MINUTES OF THE MEETING OF THE SAN JOAQUIN COUNTY HEALTH COMMISSION

February 28, 2024
Health Plan of San Joaquin – Community Room

COMMISSION MEMBERS PRESENT:

Greg Diederich, Chair
Brian Jensen, Vice-Chair
Paul Canepa
Michael Herrera, DO
Matthew Minson, MD
Christine Noguera
Jay Wilverding
Terry Woodrow
John Zeiter, MD

COMMISSION MEMBERS ABSENT:

Neelesh Bangalore, MD
Miguel Villapudua

STAFF PRESENT:

Lizeth Granados, Chief Executive Officer
Betty Clark, Chief Legal and General Counsel
Sunny Cooper, Chief Compliance Officer
Dr. Lakshmi Dhanvanthari, Chief Medical Officer
Evert Hendrix, Chief Administrative Officer
Tracy Hitzeman, Executive Director, Clinical Operations
Elizabeth “Liz” Le, Chief Operations Officer
Michelle Tetreault, Chief Financial Officer
Victoria Worthy, Chief Information Officer
Kirin Virk, Deputy County Counsel
Sue Nakata, Executive Assistant to CEO and Clerk of the Health Commission

CALL TO ORDER

Chair Diederich called the meeting of the Heath Commission to order at 5:12 p.m.

PRESENTATIONS/INTRODUCTIONS

None.

PUBLIC COMMENTS

No public comments were forthcoming.

CONSENT CALENDAR

Chair Diederich presented four consent items for approval:

1. January 31, 2024 SJC Health Commission Meeting Minutes

2. Community Reinvestment Committee – 1/31/2024
   a. November 20, 2023 Meeting Minutes
   b. SJ BeWell Project

3. Community Advisory Committee – 02/15/2024
   a. December 14, 2023 Meeting Minutes
   b. HPSJ Focus Group: Colorectal Material
   c. The Amelia Ann Adams Whole Life Center Presentation
   d. HPSJ Quality Campaign

4. Finance and Investment Committee – 02/21/2024
   a. Investment Portfolio Performance
   b. DST Health Solutions LLC: ACG Agreement
   c. ZeOmega: Fax OCR Module Agreement
   d. RecastHealth: EPT Support

ACTION: With no questions or comments, the motion was made (Commissioner Zeiter), seconded (Commissioner Canepa), to approve the four consent items as presented (9/0).

DISCUSSION and ACTION ITEMS

5. December 2023 Financial Reports

Michelle Tetreault, CFO presented for approval the December 2023 YTD financials, highlighting the following:

- Net Income is $29.9M and is -$0.8M unfavorable to budget

- Premium Revenue is -$39.7M unfavorable to budget YTD, attributed to budgeted enrollment in Long Term Care (LTC) categories of aid and an acuity factor adjustments

- Managed care expenses are $6.3M favorable to budget YTD, primarily attributable to:
  - +$26.1M favorable Institutional variance due to lower than budgeted LTC enrollment, offset by
  - -$21.2M unfavorable overall due to decrease in low and non-utilizers in our membership and increasing trend in hospital outpatient services utilization
  -

- Other Program Revenues and Expenses (Net) is $-$1.5M unfavorable to budget YTD primarily due to incentive program activity budgeted but not yet performed

- Administrative expenses are $10.3M favorable to budget due to lower than budgeted IT subscription and consulting costs of $4.9M and personnel costs of $2.1M

- Prior period adjustments are unfavorable of -$7.6M primarily related to the acuity rate adjustments mentioned in the Premium Revenue explanation

Upon review of Ms. Tetreault's report, Chair Diederich asked for clarification on the acuity rate adjustments. Ms. Tetreault reported that the acuity rate adjustment is retroactive for more than a year if the Health Plan is successful and DHCS reconsiders it advantage. The law allows for error in rate setting estimates by requiring a minimum 85% MLR; management is in the process of submitting a letter to DHCS expressing our discontent on the adjustments that we will be receiving.

ACTION: With no additional questions or comments, the motion was made (Commissioner Canepa) seconded (Commissioner Zeiter) and unanimous to approve the December 2023 YTD financial report as presented (9/0).

6. QIHEC Committee Meeting Update – 1/17/2024

Dr. Lakshmi Dhanvanthari, CMO submitted for approval the QIHEC (formerly known as QMUM) Committee meeting report for 1/17/2024, highlighting the following committee meetings, work plans, program descriptions, policies updates and reports that were reviewed and approved:

- QIHEC Charter – Structure and Membership
    - Committee Chair: Chief Medical Officer & Chief Health Equity Officer of Health Plan of San Joaquin & Mountain Valley Health Plan
    - Membership: Network Providers including hospitals, clinics, physicians and County Partners that provide care to HPSJ and MVHP Members affected by health disparities
    - Committee Responsibilities
        - Embed equity into the health plan's overall quality improvement objectives through the design of health plan programs and creation of pathways that mitigate and remove barriers that cause inequity
        - Identify and monitor key quality indicators to measure performance against clinical practice guidelines, external benchmarks, and internal targets
        - Review, make recommendations and provide input on Quality, Equity, Population Health and Utilization Management programs, work plans, annual evaluations and subcommittee activities
        - Reviewing input from plan, provider and community partners as well as all departments that provide care and services to members

- Quality Improvement Program Annual Evaluation – July 1, 2022 – June 30, 2022
    - The plans mission, vision and core values underwent triennial review and were enhanced to include a greater focus on equity and the evolving arc of change in Medi-Cal
    - In 2023, the plan gained a greater understanding of health disparities in the population
    - Based on the Plan's Managed Care Accountability Set performance in measurement year 2022, barriers identified included:
        - Children's Health- Newborn enrollment process, missed appointments, vaccine hesitancy, assigned and not seen in the adolescent population
        - Reproductive Health- depression screening data capture, late entry to care
        - Chronic Conditions- Blood pressure data capture, health literacy

        - Cancer Screening- Screening avoidance, mammography access, colorectal cancer prep aversion
        - Behavioral Health- Data capture and transmission, screening and results data sharing

- Quality Improvement Program Annual Evaluation: Plan
    - Member
        - Direct member outreach and engagement, member newsletters.
        - Increased community presence and collaboration on mutual health initiatives (*e.g.,* anticipatory guidance, medication safety program)
    - Data
        - HEDIS dashboarding to improve data volume/cadence/prospective rate monitoring with Providers
        - DxF implementation and HIE data exchange enhancements
        - Enhancing supplemental EMR data feeds from partners
    - Provider Priorities
        - Increased focus on behavioral health education and resources
        - Implement Equity and Practice Transformation programs
        - Increased investment in Provider incentive program
        - Executive leadership meetings covering comparative quality and incentive programs
        - Continued provider partnership initiatives to drive improvement

- Specialty Referral Tracking Report and Summary

Report Summary	
Report Name	Specialty Referral Monitoring
Reporting Period	July 1, 2022 – June 30, 2023 (FY22-23)
Report Purpose	Regulatory requirement to over see specialty referrals which we bump up services authorized against claims to see if the service was used
Report Highlights	**OON Referrals** • Decrease in denials overall from 10.9% FY 21—22 to 7% FY 22-23 • Indicative of appropriate OON referrals **Quality review OON Referrals:** • Overall decrease in denials related to services available in network compared to prior year where all denials were related to care available in network **Appeals**: • The most common reason for overturning a denial was the receipt of additional information needed to establish medical necessity/Continuity of Care. **OON Referral Monitoring:** • 58 out of the 172 members in the survey sample were reached • Barriers to care identified: o Member not informed by provider of needing services o Member too sick to use the referral o Declined services, and o Member not following up with provider Further analysis needed to determine how to increase number of members reached and engaged, review of survey to determine effectiveness and identify those types of referrals commonly unused to identify patterns which may lead to improved actions.

- Carelon Corrective Actions as of 1/17/2024

Source	Description	Risk Level	Issue Date	Close Date
DHCS Audit	Def 01 - UM Files provided for the DHCS audit did not include the necessary documentation.	Moderate	12/20/2023	
DHCS Audit	Def 02 - NOA Letters do not meet DHCS-approved formatting and language.	High	12/20/23	
Monitoring	Def 03 - The All-UM Activity Report is missing key data.	High	12/18/23	
Monitoring	Def 04 - "Routine" service requests are misclassified as "Concurrent Review"	High	12/18/23	
Clinical Rounds	Def 05 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) clinical criteria was incorrectly applied.	High	12/18/23	
Clinical Rounds	Def 06 - UM requests for BHT services that were missing the member's diagnosis were incorrectly placed on pended status.	High	12/18/23	
DHCS Audit	Def 07 - Monitoring of over and under utilization of services is inadequate.	Moderate	12/20/23	

- System Change: Medical Management
    - Old System: Essette
    - New System: JIVA Phase I Go Live: 2/20/2024
    - Phase I Modules: Provider Portal, Utilization Management
        - Provider Value Add
            - Integration with DRE
            - Near Real Time Integration with internal system
            - New Authorization Submission Screens
            - New Dashboard for Authorization Status for Providers
            - Access to Authorization Decisions and Letters Online
        - Internal Value Add
            - Increase in Automation
            - Increased Integration to internal and external systems
            - Vendor Supported and Compliant System
            - D-SNP Ready System

- Pharmacy and Therapeutics Committee – 1/12/2024 (Q4' 2023)
    - Coverage Policies reviewed with recommended changes:
        - Endocrine – Women's Health
    - Coverage Policies without changes:
        - Miscellaneous - Transplant
        - Miscellaneous - Pulmonary Hypertension
        - Miscellaneous – Anemia
        - Neurologic – Multiple Sclerosis

Upon review of Dr. Lakshmi's report, Chair Diederich asked if Carelon is the same company as Beacon and if so, do most of HPSJ's sister plans use them and are they experiencing the same issues. Dr. Lakshmi responded Carelon used to be called Beacon and we are experiencing the same issues as other managed care plans. Lizeth Granados, CEO also noted that HPSJ's sister plans are

going through the process of bringing BH management in-house due to Carelon's performance issues.

Commissioner Canepa asked what D-SNP is. Ms. Granados responded, D-SNP stands for Dual Eligible Special Needs Plans and are Medicare Advantage health plans which provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medicaid).

She also noted that HPSJ needs to have this line of business up and running by January 2026. Much of the work is currently being done to meet the requirements before January 2026.

ACTION: With no further questions or comments, a motion was made (Commissioner Canepa) and seconded (Commissioner Minson) to approve the QIHEC Committee Report for 1/17/24, the QIHEC Charter for 1/17/2024, the QI Program Evaluation for 1/17/2024, and the Pharmacy and Therapeutics Committee Report for 1/12/2024 as presented (9/0).

7. Chief Compliance Officer Bi-Monthly Compliance Update

Sunny Cooper, Chief Compliance Officer provided an update on compliance activities, including approval requests for the Compliance Plan and Code of Conduct and Business Ethics, highlighting the following:

- CY 2023 FWA Cases
  - Reported a total of 24 credible FWA cases to DHCS
  - A total of 28 FWA cases, including 4 cases carried over from CY 2022, are under active investigation in CY 2023
  - Incidents investigated include provider billing issues, counterfeit checks and banking fraud

Investigation Type	Q1 2023	Q2 2023	Q3 2023	Q4 2023	CY 2023
Pharmacy/Drug Issue	2	2	1	1	**6**
Potential Member Fraud	0	0	0	2	**2**
Provider Billing/Payment Issues	3	5	4	2	**14**
Stolen/Fake ID use/Banking Fraud	1	1	0	0	**2**
DOJ Investigation Assistance	0	0	0	0	**0**
Total	**6**	**8**	**5**	**5**	**24**

- 2024 Compliance Program Plan - HPSJ/MVHP implements a comprehensive Compliance Program which incorporates all elements of an effective compliance program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) and required by the CMS. The Compliance Program is continually based on compliance monitoring and identification of new areas of operations, regulatory, or legal risk. The Health Plan Commissioners, Workforce, and FDRs (First Tier, Downstream, and Related Entities) are required to conduct themselves in accordance with the requirements of the Compliance Program. The Program Plan describes the following program functions:
  - Written Standards
  - Oversight
  - Education & Training
  - Lines of Communication
  - Enforcement and Disciplinary Standards
  - Auditing & Monitoring
  - Response & Remediation
  - Fraud Prevention Program

- Code of Conduct and Business Ethics - The Code of Conduct and Business Ethics (Health Plan Code) describes the general principles that guide our business activities. It is based on the laws, regulations, and other rules that apply to our work and help us comply with all health care program requirements.

  The Health Plan Code is updated annually and published to the Health Plan Learning platform for review and attestation by the Workforce. This annual training is scheduled to launch in March of 2024. New employees are assigned this task within 30 days of hire.

  Revisions made were: (1) Updated the CEO letter from Lizeth Granados, and (2) Incorporated Co-branding to include both HPSJ and MVHP.

Upon Ms. Cooper's report, the following questions were raised pertaining to FWA:

Q: Commissioner Jensen – On FWA cases, what happens to providers if they are found at fault?
A: Ms. Cooper - HPSJ reports credible FWA cases to DHCS and CA DOJ for further investigation. HPSJ has very few "bad" providers that make poor decisions. As a prevention, Compliance in coordination with the operations team provides extensive education to providers to ensure that FWA type cases do not occur in their practice.

Q: Chair Diederich - What happens to providers who are excluded from Medi-Cal/Medicaid, but are still providing services?
A: Ms. Cooper - As a publicly funded program and governing body, we are not allowed to contract with providers who are excluded from the Medi-Cal program. Therefore, HPSJ must do monthly exclusion monitoring. For exclusion monitoring, provider's, employees and members of the governing body's information is run through the exclusion databases maintained by both federal and state government agencies monthly.

Q: Commissioner Canepa - How do we randomly check on providers that are overcharging?
A: Ms. Cooper - We do it through data mining and analytic exercises, relevant records or medical record reviews, or interview office staff and providers. We don't take this lightly and report our investigation progress to DHCS throughout the investigation.

ACTION: With no further questions or comments, a motion was made (Commissioner Canepa) and seconded (Commissioner Jensen) to approve the 2024 Compliance Program Plan and Health Plan's Code of Conduct and Business Ethics as presented (9/0).

Commissioner Woodrow stepped out of the meeting at this time.

8. Health Information Exchange (HIE) Grant Incentive Program

Victoria Worthy, CIO presented for approval, the HIE Grant Incentive Program, noting that HPSJ/MVHP has earmarked $8.775 million in Community Reinvestment funds to bolster data sharing initiatives aimed at strengthening the connection between healthcare providers and the Health Plan-supported Health Information Exchange (HIE). These funds are designed to streamline the integration of healthcare providers into the Health Plan-supported HIE or Standard Data Sharing Templates for treatment, payment, and operations.

The goal is to strengthening data-sharing between healthcare providers and the Health Plan-supported Health Information Exchange (HIE) with data accessibility and desired outcomes to

increase the number of Health Plan providers participating in a Health Plan-supported HIE or Standard Data Sharing Templates for treatment, payment, and operations:

- Standard Data Sharing Templates: Excel
  - Establish a standardized data sharing program for all entities sharing bi-directional data with MCPs to meet DHCS requirements outlined in MOUs via standard excel spreadsheets with data elements agreed upon by all MCPs

- Standard Data Sharing – HIE Connection
  - Establish a standardized data sharing program for all entities sharing bi-directional data with HPSJ through Manifest Medex to meet regulatory requirements outlined in the California Advancing and Innovating Medi-Cal (CalAIM) program, State and Federal laws (i.e. AB133/Data Exchange Framework DxF)

- Targeted Providers identified by several providers
  - High Utilization
  - Quality Measures
  - Equity Practice Transformation (EPT) Program
  - Existing Clinical Program participation
  - Existing data posture with HPSJ
  - MOU Requirements

- Grant Tiers and Grant Total of $8.775M

Connection	Requirements		Amounts
Excel	Incentive Funding that assists traditional and non-traditional providers who render services for HPSJ members to support data sharing for basic data sets such as: **Data Types:** *Claims, Encounters, Demographic, Eligibility data, Program data, outreach, lab, Rx, Screenings, Radiology, Gaps in case, Race, Ethnicity and Language, SOGI, SDOH, etc.*	Sign CalHHS DSA Sign Health Plan DSA/MOU/BAA as applicable Health Plan Standard Excel Templates	Signed State & Health Plan DSA/MOU/BAA: up to $10,000 Excel Templates: $5,000 per template (up to 20 templates) Total Incentive: up to $110,000
Basic HIE	Incentive Funding that assists traditional and non-traditional providers who render services for HPSJ members to support data sharing for **basic** data sets such as: **Data Types:** *Claims, Encounters, Demographic and Eligibility data*	Sign CalHHS DSA Sign Health Plan DSA/MOU/BAA as applicable Basic Data Sharing	Signed State & Health Plan DSA/MOU/BAA: up to $10,000 EMR HIE Connection: up to $65,000 HIE Usage: up to $90,000 Total Incentive: up to $165,000
Expanded HIE	Incentive Funding that assists traditional and non-traditional providers who render services for HPSJ members to support data sharing for **expanded** data sets such as: **Data Types:** *Program data, Outreach, Lab, Rx, Screenings, Radiology, Gaps in Care data*	Sign CalHHS DSA Sign Health Plan DSA/MOU/BAA as applicable Expanded Data Sharing	Signed State & Health Plan DSA/MOU/BAA: up to $10,000 EMR HIE Connection: up to $95,000 HIE Usage: up to $90,000 Total Incentive: up to $195,000
Enhanced HIE	Incentive Funding that assists traditional and non-traditional providers who render services for HPSJ members to support data sharing for **enhanced** data sets such as: **Data Types:** *Expanded Quality data elements, Race, Ethnicity and Language, SDOH, SOGI, and Enhances screening data.*	Sign CalHHS DSA Sign Health Plan DSA/MOU/BAA as applicable Enhanced Data Sharing	Signed State & Health Plan DSA/MOU/BAA: up to $10,000 EMR HIE Connection: up to $125,000 HIE Usage: up to $90,000 Total Incentive: up to $225,000

- Next Steps
  - Collaborate with Community Partners (Applicants) to select appropriate data sharing needs
    - Review Data Elements
    - Data Sharing Incentive Program
    - Pilot Program
    - Implementation (Development, testing, deployment)
  - Open public access to HPSJ HIE Grant Program application via HPSJ website

Upon review of Ms. Worthy's grant request, the following questions were raised by Commissioners:

Q: Chair Diederich – On HIE offerings, does it include more than what the basic offers and with 501(c)3 grant programs, with AB133, will this get us to pay for some of the costs to Manifest and why is this program going to work now vs. before?
A: Worthy – Yes, HIE offerings are inclusive of the tiers that are referenced under Grant Tiers. CA created a law for health plans to follow and DHCS providers and payers will need to go-live by 1/1/2026; hence we are ahead of this to be ready for the mandate and comply. We are being proactive to get our providers prepared.

Q: Chair Diederich - Is this a federation with the HIE?
A: Worthy - This is not the only strategy on data sharing. There are providers that share data through HIE and other data connections. Our HIE is where we get our data from and contracted, and we are working with those entities to get a holistic approach.

Q: Commissioner Canepa - Who covers this program after 3 years?
C: Commissioner Noguera - The law was created to secure provider's data, and this does not cover the costs and is still worrisome.
A: Worthy - This is one of 5 fundings over time for providers and county organizations to set up data sharing. At some point it will be an operational expense and we are getting them prepared. HPSJ/MVHP will help through some of the safeguards and do our due diligence to assist the providers as we recognize it is expensive.

Q: Commissioner Herrera – Is the grant extended to hospital data sharing?
A: Worthy - This does include support for some of the hospitals based on our member population of the hospitals they go to.

Ms. Worthy also noted that AB133 also requires that providers cannot do any type of data blocking. Currently, there are 5 of LHPC's sister plans that are utilizing Manifest.

ACTION: With no further questions or comments, a motion was made (Commissioner Canepa), and seconded (Commissioner Jensen) to approve $8.775M of the Health Plan's Community Reinvestment Program funds towards the Data Sharing/HIE Grant Program as presented (8/0).

Commissioner Woodrow returned to the meeting at this time.

9. Community Reinvestment Program - Doula and Community Health Workforce (CHW) Program

Eric Cubillo, Director of Fiscal Operations presented for approval on the Doula and Community Health Workforce Program. The program goal is to support the recruitment of Doulas and Community Health Workers (CHW) by enrolled and non-enrolled Medi-Cal entities and CBOs. HPSJ/MVHP has allocated Community Reinvestment funds to support health plan efforts to increase the availability of CHW certification programs through a partnership with CSU, Stanislaus. Funds will help increase the number of CHW certified community members in the Health Plan service areas.

The program will increase the number of CHWs trained from diverse communities to create convenient access points to public health and healthcare to reduce health disparities in health plan service areas. Community Health Workers will provide:

- Health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life and to promote physical and mental health.
- CHWs are also known as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals

CHW Program Specifications

- CHW Certification Program Core Emphasis
  - Focused on training community members with live experience to serve as CHWs who are prepared to help members navigate health care, social service, and non-profit systems of support
  - CHWs are taught evidence-based strategies in how to engage, educate, and empower individuals

- CHW Certification Program Requirements
  - 80 hours of hybrid instruction, including 4 full day in-person sessions
  - Minimum of 10 hours of experiential learning/health education/outreach
  - Stipend for CHW program students; paid out based on validated enrollment status
  - Curriculum is verified to comply with DHCS CHW program certification requirements

Program Overview

- Key Assumptions
  - 80 hours of hybrid instruction, including 4 full day in-person sessions
  - Minimum of 10 hours of experiential learning/health education/outreach
  - Stipend for CHW program students; paid out based on validated enrollment status
  - Curriculum is verified to comply with DHCS CHW program certification requirements

	Individual
Tuition	$ 2,000
Stipend	$ 1,600
Other Expenses	$ 400
Subtotal	$ 4,000
Indirect Costs	$ 1,200
Total	**$ 5,200**

Doula/Community Health Workforce Program

- Program Goal - To support the recruitment of Doulas and Community Health Workers (CHW) by enrolled and non-enrolled Medi-Cal entities and CBOs
- Program Focus
  - Providing initial funding to employers for employing and integrating certified Doula and CHW workforce members into their organization
  - Providing preventative services to referred patients

Grant Guidelines

- Eligible Positions - Certified Community Health Worker, Certified Doulas, Certified Substance Use Disorder Counselor
- Entities Must Meet The Following DCHWR Grant Funding Criteria
  - Organization must be categorized as a Federally Qualified Health Center, Health Plan credentialed provider/medical group, community-based organizations with a 501(c)(3) designation or Hospital
  - Must be contracted with the HPSJ/MVHP network & Medi-Cal enrolled
  - All applicable contracting and credentialing must be completed, and position onboarded prior to receiving approved grant funds

  - Funding for the hiring of future CHW and Doula staff
  - Maximum of 5 position recruitment grant requests per funding cycle—applicants will be reviewed based on evaluated member impact

- DCHWR Grant Guidelines
  - DCHWR Grant is for year one of position costs
  - DCHWR Grant has an initial goal of funding 100 eligible positions from contracted health plan entities
  - The $70k max grant per approved eligible position is based on position year 1 costs

- DCHWR Grant recruitment related and eligible expenses
  - 1 year salary & benefits costs
  - Bonus
  - Relocation expenses
  - Costs of maintaining professional liability insurance
  - Fees for professional recruitment agency services
  - Costs associated with advertising
  - Employee Training/Certification/CEU Costs
  - Employee Expense Reimbursements

Upon review of Mr. Cubillo's request, extensive discussion was held with the following questions raised:

Q: Chair Diederich – Are these Community Health Worker program specifications applicable to the Stanislaus State program in Stockton?
A: Granados – This program applies to both San Joaquin and Stanislaus Counties. There are two pathways for CHW certification, which require 2,000 hours of work experience. The state did not provide specific CHW program requirements. However, we believe that due to the rigor of classes, we will meet the state's forthcoming requirement. In San Joaquin and Stanislaus, this is the only program offering this type of training to certify CHWs. We are working with HealthForce Partners to coordinate with various community-based organizations.

Q: Commissioner Herrera – What services do CHWs provide and are more needed in our community?
A: Granados – CHW's are non-clinical staff, providing reimbursable services and interventions on behalf of the referring physician. This is a program to add more CHWs to the workforce and ensure more of these services are provided to members in need with the hope that it is sustainable with reimbursement.
C: Chair Diederich - The expected utilization of CHW services is built into the reimbursement rates by the state.
C: Commissioner Noguera – Most of the larger local Community-Based Organizations offer CHW services, but many may expand to offer more CHW services with the idea that it will partially help them with funding.
C: Granados – HPSJ/MVHP partners with FQHCs to provide CHW services to members in need.

Q: Commissioner Canepa – Where are the Doula Grant funds coming from?
A: Granados & Chair Diederich – Funds will be coming from the $100 million Community Reinvestment funds, which the commission approved. Based on the reserves from our revenue, these funds are designated for our Community Reinvestment. All programs being developed are aligned with DHCS requirements. These reinvestments will be posted on our website so providers in the community can apply; staff will provide updates to the Commission regarding those receiving reinvestment funds and the amounts distributed on a monthly basis.

Q: Commissioner Wilverding - Are Community Reinvestment funds set aside for the deployment of the CHW and doula programs, as well as for other programs?
A: Granados & Tetreault – The Commission allocated $100 million for Community Reinvestmen.t If the CHW and doula programs are approved, along with previous approval of the mammogram program, our Community Reinvestment will total $15 million. We will have the remainder of $85 million for these purposes. We have semi-identified opportunities for the use of $60 million of funding and will bring reconciliation back to commissioners for monthly review. Per DHCS, we are required to put 5% of our net income into this fund, up to a certain portion. If we go over 7.5% net income of revenue, then we must dedicate 7.5% of net income to reinvestment. A plan that was previously approved by the Health Commission will be submitted to DHCS for subsequent approval to ensure compliance with the state's requirements for Community Reinvestment.

Q: Commissioner Minson - How broad are the services provided through this CHW program?
A: Granados - We want to take a broad enough approach to address various social determinants of health. However, a referring physician needs to approve these CHW services for a member.

ACTION: With no further questions or comments, a motion was made (Commissioner Canepa) and seconded (Commissioner Wilverding), with one abstention (Commissioner Herrera) to approve $8.404M of the Health Plan's Community Reinvestment Program funds towards the Doula/Community Health Workforce Program ($7M for Doula DCHWR Grant and $1.404M for Community Health Woker (CHW) Training Grant) as presented (8/1).

INFORMATION ITEMS

10. CEO Report

Lizeth Granados, CEO, provided updates on the following:

Proposed Managed Care Organization (MCO) Tax and Increased Funding for Providers

To sustain recent healthcare investments, the MCO Tax proposal would generate $20.9 billion from April 1, 2023, through December 31, 2026:

- $12.9 billion is allocated to support the Medi-Cal program
- $8 billion is allocated to increase rates for Medi-Cal providers

Targeted rate increases for Medi-Cal providers include:

- Physician and Non-Physician Services (primary care, obstetric care, non-specialty mental health services, and specialty care)
- Community and Hospital Outpatient and Emergency Department Services
- Designated Public Hospital Services
- Federally Qualified Health Center Services

Physician and Non-Physician Services:

- Increase Evaluation and Management procedure codes for primary and specialty care services to 100% of Medicare.
- Raise emergency department physician services to 90% of Medicare, with other codes potentially increasing to 80% of Medicare

Designated Public Hospital (DPH) Services:

- Shift DPH inpatient services to an All Patients Refined Diagnosis Related Groups (APR-DRG) methodology
- Establish a uniform base reimbursement rate per inpatient stay, aiming for a $375 million reimbursement

- Sunset reconciliation to 100% of cost, with limited exceptions

Community and Hospital Outpatient and Emergency Department Services:

- Transition hospital outpatient and ambulatory surgical center reimbursement to a methodology like the Medicare Outpatient Prospective Payment System model by 2027
- Implement baseline increases of around 10% for outpatient services and 40% for emergency department facility services, including regional adjustments based on the Medicare hospital wage index

Federally Qualified Health Center Services:

- Transition the 340B program to managed care, generating an estimated $205-$230 million annually for the directed payment program

Due to time constraints, Ms. Granado's reported that the information is in the presentation deck for commissioner's review.

CHAIRMAN'S REPORT

Chair Diederich reported, currently the Health Commission have 12 out of 13 seats in place. Commissioner Dr. Lauren Brown-Berchtold was recently appointed and will be joining the Health Commission in March. He and Ms. Granados are working on filling the remaining seat with Stanislaus.

COMMISSIONER COMMENTS

No comments were forthcoming.

The Health Commission went into Closed Session at 6:45pm.

CLOSED SESSION

11. Closed Session – Closed Session – Trade Secrets
    Welfare and Institutions Code Section 14087.31
    Title: FY' 23-24 Quarterly Corporate Objectives Update

The Health Commission came out of Closed Session at 7:08pm, no reports or actions were forthcoming.

ADJOURNMENT

Chair Diederich adjourned the meeting at 7:09 p.m. The next regular meeting of the Health Commission is scheduled for March 27, 2024.