Quality Improvement Health Equity Committee Voting Packet

February 13, 2026

Committee Meeting Minutes

Please click on the hyperlink(s) below to direct you to the corresponding material.

QIHEC Minutes 11/14/2025

UMC Minutes 12/19/2025

A&A Minutes 11/05/2025

Quality Improvement Health Equity Committee
11/14/2025

Committee Member Name and Title	Specialty	Present
Donna Carey MD, Chief Medical Officer, Alameda Alliance for Health		☒
Lao Paul Vang, Chief Health Equity Officer, Alameda Alliance for Health		☒
Stephanie Brown, MD, Medical Director, Quality Improvement, Alameda Alliance for Health	Psychiatry	☒
James Florey, MD, Chief Medical Officer, Children First Medical Group	Pediatrician	☒
Peter Currie, Ph.D. Senior Director, Behavioral Health, Alameda Alliance for Health		☒
Michelle Stott, Senior Director, Quality, Alameda Alliance for Health		☒
Anchita Venkatesh, DMD MA, Program Director, General Practice Residency, Highland Hospital		☒
Parag Sharma, MD, Medical Director, Utilization Management, Alameda Alliance for Health		☒
Chaunise "Chaun" Powell, MD, Sr. Chief of Student Services, Alameda County Office of Education		☐
Anthony Cesspooch Guzman, MSW Chief Cultural Officer, NAHC		☐
Deka Dike CEO, Omotochi		☒
Lisa Laurent, MD, Chief Medical Officer, Alameda Health System		☐
Raj Davda, MD, Chief Medical Officer, Community Health Center Network		☐
Sirina Keesara, MD, Medical Director, Community Health Center Network		☐
La Toshia Palmer, MD, Executive Director, Alameda County Office of Education		☐

Staff Member Name and Title	Present
Allison Lam, Senior Director, Health Care Services	☒
Alma Pena. Senior Manager, Grievance and Appeals	☒
Ami Ambu, Quality Improvement Project Specialist II	☒
Andrea DeRochi, Behavioral Health Manager	☐
Ang Yen, Director Health Equity	☒

Angela Moses, Quality Review Nurse	☒
Ashley Asejo, Clinical Quality Programs Coordinator	☒
Beverly Juan, Medical Director Community Health	☒
Bob Hendrix, Quality Improvement Outreach Coordinator	☐
Cecilia Gomez, Senior Manager Provider Services	☐
Christine Rattray, Quality Improvement Supervisor	☐
Dani Staub, Director, Incentives & Reporting	☒
Daphne Lo, Medical Director Long Term Supportive Services	☒
Dona Doran, Manager, Risk Adjustment	☒
Eileen Ahn, Accreditation and Regulatory Compliance Specialist	☒
Emily Erhardt, Population Health, and Equity Specialist	☐
Falmata Abatcha, Quality Improvement Project Specialist II	☒
Farashta Zainal, Quality Improvement Manager	☒
Fiona Quan, Quality Improvement Project Specialist I	☒
Gil Duran, Manager, Population, Health and Equity	☐
Grace St. Clair, Director, Compliance & Special Investigations	☐
Hellai Momen, Quality Review Nurse	☒
Homaira Momen, Quality Review Nurse	☒
Jaini Goradia, Director, Stars Strategy and Program Manager	☐
James Burke, Lead Quality Improvement Project Specialist	☐
Jennifer Karmelich, Director, Quality Assurance	☐
Jessica Adams, Accreditation and Regulatory Compliance Specialist	☒
Jessica Jew, Population Health and Equity Specialist	☐
Kalkidan Asrat, Quality Improvement Project Specialist II	☒
Kathy Ebido, Senior Quality Improvement Nurse Specialist	☐
Katrina Vo, Senior Communications & Content Specialist	☐
Kayla Williams, Manager, Member Experience & Programs	☒
Kimberly Glasby, Director, Long Term Services and Supports	☒
Kisha Gerena, Accreditation Manager	☐
Lily Hunter, Director, Social Determinants of Health	☒
Linda Ayala, Director of Population Health and Equity	☒

Loc Tran, Manager, Access to Care	☒
Mao Moua, Manager, Cultural and Linguistic Services	☐
Matthew Woodruff, Chief Executive Officer	☐
Megan Hils, Quality Improvement Project Specialist II	☒
Michelle Findlater, Director, Utilization Management	☒
Michelle Lewis, Senior Manager Communications & Outreach	☐
MyLe Hillard, Manager, HEDIS Strategy & Program Management	☒
Patricia Carrillo, Quality Improvement Project Specialist I	☐
Richard Golfin III, Chief Compliance Officer & Chief Privacy Officer	☐
Rosa Carrodus, Disease Management Health Educator	☐
Sangeeta Singh, Quality Improvement Project Specialist I	☒
Sanya Grewal, Healthcare Services Specialist	☐
Sarbjit Lal, Quality Improvement Project Specialist	☒
Sean Pepper, Compliance Special Investigator	☐
Shatae Jones, Director Housing & Community Services Program	☒
Stephen Smythe, Director, Program Compliance & Privacy Operations	☐
Tanisha Shepard, Quality Improvement Project Specialist	☒
Tiffany Cheang, Chief Analytics Officer	☒
Yemaya Teague, Senior Analyst of Health Equity	☐
Community Members in Attendance	☐
	☐

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
I. Call to Order	D. Carey	The meeting was called to order at 9:04am		
II. Alameda Alliance Updates	D. Carey	**New Committee Members** • D. Carey welcomed new committee members, including Dr. Stephanie Brown as Medical Director of Quality, Dr. Lisa		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		Laurent as Chief Medical Officer Alameda Health System, and Dr. Latasha Palmer as Executive Director of the Alameda County Office of Education, with each briefly introduced and their backgrounds discussed. **NCQA Accreditation** • NCQA Accreditation Status: D. Carey reported that both lines of business received NCQA Health Equity Accreditation, while the health plan accreditation for the group care line was successful except for a finding in grievances and appeals, which is being addressed for a April March re-evaluation. **Quality Sanctions** • T. Cheang reported DHCS sanctions for missing MPL on asthma remediation, blood pressure control, and topical fluoride; the team contested the fluoride sanction in a meet and confer, with results pending. • J. FloreyBurke asked about state responsibility and systemic issues; Tiffany confirmed these were discussed, but efforts prioritized the larger topical fluoride sanction. **QIHEC - Committee Structure updates (UMC)** • D. Carey outlined the upcoming merger of the QIHEC and UMC committees in preparation for DSNP implementation, explaining new requirements, expanded oversight, and the addition of new members, with meeting times remaining unchanged. • The committee merger is required as part of the transition to a DSNP plan effective January 1, 2026, to meet new regulatory requirements and enhance oversight of utilization management. • The merged committee will continue to meet on the second Friday of each month from 9:00am to 11:00am, with the main		

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		changes being internal preparation and the addition of new members and UM-focused content. **DHCS Quality Conference** • D. Carey, M. Stott, and F. Zainal summarized key points from the DHCS Quality Conference, emphasizing the state's focus on children's preventive health, behavioral health integration, and maternal and birth health equity, as well as upcoming changes in quality strategy and value-based payments.		
III. **Chief of Health Equity Updates**	LP. Vang	LP. Vang updated on the Health Equity Roadmap, focusing on milestones for social determinants of health and community engagement, resource allocation, and collaboration with quality and DSNP teams.		
IV. **Policies & Procedures**	D. Carey	The Policies & Procedures packet was sent out prior to QIHEC for committee review. • QI-104 Potential Quality of Care Issues • QI-119 Provider Preventable Conditions (PPC) and Adverse Events • QI-133 Inter-Rater Reliability (IRR) - Testing for Clinical Decision Making • QI-136 Clinical Practice Guidelines • QI-101 Quality improvement and Health Equity Program • QI-D-001 Quality Improvement Project Selection Criteria • QI-D-002 Health Outcomes Survey • QI-D-003 Model of Care (MOC) Annual Evaluation Policy • QI-D-004 Core Measures and Reporting Policy • QI-D-005 DSNP MOC Staff Training • TBD-DSNP Behavioral Health Services • TBD-Behavioral Health_DSNP_Roles and Responsibilities • TBD-Behavioral Health Crisis Intervention	Move to Approve: 1st: J. Florey 2nd : D. Dike	

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		- BH-001 Behavioral Health Services - CBAS 001 Initial Member Assessment & Reassessment - CBAS 002 Expedited Initial Member Assessment - CBAS 004 Member Assignment to a CBAS Center - CBAS 005 Provision of unbundled CBAS Services - CBAS 006 Emergency Remote Services (ERS - CHS-001 CHW Services - CHS-02 Community Health Strategy – Prescreening Process - CM-010 Enhanced Care Management – Member Identification and Grouping - CM-041 Enhanced Care Management – Outreach/Member Engagement - CM-043 Child Welfare Liaison - CM-D-006 CICM Outreach/Member Engagement - CM-D-008 CICM Continuity of Care - CM-D-101 DSNP Care Coordination Expectations - CM-D-102 Case Management Care Coordination Activities - CM-D-104 Individualized Care Plan Process - CM-D-109 Internal Audit and Monitoring - CM-D-110 Care Coordination - Local Education Agency Services - CM-D-111 Case Management (CM) Staff Roles and Responsibilities - CM-D-112 DSNP Care Transitions Protocols - CM-D-113 DSNP Care Transitions Personnel - CM-D-114 DSNP Individualized Care Plan (ICP) Transfer and Care Transitions Process - CM-D-115 DSNP Planned Care Transitions Process - Member Personal Health Information		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		- CM-D-116 DSN Planned Care Transitions Process - Member Self Management Activities - CM-D-117 DSNP Planned Care Transitions Process - Notification and Point of Contact - CM-D-118 DSNP Face-to-Face Encounters - CM-D-119 Interdisciplinary Care Team (ICT) Overview - CM-D-120 Interdisciplinary Care Team (ICT) Participants - CM-D-121 DSNP Most Vulnerable Population (MVP) - CM-D-122 Disease Management Programs - CS-002 Community Supports-Housing Transition Navigation Services - CS-003 Community Supports-Housing Deposits - CS-004 Community Supports-Housing Tenancy and Sustaining Services - CS-007 Community Supports-Medically Supportive Food_Meals_Medically Tailored Meals - CS-013 Community Supports – Transitional Rent - CS-014 Non-Housing Community Supports Criteria - DSNP Case Rounds& Team Review - DSNP Integrated Organization Determinations - DSNP QIO Fastrack Appeals- for Medicare Covered Services - LTC-001Long Term Care Program - LTC-001Long Term Care - LTC-004LTC Bed Hold and Leave of Absence - LTC-006One to One Observation (Personal Attendants/Sitter) in Nursing Facilities - UM-008 Coordination of Care- California Children's Services - UM-011 Coordination of Hospice and Terminal Illness - UM-015 Emergency and Post Stabilization Services		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• UM-024 Care Coordination- Dental Services • UM-025/CM-044 Guidelines for Obstetrical Services • UM-030/CM-045 Referrals to Supplemental Food Program for Women, Infants and Children (WIC) • UM-035 Vision Services • UM-051 Timeliness of UM Decision Making and Notification • UM-051 Timeliness of UM Decision Making and Notification • UM-054 Notice of Action • UM-056 Standing Referrals • UM-057 Authorization Service Request • UM-057 Authorization Request Services • UM-067 Varicose Veins • UM-068 Tertiary Quaternary Review Process • UM-069 Continuous Glucose Monitoring Equipment • UM-070 UM Denial System Controls • UM-071 Major Organ Transplant		
V. Meeting Minutes	D. Carey	The meeting Minutes packet was sent out prior to QIHEC for committee review. • QIHEC: 8/8/25 • IQIC: 10/15/25 • IQIC: 10/15/25 • CLSS: 7/23/25 • CAC: 12/5/24, 12/16/24, 3/20/25, 6/12/25 • A&A: 9/10/25 • UMC: 8/29/25, 9/26/25, 10/31/25	Move to Approve: 1st: J. Florey 2nd:S. Brown	
VI. QI Trilogy Documents	M. Stott	• M. Stott presented updates to the program description, including DSNP-related changes, Medicare operations, care coordination, and maternal mental health.	Move to Approve: 1st: J. Florey 2nd: S. Brown	

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VII. **D-SNP Overview**	T. Meyers	• **DSNP Plan Structure and Enrollment:** T. Meyers explained that the DSNP is an exclusively aligned HMO for Alameda County residents, targeting full dual-eligible members, with sales beginning October 15 and a go-live date of January 1, 2026. • **Benefits and Competitive Landscape:** The plan offers $0 cost share, dental, vision, hearing, OTC flex card, worldwide emergency care, and member incentives, with Kaiser as the main competitor in the county. • **Sales and Member Engagement Strategy:** T. Meyers described a phased sales approach using only internal agents, concierge-like onboarding, and a focus on provider partnerships and star ratings to drive quality and financial performance. • **Discussion on Broker Practices:** J. ~~Burke~~ Florey raised concerns about external brokers, and Tome confirmed that only internal agents are used, with additional support for member education and engagement. **Findings & Recommendations:** • The Alliance is launching an exclusively aligned DSNP (Dual Eligible Special Needs Plan) for Alameda County, covering both Medi-Cal and Medicare under one organization. • Only full duals (not partial duals) are eligible; the plan is an HMO with a $0 cost share for Part C, and includes supplemental benefits like dental, vision, hearing, OTC flex card, worldwide emergency care, and member incentives. • The initial sales strategy is to start small, focus on basics, and scale up in years two and three after refining operations and member experience.		

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		• Internal agents/brokers are used for sales, avoiding external brokers to ensure better member tracking and engagement. • Collaboration with CHCN clinics and provider champions is emphasized to support member enrollment and care. • Success will be measured by Medicare star scores, which impact funding and consumer choice; closing gaps and data management are critical from day one. • **Recommendation:** Focus on operational excellence, member education, and provider partnerships in year one, then expand marketing and scale in subsequent years. • **Recommendation:** Monitor and improve star measures, member experience, and data collection to maximize plan performance and benefits. • **Recommendation:** Continue internal sales and concierge-like onboarding to build trust and support among new members.		
VIII. **Committee Member Presentation: CHCN**	K. Grewal	• **Care Transitions Program at CHCN:** Dr. Kush Grewal presented on CHCN's care transitions programs, detailing the evolution from nurse-led follow-up to a physician-led, community health worker-supported model aimed at reducing readmissions and improving post-discharge care. • **Program Structure and Outcomes:** Dr. Grewal described the CTRN program, initially funded by Sutter and now by Alameda Alliance, which embeds nurses in clinics to support post-discharge patients, resulting in significant cost savings and reduced readmissions. • **Advanced Care Transitions Model:** A new model involves community health workers in hospitals and ERs, direct SDOH assessments, provision of cell phones, and rapid RN follow-up, with Dr. Grewal providing in-person clinics for high-risk patients unable to see their PCP within seven days.		

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		• **Identified Gaps and Innovations:** The program addresses barriers such as lack of PCP access, language, and health literacy, and aims to demonstrate the value of seven-day follow-up to encourage clinics to reserve slots for post-discharge patients.		
IX. **Survey Results**	L. Tran L. Ayala	• **CAHP Survey Results and Access to Care Analysis:** L. Tran presented CAHP survey findings on access to care, highlighting trends in response rates, disparities by age and ethnicity, and ongoing efforts to improve provider education, open access scheduling, and targeted outreach to underperforming groups. • **Survey Methodology and Results:** The CAHP survey, conducted annually, showed a slight increase in "Getting Needed Care" but a decrease in "Getting Care Quickly", with variations by age and ethnicity, particularly lower ratings among Asian and certain age groups. • **Provider and Member Interventions:** Efforts include provider education, open access scheduling, provider incentives, and a new alternative access document to educate members about urgent care, telehealth, and after-hours options, with a mail campaign targeting Asian members. • **Discussion of Network and Provider Shortages:** L. Tran and D. Carey discussed the impact of provider shortages and network limitations, especially for Asian members, and the use of provider appointment surveys to monitor urgent appointment availability. • **Language Access and Interpreter Services Survey:** L. Ayala presented results from the Timely Access Requirements survey, showing high satisfaction with interpreter services across multiple languages, a slight decrease in reported need		

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		and satisfaction, and plans to improve outreach and quality monitoring, especially for Spanish-speaking members. • **Survey Administration and Findings:** The survey, administered in 15 languages, had a 5% response rate, with high satisfaction (88-89%) for interpreter services, but a slight decrease in both reported need and satisfaction compared to the previous year. • **Barriers and Outreach Strategies:** L. Ayala noted lower response rates among Spanish speakers and identified barriers such as increased membership and lack of awareness about interpreter services, with plans to enhance outreach and provider education. • **Suggestions for Improved Engagement:** Committee members suggested alternative survey methods, such as WhatsApp and face-to-face outreach, to reach anxious or hard-to-contact populations, and Linda agreed to explore these options with the vendor. **Findings & Recommendations:** **CAHP Survey Results & Access to Care Analysis** • Response rates for the CAHP survey are declining for Medi-Cal, but remain above the vendor average. • "Getting Needed Care" scores slightly increased, while "Getting Care Quickly" scores dropped. Asian members consistently rate access below plan average; Hispanic and older members rate above average. • Provider shortages and reduced urgent appointment availability are contributing factors.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• **Recommendation:** Continue provider education, encourage open access scheduling, and offer provider incentives to improve urgent and follow-up appointment access. • **Recommendation:** Implement targeted mail campaigns and alternative access documents to educate members, especially Asian populations, about urgent care, telehealth, and after-hours options. **Language Access and Interpreter Services Survey** • 47% of surveyed members reported needing an interpreter; satisfaction with interpreter services remains high (88–89%), but there was a slight decrease in satisfaction compared to the previous year. • Spanish-speaking members had lower response rates despite high demand for interpreters. • Increased membership and new members may be unfamiliar with interpreter services. • Recommendation: Increase outreach and survey engagement for Spanish-speaking members, possibly by oversampling or targeted communication. • **Recommendation:** Strengthen provider education and engagement on language access and interpreter use. • **Recommendation:** Review interpreter-related grievances and vendor training to ensure quality and consistency. • **Recommendation:** Consider alternative survey methods (e.g., WhatsApp, WeChat, face-to-face outreach) to reach anxious or hard-to-reach populations. (chat)		
X. Workplan Update	M. Findlater L. Hunter	• **Utilization Management, Case Management, and Long-Term Care Updates:** M. Findlater, L. Hunter, and K. Glasby provided		

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	K. Glasby	data-driven updates on admissions, readmissions, denial rates, ED visits, case management referrals, ECM membership, and long-term care utilization, highlighting trends, challenges, and ongoing interventions. • **Utilization and Readmission Trends:** M. Findlater reported on admits per thousand, length of stay, paydays, and readmission rates, noting a slight improvement in 2025 but continued challenges in meeting the 18% readmission goal, with facility and aid category breakdowns provided. • **Denial Rates and ED Utilization:** Inpatient and outpatient denial rates increased slightly, with main reasons being eligibility and medical necessity, while ED visits showed a downward trend, though out-of-network usage remains an area for focus. • **Case Management and ECM Data:** L. Hunter presented on PCS form compliance, referral volumes, connection rates, ECM authorization, and membership trends, noting steady enrollment and efforts to improve outreach and data accuracy. • **Long-Term Care and Community Supports:** K. Glasby summarized stable long-term care membership, consistent turnaround times, decreased length of stay and admissions, and variable community support utilization, with a focus on transitions to lower levels of care and challenges in assisted living facility transitions.		

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		Findings & Recommendations: **Utilization Management** • Admits per thousand increased slightly in 2025, with the highest rates among SPD LTC full duals; CFMG had the lowest rates. • Average length of stay is stable, but some months showed spikes; Alliance and UCSF have the highest lengths of stay. • Readmission rates remain above the 18% goal (21.4% in 2025), with SPD LTC and duals having the highest rates. CFMG consistently performs below the readmission benchmark. • Out-of-network ED visits are high, especially at non-AHN facilities and Washington Hospital. • **Recommendation:** Analyze interventions during periods of lower readmissions (e.g., April) and assess if shorter lengths of stay are contributing to higher readmissions. • **Recommendation:** Focus on follow-up within seven days post-discharge, especially for high-risk diagnoses (e.g., CHF), to reduce readmissions. **Case Management** • Physician Certification Statement (PCS) form compliance with transportation remains high; delays are usually due to late submissions. • Referral volume to case management spiked in Q3 2024 and remains elevated. • Connection rates are highest for complex cases; transitions of care and care coordination have higher rates of unsuccessful outreach, often due to lack of member awareness.		

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		• ECM membership is steadily increasing, with ongoing efforts to improve data accuracy for program completion and transitions to lower levels of care. • **Recommendation:** Continue outreach and education to improve member engagement and connection rates, especially for care coordination and transitions of care. • **Recommendation:** Refine data tracking for ECM program completion and transitions to ensure accurate reporting and support for members. **Long-Term Care** • LTC membership was stable in 2025, with a drop early in the year and a rise in June. • Admissions and average length of stay decreased compared to 2024, but admits increased in 2025. • Discharges to lower levels of care are occurring, supported by community supports and waiver services. • Community support utilization is rising, especially in Q3 and Q4, except for assisted living transitions, which are limited by member financial eligibility. • **Recommendation:** Continue promoting community supports and waiver services to facilitate transitions out of LTC. • **Recommendation:** Monitor trends in admissions, length of stay, and readmissions to identify areas for further intervention.		
XI. **Public Comment**	D. Carey	None		
XII. **Adjournment**	D. Carey	Meeting Adjourned at 11:00am		

X_____ Date_____

Dr. Donna Carey
Chief Medical Officer, Alameda Alliance for Health
Chair

Minutes prepared by: Ashley Asejo - Clinical Quality Programs Coordinator

Utilization Management Committee Meeting Minutes
December 19, 2025, 12:30 PM – 2:00 PM
Teams

Member Name and Title	Present	Member Name and Title	Present
Donna Carey, Chief Medical Officer		Katherine Goodwin, Supervisor, Health Plan Audits	X
Richard Golfin, Chief Compliance Officer		Kimberly Glasby, Director, Long Term Services & Supports	
Tiffany Cheang, Chief Analytics Officer		Kisha Gerena, Manager, Grievances & Appeals	
Allison Lam, Executive Director, Health Care Services	X	Laura Grossman-Hicks, Sr. Director, Behavioral Health Services	X
Alma Pena, Sr. Manager, G&A		Lily Hunter, Director, Social Determinants of Health	X
Amani Sattar, Executive Assistant	X	Linda Ayala, Director, Population Health & Equity	X
Andrea DeRochi, Manager, Behavioral Health		Lisha Reamer-Robinson, Manager, Compliance Audits & Investigation	X
Annie Lam, Manager, Provider Services Call Center		Loc Tran, Manager, Access to Care	
Benita Ochoa, Lead Pharmacy Tech		Luke Lim, Sr. Director, Pharmacy	
Beverly Juan, Medical Director, CM and Community Health Strategy	X	Marie Broadnax, Manager, Regulatory Affairs & Compliance	
Brittany Nielsen, Executive Assistant		Michelle Findlater, Director, Utilization Management	X
Carla Healy-London, Manager, Inpatient UM	X	Michelle Stott, Senior Director, Quality	X
Cecilia Gomez, Sr. Manager, Provider Services		Nancy Pun, Sr. Director, Analytics	
Corinne Casey-Jones, Manager, Community Supports		Nora Tomassian, Director, Pharmacy	
Darryl Crowder, Director, Provider Relations and Contracting		Oscar Macias, Manager, Housing Program	
Daphne Lo, Medical Director, LTSS		Parag Sharma, Medical Director	
Farashta Zainal, Manager, Quality Improvement		Peter Currie, Senior Director, Behavioral Health	X
Gia Degrano, Senior Director, Member Services		Rahel Negash, Pharmacy Supervisor	
Gil Duran, Manager, Population Health & Equity		Ramon Tran Tang, Clinical Pharmacist	
Heather Wanket, Clinical Manager, ECM	X	Sanya Grewal, Healthcare Services Specialist	X
Hope Desrochers, Manager, Outpatient UM		Shatae Jones, Director, Housing & Community Services Program	X
Jeffrey Bencini, Clinical Pharmacist		Stephanie Brown, Medical Director, Quality Improvement	X
Jennifer Karmelich, Director, Quality Assurance		Stephen Smythe, Director, Compliance & Special Investigations	X
Jorge Rosales, Manager, Case & Disease Management		Stephen Williams, Supervisor, OP UM	X
Judy Rosas, Sr. Manager, Member Services		Timothy Tong, Lead Clinical Pharmacist	X
Karen Marin, Manager, Long Term Care	X		

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Utilization Management Committee Meeting Minutes
December 19, 2025, 12:30 PM – 2:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
I. Call to Order/ Introductions	A. Lam	The meeting was called to order by Allison Lam at **12:30 pm**		
II. Review and Approval of minutes	A. Lam	The UM Committee Minutes from **November 21, 2025** were approved electronically by a quorum of the committee prior to the meeting.	[PDF] UMC_Meeting Minutes_11.21.25.doc	**Approved via e-vote:** 12/2/25 – 12/5/25
III. Program Scope & Structure **A. CCG** **B. Covered Services Benefits Guide**	A. Lam	• **Review** and approval of the clinical care guidelines for Liberty, the dental plan provider for DSNP members. • **Review** of the new Covered Services Benefit Guide, which replaces the previous PA grid and standardizes prior authorization requirements across all lines of business. ○ **Guide Structure and Function:** A comprehensive document indicating which codes require prior authorization across medical, group care, and DSNP lines of business. Providers can search for codes to determine authorization requirements, and only codes requiring prior authorization for any line of business are included to keep the guide manageable.	[PDF] 2026 CCGs.pdf [PDF] NEW Covered Services Benefits Gui	

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Utilization Management Committee Meeting Minutes
December 19, 2025, 12:30 PM – 2:00 PM
Teams

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		o **Provider Training and Implementation Timeline:** The guide was published on December 1 with an effective date of January 1, 2026. Providers are being trained on its use, and delegates have received copies to align their systems accordingly.		
C. CCS	H. Desrochers	• CCS carve-out services data, including case volumes, approval and denial reasons, diagnosis breakdowns, and referral pathways. o **Case Assessment and Referral Trends:** Total cases assessed and referred for quarters 1-3, noting that most cases are assessed within the direct network rather than referred out, which aligns with program goals. o **Approval and Denial Reasons:** The majority of CCS referrals are approved, with denials primarily due to ineligibility (not a CCS-eligible condition, medically ineligible, or provider not paneled). Denial rates fluctuated across quarters. o **Diagnosis and Provider Breakdown:** Top inpatient and outpatient diagnoses include congenital anomalies, diseases of the respiratory and digestive systems, and others. The top referring providers correspond to typical pediatric care sources. o **Alternative Referral Pathways:** Cases not referred to CCS are redirected to tertiary programs such as EPSCT, basic case management, or ECM, ensuring members receive appropriate follow-up.	PDF Carveout Services CCS Q3 2025.pdf	

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Utilization Management Committee Meeting Minutes
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Teams

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D. Over/Under Utilization	M. Findlater	• **Utilization Management Metrics and Trends:** Comprehensive review of utilization management data, covering ED utilization, acute admissions, readmissions, denial rates, specialty services, out-of-network usage, and unused authorizations.
		
		    o **Emergency Department Utilization:** ED visits decreased across all networks from quarter one to quarter three, with Highland Hospital consistently having the highest volume. Adult expansion members are the highest ED utilizers, often due to after-hours access issues. Recommendations include promoting alternative care options and targeted outreach.
		
		    o **Acute Admissions and Readmissions:** Acute admissions and average length of stay decreased compared to the previous year. Readmission rates improved slightly but remain above the 18% goal, with adult expansion and SPD duals as the highest groups. Interventions include on-site pilots and partnerships with Sutter facilities.
		
		    o **Denial Rates and Specialty Services:** Inpatient partial denials are more common than full denials, while outpatient full denials are higher. Denial reasons for specialty services (acupuncture, chiro, podiatry, transplant evaluations, palliative care) include out-of-network status, medical necessity, and late submissions. Provider education is planned for late submissions.
			📄 PDF Over Under Utilization.pdf	

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Utilization Management Committee Meeting Minutes
December 19, 2025, 12:30 PM – 2:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		o **Out-of-Network and Stanford Utilization:** General acute care hospitals, diagnostic radiology, and specialists are the most common out-of-network services. Stanford utilization increased significantly due to contract changes, with ongoing monitoring to prevent overutilization. o **Unused Authorizations:** Outpatient rehab, TQ, radiology, and home health are the top unused authorization types, with adult expansion members most likely not to use their authorizations. The team is focusing on ensuring providers use the correct urgency levels and investigating root causes for unused authorizations.		
E. PA Rules Update	T. Tong	• **Pharmacy Prior Authorization Updates:** Pharmacy PNT-approved prior authorization changes for quarter four of 2025, including code additions and removals. o **Summary of Changes:** Six new drug codes were added for upcoming market entries, and seven codes were removed due to CMS de-recognition or market withdrawal. A SharePoint link to the changes was provided. o **Approval and Implementation Cycle:** The committee approved the changes, with Michelle moving and Stephanie seconding. Timothy and Allison discussed the need for quarterly updates to the PA grid and related provider communications, aligning with CMS release cycles.	PDF Review of Changes to PA Rules.pdf	

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Utilization Management Committee Meeting Minutes
December 19, 2025, 12:30 PM – 2:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date

F. BH Services	P. Currie	• **Mental Health and Behavioral Health Utilization Review:** Data on mental health and behavioral health therapy (BHT/ABA) utilization, including trends, demographic breakdowns, service types, and out-of-network usage.
		
		  o **Mental Health Utilization Trends:** Mental health unique utilizers showed a slight decrease after a period of growth, possibly due to membership changes. The penetration rate reached 6.6%, with the highest utilization among adults and lower rates in the D SNP population.
		
		  o **Demographic and Service Type Analysis:** White and American Indian/Alaska Native members have higher utilization rates, while Asian and Hispanic members are below average. Psychotherapy is the most used service, followed by medication management.
		
		  o **BHT/ABA Utilization and Network Stability:** BHT/ABA utilization continues to rise, but provider network instability leads to discrepancies between authorized and delivered services. The team tracks outliers and investigates barriers to service delivery.
		
		  o **Out-of-Network Utilization:** Out-of-network usage for mental health remains stable, with some volatility in ABA services. The team monitors these trends to ensure member needs are met.
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			BH Services.pdf	

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IV. CM Program Effectiveness
A. Enhanced Care Management Measures
	H. Wanket	• **Enhanced Care Management (ECM) Program Updates:** Update on ECM program volumes, member demographics, grandfathered member management, and program challenges.
		
		   o **Authorization and Enrollment Volumes:** ECM approvals, partial approvals, and denials increased from Q1 to Q3 2025, but two-thirds of enrolled members do not have an authorization, indicating the data only partially reflects program activity.
		
		   o **Member Demographics and Trends:** Enrollment and completion numbers increased across quarters for both adults and children, with homeless individuals representing the largest group. Outreach numbers declined, possibly due to providers bypassing outreach in favor of direct authorization.
		
		   o **Grandfathered Member Management:** The number of grandfathered members decreased slightly, but the team identified a need to accelerate transitions to appropriate care levels. Lily and Heather discussed ongoing analytics work to clarify member status and eligibility.
		
		   o **Program Challenges and Follow-Up:** Challenges include managing unaccompanied minors, clarifying eligibility categories (LTC vs. NF), and ensuring street teams focus on appropriate populations. The team plans to follow up on data specifics and provider engagement.
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			CalAIM ECM.pdf	

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Utilization Management Committee Meeting Minutes
December 19, 2025, 12:30 PM – 2:00 PM
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B. Community Supports Measures	K. Glasby	• **Community Supports Utilization and Transitional Rent Implementation:** Update on community supports utilization, turnaround times, recent program updates, and the upcoming implementation of transitional rent. ○ **Utilization and Claims Trends:** Community supports utilization showed a dip in quarter two and an increase in quarter three, attributed to bulk provider submissions and program changes. The gap between authorizations and claims/encounters narrowed due to process improvements. ○ **Turnaround Time Performance:** Turnaround times for community supports generally met the 95% metric, despite staffing challenges and reporting logic updates. Education efforts addressed human error in reporting. ○ **Program Updates and Criteria Changes:** Non-housing UM processes went live in December 2024, with housing UM processes starting November 2025. New criteria for housing and non-housing supports are being implemented in response to DHCS policy updates. ○ **Transitional Rent Implementation:** Transitional rent, mandatory for all health plans, will cover up to six months of rent for eligible behavioral health populations, with reimbursement limits set by the state. The program is managed in partnership with AC Health and county partners, with a focus on compliance and sustainability.	CS Metrics.pdf	

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Utilization Management Committee Meeting Minutes
December 19, 2025, 12:30 PM – 2:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		Adjournment: 2:00 PM		**Next Meeting:** March 27, 2026, at 1:30 PM

DocuSigned by:

Meeting Minutes submitted by: _Amani Sattar_
—1515265B2F7F4DC...
Amani Sattar,
EA to the CMO

Date: 12/26/2025 | 10:47 AM PST
Date: _____

DocuSigned by:

Approved by: _Allison Lam_
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Allison Lam,
Executive Director, Health Care Services

Date: 12/26/2025 | 11:47 AM PST
Date: _____

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ACCESS AND AVAILABILITY SUBCOMMITTEE
November 05, 2025
Teams Conference, 1pm – 2:30pm

Member Name and Title	Present	Member Name and Title	Present
Dr. Donna Carey, MD, Chief Medical Officer		Michelle Stott, Sr. Director of Quality	x
Dr. Beverly Juan, MD, Community Health	x	Dr. Peter Currie, Sr. MD, Behavioral Health	
Jessica Pedden, Quality Analytics Manager		Rommel Cuevas, Regulatory Compliance Specialist	x
Tiffany Cheang, Chief Analytics Officer		Gia Degrano, Director, Medical Services	x
Cecilia Gomez, Manager, Provider Services		Jennifer Karmelich, Director, Quality Assurance	x
Christine Rattray, Supervisor, Quality Improvement		Darryl Crowder, Director, Provider Services	
Donna Ceccanti, Manager, Peer Review and Credentialing		Linda Ayala, Manager, Health Education	x
Homaira Momen, Quality Review Nurse		Hellai Momen, Quality Review Nurse	
Richard Golfin III, Chief Compliance Officer		Marie Broadnax, Manager, Compliance	
Lily Hunter, Manager, Case Management		Dr. Rosalia Mendoza, MD, Utilization Management	
Loc Tran, Manager, Access & Availability	x	Farashta Zainal, Manager, Quality Improvement	x
Angela Moses, Quality Review Nurse	x	Allison Lam, Senior Director, Health Care Services	
Fiona Quan, Project Specialist, Quality Improvement	x	Judy Rosas, Manager, Member Services	x
Heidi Torres, Quality Programs Coordinator		Kathy Ebido, Sr. QI Nurse Specialist	x
Tanisha Shepard, Project Specialist, Quality Improvement	x	Sophia Noplis, Compliance Auditor – Delegate Oversight	
Mao Moua, Manager, Cultural and Linguistic Services	x	Alma Pena, Grievance & Appeals Manager	x
Gil Duran, Manager, Population Health and Equity	x	Kathrine Goodwin, Supervisor, Health Plan Audits	x
Carlos Lopez, Manager, Quality Assurance and Regulatory Reporting		Sarbjit Lal, Project Specialist, Quality Improvement	x
Megan Hickman, Compliance Auditor – Delegation Oversight		Ami Ambu, Project Specialist II, Quality Improvement	
Crystal Hung, Quality Review Nurse	x	Rahel Negash, Pharmacy Supervisor	
Kayla Williams, Manager Member Experience & Program Management	x	Alexandra Loza, Quality Assurance Specialist	x
Robert Smith, Regulatory Compliance Specialist	x	Donna Wong, Senior Human Resources Generalist	
Leticia Alejo, Provider Services	x	Stephanie Brown, MD, Medical Director	x
Melissa Vance, Network and Contracting	x		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
I. Welcome/Agenda Review	L. Tran	The meeting was called to order by L. Tran at 1:02PM. • Introduction of Dr. Stephanie Brown, who is the newly appointed Quality Medical Director.		
II. CG-CAHPS Q3 2025	F. Quan	The first presentation covered the Q3 2025 CG-CAHPS results. The presenter reviewed the timely access standards used for the three CG-CAHPS metrics. **PCP In-Office Wait Time:** This metric measures the amount of time a member waits in the office before seeing their provider. A wait time of less than 60 minutes is considered compliant, with a target goal of 80%. Overall performance continues to exceed expectations, remaining above 90% across all provider networks, including Alameda Health System, Alliance, CFMG, and CHCN. **PCP Call Return Time:** Call return time evaluates how quickly a provider returns a member's voicemail during regular business hours. A response within one business day is compliant, with a 70% compliance goal. In Q3 2025, performance improved from the prior quarter, increasing from 68.5% to 74%, thereby meeting the compliance threshold. Improvements were observed across Alliance, CFMG, and CHCN, and while Alameda Health System remains slightly below the target, it also demonstrated improvement this quarter. **PCP Time to Answer Calls:** This metric measures how long it takes for a staff member to answer a call during regular office hours. A response within 10 minutes is compliant, with a 70% goal. Overall performance remains in the high 70% range, with a slight decrease of 0.1% compared to the previous quarter, but still meeting the compliance standard. While minor declines were noted for Alliance, CFMG and CHCN showed improvements, and Alameda Health System also demonstrated progress, though it remains slightly below the target goal. Fiona also noted that in prior years, all CG-CAHPS metrics carried an 80% compliance goal. Due to ongoing challenges providers faced in meeting the higher threshold for call-related		

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		metrics, the goals for call return time and time to answer calls were adjusted to 70% to create a more attainable benchmark. Since 2024, compliance rates for these measures have stabilized in the mid-to-high 70% range. If this trend continues, consideration may be given in the future to gradually increase the benchmark, potentially to 75%, while monitoring sustained performance. Gia DeGrano questioned whether the compliance benchmarks align with industry standards across other health plans, noting that **80%** is commonly recognized as the industry standard for call center performance and asking whether the same standard applies to provider performance. Fiona Quan confirmed that 80% is the industry standard and explained that the organization's long-term goal remains to return to that benchmark. However, many providers had trouble consistently meeting the 80% threshold, which led to the decision to temporarily lower the compliance target. The intent of this adjustment is to allow providers time to improve performance while continuing to work toward returning to the 80% target goal. Loc Tran added that over the past year, the time to answer calls and call return time metrics have consistently hovered around 70% compliance across the network. As a result, the committee reviewed and approved lowering the compliance threshold to 70% to establish a more achievable benchmark and reduce the administrative burden associated with corrective action plans (CAPs). Loc mentioned that this adjustment does not represent a permanent change. The committee will continue to closely monitor performance trends, and as compliance rates improve, leadership will re-evaluate and may increase the benchmark to 80%. Michelle Stott expressed support for increasing the compliance benchmark back to **80%** and suggested incorporating this change into the **2026 work plan**, pending committee approval. Loc Tran agreed with the proposal and confirmed that the benchmark will be updated for next year. Providers will be notified of the change during upcoming meetings, and the team will continue to work collaboratively with providers to support performance improvement and successful attainment of the revised standard.		

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		PCP Urgent and Non-Urgent Appointment Availability In addition to the three primary CG-CAHPS metrics, the team also evaluates urgent and non-urgent appointment availability from the member perspective. For Primary Care Providers (PCPs), urgent appointments are expected to be scheduled within 48 hours, while non-urgent appointments should be scheduled within 10 business days. The performance goal for both measures is 75% compliance. Over the past two quarters, urgent appointment availability has shown improvement compared to Q4 2024 and Q1 2025; however, performance remains below the 75% target. Non-urgent appointment availability experienced a slight decline this quarter and is also below the established goal. **Trending and Non-Compliant Providers** The non-compliant provider trend list was reviewed. Several CHCN clinics continue to trend for call return time and time to answer calls. Notably, CHCN Baywell East Oakland was removed from the list, while CHCN Baywell was newly added. Additionally, La Clínica – Transit Village was removed from both the trending list and the call return time list. Some Alameda Health System clinics also showed improvement, with one newer clinic dropping off the trend list this quarter. **Corrective Action Process Discussion** When a provider is found to be non-compliant for two consecutive quarters, the Quality team issues a notification letter to inform the provider of the trend and offer support. If non-compliance continues for three consecutive quarters, a Corrective Action Plan (CAP) is issued for direct providers. For delegated providers, trending data is shared during monthly meetings, Joint Operating Meetings (JOMs), or ad hoc discussions, ensuring transparency and ongoing collaboration to address performance concerns. **Behavioral Health (BH) Metrics** • In-Office Wait Time: Behavioral Health providers continue to perform well, with an overall compliance rate of 91.6%, and all provider networks exceeding the 80% goal. • Call Return Time: Performance declined from Q1 2025, with the current compliance rate at 67.7%. CHCN experienced a slight decrease, potentially related to phone system migrations during the reporting period. Alliance showed improvement, while CFMG experienced a decline.		

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		• Time to Answer Calls: Compliance increased significantly from 79.8% to 83.5% in Q3 2025, remaining well above the 70% goal. All provider networks continue to meet this benchmark. • Non–Life-Threatening Emergency Appointments: Members requiring urgent behavioral health care (non-life-threatening) should receive an appointment within six hours, with a goal of 80% compliance. Current performance is 74.4%, below the target. CFMG showed improvement, CHCN declined, and Alliance is within 0.9% of meeting the goal. **BH Urgent and Non-Urgent Appointment Availability** Urgent appointments (within 48 hours) continue to fall below target, remaining in the high 50% range, while non-urgent appointments (within 10 business days) met the 75% goal. Ongoing provider education is needed, particularly around the definition of urgent appointments, as some providers mistakenly equate urgent care with emergency services. Increased awareness is expected to improve compliance over time. **BH Non-Compliant Provider Trends** No Behavioral Health providers trended for in-office wait time or time to answer calls. However, new CHCN providers trended for non–life-threatening emergency call return time. **Specialist Metrics** Specialists represent a newly surveyed group, with data collection beginning in Q1 2025, resulting in only three quarters of available data. • Call Return Time: Overall compliance was 72.7%, meeting the 70% goal. Alliance met the benchmark, CHCN showed a decrease, and CFMG experienced a notable drop due to a very small sample size. • Time to Answer Calls: Compliance declined from 86.6% to 81.2%, but remained above the 70% goal across all networks. CFMG's fluctuation is again attributed to limited sample size. • In-Office Wait Time: Performance remains strong, with compliance in the 90% range. Alliance and CHCN improved, while CFMG saw a slight decrease. **Specialist Trending Providers**		

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		This quarter marks the first instance of three consecutive quarters of specialist data. No providers trended for in-office wait time; however, Alameda Family Physician Medical Group and Bhatra Vision Medical Group trended for three consecutive quarters in other metrics.		
III. Access CAP Dashboard	F. Quan	**Corrective Action Plan (CAP) Dashboard – Q3 2025** Fiona presented the CAP dashboard covering the period from Q4 2024 through Q3 2025. During this timeframe, a total of 394 CAPs were issued. The majority were related to PAAS, which is the annual survey assessing network providers' urgent and non-urgent appointment availability and typically generates the highest volume of CAPs. The second largest category was QMRT, a quarterly survey with similar access and availability measures. PQIs, which are grievance-driven and reviewed monthly, also contributed significantly to the total number of CAPs issued. Within this same period, 326 CAPs were closed, and 246 CAPs remained open. **Outstanding CAPs and Escalation Efforts** The next section reviewed outstanding CAPs that are past their due dates and have already gone through the escalation process. The team has made multiple outreach attempts to providers and, due to the age of some CAPs, conducted reassessments to determine whether providers had come into compliance. These reassessments showed that several providers remain non-compliant, either for both urgent and non-urgent appointment availability or for non-urgent appointments only. After exhausting outreach efforts, the team escalated these cases to Dr. Juan, who also attempted direct outreach without receiving responses. As a result, the CAPs were brought to the committee to seek additional insights, contacts, or guidance on how to proceed. Specific providers discussed included Women's Center at St. Rose, which previously communicated effectively following a management transition but has recently become unresponsive. Loma – we have attempted in-person outreach during FSR visits to obtain CAP signatures or address outstanding issues, but these efforts have not resulted in responses. NorCal Imaging was also noted as a provider that has been consistently difficult to reach. The team requested assistance from committee members who may have existing relationships or updated contact information for these providers to help facilitate CAP closure, particularly given the age of some outstanding items.		

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		Committee Input Mao Moua shared that she recently worked on a PQI involving NorCal Imaging and was able to connect with a responsive contact through their Fremont location. She offered to share this contact information with Fiona to support follow-up and resolution. Loc Tran noted the possibility of partnering during on-site provider visits. He proposed coordinating joint visits with Provider Services representatives to meet with providers in person, introduce the team, strengthen relationships, and support the closure of outstanding CAPs. Leticia Alejo confirmed that collaboration is possible and welcomed the partnership. She explained that while some providers, such as NorCal Imaging, are not routinely visited, the Provider Services team will begin quarterly packet site visits starting in November. This presents an ideal opportunity to coordinate joint outreach efforts between November and December, despite broader organizational demands during that period. Loc confirmed that the team would share the list of providers requiring follow-up and expressed interest in participating in these visits. Leticia agreed to take the lead on coordination and stated that she would email Loc with the provider list and loop in the assigned Provider Services representatives for each site to facilitate scheduling and collaboration. **CAP Dashboard – Trending Providers and Contracting Discussion** The presenter reviewed the current top five trending providers with the highest CAHPS-related non-compliance. These providers include Alameda Health System, Stanford, John Muir, La Clínica, Tiburcio Vásquez, selected CHCN clinics, and UCSF Medical Center. It was noted that several of these organizations have a large number of contracted providers, which may contribute to their frequent appearance on the trending list. The CAP dashboard presentation concluded, and the floor was open for questions. Michelle Stott inquired whether there are opportunities to address recurring non-compliance through contract modifications, particularly for providers with ongoing CAPs. Melissa Vance responded that while contract updates could be explored, caution is needed. She referenced recent ECM contract amendments, which generated significant provider	Coordinate with Provider Services on upcoming scheduled visit for A&A team to visit simultaneously that are requiring follow-up.	

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		dissatisfaction due to the volume and timing of changes. Melissa emphasized that introducing new CAP-related language not already included in existing agreements would require a thoughtful approach. She recommended providing providers with clear explanations and education before incorporating such language into contracts, in order to minimize escalation and provider pushback. Melissa further suggested that cross-departmental presentations and advanced communication would help providers understand the rationale for any contractual changes and align with existing notification standards. Michelle acknowledged the explanation and agreed that the proposed approach was reasonable.		
IV. DHCS QMRT Timely Access Monitoring	S. Lal	As a reminder, the QMRTS evaluates network compliance across multiple provider types, including Primary Care Providers (PCPs), specialists, non-physician mental health providers, and ancillary providers, for both urgent and non-urgent appointment availability. The compliance benchmark for both categories is 70%. For Q2 2025, a total of 357 providers were surveyed. The overall compliance rates declined compared to the previous quarter. Urgent appointment availability decreased from 59% to 49%, while non-urgent appointment availability declined from 73% to 66%. The lower-right section of the dashboard provides a detailed breakdown of total survey responses and the number of compliant providers. The increase in survey responses this quarter—particularly among specialist providers may have contributed to a lower compliances rate.		
V. Access Related PQI Dashboard	S. Lal	For Q3, non-urgent appointment availability continued to generate the highest volume of PQIs, with 412 cases, followed by time to answer calls (192), call return time, urgent appointment availability, and in-office wait time (8). A total of 718 PQIs were received during the quarter, of which 372 were closed. Within Behavioral Health, PQIs were primarily related to non-urgent appointment availability, followed by time to answer calls and call return time. Currently, there are no outstanding QOAs, and the oldest QOA is 58 days. **Tracking, Trending, and Corrective Action Plans**		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		As part of ongoing tracking and trending efforts, 56 providers were identified as trending for two consecutive quarters. Following reassessment, 35 providers were determined to be non-compliant and issued Corrective Action Plans (CAPs). The number of trending providers increased from 44 in the previous quarter to 56, which may be attributed to the recent increase in grievance volume. The team will continue to monitor these trends and conduct deeper analysis if the numbers continue to rise. S. Lal highlighted facilities and clinics that received 15 or more referrals. While Alameda Health System (AHS) clinics consistently appear on this list, La Clínica and Tiburcio Vásquez were newly added in Q3, having not appeared in the prior quarter. **Discussion on Corrective Action Plans (CAPs) and Access Issues** Jennifer Karmelich asked what actions facilities that received CAPs in Q3 are required to take in order to close them. She noted that several Alameda Health System (AHS) clinics continue to appear on the list with a high volume of access-related issues, raising concerns that the underlying problems are not being adequately addressed. Sarbjit Lal explained that the team follows the established CAP process and maintains ongoing engagement with these providers. The team met with AHS last month to review performance data and outstanding CAPs and continue to meet with them on a monthly or quarterly basis to support resolution and closure of CAPs. Fiona Quan acknowledged that AHS continues to appear frequently due to persistent access challenges. She clarified that CAP closure is based on confirming that providers are aware of the issues, actively working toward improvement, and demonstrating progress over time. The team recently met with AHS again to review PQI data and member grievances. As part of a new approach, the team has begun sharing monthly PQI lists with AHS so they can better understand the types of grievances being filed and take corrective action directly with affected members. Jennifer expressed continued concern, emphasizing that members are being assigned to clinics that lack sufficient access, resulting in waitlists, unmet appointments, and increased grievances. She asked how providers are formally responding to CAPs given the ongoing access issues.		

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		Loc Tran responded that CAP closure requires documented corrective actions, such as hiring additional providers, expanding clinic space, or offering telehealth services. He provided an example in which AHS reported hiring two additional providers to address access issues at a site with repeated non-compliance. He acknowledged the ongoing concerns and noted that member auto-assignment had previously been placed on hold for a Highland site due to high grievance volume, then later reopened, after which grievance numbers increased again. Loc also shared that AHS access data has now been added to the compliance tracking tool and will be discussed further at an upcoming departmental meeting. He noted that AHS has cited provider turnover and space limitations as ongoing barriers, and that they are working on recruitment efforts and telehealth expansion to improve access. Further discussion and follow-up are planned. Michelle Stott provided an update on ongoing actions, noting that previous efforts, including ongoing weaning, have not been effective. She emphasized that with the inclusion of the issue in the escalation tracker alongside compliance, there is an opportunity to establish more formal corrective action plans (CAPs). Michelle highlighted the need for further discussions with senior leadership to determine the structure of a formal CAP or whether membership closures might be appropriate, especially since memberships were reopened when there was still a significant waiting list.		
VI. OB/GYN A&A Monitoring	T. Shepard	Tanisha presented the Quarter 3 OB/GYN Access and Availability Monitoring results. The intent of this report is to continuously review, evaluate, and improve timely access to care. The team continuously reviews, evaluates, and improves timely access to care, ensuring OBGYN and PCP appointments are available within 10 business days of request, specialty care within 15 days, and first prenatal visits within two weeks. For Q3, 18 QOAS were received—17 OBGYN and 1 OBGYN/PCP. Findings showed non-urgent access issues at several providers: Access Community Health (1), Newark Healthcare (2), Highland Wellness (8), Hayward Wellness Center (1), CCCMA Women's Center (1), Saint Rose (1), and TVHC (2). Specific providers included Dr. Olivia **** and Dr. Coletta Hargis, each with one non-urgent appointment.		

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		After confirmatory surveys, 16 non-compliant cases were closed, along with one complaint and one not applicable case. Persistent barriers include providers not accepting new patients and limited availability of OBGYN appointments.		
VII. Geo-Access Update • **ANC** • **SNC (CHCN & CFMG)**	T. Shepard	The Q4 Geo Access report focused on the ANC group. No new cities failed to meet time and distance standards, nor were there improvements in previously impacted cities. The report now includes the number of members affected due to geographical access, noting that members and providers should ideally be within 15 miles or 30 minutes. The 100 Points of Light membership data highlighted limited access to specialties, particularly hospital-based services such as endocrinology, ENT, general surgery, hematology, HIV, nephrology, neurology, oncology, orthopedic surgery, physical medicine, pulmonology, and pediatrics. Ongoing engagement with providers and delegates continues to address these gaps. The CFMG SNC report, based on actual membership, showed members in various cities lacking access to specialists. For example, in cardiology pediatrics, 5 of 14 members in the Newark area were outside the 15-mile/30-minute threshold. Similar gaps were observed for endocrinology, gastroenterology, general surgery, hematology, HIV, nephrology, neurology, OBGYN, oncology, ophthalmology, orthopedic surgery, physical medicine, and pulmonology. No new cities were added or removed in this reporting period. For CHCN, Livermore and Fremont consistently appeared as areas with access issues. Seven members lacked access to PCP, cardiology, and dermatology, while additional gaps were observed across endocrinology, ENT, gastroenterology, general surgery, hematology, HIV/AIDS, nephrology, neurology, OBGYN, oncology, ophthalmology, orthopedic surgery, physical medicine, and pulmonology. The team continues to collaborate with delegates and provider services to identify alternative access solutions and ensure members receive timely care.		
VIII. Provider Network Capacity	L. Alejo/ F. Quan	Leticia Alejo introduced the Q4 quarterly capacity report. She explained that any provider appearing on the report has exceeded 80% capacity. Representatives reach out directly to these providers each month to inform them of their current capacity status. Once a provider reaches 90% capacity, auto-assignments are closed, although members can still request that provider manually. At 100% capacity, the provider is completely closed to new assignments, although Alejo noted that they have not yet reached this point.		

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		Fiona Quan added further context, explaining that the network capacity report is compared against PQIs received. She noted that some providers had no PQIs, while others received several PQIs in Q3 related to non-urgent care, but was compliant upon reassessment. Dr. Lovato received four PQIs for urgent and non-urgent care and in-office wait times, Dr. Saifulrahman received two non-urgent PQIs and was compliant, Dr. Suri received five PQIs related to call response times, and Dr. De La Cruz received three PQIs related to urgent care and call response times, all of which were compliant upon reassessment. Quan then noted that access reassessments were conducted via the confirmatory survey and introduced Alex to provide updates on access-related grievances.		
IX. Grievance & Appeals Report	A. Loza	Alexandra Loza provided the Q3 grievance report for Medi-Cal, noting a total of 5,773 access-related cases, including 3,675 standard grievances, 2 expedited grievances, and 2,096 exempt access grievances. Overall, the total number of cases for Q3 was 12,807, with compliance rates exceeding 95%. Loza detailed grievances by type and filed-against category, highlighting clinics with the highest number of access complaints, including AHS clinics (434 grievances) and CHCN clinics (221 grievances). Providers with five or more grievances were identified, including AmCare Medical Group, West Coast Medicine and Cardiology, Roots Community Health Center, East Bay Cardiovascular and Medical Specialists, La Loma Medical Group, Progressive Urgent Care, and Webster Medical Clinic. No specialists had five or more grievances for the reporting quarter. Exempt grievance tracking showed 1,099 grievances against the plan, primarily related to technology, telephone issues, replacement ID cards, and member portal access, with 415 grievances against clinics and notable complaints for Davis St. and Roots Community Health Center. For IHSS, Loza reported 300 access cases, including 212 standard, 1 expedited, and 87 exempt grievances, with a total of 578 GNA cases and compliance rates over 95%. The majority of grievances were related to technology/telephone issues, authorization, and provider availability. Clinics with five or more grievances included Hayward Wellness Center, Kylen Wellness Center, Asian Health Services, Access Community Health, and East Bay Cardio and Medical Specialists. No PCPs or specialists reached five or more grievances for the quarter. Michelle Stott inquired about ID card complaints. Loza confirmed that KP is the vendor responsible for printing. Judy Rosas explained that recent issues were due to two systems which delayed ID card processing. Both issues have been resolved, and an alert system has been implemented to prevent future delays.		

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Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
X. FSR/MRR Updated	C. Hung	Crystal Hung, Quality Review Nurse for the FSR team, presented the Q3 2025 Facility Site Review (FSR) and Medical Record Review (MRR) performance. She began by explaining the different types of reviews conducted throughout the audit cycle: initial reviews for new providers, periodic reviews required every three years by DM DHCS, focus medical record reviews for sites not meeting the 80% threshold or with specific deficiencies, interim monitoring reviews for ongoing compliance, and PARS (Physical Accessibility Review Survey) assessments measuring accessibility for individuals with disabilities. For Q3, the team conducted a total of 64 reviews, including 16 periodic site reviews, 19 medical record reviews (1 initial, 18 periodic), 3 focus medical record reviews, 13 interim monitoring reviews, and 13 PARS assessments. Additionally, nine educational training sessions were conducted to support clinics in audit preparation and corrective action plan (CAP) closure. C. Hung reported that one facility failed the FSR and was placed on a membership hold—East Bay Cardiovascular and Medical Specialists—due to deficiencies identified in both the FSR and MRR. Across all FSR/MRR reviews for the quarter, 31 CAPs were issued, with 29 responses received within 30 days, resulting in a 94% compliance rate. Critical element CAPs were addressed within 10 business days, and all CAPs are monitored to ensure closure within 90 days to prevent membership holds or escalations. Common critical element findings included the use of non-safety needles at five facilities, non-functional or missing Ambu bags, and improper syringe/needle handling, all of which were corrected within the 10-business-day timeframe. Non-safety needles were identified as those not retractable by OSHA and DHCS standards. In addition, C. Hung presented Q3 IHA audit results for 18 eligible cases, with a compliance rate of 72%. The most common deficiencies were incomplete comprehensive HMPs or system reviews and missing dental assessments. Non-compliant providers received CAPs and educational support, while passing providers were provided with audit findings for reference. Finally, the team shared CMS Star Rating monitoring for SNFs and long-term care facilities. No quality issues were identified in Q3, and outreach was conducted for any facilities with ratings of two stars or below to ensure improvement efforts were in place.		

ACCESS AND AVAILABILITY SUBCOMMITTEE
November 05, 2025
Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
XI. Member Services – Telephone wait time & Call Center Dashboard	J. Rosa	J. Rosa presented the Member Services Blended Call Center report for Q3 2025. Call volume increased by 7% compared to Q2, totaling 57,236 incoming calls. This volume matched the high levels experienced in Q1 2025. The top five reasons for calls in Q3 were eligibility, enrollment/benefits, PCP changes, grievances and appeals, and ID cards/member materials requests. The call center successfully met its key performance indicators, answering 80% or more of calls within 30 seconds and maintaining an abandonment rate of 5% or less. Future reports will also include DSNP KPIs. Gia DeGrano noted that, despite a reported decrease in membership, call volume remained nearly identical to Q1, historically the highest call volume of the year.		
XII. Q&A	All			
XIII. Meeting Adjourn	L. Tran	Next Meeting: 3/17/2026		

Meeting Minutes submitted by: Sarbjit Lal, Quality Improvement Project Specialist   **Date: 12/31/2025**