



Edmund G. Brown Jr., Governor  
State of California  
Health and Human Services Agency

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October 22, 2013

via USPS Delivery and eFile

Marc Reynolds, Chairperson of the Board  
SCRIPPS HEALTH PLAN SERVICES, INC.  
10170 Sorrento Valley Road SV4  
San Diego, CA 92121

**FINAL REPORT OF ROUTINE EXAMINATION OF SCRIPPS HEALTH PLAN SERVICES, INC.**

Dear Mr. Reynolds:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Scripps Health Plan Services, Inc. (the “Plan”), conducted by the Department of Managed Health Care (the “Department”), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on July 25, 2013. The Department accepted the Plan’s electronically filed response on September 11, 2013.

This Final Report includes a description of the compliance efforts included in the Plan’s September 11, 2013 response, in accordance with Section 1382(c).

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

Please indicate within ten (10) days from the date of the Plan’s receipt of this letter 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 excluding information held confidential pursuant to Section 1382(c).

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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, as codified in the 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 September 11, 2013 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 Corrective Action Plan system ("CAP system") within the Online Forms Section of 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 "Online Forms".
- From the Existing Online Forms menu click on the "Details" for the DFO Corrective Action Plan L13-R-377
- Go to the "Messages" tab
  - Select "Addendum to Final Report" (note this option will only be available for 10 days after the Final Report has been issued)
  - Select the deficiency(ies) that are applicable
  - Create a message for the Department
  - Attach and Upload all documents with the name "Addendum to Final Report"
  - Click "Send Message"

As noted in the attached Final Report, the Plan's response of September 11, 2013 did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on July 25, 2013. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please file the Plan's response electronically via the CAP system within the Online Forms Section of 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 "Online Forms".

- From the Existing Online Forms menu click on the “Details” for the DFO Corrective Action Plan L13-R-377
- Go to the “Data Requests” tab
  - Click on the “Details” for each data request that does not have a status of “Complete”
  - Follow the Instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement refile)

The Department will also send the Plan an e-mail(s) requesting those items that are still outstanding. The e-mail(s) will contain a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission of the above responses should be directed to Ted Zimmerman at (916) 255-2429 or email at [tzimmerman@dmhc.ca.gov](mailto:tzimmerman@dmhc.ca.gov). You may also email inquiries to [wps@dmhc.ca.gov](mailto:wps@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 [View Department Issued Final Examination Reports](#).**

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

Sincerely,

**ORIGINAL SIGNED BY**

JOAN LARSEN  
Supervising Examiner  
Office of Financial Review  
Division of Financial Oversight

Cc: Linda Pantovic, LVN, Manager Managed Care Compliance, Scripps Health Plan  
Suzanne Goodwin-Stenberg, Chief, Division of Financial Oversight  
Bill Chang, Supervising Examiner, Division of Financial Oversight  
Thomas Roedl, Examiner, Division of Financial Oversight  
Jasdeep Atwal, Monitoring Examiner, Division of Financial Oversight  
Linda Azzolina, Attorney III, Division of Licensing, Office of Health Plan Oversight  
Laura Dooley-Biele, Chief, Division of Plan Surveys

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

**DIVISION OF FINANCIAL OVERSIGHT**

**SCRIPPS HEALTH PLAN SERVICES, INC.**

**FILE NO. 933-0377**

**DATE OF FINAL REPORT: OCTOBER 22, 2013**



**SUPERVISING EXAMINER: JOAN LARSEN**

**EXAMINER-IN-CHARGE: THOMAS ROEDL**

**FINANCIAL EXAMINERS: JULIANA ASABOR,  
FRANCISCO GARCIA, MARIA MARQUEZ, AND JOHN YIN**

**BACKGROUND INFORMATION FOR  
SCRIPPS HEALTH PLAN SERVICES, INC.**

Date Plan Licensed:	April 7, 1999
Organizational Structure:	Scripps Health Plan Services, Inc. (“Plan”) is a for profit, 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 supported by administrative service agreements.
Type of Plan:	<p>The Plan is a limited licensed full-service health care service plan that contracts with the following licensed health care service plans to provide physician and hospital services to their commercial and Medicare enrollees:</p> <p>SCAN Health Net of California, Inc. United Healthcare of California/Secure Horizons</p> <p>The Plan also offers administrative service only services for claims processing to various other health plans and Risk Based Organizations.</p>
Provider Network:	The Plan contracts with certain healthcare providers for the provision of health care services through its contracted provider network and integrated healthcare system. Providers are paid on capitated, per diem, or structured fee-for-service basis.
Plan Enrollment:	Total enrollment of 27,395 as of December 31, 2012.
Service Area:	The Plan’s service area includes all of San Diego County
Date of last Final Routine Examination Report:	January 21, 2010

**FINAL REPORT OF A ROUTINE EXAMINATION OF  
SCRIPPS HEALTH PLAN SERVICES, INC.**

This is the Final Report of a routine examination of the fiscal and administrative affairs of Scripps Health Plan Services, Inc. (the “Plan”), conducted by the Department of Managed Health Care (the “DMHC” or “Department”) pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on July 25, 2013. The Department accepted the Plan’s electronically filed response on September 11, 2013.

This Final Report includes a description of the compliance efforts included in the Plan’s September 11, 2013 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 December 31, 2012, 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 Report
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Internal Control

***Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report.***

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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, as codified in the 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**

Our examination did not result in any adjustments or reclassifications to the Plan’s quarterly financial report for the quarter ended December 31, 2012 as filed with the Department. A copy of the Plan’s financial statements can be viewed at the Department’s website by typing the link <http://wps0.dmhc.ca.gov/fe/search> and selecting Scripps Health Plan Services, Inc. from the first drop down menu.

**No response required to this Section.**

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

Section 1376 states that each plan shall have and maintain TNE equal to an amount that is calculated based upon requirements set forth in Rule 1300.76. Rule 1300.76(e) states that the required amount of TNE must be maintained at all times. Rule 1300.76(a) also sets forth the method for determining the required amount of TNE that shall be maintained at all times.

Net Worth as reported by the Plan as of Quarter Ended December 31, 2012	\$8,128,520
Less: Unsecured Affiliate Receivable	<u>(4,300,000)</u>
Net Worth as of the Quarter Ended December 31, 2012	<u>\$3,828,520</u>
Required TNE	<u>6,720,370</u>
TNE Deficiency per Examination	<u>(\$2,891,850)</u>

The Plan was not in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of December 31, 2012.

The Plan reported a \$4.3 million prepayment of claims to its parent company as a “contra account” within the claims IBNR liability of their general ledger and as referenced in a footnote of the CPA’s annual audit reports. The Plan reported this amount separately as a “debit balance” for Claims Prepayment on line 11 as an Aggregate Write-In for Current Liabilities on the Balance Sheet of the DMHC Reporting Form.

Based on discussions with Plan officers and a review of documents, the Department’s position was that this \$4.3 million “contra account” represented an advance paid several years ago for outstanding claim liabilities owed by the Plan to its parent company, which was in effect an “Unsecured Affiliate Receivable” that was past due and was required to be deducted from the Plan’s calculation of TNE pursuant to Rule 1300.76(e).

**This violation was referred to the Office of Enforcement for appropriate administrative action.**

CORRECTIVE ACTION TAKEN DURING THE EXAMINATION: On June 3, 2013, the Plan disagreed with the Department's position but took immediate action to correct this TNE deficiency and had the \$4.3 million transferred from the parent company to the Plan. On June 5, 2013, the Plan submitted evidence to the Department to confirm receipt of these funds on June 4, 2013.

The Plan was required to state the procedures implemented to ensure that the required amount of TNE will be maintained at all times as required by Rule 1300.76. In addition, the Plan was required to state the date the procedures were implemented and the management position(s) responsible for ensuring continued compliance with the above Section and Rule.

*The Plan responded that it is not in agreement with the DMHC that it had a TNE deficiency. The Plan stated that the \$4.3 million prepayment to the parent organization in question was audited previously by the DMHC and external audit firms. The external audit firms of KPMG and Ernst & Young concluded that the prepayment is a contra liability, and not a receivable; and it was instructed that this disclosure followed Generally Accepted Accounting Principles ("GAAP"). The Plan reports both a receivable and a liability that inflates both the Assets and Liabilities of the organization. The Plan stated that it does have a right of offset agreement with the parent corporation.*

*The Plan asserts that this prepayment was previously reviewed by the DMHC during the audits conducted in 2003, 2006 and 2009. During the 2009 audit, the Plan states the DMHC requested, and it complied with the request that the prepayment not be deducted from the claims incurred but not reported ("IBNR") liability balance, but be shown as a "Write In" to the current liabilities.*

*The Plan responded that while it believes this prepayment is not a receivable, and that it properly recorded this prepayment as a contra liability per GAAP, it also recognized that this transaction was not standard in the industry. As a result, the Plan and its parent corporation agreed to the return of the prepayment. However, the Plan avers that it does not believe this prepayment should be counted against the TNE retro-actively, and that there was never a deficit due to the prepayment.*

**The Department acknowledges the Plan's disagreement with the finding of a TNE deficiency.**

**The Department finds the Plan's compliance efforts are responsive to the deficiency cited, but are not fully responsive to the corrective action required. The Plan did not state the procedures implemented to ensure that the required amount of TNE will be maintained at all times as required by Rule 1300.76. In addition, the Plan did not identify the management position(s) responsible for ensuring continued compliance with the above Section and Rule. The Plan is again required to do so in response to this report.**

### SECTION III. COMPLIANCE ISSUES

#### **A. FINANCIAL STATEMENT PRESENTATION**

Rules 1300.84.06 and 1300.84.2 set forth the requirements for the filing of quarterly financial statements with the Department. The rules state that the quarterly financial statements (which need not be certified) are to be prepared in accordance with generally accepted accounting principles ("GAAP") and on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c). This rule also refers to Rule 1300.84.06(b) that sets forth the requirements for the supplemental information that is to accompany the DMHC Reporting Format.

Our examination disclosed the following concerns with the DMHC Reporting Form and Supplemental Information filed for the quarter ending December 31, 2012 and the Annual Audited report for December 31, 2012:

1. The claim payable liability reported on Line 3, on Report #1: Part B: Liabilities and Net Worth is \$9.8 million. The claims payable amount calculated by the Department is \$6 million. The Plan overstated the claim payable balance for actual claims received but not yet paid on the DMHC Reporting Form. The Department noted that the total reserves for Claims Payable and Incurred But Not Reported Claims were adequately accrued for the quarter ended December 31, 2012.
2. The 2012 annual audited report incorrectly stated in footnote 5 that a prepayment for claims of \$4.3 million was received from the Plan's parent company. The amount was actually paid to the parent by the Plan.

The Plan was required to state the corrective action taken to ensure that the DMHC Reporting Format is properly completed on all future financial statement filing beginning with the quarterly report for June 30, 2013. The Plan was also required to state the corrective action taken to ensure that the 2012 annual report is factually correct. In addition, the Plan was required to state the date of implementation and the management position(s) responsible for ensuring continued compliance.

*The Plan responded to the above deficiencies as follows:*

1. *The Plan responded that the total claims payable amount is based on an evaluation of the number of claims logged into the system prior to the end of each month, but there are no dollars values assigned to these logged claims until they are adjudicated, prior to being paid. The Plan indicates that the payable amount for claims received is based on a combination of the total projected claims expense for the month, IBNR and a historical percentage of claims received prior to the end of each reporting period. The Plan also stated that it retrospectively reviews claims periods that are essentially complete, and calculates what percentage of claims were received prior to the end of each month, when compared to the IBNR balance. The Total Claims Payable (Reported) amount on the December 31, 2012 quarterly statement was estimated by looking back at the months of October 2011 to June 2012 and*

*calculating the dollar amount of claims paid after each month that were on hand at month end (based on received date). A weighted average of claims on hand and later paid, compared to total claims payable was calculated by the Plan for this 9 month period and applied to calculate the total claims payable on December 31, 2012. The Plan also provided in its response a retrospective review of the previous 17 months (October 2011 to February 201) and found that December 31, 2012 was the lowest percentage of claims received during that time.*

*The Plan agreed with the DMHC's findings that the December 2012 Total Claims Payable amount was overstated in its financial statements. The Plan stated it will continue to monitor the account, and continue to adjust its calculation of Total Claims Payable based on historical trends. The Plan believes the process used to estimate the amount is correct, although significant changes in claims submission rates cannot be identified in current reporting periods. The Plan stated it will review current claim payments closer to the DMHC financial reporting deadlines in an attempt to identify any anomalies (such as that noted for December 2012) in claim submission rates in order to adjust the payable amount.*

- 2. The Plan responded that Footnote 5 states the following: The Company has received a prepayment from SH of \$4,300,000 at September 30, 2012 and 2011, which reduced the above liability for medical claims payable." While the Plan is in agreement that the phrase "received a prepayment from" should be replaced with "made a prepayment to", the remainder of the sentence is correct in stating that the \$4,300,000 does reduce the liability for medical claims payable. The Plan further stated that it consulted with its independent auditor and will jointly ensure this footnote is corrected in the September 30, 2013 comparative financial statements.*

**The Department finds the Plan's compliance efforts are responsive to the deficiencies cited, but are not fully responsive to the corrective actions required. The Plan did not state the management position(s) responsible for ensuring continued compliance. The Plan is again required to do so in response to this report.**

## **B. AMENDMENTS – CHANGES IN KEY PERSONNEL**

Section 1352(c) requires all health care service plans to file an amendment with the director within five (5) days after any changes in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the plan. Rule 1300.52.4 sets forth standards for amendment filings.

The Department's examination disclosed that the Plan failed to comply with the filing requirements of the above Section and Rules, as follows:

- A Director of the Plan was appointed on June 7, 2012. The required filing was not completed until March 21, 2013, 282 days late.

- A Director of the Plan resigned on November 29, 2012. The required filing was not made until March 21, 2013, 107 days late.
- A Director of the Plan was appointed on December 6, 2012. The required filing was not completed until March 21, 2013, 100 days late.

The Plan was required to state the policies and procedures implemented to ensure that changes in key personnel are filed with the Department in the required timeframe, the date of implementation, and the management position(s) responsible for ensuring continued compliance with the Section and Rules stated above.

*The Plan responded that it created "Policy 1500, Change in Key Personnel" on July 15, 2013 that outlines the Plan's internal process for filing changes in key personnel with the DMHC within five (5) days to comply with Rule 1300.52.4. The Plan identified the Manager of Care Compliance as the management position responsible for ensuring continued compliance.*

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

#### **SECTION IV. INTERNAL CONTROL**

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

Statement on Auditing Standards ("SAS") No. 109 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 No. 115 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.

Rule 1300.67.3(a)(3) requires a licensed health care service plan to have written procedures for the conduct of the business of the plan so as to provide effective controls.

The Department's examination disclosed the following weaknesses in internal controls:

## A. CLAIM PAYMENT ACCURACY

The Department reviewed claims for payment accuracy.

The Department selected a statistically valid sample of 267 claims from all claims paid between October 1, 2012 and December 31, 2012. The Department reviewed these claims for payment accuracy and determined that in eleven (11) claims in the sample, the Plan incorrectly applied a member copayment to the provider payment after the member had already reached the annual maximum out-of-pocket limit.

The resulting underpayments of claims were an indication that the Plan needs to strengthen the internal controls in place to ensure that copayments are not deducted once the enrollee reaches the annual maximum for out-of-pocket costs.

The Department's examination found the following claims for which the Plan incorrectly deducted a copayment from the provider payment:

<i>Strata No.</i>	<i>Claim Sample No.</i>
1	26
3	34
3	58
3	74
4	17
4	34
4	35
4	70
4	81
5	9
5	23

The Plan was required to state the corrective action taken and the policies and procedures implemented to ensure that copayments are not deducted once an enrollee has reached their annual out-of-pocket maximum. The Plan was also to state the date the policies were implemented and the management position(s) responsible to ensure continued compliance.

*The Plan described enhancements to its claims payment system that were designed to allow easier viewing and tracking of updated information on members' out-of-pocket maximum and benefit usage and prevent additional co-pays or deductibles being applied during claim adjudication. The Plan stated the upgrade occurred in October 2012. The Plan included in its response "Policy 346, Out of Pocket Maximum" that was implemented on July 29, 2013 and sets forth these changes.*

*The Plan also represented that it will be implementing an auditing process, on a semi-annual basis, that entails a random selection of members and extracting each transaction that should be counted toward the members benefit limit and compare it to the benefit limits in the system accumulator to ensure accuracy.*

**The Department finds the Plan's compliance efforts are responsive to the deficiency cited, but not fully responsive to the corrective actions required. The Plan did not state the management position(s) responsible for ensuring continued compliance. The Plan is again required to do so in response to this report.**

## **B. UNCLAIMED FUNDS**

Section 1500 et seq. of the California Code of Civil Procedure, Title 10, Chapter 7 for Unclaimed Property Law sets forth the requirements for submitting unclaimed funds to the Controller of the State of California. Funds unclaimed for three years or more, such as uncashed checks, should be escheated to the Controller's Office of the State of California.

The Department's examination included a review of the Plan's escheatment practices. Based on discussions with Plan officers and a review of documents and records provided by the Plan during the examination, we determined that the Plan failed to escheat unclaimed funds as required by the Code of Civil Procedure.

In addition, the Department determined that the Plan did not have written policies and procedures for unclaimed funds.

The Plan was required to provide a detailed description of the policies and procedures implemented to routinely review and escheat all unclaimed funds on no less than an annual basis. The Plan was also required to submit the date these policies were implemented and the management position(s) responsible to ensure monitoring for continued compliance.

*The Plan responded that it adopted its parent company's policy "SHAS-FIN-LD-6017: Unclaimed Property Due Diligence and Reporting", effective August 16, 2013. The Plan's Director of Finance and the Senior Director of Accounting at the parent company were identified as jointly responsible for continued compliance with this policy.*

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