MINUTES OF THE MEETING OF THE SAN JOAQUIN COUNTY HEALTH COMMISSION

June 24, 2026
Health Plan of San Joaquin – Community Room

COMMISSION MEMBERS PRESENT:

Genevieve Valentine, Chair
Bryan Bucklew
Paul Canepa
Jim Diel
Michael Herrera, DO
Sandra Regalo
Michael Sorensen
Terry Withrow
Terry Woodrow

COMMISSION MEMBERS ABSENT:

Julienne Angeles, MD
Joy Farley, MD
Ruben Imperial, Vice-Chair

STAFF PRESENT:

Lizeth Granados, Chief Executive Officer
Michael Engelhard, Interim Chief Financial Officer
Dr. Lakshmi Dhanvanthari, Chief Medical Officer
Liz Le, Chief Operations Officer
Tracy Hitzeman, Chief Health Services Officer
Victoria Worthy, Chief Information Officer
Kimberly Glasby, Executive Director, Health Services
Chris Navarro, Senior Director of Finance
Edward Kiernan, 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.

Chair Valentine stated for the record that a portion of the Health Commission meeting was being conducted pursuant to California Government Code Section 54953, as Commissioner, Jim Diel was participating from ab alternate location: El Dorado County Health & Human Services Agency – 3057 Briw Road, Suite B, Placerville, CA 95667, via Microsoft Teams. In accordance with the Ralph M. Brown Act, the alternate location was included in the meeting notice and agenda.

With no questions or comments from the Commission, it was noted that Commissioners present confirmed they could hear Commissioner Diel clearly and had no doubt regarding his identity as the participant joining via teleconference.

PRESENTATIONS/INTRODUCTIONS

NONE.

PUBLIC COMMENTS

No public comments were forthcoming.

Pursuant to the requirements of the Ralph M. Brown Act (Gov. Code § 54950 et seq.) and its teleconferencing provisions, and because Commissioner Diel participated remotely (via a teleconference connection), the Commission was required to take its vote by roll call, to ensure that each member's vote was publicly identified and recorded in the minutes.

CONSENT CALENDAR

Chair Valentine presented three consent items for approval:

1. May 27, 2026 Health Commission Meeting Minutes

2. Community Advisory Committee (CAC) – 06/11/2026
   a. April 11, 2026 Meeting Minutes
   b. Cultural Linguistic Updates
   c. Grievances
   d. Member Incentive Program Update

3. Finance and Investment Committee – 05/20/2026
   a. May 20, 2026 Meeting Minutes
   b. Independent Consulting Services Contract

ACTION: With no questions or comments, the motion was made by Commissioner Canepa, seconded by Commissioner Bucklew and was unanimously approved for all three consent items as presented (9/0).

DISCUSSION/ACTION ITEMS

4. April FY 2026 Financial Reports

Michael Engelhard, Interim CFO, presented for approval the April FY 2026 financial reports, highlighting the following:

Net Income/(Loss) for April 2026 FYTD

- -$138.6M and is -$87.1M unfavorable to budget
- Medical Loss Ratio (MLR): 110.3% actual to 100.8% budgeted
- Administrative Loss Ratio (ALR): 6.4% actual to 6.2% budgeted

Premium Revenue

- +$52.6M favorable (+$9.72 PMPM) to FYTD budget as of April 2026. This is primarily driven by +$14.1M favorable due to higher member month volume and +$39.0M favorable due to more favorable rates than included in the budget. Rates are more favorable due to the 11.3% rate increase effective January 1, 2026, compared to an assumption in the budget of 4.5% increase

Other Medical Revenue & Expense

- 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 Expense

- Managed care expenses are -$194.3M unfavorable (-$45.16 PMPM) to FYTD budget. Driven by a higher trend factor experienced than assumed in the base period used to prepare the budget. The trend assumed was a 7% trend, when the actual trend was double that. This increased trend is the result of more utilization and increase in unit cost. These unfavorable trends 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

Other Program Revenue and Expense (Net)

- Net other program revenues and expenses are +$9.7M favorable (+$2.45 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

- -$5.3M unfavorable (-$1.12 PMPM) to budget driven by -$6.8M unfavorable in Salaries and Benefits primarily due to a lower-than-budget vacancy factor and more than budgeted temporary help. This is offset by +$1.5M favorable in technology expenses primarily due to underspent projects related to IT software for DSNP

Prior Period Adjustments

- Prior period adjustments of +$74.8M favorable (+$18.67 PMPM) are primarily driven by $56M prior-year IBNR adjustment and an $18M favorable adjustment to reinsurance recoveries. The reinsurance recoveries result from additional finalized large claims that were greater than anticipated in our accruals at fiscal year-end

After Mr. Engelhard presented the financial report, Commissioner Canepa asked why increased enrollment would lead to higher costs. Mr. Engelhard explained that staffing levels, PMPM rates, and administrative contracts are tied to enrollment numbers. As enrollment exceeds the originally budgeted levels, administrative expenses will be higher than expectations because volume-based activities will exceed what was originally budgeted.

Commissioner Canepa then asked about the enrollment offset trend. Lizeth Granados, CEO responded that the plan continues to lose low utilizers, while members who require higher levels of service are remaining enrolled. The pattern shows that healthier individuals are the ones disenrolled.

ACTION: With no further questions or comments, the motion was made by Commissioner Withrow, seconded by Commissioner Regalo, and was unanimous to approve the April FY 2026 financial report as presented (9/0).

5. Final Fiscal Year 2027 Budget

Chris Navarro – Senior Director, Financial Planning and Analysis presented for approval the final Fiscal Year 2027 budget, highlighting the following:

Executive Summary – 2027 Budget vs. 2026 Projection

The differences between the FY2027 budget that was presented in May and revisions made in June:

	2026 Projection	PMPM	2027 Budget	PMPM	Δ	PMPM
Enrollment (As Of June)	379,706		312,647		(67,059)	
Member Months	4,771,247		4,132,461		(638,786)	
Financial Highlights (In Thousands)						
Revenue	$2,375,681	$497.92	$2,136,182	$516.93	($239,500)	$19.01
Medical Expense	(1,735,322)	(363.70)	(1,509,342)	(365.24)	225,980	($1.54)
Other State Programs	(715,684)	(150.00)	(607,172)	(146.93)	108,512	$3.07
Administrative Expense	(106,764)	(22.38)	(99,084)	(23.98)	7,680	($1.60)
Other (Community Reinvestment, Investment Inc.)	19,189	4.02	36,070	8.73	16,881	$4.71
Net Income (Loss)	**($162,900)**	($34.14)	**($43,346)**	($10.49)	**$119,554**	$23.65
Key Metrics						
Medical Loss Ratio	104.4%		98.8%		5.6%	
Administrative Loss Ratio	6.4%		6.4%		(0.0%)	

In thousands	MMOS	Revenue	Medical Expense	Admin/ Non-Op	Income
2027 May Pass	**4,132,461**	**$2,145.5**	**(2,179.7)**	**(62.3)**	**(96.5)**
Reduction in Admin			$1.7	3.3	$5.0
UIS Risk Corridor		(9.3)			(9.3)
Cost Avoidance			$13.3		$13.3
Recoveries			$44.2		$44.2
2027 Final Budget	**4,132,461**	**$2,136.2**	**(2,120.5)**	**(59.0)**	**(43.3)**

Upon review of Mr. Navarro's report, the following questions were raised by Commissioners:

Q: Canepa – Where will the $43M in recoveries come from?
A: Navarro + Granados – The team has identified 8–9 areas with incorrect fee payment structures, particularly related to physician-administered drugs. The plan has been overpaying providers, but due to the statute of limitations, only one year of overpayment can be recovered. We expect to recover approximately $33M and are working to collect additional amounts. This issue is not new, but it has now been corrected. There will be no penalties for the plan or providers.

Q: Withrow – Are there similar issues that exists beyond pharmaceutical drugs and whether there are other recovery or cost-avoidance opportunities?
A: Granados – There are multiple areas under review. The team is auditing the system to ensure payments aligned with fee schedules and is pursuing other corrective initiatives. Although HMA helped identify this particular issue, it has been a long-standing legacy problem. Staff continue to review all legacy concerns to remediate errors and recover funds. This relates to reimbursement mistakes that affect a large portion of the membership in both San Joaquin and Stanislaus counties.
Comment: Withrow - Suggests reviewing and determining the dollar amounts on a year-to-year basis. Ms. Granados responded that the current focus is on the projected total recovery of $33M; year-by-year figures are not yet available, but staff will review and report back.
Comment: Granados and Engelhard - Communications via phone and mail have been sent to providers to notify them in advance about reimbursement deductions. Most affected providers are oncologists. The number of new drugs introduced in recent years, especially in oncology, has contributed to these issues across health plans nationwide, not only HPSJ.

ACTION: With no further questions or comments, the motion was made by Commissioner Canepa, seconded by Commissioner Sorensen, and was unanimous to approve the Fiscal Year 2027 Final Budget as presented (9/0).

INFORMATION ITEMS

6. CEO Report

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

Community Engagement Interim Final Rule

- On June 1st, CMS issued the Community Engagement Interim Final Rule (IRF) implementing 80 hour-per month community engagement requirements for certain Medicaid expansion adults, effective January 2027
- Broad exemption applies, including individuals deemed medically frail and those residing in areas with persistently high unemployment; nearly all HPSJ service areas currently qualify for the high unemployment exemption, with El Dorado County as the sole exemption
- However, the IFR adopts a significantly narrower definition of medical frailty than the state anticipated, likely reducing the number of members who will qualify for an exemption under this category
- CMS will permit states to seek a temporary “Good Faith Effort” exemption for implementation challenges, but relief is narrow and granted on a case-by-case basis, with availability limited through December 31, 2028
- While managed care plan implementation roles remain limited, the state faces significant new operational requirements that will trickle down to plans, necessitating adjustments to member engagement and navigation supports, expanded data sharing and tightened verification protocols

State Directed Payments Proposed Rule

- Last month, CMS issued a proposed rule implementing provisions of H.R. 1 that will impose stringent new payment ceilings on State Directed Payments (SDPs)
- The proposed rule would impose strict caps on key SDPs, limiting payments to Medicare-equivalent rates (100% in expansion states and 110% in non-expansion states) with these ceilings extending to all SDP categories nationwide by January 1, 2029

- Any SDP spending above the allowable limits would be treated as overpayment, thereby requiring strong state and plan-levels controls, documentation and recovery processes
- Existing SDPs that exceed the new caps may qualify for temporary grandfathering, triggering a mandatory 10-percentage-point annual phase-down beginning January 1, 2028, until fully aligned with the new SDP limits
- CMS is also proposing substantial revisions to allowable SDP categories, including phasing out new or renewed uniform increases after January 1, 2028
- Overall, the rule signals a long-term tightening of state and managed care plan payment levers, requiring greater scrutiny of provider contracting, maintaining network stability, strengthened compliance infrastructure and a more constrained and highly monitored federal payment environment

Update on State Budget Proposal to Maintain UIS Members in Managed Care

- The Governor's May Revision proposed shifting nearly two million UIS Medi-Cal members out of managed care and into full fee-for-service (FFS) due to newly enacted federal rules prohibiting UIS individuals from accessing emergency care
- The Local Health Plans of California (LHPC) championed a federally compliant alternative through a state-only contract, carving out only federally scrutinized services while achieving most projected savings
- Alternative model preserves continuity of care by keeping all carved-in services (primary care, specialty care, behavioral health, long-term are and care coordination) in managed care while carving out only federally scrutinized inpatient, emergency, hospital-based outpatient and OB services to FFS
- The Legislature ultimately agreed to transition UIS members to FFS while preserving CalAIM benefits and continuity of care, with added time provided to assess managed care options for non-emergency services
- Implementation details remain pending as the Legislature and Administration continue to evaluate operational, fiscal and member-impact considerations

After Ms. Granados provided her update, Commissioner Sorensen asked whether the exemption would also apply to other benefits, such as SNAP. Ms. Granados responded that she was not certain but would follow up with confirmation.

Ms. Granados also reported a 40,000-member drop in UIS, which has already been factored into the budget. She noted that this represents a substantial portion of the plan's previously profitable membership and will significantly impact revenue. To prepare, the team developed financial models reflecting this budget impact, which were presented. Commissioner Herrera added that all hospitals will now be affected and will be required to serve patients who are no longer covered by the health plan.

Chair Valentine and Ms. Granados expressed optimism about the potential approval of a higher unemployment-rate exemption, though it is still pending and depends on how HR.1 defines eligibility. They emphasized the importance of ensuring that the criteria for unemployment rate exemption are met.

7. COO Report – *June 2026 Operations Report are available in the Health Commission meeting packet*.

8. Legislative Update

Jedd Hampton, Director of Government and Public Affairs, provided an update on CA Budget Deal and legislative activities, highlighting the following:

CA Budget Deal

- Legislature adopts a phased Medi-Cal budget framework, delaying most previously approved and newly proposed cuts until July 1, 2027, including dental benefit reductions, clinical payment cuts, and UIS premium changes
- Agreement transitions UIS population from managed care to fee-for-service while preserving CalAIM benefits and continuity of care, with added time to evaluate options for maintaining managed care for non-emergency services
- Rejects several additional proposed cuts, including:
    - Program All-Inclusive for the Elderly (PACE) rate caps
    - Elimination of acupuncture
    - Sets Medi-Cal asset limit at $21,00 beginning in 2026-2027
- Advances in new financing strategies, including:
    - Initial steps to evaluate “Fair Share from Big Corporations Act”
    - Increases County funding for Medi-Cal eligibility workload
    - Increases funding for distressed hospital loan program
- Increases funding to reduce Covered California premiums
- Maintains targeted investments in reproductive health, gender-affirming care, public health IT and crisis response services
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Legislative Update

- With the budget passed, lawmakers are focused on moving all policy bills by the July 2 deadline before beginning summer recess
- The Legislature reconvenes August 3 for an accelerated round of fiscal committee hearings, which must conclude by August 14
- The final two weeks of session will be dedicated to floor votes as both houses work to clear remaining legislation before adjournment on August 31
- We are closely monitoring all remaining legislative bills and forthcoming budget trailer bill language to assess potential impacts as details continue to evolve

CHAIR’S REPORT

Chair Valentine announced the well-deserved retirement of Dr. Lakshmi Dhanvanthari, CMO, and expressed appreciation for her many years of service and leadership.

COMMISSIONER COMMENTS

Commissioner Herrera wished Dr. Lakshmi the very best in her retirement and noted that she has been a wonderful partner who has done exceptional work for the community and will be missed.

The Health Commission went into a Closed Session at 6:10 pm.

CLOSED SESSION

9. Closed Session – Trade Secrets
   Welfare and Institutions Code Section 14087.31
   Title: Organization Update

10. 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 6:53 pm.

ADJOURNMENT

Chair Valentine adjourned the meeting at 6:53 p.m. The next regular meeting of the Health Commission is scheduled for August 26, 2026.