COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

CAC Selection Committee Agenda

June 17, 2025
10:00 a.m.-11:00 a.m.

Microsoft Teams

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Meeting ID: 228 145 447 339
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512 W. Aten Road, Imperial, CA 92251
All supporting documentation is available for public review at https://chpiv.org

Committee Members	Representing	Present
Dr. Carlos Ramirez, Chair	Senior Consultant DRCR	
Mersedes Martinez	El Centro Regional Medical Center	
Joab Gonzales	San Diego Regional Center	
Mario Jimenez	Volunteers of America	
Isabel Andrade	Imperial Valley Food Bank	
Diana Rosas	Imperial County Social Services	
Marylou Garcia	Imperial County Social Services	
Jose Lepe	Imperial County Behavioral Health	
Ana Contreras	Imperial County Behavioral Health	

CHPIV Staff Attendees:

- Daniel O'Campo, Interim CAC Coordinator
- Donna Ponce, Commission Clerk
- Dr. Gordon Arakawa, Chief Medical and Health Equity Officer
- Julia Hutchins, Chief Operating Officer

1. CALL TO ORDER — **Dr. Carlos Ramirez**

A. Roll Call — Donna Ponce

2. **INFORMATION & DISCUSSION** — **Dr. Carolos Ramirez**
    A. Regulatory Review (APL 25-009) — Julia Hutchins
        i. Membership additions — Dr. Carlos Ramirez
        ii. Charter updates — Dr. Carlos Ramirez

    B. Review CAC Demographic Report — Dr. Gordon Arakawa
        i. CAC Membership

    C. Other new or old business

3. PUBLIC COMMENT

Public Comment is limited to items NOT listed on the agenda. This is an opportunity for members of the public to address the Committee on any matter within the Committees' jurisdiction. Any action taken as a result of public comment shall be limited to the direction of staff. When addressing the Committee, state your name for the record prior to providing your comments. Please address the Committee as a whole, through the Chairperson. Individuals will be given three (3) minutes to address the Committee.

4. **ACTION**
    A. Motion to approve adding Community Advocate Seat filled by Karen Montano, Chief Operating Officer from the Chamber of Commerce for Greater Brawley.
    B. Motion to approve adding Local Education Agencies Seat filled by Lauren Wren, Imperial County Office of Education
    C. Motion to approve updates to the Committee Charter
    D. Motion to approve CAC Member Appointments

5. COMMITTEE MEMBER REMARKS

6. ADJOURNMENT
    A. Next Meeting TBD

CAC Selection Committee Meeting Materials

1. Committee Charter revisions
2. CAC membership list
3. CAC membership criteria
4. CAC demographic report
5. DHCS All Plan Letter: Community Advisory Committee

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: May 12, 2025

ALL PLAN LETTER 25-009

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: COMMUNITY ADVISORY COMMITTEE

PURPOSE:

The purpose of this All Plan Letter (APL) is to summarize the Community Advisory Committee (CAC) requirements and provide Medi-Cal managed care plans (MCP) with information and guidance regarding their responsibility to implement, maintain, and maximize Member, family, and community engagement through the CAC.

BACKGROUND:

While the MCP Contract includes detailed requirements on the duties and expectations of the CAC, this APL provides additional clarification on CAC requirements including DHCS' monitoring process of the CACs.[1]

Pursuant to Title 22 California Code of Regulations (CCR) section 53876(c), the Department of Health Care Services (DHCS) requires MCPs to maintain a CAC that serves to inform the development and implementation of the MCP's Cultural and Linguistically Appropriate Services (CLAS) program.[2] Additionally, per Title 42 Code of Federal Regulations (CFR) section 438.110(b), the CAC must include at least a reasonably representative sample of the Long Term Supports and Services (LTSS) population within the CAC.[3] The CAC can be leveraged as a forum to better engage Members in the care they receive through their MCPs. DHCS seeks to elevate the role of the CAC by clarifying its role and member composition and prescribe the MCP's role in providing support for CAC members through process enhancements and new engagement channels designed to empower Members to become more active participants in their care.

[1] MCP Contract, Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees). The MCP boilerplate contract is available at: https://www.dhcs.ca.gov/provgovpart/Documents/2024- Managed-Care-Boilerplate-Contract.pdf.
[2] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[3] The CFR is searchable at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-C/section-438.110

POLICY:

CAC Selection Committee Composition and Duties

MCPs, in consultation with their Health Equity Officer, must convene a selection committee tasked with selecting the members of the CAC and providing the recommendations to the MCP. The CAC selection committee must select all of its CAC members no later than 180 calendar days from the effective date of the MCP Contract. MCPs must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC. If an MCP operates in multiple counties, it may have one or more selection committees as necessary to carry out the duties of the CAC selection committee listed in the APL. As a guide, the CAC selection committee should include:

- Persons who sit on the MCP's Governing Board as applicable and/or the MCP Executive Committee which represent the Medi-Cal line of Business
- Providers who represent Safety Net Providers including Federally Qualified Health Centers/Rural Health Centers,
- Indian Health Care Providers (IHCP), as applicable;
- Behavioral Health Providers;
- Person(s) who represent Regional Centers;
- Local Education Agencies;
- Dental Providers;
- Community Based Organizations
- Home and Community Based Service Providers; and
- Persons who are representatives of each county within the MCP's Service Area, adjusting for changes in membership diversity.

The CAC selection committee is not expected to replace existing CAC selection-type committees if those existing committees meet the requirements and expectations for the CAC selection committee noted below. The number of persons on the CAC selection committee should be sufficient to achieve the goal of selecting a diverse and reasonably representative CAC. The CAC selection committee is responsible for selecting new CAC members and/or replacing former CAC members whose position has been vacated. If a CAC member resigns or is asked to resign, the CAC selection committee must make its best effort to promptly replace a vacant CAC seat within 60 calendar days of the CAC vacancy. To support filling vacancies, the MCP can schedule an additional CAC selection committee meeting, use online voting, or use other methods to fill the vacant position. MCPs must ensure that CAC membership continues to be reflective of, and responsive to, the MCP's Service Area demographics. The CAC selection committee must make good faith efforts to ensure:

- CAC membership is composed primarily of the MCP's Members;
- CAC membership is reasonably reflective of the general MCP Member population in the MCP's Service Area;

- Adolescents and/or parents and/or caregivers of children, as appropriate, are represented on the CAC;
- Current/former foster youth and/or parents/caregivers of current/former foster youth, as appropriate, are represented on the CAC;
- MCP Members who receive LTSS, and/or individuals representing those MCP Members, as appropriate, are represented on the CAC;
- Representatives from IHCPs are represented on the CAC; and
- Diverse and hard-to-reach populations are reasonably represented on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with limited English proficiency (LEP), diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

The recommendations made by the selection committee are advisory in nature and not binding. The MCP retains the discretion and flexibility to deviate from these recommendations provided that there are preexisting policies in place to support such decisions.

CAC Membership

The CAC selection committee is not expected to replace existing CAC members if those current CAC members meet the requirements and expectations for CAC members and can successfully perform the CAC member duties noted below. CAC membership should reflect the general MCP Member population in the MCP's Service Area, including:

- Representatives from IHCPs,
- Representatives who receive LTSS and/or individuals representing LTSS recipients,
- Adolescents and/or parents and/or caregivers of children, including current and/or former foster youth, as appropriate

The general MCP Member population must be modified as the population changes to ensure that the MCP's community is represented and engaged. MCPs may implement term limits for CAC members, as appropriate and at lengths deemed necessary by the MCP, to ensure representation of the general MCP Member population in the MCP's Service Area. MCPs are encouraged to ensure representatives who receive Enhanced Care Management (ECM) and Community Support Services, as appropriate, are represented on the CAC. MCPs are also encouraged to establish a CAC sub-committee comprised exclusively of Members to ensure Member voices are paramount. Member composition of the CAC sub-committee may include, but is not limited to, adolescents and/or parents and/or caregivers of children, including current and/or former foster youth.

CAC Member Duties

The CAC must perform all duties noted in the MCP Contract including providing input, advice, and making recommendations to the MCP to address Quality of Care, Health Equity, Health Disparities, Population Health Management (PHM), children services, Community Reinvestment Plans, and Community Health Assessments (CHA)/Community Health Improvement Plans (CHIP).[4] The CAC must be included and involved in developing and updating CLAS policy and procedure decisions including those related to Quality Improvement, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings. The CAC must provide and make recommendations to the MCP regarding the cultural appropriateness of communications, partnerships, and services. The CAC must identify and advocate for Preventive Care practices to be utilized by the MCP. Additionally, the CAC must provide input and advice, including, but not limited to:

- Culturally appropriate services or program design;
- Priorities for health education and outreach programs;
- Member satisfaction survey results;
- Plan marketing materials and campaigns;
- Communication of needs for Network development and assessment;
- Community resources and information;
- PHM;
- Quality;
- Carved Out Services;
- Development of the covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan;
- Input on Quality Improvement and Health Equity[5,6] and the Population Needs Assessment;
- Reforms to improve health outcomes, accessibility of services, and coordination of care for Members; and
- Inform the development of the MCP's Provider Manual.

MCP CAC Duties

MCPs must perform all duties pertaining to the CAC as noted in the MCP Contract, including providing sufficient resources for the CAC to support required CAC activities

[4] MCP Contract, Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees).
[5] DHCS. April 2024, Quality Improvement and Health Equity Transformation Requirements. Available in APL 24-004 or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[6] DHCS. May 2024, CalAIM: Population Health Management Policy Guide, available on the PHM webpage at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.

and CAC members in their CAC role including engaging in listening sessions, focus groups, and/or surveys.[7] MCPs will determine the total number of established CACs reasonably necessary to ensure the fulfillment of CAC requirements and allow for meaningful engagement with Members in their service area. MCPs operating in multiple counties may have one CAC across multiple counties or separate and distinct CACs for each county as needed to support engagement.

MCPs must ensure that CAC meetings are accessible to all participants and provide appropriate accommodations allowing attendees to effectively communicate and participate in CAC meetings including providing translation and interpretation services, providing accessibility for individuals with a disability or LEP, providing transportation to CAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAC member participation possible. CAC meetings can be in-person, virtual, or held in hybrid formats. MCPs may impose security protocols as appropriate for all CAC meetings. MCPs must demonstrate, through the Annual CAC Demographic Report, consideration of CAC input and must inform CACs how their input has been incorporated.

Additionally, MCPs must designate a CAC coordinator and maintain a written job description detailing the CAC coordinator's responsibilities which must include having responsibility for managing the operations of the CAC in compliance with all statutory, rule, and Contract requirements. The CAC coordinator may be an employee of the MCP, Subcontractor, or Downstream Subcontractor. The MCP's CAC coordinator must not be a member of the CAC, or a Member enrolled with the MCP. The CAC coordinator's duties must include, but are not limited to:

- Ensuring CAC meetings are scheduled and committee agendas are developed with the input of CAC members;
- Maintaining CAC membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC;
- Actively facilitating communications and connections between the CAC and MCP leadership, including ensuring CAC members are informed of MCP decisions relevant to the feedback from the CAC;
- Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP, to effectively communicate and participate in CAC meetings; and
- Ensuring compliance with all CAC reporting and public posting requirements.

[7] MCP Contract, Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees).

MCPs are required to:

- Comply with CAC meeting reporting, posting, and submission requirements outlined in the MCP Contract;[8]
- Hold their first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee;
- Hold CAC meetings at least quarterly;
- Make the regularly scheduled CAC meetings available for the public to attend. The meeting schedule must be posted 30 calendar days prior to the meeting date, and in no event later than 72 hours prior to the meeting;
- Provide a location for CAC meetings and all necessary tools and materials to run meetings, which may include, but is not limited to, providing onboarding materials for CAC members, providing resources to support CAC members in their CAC activities, and making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings;
- Capture written meeting notes that must be posted on the MCP's website and submitted to DHCS no later than 45 calendar days after each meeting. The MCP must retain the minutes for no less than ten years and provide to DHCS upon request;
- Submit an Annual CAC Demographic Report by April 1st of each year;
- Report on their involvement in and findings from Local Health Jurisdictions' CHAs/CHIPs and obtain input/advice from their CACs on how to use findings from the CHAs/CHIPs to influence MCPs strategies and workstream;
- Convene with their CACs to develop and inform their outreach and education plan for their Members regarding covered NSMHS as articulated in APL 24-012: Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements, or any superseding APL;
- Engage with CACs to inform Community Reinvestment planning and validate Community Reinvestment Plans prior to submission to DHCS to ensure investments are adequately targeted toward the needs of the community as noted in APL 25-004; and
- Engage with the CAC for continued diversity, equity, and inclusion training program recommendations and feedback.

While these are the minimum requirements for CAC engagement, MCPs have the discretion to engage CACs in any additional capacity for planning and decision-making.

Reporting, Monitoring, and Compliance

MCPs are required to submit an Annual CAC Member Demographic Report by April 1 of each year, which must contain membership data as of December from the previous calendar year, to ensure the CAC membership reflects the general MCP Member population in the MCP's Service Area and that the CAC's input is actively utilized in

[8] MCP Contract, Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees).

polices and decision-making by the MCP. If there are multiple CACs in the MCP's Service Area, the MCP should submit one CAC Annual Demographic Report with consolidated CAC responses. The CAC Annual Demographic Report requires MCPs to report on the following information including, but not limited to:

- The demographic composition of CAC membership;
- How the MCP defines the demographics and diversity of its Members and Potential Members within MCP's Service Area;
- The data sources relied upon by the MCP to validate that its CAC membership aligns with MCP's Member demographics;
- Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within MCP's Service Area;
- Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within MCP's Service Area; and
- A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, CLAS services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped the MCP's initiatives and/or policies.

MCPs must review their contractually required policies and procedures (P&Ps) to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) Contract Oversight SharePoint Submission Portal[9] within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must attach an attestation to the Portal within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The attestation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this APL. For additional information regarding enforcement actions, see APL 25-007, and any

[9] The MCOD Contract Oversight SharePoint Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx

subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Bambi Cisneros

Acting Division Chief, Managed Care Quality and Monitoring Division

Assistant Deputy Director, Health Care Delivery Systems

COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

Community Advisory Committee (CAC)
Selection Committee Charter

Objectives

1. Select the members of the Community Advisory Committee (CAC).
2. Adjust CAC membership to account for changes in CHPIV membership.

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Responsibilities

The Committee shall have the following authority and responsibilities, together with any additional authority or responsibility delegated to the Committee by the Commission of the Imperial County Local Health Authority (Commission) from time to time:

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1. Ensure the CAC membership reflects the general Medi-Cal Member population in Imperial County, including representatives from Indian Health Service Providers, representatives who receive LTSS and/or individuals representing LTSS recipients, adolescents and/or parents and/or caregivers of children, including foster youth, as appropriate and be modified as the population changes to ensure that CHPIV's communities are represented and engaged;

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2. Review, at least annually, demographic data, including data on racial, ethnic, and linguistic composition, of residents and members living in Imperial County to ensure CAC recruitment efforts and membership aligns with and reflects the racial, ethnic, and linguistic diversity of their respective Service Area.

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3. Make a good faith effort to ensure the CAC membership is composed primarily of CHPIV Members, including representatives from diverse and hard- to-reach populations, with a specific emphasis on persons who are representative of or serving populations that experience health disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, sexual orientation, and physical disabilities.

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Committee Membership

The CAC Selection Committee shall consist of such number of directors as the Commission shall from time to time determine, but in no event shall it consist of less than two members. The members of the Committee shall be appointed or replaced by Commission with or without cause.

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The CAC Selection Committee must select all CAC members. If a CAC member resigns or is asked to resign, the CAC selection committee must make its best effort to promptly replace a vacant CAC seat within 60 calendar days of the CAC vacancy. This may be done through an additional CAC selection committee meeting or use of online or email voying.

The CAC Selection Committee should include representatives from:

1. Persons who sit on the Commission
2. Safety Net Providers including federally qualified health centers (FQHCs), behavioral health, regional centers, local education authorities, dental Providers, IHS Facilities, and home and community-based service Providers; and
3. Persons and community-based organizations who are representatives within Imperial County, adjusting for changes in membership diversity.

Frequency

The CAC Selection Committee shall meet annually, or as often as it deems necessary in order to perform its responsibilities. Except as expressly provided in the Bylaws, the Committee shall determine its own rules of procedure.

Length of Appointments

- CAC Selection Committee members will serve a two-year term and may serve an unlimited number of terms.
- Should a CAC Selection Committee member resign, be asked to resign, or otherwise unable to serve on the CAC Selection Committee, the Committee will exercise best efforts to promptly replace the vacant seat, as needed, within 60 calendar days of the vacancy.

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Reviewed and Approved by Commission:
Date:

CAC Medi-Cal Members, June 2025

First Name	Middle Na	Last Name	Gende	Age	City	Aid Code Description	Medi-Medi	Preferred Spo	Last Meeting A
Janice		Alvarado	F	68	Imperial	Aged	Y	English	12/13/2024
Anabel		Araujo	F	45	Holtville	Parents/caretaker relatives	N	Spanish	3/18/2025
Maria	A.	Alonso Castañec	F	67	El Centro	Aged	Y	Spanish	3/18/2025
Sally	Camilla	Duran	F	54	Brawley			Spanish	3/18/2025
Karime		Garay	F	27	Heber	Adult < 138% FPL	N	English	3/18/2025
Edgar		Gerardo	M	54	Brawley	Working Disabled Program	Y	Spanish	3/18/2025
Rebeca		Gomez	F	40	Brawley	Parents/caretaker relatives	N	Spanish	3/18/2025
Luciana		Gonzalez	F	35	Imperial	CalWORKS - Legal Immigrant	N	Spanish	3/18/2025
Ana	Trizon	Gutierrez	F	52	Calexico	Adult < 138% FPL	N	Spanish	3/18/2025
Arturo		Jimenez	M	79	Heber	Aged	Y	Spanish	3/18/2025
Ramona		Jiménez	F	74	Heber	Aged	Y	Spanish	3/18/2025
Angel		Martinez	M	24	Niland	Adult < 138% FPL	N	Spanish	3/18/2025
Irma		Mendoza	F	65	Imperial	Aged	Y	Spanish	3/18/2025
Maria	Elena	Mendoza	F	66	Imperial	Aged	Y	Spanish	3/18/2025
Yocelyn	Martinez	Moreno	F	25	Calexico	Adult < 138% FPL	N	Spanish	3/18/2025
Susie		Ponce	F	68	Imperial	Aged	Y	English	3/18/2025
Patricia		Rico	F	61	Imperial	Adult < 138% FPL	N	Spanish	3/18/2025
Marisela		Talamantes	F	28	Calexico	TANF Timed Out	N	Spanish	3/18/2025
Abelina		Tinajero	F	22	Brawley	Adult < 138% FPL	N	Spanish	3/18/2025
Ana	M.	Cervantes Trizon	F	22	Calexico	Adult < 138% FPL	N	Spanish	3/18/2025
Maria	Carmen	Valadez	F	70	Imperial	Aged	Y	Spanish	3/18/2025
Guillermina		Villegas	F	71	Calexico	Aged	Y	Spanish	3/18/2025
Marcos		Villegas	M	73	Calexico	Aged	Y	Spanish	3/18/2025

CAC Membership Criteria 11-Jun-25

DHCS Requirement	CAC Membership	Assessment
Composed primarily of Members	100%	Met
Reasonably reflective of the MCP member population in the service area:		
Preferred Language Spanish (57%)	87%	Overrepresented
Female (55%)	82%	Overrepresented
Age <18 (37%)	0%	Underrepresented
Age > 65 (15%)	43%	Underrepresented
Includes reasonable representation from specific populations:		
1. Adolescents and/or parents or caregivers of children		Might be met (2 - parent/care takers)
2. Current/former foster youth and/or parents or caregivers of current/former foster youth		Not met
3. Members who receive Long-Term Services and Supports and/or individuals representing those Members		
4. Representatives from Indian Health Care Providers		Not met
5. Diverse and hard-to-reach populations		Not met
Sexual orientation		
Physical disabilites		Might be met (1- working disabled)
Minority race/ethnicity (Asian, Black, Other)		
Outling Geographies		
6. Representatives who receive ECM nd Community Support services		Likely met

Note: The CAC selection committee is not expected to replace existing CAC members if those current members can meet the requirements and expectations for CAC members

CAC Annual Demographic Report		
1	Name of Managed Care Plan (MCP)	**Community Health Plan of Imperial Valley**
2	What is the total number of	1
3	What is the total number of Medi-Cal Members the MCP serves?	97,100
4	How many CACs does the MCP have?	1
5	What is the total number of current CAC Members?	74
6	Of the number of current CAC Members, how many of those are Medi-Cal Members?	58
7	What is the total number of current, vacant CAC positions, if any?	
7(a)	If there are any current CAC vacancies, what strategies are being utilized to fill those CAC vacancies?	
8	Have there been any changes made to the CAC's composition in the past 12 month?	Yes
8(a)	If yes, please describe those changes.	We continue to actively recruit new Medi-Cal members to participate. A total of 58 Community Health Plan of Imperial Valley Medi-Cal Members currently participate, which is a 78% of the committee composition.
9	Does the MCP attest that the CAC is reasonably reflective of the general Medi-Cal Members makeup within the MCP's Service Area?	Yes we attest that the CAC is reasonably reflective of the general makeup of the MCP's Service Area
9(a)	If the CAC is not reasonably reflective, identify the specific steps the MCP has taken to remedy demographic alignment.	N/A
10	Does the CAC have at least one (1) parent/and or caregiver of children representative?	Yes
10(a)	If not, please provide a detailed explanation as to why not.	N/A

11	Does the CAC have at least one (1) current or former foster youth and/or a parent or caregiver of a current or former foster youth representative?	No
11(a)	If not, please provide a detailed explanation as to why not.	Though the Plan has been successful in recruiting 78 unique stakeholders, including Medi-Cal members, to participate in the CAC we have not been able to confirm through data, aid codes, or self attestations that any of the participating individuals have experience or can represent the foster youth and/or parent of a foster youth population. The Plan remains
12	Does the CAC have at least one (1) representative from diverse and hard-to reach populations?	Yes
12(a)	If so, please identify the diverse and/or hard to reach population(s) represented.	The Plan has been working diligently to ensure the Medi-Cal member representation of the committee reflects the general Medi-Cal member population in Imperial County and meets the 2024 contractual requirements. The Plan has successfully engaged with Medi-Cal members who can represent: Seniors and Persons with Disabilities (SPD), parents, individuals with Limited English Proficiency and individuals from diverse cultural and ethnic backgrounds. We acknowledge there is more work to do to engage foster youth and/or parent of a foster youth. Through claims data, the Plan has also been able to confirm the Medi-Cal members who participate on the CAC can represent a variety of different chronic and sensitive conditions.
12(b)	If not, please provide a detailed explanation as to why not.	N/A
13	What data sources were used to identify and describe CAC member demographics?	To define the demographics and diversity of CHPIV, the Plan leveraged our claims data and diagnosis data and the Plan Member enrollment data as of 12/31/2024

14	What data sources were used to identify and describe Medi-Cal Member demographics in the MCP's Service Area?	1. DHCS enrollment for August 2024 2. CHPIV enrollment data as of 12/31/2024 3. CHPIV race and ethnicity data, which includes DHCS enrollment data plus supplemental self-reported data from call-center encounters and California Immunization Registry (CAIR) among other sources. 4. Top 5 highest-volume languages in the Reporting Unit(s). CHPIV languages indicate preferred written language for correspondence.
15	Are there any barriers and/or challenges in achieving demographic alignment between CAC members and the Medi-Cal Members within the MCP's Service	The Plan has been successful in overcoming any barriers and/or challenges to achieve demographic alignment between the CAC members and the Medi-Cal members who live in Imperial County.
16	Are there any ongoing, updated, and/or new efforts and strategies undertaken in the CAC membership recruitment to address the barriers/challenges to achieving alignment between the CAC membership and the Medi-Cal member demographics?	The Plan used a multi-pronged approach to recruit Medi-Cal members and stakeholders from the community. Outreach strategies include social media, referrals from advocacy partnerships, the public facing CAC webpage, and word of mouth from trusted community representatives. CHPIV does offer a $100 gift card to any member who attends a quarterly CAC meeting.
17	What is the CAC's ongoing role and impact in decision-making about: Health Equity, Health-Related Initiatives, C&L services, Resource Allocation, and other Community-Based Initiatives?	CAC feedback and insights inform the Plan's health equity (HE) strategy, health-related initiatives, and C&L services. They offer perspectives on HE, disparities, population health, and community based initiatives that inform HE and health ed. materials, and QI projects. CAC recommendations are shared within the Plan's Internal Health Equity Governance eco-system, CHPIV leadership, and the QIHEC. The CAC feedback is critical to CHPIV understanding the experience, and satisfaction of services.

18	How did the CAC input impact and shape the MCP's initiatives and/or policies?	CAC inputs have shaped a variety of the Plan's initiatives and decision making. Here are a few examples how the advice of the CAC has improved CHPIV's offering of the Medi-Cal program 1) Majority of CAC members speak Spanish, we used this opportunity to field test words and translations to ensure Plan's messaging is simple to understand 2) Informed strategies for the NSMHS Outreach & Education Plan to increase utilization and reduce stigma 3) informed campaigns to dispel myths about vaccines.
19	What accommodations (transportation, childcare, etc.) for CAC Members have been offered to better support CAC participation?	We ask and encourage our members to make the Plan aware of any member's needs to support their participation in the quarterly local CAC. CHPV offers various accommodations including interpreters for different languages, live transcription or captioning, and translation of materials. These efforts have been successful in ensuring all members can actively participate and contribute.

Please complete the following table identifying CAC representatives

*For individuals wishing to withhold their identify, utilizing the nomenclature *"Member 1, Mer*

Community Advisory Committee (CAC) Representatives Table	
Name of Member	**Representative Type**
Abelina Tinajero	Medi-Cal Member
Alfonso Paz	Medi-Cal Member
Alma Paz	Medi-Cal Member
Ana Cervantes Trizon	Medi-Cal Member
Ana Luisa Martija	Medi-Cal Member
Ana Trizon	Medi-Cal Member
Anabel Araujo	Medi-Cal Member
Anabel Arredondo	Medi-Cal Member
Angel Martines	Medi-Cal Member
Antonio Gutierrez	Medi-Cal Member
Arturo Jimenez	Medi-Cal Member
Arturo Rubio	Medi-Cal Member
Benita Carrillo	Medi-Cal Member
Bertha Mena	Medi-Cal Member
Blanca Mendoza	Medi-Cal Member
Brittany Brown	Medi-Cal Member
Carmen Valdez	Medi-Cal Member
Christina Araujo	Medi-Cal Member
Concise PH	Other
Daisy Beltran	Medi-Cal Member
Daisy Valadez	Medi-Cal Member
Delfina Castro	Medi-Cal Member
Disability Rights	Advocate
Dr. Carlos Ramirez: DCRC LLC	Advocate
Edgar Gerardo	Medi-Cal Member
El Centro Regional Medical Center	Provider
Filiberto Tinajero	Medi-Cal Member
Flor Mendoza	Medi-Cal Member
Francisca Moreno	Medi-Cal Member
Guillermina Villegas	Medi-Cal Member
Imperial County Behavioral Health Services	Other
Imperial County Public Health	Other
Imperial Valley Equity & Justice Coalition	Advocate
Imperial Valley Food Bank	Community Participant
InnerCare	Provider
Irma Mendoza	Medi-Cal Member
Isai Rubio Galcan	Medi-Cal Member
Ismerai Gonzalez	Medi-Cal Member
Janice Alvarado	Medi-Cal Member

Jesus Gonzalez	Medi-Cal Member
Jesus Perez Gerardo	Medi-Cal Member
Jose R Vega	Medi-Cal Member
Karime Garay	Medi-Cal Member
Laura Lopez	Medi-Cal Member
Lidicela Barreto	Medi-Cal Member
Luciana Gonzalez	Medi-Cal Member
Marcos Villegas	Medi-Cal Member
Maria (Rosio) Gonzalez	Medi-Cal Member
Maria Aguilar	Medi-Cal Member
Maria Castaneda	Medi-Cal Member
Maria Elena Mendoza	Medi-Cal Member
Maria Elena Santos	Medi-Cal Member
Maria Nidia Perez	Medi-Cal Member
Marisela Talamontes	Medi-Cal Member
Martha Vega Trizon	Medi-Cal Member
Melissa Cabrera	Medi-Cal Member
Noemi Gonzalez	Medi-Cal Member
Pioneers Memorial Healthcare District	Provider
Pricsilla Vega	Medi-Cal Member
Project Food Box	Community Participant
Ramona Jimenez	Medi-Cal Member
Rebeca Gomez	Medi-Cal Member
Ricardo Martinez	Medi-Cal Member
Roots Food Group	Provider
Sally Duran	Medi-Cal Member
San Diego Regional Center	Other
Serene Health	Provider
Stacey Johnson	Medi-Cal Member
Susie Ponce	Medi-Cal Member
Teresa Medoza	Medi-Cal Member
UCSD Moores Cancer Center	Community Participant
Valeria Chacon	Medi-Cal Member
Volunteers of America	Community Participant
Yocelyn Martinez	Medi-Cal Member

Please complete the following table identifying the general Medi-Cal members in the MCP's Ser
In the table include the total number of the **general Medi-Cal members in the MCP's Service Are**
While the MCP can provide information on any population characteristic, **at a minimum, gender, age, race/ethnicity, and language spoken must be reported.**

Community Advisory Committee (CAC) Annual Demographic
Table of the **General Medi-Cal Members in the MCP's Service Area**

	%	Enrollee Count
TOTAL MEMBERSHIP		
Gender		**98,261**
Female	55%	**53,898**
Male	45%	**44,363**
Other		
Age		
Age 00-18	37%	36,285
Age 19-44	32%	31,184
Age 45-64	17%	16,240
Age 65+	15%	14,552
Race/Ethnicity		
American Indian or Alaska Native	1%	589
Asian	0%	425
Black	1%	848
Declined to State	5%	5,153
Hispanic	88%	86,633
Native Hawaiian or Other Pacific Islander	0%	
Other	0%	
White	5%	4,613
Preferred Language Spoken		
English	42%	41,467
Spanish	57%	56,411
Armenian	0%	-
Chinese, Mandarin	0%	-
Cantonese	0%	22
Hindi	0%	-
Russian	0%	-
Other	0%	322

Additional Notes and/or Narrative:

Data was obtained from https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx. Data sets did not include Native Hawaiian or Other Pacific Islander and Other for 'Race/Ethnicity' and Armenian, Chinese Mandarin, Hindi, and Russian for 'Preferred Language Spoken.'

Please complete the following table identifying the Medi-Cal CAC Members:

In the table include the total number of the CAC Medi-Cal Members in each demographic category. MCPs are required to report on the following population characteristics of the CAC Medi-Cal Members: gender, age, race/ethnicity, and language spoken must be reported. MCPs are encouraged to report on any additional demographic category including, but not limited to: Disabilities, sexual orientation, socioeconomic status (SES), education level, chronic conditions, Seniors and Persons with Disabilities (SPD).

Community Advisory Committee (CAC) Annual Demographic Table of the **CAC Medi-Cal Members**	
	Enrollee Count
Gender	
Female	**45**
Male	**13**
Other	
Age	
Age 00-18	2
Age 19-44	18
Age 45-64	17
Age 65+	14
Race/Ethnicity	
American Indian or Alaska Native	0
Asian	0
Black	0
Declined to State	22
Hispanic	35
Native Hawaiian or Other Pacific Islander	0
Other	0
White	1
Preferred Language Spoken	
English	5
Spanish	19
Armenian	0
Chinese, Mandarin	0
Cantonese	0
Hindi	0
Russian	0
Other	0
Additional Notes and/or Narrative:	
7 committee members did not report their age. 34 committee members did not report a prefered language.	