



L.A. Care
HEALTH PLAN[®]

For All of L.A.

BOARD OF GOVERNORS

Audit Committee Meeting

December 21, 2023 • 2:30 PM

L.A. Care Health Plan

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



AGENDA
Audit Committee Meeting
Board of Governors

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Thursday, December 21, 2023, 2:30 P.M.
L.A. Care Health Plan, Conference Room 100, 1st Floor
1055 West 7th Street, Los Angeles, CA 90017

Members of the Committee, staff and the public can attend the meeting in person at the address listed above. Public comment can be made live and in person at the meeting. A form will be available at the meeting to submit public comment.

To listen to the meeting via videoconference please register by using the link below:

<https://lacare.webex.com/lacare/j.php?MTID=m21f1242f2ac5f36fddf2f3faf05d5645>

To listen to the meeting via teleconference please dial: +1-213-306-3065

Meeting Number: 2494 717 2966 Password: lacare

Teleconference Site

George Greene, Esq.
602 Indiana Place, South Pasadena, CA 91030

For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Attendees who log on to lacare.webex using the URL above will be able to use “chat” during the meeting for public comment. You must be logged into WebEx to use the “chat” feature. The log in information is at the top of the meeting Agenda. The chat function will be available during the meeting so public comments can be made live and direct.

1. The “chat” will be available during the public comment periods before each item.
2. To use the “chat” during public comment periods, look at the bottom right of your screen for the icon that has the word, “chat” on it.
3. Click on the chat icon. It will open two small windows.
4. Select “Everyone” in the “To:” window,
5. The chat message 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.
6. Type your public comment in the box that says “Enter chat message here”.
7. When you hit the enter key, your message is sent and everyone can see it.
8. L.A. Care staff will read the chat messages for up to three minutes during public comment so people who are on the phone can hear the comment.

You can also send your public comments by voicemail, email or text. If we receive your comments by 2:30 P.M. on December 21, 2023, it will be provided to the members of the Executive Committee in writing at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must include the name of the item to which your comment relates.

Once the meeting has started, public comment submitted in writing must be received before the agenda item is called by the Chair. If your public comment is not related to any of the agenda item topics, it will be read in the general public comment agenda item.

Please note that there may be delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when public comment period is over for each item. If your public comments are not received on time for the specific agenda item you want to address, your public comments will be read at the public comment section prior to the board going to closed session.

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The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Executive Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

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 (ADA) 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

Hector De La Torre
Chair

1. Approve today's Agenda *Chair*
2. Public Comment *(Please read instructions above.)* *Chair*
3. Approve August 22, 2022 meeting minutes *p.4* *Chair*
4. Chairperson's Report *Chair*
5. Chief Executive Officer / Chief Financial Officer Reports

John Baackes
Chief Executive Officer
Afzal Shah
Chief Financial Officer

Committee Issues

6. Review of Audit Report FY 2022-23
(AUD A) *p.8*

Rosie Procopio
Lead Client Service and Audit & Assurance Partner
Deloitte & Touche, LLP

Adjournment

Chair

The next meeting of the Audit Committee has not been scheduled as the Committee meets as needed.

Public comments will be read for up to three minutes.

The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE EXECUTIVE COMMITTEE BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page 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 Govt Code Section 54954.2 (a)(3) and Section 54954.3.

NOTE: THE EXECUTIVE COMMITTEE CURRENTLY MEETS ON THE FOURTH TUESDAY OF MOST MONTHS AT 2:00 P.M. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT <http://www.lacare.org/about-us/public-meetings/board-meetings> and by email request to BoardServices@lacare.org

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 1055 W. 7th Street, Los Angeles, CA, in the reception area in the main lobby or at <http://www.lacare.org/about-us/public-meetings/board-meetings> and can be requested by email to BoardServices@lacare.org.

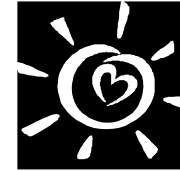
An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

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 at (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 – August 22, 2023

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



L.A. Care
HEALTH PLAN

Members

Hector De La Torre, *Chairperson*
George Greene, Esq.
Layla Gonzalez

Management/Staff

John Baackes, *Chief Executive Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Afzal Shah, *Chief Financial Officer*

Guests

Rosie Procopio, *Audit & Assurance Managing Director, Deloitte & Touche (D&T)*
Justine Lee, *Manager, D&T*
Kevin Rotman, *Senior Manager, D&T*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	<p>Board Member George Greene, Esq. called to order the L.A. Care Audit Committee and the L.A. Care Joint Powers Authority Audit Committee meetings at 2:06 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings.</p> <p>For those who provided public comment for this meeting by voice message or in writing, we are really glad that you provided input today. The Committee will hear your comments and we also have to finish the business on our Agenda today. If you have access to the internet, the materials for today’s meeting are available at the lacare.org website. If you need information about how to locate the meeting materials, please let us know.</p> <p>Information for public comment is on the Agenda available on the web site. Staff will read the comment from each person for up to three minutes.</p> <p>The Chairperson will invite public comment before the Committee starts to discuss an item. If the comment submitted is related to the topic for a specific agenda item, it will be read at the general Public Comment item 2 on today’s agenda.</p> <p>He provided information on how to submit a public comment live and directly using the “chat” feature.</p>	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING AGENDA	Today's Agenda was approved as submitted.	Approved unanimously by roll call. 2 AYES (Gonzalez and Greene)
PUBLIC COMMENT	There was no public comment.	
APPROVE MEETING MINUTES	The December 21, 2022 meeting minutes were approved as submitted.	Approved unanimously by roll call. 2 AYES
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER/CHIEF FINANCIAL OFFICER REPORT	<p>Afzal Shah, <i>Chief Financial Officer</i>, introduced Jeffrey Ingram, <i>Deputy Chief Financial Officer</i>, and Angela Bergman, <i>Controller</i>. They have been supporting the audit activities.</p> <p>Mr. Shah introduced Rosie Procopio, <i>Audit & Assurance Managing Director, Deloitte & Touche (D&T)</i> who will be the lead to present the audit plan FY 2022-23.</p>	
COMMITTEE ISSUES <ul style="list-style-type: none"> • Presentation of Audit Plan for Fiscal Year 2022-23 	<p>Ms. Procopio provided a summary of the FY 2022-23 Audit Plan. <i>(A copy of the written plan can be requested by contacting Board Services.)</i></p> <p>The FY 2021-22 audit went smoothly. D&T was able to accelerate the audit timeline through expanded interim procedures, implementation of new procedures in claims and other medical expenses and increased use of data analytics and other audit technology.</p> <p>Ms. Procopio presented the Audit Plan for FY 2022-23. Planned Procedures for this year's audit will include:</p> <ul style="list-style-type: none"> • Focus efforts on certain areas of significance to the audits. • Will obtain an understanding of all business cycles, including general information technology controls. Will perform tests of certain relevant controls for each business cycle to determine whether such controls have been appropriately designed and implemented. 	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<ul style="list-style-type: none"> • Materiality will be the basis for planning the scope of audit of the financial statements. The determination of materiality is a complex issue requiring consideration of qualitative and quantitative factors. It is a matter of professional judgment taking into account the knowledge of the entity, the assessment of engagement risk, and the reporting requirements for the financial statements. The consideration of materiality is influenced by the perception of the needs of users of the financial statements • Deloitte Omnia audit platform will be used for more efficient and focused audit. This approach will alleviate common pain points while also resulting in tangible benefits for L.A. Care Health Plan. • Use proprietary quantitative financial and benchmarking analysis capability to identify unusual trends in account balances and ratios. • Engage in fraud discussions with certain members of senior management and others. • Consider the potential for bias in judgments and estimates, including performing retrospective analysis of significant accounting estimates. • Evaluate whether L.A. Care Health Plan has entered into any significant unusual transactions and, if so, the nature, terms, and business purpose (or lack thereof) of those transactions and whether such transactions involved related parties. • Evaluate L.A. Care Health Plan’s fraud risk assessment and controls over financial reporting. Test journal entries that exhibit characteristics of possible management override of controls, identified using electronic data interrogation techniques. Test design and implementation of controls over significant, unusual transactions, particularly those that result in late or unusual journal entries and controls over journal entries and adjustments made in the period-end financial reporting process. • 2023 Proposed Audit Fee is \$423,000, excluding expenses, a 5% increase from last year’s fee. 	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<ul style="list-style-type: none"> Accept Audit Plan for Fiscal Year 2022-23 (AUD A) 	<p><u>Motion AUD A.0823</u> To accept the Audit Plans of Deloitte & Touche’s of L.A. Care’s financial statements for the fiscal year 2022-23, as presented, and authorize execution of the engagement letter.</p>	<p>Approved unanimously by roll call. 3 AYES (De La Torre, Gonzalez and Greene)</p>
<p>COMMITTEE CHAIR ELECTION</p>	<p>Committee Member Greene nominated Committee Member Hector De La Torre as Chair of the Audit Committee.</p> <p>Committee Member De La Torre was unanimously elected Chair of the Audit Committee.</p>	<p>Approved unanimously by roll call. 3 AYES</p>
<p>ADJOURNMENT</p>	<p>The Chair adjourned the meeting at 3:00 pm.</p>	

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

APPROVED BY:

Hector De La Torre, *Committee Chairperson*
Date Signed: _____

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L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: December 21, 2023

Motion No. AUD A.1223

Committee: Audit

Chairperson: Hector De La Torre

Issue: To accept the findings of the Deloitte & Touches' audit of L.A. Care's financial statements for the fiscal year ended September 30, 2023.

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, 2023, as presented.



DATE: December 21, 2023
TO: Audit Committee
FROM: Afzal Shah, *Chief Financial Officer*

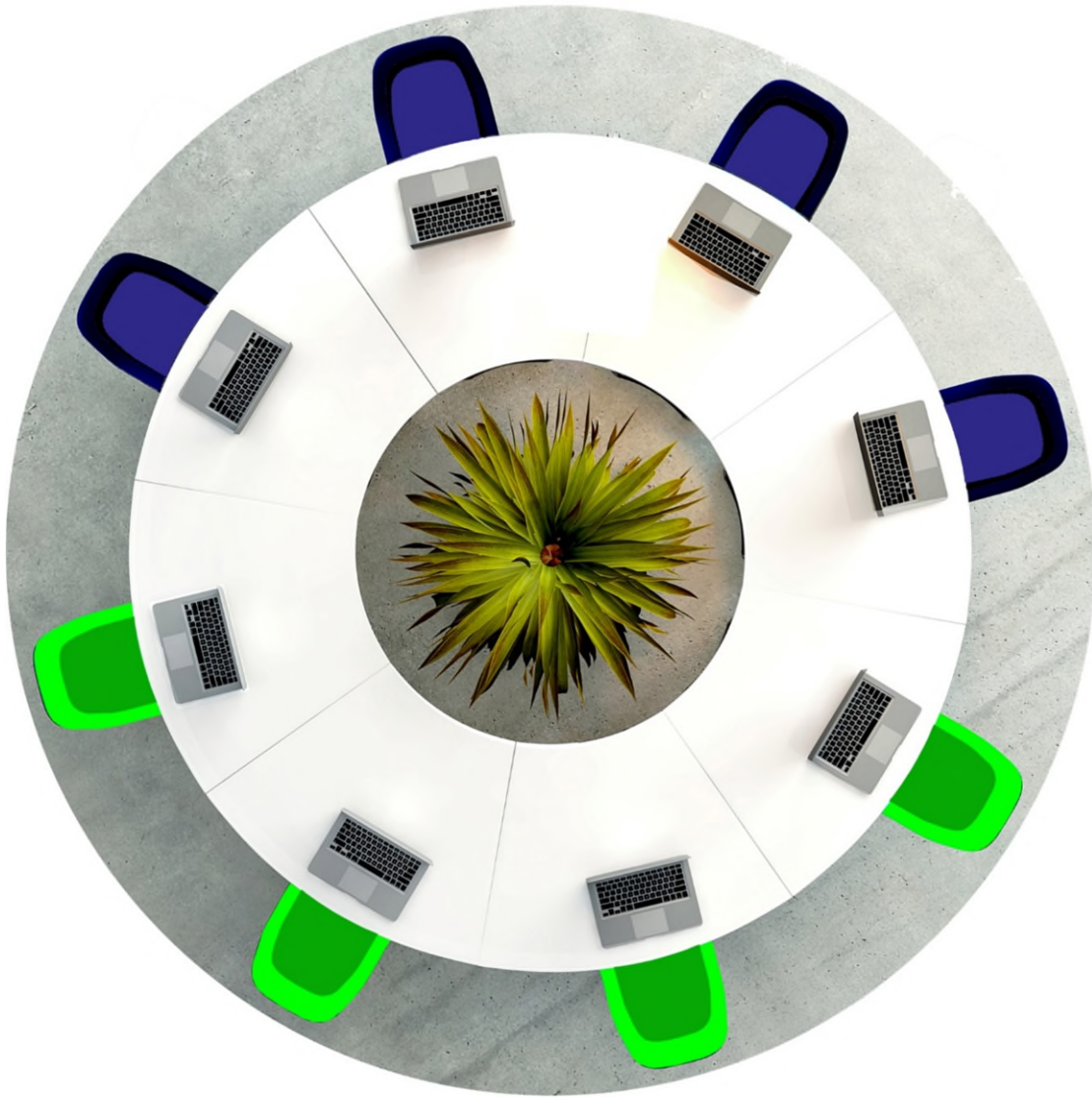
SUBJECT: Fiscal Year 2022-23 Financial Audit

The attached audit package is comprised of two parts: Governance Letter with Management Representation Letter (Appendix A), and the draft Financial Statements.

As outlined in the initial client service 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 your review:

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



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

Results of the 2023 Audit

December 21, 2023

Audit Committee of the Board of Governors
for Local Initiative Health Authority for Los Angeles County,
dba L.A. Care Health Plan and L.A. Care Joint Powers Authority
1055 West 7th Street
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 Power Authority (collectively, "L.A. Care" and the "Organization") as of and for the year ended September 30, 2023 (the "financial statements"), in accordance with auditing standards generally accepted in the United States of America and standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States (collectively "generally accepted auditing standards") and expect to issue our report thereon on or around January 5, 2024.

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 of the Board of Governors, 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

Our Responsibility under Generally Accepted Auditing Standards

Our responsibility under generally accepted auditing standards has been described in our engagement letter dated August 22, 2023, a copy of which has been provided to you. As described in that letter, our responsibilities under generally accepted auditing standards include forming and expressing an opinion about whether the financial statements that have been prepared by management with the oversight of the Audit Committee of the Board of Governors are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America (“generally accepted accounting principles”). The audit of the financial statements does not relieve management or the Audit Committee of the Board of Governors of their responsibilities. We considered internal control relevant to the Organization’s preparation of the 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.

Significant Accounting Policies

The Organization’s significant accounting policies are set forth in Note 2 to the Organization’s 2023 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, 2023.

In 2023, the Organization adopted the following Governmental Accounting Standards Board (GASB) statements as disclosed in Note 2 of the financial statements:

- GASB Statement No. 94, *Public-Private and Public-Public Partnerships and Availability Payment Arrangements*
- GASB Statement No. 96, *Subscription-Based Information Technology Arrangements*
- GASB Statement No. 99, *Omnibus 2022*

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. Our assessment of the significant qualitative aspects of the Organization’s particularly sensitive accounting estimates includes the following:

Incurred but not Reported Claims (“IBNR”) Valuation—Accounting Estimate

The valuation of IBNR reserve requires management estimation and judgment. Management uses significant assumptions and judgments in estimating the cost of claims, specifically those that are made to adjust IBNR reserve, 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. Management also leverages calculations and estimates developed by its internal actuarial team when considering the liability estimate.

	2023	2022
IBNR (in millions)	\$842.6	\$784.4

There is a significant risk that management may not use a complete, accurate, or valid set of assumptions within its estimate. This significant risk also represents a fraud risk. We performed the following procedures noting no exceptions:

- We made inquiries of management and tested the design and implementation of internal control activities involving management’s process for estimating the IBNR reserve.
 - We conducted meetings with the Organization’s actuaries to assess the consistency of the methodology utilized for calculating the accruals for IBNR estimates. Furthermore, we held discussions with claims operations personnel to better understand performance over time and its impact on the claim reserves.
 - We involved actuarial specialists from Deloitte Consulting LLP to review management’s methods and assumptions used to develop the reserve estimates and prepare an independent estimated range of reasonable reserves in order to corroborate management’s estimate of its claims-based liability. The actuarial specialists assessed information such as claims inventory, high dollar claims and other environmental factors to conclude on actuarial assumptions utilized.
 - We performed data integrity testing of information utilized by the Organization’s actuaries, including recreating the underlying lag triangles and performing test of details on paid claims and claims inventory for accuracy and completeness.
 - We also performed a retrospective look-back (recast) of management’s prior year estimates.
-

Uncorrected Misstatements and Disclosure Items Passed

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. Excepted as noted in items 6 and 7 of the management representation letter, attached to this letter as Appendix B, we did not identify any uncorrected misstatements or disclosure items passed during our audit. Management determined the uncorrected misstatement and disclosure item passed to be immaterial, both individually and in the aggregate, to the financial statements taken as a whole. Uncorrected misstatements or matters underlying these uncorrected misstatements could potentially cause future-period financial statements to be materially misstated, even if we have concluded that the uncorrected misstatements are immaterial to the financial statements for the year ended September 30, 2023.

Material Corrected 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 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 2023 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 2023.

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 of the Board of Governors.

Significant Difficulties Encountered in Performing the Audit

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 audit.

Management's Representations

We have made specific inquiries of the Organization's management about the representations embodied in the financial statements. In addition, we have requested 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 B, those representations we will request from management.

- *Appendix A: Draft 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, 2023 and 2022, Required Supplementary Information for the Year Ended September 30, 2023, and Independent Auditor's Report*
- *Appendix B: Draft Management Representation Letter*

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About Deloitte

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December 21, 2023

Deloitte & Touche LLP
555 W. 5th Street, Ste. 2700
Los Angeles, CA 90013

We are providing this letter in connection with your audits of the statements of financial position, statements of revenues, expenses and changes in financial position and statements of cash flows, and the related notes to the combined financial statements of L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (collectively L.A. Care or the "Organization"), as of and for the year ended September 30, 2023 and 2022, which collectively comprise the Organization's basic 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 State of America (GAAP).

We confirm that we are responsible for the following:

- a. The preparation and fair presentation in the financial statements of financial position, results of operations, and cash flows, in accordance with GAAP.
- 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 accordance with GAAP. In addition:
 - a. The financial statements include all component 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 include all fiduciary activities as required by Government Accounting Standards Board (GASB) Codification Section 1300.111-.116, *Fiduciary Funds*.
 - c. Majority equity interests in legally separate organizations are properly accounted for in accordance with GASB Codification Section 2600.116, *Equity Interests in Component Units*.
 - d. Net position components (net investment in capital assets, restricted, and unrestricted) are properly classified and, if applicable, approved.

- e. Deposits and investment securities are properly classified in the category of custodial credit risk.
 - f. Capital assets, including infrastructure assets, are properly capitalized, reported, and, if applicable, depreciated. Related costs have been recognized as an expense in the period in which the costs are incurred, in accordance with GASB Codification Section 1400.120-.121, *Interest Cost Incurred before the End of a Construction Period*.
 - g. Required supplementary information is measured and presented within prescribed guidelines.
 - h. Applicable laws and regulations are followed in adopting, approving, and amending budgets.
 - i. The Organization's policy regarding whether to first apply restricted or unrestricted resources when an expense is incurred for purposes for which both restricted and unrestricted net position is available is appropriately disclosed and the related net position is properly recognized under the policy.
 - j. The financial statements properly classify all funds and activities, including special and extraordinary items.
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 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.
 - b. 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.
 - c. Contracts and grant agreements (including amendments, if any) and any other correspondence that has taken place with federal agencies.
 - d. All reports and information from peer review organizations, fiscal intermediaries, third-party payors, and recovery contractors.
4. There has been no:
- a. Action taken by Organization management that contravenes the provisions of federal laws and California state laws and regulations, or of contracts and grants applicable to the Organization.
 - b. Communications (oral or written) with other regulatory agencies, governmental representatives, employees, or others concerning noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), or deficiencies in financial reporting practices or other matters that could have more than an inconsequential effect on the financial statements.

5. 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 (including departments of insurance, Office of Inspector General (OIG), and Centers for Medicare and Medicaid Services (CMS)) and the Organization.
 - b. Communications from regulatory agencies concerning noncompliance with or deficiencies in financial reporting practices.
6. We believe the effects of the uncorrected financial statement misstatements detected in the current year that relate to the prior year presented, when combined with those misstatements aggregated by you during the prior year audit engagement and pertaining to the prior year presented, are immaterial, both individually and in the aggregate, to the financial statements for the year ended September 30, 2022, taken as a whole. During the year ended September 30, 2023, the Organization (1) identified \$4.6 million in medical fee-for-service claim accruals that had previously been held from payment had not been properly reversed following re-adjudication of claims thereby decreasing the Organization's net position as of September 30, 2022, and (2) identified \$31.4 million of deferred inflow of resources of which \$30.6 million should be classified as accounts payable and accrued expenses and \$0.7 million should be classified as noncurrent liabilities with no impact to the Organization's net position as of September 30, 2022.
7. We have completed our procedures to evaluate the accuracy and completeness of the disclosures in our financial statements. As a result of the evaluation process, we identified certain disclosures that, although required by GASB have been omitted from Management's Discussion & Analysis (MD&A) accompanying our financial statements. The omitted disclosure that is regarded as more than clearly trivial pertains to the requirement that the MD&A should provide three years of comparative data – the current year, the prior year, and the year preceding the prior year. The effects of the omitted disclosures are qualitatively immaterial, both individually and in the aggregate, to the financial statements as a whole.
8. 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.
9. 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.
 - c. Others, where the fraud could have a material effect on the financial statements.
10. We have no knowledge of any allegations of fraud or suspected fraud affecting the Organization's financial statements communicated by employees, former employees, regulators, or others.

11. 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 Section C50, *Claims and Judgments*.
12. 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.
13. We have informed you of all investigations or legal proceedings that have been initiated during the year ended September 30, 2023 or are in process as of September 30, 2023.
14. We are responsible for all nonaudit services performed by you during the year ended September 30, 2023 and through December 21, 2023. We assume all management responsibilities for those services, including overseeing those services by designating an individual who possesses suitable skills, knowledge, or experience. We have evaluated the adequacy and results of the services performed and accept responsibility for the results of the services.
15. We have disclosed to you all deficiencies in the design or operation of internal control over financial reporting identified as part of our evaluation, including separately disclosing to you all such deficiencies that are significant deficiencies or material weaknesses in internal control over financial reporting.
16. We have disclosed all known noncompliance with direct and material compliance requirements occurring subsequent to September 30, 2023.
17. No changes in internal control over compliance or other factors that might significantly affect internal control over financial reporting, including any corrective actions taken by the Organization with regard to significant deficiencies and material weaknesses in internal control over compliance, have occurred subsequent to September 30, 2023.
18. We have disclosed all contracts or other agreements with service organizations.
19. We have disclosed to you all communications from service organizations relating to noncompliance with the Organization's operations at those service organizations.
20. 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.
21. We believe that we have properly identified, reported, and classified each component unit of the Organization and each activity that meets the criteria established in GASB Codification Section 2100, *Defining the Financial Reporting Entity*. No organizations or activities were identified that meet the criteria established in GASB Codification Section 2100, *Defining the Financial Reporting Entity*.
22. 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. We expect the contracts with the State to renew upon expiration of the current program on December 31, 2023.
23. The Organization has not completed the process of evaluating the impact that will result from adopting GASB Statement Nos. 99, *Omnibus 2022 (Part 2)*; 100, *Accounting Changes and Error*

Corrections; and 101, *Compensated Absences*, as discussed in Note 2 of the financial statements. The Organization is therefore unable to disclose the impact that adopting these statements will have on its financial position, results of operations, and cash flows when such statements are adopted.

24. During the year ended September 30, 2023, there were no significant changes in previously adopted accounting policies or their application, other than those disclosed in the financial statements.
25. The Organization has recorded certain investment pools measured at amortized costs as of September 30, 2023. We have evaluated the criteria in paragraph 4 of GASB Statement No. 79, *Certain External Investment Pools and Pool Participants*, and have determined that the pools measured at amortized cost meet the criteria for amortized cost reporting.
26. We have disclosed to you all significant cyber security incidents and/or breaches in which an actual or potentially adverse effect on an information system, network, or the information residing therein occurred or there was a loss of assets. We considered the cyber incident or breach to be significant if such incident or breach merited the attention of those charged with governance.
27. 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.
28. 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, 2023.
29. 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, 2023 and 2022.
30. 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. All intercompany transactions have been eliminated.

Except where otherwise stated below, immaterial matters less than \$4,500,000 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 basic financial statements.

31. There are no transactions that have not been properly recorded and reflected in the financial statements.
32. The Organization has no plans or intentions that may affect the carrying value or classification of assets and liabilities.
33. Regarding related parties:

- a. We have disclosed to you the identity of all the Organization's 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.
34. 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.
 - b. The effect of the change would be material to the financial statements.
35. 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. Known actual or likely instances of abuse that have occurred that could be quantitatively or qualitatively material to the financial statements
 - d. 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, 2023.
 - e. Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB Codification Section C50, *Claims and Judgments*.
 - f. 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.
 - g. Instances of identified or suspected noncompliance with laws and regulations whose effects should be considered when preparing the financial statements.

36. 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.
37. The Organization has complied with all aspects of contractual agreements that may affect the financial statements.
38. No department or agency of the Organization has reported a material instance of noncompliance to us.
39. 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, 2023. There were no changes in methodologies and processes used to calculate the reserves for claims incurred but not reported during fiscal year 2023 and as of September 30, 2023.
40. With respect to the Organization's liability for unpaid claims and claim adjustment expenses:
 - a. For the year ended September 30, 2023, we have processed claims received by the Organization in a manner and timing consistent with prior years.
 - 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.
 - 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 claim adjustment expenses for the Organization as of September 30, 2023 is management's best estimate and makes a reasonable provision for all reported and unreported claims incurred as of September 30, 2023, 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, 2023 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.
41. 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, 2023, management believes that no accrual is necessary, as the Organization's minimum loss ratios are all expected to exceed the statutory minimums, and that actual results will not differ materially from the established estimate.
 42. 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, 2023 or 2022.
 43. The Organization is responsible for determining and maintaining the adequacy of reserve for premium deficiencies as well as estimates used to determine such amounts. Premium deficiency reserves and the related expenses are recognized when it is probable that expected future health care expenses, claims-adjustment expenses, and administration costs under a group of existing contracts will exceed anticipated future premiums and recoveries considered over the remaining lives of the contracts. The methods for making such estimates and establishing the resulting reserves are periodically reviewed and updated, and any adjustments are reflected in operating results in the period in which the change in estimate is identified. No premium deficiency reserves have been recorded as of September 30, 2023.
 44. We have estimated accrued revenues for Medicare risk factor adjustments based on data that is available to us that was submitted or expected to be submitted to Centers for Medicare and Medicaid Services (CMS). We believe the estimates of the receivable are appropriate estimates of the amounts that we will ultimately collect from CMS.
 45. Provision has been made for any earned, but not paid, broker commissions and bonuses. We believe that such estimate is reasonable based on available information and the contractual arrangements with brokers.
 46. There are no noncontractual arrangements or "side agreements" with any brokers. For the purposes of this letter, a noncontractual arrangement or "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 broker that is not contained in the official agreement with the broker. The definition of noncontractual arrangements is not limited by any particular subject matter.

47. Management asserts the following related to the amounts estimated and recorded as of September 30, 2023, related to the permanent risk adjustment program enacted by the Affordable Care Act:
 - a. Regarding the permanent risk adjustment program:
 - i. 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.
 - ii. Management asserts that the encounter data 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.
 - iii. 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.
48. 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.
49. 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.
50. 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, 2023.
51. 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, 2023 based on the facts and circumstances at that date.
52. 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.

53. 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.
54. 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.
55. As of September 30, 2023, 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.
56. 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.
57. 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 \$55.2 million and \$9.7 million are recorded in other accrued medical expenses line item in the combined statements of net position as of September 30, 2023 and 2022, respectively.
58. 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, 2022.
59. Specifically related to Plan Partner rates, although certain rates have not been formalized in signed agreements, the rate that management is using to record current accruals is based on current negotiated rates.
60. The Organization is serving as a cash conduit to the intergovernmental transfers (IGTs) and other transfers under Welfare and Intuitions Code Sections 14182.15, 14169.51, 14301.4, 14301.5 and 14164, and Private and Public Hospitals Directed Payments from DHCS under CMS final rule 42 C.F.R. 438.6C. 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.
61. Noncash transactions have been appropriately identified and excluded from the Statements of Cash Flows. Furthermore, we believe information about all investing and financing activities that do not result in cash receipts or cash payments in the periods have been appropriately disclosed.

62. No events have occurred after September 30, 2023, but before December 21, 2023, the date the financial statements were issued, that require consideration as adjustments to, or disclosures in, the financial statements.
63. Regarding 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 GASB.
 - c. The methods and significant assumptions and interpretations underlying the measurement and presentation of the supplementary information have not changed from those used in the prior period.
64. Financial instruments with significant individual or group concentration of credit risk have been appropriately identified, properly recorded, and disclosed in the financial statements.
65. 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 after September 30, 2023, but before December 21, 2023, 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.
66. Arrangements with financial institutions involving compensating balances or other arrangements involving restrictions on cash balances, line of credit, or similar arrangements have been properly disclosed in the financial statements.
67. Provisions for uncollectible receivables have been properly identified and recorded.
68. We believe that all expenditures that have been deferred to future periods are recoverable.
69. The Organization has evaluated its leases and has properly classified, recognized, and reported all leases in accordance with the recognition, measurement, financial reporting, and disclosure requirements set forth in GASB Codification Section L20, *Leases*.
70. We have properly recorded and disclosed subscription-based information technology arrangements, including the related right to use assets, subscription liabilities, and other related amounts, in accordance with GASB Statement No. 96, *Subscription-Based Information Technology Arrangements*.
71. We have disclosed to you all new or changes to the existing pension, other postretirement benefit, 401(a), IRC Section 457, and deferred compensation.

72. We have no intention of terminating any of our pension or other postretirement benefit plans or taking any other action that could result in an effective termination or reportable event for any of the plans. We are not aware of any occurrences that could result in the termination of any of our plans to which we contribute.
73. We have properly recorded and disclosed public-private and public-public partnerships and availability payment arrangements in accordance with GASB Statement No. 94, *Public-Private and Public-Public Partnerships and Availability Payment Arrangements*.
74. 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.

John Baackes
Chief Executive Officer

Afzal Asif
Chief Financial Officer

Jeffrey Ingram
Deputy Chief Financial Officer

cc: Audit Committee of the Board of Governors

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, 2023 and 2022, Required Supplementary
Information for the Year Ended September 30, 2023, and
Independent Auditor's 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, 2023 AND 2022

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) (collectively, "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*. Since its creation, L.A. Care has also added several 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 the JPA, a licensed health maintenance organization. L.A. County's Board of Supervisors established the JPA in July 2012 under 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. Before July 1, 2016, neither L.A. Care nor the JPA was 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 ensuring solvency for the two organizations. The combined financial statements include L.A. Care and the JPA because they operate under common management and control.

Medi-Cal Product

L.A. Care provides the delivery of covered health care services to members either through its network of contracted providers (MCLA) or its network of contracted health plans ("Plan Partners"), including Anthem Blue Cross of California, Blue Shield of California Promise Health Plan, and Kaiser Foundation Health Plan. Medi-Cal membership with the Plan Partners as of September 30, 2023 and 2022, was 1,191,140 and 1,100,962 enrollees, respectively.

L.A. Care's direct Medi-Cal program MCLA receives a fixed payment per member per month (PMPM) from DHCS, and fixed case rates for maternity cases for each eligible birth, hepatitis C, institutional members, enrolled Health Homes Program (HHP), and qualified members receiving Behavioral Health Treatment (BHT). Beginning January 1, 2022, Enhanced Care Management (ECM) and Community Supports replaced the HHP program as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative which is a precursor to a statewide care management approach. The ECM program is paid on a pmpm basis. The State implemented the Medi-Cal Pharmacy transition in January 2022, shifting responsibility from health plans to the State and administered by its pharmacy vendor. Starting January 1, 2022, Hepatitis C is carved out as part of the State's responsibility under Medi-Cal Pharmacy. Starting January 1, 2023, BHT costs will be included in the monthly base rates and no longer paid on a fixed case rate basis. 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 (FFS) 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 (ACA) 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 (FPL) effective January 1, 2014. California State also expanded Medi-Cal to include various age cohorts of income-eligible individuals with unsatisfactory immigration status which contributed to membership increases beginning May 1, 2022. As of September 30, 2023 and 2022, MCLA membership was 1,516,676 and 1,439,026 enrollees, respectively.

Cal MediConnect

Coordinated Care Initiative (CCI) began as a three-year pilot program developed jointly with California's DHCS to coordinate Medi-Cal 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 the mandatory enrollment of dual eligible members and integrated LTSS; however, the In-Home Supportive Services (IHSS) benefit was removed from the program as of January 1, 2018, and as of September 30, 2023, the CCI membership has been realigned with MCLA.

L.A. Care's CMC program was launched in May 2014. CMC members are those who qualify for both Medicare and Medi-Cal. 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 on January 1, 2023, and as of September 30, 2023 all enrollees have been transferred to the new Medicare plan.

Medicare

On January 1 2023, L.A. Care launched a Medicare Advantage Dual Eligible Special Needs Plan (DSNP) as part of the California Advancing and Innovating Medi-Cal initiative (CalAIM). The DSNP plan is a plan designed to provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medi-Cal) who are also enrolled in the Medi-Cal managed care plan affiliated with the DSNP. For the purposes of tracking membership totals, the DSNP membership is eliminated and counted once as part of MCLA. As of September 30, 2023, membership for the DSNP program was 18,445.

L.A. Care Covered California

L.A. Care Covered California (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 individual health coverage under regulations established by the US 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 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 a favorable ruling from the US Court of Federal Claims. L.A. Care's premium rates effective for 2018 and onward were increased to reflect the loss of the cost-sharing reduction (CSR) 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 the 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. 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.

Beginning in 2019, the individual mandate penalty was reduced to \$0, meaning individuals no longer incurred 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 three years beginning January 1, 2020.

In April of 2021, the President signed the American Rescue Plan which, among other things, expanded the premium tax credits, qualifying those making under 150% of the FPL for subsidies that cover 100% or the second lowest price Silver premium. In addition, the expanded subsidies capped the maximum amount that individuals have to pay toward health insurance at 8.5% of annual income. The enhanced subsidies also expand income cap to qualify for subsidies to anyone who is above 400% of the FPL. These enhanced subsidies were set to expire at the end of 2022. However, Congress passed, and the President signed, the Inflation Reduction Act in August of 2022. This new law extended the enhanced subsidies to continue through the end of 2025. These expanded subsidies, combined with LACC's position as the lowest priced Silver Plan in L.A. County for 2023 and 2022, makes LACC the most attractive plan from a price perspective, with many of our members qualifying for \$0 premiums.

As of September 30, 2023 and 2022, LACC membership was 131,265 and 112,357, respectively. L.A. Care's strategy is to continue to serve Medi-Cal members who lose eligibility.

PASC-SEIU

L.A. Care's Homecare Workers Health Care Plan (PASC-SEIU) program provides health care services to the IHSS workers in the County. The PASC-SEIU program and its members were moved from L.A. Care to the JPA effective December 1, 2013. As of September 30, 2023 and 2022, PASC-SEIU membership was 48,636 and 49,851 enrollees, respectively.

Other Medi-Cal Programs

Effective July 1, 2019, L.A. Care launched the HHP for eligible members with multiple chronic conditions who are frequent utilizers of Medi-Cal services and may benefit from enhanced care management and coordination. HHP is a DHCS mandated Medi-Cal benefit authorized under Section 2703 of the ACA. The Health Homes Program network includes the Community-Based Care Management Entities, and other community-based organizations to provide linkages to community and social support services, as needed. This pilot program was sunset on December 31, 2021, and was replaced by Enhanced Care Management (ECM). L.A. Care's HHP members were transitioned to ECM.

Another significant change to Medi-Cal which began on January 1, 2022, was California Advancing and Innovating Medi-Cal (CalAIM) implementation. CalAIM is a federal waiver proposal that transforms Medi-Cal

in many ways. CalAIM's goals are 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. Components that began on January 1, 2022, include ECM which replaces the HHP and Whole Person Care, Community Supports (CS) and the Major Organ Transplant (MOT) benefit.

CS are services provided by Managed Care Plans (MCPs) to eligible Medi-Cal members to meet their social needs, including Medi-Cally supportive foods or housing supports. These new services are cost-effective alternatives to traditional Medi-Cal services or settings and are designed to address social drivers of health. There are 14 preapproved CS and are available to eligible Medi-Cal members regardless of whether they qualify for ECM services.

Effective January 1, 2022, in support of the CalAIM initiative, L.A. Care implemented ECM, CS which includes Housing Navigation, Tenancy and Sustaining Services, Recuperative Care, and Medi-Cally Tailored Meals, and MOT benefits. On July 1, 2022, four additional CS services were added, including Housing Deposits, Sobering Centers, Respite Services, and Personal Care and Homemaker Services. Another component of the CalAIM initiative starting January 1, 2022, is the mandatory managed care enrollment provision which requires beneficiaries in certain voluntary or excluded aid codes that are currently enrolled in Medi-Cal FFS to transition to and enroll in a Medi-Cal managed care plan.

Risk Corridors—Risk Corridors are used by DHCS to provide the sharing of excess gains or losses resulting from the capitated rates paid by DHCS to MCPs for various programs. These risk corridors are subject to certain thresholds of Medi-Cal expenses compared to premium revenues as it pertains to these programs. Medi-Cal expenditures not meeting a minimum threshold as a percentage of revenue set by the State will require L.A. Care to refund premium revenue to DHCS and results in a liability owed to the State. The State will pay L.A. Care additional premium to cover the Medi-Cal costs incurred on behalf of its members resulting in a receivable owed by the DHCS.

CCI Risk Corridor—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 nondual members through June 30, 2016. The risk-sharing arrangements may result in payments to or from DHCS based on the final calculation. Also subject to the risk corridor requirements was L.A. Care's CMC population and the limited risk corridors were in effect through December 31, 2017.

COVID-19 Risk Corridor—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 implement 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 which covered the period from July 1, 2019–December 31, 2020) 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. Using the most recent information from the DHCS, we estimate there is no gain sharing or loss sharing as of September 30, 2023 and 2022.

Prop 56 Risk Corridors—Prop 56 increased the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care 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 from July 1, 2017, on a state fiscal year basis and was expanded to additional qualifying services beginning July 1, 2018. 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 98% and 102% of the health care revenue earned with a rebate incurred below 98% and additional revenue earned above 102%. This arrangement has been extended to December 31, 2022.

Enhanced Care Management (ECM) and Major Organ Transplant (MOT) Risk Corridors—The ECM and MOT programs began on January 1, 2022. These programs replaced legacy Whole Person Care and the HHP. DHCS implemented a risk corridor for ECM and MOT services. If costs are below 95% of the health care funding, then a premium rebate is triggered. If costs are above 105% of the health care funding, then additional premium is earned. If costs are between 95% and 105% of the health care funding, then no adjustment to revenue is made. This arrangement has been extended through December 2023.

Current-Year and Forecasted Highlights

During the COVID-related Public Health Emergency (PHE), Medi-Cal redeterminations had been suspended, meaning that people who might have lost coverage during their renewal period were kept on Medi-Cal. With the end of the PHE, redeterminations are resuming. The Continuous Coverage unwinding period began on April 1, 2023 and continues through May 31, 2024 with disenrollments beginning July 1, 2023. L.A. Care projected an annualized disenrollment rate of 13% for L.A. Care, a loss of about 350,000 members. L.A. County is automatically renewing members for whom they have relevant information (e.g. they are enrolled in another income-eligible program) which will help mitigate membership loss. However, based on early experience, 55% of members still need to complete the renewal packet. L.A. Care is conducting extensive outreach in multiple ways to assist members with the renewal process.

Despite redetermination-related membership losses, new Medi-Cal membership will result from other policy changes. Most fee-for-service members have been converted to Medi-Cal managed care as specified by the CalAIM initiative. In addition, the state has expanded Medi-Cal to income-eligible, unsatisfactory documentation status adults aged 26-49 beginning in 2024. L.A. Care is projecting to enroll 150,000 newly eligible beneficiaries. Once this takes effect, all income-eligible residents will be Medi-Cal eligible regardless of immigration status, making universal access to health care coverage a reality.

The state's direct contract with Kaiser, beginning in 2024, will also affect L.A. Care's membership. Kaiser will no longer be L.A. Care's Plan Partner and will lose Kaiser's projected 270,000 members, along with the associated revenue and health care costs. Removing Kaiser from L.A. Care's quality score calculation may affect our overall quality rating which in turn affects auto-assignment. Although Kaiser's members comprise a small fraction of L.A. Care's total membership, its quality ratings are very high.

The CalAIM Incentive Payment Program (IPP), which was designed for MCPS to invest in building provider capacity and delivery system infrastructure, continued in FY 22-23. L.A. Care continued to deploy the incentive payments to fund our ECM and CS providers to support capacity building and infrastructure development. In June 2023, DHCS approved our IPP Program Year 2 Payment 1 submission of which payment was received in June 2023. The financial impact of the IPP, which includes the incentive revenues and the related health care and administrative expenses, is included in our FY 22-23 financial results.

The Housing and Homelessness Incentive Program (HHIP), which aims to reduce and prevent homelessness, continued into FY 22-23. L.A. Care. L.A. Care earned \$120.4M in the current FY of the \$130.6M potential available. L.A. Care will continue to refine the measurement areas and will recognize the revenue when earned and expense the costs when incurred.

Financial Highlights

The following are the significant highlights of L.A. Care's financial performance for the fiscal year ended September 30, 2023, as compared to the fiscal year ended September 30, 2022:

- Total revenue increased by \$2.3 billion, or 25.3%, to \$11.3 billion. The increase in revenue is driven by rate increases in the amount of \$1.3 billion which updated estimates for the Prop 56 Risk Corridors for the 18 month bridge period 2019 – 2020 as well as calendar year 2021 and calendar year 2022 for an increase of \$350.2 million. Additionally, the increase in membership in the current year contributed an increase of \$940.0 million as compared to the prior year.
- Total health care expenses increased by \$1.8 billion, or 21.0%, to \$10.2 billion. The increase is primarily due to the Prop 56 reconciliations and the rate developments as discussed in the revenue section above. The impact of Prop 56 reconciliations resulted in a \$394.4 million increase in capitation expenses and the rate changes resulted in an increase of \$888.4 million. Also, the increase in membership increased expenses \$877.8 million in the current year as compared to the prior year.
- Administrative expenses increased by \$25.9 million, or 5.1%, to \$532.0 million for the year ended September 30, 2023, from \$506.1 million a year ago. The increase is primarily driven by increases related to an increase in contracted services of \$20.1 million related to strategic project spending..
- L.A. Care investment expense, interest income (loss), and interest expense– net increased by \$127.2 million year-over-year. For the year ended September 30, 2023, total unrealized and realized gains (losses) net of interest income is a gain of \$127.2 million as compared to a net loss of \$24.6 million in the prior year. Interest income increased by \$84.3 million from \$18.4 million to \$102.7 million year-over-year due to higher interest rates. Investment gains increased \$42.7 million from a loss of \$38.4 million to a gain of \$4.3 million driven by the L.A. Care portfolio consisting solely of high quality bonds being discounted less due those bonds maturing during the fiscal year or getting closer to maturity, which offsets the negative effects of higher interest rates at fiscal year-end 2023 as compared with 2022.
- “Increase in net position” increased by \$608.1 million to a net surplus of \$646.0 million for the year ended September 30, 2023, as compared with a net surplus of \$37.9 million for the year ended September 30, 2022.
- During the reporting year, L.A. Care received \$2.3 billion proceeds and disbursed \$2.6 billion to designated recipients. L.A. Care serves as a pass-through enterprise without any 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 payout within 30 days as required by DHCS.

Financial Statement Presentation

L.A. Care utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on an accrual basis and all of the Organization's activities are considered a single proprietary fund. According 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, including GASB pronouncements.

L.A. Care adopted GASB Statement No. 87, *Leases* during the prior period. The Statement establishes a single model for lease accounting based on the principle that leases are financings of the right to use an underlying asset. 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. Limited exceptions to the single approach guidance are provided for short-term leases, defined as lasting a maximum of 12 months at inception, including any options to extend, financed purchases, leases of assets that are investments and certain regulated leases.

L.A. Care adopted GASB Statement No. 96, *Subscription-Based Information Technology Arrangements*, which defines the subscription-based information technology arrangements (SBITAs) for government end users (governments), establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability, provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA, and requires note disclosures regarding a SBITA. To the extent relevant, the standards for SBITAs are based on the standards established in GASB Statement No. 87, *Leases*. The statement is effective for the Organization's combined financial statements for the year ending September 30, 2023. The adoption to conform to the provisions of this Statement were applied retroactively by restating the combined financial statements and management's discussion, and analysis for the earliest period presented.

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 asset; 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 the related debt."

Revenue

L.A. Care derives most of its revenue from its DHCS contracts with the State. 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, L.A. Care's rates were and will continue to be set by the DHCS on a calendar year basis for all categories of aid.

For CMC, revenue is received from both CMS and DHCS. The payment process mirrors Medi-Cal and Medicare coverage for each component of revenue received.

LACC is the plan's Patient Protection and Affordable Care Act Health Insurance Plan also known as "Covered California." 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 FPL. L.A. Care recognizes the premium subsidy evenly over the contract period and reports it as part of health plan services premium revenue.

Risk Adjustment—The risk adjustment provision applies to individual businesses 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.

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.

Membership/Member Months

L.A. Care's combined member months for 2023 increased by 10.4% as compared to the prior year. The member month data and the percentage change in member months for the years ended September 30, 2023 and 2022, are as follows:

Member Months by Product Line (in thousands)

	Years Ended		Changes Member	
	2023	2022	Months	Percentage
Medi-Cal:				
Plan Partners	14,035.0	13,091.1	943.9	7.2 %
Medi-Cal Direct	<u>18,094.0</u>	<u>15,764.7</u>	<u>2,329.3</u>	14.8 %
Total Medi-Cal	<u>32,129.0</u>	<u>28,855.8</u>	<u>3,273.2</u>	11.3 %
Other lines of business:				
Cal MediConnect	51.3	214.5	(163.2)	(76.1)%
DSNP	162.4	0.0	162.4	100.0 %
PASC-SEIU	591.9	604.5	(12.6)	(2.1)%
LA Care Covered <i>(on and off exchange)</i>	1,476.3	1,339.0	137.3	10.3 %
Elimination (DSNP members counted under Medi-Cal)	<u>(162.4)</u>	<u>0.0</u>	<u>(162.4)</u>	100.0 %
Total other lines of business	<u>2,119.5</u>	<u>2,158.0</u>	<u>(38.5)</u>	(1.8)%
Total member months	<u>34,248.5</u>	<u>31,013.8</u>	<u>3,234.7</u>	10.4 %

L.A. Care's combined ending membership as of September 30, 2023, increased by 6.1% as compared to September 30, 2022. The membership data and the percentage change in membership for the years ended September 30, 2023 and 2022, are as follows:

Membership by Product Line (in thousands)

	<u>Year Ended</u>		<u>Changes</u>	
	<u>2023</u>	<u>2022</u>	<u>Membership</u>	<u>Percentage</u>
Medi-Cal:				
Plan Partners	1,191.1	1,101.0	90.1	8.2 %
Medi-Cal Direct	<u>1,515.7</u>	<u>1,439.0</u>	<u>76.7</u>	5.3 %
Total Medi-Cal	<u>2,707</u>	<u>2,540.0</u>	<u>166.8</u>	6.6 %
Other lines of business:				
Cal MediConnect	0.0	17.0	(17.0)	(100.0)%
DSNP	18.4	0.0	18.4	100.0 %
PASC-SEIU	48.6	49.8	(1.2)	(2.4)%
LA Care Covered (<i>on and off exchange</i>)	130.3	112.4	17.9	15.9 %
Elimination (DSNP members counted under Medi-Cal)	<u>(18.4)</u>	<u>0.0</u>	<u>(18.4)</u>	100.0 %
Total other lines of business	<u>178.9</u>	<u>179.2</u>	<u>(0.3)</u>	(0.2)%
Total membership	<u>2,885.7</u>	<u>2,719.2</u>	<u>166.5</u>	6.1 %

Financial Position**Condensed Combined Statements of Net Position (dollars in millions)**

	As of September 30		Changes	
	2023	2022	Dollar	Percentage
Assets:				
Total current assets	\$6,537.4	\$5,663.5	\$ 873.9	15.4 %
Capital assets—net	157.0	168.3	(11.3)	(6.7)
Noncurrent assets	<u>3.2</u>	<u>2.1</u>	<u>1.1</u>	<u>52.4</u>
Total assets	<u>6,697.6</u>	<u>5,833.9</u>	<u>863.7</u>	<u>14.8</u>
Deferred outflow of resources	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Liabilities:				
Total current liabilities	4,834.1	4,616.1	218.0	4.7
Lease liability	<u>41.8</u>	<u>58.0</u>	<u>(16.2)</u>	<u>(27.9)</u>
Total liabilities	<u>4,875.9</u>	<u>4,674.2</u>	<u>201.7</u>	<u>4.3</u>
Deferred inflow of resources	<u>88.4</u>	<u>72.4</u>	<u>16.0</u>	<u>22.1</u>
Net position:				
Invested in capital assets	98.9	98.7	0.2	0.2
Restricted	0.6	0.6	0.0	-
Unrestricted:				
Designated by Board of Governors	84.6	104.8	(20.2)	(19.3)
Minimum tangible net equity	235.5	207.0	28.5	13.8
Unrestricted	<u>1,313.7</u>	<u>676.2</u>	<u>637.5</u>	<u>94.3</u>
Total net position	<u>1,733.3</u>	<u>1,087.3</u>	<u>646.0</u>	<u>59.4</u>
Total	<u>\$6,697.6</u>	<u>\$5,833.9</u>	<u>\$ 863.7</u>	<u>14.8 %</u>

Net Position—L.A. Care’s net position increased by \$646.0 million to \$1.7 billion as of September 30, 2023. The increase was primarily due to the income from operations of \$575.9 million which was increased by the non-operating gains of \$70.1 million.

Current Assets and Liabilities—Current assets increased by \$873.9 million to \$6.5 billion as of September 30, 2023. The increase was primarily driven by an increase in cash and cash equivalents and investments of \$1.0 billion driven by the timing of the Private and Public Hospital Directed payment program, offset by a decrease in capitation receivable of \$238.3 million and a net increase in Plan Partner/DHS receivable which was included in other current assets.

Current liabilities increased by \$218.0 million to \$4.8 billion as of September 30, 2023. The increase was primarily driven by reserves related to SB510 of \$133.4 million, an increase in Reserve for Claims of \$58.2

million, an increase in provider settlements of \$40.6 million, and a decrease in MCO Tax and other payables of \$13.3 million.

Results of Operations

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

	Years Ended September 30		Changes	
	2023	2022	Dollar	Percentage
Revenues	\$11,290.8	\$ 9,012.2	\$ 2,278.6	25.3 %
Health care expenses	10,182.9	8,416.6	1,766.3	21.0
Administrative expenses	<u>532.0</u>	<u>506.1</u>	<u>25.9</u>	<u>5.1</u>
Income from operations	575.9	89.5	486.4	543.5
Investment, interest income (loss), and interest expense—net	102.6	(24.6)	127.2	(517.1)
Community grants	(48.9)	(38.0)	(10.9)	28.7
Gross premium tax	<u>16.4</u>	<u>11.0</u>	<u>5.4</u>	<u>49.1</u>
Increase in net position	646.0	37.9	608.1	1,604.5
Beginning net position	<u>1,087.3</u>	<u>1,049.4</u>	<u>37.9</u>	<u>3.6</u>
Ending net position	<u>\$ 1,733.3</u>	<u>\$ 1,087.3</u>	<u>\$ 646.0</u>	<u>59.4 %</u>

- Total revenue increased by \$2.3 billion, or 25.3%, to \$11.3 billion. The increase in revenue is driven by rate increases in the amount of \$1.3 billion which updated estimates for the Prop 56 Risk Corridors for the 18 month bridge period 2019 – 2020 as well as calendar year 2021 and calendar year 2022 for an increase of \$350.2 million. Additionally, the increase in membership in the current year contributed an increase of \$940.0 million as compared to the prior year.
- Total health care expenses increased by \$1.8 billion, or 21.0%, to \$10.2 billion. The increase is primarily due to the Prop 56 reconciliations and the rate developments as discussed in the revenue section above. The impact of Prop 56 reconciliations resulted in a \$394.4 million increase in capitation expenses and the rate changes resulted in an increase of \$888.4 million. Also, the increase in membership increased expenses \$877.8 million in the current year as compared to the prior year.
- Administrative expenses increased by \$25.9 million, or 5.1%, to \$532.0 million for the year ended September 30, 2023, from \$506.1 million a year ago. The increase is primarily driven by increases related to an increase in contracted services of \$20.1 million related to strategic project spending..
- L.A. Care investment expense, interest income (loss), and interest expense— net increased by \$127.2 million year-over-year. For the year ended September 30, 2023, total unrealized and realized losses net of interest income is a gain of \$127.2 million as compared to a net loss of \$24.6 million in the prior year. Interest income increased by \$84.3 million from \$18.4 million to \$102.7 million year-over-year due to higher interest rates. Investment gains increased \$42.7 million from a loss of \$38.4 million to

a gain of \$4.3 million driven by the L.A. Care portfolio consisting solely of high quality bonds being discounted less due those bonds maturing during the fiscal year or getting closer to maturity, which offsets the negative effects of higher interest rates at fiscal year-end 2023 as compared with 2022.

- “Increase in net position” increased by \$608.1 million to a net surplus of \$646.0 million for the year ended September 30, 2023, as compared with a net surplus of \$37.9 million for the year ended September 30, 2022.
- During the reporting year, L.A. Care received \$2.3 billion proceeds and disbursed \$2.6 billion to designated recipients. L.A. Care serves as a pass-through enterprise without any 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 payout within 30 days as required by DHCS.

Summary of Cash Flows

The major sources and uses of cash and cash equivalents for the years ended September 30, 2023 and 2022, 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)

	Years Ended September 30		Changes	
	2023	2022	Dollar	Percentage
Net cash provided by operating activities	\$ 1,351.5	\$ 4.6	\$ 1,346.9	29,280.4 %
Net cash (used in) provided by investing activities	(705.4)	100.2	(805.6)	(804.0)
Net cash (used in) capital and related financing activities	(47.0)	(38.7)	(8.3)	(21.4)
Net cash (used in) non-capital financing activities	<u>(259.6)</u>	<u>182.4</u>	<u>(442.0)</u>	<u>242.3</u>
Net increase (decrease) in cash and cash equivalents	339.5	248.5	91.0	(36.6)
Cash and cash equivalents—beginning of year	<u>1,239.4</u>	<u>990.9</u>	<u>248.5</u>	<u>25.1</u>
Cash and cash equivalents—end of year	<u>\$ 1,578.9</u>	<u>\$ 1,239.4</u>	<u>\$ 339.5</u>	<u>27.4 %</u>

Total cash and cash equivalents increased by \$339.5 million, or 27.4%, to \$1.6 billion for the year ended September 30, 2023.

The increase in net cash from operating activities compared to the prior year was primarily due to net cash provided by the current reporting period driven by an increase in fund net position, and a change in operating assets and liabilities that increased operating cash. For the prior year, a net increase in the fund net position and changes in assets and liabilities that increased operating cash.

The decrease in net cash from investing activities compared to the prior year was due to a decrease in net purchases of investment in securities compared to the prior fiscal year.

The decrease in net cash used in capital and related financing activities compared to the prior year reflects the impact of the new lease standard adoption. L.A. Care adopted GASB Statement No. 87, *Leases* during the prior period.

The decrease in net cash from non-capital financing activities compared to the prior year was due to cash used for the Private and Public Hospital Directed Payments Program of \$793.0 million in the current reporting year.

INDEPENDENT AUDITOR'S 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:

Opinion

We have audited the 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, 2023 and 2022, and the related combined statements of revenue, expenses, and changes in fund net position, and cash flows for the years then ended, and the related notes to the combined financial statements (collectively referred to as the "combined financial statements").

In our opinion, the accompanying combined financial statements present fairly, in all material respects, the combined financial position of L.A. Care as of September 30, 2023 and 2022, 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.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Combined Financial Statements section of our report. We are required to be independent of L.A. Care and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Combined Financial Statements

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

In preparing the combined financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about L.A. Care's ability to continue as a going concern for one year after the date that the combined financial statements are issued.

Auditor’s Responsibilities for the Audit of the Combined Financial Statements

Our objectives are to obtain reasonable assurance about whether the combined financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor’s report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the combined financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the combined financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the combined financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the L.A. Care’s internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the combined financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about L.A. Care’s ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management’s discussion and analysis on pages 1–13 and the budgetary comparison information on pages 45–47 be presented to supplement the basic combined financial statements. Such information is the responsibility of management and, 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.

_____, 2024

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, 2023 AND 2022 (In thousands)

	2023	2022
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	\$1,578,927	\$1,239,407
Investments—at fair value	1,794,938	1,085,262
Capitation receivable	2,586,084	2,824,384
Other current assets	<u>577,380</u>	<u>514,415</u>
Total current assets	6,537,329	5,663,468
CAPITAL ASSETS—Net	157,017	168,303
NONCURRENT ASSETS	3,243	2,129
DEFERRED OUTFLOW OF RESOURCES	<u>-</u>	<u>-</u>
TOTAL ASSETS	<u>\$6,697,589</u>	<u>\$5,833,900</u>
LIABILITIES		
CURRENT LIABILITIES:		
Accounts payable and accrued liabilities	\$ 159,455	\$ 164,813
Subcapitation payable	3,426,014	3,464,015
Grants payable	19,299	13,415
Reserves for claims	842,608	784,397
Other accrued medical expenses	265,546	77,929
Reserves for provider incentives	104,851	98,376
Lease liability	<u>16,334</u>	<u>13,204</u>
Total current liabilities	4,834,107	4,616,149
LONG-TERM LIABILITY	<u>72,762</u>	<u>58,007</u>
Total liabilities	<u>4,906,869</u>	<u>4,674,156</u>
DEFERRED INFLOW OF RESOURCES—Deferred revenue	<u>57,426</u>	<u>72,390</u>
Total deferred inflow of resources	<u>57,426</u>	<u>72,390</u>
COMMITMENTS AND CONTINGENCIES (Note 8)		
NET POSITION:		
Invested in capital assets	98,910	98,723
Restricted	600	600
Unrestricted:		
Designated by Board of Governors	84,624	104,822
Minimum tangible net equity	235,493	207,029
Unrestricted	<u>1,313,667</u>	<u>676,180</u>
Total net position	<u>1,733,294</u>	<u>1,087,354</u>
TOTAL	<u>\$6,697,589</u>	<u>\$5,833,900</u>

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, 2023 AND 2022 (In thousands)

	2023	2022
REVENUES—Capitation	\$ 11,290,839	\$ 9,012,228
Total revenues	<u>11,290,839</u>	<u>9,012,228</u>
HEALTH CARE EXPENSES:		
Capitation	5,911,183	4,661,634
Fee-for-service medical claims	3,882,874	3,302,501
Pharmacy claims	145,181	273,758
Provider incentives and shared risk	138,963	94,910
Medical administrative expense	<u>104,650</u>	<u>83,808</u>
Total health care expenses	<u>10,182,851</u>	<u>8,416,611</u>
ADMINISTRATIVE EXPENSES	<u>532,026</u>	<u>506,108</u>
INCOME FROM OPERATIONS	<u>575,962</u>	<u>89,509</u>
NONOPERATING (EXPENSES) REVENUE:		
Investment, interest (loss) income, and interest expense—net	102,551	(24,665)
Grant income	6,724	11,840
Provision for community grant	(55,649)	(49,793)
Gross premium tax revenue	33,414	182,421
Gross premium tax expense	<u>(17,062)</u>	<u>(171,415)</u>
Total nonoperating expenses	<u>69,978</u>	<u>(51,612)</u>
INCREASE IN FUND NET POSITION	645,940	37,897
FUND NET POSITION—Beginning of year	1,087,354	<u>1,049,457</u>
FUND NET POSITION—End of year	<u>\$ 1,733,294</u>	<u>\$ 1,087,354</u>

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, 2023 AND 2022 (In thousands)

	2023	2022
CASH FLOWS FROM OPERATING ACTIVITIES:		
Capitation revenue	\$ 11,544,255	\$ 8,709,628
Other income—net	43,708	(30,759)
Health care expenses	(9,752,981)	(8,247,668)
Operating expenses	<u>(483,461)</u>	<u>(426,513)</u>
Net cash provided by operating activities	<u>1,351,521</u>	<u>4,688</u>
CASH FLOWS FROM INVESTING ACTIVITIES:		
Net purchases of investments	(705,401)	100,202
Purchase of capital assets	-	-
Purchase of restricted investment	<u>-</u>	<u>-</u>
Net cash (used in) provided by investing activities	<u>(705,401)</u>	<u>100,202</u>
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Lease payments for right-of-use capital assets	(13,104)	(15,151)
Purchase of capital assets	<u>(33,918)</u>	<u>(23,607)</u>
Net cash (used in) capital and related financing activities	<u>(47,022)</u>	<u>(38,758)</u>
CASH FLOWS FROM NON-CAPITAL FINANCING ACTIVITIES:		
MCO tax revenue received	49,107	179,848
MCO tax paid	(29,257)	(168,736)
Pass-through programs received	2,336,700	1,949,471
Pass-through programs paid	<u>(2,616,128)</u>	<u>(1,778,205)</u>
Net cash (used in) provided by financing activities	<u>(259,578)</u>	<u>182,378</u>
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	339,520	248,510
CASH AND CASH EQUIVALENTS—Beginning of year	<u>1,239,407</u>	<u>990,897</u>
CASH AND CASH EQUIVALENTS—End of year	<u>\$ 1,578,927</u>	<u>\$ 1,239,407</u>
ADJUSTMENTS TO RECONCILE INCREASE IN FUND NET POSITION WITH CASH PROVIDED BY OPERATING ACTIVITIES:		
Increase in fund net position	\$ 645,940	\$ 37,897
Depreciation and amortization	45,204	44,140
Unrealized and realized depreciation on investments—net	(4,274)	38,433
Managed care organization tax provision	(16,352)	(11,006)
Changes in operating assets and liabilities:		
Other current and noncurrent assets	(79,769)	(390,514)
Capitation receivable	238,299	(360,043)
Accounts payable and accrued liabilities	4,709	44,532
Subcapitation payable	243,552	439,882
Grants payable	5,884	(1,996)
Reserves for provider claims	58,211	141,169
Other accrued medical expenses	187,617	(47,222)
Reserves for incentives	6,475	11,566
Deferred inflow of resources	<u>16,025</u>	<u>57,850</u>
NET CASH PROVIDED BY OPERATING ACTIVITIES	<u>\$ 1,351,521</u>	<u>\$ 4,688</u>
SUPPLEMENTAL NON CASH ACTIVITIES—Recognition of right-of-use assets and lease liabilities	<u>\$ 0</u>	<u>\$ 7,716</u>

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, 2023 AND 2022

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 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*. Since its creation, L.A. Care has also added several other products, within its mission, to protect vulnerable populations.

L.A. Care Health Plan entered into a joint exercise of powers agreement with the County to establish the JPA, a licensed health maintenance organization. The County’s Board of Supervisors established the JPA in July 2012 according 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 is 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 ensuring solvency for the two organizations and both entities operate under common management and control.

The State created the “Local Initiative and the Two-Plan Model” to realize the strategic plans of the 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. L.A. Care 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 members either through its network of contracted providers (MCLA) or its network of contracted health plans (Plan Partners), including Anthem Blue Cross of California, Blue Shield of California Promise Health Plan, and Kaiser Foundation Health Plan. Medi-Cal membership with the Plan Partners as of September 30, 2023 and 2022, was 1,191,140 and 1,100,962 enrollees, respectively.

L.A. Care’s direct Medi-Cal program MCLA receives a fixed payment PMPM from DHCS, and fixed case rates for maternity cases for each eligible birth, hepatitis C, institutional members, enrolled HHP, and qualified members receiving BHT. Beginning January 1, 2022, Enhanced Care Management (ECM) and Community Supports replaced the HHP program as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative which is a precursor to a statewide care management approach. The ECM program is paid on a pmpm basis. The State implemented the Medi-Cal Pharmacy transition in January 2022, shifting responsibility from health plans to the State and administered by its pharmacy vendor. Starting January 1, 2022, Hepatitis C is carved out as part of the State’s responsibility under Medi-Cal Pharmacy. Starting January 1, 2023, BHT costs will be included in the monthly base rates and no longer paid on a fixed case rate basis. 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 (FFS) 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 (ACA) 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 (FPL) effective January 1, 2014. California State also expanded Medi-Cal to include various age cohorts of income-eligible individuals with unsatisfactory immigration status which contributed to membership increases beginning May 1, 2022. As of September 30, 2023 and 2022, MCLA membership was 1,516,676 and 1,439,026 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 effective December 1, 2013. As of September 30, 2023 and 2022, PASC-SEIU membership was 48,636 and 49,851 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 individual health coverage under regulations established by the US 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 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 a favorable ruling from the US Court of Federal Claims. L.A. Care’s premium rates

effective for 2018 and onward were increased to reflect the loss of the cost-sharing reduction (CSR) 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 the 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. 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.

Beginning in 2019, the individual mandate penalty was reduced to \$0, meaning individuals no longer incurred 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 three years beginning January 1, 2020.

In April of 2021, the President signed the American Rescue Plan which, among other things, expanded the premium tax credits, qualifying those making under 150% of the FPL for subsidies that cover 100% or the second lowest price Silver premium. In addition, the expanded subsidies capped the maximum amount that individuals have to pay toward health insurance at 8.5% of annual income. The enhanced subsidies also expand income cap to qualify for subsidies to anyone who is above 400% of the FPL. These enhanced subsidies were set to expire at the end of 2022. However, Congress passed, and the President signed, the Inflation Reduction Act in August of 2022. This new law extended the enhanced subsidies to continue through the end of 2025. These expanded subsidies, combined with LACC's position as the lowest priced Silver Plan in LA. County for 2022 and 2023, makes LACC the most attractive plan from a price perspective, with many of our members qualifying for \$0 premiums.

As of September 30, 2023 and 2022, LACC membership was 131,265 and 112,357, respectively. L.A. Care's strategy is to continue to serve Medi-Cal members who lose eligibility.

Coordinated Care Initiative (CCI) began as a three-year pilot program developed jointly with California's DHCS to coordinate Medi-Cal 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 the 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, and as of September 30, 2023, the CCI membership has been realigned with MCLA.

L.A. Care's CMC program was launched in May 2014. CMC members are those who qualify for both Medicare and Medi-Cal. 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 on January 1, 2023 and as of September 30, 2023 all enrollees have been transferred to the new plan.

On January 1 2023, L.A. Care launched a Medicare Advantage Dual Eligible Special Needs Plan (DSNP) as part of the California Advancing and Innovating Medi-Cal initiative (CalAIM). The DSNP plan is a plan designed to provide specialized care and wrap-around services for dual eligible beneficiaries (eligible

for both Medicare and Medi-Cal) who are also enrolled in the Medi-Cal managed care plan affiliated with the DSNP. For the purposes of tracking membership totals, the DSNP membership is eliminated and counted once as part of MCLA. As of September 30, 2023, membership for the DSNP program was 18,445.

Effective July 1, 2019, L.A. Care launched the HHP for eligible members with multiple chronic conditions who are frequent utilizers of Medi-Cal services and may benefit from enhanced care management and coordination. HHP is a DHCS mandated Medi-Cal benefit authorized under Section 2703 of the ACA. The Health Homes Program network includes the Community-Based Care Management Entities (CB-CMEs), and other community-based organizations to provide linkages to community and social support services, as needed. This pilot program was sunset on December 31, 2021, and was replaced by Enhanced Care Management (ECM). L.A. Care's HHP members were transitioned to ECM.

Another significant change to Medi-Cal which began on January 1, 2022, was California Advancing and Innovating Medi-Cal (CalAIM) implementation. CalAIM is a federal waiver proposal that transforms Medi-Cal in many ways. CalAIM's goals are 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. Components that began on January 1, 2022, include Enhanced Care Management (ECM) which replaces the Health Homes Program and Whole Person Care, Community Supports (CS) and the Major Organ Transplant (MOT) benefit.

CS are services provided by Managed Care Plans (MCPs) to eligible Medi-Cal members to meet their social needs, including Medi-Cally supportive foods or housing supports. These new services are cost effective alternatives to traditional Medi-Cal services or settings and are designed to address social drivers of health. There are 14 preapproved CS and are available to eligible Medi-Cal members regardless of whether they qualify for ECM services.

Effective January 1, 2022, in support of the CalAIM initiative, L.A. Care implemented ECM, CS which includes Housing Navigation, Tenancy and Sustaining Services, Recuperative Care, and Medi-Cally Tailored Meals, and MOT benefits. On July 1, 2022, four additional CS services were added, including Housing Deposits, Sobering Centers, Respite Services, and Personal Care and Homemaker Services.

CalAIM includes an incentive program CalAIM Incentive Payment Program (IPP) to promote MCP and provider participation in, and capacity building for, ECM and CS. IPP is based on achievement of milestones with a goal to build the infrastructure required to bridge current silos across physical and behavioral health delivery, reduce health disparities, and promote healthy equity to achieve improvements in quality performance. L.A. Care is eligible to earn up to \$109.0 million in IPP funding over the program year 2, which is calendar year 2023. L.A. Care will recognize the revenue when the funding has been received and all eligibility criteria are met. The CalAIM Housing and Homeless Incentive Program (HHIP) is a voluntary incentive program that will enable MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health. L.A. Care is eligible to earn up to \$290 million over the program which extends over a two-year program period. As of September 30, 2023 and 2022, L.A. Care recognized \$90.7 million and 24.2 million in revenue for the IPP program and \$120.4 and \$14.5 million in revenue for the HHIP Program respectively.

Another component of the CalAIM initiative starting January 1, 2022, is the mandatory managed care enrollment provision which requires beneficiaries in certain voluntary or excluded aid codes that are currently enrolled in Medi-Cal FFS to transition to and enroll in a Medi-Cal managed care plan.

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 an insignificant component unit of L.A. Care. All intercompany transactions have been eliminated. Certain amounts in the combined financial statements and notes have been reclassified to conform to current period presentation. These reclassifications have no effect on fund net position, revenue, expenses, or cash flows as previously reported.

L.A. Care utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on an accrual basis and all of the Organization's activities are considered a single proprietary fund. According 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 Accounting Standards Codification, 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*, 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 amortization; 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, the effects of risk-sharing, risk adjustment, and other retroactive adjustments on capitation revenue and capitation receivable, and assumptions when determining the 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 per GASB Codification Section 150, Investments (GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and External Investment*

Pools). This statement requires that investments are 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 subcapitation 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 are included in other income and expenses.

Right-of-Use (ROU) SBITA and Lease intangible assets are recognized at the commencement date of the qualifying contract and represent the Organization's right to use an underlying asset for the contract or lease term. ROU assets are measured at the initial value of the liability plus any payments made to the lessor at or before commencement and initial direct costs.

Amortization for ROU SBITA and Lease intangible assets is computed using the straight-line method over the contracted subscription or lease term; but if the underlying subscription or lease contains a purchase option determined to be reasonably certain of being exercised, the ROU intangible asset is amortized over the estimated useful life of the asset.

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, provider capitation payables, and all pass-through programs payable as described below.

L.A. Care serves as a pass-through enterprise without any 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 payout within 30 days as required by

DHCS. As of September 30, 2023 and 2022, approximately \$302.3 million and \$583.8 million, respectively, were payable under the pass-through programs. The pass-through programs include:

- The Hospital Directed Payment program (HDP) is composed of Private Hospital Directed Payment Program (PHDP), Public Hospital Enhanced Payment Program (EPP), and Public Hospital Quality Incentive Program (QIP). HDP is an enhanced reimbursement to eligible and participating network hospital for Medi-Cal covered services rendered to an actively enrolled member per CMS guidance 42 C.F.R. 438.6C.
- Intergovernmental Transfer (IGT) means any transfers of funds from a public entity to the State in order to support the nonfederal share of payments to Medi-Cal MCPs, which are authorized by state law and conform to applicable federal requirements. IGTs include, but are not limited to, transfers of funds described in Welfare and Institutions Code Sections 14182.15, 14301.4, 14301.5, and 14164.
- Hospital Quality Assurance Fee provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. The program uses hospital fees assessed by the state to draw down federal matching funds. Participating hospitals must meet the requirements set by Welfare and Institutions Code 14169.51 to be eligible for the program.
- Cost-Based Reimbursement Clinic is a supplemental reimbursement plan to state-owned clinics under Title XIX of the Social Security Act. Costs subject to cost-based reimbursements include Medi-Cal-covered ambulatory care services rendered to Medi-Cal beneficiaries.

Reserves for Provider Incentives—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 \$104.9 million and \$98.4 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, 2023 and 2022, respectively.

Lease Liability—Lease liabilities represent the L.A. Care's obligation to make lease payments arising from leases other than short term leases. Lease liabilities are recognized at the lease commencement date based on the present value of future lease payments over the remaining lease term utilizing an estimated incremental borrowing rate, unless an implicit rate is stated in the lease agreement. Short term leases, those with a maximum period of 12 months, are expensed as incurred.

Subscription (SBITA) Liability - Subscription (SBITA) liabilities represent the Organization's obligation to make subscription payments arising from subscriptions other than short term subscriptions. Subscription (SBITA) liabilities are recognized at the contract commencement date based on the present value of future subscription payments over the remaining subscription term utilizing an estimated incremental borrowing rate of 4.5%. Short term subscriptions, those with a maximum period of 12 months, are expensed as incurred.

Deferred Revenue—L.A. Care received funding from DHCS and CMS to administer programs. Deferred Revenue includes premiums received in advance of the period of service and funds received in advance of the eligibility conditions being met for state incentive programs. As of September 30, 2023, \$31.0 million in funds received related to the state incentive programs has been deferred because the

eligibility conditions have not been fully met. As of September 30, 2023 and 2022, the ending balance for all programs recorded in deferred revenue was \$88.4 million and \$72.4 million, respectively.

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 before such a 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 nonoperating 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.

L.A. Care derives most of its revenue from its DHCS contracts with the State. 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, L.A. Care’s rates were and will continue to be set by the DHCS on a calendar year basis for all categories of aid.

For CMC, revenue is received from both CMS and DHCS. The payment process mirrors Medi-Cal and Medicare coverage for each component of revenue received.

LACC is the plan’s Patient Protection and Affordable Care Act Health Insurance Plan also known as “Covered California.” 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 FPL. L.A. Care recognizes the premium subsidy evenly over the contract period and reports it as part of health plan services premium revenue.

Risk Adjustment—The risk adjustment provision applies to individual businesses 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.

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.

Risk Corridors—Risk Corridors are used by DHCS to provide the sharing of excess gains or losses resulting from the capitated rates paid by DHCS to MCPs for various programs. These risk corridors are subject to certain thresholds of Medi-Cal expenses compared to premium revenues as it pertains to these programs. Medi-Cal expenditures not meeting a minimum threshold as a percentage of revenue set by the State will require L.A. Care to refund premium revenue to DHCS and results in a liability owed to the State. The State will pay L.A. Care additional premium to cover the Medi-Cal costs incurred on behalf of its members resulting in a receivable owed by the DHCS. As of September 30, 2023 and 2022, L.A. Care has recognized a liability of \$269.2 million and \$526.7 million, respectively, which is included in subcapitation payable and other accrued Medi-Cal expenses in the accompanying combined statements of net position. Below is a list of programs with risk corridor accruals as of September 30, 2023 and 2022.

- **Prop 56 Risk Corridors**—Prop 56 increased the excise tax rate on cigarettes and tobacco products for purposes of funding specified expenditures, including increased funding for existing health care 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 from 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 from July 1, 2019, to June 30, 2020, the DHCS implemented a two-sided risk corridor under which payments to providers must be between 98% and 102% of the revenue earned with a rebate incurred below 98% and additional revenue earned above 102%. This arrangement has been extended to December 31, 2022.
- **CCI Risk Corridor**—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 nondual members through June 30, 2016. The risk-sharing arrangements may result in payments to or from DHCS based on the final calculation. Also subject to the risk corridor requirements was L.A. Care's CMC population and the limited risk corridors were in effect through December 31, 2017.
- **Enhanced Care Management (ECM) and Major Organ Transplant (MOT) Risk Corridors**—The ECM and MOT programs began on January 1, 2022. These programs replaced the legacy Whole Person Care and HHP programs. DHCS implemented a risk corridor for ECM and MOT services. If costs are below 95% of the health care funding, then a premium rebate is triggered. If costs are above 105% of the health care funding, then additional premium is earned. If costs are between 95% and 105% of the health care funding, then no adjustment to revenue is made. This arrangement has been extended through December 2023. For the years ended September 2023 and September 2022, we recorded \$84.9 million and \$23.4 million and for ECM risk corridor we recorded \$3.8 million \$11.9 million for MOT risk corridor respectively.

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 2023 and 2022 of \$7.8 million and \$8.3 million, respectively, are included in administrative expenses in the accompanying combined 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 delivered 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 estimate 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 believes that the accrued Medi-Cal claims payable is adequate. IBNR estimates of \$842.6 million and \$784.4 million are recorded in reserves for claims in the combined statements of net position as of September 30, 2023 and 2022, respectively.

Other Accrued Medi-Cal Expenses—These expenses include shared risk liability, claims payables, and pharmacy payable. These accrued expenses are recorded at a total of \$265.5 million and \$77.9 million as of September 30, 2023 and 2022, respectively.

In May 2023, the Senate Bill 510 (SB510) mandated that health plans and health insurers reimburse health care providers, regardless of network status, for COVID-19 testing and vaccination services. SB510 requires the health plans and insurers to cover testing and vaccinations without any cost-sharing or prior authorization requirements and extended the provision back to March 4, 2020. As of September 30, 2023 L.A. Care recorded a liability of \$133.4 million for SB510.

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 L.A. Care's method of acquiring, servicing, and measuring the profitability of such contracts. We did not have any premium deficiency reserves on September 30, 2023 or 2022.

Nonoperating Revenue and Expenses—Nonoperating revenue includes investment and interest income—net, grant income, and gross premium tax revenue. Nonoperating expenses include provision for community grant and gross premium tax expense, as well as interest expense related to leases.

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. Per this agreement, L.A. Care will build, expand, and operate Community Resource Centers across the County. Grant income is recognized when all eligibility requirements are met. For the year ended September 30, 2023, L.A. Care received and recognized \$6.7 million from Promise Health Plan. For the year ended September 30, 2022, L.A. Care received and recognized \$11.5 million 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 CMS. 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 the State’s managed care organization (MCO) tax, effective January 1, 2020. L.A. Care also receives MCO tax revenue which is reimbursement on the MCO tax paid on its Medi-Cal line of business for the DHCS. This reimbursement, although also based upon a PMPM methodology, is at a different rate and a different Medi-Cal member enrollment period compared to MCO tax paid. This reimbursement can be more or less than the MCO tax paid on the Medi-Cal line of business. The current MCO Tax program expired December 2022 and a new program is scheduled to begin in January 2024 if approved. For the years ended September 30, 2023 and 2022, MCO tax revenue totaled \$33.4 million and \$182.4 million, respectively, and MCO tax expense totaled \$17.1 million and \$171.4 million for fiscal years 2023 and 2022, respectively.

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

Recently Adopted Accounting Pronouncements—

GASB Statement No. 96, *Subscription-Based Information Technology Arrangements (SBITA)* effective 2023, establishes that a SBITA results in a right-to-use subscription asset - an intangible asset - and a corresponding subscription liability. Changes adopted to conform to the provisions of this Statement were applied retroactively by restating the combined financial statements for the earliest period presented. The cumulative effect of implementing GASB Statement No. 96 on the Organization’s combined financial statements for the year ended September 30, 2022, was as follows (in thousands):

Placeholder for updated table

Recent Accounting Pronouncements—

GASB Statement No. 96, *Subscription-Based Information Technology Arrangements*, defines the subscription-based information technology arrangements (SBITAs) for government end users (governments), establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability, provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA, and requires note disclosures regarding a SBITA. To the extent relevant, the standards for SBITAs are based on the standards

established in GASB Statement No. 87, *Leases*. The statement is effective for the Organization's combined financial statements for the year ending September 30, 2023.

Other than the portion of this statement implemented in 2022, the remainder of GASB Statement No. 99, *Omnibus 2022*, is effective in 2023 and 2024. The requirements related to leases, PPPs, and SBITAs are effective 2023. The requirements related to financial guarantees and the classification and reporting of derivative instruments within the scope of GASB Statement No. 53 are effective 2024. The statement is effective for the Organization's combined financial statements for the years ending September 30, 2023 and 2024, and management is evaluating the impact that this statement will have on the combined financial statements.

GASB Statement No. 100, *Accounting Changes and Error Corrections*—an amendment of GASB Statement No. 62. This statement defines accounting changes as changes in accounting principles, changes in accounting estimates, and changes to or within the financial reporting entity and describes the transactions or other events that constitute those changes. This statement also prescribes the accounting and financial reporting for (1) each type of accounting change and (2) error corrections in previously issued combined financial statements. The statement is effective for the Organization's combined financial statements for the year ending September 30, 2024, and management is evaluating the impact that this statement will have on the combined financial statements.

GASB Statement No. 101, *Compensated Absences*, aligned the recognition and measurement guidance under a unified model and by amending certain previously required disclosures. This statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used and (2) leave that has been used but not yet paid in cash or settled through noncash means. The statement is effective for the Organization's combined financial statements for the year ending September 30, 2025, 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, 2022 and 2021, 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, 2023 and 2022, the carrying amounts of L.A. Care's deposits were \$103.7 million and \$40.1 million, respectively, and the bank balance was \$170.4 million and \$119.0 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, 2023 and 2022, 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, 2023 and 2022, as follows (in thousands):

Investments	Fair Value Measurement Using		
	2023	Level 1	Level 2
Money Market Funds	\$ 49,280	\$ 49,280	\$ -
US government, agencies, and supranational obligations	2,491,976	-	2,491,976
Negotiable and nonnegotiable Certificates of Deposit	86,296	-	86,296
Corporate obligations	338,288	-	338,288
Mortgage-backed securities	11,516	-	11,516
Asset-backed securities	178,954	-	178,954
Subtotal	3,156,310	49,280	3,107,030
Less: cash equivalent portion	(1,475,229)	(49,280)	(1,425,949)
Total investment by fair value level	1,681,081	\$ -	\$ 1,681,081
Investments measured at the NAV:			
Government pooled funds	113,857		
Total investments measured at the NAV	113,857		
Investment—total	\$ 1,794,938		

Investments	Fair Value Measurement Using		
	2022	Level 1	Level 2
Money Market Funds	\$ 73,992	\$ 73,992	\$ -
US government, agencies, and supranational obligations	1,330,467	-	1,330,467
Bank Certificates of Deposit	87,508	-	87,508
Corporate obligations	321,992	-	321,992
Mortgage-backed securities	21,676	-	21,676
Asset-backed securities	120,586	-	120,586
Subtotal	1,956,221	73,992	1,882,229
Less: cash equivalent portion	(1,199,357)	(73,992)	(1,125,365)
Total investment by fair value level	756,864	\$ -	\$ 756,864
Investments measured at the NAV:			
Government pooled funds	328,398		
Total investments measured at the NAV	328,398		
Investment—total	\$ 1,085,262		

Transfers in or out are recognized based on the beginning fair value of the fiscal year in which they occurred. There were no transfers on investments between Level 1 and Level 2 during the years ended September 30, 2023 and 2022.

	Fair Value 2023	Unfunded Commitments 2023	Redemption Frequency	Redemption Notice Period
Government Pooled Investment Funds ⁽¹⁾	<u>\$ 113,857</u>	<u>\$ _____</u>	Daily	1 day
Total	<u><u>\$ 113,857</u></u>	<u><u>\$ _____</u></u>		
	Fair Value 2022	Unfunded Commitments 2022	Redemption Frequency	Redemption Notice Period
Government Pooled Investment Funds ⁽¹⁾	<u>\$ 328,398</u>	<u>\$ _____ -</u>	Daily	1 day
Total	<u><u>\$ 328,398</u></u>	<u><u>\$ _____ -</u></u>		

- ⁽¹⁾ This type includes two pooled investment funds that invest primarily in US Treasury bills, federal agency debentures, and supranational debentures. The fair value of the investments of this type has been determined using the NAV per share (or its equivalent) of the Organization's ownership interest in the fund. These investments can be redeemed daily, have a one-day redemption notice period, and have no unfunded capital commitments.

As of September 30, 2023 and 2022, L.A. Care had investments by type and maturity as follows:

Investment	2023		
	Investment Maturities (In Years)		
	Fair Value	Less Than 1	1-5
Money Market Funds	\$ 49,280	\$ 49,280	\$ -
US government, agencies, and supranational obligations	2,491,976	2,324,599	167,377
Bank Certificates of Deposit	86,296	86,296	-
Corporate obligations	338,288	49,404	288,884
Mortgage-backed securities	11,516	1,749	9,767
Asset-backed securities	178,954	55,573	123,381
Government pooled funds	113,857	113,857	-
Total	3,270,167	2,680,758	589,409
Less: cash equivalent portion	(1,475,229)	(1,475,229)	-
Investment—total	<u>\$ 1,794,938</u>	<u>\$ 1,205,529</u>	<u>\$ 589,409</u>
Investment	2022		
	Investment Maturities (In Years)		
	Fair Value	Less Than 1	1-5
Money Market Funds	\$ 73,992	\$ 73,992	\$ -
US government, agencies, and supranational obligations	1,330,467	1,228,816	101,651
Bank Certificates of Deposit	87,508	87,508	-
Corporate obligations	321,992	33,753	288,239
Mortgage-backed securities	21,676	5,225	16,451
Asset-backed securities	120,586	43,593	76,993
Government pooled funds	328,398	328,398	-
Total	2,284,619	1,801,285	483,334
Less: cash equivalent portion	(1,199,357)	(1,199,357)	-
Investment—total	<u>\$ 1,085,262</u>	<u>\$ 601,928</u>	<u>\$ 483,334</u>

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 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; commercial paper rated a minimum of A-1 or equivalent by Standard & Poor’s Corporation (S&P), Moody’s Investor Services (“Moody’s”), or F1 by Fitch Ratings (“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 nonnegotiable 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, Interest Income, and Interest Expense—The composition of investment, interest income, and interest expense for the years ended September 30, 2023 and 2022, includes the following (in thousands):

	Years Ended	
	September 30	
	2023	2022
Interest and dividends	\$102,719	\$ 18,435
Realized (losses) gains—net	(2,099)	(243)
Unrealized (losses)—net	6,373	(38,190)
Interest expense—leases	(3,123)	(3,354)
Fees	<u>(1,313)</u>	<u>(1,313)</u>
Investment, interest (loss) income, interest expense—net	<u>\$102,557</u>	<u>\$(24,665)</u>

4. CAPITAL ASSETS

Capital asset additions for the year included office expansion and strategic software development. Depreciation and amortization expense of \$44.9 million and \$44.1 million was recorded during the years ended September 30, 2023 and 2022, respectively. A summary of changes in the capital assets for the year ended September 30, 2022, is presented below and includes adjustments made for GASB Statement No. 96. See Note 2 for further details on the restatements.

Depreciable/Amortizable Assets	Beginning Balance 2023	Additions	Disposals/ Deletions	Ending Balance 2023
Computer equipment and software	\$ 216,891	\$ 21,280	\$	\$ 238,171
Office furniture and equipment	13,048	215		13,263
Leasehold improvements	52,522	7,885		60,407
Right-of-use asset—buildings	95,741	4,379		100,120
Total capital assets	<u>\$ 378,202</u>	<u>\$ 33,759</u>	<u>\$</u>	<u>\$ 411,961</u>
Accumulated Depreciation/Amortization				
Computer equipment and software	\$ (145,976)	\$ (28,684)		\$ (174,660)
Office furniture and equipment	(11,297)	915		(10,382)
Leasehold improvements	(26,626)	(2,607)		(29,233)
Right-of-use asset—buildings	(26,161)	(14,508)		(40,669)
Total accumulated depreciation and amortization	<u>\$ (210,060)</u>	<u>\$ (44,884)</u>	<u>\$</u>	<u>\$ (254,944)</u>
Net capital assets				<u>\$ 157,017</u>
Depreciable/Amortizable Assets	Beginning Balance 2022	Additions	Disposals/ Deletions	Ending Balance 2022
Computer equipment and software	\$ 201,156	\$ 15,735	\$ -	\$ 216,891
Office furniture and equipment	12,708	345	(5)	13,048
Leasehold improvements	45,150	7,533	-	52,683
Right-of-use asset—buildings	88,025	7,716	-	95,741
Total capital assets	<u>\$ 347,039</u>	<u>\$ 31,329</u>	<u>\$ (5)</u>	<u>\$ 378,363</u>
Accumulated Depreciation/Amortization				
Computer equipment and software	\$ (119,619)	\$ (26,357)	\$ -	\$ (145,976)
Office furniture and equipment	(10,767)	(530)	-	(11,297)
Leasehold improvements	(22,714)	(3,912)	-	(26,626)
Right-of-use asset—buildings	(12,820)	(13,341)	-	(26,161)
Total accumulated depreciation and amortization	<u>\$ (46,301)</u>	<u>\$ (17,783)</u>	<u>\$ -</u>	<u>\$ (210,060)</u>
Net capital assets				<u>\$ 168,303</u>

5. RESTRICTED ASSETS

L.A. Care maintained restricted interest-bearing accounts of \$600,000 in 2023 and \$600,000 in 2022. Restricted cash balances are recorded in the noncurrent asset section of the combined statements of net position. According 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. In 2021, additional restricted accounts were opened for the Joint Powers Authority license.

6. RESERVES FOR CLAIMS

IBNR estimates of \$842.6 million and \$784.4 million are recorded in reserves for claims in the combined statements of net position as of September 30, 2023 and 2022, respectively.

The following is a reconciliation of the reserves for claims as of September 30, 2023 and 2022 (in thousands):

	Years Ended September 30	
	2023	2022
Beginning Balance	\$ <u>784,397</u>	\$ <u>643,228</u>
Incurred:		
Current	3,696,925	3,348,648
Prior ^(b)	<u>(10,468)</u>	<u>(60,099)</u>
Total incurred ^(a)	<u>3,686,457</u>	<u>3,288,549</u>
Paid:		
Current	(2,960,379)	(2,601,625)
Prior	<u>(667,867)</u>	<u>(545,755)</u>
Total paid ^(a)	<u>(3,628,246)</u>	<u>(3,147,380)</u>
Ending Balance	\$ <u>842,608</u>	\$ <u>784,397</u>

^(a) The reconciliation includes Medi-Cal claims only. Other claims, such as pharmaceutical claims, and charges, such as provider settlements, are not included.

^(b) The current fiscal year saw small favorable development from the prior year. The \$10.5 million decrease for claims incurred during the prior fiscal year ending September 30, 2022. Is due to favorable development in that fiscal year. The favorable prior-year development represents the difference between estimates of the unpaid claims liability impacted by factors such as claims inventory, adjustments, trend rate, or denial rates and the actual experience that has since emerged. These factors were taken into consideration in setting reserve estimates in the prior year; however, actual claims experience was slightly lower than estimated.

The \$60.1 million decrease for claims incurred during the year ended September 30, 2022, is due to favorable development during the 2021 fiscal year. Approximately \$48.5 million of this amount is the normal release of explicit margins included as 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 claims inventory, adjustments, trend rates, or denial rates and the actual experience that has since emerged. These factors were taken into consideration in setting reserve estimates in the prior year; however, actual claims experience was slightly 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.

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 (\$160,200, as indexed for 2023). 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 (\$330,000, as indexed for 2023), 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, under 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 \$22,500 (\$30,000, if age 50 by year-end), as indexed for 2023. Effective June 1, 2023, the plan was amended to permit Roth deferrals and Roth conversions. 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 70½, 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 the annual base salary for the chief executive officer, and approximately 10% for all other officers. The plan has a three-year graded vesting schedule. 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 before 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 agreed 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 under 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 \$13.1 million and \$12.2 million in fiscal years 2023 and 2022, respectively, and this cost is included in administrative expenses.

8. ROU ASSETS (LEASES AND SUBSCRIPTIONS)

The Organization maintains various leases for buildings. Of these leases, none of the agreements call for variable payments. See Note 4 for a summary of changes in the ROU assets, displayed by the nature of underlying assets, for the years ended September 30, 2023 and 2022. See below for the lease liability activity for the years ended September 30, 2023 and 2022.

Lease liability activity for the year ended September 30, 2023, is summarized as follows (in thousands):

	Beginning Balance 2023	Additions	Modifications	Reductions	Ending Balance 2023	Amounts due within one year
Lease Liability	<u>\$ (71,211)</u>	<u>\$ 4,379</u>	<u>\$ _____</u>	<u>\$ 17,482</u>	<u>\$ (58,107)</u>	<u>\$ 16,334</u>

Lease liability activity for the year ended September 30, 2022, is summarized as follows (in thousands):

	Beginning Balance 2022	Additions	Modifications	Reductions	Ending Balance 2022	Amounts due within one year
Lease Liability	<u>\$ (78,646)</u>	<u>\$ (7,716)</u>	<u>\$ -</u>	<u>\$ 15,151</u>	<u>\$ (71,211)</u>	<u>\$ 13,204</u>

The principal and interest expense for the next five years and beyond are projected below for lease obligations (in thousands):

Fiscal Year	Principal	Interest	Total
2024	\$ 16,314	\$ 2,675	\$ 18,989
2025	10,733	4,415	15,148
2026	11,802	4,101	15,903
2027	12,026	3,743	15,769
2028	12,246	3,357	15,603
2029-2033	59,620	10,355	69,975
2034-2037	<u>21,385</u>	<u>904</u>	<u>22,289</u>
Total	<u>\$ 144,126</u>	<u>\$ 29,550</u>	<u>\$ 173,676</u>

The Organization entered into an additional building lease that has not yet commenced as of September 30, 2023. Term range is from 2024 to 2035 with a total future commitment of \$68.3 million. The Organization does not sublease any portions of various right-of-use building assets to third parties nor does the Organization have any leases where the Organization is the lessor.

The Organization maintains various subscriptions for software. Of these subscriptions, none of the agreements call for variable payments. See Note 4 for a summary of changes in the ROU assets, displayed by the nature of underlying assets, for the years ended September 30, 2023 and 2022. See below for the subscription liability activity for the years ended September 30, 2023 and 2022.

Long-term liability activity for the year ended September 30, 2023, is summarized as follows:

Placeholder for updated table

Long-term liability activity for the year ended September 30, 2022, as restated for GASB Statement No. 96 is summarized as follows:

Placeholder for updated table

The principal and interest expense for the next five years and beyond are projected below for lease obligations:

Placeholder for updated table

The Organization entered into additional subscriptions that have not yet commenced as of September 30, 2023. Term range is from 2024 to 2026 with a total future commitment of \$1.8 million. The Organization does not assign any portions of various right-of-use subscription assets to third parties nor does the Organization have any subscriptions where the Organization is the vendor.

9. COMMITMENTS AND CONTINGENCIES

Some of L.A. Care's provider reimbursement arrangements are complex and may be subject to differing interpretations of the amounts due to providers. This may lead Medi-Cal 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 several 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 \$55.2 million and \$9.7 million are recorded in other accrued Medi-Cal expenses line item in the combined statements of net position as of September 30, 2023 and 2022, respectively.

Grants Payable—On an annual basis, the Board approves various grants to be distributed as part of the Organization's Community Health Investment Funds. Grants totaling \$12.6 million and \$9.7 million were awarded in 2023 and 2022, respectively. As of September 30, 2023 and 2022, \$19.3 million and \$13.4 million of the total original grants remained unpaid, respectively.

Credit Concentration—As of and for the years ended September 30, 2023 and 2022, substantially all operating revenues and accounts receivable are related to contracts with the DHCS. Cancellation 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, 2023 and 2022.

10. 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 \$235.5 million and \$207.0 million on September 30, 2023 and 2022, respectively. Additionally, L.A. Care must maintain minimum investment amounts for the restricted use of the regulators, which totaled \$0.6 million on September 30, 2023, and \$0.6 million on September 30, 2022, and is included in noncurrent assets.

11. BOARD-DESIGNATED FUNDS

The Board has elected to designate a certain unrestricted net position as of September 30, 2023 and 2022, for the following (in thousands):

	Balance as of 2022	Contribution	Expenditure	Balance as of 2023
Safety net and uninsured programs	\$ 9,992	\$ 10,000	\$ 12,525	\$ 7,467
Workforce Development Initiative	72,826		14,520	58,306
Blue Shield Partnership	<u>22,004</u>	<u>14,000</u>	<u>17,153</u>	<u>18,851</u>
Designated by the Board	<u>\$ 104,822</u>	<u>\$ 24,000</u>	<u>\$ 44,198</u>	<u>\$ 84,624</u>
	Balance as of 2021	Contribution	Expenditure	Balance as of 2022
Safety net and uninsured programs	\$ 9,649	\$ 10,000	\$ 9,657	\$ 9,992
Workforce Development Initiative	62,063	31,000	20,237	72,826
Blue Shield Partnership	<u>20,029</u>	<u>14,000</u>	<u>12,025</u>	<u>22,004</u>
Designated by the Board	<u>\$ 91,741</u>	<u>\$ 55,000</u>	<u>\$ 41,919</u>	<u>\$ 104,822</u>

The Board approved the 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 Medi-Cal School Scholarships. The Board also approved certain strategic initiatives related to the 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.

12. SUBSEQUENT EVENTS

L.A. Care has evaluated subsequent events through December 21, 2023, 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, 2023

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, 2023, is as follows (dollars in millions):

	Actual	Budget	Variance
Revenues	\$ 11,290.8	\$ 10,165.3	\$ 1,125.5
Health care expenses	\$ 10,182.9	\$ 9,574.5	\$ (608.4)
Administrative expenses	\$ 532.0	\$ 590.8	\$ 58.8
Income from operations	\$ 575.9	\$	\$ 575.9
Nonoperating expense	\$ 70.0	\$ 80.7	\$ (10.7)
Increase in fund net position	<u>\$ 645.9</u>	<u>\$ 80.7</u>	<u>\$ 565.2</u>

L.A. Care’s Board approves an annual operating and capital expenditure budget before the beginning of each fiscal year. Typically, the revenue assumptions incorporated in the budget include the actual capitation rates from the Department of Health Care Services (DHCS) 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 changes in rates received from the DHCS after the budget is approved. 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 2023 budget was approved by the Board on September 1, 2022, which included additional funding for community programs.

Economic Factors and Next Year’s Budget and Rate

The most significant environmental impacts on our budget for the upcoming year stem from the end of the Public Health Emergency (PHE), along with the ongoing implementation of California Advancing and Innovating Medi-Cal (CalAIM) and related initiatives.

Medi-Cal

During the COVID-related PHE, Medi-Cal redeterminations had been suspended, meaning that people who might have lost coverage during their renewal period were kept on Medi-Cal. With the end of the

PHE, redeterminations are resuming. The Continuous Coverage unwinding period began on April 1, 2023 and continues through May 31, 2024 with disenrollment beginning July 1, 2023. We projected an annualized disenrollment rate of 13% for L.A. Care, a loss of about 350,000 members. In these initial months, our disenrollment has been in this range. The County is automatically renewing members for whom they have relevant information (e.g. they are enrolled in another income-eligible program) which will help mitigate membership loss. However, based on early experience, 55% of members still need to complete the renewal packet. L.A. Care is conducting extensive outreach in multiple ways to assist members with the renewal process.

Despite redetermination-related membership losses, new Medi-Cal membership will result from other policy changes. Most fee-for-service members have been converted to Medi-Cal managed care as specified by that CalAIM initiative. In addition, the state has expanded Medi-Cal to income-eligible unsatisfactory documentation status adults aged 26-49 beginning in 2024, meaning that unsatisfactory documentation status individuals of all ages who meet income requirements can now enroll in Medi-Cal.

During the past fiscal year, the state conducted its re-procurement process to select the commercial plans in Two-Plan model counties. Ultimately, Health Net was selected as the commercial plan for Los Angeles County, with Molina as a subcontracted plan. Although this represents status quo, the state has specified a 50-50 membership split between Health Net and Molina, dramatically changing the membership balance between the two plans. Details have not yet been solidified about how that membership assignment will occur. It is not clear how or whether this might affect L.A. Care's membership, but the new arrangement might lead to more robust competition for members. In addition, all Medi-Cal plans, including L.A. Care, will be subject to a new Medi-Cal contract with additional requirements.

The state's direct contract with Kaiser, beginning in 2024, will also affect L.A. Care's membership. Kaiser will no longer be L.A. Care's Plan Partner. L.A. Care will lose Kaiser's 284,000 members, along with the revenue and health care costs associated with those members. Removing Kaiser from L.A. Care's quality score calculation may affect our overall quality rating which in turn affects auto-assignment. Although Kaiser's members comprise a small fraction of L.A. Care's total membership, its quality ratings are very high.

L.A. Care continues to implement provisions of CalAIM, the state's Medi-Cal transformation which began in FY 2021-22. CalAIM's goals are 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. As described above, the transition of members from fee-for-service to managed care has been implemented, along with other major components such as Enhanced Care Management (ECM) and Community Supports (CS). The state is providing managed care plans with the opportunity to earn Incentive Payment Program (IPP) funding, which provides plans with incentive funding to support the development of strong ECM and CS networks. The state is also providing plans with the opportunity to earn Housing and Homeless Incentive Program (HHIP) funding to support treatment and services to homeless members.

L.A. Care is also expected to benefit from a proposed increase to Medi-Cal rates in the Governor's budget for FY 2023-24. The budget calls for the reinstatement of the Managed Care Organization (MCO) tax, which can be used to ensure that Medi-Cal rates are at 87.5% of Medicare rates. Although this is a welcome change, the California Safety Net Coalition is pursuing a ballot initiative for the

November 2024 election that would make this formula permanent, as budget proposals change with administrations and budget conditions.

L.A. Care Covered

The COVID-19 emergency has also affected Covered California and our L.A. Care Covered product. Most significantly, the Inflation Reduction Act continued the increased premium assistance provided by the American Rescue Plan through the end of 2025. In many cases, members pay little to no premiums. As price is a driver for members' plan selection, continuation of this assistance is important to L.A. Care and our current and prospective members.

Legislation from 2019, SB 260, created a process where people who lose Med-Cal coverage are automatically enrolled into Covered California qualified health plans. In most cases, people will be enrolled in the lowest cost silver plan in the member's rating region. L.A. Care has historically occupied that position so Medi-Cal membership loss may be partially offset by an L.A. Care Covered membership gain. It will be important for L.A. Care to maintain its lowest cost position for 2024 to benefit from this process.

Medicare

This fiscal year will complete the sun setting of Cal MediConnect, L.A. Care's previous product for dual-eligible members, replaced by our Dual Eligible Special Needs Plan (D-SNP), called L.A. Care Medicare Plus. Cal MediConnect members have been successfully transitioned to L.A. Care Medicare Plus and we are actively marketing to new members.

The Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model was extended for calendar years 2025 through 2030. The MA VBID model is a CMS demonstration program designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, including those with low incomes such as dual-eligible, and improve the coordination and efficiency of health care service delivery. L.A. Care received a provisional approval to include the proposed VBID benefit in 2024 benefit package.