MEMORANDUM
COUNTY OF VENTURA
COUNTY COUNSEL'S OFFICE

April 5, 2018

TO: Michael B. Powers, County Executive Officer

FROM: Leroy Smith, County Counsel

RE: Patten Allegations

As part of the disclosure requirements in his severance agreement with the County, Tim Patten, the former chief deputy director of the Health Care Agency (HCA), submitted a written statement of alleged accounting irregularities and fraudulent accounting practices. Under our direction, a preliminary review of Patten's allegations has been conducted by attorneys in the County Counsel's office with the assistance of Matthew Sandoval, the Health Care Agency's current Chief Deputy Director/Compliance Officer. Thus far the review has consisted primarily of interviews with approximately 20 County officers and employees with knowledge of the HCA's accounting practices, and limited review of past audit reports and financial disclosures.

The purpose of the preliminary review is to identify potential legal and operational concerns raised by Patten's allegations. As to legal, we have not identified any area of clear legal non-compliance that requires immediate corrective action. Three areas are identified as requiring further, more comprehensive review. (See 1F, 2A and 2C, below.) Review of at least two of those items was begun before Patten began his employment with the County. If comprehensive review identifies an area of legal non-compliance, recommendations for corrective action will be made to County decision-makers.

As to operational issues, where the preliminary review identifies practices or policies needing improvement, but not raising material issues of legal compliance, HCA will consider the information and determine whether further evaluation or changes are warranted.

Patten's allegations are organized in two parts: alleged accounting irregularities and alleged fraudulent accounting practices. This memorandum tracks the formatting used by Patten, but considers whether a practice raises issues of legal compliance regardless of how Patten characterized it. The analysis set forth below is

based solely on the limited preliminary review conducted to date and not on a detailed forensic examination.

1. Alleged Accounting Irregularities in Ventura County HCA

A. Budgeting Process Is Incomplete and Inadequate to Manage an $850 Million Dollar Business

Patten's Alleged Accounting Irregularity. February 2016 Annual budgeting process begins. Generally, in a healthcare business this large ($850 Million) there is a formal budgeting process, budget software, a budget calendar and a specific set of budget assumptions and guidelines are distributed. None of this occurred. I recommended to CFO and Barry a process and list of recommendations. The CFO rejected them without comment. Additionally, the numbers used to forecast were only five months (July – November of the prior fiscal year). This is very unusual and problematic. One would normally have at least nine months particularly in healthcare where seasonality plays a big factor. The winter months of December thru March, are a high time for flu season and are the busiest and need to be factored into the budget. This was not done and distorts the process and results. At least 10 of the hospital clinics never got budgets developed and they were multi-million dollar operations.

Preliminary Analysis. It is understood and accepted that HCA's accounting systems and resources need substantial improvement to adequately manage the financial and budgeting demands of the County's health care system. Patten's observations in this regard are not new or surprising. Patten's allegation that 10 hospital clinics never got budgets developed does not appear to have any basis in fact, even though he may subjectively believe the budgeting process was inadequate.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

B. Accounting Methodology Is Inconsistent

Patten's Alleged Accounting Irregularity. Generally, in healthcare an entity chooses one general accounting method (either cash or accrual accounting) and then follows the GAAP general accounting method for the type chosen. The CFO verbalized and generally followed cash accounting principles. This was the case unless the numbers

did not support where the CFO wanted or needed the entity needed to be. The best example of this is that at the end of the 2015/2016 fiscal year, the CFO directed the accountants book a $15 million-dollar accrual (receivable) from Gold Coast Health Plan in order to get the VCMC numbers to match the projections given to the bond rating agencies and the Board of Supervisors. This accrual was based on the Affordable Care Act legislation and will not be reconciled for approximately two years from now. The CFO's staff did not want to book the entry but were directed to do it. This was not disclosed to the hospital leadership, County leadership or HCA leadership. I found out in a causal conversation with the accounting staff.

Preliminary Analysis. Patten appears to have confused the County's accrual basis accounting system, which accounts for County operations during each fiscal year (July 1 through June 30), and the County's financial management system used to manage operations in real time. The accrual system for annual budgeting necessarily requires that staff make reasonable projections for liabilities and assets (e.g., accounts receivable and accounts payable). In contrast, the financial management system requires that staff constantly monitor actual cash balances and payment deadlines. There is no inconsistency between using an accrual accounting system for fiscal year budgeting purposes and performing short-term cash flow analyses for financial management.

As to the specific example given, Patten implies that there was not a reasonable basis for projecting a $15 million payment from Gold Coast Health Plan for the 2015/2016 fiscal year. The asserted basis for Patten's allegation is a casual conversation he had with unidentified accounting staff. It appears that contrary to Patten's allegation there was a reasonable basis to recognize accrued income in the example given because sums approximating the projected amount were later received by the County.

Thus, there appears to be no material issue of legal non-compliance raised by Patten's allegation that warrant further investigation by counsel.

C. Accounting for Hospital Replacement Wing Has Several Irregularities

Patten's Alleged Accounting Irregularity. About four years ago, the County did the largest financing in its history when it placed $305 million of bonds to build a partial replacement wing for VCMC. Fifteen-year projections were done to place these bonds and there are very specific bond covenants that must be met in order to stay in compliance with the financing. At the time of my dismissal, about 75 percent of the

funding had been drawn down. Additionally, the project was running well over original projections and several other sources of funding had been put in place including a $25 million line of credit with Bank of America, a $17 million capital lease with Phillips, a $10 million line of credit with Winthrop leasing, and the transfer of $5 million of California state tobacco tax money to the project that generally would have gone to VCMC operations. There was an apparent duplicate entry for these funds on paper dispersed to the affiliated clinics.

Preliminary Analysis. The additional funds mentioned above were necessary to fund the purchases of equipment and supplies for the VCMC hospital replacement wing ("HRW") as they were not allocated as part of the $305 million of bond money. The $5 million from the tobacco tax was transferred as part of a Board letter and no duplicate entries were noted.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

D. "Shell Accounting" that Does Not Follow GAAP Rules

Patten's Alleged Accounting Irregularity. Within the Ventura County HCA apparently, there is only one legal entity the County of Ventura. All the other entities are considered departments and have discreet accounting and cash management but are not legal entities. Many also have restricted funds that per state and/or federal guidelines cannot be moved in a discretionary fashion. We had a monthly cash management meeting with a large group of leaders in the agency and the finance team in which we reviewed and updated the cash flow projections that were tied to both the budget and the HRW financing and associated projections. This meeting consisted primarily of the finance staff making up numbers to balance the projections. Millions of dollars were added and subtracted without any back up or consent on the part of the operational leaders. When the shell accounting did not balance the books properly the operators were told to come up with additional savings or revenues to balance the books. This activity was never completed just picked up the next month. When I was dismissed, the HCA was into the County general fund for a loan of $117 million, partly due to this shell accounting.

Preliminary Analysis. It is not clear what is meant by "shell accounting." Patten's allegation appears to be that VCMC management was not concerned how realistic its cash flow projections were because ultimate liability for funding VCMC

rested with the County's general fund. Even if loans from the general fund to VCMC are somewhat illusory in the sense that the Couny is loaning money to itself, the practice does not raise any legal concerns.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

E. Behavioral Health Funds Were Not Properly Handled by Finance Staff

Patten's Alleged Accounting Irregularity. The County Department of Behavioral Health has some very unique funding sources that come from Proposition 63 (the millionaire tax), MHSA funding, and EPSOT funding. These each have very specific regulations on how the funds are used, dispersed and accounted for by the entity. There are many restricted funds in this area and the reconciliation with the state can run five- to 10- years behind. On several occasions the CFO directed the accounting staff to move funds on paper and sometimes the cash from Behavioral Health to VCMC in ways that seemed inappropriate and lacked the backup documentation. This was done again to meet the projections for HRW, the bonds, the rating agencies or simply to make payroll.

Preliminary Analysis. There have been transfers from Behavioral Health to VCMC for services provided by the Inpatient Psychiatric Unit ("IPU"), which is a component of VCMC. All such transfers appear to have been appropriate and documented.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

F. Licensure Issues that Created Billing Errors and Potentially False Claims

Patten's Alleged Accounting Irregularity. Early on in my tenure, I learned that the HCA had opened several ambulatory clinics without the proper licensure. In several cases, billing was still occurring for these clinics and no one was working to resolve them. When I reported these issues to Barry he asked me to take the lead in resolving them. This included the Eastman Therapy clinic opened in about 2012 and not licensed until August 2016. The Santa Paula PT clinic opened in 2010 and still not licensed but the paperwork was in process when I left. The Magnolia FQHC clinic which never got its license and FQHC provider number properly in place since it opened in 2014. This was fixed in June 2016. In all cases I worked with our legal counsel at

Hopper Lundy Bookman to work through the issues and get the house in order. Additionally, the hospital had not kept its license current and up to date on another 10 or so ambulatory clinic licensure issues. At Barry's direction, I was working with team to resolve these matters and had issued several letters to CDPH and had a face to meeting with them in early August to set in motion the correction of these items. The 1206 exemption does not apply since primary care was not involved.

Preliminary Analysis. Even before Patten's tenure, it was understood and accepted that HCA had problems acquiring and/or maintaining all necessary licenses for all services provided at some HCA facilities. Patten himself was assigned to review and implement corrective actions in this area during his tenure. Current HCA administration continues to work on the issues.

As to Patten's allegation concerning improper billing, it appears that the allegation is unfounded, or at least significantly overstated, because systems are in place that likely would have prevented unauthorized billing. Nonetheless, because it cannot be definitively determined on preliminary review that no improper billing ever occurred, further detailed examination of such issues is warranted.

G. Ambulatory Care Billing Issues and Irregularities that Created Risk and Financial Loss for HCA

Patten's Alleged Accounting Irregularity. It appears that the prior leadership had not done their homework in relationship to changes from CMS on Specialty/E&M codes made in 2010 and facility billing fees for FQHCs. This resulted in both under billing ($5-10 million per year) and potential over billing in the case of facility fees. I was working with Hooper Lundy Bookman to resolve the matter but did not get it finished prior to my departure.

Preliminary Analysis. The allegation appears to be based upon a misconception of the FQHC reimbursement model. Rate settings for FQHC's occurred when the clinics were originally opened, and is undergoing a state audit for re-basing the preliminary rates. The rates have not been reviewed since the facility openings. There is a process involved in getting new clinic rates set through HRSA. Facility fees cannot be billed under the current CMS payment guidelines.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

H. 340B Drug Program Unstated Liability for 2015 Distorts VCMC Actual Financial Condition

Patten's Alleged Accounting Irregularity. VCMC applied for and received approval for a 340B drug program that allows the hospital to buy drugs at cost for low income patients. There are stringent requirements for storage and record keeping with this program including storing this inventory separately from the normal drug inventory. In 2015 due to constraints imposed by the CFO, the hospital fell out of compliance with the program and lost their eligibility. They however continued to get the preferred pricing since the vendors were not informed of the non-compliance. The hospital was required to self-report the problem to the vendors who are then entitled to recover the difference in pricing. The estimated liability is more than $15 million. The CFO refused to record or disclose this amount to anyone that needed to know resulting in a large overstatement in the hospital's financial position for fiscal year 2015/2016.

Preliminary Analysis. The liability issues associated with the 340B drug program are largely a matter of public record. The pharmacy director made VCMC management aware of the concerns with the 340B program. The issues revolved mainly around a software upgrade called Talyst which would allow for split billing of 340B and non-340B medications. The estimated range of possible liability was $15-$19 million, but only $2.5 million was booked as a loss in 2016. The issues were corrected and the software was purchased. The amount owed after negotiations and assistance from Vizient, a consulting company, was less than $4 million. Some payments have been made or forgiven and negotiations are still in progress with vendors.

Patten's allegation does not focus on how the 340B liability arose, but on how VCMC projected the potential liability on its books. He apparently believes that the VCMC should have recognized an accrued the liability of $15-19 million. Actual experience shows that management's estimate of liability was reasonable.

While operationally HCA should ensure that the corrective actions it has taken prevent any future mishandling of 340B billings, there does not appear to be any material issue of legal non-compliance warranting further investigation by counsel of this allegation.

2. Alleged Potentially Fraudulent Accounting Practices in HCA

A. MD Time Sheets Do Not Follow CMS Guidelines and Create Potential False Claims Liability

Alleged Fraudulent Accounting Practice. The County contracts with 350-400 independent contract MD's who are required to fill out monthly time sheets to get their compensation. The process used by the County for the past 10+ plus years violates CMS and federal standards for MD time keeping. According to staff reports and contract meeting discussions, the MD signs a blank time sheet at the beginning of the month. Their time is later recorded by a clerk in the contracting department and approved by the contract manager who has no knowledge of actual time worked by the MD. The time sheets are never reviewed or approved by the person overseeing or supervising the MD. There is no reconciliation process to be sure the time is accurate. These time sheets are used for CMS and cost report purposes. I expressed concern about this process in several public forums and to Barry. I told them how other organizations handle this process and the liability of the person signing and approving the time sheet.

Preliminary Analysis. This issue was identified by the Auditor- Controller's Office over two years ago. It found that blank invoices were signed in advance and then submitted for payment. The process was designed to ensure physicians would receive payments within the first week of the month. Once payment was made, the contracts department would receive documentation regarding the physician's time sheets and then deduct payment in the following month if the prior month's payment was an overpayment. The CFO immediately sent an e-mail to the contract administration staff to stop the process when she became aware of it. This process has been corrected to ensure payments are made only after supporting documentation is received.

Because the practice has been corrected, there does not appear to be any material issue of legal non-compliance going forward. As to past payments, the matter is currently under review by outside auditors, and the audit is nearing completion. A determination on whether further detailed investigation is appropriate should be deferred until the audit is complete.

B. Affiliated Clinic Cash Transfers and Accounting Exceed the Amount Approved in PSOA's and by the BOS

Alleged Fraudulent Accounting Practice. The County uses a public/private partnership clinic model to operate number (10 or so) clinics in the County. In this model a Professional Services Operating Agreement ("PSOA") is entered into between the

County and a single MD per clinic. The MD employs the staff MD's and other staff to run the clinic and the County provides the space, equipment, supplies, billing services EMR, etc. to run the clinic. The agreements are typically for a term of three years and specify the amount in dollars that the County can advance to each clinic above its collections. The total amount of advances allowed per year for all clinics is about $10 million with a cap per clinic. The clinics are not well run and have exceeded the advance amount for some time. Without any documentation or approvals from the Board of Supervisors, the County finance department, at the CFO's direction, transfers whatever amount is needed to fund the operations sometimes more than double the amount allowed by the PSA. Most of the funding being distributed is hospital revenue that is given to the clinics.

Preliminary Analysis. The PSOAs authorize monetary advances to the clinics. These agreements are approved by the Board of Supervisors. The advances are treated like a line of credit. The Auditor-Controller's office was aware of the advances cited by Patten, and the advances appear to be proper under the PSOAs.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

C. MD Contracting Process Has Issues Where FMV (Salary and Productivity) are Not Used or Followed Properly

Alleged Fraudulent Accounting Practice. The County HCA contracts with 350-400 MD's individually or through groups. The total budget for these contracts is just over $60 million. In many cases the federal FMV (fair market value) rules were not taken into account properly. The County uses MGMA (Medical Group Management Association) as a general guide but rarely until I got involved was the MD's productivity taken into account which is the basis for MGMA. This results in many MD's being paid above FMV for their services.

Preliminary Analysis. HCA uses a contracts committee process for negotiating physician contracts and MGMA rates are used to determine appropriate base pay for physician contracts. It appears that some physician contracts are at or above 100 percent of the recommended MGMA rates and that some contracts were negotiated outside the contract committee process. There can be a reasonable explanation for paying at or above the MGMA recommended rates, such as the shortage of needed medical specialists in the local area. However, such contracts trigger the need for particularly

close scrutiny under federal law to ensure that no illegal kick-back or improper incentive is involved.

HCA has asked Huron (an outside healthcare finance consulting firm) to include an analysis of the County's fair market value determinations in its other work for the County. Further action on the investigation of this issue should be deferred until Huron's review is complete.

D. MD Bonuses Paid Without Appropriate Back Up

Alleged Fraudulent Accounting Practice. Bonuses are usually based on RVU's or quality metrics. They are generally approved by one of the medical directors rather than an administrator, which is more common. If the precise RVU or quality metrics are not readily available, the medical directors will guestimate the numbers and pay the bonuses anyway.

Preliminary Analysis. Lacking a specific example, it appears Patten is referring to the payment period after the Cerner installation. Prior to the Cerner implementation, reports were available to support payment of physician bonuses. These reports were available and could be run based on the needed reporting period. Once Cerner was implemented, these reports had to be created in Cerner and were not available when payment of physician bonuses were due. In order to pay the bonuses on time, it was decided to pay based on the pre-Cerner performance reports and then adjust the payments when the reports were available in Cerner. Once the reports were created, the bonus payments would be adjusted for under or over payment during the next bonus payment period.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

E. Payment for Services Not in Contracts

Alleged Fraudulent Accounting Practice. The MD time sheet process described above has other problems other than the ones noted above. An example was a clinic medical director asked for his contract to amended to include payment for administrative services. When I pulled the file and reviewed his time sheets, it was discovered that he had been billing and been paid for these not contracted services for some time. This highlights the serious problems with the review and approval processes for MD time sheets.

Preliminary Analysis. Preliminary review has not uncovered any evidence of this process occurring. All services eligible for payment would be listed within the PSOAs and the Auditor-Controller's Office would not process a payment without the supporting documentation. Compliance with payment transactions appear to be adequately overseen by the Auditor-Controller.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

F. MD Purchase Order Contracts that Do Not Follow Federal Guidelines

Alleged Fraudulent Accounting Practice. When one of the medical directors cannot get what they want through the formal contract process and committee they will often direct staff to process a PO (purchase order) contract through County procurement. These contracts do not meet the requirements of federal law. County purchasing rules allow exemptions for contract under $100,000.00 per year in value and even lighter rules if the contract is under $35,000.00 per year.

Preliminary Analysis. Without a specific contract to review, preliminary review did not reveal any evidence of this process occurring. Further, the County's procurement system, managed by the General Service Agency purchasing agent, would prevent the creation of POs without required signatures from HCA managers and fiscal staff. A physician could not create a PO without appropriate approval.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

G. Lack of Contract Compliance with Vendor Contracts Using Verbal Amendments Not Completed in Writing

Alleged Fraudulent Accounting Practice. In several instances the contract management of the HCA was so poor that the written terms of contracts were not followed and vendors/providers were paid at rates well above the contract terms. Two examples of this are Community Memorial Hospital a competitor was paid billed charges instead of contracted case rates for many cardiac procedures they performed. R&J Prosthetics contract was 28 years old and a number of verbal agreement changes were made to the payment terms instead of revising the contract.

Preliminary Analysis. The two examples referenced did occur, but there is no evidence of fraud or improper motive. There is general agreement that contract management needs to improve and steps are being taken to improve operations.

There may be a need to follow up on the two transactions in question, however, as to systemic issues, there does not appear to be any material issue of legal non-compliance warranting further investigation by counsel.

H. The County Charged Both Adults and Children with Claims Billed in Inpatient Psychiatric Unit While in Violation of Its License

Alleged Fraudulent Accounting Practice. In early 2015 VCMC was cited for co-mingling adult and pediatric psychiatric patients on a unit only licensed for adults. In a normal situation, this would have been declared immediate jeopardy by DHS and stringent measures would have been taken. As I understand it the County never self-reported the claims portion of this problem and never paid back the money to the state or federal government for these claims. This comes after the hospital was operating under an integrity agreement from 2001-2006 for billing problems in the psychiatric unit.

Preliminary Analysis. It is true that at times both adults and children were housed in the IPU and that VCMC was cited by California Department of Public Health. This is a matter of public record. While this was a violation, the situation was unique in that at the time there were no resources available for the pediatric patients and the only other option was to discharge them. The IPU discontinued providing services to pediatric patients in 2015. Further, contrary to Patten's allegation, billing for these services never occurred.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.

I. Ventura County Healthcare Plan Problematic Accounting Issues

Alleged Fraudulent Accounting Practice. Due to an inadequate rate adjustment, the plan suffered heavy losses in 2015/2016 and was put on monthly financial review by the DMHC who monitors Knox Keene licensed plans. The solution developed by the CFO involved a two-part approach: (1) A loan of approximately $4.5 million from the County. All the projections done suggested this could not be repaid under any circumstances. This was not disclosed to the Board of Supervisors in the Board letter. (2) An accounting transfer of $4 to 4.5 million from VCMC to Ventura County Health Care Plan ("VCHCP") was recorded with no backup documentation or support and without approval of the Board of Supervisors, VCMC and HCA leadership. Both of these actions I believe were intended to distort the actual financial position of VCHCP to the DMHC.

Preliminary Analysis. VCHCP and VCMC have a Memorandum of Understanding which allows for the transfer of funds between the two entities. The losses for VCHCP that occurred in 2015/2016 were due to several high cost cases. A transfer from the County of $4.5 million was received by VCHCP and repaid. A transfer of $4 million was received by VCHCP from VCMC. The transfer was approved by the Board of Supervisors.

There appears to be no material issue of legal non-compliance warranting further investigation by counsel of this allegation.