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November 14, 2024

The Honorable R. Creigh Deeds, Senate of Virginia
The Honorable Ghazala F. Hashmi, Senate of Virginia
The Honorable Jeion A. Ward, Virginia House of Delegates
The Honorable Mark D. Sickles, Virginia House of Delegates
The Honorable Rodney T. Willett, 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 Submitted,

Janet L. Lawson
Director, Department of Human Resource Management

cc: Executive Director, Joint Commission on Healthcare

OMBUDSMAN ANNUAL REPORT FISCAL YEAR 2024

Virginia Department of
HUMAN RESOURCE
MANAGEMENT

Office of Health Benefits

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ANNUAL REPORT ON OMBUDSMAN ACTIVITIES & SERVICES FISCAL YEAR 2024

Office of Health Benefits

EXECUTIVE SUMMARY

This annual report on the activities of the Ombudsman for the Office of Health Benefits (OHB) covers the period from July 1, 2023 through June 30, 2024. 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 2024, the Ombudsman's team handled 8,187 requests for assistance or complaints (cases) and reviewed 198 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:

CRM Migration Project – The Office of Health Benefits is currently using an on-premises Dynamics CRM (Customer Relationship Management) system to track incoming inquiries and requests. The Department of Human Resource Management (DHRM) Information Technology team proposed a plan to migrate the existing Dynamics CRM system (on-premises) to the cloud solution, Dynamics 365, to capitalize on enhanced security, and reliability of cloud computing. The cloud reduces maintenance and system updates typically associated with on-premises upkeep.

As a part of this project, the Ombudsman and Systems Associate Director were assigned as OHB Project Managers and CRM Application Owners. They work with the DHRM IT Project Owners to coordinate activities and ensure all work is performed and meet the department's expectations and to ensure the security standards of the Commonwealth of Virginia are upheld. This is an ongoing project with expected migration to the cloud in Fiscal Year 2025.

Special Enrollment for Adult Incapacitated Dependents – Section 2.2-2818 of the Code of Virginia revised the adult incapacitated dependent (AID) requirements for continuation of coverage due to a physical or behavioral health condition under the State Employee and Retiree Health Benefits Programs. Effective July 1, 2023, the residency requirement for AID was expanded to allow eligible dependents to be receiving residential support services. This allows the AID to reside 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.

To comply with the new AID criteria, and in compliance with the program provisions, our office provided a special enrollment period to allow employees and retirees to cover their eligible over-age 26 dependents if they met the program's eligibility requirements including the new expanded residency criteria, and the health plan's medical criteria. The special enrollment period ran from July 1 through August 29, 2023. The Ombudsman and members of her team responded to inquiries about the new criteria, provided guidance on the review process and reviewed the requests received during the special enrollment period. While there were numerous inquiries related to the notification, less than 50 applications were submitted for review. Of the requests received for review, only three dependents met the new requirements and were reenrolled into the health plan coverage.

Cardinal Benefit Event Entry Tool –The Benefit Event Detail page was designed to simplify the benefit event processing in Cardinal HCM. The new tool (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 benefit event effective dates, and automatically selects the benefit event class needed for the system update. This tool minimizes errors in the processing of election requests submitted outside of the annual enrollment period.

This project was initiated in response to the trends and issues identified by the requests submitted to OHB and Cardinal Post Production Support (PPS). The initial launching was announced in a Cardinal Forum in July 2023. The Ombudsman and members of her team, along with the OHB Associate Director for Systems, worked 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. While the initial work on this project began in the prior fiscal year, this ongoing project requires regular meetings with the Cardinal PPS team, the Ombudsman and various members of the OHB team. The team continues to review and make necessary programming changes to ensure this tool is a reliable resource for the agencies and ensure program compliance.

Redesign of Open Enrollment Communications –The OHB team worked on the literature for the annual Open Enrollment period. The communication materials provide information on the changes for the new plan year, instructions on making an Open Enrollment election request and addresses program administration and policy guidance identified by monitoring the OHB inquiry trends.

This year's Open Enrollment (OE) brought a new design to the annual Spotlight on Your Benefits newsletter and the Open Enrollment page on the DHRM website. Spearheaded by the OE coordinator and the Associate Director of Policy, the redesign and implementation project included the Ombudsman, members of her team, the DHRM webmaster and communications manager. The newsletter's new look and layout, along with the redesign of the Open Enrollment webpage, received extremely positive feedback from the agencies' benefits administrators and our members.

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 four 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 184,000 active full-time and part-time employees, 10,000 retirees not eligible for Medicare, and their dependents. This Program also provides supplemental benefits to approximately 40,000 participants who are eligible for Medicare and 500 extended coverage (COBRA) enrollees, and to the dependents of these enrollees.

OHB has the responsibility for administering a health benefits program, The Local Choice (TLC), which is offered to localities and public-school systems within the Commonwealth 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 67,000 employees, retirees, and their covered dependents. OHB also administers 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 3,600 participants and covered family members in the LODA plans.

The Program offers three statewide self-insured plans for state employees and early retirees (pre-65): COVA Care, a Preferred Provider Organization (PPO) plan; COVA HDHP, a High Deductible Health Plan; and COVA HealthAware, a Consumer-Driven Health Plan (CDHP). The program also offers a regional fully insured HMO plan to employees and early retirees in the Northern Viginia service area and one in 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 a self-insured plan designed around a PPO called Key Advantage, a self-insured HDHP and the regional fully insured HMO plans in Northern Virginia and Hampton Roads. LODA Health Benefits Plans participants are enrolled in one of three plans, based on current employment, former employment, or Medicare eligibility.

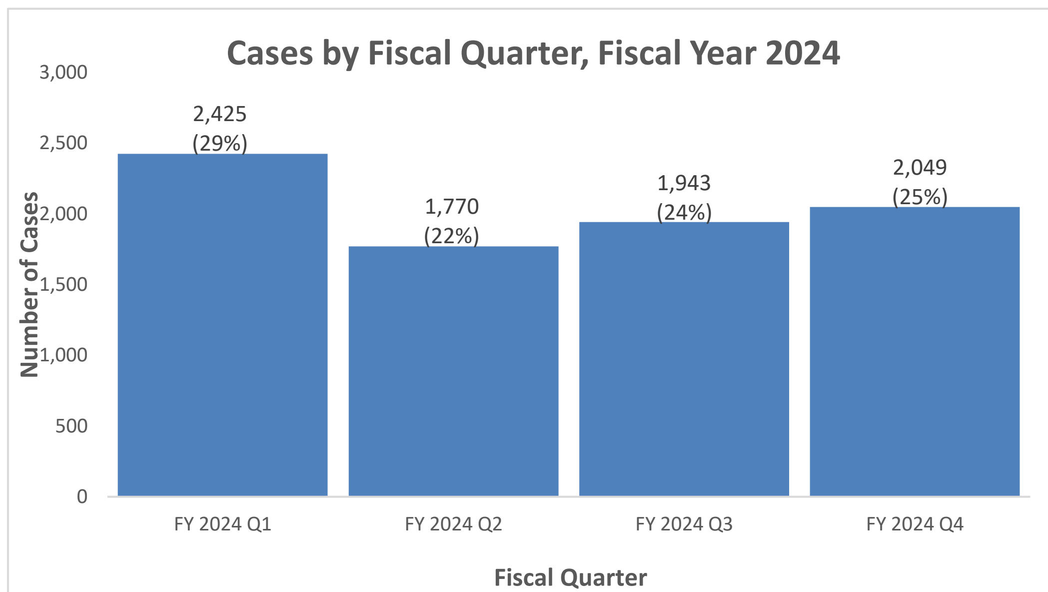
In total, the Ombudsman's team served over 300,000 state and local government employees, retirees, and family members during this period. The team helped over 500 Human Resource Benefits Administrators and Managers statewide who administer health benefits within state agencies and sought assistance with 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 works closely with the Office of the Attorney General for advice and legal counsel concerning appeals, compliance, and issues of equity. She also works with the consulting services contractor who helps 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.

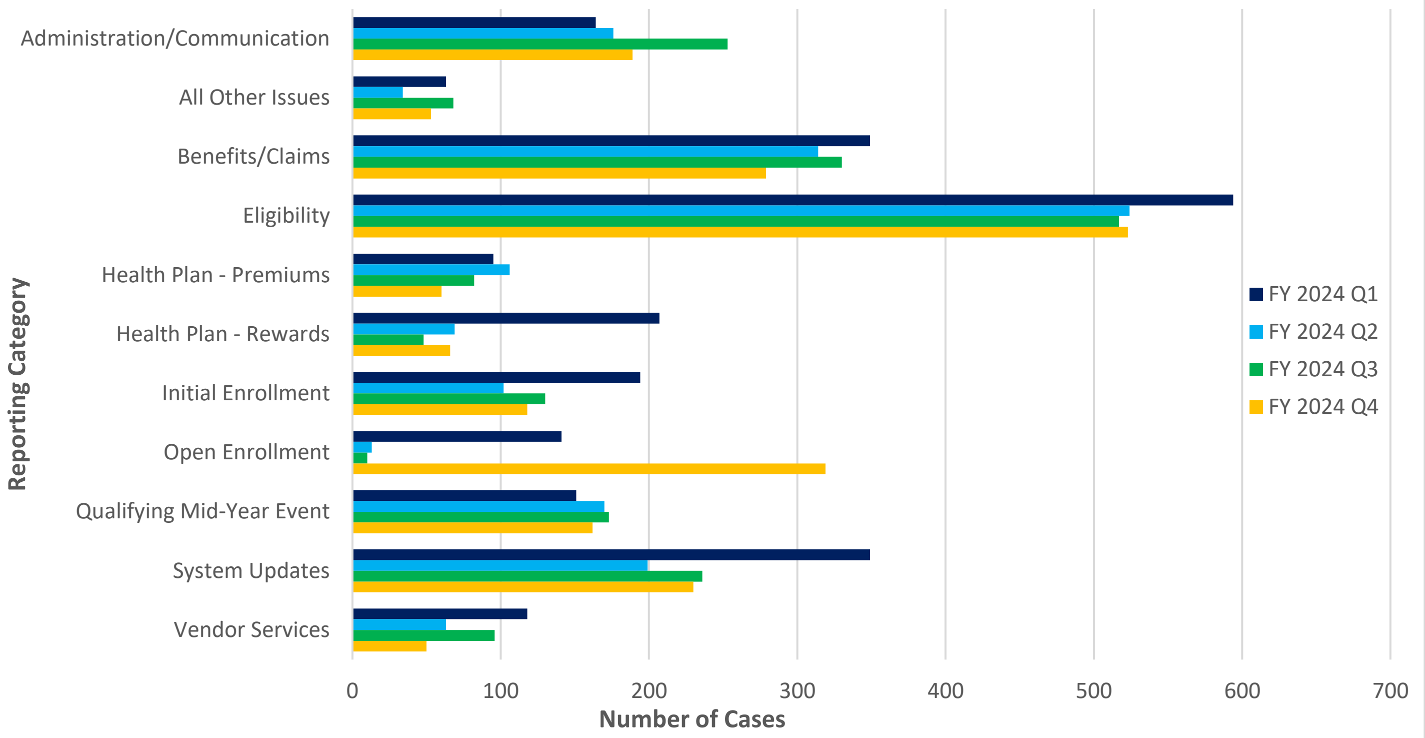
EMPLOYEE AND RETIREE SERVICES

In FY 2024, the Ombudsman team handled 8,187 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 in order to provide a final resolution or a response to the question.

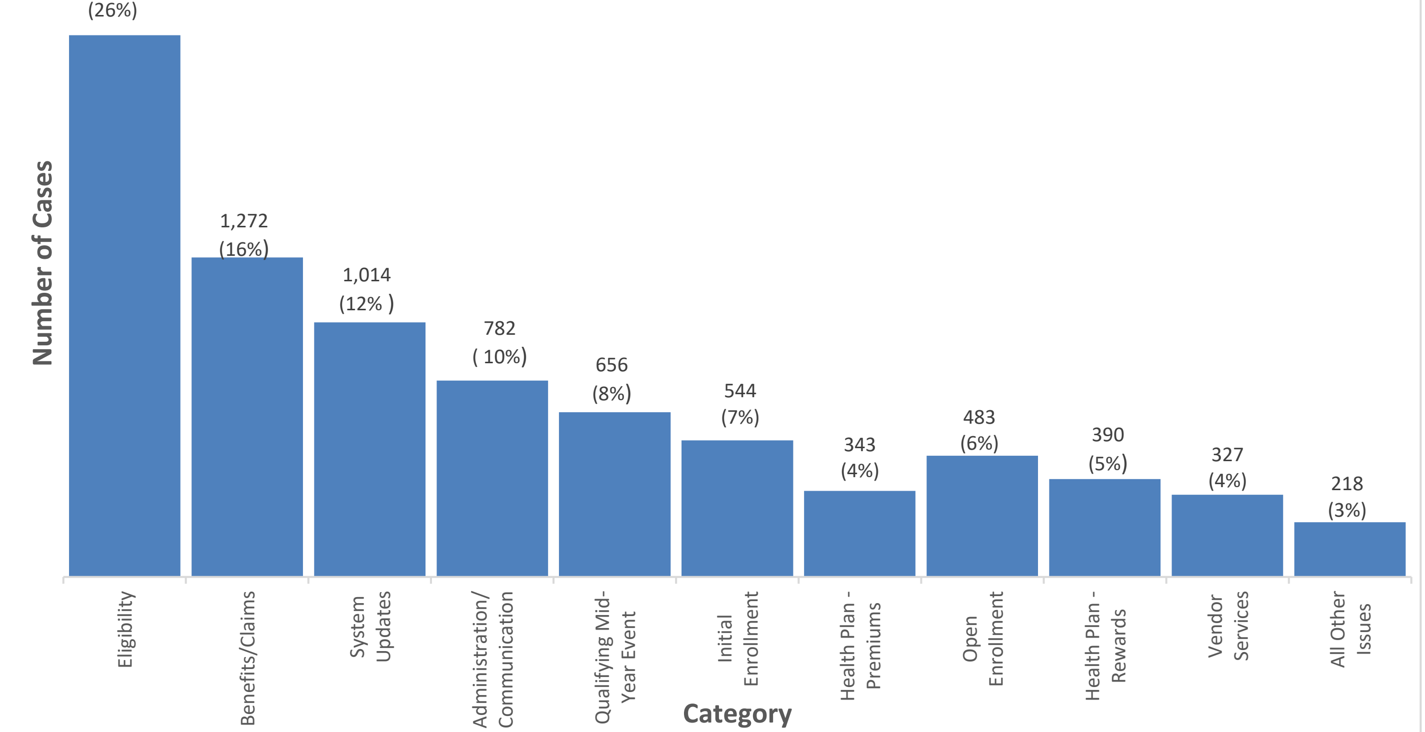
The Office of Health Benefits (OHB) normally receives a consistent number of inquiries each quarter with the primary topics varied depending on the quarter in the plan year.



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. For the first quarter of this fiscal year, there was a minimal increase in the Open Enrollment requests, but the Adult Incapacitated Dependent (AID) special enrollment did result in an overall increase during this period.



Cases by Category and Fiscal Quarter, Fiscal Year 2024
Administration/Communication
All Other Issues
Benefits/Claims
Eligibility
Health Plan - Premiums
Health Plan - Rewards
Initial Enrollment
Open Enrollment
Qualifying Mid-Year Event
System Updates
Vendor Services
Reporting Category
0
100
200
300
400
500
600
700
Number of Cases
FY 2024 Q1
FY 2024 Q2
FY 2024 Q3
FY 2024 Q4



Cases by Category, Fiscal Year 2024
2,158 (26%)
1,272 (16%)
1,014 (12%)
782 (10%)
656 (8%)
544 (7%)
343 (4%)
483 (6%)
390 (5%)
327 (4%)
218 (3%)
Number of Cases
Eligibility
Benefits/Claims
System Updates
Administration/ Communication
Qualifying Mid-Year Event
Initial Enrollment
Health Plan - Premiums
Open Enrollment
Health Plan - Rewards
Vendor Services
All Other Issues
Category

Administration and Communication – 10% 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 – 16% 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 – 26% 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 annuity will not support the premium, the enrollee will be direct billed.

Health Plan Rewards – 5% 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 – 7% 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.

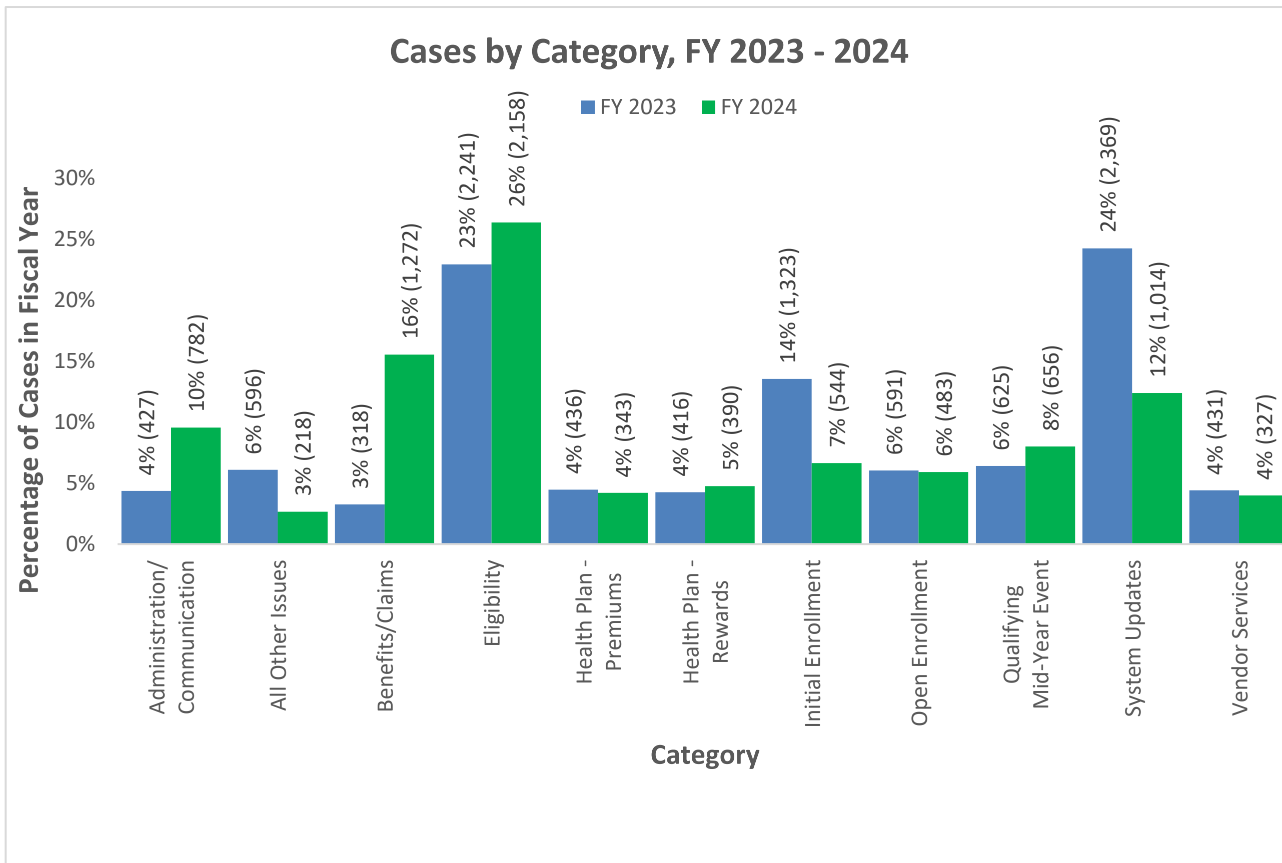
Open Enrollment – 6% The Open Enrollment period occurs each year in the spring. The period is announced in the Open Enrollment newsletter, Spotlight on Your Benefits, which is mailed to eligible employees and retirees. This is the annual opportunity to request enrollment or make

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) – 8% The IRS provides a listing of specific life events that allow plan participants to make consistent mid-plan year election changes. Under the program provisions, the participant's election change request must be submitted within 60 calendar days of the qualifying midyear event and they must provide documentation to support the event. OHB provides guidance to the agency in the approval process and when required, makes the appropriate updates to the benefits system.

System Updates and Reports – 12% This includes agency requests to update the benefits records, premium rewards and/or FSA information in Cardinal HCM, and assistance with Cardinal system reports. This category also includes requests for information housed in the legacy system (BES) by agency administrators needed to assist members and resolve issues.

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.



FY 2024 top five categories accounted for 71.8% of inquiries whereas 73.2% was the top five accountability percentage for FY 2023. **Eligibility** issues were the #1 category for the fiscal year. This increase correlates to the change in the AID eligibility criteria and required notification.

The change in the ranking for **System Update** requests (from #1 to #3), and initial enrollment requests (from #3 to #6) can be attributed to the completion of the Cardinal migration project. OHB is no longer responsible for handling the initial health care enrollment of VRS retirees. These enrollments are now processed through the online Cardinal Self-Service application or entered by the VRS benefits team. The health care system updates for employees who transfer between Cardinal and non-Cardinal agencies are now handled by the agencies with OHB assisting when requested.

Administration & Communications moved up to the top categories. We attribute this increase to the change in the COBRA administration process. Both benefits administrators and members reached out for assistance and/or clarification on the new procedures and assistance with issuance of the election notices. This fiscal year, **Benefits & Claim** issues and **Qualifying Midyear Events (QMEs)** round out the list.

Leading Case Categories, FY 2023 – 2024
Sorted by Frequency

	FY 2024			FY 2023	
Case Category	Cases	Percentage	Case Category	Cases	Percentage
Eligibility	2,158	26%	System Updates	2,369	24%
Benefits/Claims	1,272	16%	Eligibility	2,241	23%
System Updates	1,014	12%	Initial Enrollment	1,323	14%
Administration/Communication	782	10%	Qualifying Mid-Year Event	625	6%
Qualifying Mid-Year Event	656	8%	Open Enrollment	591	6%
All other issues combined	2,305	28%	*All other issues combined*	2,624	27%
Total	8,187	100%	Total	9,773	100%

APPEALS

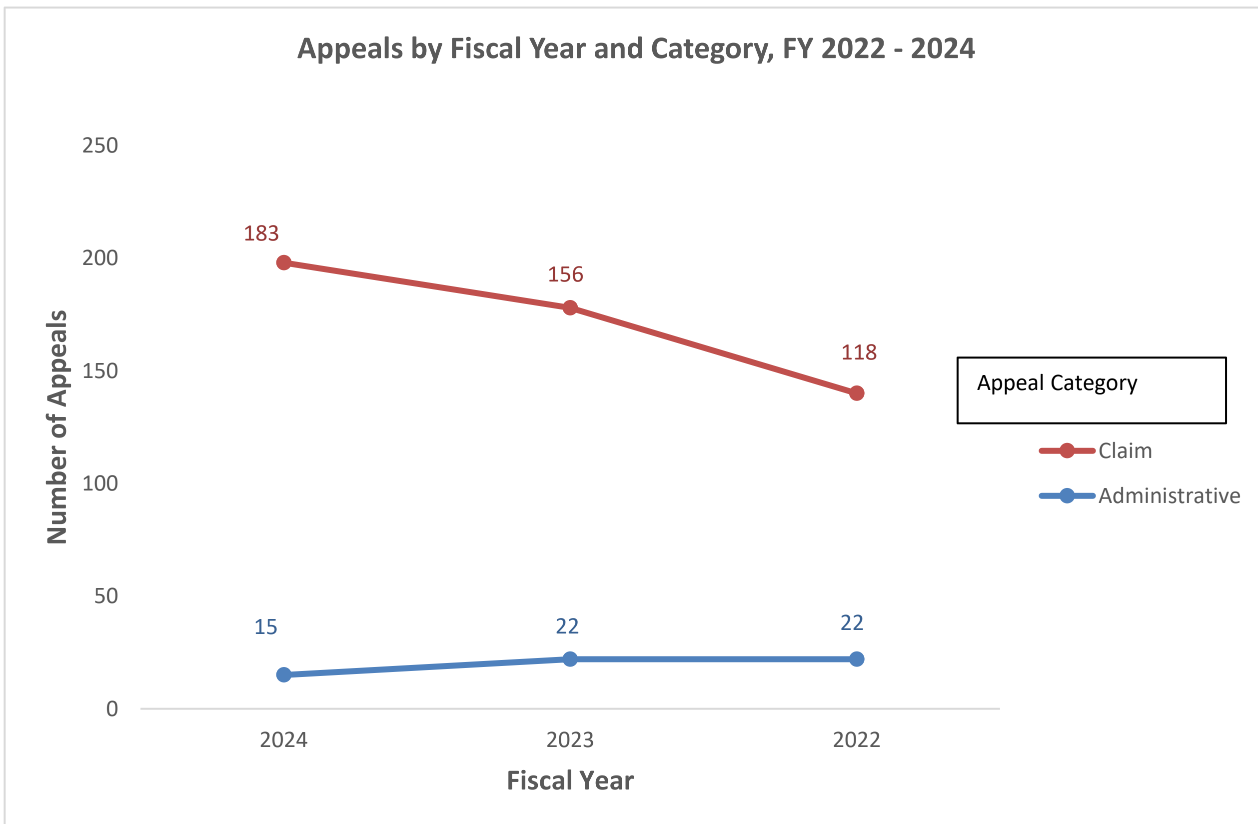
Charged with the oversight of the appeals process, the Ombudsman or an appeals examiner serves as the contact for appellants. Every effort is made to assure that all appellants receive the full extent of the benefits to which they are entitled under the rules of the program.

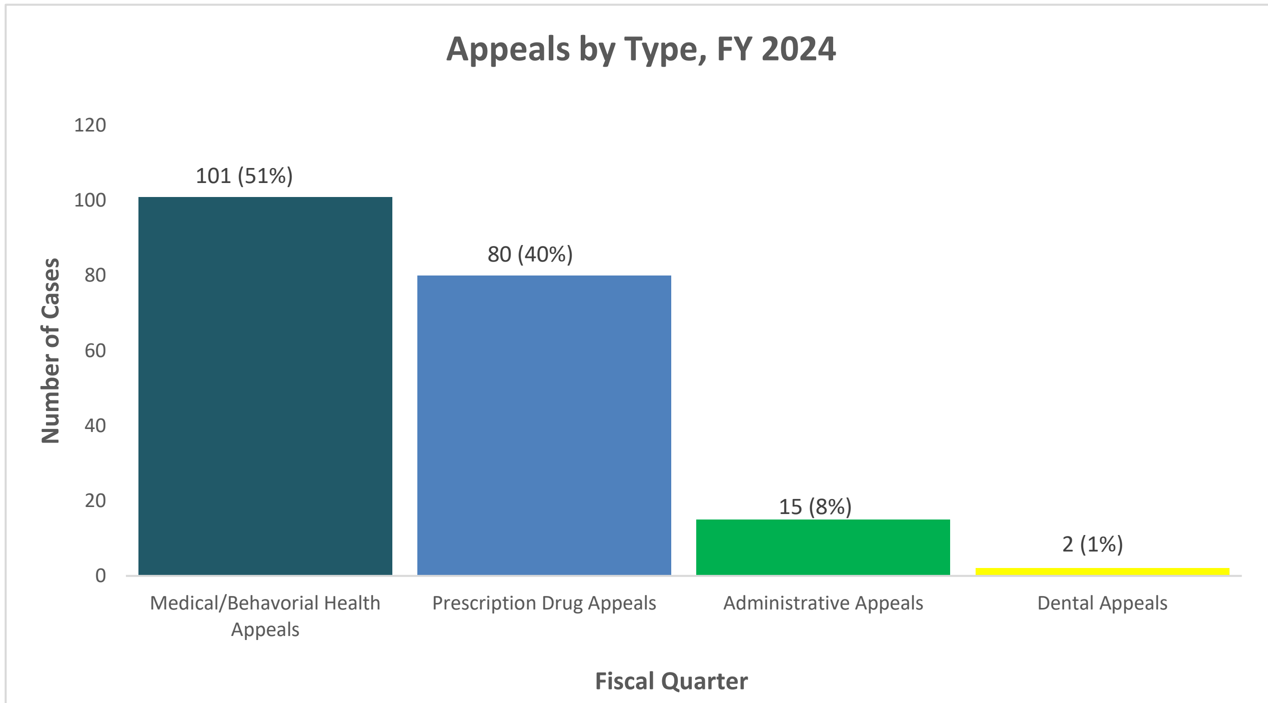
There are two classifications of appeals:

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 2024 fiscal year,198 appeals were submitted to DHRM. This compares to 178 appeals for the 2023 fiscal year and 140 for FY 2022. For FY 2024, 183, or 92%, of the appeals received were related to claims and plan benefits and 15, or 8%, were related to program administration.





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 82 appeals (41%) 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,
- 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,
- for failure to submit the State Health Benefits Appeals form and/or Authorization form allowing representation in the external appeals process,
- and accuracy of claims processing for Coordination of Benefits.

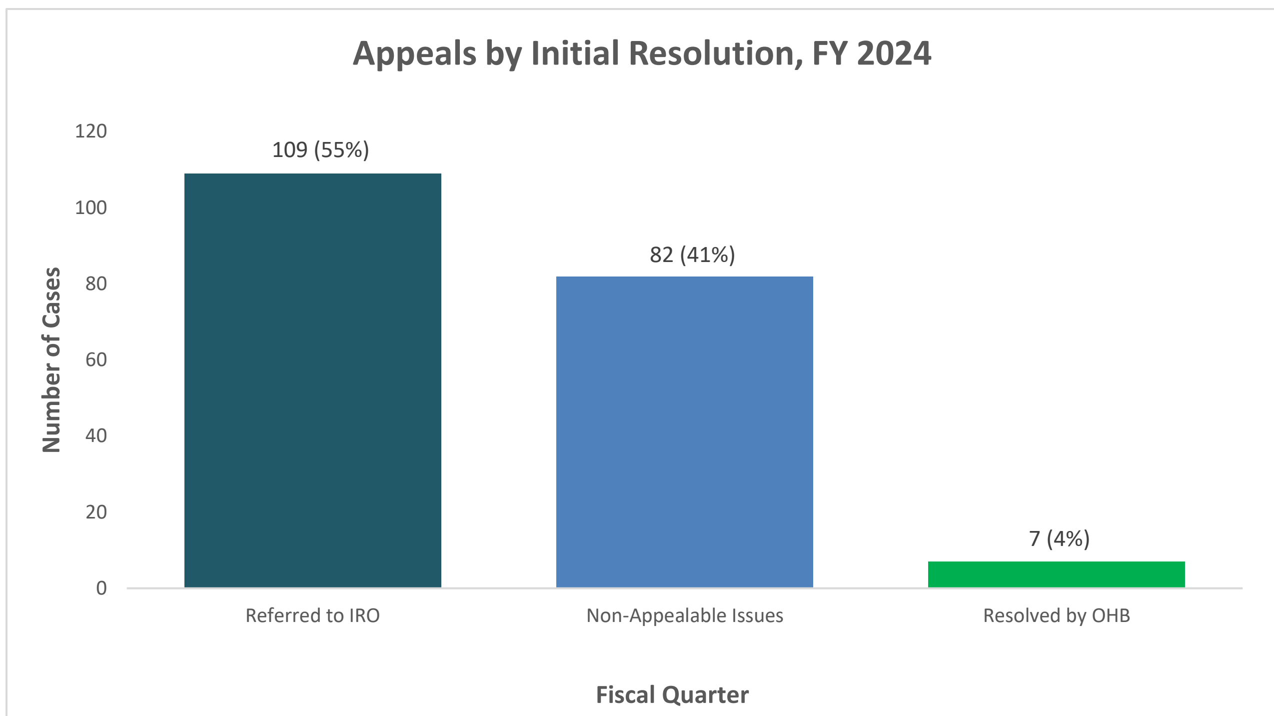
OHB Review - Each appeal request is evaluated to ensure the adverse determination was in line with the provisions of the program and no substantive errors were made. In many cases, DHRM, working with the health plan administrator and/or the member, can resolve the claim appeal without outside review. Appeals are only resolved in this phase if the resolution is in favor of the appellant. During FY 2024, the Ombudsman's team resolved 7 appeal requests (4%) by reviewing additional information provided and working with the appellant, the Director, the agency's benefits office and/or the health plan vendor.

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

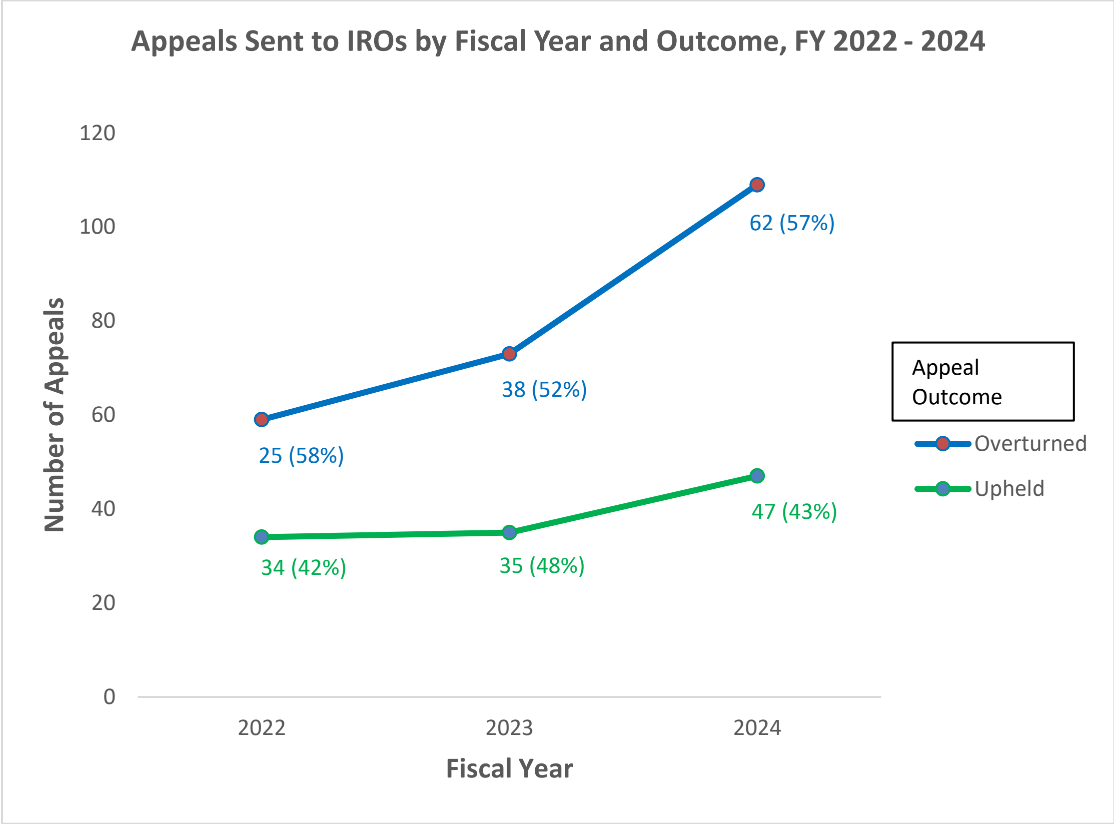
consultation (IFFC) with the Director may be offered to the appellant. There was one IFFC request this fiscal year which was resolved in favor of the appellant.

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.

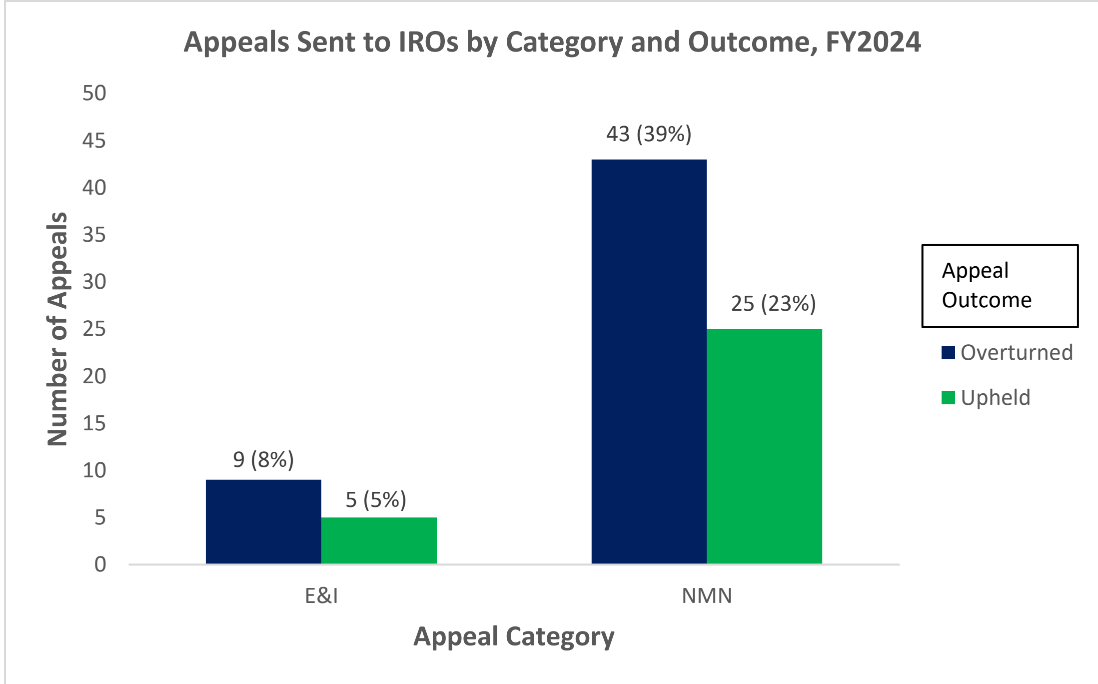
There were 109 claim appeals (55%) referred to an Independent Review Organization (IRO) for review. We will note that of the appeals submitted to the IRO, additional information was submitted to the claim administrator for review which resulted in 2 claim appeals being resolved in favor of the appellant prior to the completion of IRO review process. One appeal submitted was overturned by the claim administrator under their peer-to-peer process, so the appeal was withdrawn. Although resolved, once submitted to the IRO for review, they will continue their process and render a determination.



Independent Review Organizations Determinations – Fifty-nine (30%) of the appeals submitted for IRO review were adverse determinations for medical or behavioral health services and 50 (25%) for prescription drug services. There were 62 adverse determinations made by the claims administrators overturned by our IROs this plan year. Two of the 62 approvals were partial overturns related to a surgical procedure and durable medical equipment (DME). There were 47 health plan determinations upheld by the IROs.



Appeals Sent to IROs by Fiscal Year and Outcome, FY 2022 - 2024
120
100
80
60
40
20
0
Number of Appeals
25 (58%)
38 (52%)
62 (57%)
34 (42%)
35 (48%)
47 (43%)
2022
2023
2024
Fiscal Year
Appeal Outcome
Overturned
Upheld



Appeals Sent to IROs by Category and Outcome, FY2024
50
45
40
35
30
25
20
15
10
5
0
Number of Appeals
9 (8%)
5 (5%)
43 (39%)
25 (23%)
E&I
NMN
Appeal Category
Appeal Outcome
Overturned
Upheld

For the 109 appeals referred to an IRO this fiscal year,

- 19 (17%) 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
- 90 (83%) 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 2024
Sorted by Frequency in FY 2024

Service Requested	IRO Appeals	Overturned	Upheld
Prescription Medication	48 (43%)	27	21
DME	17 (15%)	10	7
Various Surgeries	15 (14%)	11	4
Cardiac Defibrillator Vests	11 (10%)	6	5
Cancer DX Testing	6 (5%)	2	4

The remaining 12 IRO appeals were related to various procedures and services such as inpatient procedures, genetic testing, or infusion therapy. Upon IRO review, six appeals were overturned and six were upheld.

During FY 2024, the IRO overturned adverse plan decisions for prescription drugs by a margin of 6 as compared to those upheld. Similarly, IROs overturned the majority of appeals for surgical procedures by a margin of 7. Overturned determinations were provided by each of the IROs so there was no trend noted in 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. Additionally, 13 out of 27 prescription appeals (48%) overturned were for weight loss medications (GLP1s).

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 to gauge the benefits provided for the services compared to the appeal requests, the Code of Virginia guidelines, and exclusions under the plan.

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 2024 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, website information, and vendor communications to members. The Ombudsman and her team worked closely with the DHRM Communications Manager, program managers and each of the plan vendors on the development of benefit communications on various program components. She also worked with the program managers on the member handbooks 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 the 2023-2024 fiscal year:

DHRM Human Resource Conference - This conference, held in November 2023 at the Greater Richmond Convention Center, included sessions on all aspects of HR and benefits and presenters from all office areas within DHRM. The Office of Health Benefits facilitated presentations related to OHB policies and the CommonHealth wellness program. The Ombudsman, along with the OHB Director facilitated a session entitled *Who is the Office of Health Benefits?* This session provided an overview of OHB, including what we do and how it's done. The Ombudsman led the discussion of frequently asked questions, based on trends identified from requests/inquiries submitted to OHB, followed by an open discussion to address health benefits related topics from the attendees. The HR Management roundtable discussion, hosted by the DHRM Director, included a request for OHB to host informational sessions with the agencies' Benefits Administrators on relevant topics.

Administration of COBRA Benefits -With the implementation of Cardinal HCM, the Office of Health Benefits Programs assumed the responsibility for the issuance of the COBRA election notices and initial enrollment for COBRA beneficiaries. OHB also managed the ongoing benefits changes for existing COBRA members, including system updates and working with the health plan administrators as needed for timely premium updates.

Effective July 1, 2023, PayFlex Systems USA, Inc. (now Inspira Financial) became the new COBRA Administrator for the Commonwealth of Virginia State Health Benefits Program. As part of the administration, they became responsible for:

- COBRA election and termination process,
- Premium billing and payment collection,
- Eligibility updates to carriers, and
- Issuance of the required letters/notices, including the General Rights Notice, Qualifying Event Election Notice, and COBRA Termination Notice.

The change in administration provides COBRA beneficiaries online access to enroll into coverage, view their accounts and make required premium payments. Members of the Ombudsman's team worked with the program manager and associate director of OHB policy on the transition and continue to handle inquiries and requests submitted to our office related to the administration of the COBRA benefits.

Health Plan Program Administrator Changes - January 2024 brought several changes to the names, branding and/or administrators for benefits under our program.

- **Kaiser Permanente** changed its dental administrator from Dominion Dental to **Liberty Dental Plan.**

- **PayFlex** – The Flexible Spending Account (FSA) Administrator, PayFlex, for state employees rebranded as **Inspira Financial.**
- **Optima Health** changed its branding and became **Sentara Health Plans**. There was a phased in campaign schedule and the OHB team worked on updating materials including updates to the Cardinal System as a part of the 2024 Open Enrollment.
- **Anthem** transitioned from the WebMD health assessment to a new health assessment tool called **My Health Check-in**. The health assessment is a requirement for members enrolled in COVA Care to qualify for a premium reward.

While the impact of these changes was minimal, the Ombudsman and team worked with the program managers to provide communications to the benefits administrators to share with their employees.

Benefits Administrator Informational Sessions - The Office of Health Benefits held the first virtual informational session requested during the Department of Human Resource Management (DHRM) Human Resource Conference. The topic for the session, which was held in March 2024**,** was **Open Enrollment 2024 - What You Need to Know**.

In the session OHB covered:

- Open Enrollment dates and procedures,
- key communication and materials, and
- An overview of benefit changes and enhancements.

Facilitated by the OHB Policy team, the Ombudsman and Employee Services Team Leader participated as panel members addressing questions submitted during the session. Links to the PowerPoint presentation and the recorded session were provided in an E-News communication in the event they were unable to attend the session. The survey results were positive, so the session succeeded in providing useful information for the upcoming Open Enrollment period.

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.

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.

The special enrollment period ran from July 1 through August 29, 2023. While there were numerous inquiries related to the notification, we received less than 50 applications for the enrollment of a dependent under the new criteria. Of the requests received for review, only three dependents met the new requirements and were reenrolled into the health plan coverage.

CRM Migration Project - The Office of Health Benefits is currently using an on-premises Dynamics CRM (Customer Relationship Management) system to track and record incoming inquires and requests from our customers. While the existing system is functioning, it does not offer the flexibility or scalability required and limits the opportunity for expansion.

The DHRM Information Technology team proposed a plan to migrate the existing Dynamics CRM system (on-premises) to the cloud solution, Dynamics 365, to capitalize on enhanced security, reliability and the numerous other benefits of cloud computing. DHRM is responsible for an abundance of resource management activities including the state health benefits program. It is imperative that the agency has the most advantageous infrastructure in place to support its workforce and remain a recognized leader and trusted partner. The cloud reduces maintenance and system updates typically associated with on-premises upkeep, which will allow DHRM and OHB to devote more time and resources into fulfilling their core business functions.

As a part of this project, the Ombudsman and Systems Associate Director were assigned as OHB Project Managers and CRM Application Owners. They work with the DHRM IT Project Owners to coordinate activities and ensure all work is performed and meets the department's expectations and to ensure the security standards of the Commonwealth of Virginia are upheld. This is an ongoing project with the expectation that the migration will be completed in Fiscal Year 2025.

Phoenix Testing - During this fiscal year, DHRM announced the release of the Phoenix application. Phoenix is the new application tool developed to provide access to archived records housed in the DHRM legacy systems, Personnel Management Information System (PMIS) and Benefits Eligibility System (BES). Phoenix will provide read only access to core benefits and employee historical data previously accessed through the HuRMan portal.

Members of the Ombudsman's team worked with the Office of Information Technology project manager and the OHB System team to test the functionality of the new application and provided feedback used to enhance the application. The Phoenix application was released for use by the agencies in March 2024.

Microsoft Teams Voice - The current DHRM legacy phone system has faced numerous challenges over the past few years, and the recent fixes have not proven effective. In light of these challenges, DHRM is working on the implementation of Microsoft Teams Voice, which leverages our existing Microsoft Office 365 platform for making, receiving, and routing calls. This modern solution will enhance our operational stability and efficiency while expanding our telecommunications capabilities.

The Office of Health Benefits Programs utilizes several shared email boxes for the submission of inquiries from our customers and business partners. These submissions include emails, faxes and voicemail messages to the OHB published contact lists. With the proposed implementation of the Microsoft Teams Voice, we needed to ensure the existing processes and procedures would still function within the Teams environment.

Working with the DHRM Office of the Chief Information Officer (OCIO), the Ombudsman and Employee Services team leader reviewed our internal procedures for the existing set-up of the phone and fax lines. This enabled the OCIO to incorporate the OHB requirements into the project plan so issues will be minimal during the transition. This ongoing project is scheduled for completion in FY 2025.

DHRM Intranet - The DHRM Intranet was introduced during the 2024 fiscal year and includes information for each of the office areas within the agency. A member of the Ombudsman's team, along with an OHB Program Manager, were selected to work with the DHRM webmaster on this project. The Ombudsman worked with the OHB members to review documents and make suggestions on content. Our intranet page allows DHRM staff members to review information and resources relevant to the Office of Health Benefits Programs and the benefits we provide.

Virtual Health Check-ups - The Office of Health Benefits (OHB) manages the State Health Benefits program with a goal of ensuring members are utilizing the preventive benefits that are available to them. This fiscal year, the health plan administrators for the self-insured health plans worked to identify members who had not received a recent annual preventive exam. These members were offered access to a virtual checkup with a participating network provider, Catapult Health. This provider offers a Virtual Checkup® Home Kit which allows members a convenient, simple, and comprehensive health checkup and is a part of the preventive health plan benefits.

Identified members received communication from Catapult Health with information on how to enroll for the Virtual Checkup® Home Kit. This project is ongoing and OHB will continue to monitor the enrollment and communication strategies for this service.

Cardinal Human Capital Management (HCM) – Cardinal HCM is now the primary system of record for accounting, human resource, payroll, benefits, and time management for the Commonwealth's employee population. Designed to consolidate and streamline administrative systems into one platform, core Cardinal users, such as a benefits administrator, perform their day-to-day work in Cardinal HCM. Eligible employees use the online employee self-service (ESS) portal to view and update personal information, such as a home or mailing address, email and phone numbers. The system is available for employees and retirees to make their initial enrollment into the health benefits program. The Cardinal system is also available for Open Enrollment elections for active employees.

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. She participates in the Cardinal forums and meetings on specific topics related to the benefits administered by the Office of Health Benefits. Working with the Cardinal team and the OHB Systems team, the Ombudsman and team provide guidance to the agency's benefits administrator on system information, available resources and procedures for making system updates and handling required reports.

When the benefits teams at the agencies need assistance with system updates and/or corrections, a request is submitted to the Cardinal PPS team and/or the OHB Employee Services team. If needed, a virtual meeting is scheduled with the agency to discuss the system update and/or the OHB policy that governs the requested update. Many of the virtual meeting requests involved updates to retiree records, including enrollment into the Medicare-coordinating health plan and/or requests to cancel enrollment in the Retiree Health Benefits Program. These meetings revealed a need for enhanced coding to ensure required information for ongoing policy compliance will be accurately identified in the system. The Ombudsman and team will be working with the Cardinal team on enhancements to the coding in the system for retiree records. The OHB team continues to develop internal procedures to handle reports, suggest enhancements and perform audits to ensure compliance with the Program's policies and provisions in Cardinal.

Cardinal Benefit Event Entry Tool – The Benefit Event Detail page was designed to simplify the benefit events processing in Cardinal HCM. The new tool (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 tool minimizes errors in the processing of election requests submitted outside of the annual enrollment period.

This project was initiated in response to the trends and issues identified by the requests submitted to OHB and Cardinal PPS. The initial launching was announced in a Cardinal Forum in July 2023. The Ombudsman and members of her team, along with the OHB Associate Director for Systems, continues ongoing work 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 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 program compliance.

VRS – OHB Joint Team Meetings - The migration of the VRS retiree group participants into the Cardinal HCM system identified a need for closer collaboration between OHB and the health benefits team at VRS. Regular meetings were established with the objective of understanding the processes and procedures for each agency's benefits team to identify issues so modifications, clarifications and needed changes could be addressed. The OHB Associate Director of Policy coordinates the meetings with VRS, which includes the Ombudsman and the retiree specialists and program manager. When issues are identified that involve systems processes, OHB will review the process with the Cardinal benefits team to determine if a modification can be made, and if so, initiates the formal request for the update.

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. The Ombudsman worked on one recruitment during the 2024 fiscal year. The recruitment resulted in the hiring of a new employee who began employment with the Commonwealth in August 2024. The Ombudsman also served on an interview panel for another DHRM office area during the fiscal year.

As a part of the ongoing training for the members of her team, the Ombudsman conducted training sessions on policies and procedures based on trends identified from the agency inquiries. Working with her team leader, and members of the policy team, she developed standard procedures and draft language for the team's use in handling and responding to inquiries.

Annual Flu Shot Program – Member communications and web site documents for the 2023 flu season were developed and distributed in the fall of 2023. 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 a drive-thru flu clinic at Brightpoint Community College - Midlothian Campus on October 6, 2023, for members enrolled in the COVA health plans including enrolled children 4 years and older accompanied by a parent.

Annual 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.

Annual ACA 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. The required IRS 1095 forms for 2023 were mailed to health plan participants on January 31, 2024. The Ombudsman's team addresses inquiries from members and agencies related to the 1095 forms and handles the issuance of duplicate 1095 forms when requested.

Annual Open Enrollment – The OHB team worked on the literature, forms and mailing for the annual Open Enrollment period. The open enrollment communications also addressed program administration and policy guidance identified by monitoring the OHB inquiry trends.

This year's Open Enrollment (OE) brought a new design to the annual Spotlight on Your Benefits newsletter and the Open Enrollment page on the DHRM website. Spearheaded by the OE coordinator and the Associate Director of Policy, the redesign and implementation included the Ombudsman, members of her team, the DHRM webmaster and communications manager. The annual notification to the early retiree population also took on a new look for this year's open enrollment. The newsletter's new look and layout, along with the redesign of the Open Enrollment webpage, received extremely positive feedback from the

benefits administrators and our members.

The Ombudsman, her team and the OHB Policy team worked closely with each of the plan vendors to develop materials for the 2024 Open Enrollment period. In addition to the Spotlight newsletter, annual non-Medicare retiree group notification, and website updates, other open enrollment materials developed included:

- Updates to the online benefit consultant, ALEX
- Enrollment Form revisions
- Premium Rewards Requirements and FAQs updates
- Important Health Benefits Notices including CHIP and Language Assistance Notices
- Summaries of Benefits and Coverage for all state and TLC health plans
- Individual Plan Brochures for each of the health plans:
    - COVA Care Plan
    - COVA HDHP Plan
    - COVA HealthAware Plan
    - Kaiser Permanente Plan
    - Sentara Health Vantage Plan
- Flexible Benefits Sourcebook and FSA Worksheets
- Open Enrollment Presentation for agency employee meetings

Health Benefits Vendor Oversight - 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 attend 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, 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.