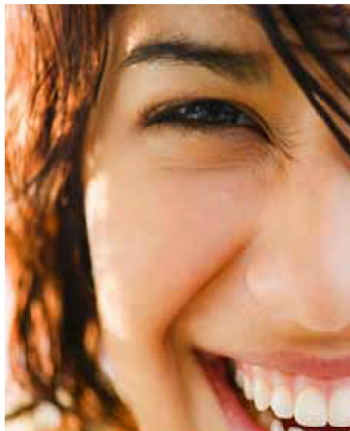
DISTRICT OF COLUMBIA

HEALTH CARE OMBUDSMAN

The Knowledge to Guide You

ANNUAL REPORT FY 2014



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MESSAGE FROM THE DIRECTOR

The Department of Health Care Finance (DHCF) continues to strive for excellence in providing medical assistance and guidance to both public health beneficiaries and members of commercial insurance health plans. Fiscal year 2014 proved a successful year and I am pleased to share with you here a few noteworthy achievements.

The Ombudsman's Office increased awareness of the services available to individuals. Partnering with *Enroll America*, a multi-phased marketing plan was developed and implemented. The plan included the branding of the OHCOBR and its programs; the creation of factsheets; and a televised public service announcement airing on the Oprah Winfrey Network (OWN), Lifetime Movie Channel (LMC), and others.

Access to benefits for low-income Medicare recipients was increased when the OHCOBR identified a more efficient way to produce Qualified Medicare Beneficiary (QMB) cards. The Ombudsman determined that producing the cards in-house would be more efficient and staff would provide better quality control. She was right! With the cooperation of her team, the practice has proved successful, dramatically shortening the time from request to delivery by nearly one month.

Other accomplishments include the establishment of an effective internal review process to hasten resolution of commercial insurance appeals and a case tracking system that is now fully automated, providing real time access by all staff and ensuring data integrity of customers' protected health information. Finally, the OHCOBR internship program continued for a seventh year, preparing future healthcare advocates and customer-centered professionals. The OHCOBR team consists of fewer than twenty individuals who advocate for the nearly 659,000 residents of the District of Columbia, as well as workers and visitors to the nation's capital. Most requests for service reach the Ombudsman's Office via calls to a dedicated hotline from people with issues of varying complexity, related to public benefits, commercial insurance plans, workman's compensation, and health plans for college students. The OHCOBR is truly making a difference for those in need of support and assistance as they navigate the health care system.

Please join me in saluting the Ombudsman and staff for another outstanding year of public service.

Wayne Turnage
Department of Health Care Finance

MESSAGE FROM THE HEALTH CARE OMBUDSMAN

On behalf of the Office of Health Care Ombudsman and Bill of Rights (OHCOBR), I am pleased to present our *Fiscal Year 2014 Annual Report.* This report is produced and distributed in accordance with DC Code: Title 7, Chapter 20A, Health Care Ombudsman Program **§7-2071.06. Data Collection and Reporting, which requires us to:**

"…submit annually to the Council, the Mayor, the Department of Health, and the Department of Insurance, Securities, and Banking a report on the activities, performance, and fiscal accounts of the Ombudsman Program, issues of concern to the consumers, and the Ombudsman's recommendations to improve health access..."

Last year was impressive for us, thanks in large part to the continuation of two federal Consumer Assistance Program (CAP) grants. Through funding from these grants and the use of mixed media approaches, we were able to expand public awareness of our services to a greater number of DC residents, policyholders, workers and visitors.

Our marketing campaign included strategies for marketing and branding our office, along with the development of multi-cultural outreach and public education materials for our new signature initiative, *Health Care on Tap*, scheduled to begin in early fiscal year 2015. This exciting new initiative takes our services into the community. You can read more about it in the annual report. We hope to see you at one of these events in the future.

Members of our Outreach and Education Subcommittee of the Ombudsman's Advisory Council were present at twenty community events attended by more than 18,000 people. They engaged the public and distributed materials to English and non-English speaking participants. These events and our marketing campaign helped spark an increase in the number of people we served to more than 7,900, significantly more than the 6,500 served in the previous year.

As you read through this report we hope you recognize and appreciate the positive advances made in FY2014, and continue to view the OHCOBR as a useful resource for consumer advocacy, education, and support.

Should you have any questions regarding this *Fiscal Year 2014 Annual Report*, please feel free to contact us by phone at 1-(877) 685-6391, (202) 724-7491, or via email at healthcareombudsman@dc.gov.

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

WHO WE ARE

HISTORY . . .

The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) was established in February 2009. It is a division of the Department of Health Care Finance (DHCF), but has legislative authority to operate with full autonomy and independence under the direction of the DC Health Care Ombudsman. DHCF was formerly the Medical Assistance Administration (MAA) in the Department of Health (DOH). In February 2008 MAA became the Department of Health Care Finance, a separate cabinet-level agency (DC Code 7-771). Besides the Ombudsman's Office, DHCF administers the District's Medicaid program, the Children's Health Insurance Program (CHIP), and other publicly funded health care benefits programs. The close organizational alliance between OHCOBR and DHCF is beneficial for meeting the mission of each.

DUTIES AND RESPONSIBILITIES . . .

The Health Care Ombudsman is responsible for providing the public with advocacy, education and community outreach services regarding access to health benefits, and ensuring that benefits meet their needs. The Ombudsman's staff function as a well-coordinated team to solve consumer complaints and facilitate the appeal and grievance process. They expedite the resolution of issues by interceding with others on behalf of consumers. The team educates the community about individual rights and responsibilities regarding health benefits and facilitates enrollment in health plans and private and public insurance programs.

FUNDING . . .

The DC Council fully supports the OHCOBR with approved funding from several sources: DC appropriations, Federal Medicaid matching funds, special purpose funds for Patient Bill of Rights expenses, and funds from commercial insurer assessments.

LEGISLATIVE AUTHORITY . . .

The OHCOBR is guided by two legislative mandates, The Ombudsman's Program, which established the Ombudsman's office, describing its purpose and duties (DC Law 15-331; DC Official Code 7-2071.01); and The Health Benefits Plan Members Bill of Rights Act, which established grievance procedures for health benefits plans (DC Law 19-546; DC 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. 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 cash remuneration, or any other kind of compensation to the office or its staff. This independence and autonomy gives the Ombudsman's office greater flexibility in resolving problems and advocating unencumbered on behalf of their customers. Their loyalt,y first and foremost, is to the people they serve.

COLLABORATIONS . . .

Although OHCOBR operates with sovereignty, being part of DHCF provides the opportunity to resolve complaints quickly through close collaboration with staff and senior leadership from the other DHCF offices and administrations. The OHCOBR also has an effective close working relationship with the Department of Insurance Securities and Banking (DISB), the District's insurance regulator. DISB includes information about OHCOBR on all customer correspondence, and the staff routinely educates private health plan members about the full range of support the OHCOBR offers in navigating the appeals process. Nurturing this collaboration has proved effective, resulting in a significant increase in cases identified for transfer from DISB to the OHCOBR, and vice versa. The OHCOBR enjoys other collaborative relationships with District agencies such as the DC Health Benefit Exchange Authority (DCHBX) and the Economic Security Administration (ESA) where eligibility for public benefit programs is determined. A more complete list of our internal and external partners is available in the section on "Collaborations."

GROWTH AND THE FUTURE . . .

Not surprisingly, the increased identification and transfer of cases to OHCOBR has resulted in an increased workload. Implementation of the Affordable Care Act and the open enrollment process through health benefit exchanges has also impacted the volume of calls from consumers seeking information, intervention and assistance. The Consumer Assistance Program grants awarded by the U.S. Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid (CMS), have helped build the necessary human capital and other resources to handle the steady flux of consumer requests for assistance and advocacy, and to maintain and foster the current collaborative relationship with DISB and others as we go forward. Ongoing efficiencies, cost savings, and annual appropriated budget requests will maintain long-term sustainability.

Meet the Ombudsman Staff

Charlita Brown, BS
Associate Health Care Ombudsman

Marlena Edwards, MSW
Associate Health Care Ombudsman

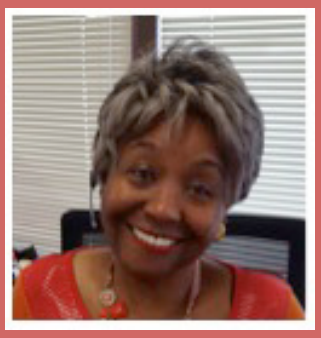
Aminata Jalloh, BS
Associate Health Care Ombudsman

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

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

Mirka Shephard
Associate Health Care Ombudsman

Loretta Smith, RN
Associate Health Care Ombudsman



Shirley Tabb, LICSW
Associate Health Care Ombudsman

Daisha Watson, BA
Associate Health Care Ombudsman

Not pictured:

Carmencita Kinsey
Associate Health Care Ombudsman

Cardiss Jacobs
Associate Health CareOmbudsman

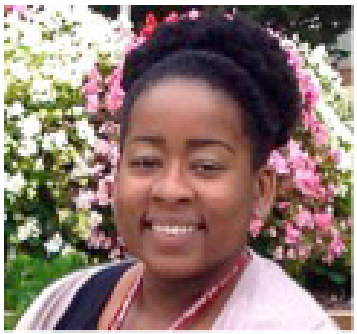
Robert Taylor
Return to Work Staff Member

Meet the Ombudsman Interns

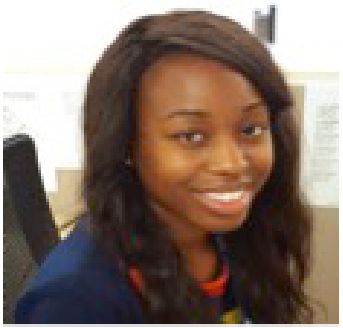
The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) offers internships so that college students can have the opportunity to work in a professional environment while pursuing their college degree. OHCOBR began offering internships in 2009; making fiscal year 2014 the seventh year the program has been available to students.

During the academic school year, interns are allowed to work up to 36 hours a week. During summer break they can work up to 40 hours a week. Each intern has a mentor assigned to him or her for guidance while performing duties that are essential to the operational efficiency of the office. They learn quickly and bring fresh energy and enthusiasm to their role as public advocates.

Below are the interns who supported the Ombudsman's office in FY2014:

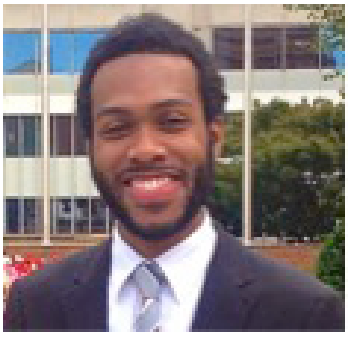


Zakia Chapman
Student Intern
George Mason U.
Major: Community Health
Graduation: Fall 2015



Blessing Adodo
Student Intern
Howard University
Major: Pharmacy
Graduation: Spring 2016

Shaquashia McDuffie
Student Intern
University of the District of Columbia
Major: Social Work
Graduation: Fall 2016



Omari Stewart
Student Intern
Howard University
Major: Architecture
Graduation: Spring 2014

Good News Stories

Throughout FY 2014 OHCOBR staff assisted consumers with issues related to denied claims, outstanding bills, and other matters. We are proud to share some true-life experiences of individuals whose circumstances were changed for the better because of the intervention and support they received from our office.

- We helped a consumer file an appeal that went to an independent review organization (IRO) for an external review of the case. The case involved a health plan member who complained to the insurance company that their payment for care was too low, leaving a large balance for the member to pay out-of-pocket. The insurer denied the member's request to reconsider and refused to pay more, which is why an appeal was filed. The IRO ruled in favor of the member after investigating the member's policy and the the insurer's payment methodology. With the help of our staff the member was reimbursed $33,800.00.

- Two commercial plan members with outstanding medical bills received our help negotiating their cases with their providers. They agreed to remediate the outstanding balances by reducing their bills. In the first case, the provider adjusted the amount due from $250 to $0.00. In the second case, two separate providers revised their bills. The first provider agreed to reduce the original bill from $8,685 to $1,496 with a three-month installment arrangement for payment. The second provider adjusted his bill from $1,330 to $619. Since the plan member had already paid that amount, the final balance on the bill was $0.00.

- We helped one consumer with a dispute on their dental bill. With our intervention the commercial dental claim was eventually adjusted and the plan member was reimbursed $4,500.

- A commercial plan member sustained a traumatic head injury from a fall. The member filed an appeal because the health plan denied payment for emergency care, which was followed by more than 24 hours in the intensive care unit due to a brain bleed. We researched information on treatment for traumatic head injury and included it in a letter to the insurer, requesting reconsideration. The findings from the research confirmed that the hospital provided the appropriate level of service. The insurer reversed its decision and paid the hospital $28,000 to cover the member's medical bill.

- We received a call from a commercial plan member who was seriously injured after being struck by a car while riding his bike. He needed our help to appeal an adverse payment decision made by his health plan. The insurer denied payment for the emergency room care he received because the treating facility was out-of-network. We sent a request to the insurer to reconsider and pay the ER bill based on the fact that the member was taken to the nearest trauma center ER for his condition at the time of the accident, which prevented him from dictating where he should be taken for care. Based on this information the insurer reconsidered the denial and paid the $12,490 claim leaving the member with only a $50.00 co-payment for the ER visit.

- A Medicaid beneficiary presented us with a complaint that for the past five months there were issues and delays in renewing her prescription from her pharmacy. The justification for the last delay was that the beneficiary was not eligible for a refill. To find the cause of the problem we collaborated with the DHCF pharmacist, the Health Care Ombudsman staff, the staff of Xerox State Healthcare, who is the Medicaid Pharmacy Benefit Management (PBM) contractor, and the consumer's primary care physician. It was determined that a miscoding error at the local pharmacy was responsible for the delays The error was corrected and going forward the beneficiary was able to get her prescriptions in a timely fashion to properly address her health care needs.

- The mother of a special needs child contacted our office for assistance with obtaining transportation service after a medical appointment. With our intervention the transportation manager arranged for them to be transported as requested and secured future transportation services for the child and mother.

Consumer Assistance Program Grants

On April 12, 2013, the District requested a twelve (12) month extension for both federal consumer assistance program grants that were initially awarded to the OHCOBR in 2012. The request was approved and the funds were used (1) to complete preparations for implementing the *Health Care on Tap* initiative scheduled for rollout in early FY 2015, (2) to continue staff training so that skills remain sharp and current, and (3) to add more funds to the *Enroll America* contract to continue the overall marketing and media campaign, with special emphasis on reaching Hispanic and non-English speaking persons. Continuation of the campaign deepened the public's familiarity with our services allowing us to help more people.

The two grant periods overlapped and ran concurrently, initially awarded on:

- June 22, 2012 - *Limited Competition for Affordable Care Act - Consumer Assistance Program (Limited Competition CAP)* grant, for twelve (12) months with the extension approved through June 21, 2014.

- August 24, 2012 - *Affordable Care Act (ACA) - Consumer Assistance Program grant (FULL CAP),* for twelve (12) months with the extension approved through August 23, 2014.

BACKGROUND

The goal for the *Limited Competition CAP* grant was to increase consumer awareness of our office and services; to educate District residents and workers who have insurance that is regulated by the Department of Insurance, Securities and Banking (DISB) about our role and the valuable services we provide as their health care advocate; and to provide useful information regarding the Affordable Care Act (ACA) and the rights and responsibilities of individuals as health care consumers.

The goal for the *FULL CAP* grant was to further expand consumer awareness of the valuable advocacy services available from the OHCOBR by creating a robust marketing and media campaign that included our signature initiative *Health Care on Tap.* This grant also increased funding and extended the length of time we could run media outlet announcements and marketing efforts, specifically and strategically targeting Hispanic and non-English speaking communities. We were also able to provide additional staff training on a number of important topics including Supreme Court decisions, changes to local laws, and assisting consumers with accessing premium tax credits.

Health Care on Tap Project

Health Care on Tap is our signature initiative, which will entail monthly staff visits to informal neighborhood settings where individuals of all walks of life can co-mingle and ask the experts questions pertaining to health care services, benefits and insurance issues. Ombudsman staff members will provide consumer education sessions both in groups and one-on-one on topics such as how to file a commercial insurance appeal/grievance, eligibility requirements for health insurance, how to access health care benefits, types of services available for the uninsured and underinsured, and other topics related to the Affordable Care Act (ACA) according to consumers individual needs and interests.

Preparations for this new program were completed in FY 2014 for an anticipated October rollout. Among other things, culturally competent brochures and literature were produced and printed in the seven most prevalent languages spoken in the District (Amharic, Chinese/Mandarin, French, Korean, Spanish, Vietnamese, and English) for distribution to consumers at these and other events.

The Israel Baptist Church in Ward 5 was selected as the location for the debut event. The largest number of requests for assistance originates from this ward.

Interest in this popular hands-on grassroots program indicates that future sessions will be well attended. We will be reporting on the progress of this innovative program in next fiscal year's annual report.

Training

The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is responsible for educating and assisting health insurance consumers, residents and persons employed in the District of Columbia with insurance that is regulated by the Department of Insurance, Securities, and Banking (DISB) concerning access to health care, health insurance and commercial insurance appeals. The Consumer Assistance Program (CAP) grant afforded the Ombudsman staff the opportunity to obtain valuable training by Families USA and other health experts on an array of topics associated with the Affordable Care Act (ACA). This training was instrumental in preparing the staff for open enrollment and in educating them on key aspects of the ACA that took effect January 1, 2014. Training began October 1, 2013 at the start of the 2014 fiscal year.

The trainings included sessions on the following topics:

- Policy Training: Financial Eligibility for Medicaid Long-Term Care Services
- What You Need to Know About the New Modified Adjusted Gross Income (MAGI) Pre-Populated Renewal Form
- The Requirement to Buy Coverage Under the Affordable Care Act Beginning in 2014
- Health Action 2014 Families USA Conference
- Penalties for Employers Not Offering Affordable Coverage Under the Affordable Care Act Beginning in 2014
- Premium Tax Credits
- Filing Whistleblower Complaints under the Affordable Care Act
- MAGI Program Codes
- Employers and the Affordable Care Act
- Overview of 2014 Changes
- DC Medicaid Changes
- DC Health Link
- Electronic Code of Federal Regulations - §155.420 Special Enrollment Periods
- COBRA and DC Health Link
- Special Enrollment in DC Health Link
- Helping Consumers After March 31
- General Guidance on Mental Health/Substance Use Appeals
- Lyme Disease

ADVISORY COUNCIL AND SUBCOMMITTEES

The Health Care Ombudsman Advisory Council was established to facilitate the resolution of health care concerns. Membership is voluntary and includes consumers, government agencies, health benefit plans, consumer advocacy groups, health care facilities, and physicians.

The Advisory Council has five (5) subcommittees that make recommendations to the Advisory Council. Below is a description of the role of each subcommittee:

CLINICAL AND BEHAVIORAL HEALTH

- Frames clinical information in a layperson's terms, detailing the clinical aspects of each case when required;
- Provides aid in researching and defining standard clinical protocols and best practices;
- Collaborates with medical professionals to educate committee members about contemporary issues;
- Serves as external peer reviewer for Medicaid and other complex medical cases.
- Focuses on 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;
- Proposes ways to improve performance and outcomes in care coordination among provider agencies, physicians, and core service agencies in the behavioral health system; and
- Identifies and overcomes barriers for sharing vital information that will assist in the care of mentally ill beneficiaries that are assigned to various home health agencies.

POLICIES AND PROCEDURES AND LEGAL

- Creates, reviews and recommends operating policies and procedures for the Office of Health Care Ombudsman and Bill of Rights;
- Keeps the Ombudsman's office abreast of health care policy, and any new laws and regulations that may impact their duties;
- Provides assistance to the other subcommittees on matters of a legal nature that may require legislative action; and
- Provides recommendations for changes to health care policy legislation, including annual budget proposals that impact on health care coverage and other related health care programs and policies.

EDUCATION AND OUTREACH

- Defines and develops an education and outreach strategy and develops materials around that strategy; and
- Conducts public outreach by providing awareness and availability of government sponsored programs such as DC Medicaid, Health Care Alliance, Qualified Medicare Beneficiary (QMB), Medicare, and the Home and Community Based Waiver programs and health care benefits plans. A complete listing of FY 2014 community outreach and education activities is included in the Appendix.

CHILDREN WITH SPECIAL NEEDS

- Reviews and recommends ways to improve access to quality comprehensive care for children with special needs;
- Provides guidance to parents of children with special needs in obtaining services; and
- Proposes ways to improve performance and outcomes in care coordination among provider agencies, physicians and other child service agencies.

COLLABORATIONS

OHCOBR 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.

- AARP/ Legal Counsel for the Elderly
- Adult Protective Services (DHS)
- AmeriHealth Caritas District of Columbia
- Bread for the City
- Centers for Medicare and Medicaid Services (CMS)
- Child and Family Services Agency (CFSA)
- Council of the District of Columbia
- DC Health Benefit Exchange Authority (DCHBX)
- DC Long Term Care Ombudsman Program
- DC Office on Aging /Aging and Disability Resource Center (ADRC)
- Delmarva Foundation
- Department of Behavioral Health (DBH)
- Department on Disability Services (DDS)
- Department of Health (DOH)
- Department of Health Care Finance (DHCF)
- Department of Insurance, Securities, and Banking (DISB)
- Economic Security Administration (ESA)
- Families USA
- George Washington Health Insurance Counseling Project (HICP)
- Health Services for Children with Special Needs, Inc. (HSCSN)
- IONA Senior Services
- Medicaid Transportation Management (MTM)
- MedStar Family Choice
- Qualis
- Seabury Resources for the Aging
- Social Security Administration (SSA)
- Trusted Health Plan
- Unity Heath Care Clinic
- Whitman-Walker Clinic

ACHIEVEMENTS

Media Campaign/Branding and Logo

A nationally recognized non-profit organization, Enroll America, lent expertise to the Ombudsman's office by developing a culturally sensitive media campaign to inform District consumers that we are here to help them with their health care issues. The campaign included branding and a distinctive new logo with the tag line *The Knowledge to Guide You*, a simple visual rendering and phrase that reflect our mission and service. We use the logo on all our emails, documents and website as we shine a light for consumers on the complex pathways to health services and wellness. The campaign included a public service announcement (PSA) that was videotaped in the Ombudsman's office, aired on several cable channels, and distributed on mobile applications, the OHCOBR website, emails, and various social media outlets like Facebook and Twitter. We credit the success of the media campaign with the uptick in the number of people who contacted our office this fiscal year seeking our help. In addition, a logo and brochures were created for our upcoming special initiative *Health Care on Tap.*

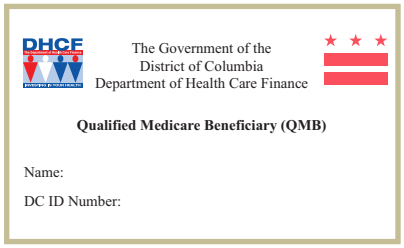
DISTRICT OF COLUMBIA
HEALTH CARE OMBUDSMAN
The Knowledge to Guide You

Preparations Completed for FY 2015 Roll Out of "Health Care On Tap"

The fiscal year ended and so did months of planning for our new informal neighborhood chat initiative that we're calling *Health Care on Tap,* scheduled for an early FY 2015 debut. We will meet you on your 'turf,' in restaurants, hotels, places of worship and other non-traditional settings, to listen to your concerns and give our best advice on how to handle your health care needs. Are you having issues with your insurance company? Don't know how to apply for Medicaid? Need to know where to get free care? Want to know where to complain about your care? We can answer your questions, tackle your issues and see you through the most difficult challenge either directly or by referring you to other more appropriate experts. The ad campaign was readied for launch on multiple media outlets, including radio, print and social media. Brochures and literature were produced in seven languages. Look for this logo after October 2014 and call our office at (202) 724-7491 to find out where and when *Health Care on Tap* will be in your neighborhood or to schedule an event. Then come out and let us hear your story and answer your questions. We may tell you something you didn't think you needed to know….to stay healthy and well.

Qualified Medicare Beneficiary (QMB) Program

From October 1, 2013 to September 30, 2014 the OHCOBR responded to a total of 2,537 requests for QMB cards. During that period we achieved a significant decrease in the turnaround time for beneficiaries to receive their QMB cards; from thirty days when the service was outsourced, to five days or less once OHCOBR began producing and distributing them directly.


The Government of the
District of Columbia
Department of Health Care Finance

Qualified Medicare Beneficiary (QMB)

Name:

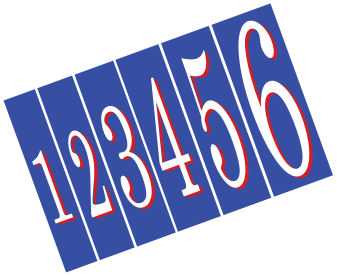
DC ID Number:

QMB beneficiaries need their cards to prove to providers that they are enrolled in the program. Until the card is issued they may need to delay care or face billing and collection issues, if, at the point of service, they can't prove they are eligible for coverage. The QMB program provides Medicare recipients with several important benefits that reduce out-of-pocket medical expenses. DC Medicaid pays Medicare co-payments, monthly Medicare Part B premiums and in some cases Part A, for QMB beneficiaries. Members also qualify for the Low Income Subsidy, which helps with Medicare drug benefit costs through Medicare Part D.

In FY 2014 the Ombudsman decided to discontinue outsourcing the production and distribution of QMB cards due to the length of time it was taking the contractor to get the cards in members' hands, opting instead to manage the process internally. Since the transition, QMB members who come to the office to request their card get it the same day, and mailing cards within three business days completes all other requests. These new processing times are far superior to the outsourced processing times that averaged thirty days from request to delivery. We will continue this process for as long as it remains the best solution to meet members' need, while we evaluate other options.

Increased Service Volume

OHCOBR is reaching and helping more people than ever. In FY 2014 the OHCOBR served nearly 1,400 more consumers and closed 1,126 more cases than in FY 2013. Cases are also being addressed and closed quicker than in previous years; ninety percent of them are closed on the same day the case is opened. We are particularly proud of this accomplishment because it shows continued growth in our ability to address issues with precision and a sense of urgency. We understand how important it is for everyone to have health care coverage, to be able to get the appropriate high quality care they need when they need it, and to get relief from unwarranted and unaffordable financial obligations.



RECOMMENDATIONS

Based on our findings for FY 2014 the Ombudsman offers the following recommendations:

- Recommend that OHCOBR continue efforts to improve mental health information sharing among providers and other essential parties, to maximize consumers' access to benefits and comprehensive care, without compromising confidentiality rights. It is recommended that this issue, including examining, recommending and instituting state-of-the-art protocols, should continue to be a priority of OHCOBR with the ongoing collaboration of the Department of Insurance, Securities and Banking (DISB), the Department of Health Care Finance (DHCF), the Department of Health (DOH) and the Department of Behavioral Health (DBH). Existing laws, including the ACA, require parity with physical medical and surgical care benefits, for mental and/or substance use treatment and services. They also require qualified health plans that are offered on the health benefits exchanges to cover many other behavioral health treatments and services. However, there are special accommodations that must be in place to integrate care and ensure coverage for this special patient group without delaying or reducing access, while also ensuring compliance with confidentiality rights.

  Members of the Clinical and Behavioral Health Subcommittee of the Ombudsman's Advisory Council have taken the lead on this initiative. Subcommittee membership includes Ombudsman's staff, physicians, psychiatrists, consumers and others. Last fiscal year they introduced new disclosure forms for OHCOBR staff to use with mental health cases. They are reviewing use of the forms to determine if they are meeting the need. If they do not, the subcommittee members will look at developing new forms and recommending new approaches to maximize service to this vulnerable population.

- It is recommended that OHCOBR consult with the regulators of commercial insurance companies regarding the denial of payment for services provided by out-of-network emergency services providers. A trend appears to be developing among commercial insurance companies in that they are denying coverage or reducing payments for these services that create financial hardships for beneficiaries. One commercial insurer consistently lowballs provider payments for out-of-network emergency services leaving significant balances for beneficiaries to address.

- Recommend updating the OHCOBR telephone system with recorded classical music and educational messages while callers are on hold, to enhance health knowledge. Messages would include information on the following:

  - Importance of applying for Medicare 3-months prior to one's 65th birthday;
  - Best times to call the ESA service centers and other helpful hints for utilizing service centers;
  - Importance of completing the Medicaid recertification form 60-days in advance of the due date to avoid a gap in coverage;
  - Who must apply for medical assistance through the District of Columbia's health exchange portal?

Data Collection Summary & Highlights

The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) tracks all incoming communications and contacts from various sources, classified as "cases" to be investigated. *(See the Appendix for a separate summary of annual data reports from commercial insurance companies on cases they investigate through their internal grievance and appeals process.)*

Fiscal year 2014 was the first year that the OHCOBR staff recorded all contacts in the new standardized *Health Care Ombudsman In-Take Tracking Log*, which allows all staff to have real-time access to case data. The system sorts cases according to specific classification categories in order to generate reports on types of issues, consumer characteristics, type of benefits and the like.

With the assistance of the Department of Health Care Finance, Division of Analytics and Policy Research, the OHCOBR staff produced the statistics, tables and graphs contained in this report for the 2014 fiscal year, for the period October 1, 2013 through September 30, 2014.

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

- Who contacts the OHCOBR?
- What concerns are trending with regard to consumer issues?
- How does the data compare to the previous year?

Definitions:

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

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

Commercial Health Plan Cases – Commercial health plans are also called private insurance plans. These cases involve beneficiaries who have health coverage through an employee-sponsored plan or a plan that was purchased by an individual from a private insurance company. Grievances and appeals for these cases are handled differently by the OHCOBR than cases involving public benefit programs, such as Medicaid or Medicare.

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

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

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

Undetermined Closed Cases – Cases that were referred to other agencies, organizations or states for resolution but OHCOBR did not know the outcome at the time the case was closed, e.g. cases referred to DISB for investigation regarding benefits and policy issues, Department of Labor to help employees of self-insured companies, Office of Personnel Management to help federal employees, or to the state of origin to help persons with out-of-state insurance. Administrative closures are also included in this category, i.e. cases where the consumer took no action.

Summary Findings from the Data Analysis

- OHCOBR served 21% more consumers in FY 2014 than in the previous year (7,904 in FY 2014 compared to 6,507 in FY 2013).
- The issues raised by all persons contacting the OHCOBR were primarily related to public benefits (Medicaid, Medicare, and the Alliance) (97%). Most of these cases were resolved the same day the case was opened (average 2 days to close a case). This was a significant improvement over FY 2013 when the average time to close a case was nearly twice as long (3.6 days).
- Medicare beneficiaries sought assistance from OHCOBR more often than any other category of consumers (31% of all cases).
- There were no contacts with an issue related to 'pre-existing conditions' in FY 2014. (5% of contacts in FY 2013). Now that ACA is in effect, which prevents denials based on 'pre-existing conditions', OHCOBR will no longer track and report on this issue.
- 'Eligibility' was the single most frequent issue among all consumer contacts (33%), closely followed by 'access/coverage' including denials (30%). Percentages were even higher for 'eligibility' issues among contacts related to Medicaid MCO (47% or 707 of 1,499 cases) and the Alliance (56% or 134 of 238 cases).

- Uninsured contacts trended higher for 'eligibility' issues (45%), which were only 16% the previous year, and away from 'access/coverage' issues (35%), which were 75% of all issues raised by uninsured contacts in FY 2013. This trend is likely due to implementation of DC Health Link and the ACA.

- Issues concerning commercial insurers continue to be challenging, taking more than two months to resolve (average 68.3 days), mainly because nearly 70% of the commercial cases (133 of 192) were sent for a formal review; however, this was a significantly shorter average time than in FY 2013 when the average number of days to close a commercial appeals/grievances case was 91.6 days.

- The commercial cases that were addressed without a formal review (43 of 49 such cases) were almost all resolved the same day the case was opened, a significant improvement over FY 2013 when the average number of days to close a commercial non-appeal/grievance case was 14 days.

- OHCOBR saved consumers nearly one million dollars in FY 2014, more than twice as much as in the previous fiscal year.

Highlights

The following highlights of OHCOBR's performance during FY 2014 is also presented visually in the pie charts below:

- The OHCOBR opened a grand total of 7,904 cases of all types, 21% increase over the 6,507 cases opened in FY 2013.

- The three types of cases included in the grand total are (1) Non-Commercial cases, which includes all public benefits cases, (2) Commercial Non-Appeals/Grievances, and (3) Commercial Appeals/Grievances (Figure 1);

Non-Commercial Cases –

- Of the 7,904 cases, 97% or 7,712 were Non-Commercial cases (Figure 1);

- Of the 7,712 Non-Commercial cases, 95% or 7,304 were closed, 5% or 408 were not closed (Figure 2); 6,550 closed cases were resolved and 694 (9%) were undetermined (see definitions);

- Of the 7,712 Non-Commercial cases, 84% or 6,472 were resolved and closed on the same day they were opened, an increase of 1,559 (32%) same-day closed cases compared to the 4,913 same-day closed cases in FY 2013 (Figure 4);

- On average, Non-Commercial cases were closed in 2 days, nearly twice as fast as in FY 2013 (3.6 average number of days to close);

- The 7,304 closed Non-Commercial cases in FY 2014 represents an increase of 1,126 (18%) closed cases when compared to 6,178 cases closed in FY 2013 (Figure 3 & 4);

Commercial Cases -

- Of the 7,904 grand total of all cases, 3% or 192 cases were related to commercial health plans, representing 82 fewer cases than the 274 commercial cases in FY 2013 (Figure 1);

- Of the 192 Commercial cases, 31% or 59 cases were classified as Commercial - Non-Appeals/ Non-Grievances (Figure 5); most were related to issues and questions about access, denials and coverage (24%), eligibility (10%), and non payment or reimbursement challenges (25%); 39% covered a wide range of other generic complaints and issues;

- Of the 59 opened Commercial - Non-Appeals/Grievances cases, 73% or 43 cases were closed and 27% or 16 cases were not yet closed (Figure 5); of the 43 closed cases, 31 or 53% were resolved, 30 of them were resolved in favor of the consumer; 28% or 12 closed cases were undetermined;

- All but one of the 43 closed Commercial - Non-Appeals/Grievances cases (42 cases) were closed on the same day the cases were opened; the other case was closed within 2 days (Figures 6 & 7). This was a significant improvement over the average of 14 days to close a commercial case in FY 2013;

- Of the 192 Commercial cases opened, 69% or 133 cases were Appeals/Grievances cases;

- Of the 133 Commercial-Appeals/Grievances cases, 48 cases or 36% were closed and 64% or 85 cases were not yet closed (Figure 8); 38 or 28% were resolved in favor of the consumer, 6 or 5% were not, and 4 or 3% were undetermined;

- On average, it took 68.3 days to close Commercial-Appeals/Grievances, as compared to 91.6 days in FY 2013 (Figure 10);

- Of the 133 opened Commercial-Appeals/Grievances cases, 53 or 40% were closed on the same day the case was opened, an improvement compared to 19 same-day closed cases in FY 2013 (Figure 10);

Consumer savings –

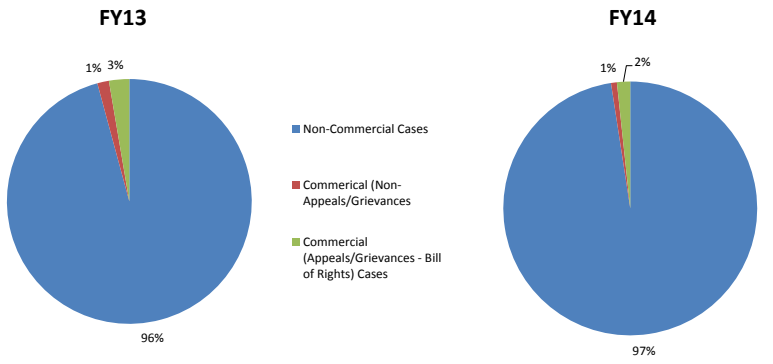
- With OHCOBR assistance, consumers saved a total of $932,651.62.
- Of the total amount saved, $457,240.56 (49%) was from Commercial Cases; $25,991.07 (2%) was removed from QMB beneficiaries' accounts for co-payments; $26,803.43 (2%) was reimbursed to beneficiaries due to non-payment of Medicare Part B Premiums; and $422,616.56 (45%) was saved or recouped on behalf of fee-for-service, MCO and Alliance beneficiaries (Figure 11);

Types of Cases, Contacts and Issues –

- Of the 162 Administrative/Fair Hearing cases filed by OHCOBR, 85 or 13% were filed on behalf of EPD Waiver beneficiaries. (Figure 12);
- Most consumers utilized the telephone to contact the office—94% or 7,462 of 7,904 total contacts, as compared to 91% or 5,901 of 6,507 total contacts in FY 2013 (Figure 13);
- Of the 7,904 total cases opened, Medicare beneficiaries were the single largest group of contacts (31% or 2,436 cases) (Figure 14);
- Contacts originated from consumers who reside in all Wards and various States within and outside of the DC Metropolitan Area (Figure 15);
- Ward 7 residents made the most contacts to OHCOBR - 1,358 or 17%, followed by Ward 5 - 1,249 or 16%, and Ward 8 - 1,168 or 15% (Figure 15);
- 'Eligibility' was the most frequent type of issue from all consumers combined (33% or 2,601 cases) (Figure 16);
- 'Eligibility' was the most frequent type of issue from both Medicaid MCO beneficiaries (47% or 707 of 1,499 cases) and Alliance beneficiaries (56% or 134 of 238 cases) (Figure 17 and Figure 18);
- 'Access/Coverage' that included denials, was the largest type of issue from both Dual Eligible - Medicaid/Medicare contacts (37% or 623 cases) and Medicaid fee-for-service contacts (43% or 687 cases) (Figure 19 and Figure 20);
- 'Other' was the largest type of issue from Medicare beneficiaries (36% or 890 cases) (Figure 21);
- A total of 148 Transportation Cases were opened, compared to 107 in FY 2013 (38% increase) (Figure 22);
- A total of 678 EPD Waiver Cases were opened in FY 2014, compared to 618 in FY 2013 (10% increase) (Figure 12);
- A total of 252 DC Health Link and Health Care Exchange Marketplace cases were opened (Figure 23).

Data Collection Report (cont'd)

Figure 1. Total Number and Percentage of Opened Cases Among All Contacts--(Non-Commercial); (Commercial-Non-Appeals/Grievances-Bill of Rights); and (Commercial-Appeals/Grievances-Bill of Rights) Contacts FY13 and FY14

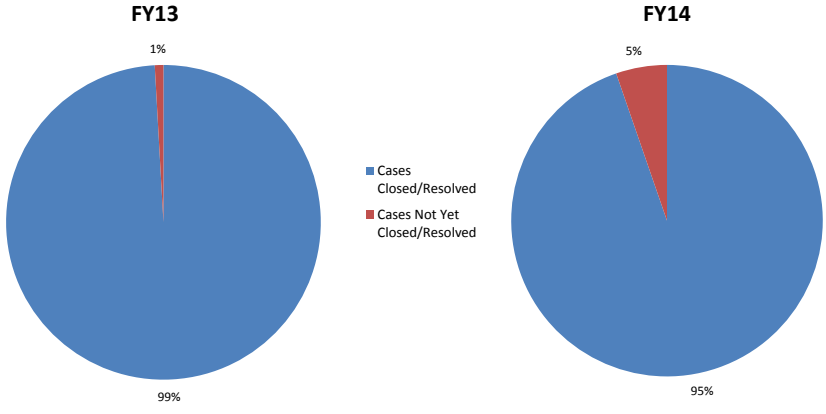


FY13 Total Sample = 6,507 contacted

FY14 Total Sample = 7,904 contacted

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Figure 2. Number and Percentage of Closed/Resolved Cases Among (Non-Commercial) Contacts FY13 and FY14



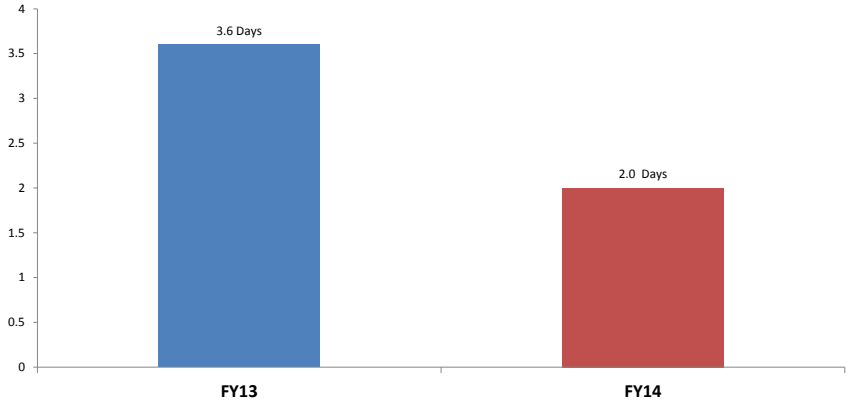
FY13 Total Sample = 6,233 contacted

FY14 Total Sample = 7,712 contacted

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Data Collection Report (cont'd)

Figure 3. Average Number of Days to Close/Resolve (Non-Commercial) Cases FY13 and FY14



FY13 Total Cases Closed/ Resolved = 6,178 **FY14 Total Cases Closed/Resolved = 7,304**

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

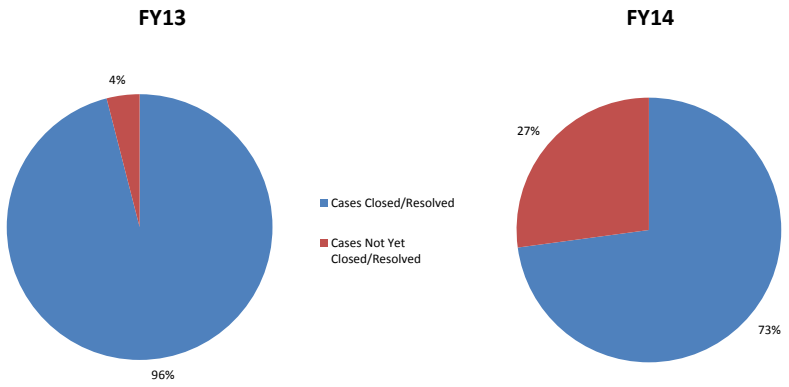
Table 4. Average Number of Days to Close/Resolve (Non-Commercial) Cases FY13 and FY14

FY13 Average Number of Days to Close/Resolve (Non-Commercial) Cases	FY13 Total	FY14 Average Number of Days to Close/Resolve (Non-Commercial) Cases	FY14 Total
Average Number of Days It Took to Close/Resolve (6,178) Cases	3.6 days	Average Number of Days It Took to Close/Resolve (7,304) Cases	2.0 days
Note: Of the (6,233) cases opened, the OHCOBR closed/resolved (4,913) cases on same day that cases were opened		Note: Of the (7,712) cases opened, the OHCOBR closed/resolved (6,472) cases on same day that cases were opened	

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Data Collection Report (cont'd)

Figure 5. Number and Percentage of Closed/Resolved Cases Among (Commercial-Non-Appeals/Grievances-Bill of Rights) Contacts FY13 and FY14

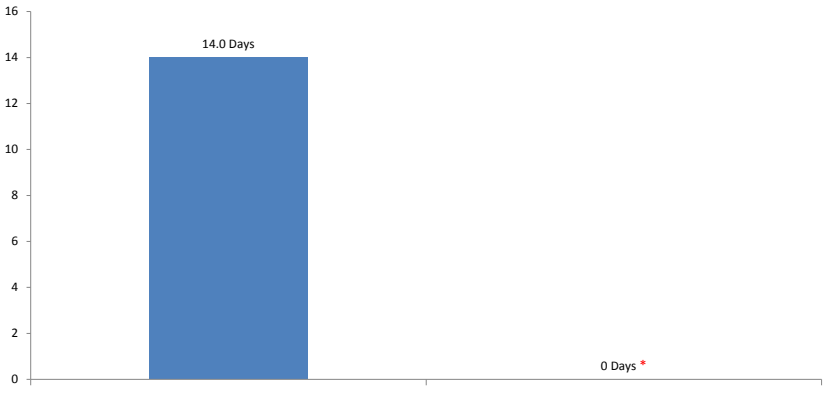


FY13 Total Sample = 100 contacted

FY14 Total Sample = 59 contacted

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Figure 6. Average Number of Days to Close/Resolve (Commercial-Non-Appeals/Grievances-Bill of Rights) Cases FY13 and FY14



FY13 Total Cases Closed/Resolved = 96

FY14 Total Cases Closed/Resolved = 43

** Out of (43) closed cases, (42) cases were closed on the same day they were opened. (1) case was closed (2) days after it was opened, resulting in an average of (0) days to close/resolve cases.*

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

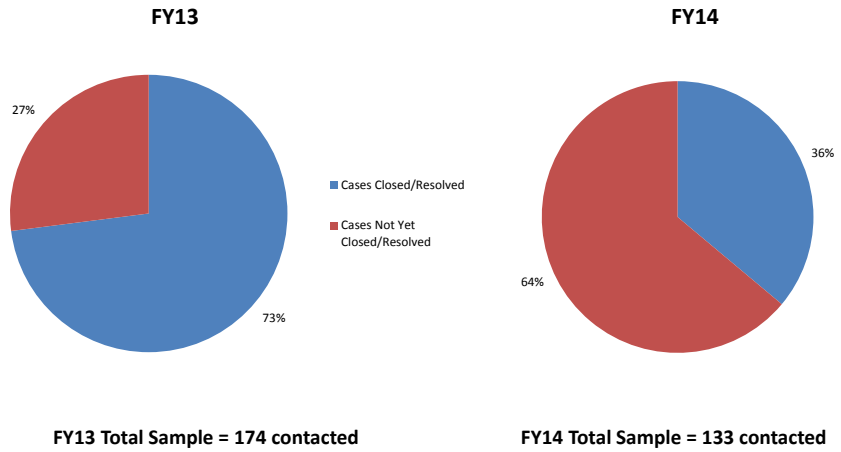
Data Collection Report (cont'd)

Table 7. Average Number of Days to Close/Resolve (Commercial-Non-Appeals/Grievances-Bill of Rights) Cases FY13 and FY14

FY13 Average Number of Days to Close/Resolve (Commercial-Non-Appeals/Grievances-Bill of Rights) Cases	FY13 Total	FY14 Average Number of Days to Close/Resolve (Commercial-Non-Appeals/Grievances-Bill of Rights) Cases	FY14 Total
Average Number of Days It Took to Close/Resolve (96) Cases	14.0 days	Average Number of Days It Took to Close/Resolve (43) Cases	0 days
Note: Of the (100) cases opened, the OHCOBR closed/resolved (70) cases on same day that cases were opened		Note: Of the (59) cases opened, the OHCOBR closed/resolved (41) cases on same day that cases were opened	

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Figure 8. Number and Percentage of Closed/Resolved Cases Among (Commercial-Appeals/Grievances-Bill of Rights) Contacts FY13 and FY14



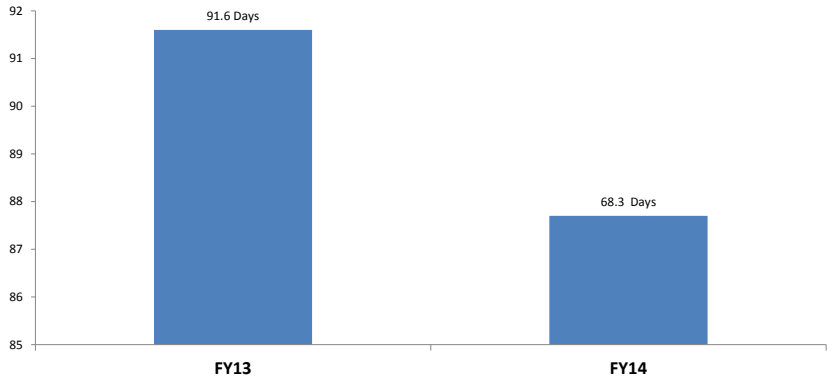
FY13 Total Sample = 174 contacted

FY14 Total Sample = 133 contacted

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Data Collection Report (cont'd)

Figure 9. Average Number of Days to Close/Resolve (Commercial-Appeals/Grievances-Bill of Rights) Cases FY13 and FY14



FY13 Total Cases Closed/Resolved = 127

FY14 Total Cases Closed/Resolved = 48

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

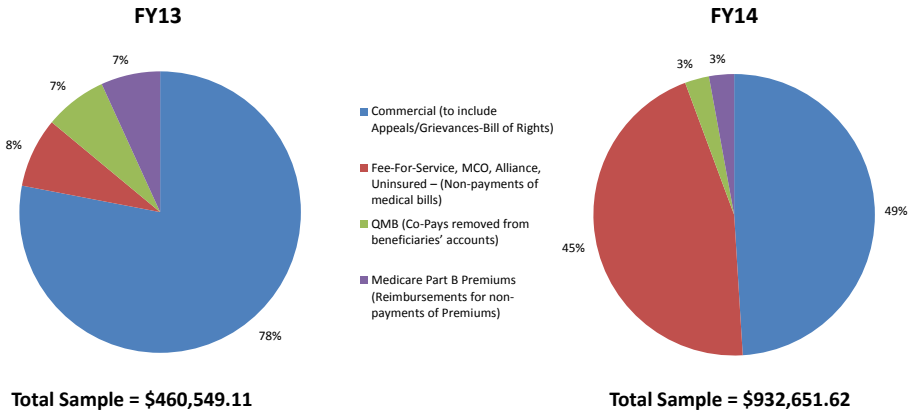
Table 10. Average Number of Days to Close/Resolve (Commercial-Appeals/Grievances-Bill of Rights) Cases FY13 and FY14

FY13 Average Number of Days to Close/Resolve (Commercial-Appeals/Grievances-Bill of Rights) Cases	FY13 Total	FY14 Average Number of Days to Close/Resolve (Commercial-Appeals/Grievances-Bill of Rights) Cases	FY14 Total
Average Number of Days It Took to Close/Resolve (127) Cases	91.6 days	Average Number of Days It Took to Close/Resolve (48) Cases	68.3 days
Note: Of the (174) cases opened, the OHCOBR closed/resolved (19) cases on same day that cases were opened		Note: Of the (133) cases opened, the OHCOBR closed/resolved (53) cases on same day that cases were opened	

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Data Collection Report (cont'd)

Figure 11. Dollar Amount of Savings on Behalf of (Non-Commercial); (Commercial-Non-Appeals/Grievances-Bill of Rights); and (Commercial-Appeals/Grievances-Bill of Rights) Contacts FY13 and FY14

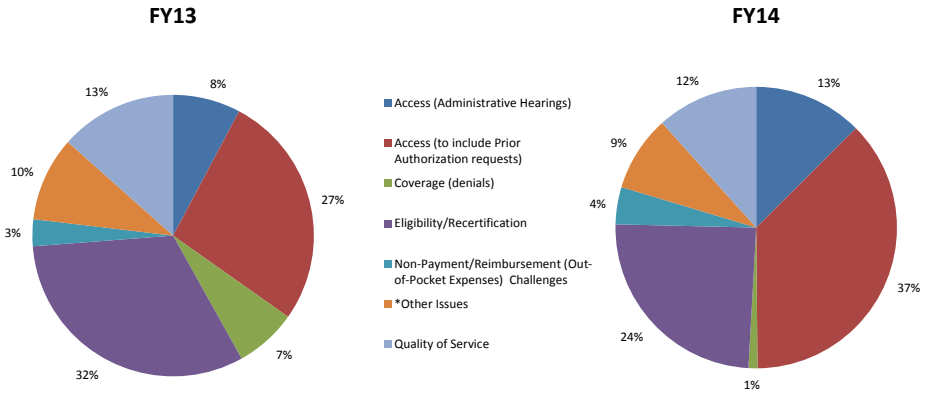


Total Sample = $460,549.11

Total Sample = $932,651.62

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Figure 12. Breakdown of Types of Issues Encountered by EPD Waiver Contacts FY13 and FY14



FY13 Total Sample = 618 contacted

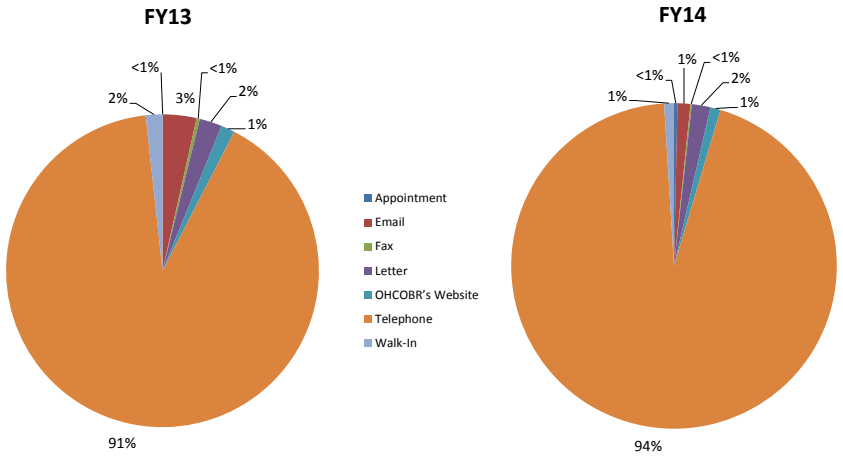
FY14 Total Sample = 678 contacted

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, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Data Collection Report (cont'd)

Figure 13. Methods of Contacting OHCOBR
FY13 and FY14

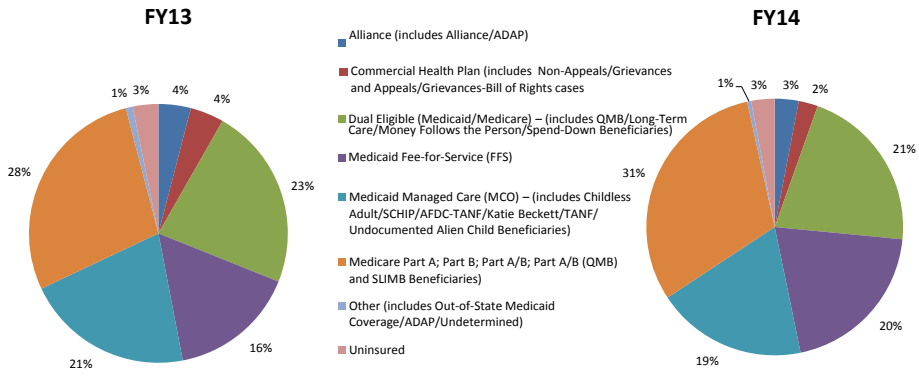


FY13 Total Sample = 6,507 contacted

FY14 Total Sample = 7,904 contacted

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Figure 14. Categories of Contacts by Insurance Type
FY13 and FY14



FY13 Total Sample = 6,507 contacted

FY14 Total Sample = 7,904 contacted

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

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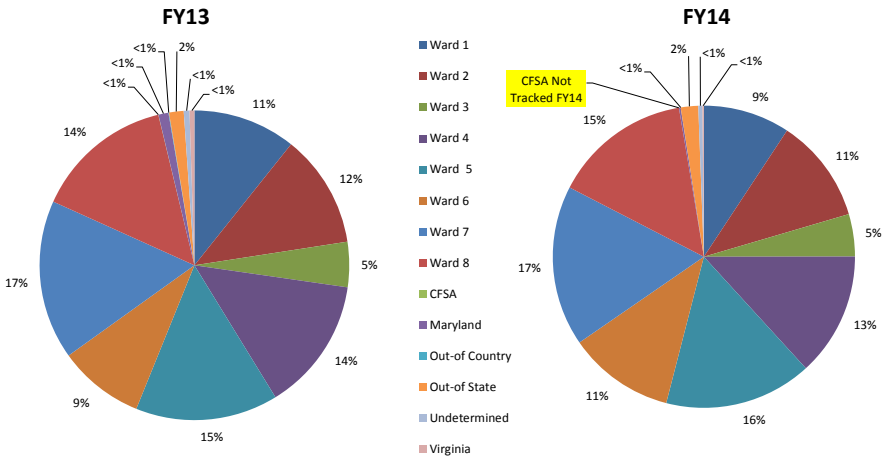
Data Collection Report (cont'd)

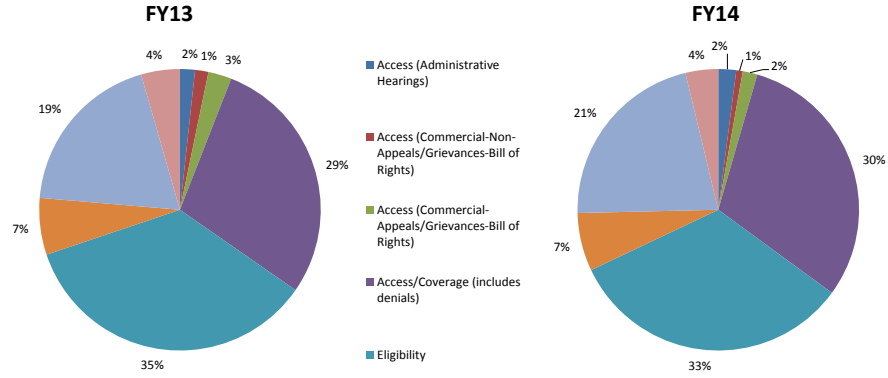
Figure 15. Contacts by Wards and States Located Within the DC Metropolitan Area and States Located Outside of the DC Metropolitan Area FY13 and FY14



FY13 Total Sample = 6,507 contacted **FY14 Total Sample = 7,904 contacted**

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Figure 16. Breakdown of Types of Issues Encountered by All Contacts – (Non-Commercial); (Commercial-Non-Appeals/Grievances-Bill of Rights); and (Commercial-Appeals/Grievances-Bill of Rights) FY13 and FY14



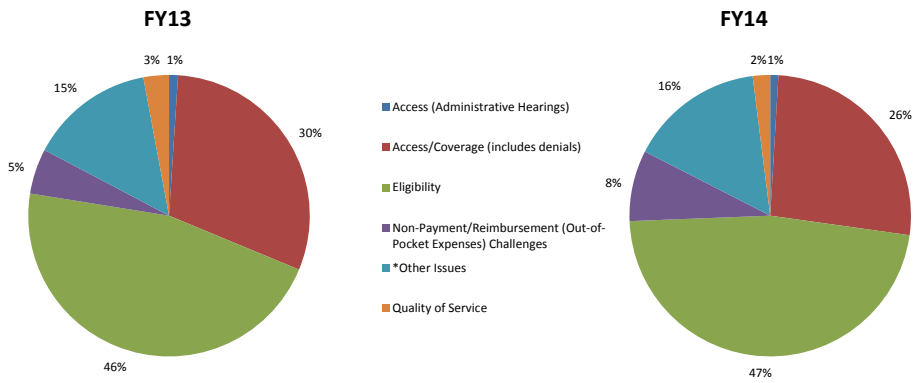
FY13 Total Sample = 6,507 contacted **FY14 Total Sample = 7,904 contacted**

*__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, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Data Collection Report (cont'd)

Figure 17. Breakdown of Types of Issues Encountered by Medicaid Managed Care (MCO) Contacts FY13 and FY14

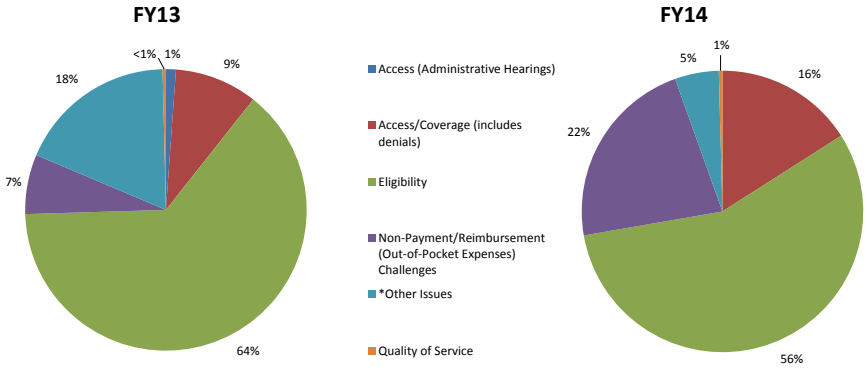


FY13 Total Sample = 1,366 **FY14 Total Sample = 1,499 contacted**

***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, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Figure 18. Breakdown of Types of Issues Encountered by Alliance Contacts FY13 and FY14



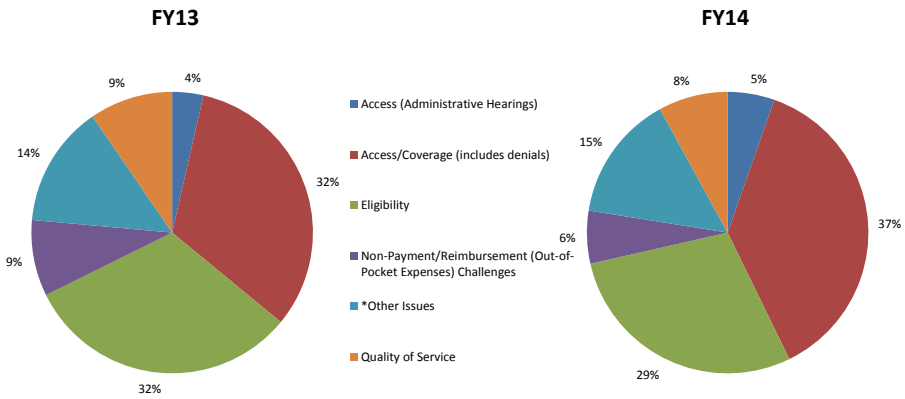
FY13 Total Sample = 263 contacted **FY14 Total Sample = 238 contacted**

***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, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Data Collection Report (cont'd)

Figure 19. Breakdown of Types of Issues Encountered by Dual Eligible (Medicare and Medicaid) Contacts FY13 and FY14

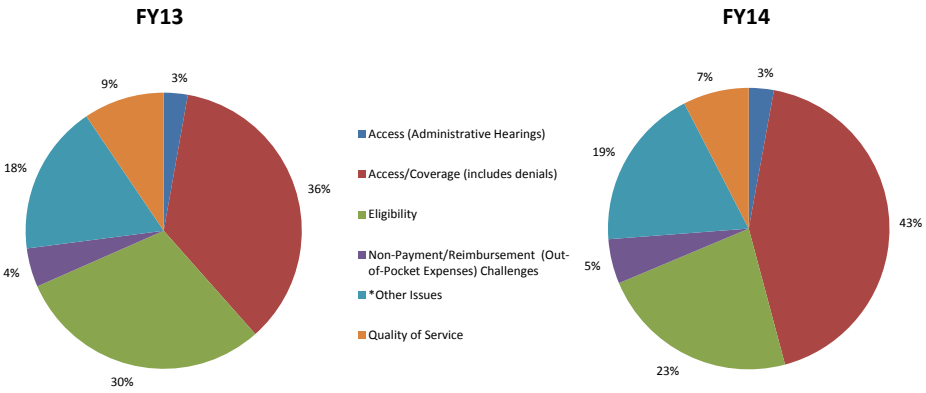


FY13 Total Sample = 1,485 contacted **FY14 Total Sample = 1,667 contacted**

***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, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Figure 20. Breakdown of Types of Issues Encountered by Medicaid Fee-for-Service (FFS) Contacts FY13 and FY14



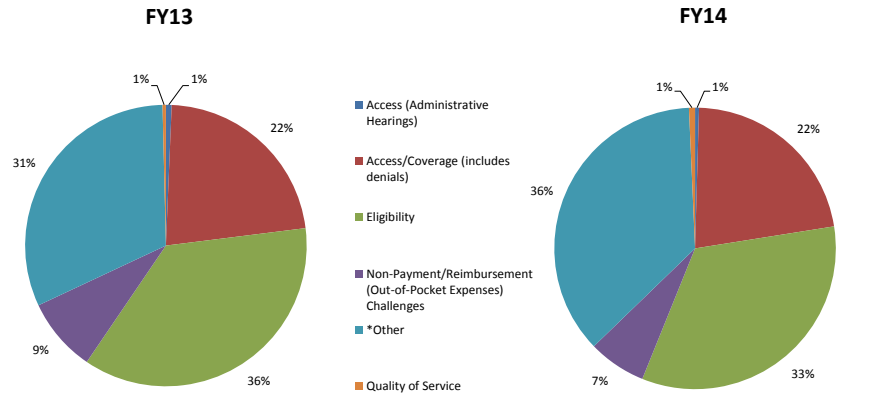
FY13 Total Sample = 1,035 contacted **FY14 Total Sample = 1,599 contacted**

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

Data Collection Report (cont'd)

Figure 21. Breakdown of Types of Issues Encountered by Medicare Part A; Part B; Part A/B; Part A/B (QMB) Contacts FY13 and FY14

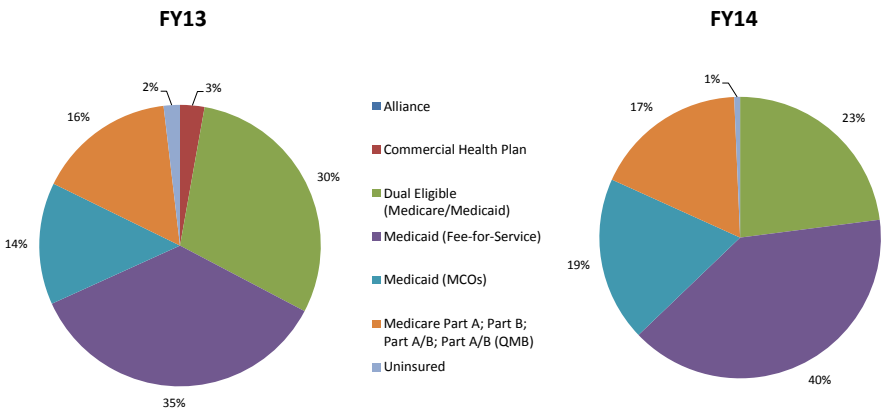


FY13 Total Sample = 1,820 contacted **FY14 Total Sample = 2,436 contacted**

***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, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Figure 22. Breakdown of Transportation Contacts by Insurance Type FY13 and FY14

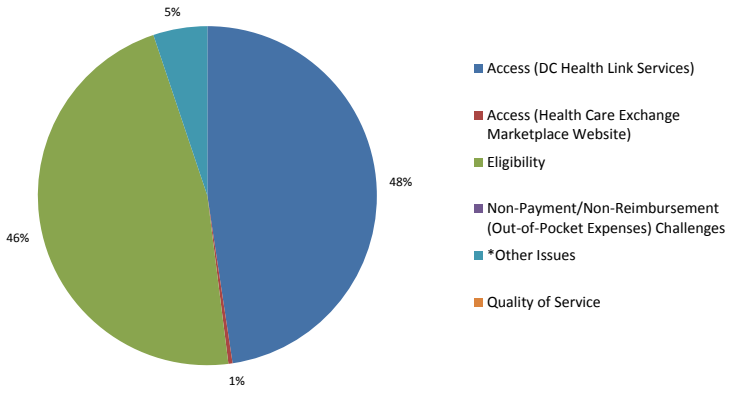


FY13 Total Sample = 107 contacted **FY14 Total Sample = 148 contacted**

Source data captured between October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014

Data Collection Report (cont'd)

Figure 23. Breakdown of Types of Issues Encountered by DC Health Link and Health Exchange Marketplace Contacts FY14



FY14 Total Sample = 252 contacted

Note: FY14 is the first year for tracking Types of Issues Encountered by DC Health Link and Health Exchange Marketplace

Source data captured between January 1, 2014 through September 30, 2014

49

Appendix – Outreach/Education Events

OCTOBER 1, 2013 - SEPTEMBER 30, 2014

EVENT DATE	OHCOBR'S PARTICIPATION	NAME OF ORGANIZATION/GROUP	NUMBER OF ATTENDEES
October 23, 2013	SPEAKER	WARD 5 – DC OFFICE ON AGING – LEAD AGENCY SOCIAL WORKERS	50
November 23, 2013	EXHIBITOR	WARD 2 – DC HEALTH LINK ENROLLMENT	200
Novembers 27, 2013	EXHIBITOR	WARD 2 – SAFEWAY'S FEAST OF SHARING – ANNUAL HEALTH AND JOB FAIR	5,000
December 3, 2013	EXHIBITOR	WARD 2 – DC GOVERNMENT ONE FUND DRIVE	200
December 19, 2013	EXHIBITOR	WARD 6 – MAYOR'S ANNUAL SENIORS HOLIDAY CELEBRATION AND EXHIBITS	4,000
FEBRUARY 1, 2014	EXHIBITOR	WARD 5 – CANAAN BAPTIST CHURCH'S HEALTH AND WELLNESS DAY	50
March 6, 2014	EXHIBITOR	WARD 3 – 6TH ANNUAL GUARDIANSHIP CONFERENCE	200
MARCH 10, 2014	PRESENTER	WARD 5 – MODEL CITIES	150
March 25, 2014	EXHIBITOR	WARD 3 – DC OFFICE ON AGING – COMMUNITY HEALTH AND WELLNESS FAIR	175
April 21, 2014	EXHIBITOR	WARD 6 – MAYOR'S FY2015 BUDGET TOWN HALL MEETING	150
April 24, 2014	EXHIBITOR	WARD 7 – DC OFFICE ON AGING COMMUNITY HEALTH, WELLNESS AND INFORMATIONAL FAIR	100
April 29, 2014	EXHIBITOR	WARD 4 – MAYORS'S FY2015 BUDGET TOWN HALL MEETING	100
May 5, 2014	SPEAKER	WARD 2 – AARP – LONG-TERM CARE OMBUDSMAN MEETING	150
May 6, 2014	EXHIBITOR	WARD 1 – MAYOR'S FY2015 BUDGET MEETING	100
May 8, 2014	EXHIBITOR	WARD 5 – MAYOR'S FY2015 BUDGET TOWN HALL MEETING	200
June 14, 2014	EXHIBITOR	WARD 5 – HSC HEALTH CARE SYSTEM'S ANNUAL 2014 FAMILY AND COMMUNITY HEALTH EXPO	200
June 21, 2014	EXHIBITOR	WARD 5 – DC OFFICE ON AGING – NORTH MICHIGAN PARK CIVIC ASSOCIATION FAMILY DAY	100
June 28, 2014	EXHIBITOR	WARD 4 – FAMILY FUN DAY	300

Appendix – Commercial Insurance Self-Reports

The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) requires commercial insurance companies to submit an annual self-report on cases processed through their internal grievances and appeals system in a format provided by OHCOBR. The report contains information on cases mostly unknown to OHCOBR that are handled within their company. In some cases, commercial insurance beneficiaries contact OHCOBR for help communicating with their insurer, or for further action if they are not satisfied with the insurance company's disposition of their case. Once OHCOBR is contacted, those cases are reported with all the other cases processed by OHCOBR (see Data Collection section) so a few of these cases may be included on both reports.

It should also be noted that the Commercial Insurer's Annual Self-Report might not include all grievances and appeals, since insurers are only required to report on the top five cases within each service category (see list of Categories below).

The Commercial Insurer's Annual Self-Report is a legislative requirement stipulated in D.C. Code 44-301.10, 2001 Edition, as stated here:

> ***§ 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.

In early 2014 the OHCOBR Advisory Committee's Policy and Procedures and Legal Subcommittee met with representatives of health plans to discuss the reports and get input on how they can be improved and unified. This will become an annual meeting to discuss trends and ways to reduce the incidence of denials that often are reversed and cause delays in care. These improvements could reduce the number of grievances and appeals and improve customer satisfaction with their health plan and their care.

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 2014)

- Twenty-one (21) of thirty-two (32) companies reported consumer grievances/appeals; eleven (11) reported they had no grievances/appeals; as compared to nineteen (19) of thirty-three (33) companies that reported grievances/appeals and fourteen (14) reporting no grievances/appeals in FY 2013.
- A total of 2,317 cases were opened by 21 of 32 companies that submitted reports; a 24% increase over FY 2013 when 1,865 cases were opened. This increase was likely due to the implementation in January 2014 of the health benefit exchange as mandated by the ACA.
- A total of 967 of 2,317 opened cases resulted in the initial decision being upheld (42%), as compared to 39% of opened cases upheld in FY 2013; the number of upheld cases increased by 234 (+32%), 967 as compared to 733 cases upheld in FY 2013;
- A total of 998 of 2,317 opened cases resulted in the initial decision being overturned (reversed) in favor of the beneficiary (43%), the same percentage of overturned cases as in FY 2013; the number of overturned cases increased by 193 (+24%), 998 as compared to 805 cases overturned in FY 2013.
- A total of 352 of 2,317 opened cases were partially overturned in favor of the beneficiary (15%), as compared to 327 cases and 18% partially overturned in FY 2013;
- The combined total of overturned and partially overturned cases was 1,350 (58% of all opened cases), as compared to 1,232 cases overturned or partially overturned (61% of all opened cases) in FY 2013, total overturned and partially overturned cases increased by 118 (+9.5%) over the previous year.
- Of the 21 companies reporting grievances/appeals, 13 had an overturned and partially overturned rate of 40% or higher of that company's opened cases, the same rate as the previous year but 62% more companies than FY 2013 (13 vs. 8).
- The three most prevalent categories of reported grievances were Physician, Lab/Radiology, and Pharmacy Services, the same as for the previous year.

The following tables summarize some of the findings from the FY 2014 annual report of internal grievances and appeals self-reported by commercial insurers.

Commercial Insurers' Annual Self-Report – FY 2014

[GRAY SHADING INDICATES NO GRIEVANCES WERE REPORTED]

TABLE 1:

NAME OF INSURER	TOTAL APPEALS/ GRIEVANCES	CASES UPHELD		CASES OVERTURNED		CASES PARTIALLY OVERTURNED	
		#	%	#	%	#	%
Aetna Health Inc.	75	58	78%	16	21%	1	1%
Allianz Life Insurance Co. of America	0						
Ameritas Life Insurance Co.	153	98	64%	42	27%	13	9%
Blue Choice, Inc.	266	89	34%	171	64%	6	2%
CareFirst of Maryland, Inc.	134	38	29%	85	63%	11	8%
Cigna Health and Life Ins. Co.	106	89	84%	15	14%	2	2%
Cigna Healthcare Mid-Atlantic Inc.	0						
Connecticut General Life Ins. Co.	52	38	73%	14	27%	0	-
Continental American Ins Co.	0						
Delta Dental Ins. Co.	13	5	38%	7	54%	1	8%
Fidelity Security Life Ins. Co.	0						
Golden Rule Ins. Co.	4	3	75%	1	25%	0	-
Group Hospitalization & Medical Services	293	93	32%	182	62%	18	6%
John Alden Life Ins. Co.	1	0		1	100%	0	-
Kaiser Permanente	116	54	47%	58	50%	4	3%
MAMSI Life & Health Ins. Co.	5	5	100%	0	-	0	-
Metropolitan Life Ins. Co.	534	70	13%	180	34%	284	53%
MDIPA	292	186	64%	102	35%	4	1%
Optimum Choice, Inc.	15	9	60%	6	40%	0	-
Principal Life Ins. Co.	2	1	50%	1	50%	0	-
Prudential Ins. Co. of America	0						
Reliance Standard Life Ins. Co.	0						
Standard Insurance Co.	4	2	50%	2	50%	0	-
Time Insurance Company	23	7	31%	15	65%	1	4%
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.	207	102	49%	100	49%	5	2%
United Healthcare Life Ins. Co.	1	0	-	0	-	1	100%
United Healthcare of Mid-Atlantic	21	20	95%	0	-	1	5%
TOTAL	**2,317**	**967**	**42%**	**998**	**43%**	**352**	**15%**

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

Commercial Insurers' Annual Self-Report – FY 2014

[GRAY SHADING INDICATES NO GRIEVANCES WERE REPORTED]

TABLE 2:

RESOLUTION TIMES BY TYPE OF CASE				
NAME OF INSURER	**MEDICAL EMERGENCY [HOURS]**	**MENTAL HEALTH EMERGENCY [DAYS AND HRS]**	**MEDICAL NON-EMERGENCY [CALENDAR DAYS]**	**MENTAL HEALTH EMERGENCY [CALENDAR DAYS]**
Aetna Health Inc.	50	24 Hours	18	30
Allianz Life Insurance Co. of America				
Ameritas Life Insurance Co.	n/a	n/a	n/a	n/a
Blue Choice, Inc.	24	Unspecified	28.4	6
CareFirst of Maryland, Inc.	168	Unspecified	31.9	0
Cigna Health and Life Ins. Co.	121.86	Unspecified	22	14
Cigna Healthcare Mid-Atlantic Inc.				
Connecticut General Life Ins. Co.	-	-	27	21
Continental American Ins Co.				
Delta Dental Ins. Co.	0	-	16	-
Fidelity Security Life Ins. Co.				
Golden Rule Ins. Co.	n/a	n/a	52	n/a
Group Hospitalization & Medical Services	2	Unspecified	34.2	2
John Alden Life Ins. Co.	n/a	n/a	15	n/a
Kaiser Permanente	22.8	21.9 Hours	26.3	103.6
MAMSI Life & Health Ins. Co.	-	-	21	-
Metropolitan Life Ins. Co.	-	-	14.4	-
MDIPA	22	22 Hours	22	5
Optimum Choice, Inc.	0	n/a	22	n/a
Principal Life Ins. Co.	n/a	n/a	10	n/a
Prudential Ins. Co. of America				
Reliance Standard Life Ins. Co.				
Standard Insurance Co.	n/a	n/a	n/a	n/a
Time Insurance Company	0	0	32.83	0
Trustmark Insurance Co.				
Trustmark Life Ins. Co.				
UniCare Life & Health Ins. Co.				
Union Security Insurance Co.				
United Concordia Life & Health				
United Healthcare Ins. Co.	115	n/a	30	n/a
United Healthcare Life Ins. Co.	n/a	n/a	60	60
United Healthcare of Mid-Atlantic	n/a	10 Hours	21	18.5

[2] **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.

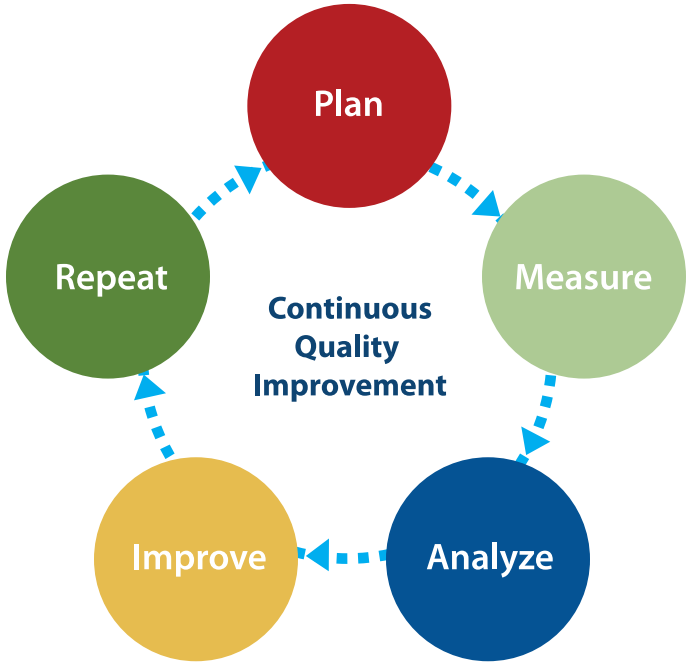
Appendix – Review of Commercial Cases (Continuous Quality Improvement)

OHCOBR implemented an internal review process for commercial appeals, in order to strengthen supportive documentation and case findings prior to sending cases for external review by the Independent Review Organization (IPRO) and DISB. When the record is returned from the IPRO and DISB, the data is compiled, tracked, and trended for improvement in processing future similar cases.

The Quality Indicators were developed and implemented in August 2013 for OHCOBR review of commercial cases. They were introduced a month later to the Clinical Subcommittee following summer break. At that time the Clinical Subcommittee provided comments and recommendations, which were adopted into the process.

Data Analysis:

The OHCOBR clinical staff created a data collection instrument, referred to as the Quality Improvement Tool, which incorporated the approved Quality Indicators. The clinical staff collects the data and divides the cases between two teams: Team A and Team B.



Initially in 2013, sample data was collected for two months to determine whether or not all the necessary elements were clearly defined and to modify the data elements, as necessary.

There were one hundred and thirty-three commercial cases opened in FY 2014. Nine cases were included in the quality review sample. They were selected for data analysis because they were earmarked for IPRO external review.

Out of the thirty-five quality indicators included in the Quality Improvement Tool, six were chosen for review and analysis. The six indicators were: (1) history/physical, (2) insurance company, (3) medical notes, (4) whether services were in- or out-of-network, (5) whether or not teaching was provided, and (6) discharge plan.

Of the nine records reviewed, the analysis of the data collected revealed the following:

- **History/Physical**: one of nine records did not have a documented history/physical. The one case missing a history/physical was an emergency ambulance case;

- **Insurance Company**: six records were CareFirst/BlueCross-BlueShield clients; one was a United Health Behavioral Health client; and two were Aetna clients;

- **Medical Notes**: eight of nine records had some form of documentation by a physician;

- **In/Out-of-Network**: In-network providers completed six procedures and three procedures were provided at out-of-network facilities. Of the three out-of-network procedures one claim decision was reversed by the insurance company and two were referred to DISB for further review;

- **Teaching**: six records documented that teaching was provided and three did not; and

- **Discharge Plan**: one record had a documented discharge plan after the procedure was completed and eight did not.

After the nine records were reviewed for inclusion of the six quality indicators, QI team members determined if the insurance companies were receiving the same documentation when rendering their payment decisions. If documentation was lacking in any record reviewed, the QI team made recommendations to the OHCOBR caseworker to obtain additional information that might help settle the case without needing to send it to the IPRO. For instance, in one of the nine cases the caseworker was advised by the QI team to request reconsideration by the insurance company based on new information. The caseworker followed the team's recommendation and the insurance company reversed its decision. This eliminated the need to submit the case to the IPRO.

Of the nine records that were reviewed, the insurance company, as stated above, overturned one; five records were submitted to the IPRO; and three cases were referred to DISB. The IPRO upheld the insurance companies' decisions in all five cases. This prompted the QI teams to seek advice from the expert members of the Clinical Subcommittee to help strengthen the clinical aspects of the five cases.

The FY 2014 data analysis supports the importance of defining the specific information needed to inform policy changes and improve work efficiencies. There were lessons learned by the clinical team that enhanced their knowledge base for achieving positive results when assisting caseworkers with commercial appeals. Learning to work as a team and listening to others with special clinical expertise was challenging for some team members. This prolonged the processing time and may have contributed to less than favorable outcomes. Eliciting help from others outside of the office with the proficiency required to successfully achieve a case reversal was a task that seemed complicated for some staff. Work is ongoing to improve in these areas based on insights gained from reviewing the process.

The Ombudsman staff encountered many challenges in FY 2014 working with commercial cases; however, it is clear that the following actions should be incorporated into standard operating procedures (SOPs) going forward:

- Require caseworkers to elicit the expertise of members of the Clinical Subcommittee and/or the physician involved with the case without hesitation, to maximize the inclusion of necessary clinical evidence to improve outcomes for the consumer;

- After a case is assessed by the QI team, require caseworkers to routinely follow the QI team's recommendations before submitting the case to the IPRO;

- Routinely revise policies and procedures or develop new ones to standardize the process for timely review and submission of commercial cases for external review, based on case reviews and previous successes and failures.

Notes

Notes

Notes

DISTRICT OF COLUMBIA

HEALTH CARE OMBUDSMAN

The Knowledge to Guide You

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