OMBUDSMAN
ANNUAL REPORT
Fiscal Year 2012

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

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ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
Fiscal Year 2012

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

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, 2011 through June 30, 2012. The Ombudsman's team helped to resolve issues encountered by employees, retirees 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 available health plan resources.

In fiscal year 2012, the Ombudsman's team handled 5,142 formal case-specific inquiries and reviewed 113 formal appeals. The team achieved its goal of continuous improvement by:

- working to resolve issues and solve problems as they arose,
- consistently analyzed issues, paying particular attention to emerging trends,
- worked to update policies and communications related to the issues,
- carefully examining the facts to identify and correct systemic issues, and
- making every effort to maximize the accessibility and effectiveness of the Health Benefits Program.

Key interventions during this fiscal year include:

- The Health Benefits Appeals Process - the Ombudsman worked extensively with the appeals examiner to ensure that the appeals process for the program was compliant with the provisions for appeal reviews in the federal Affordable Care Act (ACA). In doing so, the Ombudsman and health benefits team accomplished the following:
  - Worked with DHRM staff to secure the services of additional independent review organizations.
  - Updated the state regulations.
  - Revised plan member handbooks and web resources with the updated appeals review process.
  - Coordinated with the plan administrators and review organizations to ensure their procedures were compliant with the state's program and their communications reflected the new process.

- Commonwealth Wellness, Preventive Care & Incentive Programs – The team assisted with the plan administrators and DHRM management to analyze the outcomes of the various wellness, disease management and incentive programs within the health plan. Special projects included:

    - A comparison of the Commonwealth's health program with the health benefits programs for several other states,
    - Participation in a Wellness Panel Discussion with other state governments, and
    - The implementation of a Diabetes Management Incentive for the state's program.

- Customer Relationship Management (CRM) - The Ombudsman and team continued to work to further refine the CRM system designed to track and manage customer contact.

- Dependent Eligibility Definition – With the revision of the "eligible dependent child" definition under the program, the team worked to ensure communications were updated and responded to numerous inquiries regarding the implementation of this provision of federal health care reform.

The Ombudsman's team continued to provide a service needed by 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 former Ombudsman was promoted to the position of Director of the Office of Health Benefit Programs, and a new Ombudsman, with over thirty years experience in health benefits administration, was appointed. The Ombudsman's team consisted of two Health Benefits Specialists, five Senior Health Benefits Specialists and a Medical Appeals Examiner. Core groups within OHB supplemented the needs of the Ombudsman's team when additional expertise was required or when there was a spike in volume. This flexibility allowed the team to work efficiently and effectively, producing timely and appropriate responses to member issues.

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

The Ombudsman's team served approximately 92,000 state and 29,000 and local government employees and retirees during the same period. The State Health Benefits Program had approximately 192,000 members, including employees, dependents and early retirees. The Local Choice Health Benefits Program averaged approximately 49,000 members. In addition, the team served about 41,000 state retirees, dependents, survivors and long term disability (LTD) participants in the retiree group. In total, the Ombudsman's team served 282,000 state and local government employees, retirees, and their family members during this report period.

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 300 Group Benefit Administrators in The Local Choice Program. The Ombudsman's team provided services to over 600 human resource professionals during this period.

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.

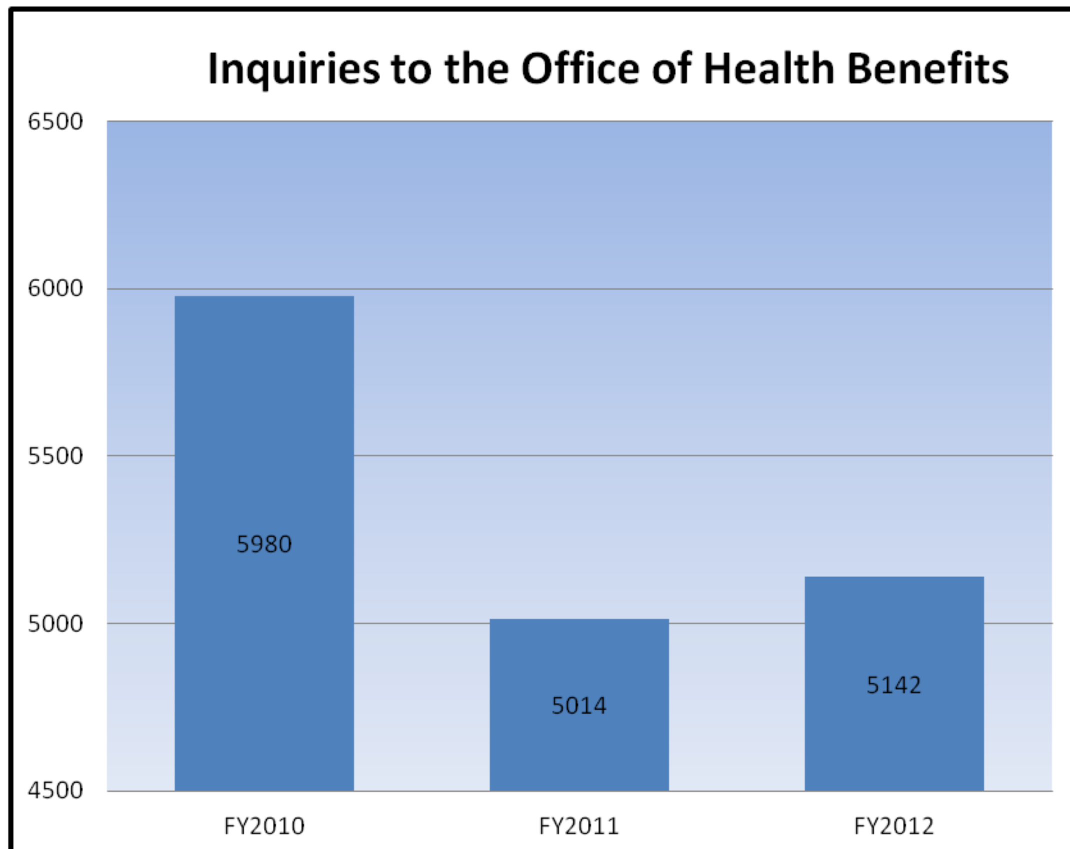
INQUIRIES

During FY 2010, the Office of Health Benefits implemented COVA Connect in the Hampton Roads area and performed the Dependent Eligibility Verification Audit (DEVA). These initiatives resulted in approximately 6,000 inquiries mainly from employees wanting clarification on the audit procedures and the benefit procedures under the COVA Connect plan.

The majority of inquiries for the 2011 fiscal year centered on the extended dependent eligibility provision of national health care reform. The revised dependent eligibility requirements were effective under the state program effective July 1, 2011.

In FY 2012, the Ombudsman's team handled 5,142 formal case-specific inquiries from employees, retirees, agency Benefits Administrators, health care vendors, legislators, providers and other interested parties. The top issues for formal contacts with the Ombudsman's team during the 2012 fiscal year were related to:

- health plan elections and allowable changes to member elections,
- eligibility requirements for dependents,
- benefits available under the program, and
- annual open enrollment changes, including statewide choice between COVA Care and COVA Connect and health care premiums.



APPEALS

Charged with the oversight of the appeals process, the Ombudsman or a member of the team serves as the contact for appellants. 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 are two categories of appeals:
1. Plan benefit appeals which involve claim issues, and
2. Plan eligibility appeals which involve whether an individual qualifies for coverage under the program.

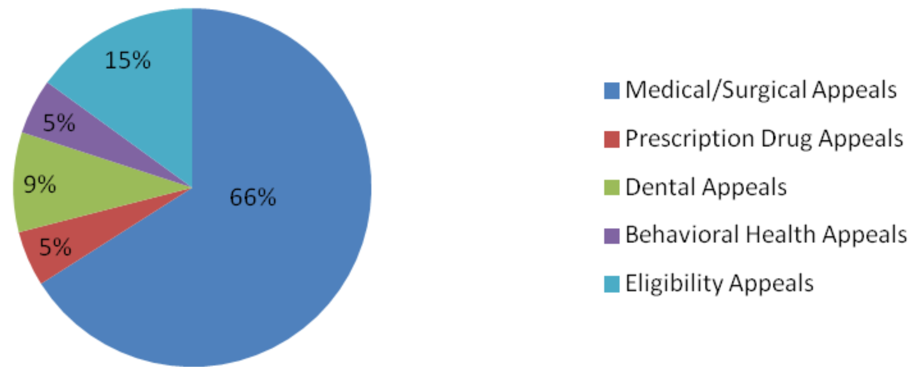
Each of the third party vendors responsible for administering the components of the Health Benefits Program has an internal process for benefits appeals. When an employee has exhausted the appeals with a specific vendor, they have the right to appeal any adverse decision to DHRM. When specific criteria are met, the employee has the right to appeal unresolved eligibility issues to the Director of DHRM.

Previously, DHRM did not accept appeals for specific excluded benefits, unless the adverse determination was based on the medical necessity of the service, and the member's cost was greater than $300. Due to health care reform, the guidelines were revised for FY 2012 allowing members to appeal any adverse benefit determination by a plan administrator that is based on the plan's requirements for

- medical necessity,
- appropriateness,
- health care setting,
- level of care,
- effectiveness of a covered benefit, or
- because the service is determined by the administrator to be experimental or investigational.

During the 2012 fiscal year, 113 appeals were submitted to the Director of DHRM. This compares to seventy-five (75) appeals for each of the last two fiscal years or an increase of 51% in the number of appeals. For FY 2012, seventy-five (66%) of the formal plan appeals related to medical/surgical issues while the second largest appeal category (15%) were related to eligibility issues.

FY 2012
Breakdown by Appeal Type

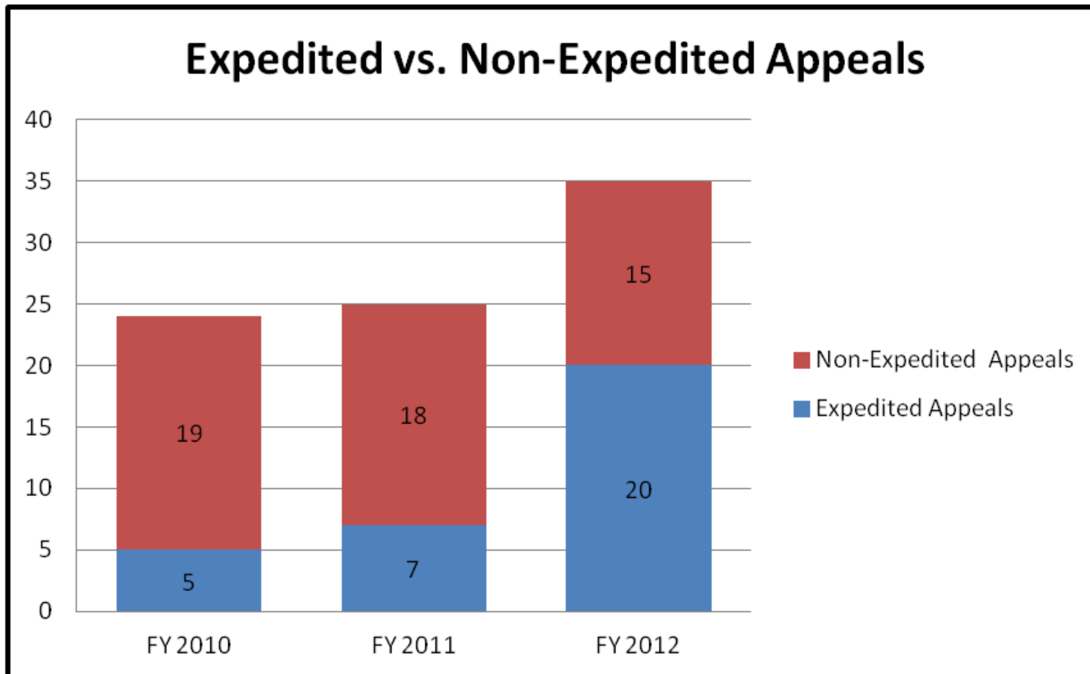


Once received by DHRM, the Ombudsman's team strives to resolve the appeal as early in the process as possible. Under the program, matters in which the sole issue is a disagreement with policy or a contractual exclusion are not appealable. Although these matters are not appealable, each case is evaluated to ensure that the program rules and benefits have been applied correctly.

Each issue is evaluated to determine whether the denial was clearly in line with the provisions of the program and no substantive error was made in the initial review process. In many cases, DHRM is able to resolve the issue in the member's favor by working with the health plan vendor and/or the member. These appeals are only resolved in this phase if the resolution is in favor of the appellant.

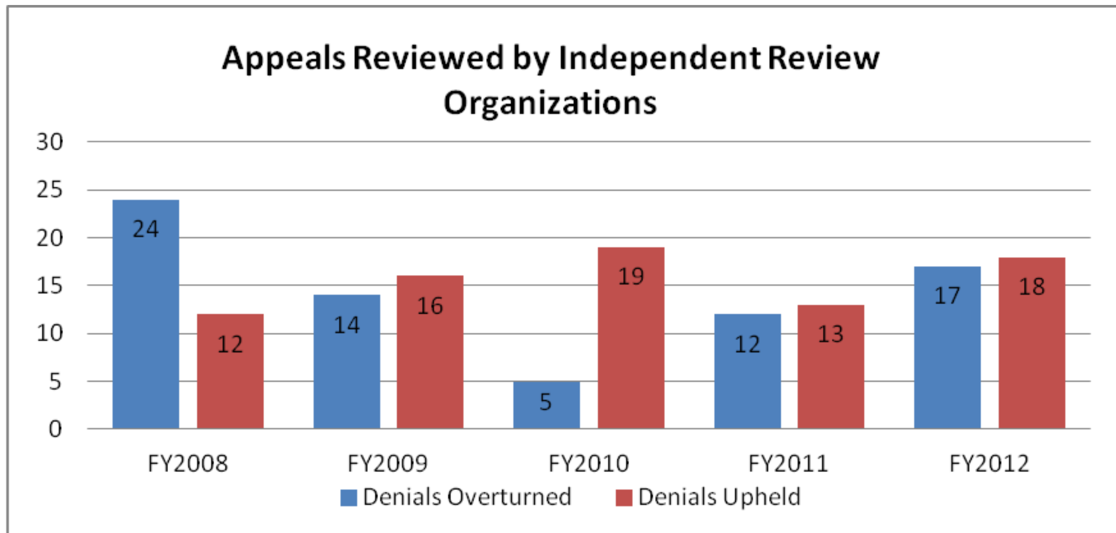
During FY 2012, 69% of the appeals received were resolved within five business days. Forty-three (43) appeals were resolved by DHRM without the need for an external review and thirty-eight (38) were determined to be non-appealable issues. The remaining thirty-five (35) appeals were handled through the independent third party review process.

In specific circumstances, members may file an expedited appeal for adverse benefit determinations and a final decision must be rendered in a shorter, specific time period. While the program previously included provisions for expedited appeals, the expedited appeal process was a point of emphasis under health care reform. Of the thirty-five appeals handled through the formal process this fiscal year, twenty or 57% were handled as expedited appeals with decisions being rendered within 72 hours.



An adverse determination of coverage for plan benefit appeals is reviewed by an independent review organization (IRO). Prior to this fiscal year, DHRM has a contract with one vendor, MAXIMUS Center for Health Dispute Resolution, to conduct independent third party reviews. In accordance with health care reform provisions, DHRM secured the services of two additional vendors, Permedion and IPRO, to perform independent reviews. Cases are assigned to the IROs on a rotational basis. It is the responsibility of the IRO to confidentially examine the final denial by the plan administrator and determine whether the decision is objective, clinically valid and compatible with established principles of health care. DHRM relies on the IRO to provide impartial reviews based on evidence and accepted standards of practice. Once the IRO has made a decision, a written notification is provided to the member, DHRM, and the plan administrator.

Of the thirty-five appeals reviewed by an IRO this fiscal year, seventeen or 49% of the adverse determinations were overturned or reversed. When a medical decision is overturned, the final decision is discussed in detail with the specific plan administrator. In this way, the Ombudsman's team facilitates the evolution of the standards of care, and thus promotes continuous learning and improvement in the administration of the Health Benefits Program. In the last few years, there were specific services that emerged as a prevailing issue with our appeal reviews. While the majority of the appeals this fiscal year were due to denials of services felt to be "experimental, and/or investigational" by the plan administrator, there was not a specific theme identified for the type of services being appealed.



An independent review is not required for appeals involving eligibility issues. When the issues deals involve whether an individual qualifies for coverage, the opportunity for an informal fact finding consultation (IFFC) with the Director is offered to the appellant. The Director and Ombudsman then collaborate with the appellant concerning the issue; reviewing any additional information that could be useful in deciding the appeal. After thorough review of all information provided, the Director makes a determination on the appeal and communicates the decision to the appellant by letter. The Director's appeal decision is final and binding. There were no IFFCs requested during the FY2012 fiscal year.

In all appeals to DHRM, if the original 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. No APA appeals were filed in FY 2012.

COMMUNICATIONS AND LIAISON WITH VENDORS

The Ombudsman is involved in the development of communications for all State Health Benefits Program publications, Web site information, and vendor communications to members. The Ombudsman and her team constantly review communications developed by OHB, as well as by the plan's third party administrators (i.e., Anthem, Optima, Medco, Delta Dental, and ValueOptions).

Along with other staff, the Ombudsman regularly participates in vendor meetings to improve coordination among vendors responsible for administering the health care plans. For example, the Ombudsman participated in meetings with Optima Health to assess the ongoing administration of the COVA Connect plan including the disease management incentive programs. Providing incentives to members has the potential to help lower costs and improve health outcomes. Since the early results of the pilot incentive program for diabetes management were positive, the Commonwealth rolled out a statewide incentive program for members enrolled in both COVA Care and COVA Connect on 7/1/2012.

Furthermore, the Ombudsman's team communicates frequently with all plan vendors to discuss coverage, eligibility and claims issues. The Ombudsman also participates in all applicable vendors' quarterly and annual meetings with OHB.

CONCLUSION

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

As the State's Health Benefits Program moves into the next fiscal year, the Ombudsman's team will strive to meet the highest standards in the most cost-effective way possible, and looks forward to continuing to provide needed services to members covered under the program and to the citizens of Virginia.