

*State of New York*  
*Office of the State Comptroller*  
*Division of Management Audit*

**DEPARTMENT OF CIVIL SERVICE**

**CUSTOMER SATISFACTION WITH  
HEALTH CARE SERVICES PROVIDED  
BY HMOs IN THE NEW YORK STATE  
HEALTH INSURANCE PROGRAM**

**REPORT 95-S-112**



*H. Carl McCall*  
*Comptroller*



# State of New York Office of the State Comptroller

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## Division of Management Audit

### Report 95-S-112

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

Dear Mr. Sinnott:

The following is our report on customer satisfaction with the health care services provided by health maintenance organizations in the New York State Health Insurance Program.

This audit was performed pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law. We list major contributors to this report in Appendix A.

*Office of the State Comptroller  
Division of Management Audit*

October 28, 1996

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# Executive Summary

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## Department of Civil Service Customer Satisfaction with Health Care Services Provided by HMOs in the New York State Health Insurance Program

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### Scope of Audit

A health maintenance organization (HMO) provides comprehensive health care services to members of an enrolled group for an advance or periodic charge. More than 20 HMOs participate in the New York State Health Insurance Program (NYSHIP), which provides health insurance coverage to State and local government employees and their dependents. In 1993, these HMOs were paid nearly \$260 million in premiums for services provided to about 85,000 NYSHIP members. About 77 percent of these members belonged to seven HMOs. NYSHIP is administered by the Department of Civil Service (Department).

For the period January 1, 1993 through June 30, 1995, our audit addressed the following questions about the Department's oversight of the HMOs participating in NYSHIP:

- ! Does the Department adequately assess customer satisfaction with the health care services provided by HMOs?
- ! Do Department procedures provide adequate assurance that customer complaints about HMOs are properly recorded and resolved?

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### Audit Observations and Conclusions

We found that the Department should be more active in trying to assess customer satisfaction with the health care services provided by HMOs. Our survey of NYSHIP members belonging to HMOs identified a number of areas in which customer satisfaction could be improved. We also found that improvements could be made in the procedures relating to customer complaints.

The HMOs participating in NYSHIP are monitored by the Department's Employee Benefits Division (Division). We examined the activities of the Division and found that it performs many useful tasks, such as monitoring the HMOs' compliance with their contracts under NYSHIP. However, the Division does little to actively monitor customer satisfaction with HMO services. As a result, the Division may not be aware of problems in HMO services that need to be addressed. For example, HMOs are required by State health regulations to maintain records summarizing the complaints made and grievances filed by patients. We examined these records at the seven HMOs with the most NYSHIP members. Primarily because Division officials require participating HMOs to report only formal grievances to the Department, we

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found that the HMOs did not report, to the Department, nearly 80 percent of the total grievances filed and complaints made by NYSHIP members during 1993 and 1994. (pp. 5-6)

To determine the extent to which NYSHIP customers are satisfied with the services provided by HMOs, we randomly surveyed NYSHIP members who belonged to HMOs and received 188 responses. The respondents were generally satisfied with the overall performance of their HMOs. However, about 36 percent of them (or about 28,000 members in total when statistically projected) were dissatisfied with some aspect of their access to health care, such as their access to specialists and the care available on nights and weekends. Our survey also indicated that most respondents did not know how to file a complaint about the services provided by their HMO, and many of those who had filed a complaint did not feel that the complaint had been resolved to their satisfaction. (pp. 7-8)

Department management believes that NYSHIP members are not significantly dissatisfied with the services provided by HMOs. However, our audit suggests that the level of dissatisfaction among NYSHIP members may be higher than suspected by the Department. If Department officials are not aware of this dissatisfaction, they cannot take the actions that are needed to reduce the dissatisfaction. We therefore believe the Department needs to be more active in seeking to learn whether NYSHIP members are satisfied with the services provided by HMOs. (pp. 9-11)

The HMOs participating in NYSHIP are required to provide their members with a process for formally contesting decisions made by the HMO with respect to medical services provided or denied. We examined this process at the seven HMOs with the most NYSHIP members and found that improvements could be made. For example, at four HMOs, the information provided to members does not adequately describe the procedures to be used in filing a complaint. In addition, the right of members to file a complaint with the State Insurance Department and State Department of Health was not accurately described by two of the HMOs and was not mentioned at all by a third HMO. Moreover, the Department does not actively monitor the complaint process at the HMOs participating in NYSHIP. We believe the process is more likely to be improved if the Department were more active in its monitoring. We also note that the Department could make better use of its resources if it coordinated to a greater extent with the New York State Insurance Department and New York State Department of Health, which monitor certain aspects of HMO operations. (pp. 13-17)

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## **Comments of Department Officials**

Department officials did not specifically agree or disagree with most of the recommendations we made in our report. According to officials, the Department believes that it has been proactive in its efforts to learn whether NYSHIP HMO enrollees are satisfied with their HMOs.

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# Introduction

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## Background

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

- ! A staff or group model HMO employs or contracts with physicians and other medical specialists directly and maintains its own health centers. Most centers are equipped with x-ray, laboratory, pharmacy and other services. Members receive most care under one roof.
- ! A network HMO provides medical services within a network that can include its own health centers, as well as outside participating physicians, medical groups and multi-specialty medical centers.
- ! An independent practice association provides medical services through physicians who contract independently with the HMO to provide services in their private offices.

In New York State, the activities of HMOs are governed by Article 44 of the Public Health Law. The HMOs in New York are also regulated by the New York State Insurance Department, and the New York State Department of Health. The Insurance Department monitors whether HMOs comply with their agreements with their members, while the Department of Health monitors the quality of care provided by HMOs.

The New York State Health Insurance Program (NYSHIP), which is administered by the Department of Civil Service (Department), provides health insurance coverage to State and local government employees and their dependents. The Department has contracts with over 20 HMOs to provide health care under NYSHIP. In 1993, the Department paid nearly \$260 million in premiums to participating HMOs for services provided to approximately 85,000 individual and family subscribers. More than 75 percent of these premiums were paid to the following seven HMOs: the Capital District Physicians' Health Plan (CDPHP), which serves the Albany area; the Health Insurance Plan of Greater New York (HIP), which serves the metropolitan New York City area; the Mohawk Valley Physicians' Health Plan (MVP); the Community Health Plan (CHP), which serves areas around Albany and in the Hudson Valley; the Independent Health Association (Independent Health), which mainly serves western New York; Blue Choice of Rochester (Blue Choice); and Community Blue, which mainly serves western New York.

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These seven HMOs also account for about 77 percent of the total HMO enrollment in NYSHIP, as follows:

HMO	INDIVIDUAL AND FAMILY SUBSCRIBERS NUMBER/PERCENT	1993 PREMIUMS (IN MILLIONS)
CDPHP	19,895/23.4	\$ 57.1
HIP	10,517/12.4	\$ 33.9
MVP	8,739/10.3	\$ 33.8
CHP	8,157/9.6	\$ 28.0
INDEPENDENT HEALTH	7,381/8.7	\$ 18.1
BLUE CHOICE	6,082/7.1	\$ 17.3
COMMUNITY BLUE	5,183/6.1	\$ 17.3
OTHERS	19,039/22.4	\$ 54.4
<b>TOTAL</b>	84,993/100.0	\$259.9

## Audit Scope, Objectives and Methodology

We audited selected aspects of the Department's oversight of the HMOs participating in NYSHIP during the period January 1, 1993 through June 30, 1995. Our objectives were to evaluate the adequacy of the Department's procedures for assessing customer satisfaction with the health care services provided by HMOs and for ensuring that customer complaints about HMOs are properly recorded and resolved. To accomplish these objectives, we reviewed records and interviewed officials at the Department and at the seven HMOs with the most subscribers in NYSHIP. We also interviewed officials at the Insurance Department and the Department of Health. In addition, we sent questionnaires to randomly selected samples of (1) NYSHIP members who were enrolled in an HMO during 1995 and (2) NYSHIP members who switched from an HMO to another health care provider during 1995.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those Department operations included in our audit scope. Further, these standards require that we review and report on the Department's internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions

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recorded in the accounting and operating records, and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments, and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions, and recommendations.

We use a risk-based approach to select the activities for audit. This approach focuses our audit efforts on those operations that are identified as having the greatest probability for needing improvement. Consequently, by design, we used our finite audit resources to identify where and how improvements can be made. Thus, we devoted little audit effort to reviewing operations that may be relatively efficient or effective. As a result, we prepare our reports on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

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## **Response of Department Officials**

We provided draft copies of this report to Department officials for their review and formal comments. Department officials did not specifically agree or disagree with most of the recommendations we made in the report. However, according to officials, the Department believes that it has been proactive in its efforts to learn whether NYSHIP HMO enrollees are satisfied with their HMOs. We have considered the Department's comments in preparing this report and have included them in Appendix B.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Civil Service shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.



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# Assessing Customer Satisfaction and Dissatisfaction

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More than 20 HMOs are under contract with the Department to provide health care services in NYSHIP. The performance of these HMOs is monitored by the Department's Employee Benefits Division (Division), which is financed in part by funds allocated from the Insurance Department.

We examined the monitoring activities conducted by the Division. We found that the Division monitors the HMOs to ensure that they provide the benefits, and meet the performance standards, specified in their contracts with the Department. The Division also reviews the NYSHIP marketing material issued by the HMOs to ensure that the material is complete and accurate. In addition, the Division resolves complaints against HMOs made by NYSHIP members, when the complaints are made directly to the Department, and reviews information about grievances, made by NYSHIP members to the HMOs themselves. We acknowledge the usefulness of the monitoring activities conducted by the Division.

However, we believe these activities do not adequately identify problems in the services provided by HMOs, as described by the following detail. When a NYSHIP member has a complaint about some aspect of the service provided by an HMO, the member may complain to the HMO. If the complaint is not resolved, the member may file a formal grievance with the HMO. Generally, this grievance is evaluated by designated staff at the HMO, and if the NYSHIP member is not satisfied with the action taken by the HMO in response to the grievance, the member may file an appeal with other designated staff at the HMO. The Department requires the HMOs to report all grievances filed, both resolved and unresolved, as prescribed by the Department's contracts with the HMOs. Department officials consider this information when they evaluate the HMOs annually for continued participation in NYSHIP.

The Department does not, however, require the HMOs to report information regarding complaints that members have not elevated to the grievance level. Consequently, Department officials generally receive rather limited information about such complaints, and therefore, may be unable to identify adequately potential problems with HMO services. (Note: In their response to the draft report [see Appendix B-3], officials say that we incorrectly state that HMOs report those complaints that have not been resolved, but leave the Department unaware of complaints that have been resolved. We have clarified this issue in this report by distinguishing complaints from grievances and noting that the Department requires information on all grievances, whether resolved or unresolved.)

We noted that, certain kinds of complaints, by their very nature, do not result in grievances. For example, a member may complain about a long delay in a

waiting room, but after the member receives medical treatment, nothing can be done about the delay. In contrast, if a member is denied a certain type of treatment by an HMO, the member can file a grievance to be allowed such treatment. Therefore, even though some complaints may indicate problems in HMO services that need to be addressed (such as waiting room time), because these complaints require no resolution, on an individual basis, they generally are not reported to the Department.

HMOs are required by State health regulations to maintain records summarizing the complaints made and grievances filed by patients. We examined these records at the seven HMOs with the most NYSHIP members and found that only about 20 percent of the grievances filed and complaints made by NYSHIP members during 1993 and 1994 were reported to the Department, as follows:

HMO	GRIEVANCES AND COMPLAINTS REPORTED TO DEPARTMENT	GRIEVANCES AND COMPLAINTS PER HMO RECORDS	(DIFFERENCE) PROBLEMS NOT REPORTED TO DEPARTMENT
CDPHP	23	443	420
HIP	107	174	67
MVP	8	52	44
CHP	6	318	312
INDEPENDENT HEALTH	151	144	<7>
BLUECHOICE	22	27	5
COMMUNITYBLUE	26	525	499
<b>TOTAL</b>	343	1,683	1,340

We therefore conclude that Division staff may not be aware of many problems in HMO services that need to be addressed, and as a result, Department officials cannot make use of this information when they negotiate the NYSHIP contracts with the HMOs. If Department officials were aware of this information, they might be able to negotiate provisions in the contracts that would reduce the problems. We note that some HMOs send questionnaires to their patients in order to identify areas of satisfaction and dissatisfaction. We believe the results of such questionnaires would make the Division more aware of problems that need to be addressed.

To demonstrate the benefit of such a procedure, we developed a survey questionnaire and sent it to 453 of the 83,741 NYSHIP members served by HMOs in 1995. We randomly selected the NYSHIP members for survey using

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statistical sampling techniques. Our questionnaire addressed the level of satisfaction with the services provided by the HMOs as well as any experience in filing a complaint about these services. A total of 188 NYSHIP members responded to our questionnaire, for a response rate of 41.5 percent. (Note: For statistical sampling purposes, the 188 responses corresponded to a one-sided confidence level of 95 percent, a sampling precision of plus or minus 4 percent, and an expected error rate of 10 percent. However, for the purposes of this report, we have included the actual numbers and corresponding percentages of respondents without statistically projecting to the total population, unless otherwise noted.)

The answers to our questions about customer satisfaction are summarized in Exhibit A. We found that about 57 percent of our respondents were very satisfied with the overall performance of their HMO, about 41 percent were somewhat satisfied with this performance, and about 2 percent were dissatisfied with this performance. In addition, about 66 percent were very satisfied with the care provided by their primary care physician and specialists. (Note: Percentages exclude a small number of respondents who responded “don’t know” or did not respond to the specific survey questions pertaining to these issues.)

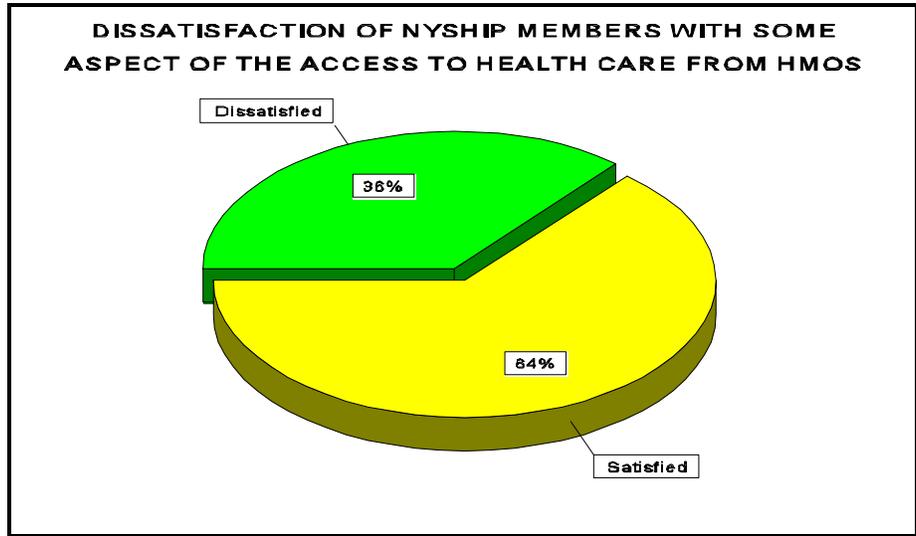
However, several respondents were dissatisfied with some aspect of their access to health care, as follows:

<b>Area of Concern</b>	<b>Percent Dissatisfied</b>
<b>Access to specialists</b>	<b>17.3</b>
<b>Waiting room time</b>	<b>16.6</b>
<b>Care on nights and weekends</b>	<b>13.6</b>
<b>Access to a doctor in an emergency</b>	<b>13.6</b>
<b>Time needed to get an appointment</b>	<b>12.7</b>
<b>Time spent with doctor</b>	<b>9.9</b>

In total, 68 of the 188 NYSHIP members who responded to our questionnaire (36 percent) were dissatisfied with at least one of these six aspects of their access to health care. If projected to the total population of NYSHIP members served by HMOs, about 28,000 members would be dissatisfied with some aspect of their access to health care. We note that questionnaires used by at least two of the seven HMOs identified similar areas of concern among their members.

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Our questionnaire also addressed customer complaints. According to the results of our questionnaire, only about 24 percent of our respondents knew how to file a complaint about the services provided by their HMO. A complaint was not filed by about one-quarter of the respondents to the questionnaire who said they had a significant problem with their HMO, and only half of those who did file a complaint felt that the complaint had been resolved to their satisfaction. We also noted that only 2 of the 20 respondents



who filed a complaint were aware that they could bring a problem to the attention of the Insurance Department or the Department of Health.

The answers to our questions about customer complaints are summarized by the following table.

Questions	Yes	%	No	%	No Reply	Total
Do you know how to file a complaint?	44	24.4	136	75.6	8	188
Have you had a significant problem with your HMO?	27	15.1	152	84.9	9	188
Did you file a complaint? (If you had a significant problem)	20		8		0	*28
Formal (complained in writing)	7					
Informal (complained by telephone)	10					
Did not answer whether formal or informal	3					
With whom was your complaint filed:						
HMO	20					**25
Both Insurance Department and Civil Service	1					**25
Union	1					**25
Doctor	3					**25
Was your complaint resolved to your satisfaction?	10		8		2	20
Do you know you can go to Insurance Dept. And Health Dept.?	2		25		1	28

Note: The respondents who did not reply to a question are not included when percentages are calculated.

\* One respondent did not have a significant problem, but did file a complaint.

\*\* Some respondents filed a complaint with more than one organization.

According to our survey results, about 15 percent of our respondents have had what they would classify as a significant problem with their HMO.

We also believe questionnaires could be used to target NYSHIP members who have terminated their membership in an HMO, as such members may be more likely to have encountered difficulties with an HMO, and therefore be better able to identify problems that need to be addressed. (We note that such questionnaires are routinely used by some HMOs.) To demonstrate the benefit of such a procedure, we sent our questionnaire to 652 of the 2,020 NYSHIP members who switched from an HMO to another health care provider during 1995. The 652 NYSHIP members were randomly selected, and 221 of the members responded to our questionnaire, for a response rate of 33.9 percent.

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The results of this survey were similar to the results of our survey of all NYSHIP members, except that the rate of dissatisfaction was higher, especially concerning access to health care. For example, 33 percent of the respondents were dissatisfied with the procedures for seeing a specialist, 29 percent of the respondents were dissatisfied with the procedures for seeing a doctor in an emergency, and 30 percent of the respondents were dissatisfied with the care available on nights and weekends. In total, 72 of the 221 respondents (33 percent) reported they had a significant problem with their prior HMO. However, only 39 of these 72 filed a complaint, and only 10 of the 39 felt their complaint had been resolved to their satisfaction. In addition, only 4 of the 39 complaints were filed with an independent party outside the HMO, indicating that the respondents may not have been aware that a complaint could be filed outside the HMO.

During the 30 months ended June 30, 1995, only 23 complaints about HMOs were filed with the Department by NYSHIP members. Because so few complaints are filed directly with the Department, and because relatively few unresolved complaints are reported to the Department by the HMOs, Department management believes that NYSHIP members are not significantly dissatisfied with the services provided by HMOs. However, our review of the grievances and complaints recorded by the HMOs, as well as our surveys of NYSHIP members, indicate that the level of dissatisfaction among NYSHIP members may be higher than suspected by the Department. If Department officials are not aware of this dissatisfaction, they cannot take the actions that are needed to reduce the dissatisfaction. We therefore believe the Department needs to be more active in seeking to learn whether NYSHIP members are satisfied with the services provided by HMOs.

In responding to the draft report, Department officials stated that it was difficult, if not impossible, to conclude whether a problem existed in the categories presented because the auditors allowed respondents to use their own subjective criteria, rather than certain performance benchmarks (or standards), to indicate their levels of satisfaction. Officials further stated that they saw little value in conducting general surveys of HMO member satisfaction.

We note, however, that we provided our survey questionnaire to Department officials for their review and comment before we mailed it to the selected HMO enrollees. Nevertheless, Department officials did not, at that time, suggest that any specific performance standards were necessary to ensure that enrollees' responses were meaningful. Moreover, we note that Department management did not (and perhaps could not) state in its response that it was certain that there were no significant problems in any of the areas we included in our survey and addressed in this report. As previously noted, perhaps as many as 28,000 NYSHIP members, served by HMOs, could be dissatisfied with an aspect of the health care they received. Thus, we maintain that Department management needs to be more active in its efforts to ensure that

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NYSHIP members are satisfied with the adequacy of the health care services provided by HMOs. Such efforts could include the use of satisfaction surveys that are targeted at specific service attributes and include specific performance standards.

**Recommendation**

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



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# Customer Complaints About HMOs

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In New York State, HMO operations are overseen by the Insurance Department and the Department of Health. These State agencies require HMOs to record and report customer complaints. We examined the complaint information overseen by each agency and identified considerable discrepancies. We concluded that the reported complaint information is significantly understated. We also examined the procedures relating to customer complaints at selected HMOs. We found these procedures could be improved to make it easier for customers to formally make complaints when they encounter problems in the services provided by HMOs. (Note: We did not have to distinguish complaints from grievances for this section of our report. Consequently any reference to complaints in this section applies to and includes grievances.)

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## Reporting Customer Complaints

HMOs are required by State health regulations to maintain a log of all the complaints made by their members. HMOs are also required by the Insurance Department to include the number of customer complaints in their annual statement. This annual statement, which is required by State insurance regulations, is filed with the Insurance Department. In addition, the number of complaints about HMOs made directly to the Insurance Department by customers or medical providers is published by the Insurance Department in an annual listing that ranks the HMOs by the number of such complaints.

We compared the complaint information recorded in the HMO logs to the complaint information included in the HMOs' annual statements and the complaint information published in the Insurance Department's annual ranking of customer and provider complaints. We made our comparison for the seven HMOs included in our audit for the two years ended December 31, 1994. As shown by the following table, we found that far fewer complaints were reported in the annual rankings and annual statements than were included in the HMO logs.

HMO	COMPLAINTS REPORTED IN ANNUAL RANKING	COMPLAINTS REPORTED IN ANNUAL STATEMENTS	COMPLAINTS IN HMO LOG
CDPHP	58	997	1,208
HIP	959	*1,980	3,364
MVP	96	88	356
CHP	40	78	8,925
INDEPENDENT HEALTH	105	3,567	3,567
BLUE CHOICE	38	599	601
COMMUNITY BLUE	65	9,055	9,574
<b>TOTAL</b>	1,361	16,364	27,595

\* For 1994 only, as HIP did not report this information for 1993.

We therefore conclude that the reported complaint activity significantly understates the number of complaints actually made. As a result of this understatement, aspects of HMO services that need to be improved may not be identified. Moreover, if the complaint information reported in the annual ranking and annual statements were accurate and complete, it could help the Department monitor the performance of the HMOs that participate in NYSHIP as well as the HMOs that seek to participate in NYSHIP.

We identified a number of reasons why many of the complaints included in the HMO logs are not included in the annual statements. For example, the Insurance Department provides no guidance to the HMOs for including complaint information in the annual statement and does not compare the number of complaints reported to the number of complaints recorded in the HMO logs. We also note that, even though the Insurance Department, the Department of Health and the Department of Civil Service monitor customer complaints against HMOs, the three State agencies have rarely coordinated with one another in this monitoring.

We further note that the definition of a complaint varies at different HMOs. For example, some HMOs record in their logs complaints made over the phone, while other HMOs will not record a complaint until it has been formalized in writing. In addition, some HMOs will not report a complaint to the Insurance Department until all action taken in response to the complaint is completed; other HMOs report a complaint as soon as it is made. As a result, what is considered a complaint by one HMO may not be considered a complaint by another HMO, and the complaint information recorded in the logs, as well as

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the complaint information included in the annual statements, is not necessarily comparable from HMO to HMO.

Subsequent to our audit fieldwork, Division staff met with officials from the Insurance Department and the Department of Health, and the three State agencies agreed to share information about customer complaints and to develop uniform definitions for recordable and reportable complaints.

However, in their response to the draft report, officials stated that it is not the Department's responsibility to ensure that customer complaint information reported in the HMOs annual statements is complete and accurate. Although we acknowledge that the Departments of Health and Insurance have the statutory responsibility in this area (and the Department does not), the fact remains that Department officials use customer complaint information submitted by the HMOs as a factor in evaluating the HMOs' programs. To be useful to management, the data in these reports must be complete and accurate. Thus, we question why Department management would not coordinate with the Departments of Health and Insurance to ensure that customer complaint information submitted by the HMOs was reliable. As noted previously in this report, several HMOs reported significantly fewer complaints than we identified through our on-site reviews of the HMOs' records.

(Note: Because of their responsibilities with respect to this issue, we have provided copies of this report to officials of the Insurance Department and Department of Health.)

### **Recommendations**

2. Coordinate with the Insurance Department and the Department of Health to ensure that the customer complaint information reported in the annual statements is complete and accurate, and the definition of a complaint is consistent from HMO to HMO.
3. Use the complaint information in the annual statements to monitor the performance of the HMOs that either participate in NYSHIP or seek to participate in NYSHIP.

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## Procedures Relating to Customer Complaints

The HMOs participating in NYSHIP are required by State health regulations, as well as by their contracts with the Department, to provide their members with a process for formally contesting decisions made by the HMO with respect to medical services provided or denied. We found that such a process is provided by the seven HMOs included in our audit. However, we also found that this process could be improved, as follows:

- ! At four of the seven HMOs, the information provided to members about the complaint process was not accurate or complete. For example, in some instances, the appeal process was not accurately described and deadlines for filing complaints were not disclosed. In addition, the right of members to file a complaint with the Insurance Department or the Department of Health was not accurately described by two HMOs and not mentioned at all by a third HMO.
- ! At one HMO, if a complaint is to be pursued, the member's formal complaint letter must be sent to the physician referenced in the complaint. We believe this procedure discourages some members from pursuing formal complaints. According to this HMO's records, 13 (26 percent) of 50 formal complaint letters, that were reviewed by the HMO's quality concern committee, were not pursued by management because the complainants did not give permission to have their letters sent to the physicians in question.
- ! Five of the seven HMOs have three or four stages to their complaint process. At each stage, a decision about the merits of the complaint is made by the HMO and this decision can be appealed by the member. We question whether such a cumbersome process is in the best interests of the members, as several appeals may need to be filed for a legitimate complaint if the complaint is to be satisfactorily resolved.

The Department does not actively monitor the complaint process at the HMOs participating in NYSHIP. We believe the process is more likely to be improved if the Department were more active in its monitoring.

In responding to our draft report, Department officials stated that they monitor HMOs complaint processes through the State Joint Labor Management Committee's (Committee) annual review of documentation submitted by HMOs that seek to participate in NYSHIP. (Note: Certain Division officials are members of the Committee.) Specifically, the Committee reviews documentation of each HMO's medical and administrative grievance procedures, including any documents, which describe the HMO's grievance procedures, that are sent to the HMO's subscribers. Nonetheless, we determined that Division officials did not assess the practices actually used by the HMOs to

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administer their grievance programs. As noted previously, we questioned whether certain HMO procedures were appropriate.

**Recommendation**

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

**Results of Survey of NYSHIP Members Served by HMOs  
Questions Addressing Customer Satisfaction**

Survey Questions	Very Satisfied	%	Somewhat Satisfied	%	Not Satisfied	%	Don't Know	% Very or Somewhat Satisfied
How satisfied are you with these services offered by your HMO:								
Availability of doctor	107	52.8%	65	35.5%	12	6.5%	2	93.5%
Accessibility by phone	99	58.9%	59	35.1%	10	6.0%	18	94.0%
Care available on nights and weekends	47	33.6%	74	52.9%	19	13.6%	44	86.4%
Selection of primary care provider	116	63.0%	53	28.8%	15	8.2%	2	91.8%
How doctor seen in emergency	56	40.0%	65	46.4%	19	13.6%	44	86.4%
How specialist is seen	78	46.4%	61	36.3%	29	17.3%	17	82.7%
HMO in general	105	57.1%	75	40.8%	4	2.2%	1	97.8%
How satisfied are you with getting care from your HMO?								
The way office staff deal with you	108	59.0%	67	36.6%	8	4.4%	3	95.6%
Advice over the phone	86	49.7%	77	44.5%	10	5.8%	13	94.2%
Waiting room time	68	37.6%	83	45.9%	30	16.6%	5	83.4%
How long it takes to get an appointment	80	44.2%	78	43.1%	23	12.7%	4	87.3%
Comfort of the waiting room	116	64.8%	55	30.7%	8	4.5%	5	95.5%
Completeness of check-ups	113	64.2%	48	27.3%	15	8.5%	10	91.5%
Care received from primary care provider	119	66.1%	50	27.8%	11	6.1%	6	93.9%
Care received from specialists	105	66.5%	43	27.2%	10	6.3%	27	93.7%
Advice in using medicine or supplies	113	64.6%	49	28.0%	13	7.4%	10	92.6%
The way health care staff speak to you	110	60.4%	65	35.7%	7	3.8%	4	96.2%
Time spent with doctor	94	51.6%	70	38.5%	18	9.9%	4	90.1%

Note 1: The shaded boxes represent the areas of greatest dissatisfaction among NYSHIP members.

Note 2: There are fewer than 188 responses to the questions, because some respondents did not answer some questions. The respondents who did not answer a question, or who answered "don't know" to a question, are not included when the percentages for that question are calculated.

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# Major Contributors to This Report

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David R. Hancox  
Carmen Maldonado  
Kevin McClune  
Brian Mason  
Michael Heim  
Robert Elliott  
William O'Toole  
Gregory Pierre  
Blanche Vellano  
Sheila Williams  
Dana Newhouse



GEORGE C. SINNOTT  
COMMISSIONER

STATE OF NEW YORK  
DEPARTMENT OF CIVIL SERVICE  
THE STATE CAMPUS  
ALBANY, NEW YORK 12239



THOMAS G. PHILLIPSWORTH  
EXECUTIVE  
DEPUTY COMMISSIONER

July 29, 1996

Mr. David R. Hancock  
Director of State Audits  
Office of the State Comptroller  
A. E. Smith State Office Building  
Albany, NY 12236

Dear Mr. Hancock:

Enclosed is our Department's response to draft audit report No. 95-S-112 resulting from your audit of member satisfaction with the services provided by health maintenance organizations that participate in the New York State Health Insurance Program (NYSHIP).

We appreciate the opportunity to respond to the findings and recommendations contained in the draft report, as well as the professionalism of your staff throughout the audit process.

Please do not hesitate to contact me, or Robert W. DuBois, Director, Employee Benefits Division, at 457-9391 if you have any questions about our response.

Sincerely,

George C. Sinnott  
Commissioner

Enclosures

cc: Hon. Patricia A. Woodworth

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

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Appendix B

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**DEPARTMENT OF CIVIL SERVICE  
RESPONSE TO OSC DRAFT AUDIT REPORT # 95-S-112  
CUSTOMER SERVICE SATISFACTION WITH HEALTH CARE SERVICES  
PROVIDED BY HMOs IN THE NEW YORK STATE HEALTH INSURANCE  
PROGRAM**

Thank you for the opportunity to respond to the draft audit report and for your consideration of our Department's response to the preliminary findings concerning this audit.

First, we are pleased that the audit found that the Employee Benefits Division (EBD) of the Department of Civil Service performs many useful tasks in the monitoring of the Health Maintenance Organizations (HMOs) that participate in the New York State Health Insurance Program (NYSHIP). The Department takes seriously its responsibility to carefully select and monitor the performance of all contractors that participate in the New York State Health Insurance Program, including the approximate 25 HMOs that provide services to NYS employees, retirees and their dependents.

We are likewise pleased, but not surprised, at the overwhelmingly positive results of the survey conducted by the auditors. Nearly **98 percent** of the respondents to the survey said that they were **"very satisfied"** or **"somewhat satisfied"** with the overall performance of their NYSHIP HMO. Additionally, in thirteen (13) of the eighteen (18) categories of satisfaction measured by the auditors' survey, **90 percent** or more of the respondents said that they were **"very satisfied"** or **"somewhat satisfied"** with their HMO in critical areas such as availability of the doctor, completeness of check-ups, care received from primary care doctors and specialists, and the manner in which health care providers interacted with the patient.

The remaining five (5) categories of satisfaction measured by the survey-- care available on nights and weekends, how the doctor is seen in an emergency, how a specialist is seen, waiting room time, and how long it takes to get an appointment-- each received satisfaction ratings of between **82.7 percent** and **87.3 percent**. Interestingly, of all the categories measured by the survey, these five are likely to be more indicative of the general level of satisfaction with health care delivery or attitudes toward common managed care features, such as specialist referrals, than the performance of any particular HMO. Because the auditors' survey allowed respondents to use their own subjective criteria to judge satisfaction, rather than benchmark performance against standards contained in the NYSHIP HMO Specifications or some other standardized measure, it is difficult, if not impossible, to conclude whether a problem exists in these categories. For example, we do not know whether a member who responded "not satisfied" with waiting room times waited fifteen minutes or one hour.

The results of the survey conducted by the auditors clearly show that the Department has been successful in achieving a very important objective -- offering NYS employees a choice of quality health care plans for themselves and their families. In the sections that follow, we have responded to each recommendation made in the draft report and commented on some of the observations and conclusions upon which the recommendations are based.

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*Recommendation #2: Be more active in seeking to learn whether NYSHIP members are satisfied with the services provided by HMOs. Toward this end, consider surveying NYSHIP members and reviewing information maintained by the HMOs about customer complaints.*

The task of ensuring that NYSHIP members are satisfied with the services provided by their HMO begins long before a complaint is ever filed by a member. Each year, the Department, in partnership with the Joint Labor Management Committee on Health Benefits, issues Specifications inviting HMOs to participate in the NYSHIP. The Specifications require an HMO to submit a proposal which contains a broad range of detailed information about the way they do business. Much of this information is requested in order to allow Joint Committee representatives to review and evaluate important areas of an HMO's policies and procedures that will ultimately impact the satisfaction of the member. Such information includes: adequacy of provider panel, credentialing and monitoring of panel providers, guidelines for waiting times and physician patient loads, specialty referral procedures, medical protocols and grievance procedures. Directly related to the scope of this audit, the Specifications require HMOs seeking participation in NYSHIP in 1997 to provide "All grievances filed with the HMO and the regulatory agencies in calendar year 1995 and 1996 to date by New York State enrollees and dependents and resolutions thereto, edited to conceal the identity of the grievant." The draft report is incorrect in its statement that HMOs report to the Department those complaints that are unresolved, thereby leaving the Department unaware of resolved complaints that may indicate a problem with an HMO. In fact, HMOs are required to report grievances to the Department whether or not they are resolved and, during the course of the field work, auditors examined many HMO proposals that contained copies of resolved grievances. The final report should be corrected.

After rigorous review of the proposals, and in some cases face-to-face interviews, the Joint Labor Management Committee selects HMOs to participate in the NYSHIP. Not all HMOs that apply for participation are approved. The monitoring of those HMOs that are approved begins immediately with a careful review of the HMOs' proposed marketing material and subscriber contracts to make certain that information given to NYSHIP members is accurate and representative of the benefits and rights they are entitled to. The Department's monitoring activities continue throughout the year to ensure that the HMO is in compliance with the terms of its contract with the Department and NYS law as it affects mandated benefits and practices.

NYSHIP HMO members have several avenues of complaint if they are not satisfied with the service provided by their HMO. A member may complain to the Department directly, in writing or by calling a toll-free number, through the Health Benefits Administrator at their employing agency and/or through their union representatives. Complaints are funneled to the Department's Employee Benefit Contract Management Unit where they are fully investigated with the HMO and brought to resolution. Unfortunately, not all complaints can be resolved to the member's satisfaction. For example, an HMO member who does not follow the HMO's specialist referral procedure and then does not receive benefits for services is not likely to be satisfied with the resolution of the complaint.

The Department also carefully monitors the annual option transfer reports. These reports show migration from one HMO to another HMO, or from an HMO to the State's Empire Plan. Historically, less than 3 percent of enrollees change options in the annual options transfer period.

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In summary, the Department believes that it has been proactive in its efforts to learn whether NYSHIP HMO enrollees are satisfied with their HMO. We see little, if any value in conducting labor intensive general surveys of HMO member satisfaction. Our contractual agreement with the HMOs allows the Department to access member-wide surveys as a means to judge general satisfaction or to customize a survey at the State's expense.

*Recommendation #2: Coordinate with the Insurance Department and the Department of Health to ensure that the customer complaint information reported in the annual statements is complete and accurate, and the definition of a complaint is consistent from HMO to HMO.*

The Department has and will continue to coordinate with the Insurance Department and the Department of Health on a variety of issues, including complaints about HMOs. We cannot, however, agree to this recommendation because it is not within the scope of the Department's responsibility or authority to "ensure that the customer complaint information reported in the annual statements is complete and accurate." The Department, as administrator of the NYSHIP, only has access to complaints by enrollees in the NYSHIP. Any significant information that we gather or learn in the process of administering HMO benefits for NYS employees and retirees will be made available to the Departments of Insurance and Health, as appropriate.

Finally, we strongly believe that the findings and conclusion contained in the report that relate to the responsibilities of other State agencies should be removed from the final report issued to the Department of Civil Service.

*Recommendation #3: Use the complaint information in the annual statements to monitor the performance of the HMOs that either participate in NYSHIP or seek to participate in NYSHIP.*

The Department of Civil Service already uses a number of sources of information to monitor the performance of HMOs participating or seeking to participate in NYSHIP. These sources include:

- Information submitted by the HMO in their proposal to participate in NYSHIP;
- NYSHIP's own experience with the HMO;
- The Health Plan Employer Data and Information Set (HEDIS) which is a core set of performance measures designed by the National Committee for Quality Assurance (NCQA) to enable plans and employers to accurately trend health plan performance in a comparative manner;
- Information that HMO must file with the NYS Insurance Department; and
- Information available from the Department of Health.

The results of the survey conducted by the auditors clearly show that this combination of information has been effective in selecting HMOs that offer quality services to NYSHIP members.

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*Recommendation #4: Actively monitor the customer complaint process at the HMOs participating in the NYSHIP to ensure that the process is fully explained to NYSHIP members, does not discourage the members from pursuing their complaints, and is not necessarily cumbersome.*

The Department spends a considerable amount of staff time monitoring the complaint process at the HMOs that participate in NYSHIP. As part of the annual proposal process, each HMO seeking participation in NYSHIP must submit specific information on its procedures for both medical and administrative grievances and copies of all documents sent to subscribers which describe the grievance procedures. This information is carefully reviewed by the Joint Labor Management Committee in the selection process, and HMOs may be asked to change their procedures or clarify explanatory materials as a condition of participation. Additionally, Department staff carefully reviews the subscriber certificates that an HMO proposes to send to NYSHIP members. We are currently in the final phase of reviewing HMOs for participation in NYSHIP in 1997 and, as always, will pay close attention to appropriateness of grievance procedures and the manner in which such procedures are explained to NYSHIP members.