



Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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July 7, 2025

Via eFile

Mr. Jung Lee, CEO
Chairman of the Board and President
EPIC Health Plan
1615 Orange Tree Lane
Redlands, CA 92374

FINAL REPORT OF A ROUTINE EXAMINATION OF EPIC HEALTH PLAN

Dear Mr. Lee:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended June 30, 2024 of the fiscal and administrative affairs, including the claims settlement practices and provider dispute resolution mechanism, 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 March 25, 2025. The Department accepted the Plan's electronically filed responses on May 9, 2025, June 6, 2025, June 17, 2025, and June 23, 2025 (Responses).

The 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 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

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

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 Responses or wishes to modify any information provided to the Department in its Responses, 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 (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 # S24-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 the Office of Financial Review administrative support team at 916-255-2345 or by e-mail at ofr_admin@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 actions.

If there are any questions regarding the Final Report, please contact me at 916-255-2425 or by e-mail at Anna.Belmont@dmhc.ca.gov.

Sincerely,

SIGNED BY

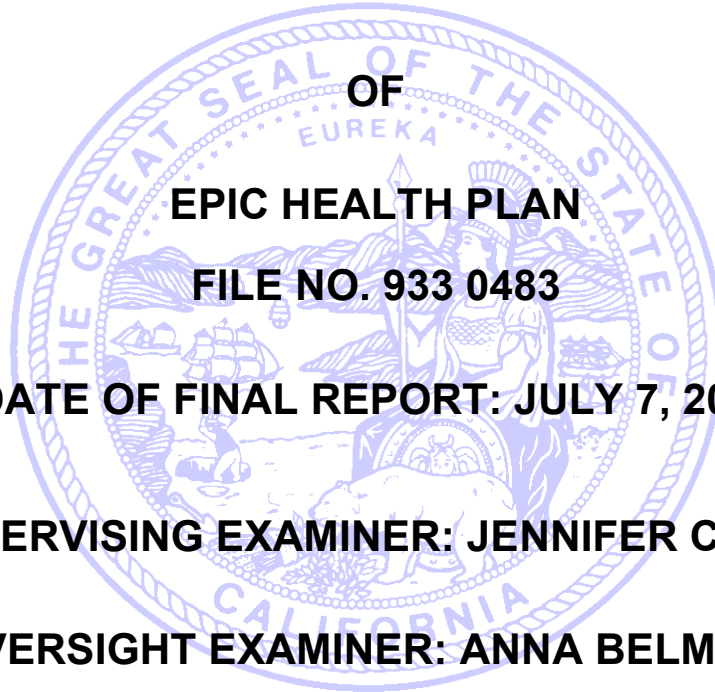
Anna Belmont
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Jennifer Swartz, Associate Director, DMHC Engagement and Operations, EPIC Health Plan
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Erica R. Short, Examiner, Division of Financial Oversight
Ashika Chiu, Examiner, Division of Financial Oversight
Danielle Phomsopha, Attorney III, Office of Plan Licensing
Chris Wordlaw, Staff Services Manager III, Office of Plan Monitoring
Chad Bartlett, Staff Services Manager II, 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: JULY 7, 2025

SUPERVISING EXAMINER: JENNIFER CLARK

OVERSIGHT EXAMINER: ANNA BELMONT

EXAMINER-IN-CHARGE: ERICA R. SHORT

FINANCIAL EXAMINERS:

TOM BRAZIL

MICHAEL CEN

ERI FUKUDA

NINA MOUA

BACKGROUND INFORMATION FOR EPIC HEALTH PLAN

Date Plan Licensed:	October 29, 2010
Organizational Structure:	EPIC Health Plan (Plan) is a for-profit, wholly-owned subsidiary of EPIC Management Services, LLC. On October 22, 2020, the Plan's parent was purchased by Collaborative Care Holdings, LLC, whose ultimate parent is UnitedHealth Group, a publicly traded company.
Type of Plan:	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 via contracts with Knox-Keene full-service health plans.
Provider Network:	The Plan contracts with medical groups, individual physicians, and hospitals to provide health care services to its enrollees.
Plan Enrollment:	As of June 30, 2024, the Plan reported 63,087 enrollees. The enrollees are contracted through other Knox-Keene licensed health care plans.
Service Area:	The Plan's service area includes portions of Los Angeles, Riverside, San Bernardino, and San Diego Counties.
Date of Prior Final Routine Examination Report:	October 05, 2021

FINAL REPORT OF A ROUTINE EXAMINATION OF EPIC HEALTH PLAN

This is the final report (Final Report) for the quarter ended June 30, 2024 of a routine examination of the fiscal and administrative affairs, including the claims settlement practices and provider dispute resolution mechanism, 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 1975.² The Department issued a preliminary report (Preliminary Report) to the Plan on March 25, 2025. The Department accepted the Plan's electronically filed responses May 9, 2025, June 6, 2025, June 17, 2025, and June 23, 2025 (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 within this Final Report.

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.

The Department examined the Plan's financial report filed with the Department for the quarter ended June 30, 2024, 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.

² References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in 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 June 30, 2024, 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://wps0.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 June 30, 2024	\$63,910,286
Required TNE	<u>11,499,587</u>
TNE Excess per Examination	<u>\$52,410,699</u>

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of June 30, 2024.

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 and defines certain claims settlement practices as “unfair payment patterns.”

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

The Department's examination found that the Plan engaged in demonstrable and unjust payment patterns and unfair payment patterns for the three-month period ended June 30, 2024, as follows:

1. CLEAR AND ACCURATE DENIAL EXPLANATION

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

Rule 1300.71(a)(8)(F) states that the Plan's failure to provide a provider with an accurate and clear 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 for the affected claims over the course of any three-month period constitutes a demonstrable and unjust payment pattern.

The Department's examination disclosed that the Plan provided an explanation that was unclear or incorrect in the following claims samples:

- 17 out of 89 denied claim samples. This deficiency was found in the following denied claims sample numbers: 3, 6, 16, 18, 22, 24, 31, 42, 48, 55, 61, 67, 68, 85, 91, 93, and 95. The Department infers with 90 percent confidence that the true compliance rate is between 73.17 percent and 86.80 percent with the upper bound being less than the required 95 percent compliance rate.
- Four out of 30 high dollar claim samples. This deficiency was found in the following high dollar sample numbers: 1, 4, 9, and 16.

In addition, the Department's examination disclosed that an inaccurate combination of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) were used in seven out of 89 denied claim samples. Specifically, along with the relevant RARC code, the Plan used "CARC 163: Attachment/other documentation referenced on the claim was not received." In these instances, the information in question was received/included in the claim, however, it was determined to be incorrect. This deficiency was found in the following denied claim sample numbers: 1, 11, 29, 59, 62, 76, and 84.

The Preliminary Report required the Plan to submit a detailed corrective action plan (CAP) that included the following:

- a. Policies and procedures, including internal claims audit procedures, implemented to ensure that all remittance advices are prepared with complete and accurate denial information. When applicable, clean and redlined versions were to be submitted to clearly identify revisions made to policies and procedures as a result of the examination.
- b. Date of implementation of the new policy and procedures.
- c. Evidence that applicable changes were made to the Plan's claim processing system.
- d. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Section and Rules.

- e. Management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that it agreed that its Policy and Procedures documents, as well as its system required updates to reflect the appropriate denial codes.

The Plan took the following actions to correct the deficiency that included the four separate issues:

- *In the cases involving RARC MA130 “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim complete/correct information,” the Plan’s leadership completed training with the staff on May 9, 2025 to instruct them to use the new codes and worked with the system improvement team to create new denial claims codes with updated language. Various new remark codes will be used based on the specifics of the claim. For example: CARC 208 “National Provider Identifier (NPI) - Not matched” if provider NPI is missing; CARC 16 “Claim/service lacks information or has submission/billing error(s)” with RARC N822 “Missing procedure modifier(s)” if modifier is missing; CARC 16 “Claim/service lacks information or has submission/billing error(s)” with RARC M49 “Missing/incomplete/invalid value code(s) or amount(s)” if value code is missing.*
- *In the case of the claims denied incorrectly with CARC 26 “Expenses incurred prior to coverage” instead of CARC 27 “Expenses incurred after coverage termination”, an examiner education was conducted on May 9, 2025 to ensure that the examiners are reminded of the importance of using the accurate codes when denying a claim.*
- *In the missing modifier case, staff was educated to not use the code CARC 163 “Attachment other documentation referenced on the claim was not received” when modifiers are missing. The new code to be used is CARC 16 “Claim/service lacks information or has submission/billing error(s)” with RARC N822 “Missing procedure modifier(s).” In addition, the leadership team will complete a random percentage audit of the denials pre-check run to ensure that these issues are captured prior to issuing a denial notice.*
- *In the case a claim is submitted with the incorrect NPI, staff were instructed on May 9, 2025 to use CARC 208 “National Provider Identifier - Not matched” rather than CARC 206 “National Provider Identifier – missing.” In addition, the Plan’s leadership worked with the system improvement team to eliminate CARC code 206 “National Provider*

Identifier – missing.”

The Plan provided the following evidence that remedial actions were taken:

- *Evidence of system correction – system ticket.*
- *Evidence of examiner correction – training attestations.*
- *Evidence of corrected policy – updated “Claims Processing” policy.*
- *Evidence of claim correction – sample remittance advices.*

The Plan will achieve and maintain compliance through the following actions:

- *It will ensure that the CARC and RARC configuration is systematically applied, therefore eliminating user error.*
- *It will ensure that the examiners remain up to date on the policy and procedure changes, thereby ensuring they are compliant with the new policy concerning denial codes.*
- *It will provide the providers with remittance advices that reflect more accurate and descriptive denials.*

The management positions responsible for ensuring continued compliance are the Manager for EPIC Facility Claims and Vice President Business Operations, Core Business Operations.

Full compliance for this deficiency was achieved on June 6, 2025.

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. OTHER CLAIMS SETTLEMENT DEFICIENCIES

1. FAILURE TO ESTABLISH FORMAL PROCEDURES FOR PROCESSING SECOND-LEVEL APPEALS

Rule 1300.71.38(f) requires the plan or the plan’s capitated provider to resolve each provider dispute or amended provider dispute, consistent with applicable state and federal law, and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.

The Department’s examination disclosed that the Plan did not issue a determination in one out of 40 provider dispute resolutions (PDRs). This occurred because it was a

second-level appeal that was forwarded to the upstream plan for review. However, neither the Plan's contract with the upstream plan nor the PDR policy specify who is responsible for reviewing second-level appeals.

The Preliminary Report required the Plan to submit a detailed CAP that included the following:

- a. Policies and procedures that addressed the handling of second-level appeals. When applicable, clean and redlined versions were to be submitted to clearly identify revisions made to policies and procedures as a result of the examination.
- b. Date the policies and procedures were implemented.
- c. Revised contracts with upstream plans that included provisions for the review of second-level appeals.
- d. Management position(s) responsible for overseeing the CAP.

The Plan agreed that its Policy and Procedures did require an update to reflect that the Plan is responsible for second-level appeals.

The Plan took the following actions to correct the deficiency:

- *A second-level appeals workflow was developed.*
- *The "PDR & Unfair Billing Pattern Policy" was updated to reflect the new second-level appeals process. The revised policy was provided to the Department.*

These actions will ensure that a monitored second level appeal process is in effect.

In addition, a revised remittance advice was provided to the Department.

The management positions responsible for ensuring continued compliance are the Manager for EPIC Facility Claims and Vice President Business Operations, Core Business Operations.

Full compliance for this deficiency was achieved on June 6, 2025.

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.