressant Medication Management - Effective Continuation Phase Treatment	47.07%	44.92%	4.90% ↗	3.67% ↗	42.96%	56.24%
	AMR	N	Asthma Medication Ratio	78.79%	79.92%	1.54% ↗	7.56% ↗	64.26%	74.21%
	APM-B	N	Blood Glucose Testing	67.48%	67.59%	67.48% ↗	34.26% ↗	54.36%	66.94%
	APM-BC	N	Blood Glucose and Cholesterol Testing	43.69%	34.48%	43.69% ↗	34.48% ↗	34.30%	51.69%
	APM-C	N	Cholesterol Testing	43.69%	34.48%	43.69% ↗	1.15% ↗	36.17%	53.75%
	COL	N	Colorectal Cancer Screening	24.53%	18.76%	NA	NA	NA	NA
	DRR-E	N	Depression Remission or Response for Adolescents and Adults	0.00%	0.00%	NA	NA	NA	NA
	DSF-F	N	Depression Screening and Follow-Up for Adolesecents and Adults	0.12%	0.11%	NA	NA	NA	NA
	FUA - 7 Day	N	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	25.74%	16.06%	20.29% ↗	12.45% ↗	13.39%	21.97%
	FUM - 7 Day	N	Follow-Up After Emergency Department Visit for Mental Illness	46.35%	64.02%	32.45% ↗	40.19% ↗	40.38%	60.58%
	PCR	N	Plan All Cause Readmissions	16.58%	15.31%	-1.11% ↘	-0.22% ↘	0.996	0.8511
	PDS-E	N	Postpartum Depression Screening and Follow Up	0.00%	0.00%	NA	NA	NA	NA
	PND-E	N	Prenatal Depression Screening and Follow-Up	0.00%	0.00%	NA	NA	NA	NA
	POD	N	Pharmacotherapy for Opiod Use Disorder	20.62%	44.44%	NA	NA	28.05%	41.42%
	PRS-E	N	Prental Immunization Status	50.24%	23.97%	NA	NA	19.93%	39.12%
	SSD	N	Diabetes Screening for Schizophrenia or Bipolar Disorder Using Antiphsychotic Meds	79.47%	79.31%	-18.15% ↘	-20.69% ↘	79.36%	86.28%

Count Below 50th
Count Above 50th
Count Above 90th
Small Denominator Measure <100

References

[1] 2024 ICD-10-CM Diagnosis Code Z65.8: Other specified problems related to psychosocial circumstances (icd10data.com). 5/31/2024.

[1] Institute of Medicine (IOM). (2002). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Retrieved from https://www.nap.edu/read/12875/chapter/1

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[i] 2024 ICD-10-CM Diagnosis Code Z65.8: Other specified problems related to psychosocial circumstances (icd10data.com). 5/31/2024.

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