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IN REPLY REFER TO
FILE NO: 933 0377

December 3, 2003

FINAL REPORT

Marc A. Reynolds, President
Scripps Clinic Health Plan Services, Inc.
10170 Sorrento Valley Road, SV4
San Diego, CA 92121

RE: ROUTINE EXAMINATION OF SCRIPPS CLINIC HEALTH PLAN SERVICES, INC.

Dear Mr. Reynolds:

Enclosed is the Final Report of the routine examination of the fiscal and administrative affairs of Scripps Clinic Health Plan Services, Inc. (the "Plan"), conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382 (b) of the Knox-Keene Health Care Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on September 29, 2003. The Department received the Plan's response on November 14, 2003.

This Final Report includes a description of the compliance efforts included in the Plan's November 12, 2003 response, in accordance with Section 1382 (c).

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

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and provide copies (hardcopy and electronically) 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.

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

Marc A. Reynolds
RE: Final Report for Routine Examination of Scripps Clinic Health Plan Services Inc.

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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 November 14, 2003 response, please provide the documentation (hardcopy and electronically) no later than ten (10) days from the date of the Plan's receipt of this letter.

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

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

Sincerely,

Richard Martin
Supervising Examiner
Office of Plan Oversight
Division of Financial Oversight

cc: Elaine Everett, Director, Managed Care Operations, SCHPS
Kirsten L. Patalano, Compliance Officer, SCHPS
Steve A. Bell, Director, Finance, SCHPS
Mark E. Wright, Chief, Division of Financial Oversight
Kristin A. Smith, Counsel
Maryam Tahriri, Examiner
Gil Riojas, Examiner

DEPARTMENT OF MANAGED HEALTH CARE
REPORT OF ROUTINE EXAMINATION
SCRIPPS CLINIC HEALTH PLAN SERVICES, INC.

FILE NO.: 933 0377

DATE OF FINAL REPORT: DECEMBER 3, 2003

SUPERVISING EXAMINER: RICHARD MARTIN

EXAMINER-IN-CHARGE: GIL RIOJAS

SCRIPPS CLINIC HEALTH PLAN SERVICES, INC.
BACKGROUND INFORMATION

Date Plan Licensed: April 7, 1999

Organizational Structure: Scripps Clinic Health Plan Services, Inc. (SCHPS) a Delaware corporation incorporated in October 1997, is a wholly owned subsidiary of SC Physicians Organization, Inc. SC Physicians Organization is a wholly owned subsidiary of Scripps Health (Parent) and is owned 100% by Scripps Health. SCHPS received its limited Knox-Keene license on April 7, 1999 to operate as a health care service plan in the state of California.

Type of Plan: Full Service.

Provider Network: The Plan has contracted with other licensed health care service providers that provide health care services to plan enrollees or covered lives.

Plan Enrollment: A total of 70,598 enrollees were reported for the month ended October 31, 2003. Commercial enrollment totaled 54,832 and Medicare enrollment totaled 15,766.

Service Area: San Diego county.

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

This is the Final Report of a routine examination of the fiscal and administrative affairs of Scripps Clinic Health Plan Services, Inc. (the “Plan”), conducted by the Department of Managed Health Care (the “Department”) pursuant to Section 1382 (b) of the Knox-Keene Health Care Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on September 29, 2003. The Department received the Plan’s response on November 14, 2003.

This Final Report includes a description of the compliance efforts included in the Plan’s September 29, 2003 response to the Preliminary Report, in accordance with Section 1382 (c).

We performed a limited examination of the financial report filed with the Department for the quarter ended March 31, 2003, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

Our findings are presented in the accompanying attachment as follows:

Section I.	Financial Report
Section II.	Tangible Net Equity
Section III.	Compliance Issues

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

SECTION I. FINANCIAL REPORT

At March 31, 2003, the Plan was in compliance with Financial Reporting requirements of Section 1384, 1345(s) and Rule 1300.45(q). Our routine examination resulted in no material adjustments or reclassifications to the financial report filed with the Department. No response to this section is required from the Plan.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

At March 31, 2003 the Plan was in compliance with the TNE requirements of Rule 1300.76. No response to this section is required from the Plan. A copy of the Plan's financial statements can be obtained at the Department's website by typing the link <http://wpso.dmhc.ca.gov/fe/search.asp> and selecting Scripps Clinic Health Plan Service, Inc. on the first drop down menu. No response was required to this Section.

Section III. COMPLIANCE ISSUES

A. CLAIMS REIMBURSEMENT

Section 1371 requires a full service plan to reimburse claims within forty-five (45) working days after receipt of the claim, unless the claim is contested or denied by the plan. Section 1371 also requires if the claim is contested by the plan, the claimant shall be notified, in writing, that the claim is contested, within 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim. Uncontested claims paid beyond the forty-five (45) working days after receipt of the claim shall accrue interest at a rate of 15 percent per annum beginning with the first calendar day after the 45-working-day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten-dollar (\$10) fee.

Section 1371.35, which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45-working days after receipt, the plan shall pay the greater of fifteen (\$15) dollars or interest at the rate of fifteen percent (15%) per annum, beginning with the first calendar day after the 45-working day period.

As part of our routine examination, we reviewed paid, pending, denied, waiting to be processed and payable claims data from January 1, 2002 to March 31, 2003. Our examination disclosed the Plan failed to pay interest and penalties on certain adjusted claims paid beyond the 45-working day timeframe as required by Section 1371 and 1371.35. These violations are being referred to the Office of Enforcement for applicable administrative penalties.

The Plan was required to pay interest and penalty fees on any past claims processed that were not reimbursed within the statutory requirements of Section 1371 and 1371.35. The Plan was also

required to provide a schedule that lists the claim number, date of service, date of receipt, date of claim payment, provider name, paid amount, check cleared date if available, check number, interest paid, penalties paid, payment date of interest, and interest payment check number.

Furthermore, the Plan was required to describe the procedures implemented that ensure compliance with Section 1371 at all times.

The Plan's response stated they will pay interest on adjusted commercial claims as identified in the audit. The Plan identified 19,568 claims lines that need to be researched to determine if interest is due. The Plan is in the process of researching these claim lines and will generate a report verifying all interest payments by December 31, 2003.

The Plan also stated the Claims Manager will be responsible for ongoing oversight of the process to ensure compliance at all times. Other steps taken to ensure compliance include updating the Plan's Claims Payment Adjustments policy, to reflect situations in which interest is due on adjusted claims and educating claims staff on paying interest on adjusted claims starting July 31, 2003. The Plan will also include adjusted claims in their Pre-Check run audit and the Plan's Compliance Officer and Claims Manager will meet monthly to ensure compliance with Section 1371. The Plan included a copy of its updated policy.

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

B. PROCEDURES FOR MONITORING CAPITATED PROVIDERS

Section 1375.1(a) requires every plan to demonstrate it has a fiscally sound operation and adequate provisions against the risk of insolvency. Rule 1300.75.1 requires every plan demonstrate fiscal soundness and assumption of full financial risk through its history of operations, projections, maintenance of positive cash flow and adequate working capital. 1375.1(b) states in part, that in determining whether the conditions of this section have been met, the commissioner shall consider the financial soundness of the plan's arrangements for health care services.

Our routine examination disclosed the Plan does not have written procedures in place to monitor the financial viability of all capitated providers.

The Plan was required to implement procedures to ensure compliance with Section 1375.1 (a)(b) and Rule 1300.75.1. The Plan was also required to state the management position responsible for the implementation of these procedures.

The Plan response stated they updated its Financial Audits of Sub-Capitated Providers policy and will now conduct on-site audits of its sub-capitated providers, initially upon contracting and annually thereafter. The Plan's Director of Finance will be responsible for ensuring all audits of sub-capitated providers are scheduled and conducted. The Plan's Compliance Officer and Director of Finance will meet after each audit to discuss the results and potential corrective action plans to implement, if necessary. The Plan included a copy of its updated policy.

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

C. CONTRACTS

Section 1379(a) requires every contract between a plan and a provider of health care services be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan.

Our routine examination disclosed the Plan utilizes contracts between Scripps Health (the Plan's Parent) and providers to price and pay claims that are the Plan's liability. The Plan considers these to be contracted providers within the Plans network even though the contracts are in the name of the Parent.

The Plan was required to electronically file, with the Department, Scripps Health's provider contracts that the Plan uses to pay claims. The Plan was also required to provide documentation that it is a party to the provider contracts referenced above. In addition, the Plan was required to provide evidence that the contracts are in compliance with Section 1379 and the enrollee is not at risk for services. The Plan was also to provide evidence that the contracts are in compliance with sections of the act and regulations identified in Rule 1300.51(c)(K)(2).

In response, the Plan electronically filed three Scripps Health contracts utilized for determination of amounts payable for services provided to enrollees. The Plan indicated they have contacted two of the providers and have begun negotiations to finalize direct contracts between the Plan and provider. The Plan has already negotiated and finalized a direct contract with the third provider and included this contract in their response to the Department's preliminary report.

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

D. RIGHT OF OFFSET AGREEMENTS

FASB Interpretation No. 39, defines a "right of setoff" as a debtor's legal right, by contract or otherwise, to discharge all or portion of the debt owed to another party by applying against the debt an amount that the other party owes to the debtor. APB Opinion No. 10, paragraph 7, states that as a general principle of accounting, the offsetting of assets and liabilities in the balance sheet is improper except where a right of offset exists. While FIN 39 does not require a written right of offset, it does require that this right of offset be enforceable at law. The Department requires a plan to execute a written right of offset to clarify and affirm the intentions of the parties.

Our routine examination disclosed receivables and payables were being offset in intercompany accounts and the Plan could not document that a right of offset exists.

RE: Preliminary Report for Routine Examination of Scripps Clinic Health Plan Services Inc.

The Plan was required to provide assurance that separate General Ledger accounts for affiliate receivables and payables would be maintained, and that these accounts would be reported separately unless a right of offset was executed and electronically filed with the Department.

In response, the Plan filed an updated Administrative Services Agreement between the Plan and Scripps Health (Parent), which added language stating “Scripps Health and Scripps Clinic Health Plan Services, Inc. agree that amounts owed by either party may be directly set off by any amounts owed by the other party.” The Plan included a copy of its filing with its response.

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