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November 21, 2022

The Honorable Richard L. Saslaw, Senate of Virginia
The Honorable L. Louise Lucas, Senate of Virginia
The Honorable George L. Barker**,** Senate of Virginia
The Honorable Robert D. Orrock, Virginia House of Delegates
The Honorable Kathy J. Byron, Virginia House of Delegates
The Honorable Margaret McDermid, 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,

Janet L. Lawson
Director
Department of Human Resource Management

cc: Executive Director, Joint Commission on Healthcare

OMBUDSMAN ANNUAL REPORT FISCAL YEAR 2022

December 1, 2022

Office of State and Local Health Benefits Programs

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ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
FISCAL YEAR 2022

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, 2021 through June 30, 2022. 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 2022, the Ombudsman's team handled 11,377 requests for assistance or complaints (cases) and reviewed 140 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:

Request for Proposals (RFPs) for IRO - The Ombudsman and members of her team worked with the DHRM contracts team on the development and review of the RFPs to secure the services of Independent Review Organizations (IRO) needed for the OHB external appeal process.

Cardinal Migration for the Health Benefits Program - With the migration of health benefits and flexible spending accounts into the Cardinal system, the Ombudsman and other members of the OHB team worked closely with Cardinal personnel, attending training sessions, participating in forums and reviewing current and future business processes. Serving as a subject matter expert (SME), the Ombudsman assisted in providing expertise to the project team on the OHB policies for specific topics related to the benefits administered by the Office of Health Benefits. OHB assumed the administration of the Extended Coverage/COBRA process for the agencies that transitioned to Cardinal during the fiscal year. The team also established interim processes for the transfer of employee records between the legacy system and Cardinal HMC and handled the initial enrollment requests for the retirees group participants with benefits through the Virginia Retirement System (VRS)

Open Enrollment - The Ombudsman, her team and the Policy team worked closely with the DHRM Communications Manager and each of the plan vendors to develop material for the 2022 Open Enrollment period. With the transition of many state agencies to Cardinal HCM, the team developed open enrollment material specific to the Cardinal population, in addition to the normal

material. The team also worked with the vendors to obtain Spanish versions of many of the documents and forms.

Health Benefits Communication Campaigns - The team wanted to increase the utilization of the wellness and preventive services offered by the health plans. The Office of Health Benefits, working with the health plan vendors, developed communications that focused on specific relevant topics, including information on the importance of taking ownership of their health and providing helpful tools, vendor apps and web site information to assist them in the process.

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 Local 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 Section 1557 Nondiscrimination provisions of the Affordable Care Act (ACA).

The State Health Benefits Program provides benefits through approximately 240 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. There are over 380 member groups covering approximately 48,000 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

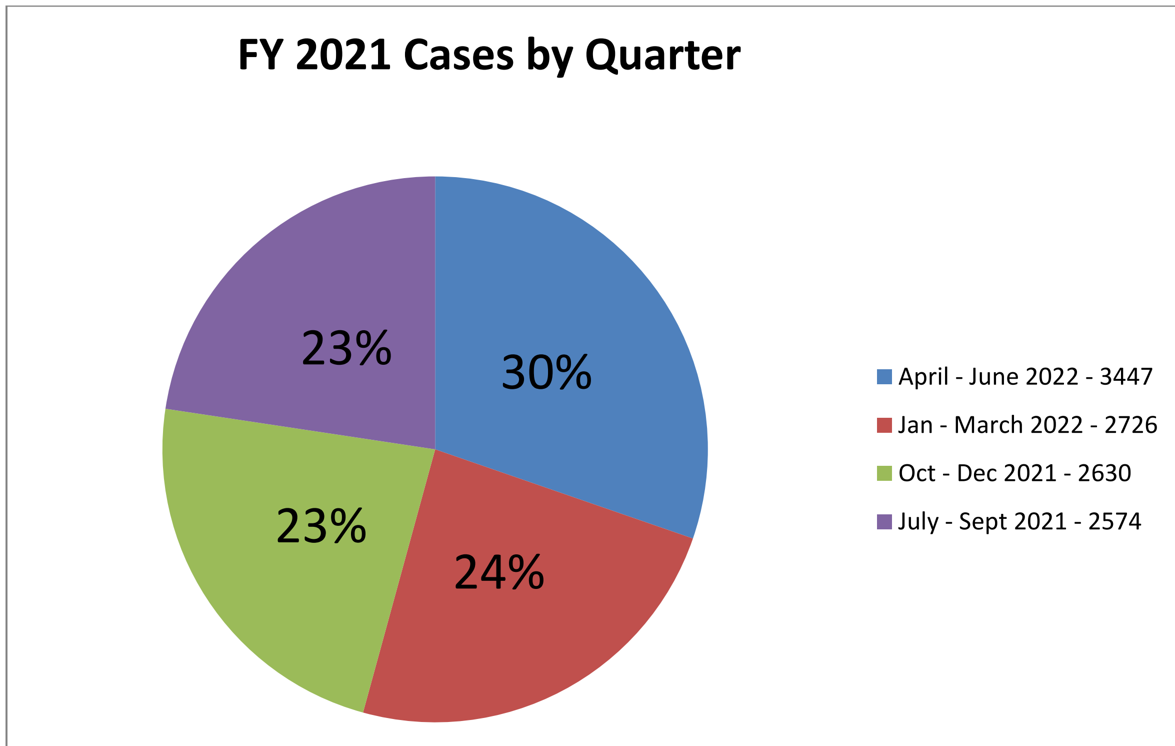
Health Benefits Plans participants are enrolled in one of three plans, based on current employment, former employment or Medicare eligibility.

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 500 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.

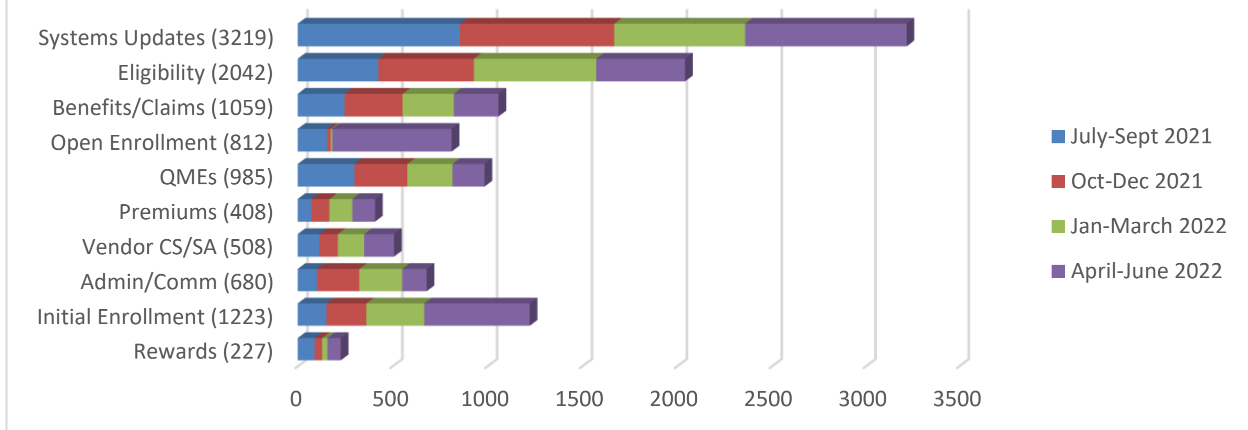
The Ombudsman worked closely with the Office of the Attorney General for advice and legal counsel concerning appeals, compliance, and issues of equity. She also worked with the consulting services contractor who provides assistance in the design and administration of the State's health benefits programs,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

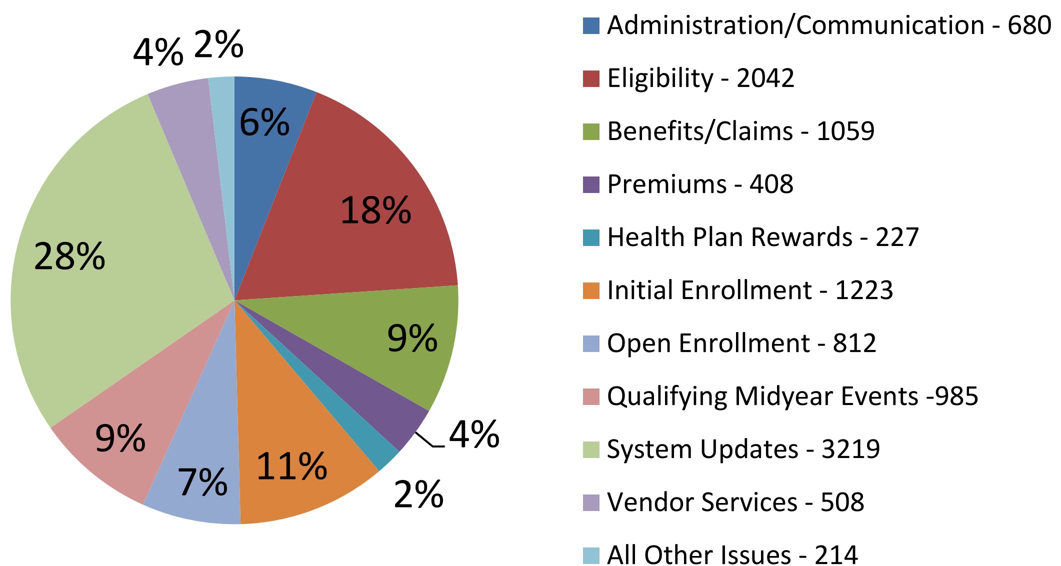
EMPLOYEE AND RETIREE SERVICES

In FY 2022, the Ombudsman's team handled 11,377 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 to provide a final resolution or a response to the question. The Office of Health Benefits (OHB) normally receives a consistent number of inquiries each quarter with the primary topics varied depending on the quarter with the plan year.



The quarterly requests related to benefits and claims, qualifying midyear events (QME), plan premiums, and eligibility issues normally remain constant throughout the year. Other topics tend to peak at specific times during the fiscal year. For example, Open Enrollment inquiries increase during the first and last quarters of the year. This fiscal year we experienced an uptake in the number of requests for assistance with system updates and initial enrollment requests due to the migration of agencies from the legacy system to Cardinal HCM. This was notably during the last quarter of the fiscal year with the transition of the second group of state agencies just prior to the annual open enrollment.





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 - 9% 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 - 18% 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 - 4% 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% 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.

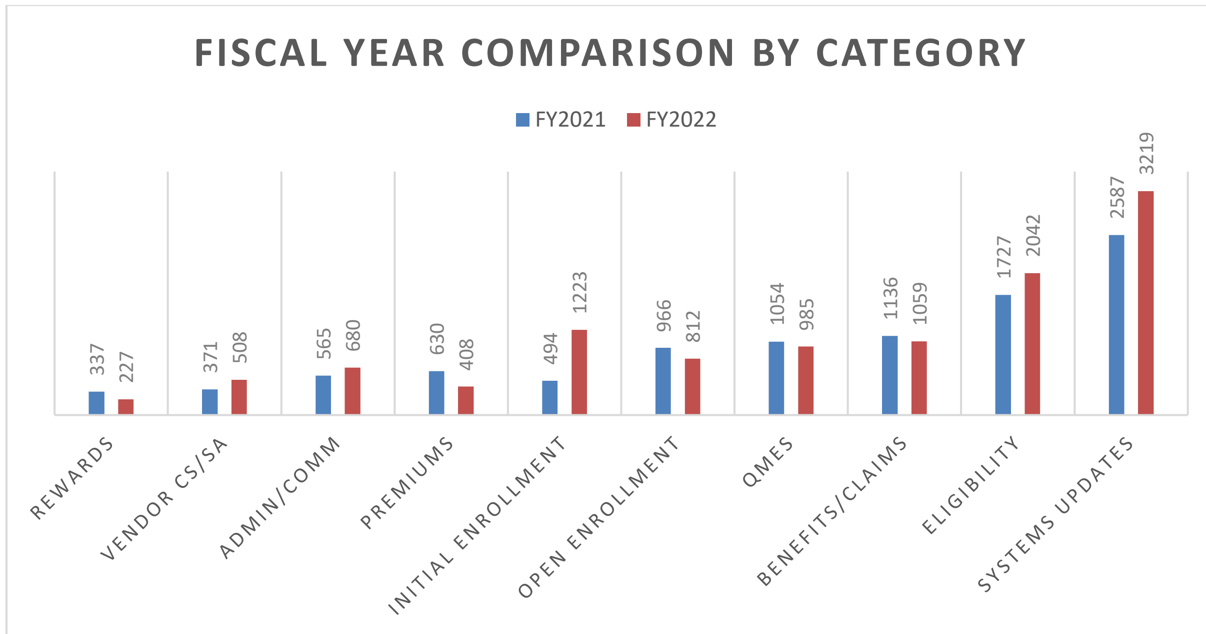
Initial Enrollment - 11% The program provides an opportunity for health care enrollments based on specified changes in employment status, such as the commencement or termination of employment, retirement, or transitioning to long-term disability. Under the program's provisions, the participants must 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. This year's requests included processing the initial retiree and LTD enrollments for the VRS participants of the Cardinal HCM agencies.

Open Enrollment - 7% The Open Enrollment period occurs each year in the spring. The period 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. 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. The online enrollment application accounted for over 22,000 transaction for the Open Enrollment period with approximately 600 requests to OHB for assistance, guidance or clarification related to the online process.

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 - 28% 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. This year also included requests related to the transition of member records between the legacy system (BES) and Cardinal HCM.

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 for FY22 changed slightly to include initial enrollment requests. These topics accounted for 75% of the inquiries for FY22 and 68% of the inquiries for FY21:

	FY 2022		FY 2021	
• System Updates and Reports	3219	28%	2587	25%
• Eligibility Requirements	2042	18%	1727	17%
• Initial Enrollments	1223	11%	494	5%
• Benefits and Claims	1059	9%	1136	11%
• Qualifying Midyear Events (QMEs)	985	9%	1054	10%
	8528	75%	6998	68%

APPEALS

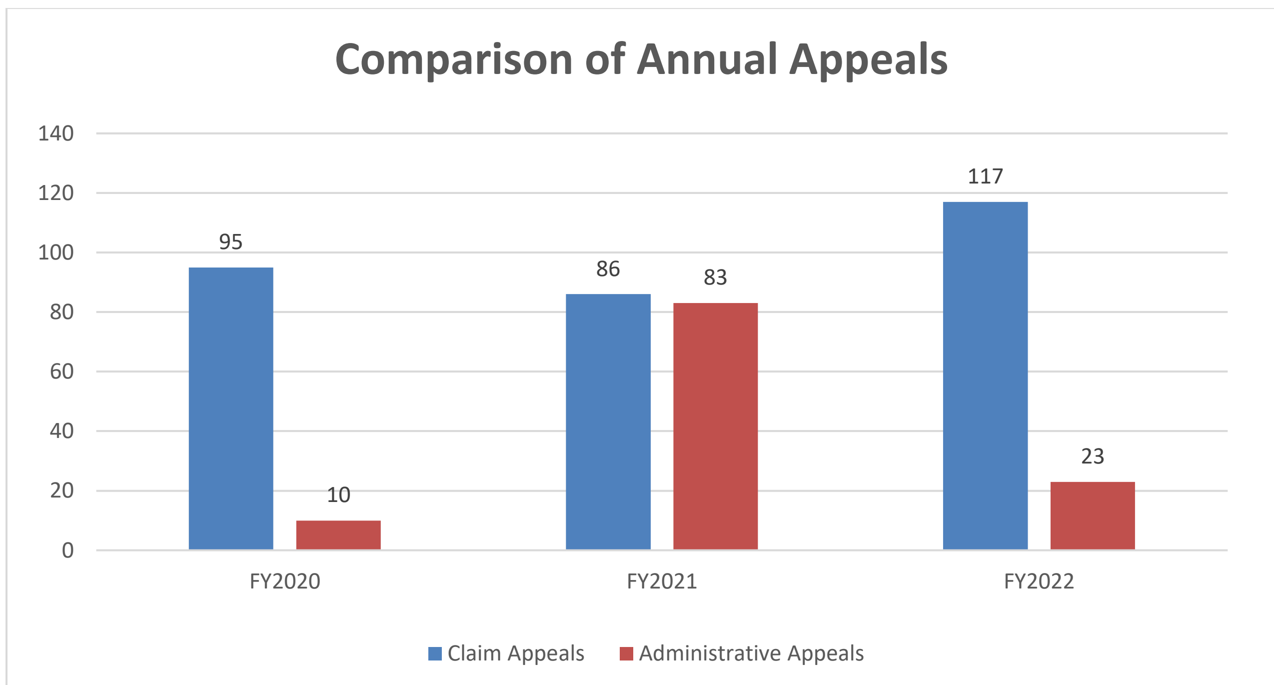
Charged with the oversight of the appeals process, the Ombudsman or an appeals examiner serves as the contact for appellants. Every effort is made to assure that all appellants receive the full extent of the benefits to which they are entitled under the rules of the program.

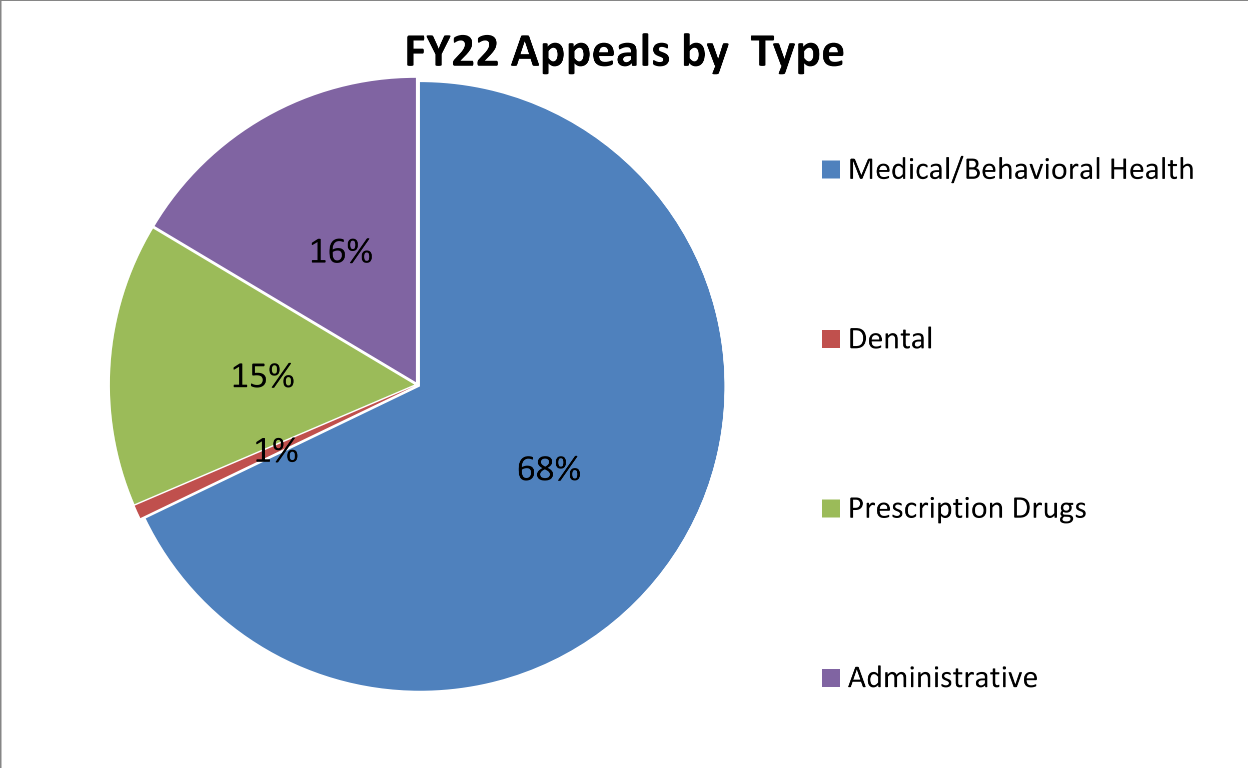
There are two classifications of appeals:

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 2022 fiscal year, 140 appeals were submitted to DHRM. This compares to 169 appeals for the 2021 fiscal year and 105 for FY20. For FY 2022, 117, or 84%, of the appeals received were related to claims and plan benefits and 23, or 16%, 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 2022, the Ombudsman's team resolved two claim appeals by reviewing 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.

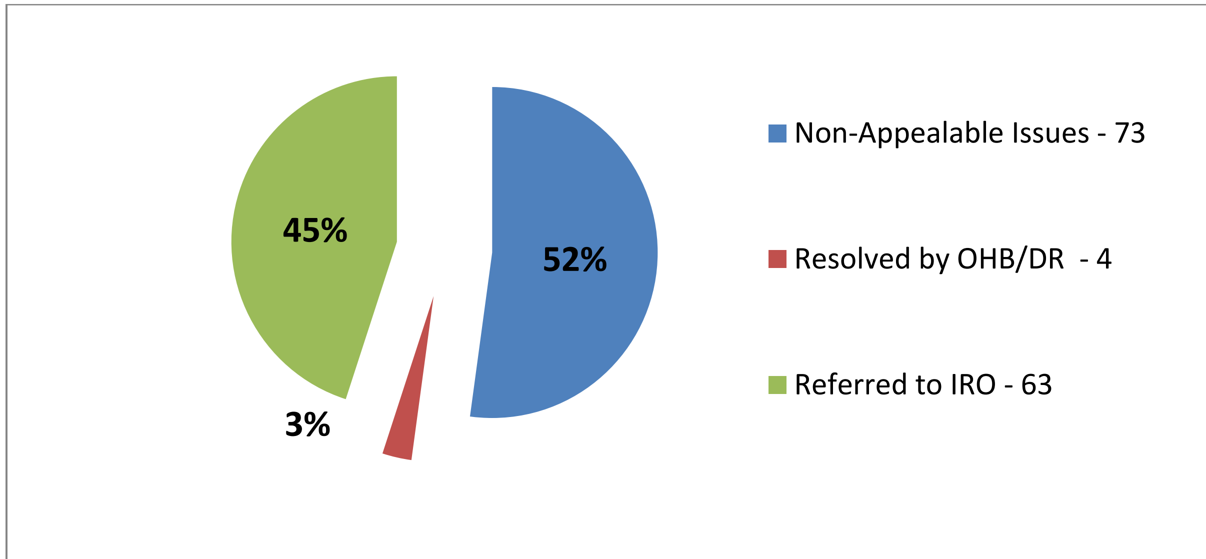
While offered, there were no face-to-face IFFC requested this fiscal year. The two valid administrative appeals submitted for a possible review by the Director were related to deadlines to enroll or make a change to the health plan election. The information submitted with the appeal provided extenuating 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. Seventy-three appeals (45%) 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:

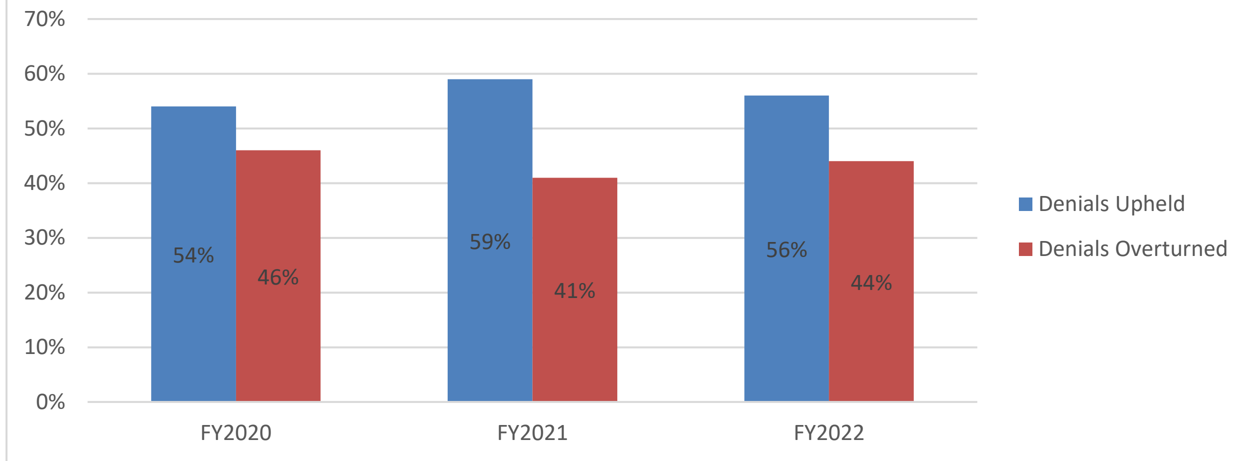
- for failure to submit a request within the program's required deadline,
- for exceptions to the program's mandatory generic prescription provision,
- for external review prior to exhausting the internal process with the health plan, and
- to cover a service that is specifically excluded under the program.

The remaining 63 appeals (52%) were referred to an Independent Review Organization (IRO) for review.



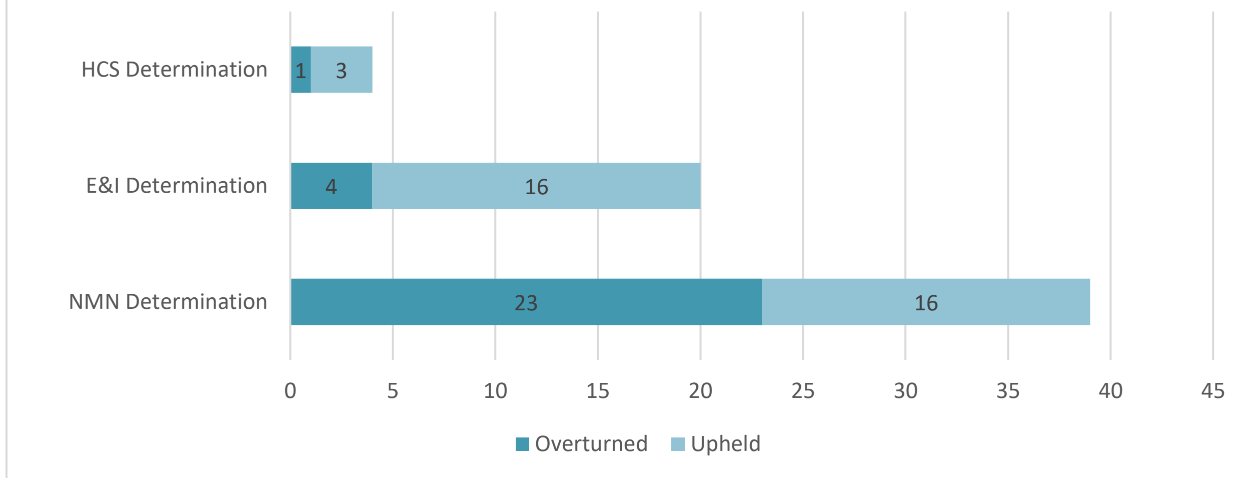
Independent Review Organizations - The program allows members to appeal any adverse benefit determination by a plan administrator that is based on the plan's requirements for **medical necessity** and **appropriateness**, **health care setting** and **level of care**, **effectiveness** of a covered benefit,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

Forty-seven (75%) of the appeals submitted for IRO review were adverse determination for medical or behavioral health services and sixteen (25%) for prescription drug services. There were 28 adverse determinations made by the claims administrators overturned by our IROs this plan year that included one appeal that was resolved by the health plan prior to the IRO determination. There were 35 health plan determinations upheld by the IROs.



For the 63 appeals referred to an IRO this fiscal year,

- four (6%) were for services related to the health care setting
- twenty (32%) 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, and
- thirty-nine (62%) were due to denials for services deemed not medically necessary (NMN) by the plan administrator.



Our review of the IRO appeal determinations revealed the following:

Services:	% of IRO Reviews	Upheld by IRO	Overturned by IRO
Prescription Medication - 15	24%	8	7
Cardiac Defibrillator Vests - 12	19%	11	1
Multiple Surgeries -12	19%	7	5
Cancer Treatment - 6	10%	3	3
Oncotype Genetic Testing - 4	6%	2	2
Inpatient/Residential Setting - 4	6%	1	3
Other DME - 4	6%	2	2

The remaining six IRO reviews were for various procedures and services determined to be not medically necessary by the health plan. Of these requests, five decisions were overturned and one was 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 continued work with the Office of the Attorney General (OAG) on one circuit court case filed under the Administrative Process Act during the prior fiscal year. The case involved a denial based on the health care setting and level of care. The provider submitted additional documentation to the health plan for review and the claim was approved for payment. The circuit court case was dismissed by the appellant prior to a hearing.

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 handbook amendments for the 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:

Cardinal Human Capital Management (HCM) Migration - Cardinal HCM 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 and retirees 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.

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.

Fiscal year 2022 included the migration of designated state agencies and TLC employer groups in two releases. The Release 1 transition, which included seventeen state agencies, three local employers and the LODA population, occurred on October 2, 2021. Release 2 occurred on April 4, 2022 and included sixty-nine state agencies. With each migration, OHB worked with the health plan vendors to establish procedures to ensure there would be a minimal impact to our health plan members during scheduled system blackout periods prior to the go-live release dates.

Extended Coverage is a term used to describe the continuation of State Health Benefits Program coverage under the provisions of the Public Health Service Act when certain qualifying events cause a loss of that coverage. These provisions for state and local government employers are comparable to COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) coverage for private employers. The OHB team assumed the administration of the Extended Coverage/COBRA process for members in the Release 1 and Release 2 groups who experienced a qualifying event as specified in the regulations that resulted in the loss of coverage. This administration includes issuance of the election notice, updating the Cardinal HCM system when coverage is elected, working with the health plan vendors to establish the premium invoicing, and handling the member inquiries related to the various steps in the process.

The migrations required the OHB team to implement additional processes to assist agencies with the health benefits records for:

- employees transferring between agencies in Cardinal HCM and the legacy system, and
- health care enrollments for retirees and long-term disability (LTD) participants eligible for benefits with the VRS.

With each migration, issues were identified quickly and, when needed, revisions and/or clarification to the processes were made. The remaining state agencies and local employer groups will migrate to Cardinal HCM in Release 3 scheduled for October 3, 2022. This release will also include the existing VRS retirees and LTD participants, along with members who are eligible for survivor healthcare coverage in our program.

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.

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 to confirm compliance with the program requirements. These requirements, which are outlined in the member handbook, include a review of 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 provided with the 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.

IRS 1095 forms for the 2021 tax year were mailed to state and local health plan participants in January 2022. 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. The team also assisted with requests for issuance of duplicate 1095 forms.

Annual Flu Shot Program - Member communications and web site documents for the 2021-2022 flu season were developed and distributed in the fall of 2021. 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 the DHRM web site www.dhrm.virginia.gov/healthcoverage/flushotinformation to find participating providers and review the 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 provide 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 Brightpoint (formerly John Tyler) Community College in October of 2021. 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.

Health and Wellness Communication Campaign - In an effort to increase awareness and engagement with the wellness benefits offered by the health plans, the Office of Health Benefits sent email communications to agencies that focused on specific relevant topics, which aligned with national campaigns on similar topics. Some of the topics for this fiscal year included:

October:	Breast Cancer
November:	Diabetes
February:	Healthy Heart
May:	Mental Health

The emails included flyers and included directions to access the plans' websites and mobile apps for additional information about the benefits under their specific coverage.

There were also communications developed about the importance of preventive care to detect and prevent illnesses, diseases and other health related problems. This communication included informational flyers with immunization and screening schedules. There was also an email developed for agencies to share with employees about the importance of dental health and the need for routine preventive dental services.

Shared Savings Programs - COVA Care, COVA HDHP and COVA HealthAware members are eligible to participate in our Shared Savings Programs and receive an incentive when they shop for certain medical services, such as a mammogram, colonoscopy, or lab work. The incentive amounts vary depending on the procedure. The programs, SmartShopper (COVA Care and COVA HDHP) or Informed Rewards (COVA HealthAware), are strictly voluntary. In August 2021, OHB team members, working with the plan administrators and the Communications Manager, provided reminder messages to enrolled members about these programs.

Impact of COVID-19 - In the continuing response to the COVID-19 pandemic, the Office of Health Benefits worked with the health plan vendors to ensure the following benefits were still available to our health plan members:

- Office Visit Out-of-Pocket Cost Waiver for non-work related COVID-19 testing and related office visits
- Virtual Office Visits
- Extended Coverage/COBRA Enrollment Deadline Extension

Reimbursement of COVID-19 At-Home Tests - In January 2022, the federal government announced that health plans should provide reimbursement for eligible over-the-counter diagnostic COVID-19 tests purchased January 15, 2022 or later. Each individual on the health plan can receive up to eight over-the-counter COVID-19 tests each month. In addition, there were free tests made available through government services. Based on the guidelines, and working with the health plans, we developed an employee communication about this mandated benefit, which included information on how to:

- order free test kits from the federal government,
- locate a COVID testing center,
- order at-home tests, and
- request reimbursement under the health plans.

Open Enrollment – The OHB team, along with the Communication Manager, worked on the literature, forms and mailing for the annual Open Enrollment period. Due to the transition of many state agencies to Cardinal HCM, the team needed to develop open enrollment communications specific to the Release 1 and Release 2 Cardinal employee population. The material needed to address differences for these employees, such as the online enrollment processes and the premium reward application for Cardinal payroll agencies. The open enrollment communications also addressed program administration issues, which were identified by monitoring the OHB inquiry trends.

The Ombudsman, her team and the Policy team worked closely with the DHRM Communications Manager and each of the plan vendors to develop material for the 2022 Open Enrollment period. The open enrollment materials 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
- Notifications for Extended Coverage/COBRA Participants

This year's open enrollment required the team to develop communication material specific to the employees and benefits offices who had migrated to the Cardinal HCM system during Release 1 and Release 2. Along with the development of a Cardinal specific version of certain documents, we also developed and posted Spanish versions of the major documents on the DHRM web site.

Flexible Spending Account (FSA) Grace Period - In an effort to continue to meet the needs of our employees during these extraordinary times, a Grace Period was added to the 2021-2022 Dependent Care Flexible Spending Account (DCFSA) Plan. This grace period extended the period for employees to incur dependent care claims until September 15, 2022. Our office developed Frequently Asked Questions (FAQs) related to the DCFSA Grace Period, which were included on the DHRM website.

Recruitment and Training – There were internal promotions within the Office of Health Benefits that created vacancies on the Employee and Retiree Services team. The Ombudsman worked on two recruitments during this fiscal year. The recruitments resulted in the hiring of two new employees for OHB. The Ombudsman also served on the interview panel for two new program managers for the OHB Policy team.

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

Request for Proposals (RFPs) for Independent Review Organizations - The Ombudsman and appeals examiner worked with the DHRM procurement team on the development of the RFPs to secure vendors to provide Independent Third Party Medical Review Services for the Health Benefits Program. These organizations are required so our appeals process remains compliant with the requirements of ACA external appeal regulations for self-insured health plans. The existing contracts were extended to allow the new contract requirements to be fully developed. This project is ongoing.

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. The team continues the review of the Health and Flexible Benefit documents and links on the DHRM web site and recommends necessary revisions and updates.

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.