



Edmund G. Brown Jr., Governor  
State of California  
Health and Human Services Agency  
**DEPARTMENT OF MANAGED HEALTH CARE**  
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Los Angeles, CA 90013-2344  
Telephone: 213-576-7541 | Fax: 213-576-7186

September 25, 2017

Via USPS Delivery and eFile

Ms. Leigh Hutchins  
Chairperson and Chief Executive Officer  
**PRIMECARE MEDICAL NETWORK, INC.**  
3990 Concourse Street, 5<sup>th</sup> Floor  
Ontario, CA 91764

**FINAL REPORT OF ROUTINE EXAMINATION OF PRIMECARE MEDICAL NETWORK, INC.**

Dear Ms. Hutchins:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of PrimeCare Medical Network, Inc. (Plan), conducted by the Department of Managed Health Care (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 May 2, 2017. The Department accepted the Plan's electronically filed responses on June 12, 2017 and August 8, 2017 (Responses).

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 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 Responses to the Final 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 Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

If so, please indicate which portions of the Plan's Responses shall be appended, and electronically file copies of those portions of the Plan's Responses excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's Responses to the Preliminary Report or wishes to modify any information provided to the Department in its Responses, 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://wps0.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 L17-R-367.
- 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"
  - Select "Send Message"

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

Questions or problems related to the electronic transmission of the response should be directed to Vijon Morales at 916-255-2447 or by email at [Vijon.Morales@dmhc.ca.gov](mailto:Vijon.Morales@dmhc.ca.gov). You may also email inquiries to [wps0@dmhc.ca.gov](mailto:wps0@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 Financial Examination Reports](#).**

If there are any questions regarding this Report, please contact me at 213-576-7541 or by email at [Maria.Marquez@dmhc.ca.gov](mailto:Maria.Marquez@dmhc.ca.gov)

Sincerely,

Maria Marquez  
Senior Examiner (Supervisor)  
Office of Financial Review  
Division of Financial Oversight

cc: Pritika Dutt, CPA, Deputy Director, Office of Financial Review  
Ned Gennaoui, Supervising Examiner, Division of Financial Oversight  
Neetu Bhangu, Examiner, Division of Financial Oversight  
Justin Goodwin, Attorney, Office of Plan Licensing  
Laura Dooley Beile, Chief, Division of Plan Surveys  
Paula Hood, Staff Services Manager I, Help Center

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

**DIVISION OF FINANCIAL OVERSIGHT**

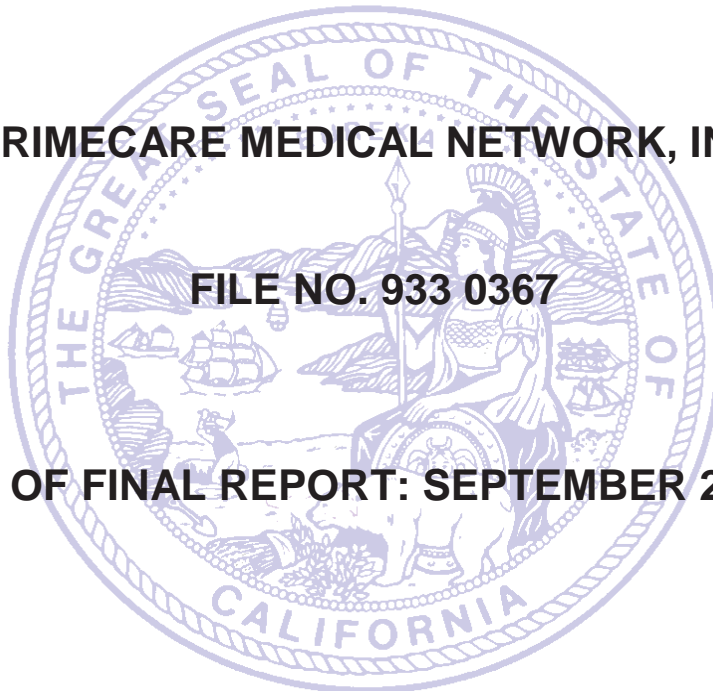
**FINAL REPORT OF ROUTINE EXAMINATION**

**OF**

**PRIMECARE MEDICAL NETWORK, INC.**

**FILE NO. 933 0367**

**DATE OF FINAL REPORT: SEPTEMBER 25, 2017**



**SUPERVISING EXAMINER: NED GENNAOUI**

**EXAMINER-IN-CHARGE: MARIA MARQUEZ**

**FINANCIAL EXAMINERS:**

**JULIANA ASABOR, JOHN ATAMIAN, FRANCISCO  
GARCIA, ZAW OO AND SUHAG PATEL**

## **BACKGROUND INFORMATION FOR PRIMECARE MEDICAL NETWORK, INC.**

Date Plan Licensed:	October 16, 1998.
Organizational Structure:	<p>PrimeCare Medical Network, Inc. (Plan) is a for-profit, wholly owned subsidiary of North American Medical Management Holdings, Inc. (NAMM Holdings). Aveta, Inc. is the parent company of NAMM Holdings. During 2012, Collaborative Care Holdings, LLC, a wholly owned subsidiary of UnitedHealth Group, acquired Aveta, Inc. and certain of its wholly owned subsidiaries, including NAMM Holdings and the Plan.</p> <p>The Plan has an administrative services agreement with North American Medical Management California, Inc., a wholly owned subsidiary of NAMM Holdings, for certain shared administrative and management services.</p>
Type of Plan:	<p>The Plan is a full service health care plan which provides physician and hospital services to enrollees of other plans through contractual arrangements. The Plan is not licensed to enter into plan contracts directly with employer groups or members of the general public.</p>
Provider Network:	<p>The Plan provides medical services through its independent physician association affiliates and contracts with specialists and hospitals. Primary care physicians are compensated on a capitated basis, and specialists and hospitals are reimbursed on a reduced fee-for-service or per diem basis.</p>
Plan Enrollment:	<p>The Plan reported 202,835 enrollees contracted from other plans at September 30, 2016.</p>
Service Area:	<p>The plan operates in the counties of Alameda, Contra Costa, Riverside, San Bernardino, Solano, Stanislaus, and parts of Orange, Los Angeles, and San Diego.</p>
Date of Prior Final Routine Examination Report:	April 17, 2014.

## FINAL REPORT OF A ROUTINE EXAMINATION OF PRIMECARE MEDICAL NETWORK, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of PrimeCare Medical Network, Inc. (Plan), conducted by the Department of Managed Health Care (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 May 2, 2017. The Department accepted the Plan's electronically filed responses on June 12, 2017 and August 8, 2017 (Responses).

This Final Report includes a description of the compliance efforts included in the Plan's Responses to the Preliminary Report, in accordance with Section 1382(c). The Plan's Responses are noted in *italics*.

The Department examined the Plan's financial report filed with the Department for the quarter ended September 30, 2016, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. The Department's 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 Issues

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

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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 Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

**SECTION I. FINANCIAL REPORT**

**A. BALANCE SHEET AT QUARTER ENDED SEPTEMBER 30, 2016<sup>1</sup>**

ASSETS Account	Bal. per F/S @ 9/30/16	AJE or RJE	Exam Adjustments		Bal. per Exam @ 9/30/16
			Dr.	Cr.	
Cash and Cash Equivalents	\$136,102,416				\$136,102,416
Short-Term Investments	78,693,280				78,693,280
Premiums Receivable – Net					
Interest Receivable	576,600				576,600
Shared Risk Receivables – Net					
Other Health Care Receivables – Net	1,495,990				1,495,990
Prepaid Expenses	152,826				152,826
Secured Affiliate Receivables – Current					
Unsecured Affiliate Receivables – Current	307,776				307,776
Aggregate Write-ins for Current Assets	53,300				53,300
<b>TOTAL CURRENT ASSETS</b>	<b>217,382,188</b>				<b>217,382,188</b>
Restricted Assets	300,000				300,000
Long-Term Investments	120,697				120,697
Intangible Assets & Goodwill – Net					
Secured Affiliate Receivables – Long Term					
Unsecured Affiliate Receivables – Past Due	39,194				39,194
Aggregate Write-ins for Other Assets	225,305				225,305
<b>TOTAL OTHER ASSETS</b>	<b>685,196</b>				<b>685,196</b>
Land, Building and Improvements					
Furniture and Equipment – Net					
Computer Equipment – Net					
Leasehold Improvements – Net					
Construction in Progress					
Software Development Costs					
Aggregate Write-ins for Other Equipment					
<b>TOTAL PROPERTY &amp; EQUIPMENT</b>					
<b>TOTAL ASSETS</b>	<b>\$218,067,384</b>				<b>\$218,067,384</b>

<sup>1</sup> This Financial report is not adjusted for any tax effect resulting from the adjusting journal entry.

**BALANCE SHEET (Continued)**

LIABILITIES AND NET WORTH Account	Bal. per F/S @ 9/30/16	AJE or RJE	Exam Adjustments		Bal. per Exam @ 9/30/16
			Dr.	Cr.	
<b>LIABILITIES</b>					
Trade Accounts Payable	\$38,564				\$38,564
Capitation Payable					
Claims Payable (Reported)	44,467,015				44,467,015
Incurred But Not Reported Claims	56,399,710	AJE 1		\$10,651,814	67,051,524
POS Claims Payable (Reported)					
POS Incurred But Not Reported Claims					
Other Medical Liability					
Unearned Premiums					
Loans & Notes Payable					
Amounts Due to Affiliates – Current	6,303,656				6,303,656
Aggregate Write-ins for Current Liabilities	48,440,194				48,440,194
<b>TOTAL CURRENT LIABILITIES</b>	<b>155,649,139</b>			<b>10,651,814</b>	<b>166,300,953</b>
Loans and Notes Payable (Not Subordinated)					
Loans and Notes Payable (Subordinated)					
Accrued Subordinated Interest Payable					
Amounts Due To Affiliates - Long Term					
Aggregate Write-Ins for Other Liabilities	126,840				126,840
<b>TOTAL OTHER LIABILITIES</b>	<b>126,840</b>				<b>126,840</b>
<b>TOTAL LIABILITIES</b>	<b>155,775,979</b>			<b>10,651,814</b>	<b>166,427,793</b>
<b>NET WORTH</b>					
Common Stock	13,591,732				13,591,732
Preferred Stock					
Paid in Surplus					
Contributed Capital	903,258				903,258
Retained Earnings (Deficit)/Fund Balance	47,164,848				47,164,848
Aggregate Write-ins for Other Net Worth Items	631,567				631,567
<b>EXAMINATION ADJUSTMENTS (from Income Statement)</b>		<b>(A)</b>	<b>10,651,814</b>		<b>(10,651,814)</b>
<b>TOTAL NET WORTH</b>	<b>62,291,405</b>		<b>10,651,814</b>		<b>51,639,591</b>
<b>TOTAL LIABILITIES &amp; NET WORTH</b>	<b>\$218,067,384</b>		<b>\$10,651,814</b>	<b>\$10,651,814</b>	<b>\$218,067,384</b>

**B. STATEMENT OF INCOME AND EXPENSES FOR THE QUARTER ENDED SEPTEMBER 30, 2016**

REVENUE AND EXPENSES Account	Bal. Per F/S @ 9/30/16	AJE or RJE	Exam Adjustments		Bal. per Exam @ 9/30/16
			Dr.	Cr.	
<b>REVENUE</b>					
Premiums (Commercial)					
Capitation	\$227,169,596				\$227,169,596
Co-payments, COB, Subrogation					
Title XVIII – Medicare					
Medicaid, Healthy Families					
Fee-For-Service					
Point-Of-Service (POS)					
Interest	270,805				270,805
Risk Pool Revenue	256,964				256,964
Aggregate Write-Ins for Other Revenues	185,919				185,919
<b>TOTAL REVENUE</b>	<b>227,883,284</b>				<b>227,883,284</b>
<b>EXPENSES</b>					
<b>Medical and Hospital</b>					
Inpatient Services – Capitated	694,361				694,361
Inpatient Services – Per Diem/Managed Hospital	88,890,439	AJE 1	\$10,651,814		99,542,253
Inpatient Services – Fee-For-Service/Case Rate					
Primary Professional Services – Capitated	62,722,968				62,722,968
Primary Professional Services – Non-Capitated	36,042,976				36,042,976
Other Medical Professional Services – Capitated					
Other Medical Professional Services – Non-Capitated					
Non-Contracted Emergency Room and Out-of-Area Expense, not including POS					
POS Out-Of-Network Expense					
Pharmacy Expense – Capitated					
Pharmacy Expense – Fee-for-Service					
Aggregate Write-Ins for Other Medical and Hospital Expenses	514,694				514,694
<b>TOTAL MEDICAL &amp; HOSPITAL EXPENSES</b>	<b>188,865,438</b>		<b>10,651,814</b>		<b>199,517,252</b>
<b>Administration</b>					
Compensation	3,496,658				3,496,658
Interest Expense					
Occupancy, Depreciation and Amortization					
Management fees	2,632				2,632
Marketing	25,655				25,655
Affiliate Administration Services	19,771,049				19,771,049
Aggregate Write-Ins for Other Administration	722,642				722,642
<b>TOTAL ADMINISTRATION EXPENSES</b>	<b>24,018,636</b>				<b>24,018,636</b>
<b>TOTAL EXPENSES</b>	<b>212,884,074</b>		<b>10,651,814</b>		<b>223,535,888</b>
<b>INCOME (LOSS)</b>	<b>14,999,210</b>		<b>10,651,814</b>		<b>4,347,396</b>
Provision for Taxes	6,035,368				6,035,368
<b>NET INCOME (LOSS)</b>	<b>\$8,963,842</b>	<b>(A)</b>	<b>\$10,651,814</b>		<b>(\$1,687,972)</b>

**C. EXPLANATION OF EXAMINATION ADJUSTMENTS**

**ADJUSTING JOURNAL ENTRY (AJE)**

AJE No.	ACCOUNT NAME	DR.	CR.
1	Inpatient Services-per Diem/Managed Hospital Expenses Incurred But Not Reported Claims  <i>To increase the claims liability for incurred but not reported claims.</i>	\$ 10,651,814	\$ 10,651,814

The Plan represented to the Department that the required adjusting journal entry was recorded in the Plan's books in the quarter ended December 31, 2016. The Plan added that the DMHC Reporting Form for the quarter ended December 31, 2016, filed with the Department on February 15, 2017, already included the additional claims expense required by the Department. As a result, the Department did not require the Plan to file a revised DMHC Reporting Form for the quarter ended September 30, 2016.

**No response was required to this Section.**

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

Net Worth per examination as of the quarter ended September 30, 2016	\$ 51,639,591
Less: Unsecured Affiliate Receivables – Past Due	<u>39,194</u>
TNE	\$ 51,600,397
Required TNE	<u>24,713,496</u>
TNE Excess per Examination	<u>\$ 26,886,901</u>

The Plan was in compliance with the TNE requirements of Section 1376 and Rule 1300.76 as of September 30, 2016.

**No response was required to this Section.**

### **SECTION III. COMPLIANCE ISSUES**

#### **A. INCURRED BUT NOT REPORTED (IBNR) CLAIMS LIABILITY**

Section 1377(c) requires each plan that reimburses providers of health care services on a fee-for-service basis to estimate and record in the books of account a liability for incurred and unreported claims. Rule 1300.77.2(a) requires that the estimate of incurred and unreported claims be pursuant to a method held unobjectionable by the Director. Such method may include a lag study, an actuarial estimate, or other reasonable method of estimating incurred and unreported claims.

The Department's examination disclosed that the Plan's estimate for total claims liability was understated by \$10,651,814 as of September 30, 2016 (examination date) using paid claims data through November 30, 2016 for September and prior dates of service. As a result, the Department's examination required Adjusting Journal Entry 1, as described in Section 1 of this Report.

The Preliminary Report required the Plan to review its methodology of determining the amount of accrual for total claims liability, to ensure that the estimate for IBNR claims liability is reasonably reported at each reporting period, including at least quarterly hindsight analysis of the previous four reporting quarters.

The Plan was also required to indicate the management position(s) responsible for ensuring an adequate estimate of IBNR claims liability was recorded in the Plan's books.

*The Plan responded that its reserve estimates are performed by an actuary team using complex lag models and other actuarially sound methods and analysis. In order to meet strict reporting deadlines, an LCD-10 (Last Calendar Day minus 10) approach is utilized. LCD-10 is a standard proven practice whereby claims payment data is cut off 10 days prior to the end of the month in order to allow adequate lead time to extract the necessary data, process the claims estimates, perform analysis and record the results. Although the paid data is initially cut off prior to month-end for estimate calculation purposes, the estimate is made for the entire month and not limited to 20 days. Because payments in the first 20 to 30 days are very volatile and statistically not a good indicator, the estimate for the initial full month is based on historical seasonality, trends, membership and other known factors. As such, the LCD-10 approach does not impact the accuracy of the final estimate and is a sound and accepted approach.*

*In addition to the current month estimate, on a monthly basis, the actuary models and analysis are updated with claims paid data to date for all prior months' dates of service and adjustments are recorded to increase or decrease as needed. During the quarter ended December 31, 2016, the Plan's methodology identified the reserve understatement that would also later be identified by the Department, with the benefit of two more months of additional payment data. As is the Plan's standard practice noted above, adjustment to the reserve was recorded when detected, to bring it to the appropriate amount. Additionally, it is important to note that as of September 30, 2016,*

*the Plan was also carrying an additional \$7.2 million in margin reserve to mitigate potential estimate variations.*

*The amount of this understatement was significantly more than the normal differences in estimate historically experienced, and remains an anomaly. The Plan continually works with the actuary team to identify any areas for possible improvement, such as increased analysis of utilization data and other leading indicators. Because the methodology is actuarially based, sound and proven, it identified the reserve estimate difference in a timely manner as designed and resulted in the immediate update to the reserve. In addition, the reserve methodology relies on monthly hindsight analysis. As such, the Plan believes that the current methodology remains trustworthy and appropriate.*

*The Plan represented that the management position responsible for ensuring an adequate estimate of IBNR claims liability is the Chief Financial Officer.*

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

## **B. PENALTY ON LATE CLAIMS**

Section 1371 and Rule 1300.71(i)(2) require a health care service plan to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan, and require that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period.

Rule 1300.71(j) states that the penalty for failure to automatically include interest due on a late claim payment shall be a fee of ten (\$10) dollars paid to the claimant.

The Department's examination disclosed that the Plan failed to pay the penalty of \$10 when the Plan paid additional interest as a result of previous underpayment of interest. This deficiency was noted in late paid claim sample numbers: 1, 16, 39, 50, 54 and 73, which were for non-emergency services.

The Preliminary Report required the Plan to submit a detailed Corrective Action Plan (CAP) to address the deficiency cited above, and to include the following:

- a. Training procedures to ensure that claim processors are properly trained on the penalty requirement of the above Rule.
- b. Audit procedures to ensure that the Plan is monitoring the correct payment of penalty of \$10 with the additional interest payment on late claims.

- c. Identification of all late claim payments for which penalty was not paid with the additional interest payment from July 1, 2013 (the date after the last date of the prior examination) through the date corrective action is implemented by the Plan.
- d. Evidence that penalty was paid retroactively for claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:
  - Claim number
  - Date of service
  - Date original claim received
  - Date new information received (date claim was complete)
  - Total billed
  - Original total paid
  - Original paid date
  - Amount of adjustment paid (with check number)
  - Date adjustment paid/mailed
  - Amount of original interest paid
  - Original interest paid date
  - Number of days used to calculate interest
  - Amount of additional interest paid (with formula)
  - Date additional interest paid
  - Penalty paid
  - Date penalty paid
  - Check number for interest and/or penalty
  - Provider name

The data file was to provide the detail of all claims remediated, including the total number of claims and the total penalty paid as a result of remediation.

- e. Revised policy and procedures implemented to ensure that the additional interest payments on late claims include penalties in compliance with the above Rule.
- f. Date the additional training, audit procedures, and revised policy and procedures were implemented and the management position(s) responsible for ensuring continued compliance.

*The Plan responded by submitting a copy of the Managing Interest Payments policy, which was implemented and distributed to processors on May 26, 2017. An email confirmation from processors was received that they understood it. The Plan conducted team training on interest within the Special Unit on February 7, 2017 and June 5, 2017. The Plan confirmed all desktop computers were loaded with the most current version of the interest calculator application.*

*The Manual and Electronic Processed Claims Auditing policy was reviewed with the Auditing and Management Team. A copy of the policy was provided for review with the Plan's Responses. The daily compliance report is reviewed by the Claims Supervisor and Team Lead. The Interest functionality within the claims system was automated as of the end of June 2017.*

*The Plan identified 36 late claims, which required remediation, for the required remediation period. The Plan completed the remediation on May 25, 2017, and paid \$1.76 and \$360 in additional interest and penalty, respectively. The Plan provided an evidence of remediation with its Responses.*

*The Plan represented that the management position responsible for ensuring continued compliance are the Associate Vice President of Transactional Services and Director of Claims.*

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

### **C. INTEREST ON LATE CLAIMS PAYMENTS**

Section 1371 and Rule 1300.71(i)(2) require a health care service plan to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan, and require that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period.

The Department's examination disclosed that the Plan underpaid the amount of interest on late claims payment due to the following reasons:

- The interest payment was issued before the claim payment by one business day. This deficiency was noted in late paid claim sample numbers: 1, 37, 39, 50 and 67.
- Errors committed by claims processors. This deficiency was noted in late paid claim sample numbers: 17, 29, 58 and 74.

The Preliminary Report required the Plan to submit a detailed CAP to address the deficiency cited above, and to include the following:

- a. Policy and procedures implemented to ensure that interest payments issued prior to claim payment include the correct interest amount up to the date of payment of the late claim in compliance with the above Section and Rule.
- b. Training procedures to ensure that claim processors are properly trained on the interest requirements.

- c. Audit procedures to ensure that the Plan is monitoring the correct payment of interest on late claim payments.
- d. Date the policy, procedures, additional training and audit procedures were implemented and the management position(s) responsible for ensuring continued compliance.

*The Plan responded, as indicated in Section III.B. of this Report, by submitting a copy of the Managing Interest Payments policy, which was implemented on May 26, 2017. The Plan conducted team training on interest on February 7, 2017 and June 5, 2017. The Interest functionality within the claims system was automated as of the end of June 2017.*

*The Plan represented that the management position responsible for ensuring continued compliance are the Associate Vice President of Transactional Services and Director of Claims.*

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

#### **D. FIDELITY BOND**

Rule 1300.76.3 requires each plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. The fidelity bond shall provide for 30 days' notice to the Director prior to cancellation.

The Department's examination disclosed that the Plan's fidelity bond policy provided for review did not provide for 30 days' notice to the Director prior to cancellation.

On January 12, 2017, prior to the issuance of the Preliminary Report, the Plan provided evidence of compliance with the 30 days' notice requirement of Rule 1300.76.3.

The Preliminary Report required the Plan to provide the policy and procedures implemented to ensure compliance with the requirements of Rule 1300.76.3, the date of implementation, and the management position(s) responsible for ensuring continued compliance.

*The Plan responded by submitting the policy and procedures implemented on July 21, 2017 to ensure continued compliance with the Fidelity Bond requirements.*

*The Plan represented that the management position responsible for continued compliance is the Vice President of Legal Affairs.*

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

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

Sections 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. 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 weakness in internal controls:

##### **A. AUTHORIZED SIGNORS FOR BANK ACCOUNTS**

The Department's review of authorized signors on the Plan's bank accounts disclosed that former employees of the Plan were still on the list of authorized signors.

The Preliminary Report required the Plan to provide a written confirmation that the Plan revised its bank signature cards so that only current officers or employees of the Plan have authority over the Plan's bank accounts. The Plan was also required to submit the policy and procedures implemented to correct the above deficiency, the date of implementation, and the management position(s) responsible for ensuring continued compliance.

*The Plan responded by confirming that it revised its signature cards so that only current officers or employees of the Plan have authority over the Plan's bank accounts. In addition, the Plan submitted the policy and procedures implemented on June 1, 2017 to ensure continued compliance.*

*The Plan represented that the management position responsible for continued compliance is the Chief Financial Officer.*

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



October 4, 2016

Maria Marquez  
Senior Examiner (Supervisor)  
Office of Financial Review  
Division of Financial Oversight  
980 Ninth Street, 5th Floor  
Sacramento, CA 95814-2725

RE: Addendum to the Final Report of Routine Examination of PrimeCare Medical Network, Inc. dated September 25, 2017

Dear Ms. Marquez:

On behalf of PrimeCare Medical Network, Inc. ("Plan"), I am respectfully requesting the Department append the following response to the Plan's Final Report, pursuant to Section 1382(c) of the Knox-Keene Health Care Plan Act of 1975.

The Plan wishes to clarify its original response in regards to the timing of the automation of the interest functionality of its claims processing system<sup>1</sup>. At the time of the Plan's response, the Plan anticipated the interest functionality would be automated by the end of June 2017, however, as a result of some system testing; the interest functionality automation was not completed by this date. The Plan has been working to finish this project and anticipates the interest functionality will be automated and fully functional by the end of October 2017.

Lastly, the Plan would like to clarify that in Section IV A. Authorized Signors for Bank, the following sentence which Plan provided in its Response to the Preliminary Report should have been included in the Final Report: *The Plan noted that the three instances identified by the Department were related to three individual \$100,000 certificates of deposit and did not involve any of the Plan's operating accounts.* The Plan believes this sentence is pertinent to its response and should be reinstated in the Final Report.

Very truly yours,

Leigh Hutchins, Chairperson and CEO  
PrimeCare Medical Network, Inc.

cc: Justin Goodwin, Attorney, Office of Plan Licensing

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<sup>1</sup> "Interest functionality within the claims system was automated as of the end of June 2017." See Sections B and C on pages 11 and 12 of the Final Report.