Finance Committee Meeting Agenda

May 21, 2025: 8:00 a.m. – 9:30 a.m.

In-person Locations:
Partnership's Fairfield Office located at 4665 Business Center Drive, Fairfield, CA (Board Room)
Partnership's Redding Office located at 2525 Airpark Dr., Redding, CA
Partnership's Santa Rosa Office located at 495 Tesconi Circle, Santa Rosa, CA
Partnership's Eureka Office located at 1036 5th Street, Eureka, CA
Partnership's Auburn Office located at 281 Nevada Street, Auburn, CA
Partnership's Chico Office located at 2760 Esplanade Ave, Suite 130, Chico, CA

Finance Committee Members: Jonathon Andrus**,** Jayme Bottke, Dave Jones, Chair, Ryan Gruver, Kathryn Powell, Nancy Starck

Public Participation
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 May 20, 2025. Comments received will be read during the meeting.

8:00A.M – Opening			
1.1 **Call to Order**			*Kathie Powell, Chairwoman Pro Tempore*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION:*** Approval of Agenda	1	*Chair*
1.4	***ACTION:*** Approval of Finance Committee Minutes from April 16, 2025	2-8	*Chair*
1.5 **Commissioner Comment**			*Chair*
1.6 **Public Comment**			*Public*
New Business			
2.1	***INFORMATION:*** CEO Health Plan Update	9	*Sonja Bjork*
2.2	***ACTION:*** Accept March 2025 Metrics and Financials and Financial Update	10-23	*Jennifer Lopez*
2.3	***ACTION:*** Approve the Preliminary Health Care Expense Budget for Fiscal Year 2025-2026	24-34	*Jennifer Lopez*
2.4	***INFORMATION:*** State Budget Update		*Jennifer Lopez*
Adjournment			

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular finance meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the committee. The Finance Committee has designated the Board Clerk as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection. The Finance Committee Meeting Agenda and supporting documentation is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all PHC regional offices (see locations above). It can also be found online at www.partnershiphp.org. PHC meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Board Clerk at least two (2) working days before the meeting at 707-863-4516 or by email at *ascott@partnershiphp.org*. Notification in advance of the meeting will enable the Clerk to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it. This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda.

MINUTES OF THE MEETING OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA FINANCE COMMITTEE
In person locations:

Partnership's Fairfield Office located at 4605 Business Center Drive, Fairfield, CA (Conference Center)
Partnership's Redding Office located at 2525 Airpark Dr., Redding, CA
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On
April 16, 2025

Members Present: Jonathon Andrus, Jayme Bottke, Dave Jones, Chair, Nancy Starck
Members Excused: Ryan Gruver, Kathie Powell
Staff: Leigha Andrews, Katherine Barresi, Sonja Bjork, Jill Blake, Tina Buop, Alexandra Chappell, Wendell Coats, Wendi Davis, Marisa Dominguez, Robert Ducay, Naomi Gordon, Mary Kerlin, Melanie Lam, John Lemoine, Jennifer Lopez, Kathryn Power, Jose Puga, Ashlyn Scott, Tim Sharp, Brian Spiker, Rebecca Stark, Amy Turnipseed, Diane Walton

AGENDA ITEM	DISCUSSION	MOTION / ACTION
1.2 Roll Call	Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a quorum.	None
1.3 Approval of Agenda	Chairman Jones asked if anyone had changes to the agenda. Hearing no requests for modification, he asked for a motion to approve the agenda.	*Commissioner Starck moved to approve the agenda as presented, seconded by Commissioner Bottke.* ***ACTION SUMMARY:*** *Yes:4* *No: 0* *Abstention: 0* *Excused: 2 (Gruver, Powell)*

		MOTION CARRIED
1.4 Approval of the March 19, 2025, Finance Committee Meeting Minutes	Chairman Jones asked if anyone had changes to the March 19, 2025, minutes. Hearing no requests for modification, he asked for a motion to approve the minutes.	*Commissioner Bottke moved to approve the minutes as presented, seconded by Commissioner Starck.* ***ACTION SUMMARY:*** *Yes:4* *No: 0* *Abstention: 0* *Excused: 2 (Gruver, Powell)* **MOTION CARRIED**
1.5 & 1.6 Public Comment and Commissioner Comment	Chairman Jones asked if there were any public or commissioner comments. There were none.	None
New Business		
2.1 CEO Report	Sonja Bjork, Chief Executive Officer, presented a report on the following topics: ***CHA CHIP Update*** Counties have long been engaged in developing Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), while health plans have similarly conducted Population Needs Assessments (PNA). With the 2024 DHCS contract amendment, health plans and counties are now required to collaborate on these efforts. This shift reflects the state's intent to align and strengthen initiatives to better serve communities. As a result, Partnership is now expected to participate in meetings with all 24 counties in our service area and to share relevant data with them. While CHA/CHIP processes incorporate data from across the entire county—not just from Partnership members—our data plays a critical role in identifying disease trends and other key health patterns. Though not required, the state also encourages health plans to provide financial support for the CHA/CHIP process. In response, Partnership has provided each county $4,000 to support meeting coordination over the past year. We are now pleased to announce that we will offer up to $100,000 per county over a three-year period. We anticipate that most counties will utilize the majority of these funds in the third year of the cycle. To ensure equitable support, we've offered the same funding amount to all counties, regardless of the number of Partnership members they serve. We recognize that smaller counties	None

may, in some cases, require this additional support to effectively carry out this work.

Commissioner Bottke expressed appreciation for the CHA/CHIP funding and requested clarification regarding the parameters on how the funds can be used.

Ms. Bjork explained that DHCS has issued an All Plan Letter outlining eligible activities, such as meeting coordination, consultation services, and related expenses. Counties will be required to submit their proposed use of the funds for review.

Commissioner Andrus shared that his hospital has faced challenges participating in the CHA/CHIP process and emphasized the importance of ensuring the funding supports collaboration between public and private providers, rather than remaining solely within the public sector.

Ms. Bjork agreed, noting that the CHA/CHIP process functions like a group project—and that hospitals, as key community stakeholders, should absolutely be part of the conversation.

Federal Updates

Dr. Mehmet Oz has been confirmed to lead the Centers for Medicare and Medicaid Services (CMS), while Drew Snyder, the current Medicaid director for Mississippi, is expected to be appointed to head the agency's Medicaid division. Lawmakers are working to pass a spending bill by Memorial Day, though some anticipate that final approval may be delayed until later in the summer or fall.

State Updates

Partnership has been actively engaging with our national and state associations, which have been leading lobbying efforts to oppose proposed Medicaid cuts. In addition, the Board and Strategic Planning Committee will dedicate time during the April retreat to review and discuss various potential budget reduction scenarios. We will also hear from various stakeholders, including hospitals, FQHCs, counties, members, and more.

Commissioner Andrus thanked Partnership for its continued advocacy efforts and noted that his hospital has a meeting scheduled with Congressman LaMalfa.

Ms. Bjork expressed enthusiasm about the opportunity for Congressman LaMalfa to hear directly from local hospitals in his district about the potential impact of proposed cuts.

CalAIM IPP and Access Grant Reminders

Partnership is encouraging eligible providers to apply to Partnership for the currently available CalAIM IPP Grants, as well as Access Grants, as these funds may not be available in the future. Partnership has Incentive Payment Program (IPP) funding available to support providers in

	building the infrastructure needed to deliver CalAIM services. The deadline to submit applications is May 16 for that program.	
2.2 *ACTION*: Accept February 2025 Metrics and Financials	Jennifer Lopez, Chief Financial Officer, presented Partnership's financial metrics for the month ending February 28, 2025. Partnership reported a surplus of $7.9 million, bringing the year-to-date surplus to $29.1 million. Medi-Cal revenue is above budget, driven by additional 2024 MCO tax revenue authorized by AB160, with a corresponding offset in MCO tax expense. Interest income is also favorable, which is positive amid ongoing stock market uncertainty, though we will continue to monitor trends. Partnership will be required to return an estimated $56 million to the state under the Unsatisfactory Immigration Status (UIS) risk corridor. Although this program was expected to end earlier this year, the state has decided to reinstate it retroactively to January 1 for the State-Only portion of these rates. It remains unclear whether the risk corridor will follow the same formula as last year. We are continuing to see some favorability tied to inpatient expenses in the expansion counties We are actively monitoring emerging patterns using claims data from the new region; however, it will take several years of complete data to establish reliable trends. Transportation utilization remains high, which is positive, as we anticipate increased transportation costs will be reflected in our future rates. Administrative costs remain favorable, primarily due to the timing of hiring qualified staff. Since finalizing the February financials, Partnership has hired 54 new employees. *Commissioner Starck asked when the state is expected to release additional information about the new UIS risk corridor.* *Ms. Lopez responded that it will likely be a few months before the new methodology is provided. In the meantime, assumptions based on the prior corridor will be included in the March financials.*	*Commissioner Starck moved to approve the metrics and financials as presented, seconded by Commissioner Andrus.* ***ACTION SUMMARY:*** *Yes:4* *No: 0* *Abstention: 0* *Excused: 2 (Gruver, Powell)* **MOTION CARRIED**
2.3 *ACTION*: Approve Budget Assumptions for Fiscal Year 2025-2026	Ms. Lopez presented the Fiscal Year 2025–2026 Budget Assumptions to the Committee, marking the first step in the three-part budget approval process. A draft Health Care Expense Budget will be shared with the Finance Committee in May, followed by the Final Budget presentation to both the Finance Committee and full Board in June. Ms. Lopez emphasized that due to ongoing federal and state budget uncertainty, Partnership will likely need to bring a mid-year budget revision to the Finance Committee and Board for approval. We are also awaiting the release of the Governor's May Budget Revision for further details on Medicaid funding. We will make every effort to incorporate any relevant updates from the May Revise into the May Finance Committee packet. ***Outlook for 2025-26*** **–** In the Governor's proposed FY 2025–26 January Budget, the state projected a $16.5 billion surplus, with a total budget of $322.3 billion, including $228.9 billion from the General Fund. The proposal includes $17 billion in reserve deposits, however, despite the planned deposits, the budget also includes a $7.1 billion withdrawal from the Budget Stabilization	*Commissioner Bottke moved to approve agenda item 2.3 as presented seconded by Commissioner Starck.* ***ACTION SUMMARY:*** *Yes:4* *No: 0* *Abstention: 0* *Excused: 2 (Gruver, Powell)* **MOTION CARRIED**

Account. The budget also proposed $188.1 billion in total Medi-Cal funding ($42.1 billion from the General Fund), and a 3.09% decrease in enrollees from the previous year.

Since the release of the initial budget, the wildfires in Los Angeles have added significant and unforeseen recovery costs. Additionally, growing concerns about a potential recession and ongoing market volatility may substantially impact California's revenue from personal income taxes derived from capital gains. As a result, we anticipate increased state scrutiny of health plan rates and expenditures, with a likely focus on identifying areas for potential funding reductions.

Despite so much uncertainty, DHCS is still moving forward with new benefits such as Transitional Rent, which is expected to be implemented by January 1, 2026. In November 2024, California voters approved Proposition 35, permanently extending the Managed Care Organization (MCO) Tax and dedicating its revenue to increase Medi-Cal provider payments starting in 2025. The measure requires DHCS to consult with a Governor- and Legislature-appointed stakeholder advisory committee before making any changes to provider payments. The first stakeholder meeting was held on April 14, 2025, but final decisions on 2025–2026 investments are not expected until late 2025.

DHCS will continue applying quality withholds to Managed Care Plans, currently withholding 1% of Partnership's revenue rates. These funds can be earned back by meeting established quality benchmarks. However, given that much of Partnership's service area is rural and has historically struggled with quality performance, this withhold presents a financial risk to overall revenue. Additionally, DHCS continues to issue monetary sanctions to plans that fail to meet quality target. Partnership has received quality sanctions over the past two fiscal years. Additionally, DHCS has finalized its Community Reinvestment policy, included in the 2024 contract amendment. This policy requires plans with net profits to reinvest 5% to 7.5% into approved community projects. Plans that have received quality sanctions may be required to contribute additional reinvestment funding.

Enrollment – Following the January 2024 10-county expansion, Partnership's membership has remained relatively flat. To align with the Governor's January budget, we are assuming a 3% decline in membership for the next fiscal year—from the current 904,000 members to approximately 870,000 in June 2026. However, given recent recession forecasts, Partnership will revisit its membership assumptions before finalizing the budget. Historically, Medi-Cal plan enrollment tends to increase during economic downturns.

Revenue – Partnership will review CY 2024 and draft CY 2025 revenue levels to determine the most appropriate baseline for budgeting. Revenue projections for the upcoming fiscal year will incorporate assumptions related to enrollment, member acuity, and other emerging factors. Additional revenue assumptions will be applied to the second half of the fiscal year, based on prior-

year trends, as updated rates will not be available until later in the calendar year. Staff will also consider known and reasonably estimable program updates and efficiency factors used in previous cycles.

As of January 1, 2025, Partnership assumed responsibility for the California Children's Services (CCS) program in the 10 expansion counties. This change extends CCS responsibilities to all counties in our service area, resulting in both increased revenue and corresponding expenses.

The budget will include CY 2024 Medi-Cal TRI program revenue and expenses. However, due to limited information on CY 2025 and 2026 TRI allocations through Proposition 35, these will not be included in the June budget. DHCS has also not finalized details for the new transitional rent benefit. Partnership will assess whether sufficient information is available to include estimated revenue and costs in the June budget; if not, these items will be addressed in an off-cycle budget review.

Interest rates currently sit at 4.33%, and we are monitoring any upcoming changes from the Federal Reserve. Partnership receives rental income from 11 tenants in Fairfield, four in Auburn, two in Eureka, and one each in Redding, Napa, and Chico. There are 10 additional leasable spaces, with two currently pending.

Health Care Costs – For FY 2025–26, healthcare cost projections are based on historical trends and emerging data. Projections for the expansion counties will be further refined using actuarial analysis, draft rate estimates, and actual claims experience available before budget finalization. Partnership continues to closely monitor healthcare costs and membership trends and will adjust budget assumptions as new information becomes available.

Administrative Costs – Partnership will continue hiring staff to meet regulatory requirements outlined in the 2024 DHCS contract amendment. Additional staffing is also needed to prepare for the Medicare D-SNP launch in January 2026. New capital purchase recommendations—primarily for IT and Facilities—will be included in the final detailed capital expenditures budget.

Reserves – Maintaining adequate reserves is essential to prepare for potential financial challenges. The state requires health plans to hold reserves equivalent to two months of State Capitation Revenue. In addition, Partnership allocates funds for the Strategic Use of Reserves (SUR), which covers Board-approved projects with expenses not yet incurred. Given current economic conditions and uncertainty around potential federal Medicaid changes, revisions to the Board-designated reserve policy may be proposed in the coming months.

Off-Cycle Budget – Due to ongoing uncertainty around federal Medicaid changes, state budget responses, TRI rate updates for CY 2025–2026, and the Medicare D-SNP bid process, Partnership staff anticipate preparing an off-cycle budget to address any significant programmatic or cost changes that arise after the June budget is finalized.

	Commissioner Andrus asked why some rural counties are experiencing the largest declines in membership. *Ms. Lopez explained that it's still unclear which types of members are falling off the rolls, but further analysis is underway and additional information will be shared in the future.* *Wendi Davis, Chief Operating Officer, added that some smaller counties have been slower to complete Medi-Cal redeterminations and are also facing fluctuations in unemployment.* *Commissioner Starck noted that the budget assumptions presented seem reasonable given current uncertainty. She expressed interest in revisiting Partnership's reserve policy if changes are warranted and asked whether there is a risk of the state viewing reserve levels as too high.* *Ms. Lopez confirmed that DHCS could potentially reclaim funds if they determine a plan's reserves exceed acceptable levels.*	
Adjournment	Chairman Jones adjourned the meeting at 9:18AM.	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Committee Approval Date: 5/21/2025

Signed: _____
Ashlyn Scott, Clerk

Finance Committee
Chief Executive Officer Update

May 21, 2025

1. **Federal & State Medicaid Developments**
2. **BCHIP Grants**
3. **CalAIM**
4. **HRP Update**

Financial Analysis for the Current Period

Total Surplus

For the month ending March 31, 2025, Partnership reported a net surplus of $85.1 million, increasing the year-to-date surplus to $114.2 million. Key variances are outlined below.

Revenue

Total Revenue exceeded the budget for the month by $169.9 million and $368.5 million for the year-to-date. Medi-Cal revenue is $388.5 million favorable to budget, primarily due to the recognition of $251.6 million in additional MCO tax revenue for calendar year 2024, as authorized by Assembly Bill (AB) 160. A corresponding offset was recorded in MCO tax expense. Additionally, revenue was adjusted to reflect the draft CY 2025 rates, retro to January, resulting in favorable variances of $142.8 million in base rates and $78.1 million in MCO tax and Voluntary Rate Range revenue; these adjustments also have matching offsets recorded in expenses. These positive variances were partially offset by an unbudgeted $84.0 million related to the UIS risk corridor for calendar years 2024 and 2025. Directed Payments were $98.5 million below budget due to lower-than-expected rates with a corresponding offset recorded in Healthcare Investment Funds (HCIF). Supplemental revenues exceeded budget by $51.3 million, primarily due to the timing of DHCS submissions primarily in the expansion counties for American Indian Health Services (AIHS) and higher than expected volumes for Maternity Kick payments. Interest income is $25.8 million favorable due to higher than anticipated interest rates accompanied with higher than budgeted cash balances. The remaining favorable variance is attributed to other revenues.

Healthcare Costs

Total healthcare costs are favorable to budget for the month by $8.4 million and $142.7 million for the year-to-date. Non-Capitated Physician and Ancillary expenses were $114.8 million unfavorable to budget due to the accrual of Targeted Rate Increases (TRI) and updates to IBNR reserves based on current utilization trends. Capitation expenses were $29.5 million favorable due to changes in the funding methodology for certain healthcare providers. Long-term care costs exceeded the budget by $6.8 million, primarily due to anticipated rate increases retroactive to January 2024. Inpatient Hospital Fee-For-Service (FFS) expenses were $153.6 million favorable, driven by downward adjustments to prior fiscal year Incurred But Not Reported (IBNR) reserves which reflected lower-than-expected utilization in the new expansion region and seasonal trends. HCIF expenses were $72.0 million favorable due to lower than anticipated directed payment rates, partially offset by the timing of IPP CalAIM incentive payments. Transportation costs were $11.2 million unfavorable, attributed to increased utilization. Quality Assurance expenses were $23.5 million favorable due to the timing of medical administrative costs. Conversely, Quality Improvement Program expenses were $3.3 million unfavorable due to the timing of incentive grant disbursements.

Administrative Costs

Administrative costs have an overall positive variance of $5.0 million for the month and $38.5 million year-to-date. The primary variance is in Employee costs due to the timing of the filling of open positions geared towards the expansion counties and the fulfilling of the 2024 DHCS Contract requirements. An additional

variance is in Occupancy due to the timing of building related costs including repairs and maintenance, as well as the depreciation of capitalizable items, most notably the new claims system. The increased negative variance in Computer and Data is primarily due to the timing of licensing cost payments and computer stock equipment purchases. 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 narrow.

Balance Sheet / Cash Flow

Total Cash & Cash Equivalents increased by $156.4 million for the month. Inflows of $1.1 billion in State Capitation payments include $573.7 million in Base and Supplemental Capitation payments, $251.0 million in Directed Payments, and $251.6 million in calendar year 2024 retro MCO tax payments, which pertain to AB 160; the Directed Payments are expected to be disbursed in the following months, and the MCO tax payment was made during the current month. Other inflows include $3.3 million in Drug Medi-Cal payments and $8.3 million in interest earnings. These inflows were offset by outflows of $622.6 million in healthcare cost payments, $7.5 million in Drug Medi-Cal payments, $251.6 million for the previously mentioned MCO tax payment, $23.8 million in administrative and capital cost payments, and the recording of $26.3 million in board designated reserve transfers. The remaining difference can be attributed to other revenues.

General Statistics

Membership

Membership had a total net increase of 1,370 members for the month.

Utilization Metrics and High Dollar Case

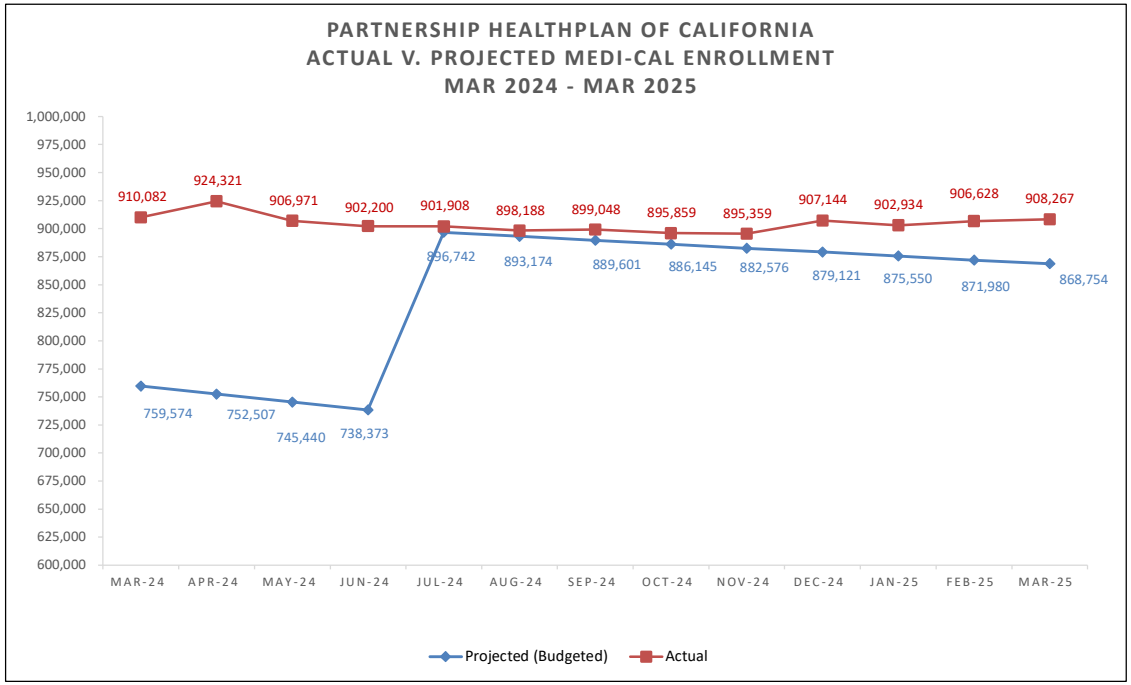
For the fiscal year 2024/25 through March 2025, 567 members reached the $250,000 threshold with an average cost of $496,814. For fiscal year 2023/24, 888 members reached the $250,000 threshold with an average cost per case of $509,877. For fiscal year 2022/23, 694 members reached the $250,000 threshold with an average claims cost of $518,875.

Current Ratio/Reserved Funds

Current Ratio Including Required Reserves:	**1.44**
Current Ratio Excluding Required Reserves:	**1.00**
Required Reserves:	**$1,344,757,623**
Total Fund Balance:	**$1,361,804,917**

Days of Cash on Hand

Including Required Reserves:	**132.91**
Excluding Required Reserves:	**67.90**



Member Months by County:

County	Mar-24 ☆	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Solano	102,065	105,274	102,979	102,062	101,490	101,565	102,138	101,685	101,430	103,225	102,170	102,511	102,443
Napa	27,005	27,891	27,017	27,071	26,878	26,697	26,466	26,242	26,374	26,961	26,991	27,197	27,289
Yolo	54,327	55,592	54,076	53,489	53,332	52,195	52,185	51,806	51,458	53,062	52,646	52,963	53,239
Sonoma	108,106	112,999	110,510	110,327	110,662	110,074	110,141	109,880	110,115	112,185	110,844	112,863	112,617
Marin	46,215	48,257	46,564	46,520	46,274	46,147	46,484	46,059	46,033	46,460	46,616	46,859	47,015
Mendocino	41,055	42,150	41,381	41,239	41,408	41,314	41,195	40,901	41,046	40,947	40,708	40,899	41,086
Lake	34,559	35,494	34,624	34,390	34,422	34,207	34,227	34,122	34,257	34,495	34,338	34,229	34,164
Del Norte	12,316	12,675	12,401	12,214	12,252	12,327	12,382	12,404	12,387	12,420	12,466	12,513	12,468
Humboldt	59,075	60,273	58,758	58,876	58,607	58,434	58,422	58,495	58,614	58,593	58,332	58,577	58,588
Lassen	8,576	8,793	8,668	8,714	8,765	8,802	8,753	8,814	8,754	8,756	8,761	8,825	8,821
Modoc	4,020	4,051	3,944	3,933	3,958	3,941	3,983	3,933	3,925	3,939	3,943	3,990	4,011
Shasta	69,820	70,514	68,436	67,907	67,685	67,173	67,073	66,723	66,780	66,863	66,195	65,800	66,052
Siskiyou	17,966	18,653	18,137	18,131	18,088	17,918	17,839	17,972	18,041	17,945	17,902	17,706	17,777
Trinity	5,567	5,704	5,607	5,540	5,540	5,464	5,437	5,422	5,380	5,419	5,286	5,348	5,345
Butte	86,303	85,581	84,795	84,347	84,598	84,856	85,378	85,666	85,502	85,772	85,639	85,539	86,256
Colusa	10,674	10,392	10,270	10,239	10,208	10,148	10,152	10,097	10,038	10,215	10,219	10,232	10,288
Glenn	13,883	13,772	13,618	13,583	13,501	13,491	13,595	13,543	13,596	13,664	13,594	13,623	13,786
Nevada	28,708	28,519	28,420	28,313	28,407	28,226	28,261	28,434	28,721	28,515	28,748	28,736	28,570
Placer	60,289	59,915	60,009	59,226	59,648	59,419	59,331	58,737	58,334	60,679	60,497	60,860	61,013
Plumas	5,975	5,942	5,925	5,903	5,938	5,924	5,857	5,820	5,870	5,866	5,792	5,858	5,925
Sierra	869	869	865	850	839	852	871	866	892	887	874	888	868
Sutter	44,558	43,816	43,711	43,619	43,542	43,122	43,076	42,418	42,244	43,425	43,430	43,691	43,601
Tehama	31,299	30,932	30,323	29,996	30,297	30,365	30,492	30,542	30,456	30,426	30,321	30,240	30,059
Yuba	36,851	36,263	35,933	35,711	35,569	35,527	35,310	35,278	35,112	36,425	36,622	36,681	36,986
All Counties Total	**910,082**	**924,321**	**906,971**	**902,200**	**901,908**	**898,188**	**899,048**	**895,859**	**895,359**	**907,144**	**902,934**	**906,628**	**908,267**

☆ 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	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25				YTD	Avg / Month As of Mar-25
Total Enrollment	898,490	898,153	897,450	895,408	895,235	905,698	901,907	904,947	906,317				8,103,605	900,401
Total Revenue	516,467,263	505,732,274	517,421,674	517,491,108	507,895,691	520,768,067	518,706,967	759,253,557	692,900,747				5,056,637,347	561,848,594
Total Healthcare Costs	455,570,291	455,587,935	449,203,390	445,671,531	422,571,150	440,227,707	443,280,032	430,197,038	480,694,520				4,023,003,590	447,000,399
Total Administrative Costs	17,164,116	20,965,109	20,303,694	22,663,983	19,787,655	21,565,508	23,537,967	22,873,201	21,628,246				190,489,480	21,165,498
Medi-Cal Hospital & Managed Care Taxes	46,566,563	46,437,851	46,436,856	46,083,262	46,460,193	46,509,845	46,696,106	298,302,026	105,449,368				728,942,070	80,993,563
Total Current Year Surplus (Deficit)	(2,833,707)	(17,258,621)	1,477,734	3,072,332	19,076,693	12,465,007	5,192,862	7,881,292	85,128,613				114,202,207	12,689,134
Total Claims Payable	884,509,979	911,448,691	890,651,592	852,864,933	830,533,762	775,002,932	770,859,204	759,273,827	639,166,969				639,166,969	812,701,321
Total Fund Balance	1,244,769,003	1,227,510,382	1,228,988,116	1,232,060,447	1,251,137,140	1,263,602,149	1,268,795,012	1,276,676,303	1,361,804,917				1,361,804,917	1,261,704,830
Reserved Funds														
State Financial Performance Guarantee	1,092,899,000	1,093,798,000	1,096,923,000	1,100,211,000	1,102,840,000	1,046,032,000	1,049,745,000	1,091,605,000	1,119,293,000				1,119,293,000	1,088,149,556
Board Approved Capital and Infrastructure Purchases	79,941,518	79,360,193	77,250,794	76,202,434	75,447,816	73,742,888	72,667,651	71,478,836	70,124,244				70,124,244	75,135,153
Capital Assets	134,500,819	148,731,129	150,227,245	152,420,562	152,556,243	152,888,655	154,088,260	154,631,556	155,340,379				155,340,379	150,598,316
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668				71,002,668	71,002,668
Unrestricted Fund Balance	(133,575,002)	(165,381,608)	(166,415,591)	(167,776,217)	(150,709,587)	(80,064,063)	(78,708,568)	(112,041,757)	(53,955,374)				(53,955,374)	(123,180,863)
Fund Balance as % of Reserved Funds	90.31%	88.13%	88.07%	88.01%	89.25%	94.04%	94.16%	91.93%	96.19%				96.19%	91.11%
Current Ratio (including Required Reserves)	1.45:1	1.41:1	1.40:1	1.40:1	1.40:1	1.39:1	1.41:1	1.37:1	1.44:1				1.44:1	1.41:1
Medical Loss Ratio w/o Tax	96.95%	99.19%	95.38%	94.54%	91.58%	92.82%	93.91%	93.33%	81.83%				92.96%	92.96%
Admin Ratio w/o Tax	3.65%	4.56%	4.31%	4.81%	4.29%	4.55%	4.99%	4.96%	3.68%				4.40%	4.40%
Profit Margin Ratio	-0.60%	-3.76%	0.31%	0.65%	4.13%	2.63%	1.10%	1.71%	14.49%				2.64%	2.64%

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	900,691	9,562,598	796,883
Total Revenue	346,807,441	341,606,254	341,452,348	336,820,011	333,606,699	704,499,918	494,922,661	507,388,749	527,490,882	524,377,176	544,442,127	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%	56.19%	89.72%	89.72%
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%	2.85%	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%	40.96%	6.73%	6.73%

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending March 31, 2025

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
906,317	904,947	1,370	**Total Membership**	900,401	760,289	140,112

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
692,900,747	522,968,606	169,932,141	**Total Revenue**	5,056,637,347	4,688,119,657	368,517,690
480,694,520	489,109,571	8,415,051	**Total Healthcare Costs**	4,023,003,590	4,165,727,585	142,723,995
21,628,246	26,652,152	5,023,906	**Total Administrative Costs**	190,489,480	228,977,795	38,488,315
105,449,368	44,643,148	(60,806,220)	**Medi-Cal Managed Care Tax**	728,942,070	409,765,295	(319,176,775)
85,128,613	**(37,436,265)**	**122,564,878**	**Total Current Year Surplus (Deficit)**	**114,202,207**	**(116,351,018)**	**230,553,225**
81.83%	102.25%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	92.96%	97.37%	
3.68%	5.57%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	4.40%	5.35%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of March 31, 2025

	March 2025	February 2025
A S S E T S		
Current Assets		
Cash & Cash Equivalents	**1,242,331,978**	**1,085,962,788**
Receivables		
Accrued Interest	1,293,600	862,900
State DHS - Cap Rec	1,429,409,288	1,817,012,660
Other Healthcare Receivable	54,144,470	52,471,490
Miscellaneous Receivable	7,681,035	7,690,236
Total Receivables	**1,492,528,393**	**1,878,037,286**
Other Current Assets		
Payroll Clearing	20,731	8,330
Prepaid Expenses	13,614,116	10,911,801
Total Other Current Assets	**13,634,847**	**10,920,131**
Total Current Assets	**2,748,495,218**	**2,974,920,205**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	515,462	515,462
Furniture & Fixtures	7,028,251	7,028,251
Computer Equipment	19,772,918	19,746,994
Computer Software	8,997,689	8,997,689
Leasehold Improvements	124,288	124,288
Land	7,619,204	7,619,204
Building	83,185,784	83,185,784
Building Improvements	39,688,760	39,688,760
Accum Depr - Motor Vehicles	(308,341)	(297,578)
Accum Depr - Furniture	(6,622,704)	(6,614,613)
Accum Depr - Comp Equipment	(16,899,673)	(16,701,543)
Accum Depr - Comp Software	(8,748,392)	(8,701,768)
Accum Depr - Leasehold Improvements	(124,288)	(124,288)
Accum Depr - Building	(13,764,140)	(13,586,392)
Accum Depr - Bldg Improvements	(15,641,741)	(15,437,327)
Construction Work-In-Progress	50,517,302	49,188,634
Total Fixed Assets	**155,340,379**	**154,631,557**
Other Non-Current Assets		
Deposits	88,468	87,968
Board-Designated Reserves	1,189,117,244	1,162,783,836
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	11,288,636	14,267,684
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	**1,210,124,122**	**1,186,769,262**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of March 31, 2025

	March 2025	February 2025
Total Non-Current Assets	**1,365,464,501**	**1,341,400,819**
Total Assets	**4,113,959,719**	**4,316,321,024**
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	330,292,676	473,461,029
Unearned Income	109,464,493	109,464,493
Suspense Account	16,801,088	14,587,394
Capitation Payable	40,296,544	40,296,544
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	1,431,822,654	1,462,731,304
Claims Payable	232,630,987	245,166,222
Incurred But Not Reported-IBNR	406,535,982	514,107,605
Quality Improvement Programs	141,711,277	137,231,029
Total Current Liabilities	**2,742,188,814**	**3,029,678,733**
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	**2,752,154,802**	**3,039,644,721**
Fund Balance		
Unrestricted Fund Balance	**(53,955,374)**	**(112,041,757)**
Reserved Funds		
State Financial Performance Guarantee	1,119,293,000	1,091,605,000
Board Approved Capital and Infrastructure Purchases	70,124,244	71,478,836
Capital Assets	155,340,379	154,631,556
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668
Total Reserved Funds	**1,415,760,291**	**1,388,718,060**
Total Fund Balance	**1,361,804,917**	**1,276,676,303**
Total Liabilities And Fund Balance	**4,113,959,719**	**4,316,321,024**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Cash Flow
For The Period Ending March 31, 2025

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Services	1,076,356,112	4,914,571,255
Other Revenues	190,381	35,782,414
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(20,236,383)	(212,199,821)
Medical Claims Payments	(602,346,352)	(3,748,349,323)
Drug Medi-Cal		
DMC Receipts from Counties	3,256,081	34,634,398
DMC Payments to Providers	(7,476,967)	(47,855,082)
Cash Payments to Vendors	(257,158,041)	(744,655,386)
Cash Payments to Employees	(17,517,327)	(149,181,764)
Net Cash Provided by Operating Activities	**175,067,504**	**82,746,691**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(699,916)	(24,578,040)
Net Cash (Used) by Capital Financial & Related Activities	**(699,916)**	**(24,578,040)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	(26,333,408)	(27,867,388)
Interest and Dividends on Investments	8,335,010	78,139,624
Net Cash (Used) Provided by Investing Activities	**(17,998,398)**	**50,272,236**
NET INCREASE IN CASH & CASH EQUIVALENTS	**156,369,190**	**108,440,887**
CASH & CASH EQUIVALENTS, BEGINNING	**1,085,962,788**	**1,133,891,091**
CASH & CASH EQUIVALENTS, ENDING	**1,242,331,978**	**1,242,331,978**
RECONCILIATION OF TOTAL OPERATING INCOMETO NET CASH PROVIDED BY OPERATING ACTIVITIES		
TOTAL OPERATING INCOME	**76,362,903**	**35,631,676**
DEPRECIATION	**645,769**	**5,658,579**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(1,663,778)	(21,774,108)
California Department of Health Services Receivable	387,603,372	(237,255,190)
Other Assets	(390,844)	(2,910,009)
Accounts Payable and Accrued Expenses	(171,863,308)	497,785,003
Accrued Claims Payable	(120,106,859)	(246,850,458)
Quality Improvement Programs	4,480,249	52,461,198
Net Cash Provided by Operating Activities	**175,067,504**	**82,746,691**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

For The Period Ending March 31, 2025

****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
906,317	**906,317**	**-**			**TOTAL MEMBERSHIP**	**8,103,605**	**8,103,605**	**-**		
					REVENUE					
683,953,858	516,950,406	167,003,452	754.65	570.39	State Capitation Revenue	4,974,697,906	4,633,669,457	341,028,449	613.89	571.80
8,765,710	5,825,900	2,939,810	9.67	6.43	Interest Income	78,570,530	52,710,400	25,860,130	9.70	6.50
181,179	192,300	(11,121)	0.20	0.21	Other Revenue	3,368,911	1,739,800	1,629,111	0.42	0.21
692,900,747	**522,968,606**	**169,932,141**	**764.52**	**577.03**	**TOTAL REVENUE**	**5,056,637,347**	**4,688,119,657**	**368,517,690**	**624.00**	**578.52**
					HEALTHCARE COSTS					
					Physician Services					
7,830,004	9,148,138	1,318,134	8.64	10.09	Pcp Capitation	67,542,150	81,069,604	13,527,454	8.33	10.00
214,896	228,731	13,835	0.24	0.25	Specialty Capitation	1,923,038	2,010,008	86,970	0.24	0.25
84,494,489	78,379,153	(6,115,336)	93.23	86.48	Non-Capitated Physician Services	709,658,776	649,699,516	(59,959,260)	87.57	80.17
92,539,389	**87,756,022**	**(4,783,367)**	**102.11**	**96.82**	**Total Physician Services**	**779,123,964**	**732,779,128**	**(46,344,836)**	**96.14**	**90.42**
					Inpatient Hospital					
16,578,405	18,052,180	1,473,775	18.29	19.92	Hospital Capitation	146,591,128	161,876,603	15,285,475	18.09	19.98
115,094,762	128,400,413	13,305,651	126.99	141.67	Inpatient Hospital - Ffs	934,111,047	1,087,745,228	153,634,181	115.27	134.23
1,575,076	1,575,076	-	1.74	1.74	Hospital Stoploss	14,304,535	14,304,534	(1)	1.77	1.77
133,248,243	**148,027,669**	**14,779,426**	**147.02**	**163.33**	**Total Inpatient Hospital**	**1,095,006,710**	**1,263,926,365**	**168,919,655**	**135.13**	**155.98**
52,624,090	56,450,827	3,826,737	58.06	62.29	Long Term Care	488,999,030	482,194,305	(6,804,725)	60.34	59.50
					Ancillary Services					
1,180,472	1,271,773	91,301	1.30	1.40	Ancillary Services - Capitated	10,559,337	11,191,243	631,906	1.30	1.38
86,304,326	85,965,199	(339,127)	95.23	94.85	Ancillary Services - Non-Capitated	754,046,969	699,250,647	(54,796,322)	93.05	86.29
87,484,798	**87,236,972**	**(247,826)**	**96.53**	**96.25**	**Total Ancillary Services**	**764,606,306**	**710,441,890**	**(54,164,416)**	**94.35**	**87.67**
					Other Medical					
6,427,668	7,267,268	839,600	7.09	8.02	Quality Assurance	41,638,766	65,118,935	23,480,169	5.14	8.04
86,348,204	81,417,631	(4,930,573)	95.27	89.83	Healthcare Investment Funds	658,439,938	730,436,656	71,996,718	81.25	90.14
128,900	142,400	13,500	0.14	0.16	Advice Nurse	1,119,300	1,288,400	169,100	0.14	0.16
	7,400	7,400		0.01	Hipp Payments	6,064	67,200	61,136	-	0.01
14,118,325	13,076,629	(1,041,696)	15.58	14.43	Transportation	111,400,520	100,196,770	(11,203,750)	13.75	12.36
107,023,097	**101,911,328**	**(5,111,769)**	**118.08**	**112.45**	**Total Other Medical**	**812,604,588**	**897,107,961**	**84,503,373**	**100.28**	**110.71**
7,774,903	7,726,753	(48,150)	8.58	8.53	Quality Improvement Programs	82,662,992	79,277,936	(3,385,056)	10.20	9.78
480,694,520	**489,109,571**	**8,415,051**	**530.38**	**539.67**	**TOTAL HEALTHCARE COSTS**	**4,023,003,590**	**4,165,727,585**	**142,723,995**	**496.44**	**514.06**
					ADMINISTRATIVE COSTS					
13,948,144	16,282,299	2,334,155	15.39	17.97	Employee	120,768,628	143,184,448	22,415,820	14.90	17.67
68,620	164,105	95,485	0.08	0.18	Travel And Meals	713,136	1,484,697	771,561	0.09	0.18
1,263,444	4,102,529	2,839,085	1.39	4.53	Occupancy	11,751,650	25,375,045	13,623,395	1.45	3.13
517,945	859,029	341,084	0.57	0.95	Operational	4,939,311	8,030,913	3,091,602	0.61	0.99
2,894,582	2,889,873	(4,709)	3.19	3.19	Professional Services	24,179,096	26,889,466	2,710,370	2.98	3.32
2,935,511	2,354,317	(581,194)	3.24	2.60	Computer And Data	28,137,659	24,013,226	(4,124,433)	3.47	2.96
21,628,246	**26,652,152**	**5,023,906**	**23.86**	**29.42**	**TOTAL ADMINISTRATIVE COSTS**	**190,489,480**	**228,977,795**	**38,488,315**	**23.50**	**28.25**
105,449,368	44,643,148	(60,806,220)	116.35	49.26	**Medi-Cal Managed Care Tax**	728,942,070	409,765,295	(319,176,775)	89.95	50.57
85,128,613	**(37,436,265)**	**122,564,878**	**93.93**	**(41.32)**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**114,202,207**	**(116,351,018)**	**230,553,225**	**14.11**	**(14.36)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
March 31, 2025

1. ORGANIZATION

The Partnership HealthPlan of California (the HealthPlan) was formed as a health insurance organization and is legally a subdivision of the State of California but is not part of any city, county or state government system. The HealthPlan has quasi-independent political jurisdiction to contract with the State for managing Medi-Cal beneficiaries who reside in various Northern California counties. The HealthPlan is a combined public and private effort engaged principally in providing a more cost-effective method of healthcare. The HealthPlan began serving Medi-Cal eligible persons in Solano County in May 1994. That was followed by 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), the HealthPlan consolidated its reporting from these fourteen counties into two regions, which are in alignment with the two DHCS rating regions. Beginning January 2024, the HealthPlan 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 the HealthPlan 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:
The HealthPlan investments can consist of U.S. Treasury Securities, Certificates of Deposits, Money Market and Mutual Funds, Government Pooled Funds, Agency Notes, Repurchase

Agreements, Shares of Beneficial Interest and Commercial Paper and are carried at fair value.

RESERVED FUNDS:
As of March 2025, the HealthPlan 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.

RECLASSIFICATIONS:
Certain reclassifications of prior period balances have been made to conform with the current period presentations. Such reclassifications do not affect the total increase in net position or total current or noncurrent assets or liabilities.

3. STATE CAPITATION REVENUE

Medi-Cal capitation revenue is based on the monthly capitation rates, as provided for in the State contract, and the actual number of Medi-Cal eligible members. Capitation revenues are paid by the State on a monthly basis in arrears based on estimated membership. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the State for projected changes in membership and trued up monthly through a State reconciliation process. These estimates are continually monitored and adjusted, as necessary, as experience develops or new information becomes known.

4. HEALTHCARE COST

The HealthPlan continues to develop completion factors to calculate estimated liability for claims Incurred But Not Reported. These factors are reviewed and adjusted as more historical data becomes available. Budgeted capitation revenues and healthcare costs are adjusted each month to reflect changes in enrollee counts.

5. QUALITY IMPROVEMENT PROGRAM

The HealthPlan maintains quality improvement contracts with acute care hospitals and primary care physicians. As of March 2025, the HealthPlan has accrued a Quality Improvement Program payout of $141.7 million.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
March 31, 2025

6. ESTIMATES

Due to the nature of the operations of the HealthPlan, it is necessary to estimate amounts for financial statement presentation. Substantial overstatement or understatement of these estimates would have a significant impact on the statements. The items estimated through various methodologies are:

- Value of Claims Incurred But Not Reported
- Quality Incentive Payouts
- Earned Capitation Revenues
- Total Number of Members
- Retro Capitation Expense for Certain Providers

7. COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the HealthPlan is party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, the HealthPlan's Management is of the opinion that any liability which may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of the operations of the HealthPlan.

8. UNUSUAL OR INFREQUENT ITEMS REPORTED IN CURRENT MONTH'S FINANCIAL STATEMENTS

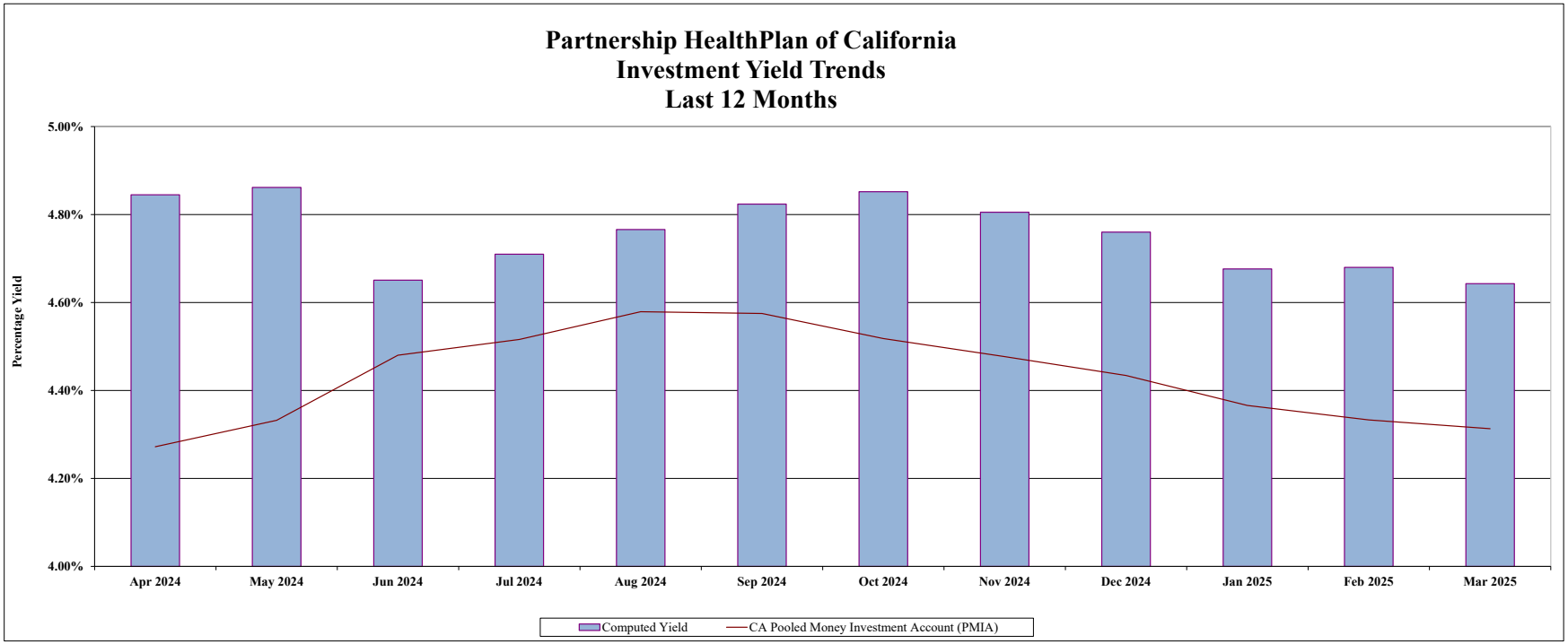
None noted.

Partnership HealthPlan of California
Investment Schedule
March 31, 2025

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	$ 1,740,043	$ 1,740,043	NA	NR
Certificate of Deposit for Knox Keene	Cash & Cash Equiv	0.0405	1/31/2025	1/30/2030	NA	$ 300,000	$ 300,000	$ 300,000	NA	NR
FUNDS HELD FOR OPERATIONS:										
Merrill Lynch Institutional	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 74,920,479		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,653,268		
US Bank - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,232,700,705		
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	$ 44,282,879		
West America Payroll	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 148,548		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:								$ 2,431,749,222		

Partnership HealthPlan of California
Investment Yield Trends

PERIOD		Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Interest Income		8,768,057	9,436,106	9,367,229	9,655,722	9,298,928	9,343,307	10,427,933	7,842,623	8,546,229	7,610,667	7,079,412	8,765,710
Cash & Investments at Historical Cost	(1)	2,306,818,656	2,186,519,113	2,295,440,947	2,234,052,950	2,273,253,498	2,415,112,928	2,185,207,714	2,223,891,960	2,419,126,236	2,214,161,851	2,249,046,624	2,431,749,222
Computed Yield	(2)	4.84%	4.86%	4.65%	4.71%	4.77%	4.82%	4.85%	4.81%	4.76%	4.68%	4.68%	4.64%
CA Pooled Money Investment Account (PMIA)	(3)	4.27%	4.33%	4.48%	4.52%	4.58%	4.58%	4.52%	4.48%	4.43%	4.37%	4.33%	4.31%



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.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: May 21, 2025
Board Meeting Date: June 25, 2025

Agenda Item Number:
2.3

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

Recommendation by:
The Finance Committee and Partnership Staff

Topic Description:
On April 23, 2025, the Board approved Budget Assumptions for Fiscal Year (FY) 2025-2026 and directed staff to prepare a full operational budget. The Preliminary Health Care Expense Budget for FY 2025-2026 is being presented to the Finance Committee today for approval. The final budget (health care, administrative, and operations) is presented to the Finance Committee and full Board for approval in June.

Reason for Resolution:
The purpose of this resolution is to present the Preliminary Health Care Expense Budget for FY 2025-2026 for review and approval.

Financial Impact:
The financial impact is material.

Requested Action of the Board:
Based on the approval of the Finance Committee and Partnership staff, the Board is asked to ratify the Preliminary Health Care Budget for FY 2025-2026.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: May 21, 2025
Board Meeting Date: June 25, 2025

Agenda Item Number:
2.3

Resolution Number:
25-

IN THE MATTER OF: RATIFYING THE FINANCE COMMITTEE'S APPROVAL OF THE PRELIMINARY HEALTH CARE EXPENSE BUDGET FOR FY 2025-2026

Recital: Whereas,

A. The Board has responsibility for establishing budget policy and specific budget approval.

B. In prior meetings, Partnership staff, the Finance Committee, and the Board have provided direction and input into the development of the budget.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To ratify the Finance Committee's approval of the Preliminary Health Care Budget for FY 2025-2026.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June 2025 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

FY 2025-26

Preliminary Health Care Budget

May 2025

Introduction

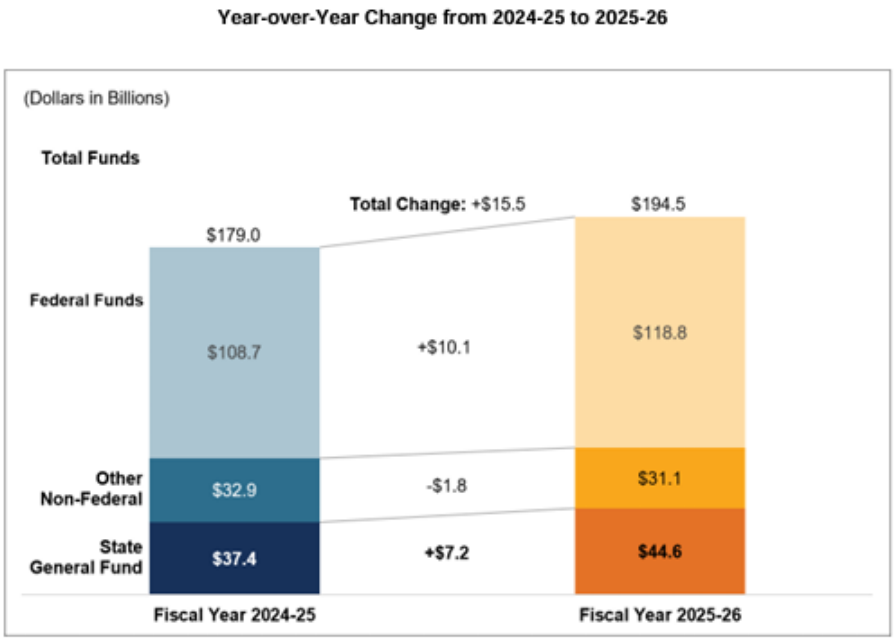
Each year, starting in January, Partnership HealthPlan of California (Partnership) begins building the annual budget for Board of Commissioner review and approval in June. As part of this process, Partnership presents to the Finance Committee and the Board key components of the budget development for review and approval. Specifically, in April the draft budget assumptions were presented and approved. The next phase of the process is to present and seek approval from the Finance Committee on the preliminary health care expense budget. In June, the final budget including previously reviewed components and a fully developed administrative budget are presented to the Board for final review and approval. This document outlines the fiscal year (FY) 2025-26 State Outlook, federal proposal that may affect Medi-Cal, and the Plan's preliminary health care expense budget in the major expense categories. Partnership staff will continue to make refinements to the health care expense budget, estimates may materially change prior to the final presentation of the full operating budget in June 2025.

FY 2025-26 State Outlook – May Revise

As of the May Revise the State presented a total budget of $321.9 billion total fund ($226.4 billion State General Fund) for FY 2025-26. The May Revise solves for a $12 billion deficit for FY 2025-26, in January, the Governor's Budget estimated a $16.5 billion surplus. The May Revise reserve balance reflects $15.7 billion in deposits, of which:

- $11.2 billion in the Budget Stabilization Account, an increase of $300 million from the January Budget.
- $4.5 billion in the Special Fund for Economic Uncertainties, no change from the January Budget.
- The January Budget earmarked a $1.5 billion deposit into the Public School System Stabilization Account, the May Revise no longer reflects this deposit.

The State budget summary specifically calls out Medi-Cal as a key factor in statewide expenditure growth. The below Department of Health Care Services (DHCS) budget chart[1], outlines the May Revise year-over-year Medi-Cal program estimated expenditures.



[1] https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2025_May_Estimate/MAY-2025-Medi-Cal-Local-Assistance-Estimate.pdf

As displayed above, $194.5 billion total fund ($44.6 billion General Fund) was requested to operate the Medi-Cal program for FY 2025-26, this is a $6.4 billion total fund ($2.5 billion General Fund) increase from the January Budget. The budget further assumes 14.8 million individuals would receive coverage through the Medi-Cal program, which is a 2.4% increase from the January Budget.

Significant May Revise Budget details that affect the Medi-Cal program are highlighted below.

- **Proposition 35 (Prop 35)** – As part of the May Revise, DHCS issued an updated Prop 35 Spending Plan for calendar year (CY) 2025 and 2026. The updated spending plan proposes to sweep and repurpose Prop 35 investments that are funded with Managed Care Organization (MCO) tax revenue. The revised spending plan for CY 2025 proposes to:
    - Keep the CY 2024 Targeted Rate Increase (TRI) investments intact.
    - Sweep nearly $1.2 billion in investments to offset the State General Fund, these funds were previously earmarked for Medi-Cal provider rate increases.
    - Shift $455 million to directed payment programs, it is anticipated these funds would be used to offset the non-federal share that is self-financed by providers for these programs.
    - Repurpose $390 million in Prop 35 investments for new proposals such as the development of flexible housing subsidy pools for rental assistance and housing supports and repurposing reproductive health investments for Department of Health Care Access and Information (HCAI) loan repayment and scholarships.

  The revised spending plan is not aligned with the parameters approved by California voters through Prop 35 which dedicated MCO tax revenues to increasing provider payment levels (in specified categories) for contracted Medi-Cal providers for CY 2025 and beyond. If legislature the approves the new spending plan it is more than likely to be challenged in court.

- **Unsatisfactory Immigration Status (UIS) Membership Changes Age 19+**
    - Enrollment Freeze: The May Revise proposes a UIS enrollment freeze for individuals age 19+ effective January 1, 2026. Currently UIS members make up just over 10% of Partnership's overall membership. If the freeze is enacted, UIS members will continue to have access to restricted-scope coverage through the Medi-Cal Fee-for-Service program for emergency and pregnancy related services.
    - Institute Medi-Cal Premiums: As of January 1, 2027, the Administration proposes to institute a $100 monthly premium for all UIS members age 19+ who are enrolled in full scope Medi-Cal. Should the institution of these premiums be included in the final budget, approximately 90,000 Partnership members could be subject to these annual premiums.
    - Full Scope Dental Benefit Elimination: In addition to the enrollment freeze and proposed premiums, the May Revise proposes to eliminate full scope Dental for UIS members age 19. However, UIS members will continue to have access to emergency dental services covered under restricted-scope Medi-Cal.

- **Eliminate Long-Term Care Services for UIS Members** – The May Revise proposes to eliminate long-term care services for UIS members. It is unclear how DHCS proposes to handle UIS members currently residing in long-term care facilities. Further, the proposed policy does not specify whether skilled nursing facility services are part of this benefit elimination.

- **Eliminate Prospective Payment System (PPS) funding for State-Only Services for UIS Members** – The May Revise proposes to eliminate PPS rate funding for Federally Qualified Health Centers

and Rural Health Clinics for state-only-funded services for UIS members. Instead, clinics would be reimbursed at the Medi-Cal Fee Schedule rate or the applicable Medi-Cal managed care rate.

- **Eliminate Proposition 56 Provider Supplemental Payments** – The May Revise proposes to eliminate $504 million in Proposition 56 supplemental payments for dental, family planning, and women's health providers statewide.

- **Eliminate the Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP)** – The May Revise proposes to eliminate the SNF WQIP directed payment program that provides enhanced funding to contracted SNFs and to suspend the requirement to maintain a backup power system for no fewer than 96 hours. This would eliminate $168.2 million in existing SNF supplemental funding statewide.

- **Changes to the Medi-Cal Minimum Loss Ratio (MLR)** – The May Revise proposes to increase the Medi-Cal Managed Care Plan MLR from 85% to 90%. This could put further strain on plan finances and could dampen the amount of funding that will be dedicated to Community Reinvestments.

- **Other Medi-Cal Proposals**
    - Reinstate the Asset Test for Medi-Cal Eligibility – This policy is proposed to be implemented for the Seniors and Persons with Disabilities population no sooner than January 1, 2026, and would limit assets to $2,000 for an individual and $3,000 for a couple. This could result in coverage loss for about 112,000 beneficiaries statewide by full implementation.
    - Eliminate Certain Over-the-Counter Drugs and Glucagon-Like Pepticde-1 (GLP-1) Drugs – This policy would eliminate Medi-Cal coverage of COVID-19 antigen tests, over-the-counter vitamins, certain antihistamines including dry eye products, and GLP-1s prescribed for weight loss effective January 1, 2026.
    - Elimination of the Acupuncture Benefit – This policy would eliminate the optional benefit Acupuncture effective January 1, 2026.
    - Implement Hospice Utilization Management – This policy would impose prior authorization requirements for hospice services.

- **Non-Medical Notable Budget Proposals**
    - In-Home Support Services (IHSS) Program Changes – The budget proposes to limit IHSS provider overtime and travel expenses and eliminate IHSS coverage for UIS members age 19+.
    - Creation of a new California Housing and Homelessness Agency – The Governor proposes to establish this new agency and cited the new agency would create a more integrated and effective administrative framework for addressing the State's housing and homelessness issues. The budget included $4.2 million ($4 million General Fund) in FY 2025-26 for this new office.

Despite the State's budgetary condition, DHCS and the Governor remain focused on California Advancing and Innovating Medi-Cal (CalAIM) and transforming Medi-Cal as noted in our April assumptions.

In previous times of budgetary hardship, the State has implemented a variety of cost cutting measures in the Medi-Cal program outside of the budget. Based on this history, we expect:

- The DHCS will continue to focus on cost-effective spending in managed care and expect pressures to be amplified.

- As noted in our prior budget, Partnership has faced increased scrutiny from DHCS on contracted heath care cost levels, some of which resulted in prior year's downward rate adjustments.

House Energy and Commerce Committee Proposal

On May 11, 2025, the House Energy and Commerce Committee (House) released its federal proposal to cut an estimated $715 billion from Medicaid, Medicare, and health care marketplaces over a 10-year period. The House proposal includes:

- **Freeze on Provider Taxes** – State imposed provider taxes would be frozen at their current levels and State's would be prohibited from establishing any new provider taxes. The Congressional Budget Office (CBO) projects that a moratorium on new taxes would recoup roughly $87 billion.
- **Limit Medicaid Directed Payments to the Medicare Payment Levels**– The House bill proposes to limit Medicaid directed payments to Medicare funding levels. The bill provides a hold harmless clause for current approved directed payments that exceed the limit. Currently a subset of the TRI procedure codes and certain hospital directed payments exceed the proposed limit. While the hold-harmless provision will ensure the funding levels are maintained, outyear program increases would be limited.
- **Medicaid Work Requirements** – Mandates every State to install a work requirement for certain beneficiaries. Able-bodied adults without any dependents would have to work at least 80 hours a month or perform other activities such as community service. It would not apply to pregnant women and only adults from 19 to 64. Tribal members are also exempt as well as those with serious medical conditions. At this time, the bill would give States until January 1, 2029, to implement. The CBO has projected that these work requirements will save $301 billion over the next decade. Partnership currently serves 355,000 members who are non-disabled adults between the ages of 19 to 64 who may be subject to these new requirements.
- **Changes to Medicaid Eligibility Verification –** Requires eligibility verification for the adult expansion population to occur every 6 months instead of annually. Implementation would be October 1, 2027. The CBO has this scored this proposal as saving over $49 billion. Nearly 30% of Partnership's current membership could be subject to these new requirements.
- **Federal Medical Assistance Percentage (FMAP) Penalty for State's who cover UIS Members** – State's who continue to cover individuals regardless of immigration status will have their federal match for the adult expansion population reduced by 10%. The FMAP penalty would be implemented October 1, 2027. The CBO has preliminary scored this proposal as $11 billion in savings. It is currently estimated California could lose over $3 billion in federal funding annually with the implementation of this policy.

Centers for Medicare and Medicaid Services (CMS) - Notice of Proposed Rulemaking

On May 12, 2025, CMS issued a Medicaid proposed rule aimed at adjusting the approval of provider tax waivers to ensure that they are broad based and generally redistributive. In short, the proposed rule would:

- Prohibit states from taxing Medicaid businesses at higher rates than non-Medicaid businesses.
- Maintain statistical testing while adding safeguards.
- Provide a transition timeline based on the age of existing waivers.

Currently, 48 states have at least one provider tax in place. Per the proposed rule, States may be provided up to 3 years to come into compliance with these new provisions based on the age of the approved waiver. However, it is unclear if California qualifies for the compliance implementation runway.

In California, the two largest provider tax programs are the MCO Tax and the Hospital Quality Assurance Fee (HQAF) program. The MCO tax proceeds fund TRI and Prop 35 directed payment investments while the HQAF funds the Private Hospital Directed Payment (PHDP) program. Currently the MCO Tax and the HQAF programs tax Medicaid provider utilization at a higher rate than non-Medicaid provider utilization. If the rule passes, we do not know how California would adjust the MCO Tax and HQAF taxing tiers. This proposal in combination with the House Budget Resolution are anticipated to have significant impacts on our providers. Ultimately this change will require the MCO Tax and the HQAF taxing tiers to be redesigned (and renegotiated with the providers that are taxed), it is anticipated tax tier changes would result in less funding for these programs.

Given the timing of finalizing the State's May Revision and the release of the House Budget Resolution and the CMS Proposed Rule it is unclear and how the State will react to the proposed federal Medicaid changes in the final enacted budget. Depending on the timing of federal action it is likely additional budget solutions will be proposed by the Governor after the enactment of the FY 2025-26 State budget.

Partnership FY 2025-26 Health Care Expenses

As noted in our April assumptions, while there is looming uncertainty, Partnership is dedicated to continue providing care to our members based on the current set of Medi-Cal benefits and services. Partnership FY 2025-26 budget will assume costs and membership for these members and services. However, Partnership staff expect to complete an off-cycle budget to account for any Medi-Cal program changes that may occur subsequent to the finalization and approval of Partnership's budget in June of 2025.

Health care cost projections for FY 2025-26 will be based on the Plan's historical claims experience for currently covered Medi-Cal members and benefits. At this time, Partnership anticipates utilizing cost experience from January 2023 through December 2024 for our respective counties which serve as the base data for budget development. Health care cost projections for the expansion counties may be further augmented based on actuarial analysis, draft rate projections, and actual claims experience received prior to budget finalization. Completion factors will be incorporated where appropriate to account for incurred but not yet reported claims. Partnership continues to closely monitor health care costs and membership changes and will adjust our budget methodology based on emerging information.

The base period costs will be adjusted for:

- Reasonable assumptions regarding underlying utilization trends based on internal analysis and a review of DHCS trends used in developing Plan capitation rates.
- Anticipated impacts of case management, utilization management, and specific disease management programs from year-to-year, or newly developed programs.
- Changes in provider contracting such as new payment amendments.

As noted in the April assumptions, Partnership will assess whether we have enough details to estimate the associated revenue and costs of the new transitional rent benefit for inclusion in our final June budget. If not, Partnership will include transitional rent along with CY 2025 and CY 2026 Prop 35 investments in our off-cycle budget review.

Considerations and estimates by cost category are presented in more detail below.

Inpatient Hospital

2025-26: $1.6 billion | 2024-25 Δ: -$-55.7 million or -3.3%

The Inpatient Hospital line item includes inpatient fee-for-service (FFS), hospital capitation, and stop loss expenses. The year-over-year decrease is primarily due to emerging trends from more comprehensive claims data in the expansion region. However, establishing reliable trends in this new region will take several years. With the implementation of the Whole Child Model program in our expansion region effective January 1, 2025, and the new statewide Medicare Buy-In program, further adjustments may be required for the final budget.

With the overall uncertainty in Medicaid and with the State' budgetary condition, Partnership must continue to be prudent in controlling health care expenses through appropriate medical management and sound contracting decisions. As contract requests are evaluated it is imperative to recognize other hospital revenue sources that are afforded to contracted providers in Medi-Cal managed care, such as the PHDP program and the District Hospital Directed Payment (DHDP) program. As of CY 2025 the PHDP and the DHDP programs grew significantly to account for the cost pressures hospitals are currently facing. Partnership is an outlier with our inpatient contracting levels in comparison to other Medi-Cal plans across the state. The state's actuaries assess the reasonableness of Partnership's contracting levels inclusive of the hospital directed payments.

Partnership staff are continuing to evaluate our budget assumptions and the final inpatient hospital expense will be presented in June. As a reminder, Partnership has faced increased scrutiny from DHCS on contracting heath care costs levels, some of which resulted in downward inpatient rate adjustments.

Physician Services

2025-26: $1.1 billion | 2024-25 Δ: $115.5 million or 12.1%

Physician Services includes Proposition 56 payments (Prop 56), specialty capitation, primary capitation, and physician FFS expenses. FFS expenses are increasing year-over-year due to a ramp up in utilization and recent contracting increases. Additionally, annual Tribal OMB rates and utilization for Indian Health Service (IHS) reimbursement have significantly increased. Over the next several weeks, Partnership staff will refine assumptions as additional run-out of paid claims data becomes available.

Effective January 1, 2024, the Prop 56 physician supplemental payment program transitioned into TRI. In CY 2024, TRI increased eligible contracted providers minimum reimbursement levels to at least 87.5% of the lowest Medicare locality in the state for certain Medi-Cal services. The CY 2024 TRI payment levels will continue for FY 2025-26. Details surrounding the final CY 2025 and CY 2026 provider investments through Prop 35 will not be known until the State's final budget is enacted.

Long-Term Care

2025-26: $703.9 million | 2024-25 Δ: $69 million or 10.9%

As explained in prior year budget cycles, the Long-Term Care expense category is challenging to budget for due to the timing and complexity of the retroactive DHCS rate increases. The rates are often released months after their effective date, more recently with multiple versions. This requires Partnership staff to complete an in-depth analysis to calculate and correct prior payments. Pursuant to Assembly Bill (AB) 86, DHCS has established the Workforce Standards Program. Facilities that opted-in receive an enhanced per diem. DHCS annual facility per diem rate increases, along with SB525 impacts, are driving the overall year-over-year increase.

Ancillary Services

2025-26: $1.1 billion | 2024-25 Δ: $121.4 million or 12.3%

Ancillary Services is comprised of FFS and capitated ancillary services, Enhanced Case Management (ECM), and Community Supports. The budget assumes increases tied to FFS utilization and unit cost increases specific to emergency department, outpatient hospital services, ECM, and Community Supports.

Other Medical

2025-26: $497.8 million | 2024-25 Δ: $63 million or 14.5%

The Other Medical category includes transportation, quality assurance, health care investment fund, nurse advice line, and the DHCS voluntary rate range program. As of April 2024, transportation benefits were directly coordinated by Partnership. The in-house administration of the non-medical and non-emergency medical transportation benefits continues to provide greater access and better customer service to our members and providers. Increases in utilization and the rural nature of the counties we serve are the main drivers for the year-over-year increase. The quality assurance and medical administrative expenses costs were held constant from the prior year; Staff will provide updated cost assumptions for these expense categories in the June budget.

DHCS Facility Directed Payment Programs

2025-26: $1.4 billion | 2024-25 Δ: $673.3 million or 89.4%

The following facility directed payments are included in this category: PHDP program, DHDP program, SNF WQIP, Designated Public Hospital Enhanced Payment program, and the Designated Public Hospital Quality Improvement program. The significant increase of the statewide pools for the PHDP program and the DHDP program are the primary driver of the year-over-year increase.

Quality Improvement Programs (Incentives)

2025-26: $89.2 million | 2024-25 Δ: $-10.8 million or -10.8%

The year-over-year decrease in QIP expenses is due to the conclusion of the Specialty Quality Access Incentive program on December 31, 2024. This program was sunset in conjunction with the CY 2024 TRI investments. Partnership continues to invest in quality improvement programs to enhance performance on quality metrics prioritized by the DHCS Quality Withhold Incentive program to provide quality, equitable and cost-effective care to our members. As in previous periods, incentive funding remains contingent on final revenue projections.

Dual Special Needs Plan (D-SNP)

The plan has undertaken significant efforts to operationalize our D-SNP by January 2026. Due the timing of finalizing our CMS bid submission, the anticipated costs for the D-SNP program have not been included in this version of the budget. Staff will incorporate D-SNP estimated costs in the final June budget. In addition to increased health care expenses, Partnership anticipates increased staffing costs, consulting costs, and capital costs associated with D-SNP systems and infrastructure needs.

Off-Cyle Budget

Due to the uncertainty regarding potential federal Medicaid program changes, the corresponding State's Budgetary reaction – Partnership staff expect to complete an off-cycle budget to account for material programmatic changes and cost changes that occur subsequent to the finalization of Partnership's budget in June.

Health Care Budget FY 2025-26 to FY 2024-25 Comparison

Health Care Categories	Budget FY 2025-26	Budget FY 2024-25	Y-o-Y △ $	Y-o-Y △ %
Inpatient Hospital	$1,643,371,839	$1,699,095,856	($55,724,017)	(3.3%)
Physician Services	$1,070,203,028	$954,692,536	$115,510,492	12.1%
Long Term Care	$703,914,904	$634,948,033	$68,966,871	10.9%
Ancillary Services	$1,105,418,263	$984,036,185	$121,382,078	12.3%
Other Medical	$497,756,774	$434,793,058	$62,963,716	14.5%
DHCS Facility Directed Payment Programs	$1,426,708,534	$753,440,101	$673,268,433	89.4%
Quality Improvement Programs	$89,200,000	$100,009,080	($10,809,080)	(10.8%)
Total Health Care Expense	**$6,536,573,342**	**$5,561,014,849**	**$975,558,493**	**17.5%**