OMBUDSMAN
Activities and Services
Fiscal Year 2007

ANNUAL REPORT

Department of Human Resource Management
Office of State and Local Health Benefits Program

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ON
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Office of State & Local Health Benefits Programs
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EXECUTIVE SUMMARY

This annual report on the activities of the Ombudsman for the Office of State and Local Health Benefits Programs covers the period from July 1, 2006 through June 30, 2007. During this time, the Ombudsman's team consisted of the Ombudsman, four (4) Senior Health Benefits Specialists, two (2) Health Benefits Specialists, one (1) Retiree Specialist and one (1) Medical Appeals Examiner. The Ombudsman's team assists covered employees in understanding their rights and the processes available to them according to their state health plan. Furthermore, the Ombudsman's team assists covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. The Ombudsman's team handled 9,881 formal case-specific inquiries and assisted with 53 formal appeals to the Director of the Department of Human Resource Management. The Ombudsman and his team continue to provide a valuable service to state employees and retirees and functions in accordance with the legislation that created the role in 2000.

INTRODUCTION

In accordance with §2.2-2818 of the Code of Virginia, the role of the Health Benefits Ombudsman was established February 1, 2000. 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.

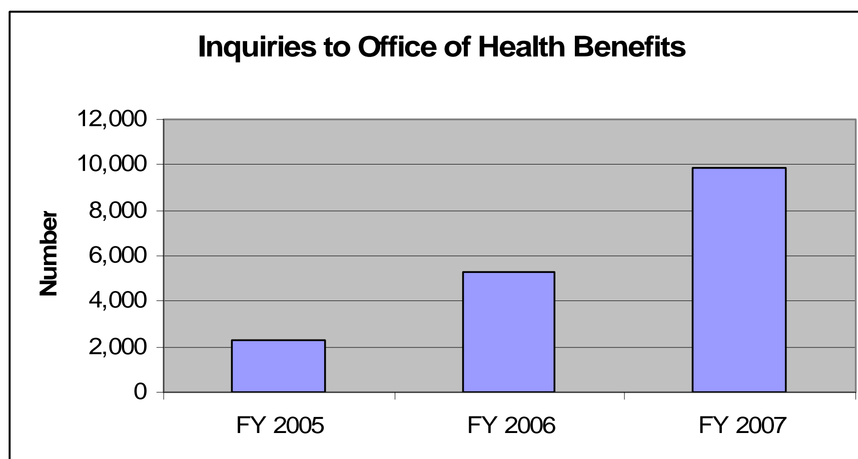
The Ombudsman works within the Office of State and Local Health Benefits Programs (OHB) in the Department of Human Resource Management (DHRM). During fiscal year 2007 (FY 2007), OHB underwent a reorganization to adapt to changing business needs, thus creating opportunities for learning and advancement and increasing effectiveness and efficiency. During this fiscal year, the Ombudsman's staff consisted of two (2) Health Benefits Specialists, a Retiree Specialist and a Medical Appeals Examiner who is a licensed registered nurse. Additionally, OHB employed four (4) Senior Health Benefits Specialists who did not report directly to the Ombudsman, but handled similar work with considerable input from the Ombudsman. Together, the Ombudsman, his staff and these Senior Specialists comprised the Ombudsman's team.

The primary objective of the Ombudsman's team is to assist covered employees in understanding their rights and the processes available to them according to their state health plan. The Ombudsman ensures that covered employees receive timely responses to their inquiries from him or the Employee Services staff. In addition, the Ombudsman's team assists covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures.

The Ombudsman's team serves approximately 85,000 State employees and 25,000 local government employees in the The Local Choice Program who are covered by the State and Local Health Benefits Programs. Furthermore, they serve approximately 27,000 State retirees. Total membership in the State and Local Health Benefits Programs is comprised of approximately 183,224 members (including dependents) in the plan for State employees, 43,000 members (including dependents) in the The Local Choice plan, and approximately 36,000 members (including dependents) in the plan for State retirees. Also, the Ombudsman's team is the resource for over 300 human resource Benefits Administrators and Managers statewide who administer health benefits within State agencies and seek assistance with Program administration and policy application from the Ombudsman. The Ombudsman's team also serves as a resource for approximately 237 Group Administrators in The Local Choice Program. 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.

INQUIRIES

During FY 2007, the Ombudsman's team recorded 9,881 formal case-specific inquiries from employees, retirees, agency Benefits Administrators, health care contractors, legislators, providers and other interested parties. The majority of formal contacts with the Ombudsman's team in FY 2007 pertained to eligibility and coverage for medical or surgical services for active employees and their dependents under the COVA Care plan. Examples of major issues involved in these inquiries include questions regarding: whether dependents are eligible for coverage and when they may be enrolled, eligibility for extended coverage following the termination of employment, rules governing medical and dependent care flexible reimbursement accounts, denial of services, and whether claims were properly paid. Inquiries for general information were not formally recorded. Inquiries take the form of correspondence, e-mails, telephone calls, and in-person consultations.



As indicated in the chart above, the number of inquiries to OHB has increased in each of the past few years. The total number of inquiries in FY 2007 represents an increase of over 4,500 inquiries over the prior year. This increase was due to several factors, including: FY 2007 representing the first full fiscal year that included the Medicare Part D plan, the implementation of various significant changes to the Health Benefits Plan (e.g., the free flu shot program, the implementation of the COVA High Deductible Health Plan, the enhanced wellness benefit, the upcoming E-Z Reimbursement Card for flexible reimbursement accounts), and the increasing complexity of medical technology, care and procedures.

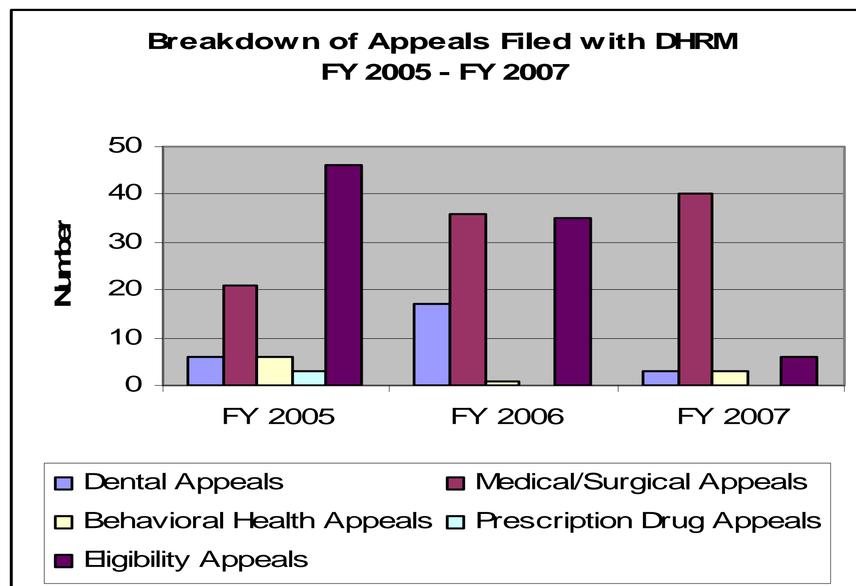
During FY 2007, the formal contacts with the Ombudsman's team included 2,549 inquiries from retirees, most of which involved the Medicare Part D plan for retiree medications, known as YOURx Plan. This is a Medicare-approved prescription drug plan offered by Medco that became available January 1, 2006, to Medicare-eligible group members participating in the State Retiree Health Benefits Program. The Ombudsman's team, as well as the entire OHB staff, has been committed to providing assistance to our retiree group by working closely with Medco on issues as they arise.

APPEALS

Every effort is made to assure that all appellants receive the full extent of the benefits to which they are entitled under the rules of the Program. There is a strong emphasis 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. The Ombudsman is charged with oversight of the appeals process and he or a member of his team is the contact for appellants throughout the process. The Ombudsman's team strives to resolve appeals as early in the process as possible. In a number of cases, employees contacting OHB to discuss submitting an appeal have their issue resolved favorably before the appeal is formally filed.

There are two kinds of appeals. Those that involve plan eligibility pertain to whether or not an employee and/or dependent is qualified to receive coverage under the State Health Benefits Program. Medical appeals involve medical, dental, prescription drug and behavioral health issues. When eligibility issues are unresolved at a lower level, the employee has the right to appeal to the Director of DHRM. Similarly, when an employee exhausts his/her medical, prescription drug, dental or mental health plan appeals, the employee has the right to appeal the denial of coverage to DHRM.

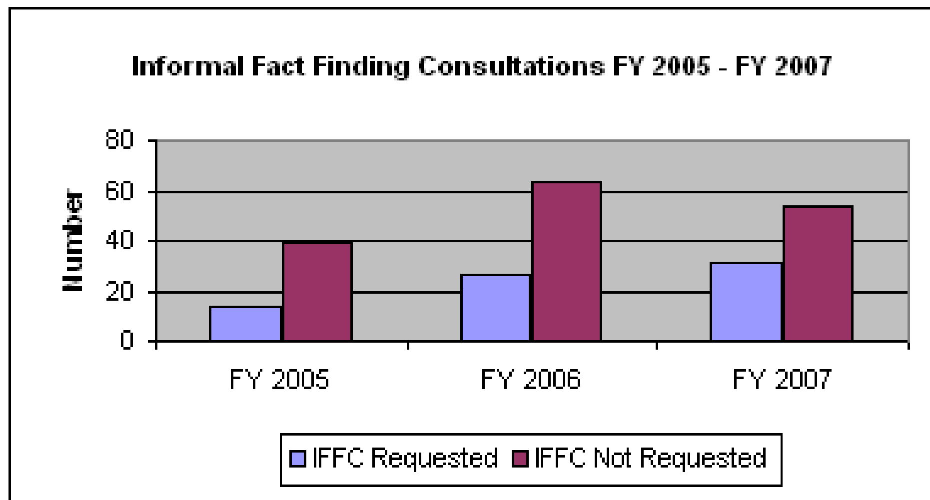
During FY 2007, there were 53 formal appeals to the Director of DHRM. Six (6) of these related to COVA Care eligibility and 46 were medical. One (1) appeal related to a flexible reimbursement account. Additionally, with intervention by the Employee Services staff, seven (7) appeals were resolved without going through the full appeal process. The total number of formal appeals to the Director of DHRM during FY 2007 represents a 40.4% decrease in the total number of appeals (89) from the previous year. This decrease was attributable in large measure to the continued and ongoing efforts of OHB to resolve issues outside of the appeal process, thus resulting in fewer appeals to OHB and greater member satisfaction.



During the last three fiscal years, the number of appeals involving eligibility issues has decreased by 87%, attributable to resolving issues outside the appeal process and carefully reviewing what is and is not appealable at DHRM. During the same period, the number of medical appeals increased by 90%. This increase was due in part to the increasing complexity of medical technology, care and procedures.

When a health plan member appeals to the Director of DHRM, the opportunity for an informal fact finding consultation (IFFC) with the Director is offered to the appellant. If the appellant chooses not to have an IFFC, the case will be decided based on the evidence submitted by the appellant and the health plan.

Fourteen (14) IFFCs were conducted during this fiscal year. The Ombudsman's team conducts in-depth research on behalf of the appellant and the Director. A packet of information is then developed and given to both the appellant and the Director prior to the IFFC. This packet includes all information containing relevant contract or policy provisions, full case-related information (including relevant medical records), and a chronology of relevant actions and communications. During the IFFC, the appellant is given the opportunity to describe the issue as he sees it, state the relief he seeks and ask questions. The Director and Ombudsman then collaborate with the appellant concerning the issue and determine any additional information that may be useful in deciding the appeal. The Ombudsman's team assists with the development of all additional information.



The percentage of appellants requesting an informal fact finding consultation with the Director of DHRM has decreased from 36% in FY 2005 to 26% in FY 2007. This may be related to the fact that a higher percentage of appeals now concern medical issues. It is possible that appellants may believe that an IFFC is not necessary because their medical records provide sufficiently relevant and convincing evidence.

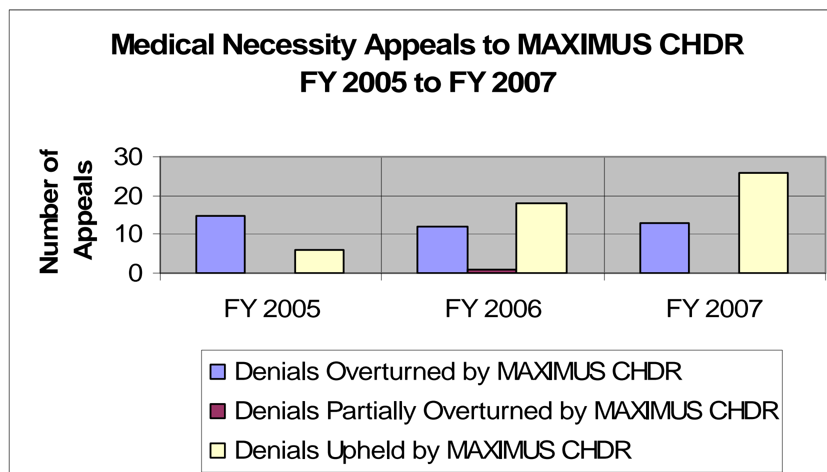
An independent review is not required for appeals involving eligibility issues or medical appeals involving contractual issues. After thorough review of the evidence, the Director

decides these appeals and communicates decisions to appellants by letter. The Director's appeal decision is final and binding.

For appeals pertaining to medical necessity, DHRM has a contract with MAXIMUS Center for Health Dispute Resolution (MAXIMUS CHDR) to conduct an independent, impartial third party review. Medical necessity 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.

For appeals involving medical necessity, the Ombudsman's team sends the entire case record to MAXIMUS CHDR to be reviewed. After reviewing the material, MAXIMUS CHDR renders a decision, which is binding on DHRM. After MAXIMUS CHDR sends its decision to DHRM, the Director of DHRM makes the final decision relating to the appeal and communicates that decision, in writing, to the appellant. As with all appeals, if the denial is upheld, the appellant is advised that he may appeal under the provisions of the Administrative Process Act (APA), Rules of the Supreme Court, within 30 days of the final denial by the Director. There were three (3) APA appeals filed during FY 2007. However, none of these appeals were resolved prior to the end of the fiscal year.

During FY 2007, 39 appeals were sent to MAXIMUS CHDR for independent external clinical review. Of those, 13 denials were overturned.



While the number of appeals overturned by MAXIMUS CHDR during the last few years has not changed considerably, the annual percentage of denials overturned by MAXIMUS CHDR has decreased from 71% in FY 2005 to 33% in FY 2007. Most of the denials upheld involved services that MAXIMUS CHDR considered to be experimental or investigational. DHRM relies on MAXIMUS CHDR's network of highly qualified

clinical reviewers, consisting of board-certified physicians, dentists or other certified health care practitioners, to provide clear and impartial reviews based on evidence and accepted standards of practice.

When MAXIMUS CHDR overturns a medical decision, the Ombudsman and the Appeals Examiner provide information regarding the decision to the plan administrator who issued the initial denial so that the administrator is able to learn from the final decision. In this way, the Ombudsman and the Appeals Examiner facilitate the evolution of standards of care, thus promoting continuous improvement in the administration of the health plan. The relative decrease in the number of denials overturned by MAXIMUS CHDR is due in large part to this feedback provided by the Ombudsman and the Appeals Examiner.

CUSTOMER FEEDBACK

At the close of each IFFC, 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 improving the Program, because the Program regularly acts on employees' suggestions. 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's team constantly reviews communications from OHB and its various contractors (i.e., Anthem, Medco, Delta Dental, and ValueOptions). Furthermore, the Ombudsman's team communicates frequently with contractors to discuss coverage, eligibility and claims issues.

During FY 2007, the Ombudsman's team continued to assist and educate employees in understanding their rights and available processes under their health plan, including the appeals process. In July 2006, DHRM updated its Web site and revised the State Health Benefits Programs Appeal Form to clarify DHRM's appeals process.

Additionally, *Spotlight*, published by DHRM, periodically includes a column entitled, "The Ombudsman Responds." This featured article provides employees the opportunity to ask questions and receive answers from the Ombudsman concerning health care benefits and health plan procedures and processes, including the appeals process.

The Ombudsman also presented the Ombudsman's Road Show during the fall of 2006. This Road Show consisted of a series of meetings for employees across the state and was designed to provide additional information outside of the standard Open Enrollment meetings. The Ombudsman's Road Show gave employees the opportunity to discuss health benefits issues and ask questions of the Ombudsman. Efforts such as this also help to promote the continuous improvement of the State's health plan.

TRAINING

In March 2007, the Ombudsman and several members of his team attended an intensive three-day General Mediation Training session. This training session was designed to provide attendees with a thorough understanding of the mediation process and to develop skills for effective mediation. This training enhanced practical skills such as active listening and patience, thus improving the team's effectiveness.

KEY INTERVENTIONS AND RESULTS

As outlined throughout this report, the Ombudsman's team made many efforts to maximize the accessibility and effectiveness of the health benefits plan. Below are examples of some key activities of the Ombudsman's team during FY 2007.

OHB worked closely with ValueOptions in the aftermath of the tragedy on the Virginia Tech campus in April 2007, to ensure that the mental health needs of the faculty and staff were being met. The Ombudsman was involved with the daily briefings between OHB, ValueOptions, and Virginia Tech staff during this time.

One example of the Ombudsman's team's efforts to correct systemic issues was accomplished when the Ombudsman identified inconsistencies involving claims that were present in a number of appeals. Together with other OHB staff, the Ombudsman worked with a vendor to modify their system for dealing with providers who submit claims with incorrect codes. As a result of these efforts, the vendor has increased its efforts to work with providers concerning the use of correct procedure codes when filing claims. Safeguards have been put into place by the vendor to ensure that correct procedure codes are being used. This was accomplished by organizing support within OHB and asking a series of questions of the vendor that identified flaws in their system. Once the vendor recognized the flaws, the vendor instituted the necessary changes to correct the systemic problem without further intervention by OHB. Similar efforts were undertaken to review and update the process for managing benefits related to air ambulance services, resulting in a better process for employees and their dependents.

CONCLUSION

In the pursuit of excellence, the Ombudsman's team continues to focus on providing assistance to covered state employees and retirees 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's team also assists Benefits Administrators statewide who seek assistance with the application and administration of health care policy. The Ombudsman's team works to make sure all employees are treated fairly and consistently, manage the expectations of employees and educate employees and Benefits Administrators regarding employee health benefits.