# OFFICE OF HEALTH CARE OMBUDSMAN AND BILL OF RIGHTS (OHCOBR)

## FY2010 Annual Report

## October 1, 2009 through September 30, 2010

# Table of Contents

## History of the Office

Established in February 2009, the District of Columbia Office of the Health Care Ombudsman and Bill of Rights (OHCOBR) is an independent office located in the District of Columbia's (D.C.) Department of Health Care Finance (DHCF) Health Care Delivery Management Administration. The Office is currently funded by D.C. appropriations and has the full support of the D.C. Council.

The OHCOBR is comprised of two legislative requirements, the Ombudsman's Program (*D.C. Code § 7-2071.01*), and the Grievance Procedures for Health Benefit Plans (*D.C. Code § 44-301*). In February, 2008, the D.C. Medical Assistance Administration of the D.C. Department of Health (DOH) became a separate, cabinet-level agency, DHCF, for the administration of the Medicaid program (*D.C. Code § 7-771)* and obtained jurisdiction over matters pertaining to both requirements.

The OHCOBR operates independently of all other government and non-government entities, and is a neutral body dedicated to advocating on behalf of the District's uninsured and underinsured residents, and insurance consumers. The Office maintains its independence by having no direct involvement, participation, investment, interest or ownership in a health care facility, health care service, health benefits plan or provider of a 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 in kind compensation to the Office or its employees.

Finally, the OHCOBR's location in DHCF does not compromise its sovereignty from the other DHCF offices and administrations or other District Government agencies, such as the Department of Insurance Securities and Banking (DISB), the District's insurance regulator. OHCOBR has been working with DISB to route appropriate cases to the Ombudsman's office and to provide an added level of education to private health plan members regarding the assistance that the OHCOBR can provide throughout the entire appeal process. In fact, this collaboration has identified a significant amount of additional cases for transfer to the OHCOBR. Not surprisingly, the increased identification and transfer of cases has also resulted in an increase in DISB's workload which is unsustainable long term. OCHOBR applied for Health and Human Services Consumer Assistance Grant. This grant would be an excellent vehicle for the OHCOBR to maintain and foster its current collaborative relationship with DISB, while possibly being able to source some much needed additional human capital.

## Staffing

The OHCOBR staff consists of six full-time professional staff members including the associate director, three management analysts, a clinical case worker and an outreach coordinator. Each staff person has been assigned a lead role on specific topics, for example eligibility, pharmacy, outreach, grievances and appeals. However, each staff member is able to work on any type of contact made with the Office. In addition, the OHCOBR professional staff is assisted by student interns from local universities.

## Scope of Program Assistance

The OHCOBR provides varied assistance with respect to matters pertaining to the health care of individuals covered by insurance licensed in the District, as well as uninsured and underinsured District residents. At times, to assist consumers in the resolution of their health care issues, the OHCOBR collaborates with other D.C. agencies and organizations in the remediation of consumer disputes in an effort to ensure a timely and efficient resolution. Such entities include but are not limited to the D.C. Office of Administrative Hearings, DHCF Health Care Fraud Unit, D.C. Long-Term Care Ombudsman (affiliated with AARP Legal Counsel for the Elderly), DISB, and the George Washington University Health Insurance Counseling Project (HICP). Cases that are entirely outside the jurisdiction of the OHCOBR are referred to the appropriate entity and are monitored regularly by OHCOBR staff to ensure the timely progression and eventual disposition of the case.

The OHCOBR provides a considerable amount of direct assistance with Medicaid/CHIP and a limited amount to Medicare cases. While the OHCOBR mostly refers Medicare cases to the GW/HICP, OHCOBR is still involved in resolving matters for dual eligible beneficiaries (Medicare and Medicaid) where more than half of its contacts are derived.

Thus far, in its first year of operation, the OHCOBR has maintained a large public insurance case portfolio reflecting the high proportion of D.C. residents on Medicaid and the Alliance. At this juncture, the OHCOBR has been actively pursuing outreach and education methods to increase its access to consumers in the private insurance market. Towards this effort, the OHCOBR has directed DISB to include a notice about the Office on all denial letters and subscribers contacts sent to consumers. Further, DISB has information about the OHCOBR on its website and is gradually developing, in conjunction with the OHCOBR, additional consumer education and outreach materials.

## FY 2010 Activities

During Fiscal Year 2010, the OHCOBR had tracked all communications, or contacts, received. The OHCOBR classified all contacts as "cases" which the Office investigated and strived to bring closure. The OHCOBR staff recorded all contacts in a standardized Health Care Ombudsman In-Take Tracking Log that has specific categories for classifying different cases. These findings summarize data from the In-Take Tracking Log for the Fiscal Year 2010 (October 1, 2009 through September 30, 2010).

In summarizing the activities from the In-Take Tracking Log, the OHCOBR sought to answer the following key questions:

- How do DC residents contact the Office of Health Ombudsman and Bill of Rights?
- Who contacts the Office of Health Care Ombudsman and Bill of Rights?
- What are the most common issues experienced by the community?

During Fiscal Year 2010, the OHCOBR received a total of **3,727** contacts by individuals (consumers) and 1,603 were unique individuals.

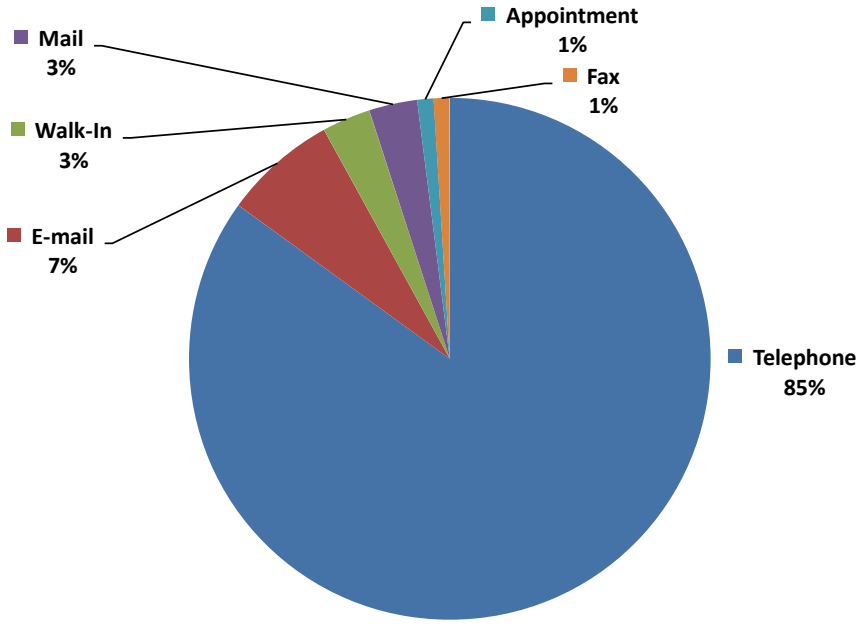
The following sections present findings from the Health Care Ombudsman's In-Take Tracking Log, specifically:

- Methods of contacting the OHCOBR;
- OHCOBR contacts by insurance type;
- OHCOBR contacts by Ward;
- Categories of issues encountered by OHCOBR consumers;
- Categories of issues encountered by consumers by insurance type; and
- Proportion of closed (resolved) cases.

## Methods of Contacting OHCOBR

Methods used by consumers to contact the OHCOBR in Fiscal Year 2010 are presented in **Figure 1**. Over four-fifths of contacts received by OHCOBR were via **Telephone Calls** (3,171 contacts, representing 85% of total contacts). The next most frequent means of communication was via **E-Mails**, which accounted for (283 contacts, representing 7% of total contacts). **Walk-Ins** (98 contacts, representing 3%), **Mail** (98 contacts, representing 3%), **Faxes** (39 contacts, representing 1%), and **Appointments** (38 contacts, representing 1%).

**Figure 1. Methods of Contacting OHCOBR**



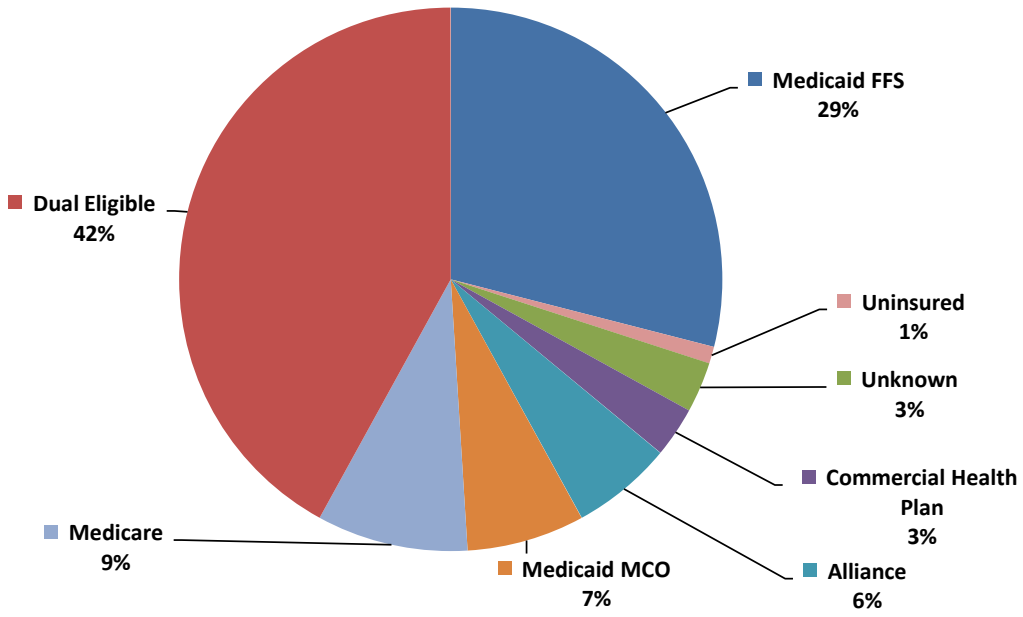

**Total Sample = 3727 contacts**
Source data captured between October 1, 2009, and September 30, 2010

***Data presented in Table A-1 of the Appendix.***

## OHCOBR Contacts by Insurance Type

**Figure 2** presents the number of contacts by insurance type for Fiscal Year 2010. About half of OHCOBR contacts were by ***Dual Eligible (Medicare/Medicaid) beneficiaries*** (1,547 contacts, representing 42%). Contacts by those enrolled in ***Medicaid FFS*** represented the next most common insurance category (1,073 contacts, representing 29%), followed by ***Medicare Part A and/or Part B*** (336 contacts, representing 9%), ***Medicaid Managed Care (MCO)*** (233 contacts, representing 7%), ***Alliance*** (226 contacts, representing 6%), ***Unknown*** (142 contacts, representing 3%), ***Commercial Health Plan members*** (137 contacts, representing 3%), and ***Uninsured*** (33 contacts, representing 1%).

### Figure 2. OHCOBR Contacts by Insurance Type



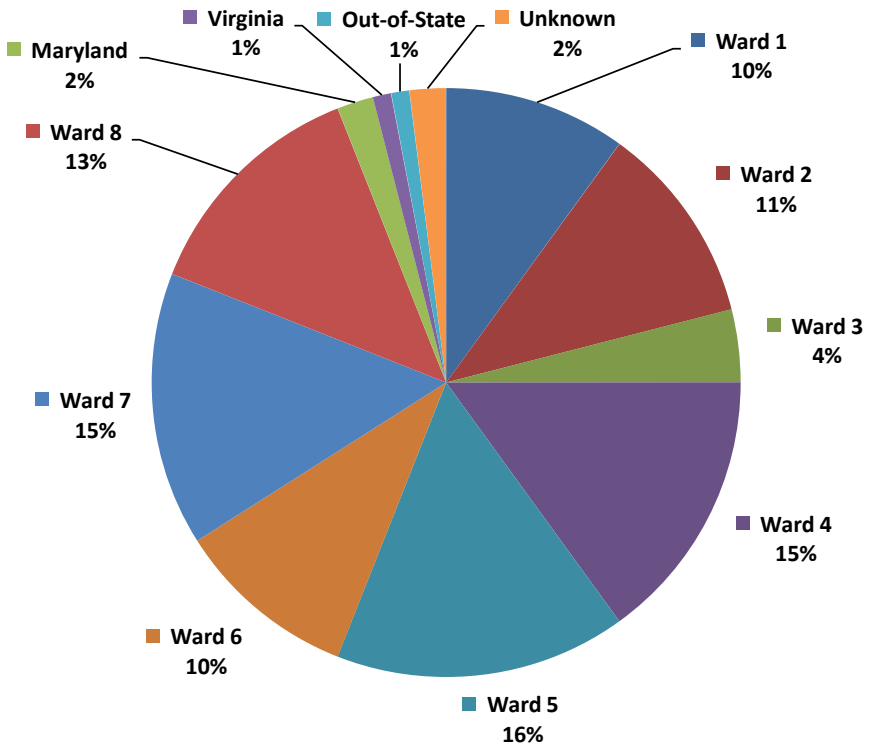

**Total Sample = 3727 contacts**
Source data captured between October 1, 2009, and September 30, 2010

***Data presented in Table A-2 of the Appendix***

## OHCOBR Contacts by Ward

Contacts by Ward for Fiscal Year 2010 are presented in **Figure 3**. The top three Wards in terms of contacts were ***Ward 5*** (573 contacts or 16%), ***Ward 7*** (569 contacts) and ***Ward 4*** (568 contacts), each accounting for 15% of total contacts. These Wards were followed by ***Ward 8*** (494 or 13%), ***Ward 2*** (396 or 11%), ***Ward 1*** (387 contacts) and ***Ward 6*** (384 contacts), each accounting for (10%) of total contacts, and ***Ward 3*** (166 contacts or 4%). **Unknown** (64 contacts or 2%), **Maryland** (64 contacts or 2%), **Out-of-State** (35 contacts or 1%), and Virginia (27 contacts or 1%).

**Figure 3. OHCOBR Contacts by Ward**




**Total Sample = 3727 contacts**

Source data captured between October 1, 2009, and September 30, 2010

***Data presented in Table A-3 of the Appendix***

## Categories of Issues Encountered by Consumers

During the Fiscal Year 2010, the OHCOBR classified all contacts into one of seven broad categories which were recorded in the Heath Care Ombudsman's In-Take Tracking Log. The types of categories were:

- **Access/Facilitation of Services**
- **Eligibility**
- **Coverage**
- **Quality of Services**
- **Pharmacy**
- **Non-Payment/Reimbursement**
- **Other**

Below are examples of consumer issues that would be classified by OHCOBR into these categories. The categories for the example issues are as following:

- ***Access/Facilitation of Services****:* Prior authorization for health services, access to health care benefits (uninsured); assisting beneficiaries in securing medical, dental, durable medical equipment (DME) services or appointments, non-emergency transportation services, etc.

- ***Eligibility****:* Determining eligibility, status of eligibility, assistance with enrollment or recertification in health care programs, explanation of Qualified Medicare Beneficiary (QMB) benefits, etc.

- ***Coverage****:* Appeals and grievances, denial of services (medical, dental, optical, prescriptions, etc.), premiums too high, QMB co-payments, unpaid Medicare Part B premiums (Buy-In), etc.

- ***Quality of Services****:* Medical, dental, durable medical equipment (DME), inpatient services, outpatient services, home health services, optical services, long-term care, etc.

- ***Pharmacy****:* Assistance in securing medications, methods of co-payments, filling prescriptions, etc.

- ***Non-Payment/Reimbursement****:* Non-payment of bills (medical, dental, hospital, emergency room bills), reimbursement of out-of-pocket expenses (medical, hospital, dental bills), etc.

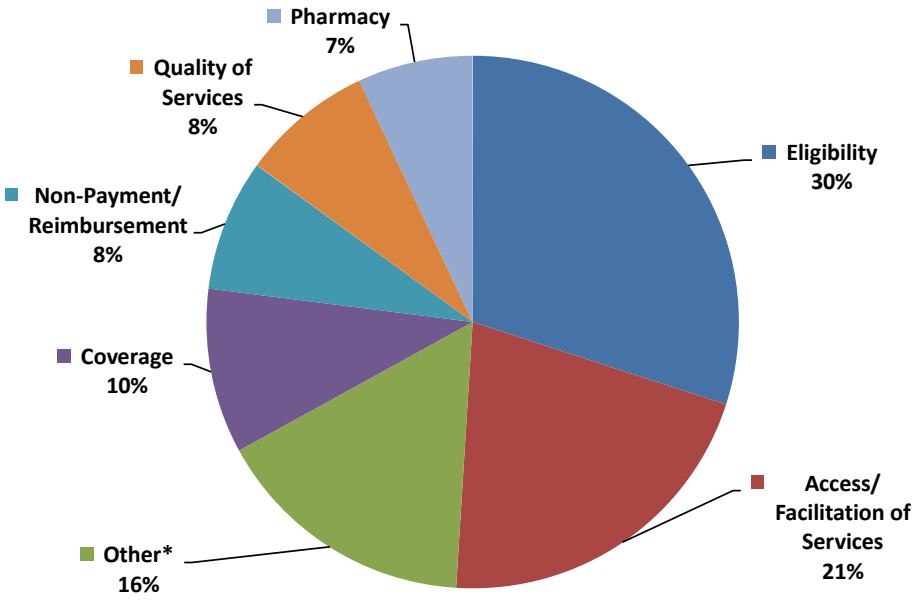
**Categories of Issues Encountered by Consumers (continued)**

- ***Other**:* Anomalous and generic complaints such as banking issues; death certificates; duplicate QMB cards; food stamps; fraud-Medicare/Medicare; termination of Home Health agencies; housing assistance; legal services; names misspelled on QMB cards; non-receipt-QMB cards; and replacement-Medicaid/Medicare/QMB cards; etc.

## Categories of Issues Encountered by Consumers (continued)

Categories of issues for Fiscal Year 2010 are presented in **Figure 4**. The most frequent category of issues encountered by consumers was ***Eligibility***, representing 30% of total contacts (3727 contacts). The next most frequent category of issues was ***Access/Facilitation of Services*** representing 21% of total contacts, and ****Other*** representing 16% of total contacts***. Coverage*** accounted for 10% of total contacts, followed by ***Non-Payment/Reimbursement*** and ***Quality of Services*** (each accounting for 8% of total contacts). ***Pharmacy*** accounted for 7% of total contacts.

**Figure 4. Categories of Issues Encountered by OHCOBR Consumers**




**Total sample =3727 contacts**

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.
Source data captured between October 1, 2009, and September 30, 2010

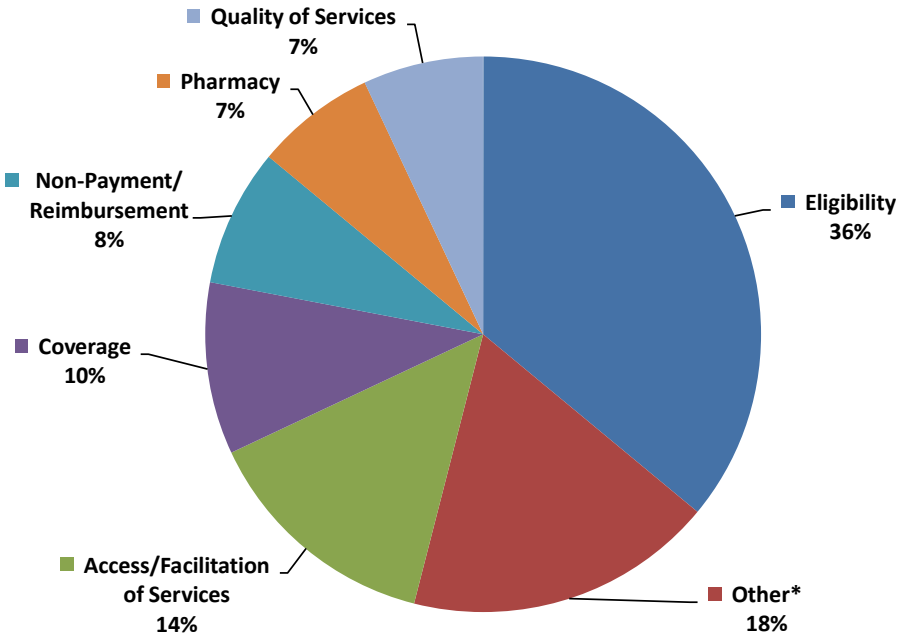
***Data presented in Table A-4 of the Appendix***

## Categories of Issues Encountered by Dual Eligible Beneficiaries (Eligible for Medicare and Medicaid)

The OHCOBR also tracked categories of issues encountered by consumers by type of insurance coverage of the beneficiaries. The following sections provide findings on categories of issues by insurance type for the following insurance categories: Beneficiaries for ***Medicare/Medicaid (Dual Eligible)***, ***Medicaid Fee-for-Service (Medicaid FFS), Medicare Part A and/or Part B), Medicaid Managed Care (Medicaid MCO), Alliance and Commercial Health Plan members***.

Issues encountered by ***Medicare/Medicaid (Dual Eligible) beneficiaries*** in Fiscal Year 2010 are presented in **Figure 5**. The most frequent issue category among the ***Dual Eligible*** was ***Eligibility*** (563 contacts, representing 36%), followed by ****Other*** (277 contacts, representing 18%) and ***Access/Facilitation of Services*** (219 contacts, representing 14%), ***Coverage*** (150 contacts, representing 10%), ***Non-Payment/Reimbursement*** (130 contacts, representing 8%), ***Pharmacy*** (107 contacts), and ***Quality of Services*** (101 contacts) each accounting for 7%).

**Figure 5. Categories of Issues Encountered by Dual Eligible Beneficiaries (Eligible for Medicaid and Medicare)**




**Total sample = 1547 contacts**

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.

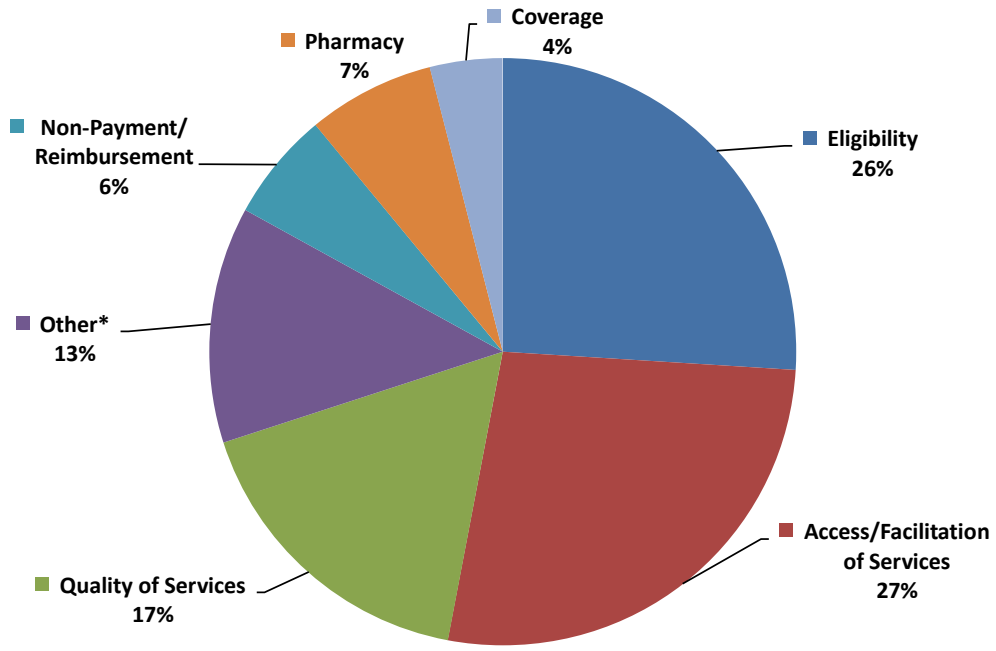
Source data captured between October 1, 2009, and September 30, 2010

***Data presented in Table A-5 of the Appendix***

## Categories of Issues Encountered by Medicaid Fee-for-Service (FFS) Beneficiaries

Issues encountered by ***Medicaid Fee-for-Service (FFS)*** beneficiaries during Fiscal Year 2010 are presented in **Figure 6**. The most frequent issue category among **Medicaid FFS** beneficiaries was ***Access/Facilitation of Services*** (286 contacts, representing 27%) followed by ***Eligibility*** (278 contacts, representing 26%), and ***Quality of Services*** (176 contacts, representing 17%), ****Other*** (139 contacts, representing 13%), ***Pharmacy*** (78 contacts, representing 7%), ***Non-Payment/Reimbursement*** (69 contacts, representing 6%), and ***Coverage*** (47 contacts, representing 4%).

**Figure 6. Categories of Issues Encountered by Medicaid Fee-for-Service (FFS) Beneficiaries**




**Total sample = 1073 contacts**

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.

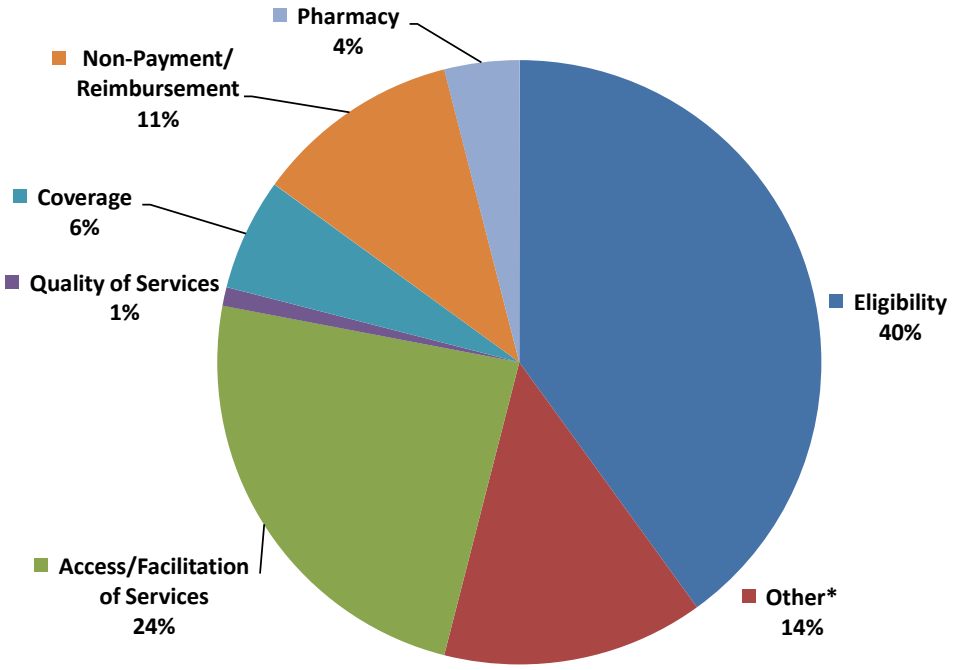
Source data captured between October 1, 2009, and September 30, 2010

***Data presented in Table A-6 of the Appendix***

## Categories of Issues Encountered by Medicare Part A and/or Part B Beneficiaries

Issues encountered by ***Medicare Part A and/or Part B beneficiaries*** during Fiscal Year 2010 are presented in **Figure 7**. The most frequent issue category among ***Medicare Part A and/or Part B beneficiaries*** was ***Eligibility*** (135 contacts, representing 40%), followed by ***Access/Facilitation of Services*** (80 cases, representing 24%), **Other (46 cases, representing 14%), **Non-Payment/Reimbursement** (38 contacts, representing 11%), **Coverage** (20 contacts, representing 6%), **Pharmacy** (12 contacts, representing 4%), and **Quality of Services** (5 contacts, representing 1%)*.

**Figure 7. Categories of Issues Encountered by Medicare Part A and/or Part B Beneficiaries**




**Total sample = 336 contacts**

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.

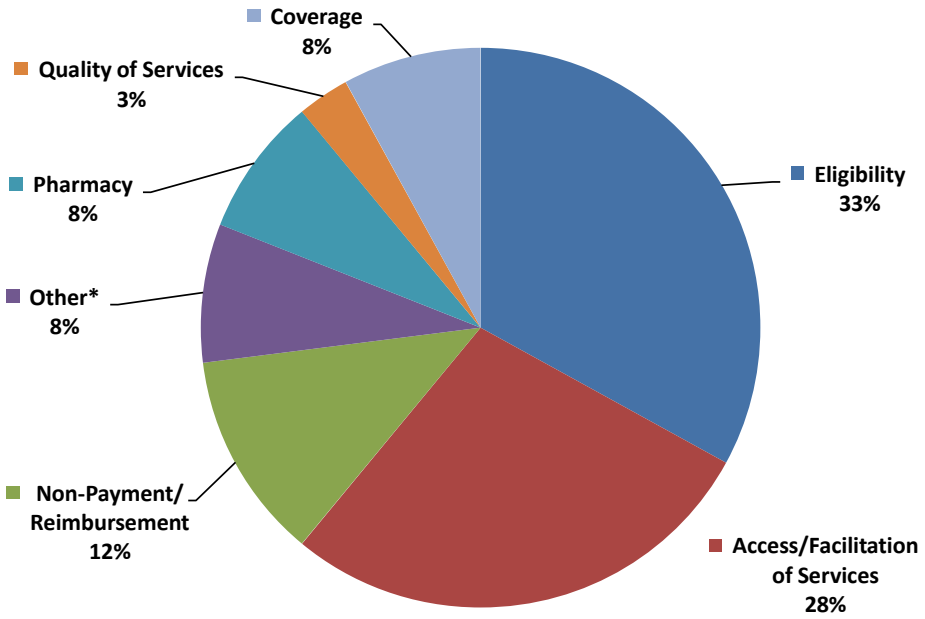
Source data captured between October 1, 2009, and September 30, 2010

***Data presented in Table A-7 of the Appendix***

## Categories of Issues Encountered by Medicaid Managed Care (MCO) Beneficiaries

Issues encountered by ***Medicaid Managed Care (MCO) beneficiaries*** during Fiscal Year 2010 are presented in **Figure 8**. The most frequent issue category among ***Medicaid MCO beneficiaries*** was ***Eligibility*** (77 contacts, representing 33%), followed by ***Access/Facilitation of Services*** (65 contacts, representing 28%) ***Non-Payment/Reimbursement*** (29 contacts, representing 12%), ****Other*** (19 contacts, representing 8%), ***Pharmacy*** (19 contacts) and ***Coverage*** (16 contacts) each accounting for (8%), and ***Quality of Services*** (8 contacts, representing 3%).

**Figure 8. Categories of Issues Encountered by Medicaid Managed Care (MCO) Beneficiaries**




**Total sample = 233 contacts**

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.

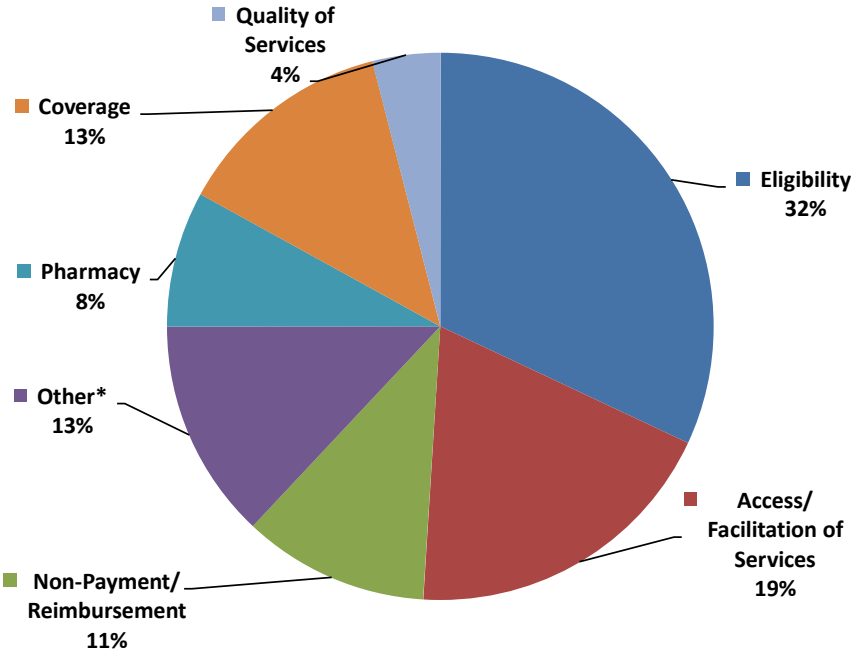
Source data captured between October 1, 2009, and September 30, 2010

***Data presented in Table A-8 of the Appendix***

## Categories of Issues Encountered by Alliance Beneficiaries

Issues encountered by ***Alliance beneficiaries*** during Fiscal Year 2010 are presented in **Figure 9**. The most frequent issue category among ***Alliance beneficiaries*** was ***Eligibility*** (72 contacts, representing 32%), followed by ***Access/Facilitation of Services*** (42 contacts, representing 19%), ***Coverage*** (30 contacts) and ****Other*** (29 contacts) each accounting for (13%), ***Non-Payment/Reimbursement*** (24 contacts, representing 11%), ***Pharmacy*** (20 contacts, representing 8%), and ***Quality of Services*** (9 contacts, representing 4%).

**Figure 9. Categories of Issues Encountered by Alliance Beneficiaries**




**Total sample = 226 contacts**

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.

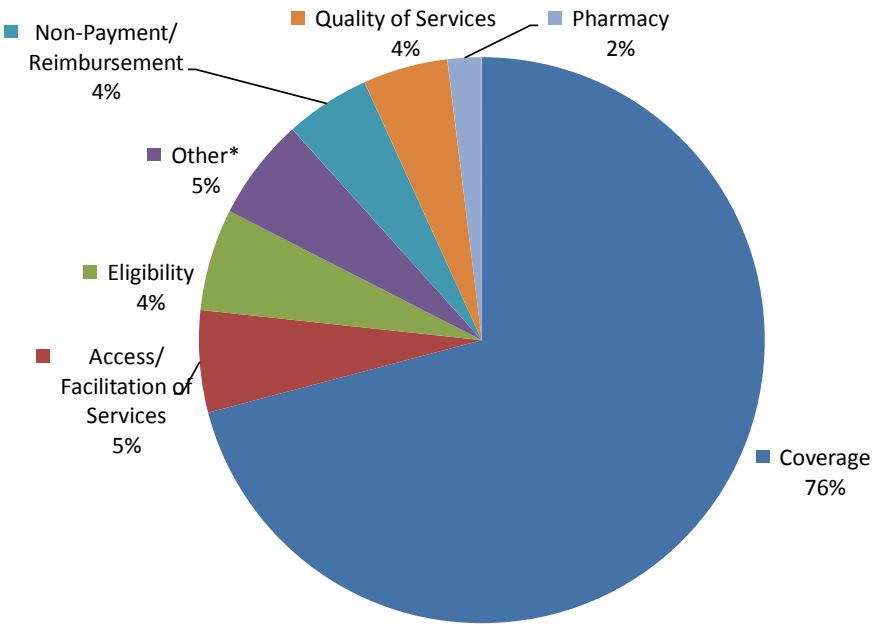
Source data captured between October 1, 2009, and September 30, 2010

***Data presented in Table A-9 of the Appendix***

## Categories of Issues Encountered by Commercial Health Plan Members

Issues encountered by the ***Commercial Health Plan members*** during Fiscal Year 2010 are presented in **Figure 10**. The most frequent issue category among the ***Commercial Health Plan members*** was ***Coverage*** (105 contacts, representing 76%), followed by **Access/Facilitation of Services** (7 contacts) and ***Other*** (7 contacts) each accounting for (5%), ***Eligibility*** (6 contacts), ***Quality of Services*** (5 contacts), and ***Non-Payment/Reimbursement*** (5 contacts) each accounting for (4%), and ***Pharmacy*** (2 contacts, representing 2%).

**Figure 10. Categories of Issues Encountered by the Commercial Health Plan Members**




**Total sample = 137 contacts**

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.

Source data captured between October 1, 2009, and September 30, 2010

***Data presented in Table A-10 of the Appendix***

## Proportion of Closed/Resolved Cases

The number and percent of **closed (resolved) cases** were tracked by OHCOBR during Fiscal Year 2010. Findings on the proportion of closed (resolved) cases for Fiscal Year 2010 are shown in **Table 1**. During this period, the OHCOBR **closed (resolved) 90% (3,355 cases)** out of 3,727 cases in Fiscal Year 2010.

### Table 1. Number and Percentage of Closed/Resolved Cases Among OHCOBR Consumers

| Cases | Totals | Percent (%) |
|---|---|---|
| **Cases Closed/Resolved** | **3355** | **90%** |
| Cases Not Yet Closed/Resolved | 372 | 10% |
| **Total Cases** | **3727** | **100%** |

Source data captured between October 1, 2009, and September 30, 2010

**Proportion of Closed/Resolved Cases (continued)**

The number and percent of **closed (resolved) grievance cases for Commercial Health Plan members** were also tracked by OHCOBR. Findings on the proportion of **closed (resolved) grievance cases** for Fiscal Year 2010 are shown in **Table 2**. During this period, the OHCOBR **closed (resolved) 80 percent (109 cases)** out of 137 cases in the Fiscal Year 2010.

## Table 2. Number and Percentage of Closed/Resolved Grievance Cases Among the Commercial Health Plan Members

| Grievances | Totals | Percent (%) |
|---|---|---|
| **Grievance Cases Closed/Resolved** | **109** | **80%** |
| Grievance Cases Not Yet Closed | 28 | 20% |
| **Total Grievances** | **137** | **100%** |

Source data captured between October 1, 2009, and September 30, 2010

## Significant Achievements

- Designed and implemented the production and distribution of identification cards for Qualified Medicare Beneficiaries (QMB);
- Processed 3,727 cases with a 90% closure rate in FY'10;
- Assisted the consumer in case review to have 55% of the commercial cases sent to Independent Review Organization (IRO) overturned in FY '10;
- Requested 9 cases for reconsideration of commercial insurer denials; 5 of these cases were overturned in FY '10;
- Increased outreach/education efforts:
  - November 7, 2009 – **EXHIBITED** – **AETNA AARP MAGIC at COMMUNITY HEALTH AND FITNESS EXPO** – Approximately **200** Attendees;
  - November 25, 2009 – **EXHIBITED** – **SAFEWAY FEAST OF SHARING** – Approximately **5,000** Attendees;
  - December 9, 2009 – **PRESENTATION** – **DHCF/LONG TERM CARE PROVIDERS** – Approximately **100** Attendees;
  - February 4, 2010 – **PRESENTATION** - **HSCSN** - Approximately **75** Attendees;
  - March 16, 2010 – **SPEAKER** – **ANC-5B03** - Approximately **150** Attendees;
  - August 4, 2010 – **EXHIBITED** – **FREE CLINIC DAY** – Approximately **10,000** Attendees;
  - September 3, 2010 - **EXHIBITED** – **JOINT UTILITY DISCOUNT DAY** - Approximately **8,000** Attendees; and
  - SEPTEMBER 16, 2010 – **EXHIBITED** – **DC CANCER CONSORTIUM ANNUAL FORUM** - Approximately **300** Attendees.
- Established and implemented the healthcare ombudsman email address healthcareombudsman@dc.gov; and
- Applied for the Consumer Assistance Grant provided by the US Dept of Health and Human Services under the Affordable Care Act (ACA) and later awarded the grant.

## Recommendations

### Office of Health Care Ombudsman and Bill of Rights

- Recommend that OHCOBR report to DHCF Director's office to maintain independence and neutrality;
- Increase the number of OHCOBR staff to accommodate the volume of calls and complaints as a result of the Healthcare reform legislation;
- Purchase information technology upgrades:
- Mini-Call Center to respond to consumers' telephone calls more efficiently;
- Database to track and trend complaints, appeals, and grievances received by the office for reporting, and to make recommendations for improvement to the appropriate stakeholders; and
- TTY Line to communicate with the deaf population;
- Incorporate OHCOBR contact information on all correspondences and policies sent to DC based commercial health plan members and Medicaid/Alliance members, and advise them of the existence of the OHCOBR and the availability of assistance at the internal appeal level;
- Improve the process for referrals to and from the Department of Insurance and Security Banking (DISB) for non-contractual related complaints;
- Provide information and forms to file appeals, complaints, and grievances on the DHCF website and OHCOBR, DHCF, and DISB websites;
- Increase the presence of the Office of Health Care Ombudsman and Bill of Rights in the community through education, outreach, and marketing; and
- Change the external appeal information that is currently included in final decision letters to identify the OHCOBR as the entity to submit requests for external reviews.

## Recommendations (continued)

### Legislation

- Amend Bill of Rights law to make the independent review organization (IRO) decisions binding to both the commercial plans and Medicaid;
- Amend Bill of Rights law to extend the time for the internal case review by the OHCOBR;
- Amend Bill of Rights legislation to change program from the authority under Department of Health (DOH) to DHCF;
- Amend Bill of Rights legislation to allow self-insured and Workman's Compensation plans to use DC's external appeals process at their expense; and
- Amend Chapter 20A Health Care Ombudsman Program Act 18-549 to include Workman's Compensation under the term "health benefits plan." This will make it clear that the Healthcare Ombudsman can represent and advocate for DC employees under the Workman's Compensation Program.

**Recommendations (continued)**

### Department of Health Care Finance

- Recommend DHCF Provider Relations Department improve relations with healthcare providers through outreach and education to improve billing practices, understanding of their remittance advices, and understanding of how to assist consumers through appeals including appeals for mental health providers;

- Recommend Office of Preventive and Acute Care (OPAC) work with dental administrative service organization (DentaQuest) to improve the adequacy of their dental network including specialists;

- Recommend the OPAC work to improve the next request for proposal regarding assistance with the elderly and disabled population to ensure the transportation contractor can assist beneficiaries to the vehicle;

- Study the feasibility of providing an attendant on the van for certain special needs population to ensure their safety in transport;

- Enhance processes that identify fraud, waste, and abuse in the use of various modes of transportation utilized by Medicaid beneficiaries;

- Increase random inspections of transportation vehicles to ensure cleanliness, timeliness, and driver's credentials;

- Recommend pricing for all Healthcare Common Procedure Coding System (HCPCS) codes associated with home infusion (namely drug "J" codes and nutritional "B" codes) needs to be completed and transfer the prior authorization process to a Quality Improvement Organization for any procedures, drugs, and supplies which may be required affiliated with home infusion only;

- Recommend that DHCF Program Operations update more frequently the contact information on DC Medicaid website for beneficiaries and providers use;

- Ensure notifications are sent to all Medicaid beneficiaries when their services are terminated, reduced, changed, or altered;

- Work with sister agencies to ensure that their providers are aware of the billing requirements for beneficiaries that receive Medicare and Medicaid services on co-pays and deductibles;

**Recommendations (continued)**

### Department of Health Care Finance

- Work with the Income Maintenance Administration (IMA), DHCF Policy and Planning Administration and Health Care Operations to obtain another program code for SSI beneficiaries currently enrolled in various waiver programs to ensure that the beneficiaries do not lose their Medicaid eligibility while waiting for a level of care;

- Work with IMA to determine which beneficiaries are eligible for Medicare and to begin the buy in process more frequently for this population;

- Collaborate with Sedqwick CMS/DC Risk Management-Workman's Compensation Program to improve service delivery for DC employees receiving health care benefits, coverage, and durable medical equipment;

- Recommend DHCF develop policies for processing hospice and emergency patients' applications needing access to care. These patients are in dire need of services but undergo the same application process as non-emergent care patients;

- Collaborate with DHCF policy unit for clarification on feeding tube policies for Medicaid beneficiaries;

- Recommend DHCF contract with National Rehabilitation Hospital (NRH) to perform Mobility Assessment Evaluations (MAE) for all Medicaid beneficiaries to determine the type of wheelchair required in accordance with medical necessity and assess the specifications for wheelchair requests;

- Provide education to providers on the medical necessary requirements for beneficiaries to receive wheelchairs and other equipment;

- Develop benefits handbook or other literature for covered services provided to Medicaid/QMB beneficiaries;

- Develop the rights and responsibilities for beneficiaries and home health care agencies regarding services provided under the various Medicaid programs;

- Ensure that all home health agencies notify DHCF of all subcontracts they plan to enter into before signing a subcontract agreement and provide to DHCF a list of their subcontractors within three (3) days of DHCF acceptance letter to the home health agency;

**Recommendations (continued)**

### Department of Health Care Finance

- Develop a quality strategy on how to improve service delivery for beneficiaries of Home Health agencies;
- Develop a plan to assess all beneficiaries that are receiving home health services to ensure that the services rendered are medically necessary; and
- Develop policies and procedures to govern how home health agencies assign personal care aides to one or more individuals in the same home.

### Mental Health

- Recommend DISB, DHCF, DOH, and the Department of Mental Health (DMH) provide guidance on what psychotherapy information can be disclosed to the insurance plans and the IRO without compromising the patient confidentiality; and
- Amend District laws and regulations as necessary.

### Other

- Continue to work with George Washington University Health Insurance Counseling Project to provide education to seniors that are eligible for the QMB program;
- Provide outreach to DC employers through the DC Chamber of Commerce about coverage gaps that cause problems for their employees;
- Recommend Department of Disability Services ensure that care coordinators provide correct telephone numbers to Medical Transportation Management (MTM) for transportation requests;
- Propose Department of Human Resources/ Office of the Chief Financial Officer notify employees when they make any changes to their benefits and/or wages to determine if the appropriate deductions are made;
- Recommend that the Office of the Chief Financial Officer, Payroll Department ensure that when adjustments for Medicare withholdings are made that there are no other adjustments done simultaneously, i.e., state and local taxes; and
- Recommend Tax and Revenue review the different types of levies and ensure the timely release of levies to avoid the interruption of services for District residents.

# Appendix

## FY 2010 Activity Data Tables

### Table A-1. Methods of Contacting OHCOBR

| Methods of Contacting OHCOBR | Totals | Contacts (%) |
|---|---|---|
| Telephone | 3171 | 85% |
| Email | 283 | 7% |
| Walk-In | 98 | 3% |
| Mail | 98 | 3% |
| Fax | 39 | 1% |
| Appointment | 38 | 1% |
| **Total Contacts** | **3727** | **100%** |

Source data captured between October 1, 2009, and September 30, 2010

# Table A-2. OHCOBR Contacts by Insurance Type

| Insurance Type | Totals | Contacts (%) |
|---|---|---|
| Dual Eligible (Medicaid/Medicare) | 1547 | 42% |
| Medicaid Fee-for-Service (FFS) | 1073 | 29% |
| Medicare Part A and/or Part B | 336 | 9% |
| Medicaid Managed Care (MCO) | 233 | 7% |
| Alliance | 226 | 6% |
| Unknown | 142 | 3% |
| Commercial Health Plan | 137 | 3% |
| Uninsured | 33 | 1% |
| **Total Contacts** | **3727** | **100%** |

Source data captured between October 1, 2009, and September 30, 2010

# Table A-3. OHCOBR Contacts by Ward

| Ward | Totals | Contacts (%) |
|---|---|---|
| Ward 5 | 573 | 16% |
| Ward 7 | 569 | 15% |
| Ward 4 | 568 | 15% |
| Ward 8 | 494 | 13% |
| Ward 2 | 396 | 11% |
| Ward 1 | 387 | 10% |
| Ward 6 | 384 | 10% |
| Ward 3 | 166 | 4% |
| Unknown | 64 | 2% |
| Maryland | 64 | 2% |
| Out-of-State | 35 | 1% |
| Virginia | 27 | 1% |
| **Total Contacts** | **3727** | **100%** |

Source data captured between October 1, 2009, and September 30, 2010

# Table A-4. Categories of Issues Encountered by OHCOBR Consumers

| Issue Category | Totals | Contacts (%) |
|---|---|---|
| Eligibility | 1121 | 30% |
| Access/Facilitation of Services | 765 | 21% |
| Other * | 600 | 16% |
| Coverage | 368 | 10% |
| Non-Payment/Reimbursement | 316 | 8% |
| Quality of Services | 315 | 8% |
| Pharmacy | 242 | 7% |
| **Total Contacts** | **3727** | **100%** |

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.

Source data captured between October 1, 2009, and September 30, 2010

# Table A-5. Categories of Issues Encountered by Dual Eligible Beneficiaries (Eligible for Medicare and Medicaid)

| Issue Category | Totals | Contacts (%) |
|---|---|---|
| Eligibility | 563 | 36% |
| Other * | 277 | 18% |
| Access/Facilitation of Services | 219 | 14% |
| Coverage | 150 | 10% |
| Non-Payment/Reimbursement | 130 | 8% |
| Pharmacy | 107 | 7% |
| Quality of Services | 101 | 7% |
| **Total Contacts** | **1547** | **100%** |

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.
Source data captured between October 1, 2009, and September 30, 2010

# Table A-6. Categories of Issues Encountered by Medicaid Fee for Service (FFS) Beneficiaries

| Issue Category | Totals | Contacts (%) |
|---|---|---|
| Access/Facilitation of Services | 286 | 27% |
| Eligibility | 278 | 26% |
| Quality of Services | 176 | 17% |
| Other * | 139 | 13% |
| Pharmacy | 78 | 7% |
| Non-Payment/Reimbursement | 69 | 6% |
| Coverage | 47 | 4% |
| **Total Contacts** | **1073** | **100%** |

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.
Source data captured between October 1, 2009, and September 30, 2010

# Table A-7. Categories of Issues Encountered by Medicare Part A and/or Part B Beneficiaries

| Issue Category | Totals | Contacts (%) |
|---|---|---|
| Eligibility | 135 | 40% |
| Access/Facilitation of Services | 80 | 24% |
| Other* | 46 | 14% |
| Non-Payment/Reimbursement | 38 | 11% |
| Coverage | 20 | 6% |
| Pharmacy | 12 | 4% |
| Quality of Services | 5 | 1% |
| **Total Contacts** | **336** | **100%** |

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.
Source data captured between October 1, 2009, and September 30, 2010

# Table A-8. Categories of Issues Encountered by Medicaid Managed Care (MCO) Beneficiaries

| Issue Category | Totals | Contacts (%) |
|---|---|---|
| Eligibility | 77 | 33% |
| Access/Facilitation of Services | 65 | 28% |
| Non-Payment/ Reimbursement | 29 | 12% |
| Other * | 19 | 8% |
| Pharmacy | 19 | 8% |
| Coverage | 16 | 8% |
| Quality of Services | 8 | 3% |
| **Total Contacts** | **233** | **100%** |

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.
Source data captured between October 1, 2009, and September 30, 2010

# Table A-9. Categories of Issues Encountered by Alliance Beneficiaries

| Issue Category | Totals | Contacts (%) |
|---|---|---|
| Eligibility | 72 | 32% |
| Access/Facilitation of Services | 42 | 19% |
| Coverage | 30 | 13% |
| Other * | 29 | 13% |
| Non-Payment/Reimbursement | 24 | 11% |
| Pharmacy | 20 | 8% |
| Quality of Services | 9 | 4% |
| **Total Contacts** | **226** | **100%** |

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.
Source data captured between October 1, 2009, and September 30, 2010

# Table A-10. Categories of Issues Encountered by Commercial Health Plan Members

| Issue Category | Totals | Contacts (%) |
|---|---|---|
| Coverage | 105 | 76% |
| Access/Facilitation of Services | 7 | 5% |
| Other * | 7 | 5% |
| Eligibility | 6 | 4% |
| Quality of Services | 5 | 4% |
| Non-Payment/Reimbursement | 5 | 4% |
| Pharmacy | 2 | 2% |
| **Total Contacts** | **137** | **100%** |

* Other issues include consumer concerns such as banking issues, death certificates, duplicate QMB cards, food stamps, fraud-Medicaid/Medicare, termination of Home Health agencies; housing assistance, legal services, names misspelled on QMB cards, non-receipt-QMB cards, replacement-Medicaid/Medicare/QMB cards, etc.
Source data captured between October 1, 2009, and September 30, 2010