Quality Improvement Health Equity Committee Voting Packet

November 14, 2025

- **2026 QI Program Description**
- **Committee Meeting Minutes**

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

2026 QI Program Description (Clean)

2026 QI Program Description (Red Lined)

QIHEC: 8/8/25

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

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM DESCRIPTION

2026

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

2026 Quality Improvement Health Equity Program Description Signature Page

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Michelle N. Stott, R.N., M.S.N. Date
Senior Director of Quality

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Stephanie Brown, MD, MPH Date
Medical Director of Quality
Vice Chair, Quality Improvement Health Equity Committee

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Lao Paul Vang Date
Chief Health Equity Officer

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Donna Carey, MD, MS Date
Chief Medical Officer
Chair, Quality Improvement Health Equity Committee

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Matthew Woodruff Date
Chief Executive Officer
Chair, Quality Improvement Health Equity Committee

_____ _____

Rebecca Gebhart Date
Board Chair

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OVERVIEW

Alameda County for Health (Alliance) is a local, Knox-Keene licensed, National Committee for Quality Assurance (NCQA) accredited, public, not-for-profit managed care health plan. The Alliance is committed to making high quality health care services accessible and affordable for vulnerable populations in Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance board of governors, staff, and provider network all reflect the county's cultural and linguistic diversity. The Alliance provides health care coverage to more than 400,000 children and adults.

Alameda Alliance for Health is licensed by the State of California and product lines include Medi-Cal, Dual Eligible Special Needs Plan (D-SNP), and Group Care commercial insurance. Medi-Cal managed care beneficiaries are eligible through one of several Medi-Cal programs, e.g. Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion. For dually eligible Medi-Cal and Medicare beneficiaries, Medicare coverage remains the primary insurance, and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Alameda Alliance Wellness plan is a specialized Medicare Advantage plan that is designed to provide specialized care for individuals who a dually eligible for Medicare and Medi-Cal. This plan offers comprehensive care coordination and wrap around services to enhance member outcomes. The Alliance operates as an Exclusively Aligned Enrollment (EAE) D-SNP plan meaning members are enrolled in both the Alliance for Medicare benefits and the Alliance Managed Care Plan (MCP) for Medi-Cal benefits. This structure facilitates care coordination and benefit integration, following the Special Needs Plan Model of Care Framework as established by the Bipartisan Budget Act (BBA) of 2018.

The plan's Quality Improvement initiatives are tailored specifically to the needs of the D-SNP population, which aims to enhance health outcomes, quality of life, and overall care experience for dually eligible beneficiaries.

The Alliance Quality Improvement Health Equity (QIHE) Program applies to all product lines and strives to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE program includes systematic and continuous activities to monitor, evaluate, and improve the health equity and health care delivered to members in accordance with the standards set forth in applicable State and Federal regulations.

The QIHE Program description is a comprehensive document with a set of interconnected documents that describes our quality program governance, structure and responsibilities, operations, scope, goals, and measurable objectives. Participation of all Alliance departments and staff in quality improvement activities is essential to the organization in achieving our QIHE goals and objectives.

The Alliance complies with applicable State and Federal civil rights laws and does not discriminate based on race, ethnicity, culture, gender, gender identity and expression, sexual orientation, socioeconomic status, religion, spirituality, disability, age, national origin, immigration status, and language The Alliance QIHE Program is committed to serving the healthcare needs of our culturally and linguistically diverse membership. The Alliance staff and provider network reflect the county's cultural and linguistic diversity.

MISSION AND VISION

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of their life.

QIHE PROGRAM SCOPE AND GOALS

The purpose of the Alliance QIHE Program is to objectively monitor and evaluate the quality, safety, appropriateness, health equity, and outcome of care and services delivered to members of the Alliance. The overall goal of the QIHE Program is to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE Program is structured to continuously pursue opportunities for improvement and problem resolution. The QIHE Program is organized to meet overall program objectives as described below and as directed each year by the QIHE and UM Work Plans. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

Although not limited to, the goals of the QIHE Program are to:

1. Maintain the delivery of high quality, safe, and appropriate medical and behavioral health care that meets professionally recognized standards of practice that are delivered to all enrollees.
2. Consider health equity principles in the conceptualization, development, delivery and evaluation metrics of all lines of business at the Alliance.
3. Utilize objective and systematic measurement, monitoring, and evaluation through qualitative and quantitative analysis of health care services and to implement QIHE activities based on the findings.
4. Conduct performance improvement activities that are designed, implemented, evaluated, and reassessed using industry recognized quality improvement models such as Plan-Do-Study-Act (PDSA).
5. Ensure physicians, appropriate licensed professionals, or clinicians, including behavioral health, are an integral and consistent part of the QIHE Program.
6. Ensure medical and behavioral health care delivery is consistent with professionally recognized standards of practice.
7. Track and trend the delivery of healthcare services to ensure care and services are not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
8. Design and maintain an ongoing organizational culture of quality to ensure continual HEDIS improvement and accreditation readiness.
9. Monitor and evaluate the Alameda Alliance Wellness Model of Care to determine if the framework adequately addresses enrollees' unique healthcare needs.

The scope of the QIHE Program is comprehensive and encompasses the following:

1. Timely access and availability to quality and safe medical, behavioral, and specialty health care and services.
2. Care and disease management services.
3. Cultural and linguistic services.
4. Patient safety.
5. Member and provider experience.
6. Continuity and coordination of care across settings, with the goal of establishing consistent

provider-patient relationships.

7. Tracking of service utilization trends, including over-and under-utilization.
8. Clinical practice guideline development, adoption, distribution, and monitoring.
9. Targeted focus on acute, chronic, and preventive care services for children and adults for Member and provider education.
10. Prenatal, primary, specialty, emergency, inpatient, and ancillary care.
11. Case review, investigation, and corrective actions of potential quality issues
12. Credentialing and re-credentialing activities.
13. Delegation of oversight and monitoring.
14. Delegate and direct provider performance improvement project collaborations.
15. Targeted support of special needs populations including seniors and persons with disabilities, dual special needs most vulnerable population, and persons with chronic conditions.
16. Population health management integration.
17. Health care diversity and equity.
18. Make recommendations to the Board of Governors (BOG) regarding the processes and outcomes of quality assurance and improvement activities.

ORGANIZATIONAL STRUCTURE AND SUPPORT COMMITTEES' RESPONSIBILITY

Overview

The Alliance Board of Governors (BOG) appoints and oversees the Quality Improvement Health Equity Committee (QIHEC), Pharmacy & Therapeutics (P&T) Committee, Peer Review Committee, Credentialing Committee, Community Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program.

The organizational chart in **Appendix A** displays the reporting relationships for key staff responsible for QIHE activities at the Alliance. **Appendix B** displays the committee reporting relationship and organizational bodies.

Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent members, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QIHE Program. Its duties include:

- Reviewing annually, updating, and approving the QIHE Program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing and approval of the annual QIHE report and evaluation of QIHE workplan, studies, activities, and data on utilization and quality of services.

- Assessing QIHE Program's effectiveness and direct modification of operations as indicated.
- Monitoring and evaluating the D-SNP Model of Care and accompanying workplan.
- Defining the roles and responsibilities of QIHEC.
- Designating a physician member of senior management with the authority and responsibility for the overall operation of the QIHE program, who serves on QIHEC.
- Appointing and approving the roles of the Chief Medical Officer (CMO), including the support of the Chief Health Equity Officer, and other management staff in the QIHE Program.
- Receiving a report from the CMO as Chair on the agenda and actions of QIHEC.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is a standing committee of the BOG and meets a minimum of four times per year, and as often as needed, to follow up on findings and required actions. The QIHEC includes oversight and representation for all lines of business including Medi-Cal, GroupCare, and Alameda Alliance Wellness. The QIHEC is responsible for the implementation, oversight, and monitoring of the QIHE Program and Utilization Management (UM) and Care Management Programs. The QIHEC approves and recommends policy decisions, analyzes and evaluates the QIHE work plan activities, and assesses the overall effectiveness of the QIHE Program. The QIHEC reviews results and outcomes for all QIHE activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. The QIHEC Program monitors and evaluates the Alliance Model of Care to determine if the overall framework adequately addresses members' unique healthcare needs. Any quality issues related to the health plans that are identified through the CAHPS, Health Outcomes Survey (HOS), Case Management, and Provider Satisfaction surveys. Health plan service reports are also discussed and addressed at QIHEC meetings. The QIHEC oversees and reviews all QI delegation summary reports and evaluates delegate quality program descriptions, program evaluations, and work plan activities. The QIHEC presents to the Board the annual QIHE Program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The Annual QIHE Program, Work Plan, and Evaluation from the QIHEC (or other related documents as requested) are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include but are not limited to:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, satisfaction surveys (i.e. CAHPS), and findings and activities of the quality committees, such as the Community Advisory Committee.
- Ensures the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis
- Determine if the Alameda Alliance Wellness MOC framework adequately addresses members' unique healthcare needs using specific quality metrics, data, analysis, improvement planning, and remeasurement.
- Approve, select, design, and schedule studies and improvement activities.
- Review member and provider survey results and related improvement initiatives.
- On-going reporting to the BOG.
- Meet at least quarterly and maintain approved minutes of all committee meetings.

- Approve definitions of outliers and develop corrective action plans.
- Recommend and approve medical necessity criteria, clinical practice guidelines, as well as pediatric and adult preventive care guidelines and review compliance monitoring.
- Review member grievance and appeals data.
- Oversee the plan's UM and Care Management Programs.
- Review advances in healthcare technology and recommend incorporation of new technology into delivery of services as appropriate.
- Institute actions to address performance deficiencies, including policy recommendations, and ensure follow-up of identified findings.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QIHE goals.
- Evaluate annually the effectiveness of the QIHE and Population Health Management program.
- Oversee the Alliance complex case management and disease management programs.
- For providers that are delegated for QI, including fully delegated subcontractors and downstream fully delegated subcontractors, are required to maintain a QIHEC that meets the QIHE program requirements.
- Review and approve annual QIHE and UM/CM program descriptions, work plans, and evaluations.
- Recommend and approve resource allocation for the QI Department Program.

The QIHEC is chaired by the CMO and vice-chaired by the Medical Director of QI. The members are representatives of the Alliance contracted provider network including those who provide health care services to members affected by health disparities, limited English proficiency (LEP) members, children with special health care needs (CSHCN), seniors and persons with disabilities (SPD), and persons with chronic conditions. The QIHEC members are appointed for two-year terms. The voting membership includes:

- Chief Medical Officer (Chair)
- Medical Director of Quality (Vice-Chair)
- Chief Executive Officer (ex officio)
- Chief Health Equity Officer
- Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group) representing:
    - Practicing provider representing Internal Medicine
    - Practicing provider representing Family Practice
    - Practicing provider representing Pediatrics
    - Practicing provider representing Behavioral Health
    - Practicing physician(s) representing common medical specialties
- Medical Directors

- Senior Director, Quality
- Executive Director, Medicare Programs

A quorum is established when the majority of voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee assists the QIHEC in oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting summaries and changes in Pharmacy related policies are presented directly to the Board of Governors.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Senior Director, Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties
- Practicing physician representing gerontology for the D-SNP population
- Practicing Behavioral Health specialist (e.g., psychologist, psychiatrist)
- Practicing community pharmacists contracted with Alliance (not to exceed three pharmacists)

Peer Review and Credentialing Committee (PRCC)

The PRCC is a standing committee of the BOG that meets a minimum of ten times per year. The Alliance separates ~~d~~ the functions of PRCC into two distinct committees – the Peer Review Committee (PRC) and the Credentialing Committee (CC). The chair of both committees is the CMO.

CREDENTIALING COMMITTEE

Primary responsibilities include:

- Ensuring that all applicants are reviewed against minimum standards or criteria and are treated fairly.
- Determining whether there is adequate/sufficient information to evaluate and make a determination/recommendation.
- Implementation and ongoing review of credentialing policies and procedures.
- Assuring that the credentialing process conforms to applicable accreditation standards and other regulatory requirements.
- Making recommendations or decisions related to participation, appointment, and privileges.

PEER REVIEW COMMITTEE

Primary responsibilities include:

- Investigating complaints regarding the quality of clinical care provided by the Alliance's contracted providers and making recommendations for corrective action.
- Reviewing conditions identified as having quality concerns.

The following Committee members have voting rights:

- Committee Chairperson
- Committee Vice Chairperson
- Committee Member: Positions held by practitioners

Internal Quality Improvement Committee (IQIC)

The IQIC assists the QIHEC in oversight and assurance of the quality of clinical care, patient safety, and customer service provided throughout the Alliance organization. Its primary roles are to maintain and improve clinical operational quality, review organization-wide performance against the Alliance quality goals, and report results to the QIHEC.

Committee Responsibilities include but are not limited to:

- Develop, approve, and monitor a dashboard of key performance and QIHE indicators compared to organizational goals and industry benchmarks.
- Oversee and evaluate the effectiveness of the Alliance performance improvement and quality activities.
- Review reports from workgroups and, if acceptable, forward them for review at the next scheduled QIHEC.
- Review plan and delegate corrective plans regarding negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the QIHEC on all matters related to:
    - Quality of Care, Patient Safety, and Member/Provider Experience.
    - Performance Measurement.
    - Preventive services including:
        - Seniors and Persons with Disability (SPD)
        - Dual Eligible Special Needs Plan members
        - Members with chronic conditions
        - Medi-Cal Expansion (MCE) members.

The Committee shall be comprised of the following members:

- Chief Medical Officer (CMO)
- Medical Director(s)
- Sr. Director, Quality
- Quality Improvement Manager
- 1 Representative from Grievances and Appeals

- 1 Representative from Compliance
- 1 Representative from Healthcare Analytics
- 1 Representative from Population Health & Equity
- 1 Representative from Health Care Services
- 1 Representative from Member Services
- 3 Representatives from Quality Improvement
- 2 Representatives from Medicare Operations
- 1 Representative from Health Equity

Utilization Management Committee (UMC)

The UMC is a forum for facilitating clinical oversight and direction. Its responsibilities are to:

- Maintain the annual review and approval of the:
    - UM and CM Program Descriptions, UM and CM Policies/Procedures, UM Criteria, and UM Decision-Making Hierarchy
    - Other pertinent UM documents such as the UM and CM Program Evaluations, UM and CM Workplan, and any trends or updates pertaining to the workplans.
    - Enhanced Care Management (ECM) and Community Supports Policies/Procedures
    - California Integrated Care Management (CICM) Policies and Procedures
    - Health Risk Assessment (HRA) and Health Information Form/Member Evaluation Tool (HIF/MET) Policies and Procedures
    - Face-to-Face Encounters Policies and Procedures
    - Transitions of Care Policies and Procedures (D-SNP)
    - Palliative Care Case Management Policies and Procedures (D-SNP)
- Participate in the utilization management/continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and under-utilization and recommend appropriate actions when indicated.
- Review and analyze utilization data for the identification of trends, including trends related to health disparities, social determinants of health, and behavioral health.
- Recommend actions to the QIHEC when opportunities for improvement are identified from review of utilization data including, but not limited to ambulatory visits, emergency visits, hospital utilization rates, hospital admission rates, average length of stay rates, and discharge rates.
- Review information about new medical technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as new benefit criteria for members.

Access and Availability Subcommittee (AASC)

The AASC reviews the Alliance's access and availability data to evaluate whether the Alliance is meeting regulatory standards and provides corrective actions and recommendations for improvement

when needed. The committee identifies opportunities for improvement and provides recommendations to maintain compliance with access and availability regulatory requirements.

Membership is comprised of Alliance staff within departments that are involved with access and availability which include the following representation:

- Chief Medical Officer
- Medical Directors
- Senior Director, Quality
-
- Access to Care Manager
- 1 Representative from Grievances and Appeals
- 1 Representative from Compliance
- 1 Representative from Healthcare Analytics
- 1 Representative from Population Health & Equity
- 1 Representative from Utilization Management
- 1 Representative from Member Services
- 1 Representative from Provider Services
- 3 Representatives from Quality Improvement
- 1 Representative from Medicare Operations
- 1 Representative from Health Equity

The following are the monitoring activities the subcommittee reviews to ensure compliance with access and availability and network adequacy requirements including but not limited to:

- Provider network capacity levels
- Facility site Reviews
- Geographic accessibility
- Appointment availability surveys
- High volume and high impact specialists
- Access-related grievances and appeals, which may include access-related potential quality issues, provider language capacity, wait time and telephone practices related to access, and member and provider satisfaction survey
- After-hours care

Cultural and Linguistic Services Subcommittee (CLSS)

The Cultural and Linguistic Services Subcommittee's role is to ensure members receive culturally and linguistically appropriate health care services and to monitor the Alliance's Cultural and Linguistic Services Program. The CLSS reviews demographic changes in the Alliance membership, language services, grievances and potential quality issues related to language access and discrimination, alternative formats and translation services, and overall execution of the Alliance's Cultural and Linguistic Services Program. The CLSS makes recommendations for organizational and program

changes as needed and reports results to the QIHEC.

Responsibilities include but are not limited to:

- Monitor the cultural and linguistic needs of members.
- Review reports related to provision of cultural and linguistic services.
- Ensure that language assistance services are provided at all points of contact.
- Maintain and update cultural and linguistic services policies and procedures to be compliant with ongoing regulatory and contractual requirements.
- Annually review and update Cultural and Linguistic Services (CLS)'s program description and workplan. Quarterly monitor the CLS Workplan.
- Review input from the Community Advisory Committee (CAC) on cultural and linguistic services and consider how it may inform Alliance's CLS programs, policies, and procedures.
- Identify issues related to access and provision of culturally and linguistically appropriate services and develop corrective actions to correct deficiencies found.
- Review plan and delegate corrective action plans related to CLS.

The CLSS is composed of the following members:

- Chief Medical Officer
- Chief Health Equity Officer
- Senior Director of Quality
- Director, Population Health, and Equity
- Manager, Cultural and Linguistic Services
- Manager, Population Health, and Equity
- 1 Representative from Compliance
- 1 Representative from Communications and Outreach
- 1 Representative from Grievance and Appeals
- 1 Representative from Population Health and Equity
- 1 Representative from Health Care Services
- 1 Representative from Member Services
- 1 Representative from Provider Services
- 1 Representative from Quality Improvement
- 1 Representative from Behavioral Health
- 1 Representative from Medicare Operations

Community Advisory Committee (CAC)

The CAC provides a link between the Alliance and the community. The CAC reflects the Alliance's member population and advises the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity. All CAC findings and/or activities are reported to the QIHEC.

The CAC carries out, but is not limited to, the following duties:

- Identify and advocate for preventive care practices to be used by the Alliance.
- Develop and update cultural and linguistic policy and procedures related to cultural competency issues, educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability.
- Advise on Alliance member and provider-targeted services, programs, and trainings.
- Provide and make recommendations about the cultural appropriateness of communications, partnerships, and services.
- Provide recommendations and feedback on the diversity, equity, and inclusion training program as applicable.
- Inform and validate the development of the Alliance's community reinvestment plans.
- Provide input, advise, and make recommendations to address quality of care, health equity, health disparities, population health management (PHM), children services such as the Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs)
- Utilize findings from the CHAs/CHIPs to influence Alliance strategies and workstreams related to the Department of Healthcare Services Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.
- Provide input and advice, including, but not limited to, the following:
    - Culturally appropriate services or program design
    - Priorities for health education and outreach program
    - Member satisfaction survey results
    - Plan marketing materials and campaigns
    - Communication of needs for Network development and assessment
    - Community resources and information
    - PHM
    - Quality
    - Development of covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan
    - Input on Quality Improvement and Health Equity and the Population Needs Assessment
    - Reforms to improve health outcomes, accessibility of services, and coordination of care for Members
    - Inform the development of the provider manual

In consultation with the Alliance's Chief Health Equity Officer, the Alliance convenes a CAC Selection Committee, tasked with selecting members of the CAC, providing the recommendations and/or replacing former CAC members whose position(s) have been vacated that reflect the general Medi-Cal, Group Care and Alameda Alliance Wellness member populations, hard to reach populations, and those that experience health disparities in Alameda County. The CAC Selection Committee will report to the Alliance Board of Governors.

The CAC membership and representation must reasonably reflect the Medi-Cal, Group Care, and Alameda Alliance Wellness populations in Alameda County, and representation must include the following:

- General population of the Alliance members.
- Adolescents and/or parents and/or caregivers of children.
- Current/former foster youth and/or parents/caregivers of current/former foster youth.
- Members who receive Long-Term Support Services and/or their representatives.
- Representatives from Indian Health Care Providers (IHCP).
- Diverse and hard-to-reach populations (with emphasis on persons who are representatives of or serving populations that experience health disparities, such as those with limited English proficiency (LEP), diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities).
- Members who receive enhanced care management (ECM) and community support (CS) services as appropriate.
- At least 51% of the committee shall be Alliance members (and/or the parents/guardians of Alliance members who are minors or dependents).
- At least 4 seats of the committee shall be Alliance Wellness Dual Eligible Special Needs (D-SNP) members and/or their caretakers.

Joint Operations Committee/Delegation

The contractual agreements between the Alliance and delegated entities specify:

- The responsibilities of both parties.
- The functions or activities that are delegated.
- The frequency of reporting on those functions and responsibilities to the Alliance and how performance is evaluated.
- Corrective action plan expectations, if applicable.

The Alliance may delegate QI, Credentialing, UM, Case Management, Disease Management, Claims, Grievance and Appeals activities to Health Plans, County entities, and/or vendors that meet the requirements as defined in a written delegation agreement, delegation policies, accreditation standards, and State and Federal regulatory standards.

To ensure delegated entities meet required performance standards, the Alliance:

- Provides oversight to ensure compliance with Federal and State regulatory standards, and accreditation standards.

- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities.
- Conducts annual oversight audits.
- Reviews reports from delegated entities.
- Collaborates with delegated entities to continuously improve health service quality.

As part of delegation responsibilities, delegated entities must:

- Develop, enact, and monitor quality plans that meet contractual requirements and Alliance standards.
- Provide encounter information and access to medical records pertaining to Alliance members as required for HEDIS and regulatory agencies.
- Provide a representative to the Joint Operations Committee.
- Submit at least semi-annual reports or more frequently if required on delegated functions.
- Cooperate with state/federal regulatory audits as well as annual oversight audits.
- Complete any corrective action deemed necessary by the Alliance.

The Alliance collaborates with delegated entities to formulate and coordinate QIHE activities and includes these activities in the QIHE work plan and program evaluation. Delegated activities are a shared function. Delegate program descriptions, work plans, reports, policies and procedures, evaluations and audit results are reviewed by the Subcontractor & Delegation Oversight Committee (SDOC) and Joint Operations Committee and findings are summarized at QIHEC meetings, as appropriate.

The Alliance currently delegates the following functions:

Table 1: Alameda Alliance Delegated Entities

ALAMEDA ALLIANCE DELEGATED ENTITIES - 2026																
	Delegated Entity Name	Utilization Management X = NCQA Accredited			Case Management			Quality Management / Quality Improvement			Credentialing X = NCQA Accredited			Claims		
		Medi-Cal	Group Care	D-SNP	Medi-Cal	Group Care	D-SNP	Medi-Cal	Group Care	D-SNP	Medi-Cal	Group Care	D-SNP	Medi-Cal	Group Care	D-SNP
1	Children's First Medical Group (CFMG)	X									X			X		
2	Community Health Center Network (CHCN)	X	X		X	X								X	X	
3	Liberty Dental			X						X			X			X
4	PerformRx (PBM)		X	X								X	X		X	X
5	Vision Service Plan (VSP)							X		X	X		X	X		X
6	Lucille Packard (Credentialing)										X	X				
7	Physical Therapy PN (Credentialing)										X	X				
8	Teladoc (Credentialing)										X	X				
9	UCSF (Credentialing)										X	X				

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM RESOURCES

Responsibilities for QIHE Program activities are an integral part of all Alliance departments. Each department is responsible for setting and monitoring quality goals and activities.

The Alliance QI Department is part of the Health Care Services Department, and responsible for implementing QIHE activities and monitoring the QIHE Program. The QI Department participates in the accreditation process, manages the HEDIS, Stars, CAHPS, and HOS data collection and improvement process, conducts facility site reviews (FSRs), processes Potential Quality Issues (PQIs), and oversees the quality activities in other departments and those performed by delegated groups.

Resource allocation for the QI Department is determined by recommendations from the QIHEC, CMO, CEO and BOG. The Alliance recruits, hires, and trains staff, and provides resources to support activities required to meet the goals and objectives of the QIHE Program.

The Alliance's commitment to the QIHE Program extends throughout the organization and focuses on QIHE activities linked to service, access, continuity and coordination of care, and member and provider experience. The Senior Director of Quality, with direction from the Medical Director of Quality CMO, and CHEO, coordinates the QIHE Program. Titles, education and/or training for key positions within the Quality Department include:

Chief Medical Officer

The Alliance Chief Medical Officer (CMO) is responsible for and oversees the QIHE Program. The CMO has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The CMO provides leadership to the QIHE Program through oversight of QI study design, development, implementation, and chairs the QIHEC, PR,CC, and P&T committees. The CMO makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the BOG. The CMO reports to the Alliance CEO.

Chief Health Equity Officer

The Chief Health Equity Officer (CHEO) reports directly to the Chief Executive Officer (CEO).The position partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees. The executive position implements policies that ensure health equity is prioritized and addressed and is responsible for setting and implementing an overarching vision of DEI for the organization, including programmatic and administrative outcomes. The position is responsible for the promotion of internal and external DEI for members, providers, and employees. With supervision by the Chief Medical Officer (or designee) of the QIHE program, the CHEO participates in QIHEC and collaborates on QIHE program activities.

Medical Director, QI

The Medical Director has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The Medical Director is part of the medical team and is responsible for strategic direction of the Quality Improvement Health Equity programs. The Medical Director also forms a dyad partner with the Sr. Director of Quality and serves as an internal expert, consultant, and resource in QI. They are responsible for clinical appropriateness, quality of care, pay for performance, access and availability, provider experience, member experience and cost-effective utilization of services delivered to Alliance members. The Medical Director participates in the grievance and external medical review procedure process, resolving medically related and potential

quality related grievances, and issuing authorizations, appeals, decisions, and denials. The Medical Director reports to the CMO.

Senior Director of Quality

The Senior (Sr.) Director of Quality is responsible for the strategic direction of the Quality Improvement Health Equity Program. This position has direct oversight for the development, implementation, and evaluation of the QIHE Program. This position is responsible for all performance improvement activities, including improving access and availability of network services, developing and managing quality programs as identified by CMS, DHCS, DMHC, and NCQA. This includes QIPs, PIPs, Improvement Programs i.e., HEDIS/MCAS measures, Stars (in collaboration with the Medicare Operations), QI Standards as well as managing, tracking, analyzing, and reporting member experience/satisfaction (i.e. Consumer Assessment Health Plan Surveys (CAHPS) as requested. The Sr. Director is also responsible for the oversight of FSR and potential quality issues (PQIs) and will direct performance improvement and access and availability activities. The Sr. Director is also the senior nurse to the organization to augment clinical oversight. This position, along with the Director of Population Health & Equity, assists with setting the priorities of the Population Health Management program, and ensures Health Education and Cultural and Linguistic Services are incorporated into the QIHE program. The Sr. Director of Quality is a dyad partner with the QI Medical Director and reports to the CMO.

Senior Director of Behavioral Health

The Senior Director of Behavioral Health has relevant experience and current knowledge in clinical program administration, including behavioral health and autism spectrum disorder management. The Sr. BH Director is responsible for and oversees the BH program. Responsibilities include participating in the QI, UM, and CM processes as they pertain to behavioral health and autism spectrum disorder programs. The Senior Director of BH reports to the Chief Medical Officer.

Director of Population Health and Equity

The Director of Population Health and Equity (PHE) provides operational oversight and leadership for the Alliance's population health assessments, strategy and evaluation. The PHE Director is also responsible for state and federal regulatory and accreditation requirements concerning Population Health Management, Cultural and Linguistic Services and the member Health Education Program. This position reports to the Senior Director of Quality Improvement and works closely with the Chief of Health Equity.

Director of Quality Performance

The Director, Quality Performance is responsible for developing, coordinating, implementing, and managing the strategic quality performance programs across multiple lines of businesses including Medi-Cal, Dual Eligible Special Needs Program (D-SNP), and Group Care. This role will work cross-functionally to monitor and implement quality initiatives to achieve state and national benchmarks for National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), Centers for Medicare & Medicaid (CMS) Star Ratings, Department of Health Care Services Medi-Cal Managed Care Accountability Set, and Department of Managed Health Care (DMHC) Health Equity and Quality Measure Set.

Manager of Population Health and Equity

The Population Health and Equity (PHE) Manager is responsible for the implementation of the Alliance's population health assessments, strategy and evaluation. In addition, the PHE Manager

oversees the execution of the Alliance's population health and health education programs and related equity initiatives, supervises PHE staff, and ensures compliance with state and federal regulatory and accreditation requirements concerning population health management and health education.

Manager of Cultural and Linguistic Services

The Cultural and Linguistic Services (CLS) Manager is responsible for direct oversight of the Alliance Cultural and Linguistic Services Program. This includes activities such as ensuring members have access to language assistance services for interpreting services, review of provider capacity to meet the cultural and linguistic needs of members, and overall assessment of the cultural and linguistic needs of members. The CLS Manager is also responsible for compliance with state and federal regulatory and accreditation requirements related to CLS. Furthermore, the CLS Manager leads the planning and implementation of internal and external committees, such as the Cultural and Linguistics Services Subcommittee and the Community Advisory Committee. The CLS manager reports directly to the Population Health and Equity Director.

Quality Performance Manager

The Quality Performance Manager (QPM), is responsible in advancing the goals of the Quality Improvement and Health Equity (QIHE) program. The QPM is responsible for the day-to-day management of the Performance Improvement Team, including but not limited to HEDIS/MCAS project improvement oversight, physician practice activities, and Quality and Performance Improvement Project oversight. The QI Manager also acts as liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The QPM works collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems including PDSA (Plan-Do-Study-Act).

Manager, Access to Care

The Manager, Access to Care is responsible for day-to-day management of access to care activities throughout the organization and includes leading and establishing appropriate access to care systems. The Manager, Access to Care ensures the access program complies with timely access standards as regulated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA). The Access to Care Manager ensures planning and oversight of access to care surveys, ensures appropriate follow-up when compliance monitoring identifies deficiencies. The Manager, Access to Care reports to the Sr. Director of Quality.

Accreditation Manager

The Accreditation Manager is responsible for management of NCQA Health Plan Accreditation and Health Equity Accreditation. Role is responsible for internal monitoring of regulatory requirements and standards.

Quality Improvement Clinical Supervisor

The Quality Improvement Clinical Supervisor works collaboratively throughout the organization to ensure appropriate oversight of performance management and clinical quality improvement assignments. The Quality Improvement Clinical Supervisor is responsible for day-to-day supervision of the work assigned to the clinical staff in the Quality Department. The Supervisor also acts as liaison between the health plan's physician leadership and community practitioners/providers of care across

all specialties and delegates. The Quality Improvement Clinical Supervisor is responsible for oversight of timely and accurate investigation and completion of Potential Quality Issues (PQI), Provider Preventable Conditions (PPC), and quality of care corrective action plans, and participation in HEDIS activities as needed. The QI Clinical Supervisor reports to the Sr. Director of Quality.

Quality Review Nurse (3)

The Quality Review Nurse is a registered nurse responsible for timely and accurate investigation and completion of Potential Quality of Care Issues (PQIs), collecting quality related data and reviewing medical records for HEDIS abstraction and overreads as able, chart audits, regulatory compliance, quality improvement (QI) activities development, data tracking and trending, and outcomes reporting. The Quality Review Nurse keeps accurate records, manages, and analyzes data, as well as responds appropriately and timely, both verbally and in writing to internal and external clinical issues of staff and regulatory agencies. The Quality Review Nurse identifies, investigates, and reports on Potential Quality Issues (PQIs) and Provider Preventable Conditions (PPCs) as appropriate. Cases involving quality-of-care issues are presented to the Medical for review and determination.

Clinical Review Nurse (2)

The Clinical Review Nurse is responsible for investigating and processing comprehensive and complex grievances and appeals requests from members and providers, coding justifications, and provider disputes. This role has oversight by the Medical Director and CMO, and matrixed to the Grievance and Appeals team within the Operational Division.

Senior Quality Improvement Nurse Specialist (1)

The Senior Quality Improvement Nurse Specialist is responsible for the training, certification and recertification of DHCS facility site reviews (FSR) and medical record reviews (MRR) for all Alliance Provider Network and Delegated Provider Oversight. The Sr. QI Nurse Specialist is also responsible for the oversight and monitoring of the qualitative and quantitative content of the medical record process and maintaining compliance with state and regulatory quality of care standards. The Sr. QI Nurse Specialist develops provider training and education materials to assist providers with meeting quality standards.

Quality Improvement Review Nurse (1)

The Quality Improvement Review Nurse conducts facility site reviews, chart audits, regulatory compliance, quality improvement (QI) activities, and provider training. The QI Review Nurse partners with the Sr. QI Nurse Specialist to certify and recertify the Alliance Provider Network and Delegated Provider Oversight.

Quality Performance Supervisor

The Supervisor, Quality Performance, plays a critical operational role in advancing the goals of the Quality Improvement and Health Equity (QIHE) program. Under the oversight of Quality Improvement Manager, this position is responsible for implementing high-impact quality initiatives, managing complex, cross-functional projects, and supervising a team to ensure the achievement of key performance indicators (KPIs) related to health outcomes, member engagement, and regulatory compliance.

Quality Improvement Project Specialist II (4)

The Quality Improvement Project Specialist II (QIPS II) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation and facilitation of performance improvement projects. The QI Project Specialist II conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Quality Improvement Project Specialist I (5)

The Quality Improvement Project Specialist I (QIPS I) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation, and facilitation of performance improvement projects. The QI Project Specialist I conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Accreditation and Regulatory Compliance Specialist (2)

The Accreditation and Regulatory Compliance Specialist is responsible for the preparation of NCQA Health Plan and Health Equity accreditation through coordination and follow-up of deliverables and requirements.

Quality Improvement Coordinator (1)

The Quality Improvement Coordinator (QIC) is responsible for performing facility site review audits and quality improvement activities in conjunction with the Sr. QI Nurse Specialists and QI Review Nurse. The position assists with coordination activities, such as access and availability reports, provider training, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, DMHC and NCQA.

Quality Program Coordinator (2)

The Quality Program Coordinator (QPC) is responsible for helping to plan, organize, and implement Alliance quality programs as assigned. Responsibilities include coordination of quality projects including case tracking (i.e. PQI, corrective action plans), assistance in audits or surveys (i.e. CAHPS), data collection and follow-up, and coordination of internal and external meetings. Supports the successful implementation of projects within timelines for associated department assignments.

Quality Improvement Engagement Coordinator (2)

The Quality Improvement Engagement Coordinator (QIEC) responsibilities include coordinating quality improvement projects, member outreach by phone and mail, provider and community collaboration, and data tracking and reporting. The goal of this role is to increase care for Alliance members by helping to connect them to services available directly related to QI measures.

ANCILLARY SUPPORT SERVICES FOR THE QIHE PROGRAM

Population Health and Equity

The Population Health and Equity team consists of a Population Health and Equity Director, a Population and Health Equity Manager, a Cultural and Linguistics Services Manager and supporting staff. The Population Health and Equity team is a component of the QI Department. The Population

Health and Equity staff ensure integration of QIHE initiatives into the Alliance Population Health Strategy and support the QI team in the development and implementation of member and provider educational interventions and community collaborations to address health care quality, health equity and access to care. The Population Health and Equity team also manages and monitors the Population Health Management, Health Education, and Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs and the Population Health Management Strategy are outlined in separate documents.

Analytics

The Analytics Department is comprised of three departments: 1) Healthcare Analytics, and 2) Quality Analytics and 3) Stars and Risk Adjustment. The department works in collaboration with the Quality Improvement Department on improvement activities and initiatives.

The Healthcare Analytics Department performs reporting and analyses across the organization on clinical, claims, provider, and member data. Quality activities include management of and production of the HEDIS NCQA certified software, HEDIS data validation/collection and HEDIS rate reporting and trending. In addition, the department collaborates on Population Health Management (PHM) strategies and initiatives, such as Risk Stratification and Segmentation (RSS), and supporting access and availability regulatory requirements. For Alameda Alliance Wellness, our Analytics Department plays a pivotal role in supporting the D-SNP by ensuring accurate data extraction and collection to meet the Centers for Medicare & Medicaid Services (CMS) Star Ratings requirements. Key contributions include comprehensive data integration, timely and accurate reporting, performance monitoring and improvement, and compliance with state and federal guidelines.

In addition to supporting Alameda Alliance Wellness, the Analytics department completes various data initiatives to provide our quality improvement, utilization management, and case management departments with access to risk-stratified, segmented data.

The Quality Analytics Department is responsible for management of HEDIS operational activities, the Pay-for-Performance program, and oversight of access and availability survey vendor. HEDIS operational activities include Roadmap and rate submissions, oversight of the annual HEDIS audits, medical record retrieval and training, monitoring, and performing overreads, and oversight of the abstraction vendor.

The Stars and Risk Adjustment Department is responsible for administration and oversight of the Medicare Stars and Risk Adjustment Programs for the Alameda Alliance Wellness members. This includes facilitating cross-functional communication to drive consistent and coordinated efforts in initiative development, implementation, and execution across all departments of the Alliance. They also provide operational guidance to improve provider engagement, enhance member-facing interactions, and streamline processes for closing care gaps and ensuring accurate risk capture to support performance towards organizational goals.

Utilization Management (UM) Services

The UM and QI Departments are part of the Alliance Health Care Services Department. These departments work collaboratively to ensure that appropriate quality and safe health care is delivered to members in a timely and organized manner. QI ensures that QIHEC can identify improvement opportunities regarding concurrent reviews, tracking key utilization data, and the annual evaluation of

UM activities.

The Alliance's Utilization Management (UM) activities are outlined in the UM Program Description which describes the UM program structure, and how UM decisions are made based on evidence-based guidelines, applied in a consistent manner. The Alliance's Case Management (CM) Program works in an integrated manner with the UM Program, in which care coordination and complex case management programs are designed to address the needs of members with complex physical, mental, or social determinant of health needs. Some high-risk populations include seniors and persons with disabilities (SPDs), members with multiple chronic conditions, or members with unmet social determinant of health needs (i.e.: housing or food insecurity). Core Case Management program interventions include outreach, assessment, and care coordination with members and their trusted supports, to ensure the improvement of member outcomes and overall member satisfaction. Care management staff also partner with the QI department in QIHE activities including conducting member outreach calls and mailings, as appropriate.

For our Alameda Alliance Wellness plan case management and care coordination is provided to all members and includes an individualized care plan, interdisciplinary team meetings, and support with care transitions. Care management is not delegated for our D-SNP members.

There are identified staff persons dedicated to working with "linked and carved out services" such as East Bay Regional Center, California Children Services (children with complex health care needs), and the Alameda County Behavioral Health Care Department. The UM and CM Program Descriptions are approved by the UMC and QIHEC. For additional information, refer to the UM and CM Program Descriptions.

Pharmacy Services

The Pharmacy Department and QI Department work collaboratively on various QIHE projects. The Pharmacy Department supports patient safety initiatives including working with the Pharmacy Benefit Manager (PerformRx) to inform members, providers, and network pharmacies of medication safety alerts. Responsibilities also include review and update of the formulary through P&T, oversight of the Pharmacy Benefit Manager, and collaboration with QIHEC. The Pharmacy department will work with the Medicare Stars Team, and QI Team ensuring that Stars ratings and HEDIS/MCAS scores are met for the Alliance Wellness line of business

Provider Services

The Provider Services Department is the primary point of contact for network providers. They assist the QI Department on various QIHE activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department collaborates with the Access and Availability team to monitor provider capacity and assess provider satisfaction. In addition, they assist with sharing information to providers about Alliance processes and provide educational material on monitoring availability and accessibility standards at physician offices, including after-hours coverage. The team coordinates with Health Care Services to deliver Alameda Alliance Wellness Model of Care Training to the provider network including in and out of network providers. Provider Services staff also assist the QI Department with practitioners who do not comply with requests from QI.

Credentialing Services

The Credentialing staff support the credentialing and re-credentialing processes for practitioners and network providers. The Credentialing staff conducts ongoing monitoring and evaluation of network practitioners to ensure the safety and quality of services to members. The QI Department provides the

Credentialing Department with Potential Quality Issue trends and Facility Site Review and Medical Record audit scores. The Credentialing staff is responsible for coordinating the PR and CC meetings.

Member Services and Member Outreach

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The Communication and Outreach conducts New Member orientations to educate new members about the health plan benefits. Member Services staff also works with the QI Department on member complaints via the PQI referral process and appeals in accordance with established policies and procedures. To assist in improving HEDIS scores and STAR ratings the QI Department may conduct member outreach activities to get HEDIS services completed. Hold messages are used to remind members of plan benefits and services offered while waiting to speak to an agent.

Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, complaints, and appeals. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue and Potential Quality Issues are forwarded to QI for review and investigation as needed. QI will collaborates with G&A for assurance of accurate reporting exempt grievance data.

Methods and Processes for Quality Improvement

The QIHE Program employs a systematic approach to identify opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any product line for which it seems relevant. The program aligns with the performance improvement framework recommended by the Department of Health Care Services (DHCS). This framework, adopted by the Alliance Quality Department, is based on the Institute for Healthcare Improvement (IHI) Model of Improvement Key concepts for DHCS performance improvement projects (PIP) utilize the following framework:

PIP Initiation

SMART Aim Data Collection

Intervention Determination

Plan-Do-Study-Act (PDSA)

PIP Conclusion

The Alliance QIHE Program ensures compliance with DHCS, DMHC, CMS, NCQA (as applicable), and other regulatory entities to effectively serve Medi-Cal and D-SNP members. In accordance with 42 CFR §422.152(c) and §422.152(d), Quality Improvement (QI) programs must incorporate Chronic Care Improvement Programs (CCIP) and Quality Improvement Projects (QIPs) to evaluate and enhance health outcomes and beneficiary satisfaction. Additionally, Alameda Alliance for Health implements Plan-Do-Study-Act (PDSA) cycles and Performance Improvement Projects (PIPs) as required by DHCS, CMS, and other regulatory agencies.

Identification of Important Aspects of Care

The Alliance uses several methods to identify aspects of care that are the focus of QIHE activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g.,

HEDIS and Stars). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members, health disparities, or identified through surveys and dialogue with member and provider communities (e.g., CAC, CAHPS, provider satisfaction survey, Joint Operating Meetings (JOM), Quality/Provider QI meetings, site visits, etc.). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

Data Sources and Systems

The Alliance utilizes various resources to develop clinical and quality reporting and analyses that provide meaningful and actionable insights. Resources to support the QIHE Program include, but are not limited to the following:

- ODS (Operational Data Store) and Datawarehouse: These are the main databases and the primary sources for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. The databases are used for storing data required for quality reporting.
- HealthSuite: Claims and eligibility processing system
- CareAnalyzer (DST): used to inform Population Health Management and Population Needs Assessment initiatives and provide QI/UM/CM access to risk-stratified, segmented data that can be effectively applied to target high-risk members for early intervention and improve the overall coordination of care.
- Cotiviti: The Alliance NCQA-certified HEDIS software that produces HEDIS/MCAS measure data and outcomes. Data integrity is audited annually through the HEDIS reporting audit process.
- CAHPS 5.1H,CG-CAHPS, Medicare CAHPS, Health Outcomes Survey (HOS): Member experience survey via SPH vendor support
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory results: Data files from Quest, Foundation, and AHS
- Cactus: credentialing database.
- Provider satisfaction and coordination of care surveys via Press Ganey vendor support
- Pre-service, concurrent, post-service and utilization review data (TruCare).
- Case management data (TruCare)
- Member and provider grievance and appeal data.
- Potential Quality of Care Issue Application database (Quality Suite) used for tracking/trending data.
- Internally developed reports (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), after-hours access and emergency instructions. Other clinical or administrative data.

Evaluation

The Analytics Department compiles various data sources to produce reporting and analyses. Quality performance staff analyzes the data to determine variances from established criteria, performance goals, and for clinical issues. Data is analyzed to determine priorities or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Subsets of our membership may be examined when they are deemed to be particularly vulnerable or at risk.

HEDIS and Stars related analyses include investigating trends in provider and member profiling,

data preparation (developing business rules for file creation, file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities involve data sets maintained by the Alliance and supplemental files submitted by various trading partners, such as delegated provider organizations and various external health registries and programs (e.g., Quest Diagnostics, and the California Immunization Registry).

Aggregated reports are forwarded to the QIHEC. Status and final reports are submitted to regulatory agencies as contractually required. Evaluation is documented in committee minutes, workplans, and attachments.

ACTIONS TAKEN AS A RESULT OF QIHE ACTIVITIES

Action plans are developed and implemented when opportunities for improvement are identified. Each performance improvement plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

Actions taken are documented in reports, minutes, attachments to minutes, workplans, and other similar documents.

An evaluation of the effectiveness of each QIHE activity is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and remeasurement. The evaluation of effectiveness is described qualitatively and quantitatively, in most cases, compared to previous measurements, with an analysis of statistical significance when indicated.

TYPES OF QI MEASURES AND ACTIVITIES

Healthcare Effectiveness Data Information Set (HEDIS)

The Managed Care Accountability Set (MCAS) Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) are calculated, audited, and reported annually as required by DHCS. Additional measures from HEDIS are also reviewed. A root cause analysis may be performed, and improvement activities are initiated for measures not meeting benchmarks.

Consumer Assessment of Health Plan Survey (CAHPS 5.1H and CG-CAHPS)

The Alliance evaluates member experience periodically. Third party vendors conduct the Consumer Assessment of Health Plan Survey (CAHPS). The Alliance assists in the administration of these surveys, receives, and analyzes the results, and follows up with prioritized improvement initiatives. Survey results are distributed to the A&A Subcommittee, followed by QIHEC, and made available to members and providers upon request. The CAHPS survey is conducted annually for the entire Medi-Cal population and the results from the CAHPS are reported in the annual QIHEC evaluation and used to identify opportunities to improve health care and service for our members.

The Medicare Consumer Assessment of Healthcare Providers and Systems (MCAHPS) and Health Outcomes Survey (HOS) are designed to understand D-SNP members' perceptions and experiences with the plan and its contracted providers. These two surveys are administered and collected by a third-party vendor, then sent to Centers for Medicare & Medicaid services (CMS). The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

State of California Measures

State Quality Improvement Activities

DHCS requires Medi-Cal Managed Care plans to conduct at least two QI projects each year. Forms provided by DHCS are used for QI project milestones.

Annually, the Alliance submits its QIHE Program Description, along with an evaluation of the prior year's QIHE Work Plan. A current year Work Plan is developed and updated throughout the year as QIHE activities are designed, implemented, and reassessed.

The Alliance complies with the requirements described in the regulatory All Plan Letters.

Star Measures for Alameda Alliance Wellness

The CMS Star Ratings system evaluates the quality and performance of D-SNPs across multiple domains of care and service. These measures assess how well Alameda Alliance for Health delivers high-quality care, ensures member satisfaction, and provides timely access to services. Key measures, such as HEDIS®, are calculated, audited, and reported annually in compliance with CMS requirements. For any measures that do not meet established benchmarks, targeted improvement activities are implemented to close gaps and drive performance.

Monitoring Satisfaction

The QIHE Program measures member and provider satisfaction using several sources of satisfaction, including the results of the CAHPS survey, the Population Health Assessment (PHA), the annual DMHC Timely Access survey, plan member and provider satisfaction surveys, complaint and grievance data, disenrollment and retention data, ad hoc member feedback surveys, Community Advisory Committee (CAC), and other data as available. These data sets are presented to the QIHEC at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QIHE studies and activities.

Model of Care

The Alliance maintains a Model of Care (MOC) which is a comprehensive plan designed to outline the Dual Eligible Special Needs Plan (D-SNP) and coordination of care to its members. The MOC ensures that healthcare services are effectively integrated and tailored to meet the unique needs of the population served. The MOC is integrated into the QIHE Program with the objective of determining whether the overall MOC framework adequately addresses members' unique healthcare needs using specific quality metrics, ongoing data collection, analysis, improvement planning, and remeasurement. There are measurable outcome-based initiatives across Alameda Alliance for Health aligned with these goals and monitored through workplans and evaluation.

The D-SNP quality metrics focus on addressing members' unique health conditions, behaviors, and Social Determinants of Health (SDOH) issues as outlined in Model of Care (MOC 1). The work plan measures member outreach effectiveness and care planning, coordinated through tools like the Health Risk Assessment Tool (HRAT), Interdisciplinary Care Plan (ICP), and the Interdisciplinary Care Team (ICT). Some metrics are designed to monitor the appropriate use of services, including preventive health and chronic care management. Outcome measures track clinical outcomes and service utilization.

Health Education Activities

The Health Education Program at the Alliance operates as part of the Population and Health Equity Unit of the Quality Improvement Department. The primary goal of Health Education is to improve members' health and well-being through the lifespan through promotion of appropriate use of health care services, preventive health care guidelines: Bright Futures/American Academy of Pediatrics, U.S. Preventive Services Task Force, and clinical guidelines from professional associations, healthy lifestyles and condition self-care and management. Health Education activities aim to provide the knowledge needed for Alameda Alliance members to maintain and support their health.

Health education programs are developed in alignment with needs identified by the population assessments and include individual, provider, and community-focused health education and disease management activities which address health concerns such as nutrition, , maternal health, diabetes, pre-diabetes, asthma, hypertension, COPD, kidney disease, tobacco cessation and mental health to improve HEDIS, CAHPS, HOS, and CMS Five-Star Quality Ratings. The Alliance also collaborates on community projects to develop and distribute important health education messages for at risk populations. The Alliance Health Education Program Description can be found in a separate document.

Cultural and Linguistic Activities

The Alliance Cultural and Linguistic Services Program operates as a part of the Population and Health Equity Unit of the Quality Improvement Department. It reflects the Alliance's adherence and commitment to the U.S. Department of Health & Human Services *National Standards for Culturally and Linguistically Appropriate Services* (CLAS). The program offers services and conducts activities designed to ensure that all members have access to quality health care services that are culturally and linguistically appropriate. These activities encompass efforts within the organization, as well as with Alliance members, providers, and our community partners.

Objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer our members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Identify, inform, and assist limited English proficient (LEP) members in accessing quality interpretation services and written information materials in threshold languages.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic services program through cultural sensitivity training.
- Integrate community and Alliance-member input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities and services aimed at achieving cultural competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed and monitored in the Cultural and Linguistic Services work plan, updated annually, and reviewed quarterly. The Alliance Cultural and Linguistic Services Program Description can be found in a separate document.

Disease Surveillance

The Alliance maintains procedures to ensure accurate, timely, and complete reporting of any disease or condition to public health authorities as required by State law. The Provider Manual describes requirements and lists the Public Health Department contact phone and fax numbers.

Patient Safety and Quality of Care

The Alliance QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for members. The following activities are performed to demonstrate the Alliance's commitment to improve quality of care and safety of its members via monitoring, investigation, track, and trending of:

- Complaints and grievances and determining quality of care impact.
- Iatrogenic events such as provider preventable conditions (PPCs) including hospital-acquired infections reported on claims and reviewing encounter submissions.
- Inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.
- Credentialing and re-credentialing of malpractice, license suspension registries, loss of hospital privileges for providers.
- Site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Operations compliance with local regulatory practices.
- Reviewing hospital readmission reports.
- Improve continuity and coordination of care between practitioners.

Quality of care issues related to Long-Term Care

Quality issues are referred to the QI Department to evaluate the issue, develop an intervention and involve the CMO when necessary.

A corrective action plan and/or additional measures may be necessary to address quality concerns resulting in adverse effects or negative health outcomes, as determined through a PQI investigation. The provider involved will be required to conduct a formal root cause analysis (RCA) before developing a corrective action plan to address the identified issue or deficiency. RCA is a structured process used to identify the fundamental factors contributing to quality variations. The corrective action plan will define the problem, outline the desired future state, and specify the steps required to resolve the identified issue effectively.

Facility Site Reviews

The Alliance conducts site reviews, including Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review (PARS), including assigning scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines. If findings are identified, corrective action plans (CAP) are issued and followed upon until appropriate documentation are

addressed for all deficiencies to close the CAP. A summary of the site reviews conducted are reported to A&A Committee or IQIC (i.e. workplan summary) followed by QIHEC to monitor the clinical safety activities of the Alliance Provider Network.

Long-Term Care Quality Monitoring

The Alliance maintains a comprehensive Quality Assurance Performance Improvement (QAPI) monitoring program for Long Term Care (LTC) services which includes on-going review of the following:

- A table-top review of quality assurance and improvement findings from California Department of Public Health (CDPH) to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings.
- Review of QAPI programs in LTC (i.e. SNFs and Subacute) based on an attestation of compliance by the facilities of the five key elements identified by CMS:
  - Element 1: Design and Scope
  - Element 2: Governance and Leadership
  - Element 3: Feedback, Data Systems and Monitoring
  - Element 4: Performance Improvement Projects (PIPs)
  - Element 5: Systematic Analysis and Systemic Action
- Review of CMS Quality Star ratings
- Monitoring of quality measures for LTC within the Managed Care Accountability Set (MCAS) of performance measures, such as emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions.
- Review and investigation of Potential Quality Issues (PQIs)
- In collaboration with the LTC team, the Alliance monitors the quality and appropriateness of care furnished to members using LTSS, including:
  - Assessment of care between care settings and a comparison of services and supports received with those set forth, and
  - Efforts supporting member community integration.
    When significant trends or non-compliance related to the QAPI program are noted, medical chart reviews or on-site visits will be conducted for LTC facilities as appropriate. Corrective action plans may be issued to address and resolve deficiencies in the quality of care of residents.

For Intermediate Care Facility for Developmentally Disabled (ICF/DD) Homes, quality monitoring includes the review of compliance findings and data from CDPH as well as service delivery findings from the Regional Centers established in the Memoranda of Understanding. Activities and monitoring are discussed at joint Alliance and Regional Center meetings on an on-going basis to ensure the quality and appropriateness of care, but not limited to:

- Any applicable performance measures (as mutually agreed upon)
- QI initiatives as well as reports that track cross-system referrals.
- Member engagement
- Service utilization and to prevent duplication of services rendered.

On-going monitoring reports are reported to the quality committees, including A&A Committee or IQIC and QIHEC on an as needed basis.

Health Equity Activities

The Alliance is committed to Health Equity by mitigating social determinants of health to prevent and reduce health disparities and health inequities that adversely affect vulnerable populations. Health Equity is integrated throughout the organization and is a collaborative effort across multiple departments. Additional data beyond the historical HEDIS,MCAS, Stars measures, or Department of Managed Health Care Health Equity Measure Set (DMHC HEQMS) might be needed to better understand the systemic barriers or SDOHs faced by our members. As part of the QIHE Program, the Alliance monitors and addresses member access, experience, and clinical outcome disparities by analyzing data stratified by race, ethnicity, and language (REL). QIHE leverages on the subject matter expertise of Health Equity and works in collaboration with Health Equity to ensure efficient, effective and non-duplicative health equity initiatives for the Alliance.

According to specific standards and/or strategies, the QIHE Program involves implementing systematic and continuous activities to monitor, evaluate, and improve upon the health equity and health care delivered to our members. There is alignment with the Alliance Population Health Strategy and related activities. The QIHEC is responsible for overseeing the QIHE Program, including activities to identify and close health disparity gaps, providing feedback to meet goals/benchmarks as set forth by governing agencies (i.e., DHCS, DMHC, or NCQA), and to recommend required actions.

ACCESS AND AVAILABILITY

The Alliance implements mechanisms to maintain an adequate network of primary care providers (PCP) and high volume and high impact specialty care providers. Alliance policy defines the types of practitioners who may serve as PCPs. Policies and procedures establish standards for the number and geographic distribution of PCPs and high-volume specialists. The Alliance monitors and assesses the cultural, ethnic, racial, and linguistic needs and preferences of members, and adjusts availability of network providers, if necessary.

The following services are also monitored for access and availability:

- Children’s preventive periodic health assessments/EPSDT
- Adult preventative health screenings
- Initial health appointments

The QIHE Program collaborates with the Provider Services Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergent, and preventive, specialty, and after-hours care. Access to medical care is ensured by monitoring compliance with timely access standards for practitioner office appointments, telephone practices, and appointment availability. The QIHEC also oversees appropriate access standards for appointment wait times. Alliance appointment access standards are no longer than CMS, DMHC and DHCS established standards. The Provider Manual, provider quarterly packet, virtual/onsite visits, and periodic fax blasts are some of the mechanisms to educate providers on Timely Access Standards.

The QIHEC reviews the following data and makes recommendations for intervention and quality activities when network availability and access improvement is indicated:

- Member complaints about access.
- CAHPS 5.1H,CG-CAHPS, Medicare CAHPS, and HOS results

- HEDIS measures for well child and adolescent primary care visits.
- Stars measures pertaining to access and care coordination
- Immunizations.
- Emergency room utilization.
- Facility site review findings.
- The review of specialty care authorization denials and appeals.
- Additional studies and surveys may be designed to measure and monitor access.
- Conduct annual access and availability audits through member surveys and secret shopper calls

The QIHE Program reports compliance with access and availability standards to CMS and DHCS annually. Findings are reviewed by the QIHEC and necessary adjustments are implemented to enhance provider network performance.

BEHAVIORAL HEALTH QUALITY

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members including, but not limited to, all medically necessary services across the health care network. The Alliance reports activities in behavioral healthcare at QIHEC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Behavioral Health Services are available for all enrolled Alameda Alliance for Health members. The pathway through which members access behavioral health care is determined by the member's severity of symptoms and the member's line of business.

Per DHCS contract, the Alliance is responsible for the administration of the mild to moderate non-specialty mental health benefit. Specialty Behavioral Health for Medi-Cal members with severe mental health conditions are excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between the Alliance and Alameda County Behavioral Health (ACBH). Some primary care physicians may choose to treat mild mental health conditions. The Alliance insourced the management and oversight of the non-specialty mental health and autism behavioral health services. The Alliance includes the involvement of a Senior Director of Behavioral Health in program oversight and implementation. The Alliance reviews reports of behavioral health quality, utilization, and surveys (i,e. timely access via member experience surveys, provider satisfaction) in its standing sub-committee meetings (i.e. A&A and IQIC subcommittees) to ensure members obtain necessary and appropriate behavioral health services.

For Alameda Alliance Wellness members, Behavioral Health is inclusive of both mental health and substance use disorder programs. Behavioral Health Services are available for all Alameda Alliance for Health D-SNP members. Behavioral services are the responsibility of the health plan. Alameda Alliance's behavioral health team collaborates with community providers to access treatment for covered services.

Alameda Alliance for Health directly contracts and manages a network of providers to deliver Behavioral Health Treatment (BHT) services. The BHT team is responsible for overseeing both Care Coordination/Management and Utilization Management of the BHT benefit. The BHT treatment plans and progress reports are reviewed by board-certified behavior analyst (BCBA). These professionals conduct utilization reviews in alignment with state-mandated guidelines. The BHT Team is overseen by

the Senior Director of Behavioral Health who is a licensed psychologist and who provides determinations according to state-mandated guidelines.

Please see the UM / CM Program Description for additional behavioral health components.

COORDINATION, CONTINUITY OF CARE AND TRANSITIONS

Member care transitions present the greatest opportunity to improve quality of care and decrease safety risks by ensuring coordination and continuity of health care as members transfer between different locations or different levels of care within the same location and/or across the healthcare continuum.

The Alliance Health Care Services focuses on interventions that support planned and unplanned transitions and promote chronic disease self-management. Primary goals of the department are to reduce unplanned transitions, prevent avoidable transitions and maintain members in the least restrictive setting possible.

Comprehensive case management services are available to each member. For Medi-Cal and Group Care, it is the PCP's responsibility to act as the primary case manager to all assigned members. For Alameda Alliance Wellness, an Alameda Alliance Wellness Care Manager is assigned for each member; this case manager acts as the primary case manager and coordinates care needs with providers including community-based organizations, long term community supports, PCP, and Specialists. Members have access to these services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All services are provided in a culturally and linguistically appropriate manner.

Members who may need or are receiving services from carved-out service providers are identified. Procedures ensure these members receive medically necessary coordinated services and joint case management, if indicated. Written policies and procedures direct the coordination of care for the following:

- Services for Children with Special Health Care Needs (CSHCN).
- California Children's Service (CCS) eligible children are identified and referred to the local CCS program.
- Overall coordination and case management for members who obtain Child Health and Disability Prevention Program (CHDP) services through local school districts or sites.
- Early Start eligible children are identified and referred to the local program.
- Members with developmental difficulties are referred to the Regional Center of the East Bay for evaluation and access to developmental services.

All new Medi-Cal and D-SNP members are expected to receive an Initial Health Appointment (IHA) within 120 days of their enrollment or provider assignment with the plan. Members are informed of the importance of scheduling and receiving an IHA from their PCP. The Provider Manual informs the PCP about the IHA, the HRA (for SPDs and D-SNP members), and recommended forms. All new Medi-Cal non-SPD members also receive a Health Information Form\Member Information Tool (HIF\MET) in the New Member Packet upon enrollment. The Alliance ensures coordination of care with primary care for all members who return the form with a condition that requires follow up.

The Alliance coordinates with PCPs to encourage members to schedule IHAs. The medical record audit of the site review process is used to monitor coordination, and whether baseline assessments, diagnosis/treatment, and medically necessary follow-up services and referrals are documented.

COMPLEX CASE MANAGEMENT PROCESS

All Alliance members are potentially eligible for participation in the complex case management program. For Alameda Alliance Wellness, this eligibility is based on the risk stratification model and those members who are stratified for high risk are outreached to and offered participation in the program. The purpose of the complex case management program is to provide the case management process and structure to a member who has complex health issues and medical conditions. The components of the Alliance complex case management program encompass member identification and selection; member assessment; member-centered care plan development, implementation, and management; evaluation of the member care plan; and closure of the case. Program structure is designed to promote quality case management, client satisfaction and cost efficiency using collaborative communication, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The complex case management program's objectives are concrete measures that assess effectiveness and progress toward the overall program goal of making high-quality health care services accessible and affordable to Alliance membership. The Chief Medical Officer, Senior Director of Health Care Services, Director of Social Determinants of Health, and Manager of Case and Disease Management develop and monitor the objectives. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with case management services as measured by member satisfaction rates.
- Improving functional health status of complex case management members as measured by member self-reports of health condition.

The complex case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

The Alliance annually measures the effectiveness of its complex case management program based on the following measures (detailed information can be found in the Case Management Program Description):

1. Satisfaction with case management services - members are mailed a survey after case closure and are asked to rate experiences and various aspects of the program's service.
2. All-cause readmission rates - the Alliance measures admission rates for all causes within six months of being enrolled in complex case management.
3. Emergency room visit rate - the Alliance measures emergency room visit rates among members enrolled in complex case management.
4. Health status rate - the Alliance measures the percentage of members who received complex case management services and responded that their health status improved because of complex case management services.

The Chief Medical Officer and the Senior Director of Health Care Services collaboratively conduct an

annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the QIHEC for review and feedback. The QIHEC makes recommendations for improvement and interventions to improve program performance, as appropriate.

DISEASE MANAGEMENT PROGRAM

The Alliance offers its members a disease management program. The purpose of the disease management program is to provide coordinated health care interventions and communications to both pediatric and adult members with chronic asthma and adults with diabetes, cardiovascular disease, and depression to support disease self-management and promote healthy outcomes. This is accomplished through the provision of interventions based on member acuity level. The intervention activities range from case management for those members at high risk, offering health coaching, educational materials, and care coordination to those members who may have gaps in care. The components of the Alliance disease management program include member identification and risk stratification, identification of gaps in care and health disparities, member outreach, provision of case management and health coaching services, and condition-specific education.

Program structure is designed to follow the National Committee for Quality and Assurance (NCQA) Population Health Management (PHM) standards. The program promotes quality condition management, member satisfaction and cost efficiency using proactive member communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes. In 2026, the Alliance Disease Management Program focuses on four conditions Asthma, Diabetes, Perinatal Depression and Cardiovascular Disease.

The objectives of the disease management program are concrete measures that assess effectiveness and progress toward the overall program goals of meeting the health care needs of members and actively supporting members and practitioners to manage chronic asthma and diabetes. The IQIC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the disease management program include:

- Achieving and maintaining member's high levels of satisfaction with disease management services as measured by member satisfaction rates.
- Reducing gaps in care as measured by HEDIS clinical effectiveness..
- Addressing disparities related to chronic conditions.
- Increasing the rate of member engagement through targeted outreach activities regarding disease management services.
- Validating the efficacy of disease management health coaching as measured by post health coaching evaluations of member’s knowledge and confidence.

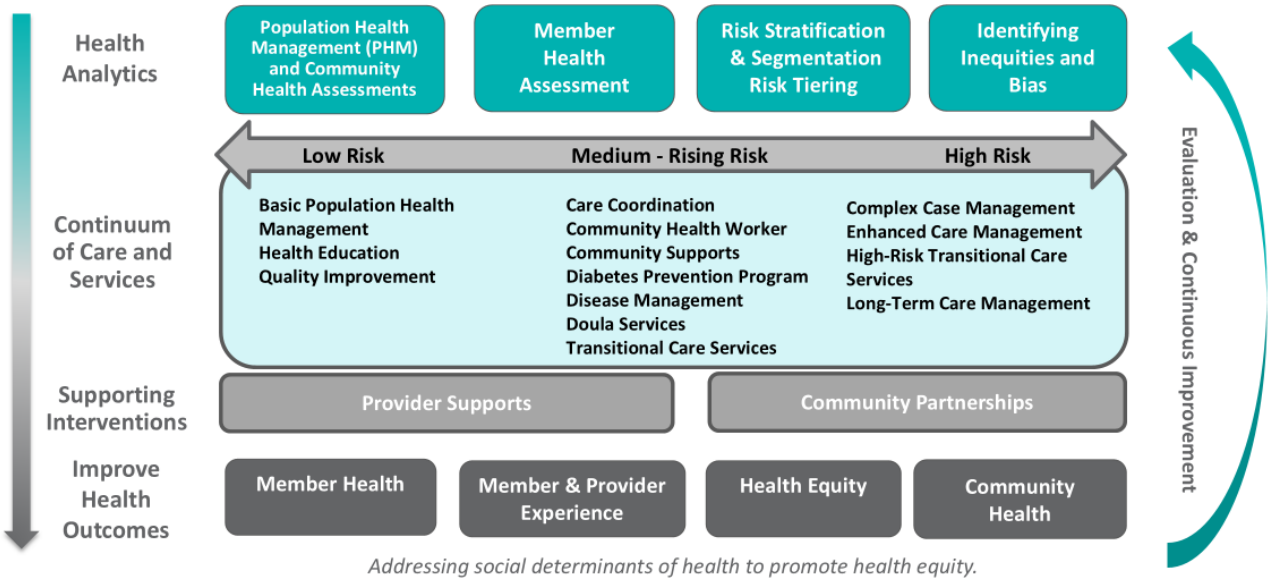
POPULATION HEALTH MANAGEMENT (PHM) PROGRAM

Alameda Alliance for Health has a Population Health Management (PHM) Program that identifies member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health outcomes and supporting an enhanced quality of life. This continuum includes intensive case management and support for members with the highest levels of needs, programs and interventions for those with emerging risks and basic population health management for all members.

The Alliance PHM Program follows the NCQA 2025 Population Health Program Standards and Guidelines and aligns with the California Department of Health Care Services Population Health Management Policy Guide.

The PHM Program is monitored via the Internal Quality Improvement Committee (IQIC), which is comprised of representatives from Health Equity, Quality Improvement, Utilization Management, Case Management, Behavioral Health, Pharmacy and Accreditation. In addition, overall outcomes, and findings from the Alliance population health assessments, population health strategy and evaluations are presented, reviewed, and approved by the QIHEC.

The Alliance PHM Framework illustrates how the utilization of health analytics through the lens of health equity would provide a continuum of care and services and interventions that lead to data-driven health outcomes. The Alliance's continuum of care and services aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through best practice and culturally affirming care. The PHM Program works in close collaboration with the Health Equity division to ensure a comprehensive and holistic population health approach to achieve health equity for all, building Social Drivers of Health (SDOH) mitigation barriers whenever possible in the healthcare pathway.



The Alliance conducts an annual Population Assessment

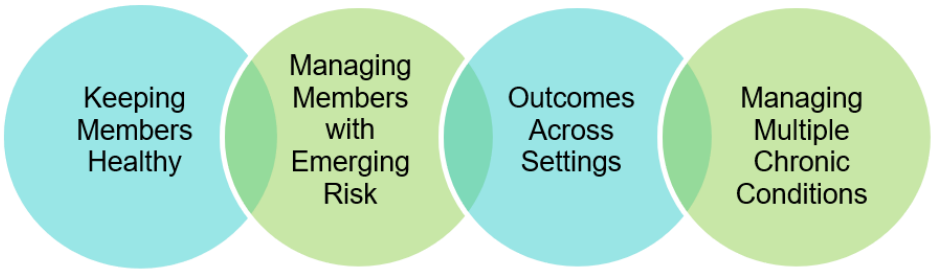
The Alliance annual PHM Assessment uses multiple data sources including member demographics, claims and encounters, HEDIS performance results, and social determinants of health to understand the health needs of our members. The HEDIS measures analyzed in the assessment include Department of Managed Health Care Health Equity Measure Set (DMHC HEQMS) and NCQA health equity measures, which are stratified by NCQA-defined race and ethnicity categories. The PHM team conducts a disparity analysis and leads cross-functional discussion of activities and resources needed to close disparities and improve measure performance. The Alliance prioritizes which programs and disparities to address in the development of the annual PHM Strategy.

The Alliance updates its PHM Strategy annually and uses it to:

- Improve case management programs including Complex Case Management (CCM), Enhanced Care Management (ECM), California Integrated Care Management (CICM), Community Supports (CS), and Transitional Care Services (TCS).
- Support development of basic population health activities to promote self-management of conditions and preventative care.
- Inform quality improvement projects.
- Guide development of health education materials and programs.
- Influence interventions that target member safety and outcomes across settings.
- Better understand utilization and identify high-risk members.
- Address identified health inequities.

The Alliance PHM strategy addresses four focus areas of population health that promote a whole-person approach to identify members at risk, and to provide strategies, programs, and services to mitigate or reduce that risk. The strategy has 4 areas of focus:

Four Areas of Focus



The Population Health Strategy includes:

- Population health assessment results
- Population risk stratification and segmentation
- PHM Strategy goals and programs
- Integration of Community Resources

- Delivery systems and provider support structures
- Sharing data – provider measures and gaps in care
- Quality Dashboards – HEDIS measure-specific data
- Comparable Data – Peer performance, local averages, and national benchmarks
- Value-Based Payment Programs
- Ongoing Education/Support – Provider Newsletters & Education

The Alliance Population Health Management Assessment and Strategy can be found in separate documents. The Alliance Population Health Evaluation is included in the QIHE Evaluation.

SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categories all new SPD members as high risk. High risk members are contacted for an HRA within 45 calendar days and low risk members are contacted within 105 calendar days from their date of enrollment. Existing SPD members receive an annual HRA on their anniversary date. The objectives of an HRA are to assess the health status, estimate health risk, and address members' needs relating to medical, specialty, pharmacy, and community resources. Alliance staff uses the responses to the HRAs, along with any relevant clinical information, to generate care plans with interventions to decrease health risks and improve care management.

DHCS has established performance measures to evaluate the quality of care delivered to the SPD population using HEDIS measures and a hospital readmissions measure.

For Alameda Alliance Wellness, all members are contacted annually for completion of the HRA. Members who are new to the plan are contacted within 90 days of enrollment for completion of the HRA regardless of risk status.

MATERNAL MENTAL HEALTH PROGRAM

The Alameda Alliance for Health Maternal Mental Health Program is a comprehensive initiative designed to improve perinatal mental health outcomes for Medi-Cal, D-SNP, and Group Care members. In alignment with CA SB1207 and AB1936, the program ensures timely screening, referral, and treatment for maternal mental health conditions through adherence to ACOG and AAP guidelines. Key components include provider education, enhanced member self-referral pathways, and care coordination across behavioral health services. The program also integrates perinatal depression disease management through the BirthWise Wellbeing initiative, doula services, and peer support via Community Health Workers.

Quality monitoring is embedded throughout the program, with regular tracking of HEDIS measures such as prenatal and postpartum depression screening and follow-up. Member satisfaction and service utilization are assessed through surveys and dashboards, informing continuous improvement efforts. The program reflects the Alliance’s commitment to equitable, evidence-based care and supports broader population health and health equity goals. The Alliance Maternal Mental Health Program Description can be found in a separate document.

PROVIDER COMMUNICATION

The Alliance contracts with its providers to foster open communication and cooperation with QIHE activities:

- Provider cooperation with QIHE activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary and appropriate care.
- Provider regulatory requirements

Provider involvement in the QIHE Program occurs through membership in standing and ad-hoc committees, Joint Operating Committee meetings, and attendance at BOG and QIHEC meetings. Providers and members may request copies of the QIHE Program description, work plan, and annual evaluation. These documents are also posted on the Alliance website. Provider participation is essential to the success of QIHE studies including HEDIS and Stars and those that focus on improving aspects of member care. Additionally, providing feedback on surveys and questionnaires is encouraged as a means of continuously improving the QIHE Program.

Providers have an opportunity to review the findings of the QIHE Program through a variety of mechanisms. The QIHEC reports findings from QIHE activities to the BOG through CMO reports (monthly), QIHE Trilogy documents (annually), and on an on-going basis. Findings include aggregate results, comparisons to benchmarks, deviation from threshold, drill-down results for provider group or type, race/ethnicity, and language, and other demographic or clinical factors. Findings are distributed directly to the provider when data is provider specific. Findings are included in an annual evaluation of the QIHE Program and made available to providers and members upon request. The Provider Bulletin contains a calendar of future BOG and standing committee dates and times.

EVALUATION OF QIHE PROGRAM (SEPARATE DOCUMENT)

The QIHEC reviews, makes recommendations, and approves a written evaluation of the overall effectiveness of the QIHE Program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Allocation of resources to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and ongoing QIHE activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QIHE Work Plan

The primary focus of the Quality Improvement Health Equity (QIHE) evaluation is to assess the effectiveness of the Model of Care (MOC) in meeting Alameda Alliance Wellness D-SNP members' unique health needs, improving care, service, health outcomes and member experience. The evaluation includes a review of completed and ongoing activities related to care quality, service, outcomes, and member satisfaction. Trended results are performance assessments compared against established targets are included. Both quantitative and qualitative analyses are conducted to measure clinical outcomes and care experiences. If performance goals are not met, analysis is performed to identify opportunities for improvement. The results of the annual evaluation inform updates to the Quality Improvement Health Equity (QIHE) program description and work plan for the following year.

The review and revision of the program may be conducted more frequently as deemed appropriate by the QIHEC, CMO, CHEO, CEO, or BOG. The QIHEC's recommendations for revision are incorporated into the QIHE Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

ANNUAL QIHE WORK PLAN (SEPARATE DOCUMENT)

A QIHE Work Plan is received and approved annually by the QIHEC. The work plan describes the QIHE goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as needed. The QIHE work plan delineates the responsible party and the time frame in which planned activities will be implemented.

The Alameda Alliance Wellness work plan is a unique and separate document that is aligned with the following but is focused on the D-SNP population.

The work plan is included as a separate document and addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Member experience

- Health equity activities
- Yearly planned activities and objectives
- Time frame within which each activity is to be achieved.
- The staff member responsible for each activity
- Monitoring previously identified issues.
- Evaluation of the QIHE Program

Progress on completion of activities in the QIHE work plan is reported to the QIHEC quarterly. A summary of this progress will be reported by the CMO to the BOG.

D-SNP MODEL OF CARE & WORKPLAN (SEPARATE DOCUMENT):

Alliance D-SNP Model of Care 2026.pdf

SUPPORTING DOCUMENTS

In addition to this program description, the annual evaluation and work plan, the other additional documents are important in communicating QI policies and procedures include and not limited to:

- "Provider Manual" provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's QIHE Program is included in the provider manual. It is distributed to all contracted provider sites.
- "Provider Bulletin" is a newsletter distributed to all contracted provider sites on topics of relevance to the provider community, and can include QIHE policies, procedures, and activities.
- "Alliance Alert" is a member newsletter that also serves as a vehicle to inform members of QIHE policies and activities.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the QIHE Program information is available on the Alliance website.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, delegated medical groups and sub-contractors of the Alliance maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions, and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QIHE activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QIHE activities must submit a written request to the CMO. Release of all information will be in accordance with state and federal laws.

All providers participating in the QIHEC or any of its subcommittees, or other QIHE Program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements. Guests or additional Alliance staff attending QIHEC

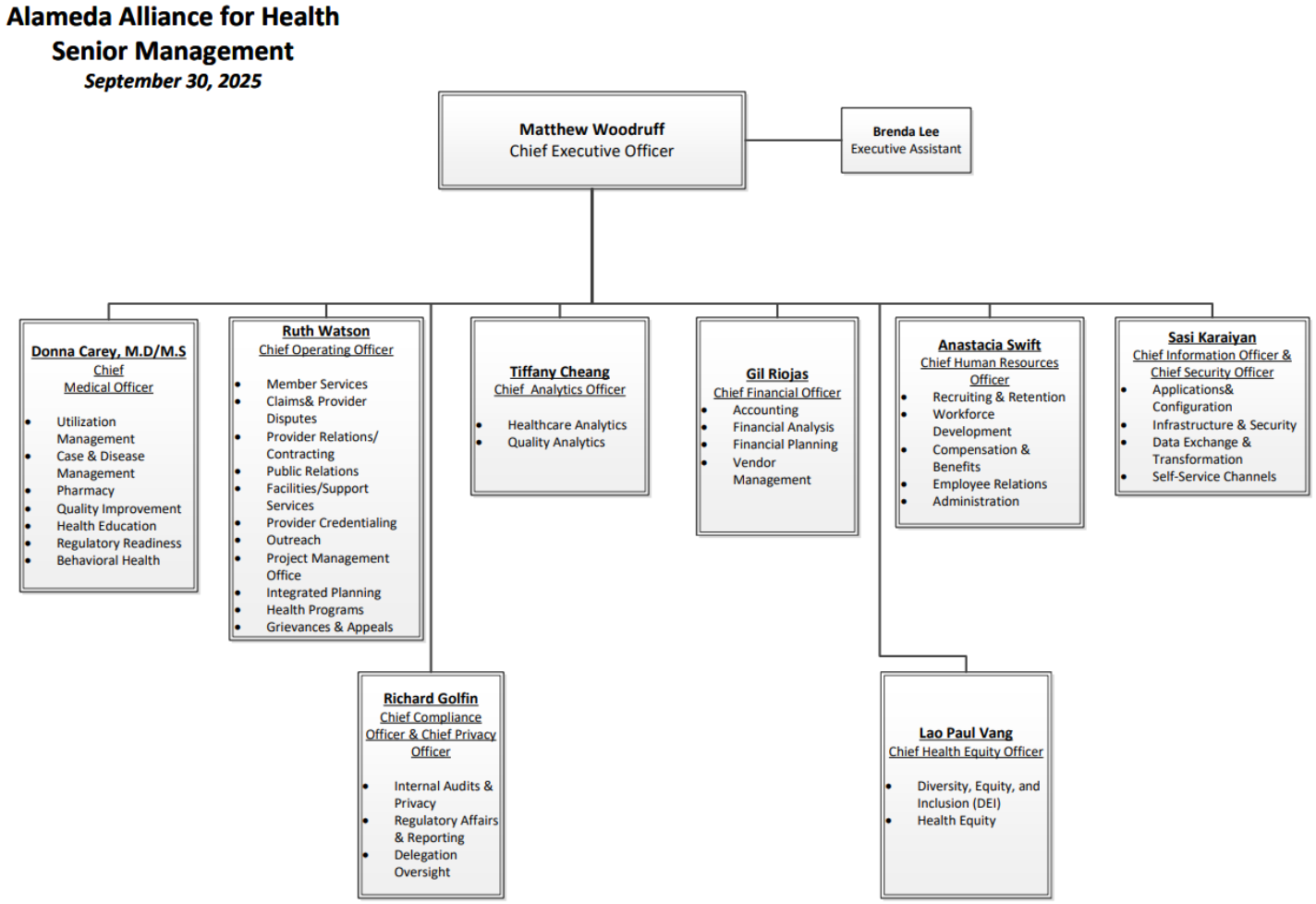
meetings will sign a confidentiality agreement.

Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

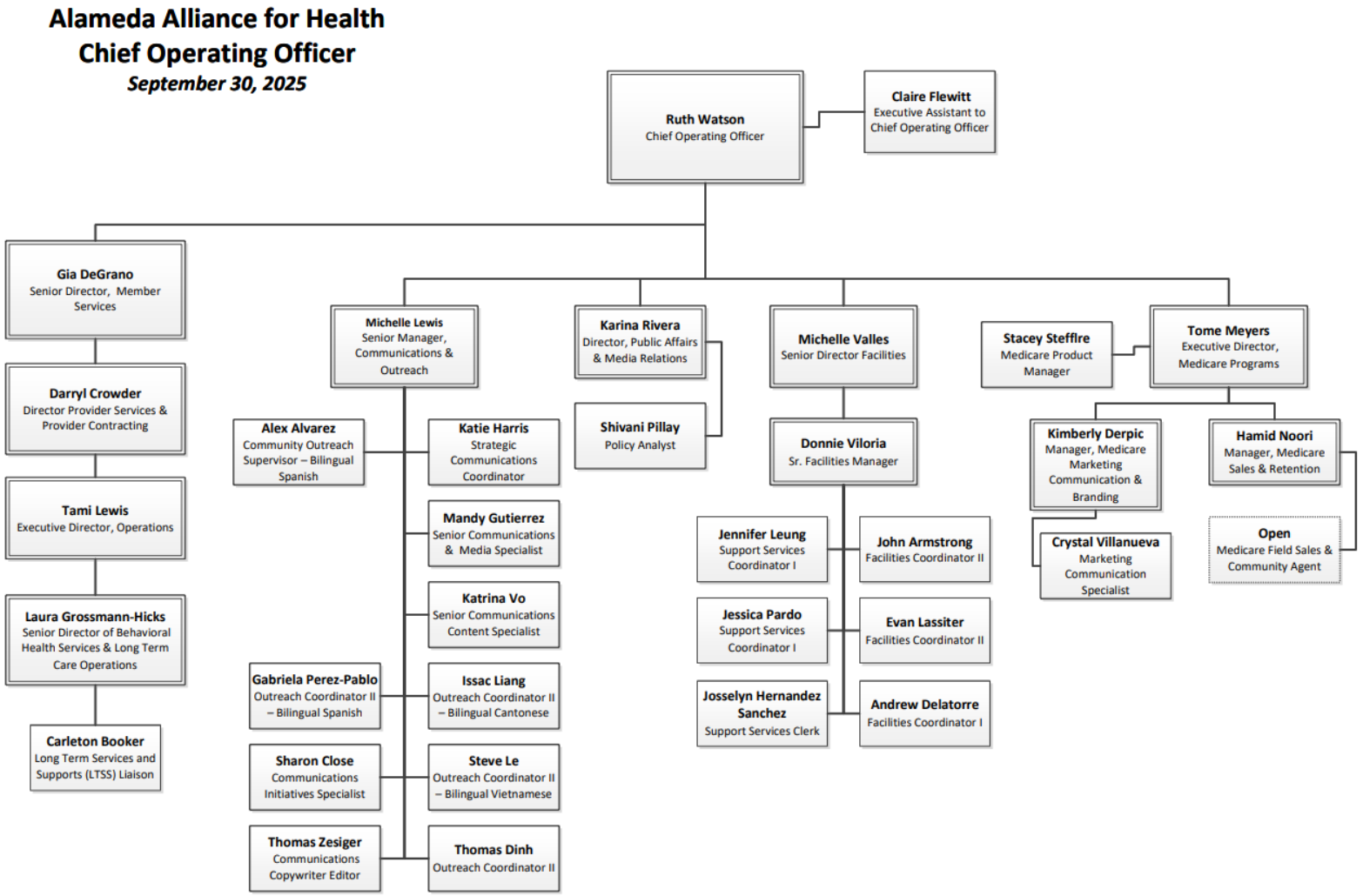
All QIHEC meeting materials and minutes are marked with the statement "Confidential". Copies of QIHE meeting documents and other QIHE data are maintained separately and secured to ensure strict confidentiality.

APPENDIX A: Organizational Charts

Senior Management

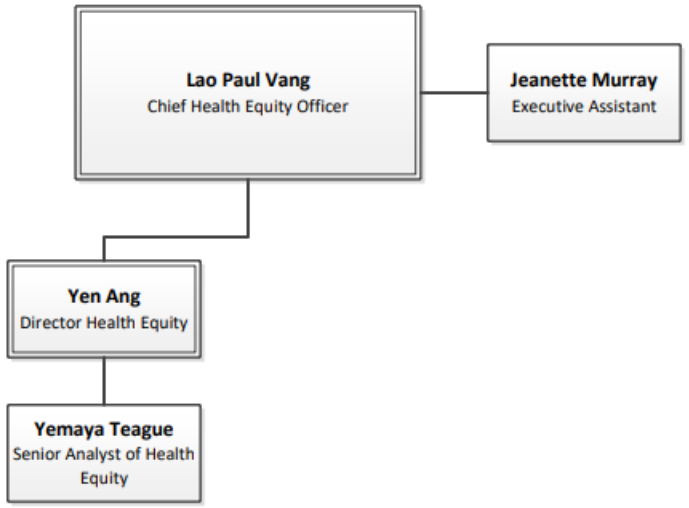


Chief Operating Officer – Medicare Operations



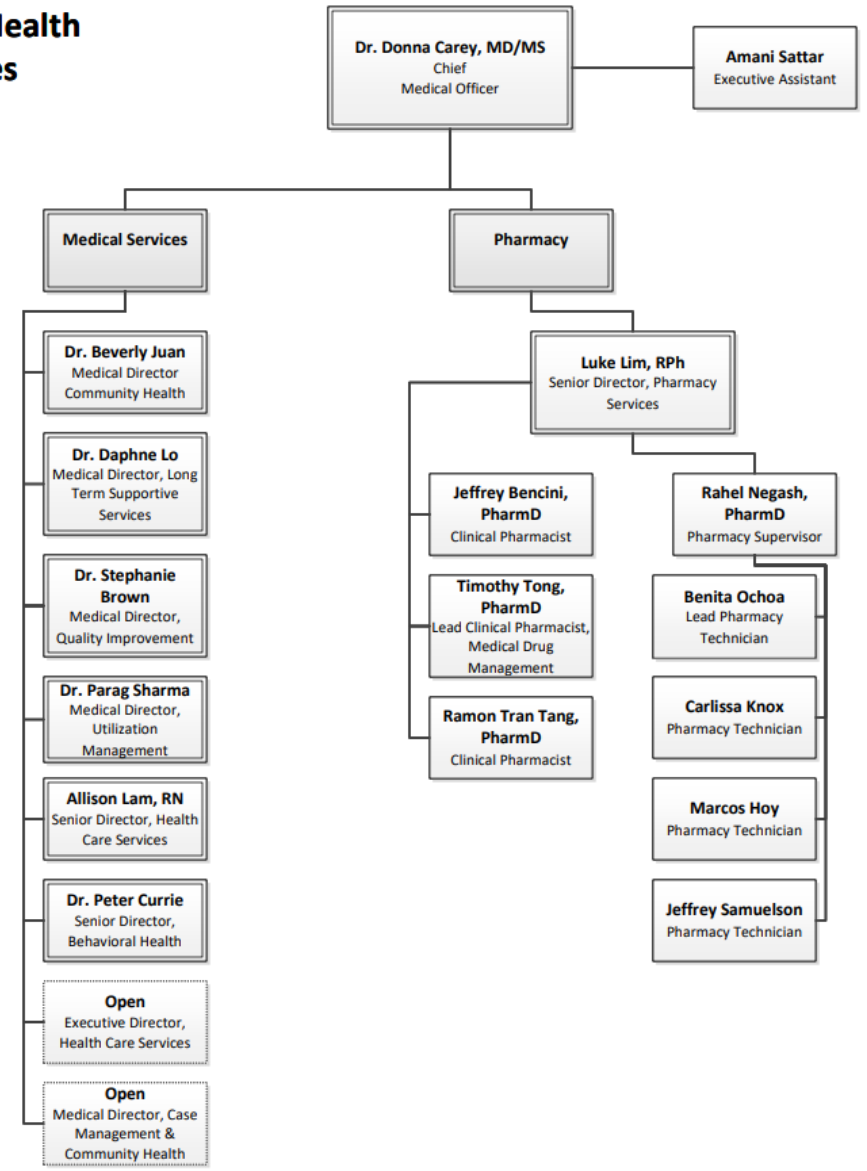
Health Equity

Alameda Alliance for Health
Health Equity
September 30, 2025

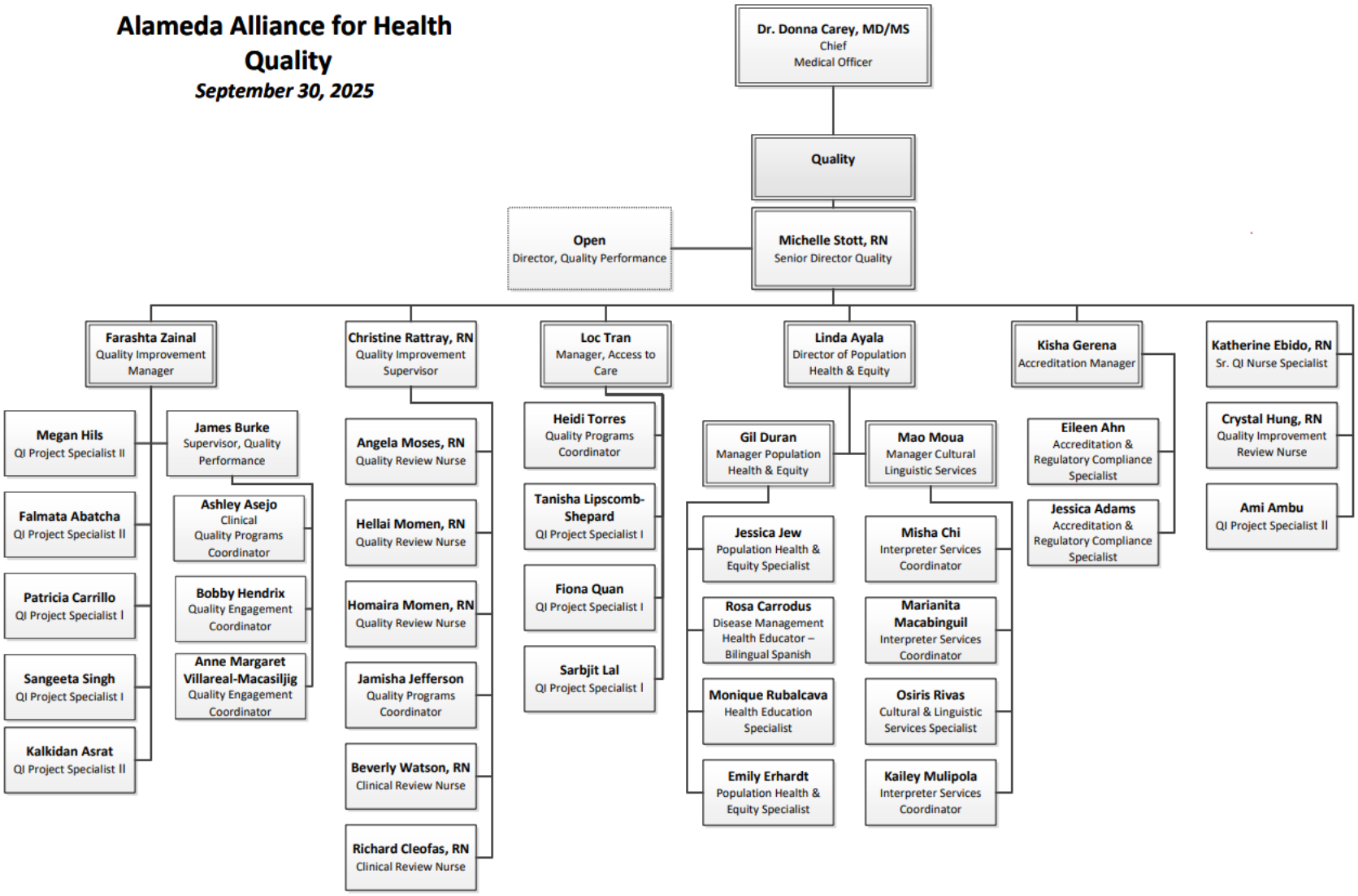


Medical Services and Pharmacy

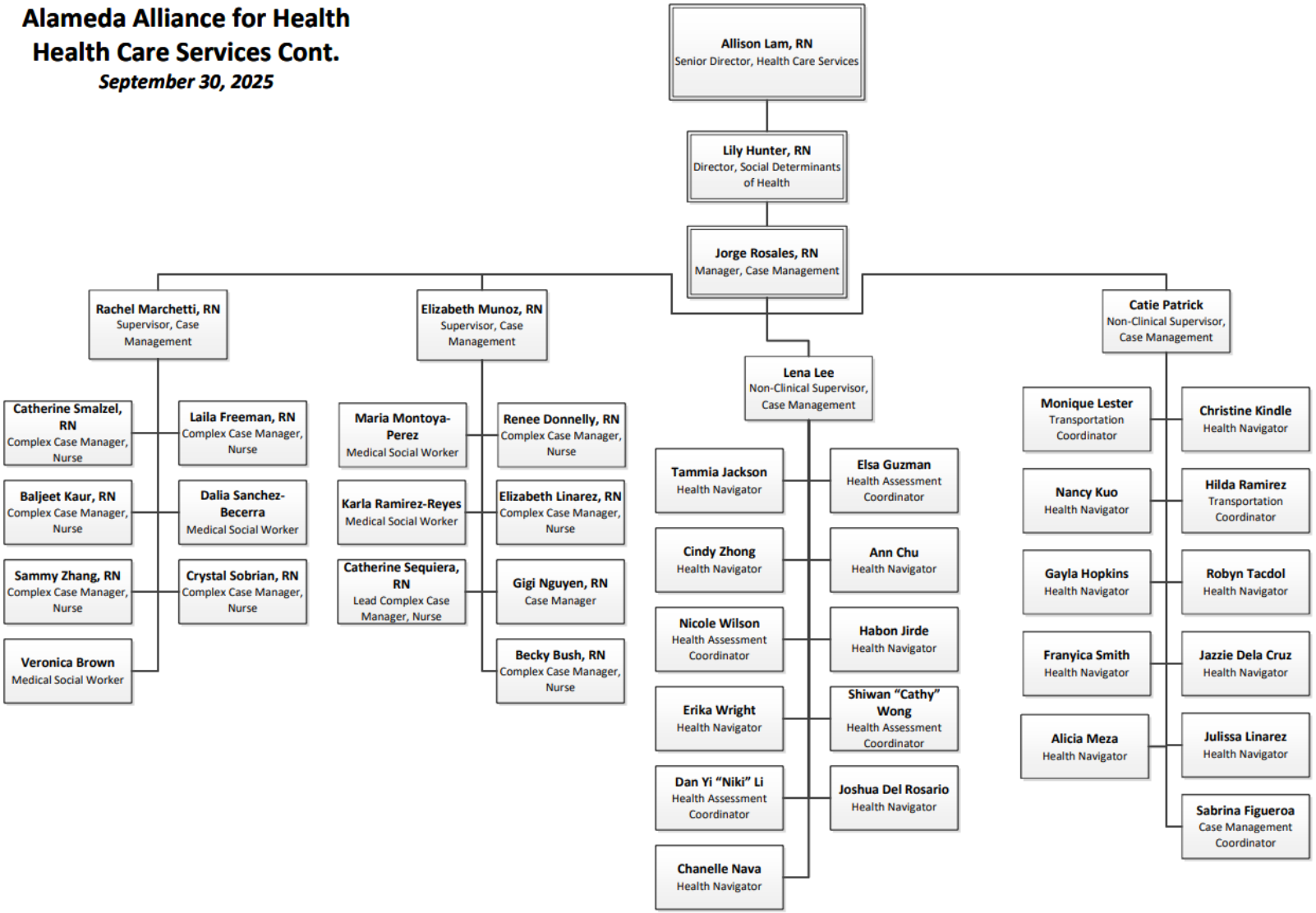
Alameda Alliance for Health
Healthcare Services
September 30, 2025



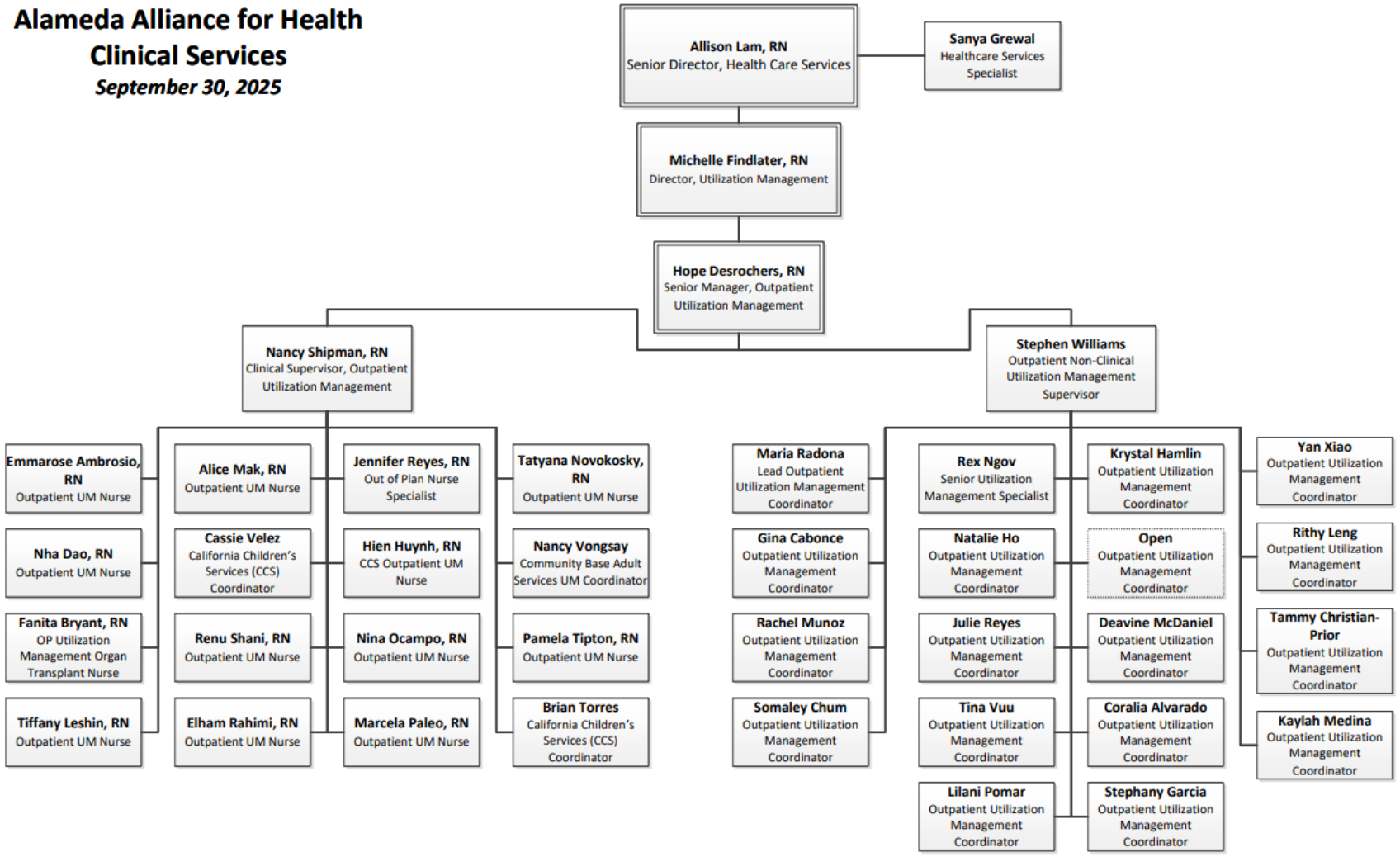
Health Care Services – Quality



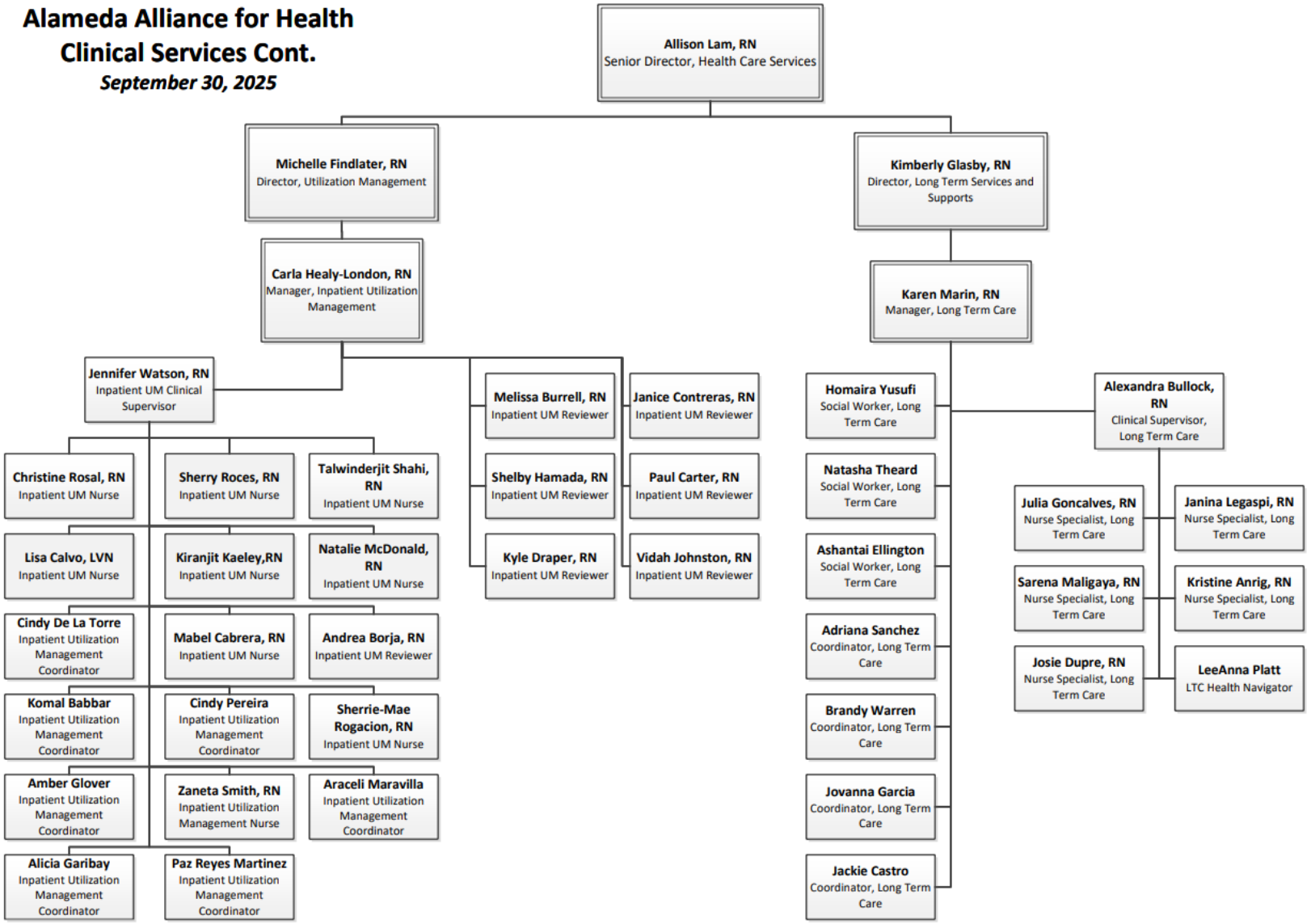
Case Management



Utilization Management – Outpatient

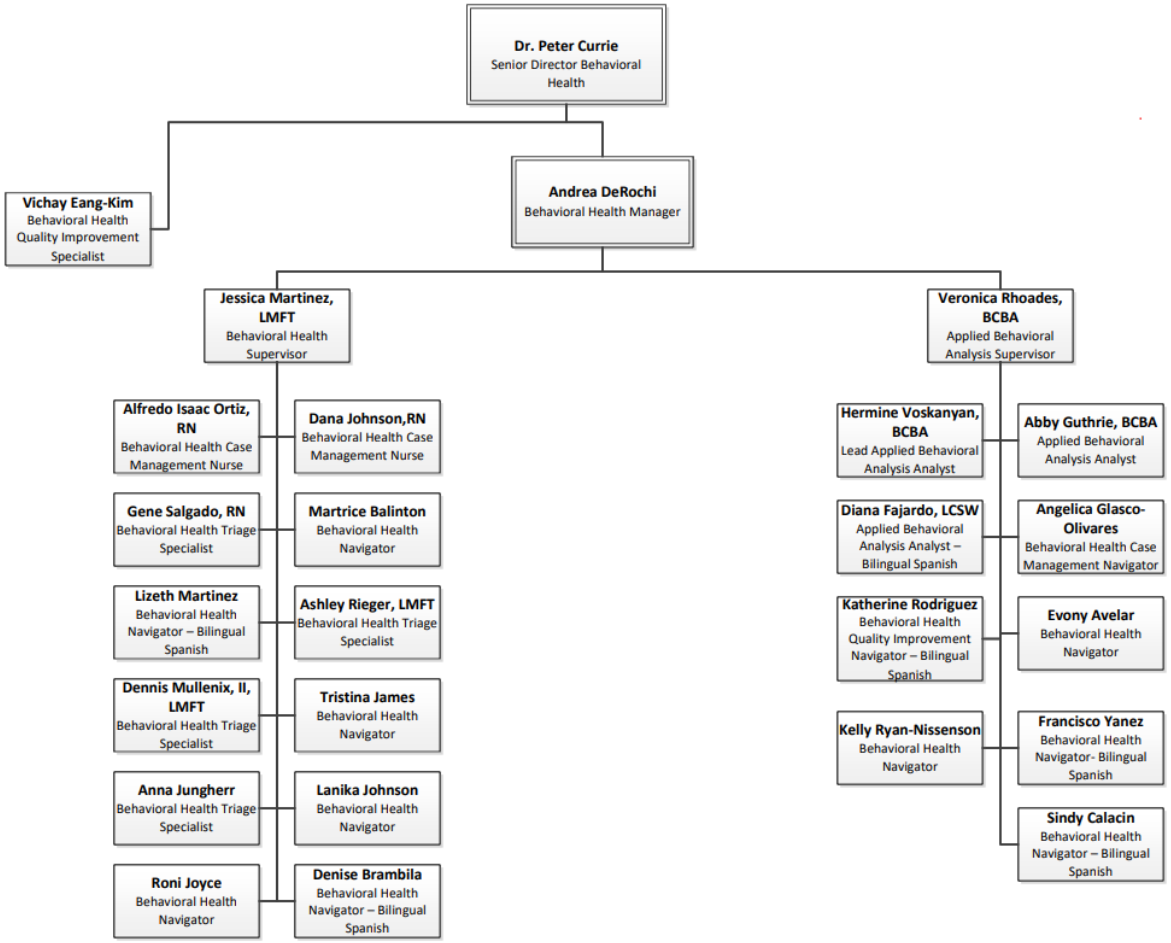


Utilization Management – Inpatient and Long-Term Care



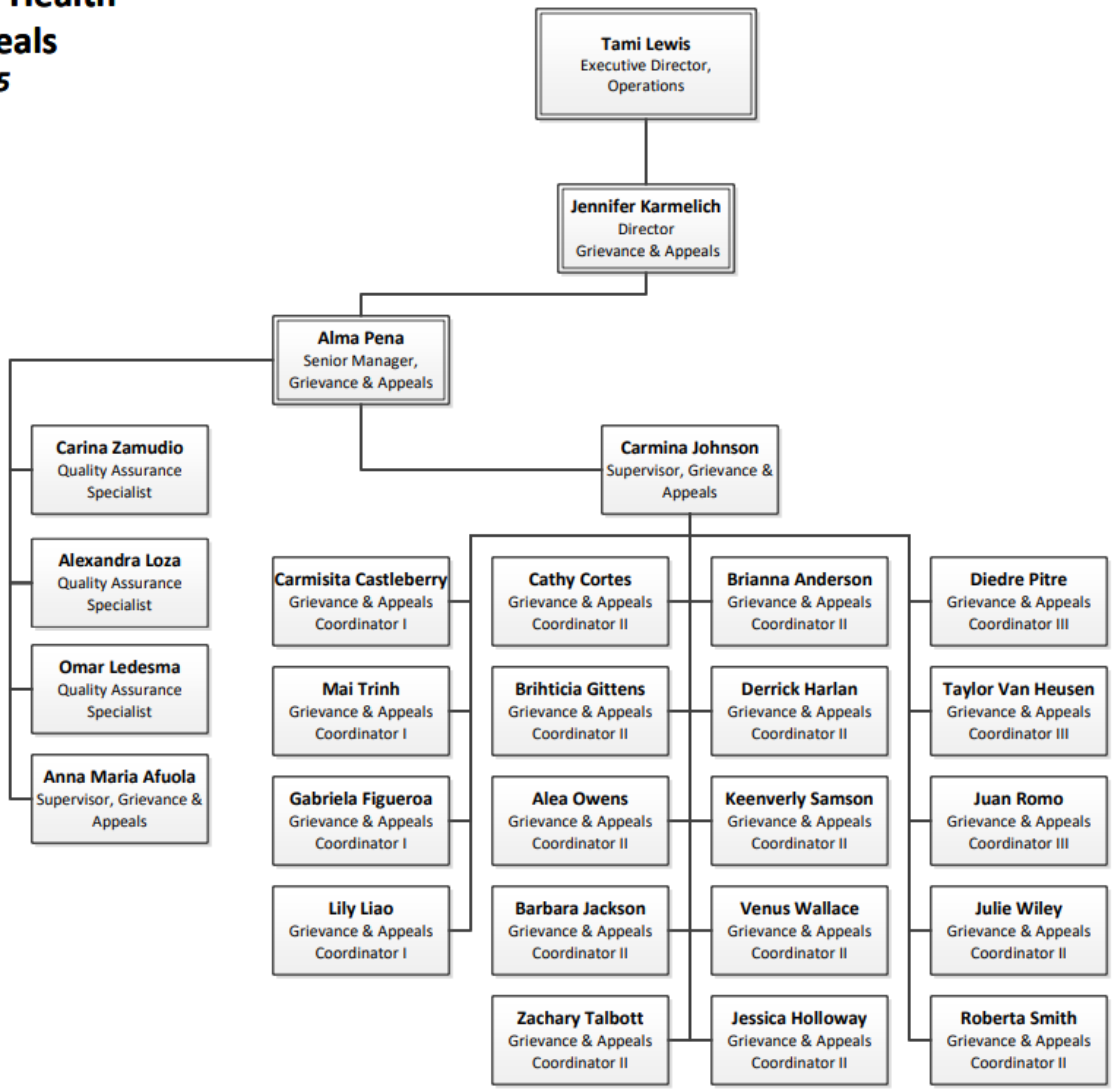
Behavioral Health

Alameda Alliance for Health
Behavioral Health
September 30, 2025

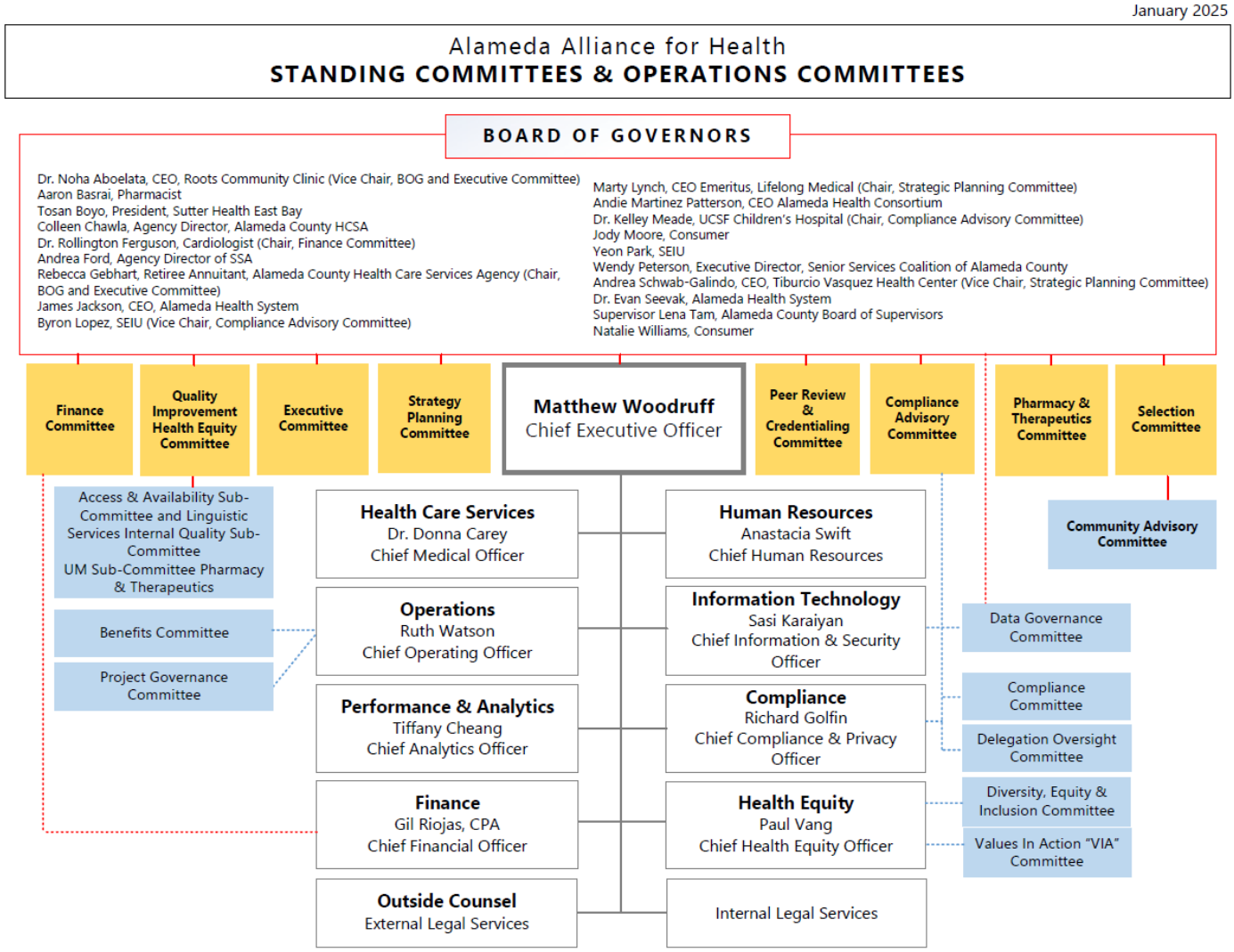


Grievance & Appeals

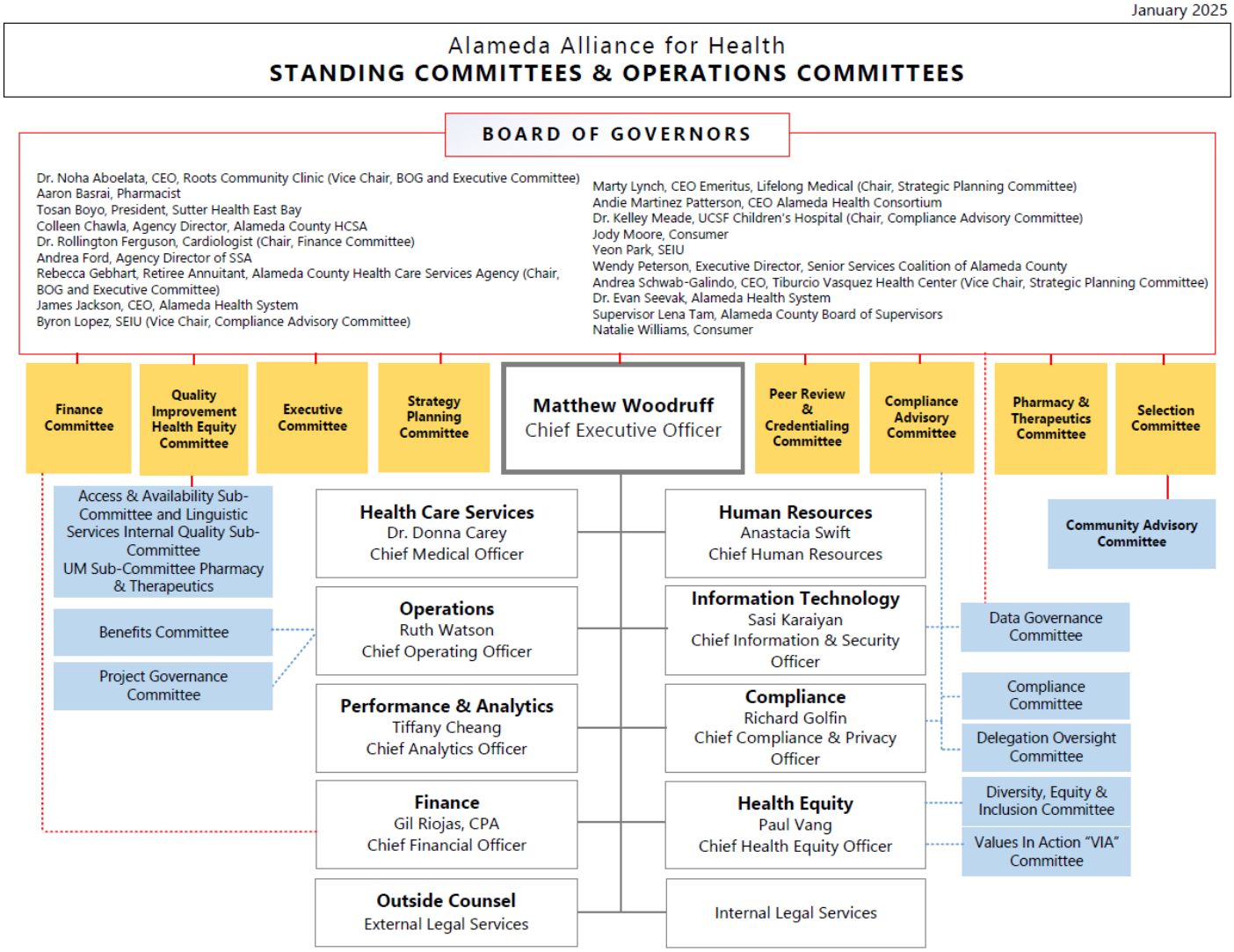
Alameda Alliance for Health
Grievance & Appeals
September 30, 2025



APPENDIX B: Alameda Alliance Committees



January 2025



ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM DESCRIPTION

2026

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

2026 Quality Improvement Health Equity Program Description Signature Page

_____ _____

Michelle N. Stott, R.N., M.S.N. Date
Senior Director of Quality

_____ _____

Stephanie Brown, MD, MPH Date
Medical Director of Quality
Vice Chair, Quality Improvement Health Equity Committee

_____ _____

Lao Paul Vang Date
Chief Health Equity Officer

_____ _____

Donna Carey, MD, MS Date
Chief Medical Officer
Chair, Quality Improvement Health Equity Committee

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Matthew Woodruff Date
Chief Executive Officer
Chair, Quality Improvement Health Equity Committee

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Rebecca Gebhart Date
Board Chair

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OVERVIEW

Alameda County for Health (Alliance) is a local, Knox-Keene licensed, National Committee for Quality Assurance (NCQA) accredited, public, not-for-profit managed care health plan. The Alliance is committed to making high quality health care services accessible and affordable for vulnerable populations in Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance board of governors, staff, and provider network all reflect the county's cultural and linguistic diversity. The Alliance provides health care coverage to more than 400,000 children and adults.

Alameda Alliance for Health is licensed by the State of California and product lines include Medi-Cal, Dual Eligible Special Needs Plan (D-SNP), and Group Care commercial insurance. Medi-Cal managed care beneficiaries are eligible through one of several Medi-Cal programs, e.g. Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion. For dually eligible Medi-Cal and Medicare beneficiaries, Medicare coverage remains the primary insurance, and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Alameda Alliance Wellness plan is a specialized Medicare Advantage plan that is designed to provide specialized care for individuals who a dually eligible for Medicare and Medi-Cal. This plan offers comprehensive care coordination and wrap around services to enhance member outcomes. The Alliance operates as an Exclusively Aligned Enrollment (EAE) D-SNP plan meaning members are enrolled in both the Alliance for Medicare benefits and the Alliance Managed Care Plan (MCP) for Medi-Cal benefits. This structure facilitates care coordination and benefit integration, following the Special Needs Plan Model of Care Framework as established by the Bipartisan Budget Act (BBA) of 2018.

The plan's Quality Improvement initiatives are tailored specifically to the needs of the D-SNP population, which aims to enhance health outcomes, quality of life, and overall care experience for dually eligible beneficiaries.

The Alliance Quality Improvement Health Equity (QIHE) Program applies to all product lines and strives to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE program includes systematic and continuous activities to monitor, evaluate, and improve the health equity and health care delivered to members in accordance with the standards set forth in applicable State and Federal regulations.

The QIHE Program description is a comprehensive document with a set of interconnected documents that describes our quality program governance, structure and responsibilities, operations, scope, goals, and measurable objectives. Participation of all Alliance departments and staff in quality improvement activities is essential to the organization in achieving our QIHE goals and objectives.

The Alliance complies with applicable State and Federal civil rights laws and does not discriminate based on race, ethnicity, culture, gender, gender identity and expression, sexual orientation, socioeconomic status, religion, spirituality, disability, age, national origin, immigration status, and language The Alliance QIHE Program is committed to serving the healthcare needs of our culturally and linguistically diverse membership. The Alliance staff and provider network reflect the county's cultural and linguistic diversity.

MISSION AND VISION

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of their life.

QIHE PROGRAM SCOPE AND GOALS

The purpose of the Alliance QIHE Program is to objectively monitor and evaluate the quality, safety, appropriateness, health equity, and outcome of care and services delivered to members of the Alliance. The overall goal of the QIHE Program is to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE Program is structured to continuously pursue opportunities for improvement and problem resolution. The QIHE Program is organized to meet overall program objectives as described below and as directed each year by the QIHE and UM Work Plans. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

Although not limited to, the goals of the QIHE Program are to:

1. Maintain the delivery of high quality, safe, and appropriate medical and behavioral health care that meets professionally recognized standards of practice that are delivered to all enrollees.
2. Consider health equity principles in the conceptualization, development, delivery and evaluation metrics of all lines of business at the Alliance.
3. Utilize objective and systematic measurement, monitoring, and evaluation through qualitative and quantitative analysis of health care services and to implement QIHE activities based on the findings.
4. Conduct performance improvement activities that are designed, implemented, evaluated, and reassessed using industry recognized quality improvement models such as Plan-Do-Study-Act (PDSA).
5. Ensure physicians, appropriate licensed professionals, or clinicians, including behavioral health, are an integral and consistent part of the QIHE Program.
6. Ensure medical and behavioral health care delivery is consistent with professionally recognized standards of practice.
7. Track and trend the delivery of healthcare services to ensure care and services are not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
8. Design and maintain an ongoing organizational culture of quality to ensure continual HEDIS improvement and accreditation readiness.
9. Monitor and evaluate the Alameda Alliance Wellness Model of Care to determine if the framework adequately addresses enrollees' unique healthcare needs.

The scope of the QIHE Program is comprehensive and encompasses the following:

1. Timely access and availability to quality and safe medical, behavioral, and specialty health care and services.
2. Care and disease management services.
3. Cultural and linguistic services.
4. Patient safety.
5. Member and provider experience.
6. Continuity and coordination of care across settings, with the goal of establishing consistent

provider-patient relationships.

7. Tracking of service utilization trends, including over-and under-utilization.
8. Clinical practice guideline development, adoption, distribution, and monitoring.
9. Targeted focus on acute, chronic, and preventive care services for children and adults for Member and provider education.
10. Prenatal, primary, specialty, emergency, inpatient, and ancillary care.
11. Case review, investigation, and corrective actions of potential quality issues
12. Credentialing and re-credentialing activities.
13. Delegation of oversight and monitoring.
14. Delegate and direct provider performance improvement project collaborations.
15. Targeted support of special needs populations including seniors and persons with disabilities, dual special needs most vulnerable population, and people with chronic conditions.
16. Population health management integration.
17. Health care diversity and equity.
18. Make recommendations to the Board of Governors (BOG) regarding the processes and outcomes of quality assurance and improvement activities.

ORGANIZATIONAL STRUCTURE AND SUPPORT COMMITTEES' RESPONSIBILITY

Overview

The Alliance Board of Governors (BOG) appoints and oversees the Quality Improvement Health Equity Committee (QIHEC), Pharmacy & Therapeutics (P&T) Committee, Peer Review Committee, Credentialing Committee, Community Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program.

The organizational chart in **Appendix A** displays the reporting relationships for key staff responsible for QIHE activities at the Alliance. **Appendix B** displays the committee reporting relationship and organizational bodies.

Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent members, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QIHE Program. Its duties include:

- Reviewing annually, updating, and approving the QIHE Program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing and approval of the annual QIHE report and evaluation of QIHE workplan, studies, activities, and data on utilization and quality of services.

- Assessing QIHE Program's effectiveness and direct modification of operations as indicated.
- Monitoring and evaluating the D-SNP Model of Care and accompanying workplan.
- Defining the roles and responsibilities of QIHEC.
- Designating a physician member of senior management with authority and responsibility for the overall operation of the QIHE program, who serves on QIHEC.
- Appointing and approving the roles of the Chief Medical Officer (CMO), including the support of the Chief Health Equity Officer, and other management staff in the QIHE Program.
- Receiving a report from the CMO as Chair on the agenda and actions of QIHEC.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is a standing committee of the BOG and meets a minimum of four times per year, and as often as needed, to follow up on findings and required actions. The QIHEC includes oversight and representation for all lines of business including Medi-Cal, GroupCare, and Alameda Alliance Wellness. The QIHEC is responsible for the implementation, oversight, and monitoring of the QIHE Program and Utilization Management (UM) and Care Management Programs. The QIHEC approves and recommends policy decisions, analyzes and evaluates the QIHE work plan activities, and assesses the overall effectiveness of the QIHE Program. The QIHEC reviews results and outcomes for all QIHE activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. The QIHEC Program monitors and evaluates the Alliance Model of Care to determine if the overall framework adequately addresses members' unique healthcare needs. Any quality issues related to the health plans that are identified through the CAHPS, Health Outcomes Survey (HOS), Case Management, and Provider Satisfaction surveys. Health plan service reports are also discussed and addressed at QIHEC meetings. The QIHEC oversees and reviews all QI delegation summary reports and evaluates delegate quality program descriptions, program evaluations, and work plan activities. The QIHEC presents to the Board the annual QIHE Program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The Annual QIHE Program, Work Plan, and Evaluation from the QIHEC (or other related documents as requested) are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include but are not limited to:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, satisfaction surveys (i.e. CAHPS), and findings and activities of the quality committees, such as the Community Advisory Committee.
- Ensures the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis.
- Determine if the Alameda Alliance Wellness MOC framework adequately addresses members' unique healthcare needs using specific quality metrics, data, analysis, improvement planning, and remeasurement.
- Approve, select, design, and schedule studies and improvement activities.
- Review member and provider survey results and related improvement initiatives.
- On-going reporting to the BOG.
- Meet at least quarterly and maintain approved minutes of all committee meetings.

- Approve definitions of outliers and develop corrective action plans.
- Recommend and approve medical necessity criteria, clinical practice guidelines, as well as pediatric and adult preventive care guidelines and review compliance monitoring.
- Review member grievance and appeals data.
- Oversee the plan's UM and Care Management Programs.
- Review advances in healthcare technology and recommend incorporation of new technology into delivery of services as appropriate.
- Institute actions to address performance deficiencies, including policy recommendations, and ensure follow-up of identified findings.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QIHE goals.
- Evaluate annually the effectiveness of the QIHE and Population Health Management program.
- Oversee the Alliance complex case management and disease management programs.
- For providers that are delegated for QI, including fully delegated subcontractors and downstream fully delegated subcontractors, are required to maintain a QIHEC that meets the QIHE program requirements.
- Review and approve annual QIHE and UM/CM program descriptions, work plans, and evaluations.
- Recommend and approve resource allocation for the QI Department Program.

The QIHEC is chaired by the CMO and vice-chaired by the Medical Director of QI. The members are representatives of the Alliance contracted provider network including those who provide health care services to members affected by health disparities, limited English proficiency (LEP) members, children with special health care needs (CSHCN), seniors and persons with disabilities (SPD), and persons with chronic conditions. The QIHEC members are appointed for two-year terms. The voting membership includes:

  - Chief Medical Officer (Chair)
  - Medical Director of Quality (Vice-Chair)
  - Chief Executive Officer (ex officio)
  - Chief Health Equity Officer
  - Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group) representing:
    - Practicing provider representing Internal Medicine
    - Practicing provider representing Family Practice
    - Practicing provider representing Pediatrics
    - Practicing provider representing Behavioral Health
    - Practicing physician(s) representing common medical specialties
  - Medical Directors
  - Senior Director, Quality

- Executive Director, Medicare Programs

A quorum is established when the majority of voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee assists the QIHEC in oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting summaries and changes in Pharmacy related policies are presented directly to the Board of Governors.

The voting membership consists of:

- Chief Medical Officer (Chair) or designee
- Senior Director, Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties
- Practicing physician representing gerontology for the D-SNP population
- Practicing Behavioral Health specialist (e.g., psychologist, psychiatrist)
- Practicing community pharmacists contracted with Alliance (not to exceed three pharmacists)

Peer Review and Credentialing Committee (PRCC)

The PRCC is a standing committee of the BOG that meets a minimum of ten times per year. The Alliance separates d the functions of PRCC into two distinct committees – the Peer Review Committee (PRC) and the Credentialing Committee (CC). The chair of both committees is the CMO.

CREDENTIALING COMMITTEE

Primary responsibilities include:

- Ensuring that all applicants are reviewed against minimum standards or criteria and are treated fairly.
- Determining whether there is adequate/sufficient information to evaluate and make a determination/recommendation.
- Implementation and ongoing review of credentialing policies and procedures.
- Assuring that the credentialing process conforms to applicable accreditation standards and other regulatory requirements.
- Making recommendations or decisions related to participation, appointment, and privileges.

PEER REVIEW COMMITTEE

Primary responsibilities include:

- Investigating complaints regarding the quality of clinical care provided by the Alliance's

contracted providers and making recommendations for corrective action.
- Reviewing conditions identified as having quality concerns.

The following Committee members have voting rights:
- Committee Chairperson
- Committee Vice Chairperson
- Committee Member: Positions held by practitioners

Internal Quality Improvement Committee (IQIC)

The IQIC assists the QIHEC in oversight and assurance of the quality of clinical care, patient safety, and customer service provided throughout the Alliance organization. Its primary roles are to maintain and improve clinical operational quality, review organization-wide performance against the Alliance quality goals, and report results to the QIHEC.

Committee Responsibilities include but are not limited to:

- Develop, approve, and monitor a dashboard of key performance and QIHE indicators compared to organizational goals and industry benchmarks.
- Oversee and evaluate the effectiveness of the Alliance performance improvement and quality activities.
- Review reports from workgroups and, if acceptable, forward them for review at the next scheduled QIHEC.
- Review plan and delegate corrective plans regarding negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the QIHEC on all matters related to:
    - Quality of Care, Patient Safety, and Member/Provider Experience.
    - Performance Measurement.
    - Preventive services include:
        - Seniors and Persons with Disability (SPD)
        - Dual Eligible Special Needs Plan members
        - Members with chronic conditions
        - Medi-Cal Expansion (MCE) members.

The Committee shall be comprised of the following members:

- Chief Medical Officer (CMO)
- Medical Director(s)
- Sr. Director, Quality
- Director, Quality Performance
- Quality Improvement (Performance) Manager
- 1 Representative from Grievances and Appeals

- 1 Representative from Compliance
- 1 Representative from Healthcare Analytics
- 1 Representative from Population Health & Equity
- 1 Representative from Health Care Services
- 1 Representative from Member Services
- 3 Representatives from Quality Improvement
- 2 Representatives from Medicare Operations
- 1 Representative from Health Equity

Utilization Management Committee (UMC)

The UMC is a forum for facilitating clinical oversight and direction. Its responsibilities are to:

- Maintain the annual review and approval of the:
    - UM and CM Program Descriptions, UM and CM Policies/Procedures, UM Criteria, and UM Decision-Making Hierarchy
    - Other pertinent UM documents such as the UM and CM Program Evaluations, UM and CM Workplan, and any trends or updates pertaining to the workplans.
    - Enhanced Care Management (ECM) and Community Supports Policies/Procedures
    - California Integrated Care Management (CICM) Policies and Procedures
    - Health Risk Assessment (HRA) and Health Information Form/Member Evaluation Tool (HIF/MET) Policies and Procedures
    - Face-to-Face Encounters Policies and Procedures
    - Transitions of Care Policies and Procedures (D-SNP)
    - Palliative Care Case Management Policies and Procedures (D-SNP)
- Participate in the utilization management/continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and under-utilization and recommend appropriate actions when indicated.
- Review and analyze utilization data for the identification of trends, including trends related to health disparities, social determinants of health, and behavioral health.
- Recommend actions to the QIHEC when opportunities for improvement are identified from review of utilization data including, but not limited to ambulatory visits, emergency visits, hospital utilization rates, hospital admission rates, average length of stay rates, and discharge rates.
- Review information about new medical technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as new benefit criteria for members.

Access and Availability Subcommittee (AASC)

The AASC reviews the Alliance's access and availability data to evaluate whether the Alliance is meeting regulatory standards and provides corrective actions and recommendations for improvement

when needed. The committee identifies opportunities for improvement and provides recommendations to maintain compliance with access and availability regulatory requirements.

Membership is comprised of Alliance staff within departments that are involved with access and availability which include the following representation:

- Chief Medical Officer
- Medical Directors
- Senior Director, Quality
- Access to Care Manager
- 1 Representative from Grievances and Appeals
- 1 Representative from Compliance
- 1 Representative from Healthcare Analytics
- 1 Representative from Population Health & Equity
- 1 Representative from Utilization Management
- 1 Representative from Member Services
- 1 Representative from Provider Services
- 3 Representatives from Quality Improvement
- 1 Representative from Medicare Operations
- 1 Representative from Health Equity

The following are the monitoring activities the subcommittee reviews to ensure compliance with access and availability and network adequacy requirements including but not limited to:

- Provider network capacity levels
- Facility site Reviews
- Geographic accessibility
- Appointment availability surveys
- High volume and high impact specialists
- Access-related grievances and appeals, which may include access-related potential quality issues, provider language capacity, wait time and telephone practices related to access, and member and provider satisfaction survey.
- After-hours care

Cultural and Linguistic Services Subcommittee (CLSS)

The Cultural and Linguistic Services Subcommittee's role is to ensure members receive culturally and linguistically appropriate health care services and to monitor the Alliance's Cultural and Linguistic Services Program. The CLSS reviews demographic changes in the Alliance membership, language services, grievances and potential quality issues related to language access and discrimination, alternative formats and translation services, and overall execution of the Alliance's Cultural and Linguistic Services Program. The CLSS makes recommendations for organizational and program changes as needed and reports results to the QIHEC.

Responsibilities include but are not limited to:

- Monitor the cultural and linguistic needs of members.
- Review reports related to provision of cultural and linguistic services.
- Ensure that language assistance services are provided at all points of contact.
- Maintain and update cultural and linguistic services policies and procedures to be compliant with ongoing regulatory and contractual requirements.
- Annually review and update Cultural and Linguistic Services (CLS)'s program description and workplan. Quarterly monitor the CLS Workplan.
- Review input from the Community Advisory Committee (CAC) on cultural and linguistic services and consider how it may inform Alliance's CLS programs, policies, and procedures.
- Identify issues related to access and provision of culturally and linguistically appropriate services and develop corrective actions to correct deficiencies found.
- Review plan and delegate corrective action plans related to CLS.

The CLSS is composed of the following members:

- Chief Medical Officer
- Chief Health Equity Officer
- Senior Director of Quality
- Director, Population Health, and Equity
- Manager, Cultural and Linguistic Services
- Manager, Population Health, and Equity
- 1 Representative from Compliance
- 1 Representative from Communications and Outreach
- 1 Representative from Grievance and Appeals
- 1 Representative from Population Health and Equity
- 1 Representative from Health Care Services
- 1 Representative from Member Services
- 1 Representative from Provider Services
- 1 Representative from Quality Improvement
- 1 Representative from Behavioral Health
- 1 Representative from Medicare Operations

Community Advisory Committee (CAC)

The CAC provides a link between the Alliance and the community. The CAC reflects the Alliance's member population and advises the Alliance on the development and implementation of policies and

procedures that affect cultural and linguistic access, quality, and health equity. All CAC findings and/or activities are reported to the QIHEC.

The CAC carries out, but is not limited to, the following duties:

- Identify and advocate for preventive care practices to be used by the Alliance.
- Develop and update cultural and linguistic policy and procedures related to cultural competency issues, educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability.
- Advise on Alliance member and provider-targeted services, programs, and trainings.
- Provide and make recommendations about the cultural appropriateness of communications, partnerships, and services.
- Provide recommendations and feedback on the diversity, equity, and inclusion training program as applicable.
- Inform and validate the development of the Alliance's community reinvestment plans.
- Provide input, advise, and make recommendations to address quality of care, health equity, health disparities, population health management (PHM), children services such as the Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs)
- Utilize findings from the CHAs/CHIPs to influence Alliance strategies and workstreams related to the Department of Healthcare Services Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.
- Provide input and advice, including, but not limited to, the following:
    - Culturally appropriate services or program design
    - Priorities for health education and outreach program
    - Member satisfaction survey results
    - Plan marketing materials and campaigns
    - Communication of needs for Network development and assessment
    - Community resources and information
    - PHM
    - Quality
    - Development of covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan
    - Input on Quality Improvement and Health Equity and the Population Needs Assessment
    - Reforms to improve health outcomes, accessibility of services, and coordination of care for Members
    - Inform the development of the provider manual

In consultation with the Alliance's Chief Health Equity Officer, the Alliance convenes a CAC Selection Committee, tasked with selecting members of the CAC, providing the recommendations and/or replacing former CAC members whose position(s) have been vacated that reflect the general Medi-

Cal, Group Care and Alameda Alliance Wellness member populations, hard to reach populations, and those that experience health disparities in Alameda County. The CAC Selection Committee will report to the Alliance Board of Governors.

The CAC membership and representation must reasonably reflect the Medi-Cal, Group Care, and Alameda Alliance Wellness populations in Alameda County, and representation must include the following:

- General population of the Alliance members.
- Adolescents and/or parents and/or caregivers of children.
- Current/former foster youth and/or parents/caregivers of current/former foster youth.
- Members who receive Long-Term Support Services and/or their representatives.
- Representatives from Indian Health Care Providers (IHCP).
- Diverse and hard-to-reach populations (with emphasis on persons who are representatives of or serving populations that experience health disparities, such as those with limited English proficiency (LEP), diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities).
- Members receive enhanced care management (ECM) and community support (CS) services as appropriate.
- At least 51% of the committee shall be Alliance members (and/or the parents/guardians of Alliance members who are minors or dependents).
- At least 4 seats of the committee shall be Alliance Wellness Dual Eligible Special Needs (D-SNP) members and/or their caretakers.

Joint Operations Committee/Delegation

The contractual agreements between the Alliance and delegated entities specify:

- The responsibilities of both parties.
- The functions or activities that are delegated.
- The frequency of reporting on those functions and responsibilities to the Alliance and how performance is evaluated.
- Corrective action plan expectations, if applicable.

The Alliance may delegate QI, Credentialing, UM, Case Management, Disease Management, Claims, Grievance and Appeals activities to Health Plans, County entities, and/or vendors that meet the requirements as defined in a written delegation agreement, delegation policies, accreditation standards, and State and Federal regulatory standards.

To ensure delegated entities meet required performance standards, the Alliance:

- Provides oversight to ensure compliance with Federal and State regulatory standards, and accreditation standards.
- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities.

- Conducts annual oversight audits.
- Reviews reports from delegated entities.
- Collaborates with delegated entities to continuously improve health service quality.

As part of delegation responsibilities, delegated entities must:

- Develop, enact, and monitor quality plans that meet contractual requirements and Alliance standards.
- Provide encounter information and access to medical records pertaining to Alliance members as required for HEDIS and regulatory agencies.
- Provide a representative to the Joint Operations Committee.
- Submit at least semi-annual reports or more frequently if required on delegated functions.
- Cooperate with state/federal regulatory audits as well as annual oversight audits.
- Complete any corrective action deemed necessary by the Alliance.

The Alliance collaborates with delegated entities to formulate and coordinate QIHE activities and includes these activities in the QIHE work plan and program evaluation. Delegated activities are a shared function. Delegate program descriptions, work plans, reports, policies and procedures, evaluations and audit results are reviewed by the Subcontractor & Delegation Oversight Committee (SDOC) and Joint Operations Committee, and findings are summarized at QIHEC meetings, as appropriate.

The Alliance currently delegates the following functions:

Table 1: Alameda Alliance Delegated Entities

ALAMEDA ALLIANCE DELEGATED ENTITIES - 2026																
	Delegated Entity Name	Utilization Management X = NCQA Accredited			Case Management			Quality Management / Quality Improvement			Credentialing X = NCQA Accredited			Claims		
		Medi-Cal	Group Care	D-SNP	Medi-Cal	Group Care	D-SNP	Medi-Cal	Group Care	D-SNP	Medi-Cal	Group Care	D-SNP	Medi-Cal	Group Care	D-SNP
1	Children's First Medical Group (CFMG)	X									X			X		
2	Community Health Center Network (CHCN)	X	X		X	X								X	X	
3	Liberty Dental			X						X			X			X
4	PerformRx (PBM)		X	X								X	X		X	X
5	Vision Service Plan (VSP)							X		X	X		X	X		X
6	Lucille Packard (Credentialing)										X	X				
7	Physical Therapy PN (Credentialing)										X	X				
8	Teladoc (Credentialing)										X	X				
9	UCSF (Credentialing)										X	X				

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM RESOURCES

Responsibilities for QIHE Program activities are an integral part of all Alliance departments. Each department is responsible for setting and monitoring quality goals and activities.

The Alliance QI Department is part of the Health Care Services Department, and responsible for implementing QIHE activities and monitoring the QIHE Program. The QI Department participates in the accreditation process, manages the HEDIS, Stars, CAHPS, and HOS data collection and improvement process, conducts facility site reviews (FSRs), processes Potential Quality Issues (PQIs), and oversees the quality activities in other departments and those performed by delegated groups.

Resource allocation for the QI Department is determined by recommendations from the QIHEC, CMO, CEO and BOG. The Alliance recruits, hires, and trains staff, and provides resources to support activities required to meet the goals and objectives of the QIHE Program.

The Alliance's commitment to the QIHE Program extends throughout the organization and focuses on QIHE activities linked to service, access, continuity and coordination of care, and member and provider experience. The Senior Director of Quality, with direction from the Medical Director of Quality CMO, and CHEO, coordinates the QIHE Program. Titles, education and/or training for key positions within the Quality Department include:

Chief Medical Officer

The Alliance Chief Medical Officer (CMO) is responsible for and oversees the QIHE Program. The CMO has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The CMO provides leadership to the QIHE Program through oversight of QI study design, development, implementation, and chairs the QIHEC, PRCC, and P&T committees. The CMO makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the BOG. The CMO reports to the Alliance CEO.

Chief Health Equity Officer

The Chief Health Equity Officer (CHEO) reports directly to the Chief Executive Officer (CEO).The position partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees. The executive position implements policies that ensure health equity is prioritized and addressed and is responsible for setting and implementing an overarching vision of DEI for the organization, including programmatic and administrative outcomes. The position is responsible for the promotion of internal and external DEI for members, providers, and employees. With supervision by the Chief Medical Officer (or designee) of the QIHE program, the CHEO participates in QIHEC and collaborates on QIHE program activities.

Medical Director, QI

The Medical Director has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The Medical Director is part of the medical team and is responsible for strategic direction of the Quality Improvement Health Equity programs. The Medical Director also forms a dyad partner with the Sr. Director of Quality and serves as an internal expert, consultant, and resource in QI. They are responsible for clinical appropriateness, quality of care, pay for performance, access and availability, provider experience, member experience and cost-effective utilization of services delivered to Alliance members. The Medical Director participates in the grievance and external medical review procedure process, resolving medically related and potential

quality related grievances, and issuing authorizations, appeals, decisions, and denials. The Medical Director reports to the CMO.

Senior Director of Quality

The Senior (Sr.) Director of Quality is responsible for the strategic direction of the Quality Improvement Health Equity Program. This position has direct oversight for the development, implementation, and evaluation of the QIHE Program. This position is responsible for all performance improvement activities, including improving access and availability of network services, developing and managing quality programs as identified by CMS, DHCS, DMHC, and NCQA. This includes QIPs, PIPs, Improvement Programs i.e., HEDIS/MCAS measures, Stars (in collaboration with the Medicare Operations), QI Standards as well as managing, tracking, analyzing, and reporting member experience/satisfaction (i.e. Consumer Assessment Health Plan Surveys (CAHPS) as requested. The Sr. Director is also responsible for the oversight of FSR and potential quality issues (PQIs) and will direct performance improvement and access and availability activities. The Sr. Director is also the senior nurse to the organization to augment clinical oversight. This position, along with the Director of Population Health & Equity, assists with setting the priorities of the Population Health Management program, and ensures Health Education and Cultural and Linguistic Services are incorporated into the QIHE program. The Sr. Director of Quality is a dyad partner with the QI Medical Director and reports to the CMO.

Senior Director of Behavioral Health

The Senior Director of Behavioral Health has relevant experience and current knowledge in clinical program administration, including behavioral health and autism spectrum disorder management. The Sr. BH Director is responsible for and oversees the BH program. Responsibilities include participating in the QI, UM, and CM processes as they pertain to behavioral health and autism spectrum disorder programs. The Senior Director of BH reports to the Chief Medical Officer.

Director of Population Health and Equity

The Director of Population Health and Equity (PHE) provides operational oversight and leadership for the Alliance's population health assessments, strategy and evaluation. The PHE Director is also responsible for state and federal regulatory and accreditation requirements concerning Population Health Management, Cultural and Linguistic Services and the member Health Education Program. This position reports to the Senior Director of Quality Improvement and works closely with the Chief of Health Equity.

Director of Quality Performance

The Director, Quality Performance is responsible for developing, coordinating, implementing, and managing the strategic quality performance programs across multiple lines of businesses including Medi-Cal, Dual Eligible Special Needs Program (D-SNP), and Group Care. This role will work cross-functionally to monitor and implement quality initiatives to achieve state and national benchmarks for National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), Centers for Medicare & Medicaid (CMS) Star Ratings, Department of Health Care Services Medi-Cal Managed Care Accountability Set, and Department of Managed Health Care (DMHC) Health Equity and Quality Measure Set.

Manager of Population Health and Equity

The Population Health and Equity (PHE) Manager is responsible for the implementation of the Alliance's population health assessments, strategy and evaluation. In addition, the PHE Manager

oversees the execution of the Alliance's population health and health education programs and related equity initiatives, supervises PHE staff, and ensures compliance with state and federal regulatory and accreditation requirements concerning population health management and health education.

Manager of Cultural and Linguistic Services

The Cultural and Linguistic Services (CLS) Manager is responsible for direct oversight of the Alliance Cultural and Linguistic Services Program. This includes activities such as ensuring members have access to language assistance services for interpreting services, review of provider capacity to meet the cultural and linguistic needs of members, and overall assessment of the cultural and linguistic needs of members. The CLS Manager is also responsible for compliance with state and federal regulatory and accreditation requirements related to CLS. Furthermore, the CLS Manager leads the planning and implementation of internal and external committees, such as the Cultural and Linguistics Services Subcommittee and the Community Advisory Committee. The CLS manager reports directly to the Population Health and Equity Director.

Quality Improvement (Performance) Manager

The Quality Improvement (Performance) Manager (QPM) is responsible in advancing the goals of the Quality Improvement and Health Equity (QIHE) program. The QPM is responsible for the day-to-day management of the Performance Improvement Team, including but not limited to HEDIS/MCAS project improvement oversight, physician practice activities, and Quality and Performance Improvement Project oversight. The QI Manager also acts as liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The QPM works collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems including PDSA (Plan-Do-Study-Act).

Manager, Access to Care

The Manager, Access to Care, is responsible for day-to-day management of access to care activities throughout the organization and includes leading and establishing appropriate access to care systems. The Manager, Access to Care ensures the access program complies with timely access standards as regulated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA). The Access to Care Manager ensures planning and oversight of access to care surveys, ensures appropriate follow-up when compliance monitoring identifies deficiencies. The Manager, Access to Care reports to the Sr. Director of Quality.

Accreditation Manager

The Accreditation Manager is responsible for management of NCQA Health Plan Accreditation and Health Equity Accreditation. Role is responsible for internal monitoring of regulatory requirements and standards.

Quality Improvement Clinical Supervisor

The Quality Improvement Clinical Supervisor works collaboratively throughout the organization to ensure appropriate oversight of performance management and clinical quality improvement assignments. The Quality Improvement Clinical Supervisor is responsible for day-to-day supervision of the work assigned to the clinical staff in the Quality Department. The Supervisor also acts as liaison between the health plan's physician leadership and community practitioners/providers of care across

all specialties and delegates. The Quality Improvement Clinical Supervisor is responsible for oversight of timely and accurate investigation and completion of Potential Quality Issues (PQI), Provider Preventable Conditions (PPC), and quality of care corrective action plans, and participation in HEDIS activities as needed. The QI Clinical Supervisor reports to the Sr. Director of Quality.

Quality Review Nurse (3)

The Quality Review Nurse is a registered nurse responsible for timely and accurate investigation and completion of Potential Quality of Care Issues (PQIs), collecting quality related data and reviewing medical records for HEDIS abstraction and overreads as able, chart audits, regulatory compliance, quality improvement (QI) activities development, data tracking and trending, and outcomes reporting. The Quality Review Nurse keeps accurate records, manages, and analyzes data, as well as responds appropriately and timely, both verbally and in writing to internal and external clinical issues of staff and regulatory agencies. The Quality Review Nurse identifies, investigates, and reports on Potential Quality Issues (PQIs) and Provider Preventable Conditions (PPCs) as appropriate. Cases involving quality-of-care issues are presented to the Medical for review and determination.

Clinical Review Nurse (2)

The Clinical Review Nurse is responsible for investigating and processing comprehensive and complex grievances and appeals requests from members and providers, coding justifications, and provider disputes. This role has oversight by the Medical Director and CMO, and matrixed to the Grievance and Appeals team within the Operational Division.

Senior Quality Improvement Nurse Specialist (1)

The Senior Quality Improvement Nurse Specialist is responsible for the training, certification and recertification of DHCS facility site reviews (FSR) and medical record reviews (MRR) for all Alliance Provider Network and Delegated Provider Oversight. The Sr. QI Nurse Specialist is also responsible for the oversight and monitoring of the qualitative and quantitative content of the medical record process and maintaining compliance with state and regulatory quality of care standards. The Sr. QI Nurse Specialist develops provider training and education materials to assist providers with meeting quality standards.

Quality Improvement Review Nurse (1)

The Quality Improvement Review Nurse conducts facility site reviews, chart audits, regulatory compliance, quality improvement (QI) activities, and provider training. The QI Review Nurse partners with the Sr. QI Nurse Specialist to certify and recertify the Alliance Provider Network and Delegated Provider Oversight.

Quality Performance Supervisor

The Supervisor, Quality Performance, plays a critical operational role in advancing the goals of the Quality Improvement and Health Equity (QIHE) program. Under the oversight of Quality Improvement (Performance) Manager, this position is responsible for implementing high-impact quality initiatives, managing complex, cross-functional projects, and supervising a team to ensure the achievement of key performance indicators (KPIs) related to health outcomes, member engagement, and regulatory compliance.

Quality Improvement Project Specialist II (4)

The Quality Improvement Project Specialist II (QIPS II) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation and facilitation of performance improvement projects. The QI Project Specialist II conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Quality Improvement Project Specialist I (5)

The Quality Improvement Project Specialist I (QIPS I) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation, and facilitation of performance improvement projects. The QI Project Specialist I conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Accreditation and Regulatory Compliance Specialist (2)

The Accreditation and Regulatory Compliance Specialist is responsible for the preparation of NCQA Health Plan and Health Equity accreditation through coordination and follow-up of deliverables and requirements.

Quality Improvement Coordinator (1)

The Quality Improvement Coordinator (QIC) is responsible for performing facility site review audits and quality improvement activities in conjunction with the Sr. QI Nurse Specialists and QI Review Nurse. The position assists with coordination activities, such as access and availability reports, provider training, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, DMHC and NCQA.

Quality Program Coordinator (2)

The Quality Program Coordinator (QPC) is responsible for helping to plan, organize, and implement Alliance quality programs as assigned. Responsibilities include coordination of quality projects including case tracking (i.e. PQI, corrective action plans), assistance in audits or surveys (i.e. CAHPS), data collection and follow-up, and coordination of internal and external meetings. Supports the successful implementation of projects within timelines for associated department assignments.

Quality Improvement Engagement Coordinator (2)

The Quality Improvement Engagement Coordinator (QIEC) responsibilities include coordinating quality improvement projects, member outreach by phone and mail, provider and community collaboration, and data tracking and reporting. The goal of this role is to increase care for Alliance members by helping to connect them to services available directly related to QI measures.

ANCILLARY SUPPORT SERVICES FOR THE QIHE PROGRAM

Population Health and Equity

The Population Health and Equity team consists of a Population Health and Equity Director, a Population and Health Equity Manager, a Cultural and Linguistics Services Manager and supporting staff. The Population Health and Equity team is a component of the QI Department. The Population

Health and Equity staff ensure integration of QIHE initiatives into the Alliance Population Health Strategy and support the QI team in the development and implementation of member and provider educational interventions and community collaborations to address health care quality, health equity and access to care. The Population Health and Equity team also manages and monitors the Population Health Management, Health Education, and Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs and the Population Health Management Strategy are outlined in separate documents.

Analytics

The Analytics Department is comprised of three departments: 1) Healthcare Analytics, and 2) Quality Analytics and 3) Stars and Risk Adjustment. The department works in collaboration with the Quality Improvement Department on improvement activities and initiatives.

The Healthcare Analytics Department performs reporting and analyses across the organization on clinical, claims, provider, and member data. Quality activities include management of and production of the HEDIS NCQA certified software, HEDIS data validation/collection and HEDIS rate reporting and trending. In addition, the department collaborates on Population Health Management (PHM) strategies and initiatives, such as Risk Stratification and Segmentation (RSS), and supporting access and availability regulatory requirements. For Alameda Alliance Wellness, our Analytics Department plays a pivotal role in supporting the D-SNP by ensuring accurate data extraction and collection to meet the Centers for Medicare & Medicaid Services (CMS) Star Ratings requirements. Key contributions include comprehensive data integration, timely and accurate reporting, performance monitoring and improvement, and compliance with state and federal guidelines.

In addition to supporting Alameda Alliance Wellness, the Analytics department completes various data initiatives to provide our quality improvement, utilization management, and case management departments with access to risk-stratified, segmented data.

The Quality Analytics Department is responsible for management of HEDIS operational activities, the Pay-for-Performance program, and oversight of access and availability survey vendor. HEDIS operational activities include Roadmap and rate submissions, oversight of the annual HEDIS audits, medical record retrieval and training, monitoring, and performing overreads, and oversight of the abstraction vendor.

The Stars and Risk Adjustment Department is responsible for administration and oversight of the Medicare Stars and Risk Adjustment Programs for the Alameda Alliance Wellness members. This includes facilitating cross-functional communication to drive consistent and coordinated efforts in initiative development, implementation, and execution across all departments of the Alliance. They also provide operational guidance to improve provider engagement, enhance member-facing interactions, and streamline processes for closing care gaps and ensuring accurate risk capture to support performance towards organizational goals.

Utilization Management (UM) Services

The UM and QI Departments are part of the Alliance Health Care Services Department. These departments work collaboratively to ensure that appropriate quality and safe health care is delivered to members in a timely and organized manner. QI ensures that QIHEC can identify improvement opportunities regarding concurrent reviews, tracking key utilization data, and the annual evaluation of

UM activities.

The Alliance's Utilization Management (UM) activities are outlined in the UM Program Description which describes the UM program structure, and how UM decisions are made based on evidence-based guidelines, applied in a consistent manner. The Alliance's Case Management (CM) Program works in an integrated manner with the UM Program, in which care coordination and complex case management programs are designed to address the needs of members with complex physical, mental, or social determinant of health needs. Some high-risk populations include seniors and persons with disabilities (SPDs), members with multiple chronic conditions, or members with unmet social determinant of health needs (i.e.: housing or food insecurity). Core Case Management program interventions include outreach, assessment, and care coordination with members and their trusted supports, to ensure the improvement of member outcomes and overall member satisfaction. Care management staff also partners with the QI department in QIHE activities including conducting member outreach calls and mailings, as appropriate.

For our Alameda Alliance Wellness plan case management and care coordination is provided to all members and includes an individualized care plan, interdisciplinary team meetings, and support with care transitions. Care management is not delegated for our D-SNP members.

There are identified staff persons dedicated to working with "linked and carved out services" such as East Bay Regional Center, California Children Services (children with complex health care needs), and the Alameda County Behavioral Health Care Department. The UM and CM Program Descriptions are approved by the UMC and QIHEC. For additional information, refer to the UM and CM Program Descriptions.

Pharmacy Services

The Pharmacy Department and QI Department work collaboratively on various QIHE projects. The Pharmacy Department supports patient safety initiatives including working with the Pharmacy Benefit Manager (PerformRx) to inform members, providers, and network pharmacies of medication safety alerts. Responsibilities also include review and update of the formulary through P&T, oversight of the Pharmacy Benefit Manager, and collaboration with QIHEC. The Pharmacy department will work with the Medicare Stars Team, and QI Team ensuring that Stars ratings and HEDIS/MCAS scores are met for the Alliance Wellness line of business.

Provider Services

The Provider Services Department is the primary point of contact for network providers. They assist the QI Department on various QIHE activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department collaborates with the Access and Availability team to monitor provider capacity and assess provider satisfaction. In addition, they assist with sharing information to providers about Alliance processes and provide educational material on monitoring availability and accessibility standards at physician offices, including after-hours coverage. The team coordinates with Health Care Services to deliver Alameda Alliance Wellness Model of Care Training to the provider network including in and out of network providers. Provider Services staff also assist the QI Department with practitioners who do not comply with requests from QI.

Credentialing Services

The Credentialing staff support the credentialing and re-credentialing processes for practitioners and network providers. The Credentialing staff conducts ongoing monitoring and evaluation of network practitioners to ensure the safety and quality of services to members. The QI Department provides the

Credentialing Department with Potential Quality Issue trends and Facility Site Review and Medical Record audit scores. The Credentialing staff are responsible for coordinating the PR and CC meetings.

Member Services and Member Outreach

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The Communication and Outreach conduct New Member orientations to educate new members about the health plan benefits. Member Services staff also work with the QI Department on member complaints via the PQI referral process and appeals in accordance with established policies and procedures. To assist in improving HEDIS scores and STAR ratings the QI Department may conduct member outreach activities to get HEDIS services completed. Hold messages are used to remind members of plan benefits and services offered while waiting to speak to an agent.

Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, complaints, and appeals. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue and Potential Quality Issues are forwarded to QI for review and investigation as needed. QI will collaborate with G&A for assurance of accurate reporting exempt grievance data.

Methods and Processes for Quality Improvement

The QIHE Program employs a systematic approach to identify opportunities for improvement and evaluate the results of interventions. All program activities are documented in writing, and all quality studies are performed on any product line for which it seems relevant. The program aligns with the performance improvement framework recommended by the Department of Health Care Services (DHCS). This framework, adopted by the Alliance Quality Department, is based on the Institute for Healthcare Improvement (IHI) Model of Improvement Key concepts for DHCS performance improvement projects (PIP) utilize the following framework:

PIP Initiation

SMART Aim Data Collection

Intervention Determination

Plan-Do-Study-Act (PDSA)

PIP Conclusion

The Alliance QIHE Program ensures compliance with DHCS, DMHC, CMS, NCQA (as applicable), and other regulatory entities to effectively serve Medi-Cal and D-SNP members. In accordance with 42 CFR §422.152(c) and §422.152(d), Quality Improvement (QI) programs must incorporate Chronic Care Improvement Programs (CCIP) and Quality Improvement Projects (QIPs) to evaluate and enhance health outcomes and beneficiary satisfaction. Additionally, Alameda Alliance for Health implements Plan-Do-Study-Act (PDSA) cycles and Performance Improvement Projects (PIPs) as required by DHCS, CMS, and other regulatory agencies.

Identification of Important Aspects of Care

The Alliance uses several methods to identify aspects of care that are the focus of QIHE activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g.,

HEDIS and Stars). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members, health disparities, or identified through surveys and dialogue with member and provider communities (e.g., CAC, CAHPS, provider satisfaction survey, Joint Operating Meetings (JOM), Quality/Provider QI meetings, site visits, etc.). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

Data Sources and Systems

The Alliance utilizes various resources to develop clinical and quality reporting and analyses that provide meaningful and actionable insights. Resources to support the QIHE Program include, but are not limited to the following:

- ODS (Operational Data Store) and Datawarehouse: These are the main databases and the primary sources for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. The databases are used for storing data required for quality reporting.
- HealthSuite: Claims and eligibility processing system
- CareAnalyzer (DST): used to inform Population Health Management and Population Needs Assessment initiatives and provide QI/UM/CM access to risk-stratified, segmented data that can be effectively applied to target high-risk members for early intervention and improve the overall coordination of care.
- Cotiviti: The Alliance NCQA-certified HEDIS software that produces HEDIS/MCAS measure data and outcomes. Data integrity is audited annually through the HEDIS reporting audit process.
- CAHPS 5.1H,CG-CAHPS, Medicare CAHPS, Health Outcomes Survey (HOS): Member experience survey via SPH vendor support
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory results: Data files from Quest, Foundation, and AHS
- Cactus: credentialing database.
- Provider satisfaction and coordination of care surveys via Press Ganey vendor support
- Pre-service, concurrent, post-service and utilization review data (TruCare).
- Case management data (TruCare)
- Member and provider grievance and appeal data.
- Potential Quality of Care Issue Application database (Quality Suite) used for tracking/trending data.
- Internally developed reports (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), after-hours access and emergency instructions. Other clinical or administrative data.

Evaluation

The Analytics Department compiles various data sources to produce reporting and analyses. Quality performance staff analyzes the data to determine variances from established criteria, performance goals, and for clinical issues. Data is analyzed to determine priorities or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Subsets of our membership may be examined when they are deemed to be particularly vulnerable or at risk.

HEDIS and Stars related analyses include investigating trends in provider and member profiling,

data preparation (developing business rules for file creation, file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities involve data sets maintained by the Alliance and supplemental files submitted by various trading partners, such as delegated provider organizations and various external health registries and programs (e.g., Quest Diagnostics, and the California Immunization Registry).

Aggregated reports are forwarded to the QIHEC. Status and final reports are submitted to regulatory agencies as contractually required. Evaluation is documented in committee minutes, workplans, and attachments.

ACTIONS TAKEN AS A RESULT OF QIHE ACTIVITIES

Action plans are developed and implemented when opportunities for improvement are identified. Each performance improvement plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

Actions taken are documented in reports, minutes, attachments to minutes, workplans, and other similar documents.

An evaluation of the effectiveness of each QIHE activity is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and remeasurement. The evaluation of effectiveness is described qualitatively and quantitatively, in most cases, compared to previous measurements, with an analysis of statistical significance when indicated.

TYPES OF QI MEASURES AND ACTIVITIES

Healthcare Effectiveness Data Information Set (HEDIS)

The Managed Care Accountability Set (MCAS) Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) are calculated, audited, and reported annually as required by DHCS. Additional measures from HEDIS are also reviewed. A root cause analysis may be performed, and improvement activities are initiated for measures not meeting benchmarks.

Consumer Assessment of Health Plan Survey (CAHPS 5.1H and CG-CAHPS)

The Alliance evaluates member experience periodically. Third party vendors conduct the Consumer Assessment of Health Plan Survey (CAHPS). The Alliance assists in the administration of these surveys, receives, and analyzes the results, and follows up with prioritized improvement initiatives. Survey results are distributed to the A&A Subcommittee, followed by QIHEC, and made available to members and providers upon request. The CAHPS survey is conducted annually for the entire Medi-Cal population and the results from the CAHPS are reported in the annual QIHEC evaluation and used to identify opportunities to improve health care and service for our members.

The Medicare Consumer Assessment of Healthcare Providers and Systems (MCAHPS) and Health Outcomes Survey (HOS) are designed to understand D-SNP members' perceptions and experiences with the plan and its contracted providers. These two surveys are administered and collected by a third-party vendor, then sent to Centers for Medicare & Medicaid services (CMS). The survey findings are analyzed to identify opportunities to improve member access to health care services within the Alliance network.

State of California Measures

State Quality Improvement Activities

DHCS requires Medi-Cal Managed Care plans to conduct at least two QI projects each year. Forms provided by DHCS are used for QI project milestones.

Annually, the Alliance submits its QIHE Program Description, along with an evaluation of the prior year's QIHE Work Plan. The current year Work Plan is developed and updated throughout the year as QIHE activities are designed, implemented, and reassessed.

The Alliance complies with the requirements described in the regulatory All Plan Letters.

Star Measures for Alameda Alliance Wellness

The CMS Star Ratings system evaluates the quality and performance of D-SNPs across multiple domains of care and service. These measures assess how well Alameda Alliance for Health delivers high-quality care, ensures member satisfaction, and provides timely access to services. Key measures, such as HEDIS®, are calculated, audited, and reported annually in compliance with CMS requirements. For any measures that do not meet established benchmarks, targeted improvement activities are implemented to close gaps and drive performance.

Monitoring Satisfaction

The QIHE Program measures member and provider satisfaction using several sources of satisfaction, including the results of the CAHPS survey, the Population Health Assessment (PHA), the annual DMHC Timely Access survey, plan member and provider satisfaction surveys, complaint and grievance data, disenrollment and retention data, ad hoc member feedback surveys, Community Advisory Committee (CAC), and other data as available. These data sets are presented to the QIHEC at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QIHE studies and activities.

Model of Care

The Alliance maintains a Model of Care (MOC) which is a comprehensive plan designed to outline the Dual Eligible Special Needs Plan (D-SNP) and coordination of care to its members. The MOC ensures that healthcare services are effectively integrated and tailored to meet the unique needs of the population served. The MOC is integrated into the QIHE Program with the objective of determining whether the overall MOC framework adequately addresses members' unique healthcare needs using specific quality metrics, ongoing data collection, analysis, improvement planning, and remeasurement. There are measurable outcome-based initiatives across Alameda Alliance for Health aligned with these goals and monitored through workplans and evaluation.

The D-SNP quality metrics focus on addressing members' unique health conditions, behaviors, and Social Determinants of Health (SDOH) issues as outlined in Model of Care (MOC 1). The work plan measures member outreach effectiveness and care planning, coordinated through tools like the Health Risk Assessment Tool (HRAT), Interdisciplinary Care Plan (ICP), and the Interdisciplinary Care Team (ICT). Some metrics are designed to monitor the appropriate use of services, including preventive health and chronic care management. Outcome measures track clinical outcomes and service utilization.

Health Education Activities

The Health Education Program at the Alliance operates as part of the Population and Health Equity Unit of the Quality Improvement Department. The primary goal of Health Education is to improve members' health and well-being through the lifespan through promotion of appropriate use of health care services, preventive health care guidelines: Bright Futures/American Academy of Pediatrics, U.S. Preventive Services Task Force, and clinical guidelines from professional associations, healthy lifestyles and condition self-care and management. Health Education activities aim to provide the knowledge needed for Alameda Alliance members to maintain and support their health.

Health education programs are developed in alignment with needs identified by the population assessments and include individual, provider, and community-focused health education and disease management activities which address health concerns such as nutrition, , maternal health, diabetes, pre-diabetes, asthma, hypertension, COPD, kidney disease, tobacco cessation and mental health to improve HEDIS, CAHPS, HOS, and CMS Five-Star Quality Ratings. The Alliance also collaborates on community projects to develop and distribute important health education messages for at risk populations. The Alliance Health Education Program Description can be found in a separate document.

Cultural and Linguistic Activities

The Alliance Cultural and Linguistic Services Program operates as a part of the Population and Health Equity Unit of the Quality Improvement Department. It reflects the Alliance's adherence and commitment to the U.S. Department of Health & Human Services *National Standards for Culturally and Linguistically Appropriate Services* (CLAS). The program offers services and conducts activities designed to ensure that all members have access to quality health care services that are culturally and linguistically appropriate. These activities encompass efforts within the organization, as well as with Alliance members, providers, and our community partners.

Objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer our members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Identify, inform, and assist limited English proficient (LEP) members in accessing quality interpretation services and written information materials in threshold languages.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic services program through cultural sensitivity training.
- Integrate community and Alliance-member input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities and services aimed at achieving cultural competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed and monitored in the Cultural and Linguistic Services work plan, updated annually, and reviewed quarterly. The Alliance Cultural and Linguistic Services Program Description can be found in a separate document.

Disease Surveillance

The Alliance maintains procedures to ensure accurate, timely, and complete reporting of any disease or condition to public health authorities as required by State law. The Provider Manual describes requirements and lists the Public Health Department contact phone and fax numbers.

Patient Safety and Quality of Care

The Alliance QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for members. The following activities are performed to demonstrate the Alliance's commitment to improve quality of care and safety of its members via monitoring, investigation, track, and trending of:

- Complaints and grievances and determining quality of care impact.
- Iatrogenic events such as provider preventable conditions (PPCs) including hospital-acquired infections reported on claims and reviewing encounter submissions.
- Inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.
- Credentialing and re-credentialing of malpractice, license suspension registries, loss of hospital privileges for providers.
- Site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Operations compliance with local regulatory practices.
- Reviewing hospital readmission reports.
- Improve continuity and coordination of care between practitioners.

Quality of care issues related to Long-Term Care

Quality issues are referred to the QI Department to evaluate the issue, develop an intervention and involve the CMO when necessary.

A corrective action plan and/or additional measures may be necessary to address quality concerns resulting in adverse effects or negative health outcomes, as determined through a PQI investigation. The provider involved will be required to conduct a formal root cause analysis (RCA) before developing a corrective action plan to address the identified issue or deficiency. RCA is a structured process used to identify the fundamental factors contributing to quality variations. The corrective action plan will define the problem, outline the desired future state, and specify the steps required to resolve the identified issue effectively.

Facility Site Reviews

The Alliance conducts site reviews, including Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review (PARS), including assigning scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines. If findings are identified, corrective action plans (CAP) are issued and followed upon until appropriate documentation are

addressed for all deficiencies to close the CAP. A summary of the site reviews conducted are reported to A&A Committee or IQIC (i.e. workplan summary) followed by QIHEC to monitor the clinical safety activities of the Alliance Provider Network.

Long-Term Care Quality Monitoring

The Alliance maintains a comprehensive Quality Assurance Performance Improvement (QAPI) monitoring program for Long Term Care (LTC) services which includes on-going review of the following:

- A table-top review of quality assurance and improvement findings from California Department of Public Health (CDPH) to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings.
- Review of QAPI programs in LTC (i.e. SNFs and Subacute) based on an attestation of compliance by the facilities of the five key elements identified by CMS:
  - Element 1: Design and Scope
  - Element 2: Governance and Leadership
  - Element 3: Feedback, Data Systems and Monitoring
  - Element 4: Performance Improvement Projects (PIPs)
  - Element 5: Systematic Analysis and Systemic Action
- Review of CMS Quality Star ratings
- Monitoring quality measures for LTC within the Managed Care Accountability Set (MCAS) of performance measures, such as emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions.
- Review and investigation of Potential Quality Issues (PQIs)
- In collaboration with the LTC team, the Alliance monitors the quality and appropriateness of care furnished to members using LTSS, including:
  - Assessment of care between care settings and a comparison of services and supports received with those set forth, and
  - Efforts supporting member community integration.
    When significant trends or non-compliance related to the QAPI program are noted, medical chart reviews or on-site visits will be conducted for LTC facilities as appropriate. Corrective action plans may be issued to address and resolve deficiencies in the quality of care of residents.

For Intermediate Care Facility for Developmentally Disabled (ICF/DD) Homes, quality monitoring includes the review of compliance findings and data from CDPH as well as service delivery findings from the Regional Centers established in the Memoranda of Understanding. Activities and monitoring are discussed at joint Alliance and Regional Center meetings on an on-going basis to ensure the quality and appropriateness of care, but not limited to:

- Any applicable performance measures (as mutually agreed upon)
- QI initiatives as well as reports that track cross-system referrals.
- Member engagement
- Service utilization and to prevent duplication of services rendered.

On-going monitoring reports are reported to the quality committees, including A&A Committee or IQIC and QIHEC on an as needed basis.

Health Equity Activities

The Alliance is committed to Health Equity by mitigating social determinants of health to prevent and reduce health disparities and health inequities that adversely affect vulnerable populations. Health Equity is integrated throughout the organization and is a collaborative effort across multiple departments. Additional data beyond the historical HEDIS, MCAS, Stars measures, or Department of Managed Health Care Health Equity Measure Set (DMHC HEQMS) might be needed to better understand the systemic barriers or SDOHs faced by our members. As part of the QIHE Program, the Alliance monitors and addresses member access, experience, and clinical outcome disparities by analyzing data stratified by race, ethnicity, and language (REL). QIHE leverages on the subject matter expertise of Health Equity and works in collaboration with Health Equity to ensure efficient, effective and non-duplicative health equity initiatives for the Alliance.

According to specific standards and/or strategies, the QIHE Program involves implementing systematic and continuous activities to monitor, evaluate, and improve upon the health equity and health care delivered to our members. There is alignment with the Alliance Population Health Strategy and related activities. The QIHEC is responsible for overseeing the QIHE Program, including activities to identify and close health disparity gaps, providing feedback to meet goals/benchmarks as set forth by governing agencies (i.e., DHCS, DMHC, or NCQA), and to recommend required actions.

ACCESS AND AVAILABILITY

The Alliance implements mechanisms to maintain an adequate network of primary care providers (PCP) and high volume and high impact specialty care providers. Alliance policy defines the types of practitioners who may serve as PCPs. Policies and procedures establish standards for the number and geographic distribution of PCPs and high-volume specialists. The Alliance monitors and assesses the cultural, ethnic, racial, and linguistic needs and preferences of members, and adjusts availability of network providers, if necessary.

The following services are also monitored for access and availability:

- Children’s preventive periodic health assessments/EPSDT
- Adult preventative health screenings
- Initial health appointments

The QIHE Program collaborates with the Provider Services Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergent, and preventive, specialty, and after-hours care. Access to medical care is ensured by monitoring compliance with timely access standards for practitioner office appointments, telephone practices, and appointment availability. The QIHEC also oversees appropriate access standards for appointment wait times. Alliance appointment access standards are no longer than CMS, DMHC and DHCS established standards. The Provider Manual, provider quarterly packet, virtual/onsite visits, and periodic fax blasts are some of the mechanisms to educate providers on Timely Access Standards.

The QIHEC reviews the following data and makes recommendations for intervention and quality activities when network availability and access improvement is indicated:

- Member complaints about access.
- CAHPS 5.1H,CG-CAHPS, Medicare CAHPS, and HOS results

- HEDIS measures for well child and adolescent primary care visits.
- Stars measures pertaining to access and care coordination
- Immunizations.
- Emergency room utilization.
- Facility site review findings.
- The review of specialty care authorization denials and appeals.
- Additional studies and surveys may be designed to measure and monitor access.
- Conduct annual access and availability audits through member surveys and secret shopper calls

The QIHE Program reports compliance with access and availability standards to CMS and DHCS annually. Findings are reviewed by the QIHEC, and necessary adjustments are implemented to enhance provider network performance.

BEHAVIORAL HEALTH QUALITY

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members including, but not limited to, all medically necessary services across the health care network. The Alliance reports activities in behavioral healthcare at QIHEC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Behavioral Health Services are available for all enrolled Alameda Alliance for Health members. The pathway through which members access behavioral health care is determined by the member's severity of symptoms and the member's line of business.

Per DHCS contract, the Alliance is responsible for the administration of the mild to moderate non-specialty mental health benefit. Specialty Behavioral Health for Medi-Cal members with severe mental health conditions are excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between the Alliance and Alameda County Behavioral Health (ACBH). Some primary care physicians may choose to treat mild mental health conditions. The Alliance insourced the management and oversight of the non-specialty mental health and autism behavioral health services. The Alliance includes the involvement of a Senior Director of Behavioral Health in program oversight and implementation. The Alliance reviews reports of behavioral health quality, utilization, and surveys (i,e. timely access via member experience surveys, provider satisfaction) in its standing sub-committee meetings (i.e. A&A and IQIC subcommittees) to ensure members obtain necessary and appropriate behavioral health services.

For Alameda Alliance Wellness members, Behavioral Health is inclusive of both mental health and substance use disorder programs. Behavioral Health Services are available for all Alameda Alliance for Health D-SNP members. Behavioral services are the responsibility of the health plan. Alameda Alliance's behavioral health team collaborates with community providers to access treatment for covered services.

Alameda Alliance for Health directly contracts and manages a network of providers to deliver Behavioral Health Treatment (BHT) services. The BHT team is responsible for overseeing both Care Coordination/Management and Utilization Management of the BHT benefit. The BHT treatment plans and progress reports are reviewed by board-certified behavior analyst (BCBA). These professionals conduct utilization reviews in alignment with state-mandated guidelines. The BHT Team is overseen by

the Senior Director of Behavioral Health who is a licensed psychologist and who provides determinations according to state-mandated guidelines.

Please see the UM / CM Program Description for additional behavioral health components.

COORDINATION, CONTINUITY OF CARE AND TRANSITIONS

Member care transitions present the greatest opportunity to improve quality of care and decrease safety risks by ensuring coordination and continuity of health care as members transfer between different locations or different levels of care within the same location and/or across the healthcare continuum.

The Alliance Health Care Services focuses on interventions that support planned and unplanned transitions and promote chronic disease self-management. Primary goals of the department are to reduce unplanned transitions, prevent avoidable transitions and maintain members in the least restrictive setting possible.

Comprehensive case management services are available to each member. For Medi-Cal and Group Care, it is the PCP's responsibility to act as the primary case manager to all assigned members. For Alameda Alliance Wellness, an Alameda Alliance Wellness Care Manager is assigned for each member; this case manager acts as the primary case manager and coordinates care needs with providers including community-based organizations, long term community supports, PCP, and Specialists. Members have access to these services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All services are provided in a culturally and linguistically appropriate manner.

Members who may need or are receiving services from carved-out service providers are identified. Procedures ensure these members receive medically necessary coordinated services and joint case management, if indicated. Written policies and procedures direct the coordination of care for the following:

- Services for Children with Special Health Care Needs (CSHCN).
- California Children's Service (CCS) eligible children are identified and referred to the local CCS program.
- Overall coordination and case management for members who obtain Child Health and Disability Prevention Program (CHDP) services through local school districts or sites.
- Early Start eligible children are identified and referred to the local program.
- Members with developmental difficulties are referred to the Regional Center of the East Bay for evaluation and access to developmental services.

All new Medi-Cal and D-SNP members are expected to receive an Initial Health Appointment (IHA) within 120 days of their enrollment or provider assignment with the plan. Members are informed of the importance of scheduling and receiving an IHA from their PCP. The Provider Manual informs the PCP about the IHA, the HRA (for SPDs and D-SNP members), and recommended forms. All new Medi-Cal non-SPD members also receive a Health Information Form\Member Information Tool (HIF\MET) in the New Member Packet upon enrollment. The Alliance ensures coordination of care with primary care for all members who return the form with a condition that requires follow-up.

The Alliance coordinates with PCPs to encourage members to schedule IHAs. The medical record audit of the site review process is used to monitor coordination, and whether baseline assessments, diagnosis/treatment, and medically necessary follow-up services and referrals are documented.

COMPLEX CASE MANAGEMENT PROCESS

All Alliance members are potentially eligible for participation in the complex case management program. For Alameda Alliance Wellness, this eligibility is based on the risk stratification model and those members who are stratified for high risk are outreached to and offered participation in the program. The purpose of the complex case management program is to provide the case management process and structure to a member who has complex health issues and medical conditions. The components of the Alliance complex case management program encompass member identification and selection; member assessment; member-centered care plan development, implementation, and management; evaluation of the member care plan; and closure of the case. Program structure is designed to promote quality case management, client satisfaction and cost efficiency using collaborative communication, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The complex case management program's objectives are concrete measures that assess effectiveness and progress toward the overall program goal of making high-quality health care services accessible and affordable to Alliance membership. The Chief Medical Officer, Senior Director of Health Care Services, Director of Social Determinants of Health, and Manager of Case and Disease Management develop and monitor the objectives. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with case management services as measured by member satisfaction rates.
- Improving functional health status of complex case management members as measured by member self-reports of health condition.

The complex case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

The Alliance annually measures the effectiveness of its complex case management program based on the following measures (detailed information can be found in the Case Management Program Description):

1. Satisfaction with case management services - members are mailed a survey after case closure and are asked to rate experiences and various aspects of the program's service.
2. All-cause readmission rates - the Alliance measures admission rates for all causes within six months of being enrolled in complex case management.
3. Emergency room visit rate - the Alliance measures emergency room visit rates among members enrolled in complex case management.
4. Health status rate - the Alliance measures the percentage of members who received complex case management services and responded that their health status improved because of complex case management services.

The Chief Medical Officer and the Senior Director of Health Care Services collaboratively conduct an

annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the QIHEC for review and feedback. The QIHEC makes recommendations for improvement and interventions to improve program performance, as appropriate.

DISEASE MANAGEMENT PROGRAM

The Alliance offers its members a disease management program. The purpose of the disease management program is to provide coordinated health care interventions and communications to both pediatric and adult members with chronic asthma and adults with diabetes, cardiovascular disease, and depression to support disease self-management and promote healthy outcomes. This is accomplished through the provision of interventions based on member acuity level. The intervention activities range from case management for those members at high risk, offering health coaching, educational materials, and care coordination to those members who may have gaps in care. The components of the Alliance disease management program include member identification and risk stratification, identification of gaps in care and health disparities, member outreach, provision of case management and health coaching services, and condition-specific education.

Program structure is designed to follow the National Committee for Quality and Assurance (NCQA) Population Health Management (PHM) standards. The program promotes quality condition management, member satisfaction and cost efficiency using proactive member communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes. In 2026, the Alliance Disease Management Program focuses on four conditions Asthma, Diabetes, Perinatal Depression and Cardiovascular Disease.

The objectives of the disease management program are concrete measures that assess effectiveness and progress toward the overall program goals of meeting the health care needs of members and actively supporting members and practitioners to manage chronic asthma and diabetes. The IQIC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the disease management program include:

- Achieving and maintaining member's high levels of satisfaction with disease management services as measured by member satisfaction rates.
- Reducing gaps in care as measured by HEDIS clinical effectiveness.
- Addressing disparities related to chronic conditions.
- Increasing the rate of member engagement through targeted outreach activities regarding disease management services.
- Validating the efficacy of disease management health coaching as measured by post health coaching evaluations of member’s knowledge and confidence.

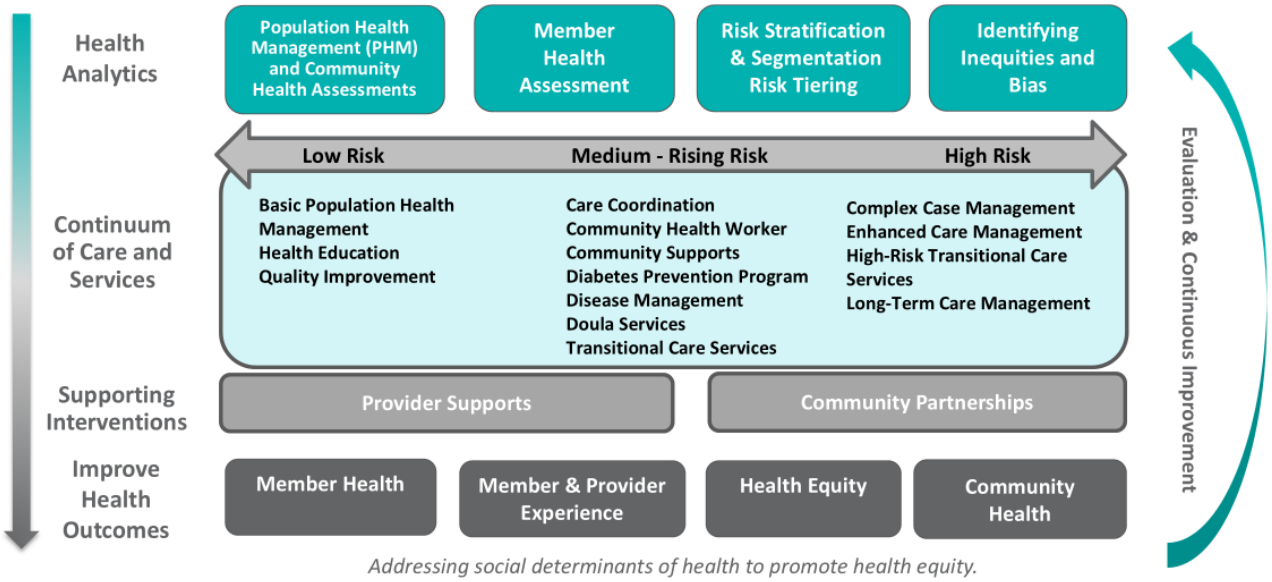
POPULATION HEALTH MANAGEMENT (PHM) PROGRAM

Alameda Alliance for Health has a Population Health Management (PHM) Program that identifies member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health outcomes and supporting an enhanced quality of life. This continuum includes intensive case management and support for members with the highest levels of needs, programs and interventions for those with emerging risks and basic population health management for all members.

The Alliance PHM Program follows the NCQA 2025 Population Health Program Standards and Guidelines and aligns with the California Department of Health Care Services Population Health Management Policy Guide.

The PHM Program is monitored via the Internal Quality Improvement Committee (IQIC), which is comprised of representatives from Health Equity, Quality Improvement, Utilization Management, Case Management, Behavioral Health, Pharmacy and Accreditation. In addition, overall outcomes, and findings from the Alliance population health assessments, population health strategy and evaluations are presented, reviewed, and approved by the QIHEC.

The Alliance PHM Framework illustrates how the utilization of health analytics through the lens of health equity would provide a continuum of care and services and interventions that lead to data-driven health outcomes. The Alliance's continuum of care and services aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through best practice and culturally affirming care. The PHM Program works in close collaboration with the Health Equity division to ensure a comprehensive and holistic population health approach to achieve health equity for all, building Social Drivers of Health (SDOH) mitigation barriers whenever possible in the healthcare pathway.



The Alliance conducts an annual Population Assessment

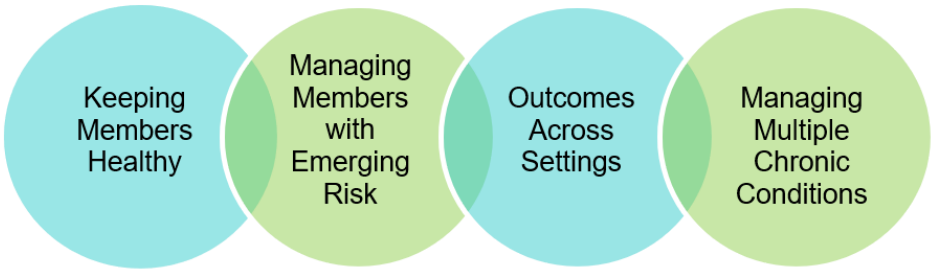
The Alliance annual PHM Assessment uses multiple data sources including member demographics, claims and encounters, HEDIS performance results, and social determinants of health to understand the health needs of our members. The HEDIS measures analyzed in the assessment include Department of Managed Health Care Health Equity Measure Set (DMHC HEQMS) and NCQA health equity measures, which are stratified by NCQA-defined race and ethnicity categories. The PHM team conducts a disparity analysis and leads cross-functional discussion of activities and resources needed to close disparities and improve measure performance. The Alliance prioritizes which programs and disparities to address in the development of the annual PHM Strategy.

The Alliance updates its PHM Strategy annually and uses it to:

- Improve case management programs including Complex Case Management (CCM), Enhanced Care Management (ECM), California Integrated Care Management (CICM), Community Supports (CS), and Transitional Care Services (TCS).
- Support development of basic population health activities to promote self-management of conditions and preventative care.
- Inform quality improvement projects.
- Guide development of health education materials and programs.
- Influence interventions that target member safety and outcomes across settings.
- Better understand utilization and identify high-risk members.
- Address identified health inequities.

The Alliance PHM strategy addresses four focus areas of population health that promote a whole-person approach to identify members at risk, and to provide strategies, programs, and services to mitigate or reduce that risk. The strategy has 4 areas of focus:

Four Areas of Focus



The Population Health Strategy includes:

- Population health assessment results
- Population risk stratification and segmentation
- PHM Strategy goals and programs
- Integration of Community Resources

- Delivery systems and provider support structures
- Sharing data – provider measures and gaps in care
- Quality Dashboards – HEDIS measure-specific data
- Comparable Data – Peer performance, local averages, and national benchmarks
- Value-Based Payment Programs
- Ongoing Education/Support – Provider Newsletters & Education

The Alliance Population Health Management Assessment and Strategy can be found in separate documents. The Alliance Population Health Evaluation is included in the QIHE Evaluation.

SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categories all new SPD members as high risk. High risk members are contacted for an HRA within 45 calendar days and low risk members are contacted within 105 calendar days from their date of enrollment. Existing SPD members receive an annual HRA on their anniversary date. The objectives of an HRA are to assess the health status, estimate health risk, and address members' needs relating to medical, specialty, pharmacy, and community resources. Alliance staff uses the responses to the HRAs, along with any relevant clinical information, to generate care plans with interventions to decrease health risks and improve care management.

DHCS has established performance measures to evaluate the quality of care delivered to the SPD population using HEDIS measures and a hospital readmissions measure.

For Alameda Alliance Wellness, all members are contacted annually for completion of the HRA. Members who are new to the plan are contacted within 90 days of enrollment for completion of the HRA regardless of risk status.

MATERNAL MENTAL HEALTH PROGRAM

The Alameda Alliance for Health Maternal Mental Health Program is a comprehensive initiative designed to improve perinatal mental health outcomes for Medi-Cal, D-SNP, and Group Care members. In alignment with CA SB1207 and AB1936, the program ensures timely screening, referral, and treatment for maternal mental health conditions through adherence to ACOG and AAP guidelines. Key components include provider education, enhanced member self-referral pathways, and care coordination across behavioral health services. The program also integrates perinatal depression disease management through the BirthWise Wellbeing initiative, doula services, and peer support via Community Health Workers.

Quality monitoring is embedded throughout the program, with regular tracking of HEDIS measures such as prenatal and postpartum depression screening and follow-up. Member satisfaction and service utilization are assessed through surveys and dashboards, informing continuous improvement efforts. The program reflects the Alliance’s commitment to equitable, evidence-based care and supports broader population health and health equity goals. The Alliance Maternal Mental Health Program Description can be found in a separate document.

PROVIDER COMMUNICATION

The Alliance contracts with its providers to foster open communication and cooperation with QIHE activities:

- Provider cooperation with QIHE activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary and appropriate care.
- Provider regulatory requirements

Provider involvement in the QIHE Program occurs through membership in standing and ad-hoc committees, Joint Operating Committee meetings, and attendance at BOG and QIHEC meetings. Providers and members may request copies of the QIHE Program description, work plan, and annual evaluation. These documents are also posted on the Alliance website. Provider participation is essential to the success of QIHE studies including HEDIS and Stars and those that focus on improving aspects of member care. Additionally, providing feedback on surveys and questionnaires is encouraged as a means of continuously improving the QIHE Program.

Providers have an opportunity to review the findings of the QIHE Program through a variety of mechanisms. The QIHEC reports findings from QIHE activities to the BOG through CMO reports (monthly), QIHE Trilogy documents (annually), and on an on-going basis. Findings include aggregate results, comparisons to benchmarks, deviation from threshold, drill-down results for provider group or type, race/ethnicity, and language, and other demographic or clinical factors. Findings are distributed directly to the provider when data is provider specific. Findings are included in an annual evaluation of the QIHE Program and made available to providers and members upon request. The Provider Bulletin contains a calendar of future BOG and standing committee dates and times.

EVALUATION OF QIHE PROGRAM (SEPARATE DOCUMENT)

The QIHEC reviews, makes recommendations, and approves a written evaluation of the overall effectiveness of the QIHE Program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Allocation of resources to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and ongoing QIHE activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QIHE Work Plan

The primary focus of the Quality Improvement Health Equity (QIHE) evaluation is to assess the effectiveness of the Model of Care (MOC) in meeting Alameda Alliance Wellness D-SNP members' unique health needs, improving care, service, health outcomes and member experience. The evaluation includes a review of completed and ongoing activities related to care quality, service, outcomes, and member satisfaction. Trended results are performance assessments compared against established targets are included. Both quantitative and qualitative analyses are conducted to measure clinical outcomes and care experiences. If performance goals are not met, analysis is performed to identify opportunities for improvement. The results of the annual evaluation inform updates to the Quality Improvement Health Equity (QIHE) program description and work plan for the following year.

The review and revision of the program may be conducted more frequently as deemed appropriate by the QIHEC, CMO, CHEO, CEO, or BOG. The QIHEC's recommendations for revision are incorporated into the QIHE Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

ANNUAL QIHE WORK PLAN (SEPARATE DOCUMENT)

A QIHE Work Plan is received and approved annually by the QIHEC. The work plan describes the QIHE goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as needed. The QIHE work plan delineates the party responsible and the time frame in which planned activities will be implemented.

The Alameda Alliance Wellness work plan is a unique and separate document that is aligned with the following but is focused on the D-SNP population.

The work plan is included as a separate document and addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Member experience

- Health equity activities
- Yearly planned activities and objectives
- Time frame within which each activity is to be achieved.
- The staff member responsible for each activity
- Monitoring previously identified issues.
- Evaluation of the QIHE Program

Progress on completion of activities in the QIHE work plan is reported to the QIHEC quarterly. A summary of this progress will be reported by the CMO to the BOG.

D-SNP MODEL OF CARE & WORKPLAN (SEPARATE DOCUMENT):

Alliance D-SNP Model of Care 2026.pdf

SUPPORTING DOCUMENTS

In addition to this program description, the annual evaluation and work plan, the other additional documents are important in communicating QI policies and procedures include and not limited to:

- "Provider Manual" provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's QIHE Program is included in the provider manual. It is distributed to all contracted provider sites.
- "Provider Bulletin" is a newsletter distributed to all contracted provider sites on topics of relevance to the provider community, and can include QIHE policies, procedures, and activities.
- "Alliance Alert" is a member newsletter that also serves as a vehicle to inform members of QIHE policies and activities.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the QIHE Program information is available on the Alliance website.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, delegated medical groups and sub-contractors of the Alliance maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions, and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QIHE activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QIHE activities must submit a written request to the CMO. Release of all information will be in accordance with state and federal laws.

All providers participating in the QIHEC or any of its subcommittees, or other QIHE Program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements. Guests or additional Alliance staff attending QIHEC

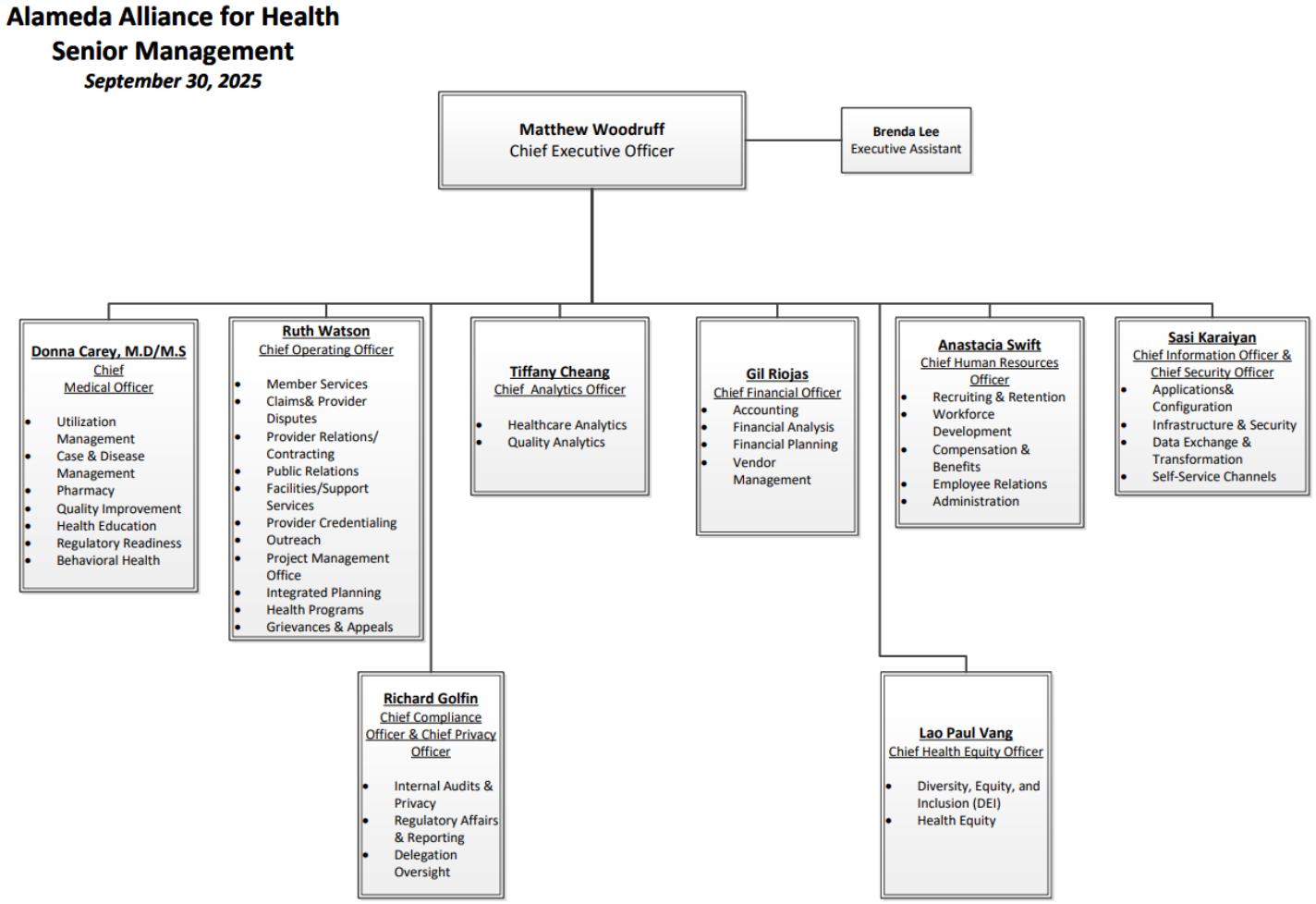
meetings will sign a confidentiality agreement.

Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

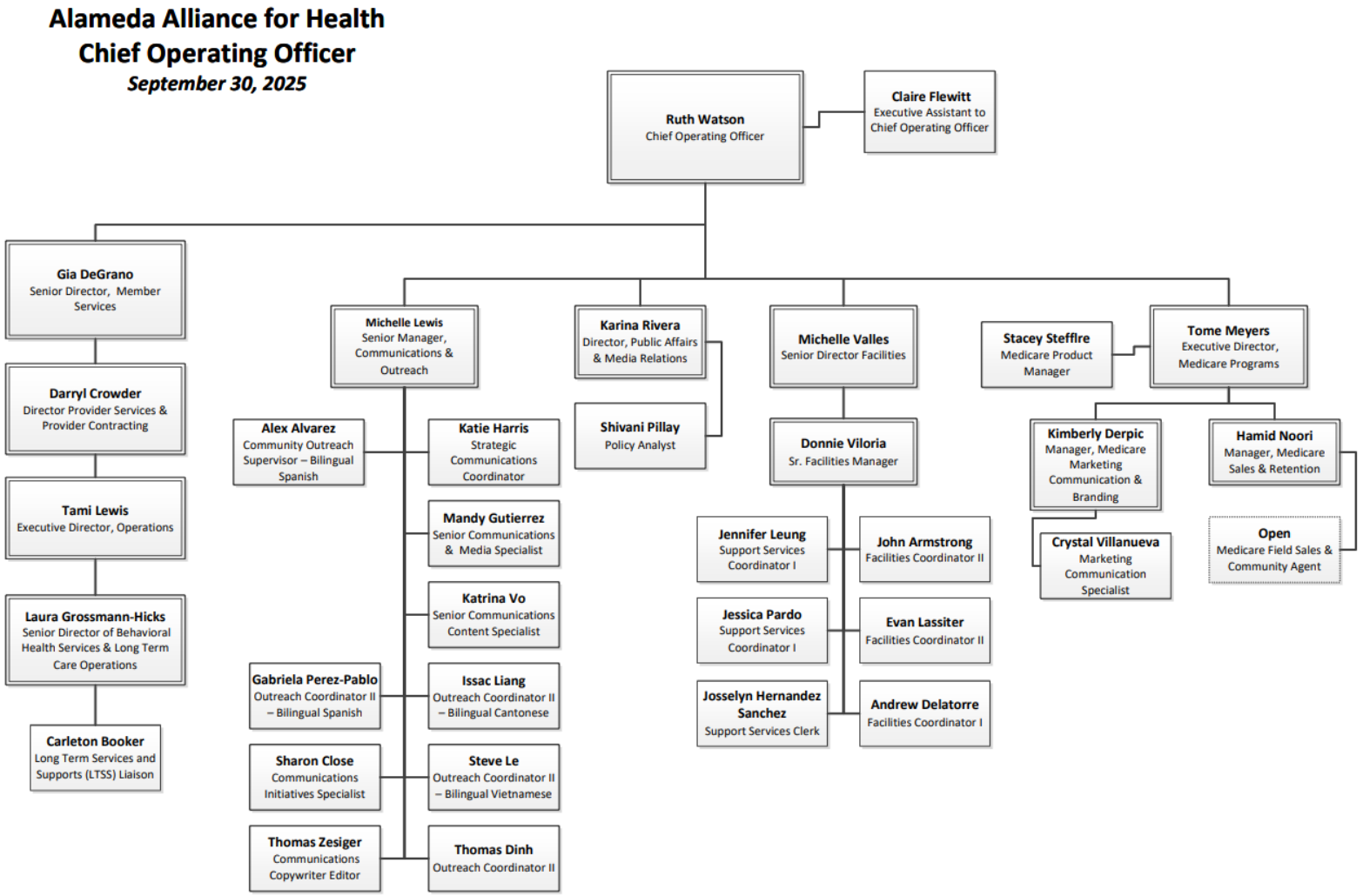
All QIHEC meeting materials and minutes are marked with the statement "Confidential". Copies of QIHE meeting documents and other QIHE data are maintained separately and secured to ensure strict confidentiality.

APPENDIX A: Organizational Charts

Senior Management

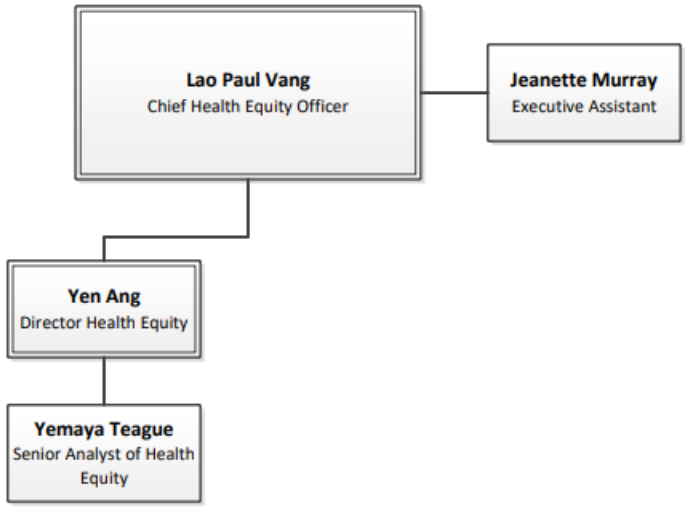


Chief Operating Officer – Medicare Operations



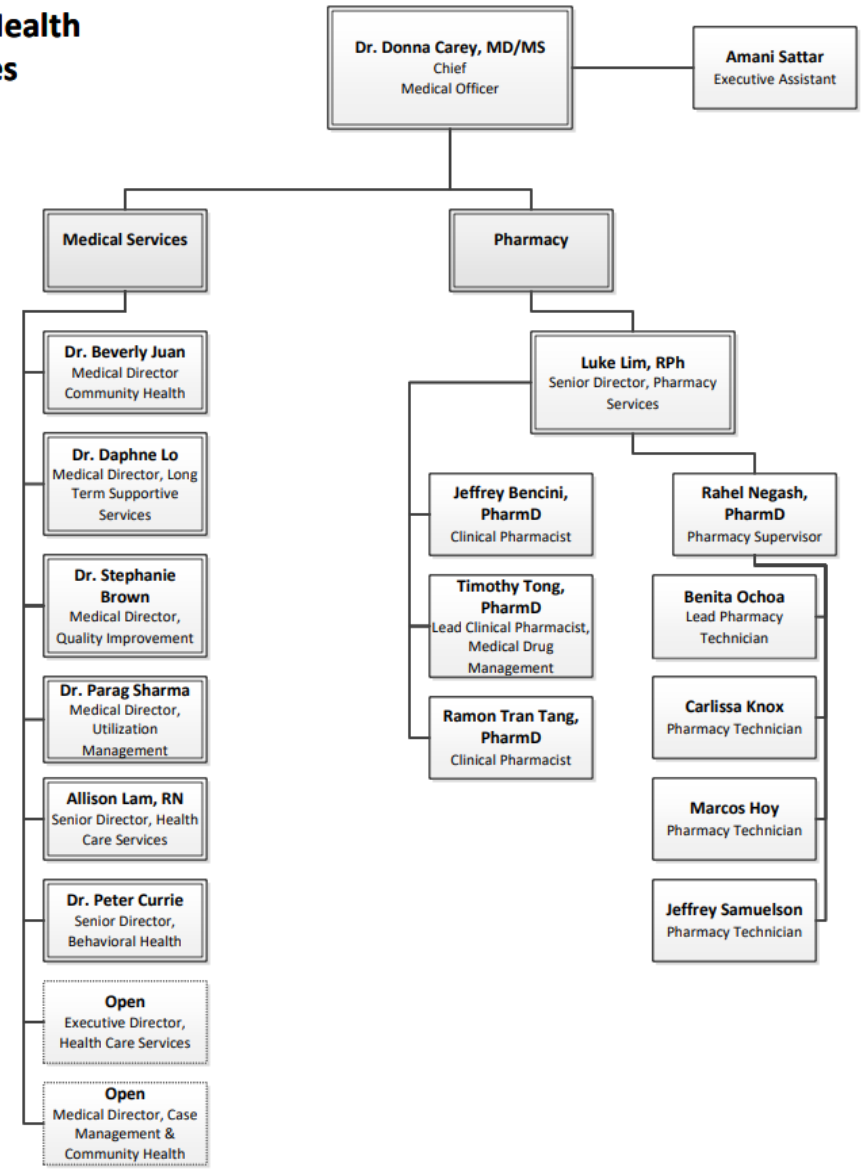
Health Equity

Alameda Alliance for Health
Health Equity
September 30, 2025

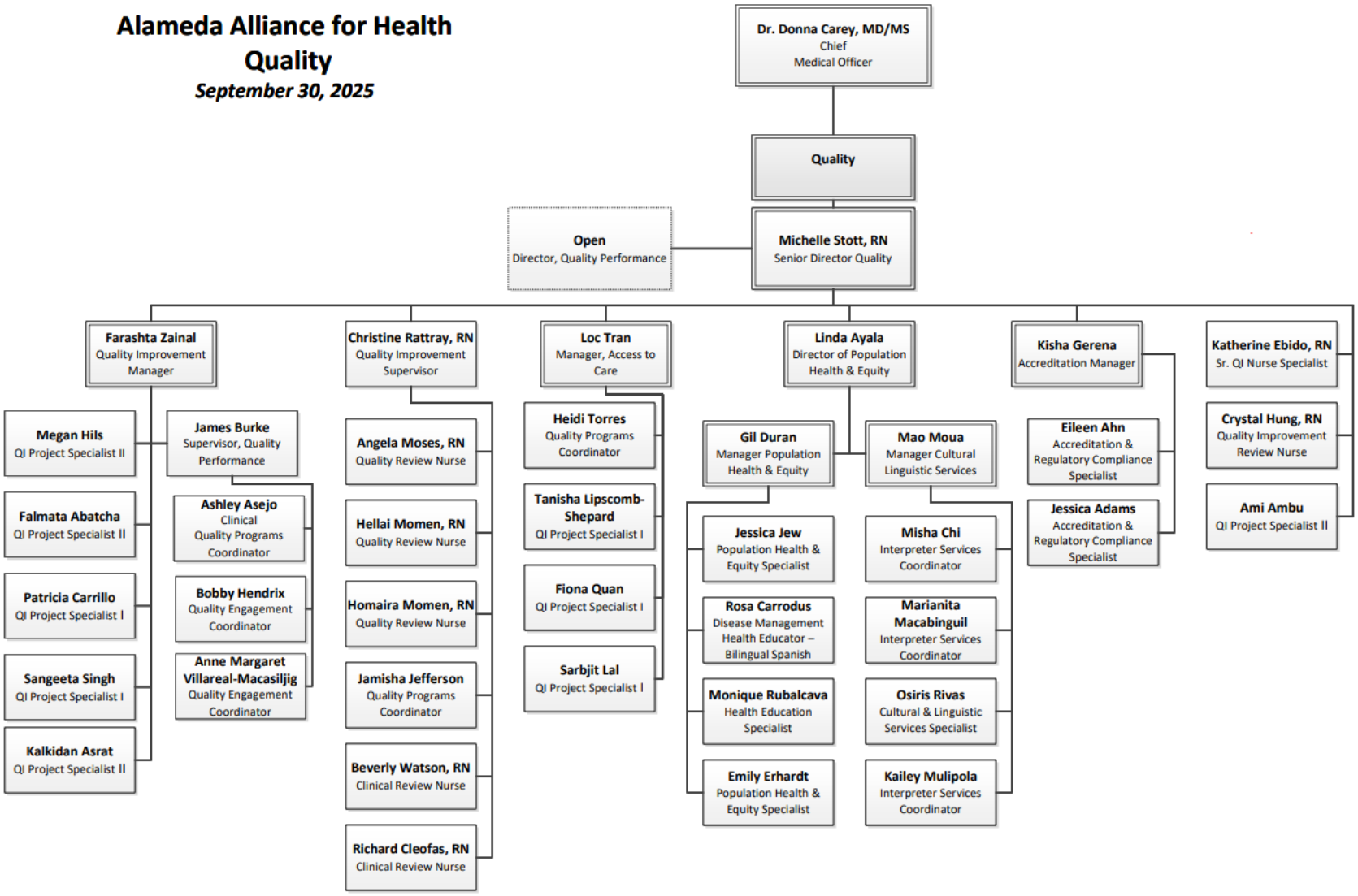


Medical Services and Pharmacy

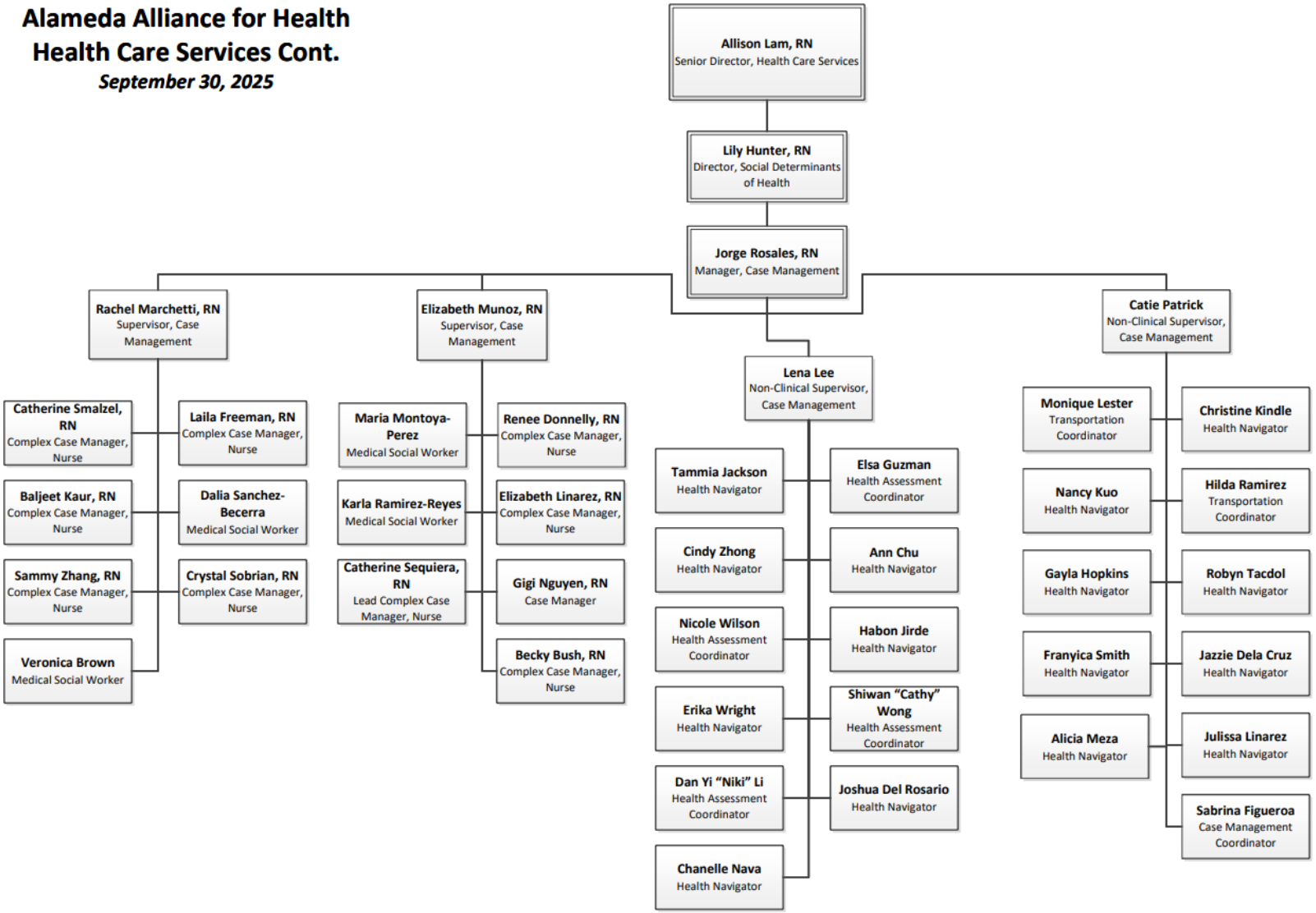
Alameda Alliance for Health
Healthcare Services
September 30, 2025



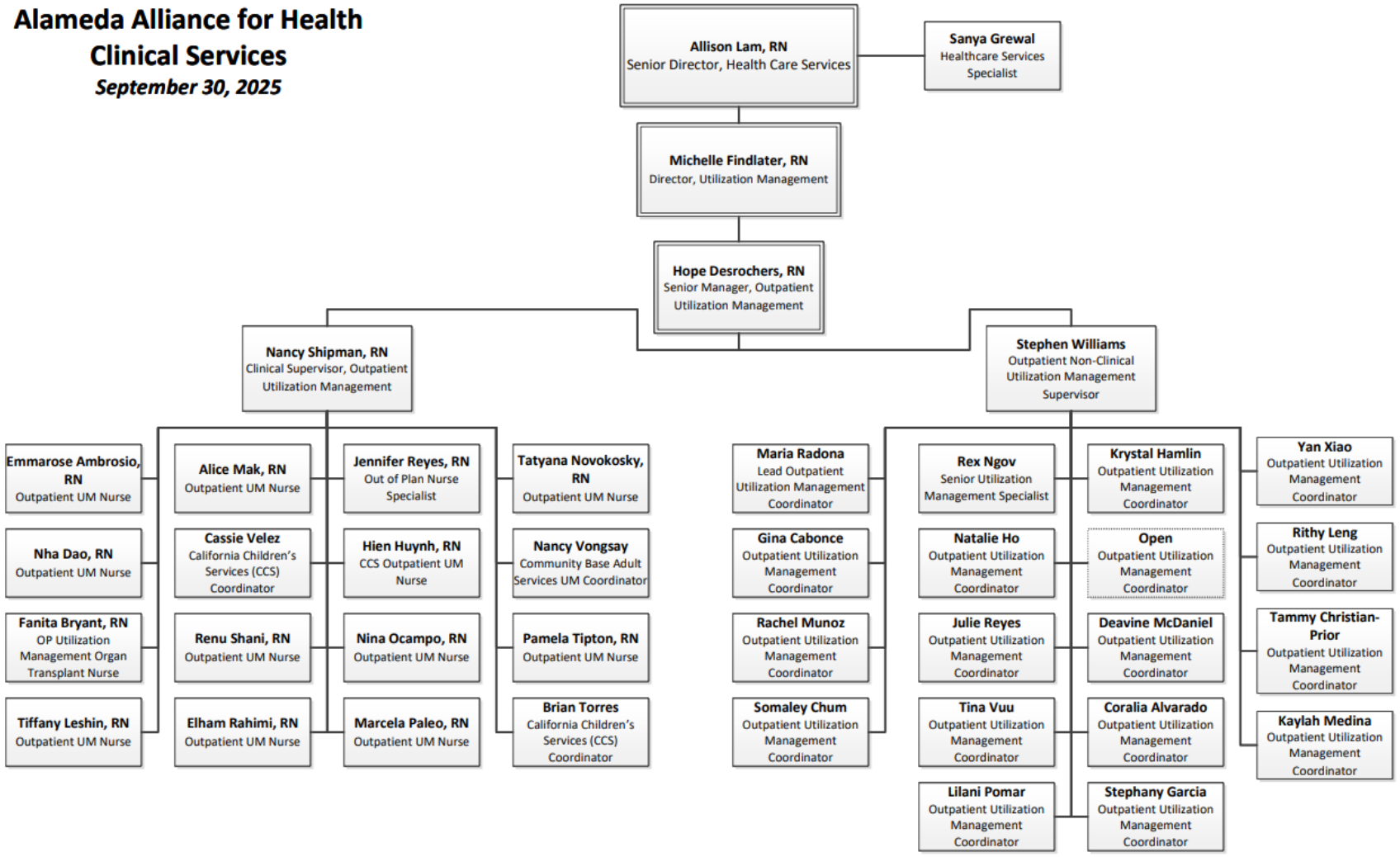
Health Care Services – Quality



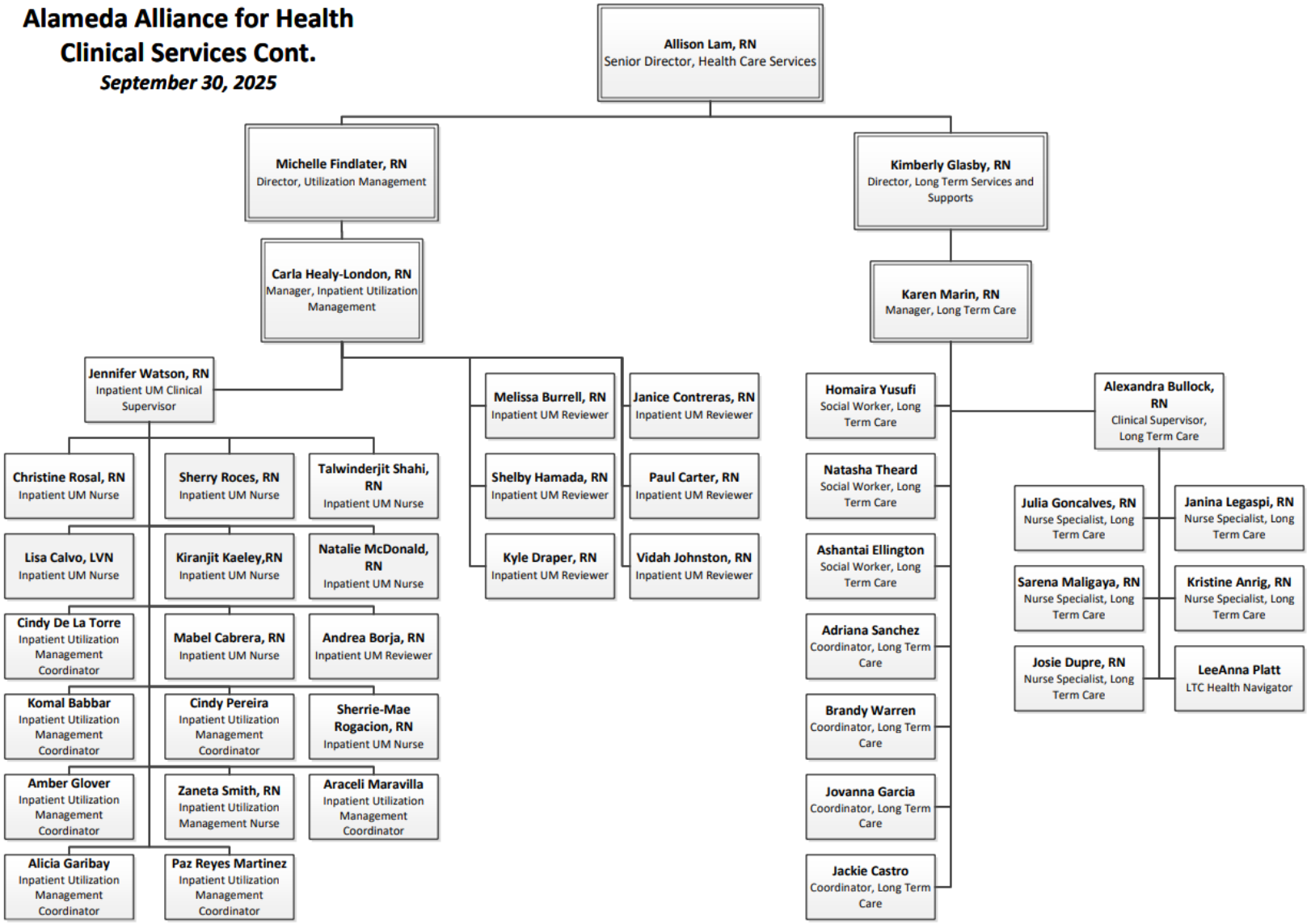
Case Management



Utilization Management – Outpatient

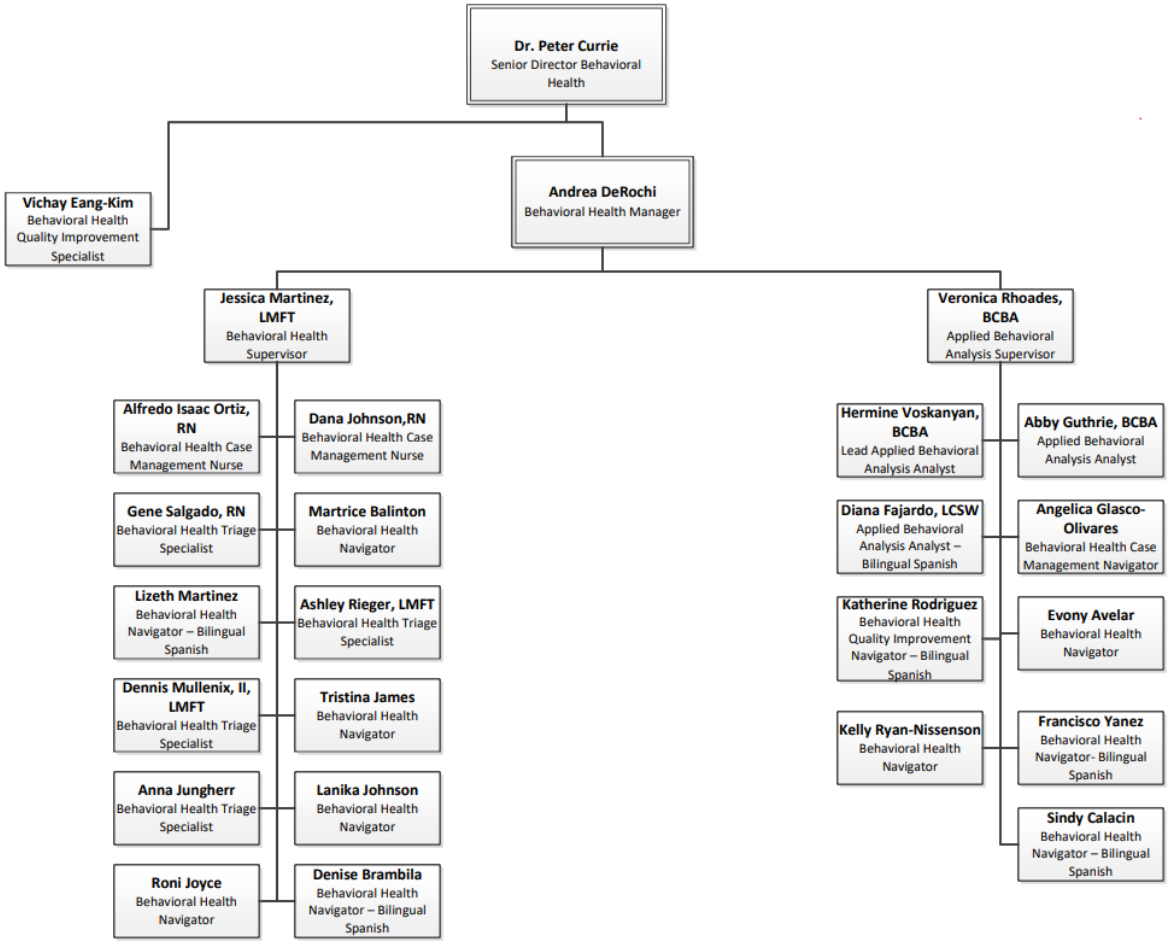


Utilization Management – Inpatient and Long-Term Care



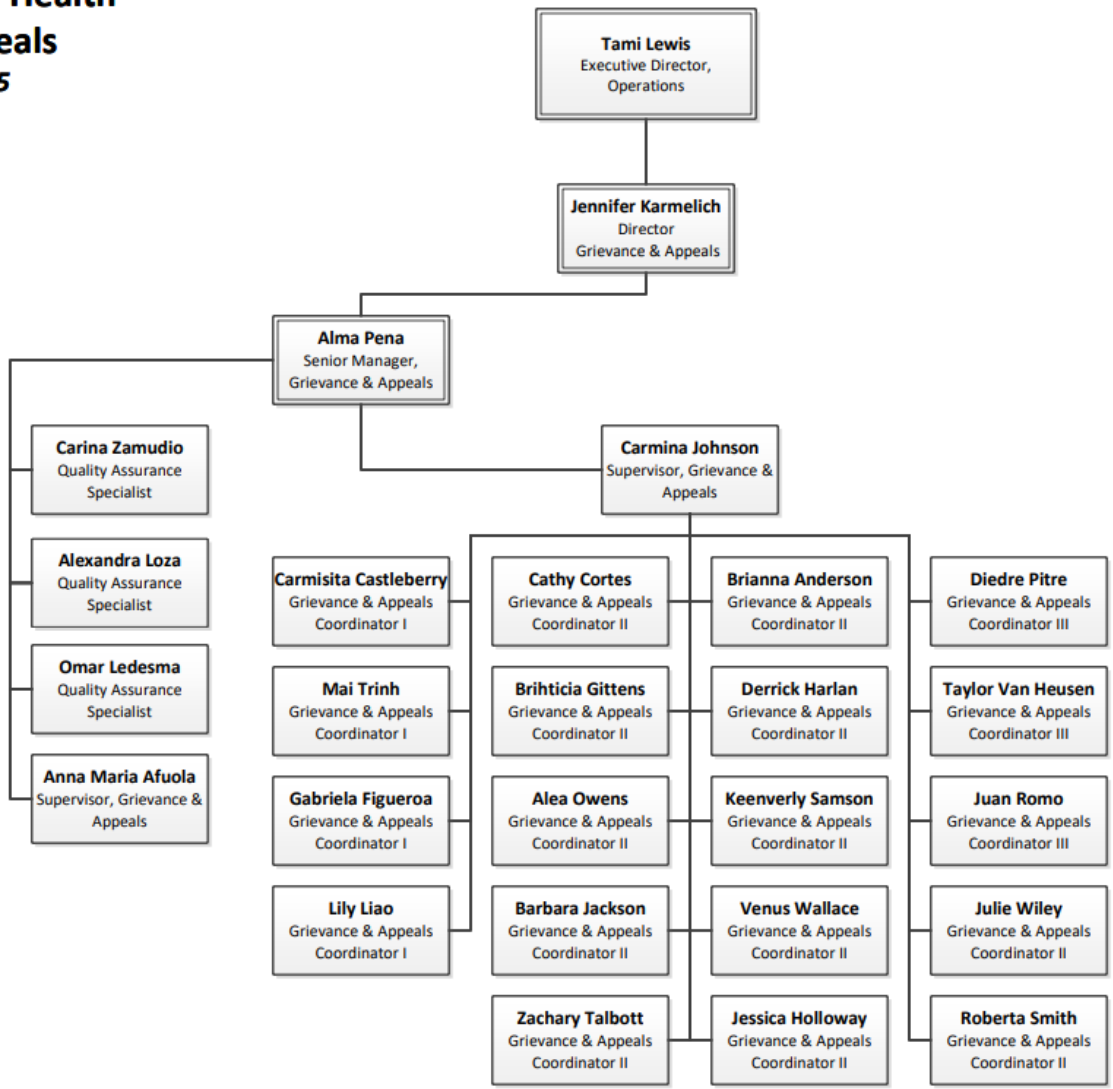
Behavioral Health

Alameda Alliance for Health
Behavioral Health
September 30, 2025

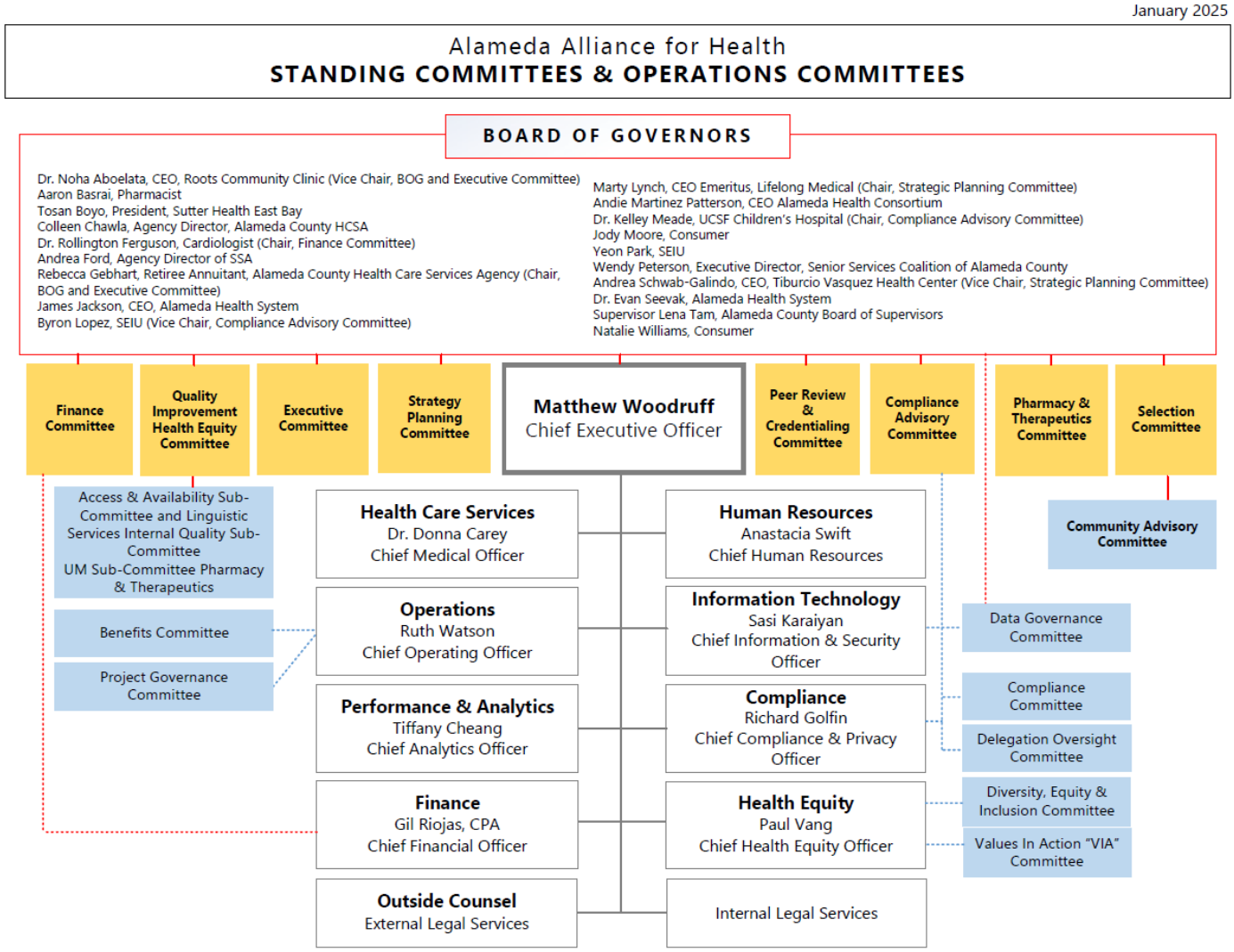


Grievance & Appeals

Alameda Alliance for Health
Grievance & Appeals
September 30, 2025



APPENDIX B: Alameda Alliance Committees



Quality Improvement Health Equity Committee
8/8/2025

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		☐
Aaron Chapman, MD, Medical Director, Alameda County Behavioral Health Care Services	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	☒
Kristin Nelson	Director, Behavioral Health Services Student Services Division, Alameda County Office of Education	☐
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	☐

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	☒
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	☐
Dr. Khush Grewal, CHCN	

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
I. Call to Order	D. Carey	The meeting was called to order at 9:05am		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
II. Alameda Alliance Updates	D. Carey	• D. Carey welcomed the participants and provided updates on the search for a new medical director of Quality Improvement. She mentioned that there are two finalists, and a decision is expected soon, with a start date in September. • D. Carey updated the committee on the progress towards the DSNP program, highlighting the ongoing preparations, including policy approvals, workflows, and training for CHCN providers and internal staff. • The program is set to go live in January, starting with a pilot approach.		

III. Chief of Health Equity Updates	Y. Ang	• **TGI (Gender Affirming Care) Training**:
		  ○ 100% staff completion; phase 2 (vendor training) began July and expected to finish in August.
		  ○ Phase 3 will extend training to subcontractors and all member-serving partners.
		• **DEI Training**:
		  ○ Pilot completed in June; launched to 1,060+ providers on July 1.
		  ○ Progress is slow, only ~100 completions in the first month.
		  ○ Rollout is cautious due to political sensitivity and federal stance on DEI/TGI.
		  ○ 3 waiver requests received so far; organization grants exemptions generously when justified.
		  ○ State has not set a firm policy on exemptions—currently handled case-by-case.
		  ○ Refusals are documented but understanding and flexibility are prioritized.
		• The organization has completed all submissions for NCQA Health Equity Accreditation, receiving strong praise from the		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		review team. They are on track to receive this accreditation, and the Health Plan Accreditation is expected in September.		
IV. Policies & Procedures	D. Carey	The Policies & Procedures packet was sent out prior to QIHEC for committee review. • BH-001 Behavioral Health Services • BH-005 Care Coordination- Behavioral Health • BH-008 Behavioral Health Services (Group Care/IHSS) • CLS001 Cultural and Linguistic Services (CLS) Program Description • CLS002 Community Engagement • CLS003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities • CLS008 Member Assessment of Cultural and Linguistic needs • CLS009 CLS Program - Contracted Providers • CLS010 CLS Program - Staff Training and Assessment • CLS011 CLS Program - Compliance Monitoring • QI-105 Facility Site Reviews (FSRs), Medical Record Reviews (MRRs) and Physical Accessibility Review Surveys (PARS) • QI-107 Appointment Access and Availability Standards • QI-108 Access to Behavioral Health Services • QI-116 Provider Appointment Availability Survey (PAAS) • QI-124 Initial Health Appointment (IHA) and Initial Preventive physical Exam (IPPE) • HED-001 Health Education Program • HED-002 Health Education Materials • HED-006 SABIRT Services • HED-007 Tobacco Cessation • HED-009 Diabetes Prevention Program • HED-010 Doula Services • PH-001 Population Health Management Program • PH-002 Basic Population Health Management • PH-003 Risk Stratification and Segmentation • PH-005 Population Assessment • GA-D-001 Integrated Grievances • GA-D-002 Integrated Reconsiderations and Redterminations (Level I Appeals)	Move to Approve: 1st: M. Stott 2nd: J. Florey	

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• GA-D-003 Complaints Tracking Module Management Policy • CM-001 Complex Case Management (CCM) Identification, Screening, Enrollment and Assessment • CM-002 Complex Case Management Plan Development and Management • CM-003 Complex Case Management Plan Evaluation and Closure • CM-004 Care Coordination of Services • CM-006 Internal Audit and Monitoring • CM-008 SPD HRA - Survey and Interventions • CM-034 Transitional Care Services • CM-D-001 CICM - Program Infrastructure • CM-D-002 CICM - Member Identification & Grouping • CM-D-003 CICM - Care Management • CM-D-004 CICM - Staffing • CM-D-005 CICM - Member Notification • CM-D-007 CICM - IT Data Sharing • CM-D-009 CICM: Adults at Risk for Long-Term Care Institutionalization • CM-D-103 DSNP Individualized Care Plan Components • CM-D-105 DSNP Individualized Care Plan Documentation, Maintenance, Updates and Notifications • CM-D-106 Developmental Disabilities • DSNP Out of Area/ Out of Network Utilization Management Review Policy RGR • DSNP Prior Authorization/ Concurrent Review/ Organization Determination Audit Process Policy RGR • DSNP UM 000 Readmissions Review Policy RGR • DSNP UM 000 Review of Hospital Logs Policy RGR (New Name ADT File Review) • UM 001 Utilization Management Process • DSNP UM 004 Over/ Under Utilization • DSNP UM 005 Second Opinions • DSNP UM 007 New and or Experimental Technology Review Process • UM 007 MediCal/ IHSS New and or Experimental Technology Review Process • CS-002 Community Supports – Housing Transition Navigation Services • CS-003 Community Supports – Housing Deposits • CS-004 Community Supports – Housing Tenancy and Sustaining Services		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• CS-007 Community Supports – Medically Tailored Meals/Medically Supportive Food • CS-008 Community Supports – Respite Services • CS-009 Community Supports – Personal Care and Homemaker Services • CS-010 Community Supports – Environmental Accessibility Adaptations (Home Modifications) • CS-011 Community Supports – Assisted Living Facility Transitions • CS-012 Community Supports – Community or Home Transition Services • UM 16 Transportation Guidelines • CM-009 Enhanced Care Management Program Infrastructure • CM-011 Enhanced Care Management - Care Management & Transitions of Care • CM-18 Enhanced Care Management - Member Notification • CM-041 Enhanced Care Management - Outreach/Member Engagement • DSNP UM 011 Coordination of Care- Hospice and Terminal Illness • DSNP UM 014 COC Identifying Abuse • DSNP UM 023 Communicable Disease Reporting and Services • DSNP UM 029 Sensitive Services • DSNP UM 036 Continuity of Care • DSNP UM 045 Communication Services • DSNP UM 046 Use of Board-Certified Consultants • DSNP UM 047 UM Subcommittee • DSNP UM 048 Triage and Screening Services • DSNP UM 049 UM Utilization Management Satisfaction Survey • UM 050 Tracking and Monitoring of services Prior Authorized • DSNP UM 052 Discharge Planning to Lower Level of Care • DSNP UM 055 Palliative Care • DSNP UM 058 Continuity of Care for New Enrollees Transitioned to Managed Care after receiving a Medical Exemption • DSNP UM 063 Gender Affirming Surgery and Services • QI-104: Potential Quality of Care Issues		
V. Meeting Minutes	D. Carey	The meeting Minutes packet was sent out prior to QIHEC for committee review. • QIHEC – 5/9/25	Move to Approve: 1st: J. Florey	

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• A&A – 5/21/25 • CLS – 4/23/25 • IQIC – 7/16/25 • UMC – 5/30/25, 6/27/25, 7/25/25	2nd: M.Stott	
VI. Provider Manual	C. Gomez	• C. Gomez presented the 2025 provider manual updates, which include modifications for the existing medical group care line of business and the incorporation of the DSNP line of business. She encouraged providers to provide feedback for further improvements.	Move to Approve: 1st: M. Stott 2nd: A. Chapman	
VII. Committee Member Presentation: CFMG HEDIS Quality Improvement Activities	J. Florey	**Background & Partnership** • James presented a retrospective of CFMG's quality improvement journey since 2019, highlighting the Alliance's critical support in building their program. 1 • CFMG initially lacked timely data and quality as a contract requirement, prompting the creation of their own data warehouse using Coziva and EasyCap claims **Data Integration & Outreach** • CFMG now ingests ~10,000 EasyCap and Alliance claims weekly, plus DHCS Med claims, Denti-Cal, California Immunization Registry, and K-links, totaling about 2.5 million records annually. • Data is reformatted for actionable provider reports and member outreach via Luma text messaging, social media, and web campaigns. • Messaging is tailored to avoid over-communication, with feedback from providers and members guiding improvements. **Provider Engagement & Incentives** • CFMG implemented quarterly meetings, tip sheets, and workflow integration to improve coding and data quality.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Incentive programs for providers and office staff were introduced, aligning financial rewards with HEDIS improvement. • Investments were made in lead screening machines and developmental screening at point of service to address member convenience and improve outcomes. **Impact & Results** • In the last year, nearly 250,000 Luma text messages were sent, reaching about 45,000 unique members. • Analysis showed members receiving text messages had 50–100% higher rates on four key HEDIS measures compared to those who opted out, demonstrating significant impact. • Year-on-year improvement in health outcomes was visualized, with CFMG moving from below the 25th percentile in 2019 to achieving MPL 75th or 90th percentile in most measures by 2024. **Challenges & Next Steps** • Some measures (e.g., lead screening, developmental screening) required changes in compensation and workflow to address barriers. • Ongoing focus areas include improving coding for blood pressure readings and continuing to refine outreach and incentive strategies.		
VIII. HEDIS Results	F. Zainal	**2024 Plan Performance** • The plan exceeded the Minimum Performance Level (MPL) on all but three measures: Asthma Medication Ratio, Controlling High Blood Pressure, and Topical Fluoride for Children.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Asthma Medication Ratio was impacted by unverified medication changes; the plan is discussing accountability with the state. • Controlling High Blood Pressure fell below MPL, with a hybrid rate of 60.10% versus the MPL of 64.48%. • Topical Fluoride for Children ended at 17.74%, below the 19% MPL. **Current Year Trends** • Most measures are currently above MPL, but some remain low: follow-up after emergency department visit for mental health, cervical and colorectal cancer screenings, controlling high blood pressure, diabetes (children), topical fluoride, and well-child visits. • Reproductive health measures are performing well, with ongoing efforts to improve rates. **Provider-Level Insights** • Unblinded data was shared to promote learning and best practices across the network. • Blood pressure coding issues, especially with Epic EHR systems, affect measure performance; efforts are underway to improve CPT II code usage. • Alameda Health System was the only network above MPL for topical fluoride. • Asthma Medication Ratio was low across all networks, attributed to medication identification issues and member/provider education gaps. **Improvement Strategies** • Focus on provider education for correct coding and prescribing practices, especially for controller and rescue asthma medications.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Encouragement of combination medications to simplify asthma management. • Collaboration with providers to share best practices and address system-level barriers, such as EHR workflows for blood pressure readings. **Discussion & Next Steps** • Continued provider engagement and data sharing to address gaps. • Ongoing dialogue with the state regarding measure accountability and medication verification. • Targeted outreach to improve underperforming measures, with specific attention to coding, workflow, and member education. **<u>Findings</u>** • **Overall Performance** – Met MPL for most measures, except: o Asthma Medication Ratio – low due to unverified medication changes and education gaps. o Controlling High Blood Pressure – 60.10% (below 64.48% MPL), impacted by coding and workflow issues. o Topical Fluoride for Children – 17.74% (below 19% MPL). • **Current Year Trends** – Most measures above MPL, but low performance in: o Follow-up after ED visits for mental health. o Cervical & colorectal cancer screenings. o Controlling high blood pressure. o Diabetes (children), topical fluoride, well-child visits. o Reproductive health measures are strong.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)

		• **Provider Insights** –
		  ○ Coding issues in Epic affecting blood pressure measure.
		  ○ Only Alameda Health System met MPL for topical fluoride.
		  ○ Asthma performance low across all networks due to medication identification and education issues.
		
		<u>Recommendations</u>
		• **Asthma** – Educate providers on correct prescribing, promote combination medications, fix medication verification process with state.
		• **Blood Pressure** – Improve CPT II coding and EHR workflows, share best practices, educate patients on monitoring.
		• **Topical Fluoride** – Train providers on application/billing, share Alameda's successful approach.
		• **Other Measures** – Target outreach for cancer screenings, ED mental health follow-up, pediatric diabetes care, and well-child visits.
		• **Overall** – Keep sharing provider data, continue state discussions on accountability, align member education with provider efforts.		

IX. Geo-Access & Provider Network Capacity	L. Tran C. Gomez	**Geo Access Review** • L. Tran reported on Geo Access, identifying areas not meeting distance and time standards, mainly in zip codes linked to Tracy, Mountain House, Byron, and Discovery Bay. • Improvement was noted for pediatric nephrology in Dublin, Livermore, and Pleasanton.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• For CFMG, several provider types did not meet requirements; these will be discussed in future meetings with CFMG. • Livermore was flagged for PCP access due to a small number of members living on the outskirts, prompting ongoing review for potential provider contracting. **Capacity Monitoring** • C. Gomez presented the PCP-to-member assignment grid, which tracks providers reaching 80%, 90%, and 100% of capacity. • At 90%, auto-assignment is closed; at 100%, it remains closed until capacity drops. Members can still request assignment manually. • The transition from Anthem to Alliance increased the number of providers on the report, requiring frequent monitoring and closure/reopening of auto-assignment. • The state is aware of the challenges but continues to enforce the requirements, impacting provider panels and access, especially in Hayward. **Advocacy & Compliance** • J. Florey and C. Gomez highlighted ongoing advocacy with the state to address the impact of panel aggregation post-Anthem transition, noting moral injury to providers and compliance burdens. • The Alliance is audited on this process and must provide proof of assignment closures as part of annual audits. **<u>Findings</u>** **Geo Access Review** • Some zip codes (Tracy, Mountain House, Byron, Discovery Bay) do not meet distance/time standards.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Improvement seen for pediatric nephrology in Dublin, Livermore, Pleasanton. • Several CFMG provider types not meeting requirements—future meetings planned. • Livermore flagged for PCP access issues due to members living on outskirts; potential need for new provider contracts. **Capacity Monitoring** • PCP capacity tracked at 80%, 90%, and 100% thresholds. • At 90%, auto-assignment closes; at 100%, remains closed until capacity drops. • Transition from Anthem to Alliance increased providers on the monitoring report, requiring frequent updates. • State enforcement of requirements affects access, especially in Hayward. **Advocacy & Compliance** • Ongoing advocacy with the state to address panel aggregation issues after Anthem transition. • Providers facing moral injury and compliance burdens. • Alliance is audited annually and must show proof of assignment closures. **<u>Recommendations</u>** • **Geo Access** – Continue reviewing underserved zip codes; explore provider contracting in Livermore; address CFMG network gaps in upcoming meetings. • **Capacity Management** – Maintain close monitoring of PCP capacity; adjust auto-assignment as needed to prevent overload; prioritize high-impact areas like Hayward. • **Advocacy & Compliance** – Continue state-level advocacy to adjust requirements post-Anthem transition; document all capacity management actions for audit readiness.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
X. Survey Results **-PAAS** **-QMRT**	L. Tran	**Survey Overview** • The 2024 Appointment Availability Survey was conducted from August to December, covering urgent and non-urgent appointments across provider types. **Compliance Rates** • Ancillary providers saw a 27% decrease in non-urgent appointment compliance compared to the previous year. • PCPs experienced an 11.2% decrease for urgent appointments and a 4.8% decrease for non-urgent appointments. • Non-physician mental health providers had a slight drop (5.1%) for urgent appointments but continued to exceed compliance thresholds for all appointment types. • Psychiatry showed improvement for both urgent and non-urgent appointments. • Specialty providers had a 7.4% drop for urgent and a 5.2% drop for non-urgent appointments. **DHCS Timely Access Study** • The compliant rate for urgent appointments averaged 48% for 2024, with non-urgent compliance steadily increasing from Q2 to Q4. **Improvement Actions** • Provider engagement includes ongoing education, on-site/virtual visits, and dissemination of survey results. • Promotion of best practices such as open access scheduling, extended office hours, and provider recruitment/retention funding. • Focused follow-up with top five noncompliant providers, including monthly/quarterly meetings and corrective action plans. • Collaboration with CMO team to educate members on alternative access and reduce ER utilization.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Data extraction pilots with Stanford and UCSF to improve survey response and member satisfaction tracking. **Additional Insights** • J. Florey shared findings from a previous pilot on extended office hours in pediatrics, noting high demand immediately after 5 PM but little use after 6 PM, suggesting urgent care is only justified up to 10 PM and ER use after that. • The Alliance will consider these insights for future access improvement strategies. **<u>Findings</u>** • **Overall Survey Results** – 2024 Appointment Availability Survey (Aug–Dec) covered urgent and non-urgent appointments across provider types. • **Compliance Changes**: o Ancillary providers – **27% decrease** for non-urgent appointments. o PCPs – **11.2% decrease** for urgent, **4.8% decrease** for non-urgent. o Non-physician mental health – **5.1% decrease** for urgent, but still above thresholds for all appointment types. o Psychiatry – improved in both urgent and non-urgent categories. o Specialty providers – **7.4% decrease** for urgent, **5.2% decrease** for non-urgent. • **DHCS Timely Access Study** – 2024 urgent compliance averaged **48%**; non-urgent compliance improved steadily from Q2 to Q4. • **Pilot Insights** – Pediatric extended hours most used immediately after 5 PM, low usage after 6 PM; urgent care justified until 10 PM, ER use after that.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		Recommendations • Continue **provider engagement** through education, visits, and sharing survey results. • Promote **best practices** – open access scheduling, extended office hours (up to 10 PM), provider recruitment/retention incentives. • **Target top five noncompliant providers** with follow-ups, monthly/quarterly check-ins, and corrective action plans. • Work with **CMO team** to educate members on alternative care options to reduce ER visits. • Expand **data extraction pilots** with Stanford and UCSF to improve survey participation and track satisfaction. • Use pediatric extended-hours pilot findings to shape **future access strategies**.		
XI. PQI	H. Momen	**PQI Dashboard** • H.Momen reported 2,000–2,600 PQI cases per quarter, totaling 9,375 cases over the last four quarters. • Most cases were classified as Quality of Service (QOS), followed by Quality of Access (QOA), Quality of Care, and Quality of Language. • Of 482 Quality of Care cases, the majority were leveled as C0 (no quality issue); 13% were C1 (adverse effect without provider negligence). Cases rated C2–C4 (potential/actual harm) received corrective action plans (CAPs). • 107 cases from late 2024 and early 2025 remain open, pending review due to lack of a medical director. **Corrective Action Plans (CAPs)** • 50 CAPs were issued in the last four quarters, with Sutter, Highland Hospital, Motive Care (transportation), and Washington Hospital receiving the most.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Motive Care issues often involved missed or delayed transportation, leading to ER visits or inpatient stays. • D. Carey explained that while specifics of CAPs for Motive Care cannot be shared, escalation and ride recovery processes are being improved and can be provided to providers upon request. **Exempt Grievance Audit** • 100 exempt grievance cases are randomly audited each quarter to ensure proper identification and referral; the goal of >90% correct identification was met with 100% performance. • Most grievances related to access, language, phone issues, service delays, transportation, and PCP location changes. • The Quality Improvement Department collaborates with Grievances and Appeals and Member Services to refine the PQI reference guide and continues quarterly audits. **RN Audit for QOS Cases** • Five QOS cases per nurse are audited each quarter for compliance with turnaround times and process standards; recent passing rates were 98–100%. • Refresher training is provided as needed to maintain compliance. **<u>Findings</u>** • **PQI Cases** – 2,000–2,600 cases per quarter (total 9,375 in past year). ○ Most cases: Quality of Service (QOS), followed by Quality of Access (QOA), Quality of Care, and Quality of Language.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		○ Of 482 Quality of Care cases: majority C0 (no issue), 13% C1 (adverse effect, no negligence), and C2–C4 (harm) required CAPs. ○ 107 cases still open due to lack of medical director review. • **Corrective Action Plans (CAPs)** – 50 issued last year, most to Sutter, Highland Hospital, Motive Care, and Washington Hospital. ○ Motive Care issues: missed/delayed rides causing ER visits or inpatient stays. ○ Escalation and ride recovery processes being improved. • **Exempt Grievance Audit** – 100 cases audited quarterly; goal of >90% correct identification met with 100%. ○ Common grievance themes: access, language, phone issues, service delays, transportation, PCP location changes. • **RN Audit for QOS Cases** – 5 cases per nurse audited quarterly; 98–100% compliance. ○ Refresher training provided when needed. **<u>Recommendations</u>** • Continue quarterly CAP monitoring, with focused follow-up on high-volume entities like Motive Care and Sutter. • Strengthen transportation vendor oversight to reduce missed/delayed rides. • Maintain quarterly exempt grievance audits and keep >90% identification accuracy. • Continue RN case audits to sustain high compliance rates; provide refresher training proactively.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Refine PQI reference guide in collaboration with Grievances, Appeals, and Member Services.		
XII. FSR Update/CAP	K. Ebido	**Team Update** • K. Ebido announced an additional review nurse was certified, increasing capacity for site reviews. **Review Process** • Facility Site Review (FSR) includes walkthroughs, staff interviews, document checks, and Medical Record Review (MRR). Results, scores, and corrective action plans (CAPs) are reported to the state. • Accessibility assessments are conducted and published in the provider directory. **Corrective Action Plans and Failed Sites** • In Q1, 25 CAPs were issued and all were closed on time; in Q2, 30 CAPs were issued with 23 closed and 7 pending. • Failed reviews (score below 80) increased, mostly due to MRR findings. • Providers who fail are placed on membership hold—no new member assignments until issues are resolved. **Trends and Challenges** • Since July 2022, a new state tool increased criteria and standards, resulting in a 7–8% drop in MRR scores. • Staffing turnover during the pandemic contributed to lower scores. **Skilled Nursing Facility Oversight** • The team monitors skilled nursing facilities using star ratings, census, PQI data, and the CDPH database. **2025 Focus Areas**		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)

		• Continued oversight and monitoring of PQIs and site reviews, process improvement, and support for providers in closing CAPs.
		• Directly contracted providers are the main focus for failed reviews, with outreach to delegated groups as needed.
		• Ongoing monitoring of PPCS (Primary Care Provider Sites).
		
		<u>Findings</u>
		• **Team Capacity** – One additional review nurse certified, increasing site review capacity.
		• **Review Process** – Facility Site Reviews (FSR) include walkthroughs, staff interviews, document checks, and Medical Record Review (MRR); results reported to state. Accessibility assessments published in provider directory.
		• **CAPs & Failed Sites** –
		  ○ Q1: 25 CAPs issued, all closed on time.
		  ○ Q2: 30 CAPs issued, 23 closed, 7 pending.
		  ○ Failed reviews (score <80) increased, mainly due to MRR findings.
		  ○ Providers failing reviews placed on membership hold until corrected.
		• **Trends/Challenges** – New state tool (July 2022) increased standards, lowering MRR scores by 7–8%. Pandemic staffing turnover also impacted results.
		• **Skilled Nursing Oversight** – Monitoring includes star ratings, census data, PQIs, and CDPH database review.
		
		<u>Recommendations</u>
		• Continue strengthening review capacity and process efficiency with added staffing.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		• Provide targeted support to providers failing reviews, especially for MRR improvements. • Prioritize closure of pending CAPs to restore provider eligibility for new member assignments. • Offer training and resources to address scoring challenges from the new state tool. • Maintain close monitoring of skilled nursing facilities using multiple data sources. • Keep focus on directly contracted providers while engaging delegated groups as needed.		
XIII. Behavioral Health Report	P. Currie	**Provider Training & ABA Forms** • P.Currie described successful development and rollout of new Applied Behavioral Analysis (ABA) treatment report forms, now available in the provider portal. • These forms automate treatment plan capture and facilitate care coordination with referring pediatricians. • Training sessions and office hours were held; a YouTube video was distributed to providers. Adoption is ongoing, with continued coaching and debugging. **DHCS Audit Findings** • Two findings from the June 2023–May 2024 period: insufficient assurance of services per approved treatment plans and timely access to ABA services. • Analysis revealed many authorized services were unused due to family vacations, scheduling mismatches, and provider availability. • Monthly reporting and oversight now track service utilization and target interventions for underperforming provider groups.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)

		• Timely access issues were addressed by tripling staff and implementing a caregiver report to monitor barriers and follow-up.
		• All corrective actions were accepted by DHCS; ongoing quality assurance procedures are in place.
		Collaboration with Alameda County Behavioral Health
		• Care coordination for eating disorders is managed under a cost-sharing agreement, with plans to review and revise the MOU after two years of experience.
		• Joint efforts are underway to address complex conditions, including dementia and psychiatric needs, especially in long-term care populations.
		• Behavioral data exchange is paused due to county system upgrades; efforts continue to restart real-time data sharing.
		• Monthly meetings focus on care transitions from inpatient psychiatric care to lower levels, improving visibility and coordination.
		
		<u>Findings</u>
		• **ABA Forms & Training** – New ABA treatment report forms developed and rolled out in the provider portal.
		  ○ Automates treatment plan captures and supports coordination with pediatricians.
		  ○ Training, office hours, and a YouTube video provided; adoption is ongoing with continued coaching.
		• **DHCS Audit Findings** – Two findings: insufficient assurance of services per treatment plans and timely access to ABA services.
		  ○ Many authorized services are unused due to family vacations, scheduling conflicts, and provider availability.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
		○ Monthly reporting and oversight now track service utilization; timely access improved by tripling staff and implementing caregiver reporting. ○ Corrective actions accepted, ongoing quality assurance in place. • **Collaboration with Alameda County Behavioral Health** – ○ Care coordination for eating disorders under cost-sharing MOU, to be reviewed after two years. ○ Joint efforts address complex conditions (dementia, psychiatric needs, long-term care). ○ Behavioral data exchange paused due to system upgrades; plans to restart. ○ Monthly meetings improve care transitions from inpatient psychiatric to lower-level care. **<u>Recommendations</u>** • Continue provider coaching and support to increase adoption of ABA forms. • Monitor service utilization monthly and target interventions for underperforming providers. • Maintain expanded staffing and caregiver reporting to ensure timely ABA access. • Review and update the Alameda County MOU based on two years of experience. • Resume behavioral data exchange with county systems once upgrades are complete. • Continue monthly care transition meetings to enhance coordination for complex behavioral health cases.		

Agenda Item	Responsible Person	Discussion	Vote	Action Items (High, Medium, Low)
XIV. Public Comment	D. Carey			
XV. Adjournment	D. Carey	Meeting Adjourned at 10:50am		

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

Minutes prepared by: Ashley Asejo - Clinical Quality Programs Coordinator

INTERNAL QUALITY IMPROVEMENT COMMITTEE
10/15/2025, 1:00pm-2:30pm
Remote

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Name	Title	Name	Title
Michelle Stott, RN, MSN	Senior Director of Quality	Dr. Donna Carey	Chief Medical Officer
Allison Lam	Director, Health Care Services	Dr. Beverly Juan	Medical Director, Utilization Management
Lilly Hunter	Director, Social Determinants of Health	Darryl Crowder	Director, Provider Relations & Provider Contracting
Jennifer Karmelich	Director of Quality Assurance	Cecilia Gomez	Sr. Manager, Provider Services
Alma Pena	Manager, Grievances & Appeals	Tiffany Cheang	Chief Analytics Officer, Healthcare Analytics
Linda Ayala	Director, Population Health	Farashta Zainal	Manager, Quality Improvement Team
Loc Tran	Manager, Access to Care	Christine Rattray	Supervisor, Quality Improvement (PQI)
Gil Duran	Manager, Population Health and Equity	Mao Moua	Manager, Cultural and Linguistic Services

INTERNAL QUALITY IMPROVEMENT COMMITTEE
10/15/2025, 1:00pm-2:30pm
Remote

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Agenda Item	Responsible Person(s)	Discussion	Follow-Up Person(s)/Action/Due By
Call to Order/Roll Call			
I. Review agenda for 10/15/2025	F. Zainal	The agenda was reviewed by Farashta.	
II. Policies & Procedures	Policy Owners	The following Policies were reviewed and will move to QIHEC in November. • QI-101: Quality improvement and Health Equity Program • 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-D-001: Quality Improvement Project Selection • QI-D-002: Health Outcomes Survey (HOS) • QI-D-003: Model of Care Annual Evaluation Policy • QI-D-004: Core Measures and Reporting	
III. Meeting Minutes - **IQIC 7/16/2025**	F. Zainal	Meeting Minutes submitted for review. • Minutes Approved 7/29/2025	
IV. QIHE Trilogy Updates	L. Ayala	• QI work plan now includes updates for Q3, with a specific focus on DSNP. • The Quality Improvement Health Equity program description for 2026 has been revised to prepare for the new year, incorporating DSNP requirements. • Updates include staff committee participation to meet CMS requirements and the inclusion of Medicare operations staff.	

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		• Added DSNP requirements for face-to-face encounters, transitions of care, and palliative care case management. The model of care framework was also updated. • A brief paragraph was added to acknowledge the maternal mental health program and its separate description. • Updates were made to organizational charts and reporting structures. • Committee Members were encouraged to review the updated packet, as many had contributed directly to the revisions.	
V. Maternal Mental Health Program Description	G. Duran	• Gil provided an overview of the Alliance's maternal mental health program. • California statutes require the Alliance to maintain a maternal mental health program, mandating at least one screening during pregnancy and one postpartum, with additional screenings as needed, following ACOG guidelines. • The program includes updated policies and procedures, provider education through orientations and online materials, updates to the provider manual, and regular communications to the provider network. • The program features behavioral healthcare coordination, proactive identification and outreach to prenatal and postpartum patients, encouragement of doula services, and mailings such as 'baby steps,' with future plans to implement peer support coaches via the CHW benefit. • Quality measures monitored include prenatal and postpartum care, depression screening and follow-up, member satisfaction surveys, and utilization of disease management and doula services, in collaboration with the quality improvement team.	

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VI. HEDIS & IHA Updates	F. Zainal	• Farashta presented current HEDIS rates and initial health appointment completion data, highlighting areas of strong performance, ongoing challenges, and interventions to improve compliance across various health measures. • **Behavioral Health and Cancer Screening:** Performing above the 75th percentile for alcohol and substance abuse follow-up and above the 50th percentile for mental health follow-up; breast, cervical, and colorectal cancer screenings are also trending positively, with targeted outreach to close remaining gaps. • **Disease Management and Chronic Conditions:** Asthma medication ratios are above the 50th percentile but require ongoing monitoring; controlling high blood pressure and diabetes remain below minimum performance levels, prompting increased outreach and provider engagement to improve blood pressure and A1C documentation. • **Child and Adolescent Health Measures:** Well child visits, immunizations, developmental and lead screenings are generally above the 50th percentile, with some measures nearing the 75th percentile; topical fluoride application rates are improving but still below target, with focused provider outreach. • **Initial Health Appointment Completion:** Completion rates for initial health appointments within 120 days are improving year over year, with variations among provider groups; delays in claims data impact apparent rates for recent months, but overall network performance is trending upward.	

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VII. Grievances & Appeals Report	A. Pena	• Alma reported on grievances and appeals for Q3, providing detailed breakdowns by type, entity, and outcome. • **Medical Grievances and Appeals Overview:** A total of 12,807 cases were reported, with a compliance rate of 96.8%; the per 1000 rate exceeded the internal goal, and grievances related to quality of care, discrimination, fraud, waste, and abuse were forwarded to appropriate teams for further review. • **Overturn Rates and Entity Analysis:** CFMG had a 50% overturn rate, CHCN 18%, and the plan 19%, all within or below the 25% benchmark; grievances were analyzed by clinics, plan, delegates, vendors, and hospitals, with mode of care and quality of service as leading categories. • **Trends and Specific Issues:** Increases in grievances were noted for certain clinics, hospitals, and ancillary providers; access to care, technology, and enrollment issues were common, with specific mention of member portal and ID card problems. • **IHSS (Group Care) Grievances and Appeals:** For IHSS, 578 cases were reported with a compliance rate of 96.8%; CHCN's overturn rate exceeded the benchmark, while the plan's was well below; most grievances were against the plan, with access to care and quality of service as primary issues. • Kisha inquired about Kaiser being listed as a delegate, and Alma clarified that grievances can still be filed against former delegates if the incident occurred during their active period.	
VIII. Newly Transitioned	A. Ambu G. Duran S. Jones	• Shatae and Gil presented outcomes and lessons from a pilot with Journey Health and CHWs to support members with uncontrolled diabetes and hypertension, focusing on engagement, care gap closure, and culturally tailored interventions.	

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Members – CHW Phase 1		• **Pilot Structure and Activities:** The pilot targeted 64 transition members with uncontrolled diabetes and hypertension, using CHWs for outreach, navigation, and a 12-week culturally tailored curriculum, with support from The Good Life Path for nutrition and disease management. • **Engagement and Outcomes:** Out of 64 members, 10 accepted services, 37 were unreachable, and 17 declined; 7 completed post-assessments, 4 showed high self-management confidence, and 4 closed HEDIS care gaps for blood pressure and A1C. • **Challenges and Barriers:** Barriers included a 58% unreachable rate due to disconnected phones, technology issues, and delays in enrollment; lessons included the need for real-time data integration, technical support, and alternative delivery models for education. • **Lessons Learned and Next Steps:** The team plans to integrate disease management risk stratification, improve tech orientation, refine CHW workflows, and offer alternative education delivery; future phases will focus on equity, targeting subpopulations with higher chronic disease prevalence.	
IX. NCQA Accreditation	K. Gerena	• Kisha provided an update on NCQA Health Equity and Health Plan accreditation, sharing scores, feedback, corrective actions, and plans for future surveys and internal process improvements. • **Accreditation Results:** The Alliance received 100% (24/24 points) for health equity accreditation and 131.5/132 for medical health plan accreditation, with 4/5 star rating for Medical and three out of five for commercial lines, based on HEDIS and member experience scores. • **Survey Feedback and Recommendations:** Surveyors praised documentation, population health strategy, and analysis; recommendations included numbering long documents, improving file	

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		review instructions, and ensuring complete documentation of assessments and dates. • **Corrective Action and Future Planning:** A corrective action plan is due for the timeliness of the UM appeals process; the team is preparing for a CAP survey in April and planning more mock audits, newsletters, and process improvements ahead of the next full survey in 2028.	
X. Blood Pressure Monitor PDSA	M. Hills	• Megan reported on the second round of the blood pressure monitor pilot with Alameda Health System, detailing process changes, member engagement, outcomes, and considerations for scaling the initiative. • **Pilot Process and Adjustments:** The team shifted to using internal QI engagement coordinators for outreach, limited delivery to partner pharmacies, confirmed mailing addresses, and removed provider scheduling from the workflow due to staffing constraints. • **Member Engagement and Outcomes:** Out of 100 members, 23 agreed to receive a monitor, 19 received it, and 7 had a blood pressure reading in the current measurement year; members appreciated home delivery, and no barriers were reported in obtaining monitors. • **Operational Challenges and Learnings:** Issues included reversed claims, ineligible members, and pharmacy reimbursement concerns; feedback indicated that pharmacy delivery is preferred due to transportation barriers, and the team is considering ways to scale the program, such as involving provider outreach teams or integrating monitor distribution into initial provider visits. • **Compliance and Quality Improvement:** Farashta emphasized the importance of having current blood pressure readings for all members with hypertension to maintain compliance, and discussed strategies to address common barriers like incorrect contact information.	

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Agenda Item	Responsible Person(s)	Discussion	Follow-Up Person(s)/Action/Due By
Adjournment	F. Zainal	Next meeting: January 2026	

Meeting Minutes submitted by: Ashley Asejo Date: 10/20/2025

Approved by: Farashta Zainal Date: 11/6/2025

Cultural and Linguistic Services Subcommittee (CLSS) Meeting
July 23, 2025

Committee Member Name	Title	Present
Linda Ayala, MPH	Director, Population Health and Equity	x
Farashta Zainal, MBA, PHP	Quality Improvement Manager	
Tran Loc	Manager, Access to Care	
Donna Carey, MD	Chief Medical Officer	
Darryl Crowder	Director, Provider Services	
Gia DeGrano	Director, Member Services	
Carlos Lopez	Quality Assurance and Regulatory Reporting Manager	x
Cecilia Gomez	Sr. Manager, Provider Services	
Beverly Juan, MD	Medical Director, Medical Services	x
Jennifer Karmelich	Director, Quality Assurance	
Michelle Lewis, MPH	Manager, Communications and Outreach	
Alma Pena	Manager, Grievances and Appeals Manager	x
Mao Moua, MPA	Manager, Cultural and Linguistic Services	x
Gil Duran, MPH	Manager, Population Health and Equity	x
Lao Paul Vang	Chief Health Equity Officer	x
Michelle Stott, MSN	Senior Director of Quality	
Anastacia Swift	Chief Human Resource Officer	
Taumaoe Gaoteote	Director, Diversity, Equity, Inclusion	
Allison Lam	Senior Director, Health Care Services	
Andrea DeRochi	Behavioral Health Manager	x
Lisha Reamer-Robinson	Manager, Compliance Audits, and Investigations	x
Marie Broadnax	Manager, Regulatory Affairs & Compliance	
Yen Ang	Director Health Equity	x

Staff Member Name	Title	Present
Kayla Williams	Manager, Experience & Program Management	x
Shatae Jones	Director, Community Health Strategy	x
Dani Staub	Director, Incentives and Reporting	x
Yemaya Teague	Senior Analyst of Health Equity	x
Mara Macabinguil	Interpreter Services Coordinator	x
Alexandra Loza	Quality Assurance Specialist	
Osiris Rivas	Cultural and Linguistic Services	x
Adrina Rodriguez	Privacy Compliance Specialist	

Mandy Gutierrez	Senior Communications & Media Specialist	x
Rosa Carrodus	Disease Management Health Educator	
Robert Smith	Regulatory Compliance Specialist	x
Rommel Cuevas	Regulatory Compliance Specialist	x
Krystaniece Wong	Regulatory Compliance Specialist	
Robert Smith	Regulatory Compliance Specialist	x
Lisa Sciutto	Regulatory Compliance Specialist	x
Debbie Spray	Manager, IT Governance and Incident Management	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
1. Call to Order/Introductions	M. Moua	M. Moua called the meeting to order.	
2. Minutes from 04/23/2025 Meeting	M. Moua	Minutes from the last meeting were reviewed by participants with no additional changes/comments and are attached to the meeting invite.	
3. Agenda review	M. Moua	M. Moua reviewed the agenda.	
4. Follow-up items from 04/23/2025	M. Moua	M. Moua reported on the follow-up items from last meeting. • Net 1A Report: Share the findings on provider and member race and ethnicity with the Behavioral Health team for further analysis and action **(Completed).** ➢ *Comment-A. DeRochi: There has been a fair number of turnover especially in FQHCs, so we're looking for alternatives. We are certainly aware that this is hard to recruit for, but we're searching for additional providers. We've got a Psych NP that is certainly only remote but is willing to contract with us. We are also looking into contracting with a behavioral health group that does evaluations for autism and ADHD. They're extraordinarily expensive because of market demand, but we're working on that. So, we're working on it from a network perspective at this point.* ➢ *Comment: L. Ayala: I was looking at the updated provider recruitment incentive, to see whether that's going to be of any assistance in recruitment. There's a couple of things in there, one for behavioral health, but there's also an incentive for bilingual providers. I'm hoping that that helps with the effort because I know it's hard.*	D. Staub to share with the provider recruitment incentive materials to the CLSS.

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		➢ *Response-A. DeRochi: I support network development with Laura Grossman, but I'm not aware of any of those programs. Is that under your shop, Linda?* ➢ *Response: L. Ayala: It might be in Dani's shop, but I'm actually not sure.* ➢ *Response-D.Staub: This is Dani, from Incentives and Reporting. The provider recruitment initiative does provide grants of up to $10,000 for new providers added to our network that speak one of our threshold languages. This applies to mid-level and above providers, as well as non-MD behavioral providers. We can email out the program materials to this group or if you want to reach out directly, that will work too. The program just launched last July 1st.* We haven't had a huge response like we did last year with provider practices that are interested in the program. So, if you have practices that you think would be interested in or want to expand their practice and hire, share it to them, that would be fantastic.	
5. CLS Workplan Q2 Update	M. Moua	M. Moua reviewed the CLS Workplan Q2 Update. • Member Cultural and Linguistic Assessment: Completed assessment at the CLSS meeting on 04/23/2025 (**Goal met).** • Language Assistance Services Fulfillment: Achieved a fulfillment rate of above 99% across all modalities (in-person, video, and telephonic interpreter services) **(Goal met).** • Language Assistance Services Fulfillment: Met with Provider Relations team to present situation and plan to address high-utilizing prescheduled interpreter services provider. Presented and reviewed situation and plan with QI Senior Leadership for review and approval. Pulled utilization data for top 5 high-utilizing preschedule interpreter services provider sites **(In-progress).** • Language Assistance for Services for Behavioral Health: Vendor reviewed call flow data and reported that utilization tracking is only feasible if the initial call prompt identifies the call as involving a behavioral health assessment. Met with Member Services Quality Assurance and Regulatory Reporting Manager to explore existing	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

		member call tracking and determine whether behavioral assessment calls are currently being identified **(In-Progress**).
		• Provider Language Capacity (Member Satisfaction)
		  ○ Q1 2025-Adult: 83.7%; Child 91.0% **(Goal met).**
		  ○ Q2 2025: Planned implementation Q3 **(Pending).**
		• Potential Quality Issues-Quality of Language (PQI-QOL)
		  ○ Q2 2025: 94% closure rate **(Unmet).**
		  ○ CLS team experienced staffing challenges and increased volumes in coordinating/scheduling interpreter services.
		  ○ All PQI cases were closed within the required 120-day TAT.
		• Language Assistance Services (Member Satisfaction)
		  ○ Data collection ended on 04/16/2025.
		  ○ Received raw data files on 04/21/2025.
		  ○ Scrubbed raw data files and developed final report.
		  ○ Submitted TAR Survey Report to DMHC via Regulatory Affairs on 04/30/2025.
		  ○ Overall, 2% increase in responses from MY 2023 **(Goal met)**.
		• Provider Language Capacity and Race and/or Ethnicity (Provider Network)
		  ○ Finalized draft Net 1A Report
		  ○ Submitted to NCQA consultants and received feedback.
		  ○ Assessed feedback and gap in reporting.
		  ○ Updated report to fill gap in reporting/data.
		  ○ Presented Net 1A Report at CLSS (04/23/2025) and QIHEC (05/09/2025) and received approval **(Goal met).**
		• Community Engagement: Community Advisory Committee (CAC)
		  ○ Connected and presented information about the CAC as part of membership recruitment efforts to the following organizations:
		  ▪ Children First Medical Group (CFMG), 04/29/2025
		  ▪ Alameda County Public Health Department-Local Health Department (ACPHD-LHD), 05/20/2025
		  ▪ Community Health Center Network (CHCN), 05/21/2025	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		▪ Native American Health Center (NAHC), 05/29/2025 ○ Held a CAC Selection Committee Meeting to present CAC interests ○ CAC Selection Committee reviewed and voted on 8 new CAC members from the following representation areas: providers, men, diverse racial and ethnic backgrounds, SPD, youth/at-risk youth, ages 19-44, and representatives from an Indian Health Center Provider.	
6. CCLSS Charter Review	L. Ayala	L. Ayala reviewed the changes in the CLSS Charter. • Alignment with DSNP requirements. • Added Medicare representation to CLSS membership. • Minor grammar and formatting updates. • Updates were made to the following areas: ○ CAC representation areas ○ CAC Selection Committee representation areas and responsibilities	
7. CLS Policies and Procedures Updates	L. Ayala	L. Ayala reviewed the updates to the CLS P&P. • CLS-001: Cultural and Linguistic Services (CLS) Program Description ○ Alignment with DSNP requirements. ○ Minor grammar and formatting updates. ○ Added DSNP as an acronym. • CLS-002: Member Advisory Committee ○ Alignment with DSNP requirements. ○ Minor grammar and formatting updates. ○ Updated designated CAC Coordinator. ○ Added Center for Medicare and Medicaid Services (CMS) as a reference. ○ Added DSNP as an acronym. • CLS-003: Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities ○ Alignment with DSNP requirements.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ Updated to comply with APL 25-006, including ability of member's representative to request alternative formats, updating name of multi-lingual "Taglines" to "Notice of Availability," and adding our process for including language access language in small notices. ○ Minor grammar, wording, and formatting updates. • CLS-008: Member Assessment of Cultural and Linguistic Needs ○ Alignment with DSNP and Health Equity requirements. ○ Minor grammar and formatting updates. ○ Added Center for Medicare and Medicaid Services (CMS) as a reference. ○ Expanded and updated language for Notice of Availability. ○ Updated and added Definition/Acronyms section. • CLS-009: CLS Program - Contracted Providers ○ Alignment with DSNP requirements. ○ Minor grammar and formatting updates. ○ Expanded and updated Quality Improvement Department's role around member and provider language capacity. ○ Updated and added Definition/Acronyms section. • CLS-010: CLS Program - Staff Training and Assessment ○ Alignment with DSNP requirements. ○ Minor grammar and formatting updates. ○ Added Center for Medicare and Medicaid Services (CMS) as a reference. ○ Updated and added Definition/Acronyms section. • CLS-011: CLS Program - Compliance Monitoring ○ Alignment with DSNP requirements. ○ Minor grammar and formatting updates. ○ Updated and added Definition/Acronyms section.	
8. CLS Program Description Review	M. Moua	M. Moua reviewed the CLS Program Description updates. • Alignment with DSNP requirements. • Added CLSP QI and DSNP workplan goals.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		• Added CLAS goals. • Minor grammar and formatting updates.	

9. Timely Access Requirement (TAR Survey)	M. Moua	M. Moua discussed the Timey Access Requirement (TAR Survey).
		
		• Background: An annual survey and a DMHC requirement for us to assess our members' experience, with timely access to care as well as interpreting services.
		• Purpose: To assess our members' experiences with timely appointments and interpreting services, informing our members of their rights to receive interpreting services, and evaluating their experience and satisfaction.
		• Methodology
		  ○ Questionnaire
		  ▪ Administered by vendor, Press Ganey
		  ▪ Survey Languages: English and 15 foreign languages
		  ▪ Data collection: Mail and online
		  ○ Sample Size
		  ▪ Eligible members: 5, 200
		  ▪ Responses: 259 (5% response rate)
		• Survey Response by Language
		  ○ Top Languages Responded
		  ▪ Chinese
		  ▪ Vietnamese
		  ▪ Tagalog
		  ▪ Spanish
		  ▪ Korean
		  ▪ English
		  ○ Responses were received in all Alliance threshold languages.
		• Findings and Analysis
		  ○ Members were asked if they needed an interpreter to speak with their doctor or other health care providers in the past 12 months.
		  ▪ Yes: 47%
		  ▪ No: 45%	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		▪ Unsure: 5% ▪ No Response: 3% ○ Members were asked to rate how satisfied they were with: ▪ Scheduling appointments with an interpreter: 89% ▪ Availability of interpreters: 89% ▪ Knowledge, skills, and quality of interpreters: 88% ○ Year-Over-Year Comparison ▪ Increase of 149 completed surveys from MY 2023 to MY 2024. ▪ Slight decrease by 7.2% in members reporting interpreter need. ▪ Satisfaction scores remained stable. ▪ Small decrease in interpreter quality satisfaction: from 90% (MY 2023) to 88% (MY 2024). ○ Notable Observations ▪ Spanish-speaking response rate was lower despite high demand for Spanish interpreters. ▪ Indicates an opportunity to strengthen outreach to Spanish-speaking members. ○ Possible Barriers ▪ Increased membership from the 2024 expansion equals higher demand for interpreter services. ▪ No definitive cause has been identified and will need further investigation to determine root causes of decreased satisfaction. • Next Action Steps ○ Continue annual survey with improved outreach to Spanish-speaking members. ○ Support providers with targeted education and engagement strategies. ○ Investigate interpreter-related grievances and PQIs. ○ Review vendor training curriculum and interpreter linguistic assessments. ○ Present survey results at Access & Availability and CLS Subcommittees.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ Questions and Discussion ▪ Are there any suggestions on how to improve outreach to Spanish-speaking members? ➢ *Question-Y. Ang: Do we happen to know which specific language saw that 2% drop in satisfaction?* ➢ *Response-M. Moua: We don't. With how the data is retrieved, we don't get that granular in terms of being able to identify by language, but we just had it overall at 2% decrease. I can look back at our results that we received as well and report, but it didn't get that granular from what I can recall.* ➢ *Question-L. Ayala: So, when you say outreach to Spanish-speaking members, you're thinking about how to get a better response rate for the survey?* ➢ *Response-M. Moua: Yes. And getting them to complete our surveys. They are our highest utilizers of interpreting services overall, yet the response rate was very low for them. Our highest came from our Chinese-speaking members. And so, thinking about ways we can continue to solicit feedback. Loc and I partner on this survey as well and work together on this report and so definitely open to suggestions either here or also offline in terms of how we can improve our outreach and whether it's looking at our sample size, how we pool members for that as well too, but open for discussion around this.* ➢ *Response-L. Ayala: Just wondering if it'll be interesting to consider the possibility of sending out text messages as a different way to have members engage. Our Spanish-speaking members tend to be in that kind of younger adult group who might be more willing and available to do that. There's lots of concerns I can imagine of a lot of barriers to making that happen, but kind of as a long term or an opportunity that might help bring in some of those members.*	
10. Compliance Updates	R. Smith L. Sciutto	R. Smith provided updates on the enterprise-wide end-to-end and enclosure process to ensure compliance and international dates in translated letters.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date

	L. Reamer-Robinson	• Enterprise-wide end-to-end letter and enclosure process to ensure compliance.
		  ○ Process is in place to ensure compliance with enclosures and letters, which includes the NAR, NOA, Non-Discrimination Notice, and Notice of Availability (formerly called Tag Lines).
		  ○ Brief overview of process:
		  ▪ Notice of an update comes from DHCS or DMHC regarding an enclosure or letter.
		  ▪ Regulatory Affairs & Compliance (RAC) team meet internally to discuss updates.
		  ▪ RAC meets with C&O to discuss updates and use the DHCS or DMHC letter/enclosure template to build the group care version.
		  ▪ RAC meets with business partners to get approval on the letter/enclosure.
		  ▪ RAC files letter/enclosure to DHCS or DMHC for approval.
		  ▪ RAC notifies C&O of approval of letter/enclosure from DHCS or DMHC.
		  ▪ C&O distributes letter/enclosure to the business and updates the C&O library.
		
		➢ *Question-M. Moua: Right now, we have one for Medi-Cal and group care, are we planning on having one as well for the DSNP line?*
		➢ *Response-R. Smith: We probably will but let me take this back to Marie and see what it looks like because it might look a little bit different.*
		
		• International dates in translated letters
		  ○ Issue was identified in international date in translated letters. In the U.S., dates are written month/day/year format, while in other countries, dates are written in the day/month/year format. This has caused confusion amongst members.	

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		○ Issue has been logged into RAC's issues log. RAC will be tracking and proving updates at the next AOC meeting. ➢ *Comment-M. Moua: As we continue to work with our translation vendors, I think it'll be good to understand what quality monitoring they're putting in place as they're doing their quality review before they send us the final translation files to ensure that they're checking those dates as well too.* L. Sciuto discussed the threshold languages for Alameda County by regulator. • Methodology ○ Medi-Cal (DHCS): Based on Medi-Cal enrollment data. ○ Medicare: 5% of the individuals in a plan's service area rather than just Medicare enrollment data. • Threshold Languages ○ Medi-Cal (DHCS): Chinese, Spanish, Vietnamese, and Farsi ○ Medicare (CMS): Chinese, Spanish, Tagalog, and Vietnamese ○ DSNP (Medi-Medi): Chinese, Spanish, Tagalog, Vietnamese, and Farsi • Notice of Availability Requirement ○ Medicare (CMS): Top 15 non-English languages in the state. ○ Medi-Cal (DHCS): Added 3 more for consistency's sake, so a total of 18 rather than 15. ➢ *Question-L. Ayala: Regarding the Notice of Availability. Will we just use one list of languages for both Medi-Cal and DSNP? I know they'll be branded differently probably, but just curious about which languages will be included. Because you would think even for DSNP, that we would have to follow DHCS because we're following both. It's the larger pool of languages that we'd have to follow.* ➢ *Response-L. Sciutto:* Yes, we do, and we checked with CMS on that as well and they said you're fine if you use more rather than fewer languages on that. So even though they're branded differently, my	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		guess is that we would use that same pool of languages. I just couldn't necessarily say that it would be exactly the same, but that would be my educated guess on that matter because we did run that past CMS and they said as long as you're doing more rather than less, it's okay. ➢ *Question-L. Ayala: Mao and I often get emails, questions from staff. Staff don't necessarily memorize the threshold languages and so they come to us or to compliance to ask what they are. But I do think it would be good to kind of share this more broadly throughout the whole organization, because it is interesting how much it does impact some of the work that we do, whether it's the reporting that analytics does, the communications that provider services have with our providers, because they sometimes call in and want to know what those languages are. So just wanted to see if there was a way either Compliance or we'd be happy to collaborate with you to make sure this is clear for the whole organization.* ➢ *Response-L. Sciutto: I don't know that there's necessarily a plan to do that, but certainly I think we'd be open to collaborating and in making that clear to everyone because it is confusing and there was a lot of back and forth to arrive at this, especially since the methodologies are so different in how those are calculated. So yes, we'd be happy to be involved with something like that. I don't know if there's necessarily a plan in the works to do that, but we're certainly open for that.* L. Reamer-Robinson provided updates on the 2024 DHCS CAP finding 4.2.1. • Monitoring of Linguistic Performance: The Plan did not assess the performance of its vendor's staff that provided linguistic services such as interpreter services. • Completed Actions ○ The following updates were provided to DHCS during the April CAP follow-up and the department has accepted with no further questions:	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		▪ Updates to vendor contracts to include reporting requirements for interpreter qualifications and reporting cadence. ▪ Contract amendments submitted to vendors CyraCom and Propio. ○ The following updates were provided to DHCS during the May CAP follow-up and the department has accepted with no further questions: ▪ JOM meeting minutes for Propio and CLSS meeting minutes were submitted. ▪ The Plan submitted the approved P&P CLS-011 to DHCS. *Comment-M. Moua: Thank you, Lisha. You and your team were instrumental also in helping us to make sure we meet and submit all these documents and a lot of back and forth that also happened to clarify our submission. So greatly appreciate it. I'm just so excited that it's accepted. We do have our monthly monitoring in place to review reports from our vendors. So again, kudos to your team and greatly appreciate the collaboration and support.*	
11. Q2 Language Access Reporting			
11. a. Grievance and Appeals Report	A. Pena	A. Pena presented on the Grievance and Appeals Report Q2 2025. Medi-Cal • Overview ○ Total of 137 unique grievances with 45 shadow cases for a total of 182 grievances resolved during Q2 2025. ○ Slight increase in complaints in Q2 2025 compared to Q1 2025. ○ Forty-one (41) grievances were related to discrimination and were forwarded to the Compliance Department for further investigation. • Grievance Type ○ Access to Care: 141	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ Quality of Service: 41 ○ Total: 182 • Grievance File Against ○ AAH Plan: 20 complaints against the plan regarding language access regarding not receiving correspondence in their preferred language, dissatisfaction with the interpreter process, and reaching representatives who speak their preferred language. ○ PCP/Clinic: Complaints filed against the following clinics are related to the members experienced language barriers with the staff: ▪ Axis Community Health-Hacienda: 4 ▪ Dr. Shagun Bagga: 4 ▪ Progressive Urgent Care: 4 ▪ Newark Health Center: 3 ○ Vendor: ▪ ModivCare: 8 ❖ Members experienced language barriers when calling to make reservations for rides because they do not have staff members who speak their preferred languages. The members experienced language barriers with drivers. ▪ Hanna: 8 ❖ The vendor did not process their interpreter requests; there were no Mam interpreters to help with the member's call; and the interpreter not staying for the entire appointment time. ▪ Cyracom: 7 ❖ The member could not reach Cyracom by phone; the member requested a Dari-speaking interpreter and was connected with a Farsi interpreter; it takes too long to connect with an interpreter by phone; and lack of Mam interpreters.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		▪ CHME: 1 ❖ The member experienced difficulty reaching a staff member that speaks their preferred language • Tracking and Trending: Grievances filed against our Delegates/Vendors are reported to the groups during our quarterly Joint Operation Meetings. Group Care • Overview: ○ No grievances related to discrimination in Q2 2025. ○ Seven (7) unique grievances with 1 shadow case for a total of 8 grievances in Q2 2025 pertaining to lack of language access. ○ Increase in complaints for language access in Q2 compared to Q1 2025. • Grievance Type ○ Access to Care: 8 ○ Quality of Service: 0 ○ Total: 8 • Grievance File Against ○ AAH Plan: Not enough Mandarin-speaking providers in the Alliance network. ○ Clinics ▪ LifeLong Medical Care – West Berkeley Family Practice: Clinic does not have any staff members who speak Russian. ▪ Newark Health Center: Clinic does not have providers who speak Mandarin ▪ San Antonio Neighborhood Health Center: Clinic does not have providers who speak Mandarin ○ Hospital ▪ ABSMC: Staff members do not speak Spanish. ○ PCP ▪ Dr. Rajesh Suri: Doctor does not speak Mandarin.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ Specialist ▪ Dr. Sarbjit Hundal: Doctor does not help the member request interpreters for her appointments. • Tracking and Trending: Grievances filed against our Delegates/Vendors are reported to the groups during our quarterly Joint Operation Meetings.	
11. b. Quality of Language-PQI Report	M. Moua	M. Moua reported presented on the Quality of Language-PQI Report. • Total of 102 QOL-PQI cases in Q2 2025. • Based on Q1 and Q2, identified 4 that meets threshold for CAP issuance. ○ AAH Plan (Q1: 5; Q2: 7) ○ Cyracom (Q1: 3; Q2: 4) ○ Hanna (Q1: 5; Q2: 7) ○ Newark Health Center (Q1: 2; Q2: 3) • AAH Type of QOL-PQI ○ Dissatisfaction with AAH's language capacity (Spanish and Mandarin). ○ Dissatisfaction with AAH's phone tree language capacity (Mandarin). ○ Member received a call in nonpreferred spoken language. • Cyracom Type of QOL-PQI ○ Dissatisfied with the quality of interpreter services provided. ▪ Next Steps: No CAP was issued, as each issue involved a different interpreter and has been individually addressed, except for one interpreter due to insufficient call details. ▪ Address at the next CyraCom JOM. • Hanna Type of QOL-PQI ○ Dissatisfied with quality of language interpreter. ○ Last-minute cancellations. ○ Availability of in-person Arabic Interpreter (preferred interpreter).	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ Availability of in-person ASL interpreter. ▪ Next Steps: All cases were reviewed and addressed with Hanna at the last JOM (07/02/2025). ▪ No CAP was issued, as each issue involved a different interpreter and has been individually addressed. ▪ Hanna has continued to work on expanding ASL interpreter capacity and fulfillment rates have improved. • Newark Wellness Center Type of QOL-PQI ○ Dissatisfied with provider language capacity (Mandarin). ▪ Next Steps: No CAP was issued. ▪ Members preferred a PCP that spoke their language. ▪ Provider office has received education.	
11. c. Member Services Representative-Multilingual Staff Report	C. Lopez	C. Lopez reported on the Member Services Multilingual Staff Report. • Staff by Language ○ Spanish: 29 ○ Vietnamese: 4 ○ Cantonese: 5 ○ Mandarin: 4 ○ Tagalog: 3 ○ Total: 45 • Forty-one (41) qualified multilingual staff that have completed a non-medical evaluation. • Four (4) of the qualified multilingual staff speak more than 1 non-English threshold language • At least 1 non-English threshold language call per month is monitored for each threshold language spoken by the Member Services Representative. • Open Positions: ○ Member Services Representative I-Bilingual Spanish: 5 ○ Member Services Representative I-Bilingual Vietnamese: 1 ○ Member Services Representative I-Bilingual Cantonese: 2	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		○ Member Services Representative I-Bilingual Mandarin 1	
11. d. Membership Reports	M. Moua	M. Moua presented on the Member Demographics. Medi-Cal (Threshold Languages) • English: 243,648 (60.03%) • Spanish: 105,630 (26.02%) • Chinese: 29,987 (7.14%) • Vietnamese: 7,887 (1.94%) • Farsi: 3, 071 (0.76%) Group Care (Threshold Languages) • English: 3,515 (59.12%) • Chinese: 1, 471 (24.74%) • Spanish: 314 (5.28%) • Vietnamese: 248 (4.17%) • Farsi: 87 (1.46%)	
11. e. Utilization of Interpreter Services	M. Moua	M. Moua reported on the Utilization of Interpreter Services. • Q2 Utilization: On Demand vs Schedule ○ April ▪ On-Demand: 8,338 Scheduled: 2,721 ○ May ▪ On-Demand: 8,300 ▪ Scheduled: 2,764 ○ June ▪ On-Demand: 7,690 ▪ Scheduled: 2,567 • Fulfillment Rate: 99% (exceeds metric goal of 95%). • On-Demand interpreter services make up to 75.3% of interpreter services provided in Q2. • Scheduled interpreter services make up to 24.7% of interpreter services provided in Q2.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		• Q2 Top 1- Utilizers: On-Demand Interpreting Services 1. CHCN: 7,248 2. All Other Providers: 4,248 3. Asian Health Services: 4,011 4. Alliance Member Services: 3,323 5. Alliance Case Management: 1,310 6. Alameda Health Systems: 1,127 7. Alameda Alliance for Health: 580 8. Alliance G&A: 468 9. Behavioral Health Providers: 397 10. Alliance Provider Services: 344 • Q2 Utilization: Top Scheduled Utilizers 1. Tri-City Physical Therapy 2. Alameda Health Systems 3. Allergy Asthma & Sinus Centers 4. San Antonio Neighborhood Health Center 5. East Bay Center for Digestive Health 6. Benioff Children's Hospital Oakland 7. Mission Peak Orthopedics 8. East Bay Rheumatology Medical Group 9. Seven Bridges Therapy 10. Center for Early Intervention on Deafness • Q2 Utilization: Top Languages 1. Spanish 2. Cantonese 3. Vietnamese 4. Mandarin 5. Mam 6. Arabic 7. Dari 8. Farsi 9. Punjabi 10. Khmer	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
11. f. Utilization of Translation Services Report	M. Gutierrez	M. Gutierrez presented on the Q2 Translation Services Utilization. • The highest number is held by the G&A team as usual. • The C&O Team has translated well over 200 documents into our threshold and non-threshold languages. • Translated documents mainly consist of Healthcare Services member letter templates and other various health related documents. • Farsi is the highest for Q2 due to August go-live preparations- translated member materials, letters, templates, and health education documents.	

11. g. Vendor Interpreter Quality Monitoring Reports	M. Moua	M. Moua presented on Vendor Interpreter Quality Monitoring Reports.
		
		• Q2 2025 Hanna
		  ○ No Interpreter Linguistic Assessment were issued for Hanna Interpreters. (Assessments are issued based on services provided.)
		• Q2 2025 Cyracom
		  ○ All CyraCom interpreters completed an Interpreter Linguistic Assessment with a “Pass”.
		  ○ No issues identified.
		• Q2 2025 Propio
		  ○ Results: 94% of Propio’s interpreters achieved a “Pass” on the Interpreter Linguistic Assessment for Q2 .
		  ○ For interpreters who did not receive a passing score, the following actions were taken:
		  ▪ Propio
		  ❖ Interpreters received coaching and feedback from Propio’s Quality Department.
		  ❖ Interpreters were reassessed. Based on their scores, they may or may not continue to take calls.	

Agenda Item	Responsible Person	Discussion	Follow-Up Action/Responsible Party/Target date
		❖ If an interpreter completed a call, their updated score will reflect in the next month's report. ▪ Alliance ❖ Reviewed reports monthly. ❖ Requested that interpreters that did not meet passing score 2 months in a row be removed from available interpreters until able to provide a passing score.	
Adjournment	M. Moua	Next meeting on October 22, 2025.	

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Services Coordinator Date: 08/22/2025

Approved By: Mao Moua, Manager, Cultural Linguistic Services Date: 09/18/2025

ALAMEDA Alliance FOR HEALTH

COMMUNITY ADVISORY COMMITTEE (CAC)

Thursday, December 5, 2024, 10:00 AM – 12:00 PM

Committee Members	Role	Present
Natalie Williams	Alliance Member	x
Valeria Brabata Gonzalez	Parent of Alliance Member	x
Cecelia Wynn	Alliance Member	x
Tandra DeBose	Community Advocate	x
Irene Garcia	Alliance Member	x
Erika Garner	Alliance Member	x
Jody Moore	Parent of Alliance Member	x
Sonya Richardson	Alliance Member	
MiMi Le	Alliance Member	x
Mayra Matias Pablo	Parent of Alliance Member	
Amy Sholinbeck	Asthma Coordinator, Alameda County Asthma Start	x
Irene Garcia	Alliance Member	x
Roxanne Furr	Alliance Member	x
Kerrie Low	Social Worker, Alameda County Public Health Department (ACPHD	x

Other Attendees	Organization	Present
Kellie Knox	City of Berkeley	x
Melodie Shubat	CHME	x
Jennifer Gudiel	ACPHD	x
Carolina Guzman	ACPHD	x
Rebecca Gebhart	Alliance Board of Governors Chair	x
Janice Chin	City of Berkeley	x
Kathrine Shea	Department of Health Care Services	x
Esmail Khaledi	Unknown	

Alliance Staff Members	Title	Present
Matthew Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Communications & Outreach	x
Alejandro Alvarez	Community Outreach Supervisor	x
Thomas Dinh	Outreach Coordinator	x
Linda Ayala	Director, Population Health and Equity	x
Mao Moua	Manager, Cultural and Linguistic Services	x

Steve Le	Outreach Coordinator	
Isaac Liang	Outreach Coordinator	x
Rosa Carrodus	Disease Management Health Educator	x
Lao Paul Vang	Chief Health Equity Officer	x
Gil Duran	Manager, Population Health and Equity	x
Emily Erhardt	Population Health and Equity Specialist	x
Gabriela Perez-Pablo	Outreach coordinator	x
Michelle Stott	Senior Director, Quality Improvement	x
Mara Macabinguil	Interpreter Services Coordinator	x
Katrina Vo	Senior Communications and Content Specialist	x
Misha Chi	Health Education Coordinator	x
Farashta Zainal	Quality Improvement Manager	x
Loc Tran	Manager, Access to Care	x
Jorge Rosales	Manager, Case Management	x
Anne Margaret Macsiljig	Quality Engagement Coordinator	
Donna Carey	Chief Medical Officer	x
Peter Currie	Senior Director of Behavioral Health	
Yen Ang	Director of Health Equity	x
Taumaoe Gaoteote	Director of Diversity, Equity, and Inclusion	
Jessica Jew	Population Health and Equity Specialist	x
Jennifer Karmelich	Director of Quality Assurance	
Monique Rubalcava	Health Education Specialist	x
Stephen Smyth	Director of Compliance and Special Investigations	x
Andrea DeRochi	Behavioral Health Manager	x
Oscar Macias	Housing Manager	x
Sean Pepper	Compliance Special Investigator	x
Cecilia Gomez	Senior Manager, Provider Services	x
Yemaya Teague	Senior Analyst of Health Equity	x
Karina Rivera	Senior Manager, Public Affairs and Medica Relations	x
Alma Pena	Senior Manager, Grievance and Appeals	x
Vanessa Suarez	Manager, Vendor Management	x
Adrina Rodriguez	Privacy Compliance Specialist	x

AGENDA ITEM SPEAKER	DISCUSSION	ACTION	FOLLOW-UP
1. WELCOME AND INTRODUCTION			
T. Debose	T. Debose called the meeting to order at 10:03 am.	None	None

	Roll call was taken and a quorum was established. An introduction of staff and visitors was completed.		
2. a. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF MINUTES FROM JUNE 13, 2024			
T. Debose	Motion to approve the September 19, 2024 meeting minutes.	Motion: N. Williams Second: C. Wynn Vote: Approved by consensus	None
2. b. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF AGENDA			
T. Debose	Motion to approve switching the order of the 3rd and 4th agenda items under New Business.	Motion: N. Williams Second: M. Le Vote: Approved by consensus	None
3. CEO UPDATE – ALLIANCE UPDATES			
M. Woodruff	Matthew Woodruff, Chief Executive Officer (CEO), presented on the Alliance updates. • Alliance CEO and Chief Financial Officer (CFO) met with the Department of Health Care Services five (5) times since July 2024, to advocate for increase in rates. • The state usually determines rates by looking at the past 2 to 3 years. Utilization was low in the past 2 to 3 years due to COVID. • Advocated for the state to look at the current utilization instead, from January 2024, since we transitioned from a two-plan model to a single-plan model. Utilization has increased since then. We now have 407,000 members. • The 2024 rates were received in September 2024 and they were not great. We met with the state a few more times to discuss the rates. • Good news: the state notified the Alliance on November 27, 2024, that they will relook at the 2024 rates. No exact timeline for revised rates. • We received the draft 2025 rates on December 2, 2024, with high-level information only, but the rates look much better. • We hope to get more information from the state today (12/05/2024) as our finance report is due tomorrow (12/06/2024) and the finance meeting is on Tuesday (12/10/2024). • In our draft, we are reporting a $125 Million loss for the fiscal year-not final until posted tomorrow (12/06/2024).	None	None

	• The finance team, claims team, and different teams in Healthcare Services have been looking at ways to mitigate in case the state does not help us. • Some utilization controls went to effect last Monday (December 2, 2024) with more to come into effect soon. • With all these measures in place, we will only be able to save $10 million per year, so the state needs to look at current utilization instead of utilization during COVID. • Other cost-saving measures include the hiring freeze, which saved us a total of $1.9 million. This will be lifted once we get more details from the state on our budget. • Overall, our financial outlook is not great, but it appears that the state is taking seriously what we have been asking them to do. ➢ *Member Question-N. Williams: What is the ideal amount, in a perfect world, we can get from the state that you expected?* ➢ *Response-M. Woodruff: I have to break it down by category, but in the largest category, we'll have to get a 20% to 25% raise, and we know that's not realistic with the state budget, but hopefully they can get us close to it.* ➢ *Member Question: T. Debose: Will you hear from them this month or in January?* ➢ *Response-M. Woodruff: For 2025 rates, hoping to hear from them today (12/05/2024), as we need to post our report tomorrow (12/06/2024) for the finance committee meeting next week. For 2024 rates, likely at some point in December, but we will know better in January, where we are financially.* • Preliminary Quality Scores: met 16 out of 18 measures. We will not meet one, which is the lead screening in children. We missed it by 7 members, and we are very close to meeting another, topical fluoride. We are waiting for final numbers. ❖ *Member Comment: So, we are on pins and needles until we hear from the state.* ➢ *Response-M. Woodruff: Pretty much.*		
4. FOLLOW-UP ITEMS - ITEMS FROM 09.20.2024			

M. Moua	Mao Moua, Manager of Cultural and Linguistic Services, presented the updates on the follow-up items. • Online resource survey link was sent via email on 09/19/2024 to CAC members. • Contact information of presenters from Alameda County Public Health Department was sent via email on 09/26/2024 to CAC members. • CEO Report was sent via email on 11/12/2024 to CAC members. • Medicare Program to be presented as a topic at the March or June 2025 CAC meeting. • Behavioral Health to be presented as a topic at the March or June 2025 CAC meeting.	None	None
5. a. NEW BUSINESS – POPULATION NEEDS ASSESSMENT-CITY OF BERKELEY			

G. Duran
J. Chin
	Gil Duran, Manager of Population Health and Equity provided an introduction on the Population Health and Management Team's work with local health jurisdictions and introduced the presenter from the City of Berkeley.
	
	• The Population Health and Management Team uses data and assessments to better understand all our members, then creates strategies for the different services offered.
	• Based on needs and gaps, work began this year with our local health jurisdictions.
	• The goal of these collaborations ultimately is to improve health and equity among our members.
	• G. Duran introduced Janice Chin, Manager for the Public Health Division at the City of Berkeley.
	
	Janice Chin, Manager of the Public Health Division, City of Berkeley presented on the City of Berkeley's Population Needs Assessment.
	.
	• The Public Health Division is under the Department of Health, Housing, and Community Services (HHCS).
	• About HHCS:
	  ○ The HHCS Department aims to promote the health of all Berkeley residents by ensuring that they have their basic needs met.
	  ○ Our Vision is for all residents to have affordable housing, a safe community, and the best possible health outcomes.
		None	None

	○ HHCS has 6 divisions: Office of the Director, Public Health, Mental Health, Housing and Community Services, Environmental; Health, and Aging Services. • The City of Berkeley is 1 of the 3 cities in the State of California that has its own local health jurisdiction. • The HHCS reports to the City Manager, the City Manager reports to the City Council, and the City Council reports to the Berkeley residents. • The Public Health Division leads the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP) for the HHCS Department as a whole. • Berkeley Wellness Blueprint: Project Process Map 1. Landscape Scan-already completed, helped inform which areas that need more deep diving in the CHA. 2. The CHA includes informant interviews, focus groups, and surveys. The CHA is focused on areas with more vulnerable populations or communities, and health disparities seen in the landscape scan. 3. Health Improvement Plan:3 to 4 work groups that will be focusing on 3 to 4 health areas of interest identified in the CHA and will dive even deeper to come up with strategies to address the health issues. Performance measures will be identified to help provide a goal in the improvement plant to guide the next 3 to 5 years. Recruiting has started for the workgroups and the goal is to complete the process by May 2025. • Community Steering Committee: helps drive, assess, and synthesize information being compiled, as well as drive the whole process. • The HHCS works with multiple community partners, as well as support from a consulting group called JSI Research and Training Institute. • Intended Outcomes: ○ A clear community-shaped vision of the most pressing health equity issue in Berkeley. ○ A set of impactful and feasible actions to address the identified issues. ○ Established relationships and partnerships to support collective accountability for the actions. ○ Identification of necessary resources to make the desired change. ➢ *Member Question-N. Williams: Where do you get the people that you're assessing? Are you getting elders, children, or is it across the board? How diversified is it?*		

	➢ *Response-J. Chin- We look at diversity as a key factor. For the Community Steering Committee, it was a month-long process to get people who are interested; we put out a recruitment call for it. About 65 individuals applied, and we went through a vetting process to make sure that each neighborhood was represented. We also looked at diversity within race, ethnicity, socioeconomic status, various types of expertise, and lived experience.* ➢ *Member Question-C. Wynn: Are you dabbing into mental health? I don't see mental health anywhere here, and I know from living in and trying to get on my feet in Berkeley, it's not easy.* ➢ *Response-J. Chin: Mental health has always been on our radar as with many communities and local health jurisdictions. This was identified in our landscape scan as a challenge in our community. It is not surprising that it was identified in our health assessment process as well. Our report is not yet finalized but in the next few slides, I will be presenting a brief overview of what was identified in our health assessment.* • Landscape Scan Summary: Overall Berkeley Residents appear to be doing fairly well in terms of health and wellness. However, the data masks ongoing inequities and disparities that were highlighted during the pandemic. o Life expectancy: 16-year difference in life expectancy between the north most census tract I in the Berkeley Hills-Cragmont neighborhood (93 years), and the southernmost census tract in the South Berkeley -Lorin neighborhood (77 years). o Economic environment: poverty rate for children (people under age 18) and among seniors (65 years or older) varies significantly by race. Marginalized groups have been cited by interviewees as experiencing high rates of poverty as well. o Physical environment: some Berkeley neighborhoods-including the Berkeley Marina, Downtown Berkeley, and South Berkeley are considered by Federal Emergency Management Agency (FEMA) to be some of the most at-risk places in the state of California. • Community Health Assessment Process: o Community Steering Committee: provides input regularly on the CHA, as well as how to shape the CHIP. Includes 11 diverse members.		

	○ We do lots of quantitative and qualitative data gathering. The Community Steering Committee takes that and synthesizes, assesses, reflects upon it, and helps is identify priority populations, as well as 10 health, safety, and equity issues to explore. ○ Based on the reflections, community surveys were completed. ○ Survey findings were then looked at and assessed through the Community Steering Committee to narrow down to the 6 key findings. • City of Berkeley Demographic Overview ○ Race/ethnicity: ▪ White: 51.9% ▪ Asian: 20.7% ▪ Hispanic or Latino: 12.1% ▪ Black Two or More Races: 6.6%. ○ Population total: increase in population in 2020, anticipating a dip going into 2025, and projecting rise again in 2030. ○ Educational attainment: the population is fairly educated based on their degrees and level of education. • Key priority areas from the CHA: ○ Housing ○ Community Safety ○ Environmental Health Hazards ○ Health Disparities ○ Mental Health • Next Steps: The CHIP & Beyond ○ The CHA is to be finalized by the end of the month (December 2024). ○ Two key questions that will be investigated in the CHIP ▪ What strategies have the greatest potential to be both impactful and feasible, and address the priorities that emerged from the assessment? ▪ Who can advance the strategies and with what resources? • Our Shared Goal with Managed Care Plans		

	○ Improve access to care for at least one priority population in the City of Berkeley (LGBTQ+), adolescent, older adults, or perinatal residents.		
5. b. NEW BUISINESS – ALLIANCE LOGO AND DSNP NAME FEEDBACK			
M. Lewis K. Rivera	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
5. c. NEW BUISINESS – PROVIDER MANUAL			
C. Gomez M. Lewis	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
5. d. NEW BUISINESS – NON-SPECIALTY MENTAL HEALTH SERVICES			
A. DeRochi	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a Tsunami Warning		
6. a. CAC BUSINESS – CAC SELECTION COMMITTEE			
L. Ayala	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
6. b. CAC BUSINESS – CAC MEMBERSHIP RECRUITMENT			
L. Ayala	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
7. ALLIANCE CARE BAGS			
M. Lewis	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
8. OPEN FORUM			
T. Debose	This agenda item was not covered as the meeting was abruptly ended due to a building evacuation in response to a tsunami warning.		
9. ADJOURNMENT			

M. Woodruff	The meeting was abruptly concluded at 11:02 am due to an emergency. Matthew Woodruff, Chief Executive Officer, instructed the attendees to evacuate the building due to a tsunami warning	None	None

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Service Coordinator Date: 12/30/2024

Approved by: DocuSigned by: CCF246548B8E46B... Date: 09/16/2025 | 4:32 PM PDT

ALAMEDA Alliance FOR HEALTH

16, 202COMMUNITY ADVISORY COMMITTEE (CAC) Special Meeting

Thursday, December 16, 2024, 12:00 PM – 1:30 PM

Committee Members	Role	Present
Natalie Williams	Alliance Member	
Valeria Brabata Gonzalez	Parent of Alliance Member	
Cecelia Wynn	Alliance Member	x
Tandra DeBose	Community Advocate	x
Irene Garcia	Alliance Member	x
Erika Garner	Alliance Member	x
Jody Moore	Parent of Alliance Member	
Sonya Richardson	Alliance Member	
MiMi Le	Alliance Member	x
Mayra Matias Pablo	Parent of Alliance Member	
Amy Sholinbeck	Asthma Coordinator, Alameda County Asthma Start	
Irene Garcia	Alliance Member	x
Roxanne Furr	Alliance Member	
Kerrie Lowe	Social Worker, Alameda County Public Health Department (ACPHD)	x

Other Attendees	Organization	Present
Melodie Shubat	CHME	x
Kathrine Shea	Department of Health Care Services	x
Jesus Verduzco	ACPHD	x
Preston Poon	Department of Health Care Services	x

Alliance Staff Members	Title	Present
Matthew Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Communications & Outreach	x
Alejandro Alvarez	Community Outreach Supervisor	x
Thomas Dinh	Outreach Coordinator	
Linda Ayala	Director, Population Health and Equity	x
Mao Moua	Manager, Cultural and Linguistic Services	x
Steve Le	Outreach Coordinator	x
Isaac Liang	Outreach Coordinator	x
Rosa Carrodus	Disease Management Health Educator	x
Lao Paul Vang	Chief Health Equity Officer	x

Gil Duran	Manager, Population Health and Equity	x
Emily Erhardt	Population Health and Equity Specialist	x
Gabriela Perez-Pablo	Outreach coordinator	
Michelle Stott	Senior Director, Quality Improvement	x
Mara Macabinguil	Interpreter Services Coordinator	x
Katrina Vo	Senior Communications and Content Specialist	x
Misha Chi	Health Education Coordinator	x
Farashta Zainal	Quality Improvement Manager	x
Loc Tran	Manager, Access to Care	
Jorge Rosales	Manager, Case Management	
Anne Margaret Macsiljig	Quality Engagement Coordinator	
Taumaoe Gaoteote	Director, Diversity, Equity, Inclusion	
Donna Carey	Chief Medical Officer	x
Peter Currie	Senior Director of Behavioral Health	x
Yen Ang	Director of Health Equity	
Taumaoe Gaoteote	Director of Diversity, Equity, and Inclusion	
Jessica Jew	Population Health and Equity Specialist	x
Jennifer Karmelich	Director of Quality Assurance	
Monique Rubalcava	Health Education Specialist	x
Stephen Smyth	Director of Compliance and Special Investigations	x
Andrea DeRochi	Behavioral Health Manager	x
Sean Pepper	Compliance Special Investigator	x
Debbie Spray	Manager, IT Governance and Incident Management	x
Yemaya Teague	Senior Analyst of Health Equity	x
Karina Rivera	Senior Manager, Public Affairs and Medica Relations	x
Cecilia Gomez	Senior Manager, Provider Services	x
Oscar Macias	Housing Manager	x
Stephen Smyth	Director of Compliance and Special Investigations	x
Krystaniece Wong	Regulatory Compliance Specialist	x

AGENDA ITEM SPEAKER	DISCUSSION	ACTION	FOLLOW-UP
1. WELCOME AND INTRODUCTION			
T. Debose	T. Debose called the meeting to order at 12:03 pm. Roll call was taken of the CAC members and a quorum was not established.	None	None

	An introduction of staff and visitors was completed.		
2. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF AGENDA			
T. Debose	The CAC was unable to approve the agenda as a quorum was not established at the time of roll call.	None	None
3. a. NEW BUISINESS – ALLIANCE LOGO AND DSNP NAME FEEDBACK			
M. Lewis K. Rivera	Michelle Lewis, Senior Manager of Communications and Outreach introduced the video which presents the proposed new logo for the Alliance and proposed names for the upcoming D-SNP product. • The video was played, and a QR code for a survey was displayed at the end. • The QR code did not work, however, the online survey link worked which could be accessed by the virtual attendees. In-person attendees were asked to complete the paper survey. ❖ *Member Feedback-T. Debose: The shapes were odd. The arch was shaped like a home and the circle encompassed everything. While it looks colorful, the different shapes don't seem to represent people. Maybe do something with the shapes so they mean something. The 4 shapes look weird to me.* ➢ *Response-K. Rivera: Part of it represents diversity of the community, they look like two little people. The pictorial marks and colors represent the different lines of service.* ❖ *Member Feedback-T. Debose: The ball on top of the house is weird. I like the colors.* ➢ *Response-M. Lewis: We will take back to the team these questions about why these shapes were selected.* ❖ *Member Feedback: M. Le: First thing that comes to mind is that service is for everybody. Different backgrounds, races, and ethnicities. Services are for all.* ❖ *Member Feedback- C. Wynn: Are there no more logo choices? I just wish there were more choices.*	None	M. Lewis and K. Rivera to take back to the Alliance team the questions around the new logo-why the shapes were selected.

	➢ *Response-M. Lewis: No, there are no other choices at this time.* ❖ *Member Feedback-T. Debose: As far as the DSNP name, Well+ is trendy, but for most people, they want it to be straightforward, Wellness.* ❖ *Member Feedback-M. Le: + is recognizable, + means better.* • M. Lewis thanked the CAC members for the feedback and acknowledged T. Debose's background in marketing. • The paper surveys were collected by Alliance staff.		
3. b. NEW BUISINESS – PROVIDER MANUAL			
C. Gomez M. Lewis	Cecilia Gomez, Senior Manager of Provider Services, presented on the Alliance Provider Manual. • Current: The Alliance Provider has been available for many years now. It includes important information such as services, benefits, requirements, and contacts for network providers and facilities. • Future: The Alliance will review the Provider Manual with CAC for suggestions or feedback. • Requirements: o Must be reviewed on an annual basis. o Must solicit feedback from contractor committees, including CAC. o Provider Manual was reviewed by the Quality Improvement Health Equity Committee (QIHEC) on 11/15/24. • Plan staff who are Subject Matter Experts (SMEs) are consulted to make sure information is accurate. • Discussion: How can the Alliance improve information that is available in our Provider Manual? ❖ *Member Feedback-T. Debose: The updated version looks really good. The layout is clear and straightforward, nothing to completely change.* • M. Lewis: The provider manual is available online. Similar to the member handbook, we do have a printed version. ➢ *Member Question-T. Debose: Does the 11/15/24 have the most recent changes?*	None	None

	➢ *Response-M. Lewis: Yes* ❖ *Member Comment-T. Debose: You did a great job.* ➢ *Member Question: Will the Care Books be incorporated?* ➢ *Response-M. Lewis: No, they will not be.* ➢ *Response-L. Ayala: But there is a connection, the members get the Care Books, and the Provider Manual goes to the providers. The Provider Manual provides information to providers on health education information like the care books, available to members, as well as immunizations are required, and how to document for billing.*		
3. c. NEW BUISINESS – NON-SPECIALTY MENTAL HEALTH SERVICES			
A. DeRochi	Andrea DeRochi, Behavioral Health Manager presented on Non-Specialty Mental Health Services (NSMHS). • Problem: mental health symptoms are undertreated, which is a problem across the country, but worse in the Medi-Cal population. • Solution: Senate Bill 1019 requires plans to develop and conduct outreach to members and primary care providers regarding covered non-specialty mental health services. • Requirements: o Align with cultural and linguistic appropriateness. o Apply best practices in stigma reduction. o List more than one point of contact for member access. o Involve stakeholder engagement, including the CAC. • Discussion: How can the Alliance encourage more members to use mental health services? ➢ *Member Question: T. Debose: How easy is it to access information and to talk to someone if they have a problem?* ➢ *Response-A. DeRochi: It is very easy to call Member Services. We also have a Behavioral Health team doing referrals. County Behavioral Health is also available. The challenge is capacity, identifying who has appointments available. We have care managers and coordinators. Primary care providers can also refer.* ➢ *Member Question-T. Debose: What happens after the first contact? Do you help them get connected?*	None	None

	➢ *Response-A. DeRochi: We ask them if they want assistance in connecting with a provider. The challenge is that members don't usually call us back after they are connected to care.* ➢ *Member Question-T. Debose: Do you do anything to make sure that the member gets connected because a person with mental health issues may not be as consistent. If you leave it to them, they may not follow through.* ➢ *Response-A. DeRochi: People want different things; some people prefer more help than others.* ➢ *Guest Question-J. Verduzco: Do you have information that we can provide? We will be happy to share.* ➢ *Response-A. DeRochi: We are developing promotional materials right now. We have a large network of mental health providers, largely telehealth. Our goal is to engage more providers to do in-office services.* ➢ *Member Question-K. Lowe: Can you clarify the self-referral process? What happens if they are pending PCP assignment?* ➢ *Response-A. DeRochi: PCP referral is not required, no prior authorization is needed, and there is also no need for PCP assignment. We complete assessments over the phone.* ❖ *Staff Comment- M. Lewis: We have the No Wrong Door messaging to let the members know that there is no wrong door to access mental health services.* • Discussion: Do you think people respond to social media? ❖ *Guest Comment-J. Verduzco: We definitely use social media (at Alameda County Public Health Department (ACPHD), we partner with wellness influencers.* ❖ *Member Comment- E. Garner: I don't follow ACPHD social media, I follow more community-based organizations. We don't usually know unless we ask.* • Discussion: What do you think about QR codes and posters?		

	❖ *Member Feedback- E. Garner: I hate automated systems. It works best when my doctor refers me. I'm not good with the internet, I get frustrated, a phone call is better for me.* ➢ *Member Question-T. Debose: Have you partnered with a sports team to take away stigma from mental health?* ➢ *Response-M. Lewis: No, we have not worked with sports teams, but I know they make public service announcements (PSAs) all the time. In the past, we were contacted by the Warriors for a health fair night, but that was before COVID. We now have digital well-child ads at the DMV.*		
4. a. CAC BUSINESS – CAC SELECTION COMMITTEE			

L. Ayala	Linda Ayala, Director of Population health and Equity provided updates on the CAC Selection Committee (CAC SC).
	• CAC SC: new committee that makes sure that CAC represents our community.
	• 1st meeting was held on 09/30/2024.
	• Kerri Lowe, Alameda County Public Health Department was approved as a new CAC member.
	• CAC SC Guidance: The CAC SC provided guidance on the following CAC member recruitment focus areas:
	  ○ Limited English Proficient (LEP)
	  ○ Men
	  ○ Ages 19-44
		None	None

4. b. CAC BUSINESS – CAC MEMBERSHIP RECRUITMENT			

L. Ayala	Linda Ayala, Director of Population Health and Equity provided updates on CAC Membership Recruitment.
	• The Alliance has connected and presented information about the CAC to the following groups:
	  ○ First 5 Alameda County Fathers Corps:
	  ▪ Father-Friendly Provider Network Members (FFPN) on 11/15/2024.
	  ▪ Healthy Relationships Learning Community (HRLC) on 11/21/2024.
	  ○ Health and Human Resource Education Center (HHREC):
	  ▪ We received interest from the Senior Program Manager.
	  ○ Alameda County Public Health Fatherhood Initiative:
		None	L. Ayala to explore the organizations suggested for recruitment.

	▪ We received interest to support recruitment and connect the Alliance with interests. ➢ *Member Question-E. Garner: How are you outreaching?* ➢ *Response-L. Ayala: It is easier through community organizations. I believe we also put it in the newsletter.* ➢ *Response-M. Moua: Yes, we did. We now have an updated flyer that we can share. Also, we would like to leverage CAC members support and you can refer interests to us.'* ❖ *Guest Comment: I can connect you with Brighter Beginnings, a community-based organization in the Latino community.* ❖ *Member Feedback-C. Wynn: Health and Human Resource Education Center (HHREC) is another good organization to reach out. Black Men Speak came out of it.* ❖ *Staff Feedback-M. Lewis: It would also be good to reach out to Peralta Colleges, it would be good to have their voices as well. We can also potentially explore holding our meetings on weekends as not everyone can attend on weekdays.* ❖ *Member Feedback-E. Garner: It would be good to reach out to Black Infant health as well. They have a connection to the Men's Group.* ❖ *Staff Feedback-M. Lewis: Churches as well.*		
5. ALLIANCE CARE BAGS			

M. Lewis	Michelle Lewis, Senior Manager of Communications and Outreach presented on the Alliance Care Bags.
	
	• This project was started by CAC members, Ms. Mello and Ms. Williams, a small and thoughtful thing that we do as helpers in the community.
	• The Alliance created 5,000 care bags this year. The bags include the following items:
	  ○ socks
	  ○ masks
	  ○ first aid kit
		None	None

	○ hand sanitizer ○ personal hygiene items ○ non-perishable food items. • The bags given to the shelters do not contain non-perishable food items as it causes issues for them. ➢ *Member Question-E. Garner: Why do shelters not like non-perishables?* ➢ *Response-M. Lewis: Community partners usually reach out to us for care bags, but they request no food items as it causes issues, such as rodents when they are storing them.* ➢ *Member Question-E. Garner: Is there an updated shelter list? And does it include family size?* ➢ *Response-M. Lewis: Yes, the county list is updated yearly. Some places do not allow children, and we include that information there. We also recommend calling 211 as they can look for shelter beds.* • 2024 Care Bag Distribution: ○ Alliance CAC members ○ Local Alameda County shelters ○ Local churches ○ Street medicine teams ○ Warming centers ❖ *Staff Comment-A. Alvarez: The Alliance Outreach team gathered in conference rooms to assemble them, 120 minutes total spent.* ❖ *Member Comment-T. Debose: I would like to share some with my church. Staff Response-M. Lewis: Of course, we can get those ready for you.*		
6. OPEN FORUM			
	❖ *Member Comment-M. Le: Thanks for this meeting, we got to finish the items we were not able to cover during the last meeting.*	None	None
7. ADJOURNMENT			

T. Debose	Tandra Debose, CAC Vice Chair adjourned the meeting at 1:20 pm.	None	None

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Service Coordinator Date: 12/31/24

Approved by: DocuSigned by: CCF246548B8E46B... Date: 09/16/2025 | 4:31 PM PDT

ALAMEDA Alliance FOR HEALTH

COMMUNITY ADVISORY COMMITTEE (CAC)

Thursday, March 20, 2025, 10:00 AM – 12:00 PM

Committee Members	Role	Present
Amy Sholinbeck	Asthma Coordinator, Alameda County Asthma Start	
Cecelia Wynn	Alliance Member	x
Erika Garner	Alliance Member	x
Irene Garcia	Alliance Member	x
Jody Moore	Parent of Alliance Member	
Kerrie Lowe	Social Worker, Alameda County Public Health	
Mayra Matias Pablo	Parent of Alliance Member	
MiMi Le	Alliance Member	
Natalie Williams	Alliance Member	x
Roxanne Furr	Alliance Member	
Sonya Richardson	Alliance Member	
Tandra DeBose	Alliance Member	x
Valeria Brabata Gonzalez	Alliance Member	x

Other Attendees	Organization	Present
Bernie Zimmer	CHME	x
Catalina Valderrama	CFMG	x
Jesus Verduzco	Alameda County	x
Melodie Shubat	CHME	x

Alliance Staff Members	Title	Present
Alejandro Alvarez	Community Outreach Supervisor	x
Alma Pena	Senior Manager, Grievance and Appeals	x
Anne Margaret Macsiljig	Quality Engagement Coordinator	
Dana Patterson	Business Analyst, Incentives and Reporting	x
Danube Serri	Senior Legal Analyst	x
Donna Carey	Chief Medical Officer	x
Emily Erhardt	Population Health and Equity Specialist	x
Farashta Zainal	Quality Improvement Manager	x
Gabriela Perez-Pablo	Outreach coordinator	x
Gil Duran	Manager, Population Health and Equity	x
Isaac Liang	Outreach Coordinator	x

Jennifer Karmelich	Director of Quality Assurance	
Jessica Jew	Population Health and Equity Specialist	
Jorge Rosales	Manager, Case Management	
Katrina Vo	Senior Communications and Content Specialist	x
Krystaniece Wong	Regulatory Compliance Specialist	x
Lao Paul Vang	Chief Health Equity Officer	x
Linda Ayala	Director, Population Health and Equity	x
Loc Tran	Manager, Access to Care	x
Mao Moua	Manager, Cultural and Linguistic Services	
Mara Macabinguil	Interpreter Services Coordinator	x
Matthew Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Communications & Outreach	
Michelle Stott	Senior Director, Quality Improvement	x
Misha Chi	Health Education Coordinator	x
Mohammed Abbas	Outreach Coordinator	x
Monique Rubalcava	Health Education Specialist	x
Peter Currie	Senior Director of Behavioral Health	x
Ronnie Wong	Program Manager, Grants and Incentives	x
Rosa Carrodus	Disease Management Health Educator	x
Shatae Jones	Director, Housing and Community Services Program	x
Stephen Smyth	Director of Compliance and Special Investigations	
Steve Le	Outreach Coordinator	x
Taumaoe Gaoteote	Director of Diversity, Equity, and Inclusion	
Thomas Dinh	Outreach Coordinator	x
Yen Ang	Director of Health Equity	

AGENDA ITEM SPEAKER	DISCUSSION	ACTION	FOLLOW-UP
1. WELCOME AND INTRODUCTION			
T. Debose	T. Debose called the meeting to order at 10:04 am. A roll call was taken, and a quorum was not established. An introduction of staff and visitors was completed.	None	None
2. a. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF MINUTES FROM DECEMBER 5, 2024 and DECEMBER 16, 2024 SPECIAL MEETING.			
T. Debose	The committee was unable to vote on the 12/05/2024 and 12/16/2024 meeting minutes approval as quorum was not established.	None	None

2. b. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF AGENDA			
T. Debose	The committee was unable to vote on the 03/20/25 meeting agenda approval as quorum was not established. T. Debose announced moving the CEO Update and Grievance and Appeals Report towards the end of the meeting.	None	None
3. FOLLOW-UP ITEMS			
L. Ayala	• CAC feedback and questions around the design rationale behind the shapes used in the new logo were shared with the Alliance Leadership team. Updated information was sent to CAC members via email on 01/22/2025. • CAC-recommended organizations were added to the Alliance CAC recruitment efforts. ○ Health and Human Resource Education Center (HHREC)-a candidate has been identified from the organization and an application was received. .	None	None
4. NEW BUINESS – COMMUNITY SSUPPORTS AND HOUSING			

S. Jones	S. Jones presented an overview of the housing landscape in Alameda County.
	• Housing and Social Determinants of Health (SDOH): social, economic, and environmental factors strongly affect health and well-being.
	• A video on SDOH was presented.
	• California Healthy Places Index: Alameda County is generally considered a very healthy place to reside and ranked in the 94th percentile.
	• City-level data reveals disparities in health rankings tied to SDOH, such as neighborhood conditions, transportation, and education.
	• Alameda County Point-in-time (PIT) Results 2025: mandatory census on people experiencing homelessness on a one-night basis.
	  ○ Single adult males are more likely to experience unsheltered homelessness.
	  ○ Senior individuals are the fastest growing population.
	  ○ Asian Americans are more likely to experience sheltered homelessness.
	  ○ African Americans are more likely to experience unsheltered homelessness.
	  ○ Self-reported disability prevalence in the population experiencing homelessness.
			Alliance staff to send information on Continuum of Care (COC) to CAC members—How to become a voting member.

	• Housing First Model: approach that prioritizes providing stable housing without preconditions such as sobriety and employment.
	• Permanent Supportive Housing (PSH): approach that combines affordable housing, targeted interventions, case management, and referral long-term resources.
	
	Medi-Cal Funded Housing Support: CalAIM benefits are referred to as the Housing Bundle here at the Alliance.
	• CalAIM: multiyear delivery system, intentionally combining social supports with clinical care to support members in a whole-person care model.
	• Fifteen Community Supports (CS) programs at the Alliance, and the Housing Department oversees 4:
	  ○ Housing Deposits: assist with identifying, security, or funding one-time services.
	  ○ Housing Tenancy Sustaining Services: provide tenancy and sustaining services.
	  ○ Housing Transition and Navigation Services: assist members with obtaining and securing housing.
	  ○ Transitional Rent: coming soon
	• Different qualifications for each CS program, but all require medical necessity, and some require prior enrollment in housing navigation.
	• Limits to how long one can receive the services varies.
	• Housing CS Provider: The Alliance is only contracted with Alameda County (AC) Health—serves as administrator, and subcontracts with 23+ housing CS service providers.
	• Members can access housing support through Alameda County Coordinated Entry.
	  ○ Members may call 211 OR
	  ○ Member presents at a Housing Resource Center
	• When a member presents at Housing Resource Center:
	  1. Housing problem solving assessment: connects members to resources upfront.
	  2. If issue/s cannot be resolved in the problem-solving phase, the member will enter the Coordinated Entry system through a screening and assessment. Based on the member responses, members will be prioritized on a waitlist and linked to appropriate resources.
	• Depending on availability, members may be referred to:
	  ○ Interim Housing
	  ○ Permanent Supportive Housing
	  ○ Private Market Housing		

	• Authorization Process 1. AC Health submits an authorization request to the Alliance Housing and Community Supports Department (HCSD). 2. Alliance HCSD reviews authorization and corresponding justification/documentation. 3. Determination is made. 4. Notification is sent to the member, referring provider, rendering provider, and PCP. The Housing team participates in the following: • Alameda County Leadership Board • Alameda County Racial Equity Committee • Alameda County Homeless Management Information System Committee • Alameda County Taskforce for 2030 Home Together Plan • Corporation for Supportive Housing Advisory Workgroups • A Housing staff is the VP of National Association of Housing • Active Alameda County Point-In-Time Count (PIT) programing and planning teams Meet the Housing Team: • Shatae Jones, LCSW: Director of Housing and Community Services • Adrienne Milles, MCP: Housing Coordinator • Michelle Pham, BA: Housing Coordinator • Oscar Macias, MPA: Program Manager S. Jones presented a list of resources which contain information from Coordinated Entry Program, California Health Care Foundation & Corporation Supportive Housing (CSH), Medi-Cal Academy for Homeless Service Providers, and Department of Healthcare Services. ➢ Member Question-T.Debose: Commented that the 94th percentile for Alameda County looked wonderful, but when it changed to 17th percentile for Oakland, it seemed more reasonable. She asked what impact the Alliance is making and how might the Alliance work with the Cit of Oakland. Certain areas of the city are cut off because of debris, and efforts are not making a difference to make the city healthier. She asked what can we do as CAC to affect that. ➢ Response-S.Jones: Responded that the built environment and social determinants of health are important to understand. Some of the “why” of		

	homelessness was designed that way. The audio book called the Color of Law discusses the structural racism in the way built environments are. Different areas of Oakland, above and below 580, were resourced differently. The CAC can use their voices. There are public meetings with your Board of Governors and Board of Supervisors, COC, and the housing development meetings that are open to the public around new affordable housing developments and wanting to hear community feedback. The leadership at the Alliance is dedicated to making sure that the Alliance resources are allocated throughout the county in a meaningful way. She recommended inviting Danny to talk about how we have invested as a community to lift those disparities that you have shared with us. The Alliance got the bundle out to the community as quickly as possible and is now serving both top and the bottom of the corridor. The Alliance also needs to show in our data how targeted intervention strategies that contributed to someone's health getting better. We want to share information on how you can get involved in community activities that impact Alameda County. ➢ Member Question-T.Debose: Asked how the funding supports employment so they can keep their housing. You can give someone first and last month's rent, however, if you can't maintain it, you end up in the streets again. ➢ Response-S.Jones: Anyone who is linked to a coordinated entry resource is also linked to permanent supportive housing model or maybe even transitional housing like rapid rehousing. The good news is that those resources are subsidized, to maintain the unit, it's 30% of their income which can be from Social Security or employment. ➢ Member Question-N Williams: Asked what permanent housing is available for elders or senior citizens. How long would it take for a homeless person to receive housing benefits? ➢ Response-S.Jones: Responded that nationally, it takes about 9 to 24 months. Now, that can change as we've seen with Covid. It depends on the resources available in each county. ➢ Member Question-N Williams: *If it takes 9 to 24 months, are these individuals provided with temporary housing or are they prioritized in any kind of way?* ➢ Response-S.Jones: Responded "yes, in some cases, but it is very individual. For example, if you presented at a coordinated entry location,		

	and you made a personal decision of going into a shelter opportunity before permanent supportive housing opportunity, that could be available. But again, as we know, homelessness is not a people issue, it is literally a production of housing issue and there's not nearly enough affordable housing or housing resources in the community.		
5. CEO UPDATE– CEO Report			
M. Woodruff	M. Woodruff presented the following updates: Homelessness • The Alliance has 15,000 homeless members currently. • Only about 2,000 out of the 15,000 are enrolled in ECM, which is now at full capacity. ➢ Member Question-T.Debose: Asked if members coming from other states. ➢ Response-M. Woodruff responded that although he didn't know the answer to that question, he has seen in the news. What we do know is that the street teams in Alameda County are seeing the same people for many years ,and understand their needs. ❖ Member Comment-T.Debose: Yes, but some people have been homeless for over five years or more. ➢ Response-M. Woodruff: When speaking to a Street team medical director, they have been treating some of the same couples and people for 15 to 20 years. ❖ *Member Comment-N. Williams:,* Some people can't even live in the house now, they've been outside so they can't function inside. CEO Report • Financials o January financials are not as good as hoped for but is due to reasons that are very different than what we've been going through. o Longterm care and operations cost came down. In-patient hospital went flat. o Main reason for loss is $8 Million in potential fraud payments. • D-SNP o Getting ready for Medicare: multiple work plans and work streams, second provider town hall next month.	None	None

	○ A decision was made to start small with Medicare so not going to actively recruit for the first 6 to 9 month, will instead work with a couple of community partners to start with. ○ Medicare has rules and requirements that are different from Medi-Cal, so the goal is to make sure that we set that up to put us in a good path. ▪ Coding: if the provider does not enter the member's diagnoses at least once a year into the member's chart, we get less money. ▪ Stars program (Medicare's quality program): involves members rating their providers. • DHCS and DMHC Audit ○ Dual audit during the first 2 weeks of March 2025. ○ DHCS audit happens yearly, findings will likely be 3 or 4. ○ DMHC audit happens every 3 years, findings will likely be around 20 due to a longer look-back period. • Potential Changes to Medi-Cal Program ○ Disenrollments: after 07/01/25, all protections in place under Covid will be discontinued. ▪ Asses test returns. ▪ Reenrollment on anniversary month, no longer automatic. ▪ People enrolled in CalFresh or SNAP are no longer automatically enrolled to Medi-Cal. ○ Projection of 12,000 to 13,000 disenrollments. ○ Ninety-day protection stays in place. ○ Potential funding changes: the state has taken $6 Billion loan from the general fund to keep what's current in Medi-Cal going. ○ The federal government might take action towards the undocumented population whether making it illegal to give them coverage or other forms of backlash. ○ In Alameda County, 80,000 undocumented people would have to go back to HealthPAC (county program). Providers are Community Health Center Network (CHCN) or Alameda Health System (AHS). ○ Result will be a $700 Million revenue loss to the Alliance. • Community Supports ○ Centers for Medicare and Medicaid Services (CMS) retroactively took back the guidance on community supports. ○ Community Supports stays as it is, nothing is going away.		

	○ The federal government stated that they will make it harder for any social determinants of health programs to be funded in the future. ○ The Alliance's waiver ends on 12/31/2026, so the new waiver will be in 2027 if we get a new one. ○ Enhanced Care Management (ECM) stays even though it's under the CalAIM umbrella, but still waiting to see what happens with transitional rent due to potential lack of funding. ➢ *Attendee Question-B. Zimmer, CHME: Asked what happens to those 80,000 members if they lose Medi-Cal, and if they go to HealthPAC. They are utilizing equipment from CHME. How is the continuity of care extended if they move?* ➢ *Response-M. Woodruff: I don't know what's covered in HealthPAC. HealthPAC never went away, it was kept intact, although they only now have 2,200 lives, whereas it used to be up to 130,000 lives. The hope is that Alameda County can keep funding the HealthPAC, but what we fund right now is much higher under Medicaid than what the county can afford under HealthPAC. I don't know if they cover DME. We're going to lose 12,000 to 13,000 members next fiscal year, so we're essentially doing a side-by-side budget of what happens if the undocumented members go back to HealthPAC, so they're no longer covered by us. Those are obviously going to be very big changes to our budgets, and for the community supports, if these go away in 2027. Are there any programs that we could keep? Could we go out and get grants? So that's the conversation that I started having with the county.* ➢ *Member Question-V. Gonzalez: For people that are in the process of seeking asylum, are they considered undocumented? Who's considered documented and who's considered undocumented?* ➢ *Response-M. Woodruff: I'm not sure how to answer that right now. I'd have to exactly see what the Medi-Cal definition is of undocumented, but I'm assuming it's anybody not born in the United States that doesn't have legal residency.* ❖ *Member Comment-N. Williams: It's very sad there's such a big gap in the undocumented member's healthcare and disparities, as well as the homeless. Then you have all these facets of the homeless. There's the mentally ill, elderly, and families. You have to approach these all at once.*		

	➢ *Member Question-V. Gonzalez: Do they have the capacity to take people back under HealthPAC?* ➢ *Response-M. Woodruff: When those 80,000 lives came into Medi-Cal they did not just have AHS or CHCN anymore, they could go to anyone in our provider network. With HealthPAC they will be limited back to those two. I'm sure we could get the data, but I don't know how many people left those two networks and how many stayed.* ❖ *Member Comment-C. Wynn: Mr. Matthew, I want to thank you for this report that you've done diligently this morning for us. What I'm going to do on my next appointment is to make sure my new doctor has all my diagnoses entered, so that the funding can keep coming. Since they finally stopped deporting my doctors. One year, I got a doctor that got deported. Second year, I got another doctor who also got deported. I have a doctor for 3 years now, and so I'll make sure my information is well updated, to turn it over to where it needs to go to keep the money coming. I'm not speaking much today because I'm very proud of the work we're doing around here lately.*		
6. ALLIANCE REPORTS – GRIEVANCE AND APPEALS 2024			

A. Pena	A. Pena presented on the 2024 Grievance and Appeals Report.
	
	Medi-Cal
	• Number of grievance cases:
	  ○ Standard Grievance: 17,114
	  ○ Expedited Grievances: 30
	  ○ Exempt Grievance: 23,557
	  ○ Standard Appeal: 478
	  ○ Expedited Appeal: 12
	  ○ Total cases: 41,191
	• All cases have been resolved within compliance timeframes.
	• 7.56 complaints per 1,000 members (goal: 1 per complaint per 1000 members
	• 32,276 unique grievance cases; 40,701 total grievance cases including all shadow cases
	• Grievances related to quality of care were forwarded to the Quality Improvement Department as Potential Quality Issue (PQI).
	• Grievances related to discrimination, fraud, waste, and abuse were forwarded to the Compliance Department for further investigation.
		None	None

	• Grievances against delegates/vendors have been reported during quarterly joint operation meetings with each entity.
	• Overturn rate: 22% (goal: 25% or below)
	• Number of grievance cases by type:
	  ○ Access to Care: 17,850
	  ○ Coverage Dispute: 4,342
	  ○ Other: 6,799
	  ○ Quality of Care: 944
	  ○ Quality of Service: 10,701
	  ○ Total cases: 40,701
	• Grievances filed against delegates/vendors:
	  ○ Delegates: 412
	  ○ Vendors: 2,048
	  ○ Total cases: 2,460
	
	In-Home Support Services (IHSS)
	• Standard Grievance: 258
	• Expedited Grievances: 0
	• Exempt Grievance: 150
	• Standard Appeal: 21
	• Expedited Appeal: 0
	• 2024 Total cases: 429
	• 20.1 complaints per 1,000 members (goal: 1 per complaint per 1000 members).
	• 349 unique grievance cases; 408 total grievance cases including all shadow cases
	• Grievances related to quality of care were forwarded to the Quality Improvement Department as Potential Quality Issue (PQI).
	• Grievances related to discrimination, fraud, waste, and abuse were forwarded to the Compliance Department for further investigation.
	• Grievances against delegates/vendors have been reported during quarterly joint operation meetings with each entity.
	• Overturn rate: 28.5% (goal: 25% or below)
	• Number of grievance cases by type:
	  ○ Access to Care: 174
	  ○ Coverage Dispute: 93
	  ○ Other: 23
	  ○ Quality of Care: 16
	  ○ Quality of Service: 102		

	○ Total cases: 408 • Grievances filed against delegates/vendors: ○ Delegates: 10 ○ Vendors: 9 ○ Total cases: 19 Top 3 categories of grievances filed against the plan: • Access to Care: 58 • Quality of Services: 43 • Coverage Disputes: 29 ➢ *Member Question-T. Debose: Do you compare number of complaints or grievances between quarters?* ➢ *Response-A.Pena: Yes, the Alliance reports quarterly to internal committees and tracks quarterly all the incoming grievances and appeals.* ➢ *Member Question-T. Debose: So, do you feel like 4th quarter is more versus summertime when people are more happy?* ➢ *Response-A.Pena: Yes, I'd like to think so, right? There was a jump in the 4th quarter and next year when we see the 1st quarter of this year, you'll see a jump also there. There was a jump due to the transition into the Alliance. Usually, we see that 4th quarter is a little lower because people are vacationing or going on holidays, but most of the time, it is the 1st quarter and last year, we did see a little spike because of the transition.* ❖ *CEO Comment-M. Woodruff: Our phone calls usually go down in May through August and then pick up when kids go back to school and needing to get to appointments. You see an uptick August through March and then it drops.*		
7. a. CAC BUSINESS – CAC CHARTER			
L. Ayala	L. Ayala reminded CAC members that the meeting packet includes a tracked version of the charter. Brief description of changes: • Under Policy/Scope, ○ Added "hard-to-reach populations". ○ Expanded on CAC duties to include review of the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) and Non-Specialty Mental Health Services Outreach (NSMHS) and Education Plan.	None	CAC Planning Team to move voting on the CAC Charter approval to the next meeting.

	○ Removed review of population needs Assessment (PNA) findings from CAC duties. • Under Officer of the CAC: ○ Updated voting process. The committee was unable to vote on the charter approval as a quorum was not established.		
7. b. CAC BUISNESS – CAC CHAIR NOMINATIONS AND VOTING			
L. Ayala	L. Ayala thanked Tandra Debose for chairing the meetings as the CAC Chair position is currently vacant. L. Ayala discussed the roles and responsibilities. • CAC Chair Roles and Responsibilities: ○ Collaborate with the CAC Planning team to develop meting agendas. ○ Lead and facilitate CAC meetings. ○ Ensure meeting follows Robert's Rules of Order and ground rules. ○ Start the meeting and review the agenda with CAC members. ○ Guide discussion on agenda topics. ○ Set aside off-topic issues for future discussion (Parking Lot). ○ Decide whether to extend discussions on the topics that go into overtime. ○ Encourage all members to participate in discussions. ○ Involve all CAC members in the decision-making process. • CAC Chair Selection Process ○ Inform members of Chair elections. ○ Request nominations (self-nomination are welcome). ○ Nominees share brief statement on their interest. ○ Motion and roll call to vote. ○ Alliance staff record votes and announce selection during the meeting. ➢ *Member Question-N. Williams: To which email address do we send our nominations to?* ➢ *Response-L.Ayala: We will actually do the nomination at the meeting, in this public forum. So, you'll be able to verbally make that nomination.* The committee was unable to nominate and vote for a new chair as a quorum was not established.	None	CAC Planning Team to move the CAC Chair Nominations and Voting to the next meeting.

7. c. CONFIDENTIALITY STATEMENT UPDATES			
M. Chi	M. Chi requested that the members sign the yearly confidentiality statement and submit it to her at the end of the meeting. M. Chi also informed members attending virtually via Teams, that she had sent them a packet containing the document with a return envelope.	None	None
8. OPEN FORUM			
T. Debose	• L. Ayala announced that the Alameda County Behavioral Health Department is going through a planning proceed that helps them determine where funding goes, to ensure that they are dedicating funding to types of services needed by Alameda County residents. Misha Chi will send an email with the survey link to the CAC members after the meeting. There will be a $25 gift card raffle for people who participate. • T. Debose asked if it would be possible for an email to be sent to CAC members with the dates of the next 2 to 3 meetings. • N. Williams requested that the Initial Health Assessment be added as a topic in a future meeting.	None	M. Chi to send an email with the Alameda County SH Department survey link to CAC members. CAC Planning Team to send an email to CAC members with the dates of the next 2-3 meetings. CAC Planning Team to add the Initial Health Assessment as a topic in a future meeting.
9. ADJOURNMENT			
T. Debose	T. Debose announced that the next CAC meeting is on 06/12/2025. T. Debose adjourned the meeting at 11:43 am.	None	None

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Service Coordinator Date: 4/16/2025

Approved by: Docusigned by: CCF246548B8E46B... Date: 09/16/2025 | 4:30 PM PDT

ALAMEDA Alliance FOR HEALTH

COMMUNITY ADVISORY COMMITTEE (CAC)

Thursday, June 12, 2025, 10:00 AM – 12:00 PM

Committee Members	Role	Present
Amy Sholinbeck	Asthma Coordinator, Alameda County Asthma Start	
Cecelia Wynn	Alliance Member	x
Erika Garner	Alliance Member	x
Irene Garcia	Alliance Member	x
Jody Moore	Parent of Alliance Member	
Kerrie Lowe	Social Worker, Alameda County Public Health	
Mayra Matias Pablo	Parent of Alliance Member	
MiMi Le	Alliance Member	x
Natalie Williams	Alliance Member	x
Roxanne Furr	Alliance Member	
Sonya Richardson	Alliance Member	
Tandra DeBose	Alliance Member	x
Valeria Brabata Gonzalez	Alliance Member	

Other Attendees	Organization	Present
Bernie Zimmer	CHME	x
Donna Leonard-Pagau	Alliance Member	x
Keith Pageau	Alliance Member	x
Marilen Biding	Alameda County Public Health	x
Melodie Shubat	CHME	x
Omoniyi Omotoso	Native American Health Center	x
Sharon Wright	UCSF	x
Alan Oiwa	CHME	x

Alliance Staff Members	Title	Present
Alejandro Alvarez	Community Outreach Supervisor	x
Alma Pena	Senior Manager, Grievance and Appeals	
Anne Margaret Macsiljig	Quality Engagement Coordinator	
Catherine Knezevic	Health Plan Privacy and Privacy Operations Manager	x
Dana Patterson	Business Analyst, Incentives and Reporting	x
Danube Serri	Senior Legal Analyst	x
Donna Carey	Chief Medical Officer	

Emily Erhardt	Population Health and Equity Specialist	x
Farashta Zainal	Quality Improvement Manager	x
Gabriela Perez-Pablo	Outreach coordinator	x
Gil Duran	Manager, Population Health and Equity	x
Isaac Liang	Outreach Coordinator	x
Jennifer Karmelich	Director of Quality Assurance	
Jessica Jew	Population Health and Equity Specialist	x
Jorge Rosales	Manager, Case Management	
Joyce Wong	Strategic Account Representative	x
Katrina Vo	Senior Communications and Content Specialist	x
Krystaniece Wong	Regulatory Compliance Specialist	x
Lao Paul Vang	Chief Health Equity Officer	x
Linda Ayala	Director, Population Health and Equity	x
Loc Tran	Manager, Access to Care	x
Mao Moua	Manager, Cultural and Linguistic Services	x
Mara Macabinguil	Interpreter Services Coordinator	x
Matthew Woodruff	Chief Executive Officer	x
Michelle Lewis	Senior Manager, Communications & Outreach	x
Michelle Stott	Senior Director, Quality Improvement	x
Misha Chi	Health Education Coordinator	x
Mohammed Abbas	Outreach Coordinator	
Monique Rubalcava	Health Education Specialist	x
Oscar Macias	Housing Program Manager	x
Peter Currie	Senior Director of Behavioral Health	
Ronnie Wong	Program Manager, Grants and Incentives	x
Rosa Carrodus	Disease Management Health Educator	x
Schuyler Hall	Communications Initiative Specialist	x
Shatae Jones	Director, Housing and Community Services Program	x
Stephen Smyth	Director of Compliance and Special Investigations	x
Steve Le	Outreach Coordinator	
Taumaoe Gaoteote	Director of Diversity, Equity, and Inclusion	
Thomas Dinh	Outreach Coordinator	x
Yen Ang	Director of Health Equity	x

AGENDA ITEM SPEAKER	DISCUSSION	ACTION	FOLLOW-UP
1. WELCOME AND INTRODUCTIONS			

T. Debose	T. Debose called the meeting to order at 10:03 am. A roll call was taken, and a quorum was not established. An introduction of staff and visitors was completed.	None	None
2. a. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF MINUTES FROM DECEMBER 5, 2024, December 16, 2024, and March 20, 2025.			
T. Debose	The committee was unable to vote on the December 5, 2024, December 16, 2024, and March 20, 2025 meeting minutes approval as quorum was not established.	None	None
2. b. APPROVAL OF MINUTES AND AGENDA – APPROVAL OF AGENDA			
T. Debose	The committee was unable to vote on the June 12, 2025 meeting agenda approval as quorum was not established.	None	None
3. CEO UPDATE – CEO Report			

M. Woodruff	Matthew Woodruff, Chief Executive Officer (CEO), presented on the Alliance Updates.
	
	• Financials
	  ○ Four (4) consecutive months of positive net income.
	• Key Performance Indicators
	  ○ The Grievance and Appeals Team (G&A) missed the expedited case criteria for grievances, 83% (5 out of 6 were compliant), and 75% (3 out of 4 were compliant). The criteria is that these cases be resolved in 3 calendar days. Non-compliance with these 2 metrics is attributed to the G&A team's current staffing shortages.
	• Medicare
	  ○ An update will be given during the July 2025 Board meeting.
	
	Summary of Medicaid Related Provisions in the Federal Reconciliation Package and California's May Revise (Budget)
	
	• Major Provisions in the House Reconciliation Bill
	  ○ Citizenship/Immigration Status
	  ▪ Removes 90-day period in which states can enroll individuals and receive Federal Financial Participation (FFP) while verifying immigration status. Effective: December 31, 2026.
	  ○ Federal Medical Assistance Percentage (FMAP) Penalty
		None	Alliance to confirm current address requirements for Medi-Cal members.
			
			Alliance staff to get information on availability of GLP-1 drugs for diabetic members.

	▪ Reduces federal match by 10% (equivalent to $4.4 billion) for expansion states that provide Medicaid coverage for undocumented individuals. Effective: October 1, 2027. ○ Work Requirements/Community Engagement ▪ Eighty (80) hours per month for 19-64 age group (without dependents), with exemption for medically frail as defined by the state. Effective: December 31, 2025. ○ Supplemental Payments ▪ Limits new State-Directed Payments (SDPs) for services provided to 100% of Medicare rates (for expansion states). ○ Redeterminations ▪ Requires determinations for adult expansion population (19-64) every 6 months. Effective: December 31, 2026. ○ Gender Services ▪ No federal match for gender transition procedures for children and adults. Effective: Upon enactment. ○ Assets ▪ $1 Million ceiling permissible home equity values for Long-Term Support Services (LTSS) eligibility. Effective: January 1, 2028. ○ Retroactive Coverage ▪ Restricted to 1 month (currently 3 months) before application. Effective: December 31, 2026. ○ Cost Sharing or Expansion Adults ▪ Cost sharing for adults over 100% Federal Poverty Levels (FPL). Effective October 1, 2028. Max $35 copay/service. ▪ No cost share for primary, prenatal, pediatric, or emergency room care services. ○ Beneficiary Addresses ▪ Requires states to obtain correct addresses. Effective: October 1, 2029. ▪ Requires states to submit Social Security Numbers. Effective: October 1, 2029. ❖ *Guest Comment-D. Leonard-Pageau: That's already happening because I did not have an address when I was homeless, so I used a P.O. box to be able to continue my coverage, however, I was told that I could not use a P.O. box. As a result, I lost coverage for a few months and had to reapply*		

	once I finally got an address. You can use building or institution addresses, but not a P.O. box. ➢ *Response-M. Woodruff: I will ask Social Services as I have not heard that before. Thank you.* Reconciliation Bill and Impacts to California • Up to 400,000 Californians in expansion population could lose their coverage due to the redetermination provisions (every 6 months). • Social Services agencies in counties are losing positions due to shrinking budget, meanwhile, the work will double. • FMAP penalty for covering undocumented population could lead to $4.4 billion loss. Revised Budget and Shortfall • The state borrowed $7 billion to get through the fiscal year. Medi-Cal Budget Proposals • Undocumented population enrollment freeze for full-scope Medi-Cal for adults, staring January 1, 2026. • The Alliance continues to see a small growth in enrollment of undocumented members, however, other counties are already seeing a decrease. • Elimination of Prospective Payment System (PPS) rates in 2026-2027 which will cause reduction on funding for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics. • Increase in the Medical Loss Ratio (MLR) for Managed Care Organizations to 90% (from current 85%), beginning January 1, 2026. • Provider Supplemental Payments ▪ Elimination of Prop 56 payments for dental, family planning, and women's health providers. ▪ Elimination of Workforce and Quality Incentive Program (Skilled Nursing Facility). • Governor moved Managed Care Organization (MCO) tax dollars to offset Medi-Cal budget (lawsuit). 100% was supposed to go to providers, but the governor is putting portions of it back to the general fund. ➢ *Staff Question-L. Ayala: Matt, can you explain the MCO tax dollars?* ➢ *Response-M. Woodruff: For medical health plans, we essentially are taxed on a per member per month basis and we pay it quarterly. It is*		

	almost like a free loan where we pay a tax and then the state and federal pay us back the same amount of money. When Prop 35 passed in November, it basically says that all of the money must go to providers, but the governor has decided to take some of the money to move to the general fund.
	
	• Other Medi-Cal Cuts-all effective in 2027
	  ○ Reinstating Medi-Cal asset limits.
	  ○ Elimination of acupuncture as an optional benefit.
	  ○ Implementation of prior authorization requirements for hospice benefits.
	  ○ Limiting payments to Program of All-Inclusive Care for the Elderly (PACE) providers.
	
	• Cal AIM
	  ○ California continues to fund Enhanced Care management (ECM) and Community Supports with an estimated $2.4 billion in expenses.
	  ○ $200 million from Prop 35 to support Flexible Housing Rental Assistance and Housing Supports over 2 years. The Alliance has started to work with Alameda County and has had 2 meetings so far. Realistically, 80% of the work will be done by Alameda County and 20% by the Alliance.
	• Pharmacy Budget Proposals
	  ○ A key change is the elimination of pharmacy coverage for COVID-19 tests (out-of-network). Once enacted, tests will still be a benefit but can only be ordered by in-network providers.
	  ○ Other drugs may no longer be covered.
	
	➢ *Guest Question-D. Leonard-Pageau: Regarding the elimination of weight loss drugs, those same drugs are used to treat diabetes, so will it still be available for diabetics? Many are using these drugs for weight loss, so we have experienced shortages.*
	➢ *Response-M. Woodruff: I do not know the answer to that as it does not go through us, but we have a pharmacist on our board, and I am hoping to get answers from him at our board meeting.*
	
	• In-Home Support Services (IHSS) Budget Proposals
	  ○ Elimination of IHSS benefits for undocumented population.		

	○ Change from 60 to 70-hour cap on IHSS provider overtime and travel, to only 50 hours beginning 2025-2026. ➢ *Member Question-E. Garner: I have people ask me questions. One is [someone] takes psychiatric meds, which she now has to pay for. I also have a person come up to me asking about his daughter as he does not have Alameda Alliance any longer. Are you cutting coverage from kids?* ➢ *Response-M. Woodruff: As far as the question regarding medications, that does not go through us, it goes through the state. But so far, the way all the rules are written, children are not affected by any of these cuts. It's only adults aged 19 and above.* • Legislatures Budget Version ○ Modifies Medi-Cal enrollment freeze proposal, applying to undocumented immigration status (UIS) 19 years and older, beginning January 1, 2026, and established a 6-month reenrollment grace period. ○ Modifies $100 Medi-Cal premiums for UIS population by lowering to $30 per month, limits to those aged 19-59, and postpones to January 1, 2027. ○ Delays elimination of dental benefits for UIS population until January 1, 2027. ○ Restores the Medi-Cal Asset limit to $130K for an individual and $195K for a couple. ○ Delays Prop 56 supplemental payments for dental until July 1, 2027 and rejects Prop 56 supplemental payments for family planning and women's health. ○ Delays proposed $1.1 billion cuts to Health Centers and Rural Clinics until July 1, 2027. ○ Approves Governor's MCO tax proposal. ○ Rejects proposal to eliminate Long-Term Care (LTC) and IHSS for UIS adults. ○ Rejects proposal to eliminate acupuncture benefit. ○ Approves Governor's proposal to eliminate the Workforce and Quality Incentive Program for skilled nursing facilities (SNFs). ○ Proposed the development of a large employer contribution requirement for employers with employees enrolled in Medi-Cal. • What Happens Next? ○ The Governor has to sign by June 15, 2025.		

	○ Depending on the final federal budget, a special session of the legislature will be called, to redo whatever needs to be redone to be in compliance with the federal budget. There might be changes across the board depending on how everything works out with the state, as well as on the federal side. ➢ *Member Question-T. Debose: Have we always been giving medical coverage to undocumented people?* ➢ *Response-M. Woodruff: No. It started in 2022 with children (under 19), then 64 and older in 2023, and then everybody in 2024. It has only been 1 full year since we covered undocumented members in all ages. Prior to that, it was the county's responsibility to provide medical coverage via the HealthPAC Program.* ➢ *Member Question-T. Debose: When you started, you talked about their status and need to be verified. Is there a time limit that they have to submit documents for verification?* ➢ *Response-M. Woodruff: It's not us, it is Alameda County that needs to verify all that information. And the answer is that we can't start claiming and they don't get care until everything is verified. There used to be a 90-day grace period, but that's gone starting in 2027.* ➢ *Member Question-K. Pageau: Regarding IHSS, does the reduction to 50-hour cap apply to the end-user or the employee?* ➢ *Response-M. Woodruff: It applies to the employee that is working, the IHSS provider.* ❖ *Guest Comment-D. Leonard-Pageau: A live-in caregiver averages about 100 hours per week, but they're only paid for 70 hours, and now it will go down to 50 hours.* L. Ayala acknowledged the presence of the Medicare team who briefly joined the meeting.		
4. FOLLOW-UP ITEMS			
M. Moua	Mao Moua, Manager of Cultural and Linguistic Services, presented updates on the follow-items from March 03, 2025. • Information on additional Housing and Community Supports resources was sent to CAC members via email on 03/20/2025.	None	None
5. a. NEW BUSINESS – FAITH-BASED COMMUNITY ENGAGEMENT			

Y. Ang	Yen Ang, Health Equity Director, presented on faith-based on community engagement.
	
	• Y. Ang started by presenting the mission and vision of the Health Equity Department.
	• Health Equity Road Map: 6 Milestones
	  ○ Organization
	  ○ Data Driven
	  ○ Education
	  ○ Communication
	  ○ Community Engagement
	  ○ Social Determinants of Health
	• Adapting the Co-Design Model which is evidence-based and has shown to be effective in eliciting participation from a group setting.
	• Co-Design-Partners
	  ○ Community-Based Organizations (CBOs)
	  ○ Safety Network
	  ○ Members
	• Co-Design Model is a ground-up approach, instead of a top-down approach.
	• The partners engage in activities wherein they collaborate and come up with collective solutions to remove Social Determinants of Health (SDOHs).
	• Faith Based Organizations (FBOs) include churches, mosques, temples, or any faith systems that people practice.
	• Why engage FBOs?
	  ○ Trusted body and support system
	  ○ Safe space
	  ○ Sensitive topic or taboo
	• Three (3) critical rules in identifying the FBOs to approach:
	  ○ Does the FBO have members that are high-risk or experiencing health disparities?
	  ○ Do we have a relationship with the FBO? Existing relationship is very helpful as an entry way to start a conversation.
	  ○ Do we have funding to support the work?
	• Y. Ang encouraged the meeting attendees to reach out to her or the Alliance if they know of any FBOs that may be receptive to partner with the Alliance on health education or intervention.
		None	Alliance staff to share CAC Member Ceceilia Wynn's contact information to Dr. Yen Ang, to connect regarding outreach to Allen Temple, Oakland.

	❖ *Member Comment-C. Wynn: I know that there are Alliance members that are also members of the Allen Temple. If you need a liaison to reach out to the pastors there, I don't mind doing something like that.* ➢ *Member Question-T. Debose: How do we send you a list of FBOs?* ➢ *Response-Y. Ang: You should have my email on the packet, so please feel free to send me an email directly.* ❖ *Member Comment-T. Debose: We can also write them down on our feedback forms.* ❖ *Guest Feedback-D. Leonard-Pageau: We just had a health screening for kidney disease and diabetes at the senior center in Berkeley. Senior centers are willing to open up for these screenings and they have big spaces, whereas some FBOs may not have the space. There are many people like me who are 65 or older who do not talk to other people who we feel do not understand us, because we all can't move fast, but we will talk to other people our age in the community. Rooms are more comfortable when they are slower, you don't worry about being knocked over. The aging population needs a much slower space; a much better explained program and you can do that with the help of senior centers because they know how to work with older people.*		
5. b. NEW BUSINESS – MEMBER SATISFACTION SURVEY			

L. Tran	Loc Tran, Access to Care Manager, presented on the Member Satisfaction Survey: Q1 2024-Q4 2024 CG-CAHPS.
	
	• Survey measures the member's experience with their healthcare providers in the past 6 months in the following metrics:
	  o In-Office Wait Time
	  o Call Return Time
	  o Time to Answer Call
	• Call Return Time Compliance MY 2024
	  o Compliant response: within 1 business day.
	  o PCP: met compliance rate goal of 70% in all quarters.
	  o BH: met compliance rate goal of 70% in Q2 and Q4, did not meet in Q3, and no data for Q1 as the survey was not expanded to include BH providers until Q2.
	• In-Office Wait Time MY 2024
	  o Compliant response: less than 60 minutes
	  o PCP: met compliance rate goal of 80% in all quarters.
		None	None

	○ BH: met compliance rate goal of 80% in Q2, Q3, and Q4. No data for Q1. • Time to Answer Call MY 2024 ○ Compliant response: within 0-10 minutes ○ PCP: met compliance rate goal of 70% in all quarters ○ BH: met compliance rate goal of 70% in Q2, Q3, and Q4. No data for Q1. CG-CAHPS Summary • The providers continue to meet the compliance rate for all 3 measures. • Improvement on ratings for measure related to Time to Answer Call. Next Steps • Share results with delegates and direct entities. • Track and trend compliant rates. • Send out non-compliant Corrective Action Plans (CAPs) to providers who are not meeting the compliance rate. • Ongoing provider education and onsite/virtual office visits to providers with trends. ➢ *Member Question-N. Williams: When it comes to the In-Office Wait Time measure, does that include the interpreters that maybe the members need to wait on to come?* ➢ *Response-L. Tran: No, it does not include the wait time for the interpreter. This measure is only designed to check if the member is seen within 60 minutes by the provider after they have checked in with the front office.* ➢ *Response: L. Ayala: There are other member and provider satisfaction surveys that we implement to see if members are getting connected to interpreters when they're needed. So, it is important but not a part of this particular survey.* ➢ *Guest Question- K. Pageau: In general, providers, as soon as you see them, ask you to complete a survey. In addition, we get these Alameda Alliance surveys in the mail. My question is why does everybody want a survey to see how they're doing when we've already told their managers how good of a job they've done? You end up just filling out 20 minutes worth of surveys per day.* ❖ *Guest Comment-D. Leonard-Pageau: This matters to me because I go to the doctor 3 days a week, and he (K. Pageau) goes 2 days a week, so together, we get 5 to 15 surveys a week.*		

	➢ *Response-L. Tran: The reason we conduct the survey is to make sure that our members are satisfied with the services of the Alliance and our providers. As for survey fatigue, we do work with our vendor to "dedupe" our sample size to make sure that our members are not getting the same questions over and over again. So, we "deduplicate" to minimize survey fatigue.* ❖ *Guest Feedback-D. Leonard-Pageau: I don't believe deduping is working. I'm not trying to be cruel or anything, but I'm seeing this 1 doctor every 3 weeks, and this other doctor every 2 weeks, and I am getting surveys on both doctors. And the surveys are pretty much the same. So, I'm pretty much getting 5 surveys a week. You need to take into consideration for people like me. We don't need all that. I have had these doctors for many years, and I'm telling you they're good every time.* ➢ *Response-M. Lewis: That's good feedback, thank you for sharing that. And it's a bigger, more global impact for the healthcare system, as a whole. Because we are required to do surveys, but that's something we could look at and take that feedback into consideration. We also have the grievance system. So, if there's something wrong, there's a way to tell us. If you feel like you're getting too many surveys, you can also use the grievance system, that way it is documented, and we can track it and then we can work to make improvements. It's just part of improving our processes and services to our members in our community because it's important.*		
5. c. NEW BUSINESS – POPULATION HEALTH MANAGEMENT STRATEGY			

L. Ayala
E. Earnhardt
F. Zainal
	Linda Ayala, Director of Population Health and Equity, presented on the Population Health Management (PHM) strategy.
	
	What is Population Health Management?
	• Understand Alliance member needs
	  ○ Assessment and data
	  ○ Medical, behavioral, and social health
	  ○ Identify groups of members at risk
	• Provide equitable access to needed services
	  ○ Wellness and prevention services
	  ○ Care coordination
	  ○ Care management programs
	• Collaborate with
	  ○ Providers
	  ○ Community partners
		None	Alliance staff to share Alliance Member, Keith Pagaeu's contact information to Farashta Zainal to connect regarding getting a covered blood pressure monitor machine.

	• Improve health and equity
	
	2025 PHM Strategy Programs
	• Address primary care gaps and inequities
	  ○ Cancer Prevention
	  ○ Under 30 Months Well-Visits—Equity
	• Support members managing health conditions
	  ○ BirthWise Wellbeing—Equity
	  ○ Blood Pressure Monitoring
	  ○ Diabetes Prevention Program (DPP)
	  ○ Diseases Management Health Education
	• Connect members in need to whole person care
	  ○ Doula Services
	  ○ Multiple Chronic Case management
	  ○ Poste ED Visit for Mental Illness
	  ○ Transitional Care Services (TCS)
	
	2025 PHM Strategy Highlighted Activities
	
	Emily Earnhardt, Population health and Equity Specialist, presented on the Community Health Worker Programs.
	
	• Community Health Worker Programs
	  ○ Diseases Management Health Education: The Good Life Nutrition and Wellness program for members with diabetes and high blood pressure.
	  ○ BirthWise Wellbeing: Our Roots peer mental health coaching for members who were pregnant in the last year.
	
	Questions for CAC Members:
	• Have you heard of or worked with a Community Health Worker (CHW) before?
	• What would encourage you to join a CHW program?
	• What other topics or populations should the Alliance consider for future CHW programs?
	
	❖ *Guest Feedback-D. Leonard-Pageau: Regarding the 12-week nutrition program, when you go in there, you try to learn things on the first month and you do not want to expose yourself too much, you do not talk much in the beginning. But, as soon as you figure out what you're supposed to do,*		

	the program is done. They don't have enough time to absorb the information and start applying it. You find a program where you find a community, people you trust, but then the program ends and you feel isolated, and you do not know what to do and where to go. I believe that 2 to 3 months longer, even without the food, would be more effective and they can apply it and make it part of their routine. ➢ *Response-E. Earnhardt: Thank you so much for sharing, and I will just highlight that this particular program just piloted with a small group of members and we're expanding it this year. So hopefully we'll have the opportunity to offer this program to more members.* ❖ *Guest Feeback-D. Leonard-Pageau: Yes, hopefully for a longer time because we can't absorb it in 12 weeks. You are talking about a life change, you're changing life patterns. You go through separation anxiety because when you finally learn to trust, the program is done.* ❖ *Member Feedback-N. Williams: To encourage members to join the CHW programs, I think you can introduce them via handouts or calls from the Alliance saying that these vendors or community organizations are partnering with you and give their contact information to members.* ❖ *Guest Feedback-D. Leonard-Pageau: They can include that information on discharge summary or after-visit summary and ask members if they would be interested in having a CHW call them, because I personally do not answer calls from phone numbers I do not recognize.* ❖ *Member Comment-T. Debose: Yes, and at these times, there are so many people out there doing scams, especially targeting seniors. So, if they do not have the association before they leave their doctor's office, or before they leave the hospital, they have no association.* ❖ *Member Feedback-T. Debose: The reason why I sit on this board is because of my daughter who has special needs, and that's a large community. And right now, my daughter is 22 and has graduated from the school system. You have a lot of young adults that are transitioning. We just did a wellness check with our doctor because she is in a new stage of life, and even though everything is great, I'm still wondering about other families who do not get their children out and mostly sitting at home. And so those people need to be a population that you're communicating with, not just with the special needs community, but also their parents who are becoming elderly. They are having to care for these children that may be heavier than them at times. We really need to look at this because we're going to end up caring for them when their parents pass on. That's a very*		

	vulnerable community that I believe you should consider in your population health management strategy. ❖ *Member Feedback-N. Williams: It is also important to make sure the community is aware of all the resources available to facilitate the care of people with special needs.* Farashta Zainal, Quality Improvement Manager, presented on the At-Home Blood Pressure Tracking and Cancer Screening Programs. • At-Home Blood Pressure Tracking and Cancer Screening Programs. o Blood Pressure Monitoring-assist Alameda Health System members with getting a blood pressure monitor though the Alliance. ❖ *Guest Comment-D. Leonard-Pageau: He (K. Pagaeu) was prescribed a blood pressure monitor last week, but we were told by Highland Hospital Pharmacy that it was not covered. It was $93.00.* ➢ *Response-F. Zainal: There is a list of blood pressure monitors that are covered that we share with our providers, as not all machines are covered. Perhaps the provider prescribed a machine that is not on the list. We will definitely reach out to them as we can surely get you a covered device.* o Cancer Prevention-at-home HPV swab test for cervical cancer and Cologuard stool test for colorectal cancer. Questions for CAC Members: • What would help members track their blood pressure or complete a cancer screening at home? • How can providers support members with blood pressure control? • Who can we partner with to increase cancer screening for groups with lower rates (Am. Indian/Alaska Native, Black, Other Asian*, White)? ❖ *Member Feedback-N. Williams: Regarding the low return rate for at-home tests, what I heard from members was that there is not a convenient way to return it. You have to either go to the post office or drop it in the mail. It's not something you want to hand off to your mail carrier. If they had maybe a drop box or something in a neighborhood or a church or somewhere else, they could be collected, it would be a lot easier.*		

	❖ *Guest Feedback-D. Leonard-Pageau: The envelope says not to take it back to the doctor's office, but I believe that's where it should go. Nobody wants to put it in the mail, and nobody wants to let the others know they did the test. Also, it will be beneficial to add a flyer or pamphlet that talks about why doing the test will benefit you and your family, and perhaps the number of people whose lives were saved by taking these tests.* ➢ *Response-F. Zainal: That's great feedback. One of the reasons why the PCPs don't want it back in their office is because the specimen must be collected and get to the lab in a timely manner, otherwise the sample is not good.* ❖ *Guest Feedback-D. Leonard-Pageau: But that's not a good excuse because the lab picks up the samples from the doctor's office every day.* T. Debose reminded the CAC members that they can also write their feedback and comments on the CAC feedback sheet. ❖ *Member Feedback-T. Debose: I would just say coming from a perspective as an African American. One of the things that we say all the time in our community is our health is our wealth. And that is what people are talking about these days. You know, we're talking about wealth and growth, and empowerment, but if you don't have your health, you can't have financial growth and all those other things. So, if you talk to other communities, you have to speak their language so that they will connect with you. I think that doctors should keep on mentioning it during appointments. We just went on a wellness appointment, and the nurse actually talked about the blood pressure monitors that you can get. So, I think that doctors and nurses should keep drilling down information because unless you have the information you may not know what you need and how to get it. The doctors and nurses should give you a list of all the things you need.* ❖ *Member Feedback-N. Williams: Well, it has to be inspirational too and not just a laundry list. If you add just a touch of inspiration and admiration to it, you'll get better results.* ❖ *Guest Feedback-D. Leonard-Pageau: I am part of LifeLong, and my daily tasks pop up every morning, take your blood pressure, take your blood sugar. With My Health Online and Sutter, you can enroll in daily tasks. So, I have been doing these for 3.5 years without missing. You might want to ask them how they did it.* ❖ *Guest Feedback-K. Pageau: When I was with LifeLong, I was enrolled in a diabetes class, and we met, but it seemed like forever until they*		

	reassigned the doctor. There, they took our blood sugar and maybe blood pressure as well. Maybe what we can do here with Alameda Alliance is maybe give members who are not enrolled in a program like that, a call every 3 or 4 months and remind the members to take their vitals and to document somewhere that you reached out to them. ❖ *Member Comment-M. Le: Regarding the BP monitors, I think it depends on how your doctor writes the prescription. My doctor had to rewrite the prescription 3 times, and include a letter with it, before the pharmacy finally gave the BP monitor for free.*		
5. d. NEW BUSINESS – ANNUAL REVIEW OF CULTURAL AND LINGUISTIC SERVICES			
M. Moua	Tandra Debose, CAC Vice Chair, announced postponement of this agenda item to the next CAC meeting due to time constraint.	None	None
6. ALLIANCE REPORTS – COMMUNICATIONS AND OUTREACH			
A. Alvarez	Alejandro Alvarez, Communications and Outreach Supervisor, presented on Alliance Outreach Report. • Reached 38,033 self-identified Alliance members during outreach activities (since July 2018). • Completed 47,497 member orientation outreach calls (since March 2020). ❖ *Member Comment-T. Debose: You do wonderful work, and I have to say, I was at the DMV getting my real ID, and I saw the Alliance poster and I took a picture. And the models are of various races, and I love seeing that, that's beautiful. I am happy to see that I keep seeing the Alliance everywhere.*	None	None
7. a. CAC BUSINESS – CAC CHAIR NOMINATIONS AND VOTING			
L. Ayala T. Debose	• The committee was unable to nominate and vote for a new chair as a quorum was not established.	None	CAC Planning Team to move the CAC Chair Nominations and Voting to the next meeting.
7. b. CAC BUSINESS – CAC MEMBERSHIP RECRUITMENT			
M. Moua	Mao Moua, Cultural and Linguistic Services Manager presented on the CAC membership recruitment updates.	None	None

	• Priority Areas for Recruitment
	  ○ Foster parents of Alliance members, advocates, and/or youth
	  ○ Long Term Support Services (LTSS) advocates, or Alliance members participating in LTSS
	  ○ Members
	  ▪ Men
	  ▪ Younger adults
	  ▪ Preferred language is non-English
	  ○ Providers
	• Connected and presented information about the CAC to the following group and organizations:
	  ○ New Beginnings: 01/17/2025
	  ○ Oakland Catholic Worker (Immigrant Services): 04/28/2025
	  ○ Children's First Medical Group (CFMG): 04/29/2025
	  ○ City of Berkeley (Local Health Department): 05/20/2025
	  ○ Community Health Center Network (CHCN): 05/21/2025
	  ○ Native American Health Center (NAHC): 05/29/2025
	• Next Steps
	  ○ Follow up with group/organization we presented to.
	  ○ CAC Recruitment Workgroup.
	  ○ Present CAC candidates at the next CAC Selection for review and voting.		

8. OPEN FORUM			
T. Debose	• N. Williams introduced and highlighted the care bags that she and former CAC Chair Melinda pioneered. It started with just 50 bags, and now at 5,000 bags. • D. Leonard-Pageau expressed dissatisfaction with grievance and appeals process due to submitting repeat grievances against CHME within a span of 5 years and took many years before getting help. The grievances were due to improper packaging of catheters, as well as mistakes in the incontinence supplies size sent. She also expressed dissatisfaction over only having one DME supplier, CHME. She commented that once she was given prior authorization and transferred to Shield, she has not experienced any issues. ➢ *Response-M. Lewis: We can definitely take this back and have our Grievance and Appeals team, reach back out you to follow-up. But that's*	None	Alliance staff to connect with the Grievance and Appeals Team and get information on the process for repeat grievance cases from the same member. Alliance staff to connect Donna Leaonard-Pageau to the G&A team for follow-up.

	great feedback, and we do have a process, but I want to defer to them to speak to it. Thank you for sharing that. ➢ *Response-L. Ayala: Like Michelle said, this is an important part of the CAC, giving an opportunity for folks to share where things are maybe going well, and where things aren't, but we need to step up so there will be continued follow-up. And I think after the meeting, we do have representatives from CHME that might be willing to chat with you. But as always, when these kinds of issues come up that are specific to individual member concerns, we will be following up on the back end to make sure we're making whatever connections we can, so the process continues.* • L. Ayala reminded CAC members that there are still focus groups and other opportunities available, and that a follow-up email will be sent with information. She also advised members that they may call her if e-mail does not work for them. • K. Pageau expressed appreciation to the Alliance for the assistance and covering the cost of renewing their First Aid and CPR cards. He also commented that the trainer used in Oakland is an excellent teacher.		
9. ADJOURNMENT			
T. Debose	• T. Debose announced that the next CAC meeting will be on September 11, 2025. • T. Debose adjourned the meeting at 12:11 pm.	None	None

Meeting Minutes Submitted by: Mara Macabinguil, Interpreter Service Coordinator Date: 07/23/2025

Approved by: DocuSigned by: CCF246548B8E46B... Date: 09/16/2025 | 4:25 PM PDT

ACCESS AND AVAILABILITY SUBCOMMITTEE

May 21, 2025

Teams Conference, 1pm – 2:30pm

Member Name and Title	Present	Member Name and Title	Present
Dr. Donna Carey, MD, Chief Medical Officer	X	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	
Tiffany Cheang, Chief Analytics Officer		Gia Degrano, Director, Medical Services	
Cecilia Gomez, Manager, Provider Services	X	Jennifer Karmelich, Director, Quality Assurance	
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	X	Hellai Momen, Quality Review Nurse	
Richard Golfin III, Chief Compliance Officer		Marie Broadnax, Manager, Compliance	X
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	X
Fiona Quan, Project Specialist, Quality Improvement	X	Judy Rosas, Manager, Member Services	X
Heidi Torres, Quality Programs Coordinator	X	Kathy Ebido, Sr. QI Nurse Specialist	X
Tanisha Shepard, Project Specialist, Quality Improvement		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		Rahel Negash, Pharmacy Supervisor	
Kayla Williams, Manager Member Experience & Program Management		Alexandra Loza, Quality Assurance Specialist	X
Robert Smith, Regulatory Compliance Specialist	X	Donna Wong, Senior Human Resources Generalist	X

ACCESS AND AVAILABILITY SUBCOMMITTEE
May 21, 2025
Teams Conference, 1pm – 2:30pm

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.		
II. A&A Committee Charter Update	L. Tran	Loc Tran reported a minor update to the accessibility charter policies. The revisions include adding the DSNP line of business and designating one representative from Medicare Operations to serve as a voting member on the committee. Gia and Linda motioned to approve.		
III. CG-CAHPS Q2 2025	F. Quan	Fiona reported that this quarter's review includes both Q1 and Q2 CG-CAHPS data due to a delay in Q1 reporting at the previous A&A Committee. She reminded the committee that CG-CAHPS captures member-reported experiences on in-office wait time, time to answer calls, call return time, as well as urgent, non-urgent, and non-life-threatening behavioral health appointment. Primary Care – In-Office Wait Time • Compliance benchmark: < 60 minutes, target 80% • Network performance remains strong, above 90% for both Q1 and Q2 • Q2 reported 92.7%, a ~2.5% increase from Q1 (90.2%) Primary Care – Call Return Time • Compliance benchmark: call back within 1 business day, target 70% • Performance was at 70% in Q4 and Q1; it dropped by ~1.5% in Q2, below the threshold goal • CFMG remains above threshold goal; Alameda Health System and CHCN are below Primary Care – Time to Answer Call • Compliance benchmark: speak to clinic staff within 10 minutes, target 70% • Slight decline of 1.4% in Q2 but still meeting the 70% threshold goal • A noticeable drop observed for Alameda Health System in Q2, falling below threshold goal Urgent & Non-Urgent PCP Appointments • Urgent appointments remained ~ 60% in Q1; improved by 5.2% in Q2 • Non-urgent appointments improved 0.3%, still below the 75% threshold goal Providers Trending Non-Compliant (3 Consecutive Quarters) • No providers trended for in-office wait time • Two La Clinica sites (San Antonio & Transit Village) trended for time to answer calls		

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

		• Multiple providers trended for call return time; improvements were noted for Alta Vista & Axis Hacienda, and they were removed from the trended list
		
		Behavioral Health – CG-CAHPS Results
		• Behavioral health in-office wait time remained above 90% for both Q1 and Q2
		• Q1: 93.6% | Q2: 92.3% slight decline but above the 80% goal
		
		Clarifying Question – Survey Goal Setting
		Judy Rosas asked how the benchmarks are determined and whether they are aligned with industry standards.
		Loc Tran responded:
		• Alliance goal for urgent/non-urgent access is 75%, while DHCS requirement is 70%
		• Upcoming DHCS thresholds are scheduled to increase:
		  ○ 2025–2026: 70%
		  ○ 2027: 80%
		  ○ 2028: 90%
		• For wait times, DHCS only requires monitoring; internal benchmarks are set by the Quality Improvement team
		
		Loc Tran noted that while most measures trend near or above 80%, the two measures that continue to underperform year over year are:
		• Time to Answer Calls
		• Call Return Time
		
		He attributed these declines primarily to staffing shortages and high turnover in call centers and front desk roles, observed consistently during provider meetings and site visits. Because of this, the benchmarks for these measures are set lower than those for in-office wait time.
		
		DSNP Inclusion in CG-CAHPS
		Kayla Williams asked whether DSNP members will be included in next year's CG-CAHPS sample.
		• Loc confirmed yes — DSNP will be incorporated in 2026.
		• Alliance has already notified the survey vendor (Press Ganey).		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		• Sampling will depend on member utilization in the previous six months, so volume may fluctuate quarter to quarter. Kayla suggested exploring separate performance goals for DSNP vs. Medi-Cal populations in future, given higher STAR rating expectations. Survey Interpretation Considerations Loc reminded the group that: • CG-CAHPS reflects member perception, not administrative or audit data. • Results are highly sensitive due to small denominators — for example, if only two responses are received and one reports non-compliance, the score becomes 50% for that site. Behavioral Health Trends: • Behavioral Health call return time dropped from 71.1% (Q1) to 69.3% (Q2) slightly below goal. • Time to answer calls dropped from 84.4% to 79.8% but stayed above threshold goal. • Non-life-threatening urgent BH access dropped from 81.7% to 77.1% — Alliance and CHCN were slightly below target goal; CFMG met goal. • Behavioral Health non-urgent appointments are meeting threshold goal; urgent access remains low (~50%), consistent with provider reports that urgent BH visits are rarely scheduled in advance. Trending Providers (3+ consecutive quarters) • Non-life-threatening BH access: Asian Health, AHS Highland, MindPath • Call- return time (BH): AHS, Davis Street, CHC, and TVHC Hayward Specialist CG-CAHPS (First 2 Quarters Collected) • Specialist call return time declined from 80.1% (Q1) to 73.9% (Q2) but remained above target goal. • Time to answer calls and in-office wait time remains above threshold across all networks. • Scores for CFMG show large percentage swings due to very low response counts Michelle Stott noted that several CG-CAHPS measures show a downward trend compared to the prior year. She emphasized the urgency of developing a robust action plan given upcoming		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		APL requirements and potential sanctions related to access measures. She recommended forming a small workgroup to conduct root cause analysis and identify innovative interventions. Fiona Quan confirmed that call-related metrics remain the most challenging. She shared that Davis Street, one of the clinics with lower scores, recently implemented a new phone triage system after previously having only one staff member answering calls. This operational change has helped improve their performance. Michelle suggested sharing such best practices with other providers, particularly where there is an opportunity to implement enhanced telephone systems. Loc Tran added that historical challenges include clinics using front desk staff, MAs, or managers to answer calls, which has been ineffective. In response to data shared during site visits, several clinics — including Davis Street and Epic Care — have now hired dedicated call center staff or moved call handling back in-house after outsourcing failed to meet standards. Loc noted that the team continues to monitor call center issues such as unreturned callback requests and directory errors and holds recurring meetings with providers that have patterns of non-compliance. Alameda Health System continues to struggle with high staff turnover, and those concerns have been escalated internally to leadership overseeing call center operations.		
IV. Access CAP Dashboard	F. Quan	Access CAP Dashboard – Q3 2024 to Q2 2025 Fiona reported that 437 Corrective Action Plans (CAPs) were issued during this timeframe. The majority were generated from PAAS, which is the largest survey tool. Additional CAPs were issued from QMRT (DHCS-administered quarterly survey) and PQI (grievance-based, issued monthly). During this period, 303 CAPs were closed. Many of the open PAAS-related CAPs involve behavioral health providers who historically did not receive direct CAPs under Beacon, requiring additional education and outreach from the team. There are currently 275 CAPs still open. Top trending providers with recurring CAPs remain:		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		• Alameda Health System • Stanford • John Muir • La Clínica / Tiburcio Vasquez (CHCN network) • UCSF Virtual On-Site Visits (2025 YTD) The team has conducted multiple virtual meetings with providers appearing frequently in access survey findings. Some providers have been engaged monthly or on an ad hoc basis depending on need and survey results. Active and Upcoming Meeting Priorities Include: • Baywell Health • La Clínica • John Muir • MindPath • Seneca • West Oakland Health The team is reviewing survey findings with these providers to understand barriers and share best practices. Anyone interested in joining upcoming sessions may request to be added once meeting dates are scheduled		
V. DHCS QMRT Timely Access Monitoring	S. Lal	Sarbjit presented the Q1 2025 QMRT results, which are aligned with the provider appointment availability survey for PCPs, non-physician mental health specialists, and ancillary providers for both urgent and non-urgent appointment availability. The State delivered the data on July 30. Corrective Action Plans (CAPs) will be issued on September 15. A total of 360 providers were surveyed, including: • 24 PCPs • 39 non-physician mental health specialists • 265 specialists • 32 ancillary providers		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		The plan met the MPL of 70% for non-urgent appointments for the second consecutive quarters. However, the urgent appointment benchmark was not met again. Per the new APL: • The 70% benchmark will remain in effect through December 2026 • It will increase to 80% effective January 2027 • It will increase again to 90% in 2028 Providers have been informed of the upcoming changes during 1:1 meetings and have expressed concern about the higher thresholds. The A&A team will continue supporting providers to work toward compliance. Sarbjit noted that response rates improved this quarter for both urgent and non-urgent measures, which is a positive indicator.		
VI. Access Related PQI Dashboard	S. Lal	Sarbjit presented the PQI update. The highest volume of PQI referrals continues to be for non-urgent appointment availability, with 407 grievances reported. PQI volume increased in Q2 to 760 total referrals, up from the three previous quarters. Of these, 26 cases were related to Behavioral Health (BH). Within BH, 50% of PQIs were due to non-urgent appointment availability, followed by time to answer calls and call return time. There are no cases exceeding the 120-day resolution timeframe. The current average is 42 days. As part of tracking and trending: • 44 providers were trended for two consecutive quarters • After reassessment, 30 providers were confirmed non-compliant and were issued CAPs • The number of trended providers has been steadily decreasing — from 96 in Q1 2023 to 44 in Q2 2025, suggesting ongoing education and engagement efforts are effective Providers with 15 or more referrals include Alameda Health System (AHS) and Davis Street. Of Davis Street's 19 PQIs, 14 were related to time to answer calls. During the August on-site meeting, Davis Street leadership reported that they have restructured their call center, and early Q3 data shows a significant decline in time-to-answer PQIs. Confirmatory surveys shows calls are now being answered within one minute, indicating improvement. If sustained, Davis Street is expected to fall off the trend list next quarter.		

ACCESS AND AVAILABILITY SUBCOMMITTEE
May 21, 2025
Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
VII. OB/GYN A&A Monitoring	T. Shepard	Tanisha presented the Quarter 2 OB/GYN Access and Availability Monitoring results. The intent of this report is to continuously review, evaluate, and improve timely access to care, including: • PCP visits within 10 business days • OB/GYN specialty visits within 15 business days • First prenatal visits within 2 weeks of request For Q2, a total of 4 QOAs were received — all related to OB/GYN. This reflects continued improvement compared to 6 findings in Q1 and higher numbers in prior quarters. Q2 Provider Findings: • The following sites each had one finding for non-urgent appointment availability: o Highland Hospital o Highland Wellness o Hayward Wellness Center o Women's Center at Saint Rose Confirmatory Survey Results: • 3 cases remained non-compliant • 1 case was closed as compliant Barriers Observed: • Ongoing limits in accepting new patients • Some clinics not offering OB/GYN appointments The team will continue to track and trend OB/GYN PQIs, identify provider-specific improvement needs, and issue CAPs after two consecutive quarters of substantiated non-compliance to ensure members have timely access to OB/GYN services.		
VIII. Geo-Access Update • **ANC** • **SNC (CHCN & CFMG)**	T. Shepard	A review of specialties not meeting time and distance standards was presented. ENT, Hematology, and HIV were highlighted. Zip code 94550 (Livermore) appeared as non-compliant this quarter after having met the standard in the prior quarter and will be further investigated. For HIV Pediatrics, the following cities are currently not meeting both time and distance: • Discovery Bay • Livermore • Tracy • Mountain House		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		Additional specialties with non-compliance were noted, including Oncology Pediatrics, Physical Medicine & Rehabilitation, and Pulmonology Pediatrics — all again impacted by 94550 (Livermore). This quarter did not show improvement overall; however, research into provider availability and member access will continue, in partnership with Provider Services and Analytics, to identify potential network solutions. SNC CFMG — Q3 Findings Minimal improvement was reported for Q3. One additional city — Newark — was added under General Surgery Pediatrics as non-compliant. Specialties continuing to miss standards include: • Cardiology • Endocrinology • Gastroenterology • General Surgery • Hematology • HIV/AIDS Many of these specialties are hospital-based, which is being evaluated further. Some improvement was noted under General Surgery Pediatrics for Tracy and Mountain House, which are now compliant. SNC CHCN — Q3 Findings No significant changes from Q2 to Q3. Livermore (94550) remains the most impacted area across multiple specialties, including: • Nephrology • Neurology • OB/GYN • Oncology • Ophthalmology • Orthopedic Surgery • Physical Medicine & Rehabilitation • Pulmonology Although overall performance remained flat, the team will continue collaborating with Provider Services and will begin including member volume data by city in future reports to support prioritization and planning.		

ACCESS AND AVAILABILITY SUBCOMMITTEE
May 21, 2025
Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
IX. Member Experience (CAHPS)	L. Tran	L. Tran provided an overview of the CAHPS MY2024 survey results, explaining that the surveys aim to assess how well member expectations are met, identify high-impact service areas, and highlight opportunities for improvement. The surveys were conducted from February to May 2025 across eligible Medicaid child, Medicaid adult, and commercial adult populations. Response rates for Medicaid adults and Medicaid dual-eligible members showed a slight decline compared to the previous year, but all lines of business exceeded the benchmark. L. Tran reviewed the composite measures, which included "getting care quickly," "getting needed care," "doctor communication," and "customer service," defining each measure and how member satisfaction was assessed. For Medicare child members, improvements were seen in three out of nine measures, including getting needed care, customer service, and rating a personal doctor. Ratings varied by race, ethnicity, and gender, with Asian and African American children generally rating below the plan score and Hispanic children above. For Medicaid adults, five of nine measures improved, though satisfaction with urgent and routine appointments showed declines. Commercial adult members showed improvement across all four measures, with routine appointment satisfaction improving but urgent appointment ratings declining slightly. Tobacco cessation measures revealed improvement in the commercial line of business but slight declines in Medicaid, with some measures still exceeding the 2024 Quality Compass benchmark. Tran highlighted the top-rated measures for each line of business, noting that low-rated measures were often related to getting care quickly or needed care. Key findings included higher satisfaction among male members, consistently lower ratings from the Asian population for timely care, and above-average ratings from Hispanic members. Next steps include continued provider education through on-site and virtual visits, encouragement of open-access scheduling, maintaining access-related performance incentives, extending office hours, and finalizing an alternate access document targeting urgent care and telehealth to improve member satisfaction, particularly among Asian members. Michelle Stott raised the need to explore additional strategies for the DSNP population, noting		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		that current measures, particularly for timely access, are significantly below expectations. She suggested scheduling a brainstorming session with Kayla to align efforts and identify innovative member engagement opportunities across the broader population. Loc Tran responded that the team has been in communication with Kayla and will follow up to coordinate, including scheduling virtual and on-site visits with DSNP-contracted providers while sharing relevant information from the medical line of business. L. Tran also highlighted concerns regarding the Asian population, whose ratings were consistently lower than other ethnic groups, despite high satisfaction reported with providers such as Asian Health Services. To address this, the team is exploring administering the medical adult CAHPS survey in Chinese to ensure more accurate data, as language barriers often lead members to rely on family members to complete surveys. L. Tran noted that a cost estimate for administering the survey in Chinese will be requested and updates will be provided to the committee as the initiative progresses.		
X. Provider Network Capacity	L. Alejo/ H. Torres	L. Alejo provided an update on the latest monthly capacity report. She explained that providers reporting over 80% capacity are contacted by their representative to inform them of their status, and once a provider reaches 90%, auto-assignments are closed. No questions were raised regarding this process. H. Torres then reviewed the PQIS (Provider Quality Improvement System) performance for the quarter. For Dr. Rajaram and Dr. Grawal, no PQIS issues were reported. Dr. Ahmadi had three non-urgent appointments, all complaints. Dr. Lovato had six instances: one in-office wait time (compliant), four non-urgent appointments (non-compliant), and one urgent appointment (non-compliant). Dr. Sufer Rahman had 4 instances of time-to-answer calls (non-compliant), two non-urgent appointments (compliant), and one call return time (compliant). Dr. Suri had five instances: four for time-to-answer calls (two compliant, two non-compliant) and one non-urgent appointment (non-compliant). Dr. de la Cruz had four time-to-answer call instances (three compliant, one non-compliant). Lastly, Dr. Lopez Arredondo had 18 instances: three compliant and five non-compliant for time-to-answer calls, and ten non-urgent appointments (one compliant, nine non-compliant).		
XI. Grievance & Appeals Report	A. Pena	A. Pena presented the quarterly review of access-related grievances across clinics, PCPS, specialists, and the plan. Key findings include: • Clinics: Newark Health Center (12), Eastmont Wellness Center (9), Highland Wellness Center (3), and CHCN clinic (8) had the highest number of grievances.		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		Non-AHS/CHCN clinics had minimal issues, except for Davis St. Primary Care Clinic and Amcare Medical Group, which showed higher timely access grievances. • PCPS: Total of 223 access-related cases; highest counts reported for Dr. Jin Kwan Kim and Dr. Jahaira Lopez Arredondo. No PCPS had five or more unique grievances overall. • Specialists: No specialists recorded five or more unique grievances this quarter. • Plan: Continued to have the highest volume of grievances, predominantly in telephone technology (656 cases), including phone system issues, ID cards, member portal, and provider directory concerns. Medi-Cal Specifics (Q2): • 12,377 cases processed; 5,787 access-related. Compliance timeframes were largely met, with only one expedited access grievance outside of standard timelines. • Timely access was the leading issue across clinics (845 cases), while telephone technology remained the top grievance category for the plan. • Exempt grievances (resolved within one business day) mirrored these trends: plan (1,011), clinics (601), PCPS (404). Summary: • Timely access and telephone technology remain the highest-priority areas. • The plan, certain clinics, and select PCPS continue to account for the majority of access-related grievances. • No specialists exceeded five unique grievances, indicating low incidence in this provider category. Next steps include continued monitoring, targeted provider engagement, and resolution strategies focusing on timely access and technology-related barriers.		
XII. Member Services – Telephone wait time & Call Center Dashboard	J. Rosa	J. Rosas presented the quarterly report on the Member Services blended call center. In Q2 2025, the call center received a total of 53,650 calls, of which 50,865 were answered. • Abandonment Rate: 5% • Average Speed to Answer: 12 seconds • Calls Answered ≤30 Seconds: 94% • Average Talk Time: 7 minutes, 35 seconds • Calls Answered ≤10 Minutes: 100% (goal met) • Trend: Call volume decreased 6.35% from Q1 2025		

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		• Top Call Reasons: 1. Change of primary care provider 2. Eligibility and enrollment 3. Grievances and appeals 4. Benefit-related inquiries 5. Provider network information		
XIII. FSR/MRR Updated	K. Ebido	K. Ebido provided an update on FSR activities and quality monitoring through Q2 2025. She began by reviewing audit counts and comparisons, explaining the types of audits conducted and the accompanying graphical summaries. The team engages providers through trainings, pre-audits, and CAP assistance. A correction was noted for Q2, changing Dr. Wahid Ibrahimi to Dr. Ahmadi. Failed Reviews and Membership Holds: • Q2 saw an increase in failed reviews due to more periodic audits, with seven providers failing site and medical record reviews or missing deadlines. • Providers with failed reviews or non-compliance were placed on membership hold. Most holds have been closed, except for Dr. Okoronkwo and Dr. Dickey at Integrated Medical Associates. • In Q3, East Bay Cardiovascular and Medical Specialist (Dr. Jane's Group) has a current membership hold for failed site and medical record reviews. Corrective Action Plans (CAPs): • All Q1 CAPs have been closed. • Q2 CAPs remain open for Dr. Okoronkwo and Dr. Dickey, with the 120-day deadline due September 13th; escalation to the state may be required if not resolved. • Providers with critical element CAPs are mostly resolved. Audit Findings: • Frequent findings included the use of non-safety needles. • Medical record reviews also highlighted suboptimal compliance with initial health appointments; provider education and CAP issuance continue. Skilled Nursing and Long-Term Care Facilities: • Facilities are required to submit attestations confirming quality improvement plans. • One-star facility: Skyline Healthcare Center (San Jose) with one member. • Two-star facilities: Eleven in San Leandro (no members), East Bay Post Acute (Castro Valley, 39 members), and Windsor (Hayward, 12 members) have not returned attestations.		

ACCESS AND AVAILABILITY SUBCOMMITTEE
May 21, 2025
Teams Conference, 1pm – 2:30pm

Agenda Item	Presenter	Discussion/Activity	Follow-Up Action/ Responsible party/ target date	Document
		• Outreach has been conducted multiple times; future efforts will include on-site visits in partnership with the RRLTC department to meet administrators or Directors of Nursing (DONs). The report concluded with a review of next steps, including continued monitoring, provider engagement, and addressing outstanding CAPs and attestations.		
XIV. Q&A	All			
XV. Meeting Adjourn	L. Tran	Next Meeting: November 5, 2025		

Meeting Minutes submitted by: Sarbjit Lal, Quality Improvement Project Specialist **Date: 10/27/2025**

Utilization Management Committee Meeting Minutes
August 29, 2025, 1:30 PM – 3:00 PM
Teams

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

Utilization Management Committee Meeting Minutes
August 29, 2025, 1:30 PM – 3:00 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 **1:30 pm**		
II. Review and Approval of minutes	A. Lam	The UM Committee Minutes from **July 25, 2025** were approved electronically by a quorum of the committee prior to the meeting.		
III. Policies and Procedures	All	• CS-014 • LTC-001 • LTC-004 • CHS-002 • CM-010 • CM-041	PP Summary of Changes_8.29.25.pdf	**Vote to Approve:** None opposed: The policies will be finalized as approved and moved forward to QIHEC

Utilization Management Committee Meeting Minutes
August 29, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
A. LTC Metrics	K. Marin	• **Membership and Admissions Trends:** A slight decline in LTC membership from Q1 to Q2, with admissions, average length of stay, and total days all decreasing, attributed to ongoing case management and discharge planning efforts. • **Turnaround Time (TAT) Performance:** LTC TAT remained high at 99% for Q2, exceeding the 95% goal, with manual checks compensating for reporting limitations, and plans to continue regular monitoring. • **Network Utilization and Emergency Visits:** In-network admissions remained stable, while out-of-network admissions decreased; emergency room visits also declined, with ongoing collaboration to reduce unnecessary visits and bring members back in-network. • **Discharges and Denials:** Discharges to lower levels of care showed variability, with increases in home health discharges; denials spiked in June due to fallout from DHCS migration and expired tars, with most denials linked to missing information.	LTC Metrics.pdf	

Utilization Management Committee Meeting Minutes
August 29, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• **Audit Results and Recommendations:** Audit scores for nurses, social workers, and UMCS remained above the 95% goal, with plans to increase social worker case audits and ongoing education for facilities to reduce denials and improve transitions.		
B. Case Management	J. Rosales	• **Transportation and Audit Activities:** Case management and vendor management teams conducted quarterly on-site audits of transportation providers, monitored PCS form compliance, and facilitated monthly meetings with key transportation vendors. • **Referral and Case Volume Trends:** There is an increase in case management referrals, especially for transitional care services, and described the impact of algorithm changes in April 2025 that expanded outreach to low-risk members, resulting in higher 'unable to reach' rates. • **Case Audit and Outreach Effectiveness:** Quarterly audits showed high assessment factor pass rates but lower care plan factor scores, prompting increased supervisor audits and real-time feedback; documentation of outreach attempts is maintained in TruCare notes. • **HRA and HIFMET Completion Efforts:** HRA completion rates for new and annual members were tracked, with most responses received via mail; Cotivity was engaged to improve completion rates, and HIFMET forms were processed for new or returning members.	Case Management Report.pdf	

Utilization Management Committee Meeting Minutes
August 29, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• **Delegation Oversight and Corrective Actions:** CHCN's failure to meet timely outreach led to case management taking over all referrals, escalation to senior leadership, and discussion of further corrective action plans or contract renegotiation if deficiencies persist.		
IV. Behavioral Health	P. Currie	• **Case Coordination Volumes and Outcomes:** The alliance processed 2,734 behavioral health service case coordination cases in the first half of 2025, with a monthly average of 455 new cases and a 64% successful closure rate, primarily due to strong member engagement. • **Challenges in ABA and Autism Services:** Case closures for behavioral health treatment (ABA/autism) were lower, with a significant portion attributed to inability to contact members, prompting further investigation into outreach and engagement strategies. • **DHCS Screening Tool Utilization:** The team used DHCS screening tools to triage members between county and alliance services, with about a fifth of members referred to county mental health and the remainder staying within the alliance's network. • **Collaboration and Process Clarification:** Screening activities are conducted by both member services and navigators, ensuring	BH Case Coordination.pdf	

Utilization Management Committee Meeting Minutes
August 29, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		consistent application of criteria and coordination with county partners.		
V. Adjournment	A. Lam	The meeting was adjourned at **2:20 pm**		**Next Meeting:** September 26, 2025 at 1:30 PM

Meeting Minutes submitted by: DocuSigned by: Amani Sattar 1515265B2F7F4DC... **Date:** 09/08/2025 | 1:08 PM PDT

Amani Sattar,
EA to the CMO

Approved by: DocuSigned by: Allison Lam 8E7713C4669F403... **Date:** 09/08/2025 | 1:52 PM PDT

Allison Lam,
Sr. Director, Health Care Services

Utilization Management Committee Meeting Minutes
September 26, 2025, 1:30 PM – 3:00 PM
Teams

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

Utilization Management Committee Meeting Minutes
September 26, 2025, 1:30 PM – 3:00 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 **1:30 pm**		
II. Review and Approval of minutes	A. Lam	The UM Committee Minutes from **August 29, 2025** were approved electronically by a quorum of the committee prior to the meeting.	UMC_Meeting Minutes_8.29.25.doc›	**Approved via e-vote:** 9/8/25 – 9/10/25
III. Policies and Procedures	All	• BH-001 • CM-D-006 • CM-D-008 • CM-D-102 • CM-D-104 • CM-D-109 • CM-D-110 • CM-D-111 • CS-013 • LTC-006 • UM-067 • UM-051 • UM-056 • UM-057 • UM-068 • UM-069	PP Summary of Changes.pdf	**Vote to Approve:** None opposed: The policies will be finalized as approved and moved forward to QIHEC

Utilization Management Committee Meeting Minutes
September 26, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
IV. Clinical Decision Support Tools **A. UM Inter-Rater Reliability (IRR)**	M. Findlater	• **IRR Testing Results:** all 39 individuals tested passed with 90% or greater • **Departmental Performance Breakdown:** Medical directors achieved 100% scores, inpatient and outpatient teams performed well, LTC require some retakes but ultimately passed, and GNA nurses also achieved 100%. • **Quality Policy Requirements:** QI 133 mandates IRR participation for all relevant departments, with pharmacy and NBH conducting their tests separately at later dates. • **Next Steps for IRR:** Plans are in line to prepare for the next MCG edition (29th), continuing adaptations to support staff and improve testing processes.	IRR Scores.pdf	
B. PA Rule Changes for Physician Administered Drugs	L. Lim	• At the September 16th Pharmacy and Therapeutics Committee meeting, 13 codes were added and seven codes removed for physician administered drugs, with documentation provided for reference.	Updated Review of Changes to PA Rules	
V. UM Program Effectiveness **A. Over/Under Utilization** **B. Over/Under Utilization BH**	M. Findlater P. Currie	• **Emergency Department Utilization:** There is a downward trend in ED visits per 1000 members across Alliance, CFMG, and CHCN, with specific facilities like Highland and Washington Hospital identified as high-volume locations; interventions include on-site inpatient nurses and monitoring out-of-network trends. • **Acute Admissions and Readmissions:** Acute admissions showed declines in average length of stay, admits per thousand, and days per thousand, with readmission rates dropping to 20.6% for June 2024–2025, and targeted	Over Under Utilization.pdf Over Under Utilization_BH.pdf	

Utilization Management Committee Meeting Minutes
September 26, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		interventions for high-risk groups and facilities with elevated readmission rates. • **Denial Rates and Specialty Services:** Denial rates for inpatient and outpatient services were presented, with full denials at 1.5% and partial denials at 2.7%; specialty services such as acupuncture, chiro, podiatry, transplant, and palliative care were analyzed for authorization and denial reasons, including retro submissions and out-of-network issues. • **Out-of-Network and Stanford Utilization:** High approval rates for diagnostic radiology and changes in MRI review processes, as well as Stanford utilization with 778 members and 1,199 authorizations, 74% approved in Q2, and highest denials in TQ services. • **Unused Authorizations and Urgent Requests:** Unused authorizations were highest among adult expansion members, with 25% of urgent authorizations not being used, prompting provider education on urgent criteria and monitoring of unused authorizations. • **Behavioral Health Prior Authorization Trends and Denials:** Prior authorization data, shows a 53% increase in requests from 2024 to 2025, with low denial rates primarily due to missing required information, and explained the process for resubmission and appeals. • **Denial Rate Analysis:** Denial rates remained low, rising from 0.14% to below the 5% threshold, with most denials attributed to out-of-network providers or failure to provide required treatment plan information, especially for autism benefit reviews.		

Utilization Management Committee Meeting Minutes
September 26, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
C. Carved-Out Services	H. Desrochers	• **CCS Case Volume and Outcomes:** There were 1,450 assessed cases in Q2, with 394 referred (27%), 248 approved (63%), and a 37% denial rate; three cases were canceled, with two approved and one denied due to retro eligibility termination. • **Denial Reasons and Provider Panel Status:** Main denial reasons included medical ineligibility and providers not being CCS paneled; Allison requested a quarterly list of non-paneled providers to facilitate paneling and improve approval rates. • **Diagnosis and Referral Breakdown:** Top inpatient diagnoses were perinatal, accidental poisonings, congenital, endocrine, and respiratory; outpatient diagnoses included congenital, accidental poisonings, musculoskeletal, nervous system, and endocrine. • **EPSDT and Case Management Referrals:** Of 144 CCS denials, 58 were referred for EPSDT and one for case management; among non-submitted cases, 105 were referred for EPSDT and four for case management.	Carveout Services CCS Q2.pdf	
VI. CM Program Effectiveness **A. Enhanced Care Management Measures**	H. Wanket	• **ECM Authorization and Enrollment Growth:** Quarter-over-quarter data showed increases in ECM approvals, partial approvals, denials, and overall member enrollment, with a 28% increase in enrolled members and a 34.1% increase in completions. • **Adult and Child Population Trends:** Adult ECM enrollment grew most among homeless and high utilizer populations, with decreases in SMI/SUD and LTC categories; child ECM enrollment increased across all focus populations, especially homeless and child welfare.	CalAIM ECM.pdf	

Utilization Management Committee Meeting Minutes
September 26, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• **Grandfathered Member Graduation:** The number of grandfathered members decreased by 13% quarter-over-quarter, with a 112% increase in completions, indicating progress in transitioning members out of ECM.		
B. Community Supports Measures	K. Glasby	• **Utilization and Criteria Changes:** Community supports utilization decreased by approximately 800 members from January to June 2025, attributed to new eligibility criteria and targeted support for vulnerable populations; authorizations and encounters became more closely aligned after UM implementation. • **Turnaround Time Reporting:** Turnaround times were affected by UM process changes and reporting logic issues, with ongoing staff education and report updates to improve accuracy and meet the 95% metric goal. • **Policy Guide Updates and Implementation:** DHCS released new policy guides with staggered go-live dates; non-housing criteria went live on 7/1, housing criteria and UM process for housing team scheduled for 1/1 and 11/1 respectively, with transitional rent policy launching on 1/1/26.	CS Metrics.pdf	
VII. Member / Provider Experience with UM & CM **A. CAHPS**	A. Lam	• **Survey Administration and Response Rates:** CAHPS surveys were administered annually by Press Ganey, with commercial adult response rates increasing and Medi-cal adult/child rates decreasing, emphasizing the importance of encouraging member participation for accurate results.	MY2024 Member Satisfaction Survey R	

Utilization Management Committee Meeting Minutes
September 26, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
		• **Trends and Areas for Improvement:** Commercial adult members reported improvements in getting needed care quickly, but decreases in doctor communication and health plan ratings; similar trends were observed in Medi-cal populations, with opportunities identified in specialist access, communication, and care coordination.		
B. CM Program	J. Rosales	• **Survey Methodology and Demographics:** Surveys were administered to members completing complex case, transitions of care, or care coordination cases, with majority English and Spanish speakers; workflow adjustments included supervisor-led phone surveys and options for electronic submission. • **Member Satisfaction and Program Impact:** Survey results showed high satisfaction with time spent, helpfulness of information, and health condition management, with most respondents rating their experience positively and indicating improved health and well-being. • **Follow-Up and Support:** Members reported satisfaction with follow-up and support, with 50% indicating a desire for future contact; low scores prompted outreach for re-engagement, and high utilizers often cycled through case management multiple times. • **Professionalism and Overall Satisfaction:** Members rated case manager professionalism highly, with strong overall satisfaction and willingness to recommend the Alliance; feedback is used for quality improvement and regulatory reporting.	Member Satisfaction Survey Results (CM).pdf	

Utilization Management Committee Meeting Minutes
September 26, 2025, 1:30 PM – 3:00 PM
Teams

Agenda Item	Presenter	Discussion/Activity	Document	Follow-Up Action/ Responsible party/ target date
VIII. Adjournment	A. Lam	The meeting was adjourned at **3:00 pm**		**Next Meeting:** October 31, 2025 at 1:30 PM

Meeting Minutes submitted by: DocuSigned by: Amani Sattar 1515265B2F7F4DC... **Date:** 10/16/2025 | 1:09 PM PDT

Amani Sattar,
EA to the CMO

Approved by: DocuSigned by: Allison Lam 8E7713C4669F403... **Date:** 10/17/2025 | 8:06 AM PDT

Allison Lam,
Sr. Director, Health Care Services

Utilization Management Committee Meeting Minutes
October 31, 2025, 1:30 PM – 3:00 PM
Teams

Member Name and Title	Present	Member Name and Title	Present
Donna Carey, Chief Medical Officer	X	Katherine Goodwin, Supervisor, Health Plan Audits	
Richard Golfin, Chief Compliance Officer		Kimberly Glasby, Director, Long Term Services & Supports	X
Tiffany Cheang, Chief Analytics Officer	X	Kisha Gerena, Manager, Grievances & Appeals	
Allison Lam, Senior 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	
Andrea DeRochi, Manager, Behavioral Health	X	Lisha Reamer-Robinson, Manager, Compliance Audits & Investigation	
Annie Lam, Manager, Provider Services Call Center		Loc Tran, Manager, Access to Care	
Benita Ochoa, Lead Pharmacy Tech		Luke Lim, Sr. Director, Pharmacy	X
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	X	Nora Tomassian, Director, Pharmacy	
Darryl Crowder, Director, Provider Relations and Contracting		Oscar Macias, Manager, Housing Program	X
Daphne Lo, Medical Director, LTSS	X	Parag Sharma, Medical Director	
Farashta Zainal, Manager, Quality Improvement		Peter Currie, Senior Director, Behavioral Health	X
Gia Degrano, Senior Director, Member Services	X	Rahel Negash, Pharmacy Supervisor	
Gil Duran, Manager, Population Health & Equity	X	Ramon Tran Tang, Clinical Pharmacist	
Heather Wanket, Clinical Manager, ECM	X	Sanya Grewal, Healthcare Services Specialist	X
Hope Desrochers, Manager, Outpatient UM	X	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	X	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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I. Call to Order/ Introductions	A. Lam	The meeting was called to order by Allison Lam at **1:32 pm**		
II. Review and Approval of minutes	A. Lam	The UM Committee Minutes from **September 26, 2025** were approved electronically by a quorum of the committee prior to the meeting.	UMC_Meeting Minutes_9.26.25.doc›	**Approved via e-vote:** 10/16/25 – 10/17/25
III. Policies and Procedures	All	• See list of policies attached	PP Summary of Changes_10.31.25.pd	**Vote to Approve:** None opposed: The policies will be finalized as approved and moved forward to QIHEC
IV. Clinical Decision Support Tools **A. Operational Utilization Review Measures (IP)** **B. Operational Utilization**	C. HealyLondon H. Desrochers P. Currie	• **Outpatient Quality Review**: Outpatient audit results for Q3 ○ 100% compliance in clinical decision-making and care coordination, 98.8% in member/provider notification, but only 64% in timeliness due to physician staffing issues, resulting in an overall score of 90.7% (below the 95% benchmark).	Operational Utilization Review_OF Operational Utilization Review_IP.	• **Denial and Appeals Data Analysis:** Overlay denial rate data with appeals information to

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Review Measures (OP)
C. Operational Utilization Review Measures (BH)
		• **Inpatient Utilization Review:** Inpatient operational data for Q3
		  ○ 3% increase in concurrent inpatient authorization volume from Q1 to Q3, overall compliance with turnaround time benchmarks except for a small IHSS fallout, fluctuating denial rates (2.8% to 5%), and ongoing efforts to optimize prior authorization and address MD staffing.
		• **Denial Rate and Appeals Data Discussion:** There are overlapping denial rates with appeals data to identify trends
		  ○ Clarification provided that current reporting reflects only initial denial decisions, not those overturned on appeal, and suggests future integration of these data sets for more comprehensive analysis.
		• **Behavioral Health Metrics**: Review of behavioral health authorization volumes, turnaround times (recovered after a system issue), denial rates (noting a July spike due to retroactive authorizations), NOAA denial audit scores (98%), and treatment plan review improvements, with ongoing monitoring and preparations for DSNP-specific audits.
			Operational Utilization Review_BH	identify trends and potential opportunities for improvement. (Carla, Hope)

V. UM Program Effectiveness **A. CBAS Measures**	H. Desrochers	• **CBAS Program Metrics:** Q3 CBAS data, includes 346 requests/assessments, 100% turnaround time, member transitions (deaths, discharges, moves), IPC renewals, emergency remote services (ERS) activity, and the impact of new direct access to the Peach portal for improved monitoring and reporting.	CBAS_Q3.pdf	• **CBAS Center DSNP Contracting:** Confirm with CBAS centers if they have any questions regarding

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				DSNP and coordinate with Melissa regarding the upcoming contract amendment outreach. (Hope)
VI. Delegation Oversight **A. CHCN** **B. CM**	M. Findlater J. Rosales	• **Delegation Oversight and Partner Performance:** Review of delegation oversight reports for CHCN and CFMG, discuss denial rates, turnaround times, notification compliance, and corrective actions to address performance gaps, particularly in CHCN's initial outreach turnaround times. ○ **CHCN Denial and Turnaround Metrics:** CHCN's combined inpatient/outpatient denial rates (0.32% in Q1, 0.29% in Q2), with group care and Medi-Cal turnaround times generally above benchmarks except for notification TAT and non-urgent pre-service TAT, which were below targets and are being audited. • **CHCN BCM Department Audit and Remediation:** Details of monthly audits of CHCN's BCM department, highlights persistent low initial outreach turnaround times (0-22%), strong care coordination once cases are started, and corrective actions including referral pauses, retraining, and gradual resumption of referrals to support improvement and compliance with delegation oversight requirements.	 Delegation Oversight_CHCN.pdf  CM Delegation Oversight_CHCN.pdf	

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C. CFMG	M. Findlater	• **CFMG Performance Metrics**: CFMG's Q2 data, show denial rates below 1% for both inpatient and outpatient, and consistent compliance (99-100%) with all Medi-Cal benchmarks.	Delegation Oversight_CFMG.pdf	
VII. Adjournment	A. Lam	The meeting was adjourned at **2:15 pm**		**Next Meeting:** November 21, 2025 at 12:30 PM

Meeting Minutes submitted by: DocuSigned by: Amani Sattar 1515265B2F7F4DC... **Date:** 11/03/2025 | 1:41 PM PST

Amani Sattar,
EA to the CMO

Approved by: DocuSigned by: Allison Lam 8E7713C4669F403... **Date:** 11/03/2025 | 1:46 PM PST

Allison Lam,
Sr. Director, Health Care Services