Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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Sacramento, CA 95814
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November 23, 2020

Via eFile

Dr. Manmohan Nayyar
Chief Executive Officer
Choice Physicians Network, Inc.
19111 Town Center Drive
Apple Valley, CA 92308

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

Dear Dr. Nayyar:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended September 30, 2019, of the fiscal and administrative affairs of Choice Physicians Network, Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report to the Plan on September 21, 2020. The Department accepted the Plan's electronically filed response on November 6, 2020.

The Final Report includes a description of the compliance efforts included in the Plan's November 6, 2020 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 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response. If so, please indicate which portions of the Plan's response should be appended, and electronically file copies of those portions 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 or wishes to modify any information provided to the Department in its

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in Health and Safety Code Section 1340 et seq.

November 6, 2020 response, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan system (CAP system) within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP #L20-R-470."
- Go to the "Messages" tab, then:
    - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
    - 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 any addendum should be directed to Vijon Morales at 916-255-2447 or by e-mail at Vijon.Morales@dmhc.ca.gov. You may also e-mail inquiries to wpso@dmhc.ca.gov.

The Department will make the Final Report available to the public in 10 days from the Plan's receipt of this letter. The Final Report will be located at the Department's web site at http://www.dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx.

If there are any questions regarding the Final Report, please contact me at 213-576-7541 or by e-mail at Maria.Marquez@dmhc.ca.gov.

Sincerely,

SIGNED BY

Maria Marquez
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Tin Kin Lee, Attorney, Law Offices of Tin Kin Lee
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Ned Gennaoui, Supervising Examiner, Division of Financial Oversight
John Atamian, Examiner, Division of Financial Oversight
Neetu Bhangu, Examiner, Division of Financial Oversight
Michael Munoz, Associate Governmental Program Analyst, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Ben Carranco, Assistant Deputy Director, Help Center
Chad Bartlett, Staff Services Manager III, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF A ROUTINE EXAMINATION

OF

CHOICE PHYSICIANS NETWORK, INC.

FILE NO. 933 0470

DATE OF FINAL REPORT: NOVEMBER 23, 2020

SUPERVISING EXAMINER: NED GENNAOUI

OVERSIGHT EXAMINER: MARIA MARQUEZ

EXAMINER-IN-CHARGE: JOHN ATAMIAN

FINANCIAL EXAMINERS:
CHANTE BIAGAS
ZAW OO

BACKGROUND INFORMATION FOR CHOICE PHYSICIANS NETWORK, INC.

Date Plan Licensed:	September 14, 2009
Organizational Structure:	Choice Physicians Network, Inc. (Plan) is a for-profit corporation owned by two shareholders. The Plan contracts with Choice Medical Group, Inc. and Horizon Valley Medical Group, affiliated with the two shareholders of the Plan. The Plan leases office space from RAM Investment Properties, LLC, wholly owned by the two shareholders of the Plan.
Type of Plan:	The Plan is a full-service health care plan. The Plan has a restricted license to contract with other Knox-Keene licensed plan for Medicare Advantage enrollees. The Plan is not licensed to enter into plan contracts directly with employer groups or members of the general public.
Provider Network:	The Plan contracts with medical groups, 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-services basis.
Plan Enrollment:	As of September 30, 2019, the Plan reported 15,044 enrollees contracted from other plans.
Service Area:	The Plan operates in parts of San Bernardino, Fresno, Kern, Los Angeles, Madera, Riverside, Modesto, and Tulare Counties.
Date of Prior Final Routine Examination Report:	December 13, 2017

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

This is the final report (Final Report) of a routine examination for quarter ended September 30, 2019, of the fiscal and administrative affairs of Choice Physicians Network, Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued preliminary report (Preliminary Report) to the Plan on September 21, 2020. The Department accepted the Plan's electronically filed response on November 6, 2020.

This Final Report includes a description of the compliance efforts included in the Plan's November 6, 2020 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in italics within this Final Report.

The Department examined the Plan's financial report filed with the Department for the quarter ended September 30, 2019, 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 Final Report as follows:

Part I.	Financial Statements
Part II.	Calculation of Tangible Net Equity
Part III.	Compliance 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.

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in Health and Safety Code Section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

PART I. FINANCIAL STATEMENTS (F/S)

A. BALANCE SHEET AT THE QUARTER ENDED SEPTEMBER 30, 2019

ACCOUNT	Balance per F/S at 09/30/19	AJE & RJE	Exam Adj. (Dr.)	Exam Adj. (Cr.)	Balance per Exam at 09/30/19
Cash and Cash Equivalents	$33,880,199				$33,880,199
Other Health Care Receivables - Net	19,438				19,438
Prepaid Expenses	106,384				106,384
Aggregate Write-ins for Current Assets	362,753				362,753
TOTAL CURRENT ASSETS	**34,368,774**				**34,368,774**
Restricted Assets	2,969,073				2,969,073
Long-Term Investments	2,000,892				2,000,892
TOTAL OTHER ASSETS	**4,969,965**				**4,969,965**
Computer Equipment - Net	86,613				86,613
Leasehold Improvements – Net	167,752				167,752
Construction in Progress	49,433				49,433
TOTAL PROPERTY AND EQUIPMENT	**303,798**				**303,798**
TOTAL ASSETS	**$39,642,537**				**$39,642,537**

ACCOUNT	Balance per F/S at 09/30/19	AJE & RJE	Exam Adj. (Dr.)	Exam Adj. (Cr.)	Balance per Exam at 09/30/19
Trade Accounts Payable	$106,245				$106,245
Claims Payable (Reported)	1,508,273	AJE 1 RJE 1		2,995,845 2,180,793	6,684,911
Incurred But Not Reported Claims	15,776,301	RJE 1	2,180,793		13,595,508
Amounts Due to Affiliates – Current	4,841,277				4,841,277
Aggregate Write-ins for Current Liabilities	118,477				118,477
TOTAL CURRENT LIABILITIES	**22,350,573**		**2,180,793**	**5,176,638**	**25,346,418**
Loans and Notes Payable (Subordinated)	3,000,000				3,000,000
Accrued Subordinated Interest Payable	106,936				106,936
TOTAL OTHER LIABILITIES	**3,106,936**				**3,106,936**
TOTAL LIABILITIES	**25,457,509**		**2,180,793**	**5,176,638**	**28,453,354**
Common Stock	2,750,000				2,750,000
Retained Earnings	14,156,184				14,156,184
Aggregate Write-Ins for other Net Worth Items	(2,721,156)				(2,721,156)
Examination Adjustments			2,995,845		(2,995,845)
TOTAL NET WORTH	**14,185,028**		**2,995,845**		**11,189,183**
TOTAL LIABILITY AND NET WORTH	**$39,642,537**		**$5,176,638**	**$5,176,638**	**$39,642,537**

B. STATEMENT OF INCOME AND EXPENSES FOR THE QUARTER ENDED SEPTEMBER 30, 2019

Account	Balance per F/S at 09/30/19	AJE & RJE	Exam Adj. (Dr.)	Exam Adj. (Cr.)	Balance per Exam at 09/30/19
Capitation	$36,797,940				$36,797,940
Interest	30,406				30,406
Aggregate Write-Ins for Other Revenues	713,415				713,415
TOTAL REVENUE	**37,541,761**				**37,541,761**
Inpatient Services - Per Diem/Managed Hospital	10,556,406	AJE 1	1,917,341		12,473,747
Inpatient Services - Fee-For-Service/Case Rate	5,719,131	AJE 1	1,018,587		6,737,718
Primary Professional Services – Capitated	14,441,358				14,441,358
Other Medical Professional Services – Capitated	156,756				156,756
Non-Contracted Emergency Room and Out-of-Area Expense, not including POS	357,142	AJE 1	59,917		417,059
Aggregate Write-Ins for Other Non-Capitated Medical and Hospital Expenses	1,384,324				1,384,324
TOTAL MEDICAL AND HOSPITAL EXPENSES	**32,615,117**		**2,995,845**		**35,610,962**
Compensation	390,363				390,363
Interest Expense	22,500				22,500
Occupancy, Depreciation and Amortization	32,322				32,322
Aggregate Write-Ins for Other Administration	435,335				435,335
TOTAL ADMINISTRATION	**880,520**				**880,520**
TOTAL EXPENSES	**33,495,637**		**2,995,845**		**36,491,482**
Provision for Taxes	1,132,251				1,132,251
NET INCOME	**$2,913,873**		**$2,995,845**		**($81,972)**

C. EXPLANATION OF EXAMINATION ADJUSTMENTS (EXAM ADJ.)

ADJUSTING JOURNAL ENTRY (AJE) AND RECLASSIFYING JOURNAL ENTRY (RJE)

AJE & RJE Number	ACCOUNT NAME	Debit (Dr.)	Credit (Cr.)
AJE 1	Inpatient Services – Per Diem/Managed Hospital	$1,917,341	
	Inpatient Services – Fee for Service/Case Rate	1,018,587	
	Non-Contracted Emergency Room and Out-of-Area Expenses, not Including POS	59,917	
	Claims Payable		$2,995,845
	To increase medical expenses and claims payable.		
RJE 1	Incurred But Not Reported Claims	$2,180,793	
	Claims Payable		$2,180,793
	To properly report incurred but not reported claims and claims payable.		

The Preliminary Report required the Plan to provide written assurance that the above AJE and RJE were posted to the books and records. In addition, the Plan was required to refile the Department's financial reporting form (Reporting Form) for the quarter ended September 30, 2019, to include the required AJE and RJE noted above, and indicate the date of refiling the requested Reporting Form.

The Plan responded by providing written assurance that the adjustment and reclassification noted in the Preliminary Report were posted to the books and records for the quarter ended September 30, 2019. In addition, the Plan refiled the Reporting Form for the quarter ended September 30, 2019, which included the adjustment and reclassification noted in the Preliminary Report, on November 3, 2020.

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

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth per examination as of quarter ended September 30, 2019 (from Part I.A. of this report)	$11,189,183
Add: Subordinated Debt and Accrued Subordinated Interest	3,106,936
TNE	14,296,119
Required TNE	4,197,497
TNE Excess per Examination	$10,098,622

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of September 30, 2019.

No response is required to this Part.

PART III. COMPLIANCE ISSUES

A. INCURRED BUT NOT REPORTED (IBNR) CLAIMS LIABILITY – REPEAT DEFICIENCY

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 (Director) of the Department. 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 approximately $2,995,845 as of September 30, 2019, using paid claims data up to April 30, 2020. As a result, the examination required AJE 1, as disclosed on page 7 of this report, to increase the claims payable balance. The Department determined that the plan's total claims liability was understated, as disclosed in the following table:

Claims Liability Analysis	Quarter Ended 09/30/2019	Quarter Ended 06/30/2019
Claims Payable	$1,508,273	$4,254,773
Add: IBNR Claims Liability	$15,776,301	$13,432,441
Total Claims Liability Reported by the Plan	$17,284,574	$17,687,214
Less: Total Claims Liability per Examination	$20,280,419	$18,076,441
Understatement of Total Claims Liability	($2,995,845)	($389,227)

This deficiency was previously noted in the Department's final report of examination, dated December 13, 2017, for the quarter ended March 31, 2017. The current examination disclosed that the Plan's compliance efforts in response to the previous examination did not achieve the necessary levels of compliance with the Section and Rule.

The Preliminary Report required the Plan to explain the reasons for the understatement of total claims liability. In addition, the Plan was required to describe why the previous corrective actions taken were not effective to prevent this repeat deficiency.

The Plan was also required to revise its methodology of estimating total claims liability. Furthermore, the Plan was required to provide a detailed description of the procedures implemented to ensure that the estimate for total claims liability was properly stated 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 positions responsible for ensuring an adequate estimate of total claims liability was recorded in the Plan’s books.

The Plan responded that the understatement of total claims liability was the result of placing sole reliance on an inadequate IBNR/claims payable calculation model. The Plan’s model had been reliable when used for calculating total claims liability for professional claims, and the previous Plan’s chief financial officer (CFO) was confident it also was appropriate to estimate institutional claims. However, after the termination of the CFO and the engagement of an actuary to certify the Plan’s IBNR in May 2018, the Plan discovered that due to the size, volatility and extended completion factors of institutional claims, the model was woefully inadequate.

The Plan revised its methodology of estimating total claims liability by implementing a licensed reliable IBNR calculation model from its actuary, conferring with the actuary on a regular basis, and engaging the actuary to review the calculations on a quarterly basis. The licensed model contains a dashboard, which provides a continuous hindsight

analysis, allowing the Plan and consulting actuary to evaluate the claims liability on a regular basis.

The Plan implemented the new procedures in September 2019. The management positions responsible for ensuring an adequate estimate of total claims liability are the Plan's Director of Operations, its Controller, and its consulting Certified Public Accountant.

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

B. NONCONTRACTED PROVIDER INSOLVENCY DEPOSIT

Section 1377(a) requires every 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 a noncontracting provider insolvency deposit; or (2) maintain adequate insurance, or a guaranty arrangement approved in writing by the Director, to pay for any loss to providers, subscribers, or enrollees claiming reimbursement due to the insolvency of the plan.

The Department's examination disclosed that the amount of noncontracted provider insolvency deposit maintained by the Plan was below the required deposit amount of $2.5 million by $16,300.

Prior to the issuance of the Preliminary Report, the Plan corrected this deficiency, and filed evidence of compliance (eFiling number 20202717). This filing was reviewed and completed by the Department on September 8, 2020.

The Preliminary Report required the Plan to provide the policy and procedure implemented to ensure compliance with the requirements of Section 1377(a) and Rule 1300.77(a) at all times, the date of implementation, and the management position responsible for ensuring continued compliance**.**

The Plan responded by submitting a new policy, "Compliance with DMHC Rules and Regulations," that was implemented on August 1, 2020.

The management position responsible for ensuring continued compliance is the Plan's Controller, which will evaluate the adequacy of the deposit assigned to the Director.

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