Board of Commissioners Meeting Agenda

October 9, 2024: 10:00 a.m. – 2:00 p.m.

In-person Locations:

Partnership Offices

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

2525 Airpark Dr., Redding, CA

1036 Fifth Street, Eureka, CA

495 Tesconi Circle, Santa Rosa, CA

249-299 Nevada Street, Auburn, CA

2760 Esplanade Ave, Suite 130, Chico, CA

External Sites

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

Public comment is welcome during designated "Public Comments" time frames or by emailing comments to the Board Clerk at Board_FinanceClerk@partnershiphp.org by 5:00p.m on October 8, 2024. Comments received will be read during the meeting.

10:00AM – Opening			
1.1 **Call to Order**			*Chair*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION:*** Approval of Agenda	1-3	*Chair*
1.4	***ACTION:*** Approval of Board Meeting Minutes for August 28, 2024	4-16	*Chair*
1.5	***INFORMATION:*** Recognizing 4th Second for Receiving an Honorable Mention for the Association for Community Affiliated Plans (ACAP) Safety Net Award		*Katherine Barresi*
1.6 **Commissioner Comment**			*Chair*
1.7 **Public Comment & Correspondence**			*Clerk*
10:35AM – Audit Presentation			
1.8	***ACTION***: Resolution to Accept the Moss Adams Audit Report for FY 2023-2024; This resolution accepts the audit report completed by Moss Adams on Partnership's financial	17-70	*Moss Adams Auditors: Rianne Suico and*

	statements for the period July 1, 2023 to June 30, 2024.		*Chris Pritchard*
1.9	***INFORMATION:*** CEO Report	71-72	*Katherine Barresi*
	11:20AM – Consent Calendar		
2 & 3	***ACTION:*** Finance Committee Resolution Ratification & Consent Calendar ▪ **2.1** Resolution to Approve Commendations and Appreciation for Board Commissioner Tina Rivera's Service to Partnership ▪ **2.2** Resolution to Approve Commendations and Appreciation for Board Commissioner Dr. Farhan Fadoo's Service to Partnership ▪ **3.1** Resolution to Accept all Advisory Committee Minutes, Partnership Policies and Program Descriptions Approved by PAC ▪ **3.2** Resolution to Approve the Quality and Performance Improvement Program Description, Work Plan, and Evaluation **Quality and Performance Improvement Program Description** **Quality and Performance Improvement Program Description - Redlined** **2023-2024 QI Program Evaluation** **2024-2025 QI Program Work Plan** ▪ **3.3** Resolution to Approve Commendations and Appreciation for Board Commissioner Gerald Huber's Service to Partnership ▪ **3.4** Resolution to Approve Committee Appointments of Dr. Christina Lascich to the Physician Advisory Committee and Dr. Phuong Luu to the Quality and Utilization Advisory Committee. ▪ **3.5** Resolution to Approve Edits to Partnership Policy, ADM21, Stipends for Committee Members	73-74 75-76 77-78 79-83 84-85 86-87 88-92	*Chair*

PAC Approved Policy Updates Consumer Advisory Committee – September 2024 Finance Committee – September 2024 Finance Committee – October 2024 Physician Advisory Committee – September 2024 Quality and Utilization Advisory Committee (Q/UAC) – September 2024			
11:30AM – Regular Agenda Items			
4.1	***ACTION:*** Resolution to Approve Request for Hospital Advance	93-94	*Jennifer Lopez*
4.2	***ACTION:*** Resolution to Approve Accepting the Gift of Properties from the Gasser Foundation.	95-96	*Mark Bontrager*
11:45AM-12:15PM – Lunch			
12:15PM – Regular Reports			
5.1	***INFORMATION:*** Metrics and Financial Update	97-110	*Jennifer Lopez / Patti McFarland*
5.2	***INFORMATION:*** Operations Update	111-113	*Wendi Davis*
5.3	***INFORMATION:*** Media & Legislative Update	114-119	*Dustin Lyda*
5.4	***INFORMATION:*** Medicare / D-SNP Update	120	*Written Report*
1:00PM – Education Sessions			
6.1	***INFORMATION:*** Quality Update		*Dr. Moore / Nancy Steffen*
6.2	***INFORMATION:*** Provider Satisfaction Survey Results		*Stephanie Nakatani*
2:00PM – Adjournment			

Upcoming Meetings:

12/04/2024 – December Board Meeting
2/26/2025 – February Board Meeting
4/22/2025-4/23/2025 – April Board Meeting and Strategic Planning Retreat

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

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External Sites:

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

Mendocino County, Ukiah Office located at 501 Low Gap Rd. Rm 1010

Ukiah, CA, Conference Room A, Executive Office

On
August 28, 2024

Members Present: Jonathon Andrus, Darcie Antle, Shelby Boston, Jayme Bottke (10:15am arrvival), Gena Bravo, Ranell Brown, Brion Burkett, Christopher Champlin, Christy Coleman, Cathryn Couch, Farhan Fadoo, M.D., Dean Germano, Ryan Gruver, Alicia Hardy, Randall Hempling, Gerald Huber, Dave Jones, Scott Kennelly, Belle Knight, Phuong Luu, M.D., Nunie Matta, Andrew Miller, M.D., Robert Oldham, M.D., Jonathan Porteus,, JoDee Read, Lisa Santora, M.D., Nancy Starck, Tory Starr, Nolan Sullivan, Kim Tangermann (Chair), Jennifer Yasumoto, Jim Yoder

Members Excused: Noemi Doohan, M.D, Liz Hamilton, Elizabeth Kelly, Liz Lara-O'Rourke, Viola Lujan, Matthew Morris, M.D., Kathryn Powell**,** Tina Rivera, Stacy Sphar, DNP
Staff: Marc Agudelo, Mark Bontrager, Tina Buop, Jessica Cifolelli, Alexandra Chappell, Dell Coats, Wendi Davis, Marisa Dominguez, Naomi Gordon, Curtis Hardwick, Mohamed Jalloh, PharmD, Mary Kerlin, Vicky Klakken, Marshall Kubota, M.D., Jennifer Lopez, Dustin Lyda, Richard Matthews, M.D., Patti McFarland, Cyress Mendiola, Robert Moore, M.D., Danielle Ogren, Kathryn Power, Jose Puga, Jeff Ribordy, M.D., Melissa Schumann, Tim Sharp, Derick Stacy, Rebecca Stark, Nancy Steffen, Amy Turnipseed, Colleen Valenti, Edna Villasenor Katherine Barresi, Acting CEO and Ashlyn Scott, Board Clerk

AGENDA ITEM	DISCUSSION	MOTION / ACTION
1.0 Opening	Commissioner Kim Tangermann, Board Chair, called the bi-monthly meeting to order and welcomed everyone to the meeting, in person, at all Partnership HealthPlan offices. Board members were reminded to abstain from voting on any agenda item where they might have a conflict of interest, and to state their name before asking questions or making motions. As a reminder, Commissioner Hardy read the Partnership Mission Statement: "to help our members, and the communities we serve, be healthy." She also stated that members of the public would have an opportunity to speak at designated times throughout the agenda.	None
1.2 Roll Call	Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a quorum.	None
1.3 Approval of Agenda and the Board Meeting Minutes for June 26, 2024	Chairwoman Tangermann asked if anyone had changes for the agenda or corrections to the June 26, 2024 minutes. Hearing no requests for modification, she asked for a motion to approve the agenda and minutes.	*Commissioner Starr moved to approve the agenda and minutes as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** *Yes: 28* *No: 0* *Abstention: 0* *Excused: 10 (*Doohan**,** Bottke (10:15am arrival), Hamilton, Kelly, Lara-O'Rourke, Lujan, Morris, Powell, Rivera, Sphar) **MOTION CARRIED**
1.4 Resolution to Approve the Board Commissioner Consumer Representative Appointment of Brion Burkett, Representing Partnership's Eastern Region and Placer	Ms. Barresi announced that per Partnership Bylaws, three members of the Commission shall be consumer representatives. One representative will be from the Northern Region, one from the Eastern Region and one from the Southern Region. Consumer representatives are appointed for two-year teams and are selected by a Consumer Representative Selection Committee, which is comprised of the Chief Executive Officer (CEO) or their designee, a Partnership staff member from Member Services, one consumer representative that is not applying for the position and one Board member.	*Commissioner Porteus moved to approve resolution 1.4 as presented, seconded by Commissioner Hardy.* ***ACTION SUMMARY:*** *Yes: 28*

County	The Consumer Representative Selection Committee recommends Brion Burkett serve as the Eastern Region Consumer Representative on the Partnership Board. Mr. Burkett lives in Placer County and he will be appointed for a two-year term of office. His term commences on August 28, 2024 and terminates on June 24, 2026.	*No: 0* *Abstention: 0* *Excused: 10 (*Doohan**,** Bottke (10:15am arrival), Hamilton, Kelly, Lara-O'Rourke, Lujan, Morris, Powell, Rivera, Sphar) **MOTION CARRIED**
1.5 Resolution to Approve the Board Commissioner Consumer Representative Appointment of Belle Knight, Representing Partnership's Northern Region and Shasta County	The Consumer Representative Selection Committee recommends Belle Knight serve as the Northern Region Consumer Representative on the Partnership Board. Ms. Knight lives in Shasta County and she will be appointed for a two-year term of office. Her term commences on August 28, 2024 and terminates on June 24, 2026.	*Commissioner Hempling moved to approve resolution 1.5 as presented, seconded by Commissioner Germano.* ***ACTION SUMMARY:*** *Yes: 29* *No: 0* *Abstention: 0* *Excused: 10 (*Doohan**,** Bottke (10:15am arrival), Hamilton, Kelly, Lara-O'Rourke, Lujan, Morris, Powell, Rivera, Sphar) **MOTION CARRIED**
1.6 Resolution to Approve the Board Commissioner Consumer Representative Appointment of Marcelo "Nunie" Matta, Representing Partnership's Southern Region and Yolo County	The Consumer Representative Selection Committee recommends Marcelo "Nunie" Matta, serve as the Southern Region Consumer Representative on the Partnership Board. Mr. Matta lives in Yolo County and she will be appointed for a two-year term of office. His term commences on August 28, 2024 and terminates on June 24, 2026.	*Commissioner Starr moved to approve resolution 1.6 as presented, seconded by Commissioner Huber.* ***ACTION SUMMARY:*** *Yes: 30* *No: 0* *Abstention: 0* *Excused: 10 (*Doohan**,** Bottke (10:15am arrival), Hamilton, Kelly, Lara-O'Rourke, Lujan, Morris, Powell, Rivera, Sphar) **MOTION CARRIED**

1.7 Recognizing the Primary Care Provider Quality Incentive Program (PCP QIP) Highest Performers	Dr. Moore recognized the top performers in the 2023 Primary Care Provider Pay for Performance program (PCP QIP). For measurement year 2023, the range of scores on the core measure set was 0 to 99 points on the core quality measures. In total, $39 million was distributed to 252 primary care sites for their performance. We extend our congratulations to the following top performers in the 2023 PCP QIP: 1. Community Medical Center in Dixon: 99 points 2. Communicare+Ole in St. Helena: 98 points 3. Petaluma health center, Petaluma: 98 points 4. Winters Healthcare foundation: 95 points 5. Communicare+Ole in Davis: 92 points 6. Open Door CHC in Eureka: 91 points 7. Sonoma Plaza Pediatrics: 91 points 8. Communicare+Ole on Pear Tree Lane (Napa): 90 points Providers who attended the meeting in-person, were presented with a plaque.	*Commissioner Porteus moved to approve resolution 1.7 as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** *Yes: 32* *No: 0* *Abstention: 0* *Excused: 9 (*Doohan, Hamilton, Kelly, Lara-O'Rourke, Lujan, Morris, Powell, Rivera, Sphar) **MOTION CARRIED**
1.8 Honoring Board Commissioner, Dr. Lewis Broschard	Ms. Barresi announced that Board Commissioner, Dr. Lewis Broschard, passed away on July 24, 2024. Dr. Broschard joined the Partnership Board of Commissioners on November 17, 2004, and served on several committees. Partnership sends it's deepest sympathy to his wife, Pat, and all of his family and friends. Partnership is grateful to have had Dr. Broschard as a longtime Commissioner, supporter, collaborator, and friend.	*Commissioner Huber moved to approve resolution 1.8 as presented, seconded by Commissioner Boston.* ***ACTION SUMMARY:*** *Yes: 32* *No: 0* *Abstention: 0* *Excused: 9 (*Doohan, Hamilton, Kelly, Lara-O'Rourke, Lujan, Morris, Powell, Rivera, Sphar) **MOTION CARRIED**
1.9 Commissioner Comment	Chairwoman Tangermann asked if there were any commissioner comments. Hearing none, she moved to Public Comment.	None
1.10 Public Comment	Chairwoman Tangermann asked if there were any public comments or correspondence. There was none.	None
1.11 CEO Report	Katherine Barresi, Acting CEO, gave a report covering the following topics: ***Changes to the Equity and Practice Transformation Payments Program* –** The Department of Health Care Services (DHCS) made significant changes to the Equity and Practice Transformation (EPT) Payments Program. Originally proposed with a funding allocation of $700 million, the	None

program's funding has been reduced to $140 million in the Fiscal Year 2024-2025 final state budget. Despite the substantial cut, 211 sites have been selected to participate out of 719 applicants.

Participating sites have the option to opt out of the program, and a vendor has been designated to assist those who choose to continue with the program in navigating the next steps. Each participating practice will receive a base payment of $250,000, along with an additional $20 per assigned member, with the maximum payment capped at $3.19 million. The focus of the program has been narrowed, now encompassing 25 equally weighted performance measurements.

Partnership staff will reach out to participating sites in our service area to offer technical assistance. Although DHCS has suggested that health plans may help fund the program, Partnership remains confident in the effectiveness of our robust Quality Improvement Program.

IT Security Rating **–** Partnership received an "A" security rating from an outside vendor, which is an important achievement in light of the growing sophistication of hackers. A high security rating serves as an indicator of our continued commitment to strengthening our security posture.

CalAIM Transitional Rent Services **–** DHCS has released a Concept Paper proposing a new Medi-Cal service known as "Transitional Rent." This initiative aims to provide coverage for rent or temporary housing under Medi-Cal, with a planned statewide implementation by January 1, 2026. DHCS is currently seeking approval from the Centers for Medicare & Medicaid Services (CMS) to cover up to six months of transitional rent. While the Partnership is enthusiastic about the potential benefits of this new service, there are concerns about the lack of available housing inventory within our service area.

Commissioner Huber asked how the Transitional Rent program aligns with the numerous other housing programs available.

Ms. Barresi responded that DHCS recognizes that the proposed service is bold. They have expressed interest in a model used in Los Angeles, where a consumer-facing agency acts as a central hub; distributing vouchers to members and assisting with applications, among other services. This agency collaborates with other vendors to share costs for these services.

However, implementing a similar model in rural counties would be challenging, and we hope the state will take into account feedback from these areas.

Dr. Luu asked if the counties are involved, as they play a crucial role in providing housing.

Ms. Barresi replied yes, DHCS sent the initial notice to counties through their associations in

	September, and they will be seeking feedback from stakeholders. *Commissioner Matta inquired about the timeline for implementing Transitional Rent Services.* *Ms. Barresi stated that health plans have the option to begin providing services in 2025, ahead of the mandatory requirement in 2026.* *Commissioner Porteus asked if Partnership is able to effectively assess members' housing needs.* *Ms. Barresi responded that data integrity challenges with HMIS data are hindering our ability to analyze those needs effectively and we want to leverage technology to exchange data more efficiently.* *Commissioner Burkett asked if there any checks and balances in place to prevent misuse of these services.* *Ms. Barresi replied that the services have not gone live yet. The first year it would be optional for managed care plans such as Partnership to offer Transitional Rent. After the first year, DHCS is proposing to have Transitional Rent be a statewide benefit. Today, Partnership provides comprehensive oversight and auditing of ECM services, and continues to monitor benefit and program integrity through our authorization processes. Additionally, Partnership's nurses and other staff continuously analyze benefit requests to identify potential fraud.*	
3 Consent Calendar	Chairwoman Tangermann stated that all items on the consent calendar would be approved with one motion unless someone requests to pull an item for further discussion. She noted that Commissioner Antle is required to abstain from agenda item 3.3. Hearing no requests, she asked for a motion to approve resolutions 3.1, 3.2, 3.3, 3.4. Calendar ▪ **3.1** Resolution to Accept all Advisory Committee Minutes, Partnership Policies and Program Descriptions Approved by PAC ▪ **3.2** Resolution to Approve HR Policies and Personnel Committee Minutes for August 21, 2024. ▪ **3.3** Resolution to Approve the Reappointment of Darcie Antle to the Partnership Board as the Mendocino County Representative. ▪ **3.4** Resolution to Approve Physician Advisory Committee Appointment of Dr. Christina Lasich	*Commissioner Starr moved to approve Resolutions 3.1, 3.2, 3.3, and 3.4 as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** *Yes: 32* *No: 0* *Abstention: 0* *Excused: 9 (*Doohan, Hamilton, Kelly, Lara-O'Rourke, Lujan, Morris, Powell, Rivera, Sphar) **MOTION CARRIED**
4.1 Resolution to Approve Board Semi-	Wendi Davis, Chief Operating Officer, presented the Semi-annual Board Dashboard. She covered the following areas in her presentation:	*Commissioner Porteus moved to approve Resolution 4.1 as presented,*

Annual Dashboard	▪ Membership Dashboard – Partnership's membership currently stands at just under 900,000 and continues to decline, as expected, due to Medi-Cal redeterminations. In the 14 legacy Partnership counties, membership has decreased by an average of about 14%, with the most significant drops occurring in counties that have also seen a loss of members to Kaiser. ▪ Call Center Dashboard – The Call Center has seen an increase of 70,000 calls on average per month since the expansion on January 1. Although adjusting to the higher call volume has been challenging, resulting in increased wait times, we are on track to meet the 30-second wait time requirement for August. ▪ Medical Utilization Dashboard – The average number of primary care physician visits has increased and emergency department visits have decreased, both of which are positive news. ▪ Transportation Dashboard – Prior to expansion, Partnership provided an average of 150,000 rides a quarter, while last quarter that figure was over 296,000. ▪ Delegate Utilization Dashboard – Partnership is required to closely monitor the utilization rates of our delegates to ensure that members are adequately accessing services, including our behavioral health services delegate, Carelon. In Partnership's legacy counties, behavioral health utilization rates were approximately 8%, compared to the state average of 7%. However, since the expansion, the average behavioral health utilization rate has declined to 6.4%. ▪ TAR Dashboard – TAR timeliness has declined over the past several months due to the expansion and a surge in PCP reassignment requests during Dignity contract negotiations. ▪ Grievance Dashboard – The Grievance Department has experienced an increase in demand following expansion, resulting in a minor decrease in the timeliness in closing cases. ▪ Claims Dashboard – 99.9% of claims are adjudicated and processed within 30 days, exceeding the state's 45-day requirement. ▪ HR Dashboard – Partnership's turnover rate remains low at 2.7% for the last quarter, and many previously vacant positions are now filled, as a result of focused recruitment efforts. ▪ IT Dashboard – All IT metrics were met, with no security breaches or major service disruptions reported. *Commissioner Matta asked how much of Partnership's membership increased as a result of the 10-county expansion?* *Ms. Davis responded that overall membership grew by approximately 30% following the January 1 expansion but membership in the legacy, non-expansion counties has decreased, on average, by 14%.* *Commissioner Champlin asked if we have any insights into how much of the membership reduction is due to members not recertifying their Medi-Cal benefits?* *Ms. Davis replied that we believe the number of members dis-enrolled for failing to renew their*	*seconded by Commissioner Coleman.* ***ACTION SUMMARY:*** *Yes: 32* *No: 0* *Abstention: 0* *Excused: 9 (*Doohan, Hamilton, Kelly, Lara-O'Rourke, Lujan, Morris, Powell, Rivera, Sphar) **MOTION CARRIED**

Medi-Cal is relatively small.

Commissioner Starr inquired about the 7% state average for behavioral health utilization, since data indicates that 20-30% of the population need these services.

Ms. Davis responded that the 7% average refers specifically to California managed care plans, and we are continually working to increase utilization.

Mark Bontrager, Senior Director of Behavioral Health added that it is important to note that the utilization rate presented reflects only a small portion of non-specialty mental health services provided by Partnership. Specialty mental health services are managed by the counties. Additionally, we anticipate that the utilization rate in the expansion counties is higher than reported, primarily due to delays in claims submissions.

Commissioner Miller asked if the behavioral health utilization data includes mental health services accessed through a member's primary care physician.

Mr. Bontrager responded that this data is collected from contracted behavioral health providers. However, since members may receive services in various ways, it could lead to potential underreporting.

Commissioner Germano asked if Partnership able to reinstate access to Dignity specialty services for members reassigned to new providers during the Dignity contract negotiations?

Ms. Davis said that many members opted to be reassigned to new PCPs and specialty providers. Now Dignity is accepting fewer specialty referrals than they had previously.

Commissioner Knight shared that she found it easy to get a referral during the Dignity contract negotiations. She also asked how long the new Dignity contract is in effect.

Ms. Davis replied that it is a three-year agreement.

Commissioner Matta said he experienced difficulty obtaining TAR approval for a new wheelchair.

Ms. Barresi clarified that there may be challenges in approving and obtaining certain durable medical equipment such as electric wheelchairs due to documentation requirements, vendors who are slow to process or obtain clinical records, and vendors who may be reluctant to accept Medi-Cal or Partnership rates for equipment.

Commissioner Miller thanked Partnership, as a new board member from an expansion county, for its prompt claims processing. He said his organization faced frequent delays with the previous

	commercial health plan. Ms. Davis' presentation was included in the packet.	
4.2 Resolution to Approve the Compliance Dashboard for Q22024	Danielle Ogren, Senior Director of Regulatory Affairs and Contracting, presented the Q2 2024 Compliance Dashboard. For the second quarter of 2024, Partnership achieved 100% in delegate audit oversight, timely report submissions, and timely fraud waste and abuse notifications. The regulatory report acceptance rate declined to 94.7% due to three reports being rejected for revisions. All three reports were resubmitted and approved within the quarter. Additionally, Partnership submitted six reportable HIPAA incidents to DHCS, but none were classified as breaches.	*Commissioner Antle moved to approve Resolution 4.2 as presented, seconded by Commissioner Starr.* ***ACTION SUMMARY:*** *Yes: 32* *No: 0* *Abstention: 0* *Excused: 9 (*Doohan, Hamilton, Kelly, Lara-O'Rourke, Lujan, Morris, Powell, Rivera, Sphar) **MOTION CARRIED**
5.1 Metrics and Financial Update	Jennifer Lopez, Deputy Chief Financial Officer, presented Partnership's metrics and financials for the month ending June 30, 2024. Partnership reported a net surplus of approximately $2.1 million for the month, which brings the year-to-date surplus to approximately $63.6 million. Although we are pleased to end the fiscal year higher than budget, there remains significant fiscal uncertainty: given the state budget condition; the forthcoming implementation of regional cost averaging which more than likely create downward rate pressure on Partnership's future revenue levels; and we still do not have a clear understanding of the expense levels in the expansion region. Additionally, Partnership has not yet received the final rates for the calendar year 2024, complicating the budgeting process. We plan to use a 13th period to reconcile claims and other estimated costs based on additional run-out data. Our auditor, Moss Adams, will present the results of the fiscal year 2023-2024 audit at the October Board meeting. *Commissioner Porteus inquired if ECM revenue that is to be returned to the state can be used to increase provider ECM rates.* *Ms. Lopez explained that given the membership uncertainty for this new program, the state implemented a risk corridor at the start of the program that would claw back excessive revenue for this new benefit. Establishment of risk corridors for new programs and benefits is not an uncommon practice in Medi-Cal. As a result of the risk corridor, Partnership will need to return some of these funds to the state. She added that Partnership continues to actively review ECM rates and continues to advocate to the state for appropriate unit cost levels for this new benefit.* *Commissioner Luu requested Partnership continue to remind the state that the low rates are*	None

	driving provider hesitation in becoming ECM providers. Ms. Lopez's full report is included in the Board packet	
5.2 Operations Update	Wendi Davis, Chief Operating Officer presented an update on Partnership's operations, beginning with a report on Partnership's fire response and disaster monitoring procedures. The Regional Directors play a key role in keeping the organization informed about the status of any disaster. We also coordinate outreach calls to evacuated members and visit evacuation centers to offer assistance. Additionally, Ms. Davis has led an internal restructuring of Partnership's regions to enhance collaboration with counties, providers, and members. Each region will now have a dedicated Partnership office, a regional lead, and a medical director. The regional directors will report to the Chief Operating Officer and serve as liaisons to the counties, members and providers in their region. This reorganization highlights Partnership's commitment to being integrated within the communities we serve and to allocating resources more equitably. *Commissioner Gruver thanked Regional Director, Rebecca Stark, for her responsiveness and for paying special attention to the expansion counties.* Ms. Davis' full report is included in the Board packet.	None
5.3 Media & Legislative Update	Written update.	None
5.4 CMO Report on Quality	Dr. Moore, Chief Medical Officer, and Nancy Steffen, Senior Director Quality & Performance Improvement presented a summary of Partnership's Measurement Year 2023(MY23) Healthcare Effectiveness Data and Information Set (HEDIS) performance. Partnership reports 42 measures (Managed Care Accountability=MCAS measures) to DHCS, of which 18 are "accountable" and subject to sanctions if the results are below average. As an NCQA-Accredited Health Plan, Partnership also reports plan-wide HEDIS measure performance and patient experience (CAHPS) results to NCQA. The MCAS measurements place a stronger emphasis on Childhood and Adolescent Preventive Care measures, while also addressing smaller domains such as Cancer Prevention, Reproductive Health, Chronic Disease, and Behavioral Health. In contrast, the NCQA Health Plan Accreditation (HPA) set includes additional focus on measures related to Adult Immunizations, Respiratory Treatment, Diabetes, Heart Disease, and Behavioral Health. NCQA's Health Plan Rating (HPR) is calculated as the weighted average of a plan's HEDIS and CAHPS measure ratings, with bonus points for plans with current Accreditation status. Partnership's projected HPR rating for MY2023 is 3.5 stars, based on best estimates using available benchmarks. This projection takes into account the decision to submit Adult CAHPS instead of Child CAHPS. NCQA will finalize and publicly post Health Plan Ratings (HPR) in September. There was no overall improvement in Accountable Measures performing above versus below the MPL. In MY2023, measures that improved to meet or exceed the MPL were offset by those that declined below. The measures evaluated against national benchmarks show a downward	None

	trend compared to MY2022 and 67% of the measures (43 out of 64) exhibited less than a 5% change in their rates compared to the previous year. Despite this, there is an overall increasing trend in national benchmarks. Partnership is facing increasing pressure from the state to meet quality metrics and Measurement Year 2024 (MY24) will mark the first year that a quality withhold will be implemented, meaning that 0.5% of Partnership's revenue will be withheld and can only be recouped through meeting quality metrics and member experience. The state expects Partnership to perform above average across all specified measures. Any measures that fall below average are publicly reported by the state, leading to sanctions that can negatively impact Partnership's reputation within the community Dr. Moore and Ms. Steffen's full report is included in the meeting packet.	
6.1 Expansion Update	Rebecca Stark, Regional Director and Dr. Richard Matthews, Medical Director, who both oversee the expansion region, presented an update on Partnership's 10-county expansion that went into effect on January 1, 2024. While some of the 10 counties have experienced fluctuations in membership, there has been an overall decrease of 2.5% since January 1st, which is consistent with the general trend of decreasing Medi-Cal membership statewide. Partnership has opened two offices in the expansion region: one in Chico and another in Auburn. Each office will be staffed with a dedicated regional director, medical director, and support staff member. Member outreach activities in the new region include informative sessions led by our Member Services Team, offering an overview of member benefits in both English and Spanish. These sessions have been completed in 9 of the 10 expansion counties. Additionally, a member from the Consumer Advisory Committee (CAC) for the Eastern region has been selected to join our board. Provider outreach activities include referral roundtables focused on building relationships between primary care providers (PCPs) and specialists, as well as providing overviews of RAF/TAR processes. Partnership is attending joint operations meetings with clinics and hospitals, along with regular meetings with county leadership. Ms. Stark and Dr. Matthews also reported on the Park Fire, a wildfire caused by arson, and at the time was mapped at 429,603 acres and 85% containment. The fire began on July 24, 2024 and has affected Butte, Tehama, Shasta, and Plumas Counties. Ms. Stark and Dr. Matthews' full report was distributed to Board Members and is available upon request.	None
6.2 IT Update	Tina Buop, Chief Information Officer, gave an update on Partnership's Information Technology (IT) Improvements. The IT Department has made several improvements focused on vision, advanced technology changes, project delivery, systems monitoring, and a culture of compliance. The IT teams work collaboratively on initiatives focusing on the cross delivery of projects	None

	improving the quality and timeliness of implementation and support. In the past four months, the IT Team has achieved several important initiatives. Partnership is introducing advanced security monitoring and communication systems for our data connection partners, including practices, clearinghouses, and hospitals. Once these systems are in place, monitored businesses will be alerted if issues arise. After the implementation, the vendor will contact the businesses to help them address outstanding security concerns and will also inform Partnership of potential vulnerabilities to safeguard our IT ecosystem. This approach benefits everyone involved. *Commissioner Luu inquired whether Partnership will provide monitoring for providers of all sizes.* *Ms. Buop replied that Partnership will begin monitoring any provider/vendor from whom we directly receive files such as claims.* *Commissioner Matta asked what improvements the IT department is implementing for members.* *Ms. Buop responded that IT is reviewing all aspects of the member experience, including the website, portal, and phone systems, to make improvements.* Ms. Buop's full presentation was distributed to Board members, and is available upon request.	
6.3 Health Equity Update	Mohamed Jalloh, PharmD, Health Equity Officer presented an update on Partnership's Health Equity activities. As a part of Partnership's health equity organizational goal, Partnership will develop a Health Equity Strategic Plan and achieve NCQA Health Equity Accreditation Internal Compliance. Goal milestones also include generating diversity, equity, and inclusion (DEI) training materials, identifying interventions to address disparities and proposing a pilot intervention to address disparities in children's preventive care, behavioral health, chronic care, and/or maternity care in at least one region. Partnership's disparity data indicates that all groups are performing well in the blood pressure control measure. However, well-child visits (WCV) are low among the majority of racial groups. Among American Indian and Alaska Native populations, there are significant disparities in prenatal care, postpartum care, and poor hemoglobin control. There are also notable disparities for Black and African American populations, in prenatal care and WCV specifically in the Southeast region. There is also a strong disparity in the WCV measure for White populations and rural communities. . Dr. Jalloh's full presentation was distributed to Board members, and is available upon request.	None
7 CLOSED SESSION	Chairwoman Tangermann adjourned the Board of Commissioners to Closed Session. She announced that the following would be discussed in Closed Session:	None

	7.1 Discussion Pursuant to Government Code section 54956.87 subsection (b), Health Plan Trade Secret: Medicare D-SNP **7.2** Discussion Pursuant to Government Code §54957(b)(1); Personnel Matter, Public Employee	
Re-Adjournment in Open Session	Chairwoman Tangermann re-convened the meeting in open session announced there was no action taken in closed session. The meeting adjourned at 2:11PM	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Board Approval Date: 10/09/24

Signed: _____
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: October 2, 2024 1.8
Board Meeting Date: October 9, 2024

Resolution Sponsor:
Katherine Barresi, Acting CEO, Partnership HealthPlan of CA

Recommendation by:
The Finance Committee & Partnership Staff

Topic Description:
Moss Adams has completed their audit of Partnership's financial statements for the period of July 1, 2023 to June 30, 2024. 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 Partnership Staff, the Board is asked to accept the attached Moss Adams Audit Report for the period of July 1, 2023 to June 30, 2024.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: October 2, 2024
Board Meeting Date: October 9, 2024

Agenda Item Number:
1.8

Resolution Number:
24-

IN THE MATTER OF: ACCEPTING THE MOSS ADAMS AUDIT REPORT FOR THE PERIOD OF JULY 1, 2023 TO JUNE 30, 2024

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, 2023 to June 30, 2024.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

Report of Independent Auditors and
Financial Statements with Supplementary Information

Partnership Health Plan of California

June 30, 2024 and 2023

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Management's Discussion and Analysis

Partnership Health Plan of California
Management's Discussion and Analysis
As of and for Years Ended June 30, 2024, 2023, and 2022

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, 2024, 2023, and 2022. 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, 2024, 2023, and 2022, and the change between periods:

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

	2024	2023	2022 (As Restated)	Change from 2023 Amount	Change from 2023 Percent	Change from 2022 Amount	Change from 2022 Percent
ASSETS							
Current assets	$ 3,532,429	$ 1,910,811	$ 1,427,191	$ 1,621,617	84.9%	$ 483,620	33.9%
Capital assets, net	133,499	118,903	107,920	14,596	12.3%	10,983	10.2%
Other assets	25,828	15,118	8,388	10,709	70.8%	6,730	80.2%
Net pension asset	4,919	2,961	3,476	1,958	66.1%	(515)	(14.8%)
Total assets	3,696,674	2,047,794	1,546,975	1,648,880	80.5%	500,818	32.4%
DEFERRED OUTFLOWS OF RESOURCES	1,620	2,861	2,885	(1,241)	(43.4%)	(24)	(0.8%)
Total assets and deferred outflows of resources	$ 3,698,294	$ 2,050,655	$ 1,549,860	$ 1,647,639	80.3%	$ 500,794	32.3%
LIABILITIES							
CURRENT LIABILITIES	$ 2,442,227	$ 1,135,614	$ 777,831	$ 1,306,613	115.1%	$ 357,783	46.0%
SUBSCRIPTION LIABILITIES, net of current portion	847	2,018	1,933	(1,171)	(58.1%)	85	4.4%
Total liabilities	2,443,074	1,137,632	779,764	1,305,442	114.8%	357,868	45.9%
DEFERRED INFLOWS OF RESOURCES	7,618	6,617	2,991	1,001	15.1%	3,626	121.2%
NET POSITION							
Invested in capital assets	$ 133,499	$ 118,903	$ 107,921	$ 14,596	12.3%	$ 10,982	10.2%
Restricted	300	300	300	-	-%	-	-%
Unrestricted	1,113,804	787,203	658,884	326,601	41.5%	128,319	19.5%
Total net position	1,247,603	906,406	767,105	341,197	37.6%	139,301	18.2%
Total liabilities, deferred inflows, and net position	$ 3,698,294	$ 2,050,655	$ 1,549,860	$ 1,647,640	80.3%	$ 500,795	32.3%

ASSETS

2023–2024

Total assets increased by $1.65 billion (80.5%) from 2023 to 2024. Current assets increased by $1.62 billion from $1.91 billion in 2023 to $3.53 billion in 2024, primarily in cash and investments. This increase is primarily from the recording of the receivable accruals for Directed Payments, Voluntary Rate Range, and Medi-Cal Managed Care Organizations (MCO) tax revenue which have corresponding offsets in current liabilities; the increase also partially reflects the increase in operating income and non-operating (investment) income for the year. Net pension asset increased by $1.96 million (66.1%) from 2023 to 2024. Deferred outflows of resources decreased by $1.24 million (43.4%) from 2023 to 2024. Refer to Note 9 of the financial statements for additional information.

2022–2023

Total assets increased by $500.8 million (32.4%) from 2022 to 2023. Current assets increased by $483.6 million from $1.43 billion in 2022 to $1.9 billion in 2023, primarily in cash and investments. This increase is primarily from the recording of the receivable accruals for Directed Payments and Voluntary Rate Range, which is offset in current liabilities; the increase also partially reflects the increase in operating income and non-operating (investment) income for the year. Net pension asset decreased by $515 thousand (14.8%) from 2022 to 2023. Deferred outflows of resources decreased by $24 thousand (0.8%) from 2022 to 2023. Refer to Note 9 of the financial statements for additional information.

LIABILITIES

2023–2024

Total current liabilities increased by $1.3 billion from $1.1 billion in 2023 to $2.4 billion in 2024. This increase, primarily in Accounts Payable and Accrued Expenses, can be attributed to the accruals for Directed Payments and Voluntary Rate Range, which is offset in current assets; an additional increase in Accounts Payable can be attributed to the additional MCO tax payable accrued for 2024, which will be addressed in the upcoming sections. Lastly, additional increases can be attributed to the increase in Accrued Claims Payable from the expansion counties.

2022–2023

Total current liabilities increased by $357.8 million from $777.8 million in 2022 to $1.14 billion in 2023. This increase, primarily in Accounts Payable and Accrued Expenses, can be attributed to the inclusion of accruals for Directed Payments and Voluntary Rate Range, which is offset in current assets.

NET POSITION

Total net position increased by $341.2 million (37.6%) in 2024 from 2023, and increased by $139.3 million (18.2%) in 2023 from 2022. In 2024, the increase is primarily due to an operating income of $249.1 million and net investment earnings of $92.1 million in 2024. In 2023, the increase is primarily due to an operating income of $90.4 million and net investment earnings of $48.9 million in 2023.

KEY OPERATING INDICATORS

The following table compares key operating indicators for the Health Plan for the years ended June 30, 2024, 2023, and 2022:

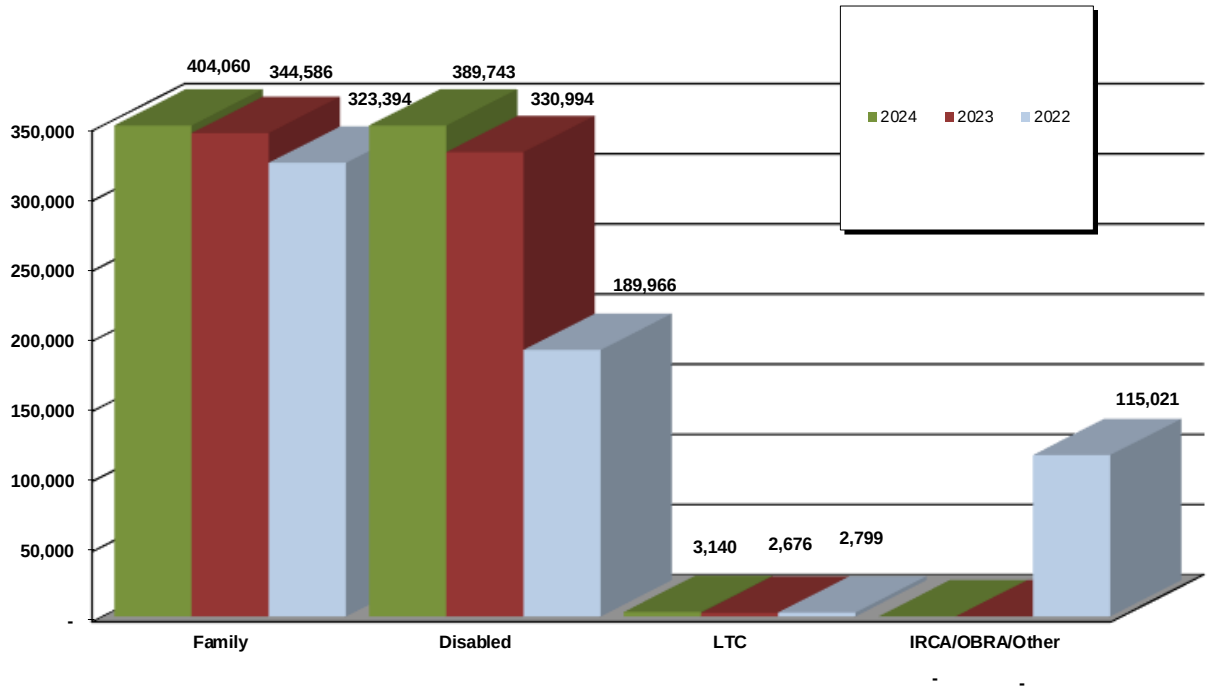
	2024	2023	2022 (As Restated)
MEMBERSHIP			
Member months for the year:			
Medi-Cal program	9,563,314	8,139,058	7,574,159
Total	9,563,314	8,139,058	7,574,159
Average member per month			
Medi-Cal program	796,943	678,255	631,180
Total	796,943	678,255	631,180
OPERATING RESULTS (in thousands)			
Operating revenues	$ 5,640,676	$ 3,698,827	$ 3,308,076
Operating expenses:			
Health care	4,455,620	3,271,089	2,816,658
General and administrative	276,630	245,885	210,188
Premium tax	659,356	91,437	166,250
Total	5,391,606	3,608,412	3,193,096
Operating income	$ 249,069	$ 90,415	$ 114,980
OPERATING RESULTS PER MEMBER PER MONTH			
Operating revenues	$ 589.8	$ 454.5	$ 436.8
Operating expenses:			
Health care	465.9	401.9	371.9
General and administrative	28.9	30.2	27.8
Premium tax	68.9	11.2	21.9
Total	563.7	443.3	421.6
Operating income	$ 26.0	$ 11.1	$ 15.2
RATIOS			
Health care cost as a percentage of operating revenues	79.0%	88.4%	85.1%
General and administrative expense as a percentage of operating revenues	4.9%	6.6%	6.4%
Premium tax as a percentage of operating revenues	11.7%	2.5%	5.0%
Operating income as a percentage of operating revenues	4.4%	2.4%	3.5%

ENROLLMENT

During the years ended June 30, 2024, 2023, and 2022, the Health Plan served Medi-Cal members at an average of 796,943, 678,255, and 631,180, respectively, per month. Enrollment from 2023 to 2024 increased steadily during the year primarily from the additional expansion counties but are offset by decreases from the termination of the global sub-capitation agreement with the Plan; these both occurred effective January 2024.

The following chart displays a comparative view of average monthly membership by Medi-Cal aid category for the years ended June 30, 2024, 2023, and 2022.

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, 2024, 2023, and 2022, and the change from prior year (in thousands):

	2024	2023	2022	Change from 2023 Amount	Change from 2023 Percent	Change from 2022 Amount	Change from 2022 Percent
			(As Restated)				
California Department of Health Care Services							
Capitation revenue	$ 5,608,959	$ 3,649,230	$ 3,285,782	$ 1,959,729	53.7%	$ 363,448	11.1%
Other income	31,717	49,598	22,294	(17,881)	(36.1%)	27,304	122.5%
Total operating revenues	5,640,676	3,698,827	3,308,076	1,941,848	52.5%	390,752	11.8%
Fee for service hospital inpatient, physician, and other services	3,404,458	2,218,400	1,583,762	1,186,058	53.5%	634,638	40.1%
Capitated physician, hospital, and other costs	450,573	578,434	576,925	(127,861)	(22.1%)	1,509	0.3%
Long-term care	551,122	373,012	387,085	178,110	47.7%	(14,073)	(3.6%)
Pharmacy	-	-	183,590	-	-%	(183,590)	(100.0%)
Quality improvement program and hospital stop loss	49,466	101,243	85,296	(51,777)	(51.1%)	15,947	18.7%
Total health care expenses	4,455,620	3,271,089	2,816,658	1,184,530	36.2%	454,431	16.1%
Total general and administrative expenses	276,630	245,885	210,188	30,745	12.5%	35,697	17.0%
Premium tax	659,356	91,437	166,250	567,919	621.1%	(74,813)	(45.0%)
Total operating expenses	5,391,606	3,608,412	3,193,096	1,783,194	49.4%	415,315	13.0%
Operating income	249,069	90,415	114,980	158,653	175.5%	(24,563)	(21.4%)
Investment income	92,127	48,887	1,478	43,240	88.4%	47,409	3,207.5%
Total nonoperating revenues	92,127	48,887	1,478	43,240	88.4%	47,409	3,207.5%
Increase in net position	$ 341,196	$ 139,303	$ 116,458	$ 201,893	144.9%	$ 22,846	19.6%

OPERATING REVENUES

The Health Plan's total operating revenues increased by $1.94 billion (52.5%) for the year ended June 30, 2024. The increase in operating revenues in 2024 is attributable to an increase in membership of 17.5%, which includes the expansion region, resulting in additional revenue of approximately $1.96 billion from fiscal year 2023. The additional increase in revenue can also be attributed to the inclusion of accruals for Directed Payments and Voluntary Rate Range, which are offset by accruals in other healthcare costs. Lastly, a new Medi-Cal Managed Care Organizations (MCO) tax revenue program with increased rates was established at the beginning of fiscal year 2024; these previous MCO tax expired in the middle of fiscal year 2023.

The Health Plan's total operating revenues increased by $390.8 million (11.8%) for the year ended June 30, 2023. The increase in operating revenues in 2023 is attributable to an increase in membership of 7.5% resulting in additional revenue of approximately $363.4 million from fiscal year 2022. The additional increase in revenue can also be attributed to the inclusion of accruals for Directed Payments and Voluntary Rate Range; these revenues are offset by accruals in other healthcare costs.

HEALTH CARE EXPENSES

2023–2024

Overall health care expenses increased by $1.18 billion or 36.2%, totaling $4.46 billion in 2024, compared to $3.27 billion in 2023. The Health Plan's health care ratio (health care costs as a percentage of operating revenue) at 79.0% in 2024 decreased, however, from 2023's health care ratio of 88.4%; the calculation of this ratio is affected by the increased revenue – primarily MCO revenue – which is addressed in the Operating Revenues section. 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 $450.6 million in 2024 compared to $578.4 million in 2023, for a decrease of $127.9 million or (22.1%), primarily due to the termination of the global sub-capitation agreement effective January 2024. Quality Improvement Program expenses decreased as well from $101.2 million in 2023 to $49.5 million in 2024 primarily due to the prior year's true-up and decrease in the number of participating providers meeting their performance measures.

- Fee for service expenses for hospital, physician, and other services increased from $2.22 billion in 2023 to $3.40 billion in 2024 due to increases in membership and utilization; the increase is also due to the inclusion of Directed Payments and Voluntary Rate Range, which have an offset in Department of Health Care Services (DHCS) Capitation Revenue. Long-term care fee-for-service expenses increased from $373.0 million in 2023 to $551.1 million in 2024; the increase can be attributed to prior year adjustments to IBNR related to increased utilization. Pharmacy costs are no longer being incurred as the pharmacy program has been carved out effective January 1, 2022.

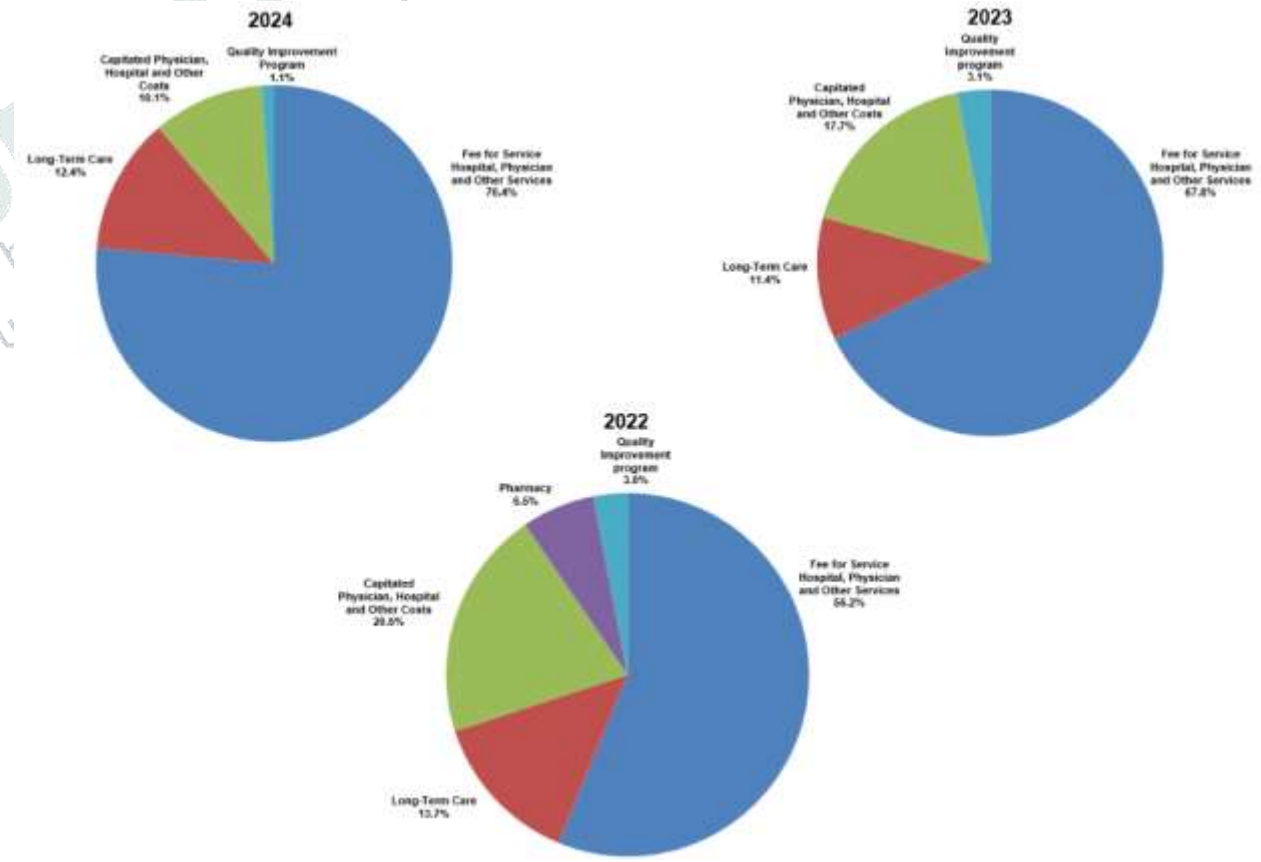
2022–2023

Overall health care expenses increased by $454.4 million or 16.1%, totaling $3.271 billion in 2023, compared to $2.82 billion in 2022. The Health Plan's health care ratio (health care costs as a percentage of operating revenue) at 88.4% in 2023 increased from 2022's health care ratio of 85.1%. 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 $578.4 million in 2023 compared to $576.9 million in 2022, for an increase of $1.5 million or 0.3%. The primary driver of the increase is due to an overall increase in membership. Quality Improvement Program expenses increased as well from $85.3 million in 2022 to $101.2 million in 2023 also due to the overall increase in membership and from the increase in the number of participating providers meeting their performance measures.

- Fee for service expenses for hospital, physician, and other services increased from $1.58 billion in 2022 to $2.22 billion in 2023 due to increases in membership; the increase is also due to the inclusion of Directed Payments and Voluntary Rate Range, which have an offset in DHCS Capitation Revenue. Long-term care fee-for-service expenses decreased from $387.1 million in 2022 to $373.0 million in 2023; the decrease can be attributed to prior year adjustments to IBNR related to decreased utilization. Pharmacy costs are no longer being incurred as the pharmacy program has been carved out effective January 1, 2022.

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, 2024, 2023, and 2022:



GENERAL AND ADMINISTRATIVE EXPENSES AND PREMIUM TAX EXPENSE

Total general and administrative expenses were $276.6 million in 2024, compared to $245.9 million in 2023. Overall administrative expenses increased by 12.5% or $30.7 million. This increase is due to the additional costs from various State Incentive Programs pertaining to Housing and Homelessness, CalAIM, and Student Behavioral Health; these costs are offset in Other Income. The Health Plan's administrative expenses as a percentage of operating of revenues were 4.9% in 2024 and 6.6% in 2023; the increase in revenue, which also affects the calculation of this ratio, is addressed in the Operating Revenues section.

Total general and administrative expenses were $245.9 million in 2023, compared to $210.2 million in 2022. Overall administrative expenses increased by 17.0% or $35.7 million. This increase is due to the additional costs from various State Incentive Programs pertaining to Housing and Homelessness, CalAIM, and Student Behavioral Health; these costs are offset in Other Income. The Health Plan's administrative expenses as a percentage of operating of revenues were 6.6% in 2023 and 6.4% in 2022.

On March 1, 2016, SB X2-2 established a new MCO tax, to be administered by the California Department of Healthcare Services (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 (CMS) on April 3, 2020. The effective date range for this approval is January 1, 2020 through December 31, 2022. Effective April 1, 2023, a revised MCO provider tax was established and is in effect through December 31, 2026. The Health Plan's premium tax expense for the years ended June 30, 2024 and 2023 was $659.4 million and $91.4 million, respectively.

NONOPERATING REVENUES

Nonoperating revenues, consisting of net investment income for fiscal years 2024 and 2023 were $92.1 million and $48.9 million, respectively. Increase in nonoperating revenues is due to an increase in interest income from increased interest rates.

LIQUIDITY

As of June 30, 2024, working capital (current assets in excess of current liabilities) was $1.09 billion, compared to $775.2 million at June 30, 2023. The significant increase is due to the current year's operating income.

As of June 30, 2023, working capital (current assets in excess of current liabilities) was $775.2 million, compared to $649.4 million at June 30, 2022. The significant increase is due to the current year's operating income.

ECONOMIC FACTORS AND FISCAL YEAR 2025 BUDGET

Given the State's overall budget condition, we continue to anticipate the DHCS will focus on cost efficient spending in managed care and expect pressures to be amplified given the budget shortfall. Historically, plan incurred health care costs were considered in future rate development. However, over the last several years Partnership has faced increased scrutiny from DHCS on contracted health care expense levels, some of which resulted in prior year downward rate adjustments. Given Partnership is an outlier with our inpatient contracting levels in comparison to other Medi-Cal plans across the state, the out-year implementation of regional rate cost averaging heightens concerns regarding future downward rate pressures to Partnership revenue levels and could significantly affect plan finances.

With Partnership's recent coverage area expansion into our 10 new counties in January 2024, there continues to be uncertainty on the revenue rate levels we will receive from DHCS for this expansion area and the associated expenses. The two previous Medi-Cal plans' cost and utilization data continues to influence Partnership's revenue rates for this new region. In October of 2023, the board approved losses of up to $150 million over the first two years of this new contract. Partnership continues to be at risk of sizeable losses tied to this expansion.

Additionally, there is uncertainty on the volume of membership loss Partnership will experience once all Medi-Cal eligibility redeterminations have been completed. This membership uncertainty continues to be a predominant variable associated with plan finances. Overall, the membership is expected to continue to decline slowly through June 2025.

The Health Plan is currently projecting a net loss for fiscal year 2024-25 of $260.7 million. However, given the many uncertainties regarding the 10-county expansion and Medi-Cal redeterminations, the budget may be revised mid-year to incorporate significant new developments. The Health Plan will continue to work through this period of unknowns by engaging in collaborative discussions with the State and Health Plan partners to ensure it remains in a stable financial condition to serve our members.

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

	2024	2023
Total assets	$ 20,780,557	$ 18,457,437
Total fiduciary net position	$ 20,780,557	$ 18,457,437
Total additions	$ 3,562,542	$ 1,704,391
Total deductions	(1,239,422)	(965,940)
Increase in fiduciary net position	2,323,120	738,451
Fiduciary net position, beginning of year	18,457,437	17,718,986
Fiduciary net position, end of year	$ 20,780,557	$ 18,457,437

Total fiduciary fund net position as of June 30, 2024, increased by $2.3 million from June 30, 2023, due to plan contributions and a net investment gain for the year ending June 30, 2024.

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, 2024 and 2023, 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, 2024 and 2023, 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 44 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 15 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 ____, 2024

Financial Statements

Partnership Health Plan of California
Statements of Net Position
June 30, 2024 and 2023

	2024	2023
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 2,295,140,947	$ 1,604,116,396
California Department of Health Care Services receivable	1,192,154,097	271,459,494
Other receivables	33,211,979	24,912,786
Lease receivable, current portion	1,903,599	1,186,819
Other current assets	10,017,878	9,135,628
Total current assets	3,532,428,500	1,910,811,123
CAPITAL ASSETS		
Nondepreciable	47,179,618	47,481,359
Depreciable, net of accumulated depreciation	86,319,215	71,421,772
Total capital assets	133,498,833	118,903,131
OTHER ASSETS	2,343,862	1,961,029
NET PENSION ASSET	4,919,453	2,961,371
LEASE RECEIVABLE, net of current portion	5,798,513	5,189,425
SUBSCRIPTION ASSET, net of amortization	17,685,202	7,967,995
Total assets	3,696,674,363	2,047,794,074
DEFERRED OUTFLOWS OF RESOURCES	1,620,052	2,861,333
Total assets and deferred outflows	$ 3,698,294,415	$ 2,050,655,407
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION		
CURRENT LIABILITIES		
Accounts payable and accrued expenses	$ 1,434,326,199	$ 503,013,515
Payable to the State of California	32,633,113	32,633,113
Accrued claims payable	886,017,427	494,469,581
Quality improvement program	89,250,080	105,498,279
Total current liabilities	2,442,226,819	1,135,614,488
SUBSCRIPTION LIABILITIES, net of current portion	846,976	2,017,951
Total liabilities	2,443,073,795	1,137,632,439
DEFERRED INFLOWS OF RESOURCES	7,617,910	6,616,582
NET POSITION		
Invested in capital assets	133,498,833	118,903,131
Restricted	300,000	300,000
Unrestricted	1,113,803,877	787,203,255
Total net position	1,247,602,710	906,406,386
Total liabilities, deferred inflows, and net position	$ 3,698,294,415	$ 2,050,655,407

See accompanying notes.

Partnership Health Plan of California
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2024 and 2023

	2024	2023
OPERATING REVENUES		
California Department of Health Care Services revenue	$ 5,608,959,006	$ 3,649,229,563
Other income	31,716,652	49,597,596
Total operating revenues	5,640,675,658	3,698,827,159
OPERATING EXPENSES		
Health care expenses		
Fee for service hospital, physician, and other services	3,404,458,422	2,218,400,461
Capitated physician, hospital, and other costs	450,572,781	578,434,026
Long-term care	551,122,436	373,011,946
Quality improvement program and hospital stop loss	49,466,395	101,243,329
Total health care expenses	4,455,620,034	3,271,089,762
General and administrative expenses	276,630,351	245,885,134
Premium tax	659,355,957	91,437,498
Total operating expenses	5,391,606,342	3,608,412,394
Operating income	249,069,316	90,414,765
NONOPERATING REVENUES		
Investment income	92,127,008	48,887,478
Total nonoperating revenues	92,127,008	48,887,478
INCREASE IN NET POSITION	341,196,324	139,302,243
NET POSITION, beginning of year	906,406,386	767,104,143
NET POSITION, end of year	$ 1,247,602,710	$ 906,406,386

See accompanying notes.

Partnership Health Plan of California
Statements of Cash Flows
Years Ended June 30, 2024 and 2023

	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from California Department of Health Care Services	$ 5,491,931,118	$ 4,024,486,204
Other income	69,700,614	37,425,603
Cash payments to providers for Medi-Cal members		
Capitation payments	(360,792,058)	(507,849,923)
Medical claims payments	(3,770,350,154)	(2,902,263,791)
Cash payments to vendors	(634,420,948)	(181,026,280)
Cash payments for salaries, wages, and related benefits	(157,762,327)	(119,440,526)
Net cash provided by operating activities	638,306,245	351,331,287
CASH FLOWS FROM FINANCING ACTIVITIES		
Payments on subscription liabilities	(17,063,242)	(1,289,411)
Purchases of capital assets	(22,180,985)	(17,398,637)
Net cash used in financing activities	(39,244,227)	(18,688,048)
CASH FLOWS FROM INVESTING ACTIVITY		
Interest and dividends on investments	91,962,533	48,337,559
Net cash provided by investing activity	91,962,533	48,337,559
INCREASE IN CASH AND CASH EQUIVALENTS	691,024,551	380,980,798
CASH AND CASH EQUIVALENTS, beginning of year	1,604,116,396	1,223,135,598
CASH AND CASH EQUIVALENTS, end of year	$ 2,295,140,947	$ 1,604,116,396

See accompanying notes.

Partnership Health Plan of California
Statements of Cash Flows (Continued)
Years Ended June 30, 2024 and 2023

	2024	2023
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 249,069,316	$ 90,414,765
Adjustment to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	7,585,282	6,416,084
Changes in operating assets and liabilities		
California Department of Health Care Services receivable	(920,694,603)	(91,879,770)
Other receivables	(8,134,718)	(7,243,765)
Lease receivables	(1,325,868)	(3,531,567)
Other assets	(10,982,290)	(9,025,243)
Net pension asset	284,527	4,162,922
Accounts payable and accrued expenses	947,204,952	307,543,898
Accrued claims payable	391,547,846	36,501,626
Quality improvement program	(16,248,199)	17,972,337
Net cash provided by operating activities	$ 638,306,245	$ 351,331,287
SUPPLEMENTAL DISCLOSURE OF CASH FLOWS INFORMATION		
Cash paid during the year for premium tax	$ 504,426,233	$ 141,843,475

See accompanying notes.

Partnership Health Plan of California

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

June 30, 2024 and 2023

	2024	2023
ASSETS		
Cash and cash equivalents	$ 570,894	$ 825,642
Investments, at fair value		
Mutual funds	20,209,663	17,631,795
Total investments, at fair value	20,209,663	17,631,795
Total assets	$ 20,780,557	$ 18,457,437
NET POSITION RESTRICTED FOR PENSIONS	$ 20,780,557	$ 18,457,437

See accompanying notes.

Partnership Health Plan of California

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

Years Ended June 30, 2024 and 2023

	2024	2023
ADDITIONS		
Contributions		
Member contributions	$ 210,692	$ 120,548
Employer contributions	1,463,028	464,413
Total contributions	1,673,720	584,961
Investment income	1,888,822	1,119,430
Total additions	3,562,542	1,704,391
DEDUCTIONS		
Benefits paid to participants	(1,168,179)	(878,858)
Administrative expenses	(71,243)	(87,082)
Total deductions	(1,239,422)	(965,940)
INCREASE IN NET POSITION	2,323,120	738,451
NET POSITION RESTRICTED FOR PENSION, beginning of year	18,457,437	17,718,986
NET POSITION RESTRICTED FOR PENSION, end of year	$ 20,780,557	$ 18,457,437

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 twenty-four (24) counties: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba. 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 its fourteen (14) counties into two regions, which are in alignment with the two CDHCS rating regions. Beginning January 2024, the Health Plan expanded into ten (10) additional counties, which comprised a third region.

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. Extensions of the program were approved by the Centers for Medicare and Medicaid Services are as follows: 1) HQAF VI, covering July 1, 2019–December 31, 2021; 2) HQAF VII, covering January 1, 2022-December 31, 2022; and 3) HQAF VIII, covering January 1, 2023-December 31, 2024.

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.

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

Subscription liabilities – The Health Plan entered into various agreements for information technology (IT) subscriptions. These agreements range in terms up to year 2028. In fiscal year 2024, the total subscription payments were $17,063,242. Variable payments based upon the use of the underlying IT asset are not fixed in substance — therefore, these payments are not included in subscription assets or subscription liabilities. There were no variable subscription expenses and payments in fiscal years ended June 30, 2024 and 2023. The Health Plan is in the process of entering into additional subscription agreements that have yet to commence as of June 30, 2024.

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

Quality improvement program – Quality improvement program pools are calculated based 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, 2024 and 2023, $5,328,350, included in accounts payable and accrued expenses, remains for the expected payout of IGT.

Accounts payable and accrued expenses – Accounts payable and accrued expenses include accruals of $794,531,104 and $244,198,746 for Directed Payments, $265,991,304 and $80,666,799 for Voluntary Rate Range, and $157,480,957 and $0 for MCO Tax respectively, as of June 30, 2024 and 2023. These liability accruals have corresponding offsets in current assets.

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, 2024 and 2023. 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, 2024 and 2023, the Health Plan's Board of Commissioners has designated $170,058,631 and $117,343,975, 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 $1,294,748,689 and $1,092,714,472 as of June 30, 2024 and 2023, 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. Nonoperating revenues and expenses consist of those revenues and expenses that are related to financing and investing types of activities and result from nonexchange transactions or net investment income and changes in the fair value of investments.

Revenues – Medi-Cal capitation revenue under the Contract is based on the monthly capitation rates, as provided for in the Contract, and the actual number of Medi-Cal eligible members. Eligibility of beneficiaries is determined by each respective county's Department of Human Services and validated by 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, 2024 and 2023, 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, 2024 and 2023.

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. Effective April 1, 2023, a revised MCO provider tax was established and is in effect through December 31, 2026.

Premium tax expense for the years ended June 30, 2024 and 2023 was $659,355,957 and $91,437,498, 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, 2024 and 2023, the Health Plan had cash and deposits with four (4) financial institutions. Cash deposits had carrying amounts of $2,295,140,947 and $1,604,116,396, respectively, and bank balances of $2,335,744,150 and $1,636,834,734, respectively. Of the bank balances at June 30, 2024 and 2023, $194,633,006 and $188,221,270, 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 2022, the GASB issued Statement No. 100, *Accounting Changes and Error Corrections - an amendment of GASB Statement No. 62*. This Statement enhances accounting and financial reporting requirements for accounting changes and error corrections. It defines accounting changes as changes in accounting principles, changes in accounting estimates, and changes to or within the financial reporting entity. This Statement requires that (1) changes in accounting principles and error corrections be reported retroactively by restating prior periods, (2) changes to or within the financial reporting entity be reported by adjusting beginning balances of the current period, and (3) changes in accounting estimates be reported prospectively by recognizing the change in the current period. The Statement is effective for fiscal years beginning after June 15, 2023. The Health Plan adopted this standard on its financial statements.

In June 2022, the GASB issued Statement No. 101, *Compensated Absences* (GASB No. 101). GASB No. 101 requires that liabilities for compensated absences be recognized for (1) leave that has not been used and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability should be recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, and (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. This Statement requires that a liability for certain types of compensated absences—including parental leave, military leave, and jury duty leave—not be recognized until the leave commences. This Statement also requires that a liability for specific types of compensated absences not be recognized until the leave is used. The requirements of this GASB No. 101 are effective for fiscal years beginning after December 15, 2023, and all reporting periods thereafter. The Health Plan is reviewing the impact of the adoption of GASB No. 101 for the fiscal year ending June 30, 2025.

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

Note 3 – Cash and Investments

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

	2024	2023
Cash on hand	$ 3,300	$ 3,300
Cash deposits	2,102,878,427	1,417,344,803
Cash equivalents	192,259,220	186,768,293
Certificates of deposit	300,000	300,000
Total cash and investments	$ 2,295,440,947	$ 1,604,416,396

The investments balance consisting of certificates of deposit of $300,000 as of June 30, 2024 and 2023, 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, 2024 and 2023, 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 $2,292,081,484 and $1,601,089,342, 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, 2024 and 2023, the Health Plan did not hold investments exposed to custodial credit risk.

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

	June 30, 2024		June 30, 2023	
Investment Type	Fair Value	Weighted Average Maturity (Years)	Fair Value	Weighted Average Maturity (Years)
Certificates of deposit	$ 300,000	0.58	$ 300,000	1.58
Total fair value	$ 300,000		$ 300,000	

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

Rating as of June 30, 2024:

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, 2023:

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 27. 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, 2024 and 2023.

Note 4 – Capital Assets

A summary of changes in capital assets for the years ended June 30, 2024 and 2023 is as follows:

	Beginning Balance 2024	Increases	Decreases	Transfers/Reclass	Ending Balance 2024
Motor vehicles	$ 221,830	$ 266,630	$ (26,348)	$ -	$ 462,112
Equipment	48,463,104	1,401,622	(22,293,098)	-	27,571,628
Furniture	7,518,859	-	(976,028)	473,051	7,015,882
Leasehold improvements	962,374	-	(838,086)	-	124,288
Land	6,767,292	-	-	-	6,767,292
Building	55,932,087	12,039,758	-	-	67,971,845
Building improvements	31,455,076	1,909,770	(132,576)	6,391,895	39,624,165
Capital projects	40,714,067	6,563,205	-	(6,864,946)	40,412,326
Total capital assets	192,034,689	22,180,985	(24,266,136)	-	189,949,538
Less: depreciation expense and accumulated depreciation related to disposals	(73,131,559)	(7,585,282)	24,266,136	-	(56,450,705)
Capital assets, net of accumulated depreciation	$ 118,903,130	$ 14,595,703	$ -	$ -	$ 133,498,833

	Beginning Balance 2023	Increases	Decreases	Transfers/Reclass	Ending Balance 2023
Motor vehicles	$ 154,341	$ 67,489	$ -	$ -	$ 221,830
Equipment	41,765,971	5,083,663	-	1,613,470	48,463,104
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	31,104,021	280,557	-	70,498	31,455,076
Capital projects	30,431,108	11,966,928	-	(1,683,968)	40,714,068
Total capital assets	174,636,053	17,398,637	-	-	192,034,690
Less: depreciation expense and accumulated depreciation related to disposals	(66,715,475)	(6,416,084)	-	-	(73,131,559)
Capital assets, net of accumulated depreciation	$ 107,920,578	$ 10,982,553	$ -	$ -	$ 118,903,131

Depreciation and amortization expense included in general and administrative expenses were $7,585,282 and $6,416,084 for the years ended June 30, 2024 and 2023, 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:

	2024	2023
Beginning balance	$ 494,469,581	$ 457,967,956
Incurred	3,217,359,142	2,269,013,964
Paid	(2,825,811,296)	(2,232,512,339)
Ending balance	$ 886,017,427	$ 494,469,581

Accrued claims liability increased by $391.5 million in comparison to the previous year. $391.9 million of this increase 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 and also reflects increased accruals resulting from the additional expansion counties. An additional increase of $70.7 million is for the accruals for the new Targeted Rate Increase for calendar year 2024. These increases are offset by a net decrease in the Proposition 56 State directed supplemental payment liability; total payments were greater than total accruals during the year resulting in a net decrease of $71.1 million in the liability.

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 contracted primary care physicians and there is no downside risk to them.

At June 30, 2024 and 2023, the Health Plan has accrued $89,250,080 and $105,498,279, respectively, due to providers under the quality improvement program.

Note 7 – Leases

The Health Plan is a lessor for various noncancelable lease of office space with lease terms through 2025. For the years ending June 30, 2024 and 2023, the Health Plan recognized $1,820,385 and $991,908, respectively, in lease revenue released from the deferred Inflows of resources related to the office leases included in other income on the statements of revenues, expenses, and changes in net position. The Health Plan recognized interest revenue of $180,725 and $175,505 for the years ending June 30, 2024 and 2023, respectively. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during the fiscal year.

Note 8 – Subscription Based Information Technology Arrangements

The Health Plan has the following subscription assets activities for the years ended June 30, 2024 and 2023:

	Balance July 1, 2023	Increase	Decrease	Balance June 30, 2024
Subscription assets	$ 9,689,320	$ 12,336,102	$ -	$ 22,025,422
Less accumulated amortization	(1,721,325)	(2,618,895)	-	(4,340,220)
Subscription assets, net	$ 7,967,995	$ 9,717,207	$ -	$ 17,685,202

	Balance July 1, 2022	Increase	Decrease	Balance June 30, 2023
Subscription assets	$ 4,906,788	$ 4,782,532	$ -	$ 9,689,320
Less accumulated amortization	(549,878)	(1,171,447)	-	(1,721,325)
Subscription assets, net	$ 4,356,910	$ 3,611,085	$ -	$ 7,967,995

For the years ended June 30, 2024 and 2023, the Health Plan recognized $2,618,895 and $1,171,447, respectively, in amortization expense.

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

	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
2024	$ 3,323,070	$ 16,088,250	$ 17,063,242	$ 2,348,078	$ 1,501,102

	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
2023	$ 2,860,421	$ 1,752,060	$ 1,289,411	$ 3,323,070	$ 1,305,119

The future principal and interest subscription payments as of June 30, 2024, are as follows:

Year Ending June 30,	Principal	Interest	Total
2025	$ 1,492,131	$ 15,429	$ 1,507,560
2026	503,777	-	503,777
2027	343,199	-	343,199
	$ 2,339,107	$ 15,429	$ 2,354,536

The Health Plan evaluated the subscription assets for impairment and determined there was no impairment for the years ended June 30, 2024 and 2023.

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

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

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

Funding policy – The Health Plan will contribute at an actuarially determined rate; the rate was 20.65% and 7.34% in 2024 and 2023, respectively, of annual covered payroll. The contribution rate is established bi-annually and may be amended by the Health Plan's Board of Commissioners.

Summary of Significant Accounting Policies

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

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

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

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

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

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

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

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

Investments by fair value level include the following as of June 30, 2024 and 2023:

	Level 1	Level 2	Level 3	Fair Value Measurement at June 30, 2024
Investments by fair value level				
Mutual funds	$ 20,209,663	$ -	$ -	$ 20,209,663
Total investments	$ 20,209,663	$ -	$ -	$ 20,209,663

	Level 1	Level 2	Level 3	Fair Value Measurement at June 30, 2023
Investments by fair value level				
Mutual funds	$ 17,631,795	$ -	$ -	$ 17,631,795
Total investments	$ 17,631,795	$ -	$ -	$ 17,631,795

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

	2024	2023
Retired and beneficiaries	7	7
Inactive	1	1
Active	18	18
Total participants	26	26

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:

	2024	2023
Pension cost		
Service cost	$ 528,958	$ 464,152
Interest on total pension liability	1,004,259	927,860
Administrative expenses	71,243	87,082
Member contributions	(210,692)	(120,548)
Expected investment return, net of investment expenses	(1,213,626)	(1,139,547)
Recognition of deferred outflows of resources		
Recognition of economic/demographic gains	299,833	328,270
Recognition of assumption changes	(9,794)	(27,575)
Recognition of investment gains	226,667	384,228
Total pension cost	$ 696,848	$ 903,922

	2024	2023
Deferred outflows of resources as of June 30		
Difference between expected and actual experience	$ 1,085,254	$ 1,407,805
Changes in assumptions	54,687	71,554
Net difference between projected and actual earnings on pension plan investments	480,111	1,381,974
Total	$ 1,620,052	$ 2,861,333
Deferred inflows of resources as of June 30		
Difference between expected and actual	$ (38,618)	$ (61,336)
Changes in assumptions	-	(26,661)
Total	$ (38,618)	$ (87,997)

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,	
2025	$ 377,527
2026	826,455
2027	81,977
2028	17,747
2029	152,787
Thereafter	124,941
	$ 1,581,434

The following table summarizes changes in pension liability (asset) for the fiscal year ended June 30, 2024:

	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance, June 30, 2023	$ 15,496,066	$ 18,457,437	$ (2,961,371)
Changes during the year			
Service cost	528,958	-	528,958
Interest on the total pension asset	1,004,259	-	1,004,259
Effect of plan changes	-	-	-
Effect of economic/demographic gains or losses	-	-	-
Effect of assumptions, changes, or inputs			-
Benefit payments, including refunds of employee contributions	(1,168,179)	(1,168,179)	-
Contributions - employer		1,463,028	(1,463,028)
Contributions - members		210,692	(210,692)
Net investment income		1,888,822	(1,888,822)
Administrative expenses		(71,243)	71,243
Net change in total pension liability (asset)	365,038	2,323,120	(1,958,082)
Balance, June 30, 2024	$ 15,861,104	$ 20,780,557	$ (4,919,453)
Total pension liability			$ 15,861,104
Plan fiduciary net position			20,780,557
Net pension asset			$ (4,919,453)
Plan fiduciary net position as a percentage of the total pension liability			131.02%
Covered-employee payroll			$7,083,809
Plan net pension asset as of a percentage of covered-employee payroll			-69.45%

The following table summarizes changes in pension liability for the fiscal year ended June 30, 2023:

	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance, June 30, 2022	$ 14,243,125	$ 17,718,986	$ (3,475,861)
Changes during the year			
Service cost	464,152	-	464,152
Interest on the total pension asset	927,860	-	927,860
Effect of plan changes	-	-	-
Effect of economic/demographic gains or losses	739,787	-	739,787
Effect of assumptions, changes, or inputs	-	-	-
Benefit payments, including refunds of employee contributions	(878,858)	(878,858)	-
Contributions - employer	-	464,413	(464,413)
Contributions - members	-	120,548	(120,548)
Net investment income	-	1,119,430	(1,119,430)
Administrative expenses	-	(87,082)	87,082
Net change in total pension liability (asset)	1,252,941	738,451	514,490
Balance, June 30, 2023	$ 15,496,066	$ 18,457,437	$ (2,961,371)
Total pension liability			$ 15,496,066
Plan fiduciary net position			18,457,437
Net pension asset			$ (2,961,371)
Plan fiduciary net position as a percentage of the total pension liability			119.11%
Covered-employee payroll			$ 6,325,907
Plan net pension asset as of a percentage of covered-employee payroll			-46.81%

The following table summarizes the actuarial assumptions used to determine net pension (asset) liability and plan fiduciary net position as of June 30, 2024:

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

The following table summarizes the sensitivity of net pension asset to changes in the discount rate as of June 30, 2024:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
Total pension liability	$17,478,722	$15,861,104	$14,481,791
Fiduciary net position	20,780,557	20,780,557	20,780,557
Net pension asset	$ (3,301,835)	$ (4,919,453)	$ (6,298,766)

The following table summarizes the sensitivity of net pension asset to changes in the discount rate as of June 30, 2023:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
Total pension liability	$ 17,049,029	$ 15,496,066	$ 14,169,747
Fiduciary net position	18,457,437	18,457,437	18,457,437
Net pension asset	$ (1,408,408)	$ (2,961,371)	$ (4,287,690)

Note 10 – Tangible Net Equity

As a limited license plan under the Knox-Keene Health Care Services Plan Act of 1975, the Health Plan is required to maintain a minimum level of tangible net equity. The required tangible net equity level was $170,058,631 and $117,343,975 at June 30, 2024 and 2023, respectively. The Health Plan's tangible net equity was $1,247,602,710 and $906,406,386, at June 30, 2024 and 2023, respectively.

Note 11 – Risk Management

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

Note 12 – Commitments and Contingencies

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

Note 13 – 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, 2024

	Actual	Budget	Variance Revenue/ Expense Over (Under)
OPERATING REVENUES			
California Department of Health Care Services revenue	$ 5,608,959,006	$ 5,359,625,695	$ 249,333,311
Other income	31,716,652	66,172,004	(34,455,352)
Total operating revenues	5,640,675,658	5,425,797,699	214,877,959
OPERATING EXPENSES			
Health care expenses			
Fee for service hospital, physician, and other services	3,404,458,422	3,456,884,938	(52,426,516)
Capitated physician, hospital, and other costs	450,572,781	463,981,640	(13,408,859)
Long-term care	551,122,436	553,326,036	(2,203,600)
Quality improvement program and hospital stop loss	49,466,395	110,672,090	(61,205,695)
Total health care expenses	4,455,620,034	4,584,864,704	(129,244,670)
GENERAL AND ADMINISTRATIVE EXPENSES			
Other admin expenses	59,003,467	59,200,476	(197,009)
Employee expenses	147,047,959	157,192,659	(10,144,700)
Travel/meeting/meals expenses	1,165,550	1,834,105	(668,555)
Occupancy costs	13,802,851	18,754,294	(4,951,443)
Operating costs	8,128,956	9,717,418	(1,588,462)
Professional services	23,773,198	27,841,103	(4,067,905)
Computer and data expenses	23,708,370	21,529,546	2,178,824
Total general and administrative expenses	276,630,351	296,069,601	(19,439,249)
Premium tax	659,355,957	659,530,616	(174,659)
Total operating expenses	5,391,606,342	5,540,464,921	(148,858,579)
Operating income	249,069,316	(114,667,222)	363,736,538
NONOPERATING REVENUES			
Investment income	92,127,008	79,186,504	12,940,504
Total nonoperating revenues	92,127,008	79,186,504	12,940,504
INCREASE IN NET POSITION	341,196,324	(35,480,718)	376,677,042
NET POSITION, beginning of year	906,406,386	906,406,386	-
NET POSITION, end of year	$ 1,247,602,710	$ 870,925,668	$ 376,677,042

Supplementary Pension Benefit Information

Partnership Health Plan of California
Supplementary Schedule of Changes in the Net Pension Liability and Related Ratios
Years Ended June 30, 2024 and 2023

	2024	2023
TOTAL PENSION LIABILITY		
Service cost	$ 528,958	$ 464,152
Interest	1,004,259	927,860
Difference between expected and actual experience	-	739,787
Benefit payments, including refunds of employee contributions	(1,168,179)	(878,858)
Net changes in total pension liability	365,038	1,252,941
TOTAL PENSION LIABILITY, beginning of fiscal year	15,496,066	14,243,125
TOTAL PENSION LIABILITY, end of fiscal year	$ 15,861,104	$ 15,496,066
PLAN FIDUCIARY NET POSITION		
Contributions - employer	$ 1,463,028	$ 464,413
Contributions - employee	210,692	120,548
Net investment income	1,888,822	1,119,430
Benefit payments, including refunds of employee contributions	(1,168,179)	(878,858)
Other changes in fiduciary net position	(71,243)	(87,082)
Net changes in fiduciary net position	2,323,120	738,451
PLAN FIDUCIARY NET POSITION, beginning of fiscal year	18,457,437	17,718,986
PLAN FIDUCIARY NET POSITION, end of fiscal year	$ 20,780,557	$ 18,457,437
PLAN NET PENSION LIABILITY	$ (4,919,453)	$ (2,961,371)
PLAN FIDUCIARY NET POSITION as a percentage of the total pension liability	131.02%	119.11%
COVERED EMPLOYEE PAYROLL	$ 7,083,809	$ 6,325,907
PLAN NET PENSION ASSET as of a percentage of covered employee payroll	-69.45%	-46.81%

Partnership Health Plan of California
Supplementary Schedule of Contributions
Years Ended June 30, 2024 and 2023

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%
2023	$ 370,177	$ 464,413	$ (94,236)	$ 6,325,907	7.34%
2024	$ 541,714	$ 1,463,028	$ (921,314)	$ 7,083,809	20.65%

Partnership Health Plan of California

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

Years Ended June 30, 2024 and 2023

Years Ended June 30,	Rate of return
2018	5.59%
2019	5.58%
2020	3.61%
2021	20.33%
2022	-11.44%
2023	6.39%
2024	10.24%

Communications with Those
Charged with the Commissioners

Partnership Health Plan of California

June 30, 2024

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, 2024, and have issued our report thereon dated October ____, 2024. 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 May 6, 2024, 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 May 6, 2024.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Partnership Health Plan of California are described in Note 2 to the financial statements. During the year ended June 30, 2024, the Health Plan adopted Governmental Accounting Standards Board (GASB) Statement No. 100, *Accounting Changes and Error Corrections — an amendment of GASB Statement No. 62*. The adoption had no material impact to the financial statements. We noted no transactions entered into by the Health Plan during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

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

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

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

Financial Statement Disclosures

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

Significant Unusual Transactions

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

Significant Difficulties Encountered in Performing the Audit

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

Disagreements with Management

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

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

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

Corrected and Uncorrected Misstatements

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

Management Representations

We have requested certain representations from management that are included in the management representation letter dated October ____, 2024.

Management Consultation with Other Independent Accountants

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

Other Significant Audit Findings or Issues

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

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

San Francisco, California
October ___, 2024

Report from the Chief Executive Officer

October 9, 2024

Community Reinvestments Draft Policy – On Sept. 6, 2024 DHCS released a draft All Plan Letter (APL) for the Community Reinvestment requirements pursuant to 2024 Medi-Cal contract requirements. The currently draft policy for Community Reinvestments contains detail language that requires that Managed Care Plans, with a positive net income, must reinvest a minimum percentage of the annual net income into community initiatives. Partnership, along with all of the other Local Health Plans have considerable concerns with this draft policy. Partnership provided feedback directly to DHCS on this draft guidance. Key areas of concerns were:

- **95% of base Community Reinvestments funds are to be in proportion to the plan's Medi-Cal membership, by county.** As a health plan that represents many rural communities we recognize that there are instances when our rural communities need more financial investments, not less, in order to address rural health disparities and to help close gaps in access and quality for those vulnerable communities. In its current form, the policy does not have the flexibility needed to account for the diversity in populations across our network.

- **Shared governance structures for oversight of the health plan's Community Reinvestments.** As a County Organized Health System (COHS) model health plan our governance model is clearly set forth in our bylaws and in collaboration with our counties. There is concern with DHCS' language that they are "exploring legal permissibility for governance structures and oversight…and decision-making structures" as it relates to Partnership's investments in the communities. This proposed policy language was shared with the legal firm DSR who provided written guidance that was shared with DHCS. Per DSR, *The DHCS contract does not permit DHCS to make changes to the MCPs' governance structure for purposes of Community Reinvestment decision-making as suggested within the draft APL. Local plans already have a clear governance structures through their local Commissioners which serve as the plans' Board with fiduciary responsibilities. Those Commissioners are identified in local plans' authorizing county ordinances and have the discretion and decision-making authority over health plan finances, investments and operations. There should be no different structure developed or shared governance model to oversee Managed Care Plan reserve funds.*

- **Timelines for implementation that do not account for multi-year investments or DHCS' rates shared with plans.** If this policy is adopted as currently worded, Partnership would need to begin planning activities in 2024 for Community Reinvestments without a guarantee or guidance from DHCS that existing or future committed projects would be recognized by DHCS.

Partnership has a long-standing history of investing locally in our communities and we are pleased to see this activity memorialized formally in a contract with DHCS. We will continue to work with our providers, community partners, LHPC and others to ensure that this policy is continually refined to ensure we can continue to have the autonomy, flexibility and opportunity to invest and serve in our local communities for many years to come.

Update: NCQA Health Equity Accreditation – Since early 2023 Partnership has been planning and working on our policies, processes, systems and operations to obtain NCQA Health Equity Accreditation by 2026. This effort lead in large part by our Health Equity Officer, Dr. Mohammed Jalloh and NCQA program team involves nearly every department in the health plan. This past August, the health plan participated in a 'mock audit' against the NCQA standards to gauge our progress and readiness towards accreditation. We received the results of our audit in September and were impressed to see that if Partnership were to be surveyed by NCQA today, we would likely be accredited as our mock audit showed a score of 23 out of 27 points; well above the 80% required by NCQA for Health Equity Accreditation. Our NCQA consulted commented that Partnership is on a "solid path" with demonstrated strengths in our in our processes in place to capture and track race, ethnicity, and language (REaL) data for a large percentage of our membership. Partnership has made Health Equity not only an organizational goal, but a strategic goal as well. Achieving Health Equity Accreditation through NCQA would further demonstrate and signal to others Partnership's full commitment to quality in addressing health equity and disparities both inside and outside the organization. We look forward to continuing this path towards excellence preparing our materials for our initial survey June 17, 2025.

California Health Care Minimum Wage Start Date – Last fall the California enacted Senate Bill 525 which raises the minimum wage for health care workers, over time, to $25 per hour. The first incremental increases were begin to start this past June, however there were several delays and amendments to the law because of the California Budget. Upon hearing of the passage, many providers increased wages preemptively as an attempt to retain and attract needed healthcare workers. On October 1, 2024 DHCS issued a letter to the Joint Legislative Committee that the data retrieval was initiated. Health care workers are eligible to receive the higher minimum wage beginning October 16, 2024 with gradual increases over several years. There are list of types of health care facilities that this applies to including: Hospitals or integrated health systems with 10,000 or more full-time employees, dialysis clinics, safety net hospitals, licensed acute care and psychiatric hospitals, community clinics, rural health clinic, or urgent care clinics that are associated with community/rural health clinics, skilled nursing facilities with special provisions and other agencies. Per early reports, this change will impact up to 470,000 workers in California. As we continue to see the impacts of workforce shortages across our network, we will continue to closely watch and monitor the effects of this new law in our network and communities.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: September 18, 2024 2.1
Board Meeting Date: October 9, 2024

Resolution Sponsor:
Katherine Barresi, Acting CEO, Partnership HealthPlan of CA

Recommendation by:
The Finance Committee and Partnership Staff

Topic Description:
Partnership Board Commissioner Tina Rivera, Sonoma County Health Services Director has resigned from her position at Sonoma County and the Partnership Board.

Commissioner Rivera has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since February 2023. She has provided excellent leadership and has been a dedicated volunteer. Her knowledge has been of great value to Partnership, and she has kept the needs of our members, providers and the community as a guiding principle.

Reason for Resolution:
To obtain Board approval to accept the resignation of Sonoma County Representative, Tina Rivera from the Partnership Board.

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

Requested Action of the Board:
Based on the recommendation of the Finance Committee and Partnership staff, the Board is asked to accept the resignation of Sonoma County Representative, Tina Rivera from the Partnership Board.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: September 18, 2024 2.1
Board Meeting Date: October 9, 2024

Resolution Number:
24-

IN THE MATTER OF: ACCEPTING THE RESIGNATION OF BOARD COMMISSIONER TINA RIVERA

Recital: Whereas,

A. The Board has authority to accept Commissioner resignations.

B. Commissioner Rivera has resigned from her position at Sonoma County and thus, the Partnership Board.

C. Tina Rivera was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept Tina Rivera's resignation from the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: September 18, 2024 2.2
Board Meeting Date: October 9, 2024

Resolution Sponsor:
Katherine Barresi, Acting CEO, Partnership HealthPlan of CA

Recommendation by:
The Finance Committee and Partnership Staff

Topic Description:
Partnership Board Commissioner Farhan Fadoo, MD, Marin Community Clinics Chief Executive Officer, has resigned from his position at Marin Community Clinics, the Partnership Board and the Finance Committee.

Commissioner Fadoo has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since April 2024. His knowledge has been of great value to Partnership, the Board and the Finance Committee.

Reason for Resolution:
To obtain Board approval to accept the resignation of Marin County Representative, Farhan Fadoo, MD, from the Partnership Board.

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

Requested Action of the Board:
Based on the recommendation of the Finance Committee and Partnership staff, the Board is asked to accept the resignation of Marin County Representative, Farhan Fadoo, MD, from the Partnership Board.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: September 18, 2024 2.2
Board Meeting Date: October 9, 2024

Resolution Number:
24-

IN THE MATTER OF: ACCEPTING THE RESIGNATION OF BOARD COMMISSIONER FARHAN FADOO, MD

Recital: Whereas,

A. The Board has authority to accept Commissioner resignations.

B. Commissioner Fadoo has resigned from his position at Marin Community Clinics and thus, the Partnership Board and Finance Committee.

C. Farhan Fadoo, MD, was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept Dr. Farhan Fadoo's resignation from the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.1

Resolution Sponsor:
Katherine Barresi, Acting CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Advisory Groups and Committees

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

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

The Board is responsible for reviewing and accepting all minutes and packets approved by the various advisory groups and committees, and approving the policies, program descriptions, and QIP changes that were approved by the PAC, in September 2024.

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

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

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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.1

Resolution Number:
24-

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

Recital: Whereas,

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

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

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept receipt of all Partnership committee minutes and committee packets.

2. To obtain approval for policy and program description changes approved and recommended by PAC.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners

ABSTAINED: Commissioners

ABSENT: Commissioners

EXCUSED: Commissioners

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.2

Resolution Sponsor:
Katherine Barresi, Acting CEO, Partnership HealthPlan of CA

Recommendation by:
Quality Utilization Advisory Committee and Physician Advisory Committee

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

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

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

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

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

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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.2

Resolution Number:
24-

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

Recital: Whereas,

A. The Board has ultimate responsibility for quality improvement.

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

Now, Therefore, It Is Hereby Resolved As Follows:

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

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

Summary of QI Trilogy Documents

August 2024

Annually, the Quality and Performance Improvement Team updates three documents that reflect past, present, and future work related to quality improvement at Partnership HealthPlan of California (Partnership):

1. Quality Improvement Program Description
2. Quality Improvement Program Evaluation
3. Quality Improvement Work Plan

Each document is a regulatory and NCQA Accreditation requirement. The Quality Improvement Project Management team in partnership with the Senior Director of Quality and Performance Improvement and Director of Quality Management, serves as the QI Trilogy Document Team. The team led the preparation of the documents for review by Partnership's quality committees. These documents will be presented during the quality committees in August and final approval will be sought from the Board of Commissioners in the fall. Along with this review cycle, each document accounts for activities on a fiscal year cycle. These documents will be submitted to the State after Board approval and shared with Partnership members via the website and upon request.

DOCUMENT SUMMARIES:

QI Program Description

The QI Program Description is a summary of the QI program with content including the structure, processes, and intra and interdepartmental work that supports quality improvement efforts at Partnership. The description contains the following components per the NCQA accreditation standards (QI 1A):

- The QI program structure.
- The behavioral healthcare aspects of the program.
- Involvement of a designated physician in the QI program.
- Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program.
- Oversight of QI functions of the organization by the QI Committee.

The Partnership fiscal year 2024-2025 document reflects revisions completed through interdepartmental review and collaboration, particularly in the following areas:

1. Updated policy language in the Approach to Quality and Performance Improvement section to clearly indicate how the QI Program fulfills recently released APL 24-004: QI and Health Equity Transformation Requirements.
2. Shifting from the IHI Triple Aim (population health, patient experience, and cost efficiency) to a Quintuple Aim. Partnership is committed to pursuing the fourth aim by supporting workforce well-being in an effort to ensure providers across our network have adequate resources to provide high-quality care for our members. Partnership is committed to pursuing the fifth aim by striving to achieve equitable health for all of our members.

3. As a tool for evaluating meaningful improvements in DEI (Diversity, Equity, and Inclusion) and for preparing for NCQA Health Equity Accreditation, Partnership will distribute a DEI Survey on an annual basis to assess the diversity of key committees. The annual DEI Survey will allow committee members to provide feedback on improving the diversity, equity, and inclusion within their respective committee.
4. Formation of the Analytics Steering Committee that functions to promote and coordinate data analytics efforts to generate information, knowledge, and wisdom to improve health outcomes, enhance the member experience of care, and reduce or maintain the cost of care by optimizing utilization of data, technology and staff.
5. In preparation to acquire NCQA Health Equity Accreditation, Partnership will conduct a full-scope HEA Mock Initial Survey to identify and address gaps to assess readiness for Initial Survey in 2025.
6. Preparing to become a Medicare Medi-Cal Health plan by offering a Dual Eligible Special Needs Plan (D-SNP) by January 2026.
7. Partnership continues to devote coaching resources designed to align with the priorities and needs of organization performing below the minimum performance level (MPL) in an effort to build capacity for quality improvement work.

QI Evaluation

The QI Evaluation is designed to assess performance on work outlined in the QI Program Description and the QI Work Plan. Per NCQA requirements (QI 1C), the evaluation must include the following:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of measures of performance in the quality and safety of clinical care and quality of service.
- Evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices.

The evaluation includes work directly completed by the Quality and Performance Improvement department and other departmental partners within Partnership. In preparing the 2023-2024 evaluation, the following items were given greater consideration.

1. Continued analysis of the QI program structure and how the roles defined within the QI department and senior leadership/physician roles fulfill it.
2. Enhanced trend analysis and implementation of interventions for measurements related to clinical quality, member safety, and member experience outcomes, reflecting the most recent 12-month period compared to the prior year
3. Continued assessment of barriers in quality improvement with corresponding health plan adaptations to member and provider engagement strategies and tactics
4. Assessment of resources and organization of quality and performance improvement activities to accommodate the growing scope and complexity of quality measurement, and reporting under both DHCS and NCQA accreditation. In FY 23-24, of particular focus was the impact of Partnership's ten-county expansion, evaluation of achieving at least a 3.5 STAR health plan rating as an NCQA accredited health plan, and preparation for NCQA Health Equity Accreditation requirements.

QI Work Plan

The QI Work Plan outlines major activities for the QI Department and organization as a whole that advance quality and performance improvement.

There are four main areas the Work Plan is designed to monitor and increase accountability of per the NCQA technical specifications (QI 1B):

- Yearly planned QI activities and objectives for improving:
  - – Quality of clinical care
  - – Safety of clinical care
  - – Quality of service
  - – Members' experience
- Time frame for each activity's completion
- Staff members responsible for each activity
- Monitoring of previously identified issues
- Evaluation of the QI program

The document and requests for semi-annual and annual updates also provide a better accounting of the following:

1. Continued improvement to clearly identify and align Work Plan activities with organizational goals and desired outcomes.
2. Enhancement of document to identify whether a goal is new or continued to better track Monitoring of Previous Conditions, which is an NCQA requirement.

Annually, the process for completing the trilogy documents is assessed for improvement. In developing the 2024-2025 Work Plan, QI leadership worked to proactively identify new and adapted projects and programs based on the closeout of the 2023-2024 Work Plan. This led to greater dialog amongst sponsors, business owners and contributors on lessons learned, which correlates to the accomplishments and challenges cited in the 2023-2024 QI Evaluation. Ultimately, this refined approach aided the work plan change process and led to sound goal setting and deliverable identification in the 2024-2025 Work Plan.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.3

Resolution Sponsor:
Katherine Barresi, Acting CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Staff

Topic Description:
Partnership Board Commissioner Gerald Huber, Solano County Health and Social Services Agency Director is retiring from his position at Solano County and the Partnership Board.

Commissioner Huber has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since December 2014. He has provided excellent leadership and has been a dedicated volunteer. His knowledge has been of great value to Partnership, and he has kept the needs of our members, providers and the community as a guiding principle.

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

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

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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.3

Resolution Number:
24-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR GERALD HUBER'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Gerald Huber provided valuable advice and support for Partnership and the Board.

B. Gerald Huber 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 Huber's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.4

Resolution Sponsor:
Dr. Moore, CMO, Partnership HealthPlan of CA

Recommendation by:
The Quality and Utilization Advisory Committee (Q/UAC) and Physician Advisory Committee (PAC)

Topic Description:
Dr. Brent Pottenger, Medical Director of Behavioral Health, Solano County Health & Social Services, has been appointed to the Physician Advisory Committee as a voting member.

Phuong Luu, MD, Bi County (Yuba/Sutter) Health Officer and Board Commissioner, has been appointed to the Quality and Utilization Advisory Committee (Q/UAC) as a voting member.

Reason for Resolution:
To accept the appointments of Dr. Brent Pottenger to the Physician Advisory Committee and Dr. Phuong Luu to the Quality and Utilization Advisory Committee (Q/UAC).

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

Requested Action of the Board:
Based on the recommendation from the Physician Advisory Committee, the Board is asked to accept the new appointment of Dr. Brent Pottenger to PAC and Dr. Phuong Luu to QUAC.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.4

Resolution Number:
24-

IN THE MATTER OF: APPROVING PHYSICIAN ADVISORY COMMITTEE APPOINTMENT OF DR. BRENT POTTENGER AND QUALITY AND UTILIZATION ADVISORY COMMITTEE APPOINTMENT OF DR. PHUONG LUU

Recital: Whereas,

A. Dr. Brent Pottenger has been appointed to PAC as a voting member.
B. Dr. Phuong Luu has been appointed to QUAC as a voting member.
C. The Board has authority to approve advisory committee membership changes.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept the appointment of Dr. Brent Pottenger to the Physician Advisory Committee.
2. To accept the appointment of Dr. Phuong Luu to the Quality and Utilization Advisory Committee.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.5

Resolution Sponsor:
Katherine Barresi, Acting CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Staff

Topic Description:
The attached Partnership policy, ADM21, Stipends for Committee Members, defines the compensation paid to Partnership committee members for attending committee meetings. Revisions were required to add additional compensation levels for committee attendance.

Reason for Resolution:
To ensure Board members are aware of current policies.

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

Requested Action of the Board:
Based on the recommendation of staff, the Board is asked to approve the attached policy, ADM21, Stipends for Committee Members

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
3.5

Resolution Number:
24

IN THE MATTER OF: APPROVING PARTNERSHIP POLICY, ADM21

Recital: Whereas,

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

B. It is important to compensate committee members for meeting attendance.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the attached policy, ADM21, Stipends for Committee Members

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: ADM21</td><td colspan="3">Lead Department: Administration</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Stipends for Committee Members Serving on Partnership's CAC, FAC, PQC, Provider Grievance Review, QIHEC and Q/UAC Committees</td><td colspan="3">☒ External Policy
☒ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/05/2010</td><td colspan="3">Next Review Date: 06/25/2025
Last Review Date: 06/26/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td></td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☐ IQI</td><td>☒ FAC</td><td>☒ QUAC</td><td>☒ PQC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☒ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ CAC</td></tr>
<tr><td>☒ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Sonja Bjork</td><td colspan="3">Approval Date: <u>10/09/2024</u></td></tr>
</table>

I. RELATED POLICIES:

A. MPQP1002 – Quality/Utilization Advisory Committee
B. MCCP2025 –Pediatric Quality Committee
C. MP PR GR 210 – Provider Grievance Review Committee

II. IMPACTED DEPTS:

A. Administration
B. Member Services
C. Quality Improvement
D. Health Services

III. DEFINITIONS:

A. Consumer – is a Partnership member or parent/guardian of a Partnership member.
B. Compensation – non-wages paid to committees members.

IV. ATTACHMENTS:

A. Consumer members on Partnership's Consumer Advisory Committee (CAC) and Family Advisory Committee (FAC) Committees Compensation Request Form, ADM21a
B. Physician / Consumer members on Partnership's Q/UAC Committee Compensation Request Form, ADM21b
C. Physician members on Partnership's Pediatric Quality Committee (PQC) and Provider Grievance Review Committee Compensation Request Form, ADM21c

V. PURPOSE:

A. This policy describes the guidelines for providing stipends to committee members serving on Partnership HealthPlan of California (Partnership) advisory committees.

VI. POLICY / PROCEDURE:

A. Guidelines for Partnership committee members to receive specified optional compensation and/or reimbursement for actual mileage for attending meetings at a Partnership location are as follows:
   1. A committee member who receives a stipend must submit a W9 form.
   2. Committee members must complete and sign a stipend form specific to their committee at each meeting they attend as described below:
      a. Consumer members serving on the Consumer Advisory Committee (CAC) and the Family Advisory Committee (FAC) must submit a Compensation Request Form, after each meeting to

the Committee Coordinator / designee to receive compensation.

b. Physician / Consumer members serving on the Quality/ Utilization Advisory Committee (Q/UAC) must submit a Compensation Request Form, ADM21b after each meeting to the Administrative Assistant to receive compensation.

c. Physician members serving on the Pediatric Quality Committee (PQC) and Provider Grievance Review Committee must submit a Compensation Request Form, ADM21c after each meeting to the Administrative Assistant to receive compensation.

3. Compensation rates for members of Partnership advisory committees:

a. The compensation rate for consumer members serving on the CAC is as follows:

1) $100.00 compensation for all CAC meetings attended for which a committee member must travel to a meeting at a Partnership location.

2) CAC committee members may request the optional mileage reimbursement for actual mileage expenses incurred for attending meetings at the current IRS mileage reimbursement rate.

3) CAC committee members who use public or group transportation (e.g. taxi, paratransit, etc) to get to meetings, may request a transportation reimbursement in lieu of a mileage reimbursement.

b. The compensation rate for physician or consumer members of the Q/UAC who are not Partnership staff (or otherwise compensated by Partnership for management responsibilities) is as follows:

1) $50.00 compensation for all Q/UAC meetings attended for which a committee member must travel to a meeting at a Partnership location.

2) Q/UAC committee members may request the optional mileage reimbursement for actual mileage expenses incurred for attending meetings at the current IRS mileage reimbursement rate.

3) Q/UAC committee members may request a "flat rate option" for compensation in lieu of a mileage reimbursement.

4) This stipend may be in addition to other compensation when a physician member serves as a clinical consultant/physician adviser.

c. The compensation rate for physician members of the Pediatric Quality Committee (PQC) and Provider Grievance Review Committee who are not Partnership staff (or otherwise compensated by their county CCS agency for attendance at PQC or by Partnership for management responsibilities) is as follows:

1) $50.00 compensation for all PQC and Provider Grievance Review Committee meetings attended for which a physician member must travel to a meeting at a Partnership location.

2) PQC and Provider Grievance Review Committee members may request the optional mileage reimbursement for actual mileage expenses incurred for attending meetings at the current IRS mileage reimbursement rate.

3) PQC and Provider Grievance Review Committee members may request a "flat rate option" for compensation in lieu of a mileage reimbursement.

4) This stipend may be in addition to other compensation when the physician member serves as a clinical consultant/physician adviser.

d. The compensation rate for members of the Family Advisory Committee (FAC) is as follows:

1) $100.00 compensation for all FAC meetings attended for which a committee member must travel to a meeting at a Partnership location.

~~2)~~ $50.00 compensation for all FAC meetings for which a committee member attended virtually. ~~Virtual FAC meeting attendance will be compensated at $50.00 for all~~

~~participants. However, f~~Family member committee ~~s attending~~members attending FAC meetings virtually will receive $100.00 in compensation. ~~$50.00 compensation for all FAC meetings attended virtually.~~

2)

3) FAC committee members may request the optional mileage reimbursement for actual mileage expenses incurred for attending meetings at the current IRS mileage reimbursement rate.

4) FAC committee members who use public or group transportation (e.g. taxi, paratransit, etc) to get to meetings, may request a transportation reimbursement in lieu of a mileage reimbursement.

e. The compensations for physician or consumer members of the Quality Improvement Health Equity Committee (QIHEC), who are not Partnership staff (or otherwise compensated by Partnership for management responsibilities) is as follows:

1) $100.00 compensation for all QIHEC meetings attended for which a committee member must travel to a meeting at a Partnership location.

2) $50.00 compensation for all QIHE~~FA~~C meetings attended virtually.

2) QIHEC committee members may request the optional mileage reimbursement for actual mileage expenses incurred for attending meetings at the current IRS mileage reimbursement rate.

4) This stipend may be in addition to other compensation when a physician member serves as a clinical consultant/physician adviser.

VII. REFERENCES:

VIII. DISTRIBUTION:

A. PowerDMS
B. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

A. Board Clerk

X. REVISION DATES:

A. Agenda Item 9.4 on 03/24/10
B. Agenda Item 9.7 on 12/14/11
C. Agenda Item 3.4 on 08/24/16
D. Agenda Item 3.5 on 02/27/19
E. Agenda Item 2.2 on 02/26/20
F. Agenda Item 3.3 on 06/26/24
~~F.~~G. Agenda Item 3.5 on 10/9/24

PREVIOUSLY APPLIED TO:

ADM36 (Retired)

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: October 2, 2024
Board Meeting Date: October 9, 2024

Agenda Item Number:
4.1

Resolution Sponsor:
Katherine Barresi, Acting CEO, Partnership Health Plan of CA

Recommendation by:
The Finance Committee and Partnership Staff

Topic Description:
Partnership has received an advance payment request from Surprise Valley Health Care District (Surprise Valley Community Hospital) in the amount of five million dollars ($5,000,000). Surprise Valley Community Hospital is a District Authority-owned hospital located in Cedarville, CA experiencing significant financial hardship, and is seeking temporary financial assistance to help with cash flow for operational purposes over the next couple of months. The advance will ensure Partnership members continue to have access to health care services provided by Surprise Valley Community Hospital. The repayment of the advance will occur in January 2025 through offsetting Surprise Valley Community Hospital's supplemental payments that will be issued by Partnership. The hospital is a licensed 26 bed facility with 4 acute care beds and 22 long term care beds. To ensure access to Partnership members, Partnership staff recommend the approval of this request.

Reason for Resolution:
To obtain Board approval to authorize the $5 million dollar advance payment to Surprise Valley Community Hospital.

Financial Impact:
The net financial impact is $0 to Partnership HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Finance Committee and Partnership Staff, the Board is asked to provide authorization for the Acting CEO to approve the advance request.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)

Meeting Date: October 2, 2024 **Agenda Item Number:**
Board Meeting Date: October 9, 2024 4.1

Resolution Number:
24-

IN THE MATTER OF: APPROVAL OF REQUEST FOR HOSPITAL ADVANCE

Recital: Whereas,

A. The Board has authority to approve the hospital advance payment request.

B. The Board is responsible for financial oversight.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To authorize the Acting CEO to approve the hospital advance payment request.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

BY: _____
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
October 9, 2024

Agenda Item Number:
4.2

Resolution Sponsor:
Katherine Barresi, Acting CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Staff

Topic Description:
The Gasser Foundation (Grantor) is the fee title owner of certain properties commonly referred to as 1930 Jefferson Street and 1950 Jefferson Street, both in Napa, California. The Gasser Foundation would like to gift two properties to Partnership HealthPlan of California. The Board of Commissioners is asked to authorize the Acting Chief Executive Officer, Katherine Barresi, to accept and execute any necessary documents in relation to the gifting of properties from the Gasser Foundation.

Reason for Resolution:
To obtain board approval to authorize the Acting Chief Executive Officer to accept the gift of two properties to Partnership HealthPlan from the Gasser Foundation.

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

Requested Action of the Board:
Based on the recommendation of Partnership staff, the Board is being asked to approve authorizing the Acting Chief Executive Officer to accept the gift of two properties to Partnership HealthPlan from the Gasser Foundation.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date
October 9, 2024

Agenda Item Number:
4.2

Resolution Number:
24-

IN THE MATTER OF: AUTHORIZING THE ACTING CEO, KATHERINE BARRESI, TO ACCEPT AND EXECUTE ANY NECESSARY DOCUMENTS FOR THE GIFT OF TWO PROPERTIES FROM THE GASSER FOUNDATION

Recital: Whereas,

A. The Board is responsible for financial oversight.

B. The Board is responsible for approving the acceptance of gifts to the plan.

Now, Therefore, It Is Hereby Resolved As Follows:

1. The Board of Commissioners hereby authorizes the Chief Executive Officer to accept the gift of properties from the Gasser Foundation. The Gasser Foundation (Grantor) is the fee title owner of certain properties commonly referred to as 1930 Jefferson Street and 1950 Jefferson Street, both in Napa, California.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 9th day of October 2024 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

ATTEST:

BY: _____
Ashlyn Scott, Clerk

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan Of California
For the Period Ending July 31, 2024

Financial Analysis for the Current Period

Total (Deficit) Surplus

For this first month of the fiscal year – the month ending July 31, 2024 – PHC reported a deficit of $2.8 million. Significant variances are explained below.

Revenue

Total Revenue is lower than budget by $2.8 million for July 2024. Medi-Cal revenue is $1.6 million favorable due to retro membership partially offset by lower than anticipated ECM utilization. Also, directed payments are $11.9 million unfavorable due to lower than budgeted rates; a corresponding offset is recorded in HCIF. Supplemental revenues are $3.8 million favorable due to timing of DHCS submissions mainly in the Expansion Counties for AIHS and higher than expected volumes for Maternity Kick. Interest income is $3.6 million favorable due to higher than anticipated interest rates.

Healthcare Costs

Total Healthcare Costs are greater than budget by $2.4 million for the month. Physician and Ancillary expenses are unfavorable to budget by $10.5 million primarily due to the accrual of TRI and adjustments to IBNR reserves to reflect the latest utilization trend. Total Capitation is $3.2 million favorable due to lower than budgeted expense. Healthcare Investment Funds (HCIF) is $7.0 million favorable due to lower than budgeted rates for directed payments partially offset by the timing of IPP CalAIM incentive payments, which will have a corresponding offset in revenue. Long Term Care expense is $0.6 million unfavorable due to retro rate increases back to January 2024. Inpatient hospital FFS expense is $3.7 million unfavorable due to adjustments to IBNR reserves and seasonality. Transportation expense is $0.5 million unfavorable due to increase in utilization. Quality Assurance expense is $3.6 million favorable due to the timing of medical admin expenses. Quality Improvement Programs is $0.9 million unfavorable due to the timing of incentive grant payouts, which will also have a corresponding offset in revenue.

Administrative Costs

Administrative costs have an overall positive variance, which is at $7.5 million for the year-to-date. The variance is primarily in Employee costs due to the timing of the filling of open positions geared towards the expansion counties and fulfilling 2024 DHCS Contract requirements. The variance in Professional Services is primarily due to the timing of consultant usage. Lastly, the variance in Occupancy costs contributes to this as well due to the timing of capital asset purchases and the accompanying depreciation.

Balance Sheet / Cash Flow

Total Cash & Cash Equivalents decreased by $72.7 million for the month. Inflows include $443.6 million in State Capitation payments, $10.4 million in Drug Medi-Cal payments, and $9.9 million in interest earnings. These inflows were offset by outflows of $375.5 million in healthcare cost payments, $5.4 million in Drug Medi-Cal payments, $19.2 million in administrative and capital cost payments, $125.5 million for a quarterly MCO tax payment, and the recording of $11.3 million in board-designated reserve transfers. The remaining difference can be attributed to other revenues.

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan Of California
For the Period Ending July 31, 2024

General Statistics

Membership

Membership had a total net increase of 55 members for the month.

Utilization Metrics and High Dollar Case

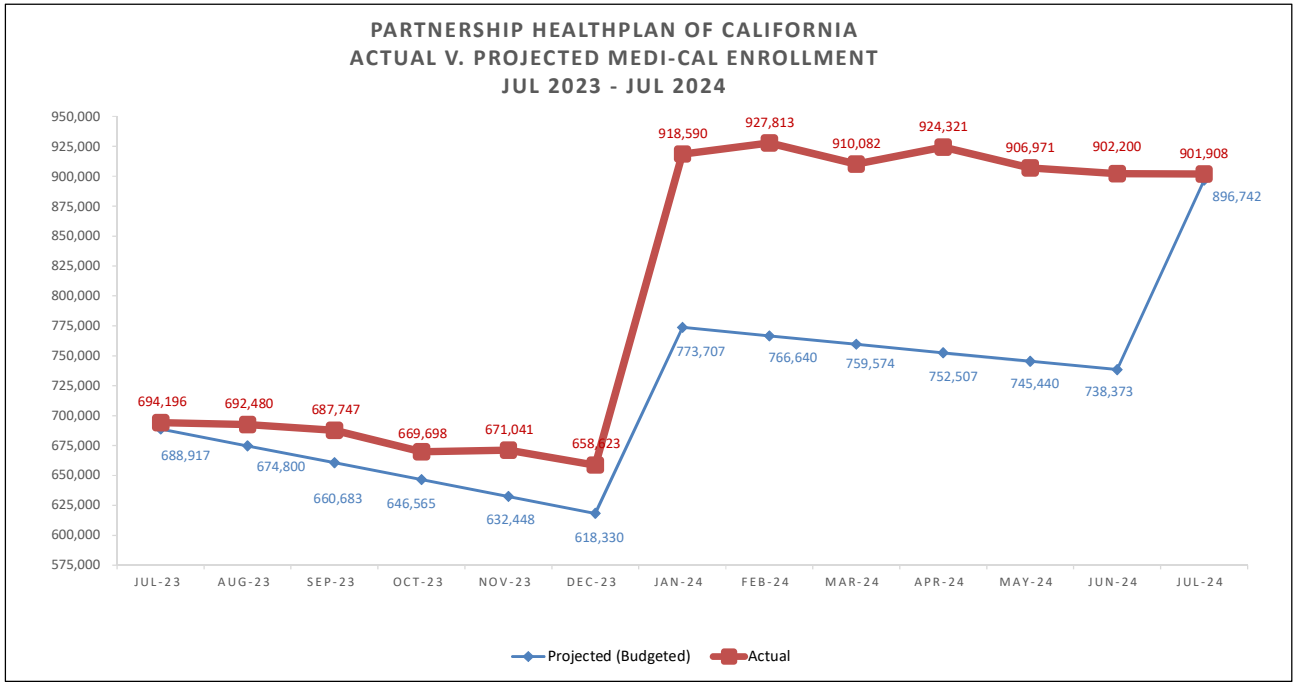
For the fiscal year 2024/25 through July 2024, 15 members reached the $250,000 threshold with an average cost of $371,989. For fiscal year 2023/24, 777 members reached the $250,000 threshold with an average cost per case of $498,135. For fiscal year 2022/23, 695 members reached the $250,000 threshold with an average claims cost of $518,224.

Current Ratio/Reserved Funds

Current Ratio Including Required Reserves	**1.45**
Current Ratio Excluding Required Reserves:	**0.97**
Required Reserves:	**$1,307,341,337**
Total Fund Balance:	**$1,244,769,003**

Days of Cash on Hand

Including Required Reserves:	**129.01**
Excluding Required Reserves:	**61.28**



Member Months by County:

County	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24 ★	Apr-24	May-24	Jun-24	Jul-24
Solano	141,591	140,953	140,988	136,597	137,807	134,534	103,140	105,208	102,065	105,274	102,979	102,062	101,490
Napa	35,882	35,969	35,439	34,269	34,043	33,710	27,596	28,140	27,005	27,891	27,017	27,071	26,878
Yolo	63,943	63,559	63,142	61,135	60,507	60,230	55,624	56,087	54,327	55,592	54,076	53,489	53,332
Sonoma	134,420	133,261	132,745	131,013	129,901	128,356	109,623	112,447	108,106	112,999	110,510	110,327	110,662
Marin	52,302	52,602	51,713	50,119	49,383	49,823	46,981	48,331	46,215	48,257	46,564	46,520	46,274
Mendocino	42,323	42,371	41,868	40,599	41,192	39,846	41,552	41,963	41,055	42,150	41,381	41,239	41,408
Lake	35,753	35,897	35,381	34,530	34,446	34,367	35,058	35,405	34,559	35,494	34,624	34,390	34,422
Del Norte	12,970	12,868	12,850	12,505	12,499	12,426	12,527	12,610	12,316	12,675	12,401	12,214	12,252
Humboldt	62,329	62,399	61,695	60,093	60,931	58,752	60,016	60,415	59,075	60,273	58,758	58,876	58,607
Lassen	9,271	9,232	9,151	8,871	9,044	8,600	8,864	8,952	8,576	8,793	8,668	8,714	8,765
Modoc	4,240	4,247	4,167	4,099	4,139	3,928	4,055	4,035	4,020	4,051	3,944	3,933	3,958
Shasta	73,539	73,456	73,179	71,113	72,049	69,783	70,605	70,880	69,820	70,514	68,436	67,907	67,685
Siskiyou	19,762	19,793	19,566	19,059	19,440	18,625	19,052	19,115	17,966	18,653	18,137	18,131	18,088
Trinity	5,871	5,873	5,863	5,696	5,660	5,643	5,660	5,739	5,567	5,704	5,607	5,540	5,540
Butte	-	-	-	-	-	-	85,751	85,856	86,303	85,581	84,795	84,347	84,598
Colusa	-	-	-	-	-	-	10,710	10,663	10,674	10,392	10,270	10,239	10,208
Glenn	-	-	-	-	-	-	13,752	13,774	13,883	13,772	13,618	13,583	13,501
Nevada	-	-	-	-	-	-	28,962	28,798	28,708	28,519	28,420	28,313	28,407
Placer	-	-	-	-	-	-	59,373	59,846	60,289	59,915	60,009	59,226	59,648
Plumas	-	-	-	-	-	-	6,015	5,978	5,975	5,942	5,925	5,903	5,938
Sierra	-	-	-	-	-	-	855	870	869	869	865	850	839
Sutter	-	-	-	-	-	-	44,339	44,438	44,558	43,816	43,711	43,619	43,542
Tehama	-	-	-	-	-	-	31,784	31,484	31,299	30,932	30,323	29,996	30,297
Yuba	-	-	-	-	-	-	36,696	36,779	36,851	36,263	35,933	35,711	35,569
All Counties Total	**694,196**	**692,480**	**687,747**	**669,698**	**671,041**	**658,623**	**918,590**	**927,813**	**910,082**	**924,321**	**906,971**	**902,200**	**901,908**

★ March 2024 actual membership includes Jan & Feb retro correction. The Jan, Feb, and Mar 2024 true memberships are 921,261, 918,516, and 916,708, respectively.

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

Partnership HealthPlan of California
Comparative Financial Indicators Monthly Report
Fiscal Year 2024 - 2025 & Fiscal Year 2023 - 2024

FINANCIAL INDICATORS	Jul-24												YTD	Avg / Month As of Jul-24
Total Enrollment	898,490												898,490	898,490
Total Revenue	516,467,263												516,467,263	516,467,263
Total Healthcare Costs	455,570,292												455,570,292	455,570,292
Total Administrative Costs	17,164,115												17,164,115	17,164,115
Medi-Cal Hospital & Managed Care Taxes	46,566,563												46,566,563	46,566,563
Total Current Year Surplus (Deficit)	(2,833,707)												(2,833,707)	(2,833,707)
Total Claims Payable	884,509,979												884,509,979	884,509,979
Total Fund Balance	1,244,769,003												1,244,769,003	1,244,769,003
Reserved Funds:														
State Financial Performance Guarantee	1,092,899,000												1,092,899,000	1,092,899,000
Board Approved Capital and Infrastructure Purchases	79,941,518												79,941,518	79,941,518
Capital Assets	134,500,819												134,500,819	134,500,819
Strategic Use of Reserve-Board Approved	71,002,668												71,002,668	71,002,668
Unrestricted Fund Balance	(133,575,002)												(133,575,002)	(133,575,002)
Fund Balance as % of Reserved Funds	90.31%												90.31%	90.31%
Current Ratio (including Required Reserves)	1.45:1												1.45:1	1.45:1
Medical Loss Ratio w/o Tax	96.95%												96.95%	96.95%
Admin Ratio w/o Tax	3.65%												3.65%	3.65%
Profit Margin Ratio	-0.60%												-0.60%	-0.60%

FINANCIAL INDICATORS	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	(Unaudited) Jun-24	YTD	Avg / Month As of Jun-24
Total Enrollment	697,169	694,364	689,096	674,680	670,710	660,101	918,590	916,349	921,546	912,331	906,971	900,691	9,562,598	796,883
Total Revenue	346,807,441	341,606,254	341,452,348	336,820,011	333,606,699	704,499,918	494,922,661	507,388,749	527,490,882	524,377,176	544,442,127	513,955,850	5,517,370,116	459,780,843
Total Healthcare Costs	327,163,476	330,010,604	317,050,232	309,178,329	314,689,553	312,699,931	427,212,628	429,268,912	475,024,262	449,448,163	476,657,036	446,020,488	4,614,423,613	384,535,301
Total Administrative Costs	11,697,451	12,604,507	11,948,835	13,398,097	13,672,021	13,241,394	16,243,013	17,074,221	15,790,362	16,678,381	18,392,413	19,266,018	180,006,712	15,000,559
Medi-Cal Hospital & Managed Care Taxes	-	-	-	-	-	376,406,250	46,790,714	48,056,922	47,537,225	47,123,221	46,838,980	46,582,645	659,355,957	54,946,330
Total Current Year Surplus (Deficit)	7,946,514	(1,008,857)	12,453,281	14,243,584	5,245,126	2,152,343	4,676,307	12,988,694	(10,860,967)	11,127,412	2,533,699	2,086,699	63,583,834	5,298,653
Total Claims Payable	422,844,079	452,077,175	486,822,447	455,222,013	481,847,695	499,411,492	589,212,971	701,382,898	808,535,908	829,697,152	838,350,235	886,964,822	886,964,822	621,047,407
Total Fund Balance	914,352,902	913,344,045	925,797,326	940,040,910	945,286,036	947,438,379	952,114,686	965,103,380	954,242,413	965,369,824	967,903,523	969,990,223	969,990,223	946,748,637
Reserved Funds:														
State Financial Performance Guarantee	946,269,906	964,438,886	980,910,354	994,265,111	1,009,422,758	1,026,741,282	1,074,004,763	1,076,192,481	1,092,267,035	1,098,614,311	1,102,328,343	1,103,012,033	1,103,012,033	1,039,038,939
Board Approved Capital and Infrastructure Purchases	47,177,080	46,374,091	45,797,964	41,394,205	40,388,299	39,549,920	37,862,493	36,225,975	35,770,696	28,270,742	27,812,009	26,342,225	26,342,225	37,747,142
Capital Assets	118,991,470	119,235,734	119,254,457	123,078,590	126,154,438	126,341,441	127,443,936	128,495,663	128,366,608	135,257,004	135,105,115	133,498,833	133,498,833	126,768,607
Strategic Use of Reserve-Board Approved	70,659,883	70,318,568	70,455,056	71,514,836	72,116,668	72,116,668	72,116,668	72,116,668	72,116,668	72,116,668	71,786,668	71,002,668	71,002,668	71,536,474
Unrestricted Fund Balance	(268,745,437)	(287,023,235)	(290,620,305)	(290,211,832)	(302,796,127)	(317,310,932)	(359,313,174)	(347,927,407)	(374,278,593)	(368,888,901)	(369,128,612)	(363,865,537)	(363,865,537)	(328,342,524)
Fund Balance as % of Reserved Funds	77.28%	76.09%	76.11%	76.41%	75.74%	74.91%	72.60%	73.50%	71.83%	72.35%	72.39%	72.72%	72.72%	74.25%
Current Ratio (including Required Reserves)	1.69:1	1.63:1	1.49:1	1.59:1	1.56:1	1.43:1	1.38:1	1.34:1	1.33:1	1.33:1	1.35:1	1.33:1	1.33:1	1.42:1
Medical Loss Ratio w/o Tax	94.34%	96.61%	92.85%	91.79%	94.33%	95.31%	95.33%	93.46%	98.97%	94.17%	95.79%	95.43%	94.99%	94.99%
Admin Ratio w/o Tax	3.37%	3.69%	3.50%	3.98%	4.10%	4.04%	3.62%	3.72%	3.29%	3.49%	3.70%	4.12%	3.71%	3.71%
Profit Margin Ratio	2.29%	-0.30%	3.65%	4.23%	1.57%	0.66%	1.04%	2.83%	-2.26%	2.33%	0.51%	0.45%	1.31%	1.31%

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending July 31, 2024

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
898,490	898,435	55	**Total Membership**	898,490	697,169	201,321

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
516,467,263	519,272,112	(2,804,849)	**Total Revenue**	516,467,263	519,272,112	(2,804,849)
455,570,292	453,170,435	(2,399,857)	**Total Healthcare Costs**	455,570,292	453,170,435	(2,399,857)
17,164,115	24,625,650	7,461,535	**Total Administrative Costs**	17,164,115	24,625,650	7,461,535
46,566,563	46,343,627	(222,936)	**Medi-Cal Managed Care Tax**	46,566,563	46,343,627	(222,936)
(2,833,707)	**(4,867,600)**	**2,033,893**	**Total Current Year Surplus (Deficit)**	**(2,833,707)**	**(4,867,600)**	**2,033,893**

96.95%	95.82%	**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	96.95%	95.82%	
3.65%	5.21%	**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	3.65%	5.21%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of July 31, 2024

	July 2024	(Unaudited) June 2024
A S S E T S		
Current Assets		
Cash & Cash Equivalents	**1,061,212,431**	**1,166,086,689**
Receivables		
Accrued Interest	605,100	862,694
State DHS - Cap Rec	1,255,183,736	972,805,747
Other Healthcare Receivable	39,452,090	32,352,399
Miscellaneous Receivable	7,724,033	6,369,935
Total Receivables	**1,302,964,959**	**1,012,390,775**
Other Current Assets		
Payroll Clearing	27,242	26,693
Prepaid Expenses	9,227,085	6,034,832
Total Other Current Assets	**9,254,327**	**6,061,525**
Total Current Assets	**2,373,431,717**	**2,184,538,989**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	482,897	462,112
Furniture & Fixtures	7,015,882	7,015,882
Computer Equipment	18,573,940	18,573,940
Computer Software	8,997,689	8,997,689
Leasehold Improvements	124,288	124,288
Land	6,767,292	6,767,292
Building	67,971,845	67,971,845
Building Improvements	39,623,760	39,624,160
Accum Depr - Motor Vehicles	(222,237)	(212,378)
Accum Depr - Furniture	(6,558,599)	(6,550,715)
Accum Depr - Comp Equipment	(15,434,379)	(15,264,313)
Accum Depr - Comp Software	(8,327,799)	(8,249,437)
Accum Depr - Leasehold Improvements	(124,288)	(124,288)
Accum Depr - Building	(12,348,043)	(12,202,804)
Accum Depr - Bldg Improvements	(14,050,369)	(13,846,766)
Construction Work-In-Progress	42,008,940	40,412,326
Total Fixed Assets	**134,500,819**	**133,498,833**
Other Non-Current Assets		
Deposits	1,256,323	1,280,599
Board-Designated Reserves	1,172,540,518	1,129,054,258
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	14,847,068	3,515,948
Net Pension Asset	4,919,453	2,961,371
Deferred Outflows Of Resources	1,620,052	2,861,333
Net Subscription Asset	2,790,269	17,931,216
Total Other Non-Current Assets	**1,198,273,683**	**1,157,904,725**
Total Non-Current Assets	**1,332,774,502**	**1,291,403,558**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of July 31, 2024

	July 2024	(Unaudited) June 2024
Total Assets	**3,706,206,219**	**3,475,942,547**
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	148,046,184	244,080,580
Unearned Income	73,894,582	73,893,879
Suspense Account	5,249,778	4,031,351
Capitation Payable	66,741,388	66,741,388
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	1,143,336,668	1,058,319,616
Claims Payable	337,764,634	312,353,916
Incurred But Not Reported-IBNR	546,745,345	574,610,906
Quality Improvement Programs	97,059,536	129,347,924
Total Current Liabilities	**2,451,471,228**	**2,496,012,673**
Non-Current Liabilities		
Deferred Inflows Of Resources	7,617,910	6,616,582
Net Subscription Liability	2,348,078	3,323,069
Total Non-Current Liabilities	**9,965,988**	**9,939,651**
Total Liabilities	**2,461,437,216**	**2,505,952,324**
Fund Balance		
Unrestricted Fund Balance	**(133,575,002)**	**(363,865,537)**
Reserved Funds		
State Financial Performance Guarantee	1,092,899,000	1,103,012,033
Board Approved Capital and Infrastructure Purchases	79,941,518	26,342,225
Capital Assets	134,500,819	133,498,833
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668
Total Reserved Funds	**1,378,344,005**	**1,333,855,759**
Total Fund Balance	**1,244,769,003**	**969,990,223**
Total Liabilities And Fund Balance	**3,706,206,219**	**3,475,942,547**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Cash Flow
For The Period Ending July 31, 2024

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Services	443,609,284	443,609,284
Other Revenues	192,314	192,314
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(16,824,323)	(16,824,323)
Medical Claims Payments	(358,655,719)	(358,655,719)
Drug Medi-Cal		
DMC Receipts from Counties	10,438,545	10,438,545
DMC Payments to Providers	(5,419,864)	(5,419,864)
Cash Payments to Vendors	(129,743,424)	(129,743,424)
Cash Payments to Employees	(13,022,457)	(13,022,457)
Net Cash (Used) Provided by Operating Activities	**(69,425,644)**	**(69,425,644)**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(1,875,669)	(1,875,669)
Net Cash Used by Capital Financial & Related Activities	**(1,875,669)**	**(1,875,669)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	(11,290,662)	(11,290,662)
Interest and Dividends on Investments	9,913,315	9,913,315
Net Cash (Used) Provided by Investing Activities	**(1,377,347)**	**(1,377,347)**
NET (DECREASE) INCREASE IN CASH & CASH EQUIVALENTS	**(72,678,660)**	**(72,678,660)**
CASH & CASH EQUIVALENTS, BEGINNING	**1,133,891,091**	**1,133,891,091**
CASH & CASH EQUIVALENTS, ENDING	**1,061,212,431**	**1,061,212,431**
RECONCILIATION OF OPERATING (LOSS) INCOME TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES:		
TOTAL OPERATING (LOSS) INCOME	**(12,489,429)**	**(12,489,429)**
DEPRECIATION	**615,014**	**615,014**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(7,124,726)	(7,124,726)
California Department of Health Services Receivable	(63,029,638)	(63,029,638)
Other Assets	(75,022)	(75,022)
Accounts Payable and Accrued Expenses	6,376,149	6,376,149
Accrued Claims Payable	(1,507,448)	(1,507,448)
Quality Improvement Programs	7,809,456	7,809,456
Net Cash Provided (Used) by Operating Activities	**(69,425,644)**	**(69,425,644)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

For The Period Ending July 31, 2024

****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
898,490	**898,490**				**TOTAL MEMBERSHIP**	**898,490**	**898,490**			
					REVENUE					
506,638,922	512,967,312	(6,328,390)	563.88	570.92	State Capitation Revenue	506,638,922	512,967,312	(6,328,390)	563.88	570.92
9,655,722	6,103,300	3,552,422	10.75	6.79	Interest Income	9,655,722	6,103,300	3,552,422	10.75	6.79
172,619	201,500	(28,881)	0.19	0.22	Other Revenue	172,619	201,500	(28,881)	0.19	0.22
516,467,263	**519,272,112**	**(2,804,849)**	**574.82**	**577.94**	**TOTAL REVENUE**	**516,467,263**	**519,272,112**	**(2,804,849)**	**574.82**	**577.94**
					HEALTHCARE COSTS					
					Physician Services					
7,227,700	8,883,064	1,655,364	8.04	9.89	Pcp Capitation	7,227,700	8,883,064	1,655,364	8.04	9.89
212,354	218,933	6,579	0.24	0.24	Specialty Capitation	212,354	218,933	6,579	0.24	0.24
84,761,770	69,672,149	(15,089,621)	94.34	77.54	Non-Capitated Physician Services	84,761,770	69,672,149	(15,089,621)	94.34	77.54
92,201,824	**78,774,146**	**(13,427,678)**	**102.62**	**87.67**	**Total Physician Services**	**92,201,824**	**78,774,146**	**(13,427,678)**	**102.62**	**87.67**
					Inpatient Hospital					
16,312,243	17,825,346	1,513,103	18.16	19.84	Hospital Capitation	16,312,243	17,825,346	1,513,103	18.16	19.84
119,987,553	116,270,035	(3,717,518)	133.54	129.41	Inpatient Hospital - Ffs	119,987,553	116,270,035	(3,717,518)	133.54	129.41
1,595,170	1,595,170		1.78	1.78	Hospital Stoploss	1,595,170	1,595,170		1.78	1.78
137,894,966	**135,690,551**	**(2,204,415)**	**153.48**	**151.03**	**Total Inpatient Hospital**	**137,894,966**	**135,690,551**	**(2,204,415)**	**153.48**	**151.03**
54,772,993	54,143,384	(629,609)	60.96	60.26	Long Term Care	54,772,993	54,143,384	(629,609)	60.96	60.26
					Ancillary Services					
1,181,053	1,220,019	38,966	1.31	1.36	Ancillary Services - Capitated	1,181,053	1,220,019	38,966	1.31	1.36
70,467,337	75,030,709	4,563,372	78.43	83.51	Ancillary Services - Non-Capitated	70,467,337	75,030,709	4,563,372	78.43	83.51
71,648,390	**76,250,728**	**4,602,338**	**79.74**	**84.87**	**Total Ancillary Services**	**71,648,390**	**76,250,728**	**4,602,338**	**79.74**	**84.87**
					Other Medical					
3,642,826	7,253,820	3,610,994	4.05	8.07	Quality Assurance	3,642,826	7,253,820	3,610,994	4.05	8.07
74,112,283	81,113,728	7,001,445	82.49	90.28	Healthcare Investment Funds	74,112,283	81,113,728	7,001,445	82.49	90.28
125,600	149,200	23,600	0.14	0.17	Advice Nurse	125,600	149,200	23,600	0.14	0.17
829	7,800	6,971	-	0.01	Hipp Payments	829	7,800	6,971	-	0.01
10,899,028	10,430,865	(468,163)	12.13	11.61	Transportation	10,899,028	10,430,865	(468,163)	12.13	11.61
88,780,566	**98,955,413**	**10,174,847**	**98.81**	**110.14**	**Total Other Medical**	**88,780,566**	**98,955,413**	**10,174,847**	**98.81**	**110.14**
10,271,553	9,356,213	(915,340)	11.43	10.41	Quality Improvement Programs	10,271,553	9,356,213	(915,340)	11.43	10.41
455,570,292	**453,170,435**	**(2,399,857)**	**507.04**	**504.38**	**TOTAL HEALTHCARE COSTS**	**455,570,292**	**453,170,435**	**(2,399,857)**	**507.04**	**504.38**
					ADMINISTRATIVE COSTS					
11,430,607	15,653,636	4,223,029	12.72	17.42	Employee	11,430,607	15,653,636	4,223,029	12.72	17.42
59,516	171,903	112,387	0.07	0.19	Travel And Meals	59,516	171,903	112,387	0.07	0.19
1,250,658	1,757,207	506,549	1.39	1.96	Occupancy	1,250,658	1,757,207	506,549	1.39	1.96
256,877	890,642	633,765	0.29	0.99	Operational	256,877	890,642	633,765	0.29	0.99
1,909,612	3,232,093	1,322,481	2.13	3.60	Professional Services	1,909,612	3,232,093	1,322,481	2.13	3.60
2,256,845	2,920,169	663,324	2.51	3.25	Computer And Data	2,256,845	2,920,169	663,324	2.51	3.25
17,164,115	**24,625,650**	**7,461,535**	**19.11**	**27.41**	**TOTAL ADMINISTRATIVE COSTS**	**17,164,115**	**24,625,650**	**7,461,535**	**19.11**	**27.41**
46,566,563	46,343,627	(222,936)	51.83	51.58	**Medi-Cal Managed Care Tax**	46,566,563	46,343,627	(222,936)	51.83	51.58
(2,833,707)	**(4,867,600)**	**2,033,893**	**(3.16)**	**(5.43)**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**(2,833,707)**	**(4,867,600)**	**2,033,893**	**(3.16)**	**(5.43)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
July 31, 2024

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 County in May 1994. That was followed by additional Northern California counties in March 1998, March 2001, October 2009, two counties in July 2011, and eight counties in September 2013. Beginning July 2018 and in accordance with direction from the Department of Health Care Services (DHCS), PHC consolidated its reporting from these fourteen counties into two regions, which are in alignment with the two DHCS rating regions. Beginning January 2024, PHC expanded into ten additional counties, which comprise a third region.

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

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

ACCOUNTING POLICIES:
The accounting and reporting policies of 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 July 2024, PHC has Total Reserved Funds of $1.4 billion. This includes $71.0 million of funds set aside for Board approved Strategic Use of Reserve (SUR) initiatives; this also includes funding for the Wellness & Recovery program. The total SUR amount represents the net amount remaining for all SUR projects that have been approved to date and is periodically adjusted as projects are completed. Reserved funds also includes $0.3 million of Knox-Keene Reserves.

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 July 2024, PHC has accrued a Quality Incentive Program payout of $97.1 million.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
July 31, 2024

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

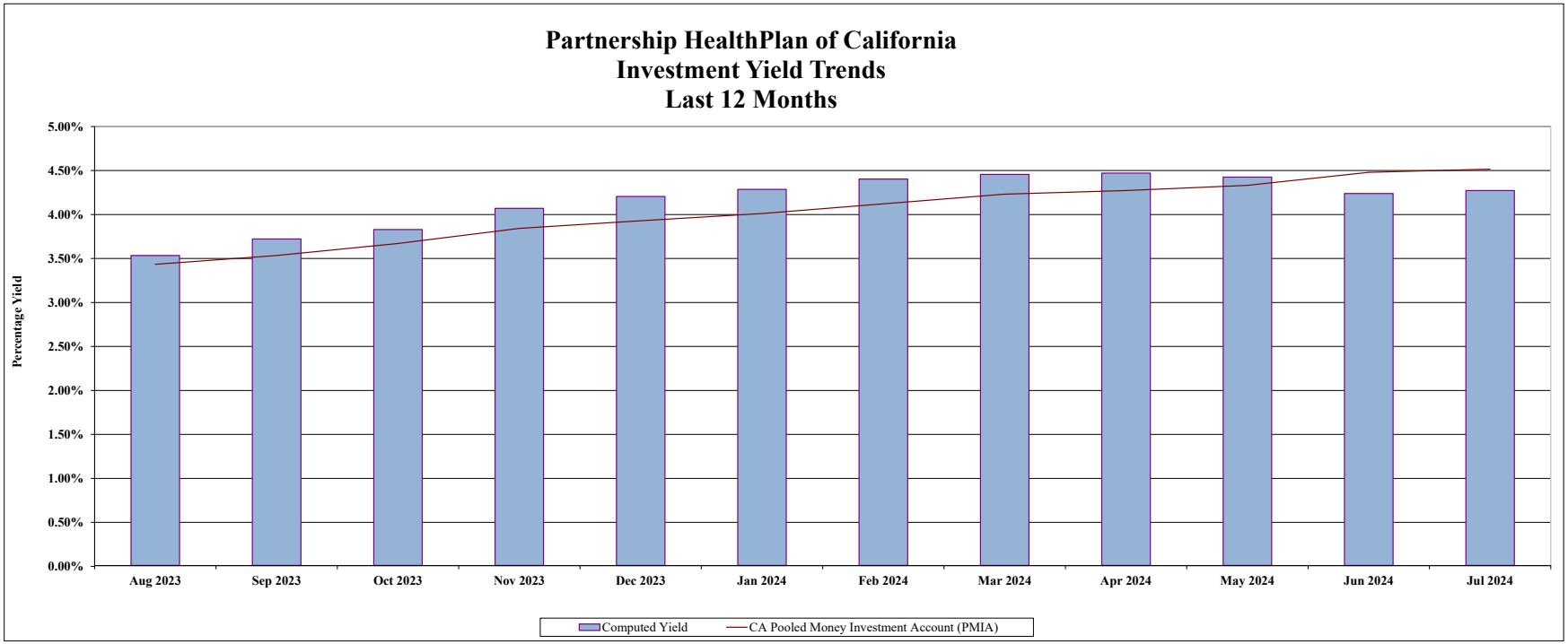
None noted.

Partnership HealthPlan of California
Investment Schedule
July 31, 2024

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	$ 1,366,572	$ 1,366,572	NA	NR
US Treasury Note	Cash & Cash Equiv	0.01375	1/11/2022	1/31/2025	NA	$ 300,000	$ 303,281	$ 284,439	Fitch	AA+
Certificate of Deposit for Knox Keene	Cash & Cash Equiv	0.0526	5/24/2023	1/31/2025	NA	$ 300,000	$ 300,000	$ 300,000	NA	NR
FUNDS HELD FOR OPERATIONS:										
Merrill Lynch Institutional	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 72,612,024		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 1,998,652		
US Bank - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,039,027,339		
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	$ 43,297,642		
West America Payroll	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 147,421		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:								$ 2,234,037,389		

Partnership HealthPlan of California
Investment Yield Trends

PERIOD		Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024
Interest Income		5,662,667	6,681,800	7,965,260	6,968,741	7,219,959	8,189,594	6,407,270	9,509,112	8,768,057	9,436,106	9,367,229	9,655,722
Cash & Investments at Historical Cost	(1)	1,644,124,824	2,054,308,786	1,722,919,248	1,755,658,813	1,834,478,790	1,880,659,210	2,097,319,746	2,404,353,123	2,306,818,656	2,186,519,113	2,295,440,947	2,234,052,950
Computed Yield	(2)	3.53%	3.72%	3.83%	4.07%	4.21%	4.29%	4.40%	4.46%	4.47%	4.43%	4.24%	4.27%
CA Pooled Money Investment Account (PMIA)	(3)	3.43%	3.53%	3.67%	3.84%	3.93%	4.01%	4.12%	4.23%	4.27%	4.33%	4.48%	4.52%



NOTES:

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

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

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

Community Integration and Collaboration

Partnership has always been dedicated to being embedded in the communities we serve, and active in participating in committees, programs, new initiatives, education and serving as a resource to our provider and County partners. A renewed commitment was made to this goal in an effort to secure our place within the communities of our 10 newest counties. The past six months it would have been difficult to visit a location in our footprint and NOT encounter a Partnership representative or information and resources provided by our teams.

This year Partnership's **Population Health Management** team has leaned into our expansion to reach new members through our health campaigns and community events. In addition to strengthening our work around Health Equity, under the department's Director Dr. DeLorean Ruffin, the team has been working to close health and care gaps identified in the health plan's disparity data. Together along with QI, and Health Equity, the department is beginning to leverage new and creative ways to reach members, and adopt interventions that lead to impactful outcomes. Examples of successes so far this year include:

- *Outreach Campaigns* (calls) 47,962 calls so far in 2024 with over 29,065 unique members contacted with 17% member agreement to participate.
  - Over 5,500 members engaged and enrolled in Health Baby program
  - Over 5,000 members enrolled in Growing Together Program (GTP – Prenatal / Postpartum)
  - 2,940 members engaged and enrolled in Health Kids program

- *Community Events:* Partnership's Population Health Management team has been very engaged in our communities as well having attended over 80+ events so far, in person. Healthy Living Coaches and/or Health Education staff attend events and meet with members, providers, and the community to engage and support Partnership's mission and programs. Examples of events attended by the team so far this year include:
  - Birth Justice Solano 2024
  - Mobile Mammography Clinics
  - Community Resource Fair – Lassen
  - Lake County Advocacy Walk & Children's Festival
  - Spring Fiesta Fair – Colusa
  - Butte County Parent University & Resource Fair
  - American Canyon High School Health Fair
  - Placer County Mental Health Fair
  - Spring Community Health & Engagement Fair – Sonoma

Another cornerstone of work for the Population Health Management department this year is supporting Partnership's activities around the revised Population Needs Assessment (PNA) activities. In 2024, DHCS revised this health plan requirement to require that Partnership collaborate with each of the Local Health Jurisdictions (LHJs) in our 24 county network as they plan, execute and evaluate their Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP).

Together, along with Kaiser in eight (8) of our counties, Partnership has been meeting with each county LHJ to develop "SMART" goals and align activities for greater community impact. The Population Health Management department has been front and center in this work, completing all necessary deliverables for DHCS, attending planning and community meetings, and offering in-kind staffing to support the implementation of activities outlined in existing goals.

The **Regional Director** position has been filled for both the Santa Rosa Region, as well as the Auburn Region. These leaders will serve as the local administrator and community liaison for their respective areas. Jill Blake, has accepted the position based in the Auburn office, supporting Placer, Nevada, Sierra and Plumas counties, and Leigha Andrews will be based in Santa Rosa, supporting Marin and Sonoma counties. With the addition of Jill and Leigha we now have six Regional Directors, one based in each regional office. All six of the Regional Directors have been spending the majority of their time meeting with stakeholders and supporting our members.

In the past couple months they have attended multiple provider and county collaborative meetings, as well as events like, *The Sierra Nevada Conservation and Wilderness Medicine Conference*, which was held near Quincy, and the *Native Spirit Indigenous Wellness Alliance*. We were also in attendance at the *Latino Leadership Council's 10th Annual Forum on the Latino Community* which was held in Rocklin.

National Health Center Week was celebrated throughout our 24 counties in early August. The Regional Directors and other staff members attended educational events and member appreciation activities at many of our clinic partners. Ampla Health, serving six rural counties including, Butte, Colusa, Glenn, Sutter, Tehama & Yuba celebrated the week under the theme of "Powering Communities Through Caring Connections". Ampla presented a series of Community Health & Resource Fairs at 11 locations, reaching over 1400 individuals.

The Senior Director of **Member Services and G&A**, Edna Villasenor, had the opportunity for an on-air interview with Radio Bilingue to spread awareness and provide insight to listeners about Partnership. Radio Bilingue is a statewide, non-commercial radio station with stations in Mendocino and Humboldt counties. Radio Bilingue is an exclusively Spanish-speaking station with a mix of news, public affairs, creative education messaging, and music. They started a series with the California Healthcare Foundation in an effort to get information out to the community regarding Medi-Cal redetermination and have interest in continuing that discussion.

The **Member Services** team was also able to continue to improve their call wait times, and are currently averaging an impressive 16 second average wait time for member calls. They were also out an about in the communities and hosted 4 Member Information workshops, and attended community events to offer support to members that were attending.

In anticipation of 2025 CCS Whole Child Model transition, the **Care Coordination** Department and leaders have been meeting with county CCS partners and DHCS to discuss readiness activities and deliverables. This includes member noticing, identification of high risk and low risk members who will need proactive outreach and coordination prior to transition, as well as developing and refinement of workflows related to Annual Medical Review (AMR) and referrals processes.

The newly formed **Enhanced Health Services** department aims to support Partnership's growing services under CalAIM. Under the leadership of the department Director, Lisa O'Connell, this department and team of leaders support our members, providers and communities, focusing on social drivers of health. Specifically, the team in this department is focused on:

- Enhanced Care Management (ECM)
- Community Supports (CS)
- Justice Initiative (JI)
- Associated Grants under CalAIM (IPP, HHIP, etc.)

This dedicated team has helped to grow and strengthen Partnership's network of providers and uptake of services; ensuring quality and access. Today, Partnership:

- Contracts with 205 ECM Provider Organizations and 134 Community Supports Provider Organizations.
- Currently there are over 5,600 members enrolled in ECM
  - The most requests for ECM we receive are for members who meet the "unhoused" Population of Focus criteria for ECM.
- Currently there are over 8,000 Community Support Services (CSS) authorized for over 5,700 members. Three most popular services requested:
  - Housing Transition / Navigation
  - Medically Tailored Meals
  - Housing Tenancy and Sustaining Services

To strengthen and grow the network of services under CalAIM for children and youth, the team recently held a webinar for all twenty four (24) First 5 agencies in Partnership's network,. The webinar was held virtually and in-person at all of Partnership's offices and was well attended by over 20+ agencies along with representation from First 5's National Advocacy group, the First 5 Center for Health Care Policy.

And lastly, it was not only our Partnership staff that have been on the move the past couple months. In August our Transportation Department provided nearly 110,000 rides to our members.

News Updates
October 2024

Partnership Press Releases:

Your Partner in Health: The Trouble with Opioids and the Importance of Naloxone
Partnership HealthPlan of California – Jeffrey DeVido, M.D.
October 2, 2024
In 2021, over half of drug overdose deaths in the United States involved an opioid.

Partnership Mentioned:

The Buzz: Downtown travel shop for sale. When will Fat Burger, Nathan's Hot Dogs open?
Redding Record Searchlight
September 21, 2024
…But commercial realtor Ken Miller, whose Northstate Commercial Partners represented State Fund in the sale to Partnership HealthPlan of California, said the new owners are leasing back 7,000 square feet on the ground floor to State Fund.

Redding Council, schools take action after spike in teen tobacco use in Shasta County
Redding Record Searchlight
September 18, 2024
A $1.2 million loan that would help the owner of the Market Street Manor Motel turn the structure into a transitional apartment complex…The money comes from Housing Homelessness Incentive Program funds the city received from Partnership HealthPlan of California.

Harnessing AI's Potential to Lift Up Underserved Communities
California Health Care Foundation
September 17, 2024
To learn more about how California safety-net health plans are grappling with these complex challenges and opportunities, CHCF spoke with chief health equity officers from three Medi-Cal plans serving highly diverse populations. They are Pooja Mittal, MD, of Health Net; Mohamed Jalloh, PharmD, of Partnership Health Plan; and Traco Matthews, MBA, of Kern Health Systems.

Will Redding motel be transformed into apartments for homeless people?
Redding Record Searchlight
September 16, 2024
…The city wants to loan $1.2 million in Housing Homelessness Incentive Program funds it received from Partnership HealthPlan of California to assist C&M Opportunities LLC redevelop Market Street Manor at 2171 Market Street, just south of Jiffy Lube.

Opinion: Another Domino Falls
North Coast Journal
September 12, 2024
…We have spoken out about this crisis to the health insurance industry and asked our elected officials to help. The only assistance has come from Partnership Health Plan, a not-for-profit insurance company that administers the Medi-Cal program in Humboldt.

News Briefs

Lake County Record Bee
September 11, 2024
In response to the ongoing Boyles Fire, Lake County Health Services (LCHS) is committed to assisting affected community members by providing comprehensive information on available resources…Partnership Health Member Services Hotline: Partnership Health Members affected by the Boyles Fire can contact the Member Services hotline at 800-863-4155 for guidance and assistance tailored to their specific needs.

Lake County Health Services updated resources for residents affected by the Boyles fire

Lake County News
September 10, 2024
Lake County Health Services has issued an update on available resources for community members impacted by the Boyles fire…Partnership Health Member Services Hotline: Partnership Health Members affected by the Boyles fire can contact the Member Services hotline at 800-863-4155 for guidance and assistance tailored to their specific needs.

New Red Bluff mental health clinic to open later this month

Action News Now
September 4, 2024
… Lembcke says that right now, N.A.M.H.S. isn't accepting private insurance, with a focus on helping those with other plans. "We serve the medi-cal population with partnership health plan. We serve medicare, we serve medi-medi's, and we are open and in the process of taking private insurance as well."

The Buzz: New outdoor gear and apparel store coming. Redding health care nonprofit expands

Redding Record Searchlight
August 31, 2024
… Partnership HealthPlan of California is expanding in Redding. In April, the nonprofit purchased the former Veterans Affairs outpatient clinic on Hartnell Avenue.

VCUSD, Touro University conclude mobile vaccination program

Times Herald
August 12, 2024
…The program — funded by Touro Cares MVP Vaccine Grants from Kaiser East Bay Community Foundation, Kaiser Foundation Hospitals, Partnership Health Plan of California, and the Solano County Department of Public Health — began its mobile clinics during the pandemic to increase vaccine access.

Lewis T. Broschard Jr., M.D.

Daily Republic
August 11, 2024
It is with sadness, admiration and love that the family of Dr. Lewis T. Broschard Jr. announces his recent passing.

OPINION: The Mental Health Insurance Contract Maze

Anderson Valley Advertiser

August 5, 2024

…Medi-Cal (California's federal Medicaid program) reimburses the County for "specialty" services provided to the "severely mentally ill." Partnership Health Plan, an amorphous statewide public/private insurance agency handles "managed care" or Obamacare (also under Medicaid) covering the less than severely mentally ill.

Partnership Board: Legislative Update
October 2024

Bills of Focus

AB 3275 (Soria) Health care coverage: claim reimbursement. SIGNED

Commencing January 1, 2026, this bill would require a health care service plan or health insurer to reimburse a clean claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim does not meet the criteria for a clean claim, to notify the claimant within 30 calendar days that the claim is contested or denied. The bill would require the DMHC and the Department of Insurance to determine the criteria for a clean claim, as specified, no later than July 31, 2025. The bill would authorize the departments to issue guidance and amend regulations related to these provisions. The bill would exempt the guidance and amendments from the Administrative Procedure Act until December 31, 2027.

Position: LHPC – Oppose

AB 236 (Holden) Health care coverage: provider directories. HELD (SUSPENCE FILE)

This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks.

Position: LHPC – Oppose

AB 2466 (Carrillo) Medi-Cal managed care: Network adequacy standards HELD (SUSPENCE FILE)

Under this bill, a Medi-Cal managed care plan would be deemed to be not in compliance with the appointment time standards if either (1) fewer than 85% of the network providers had an appointment available within the standards or (2) the department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees. Additionally, the bill would instead require a plan that has a previously approved alternative access standard to submit a renewal request on an annual basis, explaining which efforts the plan has made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard.

Position: LHPC – Oppose

AB 3260 (Pellerin) Health care coverage: reviews and grievances HELD (SENATE FLOOR)

This bill reduces the current 30 or 45 working days timeframe required for a health plan, health maintenance organization (HMO) or health insurer to pay provider claims to 30 calendar days. This bill increases the interest penalty on plans and insurers that fail to meet timelines in the law.

Position: LHPC – Oppose

Hospital Seismic Legislation

AB 869 (Wood) Hospitals: seismic safety compliance. SIGNED

This bill establishes a process for small, rural, and district hospitals, as well as hospitals that are recipients of the Distressed Hospital Loan Program, to seek a delay in the seismic compliance deadline of January 1, 2030 of up to three years, with HCAI having the discretion to extend the delay by an additional two years if the hospital continues to be in financial distress, or due to factors outside of the hospital's control

Bill Status: Chaptered by Secretary of State - Chapter 801, Statutes of 2024. 09/28/2024

SB 1119 (Newman) Hospitals: seismic compliance. VETO

This bill would add Providence St. Joseph Hospital and Providence Eureka General Hospital in the City of Eureka, Providence St. Jude Medical Center in the City of Fullerton, and Providence Cedars-Sinai Tarzana Medical Center in the City of Tarzana to the hospitals for which the department may waive the requirements of the act.

Bill Status: Enrolled and presented to the Governor. 09/28/2024

SB 1432 (Caballero) Health facilities: seismic standards. VETO

Authorizes a hospital owner or operator to submit an application to the Department of Health Care Access and Information (HCAI) for an extension of the deadline for compliance with the 2030 seismic safety regulations or standards, up to January 1, 2035.

Bill Status: Vetoed by the Governor. 09/12/2024

Additional Bills We Are Watching

SB 1423 (Dahle) Medi-Cal: critical access hospitals. VETO

This bill requires DHCS to convene a Rural Hospital Technical Advisory Group, with a certain composition of stakeholders, at least bimonthly during the 2025 calendar year. The bill would set forth the purposes of the advisory group, including, among other things, analyzing the continued ability of small, rural, or critical access hospitals, as defined, to remain financially viable under existing Medi-Cal reimbursement methodologies, to provide related recommendations, and to identify key contributors to the financial challenges of those hospitals, as specified.
The bill would require, by March 31, 2026, the department, in consultation with the advisory group, to report to the Legislature on the findings and recommendations arising out of the convenings, as specified.

Bill Status: Vetoed by the Governor. 09/22/2024

AB 1895 (Weber) Public Health: Maternity Ward Closures. VETO

Requires a general acute care hospital (GACH) that provides maternity services and determines those services are at risk of closing in the next six months to report specified information to the State Department of Health Care Services, the Department of Health Care Access and Information (HCAI), the State Department of

Public Health (DPH), and the Chairs of the Senate and Assembly Committees on Health. If the hospital plans to close its perinatal unit, the bill would require the hospital to provide public notice of the proposed closure, including the results of the community impact assessment, and other specified information on the hospital's internet website 90 days in advance of the closure.

Bill Status: Vetoed by Governor. 09/29/2024

AB 1975 (Bonta) Medi-Cal: Medically Supportive Food and nutrition interventions. VETO

Establishes medically supportive food and nutrition interventions as a Medi-Cal covered benefit when medically necessary in treating a patient's medical condition, subject to specifications and utilization controls, starting no sooner than July 1, 2026, upon appropriation.

Position: LHPC – Support

AB 1168 (Bennett) Emergency medical services (EMS): prehospital EMS. VETO

This bill would require a city to be treated as if it had retained its authorities regarding, and the administration of, prehospital EMS if specified requirements are met. If a joint powers agreement regarding prehospital EMS was initially executed on or after January 1, 2025, the bill would ensure a city or fire district retains its existing authorities regarding, and the administration of, prehospital EMS.

Position: Watch

AB 3156 (Patterson) Medi-Cal managed care plans: regional center services: beneficiaries with other primary coverage. VETO

AB 3156 would impose requirements on Medi-Cal managed care plans to ensure that enrollees who have other health coverage are able to better coordinate their care. The bill would require a Medi-Cal managed care plan to provide assistance to Medi-Cal providers and beneficiaries, upon request, on options for maintaining health care relationships between beneficiaries and existing providers that are contracted with, or have agreements with, a beneficiary's primary form of health care coverage, if the beneficiary transitions from receiving services under the Medi-Cal fee-for-service delivery system to being an enrollee of the managed care plan. The bill would also prohibit a Medi-Cal fee-for-service provider from being required to contract with a Medi-Cal managed care plan in order to provide services to an enrollee who fits the above-described criteria and to bill the Medi-Cal managed care plan. However, plans may require a letter of agreement in specified circumstances in order to pay the provider.

Partnership Advantage Update

To: Partnership HealthPlan of California's Board of Commissioners
From: Amy Turnipseed, Chief Strategy and Government Affairs Officer
Date: October 9, 2024
Subject: Partnership Advantage Update

Partnership continues to work towards implementing a Medicare Advantage Duals-Special Needs Plan (D-SNP) in January 2026. Here are key updates on our progress:

- **Regional Model:** On Friday, August 30, 2024, the Department of Health Care Services (DHCS) approved Partnership's request for a phased-in approach to our D-SNP product. In 2026, Partnership will launch a D-SNP in eight counties: Marin, Sonoma, Solano, Napa, Mendocino, Lake, Humboldt, and Del Norte. Partnership intends to expand our D-SNP to all 24 counties over the next few years, building on our experience in these eight counties.
- **Contracting:** Partnership launched its Medicare contracting efforts in late August. The Centers for Medicare and Medicaid Services (CMS) requires a D-SNP plan to have a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of the population served. The contracted network of providers must be consistent with the pattern of care in the network service area. This includes primary care, specialty, ancillary, hospitals, and behavioral health providers. As of October 1, 2024, we have engaged 306 organizations in Medicare contracting discussions and have 83 agreements signed.
- **Provider engagement:** Partnership has launched external efforts to increase awareness about our D-SNP product and engaging key providers. Over the past month, Partnership has met with health center representatives at Aliados, the Alliance for Rural Community Health, Health Alliance of Northern California, and North Coast Clinic Network.
- **Pharmacy Benefit Manager:** Partnership will be required to provide Medicare pharmacy benefits (Part D) for D-SNP members. The Pharmacy Department is leading the pharmacy benefit manager procurement process. Our goal is to have a pharmacy benefit manager selected and announced by the end of 2024.
- **Model of Care:** The model of care application is a quality improvement tool that CMS requires every D-SNP plan to submit to NCQA for evaluation and approval. Health plans must submit their model of care application to CMS by February 2025 in order to offer a Medicare program in 2026. The model of care application outlines how Partnership will design its D-SNP program and work with its provider network to coordinate care for the D-SNP population. Leaders from across the organization are working collaboratively to draft the model of care.