Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500, Sacramento, CA 95814
Telephone: 916-255-2444 | Fax: 916-255-2280

Via USPS Delivery and eFile

June 2, 2017

Dr. Jay Cohen
Chair of the Board
Monarch Health Plan
11 Technology Drive
Irvine, CA 92618

FINAL REPORT OF ROUTINE EXAMINATION OF MONARCH HEALTH PLAN

Dear Dr. Cohen:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Monarch 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 January 25, 2017. The Department accepted the Plan's electronically filed response on March 10, 2017.

This Final Report includes a description of the compliance efforts included in the Plan's March 10, 2017 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

[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.

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 modify any information provided to the Department in its March 10, 2017 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://wpso.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 S16-R-453.
- 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 Vijon Morales at 916-255-2447 or email at Vijon.Morales@dmhc.ca.gov. You may also email inquiries to wpso@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 at 916-255-2444 or email: Steven.Alseth@dmhc.ca.gov.

Sincerely,

ORGINIAL SIGNED BY

Steven J. Asleth
Examiner IV (Supervisor)
Office of Financial Review

cc: Karen Goldstein, General Manager, Monarch Health Plan
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Nina Moua, Examiner, Division of Financial Oversight
Lorilee Ambrosini, Examiner, Division of Financial Oversight
Jonathon Williams, Attorney, Office of Plan Licensing
Laura Dooley-Beile, Chief, Division of Plan Surveys
Paula Hood, Staff Services Manager I, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF ROUTINE EXAMINATION

OF

MONARCH HEALTH PLAN

FILE NO. 933-0453

DATE OF FINAL REPORT: JUNE 2, 2017

OVERSIGHT EXAMINER: STEVEN J. ALSETH

EXAMINER-IN-CHARGE: NINA MOUA FINANCIAL

EXAMINERS:

ANNA BELMONT, ERI FUKUDA AND ERICA SHORT

BACKGROUND INFORMATION FOR MONARCH HEALTH PLAN

Date Plan Licensed:	The Plan was licensed on April 18, 2007.
Organizational Structure:	Monarch Health Plan (the Plan) is a 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.
Type of Plan:	The Plan has a Restricted License to take global financial risk for Medicare Part A and B services in partnership with Medicare Advantage Plans licensed in California under the Knox-Keene Act, and for services for commercial beneficiaries of other licensed health care service plans. In addition, the Plan partnered with CalOptima to take global financial risk for CalOptima's Medi-Cal enrollees in January 2017.
Provider Network:	The Plan pays all professional services under a capitation arrangement with MHC.
Plan Enrollment:	As of June 30, 2016 the Plan had a total enrollment of 52,746. At December 31, 2015, total enrollment was 55,171.
Service Area:	The Plan's approved service area includes all zip codes in Orange County and adjacent zip codes in Los Angeles County.
Date of prior Final Routine Examination Report:	May 9, 2014

FINAL REPORT OF A ROUTINE EXAMINATION OF MONARCH HEALTH PLAN

This is the Final Report of a routine examination of the fiscal and administrative affairs of Monarch 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 January 25, 2017. The Department accepted the Plan's electronically filed response on March 10, 2017.

This Final Report includes a description of the compliance efforts included in the Plan's March 10, 2017 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in *italics*.

The Plan is hereby advised that any violations listed in this report may be referred to the Office of Enforcement for appropriate administrative action upon the issuance of this report.

The Department examined the Plan's financial report filed with the Department for the quarter ended June 30, 2016, 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.	Non-Routine Exam

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 June 30, 2016, 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://wpso.dmhc.ca.gov/fe/search/#top and selecting Monarch 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 June 30, 2016	$ 16,263,073
Add: Subordinated debt and related interest	2,000,000
Tangible Net Equity	$ 18,263,073
Required TNE	13,369,566
TNE Excess per Examination	$ 4,893,507

The Plan was in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of June 30, 2016.

No response was required to this Section.

SECTION III. COMPLIANCE ISSUES

A. CLAIMS SETTLEMENT PRACTICES

1. INCORRECT DATE OF RECEIPT

Rule 1300.71(a)(6) states "Date of receipt" means the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim.

The Department's examination disclosed that the Plan failed to record the correct date of receipt on nine (9) out of 14 late payment claims and five (5) out of 50 denied claims reviewed. The incorrect date of receipt was due to the date of process instead of actual date of receipt was recorded in some instances. The deficiencies were noted in the following samples:

- Late Payment: LP-3, LP-4, LP-5, LP-6, LP-7, LP-8, LP-9, LP-10, and LP-11.
- Denied: D-5, D-31, D-36, D-48, and D-53.

The Plan was required to submit a Corrective Action Plan (CAP) to address the deficiency cited above. The CAP shall include the following:

a. Policy and procedures implemented to ensure that the date of receipt on the original claims is entered into the claims payment processing system;

b. Training procedures to ensure that claim processors are properly trained on verifying that the correct date of receipt is input into the claims payment processing system;

c. Audit procedures to confirm that the date of receipt on the claim image matches the date of receipt input into the claims payment processing system, to determine payment timeliness and the correct amount of interest on late and late adjusted claim payments; and

d. The date of implementation of the corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

PLAN'S RESPONSE:

Use of incorrect receipt date on projects:

The Plan responded that prior to the Department's examination, when the Plan performed an internal audit or identified errors that may have caused underpayment, the Plan would generate a sweep report and would use the discovery date of the error as the received date. After the Department's examination, the Plan now adheres to guidelines put forth by the Department to use the original received date. The only exception is when the Plan is making payment as a gesture of Goodwill. The corrective action plan was implemented on October 24, 2016. The MHP Claims Manager and the Compliance and Payment Integrity Manager are responsible for monitoring the day-to-day controls to ensure compliance. The Vice President of Business Operations has accountability to ensure performance metrics are achieved.

Use of incorrect receipt date on Claims EDI:

The Plan has re-reviewed the process and staff has been re-educated to provide better awareness of regulatory and compliance timelines. An Additional Secured File Transfer Protocol (SFTP) retrieval and acknowledgement process has been inserted just prior to the close of business (5:00 p.m.) to help ensure we capture an accurate claim received date. The Plan also requested enhancements to existing

audit reports to provide better oversight and monitoring after claims have been loaded into the adjudication system. The corrective action plan was implemented on October 24, 2016. The MHP EDI Manager is responsible for monitoring the day-to-day controls to ensure compliance. The Vice President of Business Operations is responsible to ensure performance metrics are achieved.

Use of incorrect receipt date on double date claims:

Double date stamp (DDS) only applies to the senior line of business. A control report was created and implemented on November 4, 2016 to capture claims for the commercial line of business, where the received date has been changed based on DDS. The corrective action plan was implemented on November 4, 2016. The MHP Claims Manager is responsible for monitoring the day-to-day controls to ensure compliance. The Vice President of Business Operations is responsible to ensure performance metrics are achieved.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

2. INTEREST ON LATE CLAIM PAYMENTS

Rule 1300.71(i)(1) requires that late payment on a complete claim for emergency services and care, which is neither contested nor denied, automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late.

The Department's examination disclosed that the Plan failed to pay interest accurately on nine (9) out of 15 emergency services claims (a compliance rate of 40%). The Plan paid $15 plus additional interest for each late payment. The Plan should have paid the greater of $15, or interest at the rate of 15 percent per annum for the period of time that the payment is late. The deficiencies were noted in the following samples: LP-3, LP-4, LP-5, LP-6, LP-7, LP-8, LP-9, LP-10, and LP-11.

The Plan was required to submit a CAP to address the deficiency cited above. The CAP shall include the following:

a. Policy and procedures implemented to ensure that the interest on emergency services claims are paid in accordance with Rule 1300.71(i)(1);

b. Training procedures to ensure that claim processors are properly trained on verifying that the correct interest is being paid on emergency services claims;

c. Audit procedures to confirm that the interest on emergency services claims is paid in accordance with Rule 1300.71(i)(1); and

d. The date of implementation of the corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

PLAN'S RESPONSE:

The Plan responded that its claim platform has the capability to apply interest when due, if the correct received date is utilized. The error on these claims resulted because the Plan discovery date on the project was used instead of the original received date. This deficiency has been addressed in the Plan's Standard Operating Procedure for Project Oversight, as well as interest oversight Standard Operating Procedure. Claims were reprocessed for the additional interest due.

The corrective action plan was implemented on October 24, 2016. The MHP Claims Manager and the Compliance and Payment Integrity Manager are responsible for monitoring the day to day controls to ensure compliance. The Vice President of Business Operations is responsible to ensure performance metrics are achieved.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

B. PROVIDER DISPUTE RESOLUTION (PDR)

1. INTEREST ON PDR PAYMENTS

Rule 1300.71(i)(1) requires that late payment on a complete claim for emergency services and care, which is neither contested nor denied, automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late.

Rule 1300.71(j) requires a plan that fails to automatically include the interest due on a late claim payment to pay the provider a $10 penalty for the late claim in addition to any amounts due pursuant to section (i).

The Department's examination of PDR disclosed that the Plan failed to pay interest accurately on emergency service claims. The Plan paid a flat rate of $15, instead of the greater amount of $15 for each 12-month period or 15 percent per annum interest on four (4) of 50 PDRs (a compliance rate of 92%). The deficiencies were noted in the following samples: PDR-10, PDR-19, PDR-32, and PDR-47.

The Plan was required to submit a CAP to address the deficiency cited above. The CAP shall include the following:

a. Identification of all provider disputes paid from October 1, 2014 through the date corrective actions were implemented by the Plan, where interest was underpaid on emergency services PDRs for the period of time the claim was paid late.

b. Evidence that interest and penalties, as appropriate, were paid retroactively from the emergency services PDRs identified in paragraph "a" above. This evidence is to include an electronic data file/schedule (Excel or dBase) that identifies the following:

a. Claim number
b. PDR tracking number
c. Date of service
d. Date original claim received
e. Date new information received (date claim was complete)
f. Total billed
g. Original total paid
h. Original paid date
i. Amount of adjustment paid (w/check number)
j. Original interest paid date
k. Number of days used to calculate interest
l. Amount of additional interest paid (with formula)
m. Date additional interest paid
n. Penalty paid
o. Date penalty paid
p. Check number for interest and/or penalty
q. Provider name

The data file was to provide the detail of all emergency services PDRs remediated, including the total number of claims and the total additional interest and penalty paid as a result of remediation.

c. Policy and procedures implemented to ensure that the interest on emergency services PDRs are paid in accordance with Rule 1300.71(i)(1);

d. Training procedures to ensure that claim processors are properly trained on verifying that the correct interest is being paid on emergency services PDRs;

e. Audit procedures to confirm that the interest on emergency services PDRs are paid in accordance with Rule 1300.71(i)(1); and

f. The date of implementation of the corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

PLAN'S RESPONSE:

The Plan responded that the interest rules have been re-reviewed with the PDR Team to ensure that late ER claims are paid with a $15 penalty or 15% per annum, whichever is greater. Also, a new control report has been implemented for supervisors to review any ER claims that may fall in this category prior to check write. The Plan provided evidence of payments on PDR emergency services.

The corrective action plan was implemented on October 24, 2016. The Manager of Compliance and Payment Integrity is responsible for monitoring day to day controls to ensure compliance. The Vice President of Business Operations is responsible to ensure performance metrics are achieved.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

2. TIME PERIOD FOR ACKNOWLEDGMENT

Rule 1300.71.38(e)(1) and (2) provide that a plan or a plan's capitated provider shall enter into its dispute resolution mechanism system(s) each provider dispute submission (whether or not complete), and shall identify and acknowledge the receipt of each provider dispute: (1) in the case of an electronic provider dispute, the acknowledgement shall be provided within two (2) working days of the date of receipt of the electronic provider dispute by the office designated to receive provider disputes, or (2) in the case of a paper provider dispute, the acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the paper provider dispute by the office designated to receive provider disputes.

The Department's examination disclosed that the Plan failed to acknowledge four (4) out of 50 PDRs within the appropriate timeframe as stated in the Rule above (a compliance rate of 92%). The deficiencies were noted in the following samples: PDR-3, PDR-4, PDR-38, and PDR-39.

The Plan was required to submit a detailed CAP to bring the Plan into compliance with the above Rules that includes, but was not limited to, the following:

a. Policy and procedures implemented to ensure that PDRs are acknowledged timely in accordance with the above Rules;

b. Training procedures to ensure that PDRs are acknowledged timely;

c. Audit procedures to confirm PDRs are acknowledged in compliance with the above Rules; and

d. The date of training and implementation of the policy and procedures and the management position(s) responsible for ensuring ongoing compliance.

PLAN'S RESPONSE:

The Plan responded that in March and April of 2016, the Plan experienced a few staffing challenges which resulted in the deficiency. At the same time, the Plan was going through an intense monthly audit with another health plan. The same pool of resources was accommodating the audit needs as well as acknowledging PDRs, which caused the Plan to incur a backlog in acknowledging PDRs timely. Key stakeholders were notified for further action planning and staffing approvals. Due to these staffing constraints, a few claims went out of compliance on acknowledgement requirement.

The corrective action plan was implemented on May 15, 2016 by procuring a dedicated resource to assist with the audit pull. The Compliance & Payment Integrity Manager is responsible for monitoring the day to day controls to ensure compliance. The Vice President of Business Operations is responsible to ensure performance metrics are achieved.

The Department finds that the Plan's compliance effort is responsive to the corrective action required.

SECTION IV. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this Report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response is required to this Section.