# Finance Committee Meeting Agenda

April 15, 2026: 8:00 a.m. – 9:30 a.m.

**In-person Locations:**
Partnership's Chico Office located at 1000 Fortress St, Chico, CA
Partnership's Fairfield Office located at 4605 Business Center Drive, Fairfield, CA (Conference Center)
Partnership's Redding Office located at 2525 Airpark Dr., Redding, CA
Partnership's Santa Rosa Office located at 495 Tesconi Circle, Santa Rosa, CA
Partnership's Eureka Office located at 1036 5th Street, Eureka, CA
Partnership's Auburn Office located at 281 Nevada Street, Auburn, CA

**Finance Committee Members:** Jayme Bottke, Chris Champlin, Dave Jones, Chair, Ryan Gruver, Alicia Hardy, Dean Germano, Nancy Starck, Nolan Sullivan

**Public Participation**
Public comment is welcome during designated "Public Comments" time frames or by emailing comments to the Board Clerk at Board_FinanceClerk@partnershiphp.org by 5:00p.m on April 14, 2026. Comments received will be read during the meeting.

| **8:00A.M – Opening** | | | |
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| 1.1 **Call to Order** | | | *Dave Jones, Chair* |
| 1.2 **Roll Call** | | | *Clerk* |
| 1.3 | ***ACTION:*** Approval of Agenda | 1 | *Chair* |
| 1.4 | ***ACTION:*** Approval of Finance Committee Minutes from March 18, 2026 | 2-8 | *Chair* |
| 1.5 **Commissioner Comment** | | | *Chair* |
| 1.6 **Public Comment** | | | *Public* |
| **New Business** | | | |
| 2.1 | ***INFORMATION:*** CEO Health Plan Update | 9 | *Sonja Bjork* |
| 2.2 | ***ACTION:*** Accept February 2026 Metrics and Financials | 10-23 | *Jennifer Lopez* |
| 2.3 | ***ACTION:*** Resolution to Approve Budget Revisions for FY 2025-2026 | 24-27 | *Jennifer Lopez* |
| 2.4 | ***ACTION:*** Resolution to Approve Budget Assumptions for FY 2026-2027 | 28-38 | *Jennifer Lopez* |
| **Adjournment** | | | |

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular finance meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the committee. The Finance Committee has designated the Board Clerk as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection. The Finance Committee Meeting Agenda and supporting documentation is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all PHC regional offices (see locations above). It can also be found online at www.partnershiphp.org. PHC meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Board Clerk at least two (2) working days before the meeting at 707-863-4516 or by email at *ascott@partnershiphp.org*. Notification in advance of the meeting will enable the Clerk to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it. This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda.

**MINUTES OF THE MEETING OF**
**PARTNERSHIP HEALTHPLAN OF CALIFORNIA FINANCE COMMITTEE**
**In person locations:**

**Partnership's Fairfield Office located at 4605 Business Center Drive, Fairfield, CA (Conference Center)**
**Partnership's Redding Office located at 2525 Airpark Dr., Redding, CA**
**Partnership's Santa Rosa Office located at 495 Tesconi Circle, Santa Rosa, CA**
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**Partnership's Auburn Office located at 281 Nevada Street, Auburn, CA**
**Partnership's Chico Office located at 1000 Fortress Street, Chico, CA**

**On**
**March 18, 2026**

**Members Present:** Jayme Bottke, Chris Champlin, Dean Germano, Ryan Gruver Alicia Hardy, Dave Jones, Chair, Nancy Starck, Nolan Sullivan
**Members Excused:** None
**Staff**: Leigha Andrews, Jill Blake, Wendell Coats, Wendi Davis, Marisa Dominguez, Naomi Gordon, John Lemoine, Jennifer Lopez, Kathryn Power, Ashlyn Scott, Tim Sharp, Rebecca Stark, Amy Turnipseed, Colleen Valenti

| AGENDA ITEM | DISCUSSION | MOTION / ACTION |
|---|---|---|
| **1.2 Roll Call** | Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a quorum. | None |
| **1.3 Approval of Agenda** | Chairman Jones asked if anyone had changes to the agenda. Hearing no requests for modification, he asked for a motion to approve the agenda. | *Commissioner Starck moved to approve the agenda as presented, seconded by Commissioner Hardy.* |

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| | | ***ACTION SUMMARY:***<br>*Yes: 8*<br>*No: 0*<br>*Abstention: 0*<br>*Excused: 0*<br><br>**MOTION CARRIED** |
| **1.4 Approval of the February 18, 2026, Finance Committee Meeting Minutes** | Chairman Jones asked if anyone had changes to the February 18, 2026, minutes. Hearing no requests for modification, he asked for a motion to approve the minutes. | *Commissioner Starck moved to approve the minutes as presented, seconded by Commissioner Germano.*<br><br>***ACTION SUMMARY:***<br>*Yes: 8*<br>*No: 0*<br>*Abstention: 0*<br>*Excused: 0*<br><br>**MOTION CARRIED** |
| **1.5 & 1.6 Public Comment and Commissioner Comment** | Chairman Jones asked if there were any public or commissioner comments. There were none. | None |
| **New Business** | | |
| **2.1 CEO Report** | Sonja Bjork, Chief Executive Officer, reported on the following topics:<br><br>***IGTs / Voluntary Rate Range Program—*** The Voluntary Rate Range Program is a tool used to draw down federal dollars for public entities with taxing authority. Its future is not certain, but as of now, it remains allowable under H.R. 1.<br><br>In January, Partnership distributed Calendar Year 2024 payments to participating entities, including fire districts, counties, University of California campuses, and district hospitals. Entities seeking to participate in CY 2025 are required to submit letters of intent to Partnership by the end of March. Given the strict timeline, reminders will be issued to ensure timely submissions. Funds must continue to be used exclusively to offset unmet costs for Medi-Cal covered services within the managed care delivery system. | None |

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| | ***Rural Health Transformation Funding –*** California has been awarded a little over $220 million in rural health transformation funding; a relatively small amount for the entire state and insufficient to offset the significant Medicaid reductions. Implementing this program will require substantial consulting support to interpret the rules and determine which projects qualify for funding. In addition, the state's spending plan will require CMS approval.<br><br>While additional details regarding the funding application process are still pending, Partnership is working to ensure our counties can maximize available funding. Partnership will remain available to provide guidance and issue deadline reminders to support timely participation. We are encouraging providers to register on the HCAI website to receive updates on Rural Health Transformation funding, including notifications about upcoming webinars and additional information as it becomes available. Workgroups and subcommittees are also forming, and providers may be invited to participate or may request to join. Oversight of the program is extensive, and the funds must be used exclusively for new initiatives, not for existing Medicaid services. Projects must also fall within CMS-approved categories.<br><br>*Commissioner Gruver asked which entities, in addition to hospitals, are eligible for the funding.*<br><br>*Ms. Bjork responded that rural health providers such as tribal health centers, Federally Qualified Health Centers (FQHCs), and hospitals may apply. She noted that once additional information is received, eligibility can be further assessed. Ms. Bjork added that projects demonstrating strong collaboration will likely have the greatest opportunity for funding.*<br><br>***Sacramento Update –*** Last week, Partnership's Government Affairs team hosted a lunch-and-learn at the State Capitol for legislators and staff. Commissioner Chris Champlin participated on the panel representing rural hospitals. The event provided an opportunity to build awareness of Partnership's role and strengthen relationships with legislators and their staff.<br><br>Staff also met with several elected officials, including Assemblywoman Hadwick, who expressed strong satisfaction with Partnership's work. She also publicly acknowledged Partnership during an event later that day. Bipartisan collaboration is essential, particularly in light of shared concerns across parties regarding rural hospital financial restraints and potential closures. While federal advocacy efforts will continue, Partnership will place increased emphasis on state-level advocacy in the coming year.<br><br>***CalAIM –*** DHCS has expanded its expectations for Enhanced Care Management (ECM), focusing on increased engagement and documentation for higher-need populations, including individuals experiencing homelessness and those with serious mental illness (SMI). The State is emphasizing more face-to-face visits and greater rigor in encounter reporting, with reimbursement guidance favoring in-person services over virtual visits. | |

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| | There is also heightened scrutiny of the Community Supports program, with increased focus on program integrity. California is preparing for federal-level oversight similar to that experienced in Minnesota. As a result, Partnership is closely reviewing eligibility criteria, service duration, outcomes, and cost savings within its Community Supports programs. We expect these programs are likely to continue to receive significant regulatory and fiscal scrutiny.<br><br>*Commissioner Hardy shared that her organization has conducted staff surveys related to burnout and reported that Enhanced Care Management (ECM) providers showed some of the lowest rates of perceived accomplishment and the highest levels of burnout. She noted that these staff are often among the least formally trained while serving some of the most challenging populations. Commissioner Hardy expressed concern that while there are incentives to maintain ECM programs to preserve funding, it is necessary to evaluate program effectiveness and consider adjustments if outcomes are not improving, while also seeking ways to retain staff and funding.*<br><br>*Ms. Bjork acknowledged the significant challenges of working with highly complex populations, particularly when staff are tasked with securing housing in environments with limited availability. Ms. Bjork added that ongoing frustrations include limited access to short-term care, housing, and recuperative care options needed to support timely hospital discharges.* | |
| **2.2 *ACTION*: Accept January 2026 Metrics and Financials** | Jennifer Lopez, Chief Financial Officer, presented the financial metrics for the month ending January 31, 2026. At month-end, Partnership reported a deficit of $3.8 million, bringing the year-to-date surplus to $14.3 million. Total Revenue is lower than budget by $43.6 million for the month and $349.1 million for year-to-date.<br><br>She noted continued favorability in interest income, which was $6.7 million favorable year-to-date, however, we are continuing to monitor anticipated rate cuts that could affect future earnings. Directed Payments are $435.0 million unfavorable to budget due to lower than anticipated rates with a corresponding offset. Total Healthcare Costs are lower than budget by $55.1 million for the month.<br><br>There is some favorable revenue related to retroactive membership additions; however, this is not expected to continue and is being treated as a short-term benefit to help prepare for future financial challenges. Favorability in administrative costs is contributing to the year-to-date surplus. While hiring efforts are underway, recruitment is being approached cautiously, with priority given to positions necessary to meet regulatory requirements.<br><br>Ms. Lopez reported that days of cash on hand decreased to 120 days, primarily due to the timing of Managed Care Organization (MCO) tax payments. Revenue was received from the State and subsequently used to satisfy tax liabilities. In addition, funding was disbursed in January for the CY 2024 Voluntary Rate Range Program to entities such as district hospitals, University of California | *Commissioner Champlin moved to approve the January metrics and financials as presented, seconded by Commissioner Hardy.*<br><br>***<u>ACTION SUMMARY:</u>***<br>*Yes:8*<br>*No: 0*<br>*Abstention: 0*<br>*Excused: 0*<br><br>**MOTION CARRIED** |

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| | hospitals, and fire departments that participate in the program.<br><br>Membership totaled just under 883,000 as of the January close and declined to approximately 868,000 as of March.<br><br>*Commissioner Hardy asked about the acuity of members who are disenrolling.*<br><br>*Ms. Lopez responded that disenrollment trends appear to be concentrated among low and non-utilizers, while members who remain enrolled tend to have higher acuity and greater service needs.*<br><br>*Commissioner Champlin asked whether the committee could review membership declines by utilization category, including high- and low-utilizing members.*<br><br>*Ms. Lopez responded that this analysis will be presented as part of the budget process, which occurs over the April to June time period.*<br><br>***Enrollment Trends***<br>Ms. Lopez presented membership trend to the committee. The committee reviewed membership declines by citizenship status for the period of January to March 2026 Partnership observed net total membership losses of nearly 26,000 members. Partnership did regain approximately 4,300 members who had been previously disenrolled during the months of January and February that were reinstated in March. Partnership's conservative fiscal approach has positioned the organization well amid broader enrollment declines.<br><br>*Commissioner Hardy asked whether data is available indicating what percentage of membership losses may be attributable to county enrollment clean-up efforts.*<br><br>*Ms. Lopez responded that the analysis is still underway and that county input would be helpful as we are unsure if the disenrollment reason code provides this level of detail. She noted that duplicate CIN clean-up is occurring, and that additional factors may include disenrollment from mixed-status households and acknowledged potential member confusion on when work requirements to into effect could be attributing to the declines.*<br><br>*Commissioner Germano asked whether membership typically increases during an economic recession.*<br><br>*Ms. Lopez responded that membership historically does increase during recessions; however, she noted that current factors, including the enrollment freeze for members with unsatisfactory immigration status (UIS) age 19 to 64 and upcoming work requirements for Medi-Cal recipients,* | |

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| | *may counter the usual recession-driven membership growth.*<br><br>***Risk-Based Hospital Directed Payments***<br>Ms. Lopez explained that directed payments are financial arrangements in which State Medicaid agencies require managed care plans to make specific payments to providers. In California, the Department of Health Care Services (DHCS) develops and oversees directed payment programs, determines payment methodologies, identifies eligible recipients, establishes payment frequency, and ensures compliance with federal regulations. She noted that allowable directed payment types include minimum or maximum fee schedules, uniform rate increases, and value-based payments.<br><br>The current hospital directed payment framework relies on a total fixed program amount that is established annually. Payment amounts per service are calculated after the conclusion of the calendar year based on actual utilization and directed payment funding sits outside the health plan's base revenue rates. Payments are issued approximately two years in arrears, allowing for utilization reconciliation. This approach limits risk exposure across plans, hospitals, and the State.<br><br>Beginning in CY 2027, directed payment funding will be incorporated into health plan base revenue rates, and payment amounts per service will be determined prospectively, prior to the program period. Payments are anticipated to be issued more frequently, though the final frequency has not yet been determined and may be monthly or quarterly. She noted that because hospitals contribute through taxes or Intergovernmental Transfers (IGTs) to support the State share of these programs, the new structure may create cash-flow and fiscal strain for some hospitals.<br><br>Ms. Lopez discussed the sizeable statewide hospital directed payment amounts and the associated financial risk with moving to risk-based directed payments. She noted that capitation rates are set based on projected membership, and membership variability creates utilization uncertainty, increasing the risk that plan revenues may be insufficient. Many aspects of the revised programs remain under development and underscored the importance of designing payment models that are operationally feasible while mitigating fiscal risk for plans, hospitals, and the State. | |
| **2.3 *ACTION*: Resolution to Approve Edits to Partnership's Annual Investment Policy (FIN-501)** | Ms. Lopez presented Partnership's Annual Investment Policy, FIN-501, which establishes the investment guidelines used for all operating funds and Board designated reserve funds for the Health Plan. Ms. Lopez noted the policy is reviewed annually and incorporates new regulatory requirements per the Local Agency Investment Guidelines. For 2026 only a few technical updates were needed. | *Commissioner Germano moved to approve Agenda Item 2.3 as presented, seconded by Commissioner Hardy.*<br><br>***<u>ACTION SUMMARY:</u>***<br>*Yes 8*<br>*No: 0*<br>*Abstention: 0* |

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| | | *Excused: 0*<br><br>**MOTION CARRIED** |
| **Adjournment** | Chairman Jones adjourned the meeting at 9:33AM. | None |

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Committee Approval Date: 4/15/2026

Signed: ______________________________
Ashlyn Scott, Clerk

**Finance Committee**
**Chief Executive Officer Update**
**April 15, 2026**

1. **D-SNP**
2. **CalAIM/Transitional Rent**
3. **Community Reinvestments**
4. **Rual Health Transformation**

# FINANCIAL HIGHLIGHTS
# Of The Partnership HealthPlan of California
# For the Period Ending February 28, 2026

## Financial Analysis for the Current Period

### Total Surplus

For the month ending February 28, 2026, Partnership reported a surplus of $17.3 million, bringing the to-date surplus to $31.6 million. Key variances are outlined below.

### Revenue

Total Revenue is lower than budget by $46.0 million for the month and $395.2 million for year-to-date. The following summarizes the year-to-date variances. Medi-Cal revenue is $74.4 million favorable to budget primarily due to retro membership and the prior and current period risk corridor adjustments. Directed Payments are $488.0 million unfavorable to budget due to lower than anticipated rates with a corresponding offset recorded in Healthcare Investment Funds (HCIF). Supplemental revenues were $8.2 million above budget, reflecting higher Proposition 56 revenue and higher than expected volumes for Maternity Kick, partially offset by the timing of DHCS submissions for American Indian Health Services (AIHS) payments. Interest income is $7.4 million favorable to budget due to higher than anticipated interest rates. The remaining favorable variance is attributed to other revenues.

### Healthcare Costs

Total Healthcare Costs are lower than budget by $41.5 million for the month and $400.8 million year-to-date. The following summarizes the year-to-date variances. Non-Capitated Physician and Ancillary expenses are $117.8 million unfavorable to budget primarily due to adjustments to IBNR reserves which reflect the latest cost and utilization trends. Capitation expenses are $8.0 million favorable to budget due to changes in the funding methodologies for certain healthcare providers. Long-term care costs are unfavorable to budget by $4.5 million due to higher prior period rate adjustments. Inpatient Hospital Fee-For-Service (FFS) expenses are favorable to budget by $40.2 million, driven by adjustments to IBNR reserves attributed to lower utilization. HCIF expenses are $465.7 million favorable to budget due to lower than anticipated Directed Payment rates. Transportation costs are $3.8 million unfavorable to budget, attributed to increased utilization and an accrual for an increase in the GEMT-PP rate. Quality Assurance expenses are $12.8 million favorable to budget due to the timing of medical administrative costs.

### Administrative Costs

Total Administrative costs are overall favorable to budget by $9.8 million for the month and $48.4 million for the year-to-date. The primary positive variance is in Employee costs due to the timing of the filling of open positions geared towards fulfilling our regulatory requirements; this variance offsets some of the utilization of consultants in the Professional Services category. An additional variance is in Occupancy due to the timing of building related costs including repairs, maintenance, and utilities, as well as the depreciation expenses that accompany capital asset purchases. Lastly, an additional variance in Computer and Data is due to the timing of software purchases, which typically correlates to the variance in staffing.

### Balance Sheet / Cash Flow

Total Cash & Cash Equivalents increased by $50.1 million for the month. Typical significant cash

transactions include State Capitation payments received; healthcare cost payments to providers; and administrative and capital payments out to vendors, employees, and other entities. There are no significant items of note for the month.

## General Statistics

### Membership

Membership had a total net decrease of 9,243 members for the month.

### Utilization Metrics and High Dollar Case

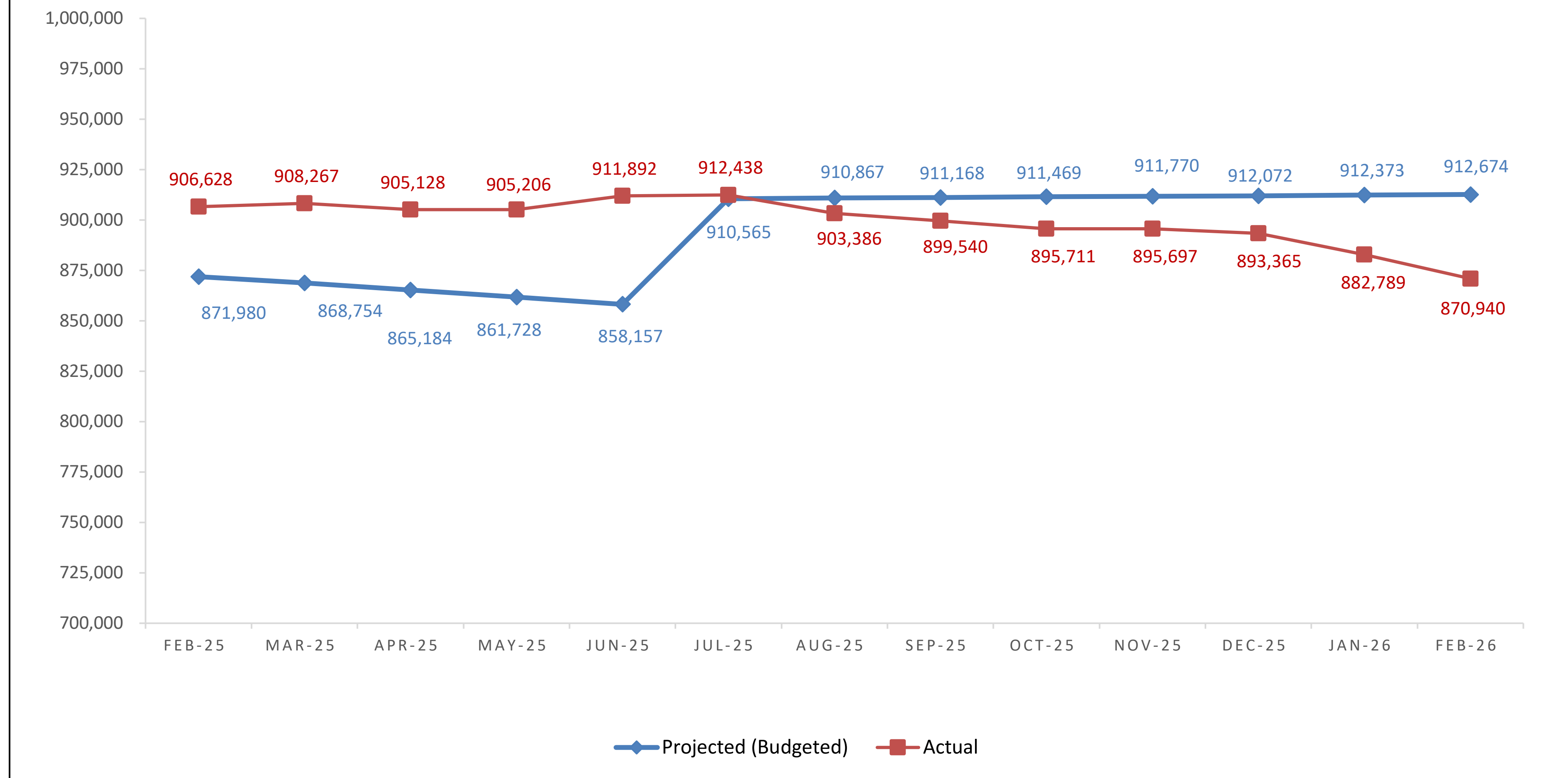
For the fiscal year 2025/26 through February 2026, 512 members reached the $250,000 threshold with an average cost of $506,554. For fiscal year 2024/25, 1,282 members reached the $250,000 threshold with an average cost per case of $515,543. For fiscal year 2023/24, 900 members reached the $250,000 threshold with an average claims cost of $512,454.

### Current Ratio/Reserved Funds

| | |
|---|---|
| Current Ratio Including Required Reserves: | **1.44** |
| Current Ratio Excluding Required Reserves: | **1.01** |
| Required Reserves: | **$ 1,449,235,829** |
| Total Fund Balance: | **$ 1,489,178,704** |

### Days of Cash on Hand

| | |
|---|---|
| Including Required Reserves: | **122.96** |
| Excluding Required Reserves: | **56.56** |




**Member Months by County:**

| County | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Solano | 102,511 | 102,443 | 102,189 | 102,658 | 103,987 | 104,011 | 102,676 | 102,240 | 101,767 | 101,583 | 101,555 | 98,608 | 97,031 |
| Napa | 27,197 | 27,289 | 27,339 | 27,450 | 27,826 | 27,732 | 27,619 | 27,642 | 27,529 | 27,480 | 27,355 | 26,951 | 26,540 |
| Yolo | 52,963 | 53,239 | 53,213 | 53,722 | 55,109 | 54,845 | 54,223 | 54,152 | 53,995 | 54,252 | 54,140 | 53,283 | 52,229 |
| Sonoma | 112,863 | 112,617 | 112,643 | 111,321 | 112,499 | 112,958 | 111,588 | 110,631 | 110,400 | 109,596 | 109,061 | 107,549 | 104,697 |
| Marin | 46,859 | 47,015 | 46,629 | 46,873 | 47,047 | 47,313 | 46,806 | 46,609 | 46,235 | 46,089 | 45,096 | 44,197 | 43,709 |
| Mendocino | 40,899 | 41,086 | 40,682 | 40,941 | 40,852 | 41,104 | 40,506 | 40,390 | 40,244 | 40,200 | 40,229 | 39,247 | 39,125 |
| Lake | 34,229 | 34,164 | 34,124 | 34,105 | 33,983 | 33,960 | 33,568 | 33,236 | 33,298 | 33,359 | 33,389 | 33,107 | 32,715 |
| Del Norte | 12,513 | 12,468 | 12,246 | 12,336 | 12,400 | 12,362 | 12,314 | 12,197 | 12,191 | 12,220 | 12,169 | 12,188 | 12,077 |
| Humboldt | 58,577 | 58,588 | 58,149 | 57,830 | 57,528 | 57,819 | 56,962 | 56,678 | 56,451 | 56,095 | 55,976 | 55,830 | 55,208 |
| Lassen | 8,825 | 8,821 | 8,767 | 8,764 | 8,656 | 8,575 | 8,358 | 8,439 | 8,412 | 8,406 | 8,491 | 8,375 | 8,305 |
| Modoc | 3,990 | 4,011 | 4,013 | 3,930 | 3,893 | 3,878 | 3,888 | 3,827 | 3,743 | 3,747 | 3,845 | 3,836 | 3,703 |
| Shasta | 65,800 | 66,052 | 65,219 | 65,101 | 65,377 | 65,400 | 64,714 | 64,742 | 64,786 | 65,062 | 64,124 | 64,876 | 63,940 |
| Siskiyou | 17,706 | 17,777 | 17,605 | 17,791 | 18,056 | 18,058 | 17,782 | 17,760 | 17,739 | 17,786 | 17,928 | 17,691 | 17,590 |
| Trinity | 5,348 | 5,345 | 5,321 | 5,325 | 5,250 | 5,193 | 5,220 | 5,103 | 5,169 | 5,118 | 5,081 | 4,955 | 4,955 |
| Butte | 85,539 | 86,256 | 85,897 | 85,920 | 85,649 | 84,789 | 84,665 | 84,532 | 84,241 | 84,407 | 84,874 | 84,412 | 83,486 |
| Colusa | 10,232 | 10,288 | 10,340 | 10,306 | 10,362 | 10,260 | 10,152 | 9,996 | 9,913 | 9,968 | 10,006 | 10,025 | 9,825 |
| Glenn | 13,623 | 13,786 | 13,690 | 13,682 | 13,647 | 13,764 | 13,687 | 13,672 | 13,523 | 13,497 | 13,456 | 13,358 | 13,182 |
| Nevada | 28,736 | 28,570 | 28,579 | 28,602 | 28,731 | 28,787 | 28,464 | 28,369 | 28,250 | 28,148 | 28,633 | 28,415 | 28,427 |
| Placer | 60,860 | 61,013 | 61,260 | 61,300 | 62,271 | 62,355 | 61,883 | 61,676 | 61,371 | 61,679 | 61,561 | 60,619 | 59,451 |
| Plumas | 5,858 | 5,925 | 5,886 | 5,807 | 5,755 | 5,784 | 5,783 | 5,616 | 5,575 | 5,478 | 5,429 | 5,395 | 5,292 |
| Sierra | 888 | 868 | 862 | 832 | 862 | 851 | 825 | 832 | 820 | 810 | 813 | 828 | 823 |
| Sutter | 43,691 | 43,601 | 43,739 | 43,829 | 44,348 | 44,796 | 44,471 | 44,294 | 43,923 | 44,223 | 44,067 | 43,956 | 43,584 |
| Tehama | 30,240 | 30,059 | 30,011 | 29,932 | 30,038 | 30,166 | 29,626 | 29,551 | 29,266 | 29,219 | 29,095 | 29,098 | 29,019 |
| Yuba | 36,681 | 36,986 | 36,725 | 36,849 | 37,766 | 37,678 | 37,606 | 37,356 | 36,870 | 37,275 | 36,992 | 35,990 | 36,027 |
| **All Counties Total** | **906,628** | **908,267** | **905,128** | **905,206** | **911,892** | **912,438** | **903,386** | **899,540** | **895,711** | **895,697** | **893,365** | **882,789** | **870,940** |

Medi-Cal Region 1: Sonoma, Solano, Napa, Yolo & Marin; Medi-Cal Region 2: Mendocino & Rural 8 Counties; Medi-Cal Region 3: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama & Yuba

# Partnership HealthPlan of California
## Comparative Financial Indicators Monthly Report
## Fiscal Year 2025 - 2026 & Fiscal Year 2024 - 2025

| FINANCIAL INDICATORS | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | | | | | YTD | Avg / Month As of Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| Total Enrollment | 911,768 | 903,653 | 898,537 | 895,299 | 893,778 | 892,208 | 880,183 | 870,940 | | | | | 7,146,366 | 893,296 |
| | | | | | | | | | | | | | | |
| Total Revenue | 593,945,794 | 596,614,742 | 614,951,654 | 605,173,794 | 589,922,935 | 597,186,401 | 597,564,630 | 582,105,182 | | | | | 4,777,465,132 | 597,183,142 |
| Total Healthcare Costs | 498,796,206 | 506,539,614 | 512,291,047 | 520,182,134 | 500,456,939 | 496,774,321 | 509,948,545 | 476,842,427 | | | | | 4,021,831,236 | 502,728,905 |
| Total Administrative Costs | 24,791,602 | 22,017,598 | 26,477,113 | 24,878,941 | 26,778,257 | 26,528,471 | 26,108,033 | 23,515,181 | | | | | 201,095,196 | 25,136,900 |
| Medi-Cal Hospital & Managed Care Taxes | 66,396,128 | 65,722,340 | 65,436,800 | 65,176,911 | 65,100,207 | 65,268,296 | 65,351,788 | 64,457,740 | | | | | 522,910,210 | 65,363,776 |
| Total Current Year Surplus (Deficit) | 3,961,858 | 2,335,190 | 10,746,694 | (5,064,192) | (2,412,468) | 8,615,313 | (3,843,736) | 17,289,834 | | | | | 31,628,490 | 3,953,561 |
| | | | | | | | | | | | | | | |
| Total Claims Payable | 629,390,689 | 669,310,022 | 649,369,505 | 691,165,158 | 693,242,993 | 695,889,424 | 733,344,288 | 698,356,590 | | | | | 698,356,590 | 682,508,584 |
| | | | | | | | | | | | | | | |
| Total Fund Balance | 1,461,512,071 | 1,463,847,260 | 1,474,593,953 | 1,469,529,761 | 1,467,117,293 | 1,475,732,606 | 1,471,888,870 | 1,489,178,704 | | | | | 1,489,178,704 | 1,471,675,065 |
| Reserved Funds | | | | | | | | | | | | | | |
| State Financial Performance Guarantee | 1,135,173,000 | 1,146,059,000 | 1,166,267,000 | 1,181,553,000 | 1,195,372,000 | 1,208,212,000 | 1,221,224,000 | 1,191,261,000 | | | | | 1,191,261,000 | 1,180,640,125 |
| Board Approved Capital and Infrastructure Purchases | 100,733,349 | 100,103,601 | 98,688,437 | 97,620,158 | 94,941,438 | 93,782,664 | 92,028,380 | 90,442,990 | | | | | 90,442,990 | 96,042,627 |
| Capital Assets | 161,362,815 | 161,328,374 | 162,223,752 | 162,679,193 | 164,744,577 | 165,348,675 | 166,558,763 | 167,531,839 | | | | | 167,531,839 | 163,972,249 |
| Strategic Use of Reserve-Board Approved | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 68,377,668 | 68,377,668 | | | | | 68,377,668 | 70,346,418 |
| Unrestricted Fund Balance | (6,759,761) | (14,646,383) | (23,587,903) | (43,325,258) | (58,943,390) | (62,613,402) | (76,299,941) | (28,434,793) | | | | | (28,434,793) | (39,326,354) |
| Fund Balance as % of Reserved Funds | 99.54% | 99.01% | 98.43% | 97.14% | 96.14% | 95.93% | 95.07% | 98.13% | | | | | 98.13% | 97.40% |
| | | | | | | | | | | | | | | |
| Current Ratio (including Required Reserves) | 1.49:1 | 1.46:1 | 1.44:1 | 1.45:1 | 1.43:1 | 1.43:1 | 1.46:1 | 1.44:1 | | | | | 1.44:1 | 1.45:1 |
| Medical Loss Ratio w/o Tax | 94.55% | 95.41% | 93.23% | 96.33% | 95.36% | 93.39% | 95.82% | 92.12% | | | | | 94.53% | 94.53% |
| Admin Ratio w/o Tax | 4.70% | 4.15% | 4.82% | 4.61% | 5.10% | 4.99% | 4.91% | 4.54% | | | | | 4.73% | 4.73% |
| Profit Margin Ratio | 0.75% | 0.44% | 1.96% | -0.94% | -0.46% | 1.62% | -0.72% | 3.34% | | | | | 0.74% | 0.74% |

| FINANCIAL INDICATORS | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | YTD | Avg / Month As of Jun-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| Total Enrollment | 898,490 | 898,153 | 897,450 | 895,408 | 895,235 | 905,698 | 901,907 | 904,947 | 906,317 | 904,513 | 903,817 | 910,264 | 10,822,199 | 901,850 |
| | | | | | | | | | | | | | | |
| Total Revenue | 516,467,263 | 505,732,274 | 517,421,674 | 517,491,108 | 507,895,691 | 520,768,067 | 518,706,967 | 759,253,557 | 692,900,747 | 592,855,121 | 595,592,203 | 643,816,561 | 6,888,901,232 | 574,075,103 |
| Total Healthcare Costs | 455,570,291 | 455,587,935 | 449,203,390 | 445,671,531 | 422,571,150 | 440,227,707 | 443,280,032 | 430,197,038 | 480,694,520 | 490,255,409 | 527,157,036 | 443,488,949 | 5,483,904,985 | 456,992,082 |
| Total Administrative Costs | 17,164,116 | 20,965,109 | 20,303,694 | 22,663,983 | 19,787,655 | 21,565,508 | 23,537,967 | 22,873,201 | 21,628,246 | 26,832,114 | 23,265,462 | 26,309,568 | 266,896,625 | 22,241,385 |
| Medi-Cal Hospital & Managed Care Taxes | 46,566,563 | 46,437,851 | 46,436,856 | 46,083,262 | 46,460,193 | 46,509,845 | 46,696,106 | 298,302,026 | 105,449,368 | 66,370,265 | 66,176,548 | 66,663,236 | 928,152,119 | 77,346,010 |
| Total Current Year Surplus (Deficit) | (2,833,707) | (17,258,621) | 1,477,734 | 3,072,332 | 19,076,693 | 12,465,007 | 5,192,862 | 7,881,292 | 85,128,613 | 9,397,333 | (21,006,843) | 107,354,808 | 209,947,503 | 17,495,625 |
| | | | | | | | | | | | | | | |
| Total Claims Payable | 884,509,979 | 911,448,691 | 890,651,592 | 852,864,933 | 830,533,762 | 775,002,932 | 770,859,204 | 759,273,827 | 639,166,969 | 601,722,478 | 648,998,299 | 613,302,418 | 613,302,418 | 764,861,257 |
| | | | | | | | | | | | | | | |
| Total Fund Balance | 1,244,769,003 | 1,227,510,382 | 1,228,988,116 | 1,232,060,447 | 1,251,137,140 | 1,263,602,149 | 1,268,795,012 | 1,276,676,303 | 1,361,804,917 | 1,371,202,250 | 1,350,195,407 | 1,457,550,213 | 1,457,550,213 | 1,294,524,278 |
| Reserved Funds | | | | | | | | | | | | | | |
| State Financial Performance Guarantee | 1,092,899,000 | 1,093,798,000 | 1,096,923,000 | 1,100,211,000 | 1,102,840,000 | 1,046,032,000 | 1,049,745,000 | 1,091,605,000 | 1,119,293,000 | 1,130,765,000 | 1,143,805,000 | 1,121,915,000 | 1,121,915,000 | 1,099,152,583 |
| Board Approved Capital and Infrastructure Purchases | 79,941,518 | 79,360,193 | 77,250,794 | 76,202,434 | 75,447,816 | 73,742,888 | 72,667,651 | 71,478,836 | 70,124,244 | 66,296,695 | 66,344,624 | 63,186,278 | 63,186,278 | 72,670,331 |
| Capital Assets | 134,500,819 | 148,731,129 | 150,227,245 | 152,420,562 | 152,556,243 | 152,888,655 | 154,088,260 | 154,631,556 | 155,340,379 | 157,165,923 | 157,852,579 | 160,862,612 | 160,862,612 | 152,605,497 |
| Strategic Use of Reserve-Board Approved | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 | 71,002,668 |
| Unrestricted Fund Balance | (133,575,002) | (165,381,608) | (166,415,591) | (167,776,217) | (150,709,587) | (80,064,063) | (78,708,568) | (112,041,757) | (53,955,374) | (54,028,036) | (88,809,464) | 40,583,655 | 40,583,655 | (100,906,801) |
| Fund Balance as % of Reserved Funds | 90.31% | 88.13% | 88.07% | 88.01% | 89.25% | 94.04% | 94.16% | 91.93% | 96.19% | 96.21% | 93.83% | 102.86% | 102.86% | 92.77% |
| | | | | | | | | | | | | | | |
| Current Ratio (including Required Reserves) | 1.45:1 | 1.41:1 | 1.40:1 | 1.40:1 | 1.40:1 | 1.39:1 | 1.41:1 | 1.37:1 | 1.44:1 | 1.45:1 | 1.43:1 | 1.48:1 | 1.48:1 | 1.42:1 |
| Medical Loss Ratio w/o Tax | 96.95% | 99.19% | 95.38% | 94.54% | 91.58% | 92.82% | 93.91% | 93.33% | 81.83% | 93.12% | 99.57% | 76.84% | 92.00% | 92.00% |
| Admin Ratio w/o Tax | 3.65% | 4.56% | 4.31% | 4.81% | 4.29% | 4.55% | 4.99% | 4.96% | 3.68% | 5.10% | 4.39% | 4.56% | 4.48% | 4.48% |
| Profit Margin Ratio | -0.60% | -3.76% | 0.31% | 0.65% | 4.13% | 2.63% | 1.10% | 1.71% | 14.49% | 1.78% | -3.97% | 18.60% | 3.52% | 3.52% |

# PARTNERSHIP HEALTHPLAN OF CALIFORNIA
## Membership and Financial Summary
## For The Period Ending February 28, 2026

| CURRENT MONTH | PRIOR MONTH | INC / DEC | MEMBERSHIP SUMMARY | CURRENT YTD AVG | PRIOR YTD AVG | VARIANCE |
|---|---|---|---|---|---|---|
| 870,940 | 880,183 | (9,243) | **Total Membership** | 893,296 | 893,296 | - |

| ACTUAL MONTH | BUDGET MONTH | $ VARIANCE MONTH | FINANCIAL SUMMARY | ACTUAL YTD | BUDGET YTD | $ VARIANCE YTD |
|---|---|---|---|---|---|---|
| 582,105,182 | 628,169,661 | (46,064,479) | **Total Revenue** | 4,777,465,132 | 5,172,678,387 | (395,213,255) |
| 476,842,427 | 518,362,605 | 41,520,178 | **Total Healthcare Costs** | 4,021,831,236 | 4,422,633,480 | 400,802,244 |
| 23,515,181 | 33,306,398 | 9,791,217 | **Total Administrative Costs** | 201,095,196 | 249,467,559 | 48,372,363 |
| 64,457,740 | 66,458,394 | 2,000,654 | **Medi-Cal Managed Care Tax** | 522,910,210 | 532,927,618 | 10,017,408 |
| **17,289,834** | **10,042,264** | **7,247,570** | **Total Current Year Surplus (Deficit)** | **31,628,490** | **(32,350,270)** | **63,978,760** |

| | | | | | | |
|---|---|---|---|---|---|---|
| 92.12% | 92.28% | | **Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)** | 94.53% | 95.32% | |
| 4.54% | 5.93% | | **Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)** | 4.73% | 5.38% | |

# PARTNERSHIP HEALTHPLAN OF CALIFORNIA
## Balance Sheet
## As Of February 28, 2026

| | February 2026 | January 2026 |
|---|---|---|
| **A S S E T S** | | |
| **Current Assets** | | |
| **Cash & Cash Equivalents** | **1,091,895,890** | **1,041,845,707** |
| **Receivables** | | |
| Accrued Interest | 786,200 | 395,400 |
| State DHS - Cap Rec | 1,810,528,538 | 1,689,463,344 |
| Other Healthcare Receivable | 43,764,153 | 42,135,030 |
| Miscellaneous Receivable | 6,246,807 | 6,227,236 |
| **Total Receivables** | **1,861,325,698** | **1,738,221,010** |
| **Other Current Assets** | | |
| Payroll Clearing | 20,348 | 7,271 |
| Prepaid Expenses | 15,708,212 | 14,904,828 |
| **Total Other Current Assets** | **15,728,560** | **14,912,099** |
| **Total Current Assets** | **2,968,950,148** | **2,794,978,816** |
| **Non-Current Assets** | | |
| **Fixed Assets** | | |
| Motor Vehicles | 1,096,330 | 1,096,330 |
| Furniture & Fixtures | 7,701,728 | 7,377,822 |
| Computer Equipment | 21,508,743 | 20,328,283 |
| Computer Software | 9,048,571 | 9,048,571 |
| Leasehold Improvements | 124,288 | 124,288 |
| Land | 11,330,439 | 11,330,439 |
| Building | 79,474,549 | 79,474,549 |
| Building Improvements | 46,066,130 | 40,418,839 |
| Accum Depr - Motor Vehicles | (535,464) | (507,941) |
| Accum Depr - Furniture | (6,747,988) | (6,728,673) |
| Accum Depr - Comp Equipment | (18,897,639) | (18,751,680) |
| Accum Depr - Comp Software | (8,976,338) | (8,960,974) |
| Accum Depr - Leasehold Improvements | (124,288) | (124,288) |
| Accum Depr - Building | (15,568,687) | (15,398,870) |
| Accum Depr - Bldg Improvements | (17,867,220) | (17,632,886) |
| Construction Work-In-Progress | 59,898,686 | 65,464,952 |
| **Total Fixed Assets** | **167,531,840** | **166,558,761** |
| **Other Non-Current Assets** | | |
| Deposits | 83,280 | - |
| Board-Designated Reserves | 1,281,403,990 | 1,312,952,380 |
| Knox-Keene Reserves | 300,000 | 300,000 |
| Prepaid - Other Non-Current | 12,296,816 | 12,411,847 |
| Net Pension Asset | 5,714,523 | 5,714,523 |
| Deferred Outflows Of Resources | 2,745,009 | 2,745,009 |
| Net Subscription Asset | 3,120,175 | 3,120,175 |
| **Total Other Non-Current Assets** | **1,305,663,793** | **1,337,243,934** |
| **Total Non-Current Assets** | **1,473,195,633** | **1,503,802,695** |
| **Total Assets** | **4,442,145,781** | **4,298,781,511** |

# PARTNERSHIP HEALTHPLAN OF CALIFORNIA
## Balance Sheet
## As Of February 28, 2026

| | February 2026 | January 2026 |
|---|---|---|
| **L I A B I L I T I E S & F U N D B A L A N C E** | | |
| **Liabilities** | | |
| **Current Liabilities** | | |
| Accounts Payable | 305,405,310 | 246,149,657 |
| Unearned Income | 53,599,270 | 56,352,383 |
| Suspense Account | 12,762,926 | 12,388,172 |
| Capitation Payable | 4,119,709 | 4,199,992 |
| State DHS - Cap Payable | 32,633,113 | 32,633,113 |
| Accrued Healthcare Costs | 1,723,573,478 | 1,622,533,749 |
| Claims Payable | 359,263,343 | 296,854,340 |
| Incurred But Not Reported-IBNR | 339,093,247 | 436,489,948 |
| Quality Improvement Programs | 113,181,060 | 109,955,666 |
| **Total Current Liabilities** | **2,943,631,456** | **2,817,557,020** |
| **Non-Current Liabilities** | | |
| Deferred Inflows Of Resources | 6,657,637 | 6,657,637 |
| Net Subscription Liability | 2,677,984 | 2,677,984 |
| **Total Non-Current Liabilities** | **9,335,621** | **9,335,621** |
| **Total Liabilities** | **2,952,967,077** | **2,826,892,641** |
| **Fund Balance** | | |
| **Unrestricted Fund Balance** | **(28,434,793)** | **(76,299,941)** |
| **Reserved Funds** | | |
| State Financial Performance Guarantee | 1,191,261,000 | 1,221,224,000 |
| Board Approved Capital and Infrastructure Purchases | 90,442,990 | 92,028,380 |
| Capital Assets | 167,531,839 | 166,558,763 |
| Strategic Use of Reserve-Board Approved | 68,377,668 | 68,377,668 |
| **Total Reserved Funds** | **1,517,613,497** | **1,548,188,811** |
| **Total Fund Balance** | **1,489,178,704** | **1,471,888,870** |
| **Total Liabilities And Fund Balance** | **4,442,145,781** | **4,298,781,511** |

# PARTNERSHIP HEALTHPLAN OF CALIFORNIA
## Statement of Cash Flow
## For The Period Ending February 28, 2026

| | Current Month Activity | Year-To-Date Activity |
|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES:** | | |
| **Cash Received From:** | | |
| Capitation from California Department of Health Care Services | 507,607,240 | 4,720,123,199 |
| Other Revenues | 224,975 | 2,049,606 |
| **Cash Payments to Providers for Medi-Cal Members** | | |
| Capitation Payments | (17,967,091) | (163,470,972) |
| Medical Claims Payments | (418,612,558) | (3,524,934,307) |
| **Drug Medi-Cal** | | |
| DMC Receipts from Counties | 3,256,128 | 50,171,345 |
| DMC Payments to Providers | (5,232,463) | (42,316,825) |
| Cash Payments to Vendors | (33,655,160) | (659,206,918) |
| Cash Payments to Employees | (21,381,931) | (160,722,822) |
| **Net Cash Provided by Operating Activities** | **14,239,140** | **221,692,306** |
| | | |
| **CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:** | | |
| Purchases of Capital Assets | (2,243,733) | (12,123,836) |
| **Net Cash (Used) by Capital Financial & Related Activities** | **(2,243,733)** | **(12,123,836)** |
| | | |
| **CASH FLOWS FROM INVESTING ACTIVITIES:** | | |
| Board-Designated Reserve Transfers | 31,548,390 | (96,602,712) |
| Interest and Dividends on Investments | 6,506,386 | 61,321,196 |
| **Net Cash (Used) Provided by Investing Activities** | **38,054,776** | **(35,281,516)** |
| | | |
| **NET INCREASE IN CASH & CASH EQUIVALENTS** | **50,050,183** | **174,286,954** |
| | | |
| **CASH & CASH EQUIVALENTS, BEGINNING** | **1,041,845,707** | **917,608,936** |
| | | |
| **CASH & CASH EQUIVALENTS, ENDING** | **1,091,895,890** | **1,091,895,890** |
| | | |
| **RECONCILIATION OF TOTAL OPERATING (LOSS) INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES** | | |
| | | |
| **TOTAL OPERATING (LOSS) INCOME** | **10,392,648** | **(29,515,405)** |
| **DEPRECIATION** | **612,313** | **4,728,402** |
| **CHANGES IN ASSETS AND LIABILITIES:** | | |
| Other Receivables | (1,648,696) | 14,789,240 |
| California Department of Health Services Receivable | (121,065,194) | (55,618,983) |
| Other Assets | (126,368) | (3,902,064) |
| Accounts Payable and Accrued Expenses | 157,836,741 | 172,585,753 |
| Accrued Claims Payable | (34,987,698) | 85,054,172 |
| Quality Improvement Programs | 3,225,394 | 33,571,191 |
| **Net Cash Provided by Operating Activities** | **14,239,140** | **221,692,306** |

# PARTNERSHIP HEALTHPLAN OF CALIFORNIA

**Statement of Revenues and Expenses**

**For The Period Ending February 28, 2026**

****The Notes to the Financial Statement are an Integral Part of this Statement****

| ACTUAL MONTH | BUDGET MONTH | $ VARIANCE MONTH | ACTUAL MONTH PMPM | BUDGET MONTH PMPM | | ACTUAL YTD | BUDGET YTD | $ VARIANCE YTD | ACTUAL YTD PMPM | BUDGET YTD PMPM |
|---|---|---|---|---|---|---|---|---|---|---|
| **870,940** | **870,940** | **-** | | | **TOTAL MEMBERSHIP** | **7,146,366** | **7,146,366** | **-** | | |
| | | | | | **REVENUE** | | | | | |
| 572,228,393 | 621,764,361 | (49,535,968) | 657.02 | 713.90 | State Capitation Revenue | 4,711,821,841 | 5,117,288,077 | (405,466,236) | 659.33 | 716.07 |
| 6,897,186 | 6,196,750 | 700,436 | 7.92 | 7.12 | Interest Income | 61,143,896 | 53,778,890 | 7,365,006 | 8.56 | 7.53 |
| 2,979,603 | 208,550 | 2,771,053 | 3.42 | 0.24 | Other Revenue | 4,499,394 | 1,611,420 | 2,887,974 | 0.63 | 0.23 |
| **582,105,182** | **628,169,661** | **(46,064,479)** | **668.36** | **721.25** | **TOTAL REVENUE** | **4,777,465,132** | **5,172,678,387** | **(395,213,255)** | **668.52** | **723.82** |
| | | | | | **HEALTHCARE COSTS** | | | | | |
| | | | | | **Physician Services** | | | | | |
| 8,414,375 | 9,433,862 | 1,019,487 | 9.66 | 10.83 | Pcp Capitation | 69,079,943 | 77,681,174 | 8,601,231 | 9.67 | 10.87 |
| 204,304 | 201,844 | (2,460) | 0.23 | 0.23 | Specialty Capitation | 1,696,930 | 1,673,635 | (23,295) | 0.24 | 0.23 |
| 83,591,055 | 76,784,771 | (6,806,284) | 95.98 | 88.16 | Non-Capitated Physician Services | 725,482,060 | 657,621,201 | (67,860,859) | 101.52 | 92.02 |
| **92,209,734** | **86,420,477** | **(5,789,257)** | **105.87** | **99.22** | **Total Physician Services** | **796,258,933** | **736,976,010** | **(59,282,923)** | **111.43** | **103.12** |
| | | | | | **Inpatient Hospital** | | | | | |
| 16,549,835 | 16,151,556 | (398,279) | 19.00 | 18.54 | Hospital Capitation | 136,044,134 | 134,281,008 | (1,763,126) | 19.04 | 18.79 |
| 97,668,523 | 107,495,609 | 9,827,086 | 112.14 | 123.42 | Inpatient Hospital - Ffs | 885,549,922 | 925,780,010 | 40,230,088 | 123.92 | 129.55 |
| 787,440 | 787,440 | - | 0.90 | 0.90 | Hospital Stoploss | 6,502,225 | 6,502,225 | - | 0.91 | 0.91 |
| **115,005,798** | **124,434,605** | **9,428,807** | **132.04** | **142.86** | **Total Inpatient Hospital** | **1,028,096,281** | **1,066,563,243** | **38,466,962** | **143.87** | **149.25** |
| 56,949,785 | 57,848,070 | 898,285 | 65.39 | 66.42 | Long Term Care | 496,237,318 | 491,784,667 | (4,452,651) | 69.44 | 68.82 |
| | | | | | **Ancillary Services** | | | | | |
| 1,435,134 | 1,304,163 | (130,971) | 1.65 | 1.50 | Ancillary Services - Capitated | 9,648,760 | 10,797,376 | 1,148,616 | 1.35 | 1.51 |
| 100,530,693 | 88,963,205 | (11,567,488) | 115.43 | 102.15 | Ancillary Services - Non-Capitated | 853,908,807 | 803,982,630 | (49,926,177) | 119.49 | 112.50 |
| **101,965,827** | **90,267,368** | **(11,698,459)** | **117.08** | **103.65** | **Total Ancillary Services** | **863,557,567** | **814,780,006** | **(48,777,561)** | **120.84** | **114.01** |
| | | | | | **Other Medical** | | | | | |
| 5,365,117 | 8,149,312 | 2,784,195 | 6.16 | 9.36 | Quality Assurance | 46,153,861 | 58,935,891 | 12,782,030 | 6.46 | 8.25 |
| 85,710,469 | 132,546,059 | 46,835,590 | 98.41 | 152.19 | Healthcare Investment Funds | 623,889,066 | 1,089,616,720 | 465,727,654 | 87.30 | 152.47 |
| 111,500 | 130,900 | 19,400 | 0.13 | 0.15 | Advice Nurse | 995,500 | 1,136,710 | 141,210 | 0.14 | 0.16 |
| 12,440,897 | 11,482,514 | (958,383) | 14.28 | 13.18 | Transportation | 108,395,580 | 104,593,103 | (3,802,477) | 15.17 | 14.64 |
| **103,627,983** | **152,308,785** | **48,680,802** | **118.98** | **174.88** | **Total Other Medical** | **779,434,007** | **1,254,282,424** | **474,848,417** | **109.07** | **175.52** |
| 7,083,300 | 7,083,300 | - | 8.13 | 8.13 | Quality Improvement Programs | 58,247,130 | 58,247,130 | - | 8.15 | 8.15 |
| **476,842,427** | **518,362,605** | **41,520,178** | **547.49** | **595.16** | **TOTAL HEALTHCARE COSTS** | **4,021,831,236** | **4,422,633,480** | **400,802,244** | **562.80** | **618.87** |
| | | | | | **ADMINISTRATIVE COSTS** | | | | | |
| 15,328,465 | 22,069,437 | 6,740,972 | 17.60 | 25.34 | Employee | 126,978,180 | 159,189,682 | 32,211,502 | 17.77 | 22.28 |
| 46,332 | 173,665 | 127,333 | 0.05 | 0.20 | Travel And Meals | 686,215 | 1,508,154 | 821,939 | 0.10 | 0.21 |
| 1,460,211 | 3,161,720 | 1,701,509 | 1.68 | 3.63 | Occupancy | 10,535,712 | 20,151,180 | 9,615,468 | 1.47 | 2.82 |
| 508,555 | 825,828 | 317,273 | 0.58 | 0.95 | Operational | 4,953,406 | 7,171,428 | 2,218,022 | 0.69 | 1.00 |
| 3,085,416 | 2,989,332 | (96,084) | 3.54 | 3.43 | Professional Services | 28,259,335 | 25,959,822 | (2,299,513) | 3.95 | 3.63 |
| 3,086,202 | 4,086,416 | 1,000,214 | 3.54 | 4.69 | Computer And Data | 29,682,348 | 35,487,293 | 5,804,945 | 4.15 | 4.97 |
| **23,515,181** | **33,306,398** | **9,791,217** | **26.99** | **38.24** | **TOTAL ADMINISTRATIVE COSTS** | **201,095,196** | **249,467,559** | **48,372,363** | **28.13** | **34.91** |
| 64,457,740 | 66,458,394 | 2,000,654 | 74.01 | 76.31 | **Medi-Cal Managed Care Tax** | 522,910,210 | 532,927,618 | 10,017,408 | 73.17 | 74.57 |
| **17,289,834** | **10,042,264** | **7,247,570** | **19.87** | **11.54** | **TOTAL CURRENT YEAR SURPLUS (DEFICIT)** | **31,628,490** | **(32,350,270)** | **63,978,760** | **4.42** | **(4.53)** |

# PARTNERSHIP HEALTHPLAN OF CALIFORNIA
# NOTES TO FINANCIAL STATEMENTS
# February 28, 2026

1. **ORGANIZATION**

The Partnership HealthPlan of California (the HealthPlan) was formed as a health insurance organization and is legally a subdivision of the State of California but is not part of any city, county or state government system. The HealthPlan has quasi-independent political jurisdiction to contract with the State for managing Medi-Cal beneficiaries who reside in various Northern California counties. The HealthPlan is a combined public and private effort engaged principally in providing a more cost-effective method of healthcare. The HealthPlan began serving Medi-Cal eligible persons in Solano County in May 1994. That was followed by additional Northern California counties in March 1998, March 2001, October 2009, two counties in July 2011, and eight counties in September 2013. Beginning July 2018 and in accordance with direction from the Department of Health Care Services (DHCS), the HealthPlan consolidated its reporting from these fourteen counties into two regions, which are in alignment with the two DHCS rating regions. Beginning January 2024, the HealthPlan expanded into ten additional counties, which comprise a third region.

As a public agency, the HealthPlan is exempt from state and federal income tax.

2. **SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

ACCOUNTING POLICIES:
The accounting and reporting policies of the HealthPlan conform to Generally Accepted Accounting Principles and general practices within the healthcare industry.

PROPERTY AND EQUIPMENT:
Effective July 2015, property and equipment totaling $10,000 or more are recorded at cost; this includes assets acquired through capital leases and improvements that significantly add to the productive capacity or extend the useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Depreciation for financial reporting purposes is provided on a straight-line method over the estimated useful life of the asset. The costs of major remodeling and improvements are capitalized as building or leasehold improvements. Leasehold improvements are amortized using the straight-line method over the shorter of the remaining term of the applicable lease or their estimated useful life. Building improvements are depreciated over their estimated useful life.

INVESTMENTS:
The HealthPlan investments can consist of U.S. Treasury Securities, Certificates of Deposits, Money Market and Mutual Funds, Government Pooled Funds, Agency Notes, Repurchase

Agreements, Shares of Beneficial Interest and Commercial Paper and are carried at fair value.

RESERVED FUNDS:
As of February 2026, the HealthPlan has Total Reserved Funds of $1.5 billion. This includes $68.4 million of funds set aside for Board approved Strategic Use of Reserve (SUR) initiatives; this also includes funding for the Wellness & Recovery program. The total SUR amount represents the net amount remaining for all SUR projects that have been approved to date and is periodically adjusted as projects are completed. Reserved Funds also includes $0.3 million of Knox-Keene Reserves.

RECLASSIFICATIONS:
Certain reclassifications of prior period balances have been made to conform with the current period presentations. Such reclassifications do not affect the total increase in net position or total current or noncurrent assets or liabilities.

## 3. STATE CAPITATION REVENUE

Medi-Cal capitation revenue is based on the monthly capitation rates, as provided for in the State contract, and the actual number of Medi-Cal eligible members. Capitation revenues are paid by the State on a monthly basis in arrears based on estimated membership. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the State for projected changes in membership and trued up monthly through a State reconciliation process. These estimates are continually monitored and adjusted, as necessary, as experience develops or new information becomes known.

## 4. HEALTHCARE COST

The HealthPlan continues to develop completion factors to calculate estimated liability for claims Incurred But Not Reported. These factors are reviewed and adjusted as more historical data becomes available. Budgeted capitation revenues and healthcare costs are adjusted each month to reflect changes in enrollee counts.

## 5. QUALITY IMPROVEMENT PROGRAM

The HealthPlan maintains quality improvement contracts with acute care hospitals and primary care physicians. As of February 2026, the HealthPlan has accrued a Quality Improvement Program payout of $113.2 million.

# PARTNERSHIP HEALTHPLAN OF CALIFORNIA
# NOTES TO FINANCIAL STATEMENTS
# February 28, 2026

6. **ESTIMATES**

Due to the nature of the operations of the HealthPlan, it is necessary to estimate amounts for financial statement presentation. Substantial overstatement or understatement of these estimates would have a significant impact on the statements. The items estimated through various methodologies are:

- Value of Claims Incurred But Not Reported
- Quality Incentive Payouts
- Earned Capitation Revenues
- Total Number of Members
- Retro Capitation Expense for Certain Providers

7. **COMMITMENTS AND CONTINGENCIES**

In the ordinary course of business, the HealthPlan is party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, the HealthPlan's Management is of the opinion that any liability which may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of the operations of the HealthPlan.

8. **UNUSUAL OR INFREQUENT ITEMS REPORTED IN CURRENT MONTH'S FINANCIAL STATEMENTS**

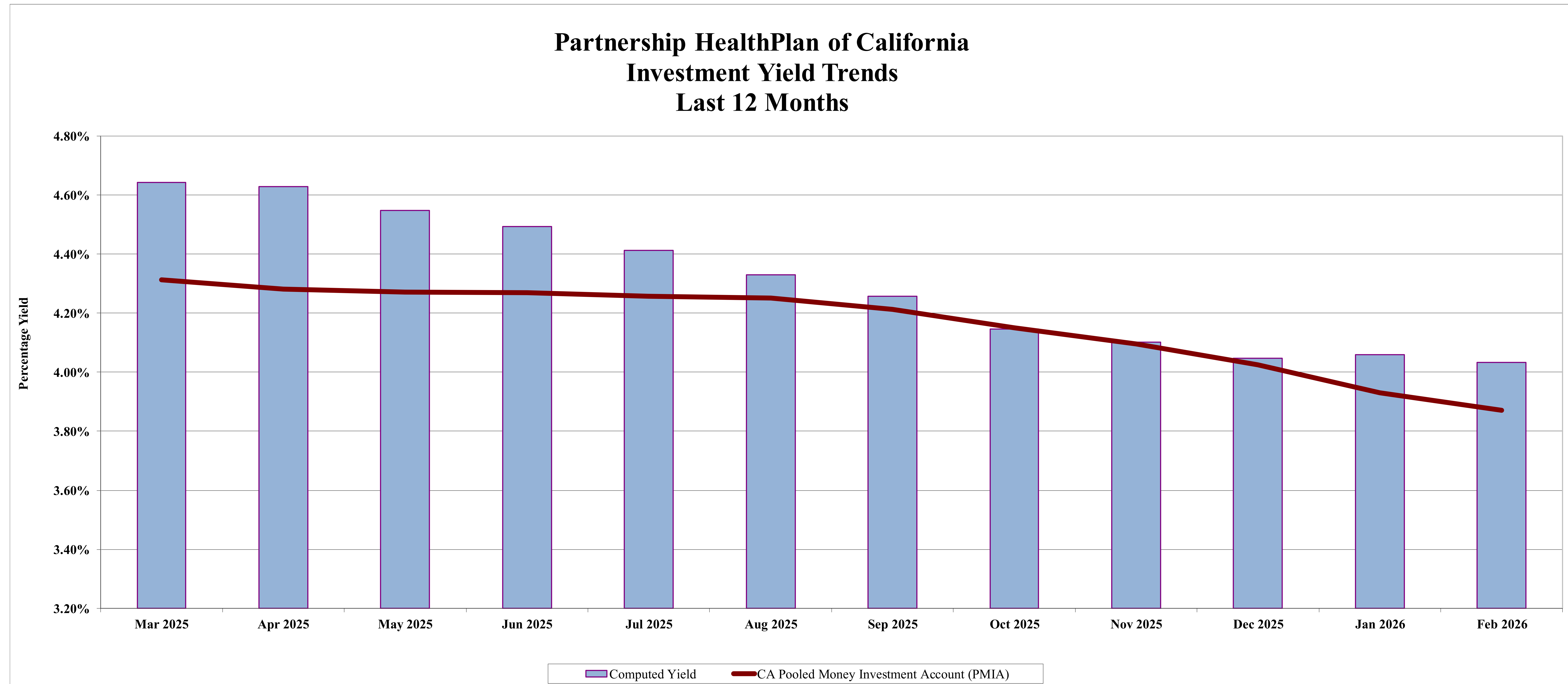
None noted.

**Partnership HealthPlan of California**
**Investment Schedule**
***February 28, 2026***

| Name of Investment | Investment Type | Yield to Maturity | Trade Date | Maturity Date | Call Date | Face Value | Purchase Price | Market Value | Credit Rating Agency | Credit Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| **FUNDS HELD FOR INVESTMENT:** | | | | | | | | | | |
| Highmark Money Market | Cash & Cash Equiv | NA | Various | NA | NA | NA | $ 1,818,189 | $ 1,818,189 | NA | NR |
| Certificate of Deposit for Knox Keene | Cash & Cash Equiv | 0.0405 | 1/31/2025 | 1/30/2030 | NA | $ 300,000 | $ 300,000 | $ 300,000 | NA | NR |
| **FUNDS HELD FOR OPERATIONS:** | | | | | | | | | | |
| Merrill Lynch Institutional | Cash for Operations | NA | NA | NA | NA | NA | NA | $ 80,872,501 | | |
| Merrill Lynch MMA - Checking | Cash for Operations | NA | NA | NA | NA | NA | NA | $ 516,497 | | |
| US Bank - General, MMA, and Sweeps | Cash for Operations | NA | NA | NA | NA | NA | NA | $ 2,168,774,588 | | |
| Government Investment Pools (LAIF) | Cash for Operations | NA | NA | NA | NA | NA | NA | $ 75,000,000 | | |
| Government Investment Pools (County) | Cash for Operations | NA | NA | NA | NA | NA | NA | $ 46,166,511 | | |
| West America Payroll | Cash for Operations | NA | NA | NA | NA | NA | NA | $ 148,294 | | |
| Petty Cash | Cash for Operations | NA | NA | NA | NA | NA | NA | $ 3,300 | | |
| **GRAND TOTAL:** | | | | | | | | $ 2,373,599,880 | | |

**Partnership HealthPlan of California**
**Investment Yield Trends**

| PERIOD | | Mar 2025 | Apr 2025 | May 2025 | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 | Oct 2025 | Nov 2025 | Dec 2025 | Jan 2026 | Feb 2026 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Interest Income** | | 8,765,710 | 8,403,962 | 7,671,506 | 7,390,920 | 7,568,557 | 7,456,341 | 7,941,176 | 8,116,523 | 6,918,278 | 7,880,097 | 8,365,738 | 6,897,186 |
| **Cash & Investments at Historical Cost** | (1) | 2,431,749,222 | 2,298,648,325 | 2,207,098,027 | 2,102,710,214 | 2,160,202,257 | 2,286,589,057 | 2,474,845,534 | 2,254,168,286 | 2,239,590,881 | 2,602,840,892 | 2,355,098,087 | 2,373,599,880 |
| ***Computed Yield*** | (2) | 4.64% | 4.63% | 4.55% | 4.49% | 4.41% | 4.33% | 4.26% | 4.15% | 4.10% | 4.05% | 4.06% | 4.03% |
| ***CA Pooled Money Investment Account (PMIA)*** | (3) | 4.31% | 4.28% | 4.27% | 4.27% | 4.26% | 4.25% | 4.21% | 4.15% | 4.10% | 4.03% | 3.93% | 3.87% |




***NOTES:***

(1) Investment balances include Restricted Cash and Board Designated Reserves

(2) Computed yield is calculated by dividing the past 12 months of interest by the average cash balance for the past 12 months.

(3) LAIF limits the amount a single government entity can deposit into LAIF; currently that amount is set at $75 million.

**REGULAR AGENDA REQUEST**
**for**
**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Board / Finance Committee (when applicable)**
**Finance Committee Meeting Date:** April 15, 2026
**Board Meeting Date:** April 22, 2026

**Agenda Item Number:**
2.3

**Resolution Sponsor:**
Sonja Bjork, CEO, Partnership HealthPlan of CA

**Recommendation by:**
Partnership Staff

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**Topic Description:**

Partnership's FY 2025–26 approved budget requires revisions to reflect evolving operational, programmatic and financial priorities identified by management.

**Reason for Resolution:**

To request approval of FY 2025-26 rebudget to allow flexible reallocation authority across budget categories. Such adjustments will not increase the overall approved budget but if necessary will permit management to reallocate funds across budget categories.

**Financial Impact:**

There is no significant financial impact associated with these revisions, as they do not increase the overall approved budget.

**Requested Action of the Board:**

Based on the recommendation of Partnership staff, the Board is asked to authorize the CEO and CFO to implement and manage the revised FY 2025-2026 budget and to make additional intra-budget adjustments in accordance with the parameters outlined above.

**REGULAR AGENDA REQUEST**
**for**
**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Board / Finance Committee (when applicable)**
**Finance Committee Meeting Date:** April 15, 2026
**Board Meeting Date:** April 22, 2026

**Agenda Item Number:** 2.3

**Resolution Number:** 26-

**IN THE MATTER OF: APPROVING BUDGET REVISIONS FOR FY2025-2026**

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**Recital: Whereas,**

A. The Board is responsible for budget approval with flexible reallocation authority.

B. The FY2025-2026 budget requires allocation revisions.

**Now, Therefore, It Is Hereby Resolved As Follows:**

1. To approve revisions to the FY2025-2026 budget.

**PASSED, APPROVED, AND ADOPTED** by the Partnership HealthPlan of California this 22nd day of April 2026, by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

______________________________
Dean Germano, Chair

______________________________
Date

**ATTEST**:

BY: ______________________________
Ashlyn Scott, Clerk

## Profit & Loss Statement

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Statement of Revenues and Expenses**

**Annual Capital & Operating Budget**

| | 2025-26 Budget | 2024-25 Budget | $ VARIANCE | 2025-26 Budget PMPM | 2024-25 Budget PMPM |
|---|---|---|---|---|---|
| **Membership at Fiscal Year End** | **913,879** | **858,157** | **55,722** | | |
| **Total Member Months** | **10,946,668** | **10,528,712** | **417,956** | | |
| **REVENUE** | | | | | |
| State Capitation Revenue | 7,046,897,376 | 5,538,765,135 | 1,508,132,241 | 643.75 | 526.06 |
| Interest Income | 80,779,000 | 70,743,000 | 10,036,000 | 7.38 | 6.72 |
| Other Revenue | 2,447,000 | 2,335,100 | 111,900 | 0.22 | 0.22 |
| **TOTAL REVENUE** | **7,130,123,376** | **5,611,843,235** | **1,518,280,141** | **651.35** | **533.00** |
| **HEALTHCARE COSTS** | | | | | |
| **Physician Services** | | | | | |
| PCP Capitation | 119,415,716 | 106,664,971 | (12,750,745) | 10.91 | 10.13 |
| Specialty Capitation | 2,570,827 | 2,628,366 | 57,539 | 0.23 | 0.25 |
| Non-Capitated Physician Services | 1,022,631,615 | 845,399,200 | (177,232,415) | 93.42 | 80.29 |
| **Total Physician Services** | **1,144,618,158** | **954,692,537** | **(189,925,621)** | **104.56** | **90.68** |
| **Inpatient Hospital** | | | | | |
| Hospital Capitation | 206,752,864 | 214,000,006 | 7,247,142 | 18.89 | 20.33 |
| Inpatient Hospital - FFS | 1,423,506,378 | 1,465,895,850 | 42,389,472 | 130.04 | 139.23 |
| Hospital Stoploss | 9,999,852 | 19,200,000 | 9,200,148 | 0.91 | 1.82 |
| **Total Inpatient Hospital** | **1,640,259,094** | **1,699,095,856** | **58,836,762** | **149.84** | **161.38** |
| Long Term Care | 740,374,189 | 634,948,033 | (105,426,156) | 67.63 | 60.31 |
| **Ancillary Services** | | | | | |
| Ancillary Services - Capitated | 16,574,512 | 14,635,449 | (1,939,063) | 1.51 | 1.39 |
| Ancillary Services - Non-Capitated | 1,228,900,510 | 969,400,736 | (259,499,774) | 112.26 | 92.07 |
| **Total Ancillary Services** | **1,245,475,022** | **984,036,185** | **(261,438,837)** | **113.78** | **93.46** |

# PARTNERSHIP HEALTHPLAN OF CALIFORNIA

## Statement of Revenues and Expenses
## Annual Capital & Operating Budget

| | 2025-26 Budget | 2024-25 Budget | $ VARIANCE | 2025-26 Budget PMPM | 2024-25 Budget PMPM |
|---|---|---|---|---|---|
| **Other Medical** | | | | | |
| Quality Assurance | 92,329,487 | 87,600,012 | (4,729,475) | 8.43 | 8.32 |
| Healthcare Investment Funds | 241,427,350 | 210,369,671 | (31,057,679) | 22.05 | 19.98 |
| Advice Nurse | 1,729,200 | 1,729,200 | - | 0.16 | 0.16 |
| Transportation | 159,645,568 | 135,094,176 | (24,551,392) | 14.58 | 12.83 |
| **Total Other Medical** | **495,131,605** | **434,793,059** | **(60,338,546)** | **45.23** | **41.30** |
| DHCS Facility Directed Payment Programs | 1,426,371,794 | 753,440,101 | (672,931,693) | 130.30 | 71.56 |
| Quality Improvement Programs | 89,200,150 | 100,009,080 | 10,808,930 | 8.15 | 9.50 |
| **TOTAL HEALTHCARE COSTS** | **6,781,430,012** | **5,561,014,851** | **(1,220,415,161)** | **619.50** | **528.18** |
| **ADMINISTRATIVE COSTS** | | | | | |
| Employee | 247,828,143 | 193,794,546 | (54,033,597) | 22.64 | 18.41 |
| Travel And Meals | 2,294,006 | 1,992,350 | (301,656) | 0.21 | 0.19 |
| Occupancy | 33,393,279 | 40,233,429 | 6,840,150 | 3.05 | 3.82 |
| Operational | 10,909,163 | 10,865,941 | (43,222) | 1.00 | 1.03 |
| Professional Services | 39,490,454 | 36,009,640 | (3,480,814) | 3.61 | 3.42 |
| Computer And Data | 53,983,631 | 28,587,942 | (25,395,689) | 4.93 | 2.72 |
| **TOTAL ADMINISTRATIVE COSTS** | **387,898,676** | **311,483,848** | **(76,414,828)** | **35.44** | **29.58** |
| Medi-Cal Managed Care Tax | - | - | - | - | - |
| **Surplus / (Deficit)** | **(39,205,312)** | **(260,655,464)** | **221,450,152** | **(3.58)** | **(24.76)** |

**REGULAR AGENDA REQUEST**
**for**
**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Board / Finance Committee (when applicable)**
**Finance Committee Meeting Date:** April 15, 2026
**Board Meeting Date:** April 22, 2026

**Agenda Item Number:** 2.4

**Resolution Sponsor:**
Sonja Bjork, CEO, Partnership HealthPlan of CA

**Recommendation by:**
Partnership Staff

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**Topic Description:**
The Partnership budget approval process is a three-step process, in which, budget assumptions are presented to the Finance Committee and full Board in April, a preliminary health care budget is presented to the Finance Committee in May and the final budget (health care, administrative, and operations) is presented to the Finance Committee and full Board for approval in June.

**Reason for Resolution:**
To provide the Board with the attached budget assumptions for fiscal year 2026-2027, and to direct staff to prepare a full operational budget.

**Financial Impact:**
The financial impact is significant.

**Requested Action of the Board:**
Based on the recommendation of Partnership staff, the Board is asked to approve budget assumptions for fiscal year 2026-2027.

**REGULAR AGENDA REQUEST**
**for**
**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Board / Finance Committee (when applicable)** **Agenda Item Number:** 2.4
**Finance Committee Meeting Date:** April 15, 2026
**Board Meeting Date:** April 22, 2026

**Resolution Number:** 26-

**IN THE MATTER OF: APPROVING BUDGET ASSUMPTIONS FOR FY 2026-2027**

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**Recital: Whereas,**

A. The Board is responsible for approving budget assumptions to direct staff to prepare the full operational budget.

B. The Board is responsible for approving the annual budget.

**Now, Therefore, It Is Hereby Resolved As Follows:**

1. To approve budget assumptions for FY 2026-2027.
2. To direct staff to prepare a full operational budget for FY 2026-2027

**PASSED, APPROVED, AND ADOPTED** by the Partnership HealthPlan of California this 22nd day of April 2026, by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

____________________________
Dean Germano, Chair

____________________________
Date

**ATTEST**:

BY: ____________________________
Ashlyn Scott, Clerk

**Partnership HealthPlan of California**

***2026-27 Budget Assumptions***

***April 2026***

**Introduction**

Each year, starting in January, Partnership HealthPlan of California (Partnership) begins building the annual budget for Board of Commissioner review and approval in June. Currently Partnership is developing its fiscal year (FY) 2026-27 budget for the period of July 1, 2026 through June 30, 2027. As part of this process, Partnership presents to the Finance Committee and the Board the key components of the budget. Specifically, in April the draft budget assumptions are presented, followed by the draft health care expense budget in May. In June, the final budget will reflect previously reviewed components which will be adjusted based on more recent available information. The June final budget will also include the administrative and capital components, all of which will be presented to the Board for final review and approval. This document outlines the Plan's draft budget assumptions that inform Partnership's revenue and cost projections as impacted by estimated changes in enrollment, health care costs, administrative costs, as well as disposition of reserves.

**Outlook for 2026-27**

As of the Governor's proposed January FY 2026-27 Budget, the State of California projected a $2.9 billion shortfall. The proposed budget used a "workload budget" approach which aims to maintain core services as the State awaits firmer revenue numbers that will be released in the May Revise. While the budget includes increased reserve deposits, the state continues to rely on reserves and borrowing to address deficits, and the budget proposed borrowing increases of nearly $6 billion. Since the release of the January budget, the Legislative Analyst's Office (LAO) has projected a $2.5 billion budget improvement due to higher revenues and recommends using these windfalls to reduce reliance on reserves and borrowing, rather than drawing on them during periods of revenue growth.

While the overall state budget deficit is smaller than in prior years, the LAO has cautioned that California faces a significant, chronic structural deficit. The LAO further noted that, despite a more optimistic administration forecast, the State continues to spend more than it collects, largely driven by rising Medi-Cal costs, even amid revenue growth. Given the overall fiscal outlook, tough budget discussions are expected to occur over the proceeding months.

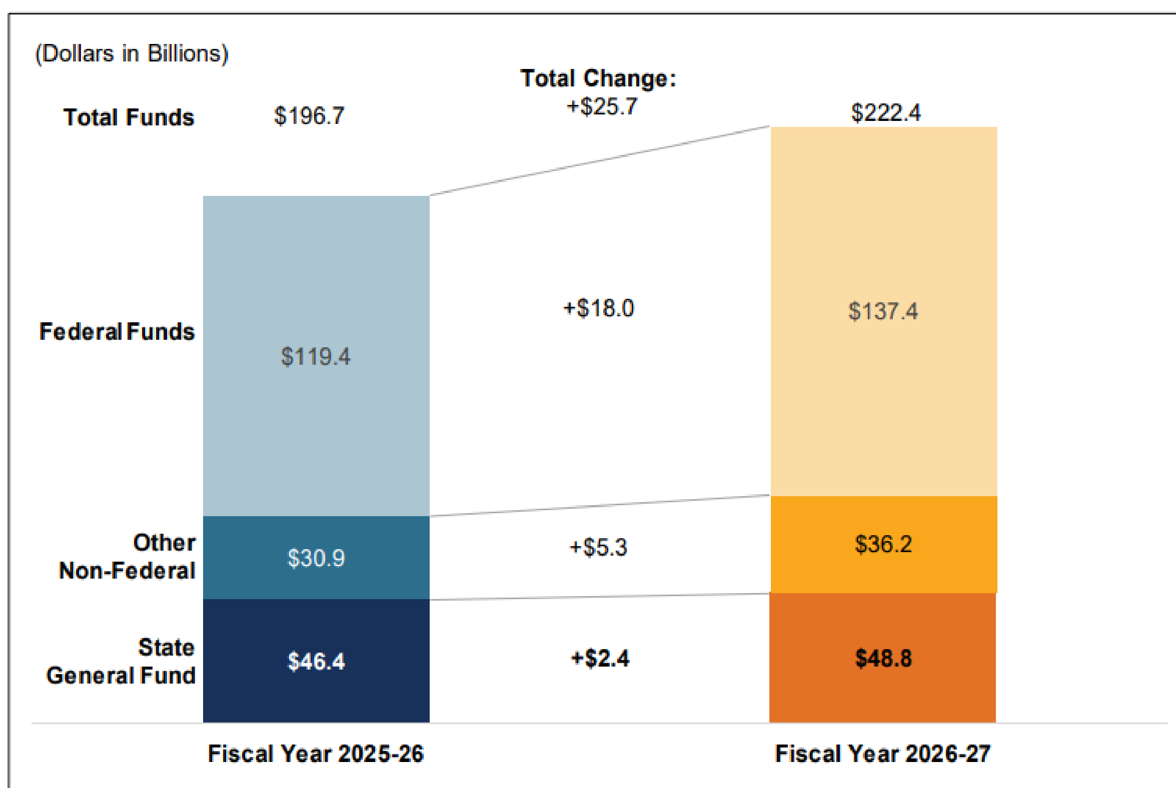
The Department of Health Care Services (DHCS) budget chart[1] below outlines the year-over-year Medi-Cal program spend that was assumed in the January budget. The budget assumed a FY 2026-27 total Medi-Cal budget of $222.4 billion ($48.8 billion General). The proposed budget estimates 14.02 million individuals would receive health care coverage through the Medi-Cal program, which is a 3.5% decrease from the prior year. Recent declines in Medi-Cal managed care enrollment indicate the May Revise may reflect greater enrollment reductions than projected in the January budget.



[1]https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2025_November_Estimate/N25-Medi-Cal-Local-Assistance-Estimate.pdf

The $25.7 billion year-over-year increase in total fund costs is primarily driven by higher per-member costs, the loss of financing offsets, and federal policy changes. Although the Governor presented a balanced budget in January, significant impacts from H.R. 1 are not fully reflected. Key cost pressures—including unbudgeted administrative workload for Medi-Cal and CalFresh, churn and re-enrollment costs, and the absence of a clear plan to replace MCO tax revenue after December 2026—remain unresolved. Over the long term, coverage losses are expected to shift fiscal pressure to counties, hospitals, and the broader safety-net system.

**Year-over-Year Change from FY 2025-26 to FY 2026-27**




Additional environmental cost pressures still loom for the following:

- ***Whether Medi-Cal Members with Unsatisfactory Immigration Status (UIS) will remain enrolled in Managed Care -*** The Centers for Medicare & Medicaid Services (CMS) issued Medicaid guidance prohibiting risk-based managed care payments for undocumented individuals tied to allowable federally funded services, these include emergency services (both inpatient and outpatient) and pregnancy related services. Based on the federal guidance there are essentially two options that State can take
    - The State can provide UIS coverage entirely through the Medi-Cal Fee-for-Service (FFS) delivery system – meaning that UIS members could be carved-out of Medi-Cal managed care.
    - The State can enter into contracts with Prepaid Inpatient Health Plans (PIHPs) and/or Prepaid Ambulatory Health Plans (PAHPs) which are types of managed care organizations to provide non-risk health care services for federally claimable services. For the non-federally claimable services, the State can continue to fund these services through Medi-Cal managed care. There are significant operational complexities surrounding this sort of relationship such as outlining which services at the individual procedure code are federal claimable. This also requires a robust

annual reconciliation of actual costs and any profits must be returned given the prohibition on risk-based relationship, and would have a high administrative burden on the State and managed care organizations if this path is chosen.

It is currently unclear how the State will choose to come into compliance with these new requirements and we are eagerly awaiting the release of the May Revise for direction. As of today, with the State's current budget condition, we are planning for a worst-case scenario where Partnership loses all UIS membership to the Medi-Cal FFS delivery system and will update our assumption based on what we learn in May Revise.

Partnership provides coverage to just over 90,000 UIS members today, which makes up approximately 11% of our membership. A membership reduction of this size will have a significant impact on overall finances.

- ***Expected Medi-Cal Managed Care revenue belt tightening*** **-** In previous times of budgetary hardship, the State has implemented a variety of cost cutting measures in the Medi-Cal program and specifically in Medi-Cal managed care. The State continues to focus on cost-effective spending in managed care and we expect:
    - Increased Efficiency Adjustments – The State has informed managed care plans that additional rate efficiency adjustments (revenue reductions) will be implemented in January 2027. The State is in the process of determining which new efficiencies will be implemented and has been engaging with managed care plans. DHCS has indicated the following new efficiency adjustments are being considered for implementation: readmissions, short hospital stays, cesarean mix, cellulitis, durable medical equipment, and outlier radiology utilization. Implementation of new revenue reductions through efficiency adjustments will create additional fiscal pressure.
    - As noted in our prior budget, Partnership has faced increased scrutiny from DHCS on contracted heath care cost levels in general, some of which resulted in prior year's downward rate adjustments. We expect these pressures to be amplified given the State's current budget outlook.

- ***Structure changes to Medi-Cal Financing and Provider Directed Payments*** – H.R. 1 limits provider tax mechanisms and State directed payments levels. Beginning in 2028, directed payments levels will be phased down over a multiyear period not to exceed Medicare payment levels. These financing changes will put pressure on hospital financing and create contracting pressures. The State has advised that directed payment reductions for these programs will not be backfilled. It is imperative that the State shares this same message with providers, as this level of transparency will be needed to navigate the fiscal pressures that both plans and providers will face in the coming years.

- ***Risk-Based Hospital Directed Payments*** **beginning January 2027**– Due to federal regulation changes California is required to incorporate over $17.5 billion dollars in hospital directed payments into risk-based managed care payments statewide. Today, plans have limited enrollment and utilization risk tied to these directed payments because program revenue and payment determinations are made after the directed payment period. With the federal regulation changes, revenue and payment amounts will need to be determined before the start of the program period. While full details of risk-based directed payment implementation are unknown at this time, what we do know is

enrollment uncertainty tied to H.R. 1 and other State policy changes will create utilization uncertainty. This uncertainty will, along with the directed payment changes, create significant fiscal pressure on plans, hospitals, and the State. Beginning in January 2027, plans will carry significantly more fiscal risk tied to the infusion of billions of dollars of directed payment obligations into plan base revenue. This change will in turn put strain on health plan reserves.

- ***DHCS remains focused on California Advancing and Innovating Medi-Cal (CalAIM), however, some benefit changes are expected***.
  - Transitional Rent – DHCS received federal waiver authority approval to implement up to 6-months of transitional rent as a permanent Medi-Cal benefit for a defined population. While the new benefit went live on January 1, 2026, DHCS is in the process of finalizing the policies tied to this new benefit. Partnership is currently working on expanding our network for this new benefit.
  - Community Supports and Enhanced Care Management (ECM) – The State is currently negotiating their 2027 Medicaid waiver with CMS. Changes to Community Support services are expected as a result of waiver negotiations and general State revenue constraints. ECM benefit changes are also expected. The State has advised that the ECM benefit is much "shallower" than expected, resulting in less acute members receiving these services. The state would like to see more intensive services provided. The State has further highlighted the modality for the delivery of this benefit has shifted largely to telephonic, when the original benefit was designed to rely more heavily on in-person engagement. DHCS has signaled changes to these services are coming, as a result we anticipate changes to how we will be reimbursed for these services.

- ***Quality Monitoring*** – DHCS continues to emphasize quality monitoring. Managed care plans are held to a 1% quality withhold which is assessed against revenue. Partnership has the ability to earn back withheld funds so long as we meet State defined quality benchmarks and metrics. DHCS has indicated they intend to increase the quality benchmarks annually. Beginning in calendar year (CY) 2027 and in subsequent years, it will be harder for Partnership to earn our quality withhold back. While DHCS has held the withhold to 1%, the withhold percentage is also at risk of being increased in subsequent years. Given that much of our footprint is rural with challenged quality performance, the quality withhold continues to pose financial risk to Partnership's overall revenue levels.
  - In addition to the quality withhold, DHCS continues to sanction Medi-Cal managed care plans who do not meet defined quality targets. Over the last three fiscal years Partnership has received monetary sanctions for not meeting state quality requirements. Partnership has appealed the monetary sanctions for CY 2023 and CY 2024 due identified data deficiencies outside of the plans control. A final determination on our appeal has not been made to date. However, given prior quality performance we anticipate quality sanctions to continue to occur.

- ***Additional Proposition 35 Investments*** – California voters approved Proposition 35 in November of 2024, which dedicated MCO tax revenues towards Medi-Cal provider increases. These increases were put on pause until further details were known surrounding H.R. 1. provider tax limitations and approvals. Now that the MCO tax has been approved through December 2026, additional time-limited provider

augmentations are expected to be implemented for July 1, 2026 dates of service. Details surrounding these time-limited augmentations are unknown at this time. If there are not enough details to estimate these increases, a rebudget may be needed to account for the revenues and associated costs.

- ***Office of Health Care Affordability (OHCA)*** –Starting in CY 2026, OHCA will begin applying statewide healthcare cost growth requirements to payers and providers, including Medi-Cal managed care plans. OHCA has set a Total Health Care Expenditure (THCE) growth benchmark of 3.5%, intended to limit the overall pace of healthcare spending growth across the system. Organizations with spending growth above the target may be subject to performance reviews and corrective action requirements. While formal enforcement is not expected until 2028, OHCA will use CY 2026 as the baseline measurement period, creating near-term accountability for cost performance.
    - Health plans will be required to submit annual THCE data using OHCA-defined methodologies, covering both claims and non-claims expenditures. The framework also establishes a multi-year cost growth path with increasingly tighter targets, signaling greater regulatory oversight and sustained scrutiny of cost drivers over time.

  OHCA further emphasizes increased investment in primary care, behavioral health, and alternative payment models, expanding expectations for both financial performance and care delivery transformation among Medi-Cal managed care plans.
    - Although enforcement actions are not anticipated until 2028, Medi-Cal managed care plans face immediate financial, regulatory, and operational risk. The requirements introduce a new level of cost accountability that may not fully align with the Medi-Cal rate-setting processes, plan influence over key cost drivers, network capacity, and the added administrative and reporting burden required to comply.

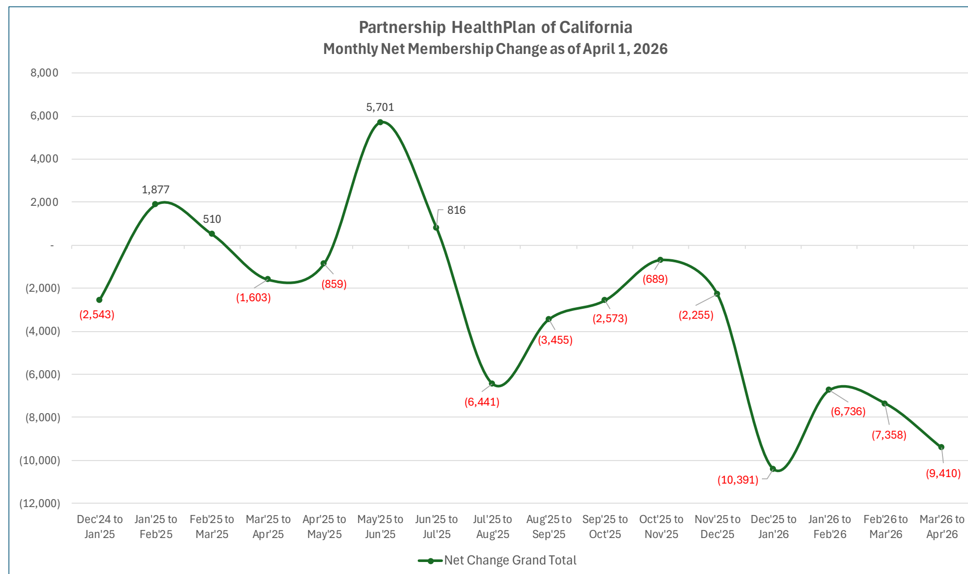
- ***Dual Special Needs Plan (D-SNP) Implementation*** – Partnership continues to work toward the implementation of our D-SNP. D-SNPs are Medicare Advantage plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi-Cal. To comply with this State requirement, the plan has undertaken significant efforts to operationalize our D-SNP. Partnership anticipates increased staffing costs, consulting costs, and capital costs associated with D-SNP systems and infrastructure needs in the upcoming FY 2026-27 period.

**Enrollment**

Partnership lost 33,895 members (nearly a 4% membership reduction) between January 2026 and April 2026. As displayed in chart below, sizeable declines outside of prior eligibility trends have been observed in both the UIS category and in the members with satisfactory immigration status (SIS) category.

UIS membership declines are largely explainable due to recent federal and state policy changes along with dual SIS membership declines which can be attributed to the increased Medi-Cal eligibility asset limits that went into effect in January 2026. Outside of the explainable membership losses, Partnership continues to see declines in the Child, Adult, and ACA Expansion

SIS categories. We believe the required DHCS monthly eligibility data scrubbing against HHS eligibility lists, mixed immigration status households, and general confusion on when federal H.R. 1 policy changes go into effect are contributors to these declines.




| Net Membership Change by Immigration Status | Dec'24 to Jan'25 | Jan'25 to Feb'25 | Feb'25 to Mar'25 | Mar'25 to Apr'25 | Apr'25 to May'25 | May'25 to Jun'25 | Jun'25 to Jul'25 | Jul'25 to Aug'25 | Aug'25 to Sep'25 | Sep'25 to Oct'25 | Oct'25 to Nov'25 | Nov'25 to Dec'25 | Dec'25 to Jan'26 | Jan'26 to Feb'26 | Feb'26 to Mar'26 | Mar'26 to Apr'26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SIS | (4,997) | 810 | (1,027) | (1,288) | (1,594) | 4,489 | 220 | (5,583) | (2,712) | (1,849) | (253) | (1,576) | (8,507) | (4,671) | (4,593) | (6,243) |
| UIS | 2,454 | 1,067 | 1,537 | (315) | 735 | 1,212 | 596 | (858) | (743) | (724) | (436) | (679) | (1,884) | (2,065) | (2,765) | (3,167) |
| **Net Change Grand Total** | **(2,543)** | **1,877** | **510** | **(1,603)** | **(859)** | **5,701** | **816** | **(6,441)** | **(3,455)** | **(2,573)** | **(689)** | **(2,255)** | **(10,391)** | **(6,736)** | **(7,358)** | **(9,410)** |

| Membership Net % Change | Dec'24 to Jan'25 | Jan'25 to Feb'25 | Feb'25 to Mar'25 | Mar'25 to Apr'25 | Apr'25 to May'25 | May'25 to Jun'25 | Jun'25 to Jul'25 | Jul'25 to Aug'25 | Aug'25 to Sep'25 | Sep'25 to Oct'25 | Oct'25 to Nov'25 | Nov'25 to Dec'25 | Dec'25 to Jan'26 | Jan'26 to Feb'26 | Feb'26 to Mar'26 | Mar'26 to Apr'26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SIS | -0.62% | 0.10% | -0.13% | -0.16% | -0.20% | 0.56% | 0.03% | -0.69% | -0.34% | -0.23% | -0.03% | -0.20% | -1.07% | -0.60% | -0.59% | -0.81% |
| UIS | 2.48% | 1.05% | 1.50% | -0.30% | 0.71% | 1.16% | 0.56% | -0.81% | -0.70% | -0.69% | -0.42% | -0.66% | -1.83% | -2.04% | -2.79% | -3.29% |
| **SIS/UIS Membership Net % Change** | **-0.28%** | **0.21%** | **0.06%** | **-0.18%** | **-0.09%** | **0.63%** | **0.09%** | **-0.71%** | **-0.38%** | **-0.29%** | **-0.08%** | **-0.25%** | **-1.16%** | **-0.76%** | **-0.84%** | **-1.08%** |

*Data refreshed as of April 7, 2026 834 Monthly file.*

We are continuing to monitor membership trends on a monthly basis; these emerging trends will be used to project the FY 2026-27 enrollment for the upcoming budget.

We will also project eligibility changes tied to the forthcoming implementation of work requirements and semi-annual redeterminations for the ACA Expansion population that go into effect in January 2027. These new federal policies are expected to amplify membership reductions in the upcoming budget year. Increased member churn is also expected due to more frequent eligibility reviews, member administrative burdens, and potential county backlogs created by these new policy changes. Enrollment projections will be finalized in June in the final budget. This will allow Partnership to account for membership changes observed in the remaining months of the current fiscal year and to incorporate any new policy changes included in the May Revision.

Enrollment loss represents the plan's greatest fiscal risk in the coming year, as declining membership directly reduces revenue and is expected to compress margins.

## Revenue

Partnership will review draft CY 2026 revenue levels to determine the most appropriate basis for budgeting. Partnership staff will make revenue assumptions specific to enrollment, member acuity, the new efficiency adjustments, and other emerging factors for the upcoming fiscal year. Further revenue assumptions will be applied to the second 6 months of the fiscal year as CY 2027

rates will not be released until later this calendar year. Staff will also account for known program updates that have been applied to prior cycles and Medi-Cal program changes that are included in the forthcoming May Revise.

- **Supplemental Revenue:** Supplemental revenue changes tied to the MCO tax, risk-based hospital directed payments, and Proposition 35 additional funding will be estimated based on best available information. There are several unknowns given the impeding changes and anticipated volatility in membership. A new MCO tax is anticipated but it is expected to be significantly reduced given the federal policy changes on provider taxes.
  - Partnership anticipates Proposition 56 supplemental payments for Development Screening, Family Planning, and Adverse Childhood Experience Screening programs to continue and will budget for these accordingly.

- **Interest Income:** During the March 2026 Federal Open Market Committee (FOMC) meeting, the committee maintained its targeted federal funds rate range of 3.50% to 3.75%. According to the Federal Reserve, the FOMC is prepared to adjust the stance of monetary policy as appropriate if risks emerge which would impede the attainment of its goals of achieving maximum employment while returning inflation to its 2 percent objective. During the March meeting, the Federal Reserve acknowledged that the uncertainty around the economic outlook remains elevated and stated rate adjustments would be considered if supported by the data. While there is not a direct correlation between the federal funds rate and the interest rate earned on deposits or investments, Partnership's overall yield tends to follow a similar direction. The Plan expects to assume an annual rate of return of 3.00% for FY 2026-27. Partnership will revise the rate accordingly based on any future actions taken by the Federal Reserve and/or best available information prior to finalizing our budget.

- **Rental Income:** Currently, Partnership leases space to 12 tenants in Fairfield, four in Auburn, three in Eureka, three in Redding, and one in Napa. Four additional spaces are available for tenant leases. Total Rental income will be estimated based on existing and anticipated lease agreements. For anticipated leases, rental income will be projected using lease rates that are approximately 90% of current market rates. Building maintenance costs associated with the leased space will be included in administrative costs.

**Health Care Costs**

Health care cost projections for FY 2026-27 will be based on the Plan's historical claims experience for covered Medi-Cal members and benefits adjusted for higher acuity given the anticipated membership decline of healthy members. Given the uncertainty tied to whether UIS members will remain in managed care, costs will be separately analyzed for UIS and SIS members. At this time, Partnership anticipates utilizing cost experience from January 2024 through December 2025 for our respective counties which serve as the base data for budget development. Additional completion factors will be incorporated where appropriate to account for incurred but not yet reported (IBNR) claims. Partnership continues to closely monitor health care costs and membership changes and will adjust our budget methodology based on emerging information prior to budget finalization.

The base period costs will be adjusted for:

- Actuarial assumptions regarding underlying utilization trends
- Anticipated impacts of case management, utilization management, and specific disease management programs from year-to-year, or newly developed programs.
- Changes in provider contracting such as new payment amendments.

## Administrative Costs

• **Staff:** As Partnership continues infrastructure building to meet the needs of the DHCS contract and implementation of the D-SNP, Partnership will propose staffing augmentations commensurate with meeting these responsibilities. Given the uncertainty with the State and Federal budget and proposed Medicaid impacts, the Plan will continue to consider the utilization of contingent resources that could be scaled accordingly dependent on final need. Staffing changes are currently being reviewed by Finance and Human Resources. Final proposed staffing levels will be presented in June.

• **Benefits:** Partnership is currently researching employer benefit trends and will present the estimated percentage change for employee medical, dental and vision benefits during the final budget presentation in June. All other benefits impacted by IRS limits will be projected accordingly. Any proposed benefit changes, to be approved by the Board, will also be incorporated.

• **Salaries:** According to the January 2026 Economic News Release from the U.S. Bureau of Labor Statistics, the Western Region of the U.S. employment cost index (ECI) for the 12 months ending December 2025 ranged from 2.6 percent to 3.6 percent. Partnership will wait for the March ECI to be released in April to obtain a better gauge on salary changes.

• **Capital:** New capital purchase recommendations, primarily related to IT and Facilities will be included on the final detailed capital expenditures budget list. Depreciation will be calculated based on anticipated purchase dates, completion dates for those items that are considered construction in progress, and existing capital assets.

## Reserves

The Total Fund Balance includes reserves for the State Financial Performance Guarantee, Capital Assets, and Strategic Use of Reserves (SUR). The State Financial Performance Guarantee is calculated at an amount equal to two months (2x) of the Plan’s state capitation revenue (based on a 12-month rolling average) and also fulfills the State Tangible Net Equity (TNE) requirements under Knox–Keene. Net capital assets are similarly included as part of the Fund Balance.

SURs represent initiatives previously approved by the Board. Over the years, these reserves have been used to expand member access, increase provider reimbursement, and enhance operational efficiency. Partnership will continue to use these funds for their approved purposes.

The projected Fund Balance as of June 30, 2027, will incorporate all reserves noted above and will be presented with the final budget.

## Off-Cyle Budget

Partnership staff may need to complete an off-cycle budget to account for Medi-Cal program changes that may occur subsequent to the finalization and approval of Partnership's budget in June of 2025 such as unanticipated impacts tied to H.R. 1 implementation and/or additional federal and state policy changes.