COMMONWEALTH of VIRGINIA

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November 29, 2016

The Honorable Frank Wagner
The Honorable Stephen Newman
The Honorable Charles Carrico, Sr.
The Honorable Terry G. Kilgore
The Honorable Robert D. Orrock, Sr.

Dear Senator Wagner, Senator Newman, Senator Carrico, Delegate Kilgore and Delegate Orrock,

The Code of Virginia, §2.2-2818, specifies that the ombudsman charged with promoting and protecting the interest of covered employees under the state's health plan shall "report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year."

Attached for your review and consideration is the report prepared and submitted on November 29, 2016 in response to this requirement.

Respectfully,

Sharon S. Finn
Ombudsman
Office of Health Benefits Programs
VA Department of Human Resource Management

cc: The Honorable Nancy Rodrigues, Secretary of Administration
Sara Redding Wilson, Director, Department of Human Resource Management

OMBUDSMAN ANNUAL REPORT FISCAL YEAR 2016

Office of State and Local Health Benefits Programs

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ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
FISCAL YEAR 2016

EXECUTIVE SUMMARY

This annual report on the activities of the Ombudsman for the Office of State and Local Health Benefits Programs (OHB) for the Virginia Department of Human Resource Management (DHRM) covers the period from July 1, 2015 through June 30, 2016. During this fiscal year, 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 members in understanding their benefits, as well as their rights, and the processes available through the program. The team also guided covered members in the utilization of available health plan resources.

In fiscal year 2016, the Ombudsman's team handled 7,337 cases and reviewed 91 formal appeals. The team achieved its goal of continuous improvement by:

- working to resolve issues and solve problems in a timely manner;
- consistently analyzing issues, identifying emerging trends and working to correct systemic issues;
- updating policies and implementing new channels of communications; and
- making every effort to maximize the accessibility and effectiveness of the Health Benefits Program.

Key initiatives and projects managed during this fiscal year include:

- **2015-2016 Health Benefits Plans and Programs** - the Ombudsman continued to work with other DHRM employees on various components of the health plans, including a comprehensive health and wellness management program, MyActiveHealth. The team worked to modify the process to qualify for the premium rewards program, and worked on plan year updates to ALEX, the health benefits program online counseling tool. Working with members of the OHB Policy Team, the Ombudsman assisted in the development of member communications and handbooks and the team worked on the benefit and claims resolutions for all plans.

  The State Corporation Commission's Bureau of Insurance (BOI) handles complaints for full-insured health plans for the Commonwealth. The Ombudsman and Appeals Examiner met with the BOI to discuss patterns and trends for services submitted as consumer complaints and appeals to both offices. The complaints identified the balance billing practices for out-of-network air ambulance providers and charges for non-covered durable medical equipment, in particular the Zoll Life Vest. Our team continues to work with the health plan vendors to develop a communication strategy aimed at educating both the provider community and members regarding these services.

- **Capitol Square Healthcare -** the Ombudsman, along with other DHRM employees, worked with Virginia Commonwealth University Health Systems (VCUHS) and QuadMed® to develop policies, procedures and communications for an onsite health and wellness clinic in the Capitol Square area. The new clinic, Capitol Square Healthcare, opened in May 2016 on the James Monroe Building's Mezzanine.

- **Independent Review Organizations –** The Ombudsman and members of her team worked with the Director of Finance and Contracts to secure vendors to provide Independent Third Party Medical Review Services for the Health Benefits Program. The Request for Proposal (RFP) published October 19, 2015, required the submission of proposals by December 10, 2015. The proposals were reviewed, scored and negotiation sessions with the finalist conducted. The notice of our intent to award contracts to Maximus Federal Services Incorporated, Medical Consultants Network, and IPRO was issued on March 11, 2016.

- **Local Option Health Plan -** In 2016, SB 364(Chafin) was signed into law and directed DHRM to develop a local health plan option to operate with a single risk pool. The plan is being offered as an additional choice for schools, local governments and other political subdivisions. It will have one risk pool and one set of rates. Its benefit design will be similar to that of state employee health plans. The Ombudsman worked closely with the OHB policy team and Director on the ongoing development of the design and provisions of the plan which will be implemented in July 2018.

- **Affordable Care Act Provisions** - The Ombudsman worked with other DHRM employees on various provisions of the Affordable Care Act (ACA) during this fiscal year and continues work on future provisions. These include:
  - Mandate for reporting health care enrollment for plan members. The Ombudsman and OHB team members worked with state agencies and local employer groups to update the information in our eligibility system to ensure the accuracy of the information included on the report to the IRS regarding enrollment in qualified health coverage mailing 1095C forms to approximately 150,000 state and local employees in March 2016.
  - Summary of Benefits and Coverage (SBC) for the available State and The Local Choice (TLC) health plans to help members compare and understand the options.

The Ombudsman's team continued to provide services to state and local government 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). The primary objective of the Ombudsman and the team is to help eligible members understand their rights and the processes available through their State Health Benefits Program, including the appeals procedures. The Ombudsman's team consists of two Health Benefits Specialists, five Senior Health Benefits Specialists and an Appeals Examiner, who also serves as the Privacy Officer for the Office of Health Benefits. Core groups within OHB supplement the needs of the Ombudsman's team when additional expertise is required or when there is a spike in volume. This flexibility allows the team to work efficiently and effectively, producing timely and appropriate responses to member issues.

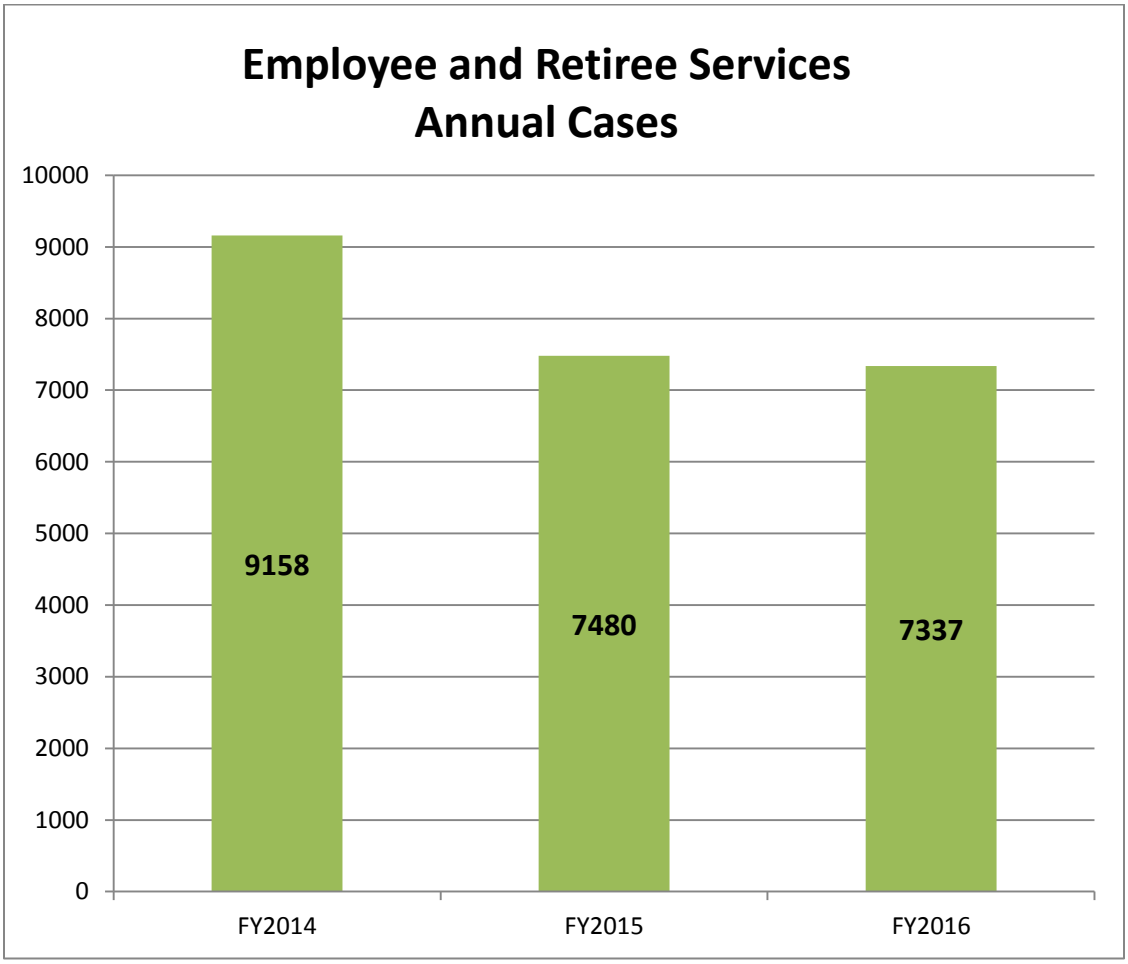
The State Health Benefits Program covered approximately 134,000 state employees and retirees during this fiscal year. The Local Choice Health Benefits Program covered 435 local employer groups. The employer groups provided benefits for approximately 47,000 employees and retirees of local school systems, governmental entities and political subdivisions. In total, the Ombudsman's team served over 300,000 state and local government employees, retirees, and dependents during fiscal year 2016.

The Ombudsman's team provided services to over 600 human resource professionals during this period. The team is 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. Team members also served as a resource for approximately 400 Group Benefit Administrators in The Local Choice Program.

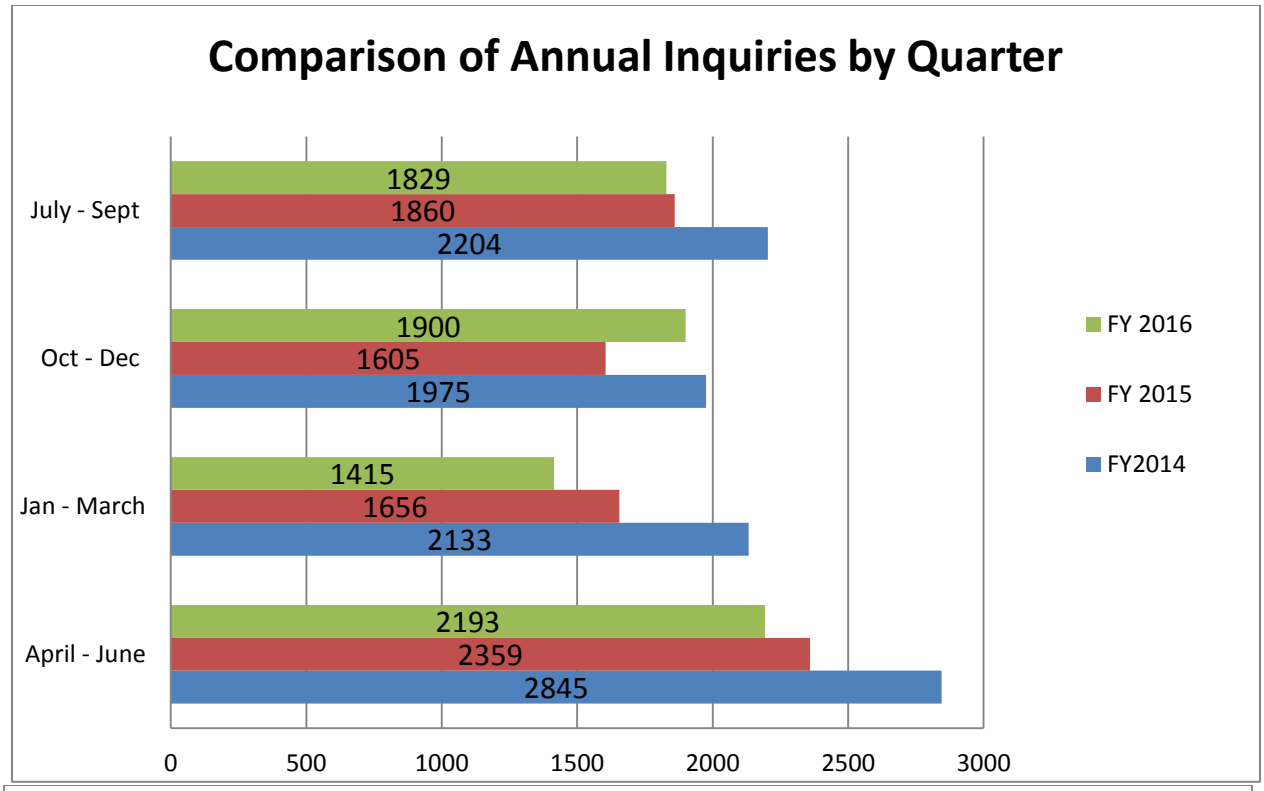
The Ombudsman worked closely with the Office of the Attorney General, which was the Ombudsman's primary resource for advice and legal counsel concerning appeals, compliance, and issues of equity. She also worked with the consulting services contractor who provides assistance in the design and administration of the State's health benefits programs particularly with respect to actuarial services, regulatory compliance, benefits design, and data integration.

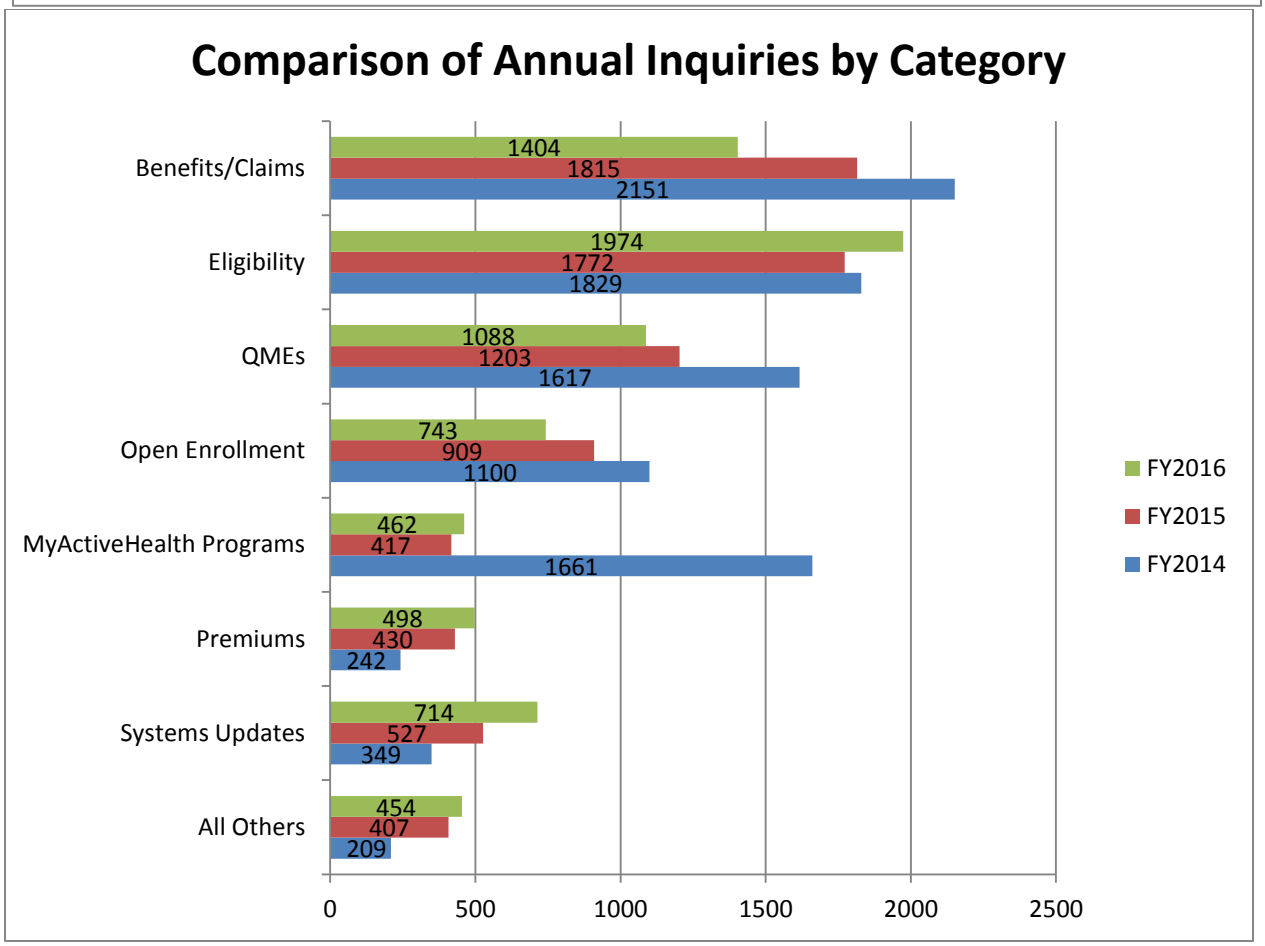
EMPLOYEE AND RETIREE SERVICES

In FY 2016, the Ombudsman's team handled 7,337 cases from employees, retirees, agency Benefits Administrators, legislators, providers, and other interested parties. These contacts included general inquiries and requests for assistance related to benefits, communications, vendor services, policy interpretation, system updates and complaints. It is important to note that cases may involve multiple contacts, such as emails and telephone calls, to resolve the issues. Depending on the issue, the team may contact the plan administrator or the benefits office to work through the process and provide a resolution for the member.



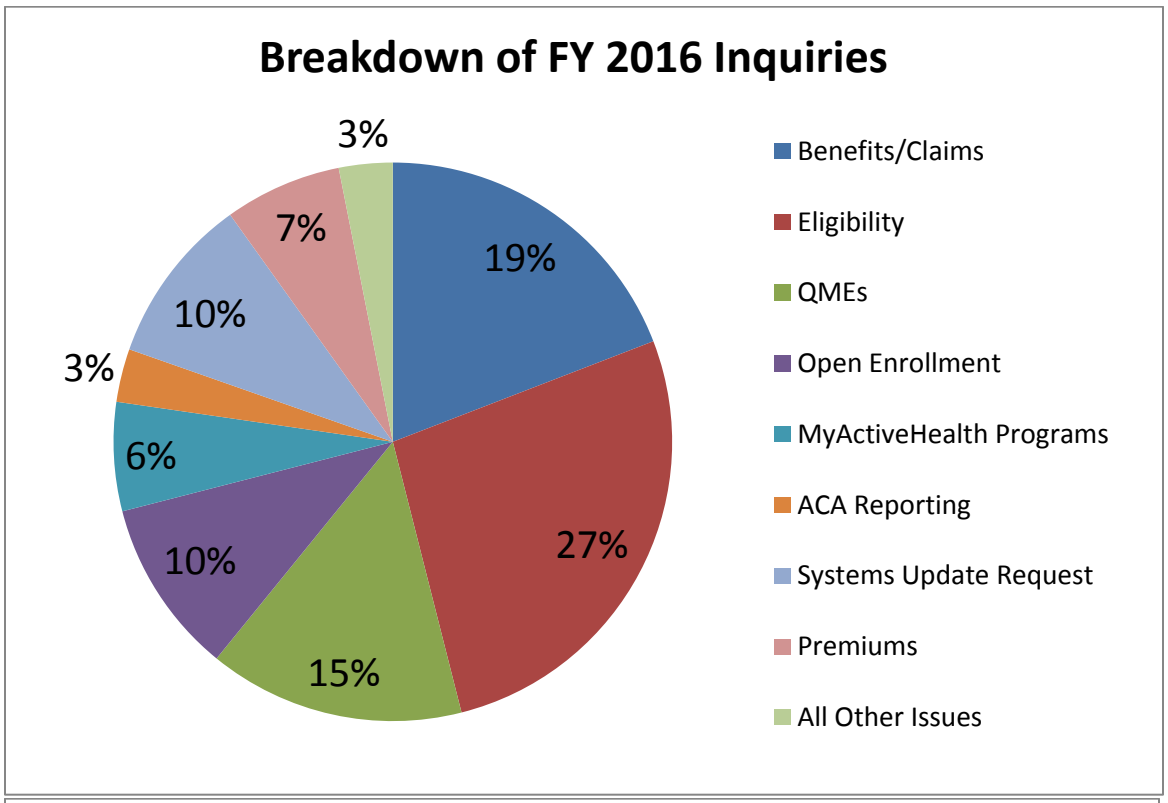
While reported cases decreased by 18% from FY 2014 to FY 2015, there was only a minimal decrease (less than 2%) in the caseload from FY2015 to FY 2016. Although the program implemented few changes to the health plan designs for the FY 2016 plan year, the introduction of a reduced copayment for physical therapy services under the COVA Care plan created a need for additional education and clarification on the benefit design. Our team addressed numerous inquiries explaining the differences in the physical therapy and spinal manipulation benefits for the plan.

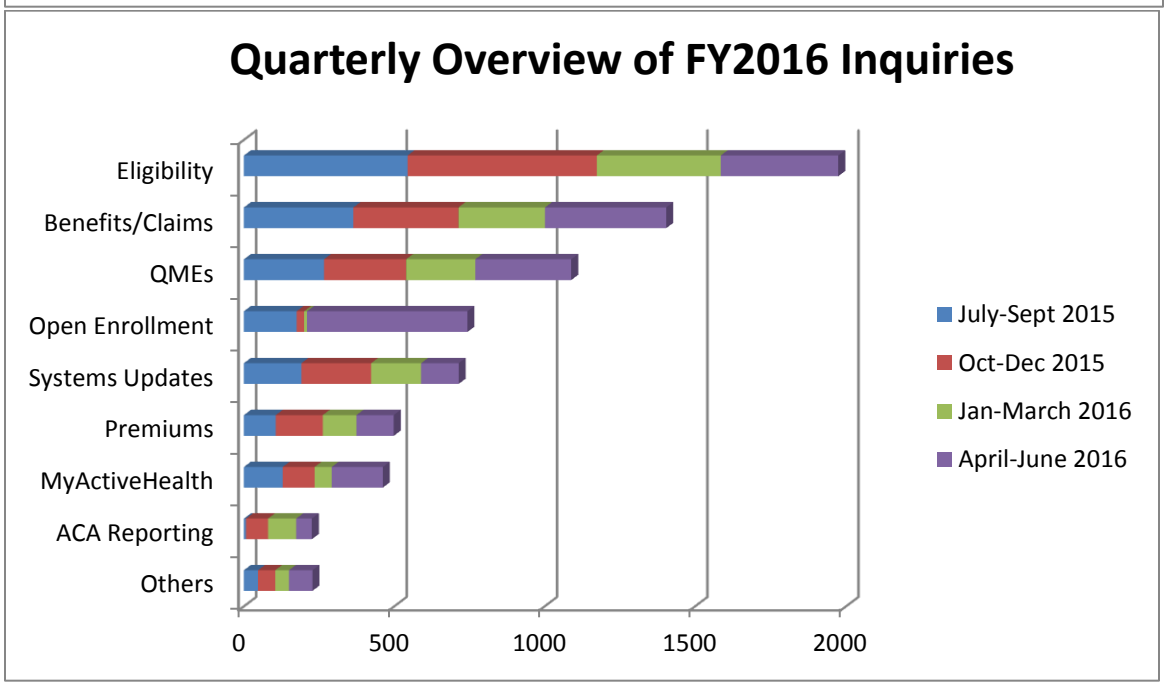

Comparison of Annual Inquiries by Quarter
July - Sept
1829
1860
2204
Oct - Dec
1900
1605
1975
Jan - March
1415
1656
2133
April - June
2193
2359
2845
0
500
1000
1500
2000
2500
3000
FY 2016
FY 2015
FY2014


Comparison of Annual Inquiries by Category
Benefits/Claims
1404
1815
2151
Eligibility
1974
1772
1829
QMEs
1088
1203
1617
Open Enrollment
743
909
1100
MyActiveHealth Programs
462
417
1661
Premiums
498
430
242
Systems Updates
714
527
349
All Others
454
407
209
0
500
1000
1500
2000
2500
FY2016
FY2015
FY2014

The major topics, which accounted for 61% of this fiscal year's cases and 64% of the cases for the 2015 fiscal year, were related to:

- eligibility requirements for employees, retirees, and dependents - 27%
- health care claims and benefits available under the program - 19%
- qualifying midyear events (QMEs) election change requests – 15%





The Office of Health Benefits (OHB) normally receives a consistent number of inquiries each quarter related to benefits and eligibility issues. Many of the eligibility and qualifying midyear event (QME) issues dealt with the program's dependent definition and the documentation required to support their eligibility. OHB received numerous agency requests for the review and approval of international adoption agreements, pre-adoptive agreements and custody agreements to ensure compliance with the program's provisions.

As in past years, the Open Enrollment inquiries, which accounted for 10% of the inquiries, were mainly received during the first and fourth quarters of the plan year. The inquiries received during the July through September period are normally participants trying to confirm their elections or correct errors made during the Open Enrollment process, while the contacts during April-June center on benefits and premium changes as well as clarification on how to qualify for various incentives, the communication materials, the enrollment process and deadlines. This year OHB also had an influx in the number of ACA inquiries due to the employer reporting mandate.

Affordable Care Act (ACA) Employer Mandate Reporting

The employer mandate provision of the Affordable Care Act (ACA) required employers, such as the Commonwealth, to offer minimum value, affordable health coverage to their full-time employees or face a penalty. To determine if the employers are offering minimum value, affordable coverage to their full-time workers, the Internal Revenue Service (IRS) requires reports from large employers. This is called Employer Mandate Reporting, or IRS Code Section 6056 Reporting.

DHRM, on behalf of the state agencies and local employers participating with the State and Local Health Benefits Program, compiled the calendar-year information about the health insurance coverage offered to employees and their covered family members and reported the information to the IRS. The employer mandate also required statements (Form 1095-C) to be provided to employees to show that the employees and other covered individuals complied with the individual shared responsibility provision of the ACA regarding qualifying health plan coverage.

The Ombudsman worked closely with the Systems Team and the Communications Manager to provide guidance and assist in the reconciliation of the agency's data in the benefits eligibility system to ensure compliance with the required reporting to the IRS on behalf of the state and local employer groups covered by our health program. IRS 1095-C forms were mailed to state and local health plan participants during March 2016 in compliance with the required deadline.

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.

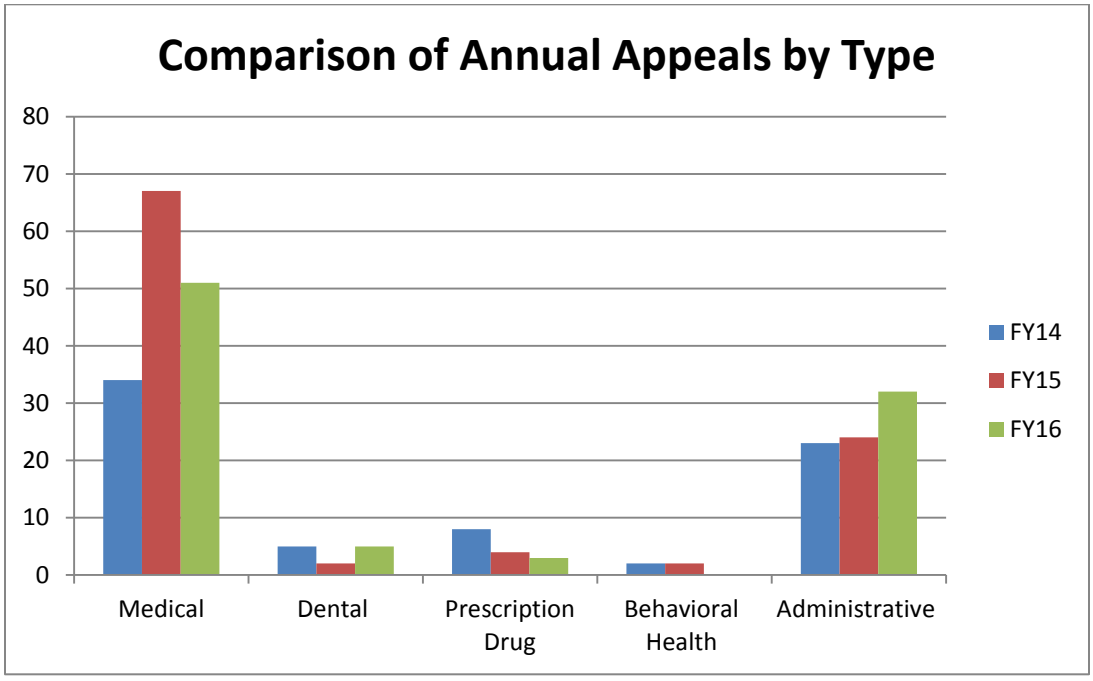
There are two classifications of appeals:

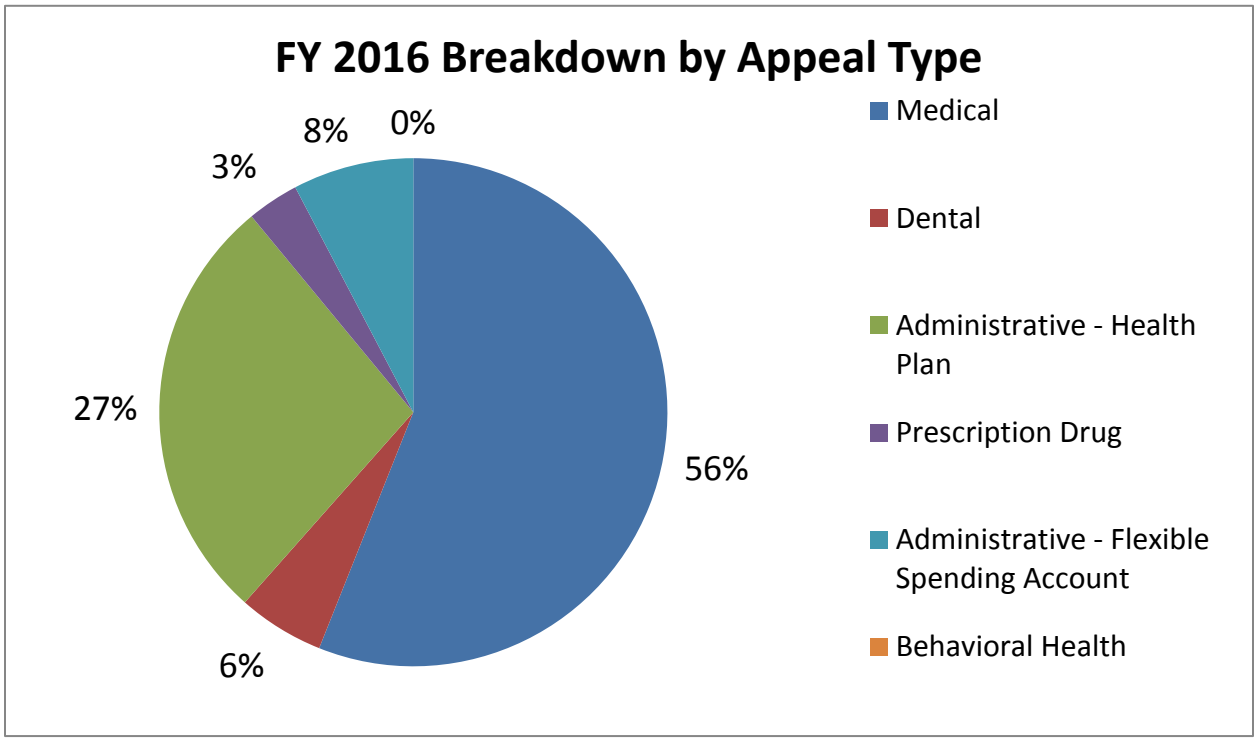
1. **Plan benefits** which involve claim and service issues, and
2. **Program administration** which involve whether an individual qualifies for coverage or a benefit under the program.

Each of the third party vendors responsible for administering the components of the Health Benefits Program has an internal process for benefits appeals. After exhausting the appeals with a specific vendor, an employee has 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.

Our appeal guidelines, which are compliant with the Affordable Care Act (ACA), allow members to appeal any adverse benefit determination by a plan administrator that is based on the plan's requirements for **medical necessity** and **appropriateness**, **health care setting** and **level of care**, **effectiveness** of a covered benefit, or services deemed to be **experimental** or **investigational**.

During the 2016 fiscal year, ninety-one (91) appeals were submitted to the Director of DHRM. This compares to one hundred and four (104) appeals for the 2015 fiscal year and seventy-three (73) for the 2014 fiscal year. For FY 2016, sixty-six, or 73%, of the appeals received were related to benefits issues and twenty-five, or 27%, were related to administration issues.



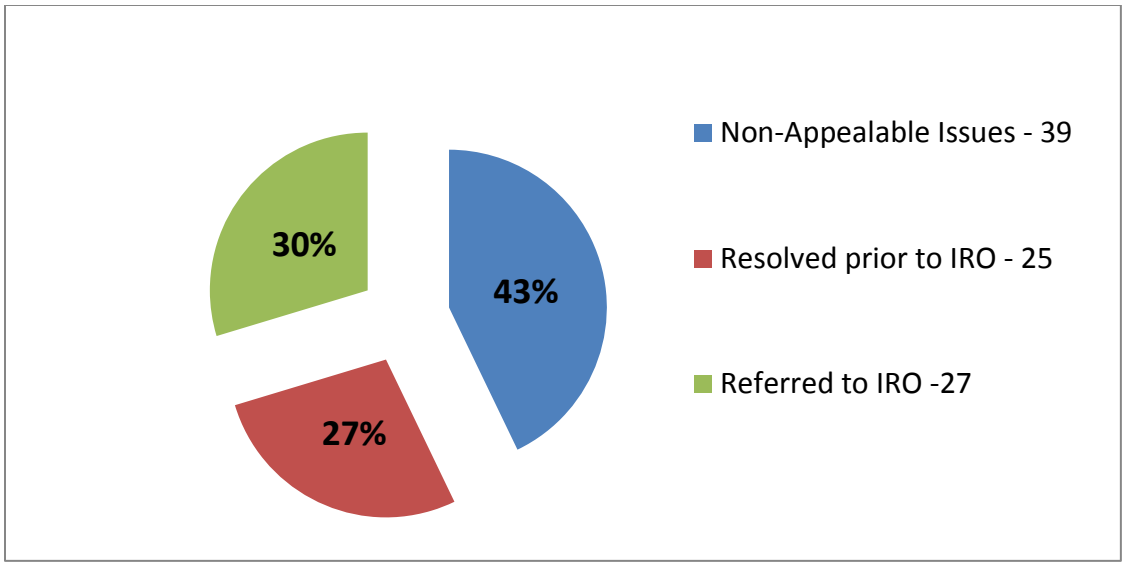


Once received by DHRM, the Ombudsman's team strives to resolve the appeal as early in the process as possible. Each issue is evaluated to ensure the denial was clearly in line with the provisions of the program and no substantive error was made in the review process. In many cases, DHRM, working with the health plan administrator and/or the member, is able to resolve the issue. Appeals are only resolved in this phase if the resolution is in favor of the appellant. During FY 2016, twenty (25) appeals or 27% were resolved by DHRM without the need for an additional review.

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 still evaluated to ensure that the program rules and benefits have been applied correctly. Thirty-nine (39) appeals filed were determined to be non-appealable issues. This represents 43% of the appeals filed and in most of these cases, the member's request was in direct conflict with a program provision or plan benefit, such as requests for:

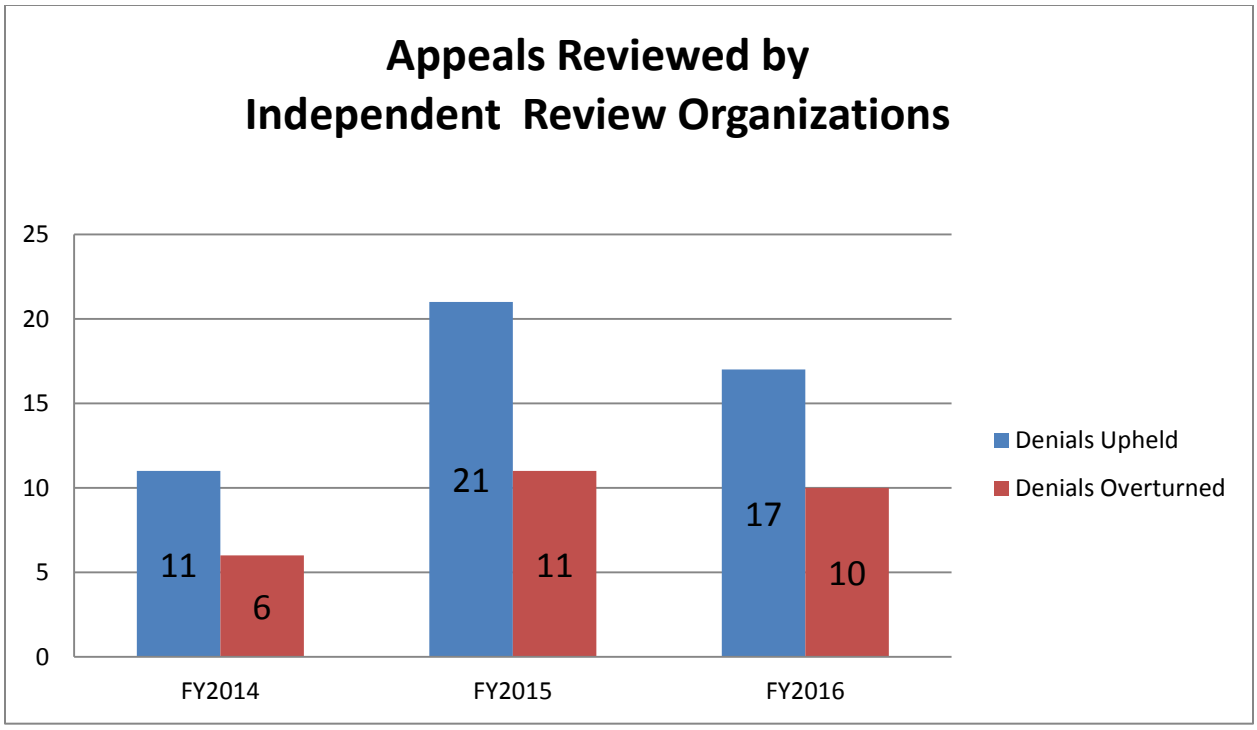
- the plan to assist with the balance billed by an out-of-network provider.
- an exception to allow coverage for an excluded service.
- an exception to the mandatory generic prescription provision.

The remaining twenty-seven (27) appeals (30%) were handled through the independent third party review process.



Independent Review Organizations - An adverse determination of coverage for plan benefit appeals is reviewed by an independent review organization (IRO). In accordance with health care reform provisions, DHRM has contracts with three vendors to conduct independent reviews. During this plan year, DHRM issued a Request for Proposal (RFP) to secure the services of Independent Review Organizations to ensure ongoing compliance with the ACA guidelines for appeals. Working with the Director of Contracts and Finance, the Ombudsman, Appeals Examiner and a health benefits specialist, who serves as a back-up to the appeals examiner, reviewed and scored the responses received for the RFPs. Contracts effective July 1, 2016, were awarded to Maximus Federal Services, IPRO and Medical Consultant Network (MCN) to provide IRO services for the program. One of the vendors, Maximus Federal Services, has been providing IRO services to DHRM for over 15 years. IPRO has been working with our program since 2011 and our new IRO, Medical Consultant Network (MCN), began providing services with the FY 2017 plan year.

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. 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. Of the appeals referred to an IRO this fiscal year, twenty-five (25), or 93%, were submitted and handled through the standard process and two (2), or 7%, were accepted as expedited appeals with a decision being rendered within 72 hours. Of the appeals reviewed by an IRO this fiscal year, ten (10), or 37%, of the determinations were overturned or reversed.



Once the IRO has made a decision, a written notification is provided to the member, DHRM, and the plan administrator. When a medical decision is overturned, the final decision is discussed in detail with the specific plan administrator. 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. 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 type of services being appealed.

Administrative Process Act - 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. One (1) APA appeals was filed in FY 2016. The oral argument for the Circuit Court hearing was held in late May 2016. The ruling, which was issued after the end of the fiscal year, requested additional documentation regarding the medical studies and evidence based outcomes for the treatment. Once received and reviewed, the original decision was reversed by the plan administrator.

Administrative Appeals - An independent review is not required for appeals involving program provisions and/or eligibility issues. When the issues involve whether an individual is eligible for coverage or a disagreement with a program provision, the opportunity for an informal fact finding consultation (IFFC) with the Director is offered to the appellant. There were two (2) IFFCs requested during the 2016 fiscal year. The Director, Ombudsman and Appeals Examiner 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.

COMMUNICATIONS

The Ombudsman is involved in the development and review of communications for all State Health Benefits Program publications, web site information, and vendor communications to members.

With the implementation of the plan changes for the 2015-2016 plan year, the Ombudsman and her team worked closely with the DHRM Communications Manager and each of the plan vendors to develop benefits communications on various program components, Open Enrollment, health plan member handbooks, and provided feedback on web site design and content. Again this year, the Affordable Care Act (ACA) required all employers to provide a standardized document that outlined benefits and the coverage provisions associated for each plan. The Ombudsman and team, along with other members of OHB, worked with the plan vendors to develop the 2016 Summary of Benefits and Coverage (SBC) for the health plans offered under the State and The Local Choice programs.

Capitol Square Health Care – This year, the Department of Human Resource Management launched Capitol Square Healthcare (CSHC), an onsite clinic in the James Monroe Building. CSHC was designed to offer another affordable healthcare option for employees at or near their workplace for non-work related conditions. The Ombudsman worked with the Office of Health Benefits (OHB) Director and the Associate Director for OHB policy on the provisions that govern the clinic. The Ombudsman, along with team members from OHB and the Communications Manager, worked on the development of the communication materials, including announcement brochures, signage and FAQs for the clinic.

The cost of a clinic visit is related to the employee's enrollment status in the State Health Benefits Program. Most State Health Benefits Program participants only pay $15 for the clinic visit, which covers most services received during the visit. Employees who do not participate in the State Health Benefits Program, are enrolled in our HMO plan, or those covered by certain plans where IRS restrictions may apply, pay a cost of $75 for a clinic visit. Medications received at the clinic are at an additional charge.

Along with the Medical Director and her staff, CSHC also has an on-site coach for the MyActiveHealth program. For COVA Care, COVA HealthAware and COVA HDHP Members, the ActiveHealth coach can assist with activities related to the Healthy Lifestyles program including:

- Exercise
- Weight management
- Stress management
- Nutrition
- Smoking cessation

The Ombudsman and members of her team handle inquiries about the clinic and assist the clinic staff with eligibility questions for employees.

Benefits Administrator Webinar Series – This fiscal year, the Office of Health Benefits completed the webinar series designed to provide the benefits administrators with information on the benefits and features of the plan. While there was one additional topic for the COVA Care and COVA HDHP plans administered by Anthem, this year's sessions dealt primarily with the health and wellness plan administrator to provide webinars on topics related to the MyActiveHealth program. The series topics included:

ActiveHealth Management:

- MyActiveHealth–Health and Wellness Programs
- Health and Wellness Incentives
- MyActiveHealth.com/COVA and Premium Rewards
- COVA HealthAware Do Rights

COVA Care and COVA HDHP:

- ER Alternatives
- Your Anthem Toolkit

The Ombudsman's team communicates frequently with all plan vendors to discuss coverage, eligibility and claims issues as well as various topics and concerns that directly affect our members. The Ombudsman works with the vendors to prepare ongoing information regarding the plan benefits and also participates in all applicable quarterly and annual vendor meetings.

CONCLUSION

In the pursuit of excellence, the Ombudsman's team focuses on delivering quality service to all of our customers. As always, the team continues to solicit and act on customer feedback. We strive to thoroughly investigate complaints and appeals, dealing with each issue fairly and consistently. Paying attention to trends as they develop, we endeavor to identify and resolve systemic issues and to promote continual improvement of the State and Local Health Benefits Program.

As the Health Benefits Program moves into the next fiscal year and the implementation and administration of new programs, the Ombudsman's team will strive to continue our high standards of service to our customers, who include not just the members covered under the program but the citizens of Virginia, in a cost-effective way.