



**Board of Directors’
Quality Assurance Committee Meeting
October 15, 2026**

Quality Improvement Health Equity Committee (QIHEC) Second Quarter 2026 Report

QIHEC Summary	
QIHEC Chair(s)	Quality Medical Director and Chief Health Equity Officer
Reporting Period	Quarter 2, 2026
QIHEC Meeting Dates	April 14, 2026, May 12, 2026, June 09, 2026

April 14, 2026, QIHEC Meeting
Compliance: No compliance issues were reported. Review/Approval of March 10, 2026, Meeting Minutes: The committee reviewed and approved the meeting minutes. Chief Medical Officer (CMO) Update: The CMO gave an update on measles outbreaks, vaccination rates, and ongoing vigilance against fraud, waste, and abuse. CalOptima Health’s internal controls and collaboration with the Department of Justice (DOJ) were emphasized. 2026 QI Work Plan: Key changes included adjusting health equity targets to meet the aggregate rate, setting separate goals for provider race and ethnicity data collection and adding a Quality Assurance Performance Improvement (QAPI) program for long-term care. Grievance and Appeals (GARS) Committee: - The GARS Committee met on March 12, 2026, with a quorum, approved prior minutes, and reviewed Q4 2025 trends. The committee reported a significant drop in discrimination grievances (103 → 40) due to interventions with transportation vendors. Appeals remained steady, with high compliance and reduced overturn rates. - Nurse specialist triage improved categorization accuracy and contributed to reductions in Quality-of-Care (QOC) grievances. Quality of service remains the top grievance category for both lines of business, and access is the second. Discrimination grievances dropped significantly National Committee for Quality Assurance (NCQA) Accreditation Updates: - On track to collect Year One deliverables for Medicaid Health Plan Accreditation. Ongoing remediation and corrective action plans address audit findings, especially in credentialing across four CalOptima Health networks. - New standards released for Health Outcomes Survey with a plan to conduct staff training. - Seeking Interim Health Plan Accreditation for Covered California. CalOptima Health Comprehensive Community Screening Program (CCCSP):

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- The CCCSP reported 35,583 screenings in Year 1, with ongoing efforts to track cancers found and reduce late-stage diagnoses.
- Performance concerns were discussed, and a formal six-month reassessment was recommended for grantees with declining rates.

Behavioral Health Quality Measures:

- Summary of Measure Changes (Year-over-Year Comparison)
 - Metabolic Monitoring for Children & Adolescents on Antipsychotics (APM): Rate decreased from 8.49% to 6.28%.
 - Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD): Rate decreased from 30.44% to 23.14%.
 - Care Coordination & Follow-Up After ED Visits (Follow-Up After ED Visit for Mental Illness (FUM), Follow-Up After ED Visit for Alcohol and Other Drug Dependence (FUA), Follow-Up After ED Visit for Other Issues (FUI) Rates increased across all 7-day and 30-day mental health and substance use follow-up measures.
 - Medication Management (Antipsychotic Medication Management (APP), Prescription Opioid Dependence (POD): APP increased by 2.29 percentage points; POD increased by 0.34 percentage points.
 - Depression Screening & Follow-Up (DSF-E): Medi-Cal screening increased from 0.00% to 0.25%; OneCare increased by 4.08 percentage points.
 - Postpartum Depression Follow-Up (PDS-E): Follow-up decreased from 100% to 64.29%; screening increased from 1.39% to 5.66%.
- Prenatal Depression Screening & Follow-Up (PND-E): Rate increased from 66.67% to 76.92%
- Several quality measures improved, particularly in care coordination and follow-up after an ED visit.
- Some measures, notably metabolic monitoring and diabetes screening, remain below benchmarks and require targeted interventions.
- Key barriers identified include challenges with member engagement, data reliability and limitations in available data.
- The Performance Improvement Plan (PIP) enrollment goal was met, but continued collaboration and process improvements are needed.

2025 Member Experience Survey (Behavioral Health)

- There were low response rates for these surveys, reflecting ongoing challenges in member engagement and outreach.
- To address these barriers, the team plans to simplify survey questions, introduce QR-coded postcards, and move to quarterly distribution with provider support.

Medication Adherence:

- Extended-day supplies of behavioral health medications, up to 100 days, are broadly available under OneCare and Medi-Cal Prescription (RX), with exceptions for safety or formulary reasons.
- Conducted outreach calls to members, providers and pharmacies for medication refills past due or at-risk for past due.

Cultural & Linguistic Accessibility:

- Language services consistently meet expedited timelines, achieving a 99% on-time rate in Q1 2026. Interpreter services—offered in person, by phone, and via video—maintained a 98% completion rate, with increased demand for Korean, Arabic, and Russian interpreters.

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- The team enhanced feedback collection through new member and staff surveys, shifting to a mail-in survey for members who have used their services, and following up with a monthly text-message campaign to keep the survey top-of-mind and increase participation.

Member Demographic Data:

- The system assessment is complete, confirming that the system has the necessary fields to store demographic data, and the project is scheduled for completion in the third quarter of 2026
- A member survey draft has been completed, is under consultant review, and is on track to launch in the third quarter to collect member disability data.

Responsive Workforce:

- CalOptima Health is ahead of schedule on employee training, with all staff completing the Optimal Health Outcomes module in November 2025 as part of annual compliance. This training, delivered through the Cornerstone system and assigned to new hires, focuses on improving the quality of care and reducing health disparities.
- A consultant assessment is underway to confirm the module meets required standards; if not, an alternative will be selected. Incorporating the training into compliance ensures 100% participation and exceeds baseline requirements.

Health Equity:

- In 2025, CalOptima Health transitioned from direct service provision to a broader focus on integrating health equity across all operations, guided by mandates and policy requirements.
- Efforts targeted low-performing quality measures and underserved populations, with tailored interventions such as improving flu vaccination rates.
- New guiding principles for 2026, learning together, member-centered care, engagement, partnership, and data-driven decisions, will shape ongoing work to reduce disparities and embed equity into governance.
- QIHEC recommended a centralized location on the CalOptima Health website for all Health Equity materials, making them accessible to both providers and members.

Items Approved by QIHEC

- Approval of March 10, 2026, QIHEC meeting minutes.

Items Accepted & Filed

- GARS Committee November 13, 2025, meeting minutes.

May 12, 2026, QIHEC Meeting

Compliance: No compliance issues reported.

Review/Approval of April 14, 2026, Meeting Minutes: The committee reviewed and approved the meeting minutes.

Chief Medical Officer Update: No CMO update was reported.

Policy Updates: The following policies on quality measure rate production, pay-for-value programs, and post-hospital discharge medication supply were approved.

- Policy GG.1601: Quality Measure Rate Production and Data Sharing Requirements for Directed Payment Initiatives and Alternative Payment Methodology Programs (New)
- Policy GG.1640: Health Network Pay for Value Program (New)
- Policy GG.1639: Post-Hospital Discharge Medication Supply (Revised)

Quality Performance:

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- Notable improvements were observed in cervical cancer screening, follow-up care after Emergency Department (ED) visits for mental health or substance abuse concerns, and prenatal depression screening.
- The following measures did not perform as well as in the previous year: breast cancer screening, developmental screening, and postpartum depression follow-up.

Cozeva PayerOne Software Solution:

- Cozeva is being deployed to provide real-time gap closure, automated quality data extraction, and monthly provider incentive payments, with Electronic Health Record (EHR) integration expanding across high-volume groups.
- Measure validation to be completed in May 2026.
- Provider engagement is supported through training, field-visit assistance, account linking, and compatibility with common EHRs (including Office Ally), while onboarding continues for networks not yet fully integrated (Noble, Regal).

At-Home Programs:

- In Q1, 683 home visits were completed, with 93% of tested members achieving a Hemoglobin A1c (HbA1c) below 9.
- Key lessons include confirming addresses, using wraparound communication, and providing clear instructions and “how-to” videos.
- The program is being refined based on member feedback and aims to increase engagement, improve chronic disease management, and close care gaps for high-risk populations.

At-Home Lab Testing:

- Varied in response rates, with higher engagement among Medi-Care members (14.8%) and lower participation from Medi-Cal members. The team is reviewing outreach strategies and considering focusing on the urine test option to improve ease of use and participation.
- The Cologuard at-home colorectal cancer screening program saw response rates of 18% among Medi-Care members and 11% among Medi-Cal members. Lessons learned include the effectiveness of wraparound messaging and the need for clearer instructions, prompting exploration of instructional videos and supportive materials to boost member completion rates.

Quality Performance Reporting:

- Healthcare Effectiveness Data and Information Set (HEDIS) reporting is nearly complete, with all Managed Care Accountability Set (MCAS) measures passing except for FUA and FUM, which fell short of minimum performance levels.
- The medical records review process is finished, auditors are validating results, and final submissions to NCQA, CMS, and the Department of Health Care Services (DHCS) were scheduled for June.

Value-Based Payment Program - Health Network: The report was deferred to July pending final HEDIS results, as the calculations rely on finalized data. In the interim, the team continues to monitor performance and implement targeted interventions to address underperforming measures.

Value-Based Payment Program – Behavioral Health:

- The Applied Behavior Analysis (ABA) Pay for Value (P4V) program has seen progress across key metrics, including increased rates of monthly direct services and supervision.
- The Mental Health P4V program's continued improvement is anticipated as incentive structures mature.
- Both programs are in active payout cycles.

Value-Based Payment Program - Hospital:

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- Managed Care Plans (MCPs) must now calculate quality measures using DHCS California Technical Specifications and supply key data files, including enrollment, claims, pharmacy, ADT feeds, and gaps-in-care, to support accurate performance rates.
- CalOptima Health is collaborating with the University of California, Irvine (UCI) to align data workflows and technical requirements, with ongoing bi-weekly meetings and a long-term data exchange solution under development. These efforts aim to streamline reporting, reduce discrepancies, and position MCPs as the single source of truth for member data.

Population Health Management (PHM) Strategy:

- Keeping Children Healthy with Performance Improvement Project (PIP): While minimum performance levels were met in 2025, key measures, especially among Black/African American, White, and Native Hawaiian/Other Pacific Islander members, remain below targets. The team is expanding culturally tailored outreach and early engagement initiatives, including targeted messaging and materials, to address low compliance and strengthen performance in priority populations.
- The Maternal Health Program conducted outreach to 1,377 CalOptima Health Community Network (CHCN) members in Q1, providing education, care coordination, and support during prenatal and postpartum periods.
 - Depression screening rates improved significantly, with postpartum screening rising from 6.12% to 13.15% and prenatal screening from 7.13% to 23.84%. The team identifies members through multiple touchpoints, including hospital and emergency department events, enabling timely connection to preventive care.
 - Outreach was conducted to 275 members who missed postpartum appointments, focused on rescheduling and reinforcing ongoing care.
 - Collaboration with the Orange County Health Care Agency connects Black maternal health members to culturally responsive services, reaching 73 members, with over half expressing interest in additional support.
 - Key initiatives include an updated PHM policy, risk stratification, and a maternal health dashboard, with outreach metrics tracked for continuous improvement.

Health Education & Disease Management:

- In Q4 2025, 1,198 health education referrals accounted for 20% of internal referrals, with continued activity in Q1 2026.
- Recent efforts emphasize chronic condition education, targeted coaching, and outreach tied to Medicare Star Ratings (STARS) gap-closure initiatives.
- Under the Health Equity Officer's leadership, the CME Planning Committee coordinates diverse training sessions for providers and care teams.
- The Health Education Resource Hub, a digital platform, offers branded content and tools to support chronic condition education and self-management, and is actively promoted in member newsletters.

Disease Management Program (Emerging Risk & Chronic Conditions Improvement Project (CCIP):

- Results showed a 6-point improvement in blood pressure and blood sugar control over the prior year.
- Recent pilots, such as Telemedicine to You (TeleMed2U) endocrinology, report strong satisfaction and faster access to specialty care.
- Outreach and engagement rates are high, with positive trends in STARS measures, especially for diabetes and kidney screenings.

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- Ongoing initiatives include at-home test kits, wellness visits, and multimodal campaigns to promote education and testing, with strong support for the Cozeva platform to drive further improvement.

California Advancing and Innovating Medi-Cal (CalAIM) & Community Supports: The outcomes methodology for the Community Supports program analyzed 9,633 members with sustained eligibility before and after their first CalAIM service, excluding medically tailored meals, from January 2022 to October 2025.

- There was a positive increase in healthcare utilization: primary care visits rose by 3%, behavioral health by nearly 21%, specialist visits by 18%, and nurse practitioner visits by 0.6%, indicating improved navigation and use of services.
- Hospital admissions and skilled nursing facility days decreased by nearly 21% and 45%, respectively, while emergency department visits increased slightly and long-term care days rose, reflecting appropriate alignment with member needs.
- The team is finalizing audits of contracted providers and developing new compliance tools to strengthen program oversight and support further.

Street Medicine:

- The team launched a new program site in Santa Ana on March 9, with AltaMed, and expansion will require at least two neighboring cities.
- Across four sites, 439 members participated in Q1, with strong primary care engagement, and 53 members achieved permanent housing since April 2023.
- The team is analyzing long-term housing stability, recognizing the importance of the first year after placement for sustained success.

Special Needs Plan (SNP) Model of Care (MOC):

The D-SNP Model of Care team is finalizing this year's submission, with a strong care plan and Interdisciplinary Care Team (ICT) compliance rates. Member encounter and wellness visit rates are improving but increasing these remains a priority. Nearly 95% of members have a complete care plan, and 92% have active interdisciplinary care team support.

Items Approved by QIHEC

- Approval of April 14, 2026, QIHEC meeting minutes.
- Policy GG.1601_Quaity Measure Rate Prod and Data Sharing Requirement for Direct Payment Initiatives and Alternative Payment Methodology
- Policy GG.1639_Post-Hospital Discharge Medication Supply
- Policy GG.1640_Health Network Pay for Value Program
 - Policy GG.1640_Attachment A - CalOptima Health Board Action Agenda Referral (November 13, 2025)

Items Accepted & Filed

- 2026 QI Work Plan Q1 Update

June 9, 2026, QIHEC Meeting

Oversight & Compliance: No compliance issues were reported.

Chief Medical Officer Update: The CMO reported on California's active state budget process and its impact on CalOptima Health. Multiple proposals and ongoing advocacy may lead to operational challenges, but a budget agreement is expected. CalOptima Health and the County of Orange operate separate budgets, and the County manages Medi-Cal eligibility.

Policy Updates: The following policies were approved.

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- Policy GG.1205: HEDIS® Data Collection and Reporting
- Policy GG.1655, Reporting of Provider Preventable Conditions

Credentialing Peer Review:

- The CPRC met on 01/29/2026, 02/26/2026 and 03/26/2026 to review provider monitoring, fair hearing updates, board certification updates, fraud and abuse reporting, hospital audit results, credentialing policy revisions, and Potential Quality Issues (PQI) case reviews.
- Reviewed terminations, suspensions, and monitoring across specialties, with 319 initial credentialing and 305 recredentialing reported; all met compliance standards.
- The committee approved updates to credentialing policies and recognized the Royal College of Physicians and Surgeons of Canada as an acceptable board certification entity.
- Eight PQI cases were reviewed, with associated actions documented. PQI trends for July - December 2025, providers with 15 or more grievances at rates five times above their specialty were flagged for discussion. No Provider Preventable Conditions (PPC) were identified in the quarter. Facility Site Review (FSR) and Medical Record Review (MRR) were also presented.

Grievance and Appeals (GARS) Committee:

- The GARS Committee met on May 19, 2026, to approve its March minutes and review Q1 trends, drivers, and remediation for grievances and appeals, as well as access and referral challenges. In Q1 2026, member grievances decreased from 5,200 in Q4 to 4,925, with a notable 61% reduction in repeat complainants. The most common issues were provider staff attitude, authorizations, and customer service, while discrimination-related grievances increased slightly.
- Appeals declined by about 70 cases, but overturn rates rose for both Medi-Cal (36%) and OneCare (43%), mainly due to new information and unmet access standards.
- Most grievances and appeals centered on quality of service, access, and referral delays, with transportation issues also prominent. The GARS team continues to monitor these trends and implement targeted interventions

Member Experience (MemX) Committee:

- The MemX Committee meeting on April 14, 2026, focused on network adequacy and regulatory monitoring, confirming that OneCare met all 2026 CMS standards and completed 2024 alternative access submissions, with corrective action plans issued where needed.
- Plan-level monitoring found all requirements met except the provider-to-member ratio in urology, prompting targeted contracting and recruitment in South County.
- Listening Post feedback highlighted ongoing member challenges with provider access, Primary Care Provider (PCP) appointments, referral delays, test results, dental scheduling, follow-up communication, and care coordination.
- Timely access improved across most DHCS measures but remained below urgent appointment standards; internal monitoring after a second resurvey showed 79% compliance, with provider corrective actions and a new Timely Access Workgroup underway.
- Behavioral health surveys showed higher response rates and satisfaction, especially for ABA services, while satisfaction with telehealth declined, except among ABA members. Customer service satisfaction remained strong, with OneCare Q1 2026 overall satisfaction at 92.2%. Medi-Cal survey responses totaled about 7,500, and Salesforce
- Customer Relationship Management (CRM) implementation is expected to strengthen performance further.
- The committee discussed clarifying flex card activation processes and leveraging Listening Post and Just-in-Time insights for targeted interventions.

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Utilization Management:

- Utilization Management Committee (UMC) meeting on May 21, 2026, covered turnaround time performance, operational reviews, sub-workgroup activities, population health management, and pharmacy outcomes.
- The committee approved their February 19, 2026, meeting minutes and the 2026 Clinical Practice Guidelines (CPG).
- Membership trends showed declines in Medi-Cal and Whole Child Model enrollment, but growth in OneCare.
- Inpatient and prior authorization turnaround times consistently exceeded targets, and emergency room utilization and bed days were reviewed.
- Sub work groups addressed utilization, high-risk management, and benefits management, with 143 codes reviewed and 14 revised policies approved.
- The committee approved the 2026 Population Needs Assessment
- Received updates on Health Risk Assessment (HRA) text campaigns and expanded specialty access via TeleMed2U.
- Pharmacy and Therapeutics reviewed 14 new drugs, adding 10 to the OneCare formulary and updating prior authorization lists for 2026.

Whole Child Model Clinical Advisory Committee (WCM CAC):

- The WCM CAC met on May 26, 2026. Key topics included upcoming dental benefit changes effective July 1, 2026, limiting coverage for certain groups, and increased hospice oversight.
- The committee introduced a three-year Transition Age Primary Care Incentive Pilot to support California Children's Services (CCS) members as they transition to adult care, with a focus on continuity and reducing Emergency Department use.
- Preliminary behavioral health metrics highlighted the need to improve immunization rates and address gaps in allergy/immunology and genetics coverage.
- Member inquiries remained stable, and a new platform was implemented to improve responsiveness.
- Psychotherapy and ABA utilization increased, though wait-time challenges persist.
- In Q1 2026, 30,000 Adverse Childhood Experiences (ACE) screenings were performed, and dashboards for autism, depression, suicide risk, and substance use disorder (SUD) were reviewed.
- Pediatric clinical services had the highest utilization in Community Supports.
- Whole Child Model membership declined slightly, with Children's Hospital of Orange County (CHOC) Health Alliance holding the largest share.
- ED admissions decreased, inpatient bed days remained stable, and authorization turnaround times exceeded 99% compliance.
- Top grievance themes included timely access, quality of care, and telephone access.
- Pharmacy updates require International Classification of Diseases, 10th Revision (ICD-10) codes and Medicare enrollment to process claims.
- The WCM CAC meeting cadence was moved to the first month of the quarter to align with other related committee reports, with the next meeting scheduled for September 1, 2026.

Delegation Oversight:

In Q1 2026, Providence Health Network received its first audit, resulting in one corrective action plan with seven findings: six in Utilization Management and one in Credentialing. The team resolved the Post-Stabilization Authorization findings and continues to address remaining items.

- CHOC Health Alliance's audit identified 16 findings, primarily in Credentialing, due to delayed NCQA policy updates. All Credentialing findings are now closed, and Utilization Management items

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are being addressed. Emerging trends include delayed policy updates to accommodate regulatory changes and a continued focus on timely notifications, decision-making, and the consistent application of clinical criteria across health networks.

Quality Assurance for Long-Term Care:

- In Q1, Long Term Support Services (LTSS) recorded no critical incidents in nursing facilities. They reviewed 11 Potential Quality Issues (PQI) case reviews, three related to quality of care and eight to quality of service.
- The team visited 17 skilled nursing facilities to conduct audits, provide recommendations, deliver training, and coordinate with social services.
- Of 418 CHCN members in long-term care, three were discharged to the community, with two readmitted within 30 days.
- CalOptima Health's 2026 goals are to increase community discharges by 5% and reduce readmissions by 15%.
- LTSS medical case managers continue to support safe discharges through Interdisciplinary Team (IDT) meetings, Durable Medical Equipment (DME) and home health coordination, and CalAIM referrals.

Actions Approved by QIHEC

- QIHEC 05/12/2026 Meeting Minutes_Draft
- Policy GG.1205: HEDIS® Data Collection and Reporting
- Policy GG.1637: Assessing Member Experience

Items Accepted & Filed

- GARS Meeting Minutes_05.20.26_Final
- UMC_Meeting Minutes_02.19.26_Final
- WCM CAC Meeting Minutes_05.27.2026_Final