

OFFICE OF HEALTH CARE  
OMBUDSMAN AND BILL OF  
RIGHTS

BIENNIAL REPORT  
FY 2011-2012

When you face health care issues there is  
"Your Health Care Advocate"



★ ★ ★ GOVERNMENT OF THE  
DISTRICT OF COLUMBIA  
VINCENT C. GRAY, MAYOR

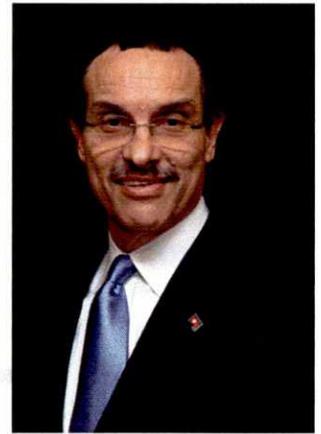


# Table of Contents

◆ MESSAGE FROM THE MAYOR	Page 2
◆ MESSAGE FROM THE DIRECTOR	Page 3
◆ MESSAGE FROM THE HEALTH CARE OMBUDSMAN	Page 4
◆ MEET THE OMBUDSMAN STAFF	Page 5
◆ WHAT IS A HEALTH CARE OMBUDSMAN?	Page 6
◆ OUR SUCCESS STORIES	Page 7
◆ CONSUMER ASSISTANCE PROGRAM GRANTS	Page 8
◆ LEGISLATIVE SUMMARY	Page 9
◆ FY 11-12 SIGNIFICANT ACHIEVEMENTS	Page 10
◆ CONSUMER SATISFACTION SURVEY	Page 11
◆ DATA REPORTS FOR FY 2011-2012	Page 13-18
◆ APPENDIX	Page 19-29
→ TABLES: DATA REPORT FINDINGS	
→ INSURERS' ANNUAL REPORT FY 11	
→ QUICK REFERENCE SHEET	

# A Word From the Mayor

FY 2011-2012 OHCOBR ANNUAL REPORT



## **Message from Mayor Vincent C. Gray:**

I am pleased to present, along with Chief Health Care Ombudsman Maude R. Holt, the 2011-2012 Biennial Report of the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) in the Department of Health Care Finance.

OHCOBR provides residents with assistance in navigating the District's health care system. The staff of OHCOBR works to educate consumers through advocacy, education, community outreach initiatives and interventions.

The District of Columbia is at the vanguard and is poised to become a leader in providing access to comprehensive, coordinated and quality health care to all District residents. The Office of Health Care Ombudsman and Bill of Rights will play a pivotal role as we transition into DC Health Link, the new health insurance marketplace that will begin enrollment in October 2013.

I applaud the work of Maude Holt and the OHCOBR staff for their compassion and commitment to the residents of the District of Columbia.

Thank You !

  
Vincent C. Gray



# A Word From Our Director

FY 2011-2012 OHCOBR ANNUAL REPORT



Message from Director Turnage:

We are proud to have the Office of Health Care Ombudsman and Bill of Rights in the Department of Health Care Finance (DHCF). This two year annual report for Fiscal Years (FY) 2011-2012 reflects the accomplishments of the Ombudsman's Office. In FY 2011, the Ombudsman's Office underwent many systematic changes for the enhancement of service delivery and to meet the needs of the people that they serve in the District of Columbia.

In FY 2011, the Ombudsman's Office filed 68 administrative hearings for Medicaid beneficiaries for services that were denied, changed, altered and/or terminated. In addition, the Ombudsman's Office received 109 appeals from consumers enrolled in commercial insurance plans.

In FY 2012, the Ombudsman's Office served over 4,400 individuals who are insured, underinsured, and without insurance. The Ombudsman's Office filed over 100 administrative hearings for Medicaid beneficiaries for services that were denied, changed, altered and/or terminated. In addition, the Ombudsman's Office received 120 appeals and 31 inquiries from consumers enrolled in commercial insurance plans.

The Health Care Ombudsman Advisory Council continues to play an integral role in guiding the Ombudsman's Office staff with their input, expertise, and knowledge of the health care arena. Their contributions were used to improve the clinical review of cases, the amendments to the Bill of Rights laws, and the education of consumers about their health care coverage and benefits. We would like to thank the Health Care Ombudsman Advisory Council for their time and effort for improving health care access for the residents of the District of Columbia.

In FY 2011, the Department of Employment Services' volunteer and local college students interned with the Ombudsman staff. The interns and volunteer demonstrated their compassion and dedication in helping individuals when handling complaints about health care benefits and services. Additionally, the Ombudsman's Office collaborated with the District of Columbia Office of Risk Management Return to Work Program and welcomed five employees to help resolve consumers' health care issues. The Ombudsman's Office continues to educate consumers about their health plans as well as how to navigate the District of Columbia health care system.

It is my pleasure to congratulate the Ombudsman's Office staff members, volunteers, interns and return to work employees for a job well done!

Thank you!

A handwritten signature in blue ink that reads "Wayne S".

Wayne Turnage, MPA.  
Director, Department of Health Care Finance



# A Word from the Health Care Ombudsman

FY 2011-2012 OHCOBR ANNUAL REPORT



## It is with great pride that we issue the Office of Health Care Ombudsman and Bill Of Rights Biennial Report

The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is authorized by the Council of the District of Columbia through 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 goal of the OHCOBR is to provide assistance to consumers while addressing issues related to health insurance coverage. OHCOBR is charged with achieving this goal on behalf of residents of the District of Columbia and individuals who are insured by plans that originate in the District of Columbia. The OHCOBR officially opened April 1, 2009.

The mission of the OHCOBR is to ensure the well-being of consumers through advocacy, education and community outreach efforts that are intended to improve access to health care services. OHCOBR focuses on assisting consumers who are insured, uninsured, and underinsured. OHCOBR faces a variety of issues including denials of medical treatment or services, issues related to eligibility and enrollment into Federal, local, and private insurance plans, and ensuring that the services requested by the consumer are appropriate and timely.

OHCOBR made advances in recovering dollars for consumers who were impacted by improper medical billing and untimely buy-ins. Additionally, OHCOBR also worked to amend District of Columbia laws that will continue to protect the rights of the consumers that we serve.

If you have any questions concerning your health care coverage, or would like to appeal the denial of your health care insurance company, please contact the Office of Health Care Ombudsman and Bill of Rights by phone at (877) 685-6391 or via email at [healthcareombudsman@dc.gov](mailto:healthcareombudsman@dc.gov).

Thank you.

A handwritten signature in black ink, appearing to read 'Maude R. Holt'. The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Maude R. Holt MBA

Health Care Ombudsman for the District of Columbia

# Meet the Ombudsman Staff



Charlita R. Brown, BS  
Associate Health Care Ombudsman  
Senior Appeals Examiner



L. Darnell Lee, MPH, RN, CPM  
Associate Health Care Ombudsman  
Director of Clinical Services



Kivon L. Allen, BS  
Associate Health Care Ombudsman



Chaise Lancaster, BA  
Associate Health Care Ombudsman



Daisha Watson  
Student Intern



Omari Stewart  
Student Intern



Paula Humphries  
Community Volunteer



Aminata Jalloh  
Student Intern

*\*Not Shown = Carmencita Kinsey, Education/Outreach Coordinator  
Additional Staffers, Interns, Volunteers*

# What is a Health Care Ombudsman?

A Health Care Ombudsman is an individual who investigates complaints by consumers regarding health care issues with their health plan or provider. A Health Care Ombudsman should be a neutral mediator in dispute resolution, with the ability to investigate and make recommendations – without authority to make or reverse a decision. He or she must also be able to work objectively and without influence from representatives and Administrators of the Government. A Health Care Ombudsman should inform consumers and help them understand their health care rights and responsibilities; help consumers resolve problems with health care coverage, access to health care, and issues regarding health care bills; and advocate on behalf of consumers until their health care needs are addressed and resolved.

If members of a commercial health plan are denied a medical service or the insurer denies payment of a specific service, the health plan members have a right to appeal the denial of service. The Ombudsman's Office received and processed approximately 109 appeals in FY 2011 and 120 appeals in FY 2012. Once a member requests an external appeal, the Ombudsman's Office contacts the health plan, treating physician, facility, and any other involved entity to obtain the medical documentation to support the appeal. At this point, the Ombudsman staff will request that the insurer reconsider its denial before it is sent for review by an independent review organization. This process has been successful and we are trying to do a better job in having the insurer reconsider denials.

Referrals are made to the Department of Insurance, Securities and Banking (DISB) for assistance when a denial relates to a coverage issue, policy interpretation or when a member has a complaint against an insurance company. The Ombudsman's Office gathers all of the pertinent information from the member, health insurer and other medical sources and forwards the file to DISB to resolve.

If the appeal is made by an employee of the Federal Government, the same process is performed as with DISB, but the appeal is forwarded to Office of Personnel Management to resolve.



## *Our Success Stories*

OHCOBR received a request for an external appeal because the health plan member had been suffering from migraine headaches for a long time which even resulted in her missing a lot of time from work and performing normal daily activities. Her doctor found that “botox” has been used to treat migraines and began treating the member. The insurance company denied the use of “botox” for the treatment of migraines because its use was considered experimental/investigational. Medical and scientific evidence about botox being used to treat migraines and additional findings were submitted to the insurer for reconsideration. The insurer upheld the denial. Subsequently, the case was forwarded to the independent review organization, who, with the additional research, reversed the insurer’s decision.

OHCOBR received a request from a member’s sister who had paid for her long-term care services for over a year because she was unable to get the member approved for Medicaid. OHCOBR was able to assist with establishing Medicaid eligibility for the beneficiary. The sister was reimbursed \$20,000 for the cost she expended in home health care (personal care aide, health and long-term care) during that period.

OHCOBR received a request for an external review because the insurer denied a claim due to the service being considered experimental/investigational. Service requested was Positron Emission Tomography (PET) scan. The claim amount totaled \$5,550 and would be billed to the member because the service was already provided. Upon gathering further evidence which included comments from various medical experts, discovering a previous case in which the insurers’ own medical director attests to the efficacy of the service, and finding an Order from the Commissioner of Michigan’s Office of Financial and Insurance Regulation in which the insurer’s denial was reversed, a reconsideration letter was submitted to the insurer asking that they review the case and reverse their decision. In accordance with the contract and OHCOBR’s request, the claim for PET scan was reviewed and approved.

OHCOBR successfully resolved a Dual Eligible beneficiary’s Durable Medical Equipment (DME) case referred to us by the Executive Office of the Mayor. The beneficiary’s motorized wheelchair was taken during an eviction from her residence in April 2012. The beneficiary did not report the incident to the DC Metropolitan Police Department; therefore, there was no police report on record. Due to the complexity of the case and multiple collaborations among inter-agencies, the beneficiary was able to obtain another motorized wheelchair on March 8, 2013.

OHCOBR received contact from a gentleman whose personal care aide stopped coming to his residence. He was concerned and contacted the Ombudsman’s Office because he received a letter that he could not read. It was determined that the beneficiary received a termination of benefits letter which meant that he lost his Medicaid benefits because the home health agency failed to recertify him for the Elderly Persons with Disabilities (EPD) waiver. He became ill and was taken to the emergency room. An analysis of the beneficiary’s Medicaid eligibility was conducted and determined that he initially had EPD waiver benefits that had lapsed and was converted to state plan benefits. At that time, the State Plan recertification was due. The beneficiary was unaware of his responsibility to recertify because this was always the responsibility of the home health agency. Thus, the beneficiary lost all of his Medicaid benefits and became uninsured which was determined at the time of his emergency room visit. OHCOBR staff collaborated with DHCF’s General Counsel in order to get the EPD waiver services re-instated.

# Consumer Assistance Program Grants

Since 2009, the District of Columbia has, through the Office of Health Care Ombudsman and Bill of Rights (OHCOBR), operated a consumer assistance program to solve consumer complaints related to program eligibility, health services, prescription drug access, insurance coverage, reimbursement for health services and quality of care for District residents and individuals covered by insurers licensed in the District. In the first year of operation, OHCOBR provided assistance to nearly 4,000 individuals utilizing appropriations, Federal Medicaid funds, and Bill of Rights funds.

In Fiscal Year (FY) December 2010, OHCOBR was awarded a Consumer Assistance Program (CAP) grant by the U.S. Department of Health and Human Services in the amount of \$149,888. OHCOBR used the grant funds to improve its program in three important ways. First, OHCOBR developed its technological infrastructure by purchasing technological software and equipment. Second, OHCOBR staff received monthly comprehensive training on specific-related topics to better equip them to resolve complaints/grievances more effectively and efficiently and to enhance their skills to improve case management through a rigorous training and case review process. Third, OHCOBR staff joined the International Ombudsman Association, in which they function and strictly adhere to the Association's Code of Ethics in the execution of their responsibilities.

In FY 2012, OHCOBR was awarded two grants by the U.S. Department of Health and Human Services: Limited Competition for Affordable Care Act Consumer Assistance Program in the amount of \$127,967 and Affordable Care Act Consumer Assistance Program in the amount of \$200,000 respectively. The Limited Competition for Affordable Care Act Consumer Assistance Program grant offers an opportunity to market the Ombudsman's Office and the Consumer Assistance Program to the public by (1) establishing a unique recognizable brand for the Office, (2) developing and executing a media campaign, and (3) producing marketing and educational materials and advertisements for distribution throughout the District of Columbia. It also included funding a new and innovative neighborhood outreach program called *Health Care on Tap* that takes health care education into local restaurants, bars, and non-traditional public/private locations.

The Affordable Care Act Consumer Assistance Program grant offers another opportunity to expand the Office of Health Care Ombudsman and Bill of Rights efforts to market our services and the CAP to the public, by adding funds to the current marketing/media campaign for an additional three to five month focused effort that specifically and strategically target non-English speaking communities, producing a culturally specific initiative to engage the District's diverse population. Additionally, the grant offers funding for training of the Ombudsman staff on a number of important topics including the Supreme Court decision, changes to local laws, and assisting consumers with accessing premium tax credits.

The OHCOBR has and is utilizing these grants to enrich the quality of services that it provides to District residents and individuals covered by insurers licensed in the District of Columbia.

# Legislative Summary

The Health Benefits Plan Members Bill of Rights Act of 1998 was established so that health plan members could appeal denials of coverage for health care services. An external appeals process was put in place for that purpose. The Office of Health Care Ombudsman and Bill of Rights receives and processes these appeals.

The Affordable Care Act (ACA) was passed by Congress in 2010 setting new standards for states related to health care, including grievance and appeals. The Federal rules set forth several minimum protections that states had to implement before January 1, 2012. The District of Columbia's existing grievance and appeals process was mostly sufficient to meet the minimum protections required. In order to comprehensively meet the minimum protections, the District of Columbia passed emergency and temporary legislation in September and October of 2011. The legislation that was passed was that the period for filing an appeal was extended to four (4) months and the decision of the independent review organization was made binding. The Health Benefits Plan members Bill of Rights Act of 2012 ensures that the District of Columbia remains compliant with the Federal law when the temporary legislation expires.

All Federal requirements must be implemented by the District by January 1, 2014 and if not, then plans must use a federally administered process.



# *Significant Achievements*

## **FY 2011 ACCOMPLISHMENTS**

Amended the Bill of Rights law to increase time to file appeal to 4 months and makes the independent review organization decision binding

Conducted telephone Satisfaction Survey informing us about the level of success and professionalism in the Office

Began the process of referring DC residents with pre-existing conditions to the PCIP Program and Blue Choice (HMO) Open Enrollment for DC residents only, which is a full service health plan

Began tracking transportation services (157 cases) and EPD waiver services (543 cases) because of the uptick in frequency

Created the Health Care Ombudsman and Bill of Rights Website

Created the Health Care Ombudsman and Bill of Rights official email address

Registered membership of all Ombudsman staff in the International Ombudsman Association (IOA)

## **FY 2012 ACCOMPLISHMENTS**

Received Economic Security Administration (ESA) buy-in reports to Ombudsman's office on a monthly basis

Re-assigned duties of Ombudsman staff to monitor administrative hearing requests and grievance and appeals

Created Peer Reviewer and Provider checklists to send to insurers, providers and reviewers to obtain background and clinical credentials of those who make appeal decisions and recommendations

Assisted the Department of Health Care Finance in drafting the handbook for Fee For Service beneficiaries that is on its website including the Ombudsman's Office information to contact for assistance

Overtured 70% of commercial denials

Awarded 2 grants: a) Limited Competition for Affordable Care Act (ACA) Consumer Assistance Program Grant; and b) ACA Consumer Assistance Program Grant - both designed to help market the Ombudsman's Office and educate consumers about their rights and responsibilities as an insured person and to assist them on how to file a grievance and appeal

Increased staff to accommodate the volume of calls and complaints as a result of Health Care Reform legislation and the proposed increase in community outreach activities

# Consumer Satisfaction Survey

The Office of Health Care Ombudsman and Bill of Rights conducted a Consumer Satisfaction Survey for FY 2011. The sample size comprised of a random selection of consumers who contacted the Ombudsman's Office inquiring about an array of health care issues. The data collected was information germane to the efficiency of office function and procedures. The nine (9) questions highlighted during the survey were:

- ◆ How did you hear about the Office of Health Care Ombudsman and Bill of Rights?
- ◆ Was this the first time you had assistance from this office?
- ◆ Were you satisfied with the ease of contacting this office?
- ◆ How satisfied were you with the promptness with which your call was returned?
- ◆ How satisfied were you with our efforts to follow up and keep you informed while your case was being handled?
- ◆ Were you able to resolve your issue? If not, what could we have done to resolve your issue?
- ◆ How would you rate your overall satisfaction with how we handled your issue/complaint?
- ◆ How likely would you contact us again if you needed assistance on another issue?
- ◆ Would you refer a friend, family member, or colleague to the Office of Health Care Ombudsman and Bill of Rights?

There were 900 consumers telephoned during the survey process in order to establish a significant valid sample size of 331. Due to many barriers presented by the population served, only 101 consumers responded to the satisfaction survey.

The Consumer Satisfaction Survey measured how our services and assistance met or surpassed customer expectations. The results revealed that 33% of respondents heard about the Ombudsman's Office by word of mouth; 80% used the Ombudsman service for the first time; 89% were satisfied with the ease of contacting the Ombudsman; 64% were satisfied with the promptness in which their call was returned; 70% were satisfied with the Ombudsman efforts to follow up and provide a status update on their case; 81% indicated that their issue was resolved; 77% were overall satisfied with how their case was handled; and 86% were very likely to contact the Ombudsman again. For more detail of the Consumer Satisfaction Survey results, [see Page 20](#).

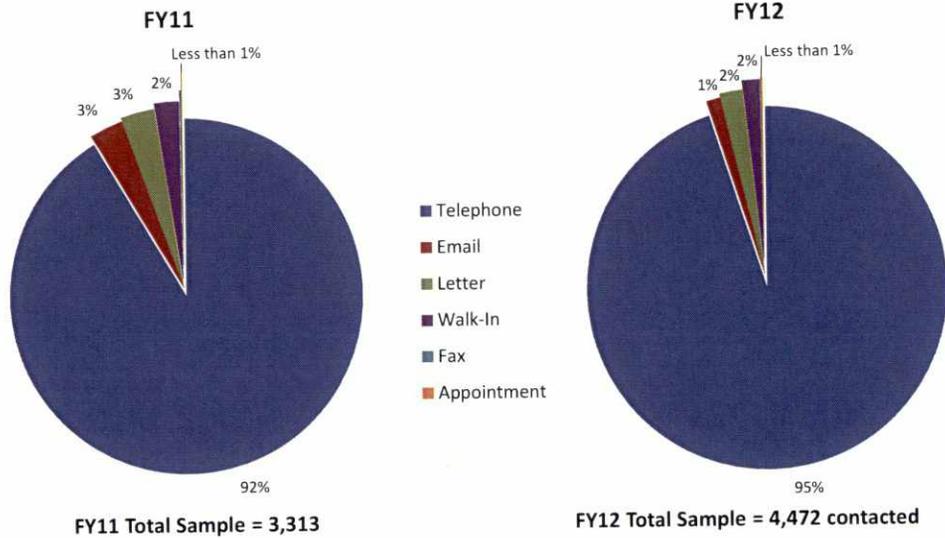
The results of the Consumer Satisfaction Survey are vital indicators of consumer content with the Office of Health Care Ombudsman and Bill of Rights. In addition, the results revealed other areas that should be utilized to assist with identifying alternative methodologies to remediate grievances and appeals, and also for the training of staff members.



# FY 2011-2012 DATA COLLECTION REPORT

# DATA COLLECTION REPORT

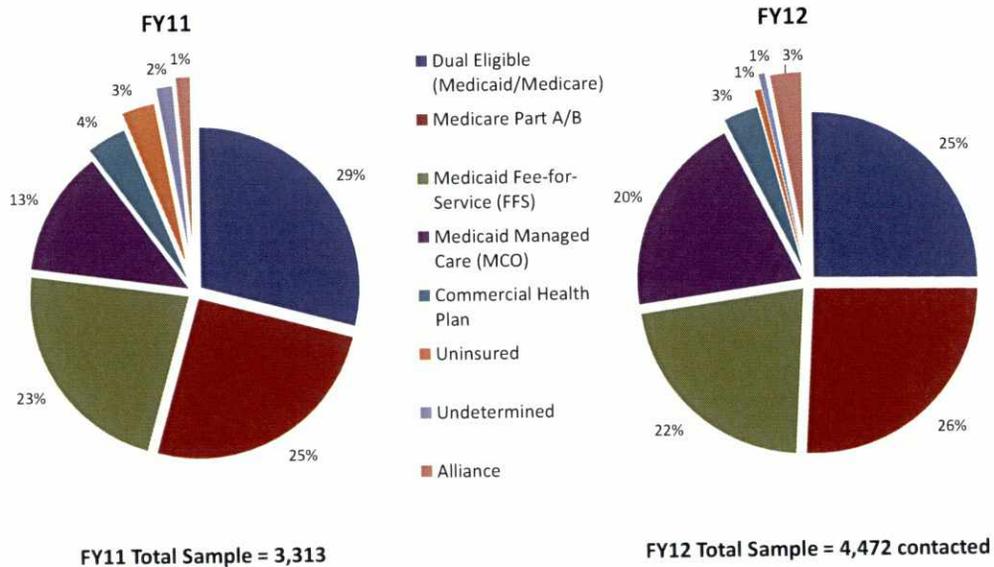
**Figure 1. Methods of Contacting OHCOBR  
FY11 and FY12**



Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

3

**Figure 2. OHCOBR Contacts by Insurance Type  
FY11 and FY12**

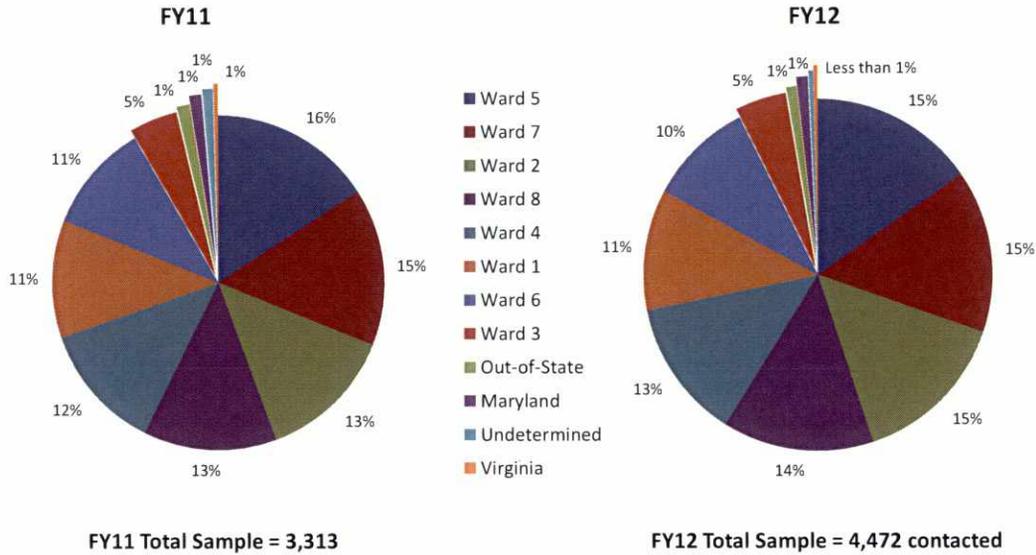


Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

5

# DATA COLLECTION REPORT

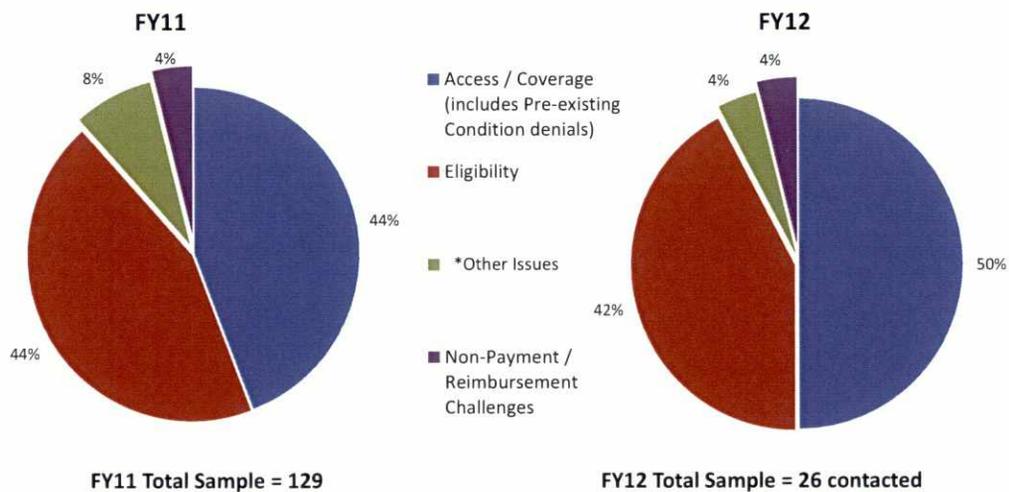
**Figure 3. OHCOBR Contacts by Ward—FY11 and FY12**



Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

7

**Figure 4. Categories of Issues Encountered by Uninsured Consumers—FY11 and FY12**



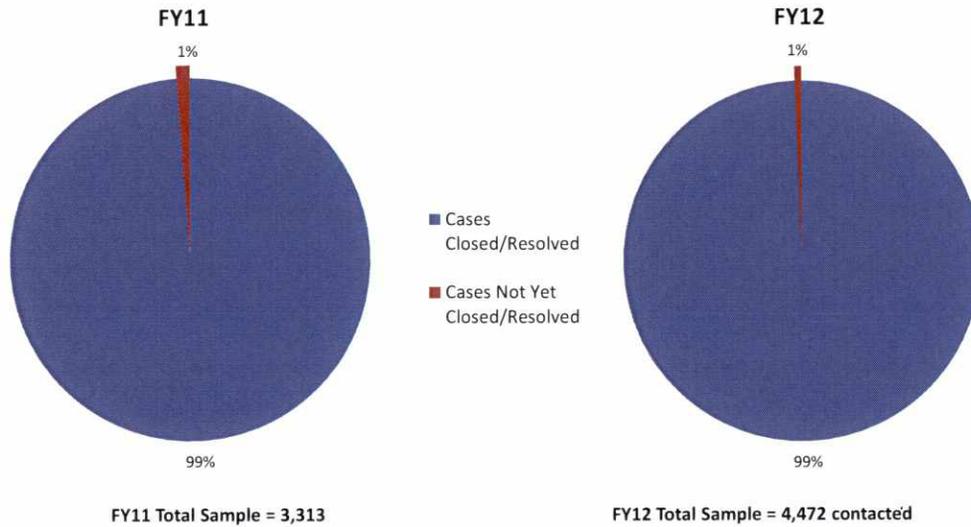
\*Other Issues: Anomalous and generic complaints such as auto repairs; banking issues; burial assistance; death certificates; duplicate QMB ID cards; food stamps; fraud-Medicaid/Medicare; housing assistance; legal services; name/address change; names misspelled on QMB ID cards; non-receipt-QMB cards; replacement of Medicaid/Medicare/MCO/QMB ID cards; and responses to Department of Health Care Finance's (DHCF) correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage; etc.

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

27

# DATA COLLECTION REPORT

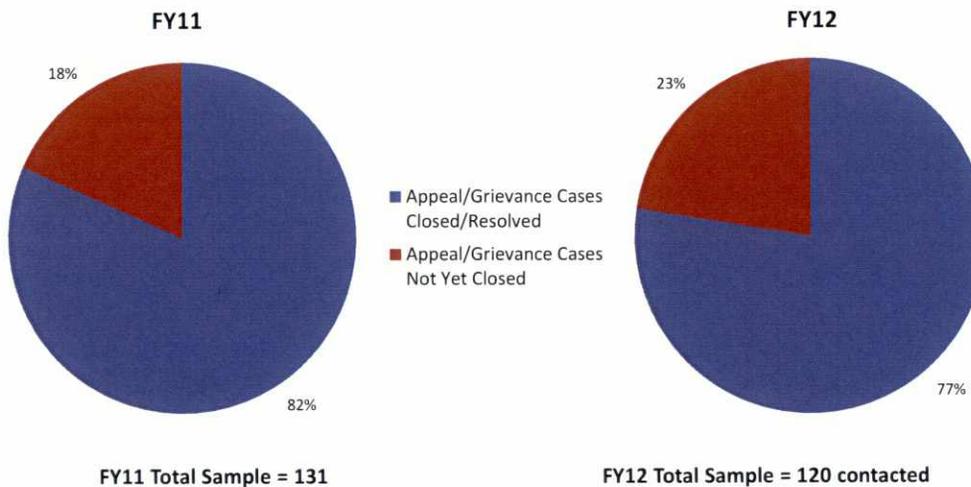
**Figure 5. Number and Percentage of Closed/Resolved Cases Among OHCOBR Consumers—FY11 and FY12**



Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

37

**Figure 6. Number and Percentage of Closed/Resolved Appeal/Grievance Cases (Bill of Rights) Among the Commercial Health Plan Members—FY11 and FY12**

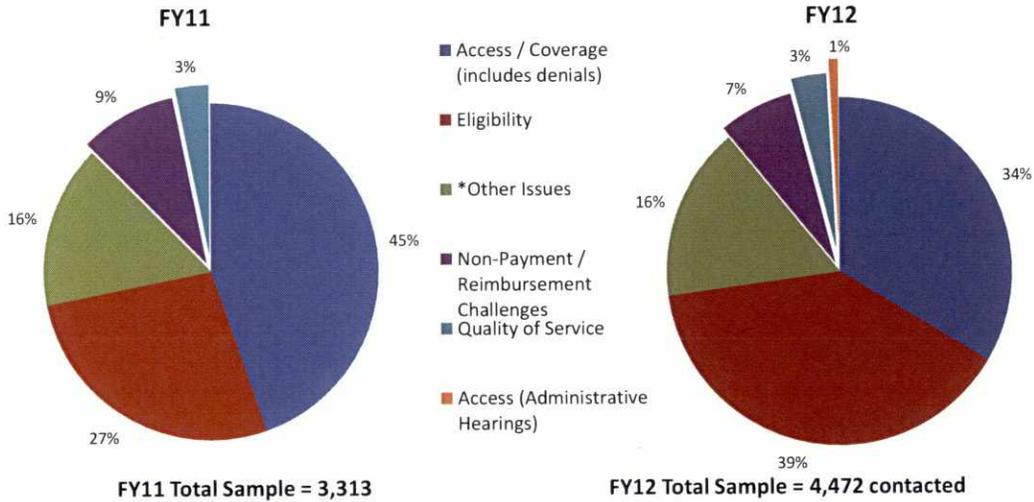


Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

39

# DATA COLLECTION REPORT

## Figure 7. Categories of Issues Encountered by Consumers—FY11 and FY12

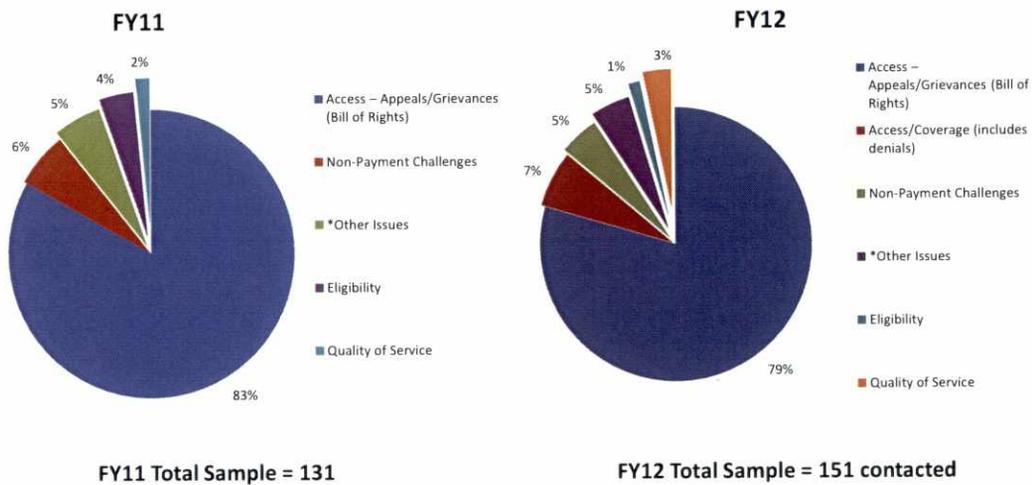


\*Other Issues: Anomalous and generic complaints such as auto repairs; banking issues; burial assistance; death certificates; duplicate QMB ID cards; food stamps; fraud-Medicaid/Medicare; housing assistance; legal services; name/address change; names misspelled on QMB ID cards; non-receipt-QMB cards; replacement of Medicaid/Medicare/MCO/QMB ID cards; and responses to Department of Health Care Finance's (DHCF) correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage; etc.

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

11

## Figure 8. Categories of Issues Encountered by Commercial Health Plan Members—FY11 and FY12



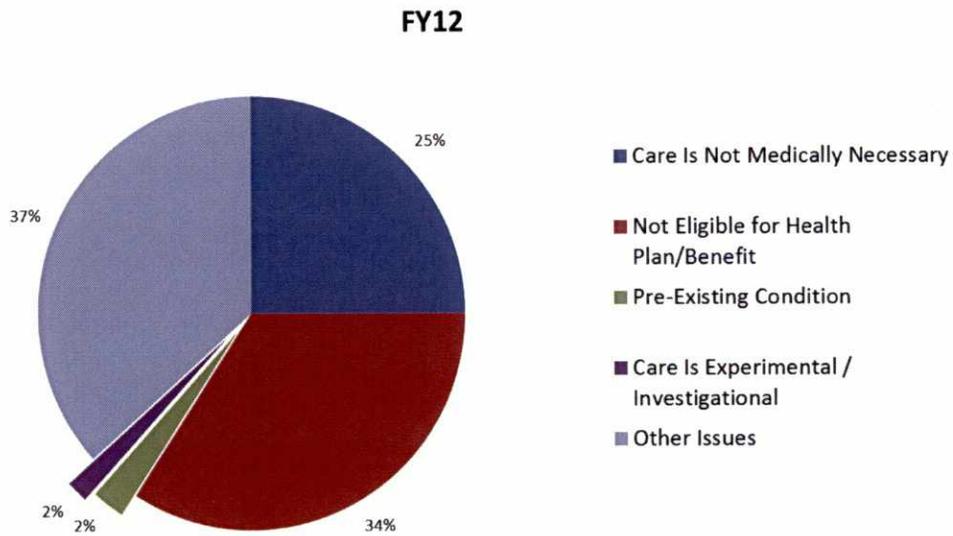
\*Other Issues: Anomalous and generic complaints such as auto repairs; banking issues; burial assistance; death certificates; duplicate QMB ID cards; food stamps; fraud-Medicaid/Medicare; housing assistance; legal services; name/address change; names misspelled on QMB ID cards; non-receipt-QMB cards; replacement of Medicaid/Medicare/MCO/QMB ID cards; and responses to Department of Health Care Finance's (DHCF) correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage; etc.

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

23

# DATA COLLECTION REPORT

**Figure 9. Categories of Types of Appeal/Grievance Cases (Bill of Rights) Encountered by Commercial Health Plan Members--FY12**



**Total Sample = 120 contacted**

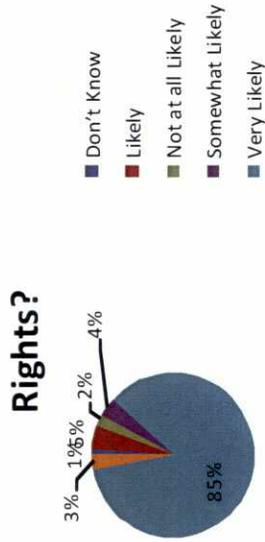
Source data captured between October 1, 2011 through September 30, 2012

25

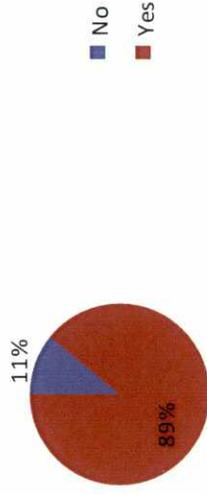
# APPENDIX

# Consumer Satisfaction Survey Results

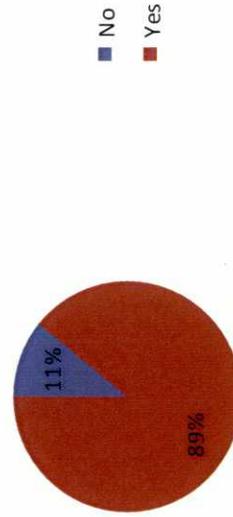
**Would you refer a friend, family member, or colleagues to the Office of Ombudsman and Bill of Rights?**



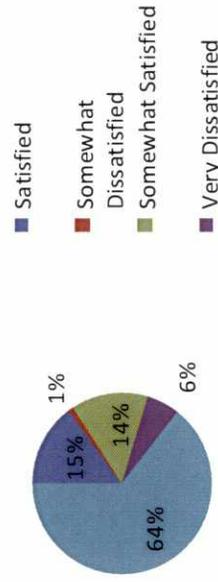
**Q2: Was this the first time you had assistance from this office?**



**Q3: Were you satisfied with the ease of contacting us?**

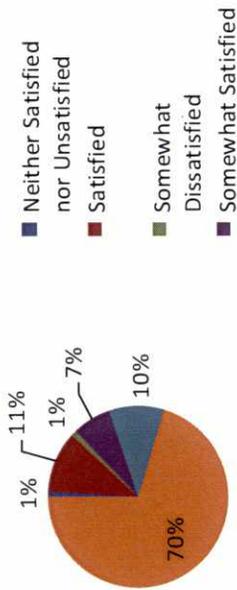


**Q4: How satisfied were you with the promptness with which your call was returned?**

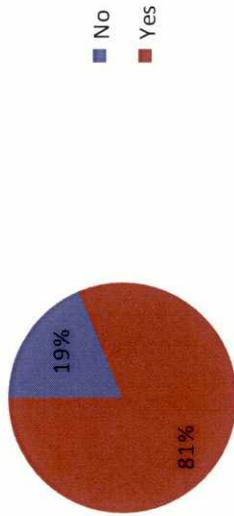


# Consumer Satisfaction Survey Results

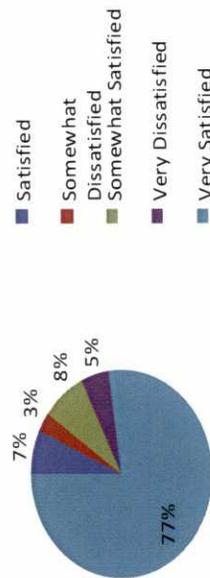
**Q5: How satisfied were you with our efforts to follow up and keep you informed...**



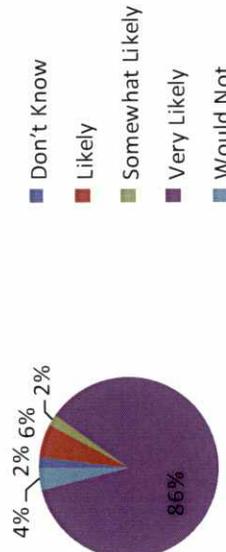
**Q6a: Were you able to resolve your issue?**



**Q7: In general, how would you rate your overall satisfaction with how we handled your issue/complaint?**



**Q8: How likely would you contact us again, if you needed assistance on...**



**Table 1. Figure 1 – Methods of Contacting OHCOBR--FY11 and FY12**

Methods of Contacting OHCOBR	FY11 Totals	FY11 Contacts (%)	FY12 Totals	FY12 Contacts (%)
Telephone	3027	90%	4247	95%
Email	102	3%	56	1%
Letter	102	3%	91	2%
Walk-In	75	2%	70	2%
Fax	5	1%	2	Less Than 1%
Appointment	2	1%	6	Less Than 1%
<b>Total Contacts</b>	<b>3313</b>	<b>100%</b>	<b>4472</b>	<b>100%</b>

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

**Table 2. Figure 2 - Contacts by Insurance Type--FY11 and FY12**

Insurance Type	FY11 Totals	FY11 Contacts (%)	FY12 Totals	FY12 Contacts (%)
Dual Eligible (Medicaid/Medicare)	962	29%	1126	25%
Medicare Part A/B	840	25%	1150	26%
Medicaid Fee-for-Service (FFS)	752	23%	976	22%
Medicaid Managed Care (MCO)	420	13%	882	20%
Commercial Health Plan	131	4%	151	3%
Uninsured	109	3%	26	1%
Undetermined	52	2%	25	1%
Alliance	47	1%	136	3%
<b>Total Contacts</b>	<b>3313</b>	<b>100%</b>	<b>4472</b>	<b>100%</b>

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

# APPENDIX

**Table 3. Figure 3 - Contacts by Ward--FY11 and FY12**

Ward	FY11 Totals	FY11 Contacts (%)	FY12 Totals	FY12 Contacts (%)
Ward 5	526	16%	686	15%
Ward 7	504	15%	670	15%
Ward 2	439	13%	652	15%
Ward 8	431	13%	625	14%
Ward 4	410	12%	578	13%
Ward 1	377	11%	498	11%
Ward 6	347	11%	433	10%
Ward 3	154	5%	210	5%
Out-of-State	41	1%	41	1%
Maryland	38	1%	46	1%
Undetermined	33	1%	18	Less than 1%
Virginia	13	1%	15	Less than 1%
<b>Total Contacts</b>	<b>3313</b>	<b>100%</b>	<b>4472</b>	<b>100%</b>

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

8

**Table 4. Figure 4 - Categories of Issues Encountered by Uninsured Consumers--FY11 and FY12**

Issue Category	FY11 Totals	FY11 Contacts (%)	FY12 Totals	FY12 Contacts (%)
Access/Coverage (includes Pre-existing Condition denials)	57	44%	13	50%
Eligibility	57	44%	11	42%
*Other Issues	10	8%	1	4%
Non-Payment/Reimbursement Challenges	5	4%	1	4%
Quality of Service	0	0%	0	0%
<b>Total Contacts</b>	<b>129</b>	<b>100%</b>	<b>26</b>	<b>100%</b>

\*Other Issues: Anomalous and generic complaints such as auto repairs, banking issues, burial assistance, death certificates, duplicate QMB ID cards, food stamps, fraud-Medicaid/Medicare; housing assistance, legal services, name/address change, names misspelled on QMB ID cards, non-receipt-QMB ID cards, replacement of Medicaid/Medicare/MCO/QMB ID cards, and responses to Department of Health Care Finance's correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage, etc.

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

28

# APPENDIX

**Table 5. Figure 5 - Number and Percentage of Closed/Resolved Cases Among OHCOBR Consumers—FY11 and FY12**

Cases	FY11 Totals	FY11 Percent (%)	FY12 Totals	FY12 Percent (%)
Cases Closed/Resolved	3273	99%	4444	99%
Cases Not Yet Closed/Resolved	40	1%	28	1%
<b>Total Cases</b>	<b>3313</b>	<b>100%</b>	<b>4472</b>	<b>100%</b>

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

**Table 6. Figure 6 - Number and Percentage of Closed/Resolved Appeal/Grievance Cases (Bill of Rights) Among the Commercial Health Plan Members—FY11 and FY12**

Grievances	FY11 Totals	FY11 Percent (%)	FY12 Totals	FY12 Percent (%)
Appeal/Grievance Cases Closed/Resolved	107	82%	93	78%
Appeal/Grievance Cases Not Yet Closed	24	18%	27	23%
<b>Total Appeals/Grievances</b>	<b>131</b>	<b>100%</b>	<b>120</b>	<b>100%</b>

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

# APPENDIX

**Table 7. Figure 7 - Categories of Issues Encountered by Consumers--FY11 and FY12**

Issue Category	FY11 Totals	FY11 Contacts (%)	FY12 Totals	FY12 Contacts (%)
Access/Coverage (includes denials)	1480	45%	1501	34%
Eligibility	900	27%	1756	39%
*Other Issues	519	16%	723	16%
Non-Payment/Reimbursement Challenges	307	9%	310	7%
Quality of Service	107	3%	145	3%
Access (Administrative Hearings)	N/A	N/A	37	1%
<b>Total Contacts</b>	<b>3313</b>	<b>100%</b>	<b>4472</b>	<b>100%</b>

*NOTE: The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is reporting in the categories of issues encountered by consumers – Access (Administrative Hearings) for the first time in FY2012 Annual Summary of Cases Report—previously FY totals did not reflect a specific breakdown.*  
*\*Other Issues: Anomalous and generic complaints such as auto repairs, banking issues, burial assistance, death certificates, duplicate QMB ID cards, food stamps, fraud-Medicaid/Medicare; housing assistance, legal services, name/address change, names misspelled on QMB ID cards, non-receipt-QMB ID cards, replacement of Medicaid/Medicare/MCO/QMB ID cards, and responses to Department of Health Care Finance's correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage, etc.*

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

12

**Table 8. Figure 8- Categories of Types of Calls/Issues Encountered by Commercial Health Plan Members**

Issue Category	FY11 Totals	FY11 Contacts (%)	FY12 Totals	FY12 Contacts (%)
Access – Appeals/Grievances (Bill of Rights)	109	83%	120	79%
Access/Coverage (includes denials)	N/A	N/A	10	7%
Non-Payment Challenges	8	6%	7	5%
*Other Issues	7	5%	7	5%
Eligibility	5	4%	2	1%
Quality of Service	2	2%	5	3%
<b>Total Contacts</b>	<b>131</b>	<b>100%</b>	<b>151</b>	<b>100%</b>

*NOTE: The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is reporting Access/Coverage (includes denials) for the first time in FY2012 Annual Summary of Cases Report—previously fiscal year totals did not reflect a specific breakdown.*  
*\*Other Issues: Anomalous and generic complaints such as auto repairs, banking issues, burial assistance, death certificates, duplicate QMB ID cards, food stamps, fraud-Medicaid/Medicare; housing assistance, legal services, name/address change, names misspelled on QMB ID cards, non-receipt-QMB ID cards, replacement of Medicaid/Medicare/MCO/QMB ID cards, and responses to Department of Health Care Finance's correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage, etc.*

Source data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

24

# APPENDIX

**Table 9. Figure 9 - Categories of Types of Appeal/Grievance Cases (Bill of Rights) Encountered by Commercial Health Plan Members--FY12**

Issue Category	FY12 Totals	FY12 Contacts (%)
Care Is Not Medically Necessary	30	25%
Not Eligible for Health Plan/Benefit	41	34%
Pre-Existing Condition	3	3%
Care Is Experimental/Investigational	2	2%
Rescission	0	0%
Grandfather Status	0	0%
<b>Other Issues</b>	<b>44</b>	<b>37%</b>
<b>Total Contacts</b>	<b>120</b>	<b>100%</b>

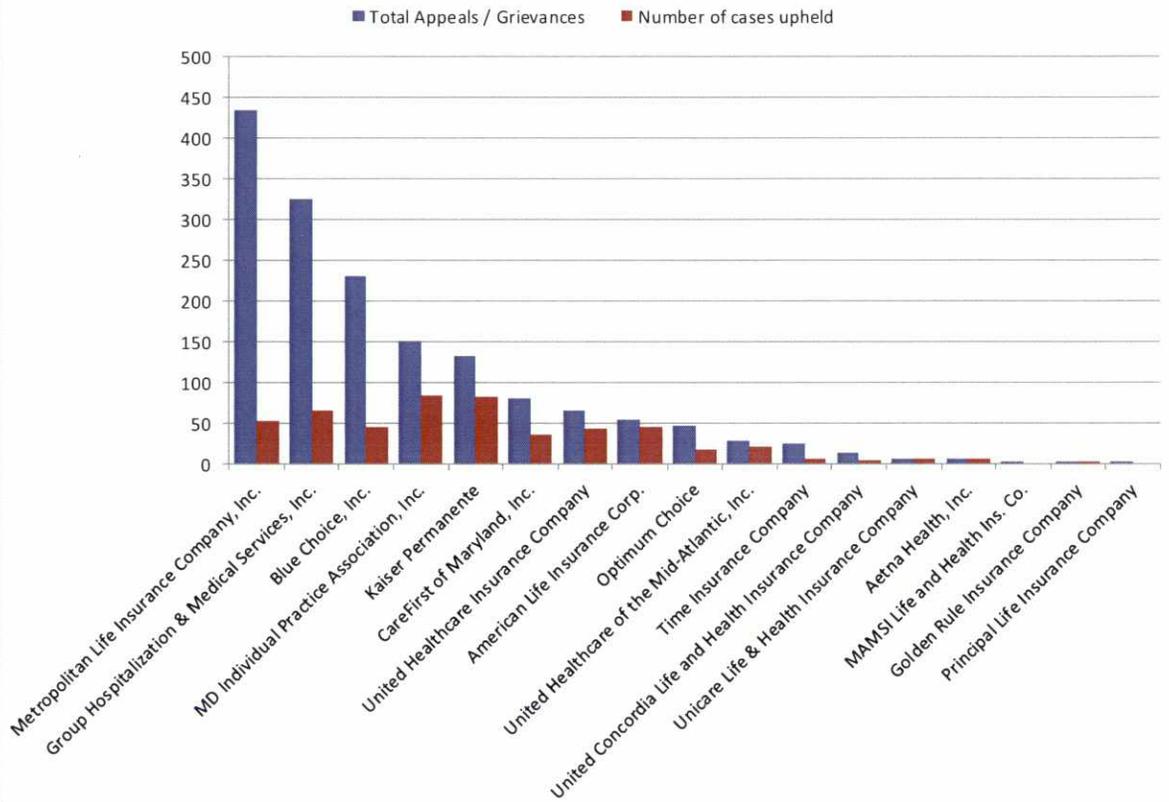
*NOTE: The Office of Health Care Ombudsman and Bill Rights (OHCOBR) is reporting Types of Appeal/Grievance Cases (Bill of Rights) cases for the first time in FY2012 Annual Summary of Cases Report—previously fiscal year totals did not reflect a specific breakdown of types Bill of Rights cases.*

Source data captured between October 1, 2011 through September 30, 2012

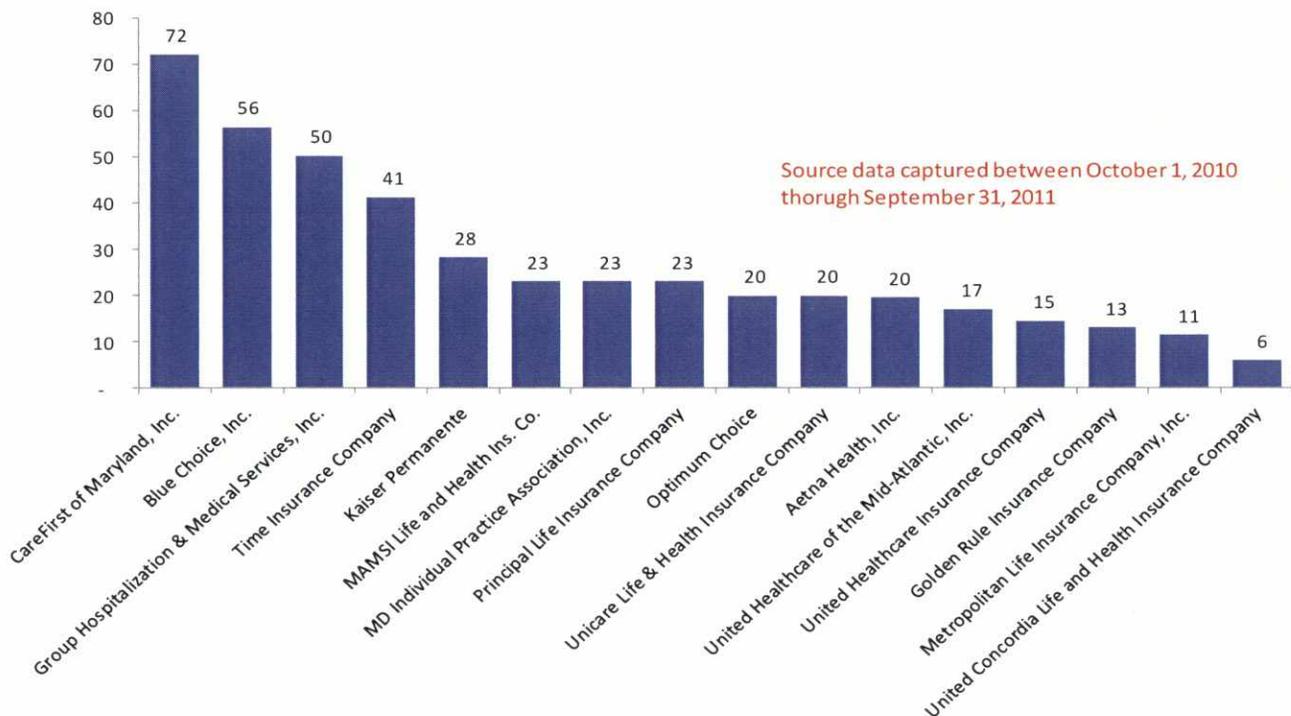
26

# APPENDIX

## Number of Total Appeals and Appeals Upheld, By Carrier, for Carriers Reporting Any Appeals

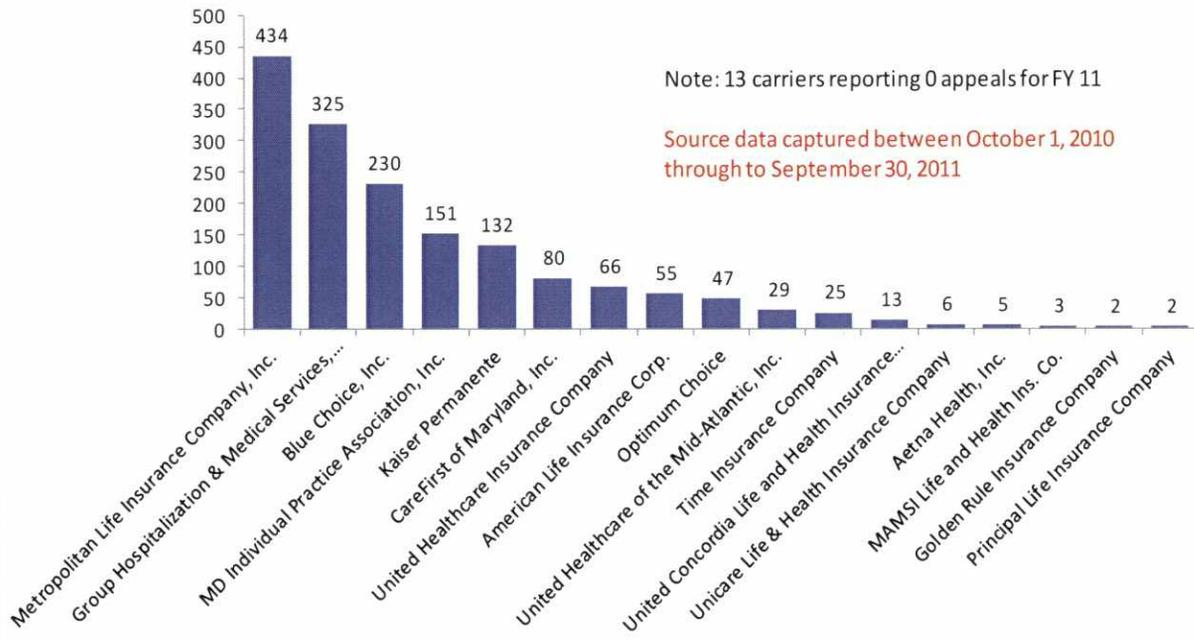


## Resolution Time for Non-Emergency Cases, in Days, for Carriers Reporting Any Appeals in FY 11

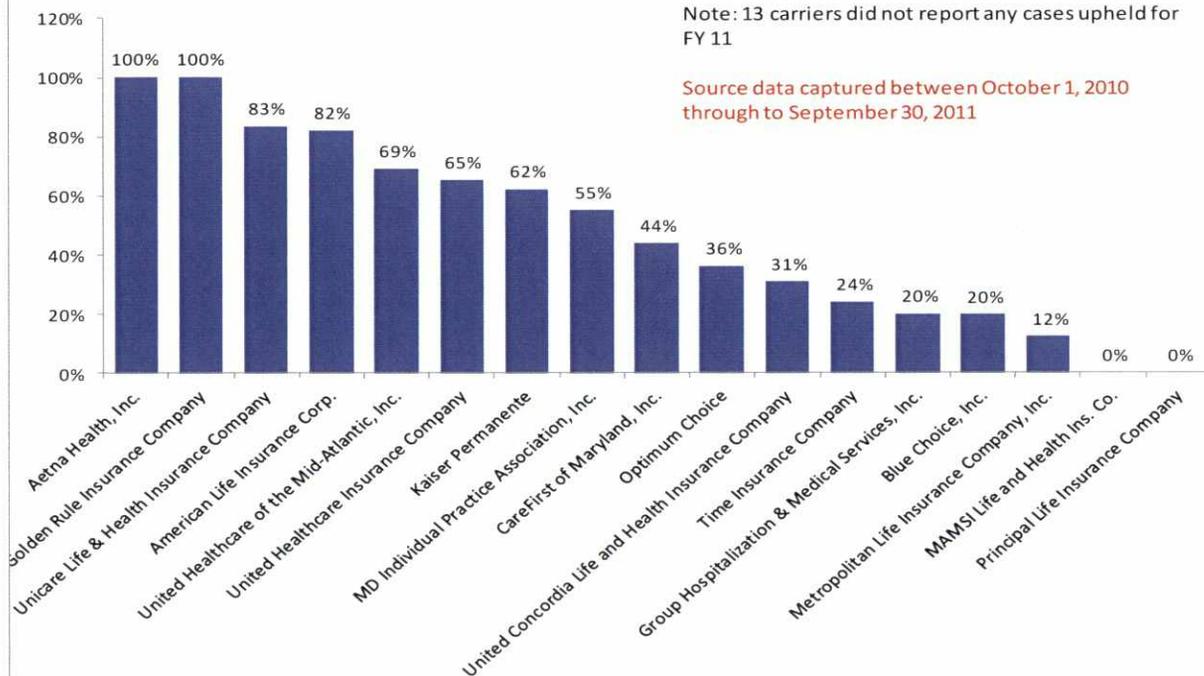


# APPENDIX

## Total Appeals / Grievances for Carriers Reporting Any Appeals in FY 11



## Percentage of Appeals Upheld for Carriers Reporting Any Appeals in FY 11



# QUICK REFERENCE SHEET

- ACA - **Affordable Care Act:** offers several new protections that are known as the “Patients’ Bill of Rights”
- Appeal- a request for relief; the process to fight a denied medical service or benefit
- CAP - **Consumer Assistance Program:** helps consumers with health insurance problems  
(Example: Office of Health Care Ombudsman and Bill of Rights)
- Commercial/Private Insurance - health insurance plan with a private insurance company  
(Examples : Aetna, CareFirst, Cigna, Kaiser, United Health Care)
- DMEPOS - Durable Medical Equipment, Prosthetics, Orthotics and Supplies
- Grievance- just cause for a complaint
- IDA - **Interim Disability Assistance-** short-term financial assistance for residents who are waiting to get federal “disability” benefits
- Medically Necessary- medical service that is essential or required for the diagnosis and/or treatment of a medical condition
- MCO - **Managed Care Organization-** organizations that provide managed care, each with slightly different business models. Some organizations are made up of physicians, while others are combinations of physicians, hospitals and other providers  
(Examples: DC Chartered, United Health Plan and MedStar)
- PCIP - **Pre-existing Condition Insurance Plan-**this program provides affordable health insurance for consumers unable to purchase health coverage in the commercial marketplace because of a pre-existing medical condition
- PPO - **Preferred Provider Organization-** a health care organization composed of hospitals, physicians and other providers
- Public Insurance- a joint federal and state-funded health insurance program for low income individuals, children, families, the elderly and people with disabilities  
(Example: Medicaid)
- QMB - **Qualified Medicare Beneficiary-** program to help Medicare beneficiaries with their Medicare expenses including monthly premiums, co-payments and deductibles and prescription drug costs



## ***“WHERE MAKING A DIFFERENCE MATTERS”***

OFFICE OF HEALTH CARE OMBUDSMAN AND BILL OF RIGHTS

899 NORTH CAPITOL STREET, NE, 6th Floor

WASHINGTON, D.C 20002

(877) 685-6391 (Toll-free)

(202) 535-1216 (FAX)

[HEALTHCAREOMBUDSMAN@DC.GOV](mailto:HEALTHCAREOMBUDSMAN@DC.GOV) (E-MAIL)

[WWW.HEALTHCAREOMBUDSMAN.DC.GOV](http://WWW.HEALTHCAREOMBUDSMAN.DC.GOV) (WEBSITE)

*Designed by Kivon L. Allen & Chaise Lancaster*



Government of the District of Columbia  
Vincent C. Gray, Mayor