MINUTES OF THE MEETING OF THE SAN JOAQUIN COUNTY HEALTH COMMISSION

August 27, 2025
Health Plan of San Joaquin – Community Room

COMMISSION MEMBERS PRESENT:

Genevieve Valentine, Chair
Brian Jensen, Vice-Chair
Paul Canepa
Joy Farley, MD
Michael Herrera, DO
Ruben Imperial
Sandra Regalo
Michael Sorensen
Terry Withrow
Terry Woodrow

COMMISSION MEMBERS ABSENT:

Julienne Angeles, MD
Jim Diel
Jay Krishnaswamy

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
Elizabeth Le, Chief Operations Officer
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
Quendrith Macedo, County Counsel
Sue Nakata, Executive Assistant and Clerk of the Health Commission

CALL TO ORDER

In Chair Valentine called the Health Commission meeting to order at 5:06 p.m.

PRESENTATIONS/INTRODUCTIONS

Chair Valentine welcomed Quendrith "Quenny" Macedo, County Counsel; Ms. Macedo replaced Kirin Virk as counsel for the Health Commission.

PUBLIC COMMENTS

No public comments were forthcoming.

CONSENT CALENDAR

Chair Valentine presented six consent items for approval:

1. June 25, 2025 Health Commission Meeting Minutes

ACTION: With no questions or comments, the motion was made (Vice-Chair Jensen), seconded (Commissioner Canepa) and unanimous to approve consent item 1 as presented (11/0).

2. Community Reinvestment Committee – 07/09/2025
   a. June 11, 2025 Meeting Minutes
   b. Grant Applications Approval Request
      i. General Grant Program
         - Aria University School of Medicine: $2,000,000
         - Adventist Health: $1,000,000
      ii. Standard Data Sharing Health Information Exchange (HIE) & Non-HIE Grant Program
         - Turning Point: $10,000
         - El Dorado Community Health Centers: $45,000

At this time, due to conflict of interest with Aria University School of Medicine, Chair Valentine, Commissioners Regalo and Canepa recused themselves from the meeting.

ACTION: With no questions or comments, Vice-Chair Jensen moved to approve the General Grant Program – Aria University School of Medicine for $2,000,000. The motion was seconded by Commissioner Sorensen and unanimously approved (7/3).

3. Community Advisory Committee – 08/07/2025
   a. June 12, 2025 Meeting Minutes
   b. GA Foods Overview
   c. Community Reinvestment Program
   d. Office Staff Survey Response

4. Community Reinvestment Committee – 08/13/2025
   a. July 9, 2025 Meeting Minutes
   b. Grant Application Approval Request
      i. Standard Data Sharing Health Information Exchange (HIE) & Non-HIE Grant Program
         - Turning Pont: $30,000

5. Finance and Investment Committee – 08/20/2025
   a. June 18, 2025 Meeting Minutes
   b. Investment Portfolio Annual Performance
   c. Propio LS, LLC (Akorbi, LLC)Contract
   d. Inovalon, Inc. Contract
   e. Medical Reviewer Consultant Contracts
      i. Kabra Satish, MD
      ii. Vijay P. Khatri, MBChB, FACS, MBA

6. Human Resources Committee – 08/27/2025
   a. June 25, 2025 Meeting Minutes

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

DISCUSSION/ACTION ITEMS

7. May and June FY 2025 Financial Reports

Ms. Tetreault presented for approval the May and June FYTD 2025 financial reports, highlighting the following:

- Premium Revenue is -$47.6M unfavorable (-$3.50 PMPM) to FYTD budget as of June 2025.This is primarily driven by -$18.4M unfavorable risk corridor agreements for the current fiscal year, of which -$15.2M is attributable to Enhanced Care Management (ECM) and -$3.2M is attributable to Major Organ Transplant (MOT) and -$35.3M unfavorable due to volume shortfalls in member months, offset by +$6.1M favorable capitation rates

- Other Medical Revenue and Expense consists of DHCS-Directed Payments. These payments are established by DHCS to support provider participation, network adequacy, access to care, and quality improvement across California's Medi-Cal delivery system. DHCS requires Managed Care Plans (MCPs) to distribute these payments to eligible providers. The programs are accounted for on a gross basis, with revenue and corresponding expense recognized in the same reporting period. Because amounts received are fully disbursed in accordance with DHCS directives, these amounts do not impact Health Plan's margin

- Managed care expenses are -$162.3M unfavorable (-$38.03 PMPM) to FYTD budget, primarily attributable to -$150.9M unfavorable variance in institutional expenses, comprised of inpatient, outpatient, hospice and emergency room services, due to increased utilization and higher-cost claims, largely resulting from higher member acuity and more complex care needs driving increased hospitalizations and specialist visits. -$17.1M unfavorable variance in professional, particularly behavioral health services and -$0.9M unfavorable variance in Capitated Services due to an increase in contracted rates associated with Targeted Rate Increases (TRI), a DHCS initiative, effective January 2024, that provides increased rates for primary care, obstetric, and non-specialty mental health services. When creating the current year's budget, Health Plan applied a 7% increase to historical rates. However, actual experience is closer to 14%. Other Medical expenses, composed of medical transportation -$6.9M unfavorable, medical equipment, -$4.3M unfavorable, and community supports -9.7M unfavorable due to increased utilization and +$15.2M favorable primary attributable to medical management administrative expense allowed in medical, driven by unfilled positions in Health Equity and Behavioral Health and unused consultant dollars and the difference in accounting treatment of ECM expense. 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. The unfavorable impacts are further offset by +$12.3M favorable reinsurance recoveries related to finalized claims exceeding initial estimates

- Net other program revenues and expenses are +$15.4M favorable (+$3.07 PMPM) primarily due to the receipt of CalAIM Incentive Payment Program (IPP) and Student Behavioral Health Incentive Program (SBHIP) funds. These are funds received due to achieving metrics outlined in the programs and are recorded as earned upon notification from DHCS

- Administrative expenses are +$12.9M favorable (+$2.22 PMPM) to budget primarily due to lower than budgeted personnel costs of +$2.9M favorable due to unfilled positions, consulting expenses of +$6.7M favorable mainly related to projects delayed for DSNP, and licenses and subscription expenses of +$3.3 favorable related to healthcare data management and healthcare productivity automation software

- Prior period adjustments of -$13.8M unfavorable (-$2.77 PMPM) are primarily driven by -$21.2M unfavorable net changes in IBNR estimates, -$6.8M unfavorable revenue adjustments (net of favorable risk factor adjustments) for Calendar Years 2022 through 2024, -$1.9M unfavorable community supports expenses, and -$1.2M unfavorable community reinvestments for CY2024 offset by +$6.3M favorable SBHIP revenue related to prior program years, +$9.8M favorable reinsurance recoveries related to finalized claims exceeding initial estimates and +$1.2M favorable revenue related to administering the DHCS Voluntary Rate Range Program, a DHCS financing arrangement involving Intergovernmental Transfers (IGTs).

ACTION: With no questions or comments, a motion to approve the May and June FY 2025 financial report as presented was made by Commissioner Withrow, seconded by Commissioner Regalgo, and was unanimously approved (10/0).

8. QIHEC Committee Meeting – 07/16/2025

Dr. Lakshmi Dhanvanthari, CMO submitted for approval the QIHEC Committee meeting report for 07/16/2025, highlighting the following committee meetings, work plans, program descriptions, policies updates and reports that were reviewed and approved:

- Annual Program Descriptions 2025-2026
  - Quality & Health Equity Transformation Program (QIHETP) Description key changes
    - New leadership positions to support the 2026 Dually Eligible Special Needs Plan (DSNP) and updates to the reporting relationships of staff to align with those roles.
    - Long-Term Care Quality Program
      - Skilled Nursing Facilities have CMS compliant quality programs
      - Annual MCAS metric reporting and quarterly grievance, PQI and review of unanticipated discharges
    - Addition of the DSNP Quality Program
      - Provides an overview of the resources, information technology, staffing and reporting structure required to perform DSNP quality improvement
      - Outlines the Model of Care metrics included in the 2025-2026 QIHETP work plan
    - Chronic Condition Improvement Program (CCIP)
      - Population of Focus- D-SNP Latino/a/x members who are diabetic and exhibiting challenges managing their condition
    - Medicare Stars Measures which will be added to the 2025-2026 QIHETP work plan
    - Pharmacy Benefit Management

- Utilization Management Program
  - Added D-SNP program structure, processes and requirements
  - Established a Behavioral Health and Care Coordination triage process
- Case Management and Disease Management Programs
  - The new medical management platform lends itself to better collaboration across teams and tracking of the members progress and status
  - Outlined prevalence data for each condition in the Disease Management Program
  - Added standardized educational tools to support member self-care for the chronic conditions
- Me and My Baby Program
  - The new medical management platform lends itself to better collaboration across teams and tracking of the members progress and status
  - Outlined prevalence data for each condition in the Disease Management Program
  - Added standardized educational tools to support member self-care for the chronic conditions

ACTION: With no questions or comments, a motion was made (Vice-Chair Jensen) and seconded (Commissioner Imperial) to approve the QIHEC Committee Report for 07/16/2025 as presented (10/0).

Peer Review and Credentialing Committee – May 8, 2025

Dr. Dhanvanthari submitted for approval the Peer Review and Credentialing Committee report for July 10, 2025:

- Direct Contracted Providers: 183
  - Initial Credentialed for 3 years = 86
  - Initial Credentialed for 1 year = 1
  - Recredentialed for 1 Year = 1
  - Recredentialed for 3 Years = 24
- Clean File Initial Credentialing Sign Off Approval by CMO: 72
- Clean File Recredentialing Sign Off Approval by CMO: 0
- Termination-Involuntary: 0

ACTION: With no questions or comments, a motion was made (Vice-Chair Jensen) and seconded (Chair Valentine), with abstention by Commissioner Herrea to approve the Peer Review and Credentialing Committee report for July 10, 2025, as presented (9/1).

INFORMATION ITEMS

9. Meketa/MetLife Investment Portfolio Annual Performance

David Sancewich Meketa and Scott Pavlak of MetLife joined the meeting to present on HPSJ's investment portfolio and annual performance, highlighting the following:

Cont.…next page.

Asset Allocation and Performance

Asset Allocation & Performance | As of June 30, 2025

	Market Value ($)	% of Portfolio	Trailing Period Performance 1 Mo (%)	QTD (%)	YTD (%)	1 Yr (%)	3 Yrs (%)	5 Yrs (%)	Inception (%)	Inception Date
Total Fund (Net)	**790,878,552**	**100.00**	**0.61**	**1.27**	**2.81**	**5.82**	**--**	**--**	**5.00**	**Jun-23**
Growth Portfolio (Net)	**617,115,600**	**78.03**	**0.66**	**1.31**	**2.95**	**6.11**	**--**	**--**	**5.18**	**Jun-23**
ICE BofA 1-3 Years U.S. Treasury Index			*0.61*	*1.18*	*2.79*	*5.68*	*--*	*--*	*4.65*	
MetLife STAMP 1-3 Year (Gross)	617,115,600	78.03	0.67	1.33	2.99	6.20	--	--	5.27	Jun-23
MetLife STAMP 1-3 Year (Net)	617,115,600	78.03	0.66	1.31	2.95	6.11	--	--	5.18	Jun-23
ICE BofA 1-3 Years U.S. Treasury Index			*0.61*	*1.18*	*2.79*	*5.68*	*--*	*--*	*4.65*	
Working Capital Portfolio (Net)	**173,762,953**	**21.97**	**0.41**	**1.14**	**2.30**	**4.80**	**--**	**--**	**4.81**	**Jun-24**
ICE BofA U.S. Treasury Index			*0.34*	*1.05*	*2.10*	*4.76*	*--*	*--*	*4.79*	
MetLife Working Capital (Gross)	173,762,953	21.97	0.42	1.16	2.35	4.90	--	--	4.91	Jun-24
MetLife Working Capital (Net)	173,762,953	21.97	0.41	1.14	2.30	4.80	--	--	4.81	Jun-24
ICE BofA U.S. Treasury Index			*0.34*	*1.05*	*2.10*	*4.76*	*--*	*--*	*4.79*	

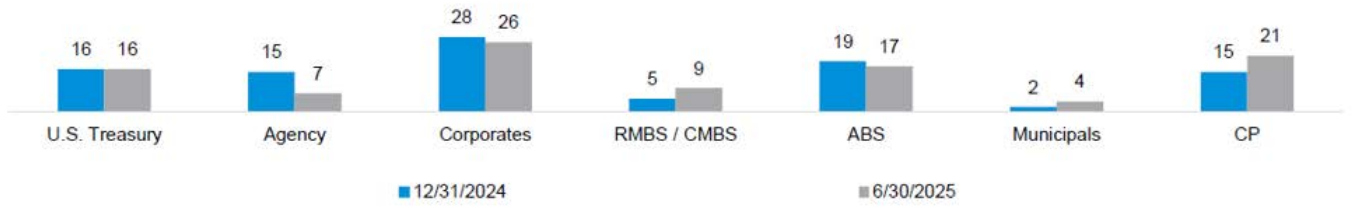
Cash Flow Summary
Quarter Ending June 30, 2025

	Beginning Market Value ($)	Net Cash Flow ($)	Net Investment Change ($)	Ending Market Value ($)
MetLife STAMP 1-3 Year	$609,109,820	-$117,000	$8,122,780	$617,115,600
MetLife Working Capital	$171,801,514	-$33,000	$1,994,438	$173,762,953
Total	**$780,911,334**	**-$150,000**	**$10,117,219**	**$790,878,552**

MetLife Investment Portfolios

Working Capital Portfolio	12/31/24	6/30/25	ICE BofA U.S. Treasury Bill[1] 6/30/25
Yield to Maturity (%)	4.58	4.52	4.30
Duration (Years)	0.38	0.35	0.25
Average Quality	AA	AA	AA
Fixed / Floater or Variable (%)	71 / 29	74 / 26	100 / 0
Market Value	$169,795,186	$173,762,953	N/A

Sector Distribution (% Market Value)

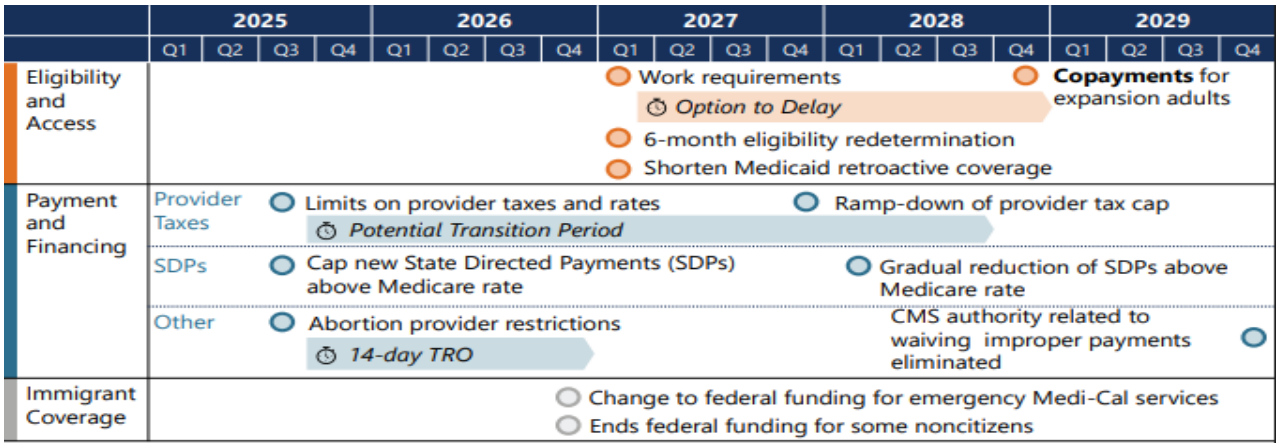


10. <u>CEO Update</u>

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

H.R. 1 – "The One Big Beautiful Bill" – Implementation Timeline and Health Plan's Public Response

On July 4th, President Trump signed H.R. 1 into law a legislative measure containing several provisions with substantial impacts to the Medi-Cal program, highlighting implantation timeline for key provisions:



Following the enactment of H.R. 1, Health Plan is continuing to engage members and provider partners to support coverage retention and ensure the stability of our local healthcare safety-net.

Health Plan issued a press release and published "A Message from Our CEO" on our website, reaffirming our commitment to protecting access to care and emphasizing our provider partnerships. Health Plan also hosted a Medi-Cal roundtable discussion with a local congressional representative, bringing together leaders from 15 hospitals, clinics, and community-based organizations; discussion centered on the implications of H.R. 1, strategies to help Medi-Cal enrollees maintain coverage, and initiatives to strengthen support for safety-net providers.

Upon review of Ms. Granados' update, Chair Valentine also noted that the co-payment will also include all county healthcare services programs., i.e., Behavioral Health.

Commissioner Withrow asked whether the Health Plan is preparing a model in response to potential federal cuts. Ms. Grandos explained that the finance team is developing scenarios based on the federal and state changes outlined in HR.1. She noted that some funds flow from the federal government to the state, and the outcome will depend on how CMS allocates funding to the state and how the state, in turn, distributes funds to the Health Plan.

Commissioner Withrow also asked, regarding membership loss, how many of those members are utilizing services. Ms. Granados responded that this is a concern, as membership dynamics may shift if some individuals choose not to undergo the redetermination process due to its complexity. She added that the Health Plan continues to lose non-utilizers, which affects payout from the state. Ongoing advocacy efforts are addressing these changes at both the state and federal levels.

Commissioner Canepa asked whether the federal government is eliminating immigrant coverage entirely. Ms. Granados explained that while federal coverage will be reduced, California will supplement the difference. No new applicants will be eligible for Medi-Cal, but the state will continue coverage for existing members.

11. Transition of Behavioral Health Services (BHS) to Health Plan

Tracy Hitzeman, Executive Director of Clinical Operations presented on transition of BHS to Health Plan, highlighting the programs impacts on funding changes:

- County may need to be more restrictive in services provision for Medi-Cal beneficiaries
- Through the "No Wrong Door" policy, Health Plan covers BH treatment (SMHS or NSMHS) until care established
- Members likely appropriate to "step-down" to Health Plan receive services like individual/group therapy and/or medication management

Members newly seeking BH services and those established with care will likely be impacted based on latest data:

Members Seeking BH Services	San Joaquin	Stanislaus	El Dorado
Behavioral Health Screening/Intake	2403	1061	64
NSMH level of care	97.9%	98.1%	96.9%
SMH level of care	2.1%	1.9%	3.1%

- 126 individual Psychiatrists and 40 psychiatric provider groups
- 1398 individual BH Clinicians and 176 provider groups

Some considerations are being made with Health Plans' BH network with quarterly county meetings, including SMHS to NSMHS transition planning.

Upon Ms. Hitzeman's update, Commissioner Canepa asked where the school district fits into this program. Ms. Granados explained that BHS in schools vary by district, as there are multiple categories connected to CYBH. Services are provided on-site at schools, and the Health Plan covers the costs; however, the payment process is slow, taking at least six months. Carelon, the state-appointed vendor, manages claims submissions to the Health Plan, and the state reimburses the Health Plan for the payments made to schools.

12. Provider Recruiter Grant Update

Liz Le, COO provided an update on the enhanced Provider Recruiter grant, highlighting the following:

- Goal
  - Kicked off grant program in January 2025
  - Expand HPSJ/MVHP's contracted provider network
  - Access to providers in specialized services for HPSJ/MVHP members

- Grant Qualifications
  - Net new provider to the HPSJ/MVHP network
  - Be a licensed practitioner serving over 25% of HPSJ members
  - Be Medi-Cal enrolled as an Ordering, Referring, and Prescribing (ORP) practitioner
  - Maintain good standing for the entire grant term
  - Separate grant program from the initial Provider Recruitment program

- Program Structure
  - Two (2) year program per applicant
  - Application window open two (2) times a year
  - January 1st – January 31st (Prior year July - December recruits)
  - July 1st – July 31st (Prior January – June recruits)
  - Requires an executed Memorandum of Understanding (MOU) between HPSJ/MVHP and hiring entity, a completed Provider Recruitment Application, and credentialing approvals

- Out of Scope – urgent care centers, ambulatory surgical centers, hospital-based specialties; 100% inpatient specialties; specialists that practice out of area or out of country; specialties where the health plan has not identified an access issue

Hard to recruit specialist MD/DO, which includes: • Plastic surgery, reconstructive surgery • Endocrinology • Rheumatology • Oncology – Hematology • Psychiatry • Neurology • OBGYN	**$150,000 Grant Funding**
All other specialist MD/DO (e.g., GI, Allergy/Immunology, Urology) • Specific specialties noted in MOU	**$125,000 Grant Funding**
PCP MD/DO • Family Medicine • Internal Medicine • Pediatrics	**$100,000 Grant Funding**
PA/NP/MFT/LCSW/LPCC/Substance Abuse Counselor/Behavioral Health Counselor/CNM/Medication Assisted Counselor for SUD (mild to moderate) Clinical Pharmacy Certified Nurse Midwife (new) Licensed Nurse Midwife	**$50,000 Grant Funding**

- July Application Window Summary: 20 Approved Applications were received

Breakdown of Practitioner Types:

Licensed Specialty Physician	**7**
Licensed Primary Care Physician	**2**
Non-Physician Provider	**11**

Breakdown of Specialty Types:

Radiology	**4**
Pulmonology	**1**
Hepato-Pancreatic Biliary Surgeon	**1**
GI	**1**
Nurse Practitioner	**6**
Pediatrics	**1**
Physician Assistant	**4**
BH Counselor	**1**
Family Medicine	**1**

Currently have a total number of 45 new providers that have been added to HPSJ-MVHP's network (January 2025 and July 2025 applicants).

Upon Ms. Le's report, Commissioner Canepa asked how the program works. Ms. Le stated that the Health Plan promotes by educating our provider network to let them know we are offering these grants.

Commissioner Herrera added that this is value added to the community, especially in the OBGYN community, including mid-wives.

13. Bi-Monthly Compliance Update

Betty Clark, Chief Regulatory Affairs and Compliance Officer, provided an update on bi-monthly compliance activities, highlighting the following:

2025 Network Adequacy Validation (NAV)

- Virtual Onsite - August 19, 2025, conducted by DHCS' external quality review organization HSAG
- Scope of Audit: To validate network adequacy reporting accuracy, completeness, and methodology during CY 2024
- Audit Activities
  - Primary source verification (provider/member data)
  - System demos, interviews, data reviews, process observation
- Plan Readiness:
  - Mock audits replicating HSAG review process
  - Key personnel prepared for technical/procedural questions
  - Documentation aligned with DHCS requirements
- Next Step: Pending issuance of HSAG preliminary report

2025 DMHC Financial Exam

- Scope of Exam: Q4 2024 Financials, Claims, Provider Disputes
- Virtual Onsite Dates: June 9 – July 21, 2025
- Exit Conference: July 21, 2025
- Preliminary Findings
  - Non-Compliance: Late filing of Key Personnel changes
- Items of Concern
  - Claims payment accuracy
  - Clarity of provider dispute responses
  - Fidelity bond deductible appropriateness
- Next Steps:
  - Review & address all noted concerns
  - Implement proactive gap-closure measures before next exam
  - Full report to follow upon DMHC's final report issuance

Compliance in the News

- DMHC Enforcement Actions
  - On 7/22/2025, DMHC fined Blue Cross of California Partnership Plan $500,000 for failing to correct deficiencies identified in a prior audit related to processing grievances and appeals
- Office of Civil Rights (OCR) Enforcement Actions
  - OCR announced a settlement with BayCare Health System of $800,000 and an agreement to be monitored for impermissible access to the complainant's e-PHI
- Office of Inspector General (OIG) Settlements
  - All Star Physical Therapy Specialists, Confluent Health, and Confluent Health California agreed to pay $636,000 for allegedly violating the Civil Monetary Penalties law by submitting claims for services by non-enrolled or uncredentialed providers

Upon reviewing Ms. Clark's update, Commissioner Imperial asked whether there are any claim concerns under ECM and community support, noting that providers have received extensive education to ramp up. Ms. Granados responded that it is still a work in progress regarding proper billing. She and Dr. Lakshmi are providing ongoing guidance, including hands-on support and audits, to ensure providers understand their responsibilities and to prevent long-term back-end issues.

14. Legislative Update on Priority Bills

Brandon Roberts, Manager, Government and Public Affairs, presented on the latest Priority Bills, highlighting the following:

The California Legislature returned from Summer Recess on August 18th. Upon returning, lawmakers are moving quickly to consider remaining legislation prior to adjourning the 2025 Legislative Year on September 12th.

Prior Authorization & Utilization Management

- AB 512 (Harabedian) – Health care coverage: prior Authorization. Shortens timelines for prior or concurrent authorization decisions
    - Standard cases: 3 business days for electronic submissions, 5 business days for non-electronic
    - Urgent cases: 24 hours for electronic submissions, 48 hours for non-electronic
- SB 306 (Becker) – Health care coverage: prior authorization. Bans prior authorization for one year on services with a 90%+ approval rate in the previous year and requires plans to post exempt services online
- SB 363 (Wiener) – Health care coverage: independent medical review. Requires health plans to report annual claims and denial or modification data, starting June 1, 2026
    - Plans with 10+ independent medical reviews in a year face penalty if over 50% are overturned

Provider Directories

- AB 280 (Aguiar-Curry) – Health care coverage: provider directories. Requires health plans to annually verify and remove inaccurate directory listings
    - Directories must be 60% accurate by July 1, 2026, increasing to 95% by July 1, 2029
    - Plans face penalties for missing prescribed benchmarks
    - Plans must cover services if enrollees rely on inaccurate directory information and reimburse out-of-network providers
    - Plans must provide in-network provider information upon request by an enrollee, including whether the provider is accepting new patients
- AB 778 (Papan) – Provider directory disclosures. Requires provider directories to include a notice advising enrollees to contact the plan for help finding in-network care and understanding out-of-network rights
    - Plans must acknowledge the request within 1 business day and provide a list of in-network providers accepting new patients within 2 days for urgent requests and 5 days for nonurgent requests

CHAIR'S REPORT

Chair Valentine reported that the BeWell project is progressing, with a groundbreaking event scheduled for September 10th. Directors from the California Health and Human Services Agency and DHCS will be

in attendance. She expressed gratitude to the Health Plan and Health Commission for their partnership and funding of the project.

Chair Valentine also announced that Mr. Roberts' last day with the Health Plan will be September 12th and wished him well in his new position.

COMMISSIONER COMMENTS

No comments were forthcoming.

The Health Commission went into a Closed Session at 6:59 pm.

CLOSED SESSION

15. Closed Session - Trade Secrets
    Welfare and Institutions Code Section 14087.31
    Title: Approval of FY 24-25 Corporate Objectives Outcome

16. Closed Session – Public Employee Performance Evaluation
    Government Code Section 54957
    Title: Chief Executive Officer – Performance Review

The Health Commission came out of Closed Session at 8:07 pm.

ACTION: A motion was made (Commissioner Canepa), seconded (Commissioner Sorensen) and unanimous, to approve the FY 24-25 Corporate Objectives outcome as presented with no incentive payout as the Health Plan did not achieve a budgeted net income (10/0).

ACTION: A motion was made (Commissioner Withrow), seconded (Commissioner Sorensen), and unanimous, to approve Lizeth Granados, CEO overall performance review rating as amended (10/0),

ADJOURNMENT

Chair Genevieve adjourned the meeting at 8:09 p.m. The next regular meeting of the Health Commission is scheduled for September 24, 2025.