COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

Quality Improvement & Health Equity (QIHEC) Committee

Date/Time	April 15, 2026, 12:00pm – 1:30pm
Location / Dial-In #	Microsoft Teams meeting Meeting ID: 267 625 714 656 29 Passcode: NZ2Sv7bw Dial in by phone: +1 469-998-7368,,602789022#

Time	Topic	Presenter	Approval Required
12:03 – 12:07	**Call to Order**	Gordon Arakawa, MD	
	Roll Call	Gordon Arakawa, MD	
12:07 – 12:15	**Consent Agenda**	Gordon Arakawa, MD	
	a. Approval of previous meeting minutes from Wednesday, January 15, 2026.	Gordon Arakawa, MD	☒
	b. Approval of meeting presentation of *2025 Q4* HNCS presentation.	Gordon Arakawa, MD	☒
	c. Approval of meeting presentation of *2026* Q1 QIHEC materials and approval packet.	Gordon Arakawa, MD	☒
	d. Approval of meeting presentation of 2026 HNCS QIHEC Charter.	Gordon Arakawa, MD	☒
12:15 - 01:19	**New Business**	Gordon Arakawa, MD	
	D-SNP Update A. Call Center Metrics B. Utilization Management Key Metrics • *Over/Under Utilization* • Specialty Access C. Appeals & Grievances • Top 5 Appeals • Top 5 QOS Grievances • Top 5 QOC Grievances • Top 5 Access to Care Grievances • PQIs D. Healthcare Effectiveness Data & Information Set (HEDIS) E. Care Management KPI Report F. Enhanced Care Management/Community Supports • ECM Enrollment • CS Authorizations/Claims Trends • Barriers to ECM & CS	Gordon Arakawa, MD	☒

Quality Improvement & Health Equity (QIHEC) Committee

	G. Long Term Support Services (LTSS) • Quarterly Totals Report H. Pharmacy • PA Metrics • Top 5 PA Requests • Top 5 Denials • QA/Reliability Results for Q3 I. Behavioral Health • CHPIV Members Served (Quarterly) • ABA Services J. Quality Improvement Projects • Quality Improvement Project • IHA • Lead Screening K. Credentialing L. 2025 EOY Language Assistance Projects M. Health Net Follow-Up Questions/Answers		
01:19 – 01:20	**Committee Recommendation to the Board of Members and Adjournment** **Next Meeting:** Date: Wednesday, July 15, 2026 Time: 12:00p.m – 1:30p.m Location: Community Health Plan of Imperial Valley Conference Room/Microsoft Teams	Gordon Arakawa, MD	☐

Quality Improvement & Health Equity (QIHEC) Committee

QIHEC Meeting Minutes: 04/15/2026

Community Health Plan of Imperial Valley QIHEC Committee convened on 15th day of April 2026 at 12:00pm.

Voting Members Attendance Record (Quorum =2) Name / Title	Present	Absent	Designee
Gordon Arakawa, MD Community Health Plan of Imperial Valley ***(Committee Chair)***	☒		
Unnati Sampat, MD Imperial Valley Family Medical Group	☒		
Masoud Afshar, MD Masoud Afshar MD	☒		
Ameen Alshareef, MD Valley Pediatric Health	☒		
Leticia Plancarte-Garcia Imperial County Behavioral Health Services	☒		
Janette Angulo Imperial County Public Health Dept.	☒		
Mersedes Martinez El Centro Regional Medical Center	☒		
Shiloh Williams San Diego State University	☒		

Voting Members Attendance Record Name / Title	Present	Absent	Designee
Hamid Zadeh, MD Imperial Valley Health District		☒	
John Teague, PharmD Imperial Valley Health District	☒		

Quality Improvement & Health Equity (QIHEC) Committee

Ad Hoc Members and Guests Present	Present	Absent	Designee
Jeanette Crenshaw Executive Director of Healthcare Services, Community Health Plan of Imperial Valley	☒		
Fernanda Ortega Project Supervisor, Community Health Plan of Imperial Valley	☒		
Priscilla Carpio Care Manager, Community Health Plan of Imperial Valley		☒	
Amanda Delgado Project Specialist, Community Health Plan of Imperial Valley	☒		
Belen Ortega Care Manager, Community Health Plan of Imperial Valley		☒	

Ad Hoc Members and Guests Present	Present	Absent	Designee
Cynthia Mesa Director of Internal and Delegation Oversight, Community Health Plan of Imperial Valley	☒		

Quality Improvement & Health Equity (QIHEC) Committee

Agenda Item	Discussion	Recommendation /Decision/ Action /Date	Responsible Party
I. Call to Order **II. Announcements**	Dr. Gordon Arakawa called the meeting to order at 12:00 p.m. Dr. Gordon Arakawa presented no new announcements.		
III. Consent Agenda	a. Dr. Gordon Arakawa presented the meeting minutes from the CHPIV QIHEC meeting held on Wednesday, January 15, 2026, for Committee review and approval.	A motion to approve the meeting minutes was made by Dr. Unnati Sampat and seconded by Dr. Ameen Alshareef.	
	b. Dr. Gordon Arakawa presented the meeting presentation from the HNCS 2025 Quarter 4 QIHEC presentation for Committee review and approval.	A motion to approve the HNCS 2025 Q4 QIHEC presentation and packet was made by Dr. Unnati Sampat and seconded by Dr. Ameen Alshareef.	
	c. Dr. Gordon Arakawa presented the meeting presentation from the 2026 Q1 QIHEC materials and approval packet for Committee review and approval.	A motion to approve the 2026 Q1 QIHEC materials and packet was made by Dr. Unnati Sampat and seconded by Dr. Ameen Alshareef.	
	d. Dr. Gordon Arakawa presented the meeting presentation from the HNCS QIHEC Charter for Committee review and approval.	A motion to approve the HNCS QIHEC Charter and packet was made by Dr. Unnati Sampat and seconded by Dr. Ameen Alshareef.	
IV. New Business			



	Dr. Gordon Arakawa presented New Business for Committee review, approval, and participation. Please reference the meeting packet New Business section for detailed information.	A motion to approve all New Business reports was made by Dr. Unnati Sampat and seconded by Dr. Ameen Alshareef.	
D-SNP Update	Jeanette Crenshaw, Executive Director of Health Services: Yes, I just wanted to introduce the implementation of our D-SNP Model of Care. So, our model care is a regulatory requirement, and it speaks about what we do here at CHPIV for our members to help improve their health outcomes. So as such we do have certain goals that help the members reach their goals. Some of those include reducing hospitalization, reducing life events index and increasing assessments and things of that nature to help improve the member's health. So, as we're just now in quarter two, we don't have much data to report yet. However, future state you'll be seeing in 2026, we'll be reporting the data on the connector, how we're helping our members to reach their goal, and we'll be watching these trends. Should a trend be doing well, we may set the goal even higher. But should we see a trend moving downwards, we'll then start subcommittees and areas where we can improve outcomes as we're watching those trends and we'll be reporting on those throughout the year. Shiloh Williams: What is a SNP? Dr. Arakawa: Dual Special Needs Plan refers to the Medi-Cal and Medicare component.		
A. Call Center Metrics	During Q4 2025, the Call Center continued to support member and provider needs through consistent engagement and high-volume service activity. Health Net is working to lower call volumes, but there will		



	always be some flow due to new patients and providers. The company is looking into implementing a member portal to improve member services. Member Services received a total of 6,549 calls during the quarter, with the highest call volume observed in October and steady activity maintained through year end. The primary drivers of member inquiries centered around Benefits and Eligibility, Primary Care Provider (PCP) updates, and demographic changes, reflecting continued member engagement related to access, enrollment, and maintenance of care information. Provider Services received a total of 3,078 calls during the quarter, with inquiries primarily focused on Benefits and Provider Eligibility as well as authorization-related questions.		
B. Utilization Management	Metrics remained stable and continued to trend favorably when compared against established benchmark targets. Not too many spikes. We asked Health Net about 2024 Q3. There's a little bit of a bump, Q2, Q3 bump. And they basically said that there was a delay in data reporting. So that seems to have stabilized and we're still using those updated benchmarks. So, we seem to be if not meeting the benchmark we're below the statewide benchmarks for Health Net in other areas of the state. Readmission rates showed an overall downward trend in recent periods. Utilization indicators such as emergency room and outpatient service use remained below benchmark thresholds, while average length of stay and inpatient utilization metrics continued to perform within anticipated ranges. Overall, current performance indicates continued stability in utilization patterns.		
C. Appeals & Grievances	During Q4 2025, CHPIV recorded a total of 29 appeals and 130 grievances. Appeals consisted of 25 pre-service appeals and 4 expedited		

	pre-service appeals. Grievances were categorized across several reporting areas, including Quality of Service (QOS), Quality of Care (QOC), and Access to Care (ATC). QOS grievances represented the largest category with 88 cases, followed by 11 Quality of Care grievances and 31 Access to Care grievances, including 3 expedited grievance cases. Within Quality of Care grievances, the most frequently reported categories included appropriateness of treatment by primary care providers and delays in referrals by primary care providers. Quality of Service grievances were primarily associated with transportation concerns, administrative issues related to Health Plan services, provider billing concerns, and interpersonal concerns involving provider interactions and staff communication. Access to Care grievances most commonly involved prior authorization delays, primary care referral requests for services, and specialist appointment availability. Additional reporting categories included Cultural and Linguistic grievances, which totaled zero cases during the quarter, and Behavioral Health grievances, which recorded five cases in Imperial County for Q4 2025.		
D. Healthcare Effectiveness Data & Information Set (HEDIS)	MY2025 Medi-Cal MCAS performance dashboard, with data reported through January 10, 2026, provides a comparative view of year-to-date (YTD) performance against benchmark rates and prior measurement period performance. Measures are categorized based on whether current YTD performance is performing better than, worse than, or consistent with the prior measurement period rate. The dashboard includes comparisons across multiple quality measures and benchmark thresholds to support ongoing monitoring of performance trends.		



	Current reporting reflects variation across measures, with several indicators performing above prior measurement period rates, some remaining stable, and others performing below prior performance levels.		
E. Care Management	CHPIV's Care Management program tracked member engagement across multiple service areas, including Physical Health (PH), Behavioral Health (BH), Maternity (MAT), Transitional Care Services (TCS), and First Year of Life (FYOL) programs. Overall Care Management engagement included 514 members, representing an engagement rate of 62%. Program specific engagement rates included 68% for Physical Health, 54% for Behavioral Health, 59% for Maternity, 73% for Transitional Care Services, and 95% for First Year of Life, reflecting variation in participation across care management populations. Care Management outcome reporting compared utilization measures during the 90 days prior to enrollment and the 90 days following enrollment in care management services. For Physical Health and Behavioral Health populations, the 30-day readmission rate decreased from 28.6% to 10.0%. Within Transitional Care Services, the 30-day readmission rate changed from 30.3% prior to enrollment to 16.9% following enrollment. First Year of Life reporting included hospital admission utilization comparisons between members not enrolled and members enrolled following engagement. Emergency Department (ED) utilization measures were also reported across care management populations. For Physical Health and Behavioral Health populations, ED claims decreased from 193 claims prior to enrollment to 101 claims following enrollment. Within Transitions of		



	Care, ED claims changed from 484 prior to enrollment to 312 following enrollment. First Year of Life reporting compared ED utilization between enrolled and non-enrolled populations during the first 90 days following referral and engagement periods.		
F. Enhanced Care Management/Community Supports	CM enrollment reporting for 2025 was relatively stable enrollment activity throughout Q1–Q3, with assigned membership showing a gradual upward trend over the reporting period while enrolled membership remained generally consistent month over month. ECM population reporting included members across multiple focus categories, including individuals experiencing homelessness, adults and children with serious mental health conditions or substance use disorders, individuals transitioning from incarceration, members at risk for avoidable hospital or emergency department utilization, and members requiring institutional or community-based transition support. Across all populations of focus, total ECM enrollment activity reflected 63,477 member assignments/enrollments during the reporting period, with monthly enrollment totals remaining relatively stable. Community Supports reporting included services such as Asthma Remediation, Environmental Accessibility Adaptations, Housing Deposits, Housing Transition and Navigation Services, Medically Tailored Meals, Personal Care Services, Recuperative Care, and Respite Services. Total utilization reflected 9,469 authorized services, 115,075 claims, and 160,468 claim units. Among reported service categories, Medically Tailored Meals, Housing Transition and Navigation Services, Recuperative Care, and Personal Care Services represented the largest utilization volumes during the reporting period.		



G. Long Term Support Services (LTSS)	Reporting reflects utilization activity across the fourth quarter reporting months of October through December 2025. For Long-Term Care (LTC) services, utilization was tracked across several facilities, including El Centro Post Acute, Imperial Manor, Pioneer Memorial Distinct Part (D/P), and out-of-county facilities. Utilization volumes remained relatively stable throughout the reporting period, with Pioneer Memorial D/P representing the largest number of unique utilizing members among reported facilities. Within Community-Based Adult Services (CBAS), the program served approximately 250 unique utilizing members monthly, with average participation ranging from 1.7 to 1.8 days per week. Reporting also reflected that there were no members identified as utilizing CBAS six months prior and subsequently transitioning into Long-Term Care settings during the reporting period. For Intermediate Care Facilities (ICF) utilization, membership activity associated with ARC facilities (#1, #2, and #3) remained stable, with reported utilization ranging between 13 and 14 unique members across the quarter.		
H. Pharmacy	Monthly PA volume fluctuated throughout the year, ranging from 41 to 83 prior authorization requests per month, with the highest volume reported in September 2025. Approval rates varied across reporting periods, ranging from 52% to 67%, while denial rates ranged from 33% to 48%. Prior authorization activity per 1,000 members also varied throughout the year. PAs range between 50 and 80. Pharmacy Denials: IV iron consistently appears among the top denial categories, with an average denial rate of around 40%. Education for		

	providers on appropriate prescribing practices is ongoing. There are concerns about the specific IV iron being prescribed and the use of biosimilars for pegfilgrastim. Even small numbers of denials can impact patient care, highlighting the need to address the issue with individual providers. Formulary Considerations: Warfarin is listed as a Tier 1 drug, but there is a lack of community INR clinics in the area. Patients may be facing higher copays for alternative medications like Xarelto/Eliz. The formulary website was used to find this information. Further review is needed to determine if Xarelto falls under medical or pharmacy benefits and if it will be reviewed. Some patients can't take Sorelto and must be on Warfarin, Zarento, or Eloquist. Zarento and Eloquist are not approved for some valvular heart diseases and other conditions. The only choice is Zarel versus Eliquis.		
I. Behavioral Health	Behavioral Health referral activity included 153 members referred to Health Net Behavioral Health through County Specialty Mental Health Programs (SMHPs). Q3 Behavioral Health Medi-Cal referrals from Health Net to Health Net Behavioral Health from the county were higher than usual. Usually, there are 50 referrals, but Q3 saw a larger number. The change is due to the system requiring reassessment at screening. 1 member referred by Health Net Behavioral Health to County Specialty Mental Health Services, and 48 members referred to Health Net Behavioral Health providers. In addition, 117 members were referred for health plan care management services during the reporting period. Member service utilization data reflected 315 members served in April, 303 members served in May, and 133 members served in June within Imperial County.		



	ABA clinical determination reporting for Q4 2025 included 379 authorizations and 377 approvals, there are very few full or partial denials for ABA services.		
J. Quality Improvement Projects	For the 2025–2026 Annual DHCS Performance Improvement Project (PIP) update, CHPIV's Clinical PIP focused on improving Well-Child Visits (WCV) for Black/African American and Hispanic/Latino members, while the Non-Clinical PIP focused on improving provider notifications for members with SUD/SMH diagnoses following Emergency Department visits. Reporting reflected high confidence ratings across both projects, with evaluation and critical element performance scores ranging from 94% to 100%. Initial Health Assessments (IHAs) numbers were below 50%, and overall compliance was below 70%. Quarter three saw the highest numbers in seven to eight quarters for medical record reviews, with around 80% completion. Health Net has an agreement with DHCS to count IHAs done plus unable to contacts (after three attempts) as an encounter. Health Net is sponsoring a program to incentivize members to complete their IHA with a $50 gift card. This is intended to bring members in within 90 days. The IHA helps assign patients to care management teams based on risk level. The incentive program is available for IHA completion, and providers may need to apply through EDGE funding. Cynthia Mesa, or Director of Internal and Delegation Oversight, is tracking the CAP, ensuring milestones are met, and fact-checking to ensure all elements are complete. Lead Screening: Question about where patients are enrolling and selecting their PCP, and why they are not getting an IHA. Medi-Cal and Member Engagement when individuals qualify for Medi-Cal, they either select a provider or are auto-assigned one, after which a membership card		

	is issued. Engagement begins with health, with case management teams welcoming new members and outlining necessary steps. Healthy individuals may not seek medical attention until they are sick, leading them to contact the call center and potentially express dissatisfaction with their assigned PCP. Initial welcome calls, similar to those on the Medicare side, are crucial for ensuring members complete their Initial Health Assessments (IHA) and other necessary tasks. Provider Assignment and Patient Care Health Net team is often the first point of contact for members, even before the provider. Providers receive monthly rosters of assigned patients, but outreach efforts may lag behind patient awareness. Some patients seek care from providers to whom they are not assigned, leading to uncompensated care. Dr. Sampat: The issue of patients is wanting to see specific doctors but being assigned elsewhere. Improving Lead Screening in Pediatricians HealthNet is willing to fund point-of-care machines or provide vouchers for clinic access to improve lead screening. A convening of seven to nine local pediatricians is planned to discuss approaches, potentially led by Dr. Alshareef. The goal is to improve lead screening rates, which currently show a high percentage of non-compliance, especially in the first quarter for age 1. There is a need for better documentation of education provided to parents, even if they refuse testing.		
K. Credentialing	For Q3 2025 investigative activity, reporting reflected one investigative case brought before the Peer Review Committee, zero incidents of appointment availability resulting in substantial harm, and zero reported incidences of adverse injury occurring during a procedure performed by a contracted practitioner.		

	Credentialing and certification activity during Q4 2025 included both provider and facility reviews. Initial provider credentialing activity included review and approval of practitioners across multiple provider types and specialties. Facility certification activity included initial certification approvals for Calexico Health Center, Pioneers Children's Health Center, Pioneers Health Center, and Pioneers Memorial Regional, with FMC Calexico Dialysis completing facility recertification. Upcoming credentialing activity for 2026 reflects projected provider review volume of 60 providers in January, 22 providers in February, and 28 providers in March.		
L. 2025 EOY Language Assistance Report	Membership demographic reporting reflected a population of 96,862 members, with Hispanic members representing 92.7% of the total membership population, followed by White (3.77%), Asian/Pacific Islander (1.05%), African American/Black (0.79%), American Indian/Alaska Native (0.39%), and other or unknown categories. LEP reporting reflected that 56% of members identified a spoken language need, while 37% reported written language needs. Language Assistance Program utilization data included requests for telephonic interpretation, face-to-face interpretation, sign language interpretation, and written translation services. Utilization rates reflected 8.94 telephonic interpreter requests per 1,000 members with LEP, 0.04 face-to-face interpreter requests per 1,000 members with LEP, and 0.37 sign language interpreter requests per 1,000 members with LEP. End-of-year reporting reflected 470 total LAP requests in 2025, compared to 1,245 requests in 2024, including 438 telephonic interpreter requests, 12 face-to-face requests, and 20 sign language requests. Grievance reporting reflected four linguistic grievances during 2025 and zero cultural grievances. Quarterly reporting showed grievance activity		

	occurring during Q2 and Q3 only. Additional review identified that one of the four LAP-related grievances was categorized as involving perceived discrimination and interpreter needs. There was also a reduction in telephonic interpreter utilization during 2025 and outlined planned efforts related to increased awareness and education activities in 2026.		
M. Health Net Follow-Up Questions/Answers	A&G 1. Would it be possible to identify when Members are identified/associated with two or more grievances at the same time? *-Yes, our current reporting allows us to see members with two or more grievances at the same time.* 2. What is the nature of balance billing-related QOS grievances? Is it due to: • Providers billing both private insurance and Medi-Cal? • Members not "declaring" to Providers that they are Medi-Cal Members prior to service? *-In Q4-2025, there were 11 Balance Billing QOSs:* *1. 1 insurance information was not provided at the time of service* *2. 1 bill sent in error by El Centro Reginal Medical Center (ECRMC)* *3. 1 case where claim was reprocessed as secondary insurance (member has Medicare as primary insurance)* *4. 4 cases where balance was zero by the time the case was received.* *5. 1 delay in processing claim due to missing information* *6. 1 Member billed as received services from an OON provider and there was no authorization*		

	7. 1 case for out of state service (Arizona General Hospital) it was determined member had AZ Medicaid for that date of service 3. Regarding the QOS Grievances related to Transportation, the committee members are asking for a breakdown of destination – what is the proportion of transportation grievances related to travel within Imperial County compared to outside Imperial County, e.g., trip to San Diego. In addition, the committee members asked if the top reasons for the QOS Transportation grievances related to in-county versus out-of-county could be shared. *-The reports we get from ModivCare include the Riders County of origin, not by destination.* CM 1. How is Health Net working to increase non-ECM Care Management engagement rates (in 2025 Q3-4, the rates were 47-88%)? *-Health Net's Care Management Goal for Engagement is 52%, which we far exceeded in all programs. All programs averaged out to 67.2% for Q4. Health Net did acknowledge very low Customer Satisfaction response rate with only 9 out of 900 CHPIV Members responding to the survey.* ME 1. How is Health Net working to increase the CAHPS Member response rate with only ~10% Members returning the survey (333/3159)? a. *Our regulatory CAHPS surveys now have email, QR code and URL links for members to take the survey*		

	b. *Increase CAHPS survey awareness with members and importance of feedback* c. *through the survey by sending out NCQA member newsletters with CAHPS article* d. *Participating in CACs while providing a CAHPS survey overview and encouraging* e. *members to complete the CAHPS survey if they receive one* f. *Engaging providers to encourage member participation in CAHPS survey* g. *Reducing the number of various surveys that go out to members due to member abrasion* 2. Is the CAPHS provided in English and Spanish? *-Yes, in both English and Spanish* GEO Access 1. Preferred Language - questions were raised about preferred language inquiries. In addition to "What is your preferred language?", should we be formally asking "What language do you speak at home?" and "What language would you prefer for provided written materials?" *-We do ask for preferred written language. However, we tend to get more data for the spoken language field. Most of our language analyses, including Geo Access, use the spoken language field data. The difference here is that the preferred language is extracted from the membership data while the other data source is extracted from the overall census.* Member Eligibility		

1. What options does a Provider have to receive payment when he/she sees a patient who has been approved for Medi-Cal but not yet assigned to an MCP? Can he/she bill FFS Medi-Cal? *-If the member is eligible for Medi-Cal, and the State has not assigned an MCP, the provider should be billing FFS directly with the State.*

Cynthia Mesa: I do want to bring up matter of fact that we have got to talk about referrals. The reason why I'm here is because as part of CHPIV we get audited by state, by CMS, but pretty much everybody.

We received a corrective action plan (CAP) from Health Net regarding referrals and so I did challenge Dr. Arakawa that I would be coming today is that it is a standing agenda that we have to find out what's happening with authorizations. So, as you providers in the community submit an authorization, not every time does a member use that authorization. Part of the challenge that the state (DHCS) is giving us is what are we going to do about that?

For this committee (QIHEC), I challenge the group to select a topic of authorizations that we can ask Health Net to validate whether they did the member did receive the authorization and if not who's going to follow up with them?

They are currently under a corrective action plan (CAP). I have a timeline of June, because I must answer to a corrective action plan (CAP) by May 1st is what are we going to do in interim?

So as this committee (QIHEC) here with physicians on the panel and everybody else, how would we like to go about that? Usually, validation means claim is paid that the member got the service. But in the

meantime, is there something that you would like me to get a sampling of about 10 charts of a specific authorization to ensure that it's been used? Because we do get referral logs, things like that in future, when that plan is proposed for this next committee (QIHEC), I can present that back to you what they're going to be doing and then this committee will take a step forward as to what would you like to continue to do with that because that's going to be a continued topic in this committee (QIHEC).

Dr. Sampat: So that's a good, good thing to have.

There is two things:

1. First thing is, of course, sampling is a great idea. We'll know what is happening how many are being used
2. Second, how many are not?

The ones that are being used, as you said, come from the claim. If they're not being used, what is happening? The solution to that would be for the providers to maybe give feedback on whether they don't need it or cancel it or something of that sort. Because sometimes we will change our plan or sometimes the conditions resolve, and we don't need that anymore or we found some other alternative.

Either we find the solution, the condition is resolved, or we just change plans, or, instead of doing this we do something else. There could be different reasons for that. How to close the loop. We can give you feedback or cancel a request, maybe?

Dr. Arakawa: I think Dr. Sampat; you're on to something. I think the idea is you want to look at the offs, you know, the odds that are completed, right? But it's the authorizations that are not. So, the idea one would be maybe like if you're looking at specialist referrals, the ones the San

	Diego are the ones that you usually go unfilled because the member can't go or whatever reason, right? We do a comparison local versus distant and. And then at the same time we could also look at, look at the authorizations and say are they offs that go to ortho? They just don't get. Just like you said, those don't get fulfilled or OS to endo. I'm going to pick on endocrine, right? Because I think we lost an endocrinologist recently, right? So maybe that's the one that goes into the black hole very specifically. And then from that I like your cancellation idea because it is a partial answer to DHCs saying that there are basically some orphan referrals that are not real. Mersedes Martinez: How do you reassign those authorizations? That's a big question, right? Dr. Arakawa: It's like assigning members to a care manager at think they're in it, but only a fraction answer. It's that same idea. You put out a bunch of us, but 1/3 of them are not real. They're not going to be fulfilled for whatever reason or they're just not Dr. Sampat: They can send us a fax, and we can say no longer needed. Mersedes Martinez: But sometimes the patient decides, well, I don't want to go there for that service. Or there was some obstacle in the way. Right. Dr. Arakawa: But if it hangs, it stays as an unfulfilled off. I like that. Dr. Sampat: Right. That's okay. Cynthia Mesa: What Health Net is doing right now is they're working on a dashboard report that's going to give me some more detail of how they're going to pull it. I'm assuming they're going to reconcile against		

	claims, because that's how I used to do it before when I was with another plan. We would get the authorizations, reconcile it against the paid adjudicated claims, and then we would get case management involved and call all those members up and start calling everybody. You call the doctor's office, call the provider, send someone to their home. Why didn't you use your authorization? We're here to help you. Do you know that you have this open? If they're getting term to expire, we would definitely make sure that we reauthorize that in case the member did need it. Maybe their appointment is six months down the line. Right. And we don't know that. A lot of that is a factor in why things are not being used. But I think for purpose of the response that I need to give by May 1st, I think the first action is just to look at the San Diego ones. I'll look at the provider list, I'll take a sample of like 10. I'll ask HealthNet what they're doing with them, because they are working on a plan. We must take action now since it's already at the state level. I will start with that and then in July, I'll come back with the update of what I discovered during this period and then what their proposed solution plan is and if you guys agree with that. Because we have the ultimate say, we are the plan. If they propose a plan out, you don't like it, this is the authority. You guys have to say, nope, you need to go back and fix this. And we're going to continue to do it our way until we get a feasible matter. But again, the power is in this committee (QIHEC) because technically you do have savior providers in the community. And if your members are being affected, that our members here at the plan. Dr. Arakawa: And I'm going to take a chance to raise that care management flag that if you have care management on board, they're the		

	ones to help you. Can they find out if that is needed anymore. They can be the conduit, right? Or the system can be the conduit for that. Cynthia Mesa: And then the other part is ICTs. I know we've talked a lot about ECM. We are having trouble with ECM. That was a corrective action that we got from ECM providers. A lot of it has to do with ICTs and care plans. Same with CCS ICTs. We are working with Health Net on those. But it seems to be that a lot of the documentation that we're getting from the community is very insufficient. documentation does really matter with these providers that are giving these services. But care plans is a big problem. So, if they are managing out the community, again you as a provider, if they're in ECM or they're with CCS, you should be getting a copy of your care plan and the ICT getting invited to it. So that is something that we are taking action on, ensuring that they're following that process. Because again it's documented that it's not happening.		
V. Adjournment	Dr. Gordon Arakawa asked if there were any recommendations, comments, or questions. There were no recommendations, comments, or questions from the committee. **Next Meeting:** Date: Wednesday, July 15, 2026 Time: 12:00p.m – 1:30p.m Location: Community Health Plan of Imperial Valley Conference Room/Microsoft Teams ***Meeting Materials Due: Friday July 10, 2026*** **Meeting adjourned at 01:20 P.M.**		