MINUTES OF THE MEETING OF THE SAN JOAQUIN COUNTY HEALTH COMMISSION

May 27, 2026
Health Plan of San Joaquin – Community Room

COMMISSION MEMBERS PRESENT:

Ruben Imperial, Vice-Chair
Julienne Angeles, MD
Bryan Bucklew
Joy Farley, MD
Michael Herrera, DO
Sandra Regalo
Michael Sorensen
Terry Withrow
Terry Woodrow

COMMISSION MEMBERS ABSENT:

Genevieve Valentine, Chair
Paul Canepa
Jim Diel

STAFF PRESENT:

Lizeth Granados, Chief Executive Officer
Betty Clark, Chief Regulatory Affairs and Compliance Officer
Dr. Lakshmi Dhanvanthari, Chief Medical Officer
Elizabeth Le, Chief Operations Officer
Michelle Tetreault, Chief Financial Officer
Victoria Worthy, Chief Information Officer
Edward Kiernan, County Counsel
Sue Nakata, Executive Assistant and Clerk of the Health Commission

CALL TO ORDER

Vice-Chair Imperial called the Health Commission meeting to order at 5:00 p.m.

PRESENTATIONS/INTRODUCTIONS

NONE.

PUBLIC COMMENTS

No public comments were forthcoming.

CONSENT CALENDAR

Vice-Chair Imperial presented three consent items for approval:

1. April 29, 2026 Health Commission Meeting Minutes

2. Finance and Investment Committee – 05/20/2026
   a. April 22, 2026 Meeting Minutes
   b. The Periscope Group Contract

3. Human Resources Committee – 05/27/2026
   a. March 25, 2026 Meeting Minutes
   b. Leaves of Absence – Medical and Military Policy

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

DISCUSSION/ACTION ITEMS

4. March FY 2026 Financial Reports

Michelle Tetreault, CFO, presented for approval the March FY 2026 financial reports, highlighting the following:

- Premium Revenue is +$35.7M favorable (+$4.35 PMPM) to FYTD budget as of March 2026.) This is primarily driven by +$14.9M favorable due to higher member month volume and +$34.4M favorable due to more favorable rates than included in the budget. These are partially offset by -$13.6M unfavorable due to risk corridor agreements for the current fiscal year related to Enhanced Care Management (ECM). This adjustment for risk corridor results from ECM utilization/cost being lower than expected by DHCS in the rate development

- 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 -$184.3M unfavorable (-$47.10 PMPM) to FYTD budget, primarily driven by -$89.5M unfavorable in Specialist fee-for-service, -$61.2M unfavorable in Hospital Outpatient, -$16.1M unfavorable in Community Support, -$14.4M unfavorable in Emergency Room, -$12.9M unfavorable in Enhanced Care Management, -$12.3M unfavorable in FQHC fee-for-service, -$12.0M unfavorable in Behavioral Health, -$6.0M unfavorable in Outpatient Mental Health. These unfavorable variances are largely attributable to higher utilization due to increased member acuity and more complex care needs, resulting in more hospitalizations and specialist

visits, combined with rising unit costs. These are partially offset by +$32.2M favorable in PCP fee-for-service, and +$5.5M favorable in Long Term care

- Net other program revenues and expenses are +$7.9M favorable (+$2.23 PMPM) primarily driven by the release of previously recorded accruals for the CalAIM Incentive Payment Program (CalAIM IPP) and the Student Behavioral Health Incentive Program (SBHIP) as the related expenditures are no longer expected to occur within the current fiscal year. These are incentives for DHCS-established programs paid to providers for achieving metrics outlined in the programs

- Administrative expenses are -$5.1M unfavorable (-$1.16 PMPM) to budget driven by -$6.3M unfavorable in Salaries and Benefits primarily due to a lower-than-budget vacancy factor and more than budgeted temporary help. This is offset by +$1.2M favorable in technology expenses primarily due to underspent projects related to IT software for DSNP

- Prior period adjustments of +$64.2M favorable (+$17.74 PMPM) are primarily driven by prior-year IBNR adjustment and a favorable adjustment to reinsurance recoveries. The additional reinsurance recoveries result from additional large claims submitted greater than anticipated in our accruals at fiscal year end

Upon Ms. Tetreault's report on the financials, Vice-Chair Imperial asked why Community Reinvestment is showing a negative balance. Ms. Tetreault responded that the Health Plan did not budget for Community Reinvestment this year, resulting in a year-to-date unfavorable variance of -$108.9K.

ACTION: With no further questions or comments, the motion was made by Commissioner Herrera, seconded by Commissioner Regalo, and was unanimous to approve the March FY 2026 financial report as presented (8/0).

Commissioner Withrow joined the meeting at this time.

5. QIHEC Committee Meeting – 5/20/2026

Dr. Lakshmi Dhanvanthari, CMO submitted for approval the QIHEC Committee meeting report for 05/20/2026, highlighting the following committee meetings, work plans, program descriptions, policies updates and reports that were reviewed and approved:

Equity and Practice Transformation (EPT) Program/Practice Update

- Participating practices have completed 44% to 60% of program requirements and received a total of $1.3 million for completing 82 milestones
- Program has been extended to allow for continued performance measurement through HEDIS MY 2026 and corresponding payments to practices
- Practices will complete 5 of 6 deliverable cycles on May 1, 2026. Final deliverables are due by November 1, 2026
- Health Plan will continue to submit HEDIS data through 2027 and potentially pay practices through March 2028

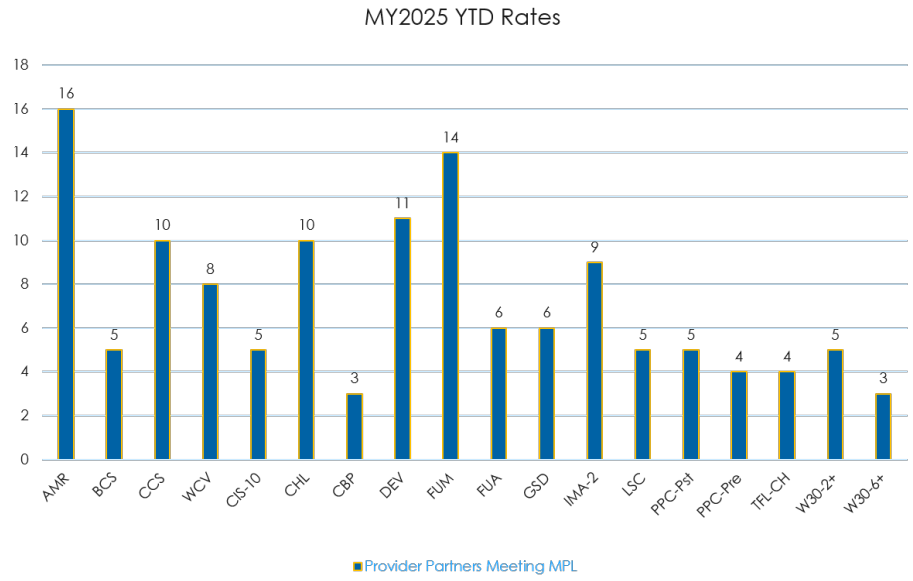
HEDIS HEQMS & MCAS FY25-26 'Q3

- Managed Care Plan Total – 8 meeting Minimum Performance Level (MPL), 5 within 5%
- San Joaquin County – 8 meeting MPL, 3 within 5%
- Stanislaus County – 7 meeting MPL, 6 within 5%
- El Dorado County – 3 Met MPL, 2 within 5%
- Alpine County – 1 met MPL, 0 within 5% (small denominator, not officially reportable)
- Measurement Year 2025 Review Season
  - February – April 25th - Chart collection is (IN PROGRESS)

- February 2nd – April 29th - Chart Abstraction (IN PROGRESS)
- April 10th – Preliminary Rate Review with Auditors (IN PROGRESS)
- May 1st – Medical Record Hybrid positive listing to auditors
- May 4th-22nd – Medical Record Review Validation (MRRV) for selected measures is conducted
- May 15th – All Audit tasks and follow up documents must be complete
- May 29th – Plan Lock on Rates applied and Final Rate Review is Conducted
- June 15th NCQA MY2025 submission Deadline – No later than 6 PM PST

Provider Partnership - MY2025 YTD Goals Met Summary- All PPP Providers (29 providers currently participating in the PPP program)

- Monthly gaps-in-care reports
- MCAS Pocket Guide
- Mobile Mammogram van
- Backpack Campaign
- Locum Providers
- Lead Screening Grants
- Pop Health Direct Scheduling
- Texting Campaigns
- Supplemental data submission
- Daily FUA/FUM reports
- EPT Program



Preventative Health Guidelines – 04/14/2026: Health Plan encourages providers to utilize the latest version of the following guidelines in delivering quality preventive healthcare to:

- Children
  - American Academy of Pediatrics (AAP) Periodicity Schedule: Bright Futures Guidelines, March 2026
  - CDC Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2026
    - Includes catch up schedule: CDC Catch-up immunization schedule for persons aged 4 months
- Adults
  - United States Preventive Service Taskforce (USPSTF) Adult Preventive Health Guidelines: Grade A and B Recommendations 2026
  - CDC Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2026 Preventive Health Guidelines

- Women's Preventive Services Initiative (WPSI) Guidelines
- California Department of Public Health
- American College of Obstetricians and Gynecologists (ACOG) Clinical Practice Guidelines

ACTION: With no questions or comments, a motion was made by Commissioner Bucklew, seconded by Commissioner Farley, and was unanimous to approve the QIHEC Committee Report for 05/20/2026 as presented (9/0).

Peer Review and Credentialing – 05/13/2026

Direct Contracted Providers: 174

- Initial Credentialed for 3 years = 112
- Initial Credentialed for 1 year = 2
- Recredentialed for 1 Year = 1
- Recredentialed for 3 Years = 58
- Clean File Initial Credentialing Sign Off Approval by Dr. Lakshmi: 0
- Clean File Recredentialing Sign Off Approval by Dr. Lakshmi: 1
- Termination/Involuntary: 1

ACTION: With no questions or comments, a motion was made by Commissioner Regalo and seconded by Commissioner Bucklew, with an abstention by Commissioner Herrera, to approve the Peer Review and Credentialing Committee report for May 13, 2026, as presented (8/1).

INFORMATION ITEMS

6. Fiscal Year 2027 Budget Preview

Ms. Tetreault presented a preview of the Fiscal Year 2027 budget, highlighting the following:

Executive Summary – 2027 Budget vs. 2026 Projection

- FY2026 projected Net Income/(Loss) is ($162.9M),
- Budget for FY2027 $96.5M loss and a $66.4M favorable change over FY2026
- Membership is expected to decline by 17%, starting at 376,328 in July 2026, ending at 312,647 in June 2027
  - Decrease in membership due to losses for members with Unsatisfactory Immigration Status (UIS). These members are expected to move from managed care to Medi-Cal fee for service
- FY2027 budgeted Revenue is $2.1B, an unfavorable change of $230M due to:
  - Fewer Members: -$241.8M
    - Total Decline -67,060
      - UIS -43,859 and SIS -23,2021
  - Higher Rates: $127.M
    - Rate Increase Components
      - CY2026 increase of 11.4% vs CY2025 (6-month impact)
      - CY2027 increase of 4.5% vs CY2026 (6-month impact)
      - CY2027 additional rate relief 4% (6-month impact)
      - Quality Withhold of 2% with 1% earn back
      - Other Programs (HQAF, QIP, EPP, PHDP, Transitional Rent)
- Medical Expenses:
  - FY2027 budgeted Medical Loss Ratio (MLR) is 102.3%
  - $62M Cost Savings Initiatives
    - Duplicate/Overpayment Recovery

  - Reduction in readmissions/lengths of stay
  - Correction to physician administered drugs reimbursement
- $135.8M due to membership declines - (23,201)
- $106.1M Unsatisfactory Immigration Status membership loss - (43,859)
- ($77.9M) Unit Volume Variance
  - Inpatient
  - Specialty Care
- ($10.6M) Unit Cost Variance
  - Inpatient
  - Behavioral Health
- ($9.9) Other/Mix

- Unsatisfactory Immigration Status (UIS)

	HPSJ	PMPM	Satisfactory	PMPM	Unsatisfactory	PMPM
Member Months	4,132,461		3,878,639		253,822	
Financial Highlights (In Thousands)						
Revenue	$2,145,516	$519.19	$1,975,856	$509.42	$169,661	$668.42
Medical Expense	(1,572,517)	(380.53)	(1,469,959)	(378.99)	(102,558)	(404.06)
Other State Programs	(607,172)	(146.93)	(566,841)	(146.14)	(40,331)	(158.90)
Administrative Expense	(98,397)	(23.81)	(98,342)	(25.35)	(56)	(0.22)
Other (Community Reinvestment, Investment Inc.)	36,070	8.73	36,070	9.30	0	0.00
Net Income (Loss)	**($96,501)**	($23.35)	**($123,216)**	($31.77)	**$26,715**	$105.25
Key Metrics						
Medical Loss Ratio	102.3%		104.3%		79.4%	
Administrative Loss Ratio	6.4%		6.9%		0.0%	

- Administrative Expenses
  - FY2027 budgeted Administrative Loss Ratio (ALR) is expected to decrease from FY2026 projection 6.5% to 6.4%
  - Elimination of 31 positions that were vacant
  - Consultants decrease primarily due to IT

- Budget Opportunities:
  - Dual Eligible Special Needs (D-SNP)
  - Dual Aligned (Stanislaus and El Dorado)
  - Rate Advocacy
  - High-Cost Drugs
  - Medical Management Intervention

- Budget Risks
  - Dual Eligible Special Needs (D-SNP)
  - Federal Changes to Medicaid Program
  - State budgetary constraints
  - High-Cost Drugs
  - SPD/LTC Blend
  - Office of Health Care Affordability

Upon Ms. Tetreault's presentation of the budget prior to the May revise, the following questions were raised by Commissioners:

Q: Herrera: Why are we expecting a reduction in medical expenses related to UIS when they are low utilizers?
A: Tetreault: We pay cap for primary care, ancillary and other services that are being utilized, so we anticipate a reduction.

Q: Herrera: What additional steps are we taking to mitigate losses?
A: Tetreault: We have identified claim overpayments and are actively recovering those funds. We are also auditing our contracts to ensure payment amounts are aligned with contract terms. Ongoing efforts include reducing MM avoidable utilization, admissions, and long lengths of stay.

Q: Bucklew: Are other health plans in the state also experiencing similar enrollment trends?
A: Tetreault: Yes, all of our sister plans are seeing significant decreases, generally between 1.5% and 2%. We are not an outlier; we fall in the middle of the range.

Q: Withrow: What is our liquid cash investments and do we have receivables pending?
A: Tetreault: As of March, we had nearly $1 billion. In April, we withdrew about $200M —this includes the MCO tax advance, which we use to cover operating expenses, quarterly taxes, and other state-directed payments made in cash. We build up cash and then disburse it quarterly. Our receivables consist of a combination of directed payments, MCO tax, and capitations (paid a month in arrears).

Ms. Tetreault thanked Commissioners and acknowledged Chris Navarro and his team for their excellent work on the budget. She noted that the final FY' 27 budget will be brought to the Health Commission for approval in June.

7. CEO Report

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

CMS Withholds $1.3 Billion in Medicaid Payments to California

- CMS issued its largest-ever payment deferral, withholding $1.3 billion from California over insufficient hospice-fraud controls
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- CMS flagged major hospice billing anomalies in Los Angeles and concluded the state hasn't validated that services were actually delivered
- CMS simultaneously suspended payments to hundreds of hospice providers and enacted a six-month moratorium on new hospice and home-health agencies
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CMS Letter on Revalidation of Medicaid Providers

- On April 23rd, CMS directed states to immediately revalidate high-risk Medicaid providers, signaling intensified federal oversight
- CMS flagged providers with National Provider Identifiers (NPI) as a key integrity vulnerability requiring urgent attention
- States must notify CMS within 10 business days whether they will conduct a rapid review and provide a completion timeline
- Within 30 days, states must submit a comprehensive provider revalidation strategy addressing broader fraud-risk concerns
- CMS made clear that responsiveness and strength of the state's plan will influence future federal assessments of Medicaid fraud-risk

Medi-Cal Provider Application and Validation for Enrollment (PAVE)

DHCS has undertaken several initiatives in anticipation of the changes mandated by H.R. 1. These initiatives include:

- The Department of Health Care Services (DHCS) will require all prescribers to obtain individual Type 1 National Provider Identifier (NPI) enrollment through PAVE; unenrolled prescribers will trigger pharmacy claim denials once the policy takes effect
- The mandate could create significant operational and compliance burdens for Health Plan, requiring accelerated enrollment, revalidation and monthly PAVE verification
- Many clinicians who routinely serve Medi-Cal members have never completed individual FFS enrollment, and 90–180-day processing times with no interim approval pose risk of temporary billing ineligibility
- Health plans, provider groups and external stakeholders warn the transition could lead to network instability, service disruptions and payment delays without adjustments

DHCS Proposed CY 2027 Clinical Efficiency Measures

In January, CMS sent California a letter outlining concerns regarding the Medi-Cal program and requested California provide a comprehensive program integrity action plan for the following categories:

- DHCS's proposed CY 2027 clinical efficiency measures are intended to improve quality and reduce avoidable spending; however, the accelerated timeline and lack of a one-year learning period create significant operational and financial risk for Medi-Cal managed care plans
- Inability to validate methods or adjust contracts before launch, combined with CMS's ban on retroactive payments, could turn proposed measures into de-facto penalties for plans
- Clinical Efficiencies being considered include overlapping and redundant measures, such as preventable readmissions, cesarean mix, cellulitis, short stays, Durable Medical Equipment and radiology
- Limited transparency on specs, data sources and risk adjustment raises concerns about misaligned benchmarks, unfair comparisons and inaccurate financial impacts
- Managed care plans have recommended a narrowed first-year measure set plus early access to data and impact analyses to ensure accuracy, fairness and successful scaling

Future of Medi-Cal Commission Update

- The Future of Medi-Cal Commission is developing a 10-year roadmap to modernize Medi-Cal amid growing state and federal fiscal pressures
- Recommendations focus on sustainable financing, stronger managed care accountability, and expanded whole-person care supported by better Social Determinants of Health data integration
- The Commission has warned of major fiscal threats, including potential federal Medicaid cuts and provider-tax elimination that could drive coverage losses and force difficult state budget choices
- Structural fragmentation across financing, governance, and data systems continues to undermine access, coordination and performance
- The Commission emphasized that without simplified financing, standardized processes, and stronger data integration, California may not be able to achieve its vision of a more equitable and financially sustainable Medi-Cal program

Vice-Chair Imperial stated, as part of the Medi-Cal Commission, discussions were held on challenges and risks. The Commission should also move forward with recommendations and solutions for needed changes. He emphasized that fragmentation is a major issue affecting the future of Medi-Cal. Drawing

from his experience in the Central Valley, he highlighted differences in structural issues and the clinical integration of behavioral health into the community, which is currently handled as a carve-out.

8. COO Report – *May 2026 Operations Report are available in the Health Commission meeting packet*.

9. Bi-Monthly Compliance Update

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

Regulatory Audit Update

- DHCS 2025 Medical Audit
  - Exit conference held on April 17, 2026
  - Final Report issued May 13, 2026
  - DHCS issued a single finding, noting delays in sending written acknowledgement letters to members within the required five-day timeframe
  - Health Plan is developing a corrective action plan to submit to DHCS

- DMHC 2026 Routine Survey
  - Review period was December 1, 2023, through November 30, 2025
  - Onsite audit took place May 5-6, 2026
  - Topics covered are Grievances & Appeals, Utilization Management, Continuity of Care, Quality Management, Access and Availability, Access to Emergency Services and Payment for Emergency Services
  - The Department requested additional documents and case files during the post-onsite review phase
  - The Plan is preparing responses and will provide updates once the audit is completed

Office of Inspector General (OIG) Information Requests – 05/14/2026

- Medi-Cal Behavioral Health Services Denials
- OIG will be conducting preliminary research of Medicaid managed care organizations' denials of behavioral health services prior authorization requests
- Medicare D-SNP 340B Modifiers and Rendering Provider NPI identifiers
- OIG will be evaluating two issues related to Health Plan's D-SNP:
  - How Medicare plans collect, store, and report 340B information on Part B drugs
  - Whether Medicare plans consistently report the rendering provider NPIs in encounters
- Health Plan will coordinate the response once the information requests are received. Other Medi-Cal plans have received the same requests.

Privacy and Security Incidents

- Health Plan investigated 130 privacy incidents during March through April 2026
- Zero (0) incidents reported to DHCS
- No incidents were reported to the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR)

Fraud, Waste and Abuse Investigations

- Health Plan investigated fifty (50) cases during March to April 2026
- Thirty-two (32) cases were initiated in a previous reporting period, and eighteen (18) new cases were opened during this reporting

- All new cases were reported to DHCS timely within 10 days of discovery

10. Legislative Update

Jedd Hampton, Director of Government and Public Affairs, provided an update on the May Revision Budget, highlighting the following:

- Governor Newsom released the May Revision on May 14, updating the January budget based on the latest economic conditions, revenue trends, and policy priorities
- The proposed $350 billion spending plan is the largest in state history and reflects a significantly improved fiscal outlook
- Stronger-than-expected personal income tax returns, capital gains, and growth in the state's AI-driven tech sector are projected to generate $16.5 billion in additional revenue
- The Administration and Legislature have begun negotiations to align priorities ahead of the constitutional deadlines
- Legislature must pass a balanced budget by June 15, with the Governor required to sign it by June 30
- Overall Medi-Cal Budget - *Revised Medi-Cal Budget Estimates:*
  - Fiscal Year 2025-2026: $194.4 billion total ($48.6 billion General Fund), reflecting $*2.3 billion decrease* over the Governor's January proposal
  - *Fiscal Year 2026-2027: $216.7.7 billion total ($44.9 billion General Fund), $3.7 billion decrease in total spending compared to the January proposal*
- H.R. 1 Implementation: Increases General Fund spending by $363.1 million General Fund in 2026-27 compared to the Governor's Budget to backfill a portion of reduced federal funding. The May Revision projects total H.R. 1 disenrollment of 44,000 in 2026-27 and 1.3 million by 2029-30, a decrease of 478,000 in 2026-27 and 446,000 by 2029-30 compared to the Governor's Budget
- Managed Care Organization Tax: Includes $4.5 billion in 2025-26 and $2.5 billion in 2026-27, while proposing a new MCO Tax beginning in 2027 to sustain targeted rate increases after recent federal rules under H.R. 1 prohibit California's current tax structure
- Transition of Individuals with Unsatisfactory Immigration Status to Fee-for-Service: Due to a new federal policy that bars states from providing certain emergency Medicaid services through managed care to individuals with unsatisfactory immigration status, these Medi-Cal members will transition to fee-for-service for all covered services beginning January 1, 2027
- County Medi-Cal Administration: Provides one-time funding to counties to implement Medi-Cal eligibility changes under H.R. 1
- Medi-Cal Efficiencies: Implements utilization management for applied behavioral analysis and transportation and eliminates the quality-withhold incentive in Medi-Cal managed care
- Covered California State Subsidy Program: Allocates $300 million to Covered California to expand state premium subsidies for enrollees with incomes up to 200 percent of the federal poverty level
- Increase Monthly Premium for Adults with Unsatisfactory Immigration Status (Aged 19–59) from $30 to $50: Increases monthly premiums for adults with unsatisfactory immigration status from $30 to $50, effective July 1, 2027
- Medi-Cal Asset Test Limits: Reinstates Medi-Cal asset limit beginning January 1, 2027
- Enhanced Care Management and Community Supports: Refines eligibility rules, service definitions, utilization management, and payment policies for the Medi-Cal enhanced care management benefit starting January 1, 2027

Upon reviewing Mr. Hampton's report, Commissioner Bucklew asked whether the Health Plan meets the unemployment criteria for both SJ and Stanislaus counties. Ms. Granados explained that the situation is

fluid based on federal guidance. The state has confirmed that 22 counties will qualify, using a national average threshold of 1.5% and a county unemployment rate of 6%; both counties will meet the criteria.

VICE-CHAIR'S REPORT

No reports were forthcoming.

COMMISSIONER COMMENTS

No comments were forthcoming.

The Health Commission went into a Closed Session at 6:42 pm.

CLOSED SESSION

11. Closed Session – Trade Secrets
    Welfare and Institutions Code Section 14087.31
    Title: Proposed FY' 26-27 Corporate Objectives

12. Closed Session - Public Employee Performance Evaluation
    Government Code Section 54957
    Title: Chief Executive Officer – Performance Evaluation Update

The Health Commission came out of Closed Session at 7:28pm.

ACTION: A motion was made by Commissioner Regalo and seconded by Commissioner Withrow, to approve the FY' 26-27 Corporate Objectives as presented (9/0).

ADJOURNMENT

Vice-Chair Imperial adjourned the meeting at 7:28 p.m. The next regular meeting of the Health Commission is scheduled for June 24, 2026.