MINUTES OF THE MEETING OF THE SAN JOAQUIN COUNTY HEALTH COMMISSION

April 30, 2025
Health Plan of San Joaquin – Community Room

COMMISSION MEMBERS PRESENT:

Genevieve Valentine, Chair
Brian Jensen, Vice-Chair
Julienne Angeles, MD
Paul Canepa
Joy Farley, MD
Ruben Imperial
Jay Krishnaswamy
Sandra Regalo
Michael Sorensen
Terry Withrow
Terry Woodrow

COMMISSION MEMBERS ABSENT:

Jim Diel
Michael Herrera, DO

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 5:03 p.m.

PRESENTATIONS/INTRODUCTIONS

1. Chair Valentine welcomed new Commissioners Drs. Julienne Angeles and Joy Farley to the Health Commission.

   Commissioner Angeles occupies the SJC HCS Director Nominee seat and is from San Joaquin General Hospital (SJGH) as the Employee and Occupational Health Services Primary Care and Respiratory Virus Surveillance.

   Commissioner Farley occupies the Stanislaus seat, nominated by Stanislaus Medical Society. She is the Medical Director Refugee Health Clinic Physician for Stanislaus County Health Services Agency.

PUBLIC COMMENTS

No public comments were forthcoming.

CONSENT CALENDAR

Chair Valentine presented five consent items for approval:

2. March 26, 2025 Health Commission Meeting Minutes

3. Community Reinvestment Committee – 04/09/2025
   a. March 12, 2025 Meeting Minutes
   b. Grant Applications
      - Capital Projects Grant Program
        - Modesto City Schools: $2,500,000
        - Gospel Center Rescue Mission (Stockton): $80,000
      - Standard Data Sharing Health Information Exchange (HIE) & Non-HIE Grant Program
        - Dr. Dubey DBA All for Kids: $45,000

4. Community Advisory Committee – 04/10/2025
   a. February 13, 2025 Meeting Minutes
   b. SJC Community Health Needs Assessment (CHNA)
   c. NCQA Health Equity Accreditation
   d. Stanislaus Community Health Needs Assessment (CHNA)
   e. STD Coalition Focus Group

5. Finance and Investment Committee – 04/23/2025
   a. March 17, 2025 Meeting Minutes
   b. Investment Portfolio Performance Update
   c. T & S West Contract – French Camp Lobby Renovation

6. Human resources Committee – 04/30/2025
   a. February 26, 2025 Meeting Minutes

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

Commissioner Withrow joined the meeting at this time.

DISCUSSION/ACTION ITEMS

7. February FYTD 2025 Financial Reports

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

- Premium Revenue is -$24.0M unfavorable (-$3.05 PMPM) to budget YTD as of February 2025, primarily driven by -$13.5M unfavorable e risk corridor agreements for the current fiscal year, of which -$10.1M and -$3.4M are attributable to Enhanced Care Management (ECM) and Major Organ Transplant (MOT), respectively. Additional drivers include -$1.4M unfavorable rate variance related to Long-Term Care (LTC) and -$13.9M unfavorable due to volume shortfalls in member months, offset by +$4.8M favorable capitation rates.

- Managed care expenses are -$115.2M unfavorable (-$38.19 PMPM) to FYTD budget, primarily attributable to -$108.7M unfavorable variance related to institutional and -$24.4M unfavorable related to professional variance due to increased utilization and higher cost claims. These unfavorable impacts are offset by +$8.2M favorable reinsurance recoveries, +$4.1M favorable in other expenses related to medical management administrative expense allowed in medical, driven by unfilled positions in Health Equity and Behavioral Health and unused consultant dollars, as well as +$6.9M 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 rather than 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 +$16.5M favorable (+$4.95 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 +$11.0M favorable (+$3.04 PMPM) to budget primarily due to lower than budgeted personnel costs of +$2.8M, consulting expenses of +$4.1M mainly related to projects delayed for DSNP, and subscription expenses of +$2.5M 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 -$25.7M unfavorable (-$7.70 PMPM) are primarily driven by a -$6.4M unfavorable rate adjustments (net of a recent favorable risk factor adjustment) for CY2023 and CY2024 and -$22.6M unfavorable changes in IBNR estimates, -$6.5M unfavorable related to estimated CY2024 liability for DHCS Community Reinvestment obligations, offset by +$9.8M favorable reinsurance recoveries related to finalized claims exceeding initial estimates

Upon reviewing Ms. Tetreault's report, the following questions were raised by Commissioners:

Q: Canepa - Where do we want to be with TNE and MLR?
A: Tetreault - Based on budget, we would like to be at 6.2% for Admin and at 90% MLR. Would like MLR to maintain at low 90%, as 99% is extremely high, which means we have no margins to move funds to other expenses – only offset would be investment income. We are seeing much higher trends from what we've seen in the past – highest claims were processed in November. Staff are working with all departments in terms of reduction of costs. As for TNE there is a Commission resolution targeting a minimum 450% of the required level of TNE.

Q: Canepa – What is the investment net income?
A: Tetrault – Current investment net income is $41.8M and is $18M favorable to budget.

Q: Imperial - What is the status of our investments?
A: Tetreault - We are in safe investments, with positive favorability. There is very little volatility with a 5% return. The investment advisor also presented performance at this month's F & I meeting, noting positive performance.

Q: Jensen - Why is premium revenue low?
A: Granados + Tetreault - Member months are low due to membership redetermination and risk corridors. We are anticipating a decline in membership based on the budget that will be presented next month. Pre-pandemic we were at 435k members, this budget will bring us up between 455k-460k members.

ACTION: With no further questions or comments, the motion was made (Commissioner Imperial) seconded (Commissioner Krishnaswamy) and unanimous to approve the February FY 2025 financial report as presented (11/0).

INFORMATION ITEMS

8. CEO Update

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

Proposition 35 – Managed Care Organization (MCO) Tax Funding

A recent news article claimed the Newsom administration missed a critical federal filing deadline related to Proposition 35, potentially costing the state millions in federal funds. The Department of Health Care Services (DHCS) has refuted these claims, indicating that the state has already received full federal approval for all MCO tax revenue.

California's MCO tax was first approved by the Centers for Medicare and Medicaid Services (CMS) in December 2023 and will expire at the end of 2026 unless renewed. The MCO tax is assessed at $205 per enrollee; with 410,000 members, the total obligation for Health Plans would total $84 million. The state will fully reimburse Health Plan for the taxed amount, with the primary goal of leveraging these funds to draw down additional federal Medicaid funding.

Proposition 35 requires DHCS to consult with a stakeholder advisory committee to guide the use of MCO tax revenues for provider rate increases and other investments in health. The Proposition 35 stakeholder advisory committee met for the first time on April 14th. Comprised of representatives from across the healthcare industry, the committee will inform how funds are allocated and ensure that the goals of Proposition 35 are met.

DHCS is implementing Proposition 35 in accordance with state and federal requirements, and federal matching funds will be drawn down as eligible expenditures occur.

Chair Valentine asked about the source of the match and whether there are any alternative proposals for local government to provide matching funds if state support is not received. Ms. Granados responded that the match is expected to come from the federal government and expressed doubt that local government would be able to contribute. She noted that during the most recent DHCS meeting, officials stated they plan to move forward with implementation of Proposition 35.

Congressional Budget Plans and Implications for Medicaid Spending

The House of Representatives passed a budget resolution on April 10th that was previously approved by the Senate. The spending plan directs the House Energy and Commerce Committee, which oversees Medicaid, to reduce the deficit by $880 billion over the next decade.

While Medicaid cuts are not explicit, the spending plan makes the program a likely target due to its size and its oversight by the committee. The House of Representatives and Senate must now align their separate budget versions through a process called budget reconciliation. Legislation affecting federal spending may pass the Senate with a simple majority, by passing the 60-vote filibuster threshold.

As negotiations continue, the Health Plan is engaging with our representatives in Congress to advocate for our members and provider partners. These meetings will educate Congressmembers on the importance of the Medicaid program in our service area and the far-reaching consequences of funding cuts. We will highlight concerns around reduced services, uncompensated care, hospital closures, worsening workforce shortages, and longer travel times to access care

State Medicaid Waivers

The Centers for Medicare and Medicaid Services (CMS) announced it will no longer approve federal matching funds for Designated State Health Programs (DSHPs). These programs have traditionally used broad interpretations of Section 1115 waivers to receive federal Medicaid funding.

Medicaid waivers give states flexibilities to deviate from federal rules to enable innovation, expand coverage, or tailor services while still receiving federal funding. This policy shift could have impacts on initiatives like the Providing Access and Transforming Health (PATH) CITED program and behavioral health workforce programs funded through BH-CONNECT.

PATH CITED helps Medi-Cal providers expand services, including Enhanced Care Management, Community Supports, and reentry services for formerly incarcerated individuals. While BH-Connect is designed to expand access to community-based care for Medi-Cal members with significant behavioral health needs.

The announcement comes after CMS' March decision to rescind prior guidance encouraging states to address Health-Related Social Needs (HRSNs) through waivers.

The impact is minimal, as California planned for the PATH CITED and BH-CONNECT waivers to expire. The Department of Health Care Services expressed confidence that previously approved HRSN initiatives, such as Community Supports, will be renewed.

Commissioner Imperial asked whether those identified under PATH CITED have been discussed as being at risk for ECM. Ms. Granados responded that no such discussions have taken place; the current focus is on Community Supports. She explained that once a waiver is submitted, it must remain in place for five years. The earliest submission to CMS is expected by mid-2028, after which CMS will determine program approval. From the state's perspective, the program is expected to continue.

9. Adventist Contract Termination

Liz Le, COO provided an update on Adventist contract termination, highlighting the following:

- Notice of Termination
  - Notice of termination received 03/11/2025, termination effective 07/01/2025
  - Impacted contracts:
    - Adventist Health Lodi Memorial – hospital
    - Adventist Health Lodi Memorial Hospital Clinics & Physicians Network – physician
    - Adventist Health Home Care – ancillary group
  - Notice includes request to renegotiate rates

- Notice to Stakeholders
  - Regulators
    - DMHC filing date: 04/17/2025
    - DHCS filing date: 05/02/2025
  - Alternate Hospitals
    - Notification was sent to the following alternate hospitals on 04/14/2025 to assess capacity to support member care
      - San Joaquin General Hospital
      - Doctors Hospital of Manteca
      - St. Joseph's Medical Center
      - Dameron Hospital Association
  - Member letters were mailed on 05/02/2025

- Member Impact
  - Hospital services: 216 members with open authorizations
  - Physician services: 2,193 members
  - Ancillary services: 16 members with open authorizations

- Access to Care
  - Emergency Services - Members can continue to access Adventist Health Lodi Memorial Hospital
  - Inpatient admission
    - Members in the hospital can finish their stays. Letters of Agreement (LOAs) will be established for dates of service following the termination date
    - Transfers to a contracted hospital will be coordinated for members stabilized in the ER and needing admission
    - Elective inpatient services will be transitioned and scheduled at other contracted hospitals
  - Outpatient Services
    - Care will be coordinated for members with open authorizations and in the middle of treatment until completion of care under LOAs between Health Plan and Adventist Health

Ms. Le and Ms. Granados both noted that this is an evergreen contract, which Adventist may terminate at their discretion. Weekly standing meetings are currently being held with Adventist.

10. Bi-Monthly Compliance Update

Betty Clark, Chief Regulatory Affairs and Compliance Office provided an update on audits and presented for approval the 2025 Compliance Program Plan and the 2025 Code of Conduct and Business Ethics, highlighting the following:

2025 Compliance Program Plan

HPSJ/MVHP implements a comprehensive Compliance Program which includes 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 CMS. The Compliance Program incorporates 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:
1) Written Standards
2) Oversight
3) Education & Training
4) Lines of Communication
5) Enforcement and Disciplinary Standards
6) Auditing & Monitoring
7) Response & Remediation
8) Fraud Prevention Program

Commissioner Sorensen asked under Network Adequacy, if Adventist is no longer a contracted hospital, will this have an impact on the Health Plan. Ms. Clark responded that the Health Plan will have to do the filing, which will be a modification to Network Adequacy.

ACTION: With no questions or comments, the motion was made (Commissioner Canepa), seconded (Commissioner Krishnaswamy) and unanimous to approve the 2025 Compliance Program as presented (11/0).

2025 Code of Conduct and Business Ethics

The Code of Conduct and Business Ethics 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 was provided in March 2025. New employees are assigned this task within 30 days of hire.

ACTION: With no questions or comments, the motion was made (Commissioner Regalo), seconded (Commissioner Sorensen) and unanimous to approve the 2025 Code of Conduct and Business Ethics as presented (11/0).

2024 DHCS Regulatory Audit Update

DHCS conducted an audit in late October/early November 2024 to review HPSJ's activities and documentation from August 1, 2024, through July 31, 2024. DHCS held a meeting with the Health Plan on March 19, 2025 to discuss seven (7) preliminary findings:

- 1 and 2 - HPSJ incorrectly applied prior authorization requirements to family planning, preventive services, and cancer biomarker testing
- 3 - HPSJ did not send adverse benefit determination notices within required timeframes
- 4 - HPSJ did not use the DHCS-issued template for prior authorization denials
- 5 - HPSJ did not apply Medi-Cal Provider Manual criteria to pharmacy services when applicable
- 6 and 7 - HPSJ did not pay all claims for family planning and abortion services within 45 working days of receipt

The Health Plan accepted 5 findings and contested Findings 6 and 7 because applicable regulations and the DHCS Contract state compliance thresholds were less than 100%. DHCS agreed to remove Findings 6 and 7. In the Final Report issued on April 9, 2025; staff is coordinating remediation efforts with business owners.

Commissioners Canepa and Imperial inquired whether the Health Plan will face sanctions for the listed items and whether this is part of the annual audit. Ms. Clark explained that the issues identified are not repeat findings, so sanctions are not expected. With two findings already removed, the remaining issues are not expected to warrant sanctions.

11. Legislative Update

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

Legislative Responses to the Medi-Cal Budget Shortfall

California approved $2.8 billion in emergency funding to sustain Medi-Cal through the 2024-25 Fiscal Year. Governor Newsom signed legislation to approve this funding on April 14th as part of a broader response to the $6.2 billion shortfall in the Medi-Cal budget. In March, the Newsom administration borrowed $3.44 billion, the maximum allowed under state law, from the general fund to make urgent Medi-Cal provider payments.

State Lawmakers Request Audit of the Medi-Cal Budget Following an Emergency Bailout:

- A group of nine California legislators is calling for an urgent audit of the Medi-Cal budget, citing increasing healthcare costs and a lack of transparency from Governor Newsom's administration.
- In a letter to the Joint Legislative Audit Committee (JLAC), lawmakers pointed to financial instability, which triggered two emergency loans totaling $6.2 billion
- The JLAC audit request seeks to determine the root causes of the cost overruns, assess the risk of violating federal Medicaid reimbursement rules, and evaluate whether the program is sustainable

Priority Bill Report – Mandates on Medi-Cal Plans

- Network Adequacy Requirements - SB 530 (Richardson D) – Medi-Cal: time and distance standards. This bill would expand the list of specialists subject to time, distance, and appointment standards to include neurosurgery, orthopedics, surgical oncology, rheumatology, urology, immunology/allergy, podiatry, sleep medicine, and general surgery subspecialties.

- Accuracy of Provider Directories - AB 280 (Aguiar-Curry D) – Health care coverage: provider directories. This bill would require health plans to maintain accurate provider directories and

remove incorrect listings annually. Directories must be 60% accurate by July 1, 2026, with annual benchmarks increasing to 95% by July 1, 2029. Deficient plans would be fined

- Expansion of Services - AB 636 (Ortega D) – Medi-Cal: diapers. This bill would provide that diapers are a covered Medi-Cal benefit for children over three diagnosed with a condition causing incontinence and for individuals under 21 when needed to treat a condition pursuant to the Early and Periodic Screening, Diagnostic, and Treatment standards

CHAIR'S REPORT

Chair Valentine reported that Commissioner Angeles has been appointed to the QIHEC Committee.

Chair Valentine announced the formation of the Ad-Hoc CEO Evaluation Committee, which includes herself and Commissioners Jensen, Krishnaswamy, and Sorensen.

Chair Valentine noted that she is scheduled to be absent from the May Health Commission meeting and that Vice-Chair Jensen will preside in her absence.

COMMISSIONER COMMENTS

No comments were forthcoming.

ADJOURNMENT

Chair Valentine adjourned the meeting at 6:15p.m. The next regular meeting of the Health Commission is scheduled for May 28, 2025.