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DIRECTOR

# COMMONWEALTH OF VIRGINIA

## *Department Of Human Resource Management*

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December 1, 2021

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 Grindly Johnson, 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 2021


**Office of State and Local Health Benefits Programs**

**December 1, 2021**

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# ANNUAL REPORT ON
# OMBUDSMAN ACTIVITIES & SERVICES
# FISCAL YEAR 2021

## 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, 2020 through June 30, 2021. 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 2021, the Ombudsman's team handled 10,190 requests for assistance or complaints (cases) and reviewed 169 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**
  The Office of Health Benefits provided a premium holiday for the month of December for those enrolled in the State Health Benefits Program. The premium holiday applied to most state employees and retiree group participants (which include retirees, survivors, LTD participants) and Extended Coverage/COBRA participants.

- **Annual Flu Shot Program**
  Under the health plans, members were able to get a free flu shot at physicians' offices or pharmacies participating in their health plan's network. Member communications and web site documents for the 2020-2021 flu season were developed and distributed in the fall of 2020. We also worked with the Capitol Square Healthcare Clinic to coordinate two Drive-Thru Flu Shot events during October 2020.

- **Premium Reward Program Engagement**
  In an effort to increase awareness and engagement in the Premium Reward program, the Office of Health Benefits sent email communications to all employees actively enrolled in COVA Care and COVA HealthAware that included directions on how to update and submit a health assessment. The mass emails was issued on 9/16/2020. There were 2,027 health assessments completed by eligible members from 9/16 - 9/30/2020.

- **Request for Proposals (RFPs) for Medicare-Coordinating Health Plans -** The Ombudsman and members of her team worked with the OHB policy team, our consultants, and the DHRM contracts team on the development and review of the RFPs for the two components of the health plans for our Medicare-eligible retiree population. This project is ongoing.

- **Open Enrollment Webinars for Benefits Administrator**
  In addition to the annual communication campaign for Open Enrollment, the Office of Health Benefits held two webinars for agency benefits administrators and managers in late April. These sessions modified the normal practice of vendor participation at agency Open Enrollment meetings and health fairs. The webinars included an Open Enrollment presentation with the health plan vendors and OHB available to answer questions. Employees submitted over 22,000 transaction for the Open Enrollment period with approximately 600 requests to OHB for assistance

- **Getting to Know Your Benefits Brochure -** This brochure provides an overview of the State Employee Health and Flexible Benefits. It was initially established to provide general information for new state employees but it was determined that the brochure would be a resource for all state employees. The Ombudsman and her team worked to update the information and expand the content to include new programs such as Shared Savings and Premium Rewards. The new brochure also provides general information on federally required notices and mandates that apply to our programs and it is now available to all prospective and current employees on the DHRM website.

- **Cardinal Migration for Health Benefits Program** – In preparation for the migration of information and data into the Cardinal system, the Ombudsman and other members of the OHB management team participated in meetings with Cardinal personnel to review current and future business processes. Serving as a subject matter expert (SME), the Ombudsman assisted in providing critical expertise to the project team, participating in the Cardinal Business Process Workshops and meetings on specific topics related to the benefits administered by the Office of Health Benefits.

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 of work. 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 Preferred Provider Organization (PPO) COVA Care, a High Deductible Health Plan (HDHP), and a Consumer Directed Health Plan (CDHP) COVA HealthAware. The program also offers two regional fully-insured Health Maintenance Organization (HMO) plans to employees and early retirees in the Northern Virginia service area and the greater Hampton Roads region. The

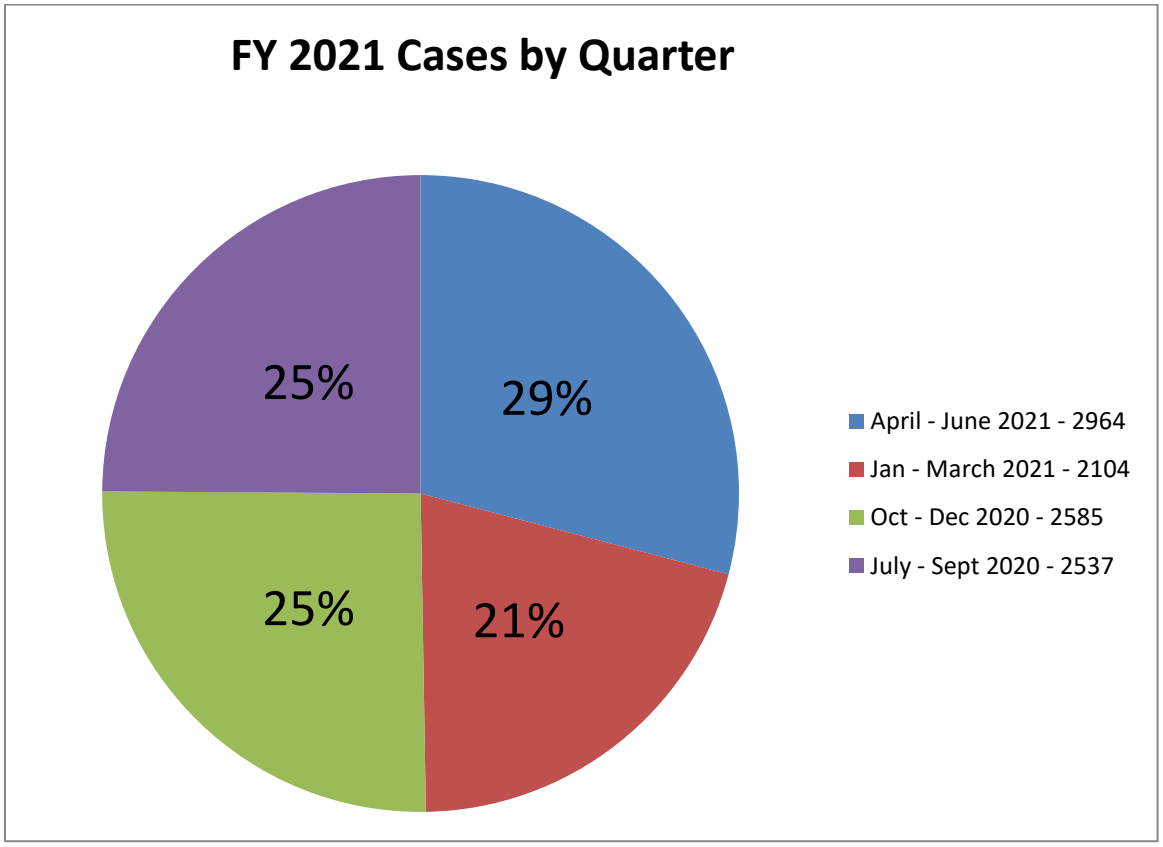
employees and early retirees may also select a plan that serves as a supplement for members who are eligible for TRICARE coverage as a military retiree. There are two Medicare Supplement options for eligible state retirees. The TLC program currently offers four self-insured plans designed around a PPO 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, 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.

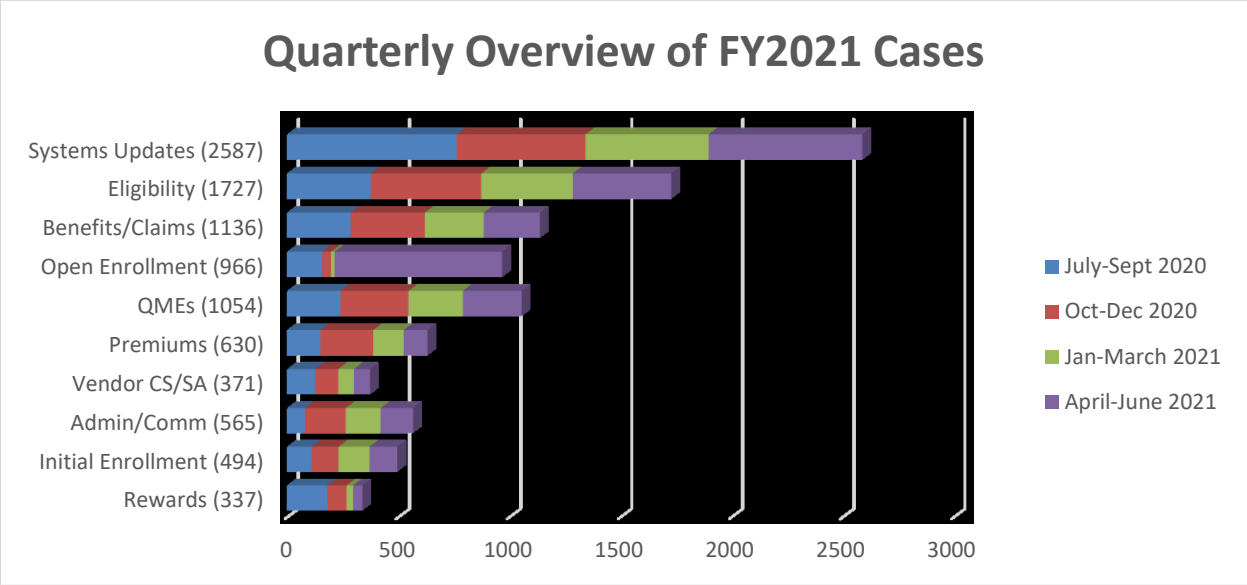
The Ombudsman worked closely with the Office of the Attorney General for advice and legal counsel concerning appeals, compliance, and issues of equity. She also worked with the consulting services contractor who provides assistance in the design and administration of the State's health benefits programs,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

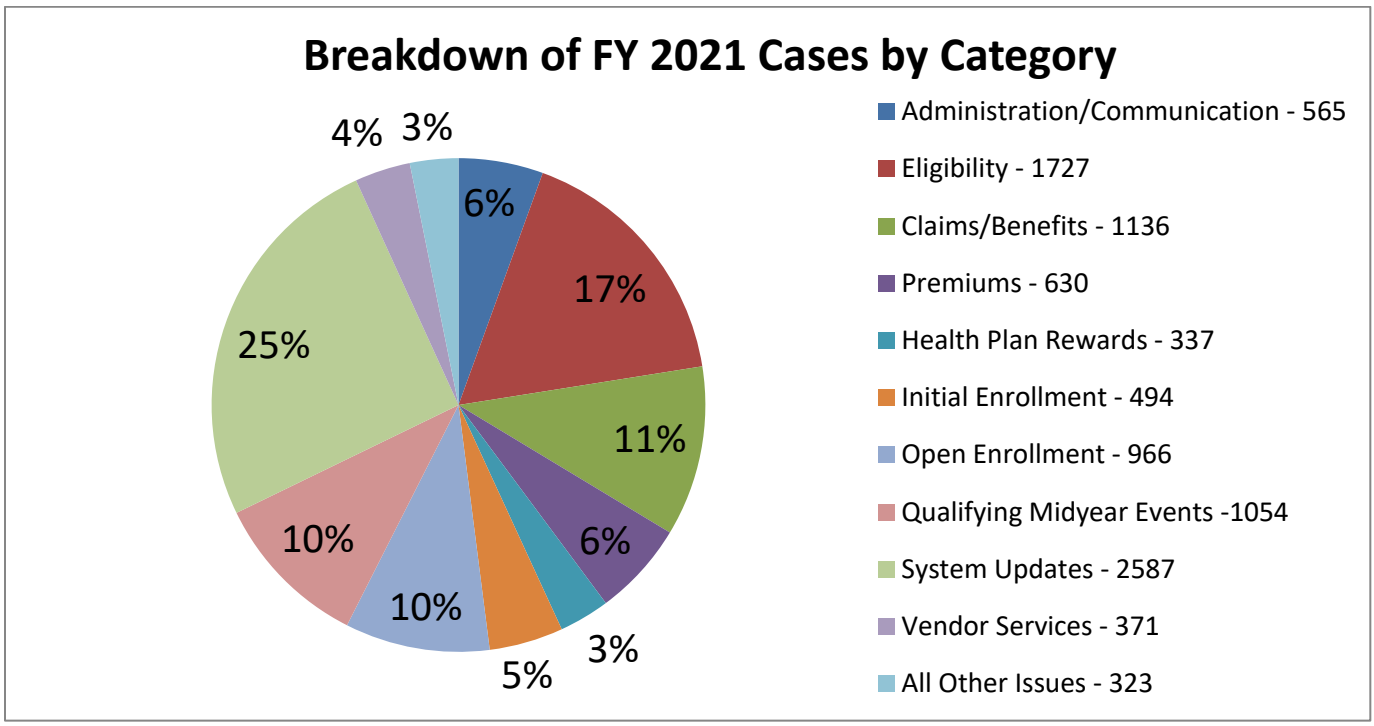
## EMPLOYEE AND RETIREE SERVICES

In FY 2021, the Ombudsman's team handled 10,190 requests 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 varied depending on the quarter with the plan year.




The quarterly requests related to system updates, 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 Affordable Care Act (ACA) Employer Mandates.


Quarterly Overview of FY2021 Cases
Systems Updates (2587)
Eligibility (1727)
Benefits/Claims (1136)
Open Enrollment (966)
QMEs (1054)
Premiums (630)
Vendor CS/SA (371)
Admin/Comm (565)
Initial Enrollment (494)
Rewards (337)
0
500
1000
1500
2000
2500
3000
July-Sept 2020
Oct-Dec 2020
Jan-March 2021
April-June 2021


Breakdown of FY 2021 Cases by Category
4%
3%
6%
17%
25%
11%
6%
10%
10%
3%
5%
Administration/Communication - 565
Eligibility - 1727
Claims/Benefits - 1136
Premiums - 630
Health Plan Rewards - 337
Initial Enrollment - 494
Open Enrollment - 966
Qualifying Midyear Events -1054
System Updates - 2587
Vendor Services - 371
All Other Issues - 323

**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, Health Insurance Portability and Accountability Act (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 - 11%** 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 - 17%** 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 review and approve 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 Virginia Retirement System (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%** COVA Care and COVA HealthAware, two of the Commonwealth's self-insured plans, 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 include 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 - 9%** 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. OHB handled the inquiries and issues presented by the Health Benefits application within EmployeeDirect which were associated with access to the portal, system browsers, and election confirmations. Over 16,500 employees used the online enrollment system to request election changes during the Open Enrollment period. There were over 22,700 open enrollment transactions processed for the plan year beginning July 1, 2021.

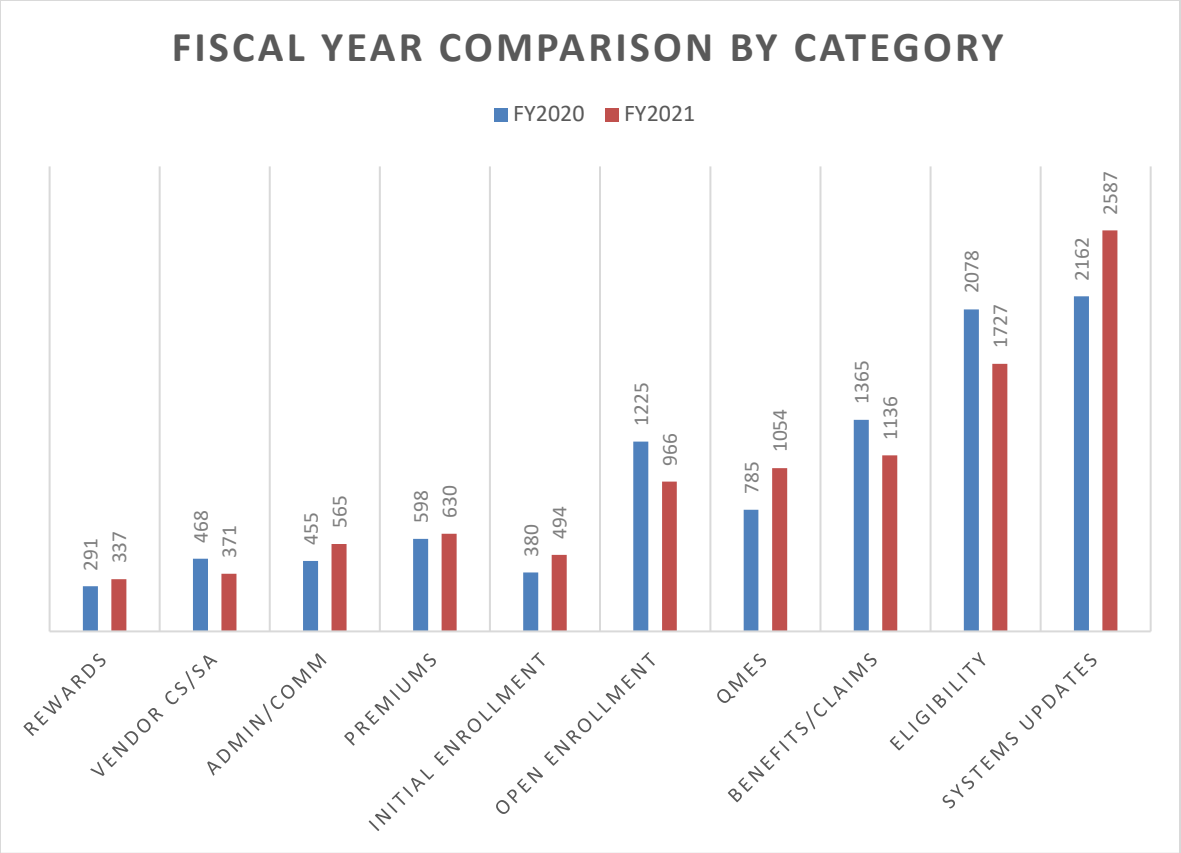
**Qualifying Midyear Events (QMEs) - 10%** The IRS provides a listing of specific life events that allow plan participants to make consistent mid-plan year election changes. Under the program provisions, the participant's election change request must be submitted within 60 calendar days of the qualifying 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 - 25%** This includes agency requests to update the Benefit Eligibility System (BES), questions related to Health Benefits Direct application within EmployeeDirect, and BES generated reports which are posted in the DHRM secure portal (HuRMan) for the agency's use.

**Vendor Services - 4%** 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 72% for FY21 and 76% of the inquiries for the FY20 fiscal year:

| | FY 2021 | FY 2020 |
|---|---|---|
| • System Updates and Reports | 25% | 21% |
| • Eligibility requirements for employees, retirees, and dependents | 17% | 21% |
| • Benefits and Claims | 11% | 14% |
| • Open Enrollment | 9% | 12% |
| • Qualifying Midyear Events (QMEs) election change requests | 10% | 8% |




**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'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 2020 tax year were mailed to state and local health plan participants in January 2021.

## APPEALS

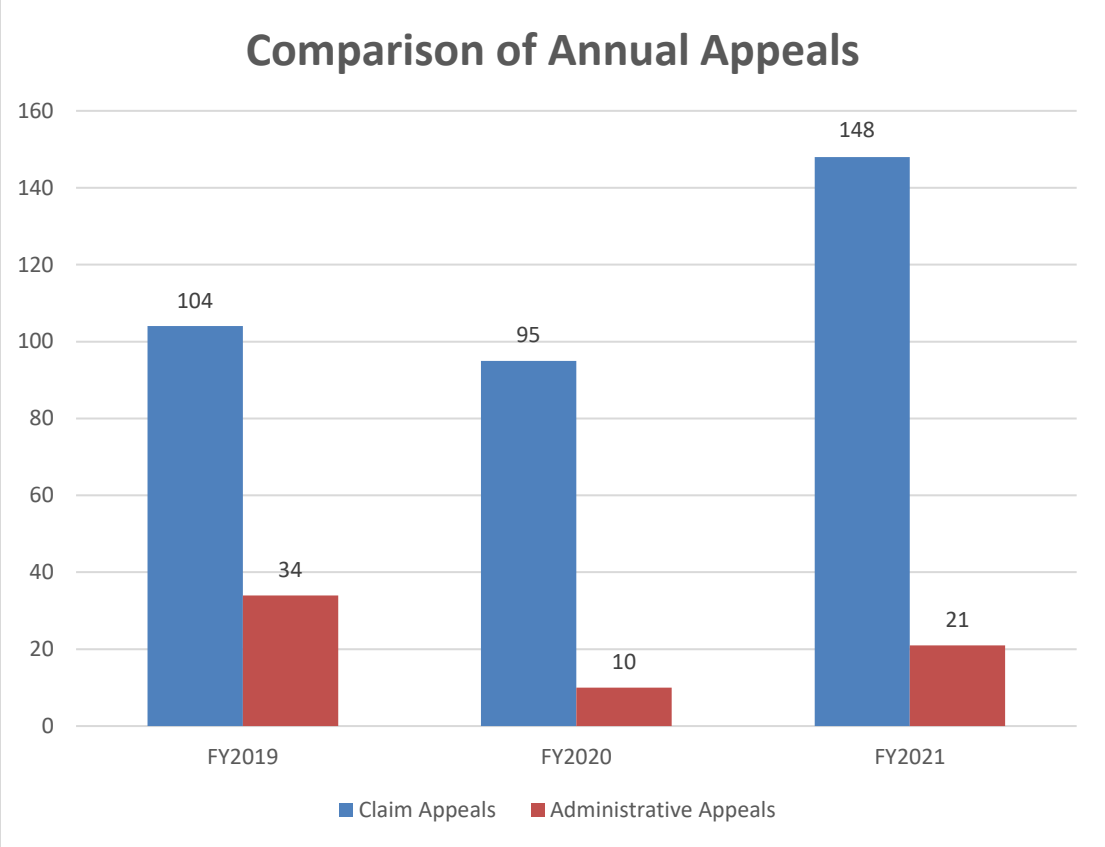
Charged with the oversight of the appeals process, the Ombudsman or an appeals examiner serve as the contact for appellants. Every effort is made to assure that all appellants receive the full extent of the benefits to which they are entitled under the rules of the program.

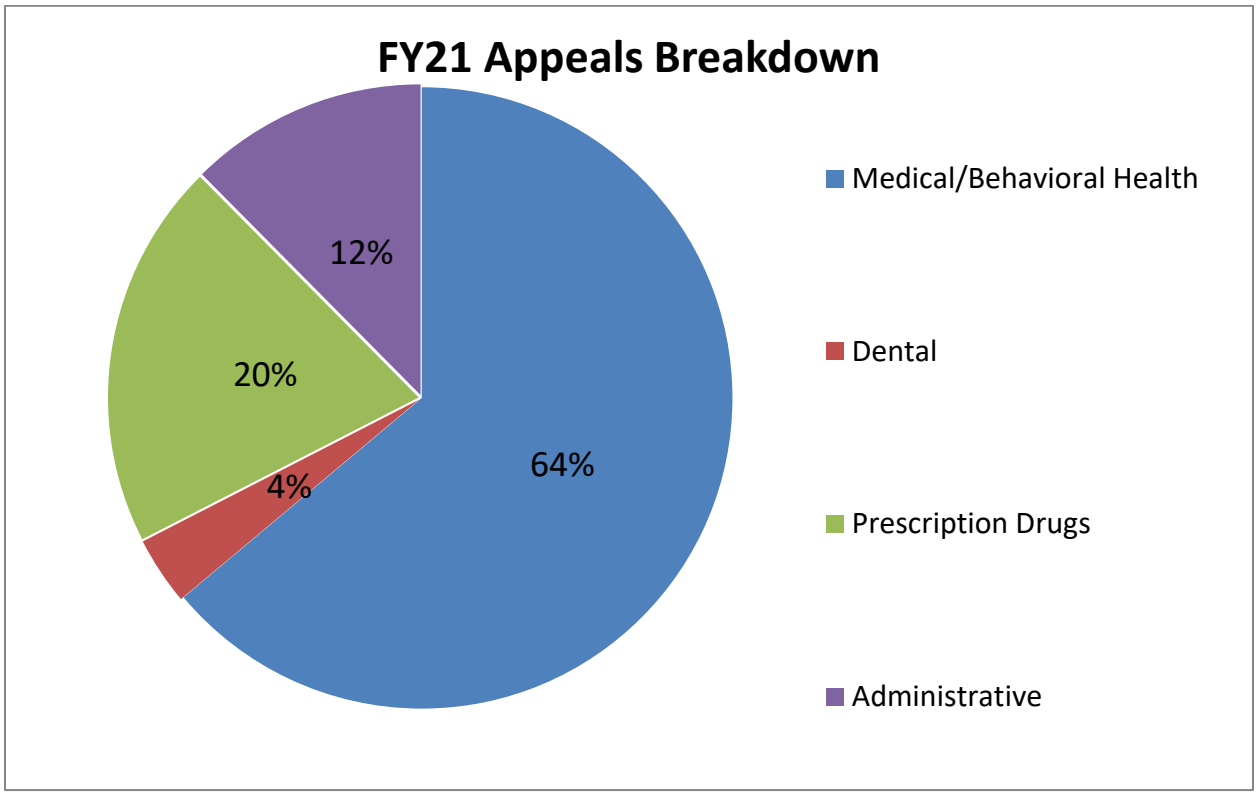
There are two classifications of appeals:

1. **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 2021 fiscal year, 169 appeals were submitted to DHRM. This compares to 105 appeals for the 2020 fiscal year and 138 for FY19. For FY 2021, 148, or 88%, of the appeals received were related to claims and plan benefits and 21, or 12%, 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 2021, the Ombudsman's team resolved three claim appeals by reviewing the additional information provided and working with the appellant and claim administrator.

**Director's Review** – For administrative appeals, the request will initially be reviewed by OHB to determine its validity. If valid, an appeal package is prepared that 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.

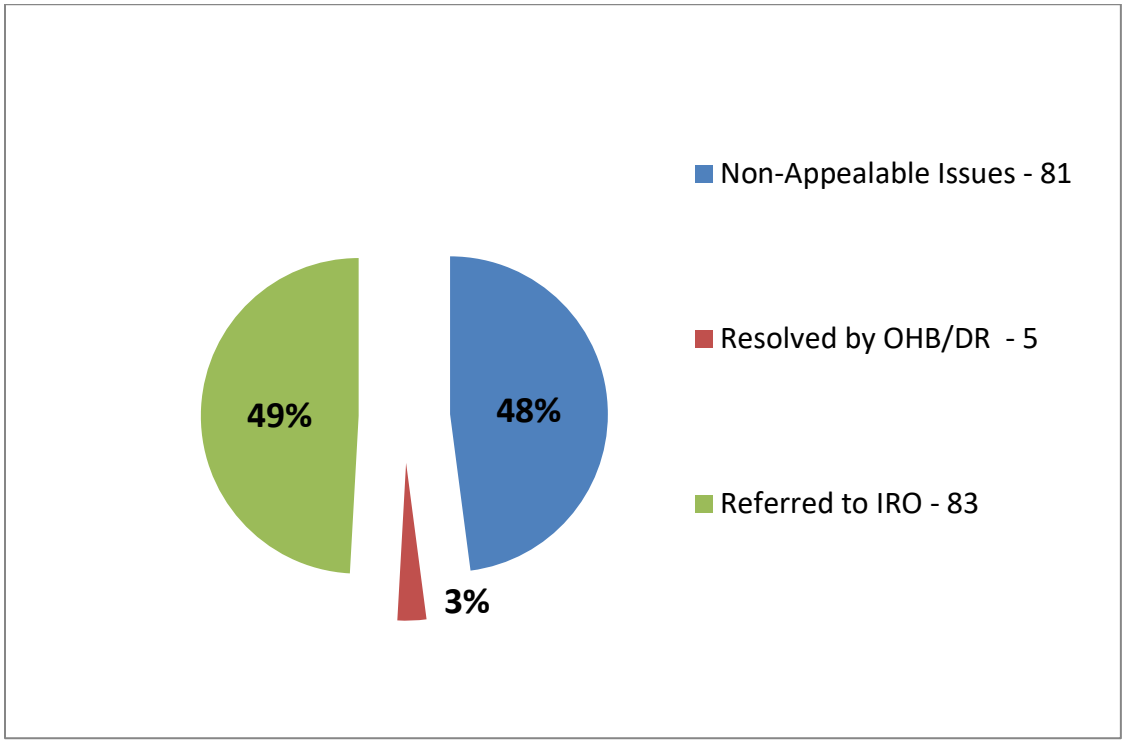
While offered, there were no face-to-face IFFC requested this fiscal year. The two valid administrative appeals submitted for a possible review by the Director were related to deadlines to enroll or make a change to the health plan election. The information submitted with the appeal provided extenuating circumstances, which were outside of the appellant's control, and the adverse determinations in both cases were 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. Eighty-one appeals (48%) 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:

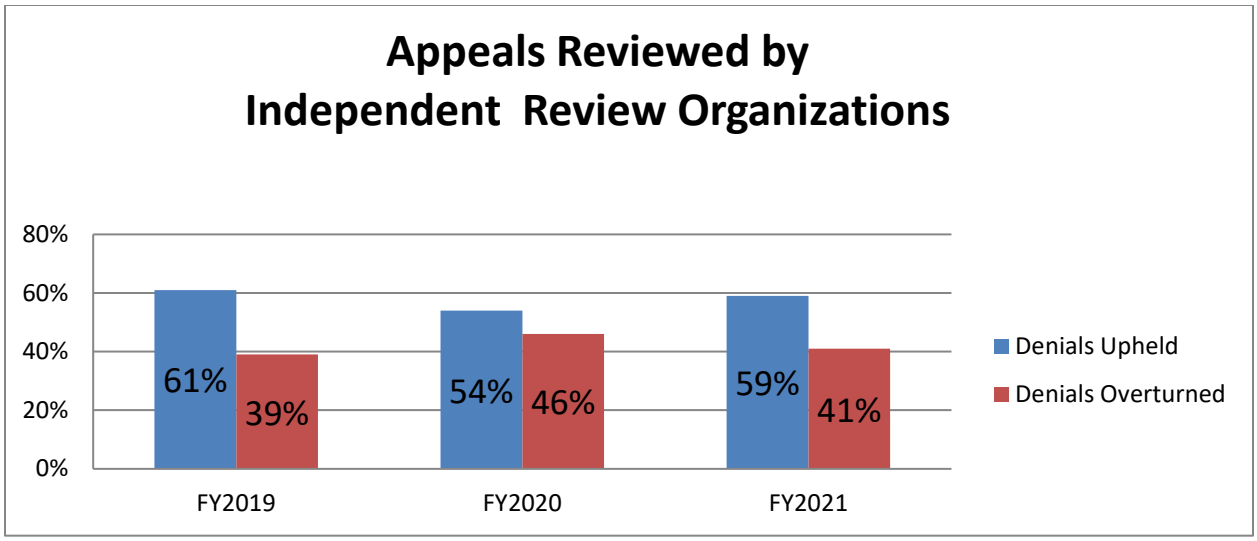
- for failure to submit a request within the program's required deadline,
- to cover a service that is specifically excluded under the program,
- for additional reimbursement to out-of-network providers (balance billing),
- for external review prior to exhausting the internal process with the health plan, and
- for exceptions to the program's mandatory generic prescription provision.

The remaining 83 appeals (49%) were referred to an Independent Review Organization (IRO) for review.



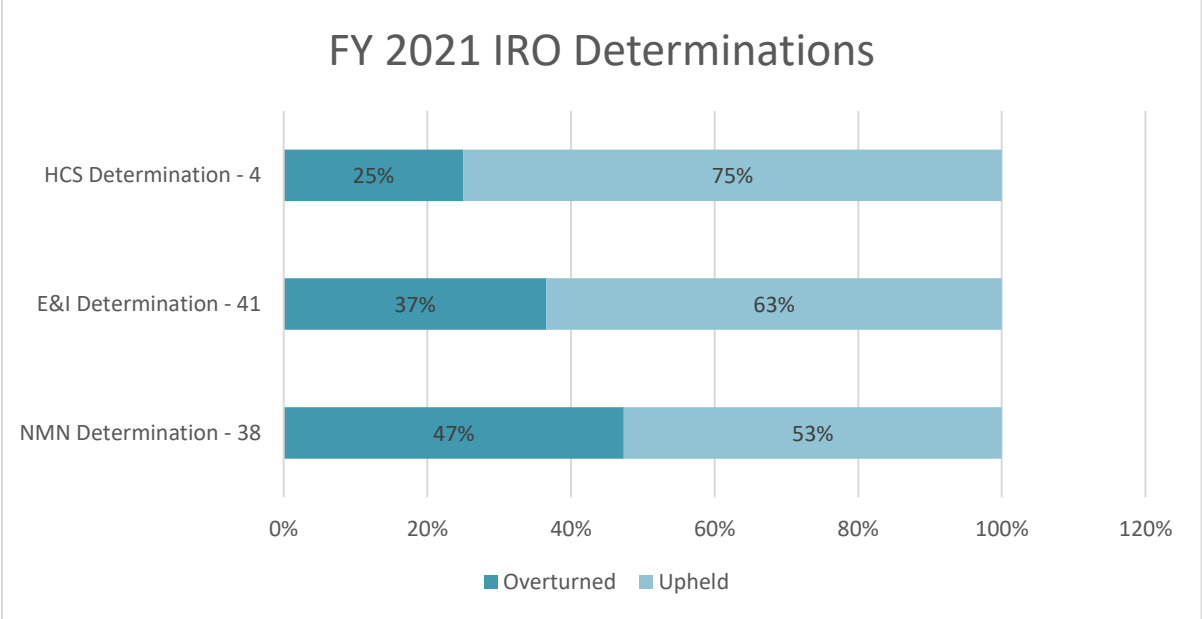

**Independent Review Organizations -** The program allows members to appeal any adverse benefit determination by a plan administrator that is based on the plan's requirements for **medical necessity** and **appropriateness**, **health care setting** and **level of care**, **effectiveness** of a covered 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 these appeals submitted for IRO review were adverse determination for medical or behavioral health services (78%) and 22% for prescription drug services. There were 34 (41%) adverse determinations made by the claims administrators overturned by our IROs this plan year with 49 (59%) of the determinations being upheld.




For the 83 appeals referred to an IRO this fiscal year,

- forty-one (49%) 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,
- thirty-eight (46%) were due to denials for services deemed not medically necessary (NMN) by the plan administrator, and
- four (5%) were for services related to the health care setting.



Our review of the IRO appeal determinations revealed the following:

| Services: | % of IRO Reviews | Upheld by IRO | Overturned by IRO |
|---|---|---|---|
| Cancer Treatment - 15 | 18% | 11 | 4 |
| Prescription Medication - 10 | 12% | 4 | 6 |
| Cardiac Defibrillator Vests - 10 | 12% | 8 | 2 |
| Decision DX Melanoma Gene Testing - 7 | 8% | 6 | 1 |
| Injections for Pain - 7 | 8% | 4 | 3 |
| Inpatient Setting - 4 | 5% | 3 | 1 |
| Hypoglossal Nerve Stimulator - 4 | 5% | 1 | 3 |
| Electric Tumor Field Treatments(TFF) - 3 | 4% | 0 | 3 |
| Joint Fusions - 2 | 2% | 1 | 1 |
| LINX Reflux Management System - 2 | 2% | 2 | 0 |
| Intracept Procedure - 2 | 2% | 2 | 0 |
| MRI/XRAY - 2 | 2% | 1 | 1 |

The remaining fifteen (18%) IRO reviews were for various procedures and services. Of these requests, nine decisions were overturned and six 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.

**Administrative Process Act -** In all appeals to DHRM, if the original denial is upheld, the appellant is advised that under the provisions of the Administrative Process Act (APA), Rules of the Supreme Court, an appeal to their local circuit court can be filed within 30 days of the final denial.

The Ombudsman and Appeals Examiner worked with the Office of the Attorney General (OAG) on two circuit court cases filed under the Administrative Process Act during this fiscal year. The team worked to prepare and review all of the required documents needed for the circuit court process.

In May 2021, the OAG appeared in the Circuit Court for the City of Colonial Heights representing DHRM on an upheld appeal determination pursuant to APA. The case was related to a "not medically necessary" denial of services. Upon consideration of the pleadings, briefs, and arguments presented to the Court, the Court ruled the appellant's appeal denied and our final decision was affirmed. As a follow-up to this case, the Appeal Examiner worked with the member to assist in resubmitting additional medical information needed to review the services for future benefits under the health plan.

The second case, a denial of the health care setting and level of care filed under the APA, has been continued with no estimated court date set.

The Ombudsman, along with the OHB Associate Director for Policy and the Program Manager for the Line of Duty Act (LODA) program, met with the OAG and the legal team for the Virginia Retirement System (VRS) on a circuit court case related to eligibility for dependents under the LODA health plan. This case was not filed under the APA process.

The Ombudsman worked with the OAG to review the details of the case, including the Code section and documents used in the eligibility determination and communications to the member. It was determined that this member did not invoke the administrative appeals process as outlined in the member handbook. The OAG provided a position from our agency for VRS consideration.

## Health Benefits Program Operations and 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 development of benefit communications on various program components. We worked on the updated COVA HDHP member handbook and handbook amendments for the other self-insured health plans. The Ombudsman reviewed monthly EAP promotions, benefits emails, notifications and memos to the benefit administrators with policy and procedural updates.

The Ombudsman and OHB team worked on the following projects during this fiscal year:

**Health Benefits Premium Holiday -** The Office of Health Benefits provided another premium holiday for the month of December for those enrolled in the State Health Benefits Program. The program previously provided a premium holiday in October 2019. The premium holiday applied to state employees, with the exception of the TRICARE Supplement enrollees*, all retiree group participants (which include retirees, survivors, LTD participants) and Extended Coverage (COBRA) participants. 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 for employees and the retiree group and COBRA participants, including an announcement from the Governor.

*Based on § 2.2-2818.1 of the Code of Virginia which requires TRICARE Supplement participants to pay the full cost of coverage, the premium holiday did not apply to those enrollees.

**Annual Flu Shot Program -** Member communications and web site documents for the 2020-2021 flu season were developed and distributed in the fall of 2020. Under the health plans, members were able to get a free flu shot at physicians' offices or pharmacies participating in their health plan's network. Members were directed to visit www.dhrm.virginia.gov/healthcoverage/flushotinformation to find participating providers and questions and answers on each plan's benefits and requirements.

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 paid for the vaccine. Capitol Square Healthcare Clinic and OHB also coordinated two drive-thru flu clinics at John Tyler Community College in October of 2020. Flu shots were administered in a covered parking garage with no required appointment. This service was available for members enrolled in COVA Care, COVA HDHP and COVA HealthAware plans, and included enrolled children 4 years and older accompanied by a parent.

**Premium Reward Program Engagement -** In an effort to increase awareness and engagement in the Premium Reward program, the Office of Health Benefits sent email communications to all employees actively enrolled in COVA Care and COVA HealthAware who have a valid email

address in the benefits system. Agencies were notified of the campaign since they may have experienced an increase in questions from employees about their Premium Reward status.

The email message to the members included directions to access the plans' websites and mobile apps to update and submit a health assessment. In addition, a flyer that reminded employees about Premium Rewards and health assessment completions was provided for the agency's use to post in common areas and share with new hires eligible for enrollment in COVA Care or COVA HealthAware.

**State Health Plans Price-A-Medication Tool -** The Ombudsman worked with the outpatient pharmacy administrator and other key members of the OHB team to provide a pharmacy Price-a-Med-Tool for the self-insured plans. The new tool was available during the 2021 Open Enrollment period for members and potential members. The tool allowed the user to price a medication for the COVA HealthAware, COVA Care and COVA HDHP plans. The tool was accessible without a member account, which made it a valuable resource in the decision making process for Open Enrollment.

**COVA Care and COVA HealthAware Member Pharmacy Incentive Requirements -** The disease management programs provide educational tools and clinical support coaching to help members better manage long-term health conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), and hypertension. Participating COVA Care and COVA HealthAware members who complete the program requirements may be eligible to receive certain medications and supplies at no cost. COVA Care and COVA HealthAware members participating in the disease management programs received notification that the 90-day compliance period for medication adherence was no longer a requirement of the program. The Ombudsman and Policy team worked with the vendors to develop communications to announce the change in the requirements to the enrolled members.

**Request for Proposals (RFPs) for Medicare-Coordinating Health Plans -** The Ombudsman and members of her team worked with the OHB policy team, our consultants and the DHRM contracts team on the development and review of the RFPs for the two components of the health plans for our Medicare-eligible retiree population. Due to the complexity of the proposals and new guidance on high-cost contracts, the existing contracts were extended to allow the new contract requirements to be fully developed in conjunction with the Department of General Services (DGS) procurement team and the Office of the Attorney General. This project is ongoing.

**Impact of COVID-19 -** In an ongoing response to the COVID-19 pandemic, the Office of Health Benefits worked with the health plan vendors to update and communicate the following benefits:

Office Visit Out-of-Pocket Cost Waiver Extended- cost share waivers for health plan members for non-work related COVID-19 testing and related office visits as recommended by CDC guidelines.

Virtual Office Visits - When members did not have access to or preferred to avoid an in-person office visit, the out of-pocket cost for virtual visits under the COVA Care, COVA HealthAware, and LODA non-Medicare plans was waived through December 31, 2020.

Extended Coverage/COBRA Deadline Extensions - As part of the National Emergency Relief, a Federal Notice was issued that provides a temporary extension of certain timeframes as it relates to Extended Coverage/COBRA Beneficiaries' Election Period and Premium Payments. In response to this new guideline, our team sent participants enrolled in COBRA a notice explaining the details of the new rule. The agencies were provided with an updated notice for any participants whose coverage was terminated on or after January 1, 2020, and were eligible for COBRA but chose not to elect coverage at that time.

ARPA COBRA Employee Subsidies -The American Rescue Plan Act ("ARPA") provided temporary COBRA subsidies for employees who are involuntarily terminated (other than for gross misconduct) or experience a reduction in hours. The COBRA subsidy amount is 100% of the cost of COBRA coverage and was available from April 1, 2021, to September 30, 2021. Final data related to the ARPA subsidies will be included in the FY22 report.

**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 2021 Open Enrollment period. This included:

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

- Open Enrollment Webinars for Benefits Administrator

**Flexible Spending Account (FSA) Grace Period -** In an effort to meet the needs of our employees during these extraordinary times, a Grace Period was added to the 2020-2021 Dependent Care Flexible Spending Account (DCFSA) Plan. This grace period extended the period for employees to incur dependent care claims until October 31, 2020. Our office developed Frequently Asked Questions (FAQs) related to the DCFSA Grace Period, which were included on the DHRM website 2021 Open Enrollment page.

**Recruitment and Training -** There were retirements and internal promotions within the Office of Health Benefits that created vacancies on the Employee and Retiree Services team. The Ombudsman worked on five recruitments during this review period. The recruitments resulted in the hiring of three new employees for OHB and the promotion of two employees. (Note: Two of the new hires for OHB did not report until the fiscal year 2022.)

Due to the COVID-19 protocols and telework schedules, we were presented with the challenge of developing and implementing a revised training procedure for our new hires that included in-person and virtual training. The Ombudsman and two senior members of the team updated our training material and developed an up-to-date training plan. We also worked with members of the DHRM team to confirm the training procedures were compliant with agency security standards and current protocols. The Senior Specialists took on a "mentoring" role in the process, working with the new hires, ensuring they were provided with resources needed to do the level of reviews expected of our team.

***Getting to Know Your Benefits* -** This brochure provides an overview of the State Employee Health and Flexible Benefits. This brochure, which was initially established to provide general information for new state employees, needed to be updated. The Ombudsman and her team worked to update the information and expand the content to include new programs such as Shared Savings and Premium Rewards. The new brochure also provides general information on federally required notices and mandates that apply to our programs. While the majority of the work for this project was performed during FY2021, due to editing, the final version of the brochure was not released for posting until FY2022.

**Cardinal Human Capital Management (HCM) Migration Project -** Cardinal will be the system of record for accounting, human resource, payroll, benefits, and time management in the Commonwealth. It is designed to consolidate and streamline administrative systems into one upgraded platform. Core Cardinal users, such as a benefits administrator, will perform their day-to-day work in Cardinal HCM. All employees will be able to use Cardinal HCM in an employee self-service (ESS) capacity to view and update information that is unique to the employee, such as updating a home address or enrolling in/updating health benefits.

In preparation for the migration of benefits into the Cardinal system, the Ombudsman and other members of the OHB management team participated in meetings with Cardinal personnel to review current and future business processes. Serving as a subject matter expert (SME), the Ombudsman assisted in providing critical expertise to the project team, participating in

the Cardinal Business Process Workshops and meetings on specific topics related to the benefits administered by our office.

**Capitol Square Healthcare Clinic** - The Ombudsman and team, working with the Communications Manager, reviewed monthly wellness communications prepared by the onsite coordinator. The Ombudsman continues to work closely with the staff of the Capitol Square Healthcare Clinic, assisting the clinic staff with eligibility and procedural issues. We also worked with the clinic to coordinate two Drive-Thru Flu Shot Clinics during October.

**Health and Flexible Benefits Web Pages -** The team, working with the Communication Manager, continues the review of the Health and Flexible Benefit documents and links on the DHRM web site. This project will continue into the next fiscal year as a part of the overall project to update the agency's web site.

The Ombudsman and her team communicate 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 self-insured health plan administrators.

## 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.