



# AUDIT COMMITTEE MEETING

## BOARD OF GOVERNORS

December 21, 2022 • 11:00 AM

L.A. Care Health Plan

1055 W. 7<sup>th</sup> Street, Los Angeles, CA 90017



**ELEVATING  
HEALTHCARE**  
IN LOS ANGELES COUNTY  
SINCE 1997



**AGENDA**  
**Audit Committee Meeting**  
**Board of Governors**

**DRAFT**

Wednesday, December 21, 2022, 11:00 A.M.  
L.A. Care Health Plan, 1055 West 7<sup>th</sup> Street, Conference Room 1025, Los Angeles

Please recheck these directions for updates prior to the start of the meeting.

This meeting will be conducted in accordance with the provisions of the Ralph M. Brown Act, allowing members of the Board, members of the public and staff to participate in person and via teleconference, because State and Local officials are recommending measures to promote social distancing. Accordingly, members of the public should join this meeting in person and via teleconference as follows:

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

<https://lacare.webex.com/lacare/j.php?MTID=md536c802be044f5e0475da0f10dba8ed>

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

**Meeting Number: 2482 248 3274 Password: lacare**

Members of the Audit Committee or staff may participate in this meeting via teleconference. *The public is encouraged to submit public comments or comments on Agenda items in writing by e-mail to [BoardServices@lacare.org](mailto: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.

We continue to use different ways to submit public comment live and direct during the meeting.

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

Your comments can also be sent by voicemail, email or text. If we receive your comments by 11:00 am on December 21, 2022, it will be provided to the members of the Audit Committee 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 also include the name of the item to which your comment relates.**

Public comments submitted will be read for up to three minutes during the meeting.

Once the meeting has started, public comment must be received before the agenda item is called by the meeting Chair and staff will read those comments for up to three minutes. Chat messages submitted will be read for up to three minutes during the public comment period for each item. If your public comment is not related to any of the agenda item topics, your public comment will be read in the general public comment agenda item.

These are extraordinary circumstances, and the process for public comment is evolving and may change at future meetings. We thank you for your patience.

There may be some 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 in time for

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the specific agenda item you want to address, your public comments will be read at the public comment section prior to the closed session.

The purpose of public comment is that it is an opportunity for members of the public to inform the governing body about their views. The Board appreciates hearing the input as it considers the business on the Agenda.

**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](mailto:BoardServices@lacare.org).

**Welcome**

Alvaro Ballesteros, *Chair*

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

John Baackes  
*Chief Executive Officer*  
Marie Montgomery  
*Chief Financial Officer*

**Committee Issues**

6. Review of Audit Report FY 2021-22  
(AUD A) P.8

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

**Adjournment**

*Chair*

**The Audit 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 AUDIT 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](mailto: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 AUDIT COMMITTEE MEETS AS NEEDED. 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](mailto: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 <http://www.lacare.org/about-us/public-meetings/board-meetings> and can be requested by email to [BoardServices@lacare.org](mailto:BoardServices@lacare.org).

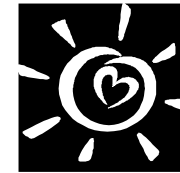
An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

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 4, 2022

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



**L.A. Care**  
HEALTH PLAN

**Members**

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

**Management/Staff**

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

**Guests**

Rosie Procopio, *Audit & Assurance Managing Director, Deloitte & Touche*

State and local officials continue to impose or recommend measures to promote social distancing to reduce transmission of the COVID 19 virus. It is prudent to use caution in protecting the health of the public, L.A. Care’s employees and its members where adequate virtual means exist to permit the meeting to occur by teleconference/videoconference with the public being afforded the ability to comment in real time. The Board of Governors and all legislative bodies of the L.A. Care Health Plan, and the Board of Directors and all legislative bodies of the Joint Powers Authority will continue to meet virtually and the Boards will review that decision on an on-going basis as provided in the Brown Act. Members of the public had the opportunity to listen to the meeting via teleconference, and share their comments via voicemail, email, or text.

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<p><b>CALL TO ORDER</b> Alvaro Ballesteros</p>	<p>On behalf of Alvaro Ballesteros, MBA, <i>Committee Chairperson</i>, who experience technical difficulty, Board Member Booth called to order the L.A. Care Audit Committee and the L.A. Care Joint Powers Authority Audit Committee meetings at 4:11 p.m. The meetings were held simultaneously. She 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>	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>The Chairperson will invite public comment before the Committee starts to discuss an item. If the comment is not on a specific agenda item, it will be read at the general Public Comment item 2 on today's agenda.</p> <p>Board Member Booth provided information on how to submit a public comment live and directly using the "chat" feature.</p>	
<p><b>APPROVE MEETING AGENDA</b></p> <p>Alvaro Ballesteros</p>	<p>Today's Agenda was approved as submitted.</p>	<p><b>Approved unanimously by roll call. 3 AYES (Ballesteros, Booth and Gonzalez)</b></p>
<p><b>PUBLIC COMMENT</b></p>	<p>There was no public comment.</p>	
<p><b>APPROVE MEETING MINUTES</b></p> <p>Alvaro Ballesteros</p>	<p>The December 13, 2021 meeting minutes were approved as submitted.</p>	<p><b>Approved unanimously by roll call. 3 AYES</b></p>
<p><b>CHAIRPERSON'S REPORT</b></p>	<p>There was no report from the Chairperson.</p>	
<p><b>CHIEF EXECUTIVE OFFICER/CHIEF FINANCIAL OFFICER REPORT</b></p>	<p>There was no CEO Report.</p> <p>Marie Montgomery, <i>Chief Financial Officer</i>, introduced Afzal Shah, <i>Deputy Chief Financial Officer</i>, and welcomed him to his first Audit Committee meeting.</p> <p>She also introduced Angela Bergman, <i>Controller</i>, and Doris Lai, <i>Senior Director, Accounting and Financial Services</i>.</p>	
<p><b>COMMITTEE ISSUES</b></p>		
<p>Presentation of Audit Plan for Fiscal Year 2021-22</p>	<p>Rosie Procopio, <i>Lead Client Service and Audit &amp; Assurance Partner, Deloitte &amp; Touche (D&amp;T)</i>, provided a summary of the Audit Plan for FY 2021-22.</p> <ul style="list-style-type: none"> <li>• Deloitte &amp; Touche presented the Audit Plan for FY 2021-22. (<i>Contact Board Services to obtain a copy of the plan.</i>)</li> </ul>	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<ul style="list-style-type: none"> <li>• The audit for FY 2020-21 went smoothly, as reported at the last meeting. Deloitte 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.</li> <li>• The proposed FY 2021-22 Audit process is adapted to changes within L.A. Care and macroeconomic environment to consider the impact of the evolving COVID-19 pandemic during preliminary risk assessment.</li> <li>• Annual debrief and assessment sessions were held with L.A. Care management and staff.</li> <li>• Discussed with management team the preliminary risk assessments. The level of claims incurred but not reported (IBNR) is still a significant risk.</li> <li>• D&amp;T issued a diversity and inclusion report. D&amp;T will continue to focus on quality, innovation and technology.</li> <li>• D&amp;T has the tools and a team that is analytic and technology driven, which increases the quality of work they do.</li> <li>• Other planned procedures will include: <ul style="list-style-type: none"> <li>○ Virtual control walkthroughs.</li> <li>○ Ongoing evaluation of nature and timing of procedures and use of audit technology.</li> <li>○ Continued evaluation of new accounting standards.</li> <li>○ Continue to communicate with management on a regular basis throughout the year for timely identification and resolution of accounting and other matters.</li> </ul> </li> </ul> <p>Board Member Booth asked about D&amp;T testing. Ms. Procopio responded that D&amp;T will test for risk and areas of adjustments.</p> <p>Ms. Procopio noted that the industry is experiencing high inflation rate (30-50%). The proposed Audit Fee for FY 2021-22 is \$404,895, excluding expenses.</p>	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<ul style="list-style-type: none"> <li>Accept Audit Plan for Fiscal Year 2021-22 (AUD A)</li> </ul>	<p><b><u>Motion AUD A.0822</u></b>  <b>To accept the Audit Plans of Deloitte &amp; Touche’s of L.A. Care’s financial statements for the fiscal year 2021-22, as presented, and authorize execution of the engagement letter.</b></p>	<p><b>Approved unanimously by roll call. 3 AYES</b></p>
<p><b>ADJOURNMENT</b></p>	<p>The Chair adjourned the meeting at 4:31 pm.</p>	

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

APPROVED BY:

\_\_\_\_\_  
Al Ballesteros, MBA, *Chairperson*  
Date Signed: \_\_\_\_\_

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**L.A. Care**  
HEALTH PLAN

**Board of Governors**  
**MOTION SUMMARY**

**Date:** December 21, 2022

**Motion No.** AUD A.1222

**Committee:** Audit

**Chairperson:** Alvaro Ballesteros

**Issue:** To accept the findings of the Deloitte & Touches' audit of L.A. Care's financial statements for the fiscal year ended September 30, 2022.

**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, 2022, as presented.





DATE: December 21, 2022  
TO: Audit Committee  
FROM: Marie Montgomery, *Chief Financial Officer*

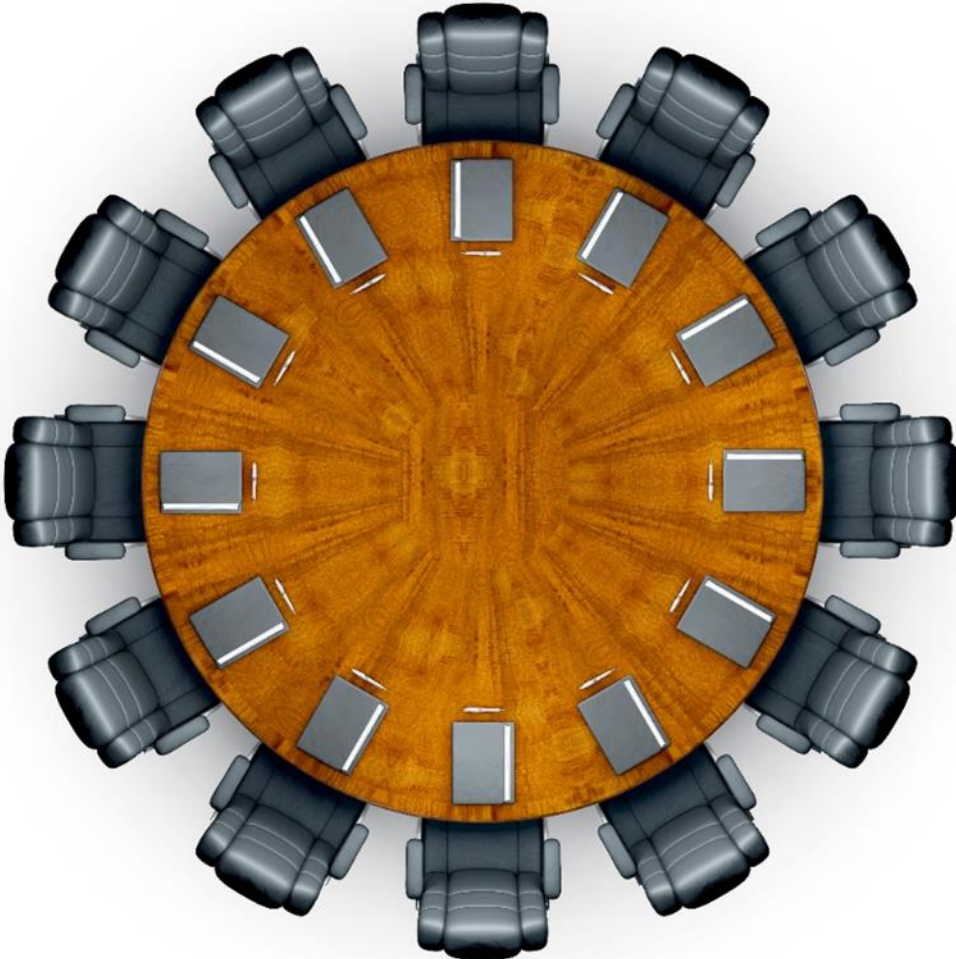
**SUBJECT: Fiscal Year 2021-22 Financial Audit**

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

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

To help navigate through the material, the following key areas are prioritized for 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 2022 Audit

December 23, 2022

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

Dear Members of the Audit Committee:

We have performed an audit of the combined financial statements of Local Initiative Health Authority for Los Angeles County, dba L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (collectively, the “Organization”) as of and for the year ended September 30, 2022, in accordance with auditing standards generally accepted in the United States of America (“generally accepted auditing standards”) and expect to issue our report thereon dated December 23, 2022.

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

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

Yours truly,

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

## Our Responsibility under Generally Accepted Auditing Standards

Our responsibility under generally accepted auditing standards has been described in our engagement letter dated September 9, 2022. As described in that letter, our responsibilities under generally accepted auditing standards include forming and expressing an opinion about whether the combined financial statements that have been prepared by management with the oversight of the Audit Committee 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 combined financial statements does not relieve management or the Audit Committee of their responsibilities. We considered internal control relevant to the Organization’s preparation of the combined financial statements in order to design audit procedures that were appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization’s internal control.

## Significant Accounting Policies

The Organization’s significant accounting policies are set forth in Note 2 to the Organization’s 2022 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, 2022.

In 2022, the Organization adopted the following Governmental Accounting Standards Board (GASB) statements as disclosed in Note 2:

- GASB Statement No. 87, *Leases*
- GASB Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans*
- GASB Statement No. 98, *The Annual Comprehensive Financial Report*
- 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:

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

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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.

	2022	2021
IBNR (in millions)	\$784.4	\$643.2

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

Our audit of the combined financial statements was designed to obtain reasonable, rather than absolute, assurance about whether the combined financial statements are free of material misstatement, whether caused by error or fraud.

We have attached to this letter, as Appendix A, the draft management representation letter which includes as items number 5 and 6, a prior year uncorrected misstatement identified by management in the current year and a disclosure item passed, respectively, that were determined by management to be immaterial, both individually and in the aggregate, to the combined financial statements taken as a whole.

Fee-for-service medical claims expense was tested using statistical or other sampling techniques and certain errors in recording fee-for-service medical claims expense as of September 30, 2022 were found in the sample items selected. The effect of the known errors identified is not material. However, the mathematical projection of the likely errors, which results in a potential overstatement of \$3.4 million and a potential understatement of \$12.8 million, for net potential misstatement of \$9.4 million. This potential misstatement is also included in Appendix A as number 7. Such potential unrecorded errors were determined by management to be immaterial to the combined 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 combined financial statements for the year ended September 30, 2022.

## Material Corrected Misstatements

Our audit of the combined financial statements was designed to obtain reasonable, rather than absolute, assurance about whether the combined 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 2022 combined 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 2022.

## Significant Findings or Issues Arising from the Audit Discussed, or Subject of Correspondence, with Management

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

## Significant Difficulties Encountered in Performing the 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 combined 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 A, those representations we will request from management.

APPENDIX A

MANAGEMENT REPRESENTATION LETTER (DRAFT)

December 23, 2022

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

We are providing this letter in connection with your audits of the combined financial statements of the L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (collectively "L.A. Care" or the "Organization"), which comprise the combined statements of net position as of September 30, 2022 and 2021, and the related combined statements of revenues, expenses, and changes in net position and cash flows, and the related notes to the combined financial statements (the "financial statements"), for the purpose of expressing an opinion as to whether the financial statements present fairly, in all material respects, the financial position, results of operations, and cash flows of the Organization in accordance with accounting principles generally accepted in the United States of America (GAAP).

We confirm that we are responsible for the following:

- a) The preparation and fair presentation in the financial statements of net position, statements of revenues, expenses, and changes in fund net position, and cash flows in conformity with 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 conformity with GAAP.
  - 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 GASB Statement No. 84, Fiduciary Activities, as amended.
  - c. The financial statements properly classify all activities, including special and extraordinary items.



- 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 category of custodial credit risk.
  - f. Capital assets are properly capitalized, reported, and, if applicable, depreciated.
  - g. Required supplementary information is measured and presented within prescribed guidelines; and
  - 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.
2. The Organization has provided to you all relevant information and access as agreed in the terms of the audit engagement letter.
3. The Organization has made available to you:
- a. All financial records and related data. The records, books, and accounts, as provided to you, record the financial and fiscal operations of all activities administered by the Organization and provide the audit trail to be used in a review of accountability. Information presented in financial reports is supported by the books and records from which the financial statements have been prepared
  - b. All minutes of the meetings of the Board of Governors and its committees, or summaries of actions of recent meetings for which minutes have not yet been prepared
  - c. Contracts and grant agreements (including amendments, if any) and other correspondence that has taken place with federal agencies
  - d. All reports and information from peer review organizations, fiscal intermediaries, third-party payers, and recovery audit contractors
4. There has been no:
- a. Actions taken by Organization management that contravenes the provisions of federal laws and California laws and regulations, or of contracts and grant applicable to the Organization; and
  - b. Communications (oral or written) from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud

and abuse statutes), deficiencies in financial reporting practices or other matters that could have more than an inconsequential effect on the financial statements.

5. We believe the effects of the uncorrected financial statement misstatement detected in the current year that relates 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, 2021 taken as a whole. During the year ended September 30, 2022, the Organization identified an overstatement of their estimate for the patient-centered outcomes research trust fund fees in the amount of \$20.7 million resulting in the prior year overstatement of accounts payable and accrued liabilities and administrative expense. Management has identified and corrected the misstatement during the year ended September 30, 2022.
6. 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.
7. We understand fee-for-service medical claims was tested using statistical or other sampling techniques and that certain errors in recording fee-for-service medical claims as of September 30, 2022, were found by you in the sample items selected. The effect of the factual errors identified are not material to the financial statements as a whole. We understand that to estimate the total amount of errors in fee-for-service medical claims, a mathematical projection of the errors has been computed, which results in a potential overstatement of \$3.4 million and a potential understatement of \$12.8 million, for net potential understatement of \$9.4 million for the year ended September 30, 2022. Only additional testing and verification by either the Organization or you would produce a more accurate estimate of the errors within fee-for-service medical claims. Based on our judgment of the materiality of the misstatement, we believe the effects of such potential unrecorded errors are immaterial to the financial statements taken 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. 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.
10. We have no knowledge of any fraud or suspected fraud affecting the Organization involving:
  - a. Management;
  - b. Employees who have significant roles in the Organization's internal control over financial reporting; and

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

11. We have no knowledge of any allegations of fraud or suspected fraud affecting the Organization received in communications from employees, former employees, regulators, or others.
12. There are no unasserted claims or assessments that we are aware of or that legal counsel has advised us are probable of assertion and must be disclosed in accordance with GASB Codification of Governmental Accounting and Financial Reporting Standards ("GASB Codification") Section C50, *Claims and Judgments*.
13. 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.
14. Significant assumptions used by us in making accounting estimates are reasonable.
15. 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*, and GASB Statement No. 84, *Fiduciary Activities*, as amended. No organizations or activities were identified that meet the criteria established in GASB Codification Section 2100, *Defining the Financial Reporting Entity*, and GASB Statement No. 84, *Fiduciary Activities*, as amended.
16. 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, 2022.
17. 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.
18. 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.
19. The financial statements include the accounts of the Local Initiative Health Authority for Los Angeles County, dba L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority. The financial statements of L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority are combined as entities under common control, whereby JPA is considered a non-significant component unit of L.A. Care. All intercompany transactions have been eliminated.
20. During the year ended September 30, 2022, there were no significant changes in previously adopted accounting policies or their application, other than those disclosed in the financial statements.
21. 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, 2022 and 2021.

22. The Organization has recorded certain investment pools measured at amortized costs as of September 30, 2022. 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.
23. The Organization has not completed the process of evaluating the impact that will result from adopting GASB Statement No. 87, *Leases*, 96, *Subscription-Based Information Technology Arrangements*, 97, *Certain Component Unit Criteria, And Accounting and Financial Reporting for Internal Revenue Section 457 Deferred Compensation Plans*, 98, *The Annual Comprehensive Financial Report*, 99, *Omnibus 2022*, 100, *Accounting Changes and Error Corrections*, and 101, *Compensated Absences*. 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 statement is adopted.

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

24. There are no transactions that have not been properly recorded and reflected in the financial statements, except as noted at item 5 above.
25. The Organization has no plans or intentions that may affect the carrying value or classification of assets and liabilities.
26. Regarding related parties:
  - a. We have disclosed to you the identity of the related parties and all the related party relationships and transactions of which we are aware.
  - b. To the extent applicable, related parties and all the related-party relationships and transactions, including sales, purchases, loans, transfers, leasing arrangements, and guarantees (written or oral) have been appropriately identified, properly accounted for, and disclosed in the financial statements.
27. In preparing the financial statements in accordance with GAAP, management uses estimates. All estimates have been disclosed in the financial statements for which known information available prior to the issuance of the financial statements indicates that both of the following criteria are met:
  - a. It is reasonably possible that the estimate of the effect on the financial statements of a condition, situation, or set of circumstances that existed at the date of the financial statements will change in the near term due to one or more future confirming events; and
  - b. The effect of the change would be material to the financial statements.
28. 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, 2022.
  - 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.
29. 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.
30. Regarding the required supplementary information:
- a. We confirm that we are responsible for the required supplementary information.
  - b. The required supplementary information is measured and presented in accordance with the guidelines prescribed by the Governmental Accounting Standards Board.
  - c. The methods of and significant assumptions underlying the measurement and presentation of the supplementary information have not changed from those used in the prior period.
31. 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.

32. The Organization has complied with all aspects of contractual agreements that may affect the financial statements.
33. With regard to the fair value measurements and disclosures of certain assets, liabilities, and specific components of equity, we believe that:
  - a. The measurement methods, including the related assumptions used in determining fair value, were appropriate consistent with market participant assumptions where available without undue cost and effort, and were consistently applied in accordance with GAAP.
  - b. The completeness and adequacy of the disclosures related to fair values are in accordance with GAAP.
  - c. No events have occurred subsequent to September 30, 2022, but before December 23, 2022, 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.
34. Financial instruments with significant individual or group concentration of credit risk have been appropriately identified, properly recorded, and disclosed in the financial statements.
35. Arrangements with financial institutions involving compensation balances or other arrangements involving restrictions on cash balances, line of credit, or similar arrangements have been properly disclosed in the financial statements.
36. We have disclosed to you any change in the Organization's internal control over financial reporting that occurred during the Organization's most recent fiscal year ended September 30, 2022 that has materially affected, or is reasonably likely to materially affect, the Organization's internal control over financial reporting.
37. Management has disclosed all communications from the Organization's third-party service organizations relating to noncompliance with the Organization's operations at those service organizations.
38. 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, 2022. There were no changes in

methodologies and processes used to calculate the reserves for claims incurred but not reported during fiscal year 2022 and as of September 30, 2022.

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

a. For the year ended September 30, 2022, we have processed claims received by the Organization in a manner and timing consistent with prior years, except as discussed with and provided to you.

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

- i. Anticipated and historical claims experience of the Organization
- ii. Anticipated and historical claims experience of the health care industry
- iii. Expected impact of inflation and other economic or social factors on future payments of losses incurred at the balance-sheet date, including the impact of COVID-19
- iv. Lines and geographical locations of the business written and assumed by the Organization
- v. The Organization's claims policies and procedures
- vi. The timeliness and reliability of reports from reinsurers
- vii. Estimates of claim recoveries, exclusive of reinsurance recoveries.

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

d. The reserve for unpaid claims and claims adjustment expenses for the Organization as of September 30, 2022 is management's best estimate and makes a reasonable provision for all reported and unreported claims incurred as of September 30, 2022 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, 2022 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.

40. 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, 2022, management believes that no accrual is necessary, as the Organization's minimum ratios are all expected to exceed the statutory minimums, and that actual results will not differ materially from the established estimate.
41. 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.
42. 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.
43. We have disclosed to you all new provisions or changes to the existing pension, other post-retirement benefit, 401a, and deferred compensation.
44. 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.
45. As of September 30, 2022, 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.
46. 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.
47. 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.
48. 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.



49. 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 \$9.7 million and \$3.2 million are recorded in other accrued medical expenses line item in the combined statements of net position as of September 30, 2022 and 2021, respectively.
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, 2022.
51. 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.
52. 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, 2022 based on the facts and circumstances at that date.
53. 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.
54. 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.
55. We believe that all expenditures that have been deferred to future periods are recoverable.
56. 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, 2022 or 2021.

57. 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, 2022.

58. Management asserts the following related to the amounts estimated and recorded as of September 30, 2022, related to the permanent risk adjustment program enacted by the Affordable Care Act:

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

b. Management asserts that the encounter data for the year ended September 30, 2022 that we provided to the third-party vendor for use in their final report is accurate and complete. We are not aware of any data issues that would indicate that this encounter data is incomplete.

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

59. 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.

60. No events have occurred after September 30, 2022, but before December 23, 2022, the date the financial statements were available to be issued that required consideration as adjustments to, or disclosures in, the financial statements or related notes.

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John Baackes  
Chief Executive Officer

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Marie Montgomery  
Chief Financial Officer

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Afzal Shah  
Deputy Chief Financial Officer

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

Combined Financial Statements and Management's  
Discussion and Analysis as of and for the Years Ended  
September 30, 2022 and 2021, Required Supplementary  
Information for the Year Ended September 30, 2022, 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, 2022 AND 2021

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### 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, 2022 and 2021, was 1,100,962 and 1,060,712 enrollees, respectively.

L.A. Care’s MCLA program is designed to complement the existing Plan Partners network. L.A. Care receives from DHCS a fixed payment PMPM, and fixed case rates for maternity cases for each eligible birth, hepatitis C, institutional members, enrolled HHP, and qualified members receiving BHT. Starting January 1, 2022, DHCS will no longer pay Hepatitis C and BHT on fixed case rates, rather the costs are included in the monthly base rate. L.A. Care contracts directly with participating physician provider groups (PPGs), hospitals, primary care, and specialty care physicians, and other ancillary professionals for health care services.

Substantially, all PPGs in the MCLA health care network are reimbursed on a PMPM capitated basis. PPG capitation rates may include or exclude hospital services. The network hospital contracts are on a

nonexclusive basis and provide for reimbursement on a per diem, case rate, a percentage of the hospital billed charges, or capitated bases. Certain physicians are reimbursed on a fee-for-service basis. The MCLA program is available to all eligible Medi-Cal beneficiaries in the County, with the same health care benefits as provided by the Plan Partners. Under the Patient Protection and Affordable Care Act (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 income-eligible undocumented individuals aged 50 and over beginning May 1, 2022. As of September 30, 2022 and 2021, MCLA membership was 1,439,026 and 1,234,616 enrollees, respectively.

The State also implemented the Medi-Cal Pharmacy transition in January 2022, shifting responsibility from health plans to the State and administered by its pharmacy vendor.

### **Cal MediConnect**

Coordinated Care Initiative (CCI) began as a three-year pilot program developed jointly with California's DHCS to coordinate medical care, behavioral health, and long-term services and supports (LTSS), which includes institutional long-term care, home, and community-based services, and other support services to individuals who are fully eligible for Medicare and Medi-Cal benefits or "dual eligible" as well as to all Medi-Cal-only individuals or "non-duals" who rely on LTSS services. The Cal MediConnect (CMC) program is one of the components of CCI, which includes the mandatory enrollment of dual eligible members and integrated LTSS; however, the IHSS benefit was removed from the program as of January 1, 2018. As of September 30, 2022 and 2021, the dual-eligible CCI membership, including MCLA and Plan Partners, was 249,175 and 236,330 enrollees, respectively.

L.A. Care's CMC program was launched in May 2014. CMC members are those who qualify for both Medicare and Medi-Cal. 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. As of September 30, 2022 and 2021, CMC membership was 17,001 and 18,733 enrollees, respectively.

### **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 Federal poverty level 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 towards 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 federal poverty level. 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, 2022 and 2021, LACC membership was 112,357 and 101,412, 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 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, 2022 and 2021, PASC-SEIU membership was 49,851 and 50,948 enrollees, respectively.

### **Other Medi-Cal Programs**

Effective July 1, 2019, L.A. Care launched the Home Health Program (HHP) for eligible members with multiple chronic conditions who are frequent utilizers of medical services and may benefit from enhanced care management and coordination. 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 ECM which replaces the HHP and Whole Person Care, Community Supports (CS) and the Major Organ Transplant (MOT) benefit.

Community Supports are services provided by Managed Care Plans (MCPs) to eligible Medi-Cal members to meet their social needs, including medically supportive foods or housing supports. These new services are

cost effective alternatives to traditional medical services or settings and are designed to address social drivers of health. There are 14 pre-approved 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 Medically 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 fee-for-service (FFS) to transition to and enroll in a Medi-Cal managed care plan.

**Risk Corridors** – Risk Corridor 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 medical expenses compared to premium revenues as it pertains to these programs. Medical 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 medical 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 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, 2022 and 2021.

**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 healthcare programs. The DHCS pays a PMPM rate for this program for all eligible Medi-Cal members. L.A. Care is required by the DHCS to make directed payments for qualifying services to eligible network providers and is at risk for these payments.

The Prop 56 program was effective on July 1, 2017, on a state fiscal year basis and was expanded to additional qualifying services beginning July 1, 2018. 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 healthcare 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 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 Highlights

As COVID-19 outbreaks continue to evolve, the US Department of Health and Human Services has repeatedly renewed the Public Health Emergency (PHE) since implementing it in January 2020. The PHE is currently set to expire on January 11, 2023. The end date of the PHE will have significant implications on Medi-Cal enrollees as it will end the continuous enrollment requirement, the redetermination process will resume, and disenrollment will begin. Based on DHCS' estimates, approximately 2 to 3 million beneficiaries statewide will lose coverage. L.A. Care is projecting a 13% decrease in enrollment over a 14-month period once the disenrollment process resumes.

As a result of the suspension of redetermination process by DHCS and the mandatory managed care enrollment provision, L.A. Care continued to experience increased Medi-Cal enrollment in FY 21-22. Additionally, L. A. Care is projecting to enroll another 104,000 members due to the mandatory managed care enrollment in January 2023.

Our Medi-Cal membership has also grown as a result of the State's expansion of Medi-Cal to include income-eligible undocumented individuals aged 50 and over beginning May 1, 2022. We received a large membership increase in July 2022 and while growth will obviously not continue at that pace, membership growth is expected to continue as undocumented residents age into eligibility. The Governor also signed SB 184, that will expand Medi-Cal to undocumented residents aged 26-49 who are income-eligible and will be in effect in January 2024. L.A. Care is projecting to enroll 140,000 newly eligible beneficiaries. Once this takes effect, all income-eligible residents will be Medi-Cal eligible regardless of immigration status, making universal access to healthcare coverage a reality. Also effective in January 2024, our Medi-Cal membership will be reduced because of AB 2724, which allows DHCS to contract directly with Kaiser for Medi-Cal managed care. L.A. Care will lose Kaiser's 250,000 members, along with the revenue associated with those members.

DHCS implemented the COVID-19 vaccination incentive program for the service period of September 1, 2021 through February 28, 2022 to incentivize COVID-19 vaccination efforts for the Medi-Cal enrollees. Managed Care Plans (MCPs) are eligible to earn incentive payments for activities that are designed to close vaccination gaps with their enrolled members. The program includes direct member vaccine incentives and process and outcome measures incentives. Direct member vaccine incentives are earned based on Medi-Cal members get a gift card after receiving their first dose of a COVID-19 vaccine. The process and outcome measures are earned based on achievement of process measure and outcome measures specified by DHCS. L.A. Care participated in the COVID-19 incentive program in FY 21-22 and will continue to promote the benefits of vaccination to its members upon the conclusion of the COVID-19 vaccination program.

Other significant changes in FY 21-22 are the implementation of ECM, CS and MOT benefits in January 2022. In order to support the implementation and expansion of ECM and CS programs, DHCS has implemented a CalAIM Incentive Payment Program (IPP) by incentivizing managed care plans to invest in building provider capacity and delivery system infrastructure. Managed Care Plans (MCPs) will only be eligible to receive incentive payments by fulfilling all the requirements of the program. With the aim of meeting the goals and achieving the measures of the program, L.A. Care has been deploying the incentive payments to fund our

ECM and CS providers to support capacity building and infrastructure development. In March 2022, DHCS approved our IPP Program Year 1 Payment 1 submission of which payment was received in April 2022. The financial impact of the IPP, which includes the incentive revenues and the related healthcare and administrative expenses, is included in our FY 21-22 financial results.

In January 2022, the California HCBS Spending Plan, including the Housing and Homelessness Incentive Program (HHIP), was approved by CMS. The HHIP aims to reduce and prevent homelessness by ensuring plans have capacity and partnerships to connect their members to housing services. Medi-Cal managed care plans are able to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. L.A. Care is participating in this program and the Local Homelessness Plan was approved by DHCS. 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, 2022, as compared to the fiscal year ended September 30, 2021:

- Total revenue decreased by \$197.9 million, or 2.1%, to \$9.0 billion. The decrease in revenue is driven by the reconciliations of the Prop 56 risk corridor for State Fiscal Year (SFY) 18-19 through September 2022, which resulted in a reduction of \$530.7 million in revenues. The previously accrued liability due to providers for Prop 56 is now a payable due to DHCS under the risk corridor provision. Another driving factor is the \$474.4 million decrease in revenue related to the pharmacy care-out effective January 1, 2022. Partially offsetting these decreases is an increase in member months of 2.3 million resulted in an increase in revenue of \$703.8 million, primarily in Medi-Cal.
- Total health care expenses decreased by \$166.3 million, or 1.9%, to \$8.4 billion. The decrease is primarily due to the Prop 56 reconciliations and the pharmacy care-out as discussed in the revenue section above. The impact of Prop 56 reconciliations resulted in a \$501.1 million reduction in capitation expenses and the pharmacy carve-out resulted in a \$491.9 million decrease in pharmacy expenses. However, mitigating these decreases is the increase in member months which drove an increase in capitation expenses of \$370.1 million and higher fee-for-service claims of \$437.0 million.
- Administrative expenses increased by \$39.4 million, or 8.4%, to \$509.5 million for the year ended September 30, 2022, from \$470.1 million a year ago. The increase is primarily driven by regulatory fines of \$55 million but offset in part by an adjustment to a governmental fee for Patient-Centered Outcomes Research Institute (PCORI) of \$22.5 million.
- L.A. Care investment and interest income decreased by \$24.6 million year-over-year. For the year ended September 30, 2022, total unrealized and realized losses net of interest income is a loss of \$21.3 million as compared to a net investment income of \$3.3 million in the prior year. Interest income increased by \$5.9 million from \$11.2 million to \$17.1 million year-over-year due to higher interest rates. Investment losses increased \$30.5 million from \$8.0 million to \$38.5 million driven by the lower market value of L.A. Care's portfolio due to higher interest rates at fiscal year-end 2022 as compared with 2021.
- "Increase in net position" decreased by \$95.1 million to a net surplus of \$37.8 million for the year ended September 30, 2022, as compared with a net surplus of \$132.9 million as of September 30, 2021.
- During the reporting year, L.A. Care received \$1.9 billion proceeds and disbursed \$1.8 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 generally accepted accounting principles, including GASB pronouncements.

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

**Net Investment in Capital Assets**—This component of net position consists of capital assets, including restricted capital 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 2022 increased by 8.2% as compared to the prior year. The member month data and the percentage change in member months for the years ended September 30, 2022 and 2021, are as follows:

### Member Months by Product Line (in thousands)

	2022	2021	Changes	
			Member Months	Percentage
Medi-Cal:				
Plan Partners	13,091.1	12,441.7	649.4	5.2 %
Medi-Cal Direct	<u>15,764.7</u>	<u>14,287.9</u>	<u>1,476.8</u>	10.3 %
Total Medi-Cal	<u>28,855.8</u>	<u>26,729.6</u>	<u>2,126.2</u>	8.0 %
Other Lines of Business:				
Cal MediConnect	214.5	223.3	(8.8)	(3.9)%
PASC-SEIU	604.5	616.9	(12.4)	(2.0)%
LA Care Covered ( <i>on and off exchange</i> )	<u>1,339.0</u>	<u>1,098.0</u>	<u>241.0</u>	21.9 %
Total Other Lines of Business	<u>2,158.0</u>	<u>1,938.2</u>	<u>219.8</u>	11.3 %
Total member months	<u>31,013.8</u>	<u>28,667.8</u>	<u>2,346.0</u>	8.2 %

L.A. Care’s combined ending membership as of September 30, 2022, increased by 10.2% as compared to September 30, 2021. The membership data and the percentage change in membership for the years ended September 30, 2022 and 2021, are as follows:

	2022	2021	Changes	
			Membership	Percentage
Medi-Cal:				
Plan Partners	1,101.0	1,060.7	40.3	3.8 %
Medi-Cal Direct	<u>1,439.0</u>	<u>1,234.6</u>	<u>204.4</u>	16.6 %
Total Medi-Cal	<u>2,540.0</u>	<u>2,295.3</u>	<u>244.7</u>	10.7 %
Other Lines of Business:				
Cal MediConnect	17.0	18.7	(1.7)	(9.1)%
PASC-SEIU	49.8	51.0	(1.2)	(2.4)%
LA Care Covered ( <i>on and off exchange</i> )	<u>112.4</u>	<u>101.4</u>	<u>11.0</u>	10.8 %
Total Other Lines of Business	<u>179.2</u>	<u>171.1</u>	<u>8.1</u>	4.7 %
Total membership:	<u>2,719.2</u>	<u>2,466.4</u>	<u>252.8</u>	10.2 %

## Financial Position

### Condensed Combined Statements of Net Position (dollars in millions)

	As of September 30		Changes	
	2022	2021	Dollar	Percentage
<b>Assets:</b>				
Total current assets	\$ 5,663.5	\$ 4,782.4	\$ 881.1	18.4 %
Capital assets - net	98.7	105.9	(7.2)	(6.8)%
Noncurrent assets	2.1	3.5	(1.4)	(40.0)%
<b>Total Assets:</b>	<b>\$ 5,764.3</b>	<b>\$ 4,891.8</b>	<b>\$ 872.5</b>	<b>17.8 %</b>
Deferred Outflow of Resources	\$	\$	\$	
<b>Liabilities:</b>				
Total current liabilities	\$ 4,603.0	\$ 3,824.4	\$ 778.6	20.4 %
Deferred rent	1.6	3.4	(1.8)	(52.9)%
<b>Total Liabilities:</b>	<b>4,604.6</b>	<b>3,827.8</b>	<b>776.8</b>	<b>20.3 %</b>
Deferred Inflow of Resources	\$ 72.4	\$ 14.5	\$ 57.9	399.0 %
<b>Net Position:</b>				
Invested in capital assets	98.7	105.9	(7.2)	(6.8)%
Restricted	0.6	0.6	0.0	-
Unrestricted				
Designated by Board of Governors	104.8	91.7	13.1	14.3 %
Minimum tangible net equity	207.0	200.8	6.2	3.1 %
Unrestricted	676.2	650.5	25.7	4.0 %
<b>Total Net Position:</b>	<b>1,087.3</b>	<b>1,049.5</b>	<b>37.8</b>	<b>3.6 %</b>
<b>Total</b>	<b>\$ 5,764.3</b>	<b>\$ 4,891.8</b>	<b>\$ 872.5</b>	<b>17.8 %</b>

**Net Position**—L.A. Care’s net position increased by \$37.8 million to \$1.1 billion as of September 30, 2022. The increase was primarily due to the income from operations of \$86.1 million which was reduced by the non-operating expense of \$48.3 million.

**Current Assets and Liabilities**—Current assets increased by \$881.1 million to \$5.7 billion as of September 30, 2022. The increase was primarily driven by an increase in cash and cash equivalents and Investments of \$109.9 million driven by the timing of the Private and Public Hospital Directed payment program, capitation receivable of \$360.0 million and Plan Partner receivable of \$319.3 million which was included in other current assets.

Current liabilities increased by \$778.6 million to \$4.6 billion as of September 30, 2022. The increase was primarily driven by Prop 56 risk corridor payable of \$286.4 million, an increase in payable of \$186.6 million due to the timing of the Private and Public Hospital Directed payment program, an increase in Reserve for Claims of \$141.2 million, an increase in Prop 56 provider payable of \$79.0 million, and an increase in capitation payable of \$30.6 million.

## Results of Operations

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

	Years Ended September 30		Changes	
	2022	2021	Dollar	Percentage
Revenues	\$ 9,012.2	\$ 9,210.1	\$ (197.9)	(2.1)%
Health care expenses	8,416.6	8,582.9	(166.3)	(1.9)%
Administrative expenses	<u>509.5</u>	<u>470.1</u>	<u>39.4</u>	8.4 %
Income from operations	86.1	157.1	(71.0)	(45.2)%
Investment and interest (loss) income	(21.3)	3.3	(24.6)	(745.5)%
Community grants	(38.0)	(37.9)	(0.1)	0.3 %
Gross Premium Tax	<u>11.0</u>	<u>10.4</u>	<u>0.6</u>	5.8 %
Increase in Net Position	37.8	132.9	(95.1)	(71.6)%
Beginning Net Position	<u>1,049.5</u>	<u>916.6</u>	<u>132.9</u>	14.5 %
Ending Net Position	<u>\$ 1,087.3</u>	<u>\$ 1,049.5</u>	<u>\$ 37.8</u>	3.6 %

- Total revenue decreased by \$197.9 million, or 2.1%, to \$9.0 billion. The decrease in revenue is driven by the reconciliations of the Prop 56 risk corridor for SFY 18-19 through September 2022, which reduces \$530.7 million in revenues. The previously accrued liability due to providers for Prop 56 is now a payable due to DHCS under the risk corridor provision. Another driving factor is the \$474.4 million decrease in revenue related to the pharmacy carve-out effective January 1, 2022. Partially offsetting these decreases is an increase in member months of 2.3 million resulted in an increase in revenue of \$703.8 million, primarily in Medi-Cal.
- Total health care expenses decreased by \$166.3 million, or 1.9%, to \$8.4 billion. The decrease is primarily due to the Prop 56 reconciliations and the pharmacy carve-out as discussed in the revenue section above. The impact of Prop 56 reconciliations resulted in a \$501.1 million reduction in capitation expenses and the pharmacy carve-out resulted in a \$491.9 million decrease in pharmacy expenses. However, mitigating these decreases is the increase in member months which drove an increase in capitation expenses of \$370.1 million and higher fee-for-service claims of \$437.0 million.
- Administrative expenses increased by \$39.4 million, or 8.4%, to \$509.5 million for the year ended September 30, 2022, from \$470.1 million a year ago. The increase is primarily driven by regulatory fines of \$55 million but offset in part by an adjustment to a governmental fee for Patient-Centered Outcomes Research Institute (PCORI) of \$22.5 million.
- L.A. Care investment and interest income decreased by \$24.6 million year-over-year. For the year ended September 30, 2022, total unrealized and realized losses net of interest income is a loss of \$21.3 million as compared to a net investment income of \$3.3 million in the prior year. Interest income increased by \$5.9 million from \$11.2 million to \$17.1 million year-over-year due to higher interest rates. Investment

losses increased \$30.5 million from \$8.0 million to \$38.5 million driven by the lower market value of L.A. Care's portfolio due to higher interest rates at fiscal year-end 2022 as compared with 2021.

- "Increase in net position" decreased by \$95.1 million to a net surplus of \$37.8 million for the year ended September 30, 2022, as compared with a net surplus of \$132.9 million for the year ended September 30, 2021.
- During the reporting year, L.A. Care received \$1.9 billion proceeds and disbursed \$1.8 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.

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## Summary of Cash Flows

The major sources and uses of cash and cash equivalents for the years ended September 30, 2022 and 2021, 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	
	2022	2021	Dollar	Percentage
Net cash (used in) provided by operating activities	\$ (10.5)	\$ 275.4	\$ (285.9)	(103.8)%
Net cash provided by investing activities	76.6	44.9	31.7	70.6 %
Net cash provided by (used in) financing activities	182.4	(474.3)	656.7	138.5 %
Net increase (decrease) in cash and cash equivalents	248.5	(154.0)	402.5	261.4 %
Cash and cash equivalents — beginning of year	990.9	1,144.9	(154.0)	(13.5)%
Cash and cash equivalents — end of year	\$ 1,239.4	\$ 990.9	\$ 248.5	25.1 %

Total cash and cash equivalents increased by \$248.5 million, or 25.1%, to \$1.2 billion for the year ended September 30, 2022.

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

An increase in cash from investing activities compared to the prior year was due to an increase in net purchases of investment in securities compared to the prior fiscal year.

An increase in cash from financing activities compared to the prior year was due to cash received for the Private and Public Hospital Directed Payments Program of \$616.6 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, 2022 and 2021, 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, 2022 and 2021, 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 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 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 42–44 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.

[Signature]

December 23, 2022

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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**

**COMBINED STATEMENTS OF NET POSITION  
 AS OF SEPTEMBER 30, 2022 AND 2021  
 (In thousands)**

	<u>2022</u>	<u>2021</u>
<b>ASSETS</b>		
CURRENT ASSETS:		
Cash and cash equivalents	\$ 1,239,407	\$ 990,897
Investments—at fair value	1,085,262	1,223,897
Capitation receivable	2,824,384	2,464,340
Other current assets	<u>514,415</u>	<u>103,304</u>
Total current assets	5,663,468	4,782,438
CAPITAL ASSETS—Net	98,723	105,915
NONCURRENT ASSETS	<u>2,129</u>	<u>3,523</u>
TOTAL ASSETS	<u>\$ 5,764,320</u>	<u>\$ 4,891,876</u>
DEFERRED OUTFLOW OF RESOURCES:		
Total deferred outflow of resources	<u>\$ -</u>	<u>\$ -</u>
<b>LIABILITIES</b>		
CURRENT LIABILITIES:		
Accounts payable and accrued liabilities	\$ 164,813	\$ 116,251
Subcapitation payable	3,464,015	2,837,547
Grants payable	13,415	15,411
Reserves for claims	784,397	643,228
Other accrued medical expenses	77,929	125,151
Reserves for provider incentives	<u>98,376</u>	<u>86,852</u>
Total current liabilities	4,602,945	3,824,440
DEFERRED RENT	<u>1,631</u>	<u>3,441</u>
Total liabilities	<u>\$ 4,604,576</u>	<u>\$ 3,827,881</u>
DEFERRED INFLOW OF RESOURCES:		
Deferred revenue	<u>\$ 72,390</u>	<u>\$ 14,540</u>
Total deferred inflow of resources	<u>\$ 72,390</u>	<u>\$ 14,540</u>
COMMITMENTS AND CONTINGENCIES (Note 8)		
NET POSITION:		
Invested in capital assets	\$ 98,723	\$ 105,915
Restricted	600	600
Unrestricted:		
Designated by Board of Governors	104,822	91,741
Minimum tangible net equity	207,029	200,751
Unrestricted	<u>676,180</u>	<u>650,448</u>
TOTAL NET POSITION	<u>\$ 1,087,354</u>	<u>\$ 1,049,455</u>
Total	<u>\$ 5,764,320</u>	<u>\$ 4,891,876</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 SEPTEMBER 30, 2022 AND 2021  
 (In thousands)**

	<b><u>2022</u></b>	<b><u>2021</u></b>
REVENUES:		
Capitation	\$ 9,012,228	\$ 9,210,117
Total revenues	<u>9,012,228</u>	<u>9,210,117</u>
HEALTH CARE EXPENSES:		
Capitation	4,661,634	4,834,938
Fee-for-service medical claims	3,302,501	2,822,674
Pharmacy claims	273,758	760,355
Provider incentives and shared risk	94,910	81,832
Medical administrative expense	<u>83,808</u>	<u>83,067</u>
Total health care expenses	<u>8,416,611</u>	<u>8,582,866</u>
ADMINISTRATIVE EXPENSES	<u>509,462</u>	<u>470,080</u>
INCOME FROM OPERATIONS	<u>86,155</u>	<u>157,171</u>
NONOPERATING (EXPENSES) REVENUE:		
Investment and interest (loss) income - net	(21,311)	3,289
Grant income	11,840	9,657
Provision for community grant	(49,793)	(47,591)
Gross premium tax revenue	182,421	163,284
Gross premium tax expense	<u>(171,415)</u>	<u>(152,915)</u>
Total nonoperating expenses	<u>(48,258)</u>	<u>(24,276)</u>
INCREASE IN FUND NET POSITION	37,897	132,895
FUND NET POSITION—Beginning of year	<u>1,049,457</u>	<u>916,562</u>
FUND NET POSITION—End of year	<u>\$ 1,087,354</u>	<u>\$ 1,049,457</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 SEPTEMBER 30, 2022 AND 2021  
 (In thousands)**

	<u>2022</u>	<u>2021</u>
<b>CASH FLOWS FROM OPERATING ACTIVITIES:</b>		
Capitation revenue	\$ 8,709,628	\$ 9,236,656
Other income—net	(30,759)	(21,415)
Health care expenses	(8,247,668)	(8,522,307)
Operating expenses	<u>(441,664)</u>	<u>(417,554)</u>
Net cash (used in) provided by operating activities	<u>(10,463)</u>	<u>275,380</u>
<b>CASH FLOWS FROM INVESTING ACTIVITIES:</b>		
Net purchases of investments	100,202	76,859
Purchase of restricted investment	-	(300)
Purchase of capital assets	<u>(23,607)</u>	<u>(31,696)</u>
Net cash provided by investing activities	<u>76,595</u>	<u>44,863</u>
<b>CASH FLOWS FROM FINANCING ACTIVITIES:</b>		
MCO Tax revenue received	179,848	171,899
MCO tax paid	(168,736)	(156,369)
Pass-through Programs Received	1,966,101	2,128,492
Pass-through Programs Paid	(1,794,835)	(2,618,282)
Net cash provided by (used in) financing activities	<u>182,378</u>	<u>(474,260)</u>
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	248,510	(154,017)
CASH AND CASH EQUIVALENTS—Beginning of year	<u>990,897</u>	<u>1,144,914</u>
CASH AND CASH EQUIVALENTS—End of year	<u>\$ 1,239,407</u>	<u>\$ 990,897</u>
<b>ADJUSTMENTS TO RECONCILE INCREASE IN FUND NET POSITION WITH CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES:</b>		
Increase in fund net position	37,897	132,895
Depreciation and amortization	30,799	32,169
Unrealized and realized depreciation on investments—net	38,433	7,980
Deferred rent	(1,810)	(34)
Managed care organization tax provision	(11,006)	(10,369)
Changes in operating assets and liabilities:		
Other current and noncurrent assets	(390,514)	(57,962)
Capitation receivable	(360,043)	26,095
Accounts payable and accrued liabilities	44,532	20,841
Subcapitation payable	439,882	84,824
Grants payable	(1,996)	3,434
Reserves for provider claims	141,169	22,493
Other accrued medical expenses	(47,222)	(5,916)
Reserves for incentives	11,566	18,486
Deferred inflow of resources	<u>57,850</u>	<u>444</u>
NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES	<u>\$ (10,463)</u>	<u>\$ 275,380</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

## NOTES TO COMBINED FINANCIAL STATEMENTS AS OF AND FOR THE YEARS ENDED SEPTEMBER 30, 2022 AND 2021

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### 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 of California (the “State”) created the “Local Initiative and the Two-Plan Model” to realize the strategic plans of the Department of Health Care Services (DHCS), formerly known as the State Department of Health Services, outlined in its March 31, 1993, report, *Expanding Medi-Cal Managed Care: Reforming the Health System—Protecting Vulnerable Populations*. Under the plan, DHCS would transition the delivery of Medi-Cal services in 12 counties, including Los Angeles, from a traditional fee-for-service system to a prepaid managed care system through a “Two-Plan” model. Under the Two-Plan model, DHCS would contract with two Knox-Keene licensed health plans, a “local initiative” and a “commercial” plan. In the County, L.A. Care is the “local initiative” and the Health Net Health Plan is the “commercial” plan. 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, 2022 and 2021, was 1,100,962 and 1,060,712 enrollees, respectively.

L.A. Care's MCLA program is designed to complement the existing Plan Partners network. L.A. Care receives from DHCS a fixed payment PMPM, and fixed case rates for maternity cases for each eligible birth, hepatitis C, institutional members, enrolled HHP, and qualified members receiving BHT. Starting January 1, 2022, DHCS is no longer paid Hepatitis C and BHT on fixed case rates, rather the costs are included in the monthly base rate. 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 is reimbursed on a PMPM capitated basis. PPG capitation rates may include or exclude hospital services. The network hospital contracts are on a nonexclusive basis and provide for reimbursement on a per diem, case rate, a percentage of the hospital billed charges, or capitated bases. Certain physicians are reimbursed on a fee-for-service basis. The MCLA program is available to all eligible Medi-Cal beneficiaries in the County, with the same health care benefits as provided by the Plan Partners. Under the Patient Protection and Affordable Care Act (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 income-eligible undocumented individuals aged 50 and over beginning May 1, 2022. As of September 30, 2022 and 2021, MCLA membership was 1,439,026 and 1,234,616 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, 2022 and 2021, PASC-SEIU membership was 49,851 and 50,948 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 Federal poverty level 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 towards 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 federal poverty level. 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, 2022 and 2021, LACC membership was 112,357 and 101,412, 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 medical care, behavioral health, and long-term services and supports (LTSS), which includes institutional long-term care, home, and community-based services, and other support services to individuals who are fully eligible for Medicare and Medi-Cal benefits or "dual eligible" as well as to all Medi-Cal-only individuals or "non-duals" who rely on LTSS services. The Cal MediConnect (CMC) program is one of the components of CCI, which includes 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. As of September 30, 2022 and 2021, the dual-eligible CCI membership, including MCLA and Plan Partners, was 249,175 and 236,330 enrollees, respectively.

L.A. Care's CMC program was launched in May 2014. CMC members are those who qualify for both Medicare and Medi-Cal. 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. As of September 30, 2022 and 2021, CMC membership was 17,001 and 18,733 enrollees, respectively.

Effective July 1, 2019, L.A. Care launched the HHP for eligible members with multiple chronic conditions who are frequent utilizers of medical 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.

Community Supports are services provided by Managed Care Plans (MCPs) to eligible Medi-Cal members to meet their social needs, including medically supportive foods or housing supports. These new services are cost effective alternatives to traditional medical services or settings and are designed to address social drivers of health. There are 14 pre-approved 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 Medically 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 1, which is calendar year 2022. 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. During the fiscal year ended September 30, 2022, L.A. Care recognized \$24.2 million in revenue for the IPP program and \$14.5 million in revenue for the HHIP Program.

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 fee-for-service (FFS) to transition to and enroll in a Medi-Cal managed care plan.

The State also implemented the Medi-Cal Pharmacy transition in January 2022, shifting responsibility from health plans to the State and administered by its pharmacy vendor.

## 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

reclassified to conform to the FY 20-21 presentation. These reclassifications have no effect on fund net position, revenue, expenses, or cash flow 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 (FASB) Accounting Standards Codification (ASC), to the extent it does not conflict with or contradict other, higher categories of accounting principles generally accepted in the United States of America ("generally accepted accounting principles" or GAAP), including GASB pronouncements.

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

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

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

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

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

Actual results will differ from these estimated amounts. Principal areas requiring the use of estimates include the determination of reserves for claims, provider incentives, 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.

**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, 2022 and 2021, approximately \$583.8 million and \$397.2 million respectively were payable under the pass-through programs. The Pass-through programs include:

- The Hospital Directed Payment program (HDP) is comprised 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 non-federal share of payments to Medi-Cal managed care plans, 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 (HQA) 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 (CBRC)** is a supplemental reimbursement plan to State-owned Clinics under Title XIX of the Social Security Act. Costs subject to cost-based reimbursements includes 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 \$98.4 million and \$86.9 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, 2022 and 2021, respectively.

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

**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 IPP. As of September 30, 2022, \$30.6 million in funds received related to IPP has been deferred because the eligibility conditions have not been fully met. As of September 30, 2022 and 2021, the ending balance for all programs recorded in Deferred Revenue was \$72.4 million and \$14.5 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 non-operating revenue and expenses. Operating revenue results from exchange transactions associated with arranging for the provision of health care services for covered members. The primary operating expense is health care costs incurred on a capitated basis whereby the Organization's obligation to provide care is transferred to the providers or network, or on an incurred claim basis for services rendered to members by providers both in and out of the Organization's network.

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 Corridor 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 medical expenses compared to premium revenues as it pertains to these programs. Medical 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 medical costs incurred on behalf of its members resulting in a receivable owed by the DHCS. As of September 30, 2022 and 2021, L.A. Care has recognized a liability of \$425.3 million and \$18.4 million, respectively, which is included in accrued expenses in the accompanying combined statements of net position. Below is a list of programs with risk corridor accruals as of September 30, 2022 and 2021.

- **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 healthcare programs. The DHCS pays a PMPM rate for this program for all eligible Medi-Cal members. L.A. Care is required by the DHCS to make directed payments for qualifying services to eligible network providers and is at risk for these payments.

The Prop 56 program was effective on July 1, 2017, on a state fiscal year basis and was expanded to additional qualifying services beginning July 1, 2018. The DHCS implemented a one-sided risk corridor for the period July 1, 2018, to June 30, 2019, under which payments to providers must be above 95% of the revenue earned or rebated to the DHCS. For the period July 1, 2019, to June 30, 2020, the DHCS implemented a two-sided risk corridor under which payments to providers must be between 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 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. For the year ended September 2022, we recorded \$8.2 million for ECM risk corridor and \$0.4 million for MOT risk corridor.

**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 2022 and 2021 of \$8.3 million and \$5.5 million, respectively, are included in administrative expenses in the accompanying statements of revenues, expenses, and changes in fund net position.

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

**Reserves for Claims**—L.A. Care arranges for comprehensive health care services for certain members through risk-based arrangements. The cost of health care provided is accrued in the period it is 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 medical claims payable is adequate. IBNR estimates of \$784.4 million and \$643.2 million are recorded in reserves for claims in the combined statements of net position as of September 30, 2022 and 2021, respectively.

**Other Accrued Medical Expenses**—These expenses include shared risk liability, claims payables, and pharmacy payable. These accrued expenses are recorded at a total of \$77.9 million and \$125.2 million as of September 30, 2022 and 2021, respectively.

**Premium Deficiency Reserves**—Insurance contracts are analyzed to determine if it is probable that a loss will be incurred. L.A. Care recognizes a premium deficiency loss when it is probable that expected



future claims, including maintenance costs (for example, claim processing costs), will exceed existing reserves, plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped in a manner consistent with 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, 2022 or 2021.

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

Effective August 1, 2019, L.A. Care and Blue Shield of California Promise Health Plan ("Promise Health Plan") entered into a grant agreement, whereby L.A. Care will receive a grant of \$72.8 million from Promise Health Plan and L.A. Care will match this amount as part of a five-year commitment. Per this agreement, L.A. Care will build, expand, and operate Community Resource Centers across Los Angeles County. Grant income is recognized when all eligibility requirements are met. For the year ended September 30, 2022, L.A. Care received and recognized \$11.5 million from Promise Health Plan. For the year-ended September 30, 2021, L.A. Care received and recognized \$9.1 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 centers for Medicare and Medicaid Services. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed at different tax rates. On April 3, 2020, CMS approved California's request for a waiver of the broad-based and uniformity requirements related to 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. For the years ended September 30, 2022 and 2021, MCO tax revenue totaled \$182.4 million and \$163.3 million, and MCO tax expense totaled \$171.4 million and \$152.9 million for fiscal years 2022 and 2021, 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. 87, *Leases*, effective 2022, 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 twelve months at inception, including any options to extend, financed purchases, leases of assets that are investments and certain regulated leases. Changes adopted to conform to the provisions of this Statement were applied retroactively by restating the financial statements for the earliest period presented, September 30, 2021. The cumulative effect of implementing GASB Statement No. 87 on the Organization's financial statements for the year ended September 30, 2021 was as follows: OPEN

GASB Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans*, clarifies that GASB Statement No. 84, *Fiduciary Activities* should be applied to all arrangements organized under IRC Section 457 to determine whether those arrangements should be reported as fiduciary activities. The Statement is effective for the Organization's combined financial statements for the year ending September 30, 2022, and management is evaluating the impact that this statement will have on the combined financial statements.

GASB Statement No. 98, *The Annual Comprehensive Financial Report*, establishes the term annual comprehensive financial report and its acronym ACFR. That new term and acronym replace instances of comprehensive annual financial report and its acronym in generally accepted accounting principles for state and local governments. GASB 98 is effective for fiscal years ending after Dec. 15, 2021. The Statement is effective for the Organization's combined financial statements for the year ended September 30, 2022, and management concluded that it did not have an impact on the combined financial statements.

GASB Statement No. 99, *Omnibus 2022*, the following portions of the statement are effective in 2022: the requirements related to extension of the use of LIBOR, accounting for the Supplemental Nutrition Assistance Program (SNAP) distributions, disclosures of nonmonetary transactions, pledges of future revenues by pledging governments, clarification of certain provisions in Statement 34, as amended, and terminology updates related to Statement 53 and Statement 63. The Statement is effective for the Organization's combined financial statements for the year ended September 30, 2022, and management concluded that it did not have an impact on the combined financial statements.

#### **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, and management is evaluating the impact that this statement will have on the combined financial statements.

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 Statement 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 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, 2022 and 2021, the carrying amounts of L.A. Care’s deposits were \$ 40.1 million and \$98.1 million, respectively, and the bank balance was \$119.0 million and \$146.1 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, 2022 and 2021, 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, 2022 and 2021, as follows (in thousands):

Investments	Fair Value Measurement Using		
	2022	Level 1	Level 2
Money Market Funds	\$ 73,992	\$ 73,992	\$
U.S. government, agencies, and supranational obligations	1,330,467		1,330,467
Negotiable and non-negotiable 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 net asset value (NAV):			
Government pooled funds	328,398		
Total investments measured at the NAV	328,398		
Investment - total:	\$ 1,085,262		

Investments	Fair Value Measurement Using		
	2021	Level 1	Level 2
Money Market Funds	\$ 68,854	\$ 68,854	\$
U.S. government, agencies, and supranational obligations	1,132,476		1,132,476
Bank Certificates of Deposit	101,040		101,040
Corporate obligations	314,340		314,340
Mortgage-backed securities	30,508		30,508
Asset-backed securities	143,800		143,800
Subtotal	1,791,018	68,854	1,722,164
Less: cash equivalent portion	(892,819)	(68,854)	(823,965)
Total investment by fair value level	898,199	\$	\$ 898,199
Investments measured at the net asset value (NAV):			
Government pooled funds	325,698		
Total investments measured at the NAV	325,698		
Investment - total:	\$ 1,223,897		

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, 2022 and 2021.

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

	<u>Fair Value 2021</u>	<u>Unfunded Commitments 2021</u>	<u>Redemption Frequency</u>	<u>Redemption Notice Period</u>
Government pooled investment funds <sup>(1)</sup>	\$ 325,698	\$ -	Daily	1 day
	<u>\$ 325,698</u>	<u>\$ -</u>		

<sup>(1)</sup> 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, 2022 and 2021, L.A. Care had investments by type and maturity as follows:

<b>Investment</b>	<b>2022</b>		
	<b>Investment Maturities (In Years)</b>		
	<u>Fair Value</u>	<u>Less Than 1</u>	<u>1-5</u>
Money Market Funds	\$ 73,992	\$ 73,992	\$
U.S. 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	<u>328,398</u>	<u>328,398</u>	_____
Total	2,284,619	1,801,285	483,334
Less: cash equivalent portion	<u>(1,199,357)</u>	<u>(1,199,357)</u>	_____
Investment - total:	<u>\$ 1,085,262</u>	<u>\$ 601,928</u>	<u>\$ 483,334</u>

Investment	2021 Investment Maturities (In Years)		
	Fair Value	Less Than 1	1-5
Money Market Funds	\$ 68,854	\$ 68,854	\$
U.S. government and agencies obligations	1,132,476	969,339	163,137
Bank Certificates of Deposit	101,040	101,040	
Corporate obligations	314,340	14,225	300,115
Mortgage-backed securities	30,508	1,374	29,134
Asset-backed securities	143,800	3,100	140,700
Government pooled funds	<u>325,698</u>	<u>325,698</u>	
Total	2,116,716	1,483,630	633,086
Less: cash equivalent portion	<u>(892,819)</u>	<u>(892,819)</u>	
Investment - total:	<u>\$ 1,223,897</u>	<u>\$ 590,811</u>	<u>\$ 633,086</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 and Interest Income**—The composition of investment and interest income for the years ended September 30, 2022 and 2021, includes the following (in thousands):

	<b>Years Ended September 30</b>	
	<b>2022</b>	<b>2021</b>
Interest and dividends	\$ 18,435	\$ 12,709
Realized (losses) gains — net	(243)	2,042
Unrealized (losses) — net	(38,190)	(10,023)
Fees	<u>(1,313)</u>	<u>(1,439)</u>
Investment and interest (loss) income - net	<u>\$ (21,311)</u>	<u>\$ 3,289</u>

#### 4. CAPITAL ASSETS

Capital asset additions for the year included office expansion and strategic software development. Depreciation and amortization expense of \$ 27.8 million and \$31.2 million was recorded during the years ended September 30, 2022 and 2021, respectively. A summary of capital assets as of September 30, 2022 and 2021, is as follows (in thousands):

	<b>Beginning Balance 2022</b>	<b>Additions</b>	<b>Disposals/ Deletions</b>	<b>Ending Balance 2022</b>
Computer equipment and software	\$ 201,156	\$ 15,735	\$	\$ 216,891
Office furniture and equipment	12,708	345	(5)	13,048
Leasehold improvements	<u>45,150</u>	<u>7,372</u>	<u>          </u>	<u>52,522</u>
Total capital assets	<u>\$ 259,014</u>	<u>\$ 23,452</u>	<u>\$ (5)</u>	282,461
Less accumulated depreciation and amortization				<u>183,738</u>
Net capital assets				<u>\$ 98,723</u>
	<b>Beginning Balance 2021</b>	<b>Additions</b>	<b>Disposals/ Deletions</b>	<b>Ending Balance 2021</b>
Computer equipment and software	\$ 182,189	\$ 18,967	\$	\$ 201,156
Office furniture and equipment	12,035	679	(6)	12,708
Leasehold improvements	<u>33,098</u>	<u>12,052</u>	<u>          </u>	<u>45,150</u>
Total capital assets	<u>\$ 227,322</u>	<u>\$ 31,698</u>	<u>\$ (6)</u>	259,014
Less accumulated depreciation and amortization				<u>153,099</u>
Net capital assets				<u>\$ 105,915</u>

## 5. RESTRICTED ASSETS

L.A. Care maintained restricted interest-bearing accounts of \$600,000 in 2022 and \$600,000 in 2021. Restricted cash balances are recorded in the Non-Current Asset section of the balance sheet. 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 (JPA) license.

## 6. RESERVES FOR CLAIMS

IBNR estimates of \$784.4 million and \$643.2 million are recorded in reserves for claims in the combined statements of net position as of September 30, 2022 and 2021, respectively.

The following is a reconciliation of the reserves for claims as of September 30, 2022 and 2021 (in thousands):

	<b>Years Ended September 30</b>	
	<b>2022</b>	<b>2021</b>
Beginning Balance	\$ 643,228	\$ 620,735
Incurred		
Current	3,348,648	3,026,265
Prior <sup>(b)</sup>	(60,099)	(142,047)
Total incurred <sup>(a)</sup>	<u>3,288,549</u>	<u>2,884,218</u>
Paid		
Current	(2,601,625)	(2,408,278)
Prior	(545,755)	(453,447)
Total paid <sup>(a)</sup>	<u>(3,147,380)</u>	<u>(2,861,725)</u>
Ending Balance	<u>\$ 784,397</u>	<u>\$ 643,228</u>

<sup>(a)</sup> The reconciliation includes medical claims only. Other claims, such as pharmaceutical claims, and charges, such as provider settlements, are not included.

<sup>(b)</sup> The current fiscal year saw small favorable development for the prior year, which combined with the release of the explicit margins that we hold to protect against unfavorable development. 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 (\$ 147,000, as indexed for 2022). 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 (\$305,000, as indexed for 2022), 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 \$19,500 (\$26,000, if age 50 by year-end), as indexed for 2021. Participants may receive a distribution from their 457(b) Plan accounts in the form of a lump sum, installments, or a combination of those options upon termination, age 70-1/2, death, or unforeseeable emergency (lump sum only).

In January 2006, L.A. Care established the L.A. Care Cash Balance Plan (“Cash Balance Plan”), a qualified cash balance defined benefit plan, for its officers. Generally, this plan is designed to provide benefits to

designated employees based on annual allocations of a fixed dollar amount calculated to provide an annual allocation equal to approximately 30% of 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 \$12.2 million and \$12.8 million in fiscal years 2022 and 2021, respectively, and this cost is included in administrative expenses.

## **8. 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 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 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 \$9.7 million and \$3.2 million are recorded in other accrued medical expenses line item in the combined statements of net position as of September 30, 2022 and 2021, respectively.

L.A. Care leases office space and certain office equipment under non-cancelable operating leases expiring at various dates. In August 2010, L.A. Care entered into a 10-year lease for its headquarters, which would have expired on November 8, 2021, and extended through September 2024. Total rent expenses relating to these leases totaled \$14.4 million and \$11.9 million in 2022 and 2021, respectively, recorded as administrative expenses. Future minimum lease payments required under these operating leases as of September 30, 2022, consist of the following (in thousands):

<b>Years Ending September 30</b>	
2023	\$ 17,214
2024	16,516
2025	10,232
2026	11,271
2027	11,470
Thereafter	89,559
Total	<u>\$ 156,262</u>

**Grants Payable**—On an annual basis, the Board approves various grants to be distributed as part of the Organization’s Community Health Investment Fund. Grants totaling \$9.7 million and \$9.2 million were awarded in 2022 and 2021, respectively. As of September 30, 2022 and 2021, \$13.4 million and \$15.4 million of the total original grants remained unpaid, respectively.

**Credit Concentration**—As of and for the years ended September 30, 2022 and 2021, 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, 2022 and 2021.

## 9. REGULATORY REQUIREMENTS

Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended, L.A. Care must comply with certain minimum capital or tangible net equity requirements. L.A. Care’s net worth exceeded the minimum tangible net equity requirement of \$207.0 million and \$200.8 million on September 30, 2022 and 2021, 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, 2022, and \$0.6 million on September 30, 2021, and is included in noncurrent assets.

## 10. BOARD-DESIGNATED FUNDS

The Board has elected to designate a certain unrestricted net position as of September 30, 2022 and 2021, for the following (in thousands):

	<b><u>Balance as of 2021</u></b>	<b><u>Contribution</u></b>	<b><u>Expenditure</u></b>	<b><u>Balance as of 2022</u></b>
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>
	<b><u>Balance as of 2020</u></b>	<b><u>Contribution</u></b>	<b><u>Expenditure</u></b>	<b><u>Balance as of 2021</u></b>
Safety net and uninsured programs	\$ 8,874	\$ 10,000	\$ 9,225	\$ 9,649
Workforce Development Initiative	56,257	31,000	25,194	62,063
Blue Shield Partnership	<u>9,621</u>	<u>18,000</u>	<u>7,592</u>	<u>20,029</u>
Designated by the Board	<u>\$ 74,752</u>	<u>\$ 59,000</u>	<u>\$ 42,011</u>	<u>\$ 91,741</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 Medical 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.

## 11. SUBSEQUENT EVENTS

L.A. Care has evaluated subsequent events through December 23, 2022, 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, 2022

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, 2022, is as follows (dollars in millions):

	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>
Revenues	\$ 9,012.2	\$ 8,638.1	\$ 374.1
Health care expenses	8,416.6	8,041.5	(375.1)
Administrative expenses	<u>509.5</u>	<u>452.5</u>	<u>(57.0)</u>
Income from operations	86.1	144.1	(58.0)
Nonoperating expense	<u>(48.3)</u>	<u>(53.3)</u>	<u>5.0</u>
Increase in fund net position	<u>\$ 37.8</u>	<u>\$ 90.8</u>	<u>\$ (53.0)</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 multiplied by the projected monthly enrollment levels. Health care costs are a function of established contracted rates with L.A. Care’s Plan Partners and affiliated provider organizations and will fluctuate accordingly with the enrollment level, utilization of services and supports, and utilization of pharmacy. The budgeted operating expenses are based upon historical costs and are modified to incorporate projected changes in staffing levels, anticipated contract changes, and fluctuations in membership levels. The fiscal year 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

##### COVID-19

COVID-19 continues to affect our health care system and economy. COVID-19 has impacted Los Angeles County significantly, with more than 3.3 million cases and more than 32,000 deaths as of August 10, 2022. New cases, hospitalizations, and deaths have decreased dramatically as more of the population has become vaccinated. However, cases persist due to fast-spreading variants. In addition, racial/ethnic disparities exist. The mortality rate (age-adjusted death rate due to COVID-19 per 100K population) was 456 and 314 for Hispanic/Latino and Black residents respectively, compared to 197 and 180 for Asian and White residents,

respectively. The mortality rate for poor areas (30-100% area poverty) was 527 per 100K residents compared to 174 per 100K residents in areas with less than 10% poverty.

L.A. Care data shows that 61 percent of our members have been vaccinated against COVID-19. Rates are higher among older members, with 75 percent of members aged 65 and older having been vaccinated. Among Asian members, 76 percent have been vaccinated compared to only 47 percent of Black/African American members. We are working with external partners to address the severe ethnic/racial disparities in vaccination rates.

COVID-19 had reduced routine healthcare utilization and increased use of telehealth services. While in-person visits have resumed and telehealth usage has declined, we expect that telehealth will continue as a regular part of care. During this period of COVID, plans have been required to pay for services such as testing, vaccines, and treatment, but vaccine costs have been and will continue to be covered by the Department of Health Services (DHCS). The end of the Public Health Emergency may result in changes in responsibility for some of these costs. L.A. Care participated in the COVID-19 incentive program during the current fiscal year and will continue to promote the benefits of vaccination to its members.

### **Medi-Cal**

During the COVID-related Public Health Emergency, Medi-Cal redeterminations have been suspended, meaning that people who might have lost coverage during their renewal period have been kept on Medi-Cal. Our Medi-Cal membership has grown and has not experienced the normal fluctuations of people churning on and off of coverage. Once the Public Health Emergency is lifted, redeterminations will resume and we anticipate losing Medi-Cal members, however, the timing is not clear. The Public Health Emergency has been extended multiple times although we do expect it to be lifted sometime during the upcoming fiscal year. If the PHE expires in the upcoming year, DHCS must resume the annual redeterminations resulting in disenrollment starting in February 2023. The redetermination process and disenrollment will be gradual over a 14-month period. We are actively working on a campaign to educate members on how to retain their Medi-Cal during the redetermination period.

Our Medi-Cal membership has also grown as a result of the State's expansion of Medi-Cal to include income-eligible undocumented older adults beginning May 1, 2022. We received a large membership increase in July 2022 and while growth will obviously not continue at that pace, membership growth is expected to continue as undocumented residents age into eligibility. The Governor also signed SB 184, which expands Medi-Cal to undocumented residents aged 26-49 who are income-eligible, however this won't take effect until 2024. Once this takes effect, all income-eligible residents will be Medi-Cal eligible regardless of immigration status, making universal access to coverage a reality.

Another factor that will affect Medi-Cal is State-wide re-procurement. The State issued a request for proposal (RFP) for the commercial plans in the Two-Plan model which won't take effect until January 1, 2024. While L.A. Care does not have to compete in the re-procurement process, there will be new Medi-Cal contract requirements that will pertain to both L.A. Care and the commercial plan.

Finally, our Medi-Cal membership will be reduced because of AB 2724, which allows DHCS to contract directly with Kaiser for Medi-Cal managed care. L.A. Care will lose Kaiser's 250,000 members, along with the revenue associated with those members. Removing Kaiser from L.A. Care's quality score calculation may also 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. This will take effect in January, 2024.

Another large change to Medi-Cal which began in FY 2021-22 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 2022 include Enhanced Care Management (ECM), Community Supports (CS), and the Major Organ Transplant (MOT) benefit. The State also implemented the Medi-Cal Pharmacy transition in 2022, shifting responsibility from health plans to the State and administered by its pharmacy vendor.

### **L.A. Care Covered**

COVID-19 has also affected Covered California and our L.A. Care Covered product. Most significantly, the American Rescue Plan, signed into law in March 2021, increased the premium assistance that subscribers could receive. In many cases, members pay little to no premiums. On August 16, 2022, President Joe Biden signed the Inflation Reduction Act into law, which extends enhanced Affordable Care Act subsidies for another three years through December 31, 2023. As price is a driver for which plan member select, continuation of the assistance is important to L.A. Care and our current and prospective members.

Also, in the next fiscal year SB 260 will go into effect, which defaults people losing Medi-Cal coverage into the lowest cost Covered California silver plan in the member's rating region. Currently, L.A. Care occupies that position so Medi-Cal membership loss may be offset by L.A. Care Covered membership gain. For 2023, L.A. Care will continue to be the lowest cost plan, which will be advantageous for growth and which reinforces the value of having a public plan on the exchange.

### **Medicare**

The upcoming fiscal year will see the transition of L.A. Care's existing product for dual-eligible members, CMC, to a D-SNP. The State is sunsetting CMC in 2022, requiring plans to offer a D-SNP in order to continue serving the dual-eligible population. L.A. Care is actively working to launch the D-SNP, called L.A. Care Medicare Plus, and transition its CMC members in addition to marketing to new members. Transition will begin in October 2022 for a January 2023 effective date.