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

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July 10, 2006

via UPS Delivery and electronic mail

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

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

Dear Mr. Reynolds:

Enclosed 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(a) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on April 20, 2006. The Department accepted the Plan's electronically filed responses on June 12, 2006 and June 30, 2006.

This Final Report includes a description of the compliance efforts included in the Plan's responses, 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.

[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.

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 June 12, and June 30, 2006 responses, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the Department's eFiling web portal <https://wpso.dmhc.ca.gov/secure/login/>. From the drop-down menu, select "Report/Other: Addendum Response to Final Routine Financial Examination Report-Public (RX005)", and then upload your response. Questions or problems related to the electronic transmission of the response should be directed to Siniva Pedro at (916) 322-5393 or email at spedro@dmhc.ca.gov. You may also email inquiries to wpso@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

The Executive Summary to the Department's most recent Medical Survey Report is located at the Department's web site at www.dmhc.ca.gov.

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

Sincerely,

JOAN LARSEN
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

cc: Kirsten Patalano, Compliance Manager, Scripps Clinic Health Plan Services, Inc.
Mark Wright, Chief, Division of Financial Oversight, DMHC
K. Kim Malme, Senior Examiner, Division of Financial Oversight, DMHC
Steven Mihara, Examiner, Division of Financial Oversight, DMHC
Marcy Gallagher, Chief, Division of Plan Surveys, DMHC
Jennifer Willis, Counsel, Division of Licensing, DMHC

STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

SCRIPPS CLINIC HEALTH PLAN SERVICES, INC.

FILE NO. 933-0377

DATE OF FINAL REPORT: JULY 10, 2006

SUPERVISING EXAMINER: JOAN LARSEN

EXAMINER-IN-CHARGE: K. Kim Malme

FINANCIAL EXAMINERS:

Galal Gado

Maryam Tahriri

BACKGROUND INFORMATION FOR SCRIPPS CLINIC HEALTH PLAN SERVICES, INC.

Date Plan Licensed:	April 7, 1999
Organizational Structure:	Scripps Clinic Health Plan Services, Inc. ("Plan") is a for-profit, limited licensed health care service plan and is a wholly owned subsidiary of SC Physicians Organization, Inc. ("Parent"). 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:	The Plan contracts with the following licensed health care service plans to provide physician and hospital services to their commercial and Medicare enrollees: Aetna Health of California, Inc. Blue Shield of California CIGNA HealthCare of California Health Net of California, Inc. PacifiCare of California
Provider Network:	The Plan pays monthly capitation fees to SH for the provision of health care services through its contracted provider network. SH reimburses its network hospitals and physicians on capitated, per diem, or discounted fee-for-services basis.
Plan Enrollment:	38,523 at quarter ended December 31, 2005, which includes 14,612 Medicare enrollees.
Service Area:	San Diego County.
Date of Last Public Routine Financial Examination Report:	December 3, 2003

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(a) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on April 20, 2006. The Department accepted the Plan's electronically filed response on June 12, 2006.

This Final Report includes a description of the compliance efforts included in the Plan's June 12, 2006 response to the Preliminary Report, in accordance with Section 1382(c).

We examined the financial report filed with the Department for the quarter December 31, 2005, 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 Equity
Section III. Compliance Issues
Section IV. Internal Control

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

[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

Our examination resulted in no adjustments or reclassifications to the Plan's December 31, 2005 quarterly financial report filed with the Department. A copy of this financial report can be viewed at the Department's website by typing the link http://wpso.dmhc.ca.gov/fe/search.asp and selecting Scripps Clinic Health Plan Services, Inc. on the first drop down menu.

No response required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Tangible Net Equity as of December 31, 2005	$ 3,807,350
Required TNE as of December 31, 2005	$ 2,561,512
Excess TNE as of December 31, 2005	$ 1,245,838

As of December 31, 2005, the Plan was in compliance with the TNE requirements of Section 1376 and Rule 1300.76.

No response required to this Section.

SECTION III. COMPLIANCE ISSUE

CLAIM FILING DEADLINE

Rule 1300.71(b)(1) requires that a Plan shall not impose a deadline for the receipt of a claim that is less than 90 days for contracted providers after the date of service, except as required by any state or federal law or regulation. If a Plan imposes a Claims Filing Deadline inconsistent with Rule 1300.71(b)(1) in three (3) or more claims over the course of any three-month period, then Rule 1300.71(a)(8)(A) defines this as an "unjust payment pattern".

Rule 1300.71(a) (8) (J) also defines an "unjust payment pattern" to include when a Plan fails to comply with the mandated contractual provisions enumerated…in three (3) or more of its contracts with its capitated providers over the course of any three-month period.

The Department selected a sample of 20 claims from contracted providers that were denied for late submission beyond the contract provision of 90 days after the date of service, during the period November 1, 2005 to January 31, 2006. Our examination noted that the Plan incorrectly denied 14 out of the sample of 20 claims for late submission, because they did not base the submission date on the date the Plan received the claim [Reference to Rule 1300.71(a)(6)].

The Preliminary Report required the Plan to provide a Corrective Action Plan ("CAP") to ensure that the Plan is now in compliance with the requirement of the above Rules. The Plan was also required to provide written policies and procedures regarding compliance. In addition, the Plan's response was to state the date the 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.

The Department issued an email on April 26, 2006 that requested the Plan to review all denied claims received January 1, 2004 through the date corrective action was implemented, for claims with date of service starting January 1, 2004 and identify those claims denied for late submission. The Plan was required to review those claims denied for late submission and determine if they were incorrectly denied due to the Plan not using the date the Plan actually received the claim. If they were incorrectly denied for late submission, then the Plan was to determine and pay the claim to include interest back to the correct date of receipt and a $10 penalty. The Plan was required to provide evidence that interest and penalty, as appropriate, were paid retroactively for all claims denied incorrectly for late submission for the time period identified above. This evidence was to include an electronic data file or spreadsheet (in Excel) that provided certain data fields, as requested in the Preliminary Report.

The Plan responded that it determined the reason for inappropriate denial of some specific claims was due to the claim having multiple dates of service. If the date of service was over the claims filing deadline the Plan's system flagged the analyst who at that time determined adjudication of the claim. In instances where there were multiple dates of service and one of the dates was before the claims filing deadline, the system flagged the claims analyst and the entire claim was denied in error.

The Plan represented that it implemented the following corrective action plan to ensure that compliance is met according to the above stated rules:

- *Policy and Procedure # 308 – Timely Claims Submission was revised to include language regarding claims with multiple dates of service. The Plan provided a signed copy of the policy in its response.*

- *The Claims Department Staff was educated on March 30, 2006 regarding processing claims with multiple dates of service with additional training on April 4 and April 18, 2006 in regards to Policy and Procedure #308.*

In addition to the above actions, the Plan reviewed all claims from January 1, 2004 to March 31, 2006 and identified 28 claims of which 24 were reprocessed and paid a total of $2,337 in interest and penalties. The Plan's response included the required spreadsheet and indicated payments were made on May 23 though May 31, 2006.

The Plan's June 30, 2006 response stated that the Manager, Claims Department and Recoveries, is the individual responsible for ongoing monitoring of the corrective action plan. The Manager, Claims and Recoveries has ensured that all eleven federal holidays are included in the calculation when determining the claims filing deadline and will monitor the claims filing deadline by reviewing monthly reports.

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

SECTION IV. INTERNAL CONTROL

Section 1384, 1345 (s), and Rule 1300.45 (q) include requirements for filing financial statements in accordance with generally accepted accounting principles ("GAAP") 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.

The following reportable conditions were noted in the Department's review of the Claim System:

1. The Plan's overall claim timeliness of 94% for the period November 1, 2005 to January 31, 2006 was not correct and is over 95%. Through our testing of late claims, we noted that 13 out of 30 (or 43%) were not delinquent because additional information was received. We noted that the Plan's claim system does not provide for a data field to record the received date for additional information, which results in the claim system using the original receipt date and the claim is incorrectly reported as delinquent on the claims system.

2. The Plan reverses an overpaid or underpaid claim on the system and then processes it as a new claim for the correct amount. This results in the new "adjusted" claim showing delinquent on the system, because the system uses the "date of receipt" of the original claim.

3. The Plan uses an incorrect "date of receipt" for misdirected claims. The Plan uses the earliest receipt date on a claim that was originally sent to an incorrect party for payment, which results in the claim being considered delinquent on

the claim system. Rule 1300.71(a)(6) states that the "date of receipt" shall be the working day when the claims is first delivered to the correct party responsible for adjudicating the claim.

The Preliminary Report required the Plan to submit a detailed description of the controls and procedures implemented by Plan management to correct the reportable conditions noted above. In addition, the Plan was required to state the date corrective actions were implemented, the management position responsible for ensuring the corrective actions taken, and the controls implemented for ongoing monitoring to assure continued compliance.

The Plan responded that the following corrective actions were taken to correct the above stated deficiencies:

1. *The Plan had an additional field programmed into its claims processing system to capture the date that additional data was received from providers. The Plan provided a sample of the additional field as located on the main claims screen titled UMCN.1. In addition, the Plan revised its Policy and Procedure #322 – Claims Payment Adjustments to reflect the process of populating the new field and implemented this new field on May 30, 2006. A signed copy of the policy was included with the plan's response.*

2. *The Plan added a new field that captures the date additional information was received as further explained in item #1.*

3. *The Claims Department clerks were educated to enter the oldest date of receipt for senior claims only. The Plan revised Policy and Procedure # 335 – Logging Incoming Claims to reflect that for commercial claims the "date of receipt" is the date the claim arrived in the Plan's Claims Department. A signed copy of the policy was included with the Plans' response and indicates an effective date of June 1, 2006.*

The Plan's June 30, 2006 response stated that the Manager, Claims Department and Recoveries, is the individual responsible for ongoing monitoring of the corrective action plan. The Claims Auditors audit processed claims on a weekly basis and any deficiencies are escalated to the Manager, Claims and Recoveries. The new "additional info" field was added to the auditing criteria. The "date of receipt" field is monitored by continual health plan audits where this field is used to provide the necessary data for their audit sample selection. The Manager, Claims and Recoveries, is involved in all health plan audits and develops corrective action plans as necessary.

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