AUDIT COMMITTEE MEETING

Board of Governors

December 16, 2020 • 1:00 PM

L.A. Care Health Plan

1055 W. 7th Street, Los Angeles, CA 90017

AGENDA
Audit Committee Meeting
Board of Governors

DRAFT

Wednesday, December 16, 2020, 1 P.M.
L.A. Care Health Plan, 1055 West 7th Street, Conference Room 1025, Los Angeles

California Governor issued Executive Order N-25-20, N-29-20, which among other provisions amends the Ralph M. Brown Act. Accordingly, members of the public must now listen to this meeting via teleconference or videoconference as follows:

To join the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m1d1dbea7da3ee5fc7d2ede465b9dbffd
You may register anonymously for the videoconference but you must provide a valid email address.

To join the meeting via teleconference please dial: (213) 306-3065 or (415) 655-0002
Access code: 146 064 9690

Members of the Board of Governors or staff may also participate in this meeting via videoconference or teleconference. *The public must submit its public comments or comments on Agenda items in writing by e-mail to BoardServices@lacare.org, or by a text or voicemail to 213 628-6420.*

The text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates.

Comments received by voicemail, email or text by 1:00 pm on December 16, 2020 will be provided in writing to the members of the Audit Committee.
Once the meeting has started, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair starts consideration of the item. The Chair will ask for public comment and will announce the item. The Chair will announce when public comment period is over for that item. Public comments will be read for up to 3 minutes at the meeting.
All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

Welcome		Alvaro Ballesteros, *Chair*
1.	Approve today's Agenda	*Chair*
2.	Public Comment	*Chair*
3.	Approve July 22, 2020 meeting minutes p.4	*Chair*
4.	Chairperson's Report	*Chair*
5.	Chief Executive Officer / Chief Financial Officer Reports	John Baackes, *Chief Executive Officer* Marie Montgomery, *Chief Financial Officer*

DRAFT

Committee Issues

6. Review of Audit Report FY 2019-20 **(AUD A)** p.9

Rosie Procopio,
Lead Client Service Provider Partner,
Deloitte & Touche, LLP

Adjournment

Chair

Please keep public comments to three minutes or less.

The order of items appearing on the agenda may change during the meeting.
The public can participate in the meeting by calling the teleconference call in number provided, note that the arrangements may change prior to the meeting. To confirm details with L.A. Care Board Services staff prior to the meeting send an *e-mail to BoardServices@lacare.org, or text or voicemail to 213 628-6420.*

THE PUBLIC MAY ADDRESS THE BOARD OF GOVERNORS BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY FOLLOWING THE INSTRUCTIONS AT THE TOP OF THIS AGENDA.

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Government Code Section 54954.2 (a)(3) and Section 54954.3.

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at www.lacare.org.
AN AUDIO RECORDING OF THE MEETING MAY BE MADE TO ASSIST IN WRITING THE MINUTES AND IS RETAINED FOR 30 DAYS.

*Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats – i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department by **sending an e-mail to BoardServices@lacare.org, or text or voicemail to 213 628-6420.** Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.*

BOARD OF GOVERNORS

Audit Committee Meeting Minutes – July 22, 2020

1055 W. 7th Street, Los Angeles, CA 90017

Members
Alvaro Ballesteros, *Chairperson*
Layla Gonzalez
Stephanie Booth, MD

Management/Staff
John Baackes, *Chief Executive Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Marie Montgomery, *Chief Financial Officer*

Guests
Rosie Procopio, *Lead Client Service Provider, Deloitte & Touche*
Angelica Kocharova, *Audit Sr. Manager, Deloitte & Touche*

** Absent ** Teleconference*

California Governor issued Executive Order No. N-29-20, which among other provisions amends the Ralph M. Brown Act Members of the public can listen to this meeting via teleconference.

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER Alvaro Ballesteros	Alvaro Ballesteros, *Committee Chair,* called the meeting to order at 11:35 a.m. He welcomed everyone to the meeting and summarized the process for public comment during this teleconference meeting as reflected on the meeting agenda. Public comments received by voicemail, email or text received prior to the start of the meeting will be sent to Committee members in writing and will be read for 3 minutes during the meeting. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair starts consideration of the item. The Chair will ask for public comment and will announce the item. The Chair will then announce when public comment period is over for that item.	
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING AGENDA Alvaro Ballesteros	Today's Agenda was approved as submitted.	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth and Gonzalez)**
APPROVE MEETING MINUTES Alvaro Ballesteros	The May 29, 2020 meeting minutes were approved as submitted.	**Approved unanimously by roll call. 3 AYES**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER/CHIEF FINANCIAL OFFICER REPORT	John Baackes, *Chief Executive Officer,* reported: • L.A. Care leadership decided, as result of resurgence of COVID-19 infection, staff will continue to work remotely until January 2021, except for specific exceptions. Management will continue to review the situation. Employees who cannot work at home productively may apply to return on September 1 but this will be limited to up to 10% of employees to maintain distancing, especially in the use of elevators. The plan was well received by staff. • Los Angeles Unified School District and other school districts help staff with school age children. • L.A. Care's Statement of Principles will be sent to Board members for consideration at the July 30 board meeting. • L.A. Care has formed an Equity Council Steering Committee, chaired by Dr. James Kyle, *Medical Director for Quality Improvement*. The Steering Committee includes conveners of three distinct Equity Councils dedicated to L.A. Care members, providers and vendors, and staff. The Steering Committee's work has just begun, and they have played an active role in refining L.A. Care's Statement of Principles, helping to ensure it is equity-focused and inclusive. Marie Montgomery, *Chief Financial Officer*, reported: • It is a challenging year. The State budget will hit health plans hard financially. • 1.5% retroactive rate reduction for Medi-Cal will result in about $55-60 million reduction in revenue for the fiscal year ending September 30, 2020. • Anticipating lower cost related to the deferral of elective procedures. • Higher paid claims as L.A. Care accelerated claims payments to assist providers. • Working closely with Deloitte & Touche (D&T) approaching year end • D&T will look at L.A. Care's financial reserve position as of August 2020 and then will move forward with September. • Staff is monitoring paid claims trends.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• A risk corridor was put in place during the bridge period (18 month rate cylcle for a transition from fiscal year to calendar year rate setting). • L.A. Care is advocating for reasonable rates and will continue to work with state representatives. • At the May 29 Audit Committee meeting the Committee accepted staff's recommendation to re-engage with D&T for the FY 2019-20 financial audit.	
COMMITTEE ISSUES		
Presentation of Audit Plan for Fiscal Year 2019-20	Rosie Procopio, *Lead Client Service Provider,* and Angelica Kocharova, *Audit Sr. Manager, Deloitte & Touche*, presented the Deloitte & Touche (D&T) Audit Plan for FY 2019-20. *(A copy of plan may be requested by contacting Board Services.)* • D&T identified the following key areas of risk in the audit: 1. IBNR reserve valuation 2. Revenue retroactive adjustment, and 3. Risk related to potential management override of controls (an AICPA audit standard) • The audit will focus on: 1. An assessment of the risk of material misstatement 2. Any significant changes to the business or level of transactions 3. Key accounting estimates and a retrospective look-back of management's prior year estimates, and 4. Knowledge of the industry and trends affecting L.A. Care. • D&T commits to complete the audit by December 2020 Member Booth asked about the references to triangles in data. Ms. Procopio responded that the triangles refer to the process where claims are received and paid, with claims paid full set data calculated independently of actuarial analysis, which it? is used to confirm. • The scope of audit, work plan and timeline were discussed. • The cost of engagement is $380,000 plus expenses	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Booth asked about the Office of Management and Budget (OMB) requirement. How much work still needs to be done? do. She emphasized the value of the information. Ms. Procopio responded that the federal grant amounts are below the requirement for a compliance audit, so that audit was removed. Ms. Montgomery noted that the information reported in prior years was only for grant activity not L.A. Care operations Member Booth asked if this is in compliance with local state and federal requirements if we receive more than the limit of federal funds other than grants. Ms. Procopio responded that D&T evaluates controls and compliance. If any information arises that calls compliance into question it is discussed. D&T will continue to bring information related to COVID-19 to L.A. Care. Ms. Procopio noted that the Public Company Accounting Oversight Board (PCAOB)'s new guidelines for audits shows D&T has lowest number of comments and findings among the big firms. D&T continues to monitor compliance with audit quality. Ms. Kocharova reviewed the engagement letter and the audit timeline agreed on with management. With help of L.A. Care management, D&T has already started updating audit plan, scope and procedures for certain areas of risk. Ms. Procopio stated that the only change in the engagement letter will be the OMB requirements. Chair Ballesteros asked about the December issues with reports, letters and results and final audit procedures. Ms. Procopio noted that the audit will be split into two periods, interim and final. The final period involves the remaining transactions through September 30. Ms. Procopio thanked L.A. Care for the re-engagement and looks forward to working with everyone. Ms. Montgomery noted that L.A. Care is in good shape with this audit plan. L.A. Care has to do its part to accelerate procedures and complete the audit timely.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Booth asked if anybody in any other profession besides medicine has to deal with the state fixing rates retroactively. Ms. Montgomery thinks that L.A. Care is unique in that regard. Ms. Procopio stated that it is unusual. **<u>Motion AUD A.0720</u>** **To accept the Audit Plans of the Deloitte & Touches' audit of L.A. Care's financial statements for the fiscal year 2019-20, as presented, and authorize execution of the engagement letter.**	**Approved unanimously by roll call. 3 AYES**
ADJOURNMENT	Committee expressed appreciation to staff for organizing the meeting. The meeting was adjourned at 12:18 pm.	

Respectfully submitted by:
Malou Balones, *Board Specialist III*
Victor Rodriguez, *Board Specialist II*
Linda Merkens, *Senior Manager, Board Services*

APPROVED BY:

_____
Al Ballesteros, MBA, *Chairperson*
Date Signed: _____

Board of Governors
MOTION SUMMARY

Date: December 16, 2020

Motion No. AUD A.1220

Committee: Audit

Chairperson: Alvaro Ballesteros

Issue: To accept the findings of the Deloitte & Touches' audit of L.A. Care's financial statements for the fiscal year ended September 30, 2020.

Background: N/A

Member Impact: Fiscal responsibility by the Board of Governors is enhanced by an independent third party audit of L.A. Care's financial condition, confirming the financial stability of the organization so important health care coverage can continue for L.A. Care's members.

Budget Impact: N/A

Motion: **To accept the findings of the Deloitte & Touches' audit of L.A. Care's financial statements for the fiscal year ended September 30, 2020, as presented.**

DATE: December 16, 2020

TO: Audit Committee

FROM: Marie Montgomery, *Chief Financial Officer*

SUBJECT: Fiscal Year 2019-20 Financial Audit

The attached audit package is comprised of two parts: Governance Letter with Management Representation Letter (Appendix A), and the Financial Statements. The No Material Weaknesses Letter and the OMB Circular A-133 material are no longer required.

As outlined in the initial audit plan, Deloitte & Touche identified and tested key areas of significance which included: revenue recognition including retroactive rate adjustments, health care costs, claims reserves (IBNR), and any management overrides. During the audit, any additional areas of materiality where there is risk for error or fraud are also identified and tested.

To help navigate through the material, the following key areas are prioritized for you review:

- Governance Letter with Management Representation Letter (Appendix A)
- Financial Statements
    - Highlights
    - Auditors' Opinion
    - Financial Position
    - Results of Operations

December 23, 2020

Audit Committee of the Board of Governors of
Local Initiative Health Authority for
Los Angeles County, dba L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority
1055 West 7th St.
Los Angeles, CA 90017

Dear Members of the Audit Committee:

We have performed an audit of the combined financial statements of The Local Initiative Health Authority for Los Angeles County, dba L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (collectively the "Organization") as of and for the year ended September 30, 2020, in accordance with auditing standards generally accepted in the United States of America ("generally accepted auditing standards") and expect to issue our report thereon dated December 23, 2020.

We have prepared the following comments to assist you in fulfilling your obligation to oversee the financial reporting and disclosure process for which management of the Organization is responsible.

This report is intended solely for the information and use of management, the Audit Committee, and others within the organization and is not intended to be and should not be used by anyone other than these specified parties.

Yours truly,

cc: The Management of L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority

Our Responsibility under Generally Accepted Auditing Standards

Our responsibility under generally accepted auditing standards has been described in our engagement letter dated August 11, 2020. As described in that letter, the objective of a financial statement audit conducted in accordance with generally accepted auditing standards is to express an opinion on the fairness of the presentation of the Organization's combined financial statements for the year ended September 30, 2020, in conformity with accounting principles generally accepted in the United States of America ("generally accepted accounting principles"), in all material respects.

Our responsibilities under generally accepted auditing standards include forming and expressing an opinion about whether the combined financial statements that have been prepared by management with the oversight of the Audit Committee of the Board of Governors (the "Audit Committee") are presented fairly, in all material respects, in conformity with generally accepted accounting principles. The audits of the combined financial statements do not relieve management or the Audit Committee of their responsibilities.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether caused by fraud or error. In making those risk assessments, we considered internal control over financial reporting relevant to the Organization's preparation and fair presentation of the combined financial statements in order to design audit procedures that were appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control over financial reporting. Our consideration of internal control over financial reporting was not designed to identify all deficiencies in internal control over financial reporting that might be significant deficiencies or material weaknesses.

SIGNIFICANT ACCOUNTING POLICIES

The Organization's significant accounting policies are set forth in Note 2 to the Organization's 2020 combined financial statements. We are not aware of any significant changes in previously adopted accounting policies or their application during the year ended September 30, 2020.

We have evaluated the significant qualitative aspects of the Organization's accounting practices, including accounting policies, accounting estimates and financial statement disclosures and concluded that the policies are appropriate, adequately disclosed, and consistently applied by management.

ACCOUNTING ESTIMATES

Accounting estimates are an integral part of the combined financial statements prepared by management and are based on management's current judgments. Those judgments are ordinarily based on knowledge and experience about past and current events and on assumptions about future events. Significant accounting estimates reflected in the Organization's 2020 financial statements include the following:

1) Reserves for Incurred but not Reported Claims ("IBNR") estimate, and
2) Retroactive Revenue Adjustments.

During the year ended September 30, 2020, we are not aware of any significant changes in accounting estimates or in management's judgments relating to such estimates.

UNCORRECTED MISSTATEMENTS

Our audit of the financial statements was designed to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement, whether caused by error or fraud. There were no uncorrected misstatements or disclosure items passed identified during our audit, except an error detected in a sample which resulted in an extrapolated misstatement. Inpatient and outpatient services account was tested using statistical sampling techniques and certain errors in recording claims expense for the year ended September 30, 2020 were found in the sample items selected. The mathematical projection of the likely errors, which results in an understatement of the claims expense in the amount of $13.7 million for the year ended September 30, 2020. Such potential unrecorded errors were determined by management to be immaterial to the financial statements taken as a whole.

MATERIAL CORRECTED MISSTATEMENTS

There were no material misstatements that were brought to the attention of management as a result of our audit procedures.

DISAGREEMENTS WITH MANAGEMENT

We have not had any disagreements with management related to matters that are material to the Organization's 2020 financial statements.

OUR VIEWS ABOUT SIGNIFICANT MATTERS THAT WERE THE SUBJECT OF CONSULTATION WITH OTHER ACCOUNTANTS

We are not aware of any consultations that management may have had with other accountants about auditing and accounting matters during 2020.

SIGNIFICANT FINDINGS OR ISSUES DISCUSSED, OR SUBJECT OF CORRESPONDENCE, WITH MANAGEMENT PRIOR TO OUR RETENTION

Throughout the year, routine discussions were held, or were the subject of correspondence, with management regarding the application of accounting principles or auditing standards in connection with transactions that have occurred, transactions that are contemplated, or reassessment of current circumstances. In our judgment, such discussions or correspondence were not held in connection with our retention as auditors.

OTHER SIGNIFICANT FINDINGS OR ISSUES ARISING FROM THE AUDIT DISCUSSED, OR SUBJECT OF CORRESPONDENCE, WITH MANAGEMENT

Throughout the year, routine discussions were held, or were the subject of correspondence, with management. In our judgment, such discussions or correspondence did not involve significant findings or issues requiring communication to the Audit Committee.

SIGNIFICANT DIFFICULTIES ENCOUNTERED IN PERFORMING THE AUDITS

In our judgment, we received the full cooperation of the Organization's management and staff and had unrestricted access to the Organization's senior management in the performance of our audits.

MANAGEMENT'S REPRESENTATIONS

We have made specific inquiries of the Organization's management about the representations embodied in the combined financial statements. Additionally, we will request that management provide to us the written representations the Organization is required to provide to its independent auditors under generally accepted auditing standards. We have attached to this letter, as Appendix A, those representations we will request from management.

* * * * *

APPENDIX A

MANAGEMENT REPRESENTATION LETTER

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December 23, 2020
Deloitte & Touche LLP
555 West 5th Street, Suite 2700
Los Angeles, CA 90013

We are providing this letter in connection with your audits of the combined financial statements of the L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (collectively "L.A. Care" or the "Organization"), which comprise the combined statements of net position as of September 30, 2020 and 2019, and the related combined statements of revenues, expenses, and changes in net position and cash flows, and the related notes to the combined financial statements (the "financial statements"), for the purpose of expressing an opinion as to whether the financial statements present fairly, in all material respects, the financial position, results of operations, and cash flows of the Organization in accordance with accounting principles generally accepted in the United States of America (GAAP).

We confirm that we are responsible for the following:

a) The preparation and fair presentation in the financial statements of net position, statements of revenues, expenses, and changes in fund net position, and cash flows in conformity with accounting principles generally accepted in the United States of America

b) The design, implementation and maintenance of internal control:

- Relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error

- To prevent and detect fraud

Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

We confirm, to the best of our knowledge and belief, the following representations made to you during your audits.

1. The financial statements referred to above are fairly presented in conformity with GAAP.

    a. The financial statements include all units as well as joint ventures with an equity interest and properly disclose all other joint ventures and other related organizations.

    b. The financial statements properly classify all activities, including special and extraordinary items.

c. Net position components (net investment in capital assets; restricted; and unrestricted) are properly classified and, if applicable, approved.

d. Expenses have been appropriately classified in or allocated to functions and programs in the statements of revenues and expenses and changes in fund net position within capitation revenues and grant revenues.

e. Revenues are appropriately classified in the statements of revenues, expenses and changes in fund net position within capitation revenues and grant revenues.

f. Deposits and investment securities are properly classified in category of custodial credit risk.

g. Capital assets are properly capitalized, reported, and, if applicable, depreciated.

h. Required supplementary information is measured and presented within prescribed guidelines; and

i. Applicable laws and regulations are followed in adopting, approving, and amending budgets.

2. The Organization has provided to you all relevant information and access as agreed in the terms of the audit engagement letter.

3. The Organization has made available to you:

   a. All financial records and related data. The records, books, and accounts, as provided to you, record the financial and fiscal operations of all activities administered by the Organization and provide the audit trail to be used in a review of accountability. Information presented in financial reports is supported by the books and records from which the financial statements have been prepared

   b. All minutes of the meetings of the Board of Governors and its committees, or summaries of actions of recent meetings for which minutes have not yet been prepared

   c. Contracts and grant agreements (including amendments, if any) and other correspondence that has taken place with federal agencies

   d. All reports and information from peer review organizations, fiscal intermediaries, third-party payers, and recovery audit contractors

4. There has been no:

   a. Actions taken by Organization management that contravenes the provisions of federal laws and California laws and regulations, or of contracts and grant applicable to the Organization; and

b. Communications (oral or written) from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices or other matters that could have more than an inconsequential effect on the financial statements.

5. There were no uncorrected misstatements or disclosure items passed identified during the audit, except an error detected in a sample which resulted in an extrapolated misstatement. Inpatient and outpatient services account was tested using statistical sampling techniques and certain errors in recording claims expense for the year ended September 30, 2020 were found in the sample items selected. The mathematical projection of the likely errors, which results in an understatement of the claims expense in the amount of $13.7 million for the year ended September 30, 2020. Such potential unrecorded errors were determined by management to be immaterial to the financial statements taken as a whole.

6. The Organization has disclosed to you the results of management's risk assessment, including the assessment of the risk that the financial statements may be materially misstated as a result of fraud.

7. We have no knowledge of any fraud or suspected fraud affecting the Organization involving:

   a. Management;

   b. Employees who have significant roles in the Organization's internal control over financial reporting; and

   c. Others, where the fraud could have a material effect on the financial statements.

8. We have no knowledge of any allegations of fraud or suspected fraud affecting the Organization received in communications from employees, former employees, regulators, or others.

9. There are no unasserted claims or assessments that we are aware of or that legal counsel has advised us are probable of assertion and must be disclosed in accordance with GASB Codification of Governmental Accounting and Financial Reporting Standards ("GASB Codification") Section C50, *Claims and Judgments.*

10. The methods, significant assumptions, and the data used by us in making the accounting estimates and the related disclosures are appropriate to achieve recognition, measurement, or disclosure that is in accordance with GAAP.

11. Significant assumptions used by us in making accounting estimates are reasonable.

12. The Organization is an integral part of the government and is exempt from federal income taxes. Management continues to believe the Organization qualifies for tax exempt status as of September 30, 2020.

13. The Organization is in compliance with the provisions of Internal Revenue Code (IRC) and is exempt from federal tax under IRC Sec. 501(a), as evidenced by a determination letter and all information returns have been filed on a timely basis with the appropriate regulatory bodies.

14. Management has identified and disclosed to you all laws and regulations that have a direct and material effect on the determination of financial statement amounts.

15. The financial statements include the accounts of the Local Initiative Health Authority for Los Angeles County, dba L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority. The financial statements of L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority are combined as entities under common control, whereby JPA is considered a non-significant component unit of L.A. Care. All intercompany transactions have been eliminated.

16. During the year ended September 30, 2020, there were no significant changes in previously adopted accounting policies or their application, other than those disclosed in the financial statements.

17. L.A. Care operates as the "Local Initiative" under the State's managed care system. Discontinuation of the program would have a material adverse effect on the Organization.

18. The Organization is exposed to various risks of loss from, among others: theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage for the years ended September 30, 2020 and 2019.

19. The Organization has properly classified investments in equity securities with readily determinable fair values on the balance sheets as available-for-sale given the Organization's intent with respect to those securities. Specifically, all investments in equity securities with readily determinable fair values are classified as available-for-sale.

    In addition, the Organization has properly recorded all individual equity securities as either current or noncurrent as appropriate under the provisions of GASB Codification Section I50, *Investments.*

Except where otherwise stated below, matters less than $3,000,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

20. There are no transactions that have not been properly recorded and reflected in the financial statements.

21. The Organization has no plans or intentions that may affect the carrying value or classification of assets and liabilities.

22. Regarding related parties:

    a. We have disclosed to you the identity of the related parties and all the related party relationships and transactions of which we are aware.

    b. To the extent applicable, related parties and all the related-party relationships and transactions, including sales, purchases, loans, transfers, leasing arrangements, and guarantees (written or oral) have been appropriately identified, properly accounted for, and disclosed in the financial statements.

23. In preparing the financial statements in accordance with GAAP, management uses estimates. All estimates have been disclosed in the financial statements for which known information available prior to the issuance of the financial statements indicates that both of the following criteria are met:

    a. It is reasonably possible that the estimate of the effect on the financial statements of a condition, situation, or set of circumstances that existed at the date of the financial statements will change in the near term due to one or more future confirming events; and

    b. The effect of the change would be material to the financial statements.

24. There are no:

    a. Instances of identified or suspected noncompliance with laws and regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid Anti-Kickback Statute, Limitations on Certain Physician Referrals (commonly referred to as the "Stark law"), and the False Claims Act, in any jurisdiction, whose effects should be considered when preparing the financial statements.

    b. Known actual or possible litigation and claims whose effects should be considered when preparing the financial statements that have not been disclosed to you and accounted for and disclosed in accordance with GAAP.

    c. We have assessed our estimate related to provider settlements in accordance with GASB Codification Section C50, *Claims and Judgments*, which represents our best estimate of such liability as of September 30, 2020.

    d. Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB Codification Section C50, *Claims and Judgments.*

e. Internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the financial statements or on the disclosures in the notes to the financial statements.

f. Instances of identified or suspected noncompliance with laws and regulations whose effects should be considered when preparing the financial statements.

25. The Organization has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral, except as disclosed in the notes to the financial statements.

26. Regarding the required supplementary information:

    a. We confirm that we are responsible for the required supplementary information.

    b. The required supplementary information is measured and presented in accordance with the guidelines prescribed by the Governmental Accounting Standards Board.

    c. The methods of and significant assumptions underlying the measurement and presentation of the supplementary information have not changed from those used in the prior period.

27. All documentation related to sales transactions is contained in customer files. We also confirm that:

    a. We are not aware of any "side agreements" with any companies that are inconsistent with the applicable sales agreement, the customer's purchase order, sales invoice, or any other documentation contained in the customer's file. For the purposes of this letter, a "side agreement" is any agreement, understanding, promise, or commitment, whether written (e.g., in the form of a letter or formal agreement or in the form of any exchange of physical or electronic communications) or oral by or on behalf of the Organization (or any subsidiary, director, employee, or agent of the Organization) with a customer from whom revenue has been recognized that is not contained in the written purchase order from the customer or sales order confirmation and sales invoice of the Organization delivered to or generated by the Organization's Accounting and Finance Department. The definition of a side agreement is not limited by any particular subject matter. For purposes of example only, any agreement not contained in the written purchase order from the customer or sales order and sales invoice of the Organization that relates to return rights, acceptance rights, future pricing, payment terms, free consulting, free maintenance, or exchange rights would be a side agreement.

    b. We are not aware of any commitments or concessions to a customer regarding pricing or payment terms outside of the terms documented in the customer's file.

28. The Organization has complied with all aspects of contractual agreements that may affect the financial statements.

29. With regard to the fair value measurements and disclosures of certain assets, liabilities, and specific components of equity, we believe that:

    a. The measurement methods, including the related assumptions used in determining fair value, were appropriate consistent with market participant assumptions where available without undue cost and effort, and were consistently applied in accordance with GAAP.

    b. The completeness and adequacy of the disclosures related to fair values are in accordance with GAAP.

    c. No events have occurred subsequent to September 30, 2020, but before December 23, 2020, the date the financial statements were available to be issued that require adjustment to the fair value measurements and disclosures included in the financial statements.

    d. The Organization, using its best estimates based on reasonable and supportable assumptions and projections, reviews long-lived assets for impairment in accordance with GASB Codification Section C50, *Claims and Judgments (GASB Statement No. 42, Accounting and Financial Reporting of Impairment of Capital Assets)*.

30. Financial instruments with significant individual or group concentration of credit risk have been appropriately identified, properly recorded, and disclosed in the financial statements.

31. Arrangements with financial institutions involving compensation balances or other arrangements involving restrictions on cash balances, line of credit, or similar arrangements have been properly disclosed in the financial statements.

32. GASB Statement No. 84, *Fiduciary Activities*, serves to enhance the consistency and comparability of fiduciary activity reporting by state and local governments. This Statement also is intended to improve the usefulness of fiduciary activity information primarily for assessing the accountability of governments in their roles as fiduciaries. The Statement is effective for the Organization's financial statements for the year ended September 30, 2021, and management concluded that it will not have a material impact on the financial statements.

33. The Organization will adopt the provisions of GASB Codification Section L20, *Leases* (GASB Statement No. 87, *Leases*) on September 30, 2023. The Organization is currently evaluating the impact on the financial statements.

34. We have disclosed to you any change in the Organization's internal control over financial reporting that occurred during the Organization's most recent fiscal year ended September 30, 2020 that has materially affected, or is reasonably likely to materially affect, the Organization's internal control over financial reporting.

35. Management has disclosed all communications from the Organization's third-party service organizations relating to noncompliance with the Organization's operations at those service organizations.

36. The Organization is responsible for determining and maintaining the adequacy of the reserves for claims incurred but not reported relating to providing services to our members, as well as estimates to determine such amounts. Management believes the recorded reserve is adequate to cover the Organization's liability for unpaid claims as of September 30, 2020. There were no changes in methodologies and processes used to calculate the reserves for claims incurred but not reported during fiscal year 2020 and as of September 30, 2020.

37. With respect to the Organization's liability for unpaid claims and claim adjustment expenses:

    a. For the year ended September 30, 2020, we have processed claims received by the Organization in a manner and timing consistent with prior years, except as discussed with and provided to you.

    b. We have considered all information that, in our judgment, is necessary to adequately estimate the claim and claim adjustment expense liabilities at the balance-sheet date, including, among other things:

        i. Anticipated and historical claims experience of the Organization

        ii. Anticipated and historical claims experience of the health care industry

        iii. Expected impact of inflation and other economic or social factors on future payments of losses incurred at the balance-sheet date, including the impact of COVID-19

        iv. Lines and geographical locations of the business written and assumed by the Organization

        v. The Organization's claims policies and procedures

        vi. The timeliness and reliability of reports from reinsurers

        vii. Estimates of claim recoveries, exclusive of reinsurance recoveries.

    c. The Organization has considered and properly disclosed in the financial statements all the information with respect to claim and claim adjustment expense liabilities and related claim recoveries, which in our judgment, is necessary to adequately identify and understand the nature of reserving estimates and underlying coverage issues, including the potential volatility, complexity, and uncertainty of such estimates and the possibility that the ultimate liability may vary significantly from the recorded liability and related recovery amounts.

    d. The reserve for unpaid claims and claims adjustment expenses for the Organization as of September 30, 2020 is management's best estimate and makes a reasonable provision for all reported and unreported claims incurred as of September 30, 2020 based upon the consideration of all information available at the date those financial statements were prepared, including actuarial indications and other factors.

e. The reserve for unpaid claims for the Organization as of September 30, 2020 is based on appropriate actuarial assumptions, is fairly stated in accordance with sound actuarial principles applied on a consistent basis and includes provision for all actuarial liabilities that should be established.

38. The Organization is required to maintain specific minimum loss ratios. These minimum loss ratios apply to comprehensive major medical coverage and vary depending on group size. As of September 30, 2020, management believes that no accrual is necessary, as the Organization's minimum ratios are all expected to exceed the statutory minimums, and that actual results will not differ materially from the established estimate.

39. Activity and balances of restricted net investments in capital assets and disclosure regarding the nature of the restrictions have been properly recorded and disclosed in the financial statements in accordance with applicable government accounting standards.

40. We have fully disclosed to you all provider contract terms, including provider incentive and such other terms which are reasonably likely to generate liabilities for those contracts. The Organization considers provider incentives to be incurred when the incentive program is announced, approved by governance and when the provider meets the defined requirements.

41. We have disclosed to you all new provisions or changes to the existing pension, other post-retirement benefit, 401a, and deferred compensation.

42. We have informed you of all regulatory financial examinations currently in process or completed within the past year, and any adjustment proposed to us by the regulatory examiners that could be material to the Organization's financial statements. We have provided to you all relevant information and access as agreed in the terms of the audit engagement letter, including:

    a. Reports (and draft reports) of examinations completed or has provided an update on those in process between regulators and the Organization.

    b. Communications from regulatory agencies concerning noncompliance with or deficiencies in financial reporting practices.

43. As of September 30, 2020, management believes that there are no matters that would materially affect the Organization's ability to continue as a going concern. The Organization believes it has adequate cash and cash equivalent reserves to meet its operating obligations for the coming fiscal year.

44. The Organization has complied, in all material respects, with all state and federal regulations regarding its operations and, to the best of our knowledge, has complied with the applicable state and/or federal restricted cash and equity requirements.

45. There are no known or expected circumstances, as of the date of this letter, that would either threaten the solvency of the Organization, or require significant capital infusions to the

Organization in order to comply with applicable regulations applicable to its domiciliary state.

46. L.A. Care is involved in various legal actions arising in the normal course of business, the outcomes of which are not determinable at this time. The Organization has insurance policies covering such potential losses where such coverage is cost effective. In the opinion of management, any liability that might be incurred by L.A. Care upon resolution of these claims and lawsuits will not, in the aggregate, have a material adverse effect on L.A. Care's financial statements.

47. The Organization is responsible for determining and maintaining the adequacy of the accrual for provider incentives. Management believes the recorded accrual is adequate to provide for currently estimated provider incentive payments for all incentives as of September 30, 2020.

48. Specifically related to Plan Partner rates, although rates have not been formalized in signed agreements, the rate management is using to record current accruals is based on current negotiated rates.

49. We confirm the following representation concerning unpaid bonus incentives to the Organization's employees:

    a. Based on our internal review of all relevant information available to us and the application of our judgment and estimates, the Organization has calculated the bonuses related to performance for the year ended September 30, 2020 based on the facts and circumstances at that date. The bonuses have been subsequently paid out in December 2020.

50. The financial statements include the impact of the capitation rate adjustments approved by the Department of Health Care Services (DHCS). Management is not aware of any additional approved rate adjustments that may impact the revenue recognized for the year ended September 30, 2020.

51. The Organization is serving as a cash conduit to the intergovernmental transfers (IGTs) and other transfers under Senate Bills 208, 239, and 857, and Private and Public Hospitals Directed Payments from DHCS under CMS final rule. Management therefore believes that the arrangement is properly accounted for as a pass-through transaction on a net basis, whereas funds received from DHCS are reported net of funds paid out to the providers and the receipt and disbursements are reflected within the cash flow from financing activities.

52. We believe that all expenditures that have been deferred to future periods are recoverable.

53. In response to the COVID-19 events, the State of California implemented the risk sharing mechanism whereby the state and plans agreed to share profit or losses if aggregate spending falls above or below specified thresholds with a symmetrical two-sided risk corridor. Management asserts that the information shared by DHCS (both in written form and via meetings) as of December 23, 2020 provides a reasonable basis for the calculation

performed by the Organization. The Company incorporated two key assumptions, Option C and 102 percent of Gross Medical Expenses, in its calculation and believes that such assumptions will be included in the final calculation approved by DHCS. Using the most recent information from the DHCS, no COVID-19 risk sharing receivable (i.e. loss share) or payable (i.e. gain share) has been recorded as of September 30, 2020.

54. We have analyzed our insurance contracts to determine if it is probable that a loss will be incurred. We recognize a premium deficiency loss when it is probable that expected future claims, including maintenance costs (for example, claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. We did not have any premium deficiency reserves at September 30, 2020 or 2019.

55. Management asserts the following related to the amounts estimated and recorded as of September 30, 2020, related to the permanent risk adjustment program enacted by the Affordable Care Act:

    a. Management's estimate for risk adjustment incorporates the Organization's risks scores by state and market relative to the market average using data provided by the participating insurers and available information about the U.S. Department of Health and Human Services (HHS) model provided by the third-party vendor.

    b. Management asserts that the encounter data for the year ended September 30, 2020 that we provided to the third-party vendor for use in their final report is accurate and complete. We are not aware of any data issues that would indicate that this encounter data is incomplete.

    c. Management asserts that the market remainder (those health plans not included in the third-party study) does not have a material impact on amounts calculated by the third-party for the markets we participate in.

56. We have complied with the health care offer of coverage reporting requirements of the Affordable Care Act (ACA), and, if applicable, have recorded all liabilities arising from the ACA Employer Shared Responsibility Payment (i.e., the employer mandate payment) and the related information reporting penalties.

57. No events have occurred after September 30, 2020, but before December 23, 2020, the date the financial statements were available to be issued that required consideration as adjustments to, or disclosures in, the financial statements or related notes.

John Baackes
Chief Executive Officer

Marie Montgomery
Chief Financial Officer

Local Initiative Health Authority for Los Angeles County, Operating and Doing Business as L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority

Combined Financial Statements and Management's Discussion and Analysis as of and for the Years Ended September 30, 2020 and 2019, Required Supplementary Information for the Year Ended September 30, 2020, and Independent Auditors' Report

LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY, OPERATING AND DOING BUSINESS AS L.A. CARE HEALTH PLAN AND L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

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LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY, OPERATING AND DOING BUSINESS AS L.A. CARE HEALTH PLAN AND L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

MANAGEMENT'S DISCUSSION AND ANALYSIS (UNAUDITED) AS OF AND FOR THE YEARS ENDED SEPTEMBER 30, 2020 AND 2019

Overview

The Local Initiative Health Authority for Los Angeles County operating and doing business as L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (JPA) ("L.A. Care" or the "Organization") is an independent local public agency that provides managed health care services to Medi-Cal beneficiaries in Los Angeles County (the "County"). The State of California (the "State") created the "Local Initiative and the Two Plan model" to realize the strategic plans of the Department of Health Care Services (DHCS), formally known as the State Department of Health Services, outlined in its March 31, 1993, report, *Expanding Medi-Cal Managed Care: Reforming the Health System—Protecting Vulnerable Populations*. Under this program, L.A. Care provides health care coverage to Medi-Cal program members, and DHCS pays L.A. Care a fixed payment per member, per month (PMPM), and fixed case rates for maternity case for each eligible birth, hepatitis C, intuitional members, enrolled Health Home members, and qualified members receiving behavioral health treatment (BHT). Our contracts with the DHCS will expire on December 31, 2023. Since its creation, L.A. Care has also added a number of other products, within its mission, to protect vulnerable populations.

L.A. Care entered into a joint exercise of powers agreement with the County to establish L.A. Care Health Plan Joint Powers Authority (JPA), a licensed health maintenance organization. L.A. County's Board of Supervisors established the JPA in July 2012 pursuant to the Joint Exercise of Powers Act Government Code Section 6500. This legislation provides that the JPA is also a public entity, separate and apart from the County, and is not an agency, division, or department of the County. The JPA is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. Prior to July 1, 2016, neither L.A. Care nor the JPA were subjected to any premium tax on the plans within the JPA. The JPA received its Knox-Keene license and commenced operations in December 2013. L.A. Care and the JPA have a mutual guarantee agreement insuring solvency for the two organizations. The combined financial statements include L.A. Care and the JPA because they are under common management and control.

L.A. Care provides the delivery of covered health care services to members either through its network of contracted providers Medi-Cal program ("MCLA") or through its contracts with Plan Partners, including Anthem Blue Cross of California ("Anthem"), Blue Shield of California Promise Health Plan, formerly Care 1st Health Plan ("Promise"), and Kaiser Foundation Health Plan ("Kaiser"). The delegated contract relationships with the three Plan Partners, Anthem, Promise, and Kaiser, were renegotiated during 2020 and include the incorporation of risk-adjusted capitation rates and a separate quality score investment program. The contracts will be subject to negotiation again in 2021. The Plan Partners' health care networks consist of physicians, hospitals, and other health care professionals who are employed either by or under contract with the Plan Partners. As of September 30, 2020 and 2019, there were 1,018,135 and 976,311 Medi-Cal enrollees, respectively, with the Plan Partners.

L.A. Care's Medi-Cal MCLA program is designed to complement the existing Plan Partner network. L.A. Care receives the same fixed per-member, per-month payment from DHCS and contracts directly with participating physician provider groups (PPGs), hospitals, primary care and specialty care physicians and other ancillary professionals for health care services.

Substantially all PPGs in the MCLA health care network are reimbursed on a PMPM capitated basis. PPG capitation rates may include or exclude hospital services. The network hospital contracts are on a nonexclusive basis and provide for reimbursement on a per diem, case rate, a percentage of the hospital billed charges or capitated bases. Certain physicians are reimbursed on a fee-for-service basis. The MCLA program is available to all eligible Medi-Cal beneficiaries in the County, with the same health care benefits as provided by the Plan Partners. Under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, ACA), Medi-Cal was expanded to include low-income adults with incomes up to 138% of the federal poverty level effective January 1, 2014. As of September 30, 2020 and 2019, MCLA membership was 1,141,207 and 1,050,610 enrollees, respectively.

L.A. Care's Homecare Workers Health Care Plan (PASC-SEIU) program provides health care services to the In-Home Supportive Services (IHSS) workers in the County. The PASC-SEIU program and its members were moved from L.A. Care to the JPA. As of September 30, 2020 and 2019, PASC-SEIU membership was 51,457 and 50,809 enrollees, respectively.

L.A. Care Covered (LACC) is a health coverage program offered under the California state- based exchange known as Covered California. LACC was launched on January 1, 2014, and offers individuals health coverage under regulations established by the U.S. Department of Health and Human Services (HHS). Qualifying low-income individuals are eligible for varying premium and cost-sharing subsidies depending on the income level in relation to the federal poverty level (FPL). In October 2017, HHS announced that the cost-sharing subsidies would not be paid to health plans beginning September 1, 2017. In February 2019, L.A. Care received favorable ruling from the U.S. Court of Federal claims. Our premium rates effective for 2018 and onward were increased to reflect the loss of the cost-sharing reduction subsidy and the resulting premium subsidy increase, compensated members for the majority of the cost-sharing subsidy decrease. In August 2018, HHS issued guidance to allow insurers to add the cost of CSR to silver plan rates for 2019 coverage. The premium tax credit reduced the qualified member's monthly payments for insurance plans purchased through the marketplace. In August 2018, HHS issued guidance to allow insurers to add the cost of CSR to silver plan rates for 2019 coverage. Effective January 2018, qualified members will receive the premium tax credit coverage, which will compensate members for the majority of the cost-sharing subsidy decrease. The premium tax credit reduces the qualified member's monthly payments for insurance plans purchased through the marketplace.

Beginning in 2019, the individual mandate was eliminated meaning individuals will no longer incur a federal tax penalty for not having health insurance. Beginning in 2020, California enacted an individual mandate to maintain minimum essential coverage or incur a state tax penalty. The State also added a new tier of subsidies for individuals between 400%–600% FPL and increased premium subsidies for individuals between 200%–400% FPL for a three-year period beginning January 1, 2020. As of September 30, 2020 and 2019, LACC membership was 80,975 and 77,993, respectively. We believe one of the factors that drove the year-over-year increase in enrollment was LACC's premiums being one of the most affordable health plans in all of Los Angeles County for the Silver, Gold and Platinum tiers, where a majority of these members are eligible for premium subsidies. Our strategy is to be able to continue to serve our Medi-Cal members who lose eligibility.

Coordinated Care Initiative (CCI) began as a three-year pilot program developed jointly with the California's DHCS to coordinate medical care, behavioral health, and long-term services and supports (LTSS), which

includes institutional long-term care, home and community-based services, and other support services to individuals who are fully eligible for Medicare and Medi-Cal benefits or "dual eligible" as well as to all Medi-Cal-only individuals or "non-duals" who rely on LTSS services. The Cal MediConnect (CMC) program is one of the components of CCI, which includes mandatory enrollment of dual eligible members and integrated LTSS has been extended through December 31, 2022; however, the IHSS benefit was removed from the program as of January 1, 2018. As of September 30, 2020 and 2019, the dual eligible CCI membership, including MCLA and Plan Partners was 222,926 and 217,345 enrollees, respectively.

L.A. Care's CMC program was launched in May 2014. CMC members are those who qualify for both Medicare and Medi-Cal ("dual eligibles"). The CMC program offers members a coordinated care model within a single health plan and is part of the larger CCI program. L.A. Care receives a PMPM payment from DHCS and PMPM payment from Centers for Medicare and Medicaid (CMS), which are based on the member's demographics and individual health risk score for the Medicare coverage. The CMC program has been extended to December 31, 2022. The DHCS plans to transition CMC to a Medicare Advantage Dual Eligible Special Needs Plans (D-SNP) by 2023. As of September 30, 2020 and 2019, CMC membership was 17,983 and 15,913 enrollees, respectively.

Effective July 1, 2019, L.A. Care launched the Medi-Cal Health Homes Program (HHP) for eligible members with multiple chronic conditions who are frequent utilizers of medical services and may benefit from enhanced care management and coordination. The Health Homes Program (HHP) is a DHCS mandated Medi-Cal benefit authorized under Section 2703 of the Affordable Care Act (ACA). The Health Homes Program network includes the Community-Based Care Management Entities (CB-CMEs), and other Community-Based Organizations (CBOs) to provide linkages to community and social support services, as needed. CB-CMEs are intended to serve as the single community-based entity with responsibility, in conjunction with the L.A. Care internal staff for ensuring that an assigned HHP member receives access to HHP services. L.A. Care internal staff provides oversight and administrative support of the program.

Proposition 56 (Prop 56) increased the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures including increased funding for existing healthcare programs. The DHCS pays a PMPM rate for this program for all eligible Medi-Cal members. L.A Care is required by the DHCS to make directed payments for qualifying services to eligible network providers and is at risk for these payments. The program was effective on July 1, 2017 on a state fiscal year basis and was expanded to additional qualifying services beginning July 1, 2018. The DHCS implemented a one-sided risk corridor for the period July 1, 2018 to June 30, 2019 under which payments to providers must be above 95% of the revenue earned or rebated to the DHCS. For the period July 1, 2019 to June 30, 2020, the DHCS implemented a two-sided risk corridor under which payments to providers must be between 95% and 100% of the revenue earned with a rebate incurred below 95% and additional revenue earned above 100%. This arrangement has been extended to June 30, 2021. Additionally, DHCS has added VBP Program and Family Planning Services for the bridge period and both have a two-sided risk corridor. There are other new Prop 56 programs added for the bridge period but are not material to L.A. Care.

In 2019, the DHCS implemented a directed payment program for increased reimbursement rates for qualifying Ground Emergency Medical Transport (GEMT) services paid to non-contracted emergency medical transportation providers for the period July 1, 2018 through June 30, 2019. The DHCS pays a PMPM rate for this program for all eligible Medi-Cal members. L.A Care is required by the DHCS to make directed payments for qualifying services and is at risk for these payments. The GEMT program has been extended and new services have been added through the end of the bridge period.

Current Year Highlights

The COVID-19 crisis has had significant economic and financial impacts on our local economies and government budgets since the onset of the pandemic and will continue to affect our health care system and economy until the virus subsides. The COVID-19 pandemic essentially plunges California economy into a massive budget deficit and the unemployment rate spiked to a record high. Amid the drastic budget impacts of the COVID-19 Recession, DHCS retroactively reduced our capitation rates for the major aid categories by 1.5% to our rates which are in effect July 1, 2019 to December 31, 2020 (the Bridge Period) except for Skilled Nursing Facility (SNF) rates which were increased by 10% for the same Bridge Period. DHCS has signaled its plan to implement further rate reductions effective January 1, 2021. Despite an expectation that we would experience lower costs due to the impacts of COVID-19, to the contrary, we have experienced higher fee for services claims trends in recent months.

Given the uncertainties including the unanticipated costs related to COVID-19 testing and treatment and the impact of the deferral of elective procedures, many states including California chose to adjust current payment rates as discussed above and implemented risk sharing arrangements to mitigate MCO and state risk. The risk sharing mechanism implemented by California is a risk corridor arrangement (COVID -19 risk corridor) whereby the state and plans agreed to share profit or losses if aggregate spending falls above or below specified thresholds with a symmetrical two-sided risk corridor. Although the specifics of the risk corridor mechanism are still being finalized by the DHCS, we believe the information shared by the state so far provides a reasonable basis for our estimation. Using the most recent information from the DHCS, we estimate there is no gain sharing or loss sharing as of September 30, 2020.

Financial Highlights

The following are the significant highlights of L.A. Care's financial performance for the fiscal year ended September 30, 2020 as compared to fiscal year ended September 30, 2019:

- Total revenue increased by $451.7 million, or 5.7%, to $8.4 billion. It is due to a net increase in revenues of $265.0 million from Medi-Cal rate annual rate changes across all category of aids including CCI rate increase for calendar year 2019, an increase in Prop 56 revenues of $143.7 million, and an increase in Health Home program revenues of $44.6 million. Revenue from prior year was negatively impacted by the RADV adjustments of $32.5 million and no such impact for the current year.
- Total health care expenses increased by $750.6 million, or 10.3%, to $8.0 billion. This increase is primarily due to increases in Capitation Expense of $292.3 million driven by an increase in Prop 56 of $150.2 million, an increase in Plan Partners' capitation expenses of $56.4 million and an increase in the Health Homes Program of $32.8 million. The increase in inpatient, outpatient and skilled nursing facility (SNF) claims expense was $436.2 million primarily related to a 10% increase in the Medi-Cal SNF reimbursement rate due to the COVID state of emergency which resulted in an increase of $110.7 million as well as increased cost and utilization particularly in inpatient claims. Pharmacy expense also increased $31.3 million in the current year as a result of increased utilization.
- Administrative expenses increased by $36.0 million, or 8.7%, to $451.7 million for the year ended September 30, 2020 from $415.7 million a year ago. The increase is primarily driven by higher compensation and benefits of $19.4 million and higher purchased services of $19.6 million driven primarily by strategic projects spending.

- L.A. Care investment and interest income decreased by $11.6 million, or 22.0%, to $41.2 million for the year ended September 30, 2020 as compared to the year ended September 30, 2019. Interest and dividends decreased $12.7 million year-over-year due to lower short-term interest rates for a greater part of the reporting period as well as lower average invested balances. Unrealized gains decreased $1.0 million driven by lower market value of our portfolio due to interest rate movements.

- "(Decrease) increase in net position" for the year ended September 30, 2020 decreased by $137.5 million to $916.6 million from $1,054.1 million a year ago. The decrease represents the net loss for the year ended September 30, 2020 due primarily to higher health care and administrative expenses, net of increased revenue as discussed above. During the reporting year, L.A. Care received $1.8 billion proceeds for various pass-through transactions including intergovernmental transfers; Senate Bills (SB) 208, 239, and 857; and the Private and Public Hospital Directed Payments program. During the reporting year, L.A. Care disbursed $1.6 million to designated recipients. The funding for the Private and Public Hospital Directed Payments program of $880.4 million was received in September 2020 and disbursed to the designated private and public hospitals in the following fiscal year.

Financial Statement Presentation

L.A. Care utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and all of the Organization's activities are considered a single proprietary fund. Pursuant to Governmental Accounting Standards Board (GASB) Codification Section P80, *Proprietary Fund Accounting and Financial Reporting*, L.A. Care applies the accounting and reporting guidance as provided in the *AICPA Audit and Accounting Guide, Health Care Entities*, to the extent it does not conflict with or contradict other, higher categories of accounting principles generally accepted in the United States of America ("generally accepted accounting principles"), including GASB pronouncements.

GASB Codification Section 1800.141, *Reporting Restrictions in Proprietary Funds*, (GASB Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments)*, establishes standards for external financial reporting for all state and local governmental entities. It requires the classification of net position into three components: net investment in capital assets—net of related debt, restricted, and unrestricted. These classifications are defined as follows:

Net Investment in Capital Assets—This component of net position consists of capital assets, including restricted capital assets; net of accumulated depreciation; and reduced by the outstanding balances of any bonds, mortgages, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted—This component of net position consists of constraints placed on net position use through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, or laws or regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation.

Unrestricted—This component of net position consists of net assets that do not meet the definition of "restricted" or "invested in capital assets—net of related debt."

Revenue

L.A. Care derives most of its revenue from its DHCS contracts with the State and the contracts will expire on December 31, 2023. L.A. Care receives PMPM payments from DHCS on behalf of each eligible member

enrolled in the Medi-Cal program. Revenues are recognized in the month of the member's eligibility, and any payments received in advance of the member's month of eligibility are recorded as deferred revenue. Accounts receivable balances are typically collected in the subsequent month. Premiums received for the Medi-Cal programs are subject to monthly retroactive adjustments due to member eligibility changes processed by each agency and recorded to revenue in the month notified. Premiums for the Medi-Cal programs are generally fixed in advance of the contract periods covered. However, retro changes can and have been implemented by the DHCS. Medi-Cal rates are subject to change as determined by DHCS routinely on July 1 of each year and coincide with the State's approved operating budget for the state fiscal year or as otherwise allowed by the contract or law. Beginning January 1, 2021, our rates will be set by DHCS on a calendar year bases for all category of aids

For the CCI program, including dual eligible members and non-dual eligible members, there have been delays in receiving the PMPM rates from the DHCS. L.A. Care estimates revenue based on the most recent rates and other information available from DHCS. These estimates are updated as more information becomes known. Premiums for this product are received from both CMS and DHCS. The payment process mirrors Medi-Cal and Medicare coverage for each component of revenue received.

PASC-SEIU provides health benefits to eligible enrolled IHSS Workers. Los Angeles County Department of Public Social Services pays L.A. Care a fixed PMPM for each eligible member in the coverage period.

LACC is the plan's Covered California Health Insurance Plan. Premium rates are subject to the annual approval of both the DMHC and Covered California and are on a calendar year basis. Member-related revenue is derived from three different sources: Member Premiums, Premium Subsidy, and Cost-Sharing Subsidy.

Member Premium—L.A. Care receives a monthly premium from members. The member premium, which is fixed for the entire plan year, is recognized evenly over the contract period and reported as part of health plan services premium revenue.

Premium Subsidy—For qualifying low-income members, HHS reimburses L.A. Care, on the member's behalf, some or all of the monthly member premium depending on the member's income level in relation to the federal poverty level. L.A. Care recognizes the premium subsidy evenly over the contract period and reports it as part of health plan services premium revenue.

Cost-Sharing Subsidy—For qualifying low-income members, HHS reimburses L.A. Care, on the member's behalf, some or all of a member's cost-sharing amounts (e.g., deductible, co-pay/coinsurance). The amount paid by HHS is dependent on the member's income level in relation to the federal poverty level. L.A. Care receives prospective payments on a monthly basis, and they represent a cost reimbursement that is finalized and settled after the end of the year. The Cost-Sharing Subsidy is recorded as a liability if the Cost-Sharing Subsidy is received in advance or a receivable if incurred health care costs exceed the Cost-Sharing Subsidy received to date. In October 2017, HHS announced that the cost-sharing subsidies would not be paid to health plans beginning September 1, 2017. In February 2019, L.A. Care received favorable ruling from the U.S. Court of Federal claims. Our premium rates effective for 2018 and onward were increased to reflect the loss of the cost-sharing reduction subsidy and the resulting premium subsidy increase, compensated members for the majority of the cost-sharing subsidy decrease. The premium tax credit reduced the qualified member's monthly payments for insurance plans purchased through the marketplace. In August 2018, HHS issued guidance to allow insurers to add the cost of CSR to silver plan rates for 2019 coverage. Effective January 2018, qualified members will receive the premium tax credit coverage, which will compensate members for the majority of the cost-sharing subsidy decrease.

The premium tax credit reduces the qualified member's monthly payments for insurance plans purchased through the marketplace.

Effective January 1, 2014, the ACA includes permanent and temporary premium stabilization provisions for transitional reinsurance, permanent risk adjustment, and temporary risk corridors (collectively, the "3Rs"), which are applicable to those insurers participating inside, and in some cases outside, of the exchanges.

Permanent Risk Adjustment—The risk adjustment provision applies to individual business and requires measurement of the relative health status risk of each health plans pool of insured members in a given market. The risk adjustment provision then operates to transfer funds from health plans whose pools of insured members have lower-than-average risk scores to those health plans whose pools have greater-than-average risk scores.

Temporary Risk Corridor—The risk corridor provisions limit health plans' gains and losses by comparing allowable medical costs to a target amount, each defined prescribed by HHS, in sharing the risks for allowable costs with the federal government. Variances from the target exceeding certain thresholds may result in HHS making additional payments to the health plans or require health plans to make payments to HHS. This premium stabilization provision expired on December 31, 2016.

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers against the HHS to collect risk corridor payments rejecting all of the insurer's statutory, contract, and constitutional claims for payment. In relation to the valuation of the risk corridor receivable, L.A. Care had, in previous periods, relied upon the HHS interpretation that the risk corridor receivables were obligations of the U.S. government. In light of this decision, L.A. Care had estimated a full valuation allowance for the gross receivable as of September 30, 2019. For the year-end September 30, 2020, we received the entire risk corridor receivable of $23.5 million consistent with the Supreme Court decision. As a result, we released the valuation allowance for the current reporting year.

Membership/Member Months

L.A. Care's combined member months for 2020 increased by 0.1% as compared to the prior year. The member month data and the percentage change in member months for the years ended September 30, 2020 and 2019, are as follows:

Member Months by Product Line (in thousands)

	2020	2019	Member Months	Percentage
Medi-Cal:				
Plan Partners	11,672.3	11,905.5	(233.2)	(2.0)%
MCLA	12,788.1	12,568.3	219.8	1.7
Total Medi-Cal	24,460.4	24,473.8	(13.4)	(0.1)
Other lines of business:				
Cal MediConnect	201.5	194.3	7.2	3.7
PASC-SEIU	617.4	605.3	12.1	2.0
LA Care Covered *(on and off exchange)*	969.5	937.0	32.5	3.5
Total other lines of business	1,788.4	1,736.6	51.8	3.0
Total member months	26,248.8	26,210.4	38.4	0.1 %

L.A. Care's combined ending membership as of September 30, 2020 increased by 6.4% as compared to September 30, 2019. The membership data and the percentage change in membership for the years ended September 30, 2020 and 2019, are as follows:

	2020	2019	Changes Membership	Changes Percentage
Medi-Cal:				
Plan Partners	1,018.1	976.3	41.8	4.3 %
MCLA	1,141.2	1,050.6	90.6	8.6
Total Medi-Cal	2,159.3	2,026.9	132.4	6.5
Other lines of business:				
Cal MediConnect	18.0	15.9	2.1	13.2
PASC-SEIU	51.5	50.8	0.7	1.4
LA Care Covered *(on and off exchange)*	81.0	78.0	3.0	3.8
Total other lines of business	150.5	144.7	5.8	4.0
Total membership	2,309.8	2,171.6	138.2	6.4 %

Financial Position

Condensed Combined Statements of Net Position (dollars in millions)

	As of September 30		Changes	
	2020	2019	Dollar	Percentage
Assets:				
Total current assets	$ 4,998.3	$ 4,959.8	$ 38.5	0.8 %
Capital assets—net	106.4	112.3	(5.9)	(5.3)
Noncurrent assets	4.6	25.9	(21.3)	(82.2)
Total assets	$ 5,109.3	$ 5,098.0	$ 11.3	0.2
Deferred outflow of resources	$ -	$ -	$ -	
Liabilities:				
Total current liabilities	$ 4,175.1	$ 4,021.6	$ 153.5	3.8
Deferred rent	3.5	3.6	(0.1)	(2.8)
Total liabilities	$ 4,178.6	$ 4,025.2	$ 153.4	3.8
Deferred inflow of resources	$ 14.1	$ 18.7	$ (4.6)	(24.6)
Net position:				
Invested in capital assets	$ 106.4	$ 112.3	$ (5.9)	(5.3)
Restricted	0.3	0.3		
Unrestricted:				
Designated by Board of Governors	74.8	59.6	15.2	25.5
Minimum tangible net equity	192.6	168.2	24.4	14.5
Unrestricted	542.5	713.7	(171.2)	(24.0)
Total net positions	$ 916.6	$ 1,054.1	$ (137.5)	(13.0)
Total	$ 5,109.3	$ 5,098.0	$ 11.3	0.2 %

Net Position—L.A. Care's net position decreased by $137.5 million to $916.6 million as of September 30, 2020. The decrease was due to the loss from operations of $131.6 million.

Current Assets and Liabilities—Current assets increased by $38.5 million to $5.0 billion as of September 30, 2020. The increase was driven by an increase in Capitation Receivable of $45.7 million due to retroactive rate adjustments received in the current fiscal year.

Current liabilities increased by $153.5 million to $4.2 billion as of September 30, 2020. The increase was primarily driven by receipt of $880.4 million and $688.9 million for the years ended September 30, 2020 and 2019, respectively, for the Private and Public Hospital Directed payment program of which no disbursements were made for FY2019 since it was the first year of this new program.

Results of Operations

Condensed Combined Statements of Revenue, Expenses, and Changes in Fund Net Position (dollars in millions)

	Year Ended September 30		Changes	
	2020	2019	Dollar	Percentage
Revenues	$ 8,353.7	$ 7,902.0	$ 451.7	5.7 %
Health care expenses	8,033.6	7,283.0	750.6	10.3
Administrative expenses	451.7	415.7	36.0	8.7
(Loss) Income from operations	(131.6)	203.3	(334.9)	(164.7)
Investment and interest income	41.2	52.8	(11.6)	(22.0)
Community grants	(46.5)	(16.2)	(30.3)	187.0
Gross Premium Tax—net	(0.6)	(3.3)	2.7	(81.8)
(Decrease) Increase in net position	(137.5)	236.6	(374.1)	(158.1)
Beginning net position	1,054.1	817.5	236.6	28.9
Ending net position	$ 916.6	$ 1,054.1	$ (137.5)	(13.0)%

- Total revenue increased by $451.7 million, or 5.7%, to $8.4 billion. It is due to a net increase in revenues of $265.0 million from Med-iCal rate annual rate changes across all category of aids including CCI rate increase for calendar year 2019, an increase in Prop 56 revenues of $143.7 million, and an increase in Health Home program revenues of $44.6 million. Revenue from prior year was negatively impacted by the RADV adjustments of $32.5 million and no such impact for the current year.
- Total health care expenses increased by $750.6 million, or 10.3%, to $8.0 billion. This increase is primarily due to increases in Capitation Expense of $292.3 million driven by an increase in Prop 56 of $150.2 million, an increase in Plan Partners' capitation expenses of $56.4 million and an increase in the Health Homes Program of $32.8 million. The increase in inpatient, outpatient and skilled nursing facility (SNF) claims expense was $436.2 million primarily related to a 10% increase in the Medi-Cal SNF reimbursement rate due to the COVID state of emergency which resulted in an increase of $110.7 million as well as increased cost and utilization particularly in inpatient claims. Pharmacy expense also increased $31.3 million in the current year as a result of increased utilization.
- Administrative expenses increased by $36.0 million, or 8.7%, to $451.7 million for the year ended September 30, 2020 from $415.7 million a year ago. The increase is primarily driven by higher compensation and benefits of $19.4 million and higher purchased services of $19.6 million driven primarily by strategic projects spending.
- L.A. Care investment and interest income decreased by $11.6 million, or 22.0%, to $41.2 million for the year ended September 30, 2020 as compared to the year ended September 30, 2019. Interest and dividends decreased $12.7 million year-over-year due to lower short-term interest rates for a

greater part of the reporting period as well as lower average invested balances. Unrealized gains decreased $1.0 million driven by lower market value of our portfolio due to interest rate movements.

- Community Grants Expense increased by $30.3 million, or 187.0% to $46.5 million for the year ended September 30, 2020 as compared to the year ended September 30, 2019. Community Grants is comprised of several programs including the Community Health Investment Fund (CHIF) grant issued by L.A. Care in support of Safety Net community projects and the Workforce Grants issued to support programs designed to increase availability of medical professionals in the community. The increase in the current year was related to an accelerated granting process intended to provide grant recipients needed funds during the COVID pandemic.

- "(Decrease) increase in net position" for the year ended September 30, 2020 decreased by $137.5 million to $916.6 million from $1,054.1 million a year ago. The decrease represents the net loss for the year ended September 30, 2020 due primarily to higher health care and administrative expenses, net of increased revenue as discussed above.

Summary of Cash Flows

The major sources and uses of cash and cash equivalents for the years ended September 30, 2020 and 2019, are as follows. Cash and cash equivalents consist of liquid investments purchased with an original maturity of three months or less, as well as cash on hand and on-demand bank deposits.

Condensed Combined Statements of Cash Flow (dollars in millions)

	Year Ended September 30		Changes	
	2020	2019	Dollar	Percentage
Net cash (used in) provided by operating activities	$ (252.8)	$ 494.8	$ (747.6)	(151.1)%
Net cash (used in) investing activities	(422.2)	(142.4)	(279.8)	196.5
Net cash provided by financing activities	185.5	683.6	(498.1)	(72.9)
Net (decrease) increase in cash and cash equivalents	(489.5)	1,036.0	(1,525.5)	(147.2)
Cash and cash equivalents—beginning of year	1,634.4	598.4	1,036.0	173.1
Cash and cash equivalents—end of year	$ 1,144.9	$ 1,634.4	$ (489.5)	(29.9)%

Total cash and cash equivalents decreased by $489.5 million, or 29.9%, to $1,144.9 million for the year ended September 30, 2020.

Decrease in cash from operating activities compared to the prior year was primarily due to net cash used in the current reporting period driven by a decrease in fund net position, and an increase in capitation receivable as well as an increase in sub-capitation payable due to timing.

Decrease in cash from investing activities compared to the prior year was due to an increase in investment in short-term securities compared to the prior fiscal year.

Decrease in cash from financing activities compared to the prior year was due to cash received for the Private and Public Hospital Directed Payments program of $880.4 million in the current reporting year but

was reduced by a disbursement the of $688.9 million from the prior year's receipt of cash. For Fiscal year 2019, L.A. Care received $688.9 million of Private and Public Hospital Directed payment program of which no disbursements were made for FY2019 since it was the first year of this new program.

INDEPENDENT AUDITORS' REPORT

To the Board of Governors of
Local Initiative Health Authority for
Los Angeles County, operating and doing business as L.A. Care Health Plan and
L.A. Care Health Plan Joint Powers Authority:

We have audited the accompanying combined financial statements of the Local Initiative Health Authority for Los Angeles County, operating and doing business as L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (collectively, "L.A. Care"), both of which are under common ownership and common management, which comprise the combined statements of net position as of September 30, 2020 and 2019, and the related combined statements of revenue, expenses, and changes in fund net position and of cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined financial position of L.A. Care as of September 30, 2020 and 2019, and the combined results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 1–12 and the budgetary comparison information on pages 37–40 be presented to supplement the basic combined financial statements. Such information, although not a part of the basic combined financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic combined financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the basic combined financial statements, and other knowledge we obtained during our audit of the basic combined financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

December 23, 2020

LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY, OPERATING AND DOING BUSINESS AS L.A. CARE HEALTH PLAN AND L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

COMBINED STATEMENTS OF NET POSITION
AS OF SEPTEMBER 30, 2020 AND 2019
(In thousands)

	2020	2019
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 1,144,914	$ 1,634,374
Investments—at fair value	1,310,365	897,935
Capitation receivable	2,490,434	2,420,401
Other current assets	52,595	7,093
Total current assets	4,998,308	4,959,803
CAPITAL ASSETS—Net	106,386	112,322
NONCURRENT ASSETS	4,542	25,882
TOTAL ASSETS	$ 5,109,236	$ 5,098,007
DEFERRED OUTFLOW OF RESOURCES—Total deferred outflow of resources	$ -	$ -
LIABILITIES		
CURRENT LIABILITIES:		
Accounts payable and accrued liabilities	$ 98,247	$ 50,138
Subcapitation and other payables	3,244,683	3,112,997
Grants payable	11,977	11,841
Reserves for claims	620,735	558,640
Other accrued medical expenses	131,068	199,709
Reserves for provider incentives	68,396	88,247
Total current liabilities	4,175,106	4,021,572
DEFERRED RENT	3,474	3,581
TOTAL LIABILITIES	$ 4,178,580	$ 4,025,153
DEFERRED INFLOW OF RESOURCES—Deferred revenue	$ 14,096	$ 18,739
TOTAL DEFERRED INFLOW OF RESOURCES	$ 14,096	$ 18,739
COMMITMENTS AND CONTINGENCIES (Note 8)		
NET POSITION:		
Invested in capital assets	$ 106,386	$ 112,322
Restricted	300	300
Unrestricted:		
Designated by Board of Governors	74,752	59,580
Minimum tangible net equity	192,597	168,236
Unrestricted	542,525	713,677
TOTAL NET POSITION	$ 916,560	$ 1,054,115

See notes to combined financial statements.

LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY, OPERATING AND DOING BUSINESS AS L.A. CARE HEALTH PLAN AND L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

COMBINED STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN FUND NET POSITION
FOR THE YEARS ENDED SEPTEMBER 30, 2020 AND 2019
(In thousands)

	2020	2019
REVENUES:		
Capitation	$ 8,353,703	$ 7,901,970
Total revenues	8,353,703	7,901,970
HEALTH CARE EXPENSES:		
Capitation—professional services	4,461,443	4,169,129
Inpatient, outpatient, and IHSS claims	2,758,981	2,322,749
Pharmacy claims	693,186	661,929
Provider incentives and shared risk	39,098	67,205
Medical administrative expense	80,887	61,943
Total health care expenses	8,033,595	7,282,955
ADMINISTRATIVE EXPENSES	451,660	415,719
(LOSS) INCOME FROM OPERATIONS	(131,552)	203,296
NONOPERATING (EXPENSES) REVENUE:		
Investment and interest income—net	41,168	52,778
Grant income	1,667	13,304
Provision for community grant	(48,232)	(29,447)
Gross premium tax revenue	105,318	112,651
Gross premium tax expense	(105,923)	(115,952)
Total nonoperating (expense) revenue	(6,002)	33,334
(DECREASE) INCREASE IN FUND NET POSITION	(137,554)	236,630
FUND NET POSITION—Beginning of year	1,054,115	817,485
FUND NET POSITION—End of year	$ 916,562	$ 1,054,115

See notes to combined financial statements.

LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY, OPERATING AND DOING BUSINESS AS L.A. CARE HEALTH PLAN AND L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

COMBINED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED SEPTEMBER 30, 2020 AND 2019
(In thousands)

	2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES:		
Capitation revenue	$ 8,257,934	$ 7,768,687
Other income—net	(41,406)	22,810
Health care expenses	(8,078,650)	(6,908,900)
Operating expenses	(390,672)	(387,784)
Net cash (used in) provided by operating activities	(252,794)	494,813
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases net of sales of investments	(397,895)	(110,082)
Purchase of capital assets	(24,343)	(32,331)
Net cash (used in) investing activities	(422,238)	(142,413)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Gross premium tax revenue received	82,372	120,174
Gross premium tax paid	(66,878)	(151,213)
SB 208 Transfer	-	108,713
SB 208 Transfer paid	-	(108,730)
SB 857 Transfer	12,213	14,771
SB 857 Transfer paid	(11,588)	(14,574)
SB 239 Transfer	345,411	591,402
SB 239 Transfer paid	(347,054)	(589,551)
Hospital directed payments received	395,619	688,886
Hospital directed payments paid	(369,787)	-
Inter-Government Transfer from the State	268,013	280,721
Inter-Government Transfer to Community Health Plan and State Agencies	(289,938)	(257,028)
Cost-Based Reimbursement Clinic (CBRC) received	218,288	-
Cost-Based Reimbursement Clinic (CBRC) paid	(97,100)	-
Enhanced Payment Program (EPP) received	473,400	-
Enhanced Payment Program (EPP) paid	(435,647)	-
Designated Public Hospital Quality Incentive Program (QIP) received	102,485	-
Designated Public Hospital Quality Inentive Program (QIP) paid	(94,237)	-
Net cash provided by financing activities	185,572	683,571
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(489,460)	1,035,971
CASH AND CASH EQUIVALENTS—Beginning of year	1,634,374	598,403
CASH AND CASH EQUIVALENTS—End of year	$ 1,144,914	$ 1,634,374

LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY, OPERATING AND DOING BUSINESS AS L.A. CARE HEALTH PLAN AND L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

COMBINED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED SEPTEMBER 30, 2020 AND 2019
(In thousands)

	2020	2019
ADJUSTMENTS TO RECONCILE INCREASE IN FUND NET POSITION WITH CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES:		
(Decrease) Increase in fund net position	$ (137,554)	$ 236,629
Depreciation and amortization	30,279	25,608
Unrealized and realized (appreciation) depreciation on investments—net	(14,655)	(13,508)
Deferred rent	(107)	726
Gross premium tax provision	605	3,301
Changes in operating assets and liabilities:		
Other current and noncurrent assets	(2,297)	87,400
Capitation receivable	(70,033)	96,757
Accounts payable and accrued liabilities	9,183	6,169
Subcapitation payable	(7,651)	241,615
Medi-Cal adult expansion payable	(29,659)	(199,746)
Grants payable	136	2,420
Reserves for provider claims	62,094	(8,964)
Other accrued medical expenses	(68,641)	14,479
Reserves for provider incentives	(19,851)	5,755
Deferred inflow of resources	(4,643)	(3,827)
NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES	$ (252,794)	$ 494,813

See notes to combined financial statements. (Concluded)

LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY, OPERATING AND DOING BUSINESS AS L.A. CARE HEALTH PLAN AND L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

NOTES TO COMBINED FINANCIAL STATEMENTS
AS OF AND FOR THE YEARS ENDED SEPTEMBER 30, 2020 AND 2019

1. DESCRIPTION OF BUSINESS

The Local Initiative Health Authority for Los Angeles County, operating and doing business as L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (JPA) (collectively, "L.A. Care" or the "Organization") is an independent local public agency created to serve Medi-Cal beneficiaries in Los Angeles County (the "County"). The County Board of Supervisors established the Local Initiative Health Authority for Los Angeles County (the "Authority") in 1994 pursuant to legislation (Senate Bill (SB) 2092 and Assembly Bill (AB) 2755) passed by the California legislature and signed into law by the governor. L.A. Care Health Plan was adopted as the business name for the Authority.

L.A. Care Health Plan entered into a joint exercise of powers agreement with the County to establish JPA, a licensed health maintenance organization. The County's Board of Supervisors established the JPA in July 2012 pursuant to the Joint Exercise of Powers Act Government Code Section 6500. This legislation provides that the JPA is also a public entity, separate and apart from the County, and is not an agency, division, or department of the County. The JPA is not governed by, nor is it subject to, the Charter of the County and is not subject to the County's policies or operational rules. Neither L.A. Care Health Plan nor the JPA are subjected to any premium tax on the plans within the JPA. The JPA received its Knox-Keene license and commenced operations in December 2013. L.A. Care Health Plan and the JPA have a mutual guarantee agreement insuring solvency for the two organizations and both entities operate under common management and control.

The State of California (the "State") created the "Local Initiative and the Two Plan Model" to realize the strategic plans of the Department of Health Care Services (DHCS), formerly known as the State Department of Health Services, outlined in its March 31, 1993, report, *Expanding Medi-Cal Managed Care: Reforming the Health System—Protecting Vulnerable Populations*. Under the plan, DHCS would transition the delivery of Medi-Cal services in 12 counties, including Los Angeles, from a traditional fee-for-service system to a prepaid managed care system through a "Two-Plan" model. Under the Two-Plan model, DHCS would contract with two Knox-Keene licensed health plans, a "local initiative" and a "commercial" plan. In the County, L.A. Care is the "local initiative" and the Health Net Health Plan is the "commercial" plan. Our contracts with the DHCS will expire on December 31, 2023.

Through a County Board of Supervisors' novation dated January 9, 1996, L.A. Care became financially independent of the County. Senate Bill 2092 describes L.A. Care as a "unit of local government" and "shall not be considered to be an agency, division, department, or instrumentality of the County, and L.A. Care shall not be subject to the personnel, procurement, or other operational rules of the County."

A 13-member Board of Governors (the "Board") sets policy for L.A. Care and oversees its planning, development, and administration. Stakeholder organizations, representing hospitals, doctors, and Medi-Cal beneficiaries, among others, nominate L.A. Care's Board members. The County Board of Supervisors confirms these nominations.

L.A. Care provides the delivery of covered health care services to Medi-Cal beneficiaries by either through its network of contracted providers Medi-Cal program ("MCLA") or contracting its Plan Partners, including Anthem Blue Cross of California ("Anthem"), Blue Shield of California Promise Health Plan, formerly Care 1st Health Plan ("Promise"), and Kaiser Foundation Health Plan ("Kaiser"). Medi-Cal membership with the Plan Partners as of September 30, 2020 and 2019, was 1,018,135 and 976,311 enrollees, respectively.

L.A. Care's Medi-Cal MCLA program is designed to complement the existing Plan Partner network. L.A. Care receives from DHCS a fixed payment per member, per month (PMPM), and fixed case rates for maternity case for each eligible birth, hepatitis C, intuitional members, enrolled Health Home members, and qualified members receiving behavioral health treatment (BHT). L.A. Care contracts directly with participating physician provider groups (PPGs), hospitals, primary care and specialty care physicians and other ancillary professionals for health care services.

Substantially all PPGs in the MCLA health care network are reimbursed on a PMPM capitated basis. PPG capitation rates may include or exclude hospital services. The network hospital contracts are on a nonexclusive basis and provide for reimbursement on a per diem, case rate, a percentage of the hospital billed charges or capitated bases. Certain physicians are reimbursed on a fee-for-service basis. The MCLA program is available to all eligible Medi-Cal beneficiaries in the County, with the same health care benefits as provided by the Plan Partners. Under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, ACA), Medi-Cal was expanded to include low-income adults with incomes up to 138% of the federal poverty level effective January 1, 2014. As of September 30, 2020 and 2019, MCLA membership was 1,141,207 and 1,050,610 enrollees, respectively.

The Homecare Workers Health Care Plan (PASC-SEIU) program provides health care services to the In-Home Supportive Services (IHSS) workers in the County. The PASC-SEIU program and its members were moved from L.A. Care to the JPA. As of September 30, 2020 and 2019, PASC-SEIU membership was 51,457 and 50,809 enrollees, respectively.

L.A. Care Covered (LACC) is a health coverage program offered under the California state- based exchange known as Covered California. LACC was launched on January 1, 2014, and offers individuals health coverage under regulations established by the U.S. Department of Health and Human Services (HHS). Qualifying low-income individuals are eligible for varying premium and cost-sharing subsidies depending on the income level in relation to the federal poverty level (FPL). In October 2017, HHS announced that the cost-sharing subsidies would not be paid to health plans beginning September 1, 2017. In February 2019, L.A. Care received favorable ruling from the U.S. Court of Federal claims. Our premium rates effective for 2018 and onward were increased to reflect the loss of the cost-sharing reduction subsidy and the resulting premium subsidy increase, compensated members for the majority of the cost-sharing subsidy decrease. In August 2018, HHS issued guidance to allow insurers to add the cost of CSR to silver plan rates for 2020 coverage. The premium tax credit reduced the qualified member's monthly payments for insurance plans purchased through the marketplace. In August 2018, HHS issued guidance to allow insurers to add the cost of CSR to silver plan rates for 2019 coverage. Effective January 2018, qualified members will receive the premium tax credit coverage, which will compensate members for the majority of the cost-sharing subsidy decrease. The premium tax credit reduces the qualified member's monthly payments for insurance plans purchased through the marketplace.

Beginning in 2019, the individual mandate was eliminated meaning individuals are no longer incur a federal tax penalty for not having health insurance. Beginning in 2020, California enacted an individual mandate to maintain minimum essential coverage or incur a state tax penalty. The State also added a new tier of subsidies for individuals between 400%–600% FPL and increased premium subsidies for individuals between 200%–400% FPL for a three-year period beginning January 1, 2020. As of September 30, 2020 and 2019, LACC membership was 80,975 and 77,993, respectively.

Coordinated Care Initiative (CCI) began as a three-year pilot program developed jointly with DHCS to coordinate medical care, behavioral health, and long-term services and supports (LTSS), which includes institutional long-term care, home and community-based services, and other support services to individuals who are fully eligible for Medicare and Medi-Cal benefits or "dual eligible" as well as to all Medi-Cal-only individuals or "non-duals" who rely on LTSS services. The CMC component of CCI, including mandatory enrollment of dual eligible members and integrated LTSS has been extended through December 31, 2022; however, effective January 1, 2018, the IHSS benefit was removed from the program. As of September 30, 2020 and 2019, the dual eligible CCI membership, including MCLA and Plan Partners was 222,926 and 217,345 enrollees, respectively.

L.A. Care's Cal MediConnect (CMC) program was launched in May 2014. CMC members are those who qualify for both Medicare and Medi-Cal ("dual eligibles"). The CMC program offers members a coordinated care model within a single health plan and is part of the larger CCI program. L.A. Care receives a PMPM payment from DHCS and PMPM payments from CMS, which are based on the member's demographics and individual health risk score for the Medicare coverage. The CMC program has been extended to December 31, 2022. The DHCS plans to transition CMC to a Medicare Advantage Dual Eligible Special Needs Plans (D-SNP) by 2023. As of September 30, 2020 and 2019, CMC membership was 17,983 and 15,913 enrollees, respectively.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation—The combined financial statements include the accounts of L.A. Care. The financial statements of L.A. Care Health Plan and JPA are combined as entities under common control, whereby JPA is considered a non-significant component unit of L.A. Care. All intercompany transactions have been eliminated.

L.A. Care utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and all of the Organization's activities are considered a single proprietary fund. Pursuant to Government Accounting Standards Board (GASB) Codification Section P80, *Proprietary Fund Accounting and Financial Reporting*, L.A. Care uses the enterprise fund basis of reporting, and accordingly, utilizes accounting and reporting as provided in the Financial Accounting Standards Board (FASB) *Accounting Standards Codification* (ASC), to the extent it does not conflict with or contradict other, higher categories of accounting principles generally accepted in the United States of America ("generally accepted accounting principles" or GAAP), including GASB pronouncements.

GASB Codification Section 1800.141, *Reporting Restrictions in Proprietary Funds*, establishes standards for external financial reporting for all state and local governmental entities. It requires the classification of net position into three components, net investment in capital assets, restricted, and unrestricted. These classifications are defined as follows:

Net Investment in Capital Assets—This component of net position consists of capital assets, including restricted capital assets; net of accumulated depreciation; and reduced by the outstanding balances of

any bonds, mortgages, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted—This component of net position consists of constraints placed on fund net position use through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, or laws or regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation.

Unrestricted—This component of net position consists of net assets that do not meet the definition of "restricted" or "invested in capital assets."

Use of Estimates—The preparation of combined financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and disclosure of contingent assets and liabilities and the reported amounts of revenues and expenses.

Actual results will differ from these estimated amounts. Principal areas requiring the use of estimates include the determination of reserves for claims, provider incentives, risk sharing, risk adjustment and assumptions when determining net realizable value of long-lived assets.

Cash and Cash Equivalents—Cash and cash equivalents consist of liquid investments purchased with an original maturity of three months or less, as well as cash on hand and on-demand bank deposits.

Investments—Investments are accounted for in accordance with GASB Codification Section 150, Investments (GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*). This statement requires that investments be reported at fair value and all investment income, including unrealized changes in the fair value of investments, be reported in the combined statements of revenues, expenses, and changes in fund net position. However, certain money market investments are permitted to be reported at amortized cost, provided that the investment has a remaining maturity of one year or less.

Restricted Investments and Deferred Inflow of Resources—The Organization receives capitation revenue under a Medi-Cal agreement with the DHCS for plan enrollees on a PMPM basis. Capitation revenue is recognized on an accrual basis in the period when members are entitled to the services.

Capitation revenue payments received in advance of being earned are recorded in deferred revenue as inflow of resources. Capitation payments are restricted, as required under the Organization's financial agreement with the DHCS, and included in restricted investments until approximately 30 days from receipt or when sub capitation payments are made to the Plan Partners.

Capital Assets—Capital assets consisting of computer equipment and software, office furniture and equipment, and leasehold improvements are recorded at cost, less accumulated depreciation. Depreciation and amortization are calculated using the straight-line method over the estimated useful lives of the assets, ranging from three to five years for computer equipment and software, three to seven years for other furniture and equipment or the remaining life of the lease for leasehold improvements, whichever is shorter.

Expenditures for maintenance and repairs are expensed as incurred. Major improvements that increase the estimated useful life of an asset are capitalized. Upon sale or retirement of properties, the accounts are relieved of the cost, and related accumulated depreciation and any gain or loss on disposal is included in other income and expense.

Subcapitation and Other Payable—L.A. Care contracts with Plan Partners, PPGs, hospitals, and others to provide health care services for members on a capitated or fixed-PMPM-fee basis. The Organization records obligations to the capitated providers on an accrual basis and releases the obligations upon receipt of capitation revenue. The Subcapitation and Other Payable also included the Prop 56 payables of $150.9 million and $200.7 million as of September 30, 2020 and 2019, respectively.

Subcapitation and Other Payable also includes proceeds resulting from SB 208, 239, 857, the Private and Public Hospital Directed Payments Program, and intergovernmental transfers that represent non-exchange transactions, whereby L.A. Care serves as a pass-through enterprise without any administrative or direct financial involvement. These funds were recorded as deposits as the transactions did not meet the revenue recognition criteria as defined under *Government Accounting Standards*. All funds received will pay out within 30 days as required by DHCS.

Provider Incentives Payable—L.A. Care has several incentive programs designed to reward providers for meeting specific benchmarks of encounter data submission, well-child/adolescent visits, initial health assessment visits, access to specialty care, and disease management. L.A. Care records obligations for provider incentive programs when they were announced and releases the payment when the related eligibility requirements are met by the participating providers. An aggregate of $68.4 million and $88.2 million is recorded in the reserves for provider incentives in the combined statements of net position for all incentive programs for the years ended September 30, 2020 and 2019, respectively.

Rent Expense and Accrued Rent—L.A. Care recognizes rent expense on a straight-line basis and records accrued rent based on scheduled rent increases.

Revenue Recognition—Capitation revenue for eligible members is reported as revenue in the month in which enrollees are entitled to receive health care services. Premiums received prior to such period are recorded as deferred inflow of resources.

L.A. Care's combined statements of revenue, expenses, and changes in fund net position distinguish between operating and non-operating revenue and expenses. Operating revenue results from exchange transactions associated with arranging for the provision of health care services for covered members. The primary operating expense is health care costs incurred on a capitated basis whereby the Organization's obligation to provide care is transferred to the providers or network, or on an incurred claim basis for services rendered to members by providers both in and out of the Organization's network.

For the CCI program, L.A. Care estimates revenue based on the most recent rates and other information available from DHCS. The estimate is updated as more information becomes known. During the current reporting year, DHCS has decided to reconcile institutional membership data retroactive back to the 2014, the beginning of the CCI program. L.A. Care had submitted the requested data and based on the submission to DHCS, L.A. Care reduced the revenue by $69.7 million for the member reclassification accrual.

Given the uncertainties including the unanticipated costs related to COVID-19 testing and treatment and the impact of the deferral of elective procedures, many states including California chose to adjust current payment rates and implemented risk sharing arrangements to mitigate MCO and state risk. The risk sharing mechanism implemented by California is a risk corridor arrangement (COVID -19 risk corridor) whereby the state and plans agreed to share profit or losses if aggregate spending falls above or below specified thresholds with a symmetrical two-sided risk corridor. Although the specifics of the

risk corridor mechanism are still being finalized by the DHCS, we believe the information shared by the state so far provides a reasonable basis for our estimation. Using the most recent information from the DHCS, we estimate there is no gain sharing or loss sharing as of September 30, 2020.

LACC revenue is derived from three different sources. Member-paid premiums, which are fixed for the entire year, billed monthly, and recognized evenly over the contract period. To initiate coverage, members must pay an initial binder payment. CMS additionally makes a monthly supplemental assistance payment in the form of advanced premium tax credit on behalf of LACC members that qualify for the assistance. The cost-sharing payments are received prospectively and represent a cost-sharing reimbursement that is finalized and settled after the end of the year. In October 2017, HHS announced that the cost-sharing subsidies would not be paid to health plans beginning September 1, 2017. In February 2019, L.A. Care received favorable ruling from the U.S. Court of Federal claims. Our premium rates effective for 2018 and onward were increased to reflect the loss of the cost-sharing reduction subsidy and the resulting premium subsidy increase, compensated members for the majority of the cost-sharing subsidy decrease. In August 2018, HHS issued guidance to allow insurers to add the cost of CSR to silver plan rates for 2020 coverage. The premium tax credit reduced the qualified member's monthly payments for insurance plans purchased through the marketplace. In August 2018, HHS issued guidance to allow insurers to add the cost of CSR to silver plan rates for 2019 coverage. Effective January 2018, qualified members will receive the premium tax credit coverage, which will compensate members for the majority of the cost-sharing subsidy decrease. The premium tax credit reduces the qualified member's monthly payments for insurance plans purchased through the marketplace.

Permanent Risk Adjustment—The risk adjustment provision applies to individual business and requires measurement of the relative health status risk of each health plans pool of insured members in a given market. The risk adjustment provision then operates to transfer funds from health plans whose pools of insured members have lower-than-average risk scores to those health plans whose pools have greater-than-average risk scores.

Temporary Risk Corridor—The risk corridor provisions limit health plans' gains and losses by comparing allowable medical costs to a target amount, each defined prescribed by HHS, in sharing the risks for allowable costs with the federal government. Variances from the target exceeding certain thresholds may result in HHS making additional payments to the health plans or require health plans to make payments to HHS. This premium stabilization provision expired on December 31, 2016.

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers against the HHS to collect risk corridor payments rejecting all of the insurer's statutory, contract, and constitutional claims for payment. In relation to the valuation of the risk corridor receivable, L.A. Care had, in previous periods, relied upon the HHS interpretation that the risk corridor receivables were obligations of the U.S. government. In light of this decision, L.A. Care had estimated a full valuation allowance for the gross receivable as of September 30, 2019. For the year-end September 30, 2020, we received the entire risk corridor receivable of $23.5 million consistent with the Supreme Court decision. As a result, we released the valuation allowance for the current reporting year.

Medical Loss Ratio Corridors—Under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, ACA), Medi-Cal was expanded to include low-income adults with income up to 138% of the federal poverty level. Coverage under the Medi-Cal

Expansion (MCE) began on January 1, 2014. Enrollment increased from 635,425 in September 2019 to 713,152 in September 2020.

L.A. Care's MCE population was subject to a medical loss ratio (MLR) provision for the period January 1, 2014 through June 30, 2016, whereby if the MLR for this population was below 85%, then L.A. Care had to pay the DHCS a rebate. If the MLR was above 95%, then the DHCS had to pay L.A. Care additional premium. The MCE MLR provision was extended to cover the period from July 1, 2016—June 30, 2018 and no rebate liability has been incurred during this extended period. As of September 30, 2020, L.A. Care had no rebate liability for MCE. As of September 30, 2019, the rebate liability for MCE was $21.1 million.

Since the inception of the CCI population, there was a risk corridor requirement in effect through March 31, 2016, for dual eligible members and another one in effect for non-dual members through June 30, 2016. The risk-sharing arrangement may result in payments to or from DHCS based on the final calculation. Also subject to the risk corridor requirements was our CMC population and the limited risk corridors were in effect through December 31, 2017. L.A. Care has accrued a risk corridor payable to the DHCS/CMS as of September 30, 2020 and 2019, of $21.3 million and $40.7 million, respectively and included in Other Accrued Expenses in the accompanying Combined Statement of Net Position.

Beginning on July 1, 2017, the DHCS included an 85% MLR reporting requirement for all categories of aid within the Medi-Cal program as required under CMS regulation for Medicaid Managed Care Plans. Specifically, L.A. Care will be required to expend at least 85% of the Medi-Cal premium revenue received for this population on allowable medical expenses as defined by DHCS. In the event L.A. Care expends less than the 85% requirement, L.A. Care may be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. During 2020 and 2019, L.A. Care expended more than 85% of the Medi-Cal premium revenue, therefore, no rebate liability has been incurred for this requirement.

Proposition 56 (Prop 56) increased the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures including increased funding for existing healthcare programs. The DHCS pays a PMPM rate for this program for all eligible Medi-Cal members. L.A Care is required by the DHCS to make directed payments for qualifying services to eligible network providers and is at risk for these payments.

The Prop 56 program was effective on July 1, 2017 on a state fiscal year basis and was expanded to additional qualifying services beginning July 1, 2018. The DHCS implemented a one-sided risk corridor for the period July 1, 2018 to June 30, 2019 under which payments to providers must be above 95% of the revenue earned or rebated to the DHCS. For the period July 1, 2019 to June 30, 2020, the DHCS implemented a two-sided risk corridor under which payments to providers must be between 95% and 100% of the revenue earned with a rebate incurred below 95% and additional revenue earned above 100%. This arrangement has been extended to June 30, 2021. Additionally, DHCS has added VBP Program and Family Planning Services for the bridge period and both have a two-sided risk corridor. There are other new Prop 56 programs added for the bridge period but are not material to L.A. Care.

Capitation Expense—L.A. Care contracts with PPGs, hospitals, and others to provide health care services for members on a capitated or fixed-PMPM-fee basis. The expense related to these provisions for covered services to L.A. Care enrolled members is recognized on an accrual basis.

Advertising—Advertising costs are expensed when incurred. Advertising costs in fiscal years 2020 and 2019 of $8.1 million and $5.4 million, respectively, are included in administrative expenses in the accompanying statements of revenues, expenses, and changes in fund net position.

Fair Value of Financial Instruments—The classification of securities as short term or long term is based upon management intent to hold the securities for less than one year, or for greater than or equal to one year, respectively. All investments are carried at fair market value. The estimated fair value amount of investments is based principally on quoted market prices. Investments for which readily determinable market values do not exist are recorded based upon the net asset value (NAV) per share of the underlying fund. All investments that are eligible to be measured at fair value using the NAV practical expedient are excluded from the fair value disclosures.

Reserves for Claims—L.A. Care arranges for comprehensive health care services for certain members through risk-based arrangements. The cost of health care provided is accrued in the period it is dispensed to the enrolled members, based in part on estimates for hospital services and other health care costs that have been incurred but not reported (IBNR). Management develops these estimates using standard actuarial methods, which include, among other factors, the average interval between the date services are rendered and the date claims are paid, utilization, seasonality patterns, changes in membership, and known environmental factors. The organization refers to its estimate of the impact of these known environmental factors as its position for adverse deviation. Estimates are continually monitored and analyzed, and as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of claims paid is dependent on future developments, management is of the opinion that the accrued medical claims payable is adequate. IBNR estimates of $620.7 million and $558.6 million are recorded in reserves for claims in the combined statements of net position as of September 30, 2020 and 2019, respectively.

Other Accrued Medical Expenses—These expenses include shared risk liability, claims payables, and pharmacy payable. These accrued expenses are recorded at a total of 131.1 million and $199.7 million as of September 30, 2020 and 2019, respectively.

Premium Deficiency Reserves—Insurance contracts are analyzed to determine if it is probable that a loss will be incurred. L.A. Care recognizes a premium deficiency loss when it is probable that expected future claims, including maintenance costs (for example, claim processing costs), will exceed existing reserves, plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. We did not have any premium deficiency reserves at September 30, 2020 or 2019.

Non-operating Revenue and Expenses—Non-operating revenue includes investment and interest income—net, grant income and gross premium tax revenue. Non-operating expenses include provision for community grant and gross premium tax expense.

Effective August 1, 2019, L.A. Care and Blue Shield of California Promise Health Plan (“Promise Health Plan”) entered into a grant agreement, whereby L.A. Care will receive a grant of $72.8 million from Promise Health Plan and L.A. Care will match this amount as part of a five-year commitment. In accordance with this agreement, L.A. Care will build, expand, and operate Community Resource Centers across Los Angeles County. Grant income is recognized when all eligibility requirements are met. During

the year ended September 30, 2020, L.A. Care did not receive cash from Promise Health Plan and no grant income was recognized. For the year ended September 30, 2019, L.A. Care received and recognized $5.3 million grant income from Promise Health Plan. For the remaining contractual grant funding, L.A. Care will recognize revenues upon meeting all timing and eligibility requirements and receipt of the funds.

Managed Care Organization Tax—Effective July 1, 2016, SB X2-2 Managed Care Organization Tax authorized the DHCS to implement a Managed Care Organization provider tax subject to approval by the federal centers for Medicare and Medicaid Services. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed at different tax rates. On April 3, 2020, CMS approved California's request for a waiver of the broad-based and uniformity requirements related to State's managed care organization (MCO) tax, effective January 1, 2020. For the years ended September 30, 2020 and 2019, Gross premium tax (GPT) revenue totaled $105.3 million and $112.7 million and GPT tax expense totaled $105.9 million and $116.0 million for fiscal years 2020 and 2019, respectively.

Income Taxes—L.A. Care is an integral part of the government and is, therefore, exempt from federal and state income taxes.

Recent Accounting Pronouncements—GASB Statement No. 84, *Fiduciary Activities,* serves to enhance the consistency and comparability of fiduciary activity reporting by state and local governments. This Statement also is intended to improve the usefulness of fiduciary activity information primarily for assessing the accountability of governments in their roles as fiduciaries. The Statement is effective for the Organization's combined financial statements for the year ended September 30, 2021, and management concluded that it will not have a material impact on the combined financial statements.

GASB Statement No. 87, *Leases*, requires recognition of certain lease assets and liabilities for leases that previously were classified as operating leases. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities. After Postponing implementation due to the COVID-19 pandemic, the Statement is effective for the Organization's combined financial statements for the year ending September 30, 2023, and management is evaluating the impact that this statement will have on the combined financial statements.

3. CASH AND INVESTMENTS

Custodial Credit Risk—Custodial credit risk is the risk that a custodial deposit in possession of an outside party is not returned in the event of a bank failure. Deposits are exposed to custodial credit risk if they are not insured or collateralized. As of September 30, 2020 and 2019, no bank deposits were exposed to custodial credit risk. L.A. Care's bank balance was covered by pledged collateral. The California Government Code requires banks to secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the State law. On September 30, 2020 and 2019, the carrying amounts of L.A. Care's deposits were $103.0 million and $61.9 million, respectively, and the bank balance was $138.9 million and $165.6 million, respectively. The difference between the carrying amount and the bank's balance is outstanding checks, and other standard reconciling items.

Cash Concentration—L.A. Care maintains its cash and cash equivalents in primarily one financial institution. This potentially subjects the Organization to concentrations of credit risk related to

temporary cash investments. As of September 30, 2020, cash equivalents were money market funds, treasury bills, US agency bonds, municipal bonds, and negotiable certificates of deposit with original maturities of less than 90 days.

Investments—Investments are measured and reported at fair value using fair value hierarchy, as defined below. The table below classifies investments in one of the following categories:

Level 1—Quoted prices are available in active markets for identical investments as of the reporting date. The type of investments reported in Level 1 includes cash equivalents.

Level 2—Pricing inputs are other than quoted prices in active markets, which are either directly or indirectly observable as of the reporting date, and fair value is determined through the use of models or other valuation methodologies. The type of investments reported in Level 2 includes asset-backed securities, corporate bonds, and US government and agency securities.

Level 3—Pricing inputs are unobservable for the investment and include situations where there is little, if any, market activity for the investment. The inputs into the determination of fair value require significant management judgment or estimation using assumptions that market participants would use, including assumptions for risk.

L.A. Care had investments as of September 30, 2020 and 2019, as follows (in thousands):

	As of September 30, 2020		
Investments	**Level 1**	**Level 2**	**Total**
Money market funds	$ 71,352	$	$ 71,352
U.S. government, agencies, and supranational bonds		1,491,314	1,491,314
Negotiable and non negotiable certificates of deposit		30,175	30,175
Corporate bonds		327,228	327,228
Mortgage-backed securities		48,888	48,888
Asset-backed securities		109,175	109,175
Subtotal	71,352	2,006,780	2,078,132
Less cash equivalent portion	(71,352)	(970,611)	(1,041,963)
Investments—total	$	$ 1,036,169	$ 1,036,169

Investments	As of September 30, 2019 Level 1	Level 2	Total
Money market funds	$ 407,416	$ -	$ 407,416
U.S. government, agencies, and supranational bonds		1,406,858	1,406,858
Negotiable and non negotiable certificates of deposit		27,551	27,551
Corporate bonds		313,414	313,414
Mortgage-backed securities		27,424	27,424
Asset-backed securities		121,382	121,382
Subtotal	407,416	1,896,629	2,304,045
Less cash equivalent portion	(407,416)	(1,165,029)	(1,572,445)
Investments—total	$ -	$ 731,600	$ 731,600

The investments, measured at the NAV per share, that do not require levelling and that are not included in the tables above, constitute the government-pooled funds of $274.2 million and $166.3 million as of September 30, 2020 and 2019, respectively.

As of September 30, 2020 and 2019, L.A. Care had investments by type and maturity as follows:

Investments	2020 Investment Maturities (in Years) Fair Value	Less than 1	1–5
Money market funds	$ 71,352	$ 71,352	$
U.S. government, agencies, and supranational obligations	1,491,314	1,301,346	189,968
Negotiable and non negotiable certificates of deposit	30,175	30,175	
Corporate obligations	327,228	26,329	300,899
Mortgage-backed securities	48,888	14,362	34,526
Asset-backed securities	109,175	4,808	104,367
Government pooled funds	274,196	274,196	
Subtotal	2,352,328	1,722,568	629,760
Less cash equivalent portion	(1,041,963)	(1,041,963)	
Investments—total	$ 1,310,365	$ 680,605	$ 629,760

Investments	2019 Investment Maturities (in Years) Fair Value	Less than 1	1–5
Money market funds	$ 407,416	$ 407,416	$ -
U.S. government, agencies, and supranational obligations	1,406,858	1,303,848	103,010
Negotiable and non negotiable certificates of deposit	27,551	27,551	
Corporate obligations	313,414	4,966	308,448
Mortgage-backed securities	27,424	3,455	23,969
Asset-backed securities	121,381	7,492	113,890
Government pooled funds	166,336	166,336	
Subtotal	2,470,380	1,921,064	549,317
Less cash equivalent portion	(1,572,445)	(1,572,445)	
Investments—total	$ 897,935	$ 348,619	$ 549,317

Investment Policy—Investment in funds may only be made as authorized by L.A. Care's Annual Investment Policy (the "Policy"), which conforms to the California Government Code and Health Safety Section 1346 (a) (11) (together, the "Code"). The Policy sets forth the investment guidelines for all operating funds and Board-designated reserve funds of the Organization. The objective of the Policy is to ensure L.A. Care's funds are prudently invested according to the Board's objectives to preserve capital, provide necessary liquidity, and to achieve a market average rate of return through economic cycles.

Credit Risk—L.A. Care's policy is to invest in high-quality instruments as permitted by the Code and subject to the limitations of the Policy. These instruments include US Treasury, federal agencies, and US government-sponsored enterprises; state and local agencies; banker acceptances rated a minimum of A-1 for short-term deposits by Standard & Poor's Corporation (S&P) or P-1 for short-term deposits by Moody's Investor Services ("Moody's") or F1 by Fitch Ratings ("Fitch"); commercial paper rated a minimum of A-1 or equivalent by S&P, Moody's, or F1 by Fitch; medium-term maturity corporate securities rated a minimum of A- or equivalent by S&P, Moody's, or Fitch; mortgage-backed and asset-backed securities rated a minimum of AA- or equivalent by S&P, Moody's, or Fitch; certain supranational obligations rated a minimum of AA- or equivalent by S&P, Moody's, or Fitch; repurchase agreements collateralized by the US Treasury, its agencies, and instrumentalities; money market accounts; government-pooled investment funds and negotiable and non-negotiable certificates of deposit.

Interest Rate Risk—The Policy limits investment maturities to five years as a means of managing its exposure to fair value losses arising from increasing interest rates.

Concentration of Credit Risk—The Policy limits investments to no more than 5% in any one issuer for banker acceptances and medium-term maturity corporate securities.

Investments and Interest Income—The composition of investment and interest income for the years ended September 30, 2020 and 2019, includes the following (in thousands):

	2020	2019
Interest and dividends	$28,014	$40,690
Realized gains (losses)—net	2,044	(116)
Unrealized (losses) gains—net	12,610	13,624
Fees	(1,500)	(1,420)
Investment and interest income—net	$41,168	$52,778

4. CAPITAL ASSETS

Capital asset additions for the year included office expansion and strategic software development. Depreciation and amortization expense of $30.3 million and $25.6 million was recorded during the years ended September 30, 2020 and 2019, respectively. A summary of capital assets as of September 30, 2020 and 2019, is as follows (in thousands):

	Beginning Balance 2020	Additions	Disposable/ Deletions	Ending Balance 2020
Computer equipment and software	$165,634	$16,555	$	$182,189
Office furniture and equipment	11,853	182		12,035
Leasehold improvements	25,493	7,605		33,098
Total capital assets	$202,980	$24,342	$	227,322
Less accumulated depreciation and amortization				120,936
Net capital assets				$106,386

	Beginning Balance 2019	Additions	Disposable/ Deletions	Ending Balance 2019
Computer equipment and software	$138,694	$27,259	$ 319	$165,634
Office furniture and equipment	12,607	307	1,061	11,853
Leasehold improvements	21,417	4,765	689	25,493
Total capital assets	$172,718	$32,331	$2,069	202,980
Less accumulated depreciation and amortization				90,658
Net capital assets				$112,322

5. RESTRICTED ASSETS

L.A. Care maintained restricted interest-bearing accounts in the amount of $300,000 in 2020 and 2019. Pursuant to the Knox-Keene Health Care Service Plan Act, L.A. Care assigns $300,000 to the Department of Managed Health Care of the State.

6. RESERVES FOR CLAIMS

IBNR estimates of $620.7 million and $558.6 million are recorded in reserves for claims in the combined statements of net position as of September 30, 2020 and 2019, respectively.

The following is a reconciliation of the reserves for claims as of September 30, 2020 and 2019 (in thousands):

	2020	2019
Beginning balance	$ 558,641	$ 567,605
Incurred:		
Current	2,784,078	2,436,363
Prior [(b)]	(1,848)	(167,850)
Total incurred [(a)]	2,782,230	2,268,512
Paid:		
Current	(2,187,923)	(1,897,378)
Prior	(532,213)	(380,098)
Total paid [(a)]	(2,720,136)	(2,277,477)
Ending balance	$ 620,735	$ 558,641

[(a)] The reconciliation includes medical claims only. Other claims, such as pharmaceutical claims, and charges, such as provider settlements, are not included.

[(b)] The current fiscal year saw some adverse development for the prior year, which was mostly offset by the release of the explicit margins that we hold to protect against such outcomes.

The $167.9 million decrease for claims incurred for FY 2017-18 is due to favorable development during FY 18-19. Approximately $42.8 million of this amount is the release of explicit margins included as the provision for adverse development. The remaining favorable prior year development represents the difference between estimates of the unpaid claims liability impacted by factors such as backlog, adjustments, or denial rates and the actual experience that has since emerged. The levels of backlog, adjustments, and denial rates had increased in the prior year as L.A. Care implemented its new claims processing policies, resulting in a “slow down” of claims payments. These factors were taken into consideration in setting reserve estimates in the prior year; however, actual claims experience was lower than estimated.

7. RETIREMENT PLAN

L.A. Care currently sponsors six retirement plans for its eligible employees, including three qualified defined contribution plans, a Section 457(b) eligible governmental deferred compensation plan, a nonqualified 457(f) defined contribution plan, and a qualified cash balance plan. As part of the redesign

of its retirement program, L.A. Care terminated its qualified defined benefit plan effective December 31, 2014, and all liabilities were paid in 2015.

L.A. Care established the L.A. Care Health Plan Retirement Benefit Plan (the "Basic Plan"), a qualified defined contribution plan, effective January 1, 2002. Effective January 1, 2015, as part of L.A. Care's retirement program redesign, all employees are eligible to participate in the Basic Plan immediately upon hire.

Effective January 1, 2017, for all employees (common law, not independent contractors or leased employees), except those covered by Social Security, the Basic Plan provides a mandatory pretax participant contribution and a fixed employer contribution, each equal to 6.2% of pay up to the Social Security wage base ($137,700, as indexed for 2020). Participants who are covered by Social Security do not make the mandatory pretax contribution or receive this fixed employer contribution. After completing one year of service, employees, other than part-time, temporary, and per-diem employees hired on or after January 1, 2013, but including those covered by Social Security, are eligible for an additional fixed employer contribution equal to 3.5% of pay, capped at the tax code's compensation limit ($285,000, as indexed for 2020), and an employer matching contribution equal to 100% the employees' elective deferrals up to 4% of pay, also capped at the tax code's compensation limit, to the 457(b) Plan (see below). These contributions are based on W-2 pay for employees hired before 2013, and base pay for employees hired after 2012. Employer contributions are subject to a three-year graded vesting schedule.

Participants may receive a distribution from the Basic Plan in the form of a lump sum or installments upon separation from service due to retirement, disability, death, other termination of employment, or attainment of age 65.

As a supplement to the Basic Plan, L.A. Care established the Supplemental Retirement Plan for Management Employees of L.A. Care Health Plan (the "Supplemental Plan"), a qualified defined contribution plan for management, effective January 1, 2003. The Supplemental Plan provides for employee pretax contributions, pursuant to an irrevocable pick-up election under section 414(h) of the tax code, of pay above the Social Security wage base up to the tax code's compensation limit. The Supplemental Plan does not provide for any matching contributions or other employer contributions. Participants may receive a distribution from the Supplemental Plan in the form of a lump sum or installments upon separation from service due to retirement, disability, death, other termination of employment, or attainment of age 70-1/2.

L.A. Care also sponsors the Deferred Compensation Plan for Eligible Employees of L.A. Care Health Plan (the "457(b) Plan"), an eligible governmental deferred compensation plan under Section 457(b) of the tax code. Under the 457(b) Plan, all employees are eligible to elect to defer from their salary on a pretax basis, and contribute to the plan, up to $19,500 ($26,000, if age 50 by year-end), as indexed for 2020. Participants may receive a distribution from their 457(b) Plan accounts in the form of a lump sum, installments, or a combination of those options upon termination, age 70-1/2, death, or unforeseeable emergency (lump sum only).

In January 2006, L.A. Care established the L.A. Care Cash Balance Plan ("Cash Balance Plan"), a qualified cash balance defined benefit plan, for its officers. Generally, this plan is designed to provide benefits to designated employees based on annual allocations of a fixed dollar amount calculated to provide an annual allocation equal to approximately 30% of annual base salary for the chief executive officer, and approximately 10% for all other officers. The plan has a three-year graded vesting schedule. In order to comply with the California Public Employees' Pension Reform Act of 2013, the plan was amended in

December 2012 to exclude employees hired on or after January 1, 2013, from eligibility to participate. That amendment also expanded the plan's coverage for employees hired prior to that date to include directors and senior directors.

As part of its retirement program redesign, L.A. Care established the L.A. Care Health Plan Qualified Supplemental Defined Contribution Plan, and the L.A. Care Health Plan Nonqualified Supplemental Defined Contribution Plan effective January 1, 2015, to provide a replacement for the Cash Balance Plan for designated employees who were hired on or after January 1, 2013. These plans are designed to provide an annual defined contribution equal to a contractually agreed-upon amount for the chief executive officer and approximately 10% of base pay for all other executive officers. The qualified plan generally has a three-year graded vesting schedule.

Before October 1, 2015, none of L.A. Care's employees were covered by Social Security because the benefits provided to them met the requirements for exclusion from mandatory Social Security coverage, and L.A. Care had not entered into an agreement to cover any of its employees under the State's Section 218 Agreement effective before that date. Effective October 1, 2015, as part of L.A. Care's retirement program redesign, all of L.A. Care's employees who elected to be covered by Social Security in the referendum held from February 2, 2015, through February 12, 2015, or who were hired after the referendum are covered by Social Security in accordance with L.A. Care's agreement to cover its employees under the State's Section 218 Agreement. All other L.A. Care employees—those who elected in the referendum not to be covered by Social Security—will continue not to be covered by Social Security.

The total cost of these programs was $11.6 million and $11.8 million in fiscal years 2020 and 2019, respectively, and this cost is included in administrative expenses.

8. COMMITMENTS AND CONTINGENCIES

Some of L.A. Care's provider reimbursement arrangements are complex in nature and may be subject to differing interpretations of the amounts due to providers. This may lead medical providers to pursue additional compensation from the Organization. In these circumstances, providers may raise issues of contract compliance, interpretation, payment methodology, and intent. Such claims may extend to services provided over a number of years. Some providers have sought additional compensation for claims. In the Organization's opinion, when these matters are fully resolved, they will not have a material adverse effect on the Organization's combined financial position, results of operations, or cash flows. Provider settlements liability of $6.3 million and $59.8 million are recorded in other accrued medical expenses line item in the combined statements of net position as of September 30, 2020 and 2019, respectively.

L.A. Care leases office space and certain office equipment under non-cancelable operating leases expiring at various dates. In August 2010, L.A. Care entered into a 10-year lease for its headquarters, which will expire on November 8, 2021, and extended through September 2024. Total rent expense relating to these leases totaled $13.3 million and $11.1 million in 2020 and 2019, respectively, recorded

as administrative expenses. Future minimum lease payments required under these operating leases as of September 30, 2020, consist of the following (in thousands):

Years Ending September 30	
2021	$15,654
2022	16,209
2023	16,705
2024	13,517
2025	1,585
Thereafter	
Total	$63,670

Grants Payable—On an annual basis, the Board approves various grants to be distributed as part of the Organization's Community Health Investment Fund. Grants totaling of $15.4 million and $6.4 million were awarded in 2020 and 2019, respectively. As of September 30, 2020 and 2019, $12.0 million and $11.8 million of the total original grants remained unpaid, respectively.

Credit Concentration—As of and for the years ended September 30, 2020 and 2019, substantially all operating revenues and accounts receivable are related to contracts with the DHCS. Cancelation of its contract with L.A. Care, or nonpayment of amounts due from the DHCS, would have a material adverse effect on the Organization.

Litigation—L.A. Care is involved in various legal actions arising in the normal course of business, the outcomes of which are not determinable at this time. The Organization has insurance policies covering such potential losses where such coverage is cost effective. In the opinion of management, any liability that might be incurred by L.A. Care upon resolution of these claims and lawsuits is not expected, in the aggregate, to have a material adverse effect on L.A. Care's combined financial statements.

Regulatory Change—L.A. Care operates as the "Local Initiative" under the State's prepaid managed care system. Discontinuation of the program would have a material adverse effect on the Organization.

Risk Management—The Organization is exposed to various risks of loss from, among others, theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage for the years ended September 30, 2020 and 2019.

9. REGULATORY REQUIREMENTS

Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended, L.A. Care must comply with certain minimum capital or tangible net equity requirements. L.A. Care's net worth exceeded the minimum tangible net equity requirement of $192.6 million and $168.2 million at September 30, 2020 and 2019, respectively. Additionally, L.A. Care must maintain minimum investment amounts for the restricted use of the regulators, which totaled $0.3 million and $0.3 million at September 30, 2020 and 2019, respectively, and is included in noncurrent assets.

10. BOARD-DESIGNATED FUNDS

The Board has elected to designate certain unrestricted net position as of September 30, 2020 and 2019, for the following (in thousands):

	Balance as of 2019	Contribution	Expenditure	Balance as of 2020
Safety net and uninsured program	$14,264	$10,000	$15,390	$ 8,874
Workforce Development Initiative	45,316	31,000	20,059	56,257
Blue Shield Partnership	-	16,300	6,679	9,621
Designated by the Board	$59,580	$57,300	$42,128	$74,752

	Balance as of 2018	Contribution	Expenditure	Balance as of 2019
Safety net and uninsured program	$10,691	$10,000	$ 6,427	$14,264
Workforce Development Initiative	25,301	31,000	10,985	45,316
Designated by the Board	$35,992	$41,000	$17,412	$59,580

The Board approved annual amount for Workforce Development Initiative including Elevating the Safety Net. The initiative includes Provider Recruitment Program, Residency Support Program, Physician Loan Repayment Program, and Medical School Scholarships. The Board also approved certain strategic initiatives related to Medi-Cal program management and the County provider safety net and health coverage initiatives to provide health care services to the uninsured as well as match funding for the Community Resource Center spending as required under the Blue Shield Partnership Grant.

11. SUBSEQUENT EVENTS

L.A. Care has evaluated subsequent events through December 23, 2020, the date the combined financial statements were available to be issued.

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REQUIRED SUPPLEMENTARY INFORMATION

LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY, OPERATING AND DOING BUSINESS AS L.A. CARE HEALTH PLAN AND L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

REQUIRED SUPPLEMENTARY INFORMATION—BUDGET COMPARISON (UNAUDITED) FOR THE YEAR ENDED SEPTEMBER 30, 2020

The following table sets forth Local Initiative Health Authority for Los Angeles County operating and doing business as L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority ("L.A. Care") actual operating performance against its adopted budget.

Statement of activities budget versus actual results for the year ended September 30, 2020, is as follows (dollars in millions):

	Actual	Budget	To Budget
Revenues	$ 8,353.7	$ 7,995.6	$ 358.1
Health care expenses	8,033.6	7,390.8	642.8
Administrative expenses	451.7	444.2	7.5
(Loss) Income from operations	$ (131.6)	$ 160.6	$ (292.2)
Nonoperating (expense) income	(5.9)	(7.7)	1.8
(Decrease) Increase in fund net position	$ (137.5)	$ 152.9	$ (290.4)

L.A. Care's Board approves an annual operating and capital expenditure budget prior to the beginning of each fiscal year. Typically, the revenue assumptions incorporated in the budget include the actual capitation rates from Department of Health Care Services multiplied by the projected monthly enrollment levels. Health care costs are a function of established contracted rates with L.A. Care's Plan Partners and affiliated provider organizations and will fluctuate accordingly with the enrollment level, utilization of services and supports, and utilization of pharmacy. The budgeted operating expenses are based upon historical costs and are modified to incorporate projected changes in staffing levels, anticipated contract changes, and fluctuations in membership levels. The fiscal year 2021 budget was approved by the Board on September 3, 2020, which included additional funding for community programs.

The year ended September 30, 2020, resulted in a deficit of $137.5 million, or -1.6% on revenues of $8.4 billion. Income from operations was a loss of $131.6 million and was $292.2 million unfavorable to plan driven by higher than budgeted health care and administrative expenses. The unfavorable variance in health care expenses was driven by higher fee for services claims trends in SNF, inpatient and outpatient costs The unfavorable variance in administrative expenses was a result of higher salaries and benefits related to increases in hiring and higher expenses in Purchased Services related to Strategic Projects.

Economic Factors and Next Year's Budget and Rates

COVID-19 dominated the landscape this past year and will continue to do so this upcoming year, dramatically affecting our health care system and economy.

California's unemployment rate was 16.3% in May 2020, compared to 4.1% in May 2019. In Los Angeles, the unemployment rate was 20.6%.[i] Based on the large number of job losses, there is the possibility of a membership increase in both Medi-Cal and Covered California. Health Management Associates estimates a Medicaid enrollment increase from 7% (moderate scenario) to 25% (severe scenario).[ii] A Kaiser Family Foundation analysis estimated that 47% of people who lost employer-sponsored coverage in May 2020 would be eligible for Medicaid with another 31% being eligible for Marketplace coverage with subsidies.[iii] Other states have started to see Medicaid enrollment growth. An analysis of 21 states' Medicaid administrative data showed a 2.8% increase in Medicaid enrollment from February to April 2020[iv].

L.A. Care has experienced an increase in Medi-Cal enrollment due to the suspension of redeterminations. Although L.A. Care did not experience a Medi-Cal enrollment surge, this may be because some people who are lost their jobs already have Medi-Cal. Many of the job losses were in the accommodation, food services, or entertainment industries, which are low wage and have lower rates of employer-sponsored coverage. For example, in the accommodation and food service sector, more than 40% of workers were either uninsured or had Medi-Cal, with another 12% purchasing insurance themselves, likely through Covered California.[v] Looking at employment status of Medi-Cal recipients, in 2018 almost 60% of Medi-Cal recipients in Los Angeles County were working full or part-time[vi]. Other reasons that Medi-Cal enrollment has not increased yet might include: people losing jobs are covered through a spouse; they think the job loss is temporary; or their income has not yet changed enough to qualify for Medi-Cal.

COVID-19 has also affected Covered California and our L.A. Care Covered product. Covered California extended its Special Enrollment Period through July 31, 2020. In addition, there was a COVID grace period which allowed enrollees extra time to pay their premiums, on top of the regular grace period.

Like providers across the country, our providers have experienced PPE shortages, insufficient testing capability, the need for telehealth services, and economic consequences of closures and the need to adapt to social distancing guidelines. L.A. Care has responded by advancing claims and incentive payments to assist our providers with cash flow. We have also advanced payments to our Community Health Investment Fund grantees, many of which are clinics, and are investing almost $6 million in grants to assist with COVID-19 related needs in the community, including housing and food needs.

L.A. Care has also advocated to ensure that federal stimulus bills include measures to strengthen Medicaid. Our key advocacy positions have been that the stimulus packages should include:

- Up to $190.0 billion in funding to State Medicaid programs for recession relief
- Elimination of Medicaid Fiscal Accountability Regulation (MFAR) proposed rules
- Presumptive eligibility for Medi-Cal enrollees at the point of application
- Rollback of Public Charge rules that went into effect February 24, 2020

COVID-19 has changed California's health priorities. Before COVID, California was planning for a federal waiver proposal called CalAIM, which would have transformed Medi-Cal in many ways. The major components of CalAIM built upon the successful outcomes of pilots such as Whole Person Care, Health Homes, and the Coordinated Care Initiative. CalAIM's goals were to manage member risk while addressing social determinants of health, reduce complexity and increase flexibility of Medi-Cal, and improve quality outcomes and the delivery system. Because of COVID-19, CalAIM has been put on hold indefinitely, and Whole Person Care and Health Homes will continue for now. However, Cal MediConnect is still slated to

sunset in 2022, requiring L.A. Care to establish a D-SNP if it wants to retain its dual eligible members. The state is also moving forward with its proposal for the state to purchase Medi-Cal prescription drugs in an attempt to save money. This proposal would take control of the formulary and pricing away from health plans.

COVID-19 has contributed to a $54.3 billion deficit in California's state budget. Initially, the Governor's proposed revisions to the state budget included substantial cuts to Medi-Cal and social service programs. L.A. Care led five Town Halls with different provider groups (PPGs, Direct Network, Skilled Nursing Facilities, hospitals, and clinics) to educate providers on the budget proposal and assure them of L.A. Care's advocacy on their behalf. Ultimately, the legislature rejected these cuts and the adopted budget did not significantly affect Medi-Cal. More budgetary changes are expected through upcoming trailer bills.

Nationally, the effort to undermine the Affordable Care Act continues. California v. Texas (known as Texas v. Azar (or US) in the lower courts), a court case challenging the constitutionality of the Affordable Care Act that has made its way through the courts, will now go to the Supreme Court. The case, brought by a group of Republican states, argues that the entire law is unconstitutional now that the individual mandate has been eliminated. Since the original case was brought, the Trump administration has joined the Republican states, supporting their efforts. A group of Democratic states challenging the case requested that the Supreme Court hear the case during its current session, along a more expedited timeline than is typical. The Supreme Court denied that motion, but did announce it would hear the case, rather than send it back to the lower courts. The Supreme Court will likely not hear the case before the November election.

Another federal action that will impact L.A. Care's membership is implementation of the public charge rule. These changes would add Medicaid, food stamps, and Section 8 housing vouchers to the list of benefits that are considered when an immigrant applies to lawfully enter the U.S. or permanent legal residency, to determine whether the immigrant is likely to be dependent on public benefits. The Supreme Court ruled in January in favor of lifting a preliminary nationwide injunction that would have stopped the public charge rule from moving forward. Similarly, in February, the Supreme Court ruled to lift an injunction in Illinois. With no more barriers in place, the Trump administration moved forward with implementing the final rule on February 24, 2020. Although L.A. Care has not yet experienced Medi-Cal disenrollment that we can attribute to public charge, we estimate that up to 170,000 members could be affected by the rule change, including the "chilling effect" that has led to many people in the immigrant community to choose to disenroll or not enroll in programs out of fear. L.A. Care is actively advocating for the public charge rule to be dismissed in light of the COVID-19 pandemic.

[i] https://www.edd.ca.gov/Newsroom/unemployment-june-2020.htm

[ii] Health Management Associates, COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, May 2020 Update. https://www.healthmanagement.com/wp-content/uploads/HMA-Updated-Estimates-of-COVID-Impact-on-Health-Insurance-Coverage-May-2020.pdf

[iii] KFF, Eligibility for ACA Health Coverage Following Job Loss, May 13, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/?utm_campaign=KFF-2020-The-Latest&utm_source=hs_email&utm_medium=email&utm_content=87890448&_hsenc=p2ANqtz--1X8oPg8ZuJD_5k8no2PlX77gMtma1k9bsyd9u28gNUU-S9i2neYzC3NYgVPBi3t8nF351EBn9tzgu9DeAssTwod94Ng&_hsmi=87890448

[iv] Georgetown University Health Policy Institute, Medicaid as First Responder: Enrollment is on the Rise, May 2020 https://ccf.georgetown.edu/wp-content/uploads/2020/05/Medicaid-and-COVID-final.pdf

[v] Public Policy Institute of California, Predicting the COVID-19 Medi-Cal Enrollment Surge, June 5, 2020 https://www.ppic.org/blog/predicting-the-covid-19-medi-cal-enrollment-surge/

[vi] California Health Interview Survey query conducted July 2020.