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AGENDA
SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Teleconference Meeting

(Pursuant to Governor Newsom's Executive Order N-29-20)

DATE: **Wednesday, December 2, 2020**

TIME: **1:30 – 2:45 p.m.**

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, Alliance offices will be closed for this meeting. The following alternatives are available to members of the public to view this meeting and to provide comment to the Board.

1. Members of the public wishing to join the meeting may do so as follows:
    a. Via computer, tablet or smartphone at: https://global.gotomeeting.com/join/648705813
    b. Or by telephone at:
    United States: +1 (872) 240-3311
    Access Code: 648-705-813
    New to GoToMeeting? Get the app now and be ready when your first meeting starts: https://global.gotomeeting.com/install/648705813

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, December 1, 2020 to the Clerk of the Board at kstagnaro@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to five minutes.
    b. Public comment during the meeting, when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

3. Mute your phone during presentations to eliminate background noise.
    a. State your name prior to speaking during comment periods.
    b. Limit background noise when unmuted (i.e. paper shuffling, cell phone calls, etc.).

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1. **Call to Order by Chairperson Molesky. 1:30 p.m.**
   A. Roll call; establish quorum.

2. **Oral Communications. 1:35 p.m.**
   A. Members of the public may address the Commission on items not listed on today's agenda that are within the jurisdiction of the Commission. Presentations must not exceed five minutes in length, and any individuals may speak only once during Oral Communications.
   B. If any member of the public wishes to address the Commission on any item that is listed on today's agenda, they may do so when that item is called. Speakers are limited to five minutes per item.

3. **Approve minutes of September 23, 2020 meeting of the Finance Committee. 1:40 p.m.**

4. **Approve Finance Committee Meeting Schedule for 2021. 1:45 p.m.**

4. **Year-to-date September 2020 Financials. 1:50 p.m.**

5. **2021 Budget and Medical Cost Assumption Detail. 2:00 p.m.**

6. **Cost Containment Plan Update. 2:30 p.m.**

The next meeting of the Commission, after this December 2, 2020 meeting will be held via teleconference unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission Finance Committee Wednesday, March 24, 2021, 1:30 – 2:45 p.m.

Members of the public interested in attending should call the Alliance at (831) 430-5523 to verify meeting dates and locations prior to the meetings.

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The complete agenda packet is available for review at Alliance offices, and on the Alliance website at www.ccah-alliance.org/boardmeeting.html. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-5523. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.

FINANCE COMMITTEE
SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, September 23, 2020
1:30 – 2:45 p.m.

Teleconference Meeting

(Pursuant to Governor Newsom's Executive Order N-29-20)

Commissioners Present:

Ms. Mimi Hall	County Health Services Agency Director
Ms. Elsa Jiménez	County Health Director
Supervisor Lee Lor	County Board of Supervisors
Mr. Michael Molesky	Public Representative
Allen Radner, MD	Provider Representative
Mr. Tony Weber	Provider Representative

Commissioners Absent:

Ms. Leslie Conner	Provider Representative

Staff Present:

Ms. Lisa Ba	Chief Financial Officer
Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Oksana Chabanenko	Finance Administrative Specialist

1. Call to Order by Chairperson Molesky. (1:34 p.m.)

Chairperson Molesky called the meeting to order at 1:34 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:35 – 1:36 p.m.)

Chairperson Molesky opened the floor for any members of the public to address the Committee on items not listed on the agenda.

No members of the public addressed the Committee.

3. Approve minutes of May 27, 2020 meeting of the Finance Committee. (1:36 – 1:37 p.m.)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the May 27, 2020 meeting. Commissioner Weber moved to approve the minutes, seconded by Commissioner Radner. Motion carried with 6 votes affirmative, 1 absent and was so ordered.

4. Year-to-date July 2020 Financials. (1:38 – 1:48 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioners on the Alliance's most recent financials. As of July 2020, the net operating loss stands at $35.7M, which is $5.7M unfavorable to budget. Enrollment is 3.4% favorable to budget, which is equivalent to over 11K members monthly. Revenue is $23.6M or 3.3% favorable. Medical Expenses are unfavorable to budget by $28.3M or 4.0%. The Medical Loss Ratio (MLR) is 98.2%, compared to the budget of 97.5%.

Capitation revenue and medical expenses are variable based on enrollment fluctuations, therefore the per member per month (PMPM) view offers more clarity than the total dollar spend. The revenue and medical costs are closer to budget on a PMPM basis. Conversely, administrative expenses do not directly correspond with enrollment and are therefore viewed in terms of total dollar spend.

The Administrative Loss Ratio (ALR) is slightly below budget at 6.6% versus 6.7%. Administrative Expenses are unfavorable to budget by $1.1M or 2.2% primarily due to accumulated staff paid time off (PTO) due to the pandemic. Staff have been asked to eliminate overtime and encouraged to take time off before the end of the year. This is expected to reduce or possibly eliminate the unfavorable administrative variance.

[Commissioner Elsa Jimenez arrived at this time: 1:43 p.m.]

Year-to-date PMPM revenue is $311, medical cost is $306 and administrative cost is $21, resulting in an operating loss of $15 PMPM. PMPM actuals across the board are very close to budget; revenue is only 0.1% unfavorable despite the State's May budget revision, which reduced the Plan's bridge period rate by 1.5% retroactive to July 2019. The overall 2020 revenue reduction is $23M or $16.6M year-to-date as of July. Barring the revenue cuts, the plan would have been below budget in PMPM expenses. PMPM medical costs are 0.7% unfavorable to budget. L. Ba explained that the PMPM equivalent provides the true cost adjusted for the enrollment variance and helps us distinguish the root cause of our financial losses. Currently, since our costs exceed revenue and we are experiencing an operating loss at the PMPM level, higher membership results in higher losses.

Utilization dropped 25% from mid-March to May and a further 10-15% in June-July; the decline then slowed to 5-10% in August and September. Despite this, medical expenses have been consistent from January through July due to several factors. Firstly, due to the claims lags, since it normally takes up to 90

days for claims to be submitted: for example, quarter one claims are still paid in April and May. Secondly, the Alliance paid claims advancement to certain providers in need of meeting their short-term cash flows. Thirdly, DHCS increased the Long-Term Care (LTC) rate by 10% retroactive back to March 1, 2020 due to COVID-19, which has caused us to increase our claims liability. Lastly, we have been accruing medical costs for COVID-19 cases. So far, 400 Alliance member cases have been reported, accrued for at $40K each, for a total of $16M. DHCS considers COVID-19 a regular medical cost that is covered in the Plan's regular capitation revenue, therefore no additional reimbursement is expected.

All of these factors have kept our financial performance consistent and no reduction in medical expenses has been realized despite the pandemic's effect on regular utilization. As we recover the claims advances from providers, close COVID-19 cases and pay LTC claims through regular claims process, we expect to see some relief in medical costs in the next couples of months.

Staff will prepare a 2020 forecast and share it with the Board at the October Board meeting. A total operating loss of $53M was budgeted in 2020, which is projected to be on budget or better.

The fund balance as of the end of July 2020 is $411.4M – about seven times the State requirement. Excluding the grant funding, the Plan is $56.8M below the Board Designated Reserve Target, which is the equivalent of three months of capitation.

Commissioner Radner inquired if the COVID case load is based on actual inpatient count. L. Ba confirmed this is the actual COVID inpatient count. The $40K per patient cost is based on the industry average.

5. 2019 Rate Development Template (RDT). (1:48-2:09 p.m.)

L. Ba described to the commissioners the Plan's rate setting process. The Rate Development Template (RDT) timeline runs three years in arrears: for example, the Alliance's current 2020 revenue is based on the 2017 cost experience, 2021 revenue will be based on 2018 data and so forth. Staff has recently completed compiling 2019 date of service data, which will be used as the basis for the 2022 rate. RDT for our current calendar year data will be submitted next year and will determine our rate for 2023.

To explain the step-by-stem RDT process, L. Ba used the 2018 data which set the rate for the Plan's 2021 revenue. As a starting point, Mercer, the State actuary, will use our historical 2018 claims data and adjust it for the trended annual increase. They will then incorporate any program changes: in 2021 we are expecting a change to maternity claims. Currently, maternity reimbursement for County Organized Health Systems (COHS) such as the Alliance is built into the capitation rate, while most other plans are reimbursed per birth. As part of the CalAIM initiative to standardize benefits across all Medi-Cal Managed Care Plans, the State will carve out maternity reimbursement from COHS rates and implement the claim based per-birth billing process.

Following the program changes, Mercer will apply managed care efficiency adjustments. For rates prior to 2021, DHCS applied only two efficiency adjustments: the Potentially Preventable Hospital Admission (PPA) adjustment and the Healthcare Common Procedure Coding System (HCPCS) Maximum Allowable Cost (MMA) adjustment intended for health plans to mitigate potential avoidable costs due to reimbursement inefficiencies for physician administered drugs billed via HCPCS codes. Effective 2021, pharmacy will be carved out from Medi-Cal managed care plans, however, two new efficiency adjustments will be implemented: the Lower Acuity Non-Emergent (LANE) service efficiency adjustment for ED and Physician Administered Drugs (PAD) adjustment. Therefore in 2021, there will be three efficiency adjustments applicable to our rates: PPA, LANE and PAD, which will all comprise the efficiency factor affecting the rate setting.

Next in the Mercer RDT process is the non-medical load component, which is related to the plans' administrative costs. This also includes underwriting gain (UWG), for which we anticipate a change in 2021 rates: the State will reduce the UWG from 2.0% to 1.5%. This concludes the rate development process for 2021.

Next, L. Ba presented the 2019 cost experience, which will determine our 2022 revenue. 2019 total medical cost increased by $90.7M or 11.7% compared to the prior year. Of that, Whole Child Model (WCM) expenses accounted for $78M and non-WCM Medi-Cal accounted for $13M. Part of the reason WCM costs were so high is because the program was implemented mid-year in July 2018. Even with the 2018 WCM expense annualized, the program still accounts for $17M or more than half of the total increase. The year-over-year WCM increase is 14%.

The top five categories of service accounted for 80% the total year-over-year increase. Most significantly, the upsurge in inpatient hospital cost accounted for one-third of the total $90.7M increase. On a PMPM basis, inpatient cost increased by 12.0% PMPM, which is comprised of the unit cost increase of 15.6% and utilization decrease of 3.1%.

L. Ba emphasized that back in 2016 the Alliance significantly increased provider reimbursements, with most hospitals signing a three-year contract establishing their rates for 2017, 2018 and 2019. In 2020 the Alliance did not increase any rates for our in-area hospitals.

The Alliance's historical medical cost trend over three years is 12%, where Mercer usually allows no more than 8%, resulting in a 4% gap. After including various efficiency adjustments, there is a potential gap of $85M between revenue and cost in 2022. This assessment shows that we need to reduce our contract rate to bend the financial loss curve and reach breakeven. This gap does not take into account our cost containment plan that has been approved by the Board in June.

Since the approval of the cost containment plan, staff has been diligently working on its deliverables. In-area hospitals have been prioritized for renegotiation, letters have been mailed to the hospital's CFOs and CEOs explaining the reasons for the Board decision, and new terms were sent to all hospitals. We are now in the negotiations phase, which is expected to last a few months. The targeted reduction in inpatient expense is $15M in 2021; the cumulative reduction in medical costs is projected at $35M by 2022 and $70-80M by 2023, which is the year the Alliance plans to achieve breakeven. The cost containment plan is staged over three years, since a single year cut to achieve the necessary savings would be too extreme for the hospitals.

Commissioner Elsa Jimenez inquired if the hospital rates are still being negotiated. L. Ba confirmed negotiations are ongoing.

Commissioner Molesky asked if the Alliance can recuperate any of the COVID-19 expenses in the future years. L. Ba explained that the State's assumption is for the health plans to cover the pandemic costs with the funds saved from the decrease in elective procedures, therefore no additional reimbursement is anticipated.

Commissioner Radner made a comment on the utilization decrease in 2020. As a provider representative, he noted a backlog of elective surgeries and other non-urgent procedures and expressed that the Alliance might need to financially plan or accrue for a potential jump in utilization that could start materializing in 2021 and 2022. L. Ba confirmed staff is building this assumption into the 2021 medical budget using authorizations data for relevant insight. Per general accepted accounting principles, however, we cannot accrue for those future projected expenses, since accruals can only occur for the year in which the cost was incurred. She added that the budget assumptions will be provided to the Finance Committee in October.

6. Investment Summary YTD through June 2020. (2:09-2:29 p.m.)

As of June 30, 2020, the Alliance holds $250.1M in investment funds. Union bank holds the biggest portion – $68.1M or 27%, followed by Local Agency Investment Fund (LAIF) with $63.5M or 25% and CalTRUST with $48.0M or 19%. Wells Fargo currently comprises only $36.6 or 15% of our portfolio. There is also an additional $224M in a Comerica sweep account as operating cash.

By holding category, the majority of our funds – $111.4M or 45% – is in the Pooled Money Investment Account (PMIA), which includes CalTRUST and LAIF. The second highest holding category is corporate bonds with $63.2M or 25%, followed by government bonds with $43.1M or 17%. PMIA is a State maintained fund that holds a total of about $140B of taxpayer funds, with more than half of its portfolio – 54% – being allocated to treasury securities, 18% to agencies debt and 15% to CDs and bank deposits.

In terms of ratings, per the Alliance's investment policy we only invest in A and above rated funds with no longer than a five-year maturity. However, due to the recent years' financial losses, we have been favoring even shorter term investments of no more than three years maturity in order to meet the operating cash need. Therefore, the maturity of our current investments is spread from 2020 through 2023. Once we are able to achieve breakeven and regain the ability to accumulate income, we can return to five-year maturity investments.

Our total yield for the second quarter of 2020 is 2.02%, compared to 2.08% in the first quarter. Compared to 2019, the Alliance's 2020 year-to-date yield has decreased slightly from 2.09% to 2.00% with the pooled account showing the biggest decrease – from 2.23% to 1.53%. This is due to the account being heavily invested in short-term treasury funds, which were particularly affected by the pandemic.

Ms. Ba summarized that the Alliance has been managing its investment portfolio per the company policy in place. Our investing goals in order of importance are: safety of principal, liquidity of funds, social responsibility and, lastly, yield.

Commissioner Molesky asked for a brief overview for the new commissioners of the investment limitations the Alliance must follow as a COHS. L. Ba explained that as a Medi-Cal health plan, the Alliance is subject to certain restrictions in investing as set by the State. Our primary investing goal is safety of capital, therefore we do not strive to follow highest market return or invest in high-risk ventures. With the same objective in mind, we are limited to investing no more than 10% in any specific fund. These regulations apply to the $119.0M the Plan holds in corporate and government bonds. The investment policy has been shared with our fund managers at Comerica, Union Bank and Wells Fargo, who, in turn, do their due diligence. PMIA, however, as a State managed fund, is by design subject to the same investing principles governing the Alliance, hence the 10% allocation rule does not apply to LAIF or CalTRUST funds. Therefore, as a qualifying local health plan, the Alliance invests heavily in these funds. LAIF is a voluntary program that offers the opportunity for its participants to be able to use the State as an investing resource. The program is governed by Local Agency Advisors, which is comprised of five members who are elected via statute. CalTRUST is a joined powers authority created by public agencies to provide convenience and a consolidation method for multiple public agencies to pool assets for investment.

The Alliance also voluntarily added the element of social responsibility in order to be a dutiful steward of public funds. The CFO added that she will cover the Alliance's investment policy in more detail in future meetings.

Commissioner Molesky asked about the possibility of investing in green bonds and pointed out that in relation to socially responsible investing objective, he had in depth discussions on the subject with the previous Finance director and will share the info with L. Ba.

Commissioner Molesky then inquired if any physical modifications are needed to the Alliance's office space as it relates to COVID-19 safety and return to work, as well as the anticipated cost of such a project. He also asked if the Plan would be able to get reimbursed by the State for these capital improvements or if there could be a grant available to cover the cost. L. Ba reported that staff had organized a committee tasked with evaluating employees' safe return to work. Among the committee members are employees from Facilities, Human Resources and Health Services, including a medical director who used to serve as a health services director for Merced County. We do not have clear projections as to when the reopening will be deemed safe, but we have communicated to staff the timeline of no earlier than February 2021. The winter season developments will help us navigate accordingly. With relation to grants, as a Medi-Cal Health Plan, we do not qualify for any, however, any additional safety improvements may qualify as part of our regular rate setting process. It is too soon to determine at this time. Our current spend will set our rates for 2023 and as of now, DHCS has not released the criteria as to rate setting for that year.

Commissioner Molesky opened the floor for any other questions about any information presented or any suggestions on the upcoming December 2, 2020 Finance Committee agenda. No feedback was received.

The Alliance's investing strategy will be discussed in depth in the first Finance Committee meeting of 2021 since the December 2, 2020 meeting will be dedicated to 2021 budget planning.

L. Ba commended the commissioners on their work, especially related to the passing of the cost containment plan. She invited any feedback or suggestions on any topics the commissioners would like covered in future meetings. Commissioner Molesky joined the CFO in thanking the committee members for their hard work during these difficult times.

The Commission adjourned its meeting of September 23, 2020 at 2:30 p.m. to December 2, 2020 at 1:30 p.m. via teleconference from the Alliance office in Scotts Valley, Salinas, and Merced.

Respectfully submitted,

Ms. Oksana Chabanenko
Finance Administrative Specialist

DATE: December 2, 2020

TO: Finance Committee

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Schedule of Finance Committee Member Participation 2021

Recommendation. Staff recommend the Finance Committee approve the 2021 schedule of member participation.

Background. Commission members serve a one year term at the end of which Commissioners vote on membership. Meetings are held at the following locations via videoconference unless otherwise noted, and are open to the public.

In Santa Cruz County:	Central California Alliance for Health Board Room 1600 Green Hills Road, Suite 101, Scotts Valley, CA
In Monterey County:	Central California Alliance for Health Board Room 950 East Blanco Road, Suite 101, Salinas, CA
In Merced County:	Central California Alliance for Health Board Room 530 West 16th Street, Suite B, Merced, CA

Based on guidance from the California Department of Public Health and pursuant to Governor Newsom's Executive Order N-29-20 to minimize the spread of COVID-19, some meetings may be held by teleconference with no access to Alliance offices. Information for attending meetings remotely will be included in the respective agenda.

Finance Committee

Meetings will be held by videoconference in Scotts Valley, Salinas and Merced or by teleconference from 1:30 – 2:45 p.m. unless otherwise noticed with a 2021 meeting schedule as follows.

Finance Committee members include:
1. Michael Molesky (Committee Chair)
2. Leslie Conner
3. Tony Weber
4. Mimi Hall
5. Elsa Jimenez
6. Alan Radner, MD

Wednesday, March 24, 2021, 1:30 – 2:45 p.m.
Wednesday, May 26, 2021, 1:30 – 2:45 p.m.
Wednesday, September 22, 2021, 1:30 – 2:45 p.m.
Wednesday, October 27, 2021, 1:30 – 2:45 p.m.

Report from the Chief Financial Officer
December 2, 2020

Financial Highlights for the Nine Months Ending September 30, 2020

- The September Net Operating loss for all lines of business stands at $3.9M
- Medical Expenses are unfavorable to budget by $9.4M or 9.4% with an MLR of 97.4%
- Administrative Expenses are favorable to budget by $0.3M or 4.1% with an ALR of 6.2%
- Fund Balance is $411.0M or 7.3 times the minimum Tangible Net Equity (TNE) required by the State

Sep-20 MTD (In $000s)

Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*358,888*	*328,140*	*30,748*	*9.4%*
Revenue	111,907	102,192	9,715	9.5%
Medical Expenses	108,964	99,599	(9,365)	-9.4%
Administrative Expenses	6,885	7,180	295	4.1%
Operating Income/(Loss)	(3,942)	(4,587)	645	14.1%
Net Income/(Loss)	(3,961)	(5,189)	1,228	23.7%
MLR %	*97.4%*	*97.5%*	*0.1%*	
ALR %	*6.2%*	*7.0%*	*0.8%*	
Operating Income %	*-3.5%*	*-4.5%*	*1.0%*	
Net Income %	*-3.5%*	*-5.1%*	*1.6%*	

Sep-20 YTD (In $000s)

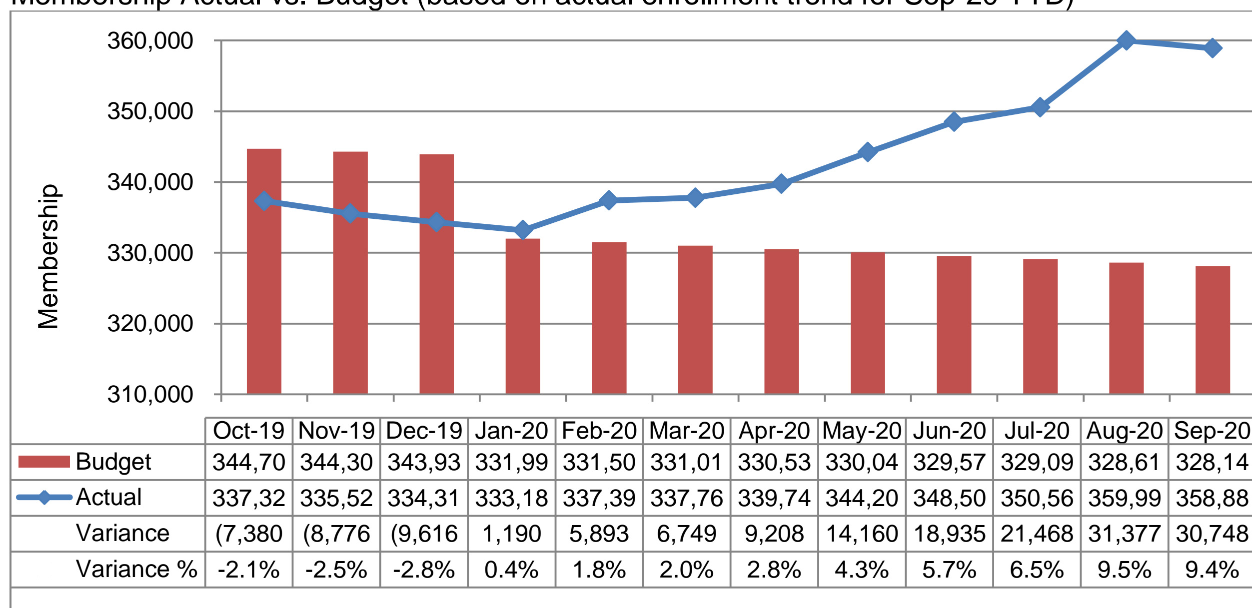
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Membership	*3,110,235*	*2,970,507*	*139,728*	*4.7%*
Revenue	968,809	925,610	43,200	4.7%
Medical Expenses	942,345	902,209	(40,136)	-4.4%
Administrative Expenses	62,302	62,414	112	0.2%
Operating Income/(Loss)	(35,838)	(39,014)	3,176	8.1%
Net Income/(Loss)	(39,737)	(44,269)	4,532	10.2%
PMPM				
Revenue	311.49	311.60	(0.11)	0.0%
Medical Expenses	302.98	303.72	0.74	0.2%
Administrative Expenses	20.03	21.01	0.98	4.7%
Operating Income/(Loss)	(11.52)	(13.13)	1.61	12.3%
MLR %	*97.3%*	*97.5%*	*0.2%*	
ALR %	*6.4%*	*6.7%*	*0.3%*	
Operating Income %	*-3.7%*	*-4.2%*	*0.5%*	
Net Income %	*-4.1%*	*-4.8%*	*0.7%*	

PMPM. Capitation revenue and medical expenses are variable based on enrollment fluctuations, therefore the per member per month (PMPM) view offers more clarity than the total dollar spend. The revenue and medical costs are closer to budget on a PMPM basis. Conversely, administrative expenses do not directly correspond with enrollment and are therefore viewed in terms of total dollar spend.

At a PMPM level, year-to-date (YTD) revenue is $311.49, medical cost is $302.98 and administrative cost is $20.03, resulting in an operating loss of $11.52 PMPM. PMPM actuals across the board are close to budget, and revenue is less than 0.1% unfavorable despite the State's May budget revision and the resulting reduction to the Plan's bridge period rate. Barring the revenue cuts, the revenue would have been below budget in PMPM. With costs exceeding revenue, we are experiencing an operating loss at the PMPM level, therefore higher membership results in higher losses.

Membership. September 2020 Member Months are favorable to budget by 9.4%. Favorability in Member Months is primarily driven by the "Family/Adult and Adult Expansion" Category of Aid, Whole Child Model (WCM), and IHSS, which account for 70.0% of the increase. The increase is attributable largely to the suspension of the Medi-Cal redetermination process during the Public Health Emergency period. Member Months are partially offset by unfavorability in "LTC and LTC Full Dual" Category of Aid by 23.9%. By county, Santa Cruz is favorable to budget by 10.0%, followed by Merced at 9.5%, and Monterey at 9.0%.

Membership Actual vs. Budget (based on actual enrollment trend for Sep-20 YTD)



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Budget	344,70	344,30	343,93	331,99	331,50	331,01	330,53	330,04	329,57	329,09	328,61	328,14
Actual	337,32	335,52	334,31	333,18	337,39	337,76	339,74	344,20	348,50	350,56	359,99	358,88
Variance	(7,380	(8,776	(9,616	1,190	5,893	6,749	9,208	14,160	18,935	21,468	31,377	30,748
Variance %	-2.1%	-2.5%	-2.8%	0.4%	1.8%	2.0%	2.8%	4.3%	5.7%	6.5%	9.5%	9.4%

Revenue. September 2020 Medi-Cal capitation revenue is $111.6M, which is favorable to budget by $9.7M or 9.5%. September 2020 YTD Medi-Cal capitation revenue of $966.4M is favorable to budget by $42.8M or 4.6%. Of this $42.8M favorability, $49.8M is attributed to enrollment favorability which is partially offset by a $6.9M net rate variance. YTD Capitation Revenue includes a rate variance adjustment from the State's May Budget Revision, which proposed a 1.5% rate reduction for Adult, Child, ACA OE, and SPD population for the bridge period of July 2019 through December 2020. The financial impact for the full bridge period is approximately $19.7M.

Sep-20 YTD Capitation Revenue Summary (In $000s)					
County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	217,557	211,080	6,477	10,041	(3,564)
Monterey	420,100	396,923	23,178	22,223	955
Merced	328,752	315,558	13,195	17,500	(4,305)
Total	**966,410**	**923,560**	**42,850**	**49,764**	**(6,914)**

Note: Excludes Sep-20 YTD In-Home Supportive Services premiums revenue of $2.4M

Medical Expenses. September 2020 YTD Medical Expenses are $942.3M, which is unfavorable to budget by $40.1M or 4.4%, with an MLR of 97.3%. Inpatient Services (Hospital) are unfavorable by $27.7M or 10.1%, Inpatient Services (LTC) are unfavorable by $20.0M or 19.3%, Pharmacy Costs are unfavorable by $3.8M or 2.7%, and Outpatient Facility is unfavorable by $1.1M or 2.2%. Medical Expenses include $6.5M Inpatient Services (Hospital) IBNR reserve for COVID-19 pandemic costs. Medical Expenses are partially offset by favorability in Other Medical of $7.6M or 4.1% and Physician Services of $4.9M or 3.3%.

Administrative Expenses. September 2020 YTD Administrative Expenses are $62.3M, which is favorable to budget by $0.1M or 0.2%, with an ALR of 6.4%. Favorability is driven by Non-Salary Administrative Expenses of $2.2M or 10.0%. Non-Salary Administrative Expenses are offset by unfavorability in Salaries, Wages and Benefits (SWB) of $2.1M or 5.2%.

Non-Operating Revenue. September 2020 YTD Total Non-Operating Revenue is unfavorable to budget by $0.9M or 12.7% and consists of $4.1M in interest income, $1.4M in unrealized investment gain and $0.8M in rental income for a total of $6.3M. Unrealized gains or losses will not be realized unless the bonds are sold prior to their maturity. The bonds have been bought with the intention of holding them to maturity. If held to maturity, unrealized gains or losses would be completely reversed.

Non-Operating Expenses. September 2020 YTD Total Non-Operating Expenses of $10.2M are favorable to budget by $2.3M or 18.2%. There is currently $150.1M in the Grant program, which is a non-operating expense.

Non-Operating Revenue/Expenses. September 2020 YTD Total Non-Operating Revenue of $6.3M was offset by $10.2M in grant distribution, resulting in a Net Non-Operating Loss of $3.9M.

Fund Balance. The Fund Balance is currently $411.0M, which is 7.3 times the minimum TNE requirement established by the State of $56.0M. The Alliance's reserves without grants are $261.0M, which is $60.0M or 18.7% below the Designated Reserves Target requirement established by the Board. Please note that the Alliance's internal State Required TNE differs from DMHC's due to a different calculation methodology.

Health Care Expense Reserve. The Plan's Health Care Expense Reserve is $320.9M, an increase from the prior reporting period of $2.1M. This line on the Alliance's Balance Sheet reflects three times capitation premiums and prior year adjustments.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Nine Months Ending September 30, 2020
(In $000s)

Assets	
Cash	$306,291
Restricted Cash	301
Short Term Investments	250,594
Receivables	139,323
Prepaid Expenses	2,766
Other Current Assets	6,785
Total Current Assets	**$706,061**
Building, Land, Furniture & Equipment	
Capital Assets	$82,300
Accumulated Depreciation	(34,793)
CIP	3,722
Total Non-Current Assets	**51,228**
Total Assets	**$757,289**
Liabilities	
Accounts Payable	$77,348
IBNR/Claims Payable	245,734
Accrued Expenses	22
Estimated Risk Share Payable	11,267
Other Current Liabilities	7,635
Due to State	4,244
Total Current Liabilities	**$346,251**
Fund Balance	
Fund Balance - Prior	$450,775
Retained Earnings - CY	(39,737)
Total Fund Balance	**411,038**
Total Liabilities & Fund Balance	**$757,289**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Nine Months Ending September 30, 2020
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*358,888*	*328,140*	*30,748*	*9.4%*	*3,110,235*	*2,970,507*	*139,728*	*4.7%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$111,623	$101,957	$9,667	9.5%	$966,410	$923,560	$42,850	4.6%
Premiums Commercial	284	235	48	20.6%	2,400	2,050	350	17.1%
Total Operating Revenue	**$111,907**	**$102,192**	**$9,715**	**9.5%**	**$968,809**	**$925,610**	**$43,200**	**4.7%**
Medical Expenses								
Inpatient Services (Hospital)	$37,276	$30,479	($6,797)	-22.3%	$301,915	$274,167	($27,748)	-10.1%
Inpatient Services (LTC)	13,465	11,681	(1,784)	-15.3%	123,959	103,941	(20,017)	-19.3%
Physician Services	15,998	16,162	164	1.0%	145,762	150,660	4,898	3.3%
Outpatient Facility	6,118	5,049	(1,069)	-21.2%	50,988	49,892	(1,096)	-2.2%
Pharmacy	15,770	14,557	(1,213)	-8.3%	142,066	138,268	(3,798)	-2.7%
Other Medical	20,337	21,671	1,334	6.2%	177,655	185,281	7,625	4.1%
Total Medical Expenses	**$108,964**	**$99,599**	**($9,365)**	**-9.4%**	**$942,345**	**$902,209**	**($40,136)**	**-4.4%**
Gross Margin	**$2,943**	**$2,593**	**$349**	**13.5%**	**$26,464**	**$23,400**	**$3,064**	**13.1%**
Administrative Expenses								
Salaries	$4,820	$4,607	($213)	-4.6%	$42,544	$40,449	($2,094)	-5.2%
Professional Fees	251	240	(12)	-4.8%	1,404	1,963	559	28.5%
Purchased Services	914	832	(83)	-9.9%	7,176	7,463	288	3.9%
Supplies & Other	279	779	500	64.2%	5,405	6,254	849	13.6%
Occupancy	89	134	45	33.4%	913	1,212	300	24.7%
Depreciation/Amortization	531	589	58	9.8%	4,860	5,072	212	4.2%
Total Administrative Expenses	**$6,885**	**$7,180**	**$295**	**4.1%**	**$62,302**	**$62,414**	**$112**	**0.2%**
Operating Income	**($3,942)**	**($4,587)**	**$645**	**14.1%**	**($35,838)**	**($39,014)**	**$3,176**	**8.1%**
Non-Op Income/(Expense)								
Interest	$311	$738	($427)	-57.9%	$4,142	$6,892	($2,751)	-39.9%
Gain/(Loss) on Investments	(271)	(44)	(227)	-100.0%	1,354	(410)	1,764	100.0%
Other Revenues	97	84	13	15.7%	824	755	69	9.2%
Grants	(157)	(1,380)	1,223	88.6%	(10,219)	(12,493)	2,274	18.2%
Total Non-Op Income/(Expense)	**($19)**	**($602)**	**$583**	**96.8%**	**($3,899)**	**($5,256)**	**$1,356**	**25.8%**
Net Income/(Loss)	**($3,961)**	**($5,189)**	**$1,228**	**23.7%**	**($39,737)**	**($44,269)**	**$4,532**	**10.2%**
MLR	*97.4%*	*97.5%*			*97.3%*	*97.5%*		
ALR	*6.2%*	*7.0%*			*6.4%*	*6.7%*		
Operating Income	*-3.5%*	*-4.5%*			*-3.7%*	*-4.2%*		
Net Income %	*-3.5%*	*-5.1%*			*-4.1%*	*-4.8%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Nine Months Ending September 30, 2020
(In $000s)

	MTD	YTD
Net Income	($3,961)	($39,737)
Items not requiring the use of cash: Depreciation	531	4,860
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	62,624	35,037
Prepaid Expenses	34	(767)
Current Assets	2,240	652
Net Changes to Assets	**$64,898**	**$34,921**
Changes to Payables:		
Accounts Payable	($16,751)	$74,547
Accrued Expenses	(9)	(68)
Other Current Liabilities	658	2,658
Incurred But Not Reported Claims/Claims Payable	27,485	60,801
Estimated Risk Share Payable	1,250	1,103
Due to State	-	(19,706)
Net Changes to Payables	**$12,634**	**$119,336**
Net Cash Provided by (Used in) Operating Activities	**$74,102**	**$119,381**
Change in Investments	($23)	$110,660
Other Equipment Acquisitions	(167)	(1,825)
Net Cash Provided by (Used in) Investing Activities	**($190)**	**$108,835**
Net Increase (Decrease) in Cash & Cash Equivalents	**$73,912**	**$228,216**
Cash & Cash Equivalents at Beginning of Period	**$232,379**	**$78,075**
Cash & Cash Equivalents at September 30, 2020	**$306,291**	**$306,291**