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

Department of Managed Health Care
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January 16, 2015

via USPS Delivery and eFile

Manmohan Nayyar, M.D., Chairman, Board of Directors
CHOICE PHYSICIANS NETWORK, INC.
18564 Highway 18, Suite 105
Apple Valley, CA 92307

FINAL REPORT OF ROUTINE EXAMINATION OF CHOICE PHYSICIANS NETWORK, INC.

Dear Dr. Nayyar:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Choice Physicians 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.[1] The Department issued a Preliminary Report to the Plan on September 30, 2014. The Department accepted the Plan's electronically filed response on November 14, 2014.

This Final Report includes a description of the compliance efforts included in the Plan's November 14, 2014 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

[1] References throughout this letter 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.

electronically file copies of those portions of the Plan's response excluding information held confidential pursuant to Section 1382(c).

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, 2014 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://wpso.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 L14-R-470
- 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"

Questions or problems related to the electronic transmission of the response should be directed to Susan Levitt at (916) 255-2443 or email at Susan.Levitt@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

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

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

NED GENNAOUI
Senior Examiner (Supervisor)
Office of Financial Review
Division of Financial Oversight

cc: Tin Kin Lee, Attorney, Choice Physicians Network, Inc.
Gil Riojas, Deputy Director, Office of Financial Review
Joan Larsen, Supervising Examiner, Division of Financial Oversight
Suhag Patel, Examiner, Division of Financial Oversight
Jessica Tran, Monitoring Examiner, Division of Financial Oversight
Sarang Chehrazi, Licensing Counsel, Office of Plan Licensing
Laura Dooley Beile, Chief, Division of Plan Surveys

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF ROUTINE EXAMINATION

OF

CHOICE PHYSICIANS NETWORK, INC.

FILE NO. 933 0470

DATE OF FINAL REPORT: JANUARY 16, 2015

OVERSIGHT EXAMINER: NED GENNAOUI

EXAMINER-IN-CHARGE: SUHAG PATEL

FINANCIAL EXAMINERS:

JULIANA ASABOR
FRANCISCO GARCIA
MARIA MARQUEZ

BACKGROUND INFORMATION FOR
CHOICE PHYSICIANS NETWORK, INC.

Date Plan Licensed:	September 14, 2009
Organizational Structure:	Choice Physicians Network, Inc. (Plan) is a for-profit, "S" corporation owned by two shareholders. The Plan contracts with two medical groups affiliated with the two shareholders. In addition, the Plan leases office space, and receives administrative services from entities controlled by the two shareholders.
Type of Plan:	The Plan is a full-service health care plan that provides health care services to Medicare Advantage enrollees of other health care service plans through contractual arrangements. The Plan does not have the authority to enter into plan contacts directly with employer groups.
Provider Network:	The Plan contracts with medical groups, including affiliated entities, independent physicians, hospitals and ancillary providers for the provision of medical services to its Medicare members. Providers are reimbursed on a capitated, per-diem, or fee-for-service basis.
Plan Enrollment:	The Plan reported 6,719 Medicare enrollees contracted from other Plans at March 31, 2014.
Service Area:	The Plan operates in parts of San Bernardino, Fresno, Kern and Los Angeles Counties.
Date of last Final Routine Examination Report:	January 6, 2012

FINAL REPORT OF A ROUTINE EXAMINATION OF CHOICE PHYSICIANS NETWORK, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of Choice Physicians 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.[1] The Department issued a Preliminary Report to the Plan on September 30, 2014. The Department accepted the Plan's electronically filed response on November 14, 2014.

This Final Report includes a description of the compliance efforts included in the Plan's November 14, 2014 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in *italics*.

The Department examined the Plan's financial report filed with the Department for the quarter ended March 31, 2014, 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 Report
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Internal Control Issues

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

[1] References throughout this letter 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 THE QUARTER ENDED MARCH, 31 2014[2]

ASSETS	Bal. per F/S @	AJE or RJE	Exam Adjustments		Bal. per Exam @
Account	**3/31/14**		**Dr.**	**Cr.**	**3/31/14**
Cash and Cash Equivalents	5,390,285	AJE 1	209,605		5,599,890
Short-Term Investments	99,956				99,956
Premiums Receivable – Net					
Interest Receivable					
Shared Risk Receivables – Net					
Other Health Care Receivables – Net					
Prepaid Expenses	19,965				19,965
Secured Affiliate Receivables – Current					
Unsecured Affiliate Receivables – Current	40,100				40,100
Aggregate Write-Ins for Current Assets					
TOTAL CURRENT ASSETS	**5,550,306**		**209,605**		**5,759,911**
Restricted Assets	2,427,794				2,427,794
Long-Term Investments	496,755				496,755
Intangible Assets & Goodwill – Net					
Secured Affiliate Receivables – Long-Term					
Unsecured Affiliate Receivables – Past Due					
Aggregate Write-Ins for Other Assets	139,126				139,126
TOTAL OTHER ASSETS	**3,063,675**				**3,063,675**
Land, Building and Improvements					
Furniture and Equipment – Net	18,541				18,541
Computer Equipment – Net	562				562
Leasehold Improvements – Net	107,571				107,571
Construction in Progress					
Software Development Costs					
Aggregate Write-Ins for Other Equipment					
TOTAL PROPERTY & EQUIPMENT	**126,674**				**126,674**
TOTAL ASSETS	**8,740,655**		**209,605**		**8,950,260**

[2] **This financial report is not adjusted for any tax effect resulting from the adjusting journal entries.**

BALANCE SHEET (Continued)

LIABILITIES	Bal. per F/S @	AJE or RJE	Exam Adjustments		Bal. per Exam @
Account	**3/31/14**		**Dr.**	**Cr.**	**3/31/14**
Trade Accounts Payable	16,758				16,758
Capitation Payable	73,704				73,704
Claims Payable (Reported)	942,775				942,775
Incurred But Not Reported Claims	2,345,210	AJE 2		1,103,806	3,449,016
POS Claims Payable (Reported)					
POS Incurred But Not Reported Claims					
Other Medical Liability					
Unearned Premiums					
Loans & Notes Payable					
Amounts Due to Affiliates – Current	1,243,168				1,243,168
Aggregate Write-Ins for Current Liabilities	13,015				13,015
TOTAL CURRENT LIABILITIES	**4,634,630**			**1,103,806**	**5,738,436**
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					
TOTAL OTHER LIABILITIES					
TOTAL LIABILITIES	**4,634,630**			**1,103,806**	**5,738,436**
NET WORTH					
Common Stock	900,000				900,000
Preferred Stock					
Paid in Surplus					
Contributed Capital					
Retained Earnings (Deficit)/Fund Balance	3,207,034				3,207,034
Aggregate Write-Ins for Other Net Worth Items	(1,009)				(1,009)
EXAMINATION ADJUSTMENTS (from Income Statement)		(A)	1,103,806	209,605	(894,201)
TOTAL NET WORTH	**4,106,025**		**1,103,806**	**209,605**	**3,211,824**
TOTAL LIABILITIES & NET WORTH	**8,740,655**		**1,103,806**	**1,313,411**	**8,950,260**

B. STATEMENT OF INCOME AND EXPENSES FOR THE QUARTER ENDED MARCH 31, 2014

	Bal. per F/S @	AJE or RJE	Exam Adjustments		Bal. per Exam @
Account	3/31/14		Dr.	Cr.	3/31/14
REVENUES:					
Premiums (Commercial)					
Capitation	12,114,769	AJE 1		209,605	12,324,374
Co-payments, COB, Subrogation					
Title XVIII – Medicare					
Medicaid, Healthy Families					
Fee-For-Service					
Point-Of-Service (POS)					
Interest	6,898				6,898
Risk Pool Revenue					
Aggregate Write-Ins for Other Revenues	2,901				2,901
TOTAL REVENUE	**12,124,568**			**209,605**	**12,334,173**
EXPENSES:					
Medical and Hospital					
Inpatient Services – Capitated					
Inpatient Services – Per Diem/Managed Hospital	2,316,223				2,316,223
Inpatient Services – Fee-For-Service/Case Rate	1,784,070	AJE 2	1,103,806		2,887,876
Primary Professional Services – Capitated	5,305,106				5,305,106
Primary Professional Services – Non-Capitated					
Other Medical Professional Services – Capitated	69,143				69,143
Other Medical Professional Services – Non-Capitated					
Non-Contracted Emergency Room and Out-of-Area Expense, not including POS	150,520				150,520
POS Out-Of-Network Expense					
Pharmacy Expense – Capitated					
Pharmacy Expense – Fee-for-Service					
Aggregate Write-Ins for Other Capitated Medical and Hospital Expenses					
Aggregate Write-Ins for Other Non-capitated Medical and Hospital Expenses	1,103,828				1,103,828
TOTAL MEDICAL AND HOSPITAL EXPENSES	**10,728,890**		**1,103,806**		**11,832,696**
Administration					
Compensation	160,458				160,458
Interest Expense					
Occupancy, Depreciation and Amortization	37,188				37,188
Management Fees					
Marketing					
Affiliate Administration Services					
Aggregate Write-Ins for Other Administration	182,030				182,030
TOTAL ADMINISTRATION EXPENSES	**379,676**				**379,676**
TOTAL EXPENSES	**11,108,566**		**1,103,806**		**12,212,372**
INCOME (LOSS)	**1,016,002**				**121,801**
Provision for Taxes	15,240				15,240
NET INCOME (LOSS)	**1,000,762**	(A)	**1,103,806**	**209,605**	**106,561**

C. EXPLANATION OF EXAMINATION ADJUSTMENTS

ADJUSTING JOURNAL ENTRIES

AJE No.	ACCOUNT NAME	DR.	CR.
1	Cash and Cash Equivalents Capitation Revenue *To properly record capitation revenue*	$209,605	$209,605

AJE No.	ACCOUNT NAME	DR.	CR.
2	Inpatient Services - Fee-For-Service/Case Rate Incurred But Not Reported Claims *To accrue an additional liabilityfor incurred but not reported claims*	$1,103,806	$1,103,806

The Plan was required to provide written assurance that the above adjusting journal entries were posted to the books and records and/or provide an explanation regarding their disposition. In addition, the Plan was required to refile the DMHC Reporting Form for the quarter ended March 31, 2014 to include the two required adjustments noted above. The Plan was to also state the date the requested DMHC Reporting Form was re-filed.

The Plan responded that it made the adjusting journal entries to its books and records as a result of the Department's findings. Additionally, the Plan re-filed the DMHC Reporting Form for the quarter ended March 31, 2014 to include the two required adjustments. The DMHC Reporting Form was re-filed on October 31, 2014.

The Department finds the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. No further response is required.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth and TNE per Examination as of Quarter Ended March 31, 2014 [From Section I.A.]	$ 3,211,824
Less: Unsecured Affiliate Receivables	40,100
Tangible Net Equity	$ 3,171,724
Required TNE per Examination	$ 1,542,591
TNE Excess per Examination	$ 1,629,133

The Plan was in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of March 31, 2014.

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 which reimburses providers of health care service 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 $1,103,806 as of March 31, 2014 (examination date) using paid claims data up to June 30, 2014. As a result, the examination required an adjusting journal entry (AJE 2 on page 7 of this Report) to increase the IBNR claims liability. The understatement of this claims liability was the result of not accruing an additional liability for increased enrollment and service area expansions. In addition, the Plan did not perform a hindsight analysis based on paid claims data to determine whether the recorded estimate for total claims liability for previous periods was adequate.

The Plan was required to review its methodology of determining the accrual for total claims liability and provide a detailed description of the procedures implemented to ensure that the estimate for IBNR claims liability was 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 date of implementation of the new procedures and the management position(s) responsible to ensure an adequate estimate of IBNR claims liability was recorded on the Plan's books.

The Plan responded that it reviewed its methodology of determining the accrual for total claims liability, and was satisfied that its estimated accruals for incurred but not reported claims and claims payable were accurate.

The Plan added that in order to monitor and verify the accuracy of its IBNR calculation, at a minimum, the Plan will prepare, for each reporting period, a quarterly hindsight analysis of the previous four quarters. The preparation of a hindsight analysis was implemented on November 1, 2014 to ensure that an adequate estimate of IBNR claims liability is recorded on its books subsequent to that date and to ensure accurate reporting for the third quarter of 2014.

The Plan stated that its outside accounting consultant, together with its contracted controller, are responsible for ensuring that adequate estimates of IBNR and total claims liability are recorded on its books.

The Department finds the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. No further response is required.

B. AMENDMENTS TO PLAN APPLICATION

Section 1352(a) and Rule 1300.52 require all plans to file an amendment with the director within thirty (30) days after any changes in the information contained in its application, other than financial or statistical information. Rule 1300.52.4 sets forth standards for amendment filings.

Section 1367 (h)(1) states that contracts with subscribers and enrollees, providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair reasonable, and consistent with the objectives of this chapter.

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

1. The Plan entered into an Administrative Services Agreement with Desert Physicians Management, LLC, a Plan affiliate, on May 1, 2011, for the provision of administrative, financial, eligibility and benefits, and accounts payable payment processing services. This Agreement was not filed with the Department.

2. The Plan entered into a Capitated IPA Agreement for Medicare Services with Corwin Medical Group, Inc. and Horizon Valley Medical Group, Inc. (individually IPA), both are Plan affiliates, for the provision or arrangement of health care services. Attachment C of each Agreement described the Institutional Risk Pool. According to Attachment C, surpluses and deficits of the Institutional Risk Pool were determined on an annual basis, and shared equally between the Plan and each IPA. Quarterly settlements of the Institutional Risk Pool fund were to be paid within 15 days of the end of the most recent quarter.

The Department's examination disclosed that quarterly settlements with each IPA were not paid by the Plan within 15 days of quarter end. In addition, the Plan retained 20 percent of the Institutional Risk Pool surplus payable quarterly to each IPA. Both practices were not in compliance with the terms of the Agreement between the Plan and each IPA. In addition, Attachment C was not incorporated into the body of the Agreement with each IPA.

The Plan was required to submit a Corrective Action Plan (CAP) to address the deficiencies cited above to include the following:

1. Evidence (eFile number) that the Administrative Services Agreement with Desert Physicians Management, LLC, was submitted through the Department electronic filing system.

2. Evidence (eFile number) that a revised Capitated IPA Agreement including Attachment C with each IPA was submitted through the Department electronic filing system. The revised Agreement with each IPA was required to incorporate Attachment C under Article 5, Compensation, and the revised Attachment C for each Agreement was required to describe in detail the Institutional Risk Pool arrangements that were currently in practice, including timing of and withholdings on quarterly settlement payments.

3. Policy and procedures implemented to ensure that changes to Plan operations were filed with the Department pursuant to the Sections and Rules stated above. In addition, the Plan was to indicate the date of their implementation and the management position(s) responsible to ensure continued compliance.

The Plan responded that it submitted through the Department's electronic filing system (eFile number 20142641) an Administrative Services Agreement with Desert Physicians Management, LLC. In addition, the Plan filed a revised Capitated IPA Agreement with each IPA describing the Institutional Risk Pool.

Furthermore, the Plan provided with its response the promulgated and implemented policy and procedure, effective November 1, 2014, to ensure that changes to Plan operations are filed with Department pursuant to Section 1352(a), Rules 1300.52 and 1300.52.4 and Section 1367(h)(1). The Plan represented that the Plan's Administrator is responsible to ensure continued compliance.

The Department finds the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. No further response is required.

C. NON-CONTRACTED PROVIDER INSOLVENCY DEPOSIT

Section 1377(a) requires a plan which reimburses providers of health care services that do not contract in writing with the plan to provide health care services, or which reimburses its subscribers or enrollees for costs incurred in having received health care

services from providers that do not contract in writing with plan, in an amount which exceeds 10 percent of its total costs for health care services for the immediately preceding six months, shall either: (1) maintain cash, or cash equivalents as defined in Rule 1300.77, and calculated in accordance with Section 1377(a); or, (2) maintain adequate insurance, or a guaranty arrangement approved in writing by the Director.

The Department's examination disclosed that the amount of the Plan's non-contracted provider insolvency deposit on the assignment form dated June 7, 2011 on file with the Department did not agree with the actual amount of the deposit. On September 14, 2012, the Department approved a decrease in the amount of the deposit. However, the Plan did not file a revised assignment form for the new deposit amount. As of March 31, 2014, the Plan was required to have a non-contracted provider insolvency deposit in the amount of $1,692,000.

On August 13, 2014, the Plan submitted through the Department's electronic filing system an executed assignment form for the non-contracted provider insolvency deposit in the amount of $2 million (eFile number 20141873).

The Plan was required to submit the policy and procedures implemented to ensure the continued adequacy of the amount of the non-contracted provider insolvency deposit and compliance with the requirements of Section 1377(a). Furthermore, the Plan was required to state the date the policy and procedures were implemented and the management position(s) responsible to ensure continued compliance.

The Plan responded that it promulgated and implemented a policy and procedure (filed with the Plan's response) to ensure the continued adequacy of the amount of the non-contracted provider insolvency deposit and compliance with the requirements of Section 1377(a). The policy and procedure was implemented on November 1, 2014. The Plan represented that the accounting consultant and contracted controller are responsible to ensure continued compliance.

The Department finds the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. No further response is required.

SECTION IV. INTERNAL CONTROL

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. 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 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.

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

CASH

The Department's examination included a review of the cash accounts.

1. The Plan did not timely record capitation receipts for covered enrollees. As a result, the examination required an adjustment (AJE 1 on page 7 of this Report) to properly report Cash and Capitation Revenue on the DMHC Reporting Form for the quarter ended March 31, 2014.

2. The Plan did not have a written policy for the proper recording of stale-dated outstanding checks. The policy was required to indicate when stale-dated outstanding checks were to be reclassified to a liability account, researched and reissued to the correct payee. If the correct payee was not found, unclaimed funds were required to be escheated to the State Controller's Office.

The Plan was required to submit a CAP to address the deficiencies cited above to include the following:

1. The policy and procedures implemented to ensure that capitation revenue was timely posted to the Plan's books, the date of their implementation and the management position(s) responsible to ensure continued compliance.

2. The written policy regarding stale-dated outstanding checks, the date of implementation and the management position(s) responsible to ensure continued compliance.

The Plan responded that it promulgated and implemented two policies and procedures (filed with the Plan's response) to ensure that capitation revenue was timely posted to the Plan's books and regarding stale-dated outstanding checks.

The Plan represented that the two policies and procedures were implemented on November 1, 2014, and the accounting consultant and contracted controller are responsible to ensure continued compliance.

The Department finds the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. No further response is required.