California HMO Help Center

Annual Report 2002

READY TO RESOLVE YOUR HMO PROBLEM

HMO HELP CENTER STAFF

READY TO RESOLVE YOUR HMO PROBLEM!

This report and more information about the HMO Help Center, the Department of Managed Health Care, the Business, Transportation and Housing Agency, our Patient Advocate, and your HMO rights and responsibilities are available at www.hmohelp.ca.gov or by calling 1-888-HMO-2219.

This report contains an aggregate summary of grievances against plans filed with the director by enrollees or subscribers as mandated by California's Patients' Rights Law in the Knox-Keene Act, Section 1397.5 and the annual audit of the independent medical review system mandated by the Knox-Keene Act, Section 1374.34(e).

In addition to providing the mandated complaint data, this report describes the accomplishments of the Department of Managed Health Care's HMO Help Center during 2002. The Department of Managed Health Care was launched on July 1, 2000, to help Californians resolve problems with their HMOs as well as to ensure a better, more solvent and stable managed health care system.

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

Annual Report 2002

A MESSAGE FROM THE ACTING DIRECTOR

Dear Friend:

The people at the Department of Managed Health Care are proud to send the attached annual report from our HMO Help Center. This report is a testament to the new era of managed health care in California, where every HMO patient can be assured that, when their rights are violated, they have an advocate on their side to get them the care to which they and their family are entitled.

Since the Department's launch in July 2000, our HMO Help Center has helped more than 400,000 people resolve their HMO problem or question. About half of these calls and inquiries came in 2002, demonstrating that more and more people know about and are taking advantage of their HMO rights through the HMO Help Center.

We're working to make sure even more people who need help get it. We will continue to make sure HMO patients' rights information, including how to contact us, is easily available at the places where patients are most likely to need help, such as in doctors' offices and through human resources contacts at the workplace.

From resolving a simple paperwork mix-up to ensuring that independent doctors have the final word on HMO care, we are ready to resolve any Californian's HMO problem.

But resolving HMO problems is just part of what we do. Making the HMO system work better is just as critical. Spiraling health care costs affect not just California and America but every nation on the globe. Just as the Department has been a beacon to the nation on HMO patients' rights, we're leading the way on addressing rising costs. Our new rules requiring HMOs to return to their roots of better preventive care are designed to keep people healthy, prevent illness and preserve health care resources. In addition, we're continuing to work for better financial solvency in the HMO system so that patients have better security about their care.

The launch of the Department of Managed Health Care and our HMO Help Center has been revolutionary, setting a standard for the nation. Now's not the time to rest. We're taking an evolutionary course, working to expand patients' rights, improve awareness, and make sure more and more patients have better security over their care.

Thank you for your continuing commitment and partnership in our efforts to ensure that every California patient has the highest possible confidence in their health care.

Sincerely,

James R. Tucker, Acting Director

2002 Accomplishments

- Helped 161,915 Californians resolve their HMO problem
- Resolved 689 complaints through Independent Medical Review; 5,317 formal complaints; 1,291 urgent cases; and 348 quick resolution cases
- Saved patients more than $1.5 million in disputes with their HMO
- Opened 112 enforcement cases and resolved 37 cases through enforcement actions that resulted in collections totaling $2,948,574
- Won critical enactment of new law that we have authority to force HMOs to provide life-saving drugs to patients
- Won landmark victory for patients' rights when the states' largest HMO agreed to pay a $1 million fine around questions over access to emergency services
- Began use of sophisticated new complaint software that will help identify systemic HMO problems early
- Established new legal program that allows us to help consumers with legal questions
- Performed 42 medical surveys to promote health plan regulatory compliance
- Conducted 53 financial examinations of HMOs to ensure financial stability for patients
- Implemented a new system for electronic filing of HMO financial and other information so that we can focus more energy on patients' rights enforcement and less on administration

Table of Contents

EXECUTIVE SUMMARY

When you're sick and need to see a doctor, you don't want to stand in line, sit on hold or fill out forms. You want to receive the quality care to which you're entitled. That's what the Department of Managed Health Care's HMO Help Center is all about: helping patients resolve their HMO problems quickly and effectively.

"Their response was fantastic, decisive and overwhelming. If I owned a business, these are the caliber of employees I would want representing me."

Stephen Hoffman
Sacramento, California

The HMO Help Center is in operation 24 hours a day, 7 days a week. Our patients rights advocates, health care professionals, and customer service representatives respond to nearly 400 consumer calls every day in any language spoken by California's diverse population.

"It is rare that government works as well as it should. The Department of Managed Health Care has risen to the mission of serving the people of California, and deserves our thanks and recognition."

Senator Don Perata
Ninth Senatorial District

The HMO Help Center is an organization solely dedicated to helping HMO patients and enforcing their rights. A wide range of HMO patient advocacy services ensure that consumers understand their rights and receive a swift and effective response to their concerns. Quality customer service is our top priority. Should your problem be outside of our jurisdiction, HMO Help Center staff make every effort to connect you to the appropriate agency or patient organization to address your concern.

"It is comforting to note that there are organizations to help the 'little guy' in California when there is a mishap. I feel my taxes are put to good use. Again congratulations on a job well done."

Dorothy Weber
Sunnyvale, California

In 2002, the HMO Help Center provided assistance to 161,915 Californians via telephone assistance, quick resolutions, urgent case resolutions, provider assistance, complaint resolutions or independent medical review. All issues were resolved through our complaint management system:

- Telephone Calls Received – 149,879
  Interactive Response - Almost 31% of all calls to the HMO Help Center are resolved by a digital interactive voice response system, which provides basic information such as the contact numbers for the major HMOs' internal customer service and complaint offices. In 2002, 46,341 calls were resolved through this system.

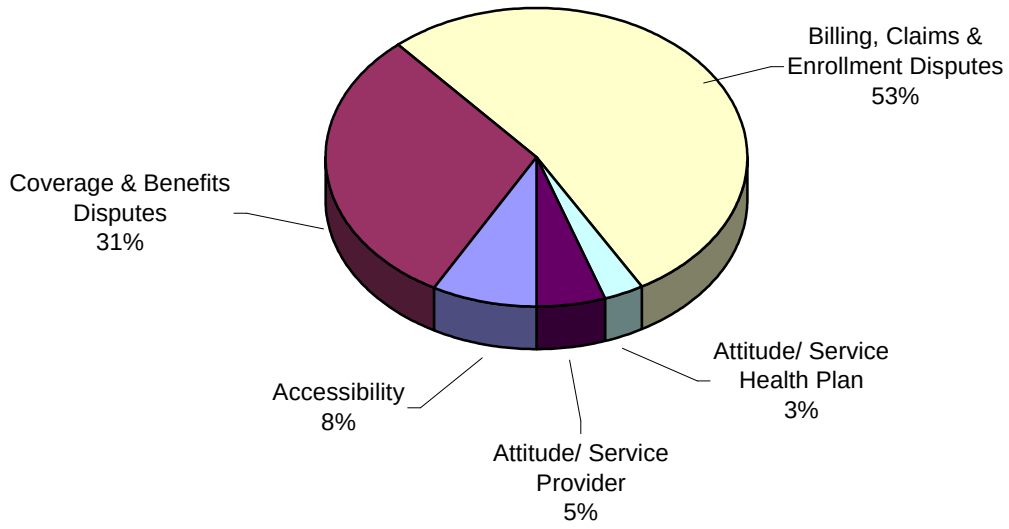
- Quick Resolutions - Another 348 calls were resolved on the spot or within days by our patients rights representatives. In some cases, our agents bring a representative from the HMO on line with the consumer in a three-way call to expedite the resolution and eliminate additional delays.

- Urgent Issues – There were 1,291 issues that required an immediate resolution. Our clinical staff deal directly with the HMO and the consumer to resolve these issues.

- Provider Line - In addition to the 149,879 calls from consumers, 2,451 calls were received on our physician/provider line. Of these calls to our physician/provider line, 90% percent involved questions about claims or a billing dispute.

- Formal Complaints – The HMO Help Center resolved 5,317 formal complaints with more complicated issues, requiring detailed information, such as medical records from patients and documentation from HMOs. These are resolved within days or weeks.

Complaint Categories

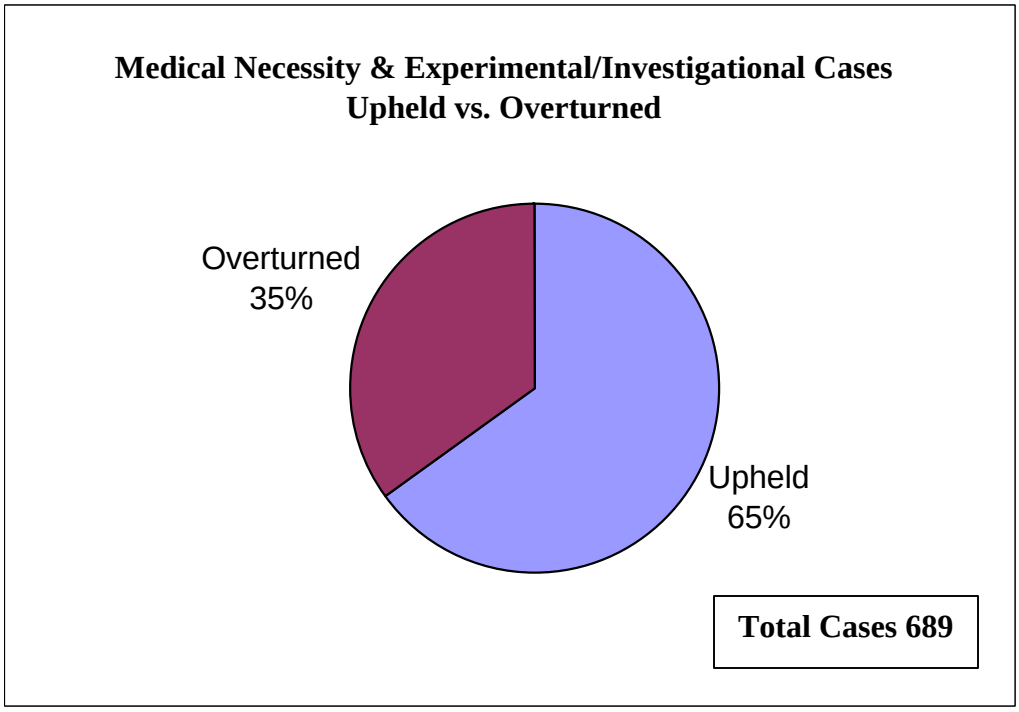


- Independent Medical Review (IMR) – In 2002, 689 patients with some of the most difficult and subjective cases involving the medical necessity or proven effectiveness of certain treatments had their cases heard before a panel of independent physicians whose decision was binding on the HMO.

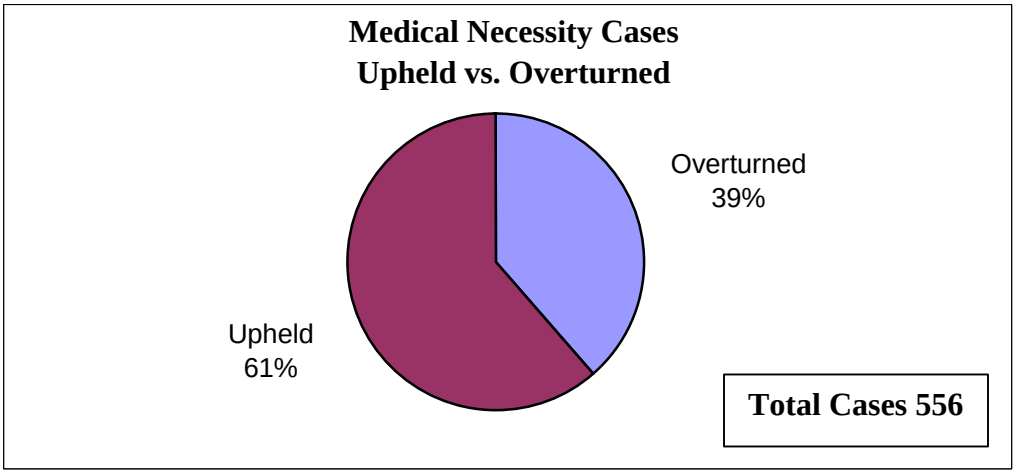
The Independent Medical Review Program has enabled consumers to receive treatment or medical care previously denied by their HMOs. We believe that the success of this program has encouraged HMOs to resolve potential cases earlier.

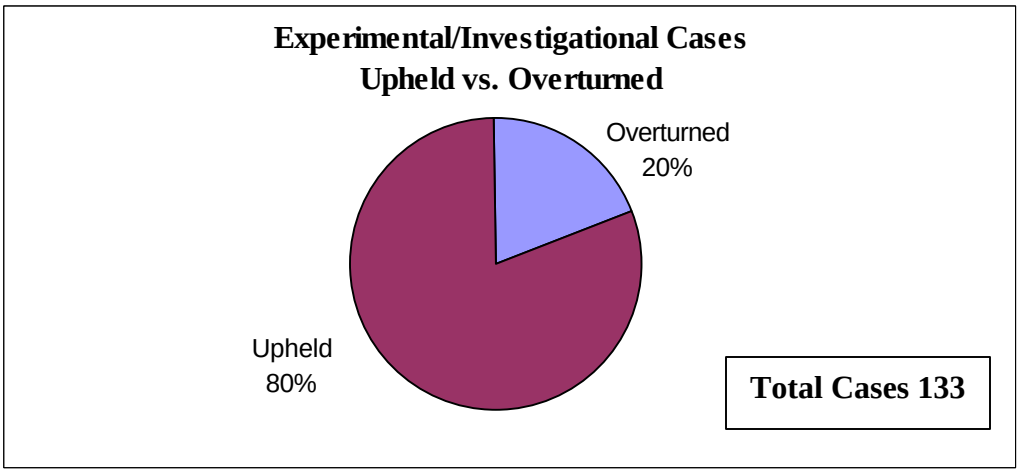
Of the 689 Independent Medical Review cases heard before a panel of independent physicians, 19 percent were based on instances where an HMO denied a service on the grounds that it was experimental or investigational. Of these, 20 percent of the original denials were overturned. The remaining Independent Medical Review cases were based on instances where the HMO denied a service on the grounds that it wasn't medically necessary. Of these, 39 percent of the original denials were overturned.

Independent Medical Review Decisions



Independent Medical Review Decisions





SUMMARY OF HMO HELP CENTER ACCOMPLISHMENTS

IMR PROGRAM ENHANCEMENTS

The HMO Help Center made the following enhancements during 2002 to increase the effectiveness of the IMR program:

- Launched an audit program to ensure that plans had developed internal systems to effectively implement the Department's IMR decisions. In all cases where the previous decision of the plan was overturned, compliance was confirmed. Copies of the plans' authorizations were reviewed to verify their prompt and appropriate compliance with the determination.

- Surveyed all enrollees, where the plan's denial was overturned through the IMR process, to determine whether they received the authorized service. Among other questions, the participants were asked to describe when they received the services authorized through the IMR decision, if they experienced any obstacles in obtaining the services from their plan or medical group, and to describe the reason if they have not obtained the medical care. Ninety-five percent of the consumers who responded received the treatment authorized through the IMR process; five percent did not receive the treatment due to a change in medical condition or situation.

- Implemented a quality assurance program in conjunction with the organization with whom we contract to implement IMR, the Center for Health Dispute Resolution (CHDR). Staff met regularly with CHDR to review quality assurance findings and resolve issues.

- Successfully launched our IMR public website that allows consumers to view the Independent Medical Review decisions rendered since the program began on January 1, 2001. See (http://www.hmohelp.ca.gov/imr/).

- Staff led a campaign before medical groups, associations, and consumer groups to raise public awareness of the Independent Medical Review program.

- Developed radio ads to inform Californians of their right to an Independent Medical Review. The ads are scheduled for broadcast in 2003.

- Continual evaluation of correspondence and other communication with enrollees.

ENSURING HMO COMPLIANCE

The HMO Help Center made HMO IMR compliance a priority during 2002. An HMO liaison program was designed to meet the following objectives:

- **Information Sharing with HMOs** The HMO Help Center staff worked to ensure that HMOs had updated information about IMR law and we were available to answer questions. A special provider section was added to the Department's website to address providers' IMR questions and concerns (http://wp.dmhc.ca.gov/imr_info/). The site alerts readers to a dedicated email address (imrinfo@dmhc.ca.gov) that provides direct access for additional questions regarding the overall IMR system or any case-specific IMR issues.

- **Early Warning System** Developed a warning system that allows the Department to respond swiftly to an HMO's withdrawal from a service area and to assist affected consumers with their transition to a new provider.

- **Increase Staff's Technical Foundation** Developed talking points for new laws, regulations and policies to help HMO Help Center staff provide timely and accurate responses to consumers' health care questions and concerns. Technical training was provided to staff as well.

- **Health Plan Advisory Newsletter** Published the first Health Plan Advisory Newsletter to promote better communication between the HMO Help Center and the HMOs. Articles feature such topics as regulatory and statutory updates, tips for responding to HMO Help Center requests for medical and benefit information, updates on the HMO Help Center's complaint processes, the HMO Help Center's referral process, and requirements of the Independent Medical Review process.

- **Ensure HMOs' Timely Response** Established procedures to monitor and follow up on HMOs' responses to consumer complaints. HMOs are required to respond to HMO Help Center requests for medical information within five calendar days. Their timely cooperation is critical to our ability to respond to consumer complaints within thirty days.

EXTERNAL COMMUNICATION AND COLLABORATION

The HMO Help Center met with health care partners in the following statewide forums to identify the needs of health care consumers and develop collaborative approaches to resolving their issues:

- Staff participated in the Industry Collaboration Effort project to develop standardized procedures and tools to assist HMOs and providers in resolving consumer grievances. This effort mobilizes health care stakeholders to streamline, simplify, and standardize regulatory policies and procedures governing the provision of health care services.

- Staff participated in an interdisciplinary work group sponsored by the Senate Office of Research to address on-call physician availability in hospital emergency rooms. The Senate Office of Research drafted a final report with recommendations.

- Staff met with HMOs during the year (Aetna, Cigna, Health Net, Health Plan of the Redwoods, and Kaiser) to discuss consumer issues and industry challenges. One of our greatest challenges was the transitioning of enrollees to new providers when medical groups withdrew from service areas or filed for bankruptcy.

  Cooperative relationships were strengthened and several statewide projects emerged:

  - Developing industry norms for the at-risk child (children 0 - 3 years that have or are at risk of having a developmental disability). The objectives were to help parents optimize available systems (school, public sector, and commercial health plans) so that care is readily accessible and make them aware of

their options in terms of services and funding.

- The grievance process was streamlined at the plan level, so that it is less confusing for consumers. Standard language and definitions were developed to ensure a more uniform appeals process within the health plans. A standardized health plan grievance form was also developed for the plans to use on their public websites.

COMPLIANCE OVERSIGHT

A new Compliance and Oversight System was launched to focus on HMO compliance with key grievance process requirements. Consumer complaints are evaluated for compliance and, when an HMO's grievance process is suspected or targeted for non-compliance, a letter is sent to the HMO requesting an explanation or description of corrective action taken by the plan. The plans' responses are carefully evaluated to identify and pursue any systemic problems.

HMO Help Center staff worked with HMOs experiencing problems or deficiencies in their consumer grievance systems and identified additional training and staffing needs for the HMOs.

When necessary, cases are referred to the Department's Office of Enforcement for formal enforcement actions against the HMO. During 2002, seventeen individual cases were referred to the Department's Office of Enforcement, and seven formal actions were taken.

STAFF TRAINING PROGRAM

The HMO Help Center made staff training a priority to increase our effectiveness in assisting consumers through the maze of managed care. Our training plan involved experts from a variety of entities: HMOs, consumer advocacy groups, other state agencies and the Department's counsel, etc.

The training program included, but was not limited to, the following topics:

- Customer Service
- California's Patients' Rights Law
- Effective Negotiation
- CMS Medigap
- COBRA
- New Legislation
- Referral Resources
- Independent Medical Review
- Standardized Grievance Processes
- Health Law
- Health Plan Operation relative to HMO Help Center complaints

Staff also participated in an inter-agency Medigap Project intended to increase the identification of Medigap-related abuses and enforcement of remedies.

HMO Help Center staff are well-trained and thus are used as a resource for both general and referral information.

EASIER ACCESS TO HMO HELP CENTER SERVICES

- Correspondence and forms used in the complaint process were translated into both Spanish and Chinese to provide easier access to services.

LEGISLATIVE ISSUES AND PROGRAM CHALLENGES

The Department followed, analyzed and provided technical assistance on approximately 80 bills that would affect California's patients' rights laws. Twenty of the eighty bills were ultimately enacted. The Department is also responsible for developing and adopting regulations that clarify, interpret and implement the statutes that have been enacted. Ten new regulations were filed with the Secretary of State in 2002, several related to grievances and Independent Medical Review.

REGULATION OF PRESCRIPTION DRUG COVERAGE

The HMO Help Center was challenged with handling many prescription drug coverage issues in a rapidly changing legal climate. Issues raised by patient complaints included coverage for weight loss drugs, non-formulary drugs, drugs used for both cosmetic and medical purposes, compound medications and off-label drugs. The changing legal climate included a court decision that put at issue the Department's regulatory authority, as well as the validity of its existing regulations regarding prescription drug coverage.

Given these circumstances, legislation that clarified the Department's regulatory authority, enacted to take effect in 2003, constituted a significant step toward addressing the challenge of handling such coverage issues. Pursuant to that new legislation, some of the specific remaining challenges for the Department and Help Center include the development of appropriate regulations to address prescription drug coverage issues such as those identified above.

RETROACTIVE DISENROLLMENT

"Retroactive disenrollment" usually refers to a situation where an employer failed to make payments on a group health plan and reached an impasse with the plan, resulting in the disenrollment of employee members as of the last date covered by an employer premium payment. This can result in an unsuspecting employee becoming liable for thousands of dollars in medical bills incurred during a time that he thought he had coverage. In the process of handling complaints regarding retroactive disenrollment, it became clear that plans were using inconsistent interpretations of the law on this matter. The Department is implementing new rules to limit the time period of retroactivity and avoid the loss of eligibility for continuation coverage.

MENTAL HEALTH PARITY AND AUTISM

Recently published reports reveal a dramatic increase in the incidence of autism in California. Challenges presented by the continuing implementation of the mental health parity statute included issues related to coverage for the diagnosis and treatment of pervasive developmental disorder (PDD) and autism, particularly concerning speech and occupational therapies, as well as other treatment programs. In the past, some plans excluded treatment for the diagnoses of autism and PDD, considering these social rather than medical problems. As a result, some medical groups continue to issue coverage denials based on obsolete evidence of coverage language.

PPO Reimbursements for Out-of-Network Care

For those HMOs that provide coverage for out-of-network care, complaints regarding the amount of reimbursement for such care continue to pose challenges. Plans are using increasingly complex methods to determine the allowed amounts from which payment levels are calculated. Enrollees face difficulty in obtaining accurate information regarding the amount of reimbursement, even if this information is requested prior to obtaining treatment. This issue arises in both elective care and emergency services. The Department is considering whether regulations concerning disclosure of benefit limitations, and requiring a uniform method of obtaining pre-treatment estimates of reimbursement amounts would help to address this challenge.

New HMO Insurance Products

In addition to the new statutes, regulations and policies implemented during the year, the HMO Help Center also has had to contend with an ever-evolving managed health care environment. HMOs have introduced new products with a variety of new structures and changes in benefits. An example of such a change is what has been called "tiered" hospital benefits within a service area by which one's benefits for equivalent services can vary depending on which hospital is used. Such new insurance products and benefit changes often require review to determine their validity under existing laws and regulations and whether they create or identify a need for new and/or modified laws and regulations.

Transitions for Enrollees

In 2002 several relatively large HMOs ceased operations and the HMO Help Center faced the resulting problems associated with allocating the enrollees into new plans.

HMO Responsiveness to Enrollees Who File Complaints

The Department continues to identify challenges in the area of HMO responsiveness to enrollee concerns. Plans have not consistently demonstrated timely response to enrollee grievances and to the notification of enrollees concerning their rights to Independent Medical Review. The HMO Help Center has addressed this challenge by identifying violations of the statutes and regulations relating to grievances, and bringing them to the plans' attention, with particular reference to the timeliness and content of responses.

On-Line Grievances Against Plans

Legislation was passed requiring health plans to (1) allow consumers to submit grievances on-line, (2) provide a hyperlink to the Department's web site, and (3) specifically inform enrollees of how to file a grievance with the Department against their health plan. Health plans are also required to provide a written acknowledgement of the receipt of an on-line grievance within five calendar days.

Timely Access To Care

The Department's authority to regulate the quality of care received by HMO enrollees was clarified in legislation. The Department's Office of Legal Services is now working to develop regulations that set standards for enrollee access to needed health care services in a timely manner. The Department will also review Plan compliance information in order to make recommendations that further protect enrollees.

CONSUMER ASSISTANCE PROGRAMS - GENERAL INQUIRIES & ASSISTANCE

The HMO Help Center's first priority is customer service. In addition to responding to formal complaints and requests for Independent Medical Review, the HMO Help Center responds to thousands of calls from consumers requesting general information or assistance.

BACKGROUND

The HMO Help Center receives from 11,000 to 14,000 calls each month from consumers, about five percent of which result in a formal complaint or Independent Medical Review. Calls are answered by the Interactive Voice Response (IVR) system or the staff of the HMO Help Center.

Consumers Require 24/7 Availability

The HMO Help Center is available 24 hours a day, 7 days a week to respond to consumer issues. Health care problems often occur outside of regular business hours, and consumers need a resource to assist them during this time.

Information Available in Multiple Languages

The HMO Help Line also provides services for consumers with limited use of the English language. A special phone line for Spanish-speaking consumers is staffed by bi-lingual Agents. The HMO Help Center also provides telephonic translation services for over 100 languages. In addition, numerous HMO Help Center forms and materials are available in Spanish and Chinese.

HMO Help Center Services for our Hearing Impaired Consumers

The HMO Help Center has a Telecommunication Device for the Deaf (TDD) available during regular business hours. Hearing-impaired consumers can call the HMO Help Center using the toll-free TDD line at (877) 688-9891. The HMO Help Center can be contacted after regular business hours by using the California Relay Service. In addition, HMO Help Center Agents have been trained in American Sign Language and are available on-site to assist hearing-impaired consumers.

Consumer Line – Cultural Linguistic Calls

Total Calls – The total call volume received during 2002.	**149,879**
Spanish Calls – The total number of calls where the consumer selected the option to hear information in Spanish. Of these calls, 4,120 were assisted through the IVR; the remaining 3,762 spoke to an HMO Help Center Spanish-speaking agent.	**7,882**
Language Line – The total number of calls for which HMO Help Center Agents utilized the AT&T Language Line. Interpretation services were used for the following languages: Korean, Mandarin, Thai, Akan, Chinese, Macedonian, Hungarian, Portuguese, Russian, Vietnamese, Somali, Samoan, and Romanian.	**23**
TDD Calls – The total number of callers who called our special TDD line for the hearing impaired.	**18**

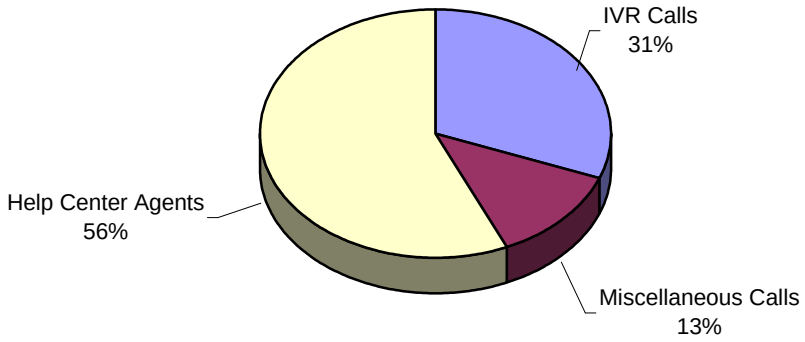
AUTOMATED RESPONSES TO INQUIRIES

When consumers call the HMO Help Line at (888) HMO-2219, they can always reach a live person to assist them. However, the HMO Help Center's automated system provides telephone numbers for the major HMO and dental plans, general information regarding the HMO Help Center, filing requirements for complaints and IMRs, and the Department's website address for additional information.

PROCESSES

Consumers generally contact the HMO Help Center by telephone. However, the HMO Help Center also receives correspondence, e-mails, faxes, and walk-in visits from consumers.

Calls Answered by the HMO Help Center in 2002



CALLS ANSWERED BY THE HMO HELP CENTER

Total Calls – 149,879
The total call volume received during 2002.

IVR Calls – 46,341
The total number of calls that were answered by the HMO Help Center's automated voice response system (IVR) in 2002**.**

Help Center Agents – 84,740
The total number of calls that were answered by HMO Help Center Agents.

Miscellaneous Calls –18,798
The total number of calls that were answered on the Provider Line, the TDD Line, or abandoned by the caller.

TYPES OF CONTACTS

General Inquiries

General inquiries cover a wide range of issues. The most frequent are described below:

♦ **Medical Group Closures / Contract Terminations –** Throughout the year, the HMO Help Center assists many consumers affected by a medical group going out of business or terminating their association with an HMO. HMO Help Center agents help patients exercise their rights under a contract termination, answer questions regarding the transition to a new medical group or take appropriate action if the transition has not yet occurred.

♦ **HMO Bankruptcy or Withdrawal from Service Area –** The HMO Help Center assists consumers affected by an HMO bankruptcy or withdrawal from a service area. Similar to calls regarding the closure of a medical group, HMO Help Center agents answer questions regarding the transition process.

♦ **Community Resource Referrals** – If necessary, the HMO Help Center will provide referrals to community resources in order to assist a consumer. Preventive health care information is also made available to consumers in an effort to promote wellness. Staff reference the Community Services Directory to locate an appropriate private or non-profit organization in the county where the consumer resides (i.e., Sacramento AIDS Foundation, American Lung Association, Alzheimer's Society).

♦ **General Education –** The HMO Help Center frequently plays an educational role with consumers. In these instances, the HMO Help Center describes the role of the Department of Managed Health Care and the HMO Help Center, outlines the complaint and Independent Medical Review processes, defines the consumer's responsibility in resolving issues with their plan, provides the Department's website address, or assists the consumer with other issues.

♦ **Status Calls –** Consumers often contact the HMO Help Center to receive information on the status of their complaint or Independent Medical Review. These calls are directed to the HMO Help Center staff member handling the consumer's case.

♦ **HMO Contact Information –** Many consumers contact the Department to request the telephone number, address, and/or contact name for their HMO.

♦ **Non-Jurisdictional Calls –** A number of consumers who contact the Department actually require referral to another department or agency for assistance because the Department does not have jurisdiction over their issue. For example, a consumer covered by an employer self-insured plan can only get help from the Department of Labor, or a consumer covered by an indemnity health insurance plan can only get help from the Department of Insurance. HMO Help Center agents provide the consumer with contact information for the appropriate agency.

♦ **"Duty Counsel" Calls** – In addition to the HMO Help Center's toll free line, the Department of Managed Health Care's Office of Legal Services staffs a "Duty Counsel" line. In the year 2002, the Department handled 1,726 "Duty Counsel" cases. The most frequently asked questions concerned COBRA issues, the arbitration process, and general questions regarding California's Patients' Rights Law and regulations.

Requests for Information

Consumers often contact the HMO Help Center to request informational pamphlets, forms or specific sections of California's patients' rights laws. This information is sent to the consumer or is obtained from the Department's website at www.hmohelp.ca.gov. The most frequently requested materials include:

♦ **The Patient Guide & California's HMO Guide** – These guides are intended to inform consumers of their rights to receive quality health care and what steps they can take if they encounter problems.

♦ **Complaint Packet** – The packet contains the DMHC complaint form and information to assist the consumer in filing a complaint if not satisfied with their health plan's resolution or if the health plan does not resolve their issue within 30 days.

♦ **Independent Medical Review Application** – The DMHC form that a consumer completes to apply for an Independent Medical Review.

♦ **Knox-Keene Act Sections** – The Knox-Keene Health Care Service Plan Act of 1975 embodies California's patients' rights laws.

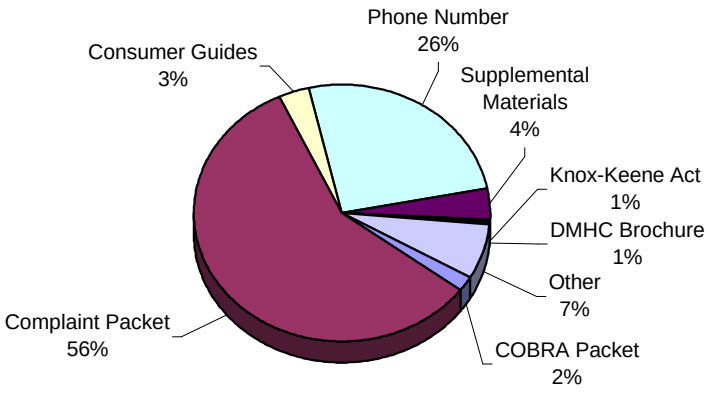
♦ **List of Licensed HMOs** – This list provides the address, contact information, and licensing information for all licensed HMOs.

♦ **HMO Report Card** - The HMO Report Card rates HMOs on quality and service with the goal of helping consumers choose the HMO that best meets their family's health care needs.

♦ **HMO Help Center Annual Report of Health Care Service Plan Complaint Data** – This annual report details the numbers and types of complaints or grievances received by the Department during the calendar year. The report also includes information on the number of Independent Medical Reviews and general inquiries received by the Department.

♦ **California COBRA Information** – Cal-COBRA provides patients the right to keep their group coverage at the same premium rates as the employer group under certain conditions when it might otherwise end. Consumers can obtain general information on eligibility requirements, benefits, and other information from the Department's website.

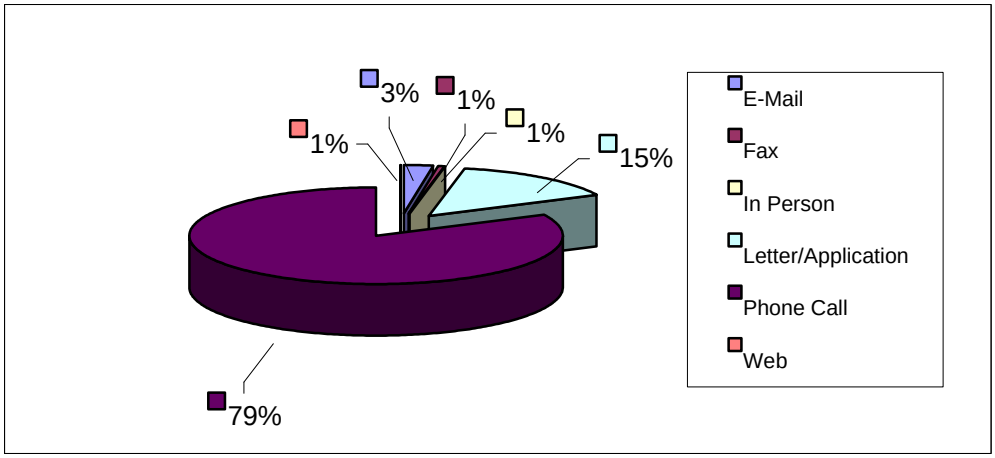
Requests for Information by Type



REQUESTS FOR INFORMATION

The chart identifies the most frequently requested information. A total of 14,475 information requests were responded to during 2002.

Consumer Methods of Contact



Quick Resolution System

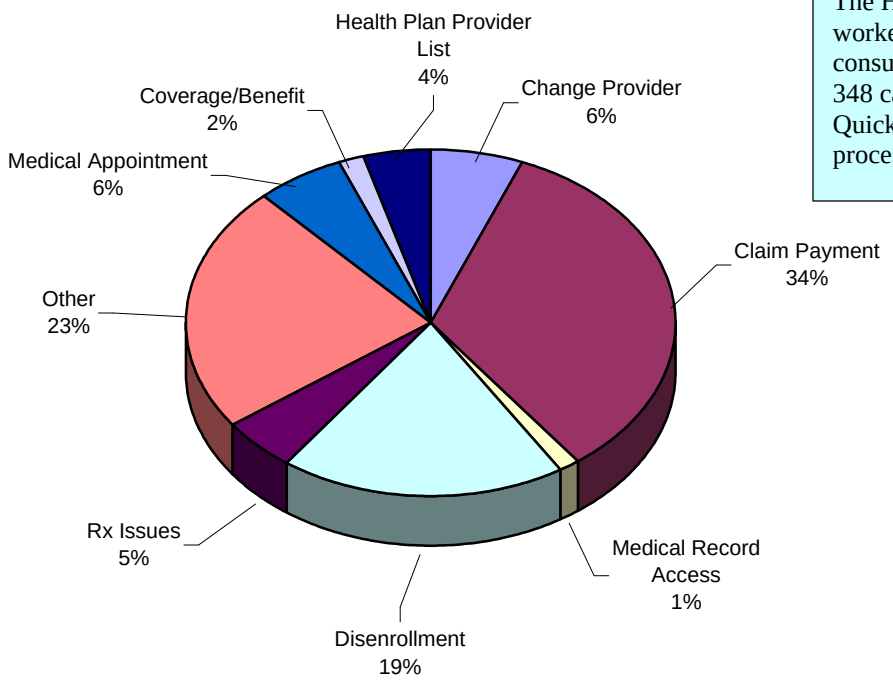
The HMO Help Center's Quick Resolution Process resolves problems through a three-way conference call with the health plan, the consumer, and an HMO Help Center agent. The goal is to quickly resolve problems before they become formal complaints or need to go to Independent Medical Review. Many issues can be resolved by opening the lines of communication between the plan and the consumer. HMO Help Center agents assist consumers in understanding their health care rights and responsibilities.

The process is completely voluntary for both plans and consumers. If either decides to pursue the issue via a formal complaint or Independent Medical Review, the issue is immediately transitioned from the Quick Resolution process to the appropriate alternative dispute resolution process.

QUICK RESOLUTIONS

The HMO Help Center worked with consumers to resolve 348 cases through the Quick Resolution process during 2002.

Quick Resolution Issues



Quick Resolution Issues	Number of Issues
Change Provider	21
Claim Payment	117
Medical Record Access	5
Disenrollment	66
Rx Issues	17
Other	80
Medical Appointment	21
Coverage/Benefit	6
Health Plan Provider List	15
Total	**348**

Urgent Issues

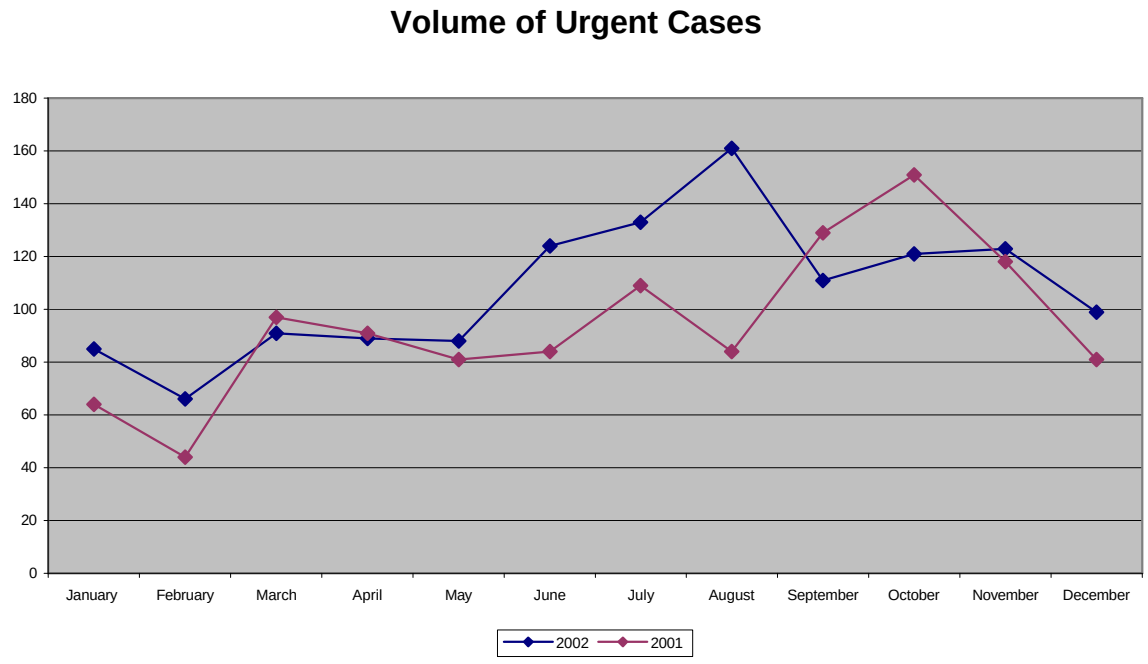
Consumers often call the HMO Help Center with issues that cannot wait 30 days for the formal complaint process. These complaints often involve issues of delays or denials in re-filling prescription medications, delays in obtaining appointments or surgery for pressing health care issues, premature release from a hospital or facility, and inability to obtain a referral for treatment.

Urgent issues are generally referred to Department clinical nurses who work with the consumer and the health plan to resolve the issue. Department staff is available 24 hours a day, 7 days a week to resolve urgent issues. The Department is responsible for assuring that health plan contacts are also available 24 hours a day, 7 days a week to support resolution of these urgent issues.

If the Department's nurse determines that the consumer does not require urgent assistance, the consumer's dispute is referred to the complaint or IMR process for resolution.

URGENT COMPLAINT VOLUME – DATA

The Department received 1,291 urgent requests during 2002, in comparison to 1,133 received in 2001.



Urgent Complaint Issues

Urgent Complaint Type	Volume 2002
Access/Referral Issue	684
Rx/Medication Supply	138
Benefit Issue	130
Other	110
Treatment Denied	63
Early Discharge - Facility	41
Diagnostic Test Access	29
Durable Medical Equipment	19
Mental Health	18
Chronic Pain Management	17
Acute Pain	13
Experimental Treatment	11
Poor Health Plan Communication	11
Medical Group Closure	4
Pregnancy Issue	3
Total	**1,291**

URGENT COMPLAINT ISSUES - 1,291

The chart summarizes the types and volume of urgent complaint issues received during 2002.

Physician Calls

Physicians and other medical professionals use the toll free Provider Line at (877) 525-1295 to notify the Department of complaints regarding a health plan or medical group. The majority of complaints received from providers are regarding claim payment delays and denials. The information gathered from these complaints contributes to the Department's on-going oversight activities by identifying systemic problems, which are then addressed with health plans or medical groups by the Department's Director of Plan and Provider Relations.

Physicians may also call the Department on behalf of their patients. These calls are referred to the appropriate consumer dispute resolution process as previously described in this report.

The HMO Help Center received a total of 2,451 calls from providers during 2002 as compared to 3,321 calls received during 2001.

ISSUES & CHALLENGES – GENERAL INQUIRIES

The HMO Help Center continues to face the following challenges related to general inquiries:

Real Time Issues

One of the most important challenges still facing the HMO Help Center is how best to use the wealth of data collected by our computer system. Beginning with incoming calls to the final resolution of complaints or IMRs, the opportunity exists to capture information regarding "real time" issues facing today's consumers. With this data, the HMO Help Center can alert other areas of the Department to enforcement matters, problems to look for when conducting medical surveys, areas needing consumer education, and occurrences of non-compliance with licensing requirements.

The Department is proactive in defining health care risks for consumers by identifying potential patterns in consumer complaints that would indicate provider, HMO and industry issues. The Department has focused on the HMO Help Center as a vital component in meeting this directive.

Data Integrity

The reliability and consistency of data in our new computer system is of utmost importance, especially when there is a possibility that it may be used to make statewide health care decisions. Therefore, staff must be thoroughly trained and continually monitored for adherence to established procedures and policies. Data fields are analyzed for accuracy and for verification that staff are correctly entering data.

Increase Awareness of the HMO Help Center

The Department is actively pursuing efforts to increase California consumers' awareness of the assistance available through the HMO Help Center.

CONSUMER ASSISTANCE PROGRAMS

Consumers file complaints about benefit and coverage disputes, claims and billing problems, eligibility, inadequate access to care, and attitude or service concerns. (Disputes regarding denials of service may qualify for Independent Medical Review, which is defined in the next section.) The HMO Help Center has developed the infrastructure necessary to ensure that their complaints are resolved and that we are responsive to all California HMO patients.

BACKGROUND

Complaints are researched and resolved by a team of HMO Help Center staff that includes consumer service representatives, analysts, patients' rights attorneys and clinical staff.

Before a complaint is eligible for review by the HMO Help Center, the HMO, through its grievance and appeals process, must have had an opportunity to assess and resolve the issue within 30 days (or 72 hours for expedited grievances).

A consumer may submit a complaint to the HMO Help Center by telephone, letter, e-mail, or by completing a *Consumer Complaint Form*, which is available on the Department's web site at www.hmohelp.ca.gov. Though it is not a requirement to complete the *Consumer Complaint Form*, it does facilitate the complaint resolution process by assuring that the HMO Help Center receives all the information necessary to resolve a complaint. We review all written information provided by both the consumer and the health plan, including relevant medical records if necessary. Complaints are generally resolved by the HMO Help Center within 30 days. There is no charge to the consumer associated with filing a complaint to the HMO Help Center for resolution.

The HMO Help Center issues a written explanation of the decision. If the complaint is resolved in the consumer's favor, the HMO will be required to provide and pay for the disputed service or take other appropriate action (as defined by the Department). If the complaint is not resolved in the consumer's favor, the consumer may pursue other remedies as defined in the HMO's evidence of coverage.

A significant number of requests for assistance are not within the Department's jurisdiction. As a result, our staff are required to have full knowledge and understanding of programs sponsored by other state and federal agencies and advocacy groups in order to refer the requests to the appropriate organization. HMO Help Center staff consistently refer consumers to the following organizations:

- U. S. Department of Labor
- Health Insurance Counseling & Advocacy Program (HICAP)
- U. S. Office of Personnel Management (OPM)
- California Public Employees' Retirement System
- Department of Health Services
- California Department of Insurance
- Center for Medicare and Medicaid Services (CMS)
- California Department of Consumer Affairs Dental & Medical Boards
- Major Risk Medical Insurance Board (MRMIB)

Finally, data on all incoming complaints, regardless of type, is entered into the Department's automated tracking system.

We ensure accurate data collection and maintenance of the automated tracking system.

Referrals to the Health Plan (also known as Refer to Plan)

If we determine that the consumer has not yet participated in the HMO's grievance and appeals process for the required 30 days, the complaint is forwarded directly to the health plan for resolution.

The HMO Help Center also notifies the consumer that if the health plan does not resolve their dispute within the required 30 days or if they are not satisfied with the resolution, they may contact the HMO Help Center to initiate a complaint.

Monetary Benefits for Consumers

Consumers often contact the Department when they are being charged for services that they feel should be covered by the HMO. The amount of money consumers saved in 2002 as a result of HMO Help Center intervention was **$1,565,664**. The amount reflects claims disputes that expressly identified a dollar reimbursement. The amount reported does not include non-reimbursable costs associated with surgery or other procedures that were initially denied by the health plan, then later authorized by the health plan.

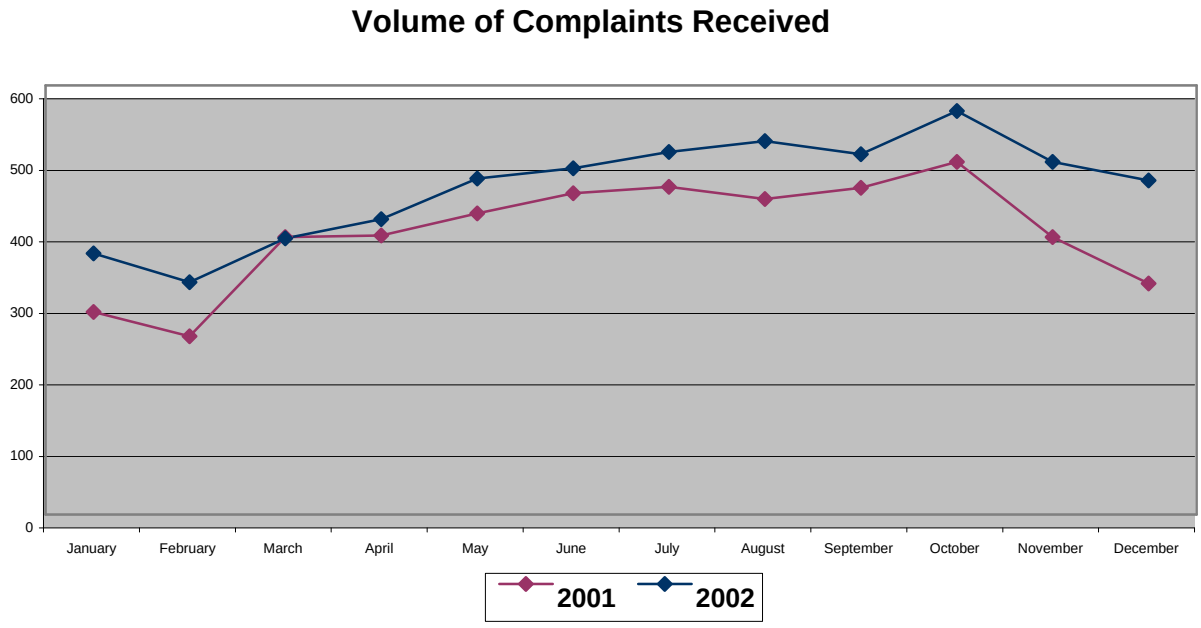
Formal Complaints

Complaints received by the HMO Help Center are first reviewed by a complaint analyst, who gathers the relevant facts and supporting documentation and informs the consumer of the Department's intended action. The analyst coordinates efforts between health plan administrators and HMO Help Center clinical and legal staff to resolve the complaint. The analysts maintain cooperative working relations with the Major Risk Medical Insurance Board, the Health Insurance Counseling and Advocacy Program, the Department of Health Services Medi-Cal program administrators, and the Department of Insurance to research and resolve complex cases. Reports of discovery and resolution are shared with the appropriate organization when necessary.

Regardless of the outcome, the consumer is notified of the Department's decision in writing.

We focus on effectively resolving complaints. If systemic problems are discovered as a result of multiple complaints, the issues are referred to the appropriate office for further action.

VOLUME OF FORMAL COMPLAINTS RECEIVED – DATA
From January 1, 2002 through December 31, 2002, consumer filed 5,500 formal complaints in comparison to the 4,740 filed in 2001. Below is a summary of the volume of complaints received by month. (This does not include IMRs.)



AVERAGE RESOLUTION TIMEFRAME – DATA

Data available from the new computer system provides the following information regarding the resolution timelines of complaints:

- Of the 5,500 complaints filed, 5,317 cases were resolved during 2002. These complaints were resolved in an average of 22 calendar days.

Early Review – Legal Complaints

A complaint will be treated as an "Early Review - Legal Complaint" if the consumer is involved in a time sensitive dispute that requires intervention prior to the 30-day mandate. Examples of these types of reviews include:

- HIPAA, Cal-COBRA, or Senior COBRA deadline issues
- Cancellation of coverage deadline issues
- Continuity of care issues involving a severe medical condition that requires the consumer to receive care from the same physician or medical group for a specified period of time
- HMO delays in implementing Department determinations

If research determines that the issue is not critically time sensitive, it will be referred to the normal complaint process to be resolved within 30 days.

COMPLAINT COMPLIANCE DETERMINATIONS

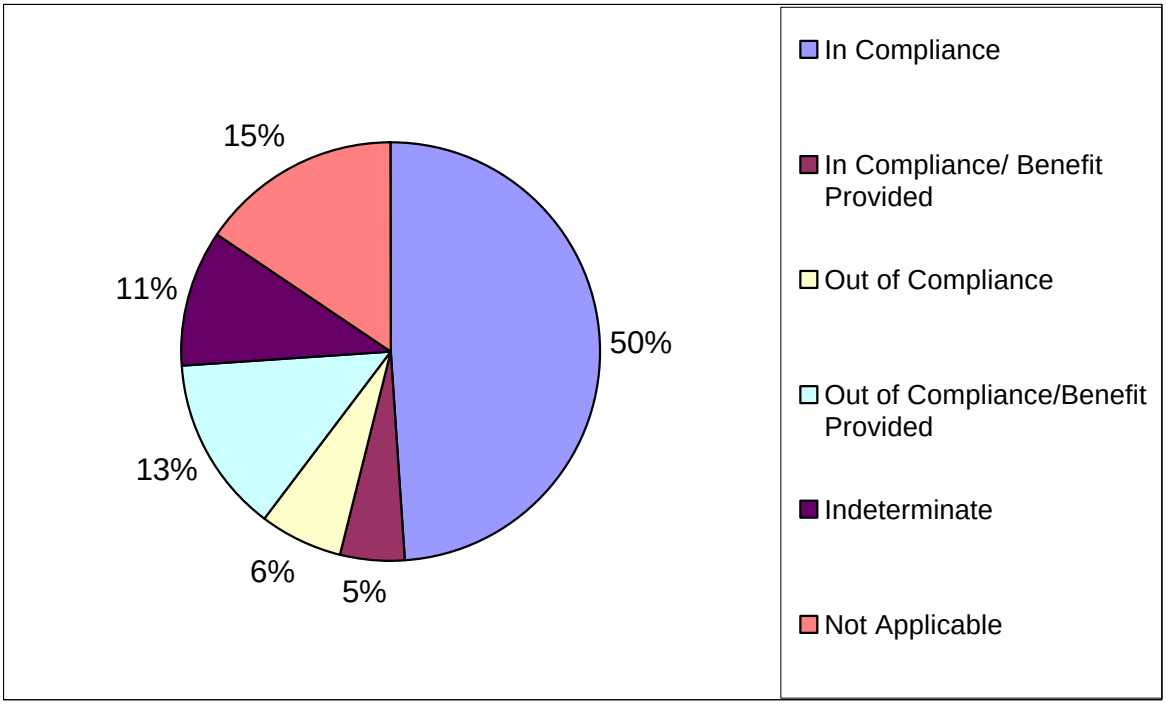
Upon resolving a complaint, HMO Help Center staff assign one of the following compliance determinations:

- **In Compliance –** Based upon staff's review of complaint documents (including the HMO's response to the complaint), no violation of California's patients' rights was found.
- **In Compliance/Benefit Provided -** The HMO initially denied a service or benefit and then reversed its position by providing the service or benefit after the enrollee accessed their HMO's grievance system or submitted a complaint to the HMO Help Center. The facts and circumstances of the case still warrant a finding that the actions taken by the HMO comply with our patients' rights laws.
- **Out of Compliance –** Based upon review of complaint documents (including the HMO's response to the complaint), staff has identified a specific violation of a section of California's patients' rights laws.
- **Out of Compliance/Benefit Provided** - The HMO initially denied a service or benefit and then reversed its position by providing the service or benefit after the enrollee accessed their HMO's grievance system or submitted a complaint to the HMO Help Center. The facts and circumstances of the case still warrant a finding that the actions taken by the HMO do not comply with California's patients' rights laws.
- **Indeterminate –** This determination is used in two scenarios: 1) there is insufficient evidence to indicate non-compliance on the part of the HMO, or 2) a compliance determination may not be applicable.
- **Not Applicable** – The subject matter

does not reasonably relate to a matter of compliance with California's patients' rights laws.

♦ **Out of Compliance/Demand Refused –** The HMO refused to provide a benefit or service after being directed to do so by the Department. This determination was not assigned to any complaints during 2002 since none of the Department's demands were refused.

Compliance with Patients' Rights Laws



COMPLIANCE WITH PATIENTS' RIGHTS LAWS – DATA

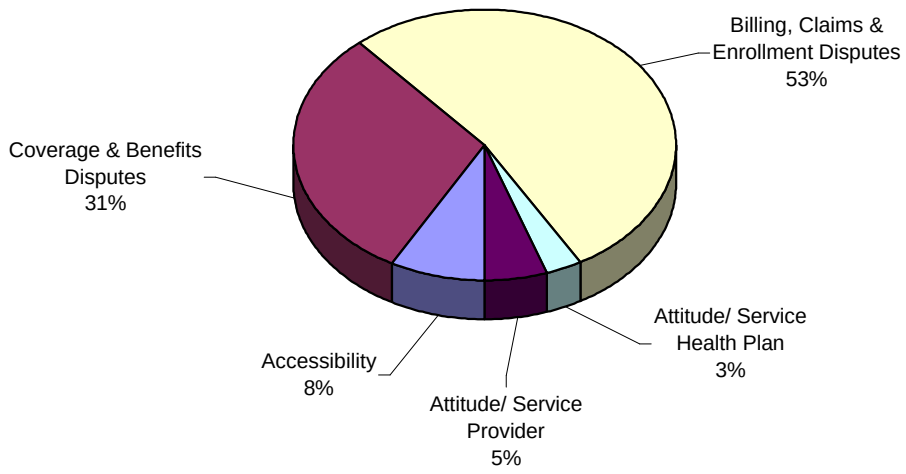
California's patients rights laws are embodied in the Knox Keene Act of 1975. This chart identifies the percentage of compliance determinations in each category for complaints resolved in 2002.

TYPES OF COMPLAINTS

The HMO Help Center researches and analyzes the following types of complaints.

COMPLAINT TYPE SUMMARY – DATA

The chart provides a summary of complaint categories for complaints received in 2002.



COMPLAINT TYPE DEFINITIONS
Accessibility These complaints include: long wait times for appointments, lack of availability of primary care or specialty physicians, delay or failure to respond to patient requests for authorization or referrals, etc.
Coverage & Benefits Disputes These complaints include: disagreement about whether a service is covered under the member's evidence of coverage; refusals to refer to a specialist, or out of network providers or denials of ancillary services on the basis that benefit maximums have been reached, etc.
Billing, Claims & Enrollment Disputes These include: disputes regarding disenrollment or termination of coverage; complaints about false or misleading marketing information; claims disputes (including slow payment and insufficient payment); premium disputes (including refund requests and premium increases); refusals to pay for medical services or durable medical equipment, denials of payment for emergency or urgent services received, etc.
Attitude & Service of Health Plan These include: complaints about health plan staff behavior (including attitude, communication, rudeness); complaints about slow responses to inquiries, etc.
Attitude & Service of Provider These include: complaints about physician or office staff behavior (including attitude, communication, rudeness); the physical condition of a hospital or physician office; complaints about inappropriate care by a hospital or physician (failure to diagnose or treat); complaints about slow responses to inquiries, etc.

ISSUES & CHALLENGES - COMPLAINTS

The HMO Help Center faces the following challenges related to consumer complaints.

HMOs Communicating Patients' Right to File Complaints

Effective and accurate communication between patients and their HMOs is critical to the effectiveness of the grievance process. In discussions or correspondence between the HMO and the patient concerning a dispute, the HMO should immediately and clearly notify the patient of the right to file a grievance.

Often patients who have contacted their medical group or health plan to resolve a problem have not been made aware of the HMO's formal grievance and appeals process. As a result, a patient may be attempting to resolve a problem informally for quite some time before they begin to use the HMO's grievance process.

The Department may allow the consumer to participate in the complaint process without a complaint determination if the consumer has been attempting to resolve the issue, either informally or formally, with the HMO (or medical group) for longer than 30 days.

Consumer Education and Awareness

The Department advocates ongoing consumer education related to health care rights, responsibilities and options in accordance with the law and the terms of the various HMOs.

Communications at all levels within the managed health care delivery system, beginning at the physician's office and continuing through the HMO's responses to consumer grievances, often contain minimal levels of explanation and information. This lack of information contributes to the consumer's difficulty in understanding the system.

Health Care Service Delivery Disruptions

Facilitating access to care in an unstable marketplace is an enormous challenge for the HMO Help Center. Plan and provider contract disputes, as well as plan withdrawals from service areas, result in the need to constantly monitor for potential disruptions to health care service delivery and to intervene for consumers in rapidly changing situations.

The Evolution of Managed Health Care

Governor Davis has proposed new rights for patients in this area, which are contained in AB 1286, sponsored by Assemblyman Frommer.

INDEPENDENT MEDICAL REVIEW (IMR)

BACKGROUND

Independent Medical Review (IMR) allows patients who have been denied treatment or medical care to have certain decisions reviewed by physicians or other appropriate medical professionals who are not affiliated with and completely independent of their HMOs.

Three types of disputes with HMOs are eligible for IMR:

- Denials based on a finding that a requested therapy is experimental or investigational for life-threatening or seriously debilitating medical conditions;

- Services that are denied, delayed or modified by the HMO or one of its contracting medical providers based on a finding that the service is not medically necessary; and

- Disputes concerning an HMO's failure to reimburse the patient for out-of-plan emergency or urgent medical services.

The Department determines whether the case involves an issue that is eligible for a medical necessity IMR. Before an IMR application is eligible for review, the HMO, through its standard grievance process, must have had an opportunity to assess and resolve the issue within 30 days, or 72 hours for expedited requests (unless the services were denied under an experimental/ investigational exclusion, for which the grievance requirement does not apply).

Regulations were promulgated by the Department in 2002 that provided forms and procedures used throughout the IMR process.

IMR requests are received and processed by an HMO Help Center team comprised of patients' rights experts and clinical nurses. Because IMR cases may be received by telephone, e-mail, or correspondence, knowledge of the IMR system is a shared responsibility of a large number of HMO Help Center staff.

There is no charge to the patient for the application, processing or resolution of an IMR. The HMO is assessed a fee for this service based on the type of case, the number of reviewers needed, and whether the determination must be expedited.

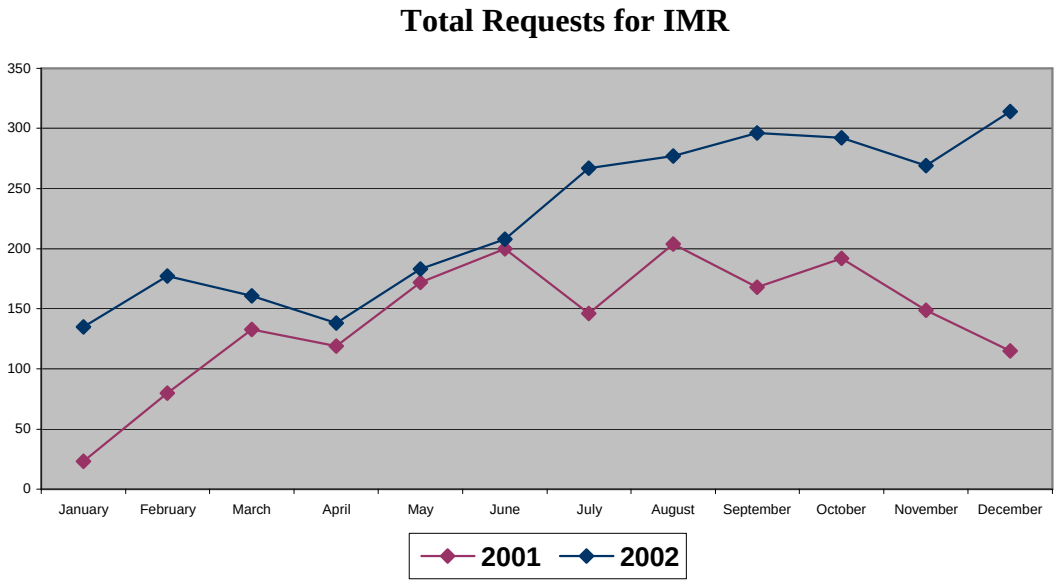
The IMR program is pivotal to the HMO Help Center's focus on resolving patient complaints with HMOs as expeditiously as possible through its clinical, legal and consumer assistance staff.

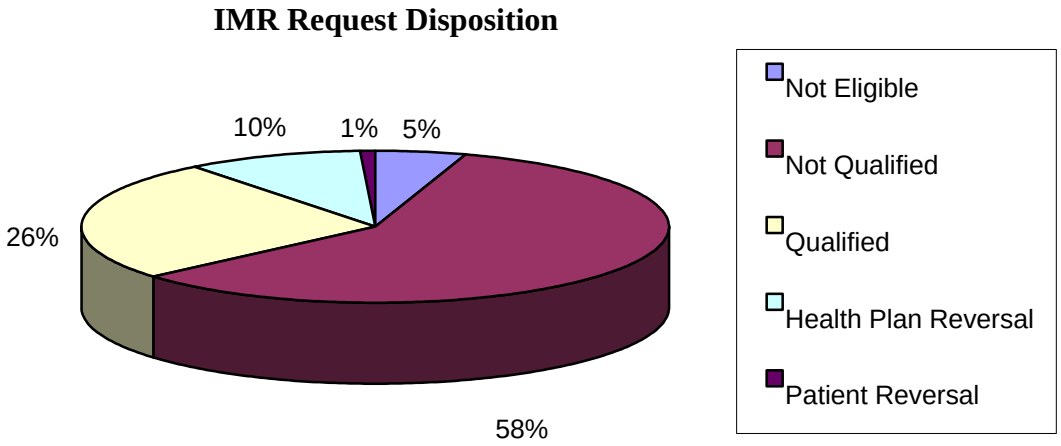
Consumer Awareness of IMR

Information about the IMR process and how to contact the Department is set out in the HMO's evidence of coverage and in the HMO or medical group's initial denial letters. At the time an HMO makes a final determination on a complaint that denies, delays or modifies the requested health care service, the HMO must send the patient an IMR application with an envelope addressed to the HMO Help Center. The application form, as well as other materials related to the IMR system, are available on the Department's Internet website at www.hmohelp.ca.gov and from the HMO Help Center. The information is also available in Spanish and Chinese.

Total Volume of IMR Requests – DATA

The Department received 2,717 requests for independent medical review during 2002, in comparison to 1,701 received in 2001. Below is a summary of the volume of IMR requests received by month.



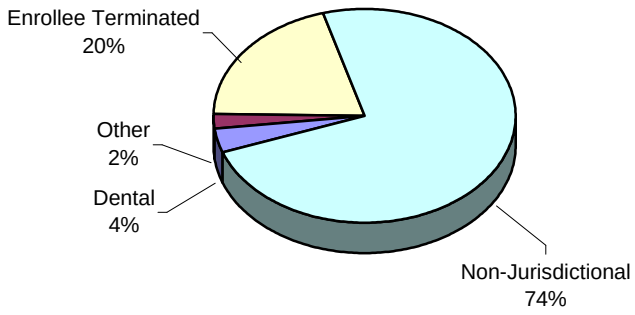


IMR Application Processing

All consumer inquiries and complaints, including applications for IMR, are received at the HMO Help Center and reviewed to determine whether an issue presented by a patient is eligible for an IMR. Some requests for IMR ultimately do not meet the criteria for the program. In these cases, the request for IMR is rejected as ineligible and a letter is sent to the patient advising them of other options available to assist them. If the request for IMR does meet the eligibility criteria, it is accepted and reviewed to determine whether the request qualifies for independent medical review. The majority of IMR requests are submitted to the HMO Help Center by mail. If additional information is required to determine eligibility, the information is obtained by phone or fax with the patient, HMO or providers, as necessary. In time-sensitive cases and requests for expedited IMRs, clinical nursing staff is consulted to attempt an immediate resolution of the dispute. Full-time nursing staff and counsel review prospective cases, address clinical questions, and ascertain whether a dispute pertains to coverage or medical necessity issues.

Requests for IMR must be submitted by patients to the Department within six months of receiving a denial from the HMO.

Reasons Requests for IMR Not Eligible



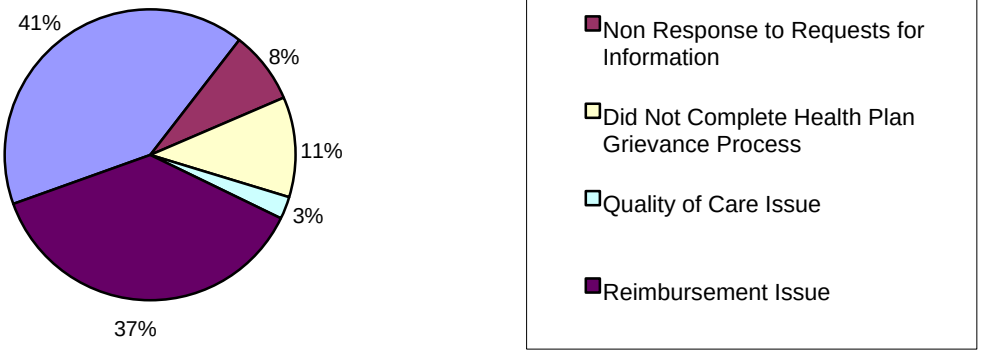
REASONS REQUESTS FOR IMR NOT ELIGIBLE – DATA

Based upon the Department's initial screening process, 134 Independent Medical Review cases that were originally considered possible IMRs were determined to be ineligible. The reasons that the cases were determined ineligible are summarized on the chart.

REASONS WHY AN IMR REQUEST IS NOT ELIGIBLE
Dental Issue Dental issues are not eligible for the IMR process.
Non-Jurisdictional Patient's health plan is under the jurisdiction of another agency (Department of Insurance, Department of Labor, Center for Medicare/Medi-Cal Services, etc.).
Enrollee No Longer Eligible The enrollee was no longer eligible for services from the health plan (e.g. termination of coverage).

REASONS WHY AN IMR REQUEST IS NOT ELIGIBLE
Other Other reasons that cases were determined to be ineligible include: the six-month deadline to file an IMR application had passed; HMO actions and denials occurred before January 1, 2001; a Medi-Cal beneficiary had utilized the Fair Hearing process or was requesting review for a non-covered service; or the condition was not life-threatening or seriously debilitating (for experimental/ investigational reviews).

Reasons IMR Requests are Not Qualified



REASONS REQUESTS FOR IMR NOT QUALIFIED – DATA

The Department determined that 1,592 Independent Medical Review cases, that were originally considered eligible IMRs, did not "qualify". The reasons that the cases were determined to be "not qualified" are summarized on the above chart.

REASONS WHY AN IMR REQUEST IS NOT QUALIFIED
Reimbursement Issue The services were already rendered. Includes medical services obtained by patient out-of-network; patient not obtaining a prior authorization; etc. These cases are referred to the Department's complaint process for resolution.
Coverage Issue The disputed service was a specific exclusion of the Evidence of Coverage.
Had Not Completed Plan Grievance This applies only to requests for Medical Necessity IMRs where the patient is required to participate in the HMO's 30-day grievance process prior to requesting an IMR.
Not Responsive to Request The patient or physician did not respond to requests by the Department for additional required information.
Quality of Care The complaint relates to the quality of care received from a provider or facility.

REASONS WHY AN IMR REQUEST IS QUALIFIED, A HEALTH PLAN REVERSAL, OR A PATIENT REVERSAL
Qualified An Independent Medical Review Application is determined to be eligible and complete.
HMO Reversal An HMO overturns a previous denial of services.
Patient Reversal A patient withdraws an independent medical review application.

Notifications Following Application Screening & Processing

If an IMR application is determined to be eligible and complete, HMO Help Center staff contact the HMO, the applicant, and the review organization.

Referral to the Independent Medical Review Organization & Selection of Reviewers

Eligible cases are referred to the primary IMR Organization, which performs the actual reviews under a contract with the Department. Following acceptance of an IMR application, the HMO Help Center notifies the Review Organization electronically (via the HMO Help Center's computer system) to determine its availability to accept the case. The Review Organization performs an internal conflict of interest check and contacts prospective reviewers.

A large panel of credentialed medical experts, primarily physicians, under contract with the Review Organization, is available. The Review Organization attempts to have professionals in all recognized specialties and sub-specialties readily available to provide timely determinations. The Review Organization selects reviewers for a specific IMR based upon information obtained from the Department, the patient, and the HMO.

Due to their unusual complexity, experimental and investigational cases are reviewed by three physicians; medical necessity cases are normally reviewed by a single reviewer. Additional reviewers may be assigned to medical necessity reviews in complex cases or when the issues presented may not be adequately addressed by one reviewer's experience or expertise.

Each reviewer is asked prior to the review (and again upon completion of the review) whether they are knowledgeable of the treatment at issue; whether they have treated patients with the condition at issue; and whether they are credentialed or have privileges from a licensed health care facility in the diagnosis and treatment of the medical condition at issue. In general, cases are reviewed by providers in the same specialty as the patient's treating provider or by providers in the specialty that the patient has requested that the HMO provide.

Within specific timeframes, the Review Organization is required to obtain written determinations by impartial medical experts, based on specific medical and scientific criteria. The medical experts consider patient's medical records, HMO denial and grievance letters, supporting documentation from the patient and treating physician(s), and other appropriate documents submitted for review. The decision of the Review Organization is sent to the HMO Help Center, the patient, the treating physician, and the HMO.

Criteria Used by the Reviewers in Experimental/Investigational Cases

Determinations made by reviewers in experimental/investigational cases are based upon:
The specific medical needs of the patient, and any of the following:

- Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
- Nationally recognized professional standards;
- Expert opinion;
- Generally accepted standards of medical practice; or
- Treatments that are likely to provide a benefit to the patient for conditions for which other treatments are not clinically efficacious.

Criteria Used by the Reviewers in Medical Necessity Cases

Determinations made by reviewers in medical necessity cases are required to state whether the disputed health care service is medically necessary and based upon the specific medical needs of the enrollee and any of the following:

- Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
- National recognized professional standards;
- Expert opinion;
- Generally accepted standards of medical practice; or
- Treatments that are likely to provide a benefit to the patient for conditions for which other treatments are not clinically efficacious.

Withdrawn IMRs

An IMR can be withdrawn in three different ways:

- An HMO may reverse its original denial at any time during the independent medical review process up until the Review Organization renders its decision.
- A patient may withdraw a request for an independent medical review at any time during the process.
- The HMO Help Center may withdraw an application if it determines – during the review process – that the application is not eligible.

A majority of IMR withdrawals are initiated by the HMO. Early in the IMR application process, the HMO Help Center contacts the HMO to provide notification that the patient's application is eligible for independent medical review. In some cases, the dispute is resolved through the Department's early intervention, and an independent medical review is no longer necessary.

WITHDRAWN IMRS – DATA

PARTY INITIATING THE WITHDRAWAL	NUMBER OF WITHDRAWALS	PERCENTAGE
HMO	249	92.0%
Patient	21	7.7%
The Department	1	.3%
TOTAL VOLUME	**271**	**100%**

Please note: Withdrawals occurred both prior to submission to the review organization (187 cases) and after submission to the review organization (84 cases).

Adoption of the Review Organization Determination

The Director of the Department of Managed Health Care formally adopts the recommendation of the IMR contractor as the Department's decision. If the HMO's decision is overturned, the HMO is required to implement the findings within five days.

IMR Resolution Data: Uphold versus Overturn Rates

This chart provides information on the total volume of IMRs and identifies whether or not the Review Organization upheld or overturned the HMO's original denial. Results are provided separately for Experimental / Investigational reviews and Medical Necessity reviews.

- Upheld – the Review Organization upheld the HMO's original denial.
- Overturned – the Review Organization overturned the HMO's original denial. The HMO is now required to provide the service to the patient.

IMRO RESOLUTIONS: UPHOLD VERSUS OVERTURN RATES – DATA

IMR TYPE	UPHELD		OVERTURNED		TOTAL
Experimental / Investigational IMR	108	80%	26	20%	**133**
Medical Necessity IMR	339	61%	216	39%	**556**
TOTAL RESOLUTIONS	**447**	**65%**	**242**	**35%**	**689**

Publication of IMR Results & Other Information on the Website

Once a decision has been adopted, the Department makes the contents of the decision available to the public. The names and identities of the patient, physician, facility and HMO are not made public. For each completed review, the Department includes a synopsis of the review's diagnosis, the disputed treatment and whether the grievance was upheld or overturned. This information, provided in a user-friendly, searchable format, is available on the Department's website (http://www.hmohelp.ca.gov/imr/) and is believed to be unique to California as a valuable resource to patients, providers and HMOs.

The Department's website also plays a key role in the distribution of general information about the IMR process. A "Frequently Asked Questions" page (http://www.hmohelp.ca.gov/imr/faq.asp) provides basic facts about the types of cases that are eligible for review and what the IMR process can accomplish for a patient.

Finally, visitors to the website can obtain copies of IMR forms that patients, providers and HMOs complete to initiate the IMR process.

Independent Medical Review Contracts and Costs of Reviews

The Department has engaged three contractors to serve as Review Organizations. The primary contractor is the Center for Health Dispute Resolution (CHDR), a subsidiary of MAXIMUS, Inc. When this primary contractor is unable to provide a review due to a conflict of interest or an inability to meet time requirements, one of the additional contractors (Medical Care Management Corporation or Hayes Plus, Inc.) provides the review.

Payment to the Review Organization is based on the type of case, the number of reviewers, and whether determinations must be expedited. The case fees for reviews performed by the primary contractor are:

REVIEW TYPE	COST	
MEDICAL NECESSITY ONE PHYSICIAN	Standard: Expedited:	$ 395 $ 500
EXPERIMENTAL/ INVESTIGATIONAL THREE PHYSICIANS	Standard: Expedited:	$1,750 $2,500

The Department pays the Review Organization on a monthly basis for the reviews completed; however, the costs for the IMR system are borne by the HMOs based on an assessment fee system established by the Department in accordance with statute. Assessments are then levied monthly on the HMOs to reimburse the Department for the cost of the reviews.

Independent Medical Review Quality Assurance System

Due to the unique and significant responsibilities delegated to the Review Organization, the HMO Help Center has incorporated several systems to evaluate the overall performance of the reviewers and the IMR program in general.

Internal quality assurance systems function at each level of the IMR process. Before a case is labeled as "ineligible" for IMR, a supervisor must review the case. Cases requiring any interpretation of statute to determine eligibility are referred to counsel. Prior to the IMR determination being adopted by the Department, counsel evaluates the entire file to assure that the determination addresses all aspects of the

dispute between the patient and the HMO. Finally, on a bi-weekly basis, the IMR program manager conducts random audits of completed cases to determine whether all statutory and internal time processing requirements were met.

The Department's IMR Advisory Council is comprised of legal counsel and HMO Help Center management. The Advisory Council meets monthly to assess any issues and problems that have been identified by HMO Help Center staff, HMOs, patients, or the Clinical Advisory Panel.

The Review Organizations under contract with the Department must have a quality assurance mechanism in place that ensures:

- Reviewers are appropriately credentialed and privileged;
- Reviews provided by the medical professionals are timely, clear and credible;
- Reviews are monitored for quality on an on-going basis;
- Reviewers are selected to achieve a fair and impartial qualified panel;
- The confidentiality of medical records and the review materials is maintained; and
- Reviewers are independent from any conflicts of interest.

The Clinical Advisory Panel provides the Department with direct access to academic medical specialists who can provide expert assistance to the Director to ensure that the IMR system is "meeting the quality standards necessary to protect the public's interest." The Panel reviews the decisions made during the independent review process to ensure that the decisions are consistent with best practices and to make recommendations where necessary. The Panel also reviews the adequacy and content of the reviews themselves, as well as the performance and quality assurance systems of the primary contractor.

Trending and Tracking IMR Results

Decisions in individual IMR cases apply only to the specific dispute submitted by the patient and that HMO. Reviewer decisions are based on the specific medical history and needs of the requesting patient and do not constitute an overall assessment of any HMO's medical policies applied in a particular case. However, the Department does evaluate the cases overall to determine if there are any trends in the types of disputes or in the results of IMRs to determine if there is a need for review of medical policies or treatments on a plan-to-plan basis or among the industry as a whole.

Working in conjunction with the Clinical Advisory Panel, the Department has an interagency agreement with University of California, San Francisco Institute of Health Policy Studies. This agreement provides available expertise to provide in-depth screening and evaluation of reviews for presentation to the panel, as well as the opportunity for more focused studies on specific clinical areas of concern raised by the IMR system. The results from the IMRs received in 2002 have been grouped (pages 41-43) to demonstrate the types of medical conditions and treatments that have gone through the review process.

IMR Program Awareness Efforts

In order for the IMR program to achieve its maximum effectiveness, it is essential that managed care patients and their health care

providers are aware of the IMR program and how to access it. The IMR Awareness program focuses on activities to promote awareness that are in addition to notifications provided by HMOs.

Throughout 2002, IMR Awareness activities were conducted with various stakeholders to provide information about the role of the Department and the Independent Medical Review process in particular. The project was conducted in three phases:

- The initial phase focused on the provider community consisting of medical groups, physician and medical associations and specialty cancer treatment centers.

- The second phase contacted the employer community (human resource organizations, unions, brokers, benefit consulting firms, etc.) and consumer groups (medical condition groups, health care support groups, etc.).

- The final phase provided information to various ancillary health care providers, including rehabilitation providers (speech, occupational, and physical therapy providers) and mental health and chemical dependency treatment providers.

The Department contacted a total of 878 different entities throughout the state during 2002. This included 96 medical groups and associations; 46 specialty care centers; 15 employer organizations; 71 consumer groups; and 333 legislative offices and other associations.

The project was accomplished through direct personal contact with the groups, organizations and associations by:

- Providing newsletter articles for printing or electronic distribution.

- Delivering on-site presentations.

- Providing brochures and posters.

- Establishing links to the Department website.

- Working with HMOs to incorporate IMR information on their home pages.

The overall goal of the project was to ensure a greater awareness about the Department and patients' rights throughout the California healthcare community. The presentations and materials were designed to increase the likelihood that IMR will be presented as an option to patients by the providers and others that are often consulted about health care problems and options.

Other efforts to provide information about the Department and to increase the utilization of IMR process were conducted during 2002.

- With the assistance of the University of California Davis Medical Center's Institute for Primary Care Studies, additional IMR information designed for providers was added to the Department's website.

- To ensure that information about the Department was available, advertisements were placed in telephone yellow pages and professionally produced radio ads were developed for airing in early 2003.

Independent Medical Review Critical Timeline

Statute requires that the Independent Medical Review Organization complete reviews within thirty days, or earlier if there is a medical need for an expedited review.

TYPES OF IMRS

Experimental/Investigational Independent Medical Reviews

A patient can apply for an experimental/investigational IMR when he or she meets all the following conditions:

- The patient has a life-threatening or seriously-debilitating disease or medical condition;
- A request for services was denied by the plan or medical group based upon a finding that the drug, procedure, device or treatment is experimental or investigational; and
- A treating or supporting physician provides a certification that:
  - The patient has a terminal, life-threatening or seriously debilitating medical condition;
  - The standard therapies have not been effective in improving the patient's condition, the standard therapies would not be medically appropriate for the patient or there is no more beneficial standard therapy covered by the HMO than the therapy proposed; and
  - A statement that the requested therapy is likely to be more beneficial than any available standard therapy.
  - If a non-plan physician is requesting the treatment, the statement must include copies of, or reference to, two documents of medical and scientific evidence that the treatment is likely to be more beneficial for the patient that any available standard therapy

Medical Necessity Independent Medical Reviews

A patient can apply for a medical necessity IMR when he or she meets one of the following conditions:

- The patient's provider has recommended a health care service as medically necessary, or
- The patient has received urgent care or emergency services that a provider determined was medically necessary, or
- The patient, in the absence of a provider recommendation or the receipt of urgent care or emergency services by a provider, has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the patient seeks independent medical review, or
  - The patient has filed a complaint with their HMO concerning the disputed care and the HMO has either upheld its initial decision or has not taken action on the complaint within 30 days. .

Medical Necessity vs. a Coverage Decision

To be eligible for a medical necessity IMR, a patient's case must involve a "disputed health care service." A disputed health care service is:

- Any health care service that is eligible for coverage and payment under an HMO contract that has been denied, modified, or delayed by a decision of the HMO or by one of its contracting providers due to a finding that the service is not medically necessary.

The statute does not provide a definition of "medically necessary services". Each HMO's evidence of coverage defines the term; however, the HMO Help Center does not consider itself bound by the HMO's definition of the term. HMO coverage decisions are not subject to IMR. A "coverage decision" is defined as:

- The approval or denial of health care services by an HMO, or by one of its contracting providers, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the HMO contract.

If an HMO, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed services are not a covered benefit under the contract that applies to the patient, the statement is required to clearly specify the provision in the contract that excludes that coverage.

Standard vs. Expedited Reviews

Generally, IMR cases are processed (through completion) within 30 days of qualification of the application. However, in certain circumstances, an IMR can be processed on an expedited basis.

For a service that has been denied based upon the finding that it is **experimental or investigational**, the IMR can be expedited if the patient's physician states that the therapy would be significantly less effective if not promptly initiated. In these cases, IMR processing is completed within nine days.

For a service that has been denied, delayed or modified based upon the finding that it is **not medically necessary**, the IMR can be expedited if there is an imminent and serious threat to the health of the patient. In these cases, IMR processing is completed within seven days.

EXPEDITED VERSUS STANDARD REVIEWS – DATA

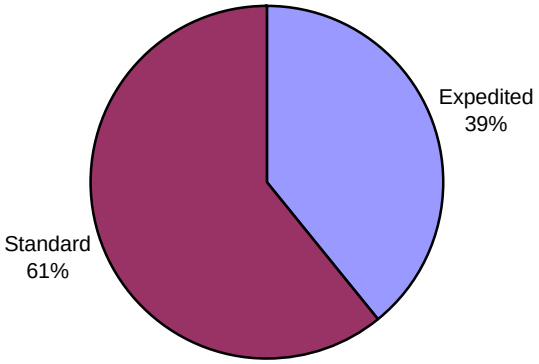
This chart provides information on the number of IMRs that were processed as expedited versus standard.

- **Standard IMR** – Resolved within 30 days of IMR application qualification.
- **Expedited Experimental/Investigational IMR** – Resolved within 9 days of IMR application qualification.
- **Expedited Medical Necessity IMR** – Resolved within 7 days of IMR application qualification.

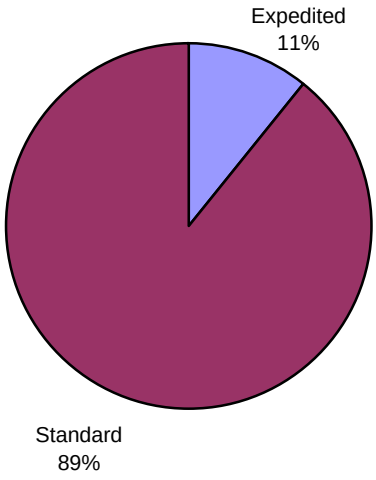
IMR TYPE	EXPEDITED	STANDARD	TOTAL
Experimental / Investigational IMR	52	81	**133**
Medical Necessity IMR	60	496	**556**
TOTAL EXPEDITED OR STANDARD CASES	**112**	**577**	**689**

This data reflects cases that were closed through the Independent Medical Review Organization in 2002.

EXPERIMENTAL/INVESTIGATIONAL
Expedited vs. Standard Cases



MEDICAL NECESSITY
Expedited vs. Standard Cases



ISSUES & CHALLENGES - IMR

Utilization of IMR

The number of IMR requests and reviews increased during the second year of the Department's IMR system. Beginning in mid-2002, there was an increase in the number of IMR applications, possibly reflecting the influence of the Department's awareness efforts. The number of reviews conducted increased gradually during 2002, but is still lower than the Department anticipated, given the large managed care enrollment in California and an expected greater awareness of the process.

During 2002, there were about 4 eligible IMR cases for each 100,000 eligible managed care enrollees in California. Comparisons with other state's IMR programs are inexact since IMR programs vary considerable from state to state. No recent data is available that would provide valid comparative utilization rates. (Information from researchers and studies of other state's data from 2000 and 2001 indicated there was a wide range – between 2 and 17 reviews per 100,000 enrollees - among states with IMR programs.)

In addition to the unique role played by the Department as a dedicated regulator of the managed care industry, a number of other patient protection efforts enhance the resolution of disputes over HMO services. Together with IMR, these efforts were intended to facilitate effective communication between patients, physicians and the HMO, as well as increase the internal resolution of treatment disputes within the plans' complaint systems. The number of disputes that must be decided through IMR in California is further reduced by the other processes utilized by the Department (quick resolution, urgent nurse reviews and the standard complaint process). In many cases, these allow the HMO Help Center to resolve disputes that otherwise would be referred for an IMR determination.

The Department continues to provide information to consumers through its awareness program and continuously ensures that HMOs provide information about IMR throughout the denial and complaint process. Periodic plan surveys also ensure that the HMOs provide information about access to the complaint system and information about the Department's toll-free telephone line and IMR.

By law and practice, information and access to the Department and IMR is readily available to consumers. Public education efforts will continue to ensure that there is general information available about how the Department can assist patients that have problems with their HMOs. While a greater number of disputes were expected to be resolved through IMR, it is unclear what, if anything, is preventing additional qualified applicants from contacting the Department.

Some reports suggest that many patients may not contact the Department for an IMR because they are emotionally or physically spent or don't appreciate the true independence of the process. The Help Center provides an informational sheet to prospective IMR applicants explaining the steps involved in the process; the lack of HMO influence over the review organization; and the impartiality of the medical reviewers.

Together with consumer groups and researchers, the Department will continue to explore ways to streamline the IMR process and remove any real or perceived barriers.

The Department also will enhance its monitoring of the HMOs' denial processes and complaint systems. This will provide further assurance to the Department that the procedures followed by the HMO and the information provided to their members complies with existing law and regulations.

Enforcement Actions

In general, HMOs have fully cooperated with the implementation of the Department's IMR system. Most HMOs had prior experience with one form or another of external reviews, either through the prior Friedman-Knowles Act or as part of their own complaint and appeal systems. Larger HMOs readily included a response to the Department's "Request for Health Plan Information" with their complaint and appeals process.

However, regulations do provide the Department with the authority to take enforcement actions against HMOs whose actions or inactions frustrate or impede the IMR system. A penalty of $5,000 per day is to be assessed when an HMO fails to implement an IMR decision within five days of its adoption by the Department.

The Department is reviewing several allegations related to HMOs' non-compliance with the notification requirements of the IMR system. Despite clear statutory requirements, several HMOs have failed to include information about IMR in their denial letters and complaint resolution letters. To date, four penalties have been assessed and paid by HMOs for the following reasons: 1) failure to provide records to the Review Organization within required timeframes; 2) failure to provide proper notice about filing a complaint and access to IMR; 3) inaccurate notice of when the enrollee may contact the HMO Help Center; and 4) failure to notify an enrollee of the right to an IMR.

Provision of Materials for Review

Most HMOs are able to appropriately respond and provide the necessary materials to the review organization upon notification by the Department that an IMR had been accepted for review. Delays in the delivery of records occasionally still occur when out-of-plan providers have seen the enrollee or when the HMO encounters difficulties in retrieving medical records from medical groups.

Notification of IMR Availability in Denial Letters

In addition to the allegations being reviewed by our Office of Enforcement, there are indications that some HMOs have failed to provide information about IMR when sending denial letters despite clear requirements defined by the statute. There are also indications of failure by some HMOs to appropriately monitor the content of letters sent by medical groups who have been delegated the authority to issue denials. The Department worked with the Industry Collaboration Effort (ICE) to develop templates for all denial letters with appropriate information about requesting IMRs. The HMOs approved the templates for implementation in 2003.

Medical Necessity vs. Coverage Issues

When there is a question whether a patient complaint is a disputed health care service or a coverage decision, the HMO Help Center makes the final determination. Since coverage under most HMOs includes only medically necessary services, the distinction is, at times, somewhat blurred. In addition, some types of care involve areas where there

exists no clear line between services that are typically considered medically necessary services and services that are excluded from coverage, such as medical vs. dental services, reconstructive vs. cosmetic surgery, and mental health vs. educational/behavioral therapy.

Some applications for IMR involve requests for care from a specific, out-of-plan provider (not contracted with the HMO) asserting that the out-of-plan physician is "better" than the in-plan physicians. These cases typically involve disputes concerning the selection or location of a **provider** rather than a disputed health care **service**. While the Department recognizes that reviewers should not be comparing providers' level of competency, the cases may present issues concerning the type of services available from the HMO. The underlying basis for the patient's request for a specific provider is reviewed to ensure that the dispute does not involve a medical condition that requires a medical specialty or a treatment alternative that is not available within the HMO.

Copies of Documents Provided to the Review Organization

HMOs are required to provide specified medical records and relevant documents to the Review Organization. The statute states "The plan shall promptly issue a notification to the enrollee, after submitting all of the required material to the Review Organization, that includes an annotated list of documents submitted and offer the enrollee the opportunity to request copies of those documents from the plan." Patients are notified that they may submit medical information or other relevant documentation to the review organization (they are not required to provide a copy to the HMO).

IMRs for the Reimbursement of Services Already Provided

Disputes eligible for the HMO Help Center's IMR system include *recommended* or *proposed* care that the HMO has denied, modified or delayed. Services that have already been provided to the patient, except emergency and urgent services, are not eligible for IMR.

The language used throughout the related statute confirms that review organizations will make determinations on future services. In general, the IMR system was designed to resolve disputes over health care services prior to any harm to the patient caused by HMO denials or delays of treatment. Following an IMR determination, the Department's authority is limited to ordering an HMO to provide reimbursement for emergency or urgent services, not claims for prior services.

Applicability to Specialized Plans

Almost all of the reviews in 2002 arose from full-service plans. Section 1374.30(b) of the Health and Safety Code appears to require that the disputed health care service decisions eligible for IMR must relate to the practice of medicine. However, the following sentence states that disputes from specialized health care service plans are also subject to IMR if their services either involve the practice of medicine **or** are provided pursuant to a contract with a full-service plan. The latter provision could broaden the scope of IMR to services not commonly provided by physicians. In addition, the statute usually refers to "providers" or "medical professionals" rather than physicians. However, the dispute must rest on a determination of whether or not the service is medically necessary and there are references only to medical records and a medical condition.

The Department has taken the position that disputes arising from specialized HMOs may be eligible for IMR only if the decisions involve matters normally within the scope of medical practice or are based on a physician's recommendation.

HMO INSPECTIONS AND SURVEYS

BACKGROUND

Beginning in July 2003 the HMO Help Center will be responsible for HMO surveys and inspections. This reorganization will ensure better oversight of the HMO complaint systems.

Surveys and inspections of all our licensed HMOs, including full service, dental, behavioral health, and vision plans must be conducted every three years or sooner as mandated by California's patients' rights laws. In addition, a follow-up review is conducted 18 months later to ensure the HMOs have corrected outstanding deficiencies.

We use public health and clinical professionals to plan and conduct these evaluations. A report is prepared, indicating HMO performance in the areas of health care accessibility, utilization management, quality improvement and complaint/appeals mechanisms. These reports are made available to the public.

We also review materials submitted by HMOs that describe their internal quality review systems, health care arrangements, and geographical areas served. These submissions may be new filings, material modifications, or amendments.

Joint surveys are conducted with the California Department of Health Services, Medi-Cal Managed Care Division, of HMOs that have contracted with DHS to provide managed care services to Medi-Cal beneficiaries. This eliminates duplication of efforts by state agencies and the HMOs themselves.

The following chart illustrates the survey activity during 2002.

STATISTICAL DATA

Surveys Completed and Reports Issued During 2002		
Plan Type	**Surveys Completed**	**Reports Issued**
Full Service	16	33
Dental	12	18
Vision	8	8
Behavioral Health	4	7
Pharmeceutical	1	2
Chiropractic	1	1
Totals	**42**	**69**

PATIENTS' RIGHTS ENFORCEMENT

BACKGROUND

The HMO Help Center and other patients' rights offices within the Department work closely with our Enforcement team to determine whether an enforcement action, such as a fine, is warranted. During 2002, our Office of Enforcement opened 112 cases and worked on 310 cases. For the 37 cases resolved with an enforcement action in 2002, the following chart identifies the HMO, the violation and the enforcement action taken.

STATISTICAL DATA

PLAN HEALTH AND SAFETY VIOLATION	PENALTY
Aetna Health of California, Inc.	
Failure to adequately address enrollee grievance	$4,375.00
Failure to maintain required tangible net equity	$110,000.00
American Healthguard Corporation, Centaguard Dental Plan	
Failure to file provider dispute resolution report	$2,500.00
Ameritas Managed Dental Plan	
Failure to file provider dispute resolution report	$2,500.00
Blue Cross	
Failure to notify enrollee of right to Independent Medical Review (IMR)	$5,000.00
Blue Shield	
Failure to specify contract provisions for coverage denial	$5,000.00
Failure to ensure cancellation notice provided to enrollees	$5,000.00
Chirosave	
Failure to maintain financial viability and meet tangible net equity	License Revocation
Cigna	
Failure to respond to grievance within 30 days; failure to include IMR notice	$7,500.00
Plan failed to timely provide records to IMR Organization	$5,000.00
Cohen Medical Corp., d.b.a. Tower	
Plan surrendered license following conservatorship.	
Eye Care Plan of America – California, Inc.	
Failure to file provider dispute resolution report	$2,500.00
Eye Care Plan of America – California, Inc.	
Failure to timely file financial statements	$7,500.00
GE Wellness Plan Dental and Vision	
Failure to file material modification prior to name change	$2,500.00
Group Intermedic	
Failure to reimburse cost of licensing application	$1,295.00
Health Net	
Failure to refer to qualified specialist in a timely manner	$ 10,000.00
Inter Valley	
Failure to maintain required tangible net equity	$27,500.00
Kaiser Foundation Health Plan, Inc.	
Inadequate procedures for authorization of home health care services	$100,000.00
Failure to: 1) timely refer an enrollee with Duchenne's muscular dystrophy to a specialist, (2) make services readily available and accessible, and (3) provide continuity of care.	$110,000.00

PLAN HEALTH AND SAFETY VIOLATION	PENALTY
Failure to implement IMR decision ordering 12 hours per day of home health care	Plan ordered to implement the IMR decision.
Failure to provide ready access to care; failure to timely and properly respond to enrollee grievance	$1,000,000.00
Failure to respond to enrollee grievance	$5,000.00
Liberty Dental	
Failure to file provider dispute resolution report	$2,500.00
Lifeguard, Inc.	
Financial issues	Conservator placed in plan.
Failure to pay claims and include interest on late claims	$40,000.00
Maxicare	
Plan agreement to pay amounts due to DMHC for financial examinations	$7,612.00
Merit Behavioral Care of California, Inc.	
Failure to pay claims timely and to include interest	$7,500.00
PacifiCare	
Failure to timely and properly respond to enrollee grievance	$10,000.00
Improper denial of referral to specialist; grievance response failed to address the issues.	$15,000.00
Plan provided wrong telephone number for non-business hour urgent grievances	$5,000.00
Safeguard	
Failure to maintain required tangible net equity	$ 3,500.00
Scan Health Plan	
Failure to maintain required tangible net equity	$250,000.00
Sharp Health Plan	
Failure to pay claims timely and to pay interest on late claims	$20,000.00
Failure to pay claims timely and to pay interest on late claims	$ 20,000.00
Universal Care	
Failure to maintain required tangible net equity	$200,000.00
Vision Service Plan	
Failure to pay special assessment timely (paid past due assessment).	$912,417.00
VisionCare	
Failure to maintain required tangible net equity	$2,500.00
TOTAL	**$2,909,199.00**

INFORMATION TECHNOLOGY

BACKGROUND

Our Technology and Innovation team supports many of the HMO Help Center's services. The Technology staff maintains and support the Help Center's Consumer Case Management System, which helps us efficiently respond to patient concerns and track relevant data on patient issues. With the use of better technology, the HMO Help Center's website provides patients with up to date "hot issues" as well as Independent Medical Review data.

HMO HELP CENTER STATISTICAL DATA

HEALTH PLAN LICENSE INFORMATION

Health Plans Granted a License in 2002

The Health Care Service Plans that received a license during 2002 are listed below.

HEALTH PLAN	DATE
Care More Insurance	11/01/02
Medcore	06/26/02

Licenses Surrendered by Health Plans in 2002

A health plan, which appeared in last year's report but does not appear in this year's, may have surrendered its Knox-Keene license. The Health Care Service Plans that surrendered their licenses during 2002 are listed below.

Health Plan	Date
Century Dental Plan	12/31/02
Cohen Medical Group	09/13/02
Ideal Dental	06/06/02
Maxicare	01/30/02
National Med	12/17/02
ProCare Eye Exam	05/30/02

COMPLAINT RESULTS BY CATEGORY & HMO

Report Definition

The *Summary of 2002 Enrollee Complaints:*

- Details the number and types of complaints closed by the Department during the 2002 calendar year. A patient's complaint can include more than one issue, such as: claim reimbursement, quality of care, access to care, etc. However, a consumer complaint resulting in multiple distinct issues is counted as only one complaint against the HMO.

- Lists HMOs licensed during the 2002 calendar year, the number of complaints closed for each HMO, the HMO's average enrollment during the year, the number of complaints per 10,000 consumers, and the number of issues for each complaint category. Enrollment data is provided for comparison purposes.

HMOs are listed according to the name they were doing business as (dba) during 2002. In instances where an HMO is known by more than one name, the dba name is shown first with additional names in parentheses.

Complaints are classified in five categories: Access to Care; Benefits/Coverage; Billing/Claims/Enrollment; Attitude/Service of the Health Plan; and Attitude/Service of the Provider.

Enrollment Information Definition

The HMO enrollment figures were provided to the Department by the HMOs on their quarterly financial filings and reflect the average of quarterly enrollment figures provided for 2002. Because Medicare + Choice enrollees are not eligible for the complaint process, the enrollment figures below exclude them.

Report

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE COMPLAINTS COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

Plan Type Plan Name	Complaints Resolved	Enrollees	Complaints per 10,000	Issue Category: Accessibility Issues	Issues Per 10,000
Full Service - Enrollment Over 400,000					
AETNA Health of California Inc.	168	600,657	2.80	17	0.28
Blue Cross of California	660	4,634,100	1.42	45	0.10
Blue Shield of California	681	2,184,018	3.12	23	0.11
Cigna HealthCare of California Inc.	98	642,552	1.53	7	0.11
Health Net of California Inc.	666	2,209,451	3.01	58	0.26
Kaiser Permanente	626	6,252,651	1.00	85	0.14
L.A. Care Health Plan	0	795,122	0.00	0	0.00
PacifiCare of California	512	1,597,978	3.20	50	0.31
Subtotals	**3,411**	**18,916,529**	**1.80**	**285**	**0.15**
Full Service - Enrollment Under 400,000					
AET Health Care Plan of California	5	111,717	0.45	1	0.09
Alameda Alliance for Health	0	85,086	0.00	0	0.00
Caloptima	0	288,489	0.00	0	0.00
Care 1st Health Plan	2	199,107	0.10	0	0.00
CareMore Insurance Services Inc.	0	0	0.00	0	0.00
Cedars-Sinai Provider Plan LLC	0	527	0.00	0	0.00
Central Coast Alliance for Health	0	82,523	0.00	0	0.00
Chinese Community Health Plan	1	5,714	1.75	0	0.00
Community Health Group	2	93,595	0.21	1	0.11
Community Health Plan	0	159,102	0.00	0	0.00
Concentrated Care Inc.	0	0	0.00	0	0.00
Contra Costa Health Plan	1	58,151	0.17	0	0.00
Health Plan of San Joaquin	0	61,301	0.00	0	0.00
Health Plan of the Redwoods	21	63,885	3.29	0	0.00
Heritage Medical Systems	0	149,842	0.00	0	0.00
IEHP (Inland Empire Health Plan)	1	240,228	0.04	0	0.00
Inter Valley Health Plan	12	16,763	0.00	0	0.00
Kern Health Systems Inc.	0	71,886	0.00	0	0.00
Lifeguard Inc.	55	168,239	3.27	6	0.36
Maxicare of California Inc.	23	0	0.00	0	0.00
Medcore	0	0	0.00	0	0.00
Molina Medical Center	0	274,737	0.00	0	0.00
National Health Plans	0	3,659	0.00	0	0.00
On Lok Senior Health Services	0	858	0.00	0	0.00
One Health Plan of California Inc.	14	62,206	2.25	3	0.48
Primecare Medical Network Inc.	0	219,680	0.00	0	0.00
ProMed HCA (Health Care Administrators)	0	8,276	0.00	0	0.00

Issue Categories							
Benefits/Coverage		Billing/Claims Enrollment		Attitude/Service of Health Plan		Attitude/Service of Provider	
Issues	Issues Per 10,000	Issues	Issues Per 10,000	Issues	Issues Per 10,000	Issues	Issues Per 10,000
46	0.77	104	1.73	5	0.08	5	0.08
220	0.47	382	0.82	12	0.03	14	0.03
297	1.36	362	1.66	7	0.03	9	0.04
26	0.40	63	0.98	1	0.02	3	0.05
216	0.98	383	1.73	17	0.08	15	0.07
157	0.25	305	0.49	48	0.08	81	0.13
0	0.00	0	0.00	0	0.00	0	0.00
174	1.09	290	1.81	5	0.03	7	0.04
1,136	**0.60**	**1,889**	**1.00**	**95**	**0.05**	**134**	**0.07**
0	0.00	3	0.27	0	0.00	1	0.09
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
1	0.05	1	0.05	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
1	1.75	0	0.00	0	0.00	0	0.00
0	0.00	1	0.11	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	1	0.17	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
10	1.57	11	1.72	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	1	0.04	0	0.00	0	0.00
6	0.00	6	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
22	1.31	27	1.60	0	0.00	0	0.00
3	0.00	19	0.00	1	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
4	0.64	7	1.13	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00

Plan Type Plan Name	Complaints Resolved	Enrollees	Complaints per 10,000	Issue Category: Accessibility Issues	Issues Per 10,000
San Francisco Health Authority	0	38,374	0.00	0	0.00
San Mateo Health Commission	0	42,159	0.00	0	0.00
Santa Barbara Regional Health Authority	0	132,114	0.00	0	0.00
Santa Clara Family Health Plan	0	74,063	0.00	0	0.00
Scripps Clinic Health Plan Services Inc.	0	135,992	0.00	0	0.00
Sharp Health Plan	4	114,612	0.35	1	0.09
Simnsa Health Care	0	10,685	0.00	0	0.00
Smartcare Health Plan	6	1,930	31.09	2	10.36
Tower Health Services	24	0	0.00	0	0.00
UCSD (University of California San Diego) Senior Health Plan	0	12,448	0.00	0	0.00
UHC Healthcare (United Healthcare of California)	6	0	0.00	0	0.00
UHP Healthcare	11	100,733	1.09	5	0.50
Universal Care	42	357,991	1.17	4	0.11
Valley Health Plan	0	46,271	0.00	0	0.00
Ventura County Health Care Plan	0	10,637	0.00	0	0.00
Western Health Advantage	20	57,444	3.48	2	0.35
Subtotals	**250**	**3,502,102**	**0.71**	**25**	**0.07**
Chiropractic					
ACN (American Chiropractic Network Inc.)	1	3,753,001	0.00	0	0.00
Avante Complementry Health Plan	0	0	0.00	0	0.00
Basic Chiropractic Health Plan	0	8	0.00	0	0.00
ChiroSave Inc.	0	752	0.00	0	0.00
Landmark Healthplan of California Inc.	0	250,670	0.00	0	0.00
Subtotals	**1**	**4,004,431**	**0.00**	**0**	**0.00**
Dental					
Access Dental Plan	0	148,697	0.00	0	0.00
Ameritas Managed Dental Plan Inc.	3	31,479	0.95	1	0.32
California Benefits Dental Plan	3	28,900	1.04	0	0.00
California Dental Network Inc.	1	24,813	0.40	0	0.00
CENTAGUARD Dental Plan	0	25,112	0.00	0	0.00
Century Dental Plan	0	12,288	0.00	0	0.00
Cigna Dental Health of California Inc.	18	419,988	0.43	1	0.02
DDS Inc./DDSI (Dedicated Dental Systems Inc.)	4	41,079	0.97	0	0.00
Delta Dental Plan of California	176	14,022,333	0.13	0	0.00
Dental Choice of California Inc.	0	138,775	0.00	0	0.00
Denticare of California Inc.	5	393,229	0.13	0	0.00

Issue Categories							
Benefits/Coverage		Billing/Claims Enrollment		Attitude/Service of Health Plan		Attitude/Service of Provider	
Issues	Issues Per 10,000	Issues	Issues Per 10,000	Issues	Issues Per 10,000	Issues	Issues Per 10,000
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
1	0.09	1	0.09	0	0.00	1	0.09
0	0.00	0	0.00	0	0.00	0	0.00
2	10.36	2	10.36	0	0.00	0	0.00
3	0.00	21	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	6	0.00	0	0.00	0	0.00
1	0.10	4	0.40	0	0.00	1	0.10
12	0.34	24	0.67	3	0.08	1	0.03
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
9	1.57	8	1.39	2	0.35	0	0.00
75	**0.21**	**142**	**0.41**	**7**	**0.02**	**4**	**0.01**
1	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
1	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	1	0.32	1	0.32	2	0.64
0	0.00	3	1.04	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	1	0.40
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
3	0.07	7	0.17	1	0.02	8	0.19
1	0.24	2	0.49	0	0.00	1	0.24
43	0.03	116	0.08	10	0.01	12	0.01
0	0.00	0	0.00	0	0.00	0	0.00
1	0.03	3	0.08	0	0.00	1	0.03

Plan Type Plan Name	Complaints Resolved	Enrollees	Complaints per 10,000	Issue Category: Accessibility Issues	Issues Per 10,000
Healthdent of California Inc.	1	14,732	0.68	0	0.00
Ideal Dental Health Plan Inc.	0	0	0.00	0	0.00
Managed Dental Care	7	66,091	1.06	0	0.00
Mida Dental	7	282,935	0.25	0	0.00
Newport Dental Centers	0	46,340	0.00	0	0.00
Pacific Union Dental	6	258,564	0.23	3	0.12
PacifiCare Dental	10	323,462	0.31	2	0.06
Preferred Dental Plan	0	4,176	0.00	0	0.00
Primecare Dental Plan Inc.	0	0	0.00	0	0.00
SmileCare	3	122,173	0.25	0	0.00
South Hills Dental Plan	1	82,907	0.12	0	0.00
United Dental Care	0	17,584	0.00	0	0.00
Western Dental PLan	5	310,127	0.16	0	0.00
Subtotals	**250**	**16,857,943**	**0.15**	**7**	**0.00**
Dental/Vision					
Golden West Vision-Dental Plan	2	271,726	0.07	0	0.00
PMI (Private Medical-Care Inc.)	53	1,272,915	0.42	5	0.04
Safeguard Health Plans Inc.	28	285,706	0.98	1	0.04
SmileSaver/Signature Vision	5	279,043	0.18	0	0.00
Subtotals	**88**	**2,109,390**	**0.42**	**6**	**0.03**
Vision					
ESP (Eyecare Service Plan)	1	68,831	0.15	0	0.00
Eye Care Plan of America California	0	8,491	0.00	0	0.00
EYEXAM 2000 of California Inc.	0	375,646	0.00	0	0.00
For Eyes Vision Plan	0	21,042	0.00	0	0.00
Health Net Vision Inc.	0	399,859	0.00	0	0.00
Medical Eye Services Inc.	0	98,097	0.00	0	0.00
NVAL Visioncare Systems of Calirornia Inc.	0	22,933	0.00	0	0.00
Pearle Visioncare Inc.	0	110,293	0.00	0	0.00
ProCare Eye Exam Inc.	0	9,155	0.00	0	0.00
Sterling Visioncare	0	70,236	0.00	0	0.00
Vision First Eye Care Inc.	0	1,989	0.00	0	0.00
Vision Plan of America	1	40,034	0.25	0	0.00
Vision Service Plan	5	8,264,495	0.01	0	0.00
Subtotals	**7**	**9,491,101**	**0.01**	**0**	**0.00**
Pharmacy					
MedcoCal Inc.	0	62,007	0.00	0	0.00
Subtotals	**0**	**62,007**	**0.00**	**0**	**0.00**

Issue Categories							
Benefits/Coverage		Billing/Claims Enrollment		Attitude/Service of Health Plan		Attitude/Service of Provider	
Issues	Issues Per 10,000	Issues	Issues Per 10,000	Issues	Issues Per 10,000	Issues	Issues Per 10,000
0	0.00	0	0.00	0	0.00	1	0.68
0	0.00	0	0.00	0	0.00	0	0.00
3	0.45	4	0.61	0	0.00	0	0.00
0	0.00	6	0.21	0	0.00	2	0.07
0	0.00	0	0.00	0	0.00	0	0.00
1	0.04	1	0.04	0	0.00	1	0.04
3	0.09	4	0.12	0	0.00	2	0.06
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	3	0.25	0	0.00	0	0.00
0	0.00	1	0.12	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	5	0.16	0	0.00	0	0.00
55	**0.03**	**156**	**0.09**	**12**	**0.01**	**31**	**0.02**
0	0.00	1	0.04	0	0.00	1	0.04
14	0.11	27	0.21	3	0.02	8	0.06
8	0.28	11	0.39	2	0.07	7	0.25
1	0.04	4	0.14	0	0.00	1	0.04
23	**0.11**	**43**	**0.20**	**5**	**0.02**	**17**	**0.08**
0	0.00	0	0.00	0	0.00	1	0.15
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	1	0.25	0	0.00	0	0.00
1	0.00	3	0.00	1	0.00	0	0.00
1	**0.00**	**4**	**0.00**	**1**	**0.00**	**1**	**0.00**
0	0.00	0	0.00	0	0.00	0	0.00
0	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**

Plan Type Plan Name	Complaints Resolved	Enrollees	Complaints per 10,000	Issue Category Accessibility Issues	Issues Per 10,000
Psychological					
Cigna Behavioral Health of California Inc.	1	529,859	0.02	0	0.00
CONCERN: Employee Assistance Program	0	57,636	0.00	0	0.00
HAI-CA (Human Affairs International of California)	0	1,136,203	0.00	0	0.00
Holman Professional Counseling Centers	0	192,864	0.00	0	0.00
Integrated Insights	0	204,103	0.00	0	0.00
Managed Health Network	30	2,131,385	0.14	2	0.01
Merit Behavioral Care of California Inc.	3	752,749	0.04	0	0.00
PacifiCare Behavioral Health of California	22	1,894,202	0.12	0	0.00
U.S. Behavioral Health Plan California	6	1,838,526	0.03	0	0.00
ValueOptions of California Inc.	1	267,769	0.04	0	0.00
Subtotals	**63**	**9,005,296**	**0.07**	**2**	**0.00**
Total	**4,070**		**0.64**	**325**	**0.05**

Issue Categories							
Benefits/Coverage		Billing/Claims Enrollment		Attitude/Service of Health Plan		Attitude/Service of Provider	
Issues	Issues Per 10,000	Issues	Issues Per 10,000	Issues	Issues Per 10,000	Issues	Issues Per 10,000
0	0.00	1	0.02	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
0	0.00	0	0.00	0	0.00	0	0.00
10	0.05	19	0.09	1	0.00	0	0.00
1	0.01	2	0.03	0	0.00	0	0.00
13	0.07	6	0.03	1	0.01	2	0.01
1	0.01	5	0.03	1	0.01	0	0.00
0	0.00	1	0.04	0	0.00	0	0.00
25	**0.03**	**34**	**0.04**	**3**	**0.00**	**2**	**0.00**
1,316	**0.21**	**2,268**	**0.35**	**123**	**0.02**	**189**	**0.03**

INDEPENDENT MEDICAL REVIEW RESULTS BY HMO

Report Definition

The *Summary of IMRs by HMO:*

- Details the number and types of IMRs closed with a determination during the 2002 calendar year. The total number of IMRs resolved (773) includes 84 cases that were withdrawn during the review process; a total of 689 cases completed the review process.

- Lists HMOs licensed during the 2002 calendar year, the HMO's average enrollment during the year, the number of IMRs closed for each HMO, the associated uphold and overturn determinations, and the number of IMR withdrawals. Enrollment data is provided for comparison purposes.

Enrollment Information Definition

The HMO enrollment figures were provided to the Department by the HMOs on their quarterly financial filings and reflect the average of quarterly enrollment figures provided for 2002. Because Medicare + Choice enrollees are not eligible for IMR, the enrollment figures below exclude them.

Total Enrollment on this report excludes Managed Health Network and PacfiCare Behavioral Health Care of California, Inc., as they are specialized HMOs, not full service HMOs.

California Department of Managed Health Care
Summary of IMRs by Health Plan
January 1, 2002 – December 31, 2002

Plan Type Plan Name	Enrollees	Total IMRs Resolved	Experimental/Investigational IMR			
			Total IMRs	Plan Upheld	Plan Over-turned	IMR With-drawn
Full Service - Enrollment Over 400,000						
AETNA Health of California Inc.	600,657	28	5	2	3	0
Blue Cross of California	4,634,100	107	37	31	2	4
Blue Shield of California	2,184,018	158	43	31	7	5
Cigna HealthCare of California Inc.	642,552	31	1	0	1	0
Health Net of California Inc.	2,209,451	178	27	23	2	2
Kaiser Permanente	6,252,651	76	3	3	0	0
PacifiCare of California	1,597,978	150	26	15	10	1
Subtotals	**18,121,407**	**728**	**142**	**105**	**25**	**12**
Full Service- Enrollment Under 400,000						
Care 1st Health Plan	199,107	1	0	0	0	0
Community Health Group	93,595	1	0	0	0	0
Health Plan of the Redwoods	63,885	15	0	0	0	0
IEHP (Inland Empire Health Plan)	240,228	1	0	0	0	0
Inter Valley Health Plan	16,763	2	0	0	0	0
Lifeguard Inc.	168,239	3	3	2	1	0
UHP Healthcare	100,733	1	0	0	0	0
Universal Care	357,991	2	0	0	0	0
Western Health Advantage	57,444	4	1	1	0	0
Subtotals	**1,297,985**	**30**	**4**	**3**	**1**	**0**
Psychological						
Managed Health Network	2,131,385	4	0	0	0	0
PacifiCare Behavioral Health of California Inc.	1,894,202	11	0	0	0	0
Subtotals	**4,025,587**	**15**	**0**	**0**	**0**	**0**
Totals	**19,419,392**	**773**	**146**	**108**	**26**	**12**

California Department of Managed Health Care
Summary of IMRs by Health Plan
January 1, 2002 – December 31, 2002

Plan Type Plan Name	Medical Necessity IMR Total IMRs	Plan Upheld	Plan Over-turned	IMR With-drawn
Full Service - Enrollment Over 400,000				
AETNA Health of California Inc.	23	11	11	1
Blue Cross of California	70	48	17	5
Blue Shield of California	115	55	20	40
Cigna HealthCare of California Inc.	30	16	13	1
Health Net of California Inc.	151	74	67	10
Kaiser Permanente	73	37	33	3
PacifiCare of California	124	81	31	12
Subtotals	**586**	**322**	**192**	**72**
Full Service- Enrollment Under 400,000				
Care 1st Health Plan	1	0	1	0
Community Health Group	1	1	0	0
Health Plan of the Redwoods	15	7	8	0
IEHP (Inland Empire Health Plan)	1	1	0	0
Inter Valley Health Plan	2	1	1	0
Lifeguard Inc.	0	0	0	0
UHP Healthcare	1	0	1	0
Universal Care	2	1	1	0
Western Health Advantage	3	0	3	0
Subtotals	**26**	**11**	**15**	**0**
Psychological				
Managed Health Network	4	2	2	0
PacifiCare Behavioral Health of California Inc.	11	4	7	0
Subtotals	**15**	**6**	**9**	**0**
Totals	**627**	**339**	**216**	**72**

EXCELLENCE IN SERVICE

The Department of Managed Health Care recognizes HMO Help Center employees who have made outstanding contributions in efforts to help consumers receive the health care to which they are entitled. These are the HMO Help Center employees that were honored in 2002.

Laura Dooley Beile

HMO Help Center

Laura was the HMO Help Center's Employee of the Month for July 2002 because of her tireless efforts in support of the Help Center's Consumer Case Management System. Laura has dedicated herself to ensuring that the system meets the needs of the Help Center and its customers. Laura is responsible for monitoring system changes, corrections, and enhancements. In addition, she lends her technical skills to designing and testing many of the modifications to the system. Her considerable expertise, attention to detail, and dedication have contributed greatly to the system's success. Congratulations, Laura!

Brigitte Golden

HMO Help Center

The HMO Help Center Managers and Staff congratulate Brigitte Golden on being September 2002 Employee of the Month. Brigitte has been with the Help Center since its inception and supervises the work done in the Call Center. Brigitte was one of the very first Consumer Assistant Technicians hired to answer the consumer complaint line. She was instrumental in the development of procedures and processes, outlining our customer service policy, and putting together a resource manual for non-jurisdictional issues. "We decided up front not to give our callers the old 'state shuffle', to make sure that we could refer them to the correct area and person the first time." The call center and its staff continue to be recognized by newspapers, advocacy groups, articles, etc. as an excellent resource for consumer complaints. Brigitte is recognized for her many contributions to the success of the Call Center. She continues to be an excellent leader, motivator, and trainer. Her dedication to the Call Center is evident in all that she does.

Jodi Pope

HMO Help Center

Congratulations to Jodi Pope on being the Employee of the Month for October 2002. Jodi has been with us since the beginning of the new HMO Help Center. Jodi has the ability to take on assignments and tasks with little instruction. She readily identifies the most efficient process or, if needed, a feasible alternative. Jodi's skills were exactly what we needed to ensure that the new HMO Help Center was up and running by July 2000. Staff had less than six weeks to establish processes and procedures, prepare training material, develop an Interactive Voice Response System, and hire staff to respond to consumer calls. Jodi was also a key player in the development of our new Consumer Case Management System. Initially, Jodi was selected to assist with system training. However, her expertise on the system's interaction with Call Center processes and thorough comprehension of the new system's functionality led to her reassignment to the HMO Help Center's "Consumer Case Management System Team". The team is responsible for all changes to the system, the development and testing of reports, and troubleshooting of system problems. Jodi has proven to be a valuable asset to the team. Jodi came on board ready to tackle any task assigned to her, and over the past two years that is exactly what she has done!

Regan Wong

HMO Help Center

Regan Wong was the HMO Help Center's Employee of the Month for December 2002. Regan has been with the HMO Help Center since its inception and helped catapult the Independent Medical Review (IMR) program. He has been a critical team player in maintaining the integrity of the IMR process. Recently, he accepted the task of providing IMR cross training for the Complaint Resolution Section staff. Regan has also been instrumental in developing the tools required for staff organization, which is a key element in processing multiple complex complaint types. Our consumers and health plan contacts have expressed their appreciation of Regan's dependability and consistency in providing complete complaint information. Regan is an exceptional and positive member of the HMO Help Center.