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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

May 1, 1998

Mr. George C. Sinnott
Commissioner
Department of Civil Service
State Office Campus - Building 1
Albany, NY 12239

Re: Report 97-F-48

Dear Mr. Sinnott:

According to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law, we have reviewed the actions taken by officials of the Department of Civil Service, as of March 12, 1998, to implement the recommendations included in our audit report on *Customer Satisfaction with Health Care Services Provided by HMOs in the New York State Health Insurance Program* (Report 95-S-112). The report, which was issued on October 28, 1996, examined certain aspects of customer satisfaction.

Background

A health maintenance organization (HMO) provides comprehensive health care services to members of an enrolled group for an advance or periodic charge. The services provided include physician services, inpatient and outpatient hospital services, diagnostic laboratory services, and emergency and preventive health services. HMOs control health care costs by attempting to provide only the services that are genuinely needed by the enrolled members. There are different types of HMOs:

- A staff- or group-model HMO employs or contracts with physicians and other medical specialists directly and maintains its own health centers. Most centers are equipped with x-ray, laboratory, pharmacy, and other services. Members receive most care under one roof.

- A network HMO provides medical services within a network that can include its own health centers, as well as outside participating physicians, medical groups, and multi-specialty medical centers.

- An independent-practice HMO provides medical services through physicians who contract independently with the HMO to provide services in their private offices.

The New York State Health Insurance Program (NYSHIP), which is administered by the Department of Civil Service (Department), provides health insurance coverage to State and local government employees and their dependents. The Department has contracts with 23 HMOs to provide health care to about 85,000 NYSHIP members under this program, for which it expects to pay approximately $315 million in premiums in 1998.

Summary Conclusions

During our prior audit, we found that the members we surveyed were generally satisfied with the overall performance of their HMOs. However, about 36 percent of the members were dissatisfied with some aspect of their access to health care, such as their access to specialists. We noted that the Department did little to actively monitor member satisfaction with HMOs; as a result, the Department may not have been aware of problems that needed to be addressed. For example, because of the nature of its reporting requirements, the Department did not receive most of the grievances and complaints members have filed against HMOs. We recommended that the Department make a more active effort to monitor member satisfaction with HMOs.

In our follow-up review, we found the Department has taken steps to be more active in assessing member satisfaction with HMOs and to ensure that the reporting of complaints by HMOs is more consistent. The Department's monitoring of the member complaint process at the HMOs participating in NYSHIP has improved; however, further improvements are needed to ensure that the process does not discourage the members from pursuing their complaints, and that it is not too cumbersome.

Summary of Status of Prior Audit Recommendations

The Department has partially implemented our four prior audit recommendations.

Follow-up Observations

Recommendation 1

Be more active in seeking to learn whether NYSHIP members are satisfied with the services provided by HMOs. Toward this end, consider surveying NYSHIP members and reviewing information maintained by the HMOs about customer complaints.

Status - Partially Implemented

Agency Action - Department officials have made some improvements to gauge member

satisfaction with HMOs. They indicate that they have access to information on customer satisfaction from the National Committee for Quality Assurance (NCQA), a private not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans. NCQA issues an Annual Member Health Care Survey that enables health plans to produce comparable data on member satisfaction for use by employer-purchasers and consumers. Department officials indicate that survey results collected by NCQA and the HMOs, as well as from our prior audit, indicate that consumers are generally satisfied with their HMOs. Without evidence that results would be different if NYSHIP members alone were surveyed, Department officials do not feel it would be cost-effective to conduct their own survey.

Moreover, the latest Department specifications, indicate that HMOs must have in place a process for receiving and responding to complaints from members and providers. In addition, HMOs must provide quarterly reports on complaint activity and complaint resolution to the Department's Joint Labor Management Committee. (The Department has prepared draft complaint reporting procedures, but has not yet issued them to the HMOs.) The specifications also indicate that whenever an HMO conducts a member satisfaction survey that includes NYSHIP enrollees, the HMO must submit a copy of the survey and survey results to the Joint Labor Management Committee.

Auditors' Comments - While the surveys conducted by NCQA provide some indication of customer satisfaction, they may not provide an accurate assessment of NYSHIP member satisfaction with HMOs, as NYSHIP members may represent only a small portion of each HMO's population. As indicated in our prior audit, satisfaction surveys targeted at specific attributes and specific performance standards should be used to assess member satisfaction.

We also reviewed the Department's draft complaint-reporting procedures. The draft procedures require submission of complaint reports and a complaint resolution status report. The proposed report formats, however, do not allow Department officials to determine the resolution status of all complaints reported. While the Department has taken steps to ensure that complaint reporting is more consistent, further improvements are needed to ensure that all complaints are reported and that the complaint reports allow Department staff to verify that HMOs are addressing and responding to all complaints in a timely manner.

Recommendation 2

Coordinate with the Insurance Department and the Department of Health to ensure that the customer complaint information reported in the annual statements is complete and accurate, and the definition of a complaint is consistent from HMO to HMO.

Status - Partially Implemented

Agency Action - In our prior audit, we found that complaint information reported to the Department by the State Insurance Department and Department of Health was neither complete nor accurate. In addition, the definition of a complaint was not consistent from HMO to HMO. Department officials indicated that they would continue to coordinate with the State Insurance Department and Department of Health on a variety of issues, including complaints about HMOs. However, they did not agree with our recommendation and indicated it was not within the scope of the Department's responsibility or authority to "ensure that the customer complaint information reported in the annual statements is complete and accurate."

Nevertheless, Department officials have taken some steps to address our recommendation. As previously discussed, the Department has developed draft complaint-reporting procedures but has not yet issued them to the HMOs. The draft procedures specify that HMOs are required to submit quarterly reports of all complaints to the Department. In addition, the guidelines provide a definition of a complaint to be used by all HMOs: ". . . a written or verbal contact to the HMO in which a member or provider describes a criticism of the HMO or treatment experienced through the HMO, its providers, or the HMO's benefit or service delivery subcontractors." This should allow the Department to get consistent information from each of the HMOs. Department officials developed this definition after reviewing similar material prepared by the Department of Health.

Auditors' Comments - Currently, the HMOs have to file complaint reports with the Department, as well as with the Department of Health and the State Insurance Department. Department officials should coordinate with the Department of Health and the State Insurance Department to determine whether they could develop a single report to meet all agencies' needs.

Recommendation 3

Use the complaint information in the annual statements to monitor the performance of the HMOs that either participate in NYSHIP or seek to participate in NYSHIP.

Status - Partially Implemented

Agency Action - As previously discussed, the Department has prepared draft complaint-reporting guidelines that provide a definition of a complaint that is to be used by all HMOs and reflected in quarterly reporting requirements. This information will be used to monitor HMO performance.

Auditors' Comments - These guidelines, once issued, should fulfill the intent of this recommendation.

Recommendation 4

Actively monitor the customer complaint process at the HMOs participating in NYSHIP to ensure that the process is fully explained to NYSHIP members, does not discourage the members from pursuing their complaints, and is not unnecessarily cumbersome.

Status - Partially Implemented

Agency Action - Department officials indicated that they review HMOs' grievance procedures as part of the annual proposal process. Department officials provided documentation showing that, because of this review, some HMOs have been contacted regarding deficiencies noted in their procedures.

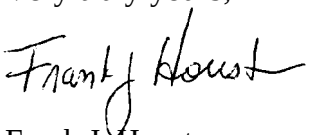
In addition, in our prior audit, we identified four HMOs that did not provide accurate or complete information to their members about the complaint process. During our follow-up review, we found that this condition has been resolved at three of these four. We also identified five HMOs at which the complaint process consisted of several stages: a decision was made about the merits of a member's complaint at each stage; and if a member was not satisfied with a decision at any stage, he or she had to appeal. We felt that this cumbersome process might discourage members from pursuing complaints. Our follow-up review found that this multi-stage complaint process was still in place at four of these five HMOs.

Auditors' Comments - Department officials should take action to ensure that the complaint-reporting procedures of HMOs are not too burdensome or contain too many steps that would discourage members from pursuing complaints. Department officials should continue their efforts to ensure that all complaints are reported to the Department as required, and that the information submitted is complete and accurate.

Major contributors to this report were Frank Russo, Michael Heim, and Tom Kulzer.

We would appreciate your written response to this report within 30 days, indicating any action planned or taken to address the unresolved matters discussed in this report. We also thank management and staff of the Department of Civil Service for the courtesies and cooperation extended to our staff during this review.

Very truly yours,



Frank J. Houston
Audit Director

cc: Robert L. King