MINUTES OF THE MEETING OF THE SAN JOAQUIN COUNTY HEALTH COMMISSION

March 26, 2025
Health Plan of San Joaquin – Community Room

COMMISSION MEMBERS PRESENT:

Genevieve Valentine, Chair
Paul Canepa
Michael Herrera, DO
Ruben Imperial
Jay Krishnaswamy
Sandra Regalo
Michael Sorensen
Terry Woodrow

COMMISSION MEMBERS ABSENT:

Brian Jensen, Vice-Chair
Jim Diel
Terry Withrow

STAFF PRESENT:

Lizeth Granados, Chief Executive Officer
Betty Clark, Chief Regulatory Affairs and Compliance Officer
Dr. Lakshmi Dhanvanthari, Chief Medical Officer
Evert Hendrix, Chief Administrative Officer
Tracy Hitzeman, Executive Director – Clinical Operations
Dr. Thomas Mahoney, Deputy Chief Medical Officer
Robert Ruiz, Executive Director – Quality Improvement and Health Equity
Michelle Tetreault, Chief Financial Officer
Victoria Worthy, Chief Information Officer
Kirin Virk, Deputy County Counsel
Sue Nakata, Executive Assistant and Clerk of the Health Commission

CALL TO ORDER

Chair Valentine called the meeting of the Health Commission to order at 5:08 p.m.

PRESENTATIONS/INTRODUCTIONS

1. Chair Valentine announced that Dr. Julienne Angeles's appointment to the Health Commission was approved by the SJC Board of Supervisors on March 25, 2025. She will begin participating in commission meetings starting in April.

PUBLIC COMMENTS

A representative from Dignity Health joined the meeting to express appreciation for the Health Plan's involvement and continued investment in Community Health Workers, who play a vital role in implementing a strong community workforce to ensure the program's success. She also thanked the Health Plan in advance for considering proposals that would provide the essential tools and support needed for the program.

Lizeth Granados, CEO introduced Dr. Thomas Mahoney, the Health Plan's new Deputy Chief Medical Officer. She also announced that Betty Clark expanded her role to include Chief Compliance Officer.

CONSENT CALENDAR

Chair Valentine presented three consent items for approval:

2. February 26, 2025 Health Commission Meeting Minutes

3. Community Reinvestment Committee – 03/12/2025
    a. February 12, 2025 Meeting Minutes
    b. Grant Applications for Approval
        - Doula/Community Health Workforce Recruitment Grant Program
            - St. Joseph's Medical Center: $350,000
        - General Grants Program
            - Gospel Center Rescue Mission: $537,264
            - Dobbins Transportation: $786,321
            - CalPride: $777,285
        - Capital Projects Grant Program
            - Emergency Food Bank of Stockton: $2,500,000

4. Finance and Investment Committee – 03/17/2025
    a. February 19, 2025 Meeting Minutes
    b. Zelis Healthcare, LLC Contract
    c. ZeOmega, Inc., Contract for PQI

ACTION: With no questions or comments, the motion was made (Commissioner Canepa), seconded (Commissioner Krishnaswamy) and unanimous to approve consent items #2 and #4 as presented (8/0).

ACTION: With no questions or comments, Commissioner Canepa made the motion, seconded by Commissioner Sorensen, to approve item #3, Grant Applications, with abstention by Commissioner Herrera on the Doula/Community Health Workforce Recruitment Grant Program – St. Joseph's Medical Center in the amount of $350,000. The motion was unanimously approved as presented (7/1).

DISCUSSION/ACTION ITEMS

5. January FYTD 2024 Financial Reports

Ms. Tetreault presented for approval the January FYTD 2025 financial reports, highlighting the following:

- Premium Revenue is -$21.6M unfavorable (-$3.58 PMPM) to budget YTD as of January 2025, primarily driven by -$10.0M unfavorable amounts due back to DHCS for risk corridor agreements related to Major Organ Transplant (MOT) and Enhancement Care Management (ECM), -$2.6M unfavorable rate variance related to Long-Term Care (LTC) and -$10.4M unfavorable due to volume shortfalls in member months, offset by +$1.4M favorable capitation rates

- Managed care expenses are -$67.4M unfavorable (-$26.43 PMPM) to FYTD budget, primarily attributable to -$80.5M unfavorable variance due to increased utilization and higher cost claims in Institutional services, and -$3.8M unfavorable variance due to increased utilization in behavioral health services, offset by +$7.2M favorable reinsurance recoveries, +$4.1M favorable in other expense related to medical management administrative expense allowed in medical, driven by unfilled positions in Health Equity and Behavioral Health as well as unused consultant dollars and +$7.1M favorable ECM expense due to a difference in accounting treatment. The budget assumed ECM expense at 95% of ECM revenue. while actuals are recorded as contra-revenue, directly reducing revenue instead of increasing expense. Contra-revenue is a result of the risk corridor, and the under-utilization of ECM services compared to expectations during rate setting by DHCS/Mercer

- Net other program revenues and expenses are +$15.9M favorable (+$5.44 PMPM) primarily due to the receipt of CalAIM Incentive Payment Program (IPP) funds. These funds are recorded as earned upon notification from DHCS. These are funds received as a result of achieving metrics outlined in the program

- Administrative expenses are +$8.1M favorable (+$2.54 PMPM) to budget primarily due to lower than budgeted personnel costs of +$1.2M, consulting expenses of +$3.4M mainly related to projects delayed for DSNP, and subscription expenses of +$2.3M mainly related to healthcare data management and healthcare productivity automation software. While favorability in personnel costs is likely permanent, favorability in consulting and subscription expenses is expected to be temporary

- Prior period adjustments of -$23.5M unfavorable (-$8.04 PMPM) are primarily driven by -$12.1M unfavorable capitation rate adjustments (net of a recent favorable risk factor adjustment) for CY2023 and CY2024 and -$21.3M unfavorable changes in IBNR estimates, offset by +$9.7M favorable reinsurance recoveries related to finalized claims exceeding initial estimates

Upon reviewing Ms. Tetreault's report, the following questions were raised by Commissioner Canepa: How is the total member months projected? What is unknown rate and how does this happen? Ms. Tetreault responded that member months are the sum of membership each month for the fiscal year. Regarding the unknown rate, DHCS provides the plan with a draft rate, which we use to make estimates. Once updated rates are received, we update our revenue accordingly. For CY 2024, it was unusual that DHCS retroactively decreased the rate without prior notice. When the final amendment was issued, the adjustment was applied retroactively to 1/1/2023 which was the prior period.

Ms. Tetreault also noted that the Community Reinvestment Committee budgeted funds for a third of the amount each fiscal year and we have yet to spend all the funds over the period; funds are also being delayed with DHCS's reimbursements on some of the programs.

ACTION: With no further questions or comments, the motion was made (Commissioner Imperial) seconded (Commissioner Sorensen) and unanimous to approve the January FY 2025 financial report as presented (8/0).

6. QIHEC Committee Update – 03/19/2025

Dr. Lakshmi Dhanvanthari, CMO submitted for approval the QIHEC Committee meeting report for 03/19/2025, highlighting the following committee meetings, work plans, program descriptions, policies updates and reports that were reviewed and approved:

QIHEOC Report – 02/13/2025

- Facility Site Reviews, Medical Record Reviews, and Physical Accessibility Reviews for FY 2025 Q2

There were 103 total site audits in FY24-25 Q 1&2

- 18 Facility site Reviews (FSRs)
- 39 Medical Record Reviews (MRRs)
- 46 Physical Accessibility Review Survey (PARS)

  - DHCS guidelines requiring a separate MRR for each provider/practitioner with his/her own panel of members assigned and the new requirements to complete PARS for high-volume specialists, ancillary providers and Community Based Adult Services resulted in an increase of both audits

- Geographic Access - Network adequacy analysis was conducted. All geographic access was met for PCP, Specialists, Hospitals, and Mental Health Providers except for one zip code where the Health Plan approval for alternative access to PCPs

- Language Access
  - Network adequacy analysis was conducted. All geographic access was met for PCP, Specialists, Hospitals, and Mental Health Providers except for one zip code where the Health Plan approval for alternative access to PCPs

Member Services- Telephone Access Report FY 2025, Quarter 2

Call Category	Result	Goal	Met Y/N
Abandonment	37.78%	<5.00%	N
Service Level	10.24%	80.00%	N
Average Speed of Answer	11:29	<30 seconds	N

Barriers: Recruitment, staff retention, a high number of employee leaves and a higher call volume.
Actions: Added 15 new Customer Service Representatives, Trainings conducted, and processes streamlined.

Member Call Quality Report

Standard	Result	Goal	Met Y/N
Interpreter Services	97.83%	90.00%	Y
Transportation	100.00%	90.00%	Y
Out of Network Services	95.56%	90.00%	Y
Balance Billing	98.67%	90.00%	Y
EOC and Directory	95.33%	90.00%	Y
Courtesy and Respect	97.78%	90.00%	Y
Regulatory	96.54%	90.00%	Y

Barriers: None, Consistency in Quality of calls maintained.
Actions: Continue monitoring and training to improve consistency and enhance recruitment retention plans.

Audit and Oversight Committee Summary – 03/06/2025

- 2025 Audit Work Plan was developed with an overall goal to meet or exceed audit goals for the six (6) designated key focus areas: Delegated Third-Parties, Non-Traditional Providers, Internal Clinical Operations, Internal Non-Clinical Operations, Vendor Oversight, and Operational Monitoring

- A Readiness Assessment was conducted for:
  - Enhanced Care Management Professional Corporation. The entity received an audit score of one hundred percent (100%) for ECM. AOC approved the recommendation to delegate ECM services
  - Cal Interpreting & Translations (CIT). The entity received a ninety-seven percent (97%) for HIPAA with one (1) deficiency, seventy-seven (77%) for IS with fifteen (15) deficiencies, and one hundred (100%) score for FWA. Health Plan approved delegation of interpreter services on the condition that A&O would ensure CAP remediation for the sixteen (16) deficiencies identified

HPSJ Pharmacy & Therapeutics Committee – 03/06/2025

Policy	Description	Summary
Endocrine Disorders	Thyroid Disorders	Our criteria will now have an exception to requiring systemic corticosteroids in patients with significant proptosis or diplopia.
Endocrine Disorders	Testosterone	Updated this policy is to add and realign coverage criteria to be consistent with the Medi-Cal provider manual for testosterone formulations that did not previously have criteria
Neurological Disorders	Multiple Sclerosis	Vumerity as an alternative option in all multiple sclerosis coverage criteria that currently require a trial of Tecfidera. add Ocrevus Zunovo

Health Plan of San Joaquin Policy PH04 Pharmacy and Therapeutics Committee defines the Health Plan of San Joaquin (HPSJ) Pharmacy and Therapeutics Committee (P&T) members, duties, tasks, and meeting agendas. The Health Plan of San Joaquin (HPSJ) Pharmacy and Therapeutics Committee (P&T) is responsible for providing input on pharmaceutical management procedures and for developing, managing, updating, and administering the Drug Formulary System for HPSJ. The P&T Committee is responsible for ensuring HPSJ's members receive high quality, cost-effective, safe, and efficacious medication therapy.

Upon review of Dr. Lakshmi's presentation, the following questions were raised by Commissioners:

Q: Commissioner Canepa – For language access, how do you determine the languages?
A: Dr. Lakshmi – The language access is based on the number of providers that provide services for the specific language relative to the member demographics under those languages to ensure members have access to the providers that can meet their language needs. In addition, we also provide interpretation services at the point of contact.

Q: Commissioner Sorensen – For member call quality, what are the call volume and what is the percentage of those calls? If we don't have staff available, we do utilize interpreter?
A: Ms. Granados - 1500-2000 per month based on call logging. The first week of the month shows higher call volumes based on member eligibility. Our customer service representatives also speak other languages. We do utilize interpreters as needed.

Q: Do we test calls with secret shoppers?
A: Ms. Granados– Yes. We utilize secret shopper as well as audit processes to include note review on actual calls. DHCS during the audit also requests for recordings of calls.

ACTION: With no additional questions or comments, a motion was made (Commissioner Canepa) and seconded (Commissioner Krishnaswamy),l to approve the QIHEC Committee Report for 03/192025 as presented (8/0).

Dr. Lakshmi presented for approval the Peer Review and Credentialing Committee report for March 6, 2025, highlighting the following:

- Total Credentialed/Recredentialed
    - Direct Contracted Providers: 173
    - Initial Credentialed for 3 years = 81
    - Initial Credentialed for 1 year = 1
    - Recredentialed for 1 Year = 4
    - Recredentialed for 3 Years = 72
    - Clean File Initial Credentialing Sign Off Approval by Dr. Lakshmi: 15
    - Clean File Recredentialing Sign Off Approval by Dr. Lakshmi: 0
    - Termination – Involuntary = 0

ACTION: With no additional questions or comments, a motion was made (Commissioner Canepa) and seconded (Commissioner Krishnaswamy), with one abstention (Commissioner Herrera) to approve the Peer Review and Credentialing Committee report for March 6, 2025 as presented (7/1).

INFORMATION ITEMS

7. CEO Update

Lizeth Granados, CEO, provided an update on the following activities:

Federal Healthcare Policy Landscape

Centers for Medicare & Medicaid Services (CMS) rescinded previous guidance on addressing the Health-Related Social Needs (HRSNs) of enrollees

- Previous guidance encouraged the use of rule waivers and other mechanisms that enable state Medicaid programs to address the social drivers of health
- Medicaid waivers give states flexibilities to deviate from federal rules to enable innovation, expand coverage, or tailor services while still receiving federal funding

Through a rule waiver, the CalAIM initiative was federally approved to offer Community Supports to address the HRSNs of Medicaid enrollees in managed care

- Under the previous framework, services like case management for housing, utility assistance, sobering centers, medically tailored meals, home accessibility modifications, and similar options were deemed allowable

CMS will begin to assess HRSN service applications on a case-by-case basis, without relying on the prior framework

- This change does not affect the validity of existing state waivers or approvals
- However, states may encounter challenges as waivers expire and federal reapproval is required to maintain services addressing HRSNs at current levels

Congress recently approved a spending plan with significant implications for Medicaid

- House Energy and Commerce Committee – which oversees Medicaid spending – is tasked with reducing the federal deficit by $880 billion over the next decade

While the spending plan does not explicitly mention cuts to Medicaid, there are concerns that proposed reductions could impact those who rely on the safety net

- A nonpartisan Congressional Budget Office report indicates that cuts to Medicaid may be necessary to meet deficit reduction goals expressed in the spending plan

- Some Members of Congress argue that cuts could be achieved without reducing benefits by focusing on eliminating waste and fraud

Medicaid represents around 8.6% of the federal budget

- When Medicare is excluded, Medicaid makes up 93% of the funding under the House Energy and Commerce Committee's jurisdiction, making it a key target for cuts

Health Plan is closely monitoring these developments and are advocating for our members.

In-Home Supportive Services (IHSS) Pilot Program

Health Plan partnered to launch an IHSS pilot program in partnership with St. Mary's, Community Medical Centers (CMC), and a Community Supports provider that offers Personal Care and Homemaker Services. The IHSS pilot will help address the growing needs of aging and disabled homeless individuals who struggle to manage basic self-care tasks. Many residents at St. Mary's face physical limitations that prevent them from dressing, showering, or completing other activities of daily living. Through the IHSS pilot, we can partner to directly provide IHSS and Personal Care services within the shelter setting.

CMC will handle the required medical assessments and certification for IHSS eligibility, while St. Mary's will connect individuals to medical and Personal Care services. These services will help some of the most vulnerable Health Plan members maintain activities of daily living and promote their overall wellbeing.

Updates on program progress will be provided in the next several months.

8. Member Utilization Overview

Dr. Lakshmi presented an overview of member utilization trends, highlighting trends for:

- Membership
- Primary Care Visit
- Specialist Visits
- Non-OB Hospital Admissions
- OB Hospital Admissions
- Major Organ Transplant
- Inpatient Admissions for Infectious Conditions and Non-Infectious Conditions
- Membership for Female Members between the Age of 15-49 Years
- OB Visits

Dr. Lakshmi noted, over time the utilization has been increasing and based on data from 2019. Membership consistently increased from 2019-2023 based on redetermination and then declined in 2024. Although membership decreased, member utilization of all types had increased

Based on D. Lakshmi's report, extensive discussions were held with the following questions raised:

Q: Commissioner Canepa - When we brought on new counties, is it two tiered?
A: Dr. Lakshmi - The two counties are brand new in 2024 and were not included in the data trends.

Q: Commissioner Valentine: Are we anticipating specialists for pain treatment to show an uptick in access based on prescribing pain medications?
A: Dr. Lakshmi - It's multipronged, we had access issues and did not have much pain providers in the network, but this has been addressed by our Networks team, they have contracted with more pain

providers. Various conditions are referred to pain medication, which includes MAT (medication assisted treatment) for opioid use, showing an increase in visits.

Q: Commissioner Canepa - Why is there a change in oncology from 23 to 24?
A: Dr. Lakshmi – An oncologist provider passed away and all his patients were transferred to other providers who are hematology -oncology providers, so you can see a big increase in utilization under these providers.

Q: Herrera - Do we track dialysis patient data?
A: Dr. Lakshmi - Yes, we do but is not included in this data.

Q: Sorensen - Are there incentives for providers?
A: Yes…we monitor the percentages of providers to members that they see. It has increased by at least 10%. There are various types of grants that we offer, and we continue to work on bringing in more providers. We also provide provider incentives based on their quality performance.

Q: Commissioner Valentine – Will some of the incentives and HEDIS measures change based on federal government ordinance?
A: Dr. Lakshmi - Yes, it will likely impact if less people are on Medicaid. This could result in less providers with less visits and decreased HEDIS rates.

9. COO Update

Liz Le, COO provided an update on the Provider Recruitment Grant and D-SNP activities, highlighting the following:

Provider Recruitment Grant

In 2023, Health Plan of San Joaquin (HPSJ)/Mountain Valley Health Plan (MVHP) successfully launched the Provider Recruitment Grant Program intended:

- To support organizations with their provider recruitment efforts in San Joaquin, Stanislaus, El Dorado and Alpine counties
- Increase access to hard-to-recruit specialties such as endocrinologists, neurologists, psychiatrists
- Expand HPSJ/MVHP's contracted provider network by adding brand new providers to the network

As of the end of 2024, the organizations have recruited a total of 29 providers in a variety of specialties that include: Family Medicine, Pediatrics, Internal Medicine, Primary Care Physician-Assistants, and OBGYN. The Health Plan has funded over $400,000. Organizations that are part of the Provider Recruitment Program include:

- Community Medical Centers (CMC): Recruited 10 providers
- Golden Valley Health Centers (GVHC): Recruited 7 providers
- El Dorado Community Health Centers, Inc (EDCHC): Recruited 12 providers

Based on the success of the program, the Health Plan has enhanced the recruitment program by increasing the funding per specialty and shortening the timeframe of the grant from a 3-year to a 2-year program for:

- Hard-to-recruit: from $80k to $150k
- Other specialties: from $60k to $125k
- PCP MD/DO: from $40k to $100k

- Non-clinical providers (e.g., PA/NP/MFT/LCSW, Clinical Pharmacist): from $20k to $50k

Upon Ms. Le's update, Commissioner Sorensen asked if the grants would pay for recruitment. Ms. Le responded that, it would pay for recruitment based on a two-year period. The plan also takes every opportunity in the community to communicate about the program, as well as posting on our website.

D-SNP Update

D-SNP Application

- D-SNPs are required to submit a CMS application to outline its structure and framework on how it will provide care to its members
- The application consists of various sections, including but not limited to management, experience, administration, compliance, fiscal soundness, contracts, provider network, model of care, and various attestations
- Cross functional teams worked to complete all elements, and the application was submitted on February 10, 2025
- CMS has completed the review of two out of three application sections and found no deficiencies. Health Plan will continue the review with CMS and share final notices in future meetings

Current Focus

- Executed contract with MedImpact to manage pharmacy benefits for the D-SNP line of business. Project teams are now focused on vendor implementation and efforts to offer pharmacy services upon go live
- In addition to our submission to CMS, we also initiated readiness efforts to assess Compliance with state contract requirements for D-SNP
- Initiated training efforts to develop required training for internal staff, providers, and stakeholders
- To prepare for our planned January 2026 launch, health plan is developing outreach and engagement strategies. Further information will be forthcoming as we obtain required approvals and as per timing of Medicare marketing guidance

Upon Ms. Le's update, Commissioner Canepa asked for clarification on D-SNP program qualification. Ms. Le reported that the applicant will have to be qualified for both Medicare and Medi-Cal in order to be qualified under D-SNP.

10. Quarterly CIO Update

Victoria Worthy, CIO provided an update on the company's security metrics, program and projects (aside from Audits and Oversight, these scorecards are done internally), with detailed information in the meeting PPT packet:

- Security Program Maturity – Overall Grade = B
- Vulnerability Management – Overall Grade = A
- M365 Security Configuration - Overall Grade = B
- Phish Testing Trends – Overall Grade = A
- Security Monitoring and Incident Response = A

The Information Security Team has streamlined the Policy lifecycle Management process to ensure ongoing review and maintenance of policies, procedures, program plans, and Desk Level Procedures to align to regulatory requirements. Per regulatory requirements in the 2024 Contract, Health Plan must conduct annual Penetration Testing. The test helps to validate the effectiveness of

our security control coverage and address identified gaps which will strengthen our posture and reduce risk to cyberattacks. The project has kicked off and is in progress to ensure compliance.

Upon review of Ms. Worthy's report, Commissioner Imperial asked if there was a time when the plan reports on totality regulatory reporting. Ms. Worthy responded that the plan does not report to the Health Commission, but management does do extensive regulatory reporting, which could be included in the quarterly reporting, especially on security.

11. Legislative Update

Brandon Roberts, Manager of Government and Public Affairs, provided an update on the current Medi-Cal Budget Shortfall, Governors May Revision to the Budget and Priority Bills:

Medi-Cal Budget Shortfall

The Medi-Cal program had to borrow $3.44 billion from the state's general fund to cover a growing shortfall in health expenses.

- The California Department of Finance explained to lawmakers that the loan was necessary to make payments to Medi-Cal providers
- The Governor asked lawmakers for another $2.8 billion to cover Medi-Cal costs

According to DHCS, Medi-Cal spending has grown due to higher drug costs, more senior enrollments, coverage for undocumented immigrants, and an increase in overall eligibility.

- Many other states are experiencing Medicaid shortfalls, often caused by lower-than-expected COVID-related redeterminations, the expiration of pandemic-era funding, rising long-term care costs, rate increases, and efforts to expand services or eligibility

As the Medi-Cal program faces these challenges, legislative leaders will continue to seek a balance between providing universal coverage and managing escalating healthcare costs.

- Impending federal budget cuts to Medicaid will put more pressure on state lawmakers

Upon Mr. Roberts' update, extensive discussions were held regarding the budget shortfall with the following questions raised:

Q: Supervisor Canepa - When we are in the business of taking care of patient health, what is included in the waiver added benefits?
A: Ms. Granados – The waiver added benefits are preventive services intended to improve health and reduce hospitalizations or more costly services. By offering these services upfront, we can help members manage their health and avoid emergency care. Utilization of these benefits has been relatively low in some counties compared to others, such as those in Southern California. We are monitoring whether the program will be modified moving forward.

Q: Commissioner Imperial – Will the state be modifying eligibility or rolling back certain benefits in response to the Medi-Cal budget shortfall?
A: Ms. Granados - At this time, it is too early to determine which services, if any, may be reduced due to budget shortfalls. We also do not yet know whether changes to eligibility will be made, although there appears to be interest among lawmakers in preserving current eligibility standards. The state has not yet identified specific areas for cuts.
A: Mr. Hendrix: Some benefits and eligibility standards could be more easily reversed than others, depending on statutory requirements that necessitate an act of the Legislature. Many Medi-Cal benefits and eligibility provisions are established in statute and cannot be unilaterally undone by the Department of Health Care Services, the Governor, the Department of Finance, or other executive agencies to quickly address the budget shortfall.

A: Ms. Granados - Based on the latest reports, there have been no changes impacting our operations, and the state has not issued any new directives in response to the budget shortfall. However, we are monitoring any proposed changes to reimbursement rates, eligibility, or benefits in the Medi-Cal program, as these are the primary levers the state may use to reduce costs.
C: Chair Valentine – It is also possible that funding could be redirected from one state program to another to address the shortfall. Some budget pressures are related to changes to behavioral health plans and intergovernmental transfer programs; the current behavioral health denial rate is at 47%.

Q: Commissioner Imperial - What is the status of Proposition 35 and targeted rate increases for Medi-Cal providers?
A: Ms. Granados - Proposition 35 stakeholder advisory committee, which will guide the state's use of Managed Care Organization tax revenues, will meet for the first time on April 14th. The committee will inform how funds are allocated and ensure the goals of Proposition 35 are met, which include rate increases for Medi-Cal providers. More information will follow the committee's first meeting

May Revision to the Governor's Budget

The May Revision to the Governor's Budget will be released on or before May 14th.

- The May Revision includes updated estimates of state revenues and expenditures
- It also includes adjustments to the Governor's proposed spending plan, reflecting revised assumptions and economic conditions

After the May Revision is released, the Legislature engages in budget negotiations to reconcile the Governor's proposal with legislative priorities. The Legislature must pass the Budget Act by June 15th.

As lawmakers address the Medi-Cal shortfall, Health Plan and our trade associations are advocating to ensure that Managed Care Organization tax revenues are used effectively.

- Targeted rate increases
- Flexibilities for Federally Qualified Health Centers
- Investing in Clinical Workforce Development
- Ensuring MCO Tax Protections and Funding Mechanisms

CHAIR'S REPORT

12. No reports were forthcoming.

COMMISSIONER COMMENTS

Commissioner Canepa reported that the VA Offices are breaking ground on new programs.

Another exciting news is discussion on a new Medical School to be located in San Joaquin County.

ADJOURNMENT

Chair Valentine adjourned the meeting at 7:10p.m. The next regular meeting of the Health Commission is scheduled for April 26, 2025.