MINUTES OF THE MEETING OF THE SAN JOAQUIN COUNTY HEALTH COMMISSION

September 27, 2023
Health Plan of San Joaquin – Community Room

COMMISSION MEMBERS PRESENT:

Greg Diederich, Chair
Brian Jensen, Vice-Chair
Neelesh Bangalore, MD
Michael Herrera, DO
Christine Noguera
Elyas Parsa, DO
Miguel Villapudua
Jay Wilverding
Terry Woodrow
John Zeiter, MD

COMMISSION MEMBERS ABSENT:

Paul Canepa
Olivia Byron-Cooper
Farhan Fadoo, MD

STAFF PRESENT:

Lizeth Granados, Chief Executive Officer
Sunny Cooper, Chief Compliance Officer
Evert Hendrix, Chief Administrative Officer
Dr. Lakshmi Dhanvanthari, Chief Medical Officer
Elizabeth “Liz” Le, Chief Operations Officer
Ildi Rabinowitz, Chief Health Equity Officer
Michelle Tetreault, Chief Financial Officer
Kirin Virk, Deputy County Counsel
Sue Nakata, Executive Assistant to CEO and Clerk of the Health Commission

CALL TO ORDER

Chair Diederich called the meeting of the Heath Commission to order at 5:00 p.m.

PRESENTATIONS/INTRODUCTIONS

Chair Diederich welcomed new commissioners, Supervisor Terry Woodrow of Alpine County and Olivia Byron-Cooper, Director of Health and Human Services of El Dorado County, to the Health Commission.

Chair Diederich also announced that Kirin Virk, Deputy County Counsel has been appointed by the Board of Supervisors as new counsel to support the Health Commission.

PUBLIC COMMENTS

No public comments were forthcoming.

MANAGEMENT REPORTS

1. CEO Report

Lizeth Granados, CEO, welcomed Commissioner Woodrow to the Health Commission and HPSJ's new COO, Elizabeth Le, followed by an update on the following:

Equity and Practice Transformation (EPT) Program

HPSJ is partnering with network providers to ensure the success of the EPT Payment Program launched by the Department of Health Care Services (DHCS). The EPT Payment Program is a one-time $700 million primary care provider practice transformation program designed to advance health equity, reduce COVID-driven care disparities, invest in upstream care models, and fund practice transformation.

Available to primary care providers, including OB/GYNs and behavioral health providers in primary care settings, the EPT Payment Program will fund activities that help Medi-Cal providers deliver value-based care and optimize equity. To be eligible, practices must complete activities related to empanelment and access, technology and data, and patient-centered population-based care. Additionally, practices may optionally complete activities related to evidenced-based models of care, leadership and culture, behavioral health, social health, and value-based care and alternative payment models.

The EPT Payment Program is an opportunity for plans and providers to receive funding over the course of a five-year period. Consisting of three components, the EPT Payment Program first designates $25 million over one year for the Medi-Cal Managed Care Plan Initial Provider Planning Incentive Payments, which incentivizes plans to lend support as practices develop transformation plans and prepare applications. In subsequent years, the EPT Payment Program will designate $650 million to the Provider Directed Payment Program for practices to implement transformation infrastructure, as well as $25 million for a Statewide Learning Collaborative, which supports participants in the Provider Directed Payment Program by sharing best practices.

Primary care practices with at least 500 Medi-Cal members assigned may apply for the EPT Provider Directed Payments. Funding depends on the number of assigned Medi-Cal members, as minimum payments begin at $375,000 for practices with 500 to 1,000 assigned members, while maximum payments rise to $10 million for practices with over 100,000 assigned members. Payments will be disbursed upon practices completing EPT Payment Program activities and milestones.

Upon review of the EPT Payment Program, Commissioner Herrera asked how providers are notified of the transformation. Ms. Granados responded that HPSJ looks at the population that the providers serve to identify and request their participation, as well as educating and informing them of the program; a good portion of HPSJ's providers are interested in participating.

Commissioner Zeiter asked how DHCS is planning to fund the program. Ms. Granados responded that an initial application process is required for submission to the state and DHCS will issue payments in increments based on meeting benchmarks.

DHCS Approves Mountain Valley Health Plan Operations in Alpine and El Dorado Counties

HPSJ is authorized by DHCS to go-live as Mountain Valley Health Plan in Alpine and El Dorado Counties on January 1, 2023. Approval by DHCS is contingent on our implementation of operational readiness deliverables detailed in the 2024 Medi-Cal contract. In preparation for our service to Alpine and El Dorado Counties, HPSJ is growing our provider network and partnering across the service areas to meet the needs of members. Additionally, representatives from Alpine and El Dorado Counties have been seated on our governing Health Commission and we are working to secure an office in Placerville to support services to the community. HPSJ's successful expansion into a new service area is the result of tremendous persistence and teamwork by our dedicated staff.

Upon Ms. Granados's update, Commissioner Jensen asked how members are distributed to different plans. Ms. Granados responded that members will be mailed a packet from DHCS, and they are given the option to choose between HPSJ and Anthem; November 1, 2023 is when HPSJ will be notified how many members we will receive.

HPSJ Partners to Support Members as Medi-Cal Redeterminations are Underway.

On April 1, 2023, following the ending of the federal public health emergency for COVID, California counties resumed routine Medi-Cal enrollment operations by initiating annual renewals to redetermine the eligibility of beneficiaries. However, HPSJ's membership has declined less than anticipated since our service area counties began processing Medi-Cal renewals.

HPSJ has been outreaching to members to provide education on having the members update their contact information, which supports counties as they process redeterminations. We have utilized a variety of mediums to connect with members, including through mail, texting campaigns, social media, radio broadcasts, and health fairs. Additionally, HPSJ is partnering with members, providers, county health agencies, community-based organizations, school districts, and other stakeholders to ensure the continuity of coverage for our members.

Upon review of the presentation, Commissioner Jensen asked if the State of CA has been active to support members so that we don't lose eligibility. Ms. Granados responded that DHCS is submitting campaigns including activities on radio, social media, T.V., etc.

Chair Diederich asked if the unwinding waivers that CMS have approved are approved for a period of time or will it be permanent. Ms. Granados responded that she is unsure of the waiver period, to follow up and will advise. As for eligibility being retroactive, the state is ensuring that they don't lose members and looking at active retro-enrollment.

HPSJ Participates in the 2024 San Joaquin Valley Affordable Housing Summit.

HPSJ's invitation to present at the Affordable Housing Summit recognizes our successful CalAIM implementation and leading role as key partners in the community, as we are continually strategizing with stakeholders to drive positive social change and optimize services to meet the complex needs of individuals experiencing homelessness.

CalAIM provides many upstream opportunities for HPSJ and other Medi-Cal managed care plans to collaborate across sectors to address issues related to housing and community homelessness. Since launching CalAIM, HPSJ has worked to implement programs that include Complex Care Management, Enhanced Care Management, and Community Supports, among other services to support our most vulnerable members. The discussion led by HPSJ at the Affordable Housing Summit focused on our innovative efforts under CalAIM to partner on supporting the provision of housing and homelessness services throughout the region.

HPSJ Increases our Health Plan Rating by the National Committee for Quality Assurance (NCQA).

The NCQA health plan rating for HPSJ increased from 3 stars to 3.5 stars in 2023. HPSJ is proudly among the few NCQA accredited Medi-Cal managed care plans in California. As an NCQA accredited health plan, HPSJ must work diligently to demonstrate our continued commitment to optimizing health care quality and access for our members.

NCQA bases a health plan's rating on its performance, as measured by the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). While HEDIS is used to evaluate the performance of a health plan in several dimensions, including effectiveness, availability, and experience of care, CAHPS is a survey that assesses healthcare services delivered in specific settings and for specific conditions. HPSJ's increased health plan rating is an achievement that reflects our upstanding efforts to continuously improve the health of our community.

Upon Mrs. Granados's update, the following questions were raised by commissioners:

Q: Wilverding: What is the scale?
A: Granados – Up to 5.

Q: Diederich – Does the scoring start at a 1?
A: Granados – Yes and to get to a 5 score is extremely difficult. I am very proud of the team because of all the work they put in.

Q: Jensen – What is the range of quality rankings in health plans?
A: Granados – Not all plans are accredited. Right now, there is a subset of plans that are NCQA accredited. The state is working to make it a requirement for health plans to be NCQA accredited.

Q: Wilverding – What is integrated model?
A: Granados – This is similar to the a "Kaiser" model; hospitals and providers are integrated into one, including clinics.

Commissioner Villapudua left the meeting at this time.

CONSENT CALENDAR

Chair Diederich presented three consent items for approval:

2. August 30, 2023 SJC Health Commission Meeting Minutes

3. Finance and Investment Committee – 09/20/2023
    a. June 15, 2023Meeting Minutes
    b. Investment Custodian Transition Agreement
    c. Investment Portfolio Performance Agreement
    d. ePlus Technology, Inc Contract
    e. Symphony Performance Health Contract Extension
        i. Adult and Child CAHPS
        ii. Provider Satisfaction
        iii. After Hours Access
        iv. Member Experience with Language Access

4. Human Resources Committee – 09/27/2023
    a. August 30, 2023 Meeting Minutes
    b. Standy Pay Policy

ACTION: With no questions or comments, the motion was made (Commissioner Jensen), seconded (Commissioner Zeiter), to approve the three consent items as presented (9/0).

REPORT ITEMS

5. July 2023 YTD Financial Reports

Michelle Tetreault, CFO presented for approval the July 2023 YTD financials, highlighting the following:

- Net Income is $13.2M and is $4.4M favorable to budget

- Premium Revenue is -$8.2M unfavorable to budget YTD, attributed to lower than budgeted enrollment in LTC categories of aid

- Managed care expenses are $8.2M favorable to budget YTD, the unfavorable YTD variance is primarily attributable to the following factors:
    - +$3M favorable impact to Institutional due to (a) decreased utilization resulting from lower than budgeted enrollment resulting in +$5M favorable change, offset by (b) LTC supplemental payments that were not factored into the budget resulting in a -$2M unfavorable change
    - +$5M favorable overall due to more low and non-utilizers in our membership than budgeted, mainly due to the timing of disenrollments due to the end of the PHE moratorium. DHCS has resumed the disenrollment process; however, the rate at which low and non-utilizers are being disenrolled is slower than we had anticipated in the budget. As DHCS ramps up it operations, we expect the timing differences to even out over the course of the fiscal year

- Other Program Revenues and Expenses (Net) - Net other revenues and expenses are -$2.1M unfavorable (-$4.59 PMPM) to budget YTD primarily due to incentive program income budgeted but not yet earned. The variance is temporary due to timing differences between the budgeted vs. earned month and is expected to be reversed later in the fiscal year

- Administrative Expenses are $2.6M favorable to budget YTD primarily due lower than budgeted IT subscription, consulting costs and personnel costs

- Prior period adjustments are primarily due to changes in estimates of IBNR

ACTION: With no questions or comments, the motion was made (Commissioner Bangalore) seconded (Commissioner Wilverding) and unanimous to approve the July 2023 YTD financial reports as presented (9/0).

6. Peer Review and Credentialing (PRC) Committee Update – 09/14/2023

Dr. Lakshmi Dhanvanthari, CMO submitted for approval the PRC Committee report from 9/14/2023:

- Direct Contract Providers: 151
    - Initial Credentialed for 1 Year = 2
    - Initial Credentialed for 3 Years = 27
    - Recredentialed for 1 Year = 4
    - Recredentialed for 3 Years = 94
    - Clean File Initial Credentialing Sign Off Approval by CMO: 24

Upon review of Dr. Dhanvanthari's report, the following questions were raised by commissioners:

Q: Jensen - For "clean" file credentialing, how long does this process go back?
A: Dr. Dhanvanthari – Clean file Credentialing has been there from day 1 and based on our policy, the CMO can sign off on clean files if a provider has a start date between credentialing cycles and has a clean file. We rarely used it in the past. But now that there is a flurry of recruitment activity, there are requests between cycles and if the provider needs to start prior to the next credentialing meeting & they have a clean file, we approve per policy. The day that the file is signed off is when the provider is considered credentialed.

Q: Diederich - Who else has credentialing capability?'
A: Dr. Dhanvanthari – Providers must prove to us that they have all the policies and procedures (P & P) in place, requirements, as well as they need to be NCQA accredited or meet NCQA accreditation requirements. Once they do this, they are accepted as being delegated. Annually, the Delegation Committee conducts delegation oversight reviews in detail for continued approval.

Q: Parsa - How long is the process for a physician to be credentialed?
A: Dr. Dhanvanthari - It depends when the Peer Review & Credentialing meeting is held relative to the application date, as meeting is held bi-monthly. It goes through the committee as soon as the application is submitted and processed. It takes longer to process an application if it is not a "clean" file. Within a 2-month window we review and take action, unless it is a complicated case then we send it out for external review, which is rare.

ACTION: With no questions or comments, a motion was made (Commissioner Parsa), seconded (Commissioner Jensen) with one abstention (Commissioner Herrera) to approve the Peer Review and Credentialing Committee report for 09/14/2023 as presented (8/1).

ACTION: With no questions or comments, a motion was made (Commissioner Parsa), seconded (Commissioner Jensen) with one abstention (Commissioner Herrera) to approve the Peer Review and Credentialing Committee report for 09/14/2023 as presented (8/1).

INFORMATION ITEMS

7. Chief Compliance Officer Bi-Monthly Compliance Update

Sunny Cooper, CCO provided an update on the bi-monthly compliance report, highlighting the following:

2023 FWA Report (June-August)

- The PIU has opened 19 new cases in 2023
  - Between June-August, the PIU opened 11 of those 19 new cases; All 11 new cases were reportable to DHCS/DOJ as credible allegations of fraud, and all were also reported timely, per policy

- 2022 DHCS Medical Audit – Remediation Status (total of 9 deficiencies)

#	Deficiency	CAP Status	Planned	Accepted	Partially Accepted*
01	**Finding 1.2.1:** The Plan did not use the appropriate coverage criteria to deny medical service requests.	Open	9	5	4
02	**Finding 2.1.1:** The Plan did not ensure the provision of oral or written blood lead anticipatory guidance to the parent(s) or guardian(s) of a child member at each PHA starting at six months of age and continuing until 72 months.	Open	4	3	1
03	**Finding 2.1.2:** The Plan did not ensure the provision of a blood lead screening (BLS) tests to members at 12 months to 72 months of age.				
04	**Finding 3.1.1:** The Plan did not ensure that corrective actions were implemented for providers who did not comply with appointment wait time standards.	Closed	2	2	0
05	**Finding 3.1.2:** The Plan did not monitor the wait times for providers to answer and return calls to members.				
06	**Finding 3.1.3:** The Plan did not have a policy and procedure to monitor providers' compliance with wait times in the providers' offices for scheduled appointments.				
07	**Finding 3.2.1:** The Plan did not ensure the use of a DHCS-approved PCS form, complete with required information, to determine the appropriate level of service for Medi-Cal members.	Open	11	6	5
08	**Finding 3.2.2:** The Plan did not ensure that its NEMT providers are enrolled in the Medi-Cal program.	Open	2	0	2
09	**Finding 4.1.1:** The Plan did not ensure full grievance resolution prior to sending resolution letters.	Open	12	10	2
			40	26	14

- 2023 DHCS FSR Audit for Expansion Counties
  - June 5th, 2023 - DHCS notified HPSJ that they would be conducting a Facility Site Review (FSR) audit of two provider groups in South Lake Tahoe and Placerville (the expansion counties service areas). The audit was conducted onsite at the providers' facilities
  - July 18th, 2023 - DHCS issued its preliminary report citing two* (2) Findings that must pass elements. HPSJ and the providers submitted corrective action plans (CAP)
  - Barton Community Health Center received an audit score of 88%. 18 deficiencies, CAPs accepted
  - Shingle Springs Tribal Health received an audit score of 93%. 8 deficiencies and *2 must pass elements; CAPS accepted
  - September 1st, 2023 - DHCS notified HPSJ that all CAPs have been closed

- 2023 DHCS Medical Survey and Focused Audit
  - Audit notification received on August 1, 2023. DHCS will conduct both Focused Audit and Annual Medical Survey Audit concurrently
  - Focused audits on Mental Health and Transportation
  - Annual Medical Survey is reviewing the following categories:

- Category 1 – UM
- Category 2 – CM and COC
- Category 3 – Access (Emergency and Family Planning only)
- Category 4 – Member's Rights
- Category 6 – Administrative and Organizational Capacity

- Virtual on-site interviews are scheduled between 10/31/23 thru 11/10/23
- HPSJ's Audit Team collects all pre-onsite documents requested by the DHCS Audit Teams. Documents were submitted by 09/15/23

Upon reviewing the compliance report, Chair Diederich asked if the DOJ are the ones that prosecutes. Ms. Cooper responded that a federal agent is assigned to the case if DOJ decides to take on the case. These federal agents are specifically assigned to the state Medi-Cal programs. When HPSJ report cases to DOJ, they look at all statistics and based on credibility, we then play a supporting role in providing them with the data upon request. They don't come back to us to tell us what happened specifically when cases are under investigation. We report to both DOJ and DHCS on credible fraudulent activities.

8. Legislative Update

Brandon Roberts, Manager of Government and Public Affairs, presented on legislative end of year wrap-up of which Priority Bills were advanced and bills that failed deadlines, which may be considered in 2024:

End of Year Wrap-Up

California's Legislature adjourned for Interim Recess on September 14th

- The Governor has until October 14th to sign or veto bills that were passed by both houses of the Legislature
- The Legislature is adjourned for the remainder of the year and reconvenes the 2023-24 Legislative Session on January 3rd

Priority Bills Advanced by the Legislature to the Governor

- AB 719 (Boerner) – Medi-Cal: nonmedical and nonemergency medical transportation. Would require Medi-Cal managed care plans to contract with public paratransit service operators who are enrolled Medi-Cal providers for the purpose of establishing reimbursement rates for trips provided by a public paratransit service operator
- AB 1085 (Maienschein) – Medi-Cal: housing support services. Would require DHCS to seek federal approval for the housing support services benefit, whereby a Medi-Cal beneficiary would be eligible for housing support services if they experience homelessness or are at risk of homelessness
- SB 525 (Durazo) – Minimum wage: health care workers. Would enact a phased in multitiered statewide minimum wage schedule for health care workers employed by covered health care facilities.
  - Minimum wage amounts and schedules would vary by the type of health care facility.
  - Schedule would range from $18 to $23 per hour in 2024, gradually increasing to $25 or more in subsequent years
- SB 770 (Wiener) – Health care: unified health care financing. Would direct the California Health and Human Services Agency to pursue waiver discussions with the federal government with the objective of a unified health care financing system that incorporates a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, without cost sharing.

Priority Bills that Failed Deadlines and May be Reconsidered in 2024

- SB 282 (Eggman) – Medi-Cal: federally qualified health centers and rural health clinics. Would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single FQHC or RHC site if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit
- SB 598 (Skinner) – Health care coverage: prior authorization. Would, on or after January 1, 2026, prohibit a health plan from requiring a contracted health professional to obtain prior authorization for any covered health care services if the plan approved not less than 90% of the prior authorization requests submitted by that health professional in a one-year contracted period

Extensive discussions were held on SB 525, with Commissioner Jensen stating that organizations are not allowed to make any adjustments, it is phased by type of hospital's overtime; ramp up in type of wages. The larger 12 systems will get to $25 by 2026. For smaller hospitals, margins are not robust and will take longer. Chair Diederich and Commissioner Noguera both stated that it is beyond hospitals and clinics will be included.

Commissioner Bangalore asked, regarding SB 770, in CA, if the state is expecting to only have one health plan. Mr. Roberts responded that local health plans will not be diminished; elements of local control and coordinating of care will be only one payer. The plan will still function as is, we will be a middle entity between the state and members. This will have more of an impact on commercial plans.

CHAIRMAN'S REPORT

Chair Diederich reported that he has been appointed the interim CEO for SJ Health.

COMMISSIONER COMMENTS

No comments were forthcoming.

Commissioner Jensen left the meeting at this time.

CLOSED SESSION

At this time, the Health Commission adjourned to Closed Session at 6:03 p.m.

Closed Session – Conference with Real Property Negotiators
California Government Code Section 54956.8
Title: Request to Negotiate Purchase of El Dorado Office
Property: 3970 Missouri Flat Rd, Placerville, CA 95667
Agency Negotiator: Tom Conwell, Jr.
Negotiating Parties: Andy Haley
Under Negotiation: Price and Terms of Payment

ACTION: A motion was made (Commissioner Noguera), seconded (Commissioner Bangalore), with one abstention (Commissioner Herrera) to approve for staff to engage in research and serious negotiations for the potential purchase of commercial real estate property to serve as the long-term Mountain Valley Health Plan Office in El Dorado County. (7/1).

The Health Commission came out of Closed Session at 6:23 p.m.

ADJOURNMENT

Chair Diederich adjourned the meeting at 6:24 p.m. The next regular meeting of the Health Commission is scheduled for October 25, 2023.