OMBUDSMAN
Activities and Services
Fiscal Year 2010

ANNUAL REPORT

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

Table of Contents

ANNUAL REPORT
ON
OMBUDSMAN ACTIVITIES & SERVICES
Fiscal Year 2010
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, 2009 through June 30, 2010. 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 appeals procedures.

In fiscal year 2010, the Ombudsman's team handled 5,680 formal case-specific inquiries and assisted with 77 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.

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, 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 additional 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 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 2010, the Ombudsman's team served approximately 83,000 state employees and 29,000 local government employees and their covered dependents. The State Health Benefits Program had approximately 192,000 members, including employees, dependents and early retirees. Fewer individuals participate in The Local Choice Health Benefits Program, which averaged approximately 49,000 members during the same period. In addition, the team served about 40,000 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 260 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

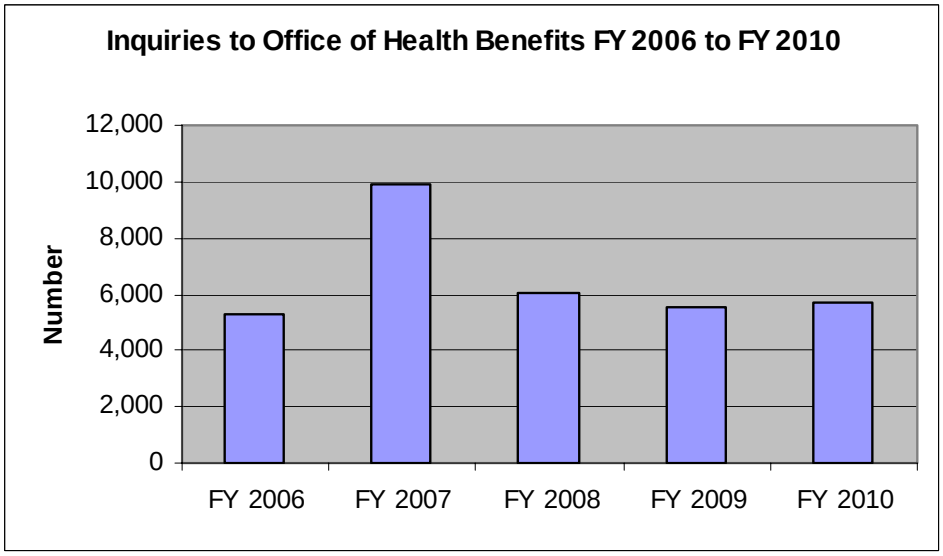
In FY 2010, the Ombudsman's team responded to 5,680 formal case-specific inquiries from employees, retirees, agency Benefits Administrators, health care vendors, legislators, providers and other interested parties. The majority of formal contacts with the Ombudsman's team pertained to eligibility and 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 are 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 claims under medical and dependent care 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 2006 through FY 2009. Overall, the number of inquiries fluctuated during that period, with a dramatic spike in FY 2007. There were several reasons for the changes in activity. The first full fiscal year that included the Medicare Part D prescription drug plan, known as YOURx Plan, was FY 2007. 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 recorded 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. The following year, retiree inquiries dropped by half, to 1,267.

The chart shows that the Ombudsman's team handled fewer inquiries in FY 2009 than it did in FY 2008, and about the same number as it handled in FY 2006. 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.

Two key initiatives from FY 2009 continued to drive a significant number of inquiries in FY 2010. The first was the development of the COVA Connect plan for members living in certain zip code areas in Tidewater. The second was the development of a Dependent Eligibility Verification Audit (DEVA) to identify and remove ineligible dependents covered under the plan.

COVA Connect

In FY 2010, 1,292 inquiries, or 22.7 percent of the total received, came from COVA Connect members. They comprised only about 10 percent of covered active state employees. This relatively high activity is consistent with the trend discussed earlier in which new programs generate a high number of inquiries. Several themes dominated inquiries regarding COVA Connect:

- employees who lived within the COVA Connect service area and who wanted a PPO plan had no alternative to COVA Connect, although they had the option to participate in the COVA High Deductible Health Plan
- delivery of initial COVA Connect communication materials was delayed for reasons beyond the control of both OHB and Optima Health
- some drugs were on different copayment tiers under COVA Connect than they were under COVA Care, and
- differences between Optima Health's and Anthem's provider networks.

Individual circumstances impacted the member's degree of satisfaction with COVA Connect. In regard to the drug tier issue, some drugs cost more for COVA Connect than for COVA Care members, and vice versa. However, both Nexium and Lipitor (which were two of the most widely used drugs in both plans) were in Tier 2 for COVA Care and Tier 3 for COVA Connect, so COVA Connect members paid higher copays for these drugs. Optima Health indicated a willingness to work with members' doctors to identify lower tier drug alternatives.

Regarding the provider networks, many providers participated in both Anthem's and Optima Health's networks. An exception has been Riverside Hospital and many of its affiliated medical professionals, who did not participate in Optima Health's network. During FY 2010, Optima Health recruited a number of physicians associated with Riverside into its network. When requested, Optima Health also worked with individual members to identify network providers who could help them.

In addition, some COVA Connect members had concerns that were rooted in misinformation. For instance, on July 1, 2009, OHB increased the cost of some member deductibles, copays and coinsurances for the PPO plans. The higher costs applied to both COVA Care and COVA Connect. One example was coinsurance for diagnostic tests and x-rays, which increased to 20% from 10%. Since these changes occurred at the same time as the introduction of COVA Connect, many COVA Connect members associated the higher costs with the move to COVA Connect, and not with the transition to a new plan year. As a result, many COVA Connect members mistakenly believed that these higher costs only applied to COVA Connect and not COVA Care.

As with the COVA Care plan, OHB fielded other inquiries related to a wide variety of subjects. Many of these were related to the transition, as members, providers and the vendor's staff became accustomed to the nuances of the plan. Whenever issues were identified, the Ombudsman, his team, and other OHB staff worked with members and Optima Health to resolve them.

DEVA

The DEVA ran from September 8, 2009 through January 31, 2010 and resulted in the removal of 1,835 ineligible dependents from the State Health Benefits Program. This is expected to produce savings of $6.3 million during the first year following the audit. The Ombudsman's team fielded 457 inquiries related to the DEVA in FY 2010. Most of these inquiries centered on dependent eligibility.

Many other issues also drove inquiries. For example, the debate over and eventual passage of national health care reform received tremendous attention during FY 2010. As a result of the national health care legislation, OHB began to receive inquiries related to the law's provision extending the age limit for dependent eligibility to age 26.

It is important to recognize that health care continues to grow more complex as advances are made in medical technology, care and procedures. As a result, in the aggregate, inquiries continue to grow more complex and take more time to resolve.

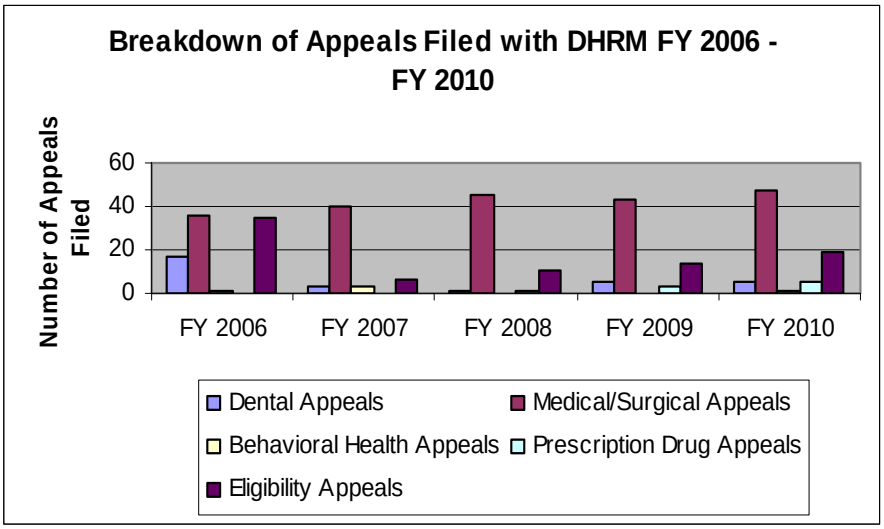
APPEALS

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. The Ombudsman's team strove to resolve appeals as early in the process as possible.

Any new appeal received was evaluated to determine whether the initial denial was clearly the result of a substantive error. If so, the decision was 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. 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, or whether an employee and/or dependent was qualified to receive coverage under the State Health Benefits Program. The second type of appeal 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 2010, there were 77 formal appeals to the Director of DHRM. Many of these appeals 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 2010 represented a 15.6% increase, up from 65 the previous year. There are no discernable trends involving specific issues that account for the increase; it is simply attributable to standard variation. Seventeen (17) appeals related to eligibility and 58 were medical. Two appeals involved contractual issues.



From FY 2006 through FY 2010, the number of appeals involving eligibility issues declined by approximately 43%. This decrease can be traced to continuous efforts by OHB to communicate the eligibility rules to employees. For example, after receiving a number of appeals involving newborns who were not enrolled timely, the Ombudsman's team has worked diligently with other OHB staff to educate employees about this issue.

Beginning in July 2006, the member handbook and the appeals form were changed to clarify that issues could not be appealed when involving:

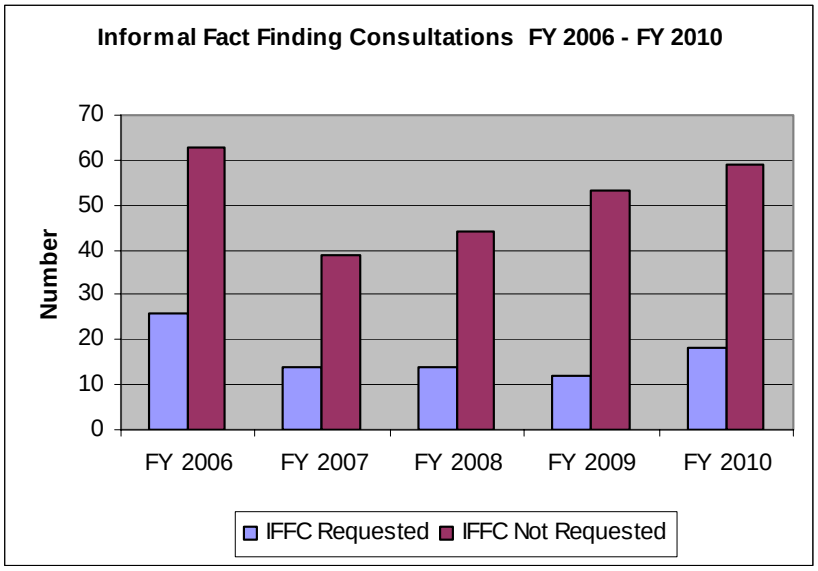
- contractual exclusions
- matters in which the sole issue was disagreement with policies, rules, regulations, contract or law
- claim amounts above the allowable charge billed by a non-participating provider, and
- claim amounts or coverage denials when the member's cost was less than $300.

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

Eighteen (18) IFFCs were conducted during this fiscal year. Thirteen (13) IFFCs pertained to medical issues and five (5) were related to eligibility issues. The

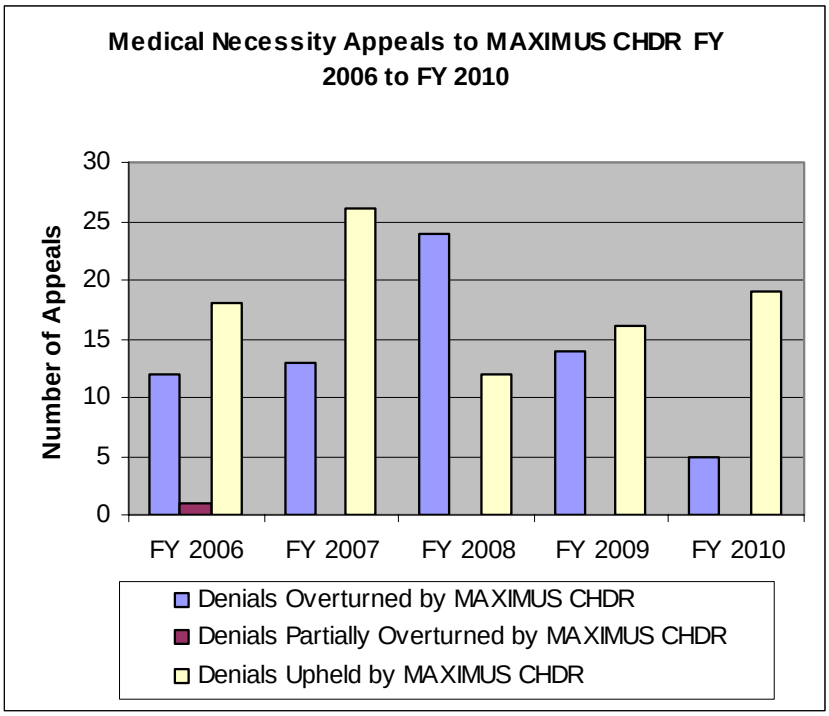
Ombudsman's team conducted in-depth research to develop a packet of information that was provided to all parties prior to the IFFC. This packet included all information containing relevant contract or policy provisions, full case-related information (including relevant medical records), and a chronology 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 all additional information.



As depicted in the chart above, the number of appellants requesting an IFFC with the Director of DHRM remained low compared to the number of appeals requested. A relatively high percentage of appeals concerned medical issues. Anecdotal evidence suggests that many appellants believed that an IFFC was not necessary because their medical records provided sufficiently relevant and convincing evidence. During FY 2010, 23.4% of appellants requested an IFFC.

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 had 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 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 communicated 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 during that time 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. This trend continued in FY 2010, as 24 appeals were sent to MAXIMUS CHDR for independent external clinical review. Of those, five denials, or approximately 21%, were overturned.

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 the example above shows, 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. No APA appeals were filed in FY 2010. However, one APA appeal that had been filed during the previous year was decided. In that case, which involved an eligibility issue, the court overturned the denial.

CUSTOMER FEEDBACK

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 was a very important tool for improving the program. For example, employee feedback from employees led to several communication efforts, including educating members about wellness benefits and dependent eligibility.

Benefits Administrators also provided valuable feedback. Furthermore, whenever multiple inquiries were received from several Benefits Administrators about the same question, it indicated potential training opportunities. These patterns were communicated to OHB staff responsible for training new and experienced Benefit Administrators.

A State Health Benefits Program Customer Satisfaction Survey for FY 2010 indicated 85% of respondents rated customer service as "good" to "excellent." These results were comparable to the 88% rating achieved in FY 2009. 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 was 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 reviewed 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 communicated frequently with vendors to discuss coverage, eligibility and claims issues.

In order to maximize the effectiveness of OHB communication efforts, the Ombudsman worked collaboratively with other OHB staff and the DHRM communications manager to develop and implement a new internal communications procedure. This procedure streamlined the development, review and approval of OHB communications to key customers, including state agencies and health plan members.

Along with other staff, the Ombudsman regularly participated in meetings with Medco to assess administration of the Medicare Part D prescription drug program and in multi-vendor meetings to improve coordination among vendors responsible for administering the COVA Care plan. The Ombudsman also participated with other staff in all applicable vendors' quarterly and annual meetings with OHB.

Ensuring that COVA Connect members received the best possible service was a high priority for the Ombudsman in FY 2010. Along with other OHB staff, the Ombudsman participated in many meetings with Optima Health to assess implementation and ongoing administration of the plan. For example, the Ombudsman participated in meetings to evaluate the strength of Optima Health's out-of-area network, and to discuss the development and roll-out 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. The Ombudsman and the OHB Appeals Examiner also worked with Optima Health staff to ensure that Optima Health had an internal appeals process that met OHB's vigorous standards.

Furthermore, beginning in FY 2010, the Ombudsman scheduled and facilitated five meetings with Optima Health and Benefits Administrators and other staff from individual agencies that had a large concentration of COVA Connect employees. These meetings addressed service and coverage issues and ensured that the Benefits Administrators fully understood the services and programs available under COVA Connect. Meetings were held with representatives of the State Police, the Department of Corrections, the Department of Transportation, the Employment Commission, and the Department of Social Services. All participants reported that these meetings were very helpful.

In another effort to improve members' understanding of the COVA Connect plan, the Ombudsman participated in an extensive team project to revise the COVA Connect member handbook. The revised version was effective for the plan year beginning July 1, 2010.

Prior to and during the DEVA audit, the Ombudsman participated in regular internal OHB meetings to discuss the project as well as in meetings with the vendor administering the project. The Ombudsman's focus was to make sure that the audit was being administered fairly.

During FY 2010, 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 provided 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 in setting up formal business writing training 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 stayed 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. Below are examples of some key activities of the Ombudsman's team during FY 2010.

- The Ombudsman and other OHB staff worked very closely with the Information Technology team 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.

- The Ombudsman's team consistently analyzed issues, paying particular attention to emerging trends and identifying any systemic problems. For example, the team worked with one of OHB's third-party vendors to resolve issues related to claims processing errors, including, but not limited to, claims for Oncotype DX testing (a test

designed to predict the likelihood of breast cancer recurrence, and thus to predict whether post-surgery chemotherapy treatment is necessary). As a result of this intervention, a number of steps have been taken to improve accuracy, including that this vendor now conducts more analytical reviews and flags all Oncotype DX claims for medical review.

- The Ombudsman led the procurement process to select an independent third party charged with reviewing adverse medical decisions under appeal. Additionally, the Ombudsman actively participated in all phases of the procurement processes for selecting vendors charged with administering medical and prescription drug benefits for Medicare retirees. These extensive undertakings included reviewing and editing the various requests for proposal, participating in pre-proposal conferences, reviewing responses to RFPs, conducting finalist interviews, and negotiating with vendors. The Ombudsman's continual focus was to bring the perspective of the everyday member to the process.

- In the third quarter of FY 2010, the Ombudsman participated in a number of meetings held by OHB to address COVA Connect member concerns and to provide information about the nuances of the plan.

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 and his 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's 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 and his team will strive to meet the highest standards in the most cost-effective way possible, and look forward to continuing to provide needed services to members covered under the program and to the citizens of Virginia.