Gray Davis, Governor
State of California
Business, Transportation and Housing Agency

320 West Fourth Street, Suite 880
Los Angeles, CA 90013
213-576-76 voice
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June 3, 2002

IN REPLY REFER TO:
FILE NO: 933 0248

FINAL REPORT

Ms. Pauline Rodriquez, Acting Director, Office of Managed Care
COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
Dba: Community Health Plan
1000 S. Fremont Ave., Building A-9, East 2nd Floor
Alhambra, CA 91803

RE: ROUTINE EXAMINATION OF COMMUNITY HEALTH PLAN

Dear Ms. Rodriquez:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of COMMUNITY HEALTH PLAN (the "Plan") for the year ended June 30, 2001, conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act")[1]. The Department issued a Preliminary Report to the Plan on January 23, 2002. The Department received the Plan's response on March 29, 2002.

This Final Report includes a description of the compliance efforts included in the Plan's March 29, 2002 response, in accordance with Section 1382 (c).

Section 1382 (d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 1 of Division 1 of Title 28, California Code of Regulations, beginning with Section 1300.43, and transferred to the Department of Managed Care pursuant to Health and Safety Code Section 1341.14.

The Department's Final Report, issued on May 13, 2002, shall be available to the public in accordance with Section 1382 (d).

As noted in the attached Final Report, the Plan's response on March 29, 2002 ("March 29 Response") failed to adequately respond to deficiencies raised in the Preliminary Report issued by the Department on January 23, 2002. Pursuant to Rule 1300.82, the Plan was required to submit a response to the Department for any requests for additional corrective action contained within the attached Final Report, within thirty (30) days after receipt of the Final Report except where requested to submit certain items, identified in the report, within fifteen (15) days after receipt.

The Plan was notified that if it failed again to adequately respond and/or resolve the deficiencies raised in the Final Report, a referral would be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

On May 24, 2002 the Plan requested that additional information contained in its supplemental response filed on May 24, 2002 be included with the final report. The additional information was submitted in response to issues remaining after review of the Plan's March 29 Response. Those issues and additional information submitted by the Plan on May 24, 2002 and on May 29, 2002 are included in this report.

If you have any questions, please contact me at (213) 576-7645 or e-mail: adougherty@dmhc.ca.gov.

Sincerely,

Agnes Dougherty
Senior Examiner
Division of Financial Oversight

cc: Dr. Gail V. Anderson Jr., Acting Assoc. Director, Co. of L.A.–Dept. of Health Services
Miles Yokota, Director of Contract Administration, Office of Managed Care
Dave Beck, Chief Financial Officer, Community Health Plan
Cheri Rice, Chief, Medi-Cal Managed Care Division, Department of Health Services
Jack Toney, Assistant Deputy Director, Office of Health Plan Oversight
Steven Goby, Senior Counsel, Division of Licensing
Mark E. Wright, Chief, Division of Financial Oversight
K. Kim Malme, Senior Examiner, Division of Financial Oversight
Kelvin Gee, Monitoring Examiner, Division of Financial Oversight

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

DBA: COMMUNITY HEALTH PLAN

FILE NO.: 933 0248

DATE: MAY 13, 2002

OVERSIGHT EXAMINER: AGNES DOUGHERTY

EXAMINER IN CHARGE: KIM MALME

BACKGROUND INFORMATION FOR COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES (DBA: COMMUNITY HEALTH PLAN)

Date Plan Licensed:	December 30, 1985
Organizational Structure:	The Plan is the Medi-Cal health maintenance organization of the County of Los Angeles Department of Health Services (DHS).
Type of Plan:	The County of Los Angeles, Department of Health Services dba Community Health Plan is a federally qualified HMO and is licensed as a full service health care service plan. The Plan arranges for the provision of health care for Medi-Cal beneficiaries under an agreement with the Local Initiative Health Authority for the County of Los Angeles (L.A. Care). The Plan also participates in the Healthy Families Program under a service agreement with the State of California.
Plan Enrollment:	The Plan reported 145,299 enrollees for the quarter ended December 31, 2001.
Service Area:	Approved service areas in Los Angeles County.
Date of Last Public Report for Non-Routine Financial Examination:	April 27, 2000

FINAL REPORT OF A ROUTINE EXAMINATION OF COUNTY OF LOS ANGELES – DEPARMENT OF HEALTH SERVICES (DBA: COMMUNITY HEALTH PLAN)

This is the Final Report of a routine examination of the fiscal and administrative affairs of Community Health Plan (the "Plan"), conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 (b) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on January 23, 2002. The Department received the Plan's response on March 29, 2002 ("March 29 Response").

This Final Report includes a description of the compliance efforts included in the Plan's March 29, 2002 response to the Preliminary Report, in accordance with Section 1382 (c).

We examined the financial report filed with the Department for the quarter ended June 30, 2001, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Our findings are presented in this report as follows:

Pursuant to Rule 1300.82, the Plan was required to submit a response to the Department for any requests for additional corrective action contained within the attached Final Report that was issued on May 13, 2002, within thirty (30) days after receipt of the Final Report except where requested to submit certain items, within fifteen (15) days after receipt.

On May 24, 2002 the Plan requested that additional information contained in its supplemental response filed on May 24, 2002 be included with the final report. The additional information was submitted in response to issues remaining after review of the Plan's March 29 Response. Those issues and additional information submitted by the Plan on May 24, 2002 and on May 29, 2002 are included in this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I.FINANCIAL REPORT[2]

A. BALANCE SHEET – AS OF JUNE 30, 2001

	Reported per F/S @ 6/30/01	Examination Adjustments Debit	Credit	Examination Balance @ 6/30/01
CURRENT ASSETS				
Cash	$41,651,878			$41,651,878
Premiums Receivables – Net	11,262,964			11,262,964
Interest Receivables	659,321			659,321
Other Receivables – Net	7,713,005			7,713,005
Aggregate Write-Ins–Current Assets	466,150			466,150
TOTAL CURRENT ASSETS	$61,753,318			$61,753,318
OTHER ASSETS				
Restricted Assets	304,773			304,773
TOTAL OTHER ASSETS	$304,773			$304,773
PROPERTY & EQUIPMENT				
Building & Improvements	0			0
Aggregate Write-Ins/Other Equip.	0			0
TOTAL PROPERTY & EQPT	$0			$0
TOTAL ASSETS	$62,058,091			$62,058,091

[2] The Department performed a limited examination of the Plan's fiscal affairs based upon its annual audited financial statements for the year ending June 30, 2001. The balance sheet and income statement are presented here for purposes of this report.

BALANCE SHEET
AS OF JUNE 30, 2001

	Reported per F/S @ 6/30/01	Examination Adjustments Debit	Examination Adjustments Credit	Examination Balance @ 6/30/01
CURRENT LIABILITIES				
Accounts Payable	$1,644,091			$1,644,091
Claims Payable	3,826,507			3,826,507
Accrued Inpatient Claims	2,450,198			2,450,198
Accrued Physician Claims	312,216			312,216
Accrued Referral Claims	56,767			56,767
Accrued Other Medical	5,601,576			5,601,576
Aggregate Write-Ins for Current Liabilities	43,120,445			43,120,445
TOTAL CURRENT LIABILITIES	$57,011,800			$57,011,800
TOTAL LIABILITIES	$57,011,800			$57,011,800
NET WORTH				
Fund Balance	$5,046,291			$5,046,291
TOTAL NET WORTH	$5,046,290			$5,046,290 (To Section II)
TOTAL LIAB. & NET WORTH	$62,058,091	$0	$0	$62,058,091

B. INCOME STATEMENT

STATEMENT OF INCOME AND EXPENSES
FOR THE YEAR ENDING JUNE 30, 2001

	Reported per F/S @ 6/30/01	Examination Adjustments Debit	Examination Adjustments Credit	Examination Balance @ 6/30/01
REVENUES				
Premium	$14,790,775			$14,790,775
Title XIX – Medicaid	111,436,652			111,436,652
Interest	2,416,994			2,416,994
Aggr Write-Ins for Other Rev.	92,419			92,419
TOTAL REVENUE	$128,736,840			$128,736,840
MEDICAL AND HOSPITAL EXPENSES				
Physician Services	$93,767,993			$93,767,993
Other Professional Services	0			0
ER, Out-of-Area, Other	3,115,347			3,115,347
Inpatient	1,076,287			1,076,287
Reinsurance Expenses	1,282,808			1,282,808
Other Medical	16,249,090			16,249,090
Incentive Pool Adjustment	0			0
TOTAL MEDICAL & HOSP	$115,491,525			$115,491,525
ADMINISTRATION				
Compensation	6,006,077			6,006,077
Aggregate Write-Ins Other Admin	6,214,567			6,214,567
TOTAL ADMINISTRATION	$12,220,644			$12,220,644
TOTAL EXPENSES	$127,712,169			$127,712,169
INCOME (LOSS)	1,024,671			1,024,671
PROVISION FOR TAXES	0			0
NET INCOME (LOSS)	1,024,671	0	0	1,024,671

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth Per Examination as of June 30, 2001 (From Section I. A)	$ 5,046,291
Tangible Net Equity	$ 5,046,291
REQUIRED TNE as of June 30, 2001	$ 2,524,549
EXCESS TNE as of June 30, 2001	$ 2,521,742

As of June 30, 2001, the Plan was in compliance with the TNE requirements of Section 1376 and Rule 1300.76.

No response was required to this Section.

SECTION III. COMPLIANCE ISSUES

A. PAYMENT OF CLAIMS

Section 1371 requires a full service plan to reimburse uncontested claims no later than 45 working days after receipt of the claim. This section also requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period. This section also requires that all interest that has accrued shall be automatically included in its claim payment. The penalty for failure to comply with this requirement shall be a ten dollar ($10) fee.

Section 1371.35, which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt, the plan shall pay the greater of $15.00 or interest at the rate of 15 percent per annum, beginning with the first calendar day after the 45 working day period.

Our examination disclosed that the Plan failed to comply with these sections for the following reasons:

- Uncontested claims were paid beyond the timeframes specified in these sections. Although, the Plan made efforts to pay interest on these claims, it did not pay the correct amount because it incorrectly estimated the date warrants were actually mailed ("warrant mailed date"). The result was that the Plan failed to pay the correct amount of interest in accordance with these sections because actual warrant mailed dates were 10 to 30 days after the estimated dates. Examples of claims that were paid late and where interest was incorrectly paid are as follows:

Claim Number	Claim Number	Claim Number	Claim Number
C0272065	C0286197	C0292513	C0228603
C0274532	C0233698	C0247211	C0262948
C0240779	C0261988	C0266098	C0260688
C0233636	C0233656	C0289952	C0284417
C0233606	C0275453	C0248396	C0243088
C0291077	C0284408	C0271898	C0248466
C0237221	C0232380	C0272148	C0293309
C0241101	C0272235	C0300706	C0305249
C0298612	C0304061	C0272104	C0250117
C0279998	C0227894	C0251324	C0272150
C0288131	C0195697	C0262046	

- We reviewed claims that were paid late and did not include any interest payments in accordance with these sections. The following are examples:

Claim Number	Claim Number	Claim Number	Claim Number
C0286197	C0274532	C0260688	C0227894
C0277993	C0275453	C0248396	C0243088
C0271898	C0248466	C0237221	C0272148
C0249012	C0272235	C0300706	

- We reviewed claims that were denied beyond 45 business days. Although these claims did not require the payment of interest, the Plan's claim system did not process these claims timely in order to determine the Plan's responsibility for payment of the claim and interest in accordance with these sections. The following are examples:

Claim Number	Claim Number	Claim Number	Claim Number
C0289970	C0297422	C0284322	C0285710
C0286129	C0286957	C0287429	C0287591
C0296971	C0301535	C0301534	C0297422
C0294520	C0298623	C0195697	C0235508
C0207952	C0264355	C0225954	C0234863

- We reviewed claims that were not paid in accordance with the provider agreement. Upon appeal by the provider or resubmission of the claim, additional payments were made. The additional payment was paid late and the Plan did not pay interest on the late payment in accordance with these sections. The following are examples:

Claim Number	Claim Number	Claim Number	Claim Number
C0274532	C0195679	C0251324	C0291077
C0195679	C0251324		

The Plan was required to demonstrate that it had implemented corrective action in order to comply with these sections. The Corrective Action Plan (CAP) was to include the following:

- Identification of all claims that were paid late beginning with claims that were paid January 1, 2000 through the current period, including emergency and non-emergency claims. Identification of late claims were to include those claims that were incorrectly paid and were subsequently reprocessed due to an appeal or other information that resulted in the reprocessing of the claim and subsequent additional payment.

- Submission of a schedule that listed the late claims and late payment amounts identified above. The schedule was to demonstrate that the correct amount of interest had been calculated and paid in accordance with Sections 1371 and 1371.35. The schedule was to list the claim number, date of service, date of claim receipt, provider name, date of original claim payment (according to the actual warrant mailed date), original claim payment amount, date of additional claim payment, additional claim payment amount, date interest paid, interest paid amount, date of additional interest paid, additional interest paid amount (after correct calculation) and additional interest payment check number.

- Revised policies and procedures that reflect the Plan's ability to comply with Sections 1371 and 1371.35. These policies and procedures were to include the Plan's system for automatically accruing and paying interest on late claims in accordance with these sections.

The Plan was required to state in its response, the management position responsible for ensuring that the Corrective Action Plan (CAP) had been implemented and the date that the CAP and revised procedures have been implemented.

The Plan's March 29 Response stated the following:

- **The Plan is preparing the summary schedules listing all late claims paid January 1, 2000 through the current period, including emergency and non-emergency claims. The Plan stated that the management positions responsible for ensuring that the Corrective Action has been implemented are Dave Beck, CFO, OMC and Steven Thompson, Claims Manager, OMC Financial Services Division. The implementation date is May 15, 2002.**

- **The Plan is preparing a schedule that lists the late claims and late payment amounts that includes the information required above. The Plan stated that the management positions responsible for ensuring that the Corrective Action has been implemented are Dave Beck, CFO, OMC and Steven Thompson, Claims Manager, OMC Financial Services Division. The implementation date is May 15, 2002.**

- **The Plan is revising policies and procedures that reflect the Plan's ability to comply with Sections 1371 and 1371.35. The Plan stated that the management positions responsible for ensuring that the Corrective Action has been implemented are Dave Beck, CFO, OMC and Steven Thompson, Claims Manager, OMC Financial Services Division**

The Plan's March 29 Response did not satisfactorily respond to this item because the Plan failed to submit the schedules and the revised policy and procedures, demonstrating the Plan's ability to comply with these Sections. The draft procedures submitted as Attachment I in the Plan's March 29 Response did not address penalties and minimum interest payment amounts. The finalized policy and procedures were required to address these requirements and reflect the date of implementation.

The Plan was required to file the required schedules and revised policies and procedures with the Department within fifteen (15) days from receipt of this report.

On May 24, 2002 the Plan submitted schedules that identified the emergency and non-emergency claims that were paid late from January 1, 2000 through February 28, 2002 as required. The Plan also submitted schedules that demonstrated the correct amount of interest owed and paid to a majority of the claimants. A schedule demonstrating payment to providers for interest owed and paid on late claim payments due to a provider appeal of an incorrectly paid claim was also submitted.

On May 29, 2002, the Plan submitted an additional schedule demonstrating that it had completed the corrective action required, by payment of additional interest to the remaining claimants to correct the miscalculation of interest owed and paid previously. In addition the Plan filed a finalized policy and procedure that reflected CHP's method for implementing automatic accrual and payment of interest on late claims in compliance with Sections 1371 and 1371.35.

The Plan's compliance efforts as described in its Response submitted on May 24, 2002 and May 29, 2002 satisfactorily responds to the deficiency cited and the corrective action required by the Department.

B. INTERIM FINANCIAL STATEMENTS

Rule 1300.84.2 requires that financial statements submitted to the Department on a quarterly basis are prepared in accordance with generally accepted accounting principles and prepared on a basis that is consistent with the certified financial report furnished by the plan pursuant to Section 1384 (c) of the Act.

Our examination disclosed that the Plan had not reported its quarterly financial statement for the period ending June 30, 2001 on a basis that was consistent with its certified financial report for the period ending June 30, 2001. For example, the balance sheet filed with the quarterly financial statements reported a fund balance of $5,904,645. The certified financial report for the

year ending June 30, 2001 reported a fund balance of $5,046,290. The difference was $858,355 and appears to be due to audit adjustments that were not reflected in the June 2001 quarterly financial statements filed with the Department.

The Plan was required to submit revised quarterly financial statements beginning with the quarter ending June 30, 2001 and for all subsequent quarters that were not previously adjusted, in order to reflect a consistent basis with the certified financial statements.

The Plan was required to submit the management position responsible for ensuring this corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action had been implemented.

The Plan's March 29 response stated that the audited financial statements for the fiscal year ending June 30, 2001 were not available at the time the quarterly statements were due. Therefore, the adjustments were not reflected in the quarterly financial statement for the period ending June 30, 2001 filed with the Department. The Plan has revised the quarterly financial statement for the period ending June 30, 2001 and submitted the revised statement as required. The Plan stated that subsequent quarterly statements were not affected and do not require resubmission.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

C. AMENDMENTS/MATERIAL MODIFICATION – REPEAT VIOLATION

Section 1352 (a) and (b), Rules 1300.52 and 1300.52.1 require all plans to file an amendment with the Director within 30 days after any change in the information contained in its application, other than financial or statistical information. Material changes to the Plan's operations are required to be filed as a notice of material modification as specified in this section and rule.

Our examination disclosed that this is a repeat violation from the prior examination as reported in the Department's[3] Public Report to Director Steven Escoboza dated January 28, 1998. The prior examination disclosed that the Plan was not filing amendments or material modifications for various agreements that included the following:

- Agreement with the County for method of settlement and procedures for settlement of County receivables and payables

- Agreements between the Plan and County providers, which document all provider arrangements, administration and compensation arrangements.

Mr. Escoboza's response on February 17, 1998, Section V.E., stated that the Plan had filed all required agreements and that "as additional agreements are executed, the Plan will file an amendment or material modification in accordance with Section 1352 (a) and (b), and rules

[3] Also referred to as the Department of Managed Care; and formerly, the Department of Corporations.

1300.52 and 1300.52.1. His response identified the Plan's Chief Financial Officer would be the responsible individual to assure ongoing compliance with the Section."

Our examination disclosed the following:

- Receivables due from Other County Funds as of June 30, 2001, were not properly supported by executed promissory notes, Memoranda of Understanding ("MOU") and other documentation to support the receivable.

- The Plan did not have a written agreement with contracted providers to support the arrangement in which receivable balances from these providers for claims paid on their behalf were offset against capitation payments owed.

The Plan was required to file the following documentation as amendments and reference the regulatory examination in the cover letter that accompanies this filing. These filings were to be submitted to the filing clerk in Sacramento.

- All signed promissory notes, MOUs and documentation necessary to support all outstanding receivables that has not been previously filed. In order to confirm that the Plan has complied with these Sections and Rules, the Plan was required to file a schedule that lists all receivables from county facilities and contracting providers, indicating which agreements and documentation have been filed with the Department.

- Written agreements, MOUs, and documentation necessary to support all provider arrangements with county facilities, that has not been previously filed. The method of reimbursement was to be filed with the Department and include details concerning the arrangements for offsetting receivables, risk pool receivables, and any other amounts against future capitation. Revised compensation arrangements that have not been previously filed, were also to be submitted. In order to confirm that the Plan has complied with these Sections and Rules, the Plan was required to file a schedule that lists all county facilities, indicating which agreements and documentation have been filed with the Department.

- An Undertaking with the Department that confirms the Plan's commitment to maintain all appropriate documentation, including promissory notes, MOUs and other necessary documentation to support receivable and payable transactions with all county facilities and contracted providers. The Undertaking was to include the management position responsible for ensuring this corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action had been implemented.

- An explanation of the reasons why the corrective action, as described in the Plan's February 17, 1998 response resulted in this repeat deficiency.

The Plan was also required to state the policies and procedures implemented to ensure that this violation is not repeated, the date those procedures were implemented, the management position(s) responsible for the oversight of those procedures, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan's March 29 Response stated the following:

- **The Plan is negotiating and preparing the required promissory notes, MOUs and documentation necessary to support all outstanding receivables that have not been previously filed. The Plan stated that the management positions responsible for ensuring that the corrective actions plan has been implemented are Dave Beck, CFO, OMC and Suzanne Garcia, Financial Specialist IV, OMC Financial Services Division. The implementation date is concurrent with all promissory notes and MOUs submitted to the Department**

- **The Plan is negotiating and preparing the required promissory notes, MOUs and documentation necessary to support all provider arrangements with county facilities, that has not been previously filed. The Plan stated that the management positions responsible for ensuring that the corrective action plan has been implemented are the OMC Staff and DHS Chief Operations Officer. The implementation date is January 3, 2003.**

- **The Plan will file an Undertaking with the Department that confirms the Plan's commitment to maintain all appropriate documentation. The Plan stated that the management positions responsible for ensuring that the corrective action plan has been implemented are Kathy Darnell, Manager, Network Administration, and OMC Operations Division.**

- **The Plan stated that the cause for the repeat deficiency was due to the significant turnover in key positions over the past four years. The Plan stated that the management positions responsible for ensuring ongoing compliance are the OMC Executive Staff and DHS Chief Operating Officer.**

The Plan's March 29 Response did not satisfactorily respond to this item because the Plan failed to file any of the documentation that was required.

The Plan was required to file the schedules that were described above, indicating the dates that the required promissory notes, written agreements, MOUs, and any other pertinent documentation would be filed with the Department. For those arrangements, in which the required documentation had not yet been filed, the Plan was required to indicate on these schedules, the dates that these filings would be made, which was not to be later than January 3, 2003. These schedules were to be submitted to the Department within fifteen (15) days from receipt of the final report, issued on May 13, 2002.

In addition, the Plan was required to submit quarterly updated schedules that reflect the Plan's progress in filing these documents. The first updates were required on or before June 30, 2002, and each quarter end thereafter.

The Plan was required to file the Undertaking with the Department within fifteen (15) days from receipt of this report.

On May 29, 2002 the Plan filed a schedule that included a timeline for developing agreements with all county facilities to document all provider arrangements, administration and compensation arrangements. The schedule listed specific dates for the different stages of completion and indicated that the MOUs would be filed with the DMHC by December 18, 2002.

The Plan confirmed that it had reviewed its records and determined that there were no agreements or other documentation that had been previously filed with the DMHC concerning receivables and provider arrangements with County facilities.

The Plan submitted an Undertaking that in accordance with Section 1352 (a) and (b) and Rules 1300.52 and 1300.52.1, the CHP (Plan) provides the Undertaking that the CHP commits to maintain all appropriate documentation, including promissory notes, MOUs or other documentation necessary to support receivable and payable transactions with all County facilities and contracted providers.

Although the Plan submitted the Undertaking and timeline for completion of the corrective action, the Plan is required to continue to submit updates every quarter. In addition, the Plan's corrective action will be reviewed upon filing of the agreements and during the nonroutine examination that is discussed under Section V. of this report.

D. MONITORING OF CONTRACTING PROVIDERS – REPEAT DEFICIENCY

Section 1367 (d) requires plans to furnish services in a manner providing continuity of care. Section 1375.1 establishes certain operational requirements for plans that include an evaluation of the financial soundness of the plan's arrangements for health care services. Contractual requirements under Rule 1300.67.8 (c) provide the plan with access to the books, records, and papers relating to the financial condition of the provider unless that provider is compensated on a fee-for-service basis.

The Department's Public Report to Steven Escoboza, Director, dated January 28, 1998 reported that the Plan did not have personnel in place to perform the procedures for monitoring and reviewing the financial capacity of its capitated provider groups, in order to demonstrate compliance.

Mr. Escoboza's response on February 17, 1998, Section V.F., stated that "Monitoring staff were hired in December 1997 and the monitoring program was implemented in January 1998."

Our examination disclosed that the Plan relies upon the Centralized Contract Monitoring Division of the County's Health Services Administration to conduct the fiscal monitoring of the Plan's contracted providers. A review of the workpapers, policies and procedures for this division indicates that it has established a system for evaluating the financial soundness of participating medical groups and providers who contract with the Plan. However, the Plan was unable to demonstrate that they have the oversight and responsibility for the fiscal monitoring of its contracted providers.

In addition, the Plan has not provided documentation to demonstrate that it performs onsite reviews of its capitated groups or that it has established procedures for implementing corrective action plans if a group has been identified as having financial concerns.

The Plan was required to file the following documentation as amendments and reference the regulatory examination in the cover letter that accompanies this filing. The filing was to be submitted to the filing clerk in Sacramento.

- Memorandum of Understanding (MOU) that documents the procedures and responsibilities of the Plan and the Centralized Contract Monitoring Division for the fiscal monitoring of the Plan's capitated providers. The MOU was to reflect the Plan's oversight and responsibility for the fiscal monitoring of its capitated providers. The MOU was also to list the reports provided by the Centralized Contract Monitoring Division to the Plan for its review.

- Policies and procedures of the Plan and of the Division, consistent with the MOU, to demonstrate that the Plan has the oversight and responsibility for the fiscal monitoring of its capitated providers. The procedures were to include the onsite review and auditing of reports filed for claim payment timeliness; corrective action plans; and other filings submitted as part of the fiscal monitoring procedures established in the MOU.

- An Undertaking with the Department that confirms the Plan's commitment to monitor its capitated medical groups and providers in accordance with the applicable Sections and Rules. The Undertaking was to include the management position responsible for ensuring this corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action had been implemented.

- An explanation for the reasons why the corrective action, as described in the Plan's February 17, 1998 response resulted in this repeat deficiency.

The Plan's March 29 Response stated that it is developing an internal protocol between the Plan and the Centralized Contract Monitoring Division (CCMD). The Plan stated that the management positions responsible for ensuring that the Corrective Action Plan has been implemented are Dave Beck, CFO, OMC, Pauline Rodriguez, Acting director, OMC and Loretta Range, Director, Centralized Contract Monitoring Division, DHS. The implementation date is July 2002.

The Plan responded that it will include the onsite review and auditing of reports filed for claim payment timeliness; corrective action plans; and other filings submitted as part of the fiscal monitoring procedures. The Plan stated that the management positions responsible for ensuring that the Corrective Action Plan has been implemented are Loretta Range, Director, Centralized Contract Monitoring, DHS, Dave Beck, CFO, OMC and Wayne Willard, Manager, Budget/Capitation & Financial Compliance Unit, OMC Financial Services Division. The implementation date is July 2002.

The Plan responded that the Undertaking will include the management position responsible for ensuring this corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action has been implemented. The Plan stated that the management positions responsible for ensuring that the Corrective Action Plan has been implemented are Dave Beck, CFO, OMC and Wayne Willard, Manager, Budget/Capitation & Financial Compliance Unit, OMC Financial Services Division.

The Plan's March 29 Response did not satisfactorily respond to this item because the Plan failed to file any of the documentation that was required.

The Plan was required to file a schedule with the Department that listed the dates that the MOU, Policy and Procedures and Undertaking would be filed with the Department. The schedules of dates for the filings were to be submitted within fifteen (15) days of receipt of this report. The dates indicated on the schedule for filing these documents were not to be later than thirty (30) days from receipt of the final report that was issued on May 13, 2002. The Plan was required to submit copies of the filings that were made with the filing clerk in Sacramento.

On May 24, 2002 the Plan submitted a letter stating that on May 29, 2002, the CHP would submit:

- ***A schedule listing the dates of filing a) the MOU between the CHP and the Department of Health Services' Centralized Contract Monitoring Division documenting the procedures and responsibilities associated with the fiscal monitoring of CHP's contracted providers, including onsite review and auditing of reports; b) the Policy and Procedures outlining CHP's oversight and responsibility for the fiscal monitoring of its contracted providers; and c) an Undertaking to confirm CHP's commitment to monitoring its contracted providers, including a description of the monitoring system and the date of implementation.***

The Plan also stated that by June 13, 2002, the CHP would file:

- ***the MOU between the CHP and DHS' Centralized Contract Monitoring Division documenting the fiscal monitoring procedures for CHP's capitated providers, the attendant Policies and Procedures, and an Undertaking to confirm CHP's commitment to monitoring its capitated providers, including a description of the monitoring system and the date of implementation.***

On May 29, 2002 the Plan filed a schedule that included a timeline for developing and filing with the Department, the MOU between the Plan and DHS' Centralized Contract Monitoring Division with their Policies and Procedures. The timeline indicated that these documents would not be filed with the DMHC until December 18, 2002. This date did not agree with the Plan's commitment to file these agreements by June 13, 2002, as stated in the Plan's May 24, 2002 Letter. The Department's Final Report issued on May 13, 2002, required the earlier filing date.

The Plan filed a statement that documented their Undertaking to monitor its capitated medical groups and providers in accordance with Sections 1367 (d) and 1375.1 and Rule 1300.67.8 (c). The Plan also stated that the CCMD (Centralized Contract Monitoring Division) would provide the CHP with contract monitoring support activities and information. The CFO is responsible for ensuring the corrective action. The implementation date is June 1, 2002.

Although the Plan submitted the Undertaking and timeline for completion of the corrective action, the Plan's March 29 Response did not satisfactorily respond to this item because the timeline submitted on March 29 extended the filing date of the MOU and policies and procedures to December 18, 2002.

The Plan is required to resubmit a revised timeline with an earlier filing date. In addition, the Plan's corrective action will be reviewed upon filing of the MOU/ Policies and Procedures and during the nonroutine examination that is discussed under Section V. of this report.

E. BOOKS AND RECORDS RETENTION

Section 1385 requires that each plan keep and maintain current such books of account and other records as the director may by rule require for the purposes of this chapter. Rule 1300.85.1 requires every plan to preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the office of the plan, the books of account and other records required under the provisions of, and for the purposes of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Director within not more than 5 days after request therefore.

Our examination disclosed that the Plan did not retain supporting documentation in accordance with this Section as follows:

- Copies of claims that were determined to be the responsibility of claimants or capitated providers were not retained by the Plan after forwarding the original claims to the claimant or provider. In addition, a copy of the original letter that was sent to claimants and providers with the reason stated for pending or denying the claim was not retained by the Plan.

- We reviewed 172 claims. Ten claims that we requested were not made available for our review.

The Plan was required to submit revised policies and procedures that reflect the Plan's corrective action.

The Plan was also required to state the management position responsible for ensuring that the corrective action had been implemented, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action had been implemented.

The Plan responded that it is preparing the required policies and procedures. Copies of claims processing procedures enacted in March 2002 were submitted. In addition, draft policy and procedure pertaining to fee-for-service claims processing was submitted. The Plan stated that a copy of the original letter that was sent to claimants and providers with the reason stated for pending or denying the claim will be retained by the Plan.

The Plan stated that the management positions responsible for ensuring that the Corrective Action Plan has been implemented are Dave Beck, CFO, OMC and Steven Thompson, Claims Manager, OMC Financial Services Division. The implementation date is April 30, 2002.

Although, the Plan's compliance efforts as described in its March 29 Response substantially addressed the deficiency cited, the Plan was required to file the finalized policy and procedures pertaining to fee-for-service claims processing.

On May 24, 2002 the Plan submitted a copy of its finalized policy and procedures pertaining to fee-for-service claims processing.

The Plan's compliance efforts as described in its Response submitted on May 24, 2002 satisfactorily responds to the deficiency cited and the corrective action required by the Department.

SECTION IV. INTERNAL CONTROL ISSUES

Sections 1384 and 1345 (s), and Rule 1300.45 (q) include requirements for filing financial statements in accordance with generally accepted accounting principles and other authoritative pronouncements of the accounting profession.

Statement on Auditing Standards (SAS) no. 78 states that "Internal control is a process---effected by an entity's board of directors, management, and other personnel---designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations."

SAS no. 60 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

Our examination disclosed that specific areas of the internal control structure as discussed in Statements on Auditing Standards (SAS) nos. 78 and 60 could be strengthened. Below are specific areas where improvements in internal accounting controls should be implemented:

- Inter-county fund transfers were not supported by adequate documentation to substantiate the Plan's oversight of the transactions. For example, administrative charges by the County Controller's Office were posted to the Plan's books at year-end without prior review of supporting documentation by the Plan's staff.

- The Plan did not maintain sufficient oversight procedures for payments of principal and interest owed by other county facilities to the Plan that had not been received in more than 60 days.

- The Plan did not maintain sufficient oversight procedures over the settlement of receivables from county facilities because they were not being settled in a timely manner.

- The Plan did not date stamp all medical records and claim documentation that was received by the Plan. Some of these records were received upon request by the Plan during processing.

The Plan was required to submit revised policies and procedures that reflect the Plan's corrective action implemented in order to address the problems stated above.

The Plan was also required to state the management position responsible for ensuring this corrective action, a description of the monitoring system implemented to ensure ongoing compliance with the corrective action, and the date corrective action had been implemented.

The Plan's March 29 Response stated that it is in the process of developing policies and controls to ensure compliance with these requirements. In the interim, the OMC has informed County organizations that it will not accept charges without adequate documentation to support billed amounts. In addition, the issue of interest owed by other county facilities will be addressed in the MOUs currently under development. The Plan stated that the management positions responsible for ensuring that the Corrective Action Plan has been implemented are Dave Beck, CFO, OMC and Steven Thompson, Claims Manager, OMC Financial Services Division. The implementation date is April 30, 2002

The Plan's March 29 Response did not satisfactorily respond to this item because the Plan failed to submit the revised policies and procedures as required. The Plan was required to

submit its revised policies and procedures that address the problems identified above, within fifteen (15) days of receipt of this report.

On May 24, 2002 the Plan submitted a letter stating that revised polices and procedures would be submitted on May 29, 2002 that would strengthen internal control and document CHP's oversight role specifically addressing: adequate documentation of inter-county fund transfers; timely payment of principal and interest owed by County facilities; timely settlement of receivables from County facilities; and the date stamping of medical records and claim documentation received by CHP.

On May 29, 2002 the Plan submitted Policy and Procedure 2.9, which reflected the Plan's revised procedure requiring the date stamping of claim documentation.

The Plan also submitted a copy of Policy and Procedure 2.10 regarding Receivables from other County Departments. This document listed the preparation of monthly billings as the responsibility of the General Accounting Supervisor and stated under action 3A that if the other County department fails to accept the billing, the supervisor was to work with the Controllers' Division to process a budget appropriation adjustment. Action 3B stated that if the budget appropriation adjustment does not occur, the billing will be settled in the County's final accounting period in accordance with Auditor-Controller guidelines and the applicable MOU.

The Policy and Procedure 2.10 does not satisfactorily respond to this item because it does not address the Department's concerns regarding retention and review of adequate supporting documentation for inter-county fund transfer transactions, principal and interest payments, and timely settlement of inter-county receivable/payable transactions.

The Plan is required to file a revised Policy and Procedure that reflects the Plan's corrective action implemented in order to address the problems stated above.

V. NONROUTINE EXAMINATION

The Plan is advised that the Department will conduct a nonroutine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

On May 24, 2002 the Plan requested that additional information be included with the final report. The additional information was submitted in response to issues remaining after review of the Plan's March 29 Response.

The additional information is included in the pages that follow.

Attachment

DEPARTMENT OF MANAGED HEALTH CARE
ROUTINE FINANCIAL EXAMINATION OF THE CHP
File # 933 0248

COMMUNITY HEALTH PLAN FINAL REPORT RESPONSE

Section III. COMPLIANCE ISSUES

A. PAYMENT OF CLAIMS

DMHC Finding

The Department finds that the Plan's compliance efforts described above are not responsive to the deficiency cited and the corrective action required because the Plan failed to submit the schedules and the revised policy and procedures, demonstrating the Plan's ability to comply with these Sections. The draft procedures submitted as Attachment I in the Plan's March 29 Response did not address penalties and minimum interest payment amounts. The finalized policy and procedures must address these requirements and reflect the date of implementation. The Plan is required to file the required schedules and revised policies and procedures with the Department within fifteen (15) days from receipt of this report.

Community Health Plan Response

Identification of All Claims that were Paid Late

The Plan has prepared a detailed schedule listing all adjudicated and paid claims during the period January 1, 2000 through February 28, 2002, including emergency and non-emergency claims. Enclosed is a CD that includes the adjudicated claims in a file named "Detail.pdf".

The file "Detail.pdf" contains 5,406 pages of claims that the Community Health Plan (CHP) adjudicated and paid during this period.

The Department of Managed Health Care examiners agreed to the format of the schedule during fieldwork and again at the audit exit conference. This format did not include the "Date of Service" information and was, therefore, not included in the preparation of the file "Detail.pdf". The file structure of this report includes the following information requested by DMHC:

- Provider Name

- Claim Number
- Estimated Interest (Original Amount of Interest Paid)
- Total Paid (Original Claim Payment Amount, Plus Original Interest Paid)
- Interest Due (Additional Interest Paid Amount)
- Received (Date of Claim Receipt)
- Actual Mailing (Mailing Date of Original Payment)

The CHP summarized the 5,406 pages of claims by provider that were adjudicated and paid during the period January 1, 2000 to February 28, 2002 in the "Summary.pdf" file on he enclosed CD.

The file structure of the "Summary.pdf" schedule is as follows:

- Provider Name
- Paid (Original Claim Payment Amount)
- Estimated Interest (Original Amount of Interest Paid)
- Total Paid
- Actual Interest (Interest Paid Amount)
- Interest Due (Additional Interest Paid Amount)

In total, CHP identified 3,114 providers that it had adjudicated claims for, and processed payment to, during the period of January 1, 2000 through February 28, 2002. Of those 3,114 providers, 737 were owed less than $0.01 in additional interest, and 172 were listed more than once (e.g., XYZ Provider-Pomona and XYZ Provider-San Gabriel). The remaining 2,205 providers were owed $86,989.36 in additional interest payments and that data is included in the "Summary.pdf" file in the enclosed CD.

A third file in Excel on the CD, named "Additional Interest Paid", contains additional information for the 2,205 interest payments. The file is in alphabetical order by provider and contains the following additional information:

- Provider Name
- Date Additional Interest Paid
- Additional Interest Paid Amount
- County Warrant Number
- Transaction Number

As of May 16, 2002, the CHP has issued 1,139 interest payments to providers totaling $85,858.85. The remaining 1,066 interest payments totaling $1,130.51 will be issued by May 28, 2002.

Identification of Late Claims Due to an Appeal

The CHP identified 119 claims during the period January 1, 2000 to February 28, 2002 that were incorrectly paid and subsequently reprocessed due to an appeal or other information that resulted in the reprocessing of the claim and subsequent additional payment. The additional 119 claims were summarized into 18 provider payments. Payments for the 119 claims have been issued. The detail supporting these payments is included in the Excel file named "Appeals-Additional Interest Paid" which is included on the enclosed CD.

The file structure of this report includes the following information requested by DMHC:

- Provider Name
- Claim Number
- Date of Service
- Original Paid Amount (Original Claim Payment Amount)
- Claim Receipt Date (Date of Claim Receipt)
- Original Claim Paid (Date of Original Claim Payment)
- Date Interest Paid
- Total (Additional Interest Paid Amount)
- County Warrant Number (Additional Interest Payment Check Number)

Policy and Procedure

Attached is the finalized policy and procedure reflecting the Plan's ability to comply with Sections 1371 and 1371.35. Policy and Procedure 2.8 was implemented on May 20, 2002.

E. Books and Records Retention

DMHC Finding

Although, the Plan's compliance efforts as described in its March 29 Response substantially addresses the deficiency cited, the Plan is required to file the finalized policy and procedures pertaining to fee-for-service claims processing.

Community Health Plan Response

Please refer to the attached Policy and Procedure 2.8 pertaining to fee-for-service claims processing.