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October 20, 2004

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FINAL REPORT

Robert Lonardo, Director
County of Los Angeles-Department of Health Services
dba Community Health Plan
313 North Figueroa Street, Room 518
Los Angeles, CA 90012

RE: ROUTINE EXAMINATION OF COUNTY OF LOS ANGELES- DEPARTMENT OF HEALTH SERVICES

Dear Mr. Lonardo:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of County of Los Angeles-Department of Health Services (the "Plan") for the quarter ended March 31, 2004, 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 July 27, 2004. The Department received the Plan's response on September 13, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's September 13, 2004 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."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the final report. If so, please indicate which portions of the Plan's

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.

response shall be appended, and provide copies of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382(c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its September 13, 2004 response, please provide the documentation no later than ten (10) days from the date of the Plan's receipt of this letter.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter.

If there are any questions regarding this report, please call.

Sincerely,

Shelley Tang
Supervising Examiner
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Division of Financial Oversight
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(916) 323-4209

cc: Dr. Gail V. Anderson Jr., Acting Assoc. Director, Co. of L.A.-Dept. of Health Services
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**CALIFORNIA DEPARTMENT OF MANAGED
HEALTH CARE**

DIVISION OF FINANCIAL OVERSIGHT

**ROUTINE FINANCIAL EXAMINATION
FINAL REPORT**

**COUNTY OF LOS ANGELES-DEPARTMENT OF
HEALTH SERVICES**

OCTOBER 20, 2004

**EXAMINER-IN-CHARGE: PATRICIA MAZZEO
SUPERVISING EXAMINER: SHELLEY TANG**



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 and provides healthcare services for In-Home-Supportive Service Workers (IHSS) and County Temporary Employees.

Plan Enrollment: The Plan reported 169,225 enrollees for the quarter ended March 31, 2004.

Service Area: Approved service areas in Los Angeles County.

Date of Last Public Report for Routine Financial Examination: June 3, 2002

**FINAL REPORT OF A ROUTINE EXAMINATION OF COUNTY OF LOS ANGELES –
DEPARTMENT 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 July 27, 2004. The Department received the Plan’s response on September 13, 2004 (“September 13 Response”).

This Final Report includes a description of the compliance efforts included in the Plan’s September 13, 2004 response to the Preliminary Report, in accordance with Section 1382 (c).

We examined the financial report filed with the Department for the quarter ended March 31, 2004, 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:

- Section I. Financial Statements and Explanation of Adjustments
- Section II. Calculation of Tangible Net Equity
- Section III. Compliance Issues
- Section IV. Internal Control Issues
- Section V. Nonroutine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of 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 & EXPLANATION OF RECLASSIFICATION**A. BALANCE SHEET**BALANCE SHEET
AS OF MARCH 31, 2004

	Balance Per F/S @ 03/31/04	EXAMINATION Adjustments & Reclassifications		Balance Per Exam @ 03/31/04
		Debit	Credit	
<u>CURRENT ASSETS</u>				
Cash	\$94,832,385			\$94,832,385
Premiums Receivable – Net	13,781,582			13,781,582
Interest Receivable	312,153			312,153
Other Health Care Receivables	13,470,101	A1	3,993	13,466,108
Prepaid Pharmacy	1,236,965			1,236,965
Aggregate Write-Ins Current Assets	99,136	A2	99,136	0
Total Current Assets	<u>123,732,322</u>		<u>103,129</u>	<u>123,629,193</u>
<u>OTHER ASSETS</u>				
Restricted Assets	303,636			303,636
Total Other Assets	\$ 303,636			\$ 303,636
TOTAL ASSETS	<u>\$ 124,035,958</u>		<u>\$103,129</u>	<u>\$123,932,829</u>

BALANCE SHEET
AS OF MARCH 31, 2004

	Balance Per F/S @ 03/31/04		EXAMINATION Adjustments & Reclassifications		Balance Per Exam @ 03/31/04
			Debit	Credit	
<u>CURRENT LIABILITIES</u>					
Accounts Payable	7,127,955				7,127,955
Capitation Payable	22,283,751	R3	3,616,155		
		R1	1,568,365		17,099,231
Claims Payable (Reported)	3,086,771				3,086,771
Incurred But Not Reported Claims	7,829,377				7,829,377
Other Medical Liability	107,693				107,693
Agg. Write-Ins Current Liabilities	1,984,588			R1 1,568,365	3,552,953
Total Current Liabilities	<u>42,420,135</u>		<u>5,184,520</u>	<u>1,568,365</u>	<u>38,803,980</u>
<u>OTHER LIABILITIES</u>					
Aggregate Write-Ins/Other Liab.	<u>60,247,873</u>			R3 <u>3,616,155</u>	<u>63,864,028</u>
TOTAL LIABILITIES	<u>102,668,008</u>		<u>5,184,520</u>	<u>5,184,520</u>	<u>102,668,008</u>
<u>NET WORTH</u>					
Retained Earnings/Fund Balance	0	A1	3,993	R2 21,367,950	21,264,821
		A2	99,136		
Aggregate Write-Ins/ Other Net Worth Items	21,367,950	R2	21,367,950		<u>0</u>
TOTAL NET WORTH	<u>21,367,950</u>		<u>21,471,079</u>	<u>21,367,950</u>	<u>21,264,821</u>
TOTAL LIABILITIES & NET WORTH	<u>\$124,035,958</u>		<u>26,655,599</u>	<u>26,552,470</u>	<u>\$123,932,829</u>

B. INCOME STATEMENTSTATEMENT OF INCOME AND EXPENSES
AS OF MARCH 31, 2004

	Balance Per F/S @ 03/31/04	EXAMINATION Adjustments & Reclassifications Debit Credit	Balance Per Exam @ 03/31/04
<u>REVENUES</u>			
Premium	12,158,122		12,158,122
Title XIX-Medicaid	36,474,365		36,474,365
Interest	378,894		378,894
TOTAL REVENUES	<u>49,011,381</u>		<u>49,011,381</u>
<u>MEDICAL AND HOSPITAL EXPENSES</u>			
Inpatient Services – Capitated	14,062,776		14,062,776
Primary Professional Svs-Capitated	18,121,675		18,121,675
Other Medical Professional Svc-Cap	180,996		180,996
Other Med Prof. Svs-Non-Capitated	303,256		303,256
Non-Contracted Emerg/ OOA	7,657,414		7,657,414
Pharmacy Expense- Fee for Service	4,672,484		4,672,484
Total Medical/Hospital Expenses	<u>44,998,601</u>		<u>44,998,601</u>
<u>ADMINISTRATIVE EXPENSES</u>			
Compensation	3,012,003		3,012,003
Interest Expense	0		0
Occupancy, Depreciation, Amort.	0		0
Aggregate Write-Ins Admin. Exp.	<u>4,251,982</u>		<u>4,251,982</u>
Total Administrative Expenses	<u>7,263,985</u>		<u>7,263,985</u>
TOTAL EXPENSES	<u>52,262,586</u>		<u>52,262,586</u>
NET INCOME (LOSS)	<u>(\$3,251,205)</u>		<u>(\$3,251,205)</u>

C. EXPLANATION OF EXAMINATION RECLASSIFICATIONS

ADJUSTING JOURNAL ENTRIES

ENTRY #	ACCOUNT NAME	DEBIT	CREDIT
A1	Retained Earnings	\$3,993	
	Other Receivable Allowed		\$3,993
	To write-off uncollectible balance (See also Section III – Financial Reporting Issues)		
A2	Retained Earnings	\$99,136	
	Due from Other County Funds		\$99,136
	To write-off unsupported balance (See also Section III – Financial Reporting Issues)		

RECLASSIFYING JOURNAL ENTRIES

ENTRY #	ACCOUNT NAME	DEBIT	CREDIT
R1	Capitation Payable	\$1,568,365	
	Aggregate Write-Ins Current Liabilities		\$1,568,365
	To properly classify Capitation overpayments from L.A. Care from Capitation Payable (see also Section III – E. Capitation Payable)		
R2	Aggregate Write-Ins for Other Net Worth Items	\$21,367,950	
	Retained Earnings/Fund Balance		\$21,367,950
	To properly classify Fund Balance from Aggregate Write-Ins for Other Net Worth Items (See also Section III – F. Aggregate Write-Ins for Other Net Worth Items)		
R3	Capitation Payable	\$3,616,155	
	Due to County Los Angeles		\$3,616,155
	To properly reflect the capitation balance payable at 3/31/04 (See also Section III – Financial Reporting Issues.)		

The Plan was required to provide written assurance that the above adjusting and reclassifying journal entries have been posted to its books and records or provide an explanation regarding their disposition.

The Plan responded, "Community Health Plan (CHP) intends to incorporate DMHC's stated adjustments and reclassifications upon completion of the CHP annual independent audit for Fiscal Year (FY) 2003-04, to ensure CHP's books and records properly reflect both DMHC's and the independent auditor's examination results for the fiscal year. The results will be presented to the DMHC in the submission of the CHP annual audited financial statements for the fiscal year ending June 30, 2004."

The Plan stated, "The reclassification amount identified as Reclassification "R1" is separately identified as Account 2406 Unearned Premiums on CHP's Balance Sheet. The account was improperly presented on the Quarterly Report to DMHC for the period ending March 31, 2004 (Page 4, Report #1 - Part B: Liabilities and Net Worth, Current Liabilities, Line 2, Capitation Payable). In future reports, all unearned premium amounts will be properly presented on Line 11, Aggregate Write-Ins for Current Liabilities under the Current Liabilities section of Report #1."

Furthermore, the Plan stated, "Likewise, Reclassification "R2" describes CHP's net worth amount that was inadvertently presented on Report #1 - Part B: Liabilities and Net Worth, Net Worth, Line 25, Aggregate Write-Ins for Other Net Worth Items, instead of Line 24, Retained Earnings (Deficit)/Fund Balance. CHP's Net Worth will be properly presented in all future DMHC filings."

The Plan responded that the Chief Financial Officer will be responsible for insuring that these entries are executed and that proper expense classification will be an ongoing focus. Chief Financial Officer will also be responsible for the Plan's compliance with Generally Accepted Accounting Principles.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

Section II. CALCULATION OF TANGIBLE NET EQUITY ("TNE")

Net Worth per Examination @ March 31, 2004 (from Section I)	\$ 21,264,821
Add: Subordinated Debt	0
Less: Receivables from Officers, Directors and Affiliates	0
Intangibles	0
Tangible Net Equity @ March 31, 2004	\$21,264,821
Required Tangible Net Equity @ March 31, 2004	<u>(4,042,609)</u>
Excess Tangible Net Equity @ March 31, 2004	<u>\$ 17,222,212</u>

As of March 31, 2004, the Plan was in compliance with the TNE requirements of Section 1376, Rule 1300.76 as it relates to the adequacy of TNE. No response was required.

However, the Plan used an unacceptable method to annualize revenue and expenses resulting in unreasonable fluctuations of its required TNE. The Plan was required to provide assurances that it will calculate and report its required TNE, pursuant to Rule 1300.76, correctly in future Department of Managed Healthcare Financial Reporting Forms.

The Plan responded that to comply with Rule 1300.76, CHP will calculate TNE by annualizing current quarter amounts for premiums and healthcare expenditures. The Plan also responded that the TNE methodology described above will be incorporated in the submission of the CHP annual audited financial statements for the fiscal year ending June 30, 2004 and the management position responsible for ensuring that the corrective action has been implemented is CHP's Chief Financial Officer.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

Section III. COMPLIANCE ISSUES

A. ADMINISTRATIVE CAPACITY

Section 1367(g) requires plans to have the organizational and administrative capacity to provide services to subscribers and enrollees.

Rule 1300.67.3(a)(2) requires plans to maintain staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the Plan's business.

Our examination disclosed that due to staff shortages in the accounting department at the Plan, several accounts were neither written off timely nor reconciled with the appropriate journal entries recorded in a timely manner. [See Adjustments A-1, A-2 and Reclassification R-3 in Section I]. In addition, several accounts remain that require research in order to post journal entries. They include the following:

- 1) Capitation deductions that are taken to recoup claims payments made by the Plan on behalf of the capitated providers are not being recouped in a timely manner. The Plan has one employee who is responsible for this function as well as other accounting functions.
- 2) The Plan is delinquent in posting approximately \$10 million dollars in clearing account transactions. Due to the large amount outstanding, and the manual intensive work required to perform the postings, additional staff will be needed. The Department acknowledges that the Plan has incorporated new computer software to reduce some of the workload, however, manual entries are still required to integrate the new software with the Plan's older computer systems.
- 3) The Plan has approximately \$5.9 million in unassigned capitation recorded on its books for Fiscal Years 2002-2003 and 2003-2004. The Plan is unsure to whom the funds should be allocated. These funds represent capitation rate increases, orthopedic

settlement funds, and retro capitation paid on retro member enrollment.

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. In addition, the Plan should include a timeline as to when these journal postings will be made. 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 has been implemented.

The Plan responded that CHP intends to implement the following corrective actions:

1. Effective August 2, 2004, CHP Finance was organizationally reassigned to report directly to the Director of Office of Managed Care/Community Health Plan. As a result, Finance reevaluated its staffing needs and reassigned additional staff to the Capitation Unit. The CHP Information Systems Division is also in the process of creating user friendly Microsoft Access-based reports to improve Finance's ability to more timely recoup amounts paid by CHP on behalf of "at risk" capitated providers. CHP anticipates bringing the accounts current by March 31, 2005.

In addition, prior to expiration of CHP's Medi-Cal contracts, on December 31, 2004, CHP will amend contract boilerplates to establish a capitation withhold arrangement with capitated providers. The withhold will provide a reserve for CHP to pay for services for which the capitated provider is at financial risk, based on historical data, and serve as an incentive to more quickly settle amounts owed CHP by its capitated providers. CHP will develop applicable policies and procedures for the capitation withholds, to be implemented upon the January 1, 2005 contract effective dates and will be filed with DMHC by December 31, 2004. Ongoing compliance will be monitored by the Capitation and General Accounting Managers and through quality assurance reviews conducted by other Finance staff and reported to the Chief Financial Officer.

The management positions responsible for ensuring these corrective actions have been implemented are the Chief Financial Officer, the Chief Information Officer and the Chief Operations Officer.

2. CHP has experienced significant turnover in key positions over the past several years. In addition, to mitigate potential budget restrictions the County of Los Angeles has been operating under a hiring freeze over the past couple of years, which delayed filling critical vacant CHP positions and in turn has contributed to the late posting of necessary journal entries. CHP is determined on hiring additional personnel by December 2004.

As acknowledged in the Preliminary Report, CHP has incorporated new computer software to reduce some of the workload, but manual entries are still required to integrate the new software with the Plan's older computer systems. We anticipate bringing these journal posting entries current by no later than December 31, 2004. Our general accounting procedures require journal posting entries be made monthly, or more frequently, as needed. Ongoing compliance will be monitored by the General

Accounting Manager and through quality assurance reviews conducted by other Finance staff and reported to the Chief Financial Officer.

The management position responsible for corrective action to CHP's books and records is the Chief Financial Officer.

3. CHP is currently seeking legal authority to retroactively amend contracts to pass on rate increases to providers, as existing language does not allow the Plan to adjust rates without approval by the Los Angeles County Board of Supervisors. CHP anticipates on completing the process of amending its contracts, allocating the rate increases and recording the appropriate journal entries on its books by March 31, 2005.

In addition, Finance and Information Systems' staff are working together to properly identify the unassigned capitation attributed to the retroactive enrollments and disenrollments and will appropriate these funds to the applicable capitated providers. The task of identifying retroactivity entails a detailed analysis of enrollment data for current and prior years, distinguishing the capitation rates applicable at each month of enrollment and examining the possible impact to costs for services for which the capitated providers are at financial risk. Due to the complexity of the work involved in identifying the retroactivity, we foresee completion of this process within approximately nine to twelve months.

By November 15, 2004, CHP will initiate and file with DMHC policies and procedures that ensure retroactivity is reconciled on a recurring basis and properly recorded on its books. Upon establishment of the policies and procedures, CHP will conduct monitoring on a quarterly basis to ensure ongoing compliance with the established procedures.

The management positions responsible for ensuring these corrective actions have been implemented are the Chief Financial Officer, the Chief Operations Officer and the Chief Information Officer.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

B. CLAIMS SETTLEMENT PRACTICES

Rule 1300.71(a)(8)(F) requires a plan to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting, or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period.

Our examination disclosed that the Plan's "Explanation of Benefits" letter sent to providers with claims payments does not include a written explanation of the specific reasons for denying or adjusting claims payments. There is no mention in the letter as to how the providers' compensation was determined (i.e. paid according to contract rates) or reasons provided when certain line items on the claim were not paid (i.e. re-bundling of the claim).

The Plan was required to develop an explanation of benefits letter that is in compliance with section 1300.71(a)(8)(F).

The Plan responded that effective July 19, 2004, CHP revised the "Explanation of Benefits" letter format to include a written explanation of the specific reasons for denying or adjusting claims payment, clarify the rates used in determining reimbursement and to comply with Section 1300.71(a)(8)(F). The Plan attached a sample revised "Explanation of Benefits" letter as part of the response.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

C. INCURRED BUT NOT REPORTED CLAIMS

Rule 1300.77.1 requires "a plan subject to subdivision (b) of Section 1377 shall estimate its liability for incurred and unreported claims and record such estimate as an accrual in its books and records at least monthly."

Rule 1300.77.2(a) requires "each plan subject to subdivision (b) of Section 1377 shall calculate the estimate of incurred and unreported claims pursuant to a method held unobjectionable by the Commissioner. Such method may include a lag study as defined and illustrated in subsection (c), and actuarial estimate as defined in subsection (d), or other reasonable method of estimating incurred and unreported claims. The amount required by Section 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the month as calculated in working papers, schedules, or reports prepared in support of the unobjectionable lag study, actuarial estimate, or other method of estimating incurred but unreported claims."

Our examination disclosed, that the Plan does not update the payout ratio on a monthly basis using current billed amount and paid data. The Plan uses the payout ratio calculated based upon payout data from July 2002 through June 2003. As a result, the Plan is grossly overestimating its claims liability. The Plan's IBNR and claims payable run-out was \$6,459,468 at 3/31/04. Thus, Plan over-accrued IBNR and claims payable amounts by \$4,041,575 (37%) at March 31, 2004. In addition, IBNR and claims payable estimates for prior periods 12/31/03, 9/30/03 and 6/30/03 had claim run out amounts of \$7,356,622, \$7,701,185 and \$8,361,948; and thus were over accrued by \$852,368 (10%), \$8,028,484 (51%) and \$525,756 (6%), respectively.

The Plan was required to develop an IBNR methodology that is based upon current claims data. The Lag should track claims paid data based upon month of service to month of payment. The Plan was also required to perform hindsight reviews of claims paid to the IBNR. In addition, the Plan was required to submit a justification for the consistent over accrual of the Plan's incurred but not reported medical claims liability.

The Plan responded, CHP agrees that the IBNR liability had been overstated, and attributes the overstatement to the following: (1) applying a payout ratio that had not been updated since

the close of the prior fiscal year, and did not account for changes in the Medi-Cal rate tables; and (2) calculating a payout ratio based on a claims paid report instead of a claims closed report. The claims report used to calculate the payout ratio excluded amounts that would have reduced the ratios used in the previous IBNR estimates.

In April 2004, CHP revised its IBNR methodology and began updating the payout ratio on a monthly basis, using the most current claims data and correct claims report. Additionally, CHP will develop reports, by October 1, 2004, to perform hindsight reviews of claims paid to the IBNR estimate to ensure consistency and accuracy. Any significant changes in IBNR will be explained in footnotes to the DMHC financial reports.

The management positions responsible for ensuring that the corrective actions have been implemented are the Chief Financial Officer and Chief Information Officer.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

Our examination disclosed that the Plan does not have a lag for its In Home Support Services (IHSS) line of business.

The Plan was required to develop a lag and IBNR estimate for its In Home Support Services (IHSS) line of business.

The Plan responded, CHP has developed a lag for its IHSS line of business with information through April 2004. CHP is currently working with L.A. Care Health Plan, contracted to provide administrative support services for the CHP's IHSS line of business, to develop a lag study for information through the fiscal year end June 30, 2004. This lag will be used to calculate an IBNR estimate for the IHSS line of business to be consistent with the IBNR estimate for CHP's remaining lines of business and to comply with Section 1377(c), Rules 1300.77.1 and 1300.77.2. CHP anticipates finalizing its analysis of IHSS data and including an IBNR estimate for its IHSS line of business for inclusion in the CHP June 30, 2004 annual audited financial statements.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

Section 1377 (c) and Rules 1300.77.1 and 1300.77.2 require a plan to calculate and record, at least monthly, a liability for incurred and unreported claims if the payments made on a fee-for-service basis exceeds 10% of total health care costs.

Our examination disclosed that the Plan does not adequately track fee-for-service paid claims to non-contracted providers. These expenditures are included in with the fee-for-service paid claims to contracted providers. Fee-for-service claims paid to contracted providers should not be included in the calculations to determine compliance with Section 1377 (c) and Rules 1300.77.1 and 1300.77.2. Thus, the liability for fee-for-service paid claims that is used to calculate compliance with Section 1377(c) and Rules 1300.77.1 and 1300.77.2 is overstated.

The Plan was required to develop procedures that allow it to segregate out fee-for-service claims paid to non-contracted providers from fee for service claims paid to contracted providers.

The Plan responded, CHP is developing a process and procedures to enable it to separately identify and track fee-for-service contract claims; fee-for-service non-contract claims; and fee-for-service claims paid to capitated contract providers for CHP members assigned to other CHP network providers. CHP anticipates implementing these changes by November 1, 2004.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required. The Plan is reminded that the process and procedures should include tracking different types of fee-for-service claims paid to contracted and non-contracted providers.

E. CAPITATION PAYABLE

Section 1345(s) states that financial statements filed with the Department shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP) and fairly present the matters that they purport to present.

Per the Department's Financial Reporting Form instructions, capitation payable is defined as amounts due to capitated providers (i.e. medical groups/IPAs, ancillary and hospitals) for medical services rendered to enrollees of the reporting entity. Unearned premiums are defined as income booked in advance of the period to which it applies.

Our examination disclosed that the Plan reported \$1,568,365 as capitation payable on line 2 of Report #1-part B: Liabilities and Net Worth. This amount represents an overpayment of capitation from affiliate L.A. Care for services to be rendered by Plan providers. Since this overpayment is the result of a contract rate change, the Plan will refund the money to L.A care at a later date. Thus, the Plan should record it as a liability under Aggregate Write-Ins Current Liabilities. [See R-1 in Section I].

The Plan was required to provide assurances to the Department that this reclassification was posted to its books or provide an explanation regarding the disposition.

The Plan responded, CHP will properly present all unearned premium amounts as Aggregate Write-Ins for Current Liabilities in its submission of the annual audited financial statements for the fiscal year ending June 30, 2004 and in all subsequent reports filed with DMHC.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

E. AGGREGATE WRITE-INS FOR OTHER NET WORTH ITEMS

Section 1345(s) states that financial statements filed with the Department shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP) and fairly present the matters that they purport to present.

Per the Department's Financial Reporting Form instructions, "Aggregate Write-ins for Other Net Worth Items" is used to report other items of net worth which do not fit the definition of preferred stock, paid in surplus, contributed capital, or retained earnings (deficit)/fund balance. "Retained earnings (Deficit)/Fund" balance is defined as cumulative earnings or deficit from operations, net of reserves, and restricted funds. Governmental entities by nature report retained earnings as fund balances.

Our examination disclosed that the Plan reported its fund balance of \$21,367,950 on line 25, "Aggregate Write-Ins Other Net Worth Items". The fund balance should be reported on line 24 of Report #1-Part B: Liabilities and Net Worth, Retained Earnings/Fund Balance. [See R-2 in Section I].

The Plan was required to provide assurances to the Department that this reclassification was posted to its books or provide an explanation regarding the disposition.

The Plan responded, CHP will properly present its fund balance as Aggregate Write-Ins Other Net Worth Items in its submission of the annual audited financial statements for the fiscal year ending June 30, 2004 and in all subsequent reports filed with DMHC.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

F. INTERIM FINANCIAL STATEMENTS

Rule 1300.82.4(a) requires Financial Statements to be prepared in accordance with generally accepted accounting principles, prepared on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c) of the Act, unless the plan receives written approval of the Director to vary from that basis and the variance is adequately noted in its report under this section.

Rule 1300.84.2 (b) states the information required pursuant to Section 1300.84.06(b) of these rules for the period covered by the report requires sufficient and appropriate supplemental information to provide adequate disclosure of at least the following:

- 1) An explanation of the method of calculating the provision for incurred and unreported claims.
- 2) Accounts and notes receivable from officers, directors, owners or affiliates, including the name of the debtor, nature of the relationship, nature of the receivable and its terms.
- 3) A calculation of the plan's tangible net equity in accordance with section 1300.76.1 of these rules.

Section 1345(s) states that financial statements filed with the Department shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP) and fairly present the matters that they purport to present.

Our examination disclosed, that the Plan does not update the notes to the financial statements quarterly to discuss significant changes from prior periods. For instance, the Plan's cash dropped \$50 million dollars from December 31, 2003 to March 31, 2004, yet the Plan did not mention the reason why in the March 31, 2004 notes to the financial statements; nor do the notes reflect how the Plan calculated its claims payable amount, amount due to Los Angeles County, or other liabilities including contingent liabilities as a result of legal matters. Review of prior quarter-end financial statement notes indicate that the Plan reported the same information for Quarter-ends March 31, 2003, June 30, 2003, September 30, 2003, December 31, 2003, and March 2004.

Secondly, the calculation of the Plan's Tangible Net Equity may be understated as a result of the Plan writing off affiliate receivables older than 60 days. Currently, when payments are received from the affiliate for receivables that were booked and later written off, the revenue is used to offset current medical expenses. These procedures are not in accordance with GAAP. GAAP requires that an allowance for doubtful accounts be established to account for estimated uncollectible amounts within accounts receivable. In addition, the Department's Financial Reporting Form instructions, requests the "net" amount of receivable balances. The Plan should either establish an allowance for doubtful accounts for these receivables or deduct them from tangible net equity. [See Section III, Tangible Net Equity Calculation and Administrative Capacity].

The Plan was required to report financial information in accordance with GAAP and to update the notes to the financial statements on a quarterly basis and in a manner consistent with the certified financial report furnished by the Plan pursuant to Section 1384(c) of the Act. Furthermore, the Plan is required to calculate its Tangible Net Equity in accordance with Rule 1300.76.1.

The Plan was also required to provide the management position responsible for ensuring compliance to the above-mentioned section and rule.

The Plan responded, in accordance with GAAP, CHP will establish an "Allowance for Doubtful Accounts" for the DMHC deficiencies noted above. However, generating the information may require reprogramming of CHP's Patient Management System to enable it to compile the appropriate billing/aging reports. CHP anticipates initiating steps to implement the revised procedures no later than October 31, 2004. CHP intends on completing the programming and generating reports by February 2005.

The Plan responded that CHP will include notes to the quarterly financial statements to ensure full disclosure of significant prior period changes. CHP will incorporate significant changes in the notes section of the annual audited financial statements for the fiscal year ending June 30, 2004.

In addition, the Plan responded, as depicted in the "CALCULATION OF TANGIBLE NET EQUITY" response that CHP will calculate Tangible Net Equity in accordance with Rule 1300.76.

The management positions responsible for ensuring that the corrective actions have been implemented are the Chief Financial Officer and Chief Information Officer.

The Department finds that the Plan's compliance efforts are substantially responsive to the corrective actions required. However, the Plan did not clarify whether they would continue offsetting medical expenses with refunds from affiliate receivables written-off in determining their required TNE.

The Plan is required to state the disposition of the affiliate receivables with regards to their effect on the TNE calculation.

G. BOOKS AND RECORDS

Section 1385 and Rule 1300.85(a) requires books and records to be maintained on a current basis.

Our examination disclosed, that the Plan was behind in reconciling and recording several journal entries for suspense and capitation payments. Review of the Plan's general ledger indicated \$10 million in the plan's suspense account and \$5.8 million of unassigned capitation that needs to be identified and either recorded on the Plan's books or forwarded to plan providers. Furthermore, the Plan failed to record adjustments to its general ledger account in a timely manner. [See adjustments in Section I and Administrative Capacity in Section III for discussion.]

The Plan was required to file a corrective action plan outlining steps that the Plan is taking to resolve the balance reported in its suspense accounts as well as its unassigned capitation accounts. In addition, the Plan is required to file revised policies and procedures that reflect the Plan's ability to comply with Section 1385 and Rule 1300.85(a).

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

The Plan responded, as noted in "SECTION III.A - ADMINISTRATIVE CAPACITY," that CHP intends to implement the following corrective actions to maintain its books and records on a current basis and assure compliance with Section 1385 and Rule 1300.85(a).

- a) CHP is determined on hiring additional personnel by December 2004. As acknowledged in the Preliminary Report, CHP has incorporated new computer software to reduce some of the workload, but manual entries are still required to integrate the new software with the Plan's older computer systems. We anticipate bringing these journal posting entries current by no later than December 31, 2004. Our general accounting procedures require journal posting entries be made monthly, or more frequently, as needed. Ongoing compliance will be monitored by the General Accounting Manager and through quality assurance reviews conducted by other Finance staff and reported to the Chief Financial Officer.
- b) CHP plans to pass on retroactive unassigned rate increases to contract providers. However, CHP must amend contracts to pass on rate increases to providers, as existing language does not allow the Plan to adjust rates without approval by the Los Angeles County Board of

Supervisors. CHP anticipates on completing the process of amending its contracts, allocating the rate increases and recording the appropriate journal entries on its books by March 31, 2005.

- c) Effective August 2, 2004, CHP Finance was organizationally reassigned to report directly to the Director, Office of Managed Care/Community Health Plan. As a result, Finance reevaluated its staffing needs and reassigned additional staff to the Capitation Unit. CHP's Information Systems Division is also in the process of creating user-friendly Microsoft Access-based reports to improve Finance's ability to more timely recoup amounts paid by CHP on behalf of "at risk" capitated providers. CHP anticipates bringing the accounts current by March 31, 2005.

In addition, prior to the expiration of the CHP Medi-Cal contracts on December 31, 2004, CHP will amend contract boilerplates to establish a capitation withhold arrangement with capitated providers. The withhold will provide a reserve for CHP to pay for services for which the capitated provider is at financial risk, based on historical data, and serve as an incentive to more quickly settle amounts owed CHP by its capitated providers. CHP will develop applicable policies and procedures for the capitation withholds, to be implemented upon the January 1, 2005 contract effective dates and will be filed with DMHC by December 31, 2004. Ongoing compliance will be monitored by the Capitation and General Accounting Managers and through quality assurance reviews conducted by other Finance staff and reported to the Chief Financial Officer.

- d) Finance and Information Systems' staff are working together to properly identify the unassigned capitation attributed to the retroactive enrollments and disenrollments and will appropriate these funds to the applicable capitated providers. The task of identifying retroactivity entails a detailed analysis of enrollment data for current and prior years, distinguishing the capitation rates applicable at each month of enrollment and examining the possible impact to costs for services for which the capitated providers are at financial risk. Due to the complexity of the work involved in identifying the retroactivity, we foresee completion of this process within approximately nine to twelve months.

By November 15, 2004, CHP will initiate and file with DMHC policies and procedures that ensure retroactivity is reconciled on a recurring basis and properly recorded on its books. Upon establishment of the policies and procedures, CHP will conduct monitoring on a quarterly basis to ensure ongoing compliance with the established procedures.

The management positions responsible for ensuring that the corrective actions have been implemented are the Chief Financial Officer and Chief Information Officer and the Chief Operations Officer.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

SECTION IV. INTERNAL CONTROL (SECOND REPEAT DEFICIENCY)

Section 1384, 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 “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 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. [See A-1, A-2 in Section I].
- Receivables due from Other County Funds as of March 31, 2004, were not supported by promissory notes or any other documentation to support the receivable. [See A-1 in Section I].
- 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. [See Administrative Capacity Discussion Section III].

This was a second repeat deficiency that was also noted in the Department’s January 28, 1998 and June 3, 2002 Final Examination Reports.

The Plan’s March 29, 2002 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 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 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 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 has been implemented.

In addition, the Plan was required to provide an explanation for the reasons why the corrective action, as described in the Plan's March 29, 2002 response resulted in this repeated deficiency.

The Plan responded, in "SECTION I - RECLASSIFYING JOURNAL ENTRIES," that CHP will write-off the uncollectible and unsupported balances as illustrated in the DMHC Adjusting Journal Entries A-1 and A-2 to be included in the submission of the CHP June 30, 2004 audited annual financial statements.

In addition, as stated in the objective of CHP's Policy & Procedure 2.10, Exhibit B, CHP will ensure that inter-county fund transfers are supported by appropriate documentation and receivables due from Other County Funds are maintained in accordance with Statement of Auditing Standards Nos. 60 and 78. In order to ensure ongoing compliance with its existing policies and procedures, CHP will monitor compliance at least quarterly of the responsible areas.

As previously stated, CHP continued to experience significant turnover in key positions. In addition, to mitigate potential budget restrictions the County of Los Angeles had been operating under a hiring freeze over the past couple of years, which contributed to delays in filling critical vacant positions, and implementation and oversight of proposed procedures. CHP is currently hiring additional personnel to enable it to address these deficiencies.

The management position responsible for ensuring that the corrective action has been implemented is CHP's Chief Financial Officer.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required.

SECTION V. NON-ROUTINE EXAMINATION

The Plan was advised that the Department may 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).

No response is required for this section.



Gloria Molina
First District

Yvonne Brathwaite Burke
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
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November 4, 2004

Shelley Tang, Supervising Examiner
Division of Financial Oversight
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814

Dear Ms. Tang:

RESPONSE TO THE FINAL REPORT OF THE ROUTINE FINANCIAL EXAMINATION OF THE COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES (d.b.a.: COMMUNITY HEALTH PLAN), FILE NO. 933-0248

Enclosed is the Community Health Plan's (CHP) request for the Director of the Department of Managed Health Care (DMHC) to append the CHP's response to the DMHC Final Report dated October 20, 2004 concerning the routine examination of the fiscal and administrative affairs of the CHP for the quarter that ended March 31, 2004. The CHP is submitting information regarding the DMHC comments contained in Item F., Interim Financial Statements in order to provide clarification whether the CHP would continue offsetting medical expenses with refunds from affiliate receivables written-off in determining tangible net equity (TNE) requirements, and the disposition of affiliate receivables with regards to their effect on the TNE calculation.

This response has also been electronically filed via the DMHC web portal. If you have any questions or require additional information, please call Dave Beck at (626) 299-3338.

Sincerely,

Robert Lonardo, Director
Office of Managed Care/Community Health Plan

RL:DB:nb
00:943

Attachment

c: Dave Beck, Chief Financial Officer, CHP
Steven Goby, Senior Counsel, Division of Licensing, DMHC
Fred Leaf, Chief Operating Officer, L.A. County-DHS
Maryam Tahriri, DMHC Examiner
Mark Wright, Chief, Division of Financial Oversight, DMHC

**COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
d.b.a.: COMMUNITY HEALTH PLAN (CHP)**

**RESPONSE TO FINAL REPORT OF THE ROUTINE EXAMINATION
OF THE COMMUNITY HEALTH PLAN**

ITEM F. INTERIM FINANCIAL STATEMENTS

In accordance with generally accepted accounting principles (GAAP) the CHP will incorporate the Allowance Method to account for estimated uncollectible amounts within accounts receivable. This methodology requires establishing an Allowance for Doubtful Accounts, and an Uncollectable Expense account. All amounts determined to be uncollectible will be identified to these Balance Sheet and Income Statement accounts respectively. CHP will no longer apply affiliate receivables that were initially written-off to offset current medical expenses. Furthermore, a deduction to tangible net equity (TNE) for these receivables is unnecessary. CHP will calculate TNE by annualizing the current quarters' premiums and healthcare expenditures to comply with Rule 1300.76.

The management position responsible for ensuring the corrective action has been implemented is the CHP Chief Financial Officer.