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December 3, 2019

The Honorable Frank Wagner, Senate of Virginia
The Honorable Stephen Newman, Senate of Virginia
The Honorable Roslyn R. Dance, Senate of Virginia
The Honorable Terry G. Kilgore, Virginia House of Delegates
The Honorable Robert D. Orrock, Sr., Virginia House of Delegates
The Honorable Keyanna Conner, Secretary of Administration

Subject: Report of the State Health Benefits Ombudsman

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 in response to this requirement.

Respectfully,

Emily S. Elliott

Emily S. Elliott
Director
Department of Human Resource Management

OMBUDSMAN ANNUAL REPORT FISCAL YEAR 2019

Office of State and Local Health Benefits Programs

Table of Contents

ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
FISCAL YEAR 2019

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, 2018 through June 30, 2019. 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 2019, the Ombudsman's team handled 8,783 issues and reviewed 138 formal appeal requests. In an effort to maximize the accessibility and effectiveness of the Health Benefits Program, the team continues to:

- resolve issues and solve problems in a timely manner;
- analyze issues, identify emerging trends and work to correct systemic issues; and
- update policies and provide meaningful communication to our customers.

Key initiatives and projects managed during the fiscal year include:

Procurement of Health Benefits Plan Administrators – the Ombudsman worked extensively with other DHRM employees to procure services for the administration of the statewide Commonwealth of Virginia employee health benefits program, The Local Choice (TLC) health benefits program, and the Line of Duty Act (LODA) health benefits plans, as well as fully-insured regional plans for the state employee and TLC programs. The TLC program is an optional health benefits program administered by OHB for political subdivisions of the Commonwealth. The LODA Health Benefits Plans cover eligible public safety employees/volunteers permanently injured or killed in the line of duty and/or their eligible family members.

Shared Savings Incentive Program - The Office of Health Benefits implemented a shared savings incentive program designed to create savings by rewarding members who choose to receive treatment at facilities that offer quality care at a lower cost. The program, SmartShopper, provides opportunities for participants in the COVA Care and COVA HDHP Plans to shop for certain medical services. If better-value facilities are chosen through the shopping process, the enrollee will receive a cash incentive. Registration with the administrator is required in order to shop. Participation in the program is strictly voluntary.

The program has particular promise for COVA Care, the state's copay-based plan which is the most popular plan among state employees. Copay-based health plans typically provide little incentive for members to shop for lower prices; this program will address that issue.

Communication - working with members of the OHB Policy Team and the DHRM Communication Manager, the Ombudsman assisted in the development of:

- annual member communications,
- updated COVA HDHP member handbook and handbook amendments,
- monthly EAP promotions, and
- emails, notifications and memos to the benefit administrators with policy and procedural updates.

- **Affordable Care Act Provisions** - The Ombudsman worked with other DHRM employees on various provisions of the Affordable Care Act (ACA) during this fiscal year. These include:

    - **Employer 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.

    - **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 and benefit available when they have an opportunity to enroll in health coverage.

Our team continues to work with the health plan vendors to develop a communication strategy aimed at educating both the members and the provider community regarding various benefits, provisions and services available through the state and TLC health benefits programs.

BACKGROUND

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 Ombudsman also serves as the Office of Health Benefits compliance officer for the ACA Section 1557 Nondiscrimination provisions.

The State Health Benefits Program provides benefits through approximately 219 state agencies to some 100,000 active full-time and part-time employees, 10,000 retirees not eligible for Medicare, and 500 extended coverage (COBRA) enrollees, and to the dependents of these enrollees. This Program also provides supplemental benefits to approximately 40,000 participants who are eligible for Medicare.

OHB has the responsibility for administering a health benefits program, The Local Choice (TLC), which is offered to localities statewide as a replacement option to other health benefits program choices. Any local government, school district, or political subdivision may join this program. Presently there are 350 member groups covering approximately 40,000 employees, retirees and their covered dependents. OHB also administers a program, the LODA Health Benefits Plans, which provides health benefits for certain public safety workers injured or killed in the line of duty and/or their eligible family members. Presently there are approximately 1,100 participants and covered family members in the LODA plans.

The Program offers three statewide self-insured plans for state employees and early retirees, a PPO (COVA Care), an HDHP (COVA HDHP), and a CDHP (COVA HealthAware), and a regional fully insured HMO to state employees within the applicable service area. There are two Medicare Supplement options for eligible state retirees. The TLC program currently offers four self-insured plans designed around a PPO called Key Advantage, a self-insured HDHP and a regional fully-insured HMO. LODA Health Benefits Plans participants are enrolled in one of three plans, one based on current employment, former employment or Medicare eligibility.

In total, the Ombudsman's team served over 300,000 state and local government employees, retirees, and family members during this period. The team provided assistance to over 300 Human Resource Benefits Administrators and Managers statewide who administer health benefits within state agencies and sought assistance with program administration and policy application. Team members also serve 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 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.

KEY INITIATIVES

HEALTH BENEFITS PROGRAM PROCUREMENT

The Office of Health Benefits engaged in an extensive project during this fiscal year to secure claims administrators for the health plans for state employees, non-Medicare retiree plan participants, The Local Choice and the Line of Duty Act (LODA) participants. While the Ombudsman managed several projects during this fiscal year, her involvement in the health benefits program procurement was a key initiative. The Ombudsman and her team, along with other members of the OHB staff, contributed significantly to this project and were instrumental in the two project phases shown below.

Request for proposals (RFP) review: OHB issued the RFP OHB19-01- Administrative Services and Fully Insured Health Benefits Plans in August 2018. This RFP encompassed the various health plan options, and the flexible spending accounts. During this phase, the Ombudsman worked with the OHB management team and our actuarial consultant to draft the proposal. Unlike prior proposals to secure the health plan administrators, this single RFP was structured into six components:

1. **Statewide Preferred Provider Organization (PPO) and High Deductible Health Plan (HDHP) Medical/Surgical, Behavioral Health** (to include Employee Assistance Plan (EAP)), Vision, and Hearing administrative services for the state employee, TLC, and LODA plans;
2. **Statewide Consumer-Driven Health Plan (CDHP) Medical/Surgical, Behavioral Health** (to include EAP), Vision, and Hearing administrative services for the state employee plan;
3. **Statewide PPO, HDHP, and CDHP Prescription Drug** administrative services for the state employee, TLC, and LODA plans;
4. **Statewide PPO, HDHP, and CDHP Dental** administrative services for the state employee, TLC, and LODA plans;
5. **Fully-insured regional plans** for state employee and TLC programs; and
6. **Section 125 Flexible Spending Account** administration for state employees.

Once the proposal was issued, the Ombudsman and members of her team participated in pre-proposal conferences, reviewed responses to RFPs, and assisted during the negotiations and finalist interviews. All members put forth tremendous effort and devoted significant time to the project. The notices of intent to award the contracts were issued in March of 2019.

Implementation Phase: Immediately following the awards, the Ombudsman and team began working to prepare for the 2019-2020 plan year Open Enrollment which included implementing new processes and procedures as we transitioned to new third party claims administrators. We also implemented a new fully-insured regional health plan, Optima Health Vantage HMO, in the Hampton Roads area. This plan was available effective 7/1/2019 for the state program and will be effective 7/1/2020 for The Local Choice program. The team held weekly meetings with the vendors, covering topics such as:

- transitioning prescription drug services without disruption,

- transitioning of the health and wellness programs, including the value based insurance design (VBID) incentive programs, the maternity management and the bariatric surgery education program to the respective medical claims administrators,
- procedures and protocols for data file transfers,
- updating ALEX, the health plan decision tool,
- premium reward criteria and procedures to transition to the medical claims administrators, and
- a communication strategy for the transitioning vendor services as well as the Open Enrollment period.

Each of these topics involved meticulous attention to detail. The team also responded to inquiries from benefits administrators, employees and retirees related to components of this project.

Shared Savings Incentive Program

During this fiscal year, OHB implemented the SmartShopper program for the state's COVA Care and COVA HDHP plans. SmartShopper is a confidential health care shopping and savings program that works with the member's health plan. When members shop for certain medical services and if they choose to have the procedure at a better-value facility on the SmartShopper list, they will earn a reward. Members can shop for routine, non-emergency procedures. For example, screenings such as mammograms and colonoscopies; diagnostic tests such as CT scans, MRIs and ultrasounds; and even some surgical procedures. Rewards vary from $25 to $500, depending on the procedure and where it takes place. There is no cap on how many rewards a member can earn.

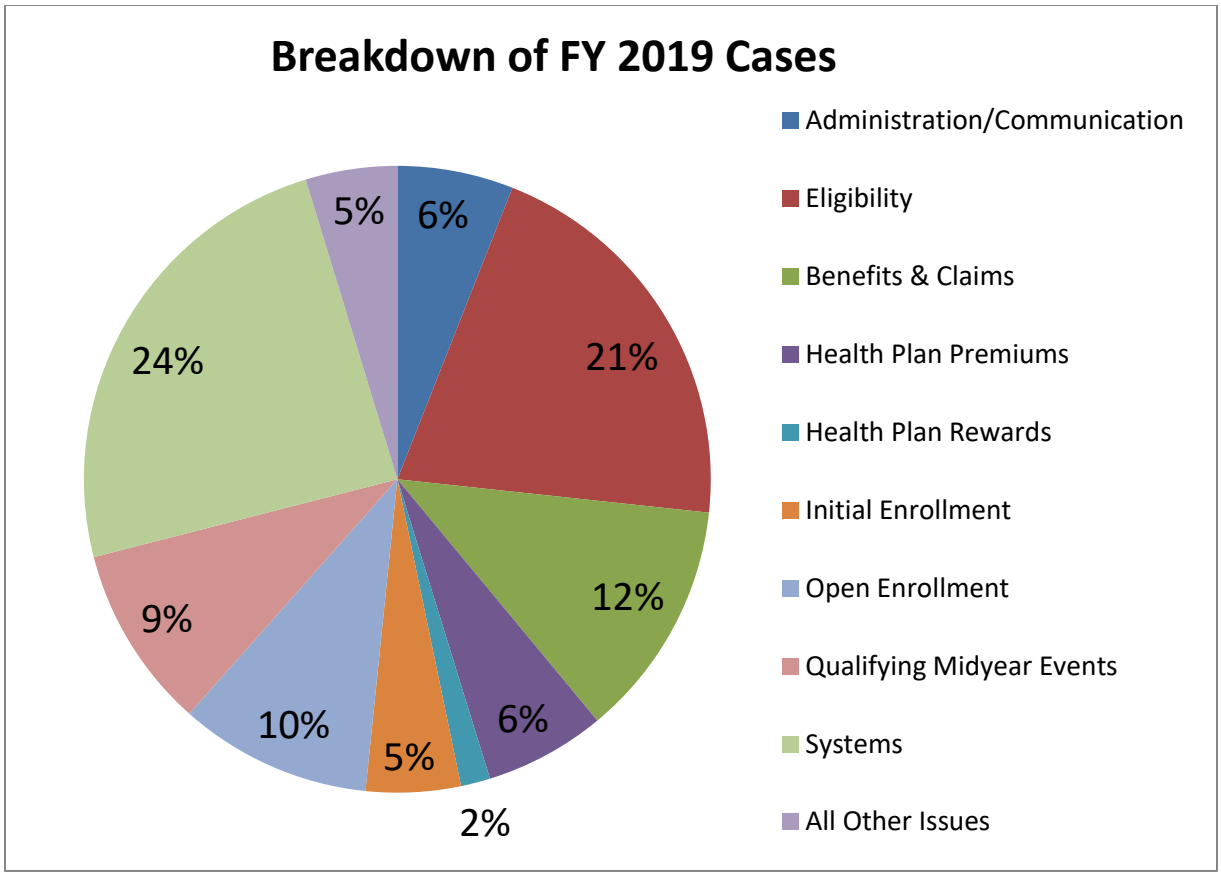
Working with the DHRM Communication Manager and other member of the OHB team, the Ombudsman was involved in the communication strategy for the implementation of the SmartShopper program. She assisted in the DHRM web site updates and the review of the communication material such as:

- Registration presentation
- Frequently Asked Questions
- List of available services
- Governor's announcement letter
- Member mailings
- Instructional memos to the benefits administrators

She also provided input into the messaging and information available on the vendor's online portal. Since the launching of the program, the Ombudsman continues to work with the team on communication materials designed to increase the awareness of the program and further engage the eligible population.

EMPLOYEE AND RETIREE SERVICES

In FY 2019, the Ombudsman's team handled 8,783 issues from employees, retirees, agency Benefits Administrators, legislators, providers, and other interested parties. These included general and member specific inquiries, complaints and requests related to benefits, communications, vendor services, policy interpretation, and system updates. Depending on the issue, the team may contact the claims administrator or the member's benefits office to obtain the details and/or information for each situation to provide a resolution for the member or a response to the question.



Administration and Communication – 6% This category includes the inquiries related to administrative requirements such as the ACA reporting and forms, OHB specific forms and publications, HIPAA and Extended Coverage (COBRA) specific notices and communications provided by our office and vendors to the agencies and/or members. Also included are general questions about the ACA reporting procedures and specific 1095 forms questions and requests.

Benefits and Claims – 12% OHB works closely with the health plan administrators, agency benefits offices and members to provide clarification on the benefits available for each health plan, assisting in the resolution of claim issues, and providing next steps as needed when claims are denied or not covered by the health plan or flexible spending account.

Eligibility – 21% The various program components have specific rules to identify who is eligible for coverage. While the eligibility for coverage as an employee is normally not an issue, the eligibility of the family members does require review and approval. The program requires proof of eligibility to be provided at any time a family member is added to health care. Retirees, long-term disability participants and survivors may also be eligible for coverage. OHB provides guidance related to the transition of employees into the retiree health program. We also reviewed and approved the documentation of dependent eligibility when requested or required by policy.

Health Plan Premiums- 6% This category includes questions related to the health care premium amounts, premium invoices for those participants who are billed directly by one of the health plan vendors and reinstatement requests for failure to pay premium invoices. In most cases, active employee premiums are payroll deducted and retiree premiums are deducted from the monthly retirement benefit when available. If there is no monthly VRS benefit (e.g., non-VRS retirees or other retiree group enrollees such as non-annuitant survivors or LTD participants) or the VRS benefit is too low, the enrollee will be direct billed. Invoices are also generated for members who elect to continue their coverage under the Extended Coverage (COBRA) provisions.

Health Plan Rewards – 2% Two of the Commonwealth's self-insured plans (COVA Care and COVA HealthAware) include incentive programs that reward compliant members for completing specific activities and/or participating with our health and wellness program. These programs were designed to encourage the utilization of plan benefits, educate the members about their personal health risks, and provide members with options to manage health conditions and/or assist with tools to encourage changes in behavior. Health Plan Rewards included the prenatal maternity management, disease management and the premium rewards programs.

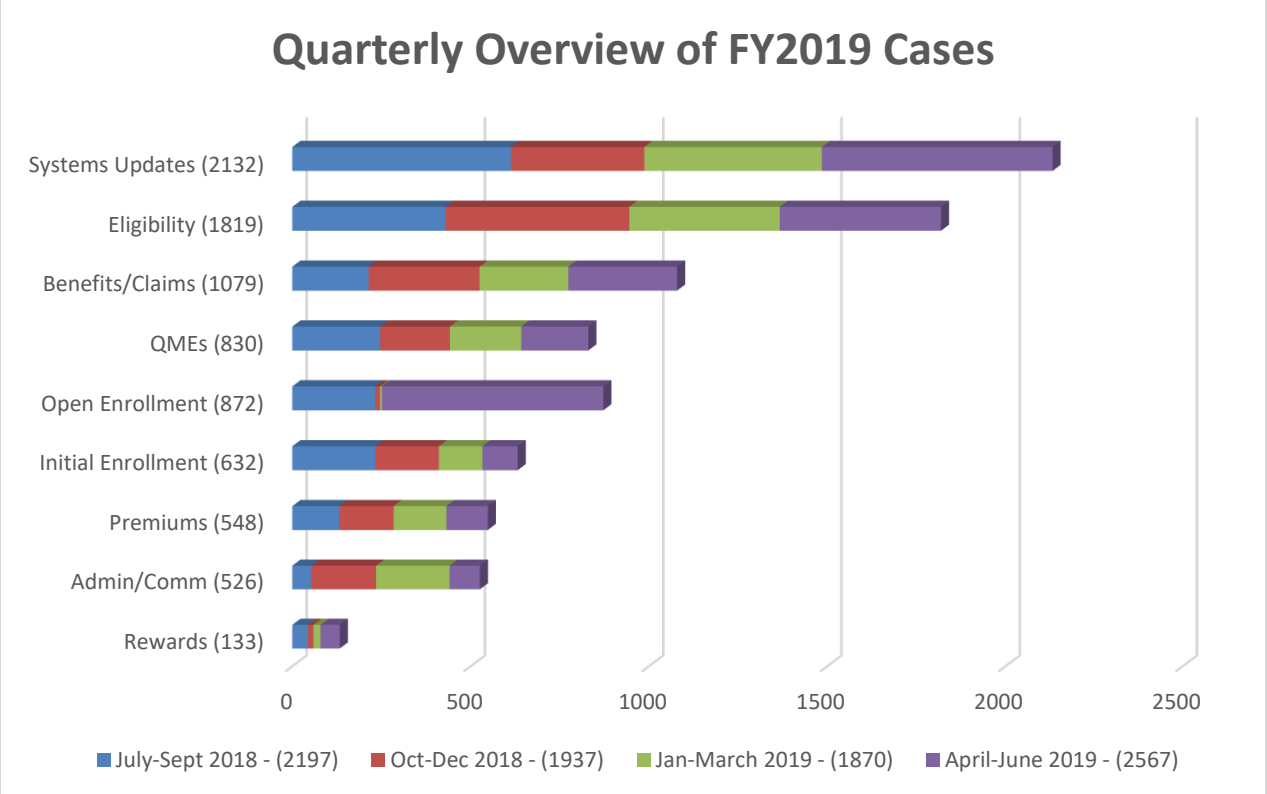
Initial Enrollment – 5% The program provides an opportunity for health care enrollments based on specified changes in employment status, such as the commencement or termination of employment, retirement, or transitioning to long-term disability. Under the program's provisions, the participants must submit their election within a defined period, based on the situation. There is normally an influx in the inquiries during the first quarter of the plan year due to new faculty contracts in the higher education agencies and with the local government schools.

Open Enrollment-10% The Open Enrollment period occurs each year in the spring and is announced in the Open Enrollment newsletter, Spotlight on Your Benefits, which is mailed to eligible employees and retirees. This is the annual opportunity to request enrollment or make election changes for health care and/or the flexible spending accounts. The elections and premium changes are effective on July 1st of each year. A new online Health Benefits enrollment application was available for the 2019 Open Enrollment period which may account for the slight decrease in the OE related contacts this year. OHB handled the inquiries and issues presented by the new application within EmployeeDirect which were associated with access to the portal, system browsers, and election confirmations. The online enrollment application accounted for 22,132 transaction for the Open Enrollment period with approximately 600 requests to OHB for assistance.

Qualifying Midyear Events (QMEs) – 9% The IRS provides a listing of specific life events that allow plan participants to make consistent mid-plan year election changes. Under the program provisions, the participant's election change request must be submitted within 60 calendar days of the qualifying midyear event and they must provide documentation to support the event. OHB provides guidance to the agency in the approval process and when required, makes the appropriate updates to the benefits system.

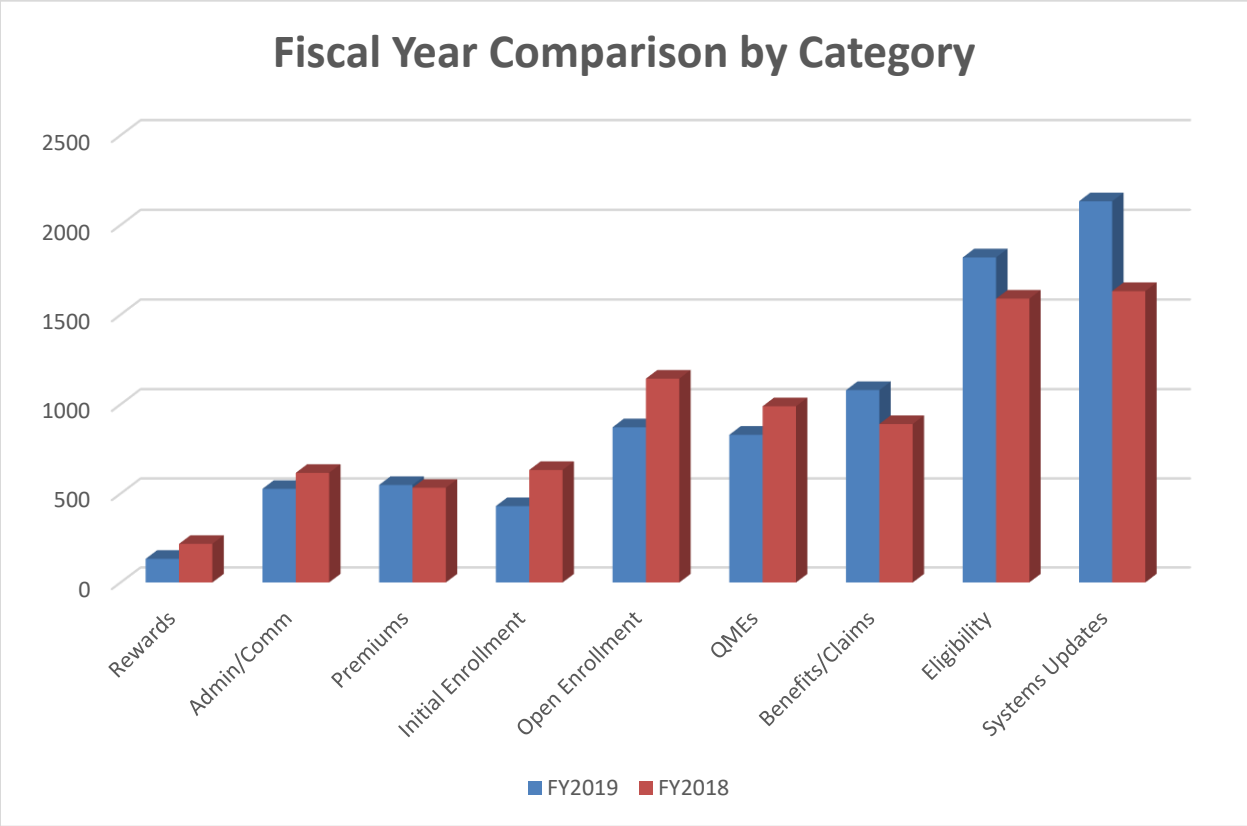
System Updates and Reports – 24% This includes agency requests to update the Benefit Eligibility System (BES), questions related to EmployeeDirect, including the new Health Benefits Direct application and BES generated reports which are posted in the DHRM secure portal (HuRMan) for the agency's use. With the transition of another large university from the state personnel management system, the number of requests increased seeking OHB assistance with transferring the health benefits records for existing employees and establishing benefits records for new hires.

The Office of Health Benefits (OHB) received a consistent number of inquiries each quarter related to system update requests, benefits and claims, qualifying midyear events (QME), plan premiums and eligibility issues. Other topics tend to peak at specific times during the plan year. For example, Open Enrollment and Health Plan Reward inquiries increase during the first and last quarters of the plan year. The Administration and Communication inquiries occur mainly during the second and third quarters due to the ACA Employer Mandates.



The five major topics accounted for 76% of this fiscal year's issues compared to 68% of the FY18 issues.

	FY 2019	FY 2018
• System Updates and Reports	24%	18%
• Eligibility requirements for employees, retirees, and dependents	21%	17%
• Benefits and Claims	12%	10%
• Open Enrollment	10%	12%
• Qualifying Midyear Events (QMEs) election change requests	9%	11%



Adult Incapacitated Dependent Review

Dependent children covered under the components of the Health Benefits Program lose eligibility at the end of the year in which they turn age 26. Dependents that are ineligible due to age are removed from coverage effective January 1 of each year. When the dependent is deemed to be incapacitated and meets specific eligibility criteria as outlined in the program policies, they may continue coverage as an Adult Incapacitated Dependent (AID) past the plan's limiting age. If the employee or retiree feels that their dependent qualifies as an incapacitated dependent due to a physical or behavioral health condition, they can request a review to verify the eligibility requirements are met and the medical condition satisfies the plan administrator guidelines.

OHB provides an annual memo to state agencies and TLC employer groups announcing the upcoming loss of eligibility for these dependents. The memo includes information on the

program policies and the procedures the agency should follow to notify their employees/retirees. The memo also includes sample letters to be used by the benefits offices to communicate the options available to the dependent losing eligibility and the options available for the employee/retiree related to the continuation of coverage for an AID.

The issuance of the annual memo as well as the system reports needed by the agencies are coordinated by a Senior Specialist on the Ombudsman's team. The team member performs the eligibility review taking into account the requirements outlined in the health plan member handbook, such as the dependent's marital status, residence and financial support. Once eligibility is confirmed, the specialist works with each of the four plan administrators to facilitate the review of the medical component of the request.

This annual AID review also includes a periodic recertification of existing AID members to ensure their continued eligibility and incapacitation. The AID recertification is performed biennially. Working with the plan administrator, the specialist ensures that the employee/retiree is contacted and provided the paperwork and instructions for the recertification of the dependent.

Employer Mandate Reporting

The employer mandate provision of the Affordable Care Act (ACA) requires 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 this Employer Mandate Reporting. DHRM, on behalf of the state agencies and local employers participating with the State and Local Health Benefits Program, compiled and reported the calendar-year information about the health insurance coverage offered to employees and their covered family members.

In addition to the issues reported above, the Ombudsman, working with the Systems Team and the Communications Manager, provided assistance with the reconciliation of the data to ensure compliance with the required reporting to the IRS on behalf of the state and local employer groups covered by the program. IRS 1095 forms for the 2018 tax year were mailed to state and local health plan participants in January 2019 before the March 2019 filing date.

APPEALS

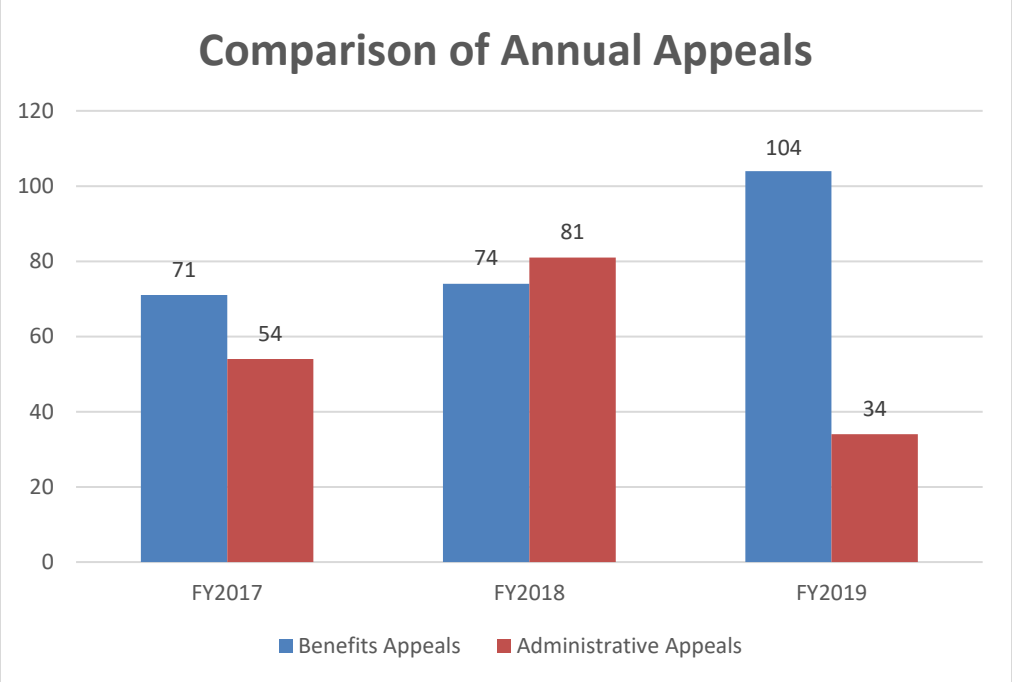
Charged with the oversight of the appeals process, the Ombudsman or an appeals examiner served as the contact for appellants. Every effort was made to assure that all appellants received the full extent of the benefits to which they were entitled under the rules of the program.

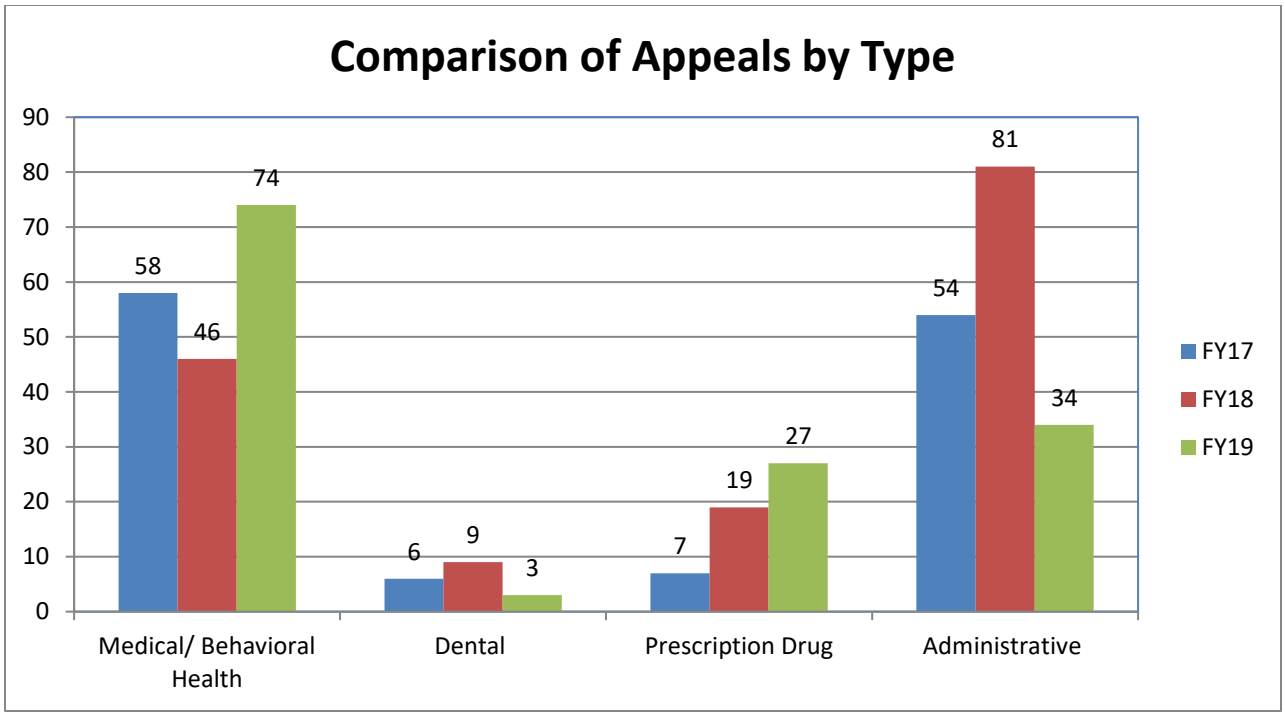
There are two classifications of appeals:

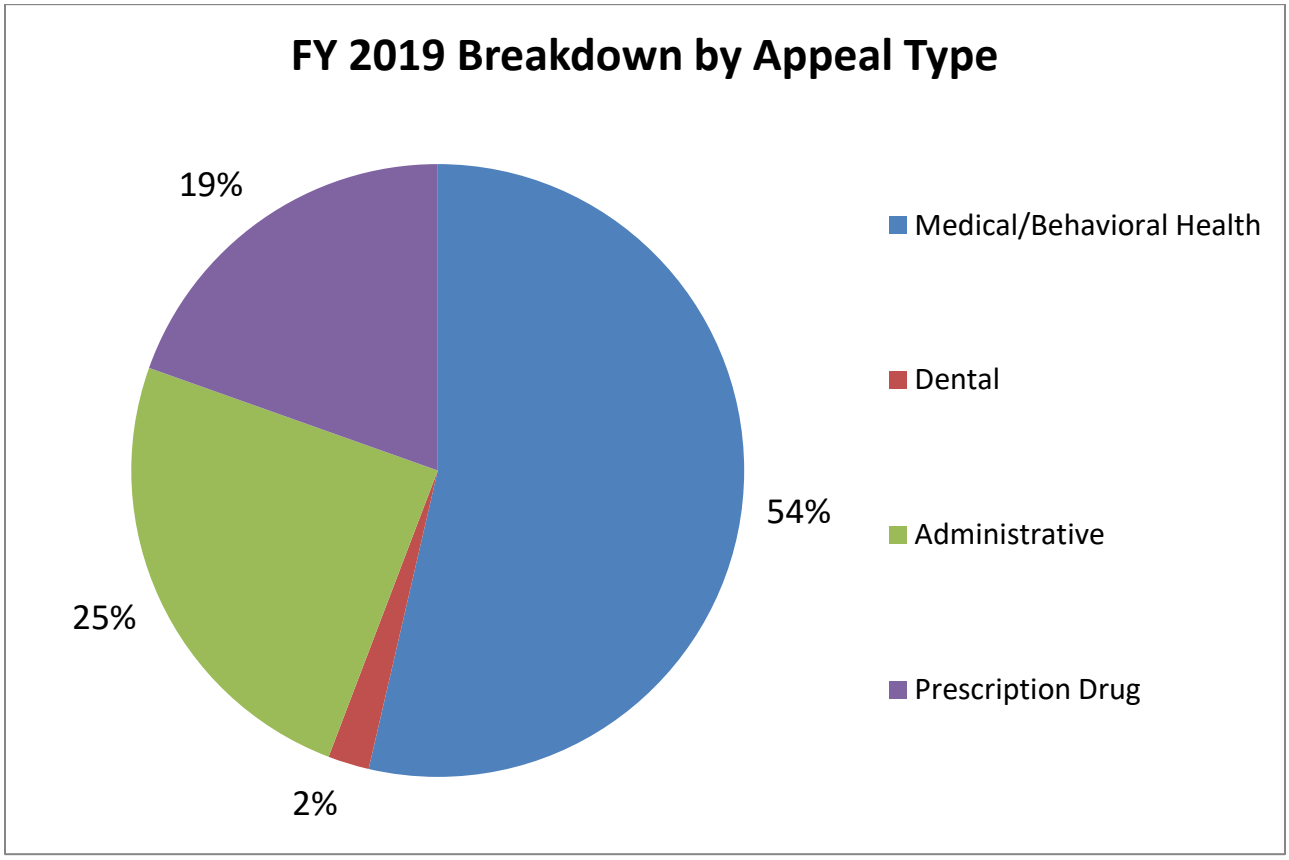
1. **Plan benefits** which involve claim and service issues, and
2. **Program administration** which involves eligibility for coverage or a benefit under the program.

Each of the third party vendors responsible for administering claim components of the Health Benefits Program has an internal process for benefits appeals. After exhausting the appeals with a specific vendor, a member has the right to appeal any adverse decision to DHRM. Members also have the right to appeal administrative denials to the Director of DHRM.

During the 2019 fiscal year, 138 appeals were submitted to DHRM. This compares to 125 appeals for the 2017 fiscal year and 152 for the 2018 fiscal year. For FY 2019, 104, or 75%, of the appeals received were related to plan benefits and 34, or 25%, were related to program administration.




Comparison of Appeals by Type
90
80
70
60
50
40
30
20
10
0
58
46
74
6
9
3
7
19
27
54
81
34
Medical/ Behavioral Health
Dental
Prescription Drug
Administrative
FY17
FY18
FY19


FY 2019 Breakdown by Appeal Type
19%
54%
25%
2%
Medical/Behavioral Health
Dental
Administrative
Prescription Drug

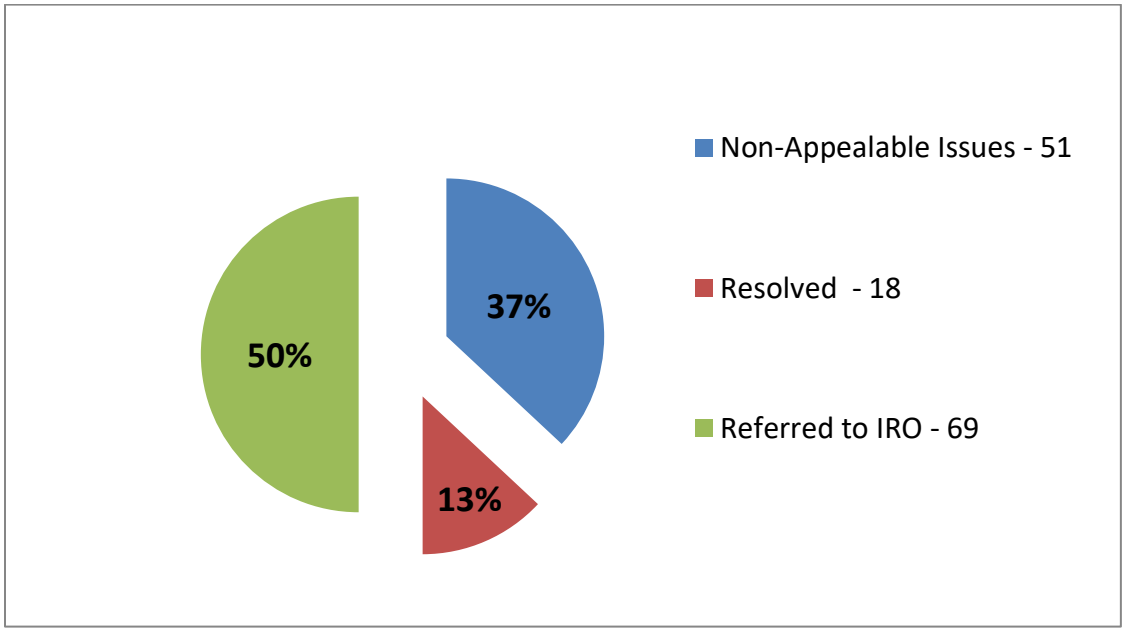
Each appeal request is evaluated to ensure the adverse determination was in line with the provisions of the program and no substantive errors were made. In many cases, DHRM, working with the health plan administrator and/or the member, is able to resolve the issue. Appeals are only resolved in this phase if the resolution is in favor of the appellant. During FY 2019, seventeen appeals were resolved by the Ombudsman's team by reviewing additional information provided. There was also one appeal which was resolved by the Director of DHRM through the informal fact finding process.

Informal Fact Finding Consultations – Depending on the administrative appeal request, the opportunity for an informal fact finding consultation (IFFC) with the Director may be offered to the appellant. While there was not a face-to-face IFFC, one of the appellants, who was requesting to be reinstated into the program following non-payment of premiums, did submit an extensive review packet of additional information for the Director's review. This information, which provided extenuating circumstances which were outside of the appellant's control, was reviewed by the Director and the adverse determination was reversed.

Invalid Appeals - Matters in which the sole issue is a disagreement with policy or a contractual exclusion are not appealable under the program. Each case was evaluated to ensure that the program rules and benefits were applied correctly. Fifty-one appeals (37%) filed were determined to be non-appealable because the member request was in direct conflict with a program provision or plan benefit. These invalid appeals included requests:

- for failure to submit an election change request within the program's required deadline,
- for an exception to the plan's dependent eligibility requirements,
- to cover a service that is specifically excluded under the program,
- for additional reimbursement to out-of-network providers (balance billing) and
- for exceptions to the program's mandatory generic prescription provision.

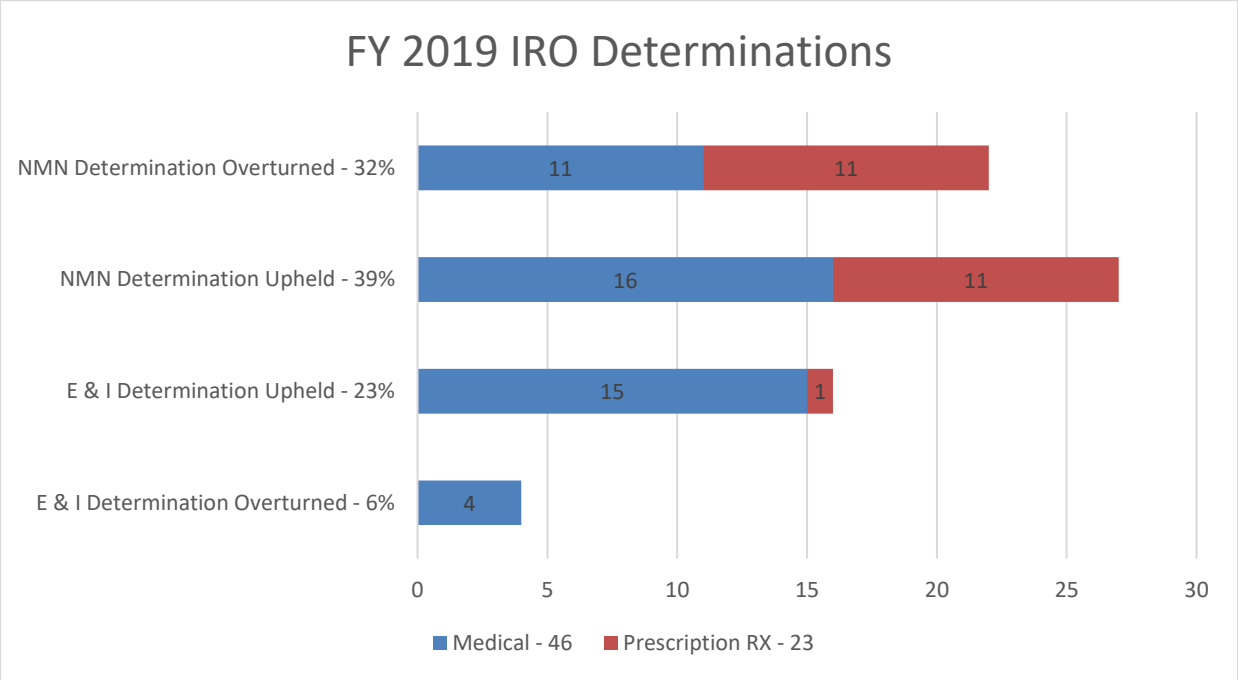
The remaining 69 appeals (50%) were referred to an Independent Review Organization (IRO) for review.



Independent Review Organizations - The program allows 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**. Adverse determinations for plan benefits are reviewed by an independent review organization (IRO), who will make a determination whether the plan administrator's 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.

The majority of the appeals this fiscal year were due to denials for services deemed not medically necessary (NMN) by the plan administrator. There were 49 NMN appeals (27 medical and 22 prescription drug) which accounted for 71% of the appeals reviewed by the IROs. These include appeals for a service not considered to be the accepted or normal course of treatment based on the administrator's coverage guidelines, such as an off-label use of a medication or a conflict with the diagnosis and treatment provided.

The remaining 20 appeals (29%) were for services considered to be experimental and/or investigational (E&I) by the administrator but the member or the provider felt the service should be covered by the plan.



There were 26 (38%) adverse determinations made by the claims administrators overturned by our IROs this plan year with 43 (62%) of the determinations being upheld. The requests that were reversed included specialized treatments, such as a nerve implant for sleep apnea, steroid injections for an ophthalmological condition, and focused testing for an oncology patient. There was a change in the coverage guidelines by a plan administrator for a specific injection for osteoarthritis. This change accounted for 9 of the NMN appeals; however, only one of the plan administrator's determinations was reversed by the IRO.

COMMUNICATIONS

The Ombudsman is involved in the development and review of communications for Health Benefits Program publications, web site information, and vendor communications to members. The Ombudsman and her team worked closely with the DHRM Communications Manager, program managers and each of the plan vendors on the implementation of the plan changes, and the development of benefit communications on various program components. In addition to working on the targeted communications for the **SmartShopper program**, the Ombudsman and team worked on the following communication projects:

Open Enrollment - The team worked on the literature, forms and mailing for the annual Open Enrollment period. The Ombudsman also worked on communications to the agencies to address program administration issues, many of which were identified by monitoring the trend of the inquiries to OHB. With the implementation of the vendor and program changes for the 2019-2020 plan year, the Ombudsman and her team worked closely with the DHRM Communications Manager and each of the plan vendors to develop material for the 2019 Open Enrollment period. This included:

- 2019 Spotlight on Your Benefits Newsletter
- 2019 Open Enrollment Presentation
- Updates to the online benefit consultant, ALEX
- Enrollment Form revisions
- 2019-2020 Premium Rewards Requirements and FAQs
- Important Health Benefits Notices including CHIP and Language Assistance Notices
- Flyer - Using Health Benefits Direct for Open Enrollment
- Summaries of Benefits and Coverage for all state and TLC health plans
- State Health Benefits Program Overview Brochure
- Individual Plan Brochures for each of the health plans:
    - COVA Care Plan
    - COVA HDHP Plan
    - COVA HealthAware Plan
    - Kaiser Permanente Plan
    - Optima Health Vantage Plan
- 2019- 20 Flexible Benefits Sourcebook and FSA Worksheets

Capitol Square Healthcare Clinic – The Ombudsman worked with the Communications Manager on the email messages to employees regarding the onsite clinic's services. The Ombudsman continues to work closely with the staff of the Capitol Square Healthcare Clinic, assisting the clinic staff with eligibility and procedural issues.

The Ombudsman's team communicated 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 worked with the vendors to prepare ongoing information regarding the plan benefits and also participates in all applicable monthly vendor meetings and attends the annual review meeting with each of the health plan administrators.

The team, working with the Communication Manager, began the review of the Health and Flexible Benefit documents and links on the DHRM web site. This project will continue into the 2019-2020 fiscal year as a part of the project to update the agency's web site.

CONCLUSION

In the pursuit of excellence, the Ombudsman's team focuses on delivering quality service to all customers. The team strives to thoroughly investigate complaints and appeals, dealing with each issue fairly and consistently. Paying attention to developing trends, team members 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, with the implementation and administration of new programs and plan administrators, the Ombudsman's team will strive to continue the high standards of service to customers, who include not just the members covered under the program, but the citizens of Virginia.