REPORT ON EXAMINATION

OF

HOMEFIRST, INC.

AS OF

DECEMBER 31, 2009

DATE OF REPORT	**OCTOBER 20, 2014**
EXAMINER	**KAIWEN K. GUO**

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October 20, 2014

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

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30485, dated February 9, 2010, and attached hereto, I have made an examination into the condition and affairs of Homefirst, Inc., a not for-profit health maintenance organization certified under the provisions of Article 44 of the New York Public Health Law; as of December 31, 2009, and submit the following report thereon.

The examination was conducted at the Homefirst, Inc.'s home office located at 6323 7th Avenue, Brooklyn, NY.

Wherever the designations the "Plan" or "Homefirst" appear herein, without qualification, they should be understood to mean Homefirst, Inc.

Wherever the designation the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

This is the first examination of the Plan. This examination is a combined (financial and market) examination and covers the five-year period from January 1, 2005, through December 31, 2009. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2010 Edition* (the "Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook and transactions occurring subsequent to December 31, 2009 were reviewed, where deemed appropriate by the examiner.

The financial portion of the examination was conducted on a risk-focused basis, in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations and utilizes that evaluation in formulating the nature and extent of the examination. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as to identify prospective risks that may threaten the future solvency of the Plan.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines and annual statement instructions.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination

evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputational

The Plan was audited annually for the years 2005 through 2009, by the accounting firm Loeb & Troper, LLP. The Plan received an unqualified opinion in each of those years. Certain audit workpapers of Loeb & Troper, LLP were reviewed and relied upon in conjunction with this examination. Homefirst is a participating agency of the Metropolitan Jewish Health System ("MJHS"). A review was also made of the MJHS's Internal Audit function as it relates to the Plan.

Homefirst's financial statements are reported in accordance with generally accepted accounting principles ("GAAP"), as it is permitted by statute. This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. DESCRIPTION OF THE PLAN

Homefirst, Inc. is a not-for-profit corporation, incorporated on July 26, 1995 in New York State, and is certified under Section 4403-f of the New York Public Health Law. Homefirst, Inc. is a capitated Medicaid managed long-term care plan ("MLTCP"). It was established to develop, sponsor and study the need for innovative programs that provide independent living in the home and community for chronically ill and disabled persons of all ages. Homefirst, Inc. began operations in 2000.

Homefirst, Inc. is a participating agency of the Metropolitan Jewish Health System ("MJHS"). MJHS was established to coordinate operations with various independent organizations that are devoted to provide health care, housing and services to the ill, impaired, disabled, elderly and children.

Subsequent to the examination date, the Plan entered into an agreement to merge its operations with Elderplan, Inc., a health maintenance organization in the MJHS. On January 1, 2011, the merger became effective. The surviving company adopted the name Elderplan, Inc.; HomeFirst, Inc. became the Medicaid Managed Long-Term Care ("MLTC") line of business for Elderplan, Inc., which initially only had a Medicare line of business.

A. Management and Controls

Article III, Section 3.01 of the Plan's by-laws provides that the Plan shall be governed by a self-perpetuating Board of Directors. The Board of Directors shall consist of no less than five (5) nor more than twenty-four (24) Directors, who shall be elected at the annual meeting of the Directors. During the examination period the Plan was in compliance with its by-laws, having

no less than five nor more than twenty-four Directors. As of December 31, 2009, the Plan's Board consisted of nine (9) members.

The members of the Board of Directors as of December 31, 2009 were as follows:

Name and Residence	Principal Business Affiliation
Isaac Assael New York, NY	Executive Director, Enwood Personnel & Temporary Services
Traci Entel New York, NY	Consultant, Booz & Company (N.A.), Inc.
Eli Feldman Marlboro, NJ	Chief Executive Officer, Metropolitan Jewish Health System
Arthur Goshin, MD Buffalo, NY	Physician, Healthy World Foundation
Howard Greenberg Woodbury, NY	Senior Manager, Deloitte Consulting, LLP
Shmuel Lefkowitz Brooklyn, NY	Consultant, Prime Resources Group
Ronald Milch New York, NY	Retired
Herman Rosen Brooklyn, NY	Retired
Josephine Terrano Brooklyn, NY	Retired

Part 98.1-11(g)(1) of the Administrative Rules and Regulations of the New York Health Department states in part:

> *"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:*
>
> *(i) In the case of a PHSP or MLTCP, enrollee or consumer representatives may be substituted for enrollees…"*

The examination review of the Plan's records revealed that no member of the Board of Directors is an enrollee or consumer representative of the Plan.

It is recommended that the Plan complies with Part 98.1-11(g)(1) of the Administrative Rules and Regulations of the New York Health Department by having at least 20% of its Board of Directors comprised of enrollees or consumer representatives.

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. However, one Director, Josephine Terrano, attended less than 50% of the meetings she was eligible to attend. Another Director, Herman Rosen, was elected at the first quarterly meeting of 2009, but there is no evidence that he attended any of the Board of Director meetings he was eligible to attend.

Members of the Board have a fiduciary responsibility and must evince an ongoing interest in the affairs of the Plan. It is essential that Board members attend meetings consistently and set forth their views on relevant matters so that appropriate policy decisions may be reached by the Board. Board members who fail to attend at least one-half of the Board's meetings, unless appropriately excused, do not fulfill such criteria.

It is recommended that any Director who attends less than 50% of the Board meetings they are eligible to attend be removed or replaced.

The principal officers of the Plan as of December 31, 2009 were as follows:

Name	Title
Eli Feldman	Chief Executive Officer
Robert Leamer	Assistant Secretary
Alexander Balko	Chief Financial Officer
Hany Abdelaal	Vice President

B. Territory and Plan of Operation

The New York State Department of Health issued a certificate of authority to Homefirst, Inc., effective June 13, 2006, pursuant to Article 44 of the New York Public Health Law. The certificate authorized the Plan to offer a partially capitated managed long-term care product to the Medicaid population in the counties of Bronx, Kings, Queens, Richmond and New York.

Written premiums for each year under examination were as follows:

Year	Total premium
2005	$ 51,199,242
2006	$ 63,398,098
2007	$ 82,210,609
2008	$ 105,410,963
2009	$ 124,834,705

C. Enrollment

During the examination period January 1, 2005 through December 31, 2009, the Plan experienced a net increase in enrollment of 2,464 members. An analysis of the enrollment is set forth below:

	2005	2006	2007	2008	2009
Enrollment, January 1st	997	1,294	1,715	2,388	2,990
Net gain	297	421	673	602	471
Enrollment at December 31st	1,294	1,715	2,388	2,990	3,461

D. Abandoned Property Law

Section 1316 of the New York Abandoned Property Law states in part:

> *"…Every insurer shall cause to be published… a list of such abandoned property in the same manner as that prescribed for life insurance companies by section seven hundred two of this chapter…"*

Section 702 of New York Abandoned Property Law states in part:

> *"…Within thirty days after making a report of abandoned property ...such life insurance corporation shall cause to be published a notice entitled: "NOTICE OF NAMES OF PERSONS APPEARING AS OWNERS OF CERTAIN UNCLAIMED PROPERTY HELD BY...*
>
> *Such notice shall be published once in at least one newspaper published in the county of the state in which is located the last-known address of the holder of a policy under which abandoned property is payable…*
>
> *Such notice shall set forth:*
>
> *(a) the names and last known addresses which were in such report, of all persons appearing to be entitled to any such abandoned property amounting to fifty dollars or more…"*

Pursuant to Section 1316 of New York Abandoned Property Law, an insurer is required to file an abandoned property report with the New York State Comptroller. An insurer is also required to publish a listing, in at least one newspaper, of persons entitled unclaimed property reimbursement whenever the amount payable is fifty dollars or more. during the examination period the Plan submitted four (4) abandoned property filings, along with two remittance checks in the amounts of $818.13 and $1,135.69, respectively. These amounts represent the total amounts for the filing periods 2006 through 2009. Amounts to individual recipients ranged from $3.12 to $566.96. It should be noted that there was no evidence that a list of such "abandoned property" was ever published in any newspaper, as required by the aforementioned statute.

It is recommended that the Plan complies with the requirements of Sections 702 and 1316 of the New York Abandoned Property Law and publish all requisite information, as required by statute.

E. Custodial Agreement

A review of the Plan's custodial agreement with Commerce Bank, National Association, for the safeguarding of cash and securities revealed that the following protective covenants as outlined in the Handbook were not included in the custodial agreement:

> *"a. If the custodial agreement has been terminated or if 100% of the account assets in any one custody account have been withdrawn, the custodian shall provide written notification within three (3) business days of termination or withdrawal, to the insurer's domiciliary commissioner.*
>
> *b. The custodian shall secure and maintain insurance protection in an adequate amount. The custodian will give the insurer 60 days written notice of any material change in the form or amount of such insurance or termination of this coverage.*
>
> *c. During regular business hours, and upon reasonable notice, an officer or employee of the insurance company, an independent accountant selected by the insurance company and a representative of an appropriate regulatory body shall be entitled to examine, on the premises of the custodian, its records relating to securities, if the custodian is given written instructions to that effect from an authorized officer of the insurance company.*
>
> *d. A provision in the agreement that would give the insurer the opportunity to secure the most recent report on the review of the custodian's system of internal controls, pertaining to custodian record keeping, issued by internal or independent auditors.*
>
> *e. In the event that the custodian gains entry in a clearing corporation through an agent, there should be a written agreement between the custodian and the agent that the agent shall be subjected to the same liability for loss of securities as the custodian.*
>
> *f. That the custodian and its agents, upon reasonable request, shall be required to send all reports which they receive from a clearing corporation, which the clearing corporation permits to be redistributed including reports prepared by the custodian's outside auditors, to the insurance company on their respective systems of internal control."*

It is recommended that the Plan include the above enumerated protective covenants and provisions, as recommended by the Handbook, in its custodial agreements.

3. FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination with those reported by the Plan in its filed annual statement as of December 31, 2009. The Plan files its annual statements on a Generally Accepted Accounting Principles basis. The balance sheet is the same as that filed by the Plan as of December 31, 2009.

Assets	Examination	Plan
Cash	$ 29,187,630	$ 29,187,630
Short-term investments	13,671,292	13,671,292
Premiums receivable-net	2,566,453	2,566,453
Interest receivable	102,185	102,185
NYS escrow account balance	5,275,631	5,275,631
Furniture and equipment	37,164	37,164
Total assets	$ 50,840,355	$ 50,840,355
Liabilities		
Accounts payable	$ 229,313	$ 229,313
Claims payable	1,245,327	1,245,327
Accrued other medical	12,245,415	12,245,415
Amounts due to affiliates	318,951	318,951
Aggregate write-ins for current liabilities:		
Accrued payroll	1,305,974	1,305,974
Unpaid claims adjustment expenses	674,537	674,537
Total liabilities	$ 16,019,517	$ 16,019,517
Capital and Surplus		
NYS contingent reserve requirement	$ 6,302,000	$ 6,302,000
Unassigned surplus	28,518,838	28,518,838
Total capital and surplus	$ 34,820,838	$ 34,820,838
Total liabilities, capital and surplus	$ 50,840,355	$ 50,840,355

Note 1: The Plan is a nonprofit cooperation as defined by Section 501(c)(3) of the Internal Revenue Code and is exempt from federal income tax.

Note 2: The Internal Revenue Service has not conducted any audits of the income tax returns filed on behalf of the Plan through tax year 2009. 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.

B. Statement of Revenue and Expenses and Capital and Surplus

Capital and surplus increased by $29,999,812 during the five-year examination period, January 1, 2005 through December 31, 2009, detailed as follows:

Revenue		
Total premium revenue	$ 427,053,617	
Total revenue		$ 427,053,617
Hospital and Medical Expenses		
Total hospital/medical benefits	$ 316,066,289	
Care management	23,760,067	
Allowable administrative expenses	41,407,282	
Total hospital and medical expenses	$ 381,233,638	
Non-allowable administrative expenses	2,847,726	
Aggregate write-ins for other expenses:	1,000,000	
Prior period adjustment and extraordinary items	(2,223,880)	
Adjustment for prior period IBNR adjustment	(7,432,676)	
Total expenses		$ 375,424,808
Net income		$ 51,628,809

Changes in Capital and Surplus

Capital and surplus as of December 31, 2004			$ 4,821,026
	Gains in Surplus	Losses in Surplus	
Net income	$ 51,628,809		
Change in net unrealized capital gains	701,028		
Change in non-admitted assets		$ 130,025	
Surplus adjustment - withdrawal of equity		22,200,000	
Net increase in capital and surplus			29,999,812
Capital and surplus, per report on examination, as of December 31, 2009			$ 34,820,838

4. ACCRUED OTHER MEDICAL

The examination liability of $12,245,415 is the same as the amount reported by the Plan in its filed annual statement as of December 31, 2009.

The examination analysis of the Accrued Other Medical liability 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 statements as verified during the examination. The examination liability was based upon actual payments made through December 31, 2009, with an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's past experience in projecting the ultimate cost of claims incurred.

5. UNPAID CLAIMS ADJUSTMENT EXPENSES

The examination liability of $674,537 is the same as the amount reported by the Plan in its filed annual statement as of December 31, 2009.

The examination analysis of the unpaid claims adjustment expense liability 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 statements as verified during the examination.

6. GRANTS TO METROPOLITAN JEWISH GERIATRIC FOUNDATION

During the examination period, the Plan provided three grants to Metropolitan Jewish Geriatric Foundation ("MJGF"), another participating entity in the Metropolitan Jewish Health System ("MJHS"). The grants, in the amounts of $10,000,000, $10,000,000 and $2,200,000 were provided to MJGF in 2006, 2007 and 2009, respectively. It should be noted that these grants, where applicable, were approved by the Department.

7. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business 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 practices of the Plan in the following major areas:

A. Claims processing
B. Prompt Pay Law
C. Grievances and appeals
D. Complaints

A. Claims Processing

A review of the Plan's claims practices and procedures was performed by using a statistical sampling methodology covering claims processed during the period January 1, 2009 through December 31, 2009, in order to evaluate the overall accuracy and compliance of the Plan's claims processing environment.

For the examination period, the Plan utilized its own claims processing system, Managed Care Optimizer ("MCO"), to process its claims. The system received both electronic claims and paper claims. The Plan received approximately 44% of its claims electronically in 2009.

The Plan maintained two sets of claims data based on claim type; one set of claims data was for medical services, which utilized the HCFA claim form; another set of claims data was for facility services, which utilized the UB92 claim form. Approximately 97% of claims were for medical services.

For the claims review, the examiner employed a statistical random sampling process which was performed using the computer software program ACL, 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 made for each claim in the sample.

As previously mentioned, the Plan's claims data consisted of two data sets: One for medical claims and the other for facility claims. A sample of 49 medical claims and 31 facility claims was selected for review.

The term "claim" can be defined in a myriad of ways. For the purposes of this report, a "claim", consistent with the Plan's determination, is defined as a grouping of all line items (e.g., procedures/services or service dates) on any one claim form. It was possible, through the computer system used, to match or "roll-up" all procedures into one item, which is 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 totaled and reconciled to the paid claims data reported by the Plan for the period January 1, 2009 through December 31, 2009, and also to the amount reported in its December 31, 2009, filed annual statement.

The results of the examiner's review indicated that the Plan had a calculated financial error rate of 29.03% and a calculated procedural error rate of 29.03% in the processing of facility claims. Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times claim transactions were processed in accordance with the Plan's guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. However, a financial error is caused by a procedural error and as such it is counted both as a financial error and a procedural error. In summary, of the 31 facility claims reviewed, 9 contained financial errors.

During the process of reviewing the claims transactions within the various claim adjudication samples, the following was noted:

- ❖ All claims processing errors in the sample pertaining to claim payments related to two providers who were participating agencies of MJHS, First to Care Home Care and Metropolitan Jewish Home Care, Inc. During 2009, the Plan processed 3,307 claims from Metropolitan Jewish Home Care, Inc. and 1,579 claims from First to Care Home Care. The aforementioned claims sample contained seven (7) claims from First to Care Home Care and thirteen (13) claims from Metropolitan Jewish Home Care, Inc. The examiner noted 9 claims processing errors, all due to incorrect reimbursement rates being applied: three (3) claims for First to Care Home Care and six (6) claims for Metropolitan Jewish Home Care, Inc. It was noted that the Plan failed to

update its rate information for these two providers in a timely manner. Such delay caused the Plan to incorrectly pay claims using a rate scale from the previous year.

- ❖ The examination also revealed that all paper claims were stored at an external storage facility after they were processed. However, the Plan did not make any back-up copies of paper claims, either at the time of processing the claims, or after the time such processing was completed. In the event of a disaster, information pertaining to such claims may not be able to be retrieved; in fact the documentation could be destroyed.

It is recommended that the Plan initiate procedures to ensure that claims are paid using the correct rates.

It is also recommended that the Plan reviews all previously adjudicated claims from First to Care Home Care and Metropolitan Jewish Home Care, Inc., and make any necessary adjustments to any claims that were paid using the incorrect rate scales.

It is further recommended, as a good business practice, that the Plan maintain back-up copies for paper claims to ensure that the information is not lost in the event the original claim documentation is destroyed.

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 Law states in part:

> *"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 Law 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."*

Two statistical samples (one for medical claims and one for facility claims) of claims not adjudicated within 45 days of receipt by the Plan were reviewed to determine whether payments were in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law and, if applicable, whether interest was appropriately paid pursuant to Section 3224-a(c) of the New York Insurance Law. Accordingly, all claims that were not adjudicated within 45 days during the period January 1, 2009 through December 31, 2009, were segregated. A statistical sample of each population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated, as required by statute. The following chart illustrates the Plan's compliance with the Prompt Pay Law, as determined by this examination:

Summary of Violations of Section 3224-a(a) and Section 3224-a(c) of the NYIL

	Section 3224-a(a)	**Section 3224-a(c)**
Total claims population	326,707	326,707
Population of claims paid after 45 days of receipt	31,082	31,082
Sample size	80	80
Number of claims with violations	66	2
Calculated violation rate	**82.50%**	**2.5%**
Upper violation limit	**90.83%**	**5.92%**
Lower violation limit	**74.17%**	**-0.92%**
Calculated claims in violation	25,643	8,167
Upper limit claims in violation	28,232	19,341
Lower limit claims in violation	23,054	NA

It should be noted that the number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated after forty-five days from receipt (Section 3224-a(a)), during the period January 1, 2009 through December 31, 2009.

The total population of medical and facility claims adjudicated during the period January 1, 2009 through December 31, 2009 was 326,707, and the population of medical claims and facility claims adjudicated after forty-five days after receipt, for the same period was 31,082.

It is recommended that the Plan implement the necessary procedures to pay its claims in accordance with the timeframe set forth by Section 3224-a(a) of the New York Insurance Law.

It is also recommended that the Plan complies with Section 3224-a(c) of the New York Insurance Law by calculating and paying the correct amount of interest on all applicable claims.

C. Grievances

The examiners reviewed the Plan's grievance log. The grievance log indicated that, during the period January 1, 2009 through December 31, 2009, the Plan processed a total number of 931 grievances. A sample of 10 grievances was selected for review. The review revealed that for three grievances the "date of acknowledgement" appearing in the grievance log was different from the date that appeared in the respective acknowledgement letter. It appears that these inconsistencies were due to clerical errors.

It is recommended that the Plan take the steps necessary to reduce errors in the recording of grievances.

D. Appeals

Section 4408-a(9) of the New York Public Health Law states in part:

> "*Within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgement of the appeal…*"

The examiner reviewed the Plan's Grievance and Appeal Policy for compliance with Section 4408-a(9) of the New York Insurance Law. No exceptions were noted.

A review of the Plan's appeals log indicated that during the period January 1, 2009 through December 31, 2009, a total of 507 appeals were received. A sample of 10 appeals was reviewed by the examiner. It should be noted that in two cases the "date of acknowledgement" that appeared in the appeal log did not agree with the date that appeared in the respective acknowledgement letter. It appears that if an appeal was received by the Plan near "close of business", it was documented in the appeal log as having been acknowledged that same day.

However, the acknowledgement which was generated would be automatically date stamped with the next business date.

It was noted that for three other appeals reviewed, in which the Plan received both an initial appeal as well as a second appeal, the Plan did not send an acknowledgement letter as required by Section 4408-a(9)of the New York Public Health Law and the Plan's Grievance and Appeal Policy.

It is recommended that the Plan take the necessary steps to improve its appeal process by ensuring that the dates of the acknowledgement in the appeal log are consistent with the dates appearing in the respective acknowledgement letters.

It is also recommended that the Plan complies with the requirements of Section 4408-a(9) of the New York Public Health Law and with its Grievance and Appeal Policy by sending the insured or the insured's designee, written acknowledgment of an appeal within fifteen business days after receipt of such appeal.

8. SUBSEQUENT EVENTS

Subsequent to the examination date, the Plan entered into an agreement to merge its operations with Elderplan, Inc., a health maintenance organization in the MJHS (see Item 2 of this report). On July 28, 2010, the Department sent a non-objection letter to the New York Department of Health regarding the merger and on January 1, 2011, the merger became effective. The surviving company adopted the name Elderplan, Inc.; HomeFirst, Inc. became the Medicaid Managed Long-Term Care ("MLTC") line of business for Elderplan, Inc., which initially only had a Medicare line of business.

9. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____/S/_____
Kaiwen K. Guo
Associate Insurance Examiner

STATE OF NEW YORK)
) SS.
)
COUNTY OF NEW YORK)

Kaiwen K. Guo, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____/S/_____
Kaiwen K. Guo

Subscribed and sworn to before me
this __ day of _____ 2014.

Appointment No. **30485**

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:

Kaiwen Guo

as a proper person to examine into the affairs of the

Home First, Inc.

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

Plan

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 9th day of February, 2010

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK ★ SUPERINTENDENT OF INSURANCE ★ EXCELSIOR