INTERIM REPORT OF PRIMARY PROVIDER MANAGEMENT COMPANY, INC.
TO THE CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE
REGARDING CLAIMS DEPARTMENT PRACTICES

May 17, 2018
I. Introduction

Primary Provider Management Company, Inc. (“PPMC” or the “Company”) provides management services, including claims adjudication and provider dispute resolution, to a network of California independent physician associations, including Vantage Medical Group, Inc. (“Vantage”), First Choice Medical Group (“FCMG”), Los Angeles Medical Center IPA (“LAMC”), and Cal Care IPA (collectively, “The IPAs”). PPMC submits this Interim Report on behalf of The IPAs regarding the disclosure letter sent to the California Department of Managed Health Care (“DMHC”) on February 15, 2018 and captioned “RBO No. 10488: Examination of Vantage Medical Group, Inc. Claims Settlement Practices and Provider Dispute Resolution Mechanism Claims” (the “Disclosure Letter”). The factual information contained in this Interim Report was developed with the assistance of outside legal counsel, Sheppard, Mullin, Richter & Hampton LLP, and Navigant Consulting, Inc. The facts relate to the historical practices of PPMC’s Claims Department that were the subject of the Disclosure Letter.

The facts in this Interim Report are based on PPMC’s internal investigation conducted to date. Related external audits and investigations conducted by DMHC and various health plans are ongoing and may cause PPMC to discover additional facts through the course of responding to various requests for information. Accordingly, PPMC reserves the right to supplement this Interim Report with additional facts as they may become available in the course of responding to parallel external audits and investigations.

II. Executive Summary

On February 15, 2018, PPMC, through its corporate parent, disclosed to DMHC certain improper practices it recently discovered within its Claims Department (the “Claims Department”). PPMC takes these matters seriously and has invested substantial resources to investigate the facts and circumstances related to the Claims Department’s historical practices. PPMC is committed to identifying and addressing these improper practices including implementation of corrective actions as appropriate. Consistent with that commitment, PPMC has cooperated, and will continue to cooperate, with audits and other requests made by DMHC and health plans contracted with The IPAs.

PPMC has confirmed the following historical practices occurred in the Claims Department:


2. PPMC recently learned from DMHC and health plans of an anonymous letter that contains allegations of improper conduct regarding PPMC’s UM and Claims Departments. Although PPMC has not yet received a copy of the anonymous letter, it has commenced a comprehensive investigation of its UM processes and practices, including employee interviews, process reviews, data and reporting assessments, and audit results, among other action items. In addition, the Company commissioned an external audit of its UM function in January 2018 and retained outside advisors to initiate a comprehensive redesign of its UM program shortly thereafter as part of a comprehensive program to upgrade the personnel, processes, and technology engaged in its MSO operations. PPMC will provide an update of its Claims and UM-related findings when its investigations are completed.

A copy of the disclosure letter is attached as Exhibit A.
1. For several years, a small group of Claims Department personnel altered documents within claims audit files before presenting them to auditors from DMHC and health plans as though they were true and correct copies of original documents.

2. During approximately the same period, a staff member in PPMC’s Information Services Department (the “IS Department”), acting at the direction of the same small group of Claims Department personnel, altered data related to closed claims within the “Xpress” database (used by PPMC to house claims-related data). These alterations were unauthorized and incorporated into documents included within claims audit files.

3. During approximately the same period, Claims Department personnel and the above-referenced IS Department staff member, acting at the direction of Claims Department management, applied specific data codes within the Xpress database to certain claims and forward-dated (i.e., made more recent) their respective “date received” data fields. As a result of this improper practice, certain claims were late-paid without interest and excluded from subsequently prepared monthly timeliness reports and audit Universes submitted to DMHC and health plans.

These improper practices were conceived and implemented several years before PPMC was acquired by its current corporate parent in approximately July 2016, and they were stopped by PPMC’s current Director of Claims immediately following their discovery in late January 2018.4 PPMC has implemented or is in the process of implementing a comprehensive set of corrective actions to address these practices.

To date, no facts have been identified that suggest these improper practices were known or directed by senior leadership above the Senior Director of Claims. The Senior Director of Claims and Director of Claims responsible for these improper practices voluntarily left PPMC in July and November, 2017, respectively. Further, no facts have been identified that suggest these improper practices were known to anyone outside of the Claims Department, except for a single IS Department staff member. And importantly, no facts have been identified that suggest these improper practices resulted in substandard quality of care for health plan members.

III. Investigation Background

A. The Current Director of Claims Identified Questionable Claims Department Practices

Wendy Magnacca, PPMC’s current Director of Claims, started working at PPMC on November 3, 2017. PPMC’s former Director of Claims, Mary Maxon, was still working at PPMC at this time. However, Ms. Maxon resigned from PPMC shortly thereafter, effective November 24, 2017.

4 The current Director of Claims was hired by PPMC’s current corporate parent as part of a program to centralize and standardize its MSO functions and integrate them within an enterprise level Compliance Department.
On January 26, 2018, two Claims Auditors in the Claims Department, Mariam Siddiq and Joanne Saycon, requested guidance from Ms. Magnacca regarding preparation for an upcoming health plan audit of the Claims Department. Specifically, Ms. Siddiq and Ms. Saycon wanted to know whether they should prepare for the audit following the same practices in place under Ms. Maxon and the former Senior Director of Claims, Roberto Aguinaldo. Ms. Siddiq and Ms. Saycon told Ms. Magnacca that, under the direction of Mr. Aguinaldo and Ms. Maxon, Claims Auditors prepared for claims audits by reviewing claims audit files and “fixing” any problems before presenting the files to outside auditors.

This was the first time that Ms. Magnacca heard that such a practice had been used in the Claims Department. Prior to this incident, Ms. Magnacca had not supervised Claims Department personnel with respect to claims audit preparation. She told Ms. Siddiq and Ms. Saycon that they were not permitted to fix or otherwise alter the contents of audit files, and that they must immediately discontinue that practice.

On January 29, 2018, two additional Claims Department staff members, Sisi King, a Claims Auditor, and Vicki Verkler, a Claims Analyst III, separately spoke with Ms. Magnacca and reported their concerns regarding potential improper applications of “special project” and “goodwill” code designations to claims. Improper uses of these code designations could cause certain claims to be excluded from monthly reports and audit Universes provided to DMHC and health plans.

On January 29, 2018, Ms. Magnacca promptly escalated these issues to her enterprise-level supervisor, Veeral Desai.

B. Investigation Tasks

On February 2, 2018, PPMC’s corporate parent formed an internal investigation team led by attorneys from Sheppard, Mullin, Richter & Hampton, LLP (“Sheppard Mullin”) to investigate the issues escalated by Ms. Magnacca. On February 6, 2018, Sheppard Mullin retained Navigant Consulting, Inc. (“Navigant”) to assist with the internal investigation. PPMC provided Sheppard Mullin and Navigant with full access to its records, data, and personnel, including current and former employees. PPMC and its corporate parent further supported the internal investigation by making available human resources as needed to perform tasks directed and supervised by Sheppard Mullin and Navigant.

1. Witnesses Interviewed

Sheppard Mullin interviewed the witnesses listed in Table 1 as part of the internal investigation:

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5 Ms. Siddiq and Ms. Saycon were subsequently reassigned to different positions within PPMC.
6 IEHP conducted a claims audit in November 2017, after Ms. Magnacca joined PPMC. However, she did not supervise the Claims Department’s effort to prepare audit files for that audit. Ms. Maxon supervised that effort.
<table>
<thead>
<tr>
<th>Witness Name</th>
<th>Witness Job Title</th>
<th>Date(s) of Interview(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joanne Saycon</td>
<td>Claims Auditor</td>
<td>2/2/2018, 2/8/2018</td>
</tr>
<tr>
<td>Mariam Siddiq</td>
<td>Claims Auditor</td>
<td>2/2/2018, 2/8/2018, 3/14/2018</td>
</tr>
<tr>
<td>Vicki Verkler</td>
<td>Claims Analyst III</td>
<td>2/2/2018</td>
</tr>
<tr>
<td>Sisi King</td>
<td>Claims Auditor</td>
<td>2/2/2018</td>
</tr>
<tr>
<td>Michael Thomas</td>
<td>Sen. Database Administrator</td>
<td>2/5/2018</td>
</tr>
<tr>
<td>Rebecca Johnson</td>
<td>(Former) Application Development Manager</td>
<td>2/7/2018, 3/7/2018</td>
</tr>
<tr>
<td>Jeremy Encarnacion</td>
<td>Claims Supervisor</td>
<td>2/8/2018, 3/7/2018</td>
</tr>
<tr>
<td>Morrison</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pauline Lozano</td>
<td>Claims Auditor</td>
<td>3/7/2018</td>
</tr>
<tr>
<td>Marvelene Phrakonekham</td>
<td>Claims Supervisor</td>
<td>3/7/2018</td>
</tr>
<tr>
<td>Michelle Shaner</td>
<td>(Former) Claims Auditor, (Current) Provider Relations Coordinator</td>
<td>3/14/2018</td>
</tr>
<tr>
<td>Karen Hiteshi</td>
<td>(Former) Chief Operating Officer</td>
<td>3/19/2018</td>
</tr>
<tr>
<td>Ion Baroi</td>
<td>(Former) Senior Vice President</td>
<td>3/19/2018</td>
</tr>
<tr>
<td>Mary Maxon</td>
<td>(Former) Director of Claims, no longer employed by PPMC</td>
<td>4/10/2018</td>
</tr>
<tr>
<td>Roberto Aguinaldo</td>
<td>(Former) Senior Director of Claims, no longer employed by PPMC</td>
<td>4/30/2018</td>
</tr>
</tbody>
</table>

Sheppard Mullin attempted to interview Diane Eagle and Amanda Castro, who are both former Claims Auditors and are no longer employed by PPMC. Both declined to be interviewed.
2. **Documents Reviewed**

Sheppard Mullin reviewed approximately 26,000 emails culled for relevance from over 2 million emails collected through the application of keyword and sender/recipient filters, date parameters, and other “smart” search techniques.

Navigant, at the direction of Sheppard Mullin, collected the computer hard drives used by the following current and former PPMC employees for evidence of potential document alteration:

- Robert Aguinaldo
- Ion Baroi
- Dianne Eagle
- Karen Hiteshi
- Rebecca Johnson
- Mary Maxon
- Jeremy Morrison
- Marvelene Phrakonekham
- Joanne Saycon
- Michelle Shaner

Navigant, at the direction of Sheppard Mullin, also forensically analyzed audit files prepared by the Claims Department in connection with the following audits for evidence of potential document alteration:

- 2014 Molina Healthcare audit of Vantage
- 2015 Inland Empire Health Plan (“IEHP”) audit of Vantage
- 2015 Blue Shield of California audit of Vantage
- 2016 Health Net audit of LAMC
- 2017 DMHC audit of Vantage
IV.  Investigation Findings

A.  Alterations of Claims Audit Files

1.  General Overview of Claims Audit Process

DMHC and health plans that contract with The IPAs periodically audit PPMC’s Claims Department. The audit process generally proceeds as follows:

First, the auditing entity (i.e., DMHC or a health plan) requests from the subject IPA a set of data – commonly called a “Universe” – related to all claims that were closed within a specified time period (e.g., January 1 through March 31 of a given year) and meet other specified criteria (e.g., paid claims, contested claims, denied claims, Medicare claims, MediCAL claims, etc.). The auditing entity may specify the types of data to be provided for each claim in the Universe (e.g., claim number, date of service, amount paid, etc.). PPMC provides Universes in response to these requests. Depending on the scope of the request, a Universe can include tens or hundreds of thousands of claims.

Second, the auditing entity selects from the Universe a subset of claims (generally numbering in the hundreds) to audit. The claims in this subset are commonly referred to as “audit selections.”

Third, PPMC prepares an audit file related to each audit selection that consists of copies of the claim form, the claim summary screen from the Xpress database, and other records related to PPMC’s processing of the claim such as correspondence between PPMC and the claimant (i.e., the provider), medical records related to the claimed service, explanation of payment (“EOP”), and bank-provided check registries showing the amounts and cashing dates of payment checks to providers. PPMC then provides the audit files to the auditing entity – in hard copy or in PDF format, depending on the preference of the auditing entity and the audit.

Finally, the auditing entity conducts its audit based primarily on the audit files.

2.  Alteration of Documents Within Claims Audit Files

Beginning no later than September 2014, and potentially as early as sometime in 2013, and running through late-January 2018, a small group of Claims Department personnel (the “Audit Preparation Group”) reviewed and altered claims audit files to change content that would potentially result in a negative audit finding. The altered files would later be presented to DMHC or the health plans as though they were unaltered original files.

a.  The Audit Preparation Group

The members of the Audit Preparation Group changed over time. The earliest members of the Group appear to have been Jeremy Encarnacion Morrison, Amanda Castro, and Dianne Eagle.7 Ms. Castro and Ms. Eagle resigned from PPMC some time ago.

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7 Mr. Encarnacion Morrison claimed that he was initially instructed to alter claims audit files by Miriam Regalado, a Director of Claims whose tenure at PPMC preceded both Mr. Aguinaldo and Ms. Maxon’s. No corroborating facts have been identified that support Mr. Encarnacion Morrison’s claim.
Roberto Aguinaldo, the former Senior Director of Claims, became aware of the Audit Preparation Group’s document alteration practice no later than early 2015. There are no facts to suggest that he affirmatively tried to stop the improper practice. Nor are there any facts suggesting that Mr. Aguinaldo affirmatively directed the Group’s activities or altered audit files himself. Mr. Aguinaldo resigned from PPMC in late-July 2017. He stated that he was “drained out.”

Former Director of Claims, Mary Maxon, also became aware of the Audit Preparation Group’s document alteration practice no later than early 2015. She, like Mr. Aguinaldo, did not attempt to stop the improper practice. To the contrary, Ms. Maxon ultimately started directing the Audit Preparation Group’s document alteration efforts, recommended specific alterations, and reviewed and approved alterations made by less experienced Group members. Ms. Maxon resigned from PPMC in late-November 2017. Her stated reason for resigning was “dissatisfaction with work.”

Other Claims Department members of the Audit Preparation Group who altered audit files are (in approximate order of when they joined the Group): Michelle Shaner, Pauline Lozano, Marvelene Phrakonekham, Mariam Siddiq, and Joanne Saycon.

A Claims Analyst, Vicki Verkler, appears to have unwittingly facilitated the Audit Preparation Group’s document alteration practice by helping them identify potential claim processing errors and advising on how to avoid them. Ms. Verkler stated that she believed her advice was prospective in nature, and did not realize that the Group was in fact using her advice to alter documents. Ms. Verkler stated that she ceased providing such assistance when she learned of the document alteration practice. No facts identified support that Ms. Verkler altered documents herself.

No facts have been identified that PPMC’s senior management, Ion Baroi and Karen Hiteshi, who were with the Company from December 2012 until May 2018, were aware of the Audit Preparation Group’s document alteration practice. All witnesses interviewed on this issue stated that they did not discuss the document alteration practice with PPMC’s senior management, and that they did not believe that PPMC’s senior management knew about the practice. To the contrary, members of the Audit Preparation Group stated that they attempted to conceal the practice from all non-Group members by, for example, making alterations outside of normal business hours. Mr. Baroi and Ms. Hiteshi denied any knowledge of the improper practice.8

b. Reasons for Document Alterations

All Audit Preparation Group members interviewed stated that they altered documents to avoid negative audit results. For example, if information appearing on the face of a document, such as a date, was (or was perceived to be) indicative that the claim was not timely dispositioned, such information would be removed from the document and/or replaced with innocuous information.

8 As further detailed in Section V (Corrective Action), Mr. Baroi and Ms. Hiteshi have been separated from PPMC, and controls to strengthen and require senior management’s visibility into Claims Department practices are planned and in development.
It should be noted, however, that no evidence has been identified to suggest that PPMC’s senior management pressured or encouraged the Claims Department to improve its claims audit results through improper means.

c. **Alteration Methodology**

The Audit Preparation Group’s primary tool used to alter documents was Adobe software. PPMC, directly or through independent third party service providers, maintains a library of digital copies of original claims-related documents. Using Adobe software, Audit Preparation Group members created a digital copy of an original document; added, changed, or removed content from the copy; then printed the altered copy and inserted it into an audit file in place of the original.

No evidence has been identified suggesting that any original documents were altered or deleted using this method.

d. **Types of Alterations**

The following types of alterations to claims files have been identified:

1. **Dates and “Date Received” Information**

   Alterations to document dates and “date received” information have been identified.

   - **Exhibit B** illustrates an alteration to the date of a document. The altered document was identified within the audit files prepared in connection with the 2017 DMHC audit of Vantage.

   - **Exhibit C** illustrates an alteration to “date received” information. The altered document was identified within the audit files prepared in connection with the 2017 DMHC audit of Vantage.

2. **Secondary Payor Information**

   Alterations to information related to secondary payors have been identified.

   - **Exhibit D** illustrates an alteration to information related to a secondary payor. The altered document was identified within the audit files prepared in connection with the 2015 Blue Shield of California audit of Vantage.

3. **Check Registries**

   Alterations to bank-generated check registries have been identified.

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9 Mr. Encarnacion Morrison claimed to be aware of document alterations made using white-out. This claim has not been corroborated.
• **Exhibit E** illustrates an alteration to a bank-generated check registry where the date on which a check was cashed was changed. The altered document was identified within the audit files prepared in connection with the 2016 Health Net audit of LAMC.

• **Exhibit F** illustrates an alteration to a bank-generated check registry where a check was added. The altered document was identified within the audit files prepared in connection with the 2016 Health Net audit of LAMC.

(4) **Provider Dispute Resolution (“PDR”) Information**

Alterations to providers’ comments on PDRs have been identified.

• **Exhibit C** illustrates an alteration to a PDR where portions of the provider’s comments were removed.

  e. **Results of Navigant’s Claims Audit Reviews**

Table 2 summarizes the results of Navigant’s review of historical claims audits.

<table>
<thead>
<tr>
<th>Date/Date Received</th>
<th>2014 Molina Audit</th>
<th>2015 IEHP Audit</th>
<th>2015 Blue Shield of CA Audit</th>
<th>2016 Health Net Audit</th>
<th>2017 DMHC Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Audit</td>
<td>9/17/2014</td>
<td>4/20/2015</td>
<td>7/17/2015</td>
<td>2/23/2016</td>
<td>8/7/2017</td>
</tr>
<tr>
<td>Claims in Audit</td>
<td>113</td>
<td>54</td>
<td>120</td>
<td>98</td>
<td>255 (^{10})</td>
</tr>
<tr>
<td>Claims Altered</td>
<td>28</td>
<td>23</td>
<td>28</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td>Total Alterations (^{11})</td>
<td>28</td>
<td>23</td>
<td>29</td>
<td>21</td>
<td>18</td>
</tr>
</tbody>
</table>

**Table 2**

10 The 2017 DMHC audit included claims processed by FCMG using its EZ CAP claims database system, which is separate from the Xpress database system used by PPMC. No alterations were identified with respect to claims processed by FCMG, and no facts identified suggest that FCMG was aware of or participated in any of the improper practices discussed in this Interim Report. FCMG joined PPMC’s network after PPMC was acquired by its current corporate parent.

11 Some claims exhibited more than one alteration.
Based on witness interviews and Navigant’s historical claims audit sampling, there is a reasonable belief that the Audit Preparation Group altered audit files from the inception of the practice through January 2018, except for claims audits where PPMC was permitted to make its own audit selections. Witnesses from the Audit Preparation Group stated that they did not alter audit files when PPMC was allowed to make its own audit selections.

3. **Alterations to Data Contained in the Xpress Database**

Certain documents such as EOPs are printed from the Xpress database and added to audit files presented to DMHC and the health plans. The Audit Preparation Group, with the assistance of a member of the IS Department, Rebecca Johnson, altered certain original data in the Xpress database before printing related documents for use in the audit file. These alterations were not authorized by PPMC’s policies and procedures. Outside auditors receiving audit files that contained such documents would not know that the documents had been altered or were different from the original versions sent to providers.

This practice appears to have occurred over substantially the same period of time as the document alteration practice described in Section IV.A.2. It also appears that the Audit Preparation Group’s reason for making data alterations in Xpress was to avoid negative audit results.

**a. Alteration Methodology**

Claims Department personnel do not have rights to alter or change claim-related data in the Xpress database after the claim has been closed. Because outside auditing entities make audit selections from a Universe of closed claims, the Audit Preparation Group requested the assistance of Ms. Johnson, who had requisite database rights, to help them alter data related to closed claims. Specifically, members of the Audit Preparation Group sent emails to Ms. Johnson with requests to alter certain data and Ms. Johnson complied.

**b. Types of Alterations**

The following types of alterations to claims files have been identified:

1. **Claim Adjudication Codes**

Alterations to claim adjudication codes have been identified.
• Exhibit G illustrates a request to change the denial codes related to a closed claim.

(2) Notes and Remarks

Alterations to notes, remarks, and other text incorporated into documents sent to providers have been identified.

• Exhibit H illustrates a request to add data in the remarks field of a closed claim.

c. Alteration Scope

Based on witness interviews and email review, there is a reasonable belief that the Audit Preparation Group altered Xpress data related to closed claims selected for audit from the inception of the practice through January 2018.

B. Manipulation of Reportable Claims Data

1. Overview of “Goodwill” and “Special Projects”

PPMC is required to process claims in compliance with applicable requirements, including rules governing timelines. In the event that properly submitted claims are processed late, PPMC may be required to pay interest to the providers. Conversely, PPMC may deny claims that are not submitted in compliance with applicable requirements.

PPMC is permitted, but not required, to deny improperly submitted claims. It has the discretion to pay such claims as a gesture of “goodwill” (“Goodwill Claims”). Thus, where a provider’s claim is technically improper, but PPMC determines there is good cause to pay the claim anyway, it may do so. Because Goodwill Claims are paid at the discretion of PPMC, such payments generally do not include interest even if they are made outside of the timeframe applicable to properly submitted claims. PPMC identifies Goodwill Claims in the Xpress database by a specific user-applied code.

Similarly, providers are permitted to waive interest owed to them due to PPMC’s noncompliance with applicable processing timelines. For example, in instances where a provider has submitted a large number of claims and some of them were paid late by PPMC, the provider may agree to waive its claim to interest on the late-paid claims in exchange for early payment of its outstanding claims or payment of a lump sum to settle all claims submitted over a specified time period. PPMC personnel commonly refer to compromises or settlements with providers related to the payment of claims as “Special Projects.” In this Interim Report, claims paid pursuant to a Special Project agreement are called “Special Project Claims.” Like Goodwill Claims, PPMC identifies Special Project Claims in the Xpress database by a specific user-applied code.

PPMC’s Contracting Department negotiates the terms of Special Projects on behalf of PPMC. Formerly, Mr. Baroi was also involved in the process; he took the lead on negotiations where there was a significant amount of money at issue. The terms of Special Projects are documented in written agreements signed by PPMC and the settling provider.
2. **Overview of Timeliness Reporting**

PPMC, on behalf of The IPAs, is required to provide Monthly Timeliness Reports ("MTRs"), among other periodic reports, to DMHC and health plans. Generally, an MTR provides claims data related to PPMC’s compliance with applicable claims processing timelines. In addition, as discussed in Section IV.A.1, PPMC prepares claims data Universes in connection with audits conducted by DMHC and health plans. Universes, which provide selected data, but not the underlying documents, associated with closed claims, typically include data sufficient to show whether claims were timely processed.

Beginning in early 2014, if not earlier, PPMC excluded Goodwill and Special Project Claims from MTRs and Universes. Witnesses stated that because Goodwill Claims are claims that PPMC could have denied, they should not be considered when evaluating PPMC’s compliance with respect to processing properly submitted claims. They also explained that because providers agreed to compromise or settle their complaints regarding Special Project Claims in exchange for payment, there was no need to report Special Project Claims to DMHC or health plans. It has also been explained that Goodwill Claims were excluded from MTRs and Universes because DMHC and health plans did not expressly request that they be included. For example, Mr. Aguinaldo stated that Ms. Maxon received permission from two health plans to exclude Goodwill and Special Project Claims from MTRs and Universes.

3. **Misuse of Goodwill and Special Project Codes and Forward-Dating**

No later than August 2014, and potentially earlier than that, Claims Department personnel had a practice of applying Goodwill and Special Project Claim codes to claims that did not qualify for either designation. Many personnel throughout the Claims Department (i.e., beyond the members of the Audit Preparation Group) had been instructed to code claims that PPMC failed to pay within the applicable timeframe (also referred to as “out-of-compliance” or “OOC” claims) as both Goodwill and Special Project Claims in the Xpress database. In addition, Claims Department personnel knew how to, and did, forward-date the “received date” data field on OOC claims to make it appear that the applicable processing timeframe had not yet expired. This practice was corroborated by emails.

a. **Effect of Code Misuse and Forward-Dating**

It appears that by applying both Goodwill and Special Project Claim codes to OOC claims, Claims Department personnel were able to exclude such claims from MTRs and audit Universes. IS Department personnel, including Ms. Johnson and potentially others, modified queries used to gather MTR and audit Universe data from the Xpress database so that they excluded claims coded as Goodwill and Special Project.

b. **Responsible Personnel**

Emails suggest that multiple levels of Claims Department personnel, as well as Ms. Johnson from the IS Department, applied codes to, and forward-dated the received dates of, OOC claims as described above. According to emails, they received direction from Mr. Aguinaldo, Ms. Maxon, and Claims Department supervisors and auditors.
c. **Unknown Scope**

The scope and amount of the code misuse and received date changes described above are unknown. Two significant obstacles to determining the scope and amount of this improper practice are (1) the unreliability of received date data in the Xpress database (due to forward-dating), (2) de-centralization of records documenting legitimate Goodwill and Special Project Claims, such as Special Project agreements, which complicates differentiating between authorized and unauthorized Goodwill and Special Project Claims.

V. **Corrective Action**

PPMC appreciates the seriousness of the above-described improper practices and is committed to implementing corrective actions to prevent them from recurring. Substantial resources have been committed to effecting appropriate remediation. Some corrective actions were promptly implemented shortly after discovery of the improper practices. Other corrective actions are in the process of being implemented in parallel with the internal investigation and with the assistance of Navigant.

A. **Corrective Actions Implemented**

1. **New Leadership**

Current ownership has affected wholesale and transformational changes throughout PPMC’s leadership and organizational structure. Since the acquisition of PPMC in July 2016, the following senior leaders have joined the Company:

- Joan Danieley, Group President, MSO Operations
- Manoj Mathew, M.D., President, California Market
- John Wallace, Chief Operating Officer, California Market
- Sunmi Janicek, Chief Compliance Officer
- John Avila, Senior Director of Information Services
- Wendy Magnacca, Director of Claims

2. **Enhanced Systems**

A transition from PPMC’s legacy Xpress database system to a new CORE technology platform with enhanced reporting, controls, functionality and performance, is already underway. CORE, which is already implemented in non-California markets, is part of current ownership’s investment in enhancing, centralizing, and standardizing its MSO functions, vendors, and capabilities. The new platform is expected to ensure payment and processing accuracy. In addition, the new technology will enable end-to-end auditing at the process, team, and oversight levels to ensure accurate, timely, and compliant reporting.
3. **Improper Practices Stopped**

The improper practices discussed in this Interim Report have been discontinued.

- PPMC senior management (Mr. Baroi and Ms. Hiteshi) have exited the Company.
- Claims Department leadership that directed and condoned the improper practices detailed herein have exited the Company.
- All Claims and IS Department personnel known to have altered audit files have been terminated.
- The current Director of Claims, Ms. Magnacca, has not been implicated in any of the improper conduct. She recognized the potential impropriety of the Audit Preparation Group’s historical practices when they were brought to her attention in late January 2018 and immediately escalated the information to appropriate supervisors.
- Since late January 2018, Ms. Magnacca and/or Ms. Janicek have supervised the Claims Department’s audit preparation activities, ensuring that (1) Universes include all required data, including claims coded as Goodwill and Special Project, and (2) audit files are not altered in any way.
- Since November 2017, the queries used to gather MTR data from the Xpress have been corrected so they no longer exclude claims coded as Goodwill or Special Project. In April 2018, Navigant completed a project to standardize PPMC’s methodologies for preparing MTRs and Universes to ensure compliance with applicable requirements.
- Ms. Magnacca has had in-person meetings with all current Claims Department personnel known to have altered audit files. She will conduct periodic refresher meetings with all Claims Department personnel to ensure ongoing compliance with the corrective actions.
- Ms. Magnacca has provided in-person coaching to Claims Department personnel regarding the proper use of Goodwill and Special Project Claim codes. The Company’s policies and procedures related to Goodwill and Special Project Claims are currently under review. Database-level corrective action to ensure compliance with these policies and procedures is in development.

**B. Corrective Actions Planned**

Table 3 sets forth additional corrective actions that are planned and/or in-progress, along with their estimated time to completion.
<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Est. Time to Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company-wide compliance training, including tailored programs for the Claims Department and PPMC’s senior management.</td>
<td>Completed</td>
</tr>
<tr>
<td>Implementation of controls to regulate access to document editing software (e.g., Adobe):</td>
<td>(a) Completed</td>
</tr>
<tr>
<td>(a) Restrict Claims Department personnel access to document editing software.</td>
<td>(b) Q3 2018</td>
</tr>
<tr>
<td>(b) Establish enhanced process for granting approval for access to document editing software.</td>
<td></td>
</tr>
<tr>
<td>Navigant will develop the MTR reporting criteria and code to be used for MTR and universe reporting going forward.</td>
<td>Q2 2018</td>
</tr>
<tr>
<td>Pending completion of this corrective action item, Navigant will assist PPMC to ensure audit universes are accurate, complete, and comply with federal and state requirements.</td>
<td>Q3 2018</td>
</tr>
<tr>
<td>Navigant will develop and document practices and procedures related to claims data reporting, including reporting requirements and criteria, quality controls, and training.</td>
<td>Q3 2018</td>
</tr>
<tr>
<td>Increased focus on compliance monitoring as a performance measurement and indicator relative to PPMC’s mid-level and senior management.</td>
<td>Q3 2018</td>
</tr>
<tr>
<td>Review and enhancement of PPMC’s legacy Compliance policies and procedures.</td>
<td>Q3 2018</td>
</tr>
<tr>
<td>Review and enhancement of Claims Department policies and procedures to ensure compliance with applicable regulatory requirements and best practices.</td>
<td>Q3 2018</td>
</tr>
<tr>
<td>Implementation of company-wide internal audit unit at PPMC for compliance with PPMC’s internal policies and procedures, PPMC’s code of conduct, and all applicable statutory, regulatory, and contractual rules and requirements. Three levels of audits are planned to be implemented:</td>
<td>Q4 2018</td>
</tr>
<tr>
<td>• Corporate Internal Audit – including audits of internal control processes of claims processing and other key functions</td>
<td></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Est. Time to Complete</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>• Compliance Internal Audit – to test compliance with applicable contract and regulatory requirements</td>
<td></td>
</tr>
<tr>
<td>• Claims Department Audit – with attention to departmental quality control</td>
<td></td>
</tr>
<tr>
<td>Document policies and procedures relative to the use of Goodwill and Special Project Claims, and develop monitoring process to for quality and compliance.</td>
<td>Q4 2018</td>
</tr>
<tr>
<td>Implementation of controls to validate the integrity of claims audit files (to be executed in collaboration with Compliance Department)</td>
<td>Q4 2018</td>
</tr>
<tr>
<td>Implementation of internal reporting and monitoring functions to ensure data integrity, identify vulnerabilities, and control database access</td>
<td>Q4 2018</td>
</tr>
<tr>
<td>Implementation of database-level controls to regulate and record data and database changes effected by IS Department personnel</td>
<td>Q4 2018</td>
</tr>
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</table>

VI. **Conclusion**

PPMC is committed to completing a thorough investigation of these improper practices and implementing appropriate corrective action and remediation. It will continue to fully cooperate with DMHC and health plan audits and investigations, and do everything possible to earn their trust.
Exhibits
Exhibit A

[February 15, 2018 Letter to DMHC]
February 15, 2018

VIA ELECTRONIC MAIL ONLY

Derek Jang
Corporations Examiner
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814
Email: derek.jang@dmhc.ca.gov

Re: RBO No. 10488
Examination of Vantage Medical Group, Inc. Claims Settlement Practices and Provider Dispute Resolution Mechanism

Dear Mr. Jang:

I am the Chief Compliance Officer for agilon health ("agilon"), whose subsidiary, Primary Provider Management Co., Inc. ("PPMC"), serves as the MSO for Vantage Medical Group, Inc. The purpose of this letter is to promptly notify you of recently-discovered events that may call into question the reliability of certain information provided to DMHC in connection with the above-referenced audit (the "Vantage Audit"). The following preliminary information is provided out of an abundance of caution and is based on an ongoing internal investigation that recently commenced and is subject to revision.

In mid-2017, agilon embarked on a program to centralize and standardize its MSO functions. As part of that process, agilon hired a new Director of Claims for PPMC in November 2017. In late January 2018, the new Director of Claims first received information that PPMC Claims Department personnel, acting on instructions given by the former Director of Claims (whose employment terminated in November 2017), reviewed and potentially altered some records compiled in connection with the Vantage Audit before providing those records to DMHC. The new Director of Claims immediately reported this information to her senior management and a task force, including outside legal counsel and consultants, was promptly created to investigate the situation.

The initial investigation included an immediate analysis of the records comprising the 255 audit files provided to DMHC in connection with the Vantage Audit. While that analysis is not yet complete, I can report the following preliminary findings:

- 2 audit files contain records signed by a provider that exhibit alteration to the signature date
- 1 audit file contains a FedEx receipt that exhibits alteration to the document date
9 audit files contain Provider Dispute Resolution forms that had provider comments removed from the "Description of Dispute" field.

We also have commenced an analysis of the claims data — also referred to as the "claims universe" — submitted to DMHC in connection with the Vantage Audit. Our initial findings identified a variance of approximately 25% of claims that potentially should have been included in the claims universe, but were not. At this point, we do not have a complete understanding of the methodology used to prepare the claims universe sent to DMHC or whether the potentially omitted claims influenced the outcome of the Vantage Audit. However, our preliminary analysis suggests that inclusion of the potentially omitted claims would not materially affect the aggregate timeliness of the claims universe.

The above-described analyses of the 255 audit files and the claims universe related to the Vantage Audit are only two components of our overall investigation plan. Additional research and analyses that are planned or already underway include (1) evaluation of the methodology used to prepare the Vantage Audit claims universe and whether it contained all required information; (2) reviews of additional audit files and claims universes prepared in connection with audits predating the Vantage Audit of all medical groups within PPMC’s MSO network, including audits conducted by health plans; and (3) reviews of historical Monthly Timeliness Reports submitted to health plans on behalf of all medical groups within PPMC’s MSO network to ensure that they comply with applicable requirements.

In addition, PPMC has already taken the following steps to prevent recurrence of the alterations noted above:

- The practice of altering audit files prior to audit submission has been stopped.
- Pending the outcome of our investigation, which may require additional corrective and/or disciplinary action, personnel believed to have altered the audit files related to the Vantage Audit have been reassigned and effectively walled-off from work related to preparing for, assisting with, or responding to, third party audits.
- All Claims Department personnel will receive targeted retraining and education.
- We have brought new leadership into the PPMC Claims Department and enhanced the Compliance organization’s oversight of the claims audit function.
We value our health plan relationships and take seriously the responsibilities entrusted to us. Compliance with the law, including operating our business ethically and with integrity, is one of our guiding principles. We are committed to conducting a thorough investigation and updating DMHC and health plans as we learn more about the issues discussed herein, including whether they affect any audits beyond the Vantage Audit. In the meantime, please do not hesitate to contact me with any questions or concerns.

Sincerely,

Sunmi Janicek, Chief Compliance Officer
agilon health
sunmi.janicek@agilonhealth.com
(714) 651-5661

cc: Sheri Lester, Blue Shield of California
sherif.lesster@blueshieldca.com

Sarah Lorance, Anthem Blue Cross of California
medicarecompliofficer@anthem.com

Connie Snyder, Brand New Day/Universal Care, Inc.
compliance@universalcare.com

Janet Eisenberg, Care1st Health Plan
jeisenberg@care1st.com

Annie Hsu Shieh, Central Health Care
compliance@centralhealth.com

John Tanner, Molina Healthcare of California
medicarecomplianceoffice@molinahealthcare.com

Christy Brosse, Health Net, Inc.
Christy.k.brosse@healthnet.com

Pamela Jackson, Inland Empire Health Plan
jackson-p@iehp.org
January 27, 2017

Dear Customer:

The following is the proof-of-delivery for tracking number 633837820538.

**Delivery Information:**

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Recipient: VICTORVILLE, CA US
Shipper: palm desert, CA US

Thank you for choosing FedEx.
Dear Customer:

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NO SIGNATURE REQUIRED
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<td>Shipper: palm desert, CA US</td>
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Thank you for choosing FedEx.
PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS
- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up status, instead of the Provider Dispute Resolution Form, please utilize our online web portal located at [https://portal.m孔雀.com/psa/gov](https://portal.m孔雀.com/psa/gov) or fax your status request to (561) 280-8206.
- Mail or fax the completed form to: Vantage Medical Group
  2115 Compton Avenue, Dept. 300
  Corona, CA 92881
  Fax: (561) 280-8206

*PROVIDER NAME: Genetic Disease Screening Program
*PROVIDER TAX ID #: Medicare ID #: 943402381

PROVIDER ADDRESS: 850 Marina Bay Parkway, Richmond, CA 94804

PROVIDER TYPE: ● MD
- Mental Health Professional
- Mental Health Institutional
- Hospital
- ASC
- SNF
- DME
- Rehab
- Home Health
- Ambulance
- Other: Laboratory

(please specify type of "other")

CLAIM INFORMATION
- Single
- Multiple "LIKE" Claims (complete attached spreadsheet) Number of claims:

* Patient Name: Please see attached
* Date of Birth: Please see attached

Health Plan ID Number: Please see attached

Patient Account Number: Please see attached

Original Claim ID Number: (if multiple claims, see attached spreadsheet)

Original Claim Amount Billed: $221.60

Reimbursement Of Overpayment Disputed: Please see attached

Original Claim Amount Paid: $0.00

DISPUTE TYPE
- Claim
- Appeal of Medical Necessity / Utilization Management Decision
- Disputing Request For Reimbursement Of Overpayment

- Selecting Resolution Of A Billing Determination
- Contract Dispute
- Other:

* DESCRIPTION OF DISPUTE:
The attached claims are paid by Vantage medical group for $204.93 after applying $12.07 reduction (5% rate reduction based upon the AB93 Reduction policy. We would like to inform that, GDSP is excluded in the AB93 Policy. Attached supporting document, indicating GDSP is excluded from the AB93 policy.

EXPECTED OUTCOME:
We require full reimbursement of the billed charges. Effective July 1*, 2016 GDSP has implemented a new rate for free rates from $204.93 to $221.60. At present, Med-Cal managed care plans are still paying at $204 until the fee schedule is updated in the Med-Cal website (see attached Operating Instructions Letter [OL]) regarding the request for updating the rates. Once updated, Med-Cal managed care plans are required to reimburse GDSP for the remaining amount.

Jeffery Adams
Contact Name (please print)

Analyst - RCM
Title

(585) 471-7800
Phone Number

Date

For Health Plan/RBO Use Only

signature

tracking number

Contracted

Non-contracted

PPMC

MAR 23, 2017

RECEIVED
Exhibit C: Altered

16258R00K2-M
PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS
- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include copies of claims that were previously processed.
- For out of state/foreign states, instead of the Provider Dispute Resolution Form, please utilize our online portal, located at https://portal.preventingcreditcardservice.com, or fax your written request to (951) 280-8280.
- Mail or fax the completed form to: Vantage Medical Group 2115 Compass Avenue, Dept. 100 Corona, CA 92881 Fax: (951) 280-8280

PROVIDER NAME: Genetic Disease Screening Program PROVIDER TAX ID #: 9430230

PROVIDER ADDRESS: 350 Marina Bay Parkway, Richmond, CA 94804

PROVIDER TYPE: [ ] MD [ ] Mental Health Professional [ ] Medical Health Institutional [ ] Hospital [ ] ASC [ ] SNF [ ] DME [ ] Rehab [ ] Home Health [ ] Ambulance [ ] Other [ ] Laboratory

CLAIM INFORMATION: [ ] Single [ ] Multiple "SAME" Claims (complete set attached separately): Number of claims: [ ]

- Patients Name: Please see attached
- Date of Birth: Please see attached

- Health Plan ID Number: Please see attached
- Patient Account Number: Please see attached
- Original Claim ID Number (if applicable, claims attached separately): Please see attached

Date of Service/Service Received Date: [ ] Required for Claim, Billing, and Reimbursement Of (Overpayment/Dispute)
- Original Claim Amount Billed: $221.50
- Original Claim Amount Paid: $0.00

DISPUTE TYPE:
[ ] Claim
[ ] Appeal of Medical Necessity/Utilization Management Decisions
[ ] Disputing Request For Reimbursement Of Overpayment

- [ ] Seeking Resolution Of A Billing Determination
[ ] Denial
[ ] Other:

- DESCRIPTION OF DISPUTE:
The attached claims are paid by Vantage Medical Group for $204.95 after applying a $1.07 reduction (0.37% reduction based upon the ASB Reduction policy). We would like to inform you that GOSI is excluded in the ASB Policy.

- EXPECTED OUTCOME:
We require full reimbursement of the billed charges

- Jeffery Adams
  Contact Name (please print)
  Title
  Phone Number
  Signature
  Date
  Fax Number

CHECK HERE IF ADDITIONAL TRACKING NUMBER, PROVIDER

- FOR HEALTH PLAN/RO Use Only
- CONTRACTED
- NON-CONTRACTED

MAY 08 2017
RECEIVED
Exhibit D: Original

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**HEALTH INSURANCE CLAIM FORM**

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**MEDICARE**

- Medicare
- Medicaid
- TRICARE
- CHAMPVA
- Alloy
- Other

**GROUP PLAN**

- HMO
- PPO
- POS
- Other

**INSURANCE ID NUMBER**

- (For Program in item 1)

**PATIENT'S NAME**

- Last Name
- First Name
- Middle Initial

**INSURED'S NAME**

- Last Name
- First Name
- Middle Initial

**PATIENT'S ADDRESS**

- Line 1
- Line 2

**INSURED'S ADDRESS**

- Line 1
- Line 2

**PHONE**

- Telephone
- Area Code

**.getProduct**

- Name
- Phone
- Mailing Address

**EMPLOYER**

- Name
- Address
- Phone

**PLACE OF SERVICE**

- (Street)
- City
- State
- ZIP Code

**DATE OF BIRTH**

- (MM-DD-YY)

**SIGNATURE ON FILE**

- 10/01/2014

**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

- Main Diagnosis
- Additional Diagnosis

**PROCEDURES, SERVICES OR SUPPLIES**

- Code
- Description
- Unit
- Charge

**SIGNATURE OF PHYSICIAN OR SUPPLIER**

- Name
- License No.

**RECEIVED**

- NOV 17 2014

**PLEASE PRINT OR TYPE**

- CLASS 112

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Exhibit D: Altered
**Exhibit E: Original**

**Hanmi Bank**

010 00026 G1
ACCOUNT: XXXXXXXXXX1895
11/30/2015 Bank

**LOS ANGELES MEDICAL CENTER IPA**

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**Exhibit F: Altered**

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CC: Marvelene Phrakonekham /o=ExchangeLabs/ou=Exchange Administrative Group
    [FYDIBOHF233PDLT/cn=Recipients/cn=057772a0242818954c207ec2d51299-Marvelene Pl]; Jeremy Encarnacion-Morrison
    /o=ExchangeLabs/ou=Exchange Administrative Group
    [FYDIBOHF233PDLT/cn=Recipients/cn=7207ee04da4a4e1d928e1c2a4d019ae5-Jeremy Enca]
Subject: RE: 17038R06X9 - Medical Claim

doer

Thank you,

Rebecca Johnson  
Manager Application Development  
Direct (951) 280-7880  
Main (951) 280-7700  
Email rjohnson@ppmcinc.com

From: Joanne Saycon
Sent: Monday, November 13, 2017 1:02 PM
To: Rebecca Johnson <rjohnson@ppmcinc.com>
CC: Marvelene Phrakonekham <marvelenepp@ppmcinc.com>; Jeremy Encarnacion-Morrison <jmorrison@ppmcinc.com>
Subject: 17038R06X9 - Medical Claim

Hi Rebecca,

For the claim referenced above, can you please add 211 in the adjustment field so an Overturn Letter can be generated? This is for the health plan audit due today.

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Thank you,

Joanne Saycon  
Claims Auditor  
Ext 7839
Exhibit H

Message

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Sent: 6/5/2017 5:43:11 PM
To: Pauline Lozano [/O=benefit management systems/OU=BMS_SD/cn=recipients/cn=paulinel]
Subject: RE: #15007RZ3FL-M BLUE SHIELD COMMERCIAL PDR'S AUDIT

done

Thank you,

Rebecca Johnson
Manager Application Development
Phone (951) 296-7860
Email rjohnson@ppmcinc.com

---

From: Pauline Lozano
Sent: Monday, June 05, 2017 9:25 AM
To: Rebecca Johnson <rjohnson@ppmcinc.com>
Subject: #15007RZ3FL-M BLUE SHIELD COMMERCIAL PDR'S AUDIT

Hi Rebecca,

Please remove denial codes D7 and D9 and replace with D175
Please remove ADJ code X59 and replace with X6
Please add comment printed on Voucher: Initial appeal not filed within 365 day filing limit. No further reviews.