CALIFORNIA STATE AUDITOR

Medi-Cal Managed Care Program

The Departments of Managed Health Care and Health Care Services Could Improve Their Oversight of Local Initiatives Participating in the Medi-Cal Two-Plan Model

December 2011 Report 2011-104

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December 13, 2011 2011-104

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the California Medical Assistance Programs (Medi-Cal) managed care two-plan model, under which both a county entity, known as a local initiative, and a commercial health plan provide services to Medi-Cal beneficiaries. The departments of Managed Health Care (Managed Health Care) and Health Care Services (Health Care Services) share oversight responsibility for the local initiatives participating in the two-plan model.

Both departments have inconsistencies in the financial reviews they conduct of local initiatives. Managed Health Care is chronically late in completing its financial report reviews, thus seriously lessening their value as an oversight tool. Further, Managed Health Care does not have an effective process to monitor local initiatives' responses to corrective action plans that result from its financial examinations. For its part, Health Care Services is inconsistent in performing financial reviews and does not always ensure that all financial requirements are included. Finally, both Managed Health Care and Health Care Services fail to conduct medical audits—intended to review several aspects of the provision of health care—of the health delivery system of each local initiative within the frequency required by law.

Although most local initiatives hold tangible net equity (TNE) balances—the central measure of financial viability under the Knox-Keene Health Care Service Plan Act of 1975—that are significantly higher than the required TNE minimum balances—Health Care Services' performance indicators show that California's eight local initiatives in operation during the time covered by our audit provide a satisfactory level of care to beneficiaries. The four local initiatives we visited generally had adequate fiscal processes and internal controls to monitor their administrative expenses, although weak past policies at Kern Health Systems allowed it to enter into two contracts for medical claims reviews that were not cost-effective. Our review also found that the four local initiatives we visited use similar methods to set and approve salaries, although the salaries and retirement benefits of their highest-paid executives vary significantly.

Respectfully submitted,

Elaine M. Howle

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State Auditor

Contents

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Summary

Results in Brief

The California Medical Assistance Program (Medi-Cal) is California's Medicaid program, which the Department of Health Care Services (Health Care Services) administers. In 1993 the State began the process of expanding the enrollment of its Medi-Cal population into managed care health plans, which the Legislature intended would reduce the cost of Medi-Cal care and provide beneficiaries with improved quality of services and access to care. One of the managed care models is the Medi-Cal two-plan model (two-plan model) in which both a county entity, known as a local initiative, and a commercial health plan provide services to Medi-Cal beneficiaries. As of October 2011, the 14 counties using the two-plan model, which includes the nine local initiatives, served 4.9 million Medi-Cal beneficiaries.

Health Care Services and the Department of Managed Health Care (Managed Health Care) share oversight responsibility for the local initiatives participating in the two-plan model. Under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), Managed Health Care monitors the financial viability of all managed care health plans, including the local initiatives, by reviewing financial reports submitted by the plans, as well as by other measures. Health Care Services contracts with the local initiatives to provide Medi-Cal managed care services and oversees compliance with Medi-Cal requirements. Health Care Services makes monthly payments to the local initiatives based on the number of enrolled beneficiaries.

However, both departments have inconsistencies in the financial reviews they conduct of local initiatives. Managed Health Care has been chronically late in completing its financial report reviews, missing its internal 30-day goal for completing 15 of the 16 reviews we tested and taking an average of more than 200 days to complete each of the 16 reviews, thus seriously lessening their value as an oversight tool. Because it did not track this information until May 2011, Managed Health Care had no way to easily determine which financial reports were still pending a review. After our inquiry, Managed Health Care developed a report that shows all financial reviews that are late.

Managed Health Care also failed to detect that two of the four local initiatives we reviewed incorrectly categorized administrative expenses as medical expenses. Specifically, Contra Costa Health Plan improperly categorized as medical expenses payments totaling $1 million to an external contractor for claims processing related to entities other than Medi-Cal beneficiaries.

Audit Highlights . . .

Our review of the State's California Medical Assistance Program (Medi-Cal) managed care two-plan model revealed:

» *Financial reviews of local initiatives participating in the two-plan model, performed by oversight agencies, need improvement.*

- *Specifically, our testing indicated that the Department of Managed Health Care (Managed Health Care):*

✓ *Took an average of more than 200 days to complete the financial reviews we tested—well over its internal 30-day goal.*

✓ *Did not detect that two of the four local initiatives we visited incorrectly categorized administrative expenses as medical expenses.*

✓ *Has an ineffective process to monitor local initiatives' responses to corrective action plans that result from the financial examinations it performs.*

- *Further, our testing indicated that the Department of Health Care Services (Health Care Services):*

✓ *Did not analyze all financial requirements in seven instances of the 16 reports from four local initiatives we reviewed.*

✓ *Performs reviews of local initiatives' financial reports that overlap with Managed Health Care's financial viability analysis.*

» *Additionally, both Managed Health Care and Health Care Services failed to conduct medical audits of the health delivery system of each health plan, including the local initiatives, within the required frequency.*

continued on next page . . .

» *All eight of the local initiatives had TNE actual balances that exceeded required minimums during fiscal years 2005–06 through 2009–10.*

» *The four local initiatives we visited generally had adequate fiscal processes and internal controls to monitor their administrative expenses and used similar methods to set and approve salaries.*

Kern Health Systems (Kern) also improperly categorized $5.3 million in claims processing costs as medical expenses rather than administrative expenses. Managed Health Care's failure to identify these errors in its financial reviews is troubling and suggests that it may be overlooking other errors as well.

For its part, Health Care Services has been inconsistent in performing financial reviews and has not always ensured that all financial requirements are reviewed. Our testing of its reviews of 16 quarterly financial reports from four local initiatives identified seven instances in which Health Care Services did not analyze all four financial soundness elements, such as working capital and administrative costs, that local initiatives are required to maintain under the Medi-Cal managed care contract. Health Care Services also has not reviewed financial reports within two weeks of receipt, as outlined in the internal policies of its fiscal monitoring unit.

Further, Health Care Services' efforts to review local initiatives' financial reports overlap the financial viability analysis that Managed Health Care performs on these reports. Health Care Services requires local initiatives to demonstrate fiscal soundness and to maintain adequate resources to carry out their contractual obligations to provide health services to Medi-Cal beneficiaries. The Knox-Keene Act also requires local initiatives to submit their financial reporting forms to Managed Health Care. However, Health Care Services could be more efficient if it obtained and relied on the financial trends and ratios of the consolidated financial statements that Managed Health Care automatically generates.

We also found that Managed Health Care does not have an effective process to monitor local initiatives' responses to corrective action plans that result from the financial examinations it performs. Our testing of 12 financial examinations occurring during fiscal years 2005–06 to 2009–10 revealed that Managed Health Care did not adequately follow up on six of the 19 corrective action plans arising from those examinations. Ineffective monitoring of corrective action plans may be due to Managed Health Care not fully using the features of the computer database it uses to communicate and exchange documents with the local initiatives. Its inadequate follow-up on local initiatives' compliance weakens Managed Health Care's ability to provide effective oversight of the local initiatives' financial viability.

In addition, both Managed Health Care and Health Care Services have failed to conduct medical audits of the health delivery system of each health plan, including the local initiatives, within the frequency required by law. Medical audits are intended to review the quality of health care services, the effectiveness of peer review, procedures for regulating utilization and assuring quality of care, and the overall performance in providing care and meeting the needs of beneficiaries.

Under the Knox-Keene Act, the main measure of a managed care health plan's financial viability is known as tangible net equity (TNE).[1] Managed Health Care has adopted regulations that establish the required TNE minimum balance a health plan must maintain to demonstrate its financial viability. Further, Health Care Services has established a required TNE minimum in its Medi-Cal managed care contracts with local initiatives. However, no upper limit for TNE is established in law or in the contracts between health plans and Health Care Services. Therefore, neither oversight entity reviews the local initiatives' TNE actual balances that are greater than the required minimums or determines whether a local initiative has valid reasons for accumulating TNE actual balances that are above the minimum. Although each local initiative's required TNE minimum balance varied due to its business practices during a given fiscal year, all eight of the local initiatives reviewed for this report[2] had TNE actual balances that exceeded their required minimum balances during fiscal years 2005–06 through 2009–10. For example, during fiscal year 2009–10, the TNE actual balances for the local initiatives ranged from 176 percent to 1,180 percent of the required minimums.

Five of the eight local initiatives have established formal policies setting a goal for the amount of TNE and/or specifying uses of those funds. The majority of local initiatives stated that the main reason for maintaining TNE beyond the required minimum is to ensure continuity of service to Medi-Cal beneficiaries and to maintain a strong provider network, especially during periods when state funding is delayed. Although the TNE actual amounts vary by local initiative, each local initiative appears to have valid reasons for the level it sets. In addition, over the past five fiscal years all of the local initiatives met or exceeded Health Care Services' minimum performance indicators, showing that they generally provide a satisfactory level of care to beneficiaries while maintaining their varying TNE actual balances.

Another area we tested was the nature of local initiatives' administrative expenses. State regulations require that administrative expenses be "reasonable and necessary." Also if, during any period, administrative costs exceed 15 percent of the total revenues received from providing services to beneficiaries, Managed Health Care may ask a local initiative to demonstrate that its administrative costs are not excessive. The four local initiatives we visited generally had adequate fiscal processes and internal controls to monitor their administrative expenses to ensure that they were reasonable

[1] TNE is the value of net equity (excess of total assets over total liabilities as defined in regulation) reduced by the value assigned to intangible assets, including goodwill, organizational expense, and start-up costs.

[2] One local initiative, CalViva Health, began accepting beneficiaries in March 2011 and is outside the scope of our review, which was fiscal years 2005–06 through 2009–10.

and necessary, although weak policies at Kern allowed it to enter into two contracts for medical claims reviews that were not cost-effective. In one of these contracts, Kern paid a contractor nearly $8 million to investigate excessive charges estimated at $1 million related to a lawsuit. Our review also found that the local initiatives use similar methods to set and approve salaries, although the salaries and retirement benefits of their top executives vary significantly. The types of compensation chief executive officers received included bonuses, car allowances, and vacation cash-out options. In addition, the contracts for the local initiatives' chief executive officers include varying levels of severance packages, ranging from no payments if the chief executive officer voluntarily resigns to ones specifying that the chief executive officer will receive up to 18 months of additional compensation if terminated without cause.

Recommendations

To monitor local initiatives' financial viability and compliance with the Knox-Keene Act requirements, Managed Health Care should develop a formal policy to ensure that it reviews financial reports in a timely manner, and that administrative expenses are correctly categorized.

To ensure that all four financial soundness elements included in Health Care Services' contract are being reviewed, it should conduct financial reviews consistently and update its reviewing tool to include working capital. In addition, Health Care Services should develop a formal policy to ensure that it conducts financial reviews in a timely manner.

To make its financial viability reviews more efficient and reduce the risk of errors, Health Care Services should coordinate with Managed Health Care when analyzing local initiatives' consolidated financial reports.

To ensure that local initiatives implement corrective action plans, Managed Health Care should devise a more effective process to track, monitor, and review the status of local initiatives' corrective actions as they relate to financial examination requirements.

Health Care Services should ensure that it performs annual medical audits of local initiatives as required by law. Managed Health Care should ensure that it obtains timely medical audits from Health Care Services. If it is unable to obtain timely medical audits from Health Care Services, it should conduct them itself.

Agency Comments

Managed Health Care agreed with our recommendations, but disagreed with our conclusion that it is chronically late completing reviews of local initiatives' financial reports. Health Care Services agreed with our conclusions and recommendations.

Introduction

Background

The California Medical Assistance Program (Medi-Cal) is California's Medicaid program, administered by the Department of Health Care Services (Health Care Services). Medi-Cal is a federal program, funded and administered through a state and federal partnership, to provide public health insurance to certain low-income individuals and families who fit eligibility requirements as recognized by federal and state law. Medi-Cal beneficiaries receive care from medical providers who bill Health Care Services directly for each medical procedure they perform, an approach known as *fee for service.*

In 1991 the Legislature directed the Medi-Cal program to increase its efforts to use managed care health plans similar to those available to the general public. The Legislature intended that this change would reduce the cost of medical care furnished under Medi-Cal and provide the Medi-Cal population with improved quality of services and access to care. In 1993 the State began the process of expanding the enrollment of its Medi-Cal population into managed care health plans. According to Health Care Services, as of October 2011 about 6.7 million Medi-Cal beneficiaries in 30 counties received their health care through the three models of managed care described in the text box, and to a lesser extent in these counties on a fee-for-service approach. The remaining 370,000 Medi-Cal beneficiaries in the other 28 counties continue to receive their care through a fee-for-service approach.

Three Models of Medi-Cal Managed Care

Two-plan model
In most cases, the Department of Health Care Services (Health Care Services) contracts with both a commercial health plan and a local initiative, which is a locally-organized health plan that the county creates but operates independently of the county.

County-organized health systems
Health Care Services contracts with a health plan that the county creates and operates.

Geographic managed care
Health Care Services contracts with several commercial health care plans in the county.

Source: Health Care Services' Web site.

Under managed care, the State pays a health plan a monthly fee, known as a *capitation rate*, for each Medi-Cal beneficiary enrolled in a plan. Medi-Cal beneficiaries enrolled in a managed care plan select a primary care physician who provides their health care services on a regular basis and refers them to a specialist when medically necessary. Managed care plans also offer assistance in various areas such as coordinating care and providing ongoing referrals to specialists, telephone advice nurses, customer service centers, and support groups for beneficiaries. Figure 1 on the following page shows the types of Medi-Cal coverage offered throughout the State.

Figure 1
Medi-Cal Managed Care and Fee-for-Service Counties
October 2011

Source: Department of Health Care Services' Web site.
Note: Amounts rounded to the nearest thousand.

Medi-Cal beneficiaries who live in one of the 14 Medi-Cal two-plan model counties have the option to choose between two managed care health plans, in most cases either a commercial plan or a local initiative. Local governments, community groups, and health care providers were able to provide input on shaping local initiatives when they were created. As a result, the local initiatives are designed to meet the needs and concerns of the community. Health Care Services also contracts with a private commercial health plan in these counties to provide care for Medi-Cal beneficiaries. As of October 2011 the two-plan model was being used in 12 counties served by nine local initiatives,[3] as well as in two additional counties in which the beneficiaries have a choice between two commercial health plans. The health plans in these 14 two-plan model counties served about 4.9 million beneficiaries either under managed care or fee-for-service.

To provide medical services, local initiatives contract directly with health care providers or a combination of health care providers and commercial plans. The local initiatives pay the health care providers and commercial health plans on a fee-for-service basis or use a capitation rate consisting of a monthly fee for each beneficiary. For example, Kern Health Systems (Kern) contracts directly with health care providers on a fee-for-service basis, while L.A. Care Health Plan (Los Angeles) contracts with health care providers and commercial health plans mostly on a capitated rate basis. The revenue sources of local initiatives vary; however, the local initiatives' primary revenue source is from Medi-Cal capitation payments. Both Health Care Services and the Department of Managed Health Care (Managed Health Care) have oversight responsibility for the health plans, as shown in Figure 2 on the following page.

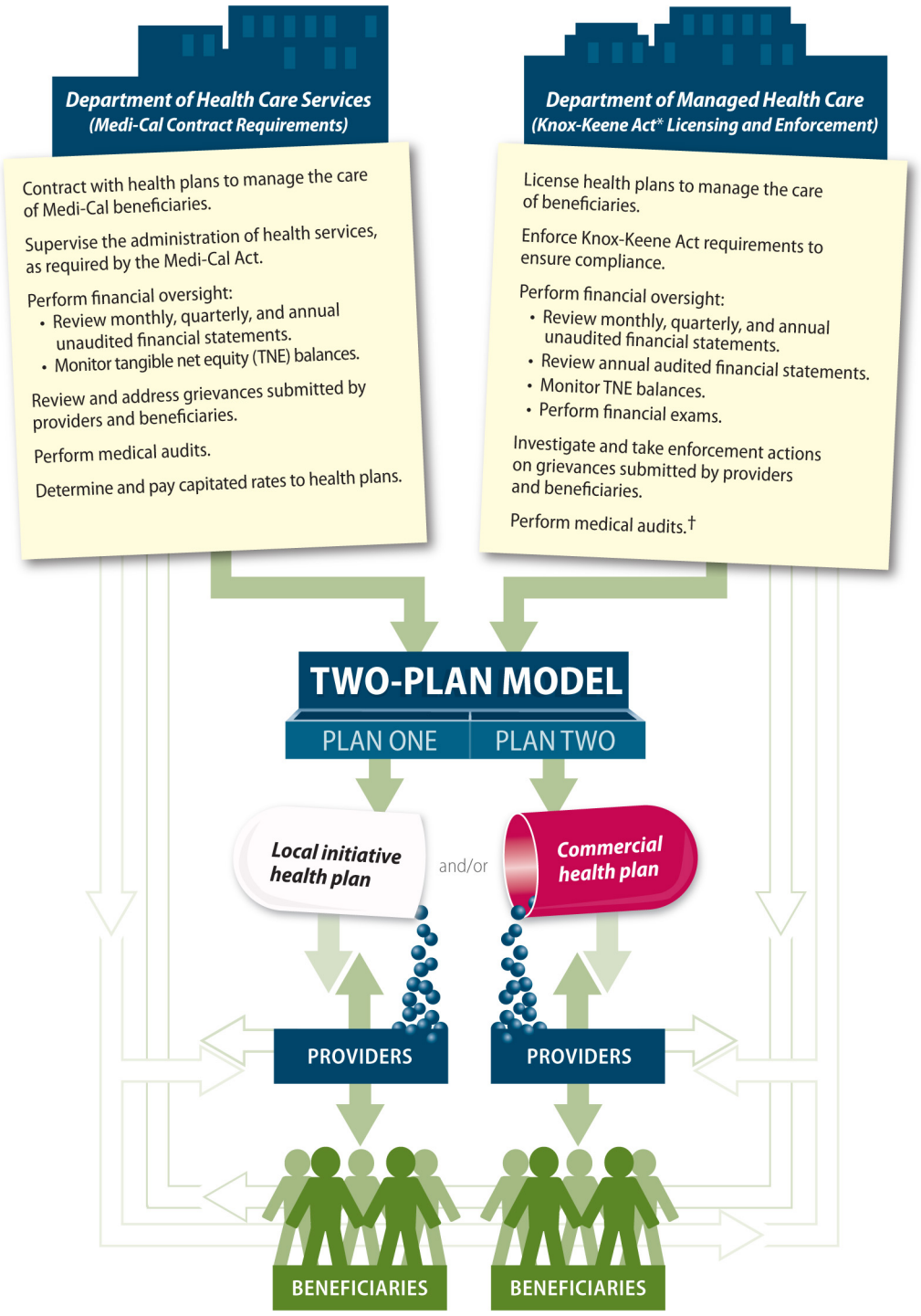
Health Care Services Is Responsible for Contracting With and Overseeing the Medi-Cal Managed Care Program

Health Care Services contracts with health plans to provide Medi-Cal services to beneficiaries. The contract states that Medi-Cal services include those which are reasonable and necessary to protect life; prevent significant illness or significant disability; or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. The contract also requires health plans to meet and maintain financial viability standards regarding their tangible net equity (TNE),[4] administrative costs, and working capital.

[3] One local initiative, CalViva Health, began accepting beneficiaries in March 2011 and is outside the scope of our review, which was fiscal years 2005–06 through 2009–10.

[4] TNE is the value of net equity (excess of total assets over total liabilities as defined in regulation) reduced by the value assigned to intangible assets, including goodwill, organizational expense, and start-up costs.

Figure 2
Responsibilities of the Departments of Health Care Services and Managed Health Care for the Medi-Cal Managed Care Two-Plan Model



Sources: California State Auditor's analysis of Health and Safety Code, and interviews with the departments of Health Care Services and Managed Health Care staff.

* Knox-Keene Health Care Service Plan Act of 1975.

† Although the statutes directed at Managed Health Care use the term "survey," we use the term "audit" throughout the report to address these issues.

Health Care Services is responsible for overseeing health plans' compliance with financial viability standards and Medi-Cal contractual requirements. It collects financial reports and performs quarterly financial reviews and can also conduct medical loss ratio evaluations. *Medical loss ratio* refers to the percentage of premium dollars that a contractor spends on providing beneficiaries with health care and improving the quality of care versus how much is spent on administrative and overhead costs, such as salaries or bonuses. Medical loss ratio evaluations review the capitation payments Health Care Services makes to the health plan against claims the health plan pays to providers. The health plans that serve seniors and persons with disabilities are required under the terms of a federal waiver agreement to have a medical loss ratio evaluation once every three years. These evaluations are also conducted when a local initiative has a dispute regarding the capitation rate it receives from Health Care Services. According to the chief of the Capitated Rates Development Division, Health Care Services has stated that the amount it pays to managed care plans includes an implied profit of no more than 2 percent. In addition, Health Care Services reports to the federal Centers for Medicare and Medicaid Services on the financial soundness of the health care plans on a quarterly basis.

Further, Health Care Services is required to conduct medical audits of health plans. The purpose of a medical audit is to evaluate the overall performance of the health plan in providing health care benefits to beneficiaries. Managed Health Care is also required to conduct medical audits.[5] In the past, Health Care Services and Managed Health Care jointly conducted some of their medical audits on a schedule set by Health Care Services. In the joint relationship, Health Care Services was responsible for conducting follow-up with the local initiatives on corrective action plans resulting from deficiencies noted during the medical audit. As of October 2010 Health Care Services and Managed Health Care no longer conduct medical audits jointly.

Federal and state laws also require Health Care Services to measure and report on the quality and appropriateness of care that the various health care plans provide to their beneficiaries. To fulfill this requirement, Health Care Services employs a health services contractor to perform annual independent external quality reviews of services provided to Medi-Cal beneficiaries by managed care plans, including local initiatives, and to conduct audits of these plans in accordance with standards established by the National Committee for Quality Assurance (NCQA). For these external quality reviews, the health care services contractor evaluates local

[5] Although the statutes directed at Managed Health Care use the term "survey," we use the term "audit" throughout the report to address these issues.

initiatives' quality of care and services provided against a subset of the NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) performance measures. HEDIS is a nationally recognized set of performance measures that the NCQA developed to measure performance on important dimensions of health care and service. These performance measures are used by more than 90 percent of United States health plans. A HEDIS audit analyzes the quality of health care and services provided, evaluates the information and reporting systems, and reviews the methodologies for calculating performance measure rates. By using a standardized national measure of quality of care that is independently audited, Health Care Services can compare health plans within and across the three managed care models.

Each year, Health Care Services establishes minimum performance levels for each HEDIS indicator using the NCQA's publication titled *Audit Means, Percentiles, and Ratios*. Health Care Services uses these minimum performance levels as benchmarks to assess a health plan's minimum satisfactory performance level relative to national thresholds. If a health plan's performance falls below an indicator's minimum performance level, it must submit an improvement plan to Health Care Services outlining the steps it will take to improve its performance. Health Care Services updates performance indicators annually to add or delete measures.

Health Care Services also addresses grievances from beneficiaries and ensures that beneficiaries receive nonmedical services in connection with their health care, such as cultural and linguistic services. In addition, Health Care Services provides technical assistance to local initiatives.

A federal waiver approved in November 2010 authorizes mandatory enrollment of Medi-Cal seniors and persons with disabilities into Medi-Cal managed care from the fee-for-service plan. Health Care Services believes that the waiver will allow it to coordinate care for these individuals to better manage chronic conditions and to improve health outcomes. Mandatory enrollment of seniors and persons with disabilities began in June 2011 and is expected to continue for 12 months, during which all two-plan model counties and geographic managed care counties will enroll these beneficiaries into their managed care plans.

Following the authorization of the waiver, Health Care Services entered into an interagency agreement to have Managed Health Care conduct financial audits, medical audits, and a review of the provider networks of the managed care health plans participating in the mandatory enrollment of seniors and persons with disabilities. In addition, the federal Centers for Medicare and Medicaid Services

has required Health Care Services to submit the results of these audits and reviews to them on a quarterly basis. The interagency agreement was signed in September 2011 and ends on June 30, 2013.

Managed Health Care Is Responsible for Compliance With the Knox-Keene Health Care Service Plan Act of 1975

Managed Health Care is responsible for ensuring that managed health care plans, including local initiatives, are financially viable and comply with requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). All local initiatives are required to electronically submit their annual audited financial statements, as well as their quarterly financial reports,[6] to Managed Health Care. Managed Health Care uses this financial information to monitor and perform various analyses, including confirming that required TNE minimum balances are met, and to ensure that local initiatives are financially viable. In addition, the state regulations that implement the Knox-Keene Act indicate that an established local initiative whose administrative expenditures exceed 15 percent of the total revenues received from providing services to beneficiaries during any period may be called upon to demonstrate the justification for those expenses.

Managed Health Care performs several other types of reviews of local initiatives. It must conduct a financial examination of each local initiative to ensure compliance with the Knox-Keene Act requirements. Although the law requires this examination to occur once every five years, Managed Health Care strives to perform these examinations on a three-year cycle. Managed Health Care is also required to perform medical audits of health plans at least once every three years, but it can rely on audits performed by Health Care Services to fulfill that obligation. For any deficiencies noted during these examinations and reviews, Managed Health Care can request that the local initiative provide a corrective action plan outlining how it will address the problem. For more severe violations, Managed Health Care has an office of enforcement that can impose monetary fines. Finally, Managed Health Care receives and responds to complaints about local initiatives from both beneficiaries and providers.

[6] If a local initiative is experiencing financial difficulty, Managed Health Care may also require that it submit financial reports on a monthly basis.

The Knox-Keene Act Requires Licensed Managed Care Health Plans to Maintain a Minimum TNE Balance

Under the Knox-Keene Act, Managed Health Care is responsible for providing safeguards with respect to the financial responsibility of managed care health plans. As part of these safeguards, state regulations establish the minimum amount of TNE that a managed care health plan must have. The TNE requirement serves as a minimum solvency standard intended to ensure the financial viability of these plans, including the local initiatives. According to statute, when a health plan falls below 130 percent of the required TNE minimum balance, the frequency of financial reporting is changed from quarterly to monthly. However, Health Care Services becomes concerned when a health plan's TNE dips below 200 percent of the required TNE minimum balance. See Appendix A for the calculation used to determine the required TNE minimum at each local initiative for fiscal year 2009–10.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) directed the California State Auditor (state auditor) to audit the fiscal processes of local initiatives that contract with the State to provide Medi-Cal services. Specifically, the audit committee was concerned about the fiscal integrity of the local initiatives that have elevated levels of TNE. The audit committee directed the state auditor to provide independently developed and verified information related to fiscal processes used by Kern, a local initiative, and three to four other local initiatives that administer Medi-Cal funds. In addition to Kern, we performed testing at Contra Costa Health Plan, Los Angeles, and Health Plan of San Joaquin. Furthermore, we reviewed financial reports and audited financial statements and for certain audit objectives we surveyed Alameda Alliance for Health, Inland Empire Health Plan, San Francisco Health Plan, and Santa Clara Family Health Plan. To address the audit committee's request, we performed the procedures shown in Table 1.

We used the local initiatives' annual financial reports for fiscal years 2005–06 through 2009–10 to calculate the TNE actual balances, required TNE minimum balances, administrative expenses, and cash and liquid investments. To validate the information in the annual financial reports, we compared them to the audited financial statements for the same period. Based on this comparison, we believe the information we obtained is sufficiently reliable for this report.

Table 1
Methods of Addressing Audit Objectives

AUDIT OBJECTIVE	METHOD
Review and evaluate the laws, rules, and regulations significant to the audit objectives.	• Reviewed relevant laws, regulations, and other background materials. • Interviewed staff from the departments of Health Care Services (Health Care Services), and Managed Health Care (Managed Health Care), and local initiatives to better understand tangible net equity (TNE) and how it is used and monitored.
Identify and assess the roles and responsibilities of the various departments and agencies involved with the two-plan model and the local initiatives. Determine which agency is authorized to oversee and monitor the composition of TNE balances.	• Interviewed staff from Health Care Services and Managed Health Care. • Reviewed both departments' internal policies and procedures.
Identify and test the controls in place at the oversight entities and determine whether such controls are appropriate and sufficient to ensure that taxpayer funds are properly used.	• Interviewed staff from Health Care Services and Managed Health Care. • Reviewed both departments' audited financial statements, financial report submissions, and tracking processes, as well as their policies and audit tools.
Identify what mechanisms are in place at the oversight entities to ensure that local initiatives take corrective action on any improper fiscal processes that may be noted during the oversight and monitoring activities.	• Interviewed staff from Health Care Services and Managed Health Care. • Reviewed financial-related deficiencies reported in tested financial reviews to determine if local initiatives submitted corrective action plans.
Select and review a sample of local initiatives—including Kern Family Health Care—and perform the following analysis over the past five years:	Interviewed staff from four local initiatives for each objective.
a) Identify the revenues and expenditures at each of the local initiatives and determine whether funds were used appropriately.	• Compiled revenue and expenditure totals for audited financial statements of all local initiatives for fiscal years 2005–06 through 2009–10 from audited financial statements.* • Visited four local initiatives and reviewed financial and payroll information.
b) Review how salaries for top management at each local initiative are set and identify their current salaries and wages. Determine whether the salaries were properly approved and are comparable with industry standards.	• Visited four local initiatives and reviewed the policies and procedures to approve salary structures and employee salary changes. • Verified salaries and other compensation for the chief executive officer and other top paid executives for the four local initiatives visited, and that salaries were developed using salary studies of comparable entities. • Compiled salary and compensation figures for all local initiatives for 2006 through 2010.
c) Review the financial statements and identify the TNE levels and compare them to the amounts required to determine instances of excess TNE amongst the local initiatives.	Reviewed the audited financial statements and financial reports filed with Managed Health Care for all the local initiatives and their commercial competitors; verified the TNE balances reported.
d) 1. Determine the reasons for excess TNE balances at the local initiatives.	Interviewed staff from Health Care Services, Managed Health Care, and the local initiatives to determine how TNE is calculated and used.
2. Determine the impact, if any, on services to beneficiaries.	Reviewed the 2006 through 2010 annual Healthcare Effectiveness Data Information Set reports for each local initiative.
e) 1. Identify each local initiative's fiscal processes and determine if management controls exist and are effective to ensure that funds are properly received and used.	Visited four local initiatives and reviewed fiscal process controls, policies, and administrative expenses.
2. Determine whether there are mechanisms to ensure that corrective action is taken for any deficiencies identified through internal or external reviews.	• Visited four local initiatives and reviewed policies and procedures manuals related to overseeing corrective action plans. • Reviewed the types of internal and external audits and reviews performed, and evaluated the corrective action plan process at the four local initiatives visited. • Reviewed deficiencies noted during internal or external reviews and resulting corrective actions taken.
Review and assess any other significant issues relevant to the processes used by local initiatives.	Interviewed staff from Local Health Plans of California and California Association of Health Plans.

Sources: Joint Legislative Audit Committee audit request #2011-104 and the California State Auditor's analysis of information gathered during the audit.

* The fiscal year end for L.A. Care Health Plan is September 30 and the fiscal year end for Kern Health Systems is December 31. For all other local initiatives, the fiscal year end is June 30.

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Chapter 1

THE DEPARTMENTS OF MANAGED HEALTH CARE AND HEALTH CARE SERVICES LATE REVIEWS OF LOCAL INITIATIVES LIMITS THE VALUE OF THEIR OVERSIGHT

Chapter Summary

As part of their compliance with the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and California Medical Assistance Program (Medi-Cal) contract, the departments of Managed Health Care (Managed Health Care) and Health Care Services (Health Care Services) require health plans serving beneficiaries, including the local initiatives, to submit financial reports. However, Managed Health Care has not always promptly and adequately reviewed the financial reports of local initiatives. It failed to meet its internal goal to complete its review of financial reports 30 days after it receives them for 15 of the 16 financial reports we tested, taking an average of more than 200 days to complete each of the reviews. In addition, Managed Health Care's financial reviews did not detect local initiatives' misclassifications of expenditures that could affect financial viability measures and Health Care Services' financial report reviews did not always address all of its contractual financial requirements, nor has it performed these reviews with the frequency suggested in its internal policy. Also, Health Care Services' efforts to review financial reports overlap the financial viability analysis that Managed Health Care's computer database automatically generates from the local initiatives' financial reports.

Managed Health Care does not have an effective process for monitoring the local initiatives' implementation of corrective action plans from financial examinations. In contrast, Health Care Services properly follows up on its corrective action plans. Further, we found that in most cases, local initiatives we reviewed have processes in place to address findings identified in internal and external reviews, but they did not always adequately implement them. Finally, we found that neither Health Care Services nor Managed Health Care is performing medical audits of the eight local initiatives[7] with the frequency that state law requires.

[7] A ninth local initiative, CalViva Health, began accepting beneficiaries in March 2011 and is outside the scope of our review, which was fiscal years 2005–06 through 2009–10.

Managed Health Care Has Not Always Promptly Reviewed Local Initiatives' Financial Reports

Managed Health Care has been chronically late in completing reviews of health plans' financial reports. According to a supervising corporation examiner (supervising examiner), Managed Health Care annually receives about 2,000 financial statements—both audited and unaudited—from all managed care health plans licensed under the Knox-Keene Act, including local initiatives, to review. These reviews are performed to ensure that the health plans are financially viable and that they comply with the financial provisions of the Knox-Keene Act. The text box identifies Managed Health Care's various financial review responsibilities. Although there is no statutory time period for these reviews, according to a supervising examiner, Managed Health Care has an expectation that they will be completed within 30 days after receiving the financial reports, giving staff and supervisors 15 days each for their respective reviews. To ensure that this expectation is met, Managed Health Care developed an automated reminder system to notify staff and supervisors of their goals. However, Managed Health Care missed its internal 30-day goal for 15 of the 16 financial reports we tested that local initiatives submitted between June 2006 and June 2010. Managed Health Care took between 33 and 987 days to complete its review of the 15 reports. Overall, Managed Health Care took an average of more than 200 days to complete its review of the 16 financial reports we tested.

Department of Managed Health Care's Financial Reviews

- Review unaudited monthly, quarterly, annual reports, and audited annual financial reports to ensure financial viability.
- Conduct financial examinations at least once every five years to determine if the health plan's financial books and records substantiate the financial reports it has submitted.

Sources: Knox-Keene Health Care Service Plan Act of 1975, Title 28 of the California Code of Regulations, and Department of Managed Health Care's examiner's guide.

Managed Health Care's chronic delays in completing these reviews lessen their value as an oversight tool. For example, the review of one local initiative's quarterly financial report was not completed until almost three years after it was due, and then only after we brought it to Managed Health Care's attention. A supervising examiner stated that Managed Health Care did not complete this review sooner due to a problem with tracking staff assignments within its automated reminder system that it implemented in January 2009. The supervising examiner indicated that this problem was not discovered until our inquiry but that Managed Health Care is currently working to correct it.

Until May 2011, Managed Health Care did not have an effective mechanism to determine which financial reports were still pending a review. Our inquiry spurred Managed Health Care to develop an automated list that shows all financial reviews that are either incomplete or were reviewed late. Managed Health Care provided us a report that identified 2,082 instances of health plan financial

reports received between July 2005 and June 2011 that were either pending review or were completed after the 15-day expectation for staff to complete their reviews. Of these late reviews, 148 are local initiatives. Managed Health Care stated that the listing includes staff review activities only, and does not take into consideration the supervisor review. However, our testing showed that supervisor reviews were late by 29 days or more for nine of the 15 late reviews we tested.

A supervising examiner stated that Managed Health Care has had to be flexible with the 30-day expectation due to increasing demands made upon staff, including the need to spend time reviewing federal health care reforms that affect rate regulation, medical loss ratio reviews, and other issues related to Medi-Cal, as well as having long-term unfilled examiner positions. However, he indicated that he periodically reminds staff that if they do not have time to perform a full review, they should at least perform a cursory review to ensure that the local initiatives have sufficient tangible net equity (TNE). A supervising examiner stated in November 2011 that although its database has the 15-day reminders for staff and supervisors to complete their respective reviews, the supervising examiner indicated that there is also an expectation that reviews will be done before the health plan's next financial report comes in, which would be 90 days for health plans that report quarterly. He further stated that there is no statutory requirement specifying how Managed Health Care should monitor and evaluate the financial viability of health plans and no deadline for when it must perform the financial reviews.

The supervising examiner also provided us with an informal financial review policy in November 2011. He stated that the unaudited financial statements are subject to three levels of review. The first level is an automated review that assigns a risk-based grade to each financial report based on the health plan's financial position. The second level generates various reports with the results of the health plan's financial position for analysis, which he indicated supervisors and the division's chief monitor at least weekly to identify health plans with financial concerns. The third level is a review of the health plan's financial reports by staff and supervisors assigned to the health plan. However, our analysis found that the review process the supervising examiner described is not functioning as indicated. In our testing of 16 financial reports, we noted no apparent priority for review based on the risk-based grades assigned to each financial report. Specifically, Managed Health Care took more than 90 days to review eight of the 16 financial reports we tested, all of which had been assigned a grade indicating a higher risk.

Managed Health Care took more than 90 days to review eight of the 16 financial reports we tested, all of which had been assigned a grade indicating a higher risk.

Managed Health Care Did Not Detect Errors in Local Initiatives' Financial Reporting

Definition of Administrative Costs

The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) defines administrative costs as including costs incurred in connection with the solicitation of beneficiaries for the plan.

California regulation further states that administrative expenses are costs that arise out of the operation of the plan, including the following:

- Salaries, bonuses, and benefits paid or incurred related to the local initiative's staff.
- Cost of soliciting and enrolling beneficiaries.
- Cost of receiving, processing, and paying provider claims.
- Legal and accounting fees and expenses.
- Premiums on fidelity and surety bonds and certain other insurance.
- All costs associated with establishing and maintaining agreements with medical providers.
- Operation expenses that are not essential to the actual provision of health care services.

Sources: Knox-Keene Act, and Title 28 of the California Code of Regulations.

Managed Health Care failed to detect several errors in local initiatives' reporting of administrative expenses in their financial reports. Regulations require that administrative expenses be reasonable and necessary. If, during any period, administrative costs exceed 15 percent of the total revenues received from providing services to beneficiaries, Managed Health Care may ask a local initiative to demonstrate that its administrative costs are not excessive.[8] Administrative costs are generally any costs not directly related to providing health care services to beneficiaries, such as the examples listed in the text box.

Our testing of the annual financial reports submitted to Managed Health Care between fiscal years 2005–06 and 2009–10[9] by the four local initiatives that we visited found that two local initiatives had repeatedly categorized administrative expenses incorrectly as medical expenses. Specifically, during those five fiscal years, Contra Costa Health Plan (Contra Costa) improperly categorized $1 million in payments to an external contractor for claims processing related to beneficiaries not covered by Medi-Cal—an administrative expense—as a medical expense. During the same five fiscal years, Kern Health Systems (Kern) improperly categorized $5.3 million in claims processing costs as medical expenses rather than as an administrative expense. The assistant controller for Contra Costa stated that it will review the appropriateness of its classification of these costs. After we brought this issue to his attention, Kern's chief financial officer agreed that these costs should be classified as administrative expenses. Further, when we discussed the nature of these errors with Managed Health Care, it agreed that these types of expenditures should have been classified as administrative costs. Because of these errors, both Contra Costa and Kern excluded these costs when calculating their administrative cost percentages. After we properly classified these costs as administrative expenses and recalculated the administrative cost

[8] For a local initiative that is in the development phase, the percentage is 25 percent.

[9] The fiscal year for all local initiatives end June 30, except for L.A. Care Health Plan, whose fiscal year ends September 30, and Kern, whose fiscal year ends December 31.

percentages for both Contra Costa and Kern, we found that their plans' administrative costs did not exceed 15 percent of their revenues for the years we reviewed, as shown in Appendix B. However, this failure to identify these errors is troubling, because it indicates that Managed Health Care might be overlooking similar misclassifications of expenses by other health plans.

The failure to identify incorrectly classified administrative expenses is troubling, because it indicates that Managed Health Care might be overlooking similar missclassification of expenses by other health plans.

According to the Knox-Keene Act, Managed Health Care is responsible for monitoring the administrative costs of managed care health plans, and it may ask a local initiative to demonstrate the reasonableness of its administrative costs when they exceed 15 percent of the revenue earned during any period from serving beneficiaries. However, a supervising examiner acknowledged that staff do not verify that administrative costs are classified appropriately when reviewing the local initiatives' financial reports. Another supervising examiner stated that Managed Health Care did not provide additional guidance to the local initiatives on this issue because he believes the requirements are clear in the regulations. However, Kern's financial reports clearly show "pharmacy and medical claims processing" as a medical expense for each of the five fiscal years we reviewed. This categorization was not questioned by Managed Health Care, although its policy states that examiners will review nonadministrative expenses to verify that they are appropriately categorized, and even a cursory review should have identified this as a potential miscategorization of $5.3 million in expenses.

Further, in fiscal years 2008–09 and 2009–10, Santa Clara Family Health Plan (Santa Clara) categorized a state-imposed fee of $8.5 million and $3 million, respectively, as an administrative expense, based on instructions from Managed Health Care. However, Managed Health Care's instructions were contrary to the regulation creating the fee, which states that it should not be considered an administrative cost for Knox-Keene Act reporting purposes. When counted as an additional administrative expense, the $8.5 million fee increased Santa Clara's administrative cost percentage to 16 percent in fiscal year 2008–09, making it appear as though Santa Clara's administrative expenses had exceeded 15 percent for that fiscal year. After removing the fee from administrative expenses, we recalculated the percentage and determined that Santa Clara's actual administrative cost percentage was 12 percent for fiscal year 2008–09. After we brought the regulation regarding the state-imposed fee to his attention, a supervising examiner for Managed Health Care informed us that Santa Clara should have categorized the fee as a reduction of revenue rather than as an administrative expense.

Health Care Services' Financial Reviews Have Been Inconsistent and Have Not Been Performed Promptly

Health Care Services requires Medi-Cal managed care health plans, including local initiatives, to demonstrate fiscal soundness and maintain adequate resources to carry out their contractual obligations to provide health care services to beneficiaries. However, our testing of its reviews of 16 quarterly financial reports between July 2007 and December 2010 from four local initiatives found seven instances in which Health Care Services did not always analyze the four financial soundness elements that local initiatives are required to maintain under the Medi-Cal contract. For example, Health Care Services did not analyze TNE, working capital, or administrative costs for Kern for the quarter ending December 31, 2009. Although Health Care Services has a financial review tool available for reviewing the contractually required elements, the fiscal monitoring unit chief stated that staff rarely used the tool. Failure to consistently review the financial reports may result in inadequate assurance that plans are meeting contractual requirements. Although this review tool does not include verification of working capital, our testing demonstrated that the tool could provide better assurance that staff are appropriately performing the financial reviews. However, Health Care Services will need to add working capital to its review tool.

Department of Health Care Services' Financial Report Submission and Review Timeline

FINANCIAL REPORT	SUBMISSION DUE DATE	REVIEW DUE DATE*
Monthly	Within 30 days of month end	15th of each month
Quarterly	Within 45 days of quarter end	May 30, August 31, November 30, February 28
Annual	Within 120 days of fiscal year end	Within 2 weeks of receipt of annual statement

Sources: California State Auditor's analysis of California Code of Regulations, titles 22 and 28; Department of Health Care Services' (Health Care Services) Medi-Cal contract with local initiatives; and internal review policies.

* Based on an internal policy set by the fiscal monitoring unit of Health Care Services.

In addition, Health Care Services has not consistently followed the internal policies of the fiscal monitoring unit to review monthly, quarterly, and annual financial reports. As the text box indicates, financial reviews should be performed for all financial reports within two weeks after the reports are submitted. According to the fiscal monitoring unit chief, the unit's staff conduct the monthly reviews; however, we found no evidence that these reviews took place. The fiscal monitoring unit chief also indicated that the staff conduct and document their reviews of the annual financial reports along with their reviews of the quarterly financial reports by including a year-to-date financial total. However, we found that staff inconsistently included the year-to-date financial total during quarterly reviews. For example, Health Care Services did not include a year-to-date analysis for the Health Plan of San Joaquin (San Joaquin) for all four quarters we tested, but it did include a year-to-date analysis for Kern for two of the four quarters we tested.

Further, Health Care Services has not performed financial reviews with the frequency outlined in its fiscal monitoring unit's internal policies. According to the fiscal monitoring unit chief, although Health Care Services tracks the date it receives the financial reports from the local initiatives, it does not have a formal tracking mechanism to assess the date that staff review financial reports. As the text box shows, the internal policy of Health Care Services' fiscal monitoring unit is to review the financial reports within two weeks after they are received. According to the assistant chief of the Capitated Rates Development Branch (capitated rates assistant chief), staff present the results of their financial reviews at an internal Medi-Cal Managed Care Division update meeting held each quarter (quarterly division meeting). The capitated rates assistant chief indicated that as of August 2011, Health Care Services has begun tracking additional information about the financial reviews, including the date the financial reports are assigned to staff, the name of the staff person assigned, the date that staff complete each review, and when the fiscal monitoring unit chief approves each review. According to the fiscal monitoring unit chief, review goals are not always met due to staffing shortages and other responsibilities, but the reviews are prioritized in time to provide the results for quarterly division meetings. However, we found that the quarterly update division meetings are held up to 82 days after a local initiative submits its quarterly financial report, which is about two and a half months after the deadline for submitting a quarterly financial report and almost two months after the quarterly review is supposed to be conducted, according to the internal policy. The inconsistencies and the lateness of Health Care Services' reviews diminish the benefit of these financial reviews as an oversight tool.

Although Health Care Services tracks the date it receives the financial reports from the local initiatives, it does not have a formal tracking mechanism to assess the date that staff review financial reports.

Health Care Services' Efforts Overlap Managed Health Care's Analysis of the Local Initiatives' Consolidated Financial Reports

Analyses performed by Health Care Services overlap the financial viability analysis that Managed Health Care generates from local initiatives' consolidated financial reports. The consolidated financial reports include Medi-Cal and other lines of business such as Healthy Families. Under state law, Managed Health Care is to ensure the financial viability of all managed care health plans operating in the State, including the local initiatives. The local initiatives submit the reports electronically through Managed Health Care's web portal, which electronically records them in its database. This database allows Managed Health Care to produce a variety of reports to assess a local initiative's financial viability. Health Care Services administers the Medi-Cal contracts with the local initiatives and directs local initiatives to submit the financial reports they prepare for Managed Health Care to Health Care Services as well.

Although Health Care Services obtains the consolidated financial reports, its main focus is on reviewing the Medi-Cal line of business. Federal regulation requires local initiatives to meet solvency standards that Health Care Services establishes as the state entity with responsibility for Medi-Cal oversight.

Many of the financial viability analyses for the consolidated financial reports that Health Care Services conducts during its financial reviews are the same analyses Managed Health Care performs during its financial reviews. For example, Managed Health Care's database automatically generates trending reports that include all of the financial viability ratios and trends that Health Care Services computes manually—net profit and loss; revenue totals; and on a per-member per-month basis, various elements of both medical and administrative expenses, extraordinary items, and tangible net equity.

When we inquired about this overlap of effort, Health Care Services' fiscal monitoring unit chief indicated that Health Care Services' staff spend approximately 24 hours per quarter, on average, reviewing the financial reports for completeness and manually computing the analyses, which is the equivalent of about 2.5 weeks of work by a full-time staff member each year. This estimate does not include the additional time necessary to analyze the financial information. Health Care Services has four employees who dedicate 60 percent of their time to monitoring health plans' organizational, administrative, and financial performance, including analyzing the health plans' quarterly and annual financial reports and audited annual financial statements. Also, according to the fiscal monitoring unit chief, Health Care Services conducts financial reviews to address financial, funding, and legal matters raised by the health plans; to determine compliance with required financial indicators and targets; and to provide insight into health plans' financial operations. Nonetheless, we believe that by relying on the financial analyses performed by Managed Health Care, Health Care Services could save time and effort that could be redirected to other responsibilities. Furthermore, because Managed Health Care's database automatically computes the financial viability ratios and trends, it avoids the risk of errors that might occur in Health Care Services' manual calculations.

By relying on the financial analyses performed by Managed Health Care, Health Care Services could save time and effort that could be redirected to other responsibilities.

Managed Health Care Has Not Effectively Monitored Local Initiatives' Responses to Corrective Action Plans

Managed Health Care does not have an effective process for monitoring local initiatives' responses to corrective action plans that result from its financial examinations. As noted in the Introduction, Managed Health Care strives to perform financial examinations of each local initiative at least once every three years, although state law requires it to perform them only once every

five years. After completing its review, Managed Health Care issues a final examination report that provides details on the deficiencies noted and corrective action plans that the local initiative must execute to address the deficiencies.

We reviewed 12 financial examination reports issued between February 2006 and May 2010 for five local initiatives, and tested 19 of 67 corrective action plans contained in the reports to evaluate the effectiveness of Managed Health Care's follow-up on the local initiatives' corrective actions. We found that Managed Health Care did not adequately follow up on six of the 19 corrective action plans we tested. According to Managed Health Care's examination guide, the examiner is responsible for following up on the local initiative's response to its plan. For two plans, Managed Health Care's follow-up was inadequate because it was unable to demonstrate that the local initiatives submitted all required documentation to resolve the problem. For one of these plans, a supervising examiner indicated that Managed Health Care had released the local initiative from submitting the required documentation, but it could not produce any evidence to support this assertion.

We found that Managed Health Care did not adequately follow up on six of the 19 corrective action plans we tested.

For the other four corrective action plans, Managed Health Care's follow-up was inadequate because it failed to obtain appropriate evidence that the deficiency was truly corrected. For example, Managed Health Care issued three financial examination reports to Alameda Alliance for Health (Alameda) during 2006, 2007, and 2009 (no examination was conducted in 2008), which included the same deficiency related to delays in processing claims. For the 2006 and 2007 reports, Alameda responded by stating that it had revised its policies and procedures to correct the deficiency. After receiving Alameda's responses to these examinations, Managed Health Care notified Alameda that its corrective actions were sufficient. However, the same deficiency was reported for a third time in March 2009. According to a supervising examiner, he believes the deficiency is now resolved because Managed Health Care required Alameda to submit logs showing that it had processed claims within the required time frames for six months after the 2009 report was issued to prove that it had corrected the deficiency. However, if Managed Health Care had required this more appropriate evidence of improvements in claims processing after the deficiency was first noted in 2006, it could have better confirmed whether Alameda had adequately addressed the deficiency. Similarly, both Contra Costa and L.A. Care Health Plan (Los Angeles) had repeat deficiencies that could have been avoided had Managed Health Care initially required appropriate evidence that the deficiencies were corrected.

Problems related to Managed Health Care's monitoring of corrective action plans may be the result of not taking advantage of all the features of the database it uses to communicate and exchange documents with the health plans, including local initiatives. Although the database has the capability to record and track corrective action plans input by staff, Managed Health Care does not currently use this feature. According to a supervising examiner, to use the database's feature to track corrective action plans, Managed Health Care would need to upgrade the database. However, this upgrade has not yet occurred because of other Managed Health Care technology priorities. Under the current process, Managed Health Care is unable to readily identify corrective action plans, their status, and the decisions it makes concerning corrective actions taken. Managed Health Care's inadequate follow-up on compliance with corrective actions weakens its ability to provide effective oversight of local initiatives' financial viability.

In contrast, we found that Health Care Services properly followed up on its corrective action plans for the medical audits it conducted jointly with Managed Health Care. After the final medical audit is issued, statute requires Managed Health Care to conduct a follow-up review, no later than 18 months after the release of the final audit, to report on the status of the local initiative's efforts to correct deficiencies. When conducting the joint medical audits, Health Care Services assumed the responsibility of following up on corrective action plans submitted by the local initiatives. For the five follow-up reports we reviewed, Health Care Services reported on the corrective action status between four and six months after the close of the audit, at which time a formal close-out letter for the plan was sent to the local initiative on behalf of both departments.

The four local initiatives we reviewed—Contra Costa, Los Angeles, Kern, and San Joaquin—have processes in place to ensure implementation of corrective action plans they receive from oversight reviews.

Further, we found that the four local initiatives we reviewed—Contra Costa, Los Angeles, Kern, and San Joaquin—have processes in place to ensure implementation of corrective action plans they receive from oversight reviews. As noted in Table 2, we identified several types of oversight reviews that local initiatives receive; however, only four of these review types issue corrective action plans. For the four local initiatives, we examined a total of 20 reviews and associated corrective action plans issued between June 2006 and April 2011, and we tested 28 of 127 outstanding corrective measures to evaluate the adequacy of the local initiatives' process. In all cases, the local initiatives submitted the information requested to the reviewing organizations. However, we found repeat deficiencies for Contra Costa and Los Angeles because the appropriate evidence was not requested, as discussed on page 23.

Table 2
Types of External Reviews of Local Initiatives

REVIEWING ORGANIZATION	TYPE OF REVIEW	CORRECTIVE ACTION PLAN	FREQUENCY
Department of Health Care Services	Financial review	NA	Monthly (when required), quarterly, and annually
	Medical audit*	Yes†	Annually
	Medical loss ratio evaluation	NA	NA‡
	Facility site review and medical record review	Yes§	Every 3 years
	Member rights/program integrity review	NA	Every 2 years
	Healthcare Effectiveness Data and Information Set audit	NA‖	Annually
Department of Managed Health Care	Financial review	NA	Monthly (when required), quarterly, and annually
	Medical audit*	Yes	Every 3 years
	Financial examination	Yes	Every 5 years**
	Enforcement action	NA	As issues arise
Independent auditor	Financial statement audit	NA††	Annually

Sources: California State Auditor's analysis of the California Health and Safety Code; California Welfare and Institution Code, titles 22 and 28 of the California Code of Regulations; departmental internal policies; and interviews with Department of Health Care Services' (Health Care Services) and Department of Managed Health Care's (Managed Health Care) staff.

Note: We identified one local initiative with an internal audit function, L.A. Care Health Plan; its internal audits are conducted as requested by management.

NA = Not applicable.

* Although the statutes directed at Managed Health Care use the term "survey," we use the term "audit" throughout the report to address these reviews.

† Although a corrective action plan is not specifically required by law, Health Care Services requires a corrective action plan for deficiencies noted during the audit.

‡ According to the chief of Capitated Rates Development Division, Health Care Services has no formal policy on the frequency of these evaluations.

§ This review is of provider sites. The health plans are responsible for follow-up with provider sites. Health Care Services is responsible for oversight and monitoring of health plans' site reviews.

‖ Health Care Services has contracted with the Health Services Advisory Group to conduct these audits and did not require corrective action plans prior to 2011.

** Although state law requires Managed Health Care to perform these reviews every five years, its internal goal is to conduct these reviews every three years.

†† Although corrective action plans are not required, the independent auditor may issue a management letter of findings that require follow-up.

Health Care Services and Managed Health Care Have Not Conducted Medical Audits at the Frequency Required by Statute

Health Care Services and Managed Health Care do not currently have a well-coordinated process for ensuring that each local initiative that serves only Medi-Cal beneficiaries receives timely

onsite medical audits.[10] State law requires Managed Health Care to conduct periodic onsite medical audits of each local initiative. These audits must be performed as often as Managed Health Care determines is necessary, but no less than once every three years, with the exception that Managed Health Care does not need to perform a review of a local initiative that serves only Medi-Cal beneficiaries if Health Care Services has performed such a review as part of its Medi-Cal contracting process during the same period. State law requires Health Care Services to conduct medical audits of Medi-Cal plans annually and except under certain circumstances, requires Health Care Services to conduct these audits jointly with Managed Health Care. The clear intent of state law is to avoid duplication in the conduct of these medical audits. By law, the purpose of a medical audit is to review the quality of health care services, the effectiveness of peer review, procedures for regulating utilization and assuring quality of care, and the overall performance in providing care and meeting the needs of beneficiaries.

Managed Health Care met its three-year requirement to perform medical audits for only one local initiative, and Health Care Services did not meet its annual medical audit requirements for any of the eight local initiatives during the five-year period we reviewed.

We reviewed the audits that both departments performed of the eight local initiatives during the five-year period from 2006 to 2010. Taking into account any medical audits that might have been conducted prior to our review period, we expected that each local initiative would have received one or two onsite medical audits by Managed Health Care, based on its three-year requirement. We also expected each local initiative to have been subjected to an annual medical audit by Health Care Services, based on its one-year requirement. However, we found that Managed Health Care met its three-year requirement to perform medical audits for only one local initiative. Further, Health Care Services did not meet its annual medical audit requirement for any of the eight local initiatives during the five-year period we reviewed.

When presented with this information, a staff counsel supervisor (staff counsel) for Managed Health Care provided various reasons why the medical audits were not conducted on a timely basis, including that Health Care Services historically has taken control of the audit schedule for the governmentally organized Medi-Cal plans and that it has often pushed back established audit dates, and thus Managed Health Care routinely waited so that the audit could be conducted jointly. In addition, the staff counsel stated that in the past three and a half years, Managed Health Care has experienced staffing shortages and budget-related delays. The chief of the Medical Review Branch (medical review chief) inferred that Health Care Services performs three other types of reviews of health plans that satisfy the medical audit requirement: a combined

[10] Although the statutes directed at Managed Health Care uses the term "survey," we use the term "audit" throughout the report to address these reviews.

facility site review and medical record review, member rights/ program integrity review, and Healthcare Effectiveness Data and Information Set review. However, our review concluded that none of the three reviews cited cover the scope and frequency of the annual medical audit requirements. The medical review chief stated that Health Care Services has now resumed responsibility for the medical audits of managed care plans and is working to achieve a cohesive, organized approach that will meet all statutory requirements.

Recommendations

To monitor local initiatives' financial viability and compliance with the Knox-Keene Act requirements, Managed Health Care should develop a formal policy to ensure that it reviews financial reports in a timely manner, and that administrative expenses are correctly categorized.

To ensure that all four financial soundness elements included in Health Care Services' contract are being reviewed, it should conduct financial reviews consistently and update its review tool to include working capital. In addition, Health Care Services should develop a formal policy to ensure that it conducts financial reviews in a timely manner.

To make its financial solvency reviews more efficient and reduce the risk of errors, Health Care Services should coordinate with Managed Health Care when analyzing local initiatives' consolidated financial reports.

To ensure that local initiatives implement corrective action plans, Managed Health Care should devise a more effective process to track, monitor, and review the status of local initiatives' corrective actions as they relate to financial examination requirements.

Health Care Services should ensure that it performs annual medical audits of local initiatives as required by law. Managed Health Care should ensure that it obtains timely medical audits from Health Care Services. If it is unable to obtain timely medical audits from Health Care Services, it should conduct them itself.

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Chapter 2

MOST LOCAL INITIATIVES CAN DEFEND THEIR TANGIBLE NET EQUITY BALANCES, AND THEIR ADMINISTRATIVE EXPENSES ARE GENERALLY REASONABLE AND NECESSARY

Chapter Summary

The Department of Managed Health Care (Managed Health Care) and the Department of Health Care Services (Health Care Services) oversee the local initiatives to ensure that they maintain sufficient tangible net equity (TNE). The oversight agencies are not required to review funds that exceed the required TNE minimum balance and place no restrictions on the use of those funds by the local initiatives. However, after analyzing their risk levels and average monthly expenses, most of the local initiatives have adopted formal policies or developed informal internal targets for their preferred levels of TNE. The local initiatives provided a variety of reasons for accumulating actual TNE balances above the required minimum amount, including the ability to maintain strong provider networks during delays in state funding and to support increased services to California Medical Assistance Program (Medi-Cal) beneficiaries.

The maintenance of a TNE actual balance that far exceeds the required TNE minimum balance does not appear to have had a negative effect on the medical care provided to beneficiaries. Local initiatives are graded on an annual basis, using nationally recognized Healthcare Effectiveness and Data Information Set (HEDIS) performance measurements for health care plans. This annual review shows that they generally met or exceeded the minimum satisfactory level of care.

Regulations require that local initiatives' administrative costs be reasonable and necessary. If, during any period, administrative costs exceed 15 percent of the total revenues received from providing services to beneficiaries, Managed Health Care may ask a local initiative to demonstrate that its administrative costs are not excessive. We found that administrative expenses generally adhered to regulatory and contract requirements and followed internal policies for the four local initiatives we visited. However, previous policies at Kern Health Systems (Kern) allowed its former chief executive officer (CEO) to enter into two contracts resulting in multimillion dollar expenditures that were not cost-effective. All of the local initiatives' methods for determining and approving salaries and compensation were comparable, but compensation levels varied widely. For example, the total annual compensation local initiatives paid to their CEOs in 2010 ranged from about

$230,000 to nearly $804,000. In addition, a CEO at one of the local initiatives is entitled to receive up to an 18-month severance package if terminated without cause.

All Local Initiatives and Commercial Plans Under the Two-Plan Model Have TNE Actual Balances Above the Required Minimum

As discussed in the Introduction, all health plans licensed by Managed Health Care, including local initiatives, are required to maintain a TNE minimum balance and to submit to Managed Health Care quarterly and annual financial reports and annual audited financial statements. According to Managed Health Care, a local initiative's TNE actual balance is one indicator of its financial viability. The Medi-Cal managed care contracts between the local initiatives and Health Care Services also contain a requirement for maintenance of the required TNE minimum balances as specified in state regulation. Appendix A shows the calculation of each local initiative's required TNE minimum balance for 2010. Appendix C compares each local initiative's required TNE minimum balance to its TNE actual balance for the five-year period we reviewed.

Managed Health Care and Health Care Services review TNE actual balances to monitor the financial viability of the local initiatives rather than for determining whether a local initiative has reasons for accumulating those funds.

The focus of Managed Health Care and Health Care Services is to monitor the financial viability of the local initiatives—a maximum limit on actual TNE is not defined in law or contract. Neither department reviews TNE actual balances to determine whether a local initiative has reasons for accumulating those funds. Managed Health Care performs financial reviews to determine whether a plan is at risk of falling below 130 percent of the required TNE minimum balance, and Health Care Services' internal policy has it monitored to ensure that 200 percent of the required TNE minimum balance is maintained. As part of the review, Managed Health Care and Health Care Services project each local initiative's TNE actual balance for the next year and take additional actions if they think the local initiative might fall below 130 percent or 200 percent, respectively, of the required TNE minimum balance.

According to a supervising corporation examiner (supervising examiner) at Managed Health Care, the department does not review the use of TNE balances that are above the required minimum because the purpose of financial reporting and review is to observe financial trends and to enable the department to take early action to help prevent insolvency by the local initiatives. Additionally, the chief of the Capitated Rates Development Division at Health Care Services explained that the Medi-Cal managed care contract between the department and the local initiatives states that "any monies not expended by [a local initiative] after having fulfilled obligations under contract will be retained by the [local initiative]." However, a regulation limits administrative expenses

to those that are reasonable and necessary. If, during any period, administrative costs exceed 15 percent of the total revenues received from providing services to beneficiaries, Managed Health Care may ask a local initiative to demonstrate that its administrative costs are not excessive.

Although each local initiative's required TNE minimum balance varied due to its annual financial position and business practices during fiscal years 2005–06 to 2009–10,[11] all eight had TNE actual balances that exceeded their required minimum amounts. For example, at the end of fiscal year 2009–10, the TNE actual balances for the local initiatives ranged from 176 percent to 1,180 percent of their required TNE minimum balances, and five of the local initiatives had TNE actual balances that equaled or exceeded 400 percent of their required TNE minimum balance, as shown in Appendix C. Figure 3 on the following page shows the percentage of the required TNE minimum balance maintained by each of the local initiatives as of their respective fiscal year ends. The figure shows a significant decline in this percentage for some local initiatives over the five-year period. This generally occurs when actual TNE declines while required minimum TNE increases. For example, the data in Appendix C indicate that the decline in the percentage for the San Francisco Health Plan (San Francisco) from 1,804 percent to 1,180 percent of the required minimum TNE is due to a decline in its actual TNE from $31.7 million to $30.6 million and an increase in its required minimum TNE from $1.8 million to $2.6 million.

The TNE actual balances for the local initiatives ranged from 176 percent to 1,180 percent of their required TNE minimum balance at the end of fiscal year 2009–10—five had actual balances that equaled or exceeded 400 percent of the required minimum balance.

Like the local initiatives, the three commercial plans participating in the Medi-Cal two-plan model as competitors to the local initiatives also maintain funds greater than their required TNE minimum balance. From 2006 through 2010, both Anthem Blue Cross and Health Net maintained a TNE actual balance that averaged roughly 500 percent of their required TNE minimum balance, while Molina Healthcare maintained a TNE actual balance that averaged almost 200 percent of its required TNE minimum balance.

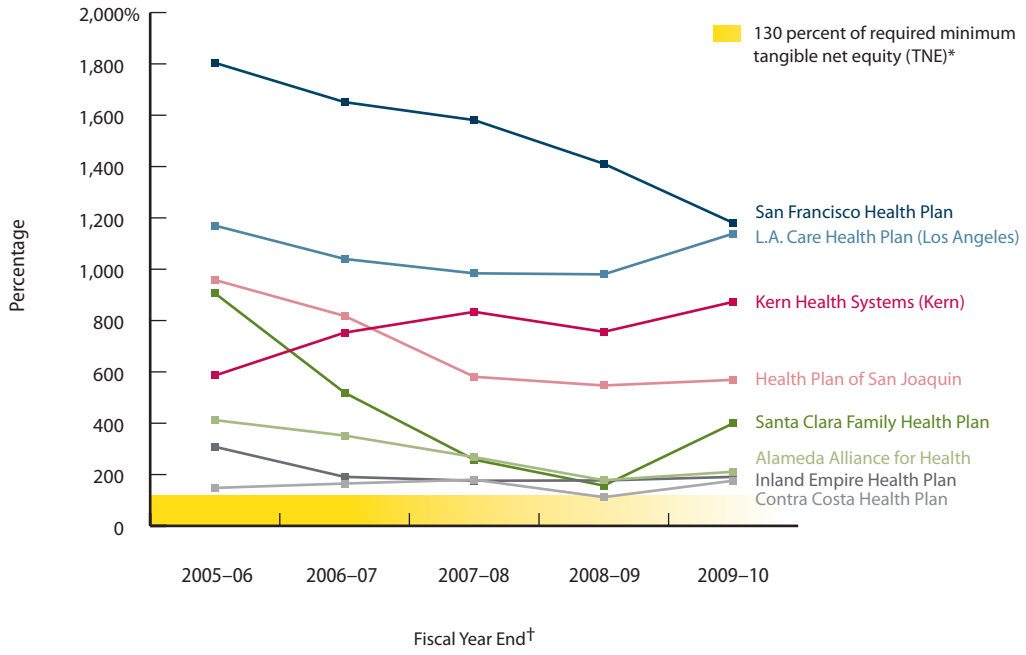
Most Local Initiatives Keep Their TNE Actual Balances Above the Required Minimum to Ensure Continuity of Services to Medi-Cal Beneficiaries

The majority of local initiatives stated that the main reasons for maintaining their TNE actual balances above the required TNE minimum balance are to ensure continuity of service to Medi-Cal beneficiaries and to maintain a strong provider network, especially

[11] The fiscal year for all local initiatives ends June 30, except for L.A. Care Health Plan, whose fiscal year ends September 30, and Kern, whose fiscal year ends December 31.

during periods when state funding is delayed. Although the purpose and TNE actual balances vary by local initiative, each appears to have valid reasons for the level it sets. Table 3 on page 34 shows the reasons provided by the local initiatives for maintaining actual TNE beyond the required minimum.

Figure 3
Local Initiatives' Tangible Net Equity Actual Year-End Balances as a Percentage of Required Minimum Balance Fiscal Years 2005–06 Through 2009–10



Source: California State Auditor's analysis of the local initiatives' financial reports as submitted to the Department of Managed Health Care (Managed Health Care) for fiscal years 2005–06 through 2009–10.

Note: TNE is the value of net equity (i.e., excess of total assets over total liabilities as defined in regulations) reduced by the value assigned to intangible assets, including goodwill, organizational expenses, and start-up costs.

* The Knox-Keene Health Care Service Plan Act of 1975 requires Managed Health Care to more closely monitor a health plan's financial viability if its TNE actual balance falls below 130 percent of the required TNE minimum balance.

† TNE balances are as of June 30 fiscal year end, except for Los Angeles, which uses a September 30 year-end date, and Kern, which uses a December 31 year-end date.

Five of the eight local initiatives established formal policies setting a goal for the amount of actual TNE or specifying the uses of those funds. Alameda Alliance for Health (Alameda) indicated that the required TNE minimum balance is sufficient to provide only one month's worth of fee-for-service medical expenses and adopted a formal policy in 2006 setting a target of accumulating actual TNE equal to six times the required TNE minimum balance. As shown in Figure 3, it has yet to achieve this goal of a TNE actual balance of at least 600 percent of the required TNE minimum balance. Kern retained an independent actuarial firm to perform a risk reserve analysis and in 2008 adopted the actuary's recommendation to

maintain capital[12] between 40 percent and 55 percent of annual revenue. Thus, assuming that the required TNE minimum balance approximates one month's noncapitated expenses,[13] both Alameda and Kern believe they need about six to seven times the required TNE minimum balance. Also in 2008, Inland Empire Health Plan (Inland Empire) adopted a policy of maintaining liquid capital[14] in the amount of 100 percent of its average total monthly operating expense. The amount was approximately $67 million as of the September 30, 2011, quarterly financial report, which it believes provides sufficient funds to cover its average total operating expenses for one month. San Francisco indicated that its 2008 capital of nearly $28 million is designated for various activities, including an insolvency protection fund, a capital acquisition fund, and a new program development fund. In March 2011 L.A. Care Health Plan's (Los Angeles) board of governors approved the principles for a formal financial reserve policy, a range of reserve levels and a periodic review of the reserve policy. In addition to maintaining the TNE requirement, the policy requires Los Angeles to maintain sufficient funds to meet board-designated uses of funds, continue timely payment to directly contracted providers in the event that payment from the State or others is delayed, and ensure solvency for both planned and unexpected events.

Of the three other local initiatives, Santa Clara Family Health Plan (Santa Clara) is planning to present a resolution to its governing board calling for a targeted TNE of two months' capitation revenue. This would be about five times the required TNE minimum balance. The Health Plan of San Joaquin (San Joaquin) had not established a formal TNE policy, but the controller and the chief financial officer told us that it has an informal policy of maintaining the TNE actual balance at between 450 percent and 650 percent of the required minimum. San Joaquin met that informal target from fiscal years 2007–08 through 2009–10 and exceeded it in fiscal years 2005–06 and 2006–07. Finally, the controller for Contra Costa Health Plan (Contra Costa) explained that the local initiative does not have a policy for TNE funds because, as a county owned and operated health plan, the county is ultimately responsible for the cash and obligations of the plan.

Local initiatives explained that TNE funds are also used to defray the costs of initiating services to beneficiaries not currently served or located in additional geographic areas. Beginning in June 2011 new Medi-Cal regulations moved seniors and persons with

Local initiatives explained that TNE funds are also used to defray the costs of initiating services to beneficiaries not currently served or located in additional geographic areas.

[12] *Capital* refers to the amount by which assets exceed liabilities.

[13] *Noncapitated expenses* are expenses paid by the health plan on a fee-for-service basis.

[14] *Liquid capital* is net assets (total assets less total liabilities) less fixed assets (for example, buildings, land, and equipment) and prepaid expenses.

disabilities from their previous Medi-Cal fee-for-service plan to the local initiatives or commercial plans in their counties. The local initiatives expressed concern that serving these populations would be more costly because the individuals in these populations use medical services more often than other plan beneficiaries do. Kern projected a loss of $2 million in the first year of providing services to these new populations despite the additional capitation revenue provided for serving the group. Los Angeles also projected a loss of $27 million in fiscal year 2011–12 as a combined result of serving these populations and the State's proposed cuts in the Medi-Cal rates. Additionally, Managed Health Care recently allowed San Joaquin to expand its service area to Stanislaus County, and plan officials stated that it was able to expand service to this area only because of the actual TNE it had accumulated.

Table 3
Reasons Local Initiatives Maintain Amounts Above the Required Tangible Net Equity Minimum Balance

	REASONS PROVIDED						
	CASH-FLOW ISSUES			CAPITAL ISSUES			
LOCAL INITIATIVE	TIMING OF THE PASSAGE OF THE STATE BUDGET	MAINTAIN A CASH RESERVE TO COVER AT LEAST ONE MONTH OF EXPENSES	FUNDS TO ENSURE THE MAINTENANCE OF AN ADEQUATE PROVIDER NETWORK†	INTERNAL SYSTEM IMPROVEMENTS AND OTHER CAPITAL IMPROVEMENTS	EXPANSION INTO OTHER SERVICE AREAS AND/OR BENEFICIARIES SERVED	OTHER‡	DATE RESERVE POLICY ADOPTED
Alameda Alliance for Health	X	X	X	X			July 2006
Contra Costa Health Plan*							NA
Inland Empire Health Plan	X	X	X	X			December 2008
Kern Health Systems	X	X	X	X	X	X	March 2008
L.A. Care Health Plan	X	X	X	X	X	X	June 2011
San Francisco Health Plan	X			X	X	X	September 2008
Health Plan of San Joaquin	X	X	X	X	X	X	NA
Santa Clara Family Health Plan	X		X	X	X	X	NA

Source: California State Auditor's analysis of data collected from the local initiatives and interviews with their staff.

NA = Not applicable.

* According to its controller, Contra Costa Health Plan is a department within Contra Costa County and does not maintain a high level of tangible net equity beyond the required minimum since the county is ultimately responsible for the cash and obligations of the health plan.

† Local Initiatives are contractually required by the Department of Health Care Services to maintain adequate provider networks and to meet minimum ratios for the number of beneficiaries per provider and ensure provider availability within a certain distance of a beneficiary's home.

‡ Other reasons include, among other things, the greater risk taken by health plans that operate on a fee-for-service basis and the Department of Health Care Services' retroactive rate reduction.

Local initiatives also highlighted the necessity of maintaining higher TNE actual balances than the required minimum for situations in which Health Care Services imposes retroactive rate cuts. Under the Medi-Cal contract, Health Care Services can adjust capitation rates during the year, but the local initiatives continue to be obligated to

provide services to Medi-Cal beneficiaries, and they asserted that some mandates are unfunded. Santa Clara and Kern both stated that higher TNE balances were necessary to mitigate the impact of these situations. Furthermore, the executive director of the Local Health Plans of California, an advocacy group representing the local initiatives and other public health care plans, told us he believes that the TNE standards are outdated as a true measure of sufficient reserves for managed care plans operating in the current Medi-Cal program. He indicates that local initiatives need sufficient reserves for several reasons, including persistent state budget-related funding delays, the ability to maintain operations in years when the health plan suffers financial losses, the enrollment of seniors and persons with disabilities into Medi-Cal managed care, and cash reserves to fund the upcoming enrollment growth in Medi-Cal under federal health reform.

Inland Empire told us it believes that the risk-based capital system used by the National Association of Insurance Commissioners is a more appropriate measure of the level of capital that a health plan needs. The risk-based capital system calculates the minimum amount of capital required based on an assessment of a health plan's risks. Inland Empire's calculation of its required capital for fiscal year 2010–11 determined that it should maintain $90 million in capital to avoid the oversight agencies becoming concerned with the health plan's financial viability. In contrast, Inland Empire needs a TNE balance of $52 million to meet Health Care Services' internal policy that health plans maintain 200 percent of the required TNE minimum balance.

Local Initiatives Have Varying Levels of Cash and Liquid Investments on Hand

The level of its TNE actual balance does not necessarily reflect a local initiative's ability to pay its monthly expenses—the amount of cash and liquid investments it has is a better measure for that purpose.

The level of its TNE balance is not necessarily the best measure of a local initiative's ability to pay its monthly expenses. Rather, the amount of cash and liquid investments it has is a better measure for that purpose. Health Care Services makes monthly capitated Medi-Cal payments to the local initiatives based upon a set rate and the number of beneficiaries enrolled in the local initiative. In the event of a delay in passing the state budget, the local initiatives are not paid monthly but receive their capitation payments once the state budget is enacted. Appendix D shows how long each local initiative could continue to operate without receiving monthly capitation payments from the State or other sources. We used the audited financial statements and discussions with the local initiatives' staffs to determine the yearly cash and liquid investments,[15] expenses, and depreciation amounts of each local initiative in order to calculate the number of days of cash and liquid investments on hand (liquid funds).

[15] Most of the local initiatives' auditors defined liquid investments as short-term, highly liquid investments that are readily convertible into cash, generally with maturities of three months or less, which is in line with the standards used in the accounting profession.

In 2010, from July 1 until October 8, no state budget was in effect, and the local initiatives did not receive Medi-Cal capitation payments. On June 30, 2010, when this period began, Contra Costa had only nine days of liquid funds to cover its operating expenses. However, according to its CEO, because Contra Costa is a part of the county government, the county is obligated to make its payments if other funds are not available. On September 30, 2010, as this period was ending, Los Angeles had 12 days of liquid funds remaining to cover operating expenses, plus another 33 days of funds if it were to liquidate its investments. According to Los Angeles's chief financial officer, in order to maintain its provider network, Los Angeles paid varying amounts to Plan Partners (partner) based on its assessment of each individual partner's fiscal health. He indicated that Los Angeles delayed payments to its largest providers: Anthem Blue Cross, Kaiser Permanente, and Community Health Plan; reduced payments by 50 percent to Care 1st Health Plan; and continued full payments to smaller medical providers. Kern and San Francisco indicated that they both had sufficient reserve funds to pay providers during the 2010 state budget delay. Similarly, San Joaquin indicated it used its reserves to continue paying providers in 2007, 2008, and 2010 when the State suspended Medi-Cal payments due to budget impasses occurring during those years.

As shown in Table 4, from fiscal years 2005–06 through 2009–10, the local initiatives' average ability to pay their expenses ranged from 39 to 145 days. San Francisco, San Joaquin, and Kern maintained the highest levels of liquid funds, with enough to sufficiently cover between 118 and 145 days of their average expenses, while the other five local initiatives maintained between 39 and 54 days of liquid funds.

Table 4
Average Number of Days of Cash and Liquid Investments Local Initiatives Had on Hand
Fiscal Years 2005–06 Through 2009–10

LOCAL INITIATIVE	AVERAGE DAYS OF CASH AND LIQUID INVESTMENTS ON HAND
Alameda Alliance for Health	53
Contra Costa Health Plan	42
Inland Empire Health Plan	39
Kern Health Systems	145
L.A. Care Health Plan	40
San Francisco Health Plan	118
Health Plan of San Joaquin	126
Santa Clara Family Health Plan	54

Sources: California State Auditor's analysis of local initiatives' audited financial statements as provided to the Department of Managed Health Care and discussions with the various local initiatives' staff.

Note: The financial data is as of June 30, except for L.A. Care Health Plan with a fiscal year ending September 30 and Kern Health Systems with a fiscal year ending December 31.

Local Initiatives' TNE Balances Do Not Adversely Affect Their Beneficiaries' Quality and Access to Care

Although most local initiatives hold TNE balances that are significantly higher than the required minimums, Health Care Services' performance indicators show that the eight local initiatives generally provide a satisfactory level of care to beneficiaries. The performance indicators that Health Care Services uses are a subset of the HEDIS, a nationally recognized way to objectively compare health plans. The HEDIS performance indicators assess the quality and access to care that health plans deliver to beneficiaries. Table 5 shows that from 2006 through 2010, local initiatives generally met or exceeded the minimum satisfactory level of care for the performance indicators that Health Care Services measured.

Table 5
Number of Minimum Healthcare Effectiveness and Data Information Set Performance Levels Met or Exceeded by Local Initiatives 2006 Through 2010

	YEARS					
LOCAL INITIATIVE	2006	2007	2008	2009	2010	FIVE-YEAR AVERAGE
Total Number of Performance Indicators Possible*	**15**	**15**	**14**	**17**	**15**	
Alameda Alliance for Health	14	11	11	14	9	78%
Contra Costa Health Plan	15	14	14	15	15	96
Inland Empire Health Plan (San Bernardino/Riverside)	14	14	14	17	15	97
Kern Health Systems	15	14	14	14	13	92
L.A. Care Health Plan	10	11	14	17	15	88
San Francisco Health Plan	14	15	14	17	15	99
Health Plan of San Joaquin	13	13	13	17	15	93
Santa Clara Family Health Plan	15	15	14	17	15	100

Source: California State Auditor's analysis of Healthcare Effectiveness and Data Information Set performance measurement indicators as measured by the Department of Health Care Services for 2006 through 2010.

* Number of performance indicators measured against prior-year baseline scores.

Over the past five years, the eight local initiatives met or exceeded Health Care Services' minimum satisfactory level of care for almost 93 percent of the selected HEDIS performance indicators, on average, while maintaining varying TNE balances. Six out of the eight local initiatives met or exceeded the minimum satisfactory level of care for all of the performance indicators in 2010, while maintaining TNE actual balances between 176 percent and 1,180 percent of the required minimum. The highest five-year HEDIS average was for Santa Clara, at 100 percent, while maintaining a TNE actual balance between 157 percent and

906 percent of the required minimum. Contra Costa maintained the lowest TNE percentage among the local initiatives, yet consistently met or exceeded the minimum satisfactory level of care for most of the HEDIS performance indicators, with a five-year HEDIS average of 96 percent. On the other hand, San Francisco consistently maintained the highest percentage of actual TNE compared to the required TNE minimum balance and, like Contra Costa, met or exceeded the minimum satisfactory level of care for nearly all of the performance indicators, with a five-year HEDIS average of 99 percent. In contrast, Alameda consistently had one of the lower TNE percentages, only achieving the minimum satisfactory level of care for 78 percent of the performance indicators. Moreover, while the local initiatives' TNE balances fluctuated from fiscal years 2005–06 through 2009–10, their HEDIS averages generally remained relatively high during this same period, showing that most local initiatives' TNE balances do not adversely affect beneficiaries' quality of and access to care.

Most local initiatives' TNE balances do not adversely affect beneficiaries' quality of and access to care.

Local Initiatives' Administrative Expenses Are Generally in Line With State Regulations and Requirements

State regulations require that administrative expenses be reasonable and necessary. Also if, during any period, administrative costs exceed 15 percent of the total revenues received from providing services to beneficiaries, Managed Health Care may ask a local initiative to demonstrate that its administrative costs are not excessive. The four local initiatives we visited generally had adequate fiscal processes and internal controls to monitor their administrative expenses, although weak past policies at Kern allowed it to enter into two contracts for medical claims reviews that were not cost-effective.

We determined that the expenses we tested at the four local initiatives were reasonable and necessary, that they did not exceed the 15 percent threshold, and that the local initiatives' current internal controls and procedures were functioning as intended. Common policies among the local initiatives include multiple levels of management reviews and sometimes a review by their governing board before implementing contracts or approving certain payments. For example, San Joaquin adopted its county's contracting and expenditure procedures. The county procedures require it to submit all administrative expenses to the county auditor/controller, which provides an additional layer of review and approval. Similarly, as a county agency Contra Costa processes all of its administrative expenses through the county's payment system, where payment requests are compared to vendor agreements and the county board approves its contracts, according to its controller. Los Angeles's internal controls require additional levels

of approval for larger contract and payment amounts. Also, additional approvals are sought if amounts spent with one vendor exceed previously approved amounts.

Conversely, Kern's past contracting policy allowed the former chief financial officer and former CEO to enter into contracts without board approval and without legal review. In April 2008, in response to an estimated $15 million lawsuit brought against Kern by two groups of emergency medical providers, Kern's former CEO entered into a contract that ultimately paid nearly $8 million to a consulting group to review and evaluate medical record documentation and analyze claim data from the emergency medical providers named in the suit. Of the $15 million sought in the lawsuit, $14 million was related to whether Kern was obligated to pay the providers only Medi-Cal rates, and in February 2010 the Kern County superior court ruled in favor of Kern on that issue. The remaining $1 million in damages sought was related to excessive charges, or *up-coding* that would benefit from a claims review. We found no indication that the contract was reviewed by Kern's board or former legal counsel. In a December 2009 report to the Kern board of directors, Kern's former CEO stated that she learned that Kern did not have internal controls in place to identify the total dollar amount paid to individual vendors and that it did not identify the lack of a spending cap in the consulting group's contract. In the same report, she also stated that Kern has since created a monthly report that tracks payment totals, and the compliance officer began reviewing contracts to ensure that they include stipulations for maximum payment amounts. In August 2011 Kern filed a lawsuit against the consulting group, claiming breach of contract and alleging grossly excessive charges. This lawsuit was ongoing as of October 2011.

In February 2009 Kern's former CEO entered into another contract with the same consulting group to research and investigate health care claims for suspected fraud, waste, and abuse. Like the first contract, this one was not reviewed by the board, and we found no evidence that the contract was reviewed by Kern's former legal counsel. From March 2009 to June 2010, Kern paid the consulting group more than $85,000 per month for review services, but Kern's analysis indicates that it achieved an average monthly savings of only $14,000 for the period from January through June 2010. In March 2011 Kern's former CEO told the Kern County board of supervisors that the local initiative did not have the expertise, staffing, or systems to satisfy state and federal laws regarding the prevention of fraud, waste, and abuse. She also stated that Kern saves money by denying payment for overcharges but acknowledged that the savings were less than the cost of the contract. In 2010 Kern imposed requirements that all future contracts be reviewed by legal counsel and that all contracts over $10,000 be approved by the local initiative's board.

Kern paid a consulting group $85,000 a month to investigate health care claims for suspected fraud, waste, and abuse but it only achieved average monthly savings of $14,000.

As discussed in Chapter 1, Kern and Contra Costa listed millions of dollars' worth of medical claims processing costs as medical rather than administrative expenses during fiscal years 2005–06 through 2009–10. In another instance, Kern reported medical claims review costs of $1.5 million as a special item that was not reported as either a medical or an administrative expense in the financial reports filed with Managed Health Care.

Local Initiatives Use Comparable Methods to Establish and Approve Executive Compensation

Salary Survey Parameters Commonly Used by Local Initiatives

- For-profit and nonprofit health care industry
- Annual revenue
- Number of beneficiaries
- Geographic region
- Other local initiatives and entities (for example, county or other specific medical groups)
- Number of employees

Source: California State Auditor's analysis of local initiatives' salary surveys.

Local initiatives have similar methods and processes to assess and set executive salaries, but their executive compensation and severance packages vary widely. To assess if their salaries are comparable to the market, the eight local initiatives conduct salary surveys of similar health industry organizations, and all except Contra Costa have restructured their salaries or benefits during the last three years. The text box presents the survey parameters the local initiatives commonly used. All, except Contra Costa, used consultants to conduct the salary surveys, and all compared their organization with national and local characteristics. Some local initiatives stated that they set their salaries at the median level of the survey results. We found that they all developed their salary structures based on a reasonable process.

Some local initiatives cited organizational changes and staff retention as reasons for restructuring salaries. For example, San Francisco's chief financial officer stated that the human resources department performs salary surveys as part of its administration of the compensation and performance management program and one of the reasons it enhanced salary levels in 2010 was due to the organization growing from a small company of approximately 75 employees to a midsized organization of approximately 149 employees over the previous three years, with staffing expected to grow to 171 employees by the end of fiscal year 2011–12. He stated San Francisco competes against commercial for-profit and not-for-profit health care organizations as well as for-profit corporate companies for employees working in non-health care related positions. The chief financial officer indicated that because he believes that these organizations can offer significantly higher salaries, it is critical to benchmark pay for jobs against pay of competitors to help lessen the difficulty of recruiting and retaining employees. According to the Los Angeles chief of

human and community resources, it typically completes a CEO salary survey annually, and leadership positions are surveyed every three to four years. In addition, Los Angeles typically completes a salary survey review when recruiting for a new leadership position or possibly if an individual in a leadership position is being offered an opportunity outside of the organization.

All of the local initiatives also have similar internal controls that they follow when making salary step increases within established pay bands. Each has a governing entity—typically a board staffed with local medical professionals and administrators—that is responsible for approving both salary pay bands and the CEO's compensation and also for approving benefit changes. For example, Kern's board changed its executive salary structure for 2010 during its November 12, 2009, meeting. For executive positions other than CEO, all local initiatives use personnel forms that must be signed by the CEO. Our review of the personnel files for the CEO and one other executive at Contra Costa, Kern, Los Angeles, and San Joaquin determined that the compensation for these individuals was properly approved in accordance with policies, contracts, and if applicable, executive salary pay structures.

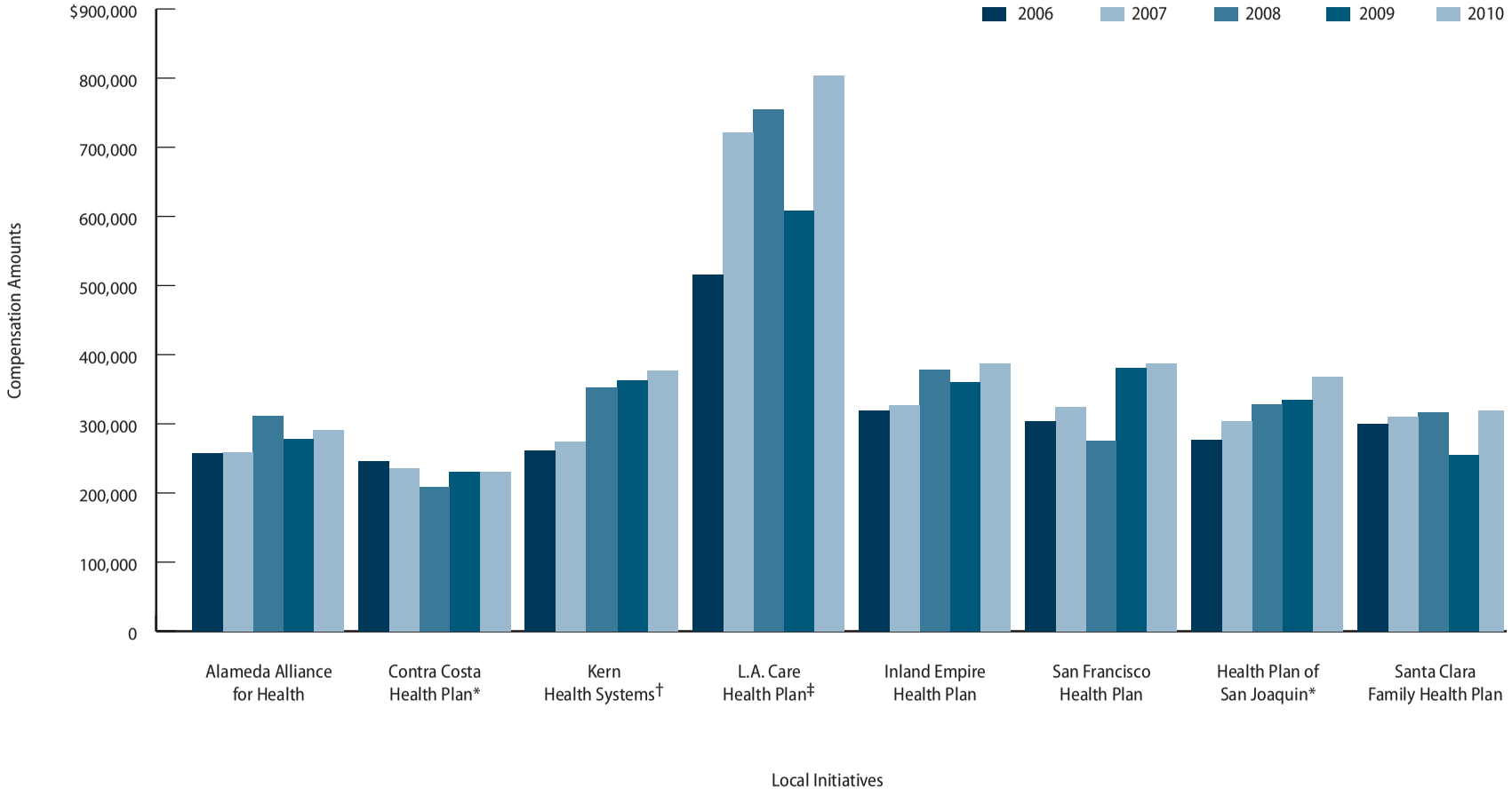
Our review of the personnel files for the CEO and one other executive at Contra Costa, Kern, Los Angeles, and San Joaquin disclosed that their compensation was approved in accordance with policies, contracts, and if applicable, executive salary pay structures.

Because Contra Costa is a division within the Department of Health Services of Contra Costa County, it handles compensation for its CEO differently than the other local initiatives. The Contra Costa CEO is a county employee who is appointed by and reports to the director of the county's Department of Health Services. Therefore, the director authorizes any salary step increases for Contra Costa's CEO. Contra Costa's countywide processes, policies, and memorandums of understanding define all other executive pay scale structures, benefits, and compensation that local initiative employees are paid. Therefore, Contra Costa's CEO does not have to negotiate her compensation and benefits, as the other local initiatives' CEOs do.

Although Local Initiatives Use Similar Salary-Setting Practices, Executive Compensation Varies Significantly

Our testing confirmed that the salaries and retirement benefits of the local initiatives' CEOs are significantly different. As shown in Figure 4 on the following page, the total compensation paid for CEOs has generally been increasing for all local initiatives except Contra Costa, which has maintained the same compensation for the past two years.

Figure 4
Total Compensation of Chief Executive Officers at the Local Initiatives
2006 to 2010



Source: California State Auditor's analysis of local initiatives' executive salary and compensation for 2006 through 2010.

* Data represent fiscal years 2005–06 through 2009–10 amounts.

† Includes a bonus earned in 2009 that was paid in 2010.

‡ Includes bonus amounts earned in both 2009 and 2010 that were paid in 2010.

The types of compensation CEOs received included bonuses, car allowances, and vacation cash-out options. Appendix E provides a summary of the compensation for each local initiative's five highest-paid employees, including the CEO, for 2010. In 2010 four of the local initiatives paid bonuses to their executives. However, Kern's board voted in 2010 to discontinue that benefit, and the bonus payment for 2009 occurred in 2010. During 2010 CEO compensation ranged from $230,272 for Contra Costa to $803,913 for Los Angeles. The Los Angeles CEO's compensation for 2010 includes two years of bonuses totaling $165,057 that its board authorized and paid in 2010.

The Los Angeles CEO received a significantly higher retirement contribution than all of the other highest-paid local initiative executive employees in 2010.

The Los Angeles CEO also received a significantly higher retirement contribution than all of the other highest-paid local initiative executive employees in 2010. The local initiative's board of governors created the retirement contribution for designated members of its senior management team. According to Los Angeles's chief of human and community resources (chief), its board chose to provide the CEO with a retirement benefit equal to at least 30 percent of his annual compensation; however, she believes that Internal Revenue Service limits prevented this from happening. The chief stated that in 2007 Los Angeles changed its retirement contribution amounts from a percentage of compensation to a fixed dollar amount in order to be in compliance with Internal Revenue Service regulations while achieving its intent to pay its CEO a retirement benefit equal to 30 percent of his annual compensation, resulting in a onetime shortfall adjustment to his retirement fund for that year. In 2010 his retirement contribution amount was $150,398, which reflects the mandatory 6.2 percent replacement contribution for Social Security, companywide matching contributions to its 401(a) retirement plan, and the contribution to the cash balance plan. Therefore, his 2010 retirement contribution amount of $150,398 reflects Los Angeles offsetting his prior year's retirement contribution shortfall.

According to the Los Angeles chief, its executive employees receive higher compensation than those of other local initiatives for a variety of reasons, including that it is the largest public health plan in the nation, with a significantly larger scope of operations and visibility than any of the other local initiatives. The chief stated that Los Angeles currently has an annual operating budget of more than $1.25 billion and serves more than 900,000 members in one of the most ethnically, culturally, and socioeconomically diverse regions in the nation. The plan also operates in one of the most complex media markets in the country. The chief told us that operating in the Los Angeles market poses unique challenges, given its highly competitive climate for top health care workforce resources

coupled with an extremely high cost of living. The chief also stated that the Los Angeles board has consistently rated the CEO as high-performing.

Local Initiatives' CEO Severance Packages Vary

Two local initiatives, including Los Angeles, specify in their CEO contracts that if the CEO resigns, he or she will not receive any severance compensation.

The local initiatives' CEO contracts have varying levels of severance packages, ranging from no payments if the CEO voluntarily resigns to specifying that the CEO will receive up to 18 months of additional compensation if terminated without cause. Contra Costa's CEO, as a county employee, will not receive severance compensation regardless of why her employment ends. The other seven local initiatives have severance packages ranging from six to 18 months if the governing body terminates the CEO without cause. For example, San Joaquin's severance package will pay its CEO his base salary and benefits for nearly one year. The contract further states that if he is employed elsewhere during the year, his compensation will be reduced by the new employment compensation. In this situation, San Joaquin will pay the difference between the new employment salary and benefits and his severance compensation for the remaining 12-month period.

However, a CEO's contract does not restrict a local initiative in terms of the amount of compensation it pays upon separation, if no amount is explicitly stated. For example, the contract for Kern's former CEO allowed for severance compensation of six months if she was terminated with or without cause, but the contract was silent on compensation if she resigned. Under some circumstances, a local initiative may enter into a settlement agreement with an employee where the amount paid upon separation may differ from the amount stated in the employment contract. When its CEO resigned in June 2011, Kern's board agreed to a settlement agreement with the former CEO. The settlement agreement called for the equivalent of one year's salary, retirement, and health benefits including long-term care, having a total value of $317,000.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the scope section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

ELAINE M. HOWLE, CPA
State Auditor

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

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Appendix A

TANGIBLE NET EQUITY CALCULATION

As discussed in the Introduction, state regulations require managed care health plans to maintain a tangible net equity (TNE) minimum balance. The calculation to determine the TNE minimum balance can be performed using three methods: a flat rate of $1 million, a revenue option, and an expenditure option. The method to be used by a health plan is the one that produces the greater amount, as discussed in state regulation. The revenue-based calculation is the sum of 2 percent of the first $150 million of annualized premium revenues[16] and 1 percent of annualized premium revenues in excess of $150 million. The expenditure-based calculation is the sum of 8 percent of the first $150 million in annualized health care noncapitated expenditures,[17] except those paid on a managed hospital payment basis;[18] 4 percent of the rest of those same expenditures in excess of $150 million; and 4 percent of annualized hospital expenditures paid on a managed hospital payment basis. Capitated expenditures are excluded from the calculation.

Table A on the following page shows the required TNE minimum balance calculation for each of the eight local initiatives in 2010. We used the local initiatives' annual financial reports as submitted to the Department of Managed Health Care to calculate their required TNE minimum balances. The local initiatives that predominantly pay providers on a capitation basis use the revenue method, while local initiatives that predominantly pay their providers on a fee-for-service basis use the expenditure method, based on our analysis of the local initiatives for fiscal year 2009–10.[19] As shown in Table A, both L.A. Care Health Plan (Los Angeles) and San Francisco Health Plan use the revenue basis.

The required TNE minimum balance for Inland Empire Health Plan (Inland Empire), based on the expenditure method, was almost twice as large as that for Los Angeles, even though Los Angeles has almost twice as much premium revenue. This difference is due in part to Inland Empire's business practice of contracting with health care providers on a fee-for-service basis, which creates more risk because the payment amounts can vary considerably. This business practice requires a higher TNE minimum balance to meet the financial viability requirement of the Knox-Keene Health Care Service Plan Act of 1975. In contrast, Los Angeles contracts primarily with other health care providers and other health care plans to provide health care to California Medical Assistance Program beneficiaries on a capitated basis, which is less risky because Los Angeles's financial obligation is limited to the capitation payments that it makes. Because the required TNE minimum balance is determined using a calculation, it is different for each local initiative, depending on the initiative's business practices.

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16 *Premium revenue* is revenue earned from subscribers or enrollees only.

17 *Noncapitated expenditure*s are expenditures paid by the health plan on a fee-for-service basis.

18 *Managed hospital payments* are payments made on a per diem basis for inpatient services.

19 The fiscal year for all local initiatives ends June 30, except for Los Angeles, whose fiscal year ends September 30, and Kern Health Systems, whose fiscal year ends December 31.

Table A

Tangible Net Equity Requirement for Local Initiatives for Fiscal Year 2009–10
(In Thousands)

			LOCAL INITIATIVE							
	ROW	2010 ANNUAL FINANCIAL REPORT INFORMATION	ALAMEDA ALLIANCE FOR HEALTH	CONTRA COSTA HEALTH PLAN	INLAND EMPIRE HEALTH PLAN	KERN HEALTH SYSTEMS	L.A. CARE HEALTH PLAN	SAN FRANCISCO HEALTH PLAN	HEALTH PLAN OF SAN JOAQUIN	SANTA CLARA FAMILY HEALTH PLAN
	A	Total 2010 premium revenues*	$222,907	$184,370	$675,752	$156,106	$1,127,646	$129,422	$147,122	$224,523
	B	Total 2010 health care expenditures (excluding capitated basis† or managed hospital payment basis‡ expenditures)	136,018	52,127	220,851	114,139	85,164	14,526	77,614	65,596
	C	Total 2010 managed hospital payments	0	0	200,869	21,787	30,503	4,693	32,382	25,729
		REQUIRED MINIMUM TANGIBLE NET EQUITY (TNE) CALCULATION IS THE GREATER OF OPTION 1, 2, OR 3								
		Minimum-Base								
1	D	$1 million	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
or		**Revenue-Base**								
	E	Total 2010 premium revenues (row A) up to $150 million x 2%	$3,000	$3,000	$3,000	$3,000	$3,000	$2,588	$2,942	$3,000
2	F	Total 2010 premium revenues (row A) exceeding $150 million x 1%	729	344	5,258	61	9,776	0	0	745
	G	Revenue required minimum TNE (sum of rows E and F)	**$3,729**	**$3,344**	**$8,258**	**$3,061**	**$12,776**	**$2,588**	**$2,942**	**$3,745**
or		**Expenditure-Base**								
	H	Total 2010 health care expenditures (row B) up to $150 million x 8%	$10,881	$4,170	$12,000	$9,131	$6,813	$1,162	$6,209	$5,248
	I	Total 2010 health care expenditures (row B) exceeding $150 million x 4%	0	0	2,834	0	0	0	0	0
3	J	Total 2010 managed hospital payments (row C) x 4%	0	0	8,035	871	1,220	188	1,295	1,029
	K	Expenditure required minimum TNE (sum of rows H, I, and J)	**$10,881**	**$4,170**	**$22,869**	**$10,002**	**$8,033**	**$1,350**	**$7,504**	**$6,277**
		Required Minimum TNE (higher amount of rows D or G or K)	**$10,881**	**$4,170**	**$22,869**	**$10,002**	**$12,776**	**$2,588**	**$7,504**	**$6,277**
		Method used to calculate required minimum TNE	Expenditure	Expenditure	Expenditure	Expenditure	Revenue	Revenue	Expenditure	Expenditure

Sources: California State Auditor's analysis of Title 28 of the California Code of Regulations and local initiatives' 2010 annual financial reports as submitted to the Department of Managed Health Care.

Note: Amounts are as of June 30 year-end, except for L.A. Care Health Plan, which uses a September 30 year-end date, and Kern Health Systems, which uses a December 31 year-end date.

* Premium revenue is revenue earned from subscribers or enrollees only.

† Capitated basis expenditures are costs paid on a fixed amount per member per month.

‡ Managed hospital payment basis expenditures are costs paid for per diem inpatient services.

Appendix B

LOCAL INITIATIVES' ADMINISTRATIVE COST PERCENTAGES FOR FISCAL YEARS 2005–06 THROUGH 2009–10

State regulations require all licensed health plans, including local initiatives, to ensure that administrative costs are reasonable and necessary. If, during any period, administrative costs exceed 15 percent of the total revenues received from providing services to beneficiaries, the Department of Managed Health Care (Managed Health Care) may ask a local initiative to demonstrate that its administrative costs are not excessive. Administrative costs are defined in regulation and discussed in Chapter 1. The local initiatives submit quarterly and annual financial reports to Managed Health Care, using a form that automatically calculates the administrative cost percentages from the entered numbers.

As shown in Table B on the following pages, we calculated the administrative cost percentages for each local initiative for fiscal years 2005–06 through 2009–10,[20] using their annual financial reports. The administrative cost percentage is calculated by dividing the total administrative expenses by the subscriber and enrollee revenues. The subscriber and enrollee revenues consist of commercial premiums, capitation payments, co-payments, and revenue from other public programs, including the State's Healthy Families Program. At the four local initiatives we visited, Contra Costa Health Plan (Contra Costa), Kern Health Systems (Kern), L.A. Care Health Plan (Los Angeles), and Health Plan of San Joaquin, we also reviewed their administrative expenses and compared them to the amounts reported in their annual financial reports.

As discussed in Chapter 1, we found improperly categorized expenditures at two of the four local initiatives visited. We adjusted the improperly categorized expenses at Contra Costa and Kern to reflect the correct administrative expense amounts. We also noted that in fiscal years 2008–09 and 2009–10, one of the local initiatives we did not visit—Santa Clara Health Plan (Santa Clara)—included a state-imposed fee in its administrative expenses, causing its administrative cost percentage to be overstated. We excluded this fee from Santa Clara's administrative expenses. After verifying the revenue amounts and making the adjustments to the local initiatives' administrative expenses identified above, we recalculated the administrative cost percentage for each local initiative.

[20] The fiscal year for all local initiatives ends June 30, except for Los Angeles, whose fiscal year ends September 30, and Kern, whose fiscal year ends December 31.

Table B

Local Initiatives' Fiscal Year 2005–06 Administrative Cost Percentages (Dollars in Thousands)

LOCAL INITIATIVE	REVENUE FROM SUBSCRIBERS AND ENROLLEES	TOTAL ADJUSTED ADMINISTRATIVE COSTS	ADMINISTRATIVE EXPENDITURE PERCENTAGE PER KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975
Alameda Alliance for Health	$144,941	$13,283	9.16%
Contra Costa Health Plan	119,573	11,512	9.63
Inland Empire Health Plan	309,272	29,033	8.20
Kern Health Systems	117,370	9,899	8.43
L.A. Care Health Plan	994,883	38,133	3.83
San Francisco Health Plan*	87,924	6,006	6.83
Health Plan of San Joaquin	84,203	9,390	11.15
Santa Clara Family Health Plan	140,958	17,238	12.23

Local Initiatives' Fiscal Year 2006–07 Administrative Cost Percentages (Dollars in Thousands)

LOCAL INITIATIVE	REVENUE FROM SUBSCRIBERS AND ENROLLEES	TOTAL ADJUSTED ADMINISTRATIVE COSTS	ADMINISTRATIVE EXPENDITURE PERCENTAGE PER KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975
Alameda Alliance for Health	$143,331	$14,608	10.19%
Contra Costa Health Plan	136,911	11,535	8.43
Inland Empire Health Plan	370,328	30,662	8.28
Kern Health Systems	123,468	11,205	9.08
L.A. Care Health Plan	1,010,554	42,949	4.25
San Francisco Health Plan*	92,541	6,976	7.54
Health Plan of San Joaquin	87,992	9,796	11.13
Santa Clara Family Health Plan	149,063	21,966	14.74

Local Initiatives' Fiscal Year 2007–08 Administrative Cost Percentages (Dollars in Thousands)

LOCAL INITIATIVE	REVENUE FROM SUBSCRIBERS AND ENROLLEES	TOTAL ADJUSTED ADMINISTRATIVE COSTS	ADMINISTRATIVE EXPENDITURE PERCENTAGE PER KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975
Alameda Alliance for Health	$158,343	$18,831	11.89%
Contra Costa Health Plan	149,834	12,387	8.27
Inland Empire Health Plan	441,515	33,468	7.58
Kern Health Systems	134,545	18,657	13.87
L.A. Care Health Plan	1,042,770	47,256	4.53
San Francisco Health Plan*	104,377	7,153	6.85
Health Plan of San Joaquin	98,752	9,768	9.89
Santa Clara Family Health Plan	181,442	24,945	13.75

Local Initiatives' Fiscal Year 2008–09 Administrative Cost Percentages (Dollars in Thousands)

LOCAL INITIATIVE	REVENUE FROM SUBSCRIBERS AND ENROLLEES	TOTAL ADJUSTED ADMINISTRATIVE COSTS	ADMINISTRATIVE EXPENDITURE PERCENTAGE PER KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975
Alameda Alliance for Health	$187,378	$17,102	9.13%
Contra Costa Health Plan	163,131	12,625	7.74
Inland Empire Health Plan	514,457	35,182	6.84
Kern Health Systems	147,204	16,236	11.03
L.A. Care Health Plan	1,127,378	47,956	4.25
San Francisco Health Plan*	109,758	8,856	8.07
Health Plan of San Joaquin	127,077	10,947	8.61
Santa Clara Family Health Plan	218,246	25,311	11.60

Local Initiatives' Fiscal Year 2009–10 Administrative Cost Percentages (Dollars in Thousands)

LOCAL INITIATIVE	REVENUE FROM SUBSCRIBERS AND ENROLLEES	TOTAL ADJUSTED ADMINISTRATIVE COSTS	ADMINISTRATIVE EXPENDITURE PERCENTAGE PER KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975
Alameda Alliance for Health	$222,907	$17,685	7.93%
Contra Costa Health Plan	184,370	12,139	6.58
Inland Empire Health Plan	675,752	36,791	5.44
Kern Health Systems	162,037	14,946	9.22
L.A. Care Health Plan	1,127,646	54,818	4.86
San Francisco Health Plan*	129,422	9,485	7.33
Health Plan of San Joaquin	147,122	11,268	7.66
Santa Clara Family Health Plan	224,523	21,774	9.70

Sources: California State Auditor's analysis of local initiatives' financial statements as provided to the Department of Managed Health Care and discussions with local initiatives' staff.

Note: Amounts are as of June 30 year end, except for L.A. Care Health Plan, which uses a September 30 year-end date, and Kern Health Systems, which uses a December 31 year-end date.

* San Francisco Health Plan (San Francisco) administrative costs show in its annual financial reports contain third-party administrative costs that should be excluded. San Francisco's chief executive officer provided us with the total adjusted administrative costs shown.

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Appendix C

TANGIBLE NET EQUITY BALANCES FOR LOCAL INITIATIVES AND COMMERCIAL PLANS PARTICIPATING IN THE CALIFORNIA MEDICAL ASSISTANCE PROGRAM MANAGED CARE TWO-PLAN MODEL

As discussed in the Introduction and Appendix A, state regulations provide direction to managed care health plans for calculating the required tangible net equity (TNE) minimum balance. In addition, the Knox-Keene Health Care Service Plan Act of 1975 requires the Department of Managed Health Care (Managed Health Care) to monitor whether health plans have TNE actual balances above 130 percent of their required minimum. Table C on the following pages provide the TNE actual balance, required TNE minimum balance, and the actual balance as a percentage of required TNE for the local initiatives and commercial plans in the California Medical Assistance Program managed care program's two-plan model for 2006 through 2010.[21] The amounts were derived from the annual financial reports submitted to Managed Health Care. As shown in Table C, while the local initiatives' required TNE minimum balances have increased each year, their TNE actual balances have varied over the years. Except in one instance in 2009, both the local initiatives and the commercial plans had TNE actual balances that exceeded the 130 percent of required minimum in each of the five years.

[21] The fiscal year for all local initiatives ends June 30, except for L.A. Care Health Plan, whose fiscal year ends September 30, and Kern Health Systems, whose fiscal year ends December 31. The commercial plans' fiscal year ends December 31.

Table C
Medi-Cal Managed Care Two-Plan Model Tangible Net Equity Comparison for Years 2006 Through 2010
(Dollars in Thousands)

2006

		YEAR END	COUNTY	TANGIBLE NET EQUITY ACTUAL BALANCE	REQUIRED TANGIBLE NET EQUITY MINIMUM BALANCE	ACTUAL TANGIBLE NET EQUITY AS PERCENTAGE OF REQUIRED BALANCE
LOCAL INITIATIVES	Alameda Alliance for Health	June 30	Alameda	$26,282	$6,379	412%
	Contra Costa Health Plan	June 30	Contra Costa	9,826	6,642	148
	Inland Empire Health Plan	June 30	Riverside	33,466	10,872	308
			San Bernardino			
	Kern Health Systems	December 31	Kern	49,470	8,435	586
	L.A. Care Health Plan	September 30	Los Angeles	133,940	11,449	1,170
	San Francisco Health Plan	June 30	San Francisco	31,730	1,758	1,804
	Health Plan of San Joaquin	June 30	San Joaquin	43,143	4,506	958
	Santa Clara Family Health Plan	June 30	Santa Clara	25,532	2,819	906
COMMERCIAL PLANS*	Anthem Blue Cross Partnership Plan	December 31	Alameda	2,043,259	313,978	651
			Contra Costa			
			San Francisco			
			San Joaquin			
			Santa Clara			
	Health Net Community Solutions, Inc.	December 31	Kern	727,577	155,525	468
			Los Angeles			
	Molina Healthcare of California Partner Plan, Inc.	December 31	Riverside	17,550	12,173	144
			San Bernardino			

2007

		YEAR END	COUNTY	TANGIBLE NET EQUITY ACTUAL BALANCE	REQUIRED TANGIBLE NET EQUITY MINIMUM BALANCE	ACTUAL TANGIBLE NET EQUITY AS PERCENTAGE OF REQUIRED BALANCE
LOCAL INITIATIVES	Alameda Alliance for Health	June 30	Alameda	$25,129	$7,139	352%
	Contra Costa Health Plan	June 30	Contra Costa	6,239	3,792	165
	Inland Empire Health Plan	June 30	Riverside	29,085	15,213	191
			San Bernardino			
	Kern Health Systems	December 31	Kern	59,996	7,969	753
	L.A. Care Health Plan	September 30	Los Angeles	120,702	11,606	1,040
	San Francisco Health Plan	June 30	San Francisco	31,317	1,897	1,651
	Health Plan of San Joaquin	June 30	San Joaquin	40,597	4,962	818
	Santa Clara Family Health Plan	June 30	Santa Clara	19,125	3,687	519
COMMERCIAL PLANS*	Anthem Blue Cross Partnership Plan	December 31	Alameda	1,811,634	316,551	572
			Contra Costa			
			San Francisco			
			San Joaquin			
			Santa Clara			
	Health Net Community Solutions, Inc.	December 31	Kern	808,767	173,132	467
			Los Angeles			
	Molina Healthcare of California Partner Plan, Inc.	December 31	Riverside	24,969	11,013	227
			San Bernardino			

2008

		YEAR END	COUNTY	TANGIBLE NET EQUITY ACTUAL BALANCE	REQUIRED TANGIBLE NET EQUITY MINIMUM BALANCE	ACTUAL TANGIBLE NET EQUITY AS PERCENTAGE OF REQUIRED BALANCE
LOCAL INITIATIVES	Alameda Alliance for Health	June 30	Alameda	$21,548	$8,032	268%
	Contra Costa Health Plan	June 30	Contra Costa	6,485	3,596	180
	Inland Empire Health Plan	June 30	Riverside	29,631	16,866	176
			San Bernardino			
	Kern Health Systems	December 31	Kern	69,021	8,276	834
	L.A. Care Health Plan	September 30	Los Angeles	117,327	11,928	984
	San Francisco Health Plan	June 30	San Francisco	34,095	2,156	1,581
	Health Plan of San Joaquin	June 30	San Joaquin	34,243	5,895	581
	Santa Clara Family Health Plan	June 30	Santa Clara	13,625	5,271	258
COMMERCIAL PLANS*	Anthem Blue Cross Partnership Plan	December 31	Alameda	1,184,178	328,042	361
			Contra Costa			
			San Francisco			
			San Joaquin			
			Santa Clara			
	Health Net Community Solutions, Inc.	December 31	Kern	1,014,038	204,050	497
			Los Angeles			
	Molina Healthcare of California Partner Plan, Inc.	December 31	Riverside	22,212	13,862	160
			San Bernardino			

2009

		YEAR END	COUNTY	TANGIBLE NET EQUITY ACTUAL BALANCE	REQUIRED TANGIBLE NET EQUITY MINIMUM BALANCE	ACTUAL TANGIBLE NET EQUITY AS PERCENTAGE OF REQUIRED BALANCE
LOCAL INITIATIVES	Alameda Alliance for Health	June 30	Alameda	$17,707	$9,947	178%
	Contra Costa Health Plan	June 30	Contra Costa	4,622	4,120	112
	Inland Empire Health Plan	June 30	Riverside	34,301	19,397	177
			San Bernardino			
	Kern Health Systems	December 31	Kern	71,025	9,391	756
	L.A. Care Health Plan	September 30	Los Angeles	125,211	12,774	980
	San Francisco Health Plan	June 30	San Francisco	30,971	2,195	1,411
	Health Plan of San Joaquin	June 30	San Joaquin	36,296	6,635	547
	Santa Clara Family Health Plan	June 30	Santa Clara	10,808	6,897	157
COMMERCIAL PLANS*	Anthem Blue Cross Partnership Plan	December 31	Alameda	1,340,387	308,967	434
			Contra Costa			
			San Francisco			
			San Joaquin			
			Santa Clara			
	Health Net Community Solutions, Inc.	December 31	Kern	1,170,367	205,158	570
			Los Angeles			
	Molina Healthcare of California Partner Plan, Inc.	December 31	Riverside	27,170	16,554	164
			San Bernardino			

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2010

		YEAR END	COUNTY	TANGIBLE NET EQUITY ACTUAL BALANCE	REQUIRED TANGIBLE NET EQUITY MINIMUM BALANCE	ACTUAL TANGIBLE NET EQUITY AS PERCENTAGE OF REQUIRED BALANCE
LOCAL INITIATIVES	Alameda Alliance for Health	June 30	Alameda	$23,003	$10,881	211%
	Contra Costa Health Plan	June 30	Contra Costa	7,341	4,170	176
	Inland Empire Health Plan	June 30	Riverside	43,573	22,869	191
			San Bernardino			
	Kern Health Systems	December 31	Kern	87,301	10,002	873
	L.A. Care Health Plan	September 30	Los Angeles	145,498	12,776	1,139
	San Francisco Health Plan	June 30	San Francisco	30,556	2,588	1,180
	Health Plan of San Joaquin	June 30	San Joaquin	42,728	7,504	569
	Santa Clara Family Health Plan	June 30	Santa Clara	25,103	6,277	400
COMMERCIAL PLANS*	Anthem Blue Cross Partnership Plan	December 31	Alameda	1,221,464	309,469	395
			Contra Costa			
			San Francisco			
			San Joaquin			
			Santa Clara			
	Health Net Community Solutions, Inc.	December 31	Kern	1,204,855	211,395	570
			Los Angeles			
	Molina Healthcare of California Partner Plan, Inc.	December 31	Riverside	36,416	15,010	243
			San Bernardino			

Sources: California State Auditor's analysis of the local initiatives' annual financial statements submitted to the Department of Managed Health Care and the Department of Health Care Services' Web site.

Note: CalViva Health is not listed because the plan started accepting members as of March 2011.

* The commercial plans' actual and required tangible net equity amounts encompass all of their California managed care licensed business.

Appendix D

LOCAL INITIATIVES' NUMBER OF DAYS OF CASH ON HAND FOR FISCAL YEARS 2005–06 THROUGH 2009–10

We calculated the average number of days covered by cash on hand for each of the local initiatives from fiscal years 2005–06 through 2009–10,[22] as shown in Table D on the following pages. This calculation shows the number of days a local initiative could pay its operating expenses without receiving funds from the State or other sources. To calculate the amounts, we used each local initiative's audited financial statements and discussions with its staff to determine the cash and liquid investments, total operating expenses, and depreciation expense. Depreciation expense is excluded from the calculation of average days of cash on hand since it is a noncash transaction.

The local initiatives' staffs stated that their ongoing concern regarding financial viability is the number of days of cash on hand rather than the tangible net equity balance. As shown in Table D, the local initiatives varied in their amount of cash and liquid investments on hand, from a low of nine days at Contra Costa Health Plan in fiscal year 2009–10 to a high of 193 days at Health Plan of San Joaquin in fiscal year 2005–06. Since L.A. Care Health Plan's (Los Angeles) fiscal year ends September 30, its cash-on-hand amounts for fiscal years 2007–08 and 2009–10 were low due to the delay in the passage of the State's budget. However, its accounts receivable amounts were higher during those same two fiscal years. Kern Health Systems (Kern) consistently maintained the highest levels of cash and liquid investments on hand, ranging from 120 days to 172 days. Kern is the only local initiative that pays nearly all of its providers on a fee-for-service basis rather than on a capitation basis. According to its chief financial officer, because the financial risks are higher with the fee-for-service basis, Kern believes it should maintain higher liquidity to address any adverse financial events.

[22] The fiscal year for all local initiatives ends June 30, except for Los Angeles, whose fiscal year ends on September 30, and Kern, whose fiscal year ends December 31.

Table D
Number of Days of Cash and Liquid Investments on Hand
Fiscal Years 2005–06 Through 2009–10

LOCAL INITIATIVE/ FISCAL YEAR	CASH AND LIQUID INVESTMENTS	TOTAL OPERATING EXPENSES, EXCLUDING DEPRECIATION EXPENSE	DAYS CASH ON HAND	AVERAGE DAYS CASH ON HAND
Alameda Alliance for Health				
2005–06	$16,777	$137,502	45	
2006–07	24,157	143,997	61	
2007–08	29,911	162,861	67	53
2008–09	15,505	190,776	30	
2009–10	39,125	221,595	64	
Contra Costa Health Plan				
2005–06	32,295	153,076	77	
2006–07	21,338	172,303	45	
2007–08	18,526	186,468	36	42
2008–09	23,828	210,118	41	
2009–10	4,860	205,937	9	
Inland Empire Health Plan				
2005–06	36,045	356,110	37	
2006–07	28,103	373,730	27	
2007–08	44,821	439,521	37	39
2008–09	59,212	507,467	43	
2009–10	89,930	664,040	49	
Kern Health Systems				
2005–06	41,541	126,106	120	
2006–07	42,350	119,993	129	
2007–08	62,490	132,609	172	145
2008–09	57,837	148,251	142	
2009–10	68,227	155,473	160	
L.A. Care Health Plan				
2005–06	107,542	995,586	39	
2006–07	141,204	1,036,002	50	
2007–08	40,676	1,052,766	14	40
2008–09	260,484	1,139,317	83	
2009–10	37,261	1,120,094	12	
San Francisco Health Plan				
2005–06	34,148	88,240	141	
2006–07	32,936	97,307	124	
2007–08	33,007	109,920	110	118
2008–09	35,843	120,058	109	
2009–10	37,667	130,001	106	

LOCAL INITIATIVE/ FISCAL YEAR	CASH AND LIQUID INVESTMENTS	TOTAL OPERATING EXPENSES, EXCLUDING DEPRECIATION EXPENSE	DAYS CASH ON HAND	AVERAGE DAYS CASH ON HAND
Health Plan of San Joaquin				
2005–06	$45,250	$85,518	193	
2006–07	37,468	93,378	146	
2007–08	32,663	107,080	111	126
2008–09	25,238	126,241	73	
2009–10	42,161	141,765	109	
Santa Clara Family Health Plan				
2005–06	31,420	140,924	81	
2006–07	21,948	153,254	52	
2007–08	23,800	188,560	46	54
2008–09	13,721	232,006	22	
2009–10	38,565	209,599	67	

Sources: California State Auditor's analysis of local initiatives' audited financial statements as provided to the Department of Managed Health Care and discussions with local initiatives' staff.

Note: The financial data is as of June 30 of the year noted, except for L.A. Care Health Plan, which uses a September 30 year-end date, and Kern Health Systems, which uses a December 31 year-end date.

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Appendix E

LOCAL INITIATIVES' EXECUTIVE COMPENSATION PAID IN 2010

As discussed in Chapter 2, local initiatives use comparable methods to establish compensation paid to executives and have internal controls in place for approving salary step increases within approved pay bands. However, compensation varied among the local initiatives reviewed. Table E on the following pages presents the compensation paid to the top five executives in 2010[23] for each local initiative, broken down by base salary, health benefits, retirement, bonus, and other compensation. Health benefits include medical, dental, vision, long-term disability, and life insurance. Retirement includes all contributions to the executives' retirement plans. Local initiatives provide their staff with one or more retirement contribution plans. Bonuses include any incentives or payouts the local initiatives provided to executives based on a variety of circumstances. For example, the Health Plan of San Joaquin provided an incentive to executive employees, which it also provided to other employees throughout the organization, based on achieving corporate and individual objectives, and it is paid only to individuals who meet or exceed performance goals. In addition, the L.A. Care Health Plan (Los Angeles) board of governors has approved an annual incentive based on executive staff accomplishments during the year. Under this plan, the Los Angeles chief executive officer can receive an annual incentive equal to no more than 20 percent of his base salary for meeting performance goals, an incentive that he received during 2010. Other compensation includes severance pay, vacation payouts, automobile allowances, and other payouts as shown in Table E. Note that in some cases an executive received compensation during 2010 that relates to a previous year, such as an incentive based on the executive's performance during 2009 that the local initiative did not pay until 2010. For example, Kern Health Systems ended its bonus program and made its last payment for 2009 in 2010. In these cases, we provided a footnote to indicate that the pay is related to 2009.

[23] Contra Costa Health Plan and Health Plan of San Joaquin information is for the fiscal year ending June 30, 2010.

Table E
Local Initiatives' Executive Compensation Paid in 2010

LOCAL INITIATIVE/TOP FIVE EXECUTIVE POSITIONS	BASE SALARY	HEALTH BENEFITS	RETIREMENT	BONUSES	OTHER PAYOUTS/ COMPENSATION	TOTALS
Alameda Alliance for Health						
Chief executive officer	$223,621	$12,693	$27,501	–	$27,064	$290,879
Medical director	230,257	12,627	28,473	–	15,202	286,559
Enterprise architect	134,856	18,852	17,159	–	98,327	269,194
Chief financial officer	211,714	7,484	27,372	–	16,395	262,965
Chief operations officer	171,942	12,060	21,042	–	9,325	214,369
Contra Costa Health Plan*†						
Chief executive officer	165,353	8,531	53,133	–	3,255	230,272
Advice nurse manager	119,350	16,817	38,411	–	8,376	182,954
Health plan director of compliance and government relations	109,820	15,302	34,352	–	2,112	161,586
Health plan pharmacy manager	115,425	7,974	35,671	–	2,220	161,290
Utilization review manager	116,211	7,336	35,578	–	65	159,190
Inland Empire Health Plan						
Chief executive officer	283,500	21,682	37,680	–	44,420	387,282
Chief medical officer	260,266	17,514	19,600	–	43,396	340,776
Medical director	240,392	14,214	19,217	–	–	273,823
Chief financial officer	200,729	21,682	16,058	–	29,872	268,341
Chief operations officer	204,263	21,682	16,341	–	19,684	261,970
Kern Health Systems						
Chief executive officer	284,490	15,460	31,250	$40,491‡	5,670	377,361
Associate medical director I	186,371	15,626	23,838	17,577‡	–	243,412
Chief operating officer	186,286	15,406	23,829	17,270‡	–	242,791
Chief health services officer	176,829	15,400	22,636	16,501‡	–	231,366
Chief compliance officer	139,977	2,981	16,314	3,572‡	–	162,844
L.A. Care Health Plan						
Chief executive officer	421,480	36,369	150,398	165,057§	30,609	803,913
Chief medical officer	308,326	23,099	55,648	42,820	10,716	440,609
Chief financial officer	250,207	29,870	49,547	–	71,893	401,517
Chief of staff	239,580	9,035	48,547	30,973	15,458	343,593
Senior medical director	241,841	9,238	22,547	20,170	14,313	308,109
San Francisco Health Plan						
Chief executive officer	289,080	18,048	24,235	55,942	–	387,305
Chief financial officer	227,105	6,444	19,039	11,684	–	264,272
Medical director	212,262	6,422	17,795	15,609	–	252,088
Chief information officer	201,156	16,652	16,871	12,111	–	246,790
Chief operations officer	194,781	6,454	16,688	9,245	–	227,168

LOCAL INITIATIVE/TOP FIVE EXECUTIVE POSITIONS	BASE SALARY	HEALTH BENEFITS	RETIREMENT	BONUSES	OTHER PAYOUTS/ COMPENSATION	TOTALS
Health Plan of San Joaquin*						
Chief executive officer	$242,684	$31,617	$52,107	$24,677	$16,697	$367,782
Medical director	217,630	7,954	34,183	10,359	–	270,126
Chief financial officer	173,979	8,169	27,327	7,891	13,573	230,939
Manager/pharmacist, care management	127,554	7,698	20,035	8,165	–	163,452
VP marketing and community relations	123,531	7,830	19,403	5,828	4,751	161,343
Santa Clara Family Health Plan						
Chief counsel and compliance	237,441	7,404	35,600	–	60,458	340,903
Chief executive officer	278,356	7,404	33,934	–	–	319,694
Chief financial officer	241,729	13,379	30,768	–	–	285,876
Chief medical director	213,034	6,664	30,009	–	19,288	268,995
Chief marketing officer	197,780	12,753	27,064	–	–	237,597

Source: California State Auditor's analysis of local initiatives' salary and compensation paid in 2010.

Note: The Other Payouts/Compensation column includes items such as auto and parking allowances; personal and vacation leave cash-outs; and severance, anniversary, shift differential, professional development, merit lump-sum, benefit waiver, and administrative leave pay.

* Data represent fiscal year 2009–10 amounts.

† Due to Contra Costa County's required agreed-upon temporary absences, a form of furlough, the base salary paid to these executives is less than their county-approved salary.

‡ Bonus amounts were earned in 2009, but were paid in 2010.

§ Bonus amount includes amounts earned in 2009 and 2010, but both were paid in 2010.

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(Agency comments provided as text only.)

Business, Transportation and Housing Agency
980 9th Street, Suite 2450
Sacramento, CA 95814

November 16, 2011

Elaine M. Howle, State Auditor*
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Attached please find a response from the California Department of Managed Health Care (Department) to your draft audit report "*Medi-Cal Managed Care Program: The Department of Managed Health Care Could Improve Its Oversight of Local Initiatives Participating in the Medi-Cal Two-Plan Model*" (#2011-104). Thank you for allowing the Department and the Business, Transportation and Housing Agency (Agency) the opportunity to respond to the report.

As noted in its response, the Department concurs with the three findings noted in the report, has already completed corrective action for one of the associated recommendations, and anticipates implementing the remaining two recommendations by October 31, 2012.

We appreciate your identification of opportunities for improvement and your recommendations related to the Department's oversight of local initiatives. If you need additional information regarding the Department's response, please do not hesitate to contact Michael Tritz, Agency Deputy Secretary for Audits and Performance Improvement, at (916) 324-7517.

Sincerely,

(Signed by: Michael Tritz for)

TRACI STEVENS
Acting Secretary

Attachment

cc: Brent Barnhart, Director, Department of Managed Health Care

* California State Auditor's comments begin on page 69.

November 14, 2011

Traci Stevens, Acting Secretary
Business, Transportation and Housing Agency
980 9th Street, Suite 2450
Sacramento, California 95814

Dear Secretary Stevens:

The Department of Managed Health Care (DMHC) thanks the Bureau of State Audits (BSA) for the opportunity to respond to its draft report titled **"***Medi-Cal Managed Care Program: The Department of Managed Health Care Could Improve Its Oversight of Local Initiatives Participating in the Medi-Cal Two-Plan Model***"** (#2011-104) issued on November 9, 2011.

At the request of the Joint Legislative Audit Committee, the BSA conducted a review of the Department of Health Care Services' (DHCS) oversight of local initiatives participating in the Medi-Cal managed care program, which included a review of DMHC activities to ensure managed care plans, including local initiatives, are financially solvent and comply with requirements of the Knox Keene Health Care Services Act of 1975 (Knox Keene Act). The BSA determined that the DMHC did not adequately monitor local initiatives under Knox Keene Act requirements.

As detailed below, the DMHC agrees with the three recommendations and is pleased to report that it has completed corrective actions for recommendation #3, and is implementing corrective actions for recommendations #1 and #2, which are expected be completed by October 31, 2012.

The BSA's recommendations and the DMHC's responses (shown in bold) follow:

Recommendations:

1. To monitor local initiatives' financial viability and compliance with the Knox-Keene Act requirements, Managed Health Care should develop a formal policy to ensure that it conducts financial report reviews in a timely manner, and that administrative expenses are correctly categorized.

Response:

The DMHC concurs with this recommendation.

The DMHC acknowledges that, in some instances, it did not review financial reports in a timely manner. DMHC did not have a formal policy regarding its review of financial reports, but utilized a multi-layer, informal process. The DMHC will develop and implement formal policies and procedures, make necessary changes or additions to the financial filing system to help implement and monitor the policies and procedures, ensure that staff and management are informed and trained on the new policies and procedures, and develop a management reporting tool to monitor adherence to the policies and procedures. DMHC will remind staff that review of administrative expenses, and correct categorization of such expenses, is part of the overall financial review process.

Planned completion date: Oct 31, 2012

Secretary Traci Stevens
Response to the Bureau of State Audits

November 14, 2011

DMHC disagrees with the statement that it is "chronically late in completing reviews of health plans' financial reports" (Page 20) primarily because it implies that the lateness applies to all reports, which is not accurate. As the report notes, there is no statutory deadline for completing reviews, but DMHC has an internal 30-day deadline. In fact, over the past five years, DMHC's review of health plans' financial statements met or exceeded its internal review time goal approximately 80 percent of the time when considering the approximately 2,000 financial statements it receives annually. As part of the policies and procedures referenced above, the DMHC will establish a realistic timeframe for reviewing monthly, quarterly, and annual financial statements. ① ②

2. To ensure that local initiatives implement corrective action plans, Managed Health Care should devise a more effective process to track, monitor, and review the status of local initiatives' corrective actions as they relate to financial examination requirements.

Response:

The DMHC concurs with this recommendation.

The DMHC acknowledges that, in some instances, DMHC did not adequately follow up on health plans' correction action plans (CAP). DMHC further acknowledges the necessary upgrade to the database to track CAPs has not yet occurred. The DMHC will develop a CAP tracking feature in the database to allow ready identification of CAPs and their related corrective action status, as well as the decisions made concerning the corrective actions taken.

Planned completion date: Oct 31, 2012

3. Managed Health Care should ensure that it obtains timely medical audits from Health Care Services. If it is unable to obtain timely medical audits from Health Care Services, it should conduct them itself.

Response:

The DMHC concurs with this recommendation.

The DMHC acknowledges that a number of medical surveys for the local initiatives were delayed.

Both the DMHC and the DHCS have responsibility for conducting medical audits of the local initiatives and other Medi-Cal managed care plans. To the extent that resources at the DHCS are not available to perform the required medical audit, the DMHC will undertake the responsibility to timely schedule and conduct a Knox-Keene Act medical audit.

The DMHC has developed and implemented formal policies and procedures: (1) to track and secure copies of the DHCS' medical audits and findings and, (2) to the extent necessary, to timely schedule a Knox-Keene Act medical audit in the event that the DHCS does not have available resources to

Secretary Traci Stevens
Response to the Bureau of State Audits

November 14, 2011

conduct its medical audit. The DMHC will monitor these new policies and procedures to ensure that management and staff are informed and trained so that medical audits of all Medi-Cal managed care plans, including local initiatives, are completed timely.

Corrective action complete; no further action required.

The DMHC appreciates the opportunity to provide a response on our plans to implement the BSA recommendations. If you have questions or concerns, please contact Dennis Balmer, Deputy Director, Financial Solvency Standards Board, at (916) 445-4565.

Sincerely,

(Signed by: Brent Barnhart)

BRENT BARNHART
Director
Department of Managed Health Care

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE BUSINESS, TRANSPORTATION AND HOUSING AGENCY, DEPARTMENT OF MANAGED HEALTH CARE

To provide clarity and perspective, we are commenting on the response to our audit report from the Department of Managed Health Care (Managed Health Care). The numbers below correspond to the numbers we placed in the margin of Managed Health Care's response.

The page that Managed Health Care refers to was in the draft version of our report and has since shifted in the final published version. (1)

We stand by our conclusion that Managed Health Care is chronically late completing its reviews of health plans' financial reports. As we indicate in our report on page 16, we found that Managed Health Care failed to meet its internal 30-day guideline for 15 of the 16 reviews we tested and that it took an average of more than 200 days to complete these 16 reviews. Further, as stated on pages 16 and 17, in response to our inquiry, Managed Health Care provided us a report that identified 2,082 instances of health plan financial reports received between July 2005 and June 2011 that were either pending review or completed after the 15-day expectation for staff to complete their reviews. Moreover, even when we used the more recent 90-day completion expectation that Managed Health Care asserted was its informal policy in November 2011, our testing of 16 financial reviews found that eight far exceeded the 90-day expectation, even though they all were designated as higher risk. (2)

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(Agency comments provided as text only.)

Department of Health Care Services
1501 Capitol Avenue, Suite 71.6001, MS 0000
P.O. 9974313
Sacramento, CA 95899

November 16, 2011

Ms. Elaine M. Howle, CPA
State Auditor
California Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services has prepared its response to the draft report entitled *Medi-Cal Managed Care Program: The Department of Health Care Services and Managed Health Care Could Improve Their Oversight of Local Intiatives Participating in the Medi-Cal Two-Plan Model.* DHCS appreciates the work performed by Bureau of State Audits and the opportunity to respond to the draft report.

Please contact Ms. Raj Khela, Audit Coordinator, at (916) 650-0298 if you have any questions.

Sincerely,

(Signed by: Karen Johnson for)

Toby Douglas
Director

Enclosure

cc: Ms. Karen Johnson
Chief Deputy Director
1501 Capitol Avenue, MS 0005
P.O. Box 997413
Sacramento, CA 95899-7413

Department of Health Care Services
Response to the Bureau of State Audits' Draft Report Entitled:

Medi-Cal Managed Care Program: The Department of Health Care Services and Managed Health Care Could Improve Their Oversight of Local Initiatives Participating in the Medi-Cal Two-Plan Model

Recommendation:	To ensure all four financial soundness elements included in Health Care Services' contract are being reviewed, it should conduct financial reviews consistently and update its review tool to include working capital. In addition, Health Care Services should develop a formal policy to ensure that it conducts financial reviews in a timely manner.
Response:	Health Care Services agrees with the recommendation. DHCS/FMU has developed and implemented a revised worksheet that includes all elements within the contractual scope of our financial review including working capital. DHCS is in the process of establishing policies and procedures that will ensure consistency and timeliness. Formal policies are anticipated in January 2012.
Recommendation:	To make its financial solvency review efforts more efficient and reduce the risk of errors, Health Care Services should coordinate with Managed Health Care when analyzing local initiatives' consolidated financial reports.
Response:	Health Care Services agrees with the recommendation. DHCS and DMHC will collaborate to eliminate duplication of effort in respect to the consolidated review of financial statements. DHCS will place reliance on the automated ratios that DMHC generates.
Recommendation:	Health Care Services should ensure that it performs the annual medical audits of local initiatives as required by law.
Response:	Health Care Services agrees with the recommendation. The Medical Review Branch, Audits and Investigations, will resume annual medical audits of all Medi-Cal Managed Care Plans effective early 2012. We will work in conjunction with the Medi-Cal Managed Care Division and to the extent feasible, with the Department of Managed Health Care.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press