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State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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February 5, 2019

Via USPS Delivery and eFile

Mr. John Goodman, President
EPIC Health Plan
1615 Orange Tree Lane
Redlands, CA 92374

FINAL REPORT OF A ROUTINE EXAMINATION OF EPIC HEALTH PLAN

Dear Mr. Goodman:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended December 31, 2017 of the fiscal and administrative affairs of EPIC Health Plan (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 October 12, 2018. The Department accepted the Plan's electronically filed response on November 20, 2018.

The Final Report includes a description of the compliance efforts included in the Plan's November 20, 2018 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

¹ References 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 regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

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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 November 20, 2018 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://wpsso.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 #L18-R-483."
- 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 wpsso@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>.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

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,

ORIGINAL SIGNED BY

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

cc: Jennifer Swartz, Executive Assistant to the Chief Executive Officer, EPIC Health Plan
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Ned Gennaoui, Supervising Examiner, Division of Financial Oversight
Juliana Asabor, Examiner, Division of Financial Oversight
Ashika Chiu, Examiner, Division of Financial Oversight
Justin Goodwin, Attorney, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Linda Armstrong, 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

EPIC HEALTH PLAN

FILE NO. 933 0483

DATE OF FINAL REPORT: FEBRUARY 5, 2019

SUPERVISING EXAMINER: NED GENNAOUI

OVERSIGHT EXAMINER: MARIA MARQUEZ

EXAMINER-IN-CHARGE: JULIANA ASABOR

**FINANCIAL EXAMINERS:
JOHN ATAMIAN
ZAW OO
SUHAG PATEL**

BACKGROUND INFORMATION FOR EPIC HEALTH PLAN

Date Plan Licensed:	October 29, 2010
Organizational Structure:	<p>EPIC Health Plan (Plan) is a for-profit, wholly-owned subsidiary of EPIC Management, L.P. (Parent).</p> <p>The Plan receives administrative services from its Parent pursuant to a management services agreement. In addition, the Plan contracts with an affiliated medical group for professional medical services.</p>
Type of Plan:	<p>The Plan is a full service health care plan. The Plan has a restricted license that allows it to accept global capitation in exchange for accepting professional and institutional risk for commercial and Medicare lines of business through contracts with other full service health care plans.</p>
Provider Network:	<p>The Plan contracts with individual practice associations, medical groups, hospitals, and other providers for the provision of medical services to its members on a capitation or fee-for-service basis. Capitation contracts often contain provisions for risk-sharing arrangements. Some of the contracted providers are affiliated with the Plan through common ownership.</p>
Plan Enrollment:	<p>As of December 31, 2017, the Plan reported 64,382 enrollees contracted from other plans.</p>
Service Area:	<p>The Plan's service area includes portions of Los Angeles, Riverside, and San Bernardino Counties.</p>
Date of Prior Final Routine Examination Report:	October 30, 2015

FINAL REPORT OF A ROUTINE EXAMINATION OF EPIC HEALTH PLAN

This is the final report (Final Report) for the quarter ended December 31, 2017 of a routine examination of the fiscal and administrative affairs of EPIC Health Plan (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 (Preliminary Report) to the Plan on October 12, 2018. The Department accepted the Plan's electronically filed response on November 20, 2018.

This Final Report includes a description of the compliance efforts included in the Plan's November 20, 2018 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in italics within this Final Report

The Plan is hereby advised that any violations listed in this Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

The Department examined the Plan's financial report filed with the Department for the quarter ended December 31, 2017, 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 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 the California 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

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended December 31, 2017, as filed with the Department. A copy of the Plan's financial statements can be viewed by selecting "EPIC Health Plan" on the second drop-down menu of the Department's financial statement database available at <http://wpsso.dmhc.ca.gov/fe/search/#top>.

No response is required to this Part.

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth and TNE as reported by the Plan as of quarter ended December 31, 2017	\$13,975,400
Required TNE	<u>5,669,887</u>
TNE Excess per Examination	<u>\$8,305,513</u>

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of December 31, 2017.

No response is required to this Part.

PART III. COMPLIANCE ISSUES

A. CLAIMS SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERN”

Section 1371.37 prohibits a health care service plan from engaging in an unfair payment pattern.

Rule 1300.71(a)(8) defines an “unfair payment pattern” as any practice, policy, or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

1. FORWARDING MISDIRECTED CLAIMS

Rule 1300.71(b)(2)(A)–(B) states that when a claim is sent to a health care service plan that has contracted with a capitated provider that is responsible for adjudicating the claim, the plan must forward the claim to the appropriate capitated provider within 10 working days of receipt of the claim, or, if the claim does not involve emergency services and the provider that filed the claim is contracted with the plan's capitated provider, send the claimant a notice of denial with instructions to bill the capitated provider within 10 working days of receipt of the claim.

Rule 1300.71(a)(8)(B) describes an “unfair payment pattern” as the failure to forward at least 95 percent of misdirected claims consistent with Rule 1300.71(b)(2)(A)–(B) over the course of any three-month period.

The Department’s examination disclosed that the Plan did not forward misdirected claims within 10 working days of receipt to the appropriate capitated provider in 16 out of 50 denied claims (a compliance rate of 68 percent). This deficiency was noted in the following denied claim sample numbers: 1, 9, 10, 13, 15, 22, 23, 25, 27, 32, 37, 39, 40, 41, 43, and 49.

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:

- Training procedures implemented to ensure that claim processors are properly trained on the requirements for forwarding misdirected claims timely.
- Audit procedures implemented to ensure that the Plan is monitoring the timeliness of forwarding misdirected claims.
- Date of implementation of the additional training and auditing procedures.
- Management position responsible for ensuring continued compliance.

The Plan responded by filing with the Department a policy and procedure describing the process for ensuring that all claims received by the Plan, which are found to be the responsibility of a capitated provider, are forwarded within the required timeframe. The training for the policy and procedure occurred during July 2018.

The Plan also implemented a tracking log for claims as part of its audit procedures. The tracking log captures when and where the misdirected claims are forwarded, and is initiated by the mailroom staff. In addition, weekly and monthly system-generated reports are created to help capture claims entered into the system, which require forwarding. The audit procedures were fully implemented on August 20, 2018.

The Plan stated that the Director of Claims is responsible for ensuring continued compliance.

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.

2. CLEAR AND ACCURATE DENIAL EXPLANATION

Rule 1300.71(d)(1) states that a plan must not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted, or contested, the plan must provide a clear and accurate written explanation of the specific reasons for the action taken.

Rule 1300.71(a)(8)(F) describes an “unfair payment pattern” as the failure to provide a provider with an accurate and clearly written explanation of the specific reasons for denying, adjusting, or contesting a claim consistent with Rule 1300.71(d)(1) at least 95 percent of the time over the course of any three-month period.

The Department examination disclosed that five out of 50 denied claims reviewed (a compliance rate of 90 percent) had denial explanations that were not clear or accurate. This deficiency was noted in the following denied claim sample numbers: 15, 25, 27, 39, and 41.

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

- Policy and procedure implemented to ensure that written explanations sent to providers for the denial of a claim are clear and accurate in compliance with Rule 1300.71(d)(1).
- Training procedures to ensure that claims processors select clear and accurate denial reasons.
- Audit procedures to confirm that claims denials include clear and accurate denial reasons.
- Date of implementation of the new policy and procedures.
- Management position responsible for ensuring continued compliance.

The Plan responded by filing a policy and procedure that describes the process for ensuring that all denied, contested, or adjusted claims have a clear and concise explanation of the final determination of the claim. The training for the policy and procedure occurred during June 2018, and the actual implementation was July 2, 2018.

The Plan implemented a system to generate reports to assist with the capturing of claims with inappropriate adjustment codes. In addition, as a safety measure and another layer of the process termination, dates were added to the old codes making them ineffective going forward. Bi-weekly reports are generated and reviewed prior to the check runs to capture claims that do not have the appropriate adjustment code. A uniform adjustment code chart with standard codes used by all staff including memo

field message was drafted and implemented. The full implementation of the audit procedures was July 23, 2018.

The Plan stated that the Director of Claims is responsible for ensuring continued compliance.

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. RESTRICTED DEPOSIT

Rule 1300.76.1 states that each plan must deposit at least \$300,000 with the director of the Department (Director) or, at the discretion of the Director, with any bank authorized to do business in California and insured by the Federal Deposit Insurance Corporation. The deposit must be assigned to the Director until released by the Director.

The Department's examination disclosed that the bank name on the restricted assignment form on file with the Department did not agree with the bank name on the certificate of deposit statement provided for review during the examination. In addition, the assignment form did not indicate the Plan's current address.

The Preliminary Report required the Plan to submit a detailed CAP to bring the Plan into compliance with the above Rule, and to include the following:

- Evidence (eFiling number) of filing a revised assignment form, as an amendment separate from the Plan's response to the Preliminary Report.
- Policy and procedure implemented, and the date of implementation, to ensure compliance with the requirements of Rule 1300.76.1 at all times.
- Management position responsible for ensuring continued compliance.

The Plan responded by filing with the Department as an amendment a revised assignment form on November 16, 2018 (eFiling number 20183256). This filing was reviewed and completed on December 7, 2018. In addition, the Plan filed a policy and procedure implemented on November 1, 2018 to ensure compliance with the requirements of Rule 1300.76.1 at all times.

The Plan stated that the Chief Financial Officer is responsible for ensuring continued compliance.

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. AMENDMENTS TO APPLICATION – Repeat Deficiency

Section 1352(a) requires all plans to file an amendment with the Director within 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.

The Department's examination disclosed that the Plan failed to comply with the filing requirements of the above Section and Rule, as the Plan did not file the following two service agreements for claims processing services:

- The Electronic Transactions Agreement between Office Ally and the Plan's Parent on behalf of the Plan.
- The Services Agreement between WCEDI-BPO, Inc. and the Plan's Parent on behalf of the Plan.

The Plan's failure to comply with the filing requirements of the above Section and Rule was a repeat deficiency, as this issue was previously reported in the Department's final report of examination dated October 30, 2015 for the quarter ended March 31, 2015. The current examination disclosed that the Plan's compliance efforts in response to the prior final examination report were not effective at achieving compliance.

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve the filing deficiency found in the Department's prior examination were not effective at achieving compliance.

The Preliminary Report also required the Plan to file the claims services agreements listed above, as an amendment separate from the Plan's response to the Preliminary Report. Furthermore, the Plan was required to provide evidence (eFiling number) in its response to the Preliminary Report that the requested filing was submitted to the Department.

In addition, the Plan was required to provide the policy and procedure implemented to ensure that agreements relating to claims processing are filed with the Department, the date of implementation, and the management position responsible for ensuring continued compliance.

The Plan responded that the policy and procedures established in 2015 required a new distinct policy with respect to service agreements for claims processing services. The distinct policy included an aspect of engagement by those directly involved in the day-to-day functions and oversight of the claims department.

The Plan filed the above requested claim service agreements, as an amendment, on November 5, 2018 (eFiling number 20183120). This filing is currently under review by the Department.

In addition, the Plan filed the policy and procedure implemented on November 6, 2018 to ensure that agreements relating to claims processing are filed with the Department.

The Plan stated that the Director of Claims is responsible for ensuring continued compliance.

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. CHANGES IN OFFICERS AND DIRECTORS – Repeat Deficiency

Section 1352(c) requires a plan to file, within five days, an amendment to its application, when there are certain changes in personnel of the plan. A plan must report the addition or deletion of a director, trustee, principal officer, general partner, general manager, or principal management person; or a person occupying a similar position or performing similar functions; or a substantial and material change in the duties of any such person.

The Department's examination disclosed that the Plan did not file the following key personnel changes with the Department within the five-day requirement:

Position Title	Reason	Effective Date	Filing Date	Number of Days Late
Manager of Quality Management	Appointment	03/29/2016	04/05/2016	2
Director of Network Development	Appointment	03/29/2016	04/05/2016	2

The Plan's failure to comply with the filing requirements of the above Section is a repeat deficiency, as this issue was previously reported in the Department's final report of examination dated October 30, 2015 for the quarter ended March 31, 2015. The current examination disclosed that the Plan's compliance efforts in response to the prior final examination report were not effective at achieving compliance.

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve the deficiency of failing to file key personnel changes within five days found in the Department's prior examination were not effective at achieving compliance.

The Plan was also required to provide the policy and procedure implemented to ensure that changes in key personnel are filed with the Department within five days, the date of implementation, and the management position responsible for the ensuring continued compliance.

The Plan responded that it focused on ensuring the information was filed within five business days instead of calendar days.

The Plan filed with the Department the policy and procedure implemented on October 15, 2018 to ensure changes in key personnel are filed with the Department within five calendar days.

The Plan stated that the Chief Executive Officer is responsible for ensuring continued compliance.

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.

E. PAYMENTS TO NONCONTRACTED PROVIDERS

Section 1377(a) requires every plan which reimburses providers of health care services that do not contract in writing with the plan, or which reimburses its subscribers or enrollees for costs incurred 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, to either maintain a noncontracting provider insolvency deposit; or 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 Plan did not report payments to noncontracted providers, subscribers or enrollees to determine whether those payments exceeded 10 percent of total health care costs for the immediately preceding six months. Those payments are required to be reported on the supplemental information schedule of the Department's reporting form, as required by Rule 1300.84.06(b).

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

- Policy and procedure implemented to capture all payments to noncontracted providers, subscribers, or enrollees.
- Written statement to report the total amount of payments to noncontracted providers, subscribers, or enrollees in the supplemental information schedule of the Department's reporting form starting with the quarter ending September 30, 2018.
- Training procedures implemented to ensure compliance with the requirements of Section 1377(a).

- Date the policy, procedure, and additional training were implemented.
- Management position responsible for ensuring continued compliance.

The Plan responded by filing with the Department the policy and procedure implemented on August 10, 2018. The Plan confirmed that it will report payments to noncontracted providers starting with the supplemental information schedule of the financial report for the quarter ended June 30, 2018. The Department's review of the Plan's financial reports disclosed that the Plan reported payments to noncontracted providers for the quarters ended June 30, 2018 and September 30, 2018. Training on the new policy and procedure was conducted on August 10, 2018.

The Plan stated that the Chief Financial Officer is responsible for ensuring continued compliance.

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.