OFFICE OF HEALTH CARE OMBUDSMAN AND BILL OF RIGHTS (OHCOBR)

FY2011 ANNUAL SUMMARY OF CASES REPORT

October 1, 2010 through September 30, 2011

Table of Contents

FY2011 Activities

During Fiscal Year 2011, the OHCOBR has tracked all communications, or contacts, received. The OHCOBR classified all contacts as "cases" which the Office investigated and strived to bring closure. The OHCOBR staff recorded all contacts in a standardized Health Care Ombudsman In-Take Tracking Log that has specific categories for classifying different cases. These findings summarize data from the In-Take Tracking Log for the Fiscal Year 2011 (October 1, 2010 through September 30, 2011).

In summarizing the activities from the In-Take Tracking Log, the OHCOBR sought to answer the following key questions:

- How do DC residents contact the Office of Health Ombudsman and Bill of Rights?
- Who contacts the Office of Health Care Ombudsman and Bill of Rights?
- What are the most common issues experienced by the community?

During Fiscal Year 2011, the OHCOBR received a total of **3,313** contacts by individuals (consumers), of which 517 individuals were repeat callers**.**

The following sections present findings from the Health Care Ombudsman's In-Take Tracking Log, specifically:

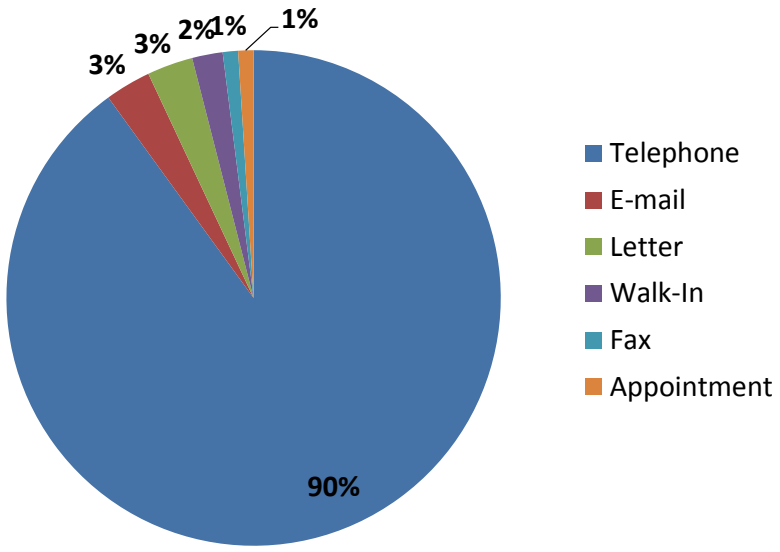
- Methods of contacting the OHCOBR;
- OHCOBR contacts by insurance type;
- OHCOBR contacts by Ward;
- Categories of issues encountered by OHCOBR consumers;
- Categories of issues encountered by consumers by insurance type and uninsured (to include pre-existing condition insurance);
- Proportion of closed (resolved) cases; and
- Average Number of Days to Close/Resolve Cases.

Source data captured between October 1, 2010 through September 30, 2011

Methods of Contacting OHCOBR

Methods used by consumers to contact the OHCOBR in Fiscal Year 2011 are presented in **Figure 1**. Nine out of ten contacts received by OHCOBR were via ***Telephone Calls*** (3,027 contacts, representing 90% of total contacts). The next most frequent means of communication was via ***E-Mails*** *(102 contacts)* and ***Letters*** *(102 contacts)*, each accounted for 3% of total contacts, **Walk-Ins** (75 contacts), represented 2% of total contacts). ***Faxes*** (5 contacts), and ***Appointments*** (2 contacts), each accounted for 1% of total contacts.

Figure 1. Methods of Contacting OHCOBR--FY11



Total Sample = 3,313 contacted

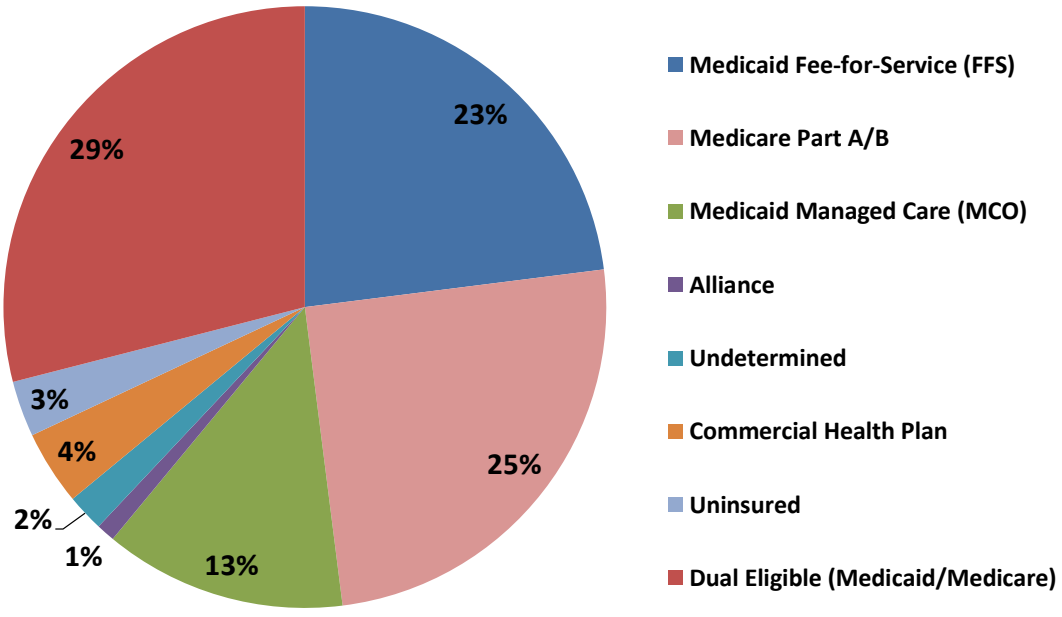
Source data captured between October 1, 2010 through September 30, 2011

OHCOBR Contacts by Insurance Type

Figure 2 presents the number of contacts by insurance type for Fiscal Year 2011. About half of OHCOBR contacts were by ***Dual Eligible (Medicare/Medicaid) beneficiaries*** (962 contacts, representing 29%). Contacts by those enrolled in **Medicare Part A/B** represented the next most common insurance category (840 contacts, representing 25%) followed by ***Medicaid FFS*** (752 contacts, representing 23%), ***Medicaid Managed Care (MCO)*** (420 contacts, representing 13%), Commercial **Health Plan members** (131 contacts, representing 4%), **Uninsured consumers** (109 contacts, representing 3%) **Undetermined consumers** (52 contacts, representing 2%), and ***Alliance*** (47 contacts, representing 1%).

Note: In 2010, approximately 35,000 beneficiaries transitioned from the Alliance program into the Medicaid program, as a result of the Affordable Care Act. This is the reason for the decline in the total OHCOBR Alliance contacts, from 226 in FY10 to 47 in FY11.

Figure 2. OHCOBR Contacts by Insurance Type--FY11

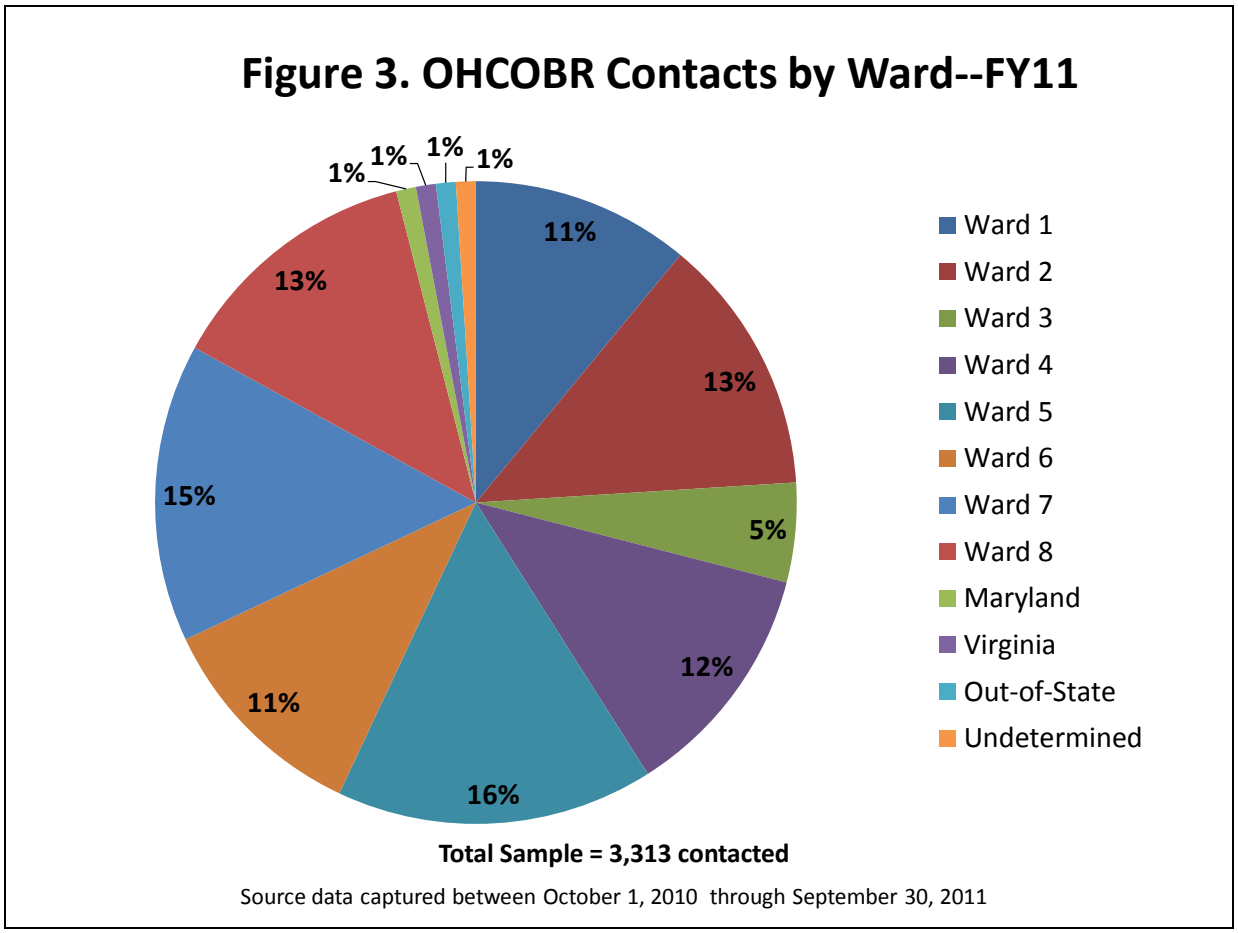


Total Sample = 3,313 contacted

Source data captured between October 1, 2010 through September 30, 2011

OHCOBR Contacts by Ward

Contacts by Ward for Fiscal Year 2011 are presented in **Figure 3**. The top four **Wards** in terms of contacts were ***Ward 5*** (526 contacts or 16%), ***Ward 7*** (504 contacts or 15%), ***Ward 2*** (439 contacts) and ***Ward 8*** (431 contacts), each accounting for 13% of total contacts. These Wards were followed by ***Ward 4*** (410 or 12%), ***Ward 1*** (377 contacts) and **Ward 6** (347 contacts) each accounting for (11%), and ***Ward 3*** (154 contacts or 5%). ***Out-of-State*** (41 contacts), ***Maryland*** (38 contacts), ***Undetermined*** (33 contacts), and ***Virginia*** (13 contacts) each accounting for (1%).



Categories of Issues Encountered by Consumers

During the Fiscal Year 2011, the OHCOBR classified all contacts into one of five broad categories which were recorded in the Heath Care Ombudsman's In-Take Tracking Log. The types of categories were:

- **Access/Coverage (includes denials)**
- **Eligibility**
- **Other**
- **Non-Payment/Reimbursement**
- **Quality of Service**

Below are examples of consumer issues that would be classified by OHCOBR into these categories. *The following issues by categories were encountered by District consumers*:

- ***Access/Coverage (includes denials)****:*

  Access: Administrative hearings; appeals/grievances; health care benefits to include: uninsured; pre-existing condition insurance plan; commercial insurance; Medicaid; Medicare; Buy-In; Qualified Medicare Beneficiary benefits (QMB); long-term care; home health agency services (EPD and State Waiver Plan); MCO enrollment; and Part D prescription plan. Assisted beneficiaries in securing medical; dental; durable medical equipment (DME); non-emergency transportation services or appointments. Assisted in obtaining prior authorizations for health related services to include home health agency services; and assistance in securing medications; methods of co-payments; and filling prescriptions, etc.

  Coverage: Denials of health related services (medical, dental, optical, durable medical equipment (DME), home health, non-emergency transportation, and prescriptions services, etc.).

- ***Eligibility:*** Determining eligibility, status of eligibility, verification of eligibility for health care programs; assistance with enrollment or recertification in health care programs; explanation of Qualified Medicare Beneficiary (QMB) benefits, and assisting with termination of coverage, etc.

- ***Quality of Service:*** Medical, dental, durable medical equipment (DME), in-patient and out-patient services, home health services, long-term care, optical services, and non-emergency transportation services, etc.

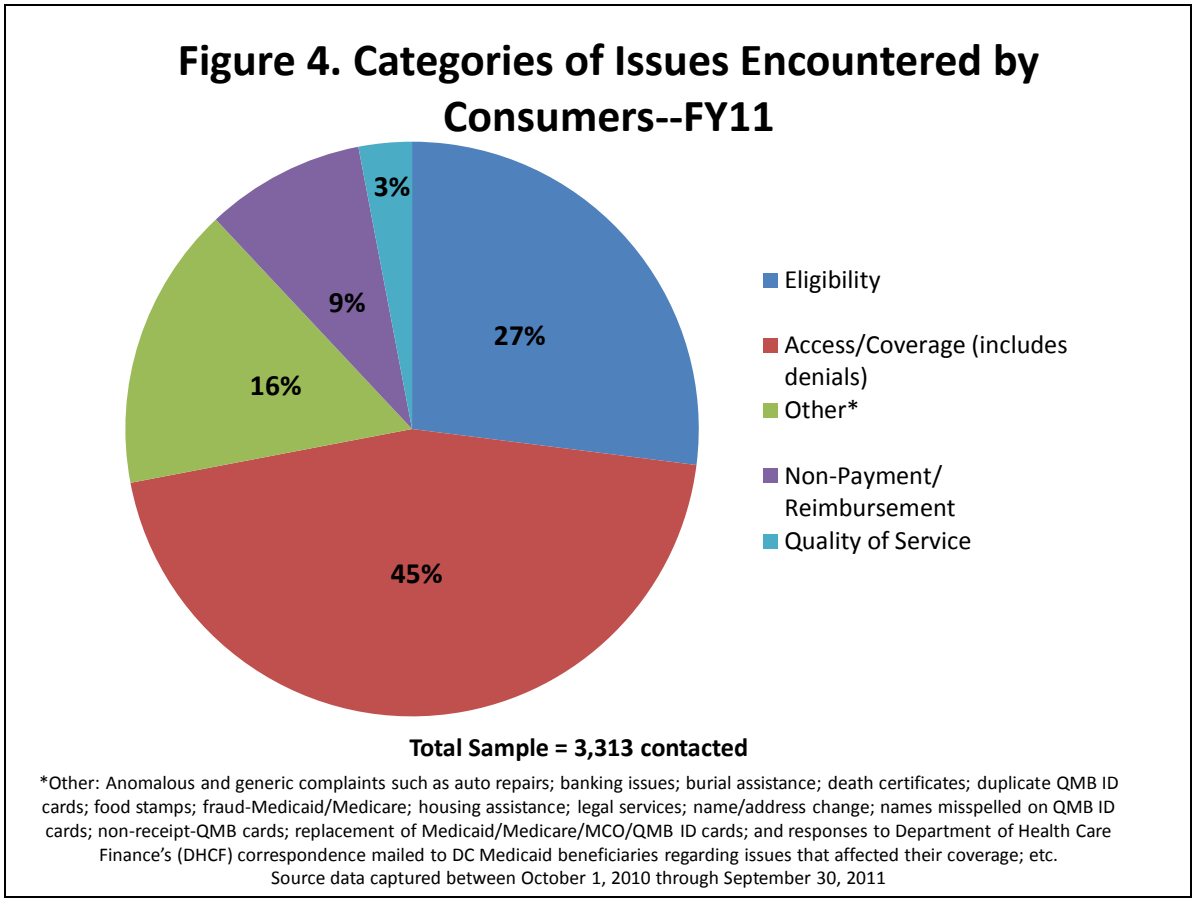
Categories of Issues Encountered by Consumers (continued)

- ***Non-Payment/Reimbursement Issues:*** Non-payment of bills (medical, dental, hospital, emergency room bills, and co-pays, to include QMB co-pays, and Part B premiums), reimbursement of out-of-pocket expenses (medical, hospital, dental bills, co-pays to include QMB co-pays, etc.).

- ***Other:*** Anomalous and generic complaints such as auto repairs; banking issues; burial assistance; death certificates; duplicate QMB ID cards; food stamps; fraud-Medicaid/Medicare; housing assistance; legal services; name/address change; names misspelled on QMB ID cards; non-receipt-QMB cards; replacement of Medicaid/Medicare/MCO/QMB ID cards; and responses to Department of Health Care Finance's (DHCF) correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage; etc.

Categories of Issues Encountered by Consumers (continued)

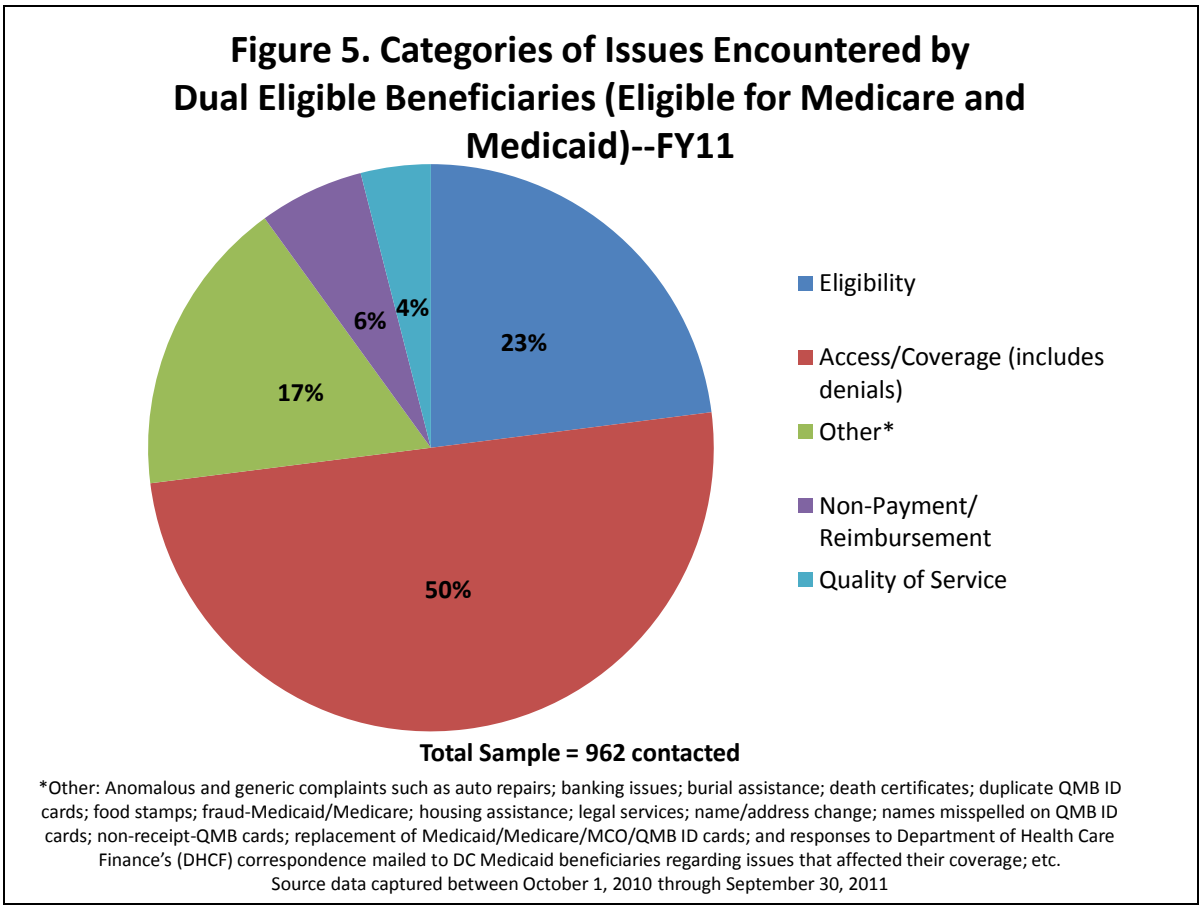
Categories of issues for Fiscal Year 2011 are presented in **Figure 4**. The most frequent category of issues encountered by consumers was ***Access/Coverage*** (includes denials) representing 45% of total contacts (3,313 contacts), ***Eligibility***, representing 27% of total contacts. The next most frequent category of issues was ****Other*** representing 16% of total contacts, ***Non-Payment/Reimbursement*** representing 9% of total contacts***,*** followed by ***Quality of Service*** *representing 3% of total contacts.*



Categories of Issues Encountered by Dual Eligible Beneficiaries (Eligible for Medicare and Medicaid)

The OHCOBR also tracked categories of issues encountered by consumers by type of insurance coverage of the beneficiaries. The following sections provide findings on categories of issues by insurance type for the following insurance categories: Beneficiaries for ***Medicare/Medicaid (Dual Eligible)***, ***Medicaid Fee-for-Service (Medicaid FFS), Medicare Part A/B), Medicaid Managed Care (Medicaid MCO), Alliance and Commercial Health Plan members***.

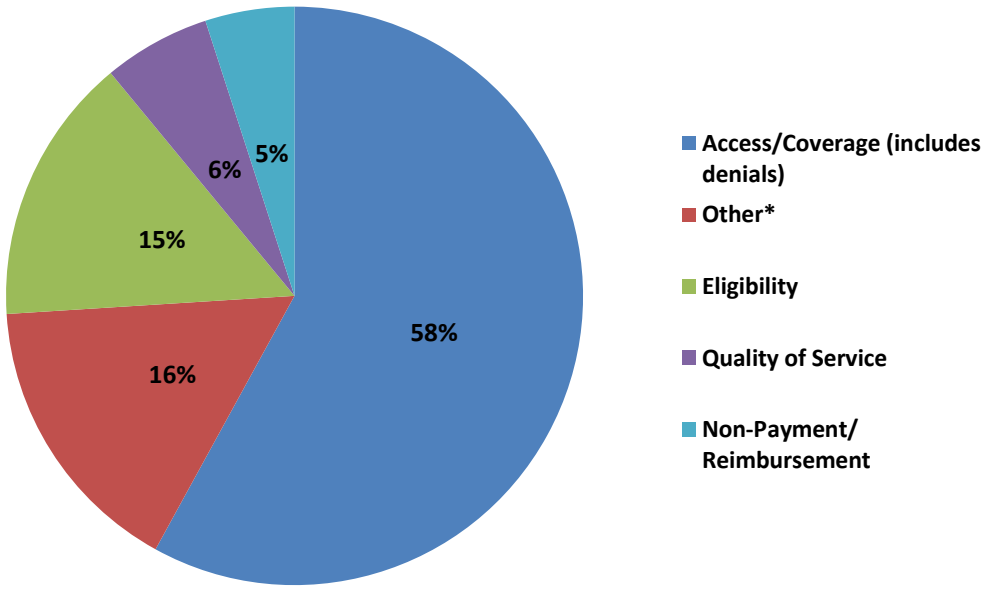
Issues encountered by ***Medicare/Medicaid (Dual Eligible) beneficia*****ries** in Fiscal Year 2011 are presented in **Figure 5**. The most frequent issue category among the ***Medicare/Medicaid*** (***Dual Eligible)*** was ***Access/Coverage*** (477 contacts, representing 50%), followed by ***Eligibility*** (223 contacts, representing 23%), ****Other*** (158 contacts, representing 17%), followed by ***Non-Payment/Reimbursement Challenges*** (62 contacts, representing 6%), and ***Quality of Service*** (42 contacts, representing 4%).



Categories of Issues Encountered by Medicaid Fee-for-Service (FFS) Beneficiaries

Issues encountered by ***Medicaid Fee-for-Service (FFS)*** beneficiaries during Fiscal Year 2011 are presented in **Figure 6**. The most frequent issue category among **Medicaid FFS** beneficiaries was ***Access/Coverage—includes denials*** (437 contacts, representing 58%) followed by ****Other*** (121 contacts, representing 16%), ***Eligibility*** (110 contacts, representing 15%), **Quality of Service** (48 contacts, representing 6%), and ***Non-Payment/Reimbursement Challenges*** (36 contacts, representing 5%).

Figure 6. Categories of Issues Encountered by Medicaid Fee-for-Service (FFS) Beneficiaries--FY11



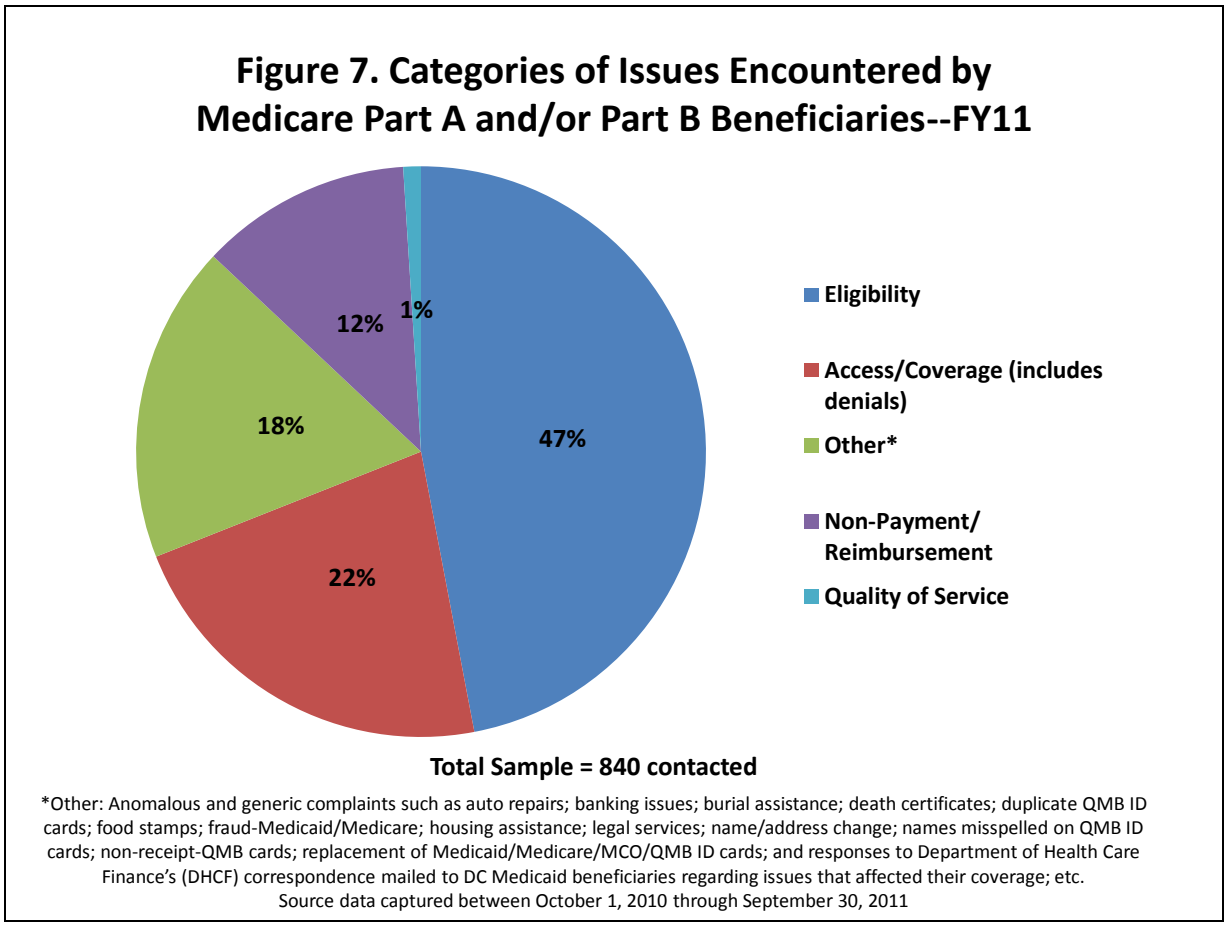
Total Sample = 752 contacted

*Other: Anomalous and generic complaints such as auto repairs; banking issues; burial assistance; death certificates; duplicate QMB ID cards; food stamps; fraud-Medicaid/Medicare; housing assistance; legal services; name/address change; names misspelled on QMB ID cards; non-receipt-QMB cards; replacement of Medicaid/Medicare/MCO/QMB ID cards; and responses to Department of Health Care Finance's (DHCF) correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage; etc.

Source data captured between October 1, 2010 through September 30, 2011

Categories of Issues Encountered by Medicare Part A and/or Part B Beneficiaries

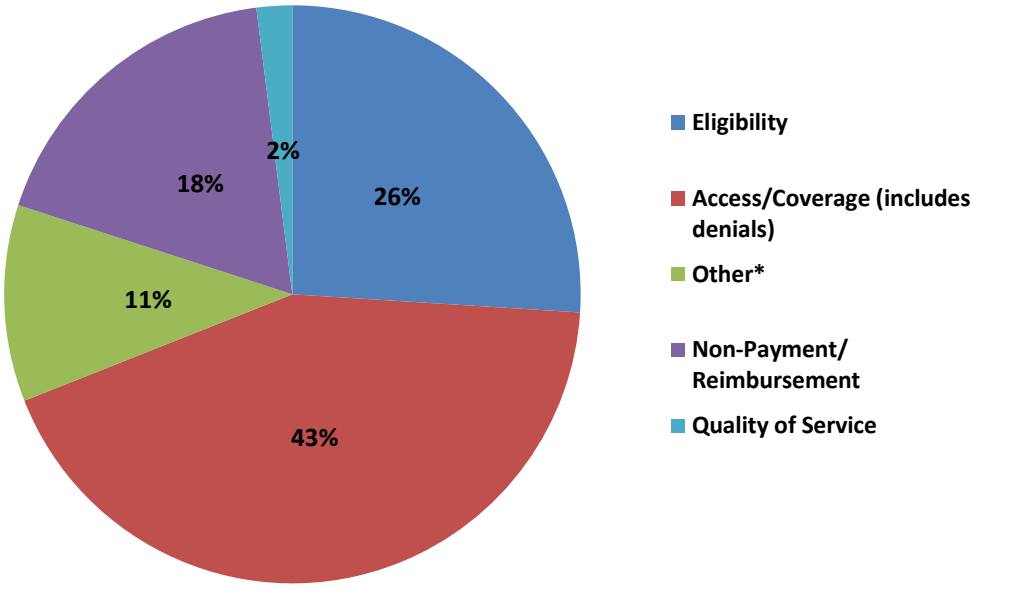
Issues encountered by ***Medicare Part A/B beneficiaries*** during Fiscal Year 2011 are presented in **Figure 7**. The most frequent issue category among ***Medicare Part A/B beneficiaries*** was ***Eligibility*** (392 contacts, representing 47%), followed by ***Access/Coverage—includes denials*** (185 cases, representing 22%), **Other* *(154 cases, representing 18%), **Non-Payment/Reimbursement Challenges** (104 contacts, representing 12%), and **Quality of Service** (5 contacts, representing 1%)*.



Categories of Issues Encountered by Medicaid Managed Care (MCO) Beneficiaries

Issues encountered by ***Medicaid Managed Care (MCO) beneficiaries*** during Fiscal Year 2011 are presented in **Figure 8**. The most frequent issue category among ***Medicaid MCO beneficiaries*** was ***Access/Coverage—includes denials*** (181 contacts, representing 43%), followed by ***Eligibility*** (109 contacts, representing 26%) ***Non-Payment/Reimbursement Challenges*** (74 contacts, representing 18%), ****Other*** (47 contacts, representing 11%), and ***Quality of Service*** (9 contacts, representing 2%).

Figure 8. Categories of Issues Encountered by Medicaid Managed Care (MCO) Beneficiaries--FY11



Total Sample = 420 contacted

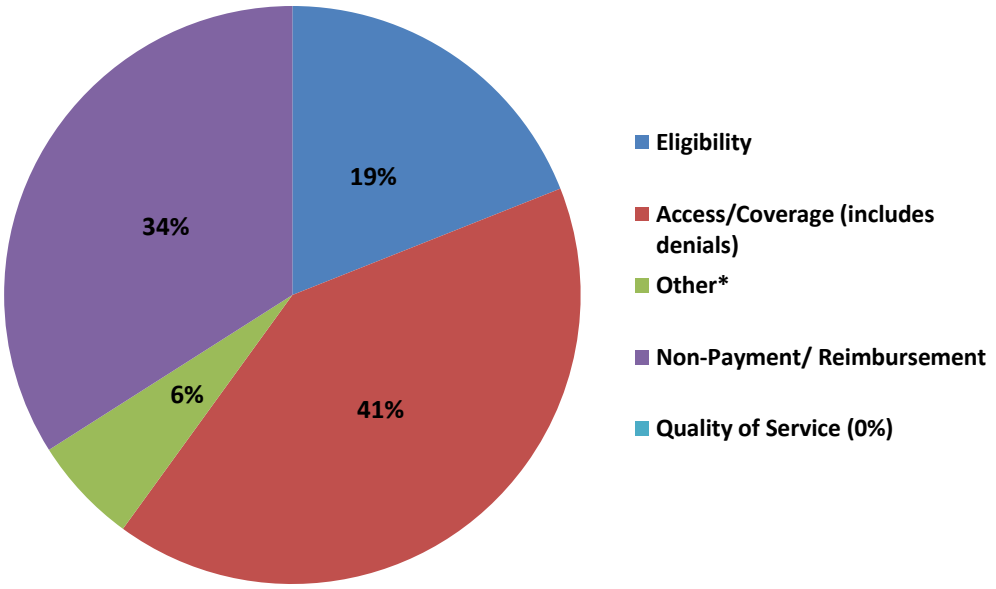
*Other: Anomalous and generic complaints such as auto repairs; banking issues; burial assistance; death certificates; duplicate QMB ID cards; food stamps; fraud-Medicaid/Medicare; housing assistance; legal services; name/address change; names misspelled on QMB ID cards; non-receipt-QMB cards; replacement of Medicaid/Medicare/MCO/QMB ID cards; and responses to Department of Health Care Finance's (DHCF) correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage; etc.

Source data captured between October 1, 2010 through September 30, 2011

Categories of Issues Encountered by Alliance Beneficiaries

Issues encountered by ***Alliance beneficiaries*** during Fiscal Year 2011 are presented in **Figure 9**. The most frequent issue category among ***Alliance beneficiaries*** was ***Access/Coverage—includes denials*** (19 contacts, representing 41%), followed by ***Non-Payment/Reimbursement Challenges*** (16 contacts, representing 34%), ***Eligibility*** (9 contacts, representing 19%), ****Other*** (3 contacts, representing 6%), and ***Quality of Service*** (0 contacts, representing 0%).

Figure 9. Categories of Issues Encountered by Alliance Beneficiaries--FY11



Total Sample = 47 contacted

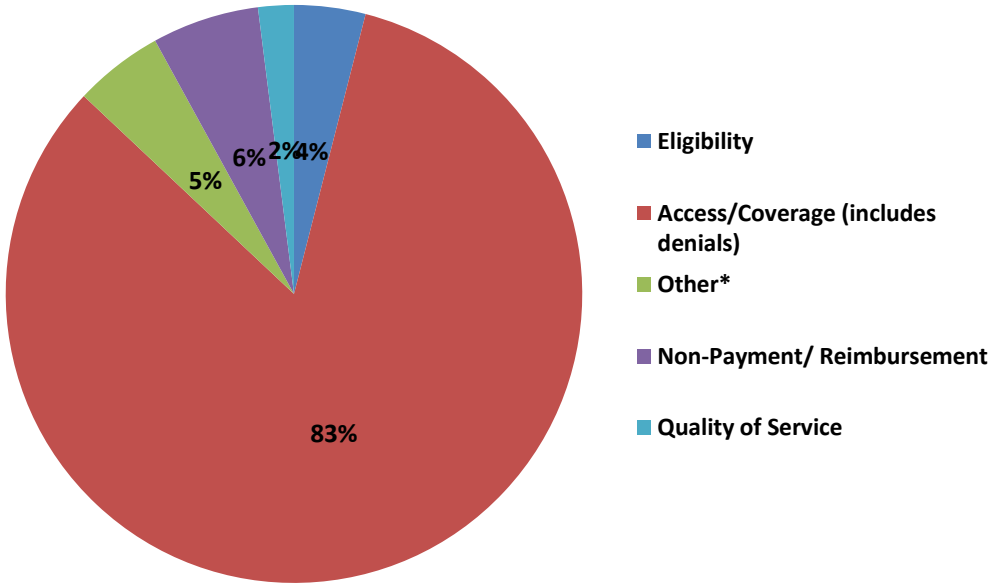
*Other: Anomalous and generic complaints such as auto repairs; banking issues; burial assistance; death certificates; duplicate QMB ID cards; food stamps; fraud-Medicaid/Medicare; housing assistance; legal services; name/address change; names misspelled on QMB ID cards; non-receipt-QMB cards; replacement of Medicaid/Medicare/MCO/QMB ID cards; and responses to Department of Health Care Finance's (DHCF) correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage; etc.

Source data captured between October 1, 2010 through September 30, 2011

Categories of Issues Encountered by Commercial Health Plan Members

Issues encountered by the ***Commercial Health Plan members*** during Fiscal Year 2011 are presented in **Figure 10**. The most frequent issue category among the ***Commercial Health Plan members*** was ***Access/Coverage—includes denials*** (109 contacts, representing 83%), followed by ***Non-Payment/Reimbursement Challenges*** (8 contacts, representing 6%) and ****Other*** (7 contacts, representing 5%), ***Eligibility*** (5 contacts, representing 4%), ***Quality of Service*** (2 contacts, representing 2%).

Figure 10. Categories of Issues Encountered by Commercial Health Plan Members--FY11



Total Sample = 131 contacted

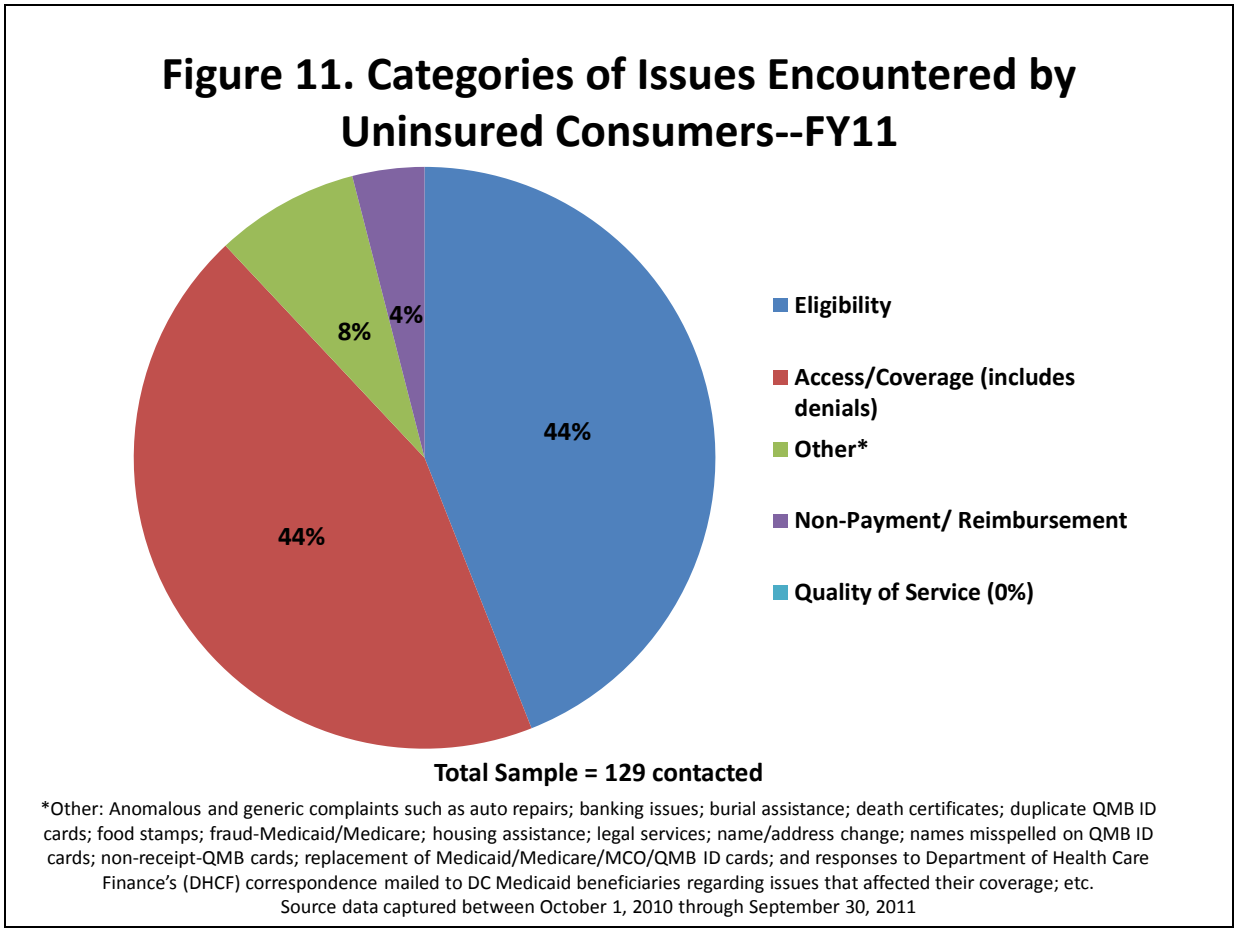
*Other: Anomalous and generic complaints such as auto repairs; banking issues; burial assistance; death certificates; duplicate QMB ID cards; food stamps; fraud-Medicaid/Medicare; housing assistance; legal services; name/address change; names misspelled on QMB ID cards; non-receipt-QMB cards; replacement of Medicaid/Medicare/MCO/QMB ID cards; and responses to Department of Health Care Finance's (DHCF) correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage; etc.

Source data captured between October 1, 2010 through September 30, 2011

Categories of Issues Encountered by Uninsured Consumers

Issues encountered by ***Uninsured consumers*** during Fiscal Year 2011 are presented in **Figure 11**. The most frequent issue category among ***Uninsured consumers*** was ***Access/Coverage—includes denials*** (57 contacts) and ***Eligibility*** (57 contacts) both representing 44%, followed by ****Other*** *(10 cases, representing 8%)*, ***Non-Payment/Reimbursement Challenges*** *(5 contacts, representing 4%), and* ***Quality of Service*** *(0 contacts, representing 0%)*.

Note: The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is reporting issues encountered by Uninsured Consumers for the first time in the FY2011 Annual Summary of Cases Report.

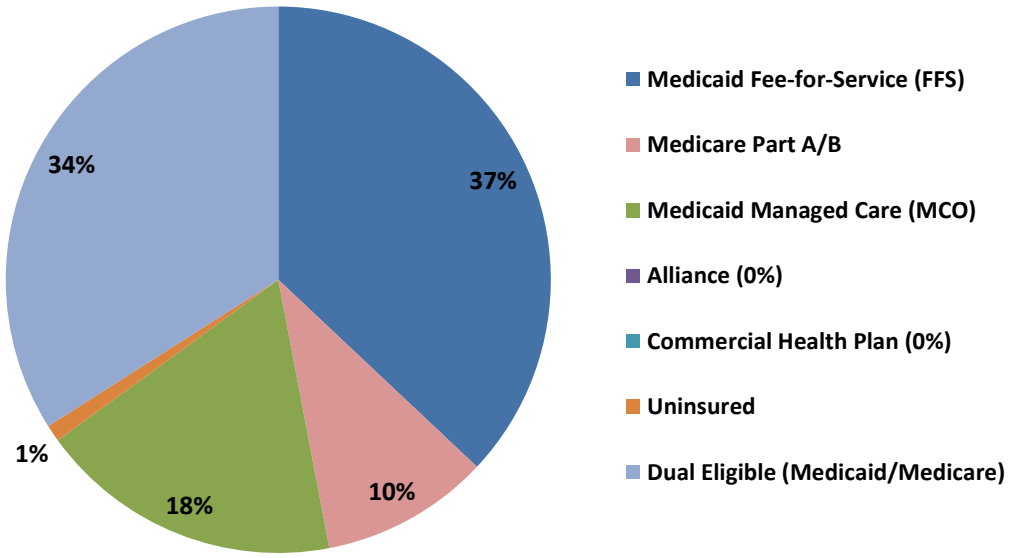


Transportation Contacts by Insurance Type

Issues encountered by ***Transportation Contacts by Insurance Type*** during Fiscal Year 2011 are presented in **Figure 12**. The most frequent issue category among ***Transportation Contacts by Insurance Type*** was ***Medicaid (Fee-for-Service)*** (58 contacts, representing 37%), followed by ***Dual Eligible (Medicare/Medicare*** (54 contacts, representing 34%), ***Medicaid MCO*** (28 contacts, representing 18%), ***Medicare Part A/B*** (16 contacts, representing 10%), ***Uninsured*** (1 contact, representing 1%), ***Alliance*** and ***Commercial Health Plan*** both at (0 contacts, representing 0%).

Note: The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is reporting Transportation Contacts by Insurance Type for the first time in the FY2011 Annual Summary of Cases Report--as this responsibility was delegated to the OHCOBR on October 1, 2010.

Figure 12. Transportation Contacts by Insurance Type--FY11



Source data captured between October 1, 2010 through September 30, 2011

Categories of Transportation Issues Encountered by Consumers

Issues encountered by ***Transportation Consumers*** during Fiscal Year 2011 are presented in **Figure 13**. The most frequent issue category among ***Transportation Issues Encountered by Consumers*** was ***Access*** (108 contacts, representing 69%), followed by ***Eligibility--status of eligibility/verification of coverage*** (24 contacts, representing 15%), ***Quality of Service*** (21 contacts, representing 13%), and ***Coverage—denials*** (4 contacts, representing 3%).

Note: The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is reporting issues encountered by Transportation Contacts by Insurance Type for the first time in the FY2011 Annual Summary of Cases Report--as this responsibility was delegated to the OHCOBR on October 1, 2010.

Figure 13. Categories of Transportation Issues Encountered by Consumers--FY11

Issue Category	FY11 Totals	FY11 Contacts (%)
Access	108	69%
Eligibility (status of eligibility/verification of coverage)	24	15%
Quality of Service	21	13%
Coverage (denials)	4	3%
Total Contacts	**157**	**100%**

Source data captured between October 1, 2010 through September 30, 2011

EPD Waiver Beneficiaries by Insurance Type

Issues encountered by ***EPD Waiver Beneficiaries by Insurance Type*** during Fiscal Year 2011 are presented in **Figure 14**. The most frequent issue category among ***EPD Waiver Beneficiaries by Insurance Type*** was ***Dual Eligible (Medicare/Medicaid*** (427 contacts, representing 79%), followed by ***Fee-for-Service (Medicaid)--***(116 contacts, representing 21%).

Note: The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is reporting EPD Waiver Beneficiaries by Insurance Type for the first time in the FY2011 Annual Report. These issues were included in aggregate totals in FY10, but not broken out as its own independent category until this year.

Figure 14. EPD Waiver Beneficiaries by Insurance Type--FY11

Issue Category	FY11 Totals	FY11 Contacts (%)
Dual Eligible (Medicare/Medicare)	427	79%
Fee-For-Service (Medicaid)	116	21%
Total Contacts	**543**	**100%**

Source data captured between October 1, 2010 through September 30, 2011

Categories of Issues Encountered by EPD Waiver Beneficiaries

Issues encountered by ***EPD Waiver Beneficiaries*** during Fiscal Year 2011 are presented in **Figure 15**. The most frequent issue category among ***EPD Waiver Beneficiaries*** was ***Access—to include Prior Authorizations*** (293 contacts, representing 54%), followed by ***Eligibility/Recertification*** (107 contacts, representing 19%), ****Other*** (69 contacts, representing 13%), ***Quality of Service*** (32 contacts, representing 6%), ***Coverage--denials and Non-Payment Challenges--Home Health Agencies and PCA Services*** *both with (21 contacts each, representing 4% each).*

Note: The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is reporting Categories of Issues Encountered by EPD Waiver Beneficiaries for the first time in the FY2011 Annual Summary of Cases Report. These issues were included in aggregate totals for FY2010, but not broken out as its own independent category until FY2011.

Figure 15. Categories of Issues Encountered by EPD Waiver Beneficiaries--FY11

Issue Category	FY11 Totals	FY11 Contacts (%)
Access (to include Prior Authorizations)	293	54%
Eligibility/Recertification	107	19%
***Other**	69	13%
Quality of Service	32	6%
Coverage (denials)	21	4%
Non-Payment Challenges (Home Health Agencies and PCA Services)	21	4%
Total Contacts	**543**	**100%**

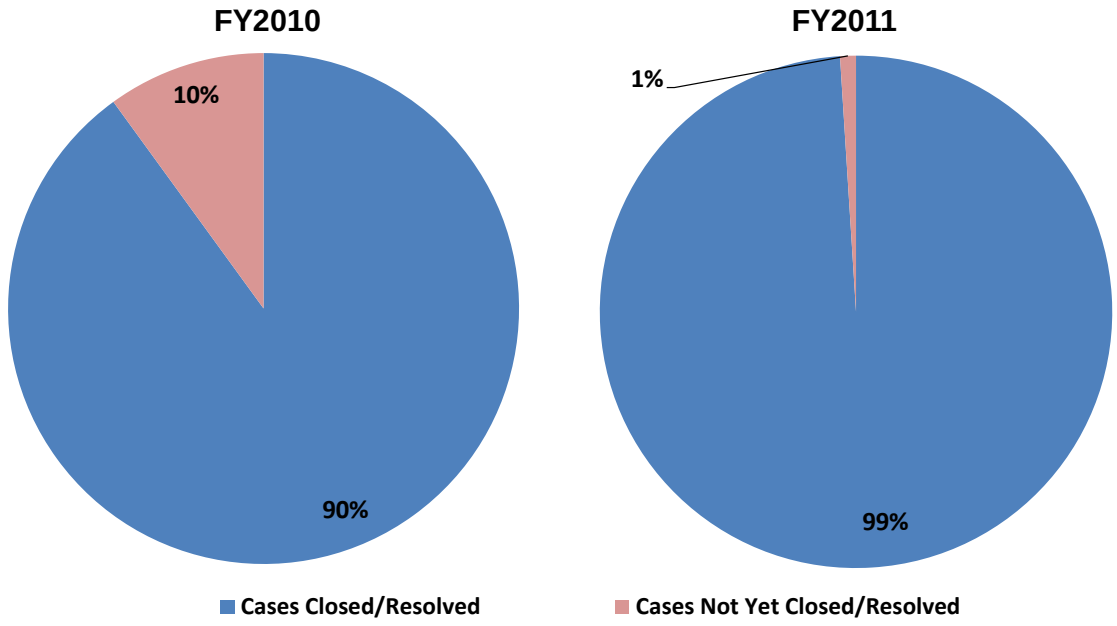
****Other issues include*** *auto repairs, banking issues, burial assistance, death certificates, duplicate QMB ID cards, food stamps, fraud-Medicaid/Medicare; housing assistance, legal services, name/address change, names misspelled on QMB ID cards, non-receipt-QMB ID cards, replacement of Medicaid/Medicare/MCO/QMB ID cards, and responses to Department of Health Care Finance's correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage, etc.*

Source data captured between October 1, 2010 through September 30, 2011

Proportion of Closed/Resolved Cases

The number and percent of **closed (resolved) cases** were tracked by OHCOBR during Fiscal Year 2011. Findings on the proportion of ***closed (resolved) cases*** for Fiscal Year 2011 are shown in **Figure 16**. During this period, the OHCOBR ***closed (resolved)*** **99% (3,273 cases)** out of 3,313 opened cases in Fiscal Year 2011.

Figure 16. Number and Percentage of Closed/Resolved Cases Among OHCOBR Consumers—FY10 and FY11

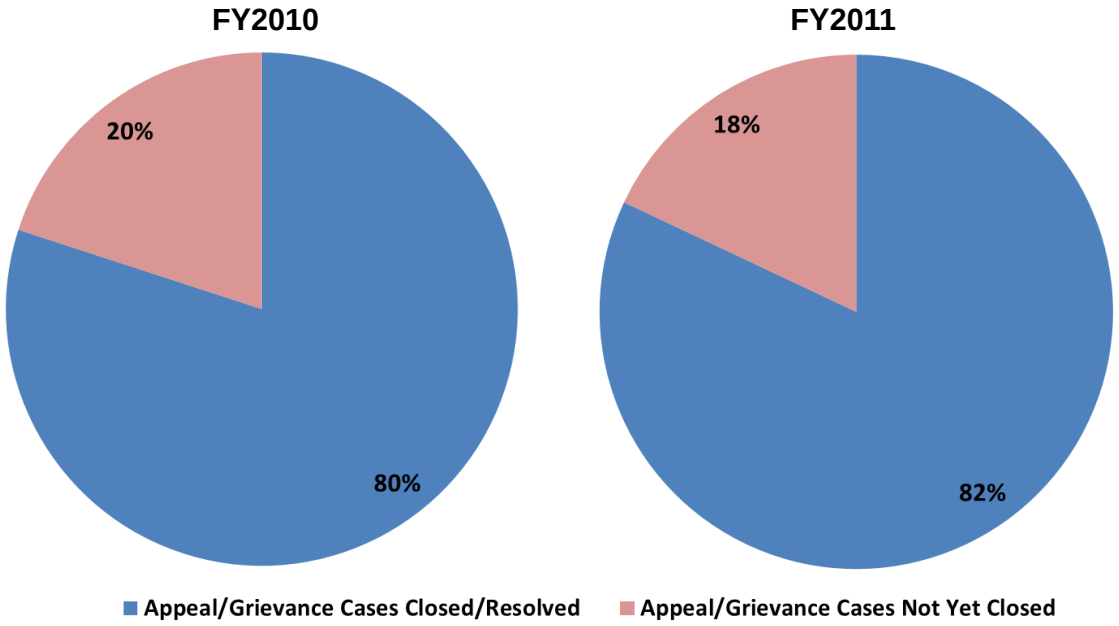


Source data captured between October 1, 2009 through September 30, 2010 and October 1, 2010 through September 30, 2011

<u>Proportion of Closed/Resolved Cases</u> (continued)

The number and percent of ***closed (resolved) appeal/grievance cases* for Commercial Health Plan members** were also tracked by OHCOBR. Findings on the proportion of **closed (resolved) appeal/grievance cases** for Fiscal Year 2011 are shown in **Figure 17**. During this period, the OHCOBR ***closed (resolved)* 82% percent (107 cases)** out of 131 opened cases in the Fiscal Year 2011.

Figure 17. Number and Percentage of Closed/Resolved Appeal/Grievance Cases Among the Commercial Health Plan Members—FY10 and FY11



Source data captured between October 1, 2010 through September 30, 2011

Average Number of Days to Close/Resolve Cases

The Average Number of Days to Close/Resolve Cases was also tracked by OHCOBR. Findings on the Average Number of Days to Close/Resolve Cases for Fiscal Year 2011 are shown in **Figure 18**. Of the **3,313 cases opened**, the OHCOBR closed/resolved **2,461 cases on same day that the cases were opened** in FY2011.

Note: The Office of Health Care Ombudsman and Bill of Rights (OHCOBR) is reporting the average number of days to close/resolve cases for the first time in the FY2011 Annual Summary of Cases Report—FY2010 averages were not reported.

Figure 18. Average Number of Days to Close/Resolve Cases—FY11

Average Number of Days	Total
Average Number of Days It Took to Close/Resolve 3,313 cases	**5.8 days**
Number of Cases closed/resolved on the same day that the cases were opened	**2,461 cases**

Source data captured between October 1, 2010 through September 30, 2011

OFFICE OF HEALTH CARE OMBUDMANS AND BILL OF RIGHTS

FY2011 SUMMARY

- ***In FY2011***, most consumers ***utilized the telephone to contact*** the Office of Health Care Ombudsman and Bill of Rights (90% of total contacts were via the telephone);
- Most of the Office of Health Care Ombudsman and Bill of Rights' contacts were ***Dual Eligible (Medicare/Medicaid) beneficiaries***;
- Consumers from all Wards contacted the Office of Health Care Ombudsman and Bill of Rights ***(Wards 5, 7 and 2 had the highest number of contacts);***
- Access/Coverage issues (to include denials) ***represented the largest category of issues encountered by consumers***;
- Access/Coverage issues (to include denials) ***represented the largest category of issues encountered by Dual Eligible (Medicare/Medicaid, Medicaid (FFS), Medicaid MCO, and MCO-Alliance beneficiaries;***
- Access/Coverage issues (to include denials) ***represented the largest category of issues encountered by the Commercial Health Plan members***;
- The Office of Health Care Ombudsman and Bill of Rights ***processed 3,313 cases with a 99% closure rate*** in FY2011 ***(3,273 closed/resolved cases over total cases opened);***
- Percentage of appeal/grievance cases closed/resolved for the Commercial Health Plan members was ***82% (107 closed appeal/grievance cases over 131 total appeal/grievance cases opened);***
- The Office of Health Care Ombudsman and Bill of Rights began ***tracking Transportation Services (non-emergency) issues*** in October 2010;
- The Office of Health Care Ombudsman and Bill of Rights began ***tracking EPD Waiver issues*** in October 2010;
- The **Average Number of Days** for the Office of Health Care Ombudsman and Bill of Rights ***to close/resolve cases was 5.8 days***; and
- **Of the 3,313 cases opened in FY2011**, the Office of Health Care Ombudsman and Bill of Rights ***closed/resolved 2,461 cases on same day that cases were opened.***

Source data captured between October 1, 2010 through September 30, 2011

MOVING FORWARD

The Office of Health Care Ombudsman and Bill of Rights intends to continue:

- Capturing data for each contact;
- Tracking types of calls received to identify changes over time;
- Expanding data analysis capability; and
- Preparing and planning for the procurement of a more robust tracking system.