OMBUDSMAN
Activities and Services
Fiscal Year 2009

ANNUAL REPORT

Department of Human Resource Management
Office of State and 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 (OHB) covers the period from July 1, 2008 through June 30, 2009. The Ombudsman's team helped to resolve issues encountered by employees and their covered dependents involving access and eligibility for health care under the Commonwealth's Health Benefits Program. As part of its responsibilities, the team assisted covered employees in understanding their rights and the processes available to them through the program. The team also guided covered employees in using the procedures and processes available to them through their health plan, including all appeal procedures.

In fiscal year 2009, the Ombudsman's team handled 5,573 formal case-specific inquiries and assisted with 65 formal appeals. The team's goal of continuous improvement was achieved by working to resolve issues and solve problems as they arose and by carefully examining the facts to identify and correct systemic issues. Working with employees, retirees, OHB staff, and the Health Benefits Program's third-party vendors, the Ombudsman's team identified and facilitated the correction of at least five significant systemic issues during this year.

The Ombudsman's team continued to provide a valuable service to State employees and retirees 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 this fiscal year, the Ombudsman's team consisted of two Health Benefits Specialists, four Senior Health Benefits Specialists and a Medical Appeals Examiner who was a licensed registered nurse. Core groups within OHB supplemented the needs of the Ombudsman's team when expertise was needed or when there was a spike in volume. This flexibility allowed the team to work efficiently and effectively, producing timely and appropriate responses to members' issues.

The primary objective of the Ombudsman's team was to help covered employees understand their rights and the processes available to them through their State Health Benefits Program, including all appeal procedures. A key aspect of the Ombudsman's role was to ensure that covered employees received timely responses from the team.

The Ombudsman's team served approximately 86,000 State employees and 28,000 local government employees in the The Local Choice Program during the fiscal year who were covered by the State and Local Health Benefits Programs. In addition, they served approximately 40,000 State retirees, dependents, survivors and Long Term Disability (LTD) participants who participated in the retiree group. The Local Choice Health Benefits Program had approximately 48,000 members including employees, dependents and early retirees. It also covered about 1,500 local government and school system Medicare retirees.

The Ombudsman's team was the resource for over 300 human resource Benefits Administrators and Managers statewide who administered health benefits within State agencies and sought assistance with Program administration and policy application from the Ombudsman. Team members also served as a resource for approximately 262 Group Benefit Administrators in The Local Choice Program. The Ombudsman worked closely with the Office of the Attorney General, which was the Ombudsman's primary resource for advice and counsel concerning appeals, legal concerns, and issues of equity.

INQUIRIES

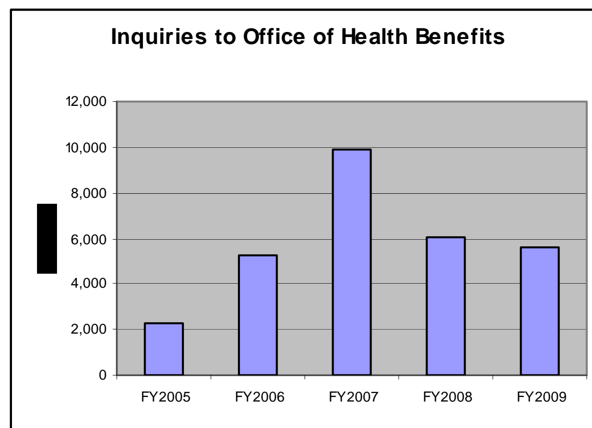
During FY 2009, the Ombudsman's team responded to 5,573 formal case-specific inquiries from employees, retirees, agency Benefits Administrators, health care vendors, legislators, providers and other interested parties. The majority of formal contacts with

the Ombudsman's team in FY 2009 pertained to eligibility and coverage for medical or surgical services for active employees and their dependents under the COVA Care plan. The COVA Care plan is a Preferred Provider Organization (PPO) plan, and was the most popular option to state employees available under the Health Benefits Program.

Examples of major issues involved in these inquiries included questions regarding:

- whether dependents were eligible for coverage and when they may have been enrolled
- eligibility for extended coverage following the termination of employment
- rules governing medical and dependent care flexible reimbursement accounts
- denial of coverage, and
- whether claims were properly paid.

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



To fully understand the significance of this chart, it is helpful to first address the number of inquiries received during the period from FY 2005 through FY 2008. Overall, the number of inquiries continued to increase during that period, with a dramatic spike in FY 2007. There were several reasons for the changes in activity during these years. FY 2007 was the first full fiscal year that included the Medicare Part D prescription drug plan, known as YOURx Plan, which became available January 1, 2006 to Medicare-eligible group members in the State Retiree Health Benefits Program. Also, FY 2007 saw the implementation of various significant changes to the Health Benefits Program, such as the free flu shot program, the introduction of the COVA High Deductible Health Plan, and the enhanced wellness benefit.

Historically, whenever significant changes have been made to the Health Benefits Program, the Ombudsman's team has recorded a corresponding increase in inquiries from agency Benefits Administrators and members seeking information to understand the impact of the changes. Over time, the volume of calls typically has subsided, as members become more familiar with the nuances of the program. Consistent with this cycle, the number of inquiries decreased dramatically in FY 2008 as members became more

accustomed to the various plans and benefit enhancements implemented during FY 2007. For example, the Ombudsman's team fielded far fewer inquiries involving Medicare Part D in FY 2008 as retirees became more familiar with this program. In FY 2007, retirees generated 2,549 inquiries, and in FY 2008 they accounted for 1,267 inquiries.

The chart above shows that the Ombudsman's team handled fewer inquiries in FY 2009 than it did in 2008, and about the same number in FY 2009 that it handled in FY 2006. This count of unique inquiries is more conservative than in prior years because of a new Customer Relationship Management (CRM) system implemented in late FY 2008 to keep track of customer contacts. The CRM system is more sophisticated than previous tracking tools used by OHB, and it allows the Ombudsman's team to enter multiple contacts with a single customer in regard to the same issue as part of the same unique case. Previous systems required each new contact to be entered as a separate new case. Therefore, in reality, the Ombudsman's team handled a similar number of unique inquiries during FY 2009 as it did in FY 2008, and more in FY 2009 than it did in FY 2006. CRM will allow accurate and consistent year-to-year comparisons going forward.

As always, the work of the Ombudsman and his team was dynamic. As issues were resolved, other issues requiring attention invariably arose. Two new initiatives announced during FY 2009 resulted in a significant number of inquiries. First, OHB developed the COVA Connect plan for members living in certain zip code areas in Tidewater. Second, OHB implemented a Dependent Eligibility Verification Audit to identify and remove ineligible dependents covered under the Plan, and a corresponding amnesty period for declaring and removing ineligible dependents without penalty. Although both of these initiatives did not officially roll out until the early part of FY 2010, they were both announced in the Spring 2009 Spotlight published in April 2009 and preparation was under way for both in the Spring of 2009.

In regard to COVA Connect, major issues included the benefit and cost design of the program relative to COVA Care and the methodology for determining which members were eligible for the program. In regard to the Dependent Eligibility Verification Audit, most inquiries centered around the rules governing dependent eligibility.

It is important to recognize that health care continues to grow more complex as advances are made in medical technology, care and procedures. Much of the overall increase in recorded inquiries between FY 2005 and FY 2009 was due to the ever-increasing complexity of health care. As a result, in the aggregate, individual inquiries continue to grow more complex and take more time to resolve.

APPEALS

Every effort was made to assure that all appellants received the full extent of the benefits to which they were entitled under the rules of the Program. There was a strong emphasis on facilitating employee understanding of the Program and providing assistance to employees who

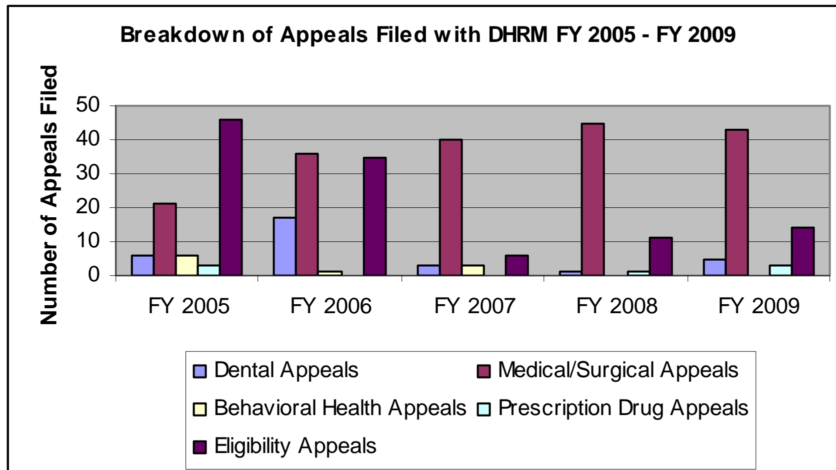
encountered difficulties navigating the sometimes complex provisions and obligations related to employee health care. The Ombudsman was charged with oversight of the appeals process and he or a member of his team was the contact for appellants throughout the process. The Ombudsman's team strove to resolve appeals as early in the process as possible.

Whenever a new appeal was received, it was first evaluated to determine whether the initial denial was clearly a substantive error. If it was a substantive error, the decision was reversed early in the process, relieving the appellant of the burden and stress associated with going through the entire appeal process and correspondingly increasing customer satisfaction. It should be noted that appeals were only resolved early in the process if the resolution was in favor of the appellant. These efforts resulted in significant financial savings for plan members and the Commonwealth. On average, whenever a case was resolved favorably for the appellant early in the process, it reduced costs to process the appeal by approximately 71%. Furthermore, in a number of cases, employees who contacted OHB to discuss submitting an appeal had their issue resolved favorably before the appeal was formally filed.

There were two kinds of appeals. One type of appeal involved plan eligibility, meaning that these appeals pertained to whether or not an employee and/or dependent was qualified to receive coverage under the State Health Benefits Program. The other kind, medical appeals, involved medical, dental, prescription drug and behavioral health issues. When specific criteria were met, the employee had the right to appeal unresolved eligibility issues to the Director of DHRM. In regard to medical appeals, the third party vendors responsible for administering the medical, prescription drug, dental or mental health components of the Health Benefits Program each had internal appeal processes. When an employee exhausted his or her appeals with a specific vendor, the employee had the right to appeal the denial of coverage to DHRM.

During FY 2009, there were 65 formal appeals to the Director of DHRM. Many of these appeal cases were complicated and required extensive work to prepare the member's file for external review.

Thirteen (13) appeals related to eligibility and 51 were medical. One appeal involved a contractual issue (coordination of benefits). The total number of formal appeals to the Director of DHRM during FY 2009 represented an 11% increase in the total number of appeals, up from 58 the previous year.



From FY 2005 through FY 2009, the number of appeals involving eligibility issues decreased by approximately 72%. This decrease can be traced to changes in the member handbook and appeals form in July 2006 to clarify that certain issues were not appealable to DHRM. In regard to eligibility issues, this clarification indicated that matters in which the sole issue was disagreement with policies, rules, regulations, contract or law were not appealable. While this exclusion existed prior to 2006, emphasizing it in the handbook and on the appeals form resulted in improved communication with members, thus increasing member understanding and satisfaction. At the same time, it reduced the number of invalid appeal requests submitted.

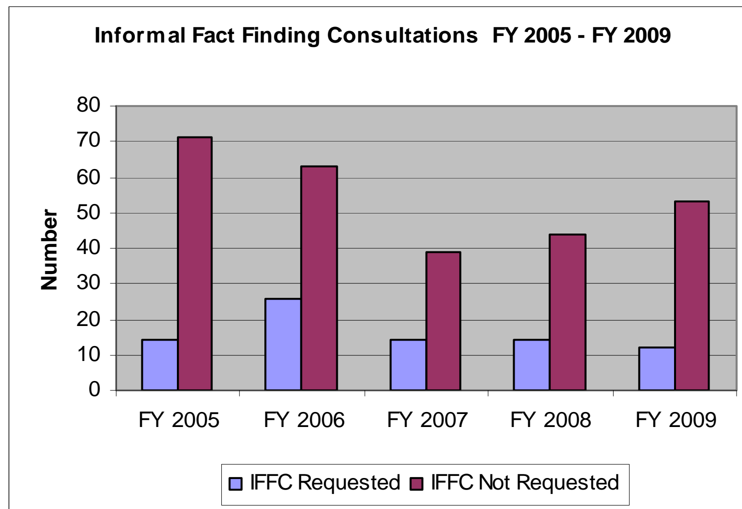
The Ombudsman's team also used other strategies to ensure that employees, retirees and their dependents received coverage to which they were entitled, and these strategies sometimes had the effect of reducing appeals to DHRM. For example, the Ombudsman's team regularly monitored appeal trends and used the data so that OHB continuously improved the administration of the State Health Benefits Program. In recent years, the Ombudsman's team has taken every opportunity to see that employees are educated about the importance of enrolling dependents within the required time period, after receiving a number of appeals involving this issue.

In regard to medical appeals, beginning in July 2006, the member handbook and the appeals form were changed to clarify that issues could not be appealed when involving contractual exclusions, matters in which the sole issue was disagreement with policies, rules, regulations, contract or law and claim amounts above the allowable charge billed by a non-participating provider. Furthermore, issues involving claim amounts or coverage denials when the member's cost was less than $300 were deemed not to be appealable, so that the State Health Benefits Program's treatment of low-cost claims was consistent with the State Corporation Commission's Bureau of Insurance appeal rules for managed care plans. Although these issues were not appealable, whenever a member raised such an issue, the case was treated as an inquiry and the issue was evaluated to ensure that the member's claim was handled correctly. As a result, the Ombudsman and his team changed the delivery channel for analyzing de minimis claims, improving cost effectiveness while continuing to thoroughly investigate member's issues, and reducing

processing costs by approximately 79% per case. During the last two fiscal years, the number of medical appeals remained relatively stable, but likely would have increased if these efforts to increase efficiency and effectiveness had not been undertaken.

When a health plan member appealed to the Director of DHRM, the opportunity for an informal fact finding consultation (IFFC) with the Director was offered to the appellant. If the appellant chose not to have an IFFC, the case was decided based on the evidence submitted by the appellant and the Health Benefits Program.

Twelve (12) IFFCs were conducted during this fiscal year. Seven (7) IFFCs pertained to medical issues and five (5) were related to eligibility issues. The Ombudsman's team conducted in-depth research on behalf of the appellant and the Director. A packet of information was then developed and given to both the appellant and the Director prior to the IFFC. This packet included 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 was given the opportunity to describe the issue as he or she saw it, state the relief he or she sought and ask questions. The Director and Ombudsman then collaborated with the appellant concerning the issue and determined any additional information that could be useful in deciding the appeal. The Ombudsman's team assisted with the development of all additional information.

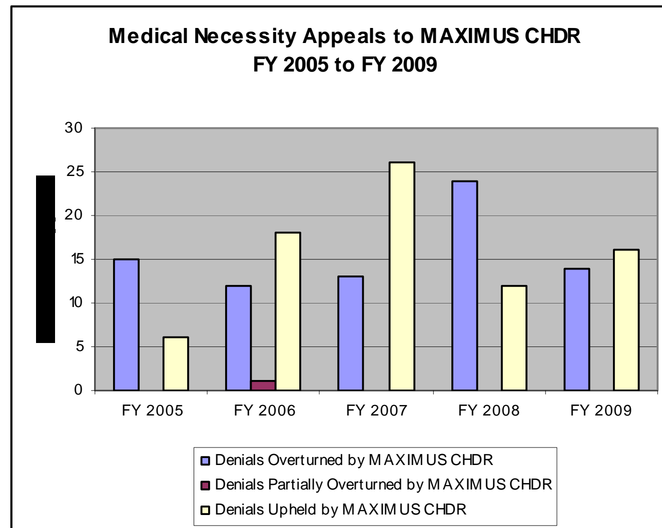


As depicted in the chart above, the number of appellants requesting an IFFC with the Director of DHRM remained consistently low compared to the number of appeals requested. A relatively high percentage of appeals concerned medical issues. Anecdotal evidence suggested that many appellants believed that an IFFC was not necessary because their medical records provided sufficiently relevant and convincing evidence. During FY 2009, 18% of appellants requested an IFFC.

For appeals pertaining to medical necessity, DHRM had a contract with MAXIMUS Center for Health Dispute Resolution (MAXIMUS CHDR) to conduct an independent,

impartial third party review. Medical necessity was defined as a service requested to treat an illness, injury or pregnancy-related condition which a provider had diagnosed or reasonably suspected. To be medically necessary, the service had to: 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 Programs.

For appeals involving medical necessity, the Ombudsman's team sent the entire case record to MAXIMUS CHDR to be reviewed. After reviewing the material, MAXIMUS CHDR rendered a decision, which was binding on DHRM. After MAXIMUS CHDR sent its decision to DHRM, the Director of DHRM made the final decision relating to the appeal and communicated that decision, in writing, to the appellant. During FY 2009, 30 appeals were sent to MAXIMUS CHDR for independent external clinical review. Of those, 14 denials were overturned.



From FY 2005 through FY 2007, there was a downward trend in the number of appeals overturned by MAXIMUS CHDR. However, in FY 2008, the annual percentage of denials overturned increased by approximately 46%. Most of the denials that MAXIMUS CHDR overturned during FY 2008 involved services that were considered by the third party vendor to be experimental or investigational, and 50% of them involved a single medical test which had recently been developed to predict recurrence of breast cancer and was consistently deemed experimental by the vendor. After identifying this trend, the Ombudsman, along with other OHB staff, initiated discussions with the vendor, which eventually changed its guidelines and approved this test when specific criteria was met. Incidentally, the vendor also applied the same updated criteria to its commercial plans. Thus, the efforts of the Ombudsman and his staff potentially resulted in an improved standard of care for many Virginians. After the new guidelines were implemented, the number of appeals involving this test dropped substantially. Primarily

as a result of this development, in FY 2009, the number of denials overturned by MAXIMUS CHDR decreased and the number of denials upheld increased.

DHRM relied 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.

As evidenced by the example above, when MAXIMUS CHDR overturned a medical decision, information regarding the decision was provided to the vendor who issued the initial denial so that the vendor was able to learn from the final decision. In this way, the Ombudsman's team facilitated the evolution of the standards of care, and thus promoted continuous learning and improvement in the administration of the Health Benefits Program.

An independent review was not required for appeals involving eligibility issues or medical appeals involving contractual issues. After thorough review of the evidence, the Director decided those appeals and communicated decisions to appellants by letter. The Director's appeal decision was final and binding.

In all appeals to DHRM, if the original denial was upheld, the appellant was 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 was one APA appeal filed during FY 2008, and the Court's decision in that case was still pending at the end of FY 2008. However, in FY 2009, that appeal was decided and the Court upheld the denial. One (1) APA appeal was filed during FY 2009 involving an eligibility issue. The outcome of that appeal was still pending at the close of FY 2009.

CUSTOMER FEEDBACK

Inquiries from plan members and appeals were handled case by case. Frequently, plan members who submitted inquiries were asked to provide feedback. Furthermore, at the close of each IFFC, the appellant was asked to suggest any area where OHB may improve the appeals process, Program communications, or any other aspect of the Health Benefits Program. Feedback from employees who experienced a problem was a very important tool for improving the Program, because the Program regularly acted on employees' suggestions. The more that OHB understood the needs of employees, the better OHB was able to serve those needs. In particular, feedback from employees informed several communication efforts, including efforts to educate members in regard to their wellness benefits and the rules involving adding and dropping dependents.

Inquiries from Benefits Administrators provided rich data for the Health Benefits Program. Their feedback was used in similar ways to that of employees. Furthermore, whenever similar questions were received from several Benefits Administrators, it

indicated potential training opportunities, and these patterns were communicated to OHB staff responsible for training new and experienced Benefit Administrators. These efforts resulted in improved training.

A State Health Benefits Program Customer Satisfaction Survey for FY 2009 indicated 88% of respondents rated customer service as "good" to "excellent." This compares to 95% for FY 2008. The decrease in the customer service rating for FY 2009 was attributable to several factors, notably the introduction of COVA Connect and the Dependent Eligibility Verification Audit in Open Enrollment communication materials, and a delay in distribution of these communication materials to employees. The new programs represented significant change initiatives, and, not surprisingly, they were received with apprehension by some State employees, contributing to slightly lower customer satisfaction ratings. With regard to the delay in communication materials, the unique nature of the COVA Connect project and the extensive approval process it required at various levels of government impacted OHB's ability to provide information in advance to employees. Historically, OHB has consistently been committed to providing timely communications related to health benefits, and so this delay negatively affected ratings. Throughout the year, whenever the Ombudsman's team encountered a customer who expressed any level of dissatisfaction, every effort was made to resolve issues successfully.

COMMUNICATIONS AND LIAISON WITH CONTRACTORS

The Ombudsman oversaw the development of communications for all State Health Benefits Program publications, Web site information, and vendor communications to employees. The Ombudsman and his team constantly reviewed communications developed for OHB and from its various vendors (i.e., Anthem, Optima, Medco, Delta Dental, and ValueOptions). Furthermore, the Ombudsman's team communicated frequently with vendors to discuss coverage, eligibility and claims issues. During this fiscal year, the Ombudsman participated, with other OHB staff, in an extensive project to revise all Health Benefits Program's member handbooks to reflect benefit changes that became effective for the plan year beginning July 1, 2009. Additionally, a member handbook was written and published for the COVA Connect Health Benefits Plan.

During this fiscal year, the Ombudsman, working extensively with other OHB staff, participated in the development of COVA Connect. Among other efforts, the Ombudsman worked to ensure that the benefit structure was similar to that of the COVA Care program, reviewed all communication materials, toured some of the vendor's facilities, and reviewed the vendor's appeal procedures.

During this fiscal year, the Ombudsman, along with other OHB staff, reviewed the process of approving alternative benefits which may be available to Health Plan members when benefits for a specific service have been exhausted. Such benefits are provided at the discretion of the Health Plan when it is determined that alternative services are

medically necessary and cost effective for the Health Plan. During this review process, a form was developed to be used by a third-party vendor, detailing the rationale for the Health Plan, when coverage of alternative benefits is being considered.

During FY 2009, as in previous years, 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.

TRAINING

During FY 2009, the Ombudsman served as an ex officio member of the Board of Directors of the United States Ombudsman Association (USOA). Through relationships with other ombudsmen, the Ombudsman stayed abreast of best practices in the field. The Ombudsman co-facilitated a USOA training workshop for new ombudsmen, instructing participants in critical skills including communication, investigation, reporting, and emotional intelligence. Informally, the Ombudsman provided coaching as appropriate to members of his team.

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 Program. Below are examples of some key activities of the Ombudsman's team during FY 2009.

The Ombudsman led an extensive project in which he and other OHB staff worked very closely with the Information Technology Department to refine the CRM system designed to track and manage customer contacts through telephone calls, e-mails, letters and faxes. By periodically refining CRM, OHB ensured that CRM was and will remain an important tool for OHB in its efforts to achieve continuous improvement in all business areas.

The Ombudsman's team recognized the importance of identifying and resolving systemic issues. Therefore, the team consistently analyzed issues, paying particular attention to emerging trends, to determine whether they involved systemic problems. The Ombudsman and his team helped to correct at least five significant systemic issues during FY 2009. One key example involved incorrect claim processing. In these cases, inconsistencies were discovered in the way several claims were paid by one of OHB's third-party vendors. Upon investigation, it was learned that due to systems issues, this vendor paid some claims in error. Working with other OHB staff, the Ombudsman's team held a series of meetings with the vendor to discuss and resolve this matter. One outcome of these meetings was that the vendor corrected these systems problems and reimbursed the Program for claims paid in error without detrimental impact on the

participant. Another outcome was that the vendor took steps to educate its providers about proper billing and benefit exclusions.

The Ombudsman actively participated in all phases of the procurement processes for selecting vendors charged with administering medical, behavioral health, prescription drug, and dental services for active employees, early retirees, and their dependents. This extensive undertaking included tasks such as reviewing and editing the various Requests for Proposal, participating in pre-proposal conferences, reviewing proposals, conducting finalist interviews, and negotiating with vendors. Throughout, the Ombudsman's continued focus was on bringing the perspective of the everyday member to the process.

The Ombudsman participated in a number of employee meetings in the Tidewater area during the Open Enrollment period of April and May 2009. The emphasis of these meetings was on educating members in regard to COVA Connect.

The Ombudsman participated extensively in the development process for the Dependent Eligibility Verification Audit, with an emphasis on ensuring that the process was fair and equitable for all members.

CONCLUSION

In the pursuit of excellence, the Ombudsman's team focused on delivering quality service in a cost-effective manner to covered State employees and retirees and members of the Local Choice program. The Ombudsman and his team continued to provide a valuable service to State employees and retirees, Local Choice enrollees, and their dependents, making a real difference in a number of ways. As always, the team continued to solicit and act on customer feedback. The team thoroughly investigated inquiries and appeals, dealing with each issue fairly and consistently. The team paid particular attention to trends as they developed in order to identify and resolve systemic issues, thus promoting continual and lasting improvement of the State's Health Benefits Program. In doing so, the Ombudsman and his team made a positive impact on OHB's vendors, both for employees and retirees of the State and the general public.

As the State's Health Benefits Program moves into the next fiscal year, the Ombudsman and his team remain committed and look forward to providing valuable services to members covered under the Program and the citizens of Virginia. The Ombudsman and his team will continue to be mindful of their responsibility to act efficiently and effectively, always striving to meet high standards in a cost-effective manner.