



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: 916-255-2425 | Fax: 916-255-2280

July 25, 2018

Via USPS Delivery and eFile

Dr. Mukesh Bhatia
President and Chief Executive Officer
ACCESS SENIOR HEALTHCARE, INC.
5375 Whitman Road
Hidden Hills, CA 91302

FINAL REPORT OF ROUTINE EXAMINATION OF ACCESS SENIOR HEALTHCARE, INC.

Dear Dr. Bhatia:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended September 30, 2017 of the fiscal and administrative affairs of Access Senior HealthCare, Inc. (Plan). The examination was 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 (Preliminary Report) to the Plan on April 20, 2018. The Department accepted the Plan's electronically filed response on June 15, 2018.

This Final Report includes a description of the compliance efforts included in the Plan's June 15, 2018 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 to the Final Report. If so, please indicate which portions of the Plan's response should be appended, and electronically file copies of those portions of the Plan's response excluding information

¹ References throughout this Final 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 of 1975 found within Title 28 of the California Code of Regulations.

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 Final Report or wishes to modify any information provided to the Department in its June 15, 2018 response, please provide the electronically filed documentation no later than 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 at <https://wps0.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 S18-R-506.
- Go to the "Messages" tab, then:
 - 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."

As noted in the attached Final Report, the Plan's response of June 15, 2018 did not adequately respond to the deficiencies raised in the Preliminary Report issued by the Department on April 20, 2018. According to Rule 1300.82, the Plan is required to respond to any request for additional corrective actions contained within the attached Final Report within 30 days of receipt of the Final Report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action.

Please file the Plan's response electronically via the CAP system within the Online Forms section of the Department's eFiling web portal at <https://wps0.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 S18-R-506.
- Go to the "Data Requests" tab, then:
 - Click on the "Details" for each data request that does not have a status of "Complete."
 - Follow the instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement refile).

The Department will also send the Plan an email(s) requesting those items that are still outstanding. The email(s) will contain a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission of the response should be directed to Vijon Morales at 916-255-2447 or by email at Vijon.Morales@dmhc.ca.gov. You may also email inquiries to wps@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in 10 days from the Plan's receipt of this letter through the eFiling system. The Final Report will be located at the Department's web site at [View Financial Examination Reports](#).

If there are any questions regarding this Final Report, please contact me at 916-255-2425 or by email at Anna.Belmont@dmhc.ca.gov.

Sincerely,

Anna Belmont
Senior Examiner (Supervisor)
Office of Financial Review
Division of Financial Oversight

cc: Paul Pew, Executive Vice President, Advanced Medical Management, Inc.
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Eri Fukuda, Examiner, Division of Financial Oversight
Ping Han, Examiner, Division of Financial Oversight
Munir Chechi, Associate Governmental Program Analyst, 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**

**OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT**

FINAL REPORT OF ROUTINE EXAMINATION

OF

ACCESS SENIOR HEALTHCARE, INC.

FILE NO. 933 0506

DATE OF FINAL REPORT: JULY 25, 2018

OVERSIGHT EXAMINER: ANNA BELMONT

EXAMINER-IN-CHARGE: ERI FUKUDA

FINANCIAL EXAMINERS:

**NINA MOUA
ERICA SHORT**

BACKGROUND INFORMATION FOR ACCESS SENIOR HEALTHCARE, INC.

Date Plan Licensed:	November 6, 2014
Organizational Structure:	Access Senior Healthcare, Inc. (Plan) was incorporated on July 16, 2013 as an S corporation. The Plan is wholly owned by one shareholder, Dr. Mukesh Bhatia. Dr. Bhatia also solely owns Access Medical Group and Access Santa Monica independent practice associations. The Plan contracts with Advanced Medical Management to provide administrative services.
Type of Plan:	The Plan is a restricted Medicare Advantage full service health care plan. The Plan is authorized to contract with other Knox-Keene licensed health care service plans that are contracted with the Center for Medicare and Medicaid Services.
Provider Network:	The Plan contracts with its affiliate provider groups and hospitals. The Plan pays the contracting provider groups on a capitated basis and hospitals on a fee-for-service basis.
Plan Enrollment:	The Plan had 3,381 plan-to-plan Medicare-Risk enrollees, consisting of 788 enrollees from Blue Shield of California, 113 enrollees from Humana, 1,117 enrollees from SCAN, 1,334 enrollees from United Health Care Senior and 29 enrollees from Easy Choice, as of September 30, 2017.
Service Area:	Los Angeles, Orange, and Santa Clara counties
Date of Prior Final Routine Examination Report:	December 9, 2015

**FINAL REPORT OF A ROUTINE EXAMINATION OF
ACCESS SENIOR HEALTHCARE, INC.**

This is the final report (Final Report) for the quarter ended September 30, 2017 of a routine examination of the fiscal and administrative affairs of Access Senior HealthCare, Inc. (Plan). The examination was 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 (Preliminary Report) to the Plan on April 20, 2018. The Department accepted the Plan's electronically filed response on June 15, 2018.

This Final Report includes a description of the compliance efforts included in the Plan's June 15, 2018 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 Final Report may be referred to the Office of Enforcement for appropriate administrative action upon the completion of all corrective actions required in response to this Final Report.

The Department examined the Plan's financial report filed with the Department for the quarter ended September 30, 2017, 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:

Section I.	Financial Statements
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Non-Routine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective actions contained within this Final Report, within 30 days of receipt of this Final Report.

¹ References throughout this Final 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 of 1975 found within Title 28 of the California Code of Regulations.

SECTION I. FINANCIAL STATEMENTS

The Department's examination resulted in the following adjustments and reclassifications to the Plan's financial statements for the quarter ended September 30, 2017, as filed with the Department.

A. BALANCE SHEET AT THE QUARTER ENDED SEPTEMBER 30, 2017

ASSETS Account	Bal. per F/S @ 9/30/17	AJE or RJE	Exam Adjustments		Bal. per Exam @ 9/30/17
			Dr.	Cr.	
Cash and Cash Equivalents	\$5,199,057				\$5,199,057
Short-Term Investments					
Premiums Receivable – Net					
Interest Receivable					
Shared Risk Receivables – Net					
Other Health Care Receivables – Net					
Prepaid Expenses	9,866				9,866
Secured Affiliate Receivables – Current					
Unsecured Affiliate Receivables – Current					
Aggregate Write-Ins for Current Assets	248				248
TOTAL CURRENT ASSETS	5,209,171				5,209,171
Restricted Assets	1,200,000	RJE1	\$901,350		2,101,350
Long-Term Investments	901,350	RJE1		\$901,350	0
Intangible Assets & Goodwill – Net	219,493				219,493
Secured Affiliate Receivables – Long-Term					
Unsecured Affiliate Receivables – Past Due					
Aggregate Write-Ins for Other Assets	1,000				1,000
TOTAL OTHER ASSETS	2,321,843				2,321,843
Land, Building and Improvements					
Furniture and Equipment – Net					
Computer Equipment – Net					
Leasehold Improvements – Net					
Construction in Progress					
Software Development Costs					
Aggregate Write-Ins for Other Equipment					
TOTAL PROPERTY & EQUIPMENT	0				0
TOTAL ASSETS	\$7,531,014				\$7,531,014

LIABILITIES	Bal. per F/S	AJE	Exam Adjustments		Bal. per
	@	or	Dr.	Cr.	Exam
Account	9/30/17	RJE			@
					9/30/17
Trade Accounts Payable	\$4,880				\$4,880
Capitation Payable					
Claims Payable (Reported)	1,573,697				1,573,697
Incurred But Not Reported (IBNR) Claims	1,122,056	AJE		\$1,321,422	2,443,478
POS Claims Payable (Reported)					
POS Incurred But Not Reported Claims					
Other Medical Liability					
Unearned Premiums					
Loans & Notes Payable					
Amounts Due to Affiliates – Current					
Aggregate Write-Ins for Current Liabilities	1,373,897				1,373,897
TOTAL CURRENT LIABILITIES	4,074,530			1,321,422	5,395,952
Loans and Notes Payable (Not Subordinated)	20,000				20,000
Loans and Notes Payable (Subordinated)					
Accrued Subordinated Interest Payable					
Amounts Due To Affiliates – Long Term					
Aggregate Write-Ins for Other Liabilities					
TOTAL OTHER LIABILITIES	20,000				20,000
TOTAL LIABILITIES	4,094,530			1,321,422	5,415,952
NET WORTH					
Common Stock	1,000				1,000
Preferred Stock					
Paid in Surplus					
Contributed Capital	2,119,000				2,119,000
Retained Earnings (Deficit)/Fund Balance	1,316,484				1,316,484
Aggregate Write-Ins for Other Net Worth Items					
EXAMINATION ADJUSTMENTS (from Income Statement)		(A)	\$1,321,422		(1,321,422)
TOTAL NET WORTH	3,436,484		1,321,422		2,115,062
TOTAL LIABILITIES & NET WORTH	\$7,531,014		\$1,321,422	\$1,321,422	\$7,531,014

**B. STATEMENT OF INCOME AND EXPENSES FOR THE QUARTER ENDED
SEPTEMBER 30, 2017**

Account	Bal. per F/S @ 9/30/17	AJE or RJE	Exam Adjustments		Bal. per Exam @ 9/30/17
			Dr.	Cr.	
REVENUES:					
Premiums (Commercial) Capitation Co-payments, COB, Subrogation Title XVIII – Medicare Medicaid, Healthy Families Fee-For-Service Point-Of-Service (POS)	\$9,505,270				\$9,505,270
Interest	347				347
Risk Pool Revenue					
Aggregate Write-Ins for Other Revenues	19,641				19,641
TOTAL REVENUE	9,525,258				9,525,258
EXPENSES:					
Medical and Hospital					
Inpatient Services – Capitated Inpatient Services – Per Diem/Managed Hospital					
Inpatient Services – Fee-For-Service/Case Rate	3,577,774	AJE	\$1,321,422		4,899,196
Primary Professional Services – Capitated	4,404,610				4,404,610
Primary Professional Services – Non-Capitated Other Medical Professional Services – Capitated					
Other Medical Professional Services – Non- Capitated	79,371				79,371
Non-Contracted Emergency Room and Out-of- Area	16,139				16,139
Expense, not including POS POS Out-Of-Network Expense					
Pharmacy Expense – Capitated Pharmacy Expense – Fee-for-Service					
Aggregate Write-Ins for Other Capitated Medical and Hospital Expenses		RJE 2	398,945		398,945
Aggregate Write-Ins for Other Non-capitated Medical and Hospital Expenses		RJE 2		6,027	(6,027)
TOTAL MEDICAL AND HOSPITAL EXPENSES	8,077,894		1,714,340		9,792,234
Administration					
Compensation Interest Expense Occupancy, Depreciation and Amortization Management Fees Marketing Affiliate Administration Services Aggregate Write-Ins for Other Administration	868,877			392,918	475,959
TOTAL ADMINISTRATION EXPENSES	868,877			392,918	475,959
TOTAL EXPENSES	8,946,771		1,714,340	392,918	10,268,193
INCOME (LOSS)	578,487				(742,935)
Provision for Taxes					
NET INCOME (LOSS)	\$578,487	(A)	\$1,321,422		(\$742,935)

This financial report is not adjusted for any tax effect resulting from the adjusting journal entry.

C. EXPLANATION OF EXAMINATION ADJUSTMENTS

ADJUSTING JOURNAL ENTRY (AJE)

	ACCOUNT NAME	DR.	CR.
AJE	Inpatient Services-Fee-For Service/Case Rate Incurred But Not Reported (IBNR) Claims <i>To accrue an additional liability for IBNR.</i>	\$ 1,321,422	\$1,321,422

The Preliminary Report required the Plan to provide written assurance that the above adjusting journal entry was posted to the books and/or provide an explanation regarding its disposition. In addition, the Plan was required to refile the reporting form (Reporting Form) for the quarter ended September 30, 2017 to include the required adjusting journal entry noted above. The Plan was also to state the date the requested Reporting Form was refilled with the Department.

The Plan responded that the requested adjusting journal entry was made to its accounting system.

The Plan filed the revised Reporting Form for the quarter ended September 30, which include the required adjusting journal entry, on July 4, 2018.

The Department finds that the Plan’s compliance effort is responsive to the corrective action required. Therefore, no further response is required.

RECLASSIFYING JOURNAL ENTRIES (RJE)

RJE No.	ACCOUNT NAME	DR.	CR.
1	Restricted Assets Long-Term Investments <i>To reclassify funds held in a CD that is restricted for use for United Healthcare to restricted assets.</i>	\$ 901,350	\$ 901,350

2	Aggregate Write-Ins for Other Capitated Medical and Hospital Expenses	\$ 398,945	
	Aggregate Write-Ins for Other Non-Capitated Medical and Hospital Expenses		\$6,027
	Aggregate Write-Ins for Other Administration		\$ 392,918
	<i>To reclassify reinsurance premiums and reinsurance recoveries to Aggregate Write-Ins for Other Capitated Medical and Hospital Expenses and Aggregate Write-Ins for Other Non-Capitated Medical and Hospital Expenses correspondingly.</i>		

The Preliminary Report required the Plan to provide written assurance to the Department that the above reclassifying journal entries were posted to the books and/or provide an explanation regarding their disposition. In addition, the Plan was required to refile the Reporting Form for the quarter ended September 30, 2017 to include the required reclassifications noted above. The Plan was to state, in its response to the Preliminary Report, the date the Reporting Form was refiled with the Department.

The Plan responded that the requested reclassifying journal entries were made to its accounting system.

The Plan refiled all the required monthly and quarterly Reporting Forms for year 2018, which included the required reclassifications, on July 19, 2018.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth and TNE per Examination as of quarter ended September 30, 2017 [From Section I.A.]	\$2,115,062
Less: Intangible Assets	<u>219,493</u>
TNE	\$1,895,569
Required TNE per Examination	<u>1,724,040</u>
TNE Excess per Examination	<u>\$171,529</u>

The Plan was in compliance with the TNE requirements of Section 1376 and Rule 1300.76 as of September 30, 2017.

No response is required to this section.

SECTION III. COMPLIANCE ISSUES

A. INCURRED BUT NOT REPORTED (IBNR) CLAIMS LIABILITY

Section 1377(c) requires each plan which reimburses providers of health care services on a fee-for-service basis to estimate and record in the books of account a liability for incurred and unreported claims. Rule 1300.77.2(a) requires that the estimate of incurred and unreported claims be made pursuant to a method held unobjectionable by the director. This method may include a lag study, an actuarial estimate, or another reasonable method of estimating incurred and unreported claims.

The Department's examination disclosed that the Plan underestimated its total claims liability by \$1,321,422 as of September 30, 2017. The Department performed hindsight analysis of the Plan's reported total claims liability using paid claims data for the period from September 29, 2015 to January 4, 2018. The Department used this historical data to validate the Plan's reported total claims liability and found the liability to be underaccrued as of September 30, 2017. As a result, the examination required an adjusting journal entry to increase the IBNR claims liability. The major cause for understating the total claims liability was the underestimate of medical acuity of newly effective members and a programming error, which resulted in delayed evidence of the increased medical acuity of these members. Those errors were corrected in October 2017. In addition, the Plan did not perform a hindsight analysis based on paid claims data to determine whether the recorded estimate for total claims liability for previous periods was adequate.

During the examination, the Plan initiated a corrective action plan (CAP) addressing its IBNR calculation methodology.

The Plan stated that it would update programming of hospital case claims reports to incorporate more accurate inpatient expenses for longer inpatient stays.

It will evaluate "Management Judgment" adjustment that was used regularly because of the discrepancy between the claims-based analysis and the hospital case-based analysis in the quarter end March 30, 2018 to determine whether to continue or discontinue its use. Management will pay particular attention to the validating indicators which are the ultimate source of ascertaining the accuracy of each monthly estimate.

The Plan will utilize a new monthly claims report that includes claims payment for the professional risk that is the financial responsibility of the Plan's three independent practice associations (IPAs) and may provide useful early warning of claims expense trending originating with the IPAs.

The Preliminary Report required the Plan to provide the status and results of the CAP addressing the IBNR claims liability estimates.

The Plan was required to provide policies and procedures implemented to ensure that an adequate estimate of IBNR liability is recorded on the Plan's books. In addition, the

Plan was required to state the date of implementation for the policies and procedures, the management position(s) responsible for overseeing the policies and procedures, and a description of the monitoring system implemented to ensure ongoing compliance

The Plan was also required to recalculate its estimated IBNR claims liability using the re-evaluated methodology, and amend its Reporting Forms with appropriate adjustment to its reported IBNR claims liability beginning with the quarter ended September 30, 2017.

The Plan responded that it continues to use the features of the CAP initiated during the examination.

The Plan stated that programming for the hospital case claims report was completed to include categories of institutional risk claims that were not adequately captured previously. The report is run monthly and summarized on the main IBNR calculation spreadsheet.

The Plan stated that management judgment, as a component of the calculation methodology, continues to be used conservatively. In September 2017, it was set at 72 percent. With the significant increase in claims payment during the fourth quarter of 2017, it was raised to 90 percent in December, prior to the Department's examination. In February 2018, it was 88 percent and most recently in May, it was 80 percent to reflect the lower claims payments. This factor is used to apply current judgement on the historical data.

The Plan stated that validating indicators, while the most accurate component of estimating IBNR, are only in arrears and slow to reflect current trending. The Plan reported that the large variance (-59 percent) that was noted in the examination for the third quarter of 2017 has not perpetuated. The variance for December 2017 was less than 1 percent and January 2018 less than -4 percent. Since February 2018, the IBNR has been overstated.

The Plan stated that it uses a new monthly process utilizing a Completion Factor (CF) model to cross-validate per member per month model. This CF model performs a claims lag triangulation to determine completion factors by service-month.

The Plan attached a policy for IBNR Calculation Methodology, which was implemented on February 1, 2018. The Plan stated that the Plan's chief executive officer (CEO) oversees the policy. The Plan's CEO, chief financial officer, and the finance director of the Plan's management services organization meet to review IBNR calculation each month and assure compliance with the policy.

The revised Reporting Form for the quarter ended September 30, 2017, which reflected the increased IBNR liability, was filed on July 4, 2018.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

B. AMENDMENTS TO PLAN APPLICATION

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

The Department's examination disclosed that the Plan did not file an amended administrative services agreement (ASA) with Advanced Medical Management, Inc. within 30 days.

During the examination, the Plan submitted via eFiling the amended ASA. This filing was completed by the Department on February 23, 2018 (eFile number 20180483).

The Preliminary Report required the Plan to state the policies and procedures implemented to ensure that amendments are filed with the Department pursuant to the above Section and Rules. In addition, the Plan was required to state the date these policies were implemented, and the management position(s) responsible for ensuring continued compliance.

The Plan attached a "Policy for Timely Filing of DMHC Amended Information," which was implemented on June 15, 2018. The Plan stated that the Plan's CEO oversees the policy.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

C. RISK POOL SETTLEMENT

Rule 1300.75.4.1(a)(6) states that the Plan is required, for all risk-sharing arrangements, to provide the organization with a preliminary payment report consistent with the prescribed requirements no later than 150 days and payment no later than 180 days after the close of the organization's contract year, or the contract termination date, whichever occurs first.

The Department's examination disclosed that the Plan did not comply with the Risk Pool Contract settlement requirements and was not in compliance with Rule 1300.75.4.1(a)(6). The Plan has risk pool agreements with its three IPAs, Seoul Medical Group, Inc. (SMG), Access Medical Group, Inc. (AMG), and Access Santa Monica, Inc. (ASM). The agreements state that the final reconciliation shall be performed 270 days from the end of the calendar year. However, the Plan settled with SMG for the 2015 and 2016 risk pool contracts on October 26, 2017. The Plan had not settled with AMG and ASM.

The Preliminary Report required the Plan to provide evidence that the Plan settled with AMG and ASM for the risk pool contracts up to 2016.

The Plan was required to provide policies and procedures implemented to ensure that the Plan is in compliance with Rule 1300.75.4.1(a)(6). In addition, the Plan was required to state the date of implementation for the policies and procedures, the management position(s) responsible for overseeing the policies and procedures, and a description of the monitoring system implemented to ensure ongoing compliance

The Plan attached a "Policy for Risk Pool Settlement and Payment," which was implemented on June 15, 2018. The Plan stated that the Plan's CEO oversees the policy. The Plan's monthly board agenda has a standing item identifying the timely calculation and payment of risk pools.

The Plan stated that amendments to the "Provider Group Agreements" between the Plan and AMG and ASM, effective November 1, 2016, provide for an allocation of shared risk surplus to the IPAs. The final settlement report shows that there was a deficit of \$84,036 for AMG and a deficit of \$1,206 for ASM, therefore no risk pool payments were made to the IPAs for 2016.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.