EMILY S. ELLIOTT
DIRECTOR

COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

James Monroe Building
101 N. 14th Street, 12th Floor
Richmond, Virginia 23219
Tel: (804) 225-2131
(TTY) 711

November 17, 2020

The Honorable Richard L. Saslow, Senate of Virginia
The Honorable L. Louise Lucas, Senate of Virginia
The Honorable Jeion A. Ward, Virginia House of Delegates
The Honorable Patrick A. Hope, Virginia House of Delegates
The Honorable Mark Sickles, 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

cc: Executive Director, Joint Commission on Healthcare

OMBUDSMAN ANNUAL REPORT FISCAL YEAR 2020

Office of State and Local Health Benefits Programs

December 2020

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ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
FISCAL YEAR 2020

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, 2019 through June 30, 2020. 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 2020, the Ombudsman's team handled 10,102 requests for assistance or complaints (cases) and reviewed 105 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:

Health Benefits Premium Holiday – Participants in the State Health Benefits Program were awarded a premium holiday for the month of October 2019. Working with the Department of Accounts (DOA), the Virginia Retirement System (VRS) and the health plan vendors, the guidelines and procedures to implement the $0 premium for employees, retirees and state agencies were developed. In addition, the Ombudsman's team handled questions and concerns related to the holiday.

Prescription Drug Explanation of Benefits - In response to a budget amendment to improve transparency in pharmacy costs, the State Health Benefits Program implemented the production of explanation of benefits (EOB) for outpatient drug coverage. The EOBs, which are the first in the health care industry, are available upon request by members in the self-insured state health plans.

State Health Program and COVID-19 - With the onset of the COVID-19 pandemic, DHRM provided guidance to agencies and employees on multiple benefit and policy topics. The Office of Health Benefits provided guidance on existing policies and services based on the changes to the "normal" health care environment and the transition to telework and virtual schooling. Members in our health plans and in the flexible spending accounts were provided with additional benefits to assist them during the time of the pandemic. Health and Flexible Benefits information that included Questions and Answers about health plan services and flexible spending account (FSA) participation and claims, developed by the Office of Health Benefits, were distributed and posted to the DHRM website

Cardinal Human Capital Management System - The Cardinal Human Capital Management (HCM) system is a new statewide administrative system that will be used to manage and administer health benefits for the Commonwealth of Virginia agencies and localities participating in The Local Choice (TLC) Health Benefits Program. Working with DHRM team members and the Cardinal project team, the Ombudsman worked to understand the functionality of the system, provide constructive feedback and address questions and concerns related to health benefits regulations and compliance.

Adult Incapacitated Dependent (AID) 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 who are ineligible due to age are removed from coverage effective January 1 of each year. When the dependent is deemed 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.

This review process includes two phases. There is the initial notification for the dependents who will be removed from coverage due to reaching the health plan's limiting age. If requested by the employee, a review of the dependent's eligibility for continued coverage under the program's provisions for incapacitation is initiated. If approved for this continuation of coverage under the program, the dependent is placed on a cycle for periodic evaluations to ensure the eligibility is maintained.

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

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

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 360 member groups covering approximately 50,000 employees, retirees and their covered dependents. OHB also administers a program, the LODA Health Benefits Plans, which provides health benefits to public employees, or volunteers who were disabled in the line of duty and their eligible dependents; and the eligible dependents of certain public employees or volunteers who were killed in the line of duty. Presently there are approximately 3,000 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). The program also offers two regional fully-insured HMO plans to employees and early retirees in the Northern Virginia service area and the greater Hampton Roads region. The employees and early retirees may also select a plan that serves as a supplement for members who are eligible for TRICARE coverage as a military retiree. 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 and 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 Premium Holiday

In the spring of 2019, Governor Northam announced a premium holiday for the month of October 2019 for those enrolled in the State Health Benefits Program. The premium holiday applied to employees, retiree group participants (which include retirees, survivors, and LTD participants) and Extended Coverage/COBRA participants. The TRICARE Supplement enrollees could not be included in the premium holiday based on § 2.2-2818.1 of the Code of Virginia which requires TRICARE Supplement participants to pay the full cost of coverage

The holiday removed the employee/retiree and employer contribution to the health care premium for one month, regardless of participant membership level (Single, Dual or Family). Working with the Communications Manager and the OHB policy team, communications were developed and distributed to state agencies, eligible employees and retiree and COBRA participants.

Health Benefits Program and COVID-19

Working with the health plan vendors, the program provided additional benefits to assist employees during the time of the pandemic. COVID-19 related information about health plan services and flexible reimbursement account participation and claims were developed by the Office of Health Benefits. The information, which was distributed to agencies, was also posted to the DHRM website. Some of the COVID-19 related benefits included:

- **Out-of-Pocket Cost Waiver for COVID-19 Testing and Related Office Visits**: In response to the COVID-19 pandemic, the DHRM Office of Health Benefits implemented cost share waivers for health plan members for COVID-19 testing and related office visits.
- **Virtual Office Visits:** In an effort to encourage continued management of their health care while members did not have access to or preferred to avoid an in-person office visit, the out of-pocket costs for virtual visits under the PPO and CDHP plans were waived.
- **Early Prescription Drug Refills**: Early 30-day refills of certain maintenance medications were made available.
- **Online EAP Resources to Wage and Waived Employees:** To assist with work, family and other personal issues during the COVID-19 pandemic, state wage employees may access website resources through the Anthem and Aetna Employee Assistance Program. These online educational services are offered at no cost to wage and waived employees who are not covered by a state health plan.
- A **Flexible Spending Account (FSA) Grace Period** was added for the 2019-2020 plan year that extended the period to incur claims until October 31, 2020.
- **Additional Vision Benefits** were provided to the COVA Care, COVA HDHP and COVA HealthAware plans with the Expanded Vision benefit to help accommodate members experiencing difficulty receiving vision services.
- **Virtual Employee Assistance Program (EAP) Services** to assist agencies help their employees to include:

- Critical Incident Response to address traumatic incidents, natural disasters and workplace issues.
- Workshops covering a variety of issues including new topics on COVID-19 and diversity/racism injustices.

News on COVID-19 continues to change every day. Many of the referenced benefits, such as the cost share waivers, are expected to be in place through the duration of the Federal Emergency.

Cardinal Migration Project

The Virginia Department of Human Resource Management (DHRM) will be replacing the current human resource management and health benefits administrative systems in March 2021. The new system, Cardinal Human Capital Management (HCM), will allow the Commonwealth to take advantage of a suite of integrated applications. Named in honor of the state bird, the Cardinal system will replace and improve outdated accounting, personnel and benefits systems for the agencies of the Commonwealth. By implementing an integrated, streamlined solution across the Commonwealth, state agencies should experience improved efficiency and better access to personnel and health benefits information.

Currently, the Personnel Management Information System (PMIS), which was implemented in 1978, and the Benefits Eligibility System (BES), implemented in 1981, serve as the Human Resource and Health Benefits Administration systems of record. The Commonwealth will be retiring PMIS and BES, along with the Commonwealth Integrated Payroll Personnel System (CIPPS) administered by the Department of Accounts. Cardinal HCM will become the Commonwealth's human resource, health benefits, and payroll management system.

The Cardinal Human Capital Management (HCM) system will also be used to administer health benefits for the Line of Duty Act (LODA) Health Plans and the localities participating in The Local Choice (TLC) Health Benefits Program. The system will also be able to handle the annual renewal process for the TLC employer groups.

The phase one launch of Cardinal is scheduled for March 2021. This fiscal year, the Ombudsman worked with the System and Policy team members on various aspects of the Cardinal project. Discussions included reviews of current and proposed system logic and protocols, messaging for the users and application of benefit policy. The work on this project will produce a change in systems that will help streamline business processes. State agencies and TLC employer groups will see positive changes in the area of health benefits administration

Prescription Drug Explanation of Benefits

In response to a budget amendment to improve transparency in pharmacy costs, the state health benefits program implemented the production of explanation of benefits (EOB) for outpatient drug coverage. The EOBs, which are the first in the health care industry, are available upon request by members in the self-insured state health plans for employees and non-Medicare retiree

group participants. The requirements of the budget language mandated the five below items be included in the EOB:

1. Drug reimbursement cost (final amount paid)
2. Dispensing fee
3. Copayment/coinsurance
4. Final payment to the dispensing pharmacy
5. Amount charged by the pharmacy benefit manager (PBM) to the Commonwealth.

The Ombudsman, working with the policy team, communications manager and the pharmacy vendor, developed the EOB process and a campaign to notify members on their availability.

Adult Incapacitated Dependent Review

OHB provides an annual memo to state agencies and TLC employer groups announcing the upcoming loss of eligibility for dependents who have turned 26 during the calendar year. 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 process available if the employee or retiree feels that their dependent qualifies as an adult incapacitated dependent (AID) due to a physical or behavioral health condition.

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

This 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 each plan administrator, the senior specialist ensures that the employee or retiree is provided the paperwork and instructions for the recertification of the dependent.

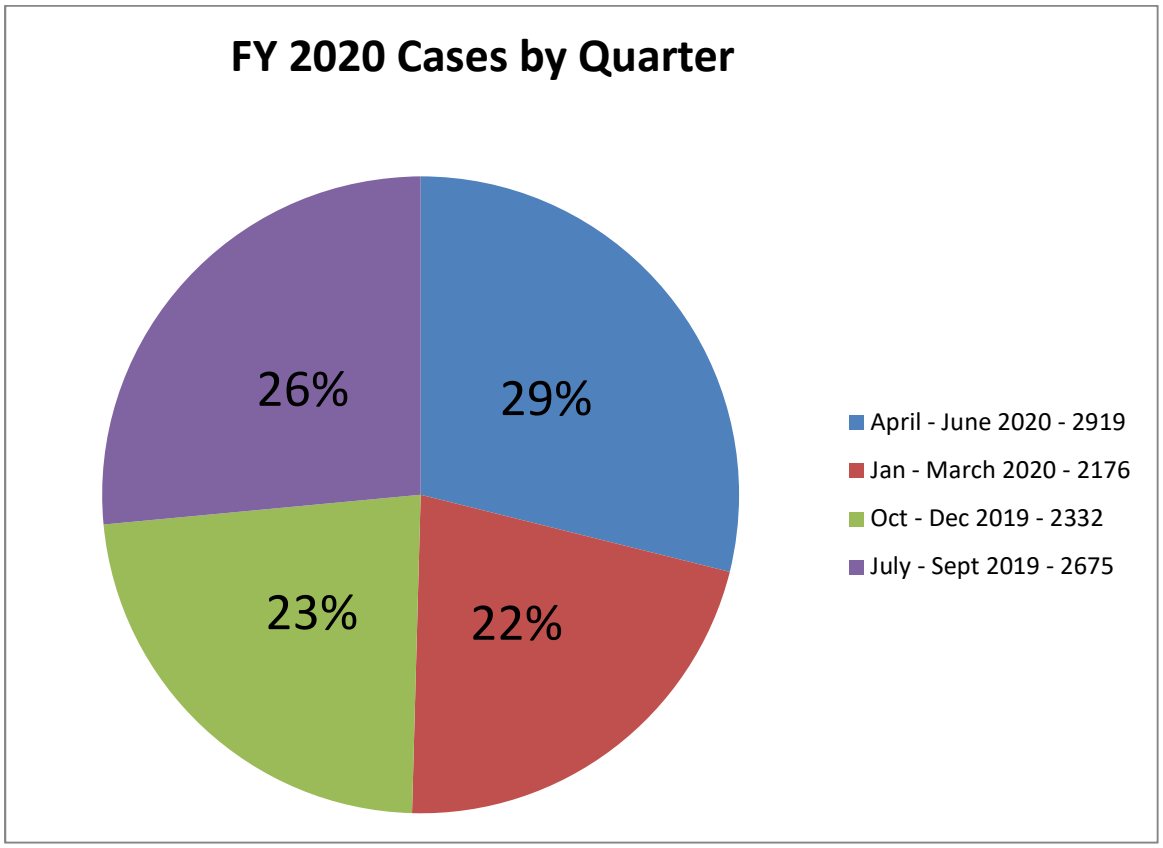
Employer Mandate Reporting

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.

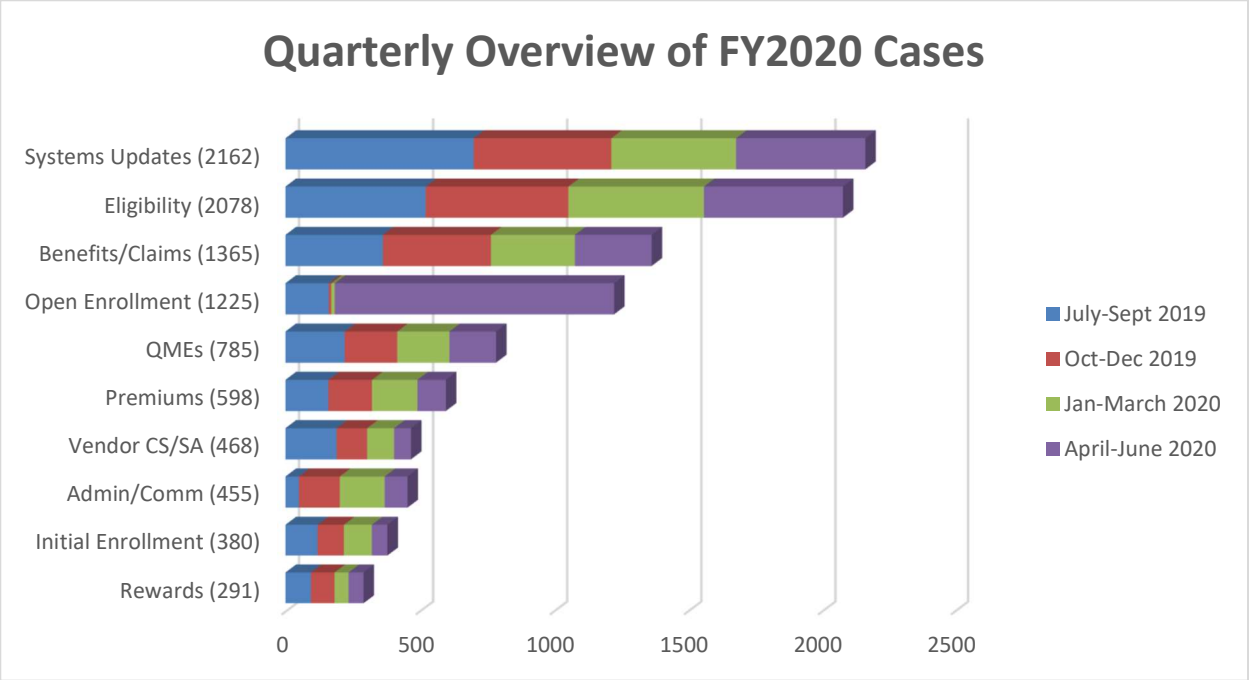
In addition to the issues reported above, the Ombudsman's team, working with the Systems Team, provided assistance with the reconciliation of the data to ensure compliance with the required reporting to the IRS on behalf of the state and local employer groups covered by the program. IRS 1095 forms for the 2019 tax year were mailed to state and local health plan participants in January 2020 before the March 2020 filing date.

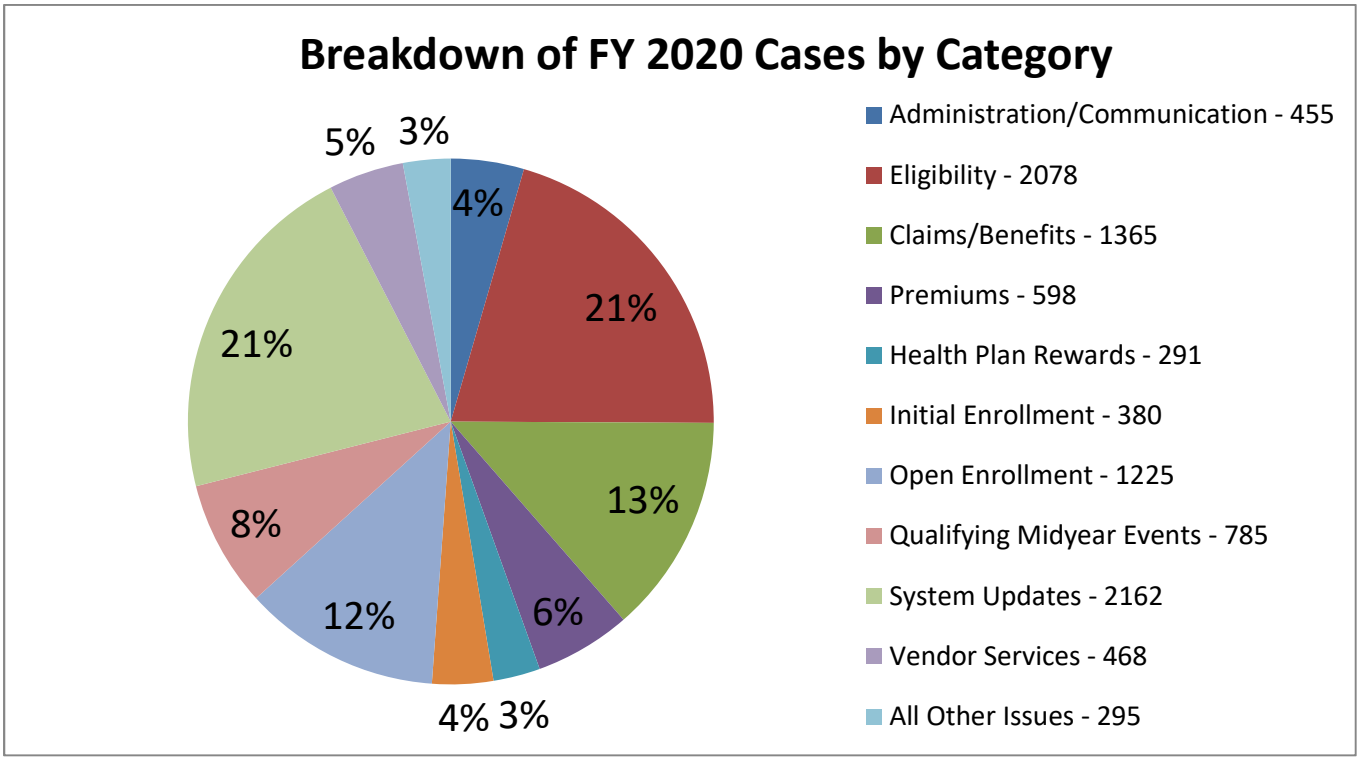
EMPLOYEE AND RETIREE SERVICES

In FY 2020, the Ombudsman's team handled 10,102 request for assistance and complaints 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. The Office of Health Benefits (OHB) received a consistent number of inquiries each quarter but the primary topics vary depending on the quarter with the plan year.



The quarterly requests related to system update, benefits and claims, qualifying midyear events (QME), plan premiums and eligibility issues remain constant throughout the year. Other topics tend to peak at specific times during the fiscal year. For example, Open Enrollment and Health Plan Reward inquiries increase during the first and last quarters of the year. The Administration and Communication inquiries occur mainly during the second and third quarters due to the ACA Employer Mandates.


Quarterly Overview of FY2020 Cases
Systems Updates (2162)
Eligibility (2078)
Benefits/Claims (1365)
Open Enrollment (1225)
QMEs (785)
Premiums (598)
Vendor CS/SA (468)
Admin/Comm (455)
Initial Enrollment (380)
Rewards (291)
0
500
1000
1500
2000
2500
July-Sept 2019
Oct-Dec 2019
Jan-March 2020
April-June 2020


Breakdown of FY 2020 Cases by Category
4%
21%
13%
6%
4%
3%
12%
8%
21%
5%
3%
Administration/Communication - 455
Eligibility - 2078
Claims/Benefits - 1365
Premiums - 598
Health Plan Rewards - 291
Initial Enrollment - 380
Open Enrollment - 1225
Qualifying Midyear Events - 785
System Updates - 2162
Vendor Services - 468
All Other Issues - 295

Administration and Communication – 4% 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 – 13% 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 – 3% 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.

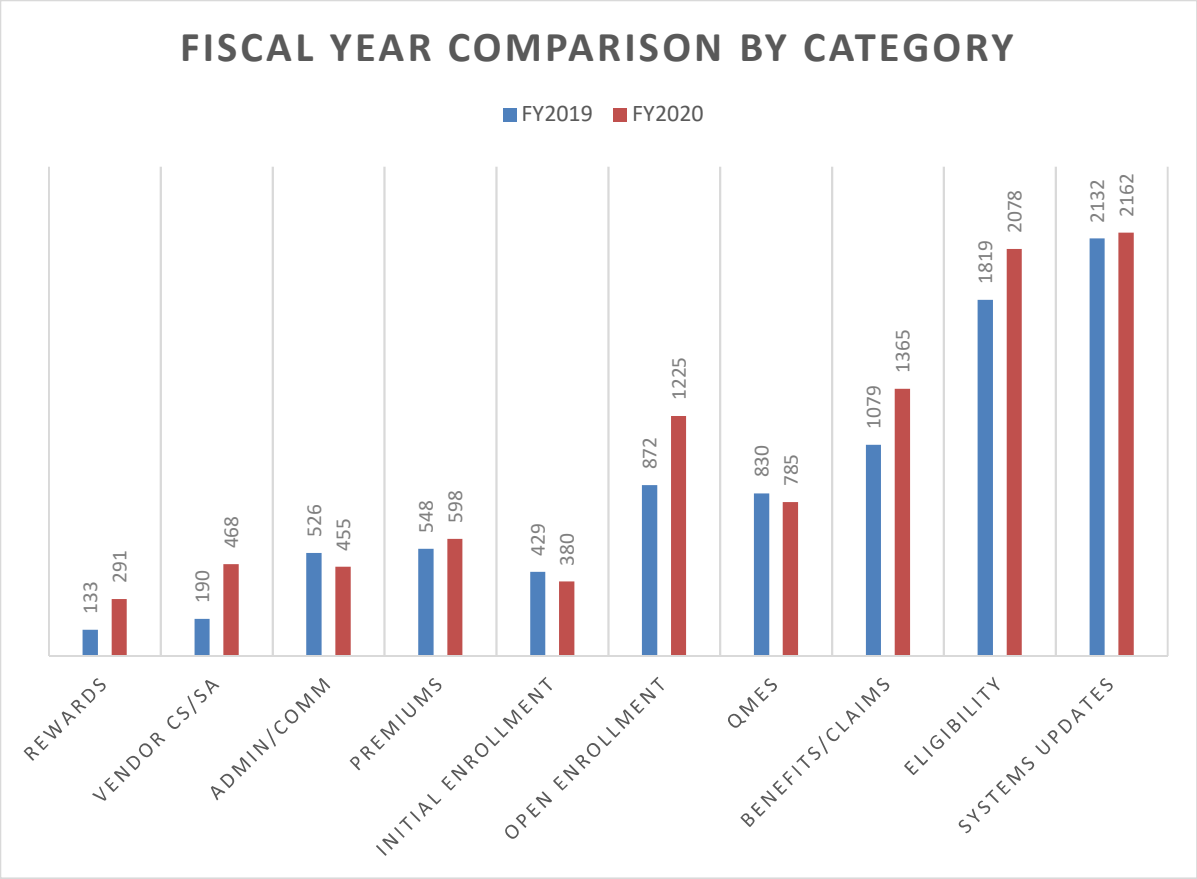
Initial Enrollment – 4% The program provides an opportunity for health care enrollments based on specified changes in employment status, such as the commencement or termination of employment, retirement, or transitioning to long-term disability. Under the program's provisions, the participants must submit 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-12% 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 1 of each year. A new online Health Benefits enrollment application was available for the 2020 Open Enrollment period that 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 that were associated with access to the portal, system browsers, and election confirmations.

Qualifying Midyear Events (QMEs) – 8% 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 – 21% This includes agency requests to update the Benefit Eligibility System (BES), questions related to Health Benefits Direct application within EmployeeDirect, and BES generated reports that are posted in the DHRM secure portal (HuRMan) for the agency's use.

Vendor Services – 5% This includes provider network issues, access to coverage due to vendor system issues, or general complaints related to the customer service provided by one of the vendors.



The five major topics remain unchanged and accounted for 75% of the inquiries for the FY20 and 76% for FY19 fiscal years:

	FY 2020	FY 2019
• System Updates and Reports	21%	24%
• Eligibility requirements for employees, retirees, and dependents	21%	21%
• Benefits and Claims	13%	12%
• Open Enrollment	12%	10%
• Qualifying Midyear Events (QMEs) election change requests	8%	9%

APPEALS

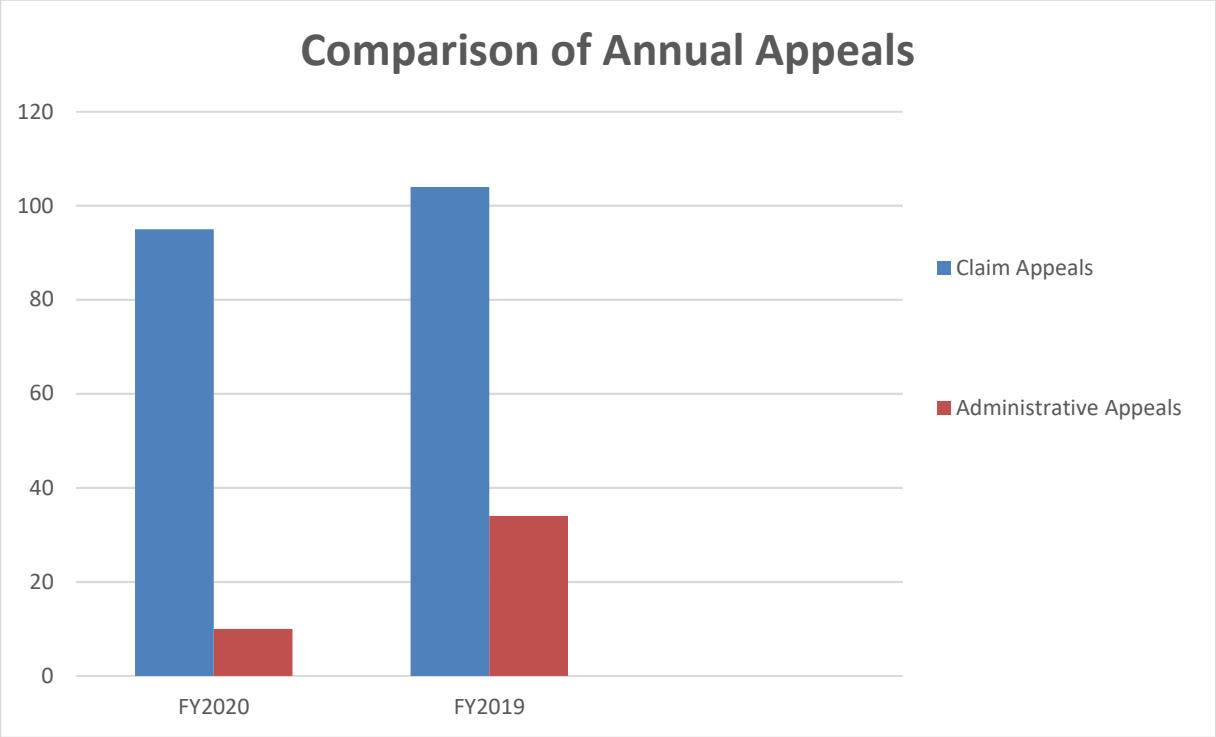
Charged with the oversight of the appeals process, the Ombudsman or an appeals examiner served as the contact for appellants. Every effort was made to assure that all appellants received the full extent of the benefits to which they were entitled under the rules of the program.

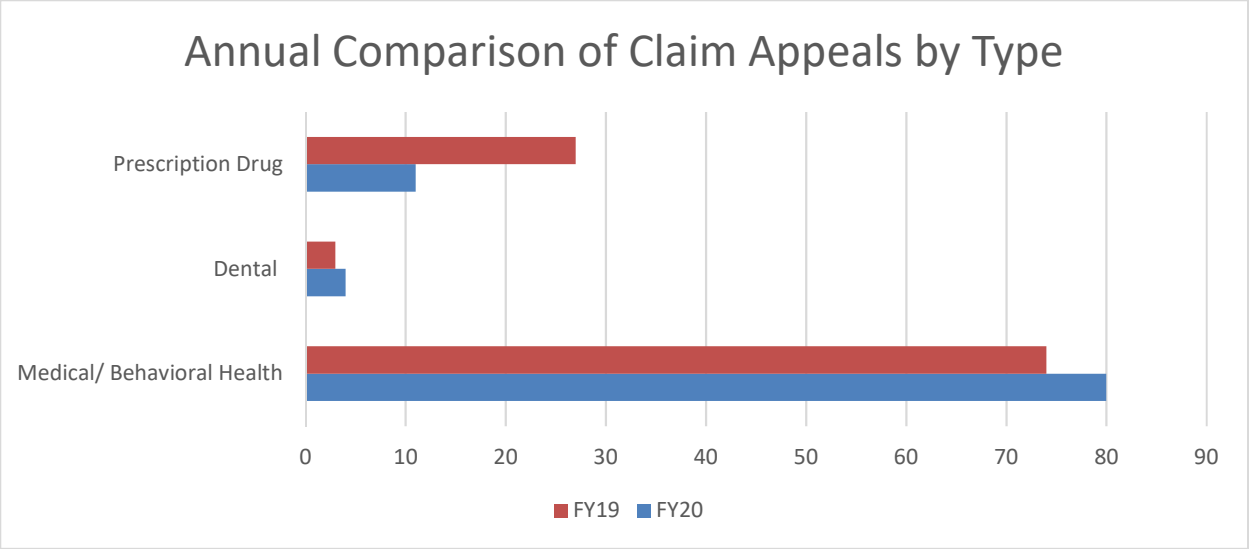
There are two classifications of appeals:

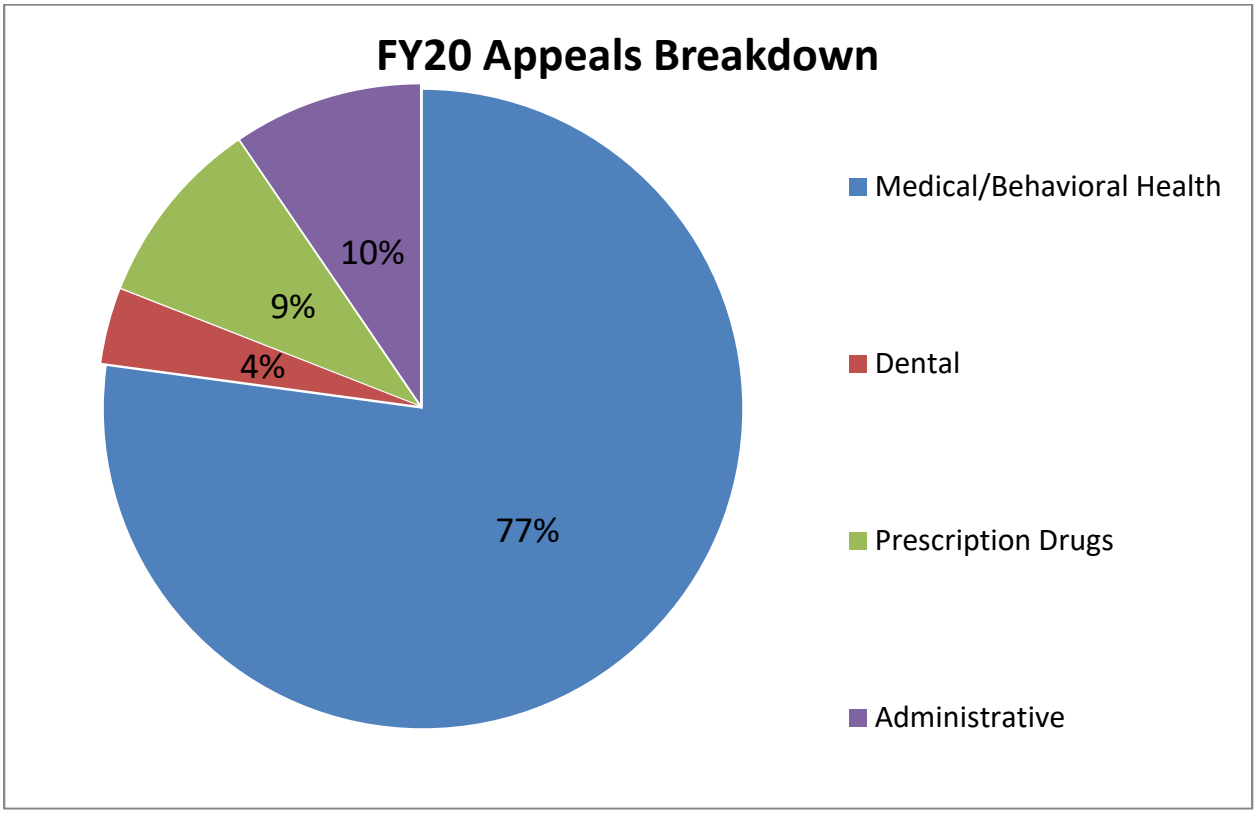
1. **Claims** which involve coverage and service issues for the self-insured health plans, and
2. **Program administration** which involves eligibility for coverage or a benefit under the program.

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

During the 2020 fiscal year, 105 appeals were submitted to DHRM. This compares to 138 for the 2019 fiscal year. For FY 2020, 95, or 90%, of the appeals received were related to claims and plan benefits and 10, or 10%, were related to program administration.







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 claim appeal without outside review. Appeals are only resolved in this phase if the resolution is in favor of the appellant. During FY 2020, the Ombudsman's team resolved fifteen appeals by reviewing additional information provided.

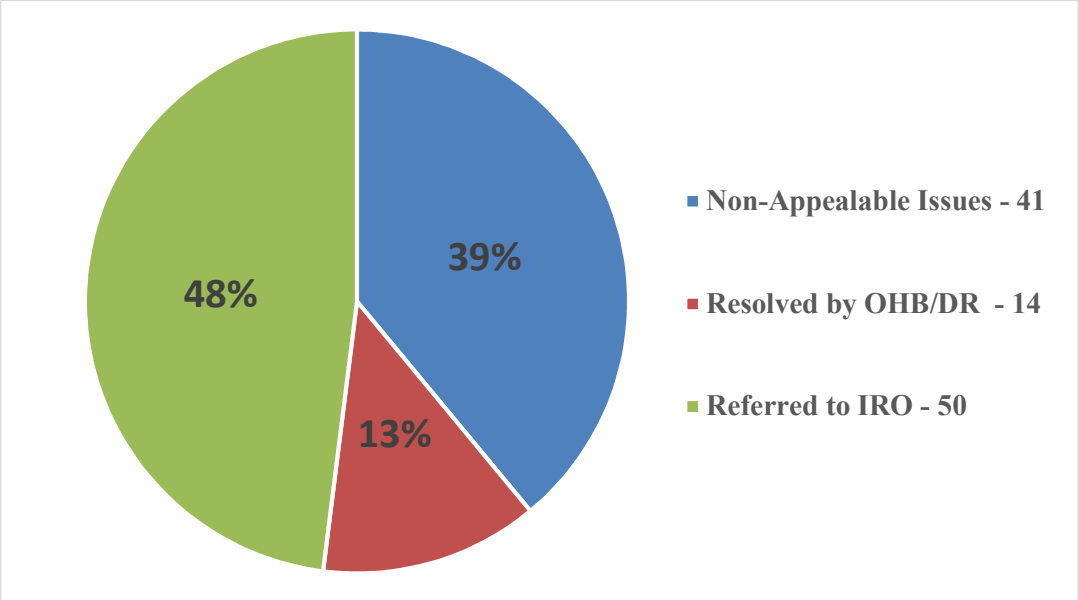
Director's Review – For administrative appeals, the request will initially be reviewed to determine its validity. If valid, an appeal package will be prepared for the Director of DHRM. The appeal package will include the appellant's request and supporting documentation, additional documentation from the agency's benefits office, if applicable, and any information from the OHB customer tracking system related to the adverse determination. Depending on the request, the opportunity for an informal fact finding consultation (IFFC) with the Director may be offered to the appellant.

While offered, there was not a face-to-face IFFC requested this fiscal year. The one administrative appeal submitted for the Director's review was related to a missed deadline to enroll a dependent. The Director reviewed this information, which provided extenuating circumstances, which were outside of the appellant's control, 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. Forty-one appeals (39%) 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 a request within the program's required deadline,
- to cover a service that is specifically excluded under the program,
- for additional reimbursement to out-of-network providers (balance billing),
- for external review prior to exhausting the internal process with the health plan, and
- for exceptions to the program's mandatory generic prescription provision.

The remaining 50 appeals (48%) were referred to an Independent Review Organization (IRO) for review.

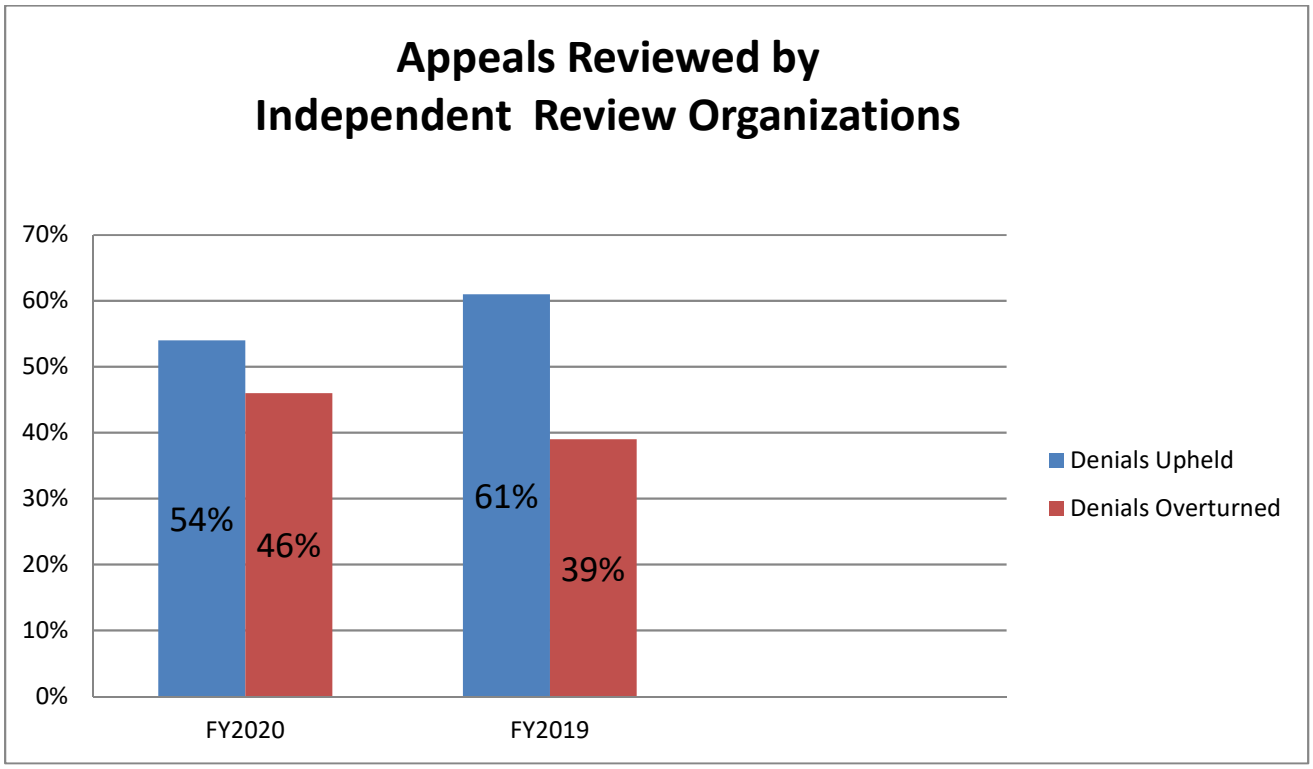


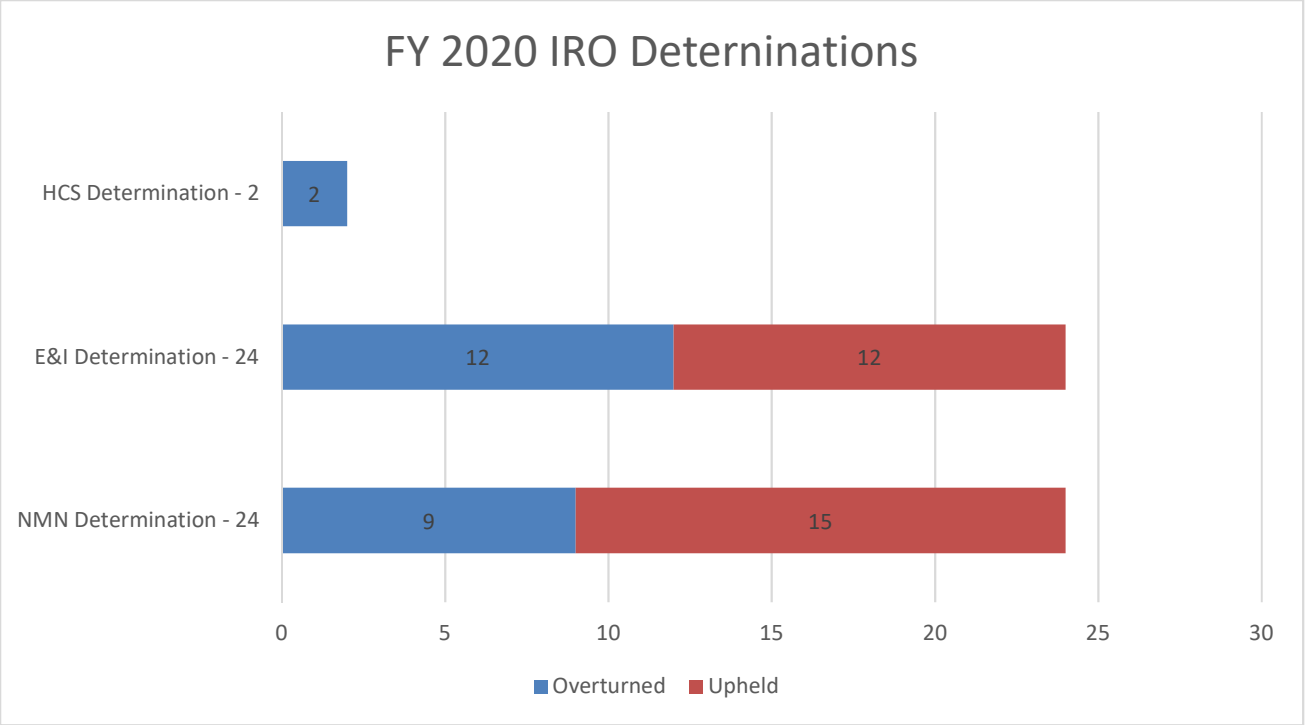
Independent Review Organizations - The program allows members to appeal any adverse benefit determination by a plan administrator that is based on the plan's requirements for **medical necessity** and **appropriateness**, **health care setting** and **level of care**, **effectiveness** of a covered benefit, 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.

For the 50 appeals referred to an IRO this fiscal year,

- twenty-four (48%) 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,
- twenty-four (48%) were due to denials for services deemed not medically necessary (NMN) by the plan administrator and
- two (4%) were for services related to the health care setting.

The majority of these appeals (92%) were adverse determination for medical or behavioral health services. Dental (2%) and prescription drug (6%) services accounted for the remaining IRO reviews. There were 23 (46%) adverse determinations made by the claims administrators overturned by our IROs this plan year with 27 (54%) of the determinations being upheld.





Our review of the IRO appeal determinations revealed the following:

Services:	% of IRO Reviews	Upheld by IRO	Overturned by IRO
Cancer Treatment	18%	6	3
Cardiac Defibrillator Vests	10%	4	1
Sleep Apnea Treatment	10%	1	4
Fusion Surgeries	8%	4	0
Injections for pain	8%	1	3
Obesity Related Procedures	4%	2	0
Prescription Medication	6%	2	1
Inpatient Setting	4%	0	2
Nerve Stimulators	4%	1	1
Air Ambulance	2%	1	0

The remaining thirteen (26%) IRO reviews were for various surgical procedures. Of these requests, five decisions were overturned and eight were upheld.

The appeals examiner and Ombudsman will review the trends with the plan administrators to ensure they are utilizing the most up-to-date medical information to make their determinations. We also review the utilization information available for the services to gauge the benefits provided for the services compared to the appeal requests.

COMMUNICATIONS

The Ombudsman is involved in the development and review of communications for Health Benefits Program publications, website 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. The Ombudsman and team worked on the following communication projects:

With the transition to new health plan vendors for 7/1/2019, additional communications were produced to provide guidance and clarification on various program and vendor changes such as:

- access to health assessments for premium rewards,
- transition of the health and wellness programs to the health plan administrator,
- engagement requirements to maintain the incentive for the disease management, maternity management and bariatric surgery programs,
- flexible spending account (FSA) debit cards,
- COVA HealthAware HRA reimbursements, and
- distribution of new member ID cards for all of the self-insured health plans.

We also worked with the Anthem team to develop communications on two administrative changes:

- New explanation of benefits format implemented for the State, TLC and LODA health plans administered by Anthem, and
- New online portal to order the health benefits materials provided through Anthem.

Annual Flu Shot Program - Under the state, TLC and LODA health plans, members were able to get an annual flu shot at no cost. The free shots can be administered at physicians' offices or pharmacies participating in their health plan's network. Guidelines were developed for agencies and employer groups that wanted to coordinate onsite flu shots clinics with a participating pharmacy in their area.

Capitol Square Healthcare (CSHC) administered flu shots for eligible state employees at agencies in and around Capitol Square. CSHC provided free shots onsite to COVA Care, COVA HDHP and COVA HealthAware members. Kaiser Permanente members, Optima Health members, TRICARE members, waived and wage employees pay for the vaccine.

Member communications, notifications to state agencies and TLC employer groups along with website documents for the 2019-2020 flu season were developed and distributed in the fall of 2019.

Capitol Square Healthcare Clinic – Capitol Square Healthcare Clinic is a joint venture between the Department of Human Resource Management (DHRM) and VCU Health Systems (VCUHS) to provide on-site medical care for state employees and non-Medicare retirees. Previously, the clinic was under the administration of an independent vendor. This fiscal year, the VCU Health Systems assumed direct administration of the clinic. The Ombudsman continues

to work with the staff of the Capitol Square Healthcare Clinic assisting with marketing and procedural issues. There is also a dedicated team member working as a liaison between OHB and the clinic staff. Working with the medical director, VCU Health Systems marketing team and the DHRM Communications Manager, the Ombudsman and her designated team member worked on revisions to the member communications and the clinic's website to update the information and the appearance of the materials.

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. The Ombudsman and her team worked closely with the DHRM Communications Manager and each of the plan vendors to develop material for the 2020 Open Enrollment period. This included:

- 2020 Spotlight on Your Benefits Newsletter
- 2020 Open Enrollment Presentation
- Updates to the online benefit consultant, ALEX
- Enrollment Form revisions
- 2020-2021 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
- 2020-21 Flexible Benefits Sourcebook and FSA Worksheets
- Notifications for Non-Medicare Retiree Group Participants.

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, continues the review of the Health and Flexible Benefit information on the DHRM website. This project will continue into the next fiscal year as a part of the project to update the agency's website.

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, 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.