COMMONWEALTH of VIRGINIA

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The Honorable Harvey B. Morgan
Chairman, Joint Commission on Health Care
Chairman, House Committee on Commerce and Labor

The Honorable William C. Wampler, Jr.
Chairman, Senate Committee on Commerce and Labor

Pursuant to §2.2-2818 of the Code of Virginia, the Department of Human Resource Management Health Benefits Ombudsman is required to submit an annual report.

The attached report is has been prepared in response to this requirement.

Respectfully submitted,

Sara Redding Wilson

Cc: The Honorable Sandra D. Bowen
Mary Habel
Angie Murphy
Eugene Raney

Annual Report on Ombudsman Activities and Services: FY 2005

Office of State & Local Health Benefits Programs
Department of Human Resource Management

In accordance with § 2.2-2818 of the Code of Virginia, the role of Health Benefits Ombudsman was established in the Department of Human Resource Management, then the Department of Personnel and Training, February 1, 2000, pursuant to legislation passed by the 1999 General Assembly. In accordance with § 2.2-2818 of the Code of Virginia, this report is submitted by the Ombudsman to the Joint Commission on Health Care and the standing committees of the General Assembly with jurisdiction over insurance and health.

The Ombudsman works within the Office of State and Local Health Benefits Programs (OHB) in the Department of Human Resource Management (DHRM). The Ombudsman and his staff, the Employees Services team of OHB, have continued to accomplish the responsibilities set forth in the Code of Virginia. The Ombudsman's staff consists of two Senior Health Benefits Specialists, two Health Benefits Specialists, a Retiree Specialist and a Medical Appeals Examiner who is a licensed registered nurse.

The Ombudsman is the point of contact for approximately 92,000 State employees and 23,000 local government employees in The Local Choice Program who are covered by the State and Local Health Benefits Programs. The Ombudsman and his staff assist covered employees in understanding their rights and the processes available to them according to their state health plan. In addition, the Ombudsman and his staff assist covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Also, the Ombudsman and Employee Services staff are the resource for over two hundred and fifty human resource Benefits Administrators statewide who administer health benefits within State agencies and seek assistance with Program administration and policy application from the Ombudsman. Further, the Ombudsman manages the quarterly training for agency Benefits Administrators and also conducts statewide employee meetings when changes occur in employee health benefits and upon request.

The Ombudsman and his Employee Services staff carry out the duties defined for the Ombudsman in the enabling legislation. The Ombudsman works closely with the Office of the Attorney General, which is the Ombudsman's primary resource for advice and counsel concerning appeals, legal concerns, and issues of equity.

ACTIVITY DURING FISCAL YEAR 2005

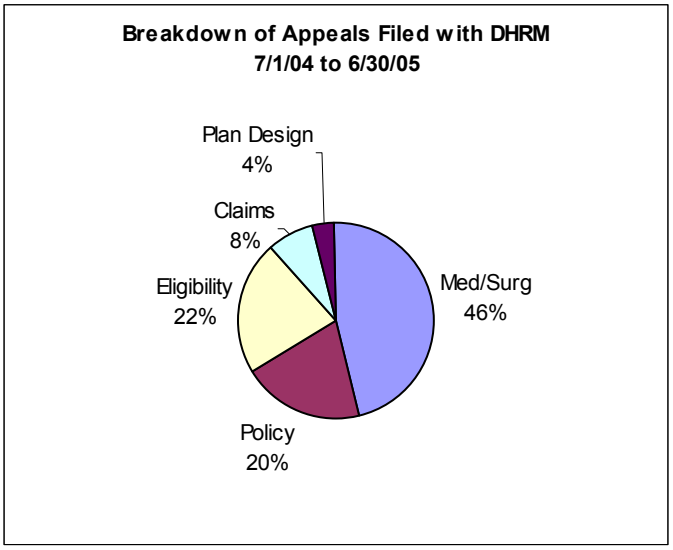
During fiscal year 2005, the Ombudsman recorded 2,296 formal case-specific inquiries from employees, agency Benefits Administrators, health care contractors, legislators, providers and

other interested parties. Inquiries for general information were not formally recorded. Inquiries take the form of correspondence, e-mails, telephone calls, and in-person consultations.

The majority of formal contacts with the Ombudsman and the Employee Services staff in FY 2005 pertained to:

- Coverage for medical or surgical services under the COVA Care plan, administered for the Commonwealth by Anthem, and
- Plan design, eligibility, or administrative policy

During FY 2005, there were 85 formal appeals to the Director of DHRM. Of these, 39 were medical in nature, while 46 were administrative and related to policy, eligibility, plan design, or claims. In all cases of appeal, every effort is made to assure that appellants receive the full extent of the benefits to which they are entitled under the rules of the Program. There is a strong emphasis placed on facilitating employee understanding of the Program and providing assistance to employees who encounter difficulties navigating the sometimes complex provisions and obligations related to employee health care, contract, and policy. The Ombudsman and his Employee Services staff strive to resolve appeals as early in the process as possible.



In the instance of a *medical or mental health appeal,* when an employee's plan appeals have been exhausted, the employee has the right to appeal a denial of coverage to DHRM. Likewise, when policy issues are unresolved at a lower level, the employee has the right to appeal to the Director of DHRM. The Ombudsman is charged with oversight of the appeals process and he or a member of his Employee Services staff is the contact for appellants throughout the process.

Each appellant is offered the opportunity for an informal fact finding consultation (IFFC) with the Director of DHRM. The Ombudsman and his staff conduct in-depth research on behalf of the appellant and the Director and develop a packet of information that is given to both prior to the fact-finding. This packet includes: all information containing relevant contract or policy

provisions, full case-related information, and a chronology of relevant actions and communications. During the fact finding, the appellant is asked to describe the issue as he sees it, and to state the relief he seeks. The appellant has the opportunity to fully present his issue and ask questions. The Director and Ombudsman then collaborate with the appellant concerning the issue and determine any additional information that may be useful to the independent review process. The Ombudsman and his Employee Services staff assist with the development of all additional information and are responsible for developing a complete body of case-specific medical information for expert review by the independent third party clinical review entity, MAXIMUS Center For Health Dispute Resolution (MAXIMUS CHDR). Once all information is accumulated, including medical information provided by the plan, the entire package goes to MAXIMUS CHDR. If the medical appeal is resolved early in the process, it is not necessary to request external clinical review.

MAXIMUS CHDR is responsible for reviewing denials of care appealed by employees and their dependents covered by the Commonwealth's self-funded health insurance plans. Such reviews pertain only to the issue of medical necessity, which is defined as a service requested to treat an illness, injury or pregnancy related condition, which a provider has diagnosed or reasonably suspects. To be medically necessary, the service must: 1) be consistent with the diagnosis of the condition; 2) be in accordance with standards of generally accepted medical practice; 3) not be for the convenience of the patient, the patient's family, or the provider; 4) be the most suitable cost-effective supply (i.e., medications, durable medical equipment, etc.) or level of service which can be safely provided; and 5) be a covered benefit under the Commonwealth's Health Benefits Plans.

MAXIMUS CHDR review personnel and consultant specialty physicians are impartial. They do not stand to personally benefit from their decisions and no undue influence is exerted upon them by the Department or any of its health care vendors. This impartial clinical review entity examines the final denial of claims to determine whether the decision is objective, clinically valid, and compatible with established principles of health care.

The decision by MAXIMUS CHDR is final and binding on DHRM. If MAXIMUS CHDR upholds the denial, the appellant is advised that he may appeal under the provisions of the Administrative Process Act, Rules of the Supreme Court, within 30 days of the final denial.

During the FY 2005, twenty-one (21) appeals were sent to MAXIMUS CHDR for independent external clinical review, of which fifteen (15) denials were overturned.

Concerning administrative appeals, the process is the same, with the exception of independent third party review. As with medical appeals, the Ombudsman and his staff conduct comprehensive research into the appellant's issue and formulate a body of information in a packet for the appellant and the Director. The Ombudsman and his assigned staff participate in the fact-finding and collaborate with the Director and appellant on the issues being appealed. The Director's decision is final and binding. As with medical appeals, once the Director has ruled on the case, if the denial is upheld, the appellant is advised that he may appeal under the

provisions of the Administrative Process Act, Rules of the Supreme Court, within 30 days of the final denial by the Director.

At the close of each fact-finding, whether medical or administrative, the appellant is asked to suggest any area where we may improve the appeals process, Program communications, or any other aspect of the Health Benefits Program. Feedback from employees who have experienced a problem is a very important tool for understanding how we may improve various aspects of the Program or communicate more effectively. The greater our understanding of employees' needs, the better we can serve those needs.

COMMUNICATIONS AND LIAISON WITH CONTRACTORS

The Ombudsman takes an active role in the development of communications for all State Health Benefits Program publications, web site information, and contractor communications to employees. The Ombudsman and his Employee Services staff constantly review communications from OHB and its various contractors (i.e., Anthem, Medco, Delta Dental, and ValueOptions). Furthermore, the Ombudsman and his Employee Services staff communicate frequently with contractors to discuss coverage, eligibility and claims issues.

A new contract for independent third party clinical review services was awarded to MAXIMUS CHDR following a Request For Proposal that was issued in February 2005. This contract is effective July 1, 2005 to June 30, 2007 with three subsequent one-year renewals available.

EFFECTIVENESS OF OMBUDSMAN'S ROLE

The Ombudsman and his Employee Services staff continue to make every effort to assure that employees receive the full extent of the benefits to which they are entitled under their health benefits plan. Included are examples of case summaries handled by the Ombudsman and his Employee Services staff:

Case # 1

Case # 1 involves a billing issue. This employee received a hospital bill for charges that Anthem denied. The member tried, without success, to resolve the matter with Anthem and the hospital. Anthem denied coverage for a number of hospital inpatient days because Anthem determined it was not medically necessary for the member to remain in the hospital. DHRM's Employee Services staff worked with an Anthem representative to resolve the problem. Because the hospital is a participating facility in Anthem's network, it should not have billed the member for services beyond the days approved by Anthem. Ultimately, all but $48.00 was dropped from the member's bill.

Case # 2

Case # 2 involves eligibility. A benefits administrator (BA) told an employee that he could not cover his grandchild. However, when the employee stated that he had custody of the child, the BA called the Ombudsman's Employee Services staff to discuss eligibility criteria. The staff member told the BA that DHRM's policy is to cover any child for whom an employee has permanent custody. The BA faxed the court papers to the Employee Services staff member and it was verified that the employee had permanent custody and that the child was eligible for coverage. The Employee Services staff member took the opportunity to educate the BA in what to look for on custody agreements to determine if a child would be eligible for coverage on an employee's health plan.

The Ombudsman and his Employee Services staff work to make sure that all cases are resolved within the bounds of OHB policies, rules and regulations. Some requests received by the Ombudsman and his Employee Services staff are not consistent with these policies, rules and regulations. Therefore, it is not possible to resolve every inquiry in the manner that employees may expect.

CONCLUSION

The Ombudsman and his Employee Services staff provides assistance to covered state employees and members of the Local Choice Program in understanding and accessing their health plan benefits. In addition employees are provided the necessary assistance in using all procedures and processes in place, including appeal procedures, in a fair and consistent manner. The Ombudsman and his Employee Services staff also assist Benefits Administrators statewide who seek assistance with the application and administration of health care policy. The Ombudsman and his Employee Services staff work to make sure that all employees are treated fairly and consistently, to manage the expectations of employees and to educate employees and Benefits Administrators regarding employee health benefits.

Respectfully submitted by:
Eugene R. Raney, Jr.
Associate Director and Ombudsman
December 1, 2005