STATE AUDITOR'S OFFICE REVIEW OF THE DEPARTMENT OF BANKING, INSURANCE, SECURITIES, AND HEALTH CARE ADMINISTRATION

MARCH 12, 1997

Executive Summary

INTRODUCTION

The State Auditor's Office, with KPMG Peat Marwick, has conducted a review of the internal controls over and compliance with certain Vermont statutes governing the state's health maintenance organizations (HMOs). Our objective was to review the internal control procedures established by the Department of Banking, Insurance, Securities and Health Care Administration (Department) and its compliance with the relevant consumer protection statutes in Titles 8 (§§5102, 5104, 5105 and 5109) and 18 (§§ 9410, 9412 and 9414).

The period covered was July 1, 1993 to January 31, 1997. We reviewed numerous documents provided by the Department and interviewed current and former officials and staff members of the Department and the Health Care Authority.

The State Auditor has undertaken this review in response to requests from the Governor and the House Health and Welfare Committee. The review has been conducted pursuant to the State Auditor's authority contained in 32 V.S.A. §§ 163 & 167.

FINDINGS AND RECOMMENDATIONS

A. Applications, Certifications, Filing

FINDING: In connection with the issuance and continuance of Certificates of Authority, the Department failed to ensure that individual HMO's were meeting certain quality and consumer protection obligations as prescribed by statute.

Our review found that:

The only comprehensive examination of an HMO concerning quality assurance (QA) and consumer protection was an unreleased 1993 Market Conduct Examination of Community Health Plan (CHP) (see Section VI. F. below).

There is no evidence the Department ever sought to obtain the necessary supporting information from the Authority (which had responsibility for QA) in order to justify continuance of a COA.

The Department has renewed or continued the HMO certificates of authority without establishing satisfactory performance by the HMO as to the "delivery, continuity, accessibility and quality of the services to which enrolled members are entitled."

RECOMMENDATION: The Department should establish procedures to ensure compliance with state law which requires that HMOs deliver quality health care to Vermonters.

B. Quality Assurance

FINDING: During the review period, the Vermont Health Care Authority failed to conduct the periodic examinations required by statute.

Our review found that:

Since July 1, 1993, no comprehensive quality assurance evaluations have been conducted by the Authority, as is required by statute at least once every three years. 18 V.S.A. § 9414(e)

As a result, the Authority failed to ensure that each health maintenance organization provides quality health care to its members... 18 V.S.A. § 9414

RECOMMENDATION: The Department should conduct comprehensive quality assurance evaluations of all HMOs operating in Vermont within the time prescribed by statute.

C. Enforcement

FINDING: The Department did not discharge its HMO enforcement responsibilities with respect to consumer protection under Vermont law.

Our review found that:

During the review period, an (unreleased) examination of one HMO (1993 CHP Market Conduct Examination, see Section VI. F., below), reported a number of serious quality assurance concerns, including accreditation and grievance procedures, and alleged statutory violations, including rates and forms filing and approval violations.

This examination was never issued, however. The problems identified were not addressed by the Commissioner and there was no administrative order requiring remedial action.

As a result, most Vermont HMO members were not afforded the protection contemplated by the enforcement authority granted to the Commissioner.

RECOMMENDATION: The Department should obtain the information necessary to discharge its enforcement responsibilities as required by law to protect HMO consumers.

D. Health Care Data Base

FINDING: The Department made significant progress in establishing and maintaining a unified health care data base in accordance with the requirements of 18 V.S.A. § 9410, but some important objectives were not accomplished during the review period.

Our review found that:

The Authority's data base does not yet contain the elements specified in § 9410(b) including 1) unique patient and provider identifiers, and a uniform coding system, and 2) all health care utilization costs and resources in the state. The collection of these elements poses as yet unresolved logistical problems.

The Authority had not used the data base to produce or distribute consumer information prior to July 1, 1996 (since that date the Authority has produced several consumer-oriented publications and established a Web Site). Instead, the information generated by the data base has largely been made available to industry and government officials.

RECOMMENDATION:

The Commissioner should monitor the progress of the Health Information Initiative to ensure that it meets the remaining requirements of the statute.

E. Grievance Procedures:

FINDING:

The Department has not conducted any examinations of CHP's grievance files.

A grievance is a consumer complaint lodged with the HMO regarding health care (i.e. denial of services, payment for services, referrals etc.). Pursuant to 8 V.S.A. § 5102a, a health maintenance organization is required to "establish and maintain a grievance or complaint handling procedure which has been approved by the Commissioner to provide for the resolution of grievances and complaints initiated by members."

During the review period, the Department issued no reports on examinations of CHP's grievances.

It is difficult to understand how the Department could be satisfied that HMO grievance procedures were actually working without conducting periodic examinations.

The lack of any examinations of CHP's grievances by the Department is remarkable in light of grievance-related observations in the Department's own unissued market conduct study (see Section VII. F. below), which described a number of serious shortcomings in CHP's policies and procedures.

RECOMMENDATION:

The Department should adopt specific plans for periodic examinations of HMO grievances.

F. Market Conduct Study

FINDING:

In 1993, the Department performed a Market Conduct Examination of CHP that contained over 40 critical observations about CHP's quality assurance and consumer protection procedures and practices. The report also noted numerous instances where CHP required consumers to pay for prohibited co-payments and deductibles, and failed to provide statutorily mandated minimum coverage to members. The report was signed by the Department's Market Conduct Chief but never released.

Prior to the passage of Act 30 (1993), the Department had responsibility for regulatory oversight of HMOs. Pursuant to that authority, the Department contracted for a "market conduct study" of CHP to "determine: 1) compliance with applicable Vermont laws regulating HMOs; 2) compliance with recognized HMO industry standards; and 3) if systems are in place at CHP to ensure appropriate and cost-effective health care is being delivered to Vermont CHP members."

The study was the first comprehensive evaluation of CHP since the company was licensed in Vermont in 1984. The Department decided to conduct the study because of concerns that "their [CHP's] growth in ... Vermont... had far outstripped their administrative capacity to support it." The draft report identified numerous areas of concern in provider credentialing, quality assurance, complaint handling and utilization

management, and included over 40 recommendations. The Department failed to make the draft report available to the company for comment (as is required by 8 V.S.A. § 3574(b)), and withdrew it instead.

In addition, to the grievance-related observations noted in Section E of this report, some of the more significant observations of the unissued report included: 1) insurance policies in violation of specific state statutes concerning coverage or charges; 2) assertions that "CHP's Credentialing Plan does not specify the means of verifying provider credentials;" 3) an assertion that there was no obligation on the part of physicians to refer member complaints to CHP; and 5) a recommendation that CHP "should eliminate its policy of holding members financially responsible for referrals made by participating primary care physicians, but not approved by CHP;"

By not issuing the report, the Department, the Authority, CHP, and consumers were deprived of the potential benefits derived from such a thorough evaluation. One of the central purposes of state regulations and such examinations is to establish public accountability for health maintenance organizations. Failure to release the Market Conduct Examination deprived consumers of potentially important information concerning CHP's performance, especially in the areas of consumer protections and quality assurance. Moreover, if the report was intended to help CHP identify and address concerns about the quality and administration of services, then its withdrawal represented another potentially significant lost opportunity**.**

Even if the Department believed it did not have the authority to release the report, it was never forwarded to the Authority for consideration, even though the Authority had assumed responsibility for quality assurance in 1993. Had the report been released, it could have accomplished several key objectives: 1) met the statutory requirement for an "evaluat[ion] of a managed care organization's performance" (at virtually no cost to the Authority); 2) documented areas of concern and created a baseline for future evaluations; 3) notified CHP of areas in need of improvement; 4) provided valuable information to consumers and policy makers.

Department staff offered several reasons why the report was not released. They are discussed in detail in the main body of the report, along with our observations. In summary, the reasons offered for not releasing the report are not compelling.

RECOMMENDATION

The Department should develop and implement internal control procedures to assure that information gathered during the course of HMO examinations is reviewed and used Department-wide in a timely fashion in order to facilitate consumer protection.

I. PURPOSE: The State Auditor’s Office, with KPMG Peat Marwick, has conducted a review of the internal controls over and compliance with certain Vermont statutes governing the state’s health maintenance organizations (HMOs).[(1)] Our objective was to

review the internal control procedures established by the Department of Banking, Insurance, Securities and Health Care Administration (Department) and its compliance with the following statutes:

18 V.S.A. § 9410	Health Care Data Base
18 V.S.A. § 9412	Enforcement
18 V.S.A. § 9414	Quality Assurance
8 V.S.A. § 5102	Application; certification, filing
8 V.S.A. § 5102 (a)	Grievance Procedures
8 V.S.A. § 5104	Filing and Approval of rates and forms
8 V.S.A. § 5105	Examinations
8 V.S.A. § 5109	Sanctions

II. SCOPE: The period covered was July 1, 1993 to January 31, 1997. Portions of the above statutes were amended as of July 1, 1996.

A review differs substantially from an audit conducted in accordance with applicable professional standards. The purpose of an audit is to express an opinion. The purpose of a review is to identify findings and make recommendations so that the reviewed agency, in this case the Department, can better accomplish its mission and more fully comply with laws and regulations. This review relies upon representations of, and information provided by, the Department and staff. If an audit had been performed, the findings and recommendations may or may not have differed.

III. METHODOLOGY: The definitions of internal controls and compliance used during this review are based upon the current standards of the American Institute of Certified Public Accountants (Statement on Auditing Standards No. 74 and 78). The review was conducted in accordance with these standards and Section VI of the Professional Standards Manual of the State Auditor's Office.

We made several written and oral requests for information and reviewed the materials provided, which are listed in Appendix A. We also interviewed numerous current and former officials and staff members of the Department, and the Health Care Authority.

IV. AUTHORITY: The review has been conducted pursuant to the State Auditor's authority contained in 32 V.S.A. §§ 163 & 167. The State Auditor has undertaken this review in response to requests from the Governor and the House Health and Welfare Committee.

V. BACKGROUND: As in the rest of the country, more and more Vermonters are receiving health care through systems of managed care. The growth of health

maintenance organizations (HMOs) in Vermont presents both opportunities and challenges. As the Department stated in a recent consumer brochure, "there are trade-offs [with HMOs], in exchange for lower costs, the HMO will limit your selection of doctors, and it will also place some limits on services, medications and types of treatment."

As HMOs gain increasing market share, there are some uncertainties about the new health care delivery system. It is essential that state regulators have the necessary legal tools and are vigilant in their efforts to ensure that Vermonters receive high quality care at a reasonable price. Recent changes to the enabling statutes (Act 180, 1996) have detailed several organizational and regulatory issues and are intended to improve the effectiveness and efficiency of the state's oversight of HMOs. Both the Commissioner of the Department and the Chair of the Health Care Authority were strong advocates for the changes effected by Act 180 as adopted by the Legislature.

In their January 1997 report to the Legislature, the Commissioner and the Chair (now Deputy Commissioner) addressed major substantive issues (e.g., access, quality, confidentiality, consumer information / protection, etc.) and various regulatory issues in the context of Act 180. With regard to the state's oversight and enforcement functions, the report acknowledges that "state laws ensuring consumer protections with respect to [managed care plans] are only as good as state oversight and enforcement of such laws."

The House Health and Welfare Committee is considering the Department's "compliance with and internal control over its oversight and enforcement responsibilities" and has asked the State Auditor to conduct an internal control and compliance review of the Department.

VI. ADMINISTRATIVE HISTORY:

Prior to 1993, the Department of Banking, Insurance and Securities had responsibility for regulatory oversight and enforcement of health maintenance organizations. In 1993, the Legislature amended Titles 8 and 18 of the Vermont statutes and re-apportioned oversight responsibilities between the Department and the Health Care Authority. For example, the Authority was given responsibility for quality assurance, but the Department retained authority for grievance procedures, examinations, certifications, and enforcement, which included quality assurance considerations. In 1996, the Legislature moved the Authority into the Department, creating the Department of Banking, Insurance, Securities and Health Care Administration.

VII. FINDINGS AND RECOMMENDATIONS

A. Applications, Certifications, Filing

FINDING: In connection with the issuance and continuance of Certificates of Authority, the Department failed to ensure that individual HMOs were meeting certain quality and consumer protection obligations as prescribed by statute.

HMOs must obtain a Certificate of Authority (COA) from the Commissioner in order to operate in the State of Vermont. 8 V.S.A. §§ 5102(a) and (b). Each HMO is required to renew its COA annually. 8 V.S.A. § 5102(c). Continuance of the COA by the Commissioner "shall be contingent upon satisfactory performance by the [HMO] as to delivery, continuity, accessibility, and quality of services to which enrolled members are entitled [and] compliance with the provisions of Vermont law." 8 V.S.A. § 5102(e)(1). Section 5102(e)(1) creates a responsibility for the Department to assess the performance of HMOs prior to continuing their COAs.

Our review found that:

- No comprehensive examinations or inquiries of an HMO concerning these quality assurance and consumer protection issues were conducted by the Department, with the exception of a 1993 Community Health Plan (CHP) Market Conduct Examination, which was not issued (see Section VII. F., below).
- The Department has failed to avail itself of other means to gather this information, including, consultation with the Health Care Authority. There is no evidence that the Department ever sought to obtain the necessary supporting information from the Authority in order to justify continuance of a COA.
- Therefore, the Department has renewed or continued the HMO certificates of authority without establishing satisfactory performance by the HMO as to the "delivery, continuity, accessibility and quality of the services to which enrolled members are entitled."

RECOMMENDATION: The Department should establish procedures to ensure compliance with state law which requires that HMOs deliver quality health care to Vermonters.

B. Quality Assurance

FINDING: During the review period, the Vermont Health Care Authority failed to conduct the periodic examinations required by statute.

Beginning in 1993, the Health Care Authority was given the "responsibility to ensure that each managed care organization provides quality health care to its members." 18 V.S.A. § 9414(a). Part of the Authority's responsibility includes an obligation to "evaluate a managed care organization's performance under the requirements of this section at least once every three years." § 9414(e). By law, the state must ensure each HMO has procedures in place to address quality assurance issues such as: accessibility, continuity of care, and follow-up of potential and actual problems in its health care delivery. §9414(b).

Our review found that:

- Since July 1, 1993, no comprehensive quality assurance evaluations have been conducted by the Authority, as is required by statute. 18 V.S.A. § 9414(e). (The

statute requires that such examinations shall be conducted at least once every three years.)

- By failing to fulfill its statutory obligation to conduct performance evaluations, the state did not assess whether or not HMOs met their responsibility in relation to the issues listed in 18 V.S.A. § 9414(b) (e.g., accessibility, continuity of care, and follow-up of potential and actual problems in HMO health care delivery).
- Therefore, during these three years, the state failed to conduct the required examinations of HMOs as part of its "responsibility to ensure that each health maintenance organization provides quality health care to its members..." 18 V.S.A. § 9414.

RECOMMENDATION: The Department should conduct comprehensive quality assurance evaluations of all HMOs operating in Vermont within the time prescribed by statute.

C. Enforcement

FINDING: The Department did not discharge its HMO enforcement responsibilities with respect to consumer protection under Vermont law.

The Commissioner had broad sanctioning and enforcement responsibilities under 8 V.S.A. § 5109. These include the authority to suspend or modify COA, impose penalties, or issue administrative orders. In addition, the Commissioner had enforcement responsibilities under the Health Care Authority's quality assurance statutes (18 V.S.A. §§ 9412(b), 9414(g)(1) and (2)). The Commissioner's enforcement authority is triggered by information gathered during the Certificate of Authority, Rates and Forms, and Examinations procedures.

Our review found that:

- During the review period, an examination of one HMO (1993 CHP Market Conduct Examination -- see Section VII. F., below), reflected a number of serious quality assurance concerns, including accreditation and grievance procedures, and statutory violations, including rates and forms filing and approval violations .
- This examination was never issued, however (see Section VII. F., below). Therefore, these identified problems were not addressed by the Commissioner and there was no administrative order requiring remedial action.
- As a result, most consumers were not afforded the protection contemplated by the enforcement authority granted to the Commissioner.

RECOMMENDATION: The Department should perform the examinations and other data collection activities, as required by statute, so that it has the information necessary to discharge its enforcement responsibilities as required by law to protect consumers who rely on managed health care insurance.

D. Health Care Data Base

FINDING: The Department made significant progress in establishing and maintaining a unified health care data base in accordance with statutory requirements outlined in 18 V.S.A. § 9410, but some important objectives were not accomplished during the review period.

In 1992, the Legislature enacted 18 V.S.A. § 9410 which gave the Health Care Authority responsibility for "establish[ing] and maintain[ing] a unified health care data base to enable the Authority to:

1) Determine the capacity and distribution of existing resources;
2) Identify health care needs and direct health care policy;
3) Evaluate the effectiveness of intervention programs on improving patient outcomes;
4) Compare costs between various treatment settings and approaches;
5) Provide information to consumers and purchasers of health care.

In addition, the statute requires that the data base contain "patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this state." 18 V.S.A. § 9410(b).

Our review found that:

- The Authority's data base does not yet contain the elements specified in § 9410(b) including 1) unique patient and provider identifiers, and a uniform coding system, and 2) all health care utilization costs and resources in the state. The collection of these elements poses as yet unresolved logistical and legal problems.
- The Authority had not used the data base to produce or distribute consumer information prior to July 1, 1996. (Since that date the Authority has produced several consumer-oriented publications and established a Web Site.) Instead, the information generated by the data base has largely been made available to industry and government officials.
- Initially, the Authority contracted with the Vermont Health Care Information Consortium (VHIC) to coordinate the development of the data base. The VHIC suspended operations in June 1995 without having met all the requirements of the statute. In November 1996, the Authority established the Health Information Initiative to develop rules for the submission of information by providers, HMOs, health care facilities and governmental entities. The Authority has negotiated a Memorandum of Understanding between the state and the other parties to establish the necessary protocols.
- The Authority has adopted a confidentiality code to ensure that privileged information is protected as required by § 9410(f).

RECOMMENDATION

The Commissioner should monitor the progress of the Health Information Initiative to ensure that it meets the remaining requirements of the statute.

E. Grievance Procedures:

FINDING

The Department did not conduct any examinations of CHP's records of grievances filed by members (health care consumers).

A grievance is an internal consumer complaint lodged by an HMO member with the HMO regarding health care, i.e. denial of services, payment for services, referrals etc. Pursuant to 8 V.S.A. . §5102a, a health maintenance organization is required to "establish and maintain a grievance or complaint handling procedure which has been approved by the Commissioner to provide for the resolution of grievances and complaints initiated by members." Further, the HMO is required to "maintain records of all grievances... until the Department has filed a report of examination on the grievances but no longer than seven years."

During the review period, the Department issued no reports on examinations of Community Health Plan (CHP) grievances, even though CHP comprised approximately 95 percent of the HMO market in the state. The Department asserts it did not believe such examinations were mandatory. Instead, they reviewed HMO grievance procedures for "reasonableness."

It is difficult to understand how the Department could be satisfied that HMO procedures were properly handling consumer grievances without conducting periodic examinations. Moreover, the Legislature clearly anticipated such examinations by requiring HMOs to "maintain records on all grievances received under this section until the Department has filed a report of examination on the grievances."

Moreover, an obligation to examine HMO grievance procedures can be inferred from 8 V.S.A. § 5102(e)(1) which states that "continuance by the Commissioner of a certificate of authority [is] contingent upon *satisfactory performance* by the organization" (emphasis added). A requirement to establish performance exceeds the abstract formality of approving HMO procedures.

The lack of any examinations of CHP's grievances by the Department is noteworthy in light of grievance-related observations in the Department's own unissued market conduct study (see Section VII. F., below). Based on a review of complaints received by CHP from April 1, 1992 through March 31, 1993, the unreleased study asserted:

> *"There are no written policies and procedures for reporting complaints, analyzing complaint trends, conducting follow-up reviews or documenting corrective action taken. The current system of categorizing complaints does not provide adequate specificity of complaint type.*
>
> *There are no written corrective action plans developed and signed by the Regional Medical Director. There are no follow-up reviews.*

There is no method utilized to coordinate complaints with QA, UM, Provider Relations and Credentialing."

We make no comment on the current status of CHP's grievance procedures and note that CHP's grievance procedures have been filed and reviewed annually by the Department since 1993. We also note that the Department had a system in place to receive complaints directly from consumers (see Section IX. D., below). However, this system does not obviate the Department of its mandate to oversee internal HMO grievances, which involves a more comprehensive review of HMO's grievance procedures than can be obtained from isolated consumer complaints made directly to the Department.

RECOMMENDATION

The Department should adopt specific plans for regular periodic examinations of HMO grievances.

F. Market Conduct Study

FINDING

In 1993, the Department performed a Market Conduct Examination of Community Health Plan (CHP) that contained over 40 critical observations about the HMO, particularly with respect to lapses in quality assurance and consumer protection. The report also noted numerous instances where CHP insurance policies included provisions that required consumers to pay for prohibited co-payments and deductibles, and failed to provide statutorily mandated minimum coverage to members. The report was signed by the Department's Market Conduct Chief but never released.

Prior to the passage of Act 30 (1993), the Department had responsibility for regulatory oversight of HMOs. Pursuant to that authority, the Department contracted for a "market conduct study" of CHP to "determine: 1) compliance with applicable Vermont laws regulating HMOs; 2) compliance with recognized HMO industry standards; and 3) if systems are in place at CHP to ensure appropriate and cost-effective health care is being delivered to Vermont CHP members."

The report was never issued and the Department never complied with the requirements of 8 V.S.A. §3574(b) which requires that the report, once completed, be made available to the company examined for comment. Thereafter, the Commissioner shall review and consider the report and company responses and adopt it with any modifications deemed appropriate. The Commissioner may then order any necessary and appropriate action, including sanctions, in response to any violations uncovered by the examination. 8 V.S.A. §§3574(c) and 5109.

Although an exit interview was conducted after the examination, we were provided with no evidence that the company was given a copy for comment. However, CHP now recounts that "...although no formal report was sent to us for comment, CHP continued to report to the Department via telephone as well as meetings on our progress."

The study was the first comprehensive evaluation of CHP since the company was licensed in Vermont in 1984. The Department decided to conduct the study because of concerns that "their [CHP's] growth in ... Vermont... had far outstripped their administrative capacity to support it." The scope of the study included the medical delivery system, quality assurance, utilization management, provider credentialing, provider relations, claims processing, complaint handling, and rates and forms. The draft report identified numerous areas of concern (including provider credentialing, quality assurance, complaint handling and utilization management) and included over 40 recommendations.

In addition, to the grievance-related observations noted in Section E of this report, some of the more significant observations and recommendations of the unissued 1993 Market Conduct Study of CHP included:

- An observation of 21 instances where CHP's health insurance polices were asserted to be in violation of specific state statutes concerning coverage or charges. Almost all related to alleged violations by CHP requiring consumers to pay for prohibited co-payments or deductibles, or failing to provide statutorily required minimum coverage to members.
- An observation asserting that CHP's Quality Assurance program was not nearly as comprehensive as examiners expected, given the age and size of the HMO. The report asserted that "CHP's QA Plan provides no QA standards, addresses no specific areas to be monitored... nor does it describe how corrective action will be taken and documented;"
- An observation asserting that there was no obligation on the part of physicians to refer member complaints to CHP;
- An observation asserting that "CHP's Credentialing Plan does not specify the means of verifying provider credentials," and that there "are no written policies and procedures for approving physicians who are not specialty board eligible or certified;"
- A recommendation that CHP "should eliminate its policy of holding members financially responsible for referrals made by participating primary care physicians, but not approved by CHP.

By not issuing the report, the Department, the Authority, CHP, and consumers were deprived of the potential benefits derived from such a thorough evaluation. One of the central purposes of state regulations and such examinations is to establish public accountability for health maintenance organizations. Failure to release the Market Conduct Examination deprived consumers of potentially important information concerning CHP's performance, especially in the areas of consumer protections and quality assurance. Moreover, if the report was intended to help CHP identify and address

concerns about the quality and administration of services, then its non-issuance represented another potentially significant lost opportunity.

It is important to note that CHP now maintains that the findings observations contained in the examination have been corrected. In correspondence with our office dated March 11, 1997, CHP specifically stated: "Our initial review of the report allows us to say that, with the exception of perhaps five or six minor areas in which we are in disagreement with the Department, CHP is in complete compliance and has either met or exceeded the recommendations of the draft 1993 market conduct examination report. This has been true for several years. Thus, the release of this draft report at this late date without our comment could easily mislead the public into thinking that all of these issues are of present concern."

We express no opinion on the disagreement between CHP and the Department nor do we express any opinion about CHP's subsequent compliance with Vermont law. Our interest in the report is as evidence of the Department's non-compliance with consumer protection responsibilities. The serious findings contained in the report and the Department's failure to issue the report with appropriate remedial orders which could have included restitution to Vermont consumers and punitive fines, underscore the Department's failure to protect Vermont consumers and comply with the relevant statutes.

Department staff offered several reasons why the report was not released. The first was because responsibility for quality assurance was transferred to the Health Care Authority by Act 30 on July 1, 1993. However:

- The study was conducted while the Department had broad oversight responsibility and dealt only with events that occurred prior to the adoption of Act 30;
- Even after the Authority assumed responsibility for quality assurance under 8 V.S.A.§9414, the Commissioner retained enforcement responsibilities under Title 8. To put it another way, the Authority was charged with information gathering concerning quality assurance, while responsibility for enforcement remained with the Department.
- If the report had been adopted and released, it would appear that the only remaining Departmental responsibilities would have been enforcement actions such as ordering the "necessary and appropriate" actions, including sanctions and restitution, in response to any violations. 8 V.S.A. §§3574(c) and 5109. The responsibilities of the Health Care Authority with regard to quality assurance were, therefore, largely irrelevant with respect to the report's release.

Secondly, Department personnel now say there was some concern at the time expressed about the reliability and expertise of the consultant and Department staff as well as the accuracy of the report. However:

- According to the Market Conduct Chief who signed the report, and according to an official in the North Carolina Department of Insurance, the consultant was

considered highly qualified and one of the most knowledgeable people in the country on these issues;
- The report was signed by the Market Conduct Chief for the Department, an attorney, who was directly involved in the production of the report;
- The former Deputy Commissioner recalls having only seen an early rough draft of the report and was unaware if it had been completed. But the Director of Insurance Regulation recalls having given the former Deputy a copy of the report that was close to a final draft.
- The report was extensively revised at the direction of, and under the direction of, the current Director of Insurance Regulation and there is no evidence that the Department contacted the contractor about any problems or inaccuracies.
- The contractor was paid for the work.

Thirdly, Department personnel now assert that there was reluctance to impose standards on the HMO during the review period because the statute contained no explicit standards and no rules had been adopted. However:

- The standards used by the contractor and adopted by the Department were drawn from those in use in North Carolina and used by the contractor in more than 20 HMO reviews he conducted prior to the one he conducted for the Department.
- In addition, there were other widely recognized standards for HMO review developed by the National Committee for Quality Assurance.

Even if the Department believed it did not have the responsibility to release the report, the report was never forwarded to the Authority for consideration in 1993 after it assumed responsibility for quality assurance. The failure to share the document is underscored by the admission of a Deputy Commissioner that there was value in the report and that he understood that the Authority had received a copy.

However, our review found that:

Although Authority staff were aware of the Department's market conduct study, they were not provided with a copy of the report. Had the report been released, it could have accomplished several key objectives: 1) met the statutory requirement for an "evaluat[ion] of a managed care organization's performance" (at virtually no cost to the Authority); 2) documented areas of concern and created a baseline for future evaluations; 3) notified CHP of areas in need of improvement; 4) provided valuable information to consumers and policy makers.

The participants have different recollections as to whether the report was in fact given to the Authority and, in some cases, their statements are contradictory (see Appendix C). There is no disagreement, however, about the fact that the Department never offered it and the Authority staff never got its own copy. Statements by participants suggest, however, that Authority staff asked the Department for a copy but were denied. Other Authority staff expected that a member of the Authority's Board would obtain the document and share it with staff. There is some disagreement about whether the Board

member received the report. If he did receive it, it is unclear as to why it wasn't shared with staff.

RECOMMENDATION

The Department should develop and implement internal control procedures whereby information gathered during the course of HMO examinations is reviewed and used Department-wide in a timely fashion. Necessary and appropriate actions should be taken to protect health care consumers.

VIII. INTERNAL CONTROLS:

This review has applied internal control standards contained in the Statement on Auditing Standards No. 78: "Internal control is a process - effected by an entity's board of directors, management and other personnel - designed to provide reasonable assurance of achievement of objectives in ... financial reporting, effectiveness and efficiency of operations [performance measurement], and compliance with applicable laws and regulations." Internal control consists of five interrelated components including control environment, risk assessment, control activities, information and communication, and monitoring.

A. Control Environment: "The control environment sets the tone of an organization, influencing the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure. The control environment encompasses the following factors: a) integrity and ethical values; b) commitment to competence; c) Board of Directors participation; d) management's philosophy and operating style; e) organizational structure; f) assignment of authority and responsibility; and, g) human resource policies and practices."

B. Risk Assessment: Risk assessment includes "identification, analysis, and management of risks relevant to" the organization. Risks relevant to the Department and Authority include: 1) uncertainty about the allocation of responsibilities under Titles 8 and 18; 2) access to adequate resources in order to achieve policy objectives; and 3) rapidity of change in the health care industry and the implications for the state's ability to successfully monitor and oversee HMOs.

C. Control Activities: "Control activities are the policies and procedures that help ensure that necessary actions are taken to address risks to achievement of the entity's objectives." Control activities usually include performance reviews, information processing, physical controls, and segregation of duties. In the case of small entities such as the Health Care Authority Board, however, some control activities may be less formal and "not relevant because of controls applied by management" (e.g., segregation of duties may present difficulties due to the size of the staff and authority for approving significant purchases may vest elsewhere).

D. Information and Communication: At base, this element of internal controls is about whether existing information systems can generate information sufficient for the entity to manage itself effectively.

E. Monitoring: "Monitoring is a process that assesses the quality of internal control performance over time. It involves assessing the design and operation of controls on a timely basis and taking the necessary corrective actions. This process is accomplished through ongoing monitoring activities, separate evaluations, or a combination of the two."

FINDINGS

Individual staff members of the Department and Authority appear to have a strong commitment to competence and the evidence suggests that both entities are well-served by able staff.

During the review period, the Department and the Authority did not have adequate policies and procedures to ensure effective coordination. As a result, there was very little oversight and monitoring of HMO's consumer protection performance from 1993 to 1996.

See Sections VII. A., B., C., E. and F., and Section IX. H. for a discussion of this issue.

RECOMMENDATION

The Department should design and implement internal controls to ensure that it will effectively fulfill its consumer protection obligations, as mandated by statute, in a timely manner.

IX. OBSERVATIONS (PRIOR TO JULY 1, 1996)

During the review period, the Department and the Health Care Authority had many other responsibilities not reviewed for this report that should be noted. Both entities experienced resource pressures and management problems that placed serious demands on them and may have affected their ability to achieve all their objectives.

A. Staff utilization and management

The Department and the Authority provided valuable information, analysis, and (in some cases) direct staff support to the Governor as the Legislature considered various health care reform proposals, including the Governor's proposed health plan, universal access plans, and the Medicaid Waiver. Staff indicated that certain responsibilities of the Authority and the Department received less attention than they might have otherwise.

During the review period, there was little continuity at the Authority Board which had three different Chairpersons. In addition, the current Chair (now Deputy Commissioner)

was not hired until December 1994. Furthermore, between 1993 and 1996, three different individuals served as the Governor's Health Care liaison.

B. Hospital Data Council

In the July 1993 - June 1996 period of the review, the Authority was responsible for staffing the Hospital Data Council, an advisory group that made recommendations to the Authority regarding the establishment of hospital budgets. In addition to assisting the Data Council in making its recommendations, the Authority (as the final decision maker on hospital budgets) held three administrative hearings in 1995 on contested hospital budgets. The Authority was also the subject of an appeal by a hospital challenging the budget adopted by it that same year. The administrative proceedings and the appeal, which is still pending before the Vermont Supreme Court, may have required substantial unplanned time and effort by staff.

C. Other Health Care Authority responsibilities

The Authority was also responsible for providing staff support to the Health Policy Council, which reviewed and made recommendations on all certificate of need (CON) applications before the Authority made final decisions on the applications. With the assistance of the Policy Council, the Authority also reviewed and revised the Health Resource Management Plan, the state's primary health planning document. In addition, beginning in 1994 the Authority adopted an expenditure target and then an annual unified health care budget as part of the general cost-containment efforts required by its enabling statute.

D. Complaint data base

The Department maintained a comprehensive data base of consumer complaints (separate from its enforcement obligations concerning internal HMO grievances) made to the state about HMOs and has developed an internal procedure for handling complaints.

E. Allocation of responsibilities

Confusion as to the division of responsibility and the extent of statutory authority followed the 1993 legislative changes to the enabling statutes for the Department and the Authority. This confusion was cited by staff interviewed as a significant reason for the limited number amount of oversight and monitoring of quality assurance during the review period.

There is no doubt that the legislation created dual and in some instances overlapping responsibilities between the Department and the Authority. But the overall statutory charge to both the Department and the Authority was clear -- monitor HMOs and protect consumers.

When read in their totality, the statutes require close cooperation in order to achieve their stated goals. The Department and the Authority both understood the need for cooperation (and in many cases did so) but sometimes became paralyzed and ineffective.

F. Industry influence on Department actions

In 1993, the Authority proposed a comprehensive set of HMO quality assurance regulations. According to the Authority's Attorney, the proposed regulations were withdrawn after representatives of CHP asserted that the Authority lacked any statutory authority to issue any such regulations and stated it would challenge the Authority's authority to do so. In addition, certain proposed regulations included enforcement powers for the Authority which were later withdrawn. Conversely, CHP challenged that Department's involvement in quality assurance information gathering activities and contended that those responsibilities were exclusively vested with the Authority.

Rather than seek independent legal advice from the Attorney General, Legislative Council or the Administrative Rules Committee, the Authority elected to reverse its legal position and withdraw the regulations. Eventually the Authority adopted regulations in 1994 that were less comprehensive than the ones it had contemplated in 1993

Such actions by industry officials and the Department's response to such actions raise some concerns as to whether the Department has always been fully prepared to resist industry pressure. Indeed the Governor's current Health Care liaison said of HMOs in general, that they had successfully lobbied for a division of responsibilities between the Department and the Authority in the 1993 legislation, and that after enactment, they had successfully exploited that division.

G. Access to resources

The size and complexity of HMOs presented a challenge for regulators, particularly because the companies' legal structure and method of service delivery were new to the state. This situation created difficulties for the Department and the Authority, which was assigned significant (and new) oversight responsibility but had limited experience in oversight. To complicate matters, the state had adopted a hiring freeze that left important positions vacant for periods of time.

However, the statutes provided authority for the Department and the Authority to bill the HMO for the costs of studies and examinations. The evidence suggests, however, that neither the Department nor the Authority effectively utilized these provisions to address the problem presented by insufficient resources. Both the Department and the Authority could have used bill-back provisions to hire contractors in order to fulfill a broad range of oversight responsibilities.

It has been asserted that the bill back provisions were of limited value because of existing state budget and accounting protocols. But this problem could have been cured by either budgeting in advance for the needed funds (based on planned examinations) and/or

seeking supplemental appropriations when needed. According to the Department's Business Manager, when requested, the Department has been successful at receiving necessary approvals for supplemental funds for examinations that can be billed back. Finally, the Department has recently returned unspent appropriations and excess funds from the Insurance Supervisory and Regulatory Fund to the General Fund.

H. Coordination of functions

In light of the risks to achieving the state's objectives posed by the division of responsibilities, one of the most important control activities should be procedures for coordinating functions. For well over two years, following the adoption of the 1993 quality assurance provisions, there appears to have been little coordination between the Department and the Authority. As a result, consumer protection suffered. However, in the Fall of 1995, the Administration addressed this need for better coordination and the result was the development, support for, and passage of the 1996 restructuring.

X. OBSERVATIONS (JULY 1, 1996- JANUARY 31, 1997)

Since the merger of the two entities in 1996, the Department has undertaken a variety of initiatives that are required by statute but had not received much attention by the Department or the Authority previously.

A. Consumer Protection

The new Division of Health Care Administration (Division) conducted research in an effort to better understand outstanding consumer protection issues. This effort involved questionnaires to and meetings with a large and diverse group of "stakeholders" (e.g., providers, consumers, advocacy groups, citizens and industry) which resulted in valuable information about the perceived needs of each interest group.

The information was organized by the Division into five major issue areas for further analysis including access, quality, due process, consumer information, and confidentiality of medical records. In response to the input from the stakeholder group, the Division has developed detailed proposed rule changes. The rule changes are an extensive and impressive elaboration of the consumer protection requirements outlined in Act 180.

We also note that the Department is currently in the midst of a limited market conduct examination of CHP.

B. Mental Health Services:

1. As noted above (see Footnote #9), the Division, during late 1995 through early 1996, carried out an evaluation of mental health and substance abuse services provided to Vermont residents by CHP. This extensive report was prepared in response to concerns raised during testimony before the House Health and Welfare Committee in 1995. The report identified numerous areas of concern

based in large part on CHP's rapid enrollment growth. The report included various recommendations and the Department intends to monitor CHP's progress over time.

2. In response to changes in and concerns about the delivery of mental health services, the Commissioner adopted Rule 95-2 in July 1995 which regulates mental health utilization review agents. Review agents are the new gatekeepers for HMOs and play a critical role in determining whether services can or should be paid for or provided.
3. In addition to regulating review agents, the Legislature created the Independent Panel of Mental Health Care Providers to hear appeals from consumers denied benefits as a result of decisions by a review agent. The Department published a very informative and accessible brochure in December 1996 in order to educate consumers about their rights of appeal to the review agents and, if necessary, to the Panel.

C. Management

Since the merger, the Department has outlined a workplan to ensure that resources needed to effectively manage the Division and the Department's responsibilities are available and properly assigned. This includes filling the position of Quality Assurance Director (created from a previous position classified as a health planner) and dedicating a full-time position to consumer complaints, and generally, to increase the number of staff assigned to Quality Assurance. The Department intends to assess and resolve personnel needs and supervisory structures and develop plans to prepare for periodic examinations and audits.

The question remains whether the Department has taken steps to correct all of the problems identified in our review. The most important of these was a lack of a clear commitment to compliance with statutory mandates relating to consumer protection. This commitment would involve at a minimum adequate and detailed planning and allocation of sufficient resources to ensure that quality assurance examinations occur on a timely basis and that the Department is prepared to follow-up with aggressive enforcement activities as necessary. We note that in the recently well-developed regulations, the sparsest areas related to enforcement. However, we also note the current Deputy Commissioner of the Division has indicated her commitment to consumer protection and enforcement.