Board of Commissioners Meeting Agenda

December 4, 2024: 10:00 a.m. – 2:00 p.m.

In-person Locations:

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 December 3, 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 and Board Meeting Minutes for October 9, 2024	1-14	*Chair*
1.4	***ACTION***: Resolution to Approve the New Appointment of Ryan Nowling, to the Partnership Board as the Lassen County Representative	15-16	*Sonja Bjork*
1.5 **Commissioner Comment**			*Chair*
1.6	***INFORMATION:*** CEO Report	17-19	*Sonja Bjork*
10:25AM – Consent Calendar			
3	***ACTION:*** Consent Calendar ▪ **3.1** Resolution to Accept all Partnership Committee Minutes, Partnership Policies and Program Descriptions Approved by the Physician Advisory Committee	20-21	*Chair*

	▪ **3.2** Resolution to Approve Membership Changes to the Physician Advisory Committee ▪ **3.3** Resolution to Approve the Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description QIHETP Program Description – Redlined QIHETP Program Description – Clean ▪ **3.4** Resolution to Approve the Cultural & Linguistic Program Description Cultural & Linguistic Program Description – Redlined Cultural & Linguistic Program Description – Clean	22-23 24-25 26-27	

PAC Approved Policy Updates
Finance Committee – November 2024
Physician Advisory Committee – October 2024
Physician Advisory Committee – November 2024
Quality and Utilization Advisory Committee (Q/UAC) – October 2024
Quality and Utilization Advisory Committee (Q/UAC) – November 2024
Strategic Planning Committee – October 2024

10:35AM – Regular Agenda Items			
4.1	***ACTION****:* Annual Board Compliance Training and Resolution to Approve Calendar Year 2025 Compliance Plan, and Audit Work Plan	28-75	*Danielle Ogren*
4.2	***ACTION:*** Resolution to Approve the Compliance Dashboard for Q32024	76-80	*Danielle Ogren*
4.3	***ACTION:*** Resolution to Approve Commendations and Appreciation for Board Commissioner Dr. Noemi Doohan's Service to Partnership	81-82	*Sonja Bjork*
4.4	***ACTION:*** Resolution to Approve Commendations and Appreciation for Board Commissioner Alicia Hardy's Service to Partnership	83-84	*Sonja Bjork*
4.5	***ACTION:*** Resolution to Approve Commendations and Appreciation for Board Commissioner Randall Hempling's Service to Partnership	85-86	*Sonja Bjork*
4.6	***ACTION:*** Resolution to Approve Commendations and Appreciation for Board Commissioner Tory Starr's Service to Partnership	87-88	*Sonja Bjork*
11:45AM-12:15PM – Lunch			
12:15PM – Reports			

5.1	***INFORMATION:*** Metrics and Financial Update	89-102	*Jennifer Lopez*
5.2	***INFORMATION:*** Operations Update	103-104	*Wendi Davis*
5.3	***INFORMATION:*** Legislative & Media Update	105-106	*Dustin Lyda*
5.4	***INFORMATION:*** CMO Report on Quality	107-109	*Dr. Moore*
5.5	***INFORMATION:*** Medicare Update		*Amy Turnipseed*
1:05PM – Education Sessions			
6.1	***INFORMATION:*** Member Experience / Grand Analysis		*Edna Villasenor / Isaac Brown*
6.2	***INFORMATION:*** Health Services Update		*Katherine Barresi*
2:00PM – Adjournment			

Upcoming Meetings:

2/26/2025 – February Board Meeting
4/22/2025 – Strategic Planning Retreat Board Dinner
4/23/2025 – April Board Meeting and Strategic Planning Retreat at Winters Hotel
6/25/2025 – June Board Meeting

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

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

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On
October 9, 2024

Members Present: Jonathon Andrus, Darcie Antle, Jayme Bottke, Gena Bravo, Brion Burkett, Christopher Champlin, Cathryn Couch, Noemi Doohan, M.D, Dean Germano, Alicia Hardy, Randall Hempling, Scott Kennelly, Belle Knight, Liz Lara-O'Rourke, Viola Lujan, Phuong Luu, M.D., Nunie Matta, Andrew Miller, M.D., Matthew Morris, M.D., Robert Oldham, M.D., Jonathan Porteus, PhD (10:08 arrival), Kathryn Powell**,** JoDee Read, Stacy Sphar, DNP, Nancy Starck, Kim Tangermann (Chair)

Members Excused: Shelby Boston, Ranell Brown, Christy Coleman, Ryan Gruver, Liz Hamilton, Gerald Huber, Dave Jones, Elizabeth Kelly, Lisa Santora, M.D., Tory Starr, Nolan Sullivan, Jennifer Yasumoto, Jim Yoder
Staff: Marc Agudelo, Jill Blake, 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, Robert Moore, M.D., Stephanie Nakatani, 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

Guests: Richard Fisher, Krissy Matta, Chris Pritchard, Rianne Suico

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 & 1.4 Approval of Agenda and the Board Meeting Minutes for August 28, 2024	Chairwoman Tangermann asked if anyone had changes for the agenda or corrections to the August 28, 2024 minutes. Hearing no requests for modification, she asked for a motion to approve the agenda and minutes.	*Commissioner Hempling moved to approve the agenda and minutes as presented, seconded by Commissioner Burkett.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 13 (*Boston, Brown, Coleman, Gruver, Hamilton, Huber, Jones, Kelly, Santora, Starr, Sullivan, Yasumoto, Yoder) **MOTION CARRIED**
1.5 Recognizing 4th Second for Receiving an Honorable Mention for the Association for Community Affiliated Plans (ACAP) Supporting the Safety Net Award	Ms. Barresi, Acting CEO, stated that Partnership nominated 4th Second for the Association for Community Affiliated Plans' 2024 Supporting the Safety Net Award. We are thrilled to present them with an honorable mention plaque in recognition of the work 4th Second is doing for our members and for the community in Vallejo (Solano County). Executive Director, Richard Fisher, accepted the award on behalf of 4th Second.	*None*

1.6 Commissioner Comment	Chairwoman Tangermann asked if there were any commissioner comments. Hearing none, she moved to Public Comment.	None
1.7 Public Comment	Chairwoman Tangermann asked if there were any public comments or correspondence. There was none.	None
1.8 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 statements for the period July 1, 2023 to June 30, 2024.	Moss Adams Auditors, Rianne Suico and Chris Pritchard, presented the results of Partnership's fiscal year 2023-2024 financial audit. Ms. Suico stated that the results of the audit are presented with an unmodified audit opinion, the highest level of opinion available. Partnership's management submitted financial statements in alignment with generally accepted accounting principles. **Statements of Net Position** ***Assets and Deferred Outflows of Resources Composition*** Partnership's assets and deferred outflow balances were verified and there were no issues reconciling. Total assets increased from 2023 to 2024, primarily in cash and in the California Department of Health Care Services receivable. This increase is predominantly the result of 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. ***Liabilities, Deferred Inflows, and Net Position Composition*** Partnership's current liabilities increased, primarily in Accounts Payable and Accrued Expenses, as a result of 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 and additional increases can be attributed to the increase in Accrued Claims Payable from the 10 expansion counties. Moss Adams analyzed management's methodology in estimating claims to be paid and found consistency in the accrued claims payable. The Quality Improvement Program (QIP) balance decreased due to the prior year's true-up and decrease in the number of participating providers meeting their performance measures. Partnership's net position increased from the prior year due to positive operating income and investment earnings. **OPERATIONS**: ***Total Operating Expenses as a % of Total Operating Revenues*** Partnership's operating revenues increased in FY23-24, which can be attributed to increased membership from the 10-county expansion and increased MCO Tax rates. Fee for service expenses for hospital, physician, and other services is Partnership's largest operating expense category and increased in 2024 due to increases in membership and utilization. Premium tax related to revenue has increased from 2% to 12%.	*Commissioner Andrus moved to approve the audit report as presented, seconded by Commissioner Matta.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 13 (*Boston, Brown, Coleman, Gruver, Hamilton, Huber, Jones, Kelly, Santora, Starr, Sullivan, Yasumoto, Yoder) **MOTION CARRIED**

	Historic Estimated Claims Liability and Historic Actual Claims Liability Claims liability as a percentage of capitation revenues is consistent year-over-year and is beginning to align with pre-pandemic levels. ***Tangible Net Equity*** Tangible Net Equity is a good indicator of the health of a risk-baring organization. Partnership's Tangible Net Equity is about seven times what is required by the State as of the fiscal year end **IMPORTANT BOARD COMMUNICATIONS:** Moss Adams had no post-audit adjustments to make. There were no issues discussed that indicated any disagreement from management and Partnership was collaborative throughout the audit process. Moss Adams claimed no awareness of any fraud or noncompliance with laws and regulations. *Commissioner Matta questioned how often Partnership is audited.* *Patti McFarland, Chief Financial Officer, responded that Partnership's financials are audited annually.* *Ms. Lujan inquired whether Partnership could assess the overall impact of the Kaiser direct contract, which went into effect on January 1.* *Jennifer Lopez, Deputy Chief Financial Officer, replied that Partnership lost approximately 90,000 members to Kaiser.* *Commissioner Germano asked about Partnership's financial standing relative to its sister plans.* *Ms. McFarland explained that the organization evaluates its financial position compared to other health plans annually as part of the budget process. Typically, Partnership's reserves fall in the middle range when compared to our sister health plans.* The full audit report was included in the packet.	
1.9 CEO Report	Katherine Barresi, Acting CEO, gave a report covering the following topics: ***Community Reinvestment Policy*** **–** The Department of Health Care Services (DHCS) released policy guidance for the Community Reinvestment Policy, in alignment with the 2024 contract	None

requirements. The Community Reinvestment Policy mandates that managed care plans allocate a portion of their net income back into the community. Partnership and our sister health plans have concerns regarding the guidance. Notably, DHCS is examining the legal viability and practicality of governance frameworks for overseeing Community Reinvestments, which could alter the responsibilities of Partnership's Board. Additionally, the guidance suggests that health plans base their investments on the number of Medi-Cal beneficiaries they serve. This approach is a concern for Partnership, as areas of our service area have a smaller Medi-Cal members in relation to the population; yet require substantial community investments. There are also worries that our current programs, such as workforce development, may not be recognized under the policy. The draft guidance also stipulates that investment projects must be completed within a year of DHCS approval, presenting challenges since many of our capital investments take several years to implement. We also would like the ability to respond flexibly to community needs during emergencies, such as natural disasters.

Our association, Local Health Plans of California (LHPC), is implementing a robust communication plan that highlights findings from a survey of local health plans, which revealed that local health plans have invested nearly $800 million in California since 2019. Given our extensive experience, we are concerned about losing credit for ongoing projects or needing to halt projects that may not align with state policies.

Commissioner Luu shared that DHCS is directing counties to seek funding from managed care plans.

Commissioner Morris expressed appreciation with Partnership advocating for counties with low Medi-Cal populations, who need more funding.

NCQA Health Equity Accreditation – Partnership successfully completed a mock NCQA Health Equity Accreditation audit with the help of our consultant. The results of the mock audit showed that if Partnership were conduct an actual survey with NCQA we would likely pass due to our high mock audit scoring. This milestone represents much progress and work by the health plan and teams, and in particular, by our Health Equity Officer Dr. Mohammed Jalloh, our QI NCQA Program Team, Human Resources and others. The next step Partnership will be for Partnership to complete a formal survey for Health Equity accreditation. Our look back period starts December of 2024, and we will begin submitting our documentation to NCQA in March of 2025. We anticipate accreditation results announced June 2025.

SB 525 – Health Care Minimum Wage Bill – SB 525 goes into effect on October 16 and will raise wages for health care workers, gradually increasing pay to $25 per hour over the next several years. The implementation of SB 525 rolls out over phases with certain facility and provider types required to begin raising wages first. Pre-emptively many providers already began raising wages in anticipation of this law. Initially, wages will rise to $18 per hour for employees at small, rural

	health care facilities. We continue to be in close contact and conversation with provider network, hospitals, and small rural hospitals and clinics to understand the impact to operations and/or potential impacts to care.	
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. Hearing no requests, she asked for a motion to approve resolutions 2.1, 2.2, 3.1, 3.2, 3.3, 3.4 & 3.5. 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 ▪ **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	*Commissioner Germano moved to approve Resolutions 2.1, 2.2, 3.1, 3.2, 3.3, 3.4 and 3.5 as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 13 (*Boston, Brown, Coleman, Gruver, Hamilton, Huber, Jones, Kelly, Santora, Starr, Sullivan, Yasumoto, Yoder) **MOTION CARRIED**
4.1 Resolution to Approve Request for Hospital Advance	Ms. Lopez presented a resolution to the Board for consideration, seeking approval for a request for a hospital advance. Partnership received a request for an advance payment of $5,000,000 from Surprise Valley Health Care District (Surprise Valley Community Hospital). Surprise Valley Community Hospital is located in Cedarville, CA, and is one of the smallest District Authority-owned hospitals in the state. The hospital is currently facing significant financial challenges and is seeking temporary financial assistance to support its cash flow and operations over the next few months. The requested advance will help ensure that Partnership members continue to have access to health care services at Surprise Valley Community Hospital. The advance will be repaid in January 2025 through an offset in the supplemental payments that Partnership will make to the hospital. Surprise Valley Community Hospital is a licensed 26-bed facility, with 4 acute care beds and 22 long-term care beds. Ms. Lopez noted that Partnership has and will continue to provide advances to providers if necessary but is bringing this advance request to the Board as the hospital is currently in bankruptcy. In the coming months staff plan will bring a formal policy to the Board for review. Partnership leadership recommends approving the request, as the closure of a hospital in our service area, particularly in a rural region, would be detrimental in maintaining access for our members. As a condition of the advance payment, Partnership will require the hospital to	*Commissioner Hardy moved to approve Resolution 4.1 as presented, seconded by Commissioner Andrus.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 13 (*Boston, Brown, Coleman, Gruver, Hamilton, Huber, Jones, Kelly, Santora, Starr, Sullivan, Yasumoto, Yoder)

	provide operational and financial reporting until the payment is offset, as well as the 12 months thereafter. *Commissioner Lujan expressed her awareness of the significant impact that the closure of a district hospital would have. She inquired about the distance to the nearest hospital from Surprise Valley Community Hospital.* *Ms. Lopez replied that the closest hospital is Modoc Medical Center, located about 30 miles away from Surprise Valley. She also stated that there is a shortage of skilled nursing facilities (SNF) beds in the area and noted that there are 22 Partnership members currently residing in the Surprise Valley SNF.* *Commissioner Knight emphasized the importance of helping Partnership members and stated it would be irresponsible not to approve the advanced funds to Surprise Valley.*	**MOTION CARRIED**
4.2 Resolution to Approve Accepting the Gift of Properties from the Gasser Foundation	Ms. McFarland presented the Board with a resolution to approve the gift of two properties from the Gasser Foundation. The Gasser Foundation is the title owner of two properties, located at 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 to help serve the needs of our communities. The Board of Commissioners were asked to authorize the Acting Chief Executive Officer to accept the gift of properties from the Gasser Foundation. *Commissioner Powell inquired about the type of properties that are being gifted.* *Ms. McFarland replied that both properties are houses. One is currently being leased by a respite care provider, and Partnership plans to continue the lease, ensuring that the provider serves a threshold of Partnership members. The second property is vacant, and it is yet to be determined how to utilize the space to best serve our members.*	*Commissioner Hardy moved to approve Resolution 4.2 as presented, seconded by Commissioner Powell.* ***ACTION SUMMARY:*** *Yes: 26* *No: 0* *Abstention: 0* *Excused: 13 (*Boston, Brown, Coleman, Gruver, Hamilton, Huber, Jones, Kelly, Santora, Starr, Sullivan, Yasumoto, Yoder) **MOTION CARRIED**
5.1 Metrics and Financial Update	Ms. Lopez announced that Partnership's September financials would be presented to the Finance Committee at the November meeting, and to the full Board in December, given the early October meeting date.	None
5.2 Operations Update	Wendi Davis, Chief Operating Officer presented an update on Partnership's operations, highlighting outreach campaigns and community events led by the Population Health Management team. The department, in collaboration with Quality Improvement (QI) and Health Equity, is adopting new and innovative approaches to engage members and implement interventions that drive meaningful outcomes. Partnership has participated in over 80 events this year, engaging	None

	with members, providers, and the community. The Population Health Management team is also leading Population Needs Assessment (PNA) activities. DHCS now requires 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). Partnership has hired two Regional Directors. 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. Partnership will now have six Regional Directors, one based in each regional office and highlights Partnership's commitment to being integrated within the communities we serve and to allocating resources more equitably. *Commissioner Doohan thanked Vicky Klakken and Dr. Ribordy for their support during a recent Lake County wildfire.* *Commissioner Champlin mentioned that there have been reports of transportation issues from local members and expressed appreciation for Partnership's ongoing efforts to improve the benefit.* *Ms. Davis responded that Partnership is conducting focus groups with members to gather input on how to improve the transportation benefit.* *Commissioner Luu shared that a member in Sutter County was asked to provide a tip after their ride to an appointment.* *Ms. Davis thanked Commissioner Luu for the feedback and stated that Partnership investigates every complaint. However, she noted that there are times that we receive only anecdotal complaints. She encouraged members to report any issues so that they can be properly addressed.* *Commissioner Lujan inquired whether there is an internal policy for members who require an immediate or special circumstance ride.* *Ms. Davis replied that there are specific processes in place for urgent requests. We never turn anyone away, and in some cases, this means using alternative vendors like Uber or Lyft. We make every effort to find solutions and will always strive to accommodate our members.* *Commissioner Antle noted that the State is communicating that health plans will begin supporting transitional rent in January 2025, and asked if this was accurate.* *Ms. Barresi confirmed that starting January 1, 2025, health plans will have the option to provide the transitional rent benefit, though it will not become a required benefit until January 1, 2026. She explained that implementing this benefit effectively will require significant planning, and there are still many questions that need clarification from the state. As such, Partnership will not be offering*	

	transitional rent starting in January 2025. We are awaiting final cost model rates for our large and diverse service area. Unfortunately, much of our service area currently lacks the necessary infrastructure and housing inventory to support this benefit. Ms. Davis' full report is included in the Board packet.	
5.3 Media & Legislative Update	Dustin Lyda, Director of Communications and Public Affairs, presented a list of 117 legislative bills that Partnership is currently tracking. Many of these bills were either not passed in committee or were vetoed by the governor. Members of Partnership's Executive Team have been actively meeting with legislators to discuss key priorities and opportunities. Three legislators from Partnership's service area have either termed out or resigned, creating vacancies that will need to be filled. Additionally, as we enter the final two years of Governor Newsom's term and approach the upcoming presidential election in November, there is an element of uncertainty regarding future priorities. We will be monitoring the evolving priorities of the new administration. Mr. Lyda's full report is included in the Board packet.	None
5.5 Medicare / D-SNP Update	A written report was included in the meeting packet.	None
6.1 Quality Update	Dr. Moore, Chief Medical Officer and Nancy Steffen, Senior Director of Quality & Performance Improvement, presented a quality update to the Board. Partnership has been NCQA accredited since January 2021. The initial survey for NCQA Health Equity Accreditation is scheduled for June 2025. Additionally, Partnership's Model of Care for its new Dual Special Needs Plan (D-SNP) line of business is on track to be submitted to CMS in early 2025. NCQA Medicaid Health Plan Ratings (HPR) are assessed on a 0-5 point scale, with half-point increments. In 2024, Partnership received a 3.5-Star rating. 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 survey measures. Previously, Partnership was rated on four separate reporting regions for the Managed Care Accountability Set (MCAS), but moving forward, we will be rated as a single reporting region for all 24 counties. Quality Withholds will be assessed by DHCS Financial Rating Region. Partnership has three designated DHCS Financial Rating Regions: • Eureka Region + Redding Region - Lake, Mendocino, Tehama • Fairfield Region + Santa Rosa Region + Lake + Mendocino • Chico Region + Auburn Region + Tehama (beginning in MY2025) Partnership has requested that DHCS assess quality sanctions using these Financial Rating Regions, but the request is still pending. Stagnant and declining quality measure performance can be attributed to three factors: 1) Performance—members who qualify under a measure did not receive the required care within the specified timeframes; 2) Data Incompleteness—gaps in the data used to generate reported rates	None

	reduce confidence in their accuracy; and 3) Measure Limitations—issues with measure specifications may hinder their ability to accurately represent performance, as they may not align with the measure's intended purpose or current clinical practice. Partnership's strategy for improving Quality Measure Scores focuses on regional performance improvement activities, scaling successful programs, and leveraging Quality Improvement Programs (QIPs). It also involves improving data completeness by strengthening existing data sources and incorporating new ones. Additionally, resources dedicated to quality measurement and analytics will be restructured to improve data integration and validation, ensuring optimal clinical quality measurement. Dr. Moore and Ms. Steffen's full report was distributed to Board Members and is available upon request.	
6.2 Provider Satisfaction Survey Results	Mary Kerlin, Senior Director of Provider Relations and Stephanie Nakatani, Provider Relations Manager, gave an overview of the results of the annual Physician Satisfaction Survey. The survey, conducted from March to June 2024, for Primary Care Physicians (PCPs) and Specialists across Partnership's fourteen legacy counties: Solano, Napa, Yolo, Sonoma, Marin, Mendocino, Lake, Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity. The main goals were to assess satisfaction with the plan, identify strengths and areas for improvement, and identify emerging trends. A total of 488 sites were surveyed, with 303 respondents, resulting in a 62% response rate, up from 46% last year. Partnership's targeted response rate is at least 40%, and our survey vendor, Press Ganey, shares that the response rate for most plans is typically between 11-30%. The Provider Relations Department focused on provider outreach to increase the 2024 response rate. 97% of providers who responded strongly agreed or agreed with the board-mandated question, "I am satisfied with the Plan." Identified opportunities for improvement include ensuring timely appointments for specialty services within 15 business days, ensuring that PCPs receive feedback from Carelon on mental health referrals, and ensuring providers are aware of the process for submitting a potential CCS child to the local County agency for eligibility. All 24 of Partnership's counties will be surveyed in March 2025. Partnership's Board-approved goal for the 2025 survey is to achieve satisfaction rates of 85% in the 14 legacy counties and 65% in the 10 expansion counties, measured by the question: "I am satisfied with the Plan" *Commissioner Hardy inquired about the decline in satisfaction with specialty access.* *Ms. Davis explained that the termination of the Dignity contract, a major specialty provider, likely contributed to the drop in satisfaction. Additionally, there have been several retirements among specialty providers in recent years. She noted that specialty access remains an ongoing issue, particularly in rural areas, and is a top priority for Partnership.*	None

	Commissioner Oldham asked why the response rate for the Provider Satisfaction Survey is higher than typical CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey response rates, and whether the issues identified in both surveys are similar. *Ms. Kerlin responded that the surveys are administered differently, with Partnership actively reaching out to providers to encourage participation and remind them to complete the survey.* *Ms. Steffen added that the CAHPS survey is more detailed than the Provider Satisfaction Survey, but noted that both surveys show similar trends. She mentioned that the CAHPS survey results will be presented to the Board at the December meeting.* *Commissioner Germano pointed out that specialty care access is a broader community issue, not just a health plan concern. He shared that his son, a pulmonary doctor in Redding, is hearing from colleagues that they want more comprehensive incentives, such as loan repayment programs. Offering 50% of the market rate salary is not enough to attract doctors to these areas.* Ms. Kerlin's full presentation was distributed to Board members, and is available upon request.	
Adjournment	Chairwoman Tangermann adjourned the meeting at 1:42P.M.	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Board Approval Date: 12/04/24

Signed: _____
Ashlyn Scott, Clerk

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
1.4

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

Recommendation by:
Lassen County Board of Supervisors

Topic Description:
On November 12, 2024, Ryan Nowling, Chief Executive Officer of Northeastern Rural Health Clinics was appointed by the Lassen County Board of Supervisors to the Partnership HealthPlan of California Commission (known as the Board) as a Health Center Representative.

Mr. Nowling has been appointed for a four year term commencing on December 4, 2024 and concluding on December 3, 2028.

Reason for Resolution:
To obtain Board approval to appoint Ryan Nowling to the Partnership Board as the Lassen County Representative.

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

Requested Action of the Board:
Based on the recommendation of the Lassen County Board of Supervisors, the Board is asked to approve the new appointment of Ryan Nowling to the Partnership Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
1.4

Resolution Number:
24-

IN THE MATTER OF: APPROVING THE NEW LASSEN COUNTY APPOINTMENT OF RYAN NOWLING TO THE PARTNERSHIP BOARD

Recital: Whereas,

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

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

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

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Lassen County appointment of Ryan Nowling to the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December, 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 from the Chief Executive Officer

December 4, 2024

National Election Impacts

Along with all health care policy observers, Partnership has been monitoring and speculating about the impact of Donald Trump's presidential victory along with Republicans gaining control of both the House and Senate. We expect that many of the proposed changes to the health care system that were considered during the last Trump administration will be revisited in the coming years. These include cuts to the Medicaid and Medicare programs, block grant funding, beneficiary work requirements and allowing the ACA Premium Tax Credits to expire.

The new administration's promise of mass deportation of those who do not have settled immigration status is likely to have a chilling effect on enrollment in Medi-Cal. We have already heard from providers and community members about people being afraid to utilize their Med-Cal benefits and instead missing appointments and forgoing needed care.

The cabinet appointments made by President elect Trump will also have a major impact on the health care delivery system. Robert F. Kennedy Jr., the nominee for Secretary of Health has very publicly opposed two major public health initiatives: vaccine mandates and fluoridated water. We will see what influence this will have in potentially weakening vaccination rates beyond the already vaccine hesitant communities. Health plan quality scores are based on rates of preventative care such as vaccination rates. As DHCS ramps up sanctions on health plan's quality performance, plans may also need to battle the impact of federal policy to meet quality goals.

President elect Trump has also nominated Dr. Mehmet Oz as administrator of Centers of Medicare and Medicaid Services (CMS). Should his nomination be confirmed, he will oversee programs including Medicaid, the Children's Health Insurance Program, Medicare and the Affordable Care Act. CMS plays a vital role in state Medicaid programs, certifying rates, directed payment programs, and reviewing waivers that allow states to make changes to their Medicaid programs. Dr. Oz would also oversee Medicare drug price negotiations that were recently established under the Inflation Reduction Act.

Partnership is an active member of state and national organizations that advocate and educate on behalf of local, community health plans like ours. The Local Health Plans of California and the Association of Community Affiliated Plans will keep us informed of policy developments and their potential impact.

California Election Results

Democrats will continue to have a super majority in both the assembly and senate. Changes in legislative representatives in our service area include:

- SD 1– Megan Dahle (replacing Brian Dahle)
- SD 3 - Christopher Cabaldon (replacing Dodd)
- AD 1– Heather Hadwick (replacing Megan Dahle)
- AD 2 – Chris Rogers (replacing Wood)

In total, there are 34 new members in the legislature (both houses) – there will be a lot of changes in committees – including the Senate health committee in which the chair is termed out.

Proposition 35

California voters approved the Managed Care Organization tax (MCO tax) by a large margin. This will result in rate increases for some of the medical providers who serve our members. These raises will be handled through "targeted rate increases" (TRIs). Not all provider types will receive increases and the approach for handling capitated providers can be very complex. Partnership organized two webinars for our provider network to explain the details. Proposition 35 also locks in dedicated funding for the Medi-Cal program in future years.

DHCS Quality Sanctions

In mid-October, Partnership was notified by DHCS that we would receive a sanction of $475,000 for low scores on certain quality measures. The majority of the sanctions were related to our scores on the application of topical fluoride for children and on measures relating to well child visits and developmental screenings.

The sanction process allows health plans to request a "meet and confer" with DHCS to raise any issues related to matters such as data or calculation of the sanction. Partnership did request this meeting and it was held on November 4. Partnership provided DHCS with extensive information about the problems with the data related to these measures. For example, because dental services are not part of our benefit package, we rely on DHCS to give us data related to this measure. We did not receive complete data and so could not provide it during the HEDIS audit. DHCS will soon notify us of their final sanction calculation and will provide an opportunity for the health plan to formally appeal their decision. Our CMO, Dr. Robert Moore, will provide more detailed information about scores and the related data issues.

Community Reinvestments

At our last board meeting, our acting CEO Katherine Barresi, gave a detailed description of the 2024 contract provision requiring Medi Cal Managed Care Plans to make community investments. DHCS also issued a draft All Plan Letter outlining the specifics of the policy. Our board members are aware that Partnership has always made investments in the communities we serve, including our past Strategic Use of Reserves (SUR) program and our years-long investments in workforce development such as the Provider Recruitment Program. We and local health plans across the state have provided feedback to DHCS on several concerns related to the proposed policy. These include: (1) ensuring that our current community reinvestments "count" and are acknowledged under the new program; (2) allowing flexibility so that we are not limited to tiny investments in the small, rural communities which often are the ones most in need of programs and infrastructure; (3) the "shared governance and oversight" of the community reinvestments must not conflict with our current health plan structure of having stakeholder board members and a multitude of stakeholder advisory committees; (4) timelines for implementation that do not account for multi-year investments.

Final guidance on Community Reinvestments has not yet been issued. Over the past months, Partnership joined with other health plans through the Local Health Plans of California on two approaches to make sure that our concerns were heard. First, we participated in a live webinar event showcasing some of the community investments projects we have engaged in over the years. Four health plans and their community

partners were featured, and Partnership was one of the four. The audience of over 200 participants was made up of DHCS staff, Legislative staffers and the media. Second, Partnership joined other health plans in showcasing our community investments through a report released earlier this month. It can be found at: www.lhpclocalimpact.org. We hope that these efforts, along with many letters and meetings, will result in a policy that acknowledges our current work and does not create bureaucracy or barriers to future work in the communities we serve.

Medi-Cal Coverage of Traditional Healers and Natural Helpers

On October 16 DHCS announced the excellent news that CMS approved California's request to cover Traditional Healer and Natural Helper Services in the Drug Medi-Cal Organized Delivery System. This means that those receiving care through Tribal Health clinics, Urban Indian organizations and Indian Health Service facilities can now access culturally based substance use disorder treatments provided by Traditional Healers and Natural Helpers. This expansion incorporates spiritual ceremonies, herbal remedies, music therapy, and other cultural practices to aid Medi-Cal members in their recovery.

Health Plan Memoranda of Understanding – Progress Update

Partnership continues to make progress on our DHCS contract requirement to enter into MOUs with a wide array of county departments and other agencies that serve the communities and our members. Although we have not met the due dates for having these MOUs completed, we are making steady progress. Because of our very large service area we are working with 24 counties and their many departments, we will be adding FTEs in order to carry out all of the related contract requirements which dictate issues such as meeting cadence, agenda topics, information published on our website and more. Here is a list of the agencies/departments where an MOU is now required across each of our 24 counties:

MOUs Effective January 1, 2024	
Agency/Entity Type	**Program(s)**
Local Government Agency (LGA)	In-Home Supportive Services (IHSS)
LGA/County Behavioral Health Departments	Specialty Mental Health Services in Medi-Cal Mental Health Plans
LGA/County Behavioral Health Departments	SUD Treatment Services in Drug Medi-Cal Organized Delivery System (ODS) Counties
Regional Centers	Intermediate Care Facility for Developmentally Disabled
Local Health Departments	Including, without limitation, California Children's Services*, Maternal and Child and Adolescent Health, Tuberculosis Direct Observed Therapy
LGA/County Social Services Department	County Social Services Programs and Child Welfare
Local Health Departments	Women, Infants, & Children (WIC)
*MCPs participating in the Whole Child Model (WCM) Program should not utilize the California Children's Services Exhibit F of the LHD MOU and instead should utilize the WCM MOU.	WCM for expansion counties are technically due 11/29/2024 – report due to 11/29 what the current status of the WCM.

MOUs Effective July 1, 2024	
Agency/Entity Type	**Program(s)**
LGA	County-Based Targeted Case Management (TCM)
LGA/County Behavioral Health Departments	SUD Treatment Services in Drug Medi-Cal State Plan Counties (DMC-SP)

MOUs Effective January 1, 2025	
Program(s)	
First 5 County Commissions	
California Department of Corrections and Rehabilitations, county jails, and youth correctional facilities (Justice Involved) (Template forthcoming)	
Local Educational Agencies (Template forthcoming)	

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
3.1

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

Recommendation by:
Partnership Advisory Groups and Committees

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

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

The Board is responsible for reviewing and accepting all minutes and packets approved by the various advisory groups and committees, and approving the policies, program descriptions, and QIP changes that were approved by the PAC, in October and November 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:
December 4, 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 4th 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:
December 4, 2024

Agenda Item Number:
3.2

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

Recommendation by:
The Physician Advisory Committee (PAC)

Topic Description:
Dr. Melanie Thompson, Chief Medical Officer at Marin Community Clinics, has resigned from PAC as a voting member.

Dr. Noemi Doohan, Lake County Public Health Officer, has resigned from PAC as a voting member.

Dr. Brian Evans, Chief Medical Officer at Tahoe Forest Hospital, has resigned from PAC as a voting member.

Dr. Derice Seid, Medical Director, Marin Community Clinics, has been appointed to PAC as a voting member.

Reason for Resolution:
To accept the resignations of Dr. Melanie Thompson, Dr. Noemi Doohan and Dr. Brian Evans and the appointment of Dr. Derice Seid to the Physician Advisory Committee.

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

Requested Action of the Board:
Based on the recommendation from the Physician Advisory Committee, the Board is asked to accept the resignations of Dr. Melanie Thompson, Dr. Noemi Doohan and Dr. Brian Evans and the appointment of Dr. Derice Seid.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
3.2

Resolution Number:
24-

IN THE MATTER OF: APPROVING PHYSICIAN ADVISORY COMMITTEE MEMBERSHIP CHANGES

Recital: Whereas,

- **A.** Dr. Melanie Thompson, Chief Medical Officer at Marin Community Clinics, has resigned from PAC as a voting member.
- **B.** Dr. Noemi Doohan, Lake County Public Health Officer, has resigned from PAC as a voting member.
- **C.** Dr. Brian Evans, Chief Medical Officer at Tahoe Forest Hospital, has resigned from PAC as a voting member.
- **D.** Dr. Derice Seid, Medical Director, Marin Community Clinics, has been appointed to PAC as a voting member.
- **E.** The Board has authority to approve advisory committee membership changes.

Now, Therefore, It Is Hereby Resolved as Follows:

1. To accept the resignations of Dr. Melanie Thompson, Dr. Noemi Doohan and Dr. Brian Evans from the Physician Advisory Committee.
2. To accept the appointment of Dr. Derice Seid to the Physician Advisory Committee.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December 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:
December 4, 2024

Agenda Item Number:
3.3

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

Recommendation by:
Quality Utilization Advisory Committee and Physician Advisory Committee

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

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

Reason for Resolution:
To allow the full Board the opportunity to annually review and approve the Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description.

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

Requested Action of the Board:
Based on the recommendation of the Quality Utilization Advisory Committee and Physician Advisory Committee, the full Board is asked to approve the QIHETP Program Description.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
3.3

Resolution Number:
24-

IN THE MATTER OF: APPROVING THE QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM DESCRIPTION

Recital: Whereas,

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

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

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December 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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
3.4

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

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

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Topic Description:
Partnership's Cultural & Linguistic Program Description demonstrates the commitment of Partnership HealthPlan of California (Partnership) to deliver culturally and linguistically appropriate health care services to a culturally and linguistically diverse population of members and potential members in a way that promotes Health Equity for all members.

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

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

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

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
3.4

Resolution Number:
24-

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

Recital: Whereas,

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

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

Now, Therefore, It Is Hereby Resolved As Follows:

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

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December 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

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.1

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

Recommendation by:
Compliance Committee and Partnership Staff

Topic Description:
The Compliance Plan clarifies how Partnership conducts its business, operations, and defines compliance activities in regards to contractual obligations, ethical standards and all applicable statues, rules and regulations pertaining to Partnership's Compliance Program.

The Compliance Audit Plan also defines internal audit activities in preparation for Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and other regulatory audits.

Reason for Resolution:
To ensure Board members understand Partnership's Compliance Program, and have the opportunity to review and approve the Compliance Program plan annually.

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

Requested Action of the Board:
Based on the recommendation of the Compliance Committee, the Board is being asked to approve Partnership's Compliance Program and Audit Plan for calendar year 2025.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.1

Resolution Number:
24-

IN THE MATTER OF: APPROVING PARTNERSHIP HEALTHPLAN (COMPLIANCE PROGRAM PLAN AND AUDIT PLAN FOR CALENDAR YEAR 2025

Recital: Whereas,

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

B. The Board has responsibility for approving the organizational Compliance Plan.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve Partnership's Compliance Program and Audit Plan for calendar year 2025.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December 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

Compliance Plan & Audit Calendar

Calendar Year 20252024

Table of Contents

ATTACHMENTS:

A. COMPLIANCE COMMITTEE CHARTER

B. FRAUD PRVENTION PROGRAM

C. 2025~~4~~ AUDIT & DELEGATION OVERSIGHT PROGRAM CALENDAR

D. 2025~~4~~ INTERNAL AUDITING & MONITORING PROGRAM CALENDAR.

SUMMARY

Partnership HealthPlan of California (PHC) is committed to conducting its business operations in compliance with ethical standards, contractual obligations, and all State and Federal applicable statutes, regulations, and rules ~~pertaining to Medi-Cal~~.

PHC has a Compliance and Fraud Prevention Officer who oversees and maintains a formal compliance program. PHC's compliance program incorporates critical compliance elements as identified by the U.S. Department of Health and Human Services (HHS), Office of the Inspector General (OIG), Code of Federal Regulations (CFR), the Centers for Medicare & Medicaid Services (CMS), the California Department of Health Care Services (DHCS) and the California Department of Managed Health Care (DMHC) related to the Medicare and Medicaid program ~~integrity~~ requirements, ~~and the California Department of Health Care Services (DHCS)~~. PHC also has a designated Chief Information Officer (CIO), whose role is to actively assess and manage security risks. The CIO provides regular updates to the PHC Board of Commissioners (Commission) and Executive Staff. Additionally, PHC's Privacy Officer, who also serves as the Compliance and Fraud Prevention Officer, actively participates in conducting risk analyses, oversees PHC audits, and manages Fraud, Waste, and Abuse (FWA) and HIPAA (Health Insurance Portability and Accountability Act of 1996)/privacy reporting. This comprehensive approach is intended to prevent and detect any violations of ethical standards, contractual obligations, and applicable laws within PHC's operations, senior leadership, or Board of Commissioners (Commission). The Compliance Plan is a continually evolving document that is annually reviewed and amended, as necessary, based on risk analysis, ongoing compliance monitoring, and newly identified areas of risk. The Compliance Plan applies to employees, temporary personnel, volunteers, interns, health care providers, commissioners, subcontractors, and delegates, collectively, workforce members and affiliates.

~~This plan has been updated to reflect the ongoing priorities of the organization. In 2024,DHCS is restructuring its managed care contracts- adding robust requirements that will have impacts across the organization. The Plan must demonstrate robust accountability, compliance, monitoring, and oversight programs, including for all delegated entities, to increase transparency, improve equity, and ensure members have access to high quality care. Managed care plans will be held accountable for the quality of care at all levels of delegation. In addition, PHC continues to move forward in our efforts to implement a new claims system, CalAIM and will expand to 10 new counties.~~

PHC prioritizes its commitments by completing an annual risk ~~analysis~~ assessment. The Compliance Plan reflects

the application of this risk analysis by focusing PHC's ~~limited~~ resources in a manner that most effectively protects PHC from FWA, HIPAA breaches, and other risks to PHC, its workforce members, affiliates, and members.

This plan is reviewed and approved annually by PHC's Board of Commissioners.

THE COMPLIANCE PLAN

This Compliance Plan sets forth PHC's commitment to legal and ethical conduct by establishing principles, standards, and policies and procedures in order to efficiently monitor compliance with applicable laws and regulations. The Compliance Plan is designed to ensure PHC's operations and the practices of its workforce members and affiliates, comply with contractual requirements, ethical standards, and applicable laws.

The first part of the Compliance Plan addresses the review and implementation of contractual, legal, and regulatory obligations for PHC's operations. Additionally, PHC maintains policies and procedures relating to its business operations and compliance program. The Compliance Plan highlights critical elements of an effective compliance program. This includes, but is not limited to, the structure and operational aspects of the program, delegation of authority, training and education processes, monitoring and auditing activities, enforcement/discipline, and corrective action.

If a PHC workforce member or affiliate has any questions about the application of this Compliance Plan**,** PHC values, or PHC policies and procedures, they can seek guidance from the Compliance Officer, or any member of the Compliance Committee. PHC workforce members and/or affiliates should be generally familiar with the contractual, legal, and regulatory requirements pertinent to their roles with PHC. All PHC workforce members receive annual evaluations, which include measurements of job-specific knowledge and knowledge of departmental and company policies and procedures.

This Compliance Plan is not intended to address all of PHC's compliance activities, but to provide the framework for the compliance program. Workforce members and affiliates should seek the guidance of their supervisor, direct report, the Compliance Officer, or PHC Senior Management, as it relates to compliance functions stated within this plan or otherwise.

WRITTEN STANDARDS, POLICIES, AND PROCEDURES

Regulatory Affairs and Compliance (RAC), under the supervision of the Compliance Officer, analyzes potential implications and prepares summaries of new requirements or changes to existing requirements, for discussion with PHC leadership and at the Compliance Committee and/or appropriate venue.

Policies and Procedures

PHC regularly and systematically reviews and updates its policies and procedures to ensure business operations are compliant with new and existing contractual, legal, accreditation, and regulatory requirements. This ~~de~~centralized process is managed ~~through PHC~~ by the Compliance Department in collaboration with operational teams and regular committee meetings to review and approve PHC's policies and procedures.

Policies and procedures shall be reviewed no less than annually to ensure that PHC, its workforce members, and affiliates operate under and comply with current standards and/or requirements. Policies and procedures are developed or amended more frequently as needed and in response to new or amended standards, requirements, and potential risk areas identified by PHC and federal and/or state regulatory agencies.

Policies and procedures are maintained and made available in a manner that assures workforce members and affiliates are able to fulfill their roles and responsibilities, in compliance with applicable standards, requirements, laws, and regulations. PHC policies and procedures are available on the PHC intranet and as applicable, accessible through the external PHC website at www.partnershiphp.org.

Code of Conduct

The Code of Conduct (Code) is PHC's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to PHC, its workforce members and affiliates. PHC's Code ~~was reviewed in August 2023~~is reviewed at least annually to ensure its alignment with current state and federal requirements and that it is representative of our mission, values, and emphasizes standards of professional conduct. Workforce members and Commissioners review and attest to their understanding of and compliance with the Code at onboarding, annually thereafter, and upon any changes.

COMPLIANCE PROGRAM ADMINISTRATION

Commission

PHC's Board of Commissioners, herein after referred to as "Commission," has the duty to assure that PHC implements and maintains a Compliance Program governing PHC's operations. The Commission receives and reviews reports from the Compliance Officer. The Commission delegates the Compliance Program oversight and day-to-day activities to the Chief Executive Officer (CEO). As the Compliance and Fraud Prevention Officer, the Senior Director of ~~Compliance and~~ Regulatory Affairs and Contracting is designated~~,~~ by the CEO, to manage the day-to-day activities and oversight of the Compliance Program and Plan. Furthermore, the Commission may deputize compliance responsibilities to subcommittees, created by the Commission. The Commission retains the ultimate responsibility of ensuring the successful implementation and effectiveness of the PHC Compliance Program. The Commission's compliance responsibility includes, but is not limited to:

- Understanding the content and operations of PHC's Compliance Program;
- Review and approval of all policies and procedures related to PHC's contractual and regulatory compliance, including operationalizing the compliance program;
- Approving the Compliance Plan;
- Reviewing semi-annual compliance reports, including, but not limited to, summaries of overall compliance activities, and upon review, making recommendations for improvement as necessary; and
- Completing annual compliance training.

Compliance and Fraud Prevention Officer

The Senior Director of ~~Compliance and~~ Regulatory Affairs and Contracting serves as the PHC Compliance and Fraud Prevention Officer and as such, is responsible for developing, implementing, and ensuring the maintenance of compliance activities and programs in accordance with applicable laws, state and federal statutes and regulations, and contractual obligations. The Compliance and Fraud Prevention Officer reports directly to the CEO and ~~the retains the authority to report matters directly to~~ the Commission ~~at any time~~.

The Compliance and Fraud Prevention Officer shall receive periodic regulatory and compliance training and has the authority to oversee and direct compliance efforts. Through annual performance evaluations, the Compliance and Fraud Prevention Officer will be assessed for fulfilling compliance responsibilities and promoting adherence to the Compliance Program. The Fraud Prevention Officer also attends and participates in DHCS' quarterly program integrity meetings, as scheduled and attends the California Department of Justice (DOJ) Managed Care Anti-Fraud trainings, as scheduled.

Privacy Officer

The Senior Director of ~~Compliance and~~ Regulatory Affairs and Contracting also serves as the Privacy Officer, is a privacy subject matter expert, and is responsible for ensuring PHC and our staff comply with all state and federal privacy laws including, but not limited to the Health

Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH) Act, The Confidentiality of Medical Information Act (CMIA) and other rules as applicable.

Security Officer

The Chief Information Officer serves as the Security Officer and is responsible for the administration of the information security program and maintaining the confidentiality, integrity and availability of data within the organization's information systems for the Health Information Exchange and in compliance with HIPAA, HITECH, and related rules.

~~**Fraud Prevention Officer**~~

~~The Director of Compliance and Regulatory Affairs serves as the Fraud Prevention Officer and reports directly to the CEO and retains the authority to report matters directly to the Board of Commissioners, "the Commission," at any time. The Fraud Prevention Officer also attends and participates in DHCS' quarterly program integrity meetings, as scheduled and attends the California Department of Justice (DOJ) Managed Care Anti-Fraud trainings, as scheduled.~~

~~**Health Equity Officer**~~

~~The Director of Health Equity serves as the Health Equity Officer (HEO). The HEO provides leadership in the design and implementation of strategies and programs improving health equity and reducing health disparities. The HEO develops quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate health inequities. The HEO ensures all PHC staff, delegates, and network providers receive mandatory diversity, equity and inclusion training.~~

Compliance Committee

Purpose

The Compliance Committee, chaired by the Compliance Officer, has general responsibility to oversee PHC's Compliance Program. The purpose of the Committee is to: (i) oversee PHC's implementation of the Compliance Program, interventions designed to mitigate compliance risk, policies and procedures that support the prevention and detection of violations with applicable law, regulations, and rules; (ii) provide a mechanism for regular and direct communication with management, those persons responsible for the internal compliance function, and the Commission; and (iii) perform any other duties as directed by the Commission or the CEO.

The Compliance Committee is comprised of Senior Management and operational staff, as designated by the CEO and staffed by RAC. The Compliance Committee Charter is included as *Attachment A*. Individuals selected as members of the Compliance Committee are department heads (or their designated proxy), and other staff, as appropriate, based upon their job function. A complete list of positions for members of the Compliance Committee is included in the Compliance Committee Charter. The Compliance Committee meets no less than four times annually. PHC maintains minutes of Compliance Committee meetings that shall include, but is not limited to, summary of reports, discussion, recommendations for corrective action that may include sanctions and/or revocation of agreements, and/or recommendations or referrals to other PHC committees (subject to the attorney/client privilege, proprietary rights, et cetera).

Delegation Oversight Review Subcommittee (DORS)

The Delegation Oversight Review Subcommittee (DORS) is a subcommittee of the Compliance Committee and is chaired by a senior staff member of RAC. Membership is comprised of key subject matter experts from internal departments that are responsible for overseeing functions for which PHC has delegated authority to an external entity. The DORS has overall responsibility for ensuring PHC's compliance with oversight of delegated responsibilities and activities set forth by PHC's policies and procedures, national accreditation standards, and applicable federal and/or state statutes, regulations, and contractual obligations.

The DORS meets no less than four times annually. RAC sets an external/delegate audit calendar that is reviewed by the Compliance Committee and/or CEO and results of these audits are reviewed by DORS.

The Physical, Technical, and Administrative Safeguards (PTAS) Subcommittee

The Physical, Technical, and Administrative Safeguards (PTAS) Subcommittee is chaired by a senior staff member of RAC. Membership is comprised of key stakeholders from internal departments. This group implements and reviews reasonable and appropriate security measures to safeguard protected health information (PHI) and has oversight of policies and procedures intended to identify, prepare for, and respond to, potential or actual privacy and/or security incidents.

The PTAS meets no less than four times annually. All privacy and security policies are reviewed by PTAS, prior to being submitted to the Compliance Committee.

The Fraud, Waste and Abuse (FWA) Subcommittee

The Fraud, Waste and Abuse (FWA) Subcommittee is chaired by a senior staff member of RAC. Membership is comprised of key stakeholders from internal departments. This group meets to identify irregularities in the practices of workforce members, affiliates, providers, vendors, subcontractors and members where potential FWA is identified and to make recommendations for prevention activities and interventions.

The FWA meets no less than four times annually. All FWA and overpayment recovery related policies are reviewed by FWA, prior to being submitted to the Compliance Committee.

Executive Leadership Team
The CEO and Executive Leadership Team at PHC shall:

- Ensure that the Compliance Officer is integrated into the organization and is given the credibility, authority, and resources necessary to operate a robust and effective compliance program;
- Review periodic reports from the Compliance Officer related to operational risk, the strategies being implemented to address them, and the results of those strategies;
- Maintain working knowledge of contractual obligations, law, regulations, and rules; and
- Be advised of all governmental compliance and enforcement findings and activity, including audit findings, notices of non-compliance, formal enforcement actions, and as applicable, imposition of corrective actions and sanctions and official responses.

Project Management Office
The Project Management Office (OpEx/PMO) is responsible for ensuring that PHC's non-provider agreements are compliant with state and federal regulations and adhere to current business associate agreement requirements.

~~Provider Relations~~ Legal Department
The ~~Provider Relations~~ Legal Department's Contracting Unit is responsible for ensuring that all provider contracts are in compliance with associated state and federal regulatory requirements. Contracting plays a vital role in securing and maintaining relationships with providers throughout our service area to continually develop our network and ensure quality care for our members.

Network Services Department
The Network Services Department supports program integrity by ensuring credentialing/re-credentialing our provider network and ensures that providers are not suspended or ineligible to participate in Medi-Cal and Medicare, and as applicable, are Medi-Cal enrolled.

Provider Relations Department

~~Additionally,~~ Provider Relations is responsible for communicating regulatory updates and PHC policy changes to the provider network and as needed, providing education to promote understanding of and compliance with updates.

Other Departments
Other PHC Departments including, but not limited to, Behavioral Health, Claims, Communications, Configuration, Grievances and Appeals, Population Health Management, Care Coordination, Utilization Management, Quality Improvement, ~~Network Services, Legal Affairs,~~ Pharmacy, Finance, Human Resources (HR), Information Technology, and Member Services serve as subject matter experts and as the liaisons between PHC and our community. It is the responsibility of these departments to respond to, implement regulatory guidance, and where applicable, support the oversight of delegated activities for their respective functional areas.

EDUCATION AND TRAINING

PHC provides general and specialized trainings and education to workforce members and affiliates to promote understanding of and adherence with the Compliance Program, including the Compliance Plan, Code of Conduct, and applicable policies and procedures. Through training and education, workforce members are apprised of applicable state and federal laws, regulations, standards of ethical conduct, and corrective and/or disciplinary action for any violation of those rules.

PHC provides training to commissioners, workforce members, and affiliates, as follows:

Initial and Continuing Education and Training
Through onboarding, workforce members receive PHC's Code of Conduct and Compliance Primer and must attest their receipt and understanding. They also have access to all PHC policies and procedures, including those pertinent to the individual's job and/or responsibilities. The HR Department, in coordination with RAC, ensure workforce members receive training on the Compliance Plan during new hire orientation.

Ongoing Compliance Training
All PHC workforce members, regardless of position, are required to complete certain mandatory Compliance Trainings at the time of hire and annually thereafter. These trainings include:

- Information privacy and security (DHCS COHS contract 08-85215, Exhibit G)
- Fraud, waste, and abuse (DHCS COHS contract 08-85215, Exhibit E, Attachment 2, Provision 27 (B))

RAC coordinates with the HR Department to manage the implementation of this training through PHC's Learning Management System (LMS).

The staff in the Compliance Department participate in regular external training to ensure that their auditing, investigative, and regulatory interpretation skillsets are up to date. ~~The Compliance and~~ Fraud Prevention Officer participates in compliance leadership training annually as well.

~~As a result of COVID-19, the physical location of staffs' place of work remains dynamic. In response, PHC maintains staff training regarding working remotely, including how to handle PHI. This training covers best practices and reminders on existing privacy related policies.~~

Specialized Training
Workforce members may receive additional compliance training as is reasonable and necessary based on the scope of their job function and duties or as necessitated by improvement opportunities or non-compliance. The Compliance Plan and compliance policies and procedures are accessible to workforce members via, PHC's intranet.

In addition to maintaining an internal/external policy on how to report potential or actual compliance incidents and the training methods described within this Compliance Plan, PHC may provide specialized training to the Commission, delegates, subcontractors, and/or providers to ensure

appropriate response and reporting of compliance inquiries and potential or actual non-compliance.

Commissioner Compliance Training
The Clerk to the Commission (*Board Clerk*) provides new commissioners with a copy of the Compliance Plan, The Code of Conduct, and Confidentiality Agreement upon their appointment. PHC's Compliance Officer, or designee, provides a general overview of the Compliance Program to all Commission members on an annual basis.

Provider Compliance Training
Under the direction of the Senior Director of Provider Relations, providers shall be familiarized with the PHC Provider Manual. This information is available on the provider section of the external PHC website. Providers are encouraged to make available and/or disseminate copies of the Provider Manual to their employees, agents, and subcontractors that furnish items or services to PHC or its members. Individual and group providers are encouraged to provide compliance training to their employees using these tools.

In compliance with the Deficit Reduction Act (DRA) of 2005, Providers are given a copy of PHC's False Claims Act policy (CMP-07) through the Provider Manual.

Failure to Participate in Annual Training
RAC & HR Departments will make a good faith effort to ensure all workforce members participate in annual compliance training. Workforce member training is tracked through the LMS and monitored by RAC for completion. If identified as having failed to participate in the annual training, the workforce member's direct report is contacted. Failure to complete annual training within a reasonable amount of time may be reported at the Compliance Committee. Additionally, the Compliance Officer may discuss training non-compliance with department directors. Non-completion of ~~Continued non-compliance with~~ training requirements may require the development and imposition of a corrective action plan.

Diversity, Equity and Inclusion Training
Under the direction and leadership of the HEO, each staff member is required to complete sensitivity, diversity and cultural competency trainings.

Documentation
RAC and/or HR shall maintain documentation of workforce member training and education via electronic means or hard copy signed attestations and/or sign-in sheets.

Other Education Program Communications
When appropriate, PHC informs workforce members and affiliates of any relevant federal and state fraud alerts and regulatory guidance, pending/new legislation reports, updates, and advisory bulletins through regular operations meetings, ad hoc workgroups, and/or via electronic communication as appropriate. -

- PHC uses electronic communication and/or other forms of communication (as appropriate) to inform workforce members and affiliates of changes in applicable federal and state laws and regulations.
- PHC informs workforce members and affiliates that they can obtain additional information

from the Compliance Officer. Any questions, which cannot be answered by the Compliance Officer, shall be referred to the Compliance Committee.

COMMUNICATION

The Compliance Program, including provisions of the Compliance Plan, is implemented and maintained on behalf of PHC by the Compliance Officer and through the Compliance Committee.

Distribution of Compliance Plan

Workforce members and the Commissioners

The Compliance Plan, Code of Conduct, and policies and procedures are made available on the PHC intranet. Workforce members receive compliance training, the Compliance Plan, and the Code of Conduct during the New Hire Orientation and annually thereafter.

A copy of this Compliance Plan, Code of Conduct, and Confidentiality Agreement is distributed to the Commission member(s) upon their appointment, and annually thereafter for review and approval. PHC's Compliance Officer or Clerk of the Commission shall have responsibility to distribute and obtain a signed Confidentiality Agreement from the Commission annually.

Annual Attestation

PHC requires that the Compliance Plan and Code of Conduct and applicable policies and procedures be affirmed each calendar year. The Compliance Plan and Code of Conduct is reviewed by workforce members annually. At the time of annual distribution, recipients will be advised of any changes. Each workforce member shall attest to their understanding of and compliance with these documents.

REPORTING

Disclosure, Confidentiality and Non-Retaliation Establishment, and Publication of Reporting System

PHC has established various avenues for the reporting of privacy incidents, FWA, misconduct or other compliance violation(s). This reporting system provides several lines of "upstream" communication to ensure an effective collection of possible misconduct. Confidentiality, when requested, will be honored to the extent allowed by law. PHC workforce members and the Commissioners have an affirmative duty and are directed in the Code of Conduct, and policies and procedures to report compliance concerns, questionable conduct or practices, and suspected or actual violations immediately upon discovery.

The various means of reporting are described below:

Open Door Policy

All PHC workforce members are notified upon hire, and annually thereafter of PHC's open door policy. This is incorporated into new hire onboarding and training. All workforce members may approach their supervisor, manager, or director with any issue. PHC encourages check-ins with supervisors, managers, or directors regarding compliance issues, complaints, or questions. Management staff is trained to handle these situations and forward any necessary information to the Compliance Officer and/or RAC for review and/or investigation. Dedicated staff members are assigned to investigate and forward reports of potential or actual privacy incidents and FWA to the State or Federal Government, as applicable.

Compliance Hotline

PHC has an anonymous telephone hotline (Compliance Hotline) for PHC workforce members, affiliates, and members, and other interested persons to report all potential or actual violations of law and/or the Compliance Program and/or questionable or unethical conduct or practices, without limitation. The Compliance Hotline also provides an anonymous and confidential way to report concerns about potential or actual violations of PHC's business standards.

The Compliance Hotline is a toll-free number: (800) 601-2146, and is accessible 24 hours a day, 7 days a week, excluding designated holidays (when callers are routed to a voice mail message alerting them to call back during established hours of operation).

PHC makes information about the Compliance Hotline accessible through PHC's intranet, external website, member handbook, e-newsletters, and/or posting hotline posters in prominent common areas.

Notification of hotline reports are sent directly to the Compliance Officer, the Privacy Officer, and the RAC Reporting inbox.

Dedicated Reporting Resources

RAC promotes and maintains a portal for use by workforce members in reporting any compliance, privacy or FWA issues. Furthermore, RAC has a dedicated email address to receive and manage reports of any compliance, privacy or FWA issues from external parties. This dedicated email address is RAC_Reporting@partnershiphp.org.

Confidentiality, Anonymous Reporting and Non-Retaliation/Non-Intimidation

PHC takes all reports of violations, suspected violations, questionable conduct or practices seriously.

Reports of compliance issues are treated with confidentiality to the extent permitted by applicable law and circumstances. For hotline reports the caller and/or author need not provide their name or identity.

Communications via the Compliance Hotline or in writing are treated as privileged to the extent permitted by applicable law.

PHC's policy prohibits any retaliatory action against a workforce member or affiliate for making any verbal or written report in good faith. In addition, PHC policy prohibits any attempt to intimidate an individual reporting a compliance issue, for any reason.

Voluntary Disclosure and Prohibition Against Insulation

PHC workforce members are notified annually during compliance training of PHC's policy of voluntary disclosure. PHC workforce members are encouraged to disclose mistakes and misconduct to their supervisors, managers, directors or the Compliance Officer to prevent or deter FWA.

PHC takes violations of this reporting policy seriously and the Compliance Officer will review disciplinary and/or other corrective action for violations, as appropriate, with the Compliance Committee or Chief ~~Senior Director of~~ Human Resources Officer.

MONITORING

Each PHC department is responsible for implementing controls and oversight mechanisms to ensure compliance with governing requirements for their respective functions. Additionally, RAC facilitates an internal oversight function designed to detect inconsistencies and/or non-compliance with contractual and regulatory requirements, accreditation standards, and policies and procedures.

RAC, in coordination with the Compliance Committee, is responsible for assisting in the development and maintenance of regular auditing and monitoring activities, through the use of a risk assessment reviewed by the Compliance Committee. RAC is responsible for developing, implementing and maintaining governing monitoring and auditing policies and procedures as approved by the Compliance Committee.

It is the responsibility of the Compliance and Fraud Prevention Officer to report compliance and risk related information in a format sufficient to satisfy the interests or concerns of the Commission and to fit their capacity to review that information.

Monitoring Systems

Organizational Monitoring

Potential compliance issues are identified, through regular monitoring and Rreports of potential or actual compliance violations, unethical conduct, privacy, FWA, and/or questionable conduct made by workforce members and/or affiliates in writing or verbally, formally or informally. They, are subject to review and investigation as provided below, as needed, in consultation with legal counsel, by PHC's Compliance and Fraud Prevention Officer and/or their designee.

The Compliance and Fraud Prevention Officer will work under the supervision of the CEO to investigate potential issues reports and initiate follow-up actions as appropriate.

Internal Monitoring

Department directors regularly review internal status/progress reports to ensure compliance and efficiency in departmental activities. "Red flags" that are identified in these reports are reviewed by the department director and/or specially trained staff to determine if misconduct has occurred. Instances of FWA or other misconduct are investigated by the department director and reported to RAC. As necessary, a report is prepared and brought before the Compliance Committee. Corrective actions may be applied by the reviewing department director under the direction of the Compliance Committee. Resolution of cases identified for possible or actual FWA are reported to the Compliance Committee at the next quarterly meeting.

Oversight of Delegated Activities

While PHC remains ultimately responsible for the obligations of the DHCS Medi-Cal contract, PHC may elect to delegate certain responsibilities. Under the context of the DHCS Medi-Cal contract and/or NCQA accreditation, PHC may give the authority of performing certain functions and/or processes to external entities, known as subcontractors and/or delegates. Before entering into such an

agreement, PHC shall assess the capacity of a potential subcontractor/delegate to perform proposed responsibilities. PHC maintains agreements, inclusive of a mutually agreed upon reporting calendar, with subcontractors and/or delegates to enforce compliance with contractual, legal, and regulatory requirements and applicable Plan policies. Furthermore, PHC maintains policies that govern the oversight requirements of subcontractor/delegate relationships, including regular monitoring and auditing, escalation of compliance issues and related corrective action plans, and administrative sanctions and penalties. Other programmatic documents include a matrix of delegated responsibilities by entity, a calendar of annual audits, tracking of corrective action, and a master calendar of reporting deliverables.

RAC, in coordination with subject matter experts from respective functional areas, ensures the regular oversight of subcontractors/delegates. No less than quarterly, evidence of oversight, monitoring, and/or auditing activities, including identification of deficiencies, improvement opportunities, and corrective actions (recommended or imposed) shall be presented to DORS. Any recommendations for the imposition of administrative or financial sanctions, up to the revocation of the agreement, shall be reported to DORS for review. Upon acceptance of recommendation, matters shall be escalated in compliance with applicable PHC policy and procedure.

Please see *Attachment C* for a schedule of Delegate Audits planned for the year2024.

Availability of Records

PHC and its delegate and provider records are available for review by regulatory agencies, or their designee. Records are maintained according to the contractual obligations specified under contract with DHCS and/or between PHC and the provider, and are not kept for a period of time less than that mandated by applicable federal and/or state law.

Records under Medi-Cal are maintained for 10 years.

Minimum Use

PHC has policies and procedures that regulate minimum use by workforce members and affiliates. Compliance with these requirements is regularly discussed during the PTAS Subcommittee and Compliance Committee meetings.

Audit Systems

Internal Audits

In order to comply with its regulatory and contractual requirements, PHC conducts periodic internal audits of its operations. Audits may be routine or ad hoc, depending on the needs of PHC, the function/department that is being assessed, or pursuant to a regulatory agency request, notification, or alert. Audits are based on assessed risk, contractual or regulatory obligations, or PHC policies and procedures.

Please see *Attachment D* for a schedule of Internal Audits planned for 2024.the year.

External Audits

Compliance with Contractual Requirements

As a Medi-Cal managed care plan, PHC maintains a contract with the Department of Health Care Services (DHCS). PHC undergoes annual audit by DHCS to ensure compliance with contractual and regulatory requirements. RAC is responsible for coordinating audits as conducted by DHCS. Results from the DHCS audit are referenced in the development, maintenance and as needed, modification of auditing plans.

Separate from the annual DHCS audit, PHC undergoes an annual Financial Audit that is conducted by an outside Certified Public Accounting Firm. The results of this audit are reported directly to the Commission.

Subcontractor and/or Delegate Oversight

PHC ensures subcontractor and/or delegate compliance with governing requirements. PHC policies and procedures, and nationally recognized accreditation requirements through regular monitoring and at least annual auditing. PHC maintains policies and procedures, an auditing calendar, and audit work plans that govern the auditing process.

Evidence of subcontractor and/or delegate oversight activities, including audit outcomes are presented to DORS no less than quarterly for review and as needed, recommendation of corrective action. DORS committee minutes are reported to the Compliance Committee.

Please see *Attachment D* for a schedule of delegate/subcontractor audits planned for ~~2024.~~the year.

Government-Identified Risk Areas

The Compliance Officer or designee monitors for specific compliance issues identified by health care regulatory agencies. This includes, but is not limited to areas of risk identified in the OIG's Annual Work Plan, specifically the OIG's Medicaid Managed Care and State Management of Medicaid work plan, the results of managed care organization oversight as conducted by health care regulatory agencies, and compliance issues identified and reported to RAC.

PHC Monitoring and Auditing Work Plan

PHC maintains policies, procedures, and a monitoring and auditing work plan that includes:

- Summary of internal monitoring processes;
- Calendar of internal and external audits;
- Audit narrative, including:
  - Audit objectives
  - Scope and methodology;
- Staff responsible for specific audits
- Audit tools and workbooks;
- Strategy to monitor and audit PHC's subcontractors and/or delegates; and
- Process for developing follow-up and corrective action.

The monitoring and auditing plan is modified based on risk assessment and/or recommendation from leadership. The risk assessment is used to determine which areas of PHC's business may be susceptible to privacy, FWA or other non-compliance risks. Audit guides, experiences of other COHS plans, resources developed by regulatory agencies and other health care industry standards, are all referenced to identify high-risk areas. RAC with input from PHC leadership and the Compliance Committee, prioritizes the monitoring and auditing strategy based on assessed risk/vulnerabilities and available resources.

Areas in PHC's business that are found to be deficient are reviewed for redress. Recommendations or corrective actions and/or sanctions may be required depending on the severity of the findings and shall be reviewed and imposed under the authority of the Compliance Committee and/or the CEO in accordance with applicable state and/or federal regulations and PHC policy and procedure.

Actions taken as a result of the audit work plan are tracked to evaluate the success of interventions. A report on internal or regulatory monitoring and auditing results are presented to the Compliance Committee in the quarter following the finalization of the audit report.

Compliance Program Annual Review

Through regular reporting of RAC activities and statistics, the Compliance Committee oversees the

effectiveness of the Compliance Program that includes an annual review of this Compliance Plan.

The Compliance Plan's functionality will be reviewed to ensure that best efforts are made to protect PHC from FWA and privacy risks and other misconduct that could endanger PHC, delivery of services, members, providers, and other affiliated parties.

Participation Status Review and Background Checks

PHC does not knowingly hire, contract with, or retain on its behalf, any person or entity that is currently suspended, excluded or otherwise ineligible to participate in federal and/or state health care programs; and/or has ever been excluded from participation in federal and/or state health care programs based on a mandatory exclusion.

Under the direction of the ~~Senior Director of~~Chief Human Resources Officer, PHC conducts participation status reviews upon hiring of new workforce members and monthly thereafter, to ensure individuals are not excluded or do not become excluded from participating in federal and state health programs.

Under the direction of the Senior Director of Provider Relations, verification of a provider's eligibility to contract with PHC is facilitated by Provider Relations through the credentialing and re-credentialing and regular exclusion/sanction checks, no less frequently than monthly. Consistent with applicable requirements, providers found to be ineligible or excluded are reported to the appropriate oversight agency. Payments made by PHC (i) to excluded persons or entities; or (ii) for items or services furnished at the medical direction; or (iii) on the prescription of an excluded or suspended physician are subject to repayment/recoupment.

The Clerk of the Commission conducts participation status reviews upon appointment of members to the Commission, and monthly thereafter, to ensure commissioners are not excluded or do not become excluded from participating in federal and state health programs.

Workforce members are required to notify the HR Department if, after hiring their ability to participate in federal and/or state health care programs changes. In the event PHC discovers the status of any workforce member no longer permits them to work for PHC, corrective actions will be taken.

ENFORCEMENT

Conduct Subject to Enforcement and Discipline

Commissioners may be subject to removal; workforce members to discipline, up to and including termination; and providers, subcontractors, and/or delegates to contract termination for non-compliance, including but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws, or failure to seek recoupment of known overpayment of a claim involving federal or state Medicaid funds;
- Conduct that results in a violation or violations of any other federal or state laws or contractual requirements relating to participation in federal and/or state health care programs;
- Failure to report potential or actual violations of the Compliance Program or applicable laws or to report suspected or actual FWA issues to an appropriate person; and
- Failing to disclose a conflict of interest.

Enforcement and Discipline

PHC maintains a "zero tolerance" policy towards any illegal conduct that affects the operation, mission, or good standing of PHC. Any workforce member or affiliate engaging in a violation of laws or regulations is subject to discipline scalable to the severity of the violation, up to and including, termination of employment or of their contract. PHC will accord no weight to a claim that any improper conduct was undertaken for the benefit of PHC. Such conduct is not for PHC's benefit and is expressly prohibited.

PHC maintains a policy on workforce member conduct and work rules which specifies unacceptable workforce member behavior. Necessary discipline is determined by the ~~Senior Director of HR.~~Chief Human Resources Officer. In determining the appropriate discipline or corrective action for any violation of the Compliance Program or applicable law, PHC will not take into consideration a particular persons or entities economic benefit to the organization.

Workforce members and affiliates should also be aware that violations of applicable laws and regulations, even unintentional, could potentially subject them or PHC to civil, criminal, or administrative sanctions and penalties. Further, violations could lead to suspension or exclusion from participation in federal and/or state health care programs.

INVESTIGATIONS AND REMEDIATION

Notice of Potential or Actual Violation

If a PHC workforce member or affiliate becomes aware of a potential or actual compliance issue, violation or questionable or unethical conduct in violation of the Compliance Plan or applicable law and program guidance, individual or entity shall notify PHC immediately. The commissioner, workforce member, or affiliate may report any violation, suspected violation, or questionable conduct to their immediate supervisor or director, including the Compliance Officer or RAC, by direct verbal or written report. Such reports may also be made to the Compliance Hotline.

Response to Notice of Violation or Suspected Violation

Upon receipt of a report of non-compliance (whether a general compliance issue, HIPAA or FWA), RAC is responsible for reviewing and ~~, and~~ investigating the issue and beginning the corrective action process. High-risk issues, including but not limited to, workforce member misconduct, may be reported directly to the Compliance and Fraud Prevention Officer or Chief ~~Senior Director of~~ Human Resources Officer for investigation as appropriate.

RAC will work with the appropriate PHC workforce members and/or affiliates to remediate any current or potential for future instances of non-compliance.

Reported issues are tracked by RAC for routine reporting on a quarterly basis to the Compliance Committee. In addition, statistics on compliance issue reporting are provided to the Commission for regular review.

Any identification of deficiencies, improvement opportunities, and corrective actions (recommended or imposed) shall be reported to the (sub)committee with subject matter jurisdiction and as necessary, forwarded to the Compliance Committee for further action. Any recommendations for the imposition of administrative or financial sanctions, penalties and/or corrective action, up to the revocation of the agreement, shall be reported to the subcommittee with subject matter jurisdiction for review and as appropriate, forwarded to the Compliance Committee and/or CEO for review and final action. It is the responsibility of the ~~Senior Director of~~Chief Human Resources Officer or their designee to implement any disciplinary action with regard to workforce member misconduct.

FRAUD

PHC must comply with specific regulatory requirements pertaining to FWA prevention. Such regulations dictate the investigative, reporting and monitoring activities related to FWA prevention. PHC's approach to identifying and monitoring potential fraud activity is multi-faceted.

Fraud, Waste, and Abuse Program (FWA)

PHC's workforce has the responsibility to understand their job functions and associated processes in order to identify irregularities in the practices of workforce members, affiliates, and members to report any potential FWA to RAC. PHC's approach to identifying and monitoring potential fraud activity is multi-faceted and further detailed in the Fraud Prevention Program, which is included as *Attachment B* to the Compliance Plan. The FWA program was established to detect and receive reports of suspected fraud, and conduct an initial investigation. RAC maintains a tracking system and records all reported allegation of fraud.

FILING SYSTEMS

The Compliance Officer, in coordination with the Security and Privacy Officer as appropriate, will establish and maintain a filing system (or systems) for all compliance- related documents. Records retention is handled according to PHC's contractual and regulatory obligations. Records related to the Compliance Program, including edits to the Compliance Plan, minutes of Compliance Committee meetings, documentation of education, and similar documentation is maintained for no less than 10 years, pursuant to CMS requirements.

RISK ASSESSMENT

~~*Risk Assessment Process*~~ *Basis for the Compliance Risk Assessment*

As a Medi-Cal managed care plan (MCP), Partnership is obligated to regularly assess and mitigate risk posed to the privacy, security, and compliance programs. The annual risk assessment facilitated by RAC is focused on activities in alignment with the Compliance Plan and does not consider the privacy and security programs, which are assessed separately. This risk assessment informs the internal auditing and monitoring schedule for each calendar year.

Methodology

The risk assessment is informed by a combination of external sources, which include oversight priorities, actions, and trends published by oversight agencies, publicly posted enforcement actions, and input from internal stakeholders. Input from internal stakeholders was gathered through a survey from organizational leaders over a three-week period. When ranking potential risks, RAC considers factors such as the likelihood of occurrence, detectability, and potential impact on reputation, finances, and legal standing. It also evaluates existing controls and the scalability across the organization. While this risk assessment measures potential threats for a point in time, RAC engages in ongoing risk assessments throughout the year, and pivots auditing and monitoring priorities to ensure appropriate and timely mitigation.

Responding to Identified Risks

Risks identified through the annual risk assessment and/or continuous assessment activities are first triaged by the RAC Department. RAC makes recommendations or takes action to mitigate reported risks. This may include additions to the auditing and monitoring calendar or referrals to impacted departments with jurisdiction for the affected domains. Whether mitigation is facilitated by RAC directly or in collaboration with other departments, RAC retains responsibility to oversee that identified risks are tracked to resolution.

~~This year RAC conducted an initial account of the compliance landscape and potential~~ risks ~~to the plan and specifically, the Compliance Program. This account took into~~ consideration ~~changes to the health care delivery system, both voluntary and mandatory,~~ and ~~those activities which have the potential to affect PHC such as, benefit~~ implementation~~, member experience, regulatory compliance, and operational~~ infrastructure~~. This assessment informed RAC's development of a risk assessment tool to~~ identify ~~organizational and regulatory risks.~~

~~*Risk Priorities Identified*~~

~~Although there are a myriad of potential risks and areas of concern for PHC, the focus is on our collaboration with operational departments to support their preparation for the many proposed~~ changes ~~demanded by the external environment.~~

~~The identified top operational and regulatory priorities are:~~

1. ~~**DHCS 2024 Contract Restatement:** PHC has prepared, submitted, and implemented~~

hundreds of deliverables in demonstration of operational readiness regarding the 2024 contract. Focus areas include, but are not limited to:

- Program integrity and fraud prevention;
- Diversity, health equity, and inclusion;
- Subcontractor delegate transparency and oversight including that of financial oversight;
- Emergency/disaster preparedness and response;
- Board of commissioner responsibilities and governance of specific programs; and
- Network provider management and oversight.

2. **Cyber Security:** PHC had a significant system disruption in March 2022 impacting all aspects of our operation In addition, the Health and Human Services (HHS) Office of Inspector General (OIG) Work Plan 2023 highlighted their priorities as it relates to cyber security. In the current climate and cybersecurity risks throughout the health care industry, it is important that PHC assess the preparedness and responsiveness of providers and subcontractors.

New Claims System Implementation: PHC is embarking on the implementation of a new core system, which not only constitutes a significant financial investment, it will impact all operational departments. This was identified in the 2019 assessment as the number one priority and continues to be top of mind as PHC prepares for the new core system implementation in quarter two of calendar year 2024.2025.

3. **Cyber Security:** PHC had a significant system disruption in March 2022 impacting all aspects of our operation In addition, the Health and Human Services (HHS) Office of Inspector General (OIG) Work Plan 2023 highlighted their priorities as it relates to cyber security. In the current climate and cybersecurity risks throughout the health care industry, it is important that PHC assess the preparedness and responsiveness of providers and subcontractors.

3. Medi-Cal Delivery System Reform/California Advancing and Innovating Medi-Cal (CalAIM): this is a multi-year initiative by DHCS to standardize the benefit delivery system, reducing complexity and building flexibilities; in doing so, improve quality outcomes and reduce health care costs. In addition by 2026, Medi-Cal managed care plans will be responsible to coordinate care for dual enrollees in Medicare and Medi Cal by operating a Dual Special Needs Plan (DSNP). Responsibility for carrying out DHCS led initiatives are passed through to managed care plans like PHC, necessitating our prioritization of operations and strategic goals in close alignment with our regulator. This effort necessitates PHC build resources, knowledge, and invest into benefits, programs, and in some cases, regulators with little to no historic familiarity.

4. **Geographic Expansion – County Plan Model Changes**: as a result of DHCS' request for proposals regarding Medi-Cal managed care plan (MCP) contract procurement and county

led MCP model changes, starting January 2024, PHC, operating as a county organized health system (COHS), will be the Health Plan for 10 additional counties in Northern California. This has necessitated PHC's investment into and demonstrated readiness of infrastructure, community familiarity, resources, and financial solvency.

By identifying key priorities, the RAC team can take proactive steps towards managing and mitigating risk. The RAC team wants to serve as partners in these key initiatives and support in the successful implementation.

A component of our risk assessment is to be actively engaged in the implementation and oversight of these initiatives. Any issues that come to our attention will be addressed at the Compliance Committee.

ATTACHMENT A

COMPLIANCE COMMITTEE CHARTER

PURPOSE

The Compliance Committee (Committee) has the fiduciary responsibility to oversee Partnership HealthPlan of California's (PHC) regulatory Compliance Program and shall ensure the establishment and maintenance of a regulatory compliance program that constitutes part of an "effective compliance program." Specifically, the Committee shall be primarily responsible for overseeing, monitoring and evaluating PHC's compliance with all regulatory and contractual obligations of PHC (federal, state and local), as applicable.

AUTHORITY AND RESPONSIBILITIES

Among its authority and responsibilities, the Compliance Committee shall:

1) Oversee the development, review, evaluation, and implementation of the annual, plan-wide, Compliance Program.

2) Assist the Compliance Officer in developing and maintaining written policies and procedures, which provide guidance and promote PHC workforce members and affiliates awareness of and compliance with all applicable laws, regulations, guidance, and contractual obligations. The Committee has final review and approval authority of PHC's compliance policies and procedures, and ensures regular review and updates, as applicable. As appropriate, the Compliance Committee participates in the review and approval of policies and procedures that are required under any contract with government agencies for PHC lines of business, or plan-wide policies and procedures.

3) Receive, review, and act upon reports and recommendations from the Compliance Officer, subcommittees, and workgroups regarding compliance and/or ethics issues generated through internal and external audits, monitoring, and individual reporting or referrals. Assists the Compliance Officer in developing initiatives to detect and prevent fraud, waste, and abuse across all lines of business.

4) The Compliance Committee is responsible for maintaining the Code of Conduct, subject to the ultimate authority of the Board of Commissioners (the Commission).

5) Assist the Compliance Officer in identifying and mitigating potential compliance and regulatory risk areas.

6) Recommend and monitor the development of policies and procedures to govern its operations as a Compliance Committee.

7) Advise the Compliance Officer in the development and implementation of general and specialized compliance and regulatory training materials related to specific compliance issues and risk areas.

8) Has the authority to conduct any investigation appropriate to fulfill its responsibilities and has direct access to anyone in the company, as well as, any third party who may perform compliance related consulting services for the company. The Committee shall retain the services of attorneys, accountants, consultants, and other professionals as needed to ensure compliance with applicable laws.

9) Respond appropriately if a violation is uncovered, including proper reporting of violations of law to the duly authorized law enforcement or regulatory agencies.

10) Maintain a working knowledge of relevant compliance issues, laws, regulations, and contractual obligations.

11) Perform other functions as reasonably necessary to assist the Compliance Officer in fulfilling the intent and purpose of the Compliance Program.

12) Ensure that legal counsel is consulted as appropriate and that all applicable privileges are preserved, including the attorney-client privilege and/or work product doctrine.

GOVERNANCE, STRUCTURE AND ORGANIZATION

The Chair of the Compliance Committee shall be PHC's Compliance Officer or their designee. The Chair, in consultation with other members of the Committee, will determine the frequency and duration of the meetings of the Committee and the agenda of items to be addressed at each meeting.

Committee Structure: To promote compliance with state and federal regulations, contractual obligations, and industry practices, the Committee shall have a director or above (or his/her designated proxy), represented from all PHC operational departments.

The following groups shall report meeting minutes and other relevant materials or details, as applicable, to the Compliance Committee at all regularly scheduled meetings:*

- Delegation Oversight Review Sub-Committee (DORS)
- Fraud, Waste, and Abuse Sub-Committee (FWA)
- Physical, Technical, and Administrative Safeguards (PTAS)
  - Sub-Committee

**Above list is subject to change, and shall not be considered an exhaustive list*

Meetings Schedule: The Committee will meet no less than four times per year. A majority of the members, or at minimum, half of the Committee, present in person or by means of a conference call or other communication equipment by means of which all persons participating in the meeting can hear each other, shall constitute a quorum.

Agenda and Minutes: The Chair shall preside over the meetings of the Committee and shall appoint a secretary (who need not be a member of the Committee) to take written minutes of the meetings. The Committee shall maintain minutes of its meetings and records relating to those meetings.

MEMBERSHIP

- Chief Executive Officer
- Chief Operating Officer
- Chief Strategy & Government Affairs Officer
- Chief Financial Officer
- Chief Medical Officer
- Chief Information Officer
- Chief Health Services Officer
- ~~Senior Director of Human Resources~~ Chief of Human Resources
- Senior Director of Behavioral Health ~~Administrator~~
- Regional Directors ~~– Northwest, Northern, Central, Eastern, Southwest, and Southeast, Administration (Santa Rosa)~~
- Senior Director, Provider Relations
- Director of Network Services
- ~~Director, Health Services~~ Senior Director of Care Management
- Senior Director, Member Services
- Director, Member Services
- ~~Director, Provider Relations~~
- Director, Pharmacy Services
- Senior Director of ~~Compliance and~~ Regulatory Affairs and Contracting (also serves as the Compliance Officer) **Chair*
- Senior Director, Claims (SR)
- Director, Claims (NR)
- Director of Configuration

- Director of Program Management Office (OpEx/PMO)
- ~~Associate~~ Director of Grievance and Appeals
- Manager of Quality Assurance and Patient Safety
- Director of Internal Audit
- ~~Regional Manager, Administration (Eureka)~~

Partnership HealthPlan of California
ATTACHMENT B

FRAUD PREVENTION PROGRAM

As a Medi-Cal managed care plan, contracted with the Department of Health Care Services (DHCS) for the administration of Medi-Cal benefits, PHC must comply with specific regulatory and/contractual requirements pertaining to Fraud Waste and Abuse "FWA" prevention. Such requirements dictate the investigative, reporting and monitoring activities related to FWA prevention. PHC's approach to identifying and monitoring potential fraud activity is multi-faceted.

PHC's FWA Program was developed in consideration of State and Federal laws and regulations as well as Centers for Medicare and Medicaid Services (CMS) and Medi-Cal requirements. PHC uses the following definitions:

Abuse – per DHCS 2024 Operational Readiness Contract 22-20196, "DHCS Contract," means any provider practices that are inconsistent with sound fiscal, business, or medical practice, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes member practices that result in unnecessary cost to Medicare or Medi-Cal.

Fraud – per DHCS contract, means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the individual or other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste – per DHCS contract, means an overutilization or misuse of resources that results in unnecessary costs to the healthcare system, either directly or indirectly.

A. Relevant Federal and State Laws and Regulations

PHC must also address relevant laws pertaining to fraud, waste, and abuse to include:

The Affordable Care Act requires providers, suppliers, Medicare Advantage plans, and Medicare Part D plans to report and return Medicare and Medicaid overpayments within 60 days of awareness.

Federal False Claims Act prohibits knowingly presenting or causing to be presented to the Federal government a false claim for payment or approval, knowingly making or using or causing to be made or used a false record or statement to have a false or fraudulent claim paid or approved by the government, and knowingly making or using or causing to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government. The False Claims Act defines "knowing" and "knowingly" to mean that a person with respect to the information: 1) has actual knowledge of the information, 2) acts in deliberate ignorance of the truth of falsity of the information, or 3) acts in reckless disregard of the truth or falsity of the information, and 4) no proof of specific intent to defraud is required. See PHC policy CMP07 False Claims Act for more information.

The Deficit Reduction Act requires PHC to disseminate information to employees and FDRs, about our mutual roles and responsibilities to detect and prevent fraud, waste, and abuse in the healthcare system.

California False Claims Act (California Government Code §12650-12656) was enacted by California to enhance the State's ability to recover and impose penalties upon the "knowing" submission of false claims to state or local government programs, including Medi-Cal and was modeled after the Federal False Claims Act. See PHC policy CMP07 False Claims Act for more information.

Federal Anti-Kickback Statute prohibits anyone from knowingly and deliberately offering, giving, or receiving remuneration in exchange for referrals or healthcare goods or services that will be paid for in whole or in part by Medicare or Medicaid.

Federal Stark Law prohibits a physician from referring patients to a facility (such as a clinical laboratory) in which the physician has a financial or ownership interest. The law applies when the facility receives reimbursement from Medicare or Medicaid. The underlying assumption of the law is that allowing such referrals would lead to unnecessary tests and increase costs. A violation of the law is a civil penalty rather than criminal penalty.

Fraud Enforcement & Recovery Act (FERA) is a public law that was enacted in 2009. The law enhanced criminal enforcement of federal fraud laws, especially regarding financial institutions, mortgage fraud, and securities fraud or commodities fraud.

Health Insurance Portability and Accountability Act (HIPAA) established the national Health Care Fraud and Abuse Control Program (""HCFAC"") to coordinate federal, state, and local law enforcement activities with respect to healthcare fraud and abuse. HIPAA also enacted an additional prohibition of healthcare fraud, forbidding knowing and willful acts to defraud a healthcare benefit program by false or fraudulent pretenses. Note: HIPAA also protects and safeguards the information health plans, and other covered entities, maintain and transmit about members, whether in paper, electronic or any other form. Member information must be kept confidential and its use and disclosure is only permitted, as required, by state and federal laws and regulations.

Health Information Technology for Economic and Clinical Health (HITECH) Act enacted as part of the American Recovery and Reinvestment Act of 2009, imposes notification requirements on covered entities, business associates, vendors of personal health records, and related entities in the event of certain security breaches relating to protected health information (PHI).

B. Fraud Prevention Officer

The PHC Fraud Prevention Officer , is responsible for developing, implementing, and ensuring the maintenance of program integrity activities including FWA in accordance with applicable laws, state and federal statutes and regulations, and contractual obligations. The Fraud Prevention Officer reports directly to the CEO and retains the authority to report matters directly to the Board of Commissioners, "the Commission," at any time. The Fraud Prevention Officer also attends and participates in DHCS' quarterly program integrity meetings, as scheduled and attends the California Department of Justice (DOJ)Managed Care Anti-Fraud trainings, as scheduled.

C. PHC Workforce Members

PHC's workforce, which includes PHC employees, volunteers, temporary personnel, interns, and/or member of the PHC Board of Commissioners, has the responsibility to understand their job functions and associated processes in order to identify irregularities in the practices of workforce members network providers, subcontractors/delegates, or members, in order to report any potential FWA to Regulatory Affairs and Compliance (RAC). PHC's approach to identifying and monitoring potential fraud activity is multi-faceted. The FWA program was established to receive and conduct investigations regarding reports of suspected fraud, which may include collaboration from various PHC departments. A RAC maintains a tracking system and records all reported allegations of fraud.

D. Training and Education

To promote awareness of and adherence with PHC's Fraud Prevention Program, PHC must ensure that fraud, waste, and abuse training and education is provided to workforce members in accordance with PHC Policy CMP28 Training Program Requirements.

E. Fraud Detection

The foundation of fraud detection is rooted in knowing what can go wrong and who may be responsible for wrongdoing. Structural elements of fraud detection include:

- Knowing what opportunities exist and understanding the systems and controls designed to minimize the opportunities; and
- Knowing the symptoms or patterns of the occurrence both at the individual and system level; ensuring workforce members are versed in problem spotting and building/maintaining programs to identify patterns.

PHC believes that knowing what can go wrong consists of identifying fraud indicators that warrant closer scrutiny, including the types of fraud, common fraud schemes and trends, "red-flags" and situations leading to potential fraud.

PHC remains apprised of trends or "global" schemes in Medicaid (Medi-Cal), Medicare or healthcare fraud and abuse as reported in newspapers, journals, through CMS Fraud Alerts, and other publications.
To monitor and detect potential or actual fraud, waste, and abuse, the PHC FWA Plan includes the following key elements, in addition to those set forth in PHC policy CMP09 Investigating and Reporting Fraud, Waste, and Abuse:

- Implement pre- and post- payment claims editing within the claims adjudication system to monitor claims for billing errors such as unbundling, double billing, the inappropriate use of modifiers, and the correct Diagnosis Related Grouping (DRG) assignment.
- Develop and maintain methods to verify that services that have been represented as rendered have been delivered, which may include but is not limited to, random sampling of medical records and chart notes, member surveying, and electronic visit verification, as applicable.
- Investigate State, Federal, and other industry referrals regarding fraud, waste, and abuse.
- Analyze claims history to identify provider outliers in service levels for members based upon current healthcare needs.
- Complete credentialing and regular exclusion/sanctions validations for all contracted network providers.
- Review contracts to include full disclosure of conflicts of interest, prices, and assure contractors understand the PHC's requirement related to the Compliance Program including the FWA Plan.
- Review appeals and grievances reports to identify case referrals to the Compliance Department.
- Validate that OIG/GSA checks are performed on Commissioners and all workforce members.
- Identify, through the Pharmacy Department potential over utilization cases and take appropriate action.
- Provide education to PHC workforce members and network providers regarding best practices to prevent, detect, make investigative referrals, and correct fraud, waste, and abuse.
- Perform internal audits of operational departments for possible noncompliance risks as informed by PHC's risk assessment, auditing, and monitoring processes.
- Educate management on how to monitor staff activities and identify fraud, waste, and abuse risk areas.

F. Departmental Monitoring Activities and Reporting requirements

I. Monitoring activities:

Fraud detection requires that fraud be proactively sought through a variety of means. Each PHC department is responsible for taking proactive steps to detect fraud. PHC exercises diligence and actively searches for possible fraudulent behavior through the course of regular business, and as a result of fraud alerts provided by regulatory agencies, which is monitoring and communicated by RAC. Once a trend or pattern has been identified, further research is warranted to determine whether or not there is reasonable suspicion of fraudulent behavior.

II. Internal Reporting

PHC Workforce Members will report suspected FWA in accordance with CMP-09, Investigating & Reporting Fraud, Waste and Abuse.

G. Important Trends in HealthCare Fraud, Waste, and Abuse

Fraud, waste, and abuse in healthcare may happen in many places and present itself in many forms. The common perpetrators of healthcare fraud and abuse may be grouped into four categories: 1) Providers, 2) Applicants or Members, 3) Employees. Some specific examples of fraud by each category are follows:

I. Provider Schemes

Common provider schemes are identified below.

- Claim for services not rendered: Submitting claims when the services were not performed.
- Invalid services: Falsifying a patient''s diagnosis to justify tests, surgeries, or procedures that are not medically necessary.
- Invalid provider: Submitting claims for non-licensed providers under another licensed individual''s name.
- Coding substitutions: Misrepresenting procedures to obtain payment for non-covered services (e.g., cosmetic surgery).
- Un-bundling: Billing each stage of a procedure as if it were a separate treatment.
- Up-coding: Billing for a costlier service than what was actually performed.

II. Member Schemes

Common member schemes are identified below.

- ID sharing: A member "loans" their insurance ID card to a friend to obtain medical services using the member's name and ID.
- False documents: An applicant provides false information, altered ID documents, bills or receipts to get health insurance coverage.
- False claims: A member requests transportation to the doctor's office. The doctor's office is next to a mall. The member actually went ~~hen~~ shopping and used the transportation services inappropriately.
- Cash payments: A member gives his or her Medicare or Medi-Cal Identification Number to a provider who pays the member $20 a month to use the member''s information to submit false claims.

III. Employee Schemes

Employee schemes are unfortunately something that the FWA Plan must deal with in conjunction with Human Resources. Common employee schemes are identified below.

- False expense reports: An employee falsifies mileage, tolls, and lunch expenses on a company expense report, e.g., bills for a business lunch when it was actually lunch with a friend.
- Misuse of business credit cards: An employee uses the business credit card for personal expenses.
- Forgery: An employee forges a signature on an application or other document.
- Inappropriately recording time and attendance: An employee arrives at work but then takes 4 hours off at to go to a ''"meeting."'' The employee was really visiting her friend while the employee was allegedly at a business meeting.

RAC, in collaboration with the Fraud Prevention Officer, is responsible to investigate and resolve any allegation of potential or actual fraud, waste, and abuse.

ATTACHMENT C

DELEGATION OVERSIGHT AUDITING SCHEDULE

Audit activities are conducted pursuant to all requirements set forth by the delegation service agreements during the review period.

At minimum, the audit plan will include compliance oversight and review of the following:

- Program Integrity
- Policies & Procedures
- DHCS Requirements *(during review period)*
- NCQA Standards *(during review period)*
- Case File Review (*only applicable scope areas*)

The following Delegation Oversight Audit Grid demonstrates all scope areas which are subject to annual evaluation by PHC for each active delegate, and includes:

1.) The current auditable scope areas; and
2.) This year's estimated start and completion dates for the annual delegation oversight audits.

Schedule of Calendar Year 2025 Subcontractor/Delegate Audits

ANNUAL OVERSIGHT AUDITS						
DELEGATED ENTITY	**DELEGATED SCOPE AREAS**	**RESPONSIBLE DEPTS.**	**REVIEW PERIOD (*LOOKBACK*)**	**BEGIN AUDIT PLANNING**	**2024 AUDIT START DATE**	**2024 AUDIT END DATE**
Name	**Subcontracted Functions**	**PHC Department**	**Calendar Year**	**90-120 days prior to Start**	**Estimated**	**Estimated**
Dignity Health Medical Foundation ***Mercy Medical Group***	CR/Re-Cred (NCQA) ; Screen/Enroll	Provider Relations	CY 2024	Nov-2024	**Mar-25**	**Mar-25**
Lucile Packard Children's Hospital Med Group	CR/Re-Cred (NCQA) ; Screen/Enroll	Provider Relations	CY 2024	Nov-2024	**Feb-25**	**Feb-25**
Sutter Medical Foundation - SMG (Yolo & Solano)	CR/Re-Cred (NCQA) ; Screen/Enroll	Provider Relations	CY 2024	Nov-2024	**Feb-25**	**Feb-25**
Sutter Pacific Medical Foundation *(PFMA/Marin Headlands/SMG Redwoods) Palo Alto Med Foundation*	CR/Re-Cred (NCQA) ; Screen/Enroll	Provider Relations	CY 2024	Nov-2024	**Mar-25**	**Mar-25**
UCSF/Bay Childrens	CR/Re-Cred (NCQA) ; Screen/Enroll	Provider Relations	CY 2024	Nov-2024	**Apr-25**	**Apr -25**
UC Davis Medical Group (UCD MG)	CR/Re-Cred (NCQA) ; Screen/Enroll	Provider Relations	CY 2024	Nov-2024	**Mar-25**	**Mar -25**
Vision Service Plan (VSP)	CR/Re-Cred (NCQA) ; Screen/Enroll	Provider Relations	CY 2024	April 2024	**Aug-25**	**Aug-25**
Vision Service Plan (VSP) Credentialing completed by PR	Call Center/Member Services	Member Services	CY 2024	Oct-2024	**Jan-25**	**Apr-25**
	Claims/PDRs	Claims				
	Compliance-*not delegated,review in admin capacity*	RAC				
	Grievance and Appeal-*not delegated,review in admin capacity*	GA				
	Cultural&Linguistic	HECL				
	Provision of Vision Services (UM)	Utilization Management				
Adventist Health: AHCL, AHSH, AHUV & MDCH (AH)	Inpatient UM	Utilization Management	CY 2024	Dec-24	**Mar-25**	**Jun-25**
Marin General Hospital (MGH)	Inpatient UM	Utilization Management	CY 2024	Dec-24	**Mar-25**	**Jun-25**
NorthBay Medical Center & VacaValley Hospital (NBMC)	Inpatient UM	Utilization Management	CY 2024	Dec-24	**Mar-25**	**Jun-25**
Queen of the Valley Medical Center (QVMC)	Inpatient UM	Utilization Management	CY 2024	Dec-24	**Mar-25**	**Jun-25**
DOME	Network Management (NCQA)	Member Services	CY 2024	April-25	**May-25**	**Jun-25**
Napa County- Housing and Homelessness Division	CR/Call center/member services	Member Services	FY2024/2025	2/1/2025	**May-25**	**Aug-25**
	Claims	Claims				
	Compliance - *not delegated, review in admin capacity*	RAC				
	Cultural and Linguistics	Health Education				
	Net Management including New Provider Training	PR				
	Vetting	PR				
Carelon/CHIPA	Call Center	Member Services	CY 2024	2/1/2025	**1-Jun**	**Sep-25**
	Case Management/Care Coordination	Care Coordination				
	Claims/PDRs/Misdirected/Prop 56	Claims				
	CR/Re-Cred (NCQA) ; Screen/Enroll	Provider Relations				
	Cultural Linguistics	Health Education				
	Quality Improvement	Quality Improvement				

	Network Management	Provider Relations				
	G&A	Grievance & Appeals				
	Utilization Management (*as applicable*)	Utilization Management				
	Member Experience	G&A/Member Services				
	Compliance-*Delegated FWA, remaining review admin Capacity*	RAC				
CareNet	Call Center/Member Services	Member Services	CY 2024	6/1/2025	**1-Sep**	**Jan-26**
	Advise Nurse	Care Coordination				
	Compliance- *not delegated, review in admin capacity*	RAC				
	Cultural Linguistics	Health Education				

ATTACHMENT D

INTERNAL AUDIT & MONITORING WORK PLAN

As the internal audits/monitoring activities are concluded, this plan will be re-evaluated to determine if recurring audits or retesting of the business function should be conducted and at what frequency. Certain risks justify the need for annual reviews, regardless of prior internal audit results.

The following internal audit calendar provides the planned internal audits and monitoring activities ~~that includes the anticipated dates which the internal audits will commence~~ for the calendar year 2025. Unexpected ad-hoc internal audits are not listed on this grid, but updates will be shared with Compliance Committee.

Area of Impact	Risk Category	Risk Description	Oversight Recommendation	Mechanism	Targeted Quarter	Impacted Departments
Regulatory Compliance – ICD/DD SNF Updates	Regulatory Implementation	New rules to ICF/DD, SNF, and LTC facilities require the Plan to update its already updated and scrutinized policies and procedures. Furthermore, DHCS is hyper focused on MCPs providing claims technical assistance to MLTSS providers to mitigate financial hardships.	Monitoring Activity	Report	Ongoing	Multiple
Operational Infrastructure – Member Core Systems and IT updates	Information System Governance	Core system replacements like Jiva (case management) and HRP (claims) impact multiple areas of the Plan there is risk to member and provider experience, as well as, financial and regulatory exposure. This the case for our current regulator and two new regulators	Monitoring Activity	Report	Ongoing	Multiple
Regulatory Compliance – *DMHC oversight*	Service Delivery	EOC guidelines are established to assist Plans with providing covered services. Operating at variance with the EOC would cause a violation that would pose a risk to client care and cause fines, reputation and financial risks, as members may be denied care for covered services. Furthermore, these violations would expose the plan to increased grievances and legal actions	Internal Audit	Audit	Q1 2025	Multiple

Regulatory Compliance – *DHCS oversight*	Non-compliance and/or Sanctions	DHCS found the plan did not track and monitor specialty referrals requiring prior authorization through the plan. If the plan does not track and monitor specialty referrals requiring prior authorization, it may result in delay in medically necessary services. The lack of capabilities to track and monitor specialty care referrals may lead to substandard medical care and member harm.	Internal Audit	Audit	Q2 2025	Utilization Management
DHCS Auditing and Monitoring	Non-compliance and/or Sanctions	DHCS's annual audits are closely examined, as they frequently result in corrective action plans (CAPs). If findings from these audits are not addressed promptly, there is an increased risk of additional audits, particularly if issues persist across multiple reviews. Repeat findings that remain uncorrected pose a serious risk, exposing the Plan to potential sanctions and disciplinary actions. To mitigate associated risk, Compliance recommends conducting follow-up testing of areas of concern as noted on DHCS issued CAPs from the past audits to confirm both implementation and sustained compliance.	Testing	Audit	Q1 2025	Multiple

Regulatory Compliance – DMHC oversight	Non-compliance and/or Sanctions	Every plan that provides prescription drug benefits shall maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary physician administered drugs (PADs) or those billed on medical/institutional claims. In this case, the plan did not send a response to the appeal of the pre-authorization denial causing the plan to fail to maintain an expeditious process for prescribing providers to obtain authorization. DHCS has allowed Plans to facilitate PAD review using utilization management turnaround timeframes, however DHCS is now proposing to hold Plans to a 24 hour turnaround time.	Monitoring Activity	Report	Ongoing	Pharmacy
DSNP Program	Benefit Implementation	Since the start of 2024, the Plan has actively engaged in readiness activities to prepare for the forthcoming Dual-Special Needs Plan (D-SNP) program, establishing work streams to develop essential programs and implement software infrastructure changes. As Partnership expands its D-SNP program, analyzing network capacity is crucial to ensure the targeted and new populations will be served adequately. Additionally, it is necessary to identify the parties responsible for contractor and vendor oversight to ensure compliance is maintained throughout contracting and operational activities.	Monitoring Activity	Other	Ongoing	All

Regulatory Compliance – DMHC oversight	Non-compliance and/or Sanctions	The health plan has a responsibility to implement timely over turned appeal decisions -including decisions made by administrative law judges (ALJ) and internal process -including those that require claim adjustments or cross-departmental involvement Delays in providing authorized treatment can lead to worsened health outcomes, and non-compliance with timeliness exposes the plan to regulatory, reputational, and legal risks.	Internal Audit	Audit	Q2 2025	Grievance & Appeals
Regulatory Compliance – DMHC oversight	Care Delivery	MCPs have the duty to maintain a robust QI program and identify quality-of-care issues. PQI/peer review has been a recurring finding in recent audits, making it a key focus area for retesting to ensure continuous improvement and adherence to corrective actions. Inadequate quality oversight can increase member harm, poor member outcomes, and potential waste of resources if issues are identifying and addressing issues related to quality care	Monitoring Activity	Report	Ongoing	Quality Improvement
Regulatory Compliance – *DHCS oversight*	Service Delivery	The plan has a responsibility to honor member's language preferences and use approved member facing documents	Internal Audit	Audit	Q1 2025	Multiple
Regulatory Compliance – *DHCS oversight*	Non-compliance and/or Sanctions	The plan and it's delegates have a responsibility to categorize complaint and member dissatisfaction as a member grievance including on a member's behalf when a member declines to file a grievance. While Partnership has an established grievance process, as facilitated by the grievance & appeals dept., there are various entry points in which a member may request to file a grievance or in which a grievance needs to be filed on a members behalf.	Internal Audit	Audit	Q3 2025	Multiple

Regulatory Compliance – *DHCS oversight*	Care Delivery	The plan has a responsibility to gather data used to track and monitor various treatment authorizations. These prior auths include BHT services and specialty referrals which must be tracked throughout the life cycle of the member's time with the Plan. To ensure efficient care related to mental health services, the Plan must ensure behavioral health diagnostic treatment services are initiated early in the treatment of members	Monitoring Activity	Report	Ongoing	Utilization Management
Member experience	Care Delivery	Medicare gap assessment initially identified services areas that pose a risk to Partnership's reputational good standing as it relates to member experience in the areas of behavioral health services, PCP quality, and consistent experience with staff at all points of entry within the Plan. Additionally, aligns with risks reported as it relates to our ability to meet STARs requirements.	Monitoring Activity	Report	Ongoing	Multiple
Member experience	Service Delivery	The internal risk survey highlights risks to Partnership’s reputation and ability to meet DHCS expectations for a geographic coverage gap. These gaps include timely and accessible services, establishing prompt payment processes for Equity and Practice Transformation (EPT) programs, and increased transparency because of expanded QES for network monitoring. These are critical for achieving quality metrics and STAR performance.	Monitoring Activity	Report	Ongoing	Multiple

Provider capacity	Service Delivery	Internal risk survey highlights risks regarding provider capacity to support existing member needs for community supports. Furthermore, concerns with current infrastructure to oversee the delivery of community supports and provider compliance. Additionally, the lack of clear guidance from DHCS on requirements, payment structures, and hub and flex pool models is necessary to mitigate these risks.	Internal Audit	Desk Level Audit	Q3 2025	Enhanced Health Services
Provider Network Capacity	Network Provider Management	Internal risk survey highlights concerns with network provider capacity's ability to ensure access to specialized care and maintain compliance with HEDIS reporting requirements. There are concerns regarding the management of provider education, and coding acuity, which may impact care delivery, provider incentives, and overall program success. Furthermore, there are concerns with provider network capacity, geographic coverage gaps, and medical record retrieval	Monitoring Activity	Report	Ongoing	Multiple
Provider & Subcontractor Contract Implementation	Contract Implementation	Internal risk survey highlights concerns with the completeness/integrity of provider/subcontractor contract implementation and awareness by operational departments. Additionally, the lack of insight into provider contracts for utilization management and potential delays in processing claims due to updated contract changes align with risks to meeting regulatory compliance and timely payment.	Internal Audit	Desk Level Audit	Q4 2025	Multiple

Medicaid Oversight	Care Delivery	The Plan has an obligation to maintain a robust utilization management program. In particular, the Plan must ensure that a second opinion is allowed from a qualified health professional at no cost to members and that ongoing training is provided to all staff regarding NOA letter requirements. Additionally, the plan must make a decision for routine authorizations within 5 working days from receipt of the information needed to make a decision. If an extension is needed, a decision must be made in no longer than 14 calendar days from the receipt of the request.	Monitoring Activity	Report	Ongoing	Utilization Management
Quality Assurance	Change Management Implementation	Internal risk survey highlights concerns of inadequate oversight or lack of quality assurance checks which can result in inconsistent system configuration and claim outcomes, which may result in the over- and under-payment of claims, and thus impact overall provider and staff satisfaction. Inconsistent system configuration can impact the integrity and stability of the changed environment.	Monitoring Activity	Report	Ongoing	Multiple

Medicaid Oversight	Care Delivery	The Plan has an obligation to maintain a robust utilization management program. In particular, the Plan must ensure that a second opinion is allowed from a qualified health professional at no cost to members and that ongoing training is provided to all staff regarding NOA letter requirements. Additionally, the plan must make a decision for routine authorizations within 5 working days from receipt of the information needed to make a decision. If an extension is needed, a decision must be made in no longer than 14 calendar days from the receipt of the request.	Monitoring Activity	Report	Ongoing	Utilization Management
Quality Assurance	Change Management Implementation	Internal risk survey highlights concerns of inadequate oversight or lack of quality assurance checks which can result in inconsistent system configuration and claim outcomes, which may result in the over- and under-payment of claims, and thus impact overall provider and staff satisfaction. Inconsistent system configuration can impact the integrity and stability of the changed environment.	Monitoring Activity	Report	Ongoing	Multiple

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.2

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

Recommendation by:
Compliance Committee and Partnership Staff

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

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

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

Requested Action of the Board:
Based on the recommendation of the Compliance Committee, the Board is being asked to approve Partnership's Q32024 Compliance Dashboard.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date
December 4, 2024

Agenda Item Number:
4.2

Resolution Number:
24-

IN THE MATTER OF: APPROVING PARTNERSHIP HEALTHPLAN COMPLIANCE DASHBOARD FOR Q32024

Recital: Whereas,

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

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

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve Partnership's Q32024 Compliance Dashboard.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December 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

2024 Regulatory Affairs and Compliance Dashboard

Category	Description	Q1	Q2	Q3	YTD	Comments
DELEGATION OVERSIGHT	**Annual Delegate / Subcontractor Audits**	**0 / 0**	**9 / 9**	**6 / 6**	**15 / 15**	
When PHC delegates administrative functions that it is required by contract or regulation to perform, PHC retains the ultimate responsibility for the performance of these functions and must monitor and evaluate the performance of these functions when performed by a delegate.	Quarterly percentage to demonstrate the total number of annual delegate/subcontractor audits completed within 30 days following the planned months, as defined by the audit calendar.	**#DIV/0!**	**100%**	**100%**	**100%**	
	Oversight of Delegate Reporting	**27 / 28**	**19 / 19**	**14 / 14**	**60 / 61**	
	Percentage of timely submissions of regulatory reports.	**96.4%**	**100.0%**	**100%**	**98.4%**	
REGULATORY REPORTING	**DHCS Reports Submitted Timely**	**47 / 47**	**57 / 57**	**51 / 51**	**155 / 155**	
Regulatory Affairs works collaboratively with all PHC departments to implement and track the timely submission of regulatory reporting requirements to PHC's governing agencies.	Percentage of regulatory reports submitted timely by RAC to DHCS with no missed due date per RAC Master Tracker and Regulatory Reporting Calendar.	**100.0%**	**100%**	**100%**	**100%**	
	Report Acceptance Rate	**46 / 47**	**54 / 57**	**51 / 51**	**151 / 155**	
	Percentage of standard regulatory reports submitted by RAC and not rejected by DHCS for being incomplete, on the wrong template, or for other findings.	**97.9%**	**94.7%**	**100%**	**97.4%**	
HIPAA REFERRALS	**Timely DHCS Privacy Notification Filings**	**7 / 8**	**6 / 6**	**6 / 6**	**19 / 20**	
Appropriate safeguards, including administrative policies & procedures, to protect the confidentiality of PHI and ensure compliance with HIPAA regulatory requirements.	Percentage of reportable notifications that PHC filed timely within applicable DHCS required timeframe. **Initial notice within 24 hours, initial PIR within 72 hours, and final PIR within 10 business days. If any deadline is missed, it will be counted as untimely.*	**87.5%**	**100.0%**	**100.0%**	**95.0%**	Q3- 6 total reportable incidents submitted to DHCS; however, none of those incidents were deemed breaches
FWA REFERRALS	**Timely DHCS FWA Notifications**	**18 / 18**	**14 / 14**	**23 / 23**	**55 / 55**	
Regulatory Affairs oversees the Fraud, Waste and Abuse Prevention program intended to prevent, detect, investigate, report and resolve suspected and/or actual FWA in the PHC daily operations and interactions, whether internal or external.	Percentage of reportable notifications that PHC filed timely with DHCS within 10 business of discovery per contractual obligations.	**100.0%**	**100%**	**100%**	**100%**	

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

CAP Tracker

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

Updated 05/14/2024

2024 CAP Tracker

CAPS IMPOSED ON PARTNERSHIP BY REGULATORY BODIES				
Category	**Description**	**2024**		**Comments**
CORRECTIVE ACTION PLANS (CAPS)		**Date of Imposition**	**Close Date**	
2024 Netowrk readiness - member to provider ratios	Failure to meet member to provider ratios in Butte, Humboldt, Lake, Nevada, Placer, Shasta, Sutter, Tehama, and Yuba counties. 1. Non-compliant for failure to meet one FTE PCP per 2,000 Members in one or more of its service area(s) DHCS has mandated PHC compliance activities to include - must authorize out-of-network access irrespective of service or transportation cost; provide monthly status updates; receive DHCS approval of training and call scripts making members and providers aware of the CAP; submit a report of in-progress contracting to address deficiencies; and submit an analysis to determine the root cause of non-compliance.	1/30/2024	TBD	*OPEN: DHCS is recalculating ratios and will advise on Partnership's progress*
2023 Annual medical audit	4.1.1 Grievance Resolution Timeframe The Plan did not complete all levels of grievance resolution or appeal within 30 days of receiving the grievance. Partnership has updated policies and training to remove the second-level grievance process and allow members to appeal an adverse decision made as the result of a grievance.	3/26/2024	TBD	*OPEN: DHCS has approved all planned action but has not yet closed the CAP*
2023 Annual medical audit	5.1.1 Quality Improvement System Oversight The Plan did not take effective action to improve deficient QOC issues to ensure professionally recognized standards of practice are delivered to members. Partnership, in consultation with a legal expert, has updated policies and trainings related to the peer review and credentialing committees. Furthermore, has developed a PQI Inter-rater Reliability (IRR process) and CMO IRR (outcome and action) of cases brought to Peer Review Committee.	3/26/2024	TBD	*OPEN: DHCS has approved all planned action but has not yet closed the CAP*
2023 Annual medical audit - focused audit; behavioral health	2.1 - 2. 3 Care Management and Care Coordination The Plan did not ensure the provision of coordination of care to deliver mental health care services its members. Nor did the Plan follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals where warranted, including for SUD services The Plan is implementing various actions to address gaps in coordination between mental and physical health services. Key steps include policy updates addressing closed loop referrals, coordinating updates to the closed loop referral process with delegate, modifying the closed loop referral tracker, and on-going internal monitoring for process adherence	8/30/2024	TBD	*OPEN: DHCS is reviewing Plan documentation to determine deem the action sufficient or advise if more information is needed*
2023 Annual medical audit - focused audit; behavioral health	2.4 Plan MOU - policies/procedures The Plan did not comply with its Policies and procedures for the management of members care, including screening, assessment, care coordination, and the exchange of medical information. The Plan's MOU failed to address, screening, assessment, care coordination, and the exchange of medical information. The Plan is addressing gaps in executing MOUs and improving the monitoring of referrals by executing MOUs across all 24 counties per DHCS newly published template , modifying the closed loop referral tracker, and on-going internal monitoring for process adherence	8/30/2024	TBD	*OPEN: DHCS is reviewing Plan documentation to determine deem the action sufficient or advise if more information is needed*
2023 Annual medical audit - focused audit; transportation	3.1 - 3.3 NEMT—Provision of Door-to-Door Assistance The Plan did not have a process nor montioring in place to ensure that door-to-door assistance was being provided for all members receiving NEMT services. Additionally, the Plan did not ensure that NEMT members do not miss their appointments if the NEMT provider is late or does not arrive at the scheduled pick-up time for the members. Partnership, is taking several actions to address gaps identified in the audit findings related to the Non-Emergency Medical Transportation (NEMT) program. This includes policy updates, updating member and provider materials regarding door-to-door assisstance, implementing monitoring mechanisms to ensure the provision of this service, and monitoring grievance data to assess if failed rides contributed to missed appointments.	8/30/2024	TBD	*OPEN: DHCS is reviewing Plan documentation to determine deem the action sufficient or advise if more information is needed*

2024 CAP Tracker

Category	Description	2024		Comments
CORRECTIVE ACTION PLANS (CAPS)		**Date of Imposition**	**Close Date**	
CAPS IMPOSED ON INTERNAL PARTNERSHIP BUSINESS UNITS				
2023 IT Oversight of Cybersecurity Rules Internal Audit	As part of the planned audit calendar, Compliance conducted an internal audit to evaluate the effectiveness of Partnership's documented process for overseeing contractor, subcontractor, and vendor compliance with cybersecurity rules. As a result of the internal audit, Compliance has issued a CAP to address gaps surrounding oversight and control mechanisms to ensure compliance with cybersecurity rules.	10/9/2024	TBD	*OPEN: Compliance is currently awaiting response from impacted depts.*
2024 Critical Incidents Monitoring and Reporting	As a result of the DHCS inquiry and further review of the quarterly reporting of critical incidents, Compliance has identified a gap in process/opportunity for improvement regarding the process for monitoring and reporting critical incidents. Compliance finds a lack of a standard mechanism/process wherein LTSS providers can report critical incidents to Partnership to be recorded, follow-up, and reporting; subsequently, awareness by impacted departments. Furthermore, there is a lack of enterprise-wide process for tracking and reporting critical incidents, including data owner, source, and logic. Compliance has issued a CAP to impacted depts. to develop a process for providers to report critical incidents to Partnership, Partnership to monitor and report critical incidents to DHCS.	9/17/2024	TBD	*OPEN: Compliance is currently awaiting response from impacted depts.*
2024 Transportation Internal Audit	As a result of a provider grievance, Compliance conducted an internal audit to assess Partnership's documented process for the transportaion program and the provider grievance process. As a result of the internal audit, Compliance has issued a CAP to address the process for vetting and credentialing transportation providers, member assignment, monitoring provider performance, and transportation grievance process.	11/7/2024	TBD	*OPEN: Compliance is currently awaiting response from impacted depts.*

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.3

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

Recommendation by:
Partnership Staff

Topic Description:
Dr. Noemi Doohan, Lake County Board Commissioner, will complete her Board seat term on December 31, 2024.

Commissioner Doohan has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since December 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 provide Commissioner Doohan with the highest level of commendations and appreciation for her 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 Dr. Noemi Doohan has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.3

Resolution Number:
24-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR DR. NOEMI DOOHAN'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Dr. Noemi Doohan provided valuable advice and support for Partnership and the Board.

B. Dr. Noemi Doohan 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 Doohan's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December 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

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.4

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

Recommendation by:
Partnership Staff

Topic Description:
Alicia Hardy, Napa County Board Commissioner, will complete her Board seat term on December 31, 2024.

Commissioner Hardy has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since April 2018. 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 provide Commissioner Hardy with the highest level of commendations and appreciation for her 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 Alicia Hardy has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.4

Resolution Number:
24-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR ALICIA HARDY'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Alicia Hardy provided valuable advice and support for Partnership and the Board.

B. Alicia Hardy 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 Hardy's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December 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

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.5

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

Recommendation by:
Partnership Staff

Topic Description:
Randall Hempling, Shasta County Board Commissioner, will complete his Board seat term on December 31, 2024.

Commissioner Hempling has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since August 2013. 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 Hempling 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 Randall Hempling has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.5

Resolution Number:
24-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR RANDALL HEMPLING'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Randall Hempling provided valuable advice and support for Partnership and the Board.

B. Randall Hempling 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 Hempling's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December 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

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.6

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

Recommendation by:
Partnership Staff

Topic Description:
Tory Starr, Humboldt County Board Commissioner, will complete his Board seat term on December 31, 2024.

Commissioner Starr has made numerous outstanding contributions to Partnership HealthPlan of California and the Commission (known as the Board) since April 2020. 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 Starr 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 Tory Starr has provided to Partnership and the Board.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
December 4, 2024

Agenda Item Number:
4.6

Resolution Number:
24-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR TORY STARR'S SERVICE TO PARTNERSHIP AND THE BOARD

Recital: Whereas,

A. Tory Starr provided valuable advice and support for Partnership and the Board.

B. Tory Starr 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 Starr's outstanding service to Partnership and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 4th day of December 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

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan Of California
For the Period Ending September 30, 2024

Financial Analysis for the Current Period

Total (Deficit) Surplus

For the month ending September 30, 2024, PHC reported a surplus of $1.5 million, reducing the year-to-date deficit to $18.6 million. Significant variances are explained below.

Revenue

Total Revenue is lower than budget by $1.5 million for the month and $ 17.9 million for the year-to-date. Medi-Cal revenue is $11.2 million unfavorable due to unbudgeted UIS risk corridor and lower than anticipated ECM utilization, partially offset by retro membership. Also, directed payments are $34.8 million unfavorable due to lower than budgeted rates; a corresponding offset is recorded in HCIF. Supplemental revenues are $17.6 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 $10.5 million favorable YTD due to higher than anticipated interest rates.

Healthcare Costs

Total Healthcare Costs are higher than budget by $1.0 million for the month and $0.8 million lower than budget for the year-to-date. Physician and Ancillary expenses are unfavorable to budget by $47.1 million primarily due to the accrual of TRI and adjustments to IBNR reserves to reflect the latest utilization trend. Total Capitation is $10.0 million favorable due to the change in funding methods for some health care providers. Healthcare Investment Funds (HCIF) is $27.6 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 $3.4 million unfavorable due to retro rate increases back to January 2024. Inpatient hospital FFS expense is $6.0 million favorable due to adjustments to IBNR reserves and seasonality. Transportation expense is $1.4 million unfavorable due to increase in utilization. Quality Assurance expense is $10.0 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 $2.7 million for the month and $14.2 million for the year-to-date. The primary variance is in Employee costs due to the timing of the filling of open positions, which are primarily geared towards the expansion counties and the fulfilling of the 2024 DHCS Contract requirements. Additional variances are in Professional Services primarily due to the timing of consultant usage; Occupancy due to the timing of building related costs including repairs, maintenance, and utilities; and Computer and Data is due to the timing of licensing cost payments and the replenishment of computer equipment stock. Most non-Employee and non-Occupancy costs are prorated relatively evenly throughout the year; as the year progresses, the variances between actual and budget in these categories are expected to even out.

Balance Sheet / Cash Flow

Total Cash & Cash Equivalents increased by $140.8 million for the month. Inflows of $560.2 in State

Capitation payments include $421.1 million in Base and Supplemental Capitation payments and $139.1 million in Directed Payments; these Directed Payments are expected to be disbursed in the following month. Other inflows include $1.6 million in Drug Medi-Cal payments, and $8.9 million in interest earnings. These inflows were offset by outflows of $388.3 million in healthcare cost payments, $5.4 million in Drug Medi-Cal payments, $35.3 million in administrative and capital cost payments, and the recording of $1.0 million in board-designated reserve transfers. The remaining difference can be attributed to other revenues.

General Statistics

Membership

Membership had a total net decrease of 703 members for the month.

Utilization Metrics and High Dollar Case

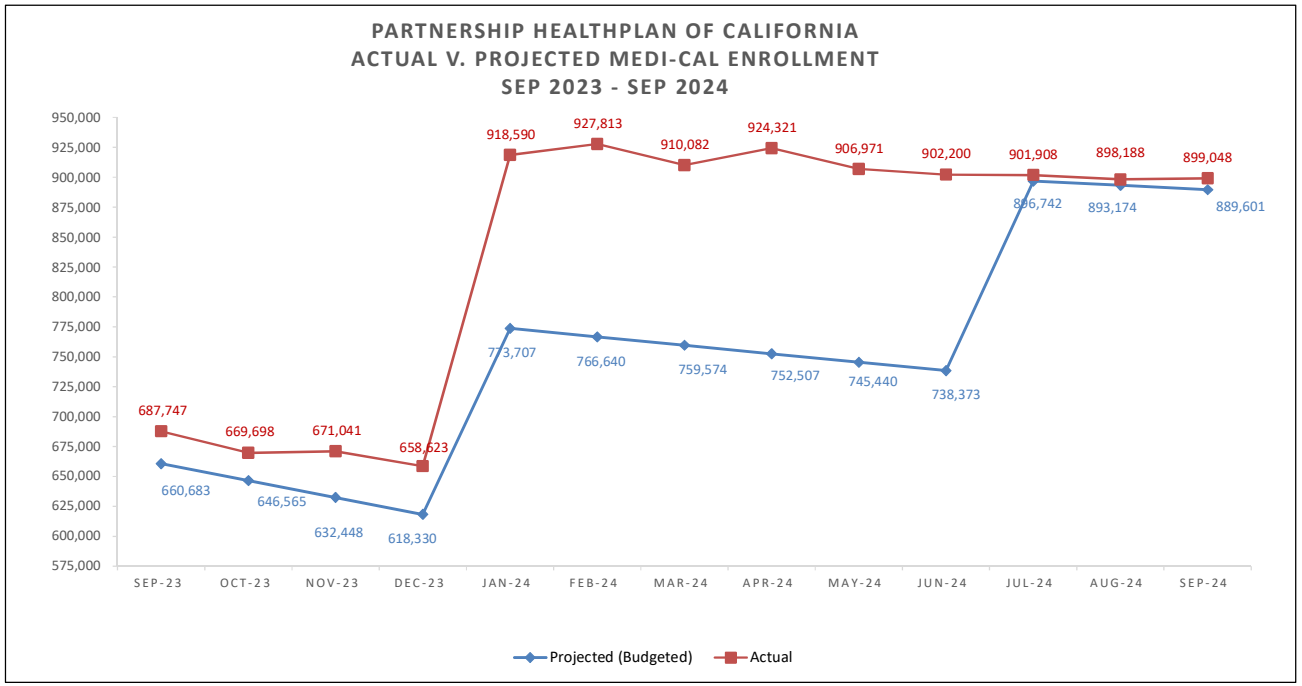
For the fiscal year 2024/25 through September 2024, 109 members reached the $250,000 threshold with an average cost of $476,863. For fiscal year 2023/24, 859 members reached the $250,000 threshold with an average cost per case of $505,111. For fiscal year 2022/23, 694 members reached the $250,000 threshold with an average claims cost of $517,587.

Current Ratio/Reserved Funds

Current Ratio Including Required Reserves	**1.40**
Current Ratio Excluding Required Reserves:	**0.96**
Required Reserves:	**$1,324,401,039**
Total Fund Balance:	**$1,228,998,116**

Days of Cash on Hand

Including Required Reserves:	**160.12**
Excluding Required Reserves:	**82.27**



Member Months by County:

County	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24 ★	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Solano	140,988	136,597	137,807	134,534	103,140	105,208	102,065	105,274	102,979	102,062	101,490	101,565	102,138
Napa	35,439	34,269	34,043	33,710	27,596	28,140	27,005	27,891	27,017	27,071	26,878	26,697	26,466
Yolo	63,142	61,135	60,507	60,230	55,624	56,087	54,327	55,592	54,076	53,489	53,332	52,195	52,185
Sonoma	132,745	131,013	129,901	128,356	109,623	112,447	108,106	112,999	110,510	110,327	110,662	110,074	110,141
Marin	51,713	50,119	49,383	49,823	46,981	48,331	46,215	48,257	46,564	46,520	46,274	46,147	46,484
Mendocino	41,868	40,599	41,192	39,846	41,552	41,963	41,055	42,150	41,381	41,239	41,408	41,314	41,195
Lake	35,381	34,530	34,446	34,367	35,058	35,405	34,559	35,494	34,624	34,390	34,422	34,207	34,227
Del Norte	12,850	12,505	12,499	12,426	12,527	12,610	12,316	12,675	12,401	12,214	12,252	12,327	12,382
Humboldt	61,695	60,093	60,931	58,752	60,016	60,415	59,075	60,273	58,758	58,876	58,607	58,434	58,422
Lassen	9,151	8,871	9,044	8,600	8,864	8,952	8,576	8,793	8,668	8,714	8,765	8,802	8,753
Modoc	4,167	4,099	4,139	3,928	4,055	4,035	4,020	4,051	3,944	3,933	3,958	3,941	3,983
Shasta	73,179	71,113	72,049	69,783	70,605	70,880	69,820	70,514	68,436	67,907	67,685	67,173	67,073
Siskiyou	19,566	19,059	19,440	18,625	19,052	19,115	17,966	18,653	18,137	18,131	18,088	17,918	17,839
Trinity	5,863	5,696	5,660	5,643	5,660	5,739	5,567	5,704	5,607	5,540	5,540	5,464	5,437
Butte	-	-	-	-	85,751	85,856	86,303	85,581	84,795	84,347	84,598	84,856	85,378
Colusa	-	-	-	-	10,710	10,663	10,674	10,392	10,270	10,239	10,208	10,148	10,152
Glenn	-	-	-	-	13,752	13,774	13,883	13,772	13,618	13,583	13,501	13,491	13,595
Nevada	-	-	-	-	28,962	28,798	28,708	28,519	28,420	28,313	28,407	28,226	28,261
Placer	-	-	-	-	59,373	59,846	60,289	59,915	60,009	59,226	59,648	59,419	59,331
Plumas	-	-	-	-	6,015	5,978	5,975	5,942	5,925	5,903	5,938	5,924	5,857
Sierra	-	-	-	-	855	870	869	869	865	850	839	852	871
Sutter	-	-	-	-	44,339	44,438	44,558	43,816	43,711	43,619	43,542	43,122	43,076
Tehama	-	-	-	-	31,784	31,484	31,299	30,932	30,323	29,996	30,297	30,365	30,492
Yuba	-	-	-	-	36,696	36,779	36,851	36,263	35,933	35,711	35,569	35,527	35,310
All Counties Total	**687,747**	**669,698**	**671,041**	**658,623**	**918,590**	**927,813**	**910,082**	**924,321**	**906,971**	**902,200**	**901,908**	**898,188**	**899,048**

★ 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	Aug-24	Sep-24										YTD	Avg / Month As of Sep-24
Total Enrollment	898,490	898,153	897,450										2,694,093	898,031
Total Revenue	516,467,263	505,732,274	517,421,674										1,539,621,211	513,207,070
Total Healthcare Costs	455,570,291	455,587,935	449,203,390										1,360,361,615	453,453,872
Total Administrative Costs	17,164,116	20,965,109	20,303,694										58,432,919	19,477,640
Medi-Cal Hospital & Managed Care Taxes	46,566,563	46,437,851	46,436,856										139,441,270	46,480,423
Total Current Year Surplus (Deficit)	(2,833,707)	(17,258,621)	1,477,734										(18,614,593)	(6,204,865)
Total Claims Payable	884,509,979	911,448,691	890,651,592										890,651,592	895,536,754
Total Fund Balance	1,244,769,003	1,227,510,382	1,228,988,116										1,228,988,116	1,233,755,834
Reserved Funds														
State Financial Performance Guarantee	1,092,899,000	1,093,798,000	1,096,923,000										1,096,923,000	1,094,540,000
Board Approved Capital and Infrastructure Purchases	79,941,518	79,360,193	77,250,794										77,250,794	78,850,835
Capital Assets	134,500,819	148,731,129	150,227,245										150,227,245	144,486,398
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668	71,002,668										71,002,668	71,002,668
Unrestricted Fund Balance	(133,575,002)	(165,381,608)	(166,415,591)										(166,415,591)	(155,124,067)
Fund Balance as % of Reserved Funds	90.31%	88.13%	88.07%										88.07%	88.83%
Current Ratio (including Required Reserves)	1.45:1	1.41:1	1.40:1										1.40:1	1.42:1
Medical Loss Ratio w/o Tax	96.95%	99.19%	95.38%										97.16%	97.16%
Admin Ratio w/o Tax	3.65%	4.56%	4.31%										4.17%	4.17%
Profit Margin Ratio	-0.60%	-3.76%	0.31%										-1.33%	-1.33%

FINANCIAL INDICATORS	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	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	898,435	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	729,388,400	5,732,802,666	477,733,555
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	383,635,425	4,552,038,550	379,336,546
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	19,471,144	180,211,837	15,017,653
Medi-Cal Hospital & Managed Care Taxes	-	-	-	-	-	376,406,250	46,790,714	48,056,922	47,537,225	47,123,221	46,858,980	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	279,699,187	341,196,322	28,433,027
Total Claims Payable	422,844,079	452,077,175	486,822,447	455,222,013	481,847,695	499,411,492	589,212,971	701,582,898	808,535,908	829,697,152	838,350,235	886,017,427	886,017,427	620,968,458
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	1,247,602,710	1,247,602,710	969,883,011
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	1,135,207,631	1,135,207,631	1,041,721,905
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)	(290,620,505)	(290,211,832)	(302,796,127)	(317,310,932)	(359,313,174)	(347,927,407)	(374,278,595)	(368,888,901)	(369,128,612)	(118,448,647)	(118,448,647)	(307,891,117)
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%	91.33%	91.33%	75.90%
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	1.45:1	1.45:1	1.43:1
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%	56.05%	89.69%	89.69%
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%	2.84%	3.55%	3.55%
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%	40.87%	6.72%	6.72%

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending September 30, 2024

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
897,450	898,153	(703)	**Total Membership**	898,031	693,543	204,488

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
517,421,674	518,887,427	(1,465,753)	**Total Revenue**	1,539,621,211	1,557,546,224	(17,925,013)
449,203,390	448,151,430	(1,051,960)	**Total Healthcare Costs**	1,360,361,615	1,361,191,697	830,082
20,303,694	22,990,042	2,686,348	**Total Administrative Costs**	58,432,919	72,616,993	14,184,074
46,436,856	45,974,580	(462,276)	**Medi-Cal Managed Care Tax**	139,441,270	138,477,439	(963,831)
1,477,734	**1,771,375**	**(293,641)**	**Total Current Year Surplus (Deficit)**	**(18,614,593)**	**(14,739,905)**	**(3,874,688)**
95.38%	94.76%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	97.16%	95.92%	
4.31%	4.86%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	4.17%	5.12%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of September 30, 2024

	September 2024	August 2024
A S S E T S		
Current Assets		
Cash & Cash Equivalents	**1,240,939,133**	**1,100,095,305**
Receivables		
Accrued Interest	1,507,500	1,056,500
State DHS - Cap Rec	1,268,128,339	1,306,089,641
Other Healthcare Receivable	45,119,474	41,157,836
Miscellaneous Receivable	7,711,151	7,686,433
Total Receivables	**1,322,466,464**	**1,355,990,410**
Other Current Assets		
Payroll Clearing	7,806	(1,391)
Prepaid Expenses	9,051,580	9,710,741
Total Other Current Assets	**9,059,386**	**9,709,350**
Total Current Assets	**2,572,464,983**	**2,465,795,065**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	515,462	515,462
Furniture & Fixtures	7,015,882	7,015,882
Computer Equipment	18,599,759	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	82,267,696	82,267,696
Building Improvements	39,623,760	39,623,760
Accum Depr - Motor Vehicles	(243,763)	(233,000)
Accum Depr - Furniture	(6,574,368)	(6,566,483)
Accum Depr - Comp Equipment	(15,775,230)	(15,604,446)
Accum Depr - Comp Software	(8,460,403)	(8,406,160)
Accum Depr - Leasehold Improvements	(124,288)	(124,288)
Accum Depr - Building	(12,699,615)	(12,523,829)
Accum Depr - Bldg Improvements	(14,448,195)	(14,254,373)
Construction Work-In-Progress	44,641,279	42,557,700
Total Fixed Assets	**150,227,245**	**148,731,130**
Other Non-Current Assets		
Deposits	174,585	167,820
Board-Designated Reserves	1,173,873,794	1,172,858,193
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	14,640,686	14,550,721
Net Pension Asset	4,919,453	4,919,453
Deferred Outflows Of Resources	1,620,052	1,620,052
Net Subscription Asset	2,790,269	2,790,269
Total Other Non-Current Assets	**1,198,318,839**	**1,197,206,508**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of September 30, 2024

	September 2024	August 2024
Total Non-Current Assets	**1,348,546,084**	**1,345,937,638**
Total Assets	**3,921,011,067**	**3,811,732,703**
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	244,851,493	193,306,998
Unearned Income	73,894,582	73,894,582
Suspense Account	7,324,475	6,649,824
Capitation Payable	40,030,398	40,030,398
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	1,277,241,085	1,210,173,256
Claims Payable	289,596,635	257,084,632
Incurred But Not Reported-IBNR	601,054,957	654,364,059
Quality Improvement Programs	115,430,225	106,119,471
Total Current Liabilities	**2,682,056,963**	**2,574,256,333**
Non-Current Liabilities		
Deferred Inflows Of Resources	7,617,910	7,617,910
Net Subscription Liability	2,348,078	2,348,078
Total Non-Current Liabilities	**9,965,988**	**9,965,988**
Total Liabilities	**2,692,022,951**	**2,584,222,321**
Fund Balance		
Unrestricted Fund Balance	**(166,415,591)**	**(165,381,608)**
Reserved Funds		
State Financial Performance Guarantee	1,096,923,000	1,093,798,000
Board Approved Capital and Infrastructure Purchases	77,250,794	79,360,193
Capital Assets	150,227,245	148,731,129
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668
Total Reserved Funds	**1,395,403,707**	**1,392,891,990**
Total Fund Balance	**1,228,988,116**	**1,227,510,382**
Total Liabilities And Fund Balance	**3,921,011,067**	**3,811,732,703**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Cash Flow
For The Period Ending September 30, 2024

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Services	560,243,823	1,449,206,564
Other Revenues	149,037	635,434
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(18,439,330)	(83,769,069)
Medical Claims Payments	(369,892,287)	(1,061,795,359)
Drug Medi-Cal		
DMC Receipts from Counties	1,594,433	17,214,539
DMC Payments to Providers	(5,363,419)	(15,482,763)
Cash Payments to Vendors	(20,852,428)	(154,598,677)
Cash Payments to Employees	(13,562,717)	(42,672,413)
Net Cash (Used) Provided by Operating Activities	**133,877,112**	**108,738,256**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(909,990)	(16,719,426)
Net Cash Used by Capital Financial & Related Activities	**(909,990)**	**(16,719,426)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	(1,015,601)	(12,623,938)
Interest and Dividends on Investments	8,892,307	27,653,150
Net Cash (Used) Provided by Investing Activities	**7,876,706**	**15,029,212**
NET (DECREASE) INCREASE IN CASH & CASH EQUIVALENTS	**140,843,828**	**107,048,042**
CASH & CASH EQUIVALENTS, BEGINNING	**1,100,095,305**	**1,133,891,091**
CASH & CASH EQUIVALENTS, ENDING	**1,240,939,133**	**1,240,939,133**
RECONCILIATION OF OPERATING (LOSS) INCOME TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES:		
TOTAL OPERATING (LOSS) INCOME	**(7,865,573)**	**(46,912,550)**
DEPRECIATION	**613,283**	**1,875,162**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(3,986,356)	(12,779,229)
California Department of Health Services Receivable	37,961,303	(75,974,241)
Other Assets	(646,174)	(734,777)
Accounts Payable and Accrued Expenses	119,286,974	212,449,581
Accrued Claims Payable	(20,797,099)	4,634,165
Quality Improvement Programs	9,310,754	26,180,145
Net Cash Provided (Used) by Operating Activities	**133,877,112**	**108,738,256**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

For The Period Ending September 30, 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
897,450	**897,450**	**-**			**TOTAL MEMBERSHIP**	**2,694,093**	**2,694,093**	**-**		
					REVENUE					
507,904,612	513,155,827	(5,251,215)	565.94	571.79	State Capitation Revenue	1,510,802,897	1,539,205,024	(28,402,127)	560.78	571.33
9,343,307	5,548,500	3,794,807	10.41	6.18	Interest Income	28,297,956	17,755,100	10,542,856	10.50	6.59
173,755	183,100	(9,345)	0.19	0.20	Other Revenue	520,357	586,100	(65,743)	0.19	0.22
517,421,674	**518,887,427**	**(1,465,753)**	**576.54**	**578.18**	**TOTAL REVENUE**	**1,539,621,211**	**1,557,546,224**	**(17,925,013)**	**571.48**	**578.14**
					HEALTHCARE COSTS					
					Physician Services					
7,386,099	8,923,126	1,537,027	8.23	9.94	Pcp Capitation	21,893,636	26,706,432	4,812,796	8.13	9.91
213,442	220,348	6,906	0.24	0.25	Specialty Capitation	638,508	658,913	20,405	0.24	0.24
89,115,463	69,268,565	(19,846,898)	99.30	77.18	Non-Capitated Physician Services	263,664,882	209,493,507	(54,171,375)	97.87	##### ##
96,715,004	**78,412,039**	**(18,302,965)**	**107.77**	**87.37**	**Total Physician Services**	**286,197,026**	**236,858,852**	**(49,338,174)**	**106.24**	**87.91**
					Inpatient Hospital					
16,156,248	17,908,131	1,751,883	18.00	19.95	Hospital Capitation	48,530,347	53,581,272	5,050,925	18.01	19.89
111,931,214	114,716,787	2,785,573	124.72	127.83	Inpatient Hospital - Ffs	342,557,392	348,581,199	6,023,807	127.15	129.39
1,591,089	1,591,089	-	1.77	1.77	Hospital Stoploss	4,778,399	4,778,399	-	1.77	1.77
129,678,551	**134,216,007**	**4,537,456**	**144.49**	**149.55**	**Total Inpatient Hospital**	**395,866,138**	**406,940,870**	**11,074,732**	**146.93**	**151.05**
56,125,067	52,610,125	(3,514,942)	62.54	58.62	Long Term Care	166,681,707	163,242,183	(3,439,524)	61.87	60.59
					Ancillary Services					
1,147,305	1,227,762	80,457	1.28	1.37	Ancillary Services - Capitated	3,521,905	3,671,695	149,790	1.31	1.36
71,044,489	73,659,578	2,615,089	79.16	82.08	Ancillary Services - Non-Capitated	218,089,922	225,172,813	7,082,891	80.95	83.58
72,191,794	**74,887,340**	**2,695,546**	**80.44**	**83.45**	**Total Ancillary Services**	**221,611,827**	**228,844,508**	**7,232,681**	**82.26**	**84.94**
					Other Medical					
3,771,115	6,946,568	3,175,453	4.20	7.74	Quality Assurance	11,642,906	21,598,747	9,955,841	4.32	8.02
70,033,503	80,860,102	10,826,599	78.04	90.10	Healthcare Investment Funds	215,377,304	242,936,789	27,559,485	79.94	90.17
118,400	135,600	17,200	0.13	0.15	Advice Nurse	368,900	434,000	65,100	0.14	0.16
829	7,100	6,271	-	0.01	Hipp Payments	2,426	22,700	20,274	-	0.01
11,198,033	10,737,795	(460,238)	12.48	11.96	Transportation	33,623,859	32,271,205	(1,352,654)	12.48	11.98
85,121,880	**98,687,165**	**13,565,285**	**94.85**	**109.96**	**Total Other Medical**	**261,015,395**	**297,263,441**	**36,248,046**	**96.88**	**110.34**
9,371,094	9,338,754	(32,340)	10.44	10.41	Quality Improvement Programs	28,989,522	28,041,843	(947,679)	10.76	10.41
449,203,390	**448,151,430**	**(1,051,960)**	**500.53**	**499.36**	**TOTAL HEALTHCARE COSTS**	**1,360,361,615**	**1,361,191,697**	**830,082**	**504.94**	**505.24**
					ADMINISTRATIVE COSTS					
11,895,829	14,896,288	3,000,459	13.26	16.60	Employee	37,515,097	46,519,061	9,003,964	13.92	17.27
84,365	156,294	71,929	0.09	0.17	Travel And Meals	202,248	500,100	297,852	0.08	0.19
1,383,628	1,656,483	272,855	1.54	1.85	Occupancy	3,954,318	5,188,897	1,234,579	1.47	1.93
560,664	835,751	275,087	0.62	0.93	Operational	1,242,921	2,614,485	1,371,564	0.46	0.97
2,513,347	2,752,670	239,323	2.80	3.07	Professional Services	6,626,756	9,261,556	2,634,800	2.46	3.44
3,865,861	2,692,556	(1,173,305)	4.31	3.00	Computer And Data	8,891,579	8,532,894	(358,685)	3.30	3.17
20,303,694	**22,990,042**	**2,686,348**	**22.62**	**25.62**	**TOTAL ADMINISTRATIVE COSTS**	**58,432,919**	**72,616,993**	**14,184,074**	**21.69**	**26.97**
46,436,856	45,974,580	(462,276)	51.74	51.23	**Medi-Cal Managed Care Tax**	139,441,270	138,477,439	(963,831)	51.76	51.40
1,477,734	**1,771,375**	**(293,641)**	**1.65**	**1.97**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**(18,614,593)**	**(14,739,905)**	**(3,874,688)**	**(6.91)**	**(5.47)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
September 30, 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 September 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 September 2024, PHC has accrued a Quality Incentive Program payout of $115.4 million.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
September 30, 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

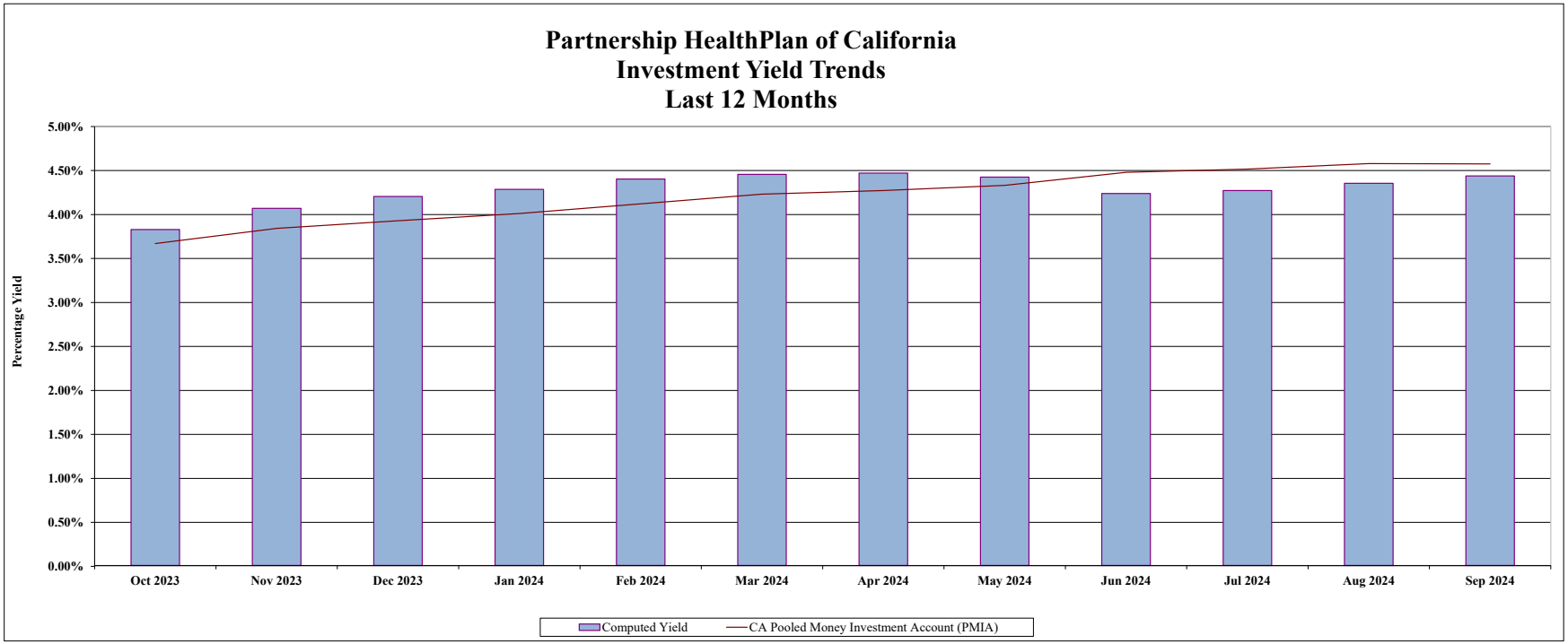
None noted.

Partnership HealthPlan of California
Investment Schedule
September 30, 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	$ 1,378,603	$ 1,378,603	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	$ 73,253,177		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,165,184		
US Bank - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,219,267,638		
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	$ 147,383		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:								$ 2,415,097,366		

Partnership HealthPlan of California
Investment Yield Trends

PERIOD		Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024
Interest Income		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	9,298,928	9,343,307
Cash & Investments at Historical Cost	(1)	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	2,273,253,498	2,415,112,928
Computed Yield	(2)	3.83%	4.07%	4.21%	4.29%	4.40%	4.46%	4.47%	4.43%	4.24%	4.27%	4.36%	4.44%
CA Pooled Money Investment Account (PMIA)	(3)	3.67%	3.84%	3.93%	4.01%	4.12%	4.23%	4.27%	4.33%	4.48%	4.52%	4.58%	4.58%



NOTES:

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

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

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

COO Board Report
December 2024

As we near the end of the year the Partnership Operations has numerous accomplishments to reflect upon, which include innovative approaches to longstanding challenges. While we celebrate our successes we also recognize that the landscape in which we operate is constantly evolving and changing. In many situations we have discovered that conventional solutions are not proving to be sufficient in making a difference with these complex issues. Our teams have adopted more creative and collaborative approaches to process improvement and problem-solving. Initiatives that often cross county lines, incorporate multiple providers and stakeholders, increase PHC presence in our communities, and incorporating ideas from “Imagination Sessions” have been instrumental in generating positive outcomes.

A particular area of focus Partnership has been an organizational focus on Well Child Visits, with an opportunity to improve HEDIS rates. Partnership staff is actively engaged with local practices to find creative ways to open up access. Efforts are being made in Solano and Shasta to host Saturday clinics and even pilot a process to staff with locum physicians to see more patients. Other pilot projects that our teams are providing resources and technical assistance for include a Disparity Sprint to increase rates of well child visits for American Indian, Alaska Native, and Pacific Islander populations. In Nevada County, Western Sierra Medical Clinic is exploring a group visit model that could enable them to increase the number of well-child visits offered.

As of October, Yuba County has gone live with the Justice Initiative in CalAIM. Partnership’s Justice Liaison, Ron Klinger, has been working closely with all 24 county probation, sheriff, HHS and Behavioral Health divisions as they work to prepare for pre-release Medi-Cal services and post-release ECM and re-entry to the community. In many instances this includes collaborating with stakeholders that historically PHC has not worked with as closely. Considerable planning has taken place to thoughtfully align systems, providers, community stakeholders, and behavioral health departments to assist members in obtaining Medi-Cal before they leave a facility, and be connected to Partnership and/or ECM providers upon exit for additional coordination and support. Even the Transportation Dept has found it necessary to think outside the box and partner with Transportation providers to train and become designated to provide specialized ride services for members being released from jail. Transportation has also been working to manage the continued increase in utilization for all transportation services. In October a record number, 121,791 rides were provided. This was an increase of 13.2% from the previous month, and resulting in nearly 4000 rides a day. To increase the efficiency of booking rides we are preparing to launch an app that will allow the member to book and verify rides without making a call. In December we are testing the app with a limited number of members, and the plan is to go live in January 2025 with a full county.

Another example of a creative approach to a complicated issue is our administration of the Regional Model of the Medi-Cal Substance Use treatment benefit, referred to as DMC-ODS, on behalf of seven of our counties. This program continues to mature and soon we will be implementing new provider types in SUD treatment that were recently approved: Tribal Healer and Traditional Helpers. We look forward to partnering with our Tribal providers to implement the use of these new provider types. Also,

in an effort to improve member experience, ensure access to services and better meet new regulatory requirements, Partnership will be bringing an in-house Behavioral Health Access Line/Call Center that is currently being operated by Carelon Behavioral Health. This is a big lift for Care Coordination and other departments, but the expectation is to improve our member's experience

Starting January 1, 2025, approximately 4,500 CCS members in our ten-county expansion area will transition to Partnership's CCS Whole Child Model (WCM). 30 day notices regarding this transition will go out to members December 1, 2024. The Care Coordination department has been actively working to ensure a smooth transition by working with CCS program partners and administrators in each of these counties to ensure a smooth transition, especially for high-risk members who will need additional support. By implementing a "warm-handoff" process, and other outreach. In addition to the mailed notices, our Member Services team have made individual phone calls to each family in an attempt to personally connect with them and provide information. MS reports they are receiving more inbound calls as a result of messages left than they received in response to the mailed notices. There will also be 9 more provider education sessions hosted through the end of 2024.

Recent surveys have indicated that despite previous efforts, Members still report not being familiar with their benefits, and so member outreach and education has expanded even more. Transportation, Population Health, Regional Directors, Member Services and Provider Relations teams have conducted 12 education sessions within the community over the past two months to educate members and providers on our benefits and programs. A special focus the next few months will also be put on providing information and training to our providers so they may also support members with benefit information. Member Services is currently scheduling nearly 50 member education sessions to take place in person throughout our network in 2025. We are also seeking suggestions for existing groups or forums that we can attend and provide information and resources.

Many of the challenges we face can be traced back to Access, and we are continuing to hit this head on with creative solutions. Providers in Solano have shared that they are challenged with recruiting and retaining Medical Assistants (MAs). Since the pandemic medical assistants who are coming directly from their MA school are often not well-trained. The clinics are using valuable resources to give in-depth comprehensive training on fundamentals that should have been taught in MA school. Partnership's Workforce Development team is exploring several options to provide assistance.

Also, just like the mobile mammography services, when members can't get to services, we work to bring the service to the member. SoHum Health/Jerrold Phelps now has a mobile "bus" for optometry services. They often go to the local schools to do eye exams, and can also do retinal scanning. They are also collaborating with Redwoods Rural Health to reach even more members, and are willing to contract with other clinics. Our team is working to connect providers that might benefit from services like this provided by others.

These are just a sampling of the many unique approaches that our teams are using to make a difference, and the coming year promises to see even more out-of-box projects.

Partnership Press Releases:

California Health Care Foundation, Partnership HealthPlan of California Award $1.2 Million to Support Provider Training in Northern California

Partnership HealthPlan of California & California Health Care Foundation
October 8, 2024
Partnership HealthPlan of California is pleased to announce its collaboration with the California Health Care Foundation (CHCF) to award $1.2 million in program expansion funding to six provider sites in the Partnership network to grow their training capacity across Northern California.

Partnership Mentioned:

Napa's CommuniCare+OLE recognized for high quality care

Napa Valley Register
November 19, 2024
CommuniCare+OLE announced that it was once again nationally recognized for clinical quality by the federal Health Resources and Services Administration (HRSA) as well as locally by Partnership Health Plan of California.

CommuniCare+OLE nationally and locally recognized

Daily Democrat
November 17, 2024
Earlier this week, CommuniCare+OLE announced that it was once again nationally and locally recognized for clinical quality by the federal Health Resources and Services Administration (HRSA) and the Partnership Health Plan of California.

Humboldt County Board of Supervisors

Lost Coast Outpost
October 29, 2024
9. Memorandum of Understanding with Partnership HealthPlan of California Regarding the Coordination of Mental Health Services in Humboldt County…11. Memorandum of Understanding with Partnership HealthPlan of California Regarding the Coordination of Drug Medi-Cal Substance Use Disorder Services in Humboldt County.

Redding moves forward on $1.2 million loan talks with owners of Market Street Manor Motel

Record Searchlight
October 29, 2024
…At that meeting, the city council approved entering discussions about loaning Cronic's group $1.2 million in Housing Homelessness Incentive Program funds that Redding received from Partnership HealthPlan of California.

Hospice Provider YoloCares Launches Enhanced Care Management to Address Social Determinants
Hospice News
October 25, 2024
…YoloCares in May became credentialed as an ECM site by Partnership Health Plan of California, a Medicaid health plan.

Naloxone can prevent opioid deaths
The Plumas Sun
October 6, 2024
In 2021, over half of drug overdose deaths in the United States involved an opioid, reports Partnership HealthPlan of California.

A collaborative town hall sparked discussion about healthcare
The Appeal Democrat
October 3, 2024
…“I think getting different perspectives is important,” Dr. Doug Matthews, who attended the event, said…Yuba-Sutter Healthcare Council, Sutter-Yuba Behavioral Health, Partnership HealthPlan of California, Sutter Health, Adventist Health, Peach Tree Health, Harmony Health, Yuba-Sutter-Colusa Medical Society, and Sutter County Health and Human Services represented on Monday.

Chief Medical Officer Quality Report

December 4, 2024

1. Results of the 2023-24 Hospital QIP

Top performers in the Hospital QIP for MY 2023-24. Twenty nine hospitals were eligible for Partnership's Hospital Pay for Performance program in MY 2023-24 For those invited in the new counties, the program was just for the first 6 months of 2024.

We commend this year's high performers:

Providence-St. Joseph System:

a.	Petaluma Valley Hospital	100%
b.	Redwood Memorial Hospital	100%
c.	Healdsburg District Hospital	100%
d.	St. Joseph Hospital Eureka	100%
e.	Queen of the Valley Hospital	90%
f.	Santa Rosa Memorial Hospital	90%

Adventist System:

a.	Adventist Health Howard Memorial	100%
b.	Adventist Health Mendocino Coast	100%
c.	Adventist Health Ukiah Valley	97%
d.	Adventist Health Clearlake	95%

Other Hospitals:

a.	Sonoma Valley Hospital	100%
b.	Tahoe Forest Hospital	100%
c.	Banner Lassen Medical Center	98%
d.	Marin General Hospital (MarinHealth)	93%
e.	Trinty Hospital (Very small hospital)	92%

We will be inviting representatives of these hospitals to attend our February Board meeting to be recognized.

2. DHCS Quality Sanctions

Measurement Year 2023. In October, DHCS announced an intent to sanction Partnership HealthPlan $475,000 for performance the four 2023 HEDIS reporting regions on the 16 measures in the Managed Care Accountability Set that were below the national NCQA median.

Of this amount, $362,752.20 was for low performance on Topical Fluoride Vanish in children. Since topic fluoride varnish is predominantly done by dental care providers, we rely on DHCS to send us this data to use for the HEDIS project. However, DHCS have never sent Dental Fluoride data for dental providers that are FQHCs, RHCs, and Tribal health centers. When we analyzed the data we did have, we back-engineered the dental visit data for children and were able to show DHCS that the services provided were above the national median, so dental access for children appears to be above average.

On November 4, the Partnership leadership team met with DHCS to argue that the topical fluoride varnish measure, as well as two others with major data issues related to actions of DHCS should be excluded from the sanctions calculation. Removal of these three measures would result in a lower sanction of $87,753.88.

As of the printing of this report, DHCS has not issued an adjustment to the sanction amount, nor have they publicly published the sanctioned amounts. We are hopeful that our presentation is sparking careful consideration within DHCS, and that this is the reason for the delay in final announcements of sanctions.

Of note, DHCS is 2 months behind their usual date in releasing the final results for all plans of the 2023 HEDIS audit. We assume that this may be related to our appeal, but are not certain.

Measurement Year 2024. In September, DHCS surprisingly announced a plan to impose sanctions at the county level in 2024. Partnership objected verbally to several DHCS leaders, but in November, the Sanctions division announced a plan to proceed with county level sanctions, in spite of our concerns. We have requested a meeting with the Sanction team to discuss further, and as of the writing of this report, we have not heard back from them.

There are many issues with proceeding with county level sanctions.

1. The rationale for county level sanctions was based (according to a slide in their November webinar) a desire for promoting rural health equity. We share the goal of working to overcome inequities in rural areas, but vigorously contest their assumption

that such rural inequity resolution is driven by factors within the control of the health plan.

2. The variation of performance in our small counties is a reflection of social determinants of health and small area variation within the health care delivery system, which are not within the ability of the Health Plan to resolve.
3. Sanctions based on county level inequities is imposing a higher level of responsibility and sanctions than race-based inequities. For racial inequities, no race-based sanctions are being applied. In fact, reduction of inequities is what is being rewarded. There is no legislative mandate to impose sanctions for rural inequities, nor any policy document looking at underlying causes/drivers of rural inequities and the tools best used to addressed this.
4. DHCS has not tested or piloted the concept of county level sanctions for validity, fairness, or operationalization before implementing this policy. In fact, they did not review any county level data nor run county level scenario testing before establishing this policy.
5. The sample size for measure denominators which are sanctionable was set at 70, far below the 411 required by NCQA. This probably violates their agreement with NCQA over permissible uses of quality benchmarks (we are exploring this). Aside from this, the confidence interval for those measures with a denominator of 70 is wide enough that many measures that are actually above average may appear randomly to be below average and subject to sanctions.

Partnership will be using several options to vigorously contest county level sanctions. We are happy to meet with any Commissioner who has questions to discuss this further.