FY17 ANNUAL REPORT

Government of the District of Columbia

OFFICE OF HEALTH CARE OMBUDSMAN & BILL OF RIGHTS

The Knowledge to Guide You

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A Message from Mayor Muriel Bowser

The health and well-being of District residents is my number one priority and we continue to look for innovative ways to not only increase access to care, but to increase the efficiency and quality of that care. In FY2017, I announced *My Health GPS*, a new care coordination program that assists Medicaid beneficiaries diagnosed with multiple chronic conditions get the care they need. As part of the *My Health GPS* program, interdisciplinary care teams from approved Medicaid primary care providers will organize and coordinate primary, acute, behavioral health, and long-term services and supports for eligible beneficiaries. This was designed to improve health outcomes while reducing inappropriate hospital utilization and hospital readmissions. By 2019, *My Health GPS* is projected to serve approximately 25,000 District Medicaid beneficiaries with three or more chronic conditions.

Three years ago, we set out to build a government that meets the needs of residents in all eight wards – a government that does not just work for us, but for the next generation, and the one after that. We are making tremendous progress, but we have more work to do. To date, 15 percent of our 131 goals have been completed and 81 percent have launched and are currently being implemented. We will continue to build on the District's progress and reflect on our accomplishments.

Going forward, we will stay focused on the values and beliefs that brought us together more than three years ago – a fierce belief that all Washingtonians deserve a fair shot and that the middle class is worth fighting for. With the help of the Executive Office of the Mayor, District Council, health care providers, federal officials, and District agency staff, we can be assured of continued progress in the coming year.

Muriel Bowser
Mayor

A Message from Director Wayne Turnage

The Department of Health Care Finance (DHCF) was established as a cabinet-level agency on February 27, 2008 to operate the District's Medicaid and Alliance programs. The mission of the Department is simple but complex – improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for residents of the District of Columbia through both insurance programs that we administer.

Our very important work is guided by three major priorities. The first is to ensure access to a comprehensive array of health care services to the more than 285,000 members that are disproportionately spread across eight wards. Our second priority is to improve patient health outcomes for those who participate in the Medicaid and Alliance programs by endeavoring to increase our members' use of preventative care services offered by their primary care doctors. This means pursuing a targeted effort to aggressively move Medicaid and Alliance recipients away from hospitals as a source of primary care – often the entry point into the health care system. Our final priority is to protect the integrity of the programs that we administer. As stewards of the District's tax dollars, we are always concerned about waste, fraud, and abuse in publicly funded health care programs.

In FY2017, DHCF spent a significant amount of time on five significant projects: procurement of DHCF's $1 billion managed care program, which secured three managed care plans for the next five years; launch of My Health GPS, a new system of care for a group of beneficiaries with serious health issues established to improve health outcomes while reducing inappropriate hospital utilization and readmissions; provider payment reform efforts for nursing homes and Federally Qualified Health Centers (FQHCs) encumbered by policies that are outdated and create disincentives for some essential, specific types of services; implementation of the District of Columbia Access System (DCAS) – our integrated eligibility system; and building a Medicaid Data Warehouse (MDW) to enhance the data management and analytical capabilities of the agency.

As we move forward, we will continue to refine My Health GPS to maximize the efficiency and effectiveness of care coordination services, continue our work on provider payment reform to improve the link between patient acuity and reimbursement, begin Release 3 of DCAS for anticipated completion in 2021, complete the validation process and federal certification for the MDW by mid-2018, and work on establishing a new hospital for the residents of Wards 7 and 8.

I would like to commend my remarkable executive team, agency fiscal officer, senior level staff, and mid-level managers who provide stewardship of the staff and the advocacy work provided by the Office of Health Ombudsman and Bill of Rights (OHCOBR).

Wayne Turnage, MPA
Director, Department of Health Care Finance

A Message from the Health Care Ombudsman

I am pleased to share with you our *Fiscal Year 2017 Annual Report*. Every day staff and I, in the Office of Health Care Ombudsman and Bill of Rights, give assistance to District consumers of health care, through advocacy, education and outreach. We serve uninsured residents; enrollees in the D.C. Medicaid and Alliance programs (more than 285,000); and commercial health plan members enrolled through the DC Health Benefits Exchange (DC Health Link) and those whose commercial health insurance policies were underwritten in the District (more than 900,000).

During the past fiscal year, we joined thirty-five community events attended by approximately 17,000 people. We directly engaged with the public through our community outreach activities – sharing information and promoting our services. Staff distributed materials printed in English, Spanish and five other prevalent languages spoken in the District. Because of these engagements, there was a rise in the number of contacts that our office received. By the end of the fiscal year, we had resolved more than 9,000 cases, a significant increase over the prior year's 8,400 cases.

One noteworthy accomplishment was the expansion of our clinical staff. The additional clinical expertise allowed us to improve outcomes when handling commercial cases.

We are also proud of the new databases created for implementation in FY 2018. These systems will allow us to track and trend disparities in pharmacy cases and cases sent to the Independent Review Organization (IRO) for external review.

In the coming fiscal year, we plan to increase education and outreach by targeting non-English speaking residents. One aspect of this plan is our investment in an extensive outreach media campaign in conjunction with the 25th Anniversary of the *NBC4 Telemundo 44 Health & Fitness Expo.*

I would like to extend my heartfelt appreciation for my caring and dedicated team. They are continually steadfast in their public service and commitment to their advocacy for District residents and employees, and people that work in the District of Columbia. We hope you will appreciate our accomplishments as presented in this report and that you will continue to view and use us as a valuable resource for consumer advocacy and education.

Should you have any questions regarding this *Fiscal Year 2017 Annual Report*, please feel free to contact the Office of the Health Care Ombudsman and Bill of Rights by phone at 1 - (877) 685-6391, (202) 724-7491, or via email at healthcareombudsman@dc.gov.

Best regards,

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

Meet the Ombudsman Staff

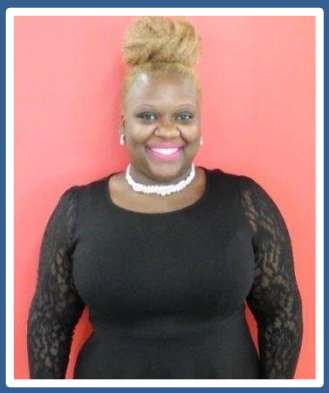
Charlita Brown, BS
Associate Health Care Ombudsman

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

Shirley Tabb, LICSW
Associate Health Care Ombudsman

Robert Taylor
Associate Health care Ombudsman

Loretta Smith, RN
Assocaite Health Care Ombudsman



Daisha Watson, BA
Associate Health Care Ombudsman

Not pictured:

Amani Alexander
Associate Health Care Ombudsman

Gina Brooks, BSN, RN
Associate Health Care Ombudsman

Aminata Jalloh, MS
Associate Health Care Ombudsman

Cardiss Jacobs
Associate Health Care Ombudsman

Carmencita Kinsey
Associate Health Care Ombudsman

Elfleta Nixon, DNP, RN
Clinical Director

Mirka Shephard
Associate Health Care Ombudsman

Meet the Ombudsman Interns

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

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

Here are the interns who supported the Ombudsman's Office in FY2017:

Alexandra Fortune
Student Intern
University of Miami
Major: Biology
Graduation: Spring 2019

Shaquashia McDuffie
Student Intern
University of the District of Columbia
Major: Social Work
Graduation: Spring 2018

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

Lamia Jackson
Student Intern
Trinity Washington University
Major: Criminal Justice
Graduation: Spring 2019

Introduction

Office of the Health Care Ombudsman and Bill of Rights

HISTORY

Established 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, the DHCF administers the District's Medicaid program, the Children's Health Insurance Program (CHIP), and other publicly funded health care benefits programs.

DUTIES AND RESPONSIBILITIES

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

FUNDING

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

LEGISLATIVE AUTHORITY

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

INDEPENDENCE AND AUTONOMY

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

benefits plan. Furthermore, the OHCOBR has no agreement or arrangement with any owner or operator of a health care service, health care facility or health benefits plan that could directly or indirectly result in remuneration, in cash or any kind of compensation to the office or its employees.

COLLABORATIONS

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

This collaboration has added a considerable number of cases to the OHCOBR's caseload.

GROWTH AND THE FUTURE

The Consumer Assistance Program (CAP) grants awarded from 2010 through 2015 by the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) helped us to build the necessary human capital and other resources to handle the influx of inquiries and advocacy service requests, and to maintain and foster the current collaborative relationship with DISB and others as we move forward.

In FY2017, the OHCOBR was able to add two additional nurses to assist with the commercial cases, to replace the clinical staff members that left in FY2016.

Regarding the Medicaid program, Mayor Bowser's FY2017 budget ensures continued access to health care services by preserving the District's eligibility levels for both the Medicaid and Alliance programs – eligibility thresholds that are among the highest in the country and now extend coverage to more than 40 percent of all District residents.

Health Care Reform Update

Affordable Care Act policy changes

As the new federal administration gets to work and the future of the Affordable Care Act (ACA) takes center stage, some changes to the ACA are scheduled to occur in 2017. More dramatic shifts could go into effect once lawmakers weigh in on the ACA's fate (and those changes likely will not take effect until 2018). The OHCOBR will keep abreast of these and other changes to provide knowledgeable assistance to consumers. Here are the changes expected to take effect in 2017.

- The **Health Insurer Tax**, which is approximately 2.3% of premium, will be suspended. This tax on health insurance companies will only be suspended in 2017.

- The **Transitional Reinsurance Program** (TRP) will end. The TRP charged fees to health plans as an effort to stabilize premiums in the individual market.

- The **reporting requirements** of the ACA will be due earlier. Copies of Forms 1095-B and/or 1095-C will need to be provided to employees and individuals by January 31, 2017. Reporting to the IRS will be due by February 28, 2017 if filing manually and March 31, 2017 if filing electronically.

- The **Employer Mandate penalties** will adjust for inflation. Penalties under Code Section 4980H(a) are expected to increase to $2,260 per full-time employee (up $100) and penalties under Code Section 4980H(b) are expected to increase to $3,390 per full-time employee (up $150). The IRS has yet to officially confirm these increases.

- The $695 **penalty related to the Individual Mandate** will also be inflation-adjusted to a higher amount, although the maximum penalty will remain at 2.5% of income.

- The **Medicare Part D "doughnut-hole"** or coverage gap will continue to shrink. Those individuals covered by a Part D plan will receive a 49% discount on generic drugs and a 60% discount on brand name drugs while in the doughnut hole.

- The **maximum out-of-pocket limits for non-grandfathered plans** will increase to $7,150 for single coverage and $14,300 for family coverage.

- **Transitional health plans** can continue to be renewed up until October 1, 2017, however, coverage must not extend beyond December 31, 2017.

- Section 1332 of the ACA becomes effective, allowing states to request **"innovation waivers"** to pursue certain parts of the ACA differently than the standard.

Advisory Council and Committees

Facilitators in the resolution of healthcare concerns

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

Policy and Procedures and Legal Subcommittee

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

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

Clinical Subcommittee

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

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

Education and Outreach Subcommittee

The Education and Outreach Subcommittee is comprised of four OHCOBR staff members. 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 responsibilities of the Education and Outreach Subcommittee are to:

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

Special Needs Subcommittee

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

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

Collaboration

Coordination of health care and other services

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

- ***AARP/Legal Counsel for the Elderly - Long-Term Care Ombudsman***
- ***Adult Protective Services (APS)***
- ***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 Office on Aging/Aging and Disability Resource Center (ADRC)***
- ***Delmarva Foundation***
- ***Department of Behavioral Health (DBH)***
- ***Department of Health (DOH)***
- ***Department of Health Care Finance (DHCF)***
- ***Department of Insurance, Securities, and Banking (DISB)***
- ***Department of Labor (DOL)***
- ***Department on Disability Services (DDS)***
- ***Economic Security Administration (ESA)***
- ***George Washington Health Insurance Counseling Project (HICP)***
- ***Health Services for Children with Special Needs (HSCSN)***
- ***IONA Senior Services***
- ***La Clinica del Pueblo***
- ***Medicaid Transportation Management (MTM)***
- ***MedStar Family Choice***
- ***Office of Personnel Management (OPM)***
- ***Qualis Health***
- ***Salvation Army/ Harbor Light Center***
- ***Seabury Resources for the Aging***
- ***Social Security Administration (SSA)***
- ***Trusted Health Plan***
- ***Unity Health Care Clinic***
- ***Whitman-Walker Clinic***

The George Washington University Law School's Health Insurance Counseling Project – Under the Leadership of Chris DeYoung

George Washington University Law School's (GW) Health Insurance Counseling Project (HICP) has been in existence since 1994. The program is part of the GW Law's Jacob Burns Community Legal Clinics. To date, the HICP has helped thousands of District residents on Medicare secure access to health care services – 3,500 seniors and persons with disabilities per year on average.

Over the last 23 years, GW Law students, attorneys and staff have worked diligently to remedy their clients' health care issues by assisting them in obtaining public benefits and resolving problems with private health insurers and public health programs. Students, attorneys and staff negotiate payment plans or persuade providers to forgive medical debt; advocate for clients who need medical care that an insurer (public or private) is unwilling to provide; untangle problems preventing a pharmacist from dispensing needed medication; or assist a client in understanding the extent and/or limitations of a public health plan benefit.

In 2011, in recognition of their outstanding efforts and continued success, the Centers for Medicare and Medicaid Services (CMS) named the HICP as the highest-performing program of its kind in the country. The CMS was the federal agency that funded State Health Insurance Assistance Programs (SHIP), like the HICP, in every state and the District of Columbia. (Authorized in the Consolidated Appropriations Act of 2014, SHIP was transferred from CMS to the U.S. Department of Health and Human Services (HHS), Administration for Community Living (ACL) in 2014).

Chris DeYoung began working at the HICP in 2008 as the Co-Director and has been the Acting Program Director since 2014. Before coming to the HICP he worked at IONA Senior Services and the Medicare Rights Center.

Mr. DeYoung is a member of the Health Care Ombudsman Advisory Council and provides community feedback; assessments on the needs of the community; develops resources for use within HICP and OHCOBR; and interprets their program, as well as the OHCOBR's program to the community.

We recognize Chris DeYoung and the HICP for their arduous work and dedication to the residents of the District and we appreciate their dependable and highly effective collaboration with the OHCOBR.

Success Stories

Behavioral Health Residential Inpatient Treatment

The representative of a 23-year old female contacted our office requesting assistance appealing the insurer's denial of coverage for residential behavioral health treatment services rendered by a hospital-based psychiatric unit.

According to a medical necessity letter from her psychiatric provider this member had a significant trauma history and four separate suicide attempts from the age of 14, as well as a history of depression and nightmares. Her clinical records document sexual abuse beginning at age 3 and again at age 18. The records also indicate that the member lives independently without any family support.

The insurer's denial letter states "The available clinical information received does not support the insurer's criteria for continued stay at an acute inpatient mental health adult level of care… There is no clinical evidence that you are very likely to cause serious bodily harm to yourself or others due to a psychiatric illness."

The member's clinical records upon discharge note that she was less anxious, more in control and in better spirits. She was alert, and fully oriented with no suicidal or homicidal ideations.

Based upon the insurer's adverse coverage denial the appeal request was sent for external medical necessity review. The external reviewers overturned the insurer's denial resulting in a $7,500 cost savings for the member.

Denial of Parking Permit for DC Resident with Disabilities

Our office was contacted regarding the District Department of Transportation's (DDOT) decision to deny a reserved on-street parking space to a household with two elderly individuals. The household consists of the member (a bedridden 95-year old) and her sister (an 85-year old that ambulates with a cane). According to the applicant the permit was denied because available off-street parking was available. The member's sister explained that the available space on their property, accessed through the backdoor, was not a usable option because physical disabilities prevented both siblings from safely maneuvering the rear stairs.

The Ombudsman's staff made numerous requests to the DDOT over a five-month period. Initially, we were told that DDOT did not have an appeals process, but staff persisted nevertheless. After leaving several messages for the person that signed the denial letter, no response was forthcoming.

Ombudsman staff requested to speak to a supervisor and was informed that the person who denied the request no longer worked there. After following up with the case for five months, the request was finally approved by the DDOT Chief Operations Officer. With the determined help of the Ombudsman Staff, the sisters can be safely transported to medical appointments and other destinations. They can now access vehicles from the front entrance that has three steps, instead of by way of the ten steps at the rear of the house.

Dental Implant Procedure

An appeal was filed due to a denial of dental coverage for the placement of dental implants. The insurer stated that there were less costly dental procedures available. The treating dentist appealed the denial with an explanation of medical necessity that justified the procedure. The case was sent for external review and the reviewers recommended that the insurer's decision be reversed based on their determination that dental implants were the best course of treatment for a long-term success. Based on the reversal, the member received a cost savings of $3,000.

Behavioral Health Residential Inpatient Treatment

A 16-year old female had been treated and discharged from a hospital after a suicide attempt by hanging. The member also exhibited self-destructive, non-suicidal self-injury behavior by cutting herself to cope with emotional pain. She was considered a high-risk for safety as she continued to lack impulse control, exhibited poor insight and judgment, and poor coping skills to deal with her stress. Her treatment team highly recommended a residential treatment program based on her need for therapeutic support, a safe environment, and psychiatric monitoring that could only be provided by that level of care. The insurer denied coverage for the continued residential behavioral health treatment. After referring the appeal for external review, the decision was reversed, and the insurer paid $352,000 for the residential treatment.

Growth Hormone Treatment

The OHCOBR received a request from a physician to assist in an appeal for her 7-year old female patient in the decision of CVS/Caremark to deny payment for Humatrope® for Temple Syndrome, a short stature disorder of imprinting. The cardinal features are low birth weight, hypotonia or decreased muscle tone, early puberty and significantly reduced final height. This patient had early puberty and was treated with Lupron to suppress her advanced bone age of 11 at age 7. The patient was also diagnosed with hypotonia.

Temple Syndrome is very rare and growth hormone is approved to help with muscle tone. By this disorder being so rare, it was difficult to find any studies with reliable results. According to one physician, whose specialty is in Genetics and Metabolism, children with Temple Syndrome have been successfully treated with growth hormone to improve their long-standing growth restrictions.

The case was sent to the independent review organization (IRO) and was reversed, with the rational being that there were two series of patients published and several other case reports supporting a trial of growth hormone treatment in children with Temple Syndrome and either short stature or hypotonia. It was advised that the treatment needed to be performed carefully with monitoring of IGF-1 and discontinued if patient showed no signs of improvement. It was determined that the growth hormone treatment was medically necessary.

Nutritional Supplies

A commercial insurance member contacted our office seeking assistance obtaining nutritional supplements for her two-month old baby. The infant's pediatrician prescribed Similac Expert Care Alimentum 2.75G/100 oral suspension, however, the insurance company informed the parents that it was not a covered pharmacy benefit under their plan.

Our office contacted the member and informed her of which part of her insurance was responsible for the payment of the Similac. The member assumed that coverage was a pharmacy benefit, but it was a medical benefit. Our office then called the medical supply company that contracted with the insurance company and they agreed to ship the

nutritional supplies the next day. The first shipment was delayed, but the second shipment arrived on time and the medical supplier ensured the member that there would be no more delays. Based on the reversal, the member received a cost savings of $133 per can or $3,744 for a one-year supply

In addition, we contacted the Clinical Appeals and Analysis Unit and requested that the infant be placed in case management for the diagnosis of failure to thrive. The member was assigned to a case manager and provided a date for the first visit.

Prescription Denial for Multiple Sclerosis Treatment

A 39-year old male with relapsing remitting multiple sclerosis, diagnosed in 2011 sought an appeal through the OHCOBR, based on his insurance company's decision to deny coverage for prescription drug Lemtrada. The insurer denied coverage based on their determination that the treatment was not medically necessary and that their criteria had not been met.

The member was previously on Copaxone from March 2012 to May 2015 and experienced symptoms of heat intolerance, fatigue, urinary urgency, right leg heaviness (which resulted in dragging) and visual changes. He was switched to Tysabri in May 2015, but in June 2016 his symptomology returned. The physician and the member also felt that his condition had not stabilized with Tysabri and discussed the benefits of a more efficacious monoclonal antibody with a different mechanism of action. The treating physician recommended switching to Lemtrada and prescribed the medication for the member.

The case was sent to the independent review organization (IRO) for an expedited review. It was determined that the member had tried and failed three medications – Copaxone, Ampyra and Tysabri, and all of these first-line treatments had failed. It was further determined that Lemtrada would block the multiple sclerosis process by "rebooting" the immune system and this approach would result in better stabilization of the patient's multiple sclerosis compared to his prior treatments. Based on this assessment, the prescription was determined by the IRO to be medically necessary and the patient received a cost savings of $158,000 for years 1 & 2.

Achievements

Office of Health Care Ombudsman and Bill of Rights' Achievements for FY 2017

In FY2017, the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) saw achievement in its continued ability to handle a heavy caseload and to address the varied and increasingly complex health care issues consumers sought help to resolve. This fiscal year, the OHCOBR was able to maintain overall service levels from the prior year and realized the following additional achievements:

- Added two additional nurses to fill existing vacancies left by clinical staff in FY2016 to assist with commercial insurance caseload;

- Created a database to track cases sent to the independent review organization (IRO) to ensure compliance with legislative timeframe requirements. This database will be implemented in FY2018;

- Created a pharmacy database to determine trends for commercial prescription cases to identify the classes of prescription drugs and demographic groups that are continually denied. This database will be implemented in FY2018;

- The OHCOBR served nine percent more consumers in FY2017 than in the previous year (9,250 in FY2017 compared to 8,420 in FY2016);

- The OHCOBR continued to improve its track record of *resolving most Non-Commercial cases the same day the case was opened.* The office had a nine percent increase in Non-Commercial same day closures over the previous year (7,683 in FY2017 vs. 6,999 in FY2016); and

- In FY2017, the OHCOBR saved consumers a total of $1,048,787.54, an increase of 32 percent over FY2016 when $715,553.11 was saved on behalf of consumers.

Recommendations

Recommendations for improving performance and outcomes

Based on our experiences during FY2017, the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) identified several recommendations from a review of problems encountered by consumers in FY2017 and the areas where service delivery could be improved by our office, administrators of government health care benefits, insurance companies, and health care providers. We anticipate that these recommendations will help consumers better understand their rights and benefits, facilitate their access to care, and promote better satisfaction at the point of service to reduce the frequency of complaints, grievances and appeals.

It is recommended that the OHCOBR:

- Increase collaboration with external and internal stakeholders to improve coordination of benefits for the Medicare and Qualified Medicare Beneficiaries (QMB) population;
- Utilize online video conference call technology to increase and retain participation in the advisory council committee meetings;
- Consult with the commercial insurance companies regarding TEFRA/Katie Beckett eligibility options for children to ensure eligible families are benefiting from the coverage offered by this special program;
- Increase collaboration with the Department of Health Care Finance (DHCF) to cut down on the incidents of Medicaid beneficiaries receiving more than one opioid prescription from one or more of their treating physician;
- Increase education and outreach to Spanish and Amharic speaking residents in the District;
- Continue efforts to improve timely medical assistance applications for infants with low birthweight; and
- Continue efforts to improve mental health information sharing among providers to maximize consumers' access to benefits and comprehensive care without compromising confidentiality rights.

Data Collection Summary and Highlights

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

The Department of Health Care Finance, Division of Analytics and Policy Research aided the OHCOBR in the production of the following statistics, tables and graphs, as well as the source document. The source document for the summary and highlights that follow is the comprehensive *FY2017 Summary of Cases* report. To view the full report, go to the OHCOBR website at https://healthcareombudsman.dc.gov and click on the tab "Publications and Forms".

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

- How do the residents of the District of Columbia contact the OHCOBR?
- Who contacts the OHCOBR?
- What are the most common issues raised by the community?
- How has the OHCOBR benefited those who contacted us?
- How did FY 2017 activity compare to prior years' experience?

Data Collection Report and Highlights:

The following are highlights of the most significant findings from our data analysis.

- OHCOBR served nine percent more consumers in FY2017 than in the previous year (9,250 in FY2017 compared to 8,420 in FY2016). [Figure 1]
- Most of the issues raised by persons contacting OHCOBR in FY2017 (97 percent) were related to public benefits (Medicaid, Medicare, and the Alliance), referred to as 'Non-Commercial' cases in this analysis. [Figure 1]
- OHCOBR continued to improve its track record of *resolving most Non-Commercial cases the same day the case was opened.* The office had a nine percent increase in Non-Commercial same day closures over the previous year (7,683 in FY 2017 vs. 6,999 in FY 2016). [Table 3]
- Dual Eligible–Medicare/Medicaid consumers sought assistance more often than any other category of insurance (28 percent of all cases). [Figure 5]
- Eligibility was the single most frequent issue among all consumer contacts (41 percent), followed by Access/Coverage including denials (25 percent). [Figure 7] Percentages were even higher for

Eligibility issues among contacts concerning MCOs (59 percent or 1,213 of 2,054 cases) [Figure 13] and the Health Care Alliance (66 percent or 187 of 285 cases) [Figure 14].

- Issues concerning commercial insurers (three percent of all contacts) continue to be challenging, averaging nearly four months to resolve appeals and grievances cases (114.3 days).
- Consumer savings are reported to be $1,048,787.54, an increase of nearly 47 percent over the $715,553.11 captured in FY2016. [Figure 18]

SELECT FINDINGS FROM THE DATA ANALYSIS

Following is a report of customer trends and concerns and OHCOBR's performance in addressing those concerns throughout the fiscal year. Some of the data is also presented graphically in Tables 1-8 and in pie charts (Figures 1-23). For a look at the entire data set go to the *FY2017 Summary of Cases* available on line at http://healthcareombudsman.dc.gov. It contains a comprehensive set of all data collected with detailed descriptions, pie charts and tables.

Two types of insurance categories included in the total of all contacts are highlighted in the next sections.

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

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

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

ALL COMMERCIAL AND NON-COMMERCIAL CASES

- The OHCOBR opened a grand total of 9,250 cases of all types in FY2017, a 10 percent increase over the 8,420 cases opened in FY2016. [Table 1, Figure 1]

Table 1. Number and Percentage of All Opened Cases by Insurance Category FY16 and FY17				
Insurance Category	**FY16 Totals**	**FY16 %**	**FY17 Totals**	**FY17 %**
Non-Commercial	8,164	97%	9,009	97%
Commercial	256	3%	241	3%
Total Opened Cases	**8,420**	**100%**	**9,250**	**100%**
Annual Variance			**+830**	**+9.9%**

NON-COMMERCIAL CASES

- Of the 9,250 of all opened cases, 97 percent or 9,009 were Non-Commercial cases. [Figure 1] In FY2016, Non-Commercial contacts were also 97 percent of all cases opened; however, FY2017 opened 845 more Non-Commercial cases, an increase of 10 percent [Table 1, Figure 2].

- Of the 9,009 Non-Commercial cases opened, 2,565 contacts were related to Dual Eligible–Medicare/Medicaid insurance issues making them the single largest insurance type of all Non-Commercial contacts (28 percent). Medicare insurance contacts have consistently been the largest year-to-year, but only represented 27 percent of all contacts in FY2017. Dual Eligible–Medicare/Medicaid insurance contacts have consistently been the second largest insurance type year-to-year, representing 24 percent compared to 29 percent of Medicare insurance contacts in FY2016 and 24 percent compared to 31 percent in FY2015.

- Eligibility was the most frequent type of issue raised among all contacts, Non-Commercial and Commercial combined (3,757 cases, 41 percent of 9,250 total contacts). [Figure 7] FY2017 had fewer Eligibility cases than the 3,903 cases in FY2016 and a smaller percentage of cases compared to 47% in FY2016; however, Eligibility continues to trend as the most frequent type of issue raised by consumers year-to-year.

- Medicare contacts raised Eligibility issues at the rate of 35 percent (888 of 2,538 cases). This represented a seven percent increase in the proportion of all Medicare cases with this issue, compared to FY2016 when 28 percent of Medicare cases had Eligibility issues. In FY2015 Medicare contacts raised Eligibility issues at nearly the same percentage share as FY2017 (37 percent). [Figure 12]

- Dual Eligible–Medicare/Medicaid contacts raised Eligibility issues at the rate of 33 percent (842 of 2,565 cases) in FY2017 (compared to 42 percent in FY2016 (853 of 2060 cases) – a nearly 10 percent drop – and 39 percent in FY2015 (784 of 2014 cases). [Figure 10]

- Medicaid MCO contacts raised Eligibility issues at the rate of 59 percent (1,213 of 2,054 cases) compared to 40 percent in FY2016 (1,198 of 1,790 cases and 59 percent in FY2015 (1,038 of 1,768 cases). [Figure 13]

- Medicaid FFS contacts raised Eligibility issues at the rate of 36 percent (495 of 1,365 cases) compared to 40 percent in FY2016 (557 of 1,406 cases) and 33 percent in FY2015 (480 of 1,445 cases). [Figure 11]

- Alliance contacts raised Eligibility issues at the rate of 66 percent (187 of 285 cases) [Figure 14].

- OHCOBR closed 96 percent of all opened Non-Commercial cases by the end of FY2017, 8,621 cases; the remaining four percent, 388 cases, were still pending resolution at the end of the fiscal year compared to 97 percent of cases closed at the end of FY2016 (7,903) cases) with 261 cases pending (four percent); and 95 percent closed at the end of FY2015 (7,817 cases) with 281 cases pending. [Table 2, Figure 2].

Table 2. Non-Commercial Cases:
Status and Resolution of Closed and Open Cases at Year-End
FY16 and FY17

Year-End Status and Resolution	FY16 Totals	FY16 %	FY17 Totals	FY17 %
Closed Cases – Successful (In favor of the consumer)	7,676	94%	8,568	95%
Closed Cases – Unsuccessful (Not in favor of the consumer)	190	2%	53	1%
Closed Cases (Referred Out) –Resolution Undetermined	35	1%	0	0%
Closed Cases - Sub-Total	**7,901**	**97%**	**8,621**	**97%**
Open Cases – Still Pending Resolution	**263**	**3%**	**388**	**4%**
Total All Non-Commercial Cases (Closed and Open)	**8,164**	**100%**	**9,009**	**100%**
Annual Variance			**+845**	**+10.4%**

- On average, Non-Commercial cases were closed in 1.8 days; up from 1.6 days in FY2016 and 1.4 days in FY2015. [Table 3, Figure 19]

- Of all Non-Commercial cases, OHCOBR resolved 85 percent *on the same day they were opened,* 7,683 cases. Compared to FY2016, 684 more cases were closed in FY2017 representing a 9 percent increase in same day closures. [Table 3] Compared to FY2015, 333 more cases were closed in FY2017.

Table 3. Non-Commercial Cases: Analysis of Days to Close a Case FY16 and FY17			
FY16 # of Cases Closed	**FY16 Average # of Days to Close**	**FY17 # of Cases Closed**	**FY17 Average # of Days to Close**
7,901	**1.6 days**	**8,621**	**1.8 days**
FY16 Same-Day Closure Cases		**FY17 Same-Day Closure Cases**	
6,999 of 8,164 total Non-Commercial cases (86%)		**7,683 of 9,009 total Non-Commercial cases (85%)**	
Annual Variance of Same-Day Closures		**+684 cases**	**9% increase in # of cases**

COMMERCIAL CASES - APPEALS AND GRIEVANCES

- Cases related to Commercial Health Plans represented three percent of all cases opened in FY2017 (241 of 9,250 total cases); a slight reduction compared to the number of cases opened in FY2016 (256). [Figure 1] There were 197 Commercial cases opened in FY2015.

- Of the 241 Commercial cases opened in FY2017, 94 (39 percent) were related to Medical Necessity, 59 (25 percent) were related to issues and questions about Eligibility, 12 (5 percent) were related to Experimental/Investigational, 7 (3 percent) were related to Part D Prescription Plans, 39 (16 percent) covered a wide range of Other generic complaints and issues, and the remaining 30 (12 percent) were issues that were Undetermined. [Table 4, Figure 9]

- Although the total number of Commercial grievances is similar for both FY2017 and FY2016 the distribution of cases is significantly different in four ways. In FY2017, Medical Necessity cases increased from 29 percent to 39 percent of cases; Eligibility issues decreased from 30 percent to 25 percent; Other cases decreased from 26 percent to 16 percent; and a Part D Prescription case category was implemented. [Table 4, Figure 9] The decrease in Other cases indicates that consumers contacted OHCOBR more often with issues that fit into the routinely tracked categories. Beginning in FY2018, the Undetermined category will be eliminated, and the disposition of all cases will be reported accordingly.

Table 4. Commercial Cases: Appeals/Grievances Types of Issues Encountered FY16 and FY17				
Issues	**FY16 Cases**	**FY16 % of Total**	**FY17 Cases**	**FY17 % of Total**
Care Is Experimental/Investigational	9	4%	12	5%
Care Is Not Medically Necessary	74	29%	94	39%
Grandfather Status	0	0%	0	0%
Not Eligible for Health Plan/Benefit	76	30%	59	25%
*Other Issues	68	26%	39	16%
Part D Prescription Plan	DID NOT TRACK	DID NOT TRACK	7	3%
Rescission	0	0%	0	0%
Undetermined	29	11%	30	12%
Total Issues (Commercial Cases)	**256**	**100%**	**241**	**100%**

- In FY 2017, 74 percent (179 cases) of all Commercial cases were closed, compared to 83 percent (213 cases) in FY2016 and 75% (148 cases) in FY 2015. [Table 5, Figure 3]

- In FY2017, 26 percent of Commercial cases remained open by the end of the fiscal year (62 cases), compared to 17 percent (43 cases) that remained open at the end of FY2016 and 25 percent (49 cases) that remained open at the end of FY 2015. [Table 5, Figure 3]

- Of the 179 closed cases in FY2017, 112 cases (46 percent) were resolved successfully in favor of the consumer, a slight decrease in comparison to 120 cases (47 percent) in FY2016, and about the same number of cases as in FY2015 (115 cases, 58 percent). [Table 5, Figure 21]

Table 5. Commercial Cases: Status and Resolution of Cases at Year-End FY16 and FY17				
Year-End Status and Resolution	**FY16 Totals**	**FY16 %**	**FY17 Totals**	**FY17 %**
Closed Cases – Successful (In favor of the consumer)	120	47%	112	46%
Closed Cases – Unsuccessful (Not in favor of the consumer)	69	27%	67	28%
Closed Cases (Referred Out) –Resolution Undetermined	24	9%	0	0%
Closed Cases - Sub-Total	**213**	**83%**	**179**	**74%**
Open Cases – Still Pending Resolution	43	17%	62	26%
Total All Non-Commercial Cases (Closed and Open)	**256**	**100%**	**241**	**100%**

- It took an average of 114.3 days to resolve or close a Commercial case [Table 6, Figure 20]. This represents an increase of 3.9 days (4 percent) in *the average days to resolve or close a case* compared to 110.4 days in FY2016, largely due to a decrease in the number of cases reversed and overturned and an increase in the amount of cases still pending. In FY2015 it took fewer days to close cases (81.3 days); however, more cases were closed in FY2017 in comparison to FY2015 (179 vs. 148).

- OHCOBR resolved or closed eight Commercial cases (three percent) *on the same day they were opened.* Similarly, in FY2016, eight of 256 total cases (three percent) were resolved on the same day they were opened. In FY2015, 10 of 197 total cases (five percent) were resolved on the same day they were opened. [Table 6]

Table 6. Commercial Cases: Average Number of Days to Close and Same-Day Closures FY16 and FY17

FY16 # of Cases Closed	FY16 Average # of Days to Close	FY17 # of Cases Closed	FY17 Average # of Days to Close
213	110.4 days	179	114.3 days
FY14 Same-Day Closure Cases		FY15 Same-Day Closure Cases	
8 of 256 total Commercial cases (3%)		8 of 241 total Commercial cases (5%)	
FY17 Variance - Same-Day Closures		0 Fewer Cases	0% Increase/Decrease

CONSUMER SAVINGS

- In FY2017, the OHCOBR saved consumers a total of $1,048,787.54. This represents an increase of 32 percent over FY2016 when $715,553.11 was saved on behalf of consumers. This increase can be attributed a gap period in FY2016 when savings figures were not being captured in the OIDS due to a mid-year change in data collection and reporting methodology. [Figure 18]

- Of the nearly 1.1 million that was saved, $571,776.28 (55 percent) was the result of resolved Commercial cases; $161,129.62 (15 percent) was saved or recouped on behalf of Medicaid fee-for-service, MCO and Alliance beneficiaries; $129,728.53 (12%) was removed from QMB beneficiaries' accounts for co-payments; and $186,153.11 (18%) was reimbursed to beneficiaries due to non-payment of Medicare Part B Premiums. [Figure 18].

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

- Most consumers, 95 percent, utilized the telephone to contact OHCOBR (8,760 of 9,250 total contacts). This continues to be the preferred method for contacting the office. In FY2016, 94 percent of total contacts were made by telephone (7,961 of 8,420 total contacts), and in FY2015, 95 percent of total contacts were made by telephone (8,011 of 8,438 total contacts) [Figure 4].

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

- Ward 7 (1,597) and Ward 8 (1,546) had the highest number of contacts to the OHCOBR with 17 percent each. The next highest number of contacts originated from Ward 5 (1,332) with 14 percent. [Table 7]

Table 7. Contacts Located in and Out of the DC Metropolitan Area FY16 and FY17

Location of Contacts	FY16 # Contacts	FY16 % Contacts	FY17 # Contacts	FY17 % Contacts
Ward 1	857	10%	947	10%
Ward 2	951	11%	1,124	12%
Ward 3	370	4%	341	4%
Ward 4	1,121	13%	1,259	13%
Ward 5	1,386	16%	1,332	14%
Ward 6	830	10%	900	10%
Ward 7	1,381	16%	1,597	17%
Ward 8	1,261	15%	1,546	17%
Maryland (Within the DC Metro Area)	13	1%	19	<1%
Virginia (Outside the DC Metro Area)	13	1%	20	<1%
Other - Outside of Metro Area	152	2%	151	2%
Out-of-Country	0	0%	0	0%
Undetermined	85	1%	14	<1%
TOTALS	**8,420**	**100%**	**9,250**	**100%**

- Eligibility continues to be the most frequent type of issue from all types of consumers combined, at 41 percent or 3,757 total cases [Figure 7]. It was the most frequent issue in FY2016, 47 percent or 3,903 total cases, and in FY2015, 41 percent or 3,492 total cases.

- The Access/Coverage issues that include denials of service was the largest type of issue raised by Dual Eligible (Medicare and Medicaid) contacts (35 percent, 910 of 2,565 cases). Compared to

FY2016, Access/Coverage issues are trending upward for Dual Eligible contacts, from 28 percent to 36 percent of all cases in FY2017, as Eligibility issues trend downward from 42 percent to 33 percent of all cases in FY2017. OHCOBR works closely with the government agency that handles Medicaid enrollment to resolve both issues quickly. [Figure 10]

- Of the 147 Administrative/Fair Hearing cases filed by OHCOBR on behalf of all types of contacts, 73 percent were filed on behalf of EPD Waiver beneficiaries (107 cases). In FY2016, 100 of a total of 164 hearings (61 percent) were on behalf of EPD Waiver beneficiaries.

- The number of Access issues for EPD Waiver beneficiaries that went to Administrative/Fair Hearings for resolution increased since FY2016, from 100 cases and 12 percent of all EPD cases to 107 cases and 21 percent of all EPD cases in FY2017. The number of Access issues for EPD Waiver beneficiaries that were handled without being referred for Administrative/Fair Hearing for resolution decreased somewhat since FY2016, from 160 cases and 19 percent in FY2016 to 137 cases in FY2017, but they represent a greater percentage share of all the cases (26 percent). In FY2015 there were only 67 cases concerning Access issues that were handled without the need for a fair hearing (11 percent of all EPD cases). [Table 8, Figure 16]

- A total of 517 EPD Waiver cases were opened in FY2017, 49 percent fewer than the 861 cases opened in FY2016. [Table 8, Figure 16]

Table 8. Types of Issues Encountered by EPD Waiver Contacts	FY16 # of Contacts	FY16 % of Contacts	FY17 # of Contacts	FY17 % of Contacts
Access (Administrative Hearings)	100	12%	107	21%
Access (Including Prior Authorizations)	160	19%	137	26%
Coverage/Service Denials	48	5%	10	2%
Eligibility/Verification of Coverage	396	46%	206	40%
Non-Payment/Reimbursement (Out-of-Pocket Expenses)	23	3%	0	0%
Other Issues	48	5%	0	0%
Quality of Services by Providers	86	10%	57	11%
Totals	**861**	**100%**	**517**	**100%**

- In FY2017, a total of 144 Transportation Cases were opened compared to 105 in FY 2016, a 27 percent increase; and 18 percent more than the 122 cases in FY2015. [Figure 15].

- A total of 482 DC Health Link and Health Care Exchange Marketplace cases were opened in FY2017, a 47 percent increase compared to the 328 cases in FY2016. [Figure 17] There was an uptick in complaints in FY2015 due to technical issues within the Exchange, such as, incorrect program codes and delays in transmission of information from DC Health Link to the insurers.

Data Collection Report

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

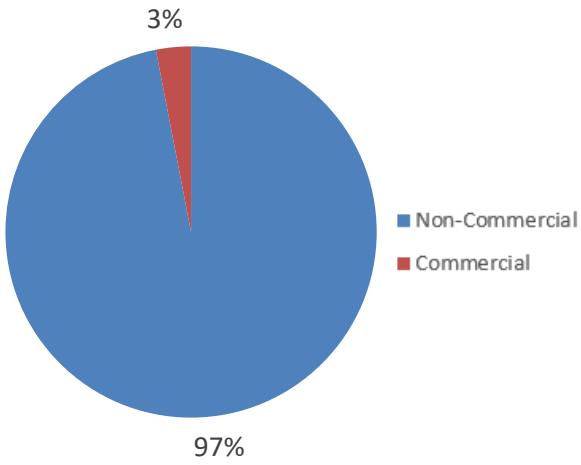
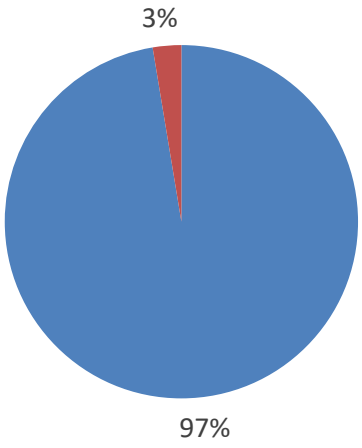
FY16	FY17
	
FY16 Total Sample = 8,420 Cases	**FY17 Total Sample = 9,250 Cases**

Figure 2. Number and Percentage of Resolved/Closed Cases and Cases Not Resolved/Closed Among (Non-Commercial) Contacts

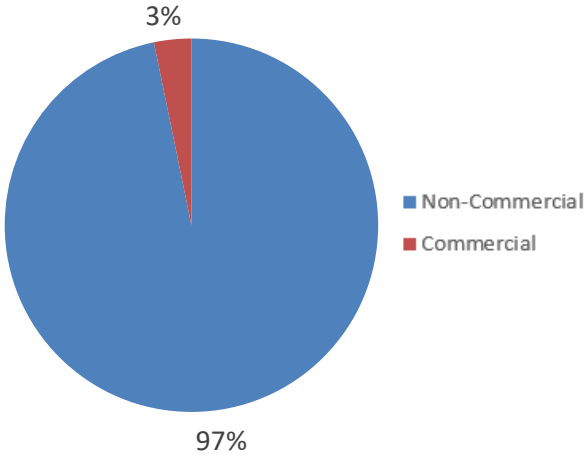
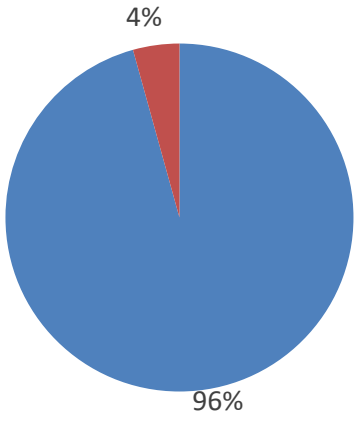
FY16	FY17
	
FY16 Total Sample = 8,164 Cases	**FY17 Total Sample = 9,009 Cases**

Figure 3. Number and Percentage of Resolved/Closed Cases and Cases Not Resolved/Closed Among (Commercial-Appeals/Grievances-Bill of Rights) Contacts

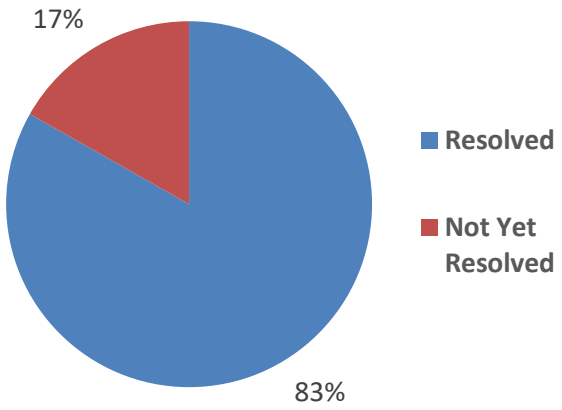
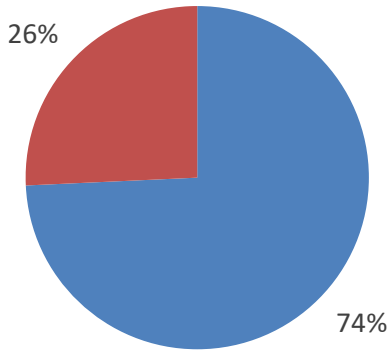
FY16	FY17
	
FY16 Total Sample = 256 Cases	**FY17 Total Sample = 241 Cases**

Figure 4. Methods of Contacting the Office of Health Care Ombudsman and Bill of Rights (OHCOBR)

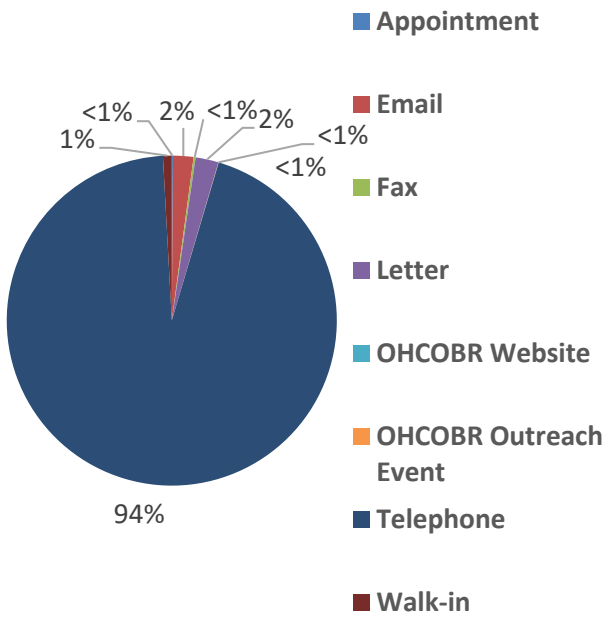
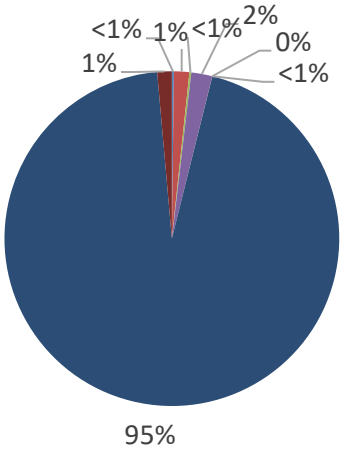
FY16	FY17
	
FY16 Total Sample = 8,420 Cases	**FY17 Total Sample = 9,250 Cases**

Figure 5. Categories of Contacts by Insurance Type

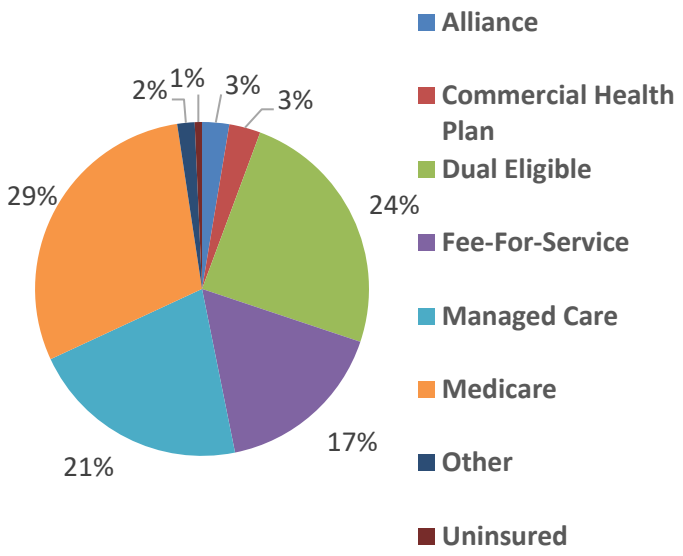
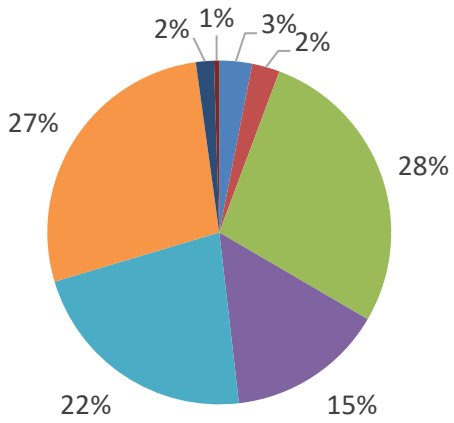
FY16	FY17
	
FY16 Total Sample = 8,420 Cases	FY17 Total Sample = 9,250 Cases

Figure 6. Contacts by Wards and States Located Within the DC Metropolitan Area and States Located Outside of the DC Metropolitan Area

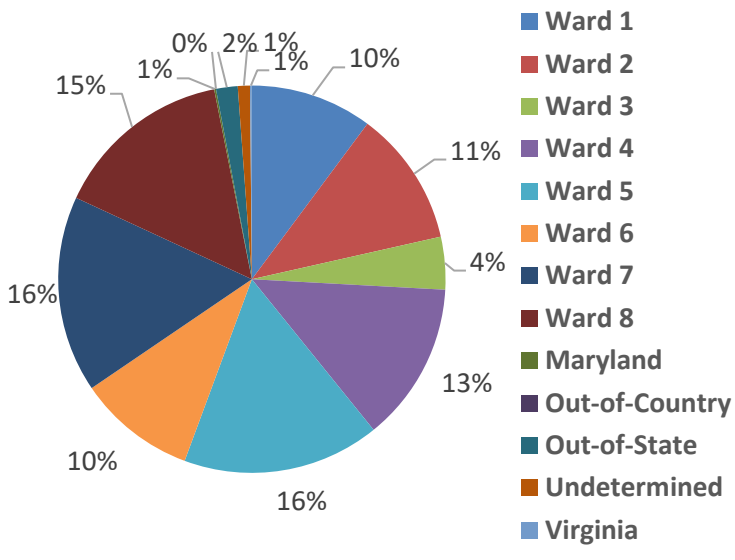
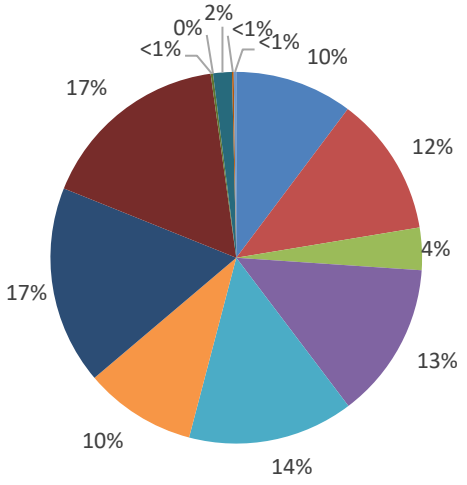
FY16	FY17
	
FY16 Total Sample = 8,420 Contacts	FY17 Total Sample = 9,250 Contacts

Figure 7. Breakdown of Types of Issues Encountered by All Contacts – (Non-Commercial); and (Commercial-Appeals/Grievances-Bill of Rights)

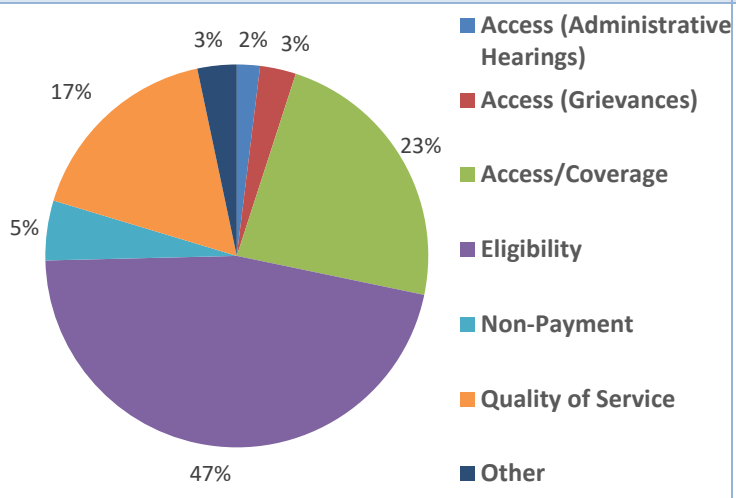
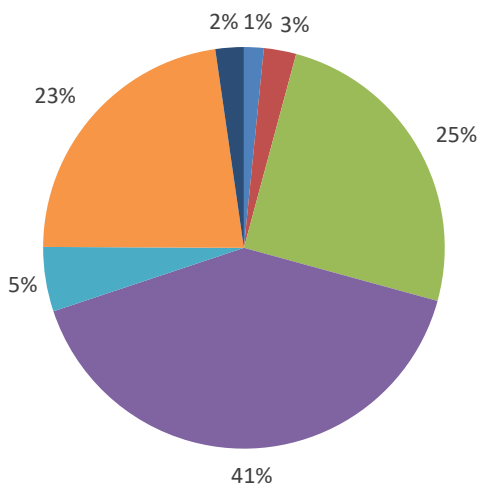
FY16	FY17
	
FY16 Total Sample = 8,420 Contacts	FY17 Total Sample = 9,250 Contacts

Figure 8. Breakdown of Types of Issues Encountered by (Non-Commercial) Contacts

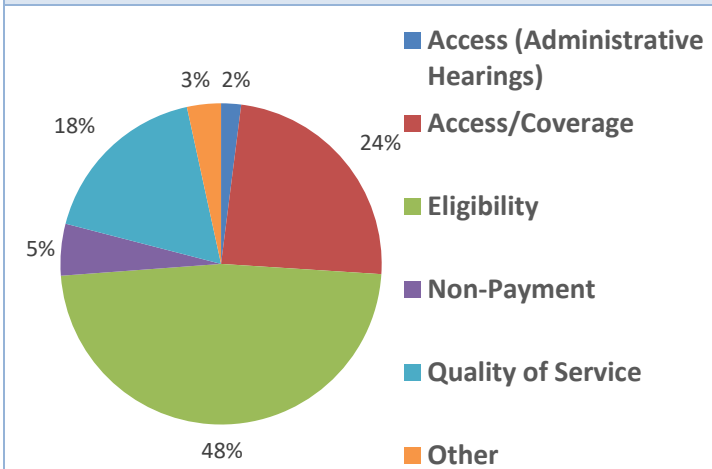
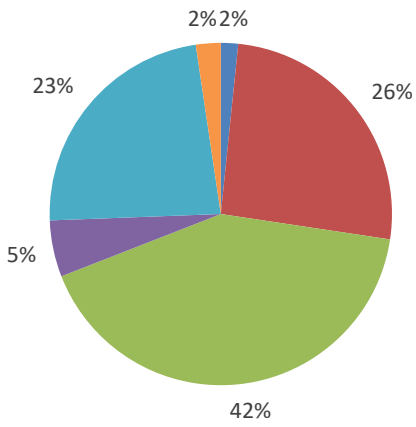
FY16	FY17
	
FY16 Total Sample = 8,164 Contacts	FY17 Total Sample = 9,009 Contacts

Figure 9. Breakdown of Types of Issues Encountered by (Commercial-Appeals/Grievances-Bill of Rights) Contacts

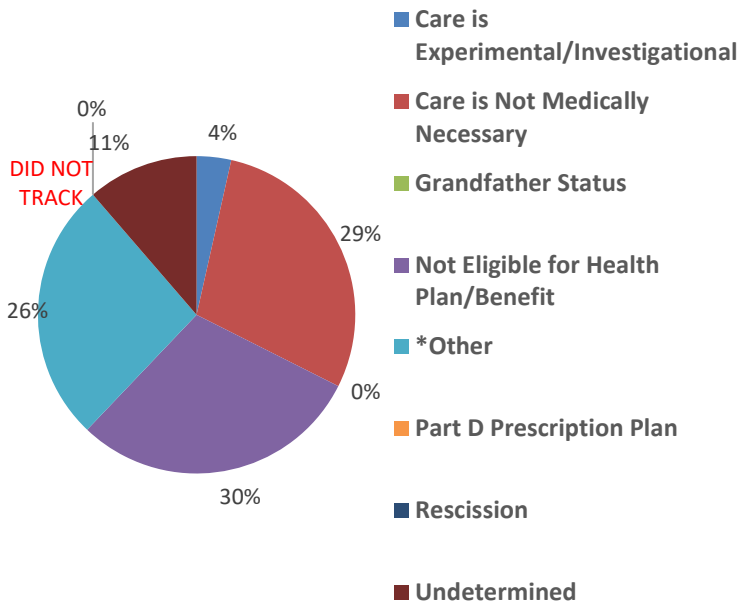
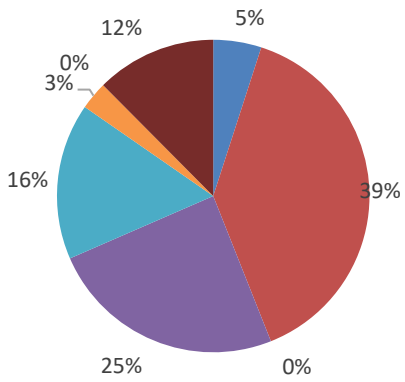
FY16	FY17
	
FY16 Total Sample = 256 Contacts	FY17 Total Sample = 241 Contacts

Figure 10. Breakdown of Types of Issues Encountered by Dual Eligible (Medicare and Medicaid) Contacts

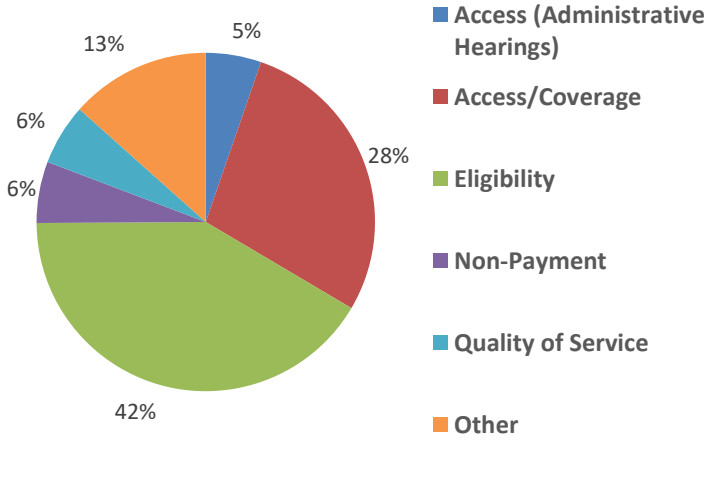
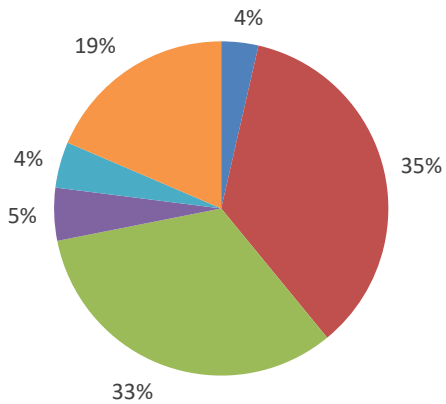
FY16	FY17
	
FY16 Total Sample = 2,060 Contacts	FY17 Total Sample = 2,565 Contacts

Figure 11. Breakdown of Types of Issues Encountered by Medicaid Fee-for-Service (FFS) Contacts

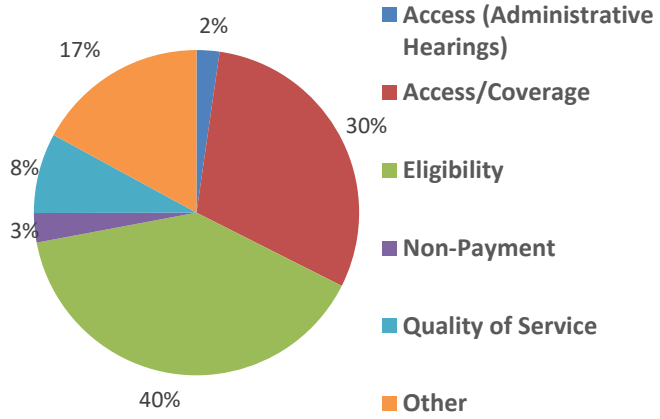
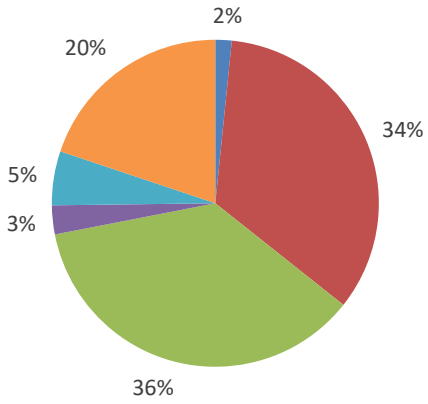
FY16	FY17
	
FY16 Total Sample = 1,406 Contacts	FY17 Total Sample = 1,365 Contacts

Figure 12. Breakdown of Types of Issues Encountered by Medicare Part A; Part B; Part A/B; Part A/B (QMB) Contacts

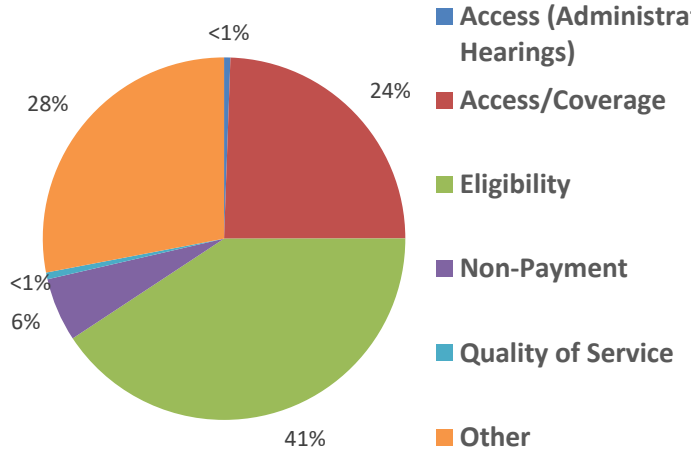
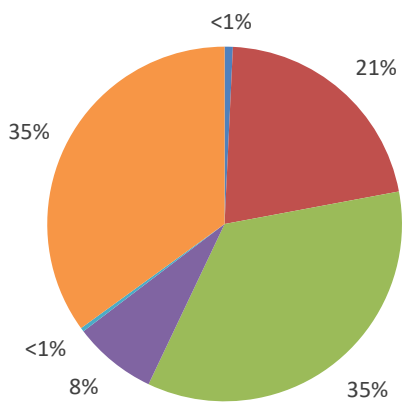
FY16	FY17
	
FY16 Total Sample = 2,486 Contacts	FY17 Total Sample = 2,538 Contacts

Figure 13. Breakdown of Types of Issues Encountered by Medicaid Managed Care (MCO) Contacts

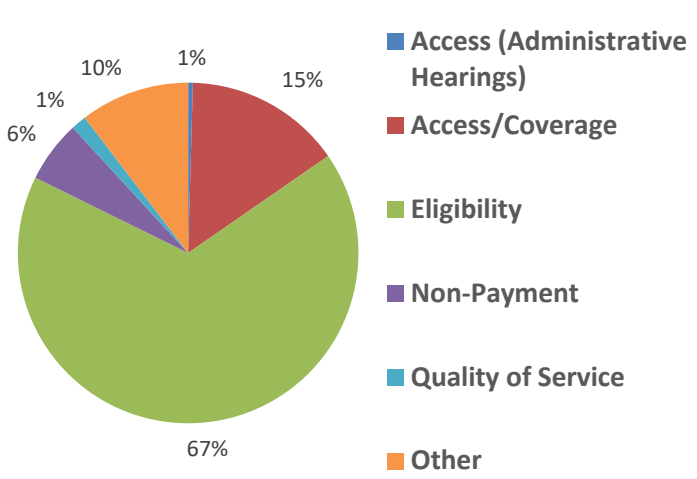
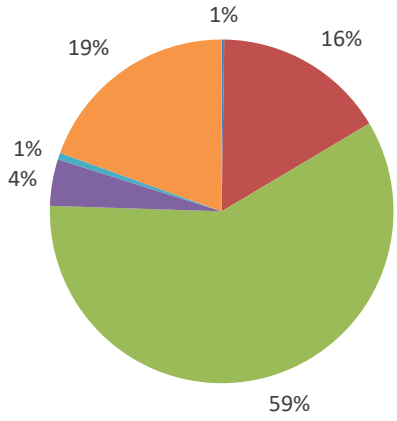
FY16	FY17
	
FY16 Total Sample = 1,790 Contacts	FY17 Total Sample = 2,054 Contacts

Figure 14. Breakdown of Types of Issues Encountered by Alliance Contacts

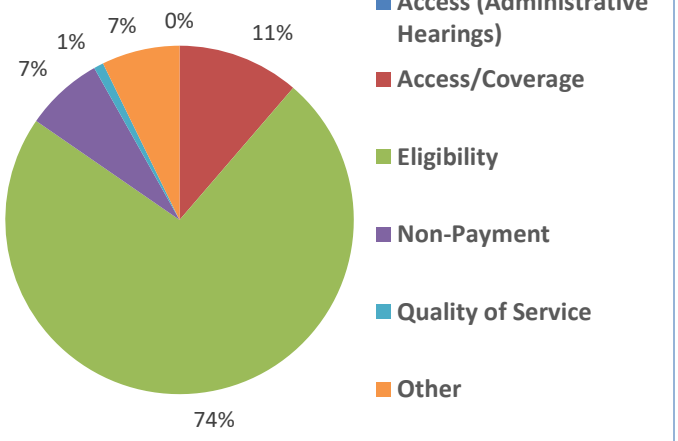
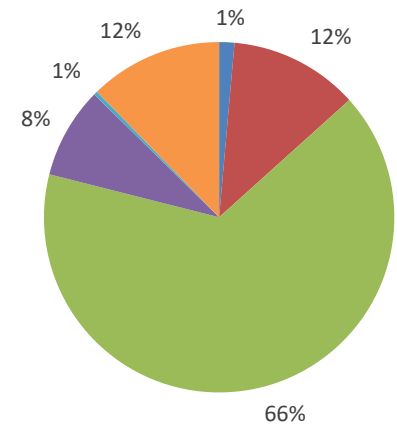
FY16	FY17
	
FY16 Total Sample = 221 Contacts	FY17 Total Sample = 285 Contacts

Figure 15. Breakdown of Transportation Contacts by Insurance Type

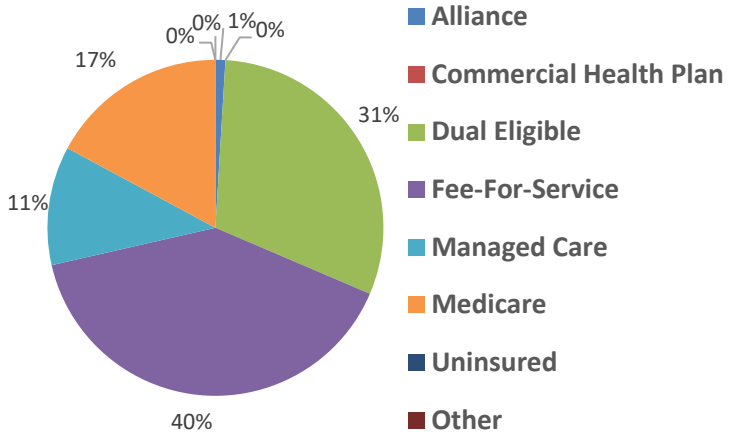
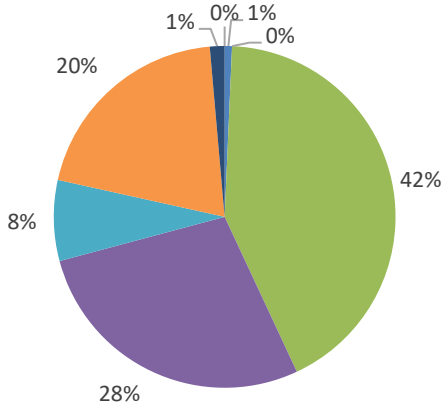
FY16	FY17
	
FY16 Total Sample = 105 Contacts	FY17 Total Sample = 144 Contacts

Figure 16. Breakdown of Types of Issues Encountered by EPD Waiver Contacts

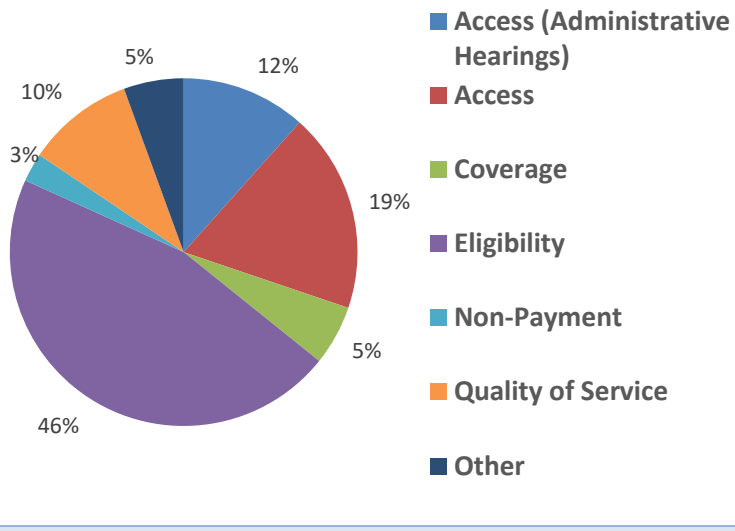
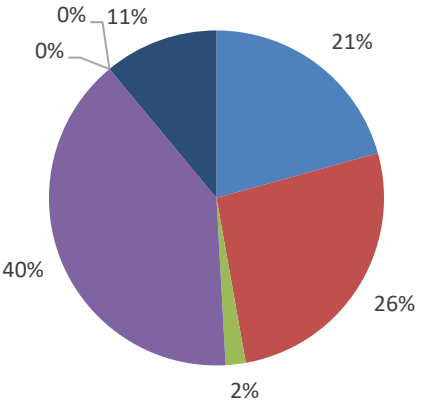
FY16	FY17
	
FY16 Total Sample = 861 Contacts	FY17 Total Sample = 517 Contacts

Figure 17. Breakdown of Types of Issues Encountered by DC Health Link and Health Exchange Marketplace Contacts

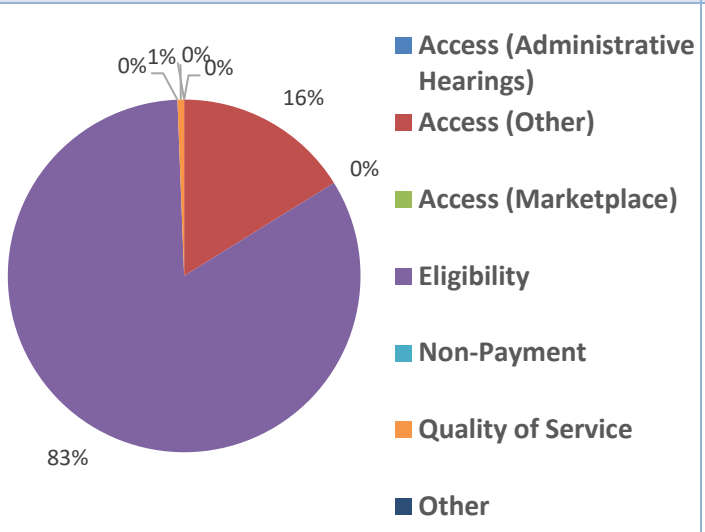
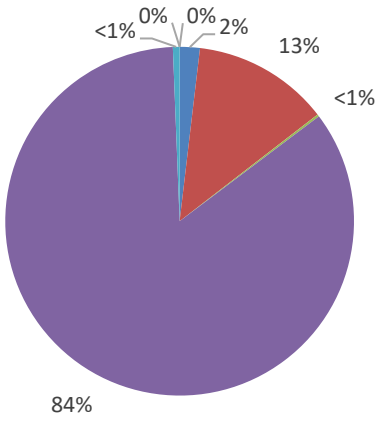
FY16	FY17
	
FY16 Total Sample = 328 Contacts	FY17 Total Sample = 482 Contacts

Figure 18. Dollar Amount of Savings on Behalf of (Non-Commercial); and (Commercial-Appeals/Grievances-Bill of Rights) Contacts

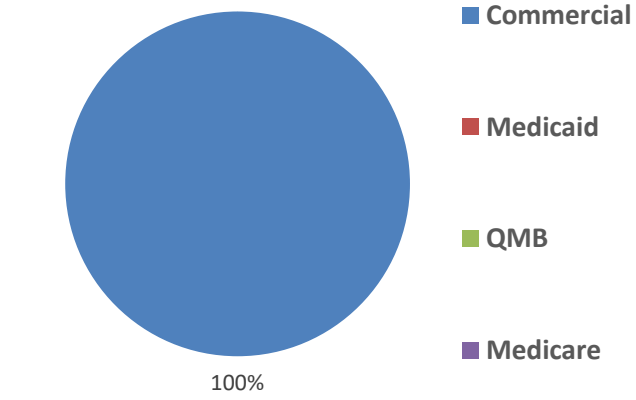
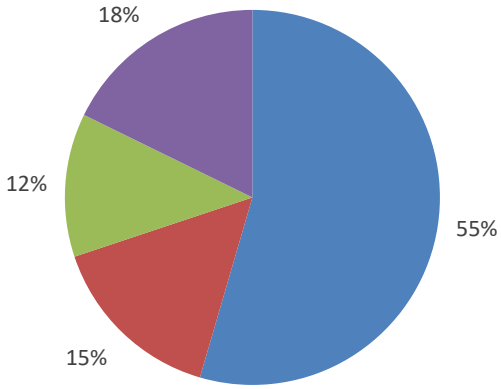
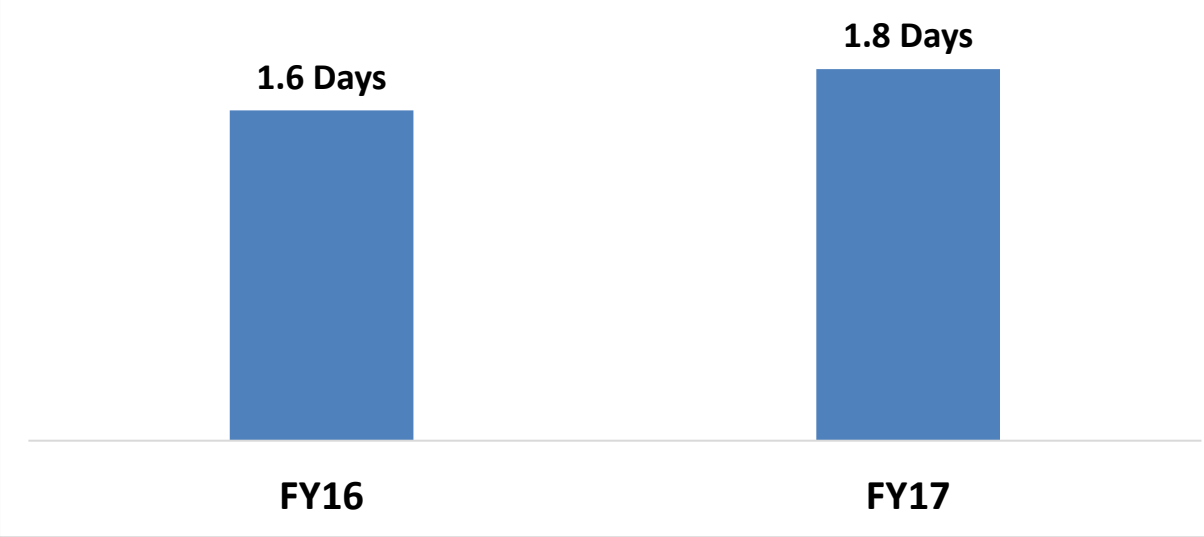
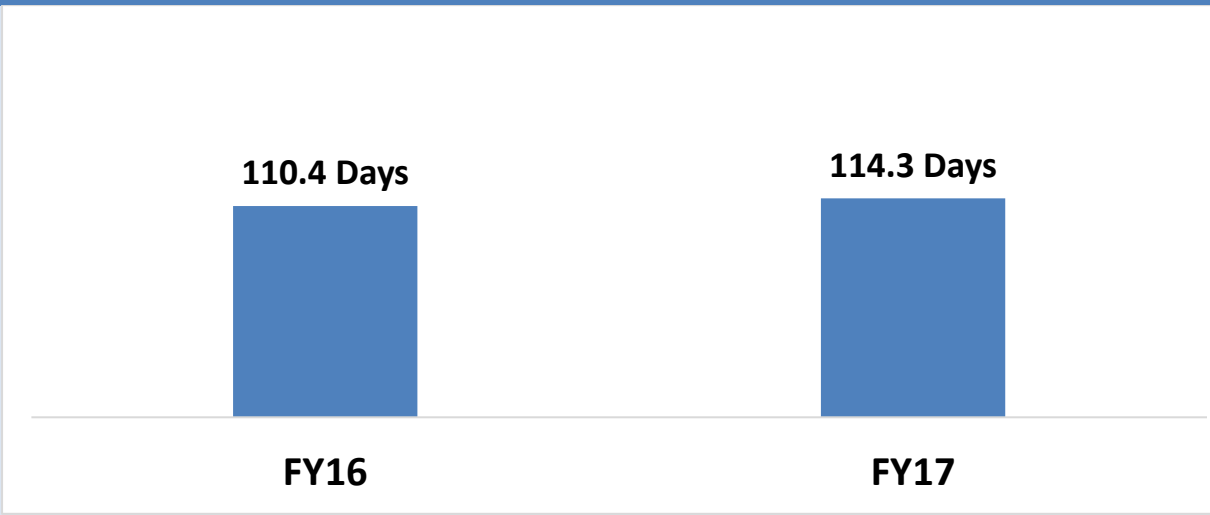
FY16	FY17
	
FY16 Total Sample = $715,553.11	FY17 Total Sample = $ 1,048,787.54

Figure 19. Average Number of Days to Resolve/Close (Non-Commercial) Cases



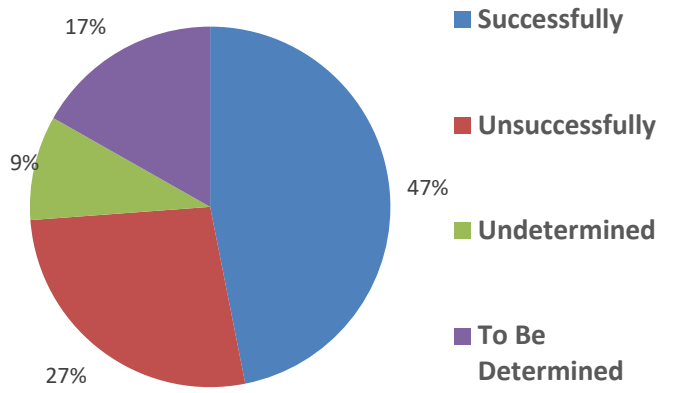
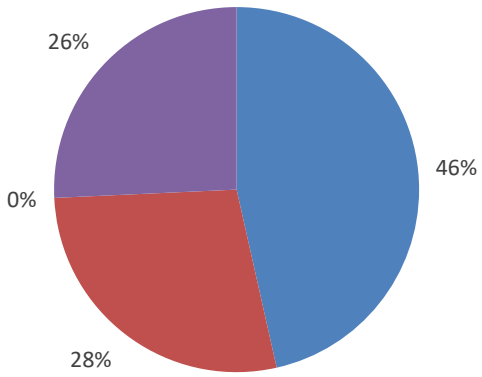
FY16 Total Cases Resolved/Closed = 7,901 Cases	**FY16 Total Cases Resolved/Closed = 8,621 Cases**

Figure 20. Average Number of Days to Resolve/Close (Commercial-Appeals/Grievances-Bill of Rights) Cases



FY16 Total Cases Resolved/Closed = 213 Cases	**FY16 Total Cases Resolved/Closed = 179 Cases**

Figure 21. Breakdown of Number and Percentage of How (Commercial-Appeals/Grievances-Bill of Rights) Cases Were Resolved/Closed and Cases Not Resolved/Closed by the OHCOBR

FY16	FY17
	
FY16 Total Sample = 256 Cases	**FY17 Total Sample = 241 Cases**

Appendices

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

Operational Function Statement

Appendix A

Office of Health Care Ombudsman & Bill of Rights Mission Statement

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

Appendix: Table 9 – Outreach/Education Events

Appendix B

OUTREACH/EDUCATION EVENTS – FY2017

OCTOBER 1, 2016 through SEPTEMBER 30, 2017

EVENT DATE	OHCOBR'S PARTICIPATION	NAME OF ORGANIZATION/GROUP	NUMBER OF ATTENDEES
OCTOBER 8, 2016	EXHIBITOR	WARD 4 – WOMEN'S MINISTRY ANNUAL HEALTH AND INFORMATIONAL FAIR	100 ATTENDEES
OCTOBER 14, 2016	EXHIBITOR	WARD 4 - DCOA IN COLLABORATION WITH HATTIE HOLMES SENIOR CENTER – COMMUNITY HEALTH, WELLNESS, & INFORMATIONAL FAIR	200 ATTENDEES
OCTOBER 19, 2016	EXHIBITOR	WARD 6 – SW WATERFRONT AARP CHAPTER & DCOA 5TH ANNUAL COMMUNITY HEALTH, WELLNESS & INFORMATIONAL FAIR	100 ATTENDEED
OCTOBER 20, 2016	EXHIBITOR	WARD 2 - EDP PROVIDERS, HOME HEALTH AGENCIES AND OTHER DC MEDICAID PROVIDERS	100 ATTENDEES
OCTOBER 20, 2016	EXHIBITOR	WARDE 4 - CC RETIRED EDUCATORS ASSOCIATION ANNUAL BUSINESS MEETING OAND DCOA SPONSORED COMMUNITY HEALTH, WELLNESS AND INFORMATIONAL FAIR	200 ATTENDEES
OCTOBER 25, 2016	EXHIBITOR	WARD 7 – MAYOR'S ANNUAL DISABILITY AWARENESS EXPO	300 ATTENDEES
OCTOBER 27, 2016	EXHIBITOR	WARD 4 – THE STATE OF THE WARD 4 SENIOR DAY	225 ATTENDEES
NOVEMBER 10, 2016	EXHIBITOR	Ward 8 – SPACE TO DREAM SPONSORED BY DEPT MAYOR SNOWDEN	200 attendees
NOVEMBER 15, 2016	EXHIBITOR	WARD 8 – DCOA IN COLLABORATION WITH COMMUNITY PRESERVATION & DEVELOPMENT CORP.	200 ATTENDEES
NOVEMBER 17, 2016	SPEAKER	WARD 6 – DHCF – LONG-TERM CARE – EPD WAIVER PROVIDERS	50 ATTENDEES
NOVEMBER 23, 2016	EXHIBITOR	WARD 2 - SAFEWAY'S FEAST OF SHARING HEALTH, JOB, AND LUCHEON	5,000 ATTENDEES
NOVEMBER 30, 2016	EXHIBITOR	WARD 8 – DCOA COLLABORATION WITH THE CONGRESS HEIGHTS SENIOR WELLNESS CENTER'S COMMUNITY HEALTH, WELLNESS AND INFORMATIONAL FAIR	200 ATTENDEES
DECEMBER 8, 2016	EXHIBITOR	WARD 6 – MAYOR'S ANNUAL SENIOR HOLIDAY CELEBRATION	5,000 ATTENDEES
JANUARY 4, 2017	EXHIBITOR/PRESENTOR	WARD 6 – HAYES SENIORS COMMUNITY HEALTH, WELLNESS AND INFORMATIONAL FAIR	100 ATTENDEES
JANUARY 18, 2017	EXHIBITOR	WARD 4 – RESIDENTS OF COLONY HOUSE COMMUNITY HEALTH, WELLNESS & INFORMATIONAL FAIR	50 ATTENDEES
JANUARY 25, 2017	EXHIBITOR/PRESENTOR	WARD 1 – RESIDENTS OF SAMUEL J. SIMMONS NCFB ESTATES –	100 ATTENDEES

		COMMUNITY HEALTH, WELLNESS & INFORMATIONAL FAIR	
FEBRUARY 22, 2017	EXHIBITOR/PRESENTOR	WARD 4 – AMERICAN KIDNEY FUND SCREENING/HOWARD UNIVERSITY COLLEGE OF DENTISTRY	200 ATTENDEES
APRIL 12, 2017	EXHIBITOR	WARD 5 – DC OFFICE OF AGING HEALTH AND RESOURCES FAIR – WASHINGTON TEACHERS UNION RETIREES CHAPTER	200 ATTENDEES
APRIL 19, 2017	EXHIBITOR/PRESENTOR	WARD 2 – SURSUM CORDA COOP SENIORS HEALTH SESSION	135 ATTENDEES
APRIL 29, 2017	EXHIBITOR	WARD 6 – NATALIE WILLIAMS BREAST CARE FOUNDATION – TEST MY BREAST 5K WALKER/WELLNESS FAIR	500 ATTENEES
MAY 4, 2017	EXHIBITOR/PRESENTOR	WARD 8 – ANNUAL HEALTH & SAFETY EVENT – WELLNESS CENTER	100 ATTENDEES
MAY 10, 2017	EXHIBITOR	WARD 5 – GREEN VALLEY SENIORS OLDER AMERICANS MONTH – AGING OUT LOUD	35 ATTENDEES
MAY 18, 2017	EXHIBITOR/PRESENTOR	WARD 8 – DCOA/ROBERFT L. WALKER HOUSE 1ST OLDER AMERICANS MONTH "AGE OUT LOUD"	200 ATTENDEES
MAY 31, 2017	EXHIBITOR/PRESENTOR	WARD 5 - MODEL CITIES SENIOR WELLNESS CEENTER OLDER AMERICANS MONTH	200 ATTENDEES
JUNE 3, 2017	EXHIBITOR	WARD 4 – ANC 4D'S RESOURCE FAIR WASHINGTON LATIN PUBLIC CHARTER	150 ATTENDEES
JUNE 20. 2017	EXHIBITOR/PRESENTOR	WARD 8 - MAYOR'S 6TH ANNUAL SENIOR SYMPOSIUM	700 ATTENDEES
JUNE 21, 2017	EXHIBITOR	WARD 3 - UDC CAUSES & DCOA SENIOR COMMUNITY HEALTH, WELLNESS AND RESOURCES	400 ATTENDEES
JUNE 29, 2017	Exhibitor	WARD 7 - 2017 SENIOR FEST PICNIC	600 attendees
JULY 12, 2017	EXHIBITOR	WARD 1 - DCOA IN COLLABORATION WITH BERNICE ELIZABETH FONTENEAU RESOURCE FAIR	300 ATTENDEES
AUGUST 1, 2017	exhibitor	WARD 8 – NATIONAL NIGHT OUT – WASHINGTON HIGHLANDS	300 ATTENDEES
AUGUST 5, 2017	EXHIBITOR	WARD 5 – ISRAEL BAPTIST CHURCH & BRENTWOOD HEALTH CENTER COMMUNITY HEALTH FAIR	200 ATTENDEES
AUGUST 12, 2017	EXHIBITOR	WARD 4 – DCOA/5TH ANNUAL NINETEEN STREET BAPTIST CHURCH BLOCK PARTY	300 ATTENDEES
SEPTEMBER 15, 2017	EXHIBITOR	WARD 8 – 3RD ANNUAL END OF SUMMER SENIOR COOKOUT	100 ATTENDEES
SEPTEMBER 18, 2017	PRESENTOR/EXHIBITOR	WARD 4 – HATTIE HOLMES SENIOR CENTER FALL HEALTH RESOURCE FAIR/DCOA	150 ATTENDEES
SEPTEMBER 20, 2017	PRESENTOR/EXHIBITOR	WARD 1 – SAMUEL KELSEY COMMUNITY HEALTH & RESOURCEI FAIR/DCOA	50 ATTENDEES

Commercial Insurance Self-Reports

Appendix C

Commercial insurance companies are required by law to submit to OHCOBR an annual report of grievances and appeals cases that they processed within their company. For uniformity in analyzing the reports, OHCOBR provides the report format. These reports give OHCOBR a better sense of the total volume of commercial grievances cases and issues effecting the public. Some commercial insurance beneficiaries do contact OHCOBR for help communicating with their insurer or for further action if they are dissatisfied with the insurance company's decision. Those cases are reported with all the other cases processed by OHCOBR (see *Data: Highlights & Analysis* section). This causes some duplication of cases reported by both OHCOBR and the private insurers.

DC Code §44.301.10 Reporting Requirements

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

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

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

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

(2) the number of cases that resulted in the initial decision being upheld; and

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

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

A breakout by company is shown in Tables 9 and 10.

DATA SUMMARY AND HIGHLIGHTS

Using data from the FY2017 *Commercial Insurer's Annual Self-Reports* submitted by each insurance company, OHCOBR assesses the volume and scope of complaints processed by each company and all the companies combined. The reports are analyzed to gauge trends, compliance with legislative mandates including timeliness of resolutions, and to identify areas that require further review and follow-up. Evaluating the benefits of the *Self-Report* and recognizing the need for value-added modifications to the report is an ongoing process.

TOTAL FY 2017 SELF-REPORTS RECEIVED:	30	100%
REPORTS WITH "NO GRIEVANCES":	18	53%
REPORTS WITH GRIEVANCES:	16	47%
REPORTS WITH 40% OR MORE GRIEVANCES OVERTURNED IN A SINGLE CATEGORY:	7	20%

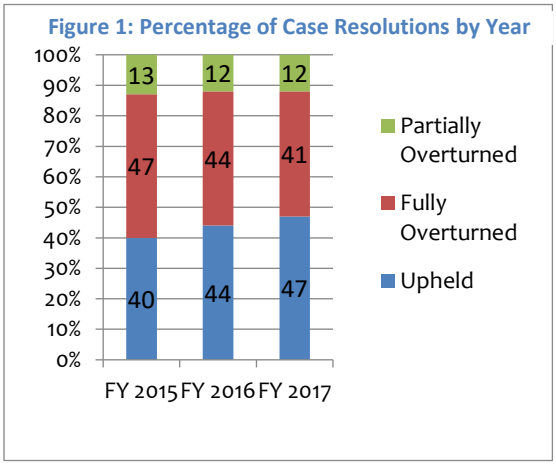
TRENDING: Grievance Turnover Rates

- The analysis of FY2017 final case results shows that one fifth of all 34 insurers (20 percent, seven of 34 insurers) overturned grievances on appeal at the rate of 40 percent or more in at least one of the service categories listed above. Since only 16 of the 34 companies reported having grievances and appeals in FY2017, nearly 44 percent (seven of the 16 insurers) overturned grievances on appeal at the rate of 40 percent or more in at least one service category.

- One outlier dental provider had an 84 percent *combined overturned* rate. Another dental provider reporting high numbers of grievances in FY2017 merged on December 31, 2016, with a company that had not previously participated in submitting annual self-reports. OHCOBR will look more closely at data submitted by dental insurers and will reach out to them to reduce the need for beneficiaries to file grievances in order to obtain covered services.

- In both FY2016 and FY2015 there were 14 companies with high decision reversal rates of 40 percent or higher in at least one service category, compared to only seven in FY2017. This 50 percent reduction in the number of providers reporting high reversal rates in FY2017 compared to the previous two fiscal years represents an overall downward trend in the percentage of grievances overturned in a single category.

- The percentage of cases by type of resolution decision for all grievances remains relatively static over the three-year period. (See Figure 1: *Percentage of Case Resolution by Year*). However, the *upheld* percentage rate has steadily climbed over the prior three-year period (up from 40 percent in FY2015 to 47 percent in FY2017, approaching half of all cases).



- Figure 1: *Percentage of Case Resolution by Year* shows slight variation in the percentages of decision outcomes by insurers in FY2017. The percentage of *fully overturned* cases is trending downward but remains above 40 percent. A *fully overturned* outcome indicates that members are initially being denied access to care that is ultimately determined to be necessary and covered. The grievance process increases adjudication costs and delays care. The OHCOBR staff will continue to encourage insurers to approve services at the point of contact and reduce the need for appeals.

TRENDING: Fewer Companies Reporting Grievances

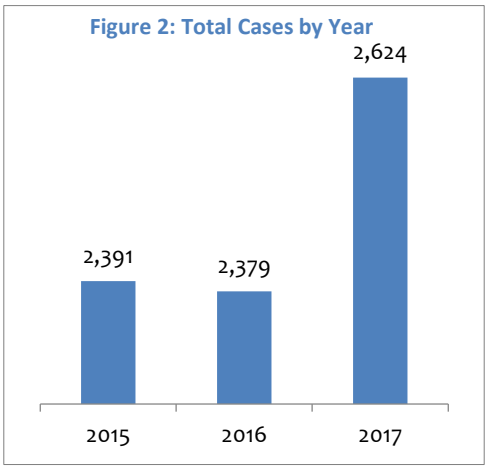
- Over the past three fiscal years, the number of companies reporting grievances has decreased from 23 in FY2015, to 22 in FY2016, to only 18 in FY2017; a 22 percent reduction since FY2015.

DATA SUMMARY: Number of Companies Reporting and Number of Cases

- A total of 34 companies submitted annual self-reports in FY2017. This number is slightly higher (four more companies) than the number of companies that submitted annual self-reports in FY2016 (30 companies) and three fewer than in FY2015 when 37 companies submitted reports. The reduction may be the result of additional companies granted approval for exemption from reporting for reasons, such as, exiting from the health care benefit plan marketplace. In FY2017, dental insurers submitted 12 percent of all self-reports and represented a significant share (40 percent) of all grievances reported.

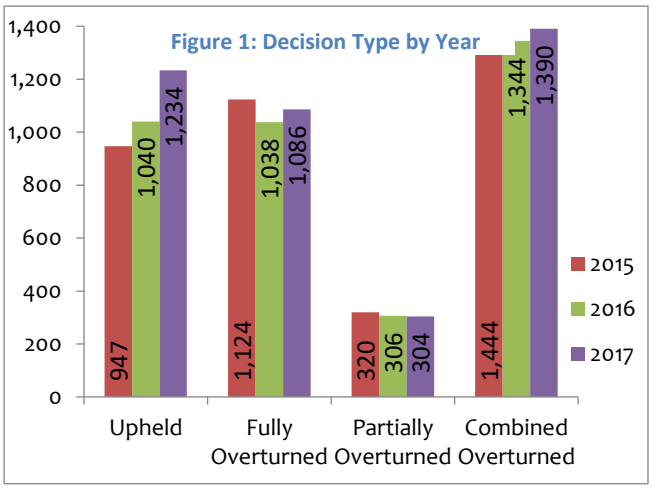
- Of the 34 companies that submitted an annual self-report, 16 reported consumer grievances and appeals and 18 reported having no grievances. In FY2016 22 of 30 insurers reported consumer grievances and appeals (six more than in FY2017) and eight reported no grievances (ten fewer than in FY2017). In FY2015, 23 of 37 companies reported consumer grievances and appeals (seven more than 16 in FY2017) and 14 reported no grievances and appeals (four fewer than 18 in FY2017).

- While there was a decrease in the total number of insurers reporting grievances in FY2017, the overall number of grievance cases reported increased by nearly 10 percent. The 16 companies that reported grievances and appeals in FY2017 opened a total of 2,624 cases; 245 more cases than the 2, 379 cases opened by 22 companies in FY2016, and 233 more than the 2,391 cases opened by 23 companies in FY2015. One explanation for the increase is that one company merged with another company that had not been included in the prior years' reporting data and reported the largest number of grievances of all the companies reporting in FY2017.



DATA SUMMARY: Case Outcomes by Type

- In FY2017, insurers *upheld* a total of 1,234 of 2,624 opened cases (47 percent) compared to 1,040 cases *upheld* in FY 2016 (44 percent of 2,379 opened cases). In FY 2015, 947 of 2,391 opened cases were *upheld* (40 percent). *Upheld* cases are those that are reviewed, and the original decision is maintained.



- Insurers *fully overturned* their original decisions in 1,086 cases (41 percent of 2,624 cases); a slight variance from the 1,038 cases *fully overturned* in FY2016 (44 percent of 2,379 cases). In FY2015, 47 percent of initial decisions being *fully overturned*, (1,124 of 2,391 cases). The percentage of *fully overturned* cases has decreased at a rate of three percent annually since FY2015. *Fully overturned* cases are those that are reviewed, and the original decision is reversed in favor of the beneficiary.

- A total of 304 of 2,624 opened cases were *partially overturned* in favor of the beneficiary (12 percent), compared to 306 of 2,379 opened cases (13 percent) in FY2016, and 320 cases of 2,391 opened cases (13 percent) in FY2015. There is slight change from year-to-year in the *partially overturned* rate.

- The *combined overturned* total of *fully overturned* plus *partially overturned* cases was 1,390 of 2,624 cases in FY2017 (53 percent of all opened cases). FY2017 had a *combined overturned* case rate of three percent fewer cases (1,344 of 2,379, 56 percent) than FY2016. In FY2015, the *combined* total was 1,444 of 2,391 cases (60 percent). This represents a seven percent decrease in the number of *combined overturned* cases in FY2017 than in FY2015

- Of the 16 companies reporting grievances and appeals in FY2017, seven had a *combined overturned* rate of 40 percent or higher *in at least one service category*. In both FY2016 and FY2015, 14 companies had a *combined overturned* rate of 40 percent or higher in at least one service category.

- In summary, the *fully overturned* rate has slightly decreased over the prior 3-year period while remaining in the 40-percent range. The *combined overturned* rate remains steady and consistently approximates half of all opened cases. The consistently high reversal rates suggest that efforts should be geared toward reducing the need for appeals that would both reduce efforts for the providers and facilitate timely care for consumers.

DATA SUMMARY: Service Category Prevalence

- The Pharmacy category ranked *most prevalent service category* for grievances by service type in FY2017. Pharmacy was also a top-ranking type of grievance in FY2016.

The following tables summarize some of the findings from the FY2017 annual *Self-Reports* submitted by commercial insurers listed in alphabetical order.

Table 10. Commercial Insurers' Annual Self-Report[1] FY2017

[GRAY SHADING INDICATES NO GRIEVANCES WERE REPORTED]

NAME OF INSURER	TOTAL APPEALS/ GRIEVANCES	CASES UPHELD		CASES OVERTURNED		CASES PARTIALLY OVERTURNED	
		#	%	#	%	#	%
Aetna Health	13	10	77%	3	23%	0	0%
Aetna Life Insurance Company	24	16	67%	8	33%	0	0%
Allianz Life Insurance Company							
American Specialty Health Ins. Co.							
Ameritas Life Insurance Company[2]	516	344	67%	138	27%	34	6
BlueChoice	206	102	50%	101	49%	3	1%
CareFirst of Maryland	92	45	49%	45	49%	2	2%
CIGNA HealthCare Mid-Atlantic							
CIGNA Health & Life Insurance Co.	40	25	63%	13	32%	2	5%
Connecticut General Life Insurance Co.							
Delta Dental Insurance Company[2]	48	22	46%	25	52%	1	2%
Fidelity Security Life Insurance Co.							
Golden Rule Insurance Company	1	1	100%	0	0%	0	0%
Group Hospitalization & Medical Svcs.	424	216	51%	202	48%	6	1%
John Alden Life Insurance Company							
Kaiser	108	44	40%	58	54%	6	6%
Mamsi Life and Health Insurance Co.							
MD-Individual Practice Association	217	100	46%	108	50%	9	4%
Metropolitan Life Insurance Company[2]	480	77	16%	180	38%	223	46%
Optimum Choice	8	6	75%	2	25%	0	0%
Principal Life Insurance Company							
Prudential Insurance Co. of America							
Reliance Standard Life Insurance Co.							
Standard Insurance Company							
State Farm Mutual Automobile Ins. Co.							
Time Insurance Company							
Trustmark Insurance Company							
Trustmark Life Insurance Company							
UniCare Life & Health Insurance Co.							
United Concordia Life and Health Ins.[2]	30	22	73%	6	20%	2	7%
United Healthcare Insurance Company	415	203	49%	197	47%	15	4%
United Healthcare Life Insurance Co.							
United Healthcare Mid-Atlantic	2	1	50%	0	0%	1	50%
Union Security Insurance Company							
SUBTOTAL - MEDICAL PROVIDERS	1550	769	50%	737	47%	44	3%
SUBTOTAL - DENTAL PROVIDERS	1074	465	43%	349	33%	260	24%
TOTAL - ALL PROVIDERS	**2624**	**1234**	**47%**	**1086**	**41%**	**304**	**12%**

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

[2]Dental Provider

Table 11. Commercial Insurers' Annual Self-Report[1] FY2017 - Cont'd

[GRAY SHADING INDICATES NO GRIEVANCES WERE REPORTED,
[BLACK SHADING INDICATES SERVICES ARE NOT COVERED BY THE PLAN]

RESOLUTION TIMES				
NAME OF INSURER	MEDICAL EMERGENCY [HOURS]	MENTAL HEALTH EMERGENCY [HOURS]	MEDICAL NON-EMERGENCY [CALENDAR DAYS]	MENTAL HEALTH NON-EMERGENCY [CALENDAR DAYS]
Aetna Health	7	7	29.14	0
Aetna Life Insurance Company	28		31.36	
Allianz Life Insurance Company				
American Specialty Health Ins. Co.				
Ameritas Life Insurance Company[2]			Not Available	
BlueChoice	11.8		46.1	
CareFirst of Maryland			39.9	
CIGNA HealthCare Mid-Atlantic				
CIGNA Health & Life Insurance Co.			24.6	15.5
Connecticut General Life Insurance Co.				
Delta Dental Insurance Company[2]			29	
Fidelity Security Life Insurance Co.				
Golden Rule Insurance Company			21	
Group Hospitalization & Medical Svcs.	8.6		25.5	
John Alden Life Insurance Company				
Kaiser	23.6		24.2	28
Mamsi Life and Health Insurance Co.				
MD - Individual Practice Association	147.75	16	25.01	17
Metropolitan Life Insurance Company[2]			12.02	
Optimum Choice	65		35.71	
Principal Life Insurance Company				
Prudential Insurance Co. of America				
Reliance Standard Life Insurance Co.				
Standard Insurance Company				
State Farm Mutual Automobile Ins. Co.				
Time Insurance Company				
Trustmark Insurance Company				
Trustmark Life Insurance Company				
UniCare Life & Health Insurance Co.				
United Concordia Life and Health Ins.[2]			16.06	
United Healthcare Insurance Company	72	55	33.94	28
United Healthcare Life Insurance Co.				
United Healthcare of the Mid-Atlantic				28
Union Security Insurance Company				

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

Definitions

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

Case/Contact – An unduplicated count of individuals who contact the OHCOBR who are insured or uninsured. For purposes of this report "case" and "contact" are used interchangeably. Each case may involve multiple interactions between OHCOBR and the customer or 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 a single case.

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

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

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

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

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

Notes

Office of Health Care Ombudsman & Bill of Rights
441 4th Street, NW
Suite 900 South
Washington, DC 20001
(877) 685-6391 (Toll-Free)
(202) 442-6724 (Fax)
healthcareombudsman@dc.gov (E-mail)
www.healthcareombudsman.dc.gov (Website)

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR