



Arnold Schwarzenegger, Governor  
State of California  
Business, Transportation and Housing Agency

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**January 21, 2010**

**Via eFile**

Marc Reynolds, President  
SCRIPPS HEALTH PLAN SERVICES  
10170 Sorrento Valley Road, SV4  
San Diego, CA 92121

**FINAL REPORT OF ROUTINE EXAMINATION OF SCRIPPS HEALTH PLAN SERVICES**

Dear Mr. Reynolds:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Scripps Health Plan Services (the “Plan”), conducted by the Department of Managed Health Care (the Department”), pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on October 29, 2009. The Department accepted the Plan’s electronically filed response on December 11, 2009.

This Final Report includes a description of the compliance efforts included in the Plan’s December 11, 2009 response, in accordance with Section 1382(c).

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

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan’s response shall be appended, and electronically file copies of those portions of the Plan’s response exclusive of information held confidential pursuant to Section 1382(c), no later than ten (10) days from the date of the Plan’s receipt of this letter.

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

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its December 11, 2009 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  - 1) File Type; select "Amendment to prior filing";
  - 2) Original Filing, select the "Filing No. 20091699" assigned by the Department; and
  - 3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: ""Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.
- After upload, then select "Complete Amendment", complete "Execution" and then click "complete filing".

Questions or problems related to the electronic transmission of the above responses should be directed to Siniva Pedro at (916) 322-5393 or email at [spedro@dmhc.ca.gov](mailto:spedro@dmhc.ca.gov). You may also email inquiries to [wpsso@dmhc.ca.gov](mailto:wpsso@dmhc.ca.gov).

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The report will be located at the Department's web site at [www.dmhc.ca.gov](http://www.dmhc.ca.gov).

If there are any questions regarding this report, please contact me.

Sincerely,

**ORIGINAL SIGNED BY**

Bill Chang  
Supervising Examiner  
Office of Health Plan Oversight  
Division of Financial Oversight

cc: Marc Reynolds, President  
Marcy Gallagher, Chief, Division of Plan Surveys  
Nancy Wong, Counsel, Division of Licensing  
Joan Larsen, Supervising Examiner, Division of Financial Oversight  
Sang Le, Examiner IV Supervisor, Division of Financial Oversight  
Jamey Matalka, Examiner, Division of Financial Oversight  
Anna Belmont, Examiner, Division of Financial Oversight

**STATE OF CALIFORNIA  
DEPARTMENT OF MANAGED HEALTH CARE**

**DIVISION OF FINANCIAL OVERSIGHT**

**SCRIPPS HEALTH PLAN SERVICES**

**FILE NO. 933-0377**

**DATE OF FINAL REPORT: JANUARY 21, 2010**

**SUPERVISING EXAMINER: Bill Chang**

**EXAMINER-IN-CHARGE: Jamey Matalka**

**FINANCIAL EXAMINERS: Sang Le, Anna Belmont**

## **BACKGROUND INFORMATION FOR SCRIPPS HEALTH PLAN SERVICES**

Date Plan Licensed:	April 7, 1999
Organizational Structure:	Scripps Health Plan Services, Inc. (“Plan”) is a for-profit, limited licensed health care service plan and is a wholly-owned subsidiary of Scripps Clinic Physicians Organization, Inc. (“Parent”), a for-profit corporation. The Parent is a wholly owned subsidiary of Scripps Health (“SH”), a California not-for-profit public benefit corporation. The Plan has various transactions with its affiliates under administrative service agreements for administrative services, provider services and office space.
Type of Plan:	<p>The Plan contracts with the following licensed health care service plans to provide physician and hospital services to their commercial and Medicare enrollees:</p> <p>SCAN Secure Horizons Health Net of California, Inc PacifiCare of California</p> <p>The Plan also offers ASO services (Claims processing) to various other health plans and Risk Based Organizations.</p>
Provider Network:	Scripps pays monthly capitation fees to SH for the provision of health care services through its contracted provider network and integrated health care system.
Plan Enrollment:	Total Enrollment of 36,507 (Medicare 30,354 and Commercial 6,153) as of June 30, 2009.
Service Area:	All zip codes in San Diego County.
Date of last Final Routine Examination Report:	July 10, 2006.

**FINAL REPORT OF A ROUTINE EXAMINATION OF SCRIPPS HEALTH PLAN SERVICES**

This is the Final Report of a routine examination of the fiscal and administrative affairs of Scripps Health Plan Services (“Plan”), conducted by the Department of Managed Health Care (the “Department”) pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on October 29, 2009. The Department accepted the Plan’s electronically filed response on December 11, 2009.

This Final Report includes a description of the compliance efforts included in the Plan’s December 11, 2009 response to the Preliminary Report, in accordance with Section 1382(c). The Plan’s response is noted in *italics*.

We examined the financial report filed with the Department for the quarter ended June 30, 2009 as well as other selected accounting records and controls related to the Plan’s various fiscal and administrative transactions. Our findings are presented in this report as follows:

Section I	Financial Statements
Section II	Calculation of Tangible Net Equity
Section III	Compliance Issues
Section IV	Internal Control
Section V	Non-Routine Examination

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

**SECTION I. FINANCIAL REPORT**

Account	Bal per G/L @ 06/30/2009	Bal. per F/S @ 06/30/2009	AJE or RJE	Exam Adjustments		Bal. per Exam @ 06/30/2009
				Dr	Cr	
Cash and Cash Equivalents	30,274,796	30,274,796				30,274,796
Short-Term Investments						
Premiums Receivable – Net	3,115,739	3,115,739	RJE 1		3,115,739	0
Interest Receivable						
Shared Risk Receivables - Net						
Other Health Care Receivables-Net	403,666	403,666	RJE 1	3,115,739		3,519,405
Prepaid Expenses	23,671	23,671				23,671
Secured Affiliate Receivables – Current						
Unsecured Affiliate Receivables – Current						
Aggregate Write-ins for Current Assets						
<b>TOTAL CURRENT ASSETS</b>	<b>33,817,872</b>	<b>33,817,872</b>		<b>3,115,739</b>	<b>3,115,739</b>	<b>33,817,872</b>
Restricted Assets	300,000	300,000				300,000
Long-Term Investments						
Intangible Assets & Goodwill- Net						
Secured Affiliate Receivables - Long-Term						
Unsecured Affiliate Receivables - Past Due						
Aggregate Write-ins for Other Assets						
<b>TOTAL OTHER ASSETS</b>	<b>300,000</b>	<b>300,000</b>				<b>300,000</b>
Land, Building and Improvements						
Furniture and Equipment – Net	2,759	2,759				2,759
Computer Equipment – Net	9,693	9,693				9,693
Leasehold Improvements - Net						
Construction in Progress						
Software Development Costs	78,963	78,963				78,963
Aggregate Write-ins for Other Equipment						
<b>TOTAL PROP &amp; EQUIP</b>	<b>91,415</b>	<b>91,415</b>				<b>91,415</b>
<b>TOTAL ASSETS</b>	<b>34,209,287</b>	<b>34,209,287</b>				<b>34,209,287</b>

RJE # 1 is to reclassify the Premiums Receivables-net to Other Healthcare Receivables-Net. The Plan does not receive premiums. The Plan receives capitation from other Health Plans since it is a limited licensee.

**The Plan is required to make the necessary adjustments to their June 30, 2009 financial statements and re-file it with the Department of Managed Health Care. Please state the management personal who is responsible for oversight of this corrective action and ongoing compliance efforts.**

**PLAN RESPONSE**

*The necessary adjustments were made to the June 30, 2009 financial statements and re-filed with the Department on December 11, 2009. Steve Bell, Director of Finance is the management personnel responsible for oversight and ongoing compliance with this corrective action.*

**The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.**

**SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)**

Net Worth as reported by the Plan as of quarter ended 6-30-2009	\$ 8,266,952
Add: Subordinated debt and related interest	0
Less: Intangible Assets and Goodwill-Net	<u>0</u>
Tangible Net Equity	\$ 8,266,952
Required TNE	<u>7,698,229</u>
TNE Excess per Examination quarter ended 6-30-2009	<u>\$ 568,723</u>

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of June 30, 2009.

**No response required to this Section.**

**SECTION III. COMPLIANCE ISSUES**

**A. REIMBURSEMENT OF CLAIMS**

Rule 1300.71 (a)(8)(K) states that failure to reimburse at least 95 percent of complete claims with the correct payment including the automatic payment of all interest and

penalties due and owing over the course of any three-month period constitutes a basis for a finding that the plan has engaged in a “demonstrable and unjust payment pattern.”

### **Retroactive-Active Authorizations**

Our examination disclosed that the Plan failed to reprocess six (6) claims out of 50 or 12% in the Provider Dispute Resolution (“PDR”) sample for lack of authorization (Also noted one (1) out of 50 in the Paid sample and one (1) out of 50 in Late sample). The Plan stated that it does not have policies and procedures for reprocessing previously denied claims after authorizations have been issued for them.

**The Plan is required to submit a detailed Corrective Action Plan (“CAP”) to bring the Plan into compliance with the above Rule that should include, but not be limited to, the following:**

- a. **Identification of all denied claims with subsequent authorizations from June 1, 2007 to the present.**
- b. **Evidence that interest and penalties, as appropriate, were paid retroactive actively for the claims identified in paragraph “a” above back to the original received date or date of retroactive-active authorization, which ever applies. This evidence is to include an electronic data file/schedule (Excel or dBase) that identifies the following:**
  - **Claim number**
  - **Date of service**
  - **Date of receipt**
  - **Total billed**
  - **Total paid**
  - **Date of payment**
  - **Number of days used to calculate interest**
  - **Amount of interest paid**
  - **Amount of penalty paid**
  - **Interest and penalty paid date**
  - **Check number for payment, interest and penalty**
  - **Provider name**

**The data file is to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation**

- c. **Policies and procedures implemented to ensure that claims are paid in compliance with the above Rules.**
- d. **Date the policies and procedures were implemented, the management**

**position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.**

**PLAN RESPONSE**

*The plan extracted all commercial claims that were denied for no authorization from the original file and sent to the DMHC covering the period of June, 2007 – August 2009. Claims for September and October, 2009 were also extracted for review: The claims that were identified were reviewed to determine if retroactive authorizations were received and if reimbursement was made within 30 days from the approved authorization date. At the time of the on-site audit the Department's Claims Examiner conveyed 30 days from the authorization approval date was the acceptable time frame. If the reimbursement of the identified claims met the criteria, then no further action was necessary and is noted on the report.*

*If claims with a retroactive authorization were identified and interest was not paid from the 31<sup>st</sup> day of the authorization approval date, the claims were reprocessed to include, interest and penalties that are provided to the Department. If the check number is not shown in the comments on the report due to recent processing of the claims, the Plan will provide it to the Department no later than December 31, 2009. The total amount of interest and penalties paid for the above time period is \$1,334.73.*

*At the time of the audit the Plan did not have a specific written policy and procedure regarding retroactive authorizations. The Plan would like to clarify that based on the information provided to the Department, a majority of the claims with retroactive authorizations were either processed within the acceptable timeframe or interest was paid as required by the regulation. This is suggested by the minimal amount of interest and penalties that were due. The Plan has been paying interest on retroactive authorization claims for several years. In addition, to the remediation of claims, the Plan has updated two of its claims policies & procedures to officially document the Plan's process. Copies of the two approved policies are provided to the Department. They are # 321 – Claims Denials and #333 Provider Dispute Resolution Mechanism. Both policies were updated on December 1, 2009.*

*The Plan would like to convey that all contracts between the provider and the Plan, state it is the responsibility and a requirement of the provider to obtain an authorization PRIOR to rendering services or submitting a claim. The Plan will continue to identify and educate providers that are not compliant in getting authorizations before rendering services.*

*The Plan will follow the process outlined below to achieve ongoing compliance with the regulations. A daily report is generated to identify any retroactive authorization approvals and any potential claims associated with the authorization. In the event of a retroactive approval of an authorization, the report is reviewed by a claims auditor to identify any claims that need to be re-processed. If a claim is identified that has a retroactive authorization it will be processed with interest and/or a penalty according to*

*the Department's regulations. The Claims Manager is the management personnel responsible for oversight and ongoing compliance with this corrective action.*

*The Plan would also like to add to its response that as of April 1, 2009, the Plan's contracts with the Full Service Health Plans have converted to a Fee-For-Service reimbursement methodology. Therefore, going forward a limited number of claims will fall into this category.*

**The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Plan provided the Department with a CD of all the claims that were reviewed and remediated (as applicable). Therefore, no further response is required.**

## **B. FORWARDING MISDIRECTED CLAIMS**

Rule 1300.71(b)(2)(A) states that failure to forward at least 95 percent of misdirected claims within ten (10) working days of receipt of the claim that was incorrectly sent to the plan over the course of any three-month period constitutes a basis for a finding that the plan has engaged in a "demonstrable and unjust payment pattern."

Claims incorrectly sent to the Plan for reimbursement and are not the financial responsibility of the Plan were not forwarded to the appropriate Health Plan within ten (10) working days of receipt by the Plan.

During our exam we performed two tests of the Plan's database using ACL software. First, we tested the entire database provided by the Plan from 2007 to 2009 and a three month window from May 1, 2009 to July 31, 2009 and the findings are as follows:

### **Commercial Claims Only**

	Number of misdirected claims:	Number of misdirected claims not forwarded within 10 working days:	Percentage of misdirected claims not forwarded within 10 working days:
2007-2009 FYE	1,347	1,183	88%
05/01/2009-7/31/2009	197	156	79%

**The Plan is required to implement a policy and procedures to forward misdirected claims within ten (10) working days of receipt. The Plan should state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.**

## **PLAN RESPONSE**

*The Plan has updated its current policy and procedure, #335 – Logging – Incoming Claims to include language regarding forwarding of claims within the mandated 10 working days of receipt. A copy of the approved policy and procedure is provided to the Department. The policy was updated on December 1, 2009. It is important to note on August 1, 2008, the Plan took on an increased volume of claims due to the acquisition by Scripps Health of Scripps Coastal Medical Center (“SCMC”). The Plan’s staff educated providers several times on where to send the claims for reimbursement effective August 1, 2008. Even after doing so the Plan continued to receive significant amounts of claims that were not our responsibility. To date the amount of misdirected claims has significantly reduced.*

*As mentioned in our response under deficiency #1, the Plan has converted its commercial contracts to a Fee-for-Service reimbursement methodology effective August 1, 2008, therefore forwarding of claims in 10 working days will be minimal. The Claims Manager is the management personnel responsible for oversight and ongoing compliance with this corrective action.*

**The Department finds the Plan’s compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.**

### **C. CLAIMS DETERMINATION**

Rule 1300.71(a):

“(2) "Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information" as defined by section (a)(10), "information necessary to determine payer liability" as defined in section (a)(11) and:...”

“(10) "Reasonably relevant information" means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.” And;

“(11) "Information necessary to determine payer liability" means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.” And;

Rule 1300.71(d) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. And;

Rule 1300.71(g) states the time period for reimbursement. "A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof..." within thirty (30) working days after receipt of the complete claim by the plan or the plan's capitated provider. If the Plan is a health maintenance organization, then forty-five (45) days after receipt of the complete claim by the plan or the plan's capitated provider.

During our examination it was discovered that the Plan does not have a policy in place for accurately processing "Health Net Responsibility" claims. In the late sample we found one (1) out of 20 or 5% (Also noted two (2) out of 50 in the PDR sample). All three claims were subsequently paid by the Plan, however the correct received date was not used.

The following issues were noted:

The Plan receives a claim from a provider and identifies it as "Special Condition" and forwards it on to Health Net for a determination of who's financially responsible to pay the claim. When a claim is returned to the Plan as their responsibility the Plan uses the date received from Health Net as additional information, even though the provider submitted nothing new to the Plan. The Plan is incorrectly using the Health Net forwarding date instead of the original received date of the claim to accrue interest, resulting in under-payments to providers and delayed reimbursements.

The amount of time allotted for reimbursement is specified in Rule 1300.71(g).

**The Plan is required to submit a detailed Corrective Action Plan ("CAP") to bring the Plan into compliance with the above Rule that should include, but not be limited to, the following:**

- e. Identification of all "Health Net Responsibility" claims processed from June 1, 2007 to the present that were incorrectly denied and subsequently paid.**
- f. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "a" above back to the original received date. This evidence is to include an electronic data file/schedule (Excel or dBase) that identifies the following:**
  - Claim number**
  - Date of service**
  - Date of receipt**
  - Total billed**
  - Total paid**

- **Date of payment**
- **Number of days used to calculate interest**
- **Amount of interest paid**
- **Amount of penalty paid**
- **Interest and penalty paid date**
- **Check number for payment, interest and penalty**
- **Provider name**

**The data file is to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation**

- g. Policies and procedures implemented to ensure that claims are paid in compliance with the above Rules.**
- h. Date the policies and procedures were implemented, the management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.**

## **PLAN RESPONSE**

*The Plan is contracted with Health net and is delegated to process specific claims on their behalf. It specifies in the Division of Financial Responsibility (DOFR) that claims with a specific diagnosis (also known as, special condition claims) are the financial responsibility of Health net. Although there is a process in place between the Plan and Health net to expedite the special condition claims, claims were not paid within the timeliness guidelines. The claims identified and affected by the delay have been reprocessed with interest and penalties. All the required information requested by the Department, such as interest, penalty amounts, date of check, and check number have been supplied to the Department. The total amount of interest and penalties paid for the above time period is \$251.71. If the check number is not shown in the comments on the report due to recent processing of the claims, the Plan will provide it to the Department no later than December 31, 2009.*

*As mentioned in our response under deficiency #1, the Plan has converted its commercial contracts to a Fee-for-Service reimbursement methodology. The Health net contract converted effective April 1, 2009. Therefore, the special condition claims will no longer be an issue in the future. For that reason the Plan is not including a policy and procedure for this deficiency. If in the future the Plan would enter into another contract that has special condition type claims the Plan will write a formal policy to document the process.*

*Should any claims be received as part of the “run-out” process, a report has been created for this specific diagnosis so that the claims are reviewed prior to payment/denial by an auditor to ensure appropriateness and timeliness. The Claims Manager is the*

*management personnel responsible for oversight and ongoing compliance with this corrective action.*

**The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. A CD was reviewed of all the claims that were reviewed and remediated (as applicable). Therefore, no further response is required.**

#### **D. SUPPLEMENTAL INFORMATION**

Section 1384(i), The director may make rules and regulations specifying the form and content of the reports and financial statements...

Rule 1300.84.2, Quarterly Financial Reports and Rule 1300.84.06 (b) sets forth additional information requirements that Health Plans must submit with their quarterly and annual financial statements filed with the Department.

During our routine examination of the Plan the following violations were found:

The Plan's June 30, 2009 financial statement had the following deficiencies:

- i) Schedule H and was not fully completed and was not presented in Dollar value
- ii) Schedule G III was not fully completed
- iii) Report 4 Enrollment-Not filled out correctly, the Plan does not have direct enrollment.
- iv) Report 1 Part B Current Liabilities-Plan was not reporting non-contracted liabilities; the Plan was reporting their non-contracted liabilities together with contracted liabilities. The non-contracted expense at June 30, 2009 is 7%, currently a deposit is made only when a Health Plan's non-contracted expenses for a six-month period exceeds 10% of their total healthcare expenses.
- v) Supplemental Information page- The Plan did not define their method for calculating IBNR.

**The Plan is required to submit a revised June 30, 2009 financial statement for the above mentioned violations with the required actions set forth:**

**1. The Plan is required to:**

- i) **Present Schedule H in Dollar Value and fully complete the schedule**
- ii) **Complete Schedule G III completely**
- iii) **Report enrollment under line 14 of Report 4 Enrollment and**

- iv) **display the Health Plan contracted with.  
The Plan is required to disclose their method for calculating  
IBNR.**

## **PLAN RESPONSE**

*The necessary adjustments were made to the June 30, 2009 financial statements and re-filed with the Department on December 11, 2009. The Plan's Director of Finance is the management personnel responsible for oversight and ongoing compliance with this corrective action.*

**The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.**

## **SECTION IV. INTERNAL CONTROL**

### **A. INTERNAL CONTROL**

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

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

SAS 60 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

Our examination disclosed the following issue:

During our examination it was discovered that the Plan has been using its own assets to cover expenses for another Health Plan under a Management Service Organization agreement ("MSO"). The agreement commenced in April 2009 with PacifiCare depositing \$400,000.00 with the Plan. The Plan is required to return the deposit on cancellation of this agreement. According to Exhibit 7 Attachment 2 PacifiCare is required to reimburse the Plan within forty-five (45) business days of PacifiCare's receipt

of the electronic paid claims file (A file containing all the claims paid for by the Plan). As of June 30, 2009 Scripps had paid \$803,665.00 worth of claims and received zero reimbursement from PacifiCare (Including the \$400,000 deposit the amount owed to the Plan was \$403,665.00.) Subsequent events show that at August 31, 2009 the Plan had paid \$1,255,985.00 worth of claims and including the \$400,000 deposit it was still owed \$855,985.47. This arrangement has caused the Plan to use its assets in such a way that is not in line with the Plan's license as a Knox-Keene Health Plan. The Plan is not in the business of providing short-term loans to other Health Plan's.

**The Plan is required to submit a detailed corrective action plan (“CAP”) to bring the Plan into compliance with the above mentioned Sections and Rule. The Plan is required to state the management position(s) responsible for overseeing the CAP.**

**In addition, the Plan is required to submit new policies and procedures, approved by its board of directors ensuring that Plan assets are not used in any manner inconsistent with their Knox-Keene license.**

**The Plan is required to state the date these policies and procedures were implemented, the management position responsible for overseeing the implementation of these procedures and a description of the monitoring system implemented to ensure ongoing compliance.**

## **PLAN RESPONSE**

*Scripps Health Plan Services, Inc. (“Plan”) entered into an agreement with PacifiCare Health Systems (“PacifiCare”) effective 4/1/09, to pay professional specialist claims on behalf of PacifiCare, for members assigned to Scripps Coastal Medical Center. These claims are paid by the Plan, using Plan assets. Claims are then billed to PacifiCare, and PacifiCare reimburses the Plan for the cost of these claims. PacifiCare initially provided the Plan a \$400,000 deposit to cover the cash outlay for the claims while processes were being developed to bill and recover the claims from PacifiCare.*

*This new process for the Plan and PacifiCare has provided some initial difficulties in the billing and collection process that are being worked through on an ongoing basis between the two parties. As a result of these issues, the balance owed to the Plan has grown each month. In response to this both the Plan and PacifiCare have been developing new processes to ensure the claims are billed and reimbursed timely, and the cash reserves for paying these claims will not remain in a deficit.*

*The Plan has formally requested that PacifiCare increase the deposit on hand to cover these claims. The Plan and PacifiCare have been working closely to determine the amount needed to ensure the Plan is compliant and does not continue to be in a deficit.*

*In addition to increasing the deposit balance, the Plan and PacifiCare have been working together to improve the process for reconciling payments made by PacifiCare to the Plan. PacifiCare will be changing the process for reimbursing the Plan within the next*

*30 days. Currently the payments intended to reimburse the Plan are co-mingled with other payments to the Scripps System. This has caused delays in being able to reconcile the payments to what the Plan has billed to PacifiCare. Going forward the payments to the Plan will be sent separately from other Scripps payments, allowing the Plan to reconcile payments sooner. The Plan has already made improvements in the time required to reconcile the payments. The Plan anticipates the time to reconcile payments will improve further once PacifiCare begins separating the Plan's payments from other Scripps payments.*

*The Plan will need additional time to fully correct the deficiency. The Plan anticipates it will be in full compliance by April 30, 2010. The Plan will provide monthly updates to the Department on its progress. These updates will occur on the 30<sup>th</sup> of each month. The first update will occur December 30, 2009 unless otherwise requested by the Department. The Plan has written a policy and procedure as requested by the Department. Once the finalized policy and procedure is approved by the SHPS Board it will be filed with the Department. The Plan will also provide updates on the receipt of the increased deposit, and will verify that the Plan's payments from PacifiCare are now separated from other Scripps payments. The Plan's Director of Finance is the management personnel responsible for oversight and ongoing compliance with this corrective action.*

**The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.**

#### **SECTION V. NON-ROUTINE EXAMINATION**

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

**No Response required for this section.**