



## Finance Committee Meeting Agenda

May 20, 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](mailto:Board_FinanceClerk@partnershiphp.org) by 5:00p.m on May 19, 2026. Comments received will be read during the meeting.

8:00A.M – Opening			
1.1	Call to Order		<i>Dave Jones, Chair</i>
1.2	Roll Call		<i>Clerk</i>
1.3	<b>ACTION:</b> Approval of Agenda	1	<i>Chair</i>
1.4	<b>ACTION:</b> Approval of Finance Committee Minutes from April 15, 2026	2-8	<i>Chair</i>
1.5	Commissioner Comment		<i>Chair</i>
1.6	Public Comment		<i>Public</i>
New Business			
2.1	<b>INFORMATION:</b> CEO Health Plan Update	9	<i>Sonja Bjork</i>
2.2	<b>ACTION:</b> Accept March 2026 Metrics, Financials and Membership	10-23	<i>Jennifer Lopez</i>
2.3	<b>ACTION:</b> Approve the Preliminary Health Care Expense Budget for Fiscal Year 2026-2027	24-37	<i>Jennifer Lopez</i>
2.4	<b>ACTION:</b> Approve Commissioner Jayme Bottke’s Resignation from the Finance Committee and Board of Commissioners	38-39	<i>Sonja Bjork</i>
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](http://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](mailto: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)**
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- Partnership’s Chico Office located at 1000 Fortress Street, Chico, CA**

**On  
April 15, 2026**

**Members Present:** Jayme Bottke, Chris Champlin, Ryan Gruver, Dave Jones, Chair, Nancy Starck, Nolan Sullivan

**Members Excused:** Dean Germano, Alicia Hardy

**Staff:** Leigha Andrews, Jill Blake, Wendell Coats, Marisa Dominguez, Naomi Gordon, John Lemoine, Jennifer Lopez, Kathryn Power, Ashlyn Scott, Tim Sharp, Rebecca Stark, Amy Turnipseed, Colleen Valenti, Melanie Lam

AGENDA ITEM	DISCUSSION	MOTION / ACTION
<b>1.2 Roll Call</b>	Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a quorum.	None
<b>1.3 Approval of Agenda</b>	Chairman Jones asked if anyone had changes to the agenda. Hearing no requests for modification, he asked for a motion to approve the agenda.	<p><i>Commissioner Starck moved to approve the agenda as presented, seconded by Commissioner Hardy.</i></p> <p><b><u>ACTION SUMMARY:</u></b>  <i>Yes: 6            No: 0            Abstention: 0            Excused: 2 (Germano, Hardy)</i></p>

		<b>MOTION CARRIED</b>
<b>1.4 Approval of the March 18, 2026, Finance Committee Meeting Minutes</b>	Chairman Jones asked if anyone had changes to the March 18, 2026, minutes. Hearing no requests for modification, he asked for a motion to approve the minutes.	<p><i>Commissioner Starck moved to approve the minutes as presented, seconded by Commissioner Germano.</i></p> <p><b><u>ACTION SUMMARY:</u></b>  <i>Yes: 6  No: 0  Abstention: 0  Excused: 2 (Germano, Hardy)</i></p> <p><b>MOTION CARRIED</b></p>
<b>1.5 &amp; 1.6 Public Comment and Commissioner Comment</b>	Chairman Jones asked if there were any public or commissioner comments. There were none.	None
<b>New Business</b>		
<b>2.1 CEO Report</b>	<p>Sonja Bjork, Chief Executive Officer, reported on the following topics:</p> <p><b><i>D-SNP Update</i></b> – Partnership has decided not to move forward with launching a D-SNP line of business in 2027. In late 2025, the vendor we had been working with chose not to proceed with a contract, which required Partnership to reevaluate its approach. Upon reassessment, it became clear that meeting the timeline for a 2027 launch would not be possible.</p> <p>Amy Turnipseed, Chief Strategy and Government Affairs Officer, led a Request for Proposals (RFP) process to identify a new vendor. In addition, Partnership reached out to experienced health plans to explore delegating D-SNP responsibilities. However, even the most experienced organizations advised that the 2027 implementation was not realistic.</p> <p>Although new vendors have been identified, the organization must also modify its contract with its pharmacy benefit manager (PBM). Additionally, all components of the D-SNP contract and related subcontracts must undergo review and approval by the Department of Managed Health Care (DMHC), which adds significant time to the process.</p> <p>Despite these challenges, the team continued working toward a January 1, 2027, go-live date and successfully completed and submitted the required network adequacy documentation and Model of Care. The next step would have been submitting a bid to the Centers for Medicare &amp; Medicaid Services (CMS), after which withdrawing could have serious repercussions.</p>	None

Amy Turnipseed has been in ongoing discussions with the Department of Health Care Services (DHCS) regarding the delay. Partnership has formally notified DHCS and is prepared for possible financial sanctions. This was a difficult decision but one made to ensure the organization is fully prepared to serve members and support providers effectively

Partnership anticipates approximately 3,100 D-SNP members at launch, which is a relatively small population. The organization wants to ensure that members have a positive experience. D-SNP members may leave a D-SNP plan at any time. We also recognize the importance of maintaining strong relationships with providers and implementing a financially viable model.

The challenges of launching a D-SNP product were compounded by the intense preparations for implementing a new core system and a new case management system. Partnership is now targeting a revised go-live date of January 1, 2028, and is working to maintain momentum among dedicated D-SNP staff.

**Transitional Rent Benefit** – Approximately half of Partnership’s counties are either ready to implement or have already begun implementing the Transitional Rent benefit. Three counties have been fully onboarded and have established plans for enrollment and housing support services, while two additional counties are close to readiness. The benefit is highly complex and has presented numerous administrative challenges.

**Community Reinvestment – Partnership** is currently working with its 14 legacy counties for the initial phase of implementing DHCS’ Community Reinvestment policy. Partnership’s 10 expansion counties will be included in the following year. We are actively working to complete reinvestment plans within required timelines and have held numerous internal meetings to address implementation challenges.

The reinvestment funds are not allocated directly to county health departments but are intended to support broader community stakeholders. Each county’s Health and Human Services and Behavioral Health Directors must approve the proposed projects. Dr. Jalloh, Partnership’s Director of Health Equity, has begun meeting with these leaders in each of the 14 legacy counties.

The process requires significant collaboration and is particularly challenging given the financial pressures that many counties and providers are currently facing. Funding allocations are based on Medi-Cal population size, meaning larger counties will receive more resources.

All 14 counties were identified as falling within Tier 2 or Tier 3 for quality scores, which influences the reinvestment funding formula. Health plans are only required to participate in Community Reinvestment if they are profitable. Given the current fiscal climate, Partnership is uncertain whether there will be dollars for this program in the coming years.

	<p><i>Commissioner Champlin stated that if his organization is contributing to lower quality scores in the county, he is committed to improving performance and helping the county achieve a Tier 1 ranking.</i></p> <p><i>In response, Ms. Bjork stated that the quality team will reach out to provide additional information. She also noted that the quality dashboard is a valuable tool for monitoring performance and identifying areas for improvement.</i></p> <p><i>Commissioner Starck reported that her county is actively engaged in Community Reinvestment efforts. She stated that stakeholders at the county level are aligned and that there is ongoing communication with clinics and community partners.</i></p> <p><i>Commissioner Sullivan shared that in Sonoma County, Behavioral Health and Health and Human Services operate under a unified structure, allowing for close collaboration. He acknowledged that he has not recently checked on progress but intends to do so. He also noted that the county's Community Health Improvement Plan (CHIP) and Community Health Assessment (CHA) processes have been challenging.</i></p> <p><b>Rural Health Transformation Funding</b> – We are expecting to learn more regarding California's Rural Health Transformation funding during an HCAI webinar scheduled for April 21. Partnership's Regional Directors are working to share and distribute information as it becomes available. Partnership will also host its own webinar on April 27 to further inform stakeholders. Our priority is to ensure that funding goes to California's rural areas.</p>	
<p><b>2.2 ACTION: Accept February 2026 Metrics and Financials</b></p>	<p>Jennifer Lopez, Chief Financial Officer, presented the Metrics and Financials for February 2026. For the month ending February 28, 2026, Partnership reported a surplus of \$17.3 million, bringing the year-to-date surplus to \$31.6 million. As of the end of February, Partnership is serving approximately 870,000 members. While overall membership continues to decline, the organization regained some members following losses experienced in January and early February.</p> <p>Ms. Lopez noted that the favorable financial performance is primarily driven by lower administrative spending and reduced fee-for-service costs on the inpatient side, partially offset by increased outpatient spending. Partnership's cash on hand at the end of February was equivalent to 123 days.</p>	<p><i>Commissioner Champlin moved to approve the February metrics and financials as presented, seconded by Commissioner Sullivan.</i></p> <p><b><u>ACTION SUMMARY:</u></b>  <i>Yes: 6  No: 0  Abstention: 0  Excused: 2 (Germano, Hardy)</i></p> <p><b>MOTION CARRIED</b></p>
<p><b>2.3 ACTION: Resolution to Approve Budget Revisions for FY 2025-2026</b></p>	<p>Ms. Lopez presented a Resolution to Approve Budget Revisions for Fiscal Year 2025–2026, noting that this is a minor revision to the current fiscal year budget. She explained that the initial budget anticipated a \$39 million deficit; however, the organization now expects some one-time favorable adjustments related to prior-year revenue.</p> <p>Ms. Lopez further noted that, despite this favorable variance, the organization continues to</p>	<p><i>Commissioner Sullivan moved to approve Agenda Item 2.3 as presented, seconded by Commissioner Bottke.</i></p>

	<p>anticipate decreasing membership and corresponding declines in revenue. The proposed resolution seeks approval to transfer funds across expense and revenue categories in order to remain within the overall approved budget. She clarified that these adjustments reflect a fungibility approach, allowing for the reallocation of funds between categories without changing the total budget.</p>	<p><b><u>ACTION SUMMARY:</u></b>  <i>Yes: 6</i>  <i>No: 0</i>  <i>Abstention: 0</i>  <i>Excused: 2 (Germano, Hardy)</i></p> <p><b>MOTION CARRIED</b></p>
<p><b>2.4 ACTION: Resolution to Approve Budget Assumptions for FY 2026-2027</b></p>	<p>Ms. Lopez presented Partnership’s Budget Assumptions for Fiscal Year 2026–2027, noting that the organization is developing the budget with limited available information. She acknowledged that Partnership is accustomed to operating in uncertain and volatile environments, including prior challenges such as COVID-19, declining membership, and Medicaid work requirements. Given the current uncertainties, a conservative fiscal approach is being applied and a rebudget is likely as conditions evolve.</p> <p>Ms. Lopez outlined the three-month budget development process, which includes establishing budget assumptions in April, developing draft healthcare assumptions in May, and finalizing the budget in June after reviewing updated state budget information and incorporating administrative and capital expenses for presentation to the Finance Committee and Board.</p> <p>The State of California is currently facing a projected \$2.9 billion deficit and described the proposed state budget as a “keep the lights on” budget. She noted that the Legislative Analyst’s Office has highlighted higher revenues but cautioned that the state faces ongoing structural budget challenges. Ms. Lopez highlighted the high level of uncertainty due to broader economic and global factors, including market volatility and geopolitical issues.</p> <p>Additional reductions to Medi-Cal, education, and correctional system funding are anticipated, along with potential changes to Medi-Cal eligibility and the Managed Care Organization (MCO) tax. The initial Medi-Cal budget totals \$222 billion, including \$50 billion from the state. Despite recent benefit and membership reductions, overall costs have continued to increase year over year.</p> <p>Declining insurance coverage is expected to place additional strain on Federally Qualified Health Centers (FQHCs) and emergency departments. There is uncertainty surrounding the future coverage for approximately 96,000 undocumented members currently served by Partnership. For undocumented Medi-Cal beneficiaries, the state is likely to follow one of two potential approaches: carving these members out into state fee-for-service or, establishing a non-risk arrangement. She stated that, for budgeting purposes, Partnership is assuming these members will be carved out to Medi-Cal fee-for-service as of January 1, 2027, as this is the most administratively straightforward approach to comply with the federal changes.</p> <p>Ms. Bjork added that carving out undocumented members would present significant challenges for providers, as reimbursement rates under fee-for-service are lower and programs such as community</p>	<p><i>Commissioner Bottke moved to approve Agenda Item 2.4 as presented, seconded by Commissioner Gruver.</i></p> <p><b><u>ACTION SUMMARY:</u></b>  <i>Yes: 6</i>  <i>No: 0</i>  <i>Abstention: 0</i>  <i>Excused: 2 (Germano, Hardy)</i></p> <p><b>MOTION CARRIED</b></p>

supports and QIP would not be available. She also noted that this approach would create confusion for both members and providers regarding billing and coverage. While a non-risk model may better support care delivery, it would be operationally complex to implement.

Ms. Lopez stated that budget assumptions will change as more information becomes available and emphasized the need for flexibility.

*Commissioner Starck inquired whether Federally Qualified Health Centers (FQHCs) are aware of these anticipated changes and whether they know to expect them.*

*Ms. Bjork responded that FQHCs are actively discussing these issues and are aware of the potential changes. She noted that if the undocumented members are carved out of managed care, providers would be reimbursed at lower rates. She also stated that FQHCs are engaged in advocacy efforts through the California Primary Care Association (CPCA) and at the state level. She further noted that the legislature is exploring options to help cover these individuals, including the use of third-party vendors or CMS-P models; however, implementing any of these options would require additional funding.*

Ms. Lopez continued her report by noting that the Governor is likely to look to the Department of Health Care Services (DHCS) to identify significant cost reductions. The state is expected to implement additional clinical efficiency adjustments, including potential revenue reductions tied to performance measures such as hospital readmissions, short hospital stays, and cesarean section rates. Partnership is prepared to challenge these proposed reductions using clinical data.

Ms. Lopez also reported that the state is examining spending related to durable medical equipment and is likely to introduce further cost controls. Additional rate reductions are anticipated and will likely affect provider reimbursement. The state actuaries have noted that Partnership's inpatient provider payments are, on average, significantly higher than those of other plans, excluding directed payments. This will likely contribute to continued pressure to reduce rates and requires careful management of provider contracted costs.

*Commissioner Gruver inquired regarding the cycle for revisiting provider contract rates.*

*Ms. Lopez explained that FQHCs and Indian Health Centers operate under predetermined rates, while specialty networks and hospital systems represent the greatest contractual risk. She noted that contracts are not negotiated on a set schedule and vary by provider, with several large systems approaching renewal periods.*

*Ms. Bjork noted that the state has the authority to reduce revenue if it determines that provider payments are excessive, which would require Partnership to cover the difference from reserves.*

	<p>Provider contracting is a financial risk in the coming years. Additionally, CalAIM initiatives continue to drive costs. The state has expressed concerns regarding the depth and utilization of Enhanced Care Management and Community Supports services, which may result in additional rate pressure.</p> <p>Finally, Ms. Lopez reported that enrollment declined by approximately 34,000 members between January and April 2026, which will significantly impact revenue projections. She stated that expense projections are being developed based on the best available data and expected retained membership. She concluded by noting that additional information is anticipated in June and will be incorporated into the final budget as available.</p>	
<b>Adjournment</b>	Chairman Jones adjourned the meeting at 9:29AM.	None

Respectfully submitted by:  
Ashlyn Scott, Board Clerk

Committee Approval Date: 5/20/2026

Signed: \_\_\_\_\_  
Ashlyn Scott, Clerk



**Finance Committee  
Chief Executive Officer Update  
May 20, 2026**

- 1. State Budget**
- 2. Rural Health Transformation Program**
- 3. Community Reinvestments**

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## **FINANCIAL HIGHLIGHTS**

### **Of The Partnership HealthPlan of California**

### **For the Period Ending March 31, 2026**

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#### **Financial Analysis for the Current Period**

##### **Total Surplus**

For the month ending March 31, 2026, Partnership reported a surplus of \$0.8 million, bringing the year-to-date surplus to \$32.5 million. Key variances are outlined below.

##### **Revenue**

Total Revenue is lower than budget by \$43.4 million for the month and \$438.6 million for year-to-date. The following summarizes the year-to-date variances. Medi-Cal revenue is \$80.6 million favorable to budget primarily due to retro membership and the prior and current period risk corridor adjustments. Directed Payments are \$541.7 million unfavorable to budget due to lower than anticipated rates with a corresponding offset recorded in Healthcare Investment Funds (HCIF). Supplemental revenues are \$10.2 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 \$8.3 million favorable to budget due to higher interest rates than anticipated. The remaining \$4.0 million favorable variance is attributed to other revenues.

##### **Healthcare Costs**

Total Healthcare Costs are lower than budget by \$45.6 million for the month and \$446.4 million year-to-date. The following summarizes the year-to-date variances. Non-Capitated Physician and Ancillary expenses are \$126.2 million unfavorable to budget primarily due to adjustments to Incurred but Not Reported (IBNR) reserves which reflect the latest cost and utilization trends. Capitation expenses are \$6.3 million favorable to budget due to changes in the funding methodologies for certain healthcare providers. Long-term care costs are favorable to budget by \$3.2 million due to lower than expected utilization. Inpatient Hospital Fee-For-Service (FFS) expenses are favorable to budget by \$45.4 million, driven by adjustments to IBNR reserves attributed to lower utilization. HCIF expenses are \$507.3 million favorable to budget due to lower than anticipated Directed Payment rates, which are partially offset by the recording of the accrual for Community Reinvestments. Transportation costs are \$4.0 million unfavorable to budget, attributed to increased utilization and an accrual for an increase in the Ground Emergency Medical Transportation – Public Provider (GEMT-PP) rate. Quality Assurance expenses are \$14.3 million favorable to budget due to the timing of medical administrative costs.

##### **Administrative Costs**

Total Administrative costs are overall favorable to budget by \$8.3 million for the month and \$56.7 million for the year-to-date. The primary driver of favorability is in Employee costs due to the timing of the filling of open positions geared towards fulfilling our regulatory requirements; which offsets the utilization costs of consultants in the Professional Services category. Additionally, the favorable variance in Occupancy is 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, the favorable variance in Computer and Data is due to the timing of software purchases, which typically correlates to the variance in staffing.

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**FINANCIAL HIGHLIGHTS**  
**Of The Partnership HealthPlan of California**  
**For the Period Ending March 31, 2026**

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**Balance Sheet / Cash Flow**

Total Cash & Cash Equivalents increased by \$420.8 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. A key highlight for the month was the receipt of \$397.8 million in Directed Payments.

**General Statistics**

**Membership**

Membership had a total net decrease of 1,234 members for the month.

**Utilization Metrics and High Dollar Case**

For the fiscal year 2025/26 through March 2026, 657 members reached the \$250,000 threshold with an average cost of \$511,389. For fiscal year 2024/25, 1,286 members reached the \$250,000 threshold with an average cost per case of \$514,492. For fiscal year 2023/24, 900 members reached the \$250,000 threshold with an average claims cost of \$512,461.

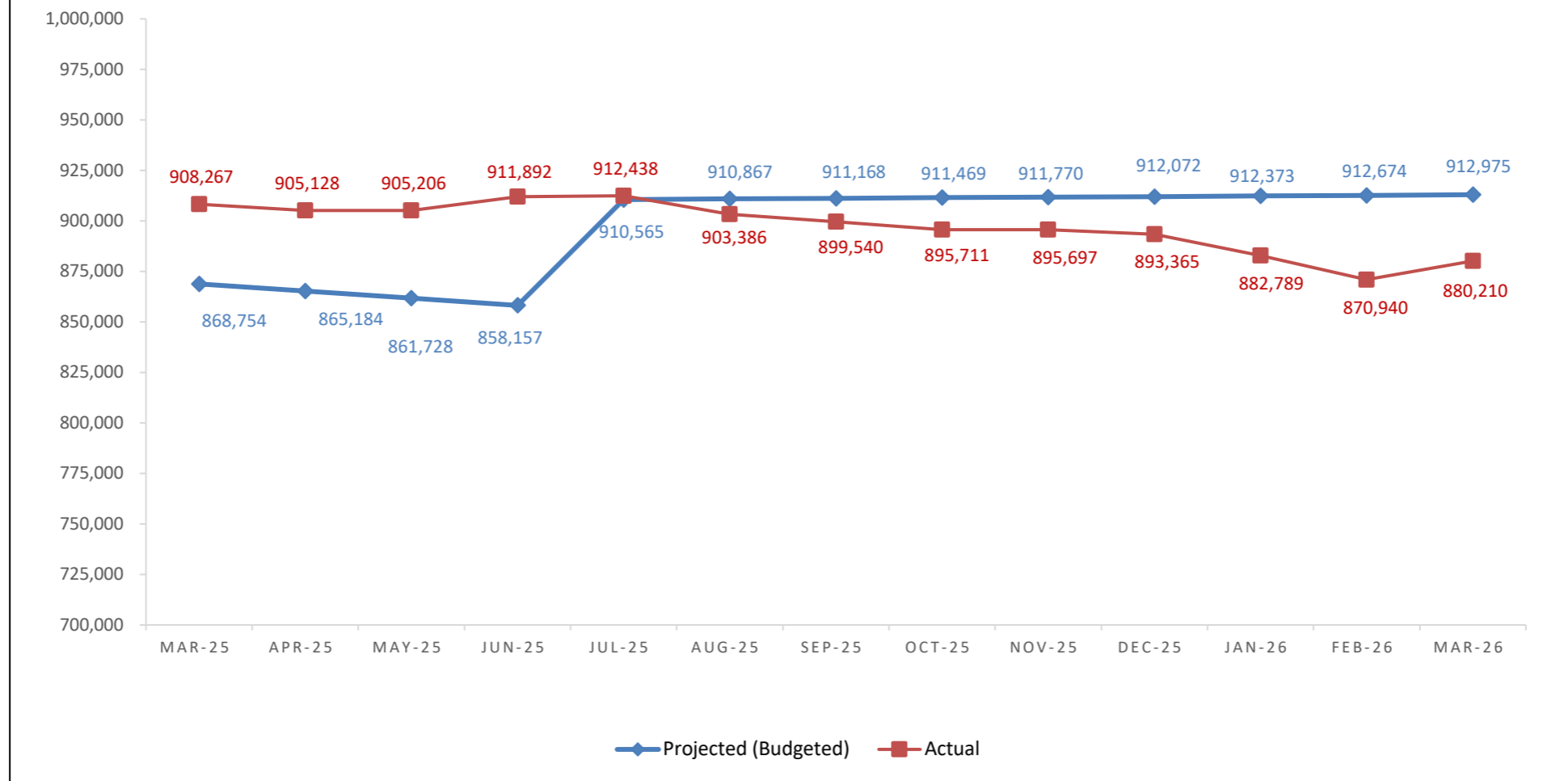
**Current Ratio/Reserved Funds**

Current Ratio Including Required Reserves:	<b>1.43</b>
Current Ratio Excluding Required Reserves:	<b>1.02</b>
Required Reserves:	<b>\$ 1,432,823,341</b>
Total Fund Balance:	<b>\$ 1,490,013,242</b>

**Days of Cash on Hand**

Including Required Reserves:	<b>146.22</b>
Excluding Required Reserves:	<b>79.63</b>

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
ACTUAL V. PROJECTED MEDI-CAL ENROLLMENT  
MAR 2025 - MAR 2026**



**Member Months by County:**

County	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Solano	102,443	102,189	102,658	103,987	104,011	102,676	102,240	101,767	101,583	101,555	98,608	97,031	98,109
Napa	27,289	27,339	27,450	27,826	27,732	27,619	27,642	27,529	27,480	27,355	26,951	26,540	26,659
Yolo	53,239	53,213	53,722	55,109	54,845	54,223	54,152	53,995	54,252	54,140	53,283	52,229	53,552
Sonoma	112,617	112,643	111,321	112,499	112,958	111,588	110,631	110,400	109,596	109,061	107,549	104,697	105,595
Marin	47,015	46,629	46,873	47,047	47,313	46,806	46,609	46,235	46,089	45,096	44,197	43,709	44,101
Mendocino	41,086	40,682	40,941	40,852	41,104	40,506	40,390	40,244	40,200	40,229	39,247	39,125	39,376
Lake	34,164	34,124	34,105	33,983	33,960	33,568	33,236	33,298	33,359	33,389	33,107	32,715	32,770
Del Norte	12,468	12,246	12,336	12,400	12,362	12,314	12,197	12,191	12,220	12,169	12,188	12,077	12,027
Humboldt	58,588	58,149	57,830	57,528	57,819	56,962	56,678	56,451	56,095	55,976	55,830	55,208	55,173
Lassen	8,821	8,767	8,764	8,656	8,575	8,358	8,439	8,412	8,406	8,491	8,375	8,305	8,255
Modoc	4,011	4,013	3,930	3,893	3,878	3,888	3,827	3,743	3,747	3,845	3,836	3,703	3,706
Shasta	66,052	65,219	65,101	65,377	65,400	64,714	64,742	64,786	65,062	64,124	64,876	63,940	64,314
Siskiyou	17,777	17,605	17,791	18,056	18,058	17,782	17,760	17,739	17,786	17,928	17,691	17,590	17,564
Trinity	5,345	5,321	5,325	5,250	5,193	5,220	5,103	5,169	5,118	5,081	4,955	4,955	5,000
Butte	86,256	85,897	85,920	85,649	84,789	84,665	84,532	84,241	84,407	84,874	84,412	83,486	83,679
Colusa	10,288	10,340	10,306	10,362	10,260	10,152	9,996	9,913	9,968	10,006	10,025	9,825	9,899
Glenn	13,786	13,690	13,682	13,647	13,764	13,687	13,672	13,523	13,497	13,456	13,358	13,182	13,222
Nevada	28,570	28,579	28,602	28,731	28,787	28,464	28,369	28,250	28,148	28,633	28,415	28,427	28,548
Placer	61,013	61,260	61,300	62,271	62,355	61,883	61,676	61,371	61,679	61,561	60,619	59,451	62,164
Plumas	5,925	5,886	5,807	5,755	5,784	5,783	5,616	5,575	5,478	5,429	5,395	5,292	5,270
Sierra	868	862	832	862	851	825	832	820	810	813	828	823	817
Sutter	43,601	43,739	43,829	44,348	44,796	44,471	44,294	43,923	44,223	44,067	43,956	43,584	44,445
Tehama	30,059	30,011	29,932	30,038	30,166	29,626	29,551	29,266	29,219	29,095	29,098	29,019	28,962
Yuba	36,986	36,725	36,849	37,766	37,678	37,606	37,356	36,870	37,275	36,992	35,990	36,027	37,003
<b>All Counties Total</b>	<b>908,267</b>	<b>905,128</b>	<b>905,206</b>	<b>911,892</b>	<b>912,438</b>	<b>903,386</b>	<b>899,540</b>	<b>895,711</b>	<b>895,697</b>	<b>893,365</b>	<b>882,789</b>	<b>870,940</b>	<b>880,210</b>

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											Avg / Month As of		
	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26			YTD	Mar-26
<b>Total Enrollment</b>	911,768	903,653	898,537	895,299	893,778	892,208	880,183	870,940	869,706			8,016,072	890,675
<b>Total Revenue</b>	593,945,794	596,614,742	614,951,654	605,173,794	589,922,935	597,186,401	597,564,630	582,105,182	598,248,494			5,375,713,626	597,301,514
<b>Total Healthcare Costs</b>	498,796,206	506,539,614	512,291,047	520,182,134	500,456,939	496,774,321	509,948,545	476,842,427	505,708,177			4,527,539,415	503,059,935
<b>Total Administrative Costs</b>	24,791,602	22,017,598	26,477,113	24,878,941	26,778,257	26,528,471	26,108,033	23,515,181	26,583,549			227,678,742	25,297,638
<b>Medi-Cal Hospital &amp; Managed Care Taxes</b>	66,396,128	65,722,340	65,436,800	65,176,911	65,100,207	65,268,296	65,351,788	64,457,740	65,122,231			588,032,441	65,336,938
<b>Total Current Year Surplus (Deficit)</b>	3,961,858	2,335,190	10,746,694	(5,064,192)	(2,412,468)	8,615,313	(3,843,736)	17,289,834	834,537			32,463,028	3,607,003
<b>Total Claims Payable</b>	629,390,689	669,310,022	649,369,505	691,165,158	693,242,993	695,889,424	733,344,288	698,356,590	626,293,648			626,293,648	676,262,480
<b>Total Fund Balance</b>	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	1,490,013,242			1,490,013,242	1,473,712,640
<b>Reserved Funds</b>													
<b>State Financial Performance Guarantee</b>	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	1,175,457,000			1,175,457,000	1,180,064,222
<b>Board Approved Capital and Infrastructure Purchases</b>	100,733,349	100,103,601	98,688,437	97,620,158	94,941,438	93,782,664	92,028,380	90,442,990	89,322,236			89,322,236	95,295,917
<b>Capital Assets</b>	161,362,815	161,328,374	162,223,752	162,679,193	164,744,577	165,348,675	166,558,763	167,531,839	168,044,105			168,044,105	164,424,677
<b>Strategic Use of Reserve-Board Approved</b>	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			68,377,668	70,127,668
<b>Unrestricted Fund Balance</b>	(6,759,761)	(14,646,383)	(23,587,903)	(43,325,258)	(58,943,390)	(62,613,402)	(76,299,941)	(28,434,793)	(11,187,767)			(11,187,767)	(36,199,844)
<b>Fund Balance as % of Reserved Funds</b>	99.54%	99.01%	98.43%	97.14%	96.14%	95.93%	95.07%	98.13%	99.25%			99.25%	97.60%
<b>Current Ratio (including Required Reserves)</b>	1.49:1	1.46:1	1.44:1	1.45:1	1.43:1	1.43:1	1.46:1	1.44:1	1.43:1			1.43:1	1.45:1
<b>Medical Loss Ratio w/o Tax</b>	94.55%	95.41%	93.23%	96.33%	95.36%	93.39%	95.82%	92.12%	94.86%			94.57%	94.57%
<b>Admin Ratio w/o Tax</b>	4.70%	4.15%	4.82%	4.61%	5.10%	4.99%	4.91%	4.54%	4.99%			4.76%	4.76%
<b>Profit Margin Ratio</b>	0.75%	0.44%	1.96%	-0.94%	-0.46%	1.62%	-0.72%	3.34%	0.16%			0.68%	0.68%

FINANCIAL INDICATORS												Avg / Month As of		
	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	Jun-25
<b>Total Enrollment</b>	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
<b>Total Revenue</b>	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
<b>Total Healthcare Costs</b>	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
<b>Total Administrative Costs</b>	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
<b>Medi-Cal Hospital &amp; Managed Care Taxes</b>	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
<b>Total Current Year Surplus (Deficit)</b>	(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
<b>Total Claims Payable</b>	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
<b>Total Fund Balance</b>	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
<b>Reserved Funds</b>														
<b>State Financial Performance Guarantee</b>	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
<b>Board Approved Capital and Infrastructure Purchases</b>	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
<b>Capital Assets</b>	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
<b>Strategic Use of Reserve-Board Approved</b>	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
<b>Unrestricted Fund Balance</b>	(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)
<b>Fund Balance as % of Reserved Funds</b>	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%
<b>Current Ratio (including Required Reserves)</b>	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
<b>Medical Loss Ratio w/o Tax</b>	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%
<b>Admin Ratio w/o Tax</b>	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%
<b>Profit Margin Ratio</b>	-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 March 31, 2026**

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
869,706	870,940	(1,234)	Total Membership	890,675	900,401	(9,726)
ACTUAL MONTH	BUDGET MONTH	\$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	\$ VARIANCE YTD
598,248,494	641,603,708	(43,355,214)	Total Revenue	5,375,713,626	5,814,282,095	(438,568,469)
505,708,177	551,314,668	45,606,491	Total Healthcare Costs	4,527,539,415	4,973,948,148	446,408,733
26,583,549	34,905,437	8,321,888	Total Administrative Costs	227,678,742	284,372,996	56,694,254
65,122,231	66,479,921	1,357,690	Medi-Cal Managed Care Tax	588,032,441	599,407,539	11,375,098
<b>834,537</b>	<b>(11,096,318)</b>	<b>11,930,855</b>	Total Current Year Surplus (Deficit)	<b>32,463,028</b>	<b>(43,446,588)</b>	<b>75,909,616</b>

94.86%	95.86%	Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)	94.57%	95.38%
4.99%	6.07%	Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)	4.76%	5.45%

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**  
**Balance Sheet**  
**As Of March 31, 2026**

	<u>March 2026</u>	<u>February 2026</u>
<b>ASSETS</b>		
<b>Current Assets</b>		
Cash & Cash Equivalents	1,512,648,195	1,091,895,890
<b>Receivables</b>		
Accrued Interest	1,172,500	786,200
State DHS - Cap Rec	1,499,298,122	1,810,528,538
Other Healthcare Receivable	43,089,039	43,764,153
Miscellaneous Receivable	6,232,741	6,246,807
<b>Total Receivables</b>	<b>1,549,792,402</b>	<b>1,861,325,698</b>
<b>Other Current Assets</b>		
Payroll Clearing	(1,463)	20,348
Prepaid Expenses	16,142,936	15,708,212
<b>Total Other Current Assets</b>	<b>16,141,473</b>	<b>15,728,560</b>
<b>Total Current Assets</b>	<b>3,078,582,070</b>	<b>2,968,950,148</b>
<b>Non-Current Assets</b>		
<b>Fixed Assets</b>		
Motor Vehicles	1,096,330	1,096,330
Furniture & Fixtures	7,701,728	7,701,728
Computer Equipment	21,552,145	21,508,743
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	46,107,883	46,066,130
Accum Depr - Motor Vehicles	(562,987)	(535,464)
Accum Depr - Furniture	(6,767,303)	(6,747,988)
Accum Depr - Comp Equipment	(19,044,299)	(18,897,639)
Accum Depr - Comp Software	(8,989,896)	(8,976,338)
Accum Depr - Leasehold Improvements	(124,288)	(124,288)
Accum Depr - Building	(15,738,505)	(15,568,687)
Accum Depr - Bldg Improvements	(18,098,835)	(17,867,220)
Construction Work-In-Progress	60,934,285	59,898,686
<b>Total Fixed Assets</b>	<b>168,044,105</b>	<b>167,531,840</b>
<b>Other Non-Current Assets</b>		
Deposits	83,280	83,280
Board-Designated Reserves	1,264,479,236	1,281,403,990
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	9,354,099	12,296,816
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
<b>Total Other Non-Current Assets</b>	<b>1,285,796,322</b>	<b>1,305,663,793</b>
<b>Total Non-Current Assets</b>	<b>1,453,840,427</b>	<b>1,473,195,633</b>
<b>Total Assets</b>	<b>4,532,422,497</b>	<b>4,442,145,781</b>

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**  
**Balance Sheet**  
**As Of March 31, 2026**

<b>LIABILITIES &amp; FUND BALANCE</b>	<b>March 2026</b>	<b>February 2026</b>
<b>Liabilities</b>		
<b>Current Liabilities</b>		
Accounts Payable	378,497,815	305,405,310
Unearned Income	52,470,131	53,599,270
Suspense Account	15,600,034	12,762,926
Capitation Payable	6,840,525	4,119,709
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	1,802,345,555	1,723,573,478
Claims Payable	165,123,996	359,263,343
Incurred But Not Reported-IBNR	461,169,652	339,093,247
Quality Improvement Programs	118,392,813	113,181,060
<b>Total Current Liabilities</b>	<b>3,033,073,634</b>	<b>2,943,631,456</b>
<b>Non-Current Liabilities</b>		
Deferred Inflows Of Resources	6,657,637	6,657,637
Net Subscription Liability	2,677,984	2,677,984
<b>Total Non-Current Liabilities</b>	<b>9,335,621</b>	<b>9,335,621</b>
<b>Total Liabilities</b>	<b>3,042,409,255</b>	<b>2,952,967,077</b>
<b>Fund Balance</b>		
<b>Unrestricted Fund Balance</b>	<b>(11,187,767)</b>	<b>(28,434,793)</b>
<b>Reserved Funds</b>		
State Financial Performance Guarantee	1,175,457,000	1,191,261,000
Board Approved Capital and Infrastructure Purchases	89,322,236	90,442,990
Capital Assets	168,044,105	167,531,839
Strategic Use of Reserve-Board Approved	68,377,668	68,377,668
<b>Total Reserved Funds</b>	<b>1,501,201,009</b>	<b>1,517,613,497</b>
<b>Total Fund Balance</b>	<b>1,490,013,242</b>	<b>1,489,178,704</b>
<b>Total Liabilities And Fund Balance</b>	<b>4,532,422,497</b>	<b>4,442,145,781</b>

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**  
**Statement of Cash Flow**  
**For The Period Ending March 31, 2026**

	<u>Current Month Activity</u>	<u>Year-To-Date Activity</u>
<b>CASH FLOWS FROM OPERATING ACTIVITIES:</b>		
<b>Cash Received From:</b>		
Capitation from California Department of Health Care Services	906,490,782	5,626,613,980
Other Revenues	221,755	2,271,361
<b>Cash Payments to Providers for Medi-Cal Members</b>		
Capitation Payments	(22,801,945)	(186,272,918)
Medical Claims Payments	(454,827,193)	(3,979,761,500)
<b>Drug Medi-Cal</b>		
DMC Receipts from Counties	3,562,423	53,733,768
DMC Payments to Providers	(6,218,774)	(48,535,599)
Cash Payments to Vendors	(6,264,721)	(665,471,639)
Cash Payments to Employees	(22,693,059)	(183,415,880)
<b>Net Cash Provided by Operating Activities</b>	<b><u>397,469,268</u></b>	<b><u>619,161,573</u></b>
<b>CASH FLOWS FROM CAPITAL FINANCING &amp; RELATED ACTIVITIES:</b>		
Purchases of Capital Assets	(1,020,889)	(13,144,725)
<b>Net Cash (Used) by Capital Financial &amp; Related Activities</b>	<b><u>(1,020,889)</u></b>	<b><u>(13,144,725)</u></b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES:</b>		
Board-Designated Reserve Transfers	16,924,754	(79,677,958)
Interest and Dividends on Investments	7,379,172	68,700,369
<b>Net Cash (Used) Provided by Investing Activities</b>	<b><u>24,303,926</u></b>	<b><u>(10,977,589)</u></b>
<b>NET INCREASE IN CASH &amp; CASH EQUIVALENTS</b>	<b>420,752,305</b>	<b>595,039,259</b>
<b>CASH &amp; CASH EQUIVALENTS, BEGINNING</b>	<b><u>1,091,895,890</u></b>	<b><u>917,608,936</u></b>
<b>CASH &amp; CASH EQUIVALENTS, ENDING</b>	<b><u>1,512,648,195</u></b>	<b><u>1,512,648,195</u></b>
<b>RECONCILIATION OF TOTAL OPERATING LOSS TO NET CASH PROVIDED BY OPERATING ACTIVITIES</b>		
<b>TOTAL OPERATING LOSS</b>	<b>(6,930,935)</b>	<b>(36,446,340)</b>
<b>DEPRECIATION</b>	<b>608,489</b>	<b>5,336,891</b>
<b>CHANGES IN ASSETS AND LIABILITIES:</b>		
Other Receivables	689,181	15,478,421
California Department of Health Services Receivable	311,230,416	255,611,433
Other Assets	2,429,939	(1,472,125)
Accounts Payable and Accrued Expenses	156,293,366	328,879,119
Accrued Claims Payable	(72,062,942)	12,991,230
Quality Improvement Programs	5,211,754	38,782,944
<b>Net Cash Provided by Operating Activities</b>	<b><u>397,469,268</u></b>	<b><u>619,161,573</u></b>

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Statement of Revenues and Expenses  
For The Period Ending March 31, 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
869,706	869,706	-			<b>TOTAL MEMBERSHIP</b>	8,016,072	8,016,072	-		
					<b>REVENUE</b>					
589,127,090	634,534,298	(45,407,208)	677.39	729.60	State Capitation Revenue	5,300,948,931	5,751,822,375	(450,873,444)	661.29	717.54
7,765,472	6,860,680	904,792	8.93	7.89	Interest Income	68,909,369	60,639,570	8,269,799	8.60	7.56
1,355,932	208,730	1,147,202	1.56	0.24	Other Revenue	5,855,326	1,820,150	4,035,176	0.73	0.23
<b>598,248,494</b>	<b>641,603,708</b>	<b>(43,355,214)</b>	<b>687.88</b>	<b>737.73</b>	<b>TOTAL REVENUE</b>	<b>5,375,713,626</b>	<b>5,814,282,095</b>	<b>(438,568,469)</b>	<b>670.62</b>	<b>725.33</b>
					<b>HEALTHCARE COSTS</b>					
					<b>Physician Services</b>					
11,021,463	9,496,789	(1,524,674)	12.67	10.92	Per Capitation	80,101,406	87,177,963	7,076,557	9.99	10.88
204,971	204,463	(508)	0.24	0.24	Specialty Capitation	1,901,902	1,878,098	(23,804)	0.24	0.23
88,183,057	86,822,997	(1,360,060)	101.39	99.83	Non-Capitated Physician Services	813,665,118	744,444,198	(69,220,920)	101.50	92.87
<b>99,409,491</b>	<b>96,524,249</b>	<b>(2,885,242)</b>	<b>114.30</b>	<b>110.99</b>	<b>Total Physician Services</b>	<b>895,668,426</b>	<b>833,500,259</b>	<b>(62,168,167)</b>	<b>111.73</b>	<b>103.98</b>
					<b>Inpatient Hospital</b>					
16,389,274	16,213,074	(176,200)	18.84	18.64	Hospital Capitation	152,433,408	150,494,082	(1,939,326)	19.02	18.77
109,116,929	114,270,408	5,153,479	125.46	131.39	Inpatient Hospital - Ffs	994,666,851	1,040,050,418	45,383,567	124.08	129.75
793,936	793,936	-	0.91	0.91	Hospital Stoploss	7,296,161	7,296,161	-	0.91	0.91
<b>126,300,139</b>	<b>131,277,418</b>	<b>4,977,279</b>	<b>145.21</b>	<b>150.94</b>	<b>Total Inpatient Hospital</b>	<b>1,154,396,420</b>	<b>1,197,840,661</b>	<b>43,444,241</b>	<b>144.01</b>	<b>149.43</b>
52,693,559	60,379,339	7,685,780	60.59	69.42	Long Term Care	548,930,877	552,164,006	3,233,129	68.48	68.88
					<b>Ancillary Services</b>					
1,287,899	1,317,310	29,411	1.48	1.51	Ancillary Services - Capitated	10,936,659	12,114,686	1,178,027	1.36	1.51
106,133,854	99,042,553	(7,091,301)	122.03	113.88	Ancillary Services - Non-Capitated	960,042,661	903,025,183	(57,017,478)	119.76	112.65
<b>107,421,753</b>	<b>100,359,863</b>	<b>(7,061,890)</b>	<b>123.51</b>	<b>115.39</b>	<b>Total Ancillary Services</b>	<b>970,979,320</b>	<b>915,139,869</b>	<b>(55,839,451)</b>	<b>121.12</b>	<b>114.16</b>
					<b>Other Medical</b>					
6,859,235	8,342,613	1,483,378	7.89	9.59	Quality Assurance	53,013,096	67,278,504	14,265,408	6.61	8.39
92,461,192	134,014,103	41,552,911	106.31	154.09	Healthcare Investment Funds	716,350,258	1,223,630,823	507,280,565	89.36	152.65
111,500	151,560	40,060	0.13	0.17	Advice Nurse	1,107,000	1,288,270	181,270	0.14	0.16
13,296,136	13,110,351	(185,785)	15.29	15.07	Transportation	121,691,716	117,703,454	(3,988,262)	15.18	14.68
<b>112,728,063</b>	<b>155,618,627</b>	<b>42,890,564</b>	<b>129.62</b>	<b>178.92</b>	<b>Total Other Medical</b>	<b>892,162,070</b>	<b>1,409,901,051</b>	<b>517,738,981</b>	<b>111.29</b>	<b>175.88</b>
7,155,172	7,155,172	-	8.23	8.23	Quality Improvement Programs	65,402,302	65,402,302	-	8.16	8.16
<b>505,708,177</b>	<b>551,314,668</b>	<b>45,606,491</b>	<b>581.46</b>	<b>633.89</b>	<b>TOTAL HEALTHCARE COSTS</b>	<b>4,527,539,415</b>	<b>4,973,948,148</b>	<b>446,408,733</b>	<b>564.79</b>	<b>620.49</b>
					<b>ADMINISTRATIVE COSTS</b>					
16,895,027	22,177,527	5,282,500	19.43	25.50	Employee	143,873,206	181,367,209	37,494,003	17.95	22.63
68,660	201,064	132,404	0.08	0.23	Travel And Meals	754,875	1,709,218	954,343	0.09	0.21
1,253,944	3,377,680	2,123,736	1.44	3.88	Occupancy	11,789,655	23,528,860	11,739,205	1.47	2.94
967,769	956,246	(11,523)	1.11	1.10	Operational	5,921,174	8,127,674	2,206,500	0.74	1.01
4,168,590	3,461,288	(707,302)	4.79	3.98	Professional Services	32,427,925	29,421,110	(3,006,815)	4.05	3.67
3,229,559	4,731,632	1,502,073	3.71	5.44	Computer And Data	32,911,907	40,218,925	7,307,018	4.11	5.02
<b>26,583,549</b>	<b>34,905,437</b>	<b>8,321,888</b>	<b>30.56</b>	<b>40.13</b>	<b>TOTAL ADMINISTRATIVE COSTS</b>	<b>227,678,742</b>	<b>284,372,996</b>	<b>56,694,254</b>	<b>28.41</b>	<b>35.48</b>
65,122,231	66,479,921	1,357,690	74.88	76.44	<b>Medi-Cal Managed Care Tax</b>	588,032,441	599,407,539	11,375,098	73.36	74.78
<b>834,537</b>	<b>(11,096,318)</b>	<b>11,930,855</b>	<b>0.98</b>	<b>(12.73)</b>	<b>TOTAL CURRENT YEAR SURPLUS (DEFICIT)</b>	<b>32,463,028</b>	<b>(43,446,588)</b>	<b>75,909,616</b>	<b>4.06</b>	<b>(5.42)</b>

# **PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

## **NOTES TO FINANCIAL STATEMENTS**

### **March 31, 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

# **PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

## **NOTES TO FINANCIAL STATEMENTS**

### **March 31, 2026**

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

#### **RESERVED FUNDS:**

As of March 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 March 2026, the HealthPlan has accrued a Quality Improvement Program payout of \$118.4 million.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**  
**NOTES TO FINANCIAL STATEMENTS**  
**March 31, 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**

The Department of Health Care Services (DHCS) requires Medi-Cal Managed Care Plans (MCPs) that report a positive net income to demonstrate a commitment to the communities in which they operate by contributing a minimum percentage of their annual net income to those communities. To satisfy this commitment for calendar year 2026, the HealthPlan recorded a Community Reinvestments accrual of \$10.1 million for the month for the applicable counties using the calculation based on the calendar year 2024 Medical Loss Ratio (MLR).

**Partnership HealthPlan of California**  
**Investment Schedule**  
*March 31, 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
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**FUNDS HELD FOR INVESTMENT:**

Highmark Money Market	Cash & Cash Equiv	NA	Various	NA	NA	NA	\$ 1,823,157	\$ 1,823,157	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:**

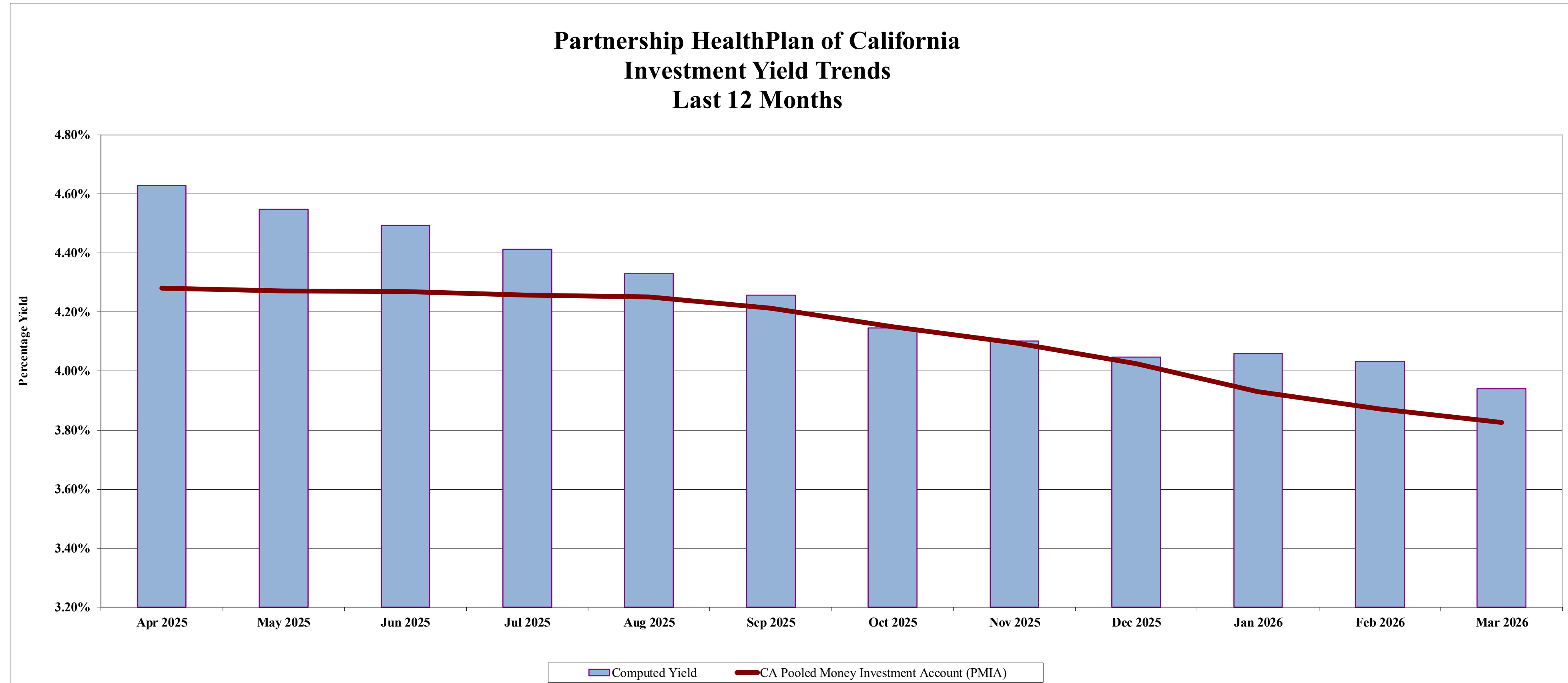
Merrill Lynch Institutional	Cash for Operations	NA	NA	NA	NA	NA	NA	\$ 81,092,625		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	\$ 620,140		
US Bank - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	\$ 2,572,273,438		
Government Investment Pools (LAIF)	Cash for Operations	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	\$ 148,260		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	\$ 3,300		

**GRAND TOTAL:**

\$ 2,777,427,431

**Partnership HealthPlan of California  
Investment Yield Trends**

PERIOD		Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Interest Income		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	7,765,472
Cash & Investments at Historical Cost	(1)	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	2,777,427,431
Computed Yield	(2)	4.63%	4.55%	4.49%	4.41%	4.33%	4.26%	4.15%	4.10%	4.05%	4.06%	4.03%	3.94%
CA Pooled Money Investment Account (PMIA)	(3)	4.28%	4.27%	4.27%	4.26%	4.25%	4.21%	4.15%	4.10%	4.03%	3.93%	3.87%	3.83%



**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.

**AGENDA REQUEST FOR RATIFICATION  
for  
PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Board / Finance Committee (when applicable)**  
**Meeting Date:** May 20, 2026  
**Board Meeting Date:** June 24, 2026

**Agenda Item Number:**  
2.3

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

**Recommendation by:**  
The Finance Committee and Partnership Staff

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**Topic Description:**

On April 22, 2026, the Board approved Budget Assumptions for Fiscal Year (FY) 2026-2027 and directed staff to prepare a full operational budget. The Preliminary Health Care Expense Budget for FY 2026-2027 is being presented to the Finance Committee for approval. The final budget (health care, administrative, and operations) is presented to the Finance Committee and full Board for approval in June.

**Reason for Resolution:**

The purpose of this resolution is to present the Preliminary Health Care Expense Budget for FY 2026-2027 for review and approval.

**Financial Impact:**

The financial impact is material.

**Requested Action of the Board:**

Based on the approval of the Finance Committee and Partnership staff, the Board is asked to ratify the Preliminary Health Care Budget for FY 2026-2027.

**AGENDA REQUEST FOR RATIFICATION  
for  
PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Board / Finance Committee (when applicable)**  
**Meeting Date:** May 20, 2026  
**Board Meeting Date:** June 24, 2026

**Agenda Item Number:**  
2.3

**Resolution Number:**  
26-

**IN THE MATTER OF: RATIFYING THE FINANCE COMMITTEE’S APPROVAL OF THE  
PRELIMINARY HEALTH CARE EXPENSE BUDGET FOR FY 2026-2027**

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**Recital: Whereas,**

- A. The Board has responsibility for establishing budget policy and specific budget approval.
- B. In prior meetings, Partnership staff, the Finance Committee, and the Board have provided direction and input into the development of the budget.

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

- 1. To ratify the Finance Committee’s approval of the Preliminary Health Care Budget for FY 2026-2027.

**PASSED, APPROVED, AND ADOPTED** by the Partnership HealthPlan of California this 24<sup>th</sup> day of June 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

**FY 2026-27**  
**Preliminary Health Care Budget**



**May 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.

## FY 2026-27 State Outlook – May Revise

As of the May Revise the State presented a total budget of \$349.4 billion total fund (\$246.6 billion State General Fund) for FY 2026-27, \$1.8 billion lower than estimated in January). The May Revise does not propose any significant new ongoing expenditures. General Fund revenues (excluding transfers and loans) are projected to be \$16.8 billion higher than what was assumed in January for FY 2025-26 and FY 2026-27, largely driven by personal income tax. The May Revise maintains reserves and reduces previously forecasted operating deficits. The increased revenue and the restraint of not introducing new sizeable ongoing expenditures have allowed the Governor to present a balanced budget for FY 2026-27 through FY 2027-28. The next Governor and State Administration will be tasked with addressing outyear budget deficits.

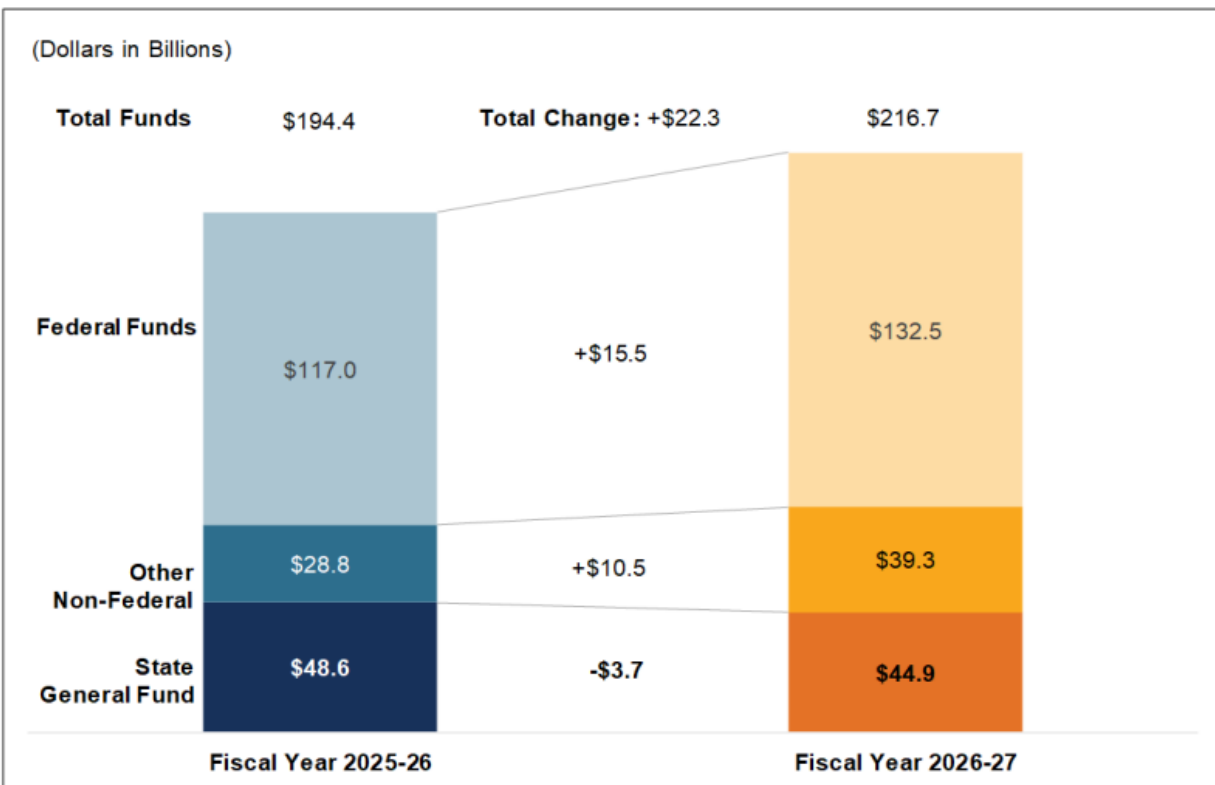
The May Revise combined reserves for FY 2026-27 are \$29.9 billion, of which:

- \$15.1 billion in the Budget Stabilization Account, an increase of \$3.9 billion from the FY 2025-26 Enacted Budget.
- \$4.5 billion in the Special Fund for Economic Uncertainties, no change from FY 2025-26 Enacted Budget.
- \$10.3 billion deposit into the Public School System Stabilization Account, an increase of \$6.2 billion from the January Budget.

Further the May Revises assumes a \$9.7 billion transfer into the Surplus Holding Account, this account was established in 2024 and allows the State to set aside a portion of anticipated surplus funds and allocate them in a subsequent fiscal year.

Medi-Cal is a large portion of overall State expenditures and continues to be a focus of this Administration. The below Department of Health Care Services (DHCS) May Revise Highlights budget chart<sup>1</sup>, outlines the May Revise year-over-year Medi-Cal program estimated expenditures.

## Medi-Cal Year Over Year Change from FY 2025-26 to FY 2026-27



<sup>1</sup> <https://www.dhcs.ca.gov/Budget/Documents/DHCS-FY-2026-27-May-Revise-Highlights.pdf>

As displayed above, \$216.7 billion total fund (\$44.9 billion General Fund) was requested to operate the Medi-Cal program for FY 2026-27. This is a \$5.7 billion total fund (\$3.9 billion General Fund) decrease from the January Budget for FY 2026-27. The budget assumes 13.9 million individuals will receive coverage through the Medi-Cal program in FY 2026-27, which is a 3.75% membership decrease from revised FY 2025-26 membership. The DHCS Medi-Cal membership projections are inclusive of Managed Care and Fee-for-Service (FFS) members.

Notable May Revise Budget details that affect the Medi-Cal program are highlighted below.

- Unsatisfactory Immigration Status (UIS) Members transitioned from Medi-Cal Managed Care to Medi-Cal FFS** - The May Revise proposes to transition all UIS members from Medi-Cal Managed Care to Medi-Cal FFS effective January 1, 2027. This change is a result of federal prohibitions tied to risk-based payments for federally eligible emergency services for these members. The budget proposes to transition these members to full scope Medi-Cal FFS. The only services these members would lose are Enhanced Care Management and Community Supports, which are available only through the Medi-Cal Managed Care delivery system. As of May 2026, Partnership serves nearly 90,000 UIS members.
- Increased UIS Adult Member Medi-Cal Premiums** - The FY 2025-26 Budget included a \$30 monthly premium for all UIS members aged 19 to 59 who are enrolled in full scope Medi-Cal. The May Revise proposed to increase the monthly premium to \$50 effective

July 1, 2027. Questions have been raised about whether the State would consider providing counties with indigent care funding to cover health care costs for UIS members who lose Medi-Cal coverage due to the implementation of premiums and the UIS member enrollment freeze that took effect January 1, 2026. It is anticipated discussions surrounding indigent care funding will occur through budget negotiations.

- **Eligibility Changes for Qualified Non-Citizens** - H.R.1 implemented federal eligibility changes for qualified non-citizens and narrows eligibility for federal funding. As a result, effective October 1, 2026, this group will transition to state-only full scope Medi-Cal with no dental coverage. Effective January 1, 2027, these members that are enrolled in Managed Care will transition to limited-scope Medi-Cal FFS. Effective July 1, 2027, this group will shift to restricted-scope Medi-Cal FFS. The cost of this change is estimated to be \$668.1 million General Fund in FY 2026-27.
- **Modify the Asset Test for Medi-Cal Eligibility** - The budget proposed to modify the asset limit for the Seniors and Persons with Disabilities population. As of January 1, 2026, Medi-Cal changed their asset test; limiting Medi-Cal eligibility to members with no more than \$130,000 of assets for one person and an additional \$65,000 for each additional family member. The budget proposed to modify the asset test effective January 1, 2027, Medi-Cal eligibility would be limited to members with assets of \$2,000 for an individual and \$3,000 for a couple. This change is expected to result in additional Partnership membership losses.
- **New Managed Care Organization (MCO) Tax** - The FY 2026-27 budget proposes adopting a new MCO Tax effective January 1, 2027, that would assess a higher tax rate on non-Medi-Cal plans. The new tax structure proposes to impose an \$8.85 PMPM tax on Medi-Cal and Non-Medi-Cal plans. H.R. 1 and other federal changes require the tax rate of non-Medi-Cal and Medi-Cal plans to be uniform. The new tax revenue is expected to result in \$575 million in FY 2026-27, \$2.3 billion in FY 2027-28 and FY 2028-29, and \$1.7 billion in FY 2029-30. Full details of the new MCO Tax have not been released at this time.
- **Existing MCO Tax Revenue Timing Adjustments** - The budget was adjusted to reflect changes in the timing of when existing MCO Tax revenues will be collected and expended. The budget proposes to spread this revenue over FY 2025-26, FY 2026-27, and FY 2027-28. Our understanding is the MCO tax revenue will be used to fund the Governor's May 2025 Proposition 35 spending plan. Subject to Centers for Medicare and Medicaid Services approval, the spending plan includes investments for the:
  - Continuation of Medi-Cal Targeted Rate Increases (TRI)
  - Time-limited supplemental payments, over and beyond TRI for primary care, specialty care, maternal health, and non-specialty mental health providers.
  - Behavioral Health Facility Throughputs
  - Graduate Medical Education
  - Medi-Cal Workforce
- **Elimination of the Adult Acupuncture Benefit** - This policy would eliminate the optional benefit for adult members effective January 1, 2027.
- **Implement Medi-Cal Efficiencies through Utilization Management** - This policy would implement applied behavioral analysis (ABA) and transportation utilization management controls. DHCS has established a joint Chief Financial Officer and Chief Medical Officer

workgroup to discuss these new policies. DHCS will consider the feedback from this workgroup to help shape final policy requirements.

- **Revisions to Community Supports and Enhanced Care Management (ECM)** - The current budget proposes to scale back California Advancing and Innovating Medi-Cal (CalAIM). Specifically, the May Revise assumes General Fund reductions of \$41.4 million in FY 2026-27 and \$99.2 million ongoing for ECM tied to refined eligibility criteria, service definitions, utilization management criteria, and payment adjustments. Further General Fund reductions of \$26.9 million in FY 2026-27, \$58.8 million in 2027-28, and \$51 million ongoing were included for Community Supports tied to refined referral pathways, eligibility criteria, service definitions, and utilization management criteria for select Medi-Cal community supports. The proposed policy changes would be effective January 1, 2027.

Other notable items:

- **Reduced Medical Assistance Percentage for Emergency Services** - The May Revise includes \$669 million in increased General Fund costs in FY 2026-27 due to the emergency services federal match reductions (match reduced from 90 percent to 50 percent) for UIS adult expansion members. This change goes into effective October 1, 2026.
- **Eliminate Prospective Payment System (PPS) funding for State-Only Services for UIS Members** - The May Revise proposes to eliminate PPS rate funding for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for state-only-funded services for UIS members effective no sooner than July 1, 2026. If implemented clinics would be reimbursed at the applicable Medi-Cal managed care rate for the period of July 1, 2026 to December 31, 2026. Effective January 1, 2027, clinics would be reimbursed at the applicable Medi-Cal FFS rate. FQHCs and RHCs are safety net providers that serve as the primary care backbone of Medi-Cal, we expect budget negotiations on this proposed policy to ensue over the proceeding weeks.
- **Funding for Hospitals in Immediate Financial Distress** – The May Revise allows for an augmentation of up to \$50 million General fund in FY 2026-27 for the Department of Health Care Access and Information. This funding will provide limited financial support to hospitals with less than 10 days of cash on hand, whose patient mix is at least 50 percent government funded or uninsured. Given the fiscal hardships hospitals and specifically rural hospitals have faced this funding can serve as a stopgap to keep hospitals afloat as longer term solutions are explored.

In previous times of budgetary hardship, the State has implemented a variety of cost cutting measures in the Medi-Cal program outside of the budget. Based on recent discussions with DHCS and history we expect:

- Additional Managed Care rate efficiency adjustments to be implemented by January 1, 2027. This will result in Partnership revenue reductions. 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.
- DHCS will continue to focus on cost-effective spending in managed care and expect pressures to be amplified.

- As noted in our prior budgets, Partnership has faced increased scrutiny from DHCS on contracted health care cost levels, some of which resulted in prior year's downward rate adjustments.

## National Medicaid Changes and Other Potential Federal Changes

H.R.1 implemented sweeping changes to Medicaid Nationally. Notable eligibility and financing changes, and Medicaid policy pressures are highlighted below.

- **Medicaid Community Engagement and Work Requirements** - H.R. 1 mandated States to implement community engagement and work requirement for able-bodied adults aged 19 to 64 without children under 13. Effective January 1, 2027, these members must meet work, volunteer, school, or training requirements to keep Medi-Cal. Exemptions apply for pregnancy, disability, serious health conditions, and other circumstances. This change is expected to result in additional Partnership membership losses.
- **Semi-annual Adult Expansion Member Medicaid Eligibility** - Effective January 1, 2027, eligibility verification for the adult expansion population must occur every 6 months instead of annually as a result of H.R.1. This change is expected to result in additional Partnership membership losses.
- **Medicaid Retro Eligibility Changes** - Effective January 1, 2027, retroactive Medicaid eligibility will be reduced from 90 days to 30 days for the adult expansion population and reduced from 90 days to 60 days for all other members. This change is expected to result in additional Partnership membership losses.
- **Limit Medicaid Directed Payments to the Medicare Payment Levels** - Effective January 1, 2028, Medicaid State Directed Payments (SDPs) must be phased-down over a multiyear period to 100% of Medicare for expansion states while non-expansion States must be phased down to a 110% of Medicare. California hospitals heavily rely on supplement SDP funding. Each Medi-Cal hospital SDP program exceeds the new Medicare limit. DHCS has indicated they will not be able to backfill hospital SDP losses. The SDP funding reductions are expected to put significant financial strain on hospital systems.
- **Risk of Future Medicaid Changes** - There is risk that future CMS regulatory changes and additional rulemaking could further alter the Medicaid program without requiring federal legislative action. Additional uncertainty remains regarding whether federal lawmakers will pursue further Medicaid funding reductions.

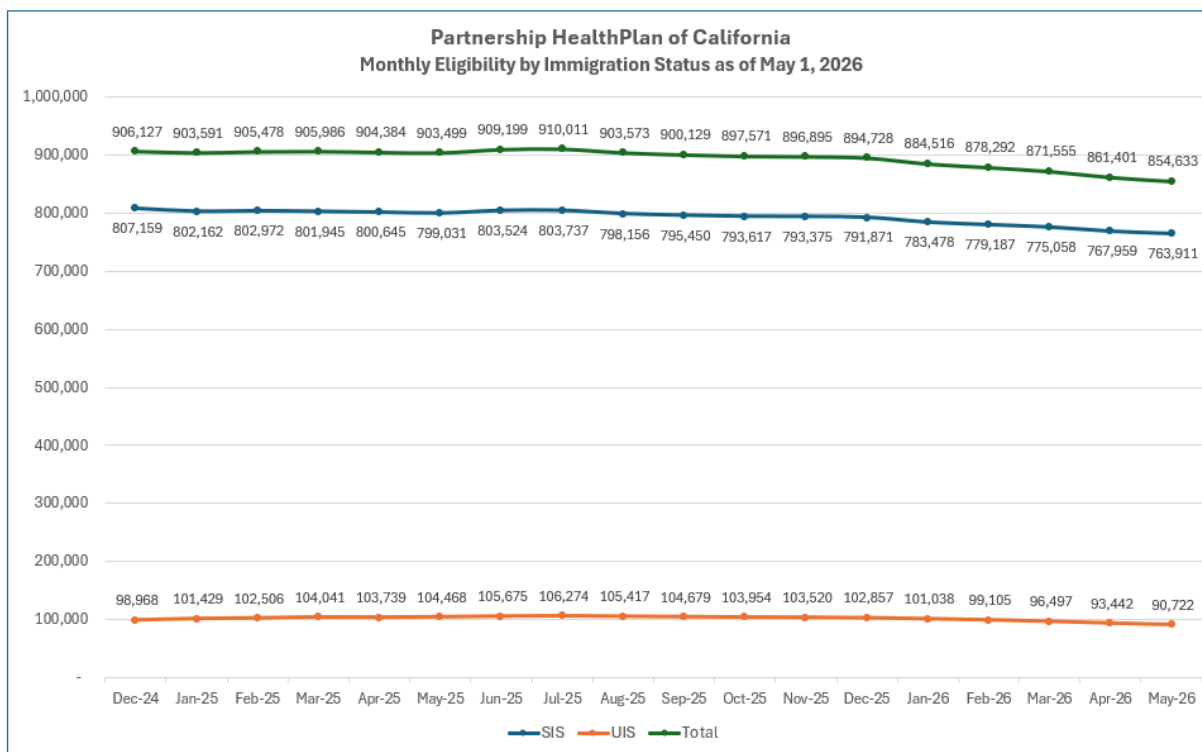
## Partnership FY 2025-26 Health Care Expenses

Partnership lost 40,095 members (nearly a 4.5% membership reduction) between December 2025 and May 2026. As noted in our April assumptions, and as displayed in the membership chart on the subsequent page, 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 on January 1, 2026. Outside of the explainable membership losses, Partnership continues to see declines in the Child, Adult, and ACA Adult

Expansion SIS categories which is concerning. 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.

Partnership’s recent membership reductions and the proposed UIS members transition from Managed Care to Medi-Cal FFS will significantly reduce the amount of revenue Partnership receives from DHCS. As of May 2026, Partnership serves 90,722 UIS members, the May Revise proposal would result in a 10.62% membership loss. Further, there is considerable uncertainty on how many members Partnership will lose as a result of upcoming January 1, 2027, H.R.1 eligibility changes.



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. Further financial risk is tied to revenue adequacy for CY 2026 and CY 2027. With the observed and anticipated future membership loss, Partnership expects to serve a higher-needs population. It is unclear if the State will adjust CY 2026 revenue and how the forthcoming CY 2027 revenue will account for these uncertainties. Rate advocacy efforts are underway through our health plan associations specific to rate adequacy and risk mitigation protective measures.

The preliminary health care cost projections for FY 2026-27 were forecasted based on historical claims experience, anticipated membership reductions, and further adjusted for anticipated member acuity. Partnership utilized cost experience from January 2025 through December 2025 when developing these projections. All UIS member expenses were removed for the period of January to June 2027 based on the May Revise proposal. Completion factors were applied to incomplete CY 2025 months where appropriate to account for incurred but not yet reported

claims. Partnership continues to closely monitor health care costs and membership changes and will adjust our budget methodology based on emerging information.

The revenue and membership uncertainty noted above cascades down to health care expense uncertainty. The preliminary health care expense projections will be further revised in June based on:

- June 2026 membership trends
- Incorporating actuarial analysis on levers and stayers
- Refined FY 2026-27 acuity assumptions
- Additional claims data and other emerging information.
- Changes in provider contracting such as new payment amendments.
- May Revise policy changes. Due to the timing of the May Revise release and our budget development process several of the proposed policy changes are not included in our estimates. Our estimates do account for the transition of all UIS members effective January 1, 2027 to Medi-Cal FFS.

Expenses for the new transitional rent benefit will be incorporated in June budget. Partnership will assess whether we have enough details to estimate the associated revenue and costs tied to Governor's Proposition 35 spending plan and other May Revise policy changes. If not, Partnership will incorporate these adjustments in an off-cycle budget.

Fiscal headwinds have already begun impacting DHCS. In fact, DHCS just recently requested a loan of \$4.3 billion from the State given cost overruns and CMS announced they are withholding \$1.3 billion in Medi-Cal funding for failure to combat fraud. DHCS has, at times, withheld monthly plan revenue payments in response to fiscal pressures.

Given the overall uncertainty related to membership, revenue adequacy, expenses, and the potential for DHCS to withhold monthly plan revenue payments, it is imperative that fiscal restraint be exercised in the coming fiscal years.

Historically, when the State has withheld monthly revenue payments, Partnership has continued to issue payments to providers despite not receiving corresponding revenue. As fiscal stewards, we must ensure that, should this situation arise again, we have the financial capacity to continue supporting our providers even in the absence of timely payments.

Maintaining and strengthening plan reserves must remain a priority in light of this uncertainty. Prudent spending and robust reserves will be essential to navigating the fiscal headwinds anticipated over the next several years.

The preliminary health care estimates by cost category are presented in more detail below.

#### Inpatient Hospital

2026-27: \$1.3 billion | 2025-26  $\Delta$ :  $-\$297.9$  million or  $-18.2\%$

The Inpatient Hospital line item includes inpatient FFS, hospital capitation, and stoploss expenses. The year-over-year decrease is primarily driven by the disenrollment of UIS members

from managed care effective January 1, 2027, as well as the implementation of H.R.1 related eligibility restrictions and more frequent eligibility redeterminations.

Despite the overall decline in enrollment, inpatient hospital costs are projected to increase on a PMPM basis due to higher acuity among the remaining membership. Anticipated impacts include longer average lengths of stay and increased severity, leading to higher unit cost trends.

Given ongoing uncertainty in Medicaid, Partnership must remain disciplined in managing health care expenses through appropriate medical management and prudent contracting decisions. As contract requests are evaluated, it is imperative to consider other hospital revenue sources that are afforded to contracted providers in Medi-Cal managed care, including the Private Hospital Directed Payment (PHDP) program and the District Hospital Directed Payment (DHDP) program. While we recognize a phase-down of funding for these programs will occur beginning in CY 2028, DHCS has advised they will not have the ability to backfill these program losses and neither will plans given our revenue comes directly from the State.

We continue to highlight that Partnership is an outlier in its inpatient contracting levels relative to other Medi-Cal plans statewide, this puts further strain on the ability to implement contracting increases. The State's actuaries assess the reasonableness of Partnership's contracting levels inclusive of the hospital directed payments and have raised concerns on our inpatient payment levels during each rating period, some of which has resulted in downward inpatient rate adjustments.

Partnership staff are continuing to evaluate our budget assumptions and the final inpatient hospital expense will be presented in June.

### Physician Services

2026-27: \$1.1 billion | 2025-26 Δ: -\$74.2 million or -6.5%

Physician Services include Proposition 56 payments (Prop 56), specialty capitation, primary capitation, and physician FFS expenses. FFS expenses are decreasing year-over-year due to the disenrollment of UIS members from managed care and impacts of H.R.1. However, the disenrollment of historically younger and lower-utilizing UIS members increases the concentration of medically complex members requiring ongoing physician care.

Primary Care spending is expected to remain slightly elevated due to increased demand for preventative services and stabilization efforts associated with transitional care management following acute episodes. Specialty Physician costs are projected to increase, driven by a higher prevalence of comorbid conditions and resulting increases in cost per visit. In addition, utilization for Indian Health Service (IHS) reimbursement have risen significantly.

Effective January 1, 2024, TRI rate increases were implemented for eligible contracted providers. This brought eligible provider minimum reimbursement levels for TRI procedure codes to at least 87.5% of the lowest Medicare locality in the state for certain Medi-Cal services. Noting a subset of the TRI procedure code rates exceed Medicare payment levels. The CY 2024 TRI payment levels will continue for FY 2026-27.

TRI will be further be augmented by the Proposition 35 time-limited supplemental payments for primary care, specialty care, maternal health, and non-specialty mental health providers. Details surrounding these new augmentations are not known at this time and are not included in our health care expense estimates.

Over the coming weeks, Partnership staff will refine assumptions as additional paid claims run out becomes available and new policy details become available.

### Long-Term Care

2026-27: \$719.3 million | 2025-26 Δ: -\$21.0 million or -2.8%

As noted in prior budget cycles, the Long-Term Care expense category is inherently difficult to forecast due to the timing and complexity of retroactive DHCS rate increases. Annual DHCS per diem rate increases remain the largest driver, reflecting inflationary pressures and cost-based reimbursement updates. Rates are often published several months after their effective dates and issued in multiple revisions. This requires Partnership staff to perform detailed analyses to reconcile and adjust prior payments. In addition, under Assembly Bill (AB) 86, DHCS established the Workforce Standards Program, through which participating facilities receive an enhanced per diem rate. Workforce-related investments, including the AB 86 Workforce Standards Program and the implementation of SB 525 minimum wage requirements, are further elevating provider labor costs and contributing to higher reimbursement levels.

### Ancillary Services

2026-27: \$1.1 billion | 2025-26 Δ: -\$156.4 million or -12.6%

Ancillary Services is comprised of FFS and capitated ancillary services, Outpatient Facility, Emergency Department, ECM, and Community Supports. The budget assumes decreases primarily driven by the UIS disenrollment from managed care, tighter eligibility H.R.1 requirements, and utilization management initiatives. Additional offsets by a continued rise in high-cost specialty drug spend, particularly advanced cell and gene therapies that are episodic in nature but carry a substantial financial impact.

### Other Medical

2026-27: \$458.9 million | 2025-26 Δ: -\$36.3 million or -7.3%

The Other Medical category includes transportation, quality assurance, health care investment fund, nurse advice line, and the DHCS voluntary rate range program. Transportation expense is also projected to decrease due to lower utilization association with UIS disenrollment from managed care, H.R.1 eligibility restrictions, and utilization management initiatives. These reductions are expected to be partially offset by Public Providers Ground Emergency Transportation (PP-GEMT) rate increases and ongoing inflationary pressures, including higher fuel and operating costs driven by global supply instability.

The voluntary rate range program is also expected to decrease as this is tied to overall managed care revenue, primarily due to the exclusion and carve-out of UIS populations from managed care and the broader eligibility tightening tied to H.R.1.

The quality assurance and medical administrative expenses costs were held constant from the prior year; Staff will provide updated cost assumptions for these expense categories in the June budget.

#### DHCS Facility Directed Payment Programs

2026-27: \$899.1 million | 2025-26 Δ: -\$527.3 billion or -37.0%

The following facility directed payments are included in this category: PHDP program, DHDP program, Designated Public Hospital Enhanced Payment program, the Designated Public Hospitals Quality Improvement programs, Health Equity Practice Transformation payments, and the new Children’s Hospital Supplement Payment program. The significant decrease in directed payments is driven by reductions to the PHDP program statewide funding. These reductions were necessary to comply with H.R.1 grandfathering provisions. The June budget may include revised directed payments amounts based on emerging information.

#### Quality Improvement Programs (Incentives)

2026-27: \$98.4 million | 2025-26 Δ: \$9.2 million or 10.3%

The year-over-year increase in QIP expenses is due to the implementation of the Extended Care Facility QIP (EXT QIP) program on January 1, 2026. The EXT QIP, formerly known as the LTC QIP, was originally established in 2016. The program was suspended in August 2020 due to the COVID-19 pandemic, reinstated in January 2022, and subsequently sunset in December 2023 following the launch of the Skilled Nursing Facility Workforce Quality Incentive Program (WQIP) by DHCS. After WQIP was phased out of the State budget on December 31, 2025, Partnership’s Board of Commissioners approved the EXT QIP, effective January 2026.

In addition, Partnership continues to invest in quality improvement programs and the member experience. The goal of these investments is to improve overall member experience and increase performance on quality metrics prioritized by the DHCS Quality Withhold program and to provide quality, equitable and cost-effective care for our members. As in previous periods, incentive funding remains contingent on final revenue projections.

#### Off-Cycle Budget

Partnership’s enrollment projections reflect our best estimates of policy changes but are highly uncertain. They therefore depend on several assumptions about disenrollments, utilization, and costs. Given these uncertainties and the State’s fiscal situation, Partnership staff expect to produce an off-cycle budget to account for any significant programmatic or cost changes after the June budget is finalized.

## Health Care Budget FY 2026-27 to FY 2025-26 Comparison

Health Care Categories	Budget	Budget	Y-o-Y $\Delta$	
	FY 2026-27	FY 2025-26	\$	%
Inpatient Hospital	\$1,342,360,258	\$1,640,259,094	(\$297,898,837)	(18.2%)
Physician Services	\$1,070,455,955	\$1,144,618,159	(\$74,162,203)	(6.5%)
Long Term Care	\$719,325,240	\$740,374,189	(\$21,048,949)	(2.8%)
Ancillary Services	\$1,089,077,296	\$1,245,475,022	(\$156,397,726)	(12.6%)
Other Medical	\$458,872,239	\$495,131,605	(\$36,259,366)	(7.3%)
DHCS Facility Directed Payment Programs	\$899,054,927	\$1,426,371,794	(\$527,316,867)	(37.0%)
Quality Improvement Programs	\$98,412,000	\$89,200,150	\$9,211,850	10.3%
<b>Total Health Care Expense</b>	<b>\$5,677,557,915</b>	<b>\$6,781,430,013</b>	<b>(\$1,103,872,098)</b>	<b>(16.3%)</b>

**AGENDA REQUEST FOR RATIFICATION  
for  
PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Board / Finance Committee (when applicable)**  
**Meeting Date:** May 20, 2026  
**Board Meeting Date:** June 24, 2026

**Agenda Item Number:**  
2.4

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

**Recommendation by:**  
The Finance Committee and Partnership Staff

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**Topic Description:**

Partnership Board Commissioner Jayme Bottke, Tehama County Executive Director of Health Services, has resigned from the Partnership Board and Finance Committee.

Commissioner Bottke has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since February 2024. She has provided excellent leadership and has been a dedicated volunteer. Her knowledge has been of great value to Partnership, and she has kept the needs of our members, providers and the community as a guiding principle.

**Reason for Resolution:**

To obtain Board approval to accept the resignation of Tehama County Representative, Jayme Bottke, from the Partnership Board.

**Financial Impact:**

There is no financial impact to the HealthPlan.

**Requested Action of the Board:**

Based on the recommendation of the Finance Committee and Partnership staff, the Board is asked to accept the resignation of Tehama County Representative, Jayme Bottke from the Partnership Board.

**AGENDA REQUEST FOR RATIFICATION  
for  
PARTNERSHIP HEALTHPLAN OF CALIFORNIA**

**Board / Finance Committee (when applicable)**

**Meeting Date:** May 20, 2026

**Board Meeting Date:** June 24, 2026

**Agenda Item Number:**

2.4

**Resolution Number:**

26-

**IN THE MATTER OF: ACCEPTING THE RESIGNATION OF BOARD COMMISSIONER  
JAYME BOTTKE**

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**Recital: Whereas,**

- A. The Board has authority to accept Commissioner Resignations.
- B. Commissioner Bottke has resigned from the Partnership Board and Finance Committee.
- C. Jayme Bottke was a faithful and active member of the Board.

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

1. To accept Jayme Bottke’s resignation from the Partnership Board and Finance Committee.

**PASSED, APPROVED, AND ADOPTED** by the Partnership HealthPlan of California this 24<sup>th</sup> day of June 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