Board of Commissioners Meeting Agenda

August 26, 2026: 10:00 a.m. – 2:00 p.m.

In-person Locations:

Partnership Offices

4605 Business Center Drive, Fairfield, CA (Conference Center)

2525 Airpark Dr., Redding, CA

1036 Fifth Street, Eureka, CA

495 Tesconi Circle, Santa Rosa, CA

281 Nevada St, Auburn, CA

1000 Fortress St, Chico, CA

External Sites

Plumas District Hospital located at 1065 Bucks Lake Rd., Quincy, CA

Public comment is welcome during designated "Public Comments" time frames or by emailing comments to the Board Clerk at ascott@partnershiphp.org by 5:00p.m on August 25, 2026. Comments received will be read during the meeting.

10:00AM – Opening			
1.1 **Call to Order**			*Chair*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION:*** Approval of Agenda and Board Meeting Minutes for June 24, 2026 ***(3 minutes)***	1-22	*Chair*
1.4	***ACTION:*** Resolution Accepting the Resignation of Commissioner Jamie Bartolome as the Yuba County Representative and Express Appreciation for Service ***(2 minutes)***	23-24	*Sonja Bjork*
1.5	***ACTION:*** Resolution to Accept the Board Commissioner Appointment of Benjamin Flores as a Yuba County Representative ***(3 minutes)***	25-26	*Sonja Bjork*
1.6	***ACTION:*** Resolution to Accept the Board	27-28	*Sonja Bjork*

	Commissioner Appointment of Raichael Stewart as a Consumer Representative from Nevada County ***(3 minutes)***		
1.7	***ACTION:*** Resolution to Accept the Board Commissioner Appointment of Ellen Payton as a Consumer Representative from Lassen County ***(3 minutes)***	29-30	*Sonja Bjork*
1.8	***ACTION:*** Resolution to Accept the Board Commissioner Appointment of Jaime Yan Faurot as a Consumer Representative from Marin County ***(3 minutes)***	31-32	*Sonja Bjork*
1.9	***INFORMATION:*** Partnership Scholarship Recipient Recognition ***(10 minutes)***		*Sonja Bjork*
1.10 **Commissioner Comment**			*Chair*
1.11 **Public Comment / Correspondence**			*Chair*
1.12	***INFORMATION:*** CEO Report ***(15 minutes)***	33-37	*Sonja Bjork*
11:20 AM – Consent Calendar			
2 & 3	***ACTION:*** Consent Calendar ▪ **3.1** Resolution to Accept all Partnership Committee Minutes, Partnership Policies and Program Descriptions Approved by the Physician Advisory Committee ▪ **3.2** Resolution to Approve the 2027 Primary Care Provider Quality Improvement Program (PCPQIP) Measurement Set as Approved by PAC ▪ **3.3** Resolution to Approve the Cultural & Linguistic Program Description ▪ **3.4** Resolution to Approve HR Policies and Personnel Committee Recommendations from the August 19, 2026 Meeting. ▪ **3.5** Resolution to Approve Commendations and Appreciation for Board Commissioner Scott Kennelly's Service to Partnership	38-42 43-51 52-54 55-57 58-59	*Chair*

Finance Committee – July 2026 (MEETING CANCELLED)
Finance Committee – August 2026
Personnel Committee – August 2026
Physician Advisory Committee – July 2026 (MEETING CANCELLED)
Physician Advisory Committee – August 2026
Quality and Utilization Advisory Committee (Q/UAC) – July 2026
Quality and Utilization Advisory Committee (Q/UAC) – August 2026
Strategic Planning Committee – July 2026

11:25AM – Regular Agenda Items			
4.1	***ACTION:*** Resolution to Approve Board Semi-Annual Dashboard ***(15 minutes)***	60-76	*Wendi Davis*
4.2	***INFORMATION:*** Strategic Plan Update ***(10 minutes)***		*Amy Turnipseed*
11:50AM-12:10PM– Lunch			
12:10AM – Regular Agenda Items Continued			
4.3	***ACTION:*** Resolution to Approve Edits to Partnership's Chart of Authority Policy and Matrix, FIN301 ***(10 minutes)***	77-87	*Marisa Dominguez / Jennifer Lopez*
4.4	***ACTION:*** Resolution to Approve Partnership's Transfer of Ownership of the Property at 1930 Jefferson Street to Napa Community Health Initiative (CHI)***(5 minutes)***	88-89	*Jennifer Lopez*
12:25PM – Reports			
5.1	***INFORMATION:*** Metrics and Financial Update ***(10 minutes)***	90-103	*Jennifer Lopez*
5.2	***INFORMATION:*** Operations Update (***10 minutes)***	104-105	*Wendi Davis*
5.3	***INFORMATION:*** Legislative & Media Update ***(10 minutes)***	106-109	*Dustin Lyda*
5.4	***INFORMATION:*** CMO Report on Quality	110-115	*Written Update*
5.5	***INFORMATION:*** MY2025 HEDIS Annual Summary of Performance ***(20 minutes)***	116-169	*Kristine Gual / Dr. Robert Moore*
5.6	***INFORMATION:*** Health Services Update ***(10 minutes)***	170-174	*Katherine Barresi*
2:00PM – Adjournment			

Upcoming Meetings:
10/28/2026 – October Board Meeting
12/2/2026 – December Board Meeting

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular commission 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 Commission. The Commission 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 Board 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 ten (10) days prior to the scheduled meeting at (707) 863-4516 or by email at Board_FinanceClerk@partnershiphp.org. Notification in advance of the meeting will enable the Board Clerk to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

MINUTES OF THE MEETING OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA BOARD OF COMMISSIONERS
Held at Partnership Offices:

4605 Business Center Drive, Fairfield, CA (Conference Center)

2525 Airpark Dr., Redding, CA

1036 Fifth Street, Eureka, CA

495 Tesconi Circle, Santa Rosa, CA

249-299 Nevada Street, Auburn, CA

1000 Fortress Street, Chico, CA

On
June 24, 2026

Members Present: Jamie Bartolome, Ranell Brown (10:13am arrival), Brion Burkett, Christy Coleman (not present for Closed Session), Cathryn Couch, Shelly Davis, Dean Germano (Chair), Ryan Gruver, Liz Hamilton, Dave Jones, Seth Kaufman, M.D., Scott Kennelly, Belle Knight, Nunie Matta, Andrew Miller, M.D., Robert Oldham, M.D., DeDe Parker, Jonathan Porteus, PhD, Tiffany Rowe, Stacy Sphar, Nancy Starck, Nolan Sullivan (not present for Closed Session), Kim Tangermann, Pedro Toledo, Jennifer Yasumoto, Jim Yoder

Members Excused: Gaby Bernal Leroi, Gena Bravo, Christopher Champlin, Emery Cowan, Lisa Davies, Alicia Hardy, JoDee Johnson, Elizabeth Kelly, Liz Lara-O'Rourke, Jennifer Malone, Monica Morales, Lisa Warhuus, M.D.

Staff: Marc Agudelo, Leigha Andrews, Katherine Barresi, Jill Blake, Jayme Bottke, Isaac Brown, Tina Buop, Greg Cafiero, Irem Conery, Wendell Coats, Wendi Davis, Marisa Dominguez, Theresa Hart, Andrew Gerber, Naomi Gordon, Amber Gross, Kristine Gual, Naomi Gordon, Mohamed Jalloh, PharmD, Kermit Jones, M.D., Vicky Klakken, James Legere, John Lemoine, Jennifer Lopez, Dustin Lyda, Lisa Malvo, Richard Matthews, M.D., Matthew Morris, M.D., Danielle Ogren, Kathryn Power, Jose Puga, Jeff Ribordy, M.D., Nikki Rotherham, Tim Sharp, Rebecca Stark, Amy Turnipseed, Colleen Valenti, Edna Villasenor, Lisa Ward, M.D., Kory Watkins, Brent Weinberg, Sonja Bjork, CEO, and Ashlyn Scott, Board Clerk

AGENDA ITEM	DISCUSSION	MOTION / ACTION

1.0 Opening	Commissioner Dean Germano, Board Chair, called the bi-monthly meeting to order and welcomed everyone to the meeting in person and at all remote Partnership HealthPlan offices. Board members were reminded to abstain from voting on any agenda item where they might have a conflict of interest, and to state their name before asking questions or making motions. As a reminder, Commissioner Germano read the Partnership Mission Statement: "to help our members, and the communities we serve, be healthy." He also stated that members of the public would have an opportunity to speak at designated times throughout the agenda.	None
1.2 Roll Call	Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a quorum.	None
1.3 Approval of Agenda and the Board Meeting Minutes for April 22, 2026	Chairman Germano asked if anyone had changes for the agenda or corrections to the April 22, 2026, minutes. Hearing no requests for modification, he asked for a motion to approve the agenda and minutes.	*Commissioner Porteus moved to approve the agenda and minutes as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** *Yes: 23* *No: 0* *Abstention: 0* *Excused: 13 (Bernal Leroi, Bravo, Brown (10:13 arrival), Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)* **MOTION CARRIED**
1.4 Resolution Accepting the Resignation of Commissioner Dr. Phuong Luu as the Yuba County Representative and Express Appreciation for Service	Sonja Bjork, CEO, reported that Dr. Phuong Luu has resigned from her roles as Bi-County Public Health Officer for Sutter and Yuba Counties and as a member of the Partnership Board. Ms. Bjork expressed appreciation for Dr. Luu's service and contributions to the Board since April 2024.	*Commissioner Oldham moved to approve agenda item 1.4 as presented, seconded by Commissioner Porteus.* ***ACTION SUMMARY:*** *Yes: 23* *No: 0* *Abstention: 0*

		Excused: 13 (Bernal Leroi, Bravo, Brown (10:13 arrival), Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus) **MOTION CARRIED**
1.5 Resolution to Accept the Board Commissioner Appointment of Jamie Bartolome as a Yuba County Representative	Sonja Bjork, CEO, reported that Jamie Bartolome, Yuba County Health & Human Services Deputy Director, was appointed by the Yuba County Board of Supervisors on May 12, 2026, to serve on the Partnership HealthPlan of California Commission (Board) as a County Representative. Ms. Bjork noted that Ms. Bartolome's appointment is interim while Yuba County conducts a search for a permanent Board representative. Her term began on June 24, 2026, and will continue at the discretion of the Yuba County Board of Supervisors.	*Commissioner Matta moved to approve agenda item 1.5 as presented, seconded by Commissioner Porteus.* ***ACTION SUMMARY:*** *Yes: 23* *No: 0* *Abstention: 0* *Excused: 13 (Bernal Leroi, Bravo, Brown (10:13 arrival), Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)* **MOTION CARRIED**
1.6 Resolution to Accept Commissioner Darcie Antle's Resignation from the Board as a Mendocino County Representative and Express Appreciation for Service	Ms. Bjork announced that Partnership Board Commissioner Darcie Antle has resigned from the Partnership Board. Ms. Bjork recognized Commissioner Antle for her numerous contributions to Partnership HealthPlan of California and the Commission (Board) during her tenure since August 2020 and expressed appreciation for her dedicated service.	*Commissioner Porteus moved to approve agenda item 1.6 as presented, seconded by Commissioner Starck.* ***ACTION SUMMARY:*** *Yes: 25* *No: 0* *Abstention: 0* *Excused: 12 (Bernal Leroi, Bravo, Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)*

		MOTION CARRIED
1.7 Resolution to Accept the Board Commissioner Appointment of DeDe Parker as a Mendocino County Representative	Ms. Bjork introduced DeDe Parker, Mendocino County Director of Social Services, who was appointed by the Mendocino County Board of Supervisors on April 21, 2026, to serve on the Partnership HealthPlan of California Commission (Board) as a County Representative. Ms. Bjork noted that Ms. Parker has been appointed to a four-year term.	*Commissioner Burkett moved to approve agenda item 1.7 as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** *Yes: 25* *No: 0* *Abstention: 0* *Excused: 12 (Bernal Leroi, Bravo, Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)* **MOTION CARRIED**
1.8 Commissioner Comment	Chairman Germano asked if there were any Commissioner comments. Commissioner Yoder recognized Partnership Chief Operating Officer Wendi Davis for her donation to The Wall That Heals, a traveling Vietnam Veterans Memorial exhibit that visited Glenn County in March 2026. He thanked Ms. Davis for her generous contribution and support in honoring Vietnam veterans. Commissioner Yoder thanked Partnership HealthPlan of California for its participation in a senior event scheduled for the following day in Glenn County. He noted that Partnership staff would be available to assist seniors in accessing available resources and services and to help connect them with appropriate community supports and information.	None
1.9 Public Comment	Chairman Germano asked for any public comments. Gregory Fearon provided public comment from the Santa Rosa office. Mr. Fearon stated that he is a former Health & Human Services Administrator for Marin County and has experience encouraging youth participation on consumer advisory boards. He reported recruiting an individual who recently attended a Partnership Community Advisory Committee meeting. According to Mr. Fearon, that individual has committed to recruiting additional consumer representatives and emphasized the importance of engaging young people in advisory and decision-making processes.	None

	Partnership member and Community Advisory Committee member Harry Boggs provided public comment from the Auburn office. Mr. Boggs reported allocating $100 per month to a travel fund but stated that, due to an upcoming medical procedure, he has been advised not to travel. Mr. Boggs indicated that he has experienced difficulties obtaining a refund of the travel funds and expressed concern that similar issues may be affecting other consumers.	
1.10 CEO Report	Ms. Bjork opened her report by discussing the earthquake that occurred in Mendocino County on the morning of June 24. She provided an overview of Partnership's emergency response process and shared information regarding the organization's response efforts. Ms. Bjork referenced the email below as an example of our internal response to community emergencies. This was sent to Partnership leadership by Regional Director Vicky Klakken shortly after the earthquake, and it outlined initial conditions and response activities. Good morning team, I am writing to inform you about an earthquake that has affected part of our service area and may impact some of our members and/or providers. The safety and well being of our members and providers, the stability of healthcare services, and community support are our top priorities and we want to ensure that everyone is informed. We are still in the early stages of finding out impact, however, I wanted to send you all a brief update on what we know now: **Event Details:** • **Nature of the Disaster: Earthquake, 5.5 to 6.0 magnitude** • **Date and Time of Occurrence: 08:10 a.m.** • **Affected Areas: 7 miles from Willits, CA – Mendocino County** **Member/Employee Impacts:** • **Service Disruptions: PR Rep, Melissa Perez indicates that there is no power and some phones are not currently working** • **Member Support: Identifying impact and working with MS on assessment . There is one CAC member in Mendocino County – MS is reaching out.** • **Employee Impact: Melissa Perez, PR Rep Mendocino County, is fine and currently without power.** **Provider Impacts:** • **Network Availability: Per Mendocino County, there is some damage at Howard Memorial Hospital and that is still being assessed. RD reached out to Howard Memorial, awaiting response. Both providers in Willits – Howard Memorial Hospital and Baechtel Creek are on generators** • **Mendocino County: RD spoke with current DHHS Director and Director SS, who are monitoring Mendocino County. Most of the impact was towards Redwood Valley and Willits** • **Round Valley Indian Health – no power, on generator. Will likely send employees home today. Currently checking on Elders, will send update if anything is needed** • **Consolidated Tribal Health – Tribal Liaison continues to reach out for an update.** **Next Steps:** • **Will continue to monitor and update this team as we receive additional information. Will send another update today.** Thank you. Vicky **Vicky Klakken, MHA, MSM** Regional Director Administration Partnership HealthPlan of California 1036 5th St., Suite E, Eureka, CA 95501 Ms. Bjork continued her report by covering the following topics:	None

Unsatisfactory Immigration Status (UIS) Update – Ms. Bjork reported that the State budget proposes transitioning members with unsatisfactory immigration status (UIS) from managed care into a Fee-For-Service (FFS) model administered by the State. For Partnership. Aas of June 2026 this change would affect approximately 87,000 members. Tracking and accounting for non-federally reimbursable services is complex, and California has previously been required to return funds to the federal government due to accounting errors. The State's position is that it will be better able to perform the required careful accounting if all UIS members are part of the program administered solely by DHCS.

Ms. Bjork noted that removing UIS members from managed care is expected to generate cost savings for California because the State's FFS model reimburses providers at lower rates and does not have capitation agreements. However, members would lose access to certain managed care benefits, including transportation services, Enhanced Care Management (ECM), and Community Supports. The proposed carve-out is scheduled to take effect on January 1, 2027.

The Local Health Plans of California (LHPC) has proposed an alternative model that would allow UIS members to remain in managed care. Local health plans believe they can provide better care coordination and continuity of care under the managed care model, including maintaining members' relationships with specialists and minimizing disruptions in care.

LHPC and participating health plans have been meeting with the Department of Health Care Services (DHCS) to discuss the alternative proposal. However, DHCS has indicated that it does not believe the necessary system configuration, rate development, and implementation work can be completed before January 1, 2027. Discussions with DHCS will continue, and LHPC has retained an actuary to explore options for implementing the alternative model.

Chairman Germano expressed concerns regarding the State's fee-for-service model and stated that he is not confident in its ability to effectively serve affected members. He noted his belief that some providers currently contracted with managed care plans may be unwilling to participate in the State's fee-for-service system. Chairman Germano also stated that he found it surprising that the State might not adopt the LHPC proposal, given its focus on maintaining continuity of care for members.

Commissioner Sullivan requested data on members with uncertain immigration status (UIS) by county to assist counties with planning efforts.

Ms. Bjork responded that the Finance team is currently developing the analysis that will be shared with the Board. She noted that Partnership recently received an updated eligibility file, which is being used to refine and update the data.

Commissioner Tangermann stated that she would appreciate reviewing Partnership's data to help better understand and prepare for potential impacts.

	April Board Strategic Planning Retreat – Ms. Bjork presented key themes from the April 2026 Board Retreat breakout sessions. She reported that participants emphasized the importance of viewing the member experience as a system-wide responsibility, with coordination across health plans, providers, counties, and community partners. Participants highlighted the importance of empathy, staff engagement, communication, continuity of care, and collaboration in improving member experiences. Ms. Bjork also noted interest in using technology and data to enhance services while maintaining a focus on human-centered care. Participants identified several opportunities for innovation and practical actions to improve access, navigation, and member satisfaction. Ms. Bjork concluded by noting that the retreat reinforced the importance of collaboration, communication, and member-centered service delivery. ***Member Experience Director*** – Ms. Bjork introduced Irem Conery, Partnership's new Director of Member Experience. Ms. Conery greeted the Board and shared that she recently relocated from San Diego and has been with Partnership for a couple weeks. She stated that she has been incredibly impressed by the dedication and commitment of Partnership staff, noting that employees bring their very best to the communities they serve each day. Ms. Conery expressed her enthusiasm for joining the organization and stated that she looks forward to advancing Partnership's member experience strategy and further enhancing the services and support provided to members	
2 & 3 Consent Calendar	Chairman Germano stated that all items on the consent calendar would be approved with one motion unless someone requests to pull an item for further discussion. Hearing no requests, she asked for a motion to approve the Consent Calendar and resolutions 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 3.6 and 3.7: ▪ **2.1** Resolution to Ratify the Preliminary Health Care Expense Budget County Representative ▪ **2.2** Resolution to Ratify Commissioner Jayme Bottke's Resignation from the Finance Committee and Board of Commissioners ▪ **3.1** Resolution to Accept all Partnership Committee Minutes, Partnership Policies and Program Descriptions Approved by the Physician Advisory Committee ▪ **3.2** Resolution to Approve Membership Changes to the Physician Advisory Committee ▪ **3.3** Resolution to Approve Utilization Management Program Description, MPUD3001 ▪ **3.4** Resolution to Approve the Hospital QIP (HQIP) 2026 Six-Month Bridge Measurement Set	*Commissioner Jones moved to approve Resolutions 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 3.6 and 3.7 as presented, seconded by Commissioner Hamilton.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 12 (Bernal Leroi, Bravo, Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)* **MOTION CARRIED**

	▪ **3.5** Resolution to Approve the Palliative Care Quality Incentive Proposed Measures for 2027 ▪ **3.6** Resolution to Approve the Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set ▪ **3.7** Resolution to Approve Partnership's 2026 Population Needs Assessment	
4.1 Resolution to Approve Final Budget for Fiscal Year 2026-2027	Ms. Lopez presented Partnership's Approve the Final Budget for Fiscal Year 2026-2027, noting that the organization developed the budget with limited available information. Ms. Lopez outlined the three-month budget development process, which includes presenting budget assumptions in April, developing draft healthcare assumptions in May, and finalizing the budget in June, which includes the review of updated state budget information and incorporation of administrative and capital expenses for presentation to the Finance Committee and Board. Ms. Lopez noted that the final budget assumes UIS members will be carved out of managed care as of January 1, 2027; therefore, the UIS proposal discussed earlier during the CEO report is not included in the budget. Should that proposal ultimately be approved, an amended budget will need to be brought back to the Board for consideration. Ms. Lopez explained that the Governor releases an initial state budget proposal in January, followed by a revised proposal in May. This year's budget differs significantly from prior years, as the Governor is exercising substantial fiscal restraint in an effort to balance the state budget. It remains uncertain how much of the proposal will ultimately be adopted. The Legislative Analyst's Office has also raised concerns regarding uncontrolled state spending that exceeds current revenues. The state budget assumes approximately 14 million Medi-Cal members for the next fiscal year, including both fee-for-service and managed care beneficiaries. The state projects a 4% decline in Medi-Cal membership compared to the prior fiscal year, largely due to H.R. 1, work requirements, and other eligibility-related factors. Medi-Cal continues to represent a significant portion of state spending, with medical costs steadily rising. Total Medi-Cal expenditures are expected to increase from $194.4 billion in FY 2025-26 to a projected $216.7 billion in FY 2026-27. Ms. Lopez reviewed several proposed Medi-Cal changes that were included in the May Revise, including: • The assumption that UIS members will be carved out of managed care. • Monthly premium increases for UIS adults increasing from $30 to $50 per month to maintain Medi-Cal coverage.	*Commissioner Jones moved to approve Resolution 4.1 as presented, seconded by Commissioner Burkett.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 12 (Bernal Leroi, Bravo, Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)* **MOTION CARRIED**

- Proposed elimination of Prospective Payment System (PPS) rates for state-only services effective July 2026.
- Modifications to the Medi-Cal asset test.
- Changes to the Managed Care Organization (MCO) tax.
- Refinements to the Enhanced Care Management (ECM) and Community Supports programs.
- New utilization management efficiencies affecting transportation and behavioral health youth services, although full details have not yet been released.

Ms. Lopez then compared the Governor's proposal with the Legislature's proposal. The Governor's proposed budget totals $394.4 billion, while the Legislature's proposal totals $355.9 billion. Reserve levels are proposed at $39.6 billion under the Governor's plan and $36.5 billion under the Legislature's plan.

While the Legislature accepted the Governor's UIS member transition proposal to fee-for-service coverage effective January 1, 2027, the Legislature noted they will work with the Administration to consider maintaining managed care for non-emergency services. Further, the Legislature proposed maintaining ECM and Community Supports services for this population. Regarding dental benefits, the Legislature has proposed delaying the elimination of dental services for UIS members by one year.

For the Medi-Cal asset test, the Governor proposes reinstating a $2,000 asset limit effective January 1, 2027, while the Legislature proposes delaying implementation until the following fiscal year and increasing the limit to $21,000.

Both proposals appear aligned on implementing an $8.85 per-member-per-month MCO tax. The Legislature continues to reject the elimination of acupuncture services, a proposal that has surfaced repeatedly in prior budget discussions. The Legislature has also proposed delaying the elimination of PPS funding for state-only UIS services until July 1, 2027, compared to the Governor's proposed date of July 1, 2026.

A final determination on the final enacted budget is expected any day.

Ms. Lopez stated that Partnership current enrollment trends are unusually volatile. Based on the recent trends, Partnership currently projects approximately 705,000 members as of July 2027, with most of the anticipated membership decline attributable to UIS members. While membership reductions decrease revenue, we anticipate serving a more complex high-needs population and expected increased per-member-per-month expenses. These projections reflect the best available information today, but substantial changes in eligibility or membership trends may require an amended budget to be brought back to the Financed Committee and Board.

Total healthcare costs are projected at approximately $5.68 billion, resulting in an overall projected net deficit of $66.9 million. Despite these challenges, Partnership continues to maintain the lowest

administrative costs among the state's managed care plans and has developed the budget with a fiscally restrained approach.

Regarding revenue, Partnership projects a decline of approximately $1.1 billion. Per-member-per-month expenses are expected to increase as the enrolled population becomes more medically complex. Partnership continues to analyze disenrollment patterns and remaining enrollment trends to support advocacy for fair state reimbursement rates.

Ms. Lopez stated that DHCS is withholding 1% of quality incentive funding for calendar year 2026. The budget assumes the 1% withhold will continue into the following calendar year, although final confirmation has not been received as to whether the state will increase the percentage. Partnership earned back 65% of its quality withhold in CY 2024, and the same earn back assumption has been incorporated into the upcoming fiscal year budget.

Interest income has remained favorable over the past several years; however, Partnership anticipates greater market volatility moving forward. The budget assumes a conservative average interest rate of 3% throughout the fiscal year.

Ms. Lopez discussed Proposition 35 funding, which is supported through the MCO tax. While the state has proposed changes, final policy details have not yet been released. Current indications suggest approval is likely, although federal-level uncertainties remain.

Administrative expenses are budgeted at $391.9 million. The budget includes merit-based salary increases for staff in recognition of rising costs of living. Ms. Lopez noted that a few administrative budget categories and new capital projects have been deferred until the October 2026 budget presentation to allow for additional evaluation, and off-cycle budget amendments may be necessary.

Commissioner Matta asked for confirmation that Partnership's membership is projected to decrease to approximately 700,000 members.

Ms. Bjork confirmed that projection.

Commissioner Sullivan requested that Ms. Lopez provide the Board with an overview of Intergovernmental Transfers (IGTs).

Ms. Lopez explained that IGTs are a funding mechanism through which a portion of Partnership's rates are designated to support eligible entities, including fire districts, district hospitals, and other entities with taxing authority, to help offset uncompensated Medi-Cal managed care covered benefits costs for Partnership's members.

	Ms. Lopez further noted that there are concerns that the federal government may adopt policies that could limit IGT contribution amounts that fund many supplemental payment programs in Medi-Cal.	
4.2 Resolution to Approve Q12026 Compliance Dashboard	Danielle Ogren, Senior Director of Regulatory Affairs and Compliance, presented Partnership's Compliance Dashboard for the first quarter of 2026. She reported that Partnership has launched its annual internal Fraud Waste and Abuse (FWA) training. At the time of reporting, seven employees had not completed their training. Of those seven employees, six were on approved leave. The dashboard showed a 100% on-time rate for regulatory reporting. Report acceptance was 93%, with some reports requiring additional clarification or follow-up information requested by DHCS.	*Commissioner Starck moved to approve Resolution 4.2 as presented, seconded by Commissioner Matta.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 12 (Bernal Leroi, Bravo, Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)* **MOTION CARRIED**
4.3 Resolution to Approve Commendations and Appreciation for Brion Burkett's Service to Partnership	Ms. Bjork reported that Commissioner Brion Burkett's Board seat term will expire at the conclusion of the June 24, 2026, Board meeting. Ms. Bjork recognized Commissioner Burkett for his outstanding service and numerous contributions to Partnership HealthPlan of California and the Commission (Board) since his appointment in August 2024 as a Consumer Board Representative. She noted that Commissioner Burkett has been a dedicated volunteer whose insight, knowledge, and thoughtful participation have been of great value to the Board.	*Commissioner Knight moved to approve Resolution 4.3 as presented, seconded by Commissioner Porteus.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 12 (Bernal Leroi, Bravo, Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)* **MOTION CARRIED**
4.4 Resolution to Approve Commendations and Appreciation for Belle Knight's Service to Partnership	Ms. Bjork announced that Commissioner Belle Knight's Board seat term as a Consumer Representative will expire at the conclusion of the June 24, 2026, Board meeting. Ms. Bjork recognized Commissioner Knight for her dedication, thoughtful insight, and volunteer service since August 2024.	*Commissioner Jones moved to approve Resolution 4.4 as presented, seconded by Commissioner Yoder.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0*

		Abstention: 0 *Excused: 12 (Bernal Leroi, Bravo, Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)* **MOTION CARRIED**
4.5 Resolution to Approve Commendations and Appreciation for Marcelo "Nunie" Matta's Service to Partnership	Ms. Bjork reported that Commissioner Marcelo "Nunie" Matta's Board seat term will expire at the conclusion of the June 24, 2026, Board meeting. She noted that, since joining the Board in August 2024 as a Consumer Board Representative, Commissioner Matta has made numerous valuable contributions to Partnership HealthPlan of California and the Commission.	*Commissioner Knight moved to approve Resolution 4.5 as presented, seconded by Commissioner Porteus.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 12 (Bernal Leroi, Bravo, Champlin, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Warhuus)* **MOTION CARRIED**
5.1 Metrics and Financial Update	Written Report	None
5.2 Operations Update	Wendi Davis, Chief Operating Officer, provided an update on recent operational activities and initiatives focused on member and provider engagement, benefit and process improvements, and ensuring services remain responsive to community needs. Staff have conducted outreach through webinars, in-person sessions, call campaigns, text notifications, and promotional efforts to help members maintain Medi-Cal coverage and better understand their benefits and program requirements. Ms. Davis highlighted the ongoing contributions of the Community Advisory Committee (CAC), whose members provide valuable feedback on member experiences, website enhancements,	None

	community reinvestment initiatives, cultural and linguistic services, and Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) activities as well as Community Reinvestment approaches She noted that the information gathered helps inform strategies to address service gaps and health disparities. Ms. Davis also reported on provider outreach efforts related to the implementation of Partnership's new claims processing system. Staff are working closely with providers by sharing testing results, individualized feedback, claims performance scorecards, and training opportunities to support a successful transition. She stated that support will continue after implementation through webinars, workshops, and on-site assistance. Ms. Davis concluded by reaffirming Partnership's commitment to providing personalized support, training, and engagement opportunities for members, providers, and community partners.	
5.3 Media & Legislative Update	Dustin Lyda, Director of Communications & Government Affairs, provided a media and legislative update. He reported that the State had anticipated a budget shortfall of approximately $20 billion to $30 billion; however, revenues have exceeded projections. He also noted that the current legislative session has seen the lowest number of bills introduced in the past 30 years. Mr. Lyda reviewed key legislative deadlines, noting that July 2 was the final day for policy committee hearings before the Legislature's summer recess, which runs through August 3. He further reported that the final two weeks of August are designated for floor sessions, after which any remaining bills not acted upon will no longer move forward. Mr. Lyda presented the list of legislation being monitored by Partnership, which was included in the Board packet. *Commissioner Porteus inquired about AB 2551 (Elhawary), Behavioral Health Care Coverage, and asked whether the California Association of Health Plans (CAHP) opposed the bill due to the administrative burden it would place on health plans.* *Mr. Lyda responded that this was his understanding and noted that he could provide additional information. He added that some commercial health plan associations generally oppose legislation that increases administrative workload, operational costs, or regulatory requirements for health plans.* *Commissioner Gruver inquired about Local Health Plans of California's (LHPC) opposition to AB 2161 (Bonta), Medi-Cal: Redeterminations and Work or Community Engagement.* *Mr. Lyda explained that the primary concern relates to data-sharing requirements, including how information would be shared and the mechanisms that would be used to facilitate that exchange. He also noted that associations will sometimes oppose legislation as a means of seeking amendments or additional language to address concerns identified during the legislative process.*	None

5.4 CMO Report on Quality	Dr. Kermit Jones, Deputy Chief Medical Officer presented an overview of the 2025 Primary Care Provider Quality Improvement Program (PCP QIP) results. He reported that 380 primary care sites representing 125 parent organizations participated in the program. The weighted average score increased to 61.4%, compared to 58.9% in 2024. Total incentive payments exceeded $55.7 million, reflecting an increase of approximately $3.9 million over the prior year. Dr. Jones highlighted several high-performing provider sites that achieved scores above 90% and noted that full PCP QIP results will be published in the coming months. He added that Board members will receive summary scores for providers located within their respective counties prior to the public release. Dr. Jones also reviewed quality-related topics planned for future Board meetings, including HEDIS results, quality program updates, Hospital QIP results, CG CAHPS findings, provider recognition events, and strategic planning activities.	None
5.5 Health Services Update	Katherine Barresi, Chief Health Services Officer, provided an update on Health Services activities and initiatives. She reported on preparations for the implementation of DHCS's Medi-Cal Connect platform and Risk Stratification, Segmentation, and Tiering (RSST) requirements. Staff have developed outreach strategies for high-risk members, including mailings, phone calls, and text messaging to support engagement and care coordination. Ms. Barresi highlighted Care Coordination efforts to strengthen support for members with Autism Spectrum Disorder through staff training and continued oversight of Applied Behavioral Analysis (ABA) and Behavioral Health Therapy (BHT) services. She also highlighted Partnership's response to a federal request for information related to behavioral health services. Ms. Barresi reported that Utilization Management maintained high performance while processing approximately 27,000 Treatment Authorization Requests (TARs) per month during the first quarter of 2026, achieving timeliness rates exceeding 98%. She also discussed ongoing efforts to develop a high-quality hospice provider network and preparations for statewide interoperability requirements. An update was provided on Behavioral Health services, including increased call volume to the Behavioral Health Access Line and expanded outreach to members following behavioral health-related emergency department visits. Efforts to strengthen data sharing and collaboration with county Behavioral Health Plans were also reviewed. Ms. Barresi further reported that the Enhanced Health Services department managed high volumes of ECM and Community Supports referrals and authorizations while continuing provider quality monitoring and oversight activities. Finally, Ms. Barresi highlighted Health Equity initiatives, including the monitoring of discrimination grievances and ongoing Tribal Health engagement efforts. She noted expanded	None

	participation in the Tribal Perinatal Program and continued collaboration with Tribal communities to improve access to services and address health disparities.	
6.1 Employee Engagement Survey	Naomi Gordon, Chief Human Resources Officer, presented the results of Partnership's 2026 Employee Engagement Survey. The survey is conducted to assess employee satisfaction, gather feedback, identify opportunities for improvement, and measure organizational health. A total of 1,257 employees responded, representing a 79% response rate, and 93% of respondents indicated that Partnership is a great place to work. Ms. Gordon reviewed the Partnership's top-performing areas as identified in the survey, including employee alignment with Partnership's mission, vision, and values; the workplace environment; and employees' understanding of their work and responsibilities. Areas identified for improvement included cross-team and departmental communication, ensuring employee opinions are valued, and employee recognition. Human Resources is working with departments to develop action plans, respond to common themes identified in the survey, and address opportunities for organizational improvement.	None

6.2 Grievance & Appeals Update	Kory Watkins, Director of Grievance & Appeals, presented the Grievance & Appeals Department's 2025 Annual Report to the Board. The presentation provided an overview of department operations, case activity, performance outcomes, key challenges, and strategic priorities for 2026. A detailed report of all grievance, appeal, and state hearing cases processed in 2025 was available for Commissioners to review at the Fairfield office or upon request. The report contains members' Protected Health Information (PHI) and Personally Identifiable Information (PII), as well as confidential details about their medical conditions, experiences, and allegations. The Grievance & Appeals department's primary responsibility is to ensure member concerns are investigated and resolved in accordance with regulatory requirements and organizational policies. The team manages grievances, appeals, exempt grievances, and State Fair Hearings while working closely with Compliance, Quality Improvement, Medical Directors, Member Services, Provider Relations, and Transportation departments. A total of 8,941 cases were closed during 2025, representing an 18% increase compared to 2024. Grievances accounted for the majority of cases, followed by exempt grievances, appeals, and State Fair Hearings. Ms. Watkins noted that case volume has increased steadily over the past three years. The Board reviewed case intake and classification data. Most cases were received by telephone, accounting for more than 90% of all cases. Only 44 cases, or 0.5%, were processed as expedited cases. Clinical cases represented a significant portion of appeals, while a majority of the grievances were non-clinical. Member demographic data showed that most cases involved English-speaking members, females, and individuals between the ages of 45 and 64. The presentation also compared case demographics with overall membership demographics to identify trends and potential disparities. Transportation issues remained the leading cause of both appeals and grievances. Transportation-related appeals represented approximately 45% of all appeals, while transportation concerns accounted for more than half of all grievances. Common concerns included missed rides, late arrivals, scheduling difficulties, customer service concerns, and driver behavior. Despite the high volume of transportation complaints, transportation-related concerns represented less than 0.4% of the more than 1.5 million rides provided during the year. The Board reviewed appeal and State Hearing outcomes. Most appeals were upheld, while a smaller portion were overturned, partially overturned, or withdrawn. State Hearing cases were most often withdrawn or dismissed. Additional grievance data showed that Trinity, Shasta, and Placer counties had the highest grievance rates per 1,000 members. Outside of transportation, the most common concerns involved provider services, access to care, and Partnership services. Members most frequently reported	None

	treatment plan disputes, communication issues, delays in obtaining appointments, and provider availability concerns. The department also reviewed civil rights allegations. A total of 384 civil rights-related concerns were reported in 2025. Disability, race or ethnicity, and limited English proficiency were the most common allegations. Ms. Watkins noted that 14% of civil rights allegations were substantiated in 2025, an increase from 10% in the previous year. Performance results showed that the department generally met its regulatory timeliness goals for case closures and acknowledgment letters throughout the year. The department met performance goals during the first two quarters, met case closure goals but missed acknowledgment letter goals in the third quarter, and met acknowledgment letter goals but missed case closure goals in the fourth quarter. Ms. Watkins discussed key challenges faced during the year, including increasing case volume, ongoing transportation-related service issues, and the need to improve the quality of resolution letters. Lessons learned included the importance of staffing assessments, cross-training, trend analysis, and implementing quality review processes. Planned actions include enhanced appeals training, improved transportation reporting, and development of a peer-review process for resolution letters. Looking ahead to 2026, the department identified four primary focus areas: implementation of the Jiva case management system, expansion of quality oversight and training functions, preparation for Partnership Advantage implementation, and continued use of data-driven improvement efforts to enhance the member experience. The presentation concluded with an opportunity for Board questions and discussion. *Commissioner Matta asked what a state hearing entails.* *Ms. Watkins explained that a Medi-Cal State Fair Hearing is an informal legal proceeding in which an impartial Administrative Law Judge reviews a decision to deny, reduce, or terminate a health service. During the hearing, both the member and the health plan have an opportunity to present information and supporting facts. The judge then issues a final written decision.* Ms. Watkins again offered the Board the opportunity to review the detailed report of all grievance, appeal, and state hearing cases processed in 2025 at the Fairfield office or upon request.	
7 Closed Session	Chairman Germano announced that the Board would adjourn to Closed Session for approximately 30 minutes. He stated that the following item would be considered during Closed Session: **7.1 PUBLIC EMPLOYEE PERFORMANCE EVALUATION** ***Action Pursuant to Section 54957 of the Ralph M. Brown Act***	*Commissioner Knight moved to approve Resolution 7.1 as presented, seconded by Commissioner Matta.*

	Title: Chief Executive Officer	***ACTION SUMMARY:*** *Yes: 24* *No: 0* *Abstention: 0* *Excused: 12 (Bernal Leroi, Bravo, Champlin, Coleman, Cowan, Davies, Hardy, Johnson, Kelly, Lara-O'Rourke, Malone, Morales, Sullivan, Warhuus)* **MOTION CARRIED**
Re-Convene in Open Session and Adjournment	Chairman Germano re-convened the meeting in open session announced the Board performed the annual evaluation of the Chief Executive Officer (CEO) and voted unanimously to approve the recommendations as presented from the CEO Evaluation Committee. Open Session was adjourned at 1:56PM	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Board Approval Date: 08/26/2026

Signed: _____
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.4

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

Recommendation by:
Yuba Board of Supervisors and Partnership Staff

Topic Description:
The Yuba County Board of Supervisors has appointed a permanent Commissioner to the Partnership Board, replacing interim Commissioner Jamie Bartolome.

Reason for Resolution:
To provide Commissioner Bartolome with the highest level of commendation and appreciation for her service.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve the commendations and appreciation for the support Commissioner Bartolome has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.4

Resolution Number:
26-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR JAMIE BARTOLOME'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Commissioner Bartolome has provided valuable guidance, insight, and support to Partnership HealthPlan of California and to the Board of Commissioners.

B. Commissioner Bartolome was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the highest level of commendations and appreciation for Commissioner Bartolome's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.5

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

Recommendation by:
Yuba County Board of Supervisors

Topic Description:
On July 14, 2026, Benjamin Flores, President and Chief Executive Officer of Ampla Health, was appointed by the Yuba County Board of Supervisors to the Partnership HealthPlan of California Commission (known as the Board) as a Health Center Representative.

Benjamin Flores has been appointed for a four-year term.

Reason for Resolution:
To obtain Board approval to appoint Benjamin Flores to the Partnership Board as the Yuba County Representative.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Mendocino County Board of Supervisors, the Board is asked to approve the new appointment of Benjamin Flores to the Partnership Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.5

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE NEW YUBA COUNTY APPOINTMENT OF BENJAMIN FLORES TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Each county board of supervisors is responsible for appointing representatives to the Partnership Board of Commissioners.

B. Yuba County has a vacancy on the Partnership Board.

C. The Board has authority to approve appointed Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Yuba County appointment of Benjamin Flores to the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August, 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, Board Clerk

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.6

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

Recommendation by:
Partnership Staff and Consumer Representative Selection Committee

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Topic Description:
Pursuant to the Partnership Bylaws, the Commission shall include three consumer representatives. One representative shall be selected from each of the following regions: Northern, Eastern, and Southern. Consumer representatives serve two-year terms and are selected by the Consumer Representative Selection Committee. The Selection Committee consists of the Chief Executive Officer (CEO) or their designee, a Member Services staff representative, one current consumer representative who is not applying for the position, and one Board member.

The Consumer Representative Selection Committee recommends Raichael Stewart serve as the Eastern Region Consumer Representative on the Partnership Board. Ms. Stewart lives in Nevada County and she will be appointed for a two-year term of office. Her term commences on August 26, 2026 and terminates on June 28, 2028.

Reason for Resolution:
To obtain Board approval to appoint Raichael Stewart to the Partnership Board as the at-large consumer representative representing the Eastern Region.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership Staff and Consumer Representative Selection Committee, the Board is asked to approve the new appointment of Raichael Stewart to the Partnership Board as the new at-large consumer representing the Eastern Region.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.6

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE NEW CONSUMER REPRESENTATIVE APPOINTMENT OF RAICHAEL STEWART TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Three members of the Commission must be consumer representatives.

B. Partnership staff and the Consumer Representative Selection Committee are responsible for reviewing applications and recommending consumer representatives to the Board. These representatives serve the Eastern, Northern, and Southern Regions within the Partnership's service area.

C. The Board has authority to approve and appoint Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new consumer commissioner appointment of Raichael Stewart to represent Partnership's Eastern Region.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.7

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

Recommendation by:
Partnership Staff and Consumer Representative Selection Committee

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Topic Description:
Pursuant to the Partnership Bylaws, the Commission shall include three consumer representatives. One representative shall be selected from each of the following regions: Northern, Eastern, and Southern. Consumer representatives serve two-year terms and are selected by the Consumer Representative Selection Committee. The Selection Committee consists of the Chief Executive Officer (CEO) or their designee, a Member Services staff representative, one current consumer representative who is not applying for the position, and one Board member.

The Consumer Representative Selection Committee recommends Ellen Payton serve as the Northern Region Consumer Representative on the Partnership Board. Ms. Payton lives in Lassen County and she will be appointed for a two-year term of office. Her term commences on August 26, 2026 and terminates on June 28, 2028.

Reason for Resolution:
To obtain Board approval to appoint Ellen Payton to the Partnership Board as the consumer representative representing the Northern Region.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership Staff and Consumer Representative Selection Committee, the Board is asked to approve the new appointment of Ellen Payton to the Partnership Board as the new at-large consumer representing the Northern Region.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.7

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE NEW CONSUMER REPRESENTATIVE APPOINTMENT OF ELLEN PAYTON TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Three members of the Commission must be consumer representatives.

B. Partnership staff and the Consumer Representative Selection Committee are responsible for reviewing applications and recommending consumer representatives to the Board. These representatives serve the Eastern, Northern, and Southern Regions within the Partnership's service area.

C. The Board has authority to approve and appoint Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new consumer commissioner appointment of Ellen Payton to represent Partnership's Northern Region.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.8

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

Recommendation by:
Partnership Staff and Consumer Representative Selection Committee

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Topic Description:
Pursuant to the Partnership Bylaws, the Commission shall include three consumer representatives. One representative shall be selected from each of the following regions: Northern, Eastern, and Southern. Consumer representatives serve two-year terms and are selected by the Consumer Representative Selection Committee. The Selection Committee consists of the Chief Executive Officer (CEO) or their designee, a Member Services staff representative, one current consumer representative who is not applying for the position, and one Board member.

The Consumer Representative Selection Committee recommends Jaime Yan Faurot serve as the Southern Region Consumer Representative on the Partnership Board. Ms. Faurot lives in Marin County and she will be appointed for a two-year term of office. Her term commences on August 26, 2026 and terminates on June 28, 2028.

Reason for Resolution:
To obtain Board approval to appoint Jaime Yan Faurot to the Partnership Board as the consumer representative representing the Southern Region.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership Staff and Consumer Representative Selection Committee, the Board is asked to approve the new appointment of Jaime Yan Faurot to the Partnership Board as the new at-large consumer representing the Southern Region.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
1.8

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE NEW CONSUMER REPRESENTATIVE APPOINTMENT OF JAIME YAN FAUROT TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Three members of the Commission must be consumer representatives.

B. Partnership staff and the Consumer Representative Selection Committee are responsible for reviewing applications and recommending consumer representatives to the Board. These representatives serve the Eastern, Northern, and Southern Regions within the Partnership's service area.

C. The Board has authority to approve and appoint Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new consumer commissioner appointment of Jaime Yan Faurot to represent Partnership's Southern Region.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

Report from the Chief Executive Officer

August 26, 2026

National Health Center Week August 2026

Earlier this month, Partnership joined with our providers to celebrate National Health Center Week. Our staff attended and supported events ranging from ribbon cutting ceremonies to appreciation breakfasts to health education efforts. This week allowed Partnership the opportunity to focus on and highlight the strong and collaborative relationships we have with our health centers. The centers and their committed staff provide high-quality health care to our members and they are an invaluable part of the safety net across our twenty-four county region. Our staff enjoyed celebrating with the teams from Western Sierra Medical Clinic, Ampla Health, CommuniCare Ole, Mountain Valleys Health Centers, Marin Community Clinics, Sonoma Valley Community Health Center and so many more. We were proud to work with Solano County Health & Human Services to co-develop a board of supervisors resolution to commemorate National Health Center Week in honor all of the health centers serving Solano County.

County CHIP/CHA Planning Grants

In April of 2025 Partnership announced that it would provide a $100,000 grant opportunity to each of our 24 counties to support their work on Community Health Assessments and Community Health Improvement Plans. CHIP/CHA forms a two-part public health planning process by local health departments and hospitals to evaluate community needs and create strategies to address them. To be eligible for the $100k planning grants, a county must have completed the majority of the Memoranda of Understanding (MOUs) that DHCS required of health plans and their county partners. Over the past two years, we have made great progress in executing MOUs and many counties have become eligible for the planning grants. To date, nine counties have applied for and received funding and nine more are eligible to do so. Five counties have not made progress on executing MOUs with Partnership and will become eligible for the funds once we make progress toward completion of these state required agreements.

CHA/CHIP Application Status (as of 08.17.26)

Approved	Under Review	MOU Eligible	Not Yet
Humboldt (check delivered)		Colusa *7/2025 meal request = $282.48	Glenn *2025 (July, August, October) meal request = $1,353.88
Nevada (check delivered)		Del Norte	Lake
Sierra (check delivered)		Mendocino	Lassen
Siskiyou (check delivered)		Modoc	Marin
Sutter (check delivered)		Napa	Shasta
Tehama (check delivered)		Placer	Solano
Sonoma (check delivered)		Trinity	
Plumas (check delivered)		Yolo	
Butte (check delivered) *partial funds $35,000		Yuba *09/2025 meal request =$1,446.80 *05/2026 meal request= $909.80 08/2026 meal request= 09/2026 Annual CHIP Meeting TBD (~$1,000)	
*fulfilled with grant funds will be deducted from total $100k			

Partnership and County Memoranda of Understanding

In 2024, DHCS added to Partnership's contract a requirement that we establish memoranda of understanding with each of the counties we serve regarding a range of services and programs for which we have shared utilizers. These included the First Five Commissions, WIC, Child Welfare, Public Health, Behavioral Health and more. We have been making steady progress in getting these agreements in place. Honorable mention for efforts in this area: Mendocino, Nevada and Placer counties all have eight MOUs in place, while Yolo county has seven completed. There are many agreements in different stages of the process, with some very close to completion. We greatly appreciate the time and effort our county partners have devoted to keeping Partnership in compliance with our state contract and will provide a full status report at our next board meeting in October.

CMS Final Rule on Medicaid and CHIP Funding Restrictions Regarding Gender-Affirming Care

On August 11, 2026, the Centers for Medicare and Medicaid Services (CMS) issued the final rule entitled Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children. The new rule prohibits federal Medicaid or Children's Health Insurance Program (CHIP) dollars from being used to pay for gender-affirming care ("sex rejecting procedures") for children under the age of 18 in the Medicaid program and under the age of 19 in CHIP. More specifically, sex rejecting procedures include puberty blockers, cross-sex hormones, and other care. For children currently receiving hormone therapy, a six-month "tapering-off" period will be allowed. It is important to note that the final rule does not prohibit coverage of counseling or psychotherapy as part of gender-affirming care.

In response to federal actions, California is investing $30 million over the next three years to pay for uncompensated care for gender-affirming care and abortion, as well as $26 million over three years to stabilize and expand the state's gender-affirming care provider network. It is being discussed that these funds will be distributed through grants, but no official guidance has been provided at this time. We will share additional details as they become available.

CalRHT: Rural Health Transformation Funding

As part of the One Big Beautiful Bill (H.R. 1), states were awarded funds to support rural health care systems. California received the sixth-lowest Rural Health Transformation Program award per rural resident. Only Texas, Ohio, North Carolina, Pennsylvania, and Michigan received less funding on a per-rural-resident basis. The funds are being administered by the Department of Health Care Access & Information (HCAI). Partnership has supported our provider network by sharing information about this funding opportunity through webinars, providing project-specific guidance through conference calls and virtual meetings, offering access to an expert consultant for application support, and providing letters of support. We also had Jennifer Hernandez, HCAI's director of Rural Health Transformation, as a featured speaker at our recent hospital convening in Redding. She informed the group that the agency is working to formally commit funds by the end of October.

By the end of this week, our consultant, DHJ Services, will have hosted six informational webinars for the network. DHJ has also offering office hours, technical workshops, one-on-one sessions, and review of draft applications. As of today, Partnership has provided 11 requests for letters of support for a wide variety of proposals. Proposal deadlines are outlined in the table below.

CalRHT Program Grants

Key Dates by Grant

Grant	Application Portal Opens	Application Deadline
TRANSFORMATIVE CARE MODEL: **Accelerator Partners**	July 15	August 14
TRANSFORMATIVE CARE MODEL: **Expand and Support Rural Workforce Capacity**	July 15	August 14
TECHNOLOGY & TOOLS: **EHR Modernization**	July 20	August 21
WORKFORCE DEVELOPMENT: **Workforce Development Recruitment & Retention**	July 31	August 31

CALIFORNIA RURAL HEALTH TRANSFORMATION

HCAI Department of Health Care Access and Information

.

The Workforce Development Recruitment and Retention Grant includes $54 million in available funding. Partnership's workforce development team is evaluating whether changes are needed to our own provider recruitment and retention program to align with this opportunity.

HCAI has established a Rural Health Policy Council and Partnership's region is strongly represented. Our Regional Medical Director, Dr. ColleenTownsend, was selected for the council as well as our colleagues Tim Rine, Executive Director, North Coast Clinics Network and Lori Link, Certified Nurse Midwife from Plumas District Hospital.

UIS Transition Update

Overview

- Effective January 1, 2027, Medi-Cal members with Unsatisfactory Immigration Status (UIS) will transition from Medi-Cal Managed Care to Medi-Cal Fee-for-Service (FFS) to comply with federal requirements.
- The change affects approximately 2 million members statewide and 84,661 Partnership members as of August 1, representing just over 10% of total membership.
- This is a delivery system change only. Affected members will retain Medi-Cal eligibility and general Medi-Cal benefits, but their care will be administered through the state FFS system rather than a managed care plan.

Clinical Implications

- Approximately 84,000 Partnership members will move out of Partnership HealthPlan and into the state FFS delivery system.
- Members will no longer be assigned to a managed care plan or primary care provider and may receive care from any Medi-Cal FFS-enrolled provider who is accepting patients.
- Pharmacy benefits will continue through Medi-Cal Rx, and county-administered specialty mental health and substance use disorder services will remain unchanged.
- PACE, IHSS, CCS, foster care programs, and state home- and community-based waiver services will continue.
- UIS FFS members will no longer be eligible for Enhanced Care Management (ECM) or Community Supports.

Partnership and DHCS Activity

- DHCS has released a UIS Transition Policy Guide and is coordinating with Partnership and other managed care plans to transition affected members to FFS.
- Close coordination will be needed for high-risk members, including those receiving dialysis, transplant candidates, members in skilled nursing facilities, CCS members, recently discharged members, and members dependent on durable medical equipment, biologics, or other ongoing supports.
- Partnership will proactively identify high-risk members and conduct outreach to help them understand the transition, available options, and provider access after January 1, 2027.
- Partnership is working with DHCS to determine what data can be shared to support continuity of care, including authorization data and inpatient census information.
- Partnership is also advocating for clear escalation pathways so health plans, providers, and counties can quickly elevate care issues during and after the transition.
- An internal Partnership workgroup is coordinating planning, communications, and operational readiness across the organization.

Key Messages for Providers and Community Partners

- Reassure patients that this transition does not affect their Medi-Cal eligibility.
- Encourage patients to keep their contact information current with their county Medi-Cal eligibility office.

- Share FFS resources with provider networks to help patients identify Medi-Cal FFS providers.
- Review medically necessary treatment plans, referrals, and medication regimens before January 1, 2027, to reduce care disruption.
- Providers who wish to continue serving these patients should confirm they are enrolled in Medi-Cal FFS through PAVE or that enrollment is in process.
- Partnership's county-specific community resource pages remain available to help connect patients, regardless of Partnership membership, to additional local supports.

Partnership & Hospital Convening

In July, Partnership convened hospital representatives from across our service area in Redding for a full-day meeting facilitated by Bobbie Wunsch. The convening was well attended, with 46 participants, and featured high-quality presentations on timely policy and financing issues affecting hospitals and the broader health care delivery system. As mentioned above, Jennifer Hernandez, Director of California Rural Health Transformation, provided the latest information on HCAI's approach to federal grant funding intended to support the rural health care delivery system.

Yingja Huang, Deputy Director of Health Care Benefits and Eligibility at DHCS, reviewed the new CMS-mandated community engagement requirements for Medi-Cal beneficiaries and answered questions about potential impacts for patients and hospitals.

An expert panel discussed State Directed Payments and how upcoming changes may affect hospital finances related to Medi-Cal. A financial policy expert from the California Hospital Association discussed how state budget decisions may impact hospital financing. We conducted a "post-event survey" and the results were very positive: the convening received an average rating of 4.9 out of 5, and 9 out of 10 respondents rated the event as excellent.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.1

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

Recommendation by:
Partnership Advisory Groups and Committees

Topic Description:
Partnership HealthPlan of California has a number of advisory groups and committees established by the Commission (known as the Board) with direct reporting responsibilities. These are the Compliance / Governance Committee, Consumer Advisory Committee, Finance Committee, Personnel Committee, Physician Advisory Committee and Strategic Planning Committee.

The Physician Advisory Committee (PAC) has responsibility for oversight and monitoring of quality and cost-effectiveness of medical care provided to Partnership's members. A number of other advisory groups and committees have direct reporting responsibilities to PAC. These include the Credentials Committee, Internal Quality Improvement Committee, Member Grievance Review Committee, Over/Under Utilization Workgroup, Pediatric Quality Committee, Peer Review Committee, Pharmacy & Therapeutics Committee, Population Health Management & Health Equity Committee, Member Grievance Review Committee, Quality/Utilization Advisory Committee, Substance Use Services Internal Quality Improvement Subcommittee and Provider Engagement Group.

The Board is responsible for reviewing and accepting all minutes and packets approved by the various advisory groups and committees, and approving the policies, program descriptions, and QIP changes that were approved by the PAC, in June through August 2026.

Reason for Resolution:
To provide the Board the opportunity to review and accept Partnership advisory committee minutes and packets. In addition, to provide the Board with all Partnership policy and program description changes approved and recommended by PAC.

Financial Impact:
Any financial impact to the HealthPlan is included in the budget.

Requested Action of the Board:
Based on the recommendation of Partnership's advisory groups & committees, the Board is asked to accept receipt of all Partnership's committee minutes and committee packets and to approve all policy and program description changes approved by PAC, linked in the agenda.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.1

Resolution Number:
26-

IN THE MATTER OF: ACCEPTING ALL PARTNERSHIP HEALTHPLAN OF CALIFORNIA ADVISORY COMMITTEE MINUTES AND COMMITTEE PACKETS AND TO APPROVE POLICY AND PROGRAM DESCRIPTION CHANGES APPROVED BY THE PHYSICIAN ADVISORY COMMITTEE (PAC)

Recital: Whereas,

A. The Board has fiduciary responsibility for the operation of the organization.

B. The Board has responsibility to review and accept all Partnership committee minutes and packets and to review and approve all policy and program description changes approved by PAC.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept receipt of all Partnership committee minutes and committee packets.
2. To obtain approval for policy and program description changes approved and recommended by PAC.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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 Policy & Procedure Updates

August 2026

Policy Number	Policy/Procedures/Guidelines
	*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **June and July 2026.*** *Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.* *Please review the redline drafts and the detailed **Synopsis of Changes** in the packet.* *The current policies shown in the online Provider Manual are hyperlinked.*
Population Health Management	
MPNP9002-D	Cultural & Linguistic Program Description Process for Culturally and Linguistically Appropriate Translations - *Attachment*
MPND9007	Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)
MPNP9008	Women, Infants and Children (WIC) Supplemental Food Program
Pharmacy Operations	
MCRP4064	Continuation of Prescription Drugs
MPRP4062	Drug Wastage Payments
MPRP4065	Drug Utilization Review (DUR) *(Not yet published online)*
Provider Relations	
MPPR207	Annual Physician Satisfaction Survey
Quality Improvement	
MPXG5008	Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing
MPXG5009	Lactation Clinical Practice Guideline
MCQP1025	Substance Use Disorder (SUD) Facility Site Review and Medical Record Review
MCQP1052	Physical Accessibility Review Survey – SR Part C

Policy Number	Policy/Procedure/Guidelines	Version Links
Utilization Management		
MCUP3041	Treatment Authorization Request (TAR) Review Process	
MCUP3140	Palliative Care: Pediatric Program for Members Under the Age of 21	
MPUG3025	Insulin Infusion Pump and Continuous Glucose Monitor Guidelines	
MPUP3039	Direct Members	
MPUP3111	Pulmonary Rehabilitation	
MPUP3139	Criteria and Guidelines for Utilization Management	
MCUG3007	Authorization of Ambulatory Procedures and Services	
MCUG3134	Hospital Bed/ Specialty Mattress Guidelines	
MCUP3015	Family Planning Bypass Services	
MCUP3114	Physical, Occupational and Speech Therapies	
MCUP3141	Delegation of Inpatient Utilization Management	
MPUG3010	Chiropractic Services	
MPUP3042	Technology Assessment	
MPUP3138	External Independent Medical Review	

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.2

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

Approved by:
Physician Advisory Committee and Partnership Staff

Topic Description:
In order to provide high quality preventive health services, staff is proposing changes to the 2027 Primary Care Provider Quality Improvement Program (PCPQIP) measurement set (see attached summary).

Reason for Resolution:
To optimize the Primary Care Provider QIP to improve quality of care.

Financial Impact:
The impact to the HealthPlan is included in the budget assumptions.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve proposed changes to the 2027 Primary Care Provider Quality Improvement Program (PCPQIP) measurement set.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.2

Resolution Number:
26-

IN THE MATTER OF: APPROVING PROPOSED CHANGES TO THE 2027 PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCPQIP) MEASUREMENT SET

Recital: Whereas,

A. The Board has responsibility to review and approve HealthPlan policies, programs, and benefits.

B. The Board has fiduciary responsibility for the operation of the organization.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve proposed changes to the Primary Care Provider Quality Improvement Program (PCPQIP) measurement set.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

Summary of Proposed Measure Changes for Measurement Year 2027

(A) Core Measurement Set Measures

Providers have the potential to earn a total of 100 points in two measurement areas: Clinical Domain and Non-Clinical Domain. Individual measure values will be assigned to the final and approved measurement set.

Key:

New Measure || Change to Measure Design || ~~Measure removed~~

2026 Measures	2027 Recommendations
Clinical Domain	
Family Medicine: 1. Breast Cancer Screening (40-74yo) 2. Cervical Cancer Screening 3. Child and Adolescent Well Care Visits 4. Childhood Immunization Status: Combo 10 5. Colorectal Cancer Screening 6. Comprehensive Diabetes Management: HbA1c Good Control 7. Comprehensive Diabetes Management: Retinal Eye Exams 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Lead Screening in Children 12. Chlamydia Screening (16-24yo) 13. Kidney Health Evaluation for Patients with Diabetes 14. Well-Child Visits in the first 15-30 months of life – **Monitoring** 15. Topical fluoride in Children – **Monitoring** 16. Reducing Healthcare Disparity (**Participation is Optional**)	**Family Medicine:** 1. Breast Cancer Screening (40-74yo) 2. Cervical Cancer Screening 3. Child and Adolescent Well Care Visits 4. Childhood Immunization Status: Combo 10 5. Colorectal Cancer Screening 6. Comprehensive Diabetes Management: HbA1c Good Control 7. ~~Comprehensive Diabetes Management: Retinal Eye Exams – **Retire to Monitoring Status**~~ 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Lead Screening in Children 12. ~~Chlamydia Screening (16-24yo) – **Retire to Monitoring Status**~~ 13. Kidney Health Evaluation for Patients with Diabetes 14. Well-Child Visits in the first 15-30 months of life – **Keep as Monitoring** 15. Topical fluoride in Children – **Keep as Monitoring** 16. Developmental Screening – **New Monitoring** 17. First Timely Prenatal Care Visit – **New Monitoring** 18. Adult Immunization – **New Monitoring** 19. Follow-up after Acute and Urgent Care Visits for Asthma – **New Monitoring** 20. Asthma Medication Ratio – **New Monitoring**

Summary of Proposed Measure Changes for Measurement Year 2027

	21. Tobacco Use Screening and Cessation – **New Monitoring** 22. ~~Reducing Healthcare Disparity (**Participation is Optional**)~~
Clinical Domain	
Internal Medicine: 1. Breast Cancer Screening (40-74yo) 2. Cervical Cancer Screening 3. Colorectal Cancer Screening 4. Controlling High Blood Pressure 5. Comprehensive Diabetes Management: HbA1c Good Control 6. Comprehensive Diabetes Management: Retinal Eye Exams 7. Chlamydia Screening (21-24yo) 8. Reducing Healthcare Disparity (**Participation is Optional**) 9. Kidney Health Evaluation for Patients with Diabetes	**Internal Medicine:** 1. Breast Cancer Screening (40-74yo) 2. Cervical Cancer Screening 3. Colorectal Cancer Screening 4. Controlling High Blood Pressure 5. Comprehensive Diabetes Management: HbA1c Good Control 6. ~~Comprehensive Diabetes Management: Retinal Eye Exams – **Retire to Monitoring Status**~~ 7. ~~Chlamydia Screening (21-24yo) – **Retire to Monitoring Status**~~ 8. Kidney Health Evaluation for Patients with Diabetes 9. First Timely Prenatal Care Visit – **New Monitoring** 10. Adult Immunization – **New Monitoring** 11. Follow-up after Acute and Urgent Care Visits for Asthma – **New Monitoring** 12. Asthma Medication Ratio – **New Monitoring** 13. Tobacco Use Screening and Cessation – **New Monitoring** 14. ~~Reducing Healthcare Disparity (**Participation is Optional**)~~
Clinical Domain	
Pediatric Medicine: 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children	**Pediatric Medicine:** 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children

Summary of Proposed Measure Changes for Measurement Year 2027

6. Well-Child Visits in the first 15-30 months of life 7. Chlamydia Screening (16-20yo) 8. Topical fluoride in Children – **Monitoring** 9. Reducing Healthcare Disparity (**Participation is Optional**)	6. Well-Child Visits in the first 15-30 months of life 7. ~~Chlamydia Screening (16-20yo) – **Retire to Monitoring Status**~~ 8. Topical fluoride in Children – **Keep as Monitoring** 9. Developmental Screening – **New Monitoring** 10. Follow-up after Acute and Urgent Care Visits for Asthma – **New Monitoring** 11. Asthma Medication Ratio – **New Monitoring** 12. Tobacco Use Screening and Cessation – **New Monitoring** 13. ~~Reducing Healthcare Disparity (**Participation is Optional**)~~

Non-Clinical Domain	
Family Medicine and Internal Medicine: 1. Ambulatory Care Sensitive Admissions 2. Follow-up within 7 days after Hospital Discharge 3. Avoidable ED Visits 4. PCP Office Visits 5. Patient Experience	**Family Medicine and Internal Medicine:** 1. Potentially Preventable Admissions 2. Follow-up within 7 days after Hospital Discharge 3. Low-Acuity Non-Emergent ED Visits 4. PCP Office Visits 5. Patient Experience
Non-Clinical Domain	
Pediatric Medicine: 1. Avoidable ED Visits 2. PCP Office Visits 3. Patient Experience	**Pediatric Medicine:** 1. Low-Acuity Non-Emergent ED Visits 2. PCP Office Visits 3. Patient Experience

(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

Summary of Proposed Measure Changes for Measurement Year 2027

Unit of Service	
All Sites: 1. Clinician Education on Improving Medication Management 2. Advance Care Planning 3. Extended Office Hours 4. PCMH Certification 5. Peer-led and Pediatric Group Visits 6. Health Information Exchange 7. Health Equity 8. Tobacco Use Screening 9. Electronic Clinical Data Systems (ECDS)	**All Sites:** 1. Clinician Education on Improving Medication Management 2. Advance Care Planning 3. Extended Office Hours 4. PCMH Certification 5. Peer-led and Pediatric Group Visits 6. Health Information Exchange 7. Health Equity 8. ~~Tobacco Use Screening - Retire~~ 9. ~~Electronic Clinical Data Systems (ECDS) – Retire~~

Programmatic Changes:

I. Descriptions of Potential 2027 Measure Changes for Core Measurement Set

A. Change(s) to Existing Measures – Core Measurement Set

1) Chlamydia Screening (Clinical Measure: All Practice Types) – Retire then adopt HEDIS criteria and make a monitoring measure. Measure is no longer an MCAS reporting measure, but screening is still important to complete and relevant to monitor.

2) Reducing Healthcare Disparity (Optional Clinical Measure: All Practice Types) – Retire as DHCS has changed its approach for plans and expectations around reducing healthcare disparities. There are also signs that there may be guidance coming from DMHC which could influence how Partnership approaches disparity reduction. In the interim, Partnership is defaulting to its current Health Equity Unit of Service measure to allow practices autonomy in identifying and closing disparities among their patient populations.

3) Patient Experience (Non-Clinical Measure: All Practice Types) – Redesign to requirements. For CG-CAHPS, part of the payment will depend on submitting a robust Improvement plan including reporting on monthly 3NA, continuity, dropped call rates, no-show rates, and recent individual provider-level satisfaction surveys. For Survey

Option, a robust improvement plan including reporting on current 3NA, continuity, dropped call rates, no-show rates, and individual provider-level satisfaction will be required with both submission templates: Part 1 and Part 2.

The two composite measures for the CG-CAHPS survey are access and communication, which are key drivers to patient satisfaction. Operational reports and clinic-level point of care survey reports can help identify barriers and develop improvement plans which can lead to increased patient satisfaction. According to Agency for Healthcare Research and Quality, when patients share their experiences about their health care, they offer crucial insights about the safety of that care. Lack of appropriate access to high-quality care, good communication, cleanliness, care coordination, information during discharge, as well as lack of responsiveness to patient requests for help, can lead to patient harm (https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html).

4) Comprehensive Diabetes Management: Retinal Eye Exams (Clinical Measure: Family Medicine and Internal Medicine): Retire and move to monitoring status. While the Diabetes Retinal Eye Exam measure may no longer be appropriate to retain as a scored measure, it should remain as a monitoring measure because it continues to provide valuable insight into preventive diabetes care performance. For the DSNP population in particular, retinal eye exam completion reflects members' access to specialty care, effectiveness of outreach and care coordination, and overall engagement in chronic disease management. Maintaining this measure in a monitoring capacity supports early identification of care gaps, helps target interventions for high-risk members, and preserves visibility into an important clinical service without requiring it to drive formal stars scoring.

B. Potential Additions as New Measures – Core Measurement Set

1) Developmental Screening (Family Medicine and Pediatric Practice) – **New Monitoring**

   According to the CDC, developmental disabilities are common. In the United States, about one in six children aged three to 17 years has one or more developmental disabilities, such as autism or attention-deficit/hyperactivity disorder. Identifying developmental delays and disabilities early is key so children and their families can get the services and support that they need as early as possible (https://www.cdc.gov/act-early/about/developmental-monitoring-and-screening.html).

2) First Timely Prenatal Care Visit (Family and Internal Medicine Practice) – **New Monitoring**

According to NCQA, preventive medicine is fundamental to prenatal care. Ensuring early initiation of prenatal care is an important component of programs that aim to improve maternal and infant health outcomes. Inadequate prenatal care raises the risk of adverse birth outcomes, potentially because the healthcare provider has fewer opportunities to identify and manage conditions that can have a negative impact (https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/prenatal-and-postpartum-care-ppc/).

3) Adult Immunization (Family and Internal Medicine Practice) – **New Monitoring**

   According to the CDC, vaccines have greatly reduced diseases that once routinely harmed or killed people. People all over the world, including in the United States, still become seriously ill or even die from diseases that vaccines can help prevent. It is important for patients stay up to date on recommended vaccines (https://www.cdc.gov/vaccines-adults/reasons/index.html).

4) Follow-up after Acute and Urgent Care Visits for Asthma (All Practice Types) – **New Monitoring**

   According to NCQA and CDC asthma data in 2021, 6.5% of children and 8% of adults in the United States had asthma and the disease was responsible for 3,517 deaths. Asthma is a complex, chronic disease that occurs in all ages. If poorly controlled or triggered by an environmental factor, it can result in episodic exacerbations with significant health and financial consequences. While asthma exacerbations are medical emergencies requiring acute interventions, they may be avoided using preventive care (https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-after-acute-and-urgent-care-visits-for-asthma-aaf-e/). This measure is highly likely to become an MCAS measure in the future.

5) Asthma Medication Ratio (All Practice Types) – **New Monitoring**

   According to NCQA, asthma is a treatable, manageable, condition that affects more than 25 million people in the United States. Managing this condition with appropriate medications could save the United States. billions of dollars in medical costs. The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication. Appropriate medication management for patients with asthma could reduce the need for rescue medication—as well as the costs associated with ER visits, inpatient admissions, and missed days of work or school (https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/asthma-medication-ratio-amr/). While NCQA and MCAS are

retiring this measure (reason for removal from accountability), this measure is associated with less ED visits for asthma, so this measure could plausibly affect the hospital admission rate for asthma.

6) Tobacco Use Screening and Cessation (All Practice Types) – **New Monitoring**

The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and United States Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco. Tobacco use is the leading preventable cause of disease, disability, and death in the United States. In 2014, it was estimated that 480,000 deaths annually are attributed to cigarette smoking, including secondhand smoke. In 2019 (the most recent data currently available), an estimated 50.6 million United States adults (20.8% of the adult population) used tobacco; 14.0% of the United States adult population currently smoked cigarettes; and 4.5% of the United States adult population used electronic cigarettes (e-cigarettes) (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions). This measure will be clarified to include screening and counselling on vaping, as well as traditional cigarette smoking.

7) Ambulatory Care Sensitive Admissions (Family Practice and Internal Medicine) – Measure name change for reporting purposes.

8) Avoidable Emergency Department (ED) Visits (All Practice Types) – Measure name change for reporting purposes.

II. Descriptions of Potential 2027 Measure Changes for Unit of Service Measurement Set

A. Change(s) to Existing Measures – Unit of Service

1) Tobacco Use Screening (All Practice Types) – Retire then adopt HEDIS criteria and make a clinical monitoring measure. Newly added MY2026 HEDIS measure includes both adolescents (12 years of age and older) and adults along with a requirement for cessation intervention.

2) Electronic Clinical Data Systems (ECDS) (All Practice Types) – Retire. No uploads will be allowed for the following core clinical measures: BCS, CCS, COL, LSC, IMA, and CIS10. NCQA and MCAS measures will be transitioning to ECDS reporting only (i.e., no manual uploads will be permitted) by 2029. This data exchange from the provider's Electronic Health Records to Datalink (a qualified HEDIS data aggregator), allows Partnership to capture clinical screenings, immunization records, follow-up care, and outcomes.

B. Potential Additions as New Measures – Unit of Service

N/A

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.3

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

Recommendation by:
Quality / Utilization Advisory Committee & Physician Advisory Committee

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Topic Description:
Partnership's Cultural & Linguistic Program Description demonstrates the commitment of Partnership HealthPlan of California (Partnership) to deliver culturally and linguistically appropriate health care services to a culturally and linguistically diverse population of members and potential members in a way that promotes Health Equity for all members. For the 2026 Cultural & Linguistic Program Description, only non-substantive edits were made to the cover page and Attachment D.

Reason for Resolution:
To allow the full Board the opportunity to review and approve Partnership's Cultural & Linguistic Program Description when there are edits and on an annual basis.

Financial Impact:
There is no measurable financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Quality / Utilization Advisory Committee and the Physician Advisory Committee, the full Board is asked to approve Partnership's Cultural & Linguistic Program Description.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.3

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE CULTURAL & LINGUISTIC PROGRAM DESCRIPTION

Recital: Whereas,

A. The Board has the authority and responsibility for ensuring Partnership has a cohesive plan for providing high quality of care, positive health outcomes, and timely access to care for all members.

B. The Board has ultimate responsibility for approving Partnership programs.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve Partnership's Cultural & Linguistic Program Description.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

Cultural & Linguistic Program Description

MPND9002

April 2026

Original Date: 02/19/2014

Previously Applied to MPLD7001 02/19/14 to 09/09/20

Revision Dates: MCND9002 09/09/20; 09/08/21; 09/14/22; 11/8/23; 11/13/24; 04/9/2025; MPND9002 08/13/25; 04/08/26; 08/12/26

DHCS – last approved on 06/12/25 for APL 25-005; 02/27/26 for APL 25-016

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.4

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

Recommendation by:
The Personnel Committee

Topic Description:
On August 19, 2026, the Personnel Committee convened to conduct its annual review of Partnership's Human Resources (HR) policies for staff. All proposed policy revisions were reviewed and approved as presented.

Reason for Resolution:
To present the Board with the Personnel Committee's recommendations from the August 19, 2026 meeting for review and approval, and to ensure Board members are informed of the current HR policies for staff.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Personnel Committee, the Board is asked to approve all current HR policies for staff, as reviewed by the Personnel Committee on August 19, 2026.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.4

Resolution Number:
26-

IN THE MATTER OF: APPROVING ALL CURRENT HR POLICIES FOR STAFF AS REVIEWED AND RECOMMENDED BY THE PERSONNEL COMMITTEE ON AUGUST 19, 2026

Recital: Whereas,

A. The Personnel Committee has the responsibility to review all current HR policies for staff on an annual basis and recommend for approval to the full Board.

B. The Personnel Committee reviewed all current HR policies for staff on August 19, 2026.

C. The Board has responsibility to review and approve all current HR policies for staff.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To obtain approval for the current HR policies for staff reviewed by the Personnel Committee on August 19, 2026.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

Group 2: Policies Containing Changes

- **HR506 – Employee Reimbursement for Employee Growth & Career Development**
- **HR507 – Remote Work Program**
- **HR508 – Compensation**
- **HR509 – Bilingual Standards & Compensation**
- **HR511 – Attendance & Punctuality**
- **HR512 – Mileage Reimbursement**
- **HR515 – Relocation & Moving Expenses**
- **HR605 – Management Incentive Program**
- **HR608 – Employee Recognition**
- **HR610 – Holiday Pay**
- **HR611 – Staff Events**
- **HR703 – Family and Medical Leave; Pregnancy Disability Leave, Reasonable Accommodation, and Transfer; Personal Medical Leave; and Service Member Leave**
- **HR710 – Paid Sick Leave**

Group 3: Policies Containing No Changes

- **HR207 – Referral Awards**
- **HR210 – Working Out of Job Class**
- **HR212 – Temporary Agency Workers**
- **HR215 – Employee Separation and Eligibility for Rehire**
- **HR404 – Performance Reviews**
- **HR503 – Meals and Rest Periods**
- **HR504 – Overtime and Shift Differentials**
- **HR514 – Employee Growth & Career Development**
- **HR517 – Disaster/Emergency Compensation**
- **HR604 – Spot Bonus**
- **HR606 – Employee Award Program**
- **HR612 – Community Service**
- **HR613 – Catering Guidelines**
- **HR701 – Paid Time Off (PTO)**
- **HR702 – Paid Time Off Cash-Out Program**
- **HR706a – 9/80 Workweek (Exempt)**
- **HR706b – 9/80 Workweek (Non-Exempt)**
- **HR712 – Other Leaves**
- **HR803 – Workers' Compensation**
- **HR807 – Cyber Security & Internet Usage**
- **HR817 – Employee Social Media**

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.5

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

Recommendation by:
Partnership Staff

Topic Description:
Partnership Board Commissioner Scott Kennelly, Director of Behavioral Health for Butte County, retired from his position at Butte County and the Partnership Board.

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

Reason for Resolution:
To provide Commissioner Kennelly with the highest level of commendations and appreciation for his excellent service.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve the commendations and appreciation for the support Commissioner Kennelly has provided to Partnership and the Board.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
3.5

Resolution Number:
26-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR SCOTT KENNELLY'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Scott Kennelly provided valuable advice and support for Partnership and the Board.

B. Scott Kennelly was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the highest level of commendations and appreciation for Commissioner Kennelly's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
4.1

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

Recommendation by:
Partnership Staff

Topic Description:
The Semi-Annual Board Dashboard is a tool developed by the Partnership management team that reflects the organization's major focus areas and priorities and allows the Board to track key metrics across the organization.

Reason for Resolution:
To present the Board with the opportunity to review and approve the Semi-Annual Board Dashboard.

Financial Impact:
There is no measurable financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve the Semi-Annual Board Dashboard.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 26, 2026

Agenda Item Number:
4.1

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE SEMI-ANNUAL BOARD DASHBOARD

Recital: Whereas,

A. The Semi-Annual Board Dashboard includes key metrics to monitor Partnership's operations.

B. The Board has ultimate responsibility for ensuing operational excellence.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the Semi-Annual Board Dashboard.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

Executive Dashboard

Date: August 26, 2026

Disclaimer: Data presented in the following slides are a snapshot moment in time. There may be some differences between what is presented below and what you've seen in other presentations.

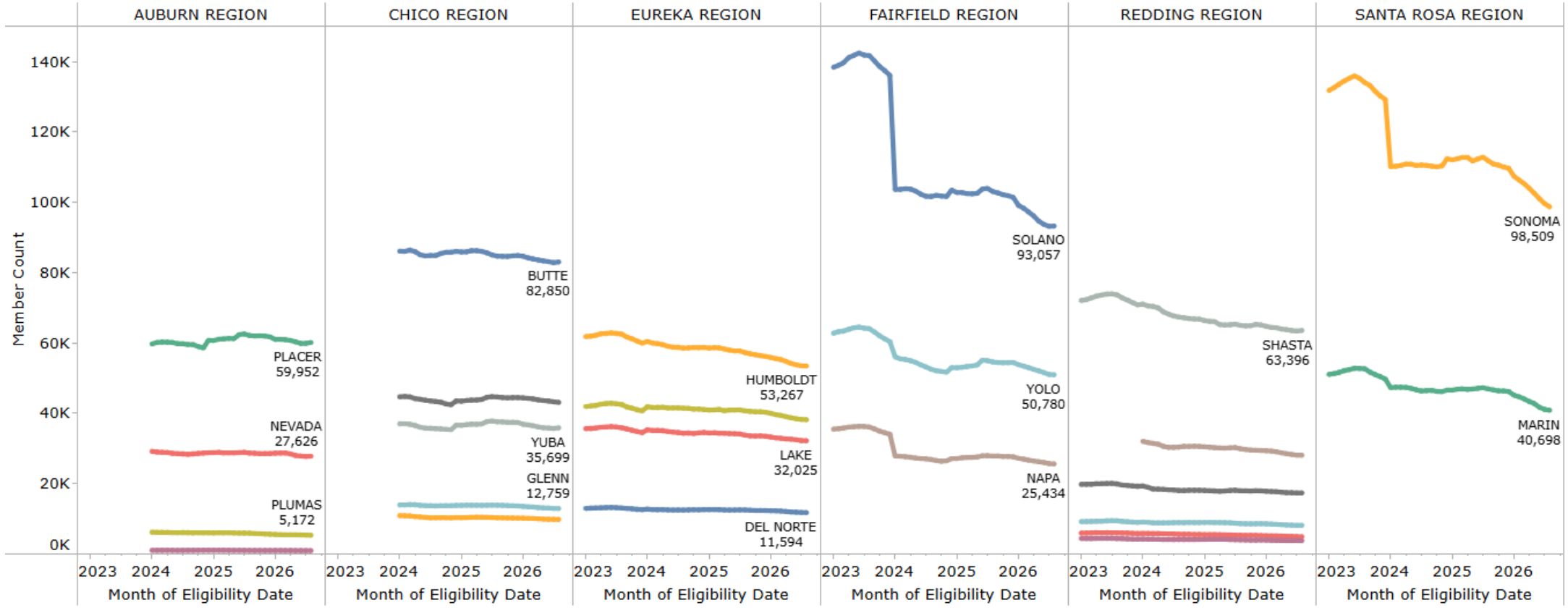
Membership Dashboard

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

August, 2026

845,603	93,532	183,887	134,893	169,271	124,813	139,207
Member Count	Auburn	Chico	Eureka	Fairfield	Redding	Santa Rosa

Membership trend, January 2023 to August 2026



NEVADA PLUMAS PLACER SIERRA

BUTTE GLENN YUBA COLUSA SUTTER

DEL NORTE LAKE HUMBOLDT MENDOCINO

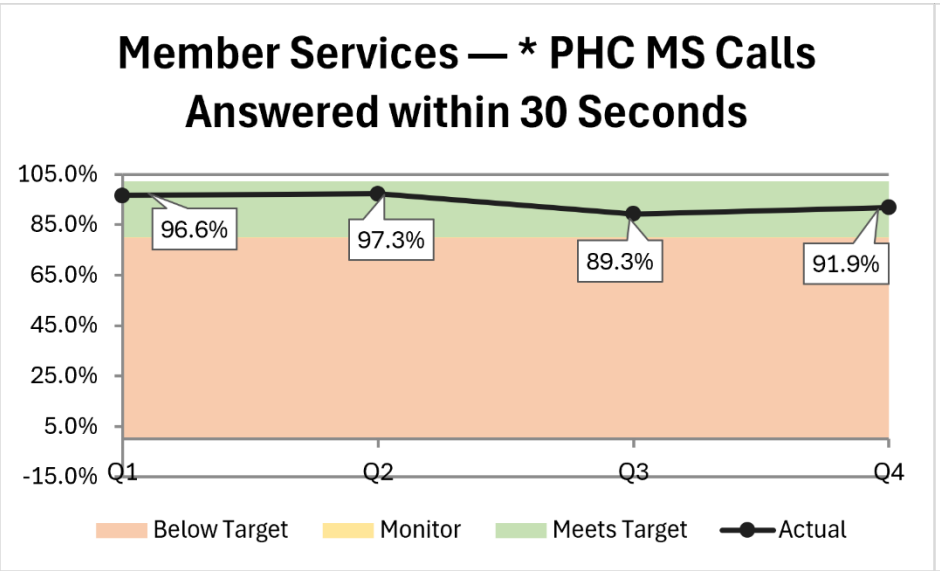
NAPA YOLO SOLANO

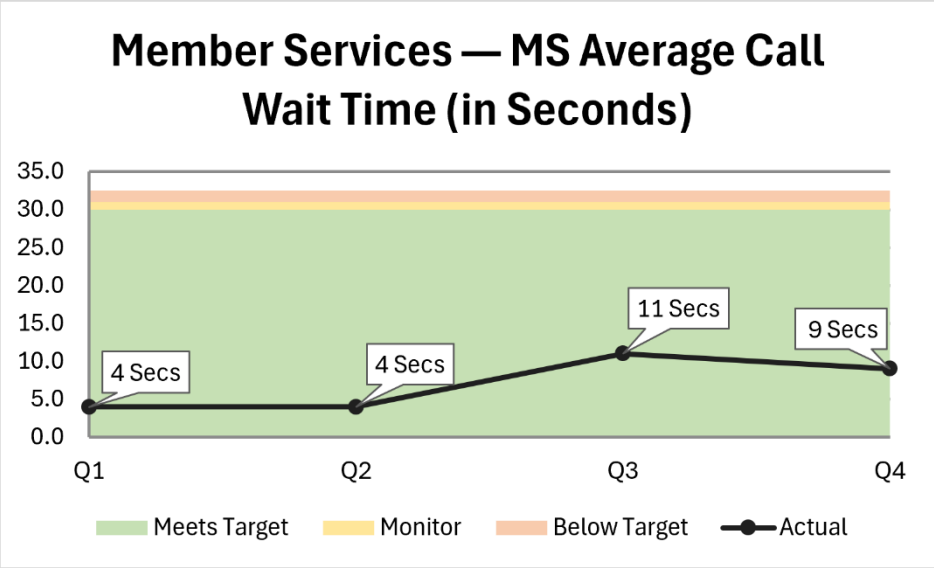
LASSEN SHASTA TEHAMA MODOC SISKIYOU TRINITY

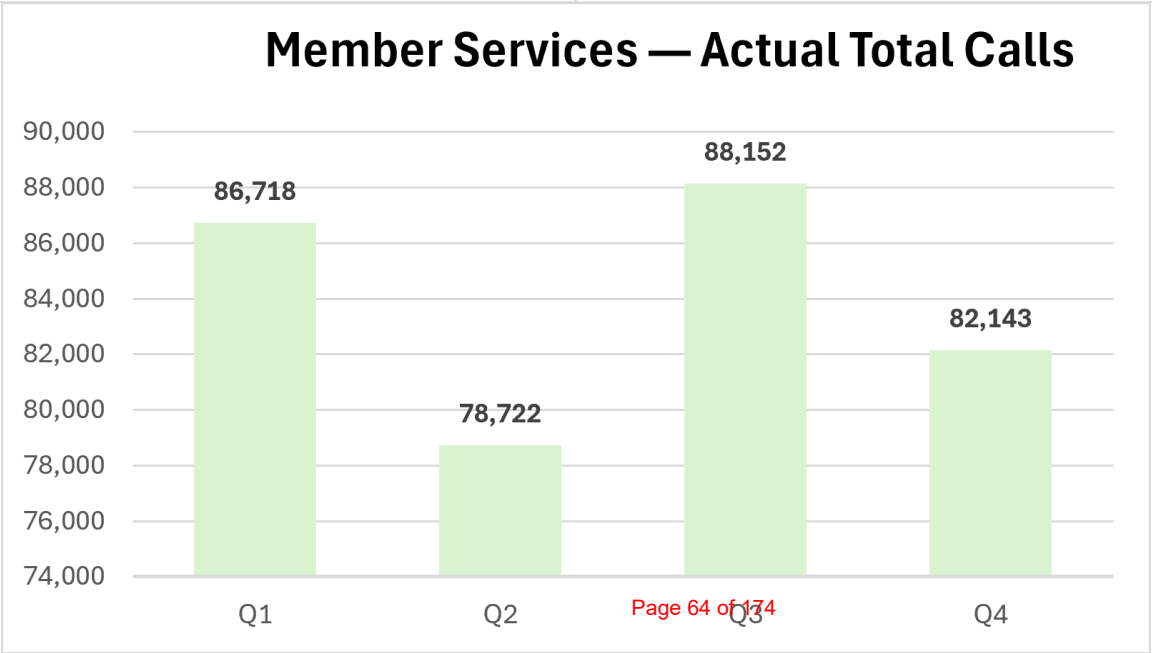
MARIN SONOMA

ACCREDITED NCQA HEALTH PLAN

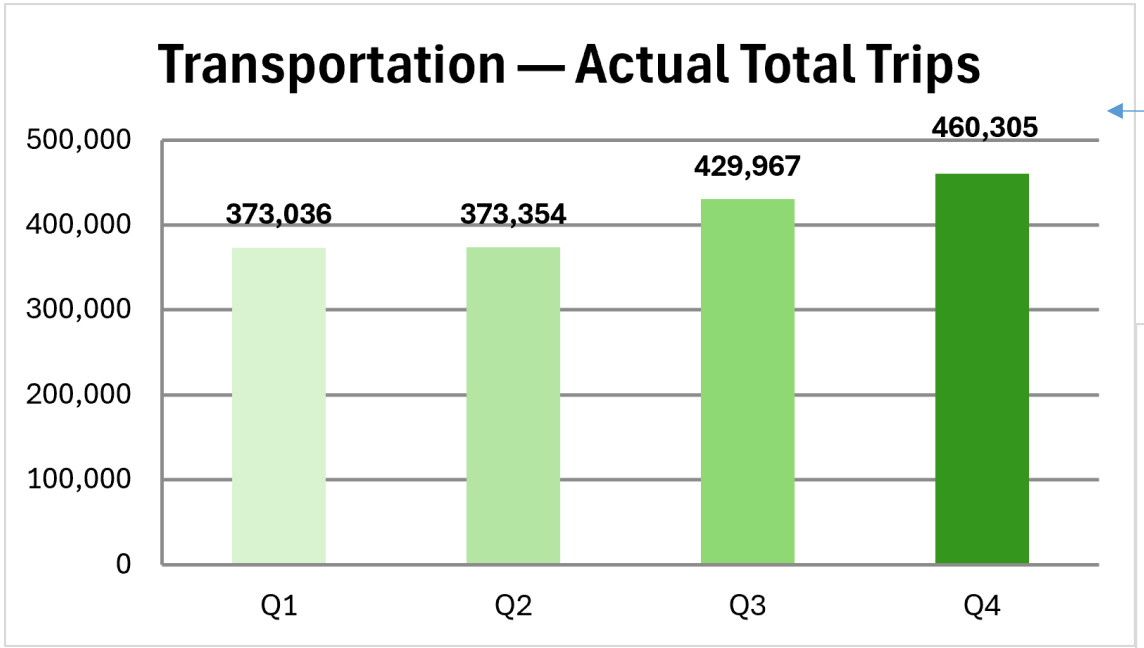
Call Center Dashboard



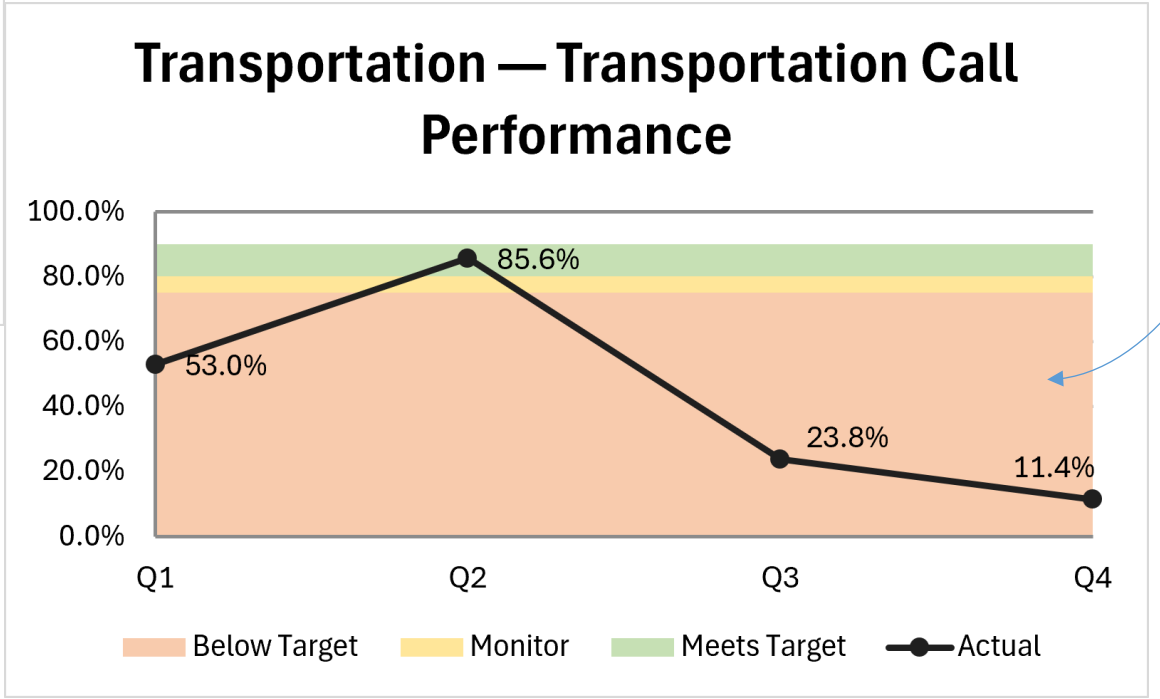




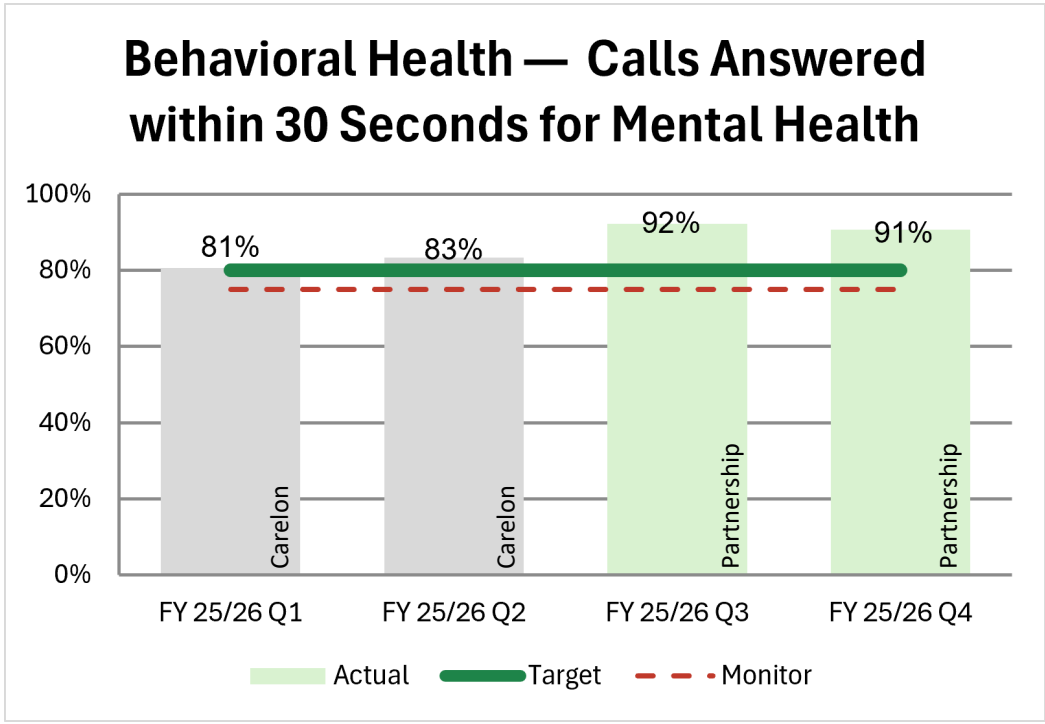
Transportation Dashboard

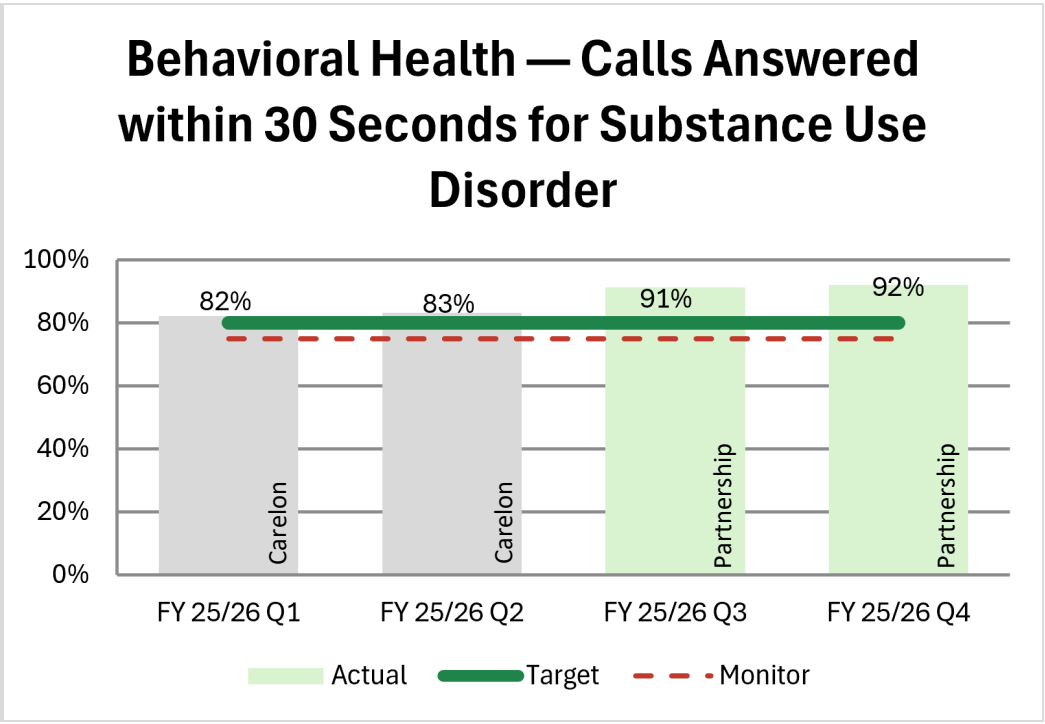


50 – 80 thousand more total trips in Q3 and Q4 respectively

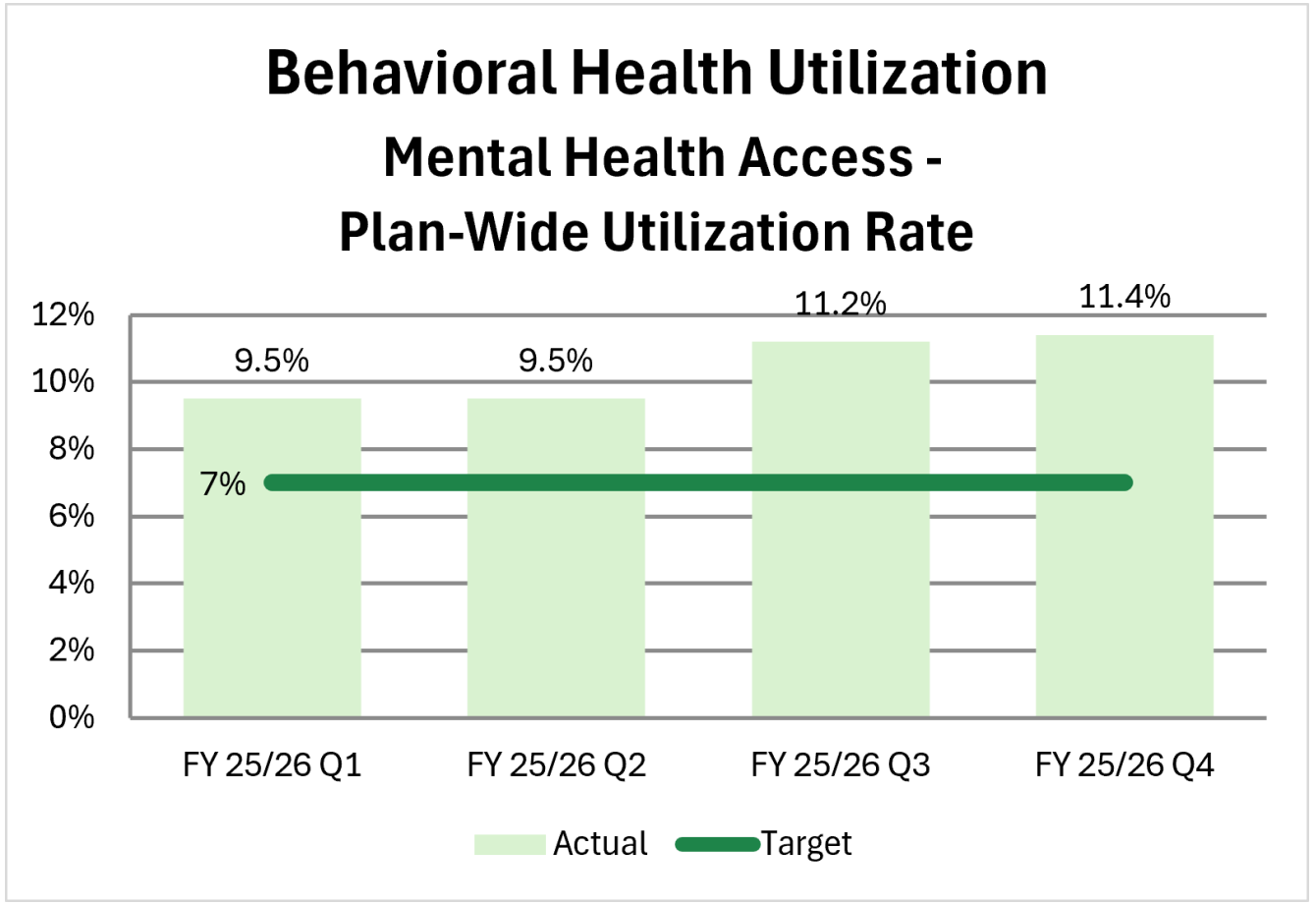


Behavioral Health Call Center Dashboard

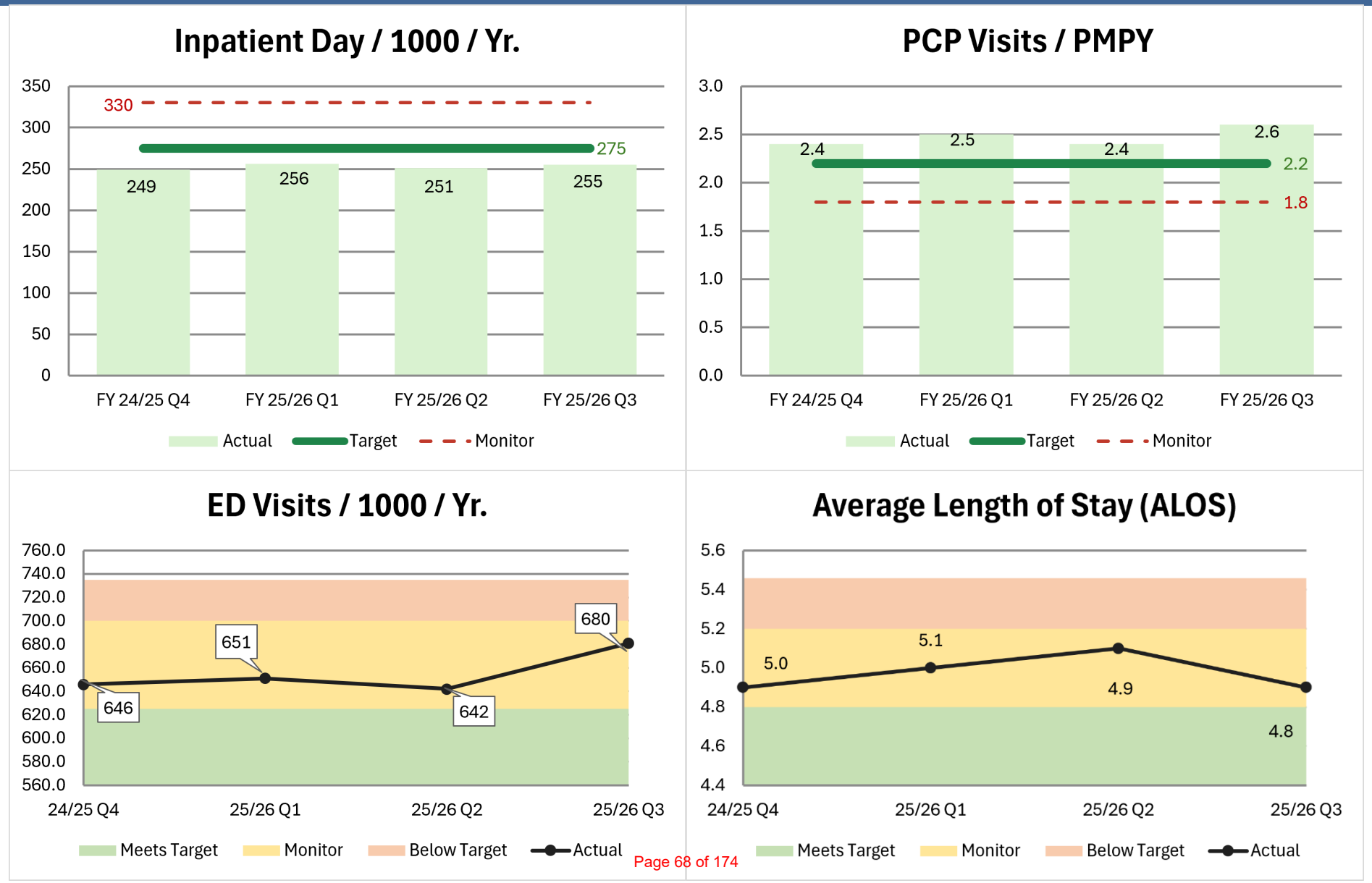




Delegate Utilization Dashboard

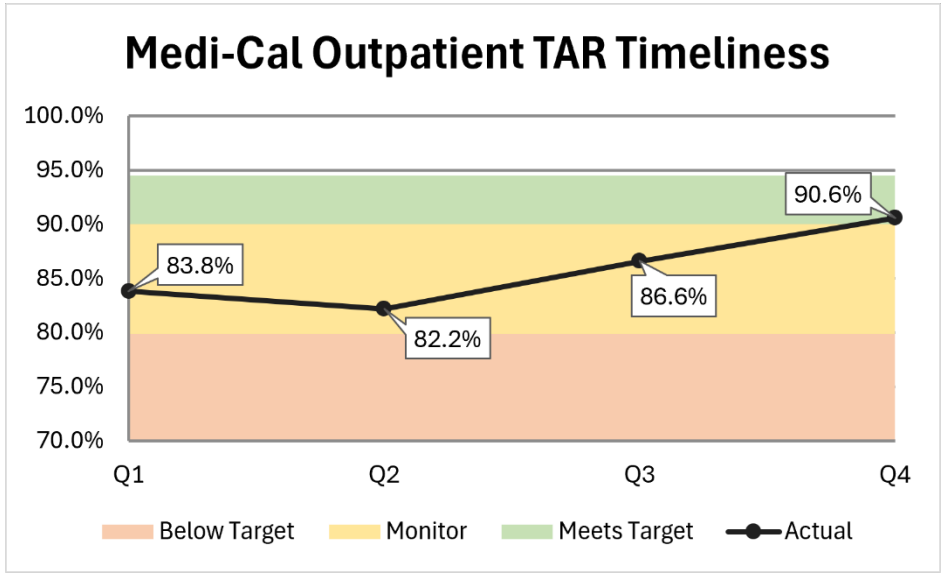


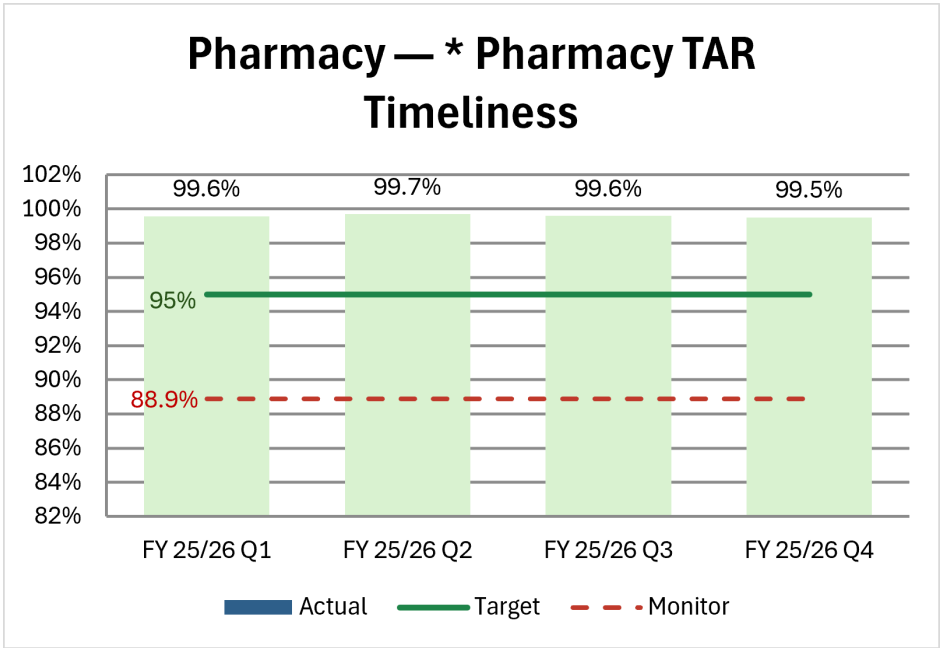
Medical Utilization Dashboard

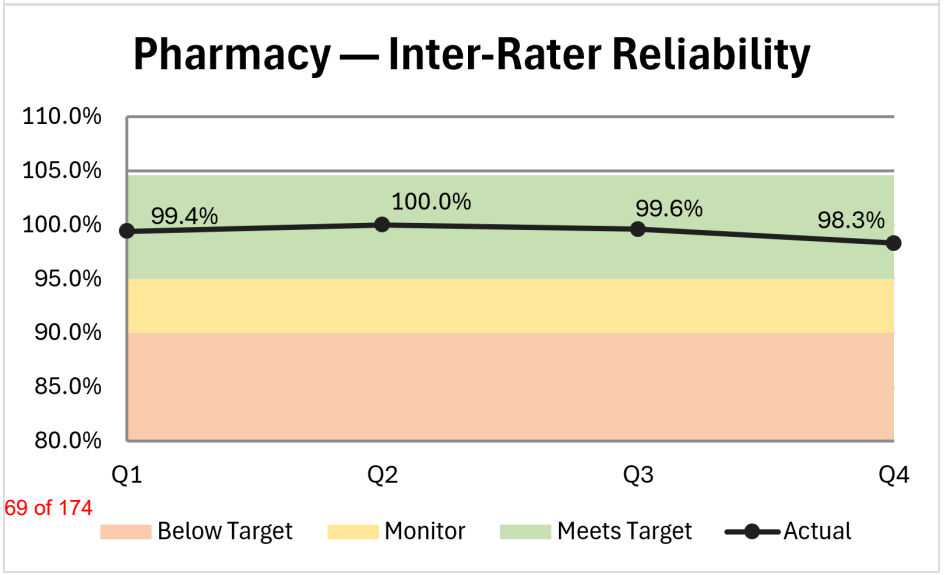


Reports one quarter behind

Treatment Authorization Request (TAR) Dashboard

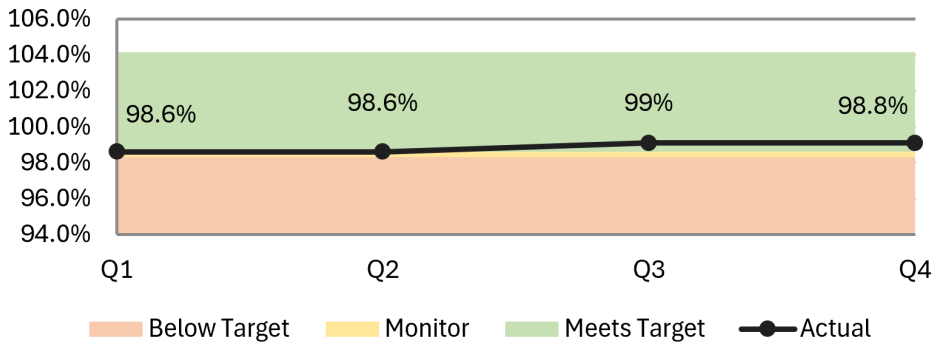




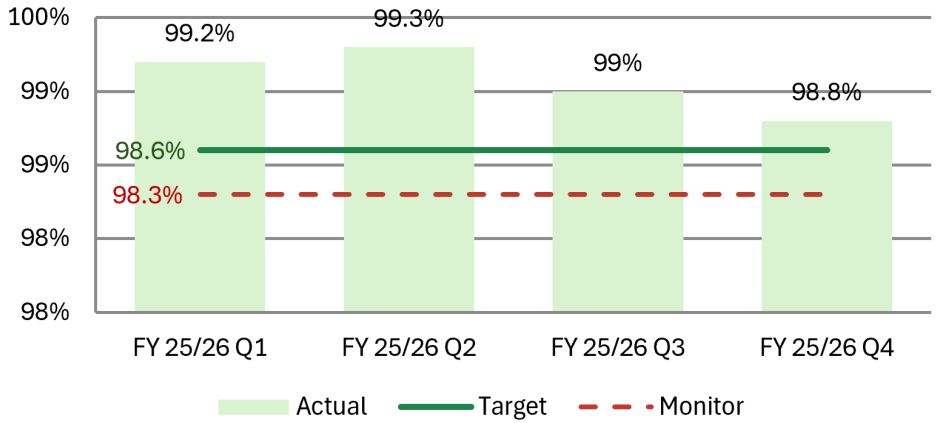


Grievances Dashboard

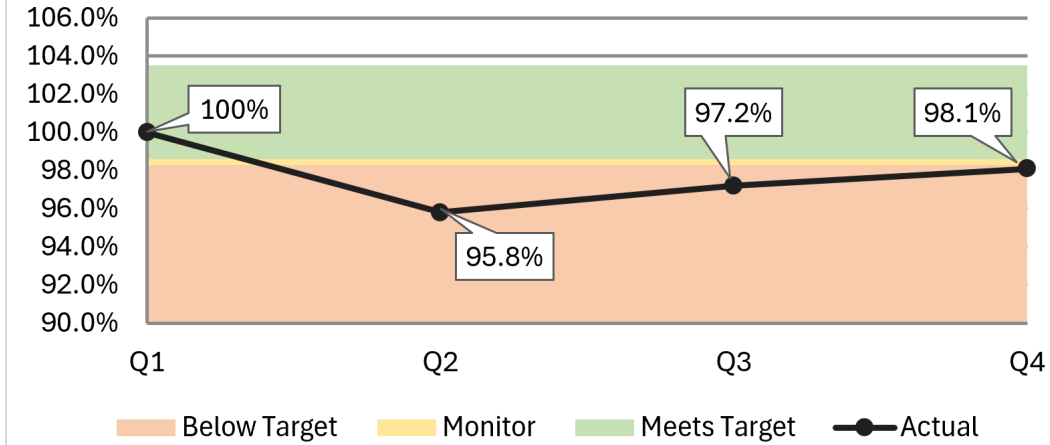
Grievances — Medi-Cal Case acknowledgement letters mailed within 5 days



Grievances — Medi-Cal Cases Closed within DHCS-Mandated Timeframes

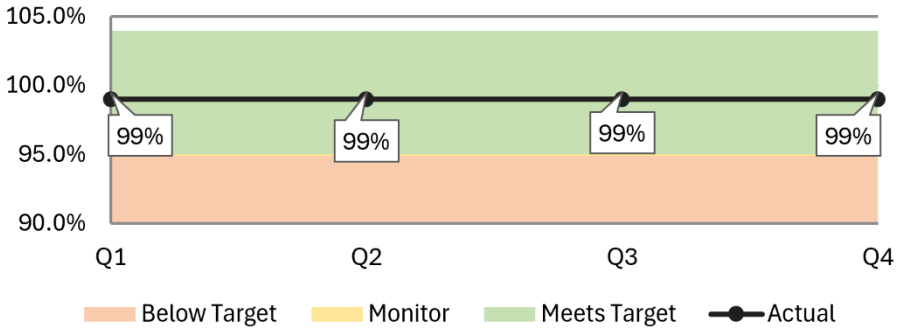


Grievances — Medi-Cal State Hearings overturned by DHCS

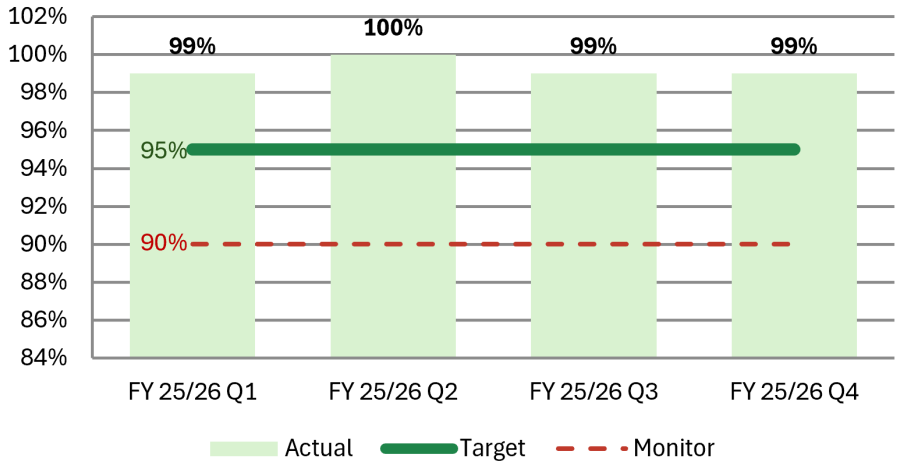


Claims Dashboard

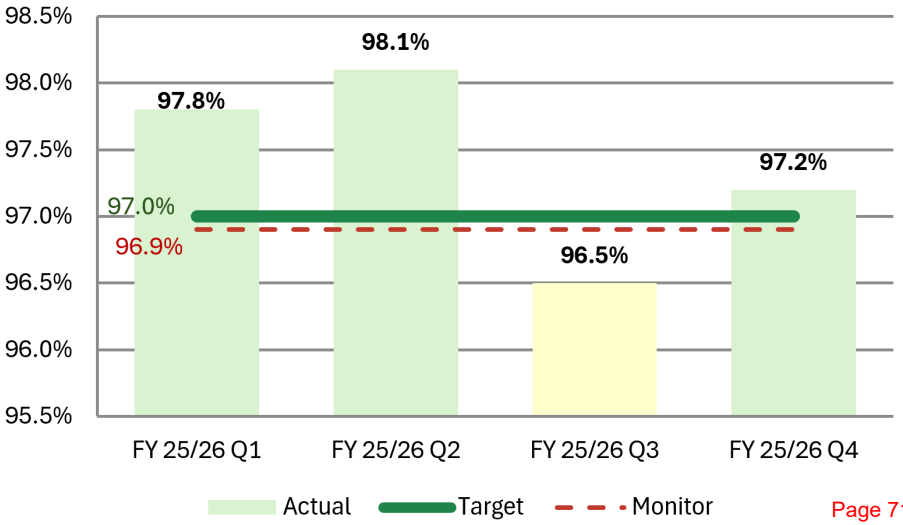
Behavioral Health — Percent of Mental Health Claims Paid within 45 Days



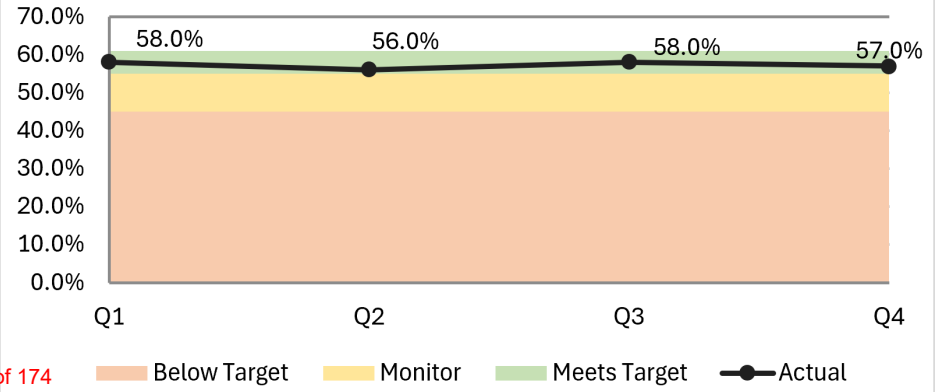
Claims — * Percent of Claims Paid / Denied Within 30 BusinessDays



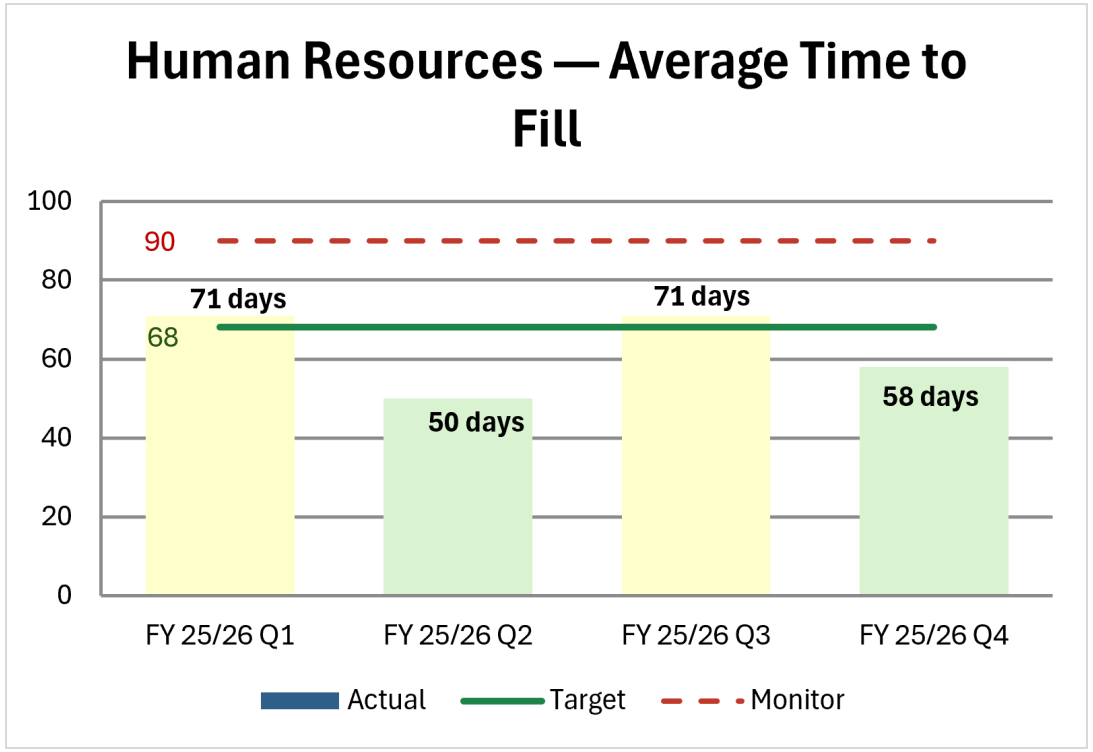
Claims — Medi-Cal Claims Accuracy

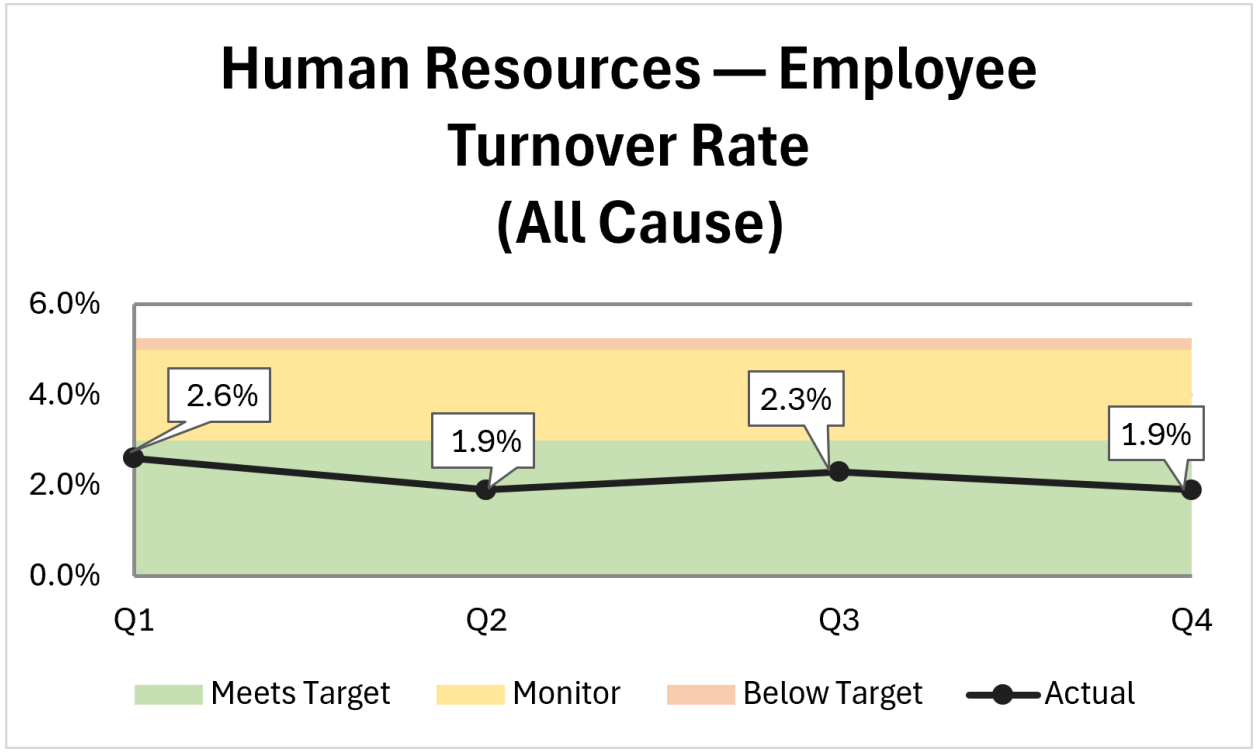


Claims — Percent of Medi-Cal Claims Auto-Adjudicated

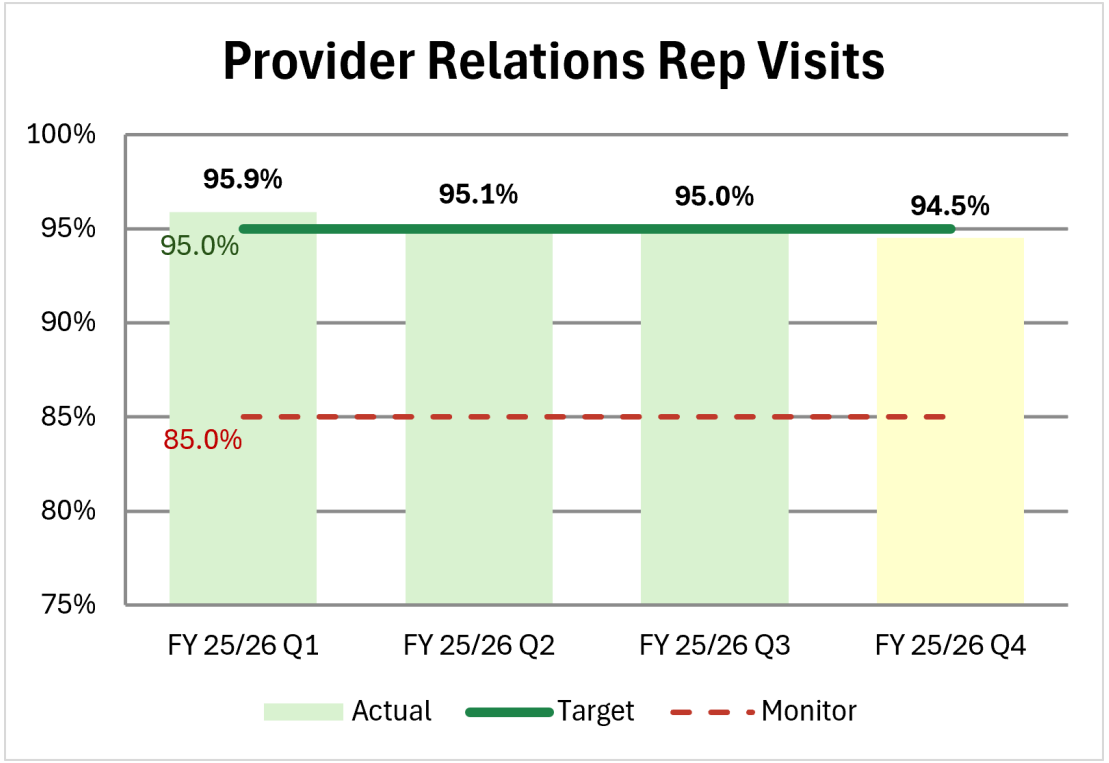


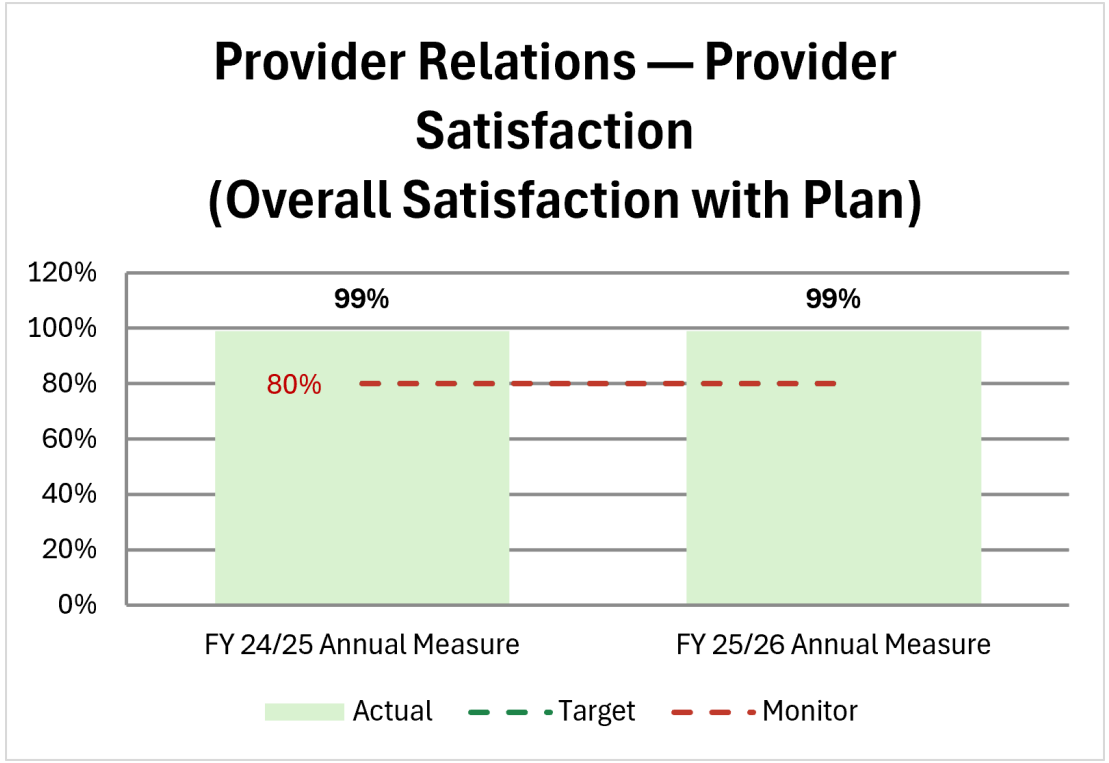
Human Resources Dashboard



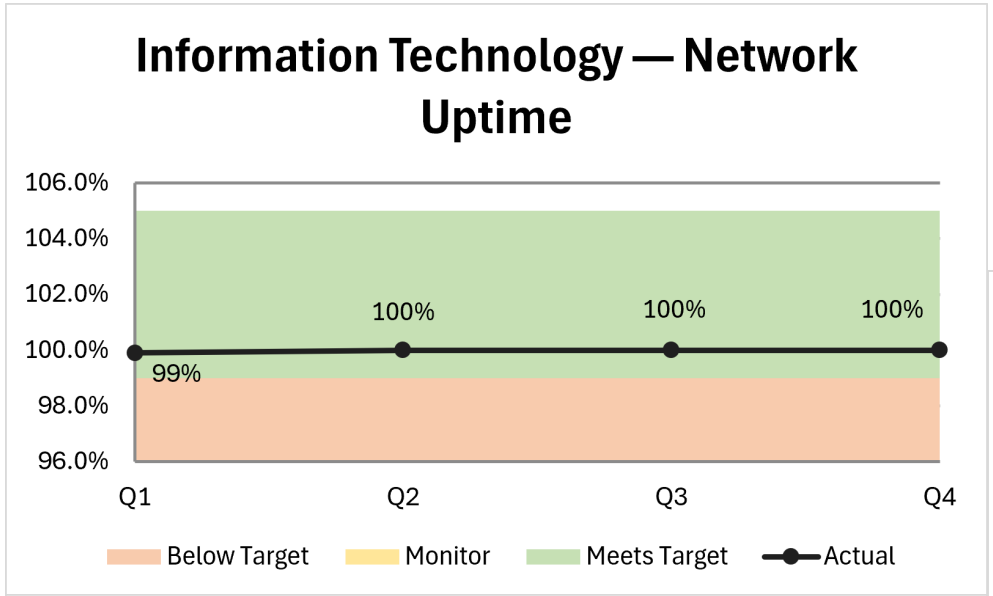


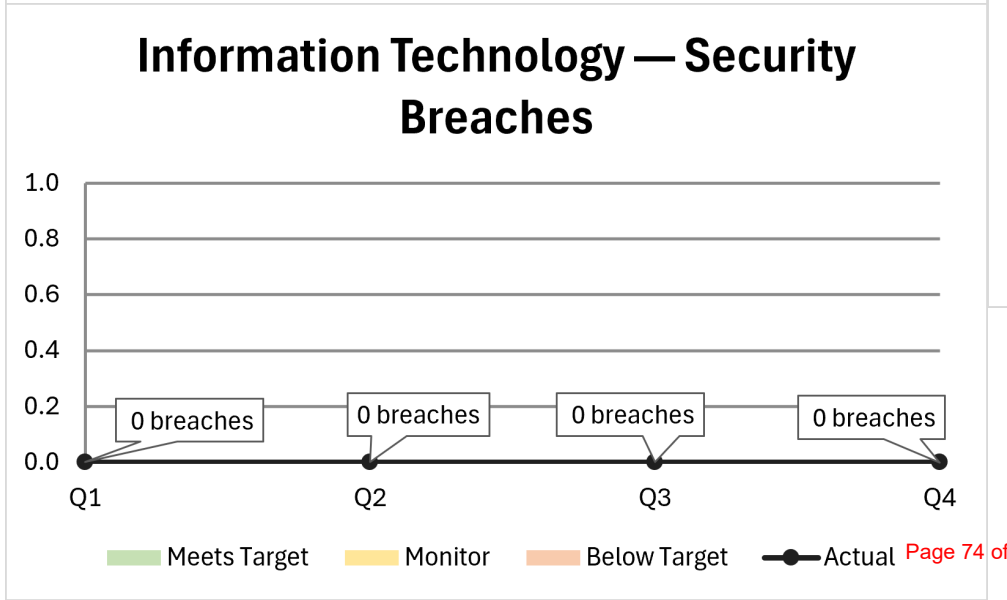
Provider Relations Dashboard

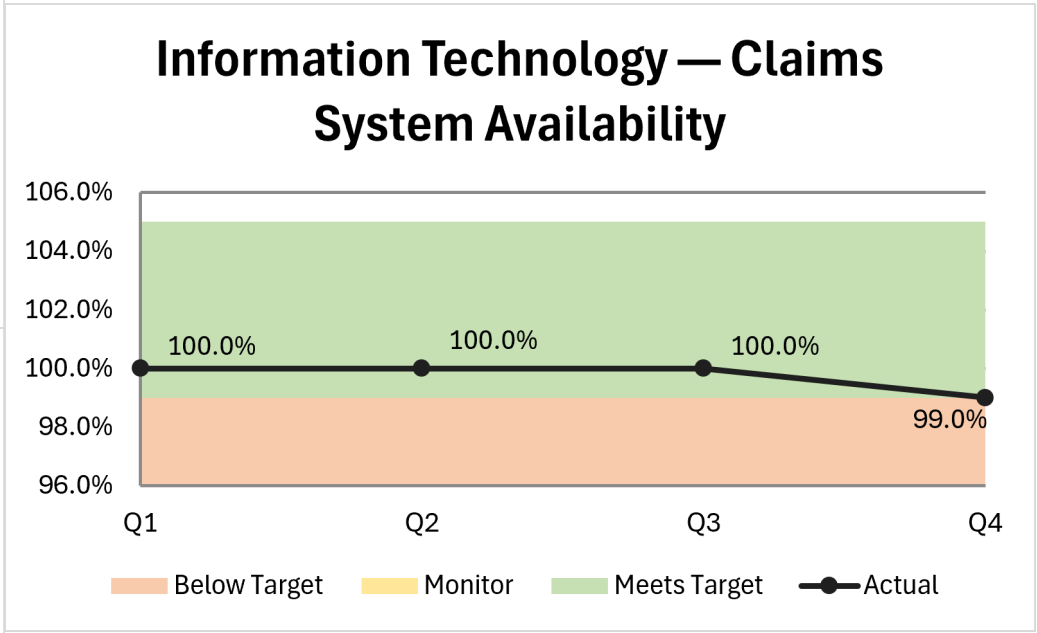




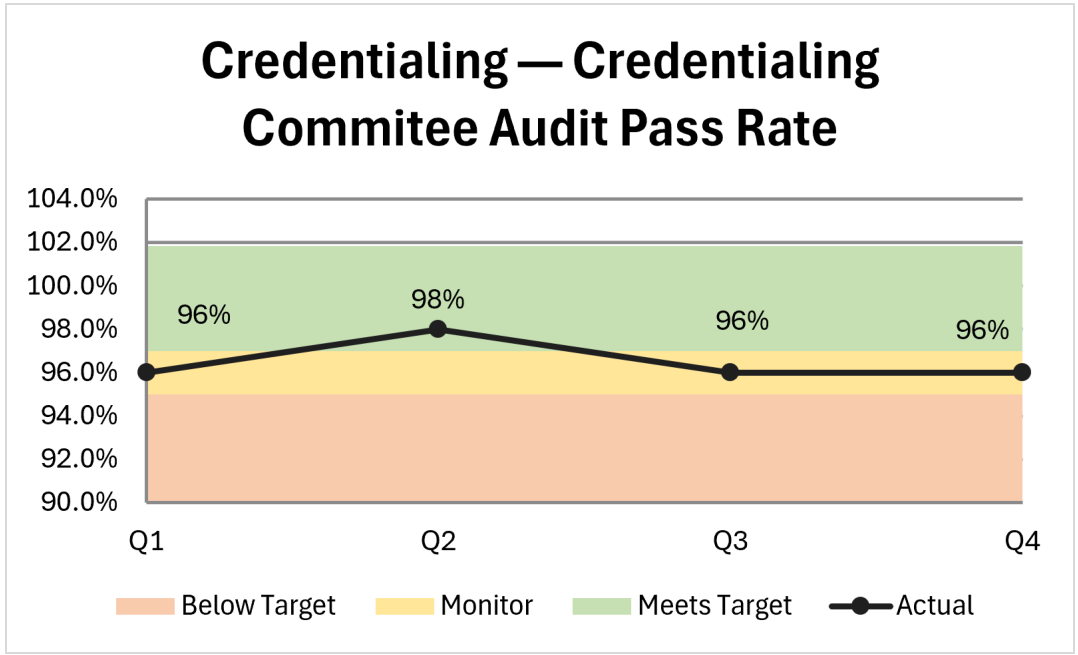
IT Dashboard

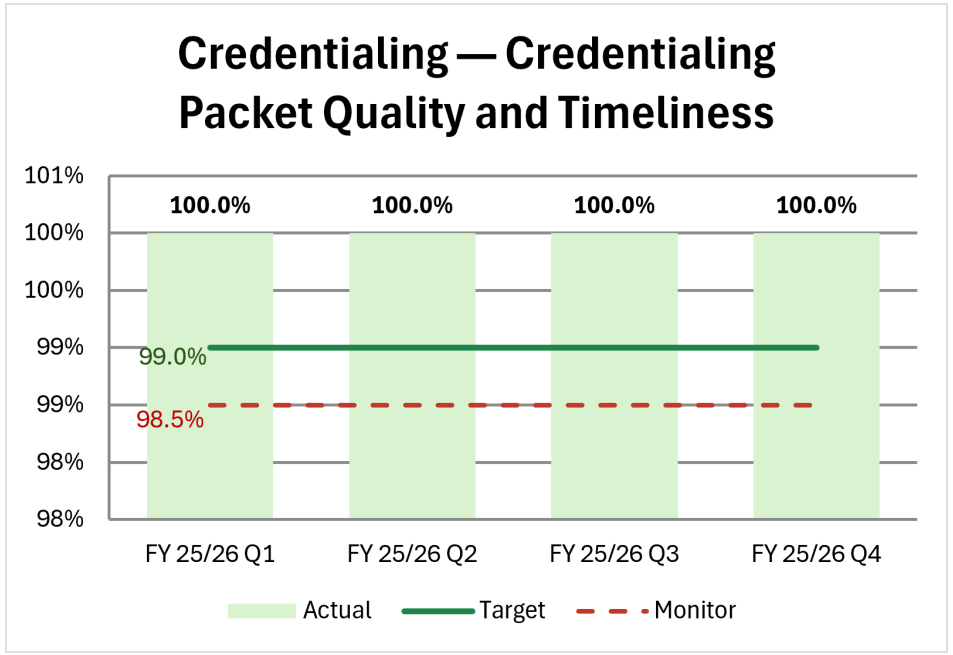




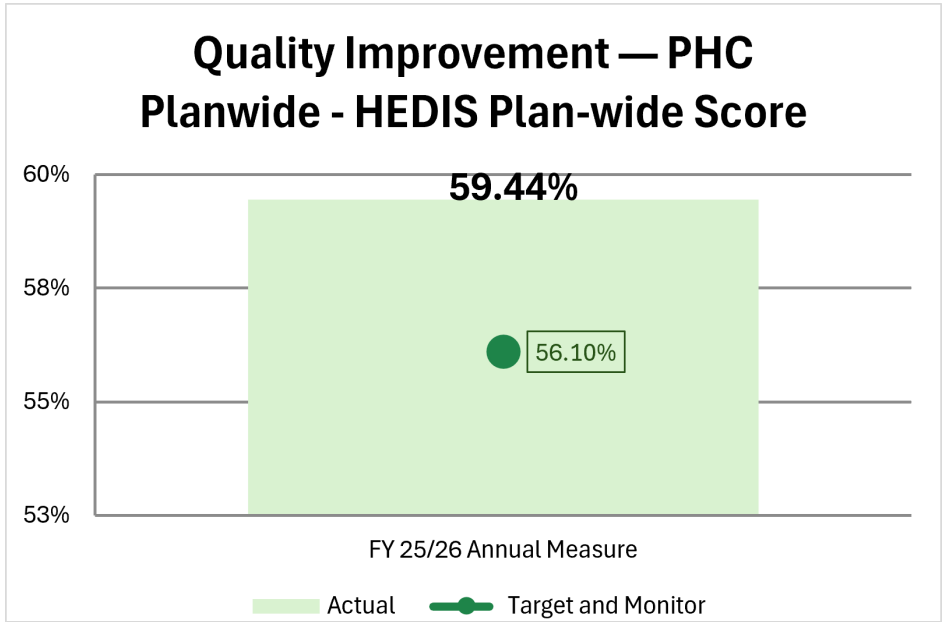


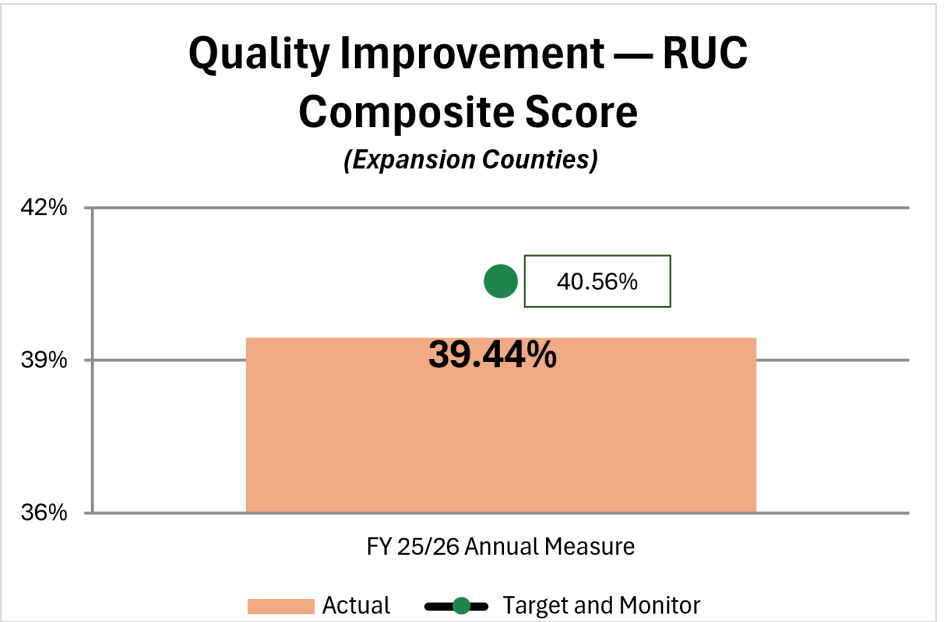
Network Services: Credentialing Dashboard

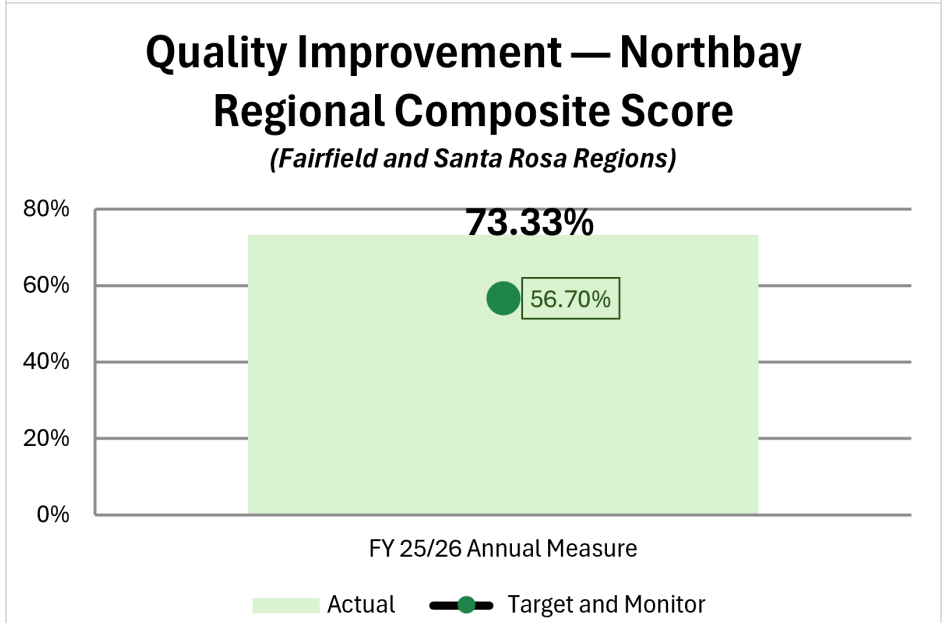


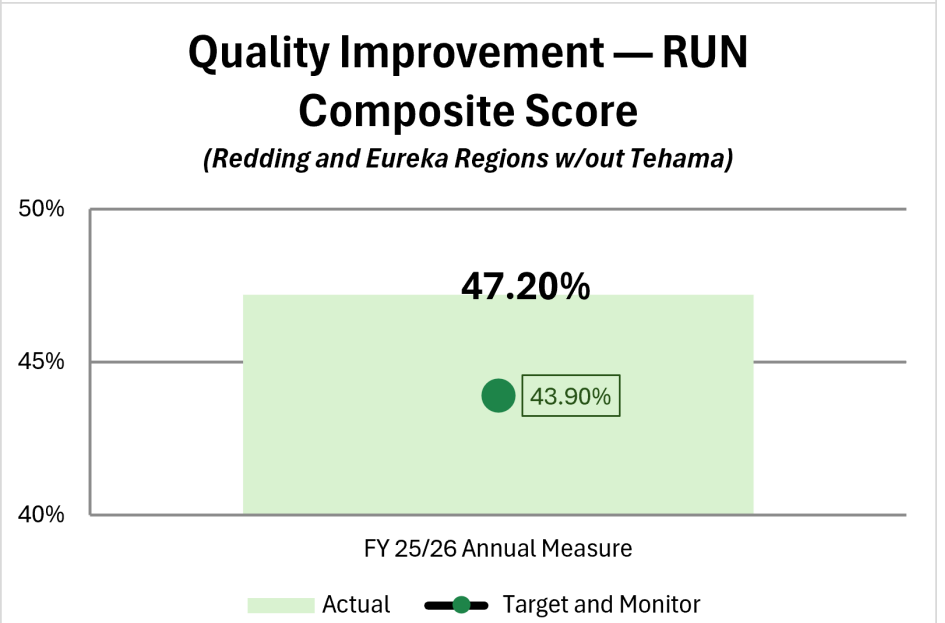


Quality Improvement Dashboard









CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: August 19, 2026
Board Meeting Date: August 26, 2026

Agenda Item Number:
4.3

Resolution Sponsor:
Sonja Bjork, Partnership HealthPlan of CA

Recommendation by:
Finance Committee

Topic Description:
The Chart of Authority policy and matrix defines the lines of authority within the HealthPlan. The policy and matrix have not been changed since November 2021.

The updated Chart of Authority provides an organization wide approval framework. The approval positions and internal control structure remain generally consistent with prior years.

The revised matrix also includes the following key changes:

- Simplifies the matrix consolidating Finance Management responsibilities, consolidating Deputy columns, replacing detailed delegation notes with a general footnote, and updating position titles.
- Renumbers and reorganizes the matrix, moves Budget to Item 1, removes Pharmacy Contracts as this is covered within Health Care Expenses, and adds items for Settlement of Claims and Pending Actions.
- Updates approval thresholds to better reflect organizational growth and current materiality levels for Item 18 - Purchase Orders, Invoices, and Check Requests and for Item 21 - General Unbudgeted All-Other.
- Added specific financial categories for Item 19 - Settlement of Claims and Item 20 - Pending Actions, which were previously encompassed within broader approval categories.

Reason for Resolution:
To provide Partnership staff's recommended changes to the current Chart of Authority policy and matrix.

Financial Impact:
There is no measurable impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to approve the attached Chart of Authority policy and matrix.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: August 19, 2026
Board Meeting Date: August 26, 2026

Agenda Item Number:
4.3

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE REVISIONS TO THE CHART OF AUTHORITY MATRIX

Recital: Whereas,

A. The Board is responsible for financial oversight.

B. The Chart of Authority policy and matrix have not been changed since November 2021.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the attached Chart of Authority policy and matrix.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August, 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

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: FIN301</td><td colspan="3">Lead Department: Finance
Business Unit: Accounting</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Chart of Authority and Delegation</td><td colspan="3">☐ External Policy
☒ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/19/2002</td><td colspan="4">Next Review Date: 08/26/2027
Last Review Date: 08/26/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td><td colspan="2">☒ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☐ IQI</td><td>☐ P & T</td><td colspan="2">☐ QUAC</td><td></td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☒ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☒ BOARD</td><td>☐ COMPLIANCE</td><td>☒ FINANCE</td><td>☐ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Name of approver</td><td colspan="3">Approval Date: Enter as mm/dd/yyyy</td></tr>
</table>

I. RELATED POLICIES:

A. ADM44 Non-provider Contract Administration
B. LAU06 Government Claims
C. FAC01 Vehicle Purchase and Use
D. FIN201 Capital Assets
E. FIN202 Requisitioning Goods, Equipment, and or Service Open PO System
F. FIN302 Accounts Payable and Recognizing Expenses
G. FIN501 Investment Policy
H. FIN506 Cash and Cash Equivalents Policy
I. HR506 Employee Reimbursement for Employee Growth & Career Development
J. IT001 Software/Hardware Purchasing and Installation
K. MPPR200 Partnership Provider Contracts

II. IMPACTED DEPTS:

A. All Departments

III. DEFINITIONS:

A. Financial Category – Classification or grouping used to organize financial information, transactions, or accounts based on their nature or purpose (revenue or expense category, or other financial statement category)
B. Financial Obligation – Contractual duty to provide monetary commitment owed to another
C. Budget Status –
   1. Budgeted – Amounts included in the annual budget approved by the Board of Commissioners
   2. Unbudgeted – Amounts not included in the annual budget approved by the Board of Commissioners
D. Claims(s) – refers to individual claims and disputes or a single presented claim
E. Department Head and Other Personnel – Directors of the various departments and their delegates.
F. Deputy – The assigned delegates who, upon approval, assumes the decision-making authority of the individual they are acting for
G. Finance Management – Members of the Finance leadership team
H. Financial Impact – A change in revenue, costs, profit, or overall financial health resulting from a specific activity or situation.

IV. ATTACHMENTS:

Policy/Procedure Number: FIN301		Lead Department: Finance
Policy/Procedure Title: Chart of Authority and Delegation		☐ **External Policy** ☒ **Internal Policy**
Original Date: 04/19/2002		**Next Review Date: 08/26/2027** **Last Review Date: 08/26/2026**
Applies to:	☒ **Medi-Cal**	☒ **Employees**

V. PURPOSE:

To promote consistent business practices and sound corporate governance by establishing clearly defined authorization limits while safeguarding the assets of Partnership HealthPlan of California (Partnership).

This document serves as the authoritative reference for the Partnership's authority limits and should be read in conjunction with related policies and procedures.

The principal objectives of the policy are to establish:

1. authoritative limits that appropriately empower management to make operational and strategic decisions on behalf of the Partnership, including entering into contracts and commitments and approving the acquisition, use, or disposition of Partnership assets in the normal course of business;
2. the delegation of those authorization limits; and
3. assigned responsibilities for each financial category.

VI. POLICY / PROCEDURE:

A. The authorization limits within this policy cannot be altered without the Board of Commissioners' authorization.

B. All staff members are expected to understand their authorization limits and related policies, as well as those of their direct reports. They are to exercise a duty of care with respect to commitments, contracts, and decisions made on behalf of Partnership.

C. An individual may not act beyond their authorized limits or where a transaction exceeds the individual's level of authority. However, if the primary approver is unavailable, approval authority may be delegated to another management team member for invoices and POs only. Contracts and other significant commitments require specific written delegation, while investments and bank signatures may not be delegated under this provision. Additionally, the CEO or CFO may authorize the use of their signature "stamp" in writing during their absence.

D. When an individual's authority limit is exceeded by a single transaction, escalation to the next level will occur. In certain circumstances, such as large and/or unusual transactions, proper execution may require the approval of more than one individual.

E. Delegates are assigned to the position, not to the individual occupying the position. The responsibilities are assigned to positions that possess sufficient expertise and decision-making authority to perform delegated responsibilities effectively, irrespective of role assignment or personnel changes.

F. Delegation

1. The Chief Financial Officer (CFO), Chief Operating Officer (COO) can delegate their signing and approval authority to their respective deputies with the approval of the Chief Executive Officer (CEO).
2. The CEO may delegate their approval authority in accordance with Board-approved authorization limits and delegation authority.
3. In the instance that a delegate is assigned and approved, the delegate (referred to as the Deputy) will model the same authority levels as the position for which they are acting.
4. In the absence of the CFO, the CFO can delegate their signing and approval authority to the Sr. Director of Financial Analysis for HCC related items, and to the Controller for all other items.

G. Practices that undermine the intention of this policy are expressly prohibited. Such practices include, but not limited to:
   1. splitting large orders into smaller parts to override authorization limits;
   2. entering a purchase order for either goods or services that is knowingly insufficient for completion of the work required or goods ordered; and
   3. exercising a Deputy's power where the delegated responsibilities have a real and/or perceived conflict of interest. Where any doubt involving conflict of interest exists, authority for approval of the transaction should be escalated to the next authority level.

VII. REFERENCES:

A. FIN301 Chart of Authority Matrix

VIII. DISTRIBUTION:

A. PowerDMS

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Controller/Sr. Director of Accounting and CFO

X. REVISION DATES:

Revised November 2021 -Final Approved by Finance Committee November 2021 and Board Consent Calendar December 2021

Revised September 2014-Final Approved by Finance Committee September 2014 and Board Consent Calendar October 2014

PREVIOUSLY APPLIED TO:

Healthy Kids MPUG3112 (Healthy Kids program ended 12/01/2016) 02/18/15; 02/17/16 to 12/01/2016

Partnership Advantage: MPUG3112 - 02/15/2012 to 01/01/2015

Healthy Families: MPUG3112 - 02/15/2012 to 03/01/2013

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: ~~FIN - 301~~FIN301			**Lead Department: Finance** Business Unit: Accounting	
Policy/Procedure Title: ~~Chart of Authority and Delegation (Previously Financial Chart of Authority - CEO Delegation Revised September 2014)~~Chart of Authority and Delegation			☐ **External Policy** ☒ **Internal Policy**	
Original Date: 04/19/2002		**Next Review Date:** ~~10/31/2022~~08/26/2027 **Last Review Date:** ~~10/31/2021~~08/26/2026		
Applies to:	☒ **Medi-Cal**	☒ **Partnership Advantage**	☐☒ **Employees**	
Reviewing Entities:	☐ **IQI**	☐ **P & T**	☐ **QUAC**	
	☐ **OPERATIONS**	☒ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☒ **BOARD**	☐ **COMPLIANCE**	☒ **FINANCE**	☐ **PAC**
	☐~~☒~~ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: Name of approver			**Approval Date:** Enter as mm/dd/yyyy	

I. RELATED POLICIES:

A. ADM44 Non-provider Contract Administration
B. ~~ADM51~~LAU06 Government Claims
C. FAC01 Vehicle Purchase and Use~~ - FAC~~
D. FIN201 Capital Assets
E. FIN202 Requisitioning Goods, Equipment, and or Service Open PO System
F. FIN302 Accounts Payable and Accrued Expenses
G. FIN501 Annual Investment Policy
H. FIN506 Cash Policy
I. HR506 Employee Reimbursement for Employee Growth & Career Development
J. IT001 Software/Hardware Purchasing and Installation
K. MPPR200 Partnership ~~PHC~~ Provider Contracts

II. IMPACTED DEPTS:

A. All Departments

III. DEFINITIONS:

A. Financial Category – ~~Revenue~~Classification or grouping used to organize financial information, transactions, or accounts based on their nature or purpose (revenue or expense category, or other financial statement category)
B. Financial Obligation – ~~Source of financial obligation~~Contractual duty to provide monetary commitment owed to another
C. Budget Status –
   1. Budgeted – Amounts included in the annual budget approved by the Board of Commissioners
   2. Unbudgeted – Amounts not included in the annual budget approved by the Board of Commissioners

~~2.~~D. Claim(s) –refers to individual claims and disputes or a single presented claim
~~D.~~E. Department Head and Other Personnel – Directors of the various departments and their delegates.
F. Deputy – The assigned delegates who, upon approval, assumes the decision-making authority of the individual they are acting for
~~E.~~G. Finance Management – Members of the Finance leadership team ~~of the finance department~~
~~F. CFO – Chief Financial Officer~~
~~G. COO – Chief Operating Officer~~
~~H. CEO – Chief Executive Officer~~

Policy/Procedure Number: FIN - 301FIN301		Lead Department: Finance
Policy/Procedure Title: ~~Chart of Authority and Delegation (Previously Financial Chart of Authority – CEO Delegation Revised September 2014)~~Chart of Authority and Delegation		☐ **External Policy** ☒ **Internal Policy**
Original Date: 04/19/2002		**Next Review Date: 10/31/202208/26/2027** **Last Review Date: 10/31/202108/26/2026**
Applies to:	☒ **Medi-Cal**	☒ **Employees**

~~I. CMO – Chief Medical Officer~~

H. Financial Impact – A change in revenue, costs, profit, or overall financial health resulting from a specific activity or situation.

IV. ATTACHMENTS:

~~A. Chart of Authority Matrix~~

V. PURPOSE:

To ~~ensure~~promote consistent ~~good~~ business ~~practice~~practices and sound corporate governance ~~as well as safeguard company assets with~~ by establishing clearly defined authorization limits ~~and their delegations within~~while safeguarding the assets of Partnership ~~Health Plan~~HealthPlan of California (~~PHC~~Partnership).

~~VI.~~ POLICY / PROCEDURE:

This document serves as the authoritative reference for the Partnership's authority limits and should be read in conjunction with related policies and procedures.

The principal objectives of the policy are to establish:

~~1. Authority~~authoritative limits ~~appropriate to~~that appropriately empower management to ~~be able to act effectively~~make operational and ~~make key~~strategic decisions ~~in relation to~~ on behalf of the ~~PHC;~~

~~2.~~1. ~~Authority limits for~~Partnership, including entering into contracts~~,~~ and commitments and ~~appropriating company~~approving the acquisition, use, or disposition of Partnership assets in the normal course of ~~conducting company~~ business;

~~3.~~2. ~~The requirements for~~ the delegation of those ~~authority~~authorization limits; and

~~4.~~3. ~~Responsibilities of review~~assigned responsibilities for each financial category.

VI. POLICY / PROCEDURE:

~~B. This document serves as a single point of reference for the PHC's authority limits. This Policy does not replace other specific policies in relation to the procedures to be followed for particular types of activities and should be read in conjunction with these other policies and procedures. If there is a conflict between this policy and any other policy, the requirements noted in this policy will prevail.~~

~~C.~~A. The authorization limits within this policy cannot be altered without the Board of Commissioners' authorization.

~~D.~~B. All staff members are expected to understand their authorization limits and related policies, as well as those of their direct reports. They are to exercise a duty of care with respect to commitments, contracts, and decisions made on behalf of ~~the organization~~Partnership.

~~E.~~C. An individual may not act ~~as if they have authority where they have no authority~~ beyond their authorized limits or where a transaction exceeds the individual's level of authority. However, if the primary approver is unavailable, approval authority may be delegated to another management team member for invoices and POs only. Contracts and other significant commitments require specific written delegation, while investments and bank signatures may not be delegated under this provision.

Additionally, the CEO or CFO may authorize the use of their signature "stamp" in writing during their absence.

~~F.~~D. When an individual's authority limit is exceeded by a single transaction, escalation to the next level will occur. In certain circumstances, such as large and/or unusual transactions, proper execution may require the approval of more than one individual.

~~G.~~E. ~~Delegations~~Delegates are ~~attached~~assigned to the position ~~occupied~~, not to the ~~occupant of~~ individual occupying the position. The responsibilities ~~of a position appear in a~~ are assigned to positions that possess sufficient expertise and decision-making authority to perform delegated responsibilities effectively, irrespective of role ~~description appropriate to the position.~~ assignment or personnel changes.

~~H.~~F. Delegation

1. The Chief Financial Officer (CFO ~~and~~), Chief Operating Officer (COO) can delegate their signing and approval authority to their respective deputies with the approval of the ~~CEO.~~Chief Executive Officer (CEO).
2. ~~In the absence of the CFO or upon delegation of the CFO and~~ The CEO may delegate their approval ~~by the CEO, the Deputy CFO's~~ authority ~~models~~in accordance with Board-approved authorization limits and delegation authority.
~~2.~~3. In the instance that ~~of the CFO.~~a delegate is assigned and approved, the delegate (referred to as the Deputy) will model the same authority levels as the position for which they are acting.
~~3.~~4. In the absence of the CFO, the CFO can delegate their signing and approval authority to the Sr. Director of Financial Analysis~~.~~ for HCC related items, and to the Controller for all other items.~~0~~

~~I.~~G. Practices that undermine the intention of ~~the Policy~~this policy are expressly prohibited. Such practices include, but not limited to:

1. ~~Splitting~~splitting large orders into smaller parts to override authorization limits;
2. ~~Entering~~entering a purchase order for either goods or services that is knowingly insufficient for completion of the work required or goods ordered; and
3. ~~Exercising~~exercising a ~~delegate's~~Deputy's power where the ~~individual with the power of delegation has~~delegated responsibilities have a real and/or perceived conflict of interest.
~~4.~~3. Where any doubt involving conflict of interest exists, authority for approval of the transaction should be escalated to the next authority level.

VII. REFERENCES:

~~A. None~~
A. FIN301 Chart of Authority Matrix

VIII. DISTRIBUTION:

A. PowerDMS

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Controller/Sr. Director of Accounting ~~-~~and CFO

X. REVISION DATES:

Policy/Procedure Number: FIN - 301FIN301		Lead Department: Finance
Policy/Procedure Title: ~~Chart of Authority and Delegation (Previously Financial Chart of Authority – CEO Delegation Revised September 2014)~~Chart of Authority and Delegation		☐ **External Policy** ☒ **Internal Policy**
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Applies to:	☒ **Medi-Cal**	☒ **Employees**

Revised November 2021 -Final Approved by Finance Committee November 2021 and Board Consent Calendar December 2021

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PREVIOUSLY APPLIED TO:

Healthy Kids MPUG3112 (Healthy Kids program ended 12/01/2016) 02/18/15; 02/17/16 to 12/01/2016

Partnership Advantage: MPUG3112 - 02/15/2012 to 01/01/2015

Healthy Families: MPUG3112 - 02/15/2012 to 03/01/2013

Partnership HealthPlan of California

Chart of Authority Matrix

Revised August 2026 - Final Approved by Finance Committee XXXXXX and Board Consent Calendar XXXXXX									
Item #	**Financial Category**	**Financial Obligation**	**Budget Status**	**Department Head and Other Personnel**	**Finance Management**	**CFO or Deputy CFO***	**COO or Deputy COO***	**CEO or Deputy CEO***	**Board of Commissioners**
1	**Budget**	All Areas	Budget Development	Prepares and recommends Department Specific Costs	Finance Management determines financial impact and compiles budget	•Reviews financial impact and makes recommendations to CEO •Presents final budget to the Board		Recommends to the Board	Approves Budget
2	**Revenue**	Execute Government Contracts (State and Federal)	Budgeted & Unbudgeted	Revenue rates are externally developed and analyzed by Finance Management	Finance Management determines financial impact	• Reviews All • CFO & CEO presents and recommends to the Board significant program changes. Revenue and health care cost impacts are presented in conjunction with the budget. Material changes from the budget will be brought back to the Board for approval as needed.		• Reviews All • CFO & CEO Presents and recommends to the Board significant program changes. Revenue and health care cost impacts are presented in conjunction with the budget. Material changes from the budget will be brought back to the Board for approval as needed.	Approves Budget
3	**Revenue**	Execute Other Sources of Revenue Contracts (i.e. Rental Income, Grant Revenue, etc.)	Budgeted	Finance Staff determine financial impact or works with Finance Management Team to determine impact	Finance Management determines financial impact	• Reviews All • CFO & CEO Recommends to the Board as considered necessary		• Reviews All • Recommends to the Board as considered necessary	• Approves Budget • Approves Rates as Applicable
4	**Healthcare Expense**	Provider Contracts	Budgeted	• Provider Contracting Unit/Management and Provider Payment Strategy Unit/Management initiates and recommends	Finance Management, as delegated by CFO, determines financial impact	CFO or CFO delegate reviews Financial impact and makes recommendations to CEO and/or COO	Reviews and makes recommendations to CFO and CEO	Reviews and authorizes, can delegate authorization to Deputy CEO, CFO and/or COO based on approved internal policy and within budget	• Approves Budget • Approves reimbursement mechanisms and concepts
5	**Healthcare Expense**	Enhanced Member Benefits	Budgeted	CMO reviews and recommends	Finance Management, as delegated by CFO, determines financial impact	Reviews Financial impact and makes recommendations to CEO		• Authorizes all within Budget • Recommends changes to the Board	• Approves Budget • Approves New Benefits
6	**Other Healthcare Expense**	Other Healthcare Cost Contracts (i.e. Care Management Programs, Ancillary Services, Advice Nurse, Transportation, etc.)	Budgeted	• Project Manager and/or Department Head Initiates and Recommends as needed • CMO and CHSO initiates and recommends when related to Care Management Program	Finance Management, as delegated by CFO, determines financial impact	Reviews financial impact and makes recommendations to CEO and/or COO	Reviews services applicable to areas of responsibility	Reviews and authorizes, can delegate authorization to Deputy CEO, CFO and/or COO based on approved internal policy and within budget	• Approves Budget • Approves reimbursement mechanisms and concepts
7	**Other Healthcare Expense**	Quality Improvement Program (QIP)	Budgeted	CMO initiates and recommends	Finance Management, as delegated by CFO, determines financial impact	Reviews financial impact and makes recommendations to CEO		Reviews and authorizes, can delegate authorization to Deputy CEO and CFO based on approved internal policy and within budget	• Approves Budget • Approves reimbursement mechanisms and concepts
8	**Employee Expenses**	Staffing and Salary Increases	Budgeted & Unbudgeted	• Department Head recommends staffing • CHRO reviews and approves all PAF's	Controller, in conjunction with CHRO, determines financial impact	CFO signs all PAF's, can delegate signing responsibility to Controller based on approved internal policies		• Reviews and authorizes, can delegate authorization to Deputy CEO and CFO based on approved internal policy and within budget • Approves exceptions to and reallocations of budget within total expense budget	• Approves Budget • Approves Policies, as applicable • Approves CEO's salary
9	**Employee Expenses**	Employee Benefits	Budgeted	CHRO initiates and recommends	Controller, in conjunction with CHRO, determines financial impact	Reviews all		Recommends changes to the Board	• Approves Budget • Approves Benefit Changes
10	**All other Admin Expenses**	Administrative Expenses	Budgeted	• Department Head recommends budget • Approval limits based on approved internal policies and as noted in Item #18	Authorizes according to approved internal policies and within budget. Also, see Item# 18 (Purchase Orders and Invoices).				Approves Budget
11	**All Administrative Expense Contracts**	Administrative Vendor Contracts	Budgeted	Department Head and/or Project Manager, initiates, researches and recommends	• Controller or assigned Director to Procurement works with Department Head and/or Project Manager to determine financial impact. • In some instances other Finance Management members may participate in the review, as delegated by CFO	Reviews financial impact and makes recommendations to CEO	-	Reviews and authorizes, can delegate authorization to Deputy CEO and CFO based on approved internal policy and within budget	Approves Budget
12	**Capital Purchases**	Capital Expenditures	Budgeted	Researches and recommends	Controller, assigned Director to Procurement or CFO delegate determines financial impact	Reviews financial impact and makes recommendations to CEO		Reviews and authorizes, can delegate authorization to Deputy CEO and CFO based on approved internal policy and within budget	Approves Budget
13	**Cash Management**	Banking	NA	Accounting Management maintains with CFO oversight	• Controller or Accounting Management Delegate are the authorized contacts for Bank Accounts • Controller is Authorized Signer on Bank Accounts, as delegated by CFO • Controller or Accounting Management Delegate are authorized for bank transactions per policy • Dual authorization are required on all bank portal transactions	• CFO is Authorized Signer on Bank Accounts • CFO recommends Policy		• Authorized Signer on Bank Accounts • Recommends Policy	Approves Policy
14	**Cash Management**	Investments	NA	Accounting Management maintains with CFO oversight	• Controller or Accounting Management Delegate are the Authorized Contacts for Investment Accounts • Controller authorizes the investment transactions per policy • Controller works with CFO on general Investment Principles	• CFO is Authorized Signer on Investment Accounts • CFO develops Investment Principles • CFO recommends and enforces Policy with transparency to the Board		• Authorized Signer on Investment Accounts • Recommends Policy	Approves Policy

Partnership HealthPlan of California

Chart of Authority Matrix

Revised August 2026 - Final Approved by Finance Committee XXXXXX and Board Consent Calendar XXXXXX									
Item #	**Financial Category**	**Financial Obligation**	**Budget Status**	**Department Head and Other Personnel**	**Finance Management**	**CFO or Deputy CFO***	**COO or Deputy COO***	**CEO or Deputy CEO***	**Board of Commissioners**
15	**Cash Management**	All Disbursements: Checks, Wires, ACH	NA	Accounting Management maintains with CFO oversight	Controller and Accounting Management Delegate manage process	• All Authorized Signers can sign for disbursements if all approvals required have been obtained • All physical check disbursements above $10,000 require signatures from two Authorized Signers • Payroll and Employee Reimbursement checks can not be signed by the Payee • All wire, ACH, transfers to/from a line of credit (if applicable), can be initiated by the Controller or Accounting Management Delegates, once authorized signatures have been obtained, per Item #18 •Two person approval required due to financial institution protocol for wires and ACH to confirm transaction			Approves Policy
16	**Lines of Credit and other Debt**	Short and Long Term Debt	Financing Costs are incorporated into the budget, when applicable	Accounting Management maintains with CFO oversight	• Controller works with CFO on securing new debt or credit lines as needed after obtaining authorization to do so • Controller or Accounting Management Delegate manages related accounting • Controller or Accounting Management Delegate is an authorized contact on loan accounts • Controller provides oversight for day to day lines of credit needed in the normal course of routine purchases that are included in the budget	• CFO works with CEO and the Board on securing debt as needed by the organization • CFO is Authorized Signer on approved lines of credit.		• Authorized to sign loan documents once issuance of debt is authorized by the Board. CEO can delegate the signing of the loan documents to the CFO. • Authorized Signer on approved lines of credit.	• Approves Budget • Authorizes the acquisition of debt through Board Resolution approval
17	**Annual Financial Audit**	All Areas	NA	Accounting Management maintains with CFO oversight	Controller or Accounting Management Delegate manages process	CFO recommends Audit Firm and Oversees		Recommends Audit Firm	• Accepts Report • Appoints Audit Firm
18	**Purchase Orders, Invoices and Check Requests**	All Areas	Budgeted & Unbudgeted	• Once appropriate approvals have been obtained for expense and capital items noted above, Purchase Orders, Invoices and Check Requests will be authorized as follows: $5,000 or below: Department Head $5,001 to $50,000: Department Head and Controller $50,001 to $100,000: Department Head, Controller, and CFO $100,001 and above: Department Head, CEO, and CFO • CEO can delegate the signing of certain items $100,001 and above based on approved internal policies • Purchase Orders, Invoices and Check Requests for unbudgeted expenses must be approved by CEO or their designee. See Item #21 (All-Other)						Approves Budget
19	**Settlement of Claims**	Healthcare Costs	Unbudgeted	Researches and recommends	Finance Management SME determines financial impact	Reviews Financial impact and makes recommendations to CEO		Approves items up to $150,000 per individual claim based on availability of funds. CEO will periodically report such actions to the Board.	Approves items over $150,000 per individual claim
20	**Pending Actions**	Healthcare Costs	Unbudgeted	Researches and recommends	Finance Management SME determines financial impact	Reviews Financial impact and makes recommendations to CEO		Approves items up to $300,000 based on availability of funds. CEO will periodically report such actions to the Board.	Approves items over $300,000
21	**All - Other**	Items #2- 12 and Item #18	Unbudgeted	Researches and recommends	Finance Management SME determines financial impact	Reviews Financial impact and makes recommendations to CEO		Approves items up to $300,000 based on availability of funds. CEO will periodically report such actions to the Board.	Approves items over $300,000

CEO = Chief Executive Officer **CFO** = Chief Financial Officer **CHRO** = Chief Health Services Officer **COO** = Chief Operating Officer **FP&A** = Financial Planning & Analysis Team **HR** = Human Resources **SME** = Subject Matter Expert **PAF =** Personnel Action Form

**** If Deputy Position applicable. Deputy positions are granted the designated authorities in the absence of the primary Chief, or if the primary Chief explicitly delegates such authority while present.***

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Finance Committee Meeting Date:
August 19, 2026

Agenda Item Number:
4.4

Board Meeting Date:
August 26, 2026

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

Recommendation by:
Partnership Staff

Topic Description:
In October 2024, the Peter A. and Vernice H. Gasser Foundation gifted Partnership HealthPlan 1930 Jefferson Street, Napa, CA. The transfer was subject to a restrictive covenant requiring that the property be used exclusively for public and charitable purposes that support cost-effective healthcare for households with limited incomes.

Partnership has identified Community Health Initiative Napa County, Inc., a California nonprofit corporation, as an entity that can fulfill the use restrictions. The Board of Commissioners is asked to authorize the Chief Executive Officer to gift 1930 Jefferson Street, Napa, CA, to Community Health Initiative Napa County, Inc.

Reason for Resolution:
To obtain board approval to authorize the Chief Executive Officer to gift 1930 Jefferson Street, Napa, CA, to Community Health Initiative Napa County, Inc.

Financial Impact:
Escrow and transfer fees are estimated to be no more than $10,000. Upon transfer of the property, Partnership staff estimate that Partnership will recognize an asset reduction/disposal of $861,465 because the property has not been fully depreciated.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is being asked to approve authorizing the Chief Executive Officer to gift this property to Community Health Initiative Napa County, Inc.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Finance Committee Meeting Date:
August 19, 2026

Agenda Item Number:
4.4

Board Meeting Date:
August 26, 2026

Resolution Number:
26-

IN THE MATTER OF: AUTHORIZING THE CEO TO GIFT A PROPERTY

Recital: Whereas,

A. The Board is responsible for financial oversight.

B. The Board is responsible for approving the gifting of this property.

Now, Therefore, It Is Hereby Resolved As Follows:

1. The Board of Commissioners hereby authorizes the Chief Executive to gift 1930 Jefferson Street, Napa, CA, to Community Health Initiative Napa County, Inc.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 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

ATTEST:

BY: _____
Ashlyn Scott, Clerk

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan of California
For the Period Ending June 30, 2026

Financial Analysis for the Current Period

Total Surplus / Deficit

For the month ending June 30, 2026, Partnership reported a deficit of $14.9 million, bringing the year-to-date deficit to $15.3 million. Key variances are outlined below.

Revenue

Total Revenue is unfavorable to budget by $25.6 million for the month and unfavorable to budget by $537.5 million for year-to-date. The following summarizes the year-to-date variances. Medi-Cal revenue is $117.1 million favorable to budget primarily due to retro membership and the prior and current period risk corridor adjustments. Directed Payments are $699.3 million unfavorable to budget due to lower than anticipated rates with a corresponding offset recorded in Healthcare Investment Funds (HCIF). Supplemental revenues are $16.3 million above budget, reflecting higher Proposition 56 revenue and higher than expected volumes for Maternity Kick, partially offset by the lower DHCS submissions for American Indian Health Services (AIHS) payments. Interest income is $10.4 million favorable to budget due to higher interest rates than anticipated. The remaining $18.0 million favorable variance is primarily from IPP-CalAIM Grant Incentive revenue, which also has a corresponding offset in HCIF.

Healthcare Costs

Total Healthcare Costs are favorable to budget by $11.9 million for the month and favorable to budget by $495.4 million year-to-date. The following summarizes the year-to-date variances. Non-Capitated Physician and Ancillary expenses are $272.9 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 $4.9 million favorable to budget due to changes in the funding methodologies for certain healthcare providers. Long-term care costs are favorable to budget by $15.4 million due to lower than expected utilization. Inpatient Hospital Fee-For-Service (FFS) expenses are favorable to budget by $62.4 million, driven by adjustments to IBNR reserves attributed to lower utilization. HCIF expenses are $655.1 million favorable to budget due to lower than anticipated Directed Payment rates, which are partially offset by IPP-CalAIM expenses; both of these expenses have offsetting revenue components as referenced above. Also included in HCIF expenses are the recording of the accrual for Community Reinvestments. Transportation costs are $12.7 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 $20.4 million favorable to budget due to lower than budgeted medical administrative costs. Quality Improvement Programs expenses are $22.4 million favorable to budget due to accrual adjustments related to prior years.

Administrative Costs

Total Administrative costs are overall favorable to budget $7.5 million for the month and $76.6 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 primary variance in Occupancy is from

depreciation and is favorable due to the timing delay of capital projects. Lastly, the favorable variance in Computer and Data is due to the timing delay of software purchases, which typically correlates to the variance in staffing.

Balance Sheet / Cash Flow

Total Cash & Cash Equivalents decreased by $62.0 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 6,526 members for the month.

Utilization Metrics and High Dollar Case

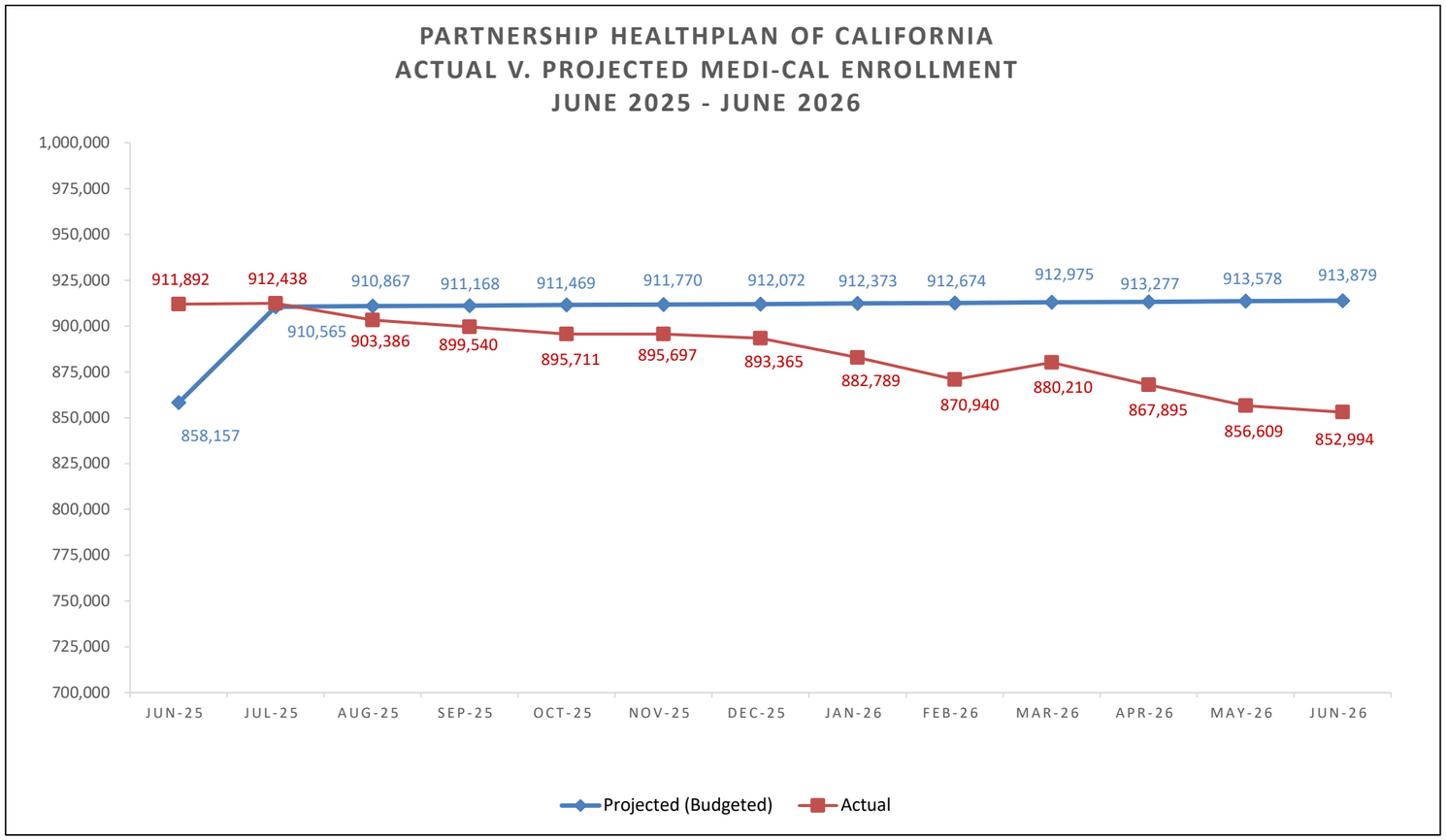
For the fiscal year 2025/26 through June 2026, 988 members reached the $250,000 threshold with an average cost of $541,572. For fiscal year 2024/25, 1,297 members reached the $250,000 threshold with an average cost per case of $513,408. For fiscal year 2023/24, 900 members reached the $250,000 threshold with an average claims cost of $512,468.

Current Ratio/Reserved Funds

Current Ratio Including Required Reserves:	**1.46**
Current Ratio Excluding Required Reserves:	**1.00**
Required Reserves:	**$ 1,428,831,883**
Total Fund Balance:	**$ 1,442,218,975**

Days of Cash on Hand

Including Required Reserves:	**111.19**
Excluding Required Reserves:	**48.11**



Member Months by County:

County	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Solano	103,987	104,011	102,676	102,240	101,767	101,583	101,555	98,608	97,031	98,109	96,112	94,063	93,037
Napa	27,826	27,732	27,619	27,642	27,529	27,480	27,355	26,951	26,540	26,659	26,242	25,959	25,962
Yolo	55,109	54,845	54,223	54,152	53,995	54,252	54,140	53,283	52,229	53,552	52,558	51,925	51,634
Sonoma	112,499	112,958	111,588	110,631	110,400	109,596	109,061	107,549	104,697	105,595	104,205	101,994	100,881
Marin	47,047	47,313	46,806	46,609	46,235	46,089	45,096	44,197	43,709	44,101	43,451	42,266	41,744
Mendocino	40,852	41,104	40,506	40,390	40,244	40,200	40,229	39,247	39,125	39,376	38,850	38,565	38,223
Lake	33,983	33,960	33,568	33,236	33,298	33,359	33,389	33,107	32,715	32,770	32,563	32,472	32,310
Del Norte	12,400	12,362	12,314	12,197	12,191	12,220	12,169	12,188	12,077	12,027	11,967	11,744	11,724
Humboldt	57,528	57,819	56,962	56,678	56,451	56,095	55,976	55,830	55,208	55,173	54,632	53,886	53,766
Lassen	8,656	8,575	8,358	8,439	8,412	8,406	8,491	8,375	8,305	8,255	8,204	8,025	8,055
Modoc	3,893	3,878	3,888	3,827	3,743	3,747	3,845	3,836	3,703	3,706	3,658	3,624	3,661
Shasta	65,377	65,400	64,714	64,742	64,786	65,062	64,124	64,876	63,940	64,314	63,758	63,487	63,606
Siskiyou	18,056	18,058	17,782	17,760	17,739	17,786	17,928	17,691	17,590	17,564	17,409	16,952	17,223
Trinity	5,250	5,193	5,220	5,103	5,169	5,118	5,081	4,955	4,955	5,000	4,962	4,894	4,890
Butte	85,649	84,789	84,665	84,532	84,241	84,407	84,874	84,412	83,486	83,679	83,341	83,296	83,128
Colusa	10,362	10,260	10,152	9,996	9,913	9,968	10,006	10,025	9,825	9,899	9,867	9,617	9,773
Glenn	13,647	13,764	13,687	13,672	13,523	13,497	13,456	13,358	13,182	13,222	13,064	12,859	12,906
Nevada	28,731	28,787	28,464	28,369	28,250	28,148	28,633	28,415	28,427	28,548	28,346	27,583	27,575
Placer	62,271	62,355	61,883	61,676	61,371	61,679	61,561	60,619	59,451	62,164	60,536	60,081	59,681
Plumas	5,755	5,784	5,783	5,616	5,575	5,478	5,429	5,395	5,292	5,270	5,278	5,297	5,255
Sierra	862	851	825	832	820	810	813	828	823	817	814	805	783
Sutter	44,348	44,796	44,471	44,294	43,923	44,223	44,067	43,956	43,584	44,445	43,563	43,174	43,484
Tehama	30,038	30,166	29,626	29,551	29,266	29,219	29,095	29,098	29,019	28,962	28,589	28,254	28,231
Yuba	37,766	37,678	37,606	37,356	36,870	37,275	36,992	35,990	36,027	37,003	35,926	35,787	35,462
All Counties Total	**911,892**	**912,438**	**903,386**	**899,540**	**895,711**	**895,697**	**893,365**	**882,789**	**870,940**	**880,210**	**867,895**	**856,609**	**852,994**

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	Mar-26	Apr-26	May-26	Jun-26	YTD	Avg / Month As of Jun-26
Total Enrollment	911,768	903,653	898,537	895,299	893,778	892,208	880,183	870,940	869,706	862,120	854,931	848,405	10,581,528	881,794
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	598,248,494	584,419,840	598,548,850	596,382,967	7,155,065,283	596,255,440
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	505,708,177	497,005,879	534,802,208	520,719,966	6,080,067,469	506,672,289
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	26,583,549	29,267,043	27,040,349	27,326,512	311,312,647	25,942,721
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	65,122,231	64,257,297	63,472,321	63,254,350	779,016,409	64,918,034
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	834,537	(6,110,379)	(26,766,028)	(14,917,861)	(15,331,242)	(1,277,604)
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	626,293,648	646,605,440	676,948,645	595,657,823	595,657,823	667,131,185
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	1,490,013,242	1,483,902,863	1,457,136,835	1,442,218,975	1,442,218,975	1,470,556,036
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	1,175,457,000	1,173,987,000	1,174,823,000	1,173,901,000	1,173,901,000	1,178,607,417
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	89,322,236	88,490,275	87,191,571	86,188,795	86,188,795	93,294,491
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	168,044,105	167,542,468	168,323,898	168,742,088	168,742,088	165,369,212
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	68,377,668	68,377,668	67,612,668	67,612,668	69,626,418
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)	(11,187,767)	(14,494,548)	(41,579,301)	(54,225,576)	(54,225,576)	(36,341,502)
Fund Balance as % of Reserved Funds	99.54%	99.01%	98.43%	97.14%	96.14%	95.93%	95.07%	98.13%	99.25%	99.03%	97.23%	96.38%	96.38%	97.59%
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	1.43:1	1.50:1	1.47:1	1.46:1	1.46:1	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%	94.86%	95.55%	99.95%	97.67%	95.36%	95.36%
Admin Ratio w/o Tax	4.70%	4.15%	4.82%	4.61%	5.10%	4.99%	4.91%	4.54%	4.99%	5.63%	5.05%	5.13%	4.88%	4.88%
Profit Margin Ratio	0.75%	0.44%	1.96%	-0.94%	-0.46%	1.62%	-0.72%	3.34%	0.16%	-1.17%	-5.00%	-2.80%	-0.24%	-0.24%

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 June 30, 2026

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
848,405	854,931	(6,526)	**Total Membership**	881,794	901,850	(20,056)

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
596,382,967	621,959,901	(25,576,934)	**Total Revenue**	7,155,065,283	7,692,591,167	(537,525,884)
520,719,966	532,621,379	11,901,413	**Total Healthcare Costs**	6,080,067,469	6,575,449,871	495,382,402
27,326,512	34,832,415	7,505,903	**Total Administrative Costs**	311,312,647	387,898,676	76,586,029
63,254,350	66,544,502	3,290,152	**Medi-Cal Managed Care Tax**	779,016,409	798,976,464	19,960,055
(14,917,861)	**(12,038,395)**	**(2,879,466)**	**Total Current Year Surplus (Deficit)**	**(15,331,242)**	**(69,733,844)**	**54,402,602**
97.67%	95.90%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	95.36%	95.38%	
5.13%	6.27%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	4.88%	5.63%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of June 30, 2026

	June 2026	May 2026
A S S E T S		
Current Assets		
Cash & Cash Equivalents	**961,153,603**	**1,023,150,597**
Receivables		
Accrued Interest	714,800	770,900
State DHS - Cap Rec	1,731,685,369	1,664,689,210
Other Healthcare Receivable	52,878,624	49,637,887
Miscellaneous Receivable	10,180,077	6,262,542
Total Receivables	**1,795,458,870**	**1,721,360,539**
Other Current Assets		
Payroll Clearing	(4,043)	402
Prepaid Expenses	15,414,956	16,908,508
Total Other Current Assets	**15,410,913**	**16,908,910**
Total Current Assets	**2,772,023,386**	**2,761,420,046**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	1,045,364	1,096,330
Furniture & Fixtures	7,701,728	7,701,728
Computer Equipment	23,160,070	23,103,612
Computer Software	9,060,595	9,060,595
Leasehold Improvements	124,288	124,288
Land	11,330,439	11,330,439
Building	79,474,549	79,474,549
Building Improvements	46,895,620	46,840,133
Accum Depr - Motor Vehicles	(578,032)	(603,975)
Accum Depr - Furniture	(6,825,248)	(6,805,933)
Accum Depr - Comp Equipment	(20,151,597)	(20,001,431)
Accum Depr - Comp Software	(9,030,451)	(9,029,037)
Accum Depr - Leasehold Improvements	(124,288)	(124,288)
Accum Depr - Building	(16,247,957)	(16,078,139)
Accum Depr - Bldg Improvements	(18,881,965)	(18,663,115)
Construction Work-In-Progress	61,788,973	60,898,142
Total Fixed Assets	**168,742,088**	**168,323,898**
Other Non-Current Assets		
Deposits		219,000
Board-Designated Reserves	1,259,789,795	1,261,714,571
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	8,464,900	8,750,979
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	**1,280,134,402**	**1,282,564,257**
Total Non-Current Assets	**1,448,876,490**	**1,450,888,155**
Total Assets	**4,220,899,876**	**4,212,308,201**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of June 30, 2026

	June 2026	May 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	380,818,038	319,987,064
Unearned Income	38,797,809	50,042,635
Suspense Account	8,522,320	11,869,280
Capitation Payable	9,474,275	8,600,879
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	1,644,066,262	1,572,563,259
Claims Payable	236,652,118	383,593,478
Incurred But Not Reported-IBNR	359,005,705	293,355,167
Quality Improvement Programs	55,477,765	73,190,870
Total Current Liabilities	**2,765,447,405**	**2,745,835,745**
Non-Current Liabilities		
Deferred Inflows Of Resources	10,555,512	6,657,637
Net Subscription Liability	2,677,984	2,677,984
Total Non-Current Liabilities	**13,233,496**	**9,335,621**
Total Liabilities	**2,778,680,901**	**2,755,171,366**
Fund Balance		
Unrestricted Fund Balance	**(54,225,576)**	**(41,579,301)**
Reserved Funds		
State Financial Performance Guarantee	1,173,901,000	1,174,823,000
Board Approved Capital and Infrastructure Purchases	86,188,795	87,191,571
Capital Assets	168,742,088	168,323,898
Strategic Use of Reserve-Board Approved	67,612,668	68,377,668
Total Reserved Funds	**1,496,444,551**	**1,498,716,137**
Total Fund Balance	**1,442,218,975**	**1,457,136,835**
Total Liabilities And Fund Balance	**4,220,899,876**	**4,212,308,201**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Cash Flow
For The Period Ending June 30, 2026

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Services	502,812,701	7,128,890,520
Other Revenues	326,746	3,011,824
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(19,930,316)	(247,603,981)
Medical Claims Payments	(518,616,351)	(5,705,656,234)
Drug Medi-Cal		
DMC Receipts from Counties	2,512,874	59,018,599
DMC Payments to Providers	(7,106,597)	(67,049,715)
Cash Payments to Vendors	(10,363,838)	(878,820,079)
Cash Payments to Employees	(20,035,534)	(248,294,887)
Net Cash (Used) Provided by Operating Activities	**(70,400,315)**	**43,496,047**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(555,879)	(16,357,085)
Net Cash (Used) by Capital Financial & Related Activities	**(555,879)**	**(16,357,085)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	1,924,776	(74,988,517)
Interest and Dividends on Investments	7,034,424	91,394,222
Net Cash Provided by Investing Activities	**8,959,200**	**16,405,705**
NET (DECREASE) INCREASE	**(61,996,994)**	**43,544,667**
CASH & CASH EQUIVALENTS, BEGINNING	**1,023,150,597**	**917,608,936**
CASH & CASH EQUIVALENTS, ENDING	**961,153,603**	**961,153,603**
RECONCILIATION OF TOTAL OPERATING LOSSTO NET CASH (USED) PROVIDED BY OPERATING ACTIVITIES		
TOTAL OPERATING LOSS	**(21,896,185)**	**(106,476,760)**
DEPRECIATION	**584,585**	**7,901,282**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(7,158,272)	1,741,499
California Department of Health Services Receivable	(66,996,159)	23,224,186
Other Assets	1,556,182	180,902
Accounts Payable and Accrued Expenses	122,513,461	158,701,637
Accrued Claims Payable	(81,290,822)	(17,644,595)
Quality Improvement Programs	(17,713,105)	(24,132,104)
Net Cash (Used) Provided by Operating Activities	**(70,400,315)**	**43,496,047**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses
For The Period Ending June 30, 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
848,405	**848,405**	**-**			**TOTAL MEMBERSHIP**	**10,581,528**	**10,581,528**	**-**		
					REVENUE					
577,609,936	615,111,451	(37,501,515)	680.82	725.02	State Capitation Revenue	7,043,403,806	7,609,365,167	(565,961,361)	665.63	719.12
6,978,324	6,639,380	338,944	8.23	7.83	Interest Income	91,145,522	80,779,000	10,366,522	8.61	7.63
11,794,707	209,070	11,585,637	13.90	0.25	Other Revenue	20,515,956	2,447,000	18,068,956	1.94	0.23
596,382,967	**621,959,901**	**(25,576,934)**	**702.95**	**733.09**	**TOTAL REVENUE**	**7,155,065,283**	**7,692,591,167**	**(537,525,884)**	**676.18**	**726.99**
					HEALTHCARE COSTS					
					Physician Services					
9,096,346	9,176,492	80,146	10.72	10.82	Pcp Capitation	107,618,493	114,982,966	7,364,473	10.17	10.87
194,744	198,453	3,709	0.23	0.23	Specialty Capitation	2,493,094	2,482,718	(10,376)	0.24	0.23
111,167,972	80,993,399	(30,174,573)	131.03	95.47	Non-Capitated Physician Services	1,121,700,542	991,341,930	(130,358,612)	106.01	93.69
120,459,062	**90,368,344**	**(30,090,718)**	**141.98**	**106.52**	**Total Physician Services**	**1,231,812,129**	**1,108,807,614**	**(123,004,515)**	**116.42**	**104.79**
					Inpatient Hospital					
16,050,141	15,490,595	(559,546)	18.92	18.26	Hospital Capitation	201,169,126	197,499,142	(3,669,984)	19.01	18.66
111,566,035	109,672,710	(1,893,325)	131.50	129.27	Inpatient Hospital - Ffs	1,314,169,784	1,371,060,790	56,891,006	124.19	129.57
(4,731,775)	772,459	5,504,234	(5.58)	0.91	Hospital Stoploss	4,127,963	9,632,197	5,504,234	0.39	0.91
122,884,401	**125,935,764**	**3,051,363**	**144.84**	**148.44**	**Total Inpatient Hospital**	**1,519,466,873**	**1,578,192,129**	**58,725,256**	**143.59**	**149.14**
52,000,868	60,657,692	8,656,824	61.29	71.50	Long Term Care	715,849,280	731,283,413	15,434,133	67.65	69.11
					Ancillary Services					
1,251,400	1,269,496	18,096	1.48	1.50	Ancillary Services - Capitated	14,726,551	15,959,728	1,233,177	1.39	1.51
135,308,333	96,346,506	(38,961,827)	159.49	113.56	Ancillary Services - Non-Capitated	1,331,608,461	1,189,023,805	(142,584,656)	125.84	112.37
136,559,733	**97,616,002**	**(38,943,731)**	**160.97**	**115.06**	**Total Ancillary Services**	**1,346,335,012**	**1,204,983,533**	**(141,351,479)**	**127.23**	**113.88**
					Other Medical					
6,383,652	8,393,358	2,009,706	7.52	9.89	Quality Assurance	71,902,469	92,329,487	20,427,018	6.80	8.73
81,264,262	130,335,643	49,071,381	95.78	153.62	Healthcare Investment Funds	961,840,346	1,616,930,866	655,090,520	90.90	152.81
114,700	151,590	36,890	0.14	0.18	Advice Nurse	1,451,900	1,729,200	277,300	0.14	0.16
16,543,457	12,210,727	(4,332,730)	19.50	14.39	Transportation	167,458,901	154,800,642	(12,658,259)	15.83	14.63
104,306,071	**151,091,318**	**46,785,247**	**122.94**	**178.08**	**Total Other Medical**	**1,202,653,616**	**1,865,790,195**	**663,136,579**	**113.67**	**176.33**
(15,490,169)	6,952,259	22,442,428	(18.26)	8.19	Quality Improvement Programs	63,950,559	86,392,987	22,442,428	6.04	8.16
520,719,966	**532,621,379**	**11,901,413**	**613.76**	**627.79**	**TOTAL HEALTHCARE COSTS**	**6,080,067,469**	**6,575,449,871**	**495,382,402**	**574.60**	**621.41**
					ADMINISTRATIVE COSTS					
17,539,713	22,177,878	4,638,165	20.67	26.14	Employee	195,838,096	247,828,143	51,990,047	18.51	23.42
96,886	200,866	103,980	0.11	0.24	Travel And Meals	1,051,082	2,294,006	1,242,924	0.10	0.22
1,256,493	3,304,779	2,048,286	1.48	3.90	Occupancy	16,476,816	33,393,279	16,916,463	1.56	3.16
405,631	955,928	550,297	0.48	1.13	Operational	7,455,747	10,909,163	3,453,416	0.70	1.03
4,528,565	3,461,395	(1,067,170)	5.34	4.08	Professional Services	46,333,186	39,490,454	(6,842,732)	4.38	3.73
3,499,224	4,731,569	1,232,345	4.12	5.58	Computer And Data	44,157,720	53,983,631	9,825,911	4.17	5.10
27,326,512	**34,832,415**	**7,505,903**	**32.20**	**41.07**	**TOTAL ADMINISTRATIVE COSTS**	**311,312,647**	**387,898,676**	**76,586,029**	**29.42**	**36.66**
63,254,350	66,544,502	3,290,152	74.56	78.43	**Medi-Cal Managed Care Tax**	779,016,409	798,976,464	19,960,055	73.62	75.51
(14,917,861)	**(12,038,395)**	**(2,879,466)**	**(17.57)**	**(14.20)**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**(15,331,242)**	**(69,733,844)**	**54,402,602**	**(1.46)**	**(6.59)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
June 30, 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 expansion into additional counties in March 1998, March 2001, October 2009, July 2011, September 2013, and January 2024. As of today, the HealthPlan serves members in 24 counties.

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:
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 June 2026, the HealthPlan has Total Reserved Funds of $1.4 billion. This includes $67.6 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 June 2026, the HealthPlan has accrued a Quality Improvement Program payout of $55.5 million.

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

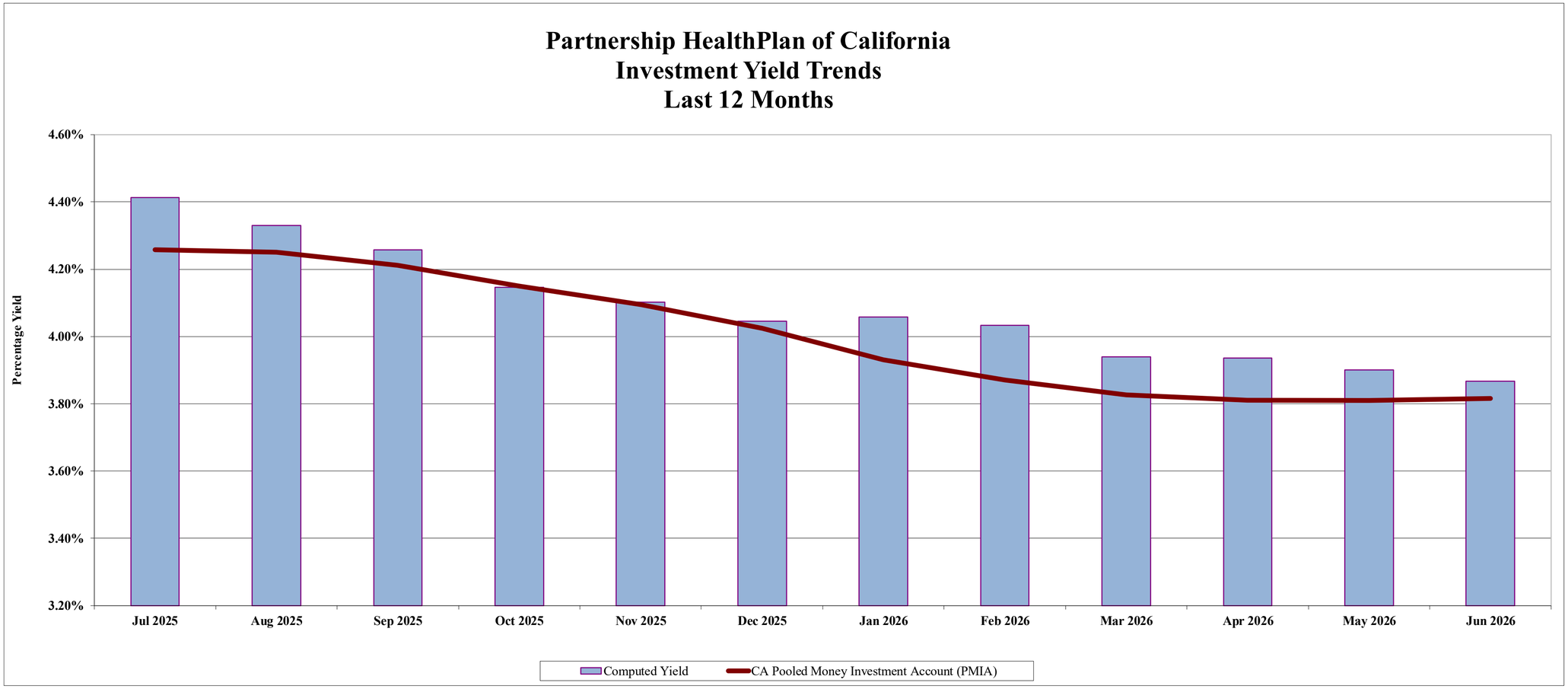
Current month includes year-to-date reconciliation adjustments pertaining to prior periods for Hospital StopLoss, Quality Incentive Programs, and Other Grant Revenues.

Partnership HealthPlan of California
Investment Schedule
June 30, 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	$ 1,839,408	$ 1,839,408	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	$ 81,819,246		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 871,498		
US Bank - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,014,207,152		
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	$ 47,054,631		
West America Payroll	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 148,163		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:								$ 2,221,243,398		

Partnership HealthPlan of California
Investment Yield Trends

PERIOD		Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Interest Income		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	8,154,675	7,103,154	6,978,324
Cash & Investments at Historical Cost	(1)	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	2,777,427,432	2,252,683,455	2,285,165,168	2,221,243,398
Computed Yield	(2)	4.41%	4.33%	4.26%	4.15%	4.10%	4.05%	4.06%	4.03%	3.94%	3.94%	3.90%	3.87%
CA Pooled Money Investment Account (PMIA)	(3)	4.26%	4.25%	4.21%	4.15%	4.10%	4.03%	3.93%	3.87%	3.83%	3.81%	3.81%	3.82%



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.

COO Board Report

Wendi Davis

August 2026

Operational teams continue to focus and dedicate time and resources to support our members in interpreting and adhering to the changing Medi-Cal enrollment requirements. In addition to doing member outreach and hosting dozens of in person member informative sessions throughout our footprint, we have also partnered with providers, counties, and various community organizations to develop and implement various strategies to support members.

As more details become available regarding requirements and procedures, we will update our resources to reflect the most current information. These efforts will continue for as long as there appears to be a need for them and members will benefit from our support.

Core Systems Modernization & Provider Education

The Claims team, IT and virtually every department in the organization are preparing to initiate a strategic upgrade of our core claims adjudication infrastructure. We are transitioning to the HealthEdge HealthRules Payor (HRP) system to enhance operational flexibility, increase processing efficiency, and better support our evolving provider network. This transition is currently in the testing phase, with a phased implementation scheduled to begin in mid-November 2026.

Our commitment to excellence—defined by accurate, timely claims payments and robust provider education—remains our priority. While our legacy system has served us well, the HRP platform provides the necessary scalability to adapt to dynamic billing regulations and complex provider requirements. This modernization is a proactive step to ensure long-term operational resilience.

The implementation of HRP introduces significant improvements to the provider experience, including:

A more streamlined billing experience, including new functionality such as the ability for providers to submit corrected claims directly, bypassing the traditional Provider Dispute Resolution (PDR) and appeal processes.

A decrease in claims processing as well as more consistency in the review and adjudication process. By automating previously manual review processes, HRP ensures more uniform adherence to long-standing billing.

Implementation is targeted to begin in mid-November 2026, however efforts to educate and inform providers of any anticipated changes began more than a year ago. We are providing this advance notice to allow providers sufficient lead time to adjust internal billing practices. In an effort to guide our provider education and notifications we have been running claims through both our legacy system and HRP to identify and mitigate potential denial or rejection trends. Our team has been actively contacting individual providers to address specific billing trends (e.g., modifiers, taxonomy codes, and bill types) identified during this dual-processing period since April of 2025. Repeated outreach is being performed when improvements do not appear to have been made in an effort to support our providers. The majority of these reminders and notifications have been in reference to long-standing standard billing requirements.

All of our contracted providers have specifically assigned Provider Representatives, that have also been sharing individual unique provider data. All providers have access to Provider Representatives, Claims Resolution Coordinators, and our Claims Customer Service line to ensure seamless communication and issue resolution throughout the transition.

In addition to outreach to individual providers, Partnership will begin hosting a series of over 20 webinars and in-person trainings this month and will continue until well after the transition.

Our focus remains on transparency and collaborative support as we move toward the HRP system launch.

Partnership Board: Legislative Update
August 2026

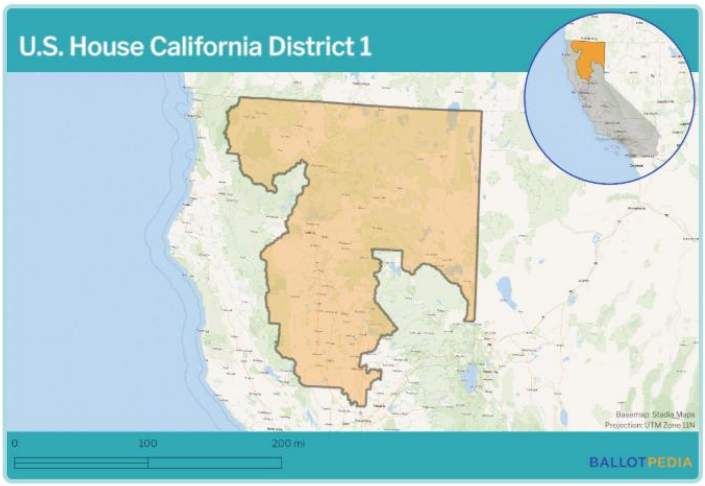
Mid-Term Election - Congress

The passage of California Proposition 50 (2025) resulted in a mid-decade redistricting. It is possible that three new congressional representatives will be elected to represent communities in the Partnership service area. The following provides a snapshot of the candidates, results from the June primary, and the district map.

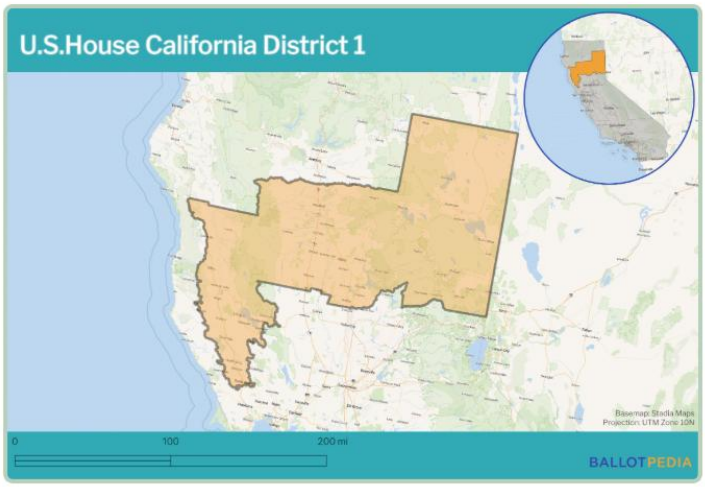
Congressional District 1:

- Candidates and Primary Results
  - Representative James Gallagher (R) – 42.1%
  - State Senator Mike McGuire (D) – 41.8%

2024



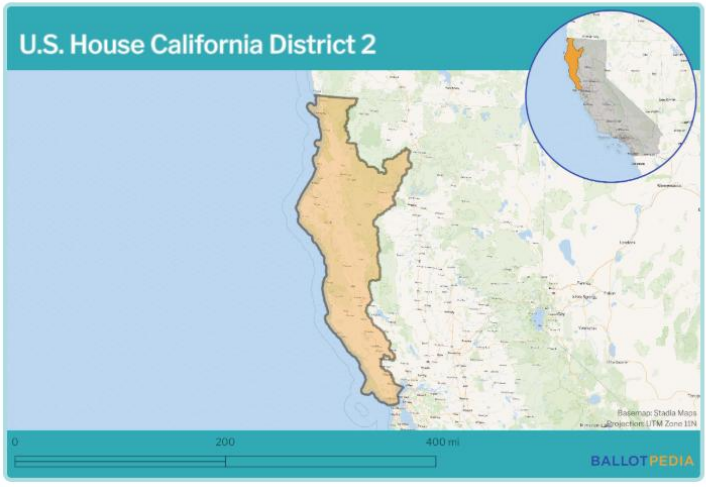
2026



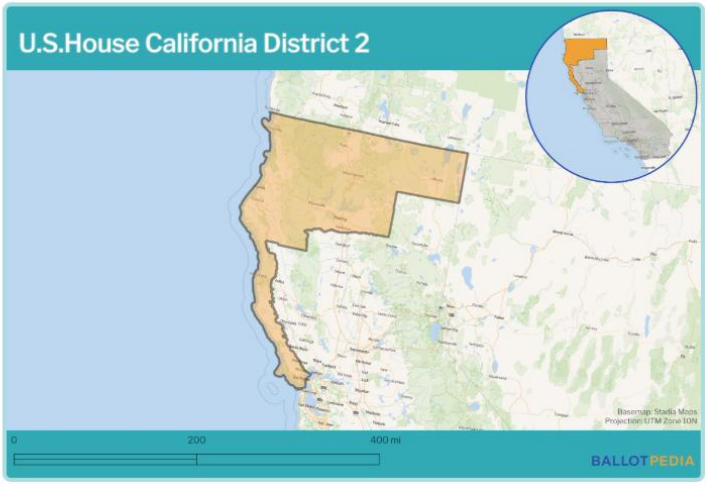
Congressional District 2:

- Candidates and Primary Results
  - Representative Jared Huffman (D) – 52.5%
  - Robin Littau (R) – 13.2%

2024



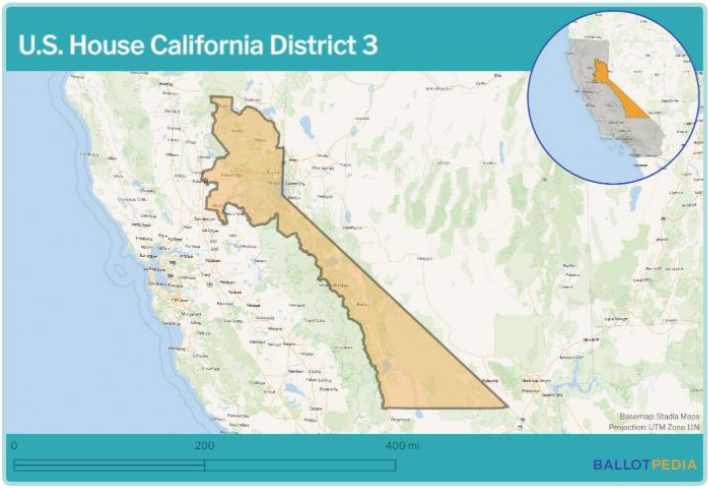
2026



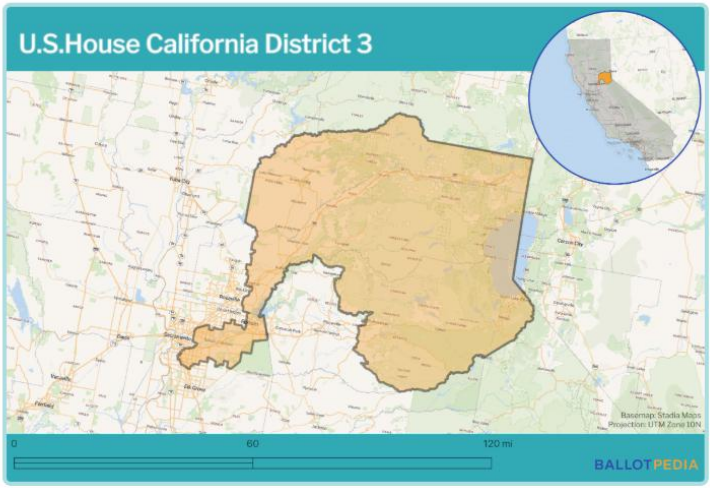
Congressional District 3:

- Candidates and Primary Results
  - Representative Dr. Ami Beri (D) – 33.0%
  - Robb Tucker (R) - 34.3%

2024



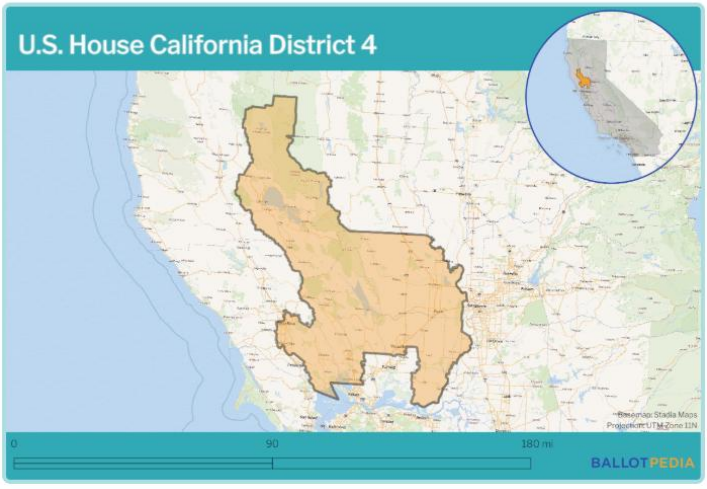
2026



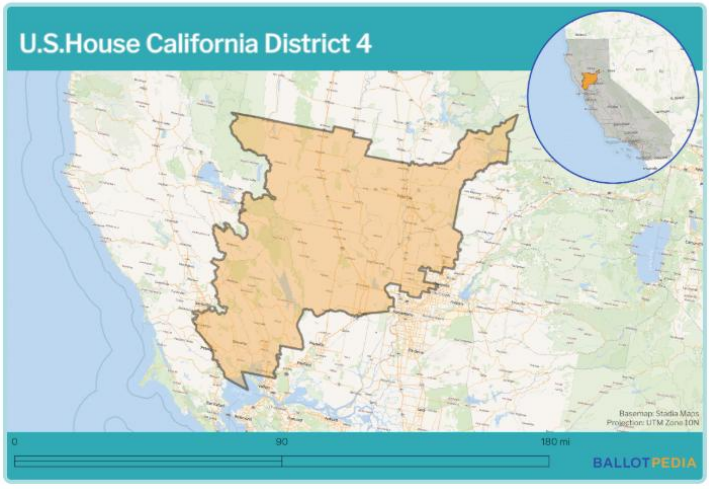
Congressional District 4:

- Candidates and Primary Results
  - Representative Mike Thompson (D) – 41.0%
  - Eric Jones (D) – 22.2%

2024



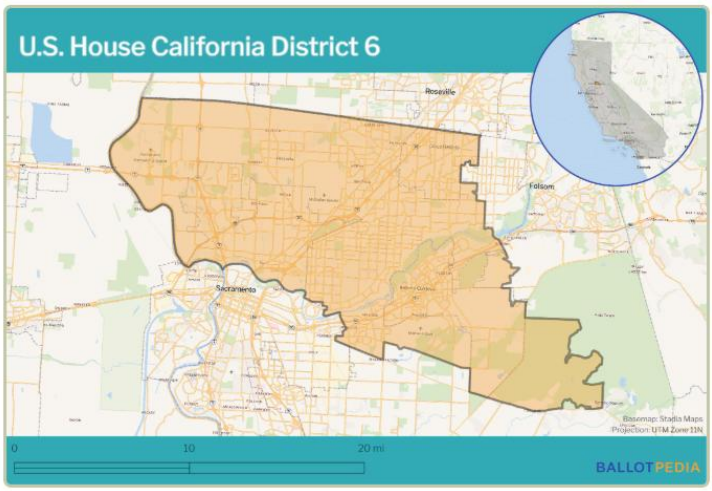
2026



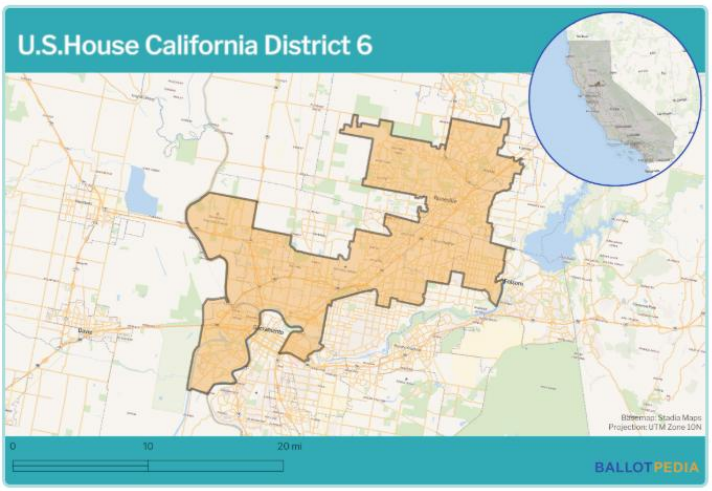
Congressional District 6:

- Candidates and Primary Results
  - Representative Kevin Kiley (No party preference) – 24.5%
  - Dr. Richard Pan (D) – 23.2%

2024



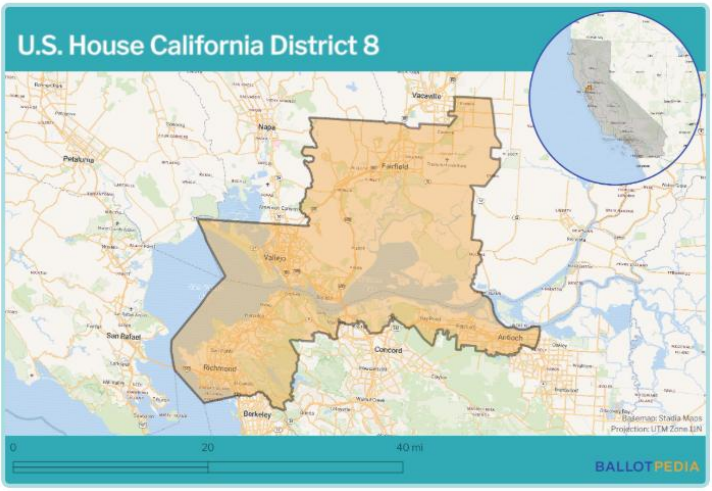
2026



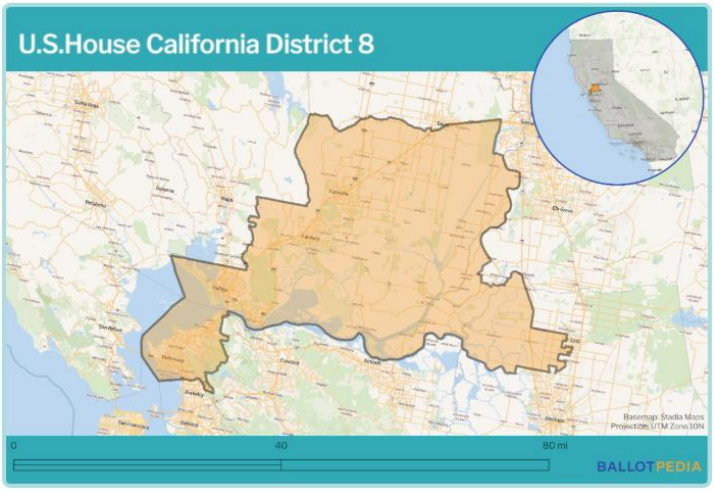
Congressional District 8:

- Candidates and Primary Results
  - Representative John Garamendi (D) – 53.7%
  - Rudy Recile (R) – 31.8%

2024



2026



News Updates
August 2026

Partnership Press Releases:

Partnership Hosts Outdoor Summer Maternity Photoshoot to Support Expectant Members in Humboldt County
Partnership HealthPlan of California
June 1, 2026
Partnership HealthPlan of California is hosting an Outdoor Summer Maternity Photoshoot on Saturday, August 8, 2026, 10 a.m. to 3 p.m., offering a family-centered event designed to support maternal health and strengthen connections to local resources

Partnership Mentioned:

Weed Health Center reopens with ribbon-cutting Aug. 3
Action News Now
July 13, 2026
The Health Resources and Services Administration, a division of the U.S. Department of Health and Human Services, Partnership HealthPlan of California, and the McConnell Foundation helped cover project costs.

Two Plumas County agencies co-sponsor Children's Fair
The Plumas Sun
July 2, 2026
This year the fair was held in partnership with the Plumas County Fire Safe Council and Partnership HealthPlan of California.

Chief Medical Officer Report

August 26, 2026

Robert Moore, Chief Medical Officer

1. **Results of Annual Quality Measure Evaluation: Measurement Year 2025 Managed Care Accountability Set (a subset of Health Effectiveness Data Information Set)**

   Also known as: MY 2025 MCAS HEDIS results.

   We will briefly review the results of the 2025 MCAS HEDIS audit during the board meeting. The complete report is attached.

   The full score using the scale set by the National Committee for Quality Assurance Medicaid measure set will be presented at the next Board meeting in October.

   One callout: a key contributor to our improved quality scores in 2025 was the capture of more data from electronic health records using DataLink, a product that extracts and normalizes difficult to capture data elements (like what was the score on the last PHQ9 screening done), to feed into our annual HEDIS audit. In the next year, we will expand further the use of DataLink to automate many more clinical quality measures.

2. **Primary Care QIP: Recognition of High Performers**

On the morning of the board meeting, from 9-9:45 a.m. we recognized the high performing sites on the 2025 primary care pay for performance program (the PCP QIP). The list of those recognized was included in the June, 2026 board packet.

This month, I wanted to highlight primary care organizations who achieved exceptional outcomes on individual measures in measurement year 2025 (excluding sites with very small denominators).

Pediatric Measures

Well Visits in First 15 Months
- Sonoma Plaza Pediatrics – 90.9%
- West County Health Centers – 88.9%

Child and Adolescent Well Visits
- Harvest Pediatrics – 96.5%
- Sonoma Plaza Pediatrics – 86.0%

Childhood Immunizations (CIS10)
- Marin Community Clinics – 49.9%

Adolescent Immunizations
- Marin Community Clinics – 76.5%

Lead Screening in Children
- Mendocino Coast Clinic – 93.3%
- Communicare+Ole – 86.0%

Adult Measures

Colorectal Cancer Screening
- NorthBay HealthCare – 71.5%
- Sutter Pacific Medical Foundation (Sonoma) – 70.2%

Controlling Blood Pressure
- Colusa Indian Health – 84.5%
- Northbay – 84.4%
- WeCare Group – 82.1%

Diabetes Control

Shasta Community Health Center – 82.8%
Fairchild Health Center – 82.6%
Mountain Valleys – 82.2%

Diabetes Retinopathy Screening

Anderson Valley CHC – 81.8%
NorthBay Health – 81.5%

Breast Cancer Screening

Baechtel Creek Medical Group – 76.9%
Sutter Pacific Medical Foundation – 76.5%

Cervical Cancer Screening

Sutter Pacific Medical Foundation (Sonoma) – 76.2%
Petaluma Health Center – 75.6%

Chlamydia Screening

Winters Healthcare Foundation – 49.3%

3. Engagement: A key strategy for Improving Quality.

Before 2019, Partnership focused on using our pay-for-performance programs (QIPs) to encourage Primary Care clinicians and other providers to focus on improving quality. While many of our providers closely watch the QIPs and respond to them, we noted that some providers, for many reasons, the pay-for-performance approach was not effective at driving improved quality. One hypothesis was that they didn't know how to improve quality, so the Performance Improvement team offered a variety of educational programming and toolkits. Again, some providers leveraged this information, but others would not. We determined then that a key factor missing from low performing sites was leadership and management engagement and prioritization of quality improvement activities.

This led to a new strategy over the past several years of using leadership and management **engagement as a strategy** for focusing the attention and resources needed to move the dial on quality within their organization. Here is a summary of the engagement activities:

1. Annual Regional Meetings with Clinical Leaders. These started in 2014 and continues. In 2026 these meetings were held in seven locations throughout our service area, with over 100 clinical leaders attending, mostly from primary care practices. A subset of highly engaged leaders who attend bring the information back to their health centers, making changes to improve quality.

2. Joint Leadership Initiative (JLI). This initiative started in 2019, focusing on 10 large primary care providers with medium or low PCP QIP scores. Senior leaders of Partnership meet 2-4 times a year with senior leaders of the primary care organizations to focus energy and attention on quality improvement. In the history of the program, five programs have graduated, due to high performance achievement, and four new organizations were added at the time of the 10-county geographic expansion. While improvement was not universal, it was very successful for several organizations, so this program continues.

3. Tribal Health Center Engagement. In 2020, when Partnership segregated quality measures by race and ethnicity, we found that the American Indian/Alaska Native category had worse outcomes than all other race/ethnicity categories. Diving deeper, we found that the dollars offered for the PCP QIP represented a smaller percentage financial incentive for Tribal Health Centers, compared to other PCPs. Furthermore, since Tribal Health Centers are governed by autonomous tribal nations, there is no state of federal requirement to deliver better quality, as measured by our HEDIS metrics. Finally, there is a strong distrust of the motivations of non-tribal governmental organizations trying to impose their priorities on tribal organizations, based on a history of broken treaties, efforts at cultural erasure, and a lack of understanding by outsiders on tribal priorities and processes of decision-making. In 2022 we launched of a portfolio of tribal engagement activities, including designating a Partnership Tribal Liaison, leadership visits with individual tribal health centers, and an annual Partnership tribal health convening (the 4th annual convening is this October in Chico). Quality outcomes are improving in most tribal health centers. A few of the smaller

health centers still struggle. Financial pressures, leadership turnover and different priorities of board and senior leaders are common factors for the challenges these sites face.

4. Enhanced Provider Engagement (EPE). Building on the success of the JLI concept, starting in 2024 we began a more intensive engagement which includes smaller low-performing primary care organizations. Additions include a requirement to give a presentation to their governing body (to model and encourage the leaders on the governing board to monitor quality more closely), and to work with assigned performance improvement coaches, focusing on a smaller group of measures to help focus their activities. The performance improvement advisor team grew and regionalized to meet this need. Some smaller providers have made good progress on improvement, while others have not been as successful.

5. Partnership Clinic Leadership Academy. The importance of strong leadership on both the clinical and non-clinical sides of healthcare organizations has been recognized in California since just after 2000. At one time there were five different leadership training programs being funded by foundations. Over time, several programs closed down or lost funding. With turnover, many of the leaders who trained in the 2000s have retired or moved on, so the current cadre of leaders have little formal leadership training. In response to this, in 2026 Partnership launched the Clinic Leadership Academy, in which 34 emerging leaders are participating in a strong leadership training program, with programmatic support of HealthForce UCSF. This first group will graduate in 2027. One unique aspect of Partnership's version of this leadership training is a more intensive inclusion of quality improvement and performance improvement methodology in the entire curriculum. As a side benefit of Partnership running the leadership training, Partnership leaders are using the program to build relationships with these emerging leaders. Thus, it is another engagement strategy.

6. Wider Community Engagement. Partnership's very name evokes the importance of working with others in the community to optimize our health care delivery system. The 2025-2027 Strategic Plan includes a strategy: "Champion Local Partnerships, Provide Statewide Leadership" this requires engagement with many community partners (in addition to our provider network). This community engagement builds trust and relationships, which makes our provider network more amenable to engagement efforts focused on quality.

Engagement of our provider network, coupled with pay for performance incentives and robust educational offerings, is a sustainable strategy for building lasting improvements in outcomes for the vulnerable community members served by Partnership HealthPlan. The ability to leverage engagement represents a key advantage of a County Organized Health System versus a commercial health plan or the centralized administration of Medi-Cal at the Department of Healthcare Services level.

Upcoming Board Topics:

1. October, 2026 (Dr. Jones representing CMO)
    a. Annual Educational session;
    b. Review of annual quality program document (including update of quality strategic plan)
2. December, 2026
    a. Report on 25-26 Hospital QIP results
    b. Report on CG CAHPS results for PCPs.
3. February, 2027
    a. At 9:30 am before Board meeting: recognition for top hospital QIP performers for 2025-26
4. April, 2027
    a. In person strategic planning retreat
5. June, 2027
    a. Announcement of High performers of QIPs

Healthcare Effectiveness Data and Information Set (HEDIS®)

Measurement Year 2025 / Reporting Year 2026

Managed Care Accountability Set (MCAS)
Summary of Performance
June 2026

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1.0 Introduction

As a Medi-Cal Managed Care Plan, Partnership provides health care coverage for 24 counties in Northern California – the largest geographic footprint of any Medi-Cal Managed Care Plan in California. The health plan covers over 900,000 members who qualify for coverage based on low household income, and who make up a substantial portion of Northern California's total population. The annual clinical measure performance analysis contained in this Annual Summary of Performance, centered on 18 HEDIS measures selected by DHCS, is intended to give the best possible understanding of the status of quality outcomes for the low-income population served in these counties.

Partnership generates a detailed Annual Summary of Performance and distributes it widely so that stakeholders in Northern California – local governments, county public health, medical and behavioral health providers, hospitals, and community foundations – can use current, local, accurate, and audited data to prioritize activities to meet the health care needs of their communities. The Summary of Performance contains regional and county-level data that show local strengths and opportunities for preventative health care based on national benchmarks. Behind each measure are many community members who were able to access the preventative services they needed to stay healthy, or who faced challenges and struggles to receive care.

In the end, it takes the entire health care delivery system working together to improve the health outcomes contained in this report. Partnership encourages everyone reading this report to review their local data closely, and look for a handful of ways their organization, alone or with others, can drive improvement on one or more measure that is important to them.

Partnership is always happy to connect organizations and community members within our network to resources and activities to help our members, and the communities we serve, be healthy. Please reach out to our Performance Improvement team at ImprovementAcademy@partnershiphp.org if you would like to learn more about activities in your area.

Thank you for your dedication to improving the health of our communities.

2.0 Notable Changes to the Measurement Year (MY) 2025 Annual Summary of Performance Report

MY2025 continued to host two required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group (HSAG) Auditor (this report's focus)
- NCQA HEDIS Health Plan Accreditation / HPA: Advent Advisory Auditor

Partnership HEDIS Reporting Populations – MY2025

In MY2025, Partnership observed slight decrease in overall membership by approximately 1.3%, to 895,339 assigned members in December 2025.

Partnership reports one Plan-Wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, HSAG.

Starting in MY2024, Partnership also reports county-wide rates for all MCAS measures and their respective sub-measures to DHCS directly. DHCS uses county-wide rates to calculate outcomes for multiple accountability programs that are described below. County level rates for hybrid measures are calculated using a county-level oversample populations (minimum size of 100 members).

The impact of population shifts in Partnership's network from the 10 new counties joining the Partnership network in January 2024 continues to impact HEDIS measure reporting populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2025 Technical Specifications. One measure, Breast Cancer Screening, ECDS (BCS-E), requires continuous enrollment greater than one year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measures' plan-wide rates in MY2025. All other MCAS measures in the 10 incoming counties have eligible populations that reflect the current membership.

DHCS Managed Care Accountability Set (MCAS) Measure Set – MY2025

Table 1 shows the MY2025 DHCS MCAS Measure Set, which are the eighteen (18) NCQA HEDIS and CMS clinical measures that all California Medi-Cal Managed Care Plans are held to the Minimum Performance Level (MPL) of the Quality Compass 50th percentile. The table includes information such as measure domain and Quality Withhold and Incentive program flags, which are relevant to DHCS Accountability programs described below. All eighteen (18) measures in the MCAS measure set are continuous from MY2023-MY2025.

Table 1: MY2025 DHCS Managed Care Accountability Set – Measures Held to MPL (50th Percentile)

Measure Domain	Measure Abbr	Measure Name	DHCS Quality Withhold Program Measure?
Behavioral Health	FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	
Behavioral Health	FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	
Children's Health	WCV	Child and Adolescent Well-Care Visits	Y
Children's Health	CIS-E	Childhood Immunization Status - Combination 10	Y
Children's Health	IMA-E	Immunizations for Adolescents - Combination 2	Y
Children's Health	W30-2	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months	Y
Children's Health	W30-6	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months	Y
Children's Health	DEV	Developmental Screening in the First Three Years of Life	
Children's Health	LSC	Lead Screening in Children	
Children's Health	TFL	Topical Fluoride for Children	
Chronic Disease	CBP	Controlling High Blood Pressure	Y
Chronic Disease	GSD	Glycemic Status Assessment for Patients With Diabetes (>9%)	Y
Chronic Disease	AMR	Asthma Medication Ratio	
Reproductive Health and Cancer Prevention	PPC-Post	Prenatal and Postpartum Care: Postpartum Care	Y
Reproductive Health and Cancer Prevention	PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Y
Reproductive Health and Cancer Prevention	BCS-E	Breast Cancer Screening	
Reproductive Health and Cancer Prevention	CCS-E	Cervical Cancer Screening	
Reproductive Health and Cancer Prevention	CHL	Chlamydia Screening in Women	

NCQA released changes to several existing clinical measures used in DHCS MCAS for MY2025:

- ECDS measure Childhood Immunization Status Combination 10 (CIS-10-E) replaced the hybrid measure Childhood Immunization Status Combination 10 (CIS-10).

- ECDS measure Immunizations for Adolescents Combination 2 (IMA-2-E) replaced the hybrid measure Immunizations for Adolescents Combination 2 (IMA-2).
- ECDS measure Cervical Cancer Screening (CCS-E) replaced hybrid measure Cervical Cancer Screening (CCS).
- Breast Cancer Screening (BCS-E)'s age band expanded from 52-75 years to include members 42-75 years.

DHCS Accountability Programs

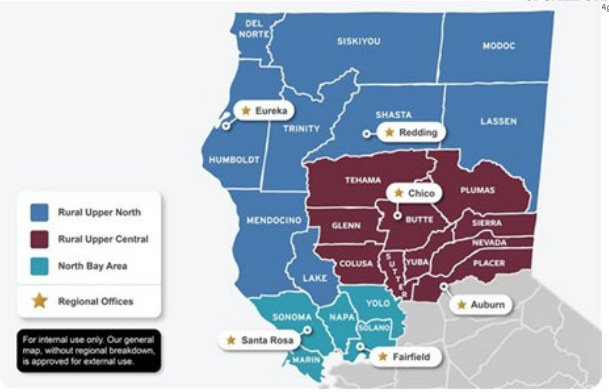
Since 2019, DHCS has introduced multiple MCP accountability programs that align plan MCAS measure performance with DHCS's Comprehensive Quality Strategy and Bold Goals Initiative. **Table 2** outlines DHCS accountability programs that are driven by MY2025 measure performance, and each program is described below. Results for each program are announced late in the Reporting Year, after the publication of the Annual Summary of Performance.

Table 2: DHCS Accountability Programs Driven by MCAS Measure Performance, MY2025

Program	Description	Geographic Impact	Financial Impact	Financial Impact Trigger
Quality Withholds and Incentive Program	MCP's earn back withheld revenue with high regional performance or improvement on subset of MCAS measures Incentive earnback with closing regional disparities on WCV measure	Quality Rating Regions	1% of MCP's annual revenue earned back	<67th percentile performance AND <25% YoY improvement
Clinical Efficiencies	Performance on clinical efficiency measures (mostly inpatient) impact MCP rate setting	Plan Wide	Plan rates	Main driver: low performance Ambulatory Sensitive Admissions
Community Reinvestments Quality	5% annual net income automatically invested in county community projects, Quality Factor is an additional investment amount based on quality measure performance	County	Additional 7.5% of annual net income - prorated by county membership	2+ measures <50th percentile in a measure domain
Quality Sanctions	Fines for performance below 50th percentile on all MCAS measures	County	Measure population not served is main factor	<50th percentile
Quality Factor Score	Composite MCAS measure score used to compare MCP performance state-wide	Plan Wide	None	None

Quality Withholds and Incentives Program

DHCS's Quality Withholds and Incentives accountability program allows Partnership to earn back a percentage of its withheld income from DHCS based on high performance or significantly improved year-over-year performance on a subset of MCAS measures, as well as two CAHPS measures. The Withholds and Incentives accountability program will be applied to Partnership's three (3) Quality Rating Regions based on MY2025 measure performance. DHCS will use county-level measure rates to calculate weighted regional rates for Partnership's three (3) Quality Rating Regions. **Table 1** (above) flags MY2025 MCAS measures that are included in the Quality Withholds program.



DHCS Quality Rating Region	Counties
North Bay	Marin, Napa, Sonoma, Solano, Yolo
Rural Upper North	Del Norte, Humboldt, Lassen, Lake, Mendocino, Modoc, Shasta, Siskiyou, Trinity
Rural Upper Central	Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba

Clinical Efficiency Program

This program focuses on reducing inefficient utilization of healthcare services by eliminating a portion of inefficient spend during MCP rate development. DHCS's program focuses on several aspects of inefficient spend: Potentially Preventable Admissions (PPA) is the largest current factor impacting Partnership. Though PPA is not an NCQA HEDIS measure, a number of drivers of PPA are indicated in MCAS measures, such as Controlling Blood Pressure (CBP) and Asthma Medication Ratio (AMR).

Quality Accountability Community Reinvestment Program

The Community Reinvestment Program is DHCS's newest accountability program for Managed Care Plans. This program requires Partnership to pay counties with multiple measures below the 50th percentile in any of four (4) measure domains 7.5 percent of annual net income, pro-rated by county membership. **Table 1** (above) shows the MY2025 MCAS measures within the four measure domains.

Quality Sanctions Program

DHCS intends to hold all California Managed Care Plans accountable for sanctions for all MCAS Accountable measures that did not reach the 50th percentile benchmark at either the county level or at the level of groups of counties. In MY2025 sanctions will be applied to all 24 counties in Partnership's network.

Quality Factor Score

DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. This score is reputational in nature and carries no financial risk for Partnership.

Partnership's Efforts to Improve Data Quality – MY2025

Partnership was able to use a number of new supplemental data sources in the MY2025 HEDIS Annual project.

Electronic Clinical Data Systems (ECDS) Vendor: Partnership expanded its use of Datalink, an NCQA Certified Data Aggregator software, in MY2025, and received auditor approval to include records in the MY2025 HEDIS Project. The use of clinical data towards HEDIS measure rate calculation is an important step towards readiness for NCQA's planned transition of hybrid measures to ECDS measures by 2029, which require structured clinical data for measure rate generation; and towards readiness for CMS's Interoperability Framework.

Records from over 30 practices within Partnership's provider network were included in the MY2025 HEDIS Annual Project. Partnership continues to make progress with leveraging Datalink as a supplemental data source:

- Even without full implementation across the Partnership network, Datalink made a significant positive impact on administrative rates for MCAS Accountable measures. To summarize, the impact of Datalink on measure rates includes:
    - 23% of total care gaps closed for the CBP administrative measure, plan-wide
    - 17% of total care gaps closed for the GSD administrative measure, plan-wide
    - 18% of total care gaps closed for the BCS-E ECDS measure, plan-wide
    - 12% of total care gaps closed for the CCS-E ECDS measure, plan-wide

- Partnership is preparing for the addition of three (3) Depression Screening measures to the MCAS accountable measure set in MY2026: Depression Screening for Adolescents and Adults (DSF-E-SC); Prenatal Depression Screening (PND-E-SC); and Postpartum Depression Screening (PDS-E-SC). Datalink will be the sole source of data for these three measures.

Year Round Medical Record Review for Well-Child Visits in the First 30 Months of Life (W30) and Prenatal and Postpartum Care (PPC) measures: In MY2024, the QI department identified a systems issue with newborns' temporary member ID's that caused underreporting of newborn visit rates for the W30 measure. To address, the HEDIS team completed a supplemental Medical Record Review of the entire W30 measure eligible population in early 2025, which was accepted as a supplemental data source by HSAG's auditor. The supplemental Medical Record Review made a dramatic impact on the rates for both W30 submeasures, and both W30 submeasure rates scored above the 67th percentile for MY2024.

In MY2025, the HEDIS team repeated the Medical Record Review as a year-round effort, which allowed the team more time to collect and review charts for the W30 eligible population. The team also expanded the scope of the year-round Medical Record Review to allow the Prenatal and Postpartum Care (PPC) submeasures to benefit from the extended review period.

Electronic Record on Demand (ERD) Clinical Data retrieval pilot: Partnership piloted an additional clinical data retrieval methodology supported by the plan's HEDIS certified software vendor, Inovalon. The pilot was focused on retrieving clinical records for measures that were not included in the ECDS Datalink scope which resulted in a slight increase in rates across 22 measures in the MCAS and NCQA Health Plan Accreditation measure sets. Further assessment is underway to determine the potential to expand this effort.

Sacramento Valley MedShare (SVMS): SVMS is a Health Information Exchange used by practices and health systems throughout Northern California. In MY2025, Partnership received auditor approval to use Encounter, Lab, and Measurement (i.e., blood pressure readings) records towards the HEDIS Annual Project, which had a significant impact on several MCAS measures in MY2025. SVMS's Immunization records did not receive auditor approval to be included in the MY2025 HEDIS rate generation.

Root cause analysis of fluoride varnish services: Partnership worked with DHCS in 2024 - 2025 to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL) MCAS measure, most of which are billed to Denti-Cal from Federally Qualified Health Center (FQHC), Rural Health Center (RHC), and Tribal Health Dental Centers and then sent to Partnership. In 2025 Partnership actively worked with DHCS and Dental Centers throughout its network to standardize and spread dental fluoride varnish coding that would accurately capture completed services towards the MY2025 measure. The plan also created a Dental Liaison role on the Quality Improvement team to promote pediatric dental care and ensure that the Partnership network has high quality dental directory resources and referral pathways for pediatric members. This has resulted in significant improvements to Partnership's ability to accurately report pediatric fluoride varnish application rates.

HEDIS Annual Project Outcomes

Partnership successfully launched our HEDIS® MY2025 / RY2026 data collection and reporting audits incorporating all changes as noted above.

DHCS MCAS Accountable Measures

In MY2025 / RY2026 HEDIS® Annual Final Reporting, DHCS announced that it is planning to hold managed care plans (MCPs) accountable and imposing financial sanctions on 18 selected Hybrid and Administrative measures performing below the minimum performance level (MPL - 50th national Medicaid percentile). The same 18 MCAS accountable measures from MY2024 continued into MY2025. See **Section 2** above for a full description of DHCS accountability programs.

Results of an additional 10 MCAS measures were reported but were not part of the accountability measure set in MY2025 (“reporting only measures”). The full list of MY2025 MCAS measures can be found on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2026.pdf

Much of the measure performance analysis that follows is based on the performance of the 18 accountable MCAS measures per NCQA Quality Compass 2025 Benchmarks, developed on MY2024 performance.

3.0 Plan-Wide MCAS Performance Relative to Quality Compass® Medicaid Benchmarks

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Plan Wide Performance			Medicaid National Benchmarks			
Abbr	Measure	Plan Wide	25TH	50TH	75TH	90TH
Behavioral Health Domain						
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	41.35%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	50.26%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain						
CIS-E	Childhood Immunization Status - Combination 10	26.74%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life1, 3	39.42%		37.40%		
IMA-E	Immunizations for Adolescents - Combination 2	39.39%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	74.94%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children 3	21.07%		21.50%		
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months 5	76.64%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months 5	64.64%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	52.57%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain						
AMR	Asthma Medication Ratio	73.33%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure1	67.40%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) 1, 4	27.74%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain						
BCS-E	Breast Cancer Screening 2	53.43%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	48.08%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	58.98%	48.48%	56.30%	65.47%	70.67%
PPC-Post	Prenatal and Postpartum Care: Postpartum Care 1	90.02%	78.10%	82.48%	85.15%	88.32%
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care 1	87.10%	82.97%	86.37%	89.78%	91.97%

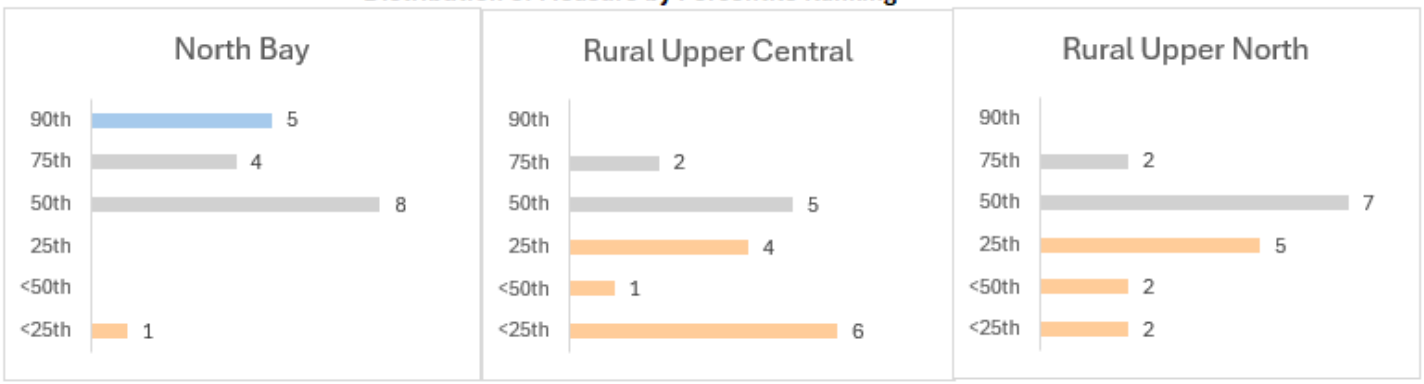
(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

4.0 MCAS Summary of Performance by Region

Regional Distribution of Measures by Percentile Ranking

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Distribution of Measure by Percentile Ranking



4.1 MCAS Measures at or Above the High Performance Level (HPL) – 90th Percentile

Measures at or Above the High Performance Level (HPL) – 90th Percentile

Abbr	Measures	North Bay
Children's Health Domain		
CIS-E	Childhood Immunization Status - Combination 10	
IMA-E	Immunizations for Adolescents - Combination 2	
Chronic Disease Domain		
AMR	Asthma Medication Ratio	
Reproductive Health and Cancer Prevention Domain		
PPC-Post	Prenatal and Postpartum Care: Postpartum Care [1]	
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care [1]	

4.2 MCAS Measures below the Minimum Performance Level (MPL) - 50th Percentile

Measures below the Minimum Performance Level (MPL) - 50th Percentile

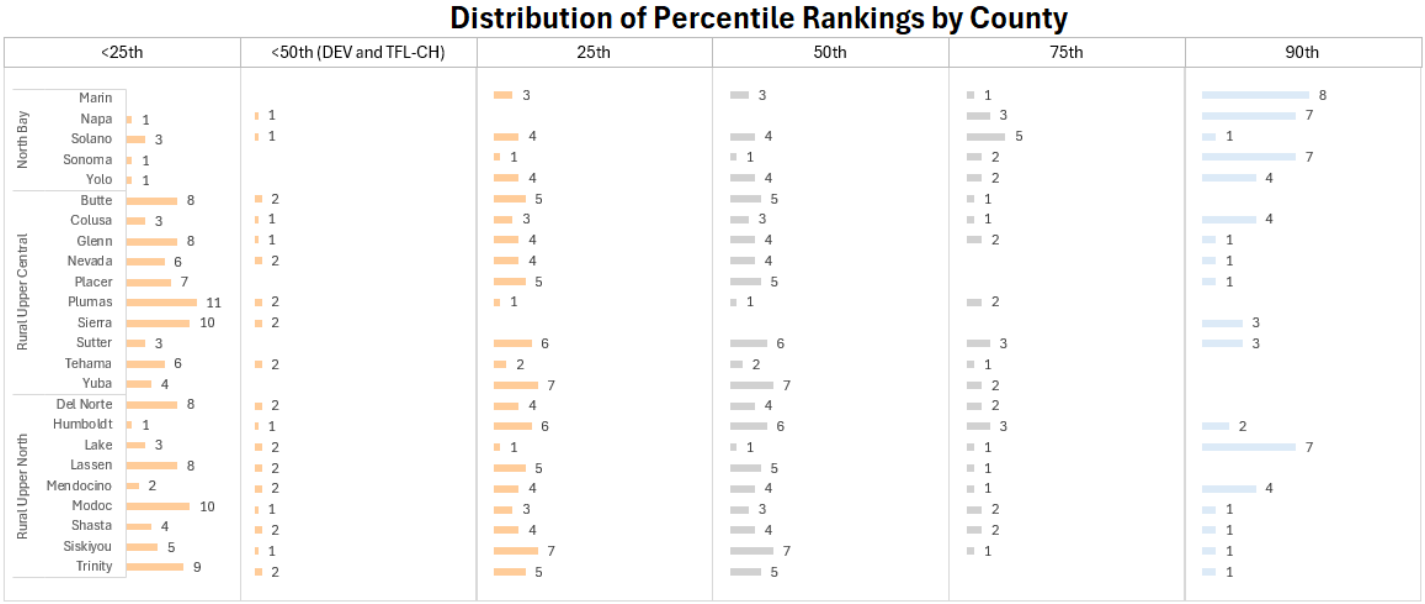
Abbr	Measures	North Bay	Rural Upper Central	Rural Upper North
Behavioral Health Domain				
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness (FUM)-30-Day Follow-Up	●	●	●
Children's Health Domain				
CIS-E	Childhood Immunization Status ECDS (CIS-E)-Combination 10			●
DEV	Developmental Screening in the First Three Years of Life (DEV-CH)-Total, All Ages		●	●
IMA-E	Immunizations for Adolescents ECDS (IMA-E)-Combination 2		●	●
LSC	Lead Screening in Children (LSC)		●	
TFL	Topical Fluoride for Children (TFL-CH)-Numerator 1 Total			●
W30-6	Well Child 30 (W30)-Well Child Visits in the First 15 Months		●	
WCV	Child and Adolescent Well-Care Visits (WCV)-Total		●	●
Chronic Disease Domain				
CBP	Controlling High Blood Pressure (CBP)-Non-Medicare Total		●	
Reproductive Health and Cancer Prevention Domain				
BCS	Breast Cancer Screening ECDS (BCS-E)-Non-Medicare Total		●	●
CCS	Cervical Cancer Screening ECDS (CCS-E)		●	
CHL	Chlamydia Screening in Women (CHL)-Total		●	●
PPC-Pre	Prenatal and Postpartum Care (PPC)-Timeliness of Prenatal Care		●	●

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.0 MCAS Summary of Performance by County

5.1 MCAS Distribution of Percentile Rankings by County

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)



NOTE: The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. Performance below the 50th percentile is indicated by the <50th column in the graph.

5.2 MCAS Percentile Ranking Change from Prior Year

Where measures remained in the MCAS in MY2025, the next set of tables show that Partnership observed a number of measures that declined or improved in percentile ranking relative to prior year. The NCQA Quality Compass 2025 Benchmarks, which were developed based on MY2024 performance, result in the percentile rankings below.

At the County level, a comparison of county-level performance between MY2024 and MY2025 in Partnership's 24 counties shows:

- 147 county-level measures, or 34% of 432 county-level measures, improved in performance and moved to a higher benchmark in MY2025.
- 204 county-level measures, or 47% of 432 county-level measures, stayed at their same benchmark as MY2024 in MY2025.
- 81 county-level measures, or 19% of 432 county-level measures, declined in performance and moved to a lower benchmark in MY2025.

5.2.1 MCAS Percentile Ranking Change MY2024-2025 – Auburn Region: Nevada, Placer, Plumas, Sierra Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		NEVADA		PLACER		PLUMAS		SIERRA	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	50th	25th	<25th	50th	<25th	50th	<25th	90th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	25th	<25th	<25th	<25th	50th	90th	<25th
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
DEV	Developmental Screening in the First Three Years of Life[1,3]	50th	<50th	50th	50th	<50th	<50th	<50th	<50th
IMA-E	Immunizations for Adolescents - Combination 2	<25th	<25th	25th	<25th	<25th	<25th	<25th	25th
LSC	Lead Screening in Children	75th	25th	50th	50th	75th	<25th	<25th	<25th
TFL	Topical Fluoride for Children[3]	<50th	<50th	50th	50th	<50th	<50th	<50th	<50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	90th	<25th	<25th	25th	<25th	<25th	<25th	<25th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	<25th	<25th	<25th	25th	<25th	<25th	<25th	<25th
WCV	Child and Adolescent Well-Care Visits	<25th	<25th	25th	25th	<25th	<25th	<25th	<25th
Chronic Disease Domain									
AMR	Asthma Medication Ratio	<25th	50th	<25th	90th	90th	25th	<25th	90th
CBP	Controlling High Blood Pressure[1]	<25th	50th	<25th	<25th	<25th	<25th	<25th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1,4]	95th	25th	<25th	25th	90th	<25th	<25th	25th
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening[2]	90th	25th	<25th	<25th	<25th	<25th	<25th	<25th
CCS-E	Cervical Cancer Screening	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
CHL	Chlamydia Screening in Women	<25th	25th	50th	50th	<25th	<25th	<25th	<25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	75th	90th	75th	25th	25th	75th	<25th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	25th	50th	<25th	<25th	75th	25th	<25th	25th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.2 MCAS Percentile Ranking Change MY2024-2025 – Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		BUTTE		COLUSA		GLENN		SUTTER		YUBA	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain											
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	25th	50th	<25th	50th	<25th	25th	<25th	50th	<25th	50th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	25th	25th	25th	<25th	<25th	50th	<25th	50th
Children's Health Domain											
CIS-E	Childhood Immunization Status - Combination 10	<25th	50th	<25th	50th	50th	75th	90th	75th	90th	75th
DEV	Developmental Screening in the First Three Years of Life[1,3]	<50th	<50th	50th	<50th	50th	50th	50th	50th	50th	50th
IMA-E	Immunizations for Adolescents - Combination 2	<25th	<25th	<25th	<25th	50th	<25th	50th	90th	50th	90th
LSC	Lead Screening in Children	<25th	<25th	90th	50th	75th	50th	90th	75th	90th	75th
TFL	Topical Fluoride for Children[3]	<50th	<50th	50th	50th	<50th	<50th	50th	50th	50th	50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	<25th	50th	90th	75th	<25th	50th	<25th	90th	<25th	90th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	<25th	25th	<25th	<25th	<25th	<25th	<25th	25th	<25th	25th
WCV	Child and Adolescent Well-Care Visits	<25th	<25th	50th	90th	50th	50th	50th	50th	50th	50th
Chronic Disease Domain											
AMR	Asthma Medication Ratio	50th	50th	<25th	90th	90th	90th	<25th	50th	<25th	50th
CBP	Controlling High Blood Pressure[1]	50th	<25th	25th	25th	75th	<25th	50th	25th	50th	25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1,4]	<25th	50th	25th	25th	90th	<25th	90th	75th	90th	75th
Reproductive Health and Cancer Prevention Domain											
BCS-E	Breast Cancer Screening[2]	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
CCS-E	Cervical Cancer Screening	<25th	<25th	<25th	25th	<25th	<25th	<25th	<25th	<25th	<25th
CHL	Chlamydia Screening in Women	25th	25th	25th	25th	25th	25th	50th	25th	50th	25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	90th	75th	90th	90th	75th	75th	90th	75th	90th	75th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	25th	<25th	<25th	90th	25th	<25th	50th	25th	50th	25th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.3 MCAS Percentile Ranking Change MY2024-2025 – Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		DEL NORTE		HUMBOLDT		LAKE		MENDOCINO	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	<25th	50th	<25th	75th	<25th	50th	25th	25th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	25th	<25th	25th	25th	25th	<25th	<25th	<25th
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	<25th	<25th	<25th	25th	25th	50th	50th	50th
DEV	Developmental Screening in the First Three Years of Life[1, 3]	<50th	<50th	50th	50th	<50th	<50th	<50th	<50th
IMA-E	Immunizations for Adolescents - Combination 2	50th	25th	50th	75th	50th	90th	<25th	50th
LSC	Lead Screening in Children	<25th	25th	90th	50th	50th	90th	75th	90th
TFL	Topical Fluoride for Children[3]	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	50th	<25th	75th	50th	75th	90th	75th	75th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	75th	<25th	75th	25th	90th	90th	90th	90th
WCV	Child and Adolescent Well-Care Visits	25th	50th	25th	25th	25th	25th	25th	25th
Chronic Disease Domain									
AMR	Asthma Medication Ratio	25th	75th	25th	50th	<25th	90th	25th	90th
CBP	Controlling High Blood Pressure[1]	<25th	25th	75th	90th	<25th	75th	25th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	25th	75th	90th	75th	90th	<25th	50th	50th
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening[2]	<25th	<25th	25th	25th	25th	<25th	50th	25th
CCS-E	Cervical Cancer Screening	<25th	<25th	25th	50th	<25th	50th	25th	50th
CHL	Chlamydia Screening in Women	<25th	25th	25th	25th	25th	50th	25th	25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	25th	<25th	90th	90th	90th	90th	90th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	<25th	<25th	<25th	<25th	50th	90th	50th	50th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+

and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.4 MCAS Percentile Ranking Change MY2024-2025 – Fairfield Region: Napa, Solano, Yolo Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		NAPA		SOLANO		YOLO	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain							
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	<25th	50th	<25th	50th	<25th	25th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	<25th	<25th	<25th
Children's Health Domain							
CIS-E	Childhood Immunization Status - Combination 10	90th	90th	50th	75th	75th	50th
DEV	Developmental Screening in the First Three Years of Life[1, 3]	<50th	<50th	<50th	<50th	50th	50th
IMA-E	Immunizations for Adolescents - Combination 2	90th	90th	75th	75th	75th	90th
LSC	Lead Screening in Children	90th	90th	75th	50th	50th	50th
TFL	Topical Fluoride for Children [3]	<50th	50th	<50th	50th	50th	50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months [5]	75th	75th	<25th	50th	75th	75th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months [5]	25th	90th	25th	25th	<25th	50th
WCV	Child and Adolescent Well-Care Visits	50th	75th	<25th	<25th	50th	25th
Chronic Disease Domain							
AMR	Asthma Medication Ratio	90th	90th	25th	75th	50th	90th
CBP	Controlling High Blood Pressure[1]	25th	75th	50th	75th	25th	75th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) [1, 4]	25th	50th	75th	25th	90th	50th
Reproductive Health and Cancer Prevention Domain							
BCS-E	Breast Cancer Screening [2]	90th	90th	50th	25th	75th	50th
CCS-E	Cervical Cancer Screening	25th	50th	<25th	<25th	25th	25th
CHL	Chlamydia Screening in Women	<25th	50th	50th	75th	25th	25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care [1]	90th	50th	90th	90th	50th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care [1]	<25th	90th	25th	25th	<25th	90th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one

(1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.5 MCAS Percentile Ranking Change MY2024-2025 – Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

Tehama County is excluded from the Redding Region table, since the County joined Partnership in 2024.

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		LASSEN		MODOC		SHASTA		SISKIYOU		TEHAMA		TRINITY	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain													
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	<25th	25th	<25th	75th	25th	75th	50th	25th	<25th	25th	<25th	25th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	<25th	<25th	50th	<25th	50th	<25th	<25th	<25th	25th
Children's Health Domain													
CIS-E	Childhood Immunization Status - Combination 10	<25th	<25th	<25th	<25th	<25th	<25th	25th	<25th	<25th	25th	<25th	<25th
DEV	Developmental Screening in the First Three Years of Life[1, 3]	<50th	<50th	<50th	50th	<50th	<50th	<50th	50th	<50th	<50th	<50th	<50th
IMA-E	Immunizations for Adolescents - Combination 2	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
LSC	Lead Screening in Children	75th	25th	90th	25th	50th	50th	25th	25th	75th	25th	75th	25th
TFL	Topical Fluoride for Children[3]	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	50th	<25th	<25th	<25th	<25th	25th	25th	<25th	75th	50th	<25th	<25th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	50th	25th	<25th	<25th	75th	50th	<25th	25th	90th	<25th	25th	<25th
WCV	Child and Adolescent Well-Care Visits	<25th	<25th	25th	<25th	<25th	25th	25th	25th	<25th	25th	25th	<25th
Chronic Disease Domain													
AMR	Asthma Medication Ratio	<25th	75th	25th	90th	<25th	50th	25th	90th	<25th	50th	<25th	<25th
CBP	Controlling High Blood Pressure[1]	50th	25th	<25th	<25th	<25th	50th	50th	75th	25th	25th	<25th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	50th	<25th	25th	75th	25th	90th	<25th	50th	90th	25th	25th	50th
Reproductive Health and Cancer Prevention Domain													
BCS-E	Breast Cancer Screening[2]	<25th	<25th	25th	25th	50th	<25th	25th	25th	<25th	<25th	25th	<25th
CCS-E	Cervical Cancer Screening	<25th	<25th	<25th	25th	25th	25th	25th	25th	<25th	<25th	25th	25th
CHL	Chlamydia Screening in Women	<25th	25th	<25th	<25th	25th	25th	<25th	25th	25th	25th	<25th	<25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	25th	50th	25th	<25th	<25th	75th	75th	<25th	25th	75th	<25th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	50th	50th	25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	25th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.6 MCAS Percentile Ranking Change MY2024-2025 – Santa Rosa Region: Marin, Sonoma Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		MARIN		SONOMA	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain					
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	<25th	50th	<25th	50th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	50th	25th	25th	25th
Children's Health Domain					
CIS-E	Childhood Immunization Status - Combination 10	50th	90th	75th	90th
DEV	Developmental Screening in the First Three Years of Life[1,3]	50th	50th	<50th	50th
IMA-E	Immunizations for Adolescents - Combination 2	90th	90th	90th	90th
LSC	Lead Screening in Children	90th	90th	25th	<25th
TFL	Topical Fluoride for Children[3]	<50th	50th	<50th	50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	90th	90th	50th	75th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	90th	90th	90th	90th
WCV	Child and Adolescent Well-Care Visits	50th	50th	50th	50th
Chronic Disease Domain					
AMR	Asthma Medication Ratio	25th	75th	50th	90th
CBP	Controlling High Blood Pressure[1]	50th	25th	75th	75th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1,4]	25th	25th	<25th	90th
Reproductive Health and Cancer Prevention Domain					
BCS-E	Breast Cancer Screening[2]	75th	50th	50th	50th
CCS-E	Cervical Cancer Screening	25th	50th	50th	50th
CHL	Chlamydia Screening in Women	90th	90th	25th	50th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	90th	90th	90th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	50th	90th	25th	90th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+

and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3 MY2025 MCAS Annual Performance by County

5.3.1 MCAS Auburn Region: Nevada, Placer, Plumas, Sierra Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Auburn				National Medicaid Benchmarks			
Abbr	**Measure**	**NEVADA**	**PLACER**	**PLUMAS**	**SIERRA**	**25TH**	**50TH**	**75TH**	**90TH**
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	38.97%	44.96%	45.71%	100.00%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	52.27%	41.97%	57.50%	12.50%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	13.61%	16.47%	0.00%	10.00%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	23.53%	43.14%	4.90%	17.39%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	13.01%	29.10%	10.13%	33.33%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	67.00%	75.00%	45.28%	20.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children[3]	13.02%	22.72%	7.38%	9.05%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	64.09%	70.53%	57.14%	66.67%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	41.76%	60.71%	30.56%	12.50%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	44.69%	50.27%	39.48%	32.61%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain									
AMR	Asthma Medication Ratio	67.27%	80.43%	63.16%	100.00%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	71.00%	53.00%	62.00%	52.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	32.00%	31.00%	73.00%	31.58%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening[2]	52.94%	50.00%	0.00%	0.00%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	38.96%	38.27%	16.37%	30.77%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	48.90%	58.83%	27.07%	7.69%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	95.00%	82.00%	86.44%	100.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	87.00%	77.00%	84.75%	83.33%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.2 MCAS Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Chico					National Medicaid Benchmarks			
Abbr	Measure	BUTTE	COLUSA	GLENN	SUTTER	YUBA	25TH	50TH	75TH	90TH
Behavioral Health Domain										
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	43.34%	39.13%	35.59%	39.47%	37.50%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	45.25%	54.02%	48.21%	59.72%	60.21%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain										
CIS-E	Childhood Immunization Status - Combination 10	27.77%	28.78%	30.41%	33.50%	23.46%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	20.59%	23.53%	48.04%	55.88%	49.02%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	25.62%	29.13%	24.44%	51.93%	43.35%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	55.00%	75.00%	75.00%	80.00%	65.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children[3]	20.23%	31.82%	14.70%	35.18%	26.02%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	74.16%	81.75%	75.17%	88.04%	76.98%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	59.95%	55.75%	35.88%	58.51%	54.14%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	44.32%	68.06%	57.58%	59.83%	50.26%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain										
AMR	Asthma Medication Ratio	68.79%	80.00%	78.35%	69.62%	64.93%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	61.00%	64.00%	62.00%	64.00%	55.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	30.00%	31.00%	36.00%	26.00%	26.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain										
BCS-E	Breast Cancer Screening[2]	36.96%	11.11%	42.86%	40.00%	44.44%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	36.16%	49.25%	44.72%	46.08%	40.79%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	54.53%	50.94%	50.75%	55.91%	58.97%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	87.00%	97.00%	87.00%	88.00%	82.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	81.00%	93.00%	69.00%	86.00%	87.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.3 MCAS Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Eureka				National Medicaid Benchmarks			
Abbr	Measures	DEL NORTE	HUMBOLDT	LAKE	MENDOCINO	25TH	50TH	75TH	90TH
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	41.73%	46.22%	39.31%	35.44%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	47.18%	53.14%	47.34%	49.04%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	5.07%	21.66%	26.90%	25.16%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	32.35%	53.92%	26.47%	17.65%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	33.94%	41.59%	50.19%	36.23%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	65.00%	74.00%	84.00%	84.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children [3]	9.86%	9.53%	7.08%	10.69%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months [5]	62.07%	75.81%	86.24%	79.66%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months [5]	56.92%	61.39%	80.12%	77.86%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	55.90%	51.56%	50.46%	55.28%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain									
AMR	Asthma Medication Ratio	74.07%	65.52%	81.37%	80.37%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	66.00%	79.00%	75.00%	58.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) [1, 4]	24.00%	25.00%	39.00%	29.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening [2]	46.57%	52.24%	47.58%	53.30%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	46.91%	53.01%	54.00%	55.98%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	52.49%	53.82%	63.70%	56.29%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care [1]	76.00%	93.00%	89.00%	94.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care [1]	80.00%	79.00%	94.00%	88.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.4 MCAS Fairfield Region: Solano, Yolo, and Napa Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Fairfield			National Medicaid Benchmarks			
Abbr	Measures	NAPA	SOLANO	YOLO	25TH	50TH	75TH	90TH
Behavioral Health Domain								
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	40.11%	40.75%	33.33%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	40.49%	47.36%	39.97%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain								
CIS-E	Childhood Immunization Status - Combination 10	38.56%	32.03%	26.68%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	11.76%	34.31%	44.12%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	57.56%	46.98%	48.03%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	86.00%	74.00%	72.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children [3]	27.05%	22.99%	25.19%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months [5]	80.13%	72.82%	78.63%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months [5]	75.36%	62.18%	66.98%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	64.08%	48.38%	54.46%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain								
AMR	Asthma Medication Ratio	84.88%	74.58%	77.20%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	73.00%	73.00%	74.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) [1, 4]	30.00%	34.00%	28.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain								
BCS-E	Breast Cancer Screening [2]	68.63%	52.50%	56.03%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	53.29%	45.82%	51.78%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	60.46%	69.97%	55.05%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care [1]	84.00%	92.00%	95.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care [1]	93.00%	86.00%	94.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.5 MCAS Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Redding						National Medicaid Benchmarks			
Abbr	Measures	LASSEN	MODOC	SHASTA	SISKIYOU	TEHAMA	TRINITY	25TH	50TH	75TH	90TH
Behavioral Health Domain											
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	29.63%	48.00%	51.58%	34.92%	28.31%	30.77%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	47.27%	41.67%	59.20%	62.81%	38.10%	52.94%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain											
CIS-E	Childhood Immunization Status - Combination 10	3.23%	11.11%	10.02%	16.49%	20.05%	3.45%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	22.55%	45.00%	35.29%	43.14%	36.27%	11.76%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	11.54%	16.92%	18.75%	19.22%	26.33%	15.49%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	62.77%	66.67%	74.00%	63.00%	68.00%	67.80%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children[3]	8.54%	5.13%	13.67%	10.63%	14.06%	10.26%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	54.08%	59.52%	71.36%	67.91%	77.10%	62.71%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	58.70%	45.71%	64.69%	59.05%	57.81%	46.51%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	33.68%	47.08%	49.71%	50.13%	51.95%	49.07%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain											
AMR	Asthma Medication Ratio	71.43%	100.00%	65.33%	78.26%	69.06%	45.71%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	67.00%	57.00%	71.00%	73.00%	65.00%	54.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	39.00%	26.00%	23.00%	28.00%	31.00%	28.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain											
BCS-E	Breast Cancer Screening[2]	39.31%	51.72%	45.02%	50.99%	50.00%	34.53%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	44.09%	49.74%	51.11%	51.49%	40.93%	49.61%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	53.59%	46.05%	54.35%	51.43%	53.02%	40.00%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	82.76%	64.86%	86.00%	76.00%	86.00%	90.91%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	88.51%	70.27%	79.00%	81.00%	78.00%	86.36%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.6 MCAS Santa Rosa Region: Marin, Sonoma Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Santa Rosa		National Medicaid Benchmarks			
Abbr	Measures	MARIN	SONOMA	25TH	50TH	75TH	90TH
Behavioral Health Domain							
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	43.18%	39.74%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	55.08%	54.83%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain							
CIS-E	Childhood Immunization Status - Combination 10	45.92%	40.14%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life[1, 3]	81.37%	41.18%		37.40%		
IMA-E	Immunizations for Adolescents - Combination 2	67.47%	55.78%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	86.00%	61.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children[3]	41.72%	27.35%		21.50%		
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months[5]	91.59%	78.86%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months[5]	78.83%	74.53%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	60.35%	58.16%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain							
AMR	Asthma Medication Ratio	73.23%	79.28%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure[1]	64.00%	74.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%)[1, 4]	34.00%	23.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain							
BCS-E	Breast Cancer Screening[2]	60.55%	57.12%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	55.26%	57.41%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	77.57%	60.86%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care[1]	98.00%	98.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care[1]	93.00%	97.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

6.0 Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS)

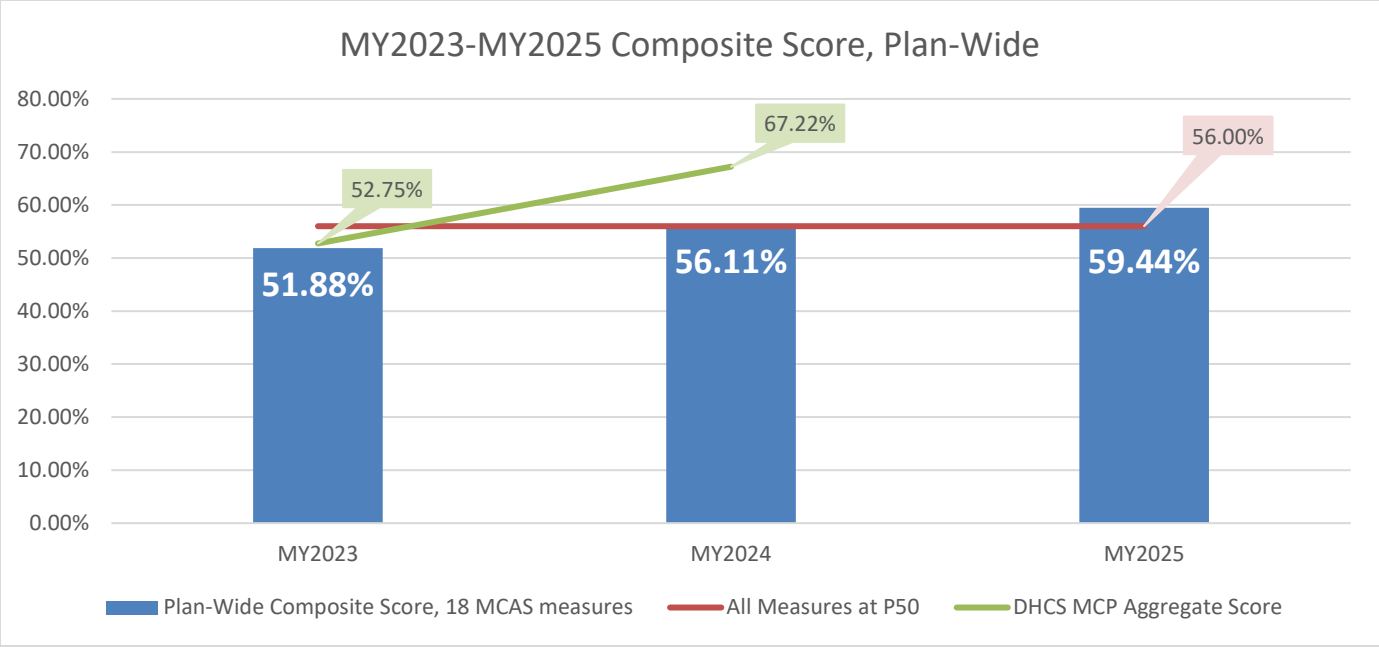
DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS' scoring methodology to determine Partnership's composite scores year over year. The composite score is based on the plan-wide measure rates for all measures in the MCAS measure set.

To calculate the composite score, each measure is given a score from one to ten based on performance relative to national benchmarks. A composite score is then calculated by dividing total earned points by total possible points.

The Quality Compass 2025 Benchmarks, which were developed based on national MY2024 performance, are the most currently available benchmarks. These benchmarks were used by Partnership to determine percentile rankings and the following composite scoring year over year analysis. Annually each fall, DHCS releases a dashboard displaying the plan's Quality Factor Scores and associated rankings to other health plans, along with the Reporting Year's MCP Aggregate Score. The results of this ranking will be published upon the release of this information later in 2026.

Overall, the MY2025 HEDIS® Composite Performance Year over Year Comparison indicates a 5.93% increase in aggregate plan-wide performance from MY2024 to MY2025.

MY2025 HEDIS® Composite Performance Year over Year Comparison: DHCS Managed Care Accountability Set (MCAS)



Note: MY2025/RY2026: Total Points Earned: 107 Points out of 180 Total Points (18 measures included)

- In MY2025, 18 measures were held accountable to the MPL. The MCAS measure set has included the same 18 measures between MY2023 – MY2025.
- The MY2025 Quality Factor Score will be released by DHCS in Fall 2026, and the MY2025 MCP Aggregate Score will be updated at that time.

7.0 Year-over-year Performance Trends and Initial Assessment of Results

7.1 Year-over-year Performance Trends

Plan-Wide, Partnership saw the following Year over Year changes in Plan-Wide rates between MY2024 and MY2025:

- 6 of 18 measures moved to a higher benchmark in MY2025.
- 7 of 18 measures stayed at their same benchmark as MY2024 in MY2025.
- 5 of 18 measures moved to a lower benchmark in MY2025.

7.2 Plan-Wide Strengths: Measure Performing Above MPL

12 of the 18 measures in the MCAS Accountable set had plan-wide rates that exceeded the Minimum Performance Level in MY2025.

Three measures are newly above the Minimum Performance Level in MY2025, as seen in the Table below.

Table: MCAS Measures Newly Above MPL in MY2025

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Follow-Up After Emergency Department Visit for Substance Use - 30-Days (FUA-30)	33rd	50th +8.08%	25th	50th	25th	50th	25th	67th
Asthma Medication Ratio (AMR)	33rd	75th +8.62%	50th	90th	<25th	75th	25th	75th
Chlamydia Screening in Women (CHL)	33rd	50th +3.40%	50th	75th	25th	33rd	25th	33rd

Benchmark
90th
67th or 75th
50th – MPL or >50th (CMS)
25th or 33rd
<25th or <50th (CMS)

Follow-up After Emergency Department (ED) Visit for Substance Use (FUA-30): Partnership's plan-wide rate for FUA-30 is newly over the 50th percentile plan-wide and in all three Rating Regions in MY2025, with a plan-wide increase over 8% in performance. Partnership worked collaboratively with county partners to close care gaps and enhance data collection and reporting of qualifying follow-up services. Additionally, MY2025 was a year of sustained focus on maximizing data capture opportunities from DHCS's data feed. Finally, DHCS released All Plan Letter 26-003 in early 2026 that mandates data sharing for behavioral health visits, including visits for substance use treatment; Partnership believes that this prescribed approach to data sharing will increase access to sensitive data required for accurate rate reporting.

Asthma Medication Ration (AMR): Partnership rates were at the 75th percentile, plan-wide and at or above the 75th percentile in all three Rating Regions, in MY2025. The HEDIS team reviewed updates to its AMR custom code mapping frequently during the MY2025 Annual Project and

requested several custom code mappings from their auditor. In MY2025, Partnership added a Unit of Service (UOS) measure to its PCP QIP, to incentivize practices to host Academic Detailing sessions with Partnership's Pharmacy team. The Pharmacy team reviews pharmacy claims data to improve medication management for asthma and other chronic conditions. The AMR measure was retired at the end of MY2025, and is replaced by a Reporting Only measure, Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E), in MY2026.

Chlamydia Screening in Women (CHL): Partnership added the CHL measure to its PCP QIP in MY2025, which allowed practices to monitor their performance on this measure. As a result Chlamydia Screening rates increased in North Bay Area in MY2025 and the plan-wide rate is over the 50th percentile. DHCS retired CHL from the MCAS measure set at the end of MY2025.

Four additional measures have sustained Plan-Wide performance above the MPL since MY2024.

Table: MCAS Measures With Sustained Performance above the MPL MY2024-2025

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Childhood Immunization Status - Combination 10 (CIS-E)	50th	50th +2.16%	67th	90th	<25th	50th	<25th	<25th
Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months (W30-2)	67th	67th +4.42%	67th	75th	<25th	50th	50th	50th
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) *	50th	67th -4.87% *	33rd	50th	25th	50th	50th	50th
Prenatal and Postpartum Care: Postpartum Care (PPC-Post)	90th	90th +0.49%	90th	90th	75th	75th	75th	75th

Benchmark
90th
67th or 75th
50th – MPL or >50th (CMS)
25th or 33rd
<25th or <50th (CMS)

* Glycemic Status Assessment is an inverse measure, and a decline in YoY performance indicates improvement.

Childhood Immunizations ECDS (CIS-E): Partnership sustained its Plan-Wide rate above the 50th percentile on this measure in MY2025, despite the measure transitioning from a hybrid measure to an ECDS measure. The sustained performance is partially due to a small plan-wide rate increase, and also due to the continuing decline in the national percentiles between MY2024 and MY2025. North Bay Area and Rural Upper Central counties had significantly stronger measure performance than Rural Upper North counties. Interestingly, Partnership's rate for influenza vaccines, which is the most widely refused vaccine in the measure series, is above the 50th percentile, which is likely the cause of our plan-wide benchmark remaining above the 50th percentile. High rates of parental refusal, especially in Rural Upper North counties, continue to be a major factor in measure performance, which is not a permitted exclusion under the HEDIS measure. Partnership recommends a focus on completing Well Child Visits for children under 2 years as a driver for higher completion rates for this measure.

Well Child Visits in the First 30 Months of Life: 2+ Visits 15-30 Months (W30-2): The W30-2 measure continues its second year at the 67th percentile and is above the 50th percentile in all three Rating Regions. Partnership continues to address the known data completeness issues around the W30 measure by completing a Medical Record Review (MRR) of the entire eligible population for the W30 measure. By requesting charts from PCP's and completing a Medical Record Review, Partnership treats the measure as a hybrid measure and receives auditor approval annually to include the W30 MRR as a supplemental data source.

In addition, the HEDIS team conducted a W30 Kaizen across the organization which primarily identified gaps in incomplete claims submission. Finally, Partnership is working closely with DHCS as an active participant in the DHCS Early Childhood Affinity State Work group to improve newborn visit capture statewide.

Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD): GSD's Plan-Wide rate improved by 4.87% in MY2025 (as an inverse measure, improvement is reflected as a lower rate). GSD is a hybrid measure, and Medical Record Review also shows sustained performance within all three Rating Regions. Partnership's Health Information Exchange, Sacramento Valley MedShare (SVMS) is a clearinghouse for lab data, which helps support the Medical Record Review for this measure. Additionally, Partnership expanded use of an NCQA Data Aggregator, Datalink, in MY2025 – as described in Section 1, Datalink is a promising new source of clinical data, including Hemoglobin A1c results. Finally, the increased use of OCHIN Epic within the PCP network means that more practices have the ability to automate the CPTII coding that is required to support this measure.

Postpartum Care (PPC-Post): Postpartum Care visits continue to be a source of strength for Partnership, with sustained performance over the 90th percentile. Interventions to maintain high postpartum care rates are described in Section 9 and include refinements to the Growing Together Program and equity focused programs centered on communities with lower prenatal and postpartum visit rates.

7.3 Opportunities for Improvement

After analyzing the MY2025 annual results and year over year performance comparisons, measures below the MPL can be categorized across three primary drivers.

1.) Performance – Members qualifying under a measure did not receive the required care per measure specifications and designated timeframes

2.) **Data Completeness** – Data used to generate reported rates has gaps, decreasing confidence that reported rates accurately reflect performance.

3.) Measure Limitations – Measure specifications determine how data is collected through the reporting of rate performance. Measure specifications can detract from a measure's intended purpose. In these cases, specifications can limit accurate representation of performance as well as detection of recent improvements that are in alignment with the measure's purpose and clinical practice.

7.3.1 MCAS Measures with Regional Performance Opportunities

Seven measures are performance improvement opportunities for specific areas of Partnership's network. These measures have sustained performance below the MPL in specific Rating Regions and counties, and data completeness issues are not the primary driver of low measure rates.

Partnership has prioritized **five measures** as its **highest priority for improvement in 2026 onward** at the regional level:

Table: Prioritized MCAS Measures with Performance Opportunities

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Child and Adolescent Well-Care Visits (WCV)	33rd	33rd +3.74%	33rd	50th	25th	25th	25th	25th
Immunizations for Adolescents - Combination 2 (IMA-E)	50th	67th +1.46%	75th	90th	25th	33rd	<25th	33rd
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6)	75th	50th -2.41%	75th	75th	<25th	<25th	75th	67th
Controlling High Blood Pressure (CBP)	75th	33rd -2.19%	50th	75th	25th	<25th	25th	50th
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)	50th	50th +1.70%	<25th	90th	25th	<25th	<25th	25th

Benchmark
90th
67th or 75th
50th – MPL or >50th (CMS)
25th or 33rd
<25th or <50th (CMS)

Child and Adolescent Well Care Visits (WCV): This measure requires an annual well care visit for children and adolescents between the ages of 3-21. While plan-wide performance improved slightly in MY2025, it was not sufficient to meet the MPL benchmark, which increased in MY2025.

Given this measure's demand, performance is largely impacted by access constraints. Young adults ages 18-21 years have by far the lowest rate of well care visit completion within the measure; for several reasons, one of which is to preserve access for younger age bands, the young adult age band is not included in Partnership's PCP QIP WCV measure. Therefore, Partnership requires very high completion rates for children ages 3-17 years (partial payment at 75th percentile and full payment at 90th percentile) in its PCP QIP.

Immunizations for Adolescents (IMA-E): Though Partnership's Plan-Wide rate was at the 67th percentile, regional rates that are approaching the 50th percentile are prioritized as an improvement opportunity for Rural Upper North and Rural Upper Central regions. Because some of the vaccinations included in this measure are required for public school enrollment, this is historically a higher performing childhood vaccination measure than Childhood Immunization Series (CIS-E). Encouragingly, MY2025 shows several counties in Rural Upper North and Rural Upper Central regions exceeding the MPL for this measure along with all North Bay Area counties, and Partnership sees high performance on IMA-E across its network as an achievable goal. The predominant causes of low rates are missing or late secondary doses of the HPV immunization series and high rates of parental refusal.

Well Child Visits in the First 30 Months of Life: 6+ Visits Birth-15 Months (W30-6): The W30-6 measure continues its strong performance in North Bay Area and Rural Upper North Rating Regions. The decline in performance was driven by low performance in the Rural Upper Central Region. MY2025 is the first year that significant numbers of children were in the eligible population for W30-6 in Rural Upper Central counties, and MY2025 should be considered a baseline year for the region. As with W30-2, Partnership completes a Medical Record Review (MRR) of the entire eligible population for the W30 measure, so low performance indicates a low service completion rate, not a data completeness issue.

Controlling Blood Pressure (CBP): This measure was one of the few measures that declined in performance in MY2025, falling from the 75th percentile to the 25th percentile. The decline in performance was driven by low performance in the Rural Upper Central Region and will be a high priority area of focus in MY2026 onward.

Timeliness of Prenatal Care (PPC-Pre): Once again, Partnership just met the MPL for the Plan-Wide rate for this measure in MY2025. While North Bay Area's regional performance improved dramatically in MY2025, PPC-Pre remains an important improvement opportunity for Rural Upper North and Rural Upper Central counties. The HEDIS team observed several performance issues around prenatal visits, noting that many members receive their first prenatal visit outside of the measure timeline, and that visits do not include all of the required components of a prenatal visit. Prenatal visits will continue to be a measure of regional focus in MY2026 onwards to overcome the challenges for birthing populations in the rural North (ie: prenatal care deserts, loss of L&D units and critical access hospitals).

An additional **four measures** are improvement opportunities in 2026 onward at the regional level:

Table: Additional MCAS Measures with Performance Opportunities

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
Measure Description	**MY2024**	**MY2025 YoY points change**	**MY2024**	**MY2025**	**MY2024**	**MY2025**	**MY2024**	**MY2025**
Developmental Screening in the First Three Years of Life (DEV)	<50th	50th +9.77%	<50th	50th	50th	<50th	<50th	<50th
Lead Screening in Children (LSC)	75th	67th +3.16%	50th	50th	50th	33rd	75th	67th
Topical Fluoride for Children (TFL)	<50th	<50th +8.67%	<50th	50th	50th	50th	<50th	<50th
Cervical Cancer Screening (CCS-E)	50th (Hybrid)	25th -11.04%	75th (Hybrid)	50th	<25th (Hybrid)	<25th	25th (Hybrid)	50th

Benchmark
90th
67th or 75th
50th – MPL or >50th (CMS)
25th or 33rd
<25th or <50th (CMS)

Developmental Screening (DEV): In MY2025, DHCS transitioned the Developmental Screening measure from administrative to hybrid, which is recommended by CMS, the measure steward. As a hybrid measure, Partnership had the opportunity to complete a Medical Record Review on this measure in MY2025, which helped to overcome measure coding limitations seen in past years' HEDIS rates.

While only one Rating Region (North Bay Area) achieved the MPL for this measure, the other two regions were very close to the 50th percentile in MY2025. Partnership recommends a focus on completing Well Child Visits for children ages 1-3 years as a driver for higher completion rates for this measure.

Lead Screening for Children (LSC): Partnership sustained performance over the 50th percentile on the LSC measure in MY2025 in North Bay Area and Rural Upper North. Sustained high performance is related to the inclusion of the measure in the PCP QIP, which allows practices to measure their improvement throughout the measurement year, as well as interventions to maintain high lead screening rates described in Section 9. This measure is at the 33rd percentile in Rural Upper Central region and represents a regional improvement opportunity. Partnership recommends a focus on completing Well Child Visits for children ages 1-3 years as a driver for higher completion rates for this measure.

Topical Fluoride for Children (TFL-CH): The largest driver of performance on this measure is Denti-Cal claims data provided by DHCS. Partnership engaged very closely with DHCS's Data Team around improving the completeness of data around this measure, with significant success in MY2025. The use of an ICD-10 code (Z29.3) indicating fluoride varnish application is now mandated on Denti-Cal claims, to allow complete data capture. For the second year in a row, Partnership showed significant year-over-year improvement in TFL-CH rates, and is less than 1 percentage point from meeting the MPL for the measure in MY2025. (There are no additional

benchmarks for this measure.) The Rural Upper North has an improvement opportunity for TFL-CH. Partnership recommends a focus on completing Well Child Visits for children ages 1-20 years as a driver for higher completion rates for this measure.

Cervical Cancer Screening (CCS-E): Cervical Cancer Screening transitioned from a hybrid to an ECDS measure in MY2025. Plan-wide performance at the 25th percentile was driven by low performance in the Rural Upper Central region. While CCS-E represents an improvement opportunity for Rural Upper Central counties, expansion of Datalink will also address data capture of historical screens that occurred prior to the network joining Partnership.

As noted in Section 9, Partnership is promoting self-swab testing to members through PCPs, now that this method has received FDA approval and can be counted towards this HEDIS measure in MY2026 and onward.

7.3.2 MCAS Measures with Data Completeness and Measure Limitation Issues

Finally, two measures performed below the MPL in MY2025 primarily because of data completeness and measure limitation issues. Partnership has documented and escalated data completeness issues around both measures directly to DHCS and is engaged in interventions and activities meant to improve the quality and completeness of data, where relevant.

Table: MCAS Measures with Data Completeness and Measure Limitation Issues

	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North		
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	Benchmark
									90th
									67th or 75th
									50th – MPL or >50th (CMS)
									25th or 33rd
									<25th or <50th (CMS)
Follow-Up After Emergency Department Visit for Mental Illness - 30-Days (FUM-30)	<25th	<25th +21.25%	<25th	<25th	<25th	<25th	<25th	33rd	
Breast Cancer Screening (BCS-E)	50th	33rd -2.86%	50th	50th	<25th	<25th	25th	<25th	

Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM-30): Partnership's plan-wide rate for FUM-30 increased over 20 percentage points in MY2025. Partnership benefitted from a revised NCQA measure definition that expanded the scope of services counting as a follow-up visit, as well as sustained focus on maximizing data capture opportunities from DHCS's data feed. While the plan made significant gains in data capture from DHCS data feeds, Partnership is still not receiving a full year's worth of data from County DBH's to apply to this measure during the HEDIS project timeline. Partnership is actively working with DHCS to improve the quality of our data feed, and exploring other opportunities to receive clinical data from County DBH EMR's to improve the completeness of our data.
Breast Cancer Screening (BCS-E): The Breast Cancer Screening measure transitioned its age range from 52-74 years to 42-74 years. This has resulted in a misalignment of the MY2025 measure (42-74 years), with the NCQA benchmark applied, that was based on MY2024 national

outcomes (52-74 years). Once NCQA creates a national benchmark based on the new age range (later in 2026), this measure limitation issue will no longer exist.

Partnership has recommended to DHCS that Medi-Cal MCP's be held accountable for the 52-74 years sub-measure, which does align with the MY2024 NCQA benchmark. In the majority of counties, Partnership's performance would be above the 50th percentile in MY2025 for DHCS accountability programs if this recommendation is acted upon by DHCS.

Because the measure has long continuous enrollment requirements for members to be included in the measure, MY2025's measure still included very few members from the Rural Upper Central Rating Region.

7.4 Comparing MY2025 MCAS Results to MY2025 PCP QIP Results

The clinical measures included in the Primary Care Provider Quality Incentive Program (PCP QIP) are designed to reflect HEDIS measure priorities. Most PCP QIP clinical measures have very similar definitions to their HEDIS measure counterparts, and strong performance on PCP QIP measures should be reflected in strong HEDIS measure performance. Differences between PCP QIP and HEDIS measures are designed to improve providers' ability to impact the population in the measure. Some examples include:

- Partnership relaxes the strict continuous enrollment requirements in PCP QIP measures that are present in many HEDIS measures. Several measures (AMR, BCS-E, and W30) require members be continuously enrolled with a MCP for 11 months to be included in the HEDIS measure; Partnership relaxed this requirement so that incoming members could be included in their PCP QIP cohorts.
- Partnership allows PCPs to upload supplemental data for all PCP QIP measures. HEDIS administrative and ECDS measures only allow claims and encounter data, as well as auditor approved supplemental data, to be applied to a HEDIS measure.
- Two PCP QIP measures have smaller age bands than their aligned HEDIS measures to prioritize focus on the highest priority age bands in the eligible populations: Child and Adolescent Well-Care Visits and Topical Fluoride for Children. An additional PCP QIP measure had a larger eligible population than the HEDIS measure: Chlamydia Screening in Women.

Overall, plan-wide performance improved significantly (>=5 percent) on the following continuous measures on the PCP QIP that are aligned with MCAS measures between MY2024 and MY2025:

- Cervical Cancer Screening
- Diabetes – HbA1c Good Control

Several measures were added to the PCP QIP measure set in MY2025 to align with the MCAS measure set:

- Breast Cancer Screening, 40-51 years (monitoring measure)

- Chlamydia Screening
- Topical Fluoride for Children – 1-5 years (monitoring measure)
- Well Child Visits 15-30 Months (monitoring measures)

The MY2025 MCAS measure plan-wide performance trends were consistent with corresponding MY2025 PCP QIP results in most cases.

Unsurprisingly, the two PCP QIP measures with smaller age bands (Child and Adolescent Well-Care Visits and Topical Fluoride for Children) had higher performance than their HEDIS measure counterpart, and the one PCP QIP measure with a larger eligible population (Chlamydia Screening in Women) had lower performance than its HEDIS measure counterpart.

The PCP QIP Cervical Cancer Screening measure performed significantly higher than its HEDIS counterpart. This is due to the HEDIS measure transitioning to an ECDS measure in MY2025, which exposed significant data completeness issues with the measure. Partnership will be addressing these issues in 2026 onward by focusing on best practices in coding and clinical data exchange via Health Information Exchanges and Datalink.

All other HEDIS measures that are aligned with PCP QIP measures showed slightly higher plan wide performance in the HEDIS measure than in the plan wide PCP QIP.

7.5 Next Steps in Finalizing Assessment of Results

- DHCS will finalize Quality Factor Scoring of all managed care plans, based on composite scoring, in fall 2026.
- DHCS has not yet announced the outcomes of MY2025 accountability programs described in Section 1. DHCS will share sanctions and the results of other accountability programs with plans including Partnership.
- Final assessment of results will be used to adapt quality measure score improvement strategies and tactics in 2026-2027.

8.0 Summary of MCAS Measures in Partnership's Quality Improvement Programs

The table below provides a summary of included in the Measures Managed Care Accountability Sets (MCAS) Measures included in Partnership's Quality Improvement Programs, Measurement Year 2025.

HEDIS® Measures	MCAS Accountable/Reporting	MY2024 QIP Measure	MY2025 QIP Measure	QIP Program
Asthma Medication Ration (AMR)*	Accountable			None
Breast Cancer Screening (BCS-E)*	Accountable	X	X	PCP QIP Ages 52-74 years – Clinical Ages 40-51 years – Monitoring
Cervical Cancer Screening (CCS-E)	Accountable	X	X	PCP QIP
Childhood Immunization Status (CIS-E) – Combo 10	Accountable	X	X	PCP QIP
Chlamydia Screening (CHL)	Accountable		X	PCP QIP Monitoring
Colorectal Cancer Screening (COL-E)	Reporting	X	X	PCP QIP
Controlling High Blood Pressure (CBP)	Accountable	X	X	PCP QIP
Developmental Screening in the First Three Years of Life (DEV)	Accountable			None
Eye Exam for Patients with Diabetes (EED)	Reporting	X	X	PCP QIP
Glycemic Status Assessment for Patients with Diabetes—Glycemic Status (>9%), Poor Control (GSD)	Accountable	X	X	PCP QIP QIP uses the inverse of this measure: Good Control, HbA1c Good Control <9%
Immunizations for Adolescents (IMA-E) – Combo 2	Accountable	X	X	PCP QIP
Lead Screening in Children (LSC)	Accountable	X	X	PCP QIP
Postpartum Depression Screening (PDS-E)	Reporting	X	X	Perinatal QIP
Prenatal Depression Screening (PND-E)	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Postpartum Care	Accountable	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	Accountable	X	X	Perinatal QIP
Prenatal Immunization Status – combo (PRS-E)	Reporting	X	X	Perinatal QIP
Topical Fluoride for Children (TFL)	Accountable		X	PCP QIP Ages 1-5 years - Monitoring
Well-Child Visits in the First 30 Months of Life—15 to 30 Months—Two or More Well-Child Visits (W30-2)	Accountable		X	PCP QIP

HEDIS® Measures	MCAS Accountable/Reporting	MY2024 QIP Measure	MY2025 QIP Measure	QIP Program
Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits (W30-6)	Accountable	X	X	PCP QIP
Child and Adolescent Well-Care Visits (WCV)	Accountable	X	X	PCP QIP

PCP QIP Measurement Set: http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

9.0 Measurement Year 2024 Managed Care Accountability Site (MCAS) Measurement Set Descriptions-Accountable Measures

HEDIS Measure	Measure Indicator	Measure Definition
Asthma Medication Ratio (AMR)	• Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Breast Cancer Screening (BCS-E)	• Non-Medicare Total	• The percentage of women 42–74 years of age who had a mammogram to screen for breast cancer as of December 31 of the measurement year.
Cervical Cancer Screening (CCS-E)	• Total	• The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: ○ Women 21–64 years of age who had cervical cytology performed within the last 3 years ○ Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
Child and Adolescent Well-Care Visits (WCV)	• Total	• The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. • Total. The sum of the age stratifications (ages 3–21) as of December 31 of the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Childhood Immunization Status (CIS-E)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
Chlamydia Screening in Women (CHL)	• Total	• The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. ○ Total: the sum of the age stratifications.
Controlling High Blood Pressure (CBP) *	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Developmental Screening in the First Three Years of Life (DEV_CH) *	• Total All Ages	• Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. • This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
Follow-Up After ED Visit for Mental Illness – 30 days (FUM)	• Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

HEDIS Measure	Measure Indicator	Measure Definition
Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	• Total	• The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
Immunizations for Adolescents (IMA-E)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. • Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Hemoglobin A1c Control for Patients With Diabetes (GSD)*	• HbA1c poor control (>9.0%)	• The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the Measure Indicators performed. o HbA1c poor control (>9.0%). The most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Lead Screening in Children (LSC) *	• Total	• The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. • At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

HEDIS Measure	Measure Indicator	Measure Definition
Prenatal and Postpartum Care (PPC) *	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. ○ Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. ○ Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Topical Fluoride for Children (TFL-CH)	• Total ages 1 through 20	• Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year. • This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
Well-Child Visits in the First 30 Months of Life (W30)	• Well-Child Visits in the First 15 Months • Well-Child Visits for Age 15 Months–30 Months.	• The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. • Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

** Hybrid Measures. A random sample of the eligible population is used in calculating performance, as opposed to the entire eligible population.*

10.0 Quality Improvement Initiatives - HEDIS Score Improvement

Partnership's Quality Improvement organization-wide goals for 2025-2026 focused on four measure domains similar to those defined under the DHCS Managed Care Accountability Set (MCAS) measures:

1. **Behavioral Health**
2. **Pediatrics**
3. **Chronic Diseases**
4. **Women's Health and Perinatal**

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases, Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2025-2026.

10.1 Behavioral Health Measure Activities

Sac Valley MedShare Data Exchange: Partnership HealthPlan of California and SacValley MedShare (SVMS): To improve data sharing capabilities between Behavioral Health Plans (BHPs) and Partnership, the partnership with SacValley MedShare (SVMS) was expanded to include county participation. By the end of 2025, Partnership and SVMS successfully onboarded all participating counties into a unified data exchange, significantly strengthening regional data-sharing infrastructure. Partnership's auditor, HSAG, approved use of the SVMS Encounters file, which contained County DBH follow-up service data, as a supplemental data source for MY2025 HEDIS rate generation.

Key Learnings:

- The collaboration facilitated the provision of medical data, including real-time admissions, discharges, and transfers, from participating hospitals.
- Some counties implemented opt-in procedures for data sharing, which have limited the number

of beneficiaries included in the data.
- Substance use disorder data has not yet been included in the exchange due to varying levels of regulatory uncertainty across counties.

DHCS Mandated Non-Clinical PIP: Improving Provider Notifications and Follow-Up for Members with Serious Mental Health Diagnoses: The Department of Health Care Services (DHCS) has mandated a non-clinical Performance Improvement Project (PIP) focused on enhancing the timeliness and consistency of provider notifications for members with Serious Mental Health (SMH) diagnoses following emergency department (ED) visits. The primary goal of this initiative is to improve the percentage of notifications sent to providers within seven days of an ED visit, thereby increasing the likelihood of timely follow-up care for affected members.

In 2024, the QI team at Partnership identified a tool with the potential to significantly improve provider notification processes: PointClickCare. Partnership subscribes to this platform, which serves as a centralized hub for real-time Admission, Discharge, and Transfer (ADT) messages from EDs and hospitals across California. To operationalize this data, Partnership launched a targeted intervention in the Eureka Region, routing daily PointClickCare reports to a large provider organization. These reports flag assigned members with recent ED visits for SMH diagnoses. In response, the provider organization is developing integrated clinical and operational workflows across its sites to proactively conduct outreach, schedule appointments, and ensure follow-up care is completed within 30 days of the ED event. This approach supports engagement for members less likely to seek care due to stigma or other barriers. The pilot will continue through 2026, with expansion planned based on promising results.

Key Learnings:
- Regular data exchange to promote shared learning, pattern recognition, and continuous quality improvement.
- Real-time data analysis to support agile adjustments and maintain program responsiveness.
- Focused efforts on increasing the rate of timely notifications and achieving compliance with follow-up targets.

DHCS 2025–27 DMC ODS Clinical and Non-Clinical Performance Improvement Projects (PIPs):
The California Department of Health Care Services (DHCS) requires all Drug Medi-Cal Organized Delivery System (DMC-ODS) plans to conduct two Performance Improvement Projects (PIPs) per contract period—one clinical and one non-clinical. The current PIP cycle began in 2025, with annual submissions due each July, and will conclude in 2027 (final submission due July 2028). Participating counties include Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano.

Within this framework, Partnership is implementing PIPs focused on improving follow-up after Emergency Department (ED) visits for substance use and increasing the number of members receiving Peer Support Services. Together, these efforts aim to strengthen engagement and continuity of care for members with behavioral health and substance use needs.

The Clinical PIP focuses on improving follow-up rates after ED visits for substance use. Root cause analysis is underway to identify barriers to timely follow-up, and targeted interventions are being implemented and monitored for effectiveness. Findings from this work will inform process improvements for upcoming reporting periods.

The Non-Clinical PIP focuses on expanding access to Peer Support Services. To support this, counties have been offered up to $10,000 per individual through HCAI funding to train and develop Peer Support Specialists, increasing workforce capacity.

Key Learning:

- Accurate and up-to-date member contact information is critical to enhance outreach effectiveness and increase successful linkage to care.

Community Health Worker (CHW) & Emergency Department: Partnership HealthPlan of California:
To bridge the gap between existing Substance Use Navigation (SUN) grants and the implementation of community health workers (CHWs), Partnership offered a grant of up to $100,000 to promote the use of CHWs in emergency departments. A total of 24 hospitals expressed interest, and 17 followed through during the grant year.

Key Learnings:

- The project achieved its primary objective of expanding CHW presence in acute care settings and concluded at the end of calendar year 2025. It also advanced the foundation for longer-term sustainability by aligning services with CHW billing pathways.
- Strengthening documentation will support accurate billing, enable reimbursement for CHW services, and ensure the long-term sustainability of this model of care.

10.2 Pediatric Medicine Measure Activities

State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County: This PIP's initial intervention addressed delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families. In 2024, the team launched a six-week phone outreach pilot project in collaboration with NorthBay Health, with

outstanding reach rates and outcomes. In 2025, the pilot expanded to Fairchild Medical Center, the primary labor and delivery hospital in Siskiyou County. The initial reach rate was lower than expected.

Key Learning:

- Overall, findings suggest that while the intervention model has potential, its effectiveness is highly dependent on consistent operational execution, data-sharing infrastructure, and strong partner accountability.

Educating Practices about Developmental Screening in the First Three Years of Life: This initiative focused on improving completion of three developmental screenings in the first three years of life by conducting one-on-one training for PCP practices with scores significantly below the MPL. The Pediatric QSMI workgroup reviewed MY2025 HEDIS rates and worked with an Associate Medical Director to set up one-on-one interventions for select practices with especially low scores and larger denominators. Practices that receive coaching will be monitored and offered additional training if their scores do not improve after 3 months.

Key Learnings:

- The current data set relies on claims submitted with code 96110. Six of the lowest performing practices were compared against a list of site audits by the Medical Record Review team and two of those sites had fully compliant charts during their last site visit so it appears at least some practices are conducting screenings but not billing correctly for them.
- Some practices discuss elements of the screenings during the actual visit and document those discussions in the EHR but may not complete the actual screening tool or correctly bill for the screening.
- Even among pediatric-only practices, some are performing well and others are far below the MPL. Proper billing and documentation appears to be an issue regardless of practice type.

Improve Data Capture of Topical Fluoride Application: Partnership launched a multi-pronged messaging campaign to providers to evangelize the use of the Z29.3 ICD code to indicate fluoride varnish application in FQHC, RHC, and Tribal Health Dental Centers. Following the messaging campaign, QI coaches and Partnership's new Dental Liaison followed up with practices during coaching calls to see if the codes had been implemented. In November 2025, DHCS released guidance to the Denti-Cal network that use of the Z29.3 ICD is now mandated for payment on claims that include fluoride varnish services.

Key Learning:

- Sustained focus on data exchange pathways, data validation exercises with provider partners, and partnership with external stakeholders including DHCS is crucial for success on measures

with less straightforward coding and claims pathways

10.3 Chronic Disease Measure Activities

Colorectal Cancer Screening: Cologuard: In 2023 Partnership conducted a pilot project with Exact Sciences who produces the Cologuard Fit DNA colorectal cancer screening product. During the pilot Partnership observed notable improvements in colorectal cancer screening rates with participating providers. Partnership has turned this effort into an ongoing program and has worked closely with Exact Sciences to spread awareness and access to the bulk ordering program. Partnership has created a Cologuard Care-gap Orders page with information and resources. Exact Sciences has a minimum number of patients required for bulk orders since it is resource intensive for them to do outreach and messaging for patients with an order. Partnership has offered to help facilitate bulk orders for smaller practices who do not have large enough denominators to do bulk orders on their own, with orders going out twice annually.

Key Learning:

- Tracking screening rates by screening type helped the team find opportunities where Cologuard bulk order might be appropriate based on availability of other screening methods.

Diabetes Management Offerings From Telemed2U: In 2025-26, Partnership monitored, evaluated, and enhanced utilization of the TeleMed2U diabetes management program through analysis of utilization and engagement data, with the goals of assessing program effectiveness, identifying participation gaps, and informing decisions regarding the continued prioritization of this intervention relative to other strategies. The workgroup partnered with Provider Relations and supported outreach and member education efforts by promoting available nutrition services as an integral component of diabetes management, developing and disseminating fax communications to the provider network to increase program awareness and encourage referrals The collaboration also extended to engagement with Care Coordination to further expand awareness of the program among members and providers who may benefit from additional diabetes support services.

Key Learning:

- Collaboration between Quality Improvement, Care Coordination, and Provider Relations was crucial for building awareness of available diabetes support services.

10.4 Women's Health and Perinatal Care Measure Activities

PPC Pre Timeliness of Prenatal Care Alignment: A multidisciplinary team review identified opportunities to improve consistency of PPC-Pre measurement support across the organization. The initiative focused on reducing variation in coding and documentation practices, standardizing best practices for qualifying perinatal encounters, and identifying allowable care models (telehealth

pathways) that support timely access to prenatal care. This was a multifaceted quality improvement effort that included targeted research, root-cause analysis, claims review, cross-departmental meetings, workflow and policy document review, and implementation of standardized guidance to improve organizational alignment and measure performance.

Key Learnings:

- Adding validated HEDIS codes to the P-QIP Value Set Directory improves clarity, reduces variation in prenatal care coding and documentation, and supports more reliable HEDIS performance monitoring.
- The PPC-Pre measure best practice resource provides a standardized, evidence-based framework for improving perinatal care delivery and operational performance. Translating measure requirements into actionable workflows can improve quality of care and patient outcomes without organizations reinventing the wheel.
- PPC-Pre Telehealth visits in both administrative and hybrid data collection methods are eligible for use in HEDIS reporting. The visit must be with an appropriate provider, within the applicable timeframe, and include a confirmation/diagnosis of pregnancy, and a visit component such as discussion of screening or lab results or last menstrual period with Obstetric (OB) history.
- Primary care, FQHC, rural, and Tribal health providers play a critical role in early pregnancy and should be included in performance visibility and improvement strategies.
- Integrating provider education efforts into existing structures strengthens the program allowing wider visibility, the prioritizing of providers based on performance data, and inclusion of improvement advisors.

Increase PPC-Pre Timeliness of Prenatal Care Awareness: This initiative focused on improving performance for the Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) measure by partnering with improvement advisors who had established relationships with providers in effort to strengthen awareness of measure timing requirements and identify barriers to timely first prenatal visits.

Key Learnings:

- Clear, repeated messaging on PPC-Pre requirements is needed to build and sustain staff awareness.
- Site-specific performance and access data supports more focused coaching and helps prioritize outreach to practices with the greatest opportunity for improvement.
- Medi-Cal Managed Care plans require first prenatal visits within 10 business days.
- Documentation of initial prenatal visit completed within four weeks of entry to prenatal care. Optimally within the first trimester.

- First prenatal visit access is a site review standard for PCPs who provide obstetric care and missed appointments and referrals require documented outreach and follow-up. Failure to follow up on missed specialty referrals results in a zero score under coordination criteria.
- If prenatal visit periodicity does not meet current ACOG standards, OB providers must document missed visits and outreach efforts.
- Established relationships through Improvement Advisors offers a valuable entry point and provides knowledge of clinics, counties, and regions, as well as insight into local barriers. This can improve provider's engagement and aid in identifying and addressing both site specific and local performance barriers.

Tribal Perinatal Program: This initiative focused on supporting Tribal entities in developing and expanding Tribal Perinatal Programs to improve access to timely prenatal and postpartum care. The Tribal Perinatal Program Tribal Birth Equity Initiative was designed to build culturally informed perinatal care capacity through training, case management, peer support, doula development, and implementation of reimbursement pathways that support sustainable services in Tribal communities. The program goal is to support Tribal communities achieve the best possible outcomes for pregnant American Indians in Northern California.

Key Learnings:

- Culturally grounded training and program design are central to building Tribal perinatal care capacity.
- Trusted entry points and sustained subject matter support, including outreach from the Tribal Liaison and education from a Medical Director champion, can strengthen engagement, improve understanding of program requirements, and support movement from interest to implementation.
- Aligning training, ECM, and PHPS within a shared implementation approach can strengthen care coordination and support long-term sustainability of Tribal perinatal services.
- Baseline performance suggests Tribal providers may be better positioned to support postpartum follow-up than timely first prenatal care, highlighting a need for continued focus on earlier pregnancy identification, access to initial prenatal visits, and stronger prenatal workflow support to improve PPC-Pre performance.

High-risk Human Papillomavirus Self-Collect Support and Education: This initiative focused on improving performance in the Cervical Cancer Screening measure by expanding and standardizing use of the high-risk HPV (hrHPV) self-collect option in healthcare settings. Work centered on strengthening network-wide awareness, updating best-practice guidance, and ensuring clinics had consistent instructions and education materials to support appropriate implementation.

Key Learnings:

- Provider and patient education materials are foundational for scaling hrHPV self-collect consistently across the network.
- Equity-centered material review is important to ensure patient instructions are accessible across threshold languages and usable by patients with different literacy levels and care access needs.
- Targeted provider education informed by site level performance data and improvement advisor insights was an efficient way to prioritize education.
- hrHPV self-collect can be integrated successfully when clinics have clear instructions, laboratory access, and practical examples of staffing, outreach, and visit workflows.

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Care Coordination

Care Coordination Support to Members

In Q2 2026, The Case Management and Care Coordination department supported 34,913 total cases, reflecting sustained engagement across Access to Care (ATC), Transitional Care Services (TCS), Complex Case Management (CCM), and Health Information Forms (HIF) programs and mandates. Access to Care accounted for 26,974 cases, representing approximately 77% of overall case volume, underscoring the continued need for member navigation and care coordination services, including appointment scheduling, referral support, durable medical equipment (DME) coordination, and assistance with other short-term health and social needs. In addition, the department continued to provide comprehensive support for children and youth with complex special health care needs through the CCS Whole Child Model (WCM) program, completing services for 696 unique members through Health Risk Assessments (HRAs) and 747 unique members through Individual Care Plans (ICPs). Through high operational throughput, strong member engagement, and consistent performance across programs, the team continued to deliver reliable, high-touch services that improve health outcomes, enhance member experience, and strengthen overall health plan performance.

Spotlight Focus: California Children Services Whole Child Model UIS Transition

Effective January 1, 2027, Medi-Cal members with Unsatisfactory Immigration Status (UIS), including California Children's Services Whole Child Model (CCS WCM) members enrolled with Partnership, will transition from managed care to the Medi-Cal Fee-for-Service (FFS) program. To prepare for this change, Care Coordination leadership and the CCS WCM Liaison have begun reviewing DHCS transition requirements and are working closely with CCS and Public Health partners across all 24 Partnership counties. Partnership's primary goal is to ensure a seamless transition for impacted members and families while minimizing disruptions to care.

Current transition planning activities include identifying affected CCS WCM members, collaborating with CCS programs on transition workflows and shared messaging, developing individualized transition-of-care plans for impacted members. These plans will include each member's current care plan, authorized CCS services, relevant clinical documentation, durable medical equipment (DME) information, and provider contacts to support continuity of care following the transition to county-

based case management. Partnership is also working to ensure approved DME is provided before transition and that any outstanding care needs are communicated to county partners.

Over the coming months, Partnership will continue targeted outreach, member and family education, and close coordination with providers and county CCS programs to support uninterrupted access to medically necessary services. Through proactive planning and strong county partnerships, the health plan remains committed to protecting necessary care needs and supporting vulnerable CCS members throughout this transition.

Utilization Management

Treatment Authorization Request (TAR) Volumes & Timeliness

During Q2 2026, the Utilization Management (UM) Department effectively managed a high volume of Treatment Authorization Requests (TARs) across Acute Inpatient, Outpatient, and Long-Term Services and Supports (LTSS) service categories. The department processed 69,598 TARs during the quarter, averaging approximately 23,200 TARs per month. Outpatient TARs represented the largest share of volume, accounting for nearly 70% of all requests, while Acute Inpatient and LTSS volumes remained stable throughout the quarter.

Despite the significant authorization workload, UM maintained strong timeliness performance across all service lines. Acute Inpatient timeliness remained consistently above 99%, while LTSS timeliness exceeded 98% throughout the quarter. Outpatient timeliness remained above 96%, reflecting the department's continued ability to manage high-volume authorization activity while supporting timely access to care and maintaining regulatory compliance.

Q2 2026 TAR Volumes

- Acute Inpatient**:** 15,667 TARs
- Outpatient: 48,889 TARs
- LTSS: 5,042 TARs
- **Total Quarter Volume:** 69,598 TARs (average of ~23,200 per month)

Q2 2026 Timeliness Performance

- Acute Inpatient: 99.81% average timely completion
- Outpatient: 97.31% average timely completion
- LTSS: 98.55% average timely completion

Long Term Support Services (LTSS) Complex Team Supports Facility Closure

During Q2 2026, the LTSS Complex Team demonstrated exceptional leadership and coordination in response to the abrupt closure of Cottonwood Post-Acute Rehab. Following notification from DHCS and CDPH that the facility would cease operations due to significant building safety concerns related to a portion of the facility's roof, the team rapidly mobilized to support impacted members and ensure continuity of care.

Partnership identified 66 members affected by the closure and worked closely with the facility, receiving skilled nursing facilities, and community partners to coordinate safe transitions. Through intensive case management, placement coordination, and expedited authorization support, the LTSS Complex Team successfully relocated all impacted members to appropriate alternative care settings while minimizing disruption to services and maintaining member safety.

This extraordinary response required daily collaboration across multiple organizations and reflected the team's unwavering commitment to some of Partnership's most vulnerable members. The successful relocation of 66 residents within a compressed timeframe is a significant operational achievement and exemplifies Partnership's mission to ensure timely access to care, support care continuity, and safeguarding member well-being during emergent situations.

Behavioral Health & Youth Services

Partnership Foster Youth Best Practice Case Study

In June 2026, Public Works Alliance published *Beyond Compliance: Partnership HealthPlan of California's Approach to Serving Children and Youth in Foster Care*, highlighting Partnership HealthPlan of California as a statewide best practice model for serving foster youth. The case study recognizes Partnership’s innovative open-access provider network for foster youth, dedicated Child Welfare Liaison Team, and strong partnerships with county child welfare agencies and Health Care Program for Children in Foster Care (HCPCFC) programs. The publication highlights Partnership’s success in reducing care disruptions, improving access to services, and supporting continuity of care for more than 15,000 child welfare-involved youth across 24 Northern California counties. The work also received recognition from California Department of Health Care Services Director Michelle Baass, who commended PHC's efforts. The study can be found at: CASE STUDY: PHC as a Best Practice Model for CYFC

DHCS Behavioral Health Transformation (BHT) Performance Measures

Over the past few months, the Behavioral Health and Health Services leaders have been busy engaging with DHCS and our county BH leaders and partners over a proposed measure set for county behavioral health plans. DHCS has now finalized this new Behavioral Health Transformation (BHT) performance measurement. The framework applies to county behavioral health plans and Medi-Cal managed care plans and includes 51 performance measures aligned with 14 statewide goals, including improving access to care, care experience, quality of life, and school/work engagement while reducing homelessness, justice involvement, overdoses, suicides, untreated behavioral health conditions, and removal of children from their homes.

Both the counties and Partnership will be required to incorporate these measures into ongoing behavioral health planning and reporting activities under the Behavioral Health Services Act (BHSA). These measures will be used to support performance monitoring, population health management, public transparency, and future accountability efforts for Medi-Cal managed care plans and county behavioral health agencies. As implementation progresses, Partnership will continue to assess performance, identify improvement opportunities, and strengthen partnerships with behavioral health and community organizations to advance equitable outcomes for members.

Enhanced Health Services

DHCS Proposed Enhanced Care Management and Community Supports (CS) Policy Changes

As DHCS approaches the end of the Section 1115 waiver this December, they have been working with providers, associations, CBOs, and managed care plans to make changes and updates to Enhanced Care Management (ECM) and Community Supports (CS). Overall, the proposed changes are designed to strengthen program fidelity, clarify service definitions, refine eligibility criteria, and improve consistency across the state. Partnership's Enhanced Health Services department and Health Services leaders have been deeply engaged with providers, the PATH CPI facilitators, LHPC and DHCS directly to provide feedback around their proposed changes. Some of the changes being proposed necessitate minor operational changes such as updates to referral criteria, while others represent larger impacts to members and the network such as the sunsetting of Short-Term Post-Hospitalization Housing (STPHH) effective December 31, 2026.

Due to DHCS timing and proposed policy complexity, an internal workgroup has kicked off to begin

Reviewing the recently released proposed CS guidance and assessing impacts to member access, provider network requirements/changes, utilization management processes, data reporting, and communication. Updated policy guidance for the ECM benefit has yet to be released by DHCS, but Partnership's Enhanced Health Services department alongside the internal workgroup is ready to ensure cross-departmental alignment to support regulatory guidance. Partnership will continue to engage with DHCS, community providers, county partners, hospitals, and CBOs to ensure successful implementation of these changes while maintaining focus on our mission and improved outcomes for members with complex health and social needs.

Health Equity

Community Reinvestments

Partnership HealthPlan remains fully prepared to submit its Community Reinvestment (CR) Plans and continues to make meaningful progress toward implementation. All required documentation has been completed, reviewed, with necessary signatures obtained from all 14 required county partners; representing a significant milestone in the application process. Partnership is currently awaiting activation of DHCS' portal, "*ReInvest 360*" to submit each of the reinvestment plans to DHCS for review. DHCS announced in mid-August that they have extended the submission deadline from September 1st to October 15, 2026 for Partnership and other MCPs to submit their Community Reinvestment Plans to the department.

To support implementation efforts, Partnership has hired two Community Reinvestment Liaisons: Roddy Grace and Amanda Harrison in the Health Equity Department. These positions will focus on community reinvestment, program and project management, county engagement, partnership development, and annual reporting required by DHCS' Community Reinvestment policy. Roddy Grace will lead efforts in the northern counties, while Amanda Harrison will support the central and southern counties, with an emphasis on community engagement and outreach. Together alongside our Regional Directors and other Health Services leaders, they will work closely with counties and community partners to implement the activities outlined in the community's respective Community Reinvestment Plan so that together we can improve the lives of our members.