Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

March 11, 2020

Via USPS Delivery and eFile

Dr. Bart Asner
Chairman of the Board of Directors
Monarch Health Plan, Inc.
11 Technology Drive
Irvine, CA 92618

FINAL REPORT OF A ROUTINE EXAMINATION OF MONARCH HEALTH PLAN, INC.

Dear Dr. Asner:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended June 30, 2019 of the fiscal and administrative affairs of Monarch Health Plan, Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report to the Plan on December 5, 2019. The Department accepted the Plan's electronically filed response on January 30, 2020.

The Final Report includes a description of the compliance efforts included in the Plan's January 30, 2020 response, in accordance with Section 1382(c).

Section 1382(d) states, "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response. If so, please indicate which portions of the Plan's response should be appended, and electronically file copies of those portions excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's response or wishes to modify any information provided to the Department in its

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

January 30, 2020 response, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan system (CAP system) within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP #L20-R-453."
- Go to the "Messages" tab, then:
    - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
    - Select the deficiency(ies) that are applicable.
    - Create a message for the Department.
    - Attach and upload all documents with the name "Addendum to Final Report."
    - Select "Send Message."

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

Questions or problems related to the electronic transmission of any addendum should be directed to Vijon Morales at 916-255-2447 or by e-mail at Vijon.Morales@dmhc.ca.gov. You may also e-mail inquiries to wpso@dmhc.ca.gov.

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

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

Sincerely,

ORIGINAL SIGNED BY

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

cc: See next page

cc: Karen Goldstein, General Manager, Monarch Health Plan, Inc.
Pritika, Dutt, CPA, Deputy Director, Office of Financial Review
Ned Gennaoui, Supervising Examiner, Division of Financial Oversight
Francisco J. Garcia, Examiner, Division of Financial Oversight
Lorilee Ambrosini, Examiner, Division of Financial Oversight
Kelsey Pruden, Attorney III, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Ben Carranco, Assistant Deputy Director, Help Center
Chad Bartlett, Staff Services Manager III, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF A ROUTINE EXAMINATION

OF

MONARCH HEALTH PLAN, INC.

FILE NO. 933 0453

DATE OF FINAL REPORT: MARCH 11, 2020

SUPERVISING EXAMINER: NED GENNAOUI

OVERSIGHT EXAMINER: MARIA MARQUEZ

EXAMINER-IN-CHARGE: FRANCISCO J. GARCIA

FINANCIAL EXAMINERS:
JULIANA ASABOR
JOHN ATAMIAN
CHANTE BIAGAS
SUHAG PATEL

BACKGROUND INFORMATION FOR MONARCH HEALTH PLAN, INC.

Date Plan Licensed:	April 18, 2007
Organizational Structure:	Monarch Health Plan, Inc. (Plan) is a for-profit, wholly-owned subsidiary of Monarch HealthCare, A Medical Group, Inc. (MHC). MHC is a wholly-owned subsidiary of Collaborative Care Holdings, LLC, which is a wholly-owned subsidiary of UnitedHealth Group Incorporated, a publicly held company. The Plan receives management, financial, legal, information system, human resources and administrative services from Monarch Management Services, Inc., a Plan affiliate, pursuant to a written administrative services agreement.
Type of Plan:	The Plan is a full service health care plan. The Plan has a restricted license to contract with other Knox-Keene licensed plans for commercial and Medicare Advantage enrollees. In addition, the Plan partners with CalOptima to take global financial risk for Medi-Cal enrollees. The Plan is not licensed to enter into plan contracts directly with employer groups or members of the general public.
Provider Network:	Professional medical care costs are fully capitated to MHC at a fixed percentage of premium capitation received from other plans. In addition, the Plan entered into fee-for-service arrangements with other providers. The inpatient medical care costs are reimbursed on a negotiated fee-for-service basis.
Plan Enrollment:	As of June 30, 2019, the Plan reported 142,036 enrollees contracted from other plans.
Service Area:	The Plan operates in Orange County and adjacent areas in Los Angeles County.
Date of Prior Final Routine Examination Report:	June 2, 2017

FINAL REPORT OF A ROUTINE EXAMINATION OF MONARCH HEALTH PLAN, INC.

This is the final report (Final Report) of a routine examination for the quarter ended June 30, 2019 of the fiscal and administrative affairs of Monarch Health Plan, Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on December 5, 2019. The Department accepted the Plan's electronically filed response on January 30, 2020.

This Final Report includes a description of the compliance efforts included in the Plan's January 30, 2020 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in italics within this Final Report.

The Department examined the Plan's financial report filed with the Department for the quarter ended June 30, 2019, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. The Department's findings are presented in this Final Report as follows:

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

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

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

PART I. FINANCIAL STATEMENTS

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended June 30, 3019, as filed with the Department. A copy of the Plan's financial statements can be viewed by selecting "Monarch Health Plan, Inc." on the second drop-down menu of the Department's financial statement database available at http://wpso.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, 2019	$88,391,257
Required TNE	20,190,254
TNE Excess per Examination	$68,201,003

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

No response is required to this Part.

PART III. COMPLIANCE ISSUES

A. CLAIM SETTLEMENT PRACTICES – "UNFAIR PAYMENT PATTERNS"

Section 1371.37 prohibits a health care service plan from engaging in an unfair payment pattern, and defines certain claim settlement practices as "unfair payment patterns."

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

The Department's examination found that the Plan engaged in "unfair payment patterns" for the three-month period ended June 30, 2019, as follows:

1. CLEAR AND ACCURATE DENIAL EXPLANATION OF CLAIMS

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

Rule 1300.71(a)(8)(F) describes one unfair payment pattern as the failure to provide a provider with an accurate and clear written explanation of the specific reasons for

denying, adjusting or contesting a claim at least 95 percent over the course of any three-month period.

The Department's examination disclosed that the Plan failed to provide a denial explanation for three out of 34 denied claims reviewed (a compliance rate of 91 percent). This deficiency was due to processors' errors, and was noted in denied claim sample numbers: 3, 9 and 21. The 34 denied claims reviewed represent the entire denied claim population for the three-month period ended June 30, 2019.

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

a. Training procedures, and date of implementation, to ensure that claims processors provide a clear and accurate denial reason.

b. Audit procedures, and date of implementation, to confirm that claims denials have a clear and accurate denial reason in compliance with Rule 1300.71(d)(1).

c. Management positions responsible for ensuring continued compliance.

The Plan responded that it provided training to its examiner staff on September 16, 2019. Additional training was provided to staff during staff meeting on November 11, 2019.

The Plan submitted a copy of its audit procedures, "Work Queue Oversight," implemented on October 1, 2019.

The Plan's Claim Manager is responsible for monitoring the day-to-day operations and controls to ensure continued compliance. The Vice President of Claims is accountable to ensure performance metrics are achieved.

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. AMENDMENTS TO APPLICATION

Section 1352(a) and Rule 1300.52 requires all plans to file an amendment with the director within 30 days after any changes in the information contained in its application, other than financial or statistical information. Rule 1300.52.4 sets forth standards for amendment filings.

Section 1367(h)(1) states that contracts with subscribers and enrollees, providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair and reasonable. 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 with the Department the following two administrative services agreements for claims processing:

- Imagenet Service Contract between Imagenet, LLC and MHC on behalf of the Plan.

- Outsourced Services Agreement between Calibrated Healthcare Network, LLC and MHC on behalf of the Plan.

In addition, the Plan did not file with the Department the federal tax-sharing agreement between MHC and the Plan for filing consolidated tax returns on behalf of the Plan and other affiliates.

Prior to the issuance of the Preliminary Report, the Plan filed with the Department the Imagenet Service Contract and Outsourced Services Agreement (eFiling number 20193386). This filing was completed and closed on December 20, 2019.

The Preliminary Report required the Plan to file the federal tax-sharing agreement with MHC, as an amendment separate from the Plan's response to the Preliminary Report. Furthermore, the Plan was required to provide evidence (eFiling number) in its response to this Preliminary Report that the requested filing was submitted to the Department.

The Plan was also required to provide the policy and procedure implemented to ensure that significant agreements are filed with the Department, the date of implementation, and the management positions responsible for ensuring continued compliance.

The Plan responded by filing the federal tax-sharing agreement, eFiling number. 20194417, on December 20, 2019. This filing was completed and closed on January 8, 2020.

The Plan submitted a copy of its policy and procedure, "Notifying the Department of Significant Changes," implemented on January 30, 2020. Beginning February 2020 and on a monthly basis thereafter, the Plan's regulatory and compliance team will solicit information from executive leadership regarding newly executed contracts and agreements and log responses, as a monitoring system to ensure ongoing compliance.

The Plan's President/Chief Executive Officer and the General Manager are the management positions responsible for ensuring continued compliance.

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.

C. CHANGES IN OFFICERS AND DIRECTORS

Section 1352(c) and Rule 1300.52.2(a) require a plan to file, within five days, an amendment to its application when there are certain changes in personnel of the plan. A

plan must report the addition or deletion of a director, trustee, principal officer, general partner, general manager, or principal management person, or a person occupying a similar position or performing similar functions, or a substantial and material change in the duties of any such person.

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

Name	Position Title	Reason	Effective Date	Filing Date	Days Late
Marilyn Ditty	Board Member	Retired	12/31/2018	01/14/2019	9
Jay Cohen	Board Member	Appointed	12/31/2018	01/14/2019	9

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

The Plan responded by providing a copy of its policy and procedure, "Notifying the DMHC of Key Personnel Changes," implemented on January 30, 2020. The Plan's President/Chief Executive Officer and the General Manager are the management positions responsible for ensuring continued compliance.

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.