REPORT ON EXAMINATION

OF

COMPREHENSIVE CARE MANAGEMENT CORPORATION

AS OF

DECEMBER 31, 2008

DATE OF REPORT	**APRIL 19, 2012**
EXAMINER	**VICTOR ESTRADA**

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April 19, 2012

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and the New York Public Health Law and acting in accordance with the instructions contained in Appointment Number 30346, dated September 21, 2009, annexed hereto, I have made an examination into the condition and affairs of Comprehensive Care Management Corporation, a not-for-profit managed long-term care plan ("MLTCP") licensed pursuant to the provisions of Article 4403-f of the New York Public Health Law, as of December 31, 2008, and submit the following report thereon.

The examination was conducted at the administrative office of Comprehensive Care Management Corporation, located at 612 Allerton Avenue, Bronx, New York.

Wherever the designations "the Plan" or "CCMC" appear herein, without qualification, they should be understood to indicate Comprehensive Care Management Corporation.

Wherever the designation "the Department" appears herein, without qualification, it should be understood to indicate the New York State Insurance Department, (On October 3, 2011 the New York State Insurance Department merged with the New York State Banking Department to become the New York State Department of Financial Services).

1. SCOPE OF THE EXAMINATION

This examination covered the three-year period January 1, 2006 through December 31, 2008. Transactions occurring subsequent to this period were reviewed where deemed appropriate by the examiner. This was the first examination of CCMC.

The examination comprised a verification of assets and liabilities as of December 31, 2008, in accordance with Generally Accepted Accounting Principles ("GAAP"), a review of income and disbursements deemed necessary to accomplish such verification, and utilized, to the extent considered appropriate, work performed by the Plan's independent certified public accountants.

A review was also made of the following items:

Board of Directors' meetings
Compliance with by-laws
Financial documents
Growth of the Plan
Market conduct activities

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, rules or regulations, or which are deemed to require explanation or description.

2. DESCRIPTION OF THE PLAN

CCMC is a voluntary not-for-profit corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code and operates a Program of All-inclusive Care for the Elderly ("PACE"), a partially capitated Medicaid Managed Long Term Care Plan ("CCM Select") and a Medicare Special Needs Plan ("CCM Direct"). CCMC contracts with health care providers for the provision of medical, acute, long-term and other health care services. Its primary sources of revenue are from Medicaid and Medicare.

The Plan has been in existence since 1992. In 2006, the Plan submitted an application to the Department to operate a managed long-term care program and on June 9, 2006, it was issued a certificate of authority to operate a managed long term care plan to serve Medicaid-eligible adults age 21 and older in the Bronx, New York, Kings, Westchester and Queens counties pursuant to Section 4403-f of the New York Public Health Law. The certificate of authority was contingent upon the execution of a contract with the New York State Department of Health and a regulatory agreement with the Department. The contract with the New York State Department of Health was in effect from January 1, 2007 to December 31, 2009. Additionally, a regulatory agreement with the Department was signed by the Plan on June 21, 2006. The certificate of authority was amended on April 21, 2007 and again on February 1, 2009.

CCMC files its annual and quarterly cost reports with the New York State Department of Health and the New York State Insurance Department on a line of business and geographic basis. The Plan's filed CPA report included a balance sheet, statement of activities and statement of cash flows consolidated by line of business.

A. Management and Controls

Pursuant to its by-laws, the management of CCMC is to be vested in a Board of Directors consisting of not less than three nor more than fifteen directors. As of the examination date, the Board of Directors was comprised of nine members. In compliance with its by-laws, CCMC's Board met at least once each quarter during the exam period.

CCMC's by-laws also require at least 20% of the Board to be composed of enrollees who are neither employees of the Plan nor providers of health services. Part 98-1.11(g)(1)(iii) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)(1)) states in part:

> "…(1) Within one year of the MCO becoming operational, no less than 20 percent of the members of the governing authority shall be enrollees of such MCO, except that…
>
> (iii) an HMO, PHSP, PCPCP or MLTCP may, as an alternative to or in addition to subparagraphs (i) and (ii) above, establish an enrollee advisory council which is representative of the HMO's, PHSP's, PCPCP's or MLTCP's enrollment and which has direct input to the governing authority;"

Part 98-1.11(g)(2) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11(g)(2)) states:

> "(2) Employees of the MCO, providers of health services or persons having a business relationship with the MCO may not serve as enrollee or consumer representatives."

During the exam period, CCMC had an Enrollee Advisory Council ("Council") that complied with the requirements of Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department as stated above.

The members of the Plan's Board of Directors as of December 31, 2008 were as follows:

Name and Residence	Principal Business Affiliation
Jean Brewster White Plains, NY	Vice President, MasterCard, Inc.
Michael S. Fassler Bayside, NY	President, Beth Abraham Family Health Services
Russell D. Fisher Farmington, CT	Retired
Kenneth Fuld New York, NY	Retired
Harvey J. Ishofsky Great Neck, NY	President and CEO, 1-877-SPIRITS.COM
Jarlath A. Johnston New York, NY	Retired
Michael R. Potack Mount Vernon, NY	Owner, Unitex Textile Rental Services
Edwin H. Stern III New York, NY	Treasurer, Seiden Krieger Associates
Mark Weinstein Flushing, NY	Owner, Golden Oldies

A review of the attendance records of the Board of Directors' meetings held during the period under examination revealed that the meetings were generally well attended, with every member attending at least 50% of the meetings they were eligible to attend.

As of December 31, 2008, the principal officers of CCMC were as follows:

Officers	**Title**
Michael S. Fassler	President
Kenneth Fuld	Vice Chairman
Michael R. Potack	Chairman
Edwin H. Stern III	Founding Chairperson
Mark Weinstein	Secretary / Treasurer
Stephen B. Mann	Assistant Treasurer
Michael M. Bialek	Second Assistant Treasurer

B. Territory and Plan of Operation

CCMC operates a Program of All-inclusive Care for the Elderly ("PACE"), a partially capitated Medicaid Managed Long Term Care Plan ("CCM Select") and a Medicare Special Needs Plan ("CCM Direct"). CCMC contracts with health care providers for the provision of medical, acute, long term and other health care services.

CCMC, d/b/a CCM Select, was issued a certificate of authority to operate a MLTCP to serve Medicaid eligible adults age 21 and older in the Bronx, New York, Kings, Westchester and Queens counties pursuant to Section 4403-f of the New York Public Health Law. Additionally, CCMC is approved to operate a Program of All-Inclusive Care for the Elderly ("PACE") consistent with the provision of Section 4403-f of the New York State Public Health Law and approval from the Centers for Medicare and Medicaid Services ("CMS") in Bronx, Kings, New York, Queens, Westchester, Nassau and Suffolk counties. CCMC contracted with the New York State Department of Health to participate in New York State's partially capitated long-term care program. The contract defines the services that must be provided and the capitation rate to be paid per member per month.

As of December 31, 2008, CCMC's total enrollment of 3,423 consisted of 2,376 PACE members and 1,047 CCM Select members. There were no CCM Direct members as of December 31, 2008.

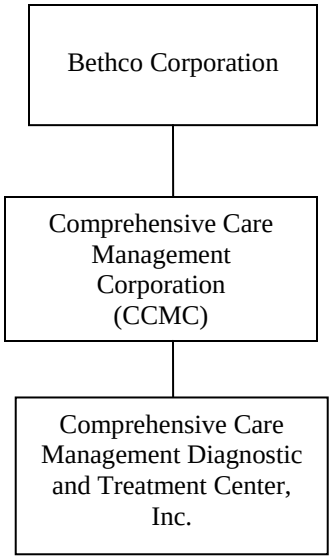
C. Stop-Loss Insurance

As of the examination date, CCMC had a stop-loss insurance agreement with HCC Insurance Company of New York, an authorized insurer, to limit its losses on individual claims for its Medicare PACE and Medicare SNP enrollees. Under the terms of the agreement, CCMC is to be reimbursed for certain health care service costs incurred for an individual enrollee in excess of the "attachment point" within a contract year. The attachment point for the contract year ending December 31, 2008, was $150,000. The individual contract year maximum was $1,000,000. This agreement was renewed on March 1, 2009.

D. Holding Company System

Bethco Corporation, a member of Beth Abraham Health Services ("BAHS") and several other organizations through common board control, is the sole member of CCMC. Bethco Corporation has contractual agreements with various healthcare providers to purchase services that include long-term health care, day care/health services, nursing services, medical care services (physician and ancillary), and rental and occupancy. Administration and general expenses are allocated between the related entities based on cost allocation statistics used on third-party payors.

The following chart illustrates CCMC's holding company system as of December 31, 2008:



CCMC has a long-term health care agreement ("Agreement") with its affiliate, Beth Abraham Hospital ("BAH") to obtain long-term health care and related services customarily furnished by BAH's long-term home health care program (including, but not limited to, supplies, nursing services, social services, occupational, physical and speech therapies, day health center services, transportation, and health equipment services). Services performed by BAH are billed to CCMC at cost. This agreement has been in effect since February 1, 1992.

E. Conflict of Interest Policy

Bethco Corporation, the Parent company of CCMC, has a system-wide written Compliance Program and Code of Conduct for its employees and directors. It describes what standards and behavior are required of its employees, including what activities or practices constitute a conflict of interest for its directors and employees.

CCMC generally follows the standards, policies and procedures of its Parent, in regard to a code of conduct, etc., however, CCMC has developed its own training, monitoring and auditing functions appropriate to its specific business in this regard.

Conflict of interest statements, which are the responsibility of the Plan's Compliance Officer, are required to be completed by members of the Plan's Board of Directors on an annual basis. A review of the conflict of interest filings for the years 2006, 2007 and 2008 was performed by the examiner. The review revealed the following:

- For calendar year 2006, one member of the Board of Directors failed to file conflict of interest forms with CCMC.
- For calendar year 2007, three members of the Board of Directors failed to file conflict of interest forms with CCMC.
- For calendar year 2008, two members of the Board of Directors failed to file conflict of interest forms with CCMC.

It is recommended that all conflict of interest statements required to be signed by each board member, be filed with the Compliance Officer on an annual basis.

F. Report of Independent Certified Public Accountant

CCMC's independent CPA report relative to its financial statements as of December 31, 2008 and during the examination period, as provided by Loeb & Troper, LLC, did not contain a reconciliation for the differences between the amounts reported by the Plan in its filed Medicaid Managed Long Term Care Operating Report ("MMCOR") and the amounts reported in the CPA's reports, as required by Section 307(b) of the New York Insurance Law.

Section 307(b)(2) of the New York Insurance Law states in part:

> "…an insurer may comply by filing statements prepared in accordance with generally accepted accounting principles, provided that appropriate reconciliation is made of the differences between net income and capital and surplus reported on that basis and that reported in the annual statutory statement filed with the superintendent."

It is recommended that CCMC comply with the requirements of Section 307(b)(2) of the New York Insurance Law and submit to this Department the applicable CPA report relative to its financial statements, including a reconciliation of the differences between the amounts reported in the filed annual statements and the amounts reported in the CPA report.

In April 2009, subsequent to the examination date, CCMC filed said reconciliation.

G. Contingent Reserve Fund

A certified operating Managed Care Organization such as CCMC is required to maintain a minimum net worth pursuant to Sections 98-1.11(e)(1) and (f)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11). The required minimum net worth is calculated as the ***greater*** of:

1. A contingent reserve, equal to five percent of its annual net premium income, or
2. An escrow deposit account consisting of five percent of the estimated expenditures for health care services for the calendar year.

As of December 31, 2008, the Plan's New York State contingent reserve was $11,434,405 and its escrow deposit account was $12,494,205; therefore its minimum net worth reported on its December 31, 2008 MMCOR should have been $12,494,205.

In its March 31, 2009 MMCOR, filed subsequent the examination date, the Plan reported its minimum net worth as $12,494,205.

It is recommended that the Plan, in its filed financial statements, report its minimum net worth as the greater of its contingent reserve or escrow deposit.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and net worth as determined by this examination with those reported by CCMC in its filed MMCOR as of December 31, 2008:

	Examination	Plan	Net Worth Increase/ (Decrease)
Assets			
Cash	$ 10,683,176	$10,683,176	
Premiums receivable-net	754,000	754,000	
Prepaid expenses	134,000	134,000	
Investments	23,191,311	32,318,000	(9,126,689)
Restricted cash and other assets	11,434,485	11,434,485	
Limited use assets	2,910,507	2,910,507	
Building and improvements	36,476,876	36,476,876	
Total assets	$ 85,584,355	$ 94,711,044	$ (9,126,689)

	Examination	Plan	Net Worth Increase/ (Decrease)
Liabilities			
Accounts payable	$ 259,506	$ 259,506	
Claims payable	120,320	120,320	
Accrued inpatient claims	155,337	155,337	
Accrued physician claims	42,293	42,293	
Loan and notes payable	1,255,000	1,255,000	
PACE New York payable	9,247,170	9,247,170	
PACE Westchester payable	826,936	826,936	
SNP Payable	60,683	60,683	
Loan and notes payable	20,580,000	20,580,000	
IDA interest payable	211,244	211,244	
Amounts due to affiliates	283,352	283,352	
Amounts due to third parties	2,946,089	2,946,089	
Total liabilities	$ 35,987,930	$ 35,987,930	
Net Worth			
NYS continent reserve	$ 11,434,485	$ 11,434,485	
Unassigned funds	38,161,940	47,288,629	$ (9,126,689)
Total net worth	$ 49,596,425	$ 58,723,114	$ (9,126,689)
Total liabilities and net worth	$ 85,584,355	$ 94,711,044	

Note 1: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2008. The Plan is a not-for-profit MLTCP which falls under IRC Section 501(C)(3), which exempts the Plan from federal income tax. The examiner is unaware of any potential exposure of the Plan to any tax assessments and no liability has been established herein relative to such contingency.

Note 2: A certified operating Managed Care Organization such as CCMC is required to maintain a minimum net worth, pursuant to Sections 98-1.11(e)(1) and (f)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11). The required minimum net worth is calculated as the ***greater*** of: (1) A contingent reserve, equal to five percent of its annual net premium income, or (2) An escrow deposit account consisting of five percent of the estimated expenditures for health care services for the calendar year. As of December 31, 2008, the Plan's New York State contingent reserve was $11,434,405 and its escrow deposit account was $12,494,205; therefore its minimum net worth reported on its December 31, 2008 MMCOR should have been $12,494,205. However, the Plan reported its minimum net worth as $11,434,405. In its March 31, 2009 MMCOR, filed subsequent the examination date, the Plan reported its minimum net worth as $12,494,205.

B. Statement of Revenue and Expenses and Net Worth

Net worth increased by $9,059,096 during the three-year examination period, January 1, 2006 through December 31, 2008, detailed as follows:

Revenue		
Medicare Part A & B premium revenue	$ 153,923,695	
Medicare Part D premium revenue	34,917,305	
Medicaid premium revenue	376,282,998	
Spenddown and NAMI	5,010,797	
Reinsurance recoveries	26,634	
HR&R revenue	2,365,705	
Total premium revenue	$ 572,527,134	
Net investment income	(449,492)	
Contributions and grants	1,157,755	
Total revenue		$ 573,235,397
Medical and Hospital Expenses		
Inpatient-acute medical surgical	$ 44,250,712	
Primary physician care	27,276,887	
Physician specialty services	18,921,579	
Other professional services	7,362,196	
Emergency room	5,052,504	
Outpatient mental health	1,302,084	
Outpatient drug and alcohol treatment	553,907	
Dental	2,335,366	
Pharmacy-Part D	36,857,710	
Pharmacy-Non-Part D	3,315,171	
Home health care	40,651,797	
Nursing facility	34,620,777	
Transportation-Emergent	2,335,318	
Transportation-Non Emergent	20,507,259	
Diagnostic test/ lab/X ray	6,031,887	
Vision care	1,837,298	
Podiatry	1,169,597	
Durable medical equipment and supplies	6,087,306	
Personal care	168,233,090	
Personal emergency response services	766,396	
Home delivered and congregate meals	557,290	
Social day care	37,257,980	
Reinsurance premium	146,823	
Total medical and hospital expenses	$ 467,430,934	
Care management	38,082,093	
Allowable administration expenses	38,186,880	

Total underwriting expenses	$ 543,699,907
Net underwriting income	$ 29,535,490
Non-allowable administrative expenses	5,599,670
Net income	$ 23,935,820

Changes in Net Worth

Net worth as of December 31, 2005			$ 40,537,329
	Gains in Net Worth	Losses in Net Worth	
Net income	$ 23,935,820		
Reconciling adjustments		$ 12,223,850	
Contributions to Bethco		8,449,314	
Changes in prior period adjustments	14,923,129		
Changes in non-admitted assets		9,126,689	
Net increase in net worth			9,059,096
Net worth, per report on examination, as of December 31, 2008			$ 49,596,425

4. INVESTMENTS

Section 1404(a)(10)(B) of the New York Insurance Law, which sets forth quantitative limitations in investment companies, states in part:

> "Investment limitations. Investments made by an insurer subject to the provisions of paragraph of paragraph two of subsection (a) or subsection (b) of section one thousand four hundred three of this article shall not exceed the following limitations:
>
> (i) in any investment company qualifying under item (i) of subparagraph (A) hereof, ten percent of such insurer's admitted assets as shown by its last statement on file with the superintendent and the aggregate amount of investment in such qualifying investment companies shall not exceed twenty-five percent of such insurer's admitted assets as shown by its last statement on file with the superintendent..."

Additionally, Section 1404(b) of the New York Insurance Law states in part:

> "(b) Leeway provision. Investments which do not qualify or are not permitted under subsection (a) hereof, but excluding any investment prohibited by the provisions of paragraph six of subsection (a) of this section…provided that:
>
> (1) the aggregate cost of such investments shall not exceed five percent of the admitted assets of the insurer as shown by its last statement on file with the superintendent."

The examination amount of $23,191,311 is $9,126,689 less than the $32,318,000 amount reported by the Plan on its filed annual statement as of December 31, 2008, for the above captioned account.

The examination change was a result of the Plan's investments exceeding the statutory limitations of the admitted assets of the Plan as shown by its last filed statement, in violation of Sections 1404(a)(10)(B) and 1404(b)(1) of the New York Insurance Law. Such nonadmitted asset is reflected in the financial statements contained herein.

It is recommended that the Plan comply with the requirements of Sections 1404(a)(10)(B) and 1404(b)(1) of the New York Insurance Law.

5. CLAIMS PAYABLE

The examination liability of $10,452,739 for the captioned account is the same as the amount reported by the Plan in its filed MMCOR as of December 31, 2008.

The examination analysis was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual and quarterly statements, as verified during the examination. The

examination reserve was based upon actual payments made through a point in time, plus an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's historical payment experience, appropriately modified for current claims payment patterns.

The Department's analysis has concluded that CCMC provisions for Claims Reserves and Liabilities at December 31, 2007 and December 31, 2008 are adequate taking into account the adjustments of $(1,393,823) and $(5,219,537), respectively, which CCMC incorporated in subsequent years' financial statements, however, a more accurate IBNR reserve estimation and an appropriate usage of prior period adjustments should be used.

It is recommended that a review of the process used in the development of the claim reserves and liabilities be initiated so as to reduce the impact of such adjustments in subsequent years.

6. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business practices and fulfills its contractual obligations to policyholders and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination.

The review was directed at the practices of the Plan in the following major areas:

A. Claims processing
B. Prompt Pay Law

A. Claims Processing

A review of the Plan's claims settlement practices and oversight of the claims adjudication process was performed by using a statistical sampling methodology covering claims adjudicated during the period January 1, 2008 through December 31, 2008, in order to evaluate the overall accuracy and compliance environment of CCMC's claims processing environment.

The claim population reviewed by the examiner consisted of only CCMC Select claims. Some of the claims reviewed included items such as: transportation services, prescription drug and durable medical equipment claims. The random statistical sample detailed below included claims from each of the aforementioned segments.

The sampling process, which was performed using the computer software program ACL, was utilized to test various attributes deemed necessary for successful claims processing activity. The objective of this sampling process was to be able to test and reach conclusions about all predetermined attributes, individually or on a combined basis. For example, if ten attributes were being tested, conclusions about each attribute individually, or on a collective basis, could be concluded for each item in the sample.

For the purpose of this report, a "claim" is defined by the Plan as the total number of items submitted by a single provider with a single claim form, as received and entered into its claims processing system. The claim may consist of various lines, procedures or service dates. It was possible, through the computer systems used for this examination, to match or "roll up" all procedures on the original form into one item, which was the basis of the Department's statistical sample of claims or the sample unit.

To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the financial data reported by the Plan for the period January 1, 2008 through December 31, 2008.

It was noted that CCMC performs quality control reviews or audits to check the accuracy of recorded claims transactions (e.g., payment dollar, payment incidence, coding, procedural and total claim accuracy). The results of CCMC's review performed in 2007, as provided to the examiners, pertained to its PACE line of business. No exceptions were noted.

B. Prompt Pay Law

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable.

Section 3224-a(a) of the New York Insurance states in part:

> "…(a) Except in a case where the obligation of an insurer…to pay a claim submitted by a policyholder or person covered under such policy or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within forty-five days of receipt of a claim or bill for services rendered."

Section 3224-a(c) of the New York Insurance states in part:

> "… any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or

> health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less than two dollars, an insurer or organization or corporation shall not be required to pay interest on such claim."

In order to test the Plan's compliance with the Prompt Pay Law, a statistical sample of 167 claims processed during the period January 1, 2008 through December 31, 2008 was drawn from claims not adjudicated within 45 days of submission to the Plan. A determination was then made regarding whether the timeliness of the payment was in violation of the timeframe requirement of Section 3224-a(a) of the New York Insurance Law, and if interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law.

There were 1,368 claims processed in 2008 that took the Plan more than 45 days to pay. Accordingly, all claims that were not paid within 45 days of receipt (Section 3224-a(a)) during 2008 were segregated. A sample of 167 claims were reviewed to determine whether the claims were in violation of Section 3224-a(a) of the New York Insurance Law, and whether they were subject to interest as required by Section 3224-a(c) of the New York Insurance Law.

Of the 167 claims paid after 45 days of receipt, eighty-six (86) claims were deemed to be violations of Section 3224-a(a) of the New York Insurance Law and five (5) of these claims were determined to be interest eligible. Interest was paid by CCMC for these five claims. Of the aforementioned eighty-six (86) claims, the Plan initially denied thirty-four (34) of those claims after 30 days. Upon receipt of additional information, the claims were subsequently paid (interest due on these claims was less than $2.00).

The following chart illustrates CCMC's compliance with Section 3224-a(a) of the New York Insurance Law as determined by this examination:

Summary of Violations of Section 3224-a(a) of the New York Insurance Law

Total claim population	19,873
Population of claims adjudicated after 45 days of receipt	1,368
Sample size	167
Number of claims with violations	86
Calculated violation rate	51.50%
Upper violation limit	59.08%
Lower violation limit	43.92%
Calculated transactions in violation	704
Upper limit transactions in violation	808
Lower limit transactions in violation	600

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

It should be noted that the violations above relate to the population of 1,368 claims used for the review, which consisted of only claims adjudicated in 2008 that were adjudicated more than forty-five days of receipt. The total population of claims pertaining to CCMC Select that were processed during calendar year 2008 was 19,873.

It is recommended that the Plan reviews and revises its procedures in order to improve its compliance with Section 3224-a(a) of the New York Insurance Law.

It is also recommended that the Plan implements the necessary controls and training in order to ensure its compliance with Section 3224-a(a) of the New York Insurance Law.

Section 3224-a(b) of the New York Insurance Law states:

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:
>
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
>
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment."

During the examination of CCMC, the examiner selected a sample of one hundred and sixty-seven (167) claims to review compliance with Section 3224-a(b) of the New York Insurance Law. The review was established through the isolation of all claims that took the Plan more than thirty (30) days to either deny or to seek additional information for claims adjudicated during the period January 1, 2008 through December 31, 2008.

The following chart illustrates CCMC's compliance with Section 3224-a(b) of the New York Insurance Law as determined by this examination:

Summary of Violations of Section 3224-a(b) of the New York Insurance Law

Total claim population	19,873
Population of claims adjudicated after 30 days of receipt	331
Sample size	167
Number of claims with violations	31
Calculated violation rate	18.56%
Upper violation limit	24.46%
Lower violation limit	12.67%
Calculated transactions in violation	61
Upper limit transactions in violation	80
Lower limit transactions in violation	41

Note: The upper and lower violation limits represent the range of potential violation (e.g. if 100 samples were selected, the rate of violation would fall between these limits 95 times).

It is recommended that CCMC comply with the requirements of Section 3224-a(b) of the New York Insurance Law.

It is also recommended that the Plan reviews and revises its procedures in order to improve its compliance with Section 3224-a(b) of the New York Insurance Law.

Additionally, the Plan did not retain sufficient information on all applicable claims to document requests for additional information. In fact, CCMC was unable to demonstrate that any such correspondence was sent out on any of the claims reviewed by the examiner in regard to the above mentioned testing of compliance with Section 3224-a(b) of the New York Insurance Law.

Part 243.2(b)(4) of Department Regulation No. 152 (11 NYCRR 243.2(b)(4)) states:

> "(b) Except as otherwise required by law or regulation, an insurer shall maintain:
>
> (4) A claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received."

Further, Part 216.11 of Department Regulation No. 64 (11 NYCRR 216.11) states in part:

> "…to enable department personnel to reconstruct an insurer's activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to a claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants."

It is recommended that CCMC comply with Part 243.2(b)(4) of Department Regulation No. 152 by retaining all documentation necessary to verify its compliance with Section 3224-a(b) of the New York Insurance Law, for a period of six years, or until after the filing of the report on examination, whichever is longer.

It is also recommended that CCMC comply with the requirements of Part 216.11 of Department Regulation No. 64 by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction.

7. SUBSEQUENT EVENTS

On December 20, 2011, subsequent the examination period, the Plan amended its Certificate of Incorporation to reflect a change in name from Comprehensive Care Management Corporation to CenterLight Healthcare, Inc.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
A.	Conflict of Interest Policy	
	It is recommended that all conflict of interest statements required to be signed by each board member, be filed with the Compliance Officer on an annual basis.	9
B.	Report of Independent Certified Public Accountant	
	It is recommended that CCMC comply with the requirements of Section 307(b)(2) of the New York Insurance Law and submit to this Department the applicable CPA report relative to its financial statements, including a reconciliation of the differences between the amounts reported in the filed annual statements and the amounts reported in the CPA report. In April 2009, subsequent to the examination date, CCMC filed said reconciliation.	10
C.	Contingent Reserve Fund	
	It is recommended that the Plan, in its filed financial statements, report its minimum net worth as the greater of its contingent reserve or escrow deposit.	11
D.	Investments	
	It is recommended that the Plan comply with the requirements of Sections 1404(a)(10)(B) and 1404(b)(1) of the New York Insurance Law.	16
E.	Claims Payable	
	It is recommended that a review of the process used in the development of the claim reserves and liabilities be initiated so as to reduce the impact of such adjustments in subsequent years.	17
F.	Prompt Pay Law	
i.	It is recommended that the Plan reviews and revises its procedures in order to improve its compliance with Section 3224-a(a) of the New York Insurance Law.	21

ITEM		PAGE NO.
F.	Prompt Pay Law (cont'd.)	
ii.	It is also recommended that the Plan implements the necessary controls and training in order to ensure its compliance with Section 3224-a(a) of the New York Insurance Law.	21
iii.	It is recommended that CCMC comply with the requirements of Section 3224-a(b) of the New York Insurance Law.	23
iv.	It is also recommended that the Plan reviews and revises its procedures in order to improve its compliance with Section 3224-a(b) of the New York Insurance Law.	23
v.	It is recommended that CCMC comply with Part 243.2(b)(4) of Department Regulation No. 152 by retaining all documentation necessary to verify its compliance with Section 3224-a(b) of the New York Insurance Law, for a period of six years, or until after the filing of the report on examination, whichever is longer.	24
vi.	It is also recommended that CCMC comply with the requirements of Part 216.11 of Department Regulation No. 64 by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction.	24

Appointment No. **30346**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Victor Estrada

as a proper person to examine into the affairs of the

Comprehensive Care Management Corporation

and to make a report to me in writing of the condition of the said

Company

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by name and affixed the official Seal of this Department, at the City of New York.

this 21st day of September, 2009

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR