MINUTES OF THE MEETING OF THE SAN JOAQUIN COUNTY HEALTH COMMISSION

March 27, 2024
Health Plan of San Joaquin – Community Room

COMMISSION MEMBERS PRESENT:

Greg Diederich, Chair
Lauren Brown-Berchtold, MD
Paul Canepa
Michael Herrera, DO
Matthew Minson, MD
Christine Noguera
Sandra Regalo
Miguel Villapudua
Terry Woodrow
John Zeiter, MD

COMMISSION MEMBERS ABSENT:

Neelesh Bangalore, MD
Brian Jensen, Vice-Chair

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
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 5:04 p.m.

PRESENTATIONS/INTRODUCTIONS

Chair Diederich welcomed new Commissioners, Dr. Lauren-Brown Berchtold, Program Director, San Joaquin General Hospital Family Medicine Residency and Sandra Regalo, Interim County Administrator.

PUBLIC COMMENTS

No public comments were forthcoming.

CONSENT CALENDAR

Chair Diederich presented four consent items for approval:

1. February 28, 2024 SJC Health Commission Meeting Minutes

2. Community Reinvestment Committee – 2/22/2024
   a. January 31, 2024 Meeting Minutes

3. Finance and Investment Committee – 3/20/2024
   a. December 6, 2023 Meeting Minutes
   b. February 21, 2024 Meeting Minutes
   c. Cognizant: EAM Agreement (D-SNP Eligibility System)

4. Human Resources Committee – 3/21/2024
   a. January 31, 2024 Meeting Minutes

5. Community Reinvestment Committee – 3/21/2024
   a. January 31, 2024 Meeting Minutes

ACTION: With no questions or comments, the motion was made (Commissioner Canepa), seconded (Commissioner Zeiter), to approve the five consent items as presented (10/0).

DISCUSSION and ACTION ITEMS

6. Resolution 2024-01: San Joaquin County Bylaws Amendments

Chair Diederich presented for approval Resolution 2024-01: San Joaquin County Bylaws Amendments, noting the amendment was made under Article 2, Section 2.2, to provide Stanislaus County membership on the Health Commission:

I. Modify San Joaquin County's physician members representation of traditional providers of Medi-Cal from three (3) to one (1)

II. Modify San Joaquin County's community representative members from two (2) to one (1)

III. Reduce San Joaquin County's Supervisor members from two (2) to one (1)

IV. Provide Stanislaus County with a total of four (4) members on the Health Commission as follows:

i. One Supervisor member
ii. One community representative member
iii. One physician member representing traditional providers of Medi-Cal, and
iv. Stanislaus County Chief Executive Officer or designee

ACTION: With no questions or comments, the motion was made (Commissioner Villapudua), seconded (Commissioner Noguera), to approve Resolution 2024-01: San Joaquin County Bylaws Amendments, as presented (10/0).

7. Resolution 2024-02: San Joaquin County Ordinance Amendments

Chair Diederich presented for approval Resolution 2024-02: San Joaquin County Ordinance Amendments, which coincides with Resolution 2024-01, to provide Stanislaus County membership on the Health Commission, effective July 1, 2024. He also noted that local initiatives are the preferred model for benefactors/members, as well as solidifying relationship with Stanislaus County long-term.

ACTION: With no questions or comments, the motion was made (Commissioner Canepa), seconded (Commissioner Noguera), to approve Resolution 2024-02: San Joaquin County Ordinance Amendments, as presented (10/0).

8. Ad-Hoc CEO Performance Evaluation Committee

Chair Diederich reported that the HR Committee met on March 27, 2024 to discuss Ms. Granados performance evaluation as CEO since her appointment in June 2023. The CEO is the only individual that reports to the Health Commission; a timeline with policies and procedures is put in place to kick-start the evaluation process; written recommendations will be presented to commissioners in August with final commission approval to be made in October.

Current members of the Ad-Hoc CEO Performance Evaluation Committee are Chair, Jensen, Commissioners Diederich and Noguera.

9. January 2024 Financial Reports

Michelle Tetreault, CFO presented for approval the January 2024 YTD financials, highlighting the following:

- Net Income is $34M and is -$1.6M unfavorable to budget
- Premium Revenue is -$48.6M unfavorable to budget YTD, attributed to lower than budgeted enrollment in Long Term Care (LTC) categories of aid and an accrual for an anticipated acuity factor adjustment
- Managed care expenses are $15.6M favorable to budget YTD, primarily attributable to:
  - +$24.7M favorable Institutional variance due to lower than budgeted LTC enrollment
  - -$10.6M 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 -$4.1M unfavorable to budget YTD primarily due to incentive program activity budgeted but not yet performed

- Administrative expenses are $13.6M favorable to budget due to lower than budgeted consulting expense of $4.3M, personnel costs of $3.0M, and IT subscription costs of $2.6M

- Prior period adjustments are unfavorable of -$12.3M primarily related to the acuity rate adjustments mentioned in the Premium Revenue explanation as well as the accrued payment for return of premium to DHCS related to an MLR for CY 2022 being lower than the 85% required minimum

Chair Diederich asked about the status of the acuity adjustment on rates. Ms. Tetreault responded that the Health Plan, along with one other plan intends to send a letter to DHCS giving feedback about the impact of retroactive changes on prospective rates.

Commissioner Herrera asked if acuity adjustment is given to hospital facilities. Ms. Tetreault responded that acuity adjustment is on health plans' rates only and not passed through to providers.

ACTION: With no additional questions or comments, the motion was made (Commissioner Villapudua) seconded (Commissioner Zeiter) and unanimous to approve the January 2024 YTD financial report as presented (10/0).

10. Community Reinvestment - Lead Screening for Children Initiative

Ilia Rolon, Director of Special Projects Quality presented for approval the Lead Screening for Children initiatives proposed by the Community Reinvestment Committee. The program goal is to increase the rate of blood lead screening for HPSJ/MVHP pediatric members aged 0-2 by reducing barriers for parents/caregivers and providers, with an outcome increase the number of providers able to perform lead screening at the point of care by equipping them with 1-2 lead analyzer machines.

Lead is a neurotoxin and a known risk factor for neurobehavioral disorders and diminished IQ. To prevent these conditions, children in Medi-Cal must receive blood lead testing at 12 and 24 months of age. DHCS requires MCPs to meet the 50th percentile for the Lead Screening in Children (LSC) Managed Care Accountability Set (MCAS) measure.

HPSJ/MVHP's LSC rates are below the Minimum Performance Level (MPL).

MEASUREMENT YEAR	HPSJ LSC RATE	LSC MPL
2020	41.36%	N/A
2021	44.53%	71.53%
2022	43.66%	63.99%
2023 (unofficial)	46.07%	62.79%

The point of care lead screening has several advantages:

- Parents/caregivers avoid a trip to a different facility for screening, and providers avoid having to create a lab order
- If screen is positive, provider can discuss result with parent/caregiver and emphasize importance of the child getting a follow-up venous blood draw for confirmation
- If parent refuses screening, it is easier for provider to get required attestation
- Screening or attestation is more likely to be documented, improving provider and plan's HEDIS rates

Although point of care lead screening is quick and relatively simple, the cost of lead analyzer machines is a barrier for some provider practices. Equipping primary care providers with point of care lead testing machines can increase the number of children tested.

Provider Participation Criteria

Provider must submit data monthly and accept responsibility for annual calibration and maintenance of the machine(s):

- Have a minimum of 100 assigned members in target age range and be actively seeing and accepting patients eligible for the measure
- Undergo training on use of lead analyzer machine
- Have a CLIA certificate or be willing to apply for one
- Follow up on positive screening results
- Submit screening codes to HPSJ
- Complete a grant application and MOU with the Plan

Program Support for Providers – Technical Assistance

HPSJ's Quality Improvement (QI) Nurses will assist with implementation in five ways:

1. Guiding providers through the CLIA certification process (as applicable)
2. Arranging for provider staff training on the machine
3. Assisting providers to develop new practice flows that incorporate point of care lead testing
4. Supplying gap lists for member/patient outreach
5. Providing DHCS-approved call and text scripts

Projected Program Cost

Total Cost: $100,000 broken down by:

- 3,500 per lead analyzer machine
- Up to 15 practices
- 1-2 machines per practice depending on number of sites with at least 100 target members

Chair Diederich and Ms. Granados also noted that only 41% of children are being tested for lead. If we can catch it early, it will help with the children's development. A lot of the time, parents are not able to take their children to the lab and with getting the screening done in real time, it will help to increase testing.

Upon review of Ms. Rolon's proposal, the following questions and comments were raised by commissioners:

Q: Canepa**:** What number do we need to get from 41%
A: Diederich and Granados: We must be at the 50th percentile, depending on how well the other plans do; any increase is going to be a positive. We are breaking down the barriers, increasing at point of care.

Q: Herrera: How do we identify which provider gets the device?
A: Granados: It's determined based on providers that have more than 100 members.

Q: Herrera: What is the children's lead toxicity in our community, what is the percentile and is the county having challenges?
A: Rolon: We don't' have county data as it is not as severe as the east coast, but it is apparent based on diversity in the population.

Commissioner Minson stated that preventive care is significant and is based on age range. This is to identify early detection and put in counter measures and noted that it should be an on-going program. Rural provider practices like El Dorado County, do not total of 100 members but could be adding practices together to help improve these measures.

ACTION: With no additional questions or comments, the motion was made (Commissioner Minson) seconded (Commissioner Herrera) and unanimous to approve $100,000 of the Community Reinvestment Program funds towards the Lead Screening for Children Initiative as presented (10/0).

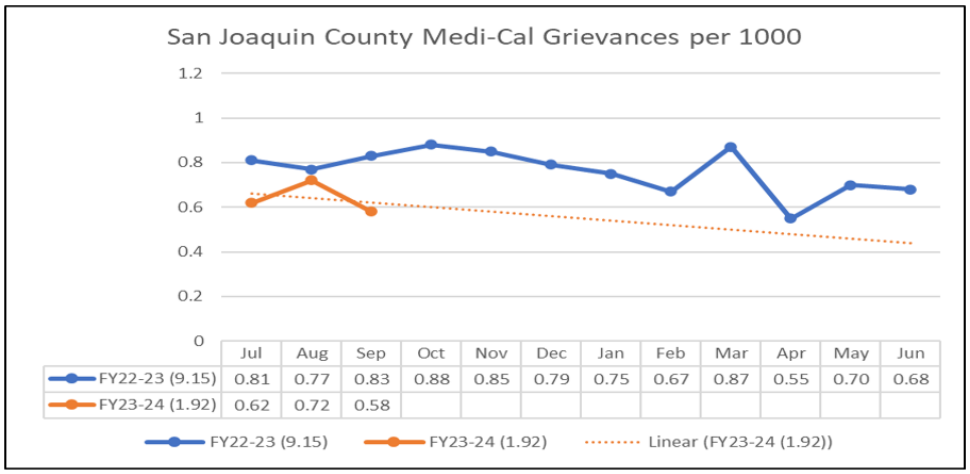
11. QIHEC Committee Update – 03/20/2024

Dr. Lakshmi Dhanvanthari, CMO submitted for approval the QMUM Committee meeting report for 3/20/2024, highlighting the following committee meetings, work plans, program descriptions, policies updates and reports that were reviewed and approved:

- Key changes to the Quality Improvement & Health Equity Transformation Program (QIHETP) Description Update Jan 24-June 24 FY 23-24
    - Additional Committees added to the Structure
    - Alignment between Quality, Population Health and Equity initiatives
        - Quality and Equity initiatives to improve populations of focus
        - Improve Managed Care Accountability Set Measures rates while decreasing disparities in care and service
    - Expand the Quality Improvement System to include Equity
        - Expand the definition, scope and role of the Health Equity Officer in Quality
        - Augment Health Plan resources to focus on Quality and Equity
    - Foster an equity focused culture of care
        - Health Plan Operations, Clinical and Non-clinical
        - Offer resources to Provider Partners, delivery system and Community Based Organizations
        - Create Member focused pathways to achieve better health
        - Coordinate care and services to increase the likelihood of better outcomes
        - Implement Data driven interventions
    - Long Term Care Quality

- Quality Improvement & Health Equity Transformation Program (QIHETP) Workplan Update - Jan 24-June 24 FY 23-24
    - Create a Diversity, Equity and Inclusion training program by 12/31/2024
    - Achieve Health Equity Accreditation (HEA) by 6/30/2025
    - Stratify Quality measures and Identify equity areas of focus by 6/30/2024
    - Collaborate with Community Based Organizations (CBOs) in each county to engage members locally by 12/31/24
    - Engage Community Advisory Committee members in focus groups to create learning opportunities by 12/31/24
    - Identify stakeholders for equity focused collaboration in alignment with DHCS 2024 Contract and Population Health Management by 6/20/2024

- QM Work Plan Updates – Q2' FY-2023-2024
  - SJC Grievances

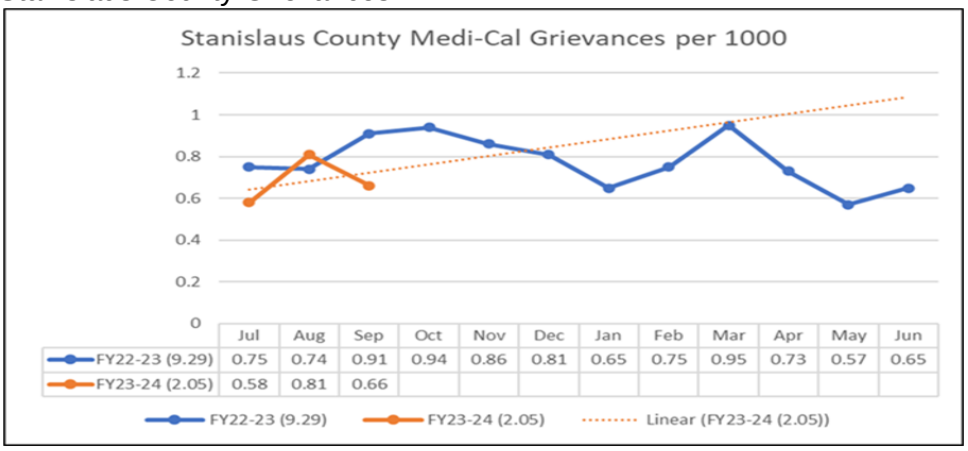


San Joaquin County Grievances: 534

- **Quality of Care: 224**
  - Resolved Member's Favor: 35
  - Resolved Plan's Favor: 187
  - PQI's opened: 2
- **Access to Care: 183**
  - Resolved Member's Favor: 53
  - Resolved Plan's Favor: 129
  - PQI's opened: 1
- **Attitude & Service/Quality of Service: 127**
  - Resolved Member's Favor: 55
  - Resolved Plan's Favor: 72

** There was a **0.74%** decrease in the total number of grievances, compared to the previous quarter.

  - Stanislaus County Grievances

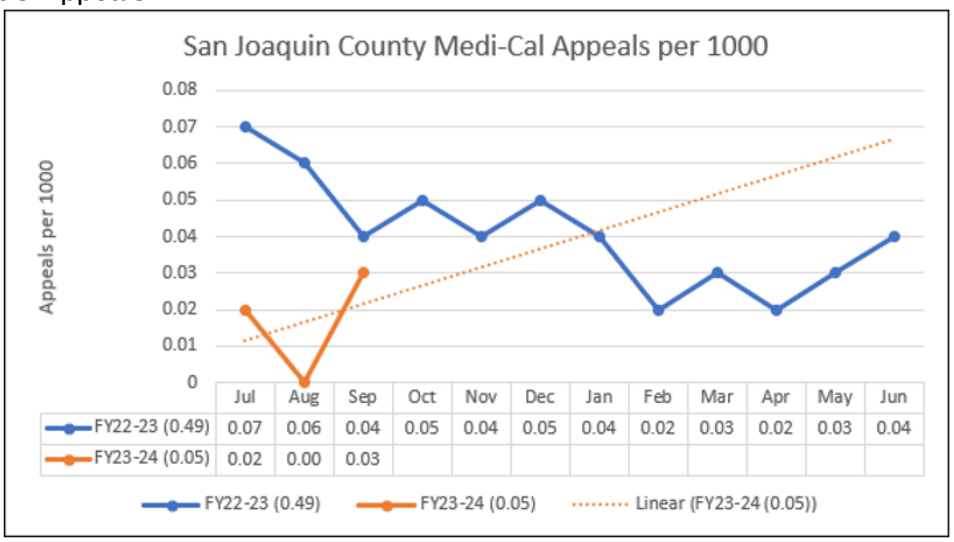


Stanislaus County Grievances: 364

- **Quality of Care: 154**
  - Resolved Member's Favor: 33
  - Resolved Plan's Favor: 117
  - PQI's opened: 4
- **Access to Care: 125**
  - Resolved Member's Favor: 45
  - Resolved Plan's Favor: 80
- **Attitude & Service/Quality of Service: 85**
  - Resolved Member's Favor: 35
  - Resolved Plan's Favor: 50

There was a **5% increase in the total number of grievances compared to the previous quarter.

o SJC Appeals



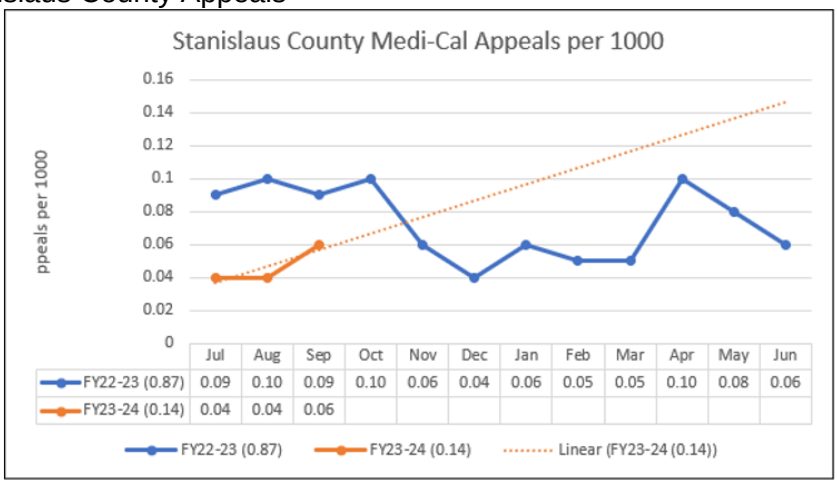
San Joaquin County Appeals: 15

- **Benefits & Coverage: 7**
  - Resolved Member's Favor: 3
  - Resolved Plan's Favor: 4
- **Medical Necessity: 8**
  - Resolved Member's Favor: 5
  - Resolved Plan's Favor: 3

- **37.5%** decrease in the total number of appeals being filed, compared to the previous quarter
- **24** appeals were filed in Q4 FY22-23, which decreased to 15 appeals filed in Q1 FY23-24

** The trends for the type of appeals being filed were related to Durable Medical Equipment (DME), Physical Therapy and services rendered at pain treatment centers that include a pain pump, radiofrequency ablation and back brace

o Stanislaus County Appeals



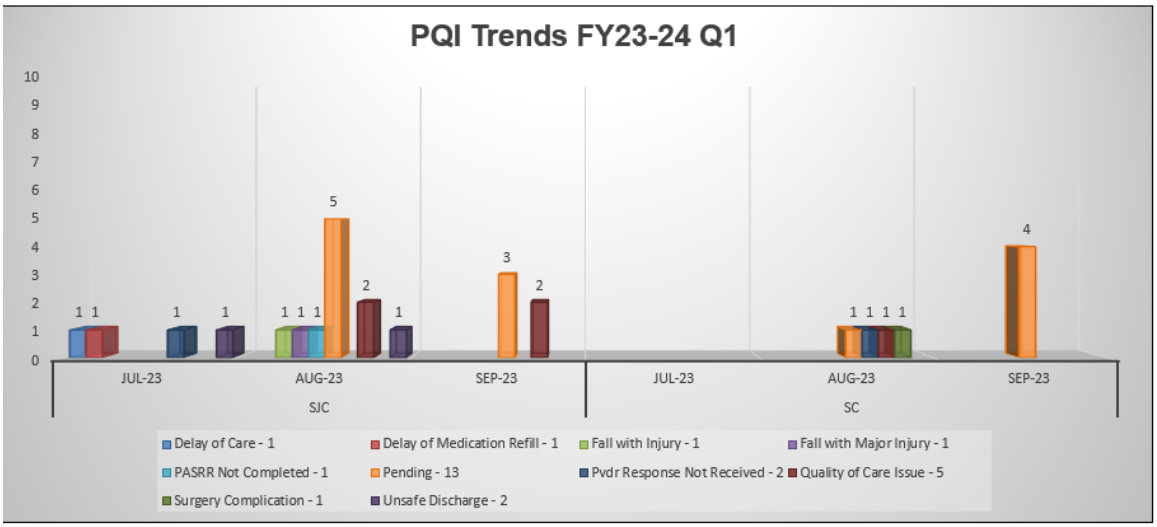
Stanislaus County Appeals: 24

- **Benefits & Coverage: 11**
  - Resolved Member's Favor: 4
  - Resolved Plan's Favor: 7
    - One appeal was related to a prior-auth; request for Tepezza
- **Medical Necessity: 13**
  - Resolved Member's Favor: 9
  - Resolved Plan's Favor: 4
    - One appeal was related to a prior-auth; request for Venofer

- **40%** decrease in the total number of appeals being filed, compared to the previous quarter
- **40** appeals were filed in FY22-23 Q4, which decreased to 24 appeals filed in Q1 FY23-24

**The trends for the type of appeals being filed were related to Custom Foot Insoles, Durable Medical Equipment (DME) related to requests for a Back Brace, and Physical Therapy.

- Potential Quality Issue (PQI)



Quality Management Department rendered the following interventions for this quarter:

✓Education letters sent to the providers, peer to peer calls were made

✓Quarterly audit for 10% of PQI's is performed by CMO about appropriate documentation by MD, case leveling and scoring by MD and appropriate case escalation to CMO or PRCC (Peer Review and Credentialing Committee) if needed and appropriate feedback is provided to the Medical Directors as needed

✓PQI Trends
- 13 Pending
- 5 Quality of Care Issue

❖ ***17 out of 28 PQI's were referred internally***

❖ ***11 out of 28 PQI's were escalated from a grievance***

- **Subcommittee Reports**

QIHEOC Meeting Update – 2/8/2024 & 2/28/2024

- MCAS Measures Interventions
- Quality Improvement Projects w/a focus on Children's Health Measures
- Telephone Access & Member Call Quality Report
- NCQA Health Equity Accreditation provides a framework for promoting health equity among healthcare organizations. By obtaining this accreditation, HPSJ demonstrates its unwavering commitment to continuously enhance health equity
- It is a regulatory requirement to obtain NCQA Health Accreditation by Jan 2026

Delegation Oversight Committee Report – 2/6/2024

Community Support Services Providers Audit Results:

- GA Foods – 94% with 2 findings
- Gospel Center Rescue Mission- 66% with 29 findings, upon reviewing responses from GCRM, 16 findings were closed and 13 remain open
- Mom's Meals – 44% with 17 findings. CAP response expected by 2/5/24
- MedZed- 88%, 18 findings. Upon CAP review 13 findings closed, 5 open
- SJHC - Audited for ECM & CS- 100%
- The Delegation Oversight Committee (DOC) name is being changed to Audits & Oversight Committee (AOC)

Delegation Oversight Committee- Follow Up from the Carelon Audit

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

Pharmacy & Therapeutics Advisory Committee - March 19, 2024

- Policy and Procedure Reviews
  - PH14- Monitoring the Safe Use of Pharmaceuticals
  - PH17- Member Communication
  - PH18- Provider Communication
  - PH32- Non-Opioid Pain Management

- Coverage Policy Updates
  - Infectious Disease- Immunization
  - Oncology- Cancer
  - Topical Anti-inflammatory Agents-Intravitreal

- Coverage Policies Without Changes
  - Endocrine Disorders- Thyroid
  - Endocrine Disorders- Testosterone
  - Miscellaneous- Non-Covered Benefits
  - Rheumatology- Gout

Upon review of Dr. Dhanvanthari's report, Chair Diederich asked who denial go to for prior authorization. Dr. Dhanvanthari responded that it is only when there is a significant impact on members' health and for high-cost procedures and for members that are likely to require case management follow up we require prior authorizations. In terms of the process itself, providers send in requests for prior auth, which are logged into our system and reviewed by our nurses. If the review guidelines are met, the nurses approve the request based on MCG guidelines. If the guidelines are not met, the request goes to a physician for review, and they make a determination to approve or deny based on medical necessity for the request. When denied, a letter goes out to the member and provider, and it gives the reason for the denial. Only physicians can make a denial and the nurses can only approve.

ACTION: With no further questions or comments, a motion was made (Chair Diederich) and seconded (Commissioner Villapudua) to approve the QIHEC Committee Report for 3/20/2024, the QIHEC Work Plan for 03/20/2024, and the QIHEC Committee for 3/20/2024 as presented (10/0).

Peer Review and Credentialing Committee – March 18, 2024

Dr. Dhanvanthari submitted for approval the Peer Review and Credentialing Committee report for March 18, 2024:

- Direct Contracted Providers
  - Initial Credentialed for 3 years = 79
  - Initial Credentialed for 1 year = 3
  - Recredentialed for 1 Year = 2
  - Recredentialed for 3 Years = 79

- Delegation Reports – Q4' 2023 Delegated Credentialing

Delegated Entity	Initial	Recredentialed	Terminations
Carelon-Beacon	226	55	147
ChildNet	36	31	0
Childrens First	4	31	1
Kaiser	46	93	0
UCSF	190	483	0
Community Psychiatry/MindPath Health	0	0	0
MD Live/CareNet	0	207	0
HubMD	1	0	0
Sutter Gould Medical Foundation	50	110	0
VSP	25	132	1
Total	578	1,114	149

ACTION: With no questions or comments, a motion was made (Chair Diederich) and seconded (Commissioner Canepa), with abstention by Commissioner Herrea to approve the Peer Review and Credentialing Committee report for March 18, 2024 as presented (9/1).

INFORMATION ITEMS

12. CEO Report

Lizeth Granados, CEO, provided updates on the following:

Response to the Change Healthcare Cyberattack

In February 2024, a cyberattack targeted Change Healthcare, leading to the shutdown of the largest healthcare payment system in the United States.

HPSJ/MVHP partners with Change Healthcare to manage our payments to providers for services rendered to members. Through Change Healthcare, providers receive payments from HPSJ/MVHP via electronic funds transfers or checks with accompanying remittance advice that outlines compensated services.

The Change Healthcare system outage challenged HPSJ/MVHP's ability to receive claims, make timely payments, and furnish remittance advice. We are actively collaborating with providers to

establish alternative methods for submitting claims. The leadership implemented a solution to issue checks throughout the outage, mitigating service disruptions and ensuring that providers receive payments. HPSJ/MVHP is issuing remittance advice to coincide with our payments to providers until Change Healthcare systems are fully restored.

Ms. Granados acknowledged management's quick response to address the issues within a week by issuing paper checks, which garnered positive feedback from providers.

Commissioner Minson asked whether there are on-going data back-up plans. Victoria Worthy, CIO responded to the affirmative and noted that the team is actively considering other options to avoid exposure. As for this cyber-attack, Change Healthcare is providing minimal information. The IT team is building processes to put in place:

- Calls are being held twice a week; no forensic details provided yet (3 external parties are examining)
- We require attestation that Change Healthcare's system has been scanned for malware
- Internally, we turned on proactive scanning activities to minimize risk

Commissioner Minson also stated that the plan should consider including a nimble clause in indemnification. Ms. Granados noted the affirmative and stated that an indemnification clause is included in our contracts.

Implementation and Utilization of Community Supports

Medi-Cal plans offer Community Supports to address the health-related social needs of members by providing cost-effective alternatives to prevent higher levels of care. The Department of Health Care Services (DHCS) encourages Medi-Cal plans to offer as many services as possible from a suite of 14 pre-approved Community Supports.

HPSJ/MVHP has grown our network to include 29 providers of Community Supports:

- San Joaquin and Stanislaus: All 14 Community Supports are offered by our plan
- Alpine and El Dorado: 13 Community Supports are offered by our plan.
    - Our ability to offer all Community Supports in Alpine and El Dorado Counties is constrained by the local absence of Sobering Centers.

The most utilized Community Supports are Housing Transition Navigation Services, Medically Supportive Food/Medically Tailored Meals, and Asthma Remediation. We are partnering to ensure providers and members are familiar with Community Supports – Utilization is expected to continue increasing.

Annual Timely Access Report

Department of Managed Health Care (DMHC) released its Annual Timely Access Report for Measurement Year 2022.

Health plans must ensure network providers offer timely appointments for members. Network providers are surveyed to allow DMHC to assess the availability of urgent and non-urgent availability within wait time standards. 63 full-service health plans across commercial, individual/family, and Medi-Cal products were surveyed. The results revealed that HPSJ/MVHP leads California health plans in ensuring timely access for members.

Appointment Type	Percent of Providers	Rank Among Plans
Urgent and Non-Urgent	87%	1st (Tied)
Non-Urgent	94%	1st
Urgent	84%	2nd

Ms. Granados thanked staff for their efforts to support providers and position HPSJ/MVHP to lead across all health plans in California.

13. Chief Information Officer Report: Quarterly Information Security Update

Victoria Worthy, CIO provided an update on the company's security metrics, program and projects, highlighting the following:

Vulnerability Management	Metrics	Values	Overall Grade
We scan our systems for vulnerabilities and correct findings based on severity and risk.	Exposure Score	B	B
	Assessment Maturity	A	
	Remediation Maturity	B	
	External Web Presence Score	A	

Process Maturity	Metrics	Values	Overall Grade
We use CIS Maturity Assessment to rate our processes in order to develop and implement our Information Security Program	HPSJ Score	32	B
	Industry Average	25	

M365 Security Score	Metrics	Values	Overall Grade
This is a score calculated by Microsoft based on security configuration in Office 365 tools.	HPSJ Score	63.37	A
	Organizations of similar size	46.82	

HPSJ Phishing Test	Metrics	Values	Overall Grade
Our testing system sends test emails emulating phishing attempts. We measure if our employees are successfully able to recognize these, or if they are prone to be phished.	Total Test emails	7844	A
	Report Percentage	49%	
	Phish Prone Percentage	1.56%	
	Industry Average	5.30%	

24x7 Security Operations Center	Metrics	Values	Overall Grade
Our SOC vendor collects data from all of our system near realtime. This data is analyzed using AI and Machine learning to identify threats and potential security events. Any events identified are investigated for unauthorized actions.	Events Analyzed:	3.94 Billion	A
	Investigations:	644	
	Escalated to HPSJ:	93	
	Average Response Time	< 1 day	
	Average Close Time	< 2 days	

Security Programs and Projects

- Moss Adams Remediation
  - All Remediation completed by 12/31/2023

- Move to Microsoft Defender
  - Implementing Microsoft Defender for enhance endpoint security and better integration with the Office365 platform

- Security Program Maturity
  - HPSJ completed an internal assessment to evaluate our security program. The assessment evaluated 18 different components of the program to identify process improvement opportunities
  - Identified our top 3 areas to increase process maturity for 2024

Upon Ms. Worthy's update, Chair Diederich asked what HPSJ/MVHP's level of integrated tools is. Ms. Worthy responded that HPSJ/MVHP's integrated tools are at a G level (G5 licensing – government side information benefits).

14. Legislative Update

Brandon Roberts, Manager of Government and Public Affairs provided an update on Priority Bills, highlighting the following:

2-Year Bills and Reintroductions

- AB 236 (Holden) – Health care coverage: provider directories. Would require a health plan to annually verify and delete inaccurate listings from its provider directory
  - Provider directories would be required to be 60% accurate by July 1, 2025, and benchmarks would increase annually until reaching 95% accuracy by July 1, 2028

- AB 2043 (Boerner) – Medi-Cal: nonmedical and nonemergency medical transportation. Would require Medi-Cal plans offering nonmedical or nonemergency medical transportation to contract with public paratransit service operators who are enrolled Medi-Cal providers

- SB 282 (Eggman) – Medi-Cal: federally qualified health centers and rural health clinics. Would require Medi-Cal reimbursement to a FQHC and RHC for two visits taking place on the same day at a single location if the patient suffers illness or injury after the first visit, or the patient has a medical visit and a mental health or a dental visit

- SB 516 (Skinner) and SB 598 (Skinner) – Health care coverage: prior authorization. Would prohibit a health plan from requiring prior authorization from a provider if at least 90% of the provider's requests were approved in the most recent one-year contracted period
    - Health plans would be required to identify and discontinue prior authorization requirements for services and items that are approved 95% of the time

New Medi-Cal Benefits

- AB 1975 (Bonta) – Medi-Cal: medically supportive food and nutrition interventions. Would make medically supportive food and nutrition interventions a covered benefit under the Medi-Cal program, effective July 1, 2026
    - Medi-Cal plans would cover at least three of the following interventions: 1) Medically tailored meals, 2) Medically supportive meals, 3) Food pharmacy, 4) Medically tailored groceries, 5) Medically supportive groceries, 6) Produce prescription

- AB 2446 (Ortega) – Medi-Cal: diapers. Would establish diapers as a Medi-Cal benefit for infants or toddlers with conditions, such as a urinary tract infection, colic, a skin disease related to inadequate diaper hygiene, or a condition that contributes to incontinence

- SB 952 (Menjivar) – Medi-Cal: menstrual products. Would add menstrual products to the schedule of covered benefits under the Medi-Cal program

Health Care Landscape

- AB 1316 (Irwin) – Emergency services: psychiatric emergency medical conditions. Would define a "psychiatric emergency medical condition" to apply regardless of whether a patient in a health facility is voluntarily or involuntarily detained for evaluation and treatment.
    - Medi-Cal plans would cover all hospital emergency department visits, including psychiatric emergencies, despite carve-outs related specialty mental health services

- AB 2200 (Kalra) – Guaranteed Health Care for All. Would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system

Upon review of Mr. Roberts report, Chair Diederich asked if the bills related to new Medi-Cal benefits would require federal approval. Mr. Roberts responded that these proposals typically require federal approval and funding is available to the extent that the federal government allows. Chair Diederich also asked whether there is precedent for diapers to be a Medi-Cal covered benefit. Ms. Granados noted for AB 2446 they that diapers are currently only available for SPD population.

CHAIRMAN'S REPORT

No reports were forthcoming.

COMMISSIONER COMMENTS

No comments were forthcoming.

ADJOURNMENT

Chair Diederich adjourned the meeting at 6:42 p.m. The next regular meeting of the Health Commission is scheduled for April 24, 2024.