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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, Sr., Virginia House of Delegates
The Honorable Terry G. Kilgore, 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

Janet L. Lawson
Director
Department of Human Resource Management

cc: Executive Director, Joint Commission on Healthcare

OMBUDSMAN
ANNUAL REPORT
FISCAL YEAR 2023

Virginia Department of
HUMAN RESOURCE
MANAGEMENT

Office of State and Local Health Benefits Programs

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ANNUAL REPORT ON OMBUDSMAN ACTIVITIES & SERVICES FISCAL YEAR 2023

Office of State and Local Health Benefits Programs

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, 2022 through June 30, 2023. 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 2023, the Ombudsman's team handled 9,773 requests for assistance or complaints (cases) and reviewed 178 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:

Cardinal Human Capital Management (HCM) Migration - Fiscal year 2023 included the final migration of designated state agencies, the retiree group participants managed by the Virginia Retirement System (VRS) and the remaining local employer groups for The Local Choice (TLC) from the legacy benefits system to Cardinal HCM.

This release included the existing VRS retirees and the long-term disability (LTD) participants, along with all members who are eligible for survivor healthcare coverage in our program. The transition of these members into Cardinal introduced some major changes in the administrative processes and procedures for the Retiree Health Benefits Program. The OHB team, including the Ombudsman and Associate Director of Policy, and the Cardinal PPS team worked closely with the LTD and Retiree Health benefits teams at VRS on the procedures for handling system updates for the initial enrollments for newly eligible members, and the ongoing administration of these members related to health care premium billing and Medicare-eligibility. We also worked with the state agencies who had to change or modify their procedures for handling the employees who are transitioning into retirement or long-term disability. We continue to refine and/or update procedures and training aids to make sure the system updates are handled correctly and in a timely manner. This helps to ensure our eligible members have the necessary access to health care coverage and benefits.

Request for Proposals (RFPs) for Independent Review Organizations - The Ombudsman, appeals examiner and a senior health benefits specialist worked with the DHRM procurement team on the procurement of the contracts for 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 RFP, OHB22-3318, was issued on September 19, 2022, with a closing date of September 30, 2022.

The OHB review team, along with the procurement team, reviewed and scored the submissions, addressing the questions and issues raised by the bidders. The Notices of Intent to Award were posted on 12/13/22 and the three new contracts were in place and effective for January 1, 2023. This procurement resulted in renewal of contracts with two review organizations from the prior procurement and the implementation of a new IRO contractor for the State Health Benefits Program.

Cardinal Benefit Event Detail Page - Working with the Cardinal team during Release 1 and 2, brought to light several compliance issues with the agencies' handling of election change requests outside of the annual enrollment period. An initial tool was developed to assist the benefits administrators (BAs) in determining the effective dates for allowable changes prior to updating the system. The tool was a spreadsheet programmed to provide information needed to complete the BAS activity table in Cardinal. While this tool was helpful, a need for a more reliable and user-friendly process was desired. Thus began the work on the new Benefits Event Entry Page.

The Benefit Event Entry Page simplifies the creation of benefit events and replaces the Life Event Tool and the BAS Activity page in Cardinal HCM. The new page in Cardinal captures all the life event detail (e.g., event date, paperwork receipt date, current and future coverage level, type of benefit change), calculates the correct benefit event dates, and automatically selects the benefit event class for the requested election change. This enhancement will allow BAs to save time and minimize errors in the processing of election requests.

The Ombudsman and members of her team, along with the OHB Associate Director for Systems, worked closely with the Cardinal PPS team on the Program's guidelines for the qualified mid-plan year life events (QMEs) and the allowable election changes for each event under the health care and flexible spending accounts. The detailed review of the system's programming and the Program requirements was performed to develop the enhanced coding and programming for the implementation of this page. The initial launching of the new page was announced in a Cardinal Forum in July 2023. This project is ongoing as we continue to review and make necessary changes to ensure this tool continues to address the needs of the agencies as well as ensure the compliance for the Program.

Adult Incapacitated Dependent (AID) Eligibility Requirement - The 2023 General Assembly session approved House Bill 2038 which amended Section 2.2-2818 of the Code of Virginia, which relates to health and related insurance for state employees, revise the adult incapacitated dependent (AID) requirements for continued coverage to a physical or behavioral health condition under the State Employee and Retiree Health Benefits Programs. The revision, which took **effect on July 1, 2023**, applied to the residency requirement for AID eligibility.

To comply with the new AID criteria, and, in compliance with the program provisions, the Office of Health Benefits (OHB) implemented a **60-day enrollment period** to allow any eligible dependents to be enrolled if they met the new expanded residency criteria (in addition to meeting the other eligibility and medical criteria). The Ombudsman, members of her team, and the OHB Policy team, worked with the health plan vendors to update the Eligibility Verification form and develop a modified review process for the special enrollment period. Notification of this eligibility change was provided to all eligible state employees, retirees, survivors, and LTD participants in mid-June.

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 250 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 Line of Duty Act (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

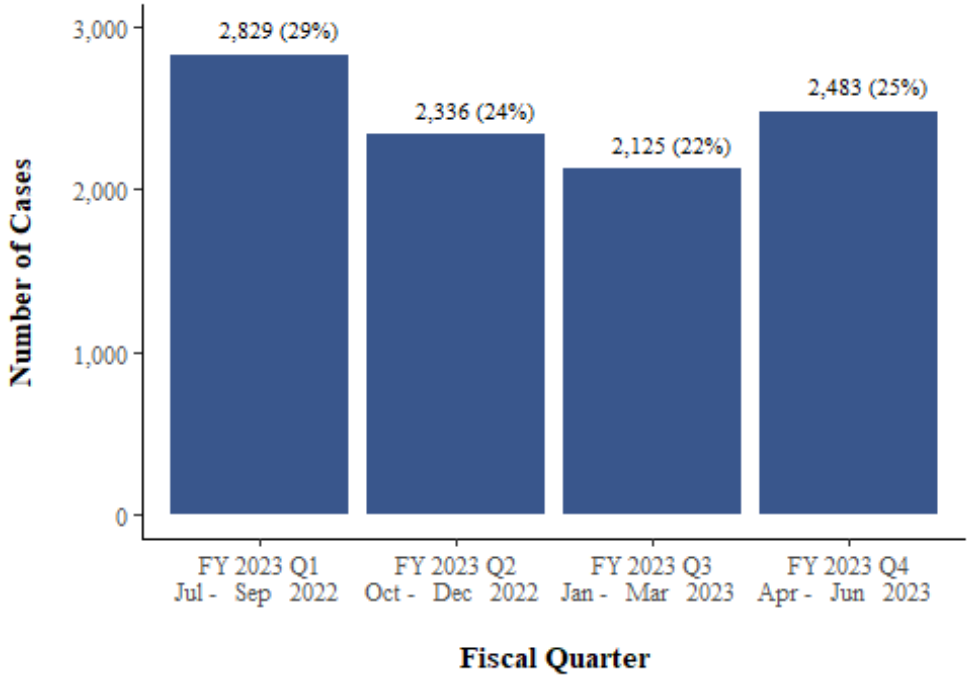
Human Resource Benefits Administrators and Managers statewide who administer health benefits within state agencies and sought assistance with program administration and policy application. Team members also serve as a resource for approximately 400 Group Benefit Administrators in The Local Choice Program.

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

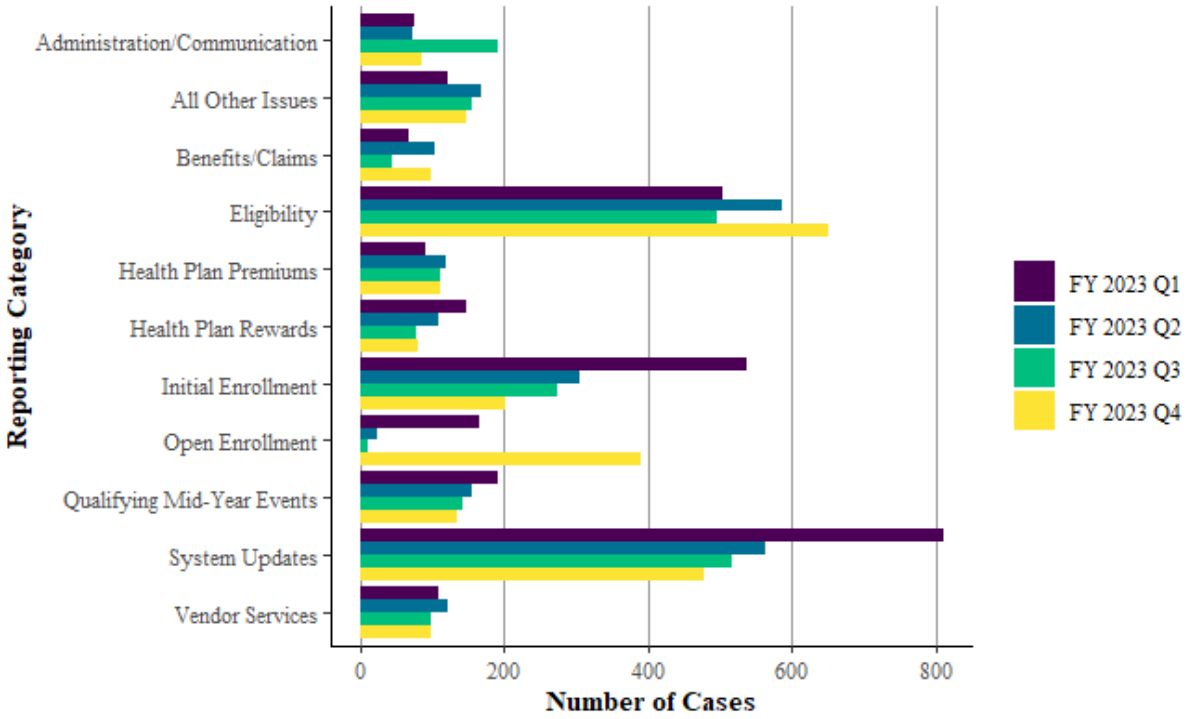
In FY 2023, the Ombudsman's team handled 9,773 requests for assistance and complaints from employees, retirees, agency Benefits Administrators, legislators, providers, and other interested parties. These included general and member specific inquiries, complaints and requests related to benefits, communications, 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 in the plan year.

Cases by Fiscal Quarter, Fiscal Year 2023

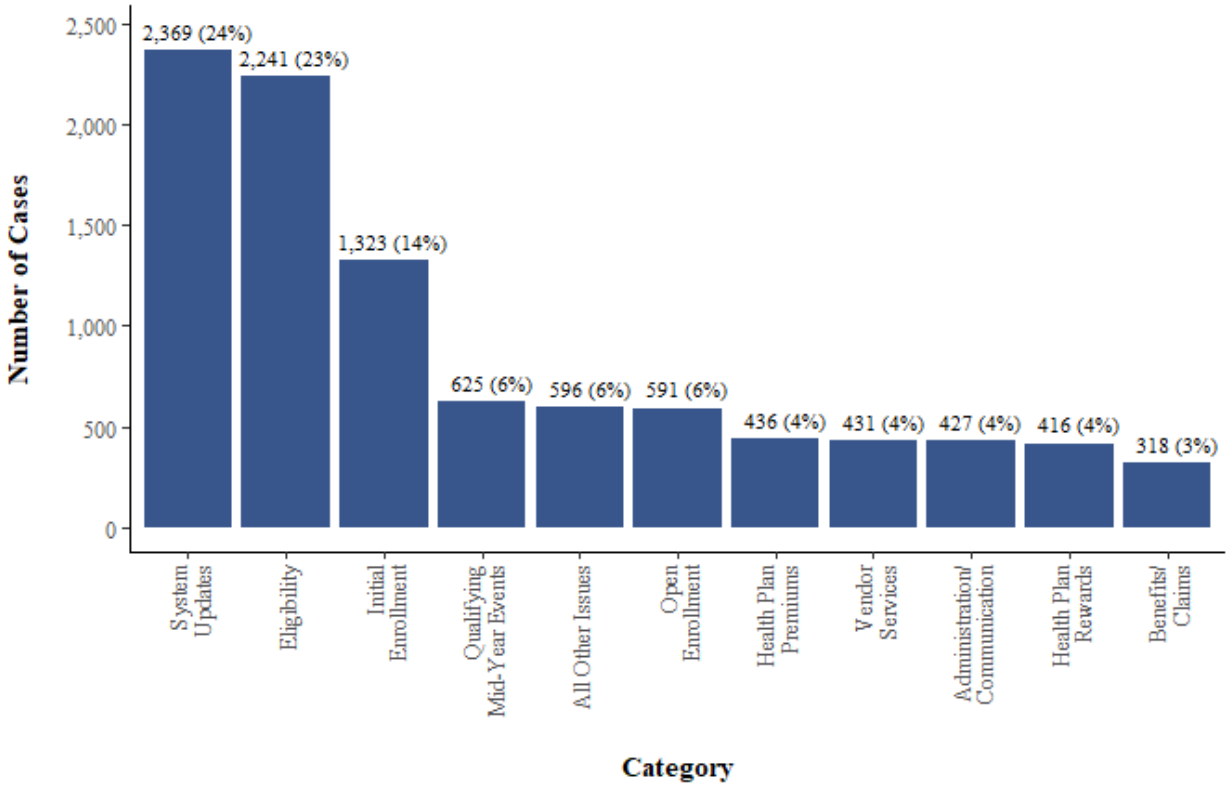


The quarterly requests related to benefits and claims, qualifying midyear events (QME), plan premiums, and eligibility issues normally remain constant throughout the year. Other topics tend to peak at specific times during the fiscal year. Open Enrollment inquiries continue to peak during the first and last quarters of the fiscal year. This fiscal year, most of the requests for assistance with system updates and initial enrollments occurred during the first quarter. With the final migration to the Cardinal HCM system during the second quarter of the fiscal year, there was a notable decrease in these requests.

Cases by Category and Fiscal Quarter, Fiscal Year 2023



Cases by Category, Fiscal Year 2023



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 - 3% 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 - 23% 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, longterm 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 - 4% 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 - 14% 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 - 6% 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

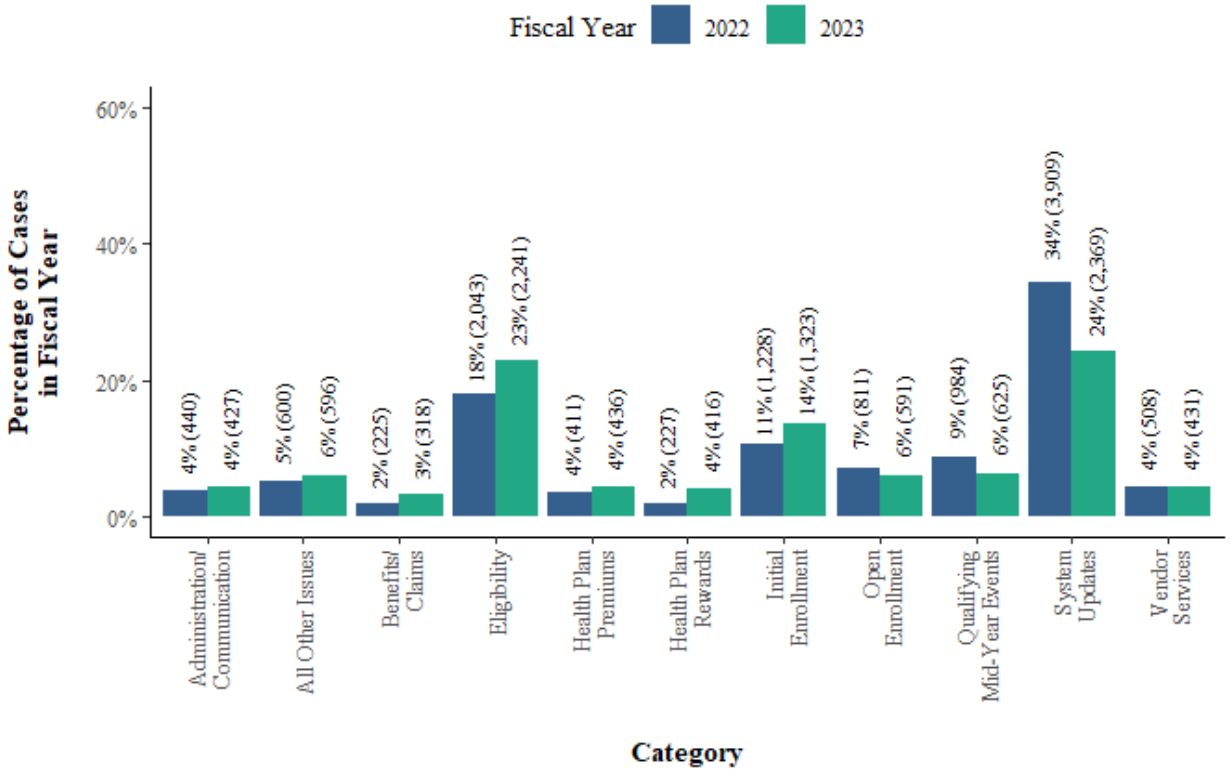
election changes for health care and/or the flexible spending accounts. The elections and premium changes are effective on July 1 of each year. OHB handled the requests to correct elections request errors, specifically to the FSA elections during the first quarter. The fourth quarter requests dealt with issues presented by the online enrollment through Cardinal Employee Self-Service (ESS), the health assessment completions for the Premium Rewards program and premiums for the new plan year.

Qualifying Midyear Events (QMEs) - 6% The IRS provides a listing of specific life events that allow plan participants to make consistent mid-plan year election changes. Under the program provisions, the participant's election change request must be submitted within 60 calendar days of the qualifying midyear event and they must provide documentation to support the event. OHB provides guidance to the agency in the approval process and when required, makes the appropriate updates to the benefits system.

System Updates and Reports - 24% This includes agency requests to update the Benefit Eligibility System (BES), questions related to 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.

Cases by Category, FY 2022 - 2023



The five major topics for FY 2023 remained consistent with FY 2022. These topics accounted for 73.2% of the inquiries for FY 2023 and 78.8% of the inquiries for FY 2022:

Leading Case Categories, FY 2022 – 2023
Sorted by Frequency in FY 2023

Case Category	FY 2023		FY 2022	
	Cases	Percentage	Cases	Percentage
System Updates	2,369	24.2%	3,909	34.3%
Eligibility	2,241	22.9%	2,043	17.9%
Initial Enrollment	1,323	13.5%	1,228	10.8%
Qualifying Mid-Year Events	625	6.4%	984	8.6%
Open Enrollment	591	6.0%	811	7.1%
All other issues combined	*2,624*	*26.9%*	*2,411*	*21.2%*
Total	9,773	100%	11,386	100%

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.

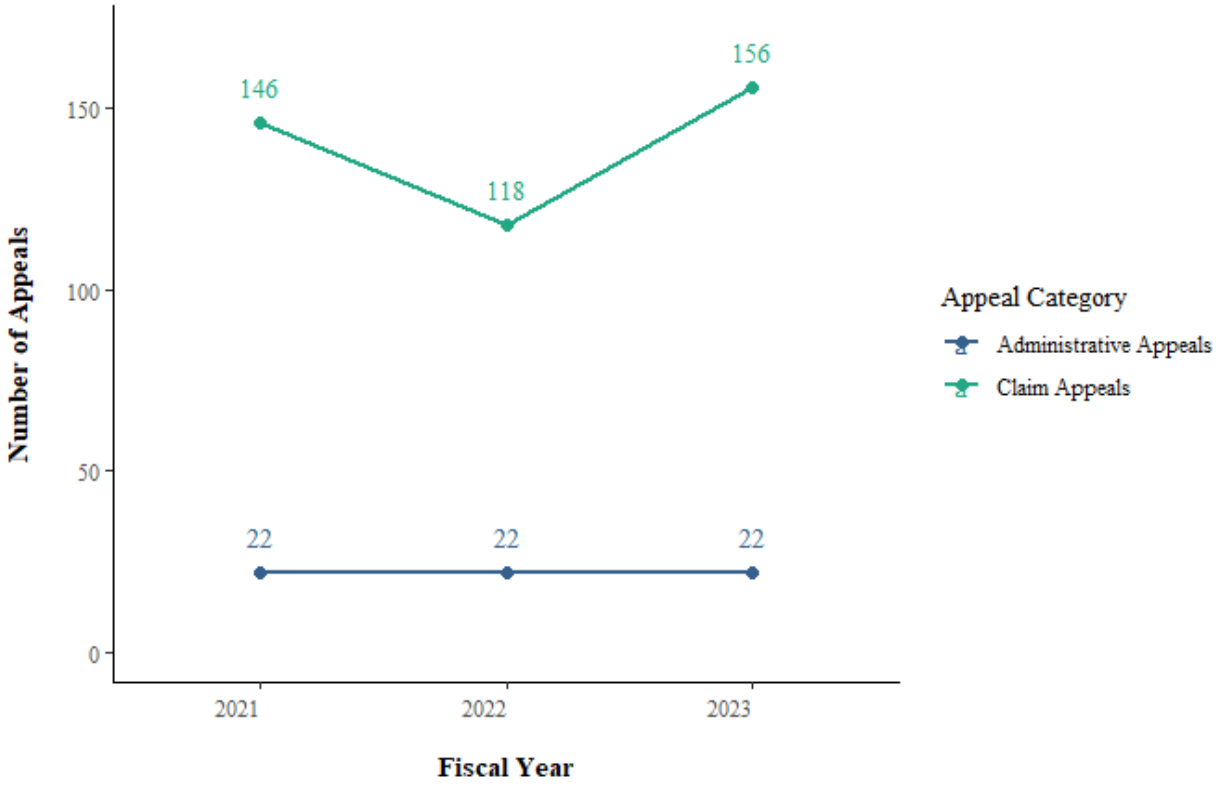
There are two classifications of appeals:

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.

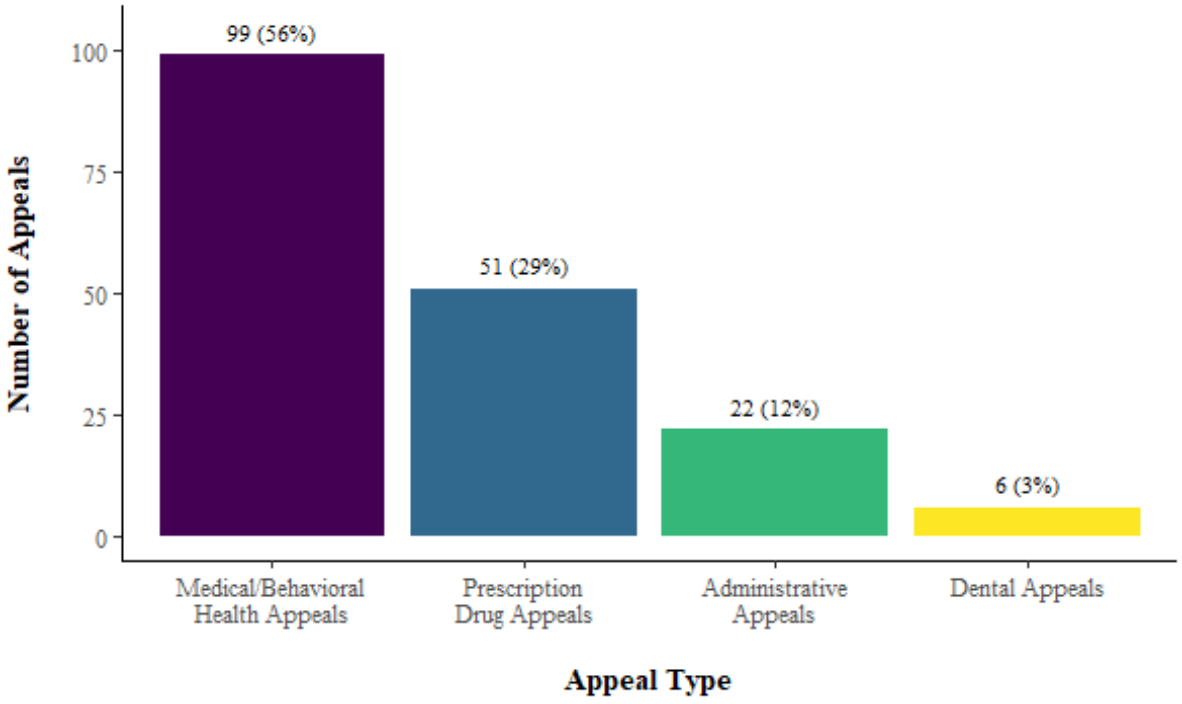
Each of the third party vendors responsible for administering claim components of the Health Benefits Program has an internal process for appeals. After exhausting the appeals with a specific vendor, a member has the right to appeal certain adverse decisions to DHRM. Members also have the right to appeal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

During the 2023 fiscal year, 178 appeals were submitted to DHRM. This compares to 140 appeals for the 2022 fiscal year and 168 for FY 2021. For FY 2023, 156, or 88%, of the appeals received were related to claims and plan benefits and 22, or 12%, were related to program administration.

Appeals by Fiscal Year and Category, FY 2021 - 2023



Appeals by Type, FY 2023



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. A total of 88 appeals (49%) filed were determined to be non-appealable because the member's 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.

OHB Review - 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, can 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 2023, the Ombudsman's team resolved 7 administrative appeals (4%) by reviewing additional information provided and working with the appellant and the agency's benefits office.

Director's Review – For administrative appeals, the request is initially 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. There were no IFFC requests this fiscal year.

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). The IRO determines 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.

There were 83 claim appeals (47%) referred to an Independent Review Organization (IRO) for review. Although the appeals had been submitted to the IRO, additional information submitted to the claim administrator was reviewed which resulted in 10 claim appeals (6%) being resolved in favor of the appellant prior to the completion of the IRO review process. There were 73 appeals (41%) were handled to completion by the IRO.

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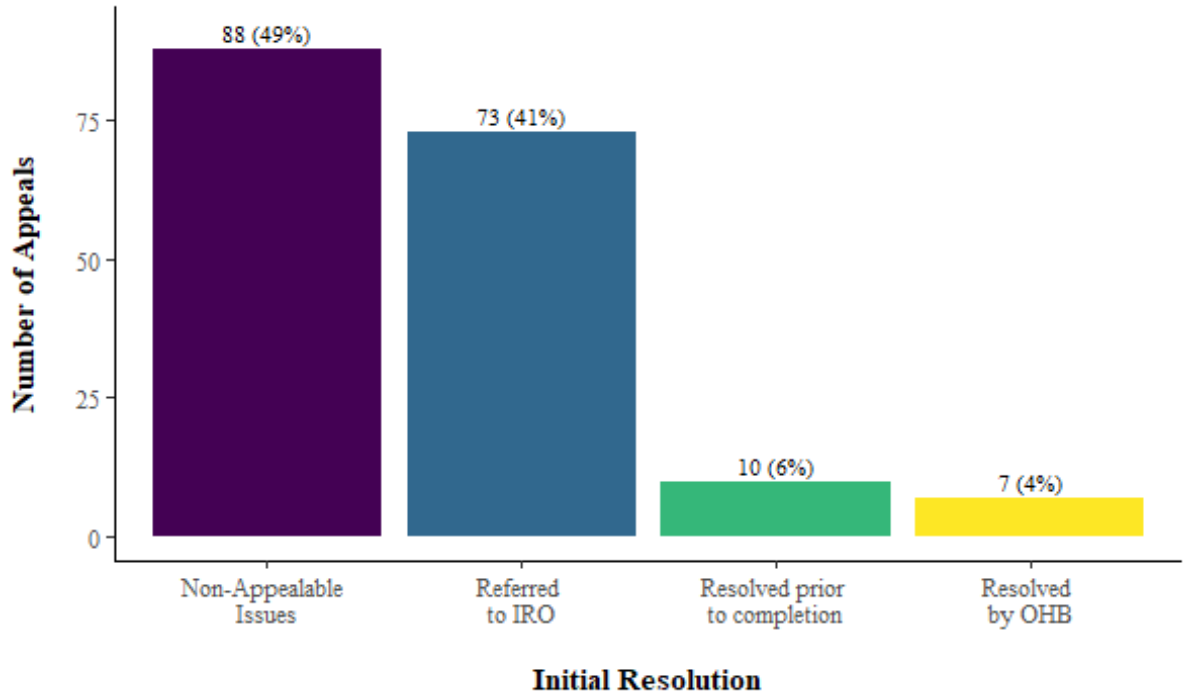
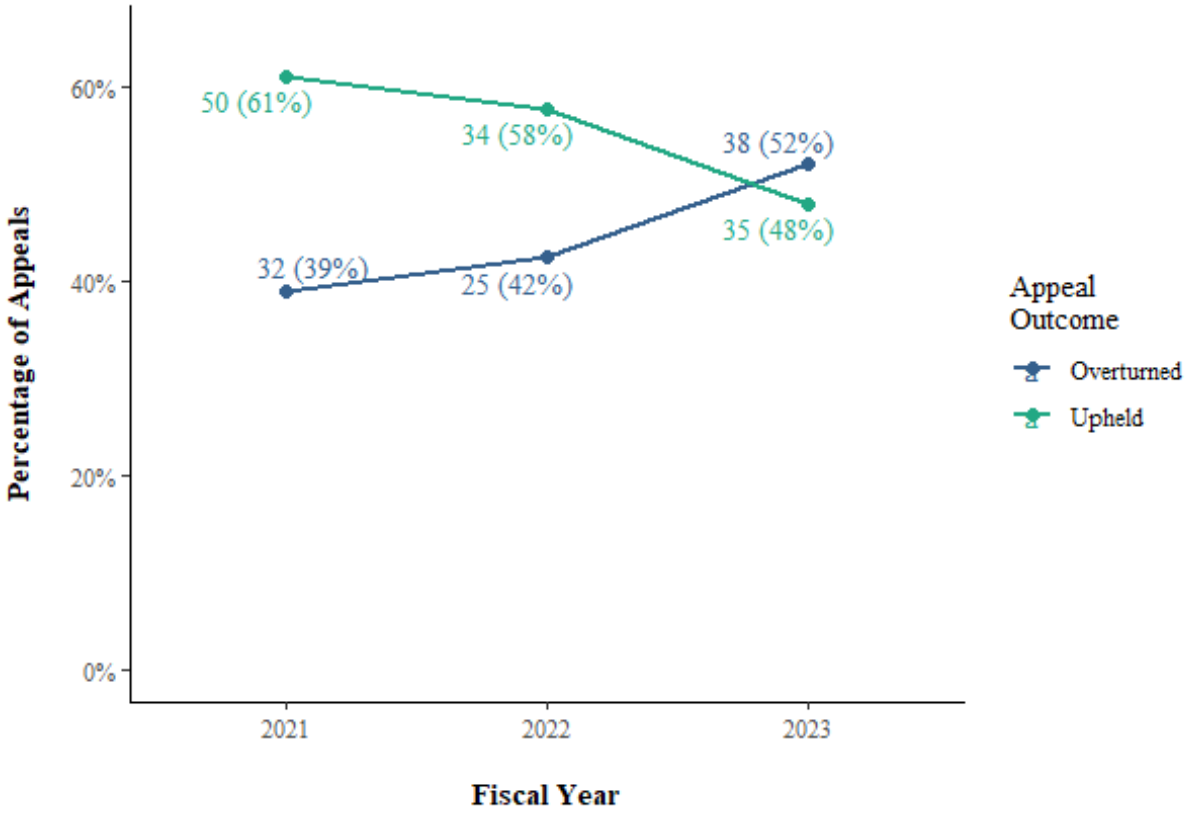
Appeals by Initial Resolution, FY 2023

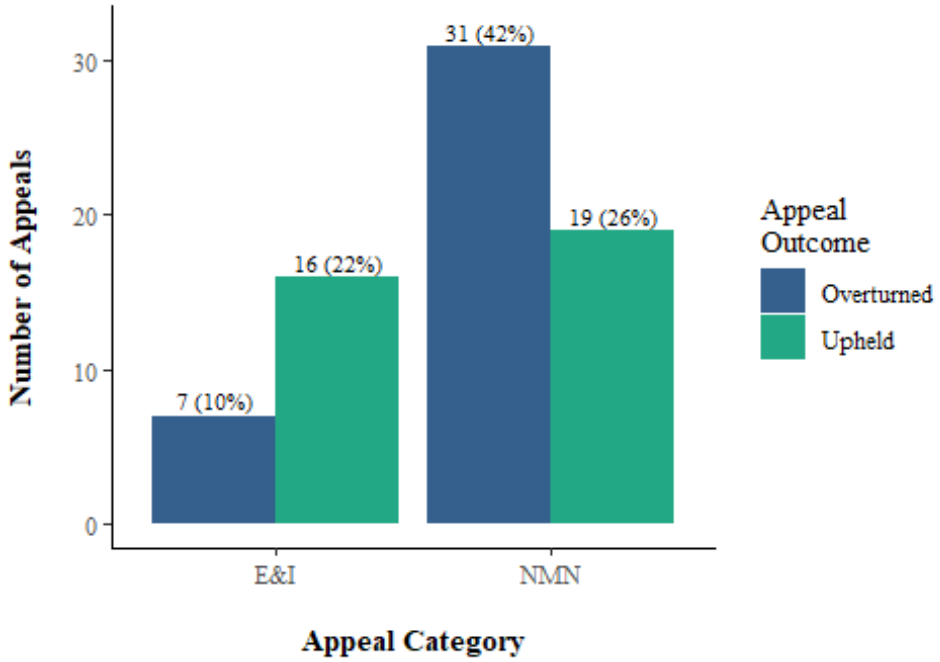


Independent Review Organizations Determinations - Forty-four (60%) of the appeals submitted for IRO review were adverse determinations for medical or behavioral health services and 27 (37%) for prescription drug services. There were 38 adverse determinations made by the claims administrators overturned by our IROs this plan year. There were 35 health plan determinations upheld by the IROs.

Appeals Sent to IROs by Fiscal Year and Outcome, FY 2021 - 2023



Appeals Sent to IROs by Category and Outcome, Fiscal Year 2023



For the 73 appeals referred to an IRO this fiscal year,

- 23 (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
- 50 (68%) 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 leading categories of appeals:

Leading Services Requested among IRO Appeals, FY 2023
Sorted by Frequency in FY 2023

Service Requested	IRO Appeals	Overturned	Upheld
Prescription Medication	27 (37%)	18	9
Various Surgeries	12 (16%)	7	5
Cardiac Defibrillator Vests	10 (14%)	2	8
Cancer DX Testing	8 (11%)	4	4
Inpatient/Residential Setting	5 (7%)	1	4

The remaining 11 IRO appeals were related to various procedures and services such as diagnostic scans, genetic testing, or dental procedures. Upon IRO review, six of these appeals were overturned and five were upheld.

During FY 2023, the IROs overturned twice as many adverse plan decisions for prescription drugs as they upheld. Similarly, IROs overturned the majority of appeals for surgical procedures. Overturned determinations were provided by each of the IROs so there was no trend noted in the decisions by a specific organization.

For most of the overturned appeals, the medical literature referenced in the IRO's determination differed from the guidelines used for the internal appeal. The previously denied services were deemed medically necessary based on new accepted standards of practice and the member's specific condition. 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.

During FY 2023, there were no appeals filed under the APA.

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 is now the primary system of record for accounting, human resource, payroll, benefits, and time management for the Commonwealth's employee population. 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 assists 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.

The Release 1 transition, which included seventeen state agencies, three TLC employer groups and the LODA population, occurred on October 2, 2021. Release 2, which occurred on April 4, 2022, included sixty-nine state agencies. Fiscal year 2023 included the Release 3 migration which occurred on October 3, 2022. Release 3 included the final migration of designated state agencies, existing VRS retirees and LTD participants, along with members who are eligible for survivor healthcare coverage in our program, and the remaining TLC employer groups from the legacy system to Cardinal HCM.

The transition of the VRS retirees and LTD participants, along with members who are eligible for survivor healthcare coverage into Cardinal introduced a major change in the administrative processes and procedures for the Retiree Health Benefits Program. The OHB team, including the Ombudsman and Associate Director of Policy, worked closely with the LTD and Retiree Health benefits teams at VRS and Cardinal on the handling and system updates for the initial enrollments for newly eligible members, and the ongoing administration of these members related to health care premium billing and Medicare-eligibility. As with each migration, OHB worked with the health plan vendors 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.

With the transition to the Cardinal HCM system, the number of inquiries and requests to OHB initially increased. We noted a 29% increase in the number of requests for assistance and inquiries submitted to OHB from FY19 through FY22. The nature of the requests and the

system configuration required additional research time to obtain the information to identify and resolve the issues. Working with the Cardinal team, OHB provided useful guidance to the agencies on the information displayed in the system and the process for making routine system updates related to the benefits. The effect of this guidance is noted by the decrease in the number of system related requests from the first quarter of FY23 to the fourth quarter of the fiscal year.

When the benefits teams at the agencies need assistance with system updates and/or corrections, they will submit a request to the Cardinal PPS team. In many situations the resolution or request will prompt a meeting with the agency. The Ombudsman and members of her team will participate in these meetings to provide the health benefits policy and/or provide guidance to the agency related to the issue.

The Cardinal HCM system does not include many of the policy edits which were programmed in the former legacy system. The OHB team had to develop internal procedures to handle reports and perform audits to ensure compliance with the Program's policies and provisions. We continue to develop the workflow procedures for standard operating guidelines within the OHB teams.

Cardinal Benefit Event Entry Tool - The Benefit Event Detail page simplifies the creation of benefit events and replaces the Life Event Tool and the BAS Activity page in Cardinal HCM. The new page captures all the life event detail (e.g., event date, paperwork receipt date, current and future coverage level, type of benefit change), calculates the correct benefit event dates, and automatically selects the benefit event class. This enhancement will allow BAs to save time and minimize errors in the processing of election requests. The Ombudsman and members of her team, along with the OHB Associate Director for Systems, worked closely with the Cardinal PPS team on the Program's guidelines for the qualified mid-plan year life events (QMEs) and the allowable election changes for each event under the health care and flexible spending accounts. This project was initiated in response to the trends and issues identified by the requests submitted to OHB and Cardinal PPS. The detailed review of the system's current programming and the program requirements, which occurred over several months, helped to develop the opportunities for enhanced coding and programming for the implementation of this page. The initial launching of the new page was announced in a Cardinal Forum in July 2023. This project is ongoing as we continue to review and make necessary changes to ensure this tool continues to address the needs of the agencies as well as ensure the compliance for the Program.

Request for Proposals (RFPs) for Independent Review Organizations - The Ombudsman, appeals examiner and a senior health benefits specialist worked with the DHRM procurement team on the procurement of the contracts for 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 RFP was issued in September 2022 and the three new contracts were in place and effective for January 1, 2023. DHRM continued to contract with two organizations for these services and secured the services of one new organization.

Annual Flu Shot Program - Member communications and web site documents for the 2022 flu season were developed and distributed in the fall of 2022. 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 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 Supplement plan 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 October 14 and 28, 2022. 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.

Adult Incapacitated Dependent Annual 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.

Special Enrollment for Adult Incapacitated Dependents - Section 2.2-2818 of the Code of Virginia revised the adult incapacitated dependent (AID) requirements for continued coverage as an AID due to a physical or behavioral health condition under the State Employee and Retiree Health Benefits Programs. Effective July 1, 2023, the residency requirement that the AID must reside full-time with the employee and/or other natural/adoptive parent as a member of the employee's household was expanded to allow the AID to be "receiving residential support

services" which means the AID can be living in a group home, nursing home/convalescent home, long-term care facility or similar facility that provides services for physically and/or mentally disabled patients."

AID criteria prior to 7/1/2023	New AID criteria effective 7/1/2023
• the incapacitation existed prior to the loss of eligibility due to age, • the adult dependent is unmarried, • the adult dependent receives more than half of their financial support from the employee and/or the other parent, and • *the adult dependent must reside full-time with the employee (or the other natural/adoptive parent) as a member of the employee's household.*	• the incapacitation existed prior to the loss of eligibility due to age, • the adult dependent is unmarried, • the adult dependent receives more than half of their financial support from the employee and/or the other parent, and • *the adult dependent is not required to reside full-time with the employee (or the other natural/adoptive parent); so long as the adult dependent is receiving residential support services.*

To comply with the new AID criteria, and in compliance with the program provisions, our office provided a **special enrollment period** to allow any eligible AID to be enrolled if they met the new expanded residency criteria (in addition to meeting the other eligibility and medical criteria). The Ombudsman, members of her team, and the OHB Policy team, worked with the health plan vendors to update the AID Eligibility Verification form and develop a modified review process for the special enrollment period. An email notification was provided to all eligible state employees and a notification was mailed to all eligible retirees, survivors, and LTD participants in mid-June. The special enrollment period ran from July 1 through August 29, 2023, so the results of this eligibility change will be noted in FY 24 data.

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 2022 tax year were mailed to state and local health plan participants beginning the week of January 30, 2023. 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 when requested.

Impact of COVID-19 - The COVID-19 Public Health Emergency (PHE) ended on May 11, 2023. With the expiration of the PHE, many federal requirements related to COVID-19 that were enacted in response to the pandemic ceased. As of May 12, 2023, coverage guidelines for

COVID-19 testing, vaccines and treatments were updated and reimbursement for services are based on applicable health plan benefits and provider/pharmacy participation status. There was, also, a change to the required coverage for over-the-counter COVID-19 tests. With the announcement, members were encouraged to review the benefits update on their health plan's website or contact the plan directly with questions about the benefits available for COVID related expenses.

Open Enrollment – The OHB team worked on the literature, forms and mailing for the annual Open Enrollment period. With the transition of all state agencies to Cardinal HCM, the OHB team worked to develop open enrollment communications to address issues specifically noted with the Release 1 and Release 2 Cardinal employee population. The material needed to address detailed guidance for employees related to the online enrollment processes. The open enrollment communications also addressed program administration and policy guidance identified by monitoring the OHB inquiry trends.

The Ombudsman, her team and the Policy team worked closely with the Cardinal team and each of the plan vendors to develop material for the 2023 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
- 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

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. The emails included flyers and information on how to access the health plan websites and mobile apps for additional information about the benefits available under their specific coverage.

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 2022.

Recruitment and Training –Internal promotions within the Office of Health Benefits last fiscal year once again, created vacancies on the Employee and Retiree Services team for this fiscal year. Also, an increase in the incoming requests to our office warranted the creation of two new positions within the Employee and Retiree Services team. One new senior specialist joined the team in July 2022 to complete a FY22 recruitment for an existing position. The Ombudsman worked on two recruitments during the 2023 fiscal year. The recruitments resulted in the hiring of a new employee in November 2022 and of two employees who began employment with the Commonwealth in July 2023. The Ombudsman also served on the two interview panels for other DHRM office areas during the fiscal year.

The Ombudsman and her team have frequent communication 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 we also participate in all applicable 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.