JANET L. LAWSON
DIRECTOR

COMMONWEALTH OF VIRGINIA

Department Of Human Resource Management

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

The Honorable R. Creigh Deeds, Senate of Virginia
The Honorable Ghazala F. Hashmi, Senate of Virginia
The Honorable Barbara A. Favola, 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 "Lyn" 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 2025

Office of State and Local Health Benefits Programs

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ANNUAL REPORT ON OMBUDSMAN ACTIVITIES & SERVICES FISCAL YEAR 2025

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, 2024 through June 30, 2025. 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 2025, the Ombudsman's team handled 9,123 requests for assistance or complaints (cases) and reviewed 255 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 was using an on-premises Dynamics CRM (Customer Relationship Management) system to track and record incoming inquiries and requests from our customers. The on-premises system was functional, but it did not offer the flexibility and accessibility needed for the efficient handling of the requests submitted to the OHB team.

The DHRM Information Technology (IT) 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. The cloud version of CRM reduces the maintenance and system updates typically associated with on-premises upkeep, which will allow OHB to devote more time and resources into fulfilling their core business functions.

The Ombudsman and Associate Director for OHB Systems worked with the DHRM IT Project Owners and an outside vendor to develop the specification for the OHB version of CRM and coordinated the activities for migrating the existing CRM information to the cloud version. All tasks were performed to ensure the project met the Department's expectations and the security standards of the Commonwealth of Virginia were upheld.

OHB migrated to the Dynamics 365 version of CRM in April 2025 with minimum issues noted. We credit the intense attention to details of the existing systems specifications and communication between the parties involved in the development process with the relatively smooth transition to the new environment.

The teams, both OHB and IT, continue to review and make recommendations to enhance the new system to ensure we maximize the available functionality.

State Employee Health & Wellness Benefits Guide - The Ombudsman, OHB Policy and the CommonHealth teams collaborated on the development of a resource to provide employees with a single document with the information on the health and wellness benefits available under the Program. The new Employee Health & Wellness Benefits Guide was released in August 2024. The guide outlined the benefits available based on the employee's health plan as well as benefits available to all employees whether they are enrolled in coverage. Many of the benefits are provided at no additional cost to members. This new informational resource will hopefully help employees as they progress towards their health and wellness goals.

Communication Campaigns - The Ombudsman and members of the OHB team worked on several communication campaigns during this fiscal year to increase employee awareness of additional programs included with their health plan benefits. Two of the main campaigns were for:

- Virtual Physical Therapy - The virtual in-home physical therapy benefit was introduced in July for state and TLC members enrolled in one of the health plans administered by Anthem. To increase awareness of the new digital physical therapy benefit, a multi-touch email and mail campaign initiated in October 2024. Several direct mailers and emails were sent to members 18 and older promoting the LiveHealth Online Thrive: Healthy Back & Joints program. Female members also received information on Bloom, the pelvic health physical therapy program. Members had the option to opt out of the emails if they wanted to stop receiving communications.

- Catapult - The Office of Health Benefits (OHB) manages the State Health Benefits Program with a goal of ensuring that our members are utilizing the preventive benefits that are available to them. As part of the engagement plan, OHB worked with the vendors to develop an employee email to promote engagement in the Catapult program. Catapult Health's Virtual Checkup® Home Kit provides members with convenient, simple, and comprehensive health checkups. The virtual checkup is provided as part of the COVA Care, COVA HealthAware and COVA HDHP plan benefits. The email campaign was directed to members who had not received an annual preventative exam.

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 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 380 employer groups covering approximately 48,000 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. There are approximately 4,000 participants and covered family members in the LODA health plans.

The Program offers three statewide self-insured plans for state employees and early retirees, 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 Virginia 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 four self-insured plans 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.

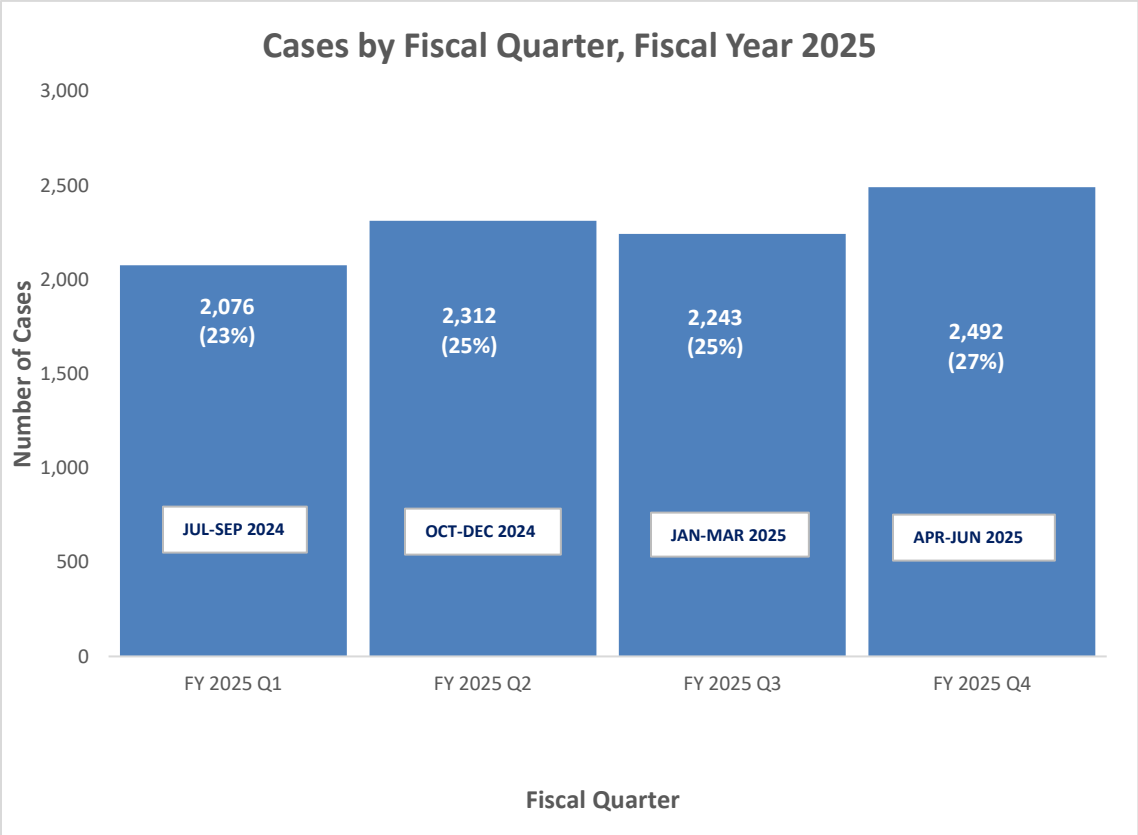
In total, the Ombudsman's team served over 300,000 state and local government employees, retirees, and family members during this period. The team helped over 500 Human Resource Benefits Administrators and Managers statewide who administer health benefits within state agencies and sought assistance with 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 other issues. 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.

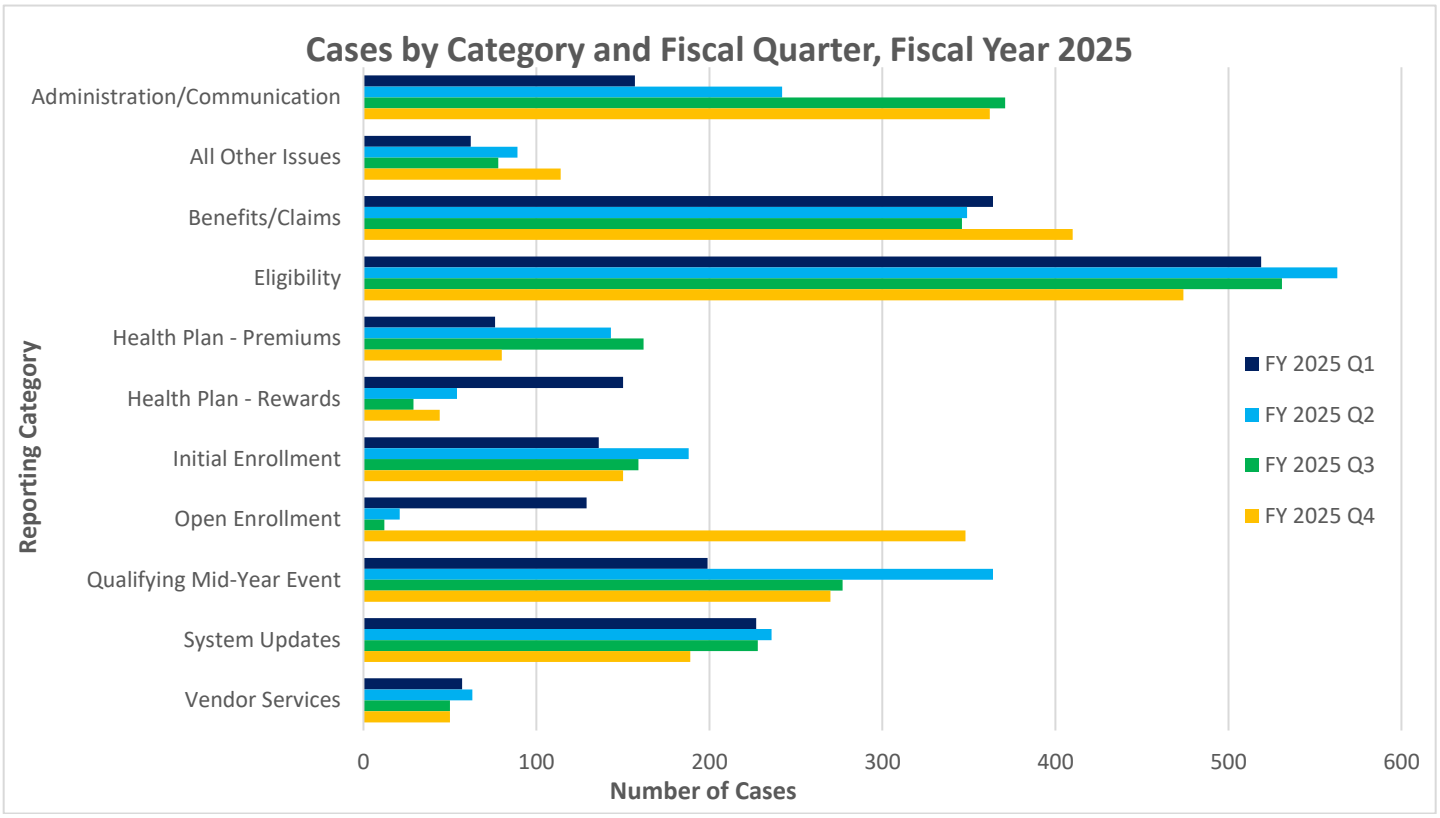
EMPLOYEE AND RETIREE SERVICES

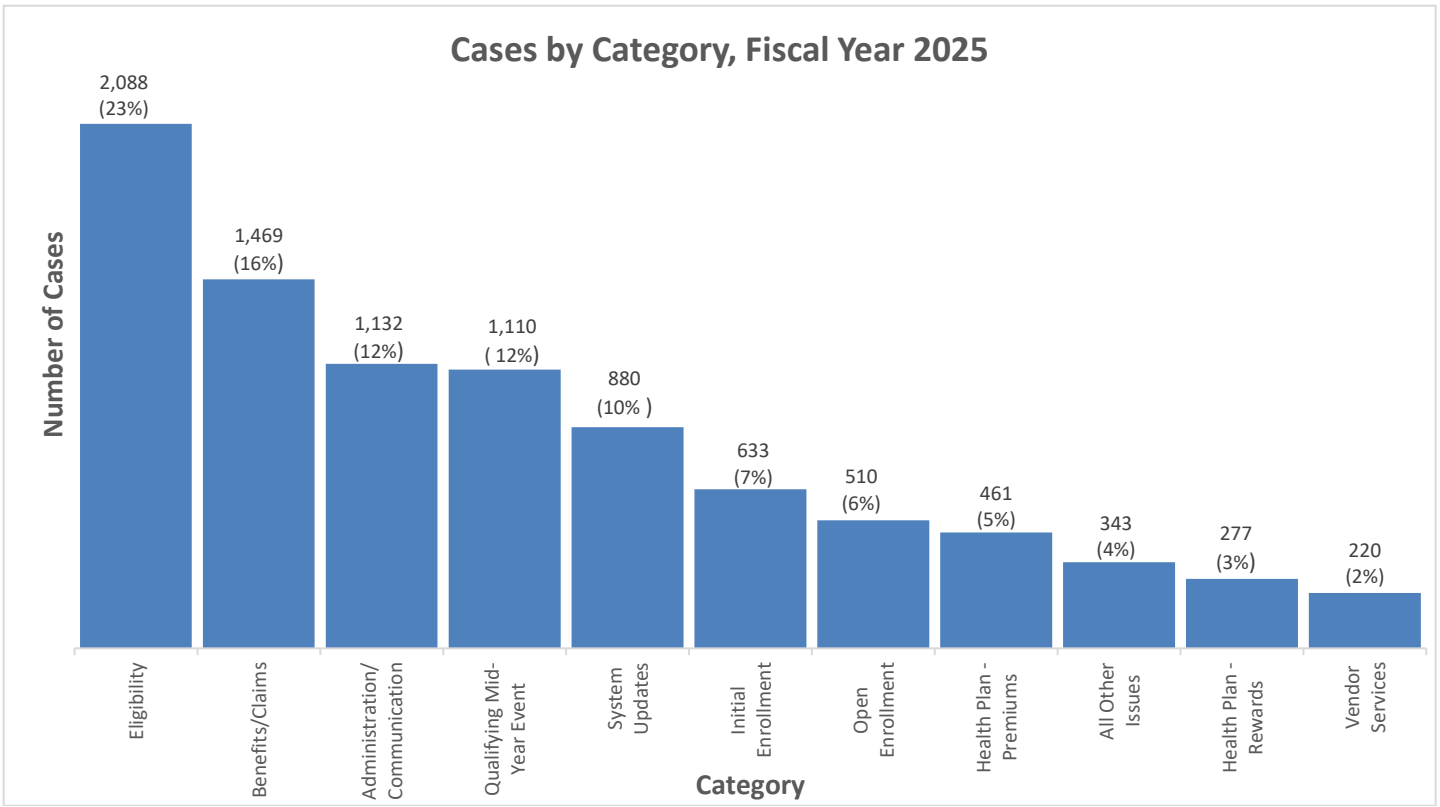
In FY 2025, the Ombudsman team handled 9,123 requests for assistance and complaints from employees, retirees, agency Benefits Administrators, legislators, providers, and other interested parties. These included general and member specific inquiries, complaints and requests related to benefits, communications, 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.



The quarterly requests related to benefits and claims, qualifying mid-year 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 these requests.


Cases by Category and Fiscal Quarter, Fiscal Year 2025
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
FY 2025 Q1
FY 2025 Q2
FY 2025 Q3
FY 2025 Q4
0
100
200
300
400
500
600
Number of Cases


Cases by Category, Fiscal Year 2025
Number of Cases
2,088 (23%)
1,469 (16%)
1,132 (12%)
1,110 (12%)
880 (10%)
633 (7%)
510 (6%)
461 (5%)
343 (4%)
277 (3%)
220 (2%)
Eligibility
Benefits/Claims
Administration/ Communication
Qualifying Mid-Year Event
System Updates
Initial Enrollment
Open Enrollment
Health Plan - Premiums
All Other Issues
Health Plan - Rewards
Vendor Services
Category

Administration and Communication – 12% 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 – 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 family members requires review and approval. The program requires proof of eligibility to be provided 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 – 5% This category includes questions related to the health care premium amounts, premium invoices for those participants who are billed directly by one of the health plan vendors, and reinstatement requests for failure to pay premium invoices. In most cases, active employee premiums are payroll deducted, and retiree premiums are deducted from the monthly retirement benefit when available. If there is no monthly VRS benefit (e.g., non-VRS retirees or other retiree group enrollees, such as non-annuitant survivors or LTD participants) or the VRS benefit is too low, the enrollee will be direct billed. Invoices are also generated for members who elect to continue their coverage under the Extended Coverage (COBRA) provisions.

Health Plan Rewards – 3% 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 Choice program's school groups.

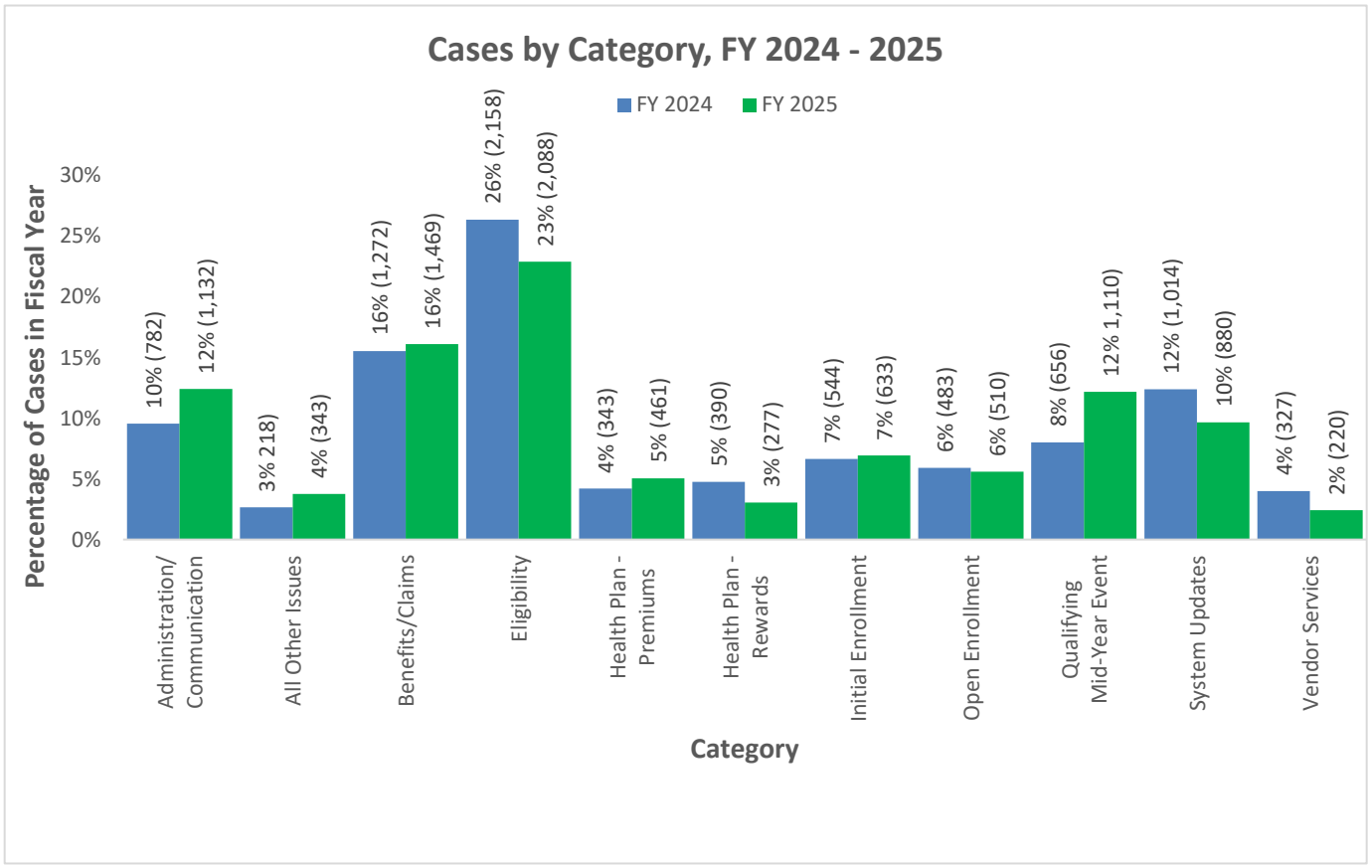
Open Enrollment – 6% The Open Enrollment period occurs each year in the spring. The period is announced in the Open Enrollment newsletter, Spotlight on Your Benefits, which is mailed to eligible employees and retirees. This is the annual opportunity to request enrollment or make

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 for the FSA elections, during the first quarter. The fourth quarter requests dealt with issues presented by 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) – 12% 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 – 10% 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 – 2% 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 2025 top five accounted for 73.2% of inquiries whereas 71.8% was the top five accountability percentage for FY 2023. While still among the top five major topics, **Eligibility** issues were the #1 category again for the fiscal year. **Benefits & Claim** issues remain as the #2 category this fiscal year and still accounts for 16% of the requests.

Administration & Communications moved up to #3, with 12% (an increase of 4%) of the total request. This increase can be attributed to inquiries related to COBRA administration. Both benefits administrators and members reached out for assistance and confirmation on the issuance of the required notices. **Qualifying Midyear Events (QMEs)** ranks as #4 with 12% of the requests again this fiscal year. While **System Update** requests remain at 10% of the inquiries, they are now ranked as the #5 category of requests down from #3 last fiscal year.

Leading Case Categories, FY 2024 – 2025
Sorted by Frequency

	FY 2025			FY 2024	
Case Category	Cases	Percentage	Case Category	Cases	Percentage
Eligibility	2,088	23%	Eligibility	2,158	26%
Benefits/Claims	1,469	16%	Benefits/Claims	1,272	16%
Administration/Communication	1,132	12%	System Updates	1,014	12%
Qualifying Mid-Year Event	1,110	12%	Administration/Communication	782	10%
System Updates	880	10%	Qualifying Mid-Year Event	656	8%
All other issues combined	2,444	27%	*All other issues combined*	2,305	28%
Total	9,123	100%	Total	8,187	100%

APPEALS

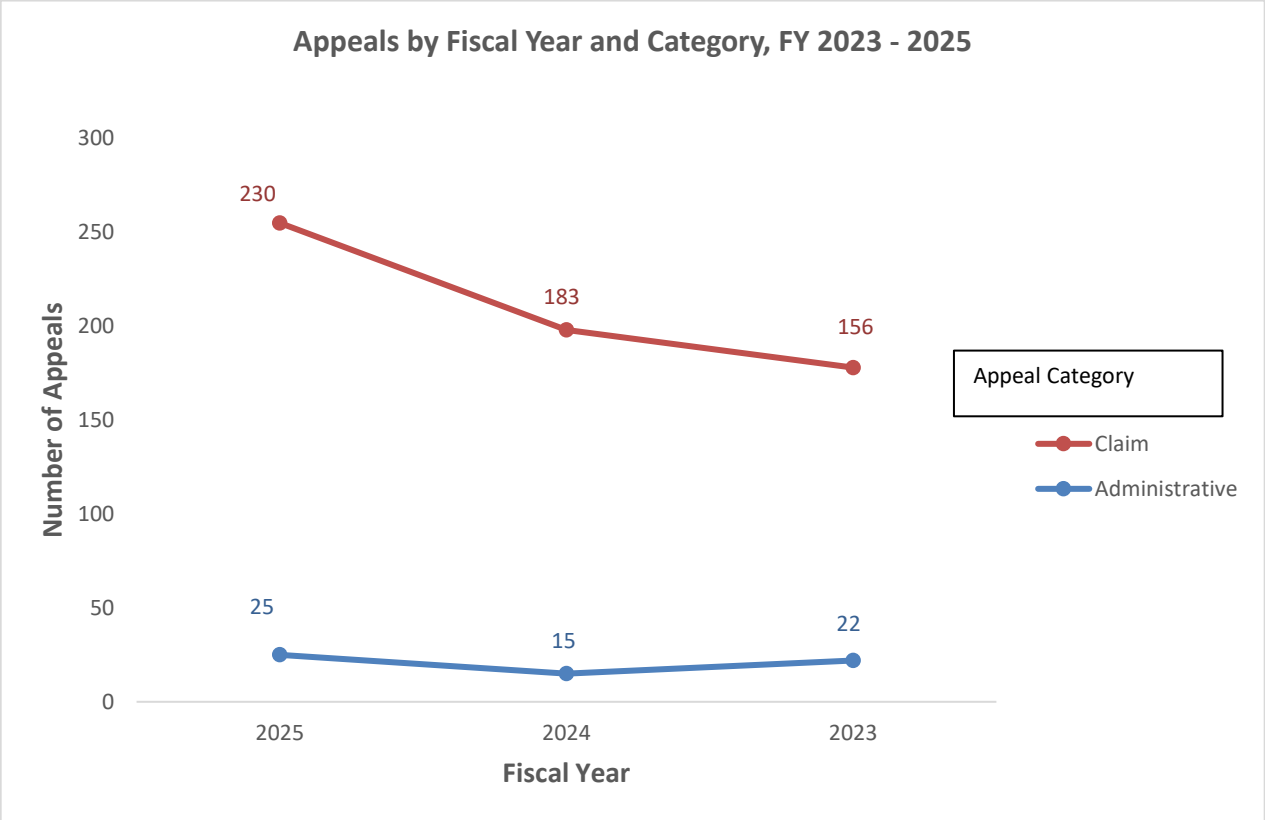
Charged with the oversight of the appeals process, the Ombudsman or an appeals examiner serves as the contact for appellants. Every effort is made to ensure that all appellants receive the full extent of the benefits to which they are entitled under the rules of the program.

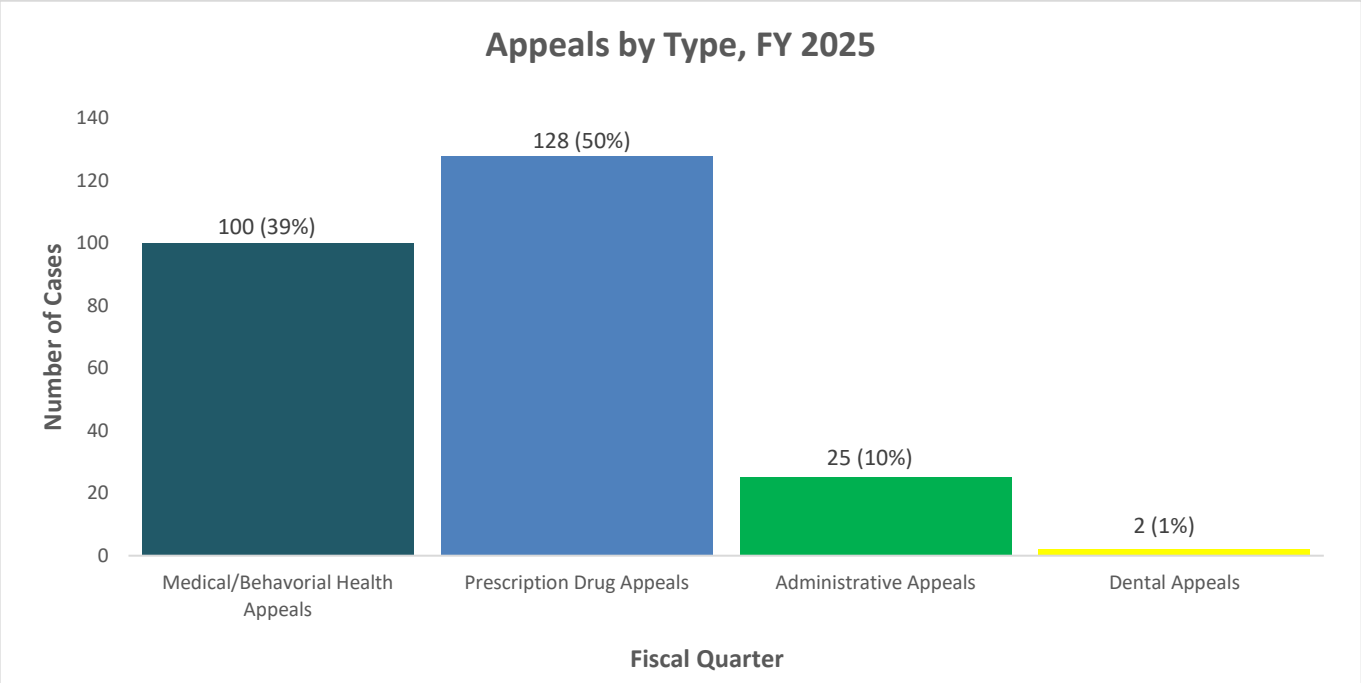
There are two classifications of appeals:

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 2025 fiscal year, 255 appeals were submitted to DHRM. This compares to 198 appeals for the 2024 fiscal year and 178 for the 2023 fiscal year. For FY 2025, 230, or 90%, of the appeals received were related to claims and plan benefits and 25, or 10%, 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 130 appeals (51%) filed were determined to be non-appealable because the member's request was in direct conflict with a program provision, plan benefit or failure to complete the health plan's internal process. 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
- requests 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. Claims appeals are only resolved in this phase if the resolution is in favor of the appellant.

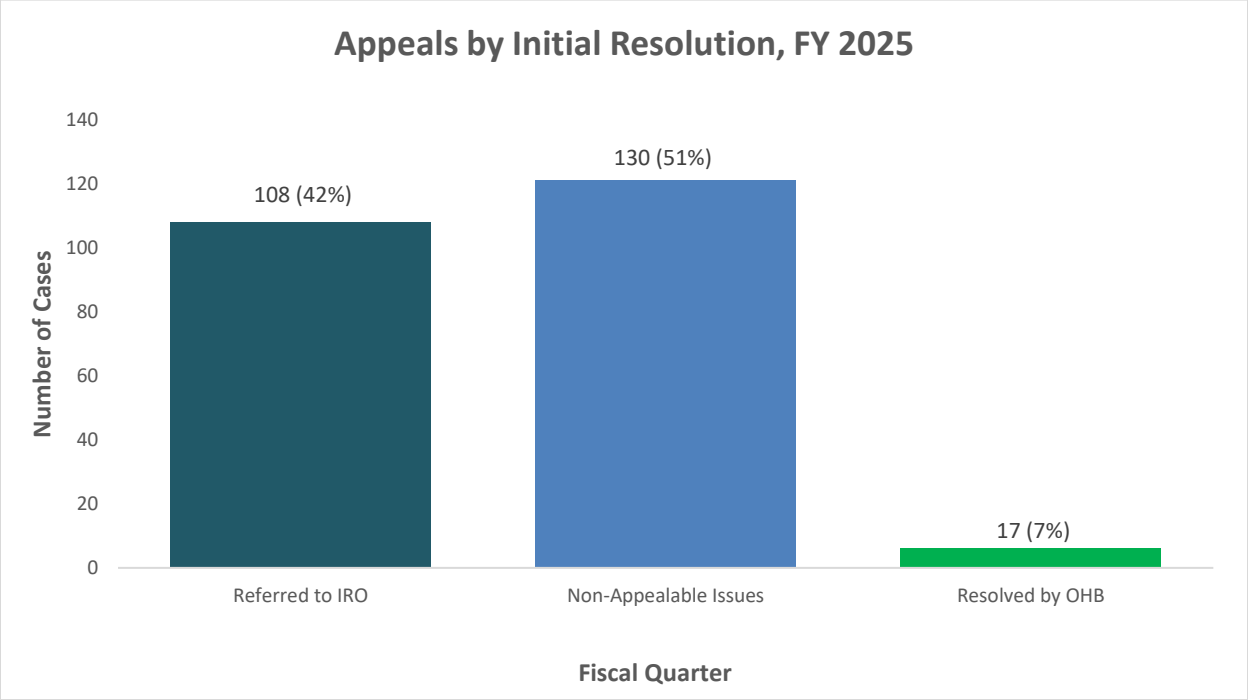
During FY 2025, the Ombudsman's team resolved 4 claims appeals by working with the health plan to review additional medical information provided. There were 13 valid administrative appeals during this fiscal year. These appeals were researched with the agency's HR and Benefits Offices to ensure the members were not provided with inaccurate information on OHB policies and procedures. The research resulted in the approval of 11 administrative appeals.

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

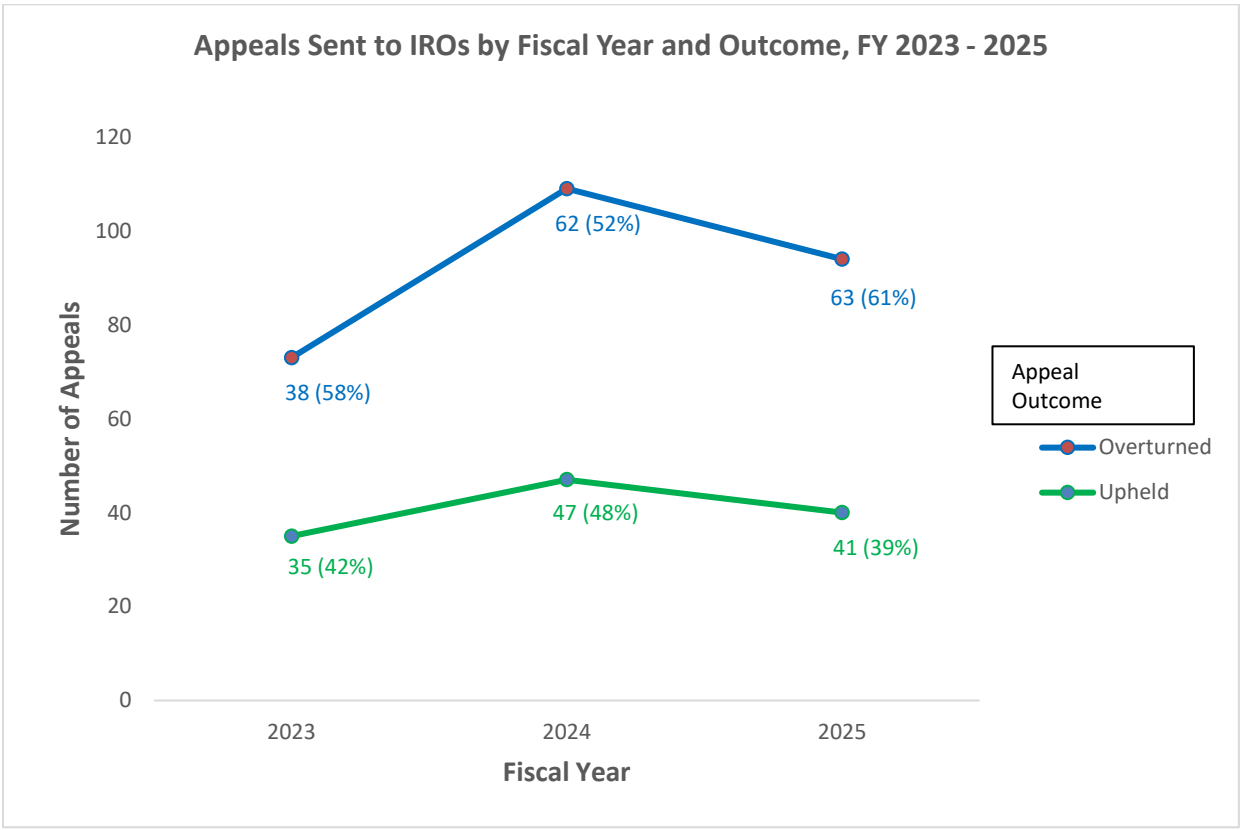
consultation (IFFC) with the Director may be offered to the appellant. There were no IFFC requests this fiscal year.

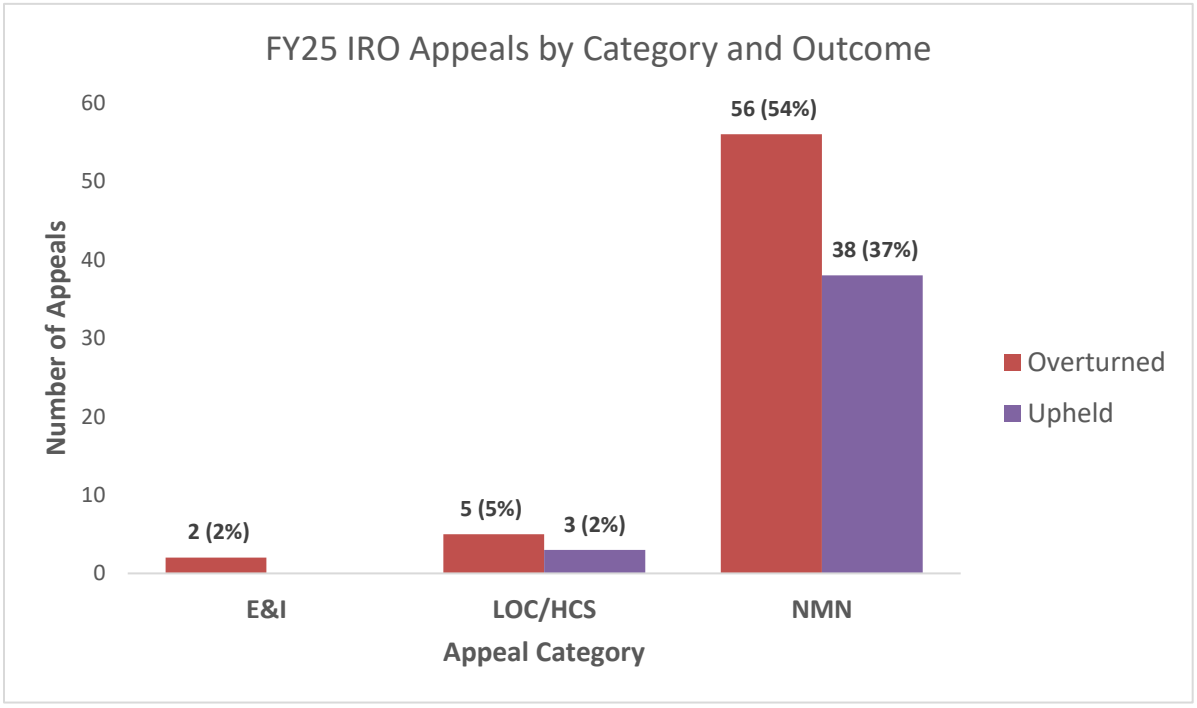
Independent Review Organizations - The program allows members to appeal any adverse benefit determination by a plan administrator that is based on the plan's requirements for medical necessity and appropriateness, health care setting and level of care, effectiveness of a covered benefit, or services 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 108 claim appeals (42%) 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 4 claim appeals being resolved in favor of the appellant prior to the completion of IRO review process.



Independent Review Organizations Determinations – Fifty-six (52%) of the appeals submitted for IRO review were adverse determinations for medical or behavioral health services and 52 (48%) for prescription drug services. There were 41 health plan determinations made by the claim administrators upheld by our IROs this plan year. Of the remaining 67 adverse determinations submitted for IRO review, 63 were overturned and 4 were withdrawn. During the appeals process the appellant may submit additional information for review. In the case of the withdrawn appeals, the health plan's review of the additional medical documentation submitted resulted in the reversal of the initial adverse determination, approving the requested service. The four withdrawn appeals were for prescription drug services.


Appeals Sent to IROs by Fiscal Year and Outcome, FY 2023 - 2025
Number of Appeals
120
100
80
60
40
20
0
62 (52%)
63 (61%)
38 (58%)
47 (48%)
41 (39%)
35 (42%)
2023
2024
2025
Fiscal Year
Appeal Outcome
Overturned
Upheld


FY25 IRO Appeals by Category and Outcome
Number of Appeals
60
50
40
30
20
10
0
2 (2%)
5 (5%)
3 (2%)
56 (54%)
38 (37%)
E&I
LOC/HCS
NMN
Appeal Category
Overturned
Upheld

For the 104 completed IRO appeal reviews this fiscal year,

- 2 (2%) 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,
- 8 (7%) were related to the health care setting (LOC/HCS), and
- 94 (91%) 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 2025
Sorted by Frequency in FY 2025

Service Requested:	IRO Appeals:	Upheld:	Overturned:
RX	48 (46%)	20	28
DME	12 (12%)	6	6
CA Treatment/Testing	10 (10%)	4	6
Level of Care	10 (10%)	5	5
Hormone TX	7 (7%)	1	6
IV Therapy	5 (5%)	1	4
Surgery	5 (5%)	2	3
Ambulance	4 (4%)	1	3

The remaining 3 IRO appeals were for diagnostic testing for diabetes, Applied Behavior Analysis (ABA) therapy and pain management services. The IRO reviews resulted in two of the appeals being overturned and the one for pain management services being upheld.

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

During FY 2025, the IRO overturned adverse plan decisions for prescription drugs by a margin of 8 as compared to those upheld. Of the 48 prescription drug appeals, 27 were requests for coverage of GLP-1 medications for weight loss. Of the 27 GLP-1 appeals, 19 were overturned by the IRO and 8 denials which were upheld as not medically necessary.

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. The OHB team is currently reviewing the benefits and coverage criteria for the GLP-1 and specialty medications with the plan administrator. 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 2025 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, the OHB program managers and each of the plan vendors on the development of benefit communications on various program components. We worked on the 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 2024-2025 fiscal year:

CRM Migration Project - The Office of Health Benefits was using an on-premises Dynamics CRM (Customer Relationship Management) system to track and record incoming inquiries and requests from our customers. While the on-premises system was functional, it did not offer the flexibility available in similar tracking tools.

The DHRM Information Technology (IT) 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 the 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 worked with the DHRM IT Project Owners and the outside vendor to develop the specification for the OHB version of CRM and coordinate the activities for migrating the existing CRM information to the cloud version. All tasks were performed to ensure the project met the department's expectations and the security standards of the Commonwealth of Virginia were upheld.

The initial testing of the new system's functions was performed by the Ombudsman's team during March 2025. This testing helped to identify coding discrepancies and processing requirements that needed to be addressed before the migration of the full staff to the cloud version. Once the major issues were resolved, the vendor's project manager performed on-site training for the OHB and IT CRM Administrators in April.

The teams, both OHB and IT, continue to review and make recommendations to enhance the new system to ensure we maximize the available functionality.

State Employee Health & Wellness Benefits Guide - The Ombudsman, OHB Policy and the CommonHealth teams collaborated on the development of a resource to provide employees with a single document with the information on the health and wellness benefits available under the Program. The initial work on this project began in the prior fiscal year and the new Employee Health & Wellness Benefits Guide was released in August 2024.

The guide outlined the benefits and special programs available under each of the state health plans, including the requirements and incentives, if any, associated with the specific program. The guide also includes information on benefits available to all employees whether or not they are enrolled in a health plan. Many of the benefits are available at no additional cost to members and others. Some benefits, such as the WeightWatchers employee discount, require a member payment. This new informational resource will hopefully help employees as they progress towards their health and wellness goals.

Microsoft Teams Voice - The DHRM legacy phone system has had numerous challenges over the past few years. Due to these challenges, DHRM implemented the use of Microsoft Teams Voice, which leverages the existing Microsoft Office 365 platform for making, receiving, and routing calls. This solution is designed to 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. The implementation of the Microsoft Teams Voice required additional review to ensure the existing processes and procedures continue to function effectively in 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 phone and fax lines. Members of the team assisted with the system testing prior to the rollout. OCIO was able to incorporate the OHB requirements and address potential issues as a part of the project plan. Microsoft Voice was implemented for the DHRM staff in December 2024 and reported issues for OHB were minimal during the transition.

Cardinal Human Capital Management (HCM) – Cardinal HCM is 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 and retirees will be able to use Cardinal HCM in an employee self-service (ESS) capacity 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 weekly meetings with Cardinal personnel to review current and future business processes. Serving as a subject matter expert (SME) for the health benefits program policy provisions, 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, procedures for making system updates and handling required reports.

Cardinal/VRS/OHB Joint Team Meetings -The Ombudsman and members of the OHB team participate in biweekly meetings with the Cardinal team and members of the Virginia Retirement System (VRS) Health Benefits and LTD teams. These meetings were established with the objective of understanding each agency's processes and procedures and to discuss issues impacting participants in the State Retiree Health Benefits Program. Issues identified include clarification, modifications and enhanced coding to ensure required information is updated for ongoing policy compliance. 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.

Recruitment and Training - 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 new hire participated in the in-house training that includes the policies and procedures specific to the health and flexible benefits programs administered by OHB, and the use of the Cardinal and Phoenix systems.

OHB offers Benefits Administration Training to the TLC employer groups and state agencies. The one-day classroom course is designed for human resources professionals, health benefits administrators and payroll employees whose job responsibilities require specific and detailed knowledge of the health benefits programs. The Ombudsman attended the TLC training in the Fall of 2024 and the State training in the Spring of 2025. The Ombudsman participated in the sessions offering input on topics as requested, including information on the Cardinal system processes and procedures.

As a part of the ongoing training for the members of her team, the Ombudsman conducts 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 develops 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 2024 flu season were developed and distributed in the fall of 2024. 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 website 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 provided free shots onsite to COVA Care, COVA HDHP and COVA HealthAware members. Kaiser Permanente members, Optima Health members, TRICARE Supplement plan members, waived employees and wage employees paid for the vaccine. Capitol Square Healthcare Clinic and OHB also coordinated drive-thru flu clinics at Brightpoint Community College-Midlothian Campus on October 11 and October 25, 2024 for members enrolled in the COVA health plans, including enrolled children 4 years and older accompanied by a parent.

Online EAP Resources to Wage and Waived State Employees - To address the effect of the natural disaster events that many state employees faced in the Fall of 2024, the OHB team worked with Anthem to provide online Employee Assistance Programs (EAP) services to wage and waived state employees. These employees, who are not covered under a state health plan, were provided access to online educational services such as:

- Emotional Wellness articles, podcasts, and videos
- Depression toolkit
- Work/Life Resources Self-Search (for childcare, eldercare, etc.)
- Online seminars
- ID Monitoring
- Web-based Legal/Financial resources including access to 100+ legal forms

The online educational services were offered at no cost to these employees until June 30, 2025.

Virtual Physical Therapy Benefit - The virtual in-home physical therapy benefit was introduced in July for COVA Care and COVA HDHP members. To increase awareness and engagement of this new virtual in-home physical therapy benefit, a direct email and mail campaign launched in October 2024 to give members more details of this new benefit.

LiveHealth Online Thrive: Healthy Back & Joints and Bloom powered by SWORD offers virtual in-home physical therapy that is effective, convenient, and addresses a broad range of musculoskeletal conditions and pelvic health issues. The in-home program includes a smart tablet with motion tracking sensors and licensed physical therapists who provide custom exercise plans and education, continuous engagement, and behavioral health resources. COVA Care and COVA HDHP members (age 18 and older) were provided direct mailer and email communications promoting the Thrive Healthy Back & Joints program. This program is available at no cost for COVA Care and COVA HDHP members and does not require a referral from a primary care provider or specialist to participate.

Catapult - The Office of Health Benefits (OHB) manages the State Health Benefits Program with a goal of ensuring that our members are utilizing the preventive benefits that are available to them. To this end, OHB working with the health plan vendors, partnered with Catapult Health to offer a virtual option to members who had not received an annual preventative exam.

Catapult Health's Virtual Checkup® Home Kit provides members with convenient, simple, and comprehensive health checkups. The Home Kit includes at-home testing materials and once returned, the members are provided a consultation with a licensed healthcare provider, and personalized recommendations to improve their overall wellness.

The Virtual Checkup Home Checkup can help identify:

- Any currently undiscovered health issues.
- Assess key health risks the members might be facing.
- Support members in managing known conditions more effectively.

The virtual checkup is provided as part of the COVA Care, COVA HealthAware and COVA HDHP plan benefits. OHB worked with the vendors to develop employee emails to promote engagement in the Catapult program.

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 2024 were mailed to health plan participants on January 31, 2025. The Ombudsman's team handle inquiries from members and agencies related to the 1095 forms, including 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.

The OHB Policy team, along with the Ombudsman and her team worked closely with the plan vendors to develop materials for the 2025 Open Enrollment period. The primary communication pieces, the Spotlight newsletter and annual non-Medicare retiree group notification, were developed

and a distribution plan was implemented. OHB coordinated with the DHRM webmaster on the website updates, and worked to revise other open enrollment materials including:

- 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
- Flexible Benefits Sourcebook and FSA Worksheet

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 updated 2024 COVA Care and COVA HDHP member handbooks were completed, and the documents were posted to the DHRM website in October.

The Ombudsman worked with the vendors to prepare ongoing information regarding the plan benefits, and we also participated in all applicable vendor meetings and attended the annual review meeting with each of the self-insured health plan administrators.

CONCLUSION

In the pursuit of excellence, the Ombudsman and the OHB team focus 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.