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A Message from Mayor Muriel Bowser

On March 11, 2020, I declared both a state of emergency and a public health emergency (PHE). The health and well-being of Washingtonians continues to be an important priority and will always remain of the utmost importance to my Administration.

Following the declared PHE, on March 24, 2020, my administration issued Mayor's Order 2020-053: Closure of Non-Essential Businesses and Prohibition on Large Gatherings During Public Health Emergency for the 2019 Novel Coronavirus (COVID-19) – this Order required temporary closure of the on-site operation of all non-essential businesses and prohibited gatherings of 10 or more people. Our message, during this time, was to stay at home, because ultimately, that was the best way to flatten the curve and to protect yourself, your family, and our entire community from COVID-19. This order specified that residents could only leave their residences to:

- Engage in essential activities, including obtaining medical care that could not be provided through telehealth and obtaining food and essential household goods;
- Perform or access essential governmental functions;
- Work at essential businesses;
- Engage in essential travel; or
- Engage in allowable recreational activities as defined by the Mayor's Order.

During Phase One, the District Government continued to work in a modified telework posture, however, there were some new services that were available through the Department of Parks and Recreation, the Department of Motor Vehicles, DC Public Library locations and through the Department of Public Works. In addition to these government services, non-essential retail businesses were opened for font door or curb-side pick-up and restaurants offered outdoor seating.

During Phase Two, effective on June 22, 2020, with the assistance of more testing, contract tracers, and larger hospital capacities -- mass gathering capacities were increased to no more than 50 people; nonessential businesses, to include: retail, indoor dining at restaurants, houses of worship and libraries could operate at 50% capacity; and gyms, health clubs, yoga and dance studios could operate in accordance with guidance from DC Health.

In the coming weeks, months, and year, please remember that this virus is still in our city and region and still presents a danger to our community. We have a shared responsibility to stop the spread of the virus even as we reopen. We also have a special responsibility to protect those who are vulnerable because of age, underlying conditions, or health disparities.

I would like to thank the Executive Office of the Mayor, the Council of the District of Columbia, health care providers, federal officials, District agency staff, and the Office of Health Care Ombudsman, who all played key roles during the PHE. These have been and continue to be challenging times, but we are getting through it together.

Stay safe, stay healthy, and don't forget your mask.

Muriel Bowser
Mayor

A Message from Director Wayne Turnage

We are indeed living in unprecedented times – a period in which we are cosigned by a virulent to cloistered living, blocked from those things that define the essence of who we are as human beings – those critical interactions which offer the powerful ingredients of a richly lived life, while shaping the social fabric of our society. But nevertheless, as a government, we progressed.

On March 16, 2020, we were required to work remotely, except in limited cases where essential staff reported at my discretion. Even with this presumed obstacle, we were still faced with the following challenges: (1) managing the surging cost of care delivery for our fee-for-service population; (2) disparities in how each managed care plan is compensated, without detriment to one plan; and (3) developing a greater understanding of enrollment issues and ways to improve the Alliance program, while pursuing efforts to slow down an unsustainable cost growth rate.

In the case of Medicaid managed care, changes were needed to offset problems created by an adverse process that impacted one plan -- a disproportionate share of unhealthy individuals gravitated to AmeriHealth Caritas DC to access physicians unavailable to members of other plans, creating a payment disparity. Also, with surging costs in our fee-for-service population, we developed a plan to transition our program into a fully managed care program over the next five years, with implementation starting October 1, 2020. With respect to the DC Alliance program, we continue to monitor the rapid cost growth in the program and the causal factors. Further, we are constantly vetting potential changes in the program's application process that could ease any questions about beneficiary access, but not at the expense of the six-month recertification requirement process that protects the integrity of the program.

We have made considerable progress this fiscal year as an almost fully remote agency during the pandemic, and this would not have been possible without our collective commitment to our city and its residents.

As DHCF enters FY 2021, we look forward to ensuring that District residents have continued access to quality health care services. I would like to commend my remarkable executive team, agency fiscal officer, senior level staff, and mid-level managers who provide stewardship of the staff and the advocacy work provided by the Office of Health Ombudsman and Bill of Rights (OHCOBR).

Wayne Turnage, MPA
Deputy Mayor of Health and Human Services and
Director of the Department of Health Care Finance

A Message from the Health Care Ombudsman

I am pleased to share with you our *Fiscal Year 2020 Annual Report*. The Office of Health Care Ombudsman and Bill of Rights assists District health care consumers, through advocacy, education and outreach. We assist uninsured residents; enrollees in the D.C. Medicaid and Alliance programs (more than 285,000); and the 18,000 commercial health plan members enrolled in the individual marketplace; and more than 76,000 residents through the small business marketplace that signed-up through DC Health Link (the District's state-based health insurance exchange established under the Affordable Care Act (ACA), and those whose commercial health insurance policies were underwritten in the District (more than 900,000).

During the fiscal year, we joined twenty-three community events attended by nearly 38,000 (37,825) people – a 62 percent decrease over last year when we impacted 100,000 (99,505) attendees, due to the Public Health Emergency (PHE) declared in March 2020. Through our community outreach activities, we directly engage with the public, but unfortunately was unable to share information and promote our services on an in-person basis beyond the Mayor's declaration. Regardless, our office received and handled 11,905 cases – a two percent increase in the number of contacts received over the prior year's 11,654 cases, and a five percent increase compared to FY 2018 (11,309 cases).

Due to the PHE, we revamped our procedures and utilized new methods for handling consumer inquiries and complaints. Due to the Mayor's order, requiring DC Government employees to work from home throughout the PHE, an online telephone system was put into place, as well as new email policies and procedures to handle the influx of email contacts.

I would like to extend my appreciation to my dedicated team, some that took on multiple roles to assist during the PHE. My staff is continually committed to public service and the advocacy of Washingtonians and those that are employed, or policies underwritten in the District of Columbia. We hope you will appreciate our accomplishments as presented in this report and that you will continue to view and use us as a valuable resource for consumer advocacy and education.

Should you have any questions regarding this *Fiscal Year 2020 Annual Report*, please feel free to contact the Office of the Health Care Ombudsman and Bill of Rights by phone at 1 - (877) 685-6391, (202) 724-7491, or via email at healthcareombudsman@dc.gov.

Best regards,

Maude R. Holt, MBA
Health Care Ombudsman for the District of Columbia

Meet the Ombudsman Staff

Charlita Brown, BS
Associate Health Care Ombudsman

Paula Johnson, MS, BS, RN
Associate Health Care Ombudsman

Shirley Tabb, LICSW
Associate Health Care Ombudsman

Robert Taylor
Associate Health care Ombudsman

Loretta Smith, RN
Associate Health Care Ombudsman

Daisha Watson, BA
Associate Health Care Ombudsman

****Not pictured:***

Amani Alexander
Associate Health Care Ombudsman

Gina Brooks, BSN, RN
Associate Health Care Ombudsman

Jennifer Gutierrez
Associate Health Care Ombudsman

Donnette Hill, MBA
Associate Health Care Ombudsman

Cardiss Jacobs
Associate Health Care Ombudsman

Lamia Jackson
Associate Health Care Ombudsman

Tamiki Jackson
Associate Health Care Ombudsman

Aminata Jalloh, MS
Associate Health Care Ombudsman

David Kennedy
Associate Health Care Ombudsman

Carmencita Kinsey
Associate Health Care Ombudsman

Brandon Lacey
Contractor

Mirka Shephard
Associate Health Care Ombudsman

Amber Wihshi
Associate Health Care Ombudsman

Meet the Ombudsman Intern

The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) offers college students in good academic standing paid internships to work in a professional environment while pursuing their degree.

During the academic school year, interns are authorized to work up to 36 hours a week and up to 40 hours a week during summer break.

Below is the intern who supported the Ombudsman's Office in FY 2020:

Student Intern
Morgan State University
Major: Political Science
Graduation: Spring 2020

Introduction

Office of the Health Care Ombudsman and Bill of Rights

HISTORY

Established in February 2009, the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is organizationally positioned within the Department of Health Care Finance (DHCF) but has authority to operate with full autonomy and independence. DHCF was established in February 2008 (D.C. Code 7-771). It was formerly the Medical Assistance Administration (MAA) in the Department of Health (DC health) and now functions as a separate cabinet-level agency. In addition to the OHCOBR, DHCF administers the District's Medicaid program, the Children's Health Insurance Program (CHIP), and other publicly funded health care benefits programs.

DUTIES AND RESPONSIBILITIES

The Health Care Ombudsman is responsible for providing advocacy, education and community outreach services to District consumers and persons who reside and/or are employed in the District, regarding access to health benefits, and to ensure that those benefits meet their needs. OHCOBR staff work to solve consumer complaints, facilitate the appeal and grievance process, and intervene on behalf of consumers with related parties to reach a quick and satisfactory resolution. OHCOBR staff educates consumers about their rights and responsibilities concerning their health benefits, and they facilitate consumer enrollment in health plans for private and public health insurance programs.

FUNDING

The Council of the District of Columbia (D.C. Council) fully supports the OHCOBR with approved funding from several sources: D.C. appropriations, Federal Medicaid matching funds, special purpose funds for Patient Bill of Rights expenses and funds from assessments by the commercial insurers.

LEGISLATIVE AUTHORITY

The OHCOBR is guided by two legislative mandates, *The Ombudsman's Program*, which established the Office and its duties (D.C. Law 15-331; D.C. Official Code 7-2701.01); and *The Health Benefits Plan Member Bill of Rights Act*, which established grievance procedures for health benefits plans (D.C. Law 19-546; D.C. Official Code 44-301).

INDEPENDENCE AND AUTONOMY

The OHCOBR operates independently of all other government and non-government entities. It is a neutral body that maintains its independence by having no direct involvement, participation, investment, interest or ownership in a health care facility, health benefits plan or a provider of health benefits plan. Furthermore, the OHCOBR has no agreement or arrangement with any owner or

operator of a health care service, health care facility or health benefits plan that could directly or indirectly result in remuneration, in cash or any kind of compensation to the office or its employees.

COLLABORATIONS

The OHCOBR's location in DHCF does not compromise its sovereignty from the other DHCF offices and administrations or other District Government agencies. Rather, it provides the opportunity to work even more closely with DHCF staff and senior leadership to resolve complaints quickly. The OHCOBR also has a close working relationship with the Department of Insurance, Securities and Banking (DISB), the District's insurance regulator, for DISB to route appropriate cases to the Ombudsman's office, and for them to provide an added level of education to private health plan member's regarding the assistance that is available from the OHCOBR throughout the entire appeals process.

This collaboration has added a considerable number of additional cases transferred from DISB to the OHCOBR.

GROWTH AND THE FUTURE

In regard to the DC Medicaid program, Mayor Bowser's FY 2020 budget ensures continued access to health care services by preserving the District's eligibility levels for both the Medicaid and Alliance program. Currently, there has been no reduction of expenditure in benefit plans; historical funding for community-based providers has been maintained; and resources to return managed care rates to the target or mid-point level have been allocated.

Starting in 2020, major steps towards reforming the DC Medicaid program towards a fully managed care program will begin to transition over the next five years. The purpose is to administer the DC Medicaid program in a more holistic manner that will improve health outcomes for beneficiaries.

The first milestone is re-procuring the managed care contract with the expectation that new contracts will be implemented on October 1, 2020. This re-procurement opportunity will provide a vehicle to transition nearly 22,000 fee-for-service beneficiaries to managed care, expand value-based purchasing requirements, and implement universal contracting for providers.

Health Care Reform Update

On December 19, 2019, both chambers of Congress passed expansive spending bills, one of which would make a series of changes to the Affordable Care Act (ACA). That bill was passed by the House by a vote of 297 to 120 and the Senate by a vote of 71 to 23. The $1.4 trillion spending bills, which are expected to be signed by President Trump, will avert a potential government shutdown ahead of a midnight deadline on December 20th. The budget deal will fund the government through September 30, 2020, although several health care programs will expire near the end of May 2020.

The wide-ranging spending deal funds or otherwise addresses many important health-related policies and programs. It bans the sale of tobacco products to those under age 21, reauthorizes Medicaid funding for the U.S. territories, funds gun violence research, and extends the Money Follows the Person demonstration program. This post focuses on the bill's ACA-related provisions, which include full repeal of various ACA taxes, marketplace-related provisions (on silver loading and auto-reenrollment), various appropriations and reporting requirements, funding for the Patient-Centered Outcomes Research Institute (PCORI), delayed cuts to disproportionate share hospital (DSH) allotments, and changes to the biosimilar approval pathway in the Biologics Price Competition and Innovation Act (which was passed as part of the ACA).

Full Repeal of Health Insurance Tax, Cadillac Tax, And Medical Device Tax

The spending deal will fully repeal three of the ACA's most significant taxes: the health insurance tax, the Cadillac tax, and the medical device tax. Repeal of the health insurance tax would not take effect until 2021, meaning the tax—which has already been built into many premiums for the 2020 plan year—will remain in effect for 2020. The Cadillac tax and medical device tax are repealed beginning in 2020.

These taxes were designed to help pay for the ACA's coverage expansion. Collectively, repeal of the three taxes would result in the loss of $373.3 billion in projected revenue over 10 years. The most significant revenue loss will come from repeal of the Cadillac tax ($197 billion) followed by the health insurance tax ($150.8 billion) and the medical device tax ($25.5 billion).

Repeal of these taxes is perhaps unsurprising given repeated delays of the taxes themselves and long-standing bipartisan support for their repeal. The medical device tax is a 2.3 percent excise tax on devices such as pacemakers; this tax initially went into effect in 2013 but was suspended by Congress from 2016 to 2020. The health insurance tax applies to all insurers that offer fully insured health insurance in the marketplaces, the group market, or public programs (such as Medicare and Medicaid). This tax went into effect in 2014 and was in place through 2016. Although Congress approved a one-year moratorium for 2017, the health insurance tax went back into effect for 2018 before being suspended again for 2019. The Cadillac tax, designed to disincentivize high-cost

employer-sponsored coverage, is a 40 percent excise tax on employer plans that exceed a certain amount in premiums. The Cadillac tax was initially scheduled to take effect in 2018 but was delayed first to 2020 and, most recently, to 2022.

Repeal of the health insurance tax has implications for some states. At least three states—Colorado, Delaware, and Maryland—will or can assess insurers to fund their state-based reinsurance program if Congress suspends the health insurance tax at the federal level. At the same time, litigation continues over how the health insurance tax applies to Medicaid managed care organizations. In July, a district court judge in Texas ruled that the government owed six states about $479 million for the health insurance tax from 2014 to 2016. These states filed a separate lawsuit to recover the health insurance tax from 2018. The decision over the tax from 2014 to 2016 is pending on appeal before the Fifth Circuit Court of Appeals, and oral arguments will be held before June 10, 2020.

Safeguarding Silver Loading For 2021

The bill includes a one sentence provision to ensure the continuation of "silver loading" for plan year 2021. Regular readers are familiar with silver loading, which was adopted by insurers in response to the Trump administration's decision to stop making cost-sharing reduction (CSR) payments in fall 2017.

Insurers in most states, often as directed or allowed by state insurance regulators, increased premiums on silver-level plans for 2018 to make up for the lack of CSR payments. The premium for the second-lowest cost marketplace silver plan is used to determine a consumer's amount of premium tax credit. By loading the cost of unpaid CSRs onto silver plan premiums, insurers received higher premium tax credits from the government which helped mitigate the effect of CSR nonpayment. Since a consumer can use their tax credit to purchase any metal tier (except a catastrophic plan), many consumers can enroll in bronze or gold plans at a much lower premium relative to prior years. Silver loading led to an increase in enrollment of about 500,000 subsidy-eligible consumers in 2019.

If silver loading were prohibited, insurers would "broad load" the cost of unpaid CSRs onto all ACA-compliant individual market policies. Instead of increasing premiums only on silver plans, broad loading would result in increased premiums on all ACA-compliant plans, resulting in decreased enrollment among both subsidized and unsubsidized consumers. A memo from the Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma to Secretary Alex M. Azar II—where she recommended against a ban on silver loading—confirms this expectation. The memo showed that requiring insurers to broad load would increase premiums for non-silver plans by 11 percent and reduce silver plan premiums by five percent. It would also result in coverage losses of about 300,000 in 2020.

There has long been speculation that the Trump administration will ban the practice of silver loading. This speculation was put to rest for the 2019 plan year by Secretary Azar in June 2018. In

the proposed payment rule for 2020, CMS asked for comment on whether to prohibit silver loading although changes would not take place until the 2021 plan year, at the earliest. CMS declined to make any changes in the final payment rule for 2020, noting that commenters unanimously supported silver loading.

Although the proposed payment rule for 2021 has not yet been released, there had been speculation that CMS would once again address silver loading. The spending deal ties the agency's hands, at least for 2021. The bill prohibits the Secretary of the Department of Health and Human Services (HHS) from taking action to "prohibit or otherwise restrict" silver loading for plan year 2021. The bill does not explicitly define silver loading but points to CMS's discussion in the final payment rule for 2020.

Maintaining Automatic Reenrollment For 2021

Congress included a similar provision with respect to the automatic reenrollment of consumers into marketplace coverage. Under current regulations, marketplace enrollees that remain eligible for a qualified health plan from one year to the next are automatically reenrolled in the same plan, unless they terminate that coverage or actively enroll in a different plan. If the same plan is not available, the marketplace uses a hierarchy to enroll the individual in a similar plan based on metal level, product, and insurer. Automatic reenrollment requirements were adopted in regulations proposed in 2011 and finalized in 2013, and automatic reenrollment has been in place since the initial year of enrollment.

The bill amends Section 1311(c) of the ACA to direct the Secretary to establish an automatic reenrollment process for plan year 2021 in the states that use HealthCare.gov. This would apply to individuals who enrolled in a 2020 qualified health plan but who did not enroll in a plan during the open enrollment period for 2021. In language that appears to be consistent with current rules, the Secretary would reenroll the individual into the same qualified health plan or, if that plan is not available, a plan determined appropriate by the Secretary. As is the case now, individuals could opt to disenroll in a qualified health plan that they are automatically reenrolled in (or simply not pay their initial premium).

As with silver loading, there has long been speculation that the Trump administration would end the automatic reenrollment process. CMS solicited comment on whether to end or make changes to this process in the proposed payment rule for 2020. Commenters unanimously supported retaining automatic reenrollment and pointed to benefits such as risk pool stabilization, reduced administrative costs, lower premiums, and higher insured rates. In the final payment rule for 2020, CMS agreed that automatic reenrollment reduces insurer administrative expenses, makes enrollment more convenient for consumers, and is consistent with broader industry practices.

The same memo cited above from Administrator Verma estimated that ending automatic reenrollment would result in 200,000 fewer individuals enrolled through the exchanges in 2020 and 100,000 fewer each subsequent year. Premiums would be about 1 percent higher because those

using this process are expected to be healthier. Requiring active reenrollment would also stress the enrollment and eligibility system by making more consumers unable to complete the enrollment process at HealthCare.gov by December 15, resulting in the need for additional resources to increase system capacity.

Reporting On Implementation and Enforcement Costs

The bill includes a series of provisions aimed at ACA spending and reporting that have been regularly included in prior spending bills. First, the bill prohibits CMS from using certain funds to make risk corridor payments to insurers, essentially limiting funds to those collected by insurers. The language—which is relevant to risk corridor litigation currently pending before the Supreme Court—is the same as prior years.

Second, the bill includes a provision requiring the Secretary to publish information about the costs associated with implementing, administering, enforcing, or otherwise carrying out the ACA. This information is focused on the cost of employing federal employees or contractors who work on the ACA. The report must include the section of the ACA under which funds were appropriated, a statement indicating which program or project received the funds, the operating division or office that administers the funding, and the amount of funding. HHS must publish this information online and in the fiscal year 2021 budget justification.

Third, the Secretary must publish, as part of the fiscal year 2021 budget, detailed information regarding funds used for the marketplaces for each year since the enactment of the ACA. HHS must also provide "detailed" monthly marketplace enrollment data to House and Senate Appropriations Committees. This information is supposed to be provided to the committees at least two days before its public release.

Fourth, the bill requires detailed public reporting of expenditures under the Prevention and Public Health Fund and limit transfers of funds under that program. It also reinforces that Section 2713 of the Public Health Service Act's requirement to cover breast cancer-related preventive services should be administered using the U.S. Preventive Services Task Force's recommendations from before 2009.

Other ACA Items

The bill also delays reductions in DSH payments, includes about $3.3 billion in funding for PCORI through fiscal year 2029, and makes a series of changes to the Biologics Price Competition and Innovation Act (which was passed as part of the ACA). As discussed more here, Congress has repeatedly delayed the ACA's DSH reduction schedule. The spending bill continues this tradition, further delaying the DSH reduction schedule until May 23, 2020.

Advisory Council and Committees

Facilitators in the resolution of healthcare concerns

According to the *Health Care Ombudsman Program Establishment Act of 2004*, effective April 12, 2005 (D.C. Law 15-331; D.C. Official Code 7-2071 et seq.), the Ombudsman shall establish an Advisory Council. The Council consists of members that represent consumers, consumer advocacy organizations, health benefit plans, health care facilities, government agencies, and physicians. The Advisory Council has four subcommittees: 1) Policies and Procedures and Legal; 2) Clinical; 3) Education and Outreach; and 4) Special Needs. The following describes each subcommittee's roles and responsibilities:

Policy and Procedures and Legal Subcommittee

The Legal Subcommittee and the Policy and Procedures Subcommittee were combined in 2010. This subcommittee was formed to track and provide recommendations for new laws, policies, and regulations that impact the day-to-day activities of OHCOBR by:

- Assisting with the development of operating policies and procedures for the Office of Health Care Ombudsman and Bill of Rights;
- Keeping OHCOBR abreast of health care policy, and any new laws and regulations that may impact program operations; and
- Providing recommendations for changes to health care policy legislation as well as other related health care programs or policies.

Clinical Subcommittee

The Clinical Subcommittee is comprised of health care professionals, including physicians, dentists, nurses, psychologists, clinical social workers and other clinical healthcare stakeholders who possess the clinical expertise to assess and evaluate current health care standards, protocols and best practices. This subcommittee was formed to make recommendations for the improvement of clinical practices within OHCOBR. The purpose of the Clinical Subcommittee is to:

- Assist, file and resolve individual cases;
- Collaborate with medical professionals, to educate committee members about contemporary issues;
- Recommend policies and procedures to enhance continuous quality improvement regarding clinical practice;
- Develop a process for reviewing clinical complaints and grievances; and
- Serve as external peer reviewers for Medicaid and complex medical cases.

Education and Outreach Subcommittee

The Education and Outreach Subcommittee is comprised of four OHCOBR staff members. This subcommittee was formed to develop and provide information regarding matters pertaining to District of Columbia residents' health care coverage through outreach to individual consumers, health care providers, advocacy agencies, and other stakeholders.
The purpose of the Education and Outreach Subcommittee is to:

- Develop an education and outreach strategy and materials for District of Columbia residents about health care benefits plans, managed care plans, and health benefits plan options, or other health care options for uninsured residents; and
- Conduct public outreach by providing awareness and availability of government sponsored programs such as DC Medicaid, HealthCare Alliance, Qualified Medicare Beneficiary (QMB), Medicare, and the Home and Community Based Waiver Programs.

Special Needs Subcommittee

The Special Needs Subcommittee was created in mid-2013 to review and recommend ways to improve access to quality comprehensive care for children with special needs.

The purpose of the Special Needs Subcommittee is to:

- Make recommendations to the Advisory Council; and
- Propose ways to improve performance and outcomes in care coordination among provider agencies, physicians and other child service agencies.

Collaboration

Coordination of health care and other services

OHCOBR works in collaboration with numerous agencies and organizations to coordinate the delivery of health care and other valuable supportive services. These critical collaborations maximize consumer access to services and information. We take great pride in the partnerships we have formed with these critical stakeholders. They are valuable in achieving our mission, which is simpatico with theirs. The cooperative relationships that we cultivate ensure highly effective and responsive action when consumers are referred for assistance.

- ***AARP/Legal Counsel for the Elderly - Long-Term Care Ombudsman***
- ***Adult Protective Services (APS)***
- ***Amerigroup DC***
- ***AmeriHealth Caritas District of Columbia***
- ***Bread for the City***
- ***Centers for Medicare and Medicaid Services (CMS)***
- ***Child and Family Services Agency (CFSA)***
- ***Comagine Health***
- ***Council of the District of Columbia***
- ***DC Health Benefit Exchange Authority (DCHBX)***
- ***Department of Aging and Community Living (DACL) and the DC Aging and Disability Resource Center (ADRC)***
- ***Department of Behavioral Health (DBH)***
- ***Department of Health (DOH)***
- ***Department of Health Care Finance (DHCF)***
- ***Department of Insurance, Securities, and Banking (DISB)***
- ***Department of Labor (DOL)***
- ***Department on Disability Services (DDS)***
- ***Economic Security Administration (ESA)***
- ***George Washington Health Insurance Counseling Project (HICP)***
- ***Health Services for Children with Special Needs (HSCSN)***
- ***IONA Senior Services***
- ***La Clinica del Pueblo***
- ***Liberty Healthcare Corporation***
- ***Medicaid Transportation Management (MTM)***
- ***Office of Personnel Management (OPM)***
- ***Salvation Army/ Harbor Light Center***
- ***Seabury Resources for the Aging***
- ***Social Security Administration (SSA)***
- ***CareFirst Community Health Plan DC***
- ***Unity Health Care Clinic***
- ***Whitman-Walker Clinic***

Success Stories

Emergency Air Transport

The Ombudsman's office was contacted by an attorney regarding a request for assistance with payment for an emergency air transport and hospital stay. The patient was admitted with several fractures and cuts to her arm.

The claim was underpaid by the insurer based on the Plan's determination that the services were not medically necessary, based on the insurer's determination that the member's surgery should have been rendered in an outpatient setting. At the time of the accident, the first responders determined that the member needed to be airlifted as she was at high risk of bleeding out.

After a review of the case, we were informed that this case was not within our situs due to the member having a Plan under the Federal Employee Health Benefits (FEHB) Program. All documents that we received from the insurer, member and member's attorney were forwarded to the Office of Personnel Management (OPM). Upon their review, it was determined that the insurer would pay the claim in the full amount of $41, 448. 60.

Prescription Denial

A law firm contacted the Ombudsman's office regarding the denial of a prior authorization by the insurer for his client, prescribed Forteo. The patient had been taking Natpara since 2015 for postprocedural hypoparathyroidism, a disease of low parathyroid hormone (PTH), which results in hypocalcemia and other complications. Takeda, the sole producer of Natpara, (temporarily) recalled Natpara from the US market on September 6, 2019, as a result the member would have run out of Natpara soon. This left the member in a potentially dangerous situation – when Natpara is suddenly discontinued, some patients can develop a transient increase in pre-Natpara calcium and calcitrol requirements.

The alternative for Natpara is Forteo, which was denied by the insurer. Reconsideration was requested from the insurer, and upon further review, Forteo was approved for a 12-month period, thus providing a savings to the member of approximately $96,000.

Gene Expression Test

An appeal was filed based on the decision of an insurer to deny coverage for the Decision Dx Melanoma gene assay test, which predicts the risk of recurrence of the melanoma, and as a result, improves clinical outcomes by identifying those Stage I and II melanoma patients who have a higher or lower risk of metastatic disease based on the individual genomic profile of the tumor biopsy.

The appeal was denied due to the insurer's determination that the gene assay test was experimental or investigational. Reconsideration was requested from the insurer, and upon review by the Medical Director, was approved based on additional information provided and further research into the specific details concerning the denial. As a result, the member saved approximately $8,500.

Surgical Assistant Services

The Ombudsman's office was contacted by a provider regarding a denial for the services of an Assistant-at-Surgery, due to the determination of the Plan that the services were not warranted for the procedure. The member underwent knee surgery for surgical debridement of articular cartilage due to a medial meniscus tear, which resulted in osteoarthritis. The Surgeon determined that a Surgical Assistant was required for the procedure, which the insurer denied based on necessity.

A reconsideration was requested from the insurer, and subsequently denied. Further contact with the provider resulted in the write-off of the claim, leaving a zero balance for the patient, and a cost savings of $15, 257.

Occupational and Speech Therapy

The Ombudsman's office received a request from a member representative to assist in an appeal, regarding the decision of an insurer to deny a request for on-going occupational and speech therapy without prior authorization. The request was denied due to the Plan's determination that the therapy was no longer medically necessary.

The case was sent to the insurer for reconsideration, along with the medical records and a medical necessity letter from the provider. After a review by the Medical Director of the insurance company, some of the therapy claims were approved based on the additional information provided. The member was able to continue with therapy, saving the member upwards of $3,500.

Laboratory Services

A member contacted the Ombudsman's office, regarding a denial of payment for a biopsy. The insurer paid the laboratory services at the out-of-network level.

A reconsideration was requested from the insurer, and upon re-review, the insurer paid the total claim in the amount of $1,075.

Breast Correction Surgery

The Ombudsman's Office was contacted by a member requesting assistance in getting a reimbursement for corrective breast surgery she obtained on an out-patient basis. Prior authorization for a bilateral reduction mammoplasty for the patient was denied for payment. The insurer initially denied the claim, based on the determination that the procedure was not medically necessary and cosmetic in nature, based on the coding provided on the claim.

Our office contacted the provider, to correct the billing codes submitted to the insurer. As a result, the provider made the correction and the claim was resubmitted, which provided the member with a reimbursement of approximately $3,400.

Achievements

Office of Health Care Ombudsman and Bill of Rights' Achievements for FY 2020

In FY 2020, the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) saw achievement in its continued ability to handle a heavy caseload and to address the varied and increasingly complex health care issues consumers sought help to resolve. OHCOBR was able to maintain overall service levels from the prior year and realized the following additional achievements:

- Implemented new telephone system to work from home during the public health emergency (PHE).
- Implemented new policies and procedures to handle the influx of emails to accommodate beneficiaries and providers during the PHE.
- Served two percent more consumers in FY 2020 than in the previous year (11,905 in FY 2020 compared to 11,654 in FY 2019).
- Continued to improve its track record of *overturning* Commercial cases. The office had a 32 percent increase over the previous year (87 in FY 2020 vs. 59 in FY 2019).
- Saved consumers a total of $2,454,019.38 on behalf of consumers.
- Hired a contractor (Nurse) to assist with the closure of commercial cases.

Recommendations

Recommendations for improving performance and outcomes

Based on our experiences during FY 2020, the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) identified several recommendations from a review of problems encountered by consumers and the areas where service delivery could be improved by our office, administrators of government health care benefits, insurance companies, and health care providers. We anticipate that these recommendations will help consumers better understand their rights and benefits, facilitate their access to care, and promote better satisfaction at the point of service to reduce the frequency of complaints, grievances and appeals.

It is recommended that the OHCOBR:

- Coordinate with the Department of Health Care Finance (DHCF) to see if implementation of holistic approaches can be covered by D.C. Medicaid and are feasible alternatives for Opioid addiction and substance abuse;

- Work with DHCF to ensure that Qualified Medicare Beneficiary (QMB) providers are covered for cross-over claims;

- Continue to work with the Department of Health (DOH), Health Regulation and Licensing Administration (HRLA) on quality issues that are found in areas that they regulate;

- Continue to work with the Economic Security Administration (ESA) and DHCF to be considered an out-station in order to receive Alliance members' medical assistance applications;

- Work with the ESA to streamline a process regarding seniors' financial information that the District has access to, i.e., Social Security, thereby eliminating duplication of efforts;

- Continue to work with employer's Benefit Managers on how to improve employee health benefits plans, based upon the cases we receive in our office;

- Continue to work with the commercial plans on improving outcomes for pharmacy denials, based upon the cases that we receive in our office; and

- Find and assign Chairs to oversee the Clinical; Policies, Procedures and Legal; and Outreach and Education Subcommittees.

Data Collection Summary and Highlights

The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) tracks all communications and contacts entered into the *Ombudsman In-Take Data System* (OIDS) – a system specially designed to accommodate and track cases throughout the year. Staff enter information daily, and each case is organized by type and other categories, to facilitate follow up, and share pertinent information.

The Department of Health Care Finance, Division of Analytics and Policy Research aided the OHCOBR in the production of the following statistics, tables and graphs, as well as the source document. The source document for the summary and highlights that follow is the comprehensive *FY 2018 Summary of Cases* report. To view the full report, go to the OHCOBR website at https://healthcareombudsman.dc.gov and click on the tab "Publications and Forms."

The following key questions form the basis for the summary analysis of data recorded in the OIDS:

- How do the residents of the District of Columbia contact the OHCOBR?
- Who contacts the OHCOBR?
- What are the most common issues raised by the community?
- How has the OHCOBR benefited those who contacted us?
- How did FY 2020 activity compare to prior years' experience?

Data Collection Report and Highlights:

The following are summary highlights that point out the most relevant findings from our data analysis.

- OHCOBR served two percent more consumers in FY 2020 than in the previous year (11,905 in FY 2020 compared to 11,654 in FY 2019). [Figure 1]
- Most of the issues raised by persons contacting OHCOBR in FY 2020 (98 percent) were related to public benefits (Medicaid, Medicare, and the Alliance), referred to as 'Non-Commercial' cases in this analysis. [Figure 1]
- OHCOBR did not improve its track record of *resolving most Non-Commercial cases the same day the case was opened*. The office had a decrease of 1 percent in Non-Commercial same day closures over the previous year (9,371 in FY 2020 vs. 9,359 in FY 2019. [Table 3]
- OHCOBR did not improve the *average number of days to close a Non-Commercial case*. In FY 2020 the average was 2.1 days, vs. 1.6 days in FY 2019. [Table 3, Figure 19]

- Consumers with Managed Care Organization (MCO) issues sought assistance more often than any other category of insurance (35 percent of all cases). [Figure 5]
- Eligibility was the single most frequent issue among all consumer contacts (48 percent), followed by Access/Coverage including denials (22 percent). [Figure 7] Percentages were even higher for Eligibility issues among contacts concerning MCOs (61 percent or 2,551 of 4,187 cases) [Figure 13] and the Health Care Alliance (50 percent or 787 of 1,582 cases). [Figure 14]
- Issues concerning commercial insurers (2 percent of all contacts) were less challenging, averaging around a little over two months (75.7 days) compared to nearly four months (109.8 days) in FY 2019 to resolve appeals and grievances cases. This is due mainly to the OHCOBR, in FY 2018, exploring and implementing methods for streamlining resolution times, including building a resource center for easy retrieval of current health and treatment information and access to documents filed on similar past cases with successful outcomes. Other remedies included developing standardized forms and making other tools available to staff and the IRO to expedite resolution and closure times, and appealing decisions made by the IRO.
- Consumer savings are reported to be $2,454,019.38, a decrease of 17 percent compared to the $2,971,024.99 captured in FY 2019. [Figure 18]

SELECT FINDINGS FROM THE DATA ANALYSIS

Following are some select details drawn from an analysis of data collected in FY 2020. These select details reveal customer trends and concerns and OHCOBR's performance in addressing those concerns throughout the fiscal year. Some of the data discussed in this section is also presented graphically in intermittent numbered tables and in the pie charts at the end of the section, referred to as Figures 1 - 23. For a look at the entire data set go to the *FY 2020 Summary of Cases* available on line at http://healthcareombudsman.dc.gov. It contains a comprehensive set of all data collected with detailed descriptions, pie charts and tables.

Two types of insurance categories included in the total of all contacts are highlighted in the next sections. The select findings from the data analysis are presented under the following two insurance categories:

1) ***Non-Commercial cases*** that includes all public benefits cases; and

2) ***Commercial Cases - Appeals and Grievances*** that includes cases OCHOBR brokered for consumers appealing grievances against their private insurance carrier. *(See the 'Appendix: Commercial Insurance Self-Reports' for a separate summary of annual data from commercial insurance companies on cases they investigate and resolve internally.)*

This analysis also includes consumer savings, types of complaints, and year-to-year trends.

ALL COMMERCIAL AND NON-COMMERCIAL CASES

- The OHCOBR opened a grand total of 11,905 cases of all types in FY 2020, a two percent increase over the 11,654 cases opened in FY 2019. [Table 1, Figure 1]

Table 1. Number and Percentage of All Opened Cases by Insurance Category FY19 and FY20

Insurance Category	FY19 Totals	FY19 %	FY20 Totals	FY20 %
Non-Commercial	11,395	98%	11,616	98%
Commercial	259	2%	289	2%
Total Opened Cases	**11,654**	**100%**	**11,905**	**100%**
Annual Variance			**+251**	**+2%**

NON-COMMERCIAL CASES

- Of the total 11,905 of all opened cases, 98 percent or 11,616 were Non-Commercial cases. In FY 2019, Non-Commercial contacts were also 98 percent of all cases opened. [Table 1, Figure 1]

- Of the 11,616 total Non-Commercial cases opened, 4,187 cases were related to MCO insurance issues making them the single largest insurance type of all Non-Commercial contacts (35 percent). The MCO category includes issues related to recipients that are enrolled in a Managed Care Organization. Prior to FY 2020, the Dual Eligible-Medicare/Medicaid insurance contacts category was the largest, representing 28 percent of all contacts in FY 2019 [Figure 5] and Medicare contacts representing 29 percent in FY 2018.

- Medicaid MCO contacts raised Eligibility issues at the rate of 61 percent (2,551 of 4,187 cases) [Figure 13]

- Alliance contacts raised Eligibility issues at the rate of 50 percent (787 of 1,582 cases). [Figure 14]

- Eligibility was the most frequent type of issue raised among all cases, Non-Commercial and Commercial combined (5,639 cases, 48 percent of 11,905 total contacts). [Figure 7]

- Medicare contacts raised Eligibility issues at the rate of 43 percent (908 of 2,119 cases) [Figure 12]

- Medicaid FFS contacts raised Eligibility issues at the rate of 39 percent (479 of 1,237 cases). [Figure 11]

- Dual Eligible–Medicare/Medicaid contacts raised Eligibility issues at the rate of 34 percent (779 of 2,264 cases) [Figure 10]

- OHCOBR closed more than 99 percent of all opened Non-Commercial cases by the end of FY 2020, 11,562 cases; the remaining, less than one percent or 54 cases, were still pending resolution at the end of the fiscal year. [Table 2, Figure 2]

Table 2. Non-Commercial Cases:
Status and Resolution of Closed and Open Cases at Year-End
FY19 and FY20

Year-End Status and Resolution	FY19 Totals	FY19 %	FY20 Totals	FY20 %
Closed Cases – Successful (In favor of the consumer)	11,384	>99%	11,562	>99%
Closed Cases – Unsuccessful (Not in favor of the consumer)	11	<1%	0	0%
Closed Cases (Referred Out) –Resolution Undetermined	0	0%	0	0%
Closed Cases - Sub-Total	**11,395**	**100%**	**11,562**	**>99%**
Open Cases – Still Pending Resolution	**0**	**4%**	**54**	**<1%**
Total All Non-Commercial Cases (Closed and Open)	**11,395**	**100%**	**11,616**	**100%**

- On average, Non-Commercial cases were closed in 2.1 days; In comparison, in FY 2019, average resolution time remained the same at 1.6 days. [Table 3, Figure 19]

- Of all Non-Commercial cases, OHCOBR resolved 81 percent *on the same day they were opened,* 9,371 cases. Compared to FY 2019, 11 more cases were closed in FY 2020, but the same day closure rate was higher (82 percent). [Table 3, Figure 19]

Table 3. Non-Commercial Cases: Analysis of Days to Close a Case FY19 and FY20			
FY19 # of Cases Closed	**FY19 Average # of Days to Close**	**FY20 # of Cases Closed**	**FY20 Average # of Days to Close**
9,360	**1.6 days**	**9,371**	**2.1 days**
FY19 Same-Day Closure Cases		**FY20 Same-Day Closure Cases**	
9,359 of 11,395 total Non-Commercial cases (82%)		**9,371 of 11,616 total Non-Commercial cases (81%)**	
Annual Variance of Same-Day Closures		**+11 cases**	**1% increase in # of cases**

COMMERCIAL CASES - APPEALS AND GRIEVANCES

- Cases related to Commercial Health Plans represented two percent of all cases opened in FY 2020 (289 of 11,905 total cases). Compared to FY 2019, 10 percent or 30 fewer commercial cases were opened (259). [Table 1, Figure 1]

- Of the 289 Commercial cases opened in FY 2020, 143 (>49 percent) were related to Not Eligible for Health Plan/Benefit, 128 (44 percent) were related to Medical Necessity, 11 (4 percent) were related to Experimental/Investigational, 1 (<1 percent) were related to Part D Prescription Plans, and the remaining 6 (2 percent) covered a wide range of Other generic complaints and issues. [Table 4, Figure 9]

Table 4. Commercial Cases: Appeals/Grievances Types of Issues Encountered FY19 and FY20				
Issues	**FY19 Cases**	**FY19 % of Total**	**FY20 Cases**	**FY20 % of Total**
Care Is Experimental/Investigational	17	>6%	11	4%
Care Is Not Medically Necessary	106	41%	128	44%
Grandfather Status	0	0%	0	0%
Not Eligible for Health Plan/Benefit	126	49%	143	>49%
*Other Issues	9	3%	6	2%
Part D Prescription Plan	1	<1%	1	<1%
Rescission	0	0%	0	0%
Total Issues (Commercial Cases)	**259**	**100%**	**289**	**100%**

- In FY 2020, >99 percent (288 cases) of all Commercial cases were closed, compared to 93 percent (242 cases) in FY 2019. [Table 5, Figure 3]

- In FY 2020, only <1 percent remained open by the end of the fiscal year (1 case), compared to seven percent (19 cases) that remained open at the end of FY 2019. [Table 5, Figure 3]

- Of the 288 Commercial cases closed in FY 2020, 250 cases (<86 percent) were resolved successfully in favor of the consumer, an increase in comparison to 208 cases (80 percent) in FY 2019. [Table 5, Figure 21]

Table 5. Commercial Cases: Status and Resolution of Cases at Year-End FY19 and FY20

Year-End Status and Resolution	FY19 Totals	FY19 %	FY20 Totals	FY20 %
Closed Cases – Successful (In favor of the consumer)	196	76%	250	>86%
Closed Cases – Unsuccessful (Not in favor of the consumer)	34	13%	38	13%
Closed Cases (Referred Out) –Resolution Undetermined	10	4%	0	0%
Closed Cases - Sub-Total	240	93%	288	>99%
Open Cases – Still Pending Resolution	19	7%	1	<1%
Total All Non-Commercial Cases (Closed and Open)	**259**	**100%**	**289**	**100%**

- It took an average of 75.7 days to resolve or close a Commercial case [Table 6, Figure 20]. This represents a decrease of 34.1 days (31 percent) in *the average days to resolve or close a case* compared to 109.8 days in FY 2019, largely due to methods and other remedies implemented in FY 2018.

- OHCOBR resolved or closed 9 Commercial cases (3 percent) *on the same day they were opened*. For comparison, in FY 2019, 8 of 259 total cases (3 percent) were resolved *on the same day they were opened*. [Table 6]

Table 6. Commercial Cases: Average Number of Days to Close and Same-Day Closures FY19 and FY20			
FY19 # of Cases Closed	**FY19 Average # of Days to Close**	**FY20 # of Cases Closed**	**FY20 Average # of Days to Close**
242	**111.3 days**	**288**	**75.7 days**
FY19 Same-Day Closure Cases		**FY20 Same-Day Closure Cases**	
7 of 259 total Non-Commercial cases (3%)		**9 of 289 total Non-Commercial cases (3%)**	
Annual Variance - Same-Day Closures		**2 More Cases**	**<1% Increase**

CONSUMER SAVINGS

- In FY 2020, the OHCOBR saved consumers a total of $2,454,019.38. This represents a decrease of 17 percent over FY 2019 when $2,971,024.99 was saved on behalf of consumers. [Figure 18]

- Of the total amount saved, $1,808,692.82 (74 percent) was from resolved Commercial Cases; $211,683.79 (17 percent) was saved or recouped on behalf of Medicaid Fee-for-Service, MCO and Alliance beneficiaries; $861.97 (<1 percent) was removed from QMB beneficiaries' accounts for co-payments; and $432,780.80 (18 percent) was reimbursed to beneficiaries due to non-payment of Medicare Part B Premiums. [Figure 18].

TYPES OF CASES, CONTACTS, AND ISSUES (ALL INSURANCE TYPES)

- Most consumers, 53 percent, utilized the telephone to contact OHCOBR (8,234 of 11,905 total cases). This continues to be the preferred method for contacting the office. In FY 2019, 91 percent of total contacts were made by telephone (10,656 of 11,654 total cases), and in FY 2018, 93 percent of total contacts were made by telephone (10,558 of 11,309 total cases) [Figure 4].

- Contacts made to OHCOBR originated from consumers residing throughout all eight Wards and various States within and outside of the DC Metropolitan area [Table 7, Figure 6].

- Ward 7 (2,058) had the highest number of contacts to the OHCOBR with 17 percent. The next highest number of contacts originated from Ward 4 (2,006) with 17 percent. [Table 7, Figure 6]

Table 7. Cases Located in and Out of the DC Metropolitan Area FY19 and FY20				
Location of Contacts	**FY19 # Contacts**	**FY19 % Contacts**	**FY20 # Contacts**	**FY20 % Contacts**
Ward 1	1,354	12%	1,743	15%
Ward 2	1,240	11%	1,026	9%
Ward 3	367	3%	334	3%
Ward 4	1,536	13%	2,006	17%
Ward 5	1,796	15%	1,718	14%
Ward 6	1,077	9%	998	8%
Ward 7	2,127	18%	2,058	17%
Ward 8	1,946	17%	1,770	15%
Maryland (Located Within the DC Metropolitan Area)	16	<1%	24	<1%
Out-of-Country	0	0%	0	0%
Out-of-State (States Located Outside of the DC Metropolitan Area)	159	1%	177	1%
Undetermined	15	<1%	37	<1%
Virginia (Located Outside of the DC Metropolitan Area)	21	<1%	14	<1%
Totals	**11,654**	**100%**	**11,905**	**100%**

- Eligibility continues to be the most frequent type of issue from all types of consumers combined, at 48 percent or 5,639 total cases [Figure 7]. It was also the most frequent issue in FY 2019, 45 percent or 5,186 total cases, and in FY 2018, 44 percent or 4,986 total cases.

- Eligibility issues were the largest type of issue raised by Managed Care Organization (MCO) beneficiaries (61 percent or 2,551 of 4,187 cases). Compared to FY 2019, Alliance cases were the largest group (72 percent or 266 out of 368 cases). OHCOBR works closely with the government agency that handles Medicaid enrollment to resolve both issues quickly. [Figure 10]

- Of the 380 Administrative/Fair Hearing cases filed by OHCOBR on behalf of all types of contacts, 72 percent were filed on behalf of EPD Waiver beneficiaries (272 cases).

- The number of access issues for EPD waiver beneficiaries that went to Administrative/Fair Hearings for resolution increased since FY 2018, from 154 cases and 16 percent of all EPD cases to 532 cases and 41 percent in FY 2019 (attributed to change in level of care (LOC) assessment contractors and new assessment tool – Delmarva to Liberty Healthcare), and 272 cases and 33

percent in FY 2020 due to the public health emergency (PHE), which resulted in the extension and non-termination of all benefits. [Table 8, Figure 20]

- A total of 821 EPD Waiver Cases were opened in FY 2020, 36 percent less than the 1,287 cases opened in FY 2019. [Table 8, Figure 20]

Table 8. Types of Issues Encountered by EPD Waiver Contacts	FY19 # of Contacts	FY19 % of Contacts	FY20 # of Contacts	FY20 % of Contacts
Access (Administrative Hearings)	532	41%	272	33%
Access (Including Prior Authorizations)	209	16%	162	20%
Coverage/Service Denials	29	2%	6	1%
Eligibility/Verification of Coverage	304	24%	183	22%
Non-Payment/Reimbursement (Out-of-Pocket Expenses)	27	2%	16	2%
Other Issues	124	10%	126	15%
Quality of Services by Providers	62	5%	56	7%
Totals	**1,287**	**100%**	**821**	**100%**

- In FY 2020, a total of 92 Transportation Cases were opened compared to 121 in FY 2019, a 24 percent decrease. [Figure 15]
- A total of 677 DC Health Link cases were opened in FY 2020, a 9 percent decrease compared to the 763 cases in FY 2019. [Figure 17]

Appendices

- Appendix A: Office of Health Care and Ombudsman & Bill of Rights (OHCOBR) Mission Statement
- Appendix B: Outreach/Education Events
- Appendix C: Commercial Insurance Self-Reports
- Appendix D: Definitions

Operational Function Statement

Appendix A

Office of Health Care Ombudsman & Bill of Rights Mission Statement

The mission of the Office of Health Care Ombudsman and Bill of Rights is to guide, advocate and help people navigate through the health care system by helping them understand their health care coverage, assisting in appealing health insurance decisions, including public health care programs, i.e., Medicaid, Medicare, Tri-Care and assisting District residents and those who have claims, medical procedures and prescriptions that have been denied by insurance companies that are regulated by the District of Columbia Department of Insurance Securities, and Banking.

Appendix: Table 9 – Outreach/Education Events

Appendix B

OUTREACH/EDUCATION EVENTS – FY 2020
OCTOBER 1, 2019 THROUGH SEPTEMBER 30, 2020

EVENT DATE	OHCOBR'S PARTICIPATION	NAME OF ORGANIZATION/GROUP	NUMBER OF ATTENDEES
OCTOBER 2, 2019	SPEAKER	WARD 6 - DEPARTMENT OF AGING AND COMMUNITY LIVING (DACL) MONTHLY MEETING 500 K STREET, NE	40 ATTENDEES
OCTOBER 5, 2019	EXHIBITOR	WARD 7 – DC HOUSING AUTHORITY BENNING TERRACE HEALTH & WELLNESS RESOURCE FAIR 4450 G STREET, SE	100 ATTENDEES
OCTOBER 7, 2019	PRESENTER	WARD 4 – SENIORS PRAISE LUNCHEON GETHSEMANE BAPTIST CHURCH 5119 4TH STREET, NW	60-100 ATTENDEES
OCTOBER 9, 2019	EXHIBITOR	WARD 5 – DACL, DCHA & FORT LINCOLN SENIOR APARTMENTS COMMUNITY HEALTH & RESOURCE FAIR 3400 BANNEKER DRIVE, NE	50 ATTENDEES
OCTOBER 16, 2019	EXHIBITOR	WARD 6 - AARP – SW WATERFRONT CHAPTER 8TH ANNUAL HEALTH, WELLNESS, AND RESOURCE FAIR RIVER PARK MUTUAL HOMES 1311 DELAWARE AVENUE, SW	200 ATTENDEES
OCTOBER 18, 2019	EXHIBITOR	WARD 4 – DACL & HATTIE HOLMES SENIOR WELLNESS CENTER'S ANNUAL COMMUNITY HEALTH, RESOURCES FAIR 324 KENNEDY STREET, NW	100 ATTENDEES
OCTOBER 23, 2019	EXHIBITOR	WARD 6 – DOH – DC AIDS DRUG ASSISTANCE OPEN HOUSE DOROTHY I. HEIGHTS/BENNING NEIGHBORHOOD LIBRARY 3935 BENNING ROAD, NE	60 ATTENDEES
OCTOBER 24, 2019	EXHIBITOR	WARD 3 - 12TH ANNUAL MAYOR'S DISABILITY AND DIVERSITY EXPO UDC STUDENT CENTER 4200 CONNECTICUT AVENUE, NW	1,000 ATTENDEES
NOVEMBER 12, 2019	EXHIBITOR	WARD 1 - DCHR OPEN ENROLLMENT FAIR FRANK D. REEVES CENTER 2000 14TH STREET, NW	200 ATTENDEES

NOVEMBER 12, 2019	**EXHIBITOR**	**WARD 5 - DCHR OPEN ENROLLMENT FAIR DC PUBLIC SCHOOLS CENTRAL OFFICE 1200 FIRST STREET, NE**	**500 ATTENDEES**
NOVEMBER 14, 2019	**EXHIBITOR**	**WARD 2 - DCHR OPEN ENROLLMENT FAIR JOHN A. WILSON BUILDING 1350 PENNSYLVANIA AVENUE, NW**	**200 ATTENDEES**
NOVEMBER 19, 2019	**SPEAKER**	**WARD 6 - DCHR OPEN ENROLLMENT FAIR OFFICE OF THE CHIEF FINANCIAL OFFICER 1101 4TH STREET, SW**	**100 ATTENDEES**
NOVEMBER 20, 2019	**EXHIBITOR**	**WARD 5 - DCHR OPEN ENROLLMENT FAIR DEPARTMENT OF BEHAVIORAL HEALTH 64 NEW YORK AVENUE, NE**	**100 ATTENDEES**
NOVEMBER 27, 2019	**EXHIBITOR**	**WARD 2 – FEAST OF SHARING SAFEWAY 801 MOUNT VERNON PLACE, NW**	**5,000 ATTENDEES**
DECEMBER 2, 2019	**EXHIBITOR**	**WARD 6 - DCHR OPEN ENROLLMENT FAIR MDC DEPARTMEENT OF HUMAN RESOURCES 1015 HALF STREET, SE**	**150 ATTENDEES**
DECEMBER 4, 2019	**EXHIBITOR**	**WARD 5 - DCHR OPEN ENROLLMENT FAIR DC HOUSING Authority 1133 NORTH CAPITOL STREET, NE**	**100 ATTENDEES**
DECEMBER 5, 2019	**EXHIBITOR**	**WARD 2 - DCHR OPEN ENROLLMENT FAIR ONE JUDICIARY SQUARE 441 4TH STREET, NW**	**200 ATTENDEES**
DECEMBER 19, 2019	**EXHIBITOR**	**WARD 6 – MAYOR'S 21ST ANNUAL SENIOR HOLIDAY CELEBRATION DC ARMORY 2001 E. CAPITOL STREET, SE**	**4,000 ATTENDEES**
JANUARY 18-19, 2020	**EXHIBITOR**	**WARD 2-NBC4 & TELEMUNDO44 ANNUAL HEALTH AND FITNESS EXPO WALTER E. WASHINGTON CONVENTION CENTER 801 MOUNT VERNON PLACE, N=-6twqhklo98**	**25,000 ATTENDEES *1,000 SPANISH SPEAKING ATTENDEES**
JANUARY 21, 2020	**ON-TAP EVENT**	**WARD 5 - PEOPLE'S CONGREGATIONAL CHURCH'S SENIORS INFORMATIONAL GATHERING 4701 13TH STREET, NW**	**50 ATTENDEES**
JANUARY 26, 2020	**EXHIBITOR/SPEAKER**	**WARD 5 - ST. MARTINS CATHOLIC CHURCH HEALTH FAIR 1900 NORTH CAPITOL STREET, NW**	**75 ATTENDEES**
FEBRUARY 7, 2020	**EXHIBITOR**	**WARD 1 – HOWARD UNIVERSITY COLLEGE OF DENTISTRY STUDENT COUNSEL DENTAL FAIR 600 W STREET, NW**	**200/300 ATTENDEES**
FEBRUARY 28, 2020	**EXHIBITOR**	**WARD 6 – HELPING RESIDENTS – CENTRAL UNION MISSION 65 MASSACHUSETTS AVENUE, NW**	**200 ATTENDEES**

Commercial Insurance Self-Reports

Appendix C

Commercial insurance companies are required by law to submit to OHCOBR an annual report of grievances and appeals cases that they process internally. OHCOBR provides the report format to the insurance companies for uniformity in analyzing the reports. These reports help OHCOBR understand issues of concern to private insurance members based on grievances they file with their health plans. On occasion these consumers also contacted OHCOBR for help communicating with their insurer or for further action if they are dissatisfied with the insurance company's decision. OHCOBR tracks and reports on those cases (see *Data: Highlights & Analysis* section), which results in duplicate reporting for a modest number of cases that are tracked by OHCOBR and the private insurer.

DC Code §44.301.10 Reporting Requirements

(a) Every insurer shall submit to the Director [of DHCF or designee] an annual grievance report that chronicles all grievance activity for the preceding year. The Director shall develop a system for classifying and categorizing all grievances and appeals that all insurers and independent peer review organizations will use when collecting, recording, and reporting grievance and appeals information. The Director shall also develop a reporting form for inclusion in the annual report that shall include the following information:
(1) The name and location of the reporting insurer;
(2) The reporting period in question;
(3) The names of the individuals responsible for the operation of the insurer's grievance system;
(4) The total number of grievances received by the insurer, categorized by cause, insurance status and disposition;
(5) The total number of requests for expedited review, categorized by cause, length of time for resolution, and disposition….
(d) …The Director shall, based upon individual cases and the patterns of grievance and appeals activity, include in the annual report [to the D.C. Council] recommendations concerning additional health consumer protections.

The *Commercial Insurer's Annual Self-Report* primarily includes:

(1) The total number of grievances within each service category as follows;

- Inpatient Hospital Services
- Emergency Room Services
- Mental Health Services
- Physician Services
- Laboratory, Radiology Services
- Pharmacy Services
- Physical Therapy, Occupational Therapy, Speech Therapy Services
- Skilled Nursing
- Durable Medical Equipment
- Podiatry Services
- Dental Services
- Optometry Services
- Chiropractic Services
- Home Health Services
- Other

(2) The number of cases that resulted in *upheld* initial decisions; and

(3) The number of *overturned* cases that resulted in a full or partial reversal of the decision that caused the grievance.

Also included in the reports are the number of emergency cases, the number of days it took to resolve certain types of cases, a sampling of procedures involved in grievance cases and other details are also included in the reports.

A breakout by company is shown in Tables 1 and 2 at the end of this section.

DATA SUMMARY AND HIGHLIGHTS

Using data from the FY 2020 *Commercial Insurer's Annual Self-Reports* submitted by each insurance company, OHCOBR is able to determine the volume and scope of complaints processed by each company and all the companies combined. The reports were analyzed to assess trends, compliance with legislative mandates including resolution timeliness, and to identify areas that may require further review and follow-up. Gauging the benefits of the *Self-Report* and recognizing the need for value-added modifications is an ongoing process.

TOTAL REPORTS REVIEWED:	27	100%
REPORTS WITH "NO GRIEVANCES":	10	37%
REPORTS WITH GRIEVANCES:	17	63%
REPORTS WITH 40% OR MORE GRIEVANCES OVERTURNED IN A SINGLE CATEGORY:	15	88%

TRENDING: Grievance Turnover Rates

- The analysis of FY 2020 final case results shows that more than half of the 27 insurers that submitted reports (65 percent, 17 of 27 insurers) overturned at least 40 percent of grievances in at least one of the service categories listed above, in favor of the member.

TRENDING: Dental Insurers

- For a fourth year in a row, OHCOBR has isolated dental insurer data to determine how that group's data varies by provider and when compared to the medical insurers.
    - Of the six dental insurers that submitted a *Self-Report*, one reported more grievances than all but three of the 11 medical insurers.
    - Of all insurers reporting grievances in FY 2020, 35 percent were dental insurers (6 of 17 insurers reporting grievances) and accounted for 12 percent of all the grievance cases (285 of 2,397).

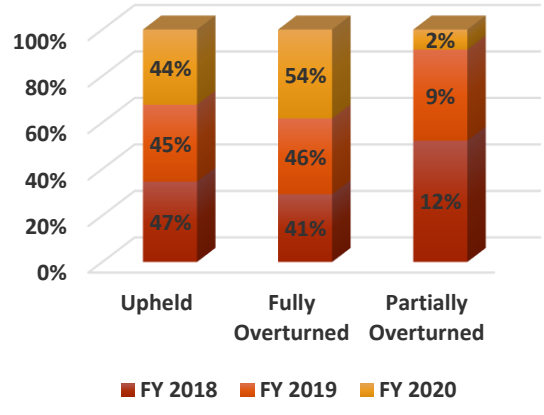
- In terms of outcomes, the six dental insurers accounted for nine percent of all grievances that were *partially* or *fully overturned* (117 cases *combined overturned*) compared to 91 percent among the 11 medical insurers (1,212 cases *combined overturned*).

- In the case of all dental insurers, denial decisions were *combined overturned* for 41 percent of the grievance cases processed.

- Instances of high numbers of grievance cases and high rates of overturned cases among some of the dental insurers indicates a need for further examination of specific providers, the reasons for the initial denials that were later overturned, and the possible need to adjust the claims process so that members can obtain covered dental services without having to file grievances.

- In FY 2020, 15 of 17 insurers overturned 40 percent or more of *grievance cases in a single category*. This is an increase from FY 2019 when only 11 of 17 insurers reported 40 percent or more *cases overturned in a single category*. FY 2018 there were 11 of 17 insurers with high decision reversal rates. In some years the measure of grievances *overturned in more than 40 percent of cases in a single category* reveals trends and issues with medically specific treatments – FY 2020 was such a year. There were apparent trends for cases that were *fully overturned* across all insurers for: In-Patient Hospital Services (56 percent), Emergency Room Services (47 percent), Physician Services (46 percent), Laboratory/Radiology Services (45 percent), Pharmacy Services (69 percent), Chiropractic (50 percent), and Optometry (50 percent). Broken down, there were eight insurers that overturned initial denials at an unusually high rate in the category for Pharmacy Services (over 60 percent turnover for each of those insurers). Six insurers had overturned rates greater than 50 percent for Physician Services, and five insurers had overturn rates of over 40 percent each for the Laboratory/Radiology Services and the In-Patient Hospital Services category. Further intervention is required to determine if a pattern related to a specific illness, drug, service or practice was responsible for the initial denial of these services in order to avoid them in the future.

Figure 1: Percentage of Case Resolutions by Year



- Figure 1: *Percentage of Case Resolution by Year* shows breaks out the percentage of case resolved by type of resolution decision for the past three fiscal years. The percentage of cases *upheld* remain consistent across the three years with FY 2020 showing a drop of one percentage point from FY 2019 and three percentage points from FY 2018. Decision outcomes changed in FY 2020 in comparison to the last two fiscal years across two main decision types. In the FY 2020 the percentage

of *fully overturned* cases increased during the three-year period, i.e., the percentage of *fully overturned* cases increased to 54 percent in FY 2020 from 46 percent in FY 2019 and 41 percent in FY 2018 (See Figure 1: *Percentage of Case Resolutions by Year*). In FY 2020 there was a large decrease in the percentage of *partially overturned* outcomes (2 percent compared to 9 percent for FY 2019 and 12 percent in FY 2018) and a decrease in grievances that were *upheld* (44 percent compared to 45 percent for FY 2019 and 47 percent in FY 2018). The grievance process increases adjudication costs and delays care to consumers. OHCOBR will continue to encourage insurers and providers to work together to approve services and properly code claims at the point of contact, to reduce the need for grievances and appeals.

TRENDING: More Companies Reporting Grievances

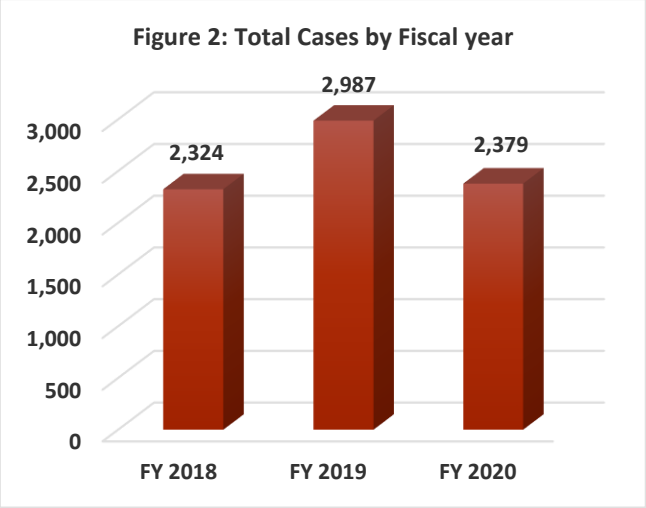
- Over the past three fiscal years, the number of companies that submitted reports *and had grievances* remained the same for both FY 2020 and FY 2019 (17 companies submitted reports). FY 2020 and FY 2019 disrupted a downward trend for the previous three fiscal years, during which the number of companies that submitted reports *and had grievances* was on a decrease from 22 in FY 2016 to 18 in FY 2017 and down to 14 in FY 2018.

DATA SUMMARY: Number of Companies Reporting and Number of Cases

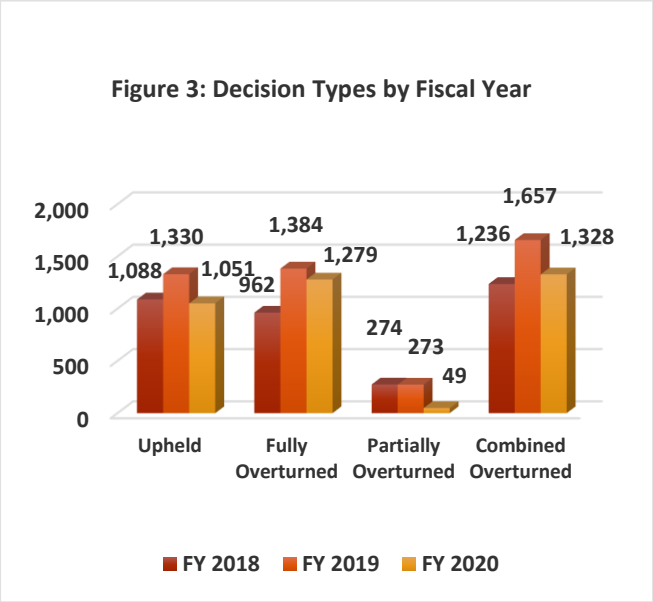
- A total of 27 companies submitted annual *Self-Reports* in FY 2020, three fewer than in FY 2019 (30 companies) and five fewer than in FY 2018 when 32 companies submitted reports.

- Of the 27 insurers that submitted an annual *Self-Report*, 17 reported opening consumer *grievance cases* in FY 2020 and 10 reported having *no grievance cases*. In FY 2019, 17 of 30 insurers reported opening *grievance cases* (the same as in FY 2020) and 13 insurers reported *no grievance cases*, (three more than what was reported in FY 2020). In FY 2018, 14 of 32 insurers reported opening *grievance cases* (three fewer than in FY 2020) and 18 insurers reported *no grievance cases*, (eight more than the number that was reported in FY 2020).

- The number of *grievance cases* declined in FY 2020 after a spike in FY 2019. The 17 companies that reported grievances in FY 2020 opened a total of 2,379 cases, resulting in 608 fewer cases than were opened in FY 2019 (20 percent decrease) and 55 more cases than 14 companies in FY 2018 (two percent increase). [See Figure 2: *Total Cases By Year*]



DATA SUMMARY: Case Outcomes by Type



- As shown in Figure 3: *Decision Type by Year*, insurers *upheld* their initial decisions in FY 2020 in a total of 1,050 of 2,379 opened cases (44 percent) compared to FY 2019 when 1,330 of 2,987 opened cases (45 percent) were *upheld*. In FY 2018 insurers *upheld* 1,088 of 2,324 opened cases (47 percent). *Upheld* cases are cases that are reviewed and the original decision to deny coverage or payment is reaffirmed.

- Insurers *fully overturned* their original decision in 1,280 cases (54 percent of 2,379 cases). This percentage is an increase over the last two fiscal years – FY 2019 with 1,384 cases (46 percent of 2,987 cases) and in FY 2018 when 962 cases (41 percent of 2,324 cases) were *fully overturned*. *Fully overturned* cases are cases that are reviewed, and the original denial decision is reversed in favor of the member.

- A total of 49 of 2,379 opened cases were *partially overturned* in favor of the member in FY 2020 (2 percent). This represents a decrease from the previous two fiscal years, when 273 of 2,987 opened cases were *partially overturned* in favor of the member in FY 2019 (nine percent) and in FY 2018 when 274 of 2,324 (12 percent) of opened cases were *partially overturned* in favor of the member.

- In FY 2020 the number of *combined overturned* cases (total of *fully overturned* plus *partially overturned* cases) was 1,329 of 2,379 total cases opened (56 percent). This represents a slight increase over the previous two fiscal years – in FY 2019, when 1,657 of 2,987 total cases (55 percent) and in FY 2018 when there were 1,236 *combined overturned* outcomes out of 2,324 cases opened (53 percent).

- In FY 2020, 15 of the 17 companies that reported grievances (88 percent) had a *combined overturned* rate of 40 percent or higher in *at least one service category*. This represents a 23 percent increase over FY 2019 when 11 of the 17 companies (65 percent) that reported grievances had a *combined overturned* rate of 40 percent or higher in *at least one service category*. In FY 2018, 11 of 14 companies (79 percent) had a *combined overturned* rate of 40 percent or higher in at least one service category. Eight insurers overturned initial denials at a high rate in the Pharmacy Services category in FY 2020 (more than 60 percent of cases overturned).

- In summary, the rate of grievance cases that were *fully overturned* increased by eight percentage points over the last fiscal year and by 13 percentage points in FY 2018. The *combined overturned*

rate, which includes both *fully* and *partially overturned* cases, also increased by one percentage point, and declined seven percentage points in the *partially overturned* category in FY 2020. The figures for FY 2020 increased 23 percentage points from FY 2019 regarding the number of insurers with more than 40 percent of cases in a single category that were reversed or overturned and nine percentage points from the numbers accounted for in FY 2018. There were high overturn rates observed in the Pharmacy Services, Physician Services, and Laboratory/Radiology Services across 12 medical insurers. Overall, the consistently high reversals, and year-over-year rate increases suggest that efforts should be focused on reducing the frequency of grievances and appeals, which would reduce efforts by insurers and providers to settle grievances and facilitate timely delivery and payment of healthcare services for consumers.

DATA SUMMARY: Service Category Prevalence

- In FY 2020, for the fifth consecutive year, the Pharmacy Services category was the *most prevalent service category* for grievances by service type. Other top categories included Dental Services, Laboratory/Radiology Services, and Physician Services.

The following tables summarize data from the FY 2020 annual *Self-Reports* that each commercial insurer submitted; including reports submitted that showed no grievances during the year. Insurers are listed in alphabetical order.

Table 1. Commercial Insurers' Annual Self-Report[1] FY 2020

[GRAY SHADING = NO GRIEVANCES REPORTED]

NAME OF INSURER	TOTAL APPEALS/ GRIEVANCES	CASES UPHELD		CASES OVERTURNED		CASES PARTIALLY OVERTURNED	
		#	%	#	%	#	%
Aetna Health Inc.	19	8	47%	11	58%	0	%
Aetna Life Insurance Co.	36	24	67%	12	33%	0	0%
Ameritas Life Insurance Co.[2]	176	109	62%	53	30%	14	8%
BlueChoice Inc.	264	109	41%	155	59%	0	0%
CareFirst of Maryland, Inc.	84	38	45%	41	49%	5	6%
CIGNA Health and Life Insurance Co.	46	27	59%	17	37%	2	4%
CIGNA HealthCare Mid-Atlantic Inc.							
Connecticut General Life Insurance Co.							
Delta Dental[2]	25	14	56%	11	44%	0	0%
Fidelity Security Life Insurance Company							
Golden Rule Insurance Co.							
Group Hospitalization and Medical Services, Inc.	745	262	35%	481	>65%	2	<1%
Kaiser Permanente	77	31	40%	46	60%	0	0%
MAMSI Life and Health Insurance Co.							
MD-Individual Practice Association, Inc.	155	82	53%	67	43%	6	4%
Optimum Choice, Inc.	9	4	44%	5	56%	0	0%
Principal Life Insurance Co.[2]	1	0	0%	1	100%	0	0%
Prudential Insurance Co. of America							
Reliance Standard Insurance Co.[2]	2	1	50%	1	50%	0	0%
Standard Insurance Co.[2]	2	2	0%	0	0%	0	0%
State Farm Mutual Auto Insurance Co.							
Trustmark Insurance Co.							
Trustmark Life Insurance Co.							
UniCare Life and Health Insurance, Co.							
United Concordia Insurance, Co.[2]	79	42	53%	35	44%	2	3%
United Healthcare Life Insurance Co.							
United Healthcare Insurance Company	654	295	45%	341	52%	18	3%
United Healthcare of the Mid-Atlantic, Inc.	5	2	40%	3	60%	0	0%
SUBTOTAL – MEDICAL PROVIDERS	2,094	882	42%	1,179	56%	33	2%
SUBTOTAL – DENTAL PROVIDERS	285	168	59%	101	35%	16	6%
TOTAL – ALL PROVIDERS	2,379	1,050	44%	1,280	54%	49	2%

[1] **Source:** Data was gathered from standardized self-reports that OHCOBR requires commercial insurers to submit annually, based on their own internal grievance and appeals process. These cases were *not* processed by OHCOBR.
[2] Dental Provider

Table 2. Commercial Insurers' Annual Self-Report[1] FY 2020 - Cont'd

[GRAY SHADING = NO GRIEVANCES REPORTED]

[BLACK SHADING = SERVICES ARE NOT COVERED BY THE PLAN]

RESOLUTION TIMES				
NAME OF INSURER	MEDICAL EMERGENCY [HOURS]	MENTAL HEALTH EMERGENCY [HOURS]	MEDICAL NON-EMERGENCY [CALENDAR DAYS]	MENTAL HEALTH NON-EMERGENCY [CALENDAR DAYS]
Aetna Health Inc.	18	22	23	17
Aetna Life Insurance Co.	12	0	15	24
Ameritas Life Insurance Co.[2]			28	
BlueChoice Inc.	14.35	0	28.6	0
CareFirst of Maryland, Inc.	0	0	35.8	0
CIGNA Health and Life Ins. Co.	71.87	22.37	23.15	0
CIGNA HealthCare Mid-Atlantic Inc.				
Connecticut General Life Ins, Co.				
Delta Dental[2]			13	
Fidelity Security Life Insurance Co.				
Golden Rule Insurance Co.				
Group Hospitalization and Medical Services, Inc.	11.1	0	23.6	18
Kaiser Permanente	20.3	0	25.4	23.5
MAMSI Life and Health Ins. Co.				
MD-Individual Practice Association, Inc.	42	0	12	0
Optimum Choice, Inc.	919	5	24	2
Principal Life Insurance Co.			19	
Prudential Ins. Co. of America				
Reliance Standard Insurance Co.			16	
Standard Insurance Co.			28	
State Farm Mutual Auto Ins. Co.				
Trustmark Insurance Co.				
Trustmark Life Insurance Co.				
UniCare Life and Health Ins. Co.				
United Concordia Insurance, Co.[2]			7	
United Healthcare Life Ins. Co.				
United Healthcare Insurance Co.	61	23	31	49
United Healthcare of the Mid-Atlantic, Inc.	18	22	41	0

[1] **Source:** Data was gathered from standardized self-reports that OHCOBR requires commercial insurers to submit annually, based on their own internal grievance and appeals process. These cases were *not* processed by OHCOBR.

[2]Dental Provider

Definitions

Appendix D

Appeal/Grievance – A written request by a member or their representative for the review of an insurer's decision to deny, reduce, limit, terminate or delay a benefit to a member, including, for example, determinations about medical necessity, appropriateness, level of care, health care setting, or effectiveness of a treatment; or for review of an insurer's decision to rescind care; or for a review of failure to pay based on eligibility.

Case – An unduplicated count of individuals who contact the OHCOBR who are insured or uninsured. Each case may involve multiple interactions between OHCOBR and the customer or customer's representative. The data for cases presented in this report do not include multiple interactions with the same customer in the course of addressing issues related to his/her case.

Commercial Cases – Commercial health plans are also called private insurance plans. These cases involve individuals who have health coverage through an employee-sponsored plan or individual. Grievances and appeals for these cases are handled differently by the OHCOBR than the cases involving public benefits programs, such as Medicaid, the Alliance and Medicare.

Non-Appeal/Grievance – Includes all cases/contacts that are resolved within the OHCOBR and are not referred for external review by an independent review organization (IRO) or are not referred for a fair hearing.

Non-Commercial Cases – Includes all cases involving public benefits including the DC Health Care Alliance (the Alliance), Fee-for-Service (FFS), Managed Care Organization (MCO), Medicare, Dual Eligible (Medicaid/Medicare), and any other non-private insurance.

Uninsured Contacts – Includes all other categories of contacts not specifically related to membership in a public or commercial insurance plan. May include issues such as denied coverage by a provider, requests for information about eligibility and other questions, fraud, legal services, requests for financial assistance, housing assistance, death certificates, burial assistance, complaints about an entity's quality of services, etc.

Undetermined Closed Cases – Cases that were referred to other agencies, organizations or states for resolution but OHCOBR did not know the outcome at the time the case was closed, e.g. cases referred to DISB for investigation regarding benefits and policy issues, to the Department of Labor (DOL) to help employees of self-insured companies, to the Office of Personnel Management (OPM) to help federal employees, to the state of origin to help persons with out-of-state insurance.

Notes