Quality Improvement Health Equity/Utilization Management Committee Meeting

Friday, August 14 2026

Alameda Alliance for Health
Meeting Agenda

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I. Meeting Information

Meeting Name: Quality Improvement Health Equity /Utilization Management Committee

Date	Time	Location
Friday, August 14, 2026	9:00am – 11:00am	Alameda Alliance for Health HQ 1240 S. Loop Rd. Alameda

Meeting Facilitator Name	Call-In Number	Webinar URL
Ashley Asejo	**Microsoft Teams**	Standing Committees – Alameda Alliance for Health

IMPORTANT PUBLIC HEALTH AND SAFETY MESSAGE REGARDING PARTICIPATION AT ALAMEDA ALLIANCE FOR HEALTH COMMITTEE MEETINGS

YOU MAY SUBMIT COMMENTS ON ANY AGENDA ITEM OR ON ANY ITEM NOT ON THE AGENDA, IN WRITING VIA MAIL TO "ATTN: ALLIANCE QIHEC COMMITTEE" 1240 SOUTH LOOP ROAD, ALAMEDA, CA 94502; OR THROUGH E-COMMENT aasejo@alamedaalliance.org YOU MAY WATCH THE MEETING LIVE BY LOGGING IN VIA COMPUTER AT THE LINK PROVIDED ABOVE. IF YOU USE THE LINK AND PARTICIPATE VIA COMPUTER, YOU MAY, THROUGH THE USE OF THE CHAT FUNCTION, REQUEST AN OPPORTUNITY TO SPEAK ON ANY AGENDIZED ITEM, INCLUDING GENERAL PUBLIC COMMENT. YOUR REQUEST TO SPEAK MUST BE RECEIVED BEFORE THE ITEM IS CALLED ON THE AGENDA.

PLEASE NOTE: ALAMEDA ALLIANCE FOR HEALTH IS MAKING EVERY EFFORT TO FOLLOW THE SPIRIT AND INTENT OF THE BROWN ACT AND OTHER APPLICABLE LAWS REGULATING THE CONDUCT OF PUBLIC MEETINGS, IN ORDER TO MAXIMIZE TRANSPARENCY AND PUBLIC ACCESS. DURING EACH AGENDA ITEM, YOU WILL BE PROVIDED A REASONABLE AMOUNT OF TIME TO PROVIDE PUBLIC COMMENT. THE COMMITTEE WOULD APPRECIATE, HOWEVER, IF COMMUNICATIONS OF PUBLIC COMMENTS RELATED TO ITEMS ON THE AGENDA, OR ITEMS NOT ON THE AGENDA, ARE PROVIDED PRIOR TO THE COMMENCEMENT OF THE MEETING.

Alameda Alliance for Health
Meeting Agenda

II. Meeting Objective

To improve quality of care and close health equity gaps for Alliance members by facilitating clinical oversight and direction.

III. Voting Members

Name	Title
☐ Donna Carey, MD	Chief Medical Officer, Alameda Alliance for Health
☐Stephanie Brown, MD	Medical Director, Quality Improvement
☐Parag Sharma, MD	Medical Director, Utilization Management
☐ James Florey, MD	Chief Medical Officer, Children First Medical Group
☐ Lisa Laurent, MD	Chief Medical Officer, Alameda Health System
☐ Raj Davda, MD	Chief Medical Officer, Community Health Center Network
☐ Sirina Keesara, MD	Medical Director, Community Health Center Network
☐ Michelle Stott	Senior Director, Quality, Alameda Alliance for Health
☐ Anchita Venkatesh, DMD MA	Program Director, General Practice Residency, Highland Hospital
☐ La Toshia Palmer, Ed. D LCSW	Executive Director, Alameda County Office of Education
☐ Deka Dike	CEO, Omotochi
☐ Monique Hedmann, MD MPH	Director, Department of Adult Medicine, Baywell Health
☐ Sherilyn Cook, MD	

IV. Meeting Agenda

Topic	Time	Document	Responsible Party	Vote to Approve or Informational
Call to Order/Roll Call	1min			
1. Alameda Alliance Updates • Staffing Update • Voting Member Update	5min	Verbal	D. Carey	Informational

Topic	Time	Document	Responsible Party	Vote to Approve or Informational
• DMHC Investigative Interrogatories				
2. Health Equity Updates • DMHC CAP Update • UIS Transition Update	5min	Verbal	S. Brown	Informational
3. Committee Member Presentation: Text Messaging Program, Children First Medical Group	15min	Document	J. Florey	Informational
4. Policies & Procedures • All Policies Listed Below	5min	Document	D. Carey	Vote
5. Approval of Committee Meeting Minutes • QIHE/UMC: 5/8/26 • AAA: 5/20/26 • CLSS: 4/22/2026 • CAC: 3/12/2026 • IQIC: 5/16/2026, 6/16/2026, 7/21/2026	1min	Document	D. Carey	Vote
Quality Improvement Health Equity Program (Complete Work Plan was included in the meeting packet)				
6. D-SNP Core Measures	1min	Document	M. Stott	Informational
7. QIHE Work Plan Update • 2026 HEDIS Update	5min	Document	F. Zainal	Informational

Topic	Time	Document	Responsible Party	Vote to Approve or Informational
8. Population Health • PHM KPIs Feedback	5min	Document	L. Ayala G. Duran	Informational
9. Access & Availability Geo-Access • Survey Results: PAAS, QMRT • Provider CAP	10min	Document	L. Tran	Informational
10. PQI • DMHC CAP: PQI CAP • PQI Internal Dashboard	5min	Document	M. Stott	Informational
11. UM Work Plan Update	10min	Document	M. Findlater	Informational
12. Stars Performance	5 min	Document	J. Goradia	Informational
13. Member Experience Report	5min	Document	J. Karmelich	Informational
14. Behavioral Health Update	5min	Document	A. DeRochi	Informational
15. Public Comments	2min	Verbal	D. Carey	Informational
Adjournment	2min	Verbal	D. Carey	Next Meeting: November 13, 2026

Americans with Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or a participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact Ashley Asejo aasejo@alamedaalliance.org at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodation to attend or participate in meetings on a regular basis.

Policies & Procedures	
QI-107: Appointment Access and Availability Standards	CM-019: Private Duty Nursing Case Management For Members under the age of 21

QI-108: Access to Behavioral Health Services	CM-046: Plan Responsibilities IHCP and American Indian Members
QI-116: Provider Appointment Availability Survey (PAAS)	BH-XXX: Behavioral Health Data Sharing
HED-001: Health Education Program	UM-001: Utilization Management Program
HED-002: Health Education Materials	UM-003: Concurrent Review and Discharge Planning Process
HED-006: SABIRT Services HED-007: Tobacco Cessation	UM-004: Over and Underutilization
HED-009: Diabetes Prevention Program	UM-005: Second Opinions
HED-010: Doula Services	UM-007: New and/or Experimental Technology Review Process
PH-001: Population Health Management Program	UM-008: Coordination of Care- California Children's Services (CCS)
PH-002: Basic Population Health Management	UM-011: Coordination of Care - Hospice Services and Terminal Illness
PH-003: Risk Segmentation and Stratification	UM-014: Identifying and Reporting Potential Child, Adult or Elder Abuse
PH-005: Population Assessment	UM-023: Communicable Disease Reporting and Services
QI: Member Data Collection, Race and Ethnicity — HO2: Element A, Collection of Data on Race and Ethnicity	UM-036: Continuity of Care for Terminated and Non- Participating Providers
QI: Member Data Collection, Language— HO2: Element B, Collection of Data on Language	UM-045: Communication Services - UM
QI: Member Data Collection, Disability Status— HO2: Element D, Collection of Data on Disability Status	UM-046: Use of Board-Certified Consultants
QI: Member Data Collection, Sexual Orientation — HO2: Element C, Collection of Data on Sexual Orientation	UM-048: Triage & Screening Services
QI: Geographic Classification— HO2: Element F, Classification of Geographic Data	UM-050: Tracking and Monitoring of Services Prior Authorized
LTC-001: Long Term Care Program	UM-051: Timeliness of UM Decision Making and Notification
LTC-002: Authorization Process and Criteria for Admission, Continued Stay, and Discharge from a Long-Term Care Facility	UM-055: Palliative Care
LTC-004: LTC Bed Hold and Leave of Absence	UM-057: Authorization Service Request
CLS-001: Cultural and Linguistic Program Description	UM-058: Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving a Medical Exemption
CLS-002: Community Engagement	UM-070: UM Information Integrity

CLS-003: Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities	UM-D-001: Prior Authorization/Concurrent Review/Organization Determination Audit Process Policy (RGR)
CLS-008: Member Assessment of Cultural and Linguistic needs	UM-D-003: Readmission Review Policy
CLS-009: CLS Program - Contracted Providers	UM-D-007: New and/or Experimental Technology Review Process
CLS-010: CLS Program - Staff Training and Assessment	QI: NCQA Accreditation Process
CLS-011: CLS Program - Compliance Monitoring	
CM-002: Complex Case Management Plan Development and Management	

Voting Member Roll Call

Dr. Donna Carey

Alameda Alliance Updates

Dr. Donna Carey

- AAH Staffing Update
- Voting member Updates
- DMHC Investigative Interrogatories

Chief of Health Equity Update

Dr. Stephanie Brown

- DMHC CAP Update
- UIS Transition Update

Committee Member Presentation: CFMG

Dr. James Florey
Chief Medical Officer,
Children First Medical Group

Voting Item: Policies & Procedures

Policies packet sent via email.

Policy Procedures Summary of Changes

Department	Policy #	Policy Name	Brief Description of Policy	Description of Changes/Current Revisions	Policy Update (X)	New Policy (X)	Annual Review or Formatting Changes (X)	Retire (X)	Presenter	Subcommittee Approval Date (QIHEC, PRCC, P&T) if applicable
QI	107	Appointment Access and Availability Standards	Describes how the Alliance implements and maintain procedures for members to obtain appointments for routine (non-urgent) and urgent care from all applicable provider types.	Annual review, minor formatting changes			X		Loc Tran	
QI	108	Access to Behavioral Health Services	Describes how the Alliance implements and maintain procedures to ensures the Alliance complies with the access and availability standards set by DMHC and DHCS.	Annual review, minor formatting changes			X		Loc Tran	
QI	116	Provider Appointment Availability Survey (PAAS)	Describes the PAAS survey process designed to monitor Alliance delegated and directly contracted provider compliance with access and availability standards for Alliance members.	Annual review, minor formatting changes			X		Loc Tran	
Quality Improvement	HED-001	Health Education Program	Descibes Alliance Health Education Program Elements	Minor upates based on DHCS nomenclature changes from *PNA* to *Local Planning* in PHM Policy Guide.			X		Gil Duran	
Quality Improvement	HED-002	Health Education Materials	Describes process for creating and approving health education and member informing materials.	Annual update.			X		Gil Duran	
Quality Improvement	HED-006	SABIRT Services	Describes alcohol and drug screening, assessment, brief interventions and referral to treatment benefit.	Annual update.			X		Gil Duran	
Quality Improvement	HED-007	Tobacco Cessation	Describes Alliance policy on tracking tobacco use and implementing cessation services.	Annual update.			X		Gil Duran	
Quality Improvement	HED-009	Diabetes Prevention Program	Describes how the Alliance offers the Diabetes Prevention Program to eligible members.	Minor refinements to D-SNP coverage language. Annual update.			X		Gil Duran	
Quality Improvement	HED-010	Doula Services	Describes how the Alliance offers the Doula Benefit to eligible members.	Annual update.			X		Gil Duran	
Quality Improvement	PH-001	Population Health Management Program	Descibes the elements of the Alliance's Population Health Management Program in alignment with the DHCS PHM Policy Guide. Refers to Alliance policies and procedures that detail Alliance population health management elements and programs.	Updated the PHM Program policy to align with the DHCS PHM Policy Guide by updating definitions and terminology for Local Planning and CHA/CHIP participation. The policy was also updated to align with NCQA Health Outcomes Accreditation standards by expanding health disparities monitoring, stratification, intervention, and evaluation requirements across race/ethnicity, language, disability status, geographic classification, and other demographic factors.	X				Gil Duran	
Quality Improvement	PH-002	Basic Population Health Management	Describes Alliance Population Health Management supports including provision of BPHM services by PCPs, role of Alliance ECM, LTC and Care Management staff, Wellness and Prevention activities and refers to related P&Ps and services.	Annual update.			X		Gil Duran	
Quality Improvement	PH-003	Risk Segmentation and Stratification	Describes Alliance Population Health Management data sources and processes for risk stratification and segmentation of members.	Annual update.			X		Gil Duran	
Quality Improvement	PH-005	Population Assessment	Describes how the Alliance understands and assesses its member population and subpopulations by demographics, health, utilization, SDOH and other characteristics in compliance with DHCS PHM Policy Guide and NCQA PHM requirements.	Minor updates to align definitions with PHM Policy Guide and refinements to D-SNP language. Annual update.			X		Gil Duran	
QI	TBD	Member Data Collection, Race and Ethnicity– HO2: Element A, Collection of Data on Race and Ethnicity	Describes direct data collection methods for member race and ethnicity.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	
QI	TBD	Member Data Collection, Language– HO2: Element B, Collection of Data on Language	Describes direct data collection methods for member language.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	
QI	TBD	Member Data Collection, Disability Status– HO2: Element D, Collection of Data on Disability Status	Describes direct data collection methods for member disability status.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	

Policy Procedures Summary of Changes

QI	TBD	Member Data Collection, Sexual Orientation – HO2: Element C, Collection of Data on Sexual Orientation	Describes direct data collection methods for member sexual orientation.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	
QI	TBD	Geographic Classification– HO2: Element F, Classification of Geographic Data	Describes standardized methodology for member geographic classification.	New policy to meet changes to NCQA Health Outcomes requirements		X			Linda Ayala	
Long Term Care	001	Long Term Care Program	Overview of Long Term Care program, including LTSS Liaison and Quality Monitoring expectations	Added new DHCS APL requirement to host quarterly LTC Provider webinars; updated APL references to current note: Policy is posted publicly	X				Allison Lam	
Long Term Care	002	Authorization Process and Criteria for Admission, Continued Stay, and Discharge from a Long-Term Care Facility	Outlines Medical Necessity Review process, including authorization and clinical documentation requirements, turnaround times, and member/provider notification expectations	Added regulatory reference noting the inability for health plan to pay nursing facilities and subacute facilities if federal PASRR process is not completed; added allowable authorization durations (up to 2 years, at the discretion of the reviewer) note: Policy is posted publicly	X				Allison Lam	
Long Term Care	004	LTC Bed Hold and Leave of Absence	Outlines requirements for Bed Hold and Leave of Absence requests, including required clinical documentation requirements	Added documentation requirements to review Bedhold and Leave of Absence requests, per DHCS LTC Provider Manual; added process for updating existing authorizations with bedhold dates note: Policy is posted publicly	X				Allison Lam	
CLS	001	Cultural and Linguistic Program Description	Describes elements of the Alliance Cultural and Linguistic Services including objectives, activities, roles, work plan and organization chart.	Minor grammar and formatting updates. Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CLS	002	Community Engagement	Describes role, function and policies for the Alliance Community Advisory Committee.	Minor grammar and formatting updates. Committee reference updated from QIHEC to QIHE/UMC. Updated: Alliance logo CAC Duties CAC Attendance			X		Linda Ayala	CLSS: July 22, 2026
CLS	003	Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities	Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities	Minor formatting and wording updates. Added the following definition: discrimination grievance. Added the term, "race" in Member Identification section. Updated: Alliance logo Alternative Format Selection (AFS) to comply with Primary Contract-Amendment 11			X		Linda Ayala	CLSS: July 22, 2026
CLS	008	Member Assessment of Cultural and Linguistic needs	Member Assessment of Cultural and Linguistic needs	Minor formatting updates. Separated "race" and "ethnicity". Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CLS	009	CLS Program - Contracted Providers	CLS Program - Contracted Providers	Minor formatting updates. Committee reference updated from QIHEC to QIHE/UMC. Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CLS	010	CLS Program - Staff Training and Assessment	CLS Program - Training and Assessment	Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CLS	011	CLS Program - Compliance Monitoring	CLS Program - Compliance Monitoring	Minor grammar and formatting updates. Committee reference updated from QIHEC to QIHE/UMC. Updated Alliance logo.			X		Linda Ayala	CLSS: July 22, 2026
CMDM	CM-002	Complex Case Management Plan Development and Management	CCM Care Plan Development	addition of language around provider method and frequency of collaboration	X				Lily Hunter	
CMDM	CM-019	Private Duty Nursing Case Management For Members under the age of 21	CM for members receiving private duty nursing	addition of APL 26-009 language, members may decline CM	X				Lily Hunter	

Policy Procedures Summary of Changes

CMDM	CM-046	Plan Responsibilities IHCP and American Indian Members	Responsibilities of AAH related to Indian Health Care Providers (IHCP) and American Indian Members in alignment with APL 24-002	new policy		X			Lily Hunter	
BH	BH-XXX	Behavioral Health Data Sharing	New policy to address APL 24-004 which requires MCPs share BH data with state, contracted network providers, and Alameda County Behavorial Health. Requires the use of DHCS consent forms for the release of BH information.	new policy		X			Andrea DeRochi	
UM	UM-001	Utilization Management Program	Overall UM Program Guidelines including hierarchy and services	Updated NCQA Factor 3 language r/t OON utilization, updated UM Committee/ QIHE Committee to QIHE/UMC- Completed 7/22/2026	X		X		Michelle Findlater	
UM	UM-003	Concurrent Review and Discharge Planning Process	This policy addresses the provision of inpatient services provided in an acute and long-term care acute inpatient settings: medical/surgical or behavioral. The attending physician is responsible for the care of the inpatient member seven (7) days a week, twenty-four (24) hours a day.	Updated language related to UM Denial Agreement. DMHC Finding #9 verbiage update requested for alignment with agreements with treating provider prior to issuance of a denial	X				Michelle Findlater	
UM	UM-004	Over and Underutilization	To establish a systematic approach for identifying, monitoring and addressing patterns of healthcare over- and underutilization to ensure appropriate allocation of healthcare resources, improve quality of care and promote cost-effectiveness while meeting members' healthcare needs	Changed spelling throughout of Over- and Underutilization to ensure alignment. Changed all references from UMC to the combined QIHE/UMC , updated the BH policy reference	X		X		Michelle Findlater	
UM	UM-005	Second Opinions	This policy establishes guidelines for requesting, processing and documenting second opinions to promote patient-centered care and informed decision-making.	Annual Review- minor formatting updates. Aligned turn around times to UM-051. Corrected Compliance Delegation Oversight policy number and reference to QIHE/UMC.	X		X		Michelle Findlater	
UM	UM-007	New and/or Experimental Technology Review Process	established mechanism for reviewing new and/or experimental technology as well as a new application of existing technology. The intent of the evaluation of new developments in technology and new applications of existing technology is to ensure that Alliance members have equitable access to safe and effective care.	Annual Review- minor formatting updates. Reference to QIHE/UMC.	X		X		Michelle Findlater	
UM	UM-008	Coordination of Care- California Children's Services (CCS)	This Policy describes how Primary care providers (PCPs) and specialists are responsible for the early identification and referral of children with potentially eligible conditions to the California Children's Services (CCS) program, notifying Alameda Alliance's Utilization Management (UM) Unit of such referrals to ensure the delivery of medically necessary care throughout the referral process regardless of CCS eligibility status.	Updated formatting (Major), Changed to new QIHE/UMC, Added scope for CCS Age out to 17 and Delegated assessments and quarterly check ins. Removed reference to outdated CCS referral workflow. Updated Compliance Policy number	X		X		Michelle Findlater	
UM	UM-011	Coordination of Care - Hospice Services and Terminal Illness	To establish a comprehensive, compassionate and regulatory-compliant approach to hospice and terminal illness care ensuring patient dignity, comfort and appropriate medical management.	Major reformatting- alignment with the draft APL related to Auth and documentation requirements. Updated Policy alignment for Compliance and Claims. Annual Review.	X		X		Michelle Findlater	
UM	UM-014	Identifying and Reporting Potential Child, Adult or Elder Abuse	PCPs are responsible for the overall health care of assigned Members including the identification and reporting of suspected child, adult, or elder abuse cases.	Annual Review. Minor Formatting. Updated QIHE/UMC reference	X		X		Michelle Findlater	
UM	UM-023	Communicable Disease Reporting and Services	reporting of communicable diseases, and to implement directives from public health authorities.	Annual Review. Minor Formatting. Updated QIHE/UMC reference	X		X		Michelle Findlater	
UM	UM-036	Continuity of Care for Terminated and Non- Participating Providers	The Alliance provides for the completion and continuity of covered services by a terminated or out-of-network/non-participating provider (NPP) of any type at the member's request in accordance with Health and Safety Code Section 1373.96, including medical and mental health service providers.	Update the new APL Block Transfer 25-019- no language needed other than the reference. Updated various outdated definitions, added in definitions for Preclusion and Exclusion, updated all APL references to newer versions. Changed listed TATs to reference UM 051 UM Timeliness policy	X		X		Michelle Findlater	

Policy Procedures Summary of Changes

UM	UM-045	Communication Services - UM	To establish and maintain procedures ensuring that members have timely access to Utilization Management (UM) staff for information about the UM process, authorization of care and status of requests in accordance with DHCS and CMS regulations.	Annual Review. Minor Formatting. Updated QIHE/UMC reference, Updated references with most Up to date	X		X		Michelle Findlater	
UM	UM-046	Use of Board-Certified Consultants	To establish standards governing the use of Board-Certified Consultants and other qualified clinical reviewers in utilization management activities to ensure medical necessity determinations, organizational determinations, and appeals are based on appropriate clinical expertise and comply with Medi-Cal Managed Care, Medicare Advantage (D-SNP), DHCS, CMS, and NCQA requirements.	Updated language related to Board Certified consultant roles in appeals, conflicts of interest, Peer-to- peer. Added more references and aligned with the QIHE/UMC terminology.	X		X		Michelle Findlater	
UM	UM-048	Triage & Screening Services	Alameda Alliance for Health ("Alliance") arranges for triage and screening services available by telephone to members 24 hours per day, 7 days per week. The plan establishes a consistent, effective, and compliant approach to patient triage and screening. Telephone triage or screening services are provided in a timely manner appropriate for the requesting member's condition.	Updated language related to BH service availability, unlicensed staff roles and responsibilities, availability of information for members and providers and updates the reference sections.	X		X		Michelle Findlater	
UM	UM-050	Tracking and Monitoring of Services Prior Authorized	This policy establishes procedures for the systematic tracking and monitoring of healthcare services subject to prior authorization (PA) requirements. It ensures compliance with CMS and Medicaid services regulations for PA and safeguards against improper utilization.	Updates for the QIHE/UMC references. Enhancements for the Interoperability data submissions requirements. Enhances language for Delegation Oversite monitoring. Added enhanced language related to health equity monitoring. Added reference documents.	X		X		Michelle Findlater	
UM	UM-051	Timeliness of UM Decision Making and Notification	Alameda Alliance will meet all applicable state and federal timely decision-making regulations, based in whole or in part on medical necessity in determining whether to approve, modify, or deny requests by providers.	DMHC #9 Follow up Updated language related to knox keene definition and clarified the 24 hours per DMHC request	X				Michelle Findlater	
UM	UM-055	Palliative Care	This policy establishes guidelines for the provision of palliative care services in alignment with Medicare and Medicaid services (CMS)	Annual Review. Minor updates to references, and clarified D-SNP language about payor.	X		X		Michelle Findlater	
UM	UM-057	Authorization Service Request	current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.	Added Exclusion, preclusion & termination language, clarified non-clinical denial scope language, minor formatting, grammar, references and affiliated policies updated, added language to clarify there are no compensation or performance evaluations based on denials reductions or limitations of services. Change P2P to business day from same day. Removed language that Bedholds & Leaves of absence require an auth	X				Michelle Findlater	
UM	UM-058	Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving a Medical Exemption	This policy establishes guidelines and procedures for ensuring continuity of care for Dual Special Needs Plan (D-SNP) and Medi-Cal plans who have Medical Exempt Requests (MER). This policy ensures compliance with federal and state regulations governing continuity of care while facilitating smooth transitions for members with complex medical conditions.	Annual update. Changed beneficiary to member throughout. Updated APL reference.	X		X		Michelle Findlater	
UM	UM-070	UM Information Integrity	maintaining and safeguarding information used in the Utilization Management (UM) decision-making and denial notification processes to ensure accuracy, completeness, readability, and protection against unauthorized or inappropriate modification.	Updated title of policy to better align with NCQA requirements, strengthened audit language, corrected dept titles. Reworded policy statement	X				Michelle Findlater	

Policy Procedures Summary of Changes

UM	UM-D-001	Prior Authorization/Concurrent Review/Organization Determination Audit Process Policy (RGR)	This policy establishes a standardized audit process to evaluate the accuracy, timeliness, and compliance of these activities, promoting high-quality care and adherence to CMS and DHCS requirements.	Annual Review. Minor grammar updates. Changed the audit cadence from monthly to quarterly due to volume limitations at this time.	X				Michelle Findlater	
UM	UM-D-003	Readmission Review Policy	The Readmission Review Policy establishes a process to evaluate readmissions for members, ensure medical necessity, optimize resource utilization, and reduce potentially preventable readmissions (PPRs).	Refined language for the CM referrals. Annual Review	X		X		Michelle Findlater	
UM	UM-D-007	New and/or Experimental Technology Review Process	established mechanism for reviewing new and/or experimental technology as well as a new application of existing technology	Updated QIHE/UMC references. And Compliance policy reference.	X		X		Michelle Findlater	
QI		NCQA Accreditation Process	This policy establishes a standardized process for planning, managing, documenting, and maintaining accreditation readiness and compliance with applicable National Committee for Quality Assurance (NCQA) standards.	MCAL, IHSS	New		X		Eileen Ahn	

Voting Item: Committee Meeting Minutes

Minutes packet sent via email.

- **Quality improvement Health Equity Utilization Management Committee** 5/8/26
- **Access & Availability Subcommittee** 5/20/26
- **Cultural Linguistic Services Subcommittee** 4/22/26
- **Community Advisory Committee** 3/12/26
- **Internal Quality Improvement Committee** 5/16/26, 6/16/26, 7/21/26

D-SNP Core Measures

Michelle Stott

Dual Special Needs Population (DSNP)

Core Measures

Reporting requirements

- Dual-Eligible Special Needs Plans (D-SNPs) have several reporting requirements for *care coordination and quality* consistent with:
  - **DHCS** – Comprehensive Quality Strategy, Long-Term Services and Supports (LTSS), and Master Plan for Aging
  - **Centers for Medicare and Medicaid (CMS)** – Medicare Advantage Plans

Report Types

- STAR measures and ratings
- Medicare Part C: Oversight of services
  - Organizational Determinations (G&A)
  - Enrollment & Disenrollment
  - Model of Care (D-SNP)
  - Quality Improvement
  - Provider Network Adequacy
  - Supplemental Benefits
  - Customer Service Operations
  - Compliance & Program Integrity
  - Encounter Data & Data Validation
- Medicare Part D:
  - Medication management

References

- DHCS: Reporting requirements: https://www.dhcs.ca.gov/d-snp-quality-and-data-reporting/
- CMS: Reporting requirements: https://www.cms.gov/files/document/cy2026-part-c-reporting-requirements-12-01-2025.pdf

Quality Improvement Work Plan Update

Complete Work Plan was sent via email

2026 HEDIS Update

2026 Medi-Cal Managed Care Accountability Measures (MCAS)

Farashta Zainal, Manager, QI Performance

2026 HEDIS/MCAS Measures Held to MPL

Behavioral Health	Cancer Prevention	Children's Health	Chronic Disease Management	Reproductive Health
*Depression Screening and Follow-Up for Adolescents and Adults – 30 Day DSF-E	Breast Cancer Screening (BCS-E)	Childhood Immunization – Combo 10 –(CIS-10)	Controlling High Blood Pressure (CBP)	*Postpartum Depression Screening and Follow-up - Screening (PDS-E-DS)
Follow-Up After ED Visit for Alcohol and Other Drug Dependence – 30 Day (FUA)	Cervical Cancer Screening (CCS-E)	Developmental Screening in the First Three Years of Life (DEV-CH)	Glycemic Status >9.0% (GSD)	*Prenatal Depression Screening and Follow-up - Screening (PND-E-DS)
Follow-Up After ED Visit for Mental Illness – 30 Day (FUM)	*Colorectal Cancer Screening (COL-E)	Immunizations for Adolescents Combo 2 (IMA-2)		Timeliness of Prenatal Care (PPC-Pre)
		Lead Screening in Children (LSC-E)		Timeliness of Postpartum Care (PPC-Pst)
		Topical Fluoride for Children (TFL-E)		
		Well Child Visit in the First 15 Mo of Life – 6 or more (W15)		
		Well Child Visit for Age 15 months to 30 months – 2 or more visits (W30)		
		Child Adolescent Well-Care Visits (WCV)		

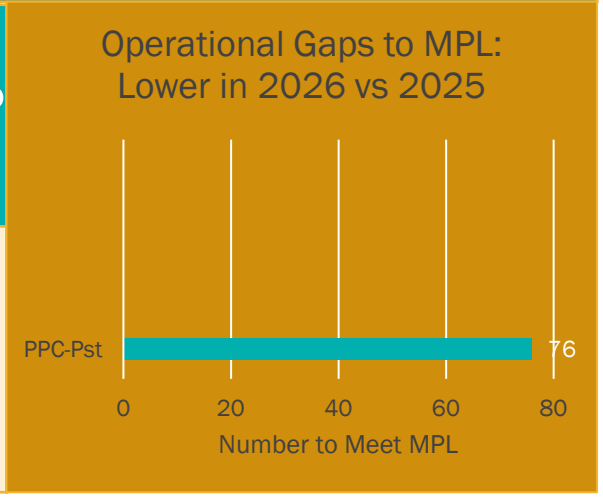
MY2026 (as of July) MCAS Rates – Benchmark Summary

10 of 20 measures meet or exceed MPL; one slipped year-over-year — PPC-Pst

MPL / 50th	75th percentile	90th percentile
6 of 20	3 of 20	1 of 18
30%	15%	.05%

OPERATIONAL GAPS TO MPL — MEASURES LOWER IN 2026 VS 2025

Code	Measure	2026 Rate	2025 Rate	Rate Gap to MPL
PPC-Pst	Timeliness of Postpartum Care (PPC-Pst)	79.3%	82.2%	3.1%



2026 (as of July)MCAS Rates

Below MPL
Met/Exceeded MPL
Met/Exceeded 75th Percentile
Met/Exceeded 90th Percentile

Source: 16080 MY26 Medicare Rates Dashboard (PowerBI)	MY 2026 (*as of 07/08/2026*)					MY25 Benchmarks		
Accountable Measures	**Admin Rate**	**Hybrid Rate**	**Number to Treat to MPL / 50th Pctl**	**Number to Treat to 75th Pctl**	**Number to Treat to 90th Pctl**	**MPL / 50th Pctl**	**75th Pctl**	**90th Pctl**
	Behavioral Health Domain Measures							
Depression Screening and Follow-Up for Adolescents and Adults - Screening (DSF-E-DS)	19.43%		0	0	0	3.59%	9.28%	18.24%
Follow-Up After ED Visit for Alcohol and Other Drug Dependence - 30 Day (FUA)	46.77%		0	0	70	39.10%	45.80%	53.27%
Follow-Up After ED Visit for Mental Illness - 30 Day (FUM)	56.95%		4	145	322	57.13%	64.91%	74.67%
	Children's Health Domain Measures							
Childhood Immunization Status - Combo 10 (CIS-10-E)	35.63%		0	0	0	23.89%	28.86%	34.79%
Developmental Screening in the First Three Years of Life (DEV-CH)	59.26%		0	0		37.40%	52.00%	
Immunizations for Adolescents Combo 2 (IMA-2-E)	45.73%		0	0	70	34.14%	40.19%	47.16%
Lead Screening in Children (LSC-E)	68.27%		70	333	602	69.96%	76.34%	82.86%
Topical Fluoride for Children (TFL-CH)	2.05%		18,567	22,080		21.60%	25.30%	
Well-Child Visits in the First 15 Months of Life - 6 or More Visits (W15)	51.60%		442	596	754	63.38%	67.49%	71.71%
Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits (W30)	74.75%		0	102	274	72.32%	77.50%	82.12%
Child and Adolescent Well-Care Visits (WCV)	29.09%		23,756	29,225	34,785	55.41%	61.47%	67.63%
	Chronic Disease Management Domain Measures							
Asthma Medication Ratio (AMR)								
Controlling High Blood Pressure (CBP)	48.41%		4,458	5,250	6,186	67.88%	71.34%	75.43%
Glycemic Status >9.0% (GSD)	46.85%		3,139	3,882	4,440	30.41%	26.52%	23.60%
	Reproductive Health Domain Measures							
Chlamydia Screening (CHL)								
Postpartum Depression Screening and Follow-up - Screening (PDS-E-DS)	24.57%		0	0	149	5.46%	12.74%	29.75%
Prenatal Depression Screening and Follow-up - Screening (PND-E-DS)	41.32%		0	0	4	9.54%	22.07%	41.53%
Timeliness of Prenatal Care (PPC-Pre)	86.56%		0	78	130	86.37%	89.78%	91.97%
Timeliness of Postpartum Care (PPC-Pst)	79.33%		76	140	216	82.48%	85.15%	88.32%
	Cancer Prevention Domain Measures							
Breast Cancer Screening (BCS-E)	51.82%		1,354	3,212	4,843	55.87%	61.43%	66.31%
Cervical Cancer Screening (CCS-E)	49.73%		1,911	5,981	10,694	52.32%	57.83%	64.21%
Colorectal Cancer Screening (COL-E)	42.40%		0	3,186	5,970	41.39%	48.22%	53.31%

Initiatives for Prenatal/Postpartum Measures

Member Outreach Calls

- Internal Engagement Coordinator calls
- Care Management outreach calls

Provider Support

- Staff incentive
- Extended office hours
- Webinars and provider 1:1 meetings
- Resource & education flyer for providers and members

In Progress

- Provider resource guide
- Partnership with hospitals for reporting and education
- Expand CHW contracted provider network
- Childbirth education program

Population Health Update

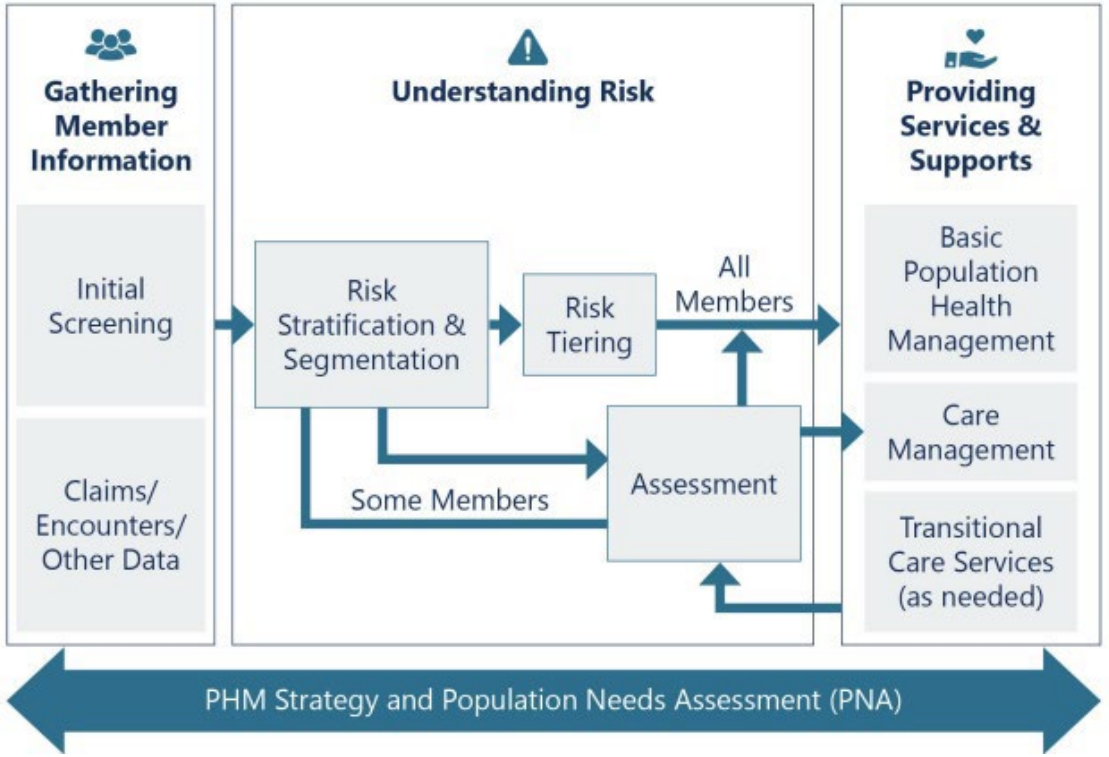
Population Health Management (PHM) KPI July Update

08/14/26

PHM KPIs

- DHCS defined six high-priority KPIs for frequent, active, and real-time monitoring of program operations and effectiveness.
- Required quarterly submissions with expectation for monthly monitoring.
- Tech specifications were updated for the April 2026 submission.

DHCS PHM Framework



PHM KPIs – April vs. July 2026

KPI	Measure	April 2026 1/1/25-12/31/25			July 2026 4/1/25-3/31/26			Difference (% points)
		%	Num	Den	%	Num	Den	
EDPC	Members Utilizing Emergency Department Care More than Primary Care	7.3	22,835	310,959	7.4	22,637	307,027	+0.1
ENPC	Members Engaged in Primary Care	44.0	136,675	310,959	44.5	136,569	307,027	+0.5
ENPC-A	Members Engaged in Primary Care at Assigned Primary Care Site	36.0	92,265	256,332	36.7	89,577	244,360	+0.7
CCME Rate A	Complex Care Management Enrollment	5.9	38	649	5.0	32	644	-0.9
CCME Rate B	*Note: Rate B looks at the subset of members from Rate A who were not enrolled in CCM in the last measurement period and thus identifies new enrollment into CCM.*	0.8	5	610	0.8	5	617	0
CMHRD	Care Management for High-Risk Members after Discharge (7 days)	20.4	3,267	15,976	30.9	4,033	13,046	+10.5
FUAH	Follow-Up Ambulatory Visit after Hospital Discharge (7 days)	32.8	4,472	13,635	33.3	4,587	13,758	+0.5

- Rates were mostly consistent except for a positive increase in CMHRD from April to May (2/1/25-1/31/26)

Access & Availability Updates

Loc Tran

MY2025 PAAS Compliant Rates

AAH Compliance rate goal for Urgent and Non-Urgent Appointment = 75%
DMHC Compliance rate goal for Urgent and Non-Urgent Appointment = 70%

- **Non-Urgent Appointments-** met goal, overall improvement.
- **Urgent Appointment-** decreased
- **Factors contributing to Urgent Appointment decline:**
  - Methodology changes
  - Physician shortage
  - Increased "On-Leave" Providers.

MY2025				Year to Year % Difference		Overall Total Score
Ancillary				Urgent	Non-Urgent	
LOB	Urgent Appt	Routine Appt				
IHSS	Not applicable	88.9%		N/A	+16.2%	Urgent: N/A
MCL	Not applicable	88.9%		N/A	+16.2%	Non-Urgent: 88.8%
PCPs						
LOB	Urgent Appt	Routine Appt				
IHSS	46.6%	73.9%		-0.9%	+2%	Urgent: 52.5%
MCL	56.1%	80.9%		-4.6%	+7.6%	Non-Urgent: 78.2%
NPMH						
LOB	Urgent Appt	Routine Appt	Follow-up Appt			
IHSS	48.0%	92.7%	93.8%	-33.9%	-0.5%	Urgent: 48.0%
MCL	48.0%	92.7%	93.8%	-33.4%	+1.9%	Non-Urgent: 92.7%
Psychiatrists						
LOB	Urgent Appt	Routine Appt				
IHSS	51.3%	93.7%		-29.1%	-2.5%	Urgent: 51.3%
MCL	51.3%	93.7%		-29.1%	-2.5%	Non-Urgent: 93.7%
Specialists						
LOB	Urgent Appt	Routine Appt				
IHSS	23.5%	67.1%		-11.2%	+15.9%	Urgent: 23.7%
MCL	23.9%	67.2%		-24.5%	+15.4%	Non-Urgent: 67.1%

Geo-Access & DHCS QMRT Summary

Geo-Access:

- No changes compared to previous quarter.
- Cities that continue to not meet time or distance:
  - -Tracy, Livermore, Mountain House, Discovery Bay, and Byron.
  - -Some of these zip-codes overlap into other nearby counties.
  - -Some zip-codes are located in uninhabitable areas where there will not be any providers. AAH **approved for alternative access** from DMHC.

DHCS QMRT MY2025:

- Urgent Appointment - 52%.
- Non-Urgent Appointment – 68%.
- Rate of compliance increased compared to the prior year for urgent & non-urgent appointment.

QI FINDING: ACCESS

Category	Deficiency	Actions Taken
Access to Care	High volume in grievances for appointment waitlist for one of the Plan's medical group	Closed new adult member assignment effective March 4, 2026. Corrective Action Plan (CAP) was issued on May 11, 2026. The CAP was discussed at the JOM, QI meetings, Senior and Operating Meetings. Provider panel was re-opened and the effective date of the new patient assignment was June 1, 2026. The Alliance will review and evaluate provider monthly access report until CAP goals are reached.

Next Steps:

- Ongoing provider education for non-compliant providers.
- Promote best practices and Provider Incentives
  - -P4P access measure
  - -Extended office hours
  - -Provider recruitment/retention grant
  - -Open access scheduling, blocking each day with urgent care and/or follow-up care appointments
- Share access data with Network and Contracting team for Network Road Map planning.

Thank you.

Questions?

PQI Updates

Michelle Stott

2025 DMHC Audit – QA Findings

Status Update: 8/14/2026

QI FINDINGS: PQI CAP

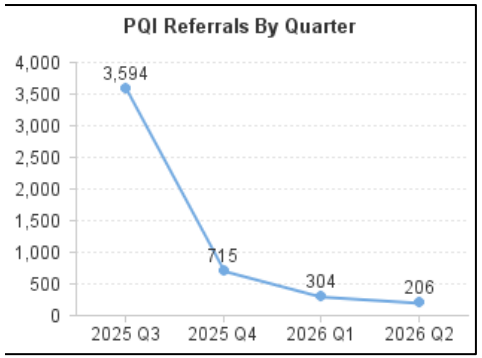
Category	Deficiencies	Actions Taken
The Plan did not document that ***quality of care provided is reviewed, problems are identified, effective action is taken*** to improve care where deficiencies are identified, and follow-up is planned where indicated. Statutory and Regulatory References: Section 1386(b)(1); Section 1370; Rule 1300.70(a)(1); Rule 1300.70(b)(1)(B).	PQI files were reviewed with the following findings: 1. The Plan did not consistently review and identify all quality issues 2. The Plan did not take effective action to improve care where deficiencies are identified 3. The Plan did not document that follow-up was planned where indicated. 4. The Plan did not consistently follow its own PQI procedures with regard to ModivCare.	1. **New standardized templates** (1/16/26) to ensure all quality issues are addressed • Medical Director CAP Review and Attestation • PQI CAP template 2. **PQI CAP workflow** amended (6/10/26) and team trained: • Strengthened escalation process and actions 3. **CAP Non-Compliance Escalation SOP** revised to include addressing deficiencies with substantial quality of care issues (in addition to untimely or incomplete CAPs) 4. **Modivcare Root Cause Analysis and CAP (6/30/26)** on missed appointments (due to spike noted in Q4 2025-Q1 2026)

Next Steps (monitoring)

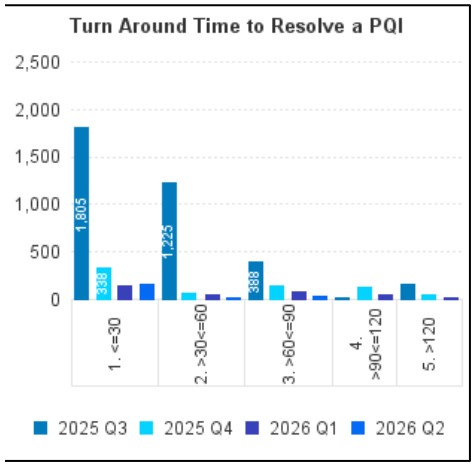
- Conduct chart audits of CAPs to assess effectiveness of workflow (September 2026)
- Monitor Modivcare PQI trends and KPIs in subsequent quarters for improvements (Qtr 3 2026)

PQI Dashboard

Run Date: 07/20/2026

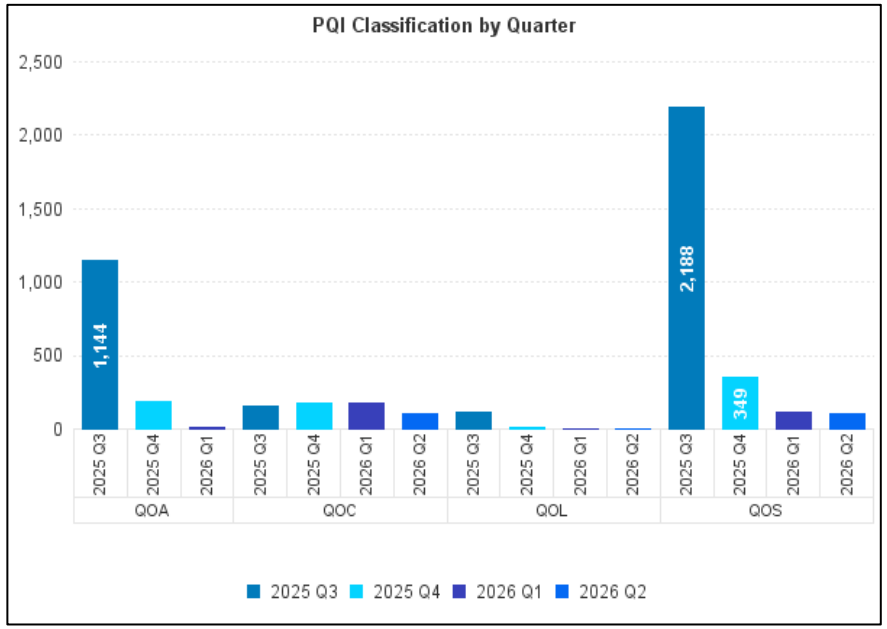


Quarter	# PQIs
2025 Q3	3594
2025 Q4	715
2026 Q1	304
2026 Q2	206
Total:	**4819**

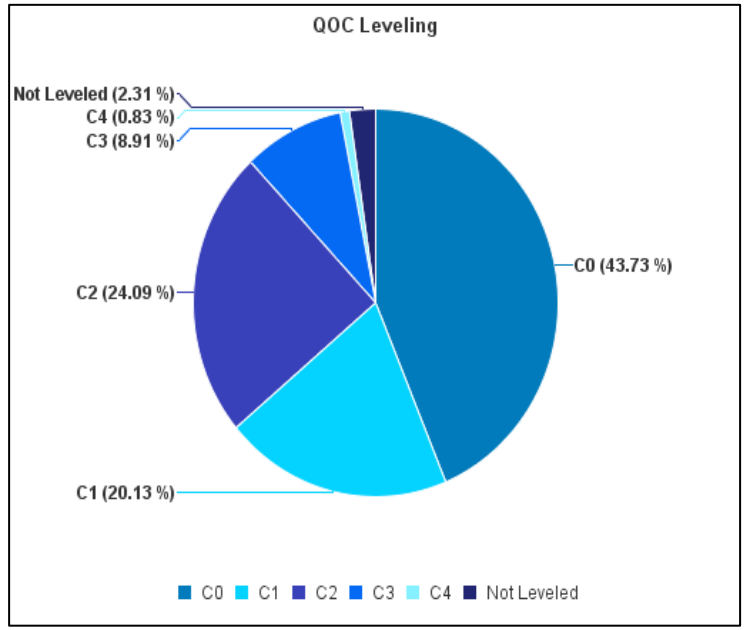


PQIs Still Open by Quarter Received

Quarter	# PQIs
2026 Q1	10
2026 Q2	95
Total:	**105**



	2025 Q3	2025 Q4	2026 Q1	2026 Q2	Total
QOA	1144	181	13		**1338**
QOC	151	172	179	104	**606**
QOL	111	13	3	1	**128**
QOS	2188	349	109	101	**2747**
Total:	**3594**	**715**	**304**	**206**	**4819**



	2025 Q3	2025 Q4	2026 Q1	2026 Q2	Total
C0	102	84	63	16	**265**
C1	12	34	45	31	**122**
C2	16	31	49	50	**146**
C3	11	18	19	6	**54**
C4	1	3		1	**5**
Not Leveled	9	2	3		**14**
Total:	**151**	**172**	**179**	**104**	**606**

Key Insights:

- PQI volume reduction due to G&A-PQI process improvements; TAT at 100% within 150 days
- QOS = 57% of all PQIs – primary improvement focus
- QOA = 28% of PQIs, mostly Q3 2025 (wait list)
- QOC leveling = C0 (44%) and C2 (24%) most common, only 5 at C4 (severe) level
- 95 Open cases (Q2 2026 current quarter)

PQI processes

- Annual PQI Inter-rater reliability (IRR) was finalized on 4/6/2026:
  - 100% concordance for PQI types and leveling following review of cases
- Strengthened PQI CAP workflow and escalation process
  - Trend noted in missed appointments in Qtr 1 for Modivcare; initiated root cause analysis and CAP
- Provider Preventable Conditions (PPCs)
  - Initiated notification letter to providers of substantiated PPCs and obligations for reporting to DHCS
- Continued cross-training of nurses for appeals, grievances, and PQIs

UM Work Plan Update

Michelle Findlater

UM Workplan Update

QIHEC
Michelle Findlater, Director Utilization Management
8/14/2026

Agenda

- The purpose is to track and trend:
- UM Metrics Summary
- Readmissions
- Emergency Department Volume
- Inpatient Denial Rates
- Outpatient Denial Rates

UM Metrics Summary

PowerBI: #12005 IP Claims Utilization

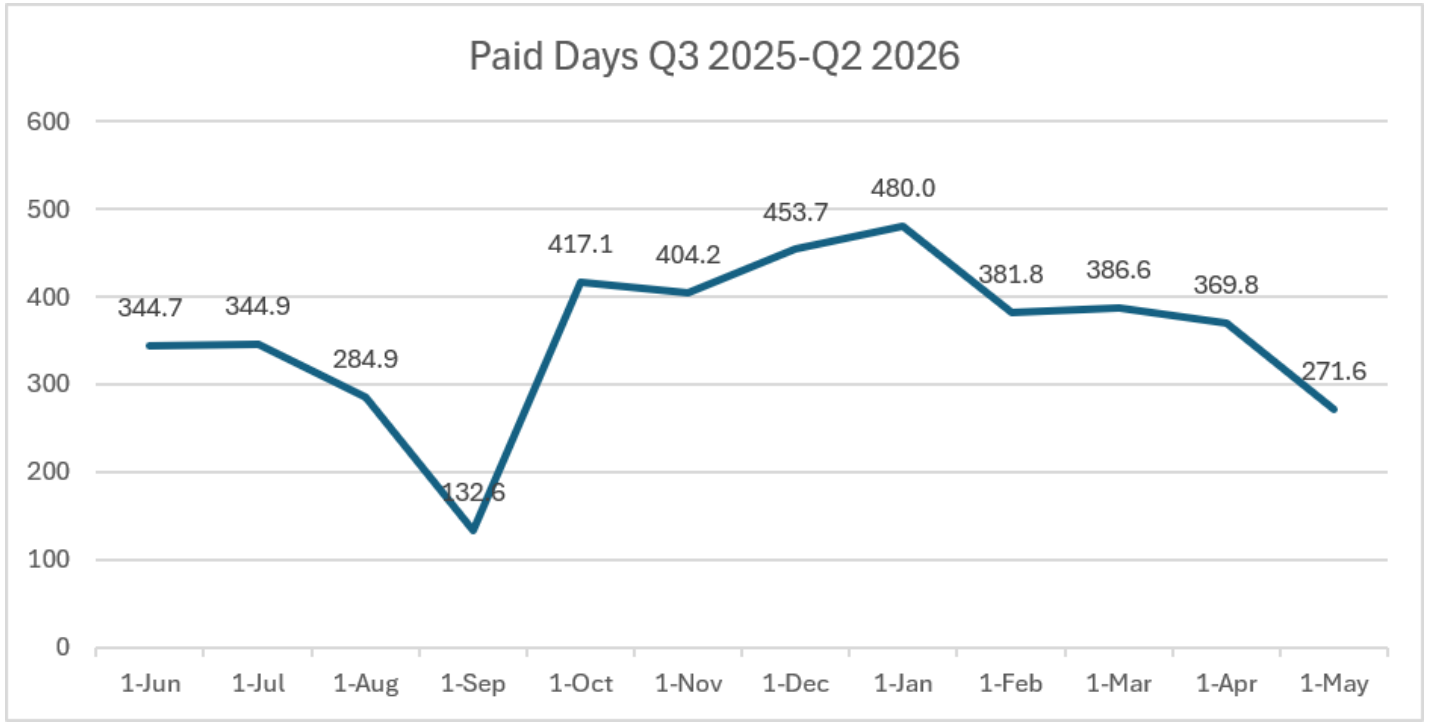
Date: Q1 2025 – Q2 2026

Excluded: LTACs and Sutter Herrick Psych Unit facilities

Paid Days
1/1/25 - 9/30/25

Paid days from Q3 2025 to present averaged 355.9 Days which is a 341.4 days which is (+14.5 Increase) from 2024.

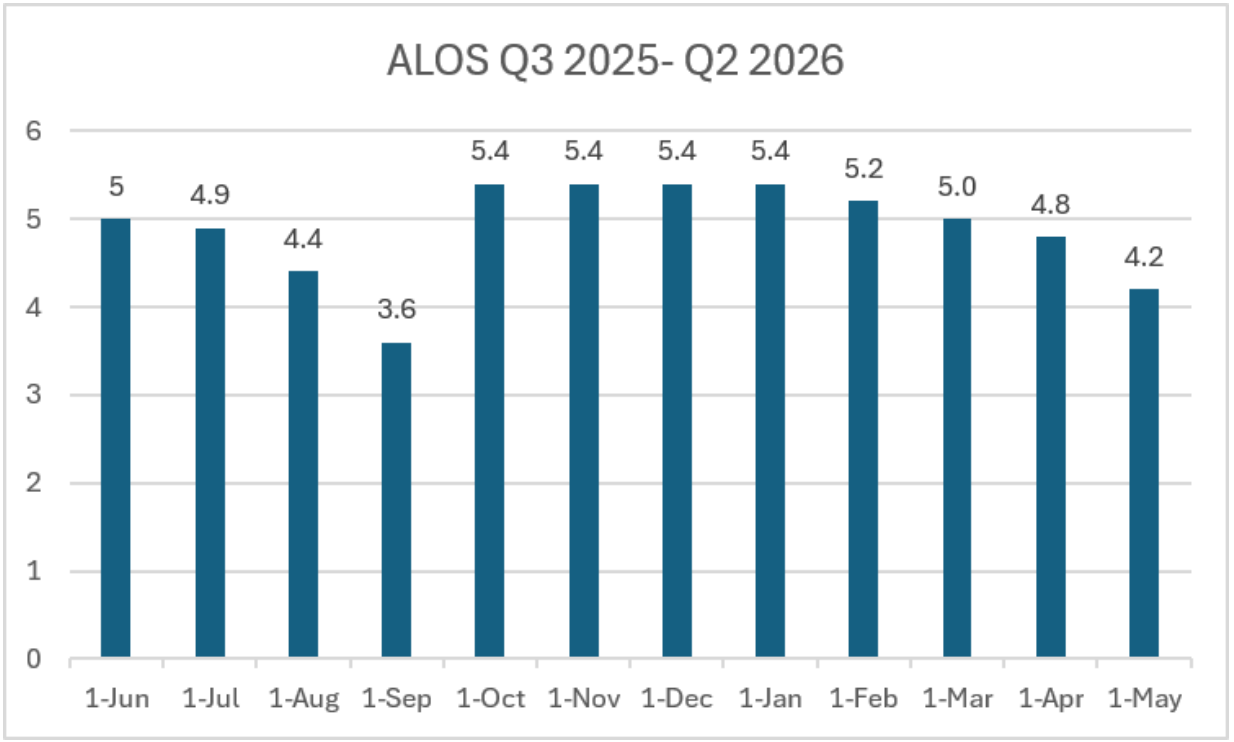
- Paid Days/ 1000 by delegate- Alliance has the highest paid days at 751.7 and CFMG the lowest at 17.9
- Paid Days/ 1000 by Facility: HGH has the highest at 57.4 and Valley Care has the lowest at 15.7
- Paid Days/ 1000 by aid category: SPD-LTC Full Dual is the highest at 1,262.3 and Children are the lowest at 20.8



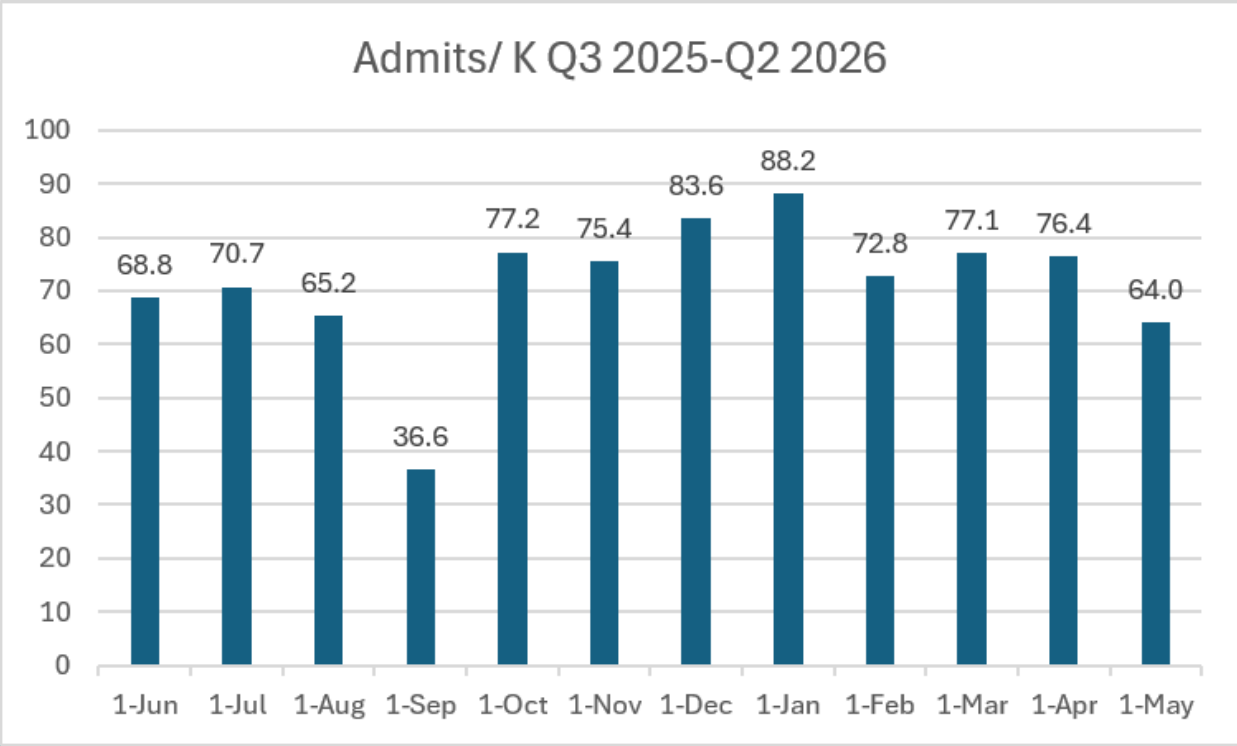
Average Length of Stay (ALOS) 6/1/25 – 5/30/2026

Average LOS for Q2 2025 to present was 4.9 days which is the same as the 2024.

- ALOS by Delegate- Alliance has the highest ALOS at 5.6 and CFMG the lowest at 2.1
- ALOS by Facility: UCSF has the highest at 7.3 and Lucille Packard at 1.6
- ALOS by aid category: SPD-LTC is the highest at 5.2 and Children are the lowest at 2.4



AAH Admits/1000 (1/1/25- 9/30/25)



- Average Admits/1000 for Q2 2025 to present was 71.3 67.9 which is an increase of 3.4 from 2024.

  - Admits/1000 by delegate- Alliance has the highest Admits/1000 at 135 and CFMG the lowest at 8.4
  - Admits/ 1000 by Facility: Highland at 11.6 and LPCH is the lowest at 0.1
  - Admits/1000 by aid category: SPD-LTC/ Full Duals is the highest at 243.3 and Children are the lowest at 5.2

Readmissions

PowerBI: #12005 IP Claims Utilization

Date: January 2025 – September 2025

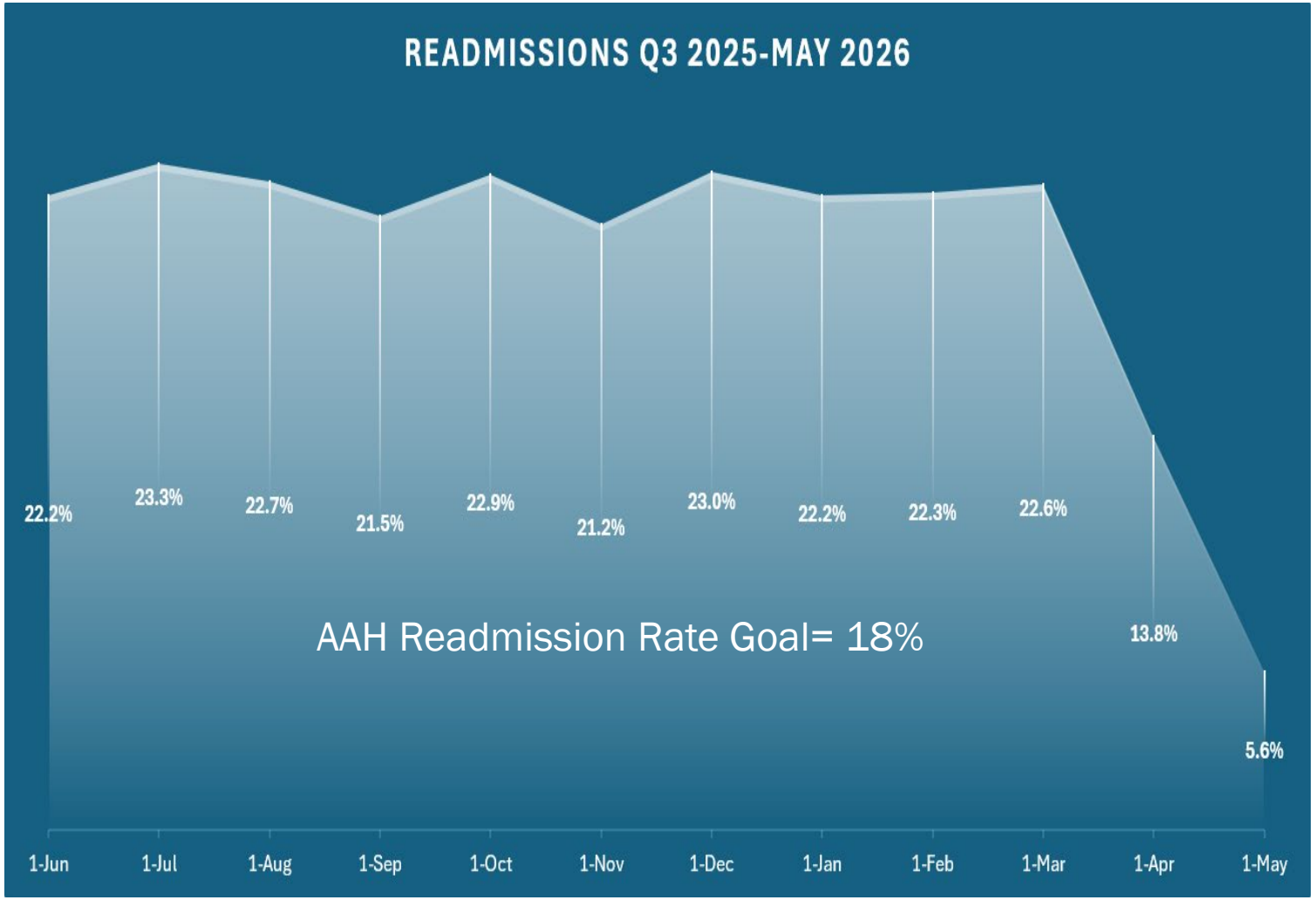
Excluded: LTACs and Sutter Herrick Psych Unit facilities

Monthly Readmissions Trend
Q3 2025-May 2026

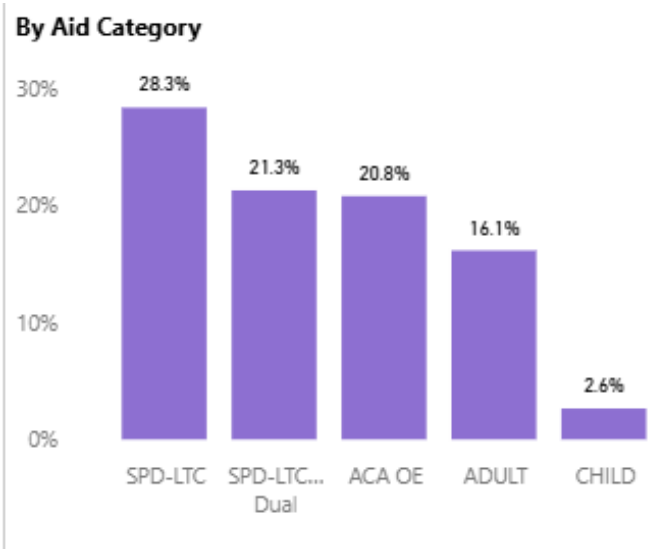
Alliance's Readmission goal remains unchanged at 18%.

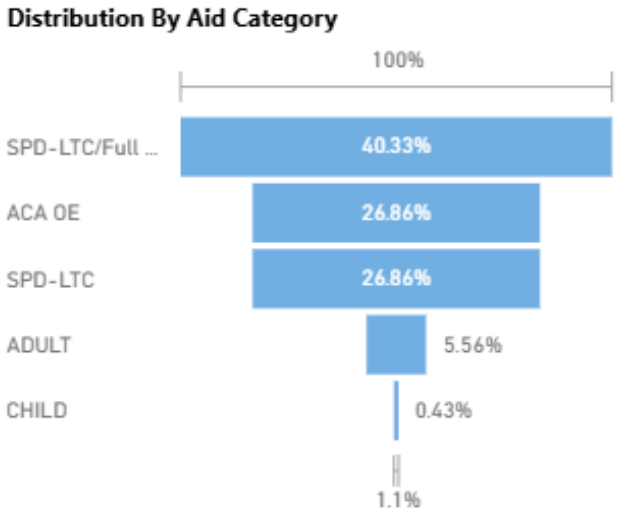
To date in 2026, the data shows the average is tracking at 20.3%, however, there are delays in data reporting for readmissions, and the Alliance predicts the readmission rate (if continue to follow Jan-May trends) but ifs closer to 22.4%

This is a slight increase from the readmission rate at this time last year which was 21.0% (+1.4%)



Readmission Rates 6/1/25-6/30/2025





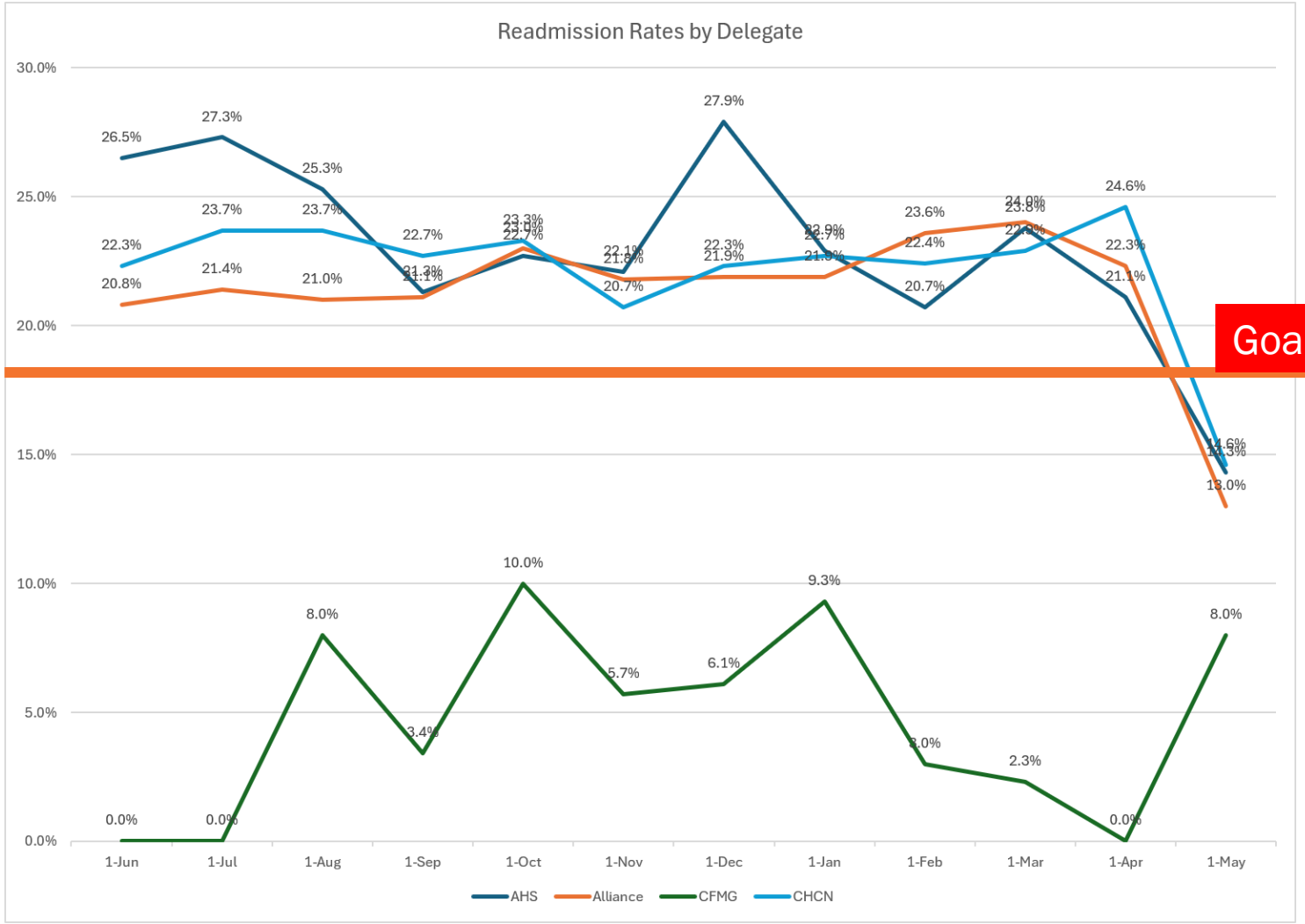
SPD-LTC carry the highest readmission rate 28.3%, followed by
SPD-LTC DUALS 21.3%
ACA OE 20.8%
Adult 16.1%
Child 2.6%

SPD/ LTC Full Duals readmits comprise ~40.33% of total readmits followed by
ACA OE 26.86
SPD- LTC ~26.86

Readmission Rate by Delegate Q3 2025-May 2026

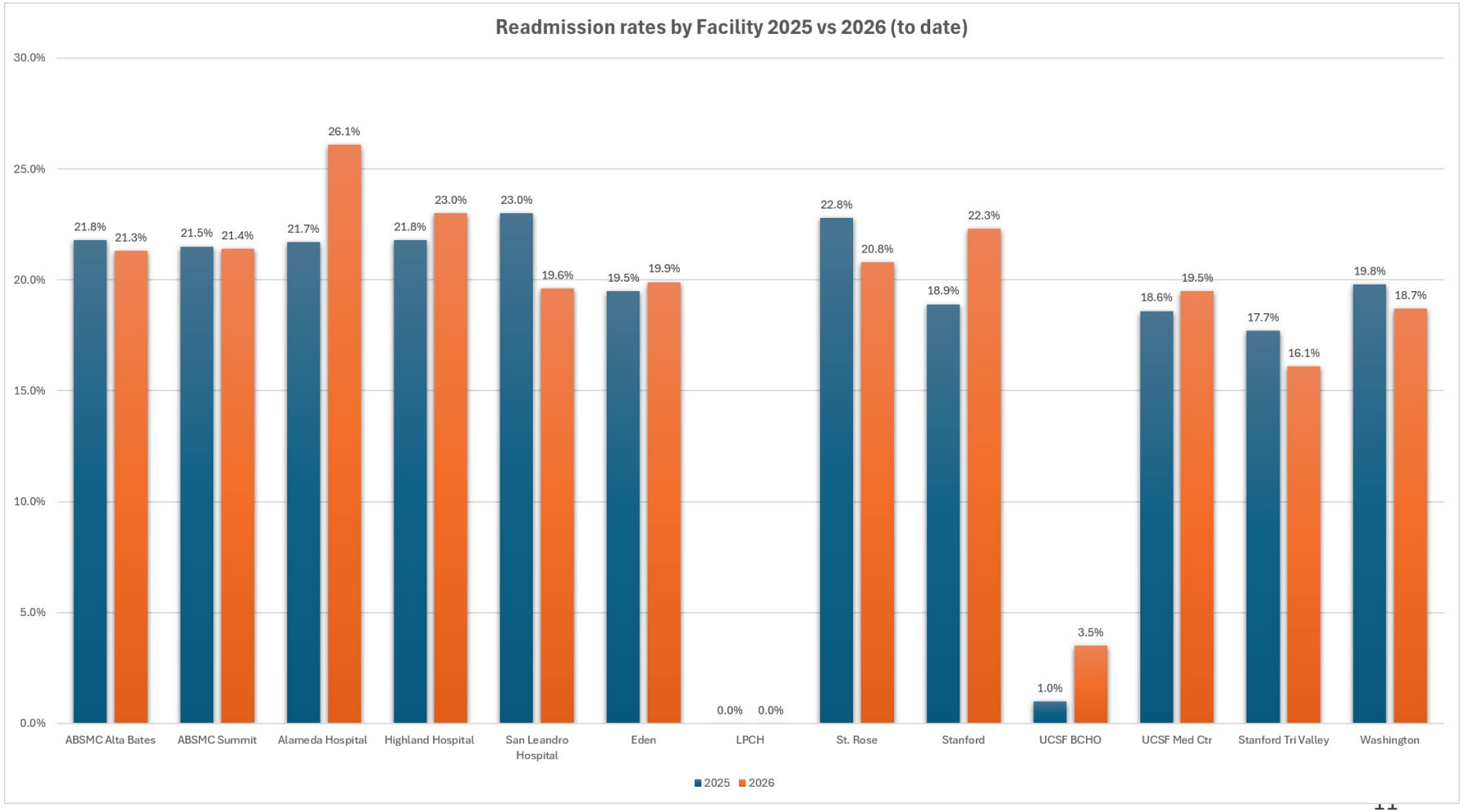
Overall, all 3 networks (except for CFMG) appear to be having readmission trends above the Alliance goal of 18%.

AHS has the highest with 1 month readmission rate at 27.9%



Readmission Rates by Facility 1/1/25-9/30/25

Comparing 2025 average readmission rates to 1/1/26-5/30/26 readmission rates it appears that 6/13 hospitals are having a decrease in readmissions so far in 2026 however Alameda Hospital and Stanford both have concerning increases



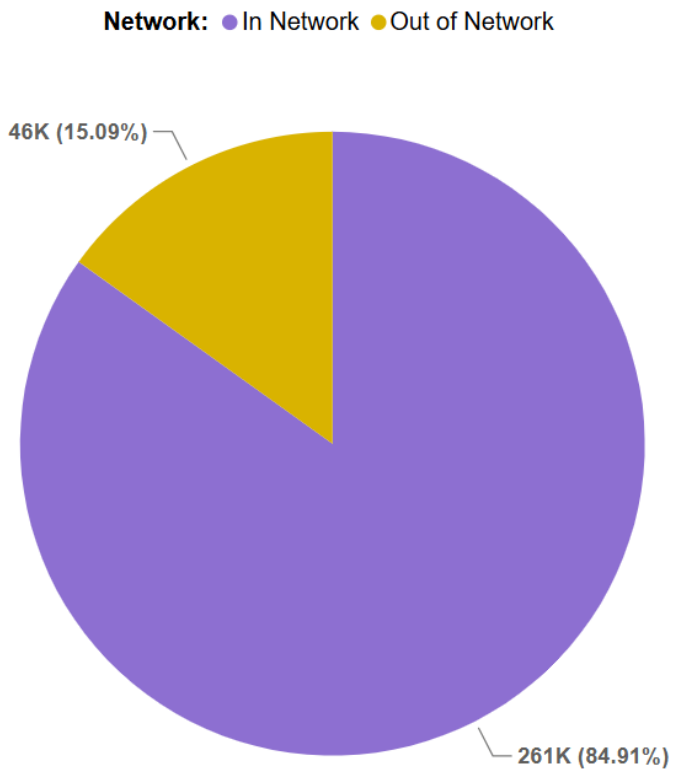
Emergency Department Volume

Excel: #03046 ER Visits by Network

Date: January 2025– September 2025

ED Visits

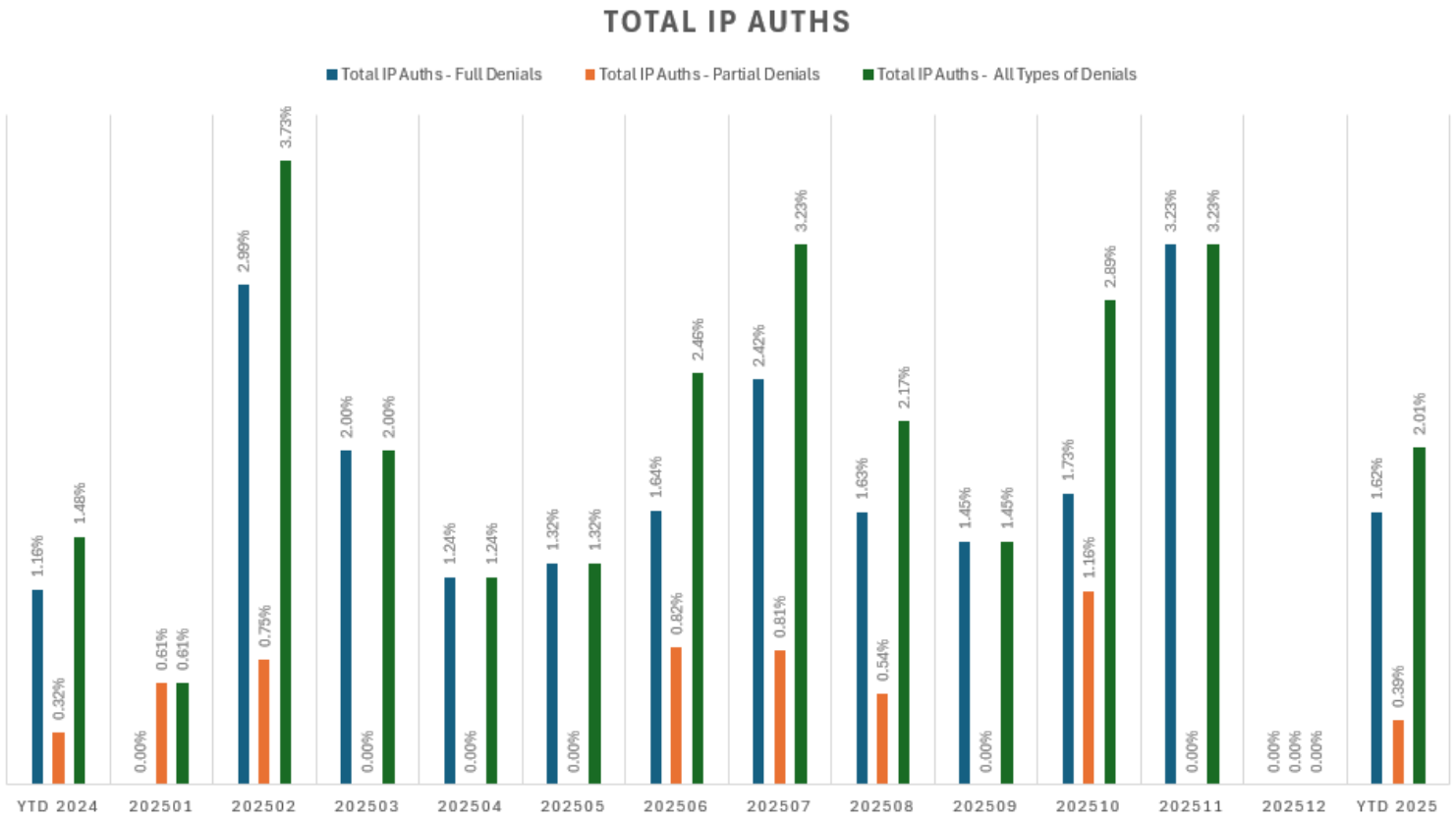
- 15.09% of all ED visits occur at an OON facility
  - Of those 7.8% of those are visiting Kaiser facilities
- For In-Network Facilities the most visited are:
  - Highland 87.9 visits/K
  - Washington 51.0 visits/K
  - UCSF CHO 43.5 visits/K



Inpatient Denial Rates

Excel: #01292 All Auth Denial Rates
Date: January 2025- November 2025

Inpatient Denial Rates



Full Denials- 1.45% (-0.20%)

Partial Denials- 2.13% (-1.40%)

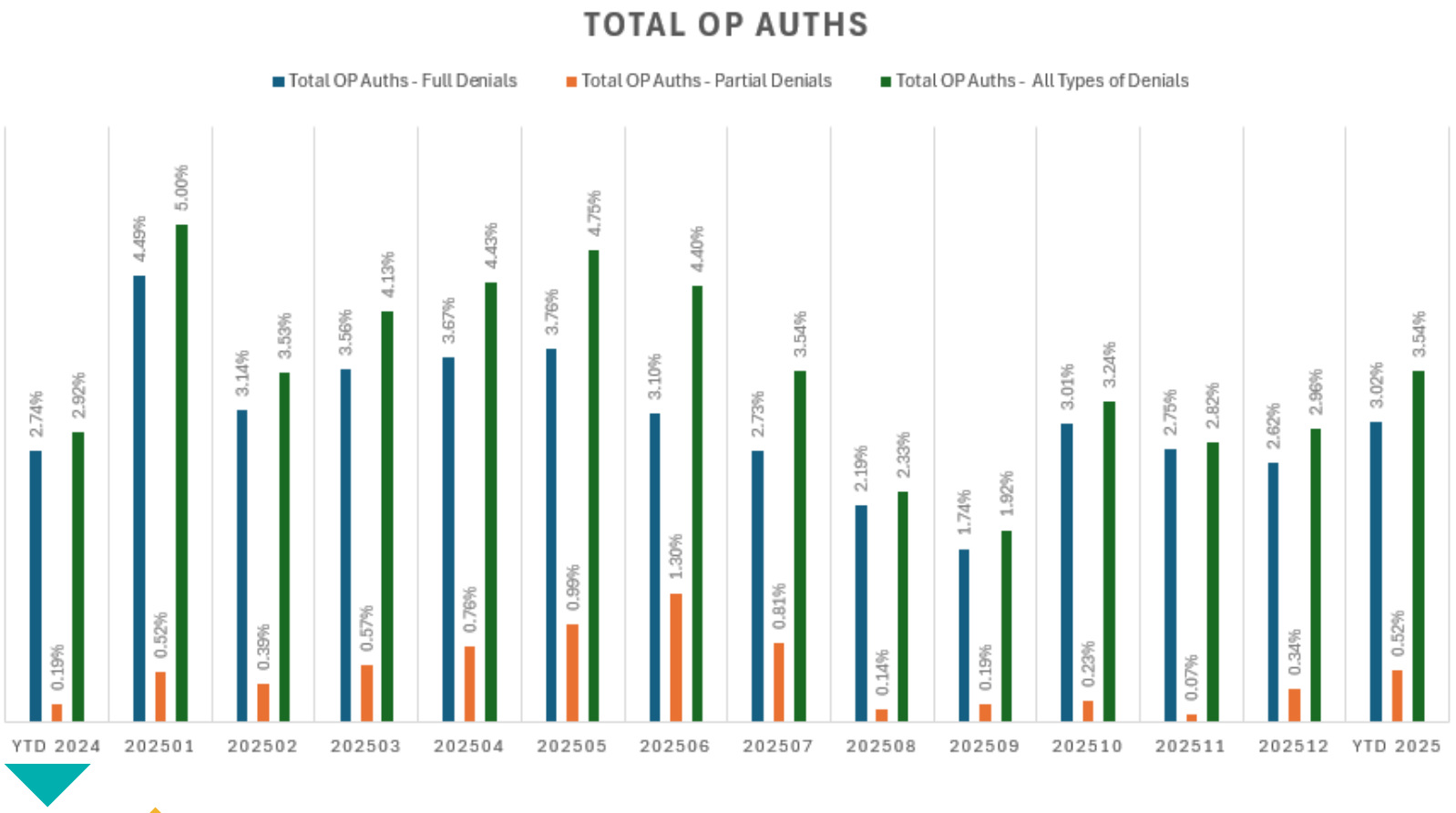
All Denials- 3.58 % (-1.60%)

Denial Rates for all types of IP denials has decreased so far in 2026 as compared to 2025

Outpatient Denial Rates

#01292 All Auth Denial Rates (Claims based)
Date: January 2025-November 2025

Outpatient Denial Rates



Full Denials- 3.80% (-0.73%)

Partial Denials- 0.2% (+0.34%)

Total Denials- 3.9% (-0.38%)

OP has seen a slight decrease in Full and Total denials in 2026 as compared to 2025

The most commonly Denied authorizations are:
Genetic Testing- 23.2%
Consultation- 21.4%
TQ- 20.0%

These are typically denied for OON requests when In-Network access is available.

Thank you.

Questions?

You can contact me at:
mfindlater@alamedaalliance.org

STARS Performance Update

Jaini Goradia

Member Experience Report

Jennifer Karmelich

ME 7EF: Member Experience

Element E: Annual Assessment of Behavioral Healthcare and Services
Element F: Behavioral Healthcare Opportunities for Improvement

Title: Annual Assessment of Behavioral Healthcare and Services-Year 1
Prepared by: Jennifer Karmelich – Director, Grievance and Appeals
Date: August 6, 2026
Reviewed by: Jennifer Karmelich – Director, Grievance and Appeals
Department: Grievances and Appeals and Behavioral Health

Introduction

The Alliance is a public; not-for-profit managed care health plan committed to making high quality health care services accessible and affordable in Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance has provided health care coverage for 2 out of every 10 Alameda County residents. We provide access to care and services to more than 400,000 people in our community. We partner with a network of more than 10,000 physicians and specialists, hospitals and pharmacies, to improve health outcomes and quality of life throughout our community.

Purpose

Alameda Alliance for Health reviews and investigates all behavioral health grievance and appeal information for all lines of business Medi-Cal and Commercial (Group Care) that have been submitted to the plan to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into exempt grievances, non-exempt grievances, and appeals. The details of the members' complaints are collected, processed, and reviewed, and actions are taken to resolve the issue. The annual Member Experience Assessment has been reviewed for systematic aggregation, evaluation of complaints, appeals and member surveys, assessment of trends, and analysis for quality improvement.

Element E | Annual Assessment of Behavioral Healthcare and Services

Factor 1 | Member Complaints and Appeals

Grievance and Appeals | Quantitative & Qualitative Analysis

Performance Goal: To be within 1 point of the per one thousand members or below from the previous year in all categories. The red identifies where the goal was not met, and the green identifies where the goal was met.

Medi-Cal Complaints

Quantitative Analysis

Overall Medi-Cal complaint volume increased from **1,836 complaints in 2024** to **2,195 complaints in 2025**, representing an increase of **359 complaints**, or approximately **19.6%**. Despite the increase

in raw complaint volume, the complaint rate per 1,000 members decreased from **21.24 in 2024** to **0.45 in 2025**, a decrease of **20.79 complaints per 1,000 members**.

Table 1: Complaint Volume Report

Medi-Cal				
Category	2024		2025	
	Complaints Total	Complaints per 1,000 Members (Total: 86,401)	Complaints Total	Complaints per 1,000 Members (Total: 4,831,192)
Quality of Care	70	0.81	63	0.01
Access	807	9.34	841	0.17
Attitude/Service	850	9.83	1,155	0.24
Billing/Financial	98	1.13	125	0.03
Quality of Practitioner Office Site	11	0.12	11	0.002
Total/Number per 1,000	1,836	21.24	2,195	0.45

Qualitative Analysis

Medi-Cal complaints increased in total volume, primarily driven by **Attitude/Service**, which increased by **305 complaints**, and **Access**, which increased by **34 complaints**. Attitude/Service was the highest volume category in 2025, accounting for **1,155 of 2,195 total complaints**, or approximately **52.6%** of all Medi-Cal complaints. Access was the second highest category, accounting for **841 complaints**, or approximately **38.3%** of total Medi-Cal complaints.

Although the raw number of complaints increased, all Medi-Cal categories met the performance goal based on the rate per 1,000 members. The most notable rate decreases were observed in **Attitude/Service**, which decreased from **9.83 to 0.24 per 1,000**, and **Access**, which decreased from **9.34 to 0.17 per 1,000**. This indicates that, relative to the reported membership denominator, complaint frequency decreased significantly across all categories.

From a quality improvement perspective, **Attitude/Service** and **Access** remain the key categories for continued monitoring because they represent the largest share of total complaint volume. Even though the rate-based goal was met, the increase in raw volume suggests continued opportunity to evaluate root causes, member touchpoints, service interactions, provider access concerns, and routing/classification practices.

Group Care Complaints

Quantitative Analysis

Overall Group Care complaint volume increased slightly from **23 complaints in 2024** to **25 complaints in 2025**, representing an increase of **2 complaints**, or approximately **8.7%**. The complaint rate per 1,000 members decreased from **15.76 in 2024** to **0.35 in 2025**, a decrease of **15.41 complaints per 1,000 members**.

Group Care				
Category	2024		2025	
	Complaints Total	Complaints per 1,000 Members (Total: 1,459)	Complaints Total	Complaints per 1,000 Members (Total: 71,445)
Quality of Care	4	2.74	1	0.01
Access	7	4.79	10	0.14
Attitude/Service	9	6.16	9	0.13
Billing/Financial	3	2.05	5	0.07
Quality of Practitioner Office Site	0	0	0	0
Total/Number per 1,000	23	15.76	25	0.35

Qualitative Analysis

Group Care complaint volume remained low overall, increasing by only **2 complaints** from 2024 to 2025. The highest volume categories in 2025 were **Access** with **10 complaints** and **Attitude/Service** with **9 complaints**. Together, these two categories represented **19 of 25 complaints**, or **76.0%** of all Group Care complaints.

All Group Care complaint categories met the performance goal based on the rate per 1,000 members. The largest rate reductions occurred in **Attitude/Service**, which decreased from **6.16 to 0.13 per 1,000**, and **Access**, which decreased from **4.79 to 0.14 per 1,000**.

Although the rate-based performance goal was met, **Access** and **Attitude/Service** will remain priority monitoring areas due to their concentration within the total complaint volume. The continued absence of complaints related to **Quality of Practitioner Office Site** suggests either limited issues in this category or potential under-identification, which may warrant periodic validation of complaint categorization.

Medi-Cal Appeals

Quantitative Analysis

Overall Medi-Cal appeal volume decreased from **79 appeals in 2024** to **7 appeals in 2025**, representing a decrease of **72 appeals**, or approximately **91.1%**. The appeal rate per 1,000 members decreased from **4.63 in 2024** to **0.00 in 2025**, based on the rounded rate reported in the table.

Table 2: Appeal Volume Report

Medi-Cal				
Category	2024		2025	
	Complaints Total	Complaints per 1,000 Members (Total: 86,401)	Complaints Total	Complaints per 1,000 Members (Total: 4,831,192)
Quality of Care	0	0	0	0
Access	50	2.93	7	0.001
Attitude/Service	0	0	0	0
Billing/Financial	29	1.70	0	0
Quality of Practitioner Office Site	0	0	0	0
Total/Number per 1,000	79	4.63	7	0

Qualitative Analysis

Medi-Cal appeal volume declined substantially year over year. The decrease was primarily driven by reductions in **Access appeals**, which decreased from **50 to 7**, and **Billing/Financial appeals**, which decreased from **29 to 0**. No appeals were reported in the Quality of Care, Attitude/Service, or Quality of Practitioner Office Site categories in either year.

All Medi-Cal appeal categories met the performance goal. The decrease in appeal volume may indicate fewer disputed adverse determinations or improved front-end resolution, but additional operational review would be needed before drawing a definitive conclusion. Continued monitoring will be conducted to determine whether the lower appeal volume reflects sustained improvement, changes in classification, changes in service utilization, or changes in reporting methodology.

Because **Access** was the only Medi-Cal appeal category with reported 2025 volume, it will remain the primary area for appeal trend monitoring. Even though the number of appeals was low, Access-related issues often have direct member experience and care continuity implications.

Group Care Appeals

Quantitative Analysis

No Group Care appeals were reported in either 2024 or 2025. All categories had **0 appeals** and **0 appeals per 1,000 members** in both years.

Group Care				
Category	2024		2025	
	Complaints Total	Complaints per 1,000 Members (Total: 1,459)	Complaints Total	Complaints per 1,000 Members (Total: 71,445)
Quality of Care	0	0	0	0
Access	0	0	0	0
Attitude/Service	0	0	0	0
Billing/Financial	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0
Total/Number per 1,000	0	0	0	0

Qualitative Analysis

Group Care reported no appeal activity in either year. Based on the stated performance goal, all categories met the goal. The absence of appeal volume may indicate limited appeal-generating activity, effective resolution before escalation to appeal, or low utilization in categories that commonly result in appeals.

However, because the reported volume is zero across all categories, periodic validation will be performed to confirm that appeals are being appropriately identified, classified, and reported. This is especially important to ensure that potential appeals are not being miscoded as complaints, inquiries, or other case types.

Performance Against Goal

All complaint and appeal categories for both Medi-Cal and Group Care met the stated performance goal when comparing the 2025 rate per 1,000 members to the 2024 rate per 1,000 members. No category exceeded the prior year rate by more than 1 point.

Key Quantitative Findings

- **Medi-Cal complaints increased by 359 cases**, from **1,836 to 2,195**, despite the rate per 1,000 members decreasing from **21.24 to 0.45**.
- **Group Care complaints increased by 2 cases**, from **23 to 25**, while the rate per 1,000 members decreased from **15.76 to 0.35**.
- **Medi-Cal appeals decreased by 72 cases**, from **79 to 7**, with the rate per 1,000 members decreasing from **4.63 to 0.00**.
- **Group Care appeals remained at zero** across both reporting years.

Key Qualitative Findings

- **Attitude/Service** was the highest volume complaint category for Medi-Cal in 2025 and accounted for more than half of all Medi-Cal complaints.
- **Access** remained a significant complaint driver for both Medi-Cal and Group Care.
- **Billing/Financial** complaints increased in raw volume for both Medi-Cal and Group Care, although the rate per 1,000 members decreased.
- **Appeal activity decreased significantly**, especially for Medi-Cal Access and Billing/Financial appeals.
- **Quality of Practitioner Office Site** remained minimal or at zero across both lines of business, suggesting limited reported concerns in this category.

Opportunities for Improvement

1. **Focus on Attitude/Service complaint drivers**
    a. Review complaint narratives to identify recurring themes related to communication, staff interaction, provider office experience, responsiveness, and member dissatisfaction.
    b. Use findings to support targeted coaching, scripting, training, and service recovery efforts.
2. **Continue monitoring Access-related complaints**
    a. Access remains one of the highest volume complaint categories across both lines of business.
    b. Review whether complaints are related to appointment availability, referral delays, provider availability, transportation, specialty access, or member navigation barriers.

3. **Evaluate Billing/Financial complaint increases**
    a. Although the rate per 1,000 members decreased, raw Billing/Financial complaints increased in both Medi-Cal and Group Care.
    b. Review whether complaints involve member billing, balance billing, reimbursement, claims confusion, or coordination of benefits.
4. **Validate appeal classification and reporting**
    a. The significant decrease in Medi-Cal appeals and zero Group Care appeals will be reviewed to confirm accurate classification.
    b. Validate that appeal-eligible cases are not being captured as grievances, inquiries, or other non-appeal case types.
5. **Strengthen trend review by both rate and raw volume**
    a. Rates per 1,000 members show that the performance goal was met; however, raw complaint volume increased in several categories.
    b. Reviewing both measures provides a more complete picture of member experience and operational workload.
6. **Review denominator methodology**
    a. The membership denominators appear materially different between 2024 and 2025, particularly for Medi-Cal and Group Care.
    b. Confirm whether the denominator represents average membership, total member months, cumulative membership, or another methodology before finalizing conclusions.

The 2025 membership denominators are substantially higher than the 2024 denominators. For example, Medi-Cal complaints use **86,401 members in 2024** and **4,831,192 members in 2025**. Group Care complaints use **1,459 members in 2024** and **71,445 members in 2025**. Because the per 1,000 member rate is highly dependent on the denominator, this may explain the large decrease in rates even when raw complaint volume increased. Before finalizing the assessment, the organization will confirm that the same denominator methodology was used for both years.

Overall, the organization met the performance goal across all complaint and appeal categories for both Medi-Cal and Group Care. Complaint rates per 1,000 members decreased in all categories or remained at zero, and appeal rates also decreased or remained flat. However, raw complaint volume increased for Medi-Cal and Group Care, with the most significant volume concentrated in Attitude/Service and Access. These categories will remain priority areas for continued monitoring, root cause analysis, and targeted improvement activities. In addition, the organization will validate the year-over-year denominator methodology to ensure accurate interpretation of rate-based performance.

Factor 2 | BH Member Experience Survey

The organization surveyed members who have "completed" Behavioral Health care coordination cases dating from January-May 2026. Of these

The decision to limit surveys to this time period was related to the survey administration date of June 2026. Many Alliance members have multiple contacts with both medical and behavioral case managers. It was hypothesized that members that had completed BH care coordination cases in the prior 5 months would more accurately report on their experience with BH care coordination program.

From January-May 2026, 96% of cases closed were Medi-cal. In-home Support Services (IHS)/Group Care represented.8% of cases.

Standardized phone surveys were administered and documented in June 2026. 34 outbound calls were made with a 44% completion rate. 15 surveys were completed.

Element F | Behavioral Healthcare Opportunities for Improvement

Factor 1 | Quantitative and Qualitative Analysis

Overall, satisfaction is very high across the board with approximately 70-80% of respondents giving a top score. When near-top scores were included, 80-90% of the scoring was positive.

Total net promoter score (NPS) is 66. This is based on this question "How likely are you to recommend the Alliance to your family or friends?". This demonstrates that members are satisfied and trust the Alliance.

Behavioral health staff relationships with members are key to our member satisfaction with 80% stating that they "strongly agree" that they felt listened to. 67 % of surveyed members stated that they can "always" reach their care coordinator.

Although primarily reflected in comments, surveyed members pointed to a few areas for improvement. These include the following:

1. **Access to care:** long wait times for ABA, difficulty accessing mental health care with providers that have specific specialties
2. **Process complexity:** unclear referral processes, lack of streamlined system navigation
3. **Timeliness/Responsiveness:** Delays in initial outreach or callbacks; delays in accessing services after the referral

Our primary challenges are operational and not related to interactions between members and BH staff.

Factor 2 | Identification of Opportunities

The following areas are identified for improvement:

1. **Access to care:** long wait times for ABA, difficulty accessing mental health care with providers that have specific specialties
2. **Process complexity:** unclear referral processes, lack of streamlined system navigation
3. **Timeliness/Responsiveness:** Delays in initial outreach or callbacks; delays in accessing services after the referral

Factor 3 | Implementing Interventions, if Applicable

- Implementation of a provider directory with detailed treatment specialties
- Improve referral hand-offs between PCPs and Alliance BH Care Coordinators via the creation of a webform

Factor 4 | Measuring Effectiveness, if Applicable

The satisfaction survey will include targeted questions to address satisfaction. For example, I was able to find a provider specialty without delays" and/or "The referral process was easy to navigate."

ME 7CD: Member Experience

Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals
Element D: Nonbehavioral Opportunities for Improvement

Title: Assessment of Nonbehavioral Healthcare Complaints and Appeals- Year 1
Prepared by: Jennifer Karmelich – Director, Grievance and Appeals
Date: August 6, 2026
Reviewed by: Jennifer Karmelich – Director, Grievance and Appeals
Department: Grievances & Appeals

Introduction

The Alliance is a public; not-for-profit managed care health plan committed to making high quality health care services accessible and affordable in Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance has provided health care coverage for 2 out of every 10 Alameda County residents. We provide access to care and services to more than 400,000 people in our community. We partner with a network of more than 10,000 physicians and specialists, hospitals and pharmacies, to improve health outcomes and quality of life throughout our community.

Purpose

Alameda Alliance for Health reviews and investigates all grievance and appeal information for all lines of business Medi-Cal and Commercial (Group Care) that have been submitted to the plan to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into exempt grievances, non-exempt grievances, and appeals. The details of the members' complaints are collected, processed, and reviewed and actions are taken to resolve the issue. The annual Member Experience Assessment is presented to the Health Care Quality Committee for systematic aggregation, evaluation of complaints, appeals and member surveys, assessment of trends, and analysis for quality improvement.

Element C | Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals

GRIEVANCE AND APPEALS | QUANTITATIVE & QUALITATIVE ANALYSIS

Performance Goal: To be within 1 point of the per one thousand members or below from the previous year in all categories. The red identifies where the goal was not met, and the green identifies where the goal was met.

Table 1: Complaint Volume Report

Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories.

Medi-Cal				
Category	2024		2025	
	Complaints Total	Complaints per 1,000 Members (Total: 4,796,661)	Complaints Total	Complaints per 1,000 Members (Total: 4,831,192)
Quality of Care	1,000	0.20	976	0.20
Access	18,042	3.76	12,597	2.61
Attitude and Service	10,312	2.14	7,434	1.54
Billing/Financial	2,547	0.53	4,417	0.91
Quality of Practitioner Office Site	147	0.03	95	0.02
Total/Number per 1,000	32,075	6.68	25,519	5.28

Group Care				
Category	2024		2025	
	Complaints Total	Complaints per 1,000 Members (Total: 68,150)	Complaints Total	Complaints per 1,000 Members (Total: 71,445)
Quality of Care	49	0.70	34	0.48
Access	640	9.34	766	10.72
Attitude and Service	494	7.21	342	4.79
Billing/Financial	152	2.21	331	4.63
Quality of Practitioner Office Site	0	0	5	0.07
Total/Number per 1,000	1,335	19.48	1,478	20.69

Table 2: Appeal Volume Report

Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories.

Medi-Cal				
Category	2024		2025	
	Appeals Total	Appeals per 1,000 Members (Total: 4,796,661)	Appeals Total	Appeals per 1,000 Members (Total: 4,831,192)
Quality of Care	0	0	0	0
Access	6,471	1.34	781	0.16
Attitude and Service	205	0.04	0	0
Billing/Financial	1,507	0.31	6	0.001

Quality of Practitioner Office Site	0	0	0	0
Total/Number per 1,000	8,183	1.70	795	0.16

Group Care				
Category	**2024**		**2025**	
	Appeals Total	**Appeals per 1,000 Members (Total: 68,150)**	**Appeals Total**	**Appeals per 1,000 Members (Total: 71,445)**
Quality of Care	0	0	0	0
Access	91	1.33	79	1.10
Attitude and Service	47	0.68	0	0
Billing/Financial	122	1.79	1	0.013
Quality of Practitioner Office Site	16	0.23	0	0
Total/Number per 1,000	276	4.04	80	1.12

Element D | Nonbehavioral Opportunities for Improvement

Factor 1 | Member complaint and appeal data from (Element C)

Quantitative Analysis: Medi-Cal Complaint Volume

Membership increased slightly from 4,796,661 in 2024 to 4,831,192 in 2025, an increase of 34,531 members. Despite the membership increase, overall complaint volume decreased.

Key Quantitative Findings: Medi-Cal

- Total Medi-Cal complaints decreased from **32,075 in 2024 to 25,519 in 2025**, representing a reduction of **6,556 complaints**.
- The overall complaint rate decreased from **6.68 to 5.28 complaints per 1,000 members**, a decrease of **1.40 per 1,000**.
- The largest improvement was in the **Access** category, which decreased from **3.76 to 2.61 per 1,000 members**, a reduction of **1.15 per 1,000**.
- **Attitude and Service** also improved, decreasing from **2.14 to 1.54 per 1,000 members**.
- **Billing/Financial complaints increased** from **0.53 to 0.91 per 1,000 members**, but the increase was **0.38**, which remains within the allowed 1-point threshold.
- All Medi-Cal categories met the performance goal.

Qualitative Analysis: Medi-Cal

The Medi-Cal line of business demonstrated strong overall performance in 2025. Complaint rates improved or remained stable in most categories, even with a slight increase in membership. The most significant improvement occurred in Access complaints, which may indicate positive movement in areas such as appointment availability, service access, provider responsiveness, or member navigation.

Attitude and Service complaints also decreased, suggesting improvement in member experience related to staff interactions, communication, service delivery, or issue resolution. Quality of Care remained stable, indicating no rate increase year over year. Quality of Practitioner Office Site remained low and improved slightly, continuing to represent a minimal portion of overall complaint volume.

Billing/Financial was the only category with an increase. Although the increase remained within the performance threshold, the rise in complaint volume from 2,547 to 4,417 indicates this category may require continued monitoring. The increase may suggest member confusion, billing disputes, claims-related concerns, cost-sharing questions, or financial communication issues. While the performance goal was met, the upward trend will be reviewed to determine whether targeted intervention is needed.

Overall, Medi-Cal performance met expectations across all required categories and showed meaningful improvement in total complaint volume and complaint rate.

Analysis of Complaints | Group Care

Quantitative Analysis: Group Care Complaint Volume

For Group Care, the 2025 membership total was reported as **71,445**. The 2024 membership total was not provided in the data; however, 2024 complaint rates per 1,000 were included and used for year-over-year rate comparison.

Key Quantitative Findings: Group Care

- Total Group Care complaints increased from **1,335 in 2024 to 1,478 in 2025**, an increase of **143 complaints**.
- The overall complaint rate increased from **19.48 to 20.69 complaints per 1,000 members**, an increase of **1.21 per 1,000**, which exceeded the performance threshold.
- **Access complaints increased** from **9.34 to 10.72 per 1,000 members**, an increase of **1.38 per 1,000**, which did not meet the goal.

- **Billing/Financial complaints increased significantly** from **2.21 to 4.63 per 1,000 members**, an increase of **2.42 per 1,000**, which did not meet the goal.
- **Attitude and Service improved substantially**, decreasing from **7.21 to 4.79 per 1,000 members**.
- **Quality of Care improved**, decreasing from **0.70 to 0.48 per 1,000 members**.
- Quality of Practitioner Office Site increased from **0.00 to 0.07 per 1,000 members**, but remained within the performance goal.

Qualitative Analysis: Group Care

Group Care showed mixed performance in 2025. While several categories improved, the overall complaint rate increased and exceeded the established performance threshold. The increase was primarily driven by Access and Billing/Financial complaints.

Access remained the highest-volume complaint category for Group Care in both years and increased further in 2025. The rate increased by 1.38 complaints per 1,000 members, exceeding the allowable threshold. This trend may indicate persistent or worsening member concerns related to obtaining timely care, appointment availability, provider access, referral processes, or service coordination. Because Access represents a significant share of total complaints, this category will be prioritized for root cause analysis and corrective action planning.

Billing/Financial showed the most significant rate increase, rising by 2.42 complaints per 1,000 members. This category did not meet the performance goal and warrants focused review. The increase may reflect issues related to billing accuracy, member financial responsibility, claims processing, explanation of benefits, payment disputes, or communication about financial obligations. Given the magnitude of the increase, additional analysis will be conducted to determine whether the trend is associated with specific provider groups, claim types, benefit changes, or member communication gaps.

Despite these areas of concern, Group Care demonstrated improvement in Attitude and Service, Quality of Care, and Quality of Practitioner Office Site. The decrease in Attitude and Service complaints was especially notable, suggesting improvement in member-facing service interactions, communication quality, or complaint handling. Quality of Care also improved, and Quality of Practitioner Office Site remained low despite a small increase.

Overall, Group Care did not meet the performance goal for total complaints per 1,000 members due to increases in Access and Billing/Financial categories. These two categories will be prioritized for deeper review, trend monitoring, and targeted improvement activities.

Analysis of Appeals | Medi-Cal

Quantitative Analysis: Medi-Cal Appeals Volume

Membership increased slightly from **4,796,661 members in 2024 to 4,831,192 members in 2025**, while appeal volume decreased significantly.

Key Quantitative Findings: Medi-Cal

- Total appeals decreased from **8,183 in 2024 to 795 in 2025**, a reduction of **7,388 appeals (90.3%)**.
- The overall appeal rate decreased substantially from **1.70 to 0.16 appeals per 1,000 members**, representing a reduction of **1.54 per 1,000 members**.
- Access appeals showed the largest improvement, decreasing from **1.34 to 0.16 per 1,000 members**.
- Billing/Financial appeals decreased significantly from **0.31 to 0.001 per 1,000 members**.
- No appeals were reported in the Quality of Care or Quality of Practitioner Office Site categories in either year.
- All categories met the established performance goal.

Qualitative Analysis: Medi-Cal

Medi-Cal appeals performance demonstrated substantial improvement in 2025. Despite membership growth, appeal volume and appeal rates declined significantly across nearly all categories.

The most notable improvement occurred in the Access category, which accounted for the majority of appeals in 2024. The significant reduction may indicate improvements in authorization processes, communication of benefit decisions, eligibility determinations, or member understanding of available services and appeal rights.

Billing/Financial appeals also declined dramatically, suggesting improvements in claims processing, coverage determinations, and communication related to financial responsibility. The elimination of Attitude and Service appeals further reflects positive member experiences and successful issue resolution before escalation to the appeal level.

Overall, the reduction in appeal rates across categories suggests improved operational effectiveness and success in addressing member concerns before formal appeals were filed.

Analysis of Appeals | Group Care

Quantitative Analysis: Group Care Appeals Volume

Membership increased from **68,150 in 2024 to 71,445 in 2025**, while appeal volume decreased considerably.

Key Quantitative Findings: Group Care

- Total appeals decreased from **276 to 80**, a reduction of **196 appeals (71.0%)**.
- The overall appeal rate decreased from **4.04 to 1.12 appeals per 1,000 members**, representing an improvement of **2.92 per 1,000 members**.
- Billing/Financial appeals demonstrated the most substantial improvement, decreasing from **1.79 to 0.013 per 1,000 members**.
- Attitude and Service appeals were eliminated entirely in 2025.
- Access appeals declined modestly from **1.33 to 1.10 per 1,000 members** and remained the highest appeal category.
- All categories met the performance goal.

Qualitative Analysis: Group Care

Group Care demonstrated significant improvement in appeals performance during 2025. Overall appeal volume and rates declined across all categories despite membership growth.

The greatest reduction occurred in Billing/Financial appeals, suggesting improved claims administration, billing accuracy, and member understanding of financial obligations and benefit coverage. The elimination of Attitude and Service and Quality of Practitioner Office Site appeals further indicates improvement in member interactions and provider office experiences.

While Access appeals also improved, they remain the most frequently cited reason for appeals within Group Care. This suggests ongoing member concerns regarding authorization decisions, care availability, referrals, or service access that continue to warrant attention.

Overall, Group Care demonstrated strong performance and met all appeal performance goals for 2025.

Identification of Opportunities

Based on the annual quantitative and qualitative analysis of complaint volume, several opportunities have been identified to further improve the member experience and reduce complaint rates across both lines of business.

Medi-Cal Opportunities

1. Billing/Financial Complaint Reduction

Although the Billing/Financial complaint rate remained within the performance goal threshold, the category experienced a notable increase from **0.53 to 0.91 complaints per 1,000 members** and complaint volume increased by **73% (2,547 to 4,417 complaints)**.

Opportunities:

- Conduct root cause analysis to identify the primary drivers of billing and financial complaints.
- Review member communications related to claims adjudication, cost-sharing responsibilities, and billing statements for clarity and consistency.
- Partner with Claims and Member Services departments to identify recurring issues and implement corrective actions.
- Enhance member education regarding benefits, coverage determinations, and financial responsibilities.

2. Sustain Access Improvements

Access complaints demonstrated the greatest improvement, decreasing by **1.15 complaints per 1,000 members**.

Opportunities:

- Identify successful interventions that contributed to reduced Access complaints and replicate best practices across provider networks.
- Continue monitoring appointment availability, referral timeliness, and provider capacity to maintain gains.
- Share successful strategies with provider groups demonstrating higher-than-average complaint rates.

3. Continuous Quality Monitoring

While Quality of Care and Quality of Practitioner Office Site complaints remained low and stable, ongoing monitoring is needed to sustain performance.

Opportunities:

- Continue provider quality oversight activities.
- Monitor emerging complaint trends that may indicate changes in member expectations or service delivery issues.
- Utilize complaint data to identify opportunities for proactive provider education.

Group Care Opportunities

1. Access Complaint Reduction (Priority Opportunity)

Access complaints increased from **9.34 to 10.72 complaints per 1,000 members**, exceeding the performance goal.

Opportunities:

- Perform detailed analysis of Access complaints by provider group, geographic region, and complaint subtype.
- Evaluate appointment wait times, provider network adequacy, referral processes, and service availability.
- Collaborate with Network Management and Provider Operations to identify barriers to care.
- Develop targeted provider interventions for high-volume complaint areas.

2. Billing/Financial Complaint Reduction (Priority Opportunity)

Billing/Financial complaints demonstrated the largest unfavorable change, increasing from **2.21 to 4.63 complaints per 1,000 members**, exceeding the performance goal by more than two points.

Opportunities:

- Conduct comprehensive root cause analysis to identify specific billing and claims issues contributing to member dissatisfaction.
- Review claim processing workflows for accuracy and timeliness.
- Improve member-facing explanations regarding benefits, cost sharing, billing statements, and claim outcomes.
- Monitor complaint trends monthly to evaluate the effectiveness of corrective actions.

3. Improve Overall Complaint Rate Performance

The overall complaint rate increased from **19.48 to 20.69 per 1,000 members**, resulting in failure to meet the annual performance goal.

Opportunities:

- Establish category-specific improvement goals for Access and Billing/Financial complaints.
- Increase operational reviews of complaint trend reports throughout the year.
- Implement targeted action plans for departments contributing to increased complaint volume.
- Develop early warning indicators to identify emerging complaint trends before annual reporting periods.

4. Sustain Improvements in Attitude and Service

Attitude and Service complaints decreased substantially from **7.21 to 4.79 complaints per 1,000 members**.

Opportunities:

- Identify best practices that contributed to improved member service outcomes.
- Share successful service recovery techniques and communication strategies across operational teams.
- Continue employee training and coaching focused on member experience and service excellence.

Organization-Wide Opportunities

Across both lines of business, the analysis identified opportunities to strengthen complaint reduction efforts through:

- Enhanced complaint trend analysis and quarterly monitoring.
- Increased collaboration among Grievance & Appeals, Member Services, Claims, Provider Services, and Network Management.
- Improved member education regarding benefits, access to care, and financial responsibilities.
- Ongoing evaluation of corrective action plans to ensure interventions effectively address identified complaint drivers.
- Utilization of complaint data to proactively identify systemic issues and opportunities for process improvement.

Conclusion

The annual analysis identified **Billing/Financial complaints as an emerging opportunity for improvement across both Medi-Cal and Group Care**, and **Access complaints as a significant opportunity within Group Care**. Future improvement efforts will focus on addressing the root causes associated with these categories while sustaining the positive results achieved in Quality of Care and Attitude and Service. Continuous monitoring and targeted interventions will support the organization's goal of reducing complaint rates and improving the overall member experience.

Element D | Nonbehavioral Opportunities for Improvement

Introduction

The Alameda Alliance for Health (The Alliance) conducts an annual Member Experience Survey to assess the quality and accessibility of healthcare services provided to its members. In 2025, the Medi-Cal and Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey was administered using the 5.1H version of the survey introduced in 2021. This version includes updates to account for the various ways members may receive care, including both in person visits and telehealth services.

Methodology

Members across each Alliance line of business (LOB) was surveyed separately through a combination of mail and phone responses. The survey aimed to capture feedback from the 410,841 members of the Alliance, with a specific focus on their experiences with nonbehavioral healthcare services.

The breakdown of member enrollment by network are as follows:

- AHS: 22.09%
- Directs: 22.95%
- CHCN: 44.15%
- CFMG: 10.82%

Table 1: Survey Response Rates by Line of Business

	Medi-Cal Adult	Medi-Cal Child	GroupCare (Commercial) Adult
2025	13.4%	12.9%	19.2%
2024	13.6%	15.8%	17.6%
2023	11.7%	12.3%	20.0%

Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	**2025**	**Previous Year Comparison**	**2024**	**2023**
Getting Needed Care	78.0%	↑	76.3%	79.2%
Getting Care Quickly	76.1%	↓	78.3%	73.0%
How Well Doctors Communicate	91.9%	↓	92.6%	92.8%

Customer Service	91.5%	↑	91.0%	92.1%
Rating of Health Care (8-10)	85.0%	↓	89.9%	81.7%
Rating of Personal Doctor (8-10)	91.3%	↓	93.4%	90.7%
Rating of Specialist (8-10)	88.5%	↑	87.7%	95.2%
Rating of Health Plan (8-10)	85.7%	↓	90.9%	86.6%
Coordination of Care	81.4%	↓	84.3%	83.0%

Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult				
Composite	**2025**	**Previous Year Comparison**	**2024**	**2023**
Getting Needed Care	73.6%	-	73.6%	75.2%
Getting Care Quickly	68.0%	↓	74.9%	72.9%
How Well Doctors Communicate	92.7%	↓	93.9%	87.5%
Customer Service	85.4%	↓	87.3%	88.7%
Rating of Health Care (8-10)	80.4%	↓	81.6%	61.1%
Rating of Personal Doctor (8-10)	83.9%	↑	83.5%	80.0%
Rating of Specialist (8-10)	86.8%	↑	73.8%	80.3%
Rating of Health Plan (8-10)	75.0%	↓	76.4%	70.9%
Coordination of Care	80.0%	↑	78.3%	91.7%

Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	**2025**	**Previous Year Comparison**	**2024**	**2023**

Getting Needed Care	71.6%	↑	71.1%	72.0%
Getting Care Quickly	66.6%	↑	65.0%	56.0%
How Well Doctors Communicate	88.7%	↓	89.7%	87.5%
Customer Service	78.8%	↓	82.7%	82.9%
Rating of Health Care (8-10)	70.2%	↓	75.0%	76.7%
Rating of Personal Doctor (8-10)	80.9%	↓	83.4%	82.4%
Rating of Specialist (8-10)	77.5%	↑	76.3%	80.6%
Rating of Health Plan (8-10)	69.6%	↓	73.7%	67.1%
Coordination of Care	84.6%	↑	78.2%	80.0%

Factor 2 | CAHPS survey results and/or QHP Enrollee Experience Survey results.

Tables below contain trended survey results for the three (3) member populations and their delegate network compared to the Alliance.

Medi-Cal Child Trended Survey Results – Delegates

MY2024 CAHPS 5.1H Child MediCal	2025 Plan Total	CHCN			CFMG			AHS			Alliance		
		2025	2024	YoYT	2025	2024	YoYT	2025	2024	YoYT	2025	2024	YoYT
Total Respondents	263	137	115		78	65		35	21		13	7	
Rating of Health Care (8-10)	85.0%	78.9%	78.6%	↑	93.3%	82.9%	↑	80.0%	92.9%	↓	100.0%	66.7%	↑
Rating of Personal Doctor (8-10)	91.3%	92.0%	87.5%	↑	95.7%	96.3%	↓	81.5%	87.5%	↓	83.3%	100.0%	↓
Rating of Specialist (8-10)	88.5%	76.2%	100.0%	↓	100.0%	91.7%	↑	100.0%	100.0%	↔	80.0%	100.0%	↓
Rating of Health Plan (8-10)	85.7%	87.2%	84.8%	↑	86.3%	90.2%	↓	81.8%	90.0%	↓	75.0%	80.0%	↓
Getting Needed Care	78.0%	76.3%	71.9%	↑	83.6%	87.1%	↓	72.5%	76.2%	↓	80.0%	83.3%	↓
Getting Care Quickly	76.1%	69.3%	70.9%	↓	88.4%	81.2%	↑	66.7%	77.8%	↓	80.0%	55.0%	↑
How Well Doctors Communicate	91.9%	88.6%	90.5%	↓	94.9%	98.5%	↓	93.4%	90.7%	↑	97.2%	93.8%	↑
Customer Service	91.5%	94.4%	88.8%	↑	87.5%	97.2%	↓	84.5%	100.0%	↓	100.0%	100.0%	↔
Coordination of Care	81.4%	73.9%	92.0%	↓	87.5%	90.0%	↓	83.3%	60.0%	↑	83.3%	100.0%	↓

YoYT = Year over Year Trend

Medi-Cal Adult Trended Survey Results – Delegates

MY2024 CAHPS 5.1H Adult MediCal	2025 Plan Total	CHCN			AHS			Alliance		
		2025	2024	YoYT	2025	2024	YoYT	2025	2024	YoYT
Total Respondents	178	89	80		47	46		42	54	
Rating of Health Care (8-10)	80.4%	83.9%	75.0%	↑	75.0%	95.7%	↓	76.9%	80.0%	↓
Rating of Personal Doctor (8-10)	83.9%	86.2%	80.4%	↑	75.0%	92.3%	↓	88.2%	81.4%	↑
Rating of Specialist (8-10)	86.8%	93.3%	64.3%	↑	88.9%	88.2%	↑	75.0%	73.7%	↑
Rating of Health Plan (8-10)	75.0%	79.3%	76.6%	↑	73.7%	81.0%	↓	67.5%	72.2%	↓
Getting Needed Care	73.6%	73.6%	73.1%	↑	77.0%	81.6%	↓	71.8%	67.9%	↑
Getting Care Quickly	68.0%	69.7%	67.8%	↑	65.4%	82.0%	↓	68.1%	79.2%	↓
How Well Doctors Communicate	92.7%	94.8%	91.4%	↑	89.6%	100.0%	↓	91.7%	93.0%	↓
Customer Service	85.4%	82.3%	86.7%	↓	88.7%	94.1%	↓	87.8%	82.6%	↑
Coordination of Care	80.0%	90.5%	70.8%	↑	80.0%	100.0%	↓	68.4%	76.9%	↓

YoYT = Year over Year Trend

Commercial Adult Trended Survey Results – Delegated Network

MY2024 CAHPS 5.1H Adult MediCal	2025 Plan Total	CHCN			AHS			Alliance		
		2025	2024	YoYT	2025	2024	YoYT	2025	2024	YoYT
Total Respondents	155	90	91		86	71		23	23	
Rating of Health Care (8-10)	70.2%	68.9%	74.6%	↓	71.7%	85.0%	↓	70.6%	52.9%	↑
Rating of Personal Doctor (8-10)	80.9%	86.2%	82.1%	↑	76.1%	83.3%	↓	81.0%	88.9%	↓
Rating of Specialist (8-10)	77.5%	71.8%	77.8%	↓	81.6%	80.6%	↑	83.3%	50.0%	↑
Rating of Health Plan (8-10)	69.6%	68.9%	72.4%	↓	69.1%	79.7%	↓	73.9%	60.9%	↑
Getting Needed Care	71.6%	74.9%	70.6%	↑	67.2%	67.5%	↓	75.0%	82.7%	↓
Getting Care Quickly	66.6%	74.5%	64.2%	↑	58.4%	68.3%	↓	65.8%	58.3%	↑
How Well Doctors Communicate	88.7%	87.7%	91.8%	↓	89.2%	86.1%	↑	90.6%	94.6%	↓
Customer Service	78.8%	77.0%	81.4%	↓	80.3%	80.4%	↓	80.0%	94.4%	↓
Coordination of Care	84.6%	77.8%	83.3%	↓	94.6%	71.8%	↑	60.0%	83.3%	↓

YoYT = Year over Year Trend

Quantitative Trends

The 2025 CAHPS survey results year-over-year trends show variation within the Alliance business lines. Across LOBs, the Medi-Cal Child population had the highest measure summary rate scores in 2025.

2024 – 2025 Alliance and Delegate Comparative Findings

Medi-Cal Child

- AHS: Six (6) of nine (9) scores decreased based on the above table. A significant increase in percentage score was noted for 'Coordination of Care.' Significant decreases in percentage scores were seen for 'Getting Care Quickly', and 'Customer Service.'
- Direct: Five (5) of nine (9) scores decreased based on the above table. With significant increase in percentage scores for 'Rating of Health Care' and 'Getting Care Quickly'. Significant decreases in percentage scores were seen for 'Rating of Personal Doctor', 'Rating

of Specialist', and 'Coordination of Care'.

- CFMG: Six (6) of the nine (9) scores decreased based on the above table. With significant increase in percentage scores for 'Rating of Health Care'. A significant decrease in percentage score was noted for 'Customer Service'.
- CHCN: Five (5) of nine (9) scores increased based on the above table. There was no significant increase in percentage scores in 2025. However, there were two Significant decreases in percentage scores for 'Rating of Specialist' and 'Coordination of Care'.

  Quantitative Trends:
  Overall, a decrease in percentage scores was seen throughout all delegate groups. Significant improvement was noted for 'Rating of Health Care' in two of the four delegate groups.

Medi-Cal Adult

- AHS: Eight (8) of nine (9) scores decreased based on the above table. A significant decrease was seen for 'Rating of Health Care,' 'Rating of Personal Doctor', 'Getting Care Quickly', 'How Well Doctors Communicate,' and 'Coordination of Care.'
- Direct: Five (5) of nine (9) scores decreased based on the above table. With a significant decrease in percentage scores for 'Getting Care Quickly'. An Increase in percentage scores was seen for 'Rating of Personal Doctor', "Rating of Specialist", "Getting Needed Care", and 'Customer Service.'
- CHCN: Eight (8) of nine (9) scores increased based on the above table. With a significant increase for 'Rating of Specialist,' and 'Coordination of Care.' A decrease in percentage score was seen for 'Customer Service.'

  Quantitative Trends:
  All delegates showed increased percentage scores in 'Rating of Specialist.'

Commercial Adult

- AHS: Six (6) of nine (9) scores decreased based on the above table. A significant decrease in percentage scores was seen for 'Rating of Health Care,' and 'Rating of Health Plan.' Significant improvement was noted for "Coordination of Care."
- Direct: Four (4) of nine (9) scores increased based on the above table. A significant increase was seen for 'Rating of Health Care,' 'Rating of Specialist,' and 'Rating of Health Plan.' A Significant decrease in percentage score was seen for 'Getting Needed Care,' 'Customer Service,' and 'Coordination of Care.'
- CHCN: Three (3) of nine (9) scores increase based on the above table. A significant increase was seen for 'Getting Care Quickly.'
  Quantitative Trends:
  Small fluctuation of percentage scores was seen overall for most of the measures but 'How Well Doctors Communicate' received the accumulative highest rating compared to other

measures.

Top and Bottom 3 Measures

Population	Top 3 Measures	Bottom 3 Measures
Medi-Cal Child	Rating of Specialist (8-10)	Ease of Filling Out Forms
	Customer Service	Getting Needed Care
	Rating of Personal Doctor (8-10)	Getting Care Quickly
Medi-Cal Adult	Rating of Personal Doctor (8-10)	Getting Care Quickly
	Rating of Health Care (8-10)	Getting Needed Care
	Rating of Specialist (8-10)	Customer Service
Commercial Adult	Rating of Health Plan (8-10)	How Well Doctors Communicate
	Coordination of Care	Customer Services
	Rating of Health Care (8-10)	Getting Needed Care

'Getting Needed Care' is identified in 2025 as the common bottom measure for all three Lines of Business. The low scoring measures provide opportunities for improvement via root cause analysis as part of the QIHE Work Plan for 2026.

Key Drivers of Rating of Health Plan

Population	Key Drivers
Medi-Cal Child	Rating of Personal Doctor
	Rating of Health Care
	Getting Routine Care
Medi-Cal Adult	Dr. Listened Carefully
	Getting Specialist Appointment
	Rating of Health Care
Commercial Adult	Rating of Health Care
	Rating of Specialist
	Ease of Filling Out Forms

The above table shows the top 3 Key Drivers for Rating of Health Plan for all three Lines of Business. 'Rating of Health Care' was found to be the most common Key Driver amongst the three Line of Businesses.

Next Steps

The Alliance will continue to collaborate interdepartmentally, focusing on maintaining power in top rated measures and improving member perception of care and services ranked at the bottom of composite scores. Additionally, the Alliance will continue to partner with providers on initiatives designed to improve the member experience and survey scores in 2025 using PDSA cycles to improve or maintain Member Satisfaction scores.

Review improvement strategies recommendations by Press Ganey (PG) for targeted improvement focus that include:

- Assess CAHPS data by direct and delegate provider/networks. Beginning Q3 2025 share results at Joint Operations Meetings (JOM) and Quality Improvement meetings with providers. Correlate with grievance data and access PQI complaint data to share with providers.
- Continue best practices for LOBs with increasing survey results.
- Educate providers and staff about Plan and regulatory appointment wait time requirements or standards (i.e., CAHPS, CMS, States, etc.). Identify opportunities for improvement.
- Virtual/onsite visits with providers not meeting Timely Access year over year.
- Encourage/support provider in approaches toward open access scheduling. Allow portions of each day to open the schedules for urgent care and/or follow-up care.
- Support members and collaborate with providers to enhance routine and urgent access to care through proactive approaches with Member Services, Provider Relations, Utilization Management, Behavioral Health, and Case and Care Management.
- Discuss and engage providers/staff on scheduling best practices, how to improve access to routine/urgent care.
- Contract with additional providers for after-hours appointments availability.
- Ensure Member Services representatives are able to accurately advise members of available alternatives for care, such as Nurse advise line, Telehealth, Urgent Care, etc.

Behavioral Health Update

Andrea DeRochi

Behavioral Health Report

August 2026

Andrea DeRochi, LCSW

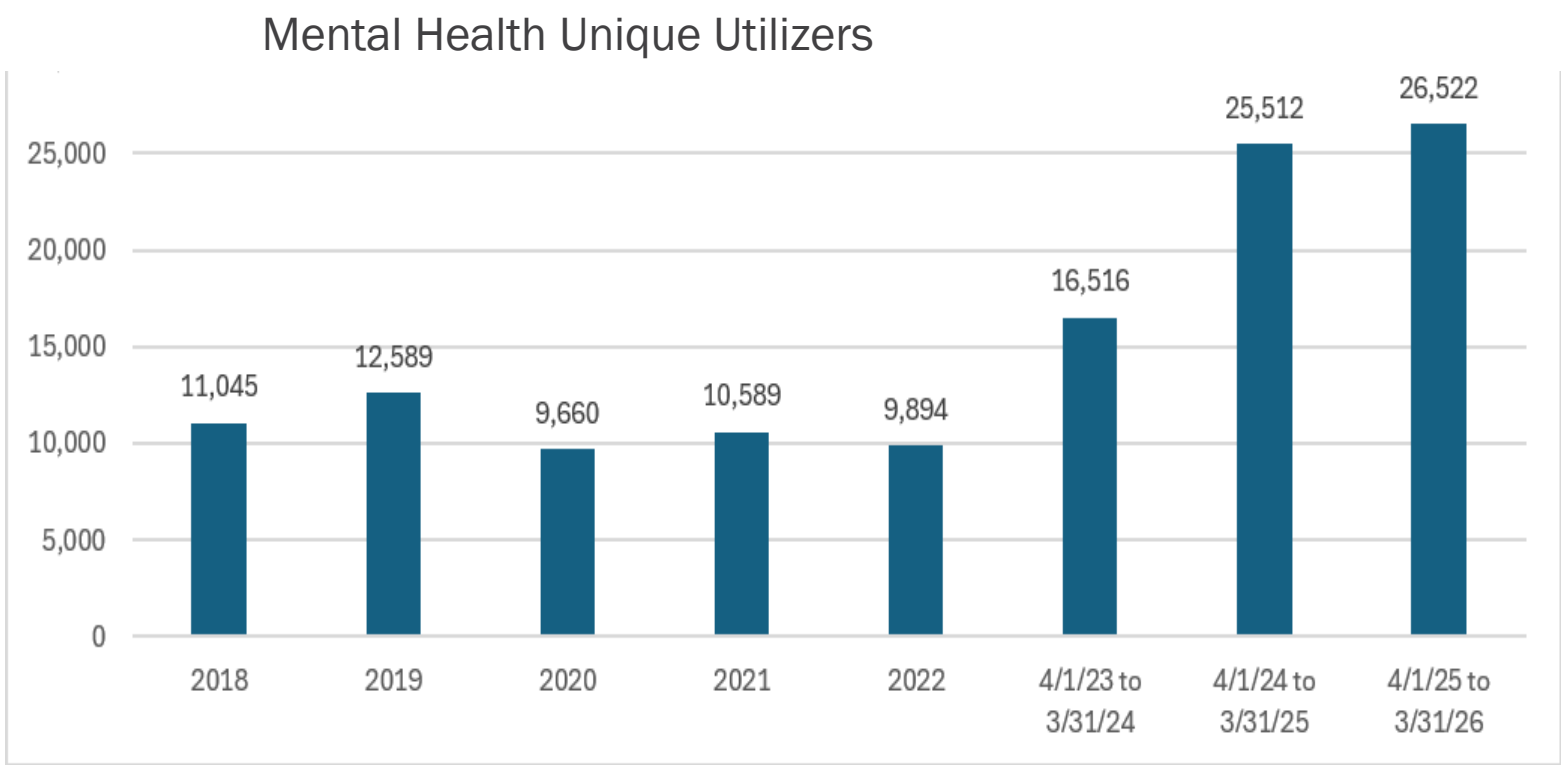
FY 2025-2026

By the numbers

Increasing Access to Mental Health Care

Since insourcing BH in April 2023, the Alliance has successfully increased the number of members utilizing mental health care.

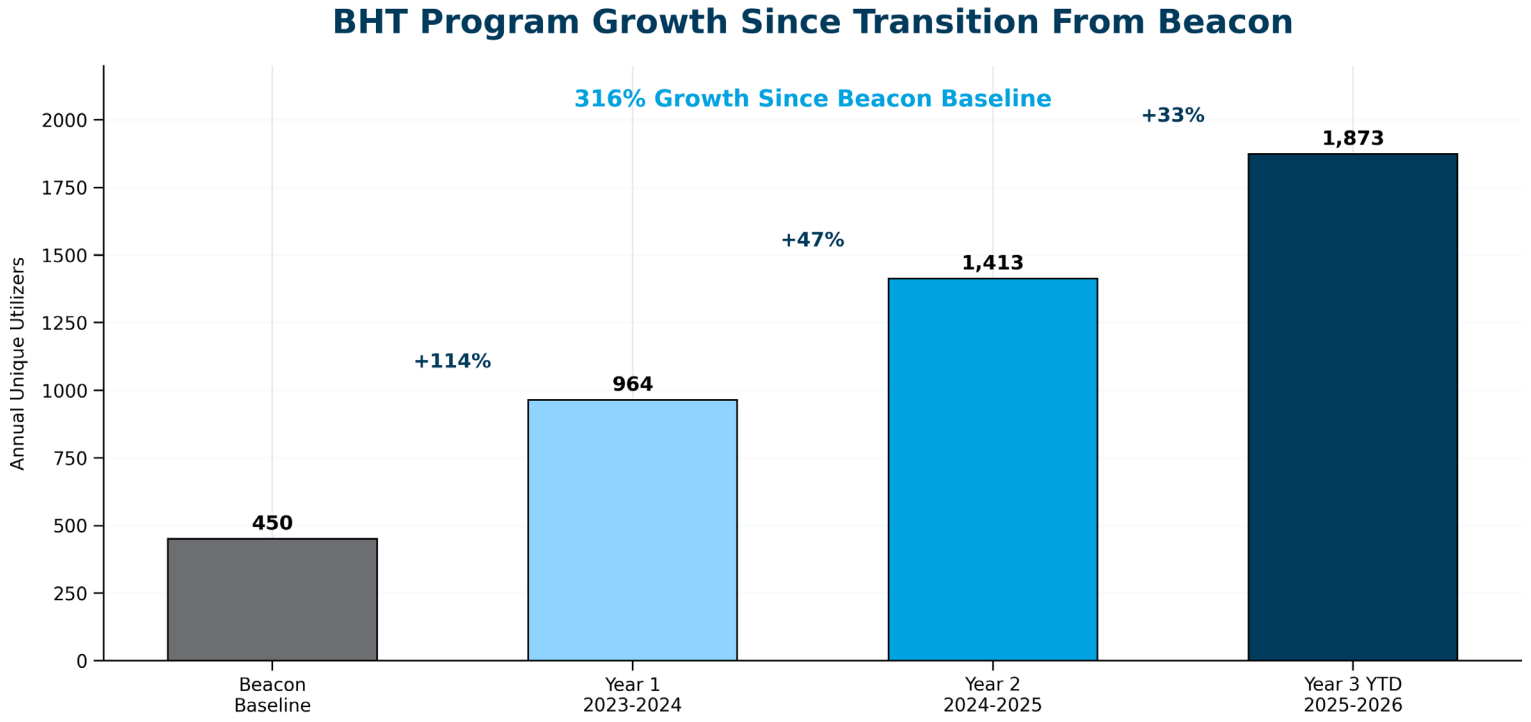
This past year saw an increase of approximately 1k new members accessing care.



Source: 14637 BH Utilization Report – Rolling 12 Months Cumulative with 2 month claim lag. Data currently available only through 3/31/26.

ABA/BHT Unique Utilizers

The number of children utilizing ABA/BHT services since insourcing on April 1, 2023 has increased. The number of children accessing ABA services has increased from 450 to 1,873.



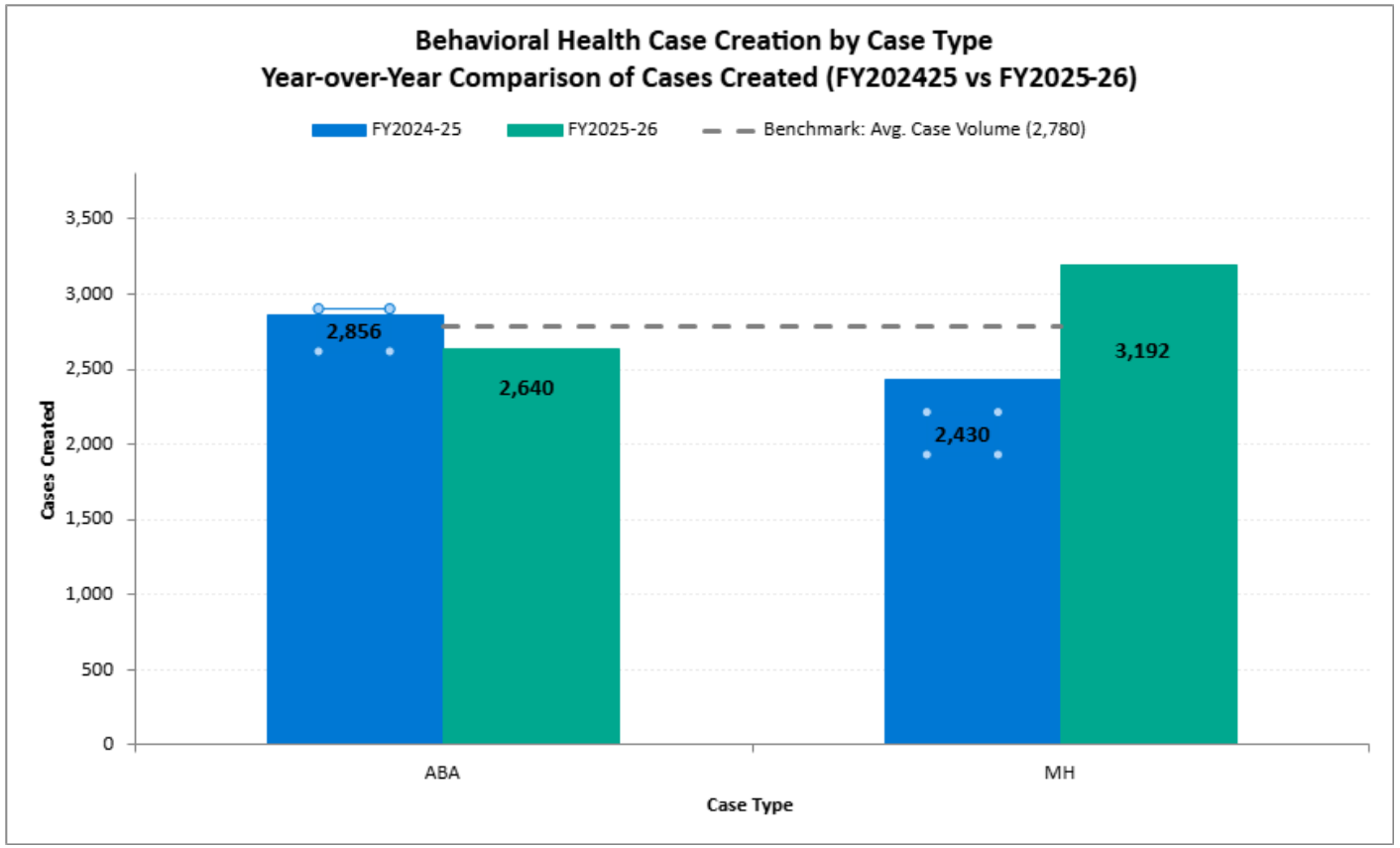
Period	Unique Utilizers
Beacon Baseline	450
Year 1 (4/1/23-3/31/24)	964
Year 2 (4/1/24-3/31/25)	1,413
Year 3 YTD (4/1/25-3/26/26)	1,873

Source: 14621 BHT Utilization Report – Rolling 12 Months Cumulative

Care Coordination Cases

The total volume of care coordination cases has risen from FY 24-25 to FY 25-26. Care coordination cases have increased for mental health and fallen slightly for ABA cases.

Annual average case volume = 2,780
DSNP cases accounted for .3 % of MH care coordination cases.



Authorizations FY 25-26

- Authorization volume has continued to climb this fiscal year increasing by
- Denial rates remain under benchmark under 5% for both the ABA and BH teams
- TAT remains above the benchmark of 95%

Service Type	Volume	Overall TAT	Overall Denial Rate
ABA/BHT (MCAL Only)	5178	99%	<1%
BH -All LOBS	2504	97%	<1%
	7682	98%	<1%

BH Member Experience Survey - 2026

15
Completed Surveys

44%
Response Rate

96%
Medi-Cal Population

66
Net Promoter Score

Key Findings

- 80% felt listened to
- 67% always reach coordinator
- 80-90%

"Would refer friends or family to AAH"

Opportunities

- Referral pathways complex
- Outreach/callback delays
- ABA wait times for children needing late afternoon appointments

2026-2027 Action Items

- Specialty provider directory
- BH referral webform which will decrease fax failures and decrease time to first outreach call
- Work with ABA agencies to increase capacity
- Continue ABA network expansion.

"It was so nice speaking to you yesterday. You made me feel so much better. I was going through a lot and I needed those words. Thank you so much. You are doing God's Work." – Parent of Child with Autism

Member satisfaction is high and driven by strong relationships with BH staff.

Improvement opportunities are primarily related to the complexity of the BH system, operational issues between community providers and AAH, and directory improvements to increase member capacity for self-service.

Looking Forward:
Data Sharing to Improve Care Coordination

BH has initiated a project to allow for increased data sharing between the health plan and community entities:

The data sharing includes the following components:

1. DHCS is requiring BH data sharing between the Alliance, Alameda County and contracted providers starting January 2027.
2. DHCS is requiring the use of a specific consent form (ASCMI) to allow for exchange of substance use and mental health information.
3. The Alliance will only share substance use and mental health information if member has consented.

Thank you.

Questions?

You can contact me at:
aderochi@alamedaalliance.org

Public Comment

Dr. Donna Carey

Thank You for Attending Today's Meeting

Next Meeting: November 13, 2026