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October 30, 2015

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

FINAL REPORT OF ROUTINE EXAMINATION OF EPIC HEALTH PLAN

Dear Mr. Goodman:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of EPIC Health Plan (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 August 18, 2015. The Department accepted the Plan's electronically filed response on October 2, 2015.

This Final Report includes a description of the compliance efforts included in the Plan's October 2, 2015 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 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

¹ 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.

modify any information provided to the Department in its October 2, 2015 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://wpsso.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 S15-R-483.
- 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 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 Susan Levitt at (916) 255-2443 or email at Susan.Levitt@dmhc.ca.gov. You may also email inquiries to wpsso@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.

Sincerely,

ORIGINAL SIGNED BY

Bill Chang, CPA
Supervising Examiner
Office of Financial Review
Division of Financial Oversight

cc: Gil Riojas, Deputy Director, Office of Financial Review
Sang Le, Examiner IV (Supervisor), Division of Financial Oversight
John Yin, Examiner, Division of Financial Oversight
Jessica Tran, Examiner, Division of Financial Oversight
John Lai, Attorney, Office of Plan Licensing
Laura Dooley-Biele, Chief, Division of Plan Surveys
Dan Southard, Health Program Manager, Help Center
Paula Hood, Staff Service Manager, Help Center

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

DIVISION OF FINANCIAL OVERSIGHT

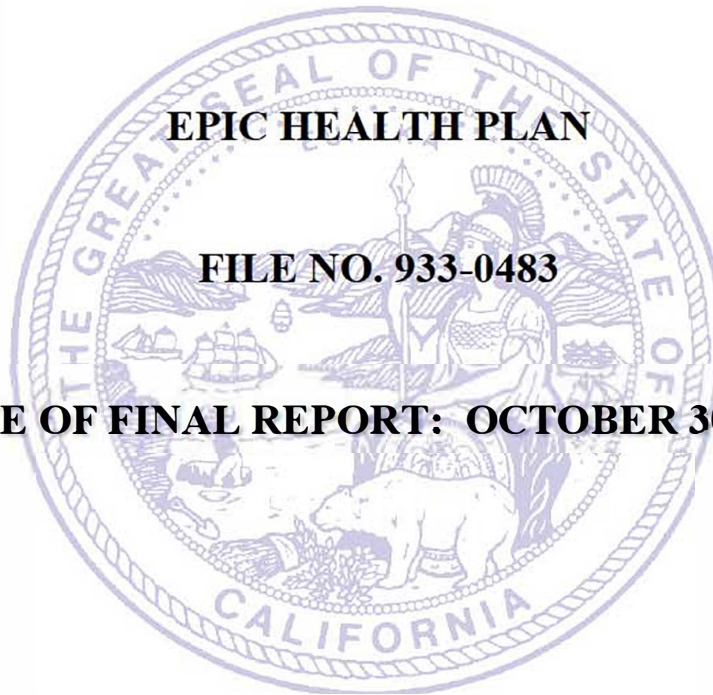
FINAL REPORT OF ROUTINE EXAMINATION

OF

EPIC HEALTH PLAN

FILE NO. 933-0483

DATE OF FINAL REPORT: OCTOBER 30, 2015



SUPERVISING EXAMINER: BILL CHANG

OVERSIGHT EXAMINER: SANG LE

EXAMINER-IN-CHARGE: JOHN YIN

FINANCIAL EXAMINERS: TOM CHANG

GETACHEW TAREKE

SULLY WONG

BACKGROUND INFORMATION FOR EPIC HEALTH PLAN

Date Plan Licensed:	October 29, 2010.
Organizational Structure:	The Plan is a wholly-owned subsidiary of EPIC Management, L.P. and was incorporated in the State of California on February 5, 2010. The Plan began its operations in January 2011 and started engaging in plan-to-plan contracts with Knox-Keene full-service health plans. The Plan has contracts with multiple Knox-Keene full-service health plans as well as a management services agreement with its parent company for designated management services.
Type of Plan:	Full Healthcare Service Plan.
Provider Network:	The Plan contracts with medical groups, individual physicians and hospitals to provide health care services to its enrollees.
Plan Enrollment:	As of March 31, 2015, the Plan has a total enrollment of 68,003.
Service Area:	The Plan's service area includes portions of Los Angeles, Riverside, and San Bernardino counties.
Date of prior Final Routine Examination Report:	April 24, 2013

FINAL REPORT OF A ROUTINE EXAMINATION OF EPIC HEALTH PLAN

This is the Final Report of a routine examination of the fiscal and administrative affairs of EPIC Health Plan (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 August 18, 2015. The Department accepted the Plan's electronically filed response on October 2, 2015.

This Final Report includes a description of the compliance efforts included in the Plan's October 2, 2015 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, 2015, 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

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 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

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended March 31, 2015, as filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link <http://wps0.dmhc.ca.gov/fe/search/#top> and selecting EPIC Health Plan on the second drop down menu.

No response was required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of quarter Ended March 31, 2015	\$ 6,484,996
Tangible Net Equity	\$ 6,484,996
Required TNE	<u>\$ 5,159,421</u>
TNE Excess per Examination	<u>\$ 1,325,575</u>

The Plan was in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of March 31, 2015.

No response was required to this Section.

SECTION III. COMPLIANCE ISSUES

A. PROVIDER DISPUTE RESOLUTION MECHANISM VIOLATIONS

Rule 1300.71.38(m)(2) states that the failure of a plan to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism shall be a basis for disciplinary action against the plan.

The Department's examination found that the Plan failed to comply with the requirements of a fast, fair and cost-effective resolution mechanism, as discussed below:

ACKNOWLEDGEMENT OF RECEIPT

Rule 1300.71.38(e)(2) requires a plan to acknowledge the receipt of each paper provider dispute within fifteen (15) working days of the date of receipt of the provider dispute by the plan office designated to receive provider disputes.

The Department's examination disclosed that the Plan had four provider disputes (PDR) during the six months ended March 31, 2015. The Plan did not issue timely acknowledgements of receipt for two (2) out of four (4) provider disputes reviewed. This deficiency was noted in provider dispute samples PDR-3 and PDR-4.

The Plan was required to state the policies and procedures implemented to resolve the above deficiency, the date of implementation, the management position(s) responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan responded that the corrective action was implemented on July 13, 2015, and the Plan's management staff responsible for ensuring continued compliance is Craig Hewitt, Director of Claims.

The Plan indicated that it has taken immediate action by realigning staff responsibilities and job duties. These corrective steps have provided the Plan with the ability to have specific, well-trained examiners that focus on processing the disputed claims. The alignment of responsibilities by IPA network will create a consistent adjudication processes with a smaller number of staff, which will also help in oversight of the process. This process provided the Plan the quickest option to address the issue immediately. The Plan has also indicated that it has taken additional steps to create an automated process in order to have the letters generated on a daily basis as opposed to its current manual process.

In addition, the Plan indicated that it has recently implemented a system upgrade to its claims processing system. One of the new features in this upgrade is to provide further monitoring of claims by system generated reports that allow the Plan to track claims as they are entered. This process includes utilizing a new system feature that allows the Plan to better track all claims, not just provider disputes.

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

B. MATERIAL MODIFICATION AND AMENDMENTS

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. Section 1352(b) and Rule 1300.52.1 require all plans to file material changes to the Plan's operations as a Notice of Material Modification to be filed twenty (20) days prior to any changes being implemented. Rule 1300.52.4 sets forth standards for amendment and notices of material modification filings.

The Department's examination disclosed that the Plan failed to comply with the filing requirements of the above Sections and Rules, as the Plan did not file the July 1, 2011 administrative service agreement (ASA) with Calibrated Healthcare Network, LLC

(Calibrated), for certain claims scanning/imaging services. Calibrated scans and forwards the claims as an electronic image to its facility in India for data entry and verification. Once the images are converted into an electronic format, they are sent back to the Plan for adjudication. The Plan was required to electronically file this ASA as an amendment with the Department through the electronic filing process. The cover page for this amendment filing was to state that it was filed as a result of the recent financial examination. The Plan was required to provide evidence (eFile number) in its response to this Report that the requested filing was submitted to the Department.

The Plan was also required to provide the policies and procedures implemented to ensure that ASA agreements are filed with the Department, the date of implementation, the management position(s) responsible for the oversight of these delegated functions and the controls implemented for monitoring continued compliance.

The Plan responded that it has electronically filed the ASA with Calibrated on September 25, 2015 as a result of the recent financial examination, and has provided eFile number 20150389-3 as evidence that the requested filing was submitted.

The Plan stated that its CEO has the overall responsibility to ensure that any change(s) in the information contained in the Plan's application, other than financial or statistical information, is filed as an amendment with the Director within thirty (30) days after the change(s) are made.

The Plan's CEO also has the overall responsibility to ensure that any material change(s) to its operations are filed as a Notice of Material Modification within twenty (20) days prior to any changes being made.

In addition, the Plan responded that its CEO has delegated to his Executive Assistant the responsibility to administer the process of providing this notification to the Department of Managed Health Care (DMHC) within the required timeframe(s).

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

C. CHANGES IN OFFICERS AND DIRECTORS

Section 1352(c) and Rule 1300.52.2 set forth the requirements that a plan shall, within five (5) days, give written notice to the director in the form as by rule maybe prescribed, of a change in the officers, directors, partners, controlling shareholders, principle creditors, or persons occupying similar positions or performing similar functions, of the plan and of a management company of the plan, and of a parent company of the plan or management company. The director may by rule define the positions, duties, and relationships which are referred to in this subdivision.

The Department's examination disclosed that the Plan did not timely file the following changes in key personnel with the Department within the five (5) day requirement:

Name	Position Title	Reason	Effective Date	Filing Date	Days > 5 days
Mark Hubbard	Board Member	New	9/24/2012	5/14/2013	154
Mel Sander	Board Member	Resigned	9/24/2012	5/14/2013	154
Dr. Roger Seheult	Board Member	New	2/17/2013	5/14/2013	55
Dr. Eric Fox	Board Member	Resigned	2/17/2013	5/14/2013	55
Dr. Charles Payton	Board Member	New	9/24/2012	5/14/2013	154
Dr. Leroy Ounanian	Board Member	Resigned	9/24/2012	5/14/2013	154
David Hutchinson	Board Member, CFO	New	9/24/2012	5/14/2013	154
Brian Fraser	Board Member	Resigned	9/24/2012	5/14/2013	154

The Plan was required to provide policies and procedures implemented to ensure that changes in key personnel are filed with the Department within five (5) days. The Plan was also required to state the date of implementation and the management position(s) responsible for ensuring continued compliance.

The Plan provided the Department with a policy and procedure relating to changes in key personnel with its response to the Preliminary Report. The Plan's policy stated that its CEO has the overall responsibility to ensure that any changes in key personnel are disclosed to the Department within five (5) business days of the change becoming effective. The Plan also indicated that its CEO has delegated to his Executive Assistant the responsibility to administer the process of providing notifications to the Department within the required five-day timeframe.

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

IV. INTERNAL CONTROL

Sections 1384 and 1345 (s), and Rule 1300.45 (q) include requirements for filing financial statements in accordance with 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.

INTEREST PAYMENT ON PROVIDER DISPUTES

The Department's examination included a review of the Plan's provider disputes and the Plan's PDR Policy and Procedures. Section #13 of this policy states that "Interest and penalties will be applied, if the payment was not shown to be a 'Gesture of Goodwill'."

The Department's review found that PDR-3 and PDR-4 were both paid as a "Gesture of Goodwill" for emergency claims; however, the Plan paid the \$15 ER interest even though no interest or penalty was due.

The overpayments of provider disputes indicate that the Plan is not consistent with its policies and procedures in handling goodwill payments, and that the Plan needs to strengthen the internal controls in place to safeguard its assets.

The Plan was required to state the policies and procedures implemented to resolve the above deficiency, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan indicated in its response to the Preliminary Report that the corrective action was implemented on July 13, 2015, and the Plan's management staff responsible for ensuring continued compliance is Craig Hewitt – Director of Claims.

The Plan responded that it had performed a systems upgrade on April 1, 2015 along with several additional feature upgrades in June 2015. During this upgrade the system was enhanced with the capability to automatically pay interest according to the established guidelines under AB1455. This new feature allows the Plan to increase controls removing the manual tracking and monitoring process from the equation, which made it vulnerable to errors. The Plan has the ability to establish many different scenarios in the system and is utilizing the feature that relates to correct interest payment. During the audit, a sample of this feature was provided to the auditors to validate the new process. The Plan has also taken some additional precautions and realigned the staff responsibilities and job duties. This has created a unique pod of examiners that focus on processing the disputed claims. By separating the responsibilities, the Plan creates consistent adjudication processes with a smaller number of staff, which helps in oversight of the process.

The Plan stated that it has a number of reports to monitor the claims by tracking the adjudication codes which are used to separately identify interest payment and reduce possible overpayments caused by the use of incorrect codes. In addition, the Plan will monitor this process on a monthly basis as it has a direct impact on reporting data accurately to the Health Maintenance Organizations that the Plan is contracted with.

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