

Board of Commissioners Meeting Agenda

October 28, 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

249-299 Nevada Street, Auburn, CA

1000 Fortress Street, 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 October 27, 2026. Comments received will be summarized during the meeting.

10:00AM – Opening			
1.1 **Call to Order**			*Chair*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION:*** Approval of Agenda ***(3 minutes)***	1-5	*Chair*
1.4	***ACTION:*** Approval of Board Meeting Minutes for August 26, 2026 ***(3 minutes)***	6-23	*Chair*
1.5 **Public Comment & Correspondence**			*Clerk*
10:25AM – Closed Session			
1.6	***Closed Session: PUBLIC EMPLOYEE DISCIPLINE / DISMISSAL / RELEASE*** ***Government Code section 54957*** ***(20 minutes)***		*Full Board, Sonja Bjork, CEO, Danielle Ogren, Chief Compliance Officer, Naomi Gordon, Chief Human Resources Officer,*

			Colleen Valenti, Assistant Clerk and Ashlyn Scott, Clerk
10:45AM – Reconvene in Open Session			
1.7 **Commissioner Comment**			*Chair*
1.8	***INFORMATION:*** Recognizing Community Health Initiative for Receiving an Honorable Mention for the Association for Community Affiliated Plans' 2026 Supporting the Safety Net Award ***(5 minutes)***		*Sonja Bjork*
1.9	***ACTION***: Resolution to Accept the Baker Tilly Audit Report for FY 2025-2026; This resolution accepts the audit report completed by Baker Tilly on Partnership's financial statements for the period July 1, 2025 to June 30, 2026. ***(20 minutes)***	24-79	*Baker Tilly Auditor, Chris Pritchard*
1.10	***INFORMATION:*** CEO Report: Community Supports Discussion ***(20 minutes)***	80-82	*Sonja Bjork*
11:35AM – Consent Calendar			
2 & 3	***ACTION:*** Finance Committee Resolution Ratification & Consent Calendar ▪ **3.1** Resolution to Accept all Advisory Committee Minutes, Partnership Policies and Program Descriptions Approved by PAC ▪ **3.2** Resolution to Approve the Quality and Performance Improvement Program Description, Work Plan, and Evaluation **Quality and Performance Improvement Program Description - Clean** **Quality and Performance Improvement Program Description - Redlined** **2025-2026 QI Program Evaluation** **2026-2027 QI Program Work Plan** ▪ **3.3** Resolution to Accept the Physician Advisory Committee Appointment of Dr. Harry Ko	83-86 87-88 89-90	*Chair*

	▪ **3.4** Resolution to Approve the Re-Appointment of Yolo County Representative, Gena Bravo, to the Board	91-92	
	▪ **3.5** Resolution to Accept the Strategic Planning Committee Appointment of Tory Starr	93-94	
	▪ **3.6** Resolution to Approve the Population Health Management Strategy & Program Description Population Health Management Strategy & Program Description - Clean Population Health Management Strategy & Program Description - Redline	95-96	
	▪ **3.7** Resolution to Approve the Health Equity and Community Reinvestment Strategy and Program Description (Previously the Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description) Health Equity and Community Reinvestment Strategy and Program Description – Clean Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description - Redline	97-98	
	▪ **3.8** Resolution to Approve the 2027 Enhanced Case Management Quality Improvement Measurement Set Proposal	99-102	
	▪ **3.9** Resolution to Approve the 2027 Hospital Quality Improvement Program Measurement Set	103-113	
	▪ **3.10** Resolution to Approve the 2027 Extended Care Center Quality Improvement Program Measurement Set	114-118	

Consumer Advisory Committee – September 2026 Finance Committee – September 2026 Finance Committee – October 2026 Governance & Compliance Committee – September 2026 Physician Advisory Committee – September 2026 Physician Advisory Committee – October 2026 Quality and Utilization Advisory Committee (Q/UAC) – September 2026 Quality and Utilization Advisory Committee (Q/UAC) – October 2026 Strategic Planning Committee – October 2026			
11:40AM – Regular Agenda Items			
4.1	***ACTION:*** Resolution to Approve 9 Applicants to the Community Advisory Committee ***(5 minutes)***	119-135	*Wendi Davis*
4.2	***ACTION:*** Resolution to Approve the Q22026 Compliance Dashboard ***(5 minutes)***	136-138	*Danielle Ogren*
11:50AM-12:15PM – Lunch			
4.3	***INFORMATION:*** Compliance Officer Update ***(15 minutes)***		*Danielle Ogren*
4.4	***ACTION:*** Resolution to Approve Capital Expenditure Budget Reallocation Authority ***(5 minutes)***	139-141	*Jennifer Lopez*
4.5	***ACTION:*** Resolution to Approve Budget Revisions for FY 2026-2027 ***(10 minutes)***	142-146	*Jennifer Lopez*
12:45PM – Regular Reports			
5.1	***INFORMATION:*** Metrics and Financial Update ***(10 minutes)***	147-160	*Jennifer Lopez*
5.2	***INFORMATION:*** Operations Update	161-162	*Written Report*
5.3	***INFORMATION:*** Media & Legislative Update	163-165	*Written Report*
5.4	***INFORMATION:*** Health Services Update	166-170	*Written Report*
1:00PM – Education Sessions			
6.1	***INFORMATION:*** Quality Update ***(20 minutes)***		*Dr. Kermit Jones / Isaac Brown*
6.2	***INFORMATION:*** Provider Satisfaction Survey Results ***(20 minutes)***		*Aaron Brincko*
2:00PM – Adjournment			

Upcoming Meetings:

12/02/2026 – December Board Meeting
2/24/2027 – February Board Meeting
4/27/2027-4/28/2027 – April Board Meeting and Strategic Planning Retreat

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:

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2525 Airpark Dr., Redding, CA

1036 Fifth Street, Eureka, CA

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1000 Fortress Street, Chico, CA

On
August 26, 2026

Members Present: Gena Bravo, Christopher Champlin, Ranell Brown, Cathryn Couch, Emery Cowan, Lisa Davies, Shelly Davis, Jaime Faurot, Benjamin Flores, Dean Germano (Chair), Ryan Gruver, Liz Hamilton, Alicia Hardy, Dave Jones, Seth Kaufman, M.D., Elizabeth Kelly, Liz Lara-O'Rourke, Jennifer Malone, Andrew Miller, M.D., Monica Morales, Robert Oldham, M.D., DeDe Parker, Ellen Payton, Jonathan Porteus, PhD, Tiffany Rowe, Nancy Starck, Kim Tangermann, Pedro Toledo, Lisa Warhuus, M.D., Jennifer Yasumoto, Jim Yoder

Members Excused: Gaby Bernal Leroi, Christy Coleman, JoDee Johnson, Stacy Sphar, Raichael Stewart, Nolan Sullivan

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., Robert Moore, M.D., 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 Tangermann read the Partnership Mission Statement: "to help our members, and the communities we serve, be healthy." She 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 June 24, 2026	Chairman Germano asked if anyone had changes for the agenda or corrections to the June 24, 2026, minutes. Hearing no requests for modification, he asked for a motion to approve the agenda and minutes.	*Commissioner Jones moved to approve the agenda and minutes as presented, seconded by Commissioner Kaufman.* ***ACTION SUMMARY:*** *Yes: 28* *No: 0* *Abstention: 0* *Excused: 5 (Bernal Leroi, Coleman, Johnson, Sphar, Sullivan)* **MOTION CARRIED**
1.4 Resolution Accepting the Resignation of Commissioner Jamie Bartolome as the Yuba County Representative and Express Appreciation for Service	Sonja Bjork, CEO, reported that the Yuba County Board of Supervisors has appointed a permanent Commissioner to the Partnership Board, replacing interim Commissioner Jamie Bartolome. She thanked Ms. Bartolome for her service.	*Commissioner Toledo moved to approve agenda item 1.4 as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** *Yes: 28* *No: 0* *Abstention: 0* *Excused: 5 (Bernal Leroi, Coleman, Johnson, Sphar, Sullivan)* **MOTION CARRIED**

1.5 Resolution to Accept the Board Commissioner Appointment of Benjamin Flores as a Yuba County Representative	Ms. Bjork reported that, 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 Board as a Health Center Representative. Mr. Flores was appointed to serve a four-year term.	*Commissioner Porteus moved to approve agenda item 1.5 as presented, seconded by Commissioner Jones.* ***ACTION SUMMARY:*** *Yes: 28* *No: 0* *Abstention: 0* *Excused: 5 (Bernal Leroi, Coleman, Johnson, Sphar, Sullivan)* **MOTION CARRIED**
1.6 Resolution to Accept the Board Commissioner Appointment of Raichael Stewart as a Consumer Representative from Nevada County	Ms. Bjork reported that, pursuant to the Partnership Bylaws, the Commission includes three consumer representatives, with one representative selected from each of the Northern, Eastern, and Southern regions. Consumer representatives serve two-year terms and are selected by the Consumer Representative Selection Committee, which consists of the Chief Executive Officer (CEO) or designee, a Member Services staff representative, one current consumer representative who is not applying for the position, and one Board member. Ms. Bjork announced that the Consumer Representative Selection Committee recommended Raichael Stewart to serve as the Eastern Region Consumer Representative on the Partnership Board. Ms. Stewart resides in Nevada County and will serve a two-year term commencing August 26, 2026, and ending June 28, 2028.	*Commissioner Gruver moved to approve agenda item 1.6 as presented, seconded by Commissioner Porteus.* ***ACTION SUMMARY:*** *Yes: 29* *No: 0* *Abstention: 0* *Excused: 5 (Bernal Leroi, Coleman, Johnson, Sphar, Sullivan)* **MOTION CARRIED**
1.7 Resolution to Accept the Board Commissioner Appointment of Ellen Payton as a Consumer Representative from Lassen County	Ms. Bjork introduced Ellen Payton who the Consumer Representative Selection Committee recommended to serve as the Northern Region Consumer Representative on the Partnership Board. Ms. Payton resides in Lassen County and will serve a two-year term commencing August 26, 2026, and ending June 28, 2028.	*Commissioner Jones moved to approve agenda item 1.7 as presented, seconded by Commissioner Hamilton.* ***ACTION SUMMARY:*** *Yes: 29* *No: 0* *Abstention: 0*

		Excused: 6 (Bernal Leroi, Coleman, Johnson, Sphar, Stewart, Sullivan) **MOTION CARRIED**
1.8 Resolution to Accept the Board Commissioner Appointment of Jaime Yan Faurot as a Consumer Representative from Marin County	Ms. Bjork reported that the Consumer Representative Selection Committee recommended Jaime Yan Faurot to serve as the Southern Region Consumer Representative on the Partnership Board. Ms. Faurot resides in Marin County and will serve a two-year term commencing August 26, 2026, and ending June 28, 2028.	*Commissioner Toledo moved to approve agenda item 1.8 as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** *Yes: 30* *No: 0* *Abstention: 0* *Excused: 6 (Bernal Leroi, Coleman, Johnson, Sphar, Stewart, Sullivan)* **MOTION CARRIED**
1.9 Partnership Scholarship Recipient Recognition	Ms. Bjork presented Partnership's 2026 Member Scholarship Winners and stated that this was the second year Partnership awarded scholarships to members pursuing careers in health care, social service, and public service. A total of five scholarships, totaling $30,000, were awarded. Ms. Bjork recognized the scholarship recipients, including Christopher Jackson of Humboldt County, who received a $10,000 scholarship. Additional $5,000 scholarships were awarded to Kailie Shoemaker of Lassen County, Vanessa Hurtado Torres of Napa County, Erica Downey of Tehama County, and Ariel Norman of Sonoma County. Ms. Bjork thanked members of the Community Advisory Committee for their assistance in the scholarship selection process. Scholarship recipient Christopher Jackson attended from Partnership's Eureka office and expressed his appreciation for receiving the scholarship. Mr. Jackson stated that he was honored and grateful for the opportunity and shared that he is pursuing a master's degree at California Polytechnic State University (Cal Poly), with the goal of giving back to and improving his community.	*None*
1.10 Commissioner Comment	Chairman Germano asked if there were any Commissioner comments. There were none	None

1.11 Public Comment & Correspondence	Chairman Germano asked for any public comments or correspondence to the Board. Board Clerk, Ashlyn Scott, reported that she received correspondence from a member on August 8, 2026, regarding concerns about services received through Partnership's Transportation Department. The member had previously filed a grievance and expressed dissatisfaction with the resolution provided. The member also requested a State Fair Hearing, which was subsequently dismissed by the State, and remained dissatisfied with that outcome. The Clerk stated that the member's concerns focused on three areas: (1) not being informed of the requirement for a Physician Certification Statement (PCS) for Non-Emergency Medical Transportation services; (2) healthcare providers not being informed of the PCS requirement; and (3) concerns regarding customer service received from the Transportation and Grievance & Appeals teams, including the belief that the member's age and health status contributed to the experience. Ms. Scott reported that, upon receipt of the correspondence, Partnership staff promptly reviewed the concerns and worked directly with the member to address and resolve the issues raised. Ms. Bjork acknowledged the challenges associated with the Transportation benefit and emphasized the importance of continually improving this highly utilized service. She noted that Partnership regularly evaluates opportunities to strengthen staff training, enhance communication, and refine internal procedures, while prioritizing service recovery efforts to ensure members receive the support they need. Ms. Bjork further reported that additional information regarding Partnership's ongoing efforts to improve the Transportation benefit and enhance the overall member experience would be presented later in the meeting as part of the Executive Dashboard report.	None
1.12 CEO Report	Ms. Bjork covered the following topics in her CEO Report: ***County CHIP/CHA Planning Grants*** – In April 2025, Partnership announced a $100,000 grant opportunity for each of its 24 counties to support local CHA and CHIP planning efforts. Eligibility for the grants is contingent upon substantial completion of the Memoranda of Understanding (MOUs) required by the Department of Health Care Services (DHCS) between health plans and county partners. Ms. Bjork stated that significant progress has been made over the past two years in executing the required MOUs. To date, nine counties have applied for and received grant funding, and an additional nine counties are currently eligible to apply. Five counties have not yet made sufficient progress toward completing the required agreements and will become eligible for funding once progress is made on the state-mandated MOUs.	None

Partnership and County Memoranda of Understanding – In 2024, the Department of Health Care Services (DHCS) added a contractual requirement for Partnership to establish Memoranda of Understanding (MOUs) with each county it serves regarding services and programs that support shared populations, including First Five Commissions, Women, Infants and Children (WIC) programs, Child Welfare, Public Health, Behavioral Health, and other county services.

Partnership has continued to make steady progress in executing the required agreements. She recognized the efforts of Mendocino County, Nevada County, and Placer County, each of which has completed eight MOUs, and Yolo County, which has completed seven MOUs.

Numerous additional agreements are in various stages of development, with several nearing completion. Ms. Bjork expressed appreciation for the time and effort county partners have devoted to helping Partnership maintain compliance with state contractual requirements.
Chairman Germano inquired whether there was a deadline for completion of the Memoranda of Understanding (MOUs).

Ms. Bjork responded that the original deadline was approximately two years ago; however, Partnership continues to provide status updates to the Department of Health Care Services (DHCS) and must demonstrate ongoing progress and good-faith efforts toward completing the required MOUs.

CalRHT: Rural Health Transformation Funding – The Rural Health Transformation Program funding is being administered in California by the Department of Health Care Access and Information (HCAI) and Partnership has supported its provider network by sharing information about funding opportunities, offering technical assistance, facilitating webinars and meetings, connecting providers with application support resources, and providing letters of support.

Partnership's consultant, DHJ Services, conducted informational webinars and provided technical assistance through office hours, workshops, individual consultations, and application reviews. Ms. Bjork also reported that Partnership issued 11 letters supporting a range of funding proposals.

Ms. Bjork noted that $54 million is available through the Workforce Development Recruitment and Retention Grant program and that Partnership's Workforce Development team is evaluating opportunities to align existing recruitment and retention efforts with the funding initiative.

HCAI established a Rural Health Policy Council and Partnership's service region is well represented. Dr. Colleen Townsend, Partnership's Regional Medical Director, was selected to serve on the Council, along with Tim Rine, Executive Director of the North Coast Clinics Network, and Lori Link of Plumas District Hospital.

Commissioner Davis commented that staff in Siskiyou County worked late into the evenings

throughout the previous week to complete their application and expressed appreciation for Partnership's consultant, noting that the support provided was instrumental to the effort. Commissioner Davis reported that the county submitted its application at approximately 2:30 p.m. on Friday and stated that the application would not have been completed without Partnership's assistance.

CalAIM Transitional Rent Community Support Benefit – Partnership received a Corrective Action Plan from the Department of Health Care Services (DHCS) regarding implementation of the now-mandatory benefit. Ms. Bjork explained that Partnership is prepared to administer the benefit and has submitted its Model of Care to DHCS.

A key challenge has been securing agreements from county behavioral health departments to fund housing costs beginning with the seventh month of tenancy, following the initial six months covered by Partnership. Several members in Yolo County have utilized the benefit after the county agreed to provide ongoing funding beyond the sixth month.

Ms. Bjork further reported that DHCS has determined Partnership does not yet have an adequate provider network for the benefit. However, she noted that DHCS has not finalized all program requirements, creating challenges in establishing provider contracts before the final guidance is issued.

Commissioner Warhuus commented that implementation of the Transitional Rent benefit is complex and noted that counties may have a variety of valid reasons for not participating. She noted Marin County is a county with unique circumstances where, despite extensive discussions, an agreement has not yet been reached.

Ms. Bjork acknowledged that counties have differing considerations regarding participation in the Transitional Rent benefit and agreed that many of those concerns are valid. She added that some counties may be delaying participation due to competing priorities and other ongoing initiatives. Ms. Bjork stated that she would provide an updated report at a future Board meeting.

Commissioner Yasumoto commented that the Transitional Rent program appears beneficial; however, counties face significant limitations on how Behavioral Health Services Act (BHSA) funds may be utilized, as expenditures must align with state-approved BHSA plans. She noted that BHSA funding was redirected from treatment services to housing initiatives, creating additional challenges for counties. Commissioner Yasumoto explained that her county received funding for Behavioral Health Bridge Housing (BHBH) funding, which must be expended by June 2027, but those funds cannot be incorporated into this program. She stated that the funding requirements are highly complex and expressed concern that Partnership is being held accountable for circumstances that are difficult to navigate. She added that counties are actively working to identify feasible solutions

	within the existing funding constraints. ***Partnership & Hospital Convening*** **–** In July, Partnership hosted a successful hospital convening held in Redding, attended by 46 representatives from hospitals across the service area. Presentations included updates on rural health transformation funding, CMS community engagement requirements, State Directed Payments, and the impact of California budget decisions on hospital financing. The event received positive feedback, earning an average rating of 4.9 out of 5, with 90% of respondents rating it as excellent.	
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. Commissioner Faurot requested pulling Ageda Item 3.3 for further discussion Chairman Germano noted Agenda Item 3.3 would be pulled from the Consent Calendar and discussed as the next agenda item. He then asked for a motion to approve the Consent Calendar resolutions 3.1, 3.2, 3.4, and 3.5. ▪ 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 ▪ 3.4 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	*Commissioner Jones moved to approve Resolutions 3.1, 3.2, 3.4, and 3.5,as presented, seconded by Commissioner Hamilton.* ***ACTION SUMMARY:*** *Yes: 31* *No: 0* *Abstention: 0* *Excused: 6 (Bernal Leroi, Coleman, Johnson, Sphar, Stewart, Sullivan)* **MOTION CARRIED**
3.3 Consent Calendar	▪ 3.3 Resolution to Approve the Cultural & Linguistic Program Description Commissioner Faurot commented that effective language access extends beyond translating written materials and should ensure that members understand, trust, and can act upon the information provided. She emphasized that true health equity is achieved when members can successfully use information to access care, make informed decisions, and navigate the healthcare system. Commissioner Faurot encouraged the Board to consider measuring the effectiveness of the Cultural and Linguistic Services Program not only by the number of translated materials produced, but also by member understanding, engagement, and improved access to care among historically underserved populations. She further noted that communication barriers can become access barriers for many members, including immigrants, communities of color, individuals with disabilities, and those with behavioral health needs. Finally, Commissioner Faurot asked how Partnership can evaluate whether cultural and linguistic services are improving members' ability to understand,	*Commissioner Hamilton moved to approve Resolution 3.3 ,as presented, seconded by Commissioner Jones.* ***ACTION SUMMARY:*** *Yes: 31* *No: 0* *Abstention: 0* *Excused: 6 (Bernal Leroi, Coleman, Johnson, Sphar, Stewart, Sullivan)* **MOTION CARRIED**

	navigate, and access healthcare, particularly among the most vulnerable, marginalized, underserved, and unserved populations. Dr. Robert Moore, Chief Medical Officer, thanked Commissioner Faurot for her comments and stated that he would connect her with Partnership's Population Health team, which oversees the Cultural and Linguistic Services Program, to further discuss the issues and recommendations she raised. Ms. Bjork noted that the proposed revisions to the Cultural and Linguistic Services Program Description were non-substantive in nature and had already been reviewed and recommended for approval by the Quality/Utilization Advisory Committee and the Physician Advisory Committee. She recommended that the Board approve the item as presented and that Commissioner Faurot's comments and concerns be addressed separately through follow-up discussions with the appropriate Partnership staff and program teams.	
4.2 Strategic Plan Update	Amy Turnipseed, Chief Strategy and Government Affairs Officer, presented an overview of Partnership's three-year strategic planning process. She stated that the plan is intended to provide a clear organizational roadmap, align priorities across the Board and staff, and establish enterprise-wide measures of success. Ms. Turnipseed reviewed the planning timeline, which includes stakeholder engagement, environmental assessments, community listening sessions, member and commissioner feedback, development of strategic priorities, and a Board retreat prior to adoption of the final 3-year strategic plan. She emphasized that the Board, leadership, staff, and stakeholders all play important roles in developing a successful Strategic Plan. She also announced that a commissioner survey would be distributed via email from Sonja Bjork to help identify opportunities and inform strategic priorities. At the April 2027 Board retreat, the Board will review commissioner survey results, stakeholder feedback, and key findings from the planning process. The Board will also discuss emerging issues and external factors affecting Partnership, including changes at the federal and state levels and the evolving healthcare environment. Commissioners were encouraged to complete the survey when received.	None
4.1 Resolution to Approve the Board Semi-Annual Dashboard	Wendi Davis, Chief Operating Officer, presented the biannual Executive Dashboard report to the Board. *Membership Dashboard:* Ms. Davis reported that Partnership's membership decreased from approximately 910,000 members at the same time last year to approximately 845,000 members currently. *Call Center Dashboard:*	*Commissioner Davis moved to approve Resolution 4.1 as presented, seconded by Commissioner Hamilton.* ***ACTION SUMMARY:*** *Yes: 31* *No: 0* *Abstention: 0*

	Ms. Davis noted that Member Services is now reporting a new key performance indicator measuring the total number of calls received by the call center. During the fourth quarter of the prior year, the call center received more than 82,000 calls while continuing to answer calls within 30 seconds and maintaining low wait times. *Transportation Dashboard:* Ms. Davis reported that approximately 460,000 transportation rides were provided during the fourth quarter of the prior year. At the current rate of utilization, Partnership is projected to provide nearly 3 million rides this year. While overall membership has declined, transportation utilization continues to increase. The Transportation Call Center receives as many as 4,200 calls on a typical Monday and handles approximately 220,000 calls during the last three quarters. There are challenges in meeting the 10-minute call wait-time threshold due to increased demand. Average wait times increased to 20 minutes in June but improved to 16 minutes in July, with an overall average wait time of 13.9 minutes. To improve service levels, Partnership has focused on filling vacant positions and expanding staffing. Ms. Davis reported that 18 new transportation staff were onboarded in June, and 23 additional staff members are currently in training. She noted that Partnership had previously delayed backfilling positions due to declining membership but has adjusted its staffing strategy to account for increasing utilization. Ms. Davis also reported an increase in provider calls related to transportation services. To address this, Partnership implemented enhancements including a provider self-service portal, updates to the call routing system with a dedicated provider queue, and a callback option allowing members to retain their place in line rather than wait on hold. She noted that callback utilization is significant and explained that reported wait-time data may be inflated because callback wait times are included in the calculations. *Chairman Germano asked whether the State had changed the eligibility criteria for transportation benefits.* *Ms. Davis responded that no changes have been implemented yet but it is possible that the benefit may be restricted in the future due to ongoing fiscal pressure.* *Commissioner Malone commented that the transportation benefit has been overwhelmingly positive for rural communities.* *Commissioner Payton stated that she has personally used Partnership's transportation services and noted that the current program is substantially better than the previous transportation vendor.*	*Excused: 6 (Bernal Leroi, Coleman, Johnson, Sphar, Stewart, Sullivan)* *Not Present: Malone* **MOTION CARRIED**

	Ms. Davis added that, unlike many local health plans that contract with transportation brokers to coordinate rides, Partnership brought these functions in-house approximately three years ago. Sonja Bjork added that DHCS has advised health plans that a new transportation policy is forthcoming, although specific details have not yet been released. She noted that transportation is an optional Medi-Cal benefit that California elected to implement and emphasized its importance in helping Partnership members access provider appointments. Ms. Bjork highlighted several challenges associated with the benefit. First, existing State policy requires members to request transportation at least five days in advance; however, Partnership has historically made every effort to accommodate even last-minute requests, which can create member expectations and potential grievances when requests cannot be fulfilled. Second, she noted that Partnership's transportation utilization is significantly higher than many other health plans, largely due to the size and rural nature of its service area, which creates additional considerations during State rate-setting discussions. *Behavioral Health Call Center Dashboard:* Ms. Davis reported that Partnership has also brought Behavioral Health call center operations in-house, a function that was previously administered by Carelon. She further noted that Partnership has the highest rate of behavioral health utilization in the state. *Commissioner Porteus asked whether Partnership tracks the acuity or severity of behavioral health calls.* *Ms. Davis explained that Partnership is responsible for mild-to-moderate behavioral health conditions, while counties are responsible for serious mental illness (SMI) cases.* *Mark Bontrager, Senior Director of Behavioral Health, stated that standardized State screening tools are used when calls are received to determine the appropriate level of care and referral destination.* *Commissioner Porteus asked how many calls are redirected to county systems.* *Mr. Bontrager responded that, generally, the ratio is approximately two-to-one for callers who remain within Partnership's system compared to those referred to county services.* *Medical Utilization Dashboard:* Ms. Davis reported that inpatient utilization remains stable while primary care provider (PCP) visits continue to increase. *Commissioner Kaufman asked about the factors contributing to the increase in PCP visits.*	

	Dr. Robert Moore, Chief Medical Officer, stated that PCP utilization is currently at the highest level Partnership has experienced. He noted that PCP visits declined significantly during the COVID-19 pandemic and have steadily recovered. Dr. Moore added that improving primary care access has been a longstanding organizational priority and that investments in provider recruitment and workforce support may be contributing to the increased utilization. He further observed that providers with strong access metrics consistently demonstrate higher performance. *Treatment Authorization Request (TAR) Dashboard:* Ms. Davis reported that Medical TAR timeliness is currently 90.8%, while pharmacy authorization timeliness continues to exceed performance expectations. *Grievance Dashboard:* Ms. Davis stated that all grievance-related key performance indicators remain within established performance thresholds. She noted that Partnership rarely loses State hearings, and because the volume is so low, occasional losses can appear disproportionately significant in reporting charts. *Claims and Human Resources Dashboards:* Ms. Davis reported that all key performance indicators remain within established performance thresholds. *Provider Relations Dashboard:* Ms. Davis reported preliminary Provider Satisfaction Survey results indicating that 99% of responding primary care and specialty providers view Partnership as a good health plan. Ms. Davis's full Executive Dashboard report was included in the Board packet and distributed to Board members.	
4.3 Resolution to Approve Partnership's Transfer of Ownership of the Property at 1930 Jefferson Street to Napa Community Health Initiative (CHI)	Jennifer Lopez, Chief Financial Officer, presented a Resolution to approve Partnership's transfer of ownership of a Napa property to the Napa Community Health Initiative (CHI). She explained that Partnership previously received two properties as a gift from the Gasser Foundation. One property is a commercial building that is currently leased to a provider and continues to operate successfully. The second property is a two-bedroom house that is zoned for commercial use but is not ADA compliant. Ms. Lopez stated that, because of the property use restrictions, it must be used in a manner that benefits Medi-Cal beneficiaries. Over the past two years, Partnership staff have worked with a consultant and Napa County Health and Human Services to identify a suitable tenant who could utilize the property while meeting the required use restrictions. Despite these efforts, Partnership was unable to secure an appropriate tenant. Through the efforts of Mark Bontrager, Senior Director of Behavioral Health, Partnership identified Napa Community Health Initiative (CHI), a local nonprofit organization capable of meeting the property's use requirements. As a result, staff are recommending that the Board	*Commissioner Porteus moved to approve Resolution 4.3 as presented, seconded by Commissioner Yoder.* ***ACTION SUMMARY:*** *Yes: 31* *No: 0* *Abstention: 0* *Excused: 6 (Bernal Leroi, Coleman, Johnson, Sphar, Stewart, Sullivan)* **MOTION CARRIED**

	approve transferring the property to Napa CHI so that it can be used in accordance with the restrictions. Ms. Lopez noted that the transfer would have minimal transaction-related costs, including escrow and county recording fees, estimated at less than $10,000. She also explained that because the property has not been fully depreciated, approval of the transfer would result in an approximately $800,000 reduction to Partnership's financial statements. She added that there are no concerns regarding the second gifted property, which remains occupied by the provider tenant.	
4.4 Resolution to Approve Edits to Partnership's Chart of Authority Policy and Matrix, FIN301	Marisa Dominguez, Senior Director of Accounting and Controller, presented proposed revisions to Partnership's Chart of Authority. She explained that the Chart of Authority establishes the internal controls and approval requirements governing the organization's financial assets and transactions. Because the policy had not been updated since 2021, staff determined that it was an appropriate time to review and revise the document to better reflect Partnership's growth and current operational needs. Ms. Dominguez noted that the proposed changes primarily clarify approval thresholds and streamline the approval matrix while maintaining the same overall internal control framework that has been in place in prior years. Key revisions include simplifying the matrix by consolidating Finance Management responsibilities, combining Deputy-level approval columns, replacing detailed delegation notes with a general footnote, and updating position titles. Additional changes include reorganizing and renumbering the matrix, moving Budget approvals to Item 1, removing a separate category for Pharmacy Contracts because those transactions are already addressed within Health Care Expenses, and adding new categories for Settlement of Claims and Pending Actions. The proposal also updates approval thresholds for Purchase Orders, Invoices, and Check Requests, as well as for General Unbudgeted All-Other expenses, to better align with the organization's current size and materiality levels. Ms. Dominguez further explained that specific approval categories have been established for Settlement of Claims and Pending Actions, which were previously included within broader approval classifications. She noted that, historically, some policies were only brought forward to the Finance Committee and Board when revisions were needed. However, due to increasing Medicare regulatory requirements, certain policies will now be required to undergo annual review and approval regardless of whether substantive changes have been made.	*Commissioner Starck moved to approve Resolution 4.4 as presented, seconded by Commissioner Porteus.* ***ACTION SUMMARY:*** *Yes: 31* *No: 0* *Abstention: 0* *Excused: 6 (Bernal Leroi, Coleman, Johnson, Sphar, Stewart, Sullivan)* **MOTION CARRIED**

5.1 Metrics and Financial Update	Ms. Lopez presented Metrics and Financials for June 2026. 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. Ms. Lopez reported that Partnership has experienced some significant changes in expenses and is actively analyzing the underlying factors driving the recent increases. While the organization had anticipated operating losses as part of its financial projections, those losses are now beginning to materialize. However, she noted that Partnership's financial performance remains more favorable than originally budgeted. Ms. Lopez reported the drop in membership is one of the factors driving lower revenue overall. At the time of the fiscal year 2025-26 budget based on the best available information, Partnership projected June 2026 membership to be approximately 914,000 members while actual June 2026 membership was just over 853,000 members. This lower-than-expected membership resulted in reduced revenue received from the State. Partnership has raised concerns with DHCS regarding the sharp decline in membership and sufficiency of our calendar year 2026 revenue. Although the organization was aware of eligibility related changes, including asset and income verification requirements, the magnitude of the enrollment decline was greater than anticipated. Some of the membership declines are attributable to COVID eligibility and income verification flexibilities which expired in June 2025. Partnership has experienced losses among the Children, Adults, and members who became eligible through the Adult ACA Expansion population. Ms. Lopez reported that for the month of August, Partnership has recently observed a slowing in membership losses and will continue to monitor enrollment trends closely. Partnership has experienced higher-than-anticipated non-inpatient service expenses in current and in prior periods. As a result of recent trends, Partnership increased its Incurred But Not Reported (IBNR) expense levels. Favorable administrative expenses have helped offset some of the financial losses. While the plan has incurred financial losses in May and June of 2026, year-to-date financial performance is still within the fiscal year 2025-26 budget. Financial forecasting remains challenging because the State can make membership eligibility adjustments retroactively for up to 13 months. Despite uncertainty, Partnership observed a positive Satisfactory Immigration Status (SIS) enrollment trend in August. While the majority of members who disenrolled during the month were individuals with Unsatisfactory Immigration Status (UIS). Partnership continues to actively monitor enrollment trends. Ms. Lopez also noted that Partnership will have a 13th accounting period to complete year-end reconciliations. She advised that Baker Tilly is scheduled to present the annual audit results to both	None

	the Finance Committee and the Board in October. *Commissioner Hardy asked about the distinction between DHCS's obligation to adequately fund Partnership and Partnership's advocacy efforts to secure actuarially sound rates for 2026.* *Ms. Lopez explained that Partnership must present data-driven evidence demonstrating that the rates established by DHCS are insufficient. She noted that Partnership is working closely with its actuaries to develop a well-supported case. Ms. Lopez added that the State has generally been willing to work collaboratively, although it is facing its own fiscal constraints.* *Commissioner Hardy then asked whether the State is obligated to increase rates if Partnership's actuaries determine that current rates are inadequate.* *Ms. Lopez responded that the State is not obligated to approve higher rates, even if actuarial analysis supports Partnership's position.*	
5.2 Operations Update	Written Report.	None
5.3 Media & Legislative Update	Dustin Lyda, Director of Communications & Government Affairs, provided a media and legislative affairs update. He reviewed key legislation being monitored by Partnership and provided an overview of congressional races within Partnership's service area. Mr. Lyda noted that the Legislature was in the final week of the legislative session and that bills not passed by the August 31 deadline would not advance. Mr. Lyda reminded the Board that, as a public agency, Partnership does not endorse candidates for elected office. He discussed the potential impacts of redistricting on congressional representation within Partnership's service area, noting that three new congressional representatives are expected to serve portions of the region. Mr. Lyda reviewed several congressional races of interest: *District 1:* Mr. Lyda explained that under the new district boundaries, the race is between James Gallagher and Mike McGuire, and current projections favored Mr. McGuire. *District 2:* Mr. Lyda noted that the newly drawn district extends from Modoc County to Marin County and has drawn significant attention due to its geographic size and political composition. Incumbent Jared Huffman and Robin Littau are running in District 2. *District 3:* Mr. Lyda reported that the race between incumbent Representative Ami Bera and Robb Tucker was one of the most competitive contests affecting Partnership's service area. *District 4:* Mr. Lyda stated that Mike Thompson was expected to prevail in the election. *District 6:* Mr. Lyda noted that Kevin Kiley, who had changed his voter registration to No Party Preference, was leading at the time of the report, although the race remained competitive. District 8: Mr. Lyda reported that John Garamendi maintained a substantial lead in his race.	None

	Mr. Lyda concluded his report by noting that Partnership staff will continue monitoring legislative developments and election outcomes that may affect the organization and its members.	
5.4 CMO Report on Quality	Dr. Robert Moore, Chief Medical Officer, and Kristine Gual, Director of Quality Measurement, presented the HEDIS MY2025 / RY2026 Summary of Performance. Ms. Gual provided an overview of DHCS quality accountability programs and reported on Partnership's performance in the Managed Care Accountability Set (MCAS). Partnership's quality strategy remains focused on achieving high performance and year-over-year improvement at the county and regional levels, which drives success in DHCS accountability programs and NCQA Star Ratings. Partnership's MCAS composite score improved from 56.11% in MY2024 to 59.44% in MY2025, reflecting continued progress across accountability measures. Several measures demonstrated sustained strong performance, including postpartum care, childhood immunizations, well-child visits, and diabetes-related care. Additional measures showing notable improvement included follow-up care after emergency department visits for substance use, asthma medication management, and chlamydia screening. Partnership has also identified priority improvement opportunities for 2026, including child and adolescent well-care visits, adolescent immunizations, blood pressure control, prenatal care timeliness, diabetes management, and select preventive screening measures. The Board was informed that data completeness and measure limitations continue to affect certain measures, including follow-up after emergency department visits for mental illness and breast cancer screening. DHCS did not impose sanctions related to these measures for MY2025. The full report was distributed to Board members and is available upon request. *Commissioner Morales questioned how Partnership is held accountable for performance measures when federal policy changes have reduced or eliminated certain underlying requirements and asked whether health plans should receive relief under those circumstances.* *Dr. Moore responded that Partnership has raised concerns with DHCS regarding these measures. However, DHCS has indicated that because the measures remain part of the NCQA measurement set, Partnership will need to advocate for changes through NCQA before corresponding changes are made to State accountability requirements.* *Commissioner Miller expressed appreciation for the Quality Improvement team's efforts to improve data collection and reporting processes for providers. He noted that it can be frustrating when improvement activities are not reflected in performance measures due to data limitations and stated that inaccurate reporting can discourage quality improvement efforts.*	None
5.5 Health Services Update	Katherine Barresi, Chief Health Services Officer, reported that the Care Coordination department supported more than 34,000 cases during the second quarter of 2026. Staff also continue to prepare	None

	for the January 2027 transition of California Children's Services Whole Child Model members with Unsatisfactory Immigration Status from managed care to fee-for-service Medi-Cal and are working with county partners to ensure continuity of care. The Utilization Management Department processed 69,598 Treatment Authorization Requests during the quarter while maintaining strong timeliness performance across inpatient, outpatient, and long-term services and supports. Ms. Barresi highlighted the successful response to the closure of Cottonwood Post-Acute Rehab, noting that Partnership coordinated the safe relocation of 66 affected members with minimal disruption to services. Ms. Barresi also reported on newly finalized DHCS Behavioral Health Transformation performance measures, upcoming Enhanced Care Management and Community Supports policy changes, and ongoing planning efforts to ensure compliance and successful implementation. Ms. Barresi reported that all required documentation has been completed and signed by county partners in alignment with DHCS' Community Reinvestments policy. Partnership is awaiting activation of the DHCS submission portal and has hired two Community Reinvestment Liaisons to support implementation efforts throughout the service region *Commissioner Morales asked how many California Children's Services (CCS) Whole Child Model children with Unsatisfactory Immigration Status (UIS) are expected to transition to county administration from Partnership.* *Katherine Barresi responded that most counties are expected to have case counts in the double digits, with the largest county having approximately 30 affected members. She stated that staff would provide more detailed information.* *Sonja Bjork added that UIS member information is confidential. She noted that Partnership has asked the State for written authorization to allow the sharing of UIS member information with counties, as there is significant concern within the affected community regarding the handling of this information.*	
Adjournment	Chairman Germano adjourned the meeting at 1:43PM	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Board Approval Date: 10/28/2026

Signed: _____

Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
1.9

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

Recommendation by:
Partnership Staff

Topic Description:
Baker Tilly has completed their audit of Partnership's financial statements for the period of July 1, 2025 to June 30, 2026. The audit was conducted in accordance with generally accepted auditing standards.

The Finance Committee reviewed the audit on October 13, 2026, but did not achieve a quorum and therefore took no action. The full Board's vote will supersede Finance Committee approval.

Reason for Resolution:
To provide Board members with the attached audit report conducted by Baker Tilly for review and acceptance.

Financial Impact:
The audited financial statements reflect a true and fair view of the HealthPlan's financial position and performance.

Requested Action of the Board:
Based on the recommendation of Partnership Staff, the Board is asked to accept the attached Baker Tilly Audit Report for the period of July 1, 2025 to June 30, 2026.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date: October 28, 2026 **Agenda Item Number:** 1.9

Resolution Number: 26-

IN THE MATTER OF: ACCEPTING THE BAKER TILLY AUDIT REPORT FOR THE PERIOD OF JULY 1, 2025 TO JUNE 30, 2026

Recital: Whereas,

A. Financial audits are a requirement of DHCS and are an essential component of the Board's oversight.

B. The Board has responsibility for reviewing and accepting independent auditor reports for Partnership HealthPlan of California.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept the attached Baker Tilly Audit Report for the period of July 1, 2025 to June 30, 2026.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

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Report of Independent Auditors and
Financial Statements with Supplementary Information

Partnership Health Plan of California

June 30, 2026 and 2025

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Management's Discussion and Analysis

Partnership Health Plan of California
Management's Discussion and Analysis
As of and for Years Ended June 30, 2026, 2025, and 2024

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Our discussion and analysis of the Partnership Health Plan of California (the Health Plan) provides an overview of the Health Plan's financial activities for the years ended June 30, 2026, 2025, and 2024. The management's discussion and analysis should be read in conjunction with the Health Plan's audited financial statements and accompanying notes.

OVERVIEW OF THE FINANCIAL STATEMENTS

The Health Plan's basic financial statements consist of the statements of net position; statements of revenues, expenses, and changes in net position; statements of cash flows; fiduciary fund financial statements for the Health Plan's Supplemental Executive Retirement Plan (SERP); and the accompanying notes to the financial statements. These statements provide different, but related, information about the Health Plan's financial position and activities.

The statements of net position present the Health Plan's assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position as of the end of each fiscal year. These statements provide information about the Health Plan's financial position and the resources available to meet its ongoing obligations. Net position represents the residual amount after liabilities and deferred inflows of resources are deducted from assets and deferred outflows of resources.

The statements of revenues, expenses, and changes in net position present the Health Plan's operating and nonoperating activities for each fiscal year and explain the changes in net position resulting from those activities. Operating revenues consist primarily of revenues received from the California Department of Health Care Services for the provision of health care services to Medi-Cal members. Operating expenses consist primarily of health care expenses, general and administrative expenses, and premium tax expense. Nonoperating activities primarily consist of investment income and reinvestment of existing funds into the community.

The statements of cash flows provide information about the Health Plan's cash receipts and cash payments during each fiscal year. Cash flows are classified according to operating, capital and related financing, and investing activities. These statements provide information about the sources and uses of the Health Plan's cash and explain the change in cash and cash equivalents from the beginning to the end of each fiscal year.

The fiduciary fund financial statements present the financial position and changes in fiduciary net position of the Health Plan's Supplemental Executive Retirement Plan. Because those resources are held for the benefit of plan participants and beneficiaries rather than for the Health Plan's operations, the SERP's fiduciary activities are presented separately from the Health Plan's proprietary fund financial statements.

FINANCIAL SUMMARY

The following table presents the condensed statements of net position for the Health Plan as of June 30, 2026, 2025, and 2024, and the change between periods:

Table 1 – Condensed statements of net position (dollars in thousands):

	2026	2025	Pre-GASB 103* 2024	Change from 2025 Amount	Change from 2025 Percent
ASSETS					
Current assets	$ 4,043,151	$ 3,930,708	$ 3,532,429	$ 112,443	2.9%
Capital assets, net	195,361	174,472	133,499	20,889	12.0%
Other assets	9,142	5,667	25,828	3,475	61.3%
Net pension asset	8,187	5,715	4,919	2,472	43.3%
Total assets	4,255,841	4,116,562	3,696,674	139,279	3.4%
DEFERRED OUTFLOWS OF RESOURCES	2,500	2,745	1,620	(245)	(8.9%)
Total assets and deferred outflows of resources	$ 4,258,341	$ 4,119,307	$ 3,698,294	$ 139,034	3.4%
LIABILITIES					
CURRENT LIABILITIES	$ 2,759,570	$ 2,654,325	$ 2,442,227	$ 105,245	4.0%
SUBSCRIPTION LIABILITIES, net of current portion	10,887	774	847	10,113	1,306.6%
Total liabilities	2,770,457	2,655,099	2,443,074	115,358	4.3%
DEFERRED INFLOWS OF RESOURCES	12,579	6,658	7,618	5,921	88.9%
NET POSITION					
Net investment in capital assets	176,805	171,795	133,499	5,010	2.9%
Restricted	300	300	300	-	0.0%
Unrestricted	1,298,200	1,285,455	1,113,804	12,745	1.0%
Total net position	1,475,305	1,457,550	1,247,603	17,755	1.2%
Total liabilities, deferred inflows, and net position	$ 4,258,341	$ 4,119,307	$ 3,698,294	$ 139,034	3.4%

*Fiscal year 2024 amounts are presented on the basis originally reported and have not been reclassified to conform to the fiscal year 2026 presentation under GASB Statement No. 103. Accordingly, certain fiscal year 2024 classifications are not directly comparable to fiscal years 2025 and 2026.

DETAILED ANALYSES

ASSETS

Current assets increased by $112.4 million from $3.9 billion in 2025 to $4.0 billion in 2026. This increase is primarily due to an increase in cash and cash equivalents primarily from the timing of cash receipts from the State. Net pension asset increased by $2.5 million (43.3%) from 2025 to 2026. Deferred outflows of resources decreased by $0.2 million (8.9%) from 2025 to 2026. Refer to Note 9 of the financial statements for additional information.

Current assets increased by $398.3 million in 2025, primarily due to receivable accruals for Directed Payments, Voluntary Rate Range, and Medi-Cal Managed Care Organizations (MCO) tax revenue (each with corresponding current liability accruals), as well as higher operating and investment income. The net pension asset and deferred outflows of resources increased by $0.8 million (16.2%) and $1.1 million (69.4%), respectively.

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LIABILITIES

Total current liabilities increased by $105.2 million from $2.7 billion in 2025 to $2.8 billion in 2026. This increase, primarily in Accounts Payable and Accrued Expenses, can be attributed to the accruals for Directed Payments and Voluntary Rate Range for calendar years 2025 and 2026, which has corresponding offsets in current assets. Also contributing to this increase is the MCO tax payable accrued for the year, which will be addressed in the upcoming sections. One last contributor to the increase is from the accrual recorded according to the Department of Health Care Services (DHCS) Community Reinvestments policy for calendar years 2024 and 2025, of which the amounts are directed by DHCS; calendar year 2024 investment amounts are final and calendar year 2025 investments amounts were estimated based on best available information and are subject to change.

Total current liabilities increased $212.1 million in 2025, primarily due to higher Accounts Payable and Accrued Expenses related to Directed Payment and Voluntary Rate Range accruals (each with corresponding receivable accruals). The increase also reflects additional MCO tax payable accrued in 2025. These increases were partially offset by lower accrued claims payable.

NET POSITION

Total net position increased by $17.8 million (1.2%) in 2026 from 2025. The increase is primarily due to a net non-operating income of $55.3 million offset by an operating loss of $37.5 million in 2026.

Total net position increased by $209.9 million (16.8%) in 2025. The increase is primarily due to an operating income of $107.9 million and net investment earnings of $102.0 million.

KEY OPERATING INDICATORS

The following table compares key operating indicators for the Health Plan for the years ended June 30, 2026, 2025, and 2024:

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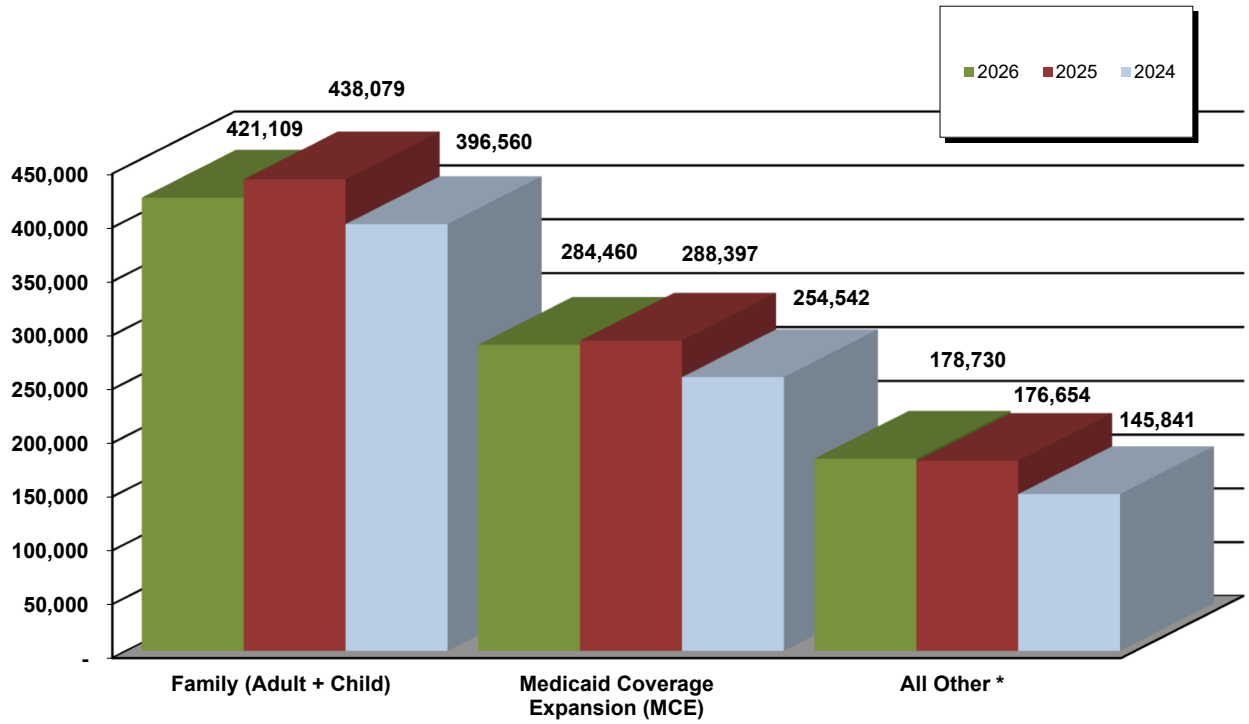
	2026	2025	2024
MEMBERSHIP			
Member months for the year:			
Medi-Cal program	10,611,574	10,837,561	9,563,314
Total	10,611,574	10,837,561	9,563,314
Average member per month			
Medi-Cal program	884,299	903,130	796,943
Total	884,299	903,130	796,943
OPERATING RESULTS (in thousands)			
Operating revenues	$ 7,119,116	$ 6,786,865	$ 5,640,676
Operating expenses:			
Health care	5,964,424	5,396,098	4,455,620
General and administrative	413,268	354,704	276,630
Premium tax	779,016	928,152	659,356
Total	7,156,708	6,678,954	5,391,606
Operating (deficit) income	$ (37,592)	$ 107,911	$ 249,069
OPERATING RESULTS PER MEMBER PER MONTH			
Operating revenues	$ 670.9	$ 626.2	$ 589.8
Operating expenses:			
Health care	562.1	497.9	465.9
General and administrative	38.9	32.7	28.9
Premium tax	73.4	85.6	68.9
Total	674.4	616.3	563.8
Operating (deficit) income	$ (3.5)	$ 10.0	$ 26.0
RATIOS			
Health care cost as a percentage of operating revenues	83.8%	79.5%	79.0%
General and administrative expense as a percentage of operating revenues	5.8%	5.2%	4.9%
Premium tax as a percentage of operating revenues	10.9%	13.7%	11.7%
Operating (deficit) income as a percentage of operating revenues	(0.5%)	1.6%	4.4%

ENROLLMENT

During the years ended June 30, 2026, 2025, and 2024, the Health Plan served Medi-Cal members at an average of 884,299, 903,130, and 796,943, respectively, per month. Enrollment from 2025 to 2026 decreased during the year primarily due to the sunset of the federal COVID-19 eligibility flexibilities and California 2025-26 Budget Act changes that resulted in more restrictive eligibility requirements for Seniors and Persons with Disabilities tied to asset test changes and the implementation of a Medi-Cal eligibility freeze for adults who lack satisfactory immigration status.

The following chart displays a comparative view of average monthly membership by Medi-Cal aid category for the years ended June 30, 2026, 2025, and 2024.

Partnership Health Plan of California's Medi-Cal membership by aid category (shown as average member months):



*All Other = Long Term Care (LTC), Seniors and Persons with Disabilities (SPD), Dual LTC-SPD, and Whole Child Model (WCM)

RESULTS OF OPERATIONS

The following table presents the results of operations for the years ended June 30, 2026, 2025, and 2024, and the change from prior year (in thousands):

	2026	2025	Pre-GASB 103* 2024	Change from 2025 Amount	Change from 2025 Percent
California Department of Health Care Services					
Capitation revenue	$ 7,098,527	$ 6,726,490	$ 5,608,959	$ 372,037	5.5%
Other income	20,589	60,375	31,717	(39,786)	(65.9%)
Total operating revenues	7,119,116	6,786,865	5,640,676	332,251	4.9%
Fee for service hospital inpatient, physician, and other services	4,854,488	4,322,071	3,404,458	532,417	12.3%
Capitated physician, hospital, and other costs	326,008	289,313	450,573	36,695	12.7%
Long-term care	715,849	690,437	551,122	25,412	3.7%
Quality improvement program and hospital stop loss	68,079	94,277	49,466	(26,198)	(27.8%)
Total health care expenses	5,964,424	5,396,098	4,455,620	568,326	10.5%
Total general and administrative expenses	413,268	354,704	276,630	58,564	16.5%
Premium tax	779,016	928,152	659,356	(149,136)	(16.1%)
Total operating expenses	7,156,708	6,678,954	5,391,606	477,754	7.2%
Operating (deficit) income	(37,592)	107,911	249,069	(145,503)	(134.8%)
Investment income	91,146	102,037	92,127	(10,891)	(10.7%)
Community reinvestments	(35,799)	-	-	(35,799)	0.0%
Total nonoperating revenues (expenses)	55,347	102,037	92,127	(46,690)	(45.8%)
Increase in net position	$ 17,755	$ 209,948	$ 341,196	$ (192,193)	(91.5%)

*Fiscal year 2024 amounts are presented on the basis originally reported and have not been reclassified to conform to the fiscal year 2026 presentation under GASB Statement No. 103. Accordingly, certain fiscal year 2024 classifications are not directly comparable to fiscal years 2025 and 2026.

OPERATING REVENUES

The Health Plan's total operating revenues increased by $332.3 million (4.9%) for the year ended June 30, 2026. The increase in operating revenues in 2026 is attributable to an increase in Capitation Revenue of $372.0 million.

For the year ended June 30, 2025, the Health Plan's total operating revenues increased by $1.1 billion, or 20.3%, primarily due to 13.3% membership growth, which generated approximately $1.1 billion in additional revenue. The increase also reflects additional MCO tax revenue retroactive to calendar year 2024 under California Assembly Bill 160.

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HEALTH CARE EXPENSES

Overall health care expenses increased by $568.3 million or 10.5%, totaling $6.0 billion in 2026, compared to $5.4 billion in 2025. The Health Plan's health care ratio (health care costs as a percentage of operating revenue) at 83.8% in 2026 increased slightly in comparison to 2025's health care ratio of 79.5%. Note that this ratio is calculated differently than DHCS's methodology, as DHCS calculates its ratios based on service year and excludes any adjustments pertaining to prior service years. Overall increased costs are explained as follows:

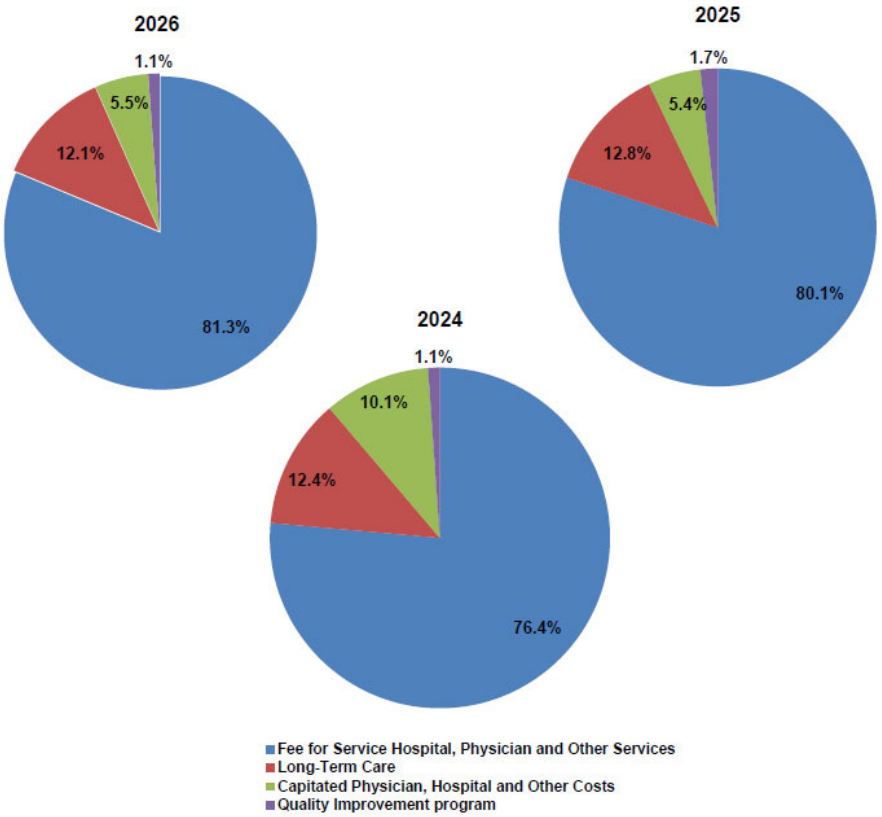
- Provider capitation is comprised of capitation payments made to the Health Plan's contracted medical groups, hospitals, physicians, and other health care service providers. Capitation expenses totaled $326.0 million in 2026 compared to $289.3 million in 2025, for an increase of $36.7 million (12.7%), primarily due to capitation increases tied to the DHCS Targeted Rate Increase (TRI) policy.

- Fee for service expenses for hospital, physician, and other services totaled $4.9 billion in 2026 compared to $4.3 billion in 2025 due to increased utilization; this also includes Directed Payments and Voluntary Rate Range, which have an offset in DHCS Capitation Revenue. Long-term care fee-for-service expenses increased to $715.8 million in 2026 from $690.4 million in 2025; the increase can be attributed to increased utilization offset by prior year adjustments to IBNR.

Overall health care expenses increased $940 million, or 21.1% in 2025, while the health care ratio remained relatively consistent at 79.5%. The increase was primarily driven by higher membership and utilization, which increased fee-for-service and long-term care expenses, partially offset by lower provider capitation following termination of the global sub-capitation agreement effective January 2024. Quality Improvement Program expenses also increased due to increased provider participation.

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The following charts show a comparison of health care expenses by major category and their respective percentages of the overall health care expenditures for the years ended June 30, 2026, 2025, and 2024:



GENERAL AND ADMINISTRATIVE EXPENSES AND PREMIUM TAX EXPENSE

Total general and administrative expenses were $413.3 million in 2026, compared to $354.7 million in 2025. Overall administrative expenses increased by 16.5% or $58.6 million. This increase is due to the increased staffing continuing from servicing the expansion counties and the fulfilling of additional DHCS contractual requirements. The Health Plan's administrative expenses as a percentage of operating of revenues were 5.8% in 2026 and 5.2% in 2025; the increase in revenue, which also affects the calculation of this ratio, is addressed in the Operating Revenues section. The Health Plan's premium tax expense for the years ended June 30, 2026 and 2025 was $779.0 million and $928.2 million, respectively.

General and administrative expenses increased $78.1 million, or 28.2% in 2025, primarily due to increased staffing related to county expansion and additional 2024 DHCS contract requirements.

NONOPERATING REVENUES (EXPENSES)

Nonoperating revenues consist of net investment income of $91.1 million in 2026 compared to $102.0 million in 2025; this decrease is due to lower interest rates in comparison to the previous year. Nonoperating expenses consist of accruals for Community Reinvestments of $35.8 million in 2026 for calendar year 2024 and 2025; there were no accruals recorded in the previous year.

Nonoperating revenues for fiscal year 2025, consisted of net investment income and increased by $9.9 million due to higher interest rates resulting in greater interest income.

LIQUIDITY

As of June 30, 2026, working capital (current assets in excess of current liabilities) remained comparable at $1.3 billion, with a slight overall increase of $7.2 million.

As of June 30, 2025, working capital increased by $719.8 billion primarily from the year's operating income.

SIGNIFICANT CAPITAL ASSET AND LONG-TERM FINANCING ACTIVITY

At June 30, 2026, the Health Plan had approximately $195.4 million in capital assets, net of accumulated depreciation and amortization, compared with $174.5 million at June 30, 2025, which is an increase of approximately $20.9 million. During fiscal year 2026, the Health Plan recorded approximately $40.4 million of capital asset additions, consisting primarily of $24.6 million of subscription assets and $14.9 million of capital projects. Capital projects totaled approximately $61.8 million at June 30, 2026. Depreciation expense and accumulated depreciation related to capital asset activity totaled approximately $19.5 million during fiscal year 2026. Additional information regarding the Health Plan's capital assets is presented in Note 4 to the financial statements.

During fiscal year 2026, the Health Plan entered into additional subscription-based information technology arrangements. Subscription liabilities increased from approximately $2.7 million at June 30, 2025, to $18.6 million at June 30, 2026, reflecting approximately $26.9 million of additions and $11.0 million of payments during the year. The Health Plan's subscription arrangements extend through fiscal year 2030. Additional information regarding these arrangements and related future payment requirements is presented in Note 8 to the financial statements.

CURRENTLY KNOWN FACTS, DECISIONS, OR CONDITIONS

ECONOMIC FACTORS AND FISCAL YEAR 2027 BUDGET

As the State addresses budgetary and regulatory changes within the Medi-Cal program, the Health Plan anticipates continued efforts by DHCS to promote cost-effective managed care while maintaining access to services for members. The State budget includes several Medi-Cal program changes that may affect enrollment, funding, and operations, including the transition of certain Unsatisfactory Immigration Status (UIS) members from managed care to fee-for-service, revised eligibility requirements and asset limits, modifications to Enhanced Care Management and Community Supports programs, and changes to MCO tax structures and directed payment programs. The state's budgetary pressures were amplified after the comprehensive federal reconciliation bill enacted on July 4, 2025 (HR 1), imposed federal restrictions on Medicaid eligibility and financing. While the State's fiscal year 2026-27 budget remains balanced, ongoing fiscal pressures within Medi-Cal and uncertainty surrounding future federal funding and regulatory changes are expected to affect plan enrollment, revenue, and operations.

The Health Plan is currently projecting a net loss of $66.9 million for fiscal year 2026-27. This budget reflects anticipated enrollment declines associated with State and federal eligibility changes, including provisions enacted under HR 1 as well as ongoing uncertainty related to future Medi-Cal funding and reimbursement methodologies. While overall membership is projected to decrease, the Health Plan expects the remaining membership population to exhibit higher health care needs and utilization. Given the evolving regulatory environment and uncertainty surrounding enrollment, revenue adequacy, and program funding, management will continue to monitor developments and may revise budget assumptions as significant new information becomes available. The Health Plan remains focused on maintaining sufficient reserves and financial flexibility to support operations and continue serving its members.

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FIDUCIARY MD&A

OVERVIEW OF THE FIDUCIARY FINANCIAL STATEMENTS

Effective May 1, 2001, the Health Plan's Board of Commissioners approved and adopted a tax-qualified governmental SERP for the benefit of certain eligible employees. The SERP is a single employer defined benefit pension plan administered by the Health Plan. The SERP provides retirement, disability, and death benefits to plan members and their beneficiaries. With respect to plan members and their beneficiaries under the trust created pursuant to this plan, the trust assets are not to be used for, or diverted to, purposes other than the exclusive benefit of the plan members or their beneficiaries, as prescribed in Section 401(a)(2) of the Internal Revenue Code of 1986.

The basic financial statements present information about the SERP's fiduciary net position and changes in fiduciary net position for the respective years. The basic financial statements also include notes that explain certain information presented in the financial statements and provide additional detail.

The statement of fiduciary net position presents the assets and liabilities and resulting fiduciary net position of the SERP as of the end of each fiscal year. Investments are reported at fair value.

The statement of changes in fiduciary net position reflects employer contributions and investment income, net of investment expenses, less benefits paid.

FINANCIAL SUMMARY

The table below is a summarized comparison of the assets, liabilities and fiduciary net position of the Partnership Health Plan of California Retirement Plan Fund as of June 30, and the changes in fiduciary net position for the years ended June 30:

	2026	2025	2024	Change from 2025 Amount	Change from 2025 Percent
ASSETS					
Cash and cash equivalents	$ 472,508	$ 437,751	$ 570,894	$ 34,757	7.9%
Investments, at fair value	27,300,390	23,701,628	20,209,663	3,598,762	15.2%
NET POSITION RESTRICTED FOR PENSION	$ 27,772,898	$ 24,139,379	$ 20,780,557	$ 3,633,519	15.1%
ADDITIONS					
Investment income	$ 3,743,399	$ 2,568,936	$ 1,888,822	$ 1,174,463	45.7%
Contributions	1,120,886	2,167,797	1,673,720	(1,046,911)	-48.3%
Total additions, net	4,864,285	4,736,733	3,562,542	127,552	2.7%
DEDUCTIONS					
Deductions	1,230,766	1,377,911	1,239,422	(147,145)	-10.7%
INCREASE IN NET POSITION RESTRICTED FOR PENSION	$ 3,633,519	$ 3,358,822	$ 2,323,120	$ 274,697	8.2%

Total fiduciary fund net position as of June 30, 2026, increased by $3.6 million from June 30, 2025, due to plan contributions and a net investment gain for the year ended June 30, 2026.

DETAILED ANALYSIS

Net position restricted for pension benefits increased by $3.6 million, or 15.1%, from $24.1 million at June 30, 2025 to $27.7 million at June 30, 2026. Investments increased from $23.7 million to $27.3 million, primarily as a result of investment returns during the year. Cash and cash equivalents increased from $0.44 million to $0.47 million due to timing.

During the year ended June 30, 2026, investment income increased by $1.1 million, from $3.7 million compared with $2.6 million in 2025. The increase in investment income was due to positive returns in global security markets and increased returns on the Health Plan's investments. Employer contributions decreased by $1.1 million, from $2.2 million compared with $1.1 million in 2026. Benefit payments decreased by $0.2 million, from $1.4 million compared with $1.2 million in 2026, due to certain participants' fixed payments concluding in 2026.

CURRENTLY KNOWN FACTS, DECISIONS, OR CONDITIONS – FIDUCIARY FUND

At present, there are no known facts or conditions that are expected to have a significant effect on the fiduciary financial position or results of operations.

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Report of Independent Auditors

The Commissioners
Partnership Health Plan of California

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Partnership Health Plan of California as of and for the years ended June 30, 2026 and 2025, and the related notes to the financial statements, which collectively comprise Partnership Health Plan of California's financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements present fairly, in all material respects, the respective financial position of the business-type activities and aggregate remaining fund information of Partnership Health Plan of California as of June 30, 2026 and 2025, and the respective changes in net position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Partnership Health Plan of California and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Partnership Health Plan of California's ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Partnership Health Plan of California's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Partnership Health Plan of California's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

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Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 12 and the supplementary schedule of changes in the net pension asset and related ratios, supplementary schedule of contributions, and supplementary schedule of investment returns on pages 45 through 47 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audits were conducted for the purpose of forming an opinion on the financial statements that comprise Partnership Health Plan of California's basic financial statements. The statement of revenues, expenses, and changes in net position – actual and budget operations on page 43 presented for purposes of additional analysis and is not a required part of the basic financial statements.

The statement of revenues, expenses, and changes in net position – actual and budget operations is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

San Francisco, California
October ___, 2026

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Financial Statements

Partnership Health Plan of California
Statements of Net Position
June 30, 2026 and 2025

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	2026	2025
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 2,220,943,398	$ 2,102,410,214
California Department of Health Care Services receivable	1,786,808,774	1,754,909,555
Other receivables	18,615,857	59,517,832
Lease receivable, current portion	2,172,312	1,787,733
Other current assets	14,610,106	12,082,273
Total current assets	4,043,150,447	3,930,707,607
CAPITAL ASSETS		
Nondepreciable	73,119,412	64,265,138
Depreciable, net of accumulated depreciation and amortization	95,622,676	96,597,473
Total capital assets	168,742,088	160,862,611
OTHER ASSETS	1,144,321	1,208,715
NET PENSION ASSET	8,186,907	5,714,523
LEASE RECEIVABLE, net of current portion	7,998,022	4,458,135
SUBSCRIPTION ASSET, net of amortization	26,619,205	13,609,573
Total assets	4,255,840,990	4,116,561,164
DEFERRED OUTFLOWS OF RESOURCES	2,500,051	2,745,009
Total assets and deferred outflows	$ 4,258,341,041	$ 4,119,306,173
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 2,056,305,919	$ 1,928,779,172
Payable to the State of California	32,633,113	32,633,113
Accrued claims payable	615,153,263	613,302,417
Quality improvement program	55,477,765	79,609,869
Total current liabilities	2,759,570,060	2,654,324,571
SUBSCRIPTION LIABILITIES, net of current portion	10,886,509	773,753
Total liabilities	2,770,456,569	2,655,098,324
DEFERRED INFLOWS OF RESOURCES	12,579,067	6,657,637
NET POSITION		
Net investment in capital assets	176,804,858	171,794,200
Restricted	300,000	300,000
Unrestricted	1,298,200,547	1,285,456,012
Total net position	1,475,305,405	1,457,550,212
Total liabilities, deferred inflows, and net position	$ 4,258,341,041	$ 4,119,306,173

See accompanying notes.

Partnership Health Plan of California
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2026 and 2025

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	2026	2025
OPERATING REVENUES		
California Department of Health Care Services revenue	$ 7,098,527,211	$ 6,726,489,726
Other income	20,588,686	60,374,586
Total operating revenues	7,119,115,897	6,786,864,312
OPERATING EXPENSES		
Health care expenses		
Fee for service hospital, physician, and other services	4,854,487,624	4,322,070,846
Capitated physician, hospital, and other costs	326,007,748	289,312,950
Long-term care	715,849,280	690,437,321
Quality improvement program and hospital stop loss	68,078,522	94,276,506
Total health care expenses	5,964,423,174	5,396,097,623
General and administrative expenses	413,268,132	354,703,986
Premium tax	779,016,409	928,152,119
Total operating expenses	7,156,707,715	6,678,953,728
Operating (deficit) income	(37,591,818)	107,910,584
NONOPERATING REVENUES (EXPENSES)		
Investment income	91,145,523	102,036,918
Community reinvestments	(35,798,512)	-
Total nonoperating revenues	55,347,011	102,036,918
INCREASE IN NET POSITION	17,755,193	209,947,502
NET POSITION, beginning of year	1,457,550,212	1,247,602,710
NET POSITION, end of year	$ 1,475,305,405	$ 1,457,550,212

See accompanying notes.

Partnership Health Plan of California
Statements of Cash Flows
Years Ended June 30, 2026 and 2025

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	2026	2025
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from California Department of Health Care Services	$ 7,128,890,520	$ 6,484,893,942
Other income	3,011,824	36,526,744
Cash payments to providers for Medi-Cal members		
Capitation payments	(247,603,981)	(294,022,700)
Medical claims payments	(5,713,687,350)	(5,325,298,755)
Cash payments to vendors	(868,330,521)	(946,048,635)
Cash payments for salaries, wages, and related benefits	(248,294,887)	(209,506,197)
Net cash provided by (used in) operating activities	53,985,605	(253,455,601)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Payments on subscription liabilities	(11,036,205)	(6,282,390)
Purchases of capital assets	(15,810,438)	(34,928,854)
Net cash used in capital and related financing activities	(26,846,643)	(41,211,244)
CASH FLOWS FROM INVESTING ACTIVITY		
Interest and dividends on investments	91,394,222	101,936,112
Net cash provided by investing activity	91,394,222	101,936,112
INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	118,533,184	(192,730,733)
CASH AND CASH EQUIVALENTS, beginning of year	2,102,410,214	2,295,140,947
CASH AND CASH EQUIVALENTS, end of year	$ 2,220,943,398	$ 2,102,410,214

See accompanying notes.

Partnership Health Plan of California
Statements of Cash Flows
Years Ended June 30, 2026 and 2025

	2026	2025
RECONCILIATION OF OPERATING (DEFICIT) INCOME TO NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES		
Operating (deficit) income	$ (37,591,818)	$ 107,910,584
Adjustment to reconcile operating (deficit) income to net cash provided by (used in) operating activities:		
Depreciation and amortization	19,506,320	14,440,898
Changes in operating assets and liabilities		
California Department of Health Care Services receivable	(31,899,220)	(562,755,458)
Other receivables	22,554,753	(26,205,043)
Lease receivables	3,924,466	1,456,244
Subscription assets/liabilities	10,249,590	(2,873,417)
Other assets	(55,963,898)	(5,145,840)
Net pension asset	2,472,384	(2,880,300)
Accounts payable and accrued expenses	143,014,286	504,951,952
Accrued claims payable	1,850,846	(272,715,010)
Quality improvement program	(24,132,104)	(9,640,211)
Net cash provided by (used in) operating activities	$ 53,985,605	$ (253,455,601)
SUPPLEMENTAL DISCLOSURE OF CASH FLOWS INFORMATION		
Cash paid during the year for premium tax	753,500,000	$ 816,406,250

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See accompanying notes.

Partnership Health Plan of California
Partnership Health Plan of California Supplemental Executive Retirement Plan – Statements of Fiduciary Net Position
Years Ended June 30, 2026 and 2025

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	2026	2025
ASSETS		
Cash and cash equivalents	$ 472,508	$ 437,751
Investments, at fair value		
Mutual funds	27,300,390	23,701,628
Total investments, at fair value	27,300,390	23,701,628
Total assets	$ 27,772,898	$ 24,139,379
NET POSITION RESTRICTED FOR PENSIONS	$ 27,772,898	$ 24,139,379

See accompanying notes.

Partnership Health Plan of California

Partnership Health Plan of California Supplemental Executive Retirement Plan – Statements of Changes in Fiduciary Net Position

Years Ended June 30, 2026 and 2025

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	2026	2025
ADDITIONS		
Contributions		
Member contributions	$ 323,173	$ 301,536
Employer contributions	797,713	1,866,261
Total contributions	1,120,886	2,167,797
Investment income	3,743,399	2,568,936
Total additions	4,864,285	4,736,733
DEDUCTIONS		
Benefits paid to participants	(1,142,453)	(1,297,080)
Administrative expenses	(88,313)	(80,831)
Total deductions	(1,230,766)	(1,377,911)
INCREASE IN NET POSITION	3,633,519	3,358,822
NET POSITION RESTRICTED FOR PENSION, beginning of year	24,139,379	20,780,557
NET POSITION RESTRICTED FOR PENSION, end of year	$ 27,772,898	$ 24,139,379

See accompanying notes.

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Note 1 – Organization

The Health Plan 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 Health Plan is a combined public and private effort engaged principally in providing a more cost-effective method of health care. 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.

The Health Plan has quasi-independent political jurisdiction to contract with the DHCS to receive Medi-Cal funding to provide health care benefits to eligible members (the Contract). The Health Plan has contracted with various health care providers to provide or arrange hospital and medical services for its members who reside in various Northern California counties. Provider agreements are typically evergreen or for a multi-year period and contain quality performance measures.

Beginning January 1, 2022, DHCS began implementing California Advancing and Innovating Medi-Cal (CalAIM) to modernize the State of California's Medi-Cal Program. CalAIM focuses on a whole-system, person-centered strategy that focuses on wellness and prevention, including assessments of each enrollee's health risks and health-related social needs, and provide care management and care transitions across delivery systems and settings.

As a public agency, the Health Plan is exempt from state and federal income taxes.

Note 2 – Summary of Significant Accounting Policies

Accounting standards – Pursuant to Governmental Accounting Standards Board (GASB) Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, the Health Plan's proprietary fund accounting and financial reporting practices are based on all applicable GASB pronouncements as well as codified pronouncements issued on or before November 30, 1989.

Proprietary fund accounting – The Health Plan utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and financial statements are prepared using the economic resources measurement focus.

Cash and cash equivalents – Cash and cash equivalents consist of demand deposits, investments in the State Treasurer's Local Agency Investment Fund (LAIF), and other short-term, highly liquid securities with original maturities of three months or less.

Other assets – Other assets consist of prepaid expenses and investments in certificates of deposit. The investments in certificates of deposit are stated at fair market value as determined by quoted market prices, with any changes in the fair value of investments included in net investment and interest income reported in the statements of revenues, expenses, and changes in net position.

Leases – The Health Plan recognizes lease contracts or equivalents that have a term exceeding one year and the cumulative future receipts on the contract exceed $10,000 that meet the definition of an other than short-term lease. The Health Plan uses the same interest rate it charges to the lessee or the rate that is implicit in the contract as the discount rate. Short-term lease receipts and variable lease receipts not included in the measurement of the lease receivable are recognized as income when earned.

Capital assets – Capital assets whose costs are greater than or equal to $10,000 are recorded at cost. Depreciation ranging from three (3) to thirty-nine (39) years is computed using the straight-line method over the estimated useful lives. Leasehold improvements are amortized over the lesser of the term of the related lease or their estimated useful life. The costs of normal maintenance, repairs, and minor replacements are charged to expense when incurred.

The Health Plan evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Subscription assets – The Health Plan has recorded subscription assets, in accordance with GASB Statement No. 96 (GASB 96), *Subscription-Based Information Technology Arrangements* (SBITA), and are initially measured at an amount equal to the initial measurement of the related subscription liability plus any contract payments made to the SBITA vendor at the commencement of the subscription term, capitalizable initial implementation cost, less any incentive payments received from the SBITA vendor at the commencement of the subscription term. The subscription assets are amortized on a straight-line basis over the shorter of the subscription term or the useful life of the underlying assets.

Subscription liabilities – The Health Plan entered into various agreements for information technology (IT) subscriptions. These agreements range in terms up to year 2030. In fiscal year 2026, the total subscription payments were $11,036,205. Variable payments based upon the use of the underlying IT asset that are not fixed in substance are not included in subscription assets or subscription liabilities. There were no variable subscription expenses and payments in fiscal years ended June 30, 2026 and 2025. The Health Plan is in the process of entering into additional subscription agreements that have yet to commence as of June 30, 2026.

The Health Plan recognizes contracts or equivalents that have a term exceeding one year with cumulative future payments on the contract exceeding $100,000 that meet the definition of an other than short-term lease. The Health Plan uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using the Health Plan's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments are expensed when incurred.

Quality improvement program – Quality improvement program pools are calculated based contractual terms and expected provider performance under the applicable quality incentive programs. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of quality improvement programs is dependent on final measurement results, management is of the opinion that the related accruals are adequate to cover such estimates.

Accounts payable and accrued expenses – Accounts payable and accrued expenses include accruals of $1,217,001,920 and $1,162,441,719 for Hospital Directed Payments, $363,858,083 and $343,132,871 for Voluntary Rate Range, and $294,743,235 and $269,226,826 for MCO Tax as of June 30, 2026 and 2025, respectively. These liability accruals have corresponding offsets in current assets. Accounts payable and accrued expenses also include accruals for Community Reinvestments.

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- **Directed Payments** – Directed payments are a regulatory mechanism established under 42 C.F.R. § 438.6(c), allowing states to implement delivery system and provider payment initiatives within Medicaid Managed Care Plan (MCP) contracts. These payments are part of CMS's modernization of Medicaid managed care regulations and are intended to support delivery system reform while maintaining actuarial soundness.

- **Voluntary Rate Range** – The Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164 and 14301.4, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the DHCS. Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation, are used to fund payments by DHCS to MCPs as part of the capitation rates.

- **Community Reinvestments** – Effective January 1, 2024, the DHCS implemented the Community Reinvestment policy which mandates MCPs to contribute a minimum percentage of net income to defined Community Reinvestment categories. Beginning in calendar year 2024, the Health Plan is subject to the state-mandated Community Reinvestment policy requirements exclusively during program periods where the net position, as calculated under the state-defined methodology, is positive. The Community Reinvestment Program is intended to improve the health and well-being of the Medi-Cal members through innovations that are locally driven. Expenses for Community Reinvestments are reported in the Nonoperating section of the Statement of Revenues, Expenses, and Changes in Net Position.

Net position – Net position is classified as invested in capital assets, restricted, or unrestricted. Invested in capital assets represents investments in motor vehicles, equipment, furniture, leasehold improvements, buildings and building improvements net of depreciation, land, and capital projects at cost. The restricted net position to meet minimum tangible net equity requirements under Knox-Keene, which represent the total cash balances that are restricted as to their use, was $300,000 as of June 30, 2026 and 2025. Unrestricted net position consists of net position that does not meet the definition of "restricted" or "invested in capital assets." Designated funds remain under the control of the Board of Commissioners, which at its discretion later, may use the funds for other purposes. Current amounts are addressed through the budget process and includes Board approved capital and infrastructure purchases as well as an estimate for the State Financial Performance Guarantee based on state contractual requirements. Management estimated the total designated reserve to be $1,269,276,795 and $1,184,801,278 as of June 30, 2026 and 2025, respectively. Determination of actions to take place in situations where the Board Designated reserve balance falls below or goes above the calculated amount will be addressed by recommendation of the Executive Management team and the Finance Committee and authorized by the Board.

Operating revenues and expenses – The Health Plan's primary operating revenue is derived from capitation. As defined by GASB Codification Section P80, *Proprietary Fund Accounting and Financial Reporting*, all operating revenues are considered program revenues since they are charges for services provided and program-specific operating grants. The primary operating expense is health care costs. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from nonexchange transactions or net investment income and changes in the fair value of investments.

Revenues – Medi-Cal capitation revenue under the Contract is based on the monthly capitation rates, as provided for in the Contract, and the actual number of Medi-Cal eligible members. Eligibility of beneficiaries is determined by each respective county's Department of Human Services and validated by DHCS. DHCS provides the Health Plan the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of capitation revenue for the respective month.

Capitation revenues are paid by the DHCS on a monthly basis in arrears based on estimated membership. Payments include retrospective adjustments that are reconciled monthly by DHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to DHCS for these retrospective adjustments. These estimates are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known.

Effective January 1, 2024, the Health Plan became subject to the DHCS medical loss ratio requirements for the Adult Expansion Population established under the Affordable Care Act (ACA). Under these requirements, the Health Plan was required to maintain a minimum MLR of 85% based on the allowable incurred medical expenses, as defined by DHCS, for the period January 1, 2014, through June 30, 2015, and for fiscal years 2016 and 2017. As of June 30, 2026, the Health Plan recorded an estimated liability of $32,633,133 related to this obligation, which is reflected in payable to the State of California.

Premium deficiencies – The Health Plan performs periodic analyses of its expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is recorded. Management determined that no premium deficiency reserves were needed at June 30, 2026 and 2025.

Health care expenses – Hospital, physician, and other service costs are based on actual paid claims plus an estimate for accrued incurred, but not reported, claims. Claims are paid primarily on a discounted fee-for-service basis. PCPs and certain hospitals are compensated primarily on a capitation basis with provisions for other ancillary services as well as additional incentive payments in certain circumstances.

Premium tax – Effective April 1, 2023, a revised Medi-Cal Managed Care Organizations (MCO) provider tax was established and is in effect through December 31, 2026. Under HR 1 new federal mandates impose federal restrictions on future MCO tax revenue structures that support the Medi-Cal program. These changes require reassessment by DHCS of the MCO payment structure to ensure compliance with federal guidelines. Premium tax expense for the years ended June 30, 2026 and 2025, was $779,016,409 and $928,152,119, respectively.

Pension – For purposes of measuring the net pension asset, deferred outflows of resources and deferred inflows of resources related to pension, and pension expense, information about the fiduciary net position of the Health Plan's SERP and additions to/deductions from the SERP's fiduciary net position have been determined on the same basis as they are reported by the SERP. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Concentrations of risk – Financial instruments potentially subjecting the Health Plan to concentrations of risk consist primarily of bank demand deposits in excess of Federal Deposit Insurance Corporation (FDIC) insurance thresholds. The Health Plan maintains its cash in bank deposit accounts, which, at times, may exceed FDIC insurance thresholds. The Health Plan believes no significant concentration of credit risk exists with these cash accounts. Management assesses the financial ability of these financial institutions periodically. At June 30, 2026 and 2025, the Health Plan had cash and deposits with four (4) financial institutions. Cash deposits had carrying amounts of $2,221,243,398 and $2,102,410,214, respectively, and bank balances of $2,366,197,571 and $ 2,243,234,988, respectively. Of the bank balances at June 30, 2026 and 2025, $207,032,947 and $201,041,771, respectively, were not covered by federal depository insurance.

The Health Plan is highly dependent upon the State of California for its revenues. All accounts receivable and substantially all revenues are from the State of California. Loss of the contracts with the State of California due to nonrenewal or legislative decisions that impact program funding or result in discontinuation could materially affect the financial position of the Health Plan.

Recent accounting pronouncements – In May 2024, the GASB issued Statement No. 103, *Financial Reporting Model Improvements*. This Statement modifies the basic financial statements and MD&A to enhance governmental financial reports. Changes include revisions to MD&A, modifications to proprietary fund statements, elimination of separate extraordinary and special item presentations, and changes to budgetary comparison information. The adoption resulted in changes to certain financial statement presentation and disclosures but did not have a material impact on the amounts reported in the financial statements.

GASB Statement No. 104, *Disclosure of Certain Capital Assets*, effective for reporting periods beginning after June 15, 2025, provides guidance requiring certain types of capital assets to be disclosed separately in the capital assets note disclosures. The requirements of this Statement will improve financial reporting by providing users of financial statements with essential information about certain types of capital assets to make informed decisions and assess accountability. Additionally, the disclosure requirements will improve consistency and comparability between governments. The Health Plan adopted the standard effective July 1, 2025, and the adoption had no material impact on the financial statements.

In December 2025, GASB issued Statement No. 105, *Subsequent Events* (GASB 105). The objective of GASB 105 is to improve the financial reporting requirements for subsequent events, thereby enhancing consistency in their application and better meeting the information needs of financial statement users. GASB 105 is effective for fiscal years beginning after June 15, 2026. Management is currently evaluating the impact of the adoption of GASB 105 on its financial statements.

Reclassifications – Certain reclassifications of prior years' balances have been made to conform with the current year presentations. Such reclassifications did not affect the total increase in net position or total current or noncurrent assets or liabilities.

Note 3 – Cash and Investments

Cash and investments as of June 30 consisted of the following:

	2026	2025
Cash on hand	$ 3,300	$ 3,300
Cash deposits	2,015,226,813	1,904,719,595
Cash equivalents	205,713,285	197,687,319
Certificates of deposit	300,000	300,000
Total cash and investments	$ 2,221,243,398	$ 2,102,710,214

The investments balance consisting of certificates of deposit of $300,000 as of June 30, 2026 and 2025, are included in other assets in the statements of net position, and relate to the Health Plan's Knox-Keene reserve requirement.

The Health Plan's Annual Investment Policy (Policy) sets forth the guidelines for the investment of all operating funds. The Policy conforms to the California Investment Code Section 53646 (Code) as well as customary standards of prudent investment management. The objectives of the Health Plan's investment policy, in order of priority, are safety of principal, maintenance of liquidity, and attainment of a market rate return that considers risk constraints and cash flow requirements.

The table below identifies the investment types that are authorized for the Health Plan. The table also identifies certain provisions that address interest rate risk, credit risk, and concentrations of risk.

Investment Type	Maximum Remaining Maturity	Maximum Specified % of Portfolio	Minimum Quality Requirements	Government Code Sections
Local Agency Bonds	5 years	None	None	53601(a)
U.S. Treasury Obligations	5 years	None	None	53601(b)
State Obligations: CA and Others	5 years	None	None	53601(d)
CA Local Agency Obligations	5 years	None	None	53601(e)
U.S. Agency Obligations	5 years	None	None	53601(f)
Bankers' Acceptances	180 days	40%	None	53601(g)
Commercial Paper: Nonpooled Funds	270 days or less	25% of the agency's money	Highest letter and number rating by an NRSRO	53601(h)(2)(c)
Commercial Paper: Pooled Funds	270 days or less	40% of the agency's money	Highest letter and number rating by an NRSRO	53635(a)(1)
Negotiable Certificates of Deposit	5 years	30%	None	53601(i)
Nonnegotiable Certificates of Deposit	5 years	None	None	53630 et seq.
Placement Service Deposits	5 years	30%	None	53601.8 and 53635.8
Placement Service Certificates of Deposit	5 years	30%	None	53601.8 and 53635.8
Repurchase Agreements	1 year	None	None	53601(j)
Reverse Repurchase Agreements and Securities Lending Agreements	92 days	20% of the base value of the portfolio	None	53601(j)
Medium-term Notes	5 years or less	30%	"A" rating category or its equivalent or better	53601(k)
Mutual Funds and Money Market Mutual Funds	N/A	20%	Multiple	53601(l) and 53601.6(b)
Collateralized Bank Deposits	5 years	None	None	53630 et seq. and 53601(n)
Mortgage Pass-through and Asset Backed Securities	5 years or less	20%	"AA" rating category or its equivalent or better	53601(o)
County Pooled Investment Funds	N/A	None	None	27133
Joint Powers Authority Pool	N/A	None	Multiple	53601(p)
Local Agency Investment Fund (LAIF)	N/A	None	None	16429.1
Voluntary Investment Program Fund	N/A	None	None	16340
Supranational Obligations	5 years or less	30%	"AA" rating category or its equivalent or better	53601(q)
Public Bank Obligations	5 years	None	None	53601(r), 53635(c) and 57603

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, the Health Plan will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The Code requires financial institutions to secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under State law. As of June 30, 2026 and 2025, uninsured deposits exposed to custodial credit risk that have been collateralized by the pledging bank was $2,375,081,087 and $2,246,412,539, respectively. The uninsured balances are collateralized in accordance with state law, which requires qualifying securities to be pledged at 110% of the uninsured balances.

Custodial credit risk for investments is the risk that, in the event of the failure of the counterparty to a transaction, the Health Plan will not be able to recover the value of its investment or collateral securities that are in the possession of another party. As of June 30, 2026 and 2025, the Health Plan did not hold investments exposed to custodial credit risk.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. In accordance with its investment policy, the Health Plan manages the risk of market value fluctuations due to overall changes in the general level of interest rates by limiting weighted average maturity of its portfolio to no more than five years. The weighted average maturity in years for the Health Plan's investment as of June 30 was as follows:

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	June 30, 2026		June 30, 2025	
Investment Type	Fair Value	Weighted Average Maturity (Years)	Fair Value	Weighted Average Maturity (Years)
Certificates of deposit	$ 300,000	4.58	$ 300,000	4.58
Total fair value	$ 300,000		$ 300,000	

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. Presented below is the minimum rating required by the California Government Code or the Health Plan's investment policy and the actual rating as of year end for each investment type (where applicable).

Rating as of June 30, 2026:

Investment Type	Fair Value	A-1
Certificates of deposit	$ 300,000	$ 300,000
Total fair value	$ 300,000	$ 300,000

Rating as of June 30, 2025:

Investment Type	Fair Value	A-1
Certificates of deposit	$ 300,000	$ 300,000
Total fair value	$ 300,000	$ 300,000

Concentration of credit risk – The investment policy of the Health Plan contains certain limitations on the amount that can be invested in any one issuer, which are stated in the previous table. There were no investments and cash equivalents that are included in cash and cash equivalents in the statements of net position that represent 5% or more of the Health Plan's total investments and cash equivalents as of June 30, 2026 and 2025.

Note 4 – Capital Assets, including Subscription Assets

A summary of changes in capital assets for the years ended June 30, 2026 and 2025, is as follows:

	Beginning Balance 2026	Increases	Decreases	Transfers/Reclass	Ending Balance 2026
Motor vehicles	$ 931,068	$ 221,497	$ (107,201)	$ -	$ 1,045,364
Equipment	29,376,853	246,690	-	2,597,120	32,220,663
Furniture	7,124,959	-	-	576,768	7,701,727
Leasehold improvements	124,288	-	-	-	124,288
Land	7,619,203	-	-	3,711,235	11,330,438
Building	83,185,783	-	-	(3,711,235)	79,474,548
Building improvements	39,870,303	417,969	-	6,607,355	46,895,627
Capital projects	56,645,935	14,924,282	-	(9,781,243)	61,788,974
Subscription assets	24,825,615	24,614,670	(4,252,324)	-	45,187,961
Total capital assets	249,704,007	40,425,108	(4,359,525)	-	285,769,590
Less: depreciation expense and accumulated depreciation related to disposals	(75,231,823)	(19,506,320)	4,329,846	-	(90,408,297)
Capital assets, net of accumulated depreciation	$ 174,472,184	$ 20,918,788	$ (29,679)	$ -	$ 195,361,293

	Beginning Balance 2025	Increases	Decreases	Transfers/Reclass	Ending Balance 2025
Motor vehicles	$ 462,112	$ 468,956	$ -	$ -	$ 931,068
Equipment	27,571,628	1,739,222	-	66,003	29,376,853
Furniture	7,015,882	92,761	-	16,316	7,124,959
Leasehold improvements	124,288	-	-	-	124,288
Land	6,767,292	851,911	-	-	7,619,203
Building	67,971,845	15,213,938	-	-	83,185,783
Building improvements	39,624,165	64,600	-	181,538	39,870,303
Capital projects	40,412,326	16,497,466	-	(263,857)	56,645,935
Subscription assets	22,025,422	2,800,193	-	-	24,825,615
Total capital assets	211,974,960	37,729,047	-	-	249,704,007
Less: depreciation expense and accumulated depreciation related to disposals	(60,790,925)	(14,440,898)	-	-	(75,231,823)
Capital assets, net of accumulated depreciation	$ 151,184,035	$ 23,288,149	$ -	$ -	$ 174,472,184

Reconciliation of capital assets and subscription assets to statements of net position:

	2026	2025
Capital assets, net	$ 168,742,088	$ 160,862,611
Subscription assets, net	26,619,205	13,609,573
Total	$ 195,361,293	$ 174,472,184

The majority of the costs in capital projects are primarily tied to the forthcoming new claims and authorization system implementations. As of June 30, 2026 and 2025, approximately $50.1 million and $45.4 million, respectively, of the $61.8 million and $56.6 million capital projects balances relate to the development of the Health Plan's new claims and authorization systems, which are multi-year technology projects that remain in progress. Depreciation and amortization expense, related to capital assets other than subscription assets, included in general and administrative expenses were $7,901,282 and $7,565,076 for the years ended June 30, 2026 and 2025, respectively. Amortization expense, related to subscription assets, included in general and administrative expenses were $11,605,038 and $6,875,822 for the years ended June 30, 2026 and 2025, respectively.

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The Health Plan evaluated the capital assets for impairment and determined there was no impairment for the years ended June 30, 2026 and 2025.

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Note 5 – Accrued Claims Payable

The cost of health care services is recognized in the period in which it is provided and includes an estimate of the cost of services that have been incurred but not yet reported.

The Health Plan estimates accrued claims payable based on historical claims payments and other relevant information. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of claims paid is dependent on future developments, management is of the opinion that the accrued claims payable is adequate.

Below is a reconciliation of accrued claims payable liability for the years ended June 30:

	2026	2025
Beginning balance	$ 613,302,417	$ 886,017,427
Incurred	4,658,869,543	4,141,135,367
Paid	(4,657,018,697)	(4,413,850,377)
Ending balance	$ 615,153,263	$ 613,302,417

At June 30, 2026 and 2025, the Health Plan has accrued $615,153,263 and $613,302,417, respectively, Of the $615.2 million of accrued claims payable accrued as of June 30, 2026, $500.9 million pertained to IBNR and $114.3 million pertained to other accrued claims primarily consisting of accruals for TRI and Proposition 56 (Prop 56) State directed supplemental payments.

Note 6 – Quality Improvement Program

The Health Plan has established various quality improvement program arrangements designed to promote performance on specified quality, access, utilization and membership experience measures. Payment methodologies, performance requirements and maximum payment amounts are defined in the applicable provider contract amendment. The final payable amount under these arrangements is determined based on final performance measure results.

At June 30, 2026 and 2025, the Health Plan has accrued $55,477,765 and $79,609,869, respectively, due to providers under the quality improvement program.

Note 7 – Leases

The Health Plan is a lessor for various noncancelable lease of office space with lease terms through 2039. For the years ended June 30, 2026 and 2025, the Health Plan recognized $2,209,450 and $1,967,845, respectively, in lease revenue released from the deferred Inflows of resources related to the office leases included in other income on the statements of revenues, expenses, and changes in net position. The Health Plan recognized interest revenue of $205,221 and $174,032 for the years ended June 30, 2026 and 2025, respectively. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during the fiscal year.

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Note 8 – Subscription Based Information Technology Arrangements

The following is a summary of changes in subscription liabilities, net of current portion for the years ended June 30:

	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
2026	$ 2,677,984	$ 26,914,656	$ 11,036,205	$ 18,556,435	$ 7,669,926

	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
2025	$ 2,348,078	$ 6,612,295	$ 6,282,390	$ 2,677,984	$ 1,904,231

The current portion of subscription liabilities is included in accounts payable and accrued expenses in the statements of net position.

The future principal and interest subscription payments as of June 30, 2026, are as follows:

Year Ending June 30,	Principal	Interest	Total
2027	$ 7,669,926	$ 310,249	$ 7,980,175
2028	4,929,639	132,000	5,061,639
2029	3,279,146	57,906	3,337,052
2030	2,177,569	-	2,177,569
	$ 18,056,280	$ 500,155	$ 18,556,435

Note 9 – Partnership Health Plan of California Executive Supplemental Retirement Plan – Fiduciary Fund

Plan description – Effective May 1, 2001, the Health Plan's Board of Commissioners approved and adopted a tax-qualified governmental SERP for the benefit of certain eligible employees. The SERP is a single-employer defined benefit pension plan administered by the Health Plan. The SERP provides retirement, disability, and death benefits to plan members and their beneficiaries. With respect to plan members and their beneficiaries under the trust created pursuant to this plan, the trust assets are not to be used for, or diverted to, purposes other than the exclusive benefit of the plan members or their beneficiaries, as prescribed in Section 401(a)(2) of the Internal Revenue Code of 1986.

Benefits provided – An employee is eligible for benefits under this plan if, at the time of retirement on or after May 1, 2001, the employee is in a director position as specified in the SERP plan document, is at least 63 years of age or has at least seven years of service and has applied for benefits under the SERP.

Funding policy – The Health Plan will contribute at an actuarially determined rate; the rate was 8.69% and 20.39% in 2026 and 2025, respectively, of annual covered payroll. The contribution rate is established bi-annually and may be amended by the Health Plan's Board of Commissioners.

Summary of Significant Accounting Policies

Basis of accounting – The SERP fiduciary financial statements are prepared using the accrual basis of accounting. The Health Plan's contributions are recognized in the period in which contributions are made. Benefits are recognized when due and payable in accordance with the terms of the SERP.

Investments – The SERP's investments, consisting of mutual funds, are reported at fair value.

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in active markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

Mutual funds – Valued at the daily closing price as reported by the fund. Mutual funds held by the SERP are open-end mutual funds that are registered with the U.S. Securities and Exchange Commission. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds held by the SERP are deemed to be actively traded.

Investments by fair value level include the following as of June 30, 2026 and 2025:

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	Level 1	Level 2	Level 3	Fair Value Measurement at June 30, 2026
Investments by fair value level				
Mutual funds	$ 27,300,390	$ -	$ -	$ 27,300,390
Total investments	$ 27,300,390	$ -	$ -	$ 27,300,390

	Level 1	Level 2	Level 3	Fair Value Measurement at June 30, 2025
Investments by fair value level				
Mutual funds	$ 23,701,628	$ -	$ -	$ 23,701,628
Total investments	$ 23,701,628	$ -	$ -	$ 23,701,628

Plan description – Participant data for the Health Plan, as of the measurement date for the indicated years, is as follows:

	2026	2025
Retired and beneficiaries	7	9
Inactive	2	2
Active	22	20
Total participants	31	31

Components of pension (benefit) cost (included in general and administrative expenses) and deferred outflows and inflows of resources for the years ended June 30 were as follows:

	2026	2025
Pension cost		
Service cost	$ 776,463	$ 694,409
Interest on total pension liability	1,211,541	1,034,618
Administrative expenses	88,313	80,831
Member contributions	(323,173)	(301,536)
Expected investment return, net of investment expenses	(1,565,545)	(1,376,003)
Recognition of deferred outflows of resources		
Recognition of economic/demographic gains	531,098	487,152
Recognition of assumption changes	13,544	16,867
Recognition of investment gains	(78,359)	(88,221)
Total pension cost	$ 653,882	$ 548,117

	2026	2025
Deferred outflows of resources as of June 30		
Difference between expected and actual experience	$ 2,475,775	$ 2,707,189
Changes in assumptions	24,276	37,820
Total	$ 2,500,051	$ 2,745,009
Deferred inflows of resources as of June 30		
Difference between expected and actual experience	$ -	$ (15,900)
Net difference between projected and actual earnings on pension plan investments	(2,724,096)	(624,601)
Total	$ (2,724,096)	$ (640,501)

Amounts reported as deferred outflows of resources and deferred inflows of resources to pension will be recognized in pension expense are as follows:

Year Ended June 30,	
2027	$ (278,195)
2028	(342,425)
2029	(207,383)
2030	(7,730)
2031	325,073
Thereafter	286,615
	$ (224,045)

The following table summarizes changes in pension (asset) liability for the fiscal year ended June 30, 2026:

	Total Pension Liability	Plan Fiduciary Net Position	Net Pension (Asset) Liability
Balance at June 30, 2025	$ 18,424,856	$ 24,139,379	(5,714,523)
Changes during the year:			
Service cost	776,463		776,463
Interest on the total pension asset	1,211,541		1,211,541
Effect of plan changes	-		-
Effect of economic/demographic gains or losses	315,584		315,584
Effect of assumptions, changes, or inputs	-		-
Benefit payments, including refunds of employee contributions	(1,142,453)	(1,142,453)	-
Contributions - employer		797,713	(797,713)
Contributions - members		323,173	(323,173)
Net investment income		3,743,399	(3,743,399)
Administrative expenses		(88,313)	88,313
Net change in total pension (asset) liability	1,161,135	3,633,519	(2,472,384)
Balance at June 30, 2026	$ 19,585,991	$ 27,772,898	$ (8,186,907)

Total pension liability	$ 19,585,991
Plan fiduciary net position	27,772,898
Net pension asset	$ (8,186,907)
Plan fiduciary net position as a percentage of the total pension asset	141.80%
Covered-employee payroll	$ 9,184,306
Plan net pension asset as of a percentage of covered-employee payroll	-89.14%

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The following table summarizes changes in pension (asset) liability for the fiscal year ended June 30, 2025:

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	Total Pension Liability	Plan Fiduciary Net Position	Net Pension (Asset) Liability
Balance at June 30, 2024	$ 15,861,104	$ 20,780,557	(4,919,453)
Changes during the year:			
Service cost	694,409		694,409
Interest on the total pension asset	1,034,618		1,034,618
Effect of plan changes	-		-
Effect of economic/demographic gains or losses	2,131,805		2,131,805
Effect of assumptions, changes, or inputs	-		-
Benefit payments, including refunds of employee contributions	(1,297,080)	(1,297,080)	-
Contributions - employer		1,866,261	(1,866,261)
Contributions - members		301,536	(301,536)
Net investment income		2,568,936	(2,568,936)
Administrative expenses		(80,831)	80,831
Net change in total pension (asset) liability	2,563,752	3,358,822	(795,070)
Balance at June 30, 2025	$ 18,424,856	$ 24,139,379	$ (5,714,523)

Total pension liability	$ 18,424,856
Plan fiduciary net position	24,139,379
Net pension asset	$ (5,714,523)
Plan fiduciary net position as a percentage of the total pension asset	131.02%
Covered-employee payroll	$ 9,152,993
Plan net pension asset as of a percentage of covered-employee payroll	-62.43%

The following table summarizes the actuarial assumptions used to determine net pension (asset) liability and plan fiduciary net position as of June 30, 2026:

Valuation date:	Actuarially determined contribution rates are calculated as of June 30, and are applicable for the next two fiscal years beginning July 1
Actuarial cost method:	Entry-age normal cost method
Amortization method:	Level dollar
Asset valuation method:	Market value
Actuarial assumptions	
Discount rate:	6.50%
Long-term expected rate of return	6.50%
Projected salary increases:	Fiscal year 2025 only - 20%, then graded rates based on years of service, 3.34% after 30 years of service
Cost-of-living adjustments:	2.00% compounded annually
Inflation:	2.30%
Mortality:	Nonindustrial rates used to value the miscellaneous CalPers

The following table summarizes the sensitivity of net pension asset to changes in the discount rate as of June 30, 2026:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
Total pension liability	$ 21,676,707	$ 19,585,991	$ 17,824,879
Fiduciary net position	27,772,898	27,772,898	27,772,898
Net pension asset	$ (6,096,191)	$ (8,186,907)	$ (9,948,019)

The following table summarizes the sensitivity of net pension asset to changes in the discount rate as of June 30, 2025:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
Total pension liability	$ 20,376,138	$ 18,424,856	$ 16,778,961
Fiduciary net position	24,139,379	24,139,379	24,139,379
Net pension asset	$ (3,763,241)	$ (5,714,523)	$ (7,360,418)

Note 10 – Tangible Net Equity

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975, the Health Plan is required to maintain a minimum level of tangible net equity. The required tangible net equity level was $235,457,449 and $214,768,160 at June 30, 2026 and 2025, respectively. The Health Plan's tangible net equity was $1,475,305,405 and $1,457,550,212 at June 30, 2026 and 2025, respectively.

Note 11 – Risk Management

The Health Plan is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruptions; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Health Plan carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Health Plan's commercial coverage.

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Note 12 – Commitments and Contingencies

In the ordinary course of business, the Health Plan is a party to claims and legal actions by enrollees, providers, and governmental and regulatory agencies. The Health Plan's policy is to accrue for amounts related to these claims and legal actions if it is probable that a liability has been incurred and the amount of the liability can be reasonably estimated. After consulting with legal counsel, Health Plan management is of the opinion that any liability that may ultimately result in claims or legal actions will not have a material effect on the financial position or results of operations of the Health Plan.

Note 13 – Federal and State Healthcare Policy and Budget Cuts

The Health Plan is subject to risks and uncertainties arising from federal and state health care legislation, regulation, and budgetary actions affecting the Medi-Cal program. Certain recently enacted federal legislation and State budget and regulatory actions are already affecting, and are expected to continue to affect, the Health Plan's enrollment, revenues, health care costs, and operations. These actions include changes to Medi-Cal eligibility requirements and asset limits, the transition of certain Unsatisfactory Immigration Status members from managed care to fee-for-service, modifications to Enhanced Care Management and Community Supports programs, changes to managed care organization tax structures and directed payment programs, and other programmatic and administrative requirements. In addition, federal legislation enacted in July 2025 imposed restrictions on Medicaid eligibility and financing that are expected to have continuing effects on the Medi-Cal program and the Health Plan.

The Health Plan is highly dependent upon the State of California for its revenues, with substantially all revenues and accounts receivable derived from the State. Accordingly, changes in State or federal funding, reimbursement methodologies, eligibility requirements, managed care financing mechanisms, or other regulatory requirements could materially affect the Health Plan's financial position and results of operations. These regulatory and budgetary changes have already contributed to changes in enrollment and operating costs and have been incorporated into management's current financial projections. The Health Plan expects these changes, together with ongoing State and federal budgetary pressures, to continue to affect enrollment, revenue adequacy, provider participation, utilization, and operations in future periods. Given the Health Plan's rural service area and limited provider network, changes in provider participation or the loss or closure of key providers could further affect access to care and the Health Plan's financial results. While certain effects are currently being experienced, the timing and magnitude of the continuing financial impact of these developments remain uncertain.

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Supplementary Information

Partnership Health Plan of California
Statement of Revenues, Expenses, and Changes in Net Position – Actual and Budget Operations
Year Ended June 30, 2026

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	Actual	Budget	Variance Revenue/Expense Over (Under)
OPERATING REVENUES			
California Department of Health Services capitation revenue	$ 7,098,527,211	$ 7,609,365,167	$ (510,837,956)
Other income	20,588,686	2,447,000	18,141,686
Total operating revenues	7,119,115,897	7,611,812,167	(492,696,270)
OPERATING EXPENSES			
Health care expenses			
Fee for service hospital, physician, and other services	4,854,487,624	5,314,967,033	(460,479,409)
Capitated physician, hospital, and other costs	326,007,748	330,924,554	(4,916,806)
Long-term care	715,849,280	731,283,413	(15,434,133)
Quality improvement program and hospital stoploss	68,078,522	96,025,184	(27,946,662)
Total health care expenses	5,964,423,174	6,473,200,184	(508,777,010)
GENERAL AND ADMINISTRATIVE EXPENSES			
Other admin expenses	28,534,184	9,920,200	18,613,984
Computer and data costs	44,275,476	53,986,455	(9,710,979)
Employee expenses	262,361,828	325,293,093	(62,931,265)
Occupancy costs	16,506,379	33,393,279	(16,886,900)
Operational costs	8,284,817	12,460,034	(4,175,217)
Professional services	51,925,222	51,684,903	240,319
Travel and meals expenses	1,380,225	3,410,399	(2,030,174)
Total general and administrative expenses	413,268,132	490,148,363	(76,880,231)
Premium tax	779,016,409	798,976,464	(19,960,055)
Total operating expenses	7,156,707,715	7,762,325,011	(605,617,296)
Operating deficit	(37,591,818)	(150,512,844)	112,921,026
NONOPERATING REVENUES (EXPENSES)			
Investment income	91,145,523	80,779,000	10,366,523
Community reinvestments	(35,798,512)	-	(35,798,512)
Total nonoperating revenues	55,347,011	80,779,000	(25,431,989)
INCREASE (DECREASE) IN NET POSITION	17,755,193	(69,733,844)	87,489,037
NET POSITION, beginning of year	1,457,550,212	1,457,550,212	-
NET POSITION, end of year	$ 1,475,305,405	$ 1,387,816,368	$ 87,489,037

See accompanying notes.

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Required Supplementary Pension Benefit Information

Partnership Health Plan of California
Supplementary Schedule of Changes in the Net Pension Asset and Related Ratios
Years Ended June 30, 2026 and 2025

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	2026	2025
TOTAL PENSION LIABILITY		
Service cost	$ 776,463	$ 694,409
Interest	1,211,541	1,034,618
Difference between expected and actual experience	315,584	2,131,805
Benefit payments, including refunds of employee contributions	(1,142,453)	(1,297,080)
Net change in total pension liability	1,161,135	2,563,752
TOTAL PENSION LIABILITY, beginning of fiscal year	18,424,856	15,861,104
TOTAL PENSION LIABILITY, end of fiscal year	$ 19,585,991	$ 18,424,856
PLAN FIDUCIARY NET POSITION		
Contributions - employer	$ 797,713	$ 1,866,261
Contributions - employee	323,173	301,536
Net investment income	3,743,399	2,568,936
Benefit payments, including refunds of employee contributions	(1,142,453)	(1,297,080)
Other changes in fiduciary net position	(88,313)	(80,831)
Net change in fiduciary net position	3,633,519	3,358,822
PLAN FIDUCIARY NET POSITION, beginning of fiscal year	24,139,379	20,780,557
PLAN FIDUCIARY NET POSITION, end of fiscal year	$ 27,772,898	$ 24,139,379
PLAN NET PENSION ASSET	$ (8,186,907)	$ (5,714,523)
PLAN FIDUCIARY NET POSITION as a percentage of the total pension (asset) liability	141.80%	131.02%
COVERED-EMPLOYEE PAYROLL	$ 9,184,306	$ 9,152,993
PLAN NET PENSION ASSET as of a percentage of covered-employee payroll	-89.14%	-62.43%

Partnership Health Plan of California
Supplementary Schedule of Contributions
Years Ended June 30, 2026 and 2025

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Fiscal Year Ending June 30	Actuarially Determined Contributions	Actual Employer Contribution	Contribution Deficiency (Excess)	Covered Payroll	Contribution as a % of Covered Payroll
2017	$ 443,798	$ 1,092,266	$ (648,468)	$ 3,854,230	28.34%
2018	$ 457,112	$ 796,124	$ (339,012)	$ 3,618,215	22.00%
2019	$ 516,967	$ 796,124	$ (279,157)	$ 3,512,096	22.67%
2020	$ 315,503	$ 2,999,233	$ (2,683,730)	$ 3,443,478	87.10%
2021	$ 308,995	$ 2,199,301	$ (1,890,306)	$ 3,783,868	58.12%
2022	$ 315,937	$ 506,632	$ (190,695)	$ 5,364,882	9.44%
2023	$ 434,568	$ 464,413	$ (29,845)	$ 6,325,907	7.34%
2024	$ 541,714	$ 1,463,028	$ (921,314)	$ 7,083,809	20.65%
2025	$ 668,071	$ 1,866,261	$ (1,198,190)	$ 9,152,993	20.39%
2026	$ 703,288	$ 797,713	$ (94,425)	$ 9,184,306	8.69%

Partnership Health Plan of California

Partnership Health Plan of California Supplemental Executive Retirement Plan – Supplementary Schedule of Investment Returns

Years Ended June 30, 2026 and 2025

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Years Ended June 30	Rate of return
2017	8.78%
2018	5.59%
2019	5.58%
2020	3.61%
2021	20.33%
2022	-11.44%
2023	6.39%
2024	10.24%
2025	12.13%
2026	15.52%

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Communications with the Commissioners

Partnership Health Plan of California

June 30, 2026

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Communications with the Commissioners

To the Commissioners
Partnership Health Plan of California

We have audited the financial statements of Partnership Health Plan of California (the Health Plan) as of and for the year ended June 30, 2026, and have issued our report thereon dated October ___, 2026. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated March 30, 2026, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Partnership Health Plan of California's internal control over financial reporting. Accordingly, we considered Partnership Health Plan of California's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated March 30, 2026.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Partnership Health Plan of California are described in Note 2 to the financial statements. During the year ended June 30, 2026, the Health Plan adopted Governmental Accounting Standards Board (GASB) Statement No. 103, *Financial Reporting Model Improvements* and GASB Statement No. 104, *Disclosure of Certain Capital Assets.* The management's discussion and analysis, and the financial statements were updated to apply these adoptions. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2026. We noted no transactions entered into by the Health Plan during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management recorded an estimated liability for incurred but unreported claims expenses. The estimated liability for unreported claims is based on management's estimate of historical claims experience and known activity subsequent to year end. We have gained an understanding of management's estimate methodology and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.
- Management recorded an estimated liability for the quality improvement program. The estimated liability is based on the providers' performance by region and are calculated based on the risk sharing agreements in the provider contracts. We have gained an understanding of management's estimate methodology and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.
- Management recorded an estimated amount due to the State of California. The estimated payable for eligible Medi-Cal program beneficiaries is based upon estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts. We found management's basis to be reasonable in relation to the financial statements taken as a whole.
- Management recorded an estimated capitation receivable. The estimated capitation receivable for eligible Medi-Cal program beneficiaries is based upon a historical experience methodology. We have gained an understanding of management's estimate methodology and have examined the documentation supporting these methodologies and formulas. We found management's process to be reasonable.
- Management's estimate of the net pension asset is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the financial

statements taken as a whole.

- The useful lives of capital assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America.
- Management's estimates of the discount rate and subscription terms related to the Health Plan's subscription assets and subscription liabilities. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the Health Plan's financial statements taken as a whole.
- Management's estimates of the discount rate and lease terms related to the Health Plan's lease receivable. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the Health Plan's financial statements taken as a whole.

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Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were related to incurred, but unreported claims expense and capitation revenues.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the Health Plan's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the Health Plan's financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected and uncorrected misstatements whose effects, as determined by management, are material, both individually and in the aggregate, to the financial statements as a whole.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October __, 2026.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Health Plan's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Commissioners and management of Partnership Health Plan of California, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
October ___, 2026

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Report from the Chief Executive Officer

October 28, 2026

Community Supports

Community Supports (CS) are services offered through Medi-Cal managed care plans to address members' health-related social needs and support better health outcomes. These services are a key component of California's CalAIM initiative and are intended to provide cost-effective alternatives to traditional medical services when they are medically appropriate.

Over the past several years, Partnership has made significant investments in Community Supports, recognizing their potential to improve member outcomes, reduce avoidable utilization, and address social factors that contribute to poor health. More recently, however, state policy changes, rate-setting concerns, and federal uncertainty have created significant challenges that may affect the sustainability of these services.

Program Overview

Community Supports are available to eligible members when Partnership determines the service is medically appropriate. DHCS and CMS have approved community supports as cost-effective alternatives to covered Medi-Cal services. Certain supports, particularly housing-related services, have become important tools in helping members stabilize their health and avoid unnecessary hospitalizations, institutional care, or homelessness.

Partnership currently offers the following Community Supports:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Sobering Centers
- Caregiver Respite
- Asthma Remediation
- Recuperative Care
- Day Habilitation Programs
- Medically Tailored Meals
- Personal Care and Homemaker Services
- Assisted Living Transition
- Transitional Rent

To build this benefit infrastructure, Partnership has invested heavily in provider network development, community partnerships, and member outreach. We have worked with health centers, community-based organizations, and specialized providers throughout our service area to establish

access to these services. Building networks in rural communities has been particularly challenging due to the limited availability of local providers.

Despite these challenges, our efforts have resulted in consistent growth in both provider participation and member utilization. Today, members in every county served by Partnership are accessing Community Supports services.

Current Challenges

Partnership is facing significant financial and operational uncertainty related to Community Supports. This year, the Department of Health Care Services (DHCS) implemented a new policy requiring health plans to designate, in advance, which Community Supports they will offer for the entire 2027 calendar year. Previously, plans had greater flexibility to add or discontinue services at six-month intervals based on utilization, effectiveness, and financial performance.

Compounding this challenge, health plans were required to make these coverage decisions before receiving final 2027 rate information. Partnership negotiated an extension that allows us to evaluate the most current information following the October Board meeting.

Based on the draft rates received to date, Partnership's actuaries project an estimated $93.5 million funding gap associated with continuing Community Supports at current utilization trends. Utilization has grown steadily as provider capacity has expanded and member awareness has increased, particularly in underserved rural communities. Current state rate assumptions do not fully reflect Partnership's recent utilization experience or projected growth.

Partnership is actively engaging with DHCS and has provided updated utilization data and continues to advocate for actuarially sound rates that accurately reflect member needs and anticipated program costs. While DHCS has expressed a willingness to continue discussions, revised rates are expected to be shared end of October, after Community Supports elections must be finalized.
At the same time, DHCS has emphasized the importance of strengthening utilization management to ensure Community Supports are provided to the right members, at the right intensity, and for the appropriate duration. Demonstrating both clinical value and cost effectiveness will be essential to the long-term sustainability of these benefits.

Federal and Policy Outlook

Additional uncertainty exists at the federal level. The waivers that currently authorize many CalAIM initiatives, including Community Supports, are scheduled to expire on December 31, 2026.
As part of the 1115 and 1915b Waiver Renewal process, DHCS states that 12 of the 14 Community Supports can continue under federal Medicaid managed care regulations using what is known as In Lieu of Services (ILOS) authority. They do not require a Section 1115 waiver. DHCS plans to move recuperative care under the ILOS umbrella and expand the service to include short term post hospitalization care. Room and board costs cannot be covered under ILOS rules. These proposed changes have not been approved by CMS.

Understanding CMS may not approve the Waiver Renewals by the end of the year,
California has submitted applications seeking continuation of these authorities. Current indications suggest existing waiver authorities may be extended for one additional year while federal review continues. However, future federal guidance is expected to place greater emphasis on demonstrating budget neutrality and measurable cost effectiveness.

Because many Community Supports are designed to influence long-term health outcomes, demonstrating return on investment requires several years of data and evaluation. Partnership will continue its analysis of utilization patterns, outcomes, and cost effectiveness to inform future decisions and support ongoing discussions

.

Next Steps

Over the coming months, Partnership will:

- Continue rate discussions with DHCS to secure adequate funding for Community Supports.
- Evaluate each Community Support service for appropriate utilization and cost effectiveness.
- Refine eligibility, service duration, and utilization management approaches where appropriate.
- Continue assessing the impact of federal waiver decisions and evolving regulatory requirements.
- Provide the Board with regular updates regarding financial exposure, utilization trends, and strategic recommendations.

Community Supports remain an important component of Partnership's strategy to improve health outcomes and address social drivers of health. However, ensuring long-term sustainability will require alignment between utilization, demonstrated value, and adequate state funding. Partnership will continue working closely with DHCS and other stakeholders to preserve member access while maintaining the organization's financial stability.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 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 August through October 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:
October 28, 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 28th day of October 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

September 2026

Policy Number	Policy/Procedures/Guidelines
	*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **August 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.*
	Care Coordination
MPCP2007	Complex Case Management
	Health Equity
MCED6001	Health Equity and Community Reinvestment Strategy and Program Description
	Member Services
MP301	Assisting Providers with Missed Appointments *(New Title)*
	Population Health Management
MPND9001	Population Health Management Strategy & Program Description
MCNP9004	Regulatory Required Notices *(Updated Attachments A – D)*
	Quality Improvement
MPQD1001	Quality Improvement Program Description
MPQP1048	Reporting Communicable Diseases
	Utilization Management
MCUP3012	Discharge Planning (Non-capitated Members)
MCUP3050	Medication Abortion in the First Trimester
MCUP3052	Medical Nutrition Therapy (MNT) Services *(New Title)*
MCUP3119	Sterilization Consent Protocol
MPUP3035	Preoperative Day Review

Partnership Policy & Procedure Updates

October 2026

Policy Number	Policy/Procedures/Guidelines
*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **September 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.*	
Provider Relations	
MPPRGR210	Provider Grievance
Quality Improvement	
MPQD1002	Quality/Utilization Advisory Committee
MPQP1008	Conflict of Interest Policy for QI Activities
MPQP1022	Site Review Requirements & Guidelines (with four changed attachments)
MPQP1053	Peer Review Committee
Utilization Management	
MCUG3022	Incontinence Guidelines
MCUG3058	Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities
MCUP3115	Community Based Adult Services
MPUP3059	Negative Pressure Wound Therapy (NPWT) Device/Pump
MPUP3078	Second Medical Opinions

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.2

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

Recommendation by:
Quality Utilization Advisory Committee and Physician Advisory Committee

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Topic Description:
The Quality and Performance Improvement Program Description provides a systematic process to monitor clinical and service aspects of health care delivery to all Partnership members and it describes the programs, purpose, goals, responsibilities, methods, measurements, and feedback.

The purpose of the Quality Improvement Program Evaluation is to evaluate Partnership HealthPlan's quality and performance improvement activities. QI also evaluates key activities done in other Partnership departments that work closely with the Quality and Performance Improvement Department in alignment with the Quality Improvement Work Plan to improve care and service to our members.

The purpose of the Quality Improvement Work Plan is to monitor key activities across Partnership to support patient safety, member and provider engagement, quality assurance, compliance and performance improvement.

Reason for Resolution:
To allow the full Board the opportunity to review and approve the Quality and Performance Improvement Program Description, Work Plan, and Evaluation.

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

Requested Action of the Board:
Based on the recommendation from the Quality Utilization Advisory Committee and Physician Advisory Committee, the full Board is asked to approve the Quality and Performance Improvement Program Description, Work Plan, and Evaluation.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.2

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE QUALITY AND PERFORMANCE IMPROVEMENT PROGRAM DESCRIPTION, WORK PLAN, AND EVALUATION

Recital: Whereas,

A. The Board has ultimate responsibility for quality improvement.

B. Quality improvement is a stated important priority for Partnership.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the Quality and Performance Improvement Program Description, Work Plan, and Evaluation.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.3

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

Recommendation by:
The Physician Advisory Committee (PAC)

Topic Description:
Dr. Harry Ko, Family Medicine, Medical Director for Feather River Tribal Health, has been appointed to the Physician Advisory Committee (PAC) voting member.

Reason for Resolution:
To accept the appointment of Dr. Harry Ko to the Physician Advisory Committee.

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

Requested Action of the Board:
Based on the recommendation from the Physician Advisory Committee, the Board is asked to accept the appointment of Dr. Harry Ko to the Physician Advisory Committee.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.3

Resolution Number:
26-

IN THE MATTER OF: APPROVING PHYSICIAN ADVISORY COMMITTEE APPOINTMENT

Recital: Whereas,

A. Dr. Harry Ko has been appointed to PAC as a voting member

B. The Board has authority to approve advisory committee membership changes.

Now, Therefore, It Is Hereby Resolved as Follows:

1. To accept the appointment of Dr. Harry Ko to the Physician Advisory Committee.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.4

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

Approved by:
Yolo County Board of Supervisors and Partnership Staff

Topic Description:
The Yolo County Board of Supervisors met on September 8, 2026 and reappointed Gena Bravo as a Yolo County Representative to the Partnership Board for another 4-year term of office, commencing on September 8, 2026 and terminating on September 7, 2030.

Reason for Resolution:
To get Board approval to reappoint Gena Bravo to the Partnership Board representing Yolo County.

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

Requested Action of the Board:
Based on the recommendation of the Yolo County Board of Supervisors and Partnership Staff, the Board is asked to approve the reappointment of Gena Bravo.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
August 28, 2026

Agenda Item Number:
3.4

Resolution Number:
26-

IN THE MATTER OF: APPROVING BOARD COMMISSIONER REAPPOINTMENT OF GENA BRAVO

Recital: Whereas,

A. The Yolo County Board of Supervisors reappointed Gena Bravo to the Partnership Board for another 4-year term of office.

B. The Board has authority to approve Commissioner appointments.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the Yolo County reappointment of Gena Bravo.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 2026 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioner:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Dean Germano, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.5

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

Recommendation by:
The Strategic Planning Committee and Partnership Staff

Topic Description:
Tory Starr has expressed interest in joining the Strategic Planning Committee (SPC).

Reason for Resolution:
Tory Starr is the President and Chief Executive Officer for the Open-Door Community Health Centers.

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

Requested Action of the Board:
Based on the recommendation of the Strategic Planning Committee the Board is being asked to accept the appointment of Tory Starr to the committee as a new member.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.5

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE NEW APPOINTMENT OF TORY STARR TO THE STRATEGIC PLANNING COMMITTEE

Recital: Whereas,

A. Tory Starr is well qualified for the Strategic Planning Committee and has expressed an interest in joining the committee.

B. The committee has a vacant seat available.

C. The Board has authority to appoint advisory committee members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept the appointment of Tory Starr to the Strategic Planning Committee.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California on this 28th day of October 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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.6

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 Population Health Management Strategy and Program Description, MCND9001 identifies the strategies utilized to meet the needs of our member population within the context of the various communities.

Reason for Resolution:
To allow the full Board the opportunity to review and approve Partnership's Population Health Management Strategy and 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 Population Health Management Strategy and Program Description, MCND9001.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.6

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE POPULATION HEALTH MANAGEMENT STRATEGY AND PROGRAM DESCRIPTION, MCND9001.

Recital: Whereas,

A. The Board has the authority and responsibility for ensuring Partnership has a cohesive plan for population health management.

B. The Board has ultimate responsibility for approving Partnership program descriptions.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve Partnership's Population Health Management Strategy and Program Description, MCND9001.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.7

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

Recommendation by:
Quality Utilization Advisory Committee and Physician Advisory Committee

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Topic Description:
The Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description was developed within the Health Equity department under the guidance of the Health Equity Officer to meet regulatory requirements for Department of Health Care Services (DHCS) and National Committee for Quality Assurance (NCQA).

The QIHETP Program Description is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The QIHETP has been renamed to the Health Equity and Community Reinvestment Strategy and Program Description. The Board reviews the program description annually.

Reason for Resolution:
To allow the full Board the opportunity to annually review and approve the Health Equity and Community Reinvestment Strategy and Program Description.

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 Physician Advisory Committee, the full Board is asked to approve the Health Equity and Community Reinvestment Strategy and Program Description.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.7

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE HEALTH EQUITY AND COMMUNITY REINVESTMENT STRATEGY AND PROGRAM DESCRIPTION

Recital: Whereas,

A. The Board has ultimate responsibility for quality improvement and health equity.

B. Quality improvement and health equity are stated important priorities for Partnership.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the Health Equity and Community Reinvestment Strategy and Program Description.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.8

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 care, the Board is asked to annually review the Enhanced Care Management Quality Improvement Program (ECMQIP) measurement set (see attached summary).

Reason for Resolution:
To continue to optimize the Enhanced Care Management 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 and the Physician Advisory Committee, the Board is asked to review the 2027 Enhanced Care Management Quality Improvement Program (ECMQIP) measurement set.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.8

Resolution Number:
26-

IN THE MATTER OF: APPROVING THE 2027 ENHANCED CARE MANAGEMENT QUALITY IMPROVEMENT PROGRAM 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 Enhanced Care Management Quality Improvement Program (ECMQIP) measurement set.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

2027 ECM QIP Measurement Set Proposal

January 1, 2027 – December 31, 2027 (Incentive payout is quarterly)

Key: New Measure | Change to Measure | ~~Removed Measure~~

2026 Measures	Proposed 2027 Measures
Gateway Measure: Timely Reporting Providers are required to submit three monthly reports on or before their due date. Incentive: $100 per member per month Dollars earned are placed into an incentive pool. • 100% is placed in incentive pool if all reports are received on or before due date. • 50% is placed in incentive pool if all reports are received within one (1) week or five (5) business days past the due date. • Reports received after five (5) business days will not be eligible for an incentive pool or participation in program measures.	No changes
Measure 1: Care Plan and Release of Information (ROI) Forms Uploaded into PointClickCare within 60 Days Providers are required to upload a Care Plan and ROI forms into PointClickCare for all ECM enrolled members within 60 days of TAR request date. Targets: • Full credit: > 70% • Partial credit: 60% - 69% No reporting to Partnership is required.	No changes
Measure 2: Depression Screening Depression screening is required for all ECM enrolled members, ages 12 years and older. Targets: • Full credit: > 90% • Partial credit: 80% - 89% Providers will submit a quarterly screening template.	No changes

2027 ECM QIP Measurement Set Proposal

Measure 3: Blood Pressure Screening Blood pressure screening is required for all ECM enrolled members ages 18 years and older. Targets: • Full credit: > 80% • Partial credit: 70% - 79% Providers will submit a quarterly screening template.	No changes
Measure 4: Timely Review of ED / Admissions Notifications in PointClickCare **Part 1:** New ECM providers are required to set up the Notification Alerts function in PointClickCare by contacting PointClickCare® for assistance. Targets: • Full credit. • No partial credit **Part 2:** Providers are required to review ED/Admissions notifications received in PointClickCare® within 72 hours of receiving notifications. Targets: • Full credit: ≥ 70% • Partial credit: 60-69% No reporting to Partnership is required.	No changes

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.9

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, the Physician Advisory Committee and Partnership staff are proposing changes to the measurement year 2027 Hospital Quality Improvement Program (HQIP) measurement set (see attached summary).

Reason for Resolution:
To optimize the Hospital 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 the Physician Advisory Committee and Partnership staff, the Board is asked to approve proposed changes to the measurement year 2027 Hospital Quality Improvement Program (HQIP) measurement set.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.9

Resolution Number:
26-

IN THE MATTER OF: APPROVING PROPOSED CHANGES TO THE MEASUREMENT YEAR 2027 HOSPITAL QUALITY IMPROVEMENT PROGRAM (HQIP) MEASUREMENT SET

Recital: Whereas,

A. The Board has responsibility to review and approve 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 measurement year 2027 Hospital Quality Improvement Program (HQIP) measurement set.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 2026 by motion of Commissioner Starr seconded by Commissioner Germano and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Dean Germano, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

HQIP 2027 Measure Proposal

HQIP 2027 Calendar Year Measurement Set (January 1 – December 31, 2027)

Providers have the potential to earn points in six domains 1) Readmissions; 2) Advanced Care Planning; 3) Clinical Quality; 4) Patient Safety; 5) Operations/Efficiency; 6) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

Key: Change to Measure Design || Proposed New Measure || Removed Measures

2026 Six-Month Bridge Set July 1 – December 31, 2026	2027 Calendar Year Measure Set Recommendations
Risk Adjusted Domain 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Doula Support 10. Increasing Mammography Capacity 11. Vaccines For Children Enrollment **Patient Safety Domain** 12. Patient Safety Organization Participation 13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT) **Operations / Efficiency Domain** 14. Hospital Quality Improvement Platform	**Risk Adjusted Domain** 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Doula Support ~~10. Increasing Mammography Capacity~~ ~~11. Vaccines For Children Enrollment~~ 10. Hepatitis B Vaccination 11. ALSO & BLSO Certification Training **Patient Safety Domain** 12. Patient Safety Organization Participation 13. Substance Use Disorder – 7-Day Follow-up After ED Visit (FUA) **Operations / Efficiency Domain** 14. QI Capacity 15. Hospital Quality Improvement Platform **Patient Experience Domain** 16. Cal Hospital Compare-Patient Experience 17. Health Equity

Programmatic Changes:

The proposed measure set on the following pages is the first calendar year program for the HQIP. In general, all the reporting timelines in this set have been adjusted to correlate to the calendar year. Those revisions are not presented here. This proposal includes changes to existing measures new measures, and measure removals.

A. Revisions to Existing Measures:

Measure 8: Expanding Delivery Privileges

It is proposed that this measure include a partial points option for X-Large size hospitals who are still working on expanding privileges to family physicians and midwives, and it is proposed to change the language from family physicians and midwives to "or" midwives for large and small size hospitals. The change to "or" is in recognition that for some of our smaller hospitals in rural areas, the resources may not exist to have both provider types.

Specifications

The expanding delivery privileges measure includes three phases requiring hospitals to develop policy and procedure, actively recruiting providers, granting delivery privileges, and ultimately demonstrating evidence of family physician and nurse midwife clinical activity.

Measure Requirement Targets

This multi-phase measure began with ***Phase One*** in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With ***Phase One*** completed in 2024-25, this measure moved into ***Phase Two*** for the 2025-26 HQIP Measurement Year. Now, in 2027, the measure requirements are delineated by sizes as noted below:

X-Large Hospitals with >100 LGA Beds:

Full Points (5 points):
By December 31, 2027, hospitals must ensure access to family physicians and certified nurse midwives for deliveries by either employing them directly or maintaining active contracts, as demonstrated by granted clinical privileges for these providers. Evidence of deliveries from these providers is required.

Partial Points (2.5 points):
Phase Two Requirement: Hospitals that have developed by-laws and/or policy and procedure allowing midwives and family physicians to hold delivery privileges, must now show evidence that they are actively recruiting and/or share their provider privileges list of midwives and family physicians who have been granted delivery privileges.

NOTE: Hospitals with existing family physicians and midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital.

Small & Large Hospitals with between 25 and 99 LGA Beds:

Full Points (5 points)
Small and Large size hospitals will remain in Phase 2 as follows:

Hospitals that have developed by-laws and/or policy and procedure allowing midwives and/**or** family physicians to hold delivery privileges, must now show evidence that they are actively recruiting these providers and/or share their provider privileges list of midwives and/**or** family physicians who have been granted delivery privileges.

NOTE: Hospitals with existing family physicians and midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital.

Measure 9: Doula Support

This measure began in 2025 with Phase 1. It is proposed to move into Phase 2 of the measure during the 2027 measurement year at which time hospitals will need to demonstrate recruitment or use of doulas in the hospitals as noted below.

Specifications

This measure is being implemented over multiple years, starting with **Phase One in** the 2025-26 measurement year. For 2027, the measure is now in **Phase Two** of implementation requiring hospitals to work toward actively recruiting and/or allowing doulas who accept Partnership HealthPlan to provide support during labor and delivery.

Phase Two Measure Requirements

1. Hospitals will develop policy and/or procedures that allow doulas to support birthing parents in the hospital during labor and delivery, **and**
2. Hospitals will submit evidence of active recruitment of doulas who are credentialed with Partnership.

NOTE: Hospitals with policy and procedure developed before 2027 allowing doulas to provide support during labor and delivery and that are utilizing them will get full points for the measure.

Measure 13 – Substance Use Disorder 7-Day Follow-up After ED Visit (FUA)

It is proposed to align the Substance Use Disorder Referral measure with the HEDIS FUA measure for 7-Day Follow-up After ED Visits. This will move this measure from focusing on prescribing buprenorphine and MAT to a broader range of services to a broader range of members. This measure will also pinpoint a shorter follow-up window moving from the previous 60-day follow-up window to 7 days.

Measure 13 Summary

The Emergency Department (ED) plays a critical role in improving care for patients with substance use disorder (SUD) and preventing overdose deaths, as it is often the entry point for acute stabilization, diagnosis, and connection to follow-up services. Individuals presenting to the ED for substance-related events face a high risk of adverse outcomes—particularly in the year after discharge—making coordinated follow-up care essential, as these patients are especially vulnerable to losing contact with the health care system after high-risk encounters.

Substance Use Disorder 7-day Follow-up After ED Visit (FUA) Specifications

The percentage of emergency department 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 a follow-up within 7 days of the ED visit (8 days total).

Numerator: Follow-up visit or pharmacotherapy dispensing event on the ED visit date or within 7 days after the ED visit (8 days total).

Denominator: The number of ED visits for members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose* on or between January 1 and December 1 of the measurement period.

Full Points Target (10 pts): > 32.60%
Partial Points Target (5 pts): Between 26.90 – 32.5 %
Hospital's percentages will be rounded to the nearest 10th.

B. New Measures/Returning Measures

Measure 10 - Hepatitis B Vaccination:

It is proposed to remove the VFC Enrollment Measure and replace it with the Hepatitis B Vaccination measure. We have had a similar measure in past years, so it is familiar to our hospitals. Despite changing CDC recommendations, Partnership believes it is important to continue to encourage Hepatitis B vaccination within 24 hours of delivery.

Hepatitis B Vaccination Measure Summary

Hospitals providing maternity services hold the valuable opportunity of optimizing their Hepatitis B birth dose practices. This measure incentivizes birthing hospitals for administering the Hep B vaccine within the first day of life. One of the most important reasons to administer the Hep B vaccination to infants is its ability to prevent chronic infections that can cause liver failure and death. Other important reasons include providing early protection against future exposure to infected blood or bodily fluids, and the high effectiveness against preventing Hep B transition from mothers to infants. The vaccine should be administered in the first 24 hours of life, because the virus can be transmitted form the mother to the child during labor and delivery without the mother knowing her status. The American Academy of Pediatrics specifically recommends universal hepatitis B vaccination for all infants, beginning with the first dose within 24 hours of life. Deferring vaccination to a future well child visit will not achieve this recommendation; it must be available in the hospital.

By State law, all immunizations must be recorded in the California Immunization Registry (CAIR), which makes immunization records easily accessible, ensures accuracy, and improves efficiency.

Specifications

To demonstrate measure compliance, hospitals must enter Hep B vaccine administrations into CAIR. Partnership will use CAIR data uploaded during the Measurement Year to measure performance.

Specification for Hospitals Providing Maternity Services:

Numerator:

Newborn Hepatitis B Vaccine entered in CAIR within first day of life

Denominator:

Newborn births at the hospital between January 1, 2027, and December 31, 2027

Measure 11 – ALSO & BLSO Certification Training:

It is proposed to add this measure to encourage hospitals to build capacity for getting their staff trained in Advanced Life Saving in Obstetrics and Basic Life Saving in Obstetrics. It is particularly important for our Critical Access Hospitals that treat patients in our rural communities to receive training. This measure may go into a second phase in following measurement years where the thresholds of providers are increased.

Specifications

This measure is designed to encourage hospitals to build capacity for ALSO and BLSO-certified care teams over the next few years. During the first year of this measure hospitals with an OB department shall begin to build capacity for an ALSO certified care team and Critical Access hospitals without OB will build capacity for a BLSO certified care team by training staff throughout the 2027 measurement period in correlation to measure targets.

ALSO & BLSO Measure Summary

The American Academy of Family Physicians has developed Advanced Life Support in Obstetrics (ALSO®) and Basic Life Support in Obstetrics (BLSO™) trainings help emergency response personnel and hospital staff to be better prepared to respond and treat obstetric emergencies. ALSO is designed for physicians and midwives who perform deliveries, along with labor & delivery nurses, whereas BLSO is appropriate for first responders, emergency department personnel, nurses, doulas, and students. ALSO training focuses on more advanced and comprehensive management of obstetric emergencies that have are high risk or have a high level of complexity requiring advanced skills and medications, while BLSO focuses on providing initial basic assessment of the patient and management of emergencies that have a moderate level of complexity. Because successful emergency treatment requires a care team to treat the member, both courses take a team-based group approach to learning.

According to the AAFP “Adapted from the Advanced Life Support in Obstetrics (ALSO®) program, BLSO is designed for pre-hospital care providers, emergency department personnel, medical and nursing students and non-delivering physicians. The course format is a blended classroom, which allows learners to work at their own pace to complete the online course portion prior to the live course skills assessment and group testing portion.”

Partnership offers some support for holding BLSO or ALSO training within our network area. Hospitals should reach out to the HQIP team to learn more.

ALSO & BLSO Measure Target Requirements

Hospitals with Obstetrics:

Full Points Target (5 pts):

30% of Physicians, i.e. MDs & CNM's and 30% of Nurses working regularly in Labor and Delivery are currently certified in ALSO

Partial Points Target (2.5 pts.):

15% of Physicians, i.e. MDs & CNM's and 15% of Nurses working regularly in Labor and Delivery are currently certified in ALSO

Hospitals without Obstetrics:

Full Points Target (5 pts):

30% of ED Clinicians, i.e. MDs & PAs and 30% of Nurses working regularly in the Emergency Department are currently certified in BLSO. Alternative simulation-based trainings in Emergency Obstetrical Care (such as Stanford's GO-MOMS-USA simulation program, done in-person at the hospital) may also be acceptable; they would be reviewed on a case-by-case basis.

Patial Points Target (2.5 pts):

15% of Physicians, i.e. MDs & PA's and 15% of Nurses working regularly in the Emergency Department are currently certified in BLSO.

Measure 14 - Quality Improvement Capacity:

This measure is designed to provide a free full day Hospital Quality Symposium each measurement year for our participating hospitals. At which, hospital quality and executive staff can stay up to date on quality topics at large and at Partnership. We had removed this measure for the 6-month bridge set for logistical reasons and propose to bring the measure back for the 2027 calendar year. There are no changes to the measure from previous measurement years.

Measure 16 - California Hospital Compare:

This measure is intended to encourage hospitals to provide excellent patient experience and Partnership's scoring of the measure relies upon California Hospital Compare's scores, which are updated annually. This measure was removed for this six-month bridge set as the scores for the 2025-26 measurement year would have just been delivered meaning there would be no new information to score the hospitals. It is proposed to bring this measure back for the 2027 calendar year. The measure will return in the same form as it was during the 2025-26 measurement year.

Measure 17 – Health Equity

This measure is designed to encourage hospitals to work toward reducing health disparities that exist in their area or patient populations. This measure was removed for the 6-month bridge period, and we propose to bring the measure back for the 2027 calendar year. It is proposed that the measure switch from hospitals submitting a CMS Commitment to Health Equity report to submitting a copy of their HCAI Health Equity Report that is required by California Assembly Bill 1204 as noted in the below measure description.

Health Equity Measure Summary

Partnership is actively engaged in Health Equity (HE) initiatives that bring about equitable awareness and result driven change within the 24 counties served and it highly encourages provider organizations to join its efforts. At Partnership, we believe in diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff. Together, we can help move our communities toward equitable access to health care.[29-32]

Partnership recognizes that hospitals are being asked to report health equity work in many ways, which can cause extra administrative burden. To reduce hospitals' reporting burden, Partnership has aligned its HQIP Health Equity measure with Assembly Bill No. 1204 requiring hospitals to share the valuable health equity work they have done without needing to present it in a different format.

Assembly Bill No. 1204 requires the California Department of Health Care Access and Information (HCAI) to establish and oversee the Hospital Equity Measures Reporting Program, which collects and publicly reports hospital performance and patient outcome data by sociodemographic factors such as age, sex, race and ethnicity, payer type, language, disability status, and sexual orientation and gender identity. Under the law, general acute care, children's, and acute psychiatric hospitals, as well as hospital systems, must annually (by September 30th) submit reports to HCAI summarizing key equity measures, identifying their top 10 disparities, and outlining plans to address those disparities.

HCAI is responsible for providing public access to these reports and equity plans through its website, and participating hospitals are also required to post the reports on their own websites.

Health Equity Measure Requirements

Hospitals shall submit a copy of their most recently published annual HCAI Health Equity Measures Report to Partnership by December 31, 2027. The submitted report should be the same report hospitals sent to HCAI during the measurement year which was due to HCAI by September 30th.

C. Removal of Existing Measures for 2027

Increased Mammography Capacity

It is proposed to remove this measure because we cannot continue to ask for increased capacity each year. Capacity at many hospitals increased during the year and a half the measure was in place.

Vaccines For Children (VFC) Enrollment

It is proposed to remove the Vaccines For Children (VFC Enrollment) and replace with the Hepatitis B Vaccination measure. This is consistent with what was planned for the measure from the beginning.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.10

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 Extended Care Center Quality Improvement Program (QIP) measurement set (see attached summary).

Reason for Resolution:
To optimize the Extended Care Center 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 Extended Care Center Quality Improvement Program measurement set.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
3.10

Resolution Number:
26-

IN THE MATTER OF: APPROVING PROPOSED CHANGES TO THE 2027 EXTENDED CARE CENTER QUALITY IMPROVEMENT PROGRAM 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 Extended Care Center Quality Improvement Program measurement set.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

2027 EXT QIP Measurement Set Proposal

2027 Extended Care Center (EXT) QIP (January 1, 2027 – December 31, 2027)

Key: New Measure | Change to Measure | ~~Removed Measure~~

2026 Measures	Proposed 2027 Measures
Gateway Measures	
Gateway Measure 1: CMS Five-Star Overall Rating Points: N/A Target: 2 or more stars to be eligible for other program measures	No changes
Gateway Measure 2: California Immunization Registry (CAIR) Enrollment Points: N/A Target: CAIR enrollment required to be eligible for other program measures	No changes
Gateway Measure 3: Quality Assurance and Performance Improvement (QAPI) Plan Submission Points: N/A Target: Submission by 6/30/27: Full credit Submission between 7/1/27 - 12/31/27: 50% decrease Submission after 12/31/27 will result in gateway not met and ineligibility for other measures.	No changes
Clinical Domain	
Measure 1: Percentage of long-stay high-risk residents with pressure ulcers Points: 10 Target: Full Points: < 5.1% Partial Points: 5.1 - 5.3%	Target: Full Points: < 4.3% Partial Points: 4.3 - 4.5% 2026 Natl AVG: 4.6% 2026 CA AVG: 4.3%

2027 EXT QIP Measurement Set Proposal

Measure 2: Percentage of long-stay residents who lose too much weight Points: 10 Target: Full Points: < 4.3% Partial Points: 4.3 - 5.4%	Target: Full Points: < 4.0 % Partial Points: 4.0 - 5.1% 2026 Natl AVG: 5.2% 2026 CA AVG: 4%
Measure 3: Percentage of long-stay residents who needed and got a flu shot Points: 10 Target: Full Points: > 98.4% Partial Points: 93.5 - 98.4%	Measure 3: Percentage of long-stay residents who needed and got a flu shot *AND* successful entry into CAIR Target: Full Points: > 98.2% Partial Point: 95.6 - 98.2% 2026 Natl AVG: 95.5% 2026 CA AVG: 98.2%
Measure 4: Percentage of long-stay residents who received a vaccine to prevent pneumonia Points: 10 Targets: Full Points: > 98.5% Partial Points: 93.5 - 98.5%	Measure 4: Percentage of long-stay residents who received a vaccine to prevent pneumonia *AND* successful entry into CAIR Target: Full Points: > 98.6% Partial Point: 93.6- 98.6% 2026 Natl AVG: 93.5% 2026 CA AVG: 98.6%
Functional Status Domain	
Measure 5: Percentage of long-stay residents experiencing one or more falls with major injury Points: 10 Target: Full Points: < 1.7% Partial Points: 1.7 - 3.2%	Target: Full Points: < 1.6% Partial Points: 1.6 - 3.1% 2026 Natl AVG: 3.2% 2026 CA AVG: 1.6%
Measure 6: Percentage of long-stay residents who have or had a catheter inserted and left in their bladder Points: 10 Target: Full Points: < 1.2% No Partial Points	Target: Full Points: < 0.8% No Partial Points 2026 Natl AVG: 0.8% 2026 CA AVG: 0.8%
Resource Use Domain	
Measure 7: Number of hospitalizations per 1,000 long-stay resident days Points: 15 Target: Full Points: < 1.83% Partial Points: 2.17 - 1.83 %	Points: 10 Target: Full Points: < 1.90 Partial Points: 2.24 - 1.90 2026 Natl AVG: 1.90 2026 CA AVG: 2.25

2027 EXT QIP Measurement Set Proposal

Operations & Satisfaction Domain	
Measure 8: Health Inspection Star Rating Points: 10 Target: Full Points: 4 or more stars Partial Points: 3 stars	No changes
Measure 9: Staffing Rating Points: 15 Target: Full Points: 4 or more stars Partial Points: 3 stars	Points: 10
	ADD: Measure 10 – Health Equity Impact Analysis and Plan Facilities are required to submit an updated Health Equity Impact Analysis and Plan that addresses health disparity in at least one of the following measures listed below: • Percent of high-risk residents with pressure ulcers • Percent of residents who lose too much weight • Long-stay residents who needed and received a flu shot • Long-stay residents who received a vaccine to prevent pneumonia • Percent of residents experiencing one or more falls with major injury • Percent of residents who have/had a catheter inserted and left in bladder Points: 10 Target: Full Points No Partial Points Providers are required to submit analysis and plan by August 31, 2027. Partnership will review and notify facilities if approved or rejected. Logic: At Partnership, health equity means ensuring everyone has a fair and just opportunity to achieve optimal health. We recognize that many factors influence health outcomes and are committed to supporting the diverse communities we serve. Every patient deserves a high-quality healthcare experience, regardless of socioeconomic status, race, gender, or other identifying characteristics.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
4.1

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

Recommendation by:
Partnership Staff

Topic Description:
The Board serves as the selection committee for the Community Advisory Committee (CAC). As such, the Board is responsible for selecting new CAC members and/or replacing former CAC members whose position has been vacated. If a CAC member resigns or is asked to resign, the CAC selection committee must make their best effort to promptly replace a vacant CAC seat within 60 calendar days of the CAC vacancy, ensuring that CAC membership continues to be reflective of, and responsive to, the MCP's Service Area demographics.

The following nominees have applied to serve as member of the CAC:
Abel Lopez – Placer County
Valerie Zeller – Del Norte County
Elizabeth Hees – Humboldt County
Krystalyn Hodson – Humboldt County
Charles Wilson – Napa County
Andrea Perez Ruiz – Solano County
Erin Elder – Shasta County
Kathleen Seifert – Shasta County
Cassandra Egan – Sonoma County

Reason for Resolution:
To obtain Board approval to approve the appointment of nine nominees as members of the Community Advisory Committee.

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 nominees above to serve as members of the CAC. These individuals are members of the health plan and have expressed interest in joining the CAC. The CAC is a diverse group who come from all walks of life and bring a wide variety of perspectives to their role.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
4.1

Resolution Number:
26-

IN THE MATTER OF: APPROVING NINE COMMUNITY ADVISORY COMMITTEE NOMINEES

Recital: Whereas,

A. The Board serves as the Selection Committee for the Community Advisory Committee and has ultimate responsibility for approving appointments.

B. Partnership is committed to conducting business in compliance with all required standards and regulations.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the nine nominations to the Community Advisory Committee.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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



Community Advisory Committee

Member Selection Evaluation Packet

October 2026

Community Advisory Committee (CAC)

CAC Member Selection Committee

Auburn Regional Office



Community Advisory Committee
Member Summary Form

Applicant Name:	Abel Lopez
County of Residence:	Placer
Available Seats:	There are two (2) available seats in Placer County
Demographics:	Age Group: 45-64 Language: Spanish Ethnicity: Hispanic
Applicant Summary:	Abel has lived in Placer County for approximately 10-15 years and currently resides in Lincoln. He learned about the Community Advisory Committee (CAC) through attending a Member Informative Session and was motivated to apply to learn more about the opportunity to become more involved in his community. Abel expressed a genuine interest in serving on the committee and gaining a deeper understanding of the programs, resources, and services available to Partnership members. Abel shared that he views participation on the CAC as a valuable opportunity for both personal growth and community involvement. He expressed a desire to learn from the experiences and perspectives of fellow committee members while contributing his own insights. He spoke about the importance of helping others access resources and information that may improve their well-being and quality of life and believes serving on the committee would allow him to better advocate for community needs and support efforts that positively impact local families. Abel is enthusiastic, thoughtful, and eager to actively participate in committee discussions and activities. He has a sincere commitment to supporting his community and sees the CAC as a meaningful way to give back. His eagerness to learn, collaborative mindset, and dedication to helping others would bring a valuable perspective to the committee.
CAC Team Recommendation:	The CAC Team, in consultation with the Health Equity Officer, recommends the appointment of this member to the Community Advisory Committee.

Community Advisory Committee (CAC)

CAC Member Selection Committee

Eureka Regional Office



Community Advisory Committee
Member Summary Form

Applicant Name:	Valerie Zeller
County of Residence:	Del Norte
Available Seats:	There are two (2) available seats in Del Norte County
Demographics:	Age Group: 45-64 Language: English Ethnicity: White
Applicant Summary:	Valerie has lived in Del Norte County for the past five years and was drawn to the area for its small-town atmosphere after previously living in Woodland. Born and raised in Humboldt County, she values the close-knit nature of rural communities. She brings more than 35 years of professional experience in child welfare, mental health, and social services, having worked with underserved populations throughout Sacramento, Yolo, Sutter, and Del Norte Counties. Her career included extensive work in mental health before transitioning to Child Protective Services, where she remained for approximately 20 years. In addition to her professional experience, she has served as a foster parent to youth transitioning from short-term residential treatment facilities and has advocated on behalf of her foster and adoptive children while navigating the health and social service systems. Valerie expressed interest in joining the Community Advisory Committee because she is passionate about advocating for individuals who are underserved, unserved, or otherwise lack a voice within existing systems. Drawing on her experience as both a service provider and a consumer, she has observed areas where systems function effectively as well as opportunities for improvement. She believes consumer perspectives are essential to creating meaningful change and hopes to use her experience and advocacy background to help improve access to services and outcomes for community members.
CAC Team Recommendation:	The CAC Team, in consultation with the Health Equity Officer, recommends the appointment of this member to the Community Advisory Committee.

Community Advisory Committee
Member Summary Form

Applicant Name:	Elizabeth Hees
County of Residence:	Humboldt
Available Seats:	There are four (4) available seats in Humboldt County
Demographics:	Age Group: 20-44 Language: English Ethnicity: White
Applicant Summary:	Elizabeth has been connected to Humboldt County for most of her life, having been born in Fortuna and raised in Mad River. After returning to the area in July of 2019, she attended Humboldt State University, earning her bachelor's degree in psychology in December 2021. She is actively engaged in several communities throughout the Humboldt County area. Her involvement includes participation with Open Door's support program for individuals living with chronic illnesses, where she became certified as a peer support group facilitator. She is also active in online library communities and involved with Queer Humboldt and other local 2S/LGBTQIA+ networks. Elizabeth learned about the Community Advisory Committee (CAC) while attending a Member Informative Session in Humboldt County. She expressed a strong interest in serving on the CAC because she believes the committee's work is impactful. Through the Member Informative Session, she gained valuable knowledge about Partnership's services and was interested in helping share information with others. As an individual living with a chronic illness, she feels that people with chronic health conditions are often underrepresented in committee discussions and decision making. Her lived experience, peer support background, and connections within the chronic illness and 2S/LGBTQIA+ communities would provide valuable insight and help strengthen the committee's understanding of the diverse needs of Partnership members.
CAC Team Recommendation:	The CAC Team, in consultation with the Health Equity Officer, recommends the appointment of this member to the Community Advisory Committee.

Community Advisory Committee
Member Summary Form

Applicant Name:	Krystalyn Hodson
County of Residence:	Humboldt
Available Seats:	There are four (4) available seats in Humboldt County
Demographics:	Age Group: 20-44 Language: English Ethnicity: White
Applicant Summary:	Krystalyn has lived in Humboldt County for the past six years and currently works with the American Red Cross as a Duty Officer, helping coordinate disaster response efforts and support the deployment of trained responders during emergencies. She also works with the Department of Health and Human Services, giving her experience navigating public service systems and community resources. She has served in community leadership roles, including as a Commissioner on the Tuolumne Historic Preservation Review Committee. She learned about the Community Advisory Committee (CAC) through Partnership's Member Newsletter and was inspired to apply because of her positive experiences as a Partnership member. She shared that she is grateful for the benefits and services Partnership provides and is interested in using her professional skills and community service experience to give back. She also noted the value of bringing both firsthand experience as a member and professional experience serving communities during times of need. Drawing from her experience in public service, emergency response, and community engagement, she understands the importance of listening to community voices, building partnerships, and working collaboratively to address challenges. Her combination of leadership experience, commitment to service, and firsthand knowledge as a Partnership member would make her a valuable contributor to the CAC.
CAC Team Recommendation:	The CAC Team, in consultation with the Health Equity Officer, recommends the appointment of this member to the Community Advisory Committee.

Community Advisory Committee (CAC)

CAC Member Selection Committee

Fairfield Regional Office



Community Advisory Committee
Member Summary Form

Applicant Name:	Charles Wilson
County of Residence:	Napa
Available Seats:	There is one (1) available seat in Napa County
Demographics:	Age Group: 45-64 Language: English Ethnicity: White
Applicant Summary:	With more than twenty years of nursing experience, Charles brings a wealth of knowledge from a career dedicated to serving individuals with complex healthcare needs. He recently relocated to Napa County from Sutter County for new employment opportunities and earned his bachelor's degree through Purdue University in Fall 2025. Throughout his career, he has provided care in a variety of healthcare settings, including acute care hospitals, behavioral health centers, and other direct care environments serving individuals with complex healthcare needs. He has worked extensively with justice-involved populations and adults with co-occurring mental health and substance use disorders. He currently works for a behavioral health center supporting adults with dual diagnoses. Charles has worked closely with individuals facing a wide range of medical, behavioral health, and social challenges. His extensive frontline experience serving vulnerable and underserved populations provides valuable insight into the complex needs of Partnership members and the barriers they may encounter when accessing care and support services. His background has given him a strong understanding of the importance of coordinated, member-centered care. His experience and understanding of the communities Partnership serves would bring a valuable perspective to Community Advisory Committee (CAC) discussions and help inform member-centered initiatives.
CAC Team Recommendation:	The CAC Team, in consultation with the Health Equity Officer, recommends the appointment of this member to the Community Advisory Committee.

Community Advisory Committee
Member Summary Form

Applicant Name:	Andrea Perez Ruiz
County of Residence:	Solano
Available Seats:	There are two (2) available seats in Solano County
Demographics:	Age Group: 20-44 Language: Spanish Ethnicity: Hispanic
Applicant Summary:	Andrea has lived in Solano County for the past six years and shared that she was drawn to the community because of its peaceful atmosphere. Andrea learned about the Community Advisory Committee (CAC) while attending a Member Informative Session in Fairfield and expressed interest in serving as an opportunity to become more involved and learn more about Partnership's work. Andrea spoke about the importance of helping others and shared an example of assisting a woman and her young children during a time of crisis, providing support where she could and helping connect the family with local resources and services. Andrea shared that experiences in her own life have also helped her recognize the importance of ensuring individuals and families have access to information, support, and community resources during difficult times. She expressed a particular interest in advocating for children and families facing difficult circumstances. Andrea highlighted the importance of ensuring information and resources are available in ways that are accessible, including for community members who may face language barriers when navigating services. Her compassion for others, commitment to helping those in need, and appreciation for the support services available in her community would bring a thoughtful and caring perspective to the CAC.
CAC Team Recommendation:	The CAC Team, in consultation with the Health Equity Officer, recommends the appointment of this member to the Community Advisory Committee.

Community Advisory Committee (CAC)

CAC Member Selection Committee

Redding Regional Office



Community Advisory Committee
Member Summary Form

Applicant Name:	Erin Elder
County of Residence:	Shasta
Available Seats:	There are two (2) available seats in Shasta County
Demographics:	Age Group: 20-44 Language: English Ethnicity: White
Applicant Summary:	Erin is a lifelong resident of Shasta County and is connected to her community through her involvement with Far Northern Regional Center. She graduated from California State University, Sacramento, with a degree in Child Development and has a strong interest in supporting children and individuals with disabilities. Erin is passionate about advocating for others and is interested in serving on the Community Advisory Committee (CAC) because she wants to use her skills and experiences to make a meaningful contribution to her community. Drawing from both her educational background and lived experience, Erin brings valuable insight into the needs of individuals with disabilities and their families. She shared the importance of recognizing that individuals with disabilities lead full, active lives and have meaningful experiences to contribute. Erin's perspective would help foster a greater understanding of the experiences, strengths, and challenges faced by members receiving services and supports in their communities. Her commitment to advocacy, inclusion, and helping others would make her a meaningful contributor to the Community Advisory Committee. She is eager to help advance meaningful discussions that reflect the diverse experiences of Partnership members.
CAC Team Recommendation:	The CAC Team, in consultation with the Health Equity Officer, recommends the appointment of this member to the Community Advisory Committee.

Community Advisory Committee
Member Summary Form

Applicant Name:	Kathleen Seifert
County of Residence:	Shasta
Available Seats:	There are two (2) available seats in Shasta County
Demographics:	Age Group: 65+ Language: English Ethnicity: White
Applicant Summary:	Kathleen brings a strong service-oriented perspective shaped by caregiving, volunteer work, and years of helping others. She has longstanding ties to the community and a deep commitment to serving others, both through her personal experiences as a caregiver and her ongoing volunteer involvement. She remains active in the community through volunteer work at her local senior center, assisting with facility rentals and community events, providing part-time healing and touch therapy services at Hilltop Springs, and participating in the Center for Spiritual Living. Through these roles, as well as her experience supporting seniors, she has gained insight into the needs, challenges, and experiences of community members across a variety of backgrounds. Kathleen shared that she has had a positive experience with Partnership HealthPlan and appreciates the organization's commitment to providing access to healthcare for low-income individuals and families. She expressed interest in serving on the Community Advisory Committee as an opportunity to support Partnership's efforts to better understand and respond to member needs. Drawing on a 30-year career in service-based businesses and workshop facilitation, along with her experience as a volunteer and caregiver, she would bring a thoughtful, service-oriented perspective and a strong commitment to supporting Partnership members.
CAC Team Recommendation:	The CAC Team, in consultation with the Health Equity Officer, recommends the appointment of this member to the Community Advisory Committee.

Community Advisory Committee (CAC)

CAC Member Selection Committee

Santa Rosa Regional Office



Community Advisory Committee
Member Summary Form

Applicant Name:	Cassandra Egan
County of Residence:	Sonoma
Available Seats:	There are two (2) available seats in Sonoma County
Demographics:	Age Group: 45-64 Language: English Ethnicity: White
Applicant Summary:	Cassandra has lived in Sonoma County for most of her life and brings a longstanding connection to the community. Through nearly ten years of supporting her husband through significant health challenges, she has gained extensive firsthand experience navigating healthcare systems, coordinating care, and advocating for the needs of her family. These experiences have provided her with valuable insight into the challenges that consumers and caregivers may face when accessing services and supports. She expressed interest in serving on the Community Advisory Committee as an opportunity to give back to her community and contribute to efforts that improve services for others. She shared a strong concern for individuals who may not fit within traditional systems or who face barriers to receiving the care and support they need. Drawing from her experiences navigating complex healthcare systems, she is particularly interested in ensuring the perspectives of underserved or underrepresented community members are considered when programs and services are developed and evaluated. Cassandra identifies her strengths as being detail-oriented, compassionate, and committed to thoroughly understanding issues and situations. She hopes to use her experiences as a caregiver and healthcare advocate, along with her thoughtful approach to problem-solving, to help ensure community voices are heard and considered in efforts to improve services and outcomes.
CAC Team Recommendation:	The CAC Team, in consultation with the Health Equity Officer, recommends the appointment of this member to the Community Advisory Committee.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 28, 2026

Agenda Item Number:
4.2

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

Recommendation by:
Compliance Committee and Partnership Staff

Topic Description:
The Compliance Dashboard outlines activities to track Partnership HealthPlan's Compliance Program and regulatory and contractual requirements.

Reason for Resolution:
To ensure Board members have the opportunity to review the Compliance dashboard biannually.

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

Requested Action of the Board:
Based on the recommendation of the Compliance Committee, the Board is being asked to approve Partnership's Q22026 Compliance Dashboard.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date
October 28, 2026

Agenda Item Number:
4.2

Resolution Number:
26-

IN THE MATTER OF: APPROVING PARTNERSHIP HEALTHPLAN COMPLIANCE DASHBOARD FOR Q22026

Recital: Whereas,

A. Partnership is committed to conducting business in compliance with all required standards.

B. The Board has responsibility for reviewing and approving the organizational Compliance Dashboard.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve Partnership's Q22026 Compliance Dashboard.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

2026 Regulatory Affairs and Compliance Dashboard

Category	Description	Q1	Q2	YTD	Comments
DELEGATION OVERSIGHT	**Annual Delegate / Subcontractor Audits**	**0 / 0**	**4 / 4**	**4 / 4**	
	Quarterly percentage to demonstrate the total number of annual delegate/subcontractor audits completed within 30 days following the planned months, as defined by the audit calendar.	**100%**	**100%**	**100%**	
	Oversight of Delegate Reporting	**5 / 5**	**4 / 4**	**9 / 9**	
	Percentage of timely submissions of regulatory reports.	**100%**	**100%**	**100%**	
TRAINING	**Annual FWA Prevention Training**	**1571 / 1575**	**1571 / 1575**	**1571 / 1575**	
	Percentage of employees that have completed the annual FWA training. **Annual training released in Q4 2025**	**99.9%**	**99.9%**	**99.9%**	
	Annual HIPAA Training	**1571 / 1575**	**1571 / 1575**	**1571 / 1575**	
	Percentage of employees that have completed the annual HIPAA training. **Annual training released in Q3 2025**	**99.9%**	**99.9%**	**99.9%**	
	Annual Code of Conduct	**1571 / 1575**	**1571 / 1575**	**1571 / 1575**	
	Percentage of completed annual Code of Conduct employee attestations.	**99.9%**	**99.9%**	**99.9%**	
REGULATORY REPORTING	**DHCS Reports Submitted Timely**	**87 / 89**	**78 / 81**	**165 / 170**	
Regulatory Affairs works collaboratively with all PHC departments to implement and track the timely submission of regulatory reporting requirements to PHC's governing agencies.	Percentage of regulatory reports submitted timely by RAC to DHCS with no missed due date per RAC Master Tracker and Regulatory Reporting Calendar.	**97.7%**	**96.3%**	**97.1%**	
	Report Acceptance Rate	**81 / 89**	**75 / 81**	**156 / 170**	
	Percentage of standard regulatory reports submitted by RAC and not rejected by DHCS for being incomplete, on the wrong template, or for other findings.	**91.0%**	**92.6%**	**91.8%**	Q2- 81 total reports submitted to DHCS. 6 Reports were rejected and returned to the Plan for correction. Some were for minor formatting or typographical issues, while others were returned for incomplete or inaccurate data.
HIPAA REFERRALS	**Timely DHCS Privacy Notification Filings**	**39 / 39**	**72 / 76**	**111 / 115**	
Appropriate safeguards, including administrative policies & procedures, to protect the confidentiality of PHI and ensure compliance with HIPAA regulatory requirements.	Percentage of reportable notifications that PHC filed timely within applicable DHCS required timeframe. **Initial PIR within 24 hours, and final PIR within 10 business days. If any deadline is missed, it will be counted as untimely.*	**100.0%**	**94.7%**	**96.5%**	Q2- 72 of 76 total reportable incidents submitted to DHCS were reported timely.
FWA REFERRALS	**Timely DHCS FWA Notifications**	**28 / 28**	**58 / 58**	**161 / 161**	
Regulatory Affairs oversees the Fraud, Waste and Abuse Prevention program intended to prevent, detect, investigate, report and resolve suspected and/or actual FWA in the PHC daily operations and interactions, whether internal or external.	Percentage of reportable notifications that PHC filed timely with DHCS within 10 business of discovery per contractual obligations.	**100.0%**	**100%**	**100%**	

***Threshold percentages for the above measures are as follows:**
≥ 95% = GREEN 90 - 94.9% = YELLOW < 90% = RED

CAP Tracker

*Please note that the above threshold percentages do not apply here

Updated 08/26/2026

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date: October 28, 2026 **Agenda Item Number:** 4.4

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

Recommendation by:
Partnership Staff

Topic Description:
Partnership's FY 2026-27 approved budget maintained the capital expenditure levels previously approved for FY 2025-26. Management is requesting authority to reallocate approved capital expenditures among budget categories, as necessary, to address evolving operational, programmatic, and financial priorities, provided that such reallocations do not result in an increase to the total Board-approved capital budget.

Reason for Resolution:
To authorize management to reallocate capital expenditure funding among budget categories during FY 2026-27, as necessary to address evolving operational and business needs, including the funding of new capital projects, provided that such reallocations remain within and do not exceed the total Board-approved capital budget for FY 2026-27.

Financial Impact:
No financial impact. The resolution does not increase the overall approved capital budget.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to authorize the CEO and CFO to reallocate previously approved capital expenditure funding among budget categories during FY 2026-27, provided that such reallocations remain within and do not exceed the total Board approved capital budget, and in accordance with the parameters outlined above.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date: October 28, 2026

Agenda Item Number: 4.4

Resolution Number: 26-

IN THE MATTER OF: APPROVING CAPITAL EXPENDITURE BUDGET REALLOCATION AUTHORITY FOR FY 2026-2027

Recital: Whereas,

A. The Board is responsible for approving the annual budget and establishing reallocation authority.
B. Management is requesting authority to reallocate approved capital expenditures within the authorized capital budget.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To authorize the CEO and CFO to reallocate previously approved capital expenditure funding across budget categories during FY 2026-27, provided total approved capital expenditures are not exceeded.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

DETAIL CAPITAL BUDGET			
DEPARTMENT	**BUDGET ITEM DESCRIPTION**	**TOTAL FY 26-27 ESTIMATED PURCHASE COSTS**	
Facilities	Airpark Office: Infrastructure Investments	$	17,810
	Avtech Office: Infrastructure Investments	$	150,000
	Building 4605: Infrastructure Investments	$	3,593,740
	Building 4665: Infrastructure Investments	$	1,144,068
	Building 4820: Infrastructure Investments	$	34,200
	Building 4820: Tenant Improvements	$	877,894
	Eureka Office: Infrastructure Investments	$	1,005,203
	Santa Rosa Office: Infrastructure Investments	$	13,141
	Santa Rosa Office: Solar/EV Charging Stations & Infrastructure	$	376,522
	281 Nevada St., Auburn: Infrastructure Investments	$	2,105,516
	1950 -Napa Building-Gasser Foundation : Infrastructure Investments	$	3,930
	2175 Shasta View-Redding: Infrastructure Investments	$	10,070,035
	351 Hartnell-Redding (the VA building): Infrastructure Investments	$	2,180,000
	1000 Fortress-Chico: Infrastructure Investments	$	100,341
Total Facilities Purchase Cost FY 2026-27		**$**	**21,672,400**
Information Technology	Annual Maintenance/renewals/upgrades	$	3,228,741
	Citrix VDI/UX Monitoring Solution	$	170,515
	Infrastructure Enhancements	$	8,363,924
	System/Software Enhancements	$	18,832,257
	Total Infrastructure and Annual Maintenance	**$**	**30,595,437**
	Phoenix Project	$	33,920,958
Total Information Technology Purchase Cost FY 2026-27		**$**	**64,516,395**
Total Purchase Cost FY 2026-27		**$**	**86,188,795**

SUMMARY OF CAPITAL BUDGET			
DEPARTMENT	**BUDGET ITEM DESCRIPTION**	**TOTAL FY 26-27 ESTIMATED PURCHASE COSTS**	
Facilities	Infrastructure and Annual Maintenance	$	21,672,400
Total Facilities Purchase Cost FY 2026-27		**$**	**21,672,400**
Information Technology	Infrastructure and Annual Maintenance		30,595,437
	Phoenix Project		33,920,958
Total Information Technology Purchase Cost FY 2026-27		**$**	**64,516,395**
Total Purchase Cost FY 2026-27		**$**	**86,188,795**

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)

Agenda Item Number: 4.5

Board Meeting Date: October 28, 2026

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

Recommendation by:
Partnership Staff

Topic Description:

Partnership's FY 2026–27 budget requires revisions. Recent expense trends in health care costs and supplemental services require an increase in expenditure authority under Partnership's FY 2026–27 budget.

As noted in the June presentation of the FY 2026-27 budget, a budget revision was expected. Uncertainty will remain throughout FY 2026-27 regarding final calendar year 2027 revenue, membership trends, and the acuity of the members served. Membership uncertainty includes the effects of the forthcoming community work requirements and semi-annual redeterminations. Further uncertainties continue to exist at the federal level as CMS is overhauling Medicaid waiver standards and their approval process. These uncertainties may require staff to make further budget revisions later in the fiscal year.

Reason for Resolution:
Approval is requested to revise the FY 2026-27 budget by increasing expense authority by $59,625,629 to address recent health care cost trends. The increase is allocated among budget categories experiencing higher expenses. Consistent with the overall FY 2026-27 budget, management will reallocate funds across budget categories if necessary.

Financial Impact:
The $59,625,629 increase in expenses increases Partnership's overall fixed budget deficit to $126,545,126.

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is asked to authorize the CEO and CFO to implement and manage the revised FY 2026-27 budget.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:** 4.5

Board Meeting Date: October 28, 2026

Resolution Number: 26-

IN THE MATTER OF: APPROVING BUDGET REVISIONS FOR FY2026-27

Recital: Whereas,

A. The Board is responsible for budget approval.

B. The FY2026-27 budget requires revisions.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve revisions to the FY2026-27 budget revision.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 28th day of October 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

Statement of Revenues and Expenses

Annual Capital & Operating Budget - Revised

	2026-27 Budget: Revised	2026-27 Budget: Original	$ VARIANCE
REVENUE			
State Capitation Revenue	5,930,930,957	5,930,930,957	-
Interest Income	73,500,000	73,500,000	-
Other Revenue	2,679,900	2,679,900	-
TOTAL REVENUE	**6,007,110,857**	**6,007,110,857**	**-**
HEALTHCARE COSTS			
Physician Services			
PCP Capitation	100,128,377	100,128,377	-
Specialty Capitation	2,352,079	2,352,079	-
Non-Capitated Physician Services	993,923,316	970,121,708	(23,801,608)
Total Physician Services	**1,096,403,772**	**1,072,602,164**	**(23,801,608)**
Inpatient Hospital			
Hospital Capitation	165,694,928	165,694,928	-
Inpatient Hospital - FFS	1,181,899,985	1,178,540,266	(3,359,720)
Hospital Stoploss	9,181,839	9,181,839	-
Total Inpatient Hospital	**1,356,776,752**	**1,353,417,033**	**(3,359,720)**
Long Term Care	701,659,419	701,659,419	-
Ancillary Services			
Ancillary Services - Capitated	13,843,128	13,843,128	-
Ancillary Services - Non-Capitated	1,118,691,315	1,089,457,399	(29,233,916)
Total Ancillary Services	**1,132,534,443**	**1,103,300,527**	**(29,233,916)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

Annual Capital & Operating Budget - Revised

	2026-27 Budget: Revised	2026-27 Budget: Original	$ VARIANCE
Other Medical			
Quality Assurance	98,339,060	98,339,060	-
Healthcare Investment Funds	218,584,865	218,584,865	-
Advice Nurse	1,560,000	1,560,000	-
Transportation	142,498,923	139,268,537	(3,230,386)
Total Other Medical	**460,982,848**	**457,752,462**	**(3,230,386)**
DHCS Facility Directed Payment Programs	899,026,750	899,026,750	-
Quality Improvement Programs	94,412,000	94,412,000	-
TOTAL HEALTHCARE COSTS	**5,741,795,984**	**5,682,170,355**	**(59,625,630)**
ADMINISTRATIVE COSTS			
Employee	257,660,943	257,660,943	-
Travel And Meals	3,023,332	3,023,332	-
Occupancy	25,240,416	25,240,416	-
Operational	12,461,223	12,461,223	-
Professional Services	39,490,454	39,490,454	-
Computer And Data	53,983,631	53,983,631	-
TOTAL ADMINISTRATIVE COSTS	**391,860,000**	**391,860,000**	**-**
Medi-Cal Managed Care Tax	-	-	-
Surplus / (Deficit)	**(126,545,127)**	**(66,919,497)**	**(59,625,630)**

Partnership Healthplan of California

Fiscal Year 2026/27 Fund Balance Analysis - Revised

Projected through June 2027

Fund Balance Analysis / TNE

Fund Balance at June 30, 2026 (Audited)	**1,475,305,405**
Projected (Deficit) for Fiscal Year 2026/27	(126,545,127)
Estimated Fund Balance at June 30, 2027	**1,348,760,278**
Estimated Fund Balance Allocated at June 30, 2027	
Reserved Funds	
State Financial Performance Guarantee	1,102,845,000
Capital Assets	246,766,000
Strategic Use of Reserve-Board Approved	32,612,668
Unrestricted (Shortfall)	(33,463,390)
Estimated Fund Balance at June 30, 2027	**1,348,760,278**

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

Financial Analysis for the Current Period

Total Surplus / Deficit

For the month ending August 31, 2026, Partnership reported a deficit of $24.3 million, bringing the year-to-date deficit to $41.4 million. Key variances are outlined below.

Revenue

Total Revenue is unfavorable to budget by $6.0 million for the month and $24.4 million for the year-to-date. The following summarizes the year-to-date variances. Medi-Cal revenue is $8.4 million favorable to budget primarily due to timing in recording risk corridor adjustments. Directed Payments are $47.7 million unfavorable to budget due to lower than anticipated rates with a corresponding offset recorded in Healthcare Investment Funds (HCIF). Supplemental revenues are $12.5 million favorable to budget, reflecting higher Proposition 56 revenue, higher DHCS submissions for American Indian Health Services (AIHS) payments, and higher than expected volumes for Maternity Kick. Interest income is $1.0 million favorable to budget due to higher interest rates than anticipated. The remaining $1.4 million favorable variance is attributed to other revenues.

Healthcare Costs

Total Healthcare Costs are unfavorable to budget by $9.2 million for the month but $5.4 million favorable for the year-to-date. The following summarizes the year-to-date variances. Non-Capitated Physician and Ancillary expenses are $51.3 million unfavorable to budget primarily due to adjustments to Incurred but Not Reported (IBNR) reserves which reflect the latest utilization trend. Capitation expenses are $2.4 million favorable to budget due to changes in the funding methodologies for certain healthcare providers. Long-term care costs are favorable to budget by $6.6 million due to lower than expected utilization. Inpatient Hospital Fee-For-Service (FFS) expenses are unfavorable to budget by $3.3 million due to higher utilization. HCIF expenses are $49.6 million favorable to budget due to lower than anticipated Directed Payment rates with an offsetting revenue component as referenced above. Transportation costs are $3.1 million unfavorable to budget, attributed to an increase in utilization. Quality Assurance expenses are $4.5 million favorable to budget due to lower than budgeted medical administrative costs.

Administrative Costs

Total Administrative costs are overall favorable to budget by $6.7 million for the month and $12.5 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; this offsets some of the unfavorability in the Professional Services category due to the timing of the utilization of consultants. Additional favorable variances in Occupancy are primarily driven by timing of maintenance and utility costs and in the Computer and Data category primarily driven by timing of software purchases, which typically correlates to the variance in staffing.

Balance Sheet / Cash Flow

Total Cash & Cash Equivalents decreased by $119.8 million for the month. Typical significant cash

transactions include State Capitation payments received; healthcare cost payments to providers; and administrative and capital payments out to vendors, employees, and other entities. A key highlight for the month was a $69.3 million payout for the calendar year 2024 Unsatisfactory Immigration Status (UIS) Risk Corridor.

General Statistics

Membership

Membership had a total net decrease of 48 members for the month.

Utilization Metrics and High Dollar Case

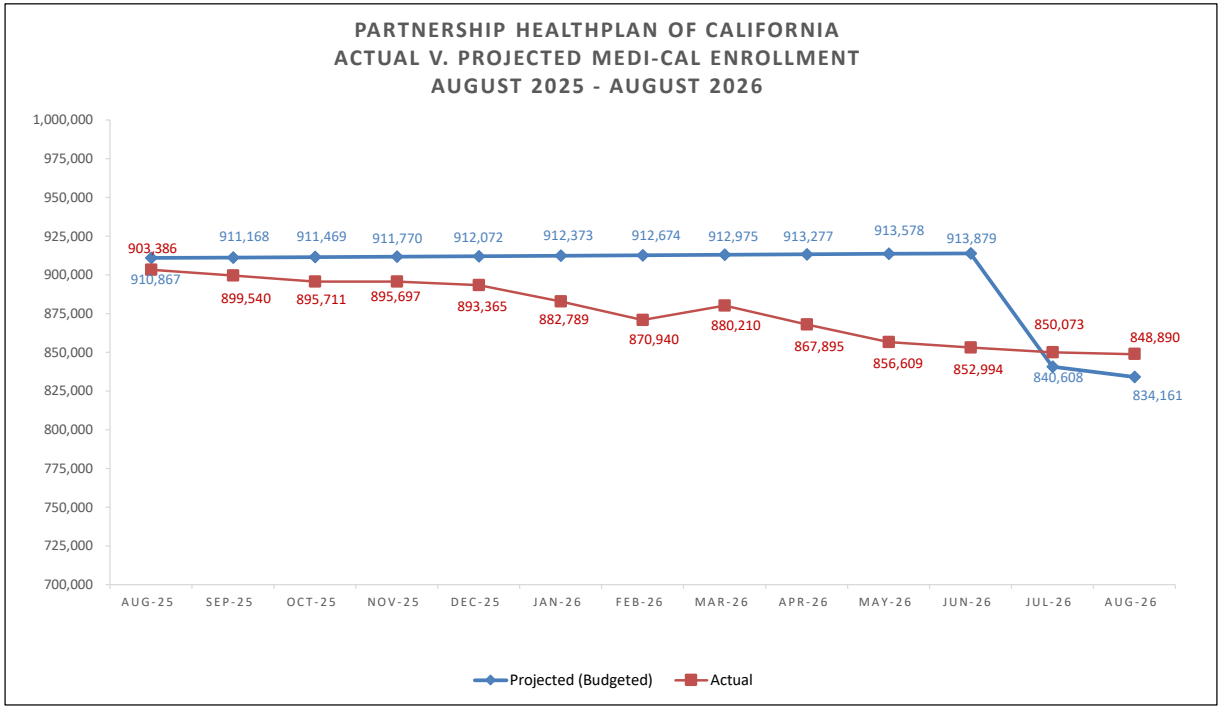
For the fiscal year 2026/27 through August 2026, 89 members reached the $250,000 threshold with an average cost of $479,049. For fiscal year 2025/26, 1,431 members reached the $250,000 threshold with an average cost per case of $512,895. For fiscal year 2024/25, 1,294 members reached the $250,000 threshold with an average claims cost of $513,867.

Current Ratio/Reserved Funds

Current Ratio Including Required Reserves:	**1.45**
Current Ratio Excluding Required Reserves:	**1.00**
Required Reserves:	**$ 1,432,215,943**
Total Fund Balance:	**$ 1,433,871,960**

Days of Cash on Hand

Including Required Reserves:	**96.27**
Excluding Required Reserves:	**34.37**



Member Months by County:

County	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Solano	102,676	102,240	101,767	101,583	101,555	98,608	97,031	98,109	96,112	94,063	93,037	93,536	93,325
Napa	27,619	27,642	27,529	27,480	27,355	26,951	26,540	26,659	26,242	25,959	25,962	25,565	25,512
Yolo	54,223	54,152	53,995	54,252	54,140	53,283	52,229	53,552	52,558	51,925	51,634	51,217	50,857
Sonoma	111,588	110,631	110,400	109,596	109,061	107,549	104,697	105,595	104,205	101,994	100,881	99,494	98,939
Marin	46,806	46,609	46,235	46,089	45,096	44,197	43,709	44,101	43,451	42,266	41,744	41,207	41,300
Mendocino	40,506	40,390	40,244	40,200	40,229	39,247	39,125	39,376	38,850	38,565	38,223	38,255	38,047
Lake	33,568	33,236	33,298	33,359	33,389	33,107	32,715	32,770	32,563	32,472	32,310	32,123	32,100
Del Norte	12,314	12,197	12,191	12,220	12,169	12,188	12,077	12,027	11,967	11,744	11,724	11,703	11,629
Humboldt	56,962	56,678	56,451	56,095	55,976	55,830	55,208	55,173	54,632	53,886	53,766	53,393	53,404
Lassen	8,358	8,439	8,412	8,406	8,491	8,375	8,305	8,255	8,204	8,025	8,055	8,049	8,022
Modoc	3,888	3,827	3,743	3,747	3,845	3,836	3,703	3,706	3,658	3,624	3,661	3,673	3,585
Shasta	64,714	64,742	64,786	65,062	64,124	64,876	63,940	64,314	63,758	63,487	63,606	63,398	63,645
Siskiyou	17,782	17,760	17,739	17,786	17,928	17,691	17,590	17,564	17,409	16,952	17,223	17,176	17,140
Trinity	5,220	5,103	5,169	5,118	5,081	4,955	4,955	5,000	4,962	4,894	4,890	4,787	4,718
Butte	84,665	84,532	84,241	84,407	84,874	84,412	83,486	83,679	83,341	83,296	83,128	83,126	83,098
Colusa	10,152	9,996	9,913	9,968	10,006	10,025	9,825	9,899	9,867	9,617	9,773	9,723	9,713
Glenn	13,687	13,672	13,523	13,497	13,456	13,358	13,182	13,222	13,064	12,859	12,906	12,892	12,806
Nevada	28,464	28,369	28,250	28,148	28,633	28,415	28,427	28,548	28,346	27,583	27,575	27,743	27,755
Placer	61,883	61,676	61,371	61,679	61,561	60,619	59,451	62,164	60,536	60,081	59,681	59,786	60,634
Plumas	5,783	5,616	5,575	5,478	5,429	5,395	5,292	5,270	5,278	5,297	5,255	5,236	5,217
Sierra	825	832	820	810	813	828	823	817	814	805	783	775	790
Sutter	44,471	44,294	43,923	44,223	44,067	43,956	43,584	44,445	43,563	43,174	43,484	43,371	43,024
Tehama	29,626	29,551	29,266	29,219	29,095	29,098	29,019	28,962	28,589	28,254	28,231	28,110	27,961
Yuba	37,606	37,356	36,870	37,275	36,992	35,990	36,027	37,003	35,926	35,787	35,462	35,735	35,669
All Counties Total	**903,386**	**899,540**	**895,711**	**895,697**	**893,365**	**882,789**	**870,940**	**880,210**	**867,895**	**856,609**	**852,994**	**850,073**	**848,890**

Partnership HealthPlan of California
Comparative Financial Indicators Monthly Report
Fiscal Year 2026 - 2027 & Fiscal Year 2025 - 2026

FINANCIAL INDICATORS	Jul-26	Aug-26											YTD	Avg / Month As of Aug-26
Total Enrollment	845,592	845,544											1,691,136	845,568
Total Revenue	574,269,489	588,313,441											1,162,582,930	581,291,465
Total Healthcare Costs	499,787,409	524,805,069											1,024,592,480	512,296,240
Total Administrative Costs	28,646,448	24,876,649											53,523,097	26,761,549
Medi-Cal Hospital & Managed Care Taxes	63,001,807	62,898,992											125,900,799	62,950,400
Total Current Year Surplus (Deficit)	(17,166,175)	(24,267,269)											(41,433,446)	(20,716,723)
Total Claims Payable	616,501,408	541,937,476											541,937,476	579,219,442
Total Fund Balance	1,458,139,229	1,433,871,960											1,433,871,961	1,446,005,595
Reserved Funds														
State Financial Performance Guarantee	1,179,810,000	1,178,447,000											1,178,447,000	1,179,128,500
Board Approved Capital and Infrastructure Purchases	84,955,473	84,193,814											84,193,814	84,574,644
Capital Assets	169,392,254	169,575,129											169,575,129	169,483,692
Strategic Use of Reserve-Board Approved	32,612,668	31,737,668											31,737,668	32,175,168
Unrestricted Fund Balance	(8,631,166)	(30,081,651)											(30,081,651)	(19,356,409)
Fund Balance as % of Reserved Funds	99.41%	97.95%											97.95%	98.68%
Current Ratio (including Required Reserves)	1.47:1	1.45:1											1.45:1	1.46:1
Medical Loss Ratio w/o Tax	97.75%	99.88%											98.83%	98.83%
Admin Ratio w/o Tax	5.60%	4.73%											5.16%	5.16%
Profit Margin Ratio	-3.36%	-4.62%											-4.00%	-4.00%

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	651,579,103	7,210,261,419	600,855,118
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	542,145,317	6,101,492,820	508,457,735
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	28,010,865	311,996,997	25,999,750
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)	18,168,570	17,755,193	1,479,599
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	615,153,264	615,153,264	668,755,805
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	1,475,305,406	1,475,305,406	1,473,313,239
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	1,183,088,000	1,183,088,000	1,179,373,000
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	32,612,668	32,612,668	66,709,751
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)	4,673,854	4,673,854	(31,433,216)
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%	100.32%	100.32%	98.65%
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	1.47:1	1.47:1	1.46:1
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%	92.10%	94.87%	98.09%
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%	4.76%	4.85%	5.02%
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%	3.09%	0.28%	0.29%

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending August 31, 2026

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
845,544	845,592	(48)	**Total Membership**	845,568	907,711	(62,143)

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
588,313,441	594,359,904	(6,046,463)	**Total Revenue**	1,162,582,930	1,186,948,683	(24,365,753)
524,805,069	515,633,077	(9,171,992)	**Total Healthcare Costs**	1,024,592,480	1,030,028,560	5,436,080
24,876,649	31,526,700	6,650,051	**Total Administrative Costs**	53,523,097	65,990,010	12,466,913
62,898,992	61,811,345	(1,087,647)	**Medi-Cal Managed Care Tax**	125,900,799	124,100,432	(1,800,367)
(24,267,269)	**(14,611,218)**	**(9,656,051)**	**Total Current Year Surplus (Deficit)**	**(41,433,446)**	**(33,170,319)**	**(8,263,127)**
99.88%	96.82%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	98.83%	96.91%	
4.73%	5.92%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	5.16%	6.21%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of August 31, 2026

	August 2026	July 2026
A S S E T S		
Current Assets		
Cash & Cash Equivalents	**700,964,460**	**820,774,457**
Receivables		
Accrued Interest	778,700	388,100
State DHS - Cap Rec	2,019,435,841	1,861,297,969
Other Healthcare Receivable	31,747,984	28,723,981
Miscellaneous Receivable	10,214,960	10,173,593
Total Receivables	**2,062,177,485**	**1,900,583,643**
Other Current Assets		
Payroll Clearing	442	5,180
Prepaid Expenses	15,526,401	16,179,596
Total Other Current Assets	**15,526,843**	**16,184,776**
Total Current Assets	**2,778,668,788**	**2,737,542,876**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	1,045,364	1,045,364
Furniture & Fixtures	7,701,728	7,701,728
Computer Equipment	23,160,070	23,160,070
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	46,911,927	46,911,927
Accum Depr - Motor Vehicles	(626,582)	(603,056)
Accum Depr - Furniture	(6,863,878)	(6,844,563)
Accum Depr - Comp Equipment	(20,449,554)	(20,301,245)
Accum Depr - Comp Software	(9,033,277)	(9,031,864)
Accum Depr - Leasehold Improvements	(124,288)	(124,288)
Accum Depr - Building	(16,587,592)	(16,417,774)
Accum Depr - Bldg Improvements	(19,316,306)	(19,099,904)
Construction Work-In-Progress	63,767,647	63,005,988
Total Fixed Assets	**169,575,130**	**169,392,254**
Other Non-Current Assets		
Board-Designated Reserves	1,262,340,814	1,264,465,473
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	8,275,475	8,275,475
Net Pension Asset	8,186,907	8,186,907
Deferred Outflows Of Resources	2,500,051	2,500,051
Net Subscription Asset	18,998,626	18,998,626
Total Other Non-Current Assets	**1,300,615,561**	**1,302,726,532**
Total Non-Current Assets	**1,470,190,691**	**1,472,118,786**
Total Assets	**4,248,859,479**	**4,209,661,662**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of August 31, 2026

	August 2026	July 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	345,081,539	285,155,516
Unearned Income	37,380,380	38,334,893
Suspense Account	11,025,275	10,122,077
Capitation Payable	11,234,628	10,354,452
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	1,731,752,506	1,663,143,497
Claims Payable	163,097,116	228,952,653
Incurred But Not Reported-IBNR	378,840,360	387,548,755
Quality Improvement Programs	72,807,099	64,141,974
Total Current Liabilities	**2,783,852,016**	**2,720,386,930**
Non-Current Liabilities		
Deferred Inflows Of Resources	12,579,067	12,579,067
Net Subscription Liability	18,556,435	18,556,435
Total Non-Current Liabilities	**31,135,502**	**31,135,502**
Total Liabilities	**2,814,987,518**	**2,751,522,432**
Fund Balance		
Unrestricted Fund Balance	**(30,081,651)**	**(8,631,166)**
Reserved Funds		
State Financial Performance Guarantee	1,178,447,000	1,179,810,000
Board Approved Capital and Infrastructure Purchases	84,193,814	84,955,473
Capital Assets	169,575,129	169,392,254
Strategic Use of Reserve-Board Approved	31,737,668	32,612,668
Total Reserved Funds	**1,463,953,611**	**1,466,770,395**
Total Fund Balance	**1,433,871,961**	**1,458,139,230**
Total Liabilities And Fund Balance	**4,248,859,479**	**4,209,661,662**

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

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Services	491,950,118	983,978,687
Other Revenues	161,557	610,403
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(18,942,183)	(41,292,219)
Medical Claims Payments	(497,405,944)	(893,221,730)
Drug Medi-Cal		
DMC Receipts from Counties	4,066,352	8,911,531
DMC Payments to Providers	(6,471,243)	(10,803,958)
Cash Payments to Vendors	(79,095,872)	(273,644,486)
Cash Payments to Employees	(21,420,286)	(43,275,613)
Net Cash (Used) by Operating Activities	**(127,157,501)**	**(268,737,385)**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(780,206)	(2,305,223)
Net Cash (Used) by Capital Financial & Related Activities	**(780,206)**	**(2,305,223)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	2,124,659	6,635,981
Interest and Dividends on Investments	6,003,051	13,404,484
Net Cash Provided by Investing Activities	**8,127,710**	**20,040,465**
NET (DECREASE) IN CASH & CASH EQUIVALENTS	**(119,809,997)**	**(251,002,143)**
CASH & CASH EQUIVALENTS, BEGINNING	**820,774,457**	**951,966,603**
CASH & CASH EQUIVALENTS, ENDING	**700,964,460**	**700,964,460**
RECONCILIATION OF TOTAL OPERATING LOSSTO NET CASH (USED) BY OPERATING ACTIVITIES		
TOTAL OPERATING LOSS	**(30,660,920)**	**(54,901,829)**
DEPRECIATION	**578,784**	**1,161,940**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(3,065,370)	(13,891,553)
California Department of Health Services Receivable	(158,137,872)	(232,627,066)
Other Assets	662,792	(430,759)
Accounts Payable and Accrued Expenses	129,363,893	87,838,336
Accrued Claims Payable	(74,563,933)	(73,215,788)
Quality Improvement Programs	8,665,125	17,329,334

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

For The Period Ending August 31, 2026

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

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	ACTUAL MONTH PMPM	BUDGET MONTH PMPM		ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD	ACTUAL YTD PMPM	BUDGET YTD PMPM
845,544	**845,544**	**-**			**TOTAL MEMBERSHIP**	**1,691,136**	**1,691,136**	**-**		
					REVENUE					
580,762,434	587,894,894	(7,132,460)	686.85	695.29	State Capitation Revenue	1,147,280,514	1,174,026,773	(26,746,259)	678.41	694.22
6,393,651	6,242,470	151,181	7.56	7.38	Interest Income	13,468,384	12,484,940	983,444	7.96	7.38
1,157,356	222,540	934,816	1.37	0.26	Other Revenue	1,834,032	436,970	1,397,062	1.08	0.26
588,313,441	**594,359,904**	**(6,046,463)**	**695.78**	**702.94**	**TOTAL REVENUE**	**1,162,582,930**	**1,186,948,683**	**(24,365,753)**	**687.46**	**701.86**
					HEALTHCARE COSTS					
					Physician Services					
9,026,138	9,478,039	451,901	10.67	11.21	Pcp Capitation	18,076,367	18,945,102	868,735	10.69	11.20
194,662	203,631	8,969	0.23	0.24	Specialty Capitation	389,899	405,273	15,374	0.23	0.24
101,870,632	85,025,812	(16,844,820)	120.48	100.56	Non-Capitated Physician Services	191,901,467	168,864,604	(23,036,863)	113.47	99.85
111,091,432	**94,707,482**	**(16,383,950)**	**131.38**	**112.01**	**Total Physician Services**	**210,367,733**	**188,214,979**	**(22,152,754)**	**124.39**	**111.29**
					Inpatient Hospital					
15,999,505	16,680,724	681,219	18.92	19.73	Hospital Capitation	31,999,850	33,398,555	1,398,705	18.92	19.75
111,163,493	107,737,157	(3,426,336)	131.47	127.42	Inpatient Hospital - Ffs	218,799,832	215,548,061	(3,251,771)	129.38	127.46
1,003,973	1,003,973	-	1.19	1.19	Hospital Stoploss	1,712,533	1,712,533	-	1.01	1.01
128,166,971	**125,421,854**	**(2,745,117)**	**151.58**	**148.34**	**Total Inpatient Hospital**	**252,512,215**	**250,659,149**	**(1,853,066)**	**149.31**	**148.22**
60,778,482	63,792,756	3,014,274	71.88	75.45	Long Term Care	120,471,445	127,048,644	6,577,199	71.24	75.13
					Ancillary Services					
1,239,843	1,305,085	65,242	1.47	1.54	Ancillary Services - Capitated	2,470,493	2,609,429	138,936	1.46	1.54
120,324,982	99,787,475	(20,537,507)	142.30	118.02	Ancillary Services - Non-Capitated	227,819,631	199,525,001	(28,294,630)	134.71	117.98
121,564,825	**101,092,560**	**(20,472,265)**	**143.77**	**119.56**	**Total Ancillary Services**	**230,290,124**	**202,134,430**	**(28,155,694)**	**136.17**	**119.52**
					Other Medical					
5,744,875	7,912,360	2,167,485	6.79	9.36	Quality Assurance	12,043,764	16,578,270	4,534,506	7.12	9.80
73,546,996	101,494,966	27,947,970	86.98	120.04	Healthcare Investment Funds	153,392,012	202,983,061	49,591,049	90.70	120.03
120,899	125,520	4,621	0.14	0.15	Advice Nurse	241,556	262,990	21,434	0.14	0.16
15,125,464	12,420,454	(2,705,010)	17.89	14.69	Transportation	27,944,297	24,817,703	(3,126,594)	16.52	14.68
94,538,234	**121,953,300**	**27,415,066**	**111.80**	**144.24**	**Total Other Medical**	**193,621,629**	**244,642,024**	**51,020,395**	**114.48**	**144.67**
8,665,125	8,665,125	-	10.25	10.25	Quality Improvement Programs	17,329,334	17,329,334	-	10.25	10.25
524,805,069	**515,633,077**	**(9,171,992)**	**620.66**	**609.85**	**TOTAL HEALTHCARE COSTS**	**1,024,592,480**	**1,030,028,560**	**5,436,080**	**605.84**	**609.08**
					ADMINISTRATIVE COSTS					
16,428,852	20,731,320	4,302,468	19.43	24.52	Employee	34,568,295	43,437,050	8,868,755	20.44	25.69
66,197	243,230	177,033	0.08	0.29	Travel And Meals	126,283	509,670	383,387	0.07	0.30
1,185,177	2,028,720	843,543	1.40	2.40	Occupancy	2,592,562	4,184,590	1,592,028	1.53	2.47
980,917	1,002,550	21,633	1.16	1.19	Operational	1,337,282	2,100,590	763,308	0.79	1.24
2,704,686	3,177,370	472,684	3.20	3.76	Professional Services	6,785,727	6,657,440	(128,287)	4.01	3.94
3,510,820	4,343,510	832,690	4.15	5.14	Computer And Data	8,112,948	9,100,670	987,722	4.80	5.38
24,876,649	**31,526,700**	**6,650,051**	**29.42**	**37.30**	**TOTAL ADMINISTRATIVE COSTS**	**53,523,097**	**65,990,010**	**12,466,913**	**31.64**	**39.02**
62,898,992	61,811,345	(1,087,647)	74.39	73.10	**Medi-Cal Managed Care Tax**	125,900,799	124,100,432	(1,800,367)	74.45	73.38
(24,267,269)	**(14,611,218)**	**(9,656,051)**	**(28.69)**	**(17.31)**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**(41,433,446)**	**(33,170,319)**	**(8,263,127)**	**(24.47)**	**(19.62)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
August 31, 2026

1. ORGANIZATION

The Partnership HealthPlan of California (the HealthPlan) was formed as a health insurance organization and is legally a subdivision of the State of California but is not part of any city, county or state government system. The HealthPlan has quasi-independent political jurisdiction to contract with the State for managing Medi-Cal beneficiaries who reside in various Northern California counties. The HealthPlan is a combined public and private effort engaged principally in providing a more cost-effective method of healthcare. The HealthPlan began serving Medi-Cal eligible persons in Solano County in May 1994. That was followed by 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 August 2026, the HealthPlan has Total Reserved Funds of $1.5 billion. This includes $31.7 million of funds set aside for Board approved Strategic Use of Reserve (SUR) initiatives. 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 August 2026, the HealthPlan has accrued a Quality Improvement Program payout of $72.8 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

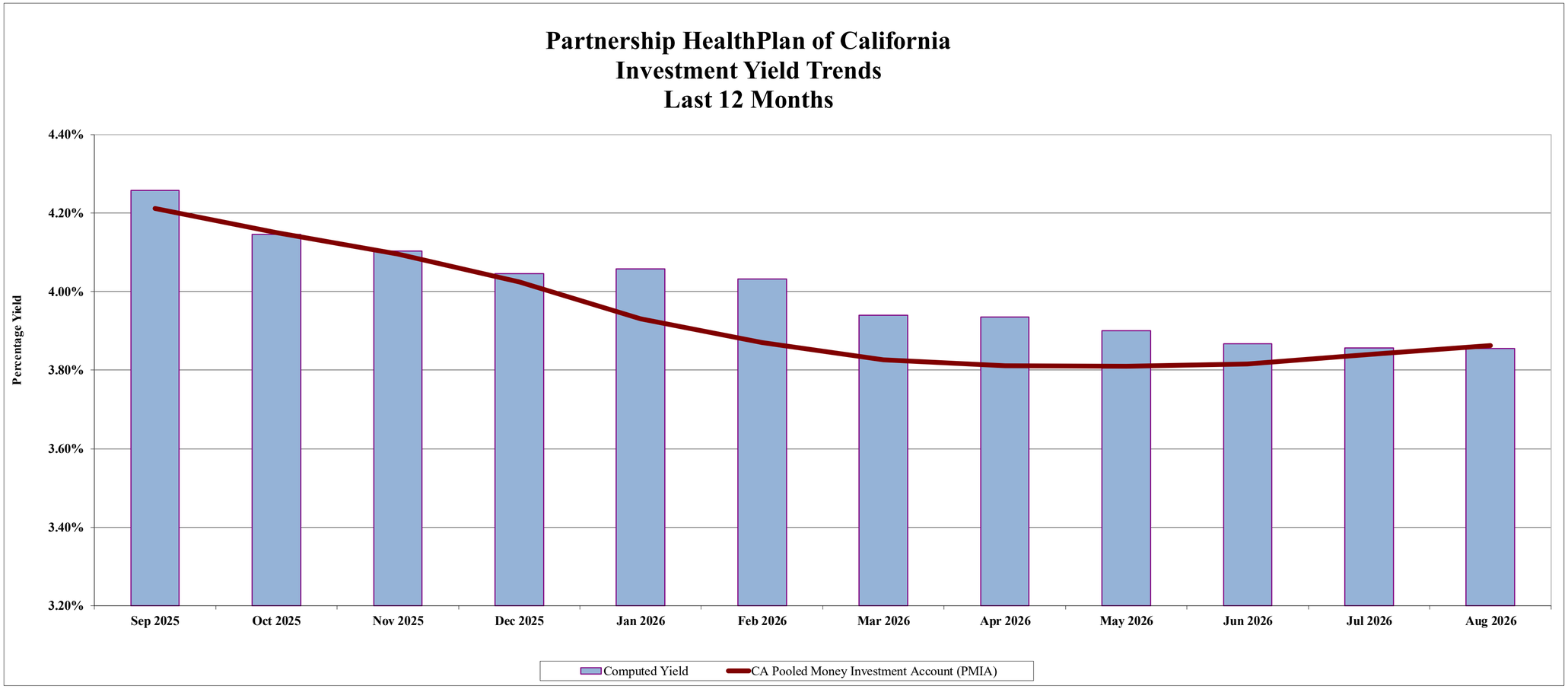
None noted.

Partnership HealthPlan of California
Investment Schedule
August 31, 2026

Name of Investment	Investment Type	Yield to Maturity	Trade Date	Maturity Date	Call Date	Face Value	Purchase Price	Market Value	Credit Rating Agency	Credit Rating
FUNDS HELD FOR INVESTMENT:										
Highmark Money Market	Cash & Cash Equiv	NA	Various	NA	NA	NA	$ 1,856,259	$ 1,856,259	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	$ 82,305,880		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 1,037,435		
US Bank - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 1,755,899,676		
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	$ 148,094		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:								$ 1,963,605,275		

Partnership HealthPlan of California
Investment Yield Trends

PERIOD		Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026
Interest Income		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	7,074,733	6,393,651
Cash & Investments at Historical Cost	(1)	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	2,085,539,930	1,963,605,275
Computed Yield	(2)	4.26%	4.15%	4.10%	4.05%	4.06%	4.03%	3.94%	3.94%	3.90%	3.87%	3.86%	3.86%
CA Pooled Money Investment Account (PMIA)	(3)	4.21%	4.15%	4.10%	4.03%	3.93%	3.87%	3.83%	3.81%	3.81%	3.82%	3.84%	3.86%



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.

Despite a consistent decline in membership, medical service utilization has increased. Primary care visits and transportation services have trended upward for several consecutive quarters, and referrals to specialists have also increased.

Operational Priorities

During the past quarter, the Operations team focused heavily on:

- Preparation and contingency planning for upcoming Medi-Cal eligibility and enrollment changes.
- Building the provider network in preparation for the 2028 D-SNP implementation.
- Preparing and educating providers for the implementation of the new claims system.
- Conducting extensive outreach to members and providers, which will continue through the beginning of the new year.

Provider education sessions have addressed what providers should expect beginning January 1, particularly regarding changes affecting their Medi-Cal patients.

Medi-Cal Eligibility and Enrollment Changes

The organization continues to focus on increasing access for Medi-Cal members through network growth and ongoing communication regarding updates from DHCS, including information related to the UIS population and general eligibility requirements.

In partnership with internal teams, Operations has supported the interpretation and communication of these changes and developed strategies to assist affected members. Outreach has encouraged members to respond promptly to renewal requests, with assistance available for form completion and follow-up.

Special attention has been given to providers treating members of the UIS population. Providers have been encouraged to continue caring for these members after their transition to FFS Medi-Cal. Provider Representatives have provided guidance on verifying FFS coverage and submitting claims for eligible services.

Efforts to communicate the anticipated impact of these changes and recommended approaches for supporting affected members are ongoing.

Member Outreach and Education

Member outreach has continued through targeted education campaigns and direct mailings designed to increase awareness and understanding of eligibility and enrollment requirements.

Member Services has also initiated quarterly, in-person new-member education sessions to help members better understand their benefits, available services, and ongoing responsibilities.

Provider Network Development

In preparation for the 2028 D-SNP implementation, the Contracting team has made significant progress toward eliminating provider network gaps. Recruitment efforts include outreach to new providers, including out-of-state providers located near county borders.

Key challenges include provider concerns regarding the PAVE and Medi-Cal certification requirements, which can be lengthy and administratively burdensome. Rate negotiations have become a secondary obstacle after the certification requirements.

Claims System Implementation

In-person and virtual education sessions regarding the upcoming claims system upgrade are continuing. Sessions are being offered through both group presentations and individual provider meetings, based on provider preference.

These efforts are intended to ensure that providers understand the system changes, operational expectations, and resources available to support a successful transition.

News Updates
October 2026

Partnership Press Releases:

Partnership's 2026 CalAIM Make a Difference Awards Honor Leaders in Whole-Person Care
Partnership HealthPlan of California
October 15, 2026
Partnership HealthPlan of California, one of the state's largest Medi-Cal managed care plans, announced the winners of the 2026 CalAIM Make a Difference Awards, recognizing organizations for their leadership and commitment to improving care for Medi-Cal members through CalAIM.

Partnership HealthPlan of California Notice of Data Breach
Partnership HealthPlan of California
September 4, 2026
Partnership HealthPlan of California recently experienced a privacy incident that affected the personal information of a small portion of its members.

Your Partner in Health: Make Sleep the Most Productive Part of Your Day
Partnership HealthPlan of California – Matthew Morris, M.D.
September 1, 2026
It may seem strange to use "sleep" and "productive" in the same sentence.

Partnership's Foster Care Model Featured in New Study
Partnership HealthPlan of California
August 10, 2026
Partnership HealthPlan of California's innovative regional approach to providing healthcare access to 15,000 youth involved in the child welfare system was featured in a recent Public Works Alliance study.

Partnership Mentioned:

County shifts $1 million in transportation funds for paratransit services
Daily Republic
October 7, 2026
A significant portion of these costs will be offset by funds currently budgeted and used to purchase administrative services for the DMC-ODS through Partnership.

'An inclusive space': Play Street in Eureka is now offering weekly 'Community Nights' for local families
Times Standard
September 27, 2026
"Fortunately, Medi-Cal/Partnership health insurances started covering doula services in 2023 and we are able to serve a much larger population in our community," she said.

OLE Health Foundation celebrates 40 years, looks ahead

Napa Valley Register
September 23, 2026
Locally, the Calistoga and St. Helena health centers meet 100% and 91%, respectively, of targets established by Partnership HealthPlan of California.

Grant helps outpatient Redding addiction center reopen doors

Record Searchlight
September 17, 2026
Since its modest beginning as an ad hoc effort to help alcoholics that was established in the former Old Crow Bar in south Redding, Empire has grown into a respected and well-known treatment program that largely services people covered by Partnership HealthPlan of California.

Medi-Cal won't pay for assisted living in most of California. One brother fought back

Lake County News
September 9, 2026
Partnership HealthPlan, which Roselie Aiello is enrolled in, contracts with the state to provide coverage to almost a million Californians on Medi-Cal, making it the largest Medi-Cal managed care plan in Northern California.

Your partner in health: Make sleep the most productive part of your day

The Union
September 8, 2026
Dr. Matthew Morris, Medical Director at Partnership HealthPlan of California, provides readers with habits and tips you can practice today to get a better night's sleep, which is an essential part of staying in good health for both the short and long-term.

Partnership HealthPlan breach exposed member personal data

Record Searchlight *(also reported in the Davis Enterprise and Mountain Messenger)*
September 4, 2026
Partnership HealthPlan of California recently experienced a data breach affecting the personal information of more than 1,500 people, the company announced on Friday, Sept. 4.

Supervisors hear about transition of county's delivery of Medi-Cal program

Daily Republic
September 2, 2026
The Solano County Board of Supervisors wrapped Tuesday's meeting with a presentation on the transition of Solano County's Drug Medi-Cal Organized Delivery System from the Partnership HealthPlan of California regional model to Solano County Behavioral Health administration.

Supervisors to hear update on substance abuse treatment program changes

The Vacaville Reporter
August 31, 2026
Since 2019, Partnership HealthPlan of California has administered the program for Solano County and other counties through a regional system.

Solano County transitioning as substance use program administrator

Daily Republic

August 30, 2026

Partnership HealthPlan of California has headed the program since 2019, but notified the county it was ending that role at the end of 2026.

CMA medical group symposium examines a sustainable path to health care affordability

California Medical Association

August 28, 2026

Kermit Jones, M.D., J.D., of Partnership HealthPlan of California, asked how Xavier Becerra's pledge to be California's "health care governor" would translate into policies that strengthen medical groups and physician practices and improve access to care.

Diaper Giveaway, Resource Fair set for Saturday

Daily Republic

August 25, 2026

Other agencies involved are the Solano County Office of Education, Fairfield-Suisun Unified School District, First 5 Solano, Partnership HealthPlan of California, Solano County WIC, county Black Infant Health Program, Optimum Wellness Group Inc., Solano HEALS, Child Start Inc., the Office of Assemblywoman Lori Wilson, CommuniCare+OLE and Kaiser Permanente.

Partnership's Foster Care Model Featured in New Study

Dixon Independent Voice

August 18, 2026

Partnership HealthPlan of California's innovative regional approach to providing healthcare access to 15,000 youth involved in the child welfare system was featured in a recent Public Works Alliance study.

Katherine Barresi, RN, BSN, PHN, NE-BC, CCM
Chief Health Services Officer

Care Coordination

Care Coordination Support to Members

In Q3 2026, The Case Management and Care Coordination department supported 29,306 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. This case volume reflects a 15% decrease from Q2 2026 and the department remains diligent in monitoring these trends as DHCS policy and Partnership membership changes.

An area of strength noted in program performance this quarter was the continued strong case management, care coordination and high-quality clinical support provided to members enrolled in the Complex Case Management program. The program, which members can opt-in/opt-out at any time, addresses the unique needs for members with multiple chronic conditions, medications, providers, social and/or behavioral health needs. Registered Nurses, Social Workers and Health Care Guides work as a multi-disciplinary team with the member to develop an individualized care plan with the member identifying and prioritizing goals they want to work on. Through motivational interviewing and high-touch efforts, Partnership staff work to coordinate care and improve health outcomes. The CCM program is audited by NCQA as part of Partnership's Health Plan Accreditation requirements, and outcomes for participants in the program are analyzed and reported as part of the health plan's Population Health Management Program Evaluation for both DHCS and NCQA.

Spotlight: Strengthening Partnerships to Improve Member Outcomes

Care Coordination is committed to ensuring that all partnerships deliver measurable value and improved outcomes for members. Over the past several months, the department has strengthened its oversight of the Adobe House Visiting Program by implementing standardized performance measures and routine reporting to better evaluate member engagement, service delivery, and outcomes. Through this collaborative effort, Adobe now provides key data on outreach and engagement rates, member retention, satisfaction, demographics, diagnoses, and individualized plans of care. These metrics provide greater transparency into services being delivered and allow Care Coordination to assess the program's impact on member health, care coordination, and prevention of avoidable hospital utilization. While there are opportunities to increase enrollment and program capacity, Care Coordination's focus on data, performance monitoring, and outcome-driven decision-making ensures

that services remain aligned with Partnership's commitment to delivering high-quality, member-centered care.

Utilization Management

Treatment Authorization Request (TAR) Volumes & Timeliness

Q3 2026 TAR Volumes

- Acute Inpatient: 16,397
- Outpatient: 49,439
- LTSS: 5,300
- **Total Quarter Volume:** 71,136 (average of ~23,700 per month)

Q3 2026 Timeliness Performance

- Acute Inpatient: 99.94% average timely completion
- Outpatient: 97.56% average timely completion
- LTSS: 98.22% average timely completion

Preparing for Interoperability Prior Authorization Requirements

The Utilization Management (UM) Department continues to advance preparations for upcoming Interoperability and electronic Prior Authorization requirements for Partnership HealthPlan pursuant to CMS-0057-F and DHCS APL 26-008. Key efforts include evaluating current authorization workflows, identifying necessary system requirements, evaluating resource needs, and collaborating with IT and Compliance on the initial phases of the project. These early, readiness activities are focused on the Prior Authorization component of Interoperability which aims to improve transparency, streamline authorization processes, reduce the administrative burden for providers, and ensure timely access to medically necessary services for members. Successful implementation of the Interoperability Prior Authorization requirements are dependent on several enterprise technology initiatives, including the deployment of the JIVA care management and utilization management platform and alignment with HealthRules Payor (HRP) functionality to support interoperable prior authorization workflows. As implementation planning continues, UM remains committed to regulatory compliance and operational excellence as implementation planning continues.

Health Services Board Report

October 28, 2026

Behavioral Health & Youth Services

Behavioral Health Call Center Performance & Quality

The Behavioral Health Access team continues to demonstrate strong performance in connecting members to appropriate mental health services. In addition to managing inbound member inquiries, the team conducts proactive outreach to members recently discharged from the Emergency Department for behavioral health conditions. These efforts support Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Hospitalization for Mental Illness (FUH) quality measures, while promoting timely access to appropriate behavioral health care. The call center activity data below reflects the department's ongoing commitment to high-quality service, care coordination, and improved health outcomes for Partnership members.

BH Access Calls: Q3 2026 (July 1, 2026 – Sept 30, 2026)

- 7,895 inbound calls were answered; this is a 23% increase in inbound call volume from Q1 2026.
- 29,931 outbound calls were conducted; this is a 44% increase in outbound call volume from Q1 2026.
  - The majority of the outbound calls represent the department's work in the FUA/FUM measures; following members who have been seen in the ED for BH condition.

Call Center Service Levels

	Speed to Answer	Service Levels	% of Abandoned Calls
August '26	.06 seconds	92.09%	0.86%
September '26	.06 seconds	92.67%	0.90%

Enhanced Health Services

CalAIM Awards

Partnership HealthPlan of California recently recognized outstanding Community Supports and Enhanced Care Management (ECM) providers through the 2026 CalAIM Making a Difference Awards. These awards celebrate provider organizations that have demonstrated exceptional commitment to advancing the goals of CalAIM by improving access to whole-person care, housing stability, care coordination, and community-based services for our members. Award recipients and

honorable mentions were recognized across multiple service categories, including Housing Supports, Personal Care and Respite Services, Recuperative Care, Medically Tailored Meals, and Enhanced Care Management for youth, adults, and justice-involved populations. Honorees were selected based on their demonstrated impact on member outcomes, operational excellence, collaborative partnerships, and commitment to addressing the social determinants of health. On Oct 8th and October 13th we recognized these outstanding providers with award ceremonies in Redding and Fairfield. Collectively, Partnership awarded a total of $152,500 to these providers who have made such a difference for our members and communities. Together, these providers exemplify the strength of our community-based network and the transformative potential of CalAIM. Their dedication helps Partnership members achieve greater housing stability, improved health outcomes, stronger community connections, and more equitable access to care in our communities.

Transitional Rent Update

Partnership remains committed to expanding access to Transitional Rent (TR) services across its service area and has made significant progress in strengthening provider network capacity. On August 24th, the Department of Health Care Services (DHCS) issued Partnership a Corrective Action Plan (CAP) due to insufficient contracted TR provider coverage in 12 of Partnership's 24 counties. Since receiving the CAP, the Enhanced Health Services (EHS) team has engaged in proactive outreach and partnership development activities with housing and community-based providers throughout the region. The team has provided DHCS with monthly progress updates, and has worked closely with county and community partners to accelerate network development. As a result of these efforts, Partnership has made substantial progress and now has signed Transitional Rent provider agreements in 18 of its 24 counties. EHS and Health Services leadership continue to actively engage county Behavioral Health (BH), Health and Human Services (HHS), housing leaders, and prospective network providers in the remaining six counties. Partnership is encouraged by the strong collaboration occurring at the local level and remains confident in its ability to continue expanding provider participation and successfully satisfy CAP requirements. Leadership will maintain close oversight of implementation activities and ongoing communications with DHCS as efforts continue toward full county-level coverage and closure of the corrective action plan.

Health Equity

Update: Provider C.A.R.E.S. Training

Partnership continues to advance provider workforce development and training through our C.A.R.E.S. training program. This provider training program covers a variety of topics geared at

supporting high-quality care and interactions with members through tailored learning that address topics such as Gender, Race and Ethnicity, Religion, Disability, Veterans and even trauma-informed care. This training is offered to both new providers and providers going through re-credentialing at Partnership. As part of the organization-wide support for this program, the Health Equity department plays a critical role in monitoring provider compliance and completion rates in completing trainings. The CARES program is more than a compliance activity – it reaffirms Partnership's commitment to high-quality, equitable care to all members in the communities we serve.