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November 21, 2005

IN REPLY REFER
TO FILE NO: 933-0176

Mr. Curtis Terry, Chairman
Aetna Health of California
2409 Camino Ramon
San Ramon, CA 94583

RE: FINAL REPORT OF THE ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA

Dear Mr. Terry:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of **Aetna Health of California** ("Plan") for the quarter ended September 30, 2004, conducted by the Department of Managed Health Care (the "Department" or "DMHC") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").¹ **This Final Report covers the statutory compliance portions related to the Provider Dispute Resolution ("PDR") and Claims Review portions of the examination only (excluding the Financial and Statutory Compliance portions of the examination). The Department has already issued a first, Final Report, addressing the Financial and Statutory Compliance portions.** The Department issued a Preliminary Report pertaining to PDR and Claims Review to the Plan on July 15, 2005. The Department accepted the Plan's electronically filed response on September 1, 2005.

This Final Report includes a description of the compliance efforts included in the Plan's responses accepted on September 1, 2005 ("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 whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response exclusive of information held confidential pursuant to section 1382(c), no later than ten (10) days from the date of the Plan's receipt of this letter.

¹ References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, 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 1 of Division 1 of Title 28, California Code of Regulations, beginning with Section 1300.43, and transferred to the Department of Managed Care pursuant to Health and Safety Code Section 1341.14.

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 September 1, 2005 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter.

As noted in the attached Final Report, the Plan's responses did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on July 15, 2005. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report. If the Plan fails to fully respond and/or resolve the deficiencies in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please email your response directly to the undersigned. In addition, file the Plan's response electronically via the Department's new eFiling web portal <https://wpso.dmhc.ca.gov/secure/login/>. Please note this process is separate from the electronic financial reporting and is for the response to this preliminary report only. From the drop-down menu, select "Miscellaneous Documents/Attachments - Public", then upload your response. Questions or problems related to the electronic transmission of the response should be directed to Siniva Pedro at (916) 322-5393 or email at spedro@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

If there are any questions regarding this report, please call.

Sincerely,

Shelley Tang
Supervising Examiner
Division of Financial Oversight

cc: Salli Thompson, Principal Financial Officer, Aetna Health of California
Reina Galanes, Ph.D., Compliance Manager, West Region, Aetna Health of California
Mark E. Wright, Chief, Division of Financial Oversight
Kathleen McKnight, Counsel
Kelvin Gee, Examiner

**CALIFORNIA DEPARTMENT OF MANAGED
HEALTH CARE, DIVISION OF
FINANCIAL OVERSIGHT**

FILE NO. 933-0176

**ROUTINE EXAMINATION
FINAL REPORT
AETNA HEALTH OF CALIFORNIA**

NOVEMBER 21, 2005

**Examiner-In-Charge: Rosemary Wilke / Kristin
Forsberg / Stephen Babich
Oversight Examiner: Shelley Tang**



BACKGROUND INFORMATION

Date Plan Licensed:	August 5, 1981
Organizational Structure:	The Plan is a wholly-owned subsidiary of Aetna Health Holdings, LLC which is a wholly-owned subsidiary of Aetna, Inc.
Type of Plan:	Full Service Plan serving Commercial, Medicare and Point-of-Service enrollees.
Provider Network:	The Plan contracts with a network of providers for the provision of healthcare services.
Plan Enrollment:	The Plan reported 304,944 enrollees as of December 31, 2004.
Service Area:	Statewide
Date of Last Routine Financial Examination Final Report:	November 5, 2002
Date of Last Medical Survey Final Report:	August 23, 2003

FINAL REPORT OF ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA

This is a Final Report of the routine examination of Aetna Health of California (“Plan”), conducted by the Department of Managed Health Care (“Department”) pursuant to Section 1382 of the Knox-Keene Health Care Plan Act of 1975. **This Final Report covers the Provider Dispute Resolution (“PDR”) and Claims Review portions of the examination only (excluding the financial and statutory compliance portions of the examination). The Department has previously issued a first, Final Report, addressing the financial and statutory compliance portions of the examination.**

Our findings are presented as follows:

- Section I. PDR Review - Compliance Issues
- Section II. Claims Review
- Section III. Non-Routine Examination

SECTION I. PDR REVIEW – COMPLIANCE ISSUES

A. TIME PERIOD FOR ACKNOWLEDGEMENT

Rule 1300.71.38(e) states: “A Plan...shall identify and acknowledge the receipt of each provider dispute...In the case of a paper dispute: Acknowledgement shall be provided within fifteen (15) working days.”

We randomly selected a sample of 50 provider disputes received by the Plan during 2004. Our review revealed that the Plan failed to send an acknowledgement letter in four (4) cases (8% of the sample), and sent the acknowledgement letter after 21 calendar days in three (3) cases (6% of the sample).

The Plan was required to submit a Corrective Action Plan (“CAP”) that discusses in detail how the Plan will comply with Rule 1300.71.38(e). The CAP should include the policies and procedures implemented to ensure disputes being processed timely. The CAP should also state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan responded that it had implemented the California Amendment to the National Provider Appeal Process on July 1, 2004. The Plan enclosed with its response a copy of the California Amendment to its Provider Appeal Process. The Plan stated that this policy and procedure manual elucidates the steps to comply with Rule 1300.71.38. Also, the Plan stated that Curtis Terry is the Plan’s Principal Officer who is responsible for overseeing compliance with these regulations and that the management positions responsible for operational compliance with these regulations are the Manager of the Provider Resolution Team and the Manager of the Medical Resolution Team. Furthermore, the Plan stated that as a result of the Department’s findings, each manager has designated one employee per team whose responsibilities include the triage and tracking of provider disputes to ensure that acknowledgement letters are sent timely. Beginning September 1, 2005, these managers will review daily and monthly reports regarding compliance with acknowledgement letter timeliness requirements.

The Department finds that the compliance effort, as set forth above, is responsive to the CAP required by the Department.

B. PAST DUE PAYMENTS

Rule 1300.71.38(g) states: “If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the Plan shall pay any outstanding monies determined to be due, and all interest and penalties required under sections 1371 and 1371.35 within five (5) working days of the issuance of the Written Determination.”

We randomly selected a sample of 50 provider disputes received by the Plan during 2004.

Our review revealed that the Plan failed to pay additional amounts determined to be due within 7 calendar days of the Written Determination in 4 cases (8% of the sample).

The Plan was required to submit a CAP that discusses in detail how the Plan will comply with Rule 1300.71.38(e). The CAP should include the policies and procedures implemented to ensure disputes being processed timely. The CAP should also state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan responded, that effective August 22, 2005, the Plan has implemented a workflow for overturned and partially overturned dispute determinations. The Plan explained that for these cases, the Resolution Team Analyst sends a priority message to claims processors to reprocess the claim and to include applicable interest, within 7 calendar days, in accordance with Rule 1300.71.38(g); and, that if the claims processor does not provide evidence of payment to the analyst within three days, then the analyst escalates the case to the Resolution Team Manager, who ensures that the claim is reprocessed timely and correctly.

The Department finds that the compliance effort, as set forth above, is responsive to the CAP required by the Department.

C. PAYMENT OF INTEREST/PENALTY

Rule 1300.71.38(g) requires that any outstanding monies determined to be due as a result of the Plan's determination in favor of the provider in a dispute include all interest and penalties required under sections 1371 and 1371.35.

Section 1371 states that if an uncontested claim is not reimbursed within 45 working days, interest shall accrue at the rate of fifteen percent (15%) per annum beginning with the first calendar day following the 45 working day period. A health care service plan shall automatically include in its payment of the claim all interest accrued pursuant to this Section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten-dollar (\$10) fee.

We randomly selected a sample of 50 provider disputes received by the Plan during 2004. Our review revealed that the Plan failed to pay the required interest and penalty (per Section 1371) in nine (9) cases (18% of the sample), as identified below:

				A	B	C							
Case ID/ PDR Tracking #	Receipt Date for Original Claim (Claim #1)	Date Paid	Date of 45th Working Day (excluding intervening federal holidays for 2004)	# of Calendar Days on which interest is due (Date Paid - 45th Working Day)	Daily Interest Rate (.15/366) [2004 was a leap year]	Amount paid (Excluding Interest)	Daily Interest on Benefit Amt.Paid (BxC)	Interest Calc. Per DMHC (AxBxC)	Plus: \$10 Penalty (if Plan did not automatically pay interest w/additional claim payment)	Interest Plus Penalty Due (Per DMHC)	Interest /Penalty Paid per Plan	Difference: Amt. Over/ (Under) Paid	
2004041400609	2/3/2004	4/15/04	4/7/04	8	0.000409836	\$1,866.00	\$0.76	6.12	10.00	16.12	0	-16.12	
2004050700818	3/3/2004	5/27/04	5/5/04	22	0.000409836	\$555.00	\$0.23	5.00	10.00	15.00	0	-15.00	
2004051900809	1/20/2004	7/8/04	3/24/04	106	0.000409836	\$1,224.00	\$0.50	53.17	10.00	63.17	0	-63.17	
2004061600443	2/21/2004	6/17/04	4/23/04	55	0.000409836	\$675.00	\$0.28	15.22	10.00	25.22	0	-25.22	
2004082500255	6/10/2004	8/26/04	8/13/04	13	0.000409836	\$784.51	\$0.32	4.18	10.00	14.18	0	-14.18	
2004091600914	2/3/2004	10/13/04	4/7/04	189	0.000409836	\$2,130.49	\$0.87	165.03	10.00	175.03	0	-175.03	
2004071400774	4/13/2004	9/17/04	6/16/04	93	0.000409836	\$934.22	\$0.38	35.61	10.00	45.61	0	-45.61	
2004092700616	4/7/2004	10/20/04	6/10/04	132	0.000409836	\$863.00	\$0.35	46.69	10.00	56.69	0	-56.69	
Source: 2004 Federal Holiday Calendar													

The Plan was required to submit a CAP that identifies all provider disputes involving payment of outstanding monies determined to be due that were paid beyond 45 working days, but did not include payment of interest/penalty as required by Section 1371. In addition, the Plan was required to submit evidence in its response that the correct amount of interest and penalty, if applicable, were paid for all disputes identified.

The CAP should include the policies and procedures implemented to ensure that the correct interest and applicable penalties are paid on all disputes processed beyond the 45 working day period. The CAP should also state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan was reminded that the \$10 penalty is imposed when interest is not paid automatically

and correctly with claim payments.

The Plan responded that it had implemented the California Amendment to the National Provider Appeal Process on July 1, 2004. The Plan enclosed with its response a copy of the California Amendment to its National Provider Appeal Process. The Plan stated that the policies and procedures contained in the amendment elucidate the steps to comply with Rule 1300.71.38. The Plan stated that the management position responsible for overseeing compliance with the payment of claims related to provider disputes is the Manager of the Provider Resolution Team. The Plan stated that per the Department's request, the Plan has identified 3,408 provider disputes for which decisions were overturned or partially overturned during the period of 1/1/2004-7/15/2005; and, that the Plan is estimating that it will complete the review and reprocessing of the claims associated with these disputes by January 31, 2006. The Plan stated that on an ongoing basis, the Manager of the Provider Resolution Team will monitor the timely and accurate payment of applicable interest by reviewing a weekly report of resolved disputes and that the manager or the manager's designee will review a percentage of all overturned and partially overturned disputes to verify whether interest was due and, if so, that it was calculated correctly.

The Department finds that the compliance efforts by the Plan are substantially responsive to the deficiencies cited above and the corrective actions required by the Department. However, the Plan still needs to report to the Department the status of the CAP to review and reprocess the claims that were paid beyond 45 working days but did not include payment of interest/penalty as required by Section 1371. In addition, the Plan is still required to submit evidence in its response that the correct amount of interest and penalty, if applicable, were paid for all disputes identified. Please provide the requested data within 15 days of your stated estimated completion date of January 31, 2006.

SECTION II. CLAIMS REVIEW – COMPLIANCE ISSUES

A. COMMERCIAL CLAIMS

1. PAYMENT OF INTEREST (Repeat Deficiency)

Section 1371 requires full service health care service plans to reimburse claims within forty-five (45) working days¹ after receipt of the claim, unless the claim is contested or denied by the plan. Section 1371 also requires that if the claim is contested or denied by the plan, the claimant shall be notified, in writing, that the claim is contested or denied, within forty-five (45) working days after receipt of the claim by the health care service plan. The notice that

¹ The Department interprets 45 “working days” to be the equivalent of 63 calendar days (excluding federal holidays).

a claim is contested or denied shall identify the portion of the claim that is contested or denied, and the specific reason(s) for contesting or denying the claim.

Section 1371 also states that if an uncontested claim is not reimbursed within forty-five (45) working days, interest shall accrue at the rate of fifteen percent (15%) per annum beginning with the first calendar day following the forty-five (45) working day period. A health care service plan shall automatically include in its payment of the claim all interest accrued pursuant to this Section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten-dollar (\$10) fee.

During our examination, it was discovered that the Plan did not pay any interest or penalties on certain claims paid outside of the statutory timeframe. [This exception was noted in 9 of the 50 claims tested for this criteria]. These claims are identified below:

Claim #	Date Rec'd	Date Paid	Amt. Paid	# of Days Overdue (after excluding Federal Holidays)	Daily Interest Rate (0.15/366)	Daily Interest Penalty	Interest Calculation per DMHC	Plus \$10 Penalty if Plan did not pay interest with claim	Total Interest Plus Penalty Due	Total Interest Plus Penalty Paid per Plan	Estimated Amount Over-(Under-) Paid
040121c00732	1/21/04	8/2/04	\$3,810.00	128	0.000409836	\$1.56	\$199.87	10	\$209.87	0	-\$209.87
040414c12837	4/14/04	7/26/04	\$1,975.00	38	0.000409836	\$0.81	\$30.76	10	\$40.76	0	-\$40.76
040510m65499	5/10/04	7/21/04	\$720.00	7	0.000409836	\$0.30	\$2.07	10	\$12.07	0	-\$12.07
040527y04447	5/27/04	8/11/04	\$6,616.48	11	0.000409836	\$2.71	\$29.83	10	\$39.83	0	-\$39.83
040615y78488	6/15/04	9/1/04	\$74,338.41	14	0.000409836	\$30.47	\$426.53	10	\$436.53	0	-\$436.53
040127y97498	1/27/04	5/11/04	\$25,219.00	41	0.000409836	\$10.34	\$423.76	10	\$433.76	0	-\$433.76
030806y96711	8/6/04	1/5/04	\$256,988.00	83	0.000409836	\$105.32	\$8,741.80	10	\$8,751.80	0	-\$8,751.80
011226y97498	12/26/04	8/3/04	\$30,989.00	866	0.000409836	\$12.70	\$10,998.55	10	\$11,008.55	0	-\$11,008.55
010821050000	12/15/04	4/8/04	\$27,600.00	49	0.000409836	\$11.31	\$554.26	10	\$564.26	0	-\$564.26

Also, it was discovered that the Plan calculated interest incorrectly on certain claims paid outside of the statutory timeframe. [This exception was noted in 4 of the 50 claims tested for this criteria]. The omission of paying interest and incorrect calculation of interest appears to be due to interest being manually calculated by the claims processors.

Claim #	Date Rec'd	Date Paid	Amt. Paid	# of Days Overdue (after excluding Federal Holidays)	Daily Interest Rate (0.15/366)	Daily Interest Penalty	Interest Calculation per DMHC	Plus \$10 Penalty if Plan did not pay interest with claim	Total Interest Plus Penalty Due	Total Interest Plus Penalty Paid per Plan	Estimated Amount over-(Under-) Paid
040414y97498	4/14/04	8/9/04	\$6,558.39	117	0.000409836	\$2.69	\$139.77	10	\$149.77	\$190.51	\$50.74
040506c47835	2/21/04	7/21/04	\$250.00	151	0.000409836	\$0.10	\$8.81	10	\$18.81	\$2.77	\$16.04
010112797498	1/12/01	1/28/04	\$31,009.00	1021	0.000409836	\$12.71	\$12,975.49	10	\$12,985.49	\$8,824.83	-\$4,160.66
031226m14235	12/24/03	3/2/04	\$34,411.00	2	0.000409836	\$14.10	\$28.21	10	\$38.21	\$210.82	\$172.61

These are repeat deficiencies that were reported in the prior routine examination Final Report (dated November 5, 2002), where it was noted that in certain circumstances the Plan

was not paying interest and that the Plan was calculating interest incorrectly. The Plan was notified, that since this was a repeat deficiency, that a referral was made to the Office of Enforcement for appropriate administrative action.

The Plan was required to describe in detail the Corrective Action Plan the Plan has implemented to ensure compliance with Sections 1371 and 1371.35. The Plan was to include procedures for monitoring compliance with Sections and 1371 and 1371.35. and to provide the management position that has the responsibility for implementing the Corrective Action Plan, and also ongoing compliance with these Sections.

Also, in the CAP, the Plan was to include procedures that will ensure that the deficiencies related to interest are corrected, and a system of monitoring will be implemented that will ensure that such deficiencies will not occur in the future.

Furthermore, the Plan was required to identify all claims, and portions of claims, paid since November 5, 2002 on which interest should have been paid and, if interest has not been paid, pay that interest. This should include those claims, or portions of claims, that were originally denied but later paid.

The Plan was told that the corrective action may not be completed by the date of its response to this report, and if so, to provide a time-frame in which the payments will be made.

The Plan stated that it has taken the following steps to address the Department's findings that incorrect calculation of interest appears to be tied to manual processing:

- 1) The Plan has instituted the automatic calculation of interest payments on its claims system. This automatic calculation is carried out on all clean claims that are auto-adjudicated.*
- 2) For those claims which require manual processing (e.g., unclean claims), the Plan is developing a mandatory training module for all CA HMO claims processors. The programming of this online course is expected to be completed by 11/1/05 and claims processors will have until 12/31/05 to complete the course.*
- 3) Effective immediately, Claims Managers will utilize a report to identify claims that are within 5 days of incurring interest, in order to expedite payment. For those claims that still require interest, Claims Managers will utilize an "Interest Penalty Paid Report" to verify that interest was calculated correctly.*
- 4) The Regulatory Audit & Compliance Unit will test the veracity of these interest calculations (automated and manual) in the 3rd Quarter 2005.*
- 5) The Plan has identified 39,750 claims and portions of claims, since 11/5/2002, that required interest or for which interest had not been paid correctly. The Plan estimates that it will complete reprocessing of these claims by February 28, 2006.*

Compliance with these corrective actions will be overseen by the Claims Managers at the Fresno site, and the Provider Resolution Team Manager at the San Diego site.

The Department finds that the compliance efforts by the Plan are substantially responsive to the deficiencies cited above and the corrective actions required by the the Department. Please submit to the Department the claims interest and penalty report by February 28, 2006.

SECTION III. NON-ROUTINE EXAMINATION

The Plan was advised that the Department will 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.



Aetna
2625 Shadelands Drive
Walnut Creek, CA 94598

Mary V. Anderson
Counsel
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(925) 948-4207
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November 22, 2005

Shelley Tang
Supervising Examiner
Division of Financial Oversight
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2738

**Re: Response to Final Report for Review of Provider Dispute Resolution
Mechanism and Claims Processing System
Aetna Health of California Inc. (933-0176)**

Dear Ms. Tang,

Reference is made to your letter of November 21, 2005, received by the Plan on November 21, 2005, containing the Department's Final Report of the Review of Provider Dispute Resolution Mechanism and Claims Processing System. The Plan wishes to modify the information provided to the Department in its September 1, 2005 Response to the Preliminary Report. Please include the following modifications in or, alternatively, append this letter to the Department's Final Report.

The Plan has taken the appropriate steps to address all deficiencies found in the Department's Final Report of the Review of Provider Dispute Resolution Mechanism and Claims Processing System. We are committed to continually improving the quality of service we provide to our members, providers, and customers, and appreciate the feedback provided in this report.

Section I. PDR Review – Compliance Issues

C. Payment of Interest/Penalty

On Page 6 of the Final Report, the Department has stated that “the Plan has identified 3,408 provider disputes for which decisions were overturned or partially overturned during the period of 1/1/2004-7/15/2005; and that the Plan is estimating that it will complete the review and reprocessing of the claims associated with these disputes by January 31, 2006”.

The Plan confirms that it has identified 3,408 provider disputes for which decisions were overturned or partially overturned during the period 1/1/2004-7/15/2005. However, the Plan also

wishes to clarify that it is not yet known whether any interest is due on the claims in this population. The status of the Plan's review of the claims associated with these disputes is as follows:

- Determine whether interest was due on each claim.
 - If interest was not due, then no further action is required on those claims.
 - If interest was due, then verify whether the interest was paid upon dispute resolution.
 - If interest was paid, then recalculate the interest to ensure that interest was originally calculated correctly.
 - If interest was calculated correctly, then no further action is required.
 - If interest was not calculated correctly, then reprocess the claim to include any additional interest or penalty owed.
 - If interest was not paid, then calculate the interest due. Reprocess the claim with the interest due and the \$10 penalty.

The Plan is on schedule to complete its review of these claims by January 31, 2006, and will provide a summary of its results to the Department by February 15, 2006.

Section II. Claims Review – Compliance Issues

A. Commercial Claims

1. Payment of Interest (Repeat Deficiency)

On Page 8 of the Final Report, the Department states that “The Plan has identified 39,750 claims and portions of claims, since 11/5/2002, that required interest or for which interest had not been paid correctly. The Plan estimates that it will complete reprocessing of these claims by February 28, 2006.”

The Plan wishes to clarify that it has identified a population of 39,750 claims and portions of claims that have been paid since 11/5/2002. It is not yet known whether any interest is due on the claims in this population. As previously stated, the Plan will submit its summary report of its findings to the Department by February 28, 2006.

Thank you for the opportunity to present these responses to the Department's Final Report.

Sincerely,



Mary V. Anderson
West Region General Counsel