OMBUDSMAN
Activities and Services
Fiscal Year 2011

ANNUAL REPORT

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

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ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
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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, 2010 through June 30, 2011. 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, including all appeals procedures.

In fiscal year 2011, the Ombudsman's team handled 5,014 formal case-specific inquiries and assisted with 75 formal appeals. The team achieved its goal of continuous improvement by working to resolve issues and solve problems as they arose and by carefully examining the facts to identify and correct systemic issues.

During FY 2011, the Ombudsman's team has made many efforts to maximize the accessibility and effectiveness of the Health Benefits Program. The team consistently analyzed issues, paying particular attention to emerging trends. Key interventions for the Ombudsman's team during this fiscal year include:

- Qualifying Midyear Events- The decision to modify the plan's enrollment windows for qualifying mid-year events (QMEs) is expected to accommodate the needs of the employees and reduce the number of eligibility appeals for the program.

- Durable Medical Equipment- The Ombudsman assisted in the resolution of issues related to an adjustable appliance used to progressively mold the shape of the cranium resulting in the modification of the review criteria for the appliance.

- Communications – The Ombudsman worked on the development of communication directed to employees seeking assistance through the Virginia State Employee Loan Program.

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

- Appeals Process - The Ombudsman's team worked to ensure that OHB's appeals process would be compliant with health care reform in FY 2012.

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 Ombudsman's team consisted of two Health Benefits Specialists, five Senior Health Benefits Specialists and a Medical Appeals Examiner. In FY 2011, the initial appeals examiner, who was a licensed registered nurse, retired and a new examiner who has a Juris Doctorate was hired. 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 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 employees received timely responses from the team.

During fiscal year 2011, the Ombudsman's team served approximately 92,000 state and 29,000 local government employees and retirees. The State Health Benefits Program had approximately 192,000 members, including employees, dependents and early retirees. Fewer individuals participated in The Local Choice Health Benefits Program, which averaged approximately 49,000 members during the same period. In addition, the team served about 41,000 state retirees, dependents, survivors and long term disability (LTD) participants in the retiree group.

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 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.

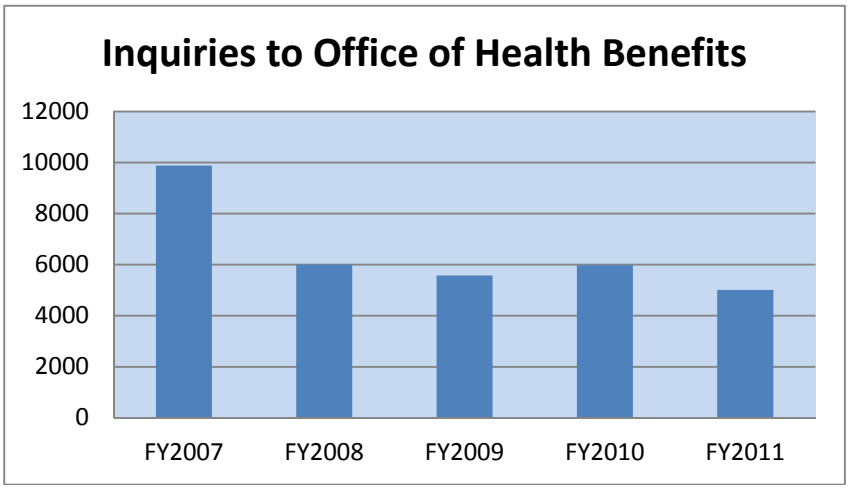
INQUIRIES

In FY 2011, the Ombudsman's team responded to 5,014 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 pertained to eligibility and coverage for medical or surgical services for active employees and their dependents in the COVA Care and COVA Connect plans. These are Preferred Provider Organization (PPO) plans, and the most popular option with state employees.

Examples of major issues involved in these inquiries included:

- dependent eligibility
- eligibility for extended coverage following the termination of employment
- allowable expenses under flexible reimbursement accounts
- denial of coverage, and
- payment of claims.

Inquiries for general information consisted 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 2007 through FY 2011. The number of inquiries was unusually high in FY 2007 as this was the first full fiscal year that included the Medicare Part D prescription drug plan, known as YOURx Plan. This plan became available January 1, 2006 to Medicare-eligible group members in the Retiree Health Benefits Program. Also, significant changes to the Health Benefits Program were implemented in FY 2007, 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 received more inquiries as agency Benefits Administrators and members seek information about the impact of the changes. Over time, as members become more familiar with the nuances of the program, the volume of calls typically subsides. 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 in the prior year. 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, while in FY2008, retiree inquiries dropped by half, to 1,267. In FY 2011, approximately 840 inquiries received were related to retiree issues.

The chart shows that the Ombudsman's team handled fewer inquiries in FY 2009 than it did in FY 2008. A new Customer Relationship Management (CRM) system introduced in FY 2008 allowed tracking by the number of issues instead of the number of calls. Because it is more sophisticated than previous OHB tracking tools, the CRM system allows the Ombudsman's team to enter multiple contacts with a single customer regarding the same issue as part of the same unique case. Previous systems required each new contact to be entered as a separate case. In FY 2011, the number of inquiries was down slightly. The tracking system helped to reduce the duplication of work within the team, which provided a more accurate picture of the number of cases reviewed.

FY 2011 Highlights

- National health care reform received tremendous attention during FY 2010 which continued into FY 2011. As a result of the national health care legislation, OHB received numerous inquiries related to the law's provision for extended dependent eligibility. The new rules were implemented for the state plan during the spring open enrollment season for FY 2012. There were approximately 2,217dependents added to the plan based on the new age 26 limit.

- The Dependent Eligibility Verification Audit (DEVA) in FY 2010 resulted in the removal of 1,835 ineligible dependents from the State Health Benefits Program. During FY 2010, the Ombudsman's team fielded inquiries related to the audit and the health plan's dependent eligibility definition. In FY 2011, there were very few inquiries related to the DEVA and as a follow-up to the audit, OHB implemented documentation requirements to validate requests to enroll dependents into the health plan.

- COVA Connect members comprise about 10 percent of covered active state employees. In FY 2010, 1,292 inquiries, or 22.7 percent of the total received, were related to COVA Connect. This relatively high activity is consistent with the trend discussed earlier in which new programs generate a high number of inquiries. As members, providers and the vendor's staff have became accustomed to the nuances of the plan, the number and type of inquiries have leveled off and are more in line with the inquiries for other plan participants. Only 346, or 6.9%

of the inquiries received this fiscal year were directly related to COVA Connect. Whenever issues were identified, the Ombudsman, his team, and other OHB staff worked with members and Optima Health to resolve them.

Health care continues to grow more complex as advances are made in medical technology, care and procedures. So while the number of inquiries has decreased, the inquiries are more complex and, on average, take more time to resolve.

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 understanding of the program and providing assistance to employees who encounter difficulties navigating the sometimes complex provisions and obligations related to health care. The Ombudsman is charged with oversight of the appeals process and he or a member of his team serves as the contact for appellants. The Ombudsman's team strives to resolve appeals as early in the process as possible. In some cases, employees who contacted OHB to discuss submitting an appeal have their issue resolved favorably before the appeal was formally filed

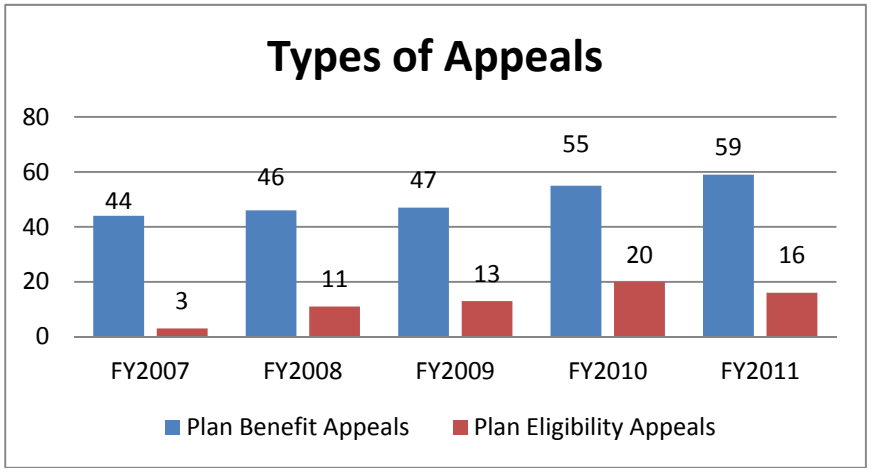
Any new appeal is evaluated to determine whether the initial denial was clearly the result of a substantive error. If so, the decision is reversed early in the process, relieving the appellant of the burden and stress associated with going through the entire appeals procedure and thus increasing customer satisfaction. Appeals are only resolved early in the process if the resolution is in favor of the appellant. These efforts have 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%.

There are two categories of appeals:

1. Plan benefit appeals which involve medical, dental, prescription drug and behavioral health claim issues, and
2. Plan eligibility appeals which involve whether an employee and/or dependent is qualified to receive coverage under the State Health Benefits Program.

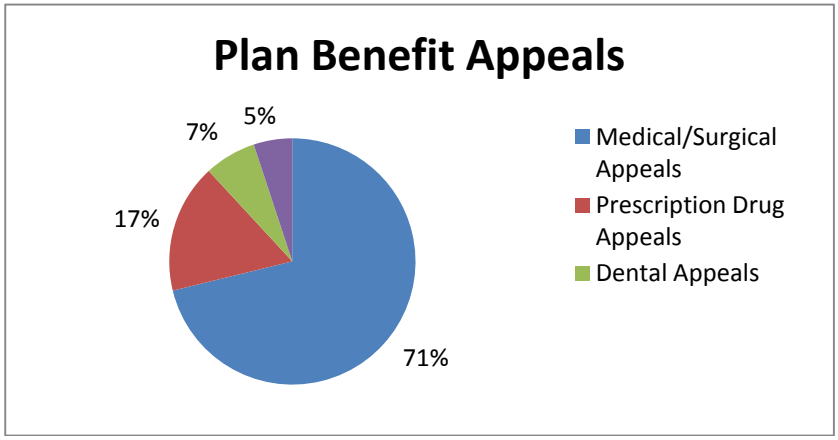
In regard to benefit appeals, the third party vendors responsible for administering the medical, prescription drug, dental or mental health components of the Health Benefits Program each has an internal appeal process. When an employee has exhausted his or her appeals with a specific vendor, the employee has the right to appeal the denial of coverage to DHRM. When specific criteria are met, the employee has the right to appeal unresolved eligibility issues to the Director of DHRM.

During FY 2011, there were 75 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. The total number of formal appeals to the Director of DHRM during FY 2011 is consistent with 77 appeals the previous year. Sixteen (16) appeals were related to eligibility and 59 were related to plan benefits.



The number of appeals involving eligibility issues began to increase in FY 2008 and steadily increased through FY 2010. The increase in FY 2009 and FY 2010 can be attributed in part to the DEVA. In FY 2011, the number of eligibility appeals declined by 20%. The decline corresponds to the increased focus by OHB to ensure the eligibility requirements for dependents were clearly communicated to the employee population along with the change in the enrollment period for qualifying midyear events.

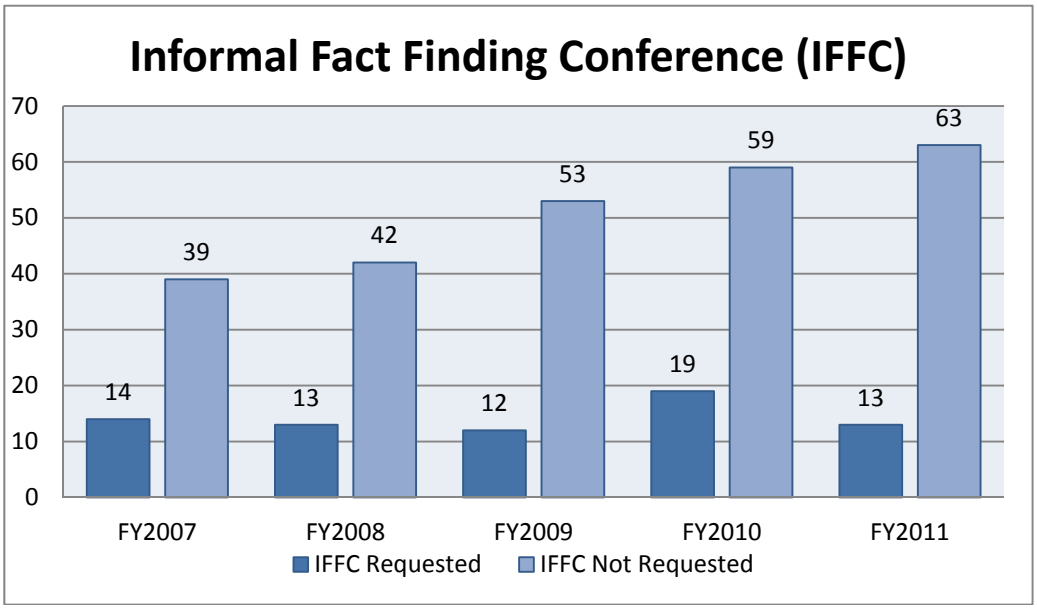
Historically, most plan benefit appeals fall into the medical/surgical category. Of the 59 formal plan benefit appeals this year, 42 or 71% fall into the medical/surgical category.



By rule, certain decisions were not appealable, such as matters which the sole issue is a disagreement with policy or a contractual exclusion. Although these matters were not appealable, whenever a member raised such an issue, the case was treated as an inquiry and 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.

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 solely on the evidence submitted by the appellant and the Health Benefits Program.

Thirteen (13) IFFCs were conducted during this fiscal year. Nine IFFCs pertained to medical issues and four were related to eligibility issues. The Ombudsman's team conducted in-depth research to develop a packet of information that was provided to all parties 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 information packets and coordinating the IFFC.

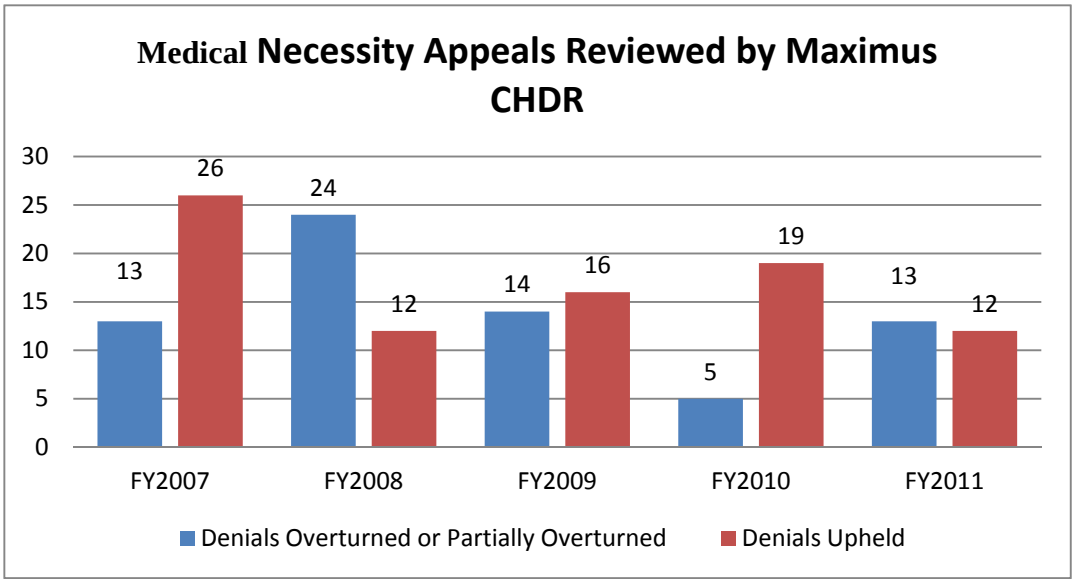


The number of appellants requesting an IFFC with the Director of DHRM remains low compared to the number of appeals requested. A relatively high percentage of appeals concern medical issues. Anecdotal evidence suggests that many appellants believe that an IFFC is not necessary because their medical records provide sufficiently relevant and convincing evidence. During FY 2011, 17.1% of appellants requested an IFFC. This is a decrease from the 23.4% who requested an IFFC in FY 2010.

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 suspected. To be medically necessary, the service has 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 (e.g., medications, durable medical equipment) 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 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 communicates the final decision in writing to the appellant.



In FY 2008, the annual percentage of denials overturned by MAXIMUS CHDR increased by approximately 46%. Most of the denials that MAXIMUS CHDR overturned then 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 for this test. Primarily as a result of this development, in FY 2010, approximately 89% of the appeals sent to MAXIMUS CHDR for independent external clinical review were upheld.

Twenty-five appeals were sent to MAXIMUS CHDR for review in FY 2011. Of the appeals reviewed, 13 or 52% were overturned or partially overturned. The majority of the overturned cases were related to the plan's mandatory generic prescription drug benefit and certain types of psychotropic, seizure and transplant drugs. Based on these

cases, the plan incorporated new processes for additional review of claims related to these specific drug classes. 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.

When MAXIMUS CHDR overturns a medical decision, information regarding the decision is provided to the vendor who issued the initial denial so that the vendor is able to learn from the final decision. 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.

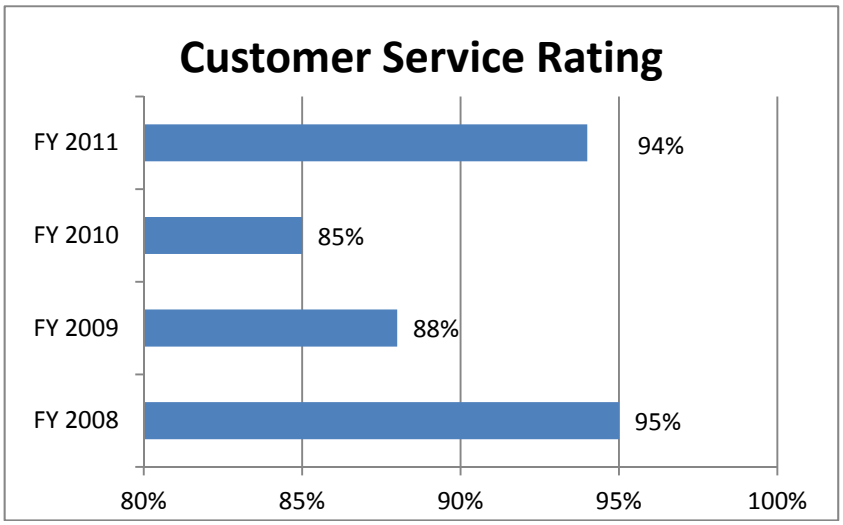
An independent review is not required for appeals involving eligibility issues. After thorough review of the evidence, the Director decides those appeals and communicates decisions to appellants by letter. The Director's appeal decision is final and binding.

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 2011.

CUSTOMER FEEDBACK

Feedback from employees is a very important tool for improving the program. Plan members who submit inquiries are asked to provide feedback and at the close of each IFFC, the appellants are asked to suggest any area where OHB may improve the appeals process, program communications, or any other aspect of the Health Benefits Program. This customer feedback has led to several communication efforts, including educating members about wellness benefits and dependent eligibility.

Benefits Administrators also provide valuable feedback. Furthermore, whenever multiple inquiries are received from several Benefits Administrators about the same question, it indicates potential training opportunities. These patterns are communicated to all benefits administrators in our semi-monthly newsletter and to the OHB staff responsible for training new and experienced Benefit Administrators.



The State Health Benefits Program Customer Satisfaction Survey for FY 2011 indicated 94% of respondents rated customer service as "good" to "excellent." These results were an 11% improvement over the rating achieved in FY 2010. Consistent with the decrease in the number of inquiries received, as members became more accustomed to the various plans and benefit enhancements implemented in prior plan years, the staff received higher marks for their professionalism, helpfulness and problem resolution skills.

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 VENDORS

The Ombudsman is involved in 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 review communications developed by OHB, as well as by the plan's third party administrators (i.e., Anthem, Optima, Medco, Delta Dental, and ValueOptions). Furthermore, the Ombudsman's team communicates frequently with vendors to discuss coverage, eligibility and claims issues.

Along with other staff, the Ombudsman regularly participates in multi-vendor meetings to improve coordination among vendors responsible for administering the COVA Care plan. The Ombudsman also participates with other staff in all applicable vendors' quarterly and annual meetings with OHB.

Ensuring that COVA Connect members received the best possible service was, again, a high priority for the Ombudsman in FY 2011. Along with other OHB staff, the Ombudsman participated in meetings with Optima Health to assess the ongoing administration of the plan including meetings to evaluate the strength of Optima Health's out-of-area network, and to discuss the progress of the COVA Connect incentive program. Providing financial incentives to members has the potential to help lower costs

and improve health outcomes, and is a key component of the COVA Connect plan. During FY 2011, 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

Informally, the Ombudsman provides coaching as appropriate to members of his team. Because the Ombudsman's team and other agency staff rely heavily on written communication when interacting with state employees, retirees, vendors and other customers, the Ombudsman was instrumental during FY 2011 in setting up the formal business writing training held for DHRM staff.

The Ombudsman served as an ex officio member of the Board of Directors of the United States Ombudsman Association. Through relationships with other ombudsmen, the Ombudsman stays abreast of best practices in the field.

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 paying particular attention to emerging trends and identifying any system problems. Below are several key interventions for FY 2011:

- **Qualifying Midyear Events**- Over the years, DHRM periodically received eligibility appeals related to timely requests to add dependents to the health plan, primarily requests for newborn coverage. OHB made the decision to modify the plan's enrollment windows for qualifying mid-year events (QMEs). The decision provided employees more time to make better decisions regarding their health care elections. This change better accommodated the needs of employees in the health care program and it is expected to reduce the number of eligibility appeals for the program.

- **Durable Medical Equipment**-The Ombudsman worked with one of the health plan vendors to resolve issues related to a claim for an adjustable appliance used to progressively mold the shape of the cranium. The Ombudsman, in conjunction with the Ombudsman for the Bureau of Insurance, challenged the handling of claims and appeals related to this service. As a result of this intervention, the vendor has modified the medical necessity review criteria for the appliance.

- **Communications** – The Ombudsman worked with other agency staff members to develop a communication piece for employees seeking assistance through the Virginia State Employee Loan Program. The financial flyer provided information

regarding services available under the health plan Employee Assistance Program (EAP).

- **Customer Relationship Management (CRM) system**- The team continued to work very closely with the other OHB members and the Information Technology staff to further refine the CRM system designed to track and manage customer contacts through telephone calls, e-mails, letters and faxes. This ensures that CRM will remain an important tool for OHB in efforts to achieve continuous improvement in all business areas.

- **Appeals Process** - The Ombudsman worked extensively with the appeals examiner to ensure that OHB's appeals process would be compliant with health care reform in FY 2012. In doing so, the Ombudsman worked with other OHB staff and consulted with outside parties, including key employees with the federal office of Health and Human Services (HHS) and the Virginia Bureau of Insurance. The appeal changes will not be effective until FY 2012.

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 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 his 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.