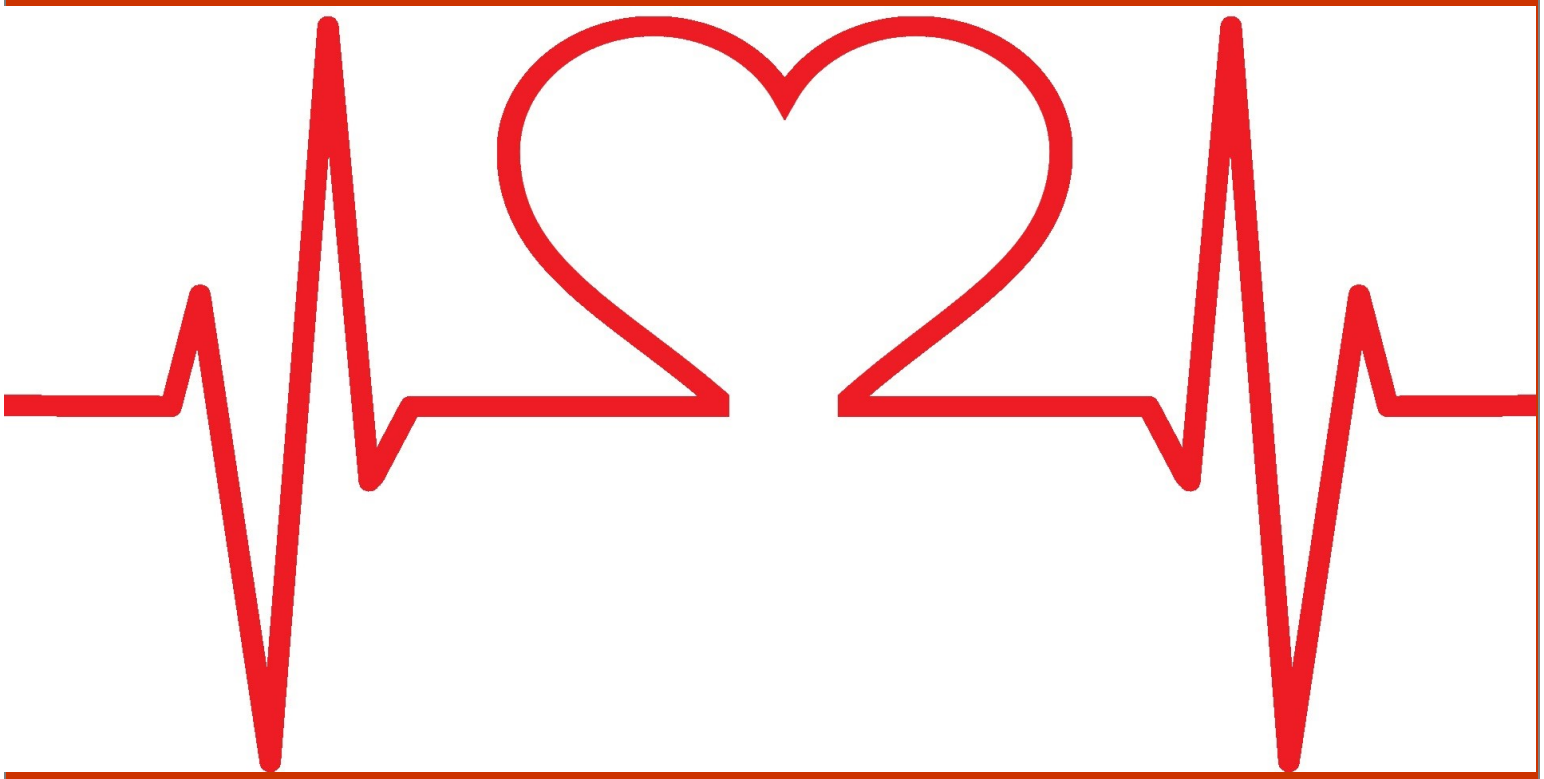
Office of Health Care Ombudsman & Bill of Rights

DISTRICT OF COLUMBIA
HEALTH CARE OMBUDSMAN



Fiscal Year 2018 Annual Report

441 4th Street, NW Suite 900 South, Washington, DC 20001

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A Message from Mayor Muriel Bowser

There is nothing more important to my Administration than the health and well-being of Washingtonians. Without our health, we cannot live up to our potential as individuals or as a community. In FY2018, we increased our investments in seven priority areas: infrastructure initiatives; education; affordable housing; public safety; access to jobs and economic opportunity; older residents; and high-quality health and human services programs. I am proud to report that we accomplished three important goals in our effort to extend the reach of vital, high-quality, and affordable health care to every resident across all eight wards.

First, we maintained our standing as having one of the highest rates of insured residents in the country with 96 percent of residents insured. We accomplished this by extending the closing date for the open enrollment period from January 31st to February 5th, and have maintained our long-time commitment to giving our residents the time and support they need to get covered and stay covered.

Our second major achievement was the release of LIVE.LONG.DC., the District's strategic plan to reduce opioid use and misuse and to reduce opioid-related deaths by 50 percent by 2020. The plan is premised on our strong belief that any preventable opioid-related death is one too many. The Substance Abuse and Mental Health Services Administration grant that we received from the U.S. Department of Health will help us to increase access to medication-assisted treatment; reduce unmet treatment needs; and lower opioid overdose related deaths through prevention, treatment, and recovery activities.

Finally, we hosted Washington, DC's first-ever Maternal and Infant Summit at the Walter E. Washington Convention Center with mayors and leaders from across the country. The summit addressed the disproportionally high rates of maternal mortality experienced by people of color in the District and across the nation. The summit complimented the work my Administration does to provide women and children with the care they need to live healthy, happy lives. The summit was so successful it was repeated this past September.

My administration and I are committed to keeping Washingtonians safe from detrimental health care reforms by the federal government. Our ongoing efforts to ensure that all Washingtonians in every neighborhood throughout our city are healthy and thriving. Through the wonderful work of the Office of Health Care Ombudsman, we extend a helping hand to all who seek assistance. The Ombudsman and her staff save lives and keep the gears of the system moving properly, for all who work, visit and live in our city.

I am grateful for the good work of my team in the Executive Office of the Mayor, the Council of the District of Columbia, our health care provider network, federal officials, District agency staff, and especially the Office of Health Care Ombudsman. With this ongoing collaborative work, we can all be assured of further progress in health outcomes in the coming years.

Muriel Bowser
Mayor

A Message from Director Wayne Turnage

In FY 2018, we continued to advance the progress that we made last fiscal year in improving the integrity, quality, and efficiency with which we operate the District's Medicaid and Alliance programs. DHCF focused on, and will continue to focus on, three major challenges that face the Medicaid and Alliance programs. These challenges: (1) managing the surging cost of care delivery for our fee-for-service population; (2) bringing the District's home and community-based services (HCBS) program back into compliance with federally-mandated cost neutrality standards; and (3) developing a greater understanding of enrollment issues and factors underpinning the growth in Alliance cost. Unaddressed, these three issues have the potential to create significant spending pressures at DHCF, while exposing the District to a potential loss of its Elderly and Persons with Disabilities (EPD) Waiver Program.

We also look to develop a plan, in partnership with Mayor Bowser, to build a hospital on the St. Elizabeths East campus in Ward 8. The goal of this venture is to create a state-of-the-art hospital that will provide residents with a first-class facility to be operated by a hospital partner—not the District—which will ensure that the hospital is eventually managed free of public operating subsidies. We anticipate that this project will take five years to construct and deliver a new, centrally located, medical center by 2023, significantly faster than initially contemplated.

DHCF is mindful of the significant challenges we face. Making preparations for the planning and construction for a new hospital in Ward 8, revisiting the cost parameters of the EPD Waiver Program, reigning in the surging cost of the fee-for-service population without adversely impacting the members' access to quality health care services, and continuing our efforts to better understand the forces behind the rapid growth in Alliance program cost but not its membership, are the issues that will define our work in the coming year.

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 2018 Annual Report*. The Office of Health Care Ombudsman and Bill of Rights assists District health care consumers, through advocacy, education and outreach. We assist uninsured residents; enrollees in the D.C. Medicaid and Alliance programs (more than 285,000); the 18,000 commercial health plan members enrolled in the individual marketplace; and more than 76,000 residents through the small business marketplace that signed-up through DC Health Link (the District's state-based health insurance exchange established under the Affordable Care Act); and those whose commercial health insurance policies were underwritten in the District (more than 900,000).

During the past fiscal year, we joined thirty-three community events attended by nearly 96,000 people—an almost 465 percent increase over last year when we impacted 17,000 attendees. Through our community outreach activities, we directly engaged with the public, sharing information and promoting our services. As a result, our office saw an increase in the number of contacts received and resolved more than 11,000 cases, a significant increase over the prior year's approximate 9,000 cases.

In FY 2018, we provided input and comments to the Department of Insurance, Securities, and Banking (DISB) and to the Centers for Medicare and Medicaid Services (CMS), which will be used to shape and form new rules for the influx of short-term policies underwritten in the District and across the United States.

We have re-invested in an extensive outreach media campaign in conjunction with the *NBC4 and Telemundo 44 Health & Fitness Expo*. We plan to continue to increase education and outreach targeting non-English speaking residents.

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 people that are employed 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 2018 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
Associate Health Care Ombudsman

Cardiss Jacobs
Associate Health Care Ombudsman

Carmencita Kinsey
Associate Health Care Ombudsman

Elfleta Nixon, DNP, RN
Associate Health Care Ombudsman

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.

Below are the interns who supported the Ombudsman's Office in FY 2018:

Lamia Jackson
Student Intern
Trinity Washington University
Major: Criminal Justice
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

Introduction

Office of the Health Care Ombudsman and Bill of Rights

HISTORY

Established in February 2009, the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is organizationally positioned within the Department of Health Care Finance (DHCF) but has authority to operate with full autonomy and independence. DHCF was established in February 2008 (D.C. Code 7-771). It was formerly the Medical Assistance Administration (MAA) in the Department of Health (DC Health) and now functions as a separate cabinet-level agency. In addition to the OHCOBR, DHCF administers the District's Medicaid program, the Children's Health Insurance Program (CHIP), and other publicly funded health care benefits programs.

DUTIES AND RESPONSIBILITIES

The Health Care Ombudsman is responsible for providing advocacy, education and community outreach services to District consumers and persons who reside and/or are employed in the District, regarding access to health benefits, and to ensure that those benefits meet their needs. OHCOBR staff work to solve consumer complaints, facilitate the appeal and grievance process, and intervene on behalf of consumers with related parties to reach a quick and satisfactory resolution. OHCOBR staff educates consumers about their rights and responsibilities concerning their health benefits, and they facilitate consumer enrollment in health plans 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 Member 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, for DISB to route appropriate cases to the Ombudsman's office, and for them to provide an added level of education to private health plan member's regarding the assistance that is available from the OHCOBR throughout the entire appeals process.

This collaboration has added a considerable number of additional cases transferred from DISB to the OHCOBR.

GROWTH AND THE FUTURE

In regard to the Medicaid program, Mayor Bowser's FY 2018 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

While the country still awaits the final cues for the U.S. Senate's take on healthcare reform, more updates arrived in FY 2018.

The Centers for Medicare & Medicaid Services (CMS) released a final rule relating to the stabilization of the Affordable care Act (ACA) Exchange for 2018. To facilitate such stabilization, the final rules sought to provide more "incentives" for individuals to maintain coverage while dis-incentivizing those who enroll only after discovering the need for medical services.

First, the open enrollment period was shortened—ending on December 15, 2017 as opposed to January 31, 2018, unless approved for special enrollment. This move aimed to time the enrollment period end with the start of plans for the new year. In addition, special enrollment prerequisites are now stricter, with period changes and new rules for verification in a stated effort to prevent the abuse of these special enrollment periods. To re-enroll for a plan in the upcoming year, providers have the option to demand all unpaid premiums up front prior to accepting enrollment.

The *de minimis* variation was also altered with respect to the actuarial values of the metal-based ranking system for coverage under the Affordable Care Act, which could possibly decrease the scope of coverage for the same premium cost. And finally, the minimum essential community provider was be lowered from 30 percent to 20 percent, with revisions to the option review process within any given network.

What this means for Americans is that while the first rendition of the Affordable Care Act sought to provide affordable healthcare coverage, the effect of these final rules may reduce coverage at the same cost. Further, tighter eligibility requirements may result in the reduced enrollment numbers. While the ACA is the law of the land for the foreseeable future, our hope is that these new rules do not harm the ACA's goal of affordable healthcare for all.

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: 1) Policies and Procedures, and Legal; 2) Clinical; 3) Education and Outreach; and 4) Special Needs. The following describes each subcommittee's 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 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 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 purpose of the Clinical Subcommittee is to:

- Assist, file and resolve individual cases;
- Collaborate with medical professionals, to educate committee members about contemporary issues;
- Recommend policies and procedures to enhance continuous quality improvement regarding clinical practice;
- 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. This subcommittee was formed 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 purpose of the Education and Outreach Subcommittee is to:

- Develop an education and outreach strategy and materials for District of Columbia residents about health care 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 purpose of the Special Needs Subcommittee is 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 great 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 for assistance.

- ***AARP/Legal Counsel for the Elderly - Long-Term Care Ombudsman***
- ***Adult Protective Services (APS)***
- ***Amerigroup DC***
- ***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)***
- ***Department of Aging and Community Living (DACL) and the DC 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***
- ***Liberty Healthcare Corporation***
- ***Medicaid Transportation Management (MTM)***
- ***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***

Success Stories

Personal Care Assistance

The Ombudsman's office was contacted by a managed care member regarding a request for assistance with obtaining personal care aide (PCA) services from a home health agency. A contractor for DC Medicaid, tasked with providing assessments and determining level of care, had already approved him for PCA services.

Based on the medical needs of the beneficiary, we were able to facilitate a transfer of his enrollment from managed care to the Elderly and Persons with Disabilities (EPD) Waiver. We contacted the contractor and requested that the prior authorization for services be forwarded to the home health agency for acceptance and to begin providing services. Ultimately, we were able to get the PCA services initiated, and the beneficiary called thanking us for the diligence, time and professionalism provided by staff.

Prescription Denial

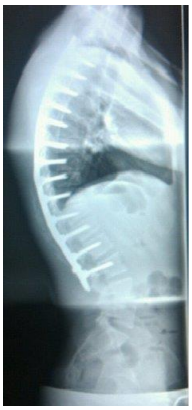
The medical provider of an insurance member contacted the Ombudsman's office regarding the denial of a prior authorization for a medication that the member was prescribed for over 18 years to prevent kidney stones. The insurer denied the prior authorization based on their determination that the member did not meet the necessary criteria to have the medication authorized.

The member's doctor stated in his medical necessity letter that the member had tried and failed the medications identified by the insurer to meet the criteria for authorization of the medication. Additionally, the doctor stated that without the medication, the member would be prone to numerous inpatient admissions, procedures and other costly tests.

Based on the physician's medical necessity letter, clinical records, and research evidence supporting the administration and ongoing effectiveness of the prescribed medication, the Ombudsman's office requested a reconsideration of the insurer's denial. Also included in the reconsideration request, was documentation demonstrating the prescribing physician's credentials as the Director of Urology at the facility where he works. After review of the additional documents, the insurer subsequently

reversed their initial denial and approved the medication for a 12-month period, thus providing a savings to the member of $97,423.00.

Anterior Lumbar Interbody Fusion

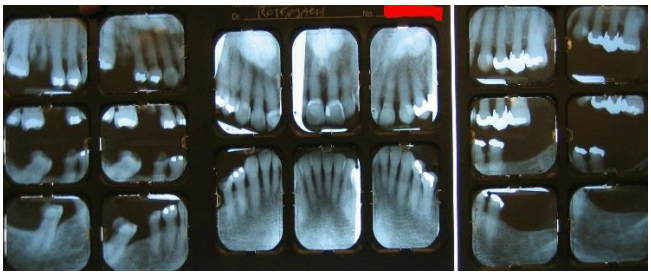


An appeal was filed based on the decision of the insurer to deny prior authorization to its member for coverage of a surgical procedure, Anterior Lumbar Interbody Fusion, to include total disc arthroplasty second level and a spinal bone allograft. The patient had a complaint of lower back pain for greater than five years, that radiated to her hips, down to her ankles due to degenerative changes in her lower lumbar and possible compression of a nerve root. The member had undergone many procedures to include: multiple injections for pain, such as a lumbar facet injection, and a nerve burn procedure.

The prior authorization was denied on the basis that there was not enough scientific evidence that shows the safety and/or success in treating the member's type of degenerative disc disease, therefore considering the procedure to be a non-covered experimental/investigational, unproven service.

After referring the appeal for independent review, it was determined that the Anterior Lumbar Interbody Fusion is considered standard of care in the member's clinical scenario as supported by current and peer reviewed medical literature, and therefore deemed medically necessary. The insurer was forced to authorize and cover the requested services, with an approximate savings to the member between $60,000 - $100,000.

Outpatient Hospital Dental Procedure



The medical provider for an insurance member contacted the Ombudsman's office regarding the denial of coverage for a patient that experienced chronic left-sided mandibular pain for the past four years. The member was diagnosed with recurrent sclerosing osteomyelitis, an infection of the bone, which in her case, caused an infection in the mandible or lower jawbone on the left side.

The member had been on several prolonged courses of antibiotics without relief. It was determined that a deep bone biopsy of the left mandible, debridement and decortication of reactive and

proliferative periostitis, debridement of sclerotic mandibular bone, and extraction of tooth #18 which was suspected to have been injured during extraction of tooth #17. She also had a peripherally inserted central catheter (PICC) line placed for long-term intravenous antibiotic therapy, culture directed antibiotics, and infectious disease consultation.

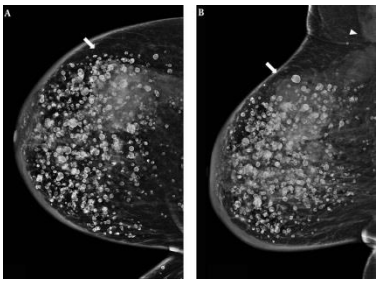
The claim was initially denied based on the Plan's interpretation that care was provided on an inpatient basis, instead of outpatient. After speaking with the insurer and the provider, the claim was resubmitted and paid in accordance with the policy. This saved the member more than $24,000.00.

Out-of-Network Provider

The Ombudsman's office received a request from a parent to assist in an appeal for his five-year old child, regarding the decision of an insurer to deny a request for a non-participating provider to provide cross facial nerve grafting (CFNG) using sural nerve followed by microvascular muscle transfer for congenital left facial nerve palsy. The request was denied based on a misinterpretation of the "minimum provider access terms" in the contract. The in-network provider that the insurer identified was outside of the contract specialist service area of 35 miles.

The case was sent to the insurer for reconsideration and was reversed, with the rational being that there was not an in-network provider in the area who was able to provide the service. Because it met the guidelines for a network deficiency, coverage was approved at the in-network benefit level for the provider to provide the specified service.

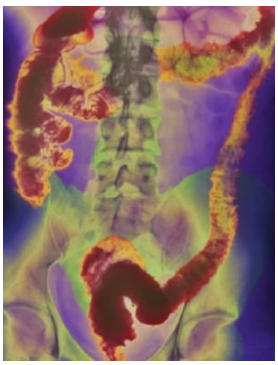
Breast Reduction Surgery



An insurance member contacted the Ombudsman's office seeking assistance getting reimbursed for a bilateral reduction mammoplasty. The member had symptomatic macromastia, significant mid and upper back pain and associated spinal irregularities, which prompted her orthopedic surgeon to suggest bilateral reduction mammoplasty to reduce the risk of any progressive degeneration in her spinal column due to the macromastia.

The insurer denied the claim because it did not contain a letter of medical necessity to support the procedure. The doctor was advised to resubmit the claim with the medical necessity letter. After the claim was reviewed by the insurer, the charges were reprocessed, and the patient received a cost savings of $15,190.00.

Prescription Denial for Crohn's Disease



A 31-year old female patient, initially diagnosed with celiac disease in 2007, later confirmed to be Crohn's sought an appeal through the Ombudsman's office, based on his insurance company's decision to deny coverage for Stelara. The insurer denied coverage based on their determination that the treatment was not medically necessary, and that treatment was experimental and investigational, on the basis that there was no medical literature to support that Stelara was more effective than the formulary preferred Humira.

The case was sent to back to the insurer for an expedited review, along with a detailed medical necessity letter from the treating provider. The insurer, after reviewing the information provided, reversed their previous adverse benefits determination and approved the medication for 2 years. Based on the insurer's review, the prescription was determined to be medically necessary and the patient received a cost savings of $67,200 for years 1 and 2.

Achievements

Office of Health Care Ombudsman and Bill of Rights' Achievements for FY 2018

In FY 2018, 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. OHCOBR was able to maintain overall service levels from the prior year and realized the following additional achievements:

- Implemented database to track cases sent to the independent review organization (IRO) to ensure compliance with legislative timeframe requirements.

- Implemented pharmacy database to determine trends for commercial prescription cases to identify the classes of prescription drugs and demographic groups that are continually denied.

- Served 22 percent more consumers in FY 2018 than in the previous year (11,309 in FY 2018 compared to 9,250 in FY 2017).

- Continued to improve its track record of *resolving most Non-Commercial cases the same day the case was opened.* The office had a 22 percent increase in Non-Commercial same day closures over the previous year (9,309 in FY 2018 vs 7,683 in FY 2017).

- Saved consumers a total of $1,956,306.77, an increase of 86 percent over FY 2017 when $1,048,787.54 was saved on behalf of consumers.

Recommendations

Recommendations for improving performance and outcomes

Based on our experiences during FY 2018, the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) identified several recommendations from a review of problems encountered by consumers 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:

- Coordinate with the Department of Health Care Finance (DHCF) to see if implementation of holistic approaches can be covered by D.C. Medicaid and are feasible alternatives for opioid use disorder and substance use disorder;

- Work with DHCF to ensure that Qualified Medicare Beneficiary (QMB) providers are covered for cross-over claims;

- Continue to work with the Department of Health (DC Health), Health Regulation and Licensing Administration (HRLA) on quality issues that are found in areas that they regulate;

- Work with the Department of Human Services (DHS), Economic Security Administration (ESA) and DHCF to be considered an out-station in order to receive Alliance members' medical assistance applications;

- Work with the ESA to streamline a process regarding seniors' financial information that the District has access to, i.e., Social Security, thereby eliminating duplication of efforts;

- Continue to work with employer's Benefit Managers on how to improve employee health benefits plans, based upon the cases we receive in our office; and

- Work with the commercial plans on improving outcomes for pharmacy denials, based upon the cases that we receive in our office.

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 and share pertinent information

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 *FY 2018 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 2018 activity compare to prior years' experience?

Data Collection Report and Highlights:

The following are summary highlights that point out the most relevant findings from our data analysis.

- OHCOBR served 22 percent more consumers in FY 2018 than in the previous year (11,309 in FY 2018 compared to 9,250 in FY 2017). [Figure 1]
- Most of the issues raised by persons contacting OHCOBR in FY 2018 (98 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 22 percent increase in Non-Commercial same day closures over the previous year (9,393 in FY 2018 vs. 7,683 in FY 2017. [Table 3]
- OHCOBR continued to maintain the *average number of days to close a Non-Commercial case*. In FY 2018 the average stayed exactly the same as FY 2017 at 1.8 days,. [Table 3, Figure 19]

- Consumers with Dual Eligible-Medicare/Medicaid issues 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 (44 percent), followed by Access/Coverage including denials (26 percent). [Figure 7] Percentages were even higher for Eligibility issues among contacts concerning Managed Care Organizations (MCOs) (60 percent or 1,861 of 3,090 cases) [Figure 13] and the Health Care Alliance (66 percent, or 209 of 315 cases). [Figure 14]
- Issues concerning commercial insurers (2 percent of all contacts) were less challenging, averaging around three months (99.5 days) in FY 2018 compared to nearly four months (114.3 days) in FY 2017 to resolve appeals and grievances cases. This is due mainly to the OHCOBR, in FY 2018, exploring and implementing methods for streamlining resolution times, including building a resource center for easy retrieval of current health and treatment information and access to documents filed on similar past cases with successful outcomes. Other remedies included developing standardized forms and making other tools available to staff and the independent review organization (IRO) to expedite resolution and closure times, and appealing decisions made by the IRO.
- Consumer savings are reported to be $1,956,306.77, an increase of 86 percent over the $1,048,787.54 captured in FY 2017. [Figure 18]

SELECT FINDINGS FROM THE DATA ANALYSIS

Following are some select details drawn from an analysis of data collected in FY 2018. These select details reveal customer trends and concerns and OHCOBR's performance in addressing those concerns throughout the fiscal year. Some of the data discussed in this section is also presented graphically in intermittent numbered tables and in the pie charts at the end of the section, referred to as Figures 1 - 23. For a look at the entire data set go to the *FY 2018 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. The select findings from the data analysis are presented under the following two insurance categories:

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

2) ***Commercial Cases - Appeals and Grievances*** that include 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.)*

This 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 11,309 cases of all types in FY 2018, a 22 percent increase over the 9,250 cases opened in FY 2017. [Table 1, Figure 1]

Table 1. Number and Percentage of All Opened Cases by Insurance Category FY17 and FY18

Insurance Category	FY17 Totals	FY17 %	FY18 Totals	FY18 %
Non-Commercial	9,009	97%	11,067	98%
Commercial	241	3%	242	2%
Total Opened Cases	**9,250**	**100%**	**11,309**	**100%**
Annual Variance			**+2,059**	**+22%**

NON-COMMERCIAL CASES

- Of the total 11,067 of all opened cases, 98 percent or 11,309 were Non-Commercial cases. In FY 2017, Non-Commercial contacts were 97 percent of all cases opened. [Table 1, Figure 1]
- Of the 11,067 total Non-Commercial cases opened, 3,141 contacts were related to Dual Eligible insurance issues making them the single largest insurance type of all Non-Commercial contacts (28 percent). The Dual Eligible category includes issues related to recipients that have both Medicare and Medicaid. Prior to FY 2018, the Medicare insurance contacts category was consistently the largest year-to-year, representing 27 percent of all contacts in FY 2017 [Figure 5] and 29 percent in FY 2016.
- Eligibility was the most frequent type of issue raised among all contacts, Non-Commercial and Commercial combined (4,986 cases, 44 percent of 11,309 total contacts). [Figure 7]
- Medicare contacts raised Eligibility issues at the rate of 38 percent (1,071 of 2,803 cases). [Figure 12]
- Dual Eligible–Medicare/Medicaid contacts raised Eligibility issues at the rate of 36 percent (1,121 of 3,141 cases). [Figure 10]

- Medicaid MCO contacts raised Eligibility issues at the rate of 60 percent (1,861 of 3,090 cases). [Figure 13]
- Medicaid FFS contacts raised Eligibility issues at the rate of 40 percent (588 of 1,492 cases). [Figure 11]
- Alliance contacts raised Eligibility issues at the rate of 66 percent (209 of 315 cases). [Figure 14]
- OHCOBR closed more than 99 percent of all opened Non-Commercial cases by the end of FY 2018, 11,045 cases; the remaining, less than one percent or 22 cases, were still pending resolution at the end of the fiscal year. [Table 2, Figure 2]

Table 2. Non-Commercial Cases:
Status and Resolution of Closed and Open Cases at Year-End
FY17 and FY18

Year-End Status and Resolution	FY17 Totals	FY17 %	FY18 Totals	FY18 %
Closed Cases – Successful (In favor of the consumer)	8,568	95%	11,001	99%
Closed Cases – Unsuccessful (Not in favor of the consumer)	53	1%	44	<1%
Closed Cases (Referred Out) –Resolution Undetermined	0	0%	0	0%
Closed Cases - Sub-Total	**8,621**	**96%**	**11,045**	**>99%**
Open Cases – Still Pending Resolution	**388**	**4%**	**22**	**<1%**
Total All Non-Commercial Cases (Closed and Open)	**9,009**	**100%**	**11,067**	**100%**

- On average, Non-Commercial cases were closed in 1.8 days; In comparison, in FY 2017, average resolution time remained the same at 1.8 days. [Table 3, Figure 19]
- Of all Non-Commercial cases, OHCOBR resolved 85 percent, or 9,393 cases, *on the same day they were opened*. Compared to FY 2017, 1,710 more cases were closed in FY 2018, but the same day closure rate remained the same (85 percent). [Table 3, Figure 19]

Table 3. Non-Commercial Cases: Analysis of Days to Close a Case FY17 and FY18			
FY17 # of Cases Closed	**FY17 Average # of Days to Close**	**FY18 # of Cases Closed**	**FY18 Average # of Days to Close**
8,621	**1.8 days**	**11,045**	**1.8 days**
FY17 Same-Day Closure Cases		**FY18 Same-Day Closure Cases**	
7,683 of 9,009 total Non-Commercial cases (85%)		**9,393 of 11,045 total Non-Commercial cases (85%)**	
Annual Variance of Same-Day Closures		**+1,710 cases**	**22% increase in # of cases**

COMMERCIAL CASES - APPEALS AND GRIEVANCES

- Cases related to Commercial Health Plans represented two percent of all cases opened in FY 2018 (242 of 11,067 total cases). Nearly the same number of commercial cases were opened in FY 2017 (241). [Table 1, Figure 1]

- Of the 242 Commercial cases opened in FY 2018, 112 (46 percent) were related to Not Eligible for Health Plan/Benefit, 76 (31 percent) were related to Medical Necessity, 20 (8 percent) were related to Experimental/Investigational, 3 (1 percent) were related to Part D Prescription Plans, 1 (1 percent) was a Rescission, 24 (10 percent) covered a wide range of Other generic complaints and issues, and the remaining 6 (3 percent) were issues that were Undetermined. [Table 4, Figure 9]

- Although the total number of Commercial grievances is similar for both FY 2018 and FY 2017 the distribution of those cases is significantly different in four ways. In FY 2018, Not Eligible for Health Plan/Benefit increased from 25 percent to 46 percent; Medical Necessity cases decreased from 39 percent to 31 percent of cases; Other cases decreased from 16 percent to 10 percent; and a Part D Prescription case category, implemented in FY 2017, decreased from three percent to one percent [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 FY 2018, the Undetermined category was eliminated.

Table 4. Commercial Cases: Appeals/Grievances Types of Issues Encountered FY17 and FY18				
Issues	**FY17 Cases**	**FY17 % of Total**	**FY18 Cases**	**FY18 % of Total**
Care Is Experimental/Investigational	12	5%	20	8%
Care Is Not Medically Necessary	94	39%	76	32%
Grandfather Status	0	0%	0	0%
Not Eligible for Health Plan/Benefit	59	25%	112	47%
***Other Issues**	39	16%	24	12%
Part D Prescription Plan	7	3%	3	1%
Rescission	0	0%	0	0%
Undetermined	30	12%	0	0%
Total Issues (Commercial Cases)	**241**	**100%**	**242**	**100%**

- In FY 2018, 72 percent (175 cases) of all Commercial cases were closed, compared to 74 percent (179 cases) in FY 2017. [Table 5, Figure 3]

- In FY 2018, only 28 percent remained open by the end of the fiscal year (67 cases), compared to 26 percent (62 cases) that remained open at the end of FY 2017. [Table 5, Figure 3]

- Of the 175 Commercial Cases closed in FY 2018, 124 cases (51 percent) were resolved successfully in favor of the consumer, an increase in comparison to 112 cases (46 percent) in FY 2017. [Table 5, Figure 21]

Table 5. Commercial Cases: Status and Resolution of Cases at Year-End FY17 and FY18				
Year-End Status and Resolution	**FY17 Totals**	**FY17 %**	**FY18 Totals**	**FY18 %**
Closed Cases – Successful (In favor of the consumer)	112	46%	124	51%
Closed Cases – Unsuccessful (Not in favor of the consumer)	67	28%	51	21%
Closed Cases (Referred Out) – Resolution Undetermined	0	0%	0	0%
Closed Cases - Sub-Total	179	74%	175	72%
Open Cases – Still Pending Resolution	62	26%	67	28%
Total All Non-Commercial Cases (Closed and Open)	**241**	**100%**	**242**	**100%**

- It took an average of 99.5 days to resolve or close a Commercial case [Table 6, Figure 20]. This represents a decrease of 14.8 days (13 percent) in *the average days to resolve or close a case* compared to 114.3 days in FY 2017, largely due to methods and other remedies implemented in FY 2018.

- OHCOBR resolved or closed 6 Commercial cases (2 percent) *on the same day they were opened*. For comparison, in FY 2017, 8 of 241 total cases (3 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 FY17 and FY18

FY17 # of Cases Closed	FY17 Average # of Days to Close	FY18 # of Cases Closed	FY18 Average # of Days to Close
179	114.3 days	175	99.5 days
FY17 Same-Day Closure Cases		FY18 Same-Day Closure Cases	
8 of 241 total Non-Commercial cases (3%)		6 of 242 total Non-Commercial cases (2%)	
FY17 Variance - Same-Day Closures		2 Fewer Cases	25% Decrease

CONSUMER SAVINGS

- In FY 2018, the OHCOBR saved consumers a total of $1,956,306.77. This represents an increase of 86 percent over FY 2017 when $1,048,787.54 was saved on behalf of consumers. This increase can be attributed to a more precise data collection and reporting methodology in FY 2018. [Figure 18]

- Of the total amount saved, $1,272,470.26 (65 percent) was from resolved Commercial Cases; $337,576.36 (17 percent) was saved or recouped on behalf of Medicaid fee-for-service, MCO and Alliance beneficiaries; $32,960.85 (2 percent) was removed from QMB beneficiaries' accounts for co-payments; and $313,299.30 (16 percent) 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, 93 percent, utilized the telephone to contact OHCOBR (10,558 of 11,309 total contacts). This continues to be the preferred method for contacting the office. In FY 2017, 95 percent of total contacts were made by telephone (8,760 of 9,250 total contacts), and in FY 2016, 94 percent of total contacts were made by telephone (7,961 of 8,420 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 (2,183) had the highest number of contacts to the OHCOBR with 19 percent. The next highest number of contacts originated from Ward 8 (1,782) with 16 percent. [Table 7, Figure 6]

Table 7. Contacts Located in and Out of the DC Metropolitan Area FY17 and FY18

Location of Contacts	FY17 # Contacts	FY17 % Contacts	FY18 # Contacts	FY18 % Contacts
Ward 1	947	10%	1,199	11%
Ward 2	1,124	12%	1,258	11%
Ward 3	341	4%	459	4%
Ward 4	1,259	13%	1,406	12%
Ward 5	1,332	14%	1,658	15%
Ward 6	900	10%	1,142	10%
Ward 7	1,597	17%	2,183	19%
Ward 8	1,546	17%	1,782	16%
Maryland (Located Within the DC Metropolitan Area)	19	<1%	26	<1%
Out-of-Country	0	0%	0	0%
Out-of-State (States Located Outside of the DC Metropolitan Area)	151	2%	150	1%
Undetermined	14	<1%	27	<1%
Virginia (Located Outside of the DC Metropolitan Area)	20	<1%	19	<1%
TOTALS	**9,250**	**100%**	**11,309**	**100%**

- Eligibility continues to be the most frequent type of issue from all types of consumers combined, at 44 percent or 4,986 total cases [Figure 7]. It was also the most frequent issue in FY 2017, 41 percent or 3,757 total cases, and in FY 2016, 47 percent or 3,903 total cases.

- Eligibility issues were the largest type of issue raised by Dual Eligible (Medicare and Medicaid) contacts (36 percent or 1,123 of 3,141 cases). Compared to FY 2017, when Access/Coverage issues were the largest category (35 percent or 910 out of 2,565 cases). OHCOBR works closely with the government agency that handles Medicaid enrollment to resolve both issues quickly. [Figure 10]

- Of the 252 Administrative/Fair Hearing cases filed by OHCOBR on behalf of all types of contacts, 61 percent were filed on behalf of EPD Waiver beneficiaries (154 cases).

- The number of access issues for EPD waiver beneficiaries that went to Administrative/Fair Hearings for resolution increased since FY 2016, from 100 cases and 12 percent of all EPD cases to 107 cases and 21 percent in FY 2017, and 154 cases and 16 percent in FY 2018. [Table 8, Figure 20]

- A total of 968 EPD Waiver Cases were opened in FY 2018, 87 percent more than the 517 cases opened in FY 2017. [Table 8, Figure 20]

Table 8. Types of Issues Encountered by EPD Waiver Contacts	FY17 # of Contacts	FY17 % of Contacts	FY18 # of Contacts	FY18 % of Contacts
Access (Administrative Hearings)	107	21%	154	16%
Access (Including Prior Authorizations)	137	26%	233	24%
Coverage/Service Denials	10	2%	37	4%
Eligibility/Verification of Coverage	206	40%	321	33%
Non-Payment/Reimbursement (Out-of-Pocket Expenses)	0	0%	29	3%
Other Issues	0	0%	95	10%
Quality of Services by Providers	57	11%	99	10%
Totals	**517**	**100%**	**968**	**100%**

- In FY 2018, a total of 134 Transportation Cases were opened compared to 144 in FY 2017, a 7 percent decrease. [Figure 15]

- A total of 797 DC Health Link and Health Care Exchange Marketplace cases were opened in FY 2018, a 66 percent increase compared to the 482 cases in FY 2017. [Figure 17]

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 FY17 and FY18

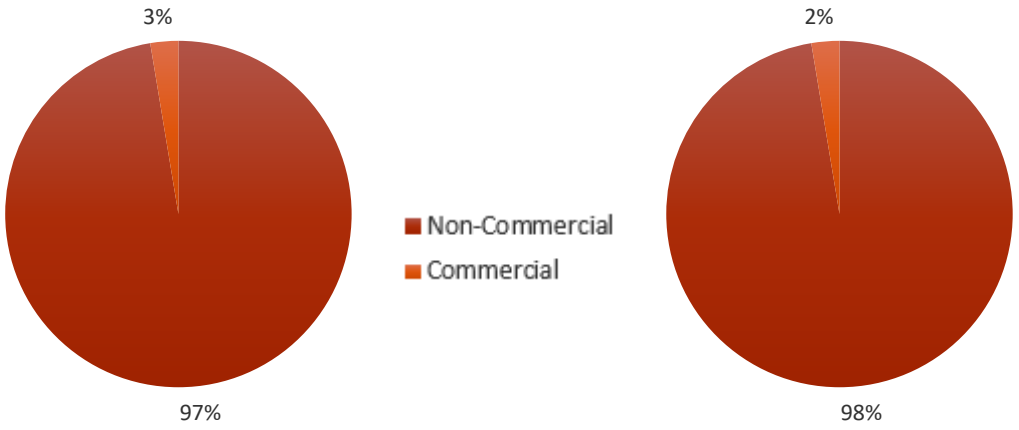
FY17	FY18
	
FY17 Total Sample = 9,250 Contacts	**FY18 Total Sample = 11,309 Contacts**

Figure 2. Number and Percentage of Resolved/Closed Cases and Cases Not Resolved/Closed Among (Non-Commercial) Contacts FY17 and FY18

FY17	FY18
	
FY17 Total Sample = 9,009 Contacts	**FY18 Total Sample = 11,067 Contacts**

Figure 3. Number and Percentage of Resolved/Closed Cases and Cases Not Resolved/Closed Among (Commercial-Appeals/Grievances-Bill of Rights) Contacts FY17 and FY18

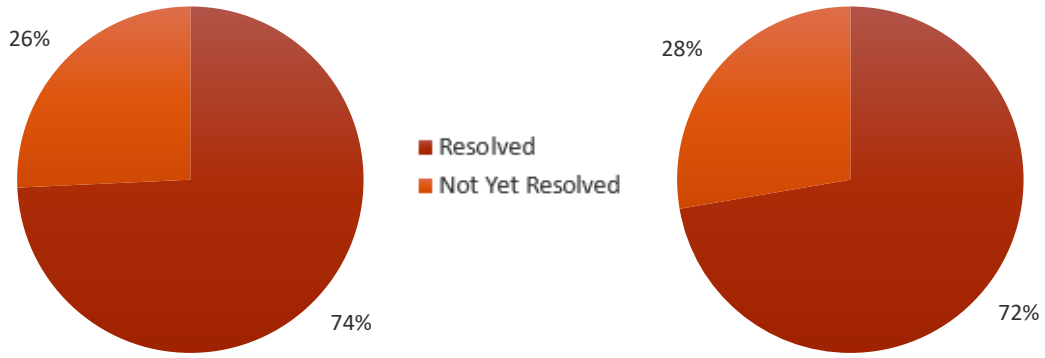
FY17	FY18
	
FY17 Total Sample = 241 Contacts	FY18 Total Sample = 242 Contacts

Figure 4. Methods of Contacting the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) FY17 and FY18

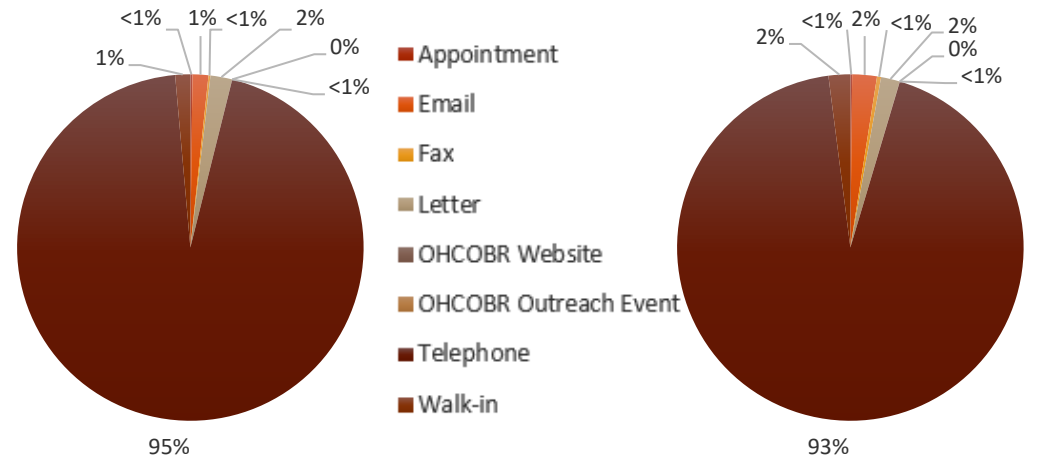
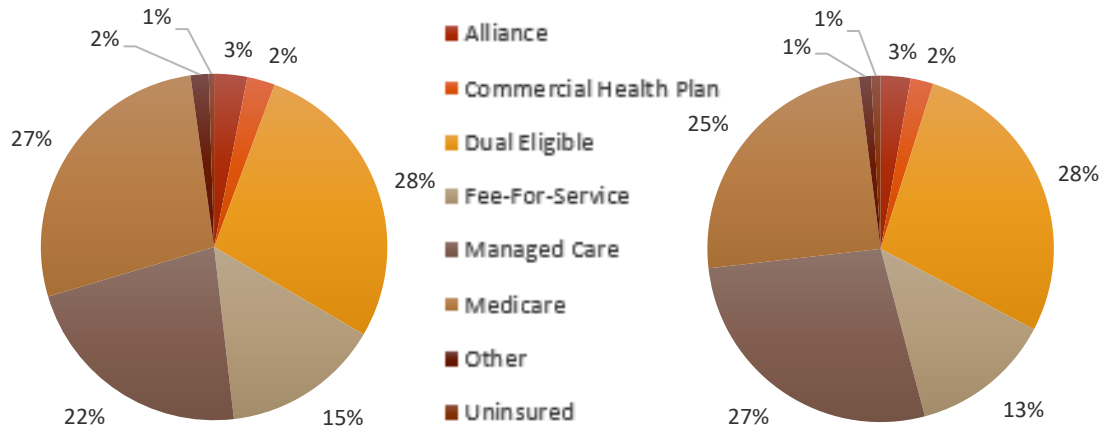
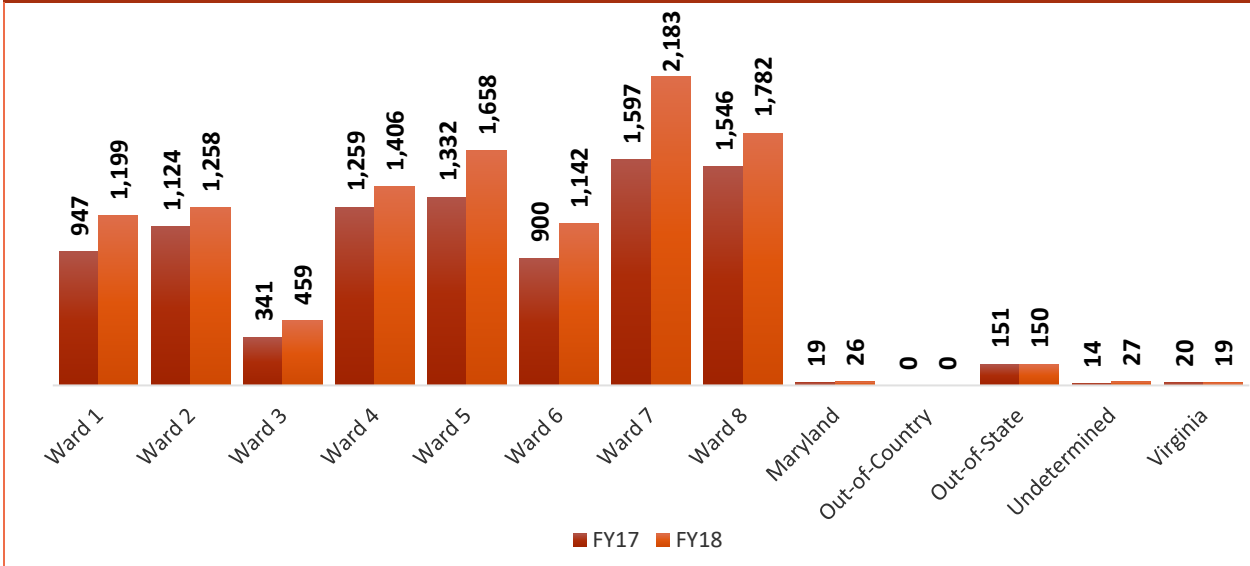
FY17	FY18
	
FY17 Total Sample = 9,250 Contacts	FY18 Total Sample = 11,309 Contacts

Figure 5. Categories of Contacts by Insurance Type FY17 and FY18



FY17 Total Sample = 9,250 Contacts	FY18 Total Sample = 11,309 Contacts

Figure 6. Contacts by Wards and States Located Within the DC Metropolitan Area and States Located Outside of the DC Metropolitan Area FY17 and FY18



FY17 Total Sample = 9,250 Contacts	FY18 Total Sample = 11,309 Contacts

Figure 7. Breakdown of Types of Issues Encountered by All Contacts – (Non-Commercial); and (Commercial-Appeals/Grievances-Bill of Rights) FY17 and FY18

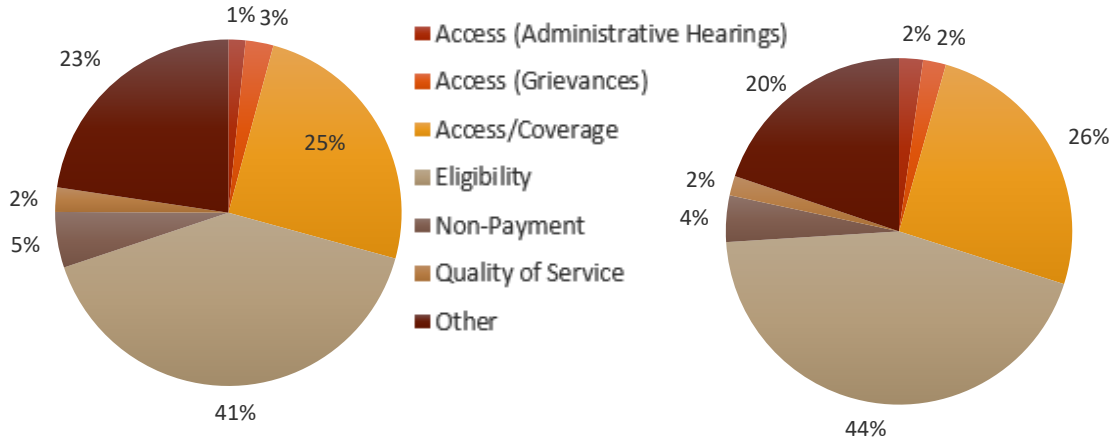
FY17	FY18
	
FY17 Total Sample = 9,250 Contacts	FY18 Total Sample = 11,309 Contacts

Figure 8. Breakdown of Types of Issues Encountered by (Non-Commercial) Contacts FY17 and FY18

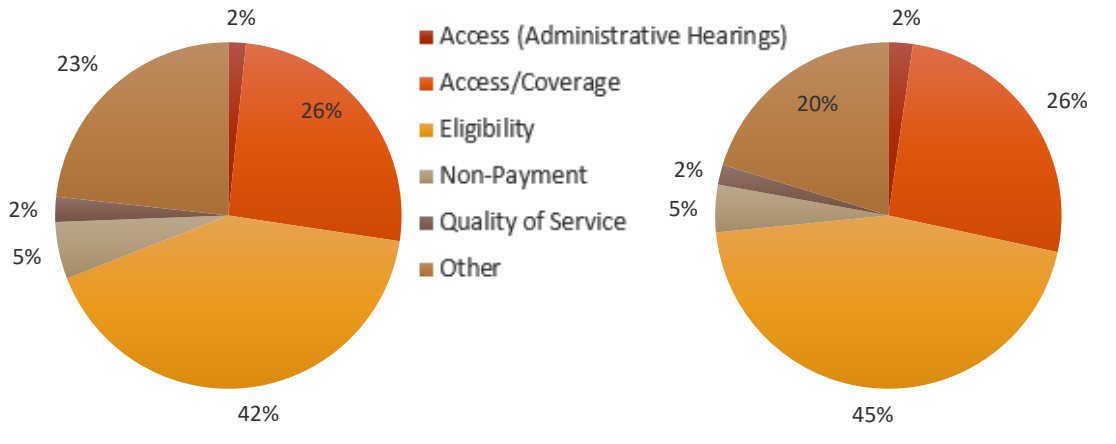
FY17	FY18
	
FY17 Total Sample = 9,009 Contacts	FY18 Total Sample = 11,067 Contacts

Figure 9. Breakdown of Types of Issues Encountered by (Commercial-Appeals/Grievances-Bill of Rights) Contacts FY17 and FY18

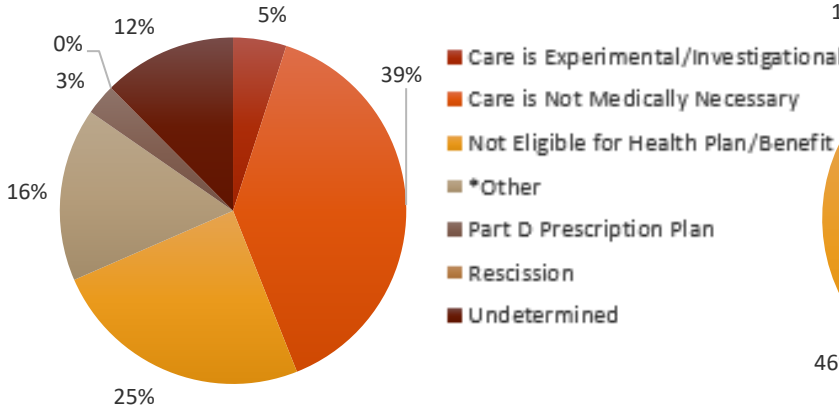
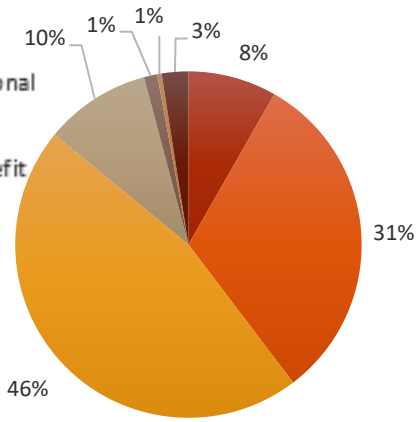
FY17	FY18
	
FY17 Total Sample = 241 Contacts	FY18 Total Sample = 242 Contacts

Figure 10. Breakdown of Types of Issues Encountered by Dual Eligible (Medicare and Medicaid) Contacts FY17 and FY18

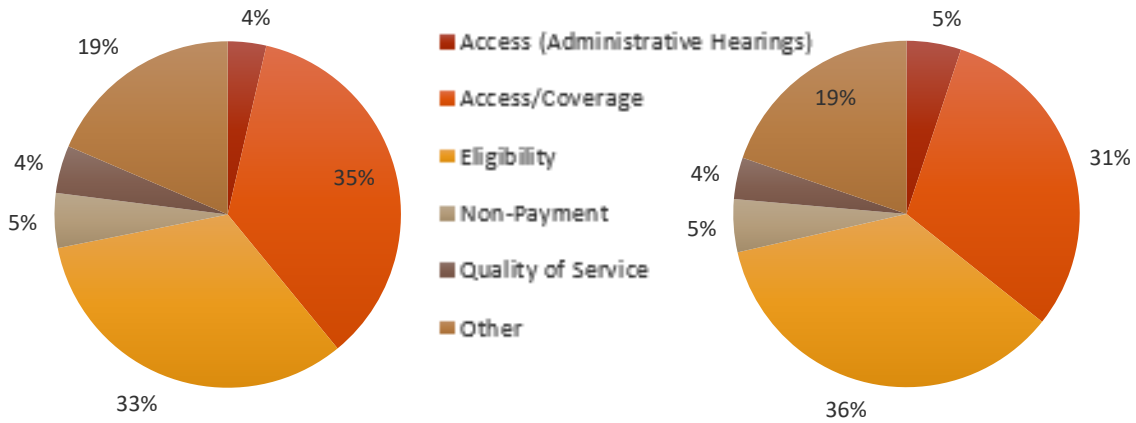
FY17	FY18
	
FY17 Total Sample = 2,565 Contacts	FY18 Total Sample = 3,141 Contacts

Figure 11. Breakdown of Types of Issues Encountered by Medicaid Fee-for-Service (FFS) Contacts FY17 and FY18

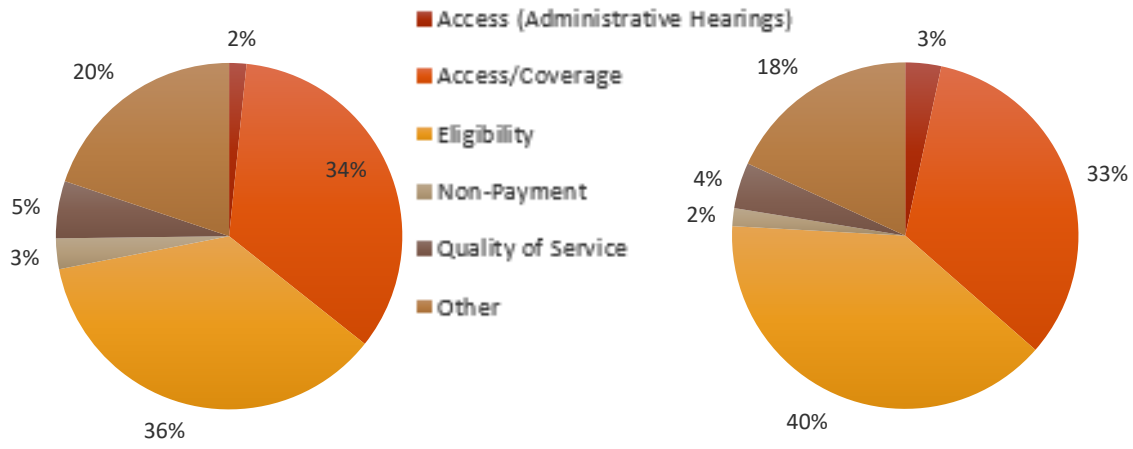
FY17	FY18
	
FY17 Total Sample = 1,365 Contacts	**FY18 Total Sample = 1,492 Contacts**

Figure 12. Breakdown of Types of Issues Encountered by Medicare Part A; Part B; Part A/B; Part A/B (QMB) Contacts FY17 and FY18

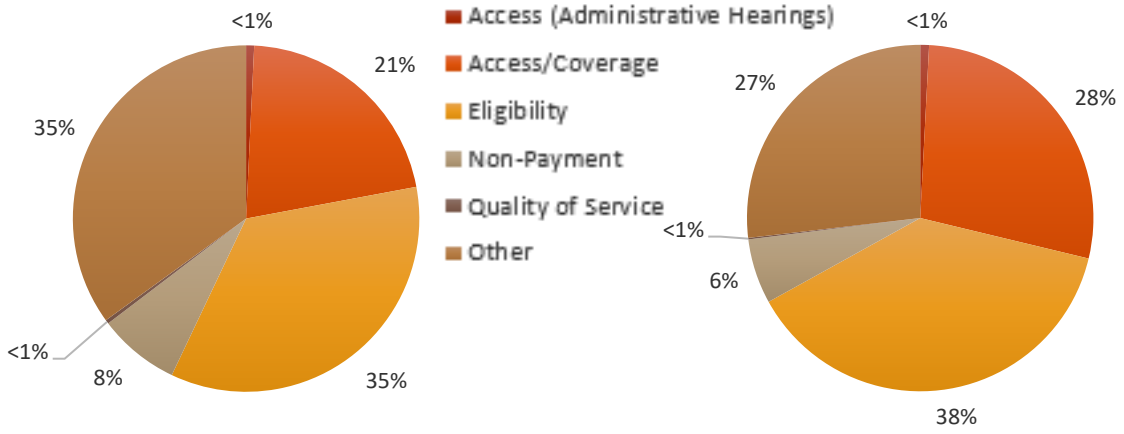
FY17	FY18
	
FY17 Total Sample = 2,538 Contacts	**FY18 Total Sample = 2,803 Contacts**

Figure 13. Breakdown of Types of Issues Encountered by Medicaid Managed Care (MCO) Contacts FY17 and FY18

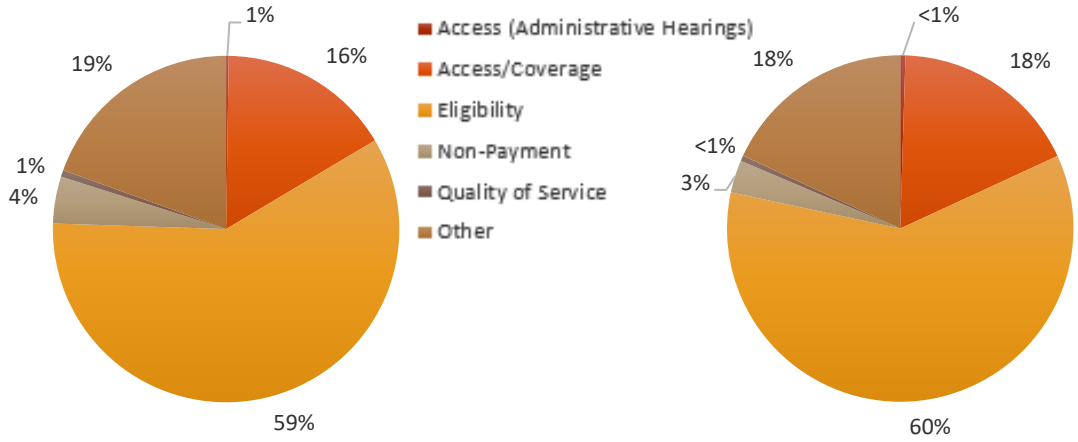
FY17	FY18
	
FY16 Total Sample = 2,054 Contacts	FY17 Total Sample = 3,090 Contacts

Figure 14. Breakdown of Types of Issues Encountered by Alliance Contacts FY17 and FY18

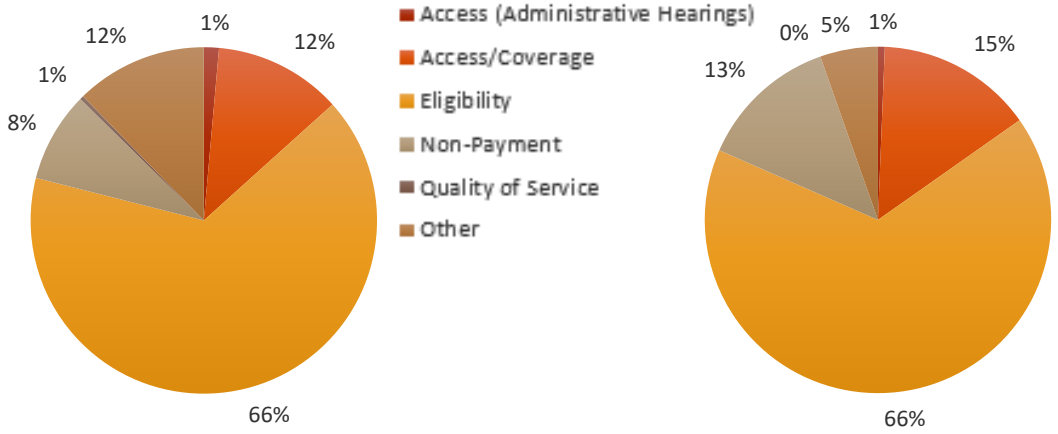
FY17	FY18
	
FY17 Total Sample = 285 Contacts	FY18 Total Sample = 315 Contacts

Figure 15. Breakdown of Transportation Contacts by Insurance Type FY17 and FY18

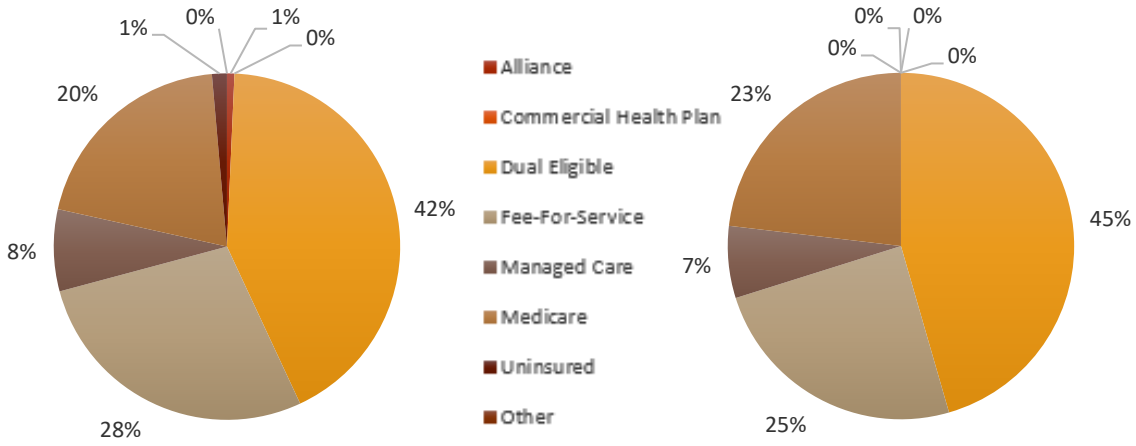
FY17	FY18
	
FY17 Total Sample = 144 Contacts	FY18 Total Sample = 134 Contacts

Figure 16. Breakdown of Types of Issues Encountered by EPD Waiver Contacts FY17 and FY18

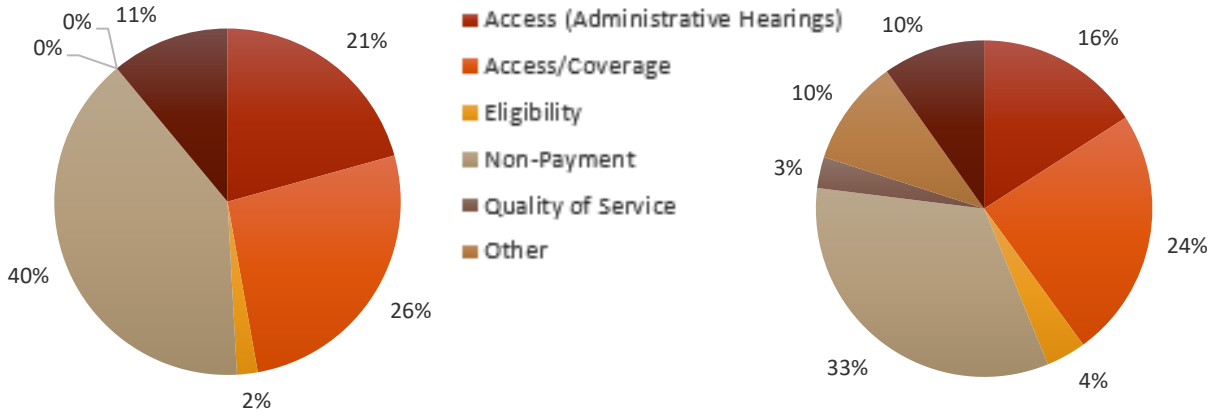
FY17	FY18
	
FY17 Total Sample = 517 Contacts	FY18 Total Sample = 968 Contacts

Figure 17. Breakdown of Types of Issues Encountered by DC Health Link and Health Exchange Marketplace Contacts FY17 and FY18

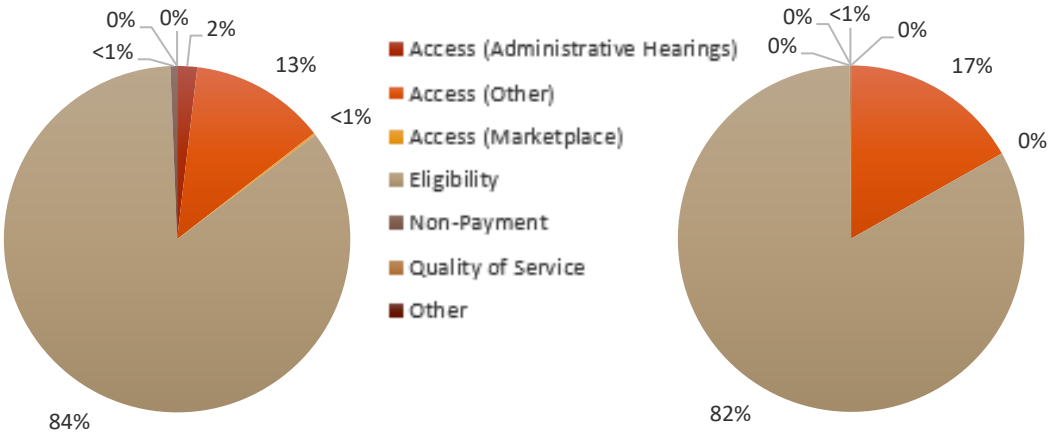
FY17	FY18
	
FY17 Total Sample = 482 Contacts	**FY18 Total Sample = 797 Contacts**

Figure 18. Dollar Amount of Savings on Behalf of (Non-Commercial); and (Commercial-Appeals/Grievances-Bill of Rights) Contacts FY17 and FY18

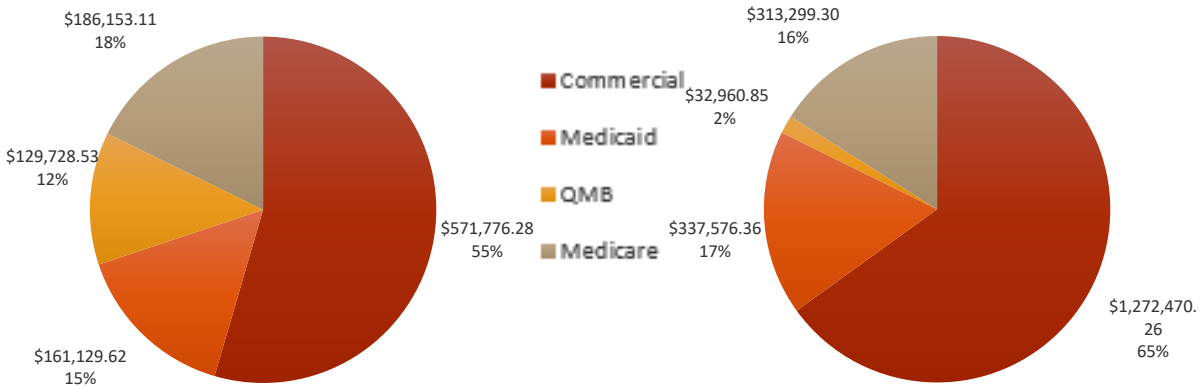
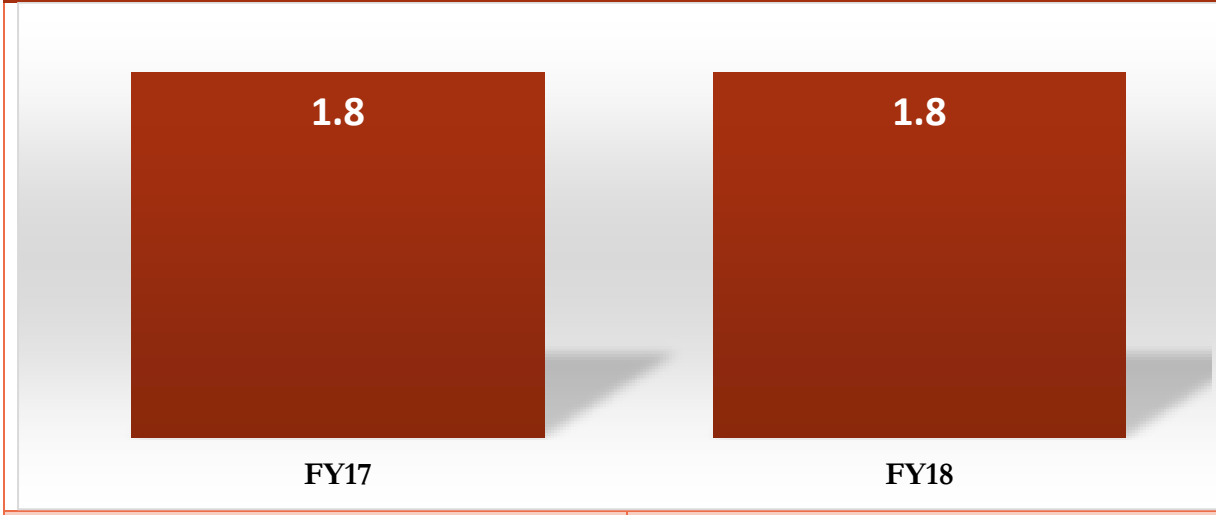
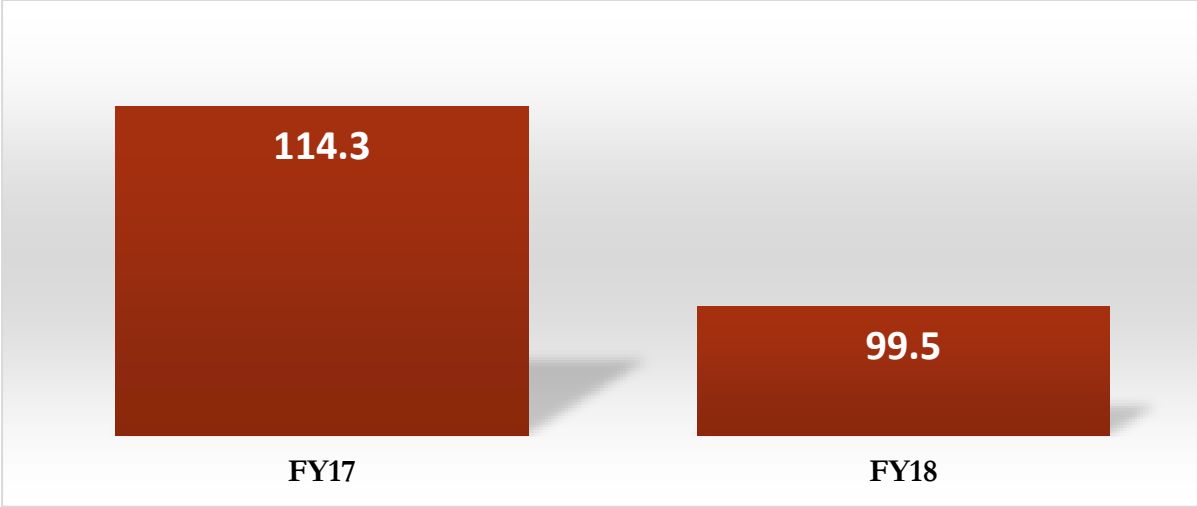
FY17	FY18
	
FY17 Total Sample = $1,048,787.54	**FY18 Total Sample = $1,956,306.77**

Figure 19. Average Number of Days to Resolve/Close (Non-Commercial) Cases FY17 and FY18



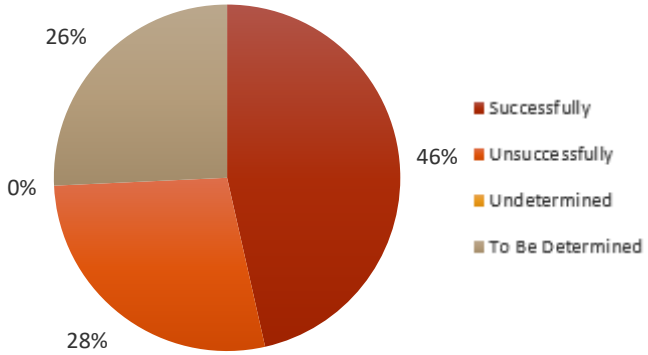
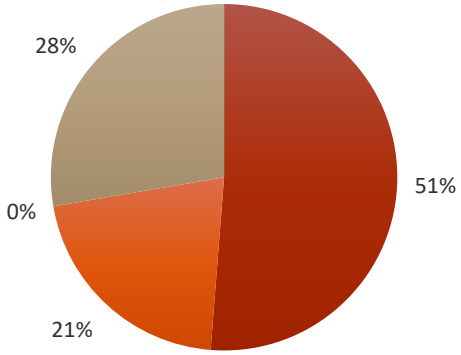
FY17 Total Cases Resolved/Closed = 8,621 Contacts	FY18 Total Cases Resolved/Closed = 11,045 Contacts

Figure 20. Average Number of Days to Resolve/Close (Commercial-Appeals/Grievances-Bill of Rights) Cases FY17 and FY18



FY17 Total Cases Resolved/Closed = 179 Contacts	FY18 Total Cases Resolved/Closed = 175 Contacts

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 FY17 and FY18

FY17	FY18
	
FY17 Total Sample = 241 Contacts	**FY18 Total Sample = 242 Contacts**

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 assisting 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 – FY2018
OCTOBER 1, 2017 THROUGH SEPTEMBER 30, 2018

EVENT DATE	OHCOBR'S PARTICIPATION	NAME OF ORGANIZATION/GROUP	NUMBER OF ATTENDEES
OCTOBER 13, 2017	SPEAKER	WARD 6 – DDS/DDA'S ADAPTIVE EQUIPMENT FORUM – DDS – 250 E STREET, SW	50 ATTENDEES
OCTOBER 18, 2017	EXHIBITOR	WARD 6 – SW WATERFRONT AARP CHAPTER'S 25TH ANNIVERSARY/6TH ANNUAL COMMUNITY HEALTH FAIR AT RIVER PARK MUTUAL HOMES – SOUTH COMMON 1311 DELAWARE AVENUE, SW	200 ATTENDEES
OCTOBER 19, 2017	EXHIBITOR	WARD 4 – DC RETIRED EDUCATION ASSOCIATION ANNUAL BUSINESS MEETING/DCOA – COMMUNITY HEALTH & RESOURCE FAIR NINETEENTH BAPTIST CHURCH 4606 16TH STREET, NW	100 ATTENDEED
OCTOBER 20, 2017	EXHIBITOR	WARD 2 – DHCF MCO OPEN HOUSE 441 4TH STREET, NW – OLD COUNCIL CHAMBERS	200 ATTENDEES
OCTOBER 26, 2017	EXHIBITOR	WARD 7 - MAYOR'S 2017 DISABILITY AWARENESS EXPO – DEPARTMENT OF EMPLOYMENT SERVICES 4058 MINNESOTA AVENUE, NE	500 ATTENDEES
NOVEMBER 14, 2017	EXHIBITOR – CHARLITA/CARMEN	WARD 2 – DCHR OPEN ENROLLMENT FAIR – DC PUBLIC SCHOOLS CENTRAL OFFICE 1200 FIRST STREET, NE	300 ATTENDEES
NOVEMBER 15, 2017	EXHIBITOR – GINA/CARMEN	WARD 6 – DCHR OPEN ENROLLMENT FAIR CHILD & FAMILY SERVICES AGENCY 200 I STREET, SE	225 ATTENDEES
NOVEMBER 22, 2017	EXHIBITOR – CARMEN/CARDISS/ROBERT	WARD 2 – SAFEWAY FEAST OF SHARING EXPO WALTER E. WASHINGTON CONVENTION CENTER 901 MOUNT VERNON PLACE, NW	5,000 ATTENDEES
NOVEMBER 28, 2017	EXHIBITOR – LORETTA/CARMEN	WARD 2 – DCHR OPEN ENROLLMENT FAIR – JOHN A. WILSON BUILDING 1350 PENNSYLVANIA AVENUE, NW	300 ATTENDEES
NOVEMBER 30, 2017	EXHIBITOR – PAULA/CARMEN	WARD 6 – DCHR OPEN ENROLLMENT FAIR – FRANK D. REEVES CENTER 2000 14TH STREET, NW	300 ATTENDEES
DECEMBER 6, 2017	EXHIBITOR – SHIRLEY/CARMEN	WARD 5 – DCHR OPEN ENROLLMENT FAIR – DC HOUSING AUTHORITY 1133 N. CAPITOL STREET, NE	300 ATTENDEES
DECEMBER 13, 2017	EXHIBITOR – CARMEN/CARDISS/ROBERT	WARD 6 – MAYOR'S 2017 SENIOR HOLIDAY CELEBRATION DC ARMORY2001 EAST CAPITOL STREET, SE HEALTH, WELLNESS AND INFORMATIONAL FAIR	4,000 ATTENDEES
JANUARY 9, 2018	EXHIBITOR	WARD 1 – RESOURCE FAIR – BERNICE ELIZABETHFONTENEAU SENIOR WELLNESS CENTER 3531 GEORGIA AVENUE, NW	300 ATTENDEES
JANUARY 25, 2018	EXHIBITOR	WARD 5 – DCOA WITH VISIONARY SQUARE – 1ST ANNUAL HEALTH & RESOURCE FAIR 2401 WASHINGTON PLACE, NE	300 ATTENDEES
FEBRUARY 7, 2018	EXHIBITOR	WARD 7 – BENNING RIDGE CIVIC ASSOCIATION FIRST ANNUAL HEALTH & RESOURCE FAIR BENNING RIDGE COMMUNITY CENTER – 830 RIDGE ROAD, NE	100 ATTENDEES (CANCELLED – INCLEMENT WEATHER)

FEBRUARY 16, 2018	**EXHIBITOR**	**WARD 4 – HATTIE HOLMES SENIOR WELLNESS CENER COMMUNITY RESOURCE FAIR 324 KENNEDY STREET, NW**	**150 ATTENDEES**
FEBRUARY 21, 2018	**EXHIBITOR**	**WARD 3 – MAYOR'S 2018 SENIOR BUDGET ENGAGEMENT FORUM #1 – UDC 4200 CONNECTICUT AVE, NW – STUDENT CENTER**	**500 ATTENDEES**
FEBRUARY 22, 2018	**EXHIBITOR**	**WARD 8 – CONGRESS HEIGHTS SENIOR WELLNESS CENTER COMMUNITY HEALTH FAIR 3500 MARTIN LUTHER KING AVENUE, SE**	**175 ATTENDEES**
FEBRUARY 26, 2018	**EXHIBITOR**	**WARD 5 – MODEL CITIES SENIOR WELLNESS CENTER'S COMMUNITY HEALTH, WELLNESS & INFORMATIONAL FAIR 1901 EVARTS STREET, NE**	**200 ATTENDEES**
MARCH 5, 2018	**EXHIBITOR**	**WARD 4 – MORTON & FLORENCE BAHR TOWERS 1ST ANNUAL COMMUNITY HEALTH, WELLNESS & INFORMATIONAL FAIR 1901 EVARTS STREET, NE**	**100 ATTENEES**
MARCH 10 & 11, 2018	**EXHIBITOR**	**WARD 2 – NBC4 & TELEMUNDO 25TH ANNIVERSARY HEALTH EXPO – WALTER WASHINGTON CONVENTION CENTER 801 MOUNT VERNON PLACE, NW – BOOTH 6000**	**75,000 ATTENDEES – OF THE 75,000 ATTENDEES – 1,000 SPANISH SPEAKING ATTENDEES WERE IMPACTED**
MARCH 12, 2018	**EXHIBITOR**	**WARD 7 – JW KING SENIOR CENTER COMMUNITY HEALTH, WELLNESS & INFORMATIONAL FAIR 4638 H STREET, SE**	**150 ATTENDEES**
MARCH 20, 2018	**EXHIBITOR**	**WARD 8 – WASHINGTON SENIOR WELLNESS CENTER – 1ST ANNUAL COMMUNITY HEALTH & RESOURCE FAIR 3001 ALABAMA AVENUE, SE**	**175 ATTENDEES**
APRIL 10, 2018	**EXHIBITOR**	**WARD 5 – HOUSE OF LEBANON – FIRST ANNUAL COMMUNITY HEALTH & RESOURCE FAIR 27 O STREET, NW**	**50 ATTENDEES**
APRIL 11, 2018	**EXHIBITOR**	**WARD 5 – WTU RETIREES CHAPTER – 2ND ANNUAL COMMUNITY HEALTH & RESOURCE FAIR STODDARD BAPTIST NURSING HOME 2601 18TH STREET, NE – CRYSTAL BALLROOM**	**75 ATTENDEES**
APRIL 13, 2018	**SPEAKER**	**WARD 6 – ADAPTIVE EQUIPMENT FORUM DEPARTMENT ON DISABILITIES 250 E STREET, SW**	**75 ATTENDEES**
APRIL 19, 2018	**EXHIBITOR**	**WARD 3 – CHEVY CHASE COMMUNITY CENTER HEALTH & RESOURCE FAIR 5601 CONNECTICUT AVENUE, NW**	**100 ATTENDEES**
JUNE 20, 2018	**EXHIBITOR**	**WARD 5 – MAYOR'S 7TH ANNUAL SENIOR SYMPOSIUM – DUNBAR SENIOR HIGH SCHOOL 101 N STREET, NW**	**900 ATTENDEES**
JUNE 21, 2018	**EXHIBITOR**	**WARD 7 – DEPARTMENT OF PARKS AND RECREATION 2018 CITY-WIDE SENIOR FEST OXON RUN PARK 900 WHEELER ROAD & VALLEY AVENUE, SE**	**2,500 TO 3,000 ATTENDEES**
JUNE 27, 2018	**EXHIBITOR**	**WARD 3 – UDC INSTITUTE OF GERONTOLOGY NUTRITION & BOBBY WISE PROGRAM COMMUNITY HEALTH, WELLNESS & NFORMATION FAIR – UDC NEW STUDENT 4200 CONNECTICUT AVE, NW**	**600 ATTENDEES**
AUGUST 7, 2018	**EXHIBITOR**	**WARD 5 – MPD NATIONAL NIGHT OUT SOUTHERN HILL APARTMENTS 4335 4TH STREET, SE**	**1,000 ATTENDEES**
AUGUST 25, 2018	**EXHIBITOR/SPEAKER**	**WARD 4 – NINETEEN STREET BAPTIST CHURCH HEALTH, RESOURCE & FUN FAIR 4606 16TH STREET, NW**	**500 ATTENDEES**
SEPTEMBER 15, 2018	EXHIBITOR	WARD 8 – **60th ANNIVERSARY – MACEDONIA BAPTIST CHURCH, SE**	**1,000 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 process internally. OHCOBR provides the report format to the insurance companies for uniformity in analyzing the reports. These reports help OHCOBR understand issues of concern to private insurance members based on grievances they file with their health plans. On occasion these consumers also contacted OHCOBR for help communicating with their insurer or for further action if they are dissatisfied with the insurance company's decision. OHCOBR tracks and reports on those cases (see *Data: Highlights & Analysis* section), which results in duplicate reporting for a modest number of cases that are tracked by OHCOBR and the private insurer.

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 *upheld* initial decisions; 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 1 and 2 at the end of this section.

DATA SUMMARY AND HIGHLIGHTS

Using data from the FY 2018 *Commercial Insurer's Annual Self-Reports* submitted by each insurance company, OHCOBR is able to determine the volume and scope of complaints processed by each company and all the companies combined. The reports were analyzed to assess trends, compliance with legislative mandates including resolution timeliness, and to identify areas that may require further review and follow-up. Gauging the benefits of the *Self-Report* and recognizing the need for value-added modifications is an ongoing process.

TOTAL REPORTS REVIEWED:	32	100%
REPORTS WITH "NO GRIEVANCES":	18	56%
REPORTS WITH GRIEVANCES:	14	44%
REPORTS WITH 40% OR MORE GRIEVANCES OVERTURNED IN A SINGLE CATEGORY:	11	34%

TRENDING: Grievance Turnover Rates

- The analysis of FY 2018 final case results shows that one third of the 32 insurers that submitted reports (34 percent, or 11 of 32 insurers) overturned at least 40 percent of grievances in at least one of the service categories listed above, in favor of the member. Among companies that reportedly had grievances, nearly 80 percent of them (78.6 percent, or 11 of 14 insurers) had an overturned rate over 40 percent in specific service categories.

- For a second year OHCOBR has isolated dental insurer data to determine how that group's data varies by provider and when compared to the medical insurers.

    - Of the four dental insurers that submitted a *Self-Report*, two reported more grievances each than all but one of the 10 medical insurers.

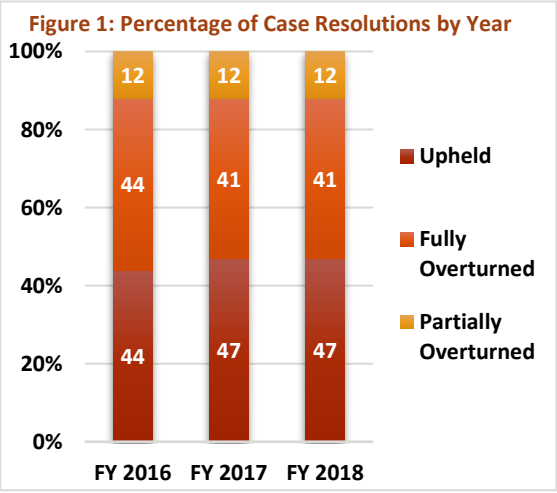
    - Looking at aggregate numbers, a disproportionate share of the total number of grievances that were overturned was attributed to the dental insurers (more of their cases were *partially overturned* than were *fully overturned*). Of all insurers reporting grievances in FY 2018, 29 percent were dental insurers (four of 14 insurers reporting grievances); however, dental insurers accounted for 40 percent of all the grievance cases (920 of 2,324).

- In terms of outcomes, the four dental insurers accounted for 46 percent of all grievances that were *partially* or *fully overturned* (563 cases *combined overturned*) compared to 54 percent among the 10 medical insurers (673 cases *combined overturned*).

- In the case of one dental insurer, denial decisions were reversed for 89 percent of the grievance cases processed.

- Instances of high numbers of grievance cases and high rates of overturned cases among some of the dental insurers indicates a need for further examination of specific providers, the reasons for the initial denials that were later overturned, and the possible need to adjust the claims process so that members can obtain covered dental services without having to file grievances.

- In FY 2018, 11 of 32 insurers overturned 40 percent or more of *grievance cases in a single category*. This is an increase from FY 2017 when only seven of 34 insurers reported 40 percent or more *cases overturned in a single category*. In FY 2016 there were 14 of 32 companies with high decision reversal rates. In some years the measure of grievances *overturned in more than 40 percent of cases in a single category* reveals trends and issues with medically specific treatments; however, there are other periods when trends cannot be surmised. FY 2018 was such a year. There were no apparent trends in any single category to account for high turnover rates. However, there were two insurers that overturned initial denials at an unusually high rate in the category Pharmacy Services (approximately 60 percent turnover). Further intervention is required to determine if a pattern related to a specific illness, drug or practice was responsible for the initial denial of Pharmacy Services cases in order to avoid them in the future.



- Figure 1: *Percentage of Case Resolution by Year* shows breaks out the percentage of case resolved by type of resolution decision for the past three fiscal years. Decision outcomes by type have been level with a slight variation in the percentage of *fully overturned* cases during the three-year period, i.e., the percentage of *fully overturned* cases decreased slightly from 44 percent in FY 2016 to 41 percent in both FY 2017 and FY 2018. Resolution categories had nearly the same percentages year-to-year despite a spike in the total number of grievances in FY 2017 as compared to FY 2016 and FY 2018 (See Figure 2: *Total Cases By Year*). A *fully overturned* outcome indicates that the plan member was initially denied access to care or payment for care that was later determined to be medically necessary with costs covered by the plan. The grievance process

increases adjudication costs and delays care to consumers. OHCOBR will continue to encourage insurers and providers to work together to approve services and properly code claims at the point of contact, to reduce the need for grievances and appeals.

TRENDING: Fewer Companies Reporting Grievances

- Over the past three fiscal years, the number of companies that submitted reports *and had grievances* during each year continued to decrease from 22 in FY 2016 to 16 in FY 2017 and down to 14 in FY 2018. This represents a 36 percent reduction in the number of companies that submitted reports with grievances since FY 2016.

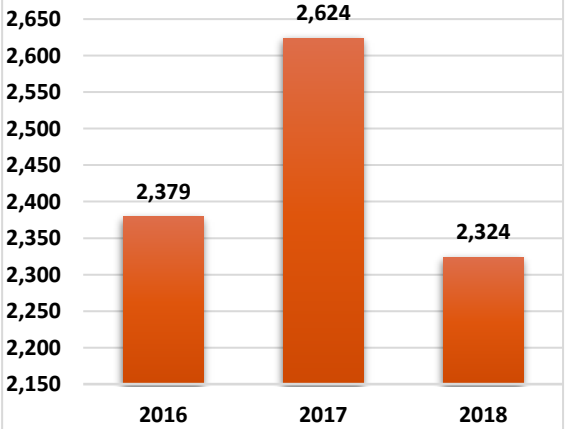
DATA SUMMARY: Number of Companies Reporting and Number of Cases

- A total of 32 companies submitted annual *Self-Reports* in FY 2018, two fewer than in FY 2017 (34 companies) and two more than in FY 2016 when 30 companies submitted reports.

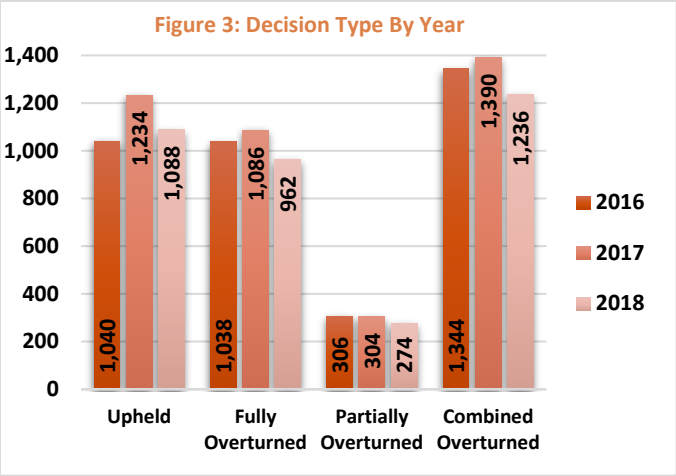
- Of the 32 insurers that submitted an annual *Self-Report*, 14 reported opening consumer *grievance cases* in FY 2018 and 18 reported having *no grievance cases*. In FY 2017, 16 of 34 insurers reported opening grievance cases (two more than in FY 2018) and 18 insurers reported no grievance cases, the same number that was reported in FY 2018. In FY 2016, 22 of 30 insurers reported consumer grievances (eight more than in FY 2018) and eight reported having no grievance cases (ten fewer than in FY 2018).

- The number of *grievance cases* declined in FY 2018 after a spike in FY 2017. The 14 companies that reported grievances in FY 2018 opened a total of 2,324 cases, 300 fewer cases (11.4 percent fewer) than the 2,624 cases opened by 16 companies in FY 2017, and 55 fewer cases (2.3 percent fewer) than the 2,379 cases opened by 22 companies in FY 2016 [See Figure 2: *Total Cases By Year*]. Dental insurers represented a disproportionate share of all grievances reported. Dental insurers reported 40 percent of all grievances in FY 2018 (920 of 2,324 cases). Only four of the 32 companies that submitted a *Self-Report* in FY 2018 were dental insurers.

Figure 2: Total Cases By Year



DATA SUMMARY: Case Outcomes by Type



- As shown in Figure 3: *Decision Type By Year*, insurers *upheld* their initial decisions in FY 2018 in a total of 1,088 of 2,324 opened cases (47 percent) compared to FY 2017 when 1,234 of 2,624 opened cases (also 47 percent) were *upheld*. In FY 2016 insurers *upheld* 1,040 of 2,379 opened cases (44 percent). *Upheld* cases are cases that are reviewed and the original decision to deny coverage or payment is reaffirmed.

- Insurers *fully overturned* their original decision in 962 cases (41 percent of 2,324 cases). This percentage was the same in FY 2017 but more cases (1,086 cases) were *fully overturned* (41 percent of 2,624 total cases). The FY 2018 rate and number of *fully overturned* cases represent a slight decrease from the 1,038 *fully overturned* cases in FY 2016 (44 percent of 2,379 total cases). *Fully overturned* cases are cases that are reviewed, and the original denial decision is reversed in favor of the member.

- A total of 274 of 2,324 opened cases were *partially overturned* in favor of the member in FY 2018 (12 percent). The rate of 12 percent was the same as in FY 2017 when 304 of 2,624 opened cases were *partially overturned* in favor of the member. This is similar to the FY 2016 rate when 306 of 2,379 opened cases (13 percent) were *partially overturned*. There is little change from year-to-year in the *partially overturned* rate (12 and 13 percent), although FY 2018 reports about 10 percent fewer total cases *partially overturned* (274 cases) compared to the two previous years (304 cases in FY 2017 and 306 cases in FY 2016).

- In the *combined overturned* category the rate remained the same as in FY 2017 and was only a few percentage points lower than in FY 2016. In FY 2018 the number of *combined overturned* cases (total of *fully overturned* plus *partially overturned* cases) was 1,236 of 2,324 total cases opened (53 percent of all opened cases) and in FY 2017 there were 1,390 *combined overturned* cases of 2,624 cases opened (also 53 percent of all opened cases). The FY 2018 *combined overturned* cases rate of 53 percent was three percentage points lower than in FY 2016 (56 percent, 1,344 of 2,379 total cases).

- In FY 2018, 11 of the 14 companies that reported grievances (78.6 percent) had a *combined overturned* rate of 40 percent or higher in *at least one service category*. This represents a 35 percent increase over FY 2017 when seven of the 16 companies (43.8 percent) that reported grievances had a *combined overturned* rate of 40 percent or higher in *at least one service category*. In FY 2016, 14

of 30 companies (46.6 percent) had a *combined overturned* rate of 40 percent or higher in at least one service category. Two insurers overturned initial denials at a high rate in the Pharmacy Services category in FY 2018 (approximately 60 percent of cases overturned).

- In summary, the rate of grievance cases that were *fully overturned* decreased slightly over the prior 4-year period while remaining near 40 percent. The *combined overturned* rate, which includes both *fully* and *partially overturned* cases, also remained steady at nearly half of all opened cases. There was a spike in the FY 2018 number of insurers with more than 40 percent of cases *in a single category* that were reversed or overturned. Overall, the consistently high reversal rates suggest that efforts should be focused on reducing the frequency of grievances and appeals, which would reduce efforts by insurers and providers to settle grievances and facilitate timely delivery and payment of healthcare services for consumers.

DATA SUMMARY: Service Category Prevalence

- In FY 2018, for the third consecutive year, the Pharmacy Services category was the *most prevalent service category* for grievances by service type, followed by mental health services, physician services, and dental services.

The following tables summarize data from the FY 2018 annual *Self-Reports* that each commercial insurer submitted; including reports submitted that showed no grievances during the year. Insurers are listed in alphabetical order.

Table 2. Commercial Insurers' Annual Self-Report[1] FY 2018

NAME OF INSURER	TOTAL APPEALS/ GRIEVANCES	CASES UPHELD		CASES OVERTURNED		CASES PARTIALLY OVERTURNED	
		#	%	#	%	#	%
Aetna Health Inc.	21	12	57%	9	43%	0	0%
Aetna Life Insurance Co.	29	19	66%	8	28%	2	6%
Allianz Life Insurance Co.							
Ameritas Life Insurance Co.[1]	333	237	71%	82	25%	14	4%
Avesis							
BlueChoice Inc.	230	124	54%	105	45%	1	1%
CareFirst of Maryland, Inc.	110	67	61%	37	34%	6	5%
CIGNA Health and Life Insurance Co.	52	26	50%	24	46%	2	4%
CIGNA HealthCare Mid-Atlantic Inc.							
Connecticut General Life Insurance Co.							
Delta Dental[2]	68	40	59%	25	37%	3	4%
Golden Rule Insurance Co.							
Group Hospitalization and Medical Services, Inc.	584	291	50%	291	49%	2	1%
John Alden Life Insurance Co.							
Kaiser Permanente	101	50	50%	51	50%	0	0%
MAMSI Life and Health Insurance Co.							
Metropolitan Life Insurance Co.[2]	477	53	11%	198	42%	226	47%
MD-Individual Practice Association, Inc.	257	128	50%	115	45%	14	5%
Optimum Choice, Inc.	19	14	74%	5	26%	0	0%
Principal Life Insurance Co.							
Prudential Insurance Co. of America							
Reliance Standard Insurance Co.							
Standard Insurance Co.							
State Farm Mutual Auto Insurance Co.							
Time Insurance Co.							
Trustmark Insurance Co.							
Trustmark Life Insurance Co.							
UniCare Life and Health Insurance, Co.							
Union Security Insurance Co.							
United Concordia Insurance, Co.[2]	42	27	64%	11	26%	4	10%
United Healthcare Life Insurance Co.							
United Healthcare of the Mid-Atlantic, Inc.	1	0	0%	1	100%	0	0%
SUBTOTAL – MEDICAL PROVIDERS	1,404	731	52%	646	46%	27	2%
SUBTOTAL – DENTAL PROVIDERS	920	357	39%	316	34%	247	27%
TOTAL – ALL PROVIDERS	2,324	1,088	47%	962	41%	274	12%

[GRAY SHADING = NO GRIEVANCES REPORTED]

[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

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 Inc.	23.5	0	18	15
Aetna Life Insurance Co.	2	5	21	27
Allianz Life Insurance Co.				
Ameritas Life Insurance Co.[2]			20.29	
Avesis				
BlueChoice Inc.	9.8	21.2	40.4	4.7
CareFirst of Maryland, Inc.			38.4	27
CIGNA Health and Life Ins. Co.	0	24	33	42
CIGNA HealthCare Mid-Atlantic Inc.				
Connecticut General Life Ins, Co.				
Delta Dental[2]			24	
Golden Rule Insurance Co.				
Group Hospitalization and Medical Services, Inc.	11.6	9.7	21.1	8
John Alden Life Insurance Co.				
Kaiser Permanente	19	22	29	16
MAMSI Life and Health Ins. Co.				
Metropolitan Life Insurance Co.[2]			17.6	
MD-Individual Practice Association, Inc.	110	192	24	93
Optimum Choice, Inc.	28	72	37	0
Principal Life Insurance Co.				
Prudential Ins. Co. of America				
Reliance Standard Insurance Co.				
Standard Insurance Co.				
State Farm Mutual Auto Ins. Co.				
Time Insurance Co.				
Trustmark Insurance Co.				
Trustmark Life Insurance Co.				
UniCare Life and Health Ins. Co.				
Union Security Insurance Co.				
United Concordia Insurance, Co.[2]			6.24	
United Healthcare Life Ins.Co.				
United Healthcare of the Mid-Atlantic, Inc.			24	

[GRAY SHADING = NO GRIEVANCES REPORTED]

[BLACK SHADING = SERVICES ARE NOT COVERED BY THE PLAN]

[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

Appendix D

Appeal/Grievance – A written request by a 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 interchangeable. 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 his/her 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 individual. 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

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