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A Message from Mayor Muriel Bowser

The health and well-being of Washingtonians continued to be an important priority to my Administration. Without adequate health care coverage and access to comprehensive health care services, our community will cease to thrive. In fiscal year 2019, we continued to build pathways to the middle class, by building on the programs that we have in place to provide more Washingtonians the opportunity to participate in our city's prosperity. And we will continue to create new opportunities that give more residents a fair shot by investing in ten priority areas: affordable housing; education and early child care; homelessness; transportation and infrastructure; seniors; a new hospital; maternal and infant health; public safety; economic development; and statehood. 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.

First, we maintained our standing as having one of the lowest rates of uninsured residents in the nation (nearly 97 percent). We continued to ensure this by: enacting a local individual responsibility requirement when the federal government repealed the federal one; adopted a three month open enrollment period after the federal government reduced open enrollment to six weeks; invested in navigators to assist with enrollment even after the federal government reduced funding; enacted laws to protect District residents from federal Administration efforts to expand short-term limited duration plans; and increased outreach activities.

Our second major achievement was the establishment of the Mayor's Commission of Healthcare Systems Transformation to make recommendations on strategies and investments necessary to transform health care delivery in the District of Columbia. The commission's work will focus on alleviating challenges in accessing critical services and developing recommendations that address the current stresses in the District's health care system.

Finally, we invested in perinatal health and the BABIES bill (Better Access for Babies to Integrated Equitable Services Act of 2018) to reinforce the goal of providing high-quality services for pregnant women, mothers, and newborns. These investments built on momentum from the Mayor's Maternal and Infant Summit and the growing public awareness and interest in this important issue. Our approach focuses on three key categories: improving women's health before pregnancy; addressing barriers to prenatal care; and preventing preterm births.

My administration and I are committed to continuing to build on our progress and advance our values, so that DC remains an inclusive city – a city that is welcoming and accessible, and full of opportunity. Through the work of the Office of Health Care Ombudsman, we can ensure that uninsured rates remain at their lowest, by assisting residents with access to care and services, and through their continued outreach and education efforts.

I would like to thank the Executive Office of the Mayor, the Council of the District of Columbia, health care providers, federal officials, District agency staff, and especially the Office of Health Care Ombudsman. With their ongoing help, we can all be assured of further progress in the coming years.

Muriel Bowser
Mayor

A Message from Director Wayne Turnage

The District continues to boast some of the highest eligibility levels in the nation, along with a comprehensive program of benefits. With high coverage levels, the District extends health care to nearly four in ten residents. For almost 90 percent of these residents, Medicaid is their source of health insurance. For the remaining residents on public insurance, the Alliance program (six percent), Children's Health Insurance Program (five percent), and Immigrant Children's Program (one percent), provide their collective path to health care.

Sustaining one of the highest uninsured rates in the nation comes with its set of challenges. These challenges are: (1) managing the surging cost of care delivery for our fee-for-service population; (2) disparities in how each managed care plan is compensated, without detriment to one plan; and (3) developing a greater understanding of enrollment issues and ways to improve the Alliance program, while pursuing efforts to slow down an unsustainable cost growth rate.

This fiscal year, we addressed important issues that we faced within the Medicaid managed care and Alliance programs, with implementation effective in FY 2020. With surging costs in our fee-for-service population, we have developed a plan to transition our program into a fully managed care program over the next five years. In the case of Medicaid managed care, changes were needed to offset problems created by an adverse process that impacted one plan—a disproportionate share of unhealthy individuals gravitated to AmeriHealth Caritas DC to access physicians unavailable to members of other plans, creating a payment disparity. With respect to the Alliance program, we continue to monitor the rapid cost-growth associated with the program in conjunction with an inconsequential increase in enrollment. And constantly vet potential changes in the program's application process that could ease any questions about beneficiary access, but not at the expense of the six-month recertification requirement process that protects the integrity of the program.

As DHCF enters FY 2020, we look forward to ensuring that District residents have continued access to quality health care services. 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 2019 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); and 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 (ACA)), and those whose commercial health insurance policies were underwritten in the District (more than 900,000).

During the past fiscal year, we joined forty-nine community events attended by nearly 100,000 (99,505) people—a four percent increase over last year when we impacted more than 95,000 (95,225) attendees. Through our community outreach activities, we directly engage 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 11,654 cases, a three percent increase over the prior year's 11,309 cases, and a significant increase compared to FY 2017 (9,009 cases).

In the previous fiscal year, we consulted with the Department of Insurance, Securities, and Banking (DISB) and provided input and comments to the Centers for Medicare and Medicaid Services (CMS), which resulted in restrictions placed on short-term plans effective in FY 2019. Short-term plans are now limited to three months, cannot be auto-renewed, and cannot exclude pre-existing conditions or eligibility based on medical history—resulting in a drop from six short-term health insurance plans in the District to one, once the new rules took effect.

I would like to extend my appreciation to my dedicated team. They are continually steadfast in their public service and commitment to advocate for the residents of the District and those that are employed, or policies underwritten 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 2019 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

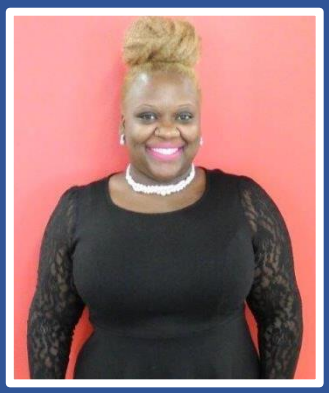
Charlita Brown, BS
Associate Health Care Ombudsman

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

Jennifer Gutierrez
Associate Health Care Ombudsman

Donnette Hill, MBA
Associate Health Care Ombudsman

Cardiss Jacobs
Associate Health Care Ombudsman

Lamia Jackson
Associate Health Care Ombudsman

Tamiki Jackson
Associate Health Care Ombudsman

Aminata Jalloh, MS
Associate Health Care Ombudsman

Carmencita Kinsey
Associate Health Care Ombudsman

Brandon Lacey
Contractor

Elfleta Nixon, DNP, RN
Associate Health Care Ombudsman

Mirka Shephard
Associate Health Care Ombudsman

Amber Whishi
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 2019:

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

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

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 DC Medicaid program, Mayor Bowser's FY 2019 budget ensures continued access to health care services by preserving the District's eligibility levels for both the Medicaid and Alliance program, Currently, there has been no reduction of expenditure in benefit plans; historical funding for community-based providers has been maintained; and resources to return managed care rates to the target or mid-point level have been allocated.

Starting in 2020, major steps towards reforming the DC Medicaid program towards a fully managed care program will begin to transition over the next five years. The purpose is to administer the DC Medicaid program in a more holistic manner that will improve health outcomes for beneficiaries.

The first milestone is re-procuring the managed care contract with the expectation that new contracts will be implemented on October 1, 2020. This re-procurement opportunity will provide a vehicle to transition nearly 22,000 fee-for-service beneficiaries to managed care, expand value-based purchasing requirements, and implement universal contracting for providers.

Health Care Reform Update

Affordable Care Act policy changes

On May 21, 2018, the Internal Revenue Service (IRS) announced in Revenue Procedure 2018-34 the 2019 shared-responsibility affordability percentage. Based on the Affordable Care Act's (ACA's) affordability standard as adjusted for inflation, health coverage will satisfy the requirement to be affordable if the lowest-cost self-only coverage option available to employees does not exceed 9.86 percent of an employee's household income, up from 9.56 percent in 2018.

For 2019 calendar-year plans using the federal poverty level (FPL) safe harbor to determine affordability, an employee's premium payment cannot exceed $99.75 per month, up from $96.08 per month in 2018.

An Annual Adjustment

The affordability standard is the highest percentage of household income an employee can be required to pay for monthly plan premiums, based on the least expensive employer-sponsored plan offered that meets the ACA's minimum essential requirements.

Employers should consider the affordability standard in developing their 2019 health care plan cost-sharing strategies, since pricing at least one plan option below the threshold will avoid triggering employer-shared responsibility penalties under Section 4980H(b), which the ACA added to the tax code.

Affordability Safe harbors

Since employers do not know their workers; household incomes, to which affordability threshold applies, the ACA created three safe harbors, any of which can be used in place of household income:

- The employee's W-2 wages—as reported in box 1—generally as of the first day of the plan year;
- The employee's rate of pay—hourly wage rate multiplied by 130 hours per month—as of the first day of the plan year; or
- The individual FPL as of six months prior to the beginning of the plan year, since the FPL is not published for a given year until January.

2019 FPL Safe Harbor

Many employers use the FPL safe harbor to develop employee contributions for self-only coverage to avoid ACA penalties under 4980H(b).

For 2019, the maximum monthly premium contribution that meets the FPL safe harbor will be 9.86 percent of the prior year's FPL ($12,140 in most states for 2018) divided by 12, or $99.75.

Plan Calendar Year	Prior Year's FPL	Affordability Percentage	Maximum Monthly Contribution (Self Coverage)
2019	$12,140	9.86%	$99.75
2018	$12,060	9.56%	$96.08
2017	$11,880	9.69%	$95.93
2016	$11,770	9.66%	$94.75
2015	$11,670	9.56%	$92.97
Sources: IRS and Conduent HR Services			

Shared-Responsibility Penalty

The IRS can impose a shared-responsibility penalty when and employer with 50 or more full-time or equivalent employees—known as an applicable large employer (ALE)—fails to offer minimum essential coverage to substantially all of its full-time employees and their dependent children during a month and at least one full-time employee receives a premium tax credit through the ACA's public marketplace exchange. An ALE satisfies the "substantially all" standard for any given month if it offered coverage to at least 95 percent of its full-time employees and their dependent children during that month.

For 2019, actuaries estimate that the Section 4980H(b) penalty for failure to offer affordable, minimum-value coverage will be $3,750 per employee (or $312.50 per month), up from $3,480 (or $290 per month) in 2018.

Additional Cost-Sharing Limits

For 2019, there are other ACA cost-sharing limits that employers must keep in mind.

Minimum Value:

An ACA-compliant plan must provide minimum value by having an actuarial value of at least 60 percent, the statute states, meaning the plan pays 60 percent of covered benefits.

Out-of-Pocket Maximums

Non-grandfathered group health plans must comply with an annual limit on cost-sharing, known as an out-of-pocket (OOP) maximum, which is set by the Department of Health and Human Services (HHS0. This limit takes into account an employee's spending under the plan deductible, as well as co-payments and percentage-of-cost co-sharing payments, but not plan premiums.

In December 2017, HHS announced that for the 2019 plan year, the OOP maximum will be $7,900 for self-only coverage and $15,800 for family coverage. In addition, the self-only OOP maximum is applied to each covered individual, whether the individual enrolled in self-only coverage or family coverage.

The IRS annually sets a separate and lower OOP maximum exclusively for high-deductible health plans (HDHPs) that can be coupled with health savings accounts (HSAs), known as HSA-qualified HDHPs.

Below are the two sets of limits for 2019 compared with 2018.

	2019	2018
Out-of-pocket limits for ACA-compliant plans (set by HHS)	Self-only: $7,900 Family: $15,800	Self-only: $7,350 Family: $14,700
Out-of-pocket limits for HAS-qualified HDHPs (set by IRS)	Self-only: $6,750 Family: $13,500	Self-only: $6,650 Family: $13,300

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

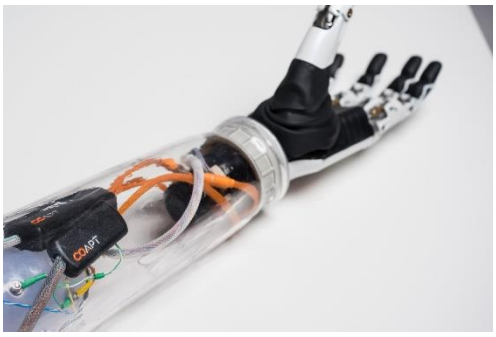
Coordination of health care and other services

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)***
- ***Comagine Health***
- ***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)***
- ***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)***
- ***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

Prosthetic Device



The Ombudsman's office was contacted by a provider regarding a request for assistance with obtaining a replacement myoelectric prosthesis for a 30-year old patient that presented with a left transradial level congenital limb deficiency. The patient's current prosthesis no longer fit or functioned properly, secondary to changes in his residual limb since the device was originally fit three years ago. A new myoelectric prosthesis including COAPT Pattern Recognition controller system with TASKA™ was prescribed by the patient's physician, as it is was deemed the most appropriate device to address his clinical and functional requirements—the device replicates the function of the human wrist and hand.

The device was denied by the insurer based on the Plan's determination that the device was not medically necessary, because the device had electrical or mechanical features that served as a "convenience function".

After a review of the case, we requested reconsideration due to the current prosthesis device no longer fitting or functioning properly, and therefore, replacement of the current prosthesis was medically necessary in order to prevent potential overuse issues. The insurer, after a review by the Medical Director approved the request for the preauthorized service, providing a cost-savings to the member in the amount of $172,923.40.

Prescription Denial

A physician contacted the Ombudsman's office regarding the denial of a prior authorization by the insurer for a patient under his care, prescribed Xiidra. The patient has been taking Xiidra since 2017 for dry eye syndrome of bilateral lacranial glands. Prior to being prescribed Xiidra, the physician had prescribed three other medications: Restasis, Claritin, and Zyrtec—with no relief.

The member's physician 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 physician stated that the patient received symptom relief with Xiidra.

Based on the physician's medical necessity letter, clinical records, researched evidence, and ongoing effectiveness of the prescribed medication, the Ombudsman's office requested a reconsideration of the insurer's denial. 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 $6,300.00.

Hypoglossal Nerve Stimulator

An appeal was filed based on the decision of an insurer to deny implantation of an upper airway stimulation device for hypoglossal nerve, due to obstructive sleep apnea. The insurer denied coverage based on the patient's body mass index (BMI), and the efficacy of the service for patients with a BMI over 32 has not been conclusively confirmed.

The patient has a history of obstructive sleep apnea and was shown to be unable to tolerate continuous positive airway pressure (CPAP). After undergoing a sleep endoscopy, the test revealed that the patient did not have complete concentric collapse of the upper airway.

Our office referred this case to the independent review organization (IRO) due to medical necessity, and provided the physician's medical necessity letter, clinical records, case notes and researched evidence. Based on the IROs review, it was determined that the patient had a trial and failure as well as intolerance to CPAP, leaving limited treatment options available to the patient. The reviewers also concluded that the patient had a BMI of less than the FDA recommendation of 32. As a result, the IRO overturned the denial of the insurer, saving the member approximately $20,000.

Physical Therapy

The Ombudsman's office was contacted by an insurance member regarding a denial for continued physical therapy (PT) treatment. The member began pre-operative PT for complaints of left knee

instability as a result of an ACL repair surgery in 2011. Initially, the insurer approved four sessions of pre-operative PT prior to undergoing ACL revision with patellar tendon autograft and donor cartilage transplant for OCD of the femoral condyle. Subsequently, eight sessions of post-operative PT were approved and completed. Once the eight sessions were completed, the provider requested an additional 14 weeks of PT—which was denied by the insurer.

The Ombudsman's office contacted the provider to retrieve medical records and medical justification to forward to the insurer to request reconsideration. After a review by the insurer, they reversed their adverse benefit determination and approved another 14 weeks of PT, saving the member approximately $3,000.

Allogenic Stem Cell Transplant

The Ombudsman's office received a request from a provider to assist in an appeal for their patient, regarding the decision of an insurer to deny a request for an allogenic stem cell transplant for Stiff Person Syndrome (SPS) or stiff-man syndrome (SMS). The request was denied due to the Plan's determination that the procedure was experimental/investigational based on the absence of published studies demonstrating the efficacy of allogenic stem cell transplant in treatment of SPS, compared to autologous stem cell transplants.

The case was sent to the insurer for reconsideration, along with the medical records and research findings. After a review by the Medical Director of the insurance company, the procedure was approved based on the additional information provided. The member was able to get the procedure, saving the member upwards of $40,000.

Dental Services

A dental provider contacted the Ombudsman's office, on behalf of his patient, regarding a denial for a bone replacement graft. The patient previously had tooth #30 extracted a year prior. There was significant bone loss which caused a boney defect of the alveolar ridge at the furcation down the mesial root. Bone replacement was deemed necessary to rebuild the alveolar ridge to proper height

and width for a hygienic Pontic space for conventional bridge or site preparation for an implant. The insurer denied authorization based on their determination that the procedure was not medically necessary.

Our office contacted the provider to request additional information. The file was sent for review to the independent review organization (IRO), along with peer reviewed literature, medical necessity letter from the treating dentist, and copies of pre-extraction periapical radiographs.

The IRO determined that the procedure was medically necessary based on the determination that ridge preservation procedures with bone grafting are an accepted standard of care in dental practice and substantiated by peer reviewed literature. The reviewers determined that the bone graft was medically necessary, saving the member over $2,000.

Breast Reduction Surgery

A provider contacted our office requesting assistance obtaining prior authorization for a bilateral reduction mammoplasty for his patient. The patient had complaints of neck, back, and shoulder pain secondary to the weight of her breasts. The patient also described intermittent inframammary intertrigo, and shoulder strap grooving. The physician also noted that the patient has significant mammary hyperplasia. The insurer denied authorization for the procedure, based on the determination that the procure was not medically necessary and cosmetic in nature.

Our office requested additional documentation from the provider, to include: medical records, photographs and a letter of medical necessity. The information gathered was forwarded to the insurer, along with a request for reconsideration based on new evidence. Based on the new information, the insurer overturned their previous decision and approved prior authorization, resulting in an approximate $6,000 savings to the member.

Achievements

Office of Health Care Ombudsman and Bill of Rights' Achievements for FY 2019

In FY 2019, 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 system to track walk-ins (consumers that visit the office directly), as the OHCOBR has received an influx of walk-ins since going public in 2014, following the inception of our office in 2010;

- Implemented billing/claims tracking system to track bills/claims to ensure that the bills/claims received are handled to completion;

- Served three percent more consumers in FY 2019 than in the previous year (11,654 in FY 2019 compared to 11,309 in FY 2018);

- Decreased *average number of days to resolve Non-Commercial cases* (1.5 days in FY 2019 compared to 1.8 days in FY 2018);

- Continued to maintain its track record of *resolving most Non-Commercial cases the same day the case was opened.* The office had an 82 percent Non-Commercial same day closure rate, which is in-line with the previous year (9,360 in FY 2019 compared to 9,393 in FY 2018);

- Increased its track record for *resolving most Commercial cases the same day the case was opened.* The office had a 14 percent increase (7 in FY 2019 compared to 6 in FY 2018); and

- Increased the closure rate for Commercial cases (93% in FY 2019 compared to 72% in FY 2018).

- Saved consumers a total of $2,971,024.99, an increase of 34 percent over FY 2018 when $1,956,306.77 was saved on behalf of consumers.

Recommendations

Recommendations for improving performance and outcomes

Based on our experiences during FY 2019, 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 addiction and substance abuse;

- 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 (DOH), Health Regulation and Licensing Administration (HRLA) on quality issues that are found in areas that they regulate;

- Continue to work with the Economic Security Administration (ESA) and DHCF to be considered an out-station in order to receive Alliance members' medical assistance applications;

- 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

- Continue to 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 2019 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 three percent more consumers in FY 2019 than in the previous year (11,654 in FY 2019 compared to 11,309 in FY 2018). [Figure 1]
- Most of the issues raised by persons contacting OHCOBR in FY 2019 (98 percent) were related to public benefits (Medicaid, Medicare, and the Alliance), referred to as 'Non-Commercial' cases in this analysis. [Figure 1]
- OHCOBR maintained its track record of *resolving most Non-Commercial cases the same day the case was opened*. The office had a less than one percent decrease in Non-Commercial same day closures over the previous year (9,359 in FY 2019 vs. 9,393 in FY 2018. [Table 3]
- OHCOBR continued to improve the *average number of days to close a Non-Commercial case*. In FY 2019 the decreased to 1.6 days, vs. 1.8 days in FY 2018. [Table 3, Figure 19]

- Consumers with Dual Eligible-Medicare/Medicaid *and* Medicaid Managed Care (MCO) 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 (45 percent), followed by Access/Coverage including denials (23 percent). [Figure 7] Percentages were even higher for Eligibility issues among contacts concerning MCOs (61 percent or 1,980 of 3,237 cases) [Figure 13] and the Health Care Alliance (72 percent or 266 of 368 cases). [Figure 14]
- Issues concerning commercial insurers (2 percent of all contacts) were more challenging, averaging around four months (109.8 days) compared to nearly three months (99.5 days) in FY 2018 to resolve appeals and grievances cases.
- Consumer savings are reported to be $2,971,024.99, an increase of 34 percent over the $1,956,306.77 captured in FY 2018. [Figure 18]

SELECT FINDINGS FROM THE DATA ANALYSIS

Following are some select details drawn from an analysis of data collected in FY 2019. 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 2019 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 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.)*

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 11,654 cases of all types in FY 2019, a three percent increase over the 11,309 cases opened in FY 2018. [Table 1, Figure 1]

Table 1. Number and Percentage of All Opened Cases by Insurance Category FY18 and FY19

Insurance Category	FY18 Totals	FY18 %	FY19 Totals	FY19 %
Non-Commercial	11,067	98%	11,395	98%
Commercial	242	2%	259	2%
Total Opened Cases	**11,309**	**100%**	**11,654**	**100%**
Annual Variance			**+345**	**+3%**

NON-COMMERCIAL CASES

- Of the 11,654 total cases opened, 98 percent or 11,395 were Non-Commercial cases. Similarly, in FY 2018, Non-Commercial contacts were also 98 percent of all cases opened. [Table 1, Figure 1]

- Of the 11,395 total Non-Commercial cases opened, 3,254 contacts were related to Dual Eligible insurance issues making them the single largest insurance type of all Non-Commercial contacts (28 percent), directly followed by Medicaid Managed Care (MCO) – also 28 percent, but with fewer contacts (3,237). The Dual Eligible category includes issues related to recipients that have both Medicare and Medicaid, and the MCO category are those assigned to one of the three Medicaid health plan carriers contracted in the District.

- Eligibility was the most frequent type of issue raised among all contacts, Non-Commercial and Commercial combined (5,186 cases, 45 percent of 11,654 total contacts). [Figure 7]

- Medicare contacts raised Eligibility issues at the rate of over 41 percent (1,106 of 2,653 cases) [Figure 12]

- Dual Eligible–Medicare/Medicaid contacts raised Eligibility issues at the rate of 34 percent (1,109 of 3,254 cases) [Figure 10]

- Medicaid MCO contacts raised Eligibility issues at the rate of 61 percent (1,980 of 3,237 cases) [Figure 13]

- Medicaid FFS contacts raised Eligibility issues at the rate of 35 percent (561 of 1,602 cases). [Figure 11]
- Alliance contacts raised Eligibility issues at the rate of 72 percent (266 of 368 cases). [Figure 14]
- OHCOBR closed 100 percent of all opened Non-Commercial cases by the end of FY 2019, 11,395 cases. [Table 2, Figure 2]

Table 2. Non-Commercial Cases:
Status and Resolution of Closed and Open Cases at Year-End
FY18 and FY19

Year-End Status and Resolution	FY18 Totals	FY18 %	FY19 Totals	FY19 %
Closed Cases – Successful (In favor of the consumer)	11,001	99%	11,384	>99%
Closed Cases – Unsuccessful (Not in favor of the consumer)	44	<1%	11	<1%
Closed Cases (Referred Out) –Resolution Undetermined	0	0%	0	0%
Closed Cases - Sub-Total	**11,045**	**>99%**	**11,395**	**100%**
Open Cases – Still Pending Resolution	**22**	**<1%**	**0**	**0%**
Total All Non-Commercial Cases (Closed and Open)	**11,067**	**100%**	**11,395**	**100%**

- On average, Non-Commercial cases were closed in 1.6 days; In comparison, in FY 2018, average resolution time remained the same at 1.8 days. [Table 3, Figure 19]
- Of all Non-Commercial cases, OHCOBR resolved 82 percent *on the same day they were opened,* 9,359 cases. Compared to FY 2018, when 9,393 cases were closed on the same day (85 percent). [Table 3, Figure 19]

Table 3. Non-Commercial Cases: Analysis of Days to Close a Case FY18 and FY19			
FY18 # of Cases Closed	**FY18 Average # of Days to Close**	**FY19 # of Cases Closed**	**FY19 Average # of Days to Close**
11,045	**1.8 days**	**11,395**	**1.6 days**
FY18 Same-Day Closure Cases		**FY19 Same-Day Closure Cases**	
9,393 of 11,045 total Non-Commercial cases (85%)		**9,359 of 11,395 total Non-Commercial cases (82%)**	
Annual Variance of Same-Day Closures		**-34 cases**	**<1% decrease in # of cases**

COMMERCIAL CASES - APPEALS AND GRIEVANCES

- Cases related to Commercial Health Plans represented two percent of all cases opened in FY 2019 (259 of 11,654 total cases). A slight increase in the number of commercial cases that were opened in FY 2018 (242). [Table 1, Figure 1]

- Of the 259 Commercial cases opened in FY 2019, 126 (49 percent) were related to Not Eligible for Health Plan/Benefit, 106 (41 percent) were related to Medical Necessity, 17 (>6 percent) were related to Experimental/Investigational, 9 (3 percent) covered a wide range of Other generic complaints and issues, and 1 (<1 percent) was related to Part D Prescription Plans. [Table 4, Figure 9]

- Although the total number of Commercial grievances is similar for both FY 2019 and FY 2018 the distribution of those cases is significantly different in two ways. In FY 2019, Medical Necessity increased from 31 percent to 41 percent, and Other cases decreased from 10 percent to 3 percent. [Table 4, Figure 9]

Table 4. Commercial Cases: Appeals/Grievances Types of Issues Encountered FY18 and FY19				
Issues	**FY18 Cases**	**FY18 % of Total**	**FY19 Cases**	**FY19 % of Total**
Care Is Experimental/Investigational	20	8%	17	>6%
Care Is Not Medically Necessary	76	32%	106	41%
Not Eligible for Health Plan/Benefit	112	47%	126	49%
***Other Issues**	24	12%	9	3%
Part D Prescription Plan	3	1%	1	<1%
Rescission	0	0%	**0**	%
Undetermined	0	0%	**0**	%
Total Issues (Commercial Cases)	**242**	**100%**	**259**	**100%**

- In FY 2019, 93 percent (240 cases) of all Commercial cases were closed, compared to 72 percent (175 cases) in FY 2018. [Table 5, Figure 3]

- In FY 2019, only seven percent remained open by the end of the fiscal year (19 cases), compared to 28 percent (67 cases) that remained open at the end of FY 2018. [Table 5, Figure 3]

- Of the 240 Commercial Cases opened in FY 2019, 196 cases (76 percent) were resolved successfully in favor of the consumer, an increase in comparison to 119 cases (49 percent) in FY 2018. [Table 5, Figure 21]

Table 5. Commercial Cases: Status and Resolution of Cases at Year-End FY18 and FY19				
Year-End Status and Resolution	**FY18 Totals**	**FY18 %**	**FY19 Totals**	**FY19 %**
Closed Cases – Successful (In favor of the consumer)	119	49%	196	76%
Closed Cases – Unsuccessful (Not in favor of the consumer)	51	21%	34	13%
Closed Cases (Referred Out) – Resolution Undetermined	5	2%	10	4%
Closed Cases - Sub-Total	175	72%	240	93%
Open Cases – Still Pending Resolution	67	28%	19	7%
Total All Non-Commercial Cases (Closed and Open)	**242**	**100%**	**259**	**100%**

- It took an average of 109.8 days to resolve or close a Commercial case [Table 6, Figure 20]. This represents an increase of 10.3 days (9 percent) in *the average days to resolve or close a case* compared to 99.5 days in FY 2018.

- OHCOBR resolved or closed 8 Commercial cases (3 percent) *on the same day they were opened*. For comparison, in FY 2018, 6 of 242 total cases (2 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 FY18 and FY19

FY18 # of Cases Closed	FY18 Average # of Days to Close	FY19 # of Cases Closed	FY19 Average # of Days to Close
175	99.5 days	240	109.8 days
FY18 Same-Day Closure Cases		FY19 Same-Day Closure Cases	
6 of 242 total Commercial cases (2%)		8 of 259 total Commercial cases (3%)	
FY19 Variance - Same-Day Closures		2 More Cases	1% Increase

CONSUMER SAVINGS

- In FY 2019, the OHCOBR saved consumers a total of $2,971,024.99. This represents an increase of 34 percent over FY 2018 when $1,956,306.77 was saved on behalf of consumers. This increase can be attributed to a more precise data collection and reporting methodology in FY 2019. [Figure 18]

- Of the total amount saved, $2,495,165.85 (84 percent) was from resolved Commercial Cases; $88,424.46 (3 percent) was saved or recouped on behalf of Medicaid fee-for-service, MCO and Alliance beneficiaries; $15,288.78 (0.5 percent) was saved or recouped on behalf of QMB beneficiaries for co-payments; and $372,145.90 (12.5 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, 91 percent, utilized the telephone to contact OHCOBR (10,656 of 11,654 total contacts). This continues to be the preferred method for contacting the office. In FY 2018, 93 percent of total contacts were made by telephone (10,558 of 11,309 total contacts), and in FY 2017, 95 percent of total contacts were made by telephone (8,760 of 9,250 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 (2,127) had the highest number of contacts to the OHCOBR with 18 percent. The next highest number of contacts originated from Ward 8 (1,946) with 17 percent. [Table 7, Figure 6]

Table 7. Contacts Located in and Out of the DC Metropolitan Area FY18 and FY19

Location of Contacts	FY18 # Contacts	FY18 % Contacts	FY19 # Contacts	FY19 % Contacts
Ward 1	1,199	11%	1,354	12%
Ward 2	1,258	11%	1,240	11%
Ward 3	459	4%	367	3%
Ward 4	1,406	12%	1,536	13%
Ward 5	1,658	15%	1,796	15%
Ward 6	1,142	10%	1,077	9%
Ward 7	2,183	19%	2,127	18%
Ward 8	1,782	16%	1,946	17%
Maryland (Located Within the DC Metropolitan Area)	26	<1%	16	<1%
Out-of-Country	0	0%	0	0%
Out-of-State (States Located Outside of the DC Metropolitan Area)	150	1%	159	1%
Undetermined	27	<1%	15	<1%
Virginia (Located Outside of the DC Metropolitan Area)	19	<1%	21	<1%
TOTALS	**11,309**	**100%**	**11,654**	**100%**

- Eligibility continues to be the most frequent type of issue from all types of consumers combined, at 45 percent or 5,186 total cases [Figure 7]. It was also the most frequent issue in FY 2018, 44 percent or 4,986 total cases, and in FY 2017, 41 percent or 3,757 total cases.

- Eligibility issues were the largest type of issue raised by Dual Eligible (Medicare and Medicaid) contacts (34 percent or 1,109 of 3,254 cases). Similarly, in FY 2018, Eligibility issues were the largest category (36 percent or 1,123 out of 3,141 cases). [Figure 10]

- Of the 911 Administrative/Fair Hearing cases filed by OHCOBR on behalf of all types of contacts, 41 percent were filed on behalf of EPD Waiver beneficiaries (532 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, 154 cases and 16 percent in FY 2018, and 532 cases and 41 percent in FY 2019. [Table 8, Figure 20]

- A total of 1,287 EPD Waiver Cases were opened in FY 2019, 25 percent more than the 968 cases opened in FY 2018. [Table 8, Figure 20]

Table 8. Types of Issues Encountered by EPD Waiver Contacts	FY18 # of Contacts	FY18 % of Contacts	FY19 # of Contacts	FY19 % of Contacts
Access (Administrative Hearings)	154	16%	532	41%
Access (Including Prior Authorizations)	233	24%	209	16%
Coverage/Service Denials	37	4%	29	2%
Eligibility/Verification of Coverage	321	33%	304	24%
Non-Payment/Reimbursement (Out-of-Pocket Expenses)	29	3%	27	2%
Other Issues	95	10%	124	10%
Quality of Services by Providers	99	10%	62	5%
Totals	**968**	**100%**	**1,287**	**100%**

- In FY 2019, a total of 121 Transportation Cases were opened compared to 134 in FY 2018, a 10 percent decrease. [Figure 15]

- A total of 763 DC Health Link and Health Care Exchange Marketplace cases were opened in FY 2019, compared to the 797 cases in FY 2018. [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 FY18 and FY19

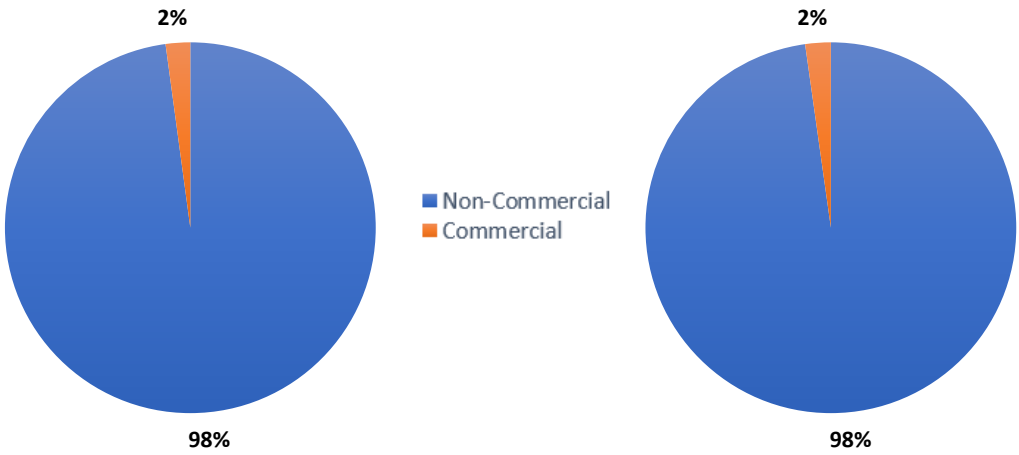
FY18	FY19
	
FY18 Total Sample = 11,309 Contacts	FY19 Total Sample = 11,654 Contacts

Figure 2. Number and Percentage of Resolved/Closed Cases and Cases Not Resolved/Closed Among (Non-Commercial) Contacts FY18 and FY19

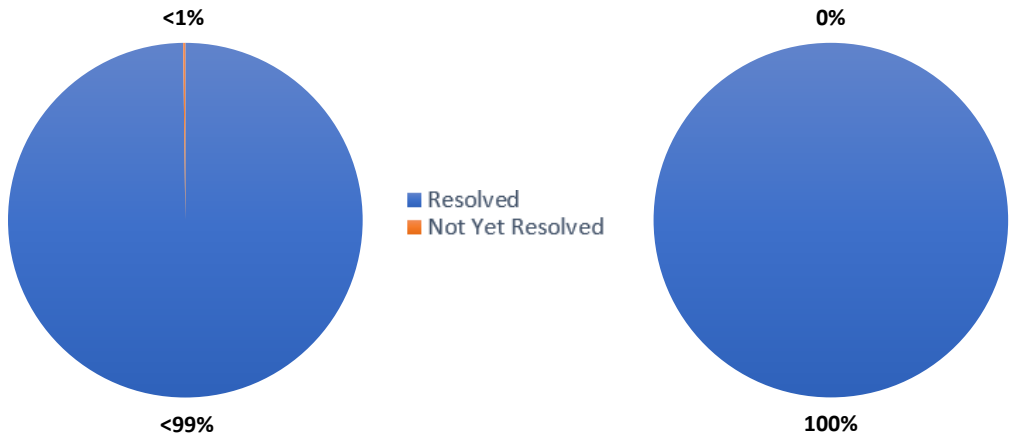
FY18	FY19
	
FY18 Total Sample = 11,067 Contacts	FY19 Total Sample = 11,395 Contacts

Figure 3. Number and Percentage of Resolved/Closed Cases and Cases Not Resolved/Closed Among (Commercial-Appeals/Grievances-Bill of Rights) Contacts FY18 and FY19

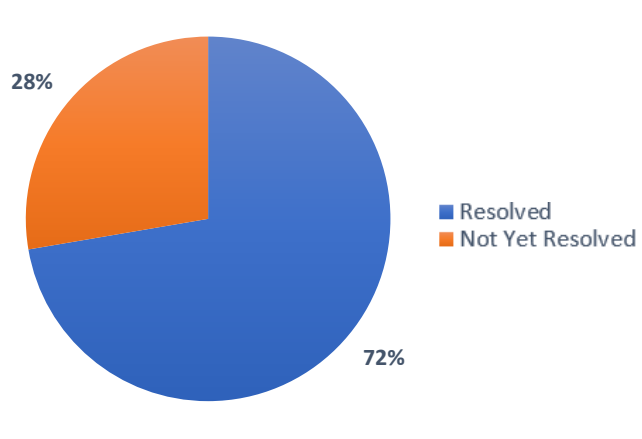
FY18	FY19
	
FY18 Total Sample = 242 Contacts	FY19 Total Sample = 259 Contacts

Figure 4. Methods of Contacting the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) FY18 and FY19

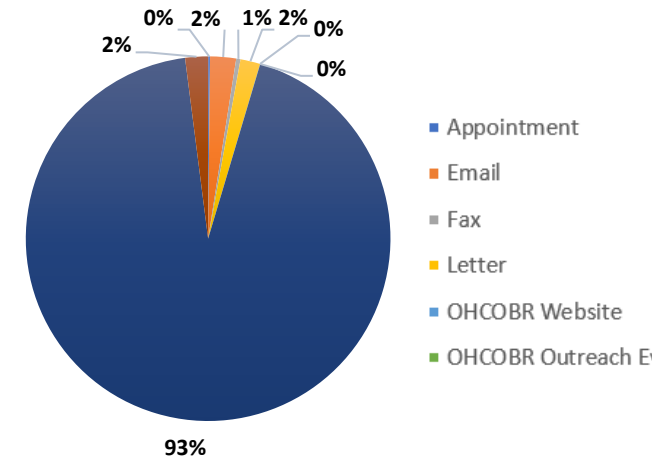
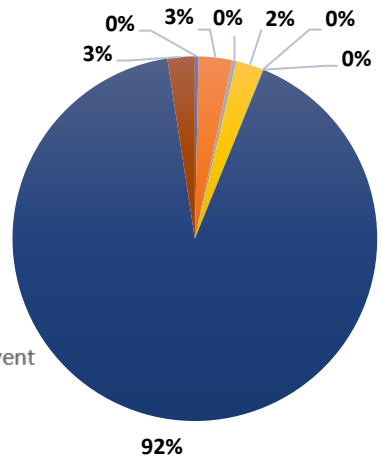
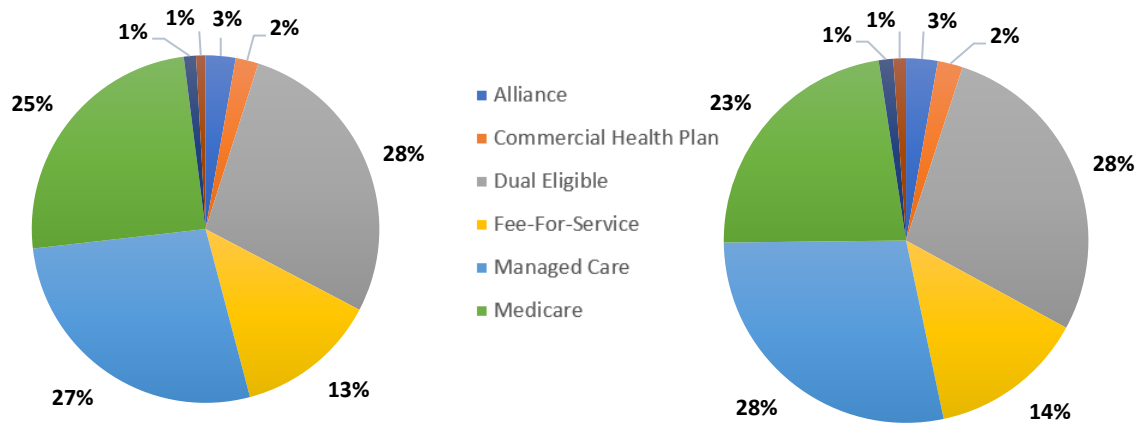
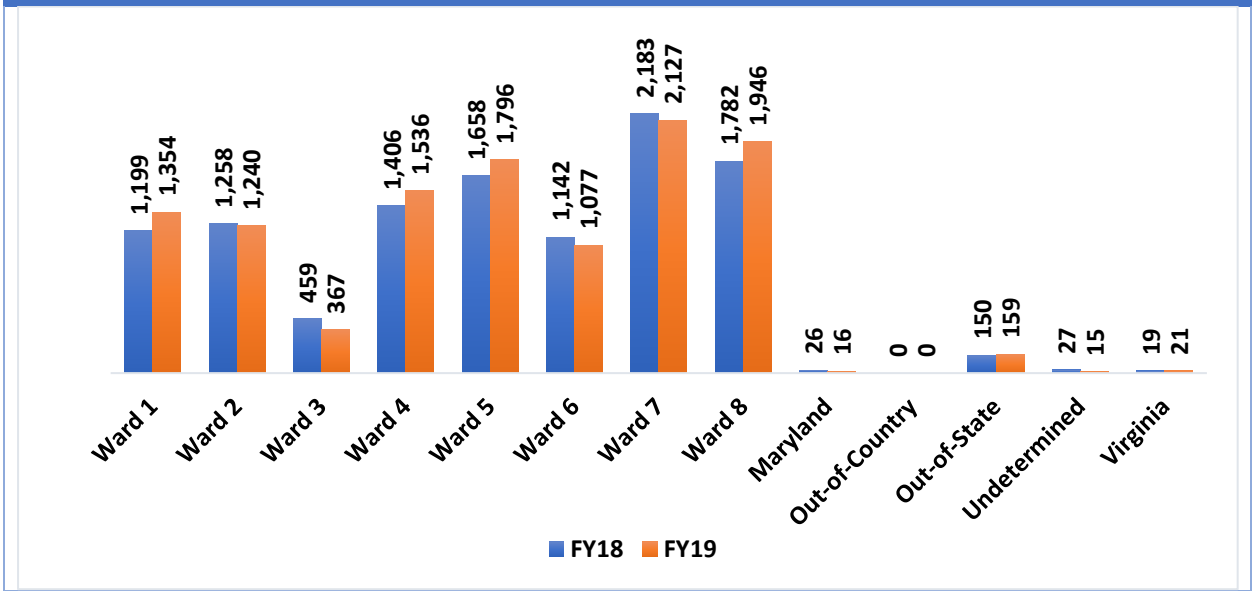
FY18	FY19
	
FY18 Total Sample = 11,309 Contacts	FY19 Total Sample = 11,654 Contacts

Figure 5. Categories of Contacts by Insurance Type FY18 and FY19



FY18 Total Sample = 11,309 Contacts	FY19 Total Sample = 11,654 Contacts

Figure 6. Contacts by Wards and States Located Within the DC Metropolitan Area and States Located Outside of the DC Metropolitan Area FY18 and FY19



FY18 Total Sample = 11,309 Contacts	FY19 Total Sample = 11,654 Contacts

Figure 7. Breakdown of Types of Issues Encountered by All Contacts – (Non-Commercial); and (Commercial-Appeals/Grievances-Bill of Rights) FY18 and FY19

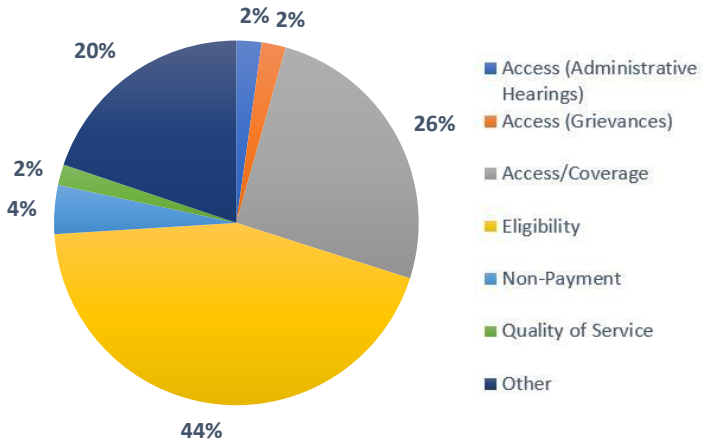
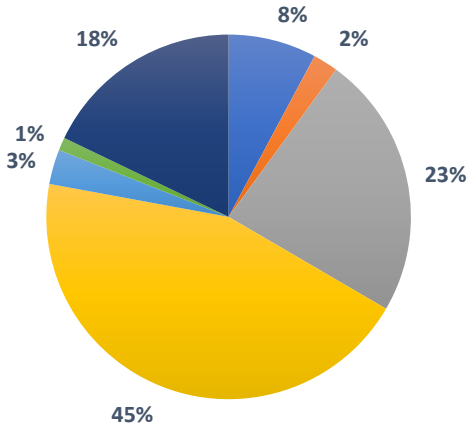
FY18	FY19
	
FY18 Total Sample = 11,309 Contacts	FY19 Total Sample = 11,654 Contacts

Figure 8. Breakdown of Types of Issues Encountered by (Non-Commercial) Contacts FY18 and FY19

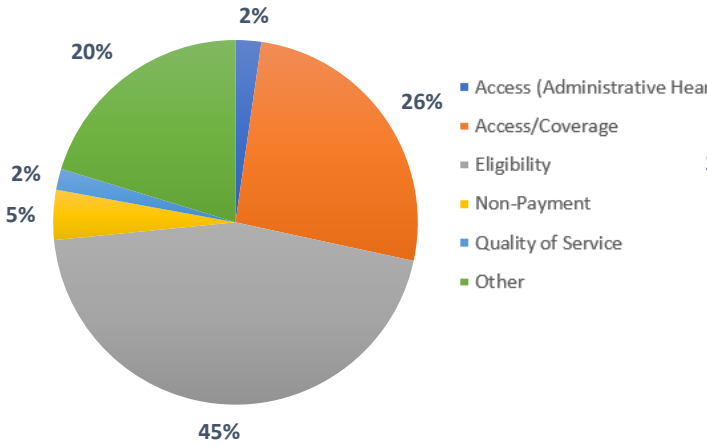
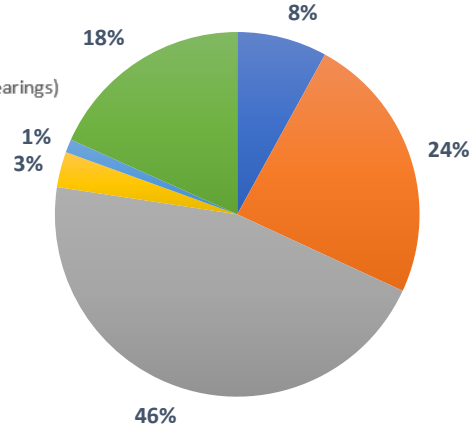
FY18	FY19
	
FY18 Total Sample = 11,067 Contacts	FY19 Total Sample = 11,395 Contacts

Figure 9. Breakdown of Types of Issues Encountered by (Commercial-Appeals/Grievances-Bill of Rights) Contacts FY18 and FY19

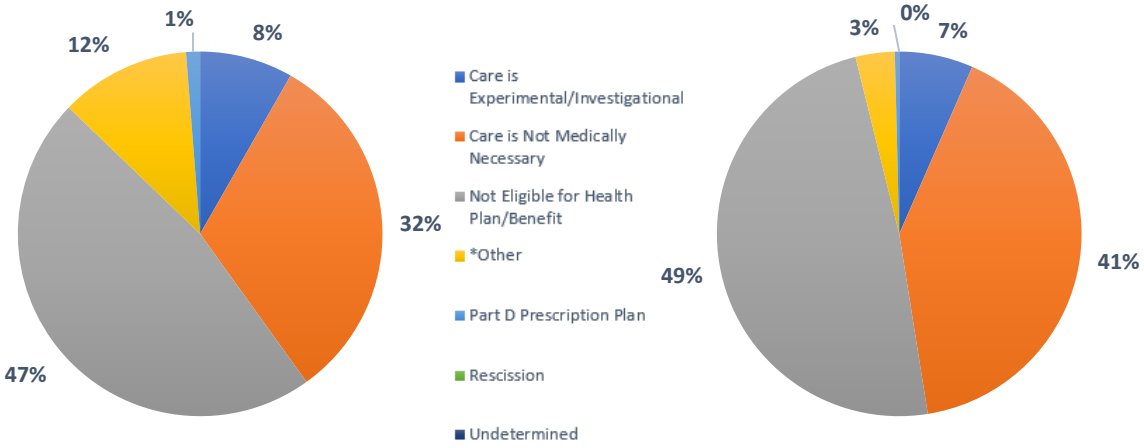
FY18	FY19
	
FY18 Total Sample = 242 Contacts	FY19 Total Sample = 259 Contacts

Figure 10. Breakdown of Types of Issues Encountered by Dual Eligible (Medicare and Medicaid) Contacts FY18 and FY19

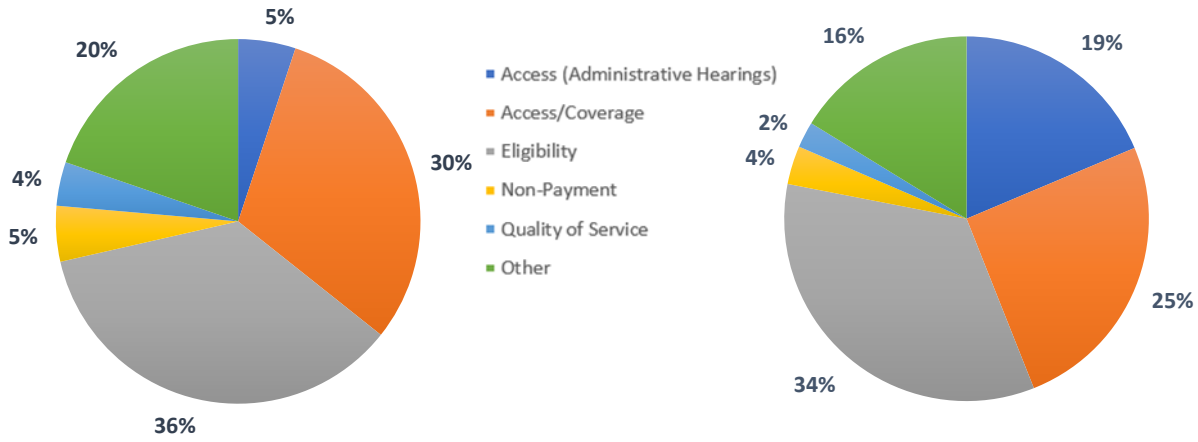
FY18	FY19
	
FY18 Total Sample = 3,141 Contacts	FY19 Total Sample = 3,254 Contacts

Figure 11. Breakdown of Types of Issues Encountered by Medicaid Fee-for-Service (FFS) Contacts FY18 and FY19

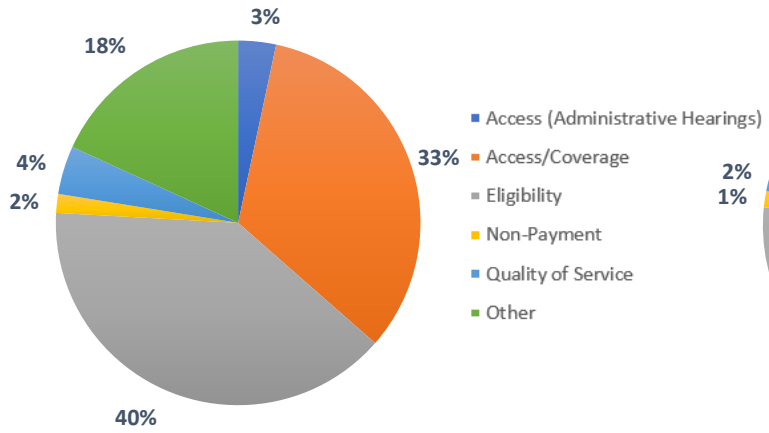
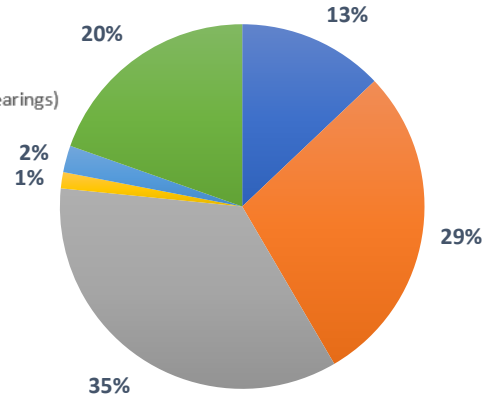
FY18	FY19
	
FY18 Total Sample = 1,492 Contacts	FY19 Total Sample = 1,602 Contacts

Figure 12. Breakdown of Types of Issues Encountered by Medicare Part A; Part B; Part A/B; Part A/B (QMB) Contacts FY18 and FY19

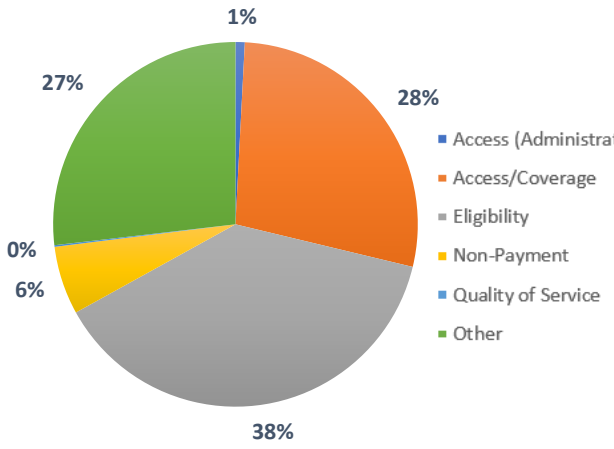
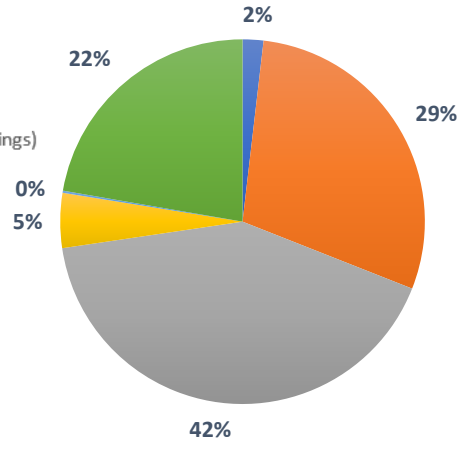
FY18	FY19
	
FY18 Total Sample = 2,803 Contacts	FY19 Total Sample = 2,653 Contacts

Figure 13. Breakdown of Types of Issues Encountered by Medicaid Managed Care (MCO) Contacts FY18 and FY19

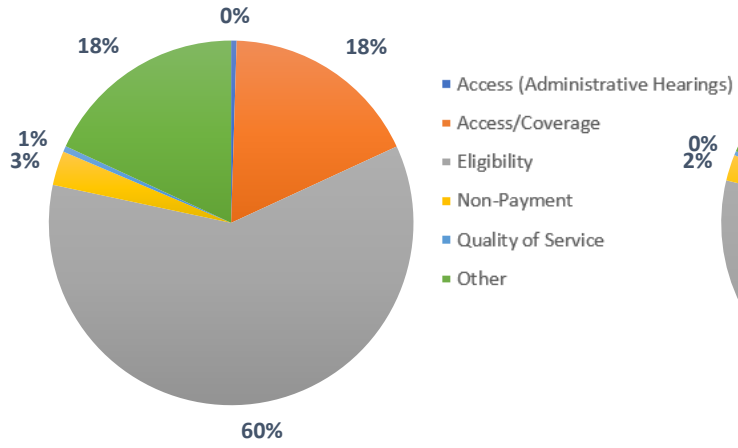
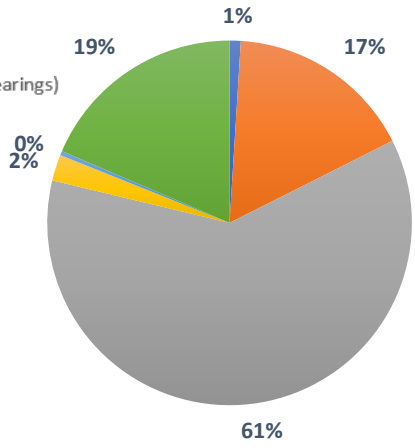
FY18	FY19
	
FY18 Total Sample = 3,090 Contacts	FY19 Total Sample = 3,237 Contacts

Figure 14. Breakdown of Types of Issues Encountered by Alliance Contacts FY18 and FY19

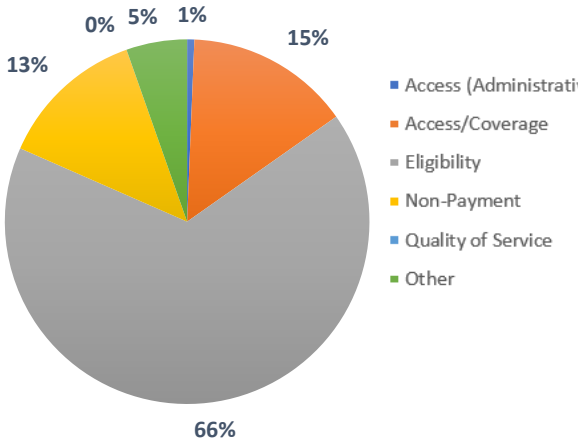
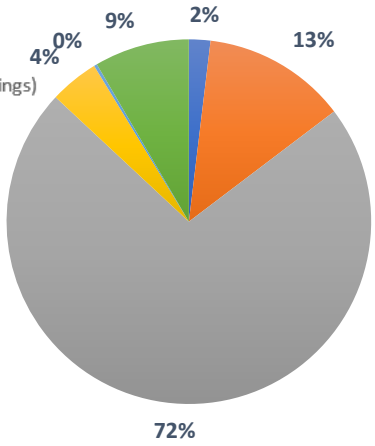
FY18	FY19
	
FY18 Total Sample = 315 Contacts	FY19 Total Sample = 368 Contacts

Figure 15. Breakdown of Transportation Contacts by Insurance Type FY18 and FY19

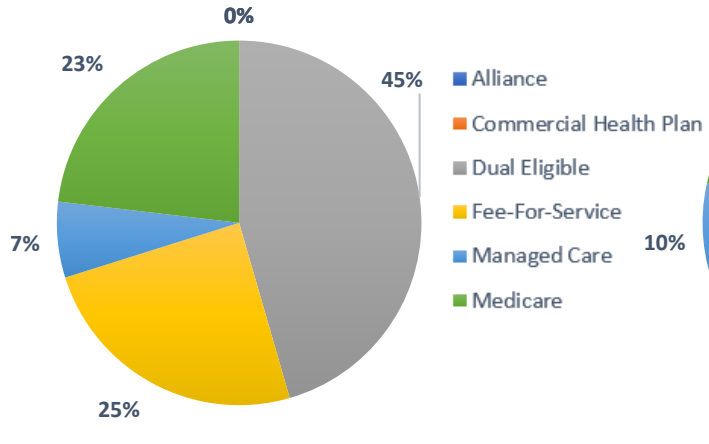
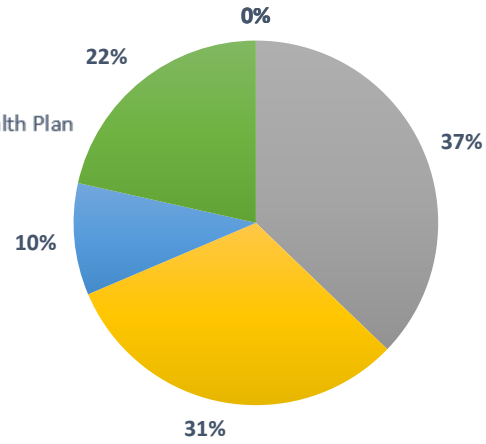
FY18	FY19
	
FY18 Total Sample = 134 Contacts	FY19 Total Sample = 121 Contacts

Figure 16. Breakdown of Types of Issues Encountered by EPD Waiver Contacts FY18 and FY19

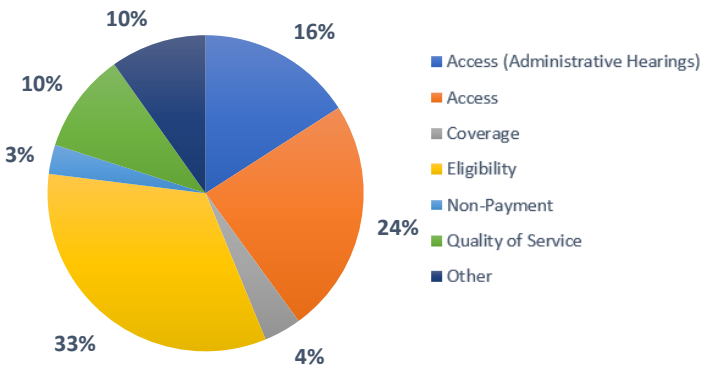
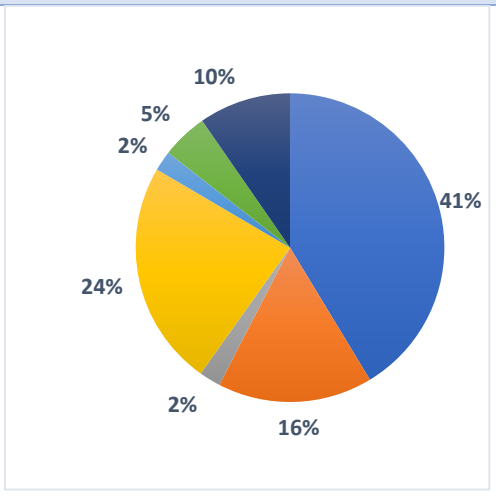
FY18	FY19
	
FY18 Total Sample = 968 Contacts	FY19 Total Sample = 1,287 Contacts

Figure 17. Breakdown of Types of Issues Encountered by DC Health Link and Health Exchange Marketplace Contacts FY18 and FY19

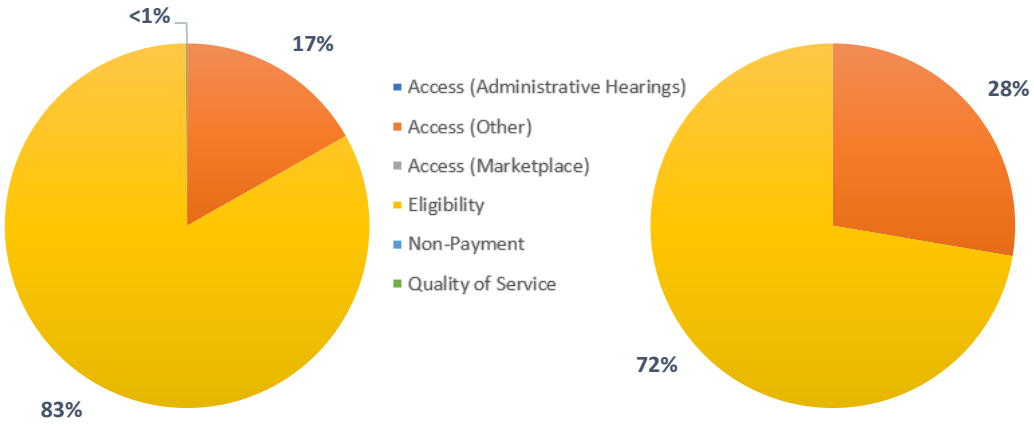
FY18	FY19
	
FY18 Total Sample = 797 Contacts	FY19 Total Sample = 748 Contacts

Figure 18. Dollar Amount of Savings on Behalf of (Non-Commercial); and (Commercial-Appeals/Grievances-Bill of Rights) Contacts FY18 and FY19

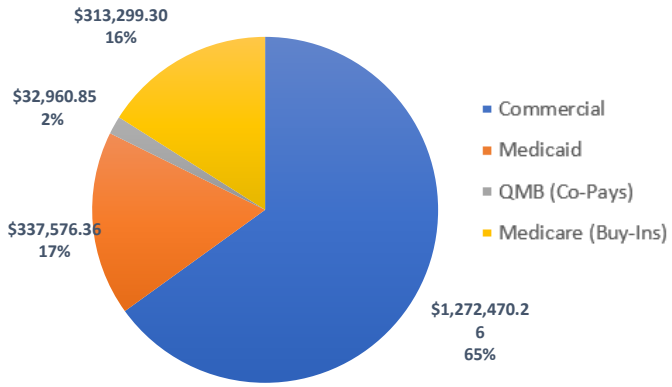
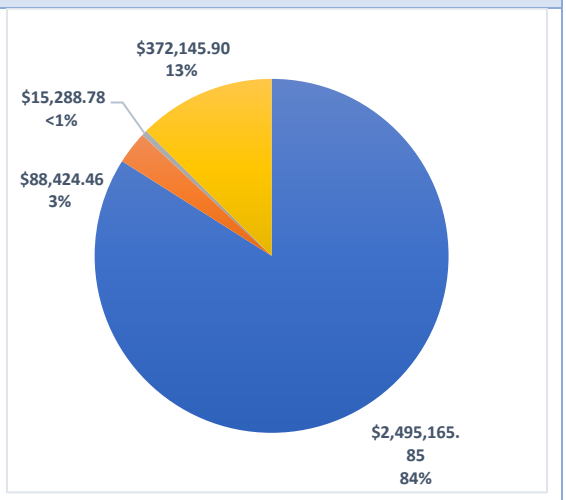
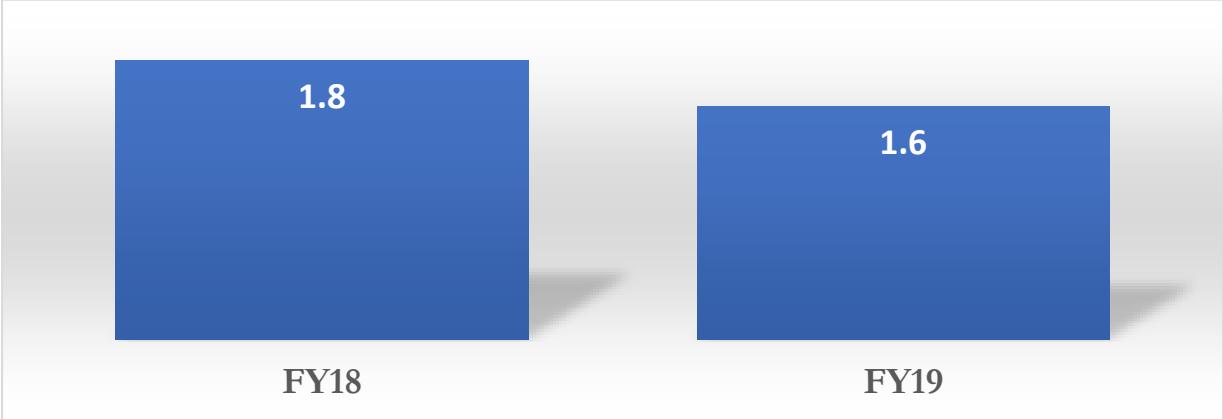
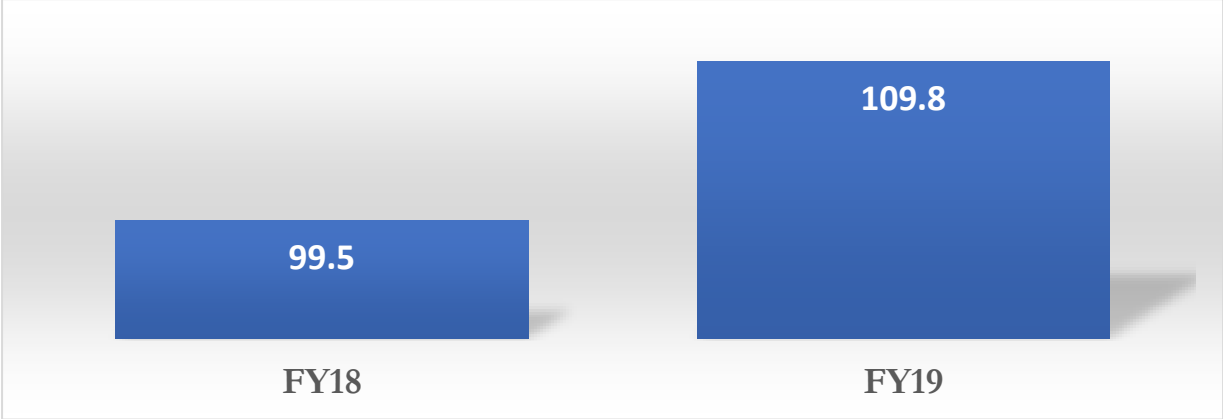
FY18	FY19
	
FY18 Total Sample = 242 Contacts	FY19 Total Sample = 259 Contacts

Figure 19. Average Number of Days to Resolve/Close (Non-Commercial) Cases FY18 and FY19



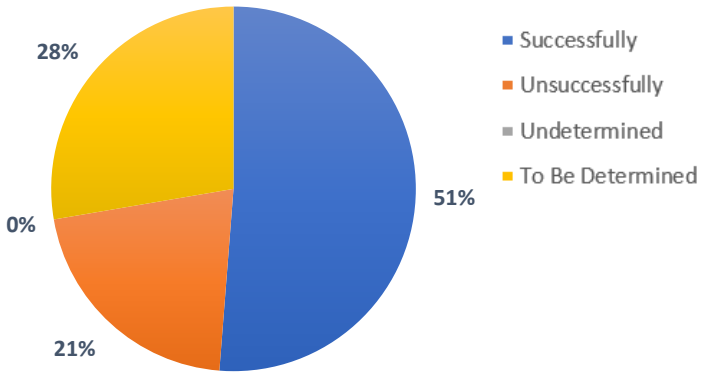
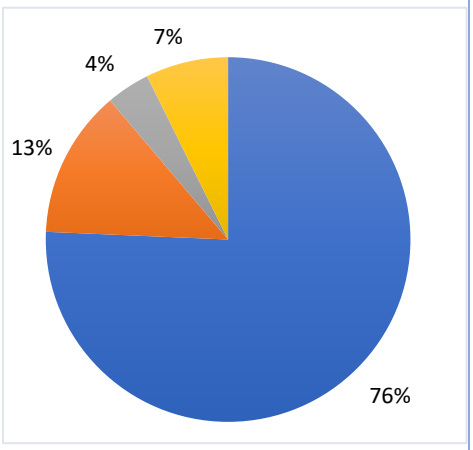
FY18 Total Cases Resolved/Closed = 11,067 Contacts	FY19 Total Cases Resolved/Closed = 11,654 Contacts

Figure 20. Average Number of Days to Resolve/Close (Commercial-Appeals/Grievances-Bill of Rights) Cases FY18 and FY19



FY18 Total Cases Resolved/Closed = 175 Contacts	FY19 Total Cases Resolved/Closed = 240 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 FY18 and FY19

FY18	FY19
	
FY18 Total Sample = 242 Contacts	**FY19 Total Sample = 259 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 – FY 2019
OCTOBER 1, 2018 THROUGH SEPTEMBER 30, 2019

EVENT DATE	OHCOBR'S PARTICIPATION	NAME OF ORGANIZATION/GROUP	NUMBER OF ATTENDEES
OCTOBER 23, 2018	EXHIBITOR	WARD 3 – ANNUAL MAYOR'S DISABILITY AWARENESS EXPO – UDC STUDENT CENTER – 4200 CONNECTICUT AVE, NW	500 ATTENDEES
NOVEMBER 13, 2018	EXHIBITOR	WARD 6 – DCHR – OPEN ENROLLMENT FAIR – OFFICE OF THE CHIEF FINANCIAL OFFICER – 1101 4TH STREET, SW	550 ATTENDEES
NOVEMBER 14, 2018	EXHIBITOR	WARD 2 – DCHR – OPEN ENROLLMENT FAIR – JOHN A. WILSON BUILDING – 1350 PENNSYVANIA AVENUE, NW	550 ATTENDEES
NOVEMBER 15, 2018	EXHIBITOR	WARD 5 – DCHR – OPEN ENROLLMENT FAIR – DEPARTMENT OF BEHAVIORAL HEALTH – 64 NEW YORK AVENUE, NW	550 ATTENDEES
NOVEMBER 21, 2018	EXHIBITOR	WARD 2 – SAFEWAY FEAST OF SHARING EXPO WALTER E. WASHINGTON CONVENTION CENTER 901 MOUNT VERNON PLACE, NW	6,000 ATTENDEES
NOVEMBER 27, 2018	EXHIBITOR	WARD 5 – DCHR – OPEN ENROLLMENT FAIR – DC PUBLIC SCHOOLS CENTRAL OFFICE 1200 FIRST STREET, NE	550 ATTENDEES
NOVEMBER 28, 2018	EXHIBITOR	WARD 2 – DCHR – OPEN ENROLLMENT FAIR – ONE JUDICIARY SQUARE – 441 4TH STREET, NW	550 ATTENDEES
DECEMBER 5, 2018	EXHIBITOR	WARD 5 – DCHR – OPEN ENROLLMENT FAIR – DC HOUSING AUTHORITY 1133 N. CAPITOL STREET, NE	550 ATTENDEES
DECEMBER 6, 2018	EXHIBITOR	WARD 6 – DCHR – OPEN ENROLLMENT FAIR – FRANK D. REEVES CENTER 2000 14TH STREET, NW	550 ATTENDEES
DECEMBER 12, 2018	EXHIBITOR	WARD 6 – MAYOR'S 2017 SENIOR HOLIDAY CELEBRATION DC ARMORY2001 EAST CAPITOL STREET, SE HEALTH, WELLNESS AND INFORMATIONAL FAIR	5,000 ATTENDEES
JANUARY 11 & 12, 2019	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
FEBRUARY 11, 2019	SPEAKER	WARD 5 – EDGEWOOD RESIDENTS – 635 EDGEWOOD STREET, NE	30 ATTENDEES
FEBRUARY 13, 2019	EXHIBITOR	WARD 3 – HATTIE HOLMES SENIOR WELLNESS CENTER – COMMUNITY HEALTH & WELLNESS FAIR – 324 KENNEDY STREET, NW	200 ATTENDEES
FEBRUARY 26, 2019	EXHIBITOR	WARD 7 – SHAWN PERRY'S SENIOR SPA DAY – FORT STANTON RECREATION CENTER – 1812 ERIE STREET, SE	50 ATTENDEES
FEBRUARY 27, 2019	EXHIBITOR	WARD 6 – DCOA AND COLLABORATING PARTNERS SUPPORTS YOUNG AT HEART SENIOR HEALTH & RESOURCE FAIR – BRENTWOOD RECREATION CENTER – 2311 14TH STREET, NEBENNING RIDGE CIVIC ASSOCIATION FIRST ANNUAL HEALTH & RESOURCE FAIR BENNING RIDGE COMMUNITY CENTER – 830 RIDGE ROAD, NE	25 ATTENDEES

MARCH 20, 2019	EXHIBITOR	WARD 3 – SHAWN PERRY'S SENIOR SPA DAY – EMERY RECREATION CENTER – 5701 GEORGIA AVENUE, NW	100 ATTENDEES
APRIL 8, 2019	EXHIBITOR	WARD 2 – JAMES APARTMENTS – COMMUNITY HEALTH AND WELLNESS – 1425 N STREET, NW	200 ATTENDEES
APRIL 9, 2019	EXHIBITOR	WARD 5 – GOLDEN RULE APARTMENTS – 2ND ANNUAL COMMUNITY RESOURCE FAIR – 1050 NEW JERSEY AVENUE, NW	200 ATTENDEES
APRIL 10, 2019	EXHIBITOR	WARD 5 – WTU RETIREES CHAPTER – 6TH ANNUAL HEALTH & RESOURCE FAIR	200 ATTENDEES
APRIL 20, 2019	EXHIBITOR	WARD 5 – EARTH DAY CELEBRATION – ENVIRONMENTAL COMMUNITY HEALTH & WELLNESS & RESOURCES FAIR – EMERY RECREATION CENTER – 5701 GEORGIA AVENUE, NW	500 ATTENDEES
APRIL 30, 2019	ORANIZER/SPEAKER/ EXHIBITOR	WARD 6 – HEALTH CARE RESOURCE FAIR FOR DENTAL TOWERS SENIORS – FLORIDA AVENUE, NE	75 ATTENDEES
MAY 1, 2019	ORGANIZER/SPEAKER/ EXHIBITOR	WARD 5 – HEALTH CARE RESOURCE FAIR FOR FORT LINCOLN'S SENIORS – 3001 BLADENSBURG ROAD, NE	50 ATTENDEES
MAY 7, 2019	EXHIBITOR	WARD 4 – OLDER AMERICANS MONTH COMMUNITY HEALTH, WELLNESS & RESOURCE FAIR – ROCK CREEK CHURCH ROAD @ WEBSTER STREET, NW	400 ATTENDEES
MAY 16, 2019	EXHIBITOR	WARD 8 – 6TH ANNUAL CPDC AMERICANS MONTH 2019 CONNECT, CREATE, CONTRIBUTE – HEALTH & RESOURCE FAIR – BALD EAGLE RECREATION CENTER – 185 JOLIET STREET, SE	50 ATTENDEES
MAY 23, 2019	EXHIBITOR	WARD 5 – SEABURY RESOURCES FOR AGING – WARD 5 COMMUNITY DAY CELEBRATION – "SENIORS DAY OUT" – 1250 SARATOGA STREET, NE	75 ATTENDEES
MAY 24, 2019	SPEAKER	WARD 3 – DACL AND PARTNERS – HOUSING AUTHORITY AND REGENCY APPARTMENTS 2ND ANNUAL COMMUNITY HEALTH & RESOURCE FAIR – 5201 CONNECTICUT AVENUE, NW	75 ATTENDEES
MAY 29 2019	EXHIBITOR	WARD 5 – MODEL CITIES WELLNESS CENTER HEALTH FAIR – 1901 EVARTS STREET, NE	100 ATTENDEES
JUNE 1, 2019	EXHIBITOR	WARD 6 – MAYA FESTIVAL – MAYA HIGH SCHOOL – 5600 EAST CAPITOL STREET, NE	900 ATTENDEES
JUNE 12, 2019	EXHIBITOR	WARD 3 – 3RD ANNUAL UDC CAUSES AND DACL ANNUAL HEALTH FAIR – NEW STUDENT CENTER – 4200 CONNECTICUT AVENUE, NW	2,500 TO 3,000 ATTENDEES
JUNE 19, 2019	EXHIBITOR	WARD 8 – MAYOR'S 8TH ANNUAL SENIOR SYMPOSIUM – BALLOU HIGH SCHOOL – 3401 4TH STREET, SE	600 ATTENDEES
JUNE 28, 2019	EXHIBITOR	WARD 8 – MAYOR'S SENIOR FEST – OXON RUN PARK – 900 WHEELER ROAD & VALLEY STREET, SE	1,000 ATTENDEES
JULY 8, 2019	EXHIBITOR	WARD 6 – GREENLEAF SENIOR BUILDING – COMMUNITY HEALTH FAIR – 1200 DELAWARE AVENUE, SW	100 ATTENDEES
JULY 10, 2019	EXHIBITOR	WARD 6 – CAPITOL HILL TOWERS – COMMUNITY HEALTH & WELLNESS FAIR – 900 G STREET, NE	75 ATTENDEES
JULY 12, 2019	EXHIBITOR	WARD 8 – HEALTH CARE POP-UP – TRUSTED HEALTH PLAN (BRIDGEPORT) – FIELD BETWEEN TRENTON PLACE & MISSISSIPPI AVENUE, SE	75 ATTENDEES

JULY 12, 2019	EXHIBITOR	WARD 8 – ST. PAUL SENIOR CENTER HEALTH AND RESOURCES FAIR WITH 7TH DISTRICT MPD – 114 WAYNE PLACE, SE	150 ATTENDEES
JULY 15, 2019	EXHIBITOR	WARD 5 – A DAY OF SERVICE – CENTRAL UNION MISSION – 3194 BLADENSBURG ROAD, NE	75 ATTENDEES
JULY 17, 2019	EXHIBITOR	WARD 3 – A DAY OF SERVICE – CENTRAL UNION MISSION SHELTER – 65 MASSACHUSETTS AVENUE, NW	150 ATTENDEES
JULY 19, 2019	EXHIBITOR	WARD 8 – HEALTH CARE POP-UP – TRUSTED HEALTH PLAN (BRIDGEPORT) – CORNER OF 9TH & BARNABY OR BARNABY & ATLANTIC AVENUE, SE	75 ATTENDEES
JULY 22, 2019	EXHIBITOR	WARD 8 – HEALTH CARE POP-UP – TRUSTED HEALTH PLAN (BRIDEPORT) – CORNERS OF EATON & WADE ROAD, SE	75 ATTENDEES
JULY 26, 2019	EXHIBITOR	WARD 8 – HEALTH CARE POP-UP – BREAST CARE FOR WASHINGTON – PARKING LOT ON CORNER OF LANGSTON RAYNOLDS PLACE, SE	75 ATTENDEES
JULY 29, 2019	EXHIBITOR	WARD 8 – HEALTH CARE POP-UP TRUSTED HEALTH PLAN (BRIDGEPORT) – BALD EAGLE RECREATION CENTER – 100 JOLIET STREET, SW	75 ATTENDEES
AUGUST 3, 2019	EXHIBITOR	WARD 5 – ISRAEL BABTIST/UNITY HEALTH CENTER – HEALTH FAIR – 1251 SARATOGA AVENUE, NE	350 ATTENDEES
AUGUST 14, 2019	EXHIBITOR	DME PROVIDERS – HOT TOPICS – TELEPHONE CONFERENCE CALL IN	50 ATTENDEES
AUGUST 23, 2019	EXHIBITOR	WARD 8 – 11TH ANNUAL OLMSTEAD COMMUNITY INTEGRATION CONFERENCE – THE ARC – 1901 MISSISSIPPI AVENUE, SE	200 ATTENDEES
SEPTEMBER 14, 2019	EXHIBITOR	WARD 5 – GETHSEMANE BAPTIST CHURCH – ANNUAL SUMMER COOKOUT – 5119 4TH STREET, NW	300 ATTENDEES
SEPTEMBER 18, 2019	EXHIBITOR	WARD 8 – 4TH ANNUAL DC SENIOR WELLNESS BBQ – GATEWAY DC PAVILLIAN – 2700 MLK JR AVENUE, SE	250 ATTENDEES
SEPTEMBER 19, 2019	EXHIBITOR	WARD 3 – 5TH ANNUAL HEALTH AND RESOURCE FAIR – SAMUEL KELSEY APTS – 3322 14TH STREET, NW	100 ATTENDEES
SEPTEMBER 21, 2019	EXHIBITOR	WARD 8 – PARAMOUNT BAPTIST CHURCH – 24TH ANNUAL HEARVEST DAY HEALTH FAIR – 3914 4TH STREET, SW	400 ATTENDEES
SEPTEMBER 30, 2019	EXHIBITOR	WARD 4 – DC LATINO CONFERENCE ON DISABILITIES – ST. STEPHEN AND THE INCARNATION EPISCOPAL CHURCH – 1525 NEWTON STREET, NW	300 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 2019 *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:	30	100%
REPORTS WITH "NO GRIEVANCES":	13	43%
REPORTS WITH GRIEVANCES:	17	57%
REPORTS WITH 40% OR MORE GRIEVANCES OVERTURNED IN A SINGLE CATEGORY:	11	37%

TRENDING: Grievance Turnover Rates

- Among companies that reportedly had grievances, almost 65 percent of them (11 of 17 insurers) had an *overturned* rate over 40 percent in specific service categories.

TRENDING: Dental Insurers

- For a third year in a row, 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 five dental insurers that submitted a *Self-Report*, two reported more grievances each than all but two of the 13 medical insurers.
    - Looking at aggregate numbers, a disproportionate share of the total number of grievances that were *partially overturned* were attributed to the dental insurers. Dental insurers accounted for 91 percent (248 of 273) of all *partially overturned* outcomes, reported across all insurer types.

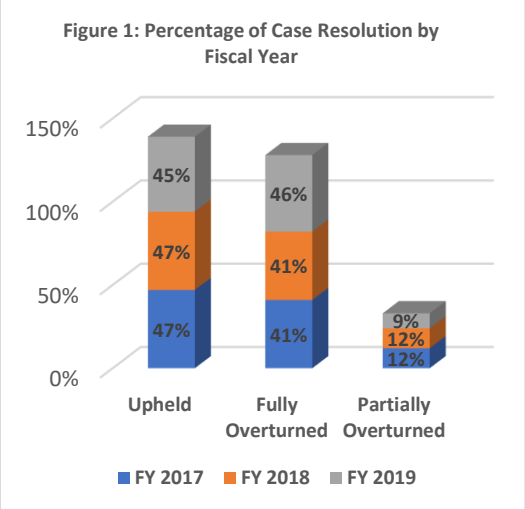
- Of all insurers reporting grievances in FY 2019, 29 percent were dental insurers (5 of 17 insurers reporting grievances) and accounted for 26 percent of all the grievance cases (789 of 2,987).

- In terms of outcomes, the five dental insurers accounted for 30 percent of all grievances that were *partially* or *fully overturned* (502 cases *combined overturned*) compared to 70 percent among the 12 medical insurers (1155 cases *combined overturned*).

- In the case of one dental insurer, denial decisions were *overturned* or *partially overturned* for 87 percent of the grievance cases processed: *partially overturned* cases (49 percent), *fully overturned* cases (38 percent).

- Instances of high numbers of grievance cases and high rates of overturned cases among some of the dental and medical 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 services without having to file grievances.

- In FY 2019, 17 of 30 insurers overturned 40 percent or more of *grievance cases in a single category*. This relatively remained the same in FY 2018 when 18 of 32 insurers reported 40 percent or more *cases overturned in a single category*. In FY 2017 there were 16 of 34 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; FY 2019 was such a year. There were apparent trends for cases that were *fully overturned* across all insurers for: In-Patient Hospital Services (45 percent), Emergency Room Services (47 percent), Physician Services (48 percent), Laboratory/Radiology Services (42 percent), Pharmacy Services (62 percent), Podiatry (67 percent), and Optometry (60 percent). Broken down, there were four insurers that overturned initial denials at an unusually high rate in the category for Pharmacy Services (over 65 percent turnover for each of those insurers). Seven insurers had overturned rates greater than 40 percent for Physician Services, and Five insurers had overturn rates of over 50 percent for the Laboratory/Radiology Services category. Further intervention is required to determine if a pattern related to a specific illness, drug, service or practice was responsible for the initial denial of these services 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 changed in FY 2019 in comparison to the last two fiscal years across all decision types. In the FY 2019 the percentage of *fully overturned* cases increased to 46 percent in FY 2019 from 41 percent in both FY 2018 and FY 2017. In FY 2019 there was a decrease in the percentage of *partially overturned* outcomes (9 percent compared to 12 percent for both FY 2018 and FY 2017) and a decrease in grievances that were *upheld* (45 percent compared to 47 percent for both FY 2018 and FY 2017). 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: Increase in Insurers Reporting Grievances

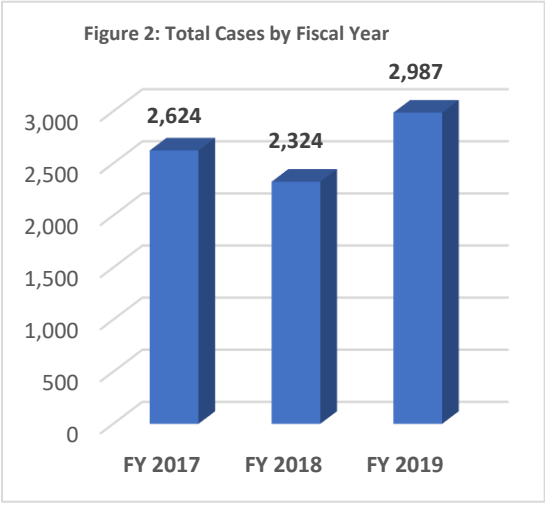
- In FY 2019, we saw an increase with 17 insurers submitting reports *and had grievances* during the year. This disrupted a downward trend of the three previous fiscal years, during which the number of insurers that submitted reports *and had grievances* was on a decrease from 22 in FY 2016 to 16 in FY 2017 and down to 14 in FY 2018.

DATA SUMMARY: Number of Insurers Reporting and Number of Cases

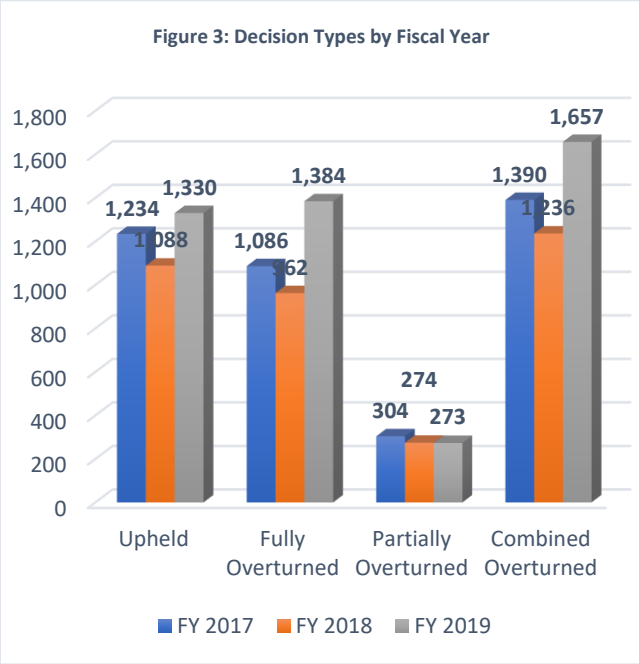
- A total of 30 insurers submitted annual *Self-Reports* in FY 2019, two fewer than in FY 2018 (32 insurers), and four fewer than in FY 2017 when 34 insurers submitted reports.

- Of the 30 insurers that submitted an annual *Self-Report*, 17 reported opening consumer *grievance cases* in FY 2019 and 13 reported having *no grievance cases*. This represents an increase over the last two fiscal years. In FY 2018, 14 of 32 insurers reported opening grievance cases (three fewer than in FY 2019) and 18 insurers reported no grievance cases, (six fewer than the number that was reported in FY 2019). In FY 2017, 16 of 34 insurers reported consumer grievances (one fewer than in FY 2019) and 18 reported having no grievance cases (five more than in FY 2019).

- The number of *grievance cases* increased in FY 2019 after a decline in FY 2018. The 17 insurers that reported grievances in FY 2019 opened a total of 2,987 cases, 663 more cases (29 percent more) than the 2,324 cases opened by 14 insurers in FY 2018, and 363 more cases (13 percent more) than the 2,624 cases opened by 16 insurers in FY 2017 [See 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 2019 in 1,330 of 2,987 cases (45 percent) compared to FY 2018 when 1,088 of 2,324 opened cases (47 percent) and in FY 2017 when 1,234 of 2,624 opened cases (also 47 percent) were *upheld*. *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 1,384 cases (46 percent of 2,987 cases). This is an increase over FY 2018 when 962 cases (41 percent of 2,324 cases) and in FY 2017 when 1,086 cases were *fully overturned* (41 percent of 2,624 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 273 of 2,987 opened cases were *partially overturned* in favor of the member in FY 2019 (nine percent). This represents a decrease from the previous two fiscal years, when 274 of 2,324 (12 percent) opened cases were *partially overturned* in favor of the member in FY 2018 and in FY 2017 when 304 of 2,624 (12 percent) of opened cases were *partially overturned* in favor of the member.

- In FY 2019 the number of *combined overturned* cases (total of *fully overturned* plus *partially overturned* cases) was 1,657 of 2,987 total cases opened (55 percent). This represents a slight increase over FY 2018, when 1,236 of 2,324 total cases (53 percent) and in FY 2017 when there were 1,390 *combined overturned* outcomes out of 2,624 cases opened (also 53 percent).

- In FY 2019, 11 of the 17 companies that reported grievances (65 percent) had a *combined overturn* rate of 40 percent or higher in *at least one service category*. This represents an almost 14 percentage point decrease compared to FY 2018, when 11 of the 14 companies (79 percent) that reported grievances had a *combined overturned* rate of 40 percent or higher in *at least one service category*. In FY 2017, seven of 16 companies (44 percent) had a *combined overturned* rate of 40 percent or higher in *at least one service category*. Four insurers overturned initial denials at a rate of 65 percent and higher in the Pharmacy Services category in FY 2019.

- In summary, the rate of grievance cases that were *fully overturned* increased five percentage points from 41 percent in FY 2017 and FY 2018 to 46 percent in FY 2019. The *combined overturned* rate, which includes both *fully* and *partially overturned* cases, increased two percentage points from 53 percent in FY 2017 and FY 2018 to 55 percent in FY 2019. P*artially overturned* cases declined three percentage points from 12 percent in FY 2017 and FY 2018 to nine percent in FY 2019. In FY 2019, 65 percent of insurers reportedly *overturned* or *partially overturned* more than 40 percent of cases *in a single category.* This is 14 percentage points more than in FY 2018 (79 percent) and 21 percent more than in FY 2017 (44 percent). Nine insurers reported overturn rates of more than 65 percent in Pharmacy Services, Physician Services, and Laboratory/Radiology Services categories. Consistently high reversal rates suggest that efforts should focus 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 2019, the Pharmacy Services category was the *most prevalent service category* for grievances by service type for the fourth consecutive year (1,107 cases or 37 percent of all grievances). Other top categories included, Dental Services (916 cases or 31 percent), Laboratory/Radiology Services (451 cases or 15 percent), and Physician Services (178 cases or 6 percent).

The following tables summarize data from the FY 2019 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 1. Commercial Insurers' Annual Self-Report[1] FY 2019

[GRAY SHADING = NO GRIEVANCES REPORTED]

NAME OF INSURER	TOTAL APPEALS/ GRIEVANCES	CASES UPHELD		CASES OVERTURNED		CASES PARTIALLY OVERTURNED	
		#	%	#	%	#	%
Aetna Health Inc.	17	8	47%	9	53%	0	0%
Aetna Life Insurance Co.	28	12	43%	15	54%	1	4%
Allianz Life Insurance Co.							
Ameritas Life Insurance Co.[2]	296	203	68%	67	23%	26	9%
BlueChoice Inc.	281	151	54%	128	45%	2	1%
CareFirst of Maryland, Inc.	139	75	54%	57	41%	7	5%
CIGNA Health and Life Insurance Co.	130	69	53%	59	45%	2	2%
CIGNA HealthCare Mid-Atlantic Inc.							
Connecticut General Life Insurance Co.							
Delta Dental[2]	10	5	50%	4	40%	1	10%
Fidelity Security Life Insurance Company							
Golden Rule Insurance Co.							
Group Hospitalization and Medical Services, Inc.	697	306	44%	390	56%	1	<1%
Kaiser Permanente	106	56	53%	50	47%	0	0%
MAMSI Life and Health Insurance Co.							
Metropolitan Life Insurance Co.[2]	439	56	13%	169	38%	214	49%
MD-Individual Practice Association, Inc.	188	85	45%	100	53%	3	5%
Optimum Choice, Inc.	10	6	60%	4	40%	0	0%
Principal Life Insurance Co.							
Prudential Insurance Co. of America							
Reliance Standard Insurance Co.[2]	3	2	67%	0	0%	1	33%
Standard Insurance Co.							
State Farm Mutual Auto Insurance Co.							
Trustmark Insurance Co.							
Trustmark Life Insurance Co.							
UniCare Life and Health Insurance, Co.							
United Concordia Insurance, Co.[2]	41	21	51%	14	34%	6	15%
United Healthcare Life Insurance Co.	1	1	100%	0	0%	0	0%
United Healthcare Insurance Company	600	273	46%	318	53%	9	1%
United Healthcare of the Mid-Atlantic, Inc.	1	1	100%	0	0%	0	0%
SUBTOTAL – MEDICAL PROVIDERS	2,198	1,043	47%	1,130	51%	25	1%
SUBTOTAL – DENTAL PROVIDERS	789	287	36%	254	32%	248	31%
TOTAL – ALL PROVIDERS	2,987	1,330	45%	1,384	46%	273	9%

[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 2. Commercial Insurers' Annual Self-Report[1] FY 2019 - Cont'd

[GRAY SHADING = NO GRIEVANCES REPORTED]

[BLACK SHADING = 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 Inc.	48	0	7	7
Aetna Life Insurance Co.	16	0	12.9	14.7
Allianz Life Insurance Co.				
Ameritas Life Insurance Co.[2]			28.9	
BlueChoice Inc.	9.7	0	24.2	31
CareFirst of Maryland, Inc.			42.8	5
CIGNA Health and Life Ins. Co.	0	0	33.9	0
CIGNA HealthCare Mid-Atlantic Inc.				
Connecticut General Life Ins, Co.				
Delta Dental[2]			29	
Fidelity Security Life Insurance Co.				
Golden Rule Insurance Co.				
Group Hospitalization and Medical Services, Inc.	12.6	0	16.3	51
Kaiser Permanente	16.6	0	27.1	21.4
MAMSI Life and Health Ins. Co.				
Metropolitan Life Insurance Co.[2]			13.7	
MD-Individual Practice Association, Inc.	51	36	2	0
Optimum Choice, Inc.	25	21	44	0
Principal Life Insurance Co.				
Prudential Ins. Co. of America				
Reliance Standard Insurance Co.	0	0	27	0
Standard Insurance Co.				
State Farm Mutual Auto Ins. Co.				
Trustmark Insurance Co.				
Trustmark Life Insurance Co.				
UniCare Life and Health Ins. Co.				
United Concordia Insurance, Co.[2]			7	
United Healthcare Life Ins. Co.	0	0	56	0
United Healthcare Insurance Co.	42	23.55	32	35
United Healthcare of the Mid-Atlantic, Inc.			56	

[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