California DMC Quality Improvement Oral Health Access Committee (QIOHAC) Meeting

Official Meeting Minutes | Second Quarter 2026

Date: August 12, 2026

Time: 10a - 11:39a, PT

Location: MS Teams Meeting ID 219 200 435 899 568, Passcode 5KN36k5M

Chair: Interim Chief Oral Health Access Officer

Minutes submitted: August 24, 2026

Attendance

14 of 25 required committee members attended. The meeting had enough members present to proceed.

Attendees
Interim Chief Oral Health Access Officer - Chair
AVP, CA Operations
CA Dental Director
Director, Quality and Outreach
AVP, Provider Network Management
Director, Regulatory and Managed Care Compliance
Senior Compliance Analyst
Senior Compliance Analyst
Operations Compliance Analyst
Director, Provider Engagement
Director, Client Engagement
Associate Director, Program Quality
Client Partner
Sr. Manager, Member Advocacy and Engagement

Meeting Minutes

Time	Agenda Item	Presenter / Title	Discussion	Decision / Outcome	Next Steps / Follow-up
2 min	Call to Order and Announcements	Interim Chief Oral Health Access Officer	The chair started the meeting. The attendance list and meeting materials were available to the committee.	The meeting followed the agenda.	None.
2 min	Review of Minutes	Interim Chief Oral Health Access Officer	The committee reviewed the minutes from the last meeting. No one asked for changes or had comments.	The committee accepted the minutes as written.	Keep the approved minutes with the committee records.
	Utilization				
12 min	Utilization Management Report	CA Dental Director	Use of dental services stayed about the same across markets and member groups. The team made small changes to codes and measures to match California rules. It also changed some surgical extraction and scaling and root planing codes so claims decisions better match the California manual. The team will watch the results for the next two to three quarters.	The committee reviewed the report. It will keep watching restorative service use and the coding changes.	Keep watching service use and the effects of the coding changes over the next few quarters. Owner: Clinical Quality Management (CQM) Team
2 min	Provider Outlier Action Report	CA Dental Director	Clinical Quality Management (CQM) tools found eight offices with high use of some codes and high costs. One was an oral surgery office. Its results were normal for its specialty and location.	The committee reviewed the report. CQM will keep checking for offices with unusual patterns.	Follow up with the other seven offices in the next few weeks. Keep reporting results by specialty and location. Owner: Clinical Quality Management (CQM) Team)
4 min	Utilization Management – Over/Under Track and Trend	CA Dental Director	After Clinical Quality Management (CQM) started, coding trend checks grew from 6 to 16 offices in the Prepaid Health Plan (PHP) market and to 14 offices in the Geographic Managed Care (GMC) market. The team contacts offices to teach them about the rules. An audit is used only if the data shows it may be needed.	The committee supports continued checks, education, and outreach. More action will be taken only if the data shows it is needed.	Keep checking provider coding patterns. Give updates on any corrective action or education. Owner: Clinical Quality Management (CQM) Team
4 min	Utilization Management - Referrals	CA Dental Director	Referrals fell from 222 last quarter to 119 this quarter. This was mainly because there were fewer commercial and individual plan members. The committee reviewed the main referral types and code use. A coding issue at one DSO was fixed. About 64% of referrals were for root canals. Oral surgery was the next-highest type. About 8% were for periodontics, and one case was for prosthodontics.	The committee reviewed the report. No other action was needed.	Keep watching referral volume, code use, and any coding issues in future quarters. Owner: Clinical Quality Management (CQM) Team
1 min	Incentive Programs Report	Director, Provider Engagement	There is no incentive program for this market right now.	No action is needed. The report will return when an incentive program is in place.	None.
5 min	Provider Satisfaction Report	Director, Provider Engagement	The committee reviewed the provider satisfaction survey. Results were positive for customer service, claims, training, and the provider portal. Satisfaction was 84% for the customer service phone line and 88% for training and credentialing help. For claims pre-authorization, 91% were satisfied with ease of use and 90% with how fast it was. Overall	The committee accepted the positive customer service, training, credentialing, and claims pre-authorization results. The portal results are an early starting point because the portal is new. The team expects results to improve as providers learn to	Keep watching provider satisfaction trends and outreach needs. Owner: Provider Engagement Team

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			satisfaction for 2025 was 83%, and providers were very likely to stay with the plan.	use it. The committee gave no other direction.	
	Access and Availability				
5 min	Network Access and Availability	Director, Provider Engagement	The committee reviewed a survey about how easy it is to get care. Most areas met the standards. Emergency appointments and after-hours contact need work, especially in the Sacramento GMC region. About 34 offices were contacted there. Eighteen could not be reached, and 16 completed the survey. About 135 offices were contacted in the Southern California PHP region. Eighty-two could not be reached. No office is on a corrective action plan because this is the first full year of monitoring.	The committee supports more provider education and another vendor survey. No office is on a corrective action plan. Provider Engagement will look at doing another survey sooner when an office does not meet the rules more than once.	Look for ways to improve follow-up with offices that do not meet emergency appointment and after-hours access rules. Owner: Director, Provider Engagement
5 min	Network Geographic Access	Director, Provider Engagement	The committee reviewed where providers are located and whether the network has enough providers. Access is strong except for a known gap on Catalina Island. GMC access was 100% for adults and children. PHP access was about 99.9%, except for Catalina Island (Avalon County). Local providers there have not agreed to the plan rates.	The committee reviewed the report. Support for other ways to get care on Catalina Island will continue.	Keep watching where providers are located and any network changes. Owner: Provider Network Management Team
5 min	Network Activity Report - Provider Additions and Terminations	Director, Provider Engagement	The committee reviewed providers who joined or left the network, active locations, and associate counts by quarter and region. Sacramento was mostly steady. Southern California had more changes. The most common reason providers left was a lapse in Medicaid status. The team had 1,335 provider contacts during the quarter, including service support and visits.	The committee reviewed the report. No other action was needed.	Keep working with providers through education, support, and retention efforts. Keep tracking why providers leave the network. Owner: Provider Engagement Team
2 min	Secret Shopper Program Report	Director, Provider Engagement	The secret shopper review found areas to improve. These were emergency appointment times and after-hours phone messages. Five offices were checked in each category. Most areas met the rules, with 4 of 5 or 5 of 5 offices passing. Only 1 of 5 offices offered an emergency appointment within the required time. None had the required after-hours message. The team plans follow-up and provider education.	The team will use its usual provider education and follow-up process to address these findings.	Keep educating and following up with offices found through secret shopper checks. Owner: Provider Engagement Team
	Appeals and Grievances				
3 min	Grievance Summary – all markets	Operations Compliance Analyst	The committee reviewed Q2 grievances. Total grievances went down for DHCS, Commercial, and Medicare. Medicare had more grievances about benefit packages, with 625 cases in Q2. Health Net had more access-to-care grievances because a large dental center used its main business address instead of treatment locations on claims and pre-authorizations. This caused out-of-network denials. The problem was fixed during the quarter, so related grievances are expected to go down. Two commercial	The committee reviewed grievance trends and response times. It noted that the provider address problem was fixed and expects those grievances to go down.	Keep checking commercial grievance response times as DentaQuest takes over the full process. Watch Health Net access-to-care grievances to make sure they go down after the provider address fix. Owner: Grievance and Appeals Team

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			grievances took longer than required because CDN and DentaQuest shared the work.		
3 min	Grievance CAP (Corrective Action Plan) Report	Operations Compliance Analyst	The committee reviewed corrective actions tied to grievances. There was one corrective action case for DHCS in Q2, or 6.6% of resolved grievance cases. Provider Engagement counseled the provider. One new counseling request was received. No office needed more than one corrective action. All corrective actions were finished during the quarter, with none still open.	The committee reviewed the corrective actions. All were finished on time, and no cases were still open at the end of the quarter.	Keep checking corrective action work and whether each action is completed. Owner: Grievance and Appeals Team
2 min	Exempt Grievances - Access and Availability Issues	Director, Regulatory and Managed Care Compliance	The committee reviewed exempt grievances. DHCS resolved 71 in Q2 2026, up from 21 in Q1. The team is improving its work steps and how grievances are grouped. The goal is to better meet member needs, make reports more accurate, and avoid duplicate entries. Access to care was the top issue, with 28 of 71 grievances (39.44%): 24 GMC and 4 PHP. Main problems included finding an in-network provider, finding a specialist, getting care from an out-of-network provider, and delays in appointments or services.	The committee noted the rise in exempt grievances. It also noted work to improve how grievances are grouped and reported and to avoid duplicate entries.	Keep improving how grievances are grouped. Watch access-to-care grievance trends for new concerns. Owner: Customer Service Team
2 min	Resolved Provider Dispute Report	Operations Compliance Analyst	The committee reviewed provider disputes. Adult disputes went up a little in PHP and went down in GMC. Child disputes went down in both. Thirty-one pre-service disputes were sent to the health plan for review and acknowledgement. Post-service appeals went up in Q2. All required response and resolution times were met.	The committee reviewed provider dispute trends and response times. All required standards were met.	Keep watching provider dispute volume and response times. Owner: Grievance and Appeals Team
	Quality Improvement Reports				
4 min	Cultural and Linguistics Report	Interim Chief Oral Health Access Officer	The committee reviewed language and interpreter services. Use of interpreters went up in Q2. A review of one Q1 case and three Q2 grievance cases found ways to improve. These included helping providers use interpreter services, making it easier to get interpreter help and accommodations, and improving how requests are recorded and tracked. Planned work includes provider education, reminders about language help, customer service coaching, and better tracking of interpreter requests. The report also found a need for better follow-up when leaders change.	The committee noted ways to improve interpreter services, provider support, and follow-up on cases.	Keep educating and counseling providers about interpreter services and language help rules. Improve how interpreter access, accommodations, requests, and tracking are handled. Add Customer Service to future committee meetings. Look for ways to keep case follow-up steady when leaders change. Owner: Cultural and Linguistic Committee
5 min	Outreach and Health Equity Activity Report	Sr. Manager, Member Advocacy and Engagement	The committee reviewed community outreach and member education in Sacramento and Los Angeles counties. In Sacramento County, the team held 15 events, handed out about 448 educational materials and 1,158 hygiene items, joined a statewide health event that served about 752 patients, and called 3,487 members. In Los Angeles County, the team held 16 events,	The committee noted the ongoing work to educate members, explain benefits, and help members get care.	Continue planned outreach and member engagement. Owner: Member Advocacy and Engagement Team

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			handed out about 530 educational materials and 4,005 hygiene items, joined a large community health event, and called 2,608 members.		
2 min	Credentialing and Re-credentialing Activity	Director, Provider Engagement	The committee reviewed provider credentialing. One provider application was denied for cause. The provider did not appeal and was not added to the network.	The committee reviewed the result. No other action was needed.	Keep checking and recording credentialing work. Owner: Provider Engagement Team
2 min	Non-Reporting Offices Report	Director, Provider Engagement	The committee reviewed offices below the 3.33% enrollment-to-utilization level. One new office was below the level. It had more than 300 assigned members, but about 2% used services during the review period. The team will contact the office to learn what may be keeping members from getting care and to help improve use.	The committee noted provider coaching and continued tracking. Corrective action or removal from the network may be considered if use stays below the required level.	Contact the office to learn what may be keeping members from using care. Give education and support as needed. Keep checking use each quarter. Owner: Provider Engagement Team
4 min	IRR (Inter-Rater Reliability) Report	CA Dental Director	The committee reviewed Inter-Rater Reliability (IRR) results. This checks how often Clinical Review Specialists and Dental Consultants agree. Results were above the 90% goal, at 96% and 98% in Q2. Reviews covered surgical extractions, scaling and root planing, dentures, root canals, and crowns. The team plans California-specific calibration work so staff use state clinical review rules the same way.	The committee reviewed the results. Q2 IRR was above the goal. The team will create California-specific calibration activities.	Put the California-specific calibration activities in place and report the results. Owner: Clinical Quality Management (CQM) Team
4 min	Provider Audits – Independent Quality Assurance Review	Director, Provider Engagement	The committee reviewed provider Quality Assurance Reviews (QARs). Routine and focused reviews check whether offices meet network rules. An office must meet 100% of the rules before it can join the network. The team completed 44 reviews of new offices. All met the required level. No problems needed corrective action.	The committee reviewed the results. All 44 offices met the network rules, and no corrective action was needed.	Keep doing quality reviews. Use corrective action when a problem is found. Owner: Provider Engagement Team
2 min	Identification and Assessment of Members with Special Health Care Needs (SHCN) / Children with Special Health Care Needs (CSHCN)	Director, Quality and Outreach	The committee reviewed how members with Special Health Care Needs (SHCN) and Children with Special Health Care Needs (CSHCN) are identified and assessed.	The committee noted the SHCN and CSHCN work.	None.
3 min	Initial Oral Health Risk Assessment	Director, Quality and Outreach	The committee reviewed Oral Health Risk Assessment (OHRA) completion rates and member outreach. The team found a membership difference in the completion data that needs review. A total of 519 OHRAs were completed in Q2, including 88 by robocall. Completion rates were 4.47% for GMC and 5.45% for PHP. Of the members referred to case management, 8 of 20 GMC members and 9 of 29 PHP members joined the program. Mail was the most common way GMC members completed the assessment (61%). Online forms were most common for PHP (48%).	The committee reviewed the report. More review and an action plan will be shared at the next meeting.	Keep tracking how members complete the assessment, response rates, and case management referrals. Owner: Case Management Team

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3 min	Case Management and Continuity of Care Coordination	Director, Quality and Outreach	The committee reviewed case management and care coordination and how the two services are different. In Q2, 49 members were referred for care coordination, and 17 were reached. GMC opened 8 new case management cases and closed 7, with 78 total open. PHP opened 9 new cases and closed 4, with about 30 total open.	The committee found that internal reports need to match state reports more closely.	Review case management reports so they show the work more clearly and better match state reporting needs. Owner: Quality and Outreach, Regulatory and Managed Care Compliance, Provider Engagement
2 min	Quarterly Policy and Procedure Report	Director, Regulatory and Managed Care Compliance	The committee reviewed Q2 policy updates. Four policies were updated: the Beneficiary Dental Exception Policy, Teledentistry Policy, Provider Maintenance and Ongoing Monitoring Policy, and Grievance and Appeals Policy. No other policies were updated.	The committee reviewed and noted the four Q2 policy updates.	Keep policies up to date and continue regular reviews. Owner: Regulatory and Managed Care Compliance Team
2 min	Clinical Services Quality Oversight Audits	CA Dental Director	The committee reviewed Clinical Services Quality Oversight Audit results. The report checked how closely Clinical Review Specialists and Dental Consultants agreed. It looked at results, errors, and error rates for services such as surgical extractions, partial dentures, and crowns. The results showed that clinical reviews stayed consistent.	The committee reviewed the audit results and noted that clinical reviews stayed consistent.	Keep checking clinical quality and give reviewer education when needed. Owner: Clinical Quality Team
2 min	Provider Billing Complaints	Operations Compliance Analyst	The committee reviewed provider billing complaints. Three member grievances about provider billing were reported in Q2. Two involved GMC adults, and one involved a PHP adult. The complaints said there may have been billing errors, including possible billing of members when it was not allowed. All three cases were reviewed and handled through the normal complaint process.	The committee reviewed the cases. The PHP adult case was substantiated, meaning the review supported the complaint.	Keep watching provider billing complaint trends. Owner: Compliance / Grievance and Appeals
3 min	Potential Quality Issues Report	CA Dental Director	The committee reviewed Potential Quality Issue (PQI) trends. There were 26 cases in Q2, down from 67 last quarter. Five of the 26 cases were found not to be supported by the review. The other cases are still being reviewed. Provider Engagement continues education and counseling.	The committee reviewed the report. Provider education and counseling will continue for cases still under review.	Keep watching PQI cases and continue provider education. Owner: Clinical Quality
	Subcommittee Reports				
1 min	Peer Review Updates	CA Dental Director	There was no peer review update this quarter.	No action was needed. The update will be given at the next meeting.	Add a peer review update to the next committee meeting agenda. Owner: Committee Administration
6 min	Open Forum	Interim Chief Oral Health Access Officer	The committee invited more questions and ideas. Members discussed using the same charts and trend signs in reports. Current templates can change if required tracking stays in place. They also discussed making internal case management reports match state reports	The committee agreed that trend signs should show favorable, unfavorable, or neutral results, not just up or down. Reports may change if tracking and trends stay in	Update report charts to show favorable, unfavorable, or neutral trends. Use this format in all committee reports. Continue other action items.

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			more closely. A follow-up work session was proposed.	place. No other formal motions were made.	Owner: CQM, Regulatory and Managed Care Compliance, Reporting Team
1 min	Closing and Next Meeting	Interim Chief Oral Health Access Officer	The meeting ended after all agenda items and open forum discussion were complete.	The meeting was adjourned.	File the final minutes with the committee and audit records. Owner: Committee Administration