REPORT BY THE AUDITOR GENERAL OF CALIFORNIA

THE DEPARTMENT OF CORPORATIONS CAN IMPROVE ITS MANAGEMENT OF MEDICAL SURVEYS AND CONSUMER COMPLAINTS IN ITS HEALTH CARE SERVICE PLAN DIVISION

P-115

MAY 1992

The Department of Corporations Can Improve Its Management of Medical Surveys and Consumer Complaints in Its Health Care Service Plan Division

P-115, May 1992

Office of the Auditor General
California

Kurt R. Sjoberg, Auditor General (acting)

State of California
Office of the Auditor General
660 J Street, Suite 300, Sacramento, CA 95814
Telephone : (916) 445-0255

May 28, 1992

P-115

Honorable Robert J. Campbell, Chairman
Members, Joint Legislative Audit Committee
State Capitol, Room 2163
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the Department of Corporations' Health Care Service Plan Division's management of medical surveys and consumer complaints. The report concludes that the department can improve its management of conducting medical surveys and releasing medical survey reports. Also, the department can improve its medical survey reports to state clearly whether health plans are complying or not complying with health care standards, its follow-up and enforcement actions against health plans who fail to comply with laws and regulations, and its process to resolve consumer complaints made against health plans.

Respectfully submitted,

KURT R. SJOBERG
Auditor General (acting)

Table of Contents

Appendices

Summary

Results in Brief

The Department of Corporations (department) is responsible for regulating the quality of medical care provided by health care service plans (health plans). To carry out this responsibility, the department conducts on-site medical surveys of health plans. However, the department can improve its management of these medical surveys. For the 114 health plans that the department licensed as of August 6, 1991, and regulated to provide full service health care, dental care, vision care, and mental health services, we found the following conditions:

- The department did not conduct 58 (56 percent) of 103 medical surveys from fiscal year 1987-88 through 1990-91 within its three-year commitment to the Legislature. Also, the department did not conduct 13 (10 percent) of 126 medical surveys from fiscal year 1986-87 through 1990-91 within the five-year legal mandate;

- From fiscal year 1986-87 through 1990-91, the department did not issue 95 (86 percent) of 110 confidential reports to health plans within its 90-day policy. The department took an average of 335 days to issue the 95 confidential reports, ranging from 91 to 899 days. In addition, in 51 (78 percent) of 65 medical surveys for which the department could provide both the health plans' responses and the public reports, the department did not issue the public reports within 45 days of receipt of the health plans' responses, as it should have done according to its policy. It took the department an average of 164 days to issue the 51 public reports, ranging from 52 to 860 days;

- Despite the statutory requirement to release reports to the public after the department's notification of deficiencies, the department inappropriately delayed release to the public beyond the 30 days allowed by law when it extended this period for at least five health plans by an average of 60 days;

- Although the law gives health plans 30 days from the date of the department's notification to respond to confidential reports, the department accepted responses after 30 days from health plans for 49 (64 percent) of 77 medical surveys for which it could provide copies of the health plans' responses and corrective action plans;

- Despite the statutory requirement for the department to make public the deficiencies that health plans have not corrected within 30 days, for 10 (28 percent) of 36 corrective action plans, the department did not disclose in the public reports the uncorrected deficiencies;

- Although the department is required to open for public inspection reports of all surveys, deficiencies, and correction plans except for those deficiencies the health plans correct within 30 days, the department has not properly maintained its records of medical survey information. During our review of medical surveys, the department could not locate 153 of 247 documents we had requested for 64 health plans. Some of these documents should have been readily available to the public to facilitate informed consumer choices in selecting health plans;

- The department has not clearly stated in 14 (25 percent) of 55 confidential survey reports whether the health plans were complying or not complying with health care standards;

- Although the department can take follow-up action and has the authority to take enforcement action, the department did not take follow-up or enforcement actions against 8 (62 percent) of 13 medical surveys to ensure that health plans correct deficiencies cited during medical surveys; and

- Although the department's goal is to process within 45 days complaints made by members against their health plans, in 78 (52 percent) of 149 complaints we reviewed, the department did not process the complaints within 45 days. The department took an average of 127 days to process these 78 complaints, ranging from 46 to 476 days. Moreover, as of January 9, 1992, the department had a backlog of 599 complaints, some received as long ago as fiscal year 1988-89. Twenty-six of these complaints have been pending since between April 14, 1989, and June 29, 1990.

Background

The Knox-Keene Health Care Service Plan Act of 1975 created a comprehensive set of requirements for health plans to promote the delivery of health and medical care to consumers who enroll in these health plans. The act assigned the responsibility for regulating health plans to the commissioner of corporations of the department. The Health and Safety Code requires the department to perform various activities to ensure that health plans provide quality medical care to their members, activities such as conducting on-site medical surveys of every health plan within specified times. As of August 6, 1991, the department licensed 114 active health plans: 51 of the health plans provide full health care services, 41 provide dental services, 11 provide vision care, and 11 provide mental health services.

As part of its oversight function, the department also assists members in resolving complaints against their health plans. The department sends copies of the complaints to the health plans for the plans to resolve and ensures that health plans respond to these complaints promptly and legally.

The Department Has Not Effectively Managed Its Medical Surveys

The department is responsible for regulating the quality of medical care provided by health plans to their members. In carrying out this responsibility, the department conducts on-site medical surveys of health plans. However, the department has not always conducted these on-site medical surveys within its three-year commitment to the Legislature or the five-year legal mandate. Specifically, the department did not conduct a medical survey for 58 (56 percent) of 103 medical surveys from fiscal year 1987-88 through 1990-91 within its three-year commitment to the Legislature. In addition, the department did not conduct 13 (10 percent) of 126 medical surveys from fiscal year 1986-87 through 1990-91 within the five-year statutory requirement. By not conducting medical surveys promptly, the department may allow some health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health.

The Department Has Not Effectively Managed the Release of Its Medical Survey Reports

The department has not effectively managed the release of its medical survey reports of health plans. From fiscal year 1986-87 through 1990-91, the department did not issue 95 (86 percent) of 110 confidential reports within its 90-day policy. The department took an average of 335 days to issue the 95 confidential reports, ranging from 91 to 899 days. Also, in 51 (78 percent) of 65 medical surveys for which the department could provide both the health plans' responses and the public reports, the department did not issue the public reports within 45 days of receiving the health plans' responses, as it should have done according to its policy. It took the department an average of 164 days to issue the 51 public reports, ranging from 52 to 860 days. By not issuing medical survey reports promptly, the department may allow some health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health.

In addition, despite the statutory requirement to release reports to the public after the department's notification, the department delayed the release of some of these reports beyond the 30 days allowed by law when it inappropriately extended this period for at least five health plans by an average of 60 days. Moreover,

although the law gives health plans only 30 days from the date of the department's notification to respond to confidential reports, the department accepted responses after 30 days from health plans for 49 (64 percent) of 77 medical surveys for which it could provide copies of the health plans' responses and corrective action plans. Further, despite the statutory requirement for the department to make public the deficiencies that health plans have not corrected within 30 days, in 10 (28 percent) of 36 public reports, the department did not disclose the uncorrected deficiencies. By not releasing these reports to the public after 30 days, the department allowed deficiencies cited in the confidential reports to remain nonpublic and possibly uncorrected.

Finally, although the department is required to open for public inspection reports of all surveys, deficiencies, and correction plans except for those deficiencies the health plans correct within 30 days, the department has not properly maintained its records of medical survey information. During our review of medical surveys, the department could not locate 153 of 247 documents we had requested for 64 health plans. Some of these documents should have been readily available to the public to facilitate informed consumer choices in selecting health plans.

Sample Selection, Notification of Compliance, and Follow-up and Enforcement Were Not Always Effective

The department's sample selection, its notification of compliance, and its actions for follow-up and enforcement were not always effective. Specifically, the department did not select in 16 (30 percent) of 54 medical survey reports statistically valid samples of patients' medical records. Also, the procedures for selecting these statistical samples were inappropriate. In addition, the department did not clearly state in 14 (25 percent) of 55 confidential survey reports whether the health plans were complying or not complying with health care standards. This makes it difficult for the health plans to determine when the department is notifying them of deficiencies. Further, although the department can take follow-up action and has authority to take enforcement action, the department did not take follow-up or enforcement actions against 8 (62 percent) of 13 health plans

whose medical surveys cited deficiencies. By not always taking follow-up or enforcement actions, the department may allow some health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health.

The Department Has Not Promptly Processed Members' Complaints

Although the department's goal is to process complaints made by members against health plans within 45 days, in 78 (52 percent) of our sample of 149 complaints closed from fiscal year 1988-89 through 1990-91, the department did not process the complaints according to its goal. The department took an average of 127 days to process these 78 complaints, ranging from 46 to 476 days. Moreover, as of January 9, 1992, the department had 599 complaints pending resolution. Twenty-six of these complaints have been pending since between April 14, 1989, and June 29, 1990. When the department does not process complaints promptly, members may face the risk of not receiving the proper health care services to which they are entitled and may experience harassment by collection agencies when health plans do not pay claims.

Recommendations

The commissioner of corporations should take the following actions:

- Establish management controls to ensure that the department conducts on-site medical surveys according to its three-year goal and five-year legal mandate;
- Implement the training plan adopted in March 1992 for new analysts and update its manual of procedures to ensure that analysts are informed of procedures based on the Policy Manual implemented in March 1992;
- Ensure that analysts have consistent supervision and direction in conducting medical surveys and issuing medical survey reports;

- Establish and implement policies and guidelines to ensure that analysts write medical survey reports clearly and uniformly;

- Establish and implement policies regarding instances when the department deems it unnecessary to issue medical survey reports;

- Formalize the policy implemented sometime after October 1986 to include the new terminology describing whether health plans are meeting health care standards;

- Ensure that the consumer services representatives comply with the timelines for processing complaints established in the department's Complaint Manual in March 1992; and

- Ensure that the backlog of pending complaints is reduced to a level consistent with the department's goal in processing complaints.

Agency Comments

The Business, Transportation and Housing Agency concurs with the conclusions and recommendations in our report. It also pointed out additional corrective actions the Department of Corporations has taken since our review.

Introduction

The Knox-Keene Health Care Service Plan Act of 1975 created a comprehensive set of requirements for health care service plans (health plans), also known as health maintenance organizations or HMOs. The purpose of the act is to promote the delivery of health and medical care to the people of California who enroll in or subscribe for services rendered by a full-service health plan or a specialized health plan. A full-service health plan provides a full range of medical services; a specialized health plan provides specific services, such as vision care, dental care, or mental health care.

The act assigned the responsibility for regulating and licensing health plans to the commissioner of corporations of the Department of Corporations (department). As of August 6, 1991, the department licensed 114 active health plans. Fifty-one of the health plans provide a full range of medical services, including inpatient and outpatient services; 41 plans provide dental services; 11 plans provide vision care; and 11 other plans provide mental health care services. The department reports that as of December 1991, 10 million Californians are enrolled in full service health plans, and 19 million are enrolled in specialized health plans.

The Health and Safety Code requires the department to perform various activities to ensure that health plans provide quality medical care. These activities include on-site medical surveys of every health plan within specified times. The department conducts these medical surveys of health plans from its Los Angeles and Sacramento offices.

Before 1992, the department was required to charge the health plans it reviewed for the cost of the medical surveys, including the cost of the actual salaries or compensation paid to the persons conducting the surveys, the expenses incurred, and the department's overhead. However, effective January 1, 1992, Assembly Bill 1669, Chapter 722, Statutes of 1991, changed the law. From that point, the department was required to charge each health plan an annual assessment fee as a reimbursement of its share of all costs and expenses incurred for routine medical surveys.

As part of its oversight function, the department also assists members in resolving complaints against their health plans. The department sends copies of the complaints to the health plans for the plans to resolve and ensures that health plans respond to these complaints promptly and legally.

The 1992-93 Governor's Budget proposes that the department spend approximately $4.6 million for its program on health plans out of a total budget of $27.5 million. Approximately $953,000 of the total health plan funding will support medical survey activities, and $308,000 will support enforcement activities.

Process for Conducting Medical Surveys

The department's health care service plan analysts (analysts) and consultants are health professionals experienced in evaluating the delivery of health care. They compose the survey teams that conduct the medical surveys at the site of the health plans and at provider offices. Although the law requires these medical surveys every five years, the department has made a commitment to the Legislature to conduct them within three years of health plans' previous on-site surveys or within three years of the date health plans begin providing service.

The medical survey teams determine the health plans' compliance with health care standards established by law, including standards governing such conditions as the quality of care, the continuity of care, and the accessibility of services. At the conclusion of the surveys, the survey teams identify the standards

the health plans complied with or did not comply with and prepares confidential reports notifying the health plans of deficiencies found during the surveys. Before the department sends the confidential reports to the health plans, the department's supervising health care service plan analyst (supervising analyst) reviews the reports to ensure their accuracy. Its legal counsel may also review the confidential reports to ensure their legal soundness.

Once the department completes its in-house reviews, the department submits the confidential reports to the health plans. The plans have 30 days to review the reports and file statements of responses and corrective action plans for any deficiencies cited. Once the department receives the responses, it is required to make the survey reports, deficiencies, and the health plans' responses open for inspection in public reports. However, the department should not make public any deficiencies that have been corrected within 30 days. The department agrees that it should conduct follow-up visits to ensure that the health plans have implemented their correction plans and have corrected deficiencies identified by the surveys. If the department determines that the health plans have violated the law by not correcting deficiencies identified in the surveys, the department has the authority to take enforcement action, such as assessing civil penalties or suspending or revoking the health plans' licenses.

Scope and Methodology

We were requested to review the department's Health Care Service Plan Division's (division) administration and regulation of health plans. To determine whether the department complied with the Knox-Keene Health Care Service Plan Act of 1975, we reviewed applicable laws and regulations and the department's own Procedures Manual for Medical Surveys of October 1986. We also reviewed the division's central file where the department maintains medical survey information for its health plans. However, we were limited in this review because the department has not properly maintained its records of medical survey information. This issue is discussed in Chapter 2, page 34. Further, we interviewed the department's supervising analyst, analysts, supervising counsel, and legal counsel regarding on-site medical surveys and medical survey reports.

To determine whether the department properly managed on-site medical surveys of health plans, we reviewed the division's files for the 114 health plans the department licensed as of August 6, 1991, and for which it conducted medical surveys from fiscal year 1986-87 through 1990-91. We reviewed the medical survey reports (confidential and public) or the consultants' reports to document the dates the department conducted the medical surveys. To determine whether, for these five fiscal years, the department conducted medical surveys within its three-year commitment to the Legislature or the five-year legal mandate, we calculated the number of days from the dates of the previous on-site medical surveys or the dates of the health plans' licenses to the dates of the most recent medical surveys. We also calculated the length of time between the most recent on-site medical surveys and February 1, 1992, to determine whether the department is currently conducting medical surveys within the specified times.

For the medical surveys conducted from fiscal year 1986-87 through 1990-91 for the 114 health plans, we also reviewed the confidential and public reports and recorded the dates the department issued these reports to determine whether the department issued medical survey reports promptly. Further, we reviewed the health plans' responses to the confidential reports to determine whether the department granted extensions to the health plans for filing these responses and whether it accepted late responses.

To determine whether the department complied with laws, regulations, and its own policies in conducting medical surveys from fiscal year 1986-87 through 1990-91, we selected a sample of 40 of the 114 health plans to review in more detail. We reviewed the confidential reports resulting from these medical surveys to determine whether the department selected statistically valid samples of patients' medical records according to its policy. We also employed a statistical consultant who assessed the department's procedure for selecting statistical samples. Further, we reviewed the confidential and public reports to determine whether the department clearly stated in these reports whether health plans were complying or not complying with health care standards. We also

reviewed the confidential reports to analyze the deficiencies the department cited and the health plans' responses and reviewed public reports to determine whether the department disclosed all deficiencies not corrected within 30 days. Finally, we reviewed the reports to determine whether the department took follow-up or enforcement actions to ensure that health plans corrected the deficiencies cited in medical surveys.

To determine whether the department promptly processed complaints made by members against health plans, we selected a sample of 150 complaints closed from fiscal year 1988-89 through 1990-91; however, we based our analysis on 149 complaints because the department did not have the date it received one of the complaints. We selected these complaints from the complaint files of the 40 health plans whose medical surveys we reviewed in detail. One hundred thirty-five of the complaints were processed by the department's Los Angeles office from fiscal year 1988-89 through 1990-91, and 15 by the Sacramento office in fiscal year 1990-91. (Prior to August 1990, the department processed all complaints from its Los Angeles office.) We reviewed the dates the department received the complaints and the date the health plans resolved the complaints to document the length of time it took the department to process them. We could not determine the total number of complaints the department closed from fiscal year 1988-89 through 1990-91.

Chapter 1 The Department of Corporations Has Not Effectively Managed Its Medical Surveys of Health Care Service Plans

Chapter Summary

The Department of Corporations (department) is responsible for regulating the quality of medical care provided by health care service plans (health plans). In carrying out this responsibility, the department conducts on-site medical surveys of health plans. However, the department has not always conducted these on-site medical surveys within its three-year commitment to the Legislature or the five-year legal mandate. Specifically, the department did not conduct a medical survey for 58 (56 percent) of 103 medical surveys from fiscal year 1987-88 through 1990-91 within its three-year goal. In addition, the department did not conduct 13 (10 percent) of 126 medical surveys from fiscal year 1986-87 through 1990-91 within the five-year statutory requirement. By not conducting medical surveys promptly, the department may allow some health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health.

The Department Has Not Always Conducted Medical Surveys Within Specified Times

Section 1380(a) and (c) of the Health and Safety Code requires the department to conduct an on-site medical survey of the health delivery system of each health plan as frequently as deemed necessary but not less frequently than once every five years. In a report to the Legislature on October 1, 1986, the department stated that it accelerated its medical survey program to conduct medical surveys every 3 to 3.5 years. According to the department's supervising counsel, since approximately July 1, 1987, the department has attempted to conduct on-site medical surveys of most health plans every three years. In fiscal year 1988-89, the

department hired three additional health care service plan analysts (analysts), an increase of 75 percent, for this purpose. In the fiscal year 1992-93 Budget Change Proposal (BCP), the department reaffirmed to the Legislature its goal of conducting medical surveys at least once every three years. The department included this rationale when it requested two additional analyst positions for fiscal year 1992-93.

Despite this increase in staff, the department has not always conducted medical surveys within its three-year commitment to the Legislature or the five years required by law. Further, on March 30, 1992, after restating the three-year goal in the fiscal year 1992-93 BCP, the assistant commissioner for the division stated that the department's policy, based on its current staffing level, is to conduct medical surveys once every five years.

In our review of 114 health plans for medical surveys conducted from fiscal year 1987-88 through 1990-91, we determined that the department completed 103 medical surveys for 87 of the health plans. (The department actually conducted 98 medical surveys and adopted 5 medical audits conducted by the Department of Health Services in lieu of its own surveys, as authorized by Section 1380(c)(2) of the Health and Safety Code.)[1] In 58 (56 percent) of the 103 medical surveys, the department did not conduct or adopt a medical survey according to the three-year goal. The department took an average of 3.8 years from the previous survey or the date of licensure to conduct 56 of the 58 medical surveys.[2] The length of time ranged from slightly more than 3 years to 6.4 years. (Appendix A presents the number of

[1] We did not evaluate the medical surveys conducted in fiscal year 1986-87 for adherence to the three-year goal because the department did not make the three-year commitment to the Legislature until July 1987.

[2] We calculated the average length of time between medical surveys for 56 of 58 medical surveys. We did not include the two medical surveys of 9.1 and 9.8 years in the average and range because they would have inflated the average.

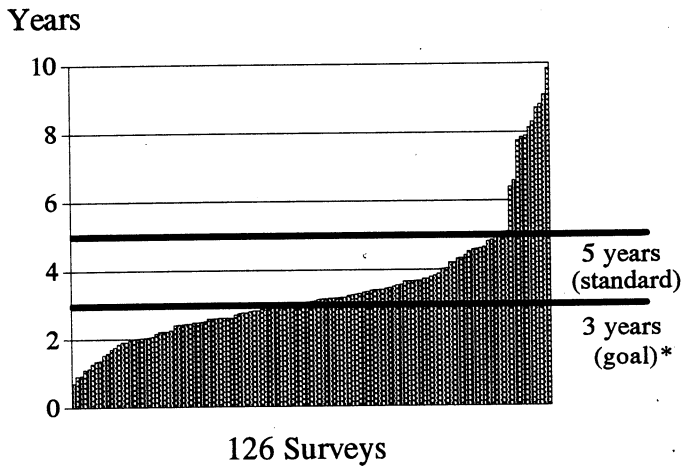
medical surveys that exceeded the three-year goal for fiscal year 1987-88 through 1990-91.) The length of time it took the department to conduct these 56 medical surveys from the previous survey increased from 3.3 years for those medical surveys conducted in fiscal year 1987-88 to 4.2 years for those conducted in fiscal year 1990-91.

In addition, we reviewed for adherence to the five-year legal mandate the medical surveys the department completed for 114 health plans from fiscal year 1986-87 through 1990-91. We determined that the department completed 126 medical surveys for 91 of the health plans from fiscal year 1986-87 through 1990-91. For 13 (10 percent) of the 126 medical surveys, the department did not conduct the medical surveys according to the five-year mandate. The department took an average of 7.7 years from the previous survey or the date of licensure to conduct a medical survey for these 13 health plans, ranging from slightly more than 5 to 9.8 years. (Appendix B presents the number of medical surveys exceeding the five-year mandate for fiscal year 1986-87 through 1990-91.) For example, the department conducted an on-site medical survey of a dental health plan in January 1979 and did not conduct another medical survey of that health plan until November 1988, 9.8 years later. Figure 1 shows the number of years it took the department to conduct medical surveys from the previous survey or the date of licensure for fiscal year 1986-87 through 1990-91.

Figure 1

Years the Department of Corporations Took To Complete Medical Surveys

Fiscal Year 1986-87 Through 1990-91



* Goal applies only to 103 surveys conducted from fiscal year 1987-88 through 1990-91.

Source: Office of the Auditor General's review of 114 health plans.

From fiscal year 1986-87 through 1990-91, the department did not conduct any medical surveys for 23 of the 114 health plans we reviewed. For 14 of the 23 health plans, the health plans were either recently licensed or had served members for less than three years. For the remaining 9 health plans, the department did not conduct a medical survey within its three-year goal. For example, the department licensed a full-service health plan in December 1986 and did not conduct a medical survey until July 1991, 4.6 years later. To have met its three-year goal, the department should have conducted a medical survey by

December 1989. Also, for 2 of the 9 health plans, the department did not conduct a medical survey according to the five-year legal mandate. For example, the department conducted an on-site medical survey of a dental health plan in March 1986. To have met the five-year mandate, the department should have conducted a medical survey by March 1991. However, as of June 30, 1991, 5.3 years later, the department had not conducted another medical survey.

To determine if the department is currently meeting its timelines in conducting medical surveys, we calculated the amount of time between the date of the most recent medical survey of the 114 health plans to February 1, 1992. We determined that the department still delays medical surveys. The delays are primarily for the three-year goal for the 114 health plans we reviewed. As of February 1, 1992, 94 of the 114 health plans had been licensed for at least three years. The department did not conduct a medical survey for 23 (25 percent) of the 94 health plans within its three-year goal. The department has exceeded the three-year goal by as much as 2.3 years for these 23 health plans. Also, as of this date, 81 of the 114 health plans had been licensed for at least five years. The department did not meet its five-year requirement for conducting a medical survey in only one instance. In this case, the department conducted the last on-site medical survey of a full-service health plan in November 1986, and it has not conducted another medical survey as of February 1, 1992, 5.3 years later.

When the department does not promptly conduct on-site medical surveys of health plans, it may allow some health plans to continue operating in a manner inconsistent with the law and possibly dangerous to their members' health. For example, the department licensed a dental health plan in late 1984 and did not conduct a medical survey until the spring of 1991, approximately 6.5 years later. In the department's confidential report to the health plan, the department identified 11 deficiencies in which the health plan was not meeting health care standards. Specifically, the department identified that the health plan's sterilization practices, oral examinations, and treatment planning were unacceptable in meeting an adequate level of care. Further, the department

indicated that the health plan had not developed and implemented procedures for ensuring that oral examinations were documented to reflect the initial status of teeth and to reflect findings for periodontal examinations and periodic soft tissue examinations.

Also, when the department does not promptly conduct medical surveys, the health plans may miss opportunities to correct deficiencies within their operations. For example, the department licensed a full-service health plan in the spring of 1979, and it did not conduct the first medical survey until the spring of 1988, 9.1 years later. In the medical survey conducted in 1988, the department identified 5 deficiencies, including deficiencies in accessibility of primary care services, specialty care services, and inpatient care and deficiencies in the provision of preventive care for children. If the department had conducted a medical survey and identified these deficiencies earlier, the health plan may have had an opportunity to correct these deficiencies.

Inadequate Management Controls Delayed Medical Surveys

The department has not always conducted the on-site medical surveys of health plans within the three-year goal or the five-year mandate because it lacks adequate management control and has not devoted the necessary attention to ensure that analysts conduct medical surveys promptly.

The Department's Automated Tracking System Is Inaccurate

The automated system the department uses to identify the dates of medical surveys did not contain accurate data. The department's automated system contained improper dates identifying when the department conducted medical surveys. For example, the department provided us with a list of 114 health plans it had licensed as of August 6, 1991, with the date of the most recent on-site medical survey for each one. We compared the department's dates for the surveys with the dates we obtained from medical survey reports in the division's files. We determined that, for 33 of the health plans, the department did not have the correct dates of the last medical surveys conducted. For 12 of the 33 dates, we determined that the errors were significant enough to affect the department's scheduling of the next medical survey required.

For example, the department's list indicated that it conducted the most recent on-site medical survey in June 1991 for a full-service health plan, when in fact it had conducted that on-site medical survey in December 1989, 1.5 years earlier. Based on the department's date on the list, the department would conduct the next on-site medical survey no later than June 1994 to meet the department's three-year goal. In fact, based on the actual date we obtained from the report itself, the department should conduct the next medical survey by December 1992. In another example, according to the department's list, it conducted an on-site medical survey in June 1991 for a dental health plan that was licensed in April 1990. The department had not conducted an on-site medical survey of the health plan. Instead, it had conducted an orientation as part of a first year follow-up to the health plan's license application. Based on the department's date, it would conduct the next medical survey by June 1994 to fulfill the department's three-year goal. In fact, the department should conduct an on-site medical survey by April 1993.

The Department's Supervision of Analysts Consistently Changed

According to the supervising counsel, during fiscal year 1986-87 through 1990-91, the department's management did not provide consistent supervision for its analysts to ensure that they conducted medical surveys within specified times. During this period, according to the supervising counsel, the department changed its supervision of analysts at least six times. These changes involved four staff members. For example, until July 1988, all of the analysts were supervised by the department's assistant commissioner for the division. Then from July 1988 to September 1989, at least one analyst continued to be supervised by the assistant commissioner, while the other analysts were supervised by a senior analyst. From September 1989 to February 1991, all of the analysts were supervised by the supervising health care service plan analyst (supervising analyst). However, from February 1991 to March 1991, another assistant commissioner supervised all of the analysts and continued to

supervise one analyst until May 1991, while the supervising counsel supervised the other analysts. Then in May 1991, the department's supervising counsel supervised all of the analysts until September 1991 when the supervising analyst resumed the supervision of all the analysts. When analysts have inconsistent supervision, direction about conducting medical surveys may be less effective.

The Department Had a Vacancy in the Assistant Commissioner Position

The department had a vacancy in the Health Care Service Plan Division's (division) assistant commissioner position. From November 1988 to August 1989, the department did not have an assistant commissioner for the division. However, according to the division's current assistant commissioner, in May 1991, the department's commissioner of corporations appointed him acting assistant commissioner, and in September 1991, the commissioner officially appointed him assistant commissioner. When the division has vacancies in management positions overseeing medical surveys, direction regarding medical surveys may be less effective.

The Department Experienced Extended Leaves of Absence

The department experienced extended leaves of absence in the analyst position during fiscal year 1988-89 and 1989-90. On two different occasions, from October 1988 to June 1989 and from March 1989 to August 1989, the department had two analysts who were on leave for eight and five months, respectively. Not all of their work loads were redistributed, however. For example, during the absence of the analyst who took an eight-month maternity leave from October 7, 1988, through June 15, 1989, the department did not redistribute all of the analyst's work load to ensure that medical surveys were conducted within specified times.

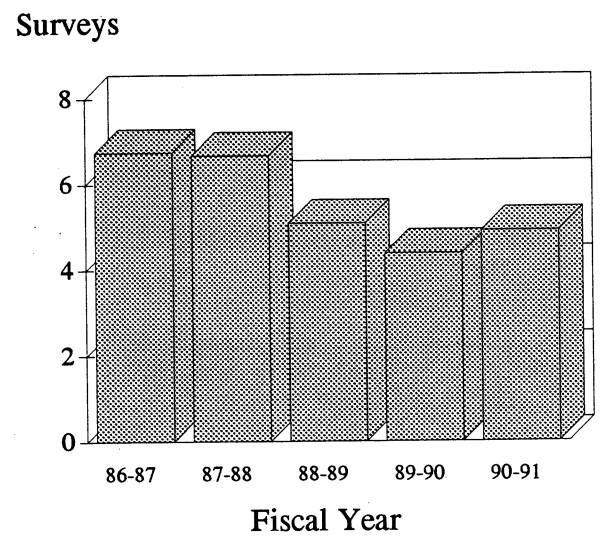
The Number of Medical Surveys Per Analyst Has Not Significantly Increased

Although the department increased its staff of analysts by 75 percent in fiscal year 1988-89, it did not significantly increase the number of medical surveys conducted for health plans in the following fiscal years. Figure 2 presents the number of medical surveys conducted per analyst during fiscal year 1986-87 through 1990-91.

Figure 2

Medical Surveys Completed by the Department of Corporations Per Analyst Each Year *

Fiscal Year 1986-87 Through 1990-91



* The number of analysts is adjusted each year to account for vacancies and leaves of absence.

Source: Department of Corporations' management and staffing reports.

Corrective Action

On March 12, 1992, the assistant commissioner of the division informed the analysts that he had established and implemented a policy making the supervising analyst responsible for maintaining records of medical surveys to ensure that the department conducts on-site medical surveys within specified times. In addition, on March 13, 1992, the assistant commissioner approved a form for the supervising analyst to use to track medical surveys conducted and reports issued to health plans. The form includes the dates of the prior surveys, the date of the most recent medical survey, the dates the confidential and public reports are issued to health plans, and the status of the medical survey reports. In addition, the form includes the date the department receives the health plans' response to the confidential reports and major survey findings.

Conclusion

The department is responsible for regulating the quality of medical care provided by health plans to their members. To carry out this responsibility, the department conducts on-site medical surveys of health plans. However, the department has not always conducted these on-site medical surveys within the three-year commitment to the Legislature or the five-year legal mandate. By not conducting medical surveys promptly, the department may allow some health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health. Also, health plans may miss opportunities to correct deficiencies within their operations.

Recommendations

To ensure that the department conducts on-site medical surveys of health plans within required times, the commissioner of corporations should take the following steps:

- Establish management controls to ensure that the department conducts on-site medical surveys according to its three-year goal and five-year legal mandate;

- Use the form the department approved in March 1992 to track the status of medical surveys conducted and confidential and public survey reports issued to health plans, record these dates from medical survey reports, and automate the tracking form;

- Improve its established automated system to ensure that the information captured on the tracking form is consistent with the information in the system;

- Ensure that analysts have consistent supervision and effective direction; and

- Redistribute the work loads of analysts when extended leaves of absence occur.

Chapter 2 The Department of Corporations Has Not Effectively Managed the Release of Its Medical Survey Reports of Health Care Service Plans

Chapter Summary

The Department of Corporations (department) has not effectively managed the release of its medical survey reports of health care service plans (health plans). From fiscal year 1986-87 through 1990-91, the department did not issue 95 (86 percent) of 110 confidential reports within its 90-day policy. Also, for 51 (78 percent) of 65 medical surveys for which the department could provide both the health plans' responses and the department's public reports, the department did not issue the public reports within 45 days of receipt of the health plans' responses, as it should have done according to its policy. By not issuing medical survey reports promptly, the department may allow some health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health.

In addition, despite the statutory requirement to release reports to the public after the department's notification, the department delayed releasing some of these reports beyond the 30 days allowed by law by inappropriately extending this period for at least five health plans by an average of 60 days. Further, although the law gives health plans only 30 days from the date of the department's notification to respond to confidential reports, the department accepted responses to the confidential report after 30 days from health plans for 49 (64 percent) of 77 medical surveys for which it could provide copies of the health plans' responses and corrective action plans. Also, it did not always disclose deficiencies not corrected within 30 days. Further, despite the statutory requirement that the department make public the deficiencies health plans have not corrected within 30 days, for 10 (28 percent) of 36 corrective action plans, the department did not disclose in the

public reports the uncorrected deficiencies. By not releasing these reports to the public after 30 days and not always making the uncorrected deficiencies public, the department allowed deficiencies cited in the confidential reports to remain nonpublic and possibly uncorrected.

Finally, the department is required to open for public inspection reports of all surveys, deficiencies, and correction plans except for those deficiencies the health plans correct within 30 days. However, the department has not properly maintained its records of medical survey information. During our review of medical surveys, the department could not locate 153 of 247 documents we had requested for 64 health plans.

The Department Has Not Issued Survey Reports Promptly After Medical Surveys

Section 1380(g) of the Health and Safety Code requires the department to notify health plans in confidential reports of deficiencies found during the medical surveys. Section 1380(h) of the code requires that the department open for public inspection reports of all surveys, deficiencies, and correction plans that the health plans have had an opportunity to review the medical surveys and file statements or responses within 30 days of the department's notification.

Since 1986, the department has had three policies regarding when to issue medical survey reports. According to the department's supervising counsel, as of July 3, 1991, the department's most recent policy is to issue confidential reports within 90 days of the last day of the on-site visits and to issue public reports within 45 days of the date the department receives the health plans' responses to the confidential reports. Because the department has not always met its previous, stricter policies for issuing medical survey reports, we used the current policy to evaluate the department's performance.

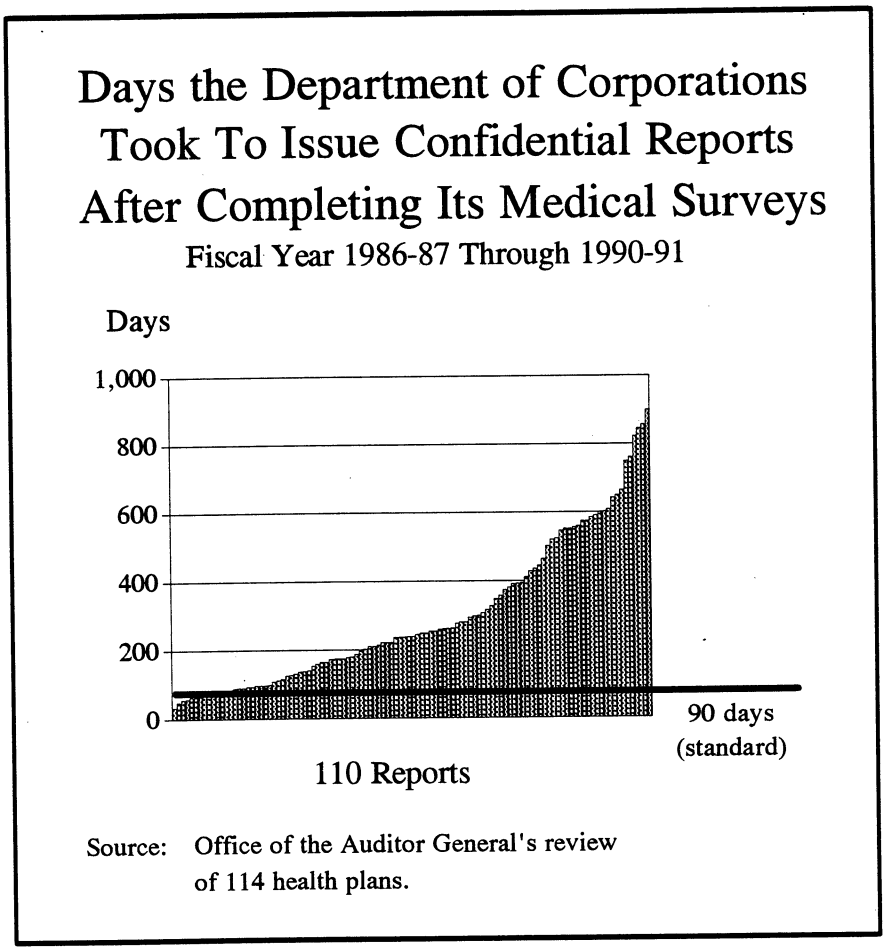
The Department Has Not Issued Confidential Reports Promptly

In our review of 114 health plans, we examined 122 medical surveys the department conducted during fiscal year 1986-87 through 1990-91. In 95 (86 percent) of the 110 medical surveys for which the department could provide the dates of the confidential reports or the reports themselves, the department did not issue the confidential reports according to its policy. For these 95 medical surveys, the department took an average of 335 days to issue the confidential reports to the health plans. The length of time ranged from 91 to 899 days. Specifically, for 15 (63 percent) of the 24 medical surveys conducted during fiscal year 1986-87, the department did not issue the medical survey reports within 90 days. For these 15 medical surveys, the department took an average of 214 days to issue the confidential reports, ranging from 94 to 573 days. Furthermore, for 26 (100 percent) of 26 medical surveys conducted during fiscal year 1989-90, the department took an average of 435 days to issue the medical survey reports, ranging from 161 to 749 days. Also, for 15 (88 percent) of the 17 medical surveys conducted during fiscal year 1990-91 and for which the department could provide confidential reports, the department took an average of 225 days to issue the confidential reports, ranging from 101 to 463 days. (Appendix C presents the number of days the department took to issue confidential reports for medical surveys conducted from fiscal year 1986-87 through 1990-91.)

For example, the department conducted an on-site medical survey of a psychological health plan in late 1988, identifying 26 deficiencies, including 6 deficiencies in the plan's internal quality of care review system. However, the department did not issue the confidential report to the health plan until the spring of 1991, 856 days later. In another example, the department conducted a medical survey of a dental health plan in the spring of 1989 in which it identified 24 deficiencies, including a failure to follow proper sterilization procedures on surgical instruments. The department did not issue the confidential report to the health plan until early 1991, 648 days after conducting the medical survey. In addition, for 7 of the 122 surveys we reviewed, the department never issued confidential reports to the health plans. Figure 3

shows the number of days it took the department to issue confidential reports for those medical surveys conducted from fiscal year 1986-87 through 1990-91.

Figure 3



Source: Office of the Auditor General's review of 114 health plans.

The Department Has Not Issued Public Reports Promptly

The department is also not meeting its policy for issuing the public reports within 45 days of the date the department receives the health plans' responses to the confidential reports. Using this policy to evaluate its performance, we determined that in 51 (78 percent) of the 65 medical surveys for which the department could provide both the health plans' responses and the public

reports, the department did not issue the public reports according to its policy. (The department could not locate all of the public reports for the 122 medical surveys we reviewed. Also, for 3 of the 122 medical surveys we reviewed, the department never issued the public reports.)

For these 51 medical surveys, the department took an average of 164 days to issue public reports. The length of time ranged from 52 to 860 days. Specifically, for 13 (93 percent) of the 14 medical surveys conducted during fiscal year 1986-87 for which the department could provide the health plans' responses and the public reports, the department took an average of 121 days to issue the reports, ranging from 56 to 402 days. For 11 (79 percent) of the 14 medical surveys conducted during fiscal year 1989-90 for which the department could provide the health plans' responses and public reports, the department took an average of 146 days to issue the reports, ranging from 63 to 401 days. For example, the department conducted an on-site medical survey of a dental plan in January 1988 and issued the confidential report to the health plan in October 1988. The health plan responded to the confidential report 30 days later; however, the department did not issue the public report until April 1991, 860 days later.

Because the department had completed only eight public reports as of February 7, 1992, for the 24 medical surveys conducted during fiscal year 1990-91, we did not analyze these eight public reports. The average and range would not be representative of the department's performance during this fiscal year. (Appendix D presents the number of days it took the department to issue public reports for medical surveys conducted during fiscal years 1986-87 through 1989-90.) Figure 4 shows the number of days it took the department to issue public reports after the health plans' responses were received for those medical surveys conducted from fiscal year 1986-87 through 1989-90.

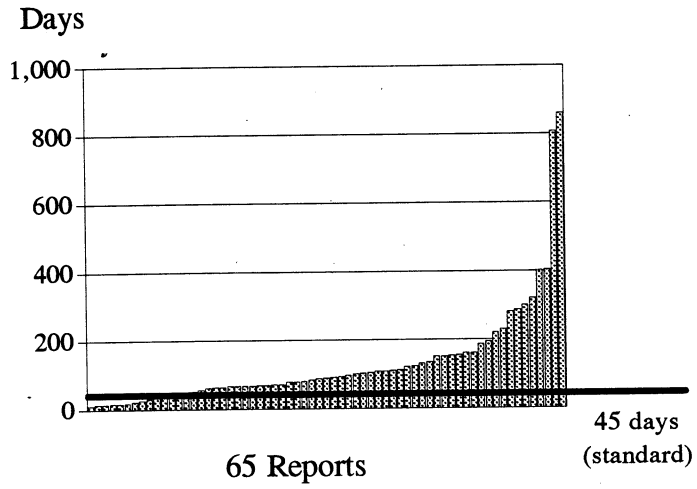
As of February 7, 1992, the department was still processing 14 survey reports, both confidential and public, for the medical surveys it conducted in fiscal year 1990-91. The delays of these reports are at least 56 and as much as 421 days more than the

department's policy for processing medical survey reports in a total of 165 days. (The 165 days consist of the 90 days the department has to issue the confidential reports from the last day of the on-site visit plus the 30 days the health plans have to respond to the confidential reports plus the 45 days after receiving the health plans' responses that the department has to issue the public reports.) Further, the department is still processing five public reports for the 26 medical surveys it conducted during fiscal year 1989-90, 587 days after the end of that fiscal year.

Figure 4

Days the Department of Corporations Took To Issue Public Reports After Receiving Responses

Fiscal Year 1986-87 Through 1990-91



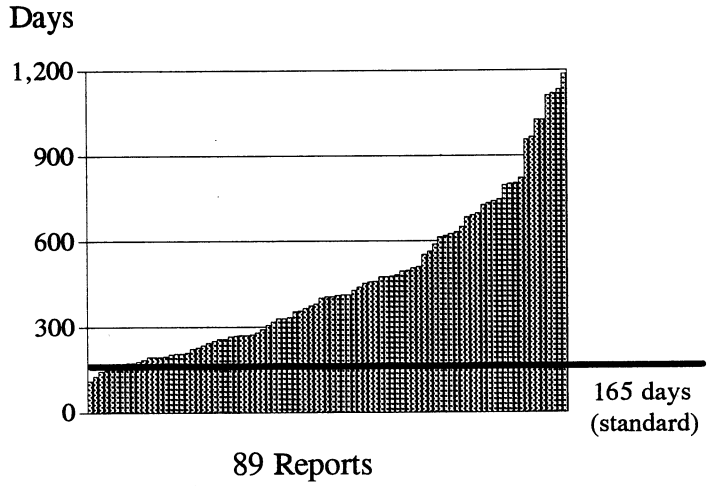
Source: Office of the Auditor General's review of 114 health plans.

Figure 5 shows the number of days the department took to issue public reports from the last date on-site for 89 medical surveys for which we had complete data.

Figure 5

Days the Department of Corporations Took To Issue Public Reports After Completing Its Medical Surveys

Fiscal Year 1986-87 Through 1990-91



Source: Office of the Auditor General's review of 114 health plans.

Report Delays Weaken Department's Position

When the department does not promptly issue or never issues confidential or public survey reports after conducting medical surveys, it may allow the health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health. Also, the information becomes outdated, thus making it difficult for the health plans to take appropriate corrective action. In an example in which the department did not

issue the confidential report, the department conducted an on-site medical survey of a dental health plan in late 1988. During this survey, the department noted a number of deficiencies, including unlicensed personnel providing dental services, inadequate sterilization procedures in some offices, and the improper billing of insurance companies by up to twice the amount charged to the health plan's members for the same services. The department's Enforcement Division advised the department to issue a confidential report.

However, the department never issued a confidential report to the health plan regarding these deficiencies, although the report had been drafted by September 1989, these deficiencies were never made public in a medical survey report. In August 1991, the State Attorney General filed suit against the health plan, alleging violations of the Dental Practices Act, including the unlicensed practice of dentistry, and violations of the Insurance Code, including misrepresentations on insurance claim forms. The department knew of these deficiencies as early as November 1988 but took no action until after the Attorney General filed suit against the health plan, almost three years later.

In addition, according to the department, delays in issuing the confidential reports place the department in a weak legal position for taking disciplinary action against a health plan with significant deficiencies. For example, the department conducted a medical survey of a dental health plan in the spring of 1987 and determined that the quality of care provided by the plan was unacceptable. The department took 573 days to issue the confidential report. Further, the health plan failed to respond to the confidential report, which is sufficient cause for the department to take disciplinary action. However, the department did not take disciplinary action because it determined that the delay of 573 days in issuing the confidential report placed it in a weak legal position for taking any disciplinary action.

The department conducted another medical survey of the same health plan in the fall of 1989 and again found certain areas of the health plan's quality of care unacceptable. The survey included a finding that one of the health plan's providers was not using proper sterilization procedures. The department took 435 days to issue this confidential report, thus allowing the provider to continue unsafe practices. The health plan's response to this second medical survey was due 30 days from the date of the confidential report; however, the health plan failed to respond. The department did not take enforcement action against the health plan until early 1992, when it revoked the plan's license five years after it had identified the original deficiencies.

Furthermore, the department's delays in promptly issuing medical survey reports deprive the members, the public, employer group benefit managers, and other health plans considering mergers or acquisitions of information necessary to make rational consumer choices and informed business decisions.

Inadequate Management Controls Delayed Reports

The department has not issued medical survey reports promptly after it conducts medical surveys because it lacks adequate management controls and has not devoted the necessary attention required to ensure that analysts issue medical survey reports according to its policy.

The Department Did Not Provide a Training Program or Update Its Manual

The department did not adequately train its health care service plan analysts (analysts) for writing medical survey reports. According to the supervising health care service analyst (supervising analyst), the department provided training sessions to its analysts in or about December 1989. However, the department's management did not have a formal training program for them. Instead, the supervising analyst stated that he provided informal on-the-job training to new analysts.

Also, the department implemented a Procedures Manual for Medical Surveys in October 1986. However, the manual is outdated and does not contain current policies and procedures for writing medical survey reports. For example, the manual contains terminology no longer used in medical survey reports to describe whether or not health plans are meeting health care standards. Also, the manual contains no guidelines for the analysts to follow in collecting, organizing, and retaining medical survey workpapers. Further, the department's management lacks formal policies and procedures for writing medical survey reports clearly and uniformly and for organizing and retaining medical survey workpapers. In at least one instance, the confidential report was delayed because the analyst who conducted the medical survey failed to collect or retain documentation sufficient for writing the survey report. Chapter 3, Page 45 discusses this issue in more detail.

However, following our review, on March 12, 1992, the department's assistant commissioner for the division established and implemented a Policy Manual for medical surveys and informed the analysts to maintain all policies in the manual related to the duties and responsibilities for medical surveys. For example, the Policy Manual includes at least nine new policies and two new procedures, such as those concerning selecting patients' medical records and conducting follow-up visits to review deficiencies cited. The manual also includes policies related to maintaining health plan files and tracking medical surveys. In addition, on March 24, 1992, the department's assistant commissioner adopted a training plan for the analysts to ensure that all new analysts receive adequate training and adhere to training requirements. The department's staff will conduct the training and will include such topics as understanding the department's mission, functions, and responsibilities; understanding the regulatory background of the Knox-Keene Health Care Service Plan Act of 1975 and its regulations; conducting on-site medical surveys; and preparing medical survey reports.

The Department Experienced Leaves of Absence for Analysts

The department experienced extended leaves of absence of analysts during fiscal year 1988-89 and 1989-90, as discussed in Chapter 1, page 14. During these periods, the department did not redistribute all of the analysts' work load. For example, the department conducted an on-site medical survey of a full-service health plan in April 1988 and issued a confidential report in July 1988. According to the department, the health plan responded to the confidential report in August 1988; however, the analyst assigned to the health plan took an eight-month maternity leave from October 7, 1988, to June 15, 1989. Because the department did not redistribute the analyst's work load, the department issued a second confidential report to the health plan in January 1990. It determined that this option was appropriate because a considerable amount of time had elapsed since the health plan had responded to the first confidential report. The department did not issue the public report until December 1990.

Supervision of Analysts Consistently Changed

According to the supervising counsel, during fiscal year 1986-87 through 1990-91, the department's management did not provide consistent supervision for its health plan analysts to ensure that they conducted medical surveys within required times and issued medical survey reports promptly. The supervision of analysts fluctuated among the department's staff during this time. Further, the department had vacancies in the assistant commissioner position for the Health Care Service Plan Division (division). These issues were discussed in Chapter 1, pages 13 and 14.

The Department Has Other Mandated Responsibilities

The analysts have other legally mandated responsibilities that have priorities over issuing medical survey reports. These responsibilities include responding to requests for material

modifications of the health plans' licenses. This legally mandated responsibility has deadlines that take precedence over issuing medical survey reports. According to one of the department's fiscal year 1992-93 Budget Change Proposals, the analysts spend 46 percent of their time responding to applications for licensing, license amendments, and material modifications of health plans. However, these activities are taken into account for staffing requests. The department should be able to perform these duties as well as those for medical surveys and medical survey reports.

Some Medical Survey Reports Were Not Issued

The department did not issued some medical survey reports because the department's management decided the reports were unnecessary. For example, the department conducted a medical survey of a full-service health plan in May 1988 and issued the confidential report in August 1988. However, the health plan filed for bankruptcy in March 1989 and subsequently filed an application to surrender its license in November 1990. After the health plan filed for bankruptcy, the department decided it was unnecessary to issue the public report.

The Department Did Not Promptly Disclose Reports to the Public When It Granted Extensions

Section 1380(g) of the Health and Safety Code requires the department to notify health plans of deficiencies found by the survey team during medical surveys. Section 1380(h) of the code requires that the department open for public inspection reports of all surveys and deficiencies and correction plans that the health plans have had an opportunity to review the medical surveys and file responses within 30 days of the department's notification. However, the department did not promptly disclose some of these reports to the public when it granted extensions of time in filing responses for some health plans. In our review of 65 medical surveys of the 114 health plans for which the department could provide public reports and the health plans' responses, the department granted at least five health plans an extension of time

for filing their responses. These five health plans submitted late responses in an average of 60 days, ranging from 19 to 46 days beyond the 30 days allowed.

When the department delayed releasing reports to the public by granting extensions, it allowed the deficiencies noted in the confidential report to remain uncorrected. Also, it violated the provisions of the law. For example, the department issued a confidential report in the summer of 1989 citing 21 deficiencies found during the medical survey. The health plan was required to respond to the report within 30 days; however, 70 days later, the health plan submitted its response to the department regarding the deficiencies identified and thanked the department for the extension it granted to the health plan.

The department did not promptly disclose reports to the public when it granted extensions to some health plans because its management had not emphasized to the analysts and legal counsel the policy of not delaying the report's release beyond the 30 days allowed.

The Department Accepted Late Responses to the Confidential Report and Did Not Always Disclose Uncorrected Deficiencies

Section 1380(h) of the Health and Safety Code requires the department to open for public inspection reports of all surveys, deficiencies, and correction plans that the health plans have had an opportunity to review the medical surveys and file responses within 30 days of the date the department notified the health plans. This section also requires the department not to make the deficiencies public if the health plans correct the deficiencies within this 30 days. Further, Section 1300.80.10, Title 10, of the California Code of Regulations requires health plans to submit correction plans to the department within 30 days of the date of the department's notification of deficiencies identified in the medical surveys.

However, the department accepted responses to the confidential reports after 30 days, and the department did not always disclose in the public reports deficiencies that the health plans had not corrected within 30 days.

The Department Accepted Responses After 30 Days

The department accepted responses to the confidential reports from health plans after 30 days. In our review of 114 health plans, we examined a total of 122 medical surveys conducted from fiscal year 1986-87 through 1990-91. In 49 (64 percent) of the 77 medical surveys for which the department could provide copies of the health plans' responses and corrective action plans, the health plans submitted the responses after 30 days. These 49 health plans submitted late responses in an average 40 days, ranging from 31 to 87 days. Further, the department could not locate responses for 38 (31 percent) of the 122 medical surveys we reviewed.

The Department Did Not Always Disclose Deficiencies Not Corrected Within 30 Days

The department did not always disclose in its public reports the deficiencies that were not corrected within 30 days. In our review of the 114 health plans, we selected a sample of 40 health plans to review in more detail. We examined 36 corrective action plans and determined that in 10 (28 percent) of the medical surveys, the department inappropriately deleted from the public reports deficiencies that the health plans had not corrected within 30 days after the department notified the health plans.

When the department accepted responses and corrective action plans after 30 days and did not always disclose deficiencies in the public reports, it allowed deficiencies cited in the confidential reports to remain nonpublic and possibly uncorrected. For example, in the summer of 1989, the department notified a dental health plan of two deficiencies related to quality of care, deficiencies such as a lack of procedures to ensure that all providers

comply with sterilization, radiation safety, and mercury safety requirements. The health plan filed its response and corrective action plan with the department 19 days beyond the 30 days allowed, yet the department subsequently deleted both of the deficiencies from the public report. Because the health plan had filed the corrective action plan beyond the 30 days allowed, the department should have included the deficiencies in the public report.

In addition, when the department did not always publicize deficiencies that the health plans had not corrected within 30 days, it deprived potential members of information about health plans necessary to make a rational consumer choice. Also, the department did not comply with the law. For example, the department notified a dental health plan in early 1988 of deficiencies in the health plan's quality of care, including a failure to ensure that the health plan's providers followed proper mercury safety procedures. The health plan responded 30 days later, describing the actions it would take to correct the deficiencies; however, the health plan did not indicate when it would take these corrective actions. The department accepted the indefinite correction plan and subsequently deleted these deficiencies from the public report, an action it should not have taken. In the next survey of this health plan in the spring of 1990, the department found that the health plan had not completely implemented its corrective action plan and cited the health plan again for not following mercury safety procedures.

The department accepted responses to the confidential reports from health plans after 30 days and did not always disclose the uncorrected deficiencies in the public reports because the department's management had not developed policies and procedures consistent with the law that requires the department to make public all deficiencies identified during medical surveys and not corrected by the health plans within 30 days. Also, according to the supervising counsel, the department did not disclose in the public reports the deficiencies that were not corrected within 30 days because its management had interpreted the law, as implemented by the department's regulations, as allowing the

department to accept corrective action plans from the health plans in lieu of actually requiring the health plans to correct deficiencies within 30 days. This policy and the regulations were inconsistent with the law.

The Department Has Not Properly Maintained Its Records of Medical Survey Information

Section 1380(h) of the Health and Safety Code requires that the department open for public inspection reports of all surveys, deficiencies, and correction plans except for those deficiencies the health plans correct within 30 days of the date of the department's notification. For this purpose, as of April 1989, the department had developed a procedure for a uniform and consistent method of organizing, filing, and maintaining medical survey documents for health plans. The procedures for organizing the division's central file are designed to ensure that certain medical survey documents, such as public reports and other public documents like the health plans' licenses, are maintained in a uniform section of the file. Also, these procedures are designed to ensure that these documents are readily available to the public, thereby facilitating informed consumer choices in selecting health plans.

However, the department has not properly maintained its records of medical survey information consistent with its procedures. In our review of all 114 health plans, we determined that the division's files did not contain all the records for medical survey information for the health plans. During our review of medical surveys for the 114 health plans, we could not locate all the necessary information related to medical surveys in the division's files. For example, on at least two occasions, we formally asked the department in writing to provide us copies of these medical survey documents. In our request on December 16, 1991, we asked the department to provide copies of 247 separate documents for 85 health plans related to medical surveys. Thirty-six days later the department provided copies of 94 documents for 21 health plans. In locating some of these documents, according to the assistant commissioner, the department found medical survey reports in boxes stored under a desk. As of February 7, 1992, the department still could not locate 153 of the documents requested for 64 health plans.

In addition, for at least 22 of the health plans, the department has maintained at least 56 of the necessary documents relating to medical surveys in files separate from the division's files. At least 16 of these were the department's only record of these documents, but because they were not in the division's files, they may not have been available to the public as required. Further, for 20 (18 percent) of 114 health plans, the health plans' licenses were not in the division's files. Following our request in December 1991, the department was able to provide all 20 licenses. For 4 of these licenses, however, the department had to obtain a copy from the health plans. Finally, we determined that for at least nine files, the department misfiled documents related to medical surveys. For example, an entire file for a dental health plan was found in a different health plan's file, and a dental health plan's confidential report was filed with another health plan's public report.

When the department has not properly maintained its records of medical survey information in the division's files, the documents are not available for the public's review. For example, during our review, the department could not provide from the division's files a copy of a full-service health plan's license and the public report issued in October 1990 for a survey conducted in November 1989. As a result, a member of the public seeking to review the license and to make an informed choice in selecting a health plan would be less able to do so. For calendar year 1991, the department had a total of 450 requests from the public in the Sacramento office alone to review various portions of the division's files for 73 health plans.

Also, misfiled medical survey documents may make documents available to the public when they should not be. This may jeopardize health plans' ability to obtain additional members. For example, in September 1991, an analyst informed the department's management that she had located the workpapers that had been lost for a full-service health plan. The analyst indicated that part of the workpapers had been marked to be included in the public files when they should not have been and that the confidential response to the health plan's prior medical survey had been placed in the public files where it had been available to the public for several years. The

workpapers contained highly confidential material pertaining to the deficiencies noted in the health plan's patient care.

Further, when the confidential reports and the health plans' responses are not in the file where they should be, the analysts cannot adequately prepare for subsequent medical surveys, nor can they identify instances of repeated deficiencies.

There are several reasons why the department has not properly maintained its records of medical survey information. One reason is that the department had not made it a priority to establish a working filing system. For example, the department did not ensure that staff place an out-card in the division's files as they should have when they removed health plan files. In addition, the department may have lost some files after a fire in March 1989 forced the department to move from its former location at the Continental National Assurance building to another Los Angeles office. Further, prior to January 1992, the department had not assigned sufficient staff to maintain the files.

Corrective Action

On March 12, 1992, the department's assistant commissioner for the division established and issued a policy informing its analysts that unless the assistant commissioner grants an extension, confidential reports will be issued within 90 days of the last day of the on-site visit. The policy also states that analysts are required to issue the public reports within 45 days of the date the department receives the health plans' responses to the confidential reports.

Further, effective April 1, 1992, the assistant commissioner for the division developed and implemented a policy informing staff that provisions of the law do not permit the department to grant extensions to health plans for filing statements or responses. If health plans fail to file written statements within the required 30 days, the commissioner of corporations will issue the confidential reports as public reports. In addition, also effective April 1, 1992, the department's assistant commissioner for the division informed staff that if health plans fail to file written

statements within the required 30 days, the department will issue the confidential reports as public reports. The policy states that, if health plans do not correct deficiencies within 30 days of the health plans' receipt of the notification, the department will include the deficiencies in the public reports and that the health plans' statements addressing the deficiencies will be attached to the public reports.

Furthermore, on February 14, 1992, the department's assistant commissioner for the division began establishing and implementing procedures to ensure that health plan files are accounted for, assembled, and stored in designated file areas in the Sacramento and Los Angeles offices. Specifically, the procedures prohibit any staff except file unit staff from removing health plan files from the shelves. In addition, file unit staff will remove files only in response to a written request and will use an out-card when they remove the files. The procedures require the department's supervising analyst to be responsible for providing missing portions of health plans' medical survey files, even if he must obtain the files from other staff or the health plans. Further, the assistant commissioner revised the procedures for organizing, filing, and maintaining medical survey documents. As of January 1992, the department had three staff persons assigned to assume responsibility for the division's health plan files. Two are assigned to the Sacramento office and one to the Los Angeles office.

Conclusion

The department has not effectively managed the release of its medical survey reports of health plans. From fiscal year 1986-87 through 1990-91, the department did not issue all its confidential reports within 90 days, and it did not issue all its public reports within 45 days of receipt of the health plans' responses, as it should have done according to its policy. By not issuing medical survey reports promptly, the department may allow some health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health. In addition, despite the statutory requirement to release reports to the public after the department's notification, the department delayed releasing some

of these reports beyond the 30 days allowed by law when it inappropriately extended this period for at least five health plans. Further, although the law gives health plans only 30 days from the date of the department's notification to respond to confidential reports, the department accepted responses to the confidential reports after 30 days, and it did not always disclose in the public reports the uncorrected deficiencies in the confidential reports. By not releasing these reports to the public after 30 days, the department allowed deficiencies cited in the confidential reports to remain nonpublic and possibly uncorrected. Finally, although the department is required to open for public inspection reports of all surveys, deficiencies, and correction plans except for the deficiencies the health plans correct within 30 days, the department has not properly maintained its records of medical survey information available to the public.

Recommendations

To ensure that the department issues medical survey reports promptly after conducting on-site medical surveys, the commissioner of corporations should take the following steps:

- Continue to implement the training plan adopted in March 1992 for new analysts and update its manual of procedures to ensure that analysts are informed of procedures based on the new Policy Manual;

- Establish and implement policies and guidelines to ensure that analysts write medical survey reports clearly and uniformly;

- Establish and implement policies and guidelines for collecting, organizing, and retaining medical survey workpapers;

- Redistribute the work load of analysts when extended leaves of absence occur;

- Ensure that analysts have consistent supervision and effective direction;

- Ensure that analysts resume preparing medical survey reports once they complete their reviews of material modifications; and

- Establish and implement policies regarding instances when the department deems it unnecessary to issue medical survey reports and ensure that analysts and legal counsel are promptly informed of the policy.

To ensure that the department properly maintains its records of medical survey information, the commissioner of corporations should take the following steps:

- Continue to implement its new filing system for health plans by giving priority to completing a workable filing system and ensuring that staff adhere to the system;

- Continue to obtain and locate missing documents for medical surveys that are necessary to ensure that health plan files are complete; and

- Continue to ensure that staff assigned to the health plan files complete the filing of all medical survey documents.

Chapter 3 The Department of Corporations' Sample Selection, Its Notification of Compliance, and Its Actions for Follow-Up and Enforcement Were Not Always Effective

Chapter Summary

The Department of Corporations' (department) sample selection, its notification of compliance, and its actions for follow-up and enforcement were not always effective. Specifically, the department did not select in 16 (30 percent) of 54 medical survey reports statistically valid samples of patients' medical records, and the procedures for selecting these samples were inappropriate. In addition, the department has not clearly stated in 14 (25 percent) of 55 confidential survey reports whether the health care service plans (health plans) were complying or not complying with health care standards. This makes it difficult for the health plans to determine when the department is notifying them of deficiencies. Further, although the department can take follow-up action and has the authority to take enforcement action, the department did not take follow-up or enforcement actions against 8 (62 percent) of 13 medical surveys to ensure that health plans corrected the deficiencies cited. By not always taking follow-up or enforcement actions, the department may allow some health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health.

The Department Did Not Always Select a Statistically Valid Sample for Medical Surveys

Section 1380(a) of the Health and Safety Code requires the department to conduct periodic on-site medical surveys of the health delivery system of health plans. Section 1300.80(b)(1)(4) of Title 10 of the California Code of Regulations requires the department to review the internal quality of care review system of health plans, including their medical records. On June 30, 1986, the department implemented a policy of selecting a statistically

valid sample of medical records to ensure that analysts can properly assess the health plans' performance in providing quality medical care to members. Statistical sampling is the selection and analysis of a limited number of items to obtain information about the larger universe from which the items are selected. Using the type of health plan and the number of members in a health plan, the department developed guidelines specifying the number of medical records to review when conducting a medical survey. For example, according to the guidelines, the department should select 100 medical records to review for health plans with more than 100,000 members.

The Department Did Not Select Samples of Medical Records According to Its Guidelines

When conducting medical surveys, the department did not always select samples of patients' medical records according to its guidelines. In our review of the 114 health plans, we selected a sample of 40 of the health plans to review in more detail. We determined that the department conducted 58 medical surveys for the 40 health plans for which it completed a medical survey from fiscal year 1986-87 through 1990-91. For 4 of the 58 medical surveys, the department either did not document the sample selection in the medical survey reports or did not issue medical survey reports. For the remaining 54 medical surveys, in 16 (30 percent), the department did not select a sample of the patients' medical records according to its procedures. For example, on June 3, 1988, the department conducted an on-site medical survey of a full-service health plan that had nearly 1.5 million members; however, the department did not review any medical records of patients. Yet, according to its own procedures, the department should have reviewed at least 100 medical records to assess the quality of the health plan's provision of medical services to its members.

The Department's Statistical Sampling Procedure Was Inappropriate

According to our statistical consultant, the department's procedure for selecting statistical samples was inappropriate. Specifically, the formula the department used to determine the sample size of medical records was based on unsubstantiated error rates. The department had assumed that the error rate of all medical record systems was 20 percent; however, this assumption was not appropriate because error rates can only be determined by a prior review of the medical record systems of all health plans. Individual error rates of medical record systems varied among health plans. Further, the department stated that it uses a 95 percent confidence level common for this type of analysis. However, the department's formula actually used a lower confidence level for calculating the sample sizes of health plans' records to review. To achieve a 95 percent confidence level, the department would have had to review more records than the formula required.

Selecting a statistically valid number of records to review is a way for the department to enhance the credibility of its findings. Although sound conclusions can be drawn from nonstatistically valid random samples of records when high error rates are found, it is especially important to ensure that enough records were reviewed when seemingly low error rates were found. Otherwise, the department risks overlooking deficiencies in a health plan, thereby exposing members to potentially substandard health care. For example, in early 1988, the department conducted an on-site medical survey of a dental health plan that had more than 76,000 members. For the survey, the department selected only 50 records to review when it should have reviewed 75. In this survey, the department found that the quality of care was acceptable. However, when the department issued the public report to the health plan in the spring of 1991, it had not reviewed enough records to assure the public that the health plan provided quality care.

The department did not always select statistically valid samples of patients' medical records because, according to the supervising analyst, since approximately 1988, the department's management did not ensure that health care service plan analysts (analysts) follow the procedures for selecting sample sizes. Also, the department did not have staff with the expertise in statistics to ensure that the formula for selecting sample sizes was appropriate. The department consulted with another state department to assist in developing the formula to select statistically valid samples.

Medical Survey Reports Have Not Always Clearly Stated the Health Plans' Compliance

Section 1380(g) of the Health and Safety Code requires the department to notify health plans of deficiencies found by the survey team during a medical survey. The department's current policy for writing medical survey reports requires the analysts to rate health care standards, such as quality of care, as "acceptable," which indicates that the health plans are in compliance; as "acceptable with modifications," which indicates that the health plans need to make changes to achieve full compliance; or as "unacceptable," which indicates that the health plans are not in compliance. Then the department lists the actions it requires the health plans to take to correct deficiencies. Despite these guidelines, however, the department has not always clearly stated in its confidential survey reports whether health plans were complying or not complying with health care standards.

In our review of a sample of 40 of the 114 health plans for medical surveys the department conducted from fiscal year 1986-87 through 1990-91, we determined that for 14 (25 percent) of 55 confidential reports issued, the department has not always clearly stated whether health plans were complying or not complying with health care standards. In many of these cases, the department used the terminology "acceptable" to rate health care standards when the health plan was not in compliance. For example, in a confidential report that the department sent to a full-service health plan in the spring of 1989, the department reported that the quality of care provided by the health plan was acceptable; however, it required the health plan to take five specific actions,

including establishing guidelines for the provision of preventive services, that were inconsistent with that assessment. More important, the department cited regulations related to quality of care as its authority for requiring these actions.

When the department has not clearly stated in the medical survey reports whether health plans are complying or not complying with health care standards, it makes it difficult for the health plans to determine when the department is notifying them of deficiencies so that they can formulate responses with corrective action plans to address the deficiencies. Also, it makes it difficult for members and other interested parties, such as benefit managers, to evaluate health plans' levels of compliance with the law and regulations, thus depriving the members of information necessary to make a rational consumer choice.

The department has not always clearly stated in medical survey reports whether health plans were complying or not complying with health care standards because of management's lack of formal policies and procedures for writing medical survey reports. The department's Manual of Procedures for medical surveys is outdated and does not include the current policies and procedures for writing medical survey reports, as discussed in Chapter 2, Page 28. For example, the manual requires the analysts to use the term "noncompliance" and "compliance" in describing whether health plans are meeting health care standards. However, according to the supervising counsel, sometime after October 1986, the department's management began to use the terminology "acceptable," "acceptable with modifications," or "unacceptable." In addition, as discussed in Chapter 2, Page 27, the department's management did not adequately train its analysts to write medical survey reports. According to the supervising health care service plan analyst (supervising analyst), the department provided training sessions to its analysts in or about December 1989. However, the department's management did not have a formal training program for its analysts. Instead, the supervising analyst stated that he provided informal on-the-job training to new analysts. However, on March 24, 1992, the department's assistant commissioner adopted a training plan for its analysts to ensure that all new

analysts receive adequate training. However, although the training plan includes guidelines for writing medical survey reports, such as guidelines for content and format, it does not specifically include a discussion of the terminology it now uses to ensure that medical survey reports clearly state whether health plans are complying or not complying with health care standards.

The Department Did Not Always Take Follow-Up or Enforcement Action

Section 1341 of the Health and Safety Code authorizes the department's commissioner of corporations to administer and enforce the Knox-Keene Health Care Service Plan Act of 1975. Section 1380(g) of the code requires the commissioner to give health plans a reasonable time to correct deficiencies identified during medical surveys. Failure on the part of the health plans to comply to the commissioner's satisfaction constitutes cause for disciplinary action against the health plans. Section 1300.80.10 of Title 10 of the California Code of Regulations requires health plans to submit corrective action plans to the department in response to deficiencies identified in the medical survey reports.

The department's management agrees that the department should conduct follow-up visits when necessary to ensure that health plans correct deficiencies identified during the medical surveys. Moreover, Sections 1386 et seq. of the Health and Safety Code provide for several types of disciplinary action the commissioner can take to ensure that health plans correct deficiencies. These actions include issuing cease and desist orders, assessing civil penalties, and suspending or revoking health plans' licenses. However, the department did not always take follow-up or enforcement action to ensure that health plans correct deficiencies cited in medical surveys.

In our review of a sample of 40 health plans for the medical surveys conducted from fiscal year 1986-87 through 1990-91, we determined that for 11 (20 percent) of the 55 medical surveys for which the department could provide confidential reports, the department identified a total of 56 deficiencies that were repeats of the ones identified in the previous surveys. Moreover, in 4 medical surveys, 2 of which were included in the 11 with repeat

deficiencies, the health plans did not provide corrective action plans to the department as required by state regulations. For 8 (62 percent) of these 13 medical surveys that had repeat deficiencies or no corrective action plans, the department did not follow-up or take enforcement action to ensure that the health plans corrected the deficiencies cited in the medical surveys. In a ninth medical survey, the department conducted a nonroutine survey as follow-up action; however, the department did not issue the confidential report to the health plan for this follow-up survey until 435 days after the survey was conducted.

When the department does not always take follow-up or enforcement action to ensure that health plans correct deficiencies identified during medical surveys, it allows health plans to continue operating in a manner inconsistent with the law and possibly dangerous to their members' health. For example, the department found that in two consecutive medical surveys conducted during the summer of 1986 and in early 1989, a dental health plan had eight deficiencies in quality of care. These deficiencies included a failure to ensure adequate diagnosis of tooth decay and periodontal disease. Although the department could have assessed civil penalties or suspended the health plan's license, it took no enforcement action against the health plan after finding that the health plan had not corrected the deficiencies. In another example, the department notified a dental health plan in the spring of 1990 of four deficiencies, including a failure to monitor and evaluate accessibility of care; however, the health plan failed to provide a corrective action plan. The department has taken no action to bring the health plan into compliance with state regulations, although as of February 1, 1992, the health plan continued to operate.

The department has not always taken follow-up or enforcement action to direct health plans to correct deficiencies cited in medical surveys because its management did not have consistent policies to ensure that analysts made recommendations to the department's management regarding repeat deficiencies. Although the department's analysts identified repeat deficiencies in medical survey reports reviewed by the department's management, the supervising analyst stated that the department did not perform follow-up or enforcement activities for these eight medical surveys.

Corrective Action

Following our review, the department changed its policy and no longer uses the guidelines based on an inappropriate formula to select statistically valid samples of patients' medical records. Instead, on March 26, 1992, the department's assistant commissioner for the division disseminated a new policy. This policy requires analysts to determine the number and type of medical records to review by using criteria such as information from previous survey reports in which the department identified deficiencies and trends of grievances from consumer complaints. The policy also states that the analysts will select medical records from one or more of five areas, such as the referral system and care of members in various age groups. Further, the policy establishes the number of medical records for analysts to review based on the health plans' enrollment size. The department's new policy requires analysts to select more medical records than required by its previous policy. For example, the department policy now requires its analysts to review 125 medical records for health plans with more than 100,000 members, whereas previously the policy required the analysts to select only 100 medical records.

In addition, in March 1992, the department's assistant commissioner for the division established and implemented a policy for follow-up and enforcement. When the supervising analyst determines that medical surveys reveal material noncompliance issues, the department will conduct either follow-up visits at the site of the health plans or will refer the plans for enforcement action. Also, the assistant commissioner will approve, in writing, all recommended enforcement actions. In addition, the policy states that the supervising analyst is responsible for monitoring repeat deficiencies identified in the confidential or public reports and for making prompt written recommendations to the assistant commissioner for follow-up visits and enforcement referrals.

Conclusion

The department's sample selection of patients' medical records, its notification of compliance, and its actions for follow-up and enforcement were not always effective. Specifically, the department did not select statistical samples of patients' medical records according to its guidelines, and the procedures for selecting these statistical samples were inappropriate. In addition, the

department has not clearly stated whether the health plans were complying or not complying with health care standards. This makes it difficult for the health plans to determine when the department is notifying them of deficiencies. Further, although the department can take follow-up action and has the authority to take enforcement action, the department did not always take follow-up or enforcement actions against health plans to ensure that they correct deficiencies cited during medical surveys. By not always taking follow-up or enforcement actions, the department may allow some health plans to continue to operate in a manner inconsistent with the law and possibly dangerous to their members' health.

Recommendations

To ensure that the department selects samples of patients' medical records according to the guidelines approved in March 1992, the commissioner of corporations should monitor the implementation of the new policy.

To ensure that the department clearly states in medical survey reports whether health plans are complying or not complying with health care standards, the commissioner of corporations should take the following steps:

- Formalize the current policy the department implemented sometime after October 1986 to include the terminology it now uses to describe whether health plans are meeting health care standards;
- Promptly inform analysts of the current policy; and
- Provide adequate training to new analysts on how to write medical survey reports that will clearly state the health plans' compliance or noncompliance.

To ensure that the department take follow-up and enforcement action against health plans so that they correct deficiencies cited in medical survey reports, the commissioner of corporations should monitor the implementation of the new policy developed in March 1992.

Chapter 4 The Department of Corporations Has Not Promptly Processed Complaints Made by Members Against Their Health Care Service Plans

Chapter Summary

As part of its oversight function, the Department of Corporations (department) assists members in resolving complaints against their health care service plans (health plans). However, the department has not processed these complaints promptly. Specifically, in our review of 149 complaints closed from fiscal year 1988-89 through 1990-91, we determined that for 78 (52 percent) of the 149 complaints, the department did not meet its goal of processing complaints within 45 days. It took the department an average of 127 days to process these 78 complaints, ranging from 46 to 476 days. Moreover, as of January 9, 1992, the department had a backlog of 599 complaints that have not been resolved since fiscal year 1988-89. Twenty-six of these complaints have been pending from between April 14, 1989, and June 29, 1990. When the department does not promptly process complaints made by members against their health plans, members may face the risk of not receiving the proper health care services to which they are entitled and may experience harassment by collection agencies when health plans do not pay claims.

Process for Handling Complaints

As part of its oversight function, the department assists members of health plans in resolving complaints made against their health plans. The department's consumer services representatives (CSR) process the complaints. The process begins when the department receives the complaints and ends when it sends letters to the members after the health plans resolve the complaints and the department closes the complaint cases. Prior to August 1990, the department processed all complaints from its Los Angeles office.

Since then, the department has had two CSRs to process complaints: one in the Los Angeles office and one in the Sacramento office. When the CSRs receive complaints from members, the CSRs send copies of the complaints to the health plans for the plans to resolve. The department routinely requests that the health plans respond within 15 days with a resolution of the complaint. If the health plans' resolutions favor the member, the CSRs inform the members of the resolutions and close the cases. However, if the resolutions favor the health plans, the CSRs forward the complaints and the resolutions to the department's legal counsel for review to ensure that the health plans' decisions are fair and legal. According to one of the department's senior trial counsel, the department reported that it received 1,247 complaints in fiscal year 1988-89, 1,296 in fiscal year 1989-90, and 1,429 in fiscal year 1990-91.

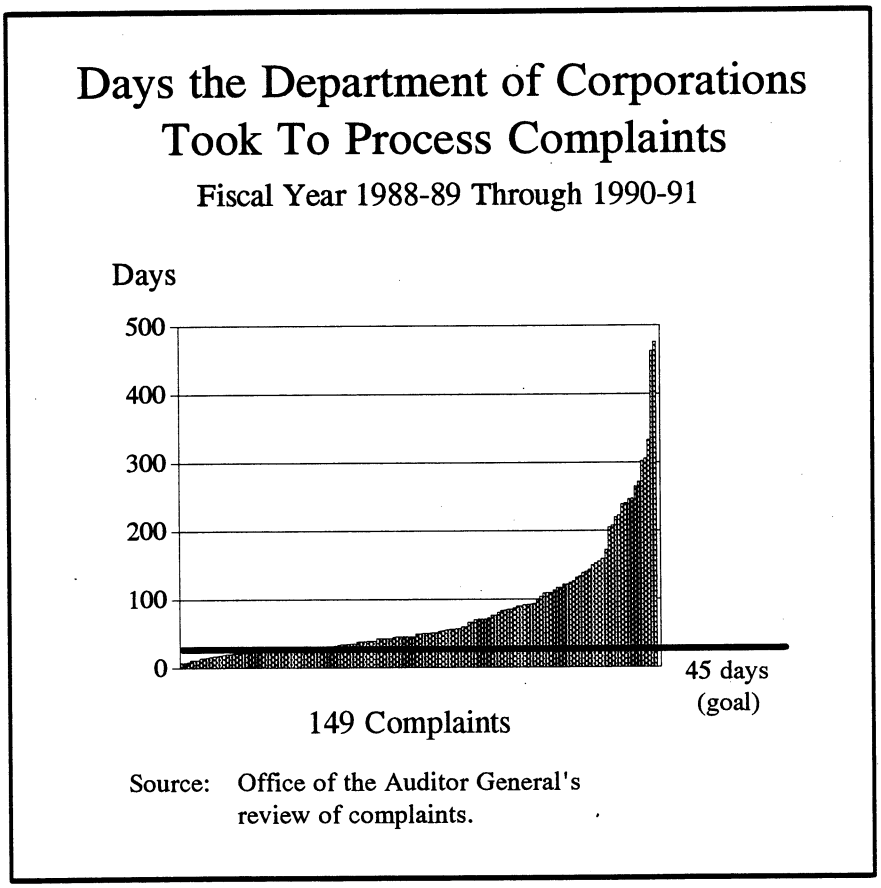
The Department Did Not Meet Its Goal in Processing Complaints

According to the department's supervising counsel, since July 1986, the department's goal has been to process complaints within 45 days unless the circumstances or complexity of the complaint extends the process. In our review of 150 complaints closed from fiscal year 1988-89 through 1990-91, we determined that for 78 (52 percent) of 149 complaints for which we had complete data, the department did not meet its goal. We could not determine for these 78 complaints whether the circumstances or complexity of the case extended the process. For these 78 complaints, the department took an average of 127 days to process the complaints, ranging from 46 to 476 days.

Specifically, for 24 (48 percent) of the 50 complaints reviewed for fiscal year 1988-89, the department did not process the complaints according to its goal. To process these 24 complaints, it took the department an average of 81 days, ranging from 46 to 155 days. Furthermore, for 38 (76 percent) of the 50 complaints reviewed for fiscal year 1990-91, the department did not meet its goal. To process the 38 complaints, the department took an average of 148 days, ranging from 46 to 476 days. (Appendix E presents the length of time the department took to process complaints

reviewed for fiscal year 1988-89 through 1990-91.) In 57 of the 78 complaints, delays occurred when the health plans failed to submit their resolution of the complaints by the date the department requested. However, we could not determine in all cases what follow-up action the department took with the health plans. Figure 6 shows the number of days it took the department to process the 149 complaints we reviewed for fiscal year 1988-89 through 1990-91.

Figure 6



Source: Office of the Auditor General's review of complaints.

The Department Has a Backlog of Complaints

Not only did the department take longer than it should have to process complaints, but it had a backlog of complaints that had not been resolved; some of these complaints were received as long ago as April 14, 1989. According to the department, as of January 9, 1992, it had pending resolution 599 complaints received between April 14, 1989, and January 3, 1992. The department received 4 of these complaints in fiscal year 1988-89, 22 in fiscal year 1989-90, 219 in fiscal year 1990-91, and 350 in fiscal year 1991-92. For 4 complaints, the department did not identify the date it received the complaint. Additionally, the 599 backlogged complaints are in various stages of the process. For example, 251 (42 percent) of the 599 complaints are awaiting responses from the health plans; 243 (41 percent) are awaiting action by the CSRs; 96 (16 percent) are pending with the department's legal counsel; and 9 (1 percent) are pending with other department personnel. Of the 243 complaints awaiting action by the CSRs, the department's Sacramento office accounts for 181 (74 percent), and the Los Angeles office accounts for 62 (26 percent).

According to the department, when the department has not promptly processed complaints made by members against their health plans, members may face the risk of not receiving the proper health care services to which they are entitled and may experience harassment by collection agencies when claims are not paid by health plans.

The department has not promptly processed complaints made by members for several reasons. According to the supervising counsel, the number of complaints the department received increased substantially during 1988 and 1989, resulting in increased difficulty in processing complaints promptly. As a result of the increase in complaints, the department requested additional staffing. In addition, transitions to a new processing system and a new computer system in the summer of 1990 and the spring of 1991, respectively, contributed to the department's difficulty in processing complaints promptly. Further, during fiscal year 1990-91, both of its CSRs had leaves of absence. The CSR in Los Angeles was on an unanticipated leave for two months; the

CSR in Sacramento was on an unanticipated leave for two weeks, and then was able to work only part-time for approximately 10 months. Despite this CSR's inability to work full-time, as of February 15, 1991, the department's management assigned this CSR to process the complaints received against 47 (41 percent) of the 114 health plans. These staffing problems and changes to the complaint processing system contributed to the backlog of complaints.

Corrective Action

Following our review, on March 23, 1992, the assistant commissioner for the division established and approved a Complaint Manual for the CSRs to use as a guide for processing consumer complaints. The manual has specific procedures for receiving complaints, following-up with health plans, and closing complaint cases. Also, the manual includes procedures for monitoring the status of complaints by issuing monthly activity reports to the department's management.

Conclusion

As part of the department's oversight function, the department assists members in resolving complaints against their health plans; however, the department has not processed these complaints promptly. Specifically, in 78 (52 percent) of the 149 complaints we reviewed for fiscal years 1988-89 through 1990-91, the department did not process the complaints within 45 days. For these 78 complaints, the department took an average of 127 days, ranging from 46 to 476 days. In addition, the department had a backlog of 599 complaints that had not been resolved. Twenty-six of these complaints have been pending since fiscal year 1988-89 and 1989-90. When the department does not promptly process complaints made by members against their health plans, members may face the risk of not receiving the health care to which they are entitled and may experience harassment by collection agencies when claims are not paid by the health plans.

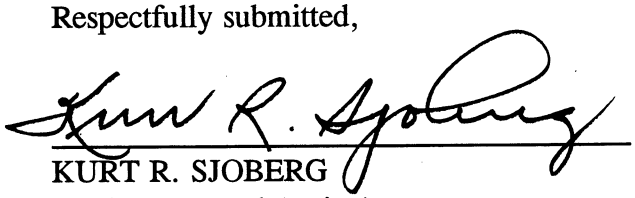
Recommendations

To ensure that the department promptly processes complaints made by members against health plans, the commissioner of corporations should take the following steps:

- Direct the consumer services representatives to comply with the timelines for processing complaints specified in the Complaint Manual established in March 1992;
- Continue to routinely monitor the status of complaints pending resolution and take appropriate action when the department does not resolve complaints according to its goal; and
- Reduce the backlog of pending complaints to a level consistent with the department's goal for processing complaints within 45 days.

We conducted this review under the authority vested in the auditor general by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



KURT R. SJOBERG
Auditor General (acting)

Date: May 26, 1992

Staff: Thomas A. Britting, Audit Manager
Cora L. Dixon
Gilbert Guadiana
James D. Lynch
Star Castro

Appendix A Medical Surveys the Department of Corporations Conducted Exceeding the Three-Year Goal Fiscal Year 1987-88 Through 1990-91

	Medical Surveys Reviewed	Medical Surveys Exceeding the Three-Year Goal	Average Number of Years Since Previous Survey
1987-88	24	3	3.3[a]
1988-89	26	15	3.5[b]
1989-90	28	17	3.5
1990-91	25	21	4.2
Total	**103**	**56**	3.8

[a] This average includes three medical surveys that exceeded the three-year goal. The fourth medical survey took 9.1 years from the previous survey but was not calculated in the average.

[b] This average includes 15 medical surveys that exceeded the three-year goal. The 16th medical survey took place 9.8 years after the previous medical survey was conducted but was not calculated in the average.

Appendix B Medical Surveys the Department of Corporations Conducted Exceeding the Five-Year Mandate Fiscal Year 1986-87 Through 1990-91

	Medical Surveys Reviewed	Medical Surveys Exceeding the Five-Year Mandate	Average Number of Years Since Last Survey
1986-87	23	8	8.0
1987-88	24	1	9.1[a]
1988-89	26	1	9.8[a]
1989-90	28	1	5.1[a]
1990-91	25	2	5.8
Total	**126**	**13**	7.7

[a] This average is the length of time from the previous survey the department took to conduct a medical survey for the one medical survey that exceeded the five-year mandate.

Appendix C Days the Department of Corporations Took To Issue Confidential Survey Reports for Medical Surveys Fiscal Year 1986-87 Through 1990-91

	Surveys Reviewed	Reports Issued in More Than 90 Days	Percent	Average Number of Days to Issue Report	Range of Days
1986-87	24	15	63%	214	94-573
1987-88	22	19	86	283	91-844
1988-89	21	20	95	426	99-899
1989-90	26	26	100	435	161-749
1990-91	17	15	88	225	101-463
Total	**110**	**95**	86%	335	91-899

Appendix D Days the Department of Corporations Took To Issue Public Survey Reports for Medical Surveys Fiscal Year 1986-87 Through 1989-90[a]

	Surveys Reviewed	Reports Issued in More Than 45 Days	Percent	Average Number of Days To Issue Report	Range of Days
1986-87	14	13	93%	121	56-402
1987-88	14	11	79	271	67-860
1988-89	16	13	81	154	62-300
1989-90	14	11	79	146	63-401
Total	**58**	**48**	83%	170	58-860

[a]For fiscal year 1990-91, we did not provide the data for the eight public reports issued because the average and range would not be representative of the department's performance.

Appendix E Length of Time the Department of Corporations Took To Process Complaints Fiscal Year 1988-89 Through 1990-91

	Complaints Reviewed	Complaints Taking More Than 45 Days	Percent	Average Number of Days To Resolve Complaints	Range of Days
1988-89	50	24	48%	81	46-155
1989-90	49	16	33	146	50-463
1990-91	50	38	76	148	46-476
Total	**149**	**78**	52%	127	46-476

STATE OF CALIFORNIA

1120 N Street
Sacramento
95814

~~(916) 445-1332~~ **916-654-4666**
Fax ~~(916) 445-5804~~ **916-653-2137**

Alcoholic Beverage Control
Banking
Corporations
California Highway Patrol
California Housing Finance Agency
Commerce

Housing & Community Development
Motor Vehicles
Real Estate
Savings and Loan
Transportation
Teale Data Center
Office of Real Estate Appraisers
Office of Small Business Advocate
Office of Traffic Safety

BUSINESS, TRANSPORTATION AND HOUSING AGENCY

CARL D. COVITZ
Secretary

May 19,1992

Mr. Kurt R. Sjoberg
Auditor General (Acting)
State of California
Office of the Auditor General
660 J Street, Suite 300
Sacramento, California 95814

Re: Report P-115

Dear Mr. Sjoberg:

We appreciate the opportunity to review and comment upon your draft report entitled: "The Department of Corporations Can Improve Its Management of Medical Surveys and Consumer Complaints in its Health Care Service Plan Division". We believe that the draft Report is based upon a thorough audit.

Overall, we concur with your conclusions and recommendations. Moreover, it is significant that before the commencement of the audit, the Department began to review and address issues in some of the same areas within the Health Care Service Plan (HCSP) Division identified by your staff.

We note that the Report, in fairness, contains reference to several specific substantive corrective actions already adopted and implemented by the HCSP Division. Examples of these include: The medical survey tracking system; the policy bulletin to all licensed health care service plans ("plans") and health analysts, dated March 12, 1992, regarding confidential and public medical survey

reports; the health analyst training plan; the HCSP Division File Project; and the HCSP Division Consumer Complaint Manual.

Concerning your recommendation that we update our existing Medical Survey Procedural Manual, dated October 1986, we want to inform you that effective May 11, 1992, the Assistant Commissioner of the HCSP Division has approved the outline of a new Medical Survey Manual. The anticipated completion date of the new Medical Survey Manual is presently June 30, 1992.

With respect to your recommendation that we clarify our notice to health care service plans of deficiencies in the medical survey reports, effective May 11, 1992, the Assistant Commissioner of the HCSP Division has approved the adoption and the implementation of a new policy for medical survey report writing which, among other things, will refer plans to statutory and rule deficiencies only, thereby eliminating the use of terms describing gradations of compliance and/or non-compliance.

Your recommendation that the Department adopt and implement policies and procedures setting forth the circumstances when medical survey reports will not be issued has been acted upon the the Assistant Commissioner of the HCSP Division. These policies and procedures took effect on April 29, 1992.

As of May 11, 1992, the Department has 258 pending consumer complaints. Of these 258 complaints, 148 have been pending 60 days or less; 110 have been pending over 60 days. The HCSP Division Complaint Manual states that Departmental management will receive monthly reports from the consumer services representatives to ensure careful and ongoing monitoring of any backlog. If necessary, we will take appropriate action minimize any backlog. Significantly, the Department continues to review the consumer complaint process with a goal of more efficiently processing enrollee complaints.

In conclusion, we welcome the recommendations in your audit report. They along with the corrective actions we have already implemented, or are ongoing, will result in more efficient and effective operation and management of our medical survey and consumer complaint programs. Ultimately, the plans and most importantly, the enrollees of plans will benefit from this process.

Sincerely,

CARL D. COVITZ

cc: Members of the Legislature
Office of the Lieutenant Governor
Attorney General
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps