COMMUNITY HEALTH PLAN OF IMPERIAL VALLEY

Quality Improvement & Health Equity (QIHEC) Committee

Date/Time	July 08, 2026, 12:00pm – 1:30pm
Location / Dial-In #	Microsoft Teams meeting Meeting ID: 287 981 565 350 14 Passcode: co9QV6T2 Dial in by phone: +1 469-998-7368,,725800494#

Time	Topic	Presenter	Approval Required
12:06 – 12:07	**Call to Order**	Gordon Arakawa, MD	
	Roll Call	Gordon Arakawa, MD	
12:07 – 12:13	**Consent Agenda**	Gordon Arakawa, MD	
	a. Approval of previous meeting minutes from Wednesday, April 15, 2026.	Gordon Arakawa, MD	☒
	b. Approval of meeting presentation of *2026* Q2 HNCS presentation.	Gordon Arakawa, MD	☒
	c. Approval of meeting presentation of *2026* Q2 HNCS packet.	Gordon Arakawa, MD	☒
	d. Approval of meeting presentation of Operations Manual changes.	Gordon Arakawa, MD	☒
	e. Approval of 2025 QIHEd Year End and Wellness Work Plan Evaluation.	Gordon Arakawa, MD	☒
	f. Approval of 2026 Population Health Management Strategy Description.	Gordon Arakawa, MD	☒
	g. Approval of QIHEd and Wellness Annual Evaluation.	Gordon Arakawa, MD	☒
12:13 - 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	Gordon Arakawa, MD	☒

Quality Improvement & Health Equity (QIHEC) Committee

	F. Enhanced Care Management/Community Supports • ECM Enrollment • CS Authorizations/Claims Trends • Barriers to ECM & CS 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, October 08, 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: 07/08/2026

Community Health Plan of Imperial Valley QIHEC Committee convened on 8th day of July 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	☒		
Amanda Delgado Project Specialist, Community Health Plan of Imperial Valley		☒	
Cynthia Mesa Interim Chief Compliance Officer, Community Health Plan of Imperial Valley	☒		**Kristi Wilkerson** Internal and Delegation Oversight Manager, Community Health Plan of Imperial Valley

Ad Hoc Members and Guests Present	Present	Absent	Designee

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, April 15, 2026, for Committee review and approval.	A motion to approve the meeting minutes was made by Dr. Unnati Sampat and seconded by Leticia Plancarte.	
	b. Dr. Gordon Arakawa presented the HNCS 2026 Quarter 2 QIHEC presentation for Committee review and approval.	A motion to approve the HNCS 2026 Quarter 2 QIHEC presentation was made by Dr. Unnati Sampat and seconded by Leticia Plancarte.	
	a. Dr. Gordon Arakawa presented the HNCS 2026 Quarter 2 QIHEC packet for Committee review and approval.	A motion to approve the HNCS 2026 Quarter 2 QIHEC packet was made by Dr. Unnati Sampat and seconded by Leticia Plancarte.	
	b. Dr. Gordon Arakawa presented the Operations Manual changes for Committee review and approval.	A motion to approve the Operations Manual changes was made by Dr. Unnati Sampat and seconded by Leticia Plancarte.	

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	c. Dr. Gordon Arakawa presented the 2025 QIHEd Year End and Wellness Work Plan Evaluation for Committee review and approval.	A motion to approve the 2025 QIHEd Year End and Wellness Work Plan Evaluation was made by Dr. Unnati Sampat and seconded by Leticia Plancarte.	
	d. Dr. Gordon Arakawa presented the 2026 Population Health Management Strategy Description for Committee review and approval.	A motion to approve the 2026 Population Health Management Strategy Description was made by Dr. Unnati Sampat and seconded by Leticia Plancarte.	
	e. Dr. Gordon Arakawa presented the QIHEd and Wellness Annual Evaluation for Committee review and approval.	A motion to approve the QIHEd and Wellness Annual Evaluation was made by Dr. Unnati Sampat and seconded by Leticia Plancarte.	
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 Leticia Plancarte.	
A. Call Center Metrics	Call Center Metrics remain relatively stable, with an approximate 2:1 to 3:1 ratio of Member Services calls compared to Provider Services calls.		

	The primary drivers of Member Services call volume continue to be: • Benefits and eligibility inquiries • Primary Care Provider (PCP) updates • Demographic updates Provider Services call trends continue to be driven primarily by: • Benefits and eligibility inquiries • Authorization-related requests Call volume has reached a steady state, with demand remaining consistent over time and no significant changes observed in the primary reasons for member or provider inquiries. Dr. Alshareef: I know we always focus on the members and with primary care, which is good, which is important. You know, step one. However, you know, I did notice and I don't know if There's a solution for this. I did notice, like it's a common practice also from ERs here in the, in the area, they do schedule follow ups or they tell the patients to follow up with the er, which is, which is like, I know I didn't see this practice somewhere else. Our ERs are great ER. I'm not saying anything bad about them, but I'm describing a situation. Often, I receive calls from the, you know, an ER doc, you know, who say, or a practitioner on the ER. And they say like we saw him yesterday and we asked him to come today to check on him again. So today he looks like, and looks like this and this, or you know, and it was like, you know, the ER		

	should not reschedule patient to come to the er, like it is an emergency. They need to schedule him to go back to their primary care I think maybe an effort from the CHPIV or from the Health Net to basically to, you know, to drive an effort to better communicate, better build a communication between the ERs and the primary cares. I mean, I don't know what they can do. Do ERs have a panel for all the primary cares with their addresses, their phone numbers, stuff like this so they can schedule the patient to go to their primary cares? You know, there's no need for the patient to come to the er. He looks a little bit dehydrated today. Well, he either needs to be admitted or if he's going home, he needs to follow up with his primary care tomorrow. Not to follow up with the ER tomorrow. This is common practice. I think that's bring a lot of ER unnecessary ER visits that can be handled by primary care by just appropriate handling from the er. Dr. Arakawa: I think your message is well taken. I guess I would ask or it's not really a caveat but a follow up question. How would you feel, because this was my experience at my prior position at the alliance in Northern California as is that the ER would schedule specialist visits. Right. So, in other words, they weren't scheduling to follow up with the er. You know, it was serious enough that it needed. But they were arranging, they were arranging specialist follow-up without going through the PCP and there was some issue. Right, because who's tracking, who's going to be able to do that follow up? So would you say that that's a concern too and then maybe this is for the greater.		

	Dr. Alshareef: I didn't know that the ER could arrange a follow-up with the specialist. I thought they still must go to their primary care. The primary care has to place a referral order even if it doesn't require prior authorization. At least in my field with Pediatric. Like I didn't see, I don't see how the ER, for example one of the ERs refers to 4 years old to see the GI at Radie's. They can't do that. They still must come to us to place a referral. The fax denotes and the demographics and the insurance and then we hear back from Radie's. I mean there's no prior authorization needed but communication is needed between us, the primary care and the specialist. But I don't see how the mechanism, I don't see how the mechanism where the ER can do a direct referral to the specialist. However, I can tell you I do see the discharge papers from the ERs. It says follow up with PCB in two to three days while if you see the discharge papers from Radie's or from UCSD, it says they come to us and it's actually spinning the provider's name and his address and his phone number on the follow up. They have all that's there. Some get discharged, they need a follow up with the pt, physical therapy, occupational therapy, with the cardiologist, with the primary care. They list all those with their address and their phone number. So, I think it's just like a simple thing. Simple things like this can make a huge difference compared to just saying, oh, follow up with your primary care. Dr. Arakawa: I'll definitely take that back and, and look at patterns like that. And that's good. You know that you're giving a comparison to some of the big brother hospitals. Right. That they're giving very kind of professional, professional follow up		

	information. So, I will take that back. So, thank you. Okay, moving on. Talking a little bit about authorization volume. So, this again a little bit of a different projection or presentation. Right. But it's this idea of trying to look at, look at trends and overall, I think compared to, definitely compared to 2024, our denial rate is a little bit higher and that, that, I'm reviewing this because we're getting ready for the audit. But I think that's really happened at the end of 2024 in which health Net reviewed some of its not necessarily denial procedures, but they looked at their indications. They use InterQual as their kind of national database of indications for studies and services and they looked at that and that's when I noticed the jump. But again, we're tracking the denials and appeals and quality of service, quality of care to ensure that these rates are not, you know, they're not abnormally high such that they're affecting patient care. Dr. Sampat: Dr. Arakawa, would you give us more details? Is it more for referrals or is it for studies? What kind of denials are those? Dr. Arakawa: don't have the information here, but it is on another slide that I have a different presentation where they break it down a little bit and I'm not sure if they do authorizations versus referrals but it was definitely kind of categories of denials, whether it was, you know, like an outpatient procedure, CT scan, you know, it was that. So, I can, I can get back to you with that.		



B. Utilization Management	Inpatient admission volumes have continued to decline from the 2024 peak and stabilized throughout 2025. Early 2026 results remain below 2024 levels and are generally consistent with 2025 performance. Readmission rates continue to demonstrate favorable year-over-year improvement, with early 2026 performance tracking below both 2024 and early 2025 results. Emergency department utilization was reported to have steadily improved year over year, with utilization decreasing from 2024 through 2025 and continuing to decline during the first quarter of 2026. Outpatient services utilization also decreased overall from 2024 to 2025, with additional reductions observed during early 2026. The primary diagnoses associated with admissions, readmissions, emergency department utilization, and outpatient services were reviewed for both SPD and Non-SPD populations to better understand utilization patterns and identify areas requiring continued monitoring. Authorization activity for the first quarter of 2026 was reviewed, including approved, denied, and modified authorization requests. It was reported that authorization volumes decreased compared to prior reporting periods, while ongoing monitoring of authorization activity and staffing adequacy continues to ensure timely processing of requests.		

	A total of 4,187 authorizations were approved, 666 were denied, and 296 were modified through March 2026. Monthly authorization activity was reviewed, with March reflecting the highest volume of approved and denied authorizations during the reporting period.		
C. Appeals & Grievances	A total of 34 appeals were received during the reporting period, consisting of 33 pre-service appeals and 1 expedited pre-service appeal. Appeal volume increased from the previous quarter, with the appeals rate rising to 1.07 PTMPY. A total of 141 grievances were reported during Q1 2026, representing an increase from 130 grievances in Q4 2025. The grievance rate increased to 4.43 PTMPY. Grievance activity consisted primarily of 76 Quality of Service (QOS) grievances, 10 Clinical/Quality of Care (QOC) grievances, and 55 Access to Care (ATC) grievances, including 8 expedited grievances. Historical trend data demonstrated a continued increase in QOS grievances over the reporting periods, while Clinical/Quality of Care grievances remained comparatively low and stable. Dr. Alshareef: Dr. Arakawa, sorry, can I ask a question here? Because I think this is also another field. for the balance, for the statements received by providers, I have a simple question, like, do we know if those members ever tried to reach out to their primary care inquire about this balance and the office confirmed that this is the balance they need to pay? Or it's just an error statement by error, you know, for lack of information or for a		

	human error because, you know, and you know, the other providers here on the meeting, they can probably confirm that offices normally send like, you know, thousands of the statement every day. I mean, I will give you, I can give you a real, real example. That can happen any day. Patients who come, who have blue shield as an primary insurance and they have health and as a secondary, they come to our office, they are new patients, we don't know you have insurance. Yes, they give us the blue shield, we take it, we see the patient, we bill, you know, Blue Shield. Apply this 50 bucks to the deductible. Then, our EMR automatically applies this when the postman automatically applies it to the patient. Send them to statement while they have health net. We did not know this patient has health net as a primary, as a secondary insurance. Now, if this member calls us back and says like, hey guys, you send me a statement for 50 bucks, I have medical or health insecurity, the writer will say, excuse us, then this was a mistake. We didn't know about that. What is your member ID for the health net? They give it to us and we're like, then ignore the statement, shred it, do whatever you want to do with it. We build the lift over to the health net and you can keep counting for this number of scenarios where could be just like an office error or incomplete information rather than an intentional billing for medical patients. So, this is why I wonder if those cases, if they were filtered by asking the members if they made any effort to communicate with the office, you know, or they just saw a belt, they said, oh, oh, no way, they can't do that. We are fighting a grievance.		

	Dr. Arakawa: Fernanda, if we can capture this as an issue as well. And so, it's the idea we'll, we'll increase. So, I have direct connection with the A&G program that works on QOC grievances. But I don't really, I don't often review many of the QOS, but I think it's important to do that. We can look at cases, and we'd be able to see if these are just members directly filing grievance because they got the bill, or are they getting read, you know, in the investigation, are they making a loop with the provider? Because, like, just like you said, if they're looping through the provider, that might be a place where they can resolve it. Right. They can resolve that without going on. But again, if they're doing it directly, obviously that's going to be an issue. Now, it's not huge. Dr. Sampat: We need more detail; we have had this conversation already in the last quarters. Dr. Arakawa: I will ask HN for a root cause analysis from HN. QOC- The most frequently reported concerns involving Primary Care Provider appropriateness of treatment and Primary Care Provider refusal to refer. QOS grievance activity was primarily attributed to transportation vendor complaints, administrative issues involving the health plan, and balance billing concerns. Additional grievance categories included transportation safety concerns, interpersonal issues		

	involving providers, and member concerns related to vendor services. ATC grievance activity was largely associated with prior authorization delays, Primary Care Provider referrals, transportation-related missed appointments, durable medical equipment (DME) delivery issues, and specialist appointment availability. These categories continue to be monitored to identify trends affecting timely access to care. Cultural and Linguistic- five grievances reported during the first quarter of 2026. Behavioral Health grievance activity included two grievances during the same reporting period. Dr. Sampat: So, I have one feedback here for recuperative care. I attended one of those sessions at ECRMC and it looks like it's straightforward. If the member, when they do their verification, it's as simple as just calling the member. And if they say that they have difficulty with housing or they're about to have a problem, that's it. That's simply the criteria. So, I'm not so sure why anybody would have grievance. I mean, if somebody would have an objection, it would be like in, why is it so easy to get in, not the other way around. Dr. Arakawa: Okay.			

	Dr. Sampat: No, I think it's just not making sense. As in, it looks like almost everybody would qualify. Dr. Arakawa: Yeah, but I think it's really my experience because I kind of asked the same question. And this was also discussed at the state level at one of the CMO meetings. Is that the idea? I think you're exactly right, Dr. Sampat, but it's got to be tied to that condition. And if that condition or the one condition that kicked them over into getting them into care, if that's resolving or improving enough that it's no longer, you know, that, that whatever that condition was to kick them over, if that's improving, they, you know, they're still getting approved. And so, it's just one of those balancing between over utilization and not. And as you can see, four were overturned. It's at the point where just kind of like the food support, you just can't keep supplying something when there's others with need. So. But we, you know, again, I think it's all important. Just like I said, the theme for these is to get. Make sure that we get the reasons right. These are reasons for the appeals, but it's the reasons why they were appealed. I think that's the important point. Okay. In terms of HEDIS measures, I guess I look at this as good news, but little bit bad news. No, I shouldn't say that. I guess it's good news, but it could be better news. All they have to do is just tell them that we have a problem. As all of you remember, in 2024, so these are basically the 18, right? These are 18 of the HEDIs measures by which we report to the state and we report to CMS. And you know, the. The goal is obviously to get all 18, right? You		

	want to at least hit the 50th percentile for all 18 categories. Now, as you look in the bottom row, this was last 2024. So, our first year CHPIV coming into existence, we hit 14 out of 18 in the mark. And that is in comparison to California Health and Wellness and Molina in general doing somewhere between 7 to 10 measures crossing midpoint or mean out of 18. So, it was an improvement. I haven't gotten a commitment that was the best one for Imperial County, but they said it's amongst the best. So, we hit 14 out of 18 categories. And the frustration I had in 2024 was that in the WC30 as well as chlamydia, we were very close that those numbers on top are basically the number needed to treat to cross that 50th percentile. Okay, so we were very close, but nevertheless we did 14 out of 18, which was great. So now we roll into 2020. And what we see in 2025 is, you know, there's only 13 out of 18 who have crossed the mean. So that means we performed less well than last year. However, there are some caveats. The one caveat is the BCS. That's breast cancer screening. So, this is second to last on the right that basically we cross the median or mean last year, but we were 200 short this year. That's because we still have the right number of members that cross the meaning compared with last year. It's just NCQA changed the boundary. So, they basically said, I think this was a year where they moved the lower limit from 50 to age 40. And so, because they expanded the denominator, that meant that's why we went out of range. So, what happened is many of the plans said, hey, that's not fair. You're just changing it one year from the next. So DHCS decided to not count, not count this. So, they're basically for, for 2026, it's reported here, but it's not going to count. So, in theory we hit, you		

	know, it's as if we passed, we got a free pass on that. So, it remains as 14 out of 18, but also within that, if you notice prenatal, even though prenatal was not an issue in 2024, we were very close. 2025 and then the, well, child visits at age 30, we were only two away. So, we were very close to hitting almost 16 out of 18 measures. Now, I don't want to belabor this point. I want to make sure we stay intact. But it's important to note the prenatal, this prenatal third to the last on the right with five away. The Health Net team did some investigation and what they noticed is that they had to count in the denominators women who came in to see their first OBGYN visit with an ultrasound already performed. And guess where that ultrasound was performed? It was performed in Mexico. So, they don't have the results, they don't have the pictures, they don't have it. So, what happened is they would lose out on the checkpoint for those prenatal and it ended up being something like eight. Eight individuals got their sonogram. So HealthNet's working in a couple ways, they're anticipating this. Right. Couple of ways, better education. Right. Maybe doula interactions with patients. But you know, you don't know when these patients are going to test positive and sometimes, they will automatically go to Mexico. So, what HealthNet is already doing is they're reaching out to the top OBGYNs on, on the, the Mexicali side and trying to make some arrangements. So, we'll see how that goes. But again, we were eight. Eight women were documented as getting their non counting ultrasound and we would have crossed		

	that boundary again, not that chasing these boundaries are important. Yes, I guess they are, but it's really the, the care to the members. Right. Making sure they get it. So. Okay, and then we move to 2026. So, we are about halfway through. Right. So well, this data is up through April, so through the little bit more than in the first quarter. So out of the 18 measures here, we are doing better than last year at 17 out of 18. Okay. Dr. Alshareef: HealthNet is partnering with Cozeva. They pull their information to the cause of now because you get their information from the Health Net. You know, providers see patient. They submit the claim from their billing system. Because they submit, they said the provider did this and this and this. And then they. And then they. They capture the data. So, you know, as you can see, there's like, you know, three angles, you know, for this process and there's a middle person and this equation, which is Health Net billing. So, you are sending the codes to the Health Net billing. Cozeva is taking those codes from the Health Net. Assume a scenario where a patient is seen for, let's say, lid screening. We submit the code to the lead. But if it takes us like three months to submit that claim to the Health Net, Cozeva will not know that we did this lid screening. Besides, there is a lag between the information received by Health Net and the information crossed into Cozeva. So, add this lab to that lab. Sometimes you would truly do the service today. And it takes six months until Cozeva gets the fact that this service was done. Because again, it took some time for us or for the office to submit the claim to the Health		

	Net. It takes time from. Cause if I had to pick the information from the health billing system now. Dr. Sampat, thank you. You know, brought to my attention last meeting that she has integrated her EMR with Cozeva directly. So, kind of like you are skipping this middleman, you know? Dr. Arakawa: Your point that you made that when you have the results, it may. There may be a lag, so integration doesn't mean everything is going to be uploaded. So, I think we'll always have a lag because the test report is not available, for example, mammogram, it'll never get integrated until the patient goes does the mammogram until the hospital bills for that mammogram. So, everything will be delayed. You're right. Absolutely Dr. Alshareef: this is true obviously for some, but there are others, like the WC30, for example, you know, you see the patient today and the information is there. So it can be that. Anyway, we went to the Cozeva, and we went to that place where they say you can do integration for the EMR. We put a request for them to integrate our AMR. And I just asked my manager before this meeting. She initiated the process or the request with them exactly on 4, April 23rd. So, we are talking about almost three months. It has been tough experience. Like, you know, we have somebody jump to the chat. There's nobody you can call them. You know, just like you send a message on the casino website, somebody starts answering you. And we spend like three months back and forth with them. And every like few weeks, somebody comes like new and the		

	colleague, they start all over again like, hey, Dr. Al Sharif, so what do you want to do? And was like, you know, if you just look at the chat trend, you will know what we want. We just simply want to integrate our EMR, which is sweet. So, if CHPIV can help us with this, I think helping to build this integration, I mean, this is great for. I mean, everybody is now pushing for this integration between those. This is like an instant change of information, instant exchange of data. I can tell from our experience as for today, we are unable to still build this integration between our AMR and cozy. But though it's a service available, it's on their website. You go to the website and request, you know, request that integration. But if CHPIV can help us with that, that would be, you know, really great things to happen. Dr. Arakawa: We will take this back.		
D. Healthcare Effectiveness Data & Information Set (HEDIS)	MY2025 MCAS final performance results- 13 of 18 measures achieved or exceeded the Minimum Performance Level (MPL), compared to 14 of 18 measures in MY2024. Overall performance reflected 72% of measures meeting the MPL, compared to 78% in MY2024, representing a 6% decrease year over year. Measure-specific performance was discussed, noting continued strengths in several clinical quality measures while identifying opportunities for improvement in measures that remained below the MPL. Performance trends will continue to be monitored to		

	support quality improvement initiatives and targeted interventions for measures requiring additional focus.		
E. Care Management	Overall, 548 members were actively engaged in Care Management, representing an overall engagement rate of 66%. Program-specific engagement rates included 61% for Physical Health, 63% for Behavioral Health, 71% for Maternal Health, 84% for Transitional Care Services (TCS), and 100% engagement for the First Year of Life (FYOL) program. Readmission outcomes were reviewed for Physical Health, Behavioral Health, Transitional Care Services, and First Year of Life populations. Members enrolled in Care Management experienced lower 30-day readmission rates following enrollment when compared to the 90-day period prior to enrollment. Physical Health and Behavioral Health members demonstrated a reduction in readmission rates from 26.7% to 11.4%, while Transitional Care Services members demonstrated a reduction from 29.0% to 15.1%. FYOL outcome data also reflected lower hospital admission utilization among enrolled members compared to members who were not enrolled during the first 90 days following referral.		
F. Enhanced Care Management/Community Supports	ECM census and enrollment trends demonstrated continued growth in the number of members assigned to ECM throughout the reporting period. Enrollment remained relatively stable while assigned membership increased over time, reflecting continued		

	expansion of the program and ongoing outreach to eligible members. ECM enrollment by Population of Focus (POF)- The highest enrollment continued to occur among Adults at Risk for Avoidable Hospitalization or Emergency Department Utilization, followed by Adults Experiencing Homelessness and Adults with Serious Mental Health or Substance Use Disorders. Enrollment trends across each POF category were presented to monitor program participation and identify opportunities for additional outreach and engagement. Program performance identified opportunities to improve ECM participation within the Child Welfare and Adult Birth Equity Populations of Focus. Planned activities include onboarding additional ECM providers specializing in foster youth services and increasing member awareness and outreach efforts to improve participation within the Adult Birth Equity population.		
G. Long Term Support Services (LTSS)	Long-Term Care utilization remained relatively stable throughout the reporting period. Utilization by contracted facilities was presented for El Centro Post Acute, Imperial Manor, Pioneer Memorial Distinct Part (D/P), and out-of-county facilities, with only minor month-to-month fluctuations observed. El Centro Post Acute continued to represent the largest proportion of Long-Term Care utilization during the quarter.		

	Community-Based Adult Services (CBAS) utilization also remained consistent, with approximately 240 to 245 unique members utilizing CBAS services each month. The average number of service days per week increased from 1.7 days in January to 2.0 days in both February and March, reflecting stable member participation. Minimal transition from CBAS to Long-Term Care was observed during the reporting period. Intermediate Care Facility (ICF) utilization remained stable, with 13 to 14 unique members receiving services across ARC facilities during the quarter.		
H. Pharmacy	The top requested medications were reviewed to identify utilization trends across the reporting period. Frequently requested medications continued to include botulinum toxin, pegfilgrastim, pembrolizumab, IV iron, denosumab, and other specialty medications commonly used for oncology, hematology, and complex chronic conditions. Monthly utilization trends demonstrated relative consistency in the medications most frequently requested, reflecting ongoing demand for specialty pharmaceutical therapies. Pharmacy denial activity was evaluated based on both the percentage of requests denied and the total number of denied requests to provide a balanced assessment of utilization patterns. Medications with the highest denial percentages included epoetin alfa, octreotide, IV iron, denosumab, and epoetin beta, while IV iron, pegfilgrastim, botulinum toxin, denosumab, and		



		pembrolizumab accounted for the greatest number of denied requests during the reporting period.		
I.	**California Children Services (CCS)**	CCS approval rate trends demonstrated improvement during the reporting period. Average quarterly approval rates increased from 55% in Q4 2025 to 64% in Q1 2026, representing a 16% increase. Monthly approval rate trends were reviewed to monitor consistency in CCS eligibility determinations and authorization processing. Pending review activity number of cases awaiting review increasing by 2% during the quarter. Ongoing monitoring of pending cases will continue to support timely eligibility determinations and efficient case processing. Identification of members under 21 years of age meeting active CCS criteria for fee-for-service, non-delegated services also increased during the reporting period. The percentage of members identified as active CCS increased from 5.0% to 5.1%, reflecting continued monitoring of eligible pediatric populations. Additionally, the volume of Utilization Management cases reviewed for CCS eligibility increased by 6% from Q4 2025 to Q1 2026, demonstrating continued oversight of pediatric members who may qualify for CCS services.		
J.	**Quality Improvement Projects**	Kapoor Pediatrics:		

	Multiple Phase 2 interventions remain in progress to improve scheduling, access, and completion of well-child visits for Hispanic members between 0 and 30 months of age. Current interventions include utilization of standardized patient education talking points during outreach, expansion of appointment availability through Saturday clinics, walk-in and same-day appointments, implementation of online appointment scheduling, and use of text message reminders through the patient portal. Additional interventions focus on increasing caregiver awareness and utilization of the CDC Milestone Tracker Application and Newborn Checklist to promote timely completion of recommended well-child visits. Medical record review results demonstrated variation in compliance across reporting periods. Pediatric IHA compliance increased to 100% during Q2 2025 before declining in subsequent quarters, while Adult IHA compliance also demonstrated fluctuations throughout the reporting period. Claims and encounter data were reviewed to monitor completion of IHAs within 120 days of enrollment, member outreach compliance following three documented contact attempts, and overall compliance with outreach and IHA completion requirements. Lead Screening: Overall compliance improved across all three age groups from Q1 to Q3 2025, with the largest improvement observed in the 18–30-month age group (23.70% to 47.85%).		

	The 31–72-month age group showed the greatest increase in screening volume, with the numerator increasing from 1,511 in Q1 to 2,560 in Q3, while maintaining a large eligible population of over 7,200 children. CPT 83655-only screening trends closely mirrored the overall compliance measures, demonstrating steady improvement throughout 2025 across all age groups. By Q3 2025, screening compliance reached: • 47.40% for children aged 6–17 months (overall) • 47.85% for children aged 18–30 months (overall) • 35.53% for children aged 31–72 months (overall)		
K. Credentialing	Peer Review and Access monitoring results indicate no investigative cases were referred to the Peer Review Committee during the reporting period. Additionally, no incidents of appointment availability resulting in substantial harm and no adverse injuries occurring during procedures performed by contracted practitioners were reported during the quarter. Credentialing:One provider successfully completed the initial credentialing process, and one provider completed the recredentialing process. Credentialing reviews included verification of licensure, specialty qualifications, board certification status, and all required credentialing elements in accordance with established organizational and regulatory standards.		



L. Facility Site Reviews	A total of 12 Facility Site Reviews were completed, resulting in an average compliance score of 96% for the Q3–Q4 2025 review period. 10 Medical Record Reviews were completed, achieving an average compliance score of 95% for the Q3–Q4 2025 review period.		
M. Provider Directory Accuracy Report	A total of 164 provider offices participated in the validation process to assess the accuracy of provider directory information and compliance with established directory accuracy standards. Performance exceeded the established 80% compliance goal across all measured categories. Office location information achieved 100% accuracy (109 of 109 locations). Office telephone numbers were verified at 88.6% accuracy (109 of 123), while 93.2% (96 of 103) of provider offices confirmed acceptance of new patients. Office staff awareness of the health plan networks in which practitioners participate was verified at 93.9% (92 of 98). All performance measures met or exceeded the required performance threshold. Ongoing provider and practitioner outreach fatigue continues to affect response rates due to multiple requests for similar information. Delays in providers communicating demographic changes in a timely manner also contribute to directory inaccuracies. In addition, provider directory information may become outdated between validation cycles as provider demographic information changes.		



N. Population Segmentation	Programs with the largest eligible populations included Health Information Forms, Initial Health Appointments, Behavioral Health Care Management, and Telemedicine, each encompassing a substantial portion of the eligible membership. High member eligibility was also reported for Influenza Vaccinations, Tobacco Cessation, Teladoc Mental Health, and Depression Screening and Follow-Up Care, reflecting ongoing preventive health and behavioral health initiatives. Additional segmentation categories included Diabetes Management, Cardiac Disease Management, Chronic Obstructive Pulmonary Disease (COPD) and Asthma, Oncology, Substance Use Disorder–Opioid (SUD-O) Program, Disease Management/Health Coaching, Care Management, and Transitional Care Management, allowing targeted identification of members who may benefit from specialized interventions and care coordination services. It was noted that certain behavioral health populations, including members with Serious and Persistent Mental Illness (SPMI) and members requiring follow-up after Substance Use Disorder Emergency Department visits, currently do not have available eligibility data and will continue to be evaluated as data becomes available.		
O. Health Net Follow-Up Questions/Answers	N/A		
P. DSNP QIHEC	<u>Categories:</u>		

Quality Improvement & Health Equity (QIHEC) Committee

- Member/Provider Metrics
- Utilization Management
- Appeals and Grievances
- Quality
    - STARS/HEDIS
    - Process Improvement
- Care Management
- Health Equity
- Credentialing

Utilization Management metrics indicated 14 inpatient admissions, including 3 readmissions, with an average length of stay (ALOS) of 8.3 days during the reporting period. In addition, 39 Emergency Department visits and 89 outpatient specialty visits and procedures were reported for the first quarter, providing an overview of healthcare utilization among members enrolled in the program.

Appeals and Grievances activity remained minimal during the reporting period, with one grievance reported during the first quarter of 2026.

Credentialing: A total of 97 providers completed credentialing during the first quarter of 2026, with an additional 16 providers credentialed during the second quarter to date. Credentialing activities continue to support provider network adequacy and ensure practitioners meet established organizational and regulatory credentialing standards.

Quality Improvement & Health Equity (QIHEC) Committee

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, October 08, 2026 Time: 12:00p.m – 1:30p.m Location: Community Health Plan of Imperial Valley Conference Room/Microsoft Teams ***Meeting Materials Due: Friday October 02, 2026*** **Meeting adjourned at 01:20 P.M.**		