Board of Commissioners Meeting Agenda

Via Webex

October 26, 2022: 10:00 a.m. – 1:30 p.m.

In-person Locations:

PHC's Southeast Region Office located at 4605 Business Center Drive, Fairfield, CA

PHC's Northeast Region Office located at 2525 Airpark Dr., Redding, CA

****** As signed by the Governor on September 16, AB361, allows for Brown Act teleconferencing flexibilities during states of emergency ******

AB361 authorizes public meetings with Brown Act requirements to be held via teleconference or telephone. It waives the Brown Act requirement for physical presence at the meeting for members, the clerk, and/ or other personnel of the body as a condition of participation for a quorum.

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Public Participation

The PHC Board of Commissioners meeting may be accessed through Webex:
https://partnershiphp.webex.com/meet/boardmeeting

Participant Pin: 803 736 976

Toll Free Number: 1-844-621-3956

Public comment is welcome during designated "Public Comments" time frames or by emailing comments to the Board Clerk at Board_FinanceClerk@partnershiphp.org by 5:00p.m on October 25, 2022. Comments received will be read during the meeting.

10:00A.M – Opening			
1.1 **Call to Order**			*Alicia Hardy, Chair*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION***: Resolution to Approve the New Board Member Appointment of Ranell Brown	4-5	*Liz Gibboney*
1.4	***ACTION***: Resolution to Approve the New Board Member Appointment of Nolan Sullivan	6-7	*Liz Gibboney*
1.5	***ACTION:*** Approval of Agenda and Board Meeting Minutes for August 24, 2022	8-15	*Chair*
1.6 **Commissioner Comment**			*Chair*
1.7 **Public Comment & Correspondence**			*Clerk*
1.8	***INFORMATION:*** **CEO Report**	16-17	*Liz Gibboney*

10:30A.M. – Consent Calendar			
2 & 3	***ACTION:*** Consent Calendar and Finance Committee Ratification ▪ **2.1** Resolution to Ratify Finance Committee's Approval of the Q2-2022 Compliance Dashboard ▪ **3.1** Resolution to Accept all PHC Committee Minutes, Department Operating Report, and PHC Policies, Program Descriptions, and PCP QIP Changes Approved by PAC. ▪ **3.2** Resolution to Approve the Quality and Performance Improvement Program Description, Work Plan, and Evaluation. QI 2022-2023 Work Plan QI 2021-2022 Work Plan QI Program Description (Clean) QI Program Description (Redline) QI Program Evaluation ▪ **3.3** Resolution to Approve the 2023 Primary Care Provider Quality Improvement Program (PCPQIP) Measurement Set as Approved by PAC. ▪ **3.4** Resolution to Approve the 2023 Proposed Measure Changes for Long Term Care Quality Improvement Program (LTCQIP) as Approved by PAC. ▪ **3.5** Resolution to Approve Commendations and Appreciation for Erik McLaughlin's Service to PHC ▪ **3.6** Resolution to Approve Findings That, as a Result of the Continuing COVID-19 Pandemic State of Emergency, Meeting in Person Would Present Imminent Risks to the Health or Safety of Attendees	18-20 21-23 24-25 26-30 31-35 36-75 38-39	*Liz Gibboney*

Operational Reports PAC Approved Policy Updates Finance Committee – September 2022 Finance Committee – October 2022 Physician Advisory Committee for September 2022 Physician Advisory Committee for October 2022 Quality and Utilization Advisory Committee (Q/UAC) – September 2022 Quality and Utilization Advisory Committee (Q/UAC) – October 2022 Northern Region Consumer Advisory Committee – September 2022 Southern Region Consumer Advisory Committee – September 2022			
10:40A.M. – Regular Agenda Items			
4.1	***ACTION:*** Resolution to Accept the Moss Adams Audit Report for FY 2021-2022; This resolution accepts the audit report completed by Moss Adams on PHC's financial statements for the period July 1, 2021 to June 30, 2022.	40-104	*Moss Adams Auditors: Rianne Suico and Chris Pritchard*
11:10A.M. – Reports			
5.1	***INFORMATION:*** Metrics and Financial Update	105-118	*Patti McFarland/ Jeff Ingram*
5.2	***INFORMATION:*** Operations Update	119-124	*Sonja Bjork*
5.3	***INFORMATION:*** Legislative & Media Update	125-126	*Written Report*
11:40A.M – Education Sessions			
6.1	***INFORMATION:*** Quality and Pharmacy Update		*Dr. Moore / Nancy Steffen*
6.2	***INFORMATION:*** Northern Region Update		*Wendi West*
6.3	***INFORMATION:*** Provider Relations Update		*Mary Kerlin*
12:30 P.M. – Adjournment			

Upcoming Meetings:

12/07/2022 – PHC's Santa Rosa Office
02/22/2023 – Strategic Planning Retreat (location is TBD)
04/26/2023 – PHC's Fairfield Office

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
1.3

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Del Norte County Board of Supervisors

Topic Description:
On April 26, 2022, Ranell Brown, Director of Department of Health at Del Norte County was appointed by the Del Norte County Board of Supervisors to the Partnership HealthPlan of California (PHC) Commission (known as the Board) to replace Heather Snow.

Ranell Brown's appointment commences on October 26, 2022 and concludes October 25, 2026.

Reason for Resolution:
To obtain Board approval to appoint Ranell Brown to the PHC Board as a Del Norte County Representative.

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

Requested Action of the Board:
Based on the recommendation of the Del Norte County Board of Supervisors, the Board is asked to approve the new appointment of Ranell Brown to the PHC Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
1.3

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE NEW DEL NORTE COUNTY APPOINTMENT FOR RANELL BROWN TO THE PHC BOARD

Recital: Whereas,

A. Certain agencies have responsibility for appointing Board members.

B. Del Norte County has a vacant seat.

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

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Del Norte County appointment of Ranell Brown to the PHC Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of October 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
1.4

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Yolo County Board of Supervisors

Topic Description:
On August 30, 2022, Nolan Sullivan, Director of the Yolo County Health and Human Services Agency was appointed by the Yolo County Board of Supervisors to the Partnership HealthPlan of California (PHC) Commission (known as the Board) to replace Karen Larsen.

Nolan Sullivan's appointment commences on October 26, 2022 and concludes October 25, 2026.

Reason for Resolution:
To obtain Board approval to appoint Nolan Sullivan to the PHC Board as a Yolo County Representative.

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, the Board is asked to approve the new appointment of Nolan Sullivan to the PHC Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
1.4

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE NEW YOLO COUNTY APPOINTMENT FOR NOLAN SULLIVAN TO THE PHC BOARD

Recital: Whereas,

A. Certain agencies have responsibility for appointing Board members.

B. Yolo County has a vacant seat.

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

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Yolo County appointment of Nolan Sullivan to the PHC Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of October 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

MINUTES OF THE MEETING OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC) BOARD OF COMMISSIONERS
Meeting held via Webex
In person locations:
PHC's Southeast Office located at 4665 Business Center Drive, Fairfield
PHC's Northeast Office located at 2525 Airpark, Redding
On
August 24, 2022

Members Present: Darcie Antle, Mary Kay Brooks, Lewis Broschard, M.D., Paula Cohen, Dean Germano, Greta Elliott, Liz Hamilton, Alicia Hardy (Chair), Randall Hempling, Gerald Huber, Dave Jones, Liz Lara O'Rourke, Wendy Longwell, Viola Lujan, Melissa Marshall, M.D., Benita McLarin, Mitesh Popat, M.D. Kim Tangermann Nancy Starck, Keri Thomas, Jennifer Yasumoto.
Members Absent: None
Members Excused:, Gena Bravo, Laura Burch, Cathryn Couch, Kathryn Powell, Tory Starr
Staff: Amy Agle, Sonja Bjork, Rebecca Boyd-Anderson, Katherine Barresi, Mark Bontrager, Dell Coats, Marissa Dominguez, Kim Fillette, Patty Hayes, Matt Hintereder, Peggy Hoover, Jeff Ingram, Kirt Kemp, Mary Kerlin, Vicky Klakken, Marshall Kubota M.D., John Lemoine, Regina Littlefield, Dustin Lyda, Lisa Malvo, Melissa McCartney, Patti McFarland, Robert Moore M.D., Lisa O'Connell, Jose Puga, Kathryn Power, Jeff Ribbordym Nikki Rotherham, Jing Sancho, Lynn Scuri, Nancy Steffen, Colleen Valenti, Wendi West, Liz Gibboney, CEO and Ashlyn Scott, Board Clerk
Guests: Irene Baluyut, Vivian Belmusto, Elisabeth Chicoine, Joanna Ekstrom, Steven Ghidinelli, Lance LeClair, Luisa Ramirez, Stephanie Tarter

AGENDA ITEM	DISCUSSION	MOTION / ACTION
1.0 Opening	Commissioner Alicia Hardy, Board Chair, called the bi-monthly meeting to order via Webex video conference and welcomed everyone to the meeting. Board members and attendees were informed that California bill AB 361, which relates to social distancing measures being taken for COVID-19, waives the Brown Act requirement for physical presence at the meeting for members, the clerk and/ or other personnel of the body as a condition of participation for a quorum. 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 Hardy read the PHC Mission Statement: "to help our members, and the communities we serve, be healthy." She also mentioned that guests 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 Resolution to Approve the New Board Member Appointment of Liz Lara-O'Rourke	Ms. Gibboney introduced Liz Lara-O'Rourke, whom the Humboldt county of Supervisors appointed as the Health Center Representative for Humboldt County on the PHC Board. Ms. Lara-O'Rourke expressed her excitement to join the PHC Board and added that she has been a lifelong Humboldt resident and has been with United Indian Health Services (UIHS) for twenty-five years, serving in several capacities.	*Commissioner Starck moved to approve resolution 1.3 as presented, seconded by Commissioner Marshall.* ***ACTION SUMMARY:*** Yes: 20 No: 0 Abstention: 0 Excused: 5 (Bravo, Burch, Couch, Powell, Starr) Absent: 0 **MOTION CARRIED**
1.4 Resolution to Approve Primary Care Provider Quality Incentive Program (PCP QIP) Highest Performers	Ms. Gibboney and Dr. Moore recognized the following fifteen providers who scored 90% or higher in PHC's Primary Care Provider Quality Incentive Program in 2021: **Provider Site Name** 1. Sonoma Plaza Pediatrics Medical Group Cueto 2. Annadel Medical Group, Rohnert Park 3. Marin Community Clinics, Greenbrae 4. Annadel Medical Group - 71594 5. Davis Community Clinic 6. Shasta Family Care 7. NorthBay Center for Primary Care, Vacaville 8. NorthBay Center for Primary Care, Hilborn Rd. 9. SRCH Pediatric Campus 10. NorthBay Center for Primary Care, Green Valley 11. Petaluma Health Center 12. Rohnert Park Health Center 13. SRCH Elsie Allen Campus 14. Alexander Valley Healthcare 15. West Marin Medical Center The providers were acknowledged for their hard work and resilience, during another difficult year. Representatives from each provider virtually accepted their awards.	*Commissioner Starck moved to approve resolution 1.4 as presented, seconded by Commissioner Huber.* ***ACTION SUMMARY:*** Yes: 21 No: 0 Abstention: 0 Excused: 5 (Bravo, Burch, Couch, Powell, Starr) Absent: 0 **MOTION CARRIED**
1.5 Approval of Agenda and the Board Meeting Minutes for June 22, 2022	Chairwoman Hardy asked if anyone had changes for the agenda or corrections for the June 22, 2022 minutes. Hearing no requests for modification, she asked for a motion to approve the agenda and minutes.	*Commissioner Jones moved to approve the agenda and minutes as presented, seconded by Commissioner Hempling.*

		ACTION SUMMARY: Yes: 21 No: 0 Abstention: 0 Excused: 5 (Bravo, Burch, Couch, Powell, Starr) Absent: 0 **MOTION CARRIED**
1.6 Commissioner Comment	Chairwoman Hardy asked if there were any commissioner comments. Hearing none, she moved to Public Comment.	None
1.7 Public Comment and Correspondence	Chairwoman Starck asked if there were any public comments. Hearing no requests, she moved on to correspondence. Ashlyn Scott, Clerk, stated that there had been no correspondence since the last Board Meeting.	None
1.8 Recognizing Commissioner, Dr. Lewis Broschard for receiving an Honorable Mention from the Association for Community Affiliated Plans (ACAP) for the Supporting the Safety Net Award	Ms. Gibboney presented Commissioner Dr. Lewis Broschard with a plaque from the Association for Community Affiliated Plans (ACAP) for the Supporting the Safety Net Award. PHC nominated Commissioner Broschard to recognize his many years of work in the safety net. Dr. Broschard has served on the PHC Board for nearly twenty years and continues to serve his community by volunteering at a local food bank.	None
1.9 CEO Report	Ms. Gibboney gave a report on covering the following topics: ***California Budget*** – the final budget includes Undocumented Adult Coverage, which is the Last "slice of the pie" by covering adults ages 26-49 with full scope MediCal. The coverage will begin no sooner than January 2024 and would cover about 31,000 new members in PHC's service area. The Kaiser Direct Contract Bill (AB 2724) did pass and we are now assessing operational and governance impacts. *Commissioner Hardy questioned if PHC's working relationship with Kaiser can be repaired.* *Ms. Gibboney responded that the relationship does feel strained and there has not yet been a meeting with Kaiser leadership. Kaiser will circulate a transition plan ahead of the January 1, 2024 go-live date, which PHC will assess upon receiving.* Provider Health Equity Payments were also included in the budget, which consists of $700M over 5 years, including $25M for a statewide learning collaborative, $25M for initial planning grants,	None

	$25M for transformation payments and $650M for Whole Person Car (WPC), maternity, early childhood, and social determinants of Health (SDOH). The funding will begin in January 2023 in an effort to reduce inequities, reduce gaps in care made worse during COVID and provide resources to support practice transformation efforts. The Public Health Emergency end date is set for October 15, 2022 but another 90-day extension is expected. MediCal redeterminations will begin 60 days following end of PHE. ***Additional State Updates –*** CalAIM; PHC currently has 721 members enrolled in Enhanced Care Management (ECM), with another 840 in the outreach process. PHC has provided 616 Community Support (CS) services for 509 members. The Housing and Homelessness Incentive Program (HHIP) will administer $89M in one-time funds to PHC for providers in our service area. PHC is currently recruiting for a housing leadership position to cover housing programs, due to the incoming significant funding. PHC is required to sign a preparedness agreement ahead of the new DHCS Base Contract that will go into effect in 2024. DHCS has also released a draft Street Medicine Guidance policy letter, which we are currently reviewing. ***CalAIM/Medicare D-SNP Feasibility Study*** – The State claims the study found D-SNPS are viable everywhere. Plans should expect to lose money for the first 3-5 years after implementing the program and plan reserves should be used to subsidize the program during that time. PHC did have a D-SNP from 2007-2014, named, "Partnership*Advantage*." The study assumed all plans will quickly become 4-star plans, which will be especially difficult in rural areas. We have some questions about their assumptions that we will share with the State. ***Geographic Expansion*** – PHC has gone to initial provider visits in 8/10 of the expansion counties, so far, with hospitals and health centers. The key themes from these meetings are communication, building relationships and billing support. ***Upcoming Board Events & Meetings*** • Board Tour: Tuesday, October 25, 2022* • Board Dinner: Tuesday, October 25, 2022 (Redding)* • Board Meeting: Wednesday, October 26, 2022 ***Since cancelled**	
2 & 3 Consent Calendar	Chairwoman Hardy stated that all items on the consent calendar would be approved with one motion unless someone requests to pull an item for further discussion. Hearing no requests, she asked for a motion to approve resolutions 2.1, 3.1, 3.2, 3.3, 3.4 ▪ **2.1** Resolution to Ratify Finance Committee's Approval to Execute the DHCS Operational Readiness Contract, Number 22-20196.	*Commissioner Antle moved to approve Resolutions 2.1, 3.1, 3.2, 3.3, 3.4 as presented, seconded by Commissioner Brooks.*

	▪ **3.1** Resolution to Accept all PHC Committee Minutes, Department Operating Report, and PHC Policies, Program Descriptions, and PCP QIP Changes Approved by PAC. ▪ **3.2** Resolution to Approve Population Health Management Strategy & Program Description 2021 (MCND90013.4) ▪ **3.3** Resolution to Approve Physician Advisory Committee, Quality / Utilization Advisory and Peer Review Committees Membership Changes. ▪ **3.4** Resolution to Approve Findings That, as a Result of the Continuing COVID-19 Pandemic State of Emergency, Meeting in Person Would Present Imminent Risks to the Health or Safety of Attendees	***ACTION SUMMARY:*** Yes: 21 No: 0 Abstention: 0 Excused: 5 (Bravo, Burch, Couch, Powell, Starr) Absent: 0 **MOTION CARRIED**
4.1 Resolution to Approve Semi-Annual Dashboard	Sonja Bjork, Chief Operating Officer, presented the Board with the Semi-Annual Dashboard, which includes several metrics and graphs that PHC monitors closely. The Membership Dashboard showed PHC's membership at over 650,000, which is trending high due to the counties' hold on redeterminations during the Public Health Emergency. The Call Center dashboard demonstrated PHC's performance in answering calls within 30 seconds, as this is a regulatory requirement, an NCQA accreditation standard, and, also, good customer service. The Call Center maintained these levels during the company-wide system outage. PHC also holds delegates to the same high standards and MTM and Beacon continue to meet the high service levels. Ms. Bjork summarized the Medical Utilization dashboard, which includes measurements such as inpatient days, average length of stay, emergency department visits and primary care provider (PCP) visits. Many of these measurements were affected by the pandemic, for example, it was difficult to discharge hospital patients to long term care facilities, due to COVID-19 protocol, increasing length of stay in many instances. The COVID-19 delta and omicron waves continued to negatively impact PCP visits. Over the past four quarters, transportation utilization has increased to levels higher than pre-pandemic levels. Ms. Bjork continued to the TAR Dashboard and explained that TAR timeliness was impacted by the system outage, as during that time, TARs could not be processed. To ensure patient care needs were not disrupted PHC suspended TAR requirements until the system was restored. The Grievance Dashboard also reflected decreased levels as a result of the system outage. During that time, G&A was unable to process cases. Lastly, Ms. Bjork presented the HR Dashboard and IT Dashboard. Ms. Bjork's presentation was included in the Board Packet and is available upon request.	*Commissioner Lujan moved to approve Resolution 4.1 as presented, seconded by Commissioner Brooks.* ***ACTION SUMMARY:*** Yes: 21 No: 0 Abstention: 0 Excused: 5 (Bravo, Burch, Couch, Powell, Starr) Absent: 0 **MOTION CARRIED**
5.1 Metrics and Financial Update	Jeff Ingram, Senior Director of Financial Analysis, reported on PHC's July 2022 financial performance. PHC experienced a slight gain of $493,000 for the month. Revenue is unfavorable by $3.9 million due to the timing of supplemental revenue submissions- specifically relating to BHT, AIHS, and Maternity. PHC has assumptions accrued for the retro rate adjustments and will be reconciled once the rates are made available by DHCS in the first quarter of 2023. Health Care	None

	Costs are unfavorable by $6.2 million in the areas of physician and ancillary FFS. Admin costs are favorable by $3.3M, which partly can be attributed to capital projects, such as having additional budget for HealthEdge, which will likely decrease as the go-live date approaches. Moss Adams will be presenting PHC's annual audit report at the October Board Meeting. Mr. Ingram's presentation was included in the Board Packet and is available upon request.	
5.2 Operations Update	Sonja Bjork, Chief Operating Officer, gave a brief update on operations company-wide. Ms. Bjork's full report is included in the Board packet.	None
5.3 Media Update	Dustin Lyda, Associate Director of Communications & Public Affairs, gave an updates bills that PHC is monitoring. Many high priority bills have been held in committee or rolled into the budget. The Senate and Assembly will meet August 25 to review hundreds of bills. The Legislature has until August 31 to pass legislation and the Governor has until September 30 to sign or veto bills. The list of bills PHC is monitoring is included in the meeting packet.	None
5.4 CMO Report on Quality	Dr. Moore, Chief Medical Officer, and Nancy Steffen, Senior Director Quality & Performance Improvement presented a summary review of PHC's MY2021 Healthcare Effectiveness Data and Information Set (HEDIS) performance. The presentation covered HEDIS reporting populations and the performance impact of COVID-19 and PHC's system-wide outage. Measurement year 2021/reporting year 2022 results in PHC's final performance. Additionally, NCQA's new health plan rating methodology was discussed in regards to NCQA/HEDIS health plan accreditation and performance. The Managed Care Accountability Set (MCAS) and Department of Health Care Services (DHCS) required reporting includes four reporting populations: Northwest – Humboldt and Del Norte; Northeast – Lassen, Modoc, Siskiyou, Trinity, Shasta; Southwest – Sonoma, Marin, Mendocino, Lake; Southeast – Solano, Yolo, Napa. NCQA required all 14 counties' population reporting for PHC's health plan accreditation. In 2022, PHC hosted two separate audits to support both the MCAS and Health Plan Accreditation (HPA) required reporting. As an NCQA-Accredited Health Plan, PHC is required to report its HEDIS measure performance and patient experience (CAHPS) results annually. PHC will be formally scored next year (Measurement Year 2022). COVID-19 continued to impact MY2021 HEDIS performance by continued decline in claims, and office and ED visits. A subset of preventive health services and screenings still require in-person visits. Also, a continuation of the hold on all eligibility re-determinations and adverse actions increased PHC eligible population across multiple measures PHC's system outage also impacted the HEDIS MY2021 results. Dr. Moore and Ms. Steffen's encouraged commissioners to review the full report that was included in the packet.	None

6.1 Employee Engagement Survey	Regina Littlefield, Sr. Director of Human Resources presented the results of the annual Employment Engagement Survey. The survey helps determine employee engagement and connection to PHC. It also allows employees the opportunity to provide feedback and in response, gives PHC the opportunity to address employee concerns. The survey included 14 questions and allowed for comments. 85% of staff responded, of which 96% said PHC is a great place to work. The top 3 words the employees used to describe PHC culture were: communication, support and flexibility. Three areas for improvement identified were: Employee Growth and Development, Appropriate Employee Recognition and Communication. *Commissioner Germano and Hardy congratulated PHC on such high scores on the survey, even after a very difficult few years.* Ms. Littlefield's presentation has been distributed to Board Members and is available upon request.	None
6.2 Behavioral Health Update	Mark Bontrager, Behavioral Health Administrator, gave a brief update on the many behavioral health initiatives that are in process. Since January 1, 2021 PHC has awarded $36 million to over 30 contracted providers. Preliminary outcomes from Behavioral Health Integration (BHI) include, 32,000 screened for depression and 34,000 screened for unhealthy alcohol use in PCP settings. Substance use navigators have been placed in hospitals to assist with members connecting with substance use disorder treatment and telehealth kiosks placed in various settings to assist with mental health and substance use disorder screenings. The Student Behavioral Health Incentive Program will funnel $400M through managed care plans, in collaboration with county offices of education, with the goal of increasing access and utilization of behavioral health services at school site and improving coordination between MCPs, Schools and School-linked BH providers. There are currently seven counties participating the Wellness and Recovery Program (or Regional Model: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano. Lake county will join the model on July 1, 2023. Mr. Bontrager's full presentation has been distributed to Board Members and is available upon request.	None
7.1 Closed Session	Chairwoman Hardy adjourned the Board of Commissioners to Closed Session at 12:18PM. Ms. Gibboney announced the following items to be discussed in closed session: **AGENDA ITEM 7.1 CLOSED SESSION - ACTION PURSUANT TO GOVERNMENT**	

	CODE §549547 - PUBLIC EMPLOYEE PERFORMANCE EVALUATION (CEO) AND ORGANIZATIONAL ASSESSMENT (INFORMATION/ACTION) Commissioner Hardy opened the closed session of the meeting at 12:20 PM. Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a forum. The following actions were taken in the closed session. The closed session adjourned at 1:34 PM. 1. The CEO's annual performance evaluation and CEO Evaluation Committee minutes for August 17, 2022 were approved as presented. 2. The CEO's one-year annual incentive goals for the period 7/1/21-6/30/22 were approved as presented. 3. The CEO's year one of the three-year long-term incentive goals were approved, with five out of five goals completed. 4. The CEO was awarded a COLA adjustment of 4% retroactive to August 2021 and increase in base pay to the mid-point for the CEO position according to the salary survey conducted this year. 5. The committee recommended that Ms. Gibboney maintain current performance levels for ongoing goals and ensure a smooth transition to the next CEO, without a need for formal goals.	
Adjournment	The Board reconvened in open session at 12:38PM and adjourned at 12:39P.M.	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Board Approval Date: 10/26/22

Signed: _____ _____
Ashlyn Scott, Clerk Alicia Hardy, Chair

Report from the Chief Executive Officer

October, 2022

CalAIM Waiver/Enhanced Care Management and Community Supports. As we continue to grow our provider network under both initiatives, we are also growing our membership. Further, we are pleased to be partnering with DHCS leadership to plan and hold three "regional convenings" for our many partners to speak directly with DHCS leaders about CalAIM and other topics pertaining to MediCal, during the month of November. Additional "populations of focus" will come online in January and July, some of which remain contingent on pending CMS approval. We will begin planning for Medicare D-SNP to come online in 2026, soon.

Project Phoenix. We are on track to begin the month-long "cutover" to Health Rules Payor ("HRP") beginning April 6, 2023 and finishing May 5, 2023. Testing with providers is a critical component of any new system implementation and we have schedules in place to accomplish this. We will be sharing more specific dates and objectives with our provider community in the coming weeks.

Geographic Expansion & Procurement. We continue to meet with providers and stakeholders in the expansion counties. With the next round being focused on County behavioral health leaders and programs. Those vitis will occur in November. Although we are not part of the DHCS MediCal contract procurement process, at least one plan has filed suit against DHCS relative to its decision of commercial contract awards effective January 1, 2024.

California State Budget/Provider Health Equity Payments. We continue to await more state guidance on the upcoming $700M in provider "equity" payments have been approved to be administered in large part by managed care plans like PHC. These will be a combination of grants focused on infrastructure building for quality improvement as well as incentives. The entire program is planned to span five years.

Housing and Homeless Incentive Program ("HHIP"). This is just one of a number of major initiatives at the state to addressing homelessness and housing. As required, we did submit "Investment Plans" for all fourteen counties to DHCS at the end of September. Additionally, we are pleased to have selected a new Associate Director of Housing/Incentive Programs to lead our housing work, along with other State incentive programs.

Alternative Payment Methodology ("APM"). The State is requiring health centers who are interested in participating in phase 1 of the APM to submit Letters of Interest with an endorsement from their local health plan, in November. We are reviewing each request as an Executive Team, and are looking at

factors including past and current performance on quality metrics, current patient visit rates, and leadership engagement on other initiatives, among other indicators. The APM program starts statewide in 2024.

Behavioral Health. Under the banner of the Student Behavioral Health Incentive Program, as school districts and Offices of Education submit their "gap assessments" conducted over the summer, we are looking forward to securing implementation dollars to fund needed improvement in services called for in the assessments. These funds will begin to roll out once DHCS has reviewed and approved the assessments, but we expect these to begin in early 2023. Regarding expansion of our Wellness and Recovery drug treatment benefit into Lake County in 2023, we are awaiting DHCS' review of our implementation proposal.

NCQA Accreditation & HEDIS Performance. We completed our "mock" NCQA audit in early September, and are currently reviewing new NCQA standards addressing health equity. Additionally, DHCS is meeting with plans to review performance on metrics during measurement year 2021, which was obviously still significantly impacted by COVID and workforce challenges. Dr. Moore will address this issue during his Board report.

DHCS Contract. We are continuing to submit documentation and information to DHCS as required as part of their "readiness" contract in preparation for a host of new requirements under an even more comprehensive DHCS contract. Submissions should be completed by June, 2023.

Diversity, Equity and Inclusion. As DHCS launches its equity metrics as part of its new quality strategic plan, we are also looking towards very significant Provider Health Equity incentives to begin in 2023. Additionally, we continue to recruit for a new Director of Diversity, Equity and Inclusion, here at PHC.

Staff Count. We currently have 877 employees.

Upcoming 2022 & 2023 Board Meetings and Events.

- December 7th – Board Meeting
- February 21st – Board Dinner
- February 22nd – Board Meeting and Strategic Planning Retreat
- April 26th – Board Meeting
- June 28th – Board Meeting

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Finance Committee Meeting Date:
September 21, 2022

Board Meeting Date:
October 26, 2022

Agenda Item Number:
2.1

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Compliance Committee and PHC 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 PHCs Q22022 Compliance Dashboard.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Finance Committee Meeting Date:
September 21, 2022

Agenda Item Number:
2.1

Board Meeting Date
October 26, 2022

Resolution Number:
22-

IN THE MATTER OF: APPROVING PARTNERSHIP HEALTHPLAN (PHC) COMPLIANCE DASHBOARD

Recital: Whereas,

A. PHC staff 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 PHCs Q12022 Compliance Dashboard.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

2022 Regulatory Affairs and Compliance Dashboard

Category	Description	Q1	Q2	YTD	Comments
DELEGATION OVERSIGHT	**Annual Delegate / Subcontractor Audits**	**5 / 5**	**2 / 2**	**7 / 7**	
When PHC delegates administrative functions that it is required by contract or regulation to perform, PHC retains the ultimate responsibility for the performance of these functions and must monitor and evaluate the performance of these functions when performed by a delegate.	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	**139 / 147**	**125 / 127**	**264 / 274**	
	Percentage of timely submissions of regulatory reports.	**94.6%**	**98.4%**	**96.4%**	
REGULATORY REPORTING	**DHCS Reports Submitted Timely**	**49 / 55**	**56 / 56**	**105 / 111**	
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.	**89.1%**	**100%**	**95%**	6 regulatory reports were late due to the system disruption in March.
	Report Acceptance Rate	**49 / 49**	**53 / 56**	**102 / 105**	
	Percentage of standard regulatory reports submitted by RAC and not rejected by DHCS for being incomplete, on the wrong template, or for other findings.	**100.0%**	**94.6%**	**97.1%**	3 regulatory reports were sent back from DHCS for revisions or additional information.
HIPAA REFERRALS	**Timely DHCS Privacy Notification Filings**	**15 / 15**	**9 / 9**	**24 / 24**	
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 notice within 24 hours, initial PIR within 72 hours, and final PIR within 10 business days. If any deadline is missed, it will be counted as untimely.*	**100.0%**	**100.0%**	**100.0%**	Q1 2022- 2 PHC Breach, 2 Delegate Breach. Q2 2022- no breaches were reported.
FWA REFERRALS	**Timely DHCS FWA Notifications**	**15 / 17**	**14 / 14**	**29 / 31**	
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.	**88.2%**	**100%**	**94%**	2 Incidents not reported timely due to system disruption in March.

***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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.1

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Advisory Groups and Committees

Topic Description:
Partnership HealthPlan of California (PHC) has a number of advisory groups and committees established by the Commission (known as the Board) with direct reporting responsibilities. These are the 340B, Compliance, Consumer Advisory, Finance, Personnel, Policies and Benefits, Physicians Advisory, Substance Use Services, Provider Advisory and Strategic Planning.

The Physician's Advisory Committee (PAC) has responsibility for oversight and monitoring for the quality and cost-effectiveness of medical care provided to PHC's members. A number of other PHC advisory groups and committees have direct reporting responsibilities to PAC. These are the Credentialing, Cultural & Linguistics & Health Education, Internal Quality Improvement, Member Grievance Review, Over/Under Utilization Workgroup, Peer Review, Pharmacy & Therapeutics, Provider Grievance Review, Quality/Utilization Advisory, Substance Use Services Internal Quality Improvement and Substance Use Services.

The Board is responsible for reviewing and accepting all minutes and packets approved by the various PHC advisory groups and committees, and approving the policies, program descriptions, and QIP policy changes that were approved by the PAC, from August 2022 through October 2022. In addition, the Board reviews and accepts PHC's Claims, Health Services, Human Resources, Member Services and Provider Relations department operating reports.

Reason for Resolution:
To provide commissioners with all PHC committee minutes, committee packets and departmental operational reports. In addition, to provide commissioners with all PHC policies and program descriptions approved by PAC and recommended for approval.

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

Requested Action of the Board:
Based on the recommendation of PHC's advisory groups & committees, the Board is asked to accept receipt of all PHC committee minutes, committee packets and the departmental operational reports. In addition, to approve all PHC policies and program descriptions approved by PAC linked to the packet.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.1

Resolution Number:
22-

IN THE MATTER OF: ACCEPTING ALL PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC) COMMITTEE MINUTES, COMMITTEE PACKETS, AND DEPARTMENTAL OPERATING REPORTS. IN ADDITION, TO APPROVE ALL PHC POLICIES AND PROGRAM DESCRIPTIONS APPROVED BY THE PHYSICIANS 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 PHC committee minutes, packets and departmental operational reports. In addition to review and approve all PHC policies and program descriptions approved by PAC.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept receipt of all PHC committee minutes, committee packets and departmental operational reports.
2. To obtain approval for all PHC policies and program descriptions approved by PAC and recommended for Board approval.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of October 2022 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners

ABSTAINED: Commissioners

ABSENT: Commissioners

EXCUSED: Commissioners

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.2

Resolution Sponsor:
Liz Gibboney, 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 PHC members and it describes the programs, purpose, goals, responsibilities, methods, measurements, and feedback.

The purpose of the Quality Improvement Department Evaluation is to evaluate Partnership HealthPlan's quality and performance improvement activities. QI also evaluates key activities done in other PHC departments that work closely with the Quality and Performance Improvement Department (QI/PI) 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 PHC 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 26, 2022

Agenda Item Number:
3.2

Resolution Number:
22-

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 PHC.

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 26th day of October 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.3

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Approved by:
Physician Advisory Committee and PHC Staff

Topic Description:
In order to provide high quality preventive health services, staff is proposing changes to the 2023 Primary Care Provider Quality Improvement Program (PCPQIP) measurement set (see attached summary).

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

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

Requested Action of the Board:
Based on the recommendation of PHC staff, the Board is asked to approve proposed changes to the 2023 Primary Care Provider Quality Improvement Program (PCPQIP) measurement set.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.3

Resolution Number:
22-

IN THE MATTER OF: APPROVING PROPOSED CHANGES TO THE 2023 PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCPQIP) MEASUREMENT SET

Recital: Whereas,

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

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

Now, Therefore, It Is Hereby Resolved As Follows:

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

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of October 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

Summary of Proposed Measure Changes for Measurement Year 2023

(A) Core Measurement Set Measures

Providers have the potential to earn a total of 100 points in four measurement areas: 1) Clinical Domain; 2) Appropriate Use of Resources; 3) Access and Operations; and 4) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

Key:

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

2022 Measures	2023 Recommendations
Clinical Domain	
Family Medicine: 1. Asthma Medication Ratio 2. Breast Cancer Screening 3. Cervical Cancer Screening 4. Child and Adolescent Well Care Visits 5. Childhood Immunization Status: Combo 10 6. Colorectal Cancer Screening 7. Comprehensive Diabetes Care: HbA1c Control 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life **Monitoring Measures:** Diabetes Management: Eye Exams	**Family Medicine:** 1. Asthma Medication Ratio 2. Breast Cancer Screening 3. Cervical Cancer Screening 4. Child and Adolescent Well Care Visits 5. Childhood Immunization Status: Combo 10 6. Colorectal Cancer Screening 7. Comprehensive Diabetes Care: HbA1c Control 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Diabetes Management: Eye Exams **Monitoring Measures:** ~~Diabetes Management: Eye Exams~~
Clinical Domain	
Internal Medicine: 1. Asthma Medication Ratio 2. Breast Cancer Screening 3. Cervical Cancer Screening 4. Colorectal Cancer Screening 5. Comprehensive Diabetes Care: HbA1c Control 6. Controlling High Blood Pressure **Monitoring Measures:** Diabetes Management: Eye Exams	**Internal Medicine:** 1. Asthma Medication Ratio 2. Breast Cancer Screening 3. Cervical Cancer Screening 4. Colorectal Cancer Screening 5. Comprehensive Diabetes Care: HbA1c Control 6. Controlling High Blood Pressure 7. Diabetes Management: Eye Exams **Monitoring Measures:** ~~Diabetes Management: Eye Exams~~
Clinical Domain	

Pediatric Medicine: 1. Asthma Medication Ratio 2. Child and Adolescent Well Care Visits 3. Childhood Immunization Status: Combo 10 4. Counseling for Nutrition for Children/Adolescents 5. Counseling for Physical Activity for Children/Adolescents 6. Immunizations for Adolescents – Combo 2 7. Well-Child Visits in the First 15 Months of Life	**Pediatric Medicine:** 1. Asthma Medication Ratio 2. Child and Adolescent Well Care Visits 3. Childhood Immunization Status: Combo 10 ~~4. Counseling for Nutrition for Children/Adolescents~~ ~~5. Counseling for Physical Activity for Children/Adolescents~~ 6. Immunizations for Adolescents – Combo 2 7. Well-Child Visits in the First 15 Months of Life

Appropriate Use of Resources	
Family Medicine & Internal Medicine: 1. Ambulatory Care Sensitive Admissions 2. Risk Adjusted Readmission Rate (RAR)	**Family Medicine & Internal Medicine:** 1. Ambulatory Care Sensitive Admissions 2. Risk Adjusted Readmission Rate (RAR)
Access and Operations	
All Practice Types: 1. Avoidable ED Visits **Monitoring Measures:** PCP Office Visits	**All Practice Types:** 1. Avoidable ED Visits 2. PCP Office Visits **Monitoring Measures:** ~~PCP Office Visits~~
Patient Experience	
All Sites: 1. Patient Experience	**All Sites:** 1. Patient Experience

(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

Unit of Service	
All Sites: 1. Advance Care Planning Attestations 2. Extended Office Hours 3. PCMH Certification 4. Peer-led Self-Management Support Groups 5. Health Information Exchange 6. Initial Health Assessment 7. Health Equity 8. Dental Fluoride Varnish Use 9. Blood Lead Screening 10. Electronic Clinical Data Systems (ECDS)	**All Sites:** 1. Advance Care Planning Attestations 2. Extended Office Hours 3. PCMH Certification 4. Peer-led Self-Management Support Groups 5. Health Information Exchange 6. ~~Initial Health Assessment~~ 7. Health Equity 8. Dental Fluoride Varnish Use 9. Blood Lead Screening 10. Electronic Clinical Data Systems (ECDS)

Programmatic Changes:

I. Descriptions of Potential 2023 Measure Changes for Core Measurement Set

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

1. **Colorectal Cancer Screening (Family and Internal Medicine)**
   Denominator change: Age range changed from 50 to 75 years of age **TO** 45 to 75 years of age.
2. **Diabetes Management: Eye Exams (Family and Internal Medicine)**
   Rationale: Move from Monitoring Measurement set to the Internal Medicine and Family Medicine domains.

3. **PCP Office Visits: (All Practice types)**
   Rationale: Move from Monitoring Measurement set to the Family, Internal and Pediatric Medicine domains.

II. Descriptions of Potential 2022 Measure Changes for Unit of Service Measurement Set

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

1. **Retire the Initial Health Assessment (IHA) Unit of Service measure:**
   Rationale: The Staying Health Assessment (SHA) may no longer be a State mandated assessment tool in 2023 and the IHA will be transitioned to Initial Health Appointment. Looking forward, it is a possibility the IHA APL will be retired

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.4

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Approved by:
Physician Advisory Committee and PHC Staff

Topic Description:
In order to provide high quality preventive health services, staff is proposing changes to the 2023 Long Term Care Quality Improvement Program (LTCQIP) measurement set (see attached summary).

Reason for Resolution:
To optimize the Long Term Care 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 PHC staff, the Board is asked to approve proposed changes to the 2023 Long Term Care Quality Improvement Program (LTCQIP) measurement set.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.4

Resolution Number:
22-

IN THE MATTER OF: APPROVING PROPOSED CHANGES TO THE 2023 LONG TERM CARE QUALITY IMPROVEMENT PROGRAM (LTCQIP) 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 Long Term Care Quality Improvement Program (LTCQIP) measurement set.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of October 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

PROPOSAL

2023 LTC QIP Measurement Set

Current 2022 Measures	Proposed 2023 Measures
Gateway Measure: CMS Five-Star Quality Rating Points: N/A Target: 2 or more stars in order to be eligible for other program measures	No changes
	NEW **Gateway Measure:** California Immunization Registry (CAIR) Enrollment Points: N/A Target: CAIR enrollment in order to be eligible for other program measures
Clinical Domain	
Measure 1: Percentage of long-stay high-risk residents with pressure ulcers Points: 10 Target: Full Points: < 7.4% Partial Points: 7.4 – 8.0%	No changes
Measure 2: Percentage of long-stay residents who lose too much weight Points: 10 Target: Full Points: < 5.1% Partial Points: 5.1 – 5.9%	No changes
Measure 3: Percentage of long-stay residents who needed and got a flu shot *AND* successful entry into CAIR Points: 10 Target: Full Points: > 98.5% Partial Points: 95.5 – 98.5%	No changes

Measure 4: Percentage of long-stay residents who received a vaccine to prevent pneumonia *AND* successful entry into CAIR Points: 10 Target: Full Points: > 98% Partial Points: 92.9 – 98%	No changes
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 – 3.3%	No changes
Measure 6: Percentage of long-stay residents who have or had a catheter inserted and left in their bladder Points: 10 Target: Full Points: < 1.6% No Partial Points	No changes
Resource Use Domain	
Measure 7: Number of hospitalizations per 1,000 long-stay resident days Points: 10 Target: Full Points: < 1.50% No Partial Points	No changes
Operations & Satisfaction Domain	
Measure 8: Health Inspection Star Rating Points: 10 Target: Full Points: 4 or more stars Partial Points (5): 3 stars	No changes
Measure 9: Staffing Rating Points: 10 Target: Full Points: 4 or more stars Partial Points (5): 3 stars	No changes

Measure 10: QI Training Points: 5 Target: Full Points: Facilities attending PHC's Hospital Quality Symposium do not need to submit evidence of attendance. Facilities attending other trainings must submit evidence of training attendance by February 2023. No Partial Points	Reduction from 10 to 5 points
	NEW **Measure 11:** Health Equity Points: 5 Full Points: Facilities will submit a project addressing Health Equity at the beginning of the measurement year. The submission will be an outline of their project that PHC will review and approve or reject. No Partial Points

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.5

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Staff

Topic Description:
Commissioner Erik McLaughlin, MD, County Representative for Lake County has resigned from his position at Lake County and his seat on the PHC Board.

Reason for Resolution:
To provide Commissioner McLaughlin with commendations and appreciation for his excellent service.

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

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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.5

Resolution Number:
22-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR ERIK MCLAUGHLIN'S SERVICE TO PHC AND THE BOARD

Recital: Whereas,

A. Erik McLaughlin, MD, provided valuable advice and support for PHC and the Board.

B. Erik McLaughlin, MD, was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

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

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of October 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.6

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Staff

Topic Description:
AB361 authorizes public meetings with Brown Act requirements to be held via teleconference or telephone during a state of emergency. Virtual public meetings still require standard meeting agendas and notices and the ability for the public to provide public comment. To continue virtual meetings, the Commission must make findings every 30 days that 1) it has reconsidered the circumstances of the ongoing COVID-19 pandemic state of emergency and 2) either the state of emergency continues to directly impact the ability of the public to meet safely in person, or state or local officials continue to impose or recommend measures to promote social distancing.

Due to the ongoing risk of community transmission of COVID-19, it is recommended that the Partnership HealthPlan of California Commission continues to offer virtual attendance as an option and encourages in-person attendance following current PHC guidelines with regard to vaccinations, masking, social distancing and other protective measures.

Reason for Resolution:
To allow the Board the opportunity to review and approve ongoing virtual Board Meetings, due to the ongoing risk of community transmission of COVID-19.

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

Requested Action of the Board:
Based on the recommendation of PHC staff and public health officials, the Board is asked to approve the recommended to continue to offer virtual attendance, due to the ongoing risk of community transmission of COVID-19.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 26, 2022

Agenda Item Number:
3.6

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE RECOMMENDED CONTINUATION OF MEETING VIRTUALLY

Recital: Whereas,

A. AB361, signed by Governor Newsom on September 16, 2021, requires the Commission must make findings every 30 days to continue to offer virtual attendance.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the recommended continuation of offering virtual attendance for meetings, due to the ongoing risk of COVID-19 transmission, for the next 30 days, per AB 361.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of August 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: October 19, 2022 4.1
Board Meeting Date: October 26, 2022

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Staff

Topic Description:
Moss Adams has completed their audit of PHC's financial statements for the period of July 1, 2021 to June 30, 2022. The audit was conducted in accordance with generally accepted auditing standards.

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

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

Requested Action of the Board:
Based on the recommendation of PHC Staff, the Board is asked to accept the attached Moss Adams Audit Report for the period of July 1, 2021 to June 30, 2022.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: October 19, 2022
Board Meeting Date: October 26, 2022

Agenda Item Number:
4.1

Resolution Number:
22-

IN THE MATTER OF: ACCEPTING THE MOSS ADAMS AUDIT REPORT FOR THE PERIOD OF JULY 1, 2021 TO JUNE 30, 2022

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 Moss Adams Audit Report for the period of July 1, 2021 to June 30, 2022.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 26th day of October 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

MOSSADAMS

Partnership Health Plan of California

Report of Independent Auditors

Chris Pritchard, Health Care Services Partner

Rianne Suico, Health Care Services Partner

(415) 956-1500

Report of Independent Auditors

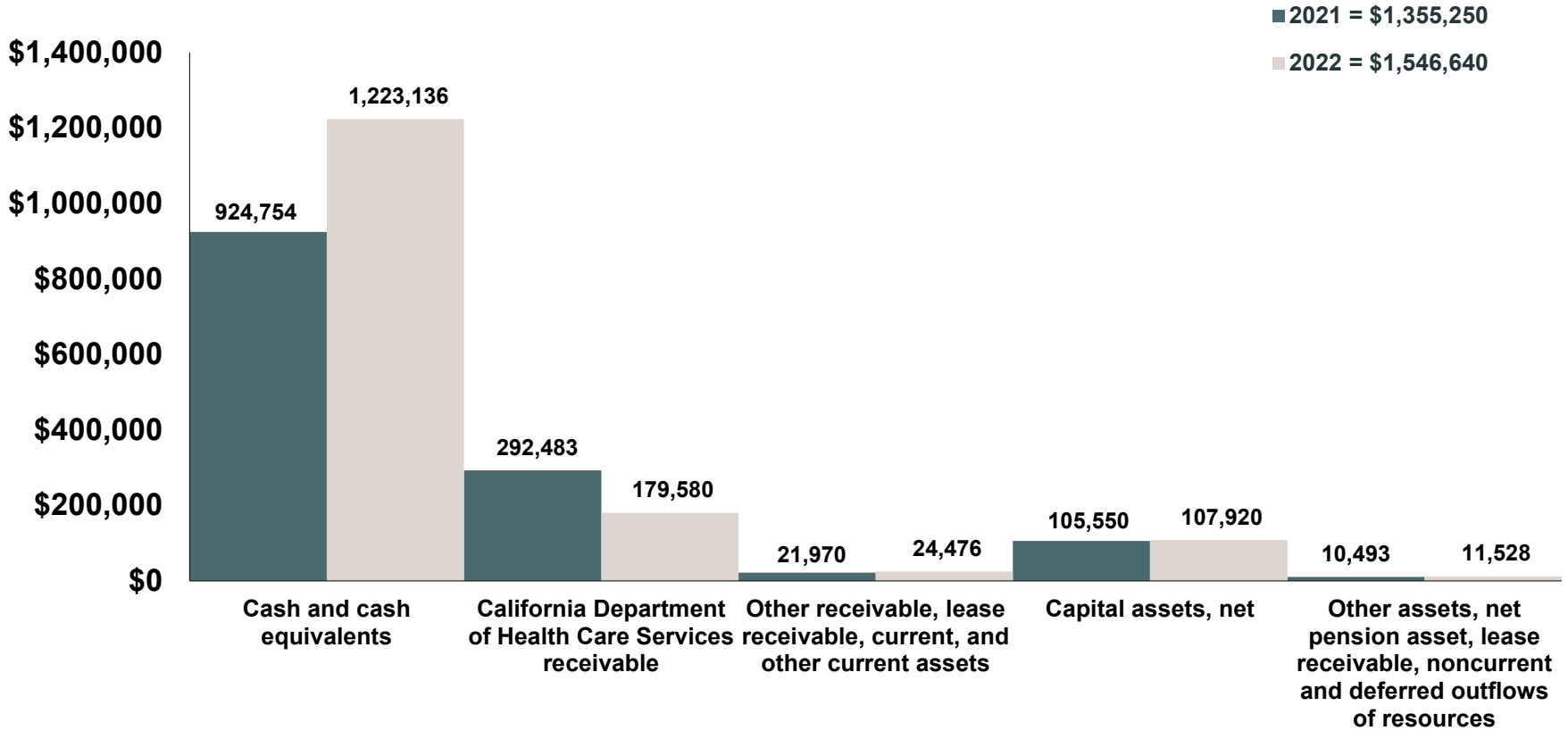
Unmodified Opinion

Financial statements are fairly presented in accordance with generally accepted accounting principles.

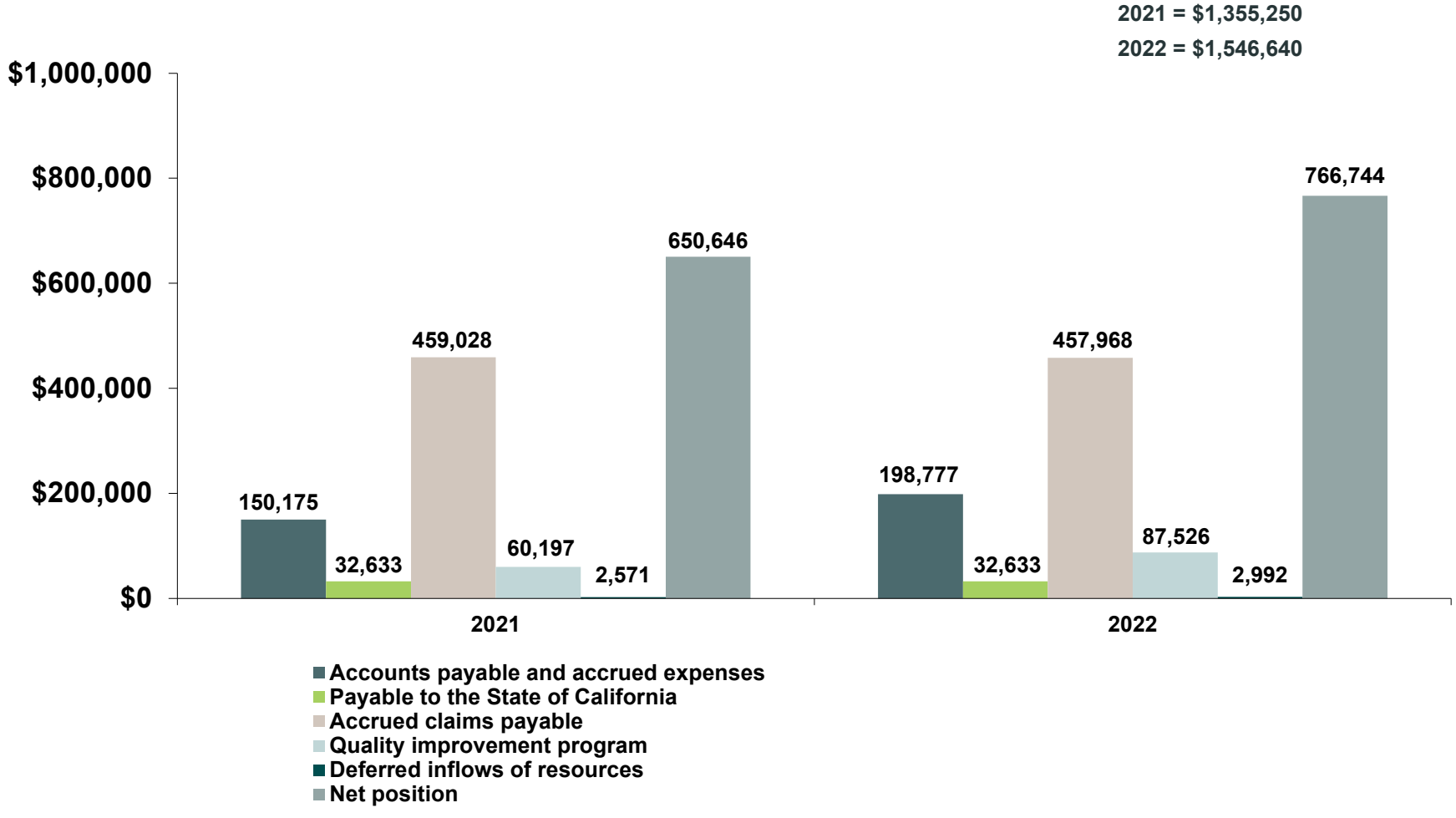
MOSSADAMS

Statements of Net Position

Assets and Deferred Outflows of Resources Composition (in thousands)



Liabilities, Deferred Inflows, and Net Position Composition (in thousands)

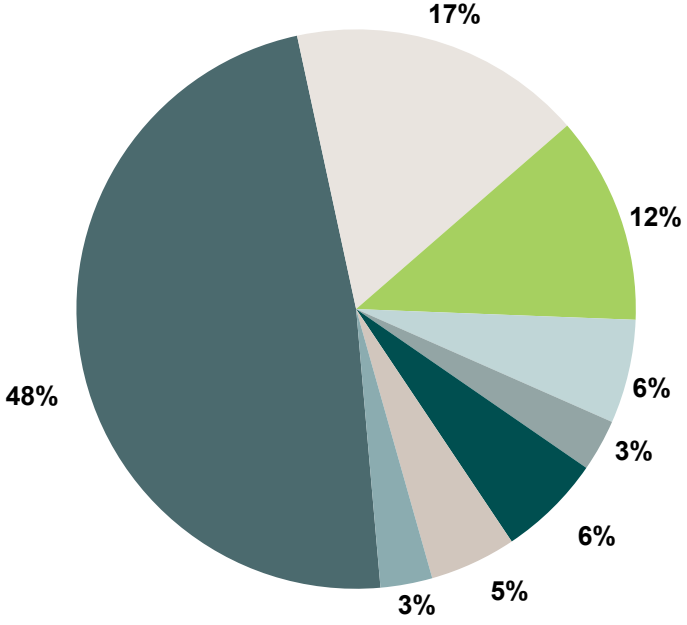


MOSSADAMS

Operations

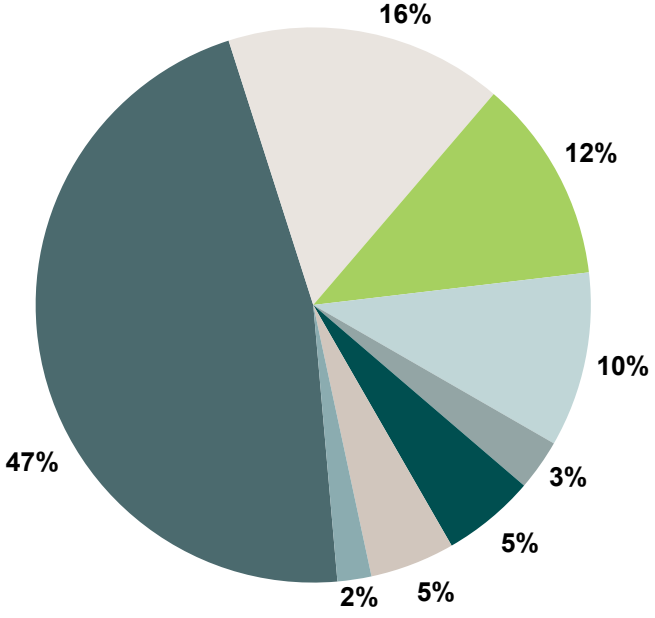
Total Operating Expenses as a % of Total Operating Revenues (in thousands)

June 30, 2022
(Total operating revenues)
$3,308.1

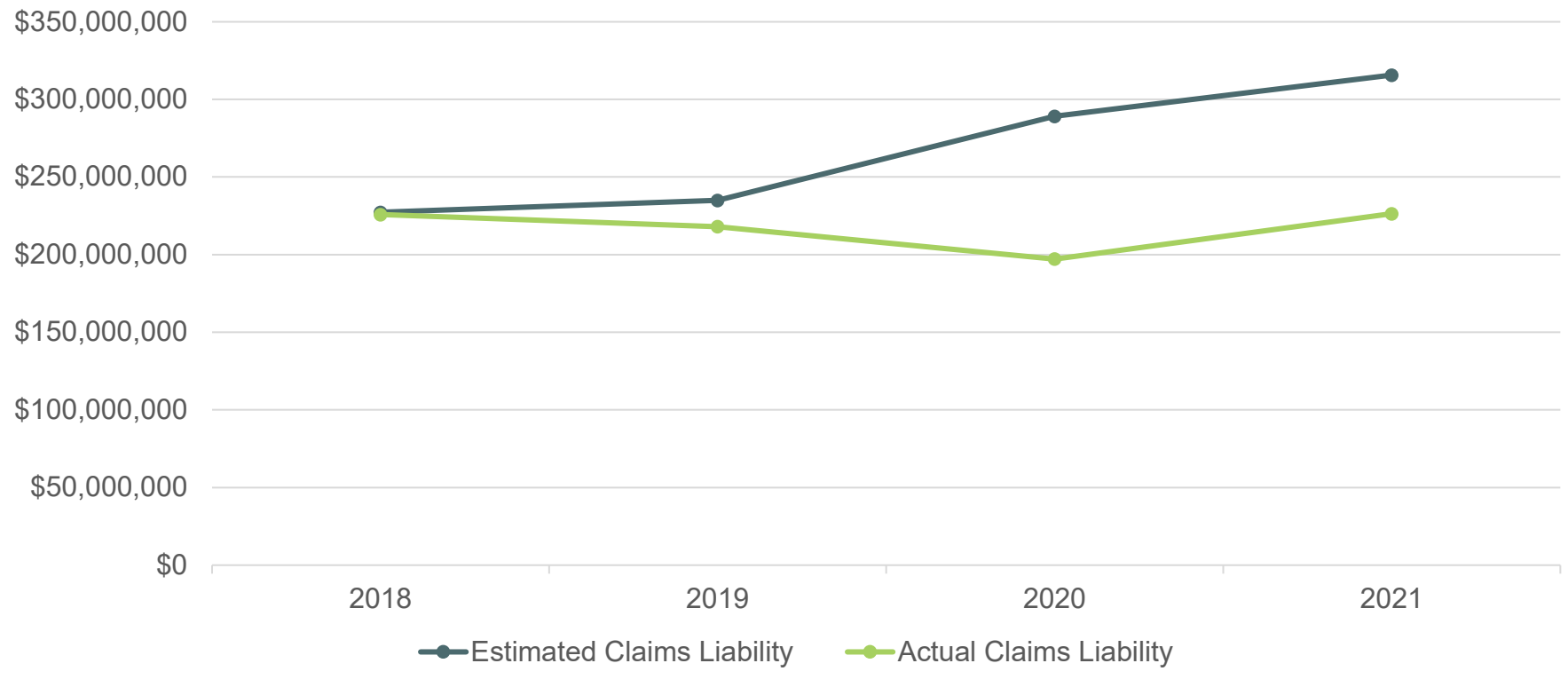


- Fee for service hospital, physician, and other costs
- Capitated physician, hospital, and other costs
- Long-term care
- Pharmacy
- Quality improvement program and hospital stop loss
- General and administrative expenses
- Premium tax
- Operating income

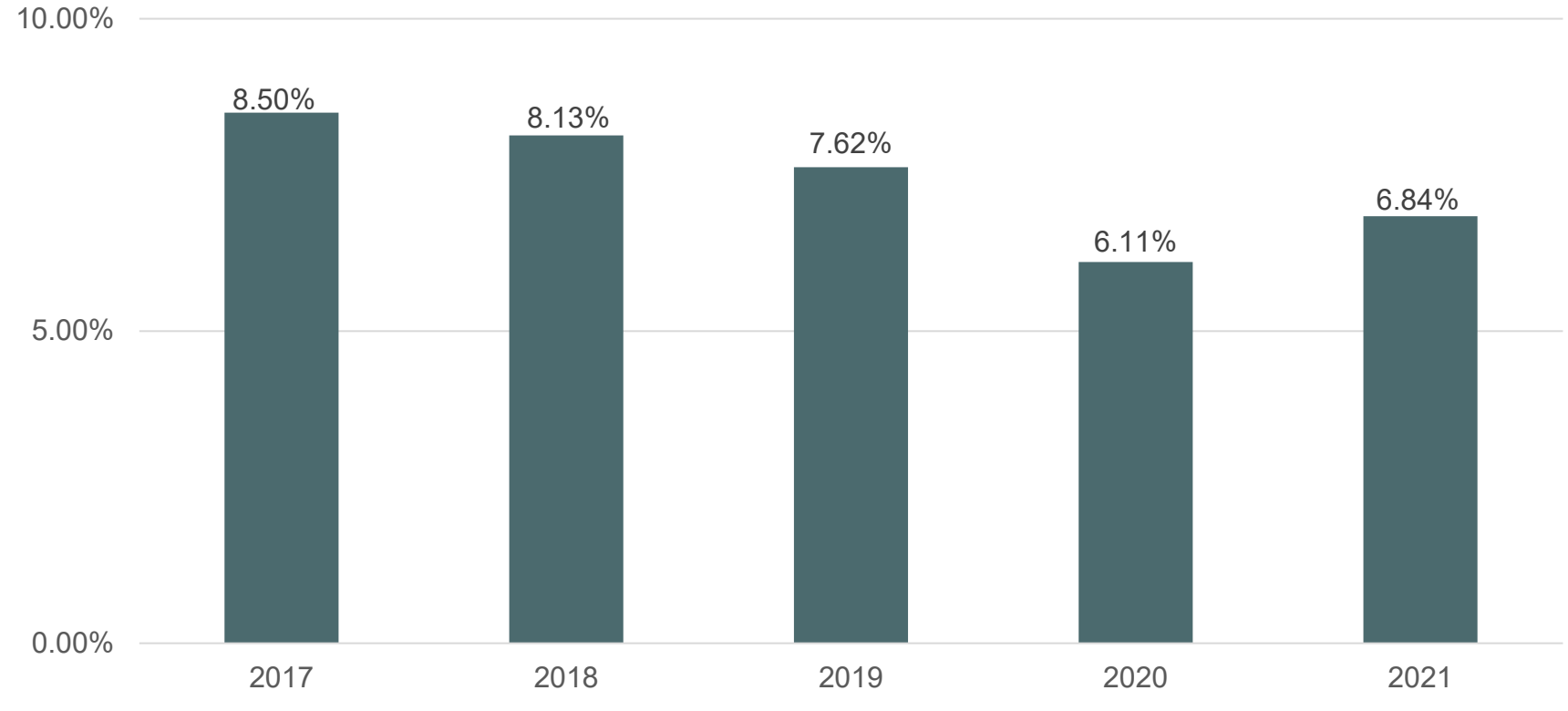
June 30, 2021
(Total operating revenues)
$3,204.9



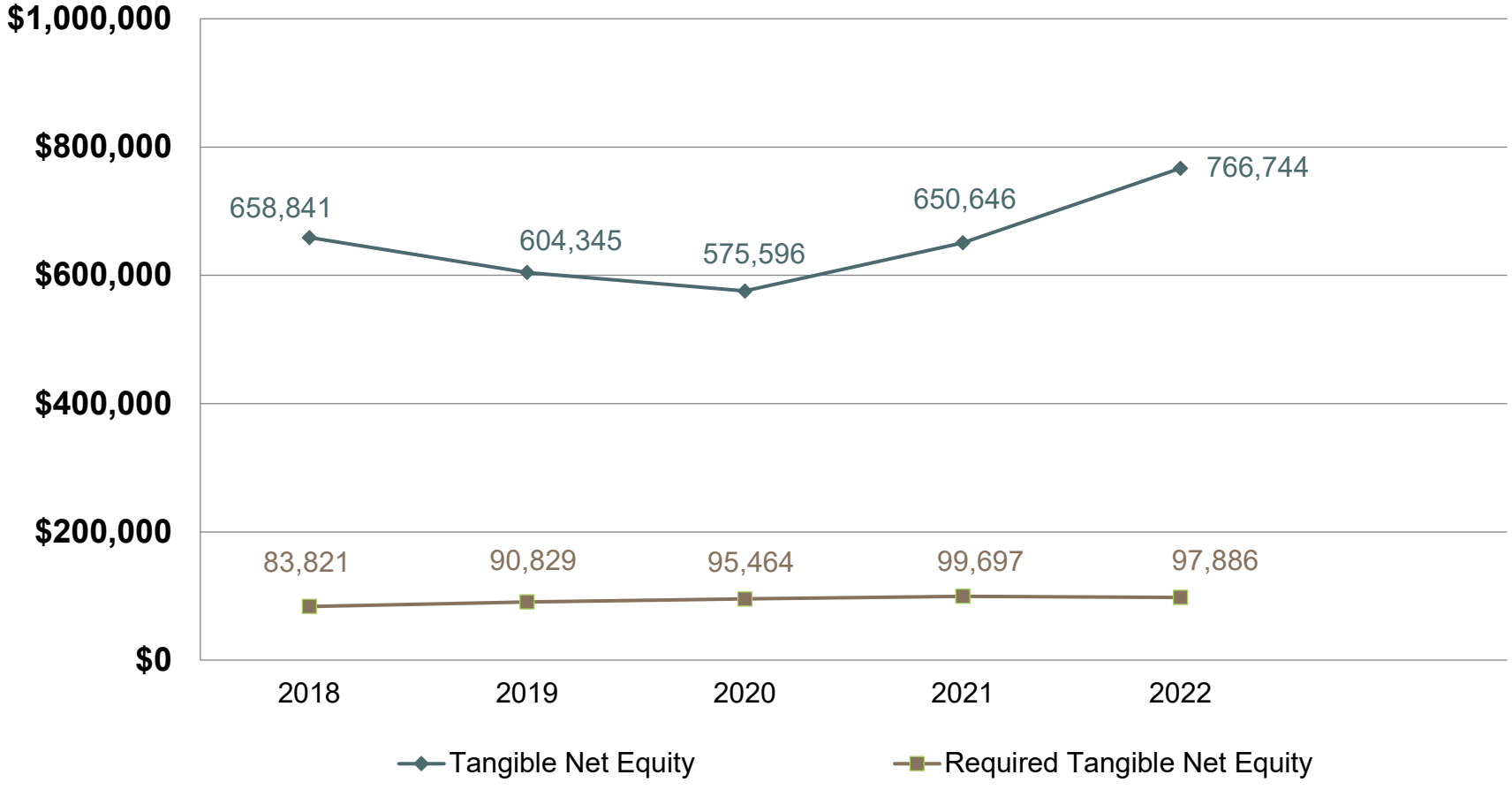
Historic Estimated Claims Liability and Historic Actual Claims Liability



Historic Actual Claims Liability as a % of Capitation Revenues



Tangible Net Equity (in thousands)



Source: Annual Department of Managed Health Care Filing

Important Board Communications

- AU-C Section 260 – *The Auditors' Communication with Those Charged with Governance*
- Significant accounting policies
- Accounting estimates are reasonable
- No audit adjustments
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of material fraud and noncompliance with laws and regulations

MOSSADAMS

Questions?

THANK YOU

Report of Independent Auditors and
Financial Statements with Supplementary Information

Partnership Health Plan of California

June 30, 2022 and 2021

Table of Contents

Management's Discussion and Analysis

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, 2022, 2021, and 2020. The management's discussion and analysis should be read in conjunction with the Health Plan's audited financial statements and accompanying notes.

The following table presents the condensed statements of net position for the Health Plan as of June 30, 2022, 2021, and 2020, and the change between periods:

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

	2022	2021	2020	Change from 2021 Amount	Change from 2021 Percent	Change from 2020 Amount	Change from 2020 Percent
ASSETS							
Current assets	$ 1,427,191	$ 1,239,206	$ 1,221,290	$ 187,985	15.2%	$ 17,916	1.5%
Capital assets, net	107,920	105,550	106,307	2,370	2.2%	(757)	(0.7%)
Other assets	5,167	2,332	1,485	2,835	121.6%	847	57.0%
Net pension asset	3,476	7,231	3,546	(3,755)	(51.9%)	3,685	103.9%
Total assets	1,543,754	1,354,319	1,332,628	189,435	14.0%	21,691	1.6%
DEFERRED OUTFLOWS OF RESOURCES	2,885	930	965	1,955	210.2%	(35)	(3.6%)
Total assets and deferred outflows of resources	$ 1,546,639	$ 1,355,249	$ 1,333,593	$ 191,390	14.1%	$ 21,656	1.6%
LIABILITIES							
CURRENT LIABILITIES	$ 776,904	$ 702,033	$ 757,587	$ 74,871	10.7%	$ (55,554)	(7.3%)
Total liabilities	776,904	702,033	757,587	74,871	10.7%	(55,554)	(7.3%)
DEFERRED INFLOWS OF RESOURCES	2,992	2,571	410	421	16.4%	2,161	527.1%
NET POSITION							
Invested in capital assets	107,921	105,550	106,306	2,371	2.2%	(756)	(0.7%)
Restricted	300	300	300	-	-%	-	-%
Unrestricted	658,522	544,795	468,990	113,727	20.9%	75,805	16.2%
Total net position	766,743	650,645	575,596	116,098	17.8%	75,049	13.0%
Total liabilities, deferred inflows, and net position	$ 1,546,639	$ 1,355,249	$ 1,333,593	$ 191,390	14.1%	$ 21,656	1.6%

ASSETS

2021–2022

Total assets increased by $189.4 million (14.0%) from 2021 to 2022. Current assets increased by $188.0 million from $1.24 billion in 2021 to $1.43 billion in 2022, primarily in cash and investments. This increase is a result of timing differences related to the distribution of funds related to various State programs, including the CalAIM Incentive Payment Program. Net pension asset decreased by $3.8 million, from $7.2 million in 2021 to $3.5 million (51.9%) in 2022. Deferred outflows of resources increased by $2.0 million from $0.93 million in 2021 to $2.9 million in 2022. Refer to Note 8 of the financial statements for additional information.

2020–2021

Total assets increased by $20.9 million (1.6%) from 2020 to 2021. Current assets increased by $17.6 million from $1.22 billion in 2020 to $1.24 billion in 2021, primarily in cash and investments; this increase is a result of timing differences related to the distribution of funds related to various State programs. Net pension asset increased by $3.7 million, from $3.5 million in 2020 to $7.2 million (103.9%) in 2021. Deferred outflows of resources decreased by $0.04 million from $0.97 million in 2020 to $0.93 million in 2021. Refer to Note 8 of the financial statements for additional information.

LIABILITIES

2021–2022

Total current liabilities increased by $74.9 million from $702.0 million in 2021 to $776.9 million in 2022. The 2022 increase can be attributable to the increases in accruals for the supplemental retirement plan, system disruption, and supplemental capitation expense. An additional increase can be attributable to unearned CalAIM Incentive Payment Program income.

2020–2021

Total current liabilities decreased by $55.6 million from $757.6 million in 2020 to $702.0 million in 2021. The 2021 decrease is primarily attributable to timing of when Directed Payments were made in 2020 compared to 2021.

NET POSITION

Total net position increased by $116.1 million (17.8%) in 2022 from 2021, and increased by $75.0 million (13.0%) in 2021 from 2020. In 2022, the increase is primarily due to an operating income of $114.6 million and net investment earnings of $1.5 million in 2022. In 2021, the increase is primarily due to an operating income of $74.1 million and net investment earnings of $0.9 million in 2021.

KEY OPERATING INDICATORS

The following table compares key operating indicators for the Health Plan for the years ended June 30, 2022, 2021, and 2020:

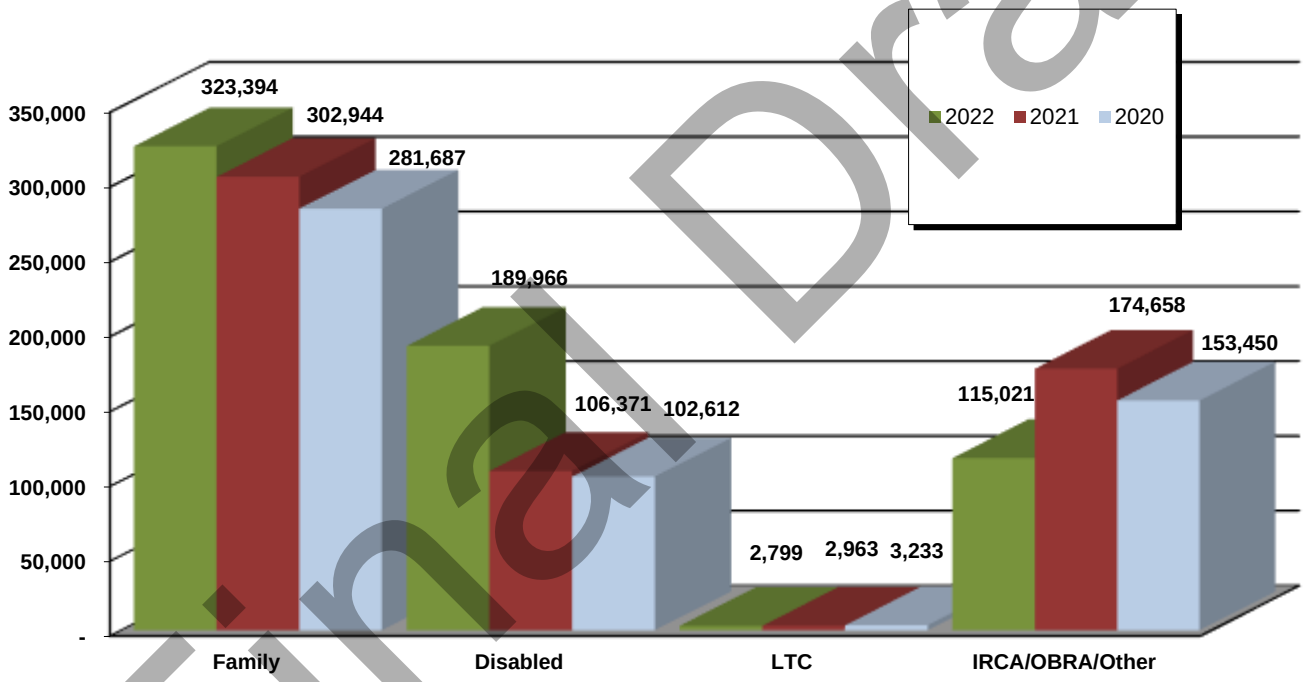
	2022	2021	2020
MEMBERSHIP			
Member months for the year:			
Medi-Cal program	7,574,159	7,043,228	6,491,783
Total	7,574,159	7,043,228	6,491,783
Average member per month			
Medi-Cal program	631,180	586,936	540,982
Total	631,180	586,936	540,982
OPERATING RESULTS (in thousands)			
Operating revenues	$ 3,308,076	$ 3,204,891	$ 2,859,230
Operating expenses:			
Health care	2,816,658	2,815,331	2,669,549
General and administrative	210,548	166,192	156,701
Premium tax	166,250	149,230	66,895
Total	3,193,456	3,130,753	2,893,145
Operating income (loss)	$ 114,620	$ 74,138	$ (33,915)
OPERATING RESULTS PER MEMBER PER MONTH			
Operating revenues	$ 436.8	$ 455.0	$ 440.4
Operating expenses:			
Health care	371.9	399.7	411.2
General and administrative	27.8	23.6	24.1
Premium tax	21.9	21.2	10.3
Total	421.6	444.5	445.7
Operating income (loss)	$ 15.1	$ 10.5	$ (5.2)
RATIOS			
Health care cost as a percentage of operating revenues	85.1%	87.8%	93.4%
General and administrative expense as a percentage of operating revenues	6.4%	5.2%	5.5%
Premium tax as a percentage of operating revenues	5.0%	4.7%	2.3%
Operating income (loss) as a percentage of operating revenues	3.5%	2.3%	(1.2%)

ENROLLMENT

During the years ended June 30, 2022, 2021, and 2020, the Health Plan served Medi-Cal members at an average of 631,180, 586,936, and 540,982, respectively, per month. Enrollment from 2021 to 2022 increased steadily during the year due to the pausing in membership redeterminations that were implemented as part of the novel coronavirus ("COVID-19") Public Health Emergency ("PHE").

The following chart displays a comparative view of average monthly membership by Medi-Cal aid category for the years ended June 30, 2022, 2021, and 2020.

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



RESULTS OF OPERATIONS

The following table presents the results of operations for the years ended June 30, 2022, 2021, and 2020, and the change from prior year (in thousands):

	2022	2021	2020	Change from 2021 Amount	Change from 2021 Percent	Change from 2020 Amount	Change from 2020 Percent
California Department of Health Care Services							
Capitation revenue	$ 3,285,782	$ 3,194,351	$ 2,857,506	$ 91,431	2.9%	$ 336,845	11.8%
Other income	22,294	10,540	1,724	11,754	111.5%	8,816	511.4%
Total operating revenues	3,308,076	3,204,891	2,859,230	103,185	3.2%	345,661	12.1%
Fee for service hospital inpatient, physician, and other services	1,583,762	1,510,366	1,447,368	73,396	4.9%	62,998	4.4%
Capitated physician, hospital, and other costs	576,925	515,027	468,513	61,898	12.0%	46,514	9.9%
Long-term care	387,085	373,741	358,893	13,344	3.6%	14,848	4.1%
Pharmacy	183,590	333,918	294,605	(150,328)	(45.0%)	39,313	13.3%
Quality improvement program and hospital stop loss	85,296	82,279	100,170	3,017	3.7%	(17,891)	(17.9%)
Total health care expenses	2,816,658	2,815,331	2,669,549	1,327	0.0%	145,782	5.5%
Total general and administrative expenses	210,548	166,192	156,701	44,356	26.7%	9,491	6.1%
Premium tax	166,250	149,230	66,895	17,020	11.4%	82,335	123.1%
Total operating expenses	3,193,456	3,130,753	2,893,145	62,703	2.0%	237,608	8.2%
Operating inome (loss)	114,620	74,138	(33,915)	40,482	54.6%	108,053	(318.6%)
Investment income	1,478	912	5,166	566	62.1%	(4,254)	(82.3%)
Total nonoperating revenues	1,478	912	5,166	566	62.1%	(4,254)	(82.3%)
Increase (decrease) in net position	$ 116,098	$ 75,050	$ (28,749)	$ 41,048	54.7%	$ 103,799	(361.1%)

OPERATING REVENUES

The Health Plan's total operating revenues increased by $103.2 million (3.2%) for the year ended June 30, 2022. The increase in operating revenues in 2022 is attributable to an increase in membership of 7.5% resulting in additional revenue of approximately $91.4 million from fiscal year 2021. The additional increase in revenue can also be attributable to various State Incentive Programs. The State Incentive Programs revenue is offset by an increase in other healthcare costs.

The Health Plan's total operating revenues increased by $345.6 million (12.1%) for the year ended June 30, 2021. The increase in operating revenues in 2021 is due to the increases in membership and a slight increase in base rates at the beginning of the calendar year.

HEALTH CARE EXPENSES

2021–2022

Overall health care expenses increased by $1.3 million or 0.05%, totaling $2.817 billion in 2022, compared to $2.815 billion in 2021. The Health Plan's health care ratio, or health care costs as a percentage of operating revenue, at 85.1% in 2022 decreased from 2021's health care ratio of 87.8%. 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 $576.9 million in 2022 compared to $515.0 million in 2021, for an increase of $61.9 million or 12.0%. The primary driver of the increase is due to an overall increase in membership. Quality Improvement Program expenses also increased from $82.3 million in 2021 to $85.3 million in 2022 as a number of participating providers met their performance measures, and had an increase in assigned membership.

- Fee for service expenses for hospital, physician, and other services increased from $1.51 billion in 2021 to $1.59 billion in 2022 and long-term care fee-for-service expenses increased from $373.7 million in 2021 to $387.1 million in 2022. The increase in long-term care and hospital expenses can be attributed to prior period IBNR adjustments while fee for service expenses increased primarily due to an increase in membership. Pharmacy costs decreased by 45.0% from $333.9 million in 2021 to $183.6 million in 2022 due to the pharmacy carve-out beginning January 1, 2022.

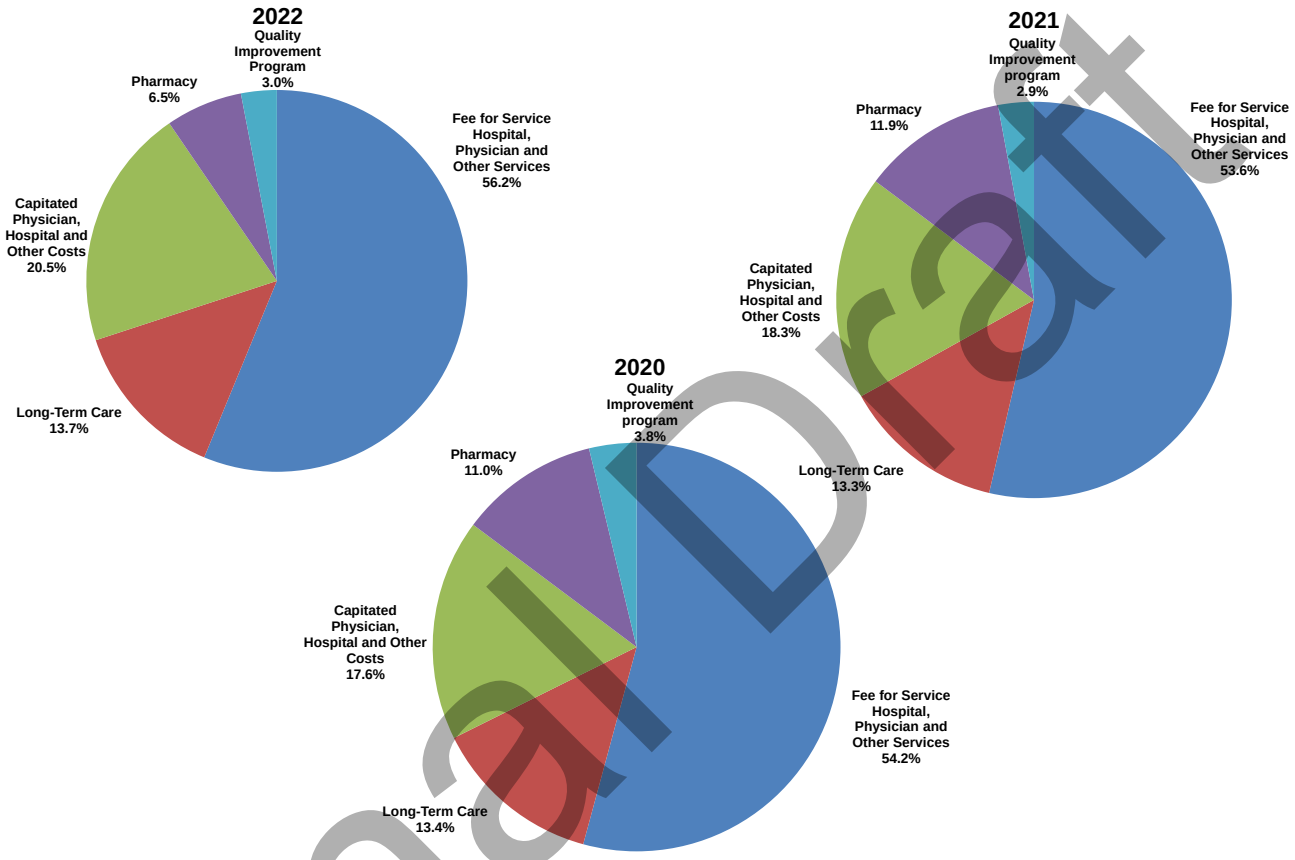
2020–2021

Overall health care expenses increased by $145.8 million or 5.5%, totaling $2.82 billion in 2021, compared to $2.67 billion in 2020. The Health Plan's health care ratio, or health care costs as a percentage of operating revenue, at 87.8% in 2021 decreased from 2020's health care ratio of 93.4%. 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 $515.0 million in 2021 compared to $468.5 million in 2020, for an increase of $46.5 million or 9.9%. The primary driver of the increase is due to an overall increase in membership. However, Quality Improvement Program expenses decreased from $100.2 million in 2020 to $82.3 million in 2021 as a number of participating providers did not meet their performance measures.

- Fee for service expenses for hospital, physician, and other services increased from $1.45 billion in 2020 to $1.51 billion in 2021 and long-term care fee for service expenses increased from $358.9 million in 2020 to $373.7 million in 2021. The increase in long-term care expense can primarily be attributed to the required 10% increase due to the COVID-19 public health emergency while fee for service expenses increased primarily due to an increase in membership. Pharmacy costs increased by 13.3% from $294.6 million in 2020 to $333.9 million in 2021 and can be attributed to the delay in the pharmacy carve-out.

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, 2022, 2021, and 2020:



GENERAL AND ADMINISTRATIVE EXPENSES AND PREMIUM TAX EXPENSE

Total general and administrative expenses were $210.5 million in 2022, compared to $166.2 million in 2021. Overall administrative expenses increased by 26.7% or $44.4 million, corresponding to higher salaries and benefits due to additional staffing and the Supplemental Executive Retirement Plan (SERP). The Health Plan's administrative expenses as a percentage of operating of revenues were 6.4% in 2022 and 5.2% in 2021.

Total general and administrative expenses were $166.2 million in 2021, compared to $156.7 million in 2020. Overall administrative expenses increased by 6.1% or $9.5 million. The increases are primarily in employee costs which are due to increases in salaries and benefits as well as from the filling of budgeted positions that were previously vacant. The Health Plan's administrative expenses as a percentage of operating of revenues were 5.2% in 2021 and 5.5% in 2020.

On March 1, 2016, SB X2-2 established a new Medi-Cal Managed Care Organizations ("MCO") tax, to be administered by CDHCS, effective July 1, 2016 through July 1, 2019. The tax would be assessed by CDHCS on licensed health care service plans, managed care plans contracted with CDHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, for all enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized CDHCS to implement a modified MCO tax model on specified health plans, which was approved by the Centers for Medicare & Medicaid Services on April 3, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022. The Health Plan's premium tax expense for the years ended June 30, 2022 and 2021 was $166.2 million and $149.2 million, respectively.

NON-OPERATING REVENUES

Non-operating revenues, consisting of net investment income for fiscal years 2022 and 2021 were $1.5 million and $0.9 million, respectively. Increase in non-operating revenues is due to an increase in interest income.

LIQUIDITY

As of June 30, 2022, working capital (current assets in excess of current liabilities) was $650.3 million, compared to $ 537.2 million at June 30, 2021. The significant increase is due to the current year's operating income.

As of June 30, 2021, working capital (current assets in excess of current liabilities) was $536.9 million, compared to $463.7 million at June 30, 2020. The significant increase is due to the current year's operating income.

ECONOMIC FACTORS AND FISCAL YEAR 2022 BUDGET

The impacts of the COVID-19 pandemic have been winding down, but the PHE continues to remain in effect. This means the pause in redeterminations has continued to add membership throughout the last calendar year and will continue to do so until the PHE has concluded. Membership will likely see significant reductions over the subsequent 12 months as each of the respective counties processes Medi-Cal renewal applications. Membership reductions, though, could be offset by any significant changes in the employment landscape as the broader economy faces headwinds with high inflation and changes to monetary policy.

The Health Plan's health care costs are projected to decrease 3.1% from prior year's budget, mainly due to the carve-out of the pharmacy benefit. This reduction is offset by increases in fee-for-service, across multiple categories of service, due to cost pressures and overall increases in members served. The Health Plan has been working to analyze claims patterns as the COVID waves subside, returning to more normal incurred but not reported reserve modeling. Inflation, both wage and supply chain, will continue to add cost pressures to the delivery system in the coming year as providers struggle with employee retention and managing overall expenses.

PHC is planning for a small net surplus in fiscal year 2022-23 of $49.9 million. DHCS has not yet provided final calendar year ("CY") 2022 or draft CY 2023 rates due to complications with the prior year's rate development. The Plan has accounted for significant changes to base revenues as membership continues to remain higher than originally expected. DHCS has publicly stated rates will be adjusted downward to account for the under estimation of gross membership for CY 2022. PHC will continue to carefully navigate the vast landscape of unknowns to ensure it remains in a stable financial condition as plans of expansion materialize ahead of January 2024.

FINANCIAL HIGHLIGHTS – FIDUCIARY FUND

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 December 31, and the changes in fiduciary net position for the years ended June 30:

	2022	2021
Total assets	$ 17,718,986	$ 20,496,309
Total fudiciary net position	$ 17,718,986	$ 20,496,309
Total additions	$ (1,739,309)	$ 5,537,892
Total deductions	(1,038,014)	963,228
Increase in fudiciary net position	(2,777,323)	4,574,664
Fudiciary net position, beginning of year	20,496,309	15,921,645
Fudiciary net position, end of year	$ 17,718,986	$ 20,496,309

Total fiduciary fund net position as of June 30, 2022, decreased by $2.8 million from June 30, 2021, due to a decrease in contributions and net investment loss for the year ending June 30, 2022.

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, 2022 and 2021, 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, 2022 and 2021, 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 twelve 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.

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 9 and the supplementary schedule of changes in the net pension assets and related ratios, supplementary schedule of contributions, and supplementary schedule of investment returns on pages 40 through 42 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 38 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 ____, 2022

Financial Statements

Partnership Health Plan of California
Statements of Net Position
June 30, 2022 and 2021

	2022	2021 (As Restated)
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 1,223,135,598	$ 924,753,629
California Department of Health Care Services receivable	179,579,724	292,483,146
Other receivables	17,119,102	15,889,166
Lease receivable, current portion	1,105,915	318,902
Other current assets	6,251,010	5,761,439
Total current assets	1,427,191,349	1,239,206,282
CAPITAL ASSETS		
Nondepreciable	37,198,399	28,010,476
Depreciable, net of accumulated depreciation	70,722,179	77,539,893
Total capital assets	107,920,578	105,550,369
OTHER ASSETS	3,428,107	1,852,211
NET PENSION ASSET	3,475,861	7,231,258
LEASE RECEIVABLE, net of current portion	1,738,762	479,314
Total assets	1,543,754,657	1,354,319,434
DEFERRED OUTFLOWS OF RESOURCES	2,884,773	930,354
Total assets and deferred outflows	$ 1,546,639,430	$ 1,355,249,788
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 198,776,977	$ 150,174,694
Payable to the State of California	32,633,113	32,633,113
Accrued claims payable	457,967,956	459,028,387
Quality improvement program	87,525,942	60,197,271
Total current liabilities	776,903,988	702,033,465
Total liabilities	776,903,988	702,033,465
DEFERRED INFLOWS OF RESOURCES	2,991,590	2,570,745
NET POSITION		
Invested in capital assets	107,920,578	105,550,369
Restricted	300,000	300,000
Unrestricted	658,523,274	544,795,209
Total net position	766,743,852	650,645,578
Total liabilities, deferred inflows, and net position	$ 1,546,639,430	$ 1,355,249,788

See accompanying notes.

Partnership Health Plan of California
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2022 and 2021

	2022	2021 (As Restated)
OPERATING REVENUES		
California Department of Health Care Services revenue	$ 3,285,782,331	$ 3,194,350,710
Other income	22,294,264	10,539,866
Total operating revenues	3,308,076,595	3,204,890,576
OPERATING EXPENSES		
Health care expenses:		
Fee for service hospital, physician, and other services	1,583,762,419	1,510,365,767
Capitated physician, hospital, and other costs	576,924,916	515,026,767
Long-term care	387,085,317	373,741,213
Pharmacy	183,589,558	333,918,121
Quality improvement program and hospital stop loss	85,295,989	82,279,453
Total health care expenses	2,816,658,199	2,815,331,321
General and administrative expenses	210,548,175	166,191,797
Premium tax	166,250,000	149,229,691
Total operating expenses	3,193,456,374	3,130,752,809
Operating income	114,620,221	74,137,767
NONOPERATING REVENUES		
Investment income	1,478,053	911,618
Total nonoperating revenues	1,478,053	911,618
INCREASE IN NET POSITION	116,098,274	75,049,385
NET POSITION, beginning of year	650,645,578	575,596,193
NET POSITION, end of year	$ 766,743,852	$ 650,645,578

See accompanying notes.

Partnership Health Plan of California
Statements of Cash Flows
Years Ended June 30, 2022 and 2021

	2022	2021 (As Restated)
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from California Department of Health Care Services	$ 3,403,788,898	$ 3,189,722,921
Other income	22,636,004	1,542,046
Cash payments to providers for Medi-Cal members:		
Capitation payments	(522,346,928)	(470,306,374)
Medical claims payments	(2,379,125,295)	(2,410,780,427)
Cash payments to vendors	(107,878,429)	(99,926,463)
Cash payments for salaries, wages, and related benefits	(108,474,162)	(100,096,909)
Net cash provided by operating activities	308,600,088	110,154,794
CASH FLOWS FROM FINANCING ACTIVITY		
Purchases of capital assets	(11,635,972)	(9,805,967)
Net cash used in financing activity	(11,635,972)	(9,805,967)
CASH FLOWS FROM INVESTING ACTIVITY		
Interest and dividends on investments	1,417,853	1,128,418
Net cash provided by investing activity	1,417,853	1,128,418
INCREASE IN CASH AND CASH EQUIVALENTS	298,381,969	101,477,245
CASH AND CASH EQUIVALENTS, beginning of year	924,753,629	823,276,384
CASH AND CASH EQUIVALENTS, end of year	$ 1,223,135,598	$ 924,753,629

See accompanying notes.

	2022	2021 (As Restated)
RECONCILIATION OF OPERATING INCOME TO NET CASH FROM OPERATING ACTIVITIES		
Operating income	$ 114,620,221	$ 74,137,767
Adjustment to reconcile operating income to net cash from operating activities		
Depreciation and amortization	9,265,763	10,562,138
Changes in operating assets and liabilities:		
California Department of Health Care Services receivable	112,903,422	98,159,285
Other receivables	(1,169,736)	(13,931,872)
Lease receivables	(2,046,461)	(798,216)
Other assets	(2,065,467)	(145,336)
Net pension asset	2,221,823	(2,275,282)
Accounts payable and accrued expenses	48,602,283	(101,789,611)
Payable to the State of California	-	(667,620)
Accrued claims payable	(1,060,431)	59,639,169
Quality improvement program	27,328,671	(12,735,628)
Net cash provided by operating activities	$ 308,600,088	$ 110,154,794
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for premium tax	$ 162,093,750	$ 178,718,750

Partnership Health Plan of California
Partnership Health Plan of California Supplemental Executive Retirement Plan – Statements of Fiduciary Net Position
June 30, 2022 and 2021

	2022	2021
ASSETS		
Cash and cash equivalents	$ 854,921	$ 115,329
Investments, at fair value:		
Mutual funds	16,864,065	20,380,980
Total investments, at fair value	16,864,065	20,380,980
Total assets	$ 17,718,986	$ 20,496,309
NET POSITION RESTRICTED FOR PENSIONS	$ 17,718,986	$ 20,496,309

See accompanying notes.

Partnership Health Plan of California Supplemental Executive Retirement Plan – Statements of Changes in Fiduciary Net Position
Years Ended June 30, 2022 and 2021

	2022	2021
ADDITIONS		
Member contributions	$ 70,605	$ 67,292
Employer contributions	506,632	2,199,301
Total contributions	577,237	2,266,593
Investment income	(2,316,546)	3,271,299
Total additions	(1,739,309)	5,537,892
DEDUCTIONS		
Benefits paid to participants	(894,232)	832,676
Administrative expenses	(143,782)	130,552
Total deductions	(1,038,014)	963,228
INCREASE (DECREASE) IN NET POSITION	(2,777,323)	4,574,664
NET POSITION RESTRICTED FOR PENSION, beginning of year	20,496,309	15,921,645
NET POSITION RESTRICTED FOR PENSION, end of year	$ 17,718,986	$ 20,496,309

See accompanying notes.

NOTE 1 – ORGANIZATION

Partnership Health Plan of California (the "Health Plan"), a County Organized Health System, is a joint public/private managed health care system serving Medi-Cal eligible persons in fourteen (14) counties: Solano, Napa, Yolo, Sonoma, Mendocino, Marin, Lake, Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity. The Health Plan is an independent public agency separate and distinct from each County's government. Pursuant to the California Welfare and Institutions Code, the Health Plan was created by the Solano County Board of Supervisors through the adoption of an ordinance on November 3, 1992. The Health Plan began operations on May 1, 1994. The Health Plan began covering Medi-Cal eligible persons in Napa County on March 1, 1998, Yolo County on March 1, 2001, Sonoma County on October 1, 2009, Mendocino and Marin counties on July 1, 2011, and began serving Medi-Cal beneficiaries in eight (8) counties in the Northern Region on September 1, 2013. Beginning July 2018 and in accordance with direction from the California Department of Health Care Services ("CDHCS"), the Health Plan has consolidated its reporting from these fourteen counties into two regions to the CDHCS; these are in alignment with the two CDHCS rating regions.

The Health Plan has contracted with CDHCS 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. Provider agreements are typically for one year with provisions for annual renewal and contain quality performance measures.

Established by Assembly Bill ("AB") AB 1653, the Health Quality Assurance Fee ("HQAF") program allows additional draw down of federal funding to be used for increased payments to general acute care hospitals for inpatient services rendered to Medi-Cal beneficiaries. CDHCS provides increased capitation payments to Medi-Cal managed health care plans who in turn expend 100 percent of any increased capitation payments on hospital services. In April 2011, Senate Bill ("SB") SB90 was signed into law, which extended the HQAF through June 30, 2011. SB335, signed into law in September 2011, extended the HQAF portion of SB90 for an additional 30 months through December 31, 2013. The payments were received and distributed in a manner prescribed as a pass through to revenue. SB239, signed into law October 8, 2013, extended the program for an additional 36 months from January 1, 2014 through December 31, 2016. In November of 2016, California approved Proposition 52, which made SB239 permanent and also created HQAF V. The program period for HQAF V is from January 1, 2017 through June 30, 2019. An extension of the program known as HQAF VI, covering July 1, 2019–December 31, 2021 was approved by the Centers for Medicare & Medicaid Services in February 2020.

Beginning January 1, 2022, CDHCS began implementing California Advancing and Innovating Medi-Cal ("CalAIM") to modernize the state of California's Medi-Cal Program. CalAIM will require managed care plans to implement 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. CalAIM is expected to provide additional new funding to the Health Plan and increase expenses, the total magnitude of which are unknown at this time.

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 are included in net investment and interest income reported in the statements of revenues, expenses, and changes in net position.

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.

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 lessee as the discount rate or that is implicit in the contract to the lessee. Short-term lease receipts and variable lease receipts not included in the measurement of the lease receivable are recognized as income when earned.

Quality improvement program – Quality improvement program pools are calculated based upon a budgeted fixed per member per month rate for primary care providers ("PCP"), percentage of capitation or contracted rate hospital, and percentage of contracted rate for long-term care providers ("LTC"). The rate is subject to adjustment depending on the Health Plan's financial performance and may change pending unforeseen State of California budget impacts to the plan and changes in the regulatory environment. 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 future developments, management is of the opinion that the quality improvement programs are adequate to cover such estimates.

Intra-governmental transfer ("IGT") payable – Approved in June 2011 and effective retroactively to July 2009, CDHCS implemented a supplemental revenue or intra-governmental transfer program. This program assesses a fee on the revenue of certain participating health plan providers. CDHCS then uses this assessment to obtain matching federal funds based on that approved program. Once CDHCS obtains the federal match, it returns the original assessed fee and a portion of the matched federal funds to the participating health plan provider through the Health Plan's administration. As of June 30, 2022 and 2021, $5,328,350, included in accounts payable and accrued expenses, remains for the expected payout of IGT.

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, 2022 and 2021. Unrestricted net position consists of net position that does not meet the definition of "restricted" or "invested in capital assets." Of the total amount of unrestricted net position reported as of June 30, 2022 and 2021, the Health Plan's Board of Commissioners has designated $97,886,315 and $99,696,761, respectively, toward the tangible net equity requirement of DMHC. Designated funds remain under the control of the Board of Commissioners, which at its discretion later, may use the funds for other purposes. The capital reserve policy was subsequently revised to include Board approved capital and infrastructure purchases as well as an estimate for the State Financial Performance Guarantee based on new state contract requirements for 2024. Management estimated the designated reserve under this revised methodology to be $981,979,475 and $529,644,297 as of June 30, 2022 and 2021, respectively.

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. Non-operating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from non-exchange 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 CDHCS. CDHCS 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 CDHCS on a monthly basis in arrears based on estimated membership. Payments include retrospective adjustments that are reconciled monthly by CDHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to CDHCS for these retrospective adjustments. These estimates are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known.

Effective with the enrollment of the Adult Expansion Population per the Affordable Care Act ("ACA") on January 1, 2014, the Health Plan is subject to CDHCS requirements to meet a minimum 85% medical loss ratio for this population for the periods January 1, 2014 through June 30, 2015, and for fiscal years ending June 30, 2017 and 2016. Specifically, the Health Plan is required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by CDHCS. In the event the Health Plan expends less than the 85% requirement, the Health Plan will be required to return to CDHCS the difference between the minimum threshold and the actual allowed medical expenses. As of June 30, 2022 and 2021, the Health Plan included, in the payable to the State of California, an estimated return of funds of $32,633,113 as a reduction to the total amount expected from CDHCS, pending final reconciliation from CDHCS.

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, 2022 or 2021.

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 additional incentive payments in certain circumstances.

Premium tax – On March 1, 2016, SB X2-2 established a new Medi-Cal Managed Care Organizations ("MCO") tax, to be administered by CDHCS, effective July 1, 2016 through July 1, 2019. The tax would be assessed by CDHCS on licensed health care service plans, managed care plans contracted with CDHCS to provide Medi-Cal services, and alternate health care service plans ("AHCSP"), as defined, except as excluded by the bill. This bill would establish applicable taxing tiers and per enrollee amounts for the 2016–2017, 2017–2018, and 2018–2019 fiscal years, for all enrollees, as defined. On September 27, 2019, Assembly Bill 115 (Chapter 348, Statutes 2019) authorized DHCS to implement a modified MCO tax model on specified health plans, which was approved by the Centers for Medicare & Medicaid Services on April 3, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022.

Premium tax expense for the years ended June 30, 2022 and 2021 was $166,250,000 and $149,229,691, 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 Supplemental Executive Retirement Plan ("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, 2022 and 2021, the Health Plan had cash and deposits with four (4) financial institutions. Cash deposits had carrying amounts of $1,223,135,598 and $924,753,629, respectively, and bank balances of $1,257,720,330 and $998,395,074, respectively. Of the bank balances at June 30, 2022 and 2021, $184,450,393 and $187,655,970, respectively, were not covered by federal depository insurance.

The Health Plan's business could be impacted by federal and state legislation, and governmental licensing regulations of Health Maintenance Organizations ("HMOs") and insurance companies. External influences in these areas could have the potential to adversely impact the Health Plan's operations in the future.

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.

New accounting pronouncements – In June 2017, the GASB issued Statement No. 87, *Leases* ("GASB No. 87"), which is effective for financial statements for periods beginning after December 15, 2019. GASB No. 87 increases the usefulness of financial statements by requiring recognition of certain leased assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB No. 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, ("GASB No. 95"), *Postponement of the Effective Dates of Certain Authoritative Guidance*, which deferred the effective date of GASB No. 87 to fiscal years beginning after June 15, 2021, and all reporting period thereafter. The Health Plan adopted GASB No. 87 as of July 1, 2021 and retrospectively applied it to July 1, 2020. The Health Plan evaluated contracts that were formerly accounted for as operating leases to determine whether they meet the definition of a lease as defined in GASB 87. The contracts related to the leases of the buildings meet the definition of a lease and the Health Plan calculated and recognized a lease receivable of $798,216 and deferred inflows of resources of $785,804 as of June 30, 2021. The beginning net position was restated by $352,989 for the adoption of GASB 87.

NOTE 3 – CASH AND INVESTMENTS

Cash and investments as of June 30, 2022 and 2021 consisted of the following:

	2022	2021
Cash on hand	$ 3,300	$ 3,300
Cash deposits	1,039,282,091	740,343,903
Cash equivalents	183,850,207	184,406,426
Certificates of deposit	300,000	300,000
Total cash and investments	$ 1,223,435,598	$ 925,053,629

The investments balance consisting of certificates of deposit of $300,000 as of June 30, 2022 and 2021, 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, 2022 and 2021, deposits exposed to custodial credit risk as they were uninsured, and the collateral held by the pledging bank not in the Health Plan's name were $1,220,325,456 and $921,847,109, respectively.

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, 2022 and 2021, 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, 2022 and 2021 was as follows:

	June 30, 2022		June 30, 2021	
Investment Type	Fair Value	Weighted Average Maturity (Years)	Fair Value	Weighted Average Maturity (Years)
Certificates of Deposit	$ 300,000	0.86	$ 300,000	0.51
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, 2022:

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, 2021:

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 listed in the table on page 25. 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, 2022 and 2021.

NOTE 4 – CAPITAL ASSETS

A summary of changes in capital assets for the years ended June 30, 2022 and 2021 is as follows:

	Beginning Balance 2022	Increases	Decreases	Transfers/Reclass	Ending Balance 2022
Motor vehicles	$ 154,341	$ -	$ -	$ -	$ 154,341
Equipment	40,378,221	1,135,968	-	251,782	41,765,971
Furniture	7,518,859	-	-	-	7,518,859
Leasehold improvements	962,374	-	-	-	962,374
Land	6,767,292	-	-	-	6,767,292
Building	55,932,087	-	-	-	55,932,087
Building improvements	30,043,722	391,898	-	668,401	31,104,021
Capital projects	21,243,185	10,108,106	-	(920,183)	30,431,108
Total capital assets	163,000,081	11,635,972	-	-	174,636,053
Less: depreciation expense and accumulated depreciation related to disposals	(57,449,712)	(9,265,763)	-	-	(66,715,475)
Capital assets, net of accumulated depreciation	$ 105,550,369	$ 2,370,209	$ -	$ -	$ 107,920,578

	Beginning Balance 2021	Increases	Decreases	Transfers/Reclass	Ending Balance 2021
Motor vehicles	$ 140,518	$ 13,823	$ -	$ -	$ 154,341
Equipment	38,695,182	758,867	-	924,172	40,378,221
Furniture	7,518,859	-	-	-	7,518,859
Leasehold improvements	962,374	-	-	-	962,374
Land	6,767,292	-	-	-	6,767,292
Building	55,932,087	-	-	-	55,932,087
Building improvements	28,441,442	429,261	-	1,173,019	30,043,722
Capital projects	14,736,360	8,604,016	-	(2,097,191)	21,243,185
Total capital assets	153,194,114	9,805,967	-	-	163,000,081
Less: depreciation expense and accumulated depreciation related to disposals	(46,887,574)	(10,562,138)	-	-	(57,449,712)
Capital assets, net of accumulated depreciation	$ 106,306,540	$ (756,171)	$ -	$ -	$ 105,550,369

Depreciation and amortization expense included in general and administrative expenses were $9,265,763 and $10,562,138 for the years ended June 30, 2022 and 2021, respectively.

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, 2022 and 2021:

	2022	2021
Beginning balance	$ 459,028,387	$ 399,389,218
Incurred	2,154,874,283	2,221,926,309
Paid	(2,155,934,714)	(2,162,287,140)
Ending balance	$ 457,967,956	$ 459,028,387

Accrued claims liability decreased by $1.1 million in comparison to the previous year. $28.4 million of this decrease is in the general medical claims payable reserves and is due to the changes between actual payments for medical services and estimated amounts in previous years. An additional decrease of $0.6 million can be attributed to other accrued claims and claim settlements. This is offset by an increase of $27.9 million from the accruals and payments of State directed Proposition 56 supplemental payments.

NOTE 6 – QUALITY IMPROVEMENT PROGRAM

Under the terms of certain provider agreements, the Health Plan has agreed to various quality improvement program arrangements. Effective July 1, 2010, the Health Plan sets aside a pre-determined amount to distribute to primary care providers participating in their Quality Improvement Program. The total allotted dollar amount may fluctuate according to financial performance. The amount paid to each provider is determined by points earned across several quality measures within the following domains: Healthcare Effectiveness Data and Information Set ("HEDIS"), Disease Management, Use of Resources, Access, Health Information Technology ("HIT"), and Member Satisfaction. Participation in the quality program is mandatory for contacted primary care physicians and there is no downside risk to them.

At June 30, 2022 and 2021, the Health Plan has accrued $87,525,942 and $60,197,271, respectively, due to providers under the quality improvement program.

NOTE 7 – LEASES

The Health Plan is a lessor for various noncancellable lease of office space with lease terms through 2025. For the year ending June 30, 2022, the Health Plan recognized $1,001,416 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 $50,261 for the year ending June 30, 2022. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during the fiscal year.

NOTE 8 – 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 Supplemental Executive Retirement Plan ("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 10 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 9.44% and 58.12% in 2022 and 2021, respectively, of annual covered payroll. The contribution rate established bi-annually and maybe 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:

	Level 1	Level 2	Level 3	Fair Value Measurement at June 30, 2022
Investments by fair value level				
Mutual funds	$ 16,864,065	$ -	$ -	$ 16,864,065
Total investments	$ 16,864,065	$ -	$ -	$ 16,864,065

	Level 1	Level 2	Level 3	Fair Value Measurement at June 30, 2021
Investments by fair value level				
Mutual funds	$ 20,380,980	$ -	$ -	$ 20,380,980
Total investments	$ 20,380,980	$ -	$ -	$ 20,380,980

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

	2022	2021
Retired and beneficiaries	5	5
Inactive	-	1
Active	17	11
Total participants	22	17

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:

	2022	2021
Pension cost:		
Service cost	$ 496,313	$ 345,867
Interest on total pension liability	865,883	800,244
Administrative expenses	143,782	130,552
Member contributions	(70,605)	(67,292)
Expected investment return, net of investment expenses	(1,317,521)	(1,044,136)
Recognition of deferred outflows of resources:		
Recognition of economic/demographic gains	217,534	167,868
Recognition of assumption changes	(27,575)	(33,356)
Recognition of investment gains	401,276	(375,728)
Total pension (benefit) cost	$ 709,087	$ (75,981)

	2022	2021
Deferred outflows of resources as of June 30:		
Difference between expected and actual experience	$ 1,050,267	$ 878,247
Changes in assumptions	88,421	52,107
Net difference between projected and actual earnings on pension plan investments	1,746,085	-
Total	$ 2,884,773	$ 930,354
Deferred inflows of resources as of June 30:		
Difference between expected and actual	$ (115,315)	$ (182,690)
Changes in assumptions	(71,103)	(115,545)
Net difference between projected and actual earnings on pension plan investments	-	(1,486,706)
Total	$ (186,418)	$ (1,784,941)

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

Years Ending June 30,	
2023	$ 583,560
2024	550,382
2025	411,203
2026	860,131
2027	115,651
Thereafter	177,428
	$ 2,698,355

The following table summarizes changes in pension (asset) liability for the fiscal year ended June 30, 2022:

	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance, June 30, 2021	$ 13,265,051	$ 20,496,309	$ (7,231,258)
Changes during the year:			
Service cost	496,313		496,313
Interest on the total pension asset	865,883		865,883
Effect of plan changes			-
Effect of economic/demographic gains or losses	456,929		456,929
Effect of assumptions, changes, or inputs	53,181		53,181
Benefit payments, including refunds of employee contributions	(894,232)	(894,232)	-
Contributions - employer		506,632	(506,632)
Contributions - members		70,605	(70,605)
Net investment income		(2,316,546)	2,316,546
Administrative expenses		(143,782)	143,782
Net change in total pension liability (asset)	978,074	(2,777,323)	3,755,397
Balance, June 30, 2022	$ 14,243,125	$ 17,718,986	$ (3,475,861)
Total pension liability			$ 14,243,125
Plan fiduciary net position			17,718,986
Net pension asset			$ (3,475,861)
Plan fiduciary net position as a percentage of the total pension liability			124.40%
Covered-employee payroll			$ 5,364,882
Plan net pension asset as of a percentage of covered-employee payroll			-64.79%

The following table summarizes changes in pension liability for the fiscal year ended June 30, 2021:

	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance, June 30, 2020	$ 12,375,376	$ 15,921,645	$ (3,546,269)
Changes during the year			
Service cost	345,867		345,867
Interest on the total pension asset	800,244		800,244
Effect of plan changes			-
Effect of economic/demographic gains or losses	576,240		576,240
Effect of assumptions, changes, or inputs			-
Benefit payments, including refunds of employee contributions	(832,676)	(832,676)	-
Contributions - employer		2,199,301	(2,199,301)
Contributions - members		67,292	(67,292)
Net investment income		3,271,299	(3,271,299)
Administrative expenses		(130,552)	130,552
Net change in total pension liability (asset)	889,675	4,574,664	(3,684,989)
Balance, June 30, 2021	$ 13,265,051	$ 20,496,309	$ (7,231,258)
Total pension liability			$ 13,265,051
Plan fiduciary net position			20,496,309
Net pension asset			$ (7,231,258)
Plan fiduciary net position as a percentage of the total pension liability			154.51%
Covered-employee payroll			$ 3,783,868
Plan net pension asset as of a percentage of covered-employee payroll			-191.11%

The following table summarizes the actuarial assumptions used to determine net pension (asset) liability and plan fiduciary net position as of June 30, 2022:

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:	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 Pension Plans

The following table summarizes the sensitivity of net pension asset to changes in the discount rate as of June 30, 2022:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
Total pension liability	$ 15,297,630	$ 14,243,125	$ 13,300,032
Fiduciary net position	17,718,986	17,718,986	17,718,986
Net pension asset	$ (2,421,356)	$ (3,475,861)	$ (4,418,954)

The following table summarizes the sensitivity of net pension asset to changes in the discount rate as of June 30, 2021:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
Total pension liability	$ 14,249,977	$ 13,265,051	$ 12,303,806
Fiduciary net position	20,496,309	20,496,309	20,496,309
Net pension asset	$ (6,246,332)	$ (7,231,258)	$ (8,192,503)

NOTE 9 – 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 $97,886,315 and $99,696,761 at June 30, 2022 and 2021, respectively. The Health Plan's tangible net equity was $766,743,852 and $650,645,578 at June 30, 2022 and 2021, respectively.

NOTE 10 – 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.

NOTE 11 – 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 12 – HEALTH CARE REFORM

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates or benefits. The ultimate outcome of these proposals, including the potential effects of or changes to health care reform that will be enacted cannot presently be determined.

Supplementary Information

Partnership Health Plan of California
Statement of Revenues, Expenses, and Changes in Net Position – Actual and Budget Operations
Year Ended June 30, 2022

	Actual	Budget	Variance Revenue/ Expense Over (Under)
OPERATING REVENUES			
California Department of Health Care Services revenue	$ 3,285,782,331	$ 3,280,109,976	$ 5,672,355
Other income	22,294,264	5,413,476	16,880,788
Total operating revenues	3,308,076,595	3,285,523,452	22,553,143
OPERATING EXPENSES			
Health care expenses:			
Fee for service hospital, physician, and other services	1,583,762,419	1,661,125,583	(77,363,164)
Capitated physician, hospital, and other costs	576,924,916	559,784,846	17,140,070
Long-term care	387,085,317	392,402,212	(5,316,895)
Pharmacy	183,589,558	178,908,641	4,680,917
Quality improvement program and hospital stop loss	85,295,989	105,887,620	(20,591,631)
Total health care expenses	2,816,658,199	2,898,108,902	(81,450,703)
GENERAL AND ADMINISTRATIVE EXPENSES			
Other admin expenses	31,192,619	17,280,816	13,911,803
Employee expenses	115,268,874	115,577,927	(309,053)
Travel/meeting/meals expenses	319,644	979,217	(659,573)
Occupancy costs	13,330,762	20,303,257	(6,972,495)
Operating costs	4,218,969	6,389,966	(2,170,997)
Professional services	35,324,938	23,903,251	11,421,687
Computer and data expenses	10,892,369	11,186,621	(294,252)
Total general and administrative expenses	210,548,175	195,621,055	14,927,120
Premium tax	166,250,000	171,800,004	(5,550,004)
Total operating expenses	3,193,456,374	3,265,529,961	(72,073,587)
Operating income	114,620,221	19,993,491	94,626,730
NONOPERATING REVENUES			
Investment income	1,478,053	1,218,996	259,057
Total nonoperating revenues	1,478,053	1,218,996	259,057
INCREASE IN NET POSITION	116,098,274	21,212,487	94,885,787
NET POSITION, beginning of year	650,645,578	650,645,578	-
NET POSITION, end of year	$ 766,743,852	$ 671,858,065	$ 94,885,787

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, 2022 and 2021

	2022	2021
TOTAL PENSION LIABILITY		
Service cost	$ 496,313	$ 345,867
Interest	865,883	800,244
Difference between expected and actual experience	456,929	576,240
Changes of assumptions	53,181	-
Benefit payments, including refunds of employee contributions	(894,232)	(832,676)
Net change in total pension liability	978,074	889,675
TOTAL PENSION LIABILITY, beginning of fiscal year	13,265,051	12,375,376
TOTAL PENSION LIABILITY, end of fiscal year	$ 14,243,125	$ 13,265,051
PLAN FIDUCIARY NET POSITION		
Contributions - employer	$ 506,632	$ 2,199,301
Contributions - employee	70,605	67,292
Net investment income	(2,316,546)	3,271,299
Benefit payments, including refunds of employee contributions	(894,232)	(832,676)
Other changes in fiduciary net position	(143,782)	(130,552)
Net change in fiduciary net position	(2,777,323)	4,574,664
PLAN FIDUCIARY NET POSITION, beginning of fiscal year	20,496,309	15,921,645
PLAN FIDUCIARY NET POSITION, end of fiscal year	$ 17,718,986	$ 20,496,309
PLAN NET PENSION ASSET	$ (3,475,861)	$ (7,231,258)
PLAN FIDUCIARY NET POSITION as a percentage of the total pension asset	124.40%	154.51%
COVERED EMPLOYEE PAYROLL	$ 5,364,882	$ 3,783,868
PLAN NET PENSION ASSET as of a percentage of covered employee payroll	-64.79%	-191.11%

Partnership Health Plan of California
Supplementary Schedule of Contributions
Years Ended June 30, 2022 and 2021

Fiscal Year Ending June 30	Actuarially Determined Contributions	Actual Employer Contribution	Contribution Excess	Covered Payroll	Contribution as a % of Covered Payroll
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%

Partnership Health Plan of California
Partnership Health Plan of California Supplemental Executive Retirement Plan – Supplementary Schedule of Investment Returns
Years Ended June 30, 2022 and 2021

Years Ended June 30	Rate of return
2018	5.59%
2019	5.58%
2020	3.61%
2021	20.33%
2022	-11.44%

Communications with the Commissioners

Partnership Health Plan of California

June 30, 2022

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, 2022 and have issued our report thereon dated October ___, 2022. 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 4, 2022 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 4, 2022.

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. There were no changes in the application of existing policies and the Health Plan adopted Governmental Accounting Standards Board (GASB) Statement No. 87, *Leases* during 2022. 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 combined 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.

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 was 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 or 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 ____, 2022.

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 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 ____, 2022

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan Of California
For the Period Ending August 31, 2022

Financial Analysis for the Current Period

Total (Deficit) Surplus

For the month ending August 31, 2022, PHC reported a net deficit of -$3.7 million, bringing the year-to-date deficit to -$3.3 million . Significant variances are explained below.

Revenue

Total Revenue is greater than budget by $1.8 million for the month and lower than budget by $2.1 million for the year-to-date. The unfavorable variance is due to timing differences of supplemental submissions to DHCS along with unbudgeted revenue adjustments related to estimated acuity adjustments for CY 2022 rates.

Healthcare Costs

Total Healthcare Costs are greater than budget by $7.0 million for the month and $13.2 million for the year-to-date. Physician and Ancillary expenses are $5.0 million unfavorable due to increase in utilization. Global Subcapitation is $3.3 million unfavorable due primarily to timing of contracted rate changes; pending contract changes will continue to produce a variance until agreements are finalized and true-ups are completed. Transportation expense is $1.4 million favorable for the month due to lower than budgeted expenses. Healthcare Investment Funds and Quality Assurance are $1.5 million favorable due to timing differences.

Administrative Costs

Total administrative costs are lower than budget by $2.4 million for the month and $5.7 million for the year-to-date. The positive variance in Employee expenses continues to be from the higher number of open positions that were budgeted for but have not yet been filled. The positive variance in Computer and Data are from the budgeted dollars for HealthEdge, and the positive variance in Professional Services are from the budgeted dollars for consultants; as these costs are realized in the upcoming months, the variances in these categories should decrease.

Balance Sheet

Total Cash & Cash Equivalents decreased by $14.3 million for the month. $267.8 million in State Capitation payments, $2.9 million in Drug Medi-Cal payments, $1.6 million in incentive program payments, and $1.2 million in interest earnings were received during the month; additionally, $3.8 million in board-designated reserve transfers were recorded during the month. These inflows were offset by $271.8 million in healthcare cost payments, $3.3 million in Drug Medi-Cal payments, $16.7 million in administrative and capital costs. The remaining difference can be attributed to other revenues.

General Statistics

Membership

Membership had a total net increase of 2,839 members for the month.

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan Of California
For the Period Ending August 31, 2022

Utilization Metrics and High Dollar Case

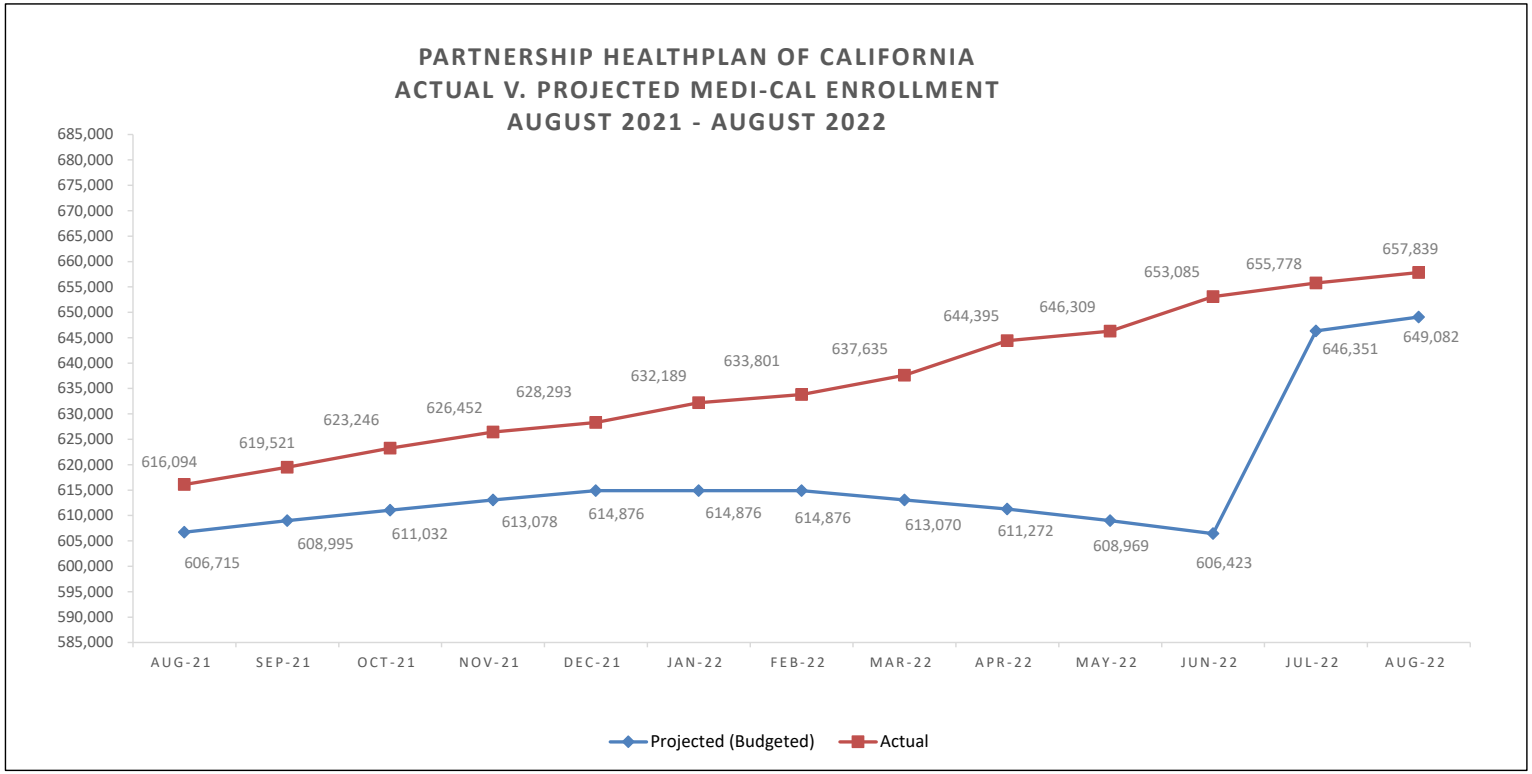
For the fiscal year 2022/23 through August 31, 2022, 6 members reached the $250,000 threshold with an average cost of $563,082. For fiscal year 2021/22, 432 members reached the $250,000 threshold with an average cost per case was $454,914. For fiscal year 2020/21, 508 members reached the $250,000 threshold with an average claims cost of $491,245.

Current Ratio/Required Reserves

Current Ratio Including Required Reserves	**1.84**
Current Ratio Excluding Required Reserves:	**0.71**
Required Reserves:	**$981,646,296**
Total Fund Balance:	**$763,492,462**

Days of Cash on Hand

Including Required Reserves:	**138.28**
Excluding Required Reserves:	**41.17**



Member Months by County:

County	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Solano	122,560	123,349	124,247	125,202	125,748	126,876	127,721	128,602	130,389	130,408	132,152	132,795	133,221
Napa	31,786	31,879	31,874	32,186	32,223	32,566	32,447	32,696	33,096	33,622	33,994	33,921	34,122
Yolo	56,290	56,687	57,644	58,371	58,386	58,531	58,770	59,008	59,247	59,768	60,067	60,315	60,352
Sonoma	118,045	118,578	119,138	119,850	120,345	121,061	121,635	122,221	123,035	124,906	125,724	126,276	127,033
Marin	43,883	44,239	44,637	44,731	44,833	45,288	45,344	45,716	46,275	47,488	48,025	48,307	48,355
Mendocino	38,773	38,942	39,128	39,272	39,266	39,507	39,422	39,655	40,143	39,955	40,422	40,476	40,585
Lake	32,933	33,083	33,137	33,281	33,340	33,552	33,537	33,682	33,892	34,005	34,202	34,267	34,460
Del Norte	12,147	12,138	12,175	12,166	12,271	12,233	12,245	12,323	12,378	12,331	12,415	12,470	12,438
Humboldt	57,547	57,895	58,203	58,217	58,347	58,779	58,818	59,127	59,837	59,059	59,637	59,988	60,064
Lassen	8,129	8,186	8,189	8,264	8,343	8,413	8,383	8,459	8,616	8,474	8,631	8,692	8,696
Modoc	3,761	3,785	3,809	3,803	3,820	3,871	3,883	3,896	3,981	3,887	3,976	3,990	4,000
Shasta	66,323	66,734	66,922	67,042	67,225	67,304	67,413	67,990	68,974	68,078	69,215	69,530	69,767
Siskiyou	18,733	18,826	18,926	18,830	18,859	18,921	18,911	18,900	19,094	18,865	19,120	19,184	19,208
Trinity	5,184	5,200	5,217	5,237	5,287	5,287	5,272	5,360	5,438	5,463	5,505	5,567	5,538
All Counties Total	**616,094**	**619,521**	**623,246**	**626,452**	**628,293**	**632,189**	**633,801**	**637,635**	**644,395**	**646,309**	**653,085**	**655,778**	**657,839**

Medi-Cal Region 1: Solano, Napa, Yolo & Marin; Medi-Cal Region 2: Sonoma, Mendocino & Rural 8 Counties

Partnership HealthPlan of California
Comparative Financial Indicators Monthly Report
Fiscal Year 2022 - 2023 & Fiscal Year 2021 - 2022

FINANCIAL INDICATORS	Jul-22	Aug-22											YTD	Avg / Month As of Aug-22
Total Enrollment	656,979	659,818											1,316,797	658,399
Total Revenue	267,284,264	274,023,503											541,307,768	270,653,884
Total Healthcare Costs	241,534,619	251,300,354											492,834,973	246,417,486
Total Administrative Costs	10,017,179	11,227,839											21,245,019	10,622,509
Medi-Cal Hospital & Managed Care Taxes	15,239,583	15,239,583											30,479,166	15,239,583
Total Current Year Surplus (Deficit)	492,883	(3,744,273)											(3,251,390)	(1,625,694)
Total Claims Payable	477,170,822	462,743,832											462,743,832	469,957,327
Total Fund Balance	767,236,734	763,492,462											763,492,462	765,364,598
Reserved Funds														
State Financial Performace Guarantee	544,383,000	541,137,000											541,137,000	542,760,000
State Financial Performace Guarantee - 2024 Expansion Counties	176,589,000	176,452,000											176,452,000	176,520,500
Regulatory Reserve Requirement	95,682,198	96,841,016											96,841,016	96,261,607
Board Approved Capital and Infrastructure Purchases	58,903,733	57,323,454											57,323,454	58,113,594
Capital Assets	108,759,668	109,892,826											109,892,826	109,326,247
Strategic Use of Reserve-Board Approved Community Reinvestments	73,609,149	73,596,300											73,596,300	73,602,724
Unrestricted Fund Balance	(290,690,013)	(291,750,135)											(291,750,135)	(291,220,074)
Fund Balance as % of Reserved Funds	72.52%	72.35%											72.35%	72.44%
Current Ratio (including Required Reserves)	1.83:1	1.84:1											1.84:1	1.84:1
Medical Loss Ratio w/o Tax	96.06%	97.35%											96.71%	96.71%
Admin Ratio w/o Tax	3.98%	4.35%											4.17%	4.17%
Profit Margin Ratio	0.18%	-1.37%											-0.60%	-0.60%

FINANCIAL INDICATORS	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD	Avg / Month As of Jun-22
Total Enrollment	612,565	615,504	619,135	622,749	625,752	627,918	632,226	633,903	637,424	643,907	650,413	653,187	7,574,683	631,224
Total Revenue	285,770,409	290,492,773	289,217,239	289,434,715	295,168,702	291,059,764	280,860,131	279,174,488	277,787,868	221,339,725	251,583,638	257,635,957	3,309,525,408	275,793,784
Total Healthcare Costs	258,057,572	256,910,666	252,438,582	251,402,013	258,737,530	263,716,815	230,109,224	227,347,263	219,750,867	215,289,341	225,173,550	215,139,622	2,874,073,045	239,506,087
Total Administrative Costs	9,527,532	9,674,878	10,915,842	10,456,654	10,013,386	12,195,146	11,432,906	10,800,639	16,431,194	10,231,596	11,360,634	29,890,467	152,930,874	12,744,239
Medi-Cal Hospital & Managed Care Taxes	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,163	166,250,000	13,854,167
Total Current Year Surplus (Deficit)	4,331,138	10,053,062	12,008,648	13,721,881	12,563,619	1,293,636	25,463,834	27,172,419	27,751,640	(18,035,379)	1,195,287	(1,248,295)	116,271,489	9,689,291
Total Claims Payable	479,612,906	469,987,817	490,436,456	489,196,877	474,284,933	488,534,512	474,970,355	492,259,098	538,975,371	558,387,815	481,431,569	457,967,956	457,967,956	491,337,139
Total Fund Balance	654,962,002	665,015,064	677,023,711	690,745,592	703,309,211	704,602,847	730,066,681	757,239,100	784,990,740	766,955,362	768,150,648	766,743,852	766,743,852	722,483,734
Reserved Funds														
Required Reserves	316,541,291	315,879,635	319,469,943	321,526,405	323,304,964	326,844,174	328,526,038	328,039,443	325,955,436	322,661,996	319,373,345	-	-	295,676,889
State Financial Performace Guarantee	-	-	-	-	-	-	-	-	-	-	-	547,630,000	547,630,000	45,635,833
State Financial Performace Guarantee - 2024 Expansion Counties	-	-	-	-	-	-	-	-	-	-	-	168,159,000	168,159,000	14,013,250
Regulatory Reserve Requirement	102,368,056	105,893,648	103,703,232	103,061,873	104,622,613	105,274,263	101,599,402	101,205,061	100,276,930	97,507,282	98,770,865	98,186,315	98,186,315	8,182,193
Board Approved Capital and Infrastructure Purchases	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	60,383,581	60,383,581	18,781,965
Capital Assets	105,684,355	105,331,238	106,055,796	106,519,267	106,191,511	106,189,354	106,721,219	106,521,169	106,252,966	108,221,301	107,962,012	107,920,578	107,920,578	106,630,897
Strategic Use of Reserve-Board Approved Community Reinvestments	80,012,212	79,785,705	76,769,579	76,300,252	76,231,209	76,149,155	75,717,707	74,488,498	73,989,726	73,956,826	73,743,606	73,686,338	73,686,338	75,902,568
Unrestricted Fund Balance	35,356,088	43,124,838	56,025,161	68,337,796	77,958,915	75,145,902	102,502,315	131,984,929	163,515,682	149,607,956	153,300,820	(289,221,960)	(289,221,960)	63,969,870
Fund Balance as % of Reserved Funds	105.71%	106.93%	109.02%	110.98%	112.47%	111.94%	116.33%	121.11%	126.31%	124.23%	124.93%	72.61%	72.61%	109.71%
Current Ratio (including Required Reserves)	1.77:1	1.77:1	1.74:1	1.79:1	1.80:1	1.71:1	1.68:1	1.83:1	1.68:1	1.79:1	1.84:1	1.84:1	1.84:1	1.77:1
Medical Loss Ratio w/o Tax	94.94%	92.93%	91.76%	91.34%	92.11%	95.29%	86.64%	86.16%	83.75%	104.62%	95.42%	83.59%	91.32%	91.32%
Admin Ratio w/o Tax	3.51%	3.50%	3.97%	3.80%	3.56%	4.41%	4.30%	4.09%	6.26%	4.97%	4.81%	11.69%	4.87%	4.87%
Profit Margin Ratio	1.52%	3.46%	4.15%	4.74%	4.26%	0.44%	9.07%	9.73%	9.99%	-8.15%	0.48%	-0.55%	3.51%	3.51%

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending August 31, 2022

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
659,818	656,979	2,839	**Total Membership**	658,399	614,035	44,364

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
274,023,503	272,240,051	1,783,452	**Total Revenue**	541,307,768	543,454,748	(2,146,980)
251,300,354	244,291,633	(7,008,721)	**Total Healthcare Costs**	492,834,973	479,671,363	(13,163,610)
11,227,839	13,642,208	2,414,369	**Total Administrative Costs**	21,245,019	26,925,114	5,680,095
15,239,583	15,239,583	-	**Medi-Cal Managed Care Tax**	30,479,166	30,479,166	-
(3,744,273)	**(933,373)**	**(2,810,900)**	**Total Current Year Surplus (Deficit)**	**(3,251,390)**	**6,379,105**	**(9,630,495)**
97.35%	95.15%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	96.71%	93.60%	
4.35%	5.31%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	4.17%	5.25%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of August 31, 2022

	August 2022	July 2022
A S S E T S		
Current Assets		
Cash &Cash Equivalents	**369,544,156**	**383,827,154**
Receivables		
Accrued Interest	257,100	134,100
State DHS - Cap Rec	148,783,121	149,508,441
Other Healthcare Receivable	12,116,302	12,950,681
Miscellaneous Receivable	8,291,544	5,488,106
Total Receivables	**169,448,067**	**168,081,328**
Other Current Assets		
Payroll Clearing	6,931	(3,787)
Prepaid Expenses	6,145,811	5,681,365
Total Other Current Assets	**6,152,742**	**5,677,578**
Total Current Assets	**545,144,965**	**557,586,060**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	154,341	154,341
Furniture & Fixtures	7,518,859	7,518,859
Computer Equipment - HP	541,886	541,886
Computer Equipment	20,760,657	20,679,850
Computer Software	20,714,113	20,714,113
Leasehold Improvements	962,374	962,374
Land	6,767,292	6,767,292
Building	55,932,088	55,932,088
Building Improvements	31,231,667	31,132,938
Accum Depr - Motor Vehicles	(148,720)	(147,707)
Accum Depr - Furniture	(7,172,397)	(7,143,685)
Accum Depr - Comp Equip - HP	(541,886)	(541,886)
Accum Depr - Comp Equipment	(20,041,245)	(19,983,503)
Accum Depr - Comp Software	(19,529,839)	(19,460,770)
Accum Depr - Leasehold Improvements	(962,374)	(962,374)
Accum Depr - Building	(9,418,614)	(9,299,101)
Accum Depr - Bldg Improvements	(9,988,276)	(9,817,203)
Construction Work-In-Progress	33,112,899	31,712,157
Total Fixed Assets	**109,892,825**	**108,759,669**
Other Non-Current Assets		
Deposits	81,785	69,883
Board-Designated Reserves	871,453,470	875,257,931
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	3,527,897	3,448,884
Net Pension Asset	3,475,861	3,475,861
Deferred Outflows Of Resources	2,884,773	2,884,773
Total Other Non-Current Assets	**881,723,786**	**885,437,332**
Total Non-Current Assets	**991,616,611**	**994,197,001**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of August 31, 2022

	August 2022	July 2022
Total Assets	**1,536,761,576**	**1,551,783,061**
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	122,788,000	119,349,156
Unearned Income	22,319,415	23,393,489
Suspense Account	2,709,684	2,488,614
Capitation Payable	18,867,146	23,737,052
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	7,252,527	8,499,375
Claims Payable	108,964,166	145,379,062
Incurred But Not Reported-IBNR	353,779,666	331,791,760
Quality Improvement Programs	100,963,807	94,283,116
Total Current Liabilities	**770,277,524**	**781,554,737**
Non-Current Liabilities		
Deferred Inflows Of Resources	2,991,590	2,991,590
Total Non-Current Liabilities	**2,991,590**	**2,991,590**
Total Liabilities	**773,269,114**	**784,546,327**
Fund Balance		
Unrestricted Fund Balance	**(291,750,135)**	**(290,690,013)**
Reserved Funds		
State Financial Performance Guarantee	541,137,000	544,383,000
State Financial Performance Guarantee - Expansion Counties	176,452,000	176,589,000
Regulatory Reserve Requirement	96,841,016	95,682,198
Board Approved Capital and Infrastructure Purchases	57,323,454	58,903,733
Capital Assets	109,892,826	108,759,668
Strategic Use of Reserve-Board Approved Community Reinvestments	73,596,300	73,609,149
Total Reserved Funds	**1,055,242,596**	**1,057,926,748**
Total Fund Balance	**763,492,462**	**767,236,734**
Total Liabilities And Fund Balance	**1,536,761,576**	**1,551,783,061**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Cash Flow
For The Period Ending August 31, 2022

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Services	267,798,762	563,126,528
Other Revenues	1,684,302	1,892,026
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(50,341,528)	(94,131,611)
Medical Claims Payments	(221,411,872)	(384,468,390)
Drug Medi-Cal		
DMC Receipts from Counties	2,900,600	6,004,175
DMC Payments to Providers	(3,261,571)	(5,974,624)
Cash Payments to Vendors	(4,144,120)	(49,440,981)
Cash Payments to Employees	(9,887,920)	(18,323,630)
Net Cash (Used) Provided by Operating Activities	**(16,663,347)**	**18,683,493**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(2,640,612)	(3,016,925)
Net Cash Used by Capital Financial & Related Activities	**(2,640,612)**	**(3,016,925)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	3,804,461	2,605,426
Interest and Dividends on Investments	1,216,500	2,195,460
Net Cash (Used) Provided by Investing Activities	**5,020,961**	**4,800,886**
NET (DECREASE) INCREASE IN CASH & CASH EQUIVALENTS	**(14,282,998)**	**20,467,454**
CASH & CASH EQUIVALENTS, BEGINNING	**383,827,154**	**349,076,702**
CASH & CASH EQUIVALENTS, ENDING	**369,544,156**	**369,544,156**
RECONCILIATION OF OPERATING (LOSS) INCOME TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES:		
TOTAL OPERATING (LOSS) INCOME	**(5,083,773)**	**(5,555,651)**
DEPRECIATION	**447,121**	**1,087,879**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(1,969,058)	(592,366)
California Department of Health Services Receivable	725,320	30,796,602
Other Assets	494,254	(1,619,722)
Accounts Payable and Accrued Expenses	(3,530,912)	(23,646,990)
Accrued Claims Payable	(14,426,990)	4,775,876
Quality Improvement Programs	6,680,691	13,437,865
Net Cash Provided (Used) by Operating Activities	**(16,663,347)**	**18,683,493**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

For The Period Ending August 31, 2022

****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
659,818	**659,818**	**-**			**TOTAL MEMBERSHIP**	**1,316,797**	**1,316,797**	**-**		
					REVENUE					
267,923,967	271,072,013	(3,148,046)	406.06	410.83	State Capitation Revenue	534,030,976	541,118,672	(7,087,696)	405.55	410.94
1,339,500	97,781	1,241,719	2.03	0.15	Interest Income	2,304,261	195,562	2,108,699	1.75	0.15
4,760,036	1,070,257	3,689,779	7.21	1.62	Other Revenue	4,972,531	2,140,514	2,832,017	3.78	1.63
274,023,503	**272,240,051**	**1,783,452**	**415.30**	**412.60**	**TOTAL REVENUE**	**541,307,768**	**543,454,748**	**(2,146,980)**	**411.08**	**412.72**
					HEALTHCARE COSTS					
21,804,594	18,657,496	(3,147,098)	33.05	28.28	Global Subcapitation	43,700,658	37,291,432	(6,409,226)	33.19	28.32
2,475,626	2,478,616	2,990	3.75	3.76	Capitated Medical Groups	4,936,438	4,952,864	16,426	3.75	3.76
					Physician Services					
6,391,942	6,179,447	(212,495)	9.69	9.37	PCP Capitation	12,742,192	12,359,227	(382,965)	9.68	9.39
222,573	233,184	10,611	0.34	0.35	Specialty Capitation	442,674	466,078	23,404	0.34	0.35
41,481,345	36,938,522	(4,542,823)	62.87	55.98	Non-Capitated Physician Services	83,479,664	73,522,100	(9,957,564)	63.40	55.83
48,095,860	**43,351,153**	**(4,744,707)**	**72.90**	**65.70**	**Total Physician Services**	**96,664,530**	**86,347,405**	**(10,317,125)**	**73.42**	**65.57**
					Inpatient Hospital					
18,654,541	18,103,248	(551,293)	28.27	27.44	Hospital Capitation	37,174,678	36,165,015	(1,009,663)	28.23	27.46
63,895,218	69,080,844	5,185,626	96.84	104.70	Inpatient Hospital - FFS	125,481,441	130,268,011	4,786,570	95.29	98.93
1,326,589	1,326,589	-	2.01	2.01	Hospital Stoploss	2,650,140	2,650,140	-	2.01	2.01
83,876,348	**88,510,681**	**4,634,333**	**127.12**	**134.15**	**Total Inpatient Hospital**	**165,306,259**	**169,083,166**	**3,776,907**	**125.53**	**128.40**
35,218,459	33,390,686	(1,827,773)	53.38	50.61	Long Term Care	67,589,360	66,031,780	(1,557,580)	51.33	50.15
					Ancillary Services					
1,023,878	966,605	(57,273)	1.55	1.46	Ancillary Services - Capitated	2,040,806	1,933,239	(107,567)	1.55	1.47
38,688,658	39,853,133	1,164,475	58.64	60.40	Ancillary Services - Non-Capitated	78,621,501	80,220,162	1,598,661	59.71	60.92
39,712,536	**40,819,738**	**1,107,202**	**60.19**	**61.86**	**Total Ancillary Services**	**80,662,307**	**82,153,401**	**1,491,094**	**61.26**	**62.39**
					Other Medical					
2,104,104	2,801,786	697,682	3.19	4.25	Quality Assurance	3,956,184	5,226,784	1,270,600	3.00	3.97
5,190,074	1,184,417	(4,005,657)	7.87	1.80	Healthcare Investment Funds	5,466,108	2,368,834	(3,097,274)	4.15	1.80
91,700	117,876	26,176	0.14	0.18	Advice Nurse	183,000	235,647	52,647	0.14	0.18
635	8,567	7,932	-	0.01	HIPP Payments	1,211	17,126	15,915	-	0.01
5,718,794	6,159,693	440,899	8.67	9.34	Transportation	10,560,120	12,354,826	1,794,706	8.02	9.38
13,105,307	**10,272,339**	**(2,832,968)**	**19.87**	**15.58**	**Total Other Medical**	**20,166,623**	**20,203,217**	**36,594**	**15.31**	**15.34**
7,011,624	6,810,924	(200,700)	10.63	10.32	Quality Improvement Programs	13,808,798	13,608,098	(200,700)	10.49	10.33
251,300,354	**244,291,633**	**(7,008,721)**	**380.89**	**370.26**	**TOTAL HEALTHCARE COSTS**	**492,834,973**	**479,671,363**	**(13,163,610)**	**374.28**	**364.26**
					ADMINISTRATIVE COSTS					
7,344,184	8,471,006	1,126,822	11.13	12.84	Employee	14,334,186	16,120,963	1,786,777	10.89	12.24
48,263	47,901	(362)	0.07	0.07	Travel And Meals	70,167	94,579	24,412	0.05	0.07
778,219	1,066,352	288,133	1.18	1.62	Occupancy	1,715,843	2,278,824	562,981	1.30	1.73
352,046	448,339	96,293	0.53	0.68	Operational	477,000	910,138	433,138	0.36	0.69
1,354,080	1,482,180	128,100	2.05	2.25	Professional Services	2,351,129	3,161,817	810,688	1.79	2.40
1,351,047	2,126,430	775,383	2.05	3.22	Computer And Data	2,296,694	4,358,793	2,062,099	1.74	3.31
11,227,839	**13,642,208**	**2,414,369**	**17.01**	**20.68**	**TOTAL ADMINISTRATIVE COSTS**	**21,245,019**	**26,925,114**	**5,680,095**	**16.13**	**20.44**
15,239,583	15,239,583	-	23.10	23.10	Medi-Cal Managed Care Tax	30,479,166	30,479,166	-	23.15	23.15
(3,744,273)	**(933,373)**	**(2,810,900)**	**(5.70)**	**(1.44)**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**(3,251,390)**	**6,379,105**	**(9,630,495)**	**(2.48)**	**4.87**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
August 31, 2022

1. ORGANIZATION

The Partnership HealthPlan of California (PHC) 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. PHC has quasi-independent political jurisdiction to contract with the State for managing Medi-Cal beneficiaries who reside in various Northern California Counties. PHC is a combined public and private effort engaged principally in providing a more cost-effective method of healthcare. PHC began serving Medi-Cal eligible persons in Solano in May 1994. That was followed by Napa in March of 1998, Yolo in March of 2001, Sonoma in October 2009, Marin and Mendocino in July 2011, and eight Northern Counties in September 2013. Beginning July 2018 and in accordance with direction from the Department of Health Care Services (DHCS), PHC has consolidated its reporting from these fourteen counties into two regions; these are in alignment with the two DHCS rating regions.

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 PHC conform to generally-accepted accounting principles and general practices within the healthcare industry.

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

INVESTMENTS:
PHC 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 2022, PHC has Reserved Funds of $981.6 million, which includes $0.3 million of Knox-Keene Reserves. To account for Board approved Strategic Use of Reserves (SUR) initiatives, which includes funding for the Wellness & Recovery program, an additional $73.6 million has been set aside as a "Strategic Use of Reserve" for community reinvestments. The amount represents the net amount remaining of all of the SUR projects that have been approved to date; this balance is periodically adjusted as projects are completed.

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

PHC 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 become available. Budgeted capitation revenues and healthcare costs are adjusted each month to reflect changes in enrollee counts.

5. QUALITY IMPROVEMENT PROGRAM

PHC maintains quality incentive contracts with acute care hospitals and primary care physicians. As of August 2022, PHC has accrued a Quality Incentive Program payout of $101.0 million.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
August 31, 2022

6. **ESTIMATES**

Due to the nature of the operations of the Partnership 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 Received
- 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, HealthPlan management is of the opinion any liability that 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**

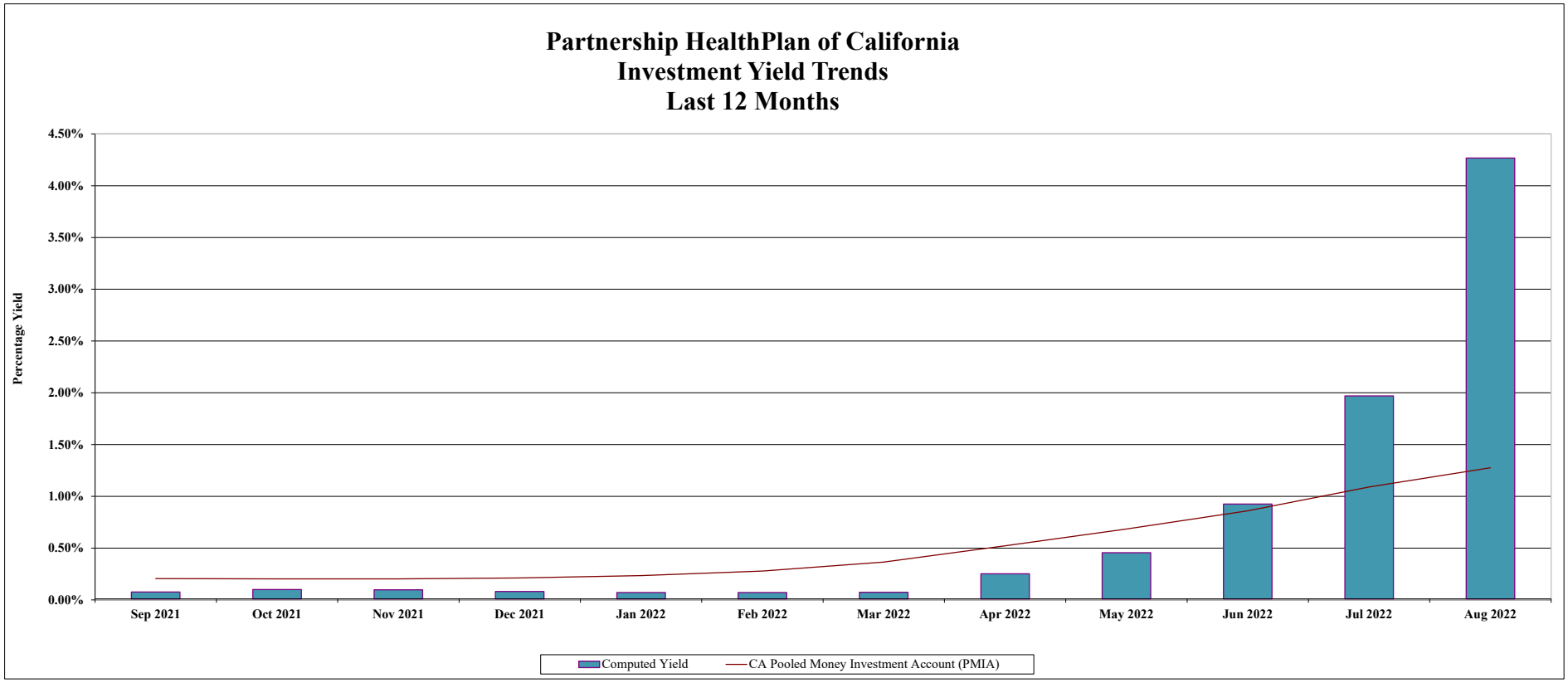
None noted.

Partnership HealthPlan of California
Investment Schedule
August 31, 2022

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	$ 1,536,823	$ 1,536,823	NA	NR
US Treasury Note for Knox Keene	Cash & Cash Equiv	0.01375	1/11/2022	1/31/2025	NA	$ 300,000	$ 303,281	$ 289,218	NA	NR
FUNDS HELD FOR OPERATIONS:										
Merrill Lynch Institutional	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 66,713,923		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 128,108		
UB - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 1,056,410,686		
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	$ 40,625,867		
West America Payroll	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 578,919		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:								$ 1,241,286,844		

Partnership HealthPlan of California
Investment Yield Trends

PERIOD		Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022
Interest Income		35,073	48,030	35,292	32,599	43,164	43,000	49,137	180,039	300,085	607,934	964,760	1,339,500
Cash & Investments at Historical Cost	(1)	588,066,155	570,252,227	294,587,864	673,772,755	780,352,876	677,905,415	919,704,699	793,880,293	785,132,989	791,201,036	383,827,153	369,544,156
Computed Yield	(2)	0.08%	0.10%	0.10%	0.08%	0.07%	0.07%	0.07%	0.25%	0.46%	0.93%	1.97%	4.27%
CA Pooled Money Investment Account (PMIA)	(3)	0.21%	0.20%	0.20%	0.21%	0.23%	0.28%	0.37%	0.52%	0.68%	0.86%	1.09%	1.28%



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

(2) Computed yield is calculated by annualizing the current month's interest divided by the current month's average balance.

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

Operations Report

Sonja Bjork, Deputy Chief Executive Officer/Chief Operating Officer
October 26, 2022

Northwest Region

Leadership Changes

Our new Regional Manager, Vicky Klakken, started at PHC in August. Vicky is located in the Eureka office and oversees our work in both Humboldt and Del Norte Counties. A New CEO, Darian Harris, started with Providence St Joseph in August. Darian is based in Eureka after relocating from Santa Rosa. A breakfast "meet and greet" was held at St Joseph Hospital, where all local hospital CEOs, Hospital Council, Cal Poly Humboldt and PHC representatives were in attendance.

Workforce Development

Our Provider Recruitment Program continues to actively serve our network. Since the last PHC Board meeting, there have been 28 offers to candidates. Of those offers, seven were accepted. Since January 1, 2022 we extended 113 offers and 55 were accepted. The accepted offers included family medicine practitioners, physician assistants and physicians as well as a licensed clinical social worker.

Physician Residency rotations are ongoing. These involve residents spending half of their day at our Eureka office, learning about PHC and Medi-Cal Managed Care. They also learn about HEDIS and the health plan's robust quality improvement program. Two residents from Open Door rotated through the Eureka office in September.

Local Health Fair

On Saturday, September 24th, PHC participated in Mad River Community Hospital's Health Fair. This was a celebration of the 50th Anniversary of Mad River Hospital. The event included community partners such as the National Alliance on Mental Illness, Area 1 Agency on Aging, DHHS Older Adult Services, Humboldt Domestic Violence Services, and many more. PHC was able to meet with some of our members, provide health plan and benefit information, answer questions and give out some PHC "swag."

Northeast Region

CalAIM Provider Outreach

Our focus over the past several months has been on meeting with potential providers for Enhanced Case Management (ECM) and Community Supports (CS). We have

emphasized in person meetings to allow for individualized planning, strategy and technical assistance. This has been very effective and we now have many new providers in various stages of contracting throughout the region

Wellness and Recovery

We are collaborating with one of our northern region hospitals on implementing a pilot program to perform assessments on patients in the ER or in the hospital as inpatient for potential linkage to residential treatment and other Wellness and Recovery services. Rather than discharging members and following up later on, we are attempting to transfer then directly to residential care if that service is appropriate.

Shasta Medical Society

We are coordinating with the Shasta Medical Society to relocate their offices to our Airpark building in Redding and are pleased to have them joining our location.

Southwest Region

Two important Open House events recently took place in the Southwest region. First was the long anticipated opening of the new Russian River Health Center located in Guerneville. This new and modern health center replaced the old facility that was damaged by a fire approximately 5 years ago. Several PHC staff were on-site for the opening including Drs. Kubota and Netherda who previously worked at Russian River Clinic prior to coming to Partnership. I attended this wonderful event along with Colleen Valenti and Dr. Robert Moore to celebrate this beautiful facility serving the Russian River community. Just a few weeks later, the new Caritas Center opened providing a wide variety of support services to homeless and unstably housed individuals in Sonoma County. Services include temporary housing, childcare services, showers and laundry facilities and much more. Santa Rosa Community Health will be expanding and relocating their clinic dedicated to providing services to homeless individuals to the new center early next year.

Other work in the Region has focused on supporting the three major initiatives PHC is leading including CalAIM and two major grant programs: 1) HHIP supporting the integration of health and housing services to coordinate services to homeless individuals and, 2) SBHIP providing funds to local offices of education with the goal of integrating and enhancing behavioral services to youth, on-site or adjacent to school facilities. Regional staff's main role has been to help facilitate local connections between PHC and community resources.

Southeast Region

Our Southeast Region team is working on two important projects related to healthcare access. One involves collaboration with a local school district and health education council on Tdap vaccine promotion activities. The second project is PHC participation with one of the Community Health Improvement Plans in our region. This group has been focused on vision screening for children and families.

Like other regional focused staff, we have been working with local stakeholders on Housing and Homelessness Incentive Program (HHIP) and additional rollouts of CalAIM. Efforts have included providing information to the community on PATH funds and supporting local efforts to increase the amount of CHWs within our local workforce.

Claims

Increased Efficiency

Letters of Agreement (LOAs) often present challenges to efficient claims processing. They can be used in place of a contract, where PHC agrees to compensate a contracted or non-contracted provider for specific services rendered to PHC members. Unfortunately, like many other processes implemented in our current claims system, Amisys, all executed LOAs result in a completely manual process for claims staff. Manual adjudication, as opposed to auto-adjudication, increases the time it takes to process and pay a claim for two reasons: 1) Manual adjudication requires the claim to suspend for claims staff to review it against billing requirements and coding rules and 2) The claims examiner will then complete the claim manually to pay or deny it. In the case of an LOA, each claim has to be reviewed against the terms of the LOA and manually priced according to the LOA's specific compensation arrangement. This one of the many reasons we look forward to the implementation of our new claims system. Health Edge's Health Rules Payer (HRP) works with simpler and more efficient configuration, allowing for the details of each LOA to be entered with the authorization and the associated claim to auto-adjudicate whenever possible.

Claims Clearinghouse Selection

PHC is committed to providing education and training for our providers, trading partners and stakeholders. At the start of CalAIM, we found that many of our Enhanced Case Management and Community Supports providers did not have the technical capabilities to generate and submit Medi-Cal claims. This is an ongoing challenge for providers unaccustomed to billing health plans for payment of the services they provide, as they have not traditionally been covered by Medi-Cal. As a short term fix, the Claims Department created an invoice submission process, whereby the Claims team accepts and converts provider invoice spreadsheets into compliant claims for manual processing. However, to further eliminate these billing challenges for both the provider and PHC, we are contracting with a claims clearinghouse. This service will be offered to our ECM and CS providers at no cost. Office Ally, the clearinghouse vendor we selected, will allow providers to submit all of their claims at once, either via a batch invoice process or submitting through their direct entry portal. Submitting claims through a clearinghouse usually results in fewer errors and claim denials and can reduce payment wait time to under fifteen days. Clearinghouses are ideal for non-traditional ECM and CS providers, who do not have staff that are experienced at billing claims electronically and do not hve billing software capable of completing claim forms. We estimate that our new clearinghouse process will be implemented and available to ECM and CS providers by the first quarter of 2023.

Configuration

The Configuration team has been moving full speed ahead on implementation of our new core system, Health Rules Payor (HRP). After a period of planning and reprioritization we began loading new code sets. These are procedure and diagnosis codes that were released by DHCS during our disruption. With the foundational code sets underway, the team turned to contracts and Medi-Cal benefit changes. Along with new configuration we supported our testing teams as they worked to ensure the highest level of accuracy. The Configuration department has continued to support the health plan's efforts related to CalAIM ECM/CS. Throughout CalAIM Phases I and II, we configured benefits and contracts to get providers properly set up in our system. We are currently collaborating with several departments to support updates to our provider portal in preparation for phase III of ECM and CS as well as the population health initiatives.

Health Services

Population Health

The Population Health Department has been focused on building staff capacity to increase outreach and efforts to improve the lives of our members. Recruitment efforts are in progress for a Director of Health Equity. Member outreach activities and partnering with community efforts continue. The Population Health team has been finding ways to build relationships and trust with many of the underrepresented populations we serve. Our team recently attended California Native American Day at the state capitol. In addition, we attended a policy forum on Murdered and Missing Indigenous People (MMIP), several blood pressure clinics focused on reaching our Black/African American members, and MPX vaccination clinics throughout our service area. Our team members attended training on Roles of Trust and Health Literacy in Achieving Health Equity. All these efforts support our PHM Readiness for the next phase of CalAIM and our ongoing efforts to engage with our communities.

Care Coordination

Phase III ECM

PHC's Care Coordination team is preparing to provide direct ECM to those members who may be eligible for transition from a skilled nursing facility to the community. Internal stakeholders and subject matter experts are meeting regularly for program development and staff positions being filled. The required "Model of Care" and "Provider Exception" template were recently submitted to DHCS and we are awaiting feedback or approval.

Case Management Conference

PHC participated in the annual conference of the Camden Coalition's National Center for Complex Health and Social Needs. This year, the conference was held in Sacramento and PHC took full advantage of having this high quality conference near our service area. We sponsored conference attendance and hotel stays for our ECM and CS service providers. Each agency could send two staff members and we filled 80 conference slots.

Several of our own PHC staff were also able to attend. PHC held a luncheon at the conference and this provided an opportunity for those who are involved in CalAIM ECM and CS to meet each other and PHC staff in person.

Utilization Management

The UM Team has resumed activities in preparation for implementation of the new HRP system scheduled to go live in the spring of 2023. In addition, multiple policies are being updated or created to meet new requirements for the upcoming 2024 DHCS Contract.

PHC staff continue to meet regularly with discharge planners at several hospitals to discuss specific members and work collaboratively to create solutions for moving members to alternative levels of care as appropriate. We will build on these current relationships as we prepare to implement new requirements from DHCS related to transitions of care after inpatient stays.

Member Services

CART Services

Member Services is happy to announce we have secured a new partnership to provide CART (Communication Access Realtime Translation) services for our deaf and/or hard of hearing members. The vendor we selected is called Deaf Services Unlimited. They offer virtual and in person translation services for members who need real time translation that is similar to closed captioning on TV. A good example of members who would leverage these services are those who have just experienced hearing loss and are not proficient in ASL (American Sign Language). We have offered these services in the past on an ad hoc basis and the requests have been rare. To ensure we have these services at the ready, we entered into a contract rather than relying on letters of agreement for individual cases.

Grievance and Appeals

The Grievance and Appeals department is exploring a new solution for handling and processing the grievance and appeals submitted by our members. Our current system, lacks the ability for customization. This limits our ability to adjust process flows and customize reporting. We are looking to leverage a system that will provide efficiency and accuracy along with robust reporting capabilities. This will help tremendously in tracking various provider grievances and allow for better segmentation reporting. It will promote better issue spotting and trending, especially as it relates to improving our CAHPS/HEDIS scores and overall member satisfaction. We will begin platform analysis in October, and will evaluate each solutions' offerings against an established business requirement plan focused on department and organizational needs. The goal is to begin development during the first quarter of the 2023 calendar year.

Statewide CAC (Consumer Advisory Committee)

DHCS has begun implementation of a statewide Consumer Advisory Committee with Medi-Cal recipients from throughout the state. The state sought input from health plans like PHC that have an established and active CAC. The Member Services team

participated in a DHCS interview process designed to gather feedback from health plan staff who work closely to support their respective CACs. We emphasized the need for flexibility on modes of attendance, while staying in alignment with Brown Act requirements. During the Public Health Emergency, many CAC members attended virtually, allowing those who live far from official meeting sites to participate. This has been especially helpful for rural participants. In addition, we emphasized the need for a well-established feedback loop between participants and plan staff. This includes ensuring committee members are consulted with regard to discussion topics and providing them with advanced notice and details around topics that will be covered in the meetings. This will allow for preparation and will maximize effectiveness of the meetings. We are excited for this new committee as it will strengthen the voice of Medi-Cal recipients in shaping policy and process for Medi-Cal. We have been advised we will hear more in early 2023 and may have the opportunity to nominate potential committee members.

News Updates
October 2022

PHC Press Releases: **None at this time.**

PHC Mentioned:

For Your Health: Get vaccinated for National Immunization Awareness Month
Daily Republic
August 7, 2022
Vaccines have been a major point of conversation for a while, essentially since the Covid-19 pandemic began. With the focus on Covid-19 vaccines, many have forgotten the importance of other vaccines, including flu, shingles and hepatitis B. The month of August is recognized as National Immunization Awareness Month, with the intention to highlight the importance of vaccination for people of all ages.

October 2022 - BOARD: Legislative Update

LEGISLATIVE BILLS

AB 1355 (Levin) - Medi-Cal: Public social services: hearings. – *Signed by the governor*
Establishes new requirements for state fair hearing decisions, by allowing a director to order a further hearing to be conducting, to afford the parties the opportunity to present and respond to additional evidence, and by requiring alternated decisions (where the state department director does not adopt a state fair decision) to be made after reviewing the transcript or recording of the hearing.

Position: Watch

SB 250 (Pan) - Health care coverage: Prior Authorizations – *Held on Suspense*
Prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period.

Position: CAHP – Oppose

SB 987 (Portantino) – California Cancer Care Equity Act. – *Signed by the governor*
Require a Medi-Cal managed care plan to, among other things, make a good faith effort to contract with at least one National Cancer Institute (NCI)-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), as specified within each county in which the Medi-Cal managed care plan operates. Authorize any eligible enrollee diagnosed with a complex cancer diagnosis to request a referral to any of those centers to receive medically necessary services unless the enrollee chooses a different cancer treatment provider.

Position: LHPC – Oppose

SB 966 (Limon) - FQHC and RHC: visits. – *Signed by the governor*
This bill requires DHCS to seek any necessary federal approvals and issue appropriate guidance to allow a FQHCs or RHCs to bill for an encounter between an FQHC or RHC patient and an associated clinical social worker (ACSW) or an associate marriage and family therapist (AMFT).

Position: LHPC – Support