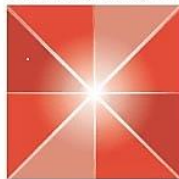




DISTRICT OF
COLUMBIA



HEALTH CARE
OMBUDSMAN
The Knowledge to Guide You

***OFFICE OF HEALTH CARE
OMBUDSMAN AND BILL OF RIGHTS***

Fiscal Year 2015 Annual Report

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MESSAGE FROM THE MAYOR, DISTRICT OF COLUMBIA



It is with great pride that I join the District of Columbia's Health Care Ombudsman, Maude R. Holt, in presenting you with the *Fiscal Year 2015 Annual Report of the Office of Health Care Ombudsman and Bill of Rights (OHCOBR)*.

Throughout the year, well-trained professional staff worked with public and commercial insurers, government agencies and other community service providers, to offer consumers guidance that provided a swift and accurate pathway to health care coverage, health services, and relief from crippling debt.

During FY 2015, my first year in office as Mayor, I repeated my campaign commitment in my State of the District address; the commitment that my administration will work for you, the residents of the District, and reflect your values and beliefs, including the belief that healthcare should be available for everyone regardless of cost. We are close to meeting that commitment through a robust Medicaid program and choice private healthcare plans offered through DC Health Link, the District's health insurance marketplace. The service that the Healthcare Ombudsman and her staff provide is crucial to meeting other facets of that commitment. They facilitate access to affordable benefits, ensure fairness in healthcare delivery, and recommend essential improvements to District leaders and providers that benefit their customers.

Each year, staff of the OHCOBR help thousands of individuals and families to be healthier and more informed by community engagement, collaborating with relevant parties to solve complex problems, reversing service denials, and reducing out-of-pocket expenses. You will learn from reading this year's impressive report that their efforts have a genuine impact on the health status of the city's populace.

And so, I proudly commend the OHCOBR staff and the outstanding leadership of Ms. Holt for another year of hard work and dedication, in fulfillment of our mutual pledge to foster a city government that works for you.

Muriel Bowser
Mayor

MESSAGE FROM THE DIRECTOR



It is the mission of the Department of Health Care Finance (DHCF) to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia. One of the most effective ways we achieve our mission is through collaboration with Maude Holt, the DC Health Care Ombudsman, and her staff. The Office of the Health Care Ombudsman and Bill of Rights (OHCOBR) is an independently operated sector within DHCF that advocates tirelessly for residents, employees and visitors to the nation's capital; helping them understand their rights and benefits as healthcare consumers, and gain access to safe, quality services and affordable coverage. Like DHCF, OHCOBR shares goals of high quality service delivery and strong accountability. Their annual report is a testament to this commitment. It gives me great pleasure to share with you some noteworthy achievements by Ms. Holt and her staff in fiscal year 2015.

FY 2015 marked the eighth year of the OHCOBR Internship Program. Pharmacy interns and students from other disciplines developed skills and served as Associate Ombudsmen during their tenure in the Program. This newest crop of budding professionals was exposed to a unique opportunity, to learn the basic tenets associated with health care delivery, consumer advocacy, and the honor associated with public service.

Thanks to the continued support of a Federal Consumer Assistance Program (CAP) Grant award, *Enroll America* helped OHCOBR develop and implement a multi-phased, culturally sensitive marketing plan to publicize the Ombudsman's Office and the services it provides to the community. On January 22, 2015 OHCOBR proudly launched a new website with an embedded informational video. The new website is handicap capable for the hearing impaired. OHCOBR Advisory Council Subcommittee members are currently developing foreign language sections for the website, to expand reach and convenience to all.

The grant also paid for a full-time employee to handle data and statistics.

Through daily diligence, Ms. Holt and her team save consumers thousands of dollars each fiscal year from reversed medical denials, reimbursements and cancelled bills. Please join me in saluting Maude Holt and her team for another outstanding year of public service.

Wayne Turnage, MBA

Director, Department of Health Care Finance

MESSAGE FROM THE HEALTH CARE OMBUDMAN



On behalf of the Office of Health Care Ombudsman and Bill of Rights (OHCOBR) I am pleased to present the *Fiscal Year 2015 Annual Report*. We hope you find this report useful and informative. It tells you who we are, the types and frequency of concerns voiced by our customers, and how we addressed those concerns. It also presents the many partnerships we share with other providers and stakeholders, to meet our common goals. The good news stories in the report demonstrate how we assisted with issues of access to care and benefits, for consumers in both the public and private healthcare markets. The report also offers our recommendations for future advancement and improvement in the industry's response to consumers' healthcare needs and concerns. No one should have to forgo health care services or risk financial ruin because they need treatment.

Last year we used mixed media notices to expand public awareness of OHCOBR, with the continued federal support of two Consumer Assistance Program (CAP) grants. The year-end tally shows that we handled nearly 8,500 cases in FY2015 - an increase from 7,900 the previous year and 6,500 the year before that - evidence that public awareness and our reputation for effective support continues to grow.

We engaged with the public at twenty-two community events attended by more than 17,000 people, including seven *Health Care on Tap* gatherings. I encourage you to come out to meet us at a future event and ask that you help spread the word that we're here and eager to serve.

Other accomplishments include the development of quality indicators, and a more efficient, fully automated, real-time accessible case tracking system that maintains the security of our customers' protected health information.

Finally, I'd like to commend my dedicated staff that are always persistent and always striving for excellence.

Upon reading the report, please let us know how we're doing or if you have any questions. We can be reached at 1 (877) 687-6391, (202) 724-7491, or via email at healthcareombudsman@dc.gov.

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

WHO WE ARE

HISTORY

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

DUTIES AND RESPONSIBILITIES

The Health Care Ombudsman is responsible for providing the public with advocacy, education and community outreach services regarding access to health benefits and ensuring that benefits meet their needs. The staff offers advice and helps customers enroll in suitable health plans directly and through referral, and helps them resolve complaints against their current plan and service providers. The OHCOBR team facilitates the appeal and grievance process for customers, including applying for fair hearings and forwarding cases for external review to a designated independent review organization (IRO). The IRO reviews cases and renders decisions that are binding on all parties. The team uses collective knowledge and established relationships to intercede and resolve issues on behalf of customers. The team also educates the community about individual rights and responsibilities regarding their health benefits.

FUNDING

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

LEGISLATIVE AUTHORITY

The OHCOBR is guided and authorized by two legislative mandates, *The Ombudsman's Program* (DC Law 15-331; DC Official Code 7-2071.01), which established the Ombudsman's office and describes its purpose and duties; and *The Health Benefits Plan Members Bill of Rights Act* (DC Law 19-546; DC Code 44-301), which established grievance procedures that health benefits plans are required to follow.

INDEPENDENCE AND AUTONOMY

The OHCOBR operates independent of all other government and non-government entities. It is a neutral body that maintains its independence by having no direct involvement, participation, investment, interest or ownership in a health care facility, health care service, health benefits plan or provider of a health benefits plan. The OHCOBR has no agreement or arrangement with any owner or operator of a health care service, health care facility, or health benefits plan that could directly or indirectly result in cash remuneration, or any other kind of compensation to the office or its staff. This independence and autonomy gives the Ombudsman's office greater flexibility in resolving problems and advocating unencumbered on behalf of their customers. Their loyalty, first and foremost, is to the people they serve.

COLLABORATIONS

Although OHCOBR operates with sovereignty, being part of DHCF helps resolve complaints more quickly through collaboration with staff and senior leadership from other DHCF offices and administrations. The OHCOBR also has an effective close working relationship with the Department of Insurance Securities and Banking (DISB), the District's insurance regulator. All DISB's customer correspondence includes contact and other information about OHCOBR, should their customers need our help. DISB staff routinely educates private health plan members about the full range of support OHCOBR offers in navigating the appeals process. OHCOBR and DISB routinely exchange cases as appropriate. Collaborative relationships exist with other District agencies such as the DC Health Benefit Exchange Authority (DCHBX) that operates *DC Health Link*, the District's online health care marketplace, and the Economic Security Administration (ESA) where eligibility is determined for enrollment in Medicaid and other publicly funded health benefit programs. A more complete list of our numerous other internal and external partners is available in the *Collaborations* section of this report.

GROWTH AND THE FUTURE

OHCOBR was recently re-branded with a new logo and implementation of a robust community-marketing plan. These initiatives have familiarized much of the public with our office and services, thanks to the continuation of funds from two Consumer Assistance Program (CAP) grants by the U.S. Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid (CMS). Implementation of the *Affordable Care Act* and the open enrollment process through the health benefit exchange, *DC Health Link*, has continued to impact the increased volume of calls from consumers seeking information, intervention and assistance. Ongoing efficiencies, cost savings, and an increase in the annual appropriated budget for newly hired staff salaries, initially jumpstarted with CAP grant funds, are helping to ensure long-term sustainability.

MEET THE OMBUDSMAN STAFF

PHOTO
NOT
AVAILABLE

*Amani Alexander
Contractor
CAP Data Entry*



*Charlita Brown, BS
Associate Health Care
Ombudsman*



*Marlena Edwards, MSW
Associate Health Care
Ombudsman*

PHOTO
NOT
AVAILABLE

*Aminata Jalloh, BS
Associate Health Care
Ombudsman*

PHOTO
NOT
AVAILABLE

*Cardiss Jacobs
Associate Health Care
Ombudsman*



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

PHOTO
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*Carmencita Kinsey
Associate Health Care
Ombudsman*



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



*Shirley Tabb, LICSW
Associate Health Care
Ombudsman*



*Robert Taylor
Return to Work Staff
Member*

PHOTO
NOT
AVAILABLE

*Mirka Shephard
Associate Health Care
Ombudsman*



*Loretta Smith, RN
Associate Health Care
Ombudsman*



*Daisha Watson, BA
Associate Health Care
Ombudsman*

MEET THE OMBUDSMAN INTERNS

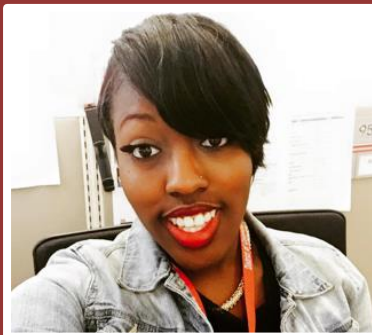
The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) offers internships to college students for the opportunity to work in a professional environment while pursuing their degree. FY 2015 is the eighth year this program has been in operation. It began in 2009 when the OHCOBR was first established.

During the academic school year, interns can work up to 36 hours a week and up to 40 hours a week during summer break. A mentor is assigned to each intern to guide him or her in the performance of a wide range of supportive services that are essential to the operational efficiency of the office. This year, for example, the pharmacy interns from Howard University conducted research and provided staff education on different types of drugs and the medical necessity for their use as a covered benefit. By recognizing these “markers” in a consumer’s medical documents, OHCOBR staff was able to provide evidence of medical necessity to insurance companies that helped overturn denials.

Below are the interns who supported the Ombudsman’s Office in FY 2015:



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



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



Katya Medrano
Student Intern
Trinity Washington University
Major: Mathematics
Graduation: Spring 2017

Below are the pharmacy interns who supported the Department of Health Care Finance and the Ombudsman's Office in FY 2015, and a description of the type of research that was provided during their time here:

<i>Information Regarding Intern</i>	<i>Assistance Provided</i>
<i>Blessing Adodo</i> <i>Pharmacy Intern</i> <i>Howard University College of Pharmacy</i> <i>Major: Doctorate of Pharmacy</i> <i>Graduation: Spring 2016</i>	<ul style="list-style-type: none"> • <i>Presentation on Pharmaceutical prices skyrocketing</i> • <i>HPV vaccination benefit in over age specification</i> • <i>Rheumatoid arthritis – researched additional biological agents in the class prescribed and adverse effects</i>
<i>Jessica Chung</i> <i>Pharmacy Intern</i> <i>Howard University College of Pharmacy</i> <i>Major: Doctorate of Pharmacy</i> <i>Graduation: Spring 2015</i>	<ul style="list-style-type: none"> • <i>Risk evaluation and mitigation strategy for Saxenda® REMS</i>
<i>Afoma Nwizu</i> <i>Pharmacy Intern</i> <i>Howard University College of Pharmacy</i> <i>Major: Doctorate of Pharmacy</i> <i>Graduation: Spring 2016</i>	<ul style="list-style-type: none"> • <i>Provider appeals protocol for chantix, Cialis and viagra</i> • <i>Beer's criteria (potentially inappropriate medication use in older adults)</i>
<i>Damika Watley</i> <i>Pharmacy Intern</i> <i>Howard University College of Pharmacy</i> <i>Major: Doctorate of Pharmacy</i> <i>Graduation: Spring 2015</i>	<ul style="list-style-type: none"> • <i>Overview of 340B drug pricing program</i> • <i>Single-pill combination regimens for treatment of HIV-1 infection</i>

GOOD NEWS STORIES



The Ombudsman's office intervenes daily on behalf of those who reach out to us for assistance. They may need assistance with enrollment in a health benefit plan, getting their insurer to authorize or pay for services, or may just be seeking information. There are times when we are unsuccessful in reaching a resolution, but that does not deter us from attempting. Our experienced staff is most often able to relieve callers' worries about an unexpected financial burden or assist them in overcoming difficulties accessing care for a pressing health care concern. The following are some examples of those successes that our intervention efforts produced in fiscal year 2015.



Overturing Denied Coverage Decisions

Hospital Admission: A member of a commercial insurance health plan was having headaches for approximately three weeks. His symptoms included difficulty speaking, ringing in the ears and dizziness. He was admitted to the hospital for two days. A neurologist treated him and he received CT and MRI diagnostic tests. He was charged \$8,883.62 for the hospitalization because the insurance company denied payment based on insufficient information available to support the medical necessity for the admission. The member appealed the denial and sought help from the Ombudsman's office. Our staff person provided the insurer with documentation demonstrating that the admission and treatment were medically necessary. The services were approved on appeal and the insurance company paid for the member's hospitalization.

Substance Use Rehabilitation: A commercial insurance plan member contacted our office seeking help with an appeal for payment by his insurer. He explained that he had a growing concern for his family's safety because more and more frequently his wife was driving the children around after drinking alcoholic beverages. He said that he had been unable to persuade his wife to stop the practice. A family intervention was arranged with a psychologist who recommended that his wife be admitted to an inpatient treatment facility. She was admitted and remained in treatment for twelve days. Post discharge, the rehabilitation treatment proved to be effective; however, the member's insurer denied payment claiming that the services provided were not medically necessary. The member appealed the insurer's decision. We referred the case to the external reviewer to assess medical necessity. The external reviewer determined that the treatment was medically necessary and reversed the insurer's decision to withhold payment. The insurer paid \$33,000.00 for the rehabilitation treatment.

Mental Health Treatment: We received a request for assistance from the parents of a 25-year-old woman in an appeal case challenging their insurer for denying coverage for their daughter's intensive outpatient and residential mental health treatment. She has three severe mental illnesses that have debilitated and troubled her since kindergarten, necessitating regular hospitalizations and in-patient residential treatment over the years. Her parents had spent more than \$100,000 for residential treatment alone, due to the insurer's repeated decision to deny coverage. The insurer persisted in asserting that her symptoms were stable and could have been treated in an outpatient setting.

The OHCOBR clinical case manager assigned to the appeal researched the mental illnesses, history and treatment, and presented a strong case to the external reviewers for reversing the denial decision to cover the mental health treatment. The external reviewers agreed and recommended approval of coverage. The insurer was required to reimburse the family including interest accrued during the long appeal process due to multiple denials.



Facilitating Access to Care

Prescription Assistance: We received a call from a DC resident that had just been discharged from a hospital and urgently needed medications prescribed by his treating physician. He had applied for Medicaid two weeks earlier but his application was still pending. Unfortunately, he could not afford to fill the prescriptions and asked for our help. We immediately contacted the Economic and Security Administration (ESA) to get his Medicaid application approved expeditiously. Our intervention worked. His application was processed and approved quickly, and the beneficiary was able to obtain the medications he needed.

Sleep Apnea: One member of our team, who is also a registered nurse, represented us on a complicated case for a customer that was being denied access to a lifesaving procedure by his private insurance carrier. The beneficiary had severe sleep apnea with underlying COPD and other health complications, including a heart condition. He was scheduled for a procedure that would improve the effectiveness of his sleep aid device, which had in the past caused him to suffer mini strokes while he slept. Without the procedure, he was at high risk of death during sleep. The health plan required pre-authorization for the procedure and the insurer denied the request. The beneficiary and his physician had already appealed the denial twice. But the insurer continually denied coverage, despite the physician's thorough written justifications and explanations for ruling out other measures recommended by the insurer. This led them to contact our office.

We conducted a preliminary internal case review. The clinical reviewer validated the member's plan membership and agreed that all the necessary information had been provided to justify approval based on medical necessity. She worked with the member's wife, his physician, staff at the out-of-state treating clinic, and the insurance carrier to obtain approval, citing the letters and phone calls previously made to the carrier. The insurance company still refused to approve the procedure.

The clinical reviewer then requested an expedited external review by an independent review organization (IRO), which normally requires a decision within seventy-two hours. Decisions made by IROs are binding on all parties. The IRO determined that the beneficiary had been deprived of medically necessary covered services and recommended that the requested services be approved. Consequently, the insurer was required to reverse their denial and approve the procedure.

Home and Community Services: A sight-impaired, elderly Medicaid beneficiary in Ward 7 needed assistance paying his mortgage and utility bills. He explained that his relationship with his children was contentious and distrustful so he called us. We verified his Medicaid eligibility and discussed best options for him to manage his bill payments. With his consent, a three-way conference call was placed with his bank to discuss the matter. The bank representative helped him send a wire transfer to pay his mortgage for that month and to set up future monthly auto-payments. Pepco and DC Water were also contacted and arrangements were made to extend time to pay these utility companies and avoid disruption of services. The DC Office of the People's Council collaborated on the call. That office is the intermediary for DC residents that have utility company issues.

As lunchtime approached the caller mentioned he was hungry, but because of his impairment he had no way to go out to get food. We identified and arranged for neighborhood delivery food service, and remained on the phone with him to ensure that the order was safely delivered. While waiting for the delivery, we arranged a referral for home and community based services and community case management. The caller was extremely grateful for our help.

HEALTH CARE ON TAP

Health Care on Tap is our signature initiative that involves staff making regular visits to informal neighborhood settings where individuals of all walks of life can co-mingle and ask the OHCOBR experts questions pertaining to health care services, benefits and insurance issues. We provide consumer education sessions both in groups and one-on-one, covering topics such as how to file a commercial insurance appeal or grievance, eligibility requirements for health insurance, how to access health care benefits, types of services available for the uninsured and underinsured, and other topics related to the Affordable Care Act (ACA), depending on the consumer's individual needs and interests.

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

In FY 2015, more than 500 District of Columbia residents attended seven *Health Care on Tap* sessions¹. The Israel Baptist Church in Ward 5 hosted the successful debut event in October 2014. In FY 2015, the largest number of requests for assistance from OHCOBR originated from Ward 5.

Highlights of other targeted community sessions include staff attendance at Providence Hospital to meet with members of the *Alzheimer's Patient Support Group*. Another example is a session co-hosted with Terrific Inc. at the Garfield Terrace senior and family public housing site in Ward 1. Terrific Inc. is a community based non-profit organization that operates several diverse housing, residential care and human service programs and specializes in responding to family crises. Two sessions were also held in FY 2015 at two different locations for the *District Alliance for Safe Housing (DASH)* residents; one in Ward 2 in June, and one in Ward 5 in August. More than 150 adults and children attended the DASH sessions. DASH is also a community non-profit organization that provides access to safe housing and services to survivors of domestic and sexual violence, and their families.

¹ A complete listing of *Health Care on Tap* and other community outreach events is included in the Appendix.

CONSUMER ASSISTANCE PROGRAM GRANTS – CLOSE-OUT

The goal for the *Limited Competition* CAP grants, awarded in FY 2012, was to increase consumer awareness of our office and services; to educate District residents and workers who have insurance that is regulated by the DC Department of Insurance, Securities and Banking (DISB) about our role and the valuable services we provide as their health care advocate; and to provide useful information regarding the Affordable Care Act (ACA) and the rights and responsibilities of individuals as health care consumers.

FY 2015, marked the cut-off for the extension of the *Limited Competition for Affordable Care Act - Consumer Assistance Program* grant (*Limited Competition* CAP grant). The remaining funds were used to (1) hire a Data Entry Assistant for tracking and reporting cases served, and (2) to continue the overall marketing and media campaign, with special emphasis on reaching Hispanic and non-English speaking persons. The campaign included launching a new website that features an embedded information video and handicap capable features for the hearing impaired. We credit continuation of the media campaign for the increase in the number of commercial insurance cases processed in FY 2015.

TRAINING

The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is tasked with educating and assisting health insurance consumers that reside in the District residents and/or persons with insurance that is regulated by the Department of Insurance, Securities, and Banking (DISB), concerning access to health care, health insurance and commercial insurance appeals.

The Consumer Assistance Program (CAP) grant afforded the Ombudsman staff the opportunity to obtain valuable training by Families USA and other health experts on an array of topics associated with the Affordable Care Act (ACA). This training was instrumental in preparing the staff to be able to answer any questions regarding open enrollment and in educating them on key aspects of the ACA that took effect January 1, 2014. Training occurred throughout fiscal years 2013 and 2014. This completed two full years of intensive staff training on a variety of subjects critical to OHCOBR operations that was essential to our success in supporting our customers.

In FY 2015, staff participated in in-service trainings provided through the Department of Health Care Finance (DHCF). These trainings included sessions on the following topics:

- Introduction to DC Medicaid;
- Medicaid State Plan, State Plan Amendments, Rules and Waivers;
- Budget Development; and
- Ethics

ADVISORY COUNCIL AND SUBCOMMITTEES

The Health Care Ombudsman Advisory Council was established pursuant to DC Code: Title 7, Chapter 20A, § 7–2071.11. The Council is required to minimally perform the following functions:

- Advise the Ombudsman on program design and operational issues;
- Recommend the criteria to be used in evaluating the performance of the Ombudsman Program;
- Recommend changes in the Ombudsman Program; and
- Review data on cases handled by the Ombudsman Program and make recommendations based on that data.

Our office seeks the input of the Council to facilitate lasting resolution to health care concerns expressed by consumers and on issues raised by staff and committee members based on their knowledge of pending changes to laws, policies, and practices in the health care industry. Members also assist us in our effort to reach greater numbers of consumers requiring assistance by enhancing public knowledge of the Ombudsman’s office through strategizing, planning and participating in targeted community outreach sessions and public events throughout the District of Columbia. The Council consists of members that represent: consumers, consumer advocacy organizations, health benefit plans, health care facilities, and physicians.

There are four primary subcommittees and one ad hoc subcommittee that support and make recommendations to the Advisory Council. Below is a description of each of their roles:

CLINICAL AND BEHAVIORAL HEALTH SUBCOMMITTEE

- Makes presentations at subcommittee meetings on record review findings;
- Fact-finds and compiles information to transmit to the Policy and Procedures and Legal Subcommittee for policy and legislative change;
- Researches and defines standard clinical protocols and best practices;
- Serves as external peer reviewer for Medicaid, the Alliance and other complex cases.
- Focuses on greater care continuity and improved level of care for people receiving home or community based services that have a history of mental illness or exhibit signs of behavioral distress;
- Proposes ways to improve performance and outcomes in care coordination among provider agencies, physicians, and core service agencies in the behavioral health system;
- Identifies and overcomes barriers for sharing vital information that will assist in the care of mentally ill beneficiaries, including those assigned to various home health agencies.

POLICIES AND PROCEDURES AND LEGAL SUBCOMMITTEE

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

EDUCATION AND OUTREACH SUBCOMMITTEE

- Defines and develops an education and outreach strategy and develops materials around that strategy; and
- Conducts public outreach by providing awareness and availability of government sponsored programs such as DC Medicaid, Health Care Alliance, Qualified Medicare Beneficiary (QMB), Medicare, the Home and Community Based Waiver programs, and health care benefits plans. A complete listing of FY2015 community outreach and education activities is included in the Appendix.

CHILDREN WITH SPECIAL NEEDS SUBCOMMITTEE

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

MENTAL HEALTH AD HOC COMMITTEE

- Proposes ways to improve performance and outcomes in care coordination among provider agencies, physicians, and core service agencies in the behavioral health system; and
- Identifies and overcomes barriers for sharing vital information that will assist in the care of the beneficiaries that are assigned to various home health agencies.

COLLABORATIONS

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

In FY2015, we collaborated with the following entities:

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

ACHIEVEMENTS

In FY 2015, the Office of Health Care Ombudsman and Bill of Rights saw many achievements over the preceding year. The OHCOBR saw achievement in its ability to handle an increased caseload and to address the varied and increasingly complex health care issues that consumers sought help to resolve. In FY 2015, our office accomplished the following:

- OHCOBR resolved most Non-Commercial cases on the same day opened, which was an increase of 14 percent over the previous year. 89 percent of these cases were resolved on the same day, totaling 7,350 cases.
- OHCOBR reduced the number of days it takes to close a Non-Commercial case from 2 days in FY 2014 to 1.4 days in FY 2015.
- OHCOBR closed 97 percent of all Non-Commercial case by the end of FY 2015, totaling 7,960 cases.
- OHCOBR saved consumers a total of \$627, 681.41 by mid-fiscal year 2015.
- OHCOBR closed 75 percent (148 cases) of all Commercial cases opened within the same fiscal year, an increase over the previous year when only 47 percent (91 cases) of cases were closed.

RECOMMENDATIONS

During each fiscal year, staff and members of the Advisory Council and Subcommittees note areas where improvements would benefit consumers, as it relates to the mission and goals of the Office of Health Care Ombudsman and Bill of Rights, the Department of Health Care Finance, and the Executive Office of the Mayor. Here are the recommendations that the Ombudsman considers appropriate for action during the upcoming fiscal year.

- Develop a Bill of Rights pertaining to coverage of medical benefits and autonomy in guarding personal health information.
- Develop a fact sheet to be written at a 5th grade reading level that explains the universal consent form and its uses. The universal consent form was developed by the Clinical Subcommittee in FY2014 to improve access to mental health services. It is intended to facilitate information sharing and coordination of care between agencies and programs and simultaneously protect consumer confidentiality.
- Continue to improve the Quality Review Resource Center within the office, for easy access to documents filed on similar past cases and current health related information, in order to expedite the resolution of cases.
- Review treatment guidelines for mental health services in order to reduce the number of denials, especially since there was a rise in the number of mental health commercial appeals this fiscal year.
- Work with Department of Insurance, Securities, and Banking (DISB) to reduce the number of complaints and commercial appeals regarding coverage for ambulance services, which increased this fiscal year.

DATA: HIGHLIGHTS & ANALYSIS

All incoming communications and contacts that OHCOBR investigates are tracked throughout the year. (*See the Appendix for a separate summary of annual data reports from commercial insurance companies on cases they investigate through their internal grievance and appeals process.*) Information about each contact or “case” is entered into the *Ombudsman In-Take Data System* (OIDS), specially designed to accommodate and track office operations. The OIDS In-Take Tracking Log receives and classifies cases by type and other categories, to facilitate follow up, share information as appropriate, and generate reports on outcomes to measure trends, quality and performance. The findings in this annual report summarize data gleaned from the OIDS In-Take Tracking Log for FY 2015 (October 1, 2014 through September 30, 2015). The DHCF Division of Analytics and Policy Research aided OHCOBR in the production of the statistics, tables and graphs below. The information in this report summarizes and highlights some of the data in the *FY2015 Summary of Cases* report. To view that more in-depth data 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 DC residents contact OHCOBR?
- Who contacts OHCOBR?
- What are the most common issues experienced by the community?

DEFINITIONS

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

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

Commercial Cases – Commercial health plans are also called private insurance plans. These Commercial Cases involve beneficiaries who have health coverage through an employee-sponsored plan or a plan that was purchased by an individual from a private insurance company.

Grievances and appeals for these cases are handled differently by the OHCOBR than cases involving public benefit programs, such as Medicaid, the Alliance or Medicare.

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

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

Uninsured Contacts – Includes all other categories of contacts not specifically related to 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 to help employees of self-insured companies, to the Office of Personnel Management to help federal employees, to the state of origin to help persons with out-of-state insurance. Administrative closures are also included in this category, i.e. cases where the consumer did not take required action.

HIGHLIGHTS

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

- OHCOBR served seven percent more consumers in FY 2015 than in the previous year (8,438 in FY 2015 compared to 7,904 in FY 2014). [Figure 1]
- Most of the issues raised by persons contacting OHCOBR in FY 2015 (98 percent) were related to public benefits (Medicaid, Medicare, and the Alliance), referred to as 'Non-Commercial' cases in this analysis. [Figure 1]
- OHCOBR continued to improve its track record of *resolving most Non-Commercial cases the same day the case was opened*. The office had a 14 percent increase in Non-Commercial same day closures over the previous year (7,350 in FY 2015 vs. 6,472 in FY 2014). [Table 3]

- OHCOBR continued to reduce the *average number of days to close a Non-Commercial case*. In FY 2015 the average was lowered to 1.4 days, compared to a 2-day average in FY 2014. [Table 3] This was a significant improvement over FY 2013 when the average was more than twice as many days (3.6 days).
- Consumers with Medicare issues sought assistance more often than any other category of insurance (31 percent of all cases). [Figure 3]
- Eligibility was the single most frequent issue among all consumer contacts (41 percent), followed by Access/Coverage including denials (27 percent). [Figure 4] Percentages were even higher for Eligibility issues among contacts concerning Medicaid Managed Care Organizations (MCOs) (59 percent or 1,043 of 1,768 cases) [Figure 9] and the Health Care Alliance (60 percent or 107 of 179 cases) [Figure 11].
- OHCOBR no longer tracks and reports on ‘pre-existing conditions’ since the Affordable Care Act went into effect, which prevents denials. In FY2013, the last reported year, five percent of contacts were related to ‘pre-existing conditions’. [Figure 19]
- Issues concerning commercial insurers (2% of all contacts) continue to be challenging, averaging nearly three months to resolve appeals and grievances cases (81.3 days), mainly because the complexity of each unique case and the amount of research and documentation required from third parties can vary widely, which affects the amount of time it takes to reach a decision and close a case. OHCOBR continues to explore and implement methods for streamlining resolution times, including building a resource center for easy retrieval of current health and treatment information and access to documents filed on similar past cases with successful outcomes. Other remedies include developing standardized forms and making other tools available to staff and the IRO to expedite resolution and closure.
- Despite the increase in resolution time, more cases were closed in FY 2015 (148) than in FY 2014 (91) and more were resolved in favor of the consumer (115 vs. 68). In addition, the number of days to resolve a case in FY 2015 was still less than the 91.6-day average in FY 2013. [Table 5]
- Consumer savings are reported to be in excess of \$625,000 in FY 2015, but this amount is not the annual amount. The actual annual consumer savings is significantly greater but unavailable to report precisely. A mid-year change in the reporting methodology temporarily halted data entry of case-by-case savings. Based on an informal review of case files, OHCOBR estimates that the actual total savings was on par with FY 2014 when nearly one million dollars was saved on behalf of consumers. Figure 23 shows the breakdown of the partial amount and source of those savings that were entered into the database.

SELECT FINDINGS FROM THE DATA ANALYSIS

Following are some select details drawn from an analysis of data collected in FY 2015. 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 2015 Summary of Cases* available on line at <https://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. In prior years' reports, three categories of data were reported; the third category was *Commercial Non-Appeals and Grievances* [see Definitions]. However, in FY 2015 OHCOBR began incorporating *Commercial Non-Appeals and Grievances* into data reported for *DC Health Link* contacts. This year, 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 8,438 cases of all types in FY2015, a seven percent increase over the 7,904 cases opened in FY 2014. [Table 1, Figure 1]

Table 1. Number and Percentage of All Opened Cases by Insurance Category FY14 and FY15				
Insurance Category	FY14 Totals	FY14 %	FY15 Totals	FY15 %
Non-Commercial	7,712	98%	8,241	98%
Commercial	192	2%	197	2%
Total Opened Cases	7,904	100%	8,438	100%
Annual Variance			+534	+7%

NON-COMMERCIAL CASES

- Of the 8,438 total of all opened cases, 98 percent or 8,241 were Non-Commercial cases. [Figure 1] In FY 2014, Non-Commercial contacts were also 98 percent of all cases opened; however, FY 2015 had 529 more Non-Commercial cases, an increase of 7 percent [Table 1, Figure 12].
- Of the 8,438 total cases opened, 2,595 contacts were related to Medicare insurance issues making them the single largest insurance type of all Non-Commercial contacts (31 percent). The Medicare category includes issues related to Medicare Part A; Part B; Part A/B, and Part A/B QMB. This group of Medicare insurance contacts is consistently the largest year-to-year, representing 31 percent of all contacts in FY 2014 [Figure 3] and 28 percent in FY 2013.
- Eligibility was the most frequent type of issue raised among all contacts, Non-Commercial and Commercial combined (3,492 cases, 41 percent of 8,438 total contacts). [Figure 4]
- Medicare contacts raised Eligibility issues at the rate of 37 percent (964 of 2,595 cases) [Figure 7]
- Dual Eligible–Medicaid/Medicare contacts raised Eligibility issues at the rate of 39 percent (784 of 2,014 cases) [Figure 8],
- Medicaid MCO contacts raised Eligibility issues at the rate of 59 percent (1,038 of 1,768 cases) [Figure 9]
- Medicaid FFS contacts raised Eligibility issues at the rate of 33 percent (480 of 1,445 cases) [Figure 10]
- Alliance contacts raised Eligibility issues at the rate of 60 percent (108 of 179 cases) [Figure 11].
- OHCOBR closed 97 percent of all opened Non-Commercial cases by the end of FY 2015, 7,960 cases; the remaining 3 percent, 281 cases, were still pending resolution at the end of the fiscal year. [Table 2, Figure 12].

**Table 2. Non-Commercial Cases:
Status and Resolution of Closed and Open Cases at Year-End
FY14 and FY15**

Year-End Status and Resolution	FY14 Totals	FY14 %	FY15 Totals	FY15 %
Closed Cases – Successful (In favor of the consumer)	6,550	85%	7,814	95%
Closed Cases – Unsuccessful (Not in favor of the consumer)	60	1%	80	1%
Closed Cases (Referred Out) – Resolution Undetermined	694	9%	66	1%
Closed Cases - Sub-Total	7,304	95%	7,960	97%
Open Cases – Still Pending Resolution	408	5%	281	3%
Total All Non-Commercial Cases (Closed and Open)	7,712	100%	8,241	100%

- On average, Non-Commercial cases were closed in 1.4 days; down from 2 days in FY 2014. [Table 3, Figure 5]
- Of all Non-Commercial cases, OHCOBR resolved 89 percent *on the same day they were opened*, 7,350 cases. Compared to FY 2014, 878 more cases were closed in FY 2015 representing a 14 percent increase in same day closures. [Table 3]

**Table 3. Non-Commercial Cases: Analysis of Days to Close a Case
FY14 and FY15**

FY14 # of Cases Closed	FY14 Average # of Days to Close	FY15 # of Cases Closed	FY15 Average # of Days to Close
7,304	2.0 days	7,960	1.4 days
FY14 Same-Day Closure Cases		FY15 Same-Day Closure Cases	
6,472 of 7,712 total Non-Commercial cases (84%)		7,350 of 8,241 total Non-Commercial cases (89%)	
Annual Variance of Same-Day Closures		+878 cases	14 % increase in # of cases

COMMERCIAL CASES - APPEALS AND GRIEVANCES

- Cases related to Commercial Health Plans represented two percent of all cases opened in FY 2015 (197 of 8,428 total cases). Nearly the same number of commercial cases was opened in FY 2014 (192). [Figure 20]

- Of the 197 Commercial cases opened in FY 2015, 62 (32 percent) were related to issues and questions about Eligibility, 59 (30 percent) were related to Medical Necessity, and the remaining 135 (38 percent) covered a wide range of Other generic complaints and issues. [Table 4, Figure 19]
- Although the total number of Commercial grievances is similar for both FY 2015 and FY 2014 the distribution of those cases is significantly different in three ways. In FY 2015, Medical Necessity cases increased from 22 percent to 30 percent of cases; Other cases decreased from 38 percent to 13 percent; and Undetermined cases increased from 5 percent to 19 percent. [Table 4, Figure 19] The decrease in Other cases indicates that consumers contacted OHCOBR more often with issues that fit into the routinely tracked categories. And the increase in the number of cases with Undetermined results can be attributed to an increase in the number of cases referred outside of OHCOBR for resolution. OHCOBR currently does not track outcomes for Undetermined cases but is considering doing so in the future.

Table 4. Commercial Cases: Appeals/Grievances Types of Issues Encountered FY14 and FY15				
Issues	FY14 Cases	FY14 % of Total	FY15 Cases	FY15 % of Total
Care Is Experimental/Investigational	11	5%	11	5%
Care Is Not Medically Necessary	42	22%	59	30%
Grandfather Status	0	0%	0	0%
Not Eligible for Health Plan/Benefit	55	29%	62	32%
*Other Issues	74	38%	26	13%
Pre-Existing Condition	Discontinued	Discontinued	Discontinued	Discontinued
Rescission	1	1%	1	1%
Undetermined	9	5%	38	19%
Total Issues (Commercial Cases)	192	100%	197	100%

- In FY 2015, 75 percent (148 cases) of all Commercial cases were closed, compared to only 47 percent (91 cases) in FY 2014. [Table 5, Figure 20]
- In FY 2015, only 25 percent remained open by the end of the fiscal year (49 cases), compared to 53 percent (101 cases) that remained open at the end of FY 2014. [Table 5, Figure 20]
- Of the 148 closed cases in FY 2015, 115 cases (58 percent) were resolved successfully in favor of the consumer, a significant increase over 68 cases (35 percent) in FY 2014. [Table 5, Figure 21]

Table 5. Commercial Cases: Status and Resolution of Cases at Year-End FY14 and FY15				
Year-End Status and Resolution	FY14 Totals	FY14 %	FY15 Totals	FY15 %
Closed Cases – Successful (In favor of the consumer)	68	35%	115	58%
Closed Cases – Unsuccessful (Not in favor of the consumer)	7	4%	19	10%
Closed Cases (Referred Out) –Resolution Undetermined	16	32%	14	7%
Closed Cases - Sub-Total	91	47%	148	75%
Open Cases – Still Pending Resolution	101	53%	49	25%
Total All Non-Commercial Cases (Closed and Open)	192	100%	197	100%

- It took an average of 81.3 days to resolve or close a Commercial case [Table 6, Figure 18]. This represents an increase of 44.2 days (119 percent) in *the average days to resolve or close a case* compared to 37.1 days in FY 2014, largely due to the increase in the number of cases referred for external review by the Independent Review Organization (IRO). Despite the longer time to close cases, more cases were closed in FY 2015 (148) than in FY 2014 (91), and more were resolved in favor of the consumer (115 vs. 68) [Table 5]. Also, the FY 2015 average is still fewer days than in FY 2013 when the average time to close a commercial case was 91.6 days.
- OHCOBR resolved or closed 10 Commercial cases (5 percent) *on the same day they were opened*. In FY 2014, 53 of 192 total cases (28 percent) were resolved on the same day they were opened. This decrease in same day closures is largely due to the increase in the number of cases referred for external review by the IRO. [Table 6]

Table 6. Commercial Cases: Average Number of Days to Close and Same-Day Closures FY14 and FY15			
FY14 # of Cases Closed	FY14 Average # of Days to Close	FY15 # of Cases Closed	FY15 Average # of Days to Close
91	37.1 days	148	81.3 days
FY14 Same-Day Closure Cases		FY15 Same-Day Closure Cases	
53 of 192 total Non-Commercial cases (28%)		10 of 197 total Non-Commercial cases (5%)	
FY15 Variance - Same-Day Closures		43 Fewer Cases	81% Decrease

CONSUMER SAVINGS

- By mid-fiscal year 2015 OHCOBR saved consumers a total of \$627,681.41. The precise annual amount of consumer savings is not available due to a mid-year change in the data collection and reporting methodology; however, it is estimated that the total savings was on par with FY 2014 results when \$932,651.62 was saved on behalf of consumers. [Figure 23]
- Of the total amount saved by mid-year, \$471,963.02 (75 percent) was from resolved Commercial Cases; \$138,308.79 (23 percent) was saved or recouped on behalf of Medicaid fee-for-service, MCO and Alliance beneficiaries; \$8,995.70 (1%) was removed from QMB beneficiaries' accounts for co-payments; and \$8,413.90 (1%) was reimbursed to beneficiaries due to non-payment of Medicare Part B Premiums. [Figure 23].

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

- Most consumers, 95 percent, utilized the telephone to contact OHCOBR (8,011 of 8,438 total contacts). This continues to be the preferred method for contacting the office. In FY 2014, 94 percent of total contacts were made by telephone (7,462 of 7,904 total contacts), and in FY 2013, 91 percent of total contacts were made by telephone (5,901 of 6,507 total contacts) [Figure 22].
- 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].

- Ward 7 residents made 17 percent of all contacts to OHCOBR (1,459), which was the largest number of contacts from a single ward. The second highest number of contacts originated from Wards 5 (1,375) and 8 (1,320), each with 16 percent. [Table 7]

**Table 7. Contacts Located in and Out of the DC Metropolitan Area
FY14 and FY15**

Location of Contacts	FY14 # Contacts	FY14 % Contacts	FY15 # Contacts	FY15 % Contacts
Ward 1	733	9%	867	10%
Ward 2	883	11%	975	11%
Ward 3	358	5%	378	4%
Ward 4	1,046	13%	1,045	12%
Ward 5	1,249	16%	1,375	16%
Ward 6	900	11%	830	11%
Ward 7	1,358	17%	1,459	17%
Ward 8	1,168	15%	1,320	16%
Maryland (Within the DC Metro Area)	15	<1%	28	<1%
Virginia (Outside the DC Metro Area)	12	<1%	13	<1%
Other - Outside of Metro Area	147	2%	108	1%
Out-of-Country	0	0%	0	0%
Undetermined	35	<1%	40	1%
TOTALS	7,904	100%	8,438	100%

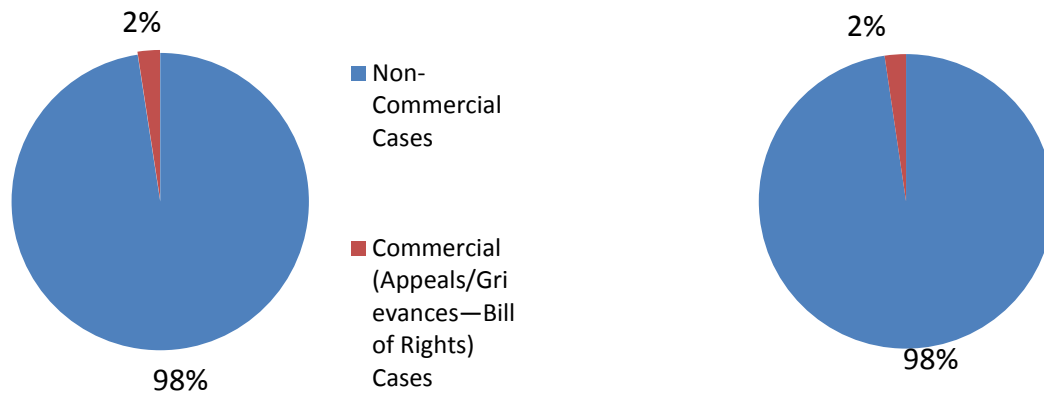
- Eligibility continues to be the most frequent type of issue from all types of consumers combined, at 41 percent of 3,492 total cases [Figure 4]. It was the most frequent issue in FY 2014, 33 percent of 2,501 total cases, and in FY 2013, 35 percent of 2,288 total cases.
- The Access/Coverage issue that includes denials of service was the largest type of issue raised by Medicaid Fee-for-Service contacts (36 percent, 519 of 1,445 cases). Compared to FY 2014, Access/Coverage issues are trending downward for Medicaid FFS contacts, from 43 percent to 36 percent of all cases in FY 2015, as Eligibility issues trend upward from 23 percent to 33 percent of all cases in FY 2015. OHCOBR works closely with the government agency that handles Medicaid enrollment to resolve both issues quickly. [Figure 10]

- Of the 180 Administrative/Fair Hearing cases filed by OHCOBR on behalf of all types of contacts, 66 percent were filed on behalf of EPD Waiver beneficiaries (119 cases).
- The number of access issues for EPD waiver beneficiaries that went to Administrative/Fair Hearings for resolution increased significantly since FY 2014, from 85 cases and 13 percent of all EPD cases to 119 cases and 20 percent in FY 2015. [Table 8, Figure 15]
- A total of 595 EPD Waiver Cases were opened in FY 2015, 12 percent fewer than the 678 cases opened in FY 2014. [Table 8]

Table 8. Types of Issues Encountered by EPD Waiver Contacts	FY14 # of Contacts	FY14 % of Contacts	FY15 # of Contacts	FY15 % of Contacts
Access (Administrative Hearings)	85	13%	119	20%
Access (Including Prior Authorizations)	253	37%	67	11%
Coverage/Service Denials	7	1%	13	2%
Eligibility/Verification of Coverage	166	24%	311	52%
Non-Payment/Reimbursement (Out-of-Pocket Expenses)	29	4%	2	1%
Other Issues	59	9%	0	0%
Quality of Services by Providers	79	12%	83	14%
Totals	678	100%	595	100%

- In FY 2015, a total of 122 Transportation Cases were opened compared to 148 in FY 2014, an 18 percent decrease [Figure 16].
- A total of 376 DC Health Link and Health Care Exchange Marketplace cases were opened in FY 2015, a 49 percent increase compared to the 252 cases in FY 2014. [Figure 17] There was an uptick in complaints in FY 2015 due to technical issues within the Exchange, such as, incorrect program codes and delays in transmission of information from DC Health Link to the insurers. As these issues were resolved during the fiscal year the number of complaints decreased.

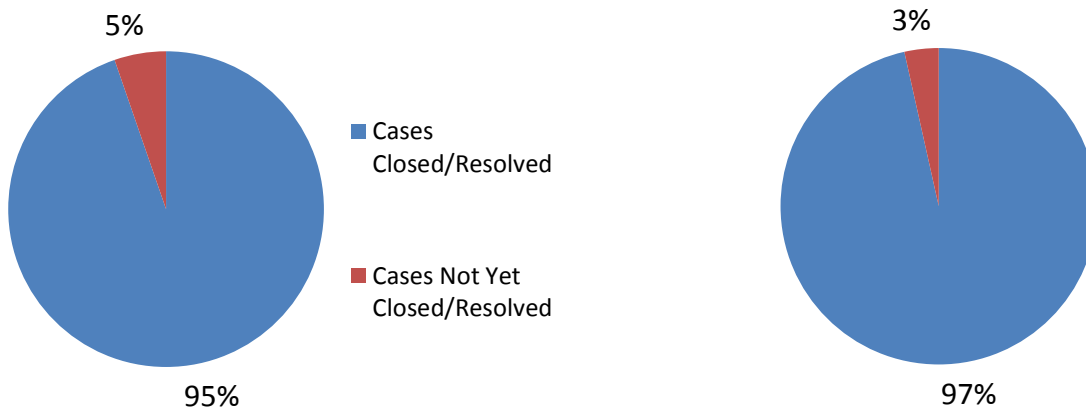
**Figure 1. ALL CASES:
Opened Cases by Insurance Company**



FY14 Total Sample = 7,904 contacted

FY15 Total Sample = 8,438 contacted

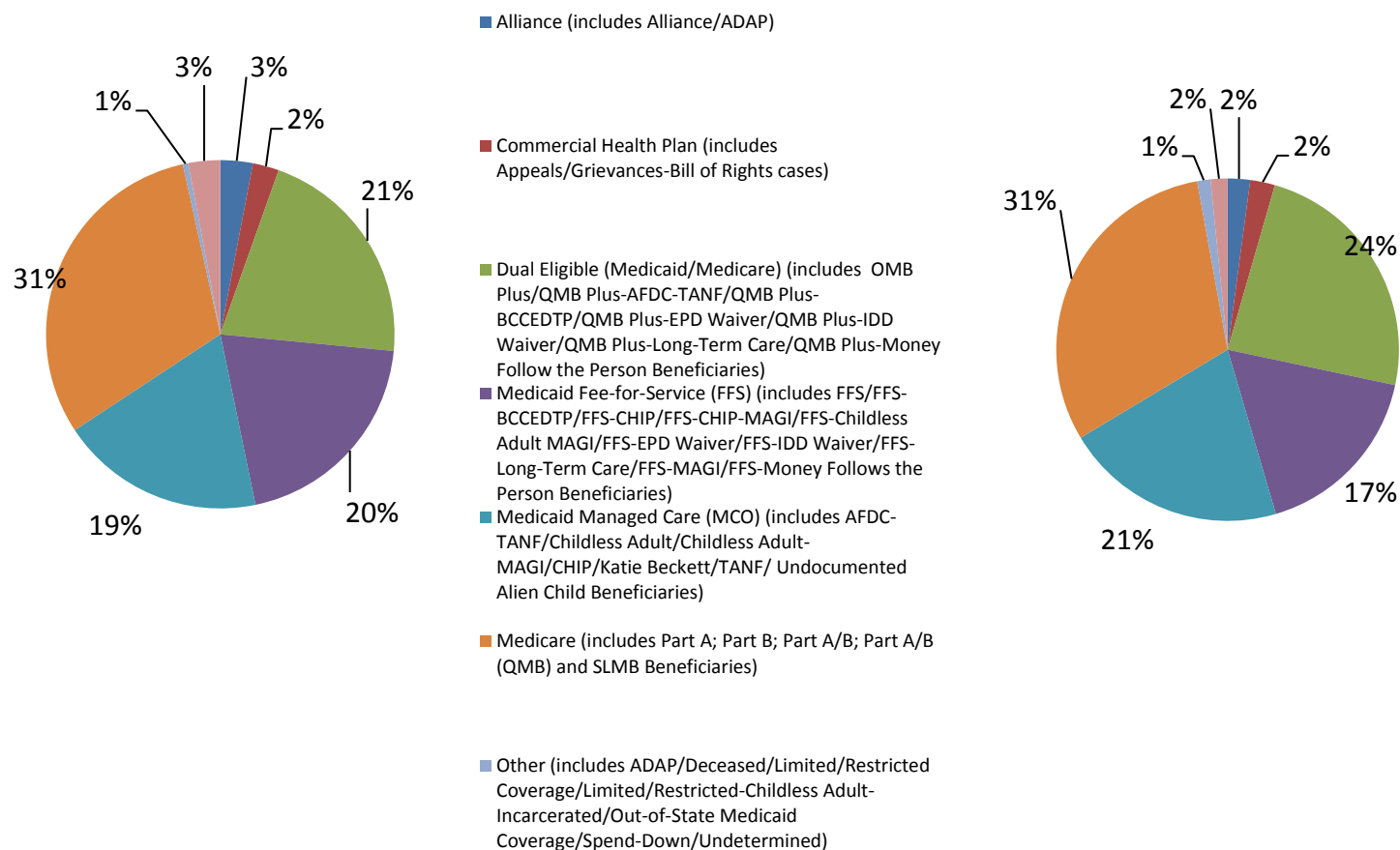
**Figure 2. ALL CASES:
Closed and Open Cases at Year-End**



FY14 Total Sample = 7,712 contacted

FY15 Total Sample = 8,241 contacted

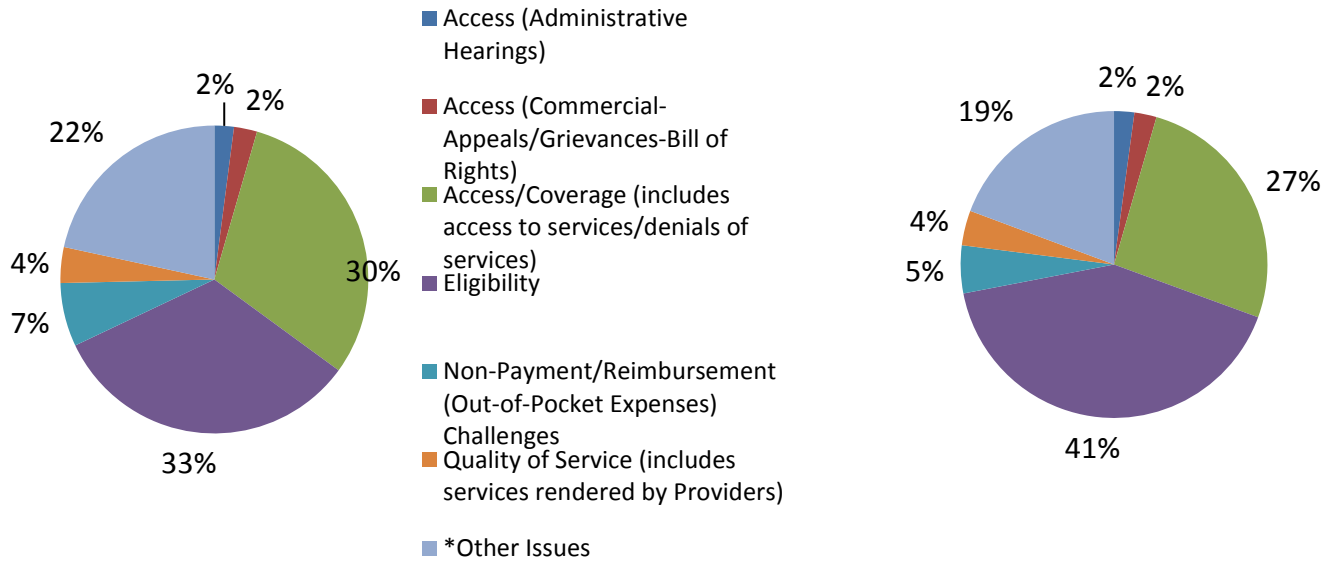
**Figure 3. ALL CASES:
Contacts by Insurance Type**



FY14 Total Sample = 7,904 contacted

FY15 Total Sample = 8,438 contacted

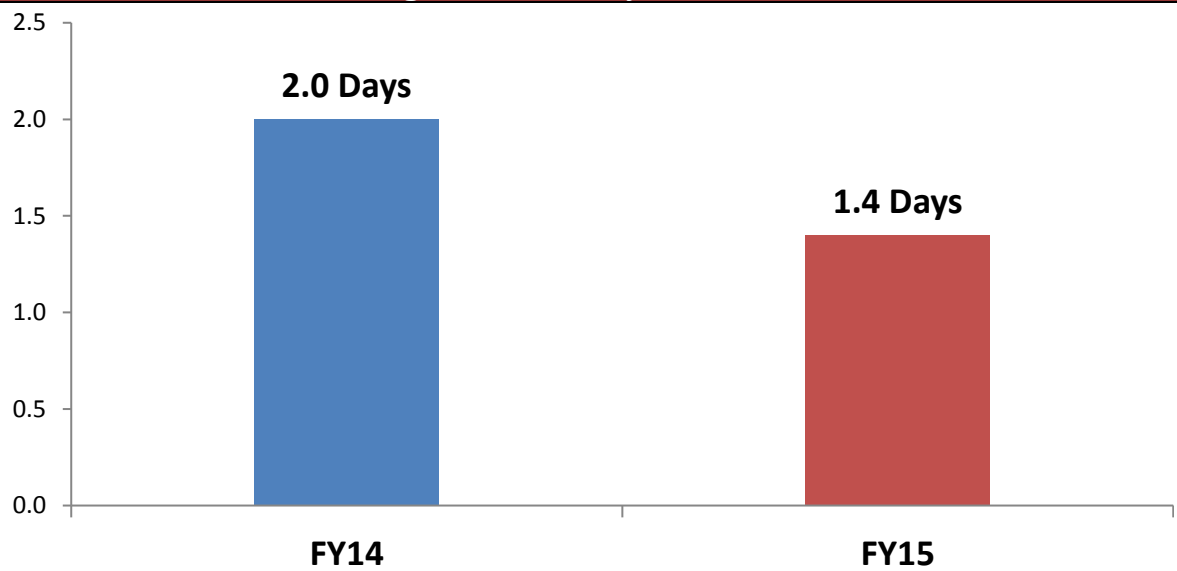
**Figure 4. ALL CASES:
Types of Issues Encountered**



FY14 Total Sample = 7,904 contacted

FY15 Total Sample = 8,438 contacted

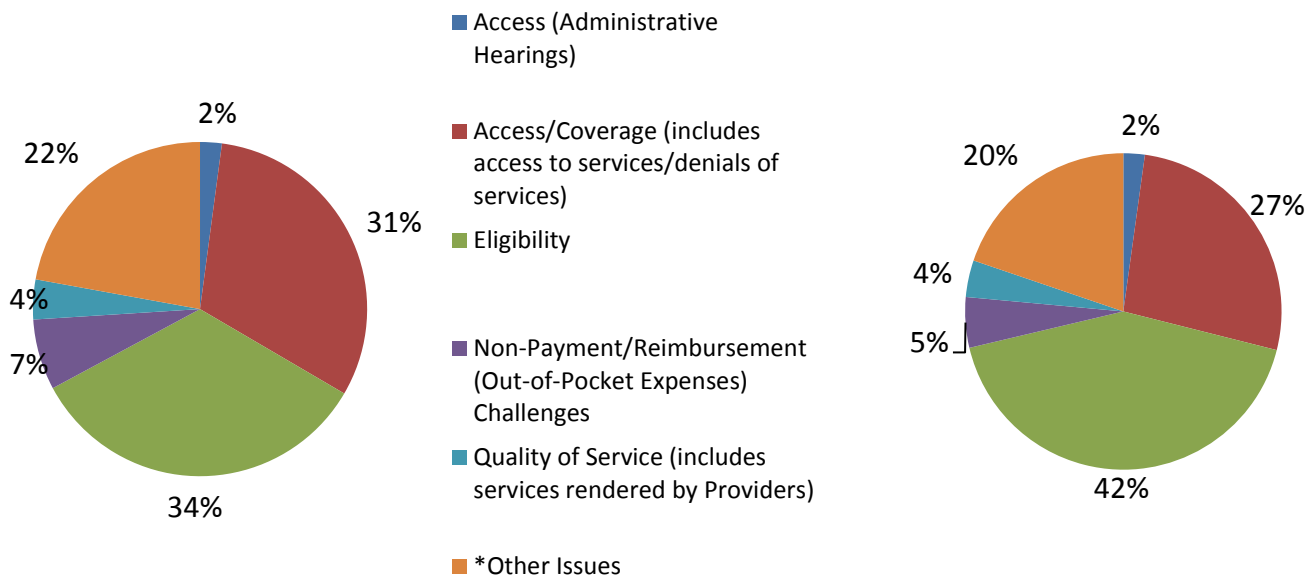
**Figure 5. NON-COMMERCIAL CASES:
Average Number of Days to Close a Case**



FY14 Total Cases Resolved/Closed = 7,304

FY15 Total Cases Resolved/Closed = 7,960

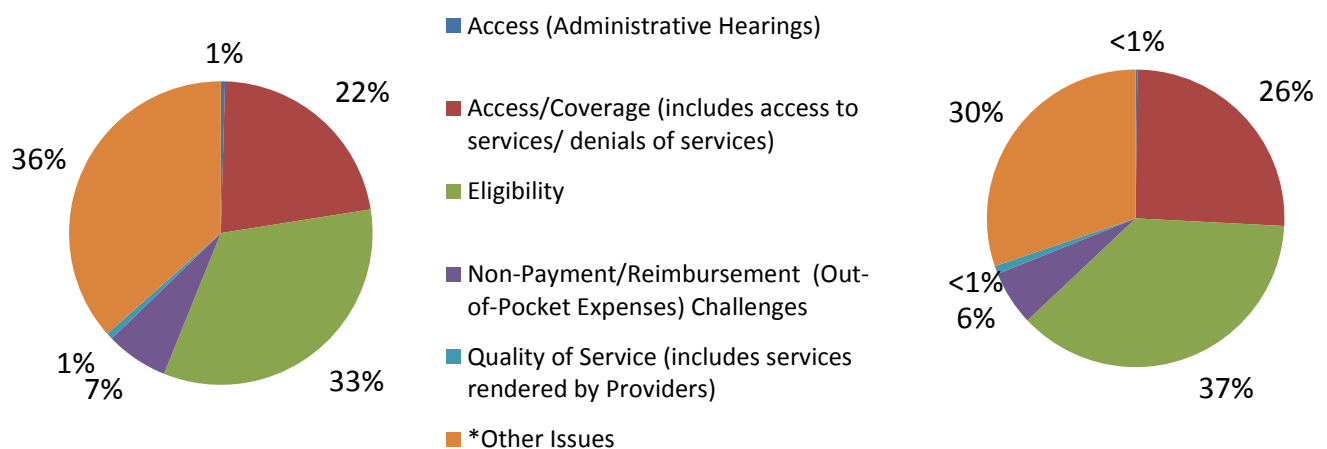
**Figure 6. NON-COMMERCIAL CASES:
Types of Issues Encountered by All**



FY14 Total Sample = 7,712 contacted

FY15 Total Sample = 8,241 contacted

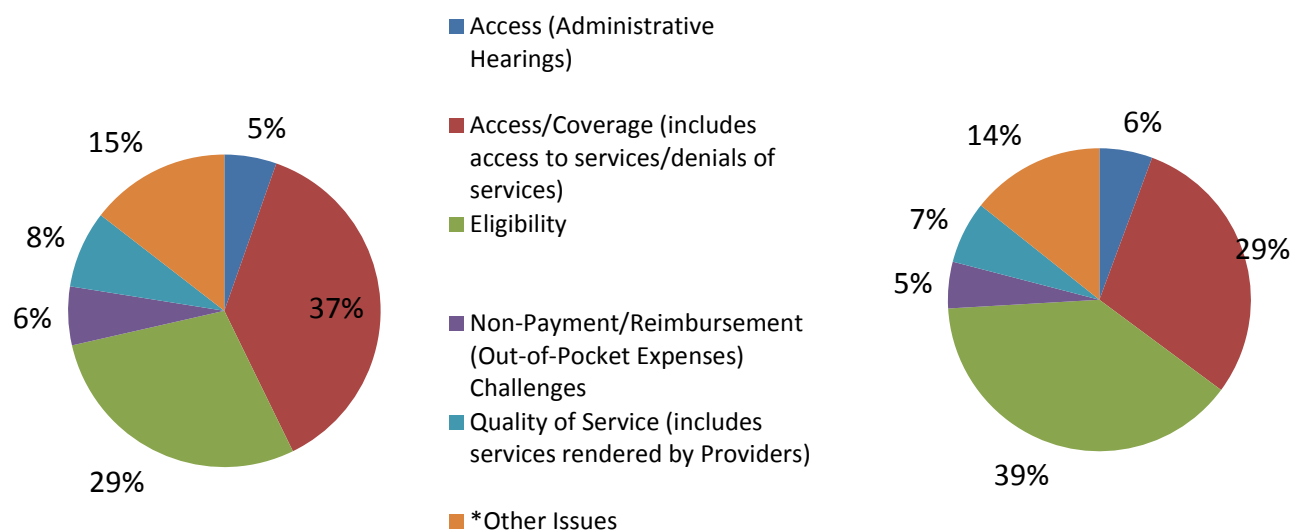
**Figure 7. NON-COMMERCIAL CASES:
Types of Issues Encountered by
'Medicare' Contacts Only (Part A, Part B, Part A/B, Part A/B QMB)**



Y14 Total Sample = 2,436 contacted

FY15 Total Sample = 2,595 contacted

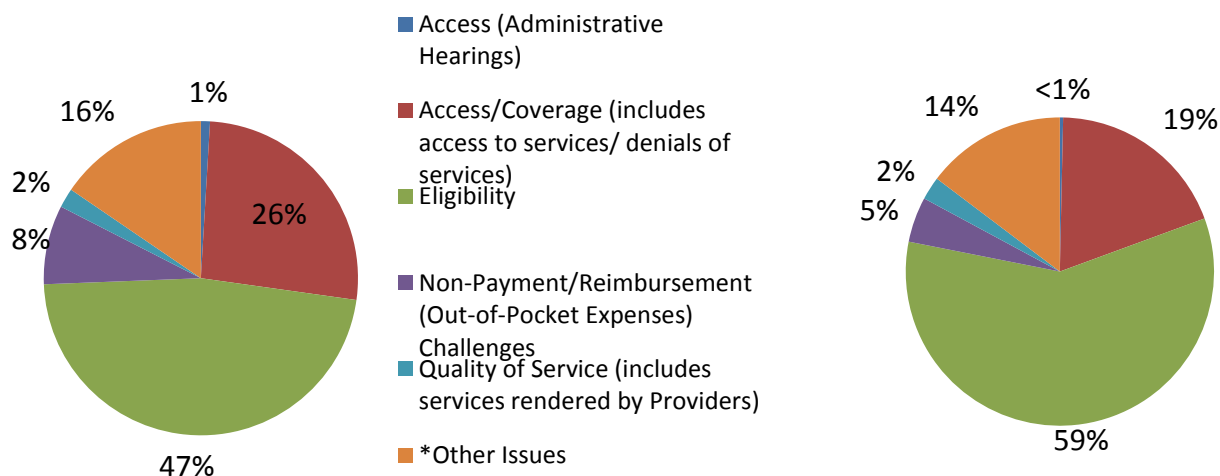
**Figure 8. NON-COMMERCIAL CASES:
Types of Issues Encountered by
'Dual Medicare/Medicaid Contacts Only**



FY14 Total Sample = 1,667 contacted

FY15 Total Sample = 2,014 contacted

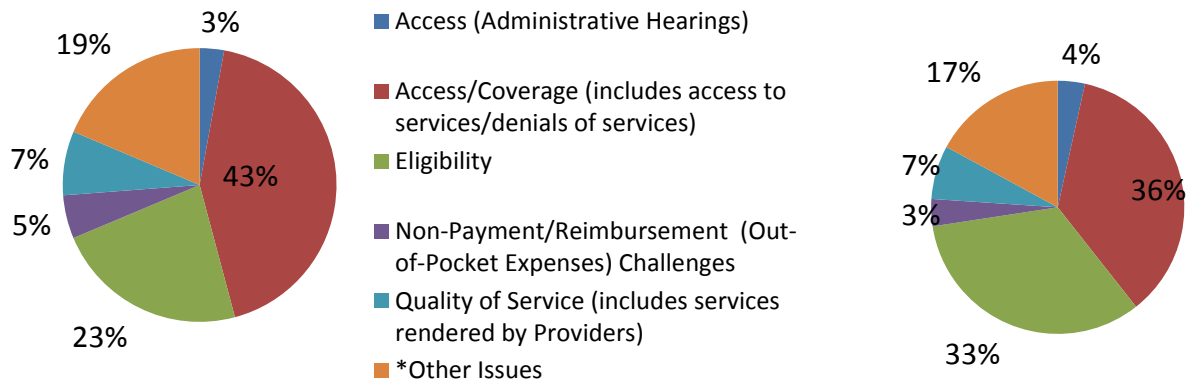
**Figure 9. NON-COMMERCIAL CASES:
Types of Issues Encountered by
'Medicaid Managed Care' (MCO) Contacts Only**



FY14 Total Sample = 1,499 contacted

FY15 Total Sample = 1,768 contacted

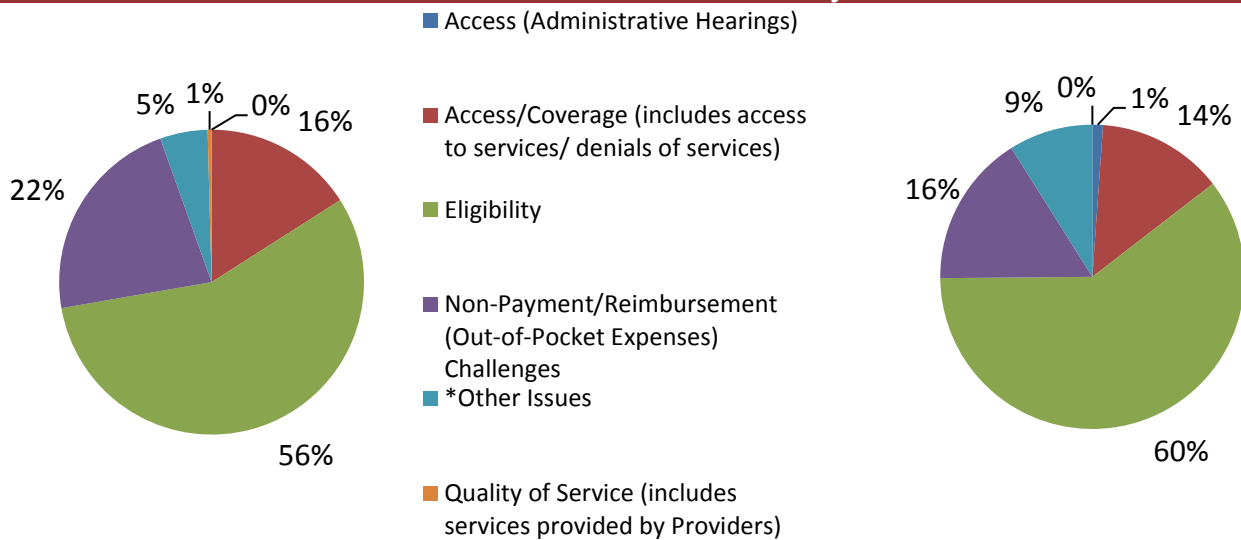
**Figure 10. NON-COMMERCIAL CONTACTS:
Types of Issues Encountered by
'Medicaid Fee-for-Service' (FFS) Contacts**



FY14 Total Sample = 1,599 contacted

FY15 Total Sample = 1,445 contacted

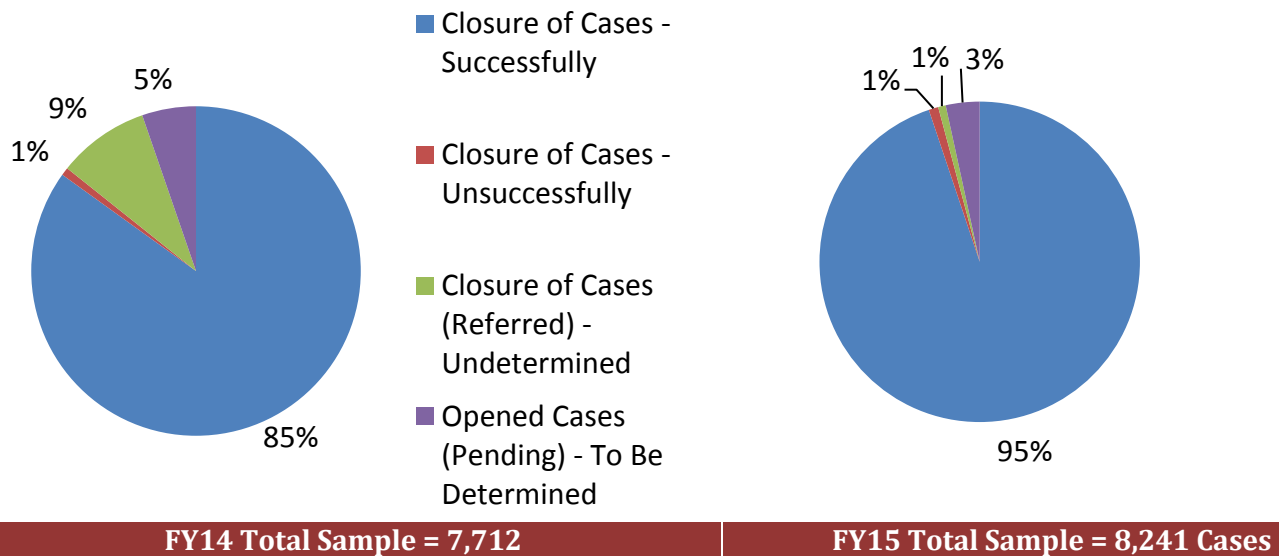
**Figure 11. NON-COMMERCIAL CONTACTS: Types of Issues Encountered by
'Alliance Contacts' Only**



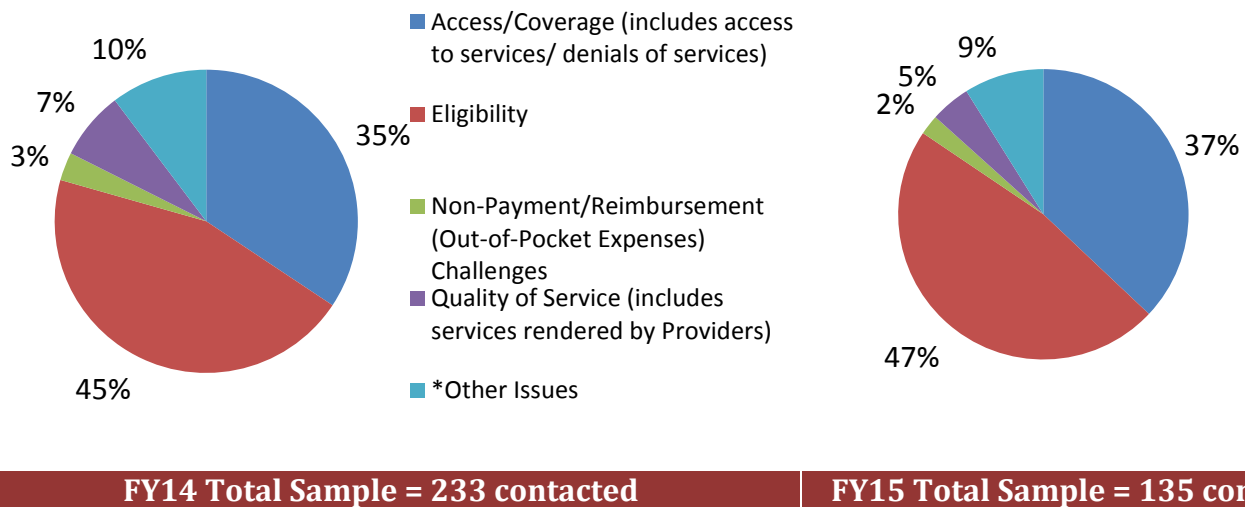
FY14 Total Sample = 238 contacted

FY15 Total Sample = 179 contacted

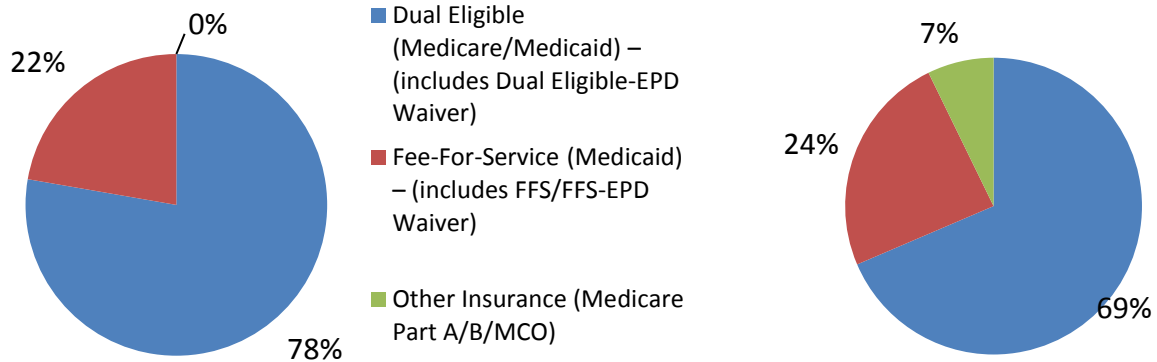
**Figure 12. NON-COMMERCIAL CONTACTS:
Closed and Pending Cases at Year-End by Status**



**Figure 13. UNINSURED CONTACTS:
Types of Issues Encountered by**



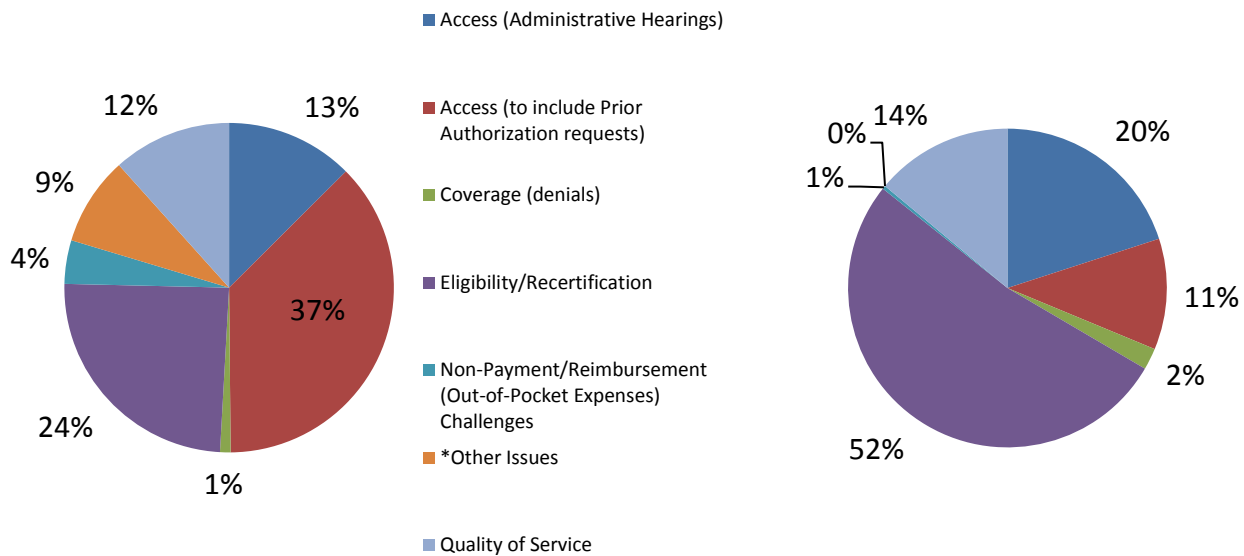
**Figure 14. EPD* WAIVER PROGRAM:
Contacts by Insurance Type**



FY14 Total Sample = 678 contacted

FY15 Total Sample = 595 contacted

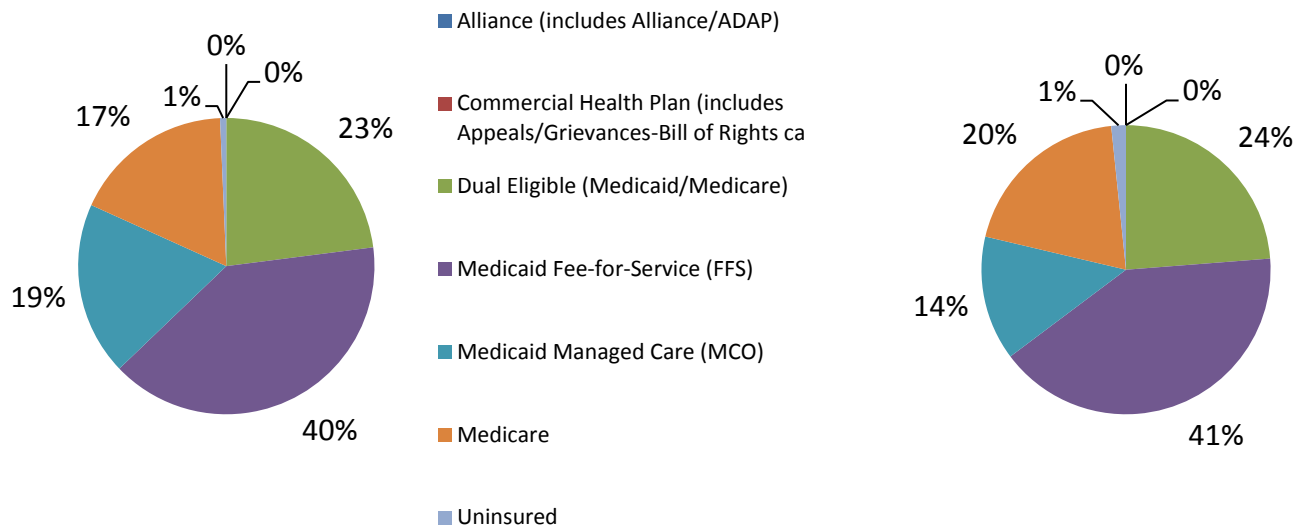
**Figure 15. EPD* WAIVER PROGRAM:
Types of Issues Encountered by
[Elderly and Persons with Disabilities]**



FY14 Total Sample = 678 contacted

FY15 Total Sample = 595 contacted

**Figure 16. TRANSPORTATION:
Contacts by Insurance Type**

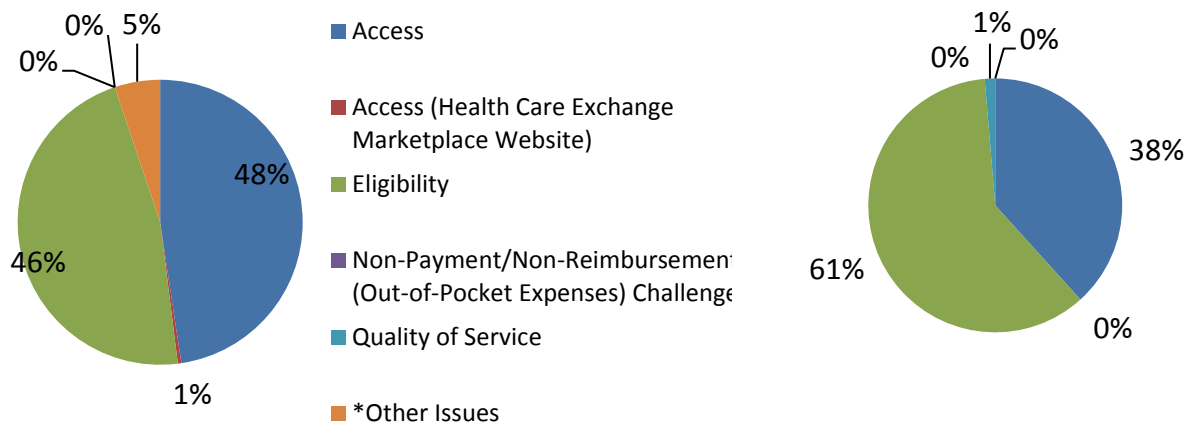


FY14 Total Sample = 678 contacted

FY15 Total Sample = 595 contacted

**Figure 17. DC HEALTH LINK AND HEALTH EXCHANGE MARKETPLACE:
Types of Issues Encountered**

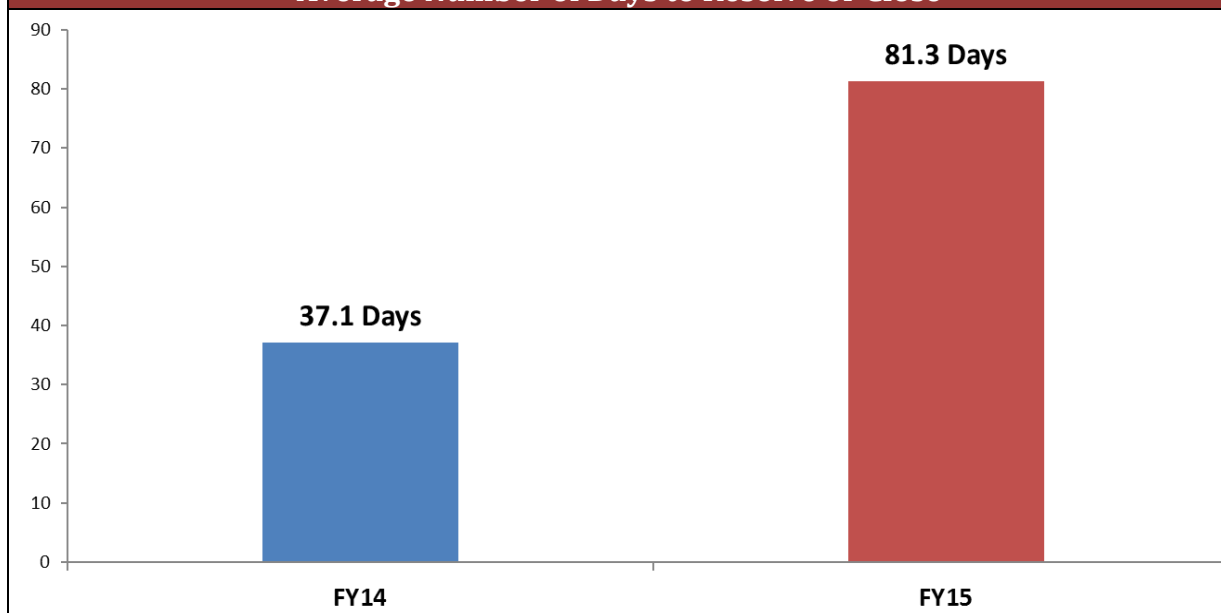
[NOTE: Included Non-Commercial Cases and Commercial Non-Appeals/Grievances Cases]



FY14 Total Sample = 252 contacted

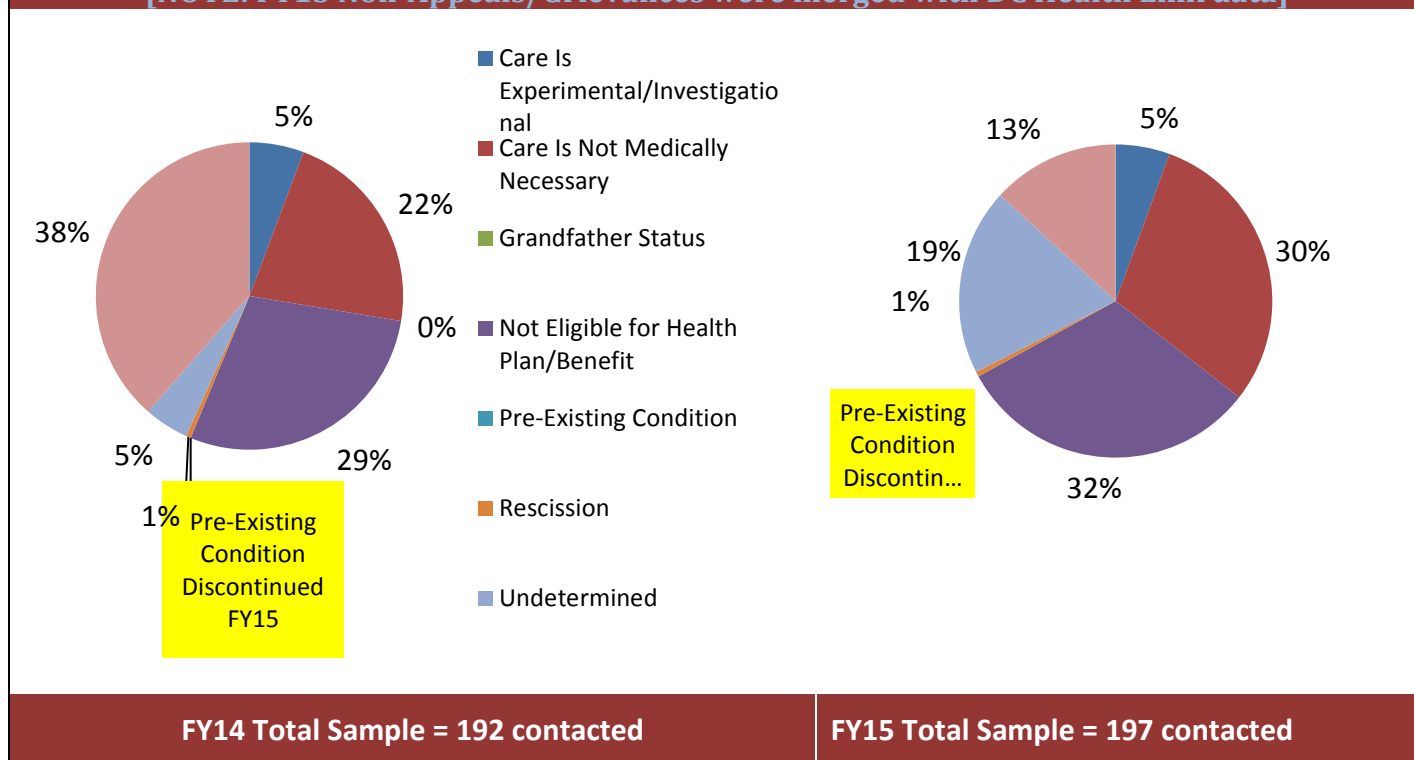
FY15 Total Sample = 376 contacted

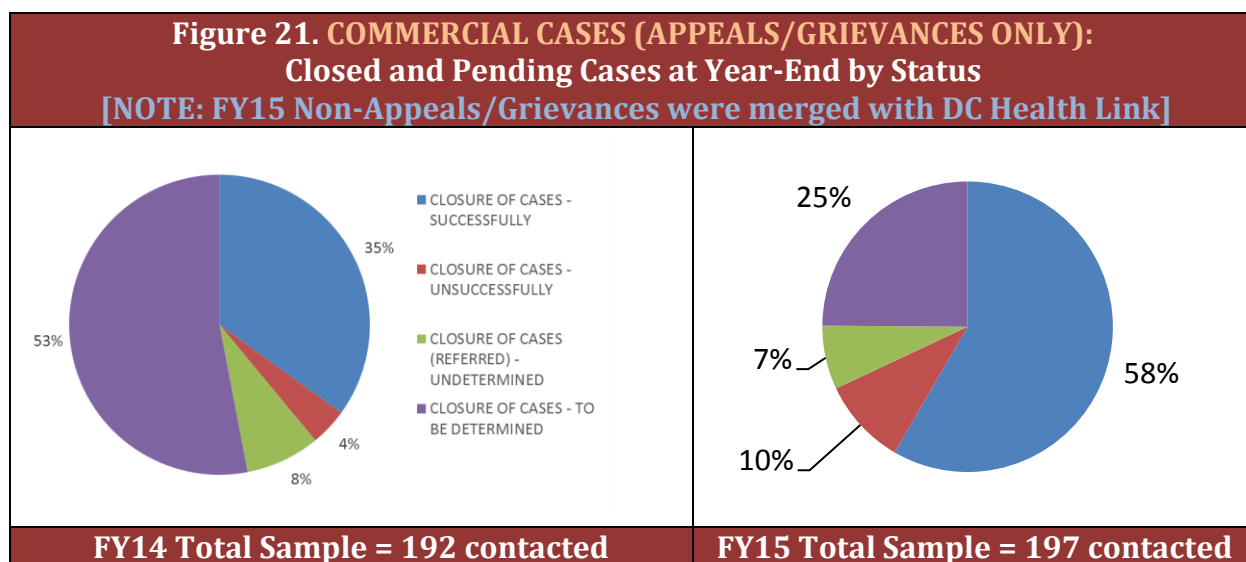
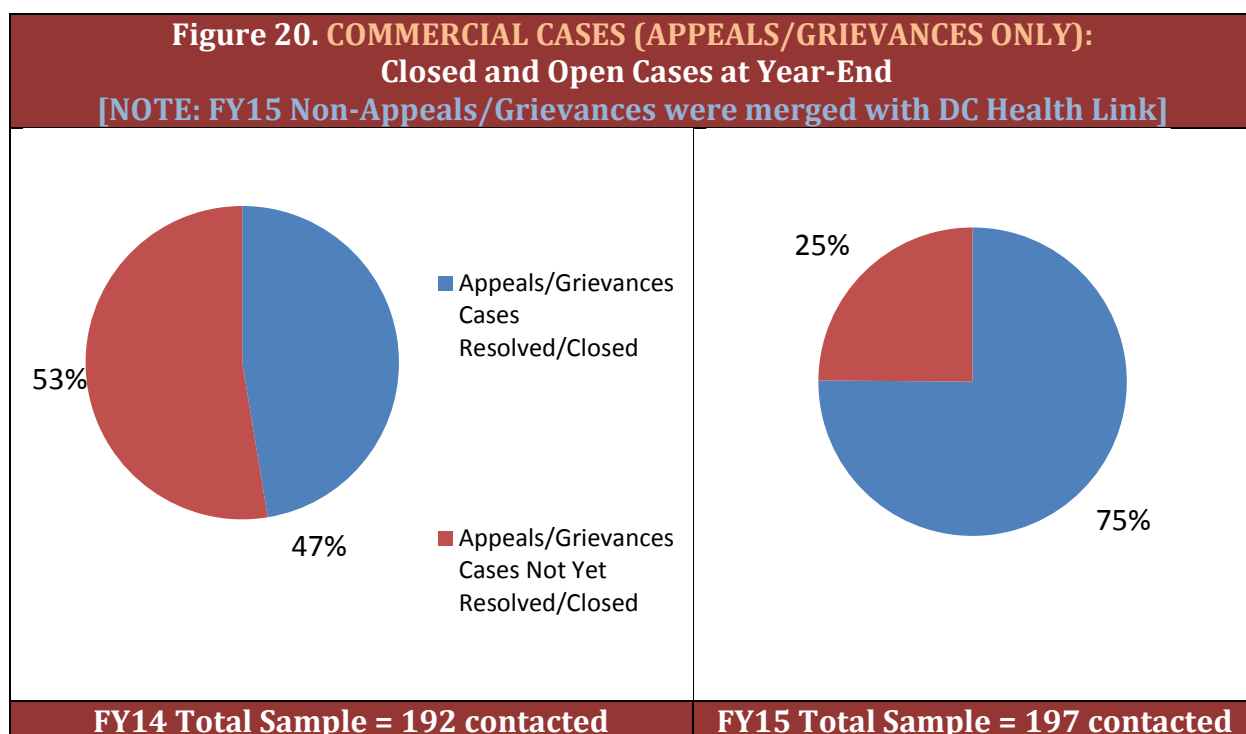
**Figure 18. COMMERCIAL CASES (APPEALS/GRIEVANCES ONLY):
Average Number of Days to Resolve or Close**



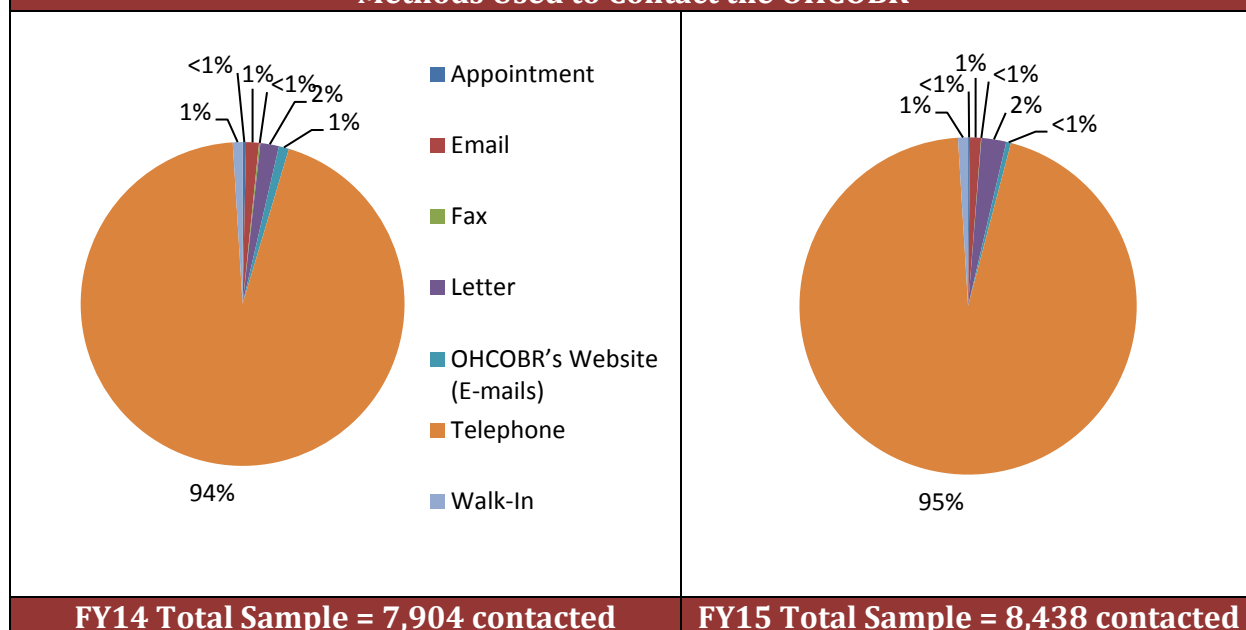
**Figure 19. COMMERCIAL CASES (APPEALS/GRIEVANCES ONLY):
Types of Issues**

[NOTE: FY15 Non-Appeals/Grievances were merged with DC Health Link data]



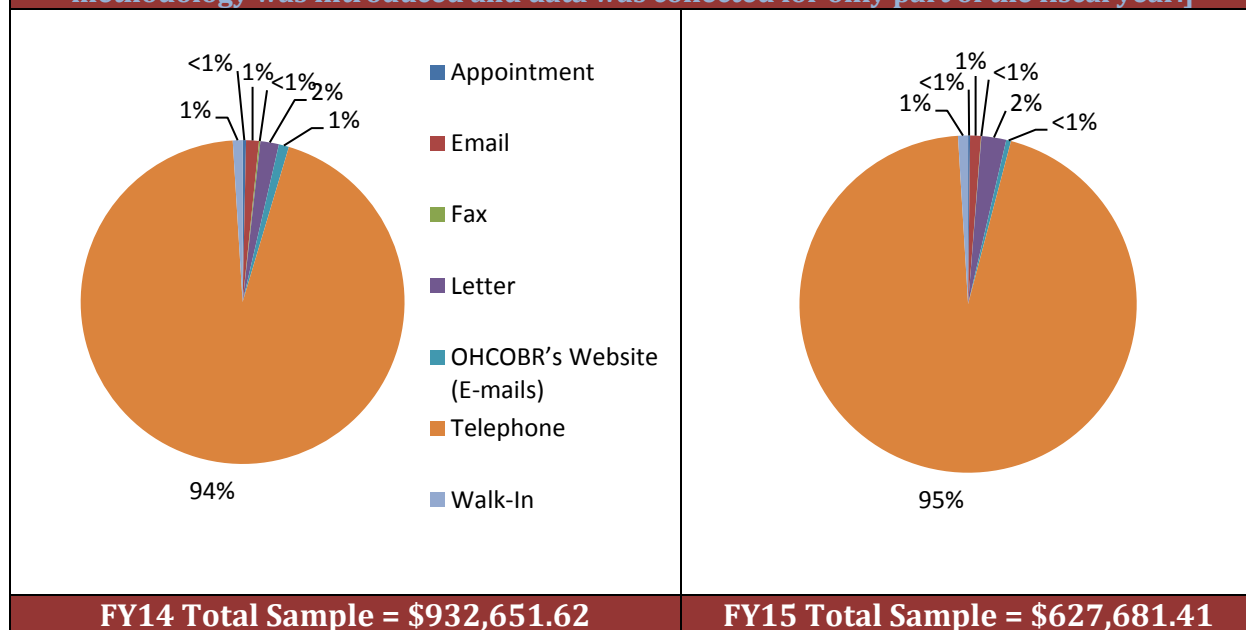


**Figure 22. ALL CASES:
Methods Used to Contact the OHCOBR**



**Figure 23. ALL CASES:
Consumer Savings**

[NOTE: FY15 figures are underrepresented because new mid-year data collection methodology was introduced and data was collected for only part of the fiscal year.]



APPENDIX: TABLE 9 – OUTREACH & EDUCATION EVENTS

OCTOBER 2, 2014 – SEPTEMBER 30, 2015

EVENT DATE	OHCOBR'S PARTICIPATION	NAME OF ORGANIZATION/GROUP	NUMBER OF ATTENDEES
OCTOBER 9, 2014	EXHIBITOR	WARD 2 – 2014 MAYOR'S ANNUAL DISABILITY AWARENESS EXHIBITION	500
OCTOBER 12, 2014	EXHIBITOR/ SPEAKERS	WARD 5 – OHCOBR HEALTH CARE ON TAP	100
NOVEMBERS 13, 2014	EXHIBITOR	WARD 2 – 2015 DC ONE FUND DRIVE	75
NOVEMBERS 28, 2014	EXHIBITOR/ SERVOR	WARD 2 – SAFEWAY'S FEAST OF SHARING – ANNUAL HEALTH AND JOB FAIR	5,000
DECEMBER 10, 2013	EXHIBITOR	WARD 6 – MAYOR'S ANNUAL SENIORS HOLIDAY CELEBRATION AND EXHIBITS	6,000
FEBRUARY 23, 2015	EXHIBITOR	WARD 5 – MAYOR'S BUDGET ENGAGEMENT FORUM	600
FEBRUARY 25, 2015	EXHIBITOR	WARD 1 – DC OFFICE ON AGING COMMUNITY HEALTH & WELLNESS INFORMATION FAIR	300
APRIL 6, 2015	SPEAKER	WARD 6 – SENIOR CITIZENS INFORMATION ASSISTANCE MINISTRY 10 TH STREET BAPTIST CHURCH	50
APRIL 8, 2015	EXHIBITOR	WARD 4 – DC OFFICE ON AGING & DEPT. OF PARKS AND RECREATION - COMMUNITY HEALTH, WELLNESS AND INFORMATION FAIR	500
MAY 13, 2015	EXHIBITOR	WARD 2 – MAYOR'S 4 TH ANNUAL SENIOR SYMPOSIUM	1,000
MAY 19, 2015	PRESENTOR	WARD 5 – HEALTH CARE ON TAP PROVIDENCE HOSPITAL - ALZHEIMER'S ASSOCIATION MEETING	20
MAY 27, 2015	EXHIBITOR	WARD3 – GARFIELD TERRACE	20
JUNE 4, 2015	EXHIBITOR	WARD 2 – DC HOUSING FORUM FOR PEOPLE WITH DISABILITIES	300
JUNE 11, 2015	EXHIBITOR	WARD 8 – DCOA – SENIOR FESTIVAL PICNIC	1,000
JUNE 13, 2015	EXHIBITOR	WARD 5 – HSCSN ANNUAL FAMILY AND COMMUNITY FAIR	1,000
JUNE 16, 2015	EXHIBITOR	WARD 2 – HEALTH CARE ON TAP - DASH	50
JUNE 17, 2015	EXHIBITOR	WARD 8 – MENTAL & BEHAVIORAL HEALTH DAY	100
JUNE 19, 2015	EXHIBITOR	WARD 7 – HEALTH CARE ON TAP - CHILDEN'S NATIONAL HEALTH SYSTEM	200
AUGUST 12, 2015	EXHIBITOR	WARD 4 – HEALTH CARE ON TAP – DASH – ABUSED RESIDENTS	40 ADULTS 60 CHILDREN
AUGUST 20, 2015	EXHIBITOR	WARD 8 – OUTREACH AND BUSINESS MINISTRY – TEMPLE OF PRAISE 2015 NUTRITION AND HEALTH FAIR	150
SEPTEMBER 10, 2015	PRESENTOR	WARD 6 – TRUSTED HEALTH PLAN MEMBERS	20
SEPTEMBER 18, 2015	PRESENTOR	HEALTH CARE ON TAP - CLARIE TOWERS - SENIORS	20

APPENDIX: COMMERCIAL INSURANCE SELF-REPORTS

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

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

§ 44.301.10. Reporting Requirements

(A) EVERY INSURER SHALL SUBMIT TO THE DIRECTOR [OF DHCF OR DESIGNEE] AN ANNUAL GRIEVANCE REPORT THAT CHRONICLES ALL GRIEVANCE ACTIVITY FOR THE PRECEDING YEAR. THE DIRECTOR SHALL DEVELOP A SYSTEM FOR CLASSIFYING AND CATEGORIZING ALL GRIEVANCES AND APPEALS THAT ALL INSURERS AND INDEPENDENT PEER REVIEW ORGANIZATIONS WILL USE WHEN COLLECTING, RECORDING, AND REPORTING GRIEVANCE AND APPEALS INFORMATION. THE DIRECTOR SHALL ALSO DEVELOP A REPORTING FORM FOR INCLUSION IN THE ANNUAL REPORT THAT SHALL INCLUDE THE FOLLOWING INFORMATION:

- (1) THE NAME AND LOCATION OF THE REPORTING INSURER;
- (2) THE REPORTING PERIOD IN QUESTION;
- (3) THE NAMES OF THE INDIVIDUALS RESPONSIBLE FOR THE OPERATION OF THE INSURER'S GRIEVANCE SYSTEM;
- (4) THE TOTAL NUMBER OF GRIEVANCES RECEIVED BY THE INSURER, CATEGORIZED BY CAUSE, INSURANCE STATUS AND DISPOSITION;
- (5) THE TOTAL NUMBER OF REQUESTS FOR EXPEDITED REVIEW, CATEGORIZED BY CAUSE, LENGTH OF TIME FOR RESOLUTION, AND DISPOSITION....

(D) ...THE DIRECTOR SHALL, BASED UPON INDIVIDUAL CASES AND THE PATTERNS OF GRIEVANCE AND APPEALS ACTIVITY, INCLUDE IN THE ANNUAL REPORT [TO THE D.C. COUNCIL] RECOMMENDATIONS CONCERNING ADDITIONAL HEALTH CONSUMER PROTECTIONS.

The *Commercial Insurer's Annual Self-Report* includes the total number of grievances within each service category listed below, the number of cases that resulted in the initial decision being upheld, and the number of overturned cases that resulted in a full or partial reversal of the decision that caused the grievance. 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 reported. The data from the reports is examined below and summarized on Tables 10 and 11.

SERVICE CATEGORIES REPORTED

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

DATA SUMMARY AND HIGHLIGHTS

The *Self-Reports* includes the total number of grievances within each service category listed above, the number of cases that resulted in the initial decision being upheld, and the number of overturned cases that resulted in a full or partial reversal of the decision that caused the grievance. The number of emergency cases, the number of days it took to resolve emergency and mental health cases, a sampling of procedures involved in grievance cases and other details are also contained in the reports.

Using the data from the FY 2015 *Commercial Insurer's Annual Self-Reports*, OHCOBR could 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 timely resolutions, and determine areas that require further review and follow-up. Gauging the benefits of the *Self-Report* and identifying value-added modifications is an ongoing process. Data from the *Self-Reports* are examined below and summarized on Tables 10 and 11.

- A total of 37 companies submitted annual self-reports. This was an increase of five more companies than in FY 2014 (32) and four more companies than in FY 2013 (33).

- Of the 37 companies that submitted an annual self-report, 23 reported consumer grievances and appeals and 14 reported no grievances and appeals. In FY 2014, 21 of 32 companies reported consumer grievances and appeals (two fewer than in FY 2015) and 11 reported no grievances and appeals (three fewer than in FY 2015). In FY 2013, 19 of 33 companies reported grievances and appeals (four fewer than in FY 2015) and 14 reported no grievances and appeals (the same number as FY 2015).
- The 23 companies that reported grievances and appeals opened a total of 2,391 cases. This is slightly more than the 2,317 cases opened by 21 companies in FY 2014 (74 more cases, 3 percent increase). In FY 2013, before the Affordable Care Act (ACA) went into effect, 19 companies opened 1,865 cases (526 fewer cases, 28 percent less than FY 2015).
- A total of 947 of 2,391 opened cases resulted in the initial decision being upheld (40 percent) compared to 967 cases upheld in FY 2014 (42 percent of 2,317 opened cases). In FY 2013, 733 cases were upheld, which was 39 percent of the 1,865 cases that were opened. Upheld cases are those that are reviewed and the original decision does not change.
- A total of 1,124 opened cases (47 percent) resulted in the initial decision being overturned. There were 74 more cases opened in FY 2015 than in FY 2014 (2,391 vs. 2,317) and a higher percentage of cases were reversed (4 percent more than in FY 2014). The reversal rate in FY 2014 was 43 percent (998 of 2,317 opened cases). Both FY 2014 and FY 2013 had the same percentage of overturned cases (43 percent). Overturned cases are those that are reviewed and the original decision is reversed in favor of the beneficiary.
- A total of 320 of 2,391 opened cases were *partially* overturned in favor of the beneficiary (13 percent), compared to 352 of 2,317 opened cases (15 percent) in FY 2014, and 327 cases of 1,865 opened cases (18 percent) in FY 2013.
- The combined total of overturned and partially overturned cases was 1,444 cases (60 percent of all opened cases), 94 more cases than in FY 2014. The year-to-year variance between FY 2014 and FY 2015 was an increase of 2 percent. In FY 2013, the combined total was 1,232 cases (61% of all opened cases). There were 212 more cases in FY2015 than in FY2013, an increase of 17 percent.
- Of the 23 companies reporting grievances and appeals in FY 2015, 14 had an overturned and partially overturned rate of 40 percent or higher in at least one service category. In FY 2014 there were 13 companies with these high reversal rates. In FY 2013 only 8 of 19 companies reporting had a reversal rate of 40 percent or higher in at least one service category. This indicates that more cases are now being reversed upon appeal, which

benefits the covered member, but raises questions as to what is causing so many cases to be initially denied.

- The four service categories with the most prevalent grievances in FY 2015 were Inpatient, Physician, Lab/Radiology, and Pharmacy. Inpatient Services is a new addition to this list. The other three categories were the most prevalent service categories of reported grievances during the two previous fiscal years.

The following tables summarize some of the details and findings from the FY 2015 annual *Self-Reports* submitted by commercial insurers.

Table 10. Commercial Insurers' Annual Self-Report² FY 2015
[GRAY SHADING INDICATES NO GRIEVANCES TO REPORT OR EXEMPT]

NAME OF INSURER	TOTAL GRIEVANCES	UPHELD		OVERTURNED		PARTIALLY OVERTURNED	
		#	%	#	%	#	%
Aetna Health Inc.	13	8	62%	4	31%	1	8%
Aetna Life Insurance Co.	29	20	69%	9	31%	0	0%
Allianz Life Ins. Co. of America							
American Specialty Health Ins. Co.							
Ameritas Life Insurance Co.	229	143	62%	72	31%	14	6%
Blue Choice, Inc.	335	102	30%	229	68%	4	1%
CareFirst of Maryland, Inc.	138	49	36%	80	58%	9	7%
Cigna Health and Life Ins. Co.	174	136	78%	33	19%	5	3%
Cigna Healthcare Mid-Atlantic Inc.							
Connecticut General Life Ins. Co.	23	18	78%	4	17%	1	4%
Continental American Ins Co.	1	0	0%	1	100%	0	0%
Delta Dental Ins. Co.	11	5	45%	6	55%	0	0%
Fidelity Security Life Ins. Co.							
Golden Rule Ins. Co.	2	1	50%	1	50%	0	0%
Group Hosp. & Medical Services	324	116	36%	191	59%	17	5%
John Alden Life Ins. Co.	2	0	0%	2	100%	0	0%
Kaiser Permanente	119	45	38%	70	59%	4	3%
MAMSI Life & Health Ins. Co.							
MDIPA	338	160	47%	175	52%	3	1%
Metropolitan Life Ins. Co.	525	62	12%	205	39%	258	49%
Mutual of Omaha Insurance Co.	EXEMPTION GRANTED BY OHCOBR						
Nat'l Union Fire Ins. Co. of Pitts., PA	37	24	65%	12	32%	1	3%
Optimum Choice, Inc.	8	2	25%	6	75%	0	0%
Principal Life Ins. Co.							
Prudential Ins. Co. of America							
Reliance Standard Life Ins. Co.	2	2	100%	0	0%	0	0%
Standard Insurance Co.	2	2	100%	0	0%	0	0%
Time Insurance Company	15	7	47%	8	53%	0	0%
Trustmark Insurance Co.							
Trustmark Life Ins. Co.							
UniCare Life & Health Ins. Co.							
Union Security Insurance Co.							
United Concordia Life & Health	23	15	65%	6	26%	2	9%
United Healthcare Ins. Co.	36	27	75%	8	22%	1	3%
United Healthcare Life Ins. Co.							
United Healthcare of Mid-Atlantic	5	3	60%	2	40%	0	0%
United of Omaha Life Insurance Co.	EXEMPTION GRANTED BY OHCOBR						
TOTAL	2,391	947	40%	1124	47%	320	13%

² **Source:** Data was gathered from standardized annual self-reports required by legislative mandate, based on their own internal grievance and appeals process. OHCOBR did *not* participate in resolving most of these cases.

Table 11. Commercial Insurers' Annual Self-Report³ FY 2015 (Cont'd)

[GRAY SHADING INDICATES NO GRIEVANCES TO REPORT OR EXEMPT]

[BLACK SHADING INDICATES SERVICE IS NOT COVERED BY PLAN]

RESOLUTION TIMES BY TYPE OF CASE				
NAME OF INSURER	EMERGENCY CASES [HOURS]	EMERGENCY MENTAL HEALTH [HOURS]	NON-EMERGENCY CASES [CALENDAR DAYS]	NON-EMERGENCY MENTAL HEALTH [CALENDAR DAYS]
Aetna Health Inc.	5	Unspecified	53	Unspecified
Aetna Life Insurance Co.	22	Unspecified	39	37
Allianz Life Ins. Co. of America				
American Specialty Health Ins. Co.				
Ameritas Life Insurance Co.	Unspecified		Unspecified	
Blue Choice, Inc.	11	Unspecified	23	29
CareFirst of Maryland, Inc.	0	Unspecified	31.3	38
Cigna Health and Life Ins. Co.	56.62	0	22	23
Cigna Healthcare Mid-Atlantic Inc.				
Connecticut General Life Ins. Co.	0	0	22.5	27.5
Continental American Ins Co.	0	0	1	0
Delta Dental Ins. Co.	0	0	28	0
Fidelity Security Life Ins. Co.				
Golden Rule Ins. Co.	0		13	
Group Hosp. & Medical Services	8	0	34	3
John Alden Life Ins. Co.	0		41	
Kaiser Permanente	18.3	24	24.9	23.4
MAMSI Life & Health Ins. Co.				
MDIPA	22	35	16	96
Metropolitan Life Ins. Co.	0		13.5	
Mutual of Omaha Insurance Co.	EXEMPTION GRANTED BY OHCOBR			
Nat'l Union Fire Ins. Co. of Pitts., PA	0	0	6	0
Optimum Choice, Inc.	0	0	9	0
Principal Life Ins. Co.				
Prudential Ins. Co. of America				
Reliance Standard Life Ins. Co.	0		0	
Standard Insurance Co.	0		0	
Time Insurance Company	0	0	39.47	0
Trustmark Insurance Co.				
Trustmark Life Ins. Co.				
UniCare Life & Health Ins. Co.				
Union Security Insurance Co.				
United Concordia Life & Health	0		13.4	
United Healthcare Ins. Co.	0	27.5	7	316
United Healthcare Life Ins. Co.				
United Healthcare of Mid-Atlantic	0	0	41	0
United of Omaha Life Insurance Co.	EXEMPTION GRANTED BY OHCOBR			

³ **Source:** Data was gathered from standardized annual self-reports required by legislative mandate, based on their own internal grievance and appeals process. OHCOBR did *not* participate in resolving most of these cases.

NOTES

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