

# Office of Health Care Ombudsman and Bill of Rights

## Fiscal Year 2013 Annual Report



*The Knowledge to Guide You*

September 2014

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## *A Message from the Mayor*

It is with great pleasure that I present, along with the Health Care Ombudsman, Maude R. Holt, the FY 2013 Annual Report of the Office of Health Care Ombudsman and Bill of Rights (OHCOBR).

OHCOBR provides residents and individuals insured by health plans in the District of Columbia with assistance in navigating the District's health care system. The staff of OHCOBR ensures the safety and well-being of District residents and individuals insured by health plans licensed in the District of Columbia. This is done through advocacy, education and community outreach.

The District of Columbia is a leader in providing access to comprehensive, coordinated and quality health care to residents and individuals insured by health plans in the District of Columbia. OHCOBR played a major role in our transition into the new health insurance marketplace, DC Health Link, launched on October 1, 2013.

I commend Maude Holt and the OHCOBR staff for their compassion and commitment to the residents of the District of Columbia and their insurance health care needs.

Vincent C. Gray  
Mayor



## *A Message from the Director*

Whenever I think back over the span of my career, I am always amazed at the unpredictability of life's journey. As a young man I left my hometown in Richmond Virginia in 1976 to obtain a Bachelor of Science from North Carolina Agricultural and Technical State University. My goal was to play four years of college baseball, have fun, and get a degree. In the back of my mind, I always assumed I would graduate, land a job as a high school history teacher, and coach the school baseball team.

However, after receiving my degree in 1980, I was advised to consider graduate work at Ohio State University. Reluctantly, I pursued this opportunity and in two years, earned a Masters of Public Administration (MPA). While working on my MPA, I developed a strong interest in public policy research and the Master's Degree opened the door for me to accept a job as a research associate for a national firm in New York City.

The job in New York, at the Manpower Demonstration Research Corporation (MDRC), provided me with invaluable experience. I eventually used this experience as leverage to land a position with one of the top legislative oversight agencies in the United States, the Joint Legislative Audit and Review Commission (JLARC) in 1985. In this research role, I designed and implemented nearly 20 studies in the field of program evaluation and policy analysis. In fact, it was as a researcher at JLARC that I received my initial exposure to the Medicaid program, working on studies of long-term care, Medicaid asset transfers, and Medicaid hospital reimbursements.

Although I left JLARC in 2002 to work for Governors Mark Warner and Tim Kaine, respectively, I remained keenly interested in health policy and was honored and humbled when Mayor Vincent Gray asked me to serve as Director of the Department of Health Care Finance (DHCF) in 2011.

I came into the agency with high expectations and a particular focus on three (3) main goals.

First, I wanted to ensure that DHCF would be a critical and successful agent in the implementation of the Affordable Care Act (ACA). I firmly believe that the ACA is the most important piece of social policy legislation since the passage of the 1964 Civil Rights Act and I wanted to make sure that DHCF played a key role in making the goals of this legislation a reality for District of Columbia residents.

Second, I wanted to make the necessary systemic changes in the District's Medicaid program to ensure that program dollars were allocated wisely, producing value for Medicaid beneficiaries. To that end, I cannot say enough about the good work of the Office of the Health Care Ombudsman and Bill of Rights under the direction and leadership of Maude Holt. As director of the office, Ms. Holt has a wonderful base of health care knowledge, a strong work ethic, and demands exemplary performance from her very capable staff. She is truly a model for her peers.

Third, I wanted to establish DHCF as the top performing agency in the District government. With this in mind, as we approach FY 2015, I plan a continued focus on the creation of a cohesive, well-functioning team of managers and staff to achieve this important goal. To accomplish this, we will place a key emphasis on raising the performance profile of DHCF. My goal is to send a consistent and strong message about the type of work ethic and performance culture that we want to sew into the fabric of this agency.

After nearly three years of both setbacks and progress, I believe that we are on the road to building at DHCF, an agency that sets expectations and standards for excellence, and rewards those employees who achieve this goal. I expect all of our employees to pursue the unattainable goal of perfection and in the process, achieve excellence. This will produce benefits for not only the employees of the agency, but more importantly, the 200,000 plus District residents who rely on Medicaid to meet their critical health care needs.

Thank you,

Wayne Turnage, MPA  
Director, Department of Health Care Finance



## *A Message from the Health Care Ombudsman*

It is with great pride and pleasure that I present to you our *Fiscal Year 2013 Annual Report*. The year was pivotal for the Office of the Health Care Ombudsman. We played an integral role in the full implementation of the Affordable Care Act, which brought health care within reach of all Americans and broadened the volume and scope of our efforts; and, thanks in large measure to two Consumer Assistance Program federal grants awarded in 2012, we achieved tremendous growth and realized many accomplishments in serving District of Columbia residents, workers and visitors.

The more than \$300,000 in grant funds helped improve service delivery, expand consumer awareness of our Office, and increase access to useful information on health care reform, health services and consumer rights. We reached out to the community at thirty-five events attended by more than 24,000 people, engaging and distributing materials printed in both English and Spanish. The grants also supported staff training to boost their professional skills and the cost of staff memberships in the International Ombudsman Association. Look for our ads throughout the District and on cable TV in the coming months, branded with our new logo, all courtesy of federal funding.

We embraced these core enhancements with excitement and renewed dedication to our mission, in tandem with the dynamic and welcomed changes in the healthcare environment. As a result, our office resolved 6,507 cases in 2013, a significant increase over the prior year's 4,472 cases.

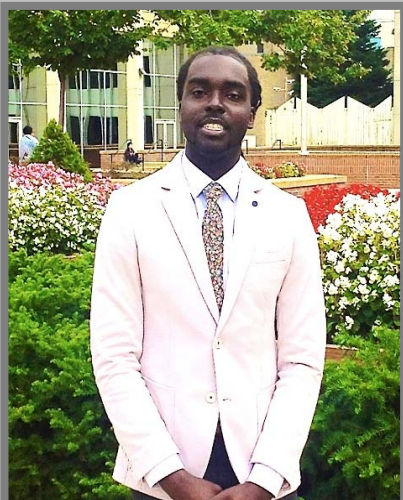
I am proud of the good work produced by our staff of well trained professionals, committed to the well-being and safety of our customers, dedicated to equipping them to navigate the health care system to their best advantage, and persistently assisting them to that end. Through this report, we hope you will appreciate the gains realized and continue to view us as a valuable resource for consumer advocacy, education, and support.

Should you have any questions regarding this *Fiscal Year 2013 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](mailto:healthcareombudsman@dc.gov).

Best regards,

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

## *Meet the Ombudsman Staff*



Kivon Allen, BS  
Associate Healthcare  
Ombudsman



Charlita Brown, BS  
Associate Healthcare  
Ombudsman



Zakia Chapman  
Student Intern



Angela Clark  
Return to Work (RTW)  
Staff Member



Marlena Edwards, MSW  
Associate Healthcare  
Ombudsman



Aminata Jalloh, BS  
Assistant Associate Healthcare  
Ombudsman



**Paula Johnson, MS, BSN, RN**  
Associate Healthcare  
Ombudsman



**L. Darnell Lee, MPH, RN, CPM**  
Director of Clinical Services  
Associate Healthcare  
Ombudsman



**Mirka Shephard**  
Associate Healthcare  
Ombudsman



**Loretta Smith, RN**  
Associate Healthcare  
Ombudsman



**Omari Stewart**  
Student Intern



**Shirley Tabb, LICSW**  
Associate Healthcare  
Ombudsman





Daisha Watson, BA  
Assistant Associate Healthcare  
Ombudsman

***\*Not Pictured:***

***Terrell Ford, Return to Work***

***Cardiss Jacobs, Associate Healthcare Ombudsman***

***Carmen Kinsey, Associate Healthcare Ombudsman,  
Education/Outreach Coordinator***

***Robert Taylor, Return to Work***

# Success Stories



## Gastric Bypass Surgery

A commercial insurance member sought gastric bypass surgery but the insurer denied coverage stating that the member did not meet the “criteria”. The Health Care Ombudsman’s staff thoroughly reviewed the member’s medical records and other available documentation, including the insurer’s guidelines and requirements. Based on the supplemental information that the Ombudsman’s staff submitted to the insurer it was determined that the member did meet the criteria and the gastric bypass surgery was approved.



## Prescription Denial

A Commercial insurance member was denied medication based on language written in their policy. Under the policy, a different medication could replace the one prescribed as long as it offered the same therapeutic effect; however, the replacement medication was contraindicated for the member. After the Ombudsman’s staff intervened, the insurer reconsidered the case and overturned their initial adverse decision.

## Human Growth Hormone (HGH) Therapy

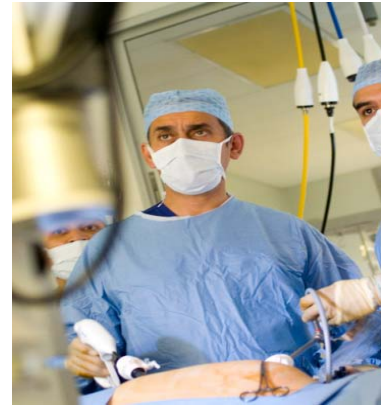
The minor child of a commercial insurance member was denied Human Growth Hormone (HGH) therapy after several years of approved coverage. The OHCOR staff requested reconsideration based on findings from a similar appeal a year earlier. As a result, the insurer reversed the denial.



# Success Stories

## Emergency Surgery

A six (6) year old boy experienced a catastrophic injury to his hand that required emergency surgery. The father took the child to a Preferred Network Provider where emergency surgery was performed by the surgeon on duty. The medical expenses totaled \$67,000. Initially, the insurer paid only \$2,312 leaving an outstanding of \$64,688 for the covered member to address. The OHCOBR was eventually able to get the outstanding balance remediated.



## Prescription Assistance

OHCOBR staff received a request for assistance from a University student on an extended internship in the Middle East, seeking a 3-month override for medications. OHCOBR staff worked with DHCF and the member's primary care doctor to obtain authorization for the supply. The prescription claim was processed and beneficiary was able to get the medications.

## DC Healthcare Alliance Program Member

OHCOBR received a request for assistance from a news reporter on behalf of her 25-year-old friend who happened to be an Alliance member. The friend was diagnosed with a life-threatening medical condition, Hodgkin's Lymphoma, and was unable to get treatment due to limitations in her Alliance coverage. Also, it seemed that she did not meet the 5-year residency requirement to convert to DC Medicaid. OHCOBR met with DHCF leadership, Councilwoman Bowers office, the treating physicians and DC Medicaid Medical Director to determine what could be done to commence treatment and preserve life. OHCOBR also met with immigration officials to determine the date of entry into the United States. This information was forwarded to the Economic Security Administration and it was determined that the beneficiary met the residency requirements for eligibility under the DC Medicaid program.



# Success Stories

## Cranial Helmet



The child of a commercial insurance member had a condition from birth that was later diagnosed with plagiocephaly without synostosis (asymmetrical distortion of the skull that is not due to bone fusion). The parents detected the problem early and consulted the appropriate medical personnel. Treatment and a cranial orthosis (“helmet”) were prescribed. The parents proceeded to fill the orders without getting prior approval from the insurance company because they understood the importance of immediate intervention and the risk to their infant child if they did not take steps promptly to begin the prescribed treatment. When the insurance company denied coverage, the parents contested the decision. The OHCOBR staff researched the disease and confirmed that it is critical for an intervention to occur within the early months of life for treatment to be effective. The Independent Review Peer Review Organization (IPRO) reversed the adverse decision made by the insurer and the member was reimbursed in the amount of approximately \$2,500.

## MRI

A 56 year-old beneficiary with a brain tumor was unable to successfully arrange for a medically necessary brain scan at a local hospital, which was overdue by more than 30 days. It was discovered that the beneficiary’s eligibility was inactive. The beneficiary’s eligibility was reactivated and the beneficiary was able to schedule the brain scan with much gratitude to all involved.



## Pregnancy Complications

A 31 year-old Medicaid beneficiary found herself at risk of spontaneous abortion due to complications of liver failure, and the possibility of her child being born with Down Syndrome. The treating physician intervened and contacted the Ombudsman’s Office after numerous failed attempts to get DC Medicaid to pay for the weekly injection of hydroxyprogesterone that she needed. Collaborative efforts between the physician’s office, the beneficiary, and DHCF Pharmacy Unit resulted in a positive outcome. The drug was approved, a referral was made for an amniosynthesis test, and the expectant mother was provided resource information on Down Syndrome.



## *Background*

### *Office of 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 (DOH) 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 regarding access to health benefits, and to ensure 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 and private and public insurance programs.

#### *FUNDING*

The 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 7-2071.01); and *The*

## *Background (cont'd)*

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*Health Benefits Plan Members Bill of Rights Act*, which established grievance procedures for health benefits plans (D.C. Law 19-546; D.C. Code 44-301).

### *INDEPENDENCE AND AUTONOMY*

The OHCOBR operates independent 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 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 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 OHCOBR throughout the entire appeals process.

This collaboration has identified a significant number of additional cases transferred from DISB to the OHCOBR.

### *GROWTH AND THE FUTURE*

Not surprisingly, the increased identification and transfer of cases has also resulted in an increase in workload, which is unsustainable long term. Implementation of the Affordable Care Act and the open enrollment process through health benefit exchanges across the country has also impacted the volume of calls the office receives from consumers seeking information, intervention and assistance. The Consumer Assistance Program grants awarded to OHCOBR by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid (CMS) is helping us build the necessary human capital and other resources to handle the flux of inquiries and advocacy service requests, and to maintain and foster the current collaborative relationship with DISB and others as we go forward.



## Legislative Summary

### *Health Benefits Plan Members Bill of Rights Act of 1990 and Affordable Care Act*

The Health Benefits Plan Members Bill of Rights Act of 1998 gives health plan members the right to appeal denials of coverage for health care services through an external appeals process used by the Office of Health Care Ombudsman and Bill of Rights.



The Affordable Care Act (ACA) was passed by Congress in 2010 setting new standards for states related to health care, including grievances and appeals. The Federal rules set forth several minimum protections that states had to implement before January 1, 2012. If all the Federal requirements were not implemented by January 1, 2014, then health plans were required to use a federally administered process. 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, known as the *Health Benefits Plan Members Bill of Rights Amendment Act of 2011* in September and October 2011. This legislation became permanent on March 22, 2013 and increased the period for filing an appeal from thirty (30) days to four (4) months. More importantly, it made the decision of the independent review organization binding, for all appeals.

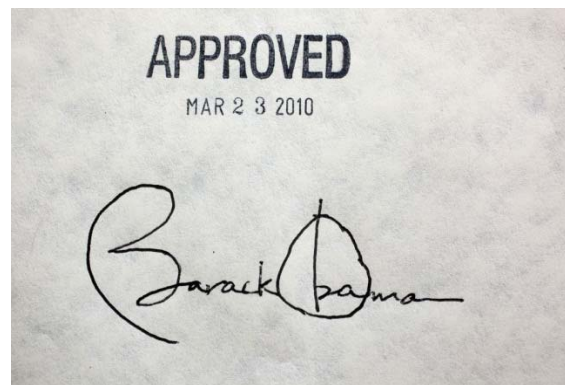


## *Health Care Reform Update*

### *Affordable Care Act policy changes*

The Patient Protection and Affordable Care Act (ACA) of 2010, signed into law by President Obama on March 23, 2010 has brought comprehensive and equitable health insurance coverage to most Americans, thus ensuring increased access to affordable healthcare. Americans previously denied coverage by private insurance companies due to preexisting medical conditions are no longer subject to those denials. In 2010, the Affordable Care Act banned pre-existing condition exclusions for children and the Pre-Existing Condition Insurance Plan (PCIP) allowed uninsured adults with pre-existing conditions to buy a plan. In 2014, the Act expanded guarantees to all Americans that they can access quality, affordable coverage regardless of their health status or pre-existing condition.

The ACA also created market places, otherwise known as Exchanges, in order to help individuals find health insurance that fits their budget and provides essential coverage. States can choose to implement their own Exchanges or elect to use a federally-facilitated exchange (FFE). The District of Columbia opted to implement, regulate, and administer its own marketplace, DC Health Link.



The ACA also affords tax filing individuals and families the ability to receive Advanced Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSR) to assist with premium and co-insurance payments. In 2010, some small businesses were able to receive tax credits for covering their employees. Beginning in 2014, small businesses can use the SHOP exchange (operated in DC through DC Health Link) to find coverage. Key aspects of the ACA took effect January 1, 2014 and open enrollment began October 1, 2013.

The ACA also creates a new national Medicaid eligibility threshold of 133% of Federal Poverty Level (FPL) that, for instance, raises the



## Health Care Reform Update (cont'd)

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maximum annual income level for a household of two to \$20,628<sup>1</sup>. The District of Columbia expanded local Medicaid coverage to include childless adults even before the ACA expansion went into effect.



In compliance with the ACA, the Modified Adjusted Gross Income (MAGI) is the new income methodology used to verify financial eligibility Medicaid and the Qualified Health Plans (QHPs). Eligibility for cost sharing reductions and tax credits will also be computed based on this MAGI methodology. MAGI will establish financial eligibility primarily for pregnant women, children, childless adults, parents and caregiver relatives.

Under MAGI there is no “asset testing”. All current income disregards have been replaced with a single income disregard of 5%. This new method of determining Medicaid eligibility will affect approximately 160,000 Medicaid beneficiaries. Non-MAGI populations still use current income counting standards with eligibility determined by Automated Client Eligibility Determination System (ACEDS) until full enrollment into *DC Health Link*.

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<sup>1</sup> FIGURE COMPOSED USING 2013 FEDERAL POVERTY GUIDELINES



## *Meet Israel Owolabi, Pharm.D.*

### *Set precedent for OHCOBR's Hormone Therapy cases*

Before adding “doctor” to his name, Israel Owolabi completed a five (5) week internship at the Department of Health Care Finance (DHCF), under the leadership of DHCF Pharmacist, Charlene Fairfax, while he was a student at the Howard University School of Pharmacy.

During his internship he lent his special expertise to the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) and was instrumental in reversing a challenging trend – OHCOBR’s success rate in overturning denials for human growth hormone (HGH) therapy.

Using his pharmaceutical knowledge, Israel helped impact the clinical review and research process for external appeals cases by creating a critical tool for use by office staff to justify insurance coverage for hormone therapy: “The Human Growth Hormone for the Treatment of Idiopathic Short Stature” tool.

A diagnosis of Idiopathic Short Stature is given when a child is shorter than 98% of other children of the same comparable age and sex, and is growing at a rate where he or she is not likely to reach normal adult height. Dr. Owolabi’s tool highlighted six indicators to show medical necessity and scientific justification for insurance coverage.

To develop the tool, student intern Owolabi met with pharmaceutical representatives, conducted extensive hormone therapy research and used scientific methodology to analyze and compare outcomes of these cases among various insurance companies.



The OHCOBR began using a combined strategy that included Dr. Owolabi’s tool to make its determinations, starting with the case of a nine-year-old child diagnosed with Idiopathic Short Stature whose hormone therapy

## *Meet Israel Owolabi (cont'd)*

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was denied by his Washington, DC based commercial insurance plan. That strategy included a review of independent clinical research on the treatment of growth hormone deficiency, a review of the child's health insurance records and commercial health insurance policy to determine if the treatment was a covered service, and an examination into the reason hormone therapy was denied, even though it was recommended by the child's expert care provider at the National Institute of Health. This strategy led to a determination by the OHCOBR that the service was covered and the diagnostic criteria for the therapeutic treatment had been met. In large thanks to Dr. Owolabi, the Independent Review Organization (IRO) agreed with our findings and reversed the decision of the local insurance company; determining that the denial was unjustified and requiring that the plan cover the cost of the young child's HGH therapy treatment.

Dr. Owolabi's tool is a powerful litmus test for the remediation of denied cases diagnosed with Idiopathic Short Stature. It has helped OHCOBR improve its role as advocate for consumers in reversing hormone therapy denials referred for external review.

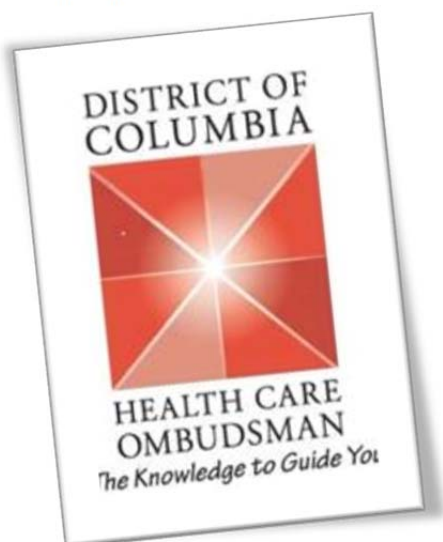


## Consumer Assistance Program (CAP)

### *Grant funding opportunities and their impact*

Since 2009, the District of Columbia has operated a consumer assistance program through the Office of Health Care Ombudsman and Bill of Rights (OHCOBR), 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. Since that time, OHCOBR has applied for and received three grants from the federal government to support the consumer assistance program.



In December 2010, OHCOBR was awarded a Consumer Assistance Program (CAP) grant by the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid (CMS) 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 new software and equipment.

Second, staff received monthly comprehensive training on specific topics to better equip them to resolve complaints and grievances more effectively and efficiently. They also participated in a rigorous training and case review process to enhance their case management skills.

Third, OHCOBR staff joined the International Ombudsman Association using grant funds to cover membership fees. As members, staff strictly adheres to the Association's Code of Ethics in the execution of their responsibilities.

In FY 2012, OHCOBR was awarded two more HHS Consumer Assistance Program Grants: the Limited Competition for Affordable Care Act Consumer Assistance Program in the amount of \$127,967, and the Affordable Care Act Consumer Assistance Program grant in the amount of \$200,000. These grant awards made

## Consumer Assistance Program (cont'd)

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it possible for OHCOBR 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, (3) producing marketing and educational materials and advertisements for distribution throughout the District of Columbia, and (4) conducting focused efforts that specifically and strategically target non-English speaking communities, producing a culturally specific initiative to engage the city's diverse population.

The grants are also 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. Watch for these sessions in your neighborhood in the coming months.

Additionally, grant funds were made available for staff training covering a number of important topics including the June 2013 Supreme Court decision, changes to local and federal laws, and how to help consumers access premium tax credits.

The OHCOBR utilized these grant funds to enrich the quality of services we provide to our customers. As future funding opportunities arise we will make every effort to obtain additional awards.



# Training

## *Families USA, Health Insurance Counseling Project (HICP) and other experts*



Staff in the Office of Health Care Ombudsman undergo periodic training from Families USA, the George Washington School of Law's Health Insurance Counseling Project (HICP), and other topic specific experts in order to keep abreast of the new changes to laws, policies and regulations that govern the Medicaid/Medicare programs, the ACA, health care for the mentally ill and other relevant subjects.

Following is a list of trainings that benefited staff in FY 2013:

- Families USA Health Action Conference;
- How the Affordable Care Act will affect Medicare beneficiaries;
- Employees and the Affordable Care Act, including the employees' household composition;
- Human Growth Hormone for the Treatment of Idiopathic Short Stature;
- Durable Medical Equipment Prosthetics, Orthotics and Supplies
- In-depth training on household composition rules for Medicaid and premium tax credits, including an overview/review of the DC Health Link;
- Qualified Medicare Beneficiary (QMB);
- DC Health Link, the streamlined application, and premium credits;
- Mental Health Parity Law and training on the provisions of District of Columbia's appeal procedures specific to mental health consumers;
- Affordable Care Act enrollment and Subtopics: Outreach and assistance resources in the District of Columbia, insurance rates in the new marketplace, Medicaid eligibility changes for the MAGI population, eligibility for immigrants, and marketplace residency requirements; and
- Outreach Now and DC Health Link. This training included the MAGI and the new insurance rates and plans.

## *Subcommittees and Ad Hoc 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 consisting of members that represent consumers, consumer advocacy organizations, health benefit plans, health care facilities, and physicians.

The Advisory Council has three (3) subcommittees: Clinical, Policies and Procedures and Legal, Education and Outreach; and two (2) ad hoc committees: Mental Health and Special Needs. The subcommittees and ad hoc committees are presented in the following pages with a description of their roles and responsibilities:



*Health Care Ombudsman  
Advisory Council*

## *Policies & Procedures and Legal Subcommittee*

### *A synopsis of processes and accomplishments*

The Legal Subcommittee and the Policies and Procedures Subcommittee were combined in 2010 because they both dealt with the same issues. The Policies and Procedures and Legal Subcommittee was formed in order to track and provide recommendations for new laws, policies, and regulations that impact the day-to-day activities of the OHCOBR. The subcommittee meets every other month during months when the full Advisory Council does not meet, and consists of members from commercial insurance plans, MCOs, non-profit agencies, attorneys, consumers and residents of the District.



### *The purpose of the Policies and Procedures and Legal Subcommittee is to:*

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

### *Legislative mandates:*

*(Health Care Ombudsman Program Establishment Act 2004)*

1. Comments on behalf of consumers on related health care policy legislation and regulations in the District (§ 7-2071.04. (7)); and
2. Provides information to the public, government agencies, the Council, and others regarding problems and concerns of consumers and make recommendations for resolving those problems and concerns (§ 7-2071.04. (9)).



## *Policies & Procedures and Legal Subcommittee (cont'd)*

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### *FY 2013 Accomplishments:*

- Instrumental in the passage of the Health Benefits Plan Members Bill of Rights Amendment Act of 2012 by recommending language to comply with the Affordable Care Act and to improve beneficiary rights;
- Involved in changes to the Mental Health Parity Law;
- Developed the internal policies and procedures for the Office of Health Care Ombudsman and Bill of Rights; and
- Initiated preliminary work on a 2014 project to improve data gathering and reporting by commercial health plans for the OHCOBR annual report, and to establish a uniform protocol for improving processes and feedback that will benefit consumers.



## *Clinical Subcommittee*

### *Improving processes utilizing clinical practices*

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. The subcommittee meets every other month during months when full Advisory Council does not meet, to address medical issues of concern to OHCOBR's customers.



### *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 in regards to clinical practices;
- Develop a process for reviewing clinical complaints and grievances;
- Serve as external peer reviewers for Medicaid and complex medical cases;

### *Accomplishments:*

- Instituted the *Mental Health Treatment Peer Review Checklist* and the *Non-Behavioral Peer Review Checklist* to document reviewer qualifications during the appeal of an adverse decision in commercial insurance cases. These forms provide a quality measure to ensure that the insurance company's reviewers have credentials similar to the member's treating provider with regard to education and experience, for both mental health and non-mental health cases.
- Drafted and enacted policies and procedures in commercial case appeals to provide consistency and improve outcomes for external reviews. This process includes two (2) review teams, each consisting of one nurse and one social worker designated to perform a secondary review prior to forwarding cases for external review.

## Education and Outreach Subcommittee

### *Providing education through outreach*

The Education and Outreach Subcommittee is comprised of three consumer advocates, an OHCOBR staff member and, two consumer advocates from the OHCBOR Advisory Council. The purpose of the Education and Outreach Subcommittee is 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 Education and Outreach Subcommittee meets one month prior to the Ombudsman Advisory Council Meeting and more frequently as needed.

### *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 benefit 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 Medicaid Beneficiary (QMB), Medicare, and the Home and Community Based Waiver Programs.



### *This is achieved through:*

- Educating consumers about health benefits plans, managed care health plans, and their health benefits plan options, or other health care options available for uninsured consumers in the District of Columbia;
- Implementing innovative strategies and tools to maximize outreach to consumers, including provision of the following accessible information sources and services:
  - a. Establishment of a toll-free telephone number (1-877-685-6391) that operates in the District of Columbia Metropolitan Area;
  - b. Internet and website access;
  - c. In-person counseling;
  - d. Language line access upon request;
  - e. TTY services and other reasonable accommodations upon request;
  - f. Establishing relationships with organizations in each Ward of the city to provide outreach and receive referrals;

- g. Providing active liaison, partnerships, and information sharing with community, consumers, health care providers, disability agencies, religious affiliates, ethnic-based organizations, and other community-based entities; and
  - h. An easy-to-read, one-page flyer in English and Spanish describing the Ombudsman program's services available to the public.
- Working with health care providers, advocacy agencies and other stakeholders to develop working relationships that enhance coordination of services and referrals.

*FY 2013 Accomplishments:*

See Table 1. Figure 13 – Outreach/Education Events, FY 2013.



## *Mental Health Ad Hoc Committee*

### *Health care continuity and improved level of care*

Created in 2013, the focus of the Mental Health Ad Hoc Committee is greater care continuity and improved level of care for people receiving home or community based services who have a history of mental illness or who exhibit signs of behavioral distress.

Agencies and organizations in this ad hoc partnership, include home health agencies, DHCF programs, (Money Follows the Person, Clinical Services, and the Division of Chronic and Long Term Care), managed care organizations, Department of Health, AARP's Long Term Care Ombudsman, Department of Human Services, Adult Protective Services, and the Department of Behavioral Health.



### *The purpose of the Mental Health Ad Hoc Committee is to:*

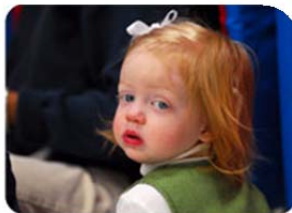
- Make recommendations to the Advisory Board;
- Propose ways to improve performance and outcomes in care coordination among provider agencies, physicians, and core service agencies in the behavioral health system;
- Identify and overcome barriers for sharing vital information that will assist in the care of the beneficiaries that are assigned to various home health agencies.

## *Special Needs Ad Hoc Committee*

The Special Needs Ad Hoc Committee was created in mid-2013 to review and recommend improved access to quality comprehensive care for children with special needs.

*The Purpose of the Special Needs Ad Hoc Subcommittee is to:*

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





## Collaboration

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### *Coordination of healthcare and other services*

OHCOCR works in collaboration with numerous agencies and organizations to coordinate the delivery of health care and other valuable supportive services. These collaborations are important for maximizing consumer access and information. We take great pride in the partnerships we have formed with these critical stakeholders and recognize the essential value they hold in the achievement of our mission. The cooperative relationships that we cultivate ensure highly effective and responsive action when consumers are referred for assistance.

Following is a list of our 2013 partners.

- Families USA
- Economic Security Administration (ESA)
- George Washington Health Insurance Counseling Project (HICP)
- Department of Health (DOH)
- Centers for Medicare and Medicaid Services (CMS)
- Social Security Administration (SSA)
- Department of Labor (DOL)
- Department of Insurance, Securities, and Banking (DISB)
- Department of Mental Health (DMH)
- Council of the District of Columbia
- AARP/Legal Counsel for the Elderly - Long-Term Care Ombudsman
- Department of Health Care Finance (DHCF)
- DC Chartered Health Plan
- MedStar Family Choice
- United Healthcare
- AmeriHealth DC
- Thrive Health Plan
- Health Services for Children with Special Needs (HSCSN)
- Medicaid Transportation Management (MTM)
- Delmarva Foundation
- Whitman-Walker Clinic
- Legal Aid Society
- DC Health Benefit Exchange Authority
- Office of Personnel Management (OPM)
- MedStar Washington Hospital Center
- IONA Senior Services
- Department on Disability Services (DDS)
- Salvation Army/ Harbor Light Center
- Terris, Pravlik and Millian
- Bread for the City



## Achievements



### *Office of the Health Care Ombudsman and Bill of Rights' achievements for FY2013*

In FY2013 the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) saw achievement in its ability to handle an increased caseload and to address the varied and increasingly complex health care issues that consumers sought help to resolve. We were able to hire additional staff to accommodate the influx in Medicare, Medicaid and commercial cases, including four new clinical staff members who were instrumental in realizing the following achievements:

- Improved the percentage of commercial grievances and appeals that were reversed or overturned;
- Established an internal quality improvement process for commercial cases that included the development of a Quality Review Instrument used prior to referring cases to the IRO and DISB, and prior to closing cases.
- Effective recommendations from the clinical review team strengthened cases and helped produce favorable outcomes from the external IRO and DISB;
- Realized a significant increase in the number of public insurance cases processed and remediated.

### *Other achievements include the following:*

- Director's Award for Employee Excellence (Group Achievement);
- One year extension for the Limited Competition Consumer Assistance Grant and Full Consumer Assistance Program Grants resulting in \$400,000 in additional funding to support operations; and
- Filed 167 Administrative Fair Hearings to assist Medicaid beneficiaries.



# Recommendations

## *Recommendations for improving performance and outcomes*

Based on our experiences during fiscal year 2013, the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) identified several key recommendations to help increase consumer knowledge about their rights and benefits, improve their access of care, and reduce the incidences of complaints, grievances and appeals. Recommendations focus on problems encountered by consumers in their attempts to access quality health care services and private and public health insurance benefits to which they are entitled.

We saw a range of concerns during the year, from simple questions of eligibility to more complex matters, such as medication coverage, continuity of care and home health care issues particularly for residents with co-occurring behavioral health care needs.

The concerns that were raised throughout the year came to us through several channels:

- Individual complaints and requests for assistance from consumers, their representatives and family members;
- Information and inquiries received from other government and non-governmental organizations; and
- Collaborative interactions and meetings with uninsured and insured individuals, fellow employees, health care providers, non-governmental entities, including community based and private businesses and organizations.

Based on the OHCOBRs collective experience, the following recommendations are made with the goal of influencing change and improving the service delivery by administrators of health care benefits and health care providers in the District of Columbia.

- We recommend that OHCOBR work with government agencies, community-based organizations and advocacy groups to improve their understanding of the unique responsibility of the Economic Security Administration (ESA) in determining eligibility for public benefits. This will improve the system of getting the customer to the right resource for assistance more quickly.
- We recommend that the Office on Aging and the George Washington University Health Insurance Counseling Project (HICP) establish a community services initiative to educate residents enrolled in the Qualified Medicare Beneficiary (QMB) Program about services and benefits for which they are eligible. OHCOBR will work with these organizations to follow through on this needed service.

## *Recommendations (cont'd)*

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- We recommend that OHCOBR continue to aggressively pursue grant funding as opportunities become available, to further expand and enhance its operations.
- We recommend that OHCOBR continue to work with the Department of Behavioral Health (DBH) and other health care providers and insurance plans to reduce barriers to mental health and substance abuse services. Continuity and integration of care are ongoing challenges in light of current laws and rules governing the sharing of Protected Health information (PHI). Sharing PHI among a consumer's health care providers and insurers is essential. This issue needs to be resolved in a manner that is legal and guarantees the best possible treatment and outcome for the consumer.
- We recommend that OHCOBR work with DBH, the Department of Health (DOH) and the District's home health agency (HHA) representatives to improve care and outcomes for HHA consumers, especially those who have behavioral health issues. Suggested enhanced training for HHA staff and aides includes:
  - Assessment and record keeping, case management, and care coordination;
  - Behavioral health training and on-going in-service instruction around behavioral health issues for all home health aides;
  - Pre-placement orientations to make aides aware of behavioral health issues, diagnoses, and medical triggers that require a call to their supervisor;
  - Advanced training of aides on what to expect when working with Alzheimer and Dementia patients, before the aides are assigned to these patients;
  - Ensuring that HHA's aides are familiar with how to access the DBH Mobile Crisis Team and know when to call;
  - Ensure that home health aides know how and when to make 911 calls for emergency assistance; and
  - Ensure mandatory on-going training for home health aides on cultural awareness, on-the-job etiquette, and ethics, with periodic competency testing.
- We recommend stakeholder collaboration to ensure that home and community-based consumers serviced by Medicaid MCOs, core service agencies, and home health agencies have immediate access to community behavioral health programs.
- We recommend that Medicaid MCOs work with the HHAs to make them aware of the services that are available to the members that are being served by the HHAs, i.e. 24/7 toll free hotlines, holistic approaches to a comprehensive continuum of care that offers comprehensive health assessment, maintenance and preventative care measures and includes behavioral health, suicidology specialists, community services, and hospitalization.
- We recommend that all home health agencies maintain a reserve fund in an amount based on their business model and number of people served to protect consumers and employees from disruptions in service and to stabilize care delivery and continuity.



*FY 2013 DATA  
COLLECTION REPORT*

# *Data Collection Summary & Highlights*

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During FY 2013 the OHCOBR tracked all communications and contacts received. The OHCOBR classified all contacts as “cases” investigated by our Office. (A separate summary of the annual data reports provided by commercial insurance companies on cases they investigate through their internal grievance and appeals process is located in the Appendix.) The OHCOBR staff recorded all contacts in a standardized *Health Care Ombudsman In-Take Tracking Log* that has specific categories for classifying cases. With the assistance of the Department of Health Care Finance, Division of Analytics and Policy Research, we were able to produce the necessary statistics, tables and graphs for FY 2013 (October 1, 2012 through September 30, 2013) as presented below.

*In collecting data, the OHCOBR sought to answer the following key questions:*

- How do the residents of the District of Columbia contact the OHCOBR?
- Who contacts the OHCOBR?
- What are the most common issues experienced by the community?

## *Data Collection Report Highlights:*

- In FY2013, the Office of Health Care Ombudsman and Bill of Rights opened a grand total of 6,507 non-commercial and commercial cases;
- Percentage of closed/resolved non-commercial cases was (96% - 6,233 closed/resolved cases) out of a grand total of the 6,507 non-commercial cases opened);
- Of the 6,507 non-commercial and commercial cases opened, the Office of Health Care Ombudsman and Bill of Rights opened a total of 274 Commercial Health Plan member cases;
- Of the 274 Commercial Health Plan member plan member cases, 174 cases were Access-Appeals/Grievances (Bill of Rights) issues, which presented the largest category of issues encountered by the members;
- One hundred percent (100%) of the 100 Non-Appeals/Grievances (Bill of Rights) cases for the Commercial Health Plan members were closed/resolved;
- Sixty percent (60%) of the 174 Appeals/Grievances (Bill of Rights) cases for the Commercial Health Plan members were closed/resolved;
- In FY2013, the Average Number of Days for the Offices of Health Care Ombudsman and Bill of Rights to close/resolve non-commercial cases was 4 days;
- In FY2013, the Average Number of Days for the Office of Health Care Ombudsman and Bill of Rights to close/resolve Commercial (Appeals/Grievances-Bill of Rights) cases was 92 days; and the Average Number of Days for the Office of Health Care Ombudsman and Bill of Rights to close/resolve Commercial (Non-Appeals/Grievances-Bill of Rights cases was 14 days;

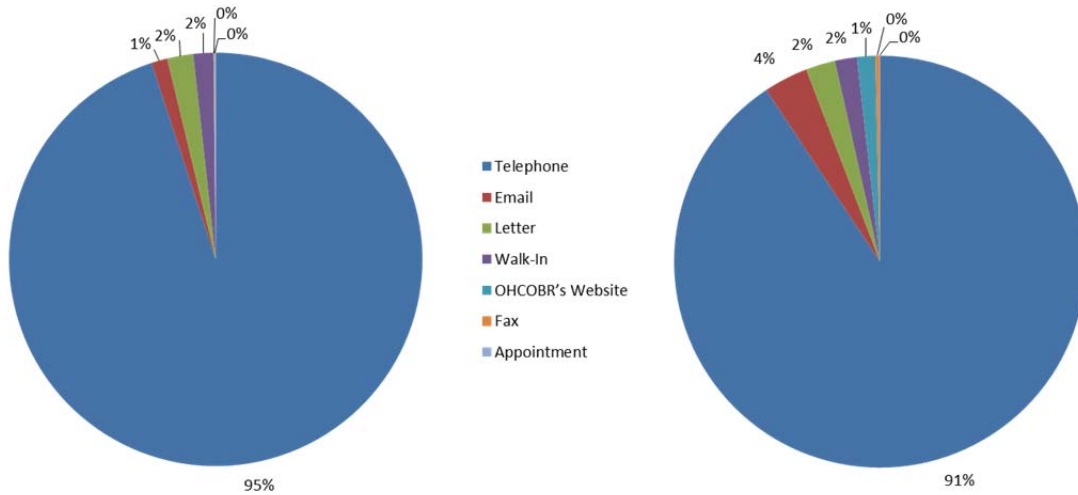
## *Data Collection Summary & Highlights (cont'd)*

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- Of 6,507 cases opened 98% (6,401 cases) were closed/resolved;
- Of 6,401 cases closed/resolved 6,200 were closed successfully;
- Of 6,507 cases opened 274 were from beneficiaries of Commercial Health Plans (Commercial cases);
- Of 274 opened Commercial cases 174 had issues related to Access-Appeals/Grievances (Bill of Rights) which was the largest category of issues encountered by the Commercial Health Plan members;
- OHCOBR closed/resolved 60% (105 cases) of the 174 Commercial Health Plan member cases opened with the issue Access-Appeals/Grievances (Bill of Rights) – the remaining 40% (69 cases) are still pending;
- Of 6,401 total number of closed/resolved cases the OHCOBR saved consumers a total of \$460,549.11 broken down as follows:
  - \$359,286.35 (78%) was the result of successful Appeal/Grievance cases;
  - \$33,007.36 (7%) in co-pays was removed from QMB beneficiaries' accounts;
  - \$31,386.60 (7%) was reimbursed to beneficiaries due to non-payment of Medicare Part B Premiums; and
  - \$36,868.80 (8%) was other money saved or recouped for Fee-for-Service (FFS) and MCO Alliance beneficiaries;
- The Average Number of Days for the OHCOBR to close/resolve cases was 5.5 days;
- OHCOBR closed/resolved 5,200 on the same day the case was opened (80% of 6,507 cases opened);
- Of the 111 cases filed by the OHCOBR for Administrative/Fair Hearings - 48 cases were filed on behalf of EPD Waiver beneficiaries;
- Most consumers (91%) utilized the telephone to contact the OHCOBR;
- Medicare Part A/B (QMB) beneficiaries represented the largest group that contacted the OHCOBR;
- Ward 7 had the highest number of contacts of all consumer contacts across all eight wards, followed by Ward 5 and Ward 8;
- Eligibility issues represented the largest category of issues encountered by all consumers;
- Eligibility issues represented the largest category of issues encountered by MCO and MCO-Alliance beneficiaries;
- Access/Coverage issues (to include denials) represented the largest category of issues encountered by Dual Eligible (Medicaid/Medicare), and Medicaid FFS beneficiaries;
- Eligibility issues represented the largest category of issues encountered by Medicare Part A/B (QMB) beneficiaries;
- The OHCOBR opened a total of 107 Transportation cases in FY 2013 versus 110 Transportation cases opened in FY 2012, indicating that these issues continued to present themselves at a consistent rate; and
- The OHCOBR opened a total of 208 Uninsured cases in FY 2013 versus 26 Uninsured cases opened in FY2012, representing a twelvefold increase over the previous year.

# Data Collection Report

**Figure 1. Methods of Contacting OHCOBR  
FY12 and FY13**

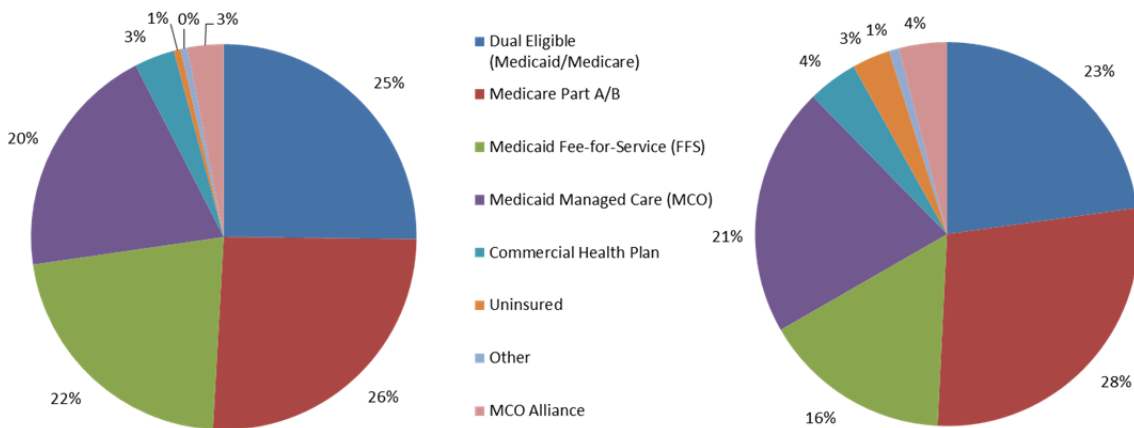


**FY12 Total Sample = 4,472 contacted**

**FY13 Total Sample = 6,507 contacted**

Source data captured between October 1, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

**Figure 2. OHCOBR Contacts by Insurance Type  
FY12 and FY13**



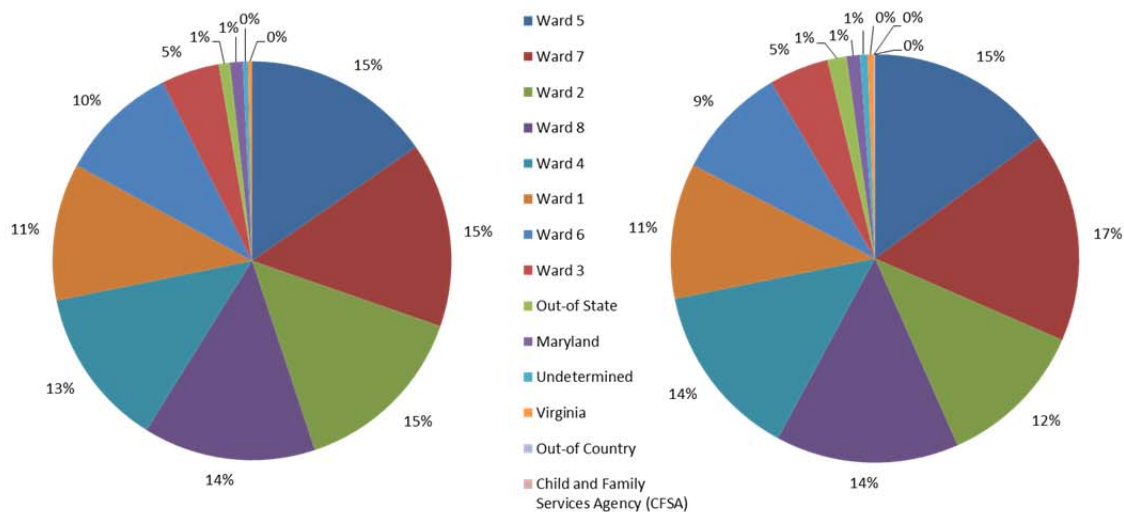
**FY12 Total Sample = 4,472 contacted**

**FY13 Total Sample = 6,507 contacted**

Source data captured between October 1, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

# Data Collection Report (cont'd)

## Figure 3. OHCOBR Contacts by Ward—FY12 and FY13

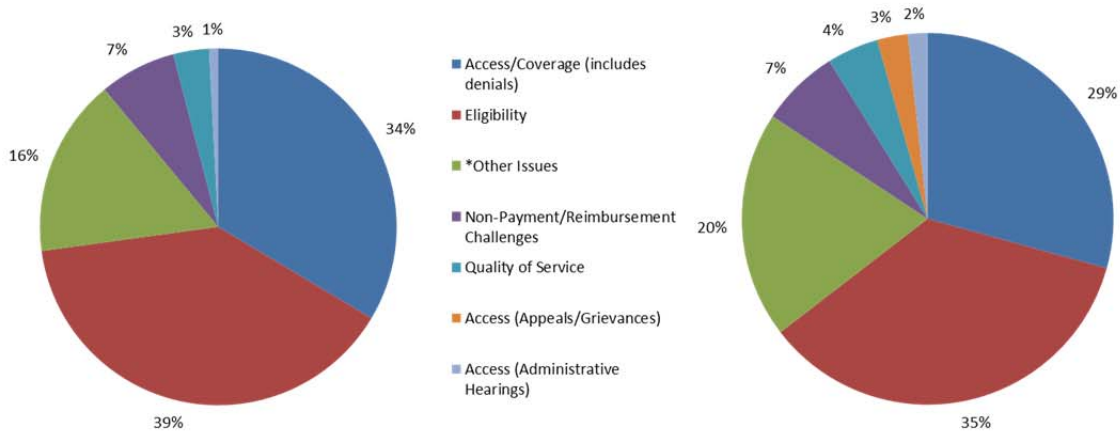


FY12 Total Sample = 4,472 contacted

FY13 Total Sample = 6,507 contacted

Source data captured between October 1, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

## Figure 4. Categories of Issues Encountered by Consumers—FY12 and FY13



FY12 Total Sample = 4,472 contacted

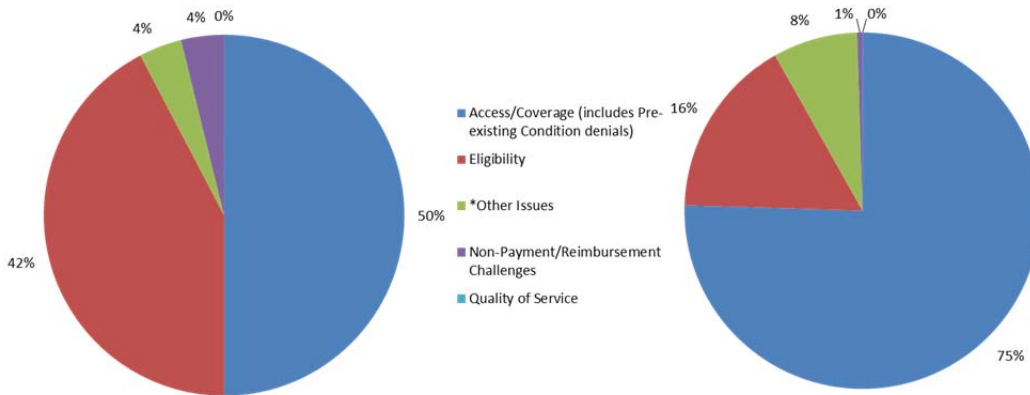
FY13 Total Sample = 6,507 contacted

\*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, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

# Data Collection Report (cont'd)

## Figure 5. Categories of Issues Encountered by Uninsured Consumers—FY12 and FY13



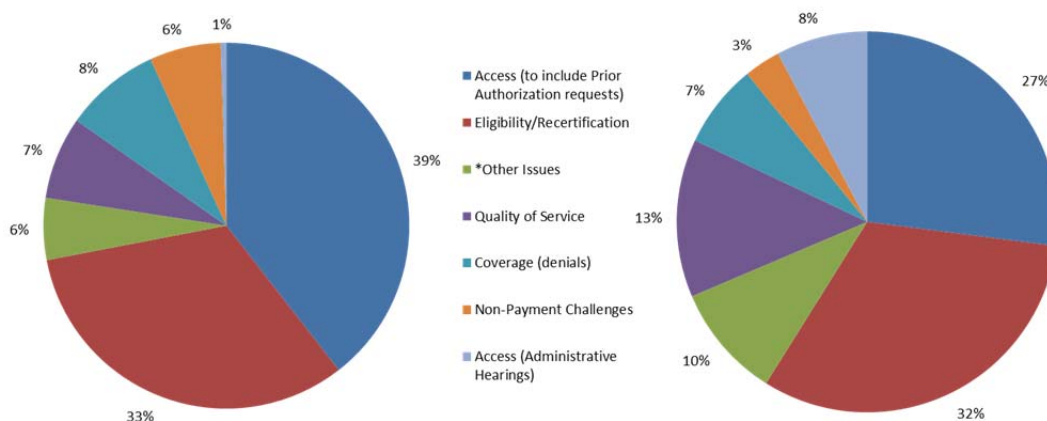
FY12 Total Sample = 26 contacted

FY13 Total Sample = 208 contacted

\*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, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

## Figure 6. Categories of Issues Encountered by EPD Waiver Beneficiaries--FY12 and FY13



FY12 Total Sample = 603 contacted

FY13 Total Sample = 618 contacted

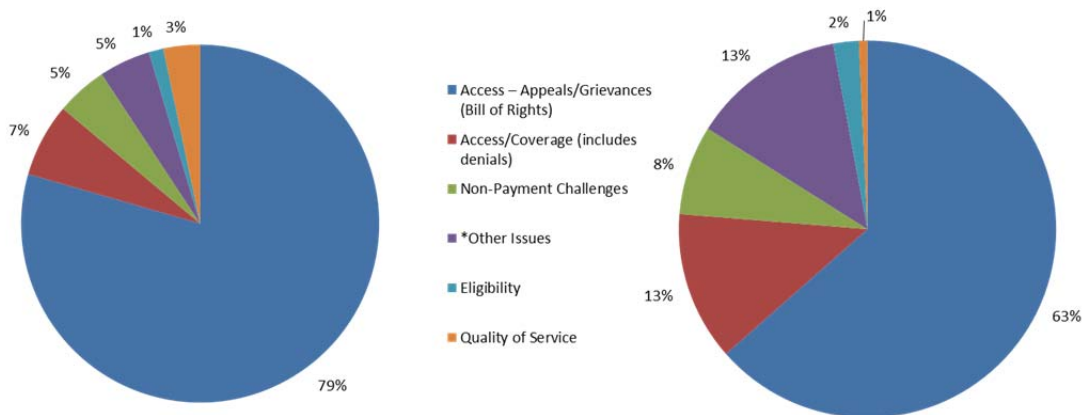
\*Other Issues: Anomalous and generic complaints such as auto repairs, banking issues, burial assistance, death certificates, duplicate QMB ID cards, food stamps, fraud-Medicaid/Medicare; housing assistance, legal services, name/address change, names misspelled on QMB ID cards, non-receipt-QMB ID cards, 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, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013



# Data Collection Report (cont'd)

**Figure 7. Categories of Issues Encountered by Commercial Health Plan Members—FY12 and FY13**



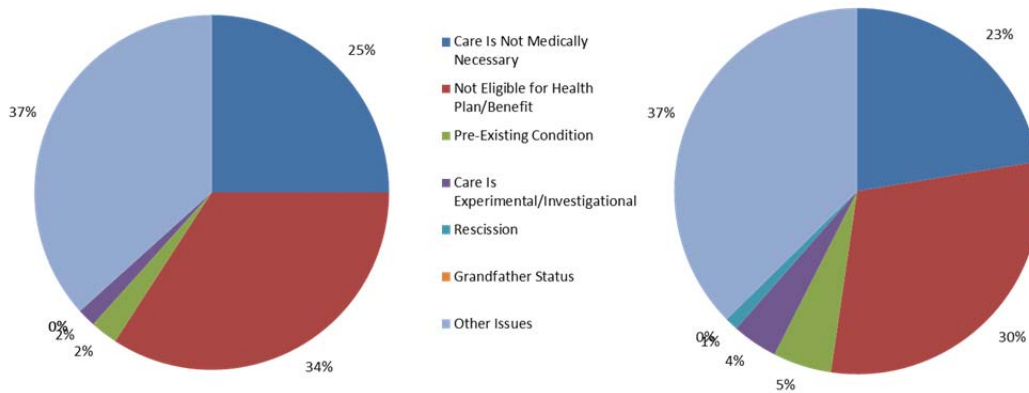
**FY12 Total Sample = 151 contacted**

**FY13 Total Sample = 274 contacted**

\*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, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

**Figure 8. Categories of Types of Appeal/Grievance Cases (Bill of Rights) Encountered by Commercial Health Plan Members--FY12 and FY13**

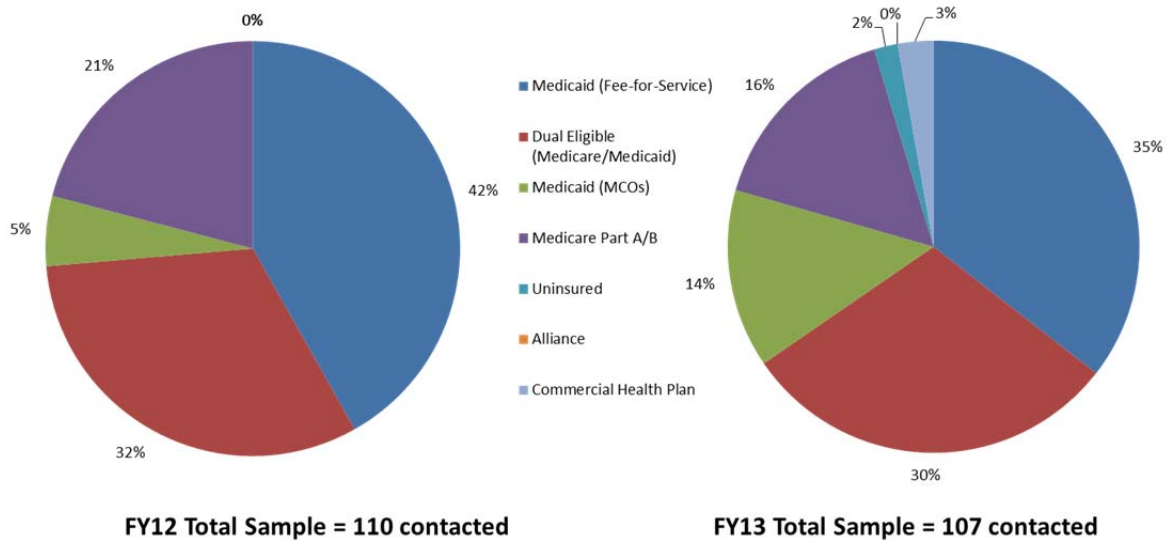


**FY12 Total Sample = 120 contacted**    **FY13 Total Sample = 174 contacted**

Source data captured between October 1, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

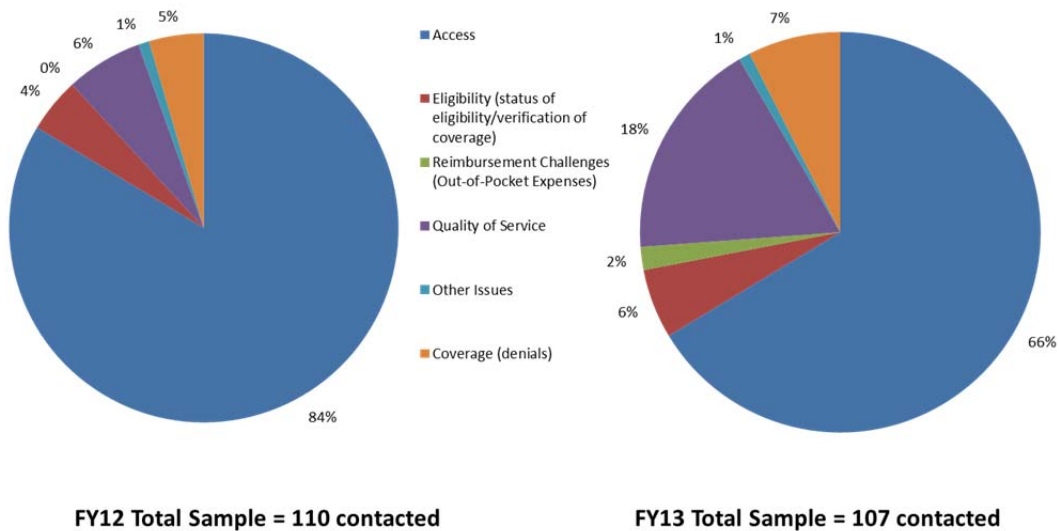
# Data Collection Report (cont'd)

**Figure 9. Transportation Contacts by Insurance Type—  
FY12 and FY13**



Source data captured between October 1, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

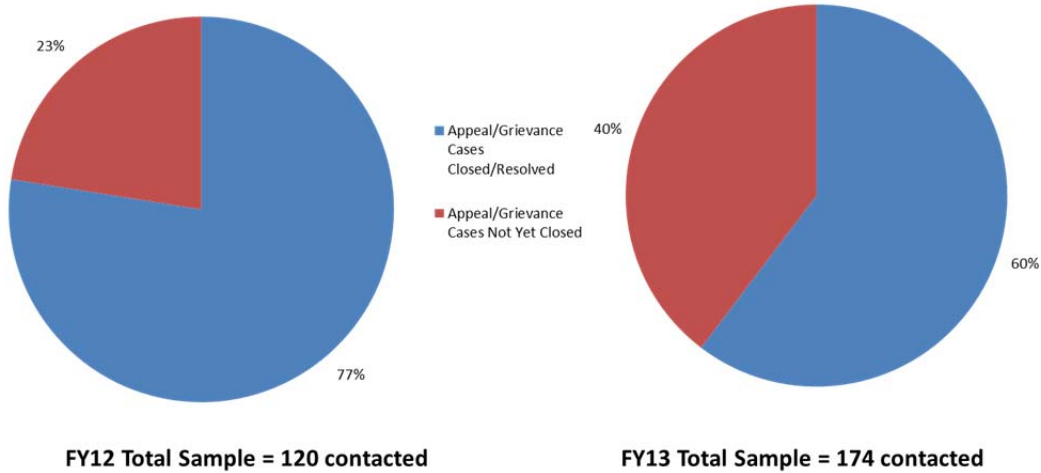
**Figure 10. Categories of Transportation Issues Encountered by  
Contacts—FY12 and FY13**



Source data captured between October 1, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

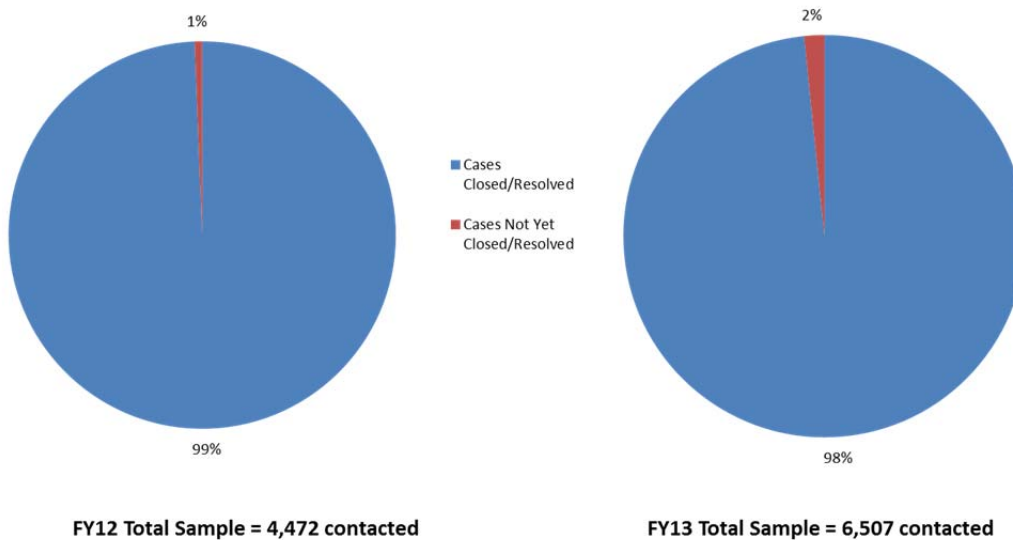
# Data Collection Report (cont'd)

**Figure 11. Number and Percentage of Closed/Resolved Appeal/Grievance Cases (Bill of Rights) Among the Commercial Health Plan Members—FY12 and FY13**



Source data captured between October 1, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

**Figure 12. Number and Percentage of Closed/Resolved Cases Among OHCOBR Consumers—FY12 and FY13**



Source data captured between October 1, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013

# *Appendix*

## Appendix – Outreach/Education Events

Table 1. - Outreach/Education Events – FY 2013

### OCTOBER 1, 2012 - SEPTEMBER 30, 2013

EVENT DATE	OHCOCR'S PARTICIPATION	NAME OF ORGANIZATION/GROUP	NUMBER OF ATTENDEES
November 21, 2012	EXHIBITOR/FOOD SERVER	WARD 2 – SAFEWAY'S FEAST OF SHARING ANNUAL HEALTH, JOB AND LUNCH	4,000
December 5, 2012	EXHIBITOR	WARD 6 – MAYOR ANNUAL SENIOR HOLIDAY CELEBRATION	3,900
April 10, 2013	EXHIBITOR	WARD 5 – PUBLIC MEETING - MAYOR VINCENT C. GRAY'S FY2014 BUDGET TOWN HALL MEETING	250
April 18, 2013	EXHIBITOR	WARD 4 – PUBLIC MEETING - MAYOR VINCENT C. GRAY'S FY2014 BUDGET TOWN HALL MEETING	300
April 24, 2013	PARTICIPANT	AARP  TEAM ORIENTATION & TRAINING FOR OUTREACH COORDINATORS ON HEALTH REFORM IN THE DISTRICT OF COLUMBIA	20
April 25, 2013	EXHIBITOR	WARD 6 – PUBLIC MEETING – MAYOR VINCENT C. GRAY'S FY2014 BUDGET TOWN HALL MEETING	350
April 30, 2013	EXHIBITOR	WARD 3 – PUBLIC MEETING – MAYOR VINCENT C. GRAY'S FY2014 BUDGET TOWN HALL MEETING	275
May 2, 2013	EXHIBITOR	WARD 7 – PUBLIC MEETING – MAYOR VINCENT C. GRAY'S FY2014 BUDGET TOWN HALL MEETING	375

## Appendix – Outreach/Education Events (cont'd)

Table 1. (cont'd) – Outreach/Education Events – FY 2013

### OCTOBER 1, 2012 – SEPTEMBER 30, 2013

<b>May 10, 2013</b>	EXHIBITOR	WARD 3 – MAYOR'S AGE-FRIENDLY CITY SENIORS SYMPOSIUM – HOSTED BY DISTRICT OF COLUMBIA OFFICE ON AGING	500
<b>May 29, 2013</b>	EXHIBITOR	WARD 1– 3 <sup>RD</sup> ANNUAL NATIONAL SENIOR HEALTH & FITNESS DAY	100
<b>June 1, 2013</b>	EXHIBITOR	WARD 3 – AFRICAN HEALTH AND WELLNESS FETA – SPONSORED BY THE OFFICE OF THE MAYOR	300
<b>June 15, 2013</b>	EXHIBITOR	WARD 4 - COUNCILMEMBER BOWSER'S FAMILY FUND DAY	300
<b>June 20, 2013</b>	EXHIBITOR	CONGRESSWOMAN NORTON'S COMMUNITY HEALTH OUTREACH EVENT	200
<b>June 28, 2013</b>	EXHIBITOR	MARTHA'S TABLE HEALTH FAIR	500
<b>August 24, 2013</b>	EXHIBITOR	MEDSTAR FAMILY CHOICE – FAMILY FUN DAY	500
<b>September 7, 2013</b>	EXHIBITOR	11 <sup>TH</sup> STREET BRIDGE CELEBRATION – OFFICE OF THE MAYOR	500
<b>September 17, 2013</b>	EXHIBITOR	DHCF – LONG-TERM CARE	300

# Appendix – Commercial Insurance Self-Reports

## Commercial Insurance Annual Self-Reports

The office of Health Care Ombudsman and Bill of Rights (OHCOBR) requires commercial insurance companies to submit an annual report on cases processed through their internal grievances and appeals system, using a format provided by OHCOBR. The report contains information on cases they review and resolve internally, without input from the OHCOBR. In some cases, beneficiaries of commercial insurers contact OHCOBR for assistance, or if they are not satisfied with the disposition of their case by their health plan. Once OHCOBR is contacted, those cases are reported separately along with all the other cases processed by OHCOBR (see Figures 2, 7, 8 and 11); consequently, a beneficiary's case may be included on both reports.

(The *Commercial Insurer's Annual Self-Report* is a legislative requirement stipulated in D.C. Code 44-301.10, 2001 Edition.)

### § 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 OHCOBR's Policy and Procedure and Legal Subcommittee is in the process of analyzing the FY 2013 annual reports and will make recommendations for changes to the reporting format, with input from commercial health plan representatives. The goal is to improve data gathering so that OHCOBR can be

## *Appendix – Commercial Insurance Self-Reports (cont'd)*

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more strategic in its analysis and put forth more meaningful recommendations to the D.C. Council and to commercial health plans on how their internal grievances and appeals activities can be improved to better serve District health care consumers.

### *Service Categories Reported*

- 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

### *Data Summary and Highlights (FY 2013)*

- Nineteen (19) of thirty-three (33) companies reported consumer grievances/appeals; fourteen (14) reported they had no grievances/appeals.
- A total of 1,865 cases were opened by 19 of 33 companies that submitted reports.
- A total of 733 of 1,865 opened cases resulted in the initial decision being upheld (39%).
- A total of 805 of 1,865 opened cases resulted in the initial decision being overturned in favor of the beneficiary (43%).
- A total of 327 of 1,865 opened cases were partially overturned in favor of the beneficiary (18%), for a combined total of 1,232 cases overturned and partially overturned (61% of all opened cases).
- Of the 19 companies reporting grievances/appeals 8 had an overturned and partially overturned rate of 40% or higher of that company's opened cases.
- The three most prevalent categories of reported grievances were Physician, Lab/Radiology, and Pharmacy Services.

The following tables summarize some of the findings from the FY 2013 annual report of internal grievances and appeals submitted to OHCOBR by commercial insurers.



## Appendix – Commercial Insurance Self-Reports (cont'd)

Table 2. – Commercial Insurers' Annual Self-Report<sup>2</sup> – FY 2013

[GRAY SHADING INDICATES NO GRIEVANCES WERE REPORTED]

NAME OF INSURER	TOTAL APPEALS/ GRIEVANCES	CASES UPHELD		CASES OVERTURNED		CASES PARTIALLY OVERTURNED	
		#	%	#	%	#	%
Aetna Health Inc.	59	40	68%	18	31%	1	1%
Allianz Life Insurance Co. of America	0						
American Specialty Hospital	0						
Ameritas Life Insurance Co.	92	73	79%	17	18%	2	3%
Blue Choice, Inc.	248	80	32%	166	67%	2	1%
CareFirst of Maryland, Inc.	108	45	42%	54	50%	9	8%
Cigna Health and Life Ins. Co.	31	25	81%	6	19%	0	
Cigna Healthcare Mid-Atlantic Inc.	0						
Connecticut General Life Ins. Co.	118	98	83%	16	14%	4	3%
Continental American Ins Co.	0						
Delta Dental Ins. Co.	40	20	50%	18	45%	2	5%
Fidelity Security Life Ins. Co.	1	0		1	100%	0	
Golden Rule Ins. Co.	2	2	100%	0		0	
Group Hospitalization & Medical Services	309	112	36%	188	61%	9	3%
John Alden Life Ins. Co.	5	5	100%	0		0	
Kaiser Permanente	149	68	46%	77	52%	4	2%
MAMSI Life & Health Ins. Co.	0						
Metropolitan Life Ins. Co.	593	90	15%	213	36%	290	49%
MDIPA	16	14	88%	1	6%	1	6%
Optimum Choice, Inc.	0						
Principal Life Ins. Co.	1	1	100%	0		0	
Prudential Ins. Co. of America	0						
Reliance Standard Life Ins. Co.	0						
Standard Insurance Co.	20	16	80%	4	20%	0	
Time Insurance Company	35	12	34%	22	63%	1	3%
Trustmark Insurance Co.	0						
Trustmark Life Ins. Co.	0						
UniCare Life & Health Ins. Co.	0						
Union Security Insurance Co.	0						
United Concordia Life & Health	0						
United Healthcare Ins. Co.	3	3	100%	0		0	
United Healthcare Life Ins. Co.	0	0		0		0	
United Healthcare of Mid-Atlantic	35	29	83%	4	11%	2	6%
<b>TOTAL</b>	<b>1,865</b>	<b>733</b>	<b>39%</b>	<b>805</b>	<b>43%</b>	<b>327</b>	<b>18%</b>

<sup>2</sup> **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.

## Appendix – Commercial Insurance Self-Reports (cont'd)

Table 3. Cont. – Commercial Insurers' Annual Self-Report<sup>3</sup>– FY 2013

[GRAY SHADING INDICATES NO GRIEVANCES WERE REPORTED]

NAME OF INSURER	RESOLUTION TIMES BY TYPE OF CASE			
	MEDICAL EMERGENCY [HOURS]	MENTAL HEALTH EMERGENCY [DAYS AND HRS]	MEDICAL NON-EMERGENCY [CALENDAR DAYS]	MENTAL HEALTH NON-EMERGENCY [CALENDAR DAYS]
Aetna Health Inc.		13.5 Calendar Days	15	
Allianz Life Insurance Co. of America				
American Specialty Hospital				
Ameritas Life Insurance Co.	n/a	n/a	n/a	n/a
Blue Choice, Inc.	12		47.6	23
CareFirst of Maryland, Inc.			53.1	
Cigna Health and Life Ins. Co.			21	4
Cigna Healthcare Mid-Atlantic Inc.				
Connecticut General Life Ins. Co.	192	96 Hrs	24	4
Continental American Ins Co.				
Delta Dental Ins. Co.			26	
Fidelity Security Life Ins. Co.			10	
Golden Rule Ins. Co.			45	
Group Hospitalization & Medical Services	10		55.8	14
John Alden Life Ins. Co.			21	
Kaiser Permanente	21.5	10.9 Hrs	26.6	23.9
MAMSI Life & Health Ins. Co.				
Metropolitan Life Ins. Co.			17.89	
MDIPA		24 Hrs		27
Optimum Choice, Inc.	n/a	n/a	n/a	n/a
Principal Life Ins. Co.			7	
Prudential Ins. Co. of America				
Reliance Standard Life Ins. Co.				
Standard Insurance Co.	n/a	n/a	n/a	n/a
Time Insurance Company			22.43	
Trustmark Insurance Co.				
Trustmark Life Ins. Co.				
UniCare Life & Health Ins. Co.				
Union Security Insurance Co.				
United Concordia Life & Health				
United Healthcare Ins. Co.		24 Hrs		12
United Healthcare Life Ins. Co.	n/a	n/a	n/a	n/a
United Healthcare of Mid-Atlantic		24 Hrs		19

<sup>3</sup> **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.



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Vincent C. Gray, Mayor**