MINUTES OF THE MEETING OF THE SAN JOAQUIN COUNTY HEALTH COMMISSION

December 10, 2025
Health Plan of San Joaquin – Community Room

COMMISSION MEMBERS PRESENT:

Genevieve Valentine, Chair
Brian Jensen, Vice-Chair
Julienne Angeles, MD
Joy Farley, MD
Michael Herrera, DO
Jay Krishnaswamy
Sandra Regalo
Michael Sorensen
Terry Woodrow

COMMISSION MEMBERS ABSENT:

Paul Canepa
Jim Diel
Ruben Imperial
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
Elizabeth Le, Chief Operations Officer
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

Chair Valentine called the Health Commission meeting to order at 5:05 p.m.

PRESENTATIONS/INTRODUCTIONS

None.

PUBLIC COMMENTS

Chris Nichols, an HPSJ member and caregiver for a disabled senior member, expressed his frustrations regarding communication with staff about grievances related to mileage reimbursement for transportation.

CONSENT CALENDAR

Chair Valentine presented four consent items for approval:

1. October 29, 2025 Health Commission Meeting Minutes

2. Community Reinvestment Committee – 11/12/2025
   a. October 8, 2025 Meeting Minutes
   b. Grant Applications Approval Request
      i. Capital Projects Grant Program – Marshall Medical Center: $1,407,102

3. QIHEC Committee Meeting Report – 11/19/2025
   a. September 17, 2025 Meeting Minutes
   b. QIHEC Committee Charter Revision Review
   c. D-SNP Training
   d. Last Quarter HEDIS Sprint
   e. Chronic Disease Management Class
   f. PCP Member Referral Notification
   g. Addition of Voluntary Termination and Credentialing & Recredentialing Reports by Provider & Provider Extenders
   h. Policies Review & Approval
      i. Clinical Operations
      ii. Quality Improvement Health Equity
      iii. Grievances and Appeals
      iv. Health Education
   i. Program Evaluations FY 2024-2025
      i. Advice Nurse Program
      ii. Utilization Management
      iii. QIHETP
         - Credentialing & Ongoing Monitoring
         - Customer Service
         - Continuity & Coordination of Care Projects
         - Network Management & Semi-Annual Update
         - Member Experience CAHPS & Behavioral Health
         - HEDIS
      iv. Cultural and Linguistics
   j. Program Work Plan
      i. FY 2025-2026 Cultural & Linguistics and Semi-Annual Update (Q1 & Q2)
   k. Program Description FY 2025-2026
      i. Cultural & Linguistics
      ii. Advice Nurse Program
   l. Subcommittee Reports
      i. Audit & Oversight Committee – 10/7/2025

ii. Audit & Oversight Committee – 11/10/2025

4. Human Resources Committee – 12/10/2025
   a. August 27, 2025 Meeting Minutes
   b. Policy Updates
      i. Base Salary Program (Red Circling section)
      ii. Bilingual Pay Schedule
      iii. Miscellaneous Pay Provisions
      iv. Training and Education

ACTION: With no questions or comments, the motion was made by Commissioner Regalo, seconded by Commissioner Woodrow and the four consent items were unanimously approved as presented (8/0).

DISCUSSION/ACTION ITEMS

5. September FY 2025 Financial Reports

Ms. Tetreault presented for approval the September FY 2025 financial reports, highlighting the following:

- Premium Revenue is -$0.7M unfavorable (-$1.98 PMPM) to budget. This is primarily driven by +$2.7M favorable due to favorable volume in member months, offset by -$3.4M unfavorable Enhanced Care Management (ECM) risk corridor agreements for the current fiscal year

- Other Medical Revenue & 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 -$109.2M unfavorable (-$88.63 PMPM) to FYTD budget, primarily driven by -$50.9M unfavorable in specialist fee-for-service, -$23.7M unfavorable in hospital inpatient, -$19.0M unfavorable in emergency room, -$14.4M unfavorable in hospital outpatient, -$8.4M unfavorable in medical transportation, -$5.2M unfavorable in outpatient mental health, and -$4.3M unfavorable in FQHC fee-for-service. The unfavorable variances are largely attributable to higher utilization due to increased member acuity and more complex care needs, resulting in greater hospitalizations and specialist visits, combined with rising unit costs. These were partially offset by +$10.9M favorable in PCP fee-for-service, and +$4.8M favorable long-term care

- Net Other Program Revenues and Expenses are +$1.0M favorable (+$0.87 PMPM) primarily due to the timing of CalAIM Incentive Payment Program (IPP) and Student Behavioral Health Incentive Program (SBHIP). These are incentives for DHCS-established programs paid to providers for achieving metrics outlined in the programs

- Administrative Expenses are +$2.8M favorable (+$2.38 PMPM) to budget primarily driven by +$1.0M favorable in subscription expenses due to underspent IT projects, +$0.9M favorable in consultant expenses mainly due to timing of utilization of services, +$0.5M favorable in QM license fees primarily related to IT software for DSNP, and +$0.3M favorable in printing and communication to member

- Prior period adjustments of +$43.0M favorable (+$35.44 PMPM) are primarily driven by prior-year IBNR adjustment.

Ms. Tetreault noted that the preliminary financials remain volatile, but she is hopeful that performance will improve by the next calendar year. HPSJ received a draft rate increase of 3.1 percent and requested an additional increase; and received an additional 8.2 percent bringing the final approved rate to 11.3 percent. This is one of the highest rate increases in the state and is expected to contribute favorably to the organization's bottom line beginning in January 2026.

Commissioner Herrera asked whether this increase was a surprise to HPSJ and whether it represents a typical percentage received by health plans. Lizeth Granados, CEO, responded that the rate increase was largely attributable to higher utilization over the past year. The health plan acknowledged this trend and, with assistance from HMA, was able to secure the approved rate increase.

ACTION: With no further questions or comments, the motion was made (Commissioner Herrera) seconded (Commissioner Angeles) and was unanimous to approve the September FY 2025 financial reports as presented (8/0).

6. Edifecs FHIR 57F SOW for CMS Interoperability Contract

Victoria Worthy, CIO, presented for approval the Edifecs FHIR 57F SOW for CMS Interoperability contract. This new statement of work (SOW) with Edifecs, Inc. (Edifecs) will allow Health Plan to become compliant with Centers for Medicare and Medicaid Services (CMS) and Department of Health Care Services (DHCS) specifications for Fast Healthcare Interoperability Resources (FHIR) interoperability under CMS-0057-F (57F) for the existing FHIR gateway. The professional services outlined in the SOW are one-time implementation activities based on the known deliverables outlined by the CMS FHIR regulatory requirements, which must be implemented by January 1, 2027.

Services

The Edifecs SOW is to support the Implementation (turn on)

- Consent Management solution
- Provider Attribution Module
- Provider Access Module
- Patient Access API Module
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The implemented functionality and modules will support the following CMS Regulatory Requirements

- Patient Access API
- Payer to Payer API
- Provider Access API
- Prior Authorization API
- Member Consent Management

ACTION: With no questions or comments, Commissioner Krishnaswamy moved to approve Health Plan to execute the SOW with Edifecs, Inc. for professional services to implement FHIR 57F CMS Interoperability requirements solution in an amount not to exceed $245,345. The motion was seconded by Commissioner Herrera and was unanimously approved (8/0).

7. CEI, GeBBS, Qualmission, and SVAM Contract

Ms. Worthy also presented for approval the CEI, GeBBS, Qualmission, and SVAM contract. She reported that Health Plan has embarked on an operational transformation to elevate its current operational processes so that they can be enhanced to accommodate for current and future needs. With the changes that bring the Health Plan, Clinical Care, the Member, Social Services, and Community Partners together to coordinate care across all forums, it is required to have a more integrated and interoperable infrastructure.

To tackle the complexity of these changes, this is being accomplished through people, processes, and technology outlined by the State of California, Department of Health Care Services (DHCS), though its California Advancing and Innovating Medi-Cal (CalAIM) initiatives and a Health Plan IT Strategic Roadmap.

Health Plan is challenged with the resource demands of the organizational projects required to implement this transformation, the day-to-day operations that need to be maintained, and the technical re-design to accommodate all changes. There is a demand to leverage consulting services of experts in the field to support our internal IT team.

To accommodate DHCS regulatory requirements and Health Plan's operational needs, the recommendation is leveraging consultant services across several firms to implement the critical and complex, specialized systems and new technological infrastructure required to support the organization's needs. Health Plan has entered into separate Master Service Agreements (MSA) with CEI, GeBBS, Qualmission and SVAM, under which Health Plan accesses services from a range of highly qualified analysts, project managers, and various other consultants. These four vendors have a proven track record of delivering the necessary services and have demonstrated the capacity and expertise required to support the technical operational needs of the organization.

Major Initiatives

A. D-SNP Implementation
- System Readiness for existing core systems
- Implementation of Enrollment, Financial, and Sales system
- Implementation of ancillary systems to support D-SNP

B. Rebuild:
- EDI Transaction Reconciliation
- Provider & Member Data Audit
- Enhance Operational Processes and Automation
- System Integration
- Enhanced, Accurate and Timely Provider Payments

C. Medical Management Implementation Phase II-IV
- Requirement to migrate to a new system due to the current system being no longer supported by vendor
- Implement critical medical management modules and processes for Appeals & Grievance, Case Management, Behavioral Health, SDOH, Social Services Referrals, PQI

Financial Impact

Vendor	SOW Amount
CEI	$1,191,000
GeBBS	$610,855
Qualmission	$1,057,000
SVAM	$464,500
Total	$3,323,355
Budget	$4,004,588
Variance	$681,233

Upon review of Ms. Worthy's proposal, Commissioner Krishnaswamy asked about the anticipated timeframe for completing project work. Ms. Worthy explained that for certain projects, the work is reviewed every six months to determine whether continued work is still needed.

ACTION: With no additional questions or comments, Commissioner Krishnaswamy moved to approve Health Plan's execution of separate SOW, under the existing MSAs with CEI, GeBBS, Qualmission, and SVAM, to provide independent consultant services to support the implementation of various technical projects, in a total amount not to exceed $3,323,355.The motion was seconded by Commissioner Regalo and was unanimously approved (8/0).

8. Smart Data Solutions, LLC Contract

Ms. Tetreault presented for approval, the Smart Data Solutions, LLC contract, noting that this contract with Smart Data Solutions, LLC (SDS) allows Health Plan to process claims efficiently and to meet timely payment standards required by the California Department of Health Care Services (DHCS), Department of Managed Health Care Services (DMHC), and Centers for Medicare and Medicaid Services (CMS). It was necessary to execute an updated contract to bring the engagement into compliance with current Health Plan and regulatory requirements.

Services

Continuing SDS services will ensure the seamless conversion of paper and non-standard claims data into industry-standard electronic claims format. These services streamline claims processing. SDS key solutions overview include:

- Digital Mailroom for handling of inbound claims related mail
- Claims Operations for performing intake, data capture, and validation functions for paper and non-standard claims data into industry standard claims format, and
- Clearinghouse Services Solutions that support smooth data exchange between Health Plan, providers and SDS

Cost

Onshore service rates average $1,017,065 a year over a three-year period. Estimated total contract cost is $3,052,000 (c*ost is volume-dependent with estimates based on historical and projected service volumes).*

Upon review of Ms. Tetreault's proposal, Commissioner Herrera asked how much paper is still being used, and Ms. Tetreault responded that approximately 10 percent of claims are received on paper.

Commissioner Sorensen asked how often a contract of this type is put out for bid. Ms. Tetreault explained that the Health Plan intends to go out for bid, noting that the current vendor's performance in the recent past year has been suboptimal and that changes can be made within the contract term. As a result, the Health Plan will most likely change vendors. Commissioner Krishnaswamy asked whether the vendor is formally placed on notice regarding performance issues. Ms. Tetreault confirmed that the vendor is placed on notice in accordance with state and federal guidelines, based on communication with DHCS.

ACTION: With no additional questions or comments, Commissioner Krishnaswamy moved to approve Health Plan's execution of an updated contract, including the comprehensive SOW 01 representing all current services with Smart Data Solutions, LLC. The updated agreement will support electronic data interchange services and ensure compliance with claims processing for the timely payment of claims using an onshore solution. The total contract value is approximately $3,052,000*, over a 3-year term, with one-year automatic renewals thereafter. The motion was seconded by Commissioner Herrera and was unanimously approved (8/0).

9. 2026 Compliance Program Plan and 2026 Code of Conduct & Business Ethics

Betty Clark, CCO/CPO, presented for approval the 2026 Compliance Program Plan and 2026 Code of Conduct & Business Ethics, highlighting the following changes for both:

2026 Compliance Program Plan

- "Governing Body" section was revised to reflect changes to Compliance Committee structure. The responsibilities of the Policy Review Committee and Program Integrity Committee were consolidated into the main Compliance Committee.
- "Policies and Procedures" section was revised to reflect that policies are now approved by the Compliance Committee (previously the Policy Review Committee)
- Paragraph about reporting to regulatory agencies was removed from the "Confidentiality and Non-Retaliation" section because it was not relevant to the subject matter of the section
- Other minor clean-up was made throughout, including updating of staff titles and acronyms

2026 Code of Conduct and Business Ethics

- Added section called "Exclusion Lists" which summarizes Health Plan's process ensuring it does not employ or contract with individuals or entities excluded from participating in Medi-Cal and Medicare
- Added references to CMS and Medicare throughout
- Minor clean-up changes were made throughout, including updating of staff titles and acronyms

ACTION: With no questions or comments, the motion was made by Commissioner Sorensen, seconded by Commissioner Angeles and was unanimously approved, both the 2026 Compliance Program Plan and 2026 Code of Conduct Business Ethics as presented (8/0).

10. Peer Review and Credentialing Committee (PRCC)– 11/20/2025

Dr. Lakshmi Dhanvanthari, CMO presented for approval the credentialed and recredentialed providers from the PRCC meeting on 11/20/2025:

Direct Contracted Providers: 195
- Initial Credentialed for 3 years = 74
- Initial Credentialed for 1 year = 0
- Recredentialed for 1 Year = 0
- Recredentialed for 3 Years = 57
- Clean File Initial Credentialing Sign Off Approval by Dr. Lakshmi: 62
- Clean File Recredentialing Sign Off Approval by Dr. Lakshmi: 2

Termination/Involuntary: 1

Commissioner Sorensen asked about the cause for termination. It was explained that involuntary termination occurs when a provider fails to submit required credentialing or recredentialing paperwork. Termination for cause, which involves issues related to poor quality of care or inappropriate practice, did not apply in this situation.

ACTION: With no questions or comments, a motion was made by Commissioner Sorensen and seconded by Commissioner Angeles), to approve the Peer Review and Credentialing Committee report for November 20, 2025, as presented (8/0).

Vice-Chair Jensen joined the meeting at this time.

INFORMATION ITEMS

11. Kick-Off FY' 2026-2028 Strategic Planning Session

Margaret Tatar and Steve Soto of HMA, joined the meeting to kick-off the Health Plan's FY 2026-2028 Strategic Planning work, highlighting on the following:

- Strategic Planning Process Timeline/Overview
- Business Landscape
- Current Strategic Plan (2023-2026)
- Proposed Strategic Plan Framework for 2026
  - Access and Continuity of Care
  - Programs and Performance Metrics
  - Efficiency and Sustainability
  - Workforce Resilience and Innovation
  - Act as a Catalyst for Community Health

Next Steps

- Strategic Planning Ad Hoc Committee to update the strategic plan framework to reflect Commission input
- Strategic Planning Ad Hoc Committee to consider any necessary updates to the Strategic Plan based on the Governor's Budget to be released in January 2026
- HMA and the Strategic Planning Ad Hoc Committee to present the strategic plan at March 25, 2026, Commission meeting

Upon review, Ms. Granados noted that under the Potential Pillars, management recognizes the significant changes ahead. The pillars are intended to provide flexibility in how the organization pivots, while also acknowledging the challenges of managing two lines of business simultaneously.

Commissioner Krishnaswamy emphasized the need to focus more on specific tactics and measurable outcomes.

Chair Valentine added that technology is being leveraged to meet data-driven measures and to enhance existing strengths within the organization.

12. CEO Report

Ms. Granados introduced Jedd Hampton, new Director of Government and Public Affairs, who will be providing monthly Legislative Updates at the Health Commission.

Ms. Granados then provided an update on the following activities:

State of the Medi-Cal Program: Potential Mitigation at the State Level

Implement systems to evaluate the 80-hour work requirement based on overall income against federal minimum wage

- Example: Under an income-based approach, members would be required to earn at least $580 each month—the federal minimum wage ($7.25 per hour) multiplied by 80 hours
- Could result in fewer disenrollments because California's minimum wage ($16.50 per hour for most employers in 2025) is notably higher than the federal minimum wage

Implement exclusions to the community engagement requirement by exempting counties that have high unemployment rates compared to national averages

- Could exclude a least a few hundred thousand individuals from disenrollment
- Potentially volatile unemployment rate depending on the county

Implement cost-sharing strategies to mitigate disenrollment and incentivize high-value care
- Example 1: impose relatively minimal copays to mitigate the cost to members who are at or near the poverty level and could struggle to pay the charges
- Example 2: structure copays in ways that promote high-value care, such as by adopting higher charges for less medically necessary services

State of the Medi-Cal Program: Considerations for the Future of the Medi-Cal Program

State legislature should evaluate Medi-Cal program goals that answer key questions
- Who should Medi-Cal serve?
  - Eligibility could be expanded to higher-income children and higher-income people with medical need, who can draw down federal funds compared to other populations (e.g., UIS) where the state pays more
- What per-enrollee service level should Medi-Cal provide?
  - Review of optional benefits, though cost savings may be minimal
  - Determine short vs long-term impact of any changes to benefits
- What non-General Fund financing options are available?
  - MCO tax was hindered significantly due to H.R.1, so provider taxes will become a smaller part of the Medi-Cal budget
  - Tobacco revenue tax is also declining

Possibilities for leveraging other sources of health care coverage
- Rebuilding the county's indigent programs
  - It would require fiscal restructuring and funding from state and local funds
  - Scope of coverage for these programs varies by county and may not adequately cover scope of previous coverage
- Expanding access to Covered CA
  - Subsidies are ending at the end of 2025 and are not guaranteed to be extended or renewed
  - H.R.1 bans people who do not meet community engagement requirements from accessing subsidies
- Increasing employer-sponsored coverage
  - May exclude a significant portion of the Medi-Cal population who will lose coverage

13. COO Report – D-SNP Update

Liz Le, COO, provided an update on the launch of the Health Plan's Advantage D-SNP (HMO) program. In support of the Annual Election Period (AEP), which began on October 15, 2025, the Customer Service, Marketing, Sales, and Enrollment teams conducted outreach and engagement activities throughout October to enroll members in the new D-SNP program. Members who enroll during the AEP will have coverage effective January 1, 2026, when the program officially goes live.

AEP Activities:
- 10/1/25 - Marketing team successfully launched HPSJ/MVHP D-SNP website
- 10/1/25 - Customer Service team began taking D-SNP calls from prospective members and providers
- Call Center phone hours during the AEP
  - 8 am – 8 pm, 7 days a week from October to March and Monday - Friday from April to September
  - HPSJ/MVHP is contracted with a vendor to support calls received after 5 pm
- 10/15/25 - Enrollment team began processing enrollment applications

Next Steps:

- Continue with system/process readiness activities, as well as gauge and apply experiences from the AEP to prepare for the 1/1/26 go live.

Commissioner Sorensen asked how eligibility is determined based on enrollment and what the approval rate is. Ms. Granados explained that all applicants undergo a verification process during the application review. Enrollment projections primarily include individuals transitioning from Medi-Cal to Medicare, with approximately 1,700 individuals expected in the first year. Chair Valentine added that the D-SNP program also offers specialized behavioral health services, which are subcontracted through the county. None of the counties in the state are contracted to offer the services due to the low reimbursement rate. This issue has been brought forth by the counties to DHCS.

CHAIR'S REPORT

Chair Valentine announced that this would be Vice-Chair Jensen's last meeting with the Health Commission, noting that he has served since July 2013. Chair Valentine thanked Vice-Chair Jensen for his dedication, service, and support during his tenure on the Commission. Ms. Granados also thanked Vice-Chair Jensen for his efforts and the support he has provided for the Health Plan throughout his time with the Commission.

Vice-Chair Jensen expressed his gratitude to the Health Commission for their support of the organization and thanked the staff for their ongoing work and contributions.

Chair Valentine appointed Commissioner Sorensen to the HR Committee to replace Vice-Chair Jensen.

Chair Valentine reported that a new Vice-Chair will be appointed at the January 2026 Health Commission meeting.

Quendrith Macedo, County Counsel, announced a new procedural change for the Health Commission. When a member is voting remotely, a roll-call vote will be conducted. Additionally, county ex officio members are no longer required to step out or recuse themselves during votes due to county-related conflicts.

COMMISSIONER COMMENTS

Commissioner Herrera thanked Vice Chair Jensen for his time and service, recognized as a valuable resource to the Commission, and appreciated the opportunity to work with him.

ADJOURNMENT

Chair Valentine adjourned the meeting at 6:50 p.m. The next regular meeting of the Health Commission is scheduled for January 28, 2026.