Oregon Health Authority Ombuds Program
2022 Year-End Report

EXTERNAL RELATIONS DIVISION
Ombuds Program

March 2023

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Executive Summary

Oregon Revised Statute (ORS) 414.712 directs the Oregon Health Authority (OHA) Ombuds Program to serve as the advocate for Oregon Health Plan (OHP - Medicaid and Children's Health Insurance Program) members for access to care, quality of care, and channeling member experience into recommendations for Medicaid systems, policy, and program improvement.

OHA responds to Ombuds reports as formal audits with a formal response and implements an action plan to address findings.

This 2022 year-end report prioritizes Ombuds Program recommendations about OHP members' access to behavioral health care in three key areas:

- Residential capacity,
- Discharge planning and
- Access to OHA-administered Home and Community-Based Services (HCBS) 1915(i).

The Ombuds Program recommends OHA prioritize and solve these issues to significantly improve member access to care. Many of these areas disproportionately impact people whose primary language is not English, people with disabilities and other priority populations.

This report uses Ombuds Program data, member stories and experiences, OHA claims data, coordinated care organization (CCO) financial reporting data and other statewide data sources to elevate and document the systems barriers experienced by many OHP members.

In 2022, the OHP services most frequently involved brought to the Ombuds Program by members were NEMT, dental care, speciality care, access to primary care providers, mental health care and pharmacy concerns.

Programmatic recommendations

- Ensure OHP members have timely access to appropriate substance use disorder (SUD) treatment.
- Expand statewide service capacity for all residential providers, particularly SUD providers and for certified mental health home care agencies.

Reduce inequitable access for individuals with mental health disabilities to HCBS.

- Set clear expectations and standards for coordinating access to:
    - OHP services carved out of CCO contract and
    - Oregon Department of Human Services (ODHS) benefits for fee-for-service (FFS) and CCO members.
- Leverage opportunities in Oregon's new Centers for Medicare and Medicaid Services (CMS) 1115 Demonstration Waiver to improve coordination and access to appropriate services and supports for justice involved individuals upon release, such as health navigators, medication-assisted treatment (MAT), CCO care coordinators, peer support specialists, personal support workers, SUD treatment, HCBS 1915(i) evaluation and referral.
- Reduce inequitable access to HCBS 1915(i) for individuals with mental health disabilities. OHA and ODHS should have a "no wrong door" policy for all Medicaid-funded HCBS evaluations and referrals. This means:
    - A person receiving a physical or intellectual/developmental disability (I/DD) screening through ODHS should also get a mental health disability screening.
    - A person receiving a mental health disability screening through OHA should also get physical and I/DD screenings.

    - People are screened for all available HCBS services at one time. They would not need to go through multiple doors depending on their specific needs.
- Expand and clarify definition for HCBS 1915(i) and services available through 1915(i). Current language is unclear and seems to exclude some diagnoses. Expand language to Any Mental Illness (AMI) to support individuals with recurring mental health needs who are at risk of homelessness and other significant impacts during their periodic acute mental illness.
- Provide education on how to access HCBS 1915(i) services. Staff of ODHS, OHA, mental health crisis lines, and community mental health providers need training about referral processes, warm hand-offs and program eligibility.
- Require use of evidence-based processes, assessment tools and procedures for implementing and administering HCBS 1915(i) benefits.

OHA response to formal Ombuds recommendations from 2021

Appendix C reviews recommendations made in previous reports and highlights key successes, progress forward, and gaps in resolving each finding/problem. OHA's response to the 2021 report and update on activities since the six-month Ombuds 2022 report highlighted positive actions in many areas. However, OHA still needs to act on many critical needs to improve OHP member access to care.

The Ombuds Program recommends that OHA agency leadership, the Oregon Health Policy Board, the governor and the Oregon Legislature use the recommendations and needs identified in the Ombuds reports to drive action centered on improving access to and quality of care for OHP members.

Ombuds Program recommendations

- Continue OHA's formal annual audit response to Ombuds Program reports.
- Ensure adequate project management and subject matter expert (SME) support to operationalize recommended changes.
- Increase receptiveness and understanding of OHP member experience through Ombuds work and learning by other OHA programs and divisions.
- Strengthen responsiveness to members. Across the agency, OHA should prioritize giving members the same level of responsiveness whether their concern is raised by the Ombuds Program, the member, the member's family or advocate, legislators or media.
- Strengthen Ombuds Advisory Committee with a formal governance structure for the Ombuds Program.
- Increase and strengthen Ombuds Program community reach to populations impacted by health inequities and less likely to reach out to the Ombuds Program for support.

Conclusion

Each person who seeks Ombuds Program assistance deserves nurturing and support. The stories they share often illustrate challenges many others experience. Each story brings lessons for ways to improve Oregon's Medicaid delivery system and to understand the impact of health inequities on Oregonians who receive or are eligible for the Oregon Health Plan.

It is an honor to work within an agency that embraces Oregon Health Plan member experience as essential to successful transformation. The Ombuds Program is privileged to support Oregon's efforts to ensure health equity through advancing better health, lower costs, and improved patient experience for all people in Oregon, particularly populations experiencing health inequities.

Background

Oregon Revised Statute (ORS) 414.712 directs the Oregon Health Authority (OHA) Ombuds Program to serve as the advocate for Oregon Health Plan (OHP - Medicaid and Children's Health Insurance Program) members for:

- Access to care,
- Quality of care, and
- Channeling member experience into recommendations for Medicaid systems, policy, and program improvement.

The Ombuds Program is independent of Medicaid program implementation, operations or compliance. The program provides recommendations and oversight internally to OHA Medicaid programs and externally to Medicaid contractors.

Ombuds data and member experiences support Medicaid/OHP improvement.

- One member and their experience can give voice to many others. Many OHP members specifically state that they have contacted the Ombuds Program because they want OHA to use their own experience and voice to improve services for other OHP members. **As part of OHA's commitment to eliminating health inequities and co-creating with community, it is essential for OHA as an agency to listen and learn from individual concerns.**
- OHA should at times act on concerns even without larger amounts of data, particularly for concerns impacting health equity.

This 2022 year-end report prioritizes Ombuds Program recommendations about OHP members' access to behavioral health care in three key areas:

- Residential capacity,
- Discharge planning and
- Access to OHA-administered Home and Community-Based Services (HCBS) 1915(i).

The Ombuds Program recommends that OHA prioritizes and solves these issues and those identified in Appendix B to significantly improve member access to care. Many of these areas disproportionately impact people whose primary language is not English, people with disabilities and other priority populations.

OHA provides a written, formal response to Ombuds reports as formal audits and implements an action plan to address findings. The Ombuds Program also reports these findings to the governor, the Oregon Health Policy Board and OHA Director.

Ombuds recommend improvements based on OHP member experience and prioritize recommendations impacting health equity.

Ombuds Report

Introduction

This 2022 year-end report focuses on Ombuds recommendations to prioritize resolution of behavioral health access issues for OHP members in three interconnected areas:

- Mental health and substance use disorder (SUD) residential capacity,
- Hospital discharge planning for OHP members into behavioral health residential and supported community settings, and
- Access to OHA-administered Home and Community Based Services (HCBS) 1915(i).

Gaps in OHP member access to any of these areas negatively impact access to the others. These areas have both upstream and downstream impacts on Oregon's overall behavioral health system, such as:

- Increases in Oregon's unhoused population,
- The deaths of unhoused individuals in Oregon,
- Reduced availability of community-based services, and
- For individuals in need of civil commitment to the Oregon State Hospital (OSH), lack of civil commitment beds at OSH.

This report uses Ombuds Program data, member stories and experiences, OHA claims data, CCO financial reporting data and other statewide data sources to elevate and document the systems barriers experienced by the Ombuds Program working alongside OHP members.

Table 1: 2022 Ombuds concerns highlighting access and quality concerns in behavioral health residential capacity, hospital discharge planning and access to 1915(i) services.

	Q1	Q2	Q3	Q4	2022 Total N
Mental health	25	35	35	25	**120**
Hospital	13	26	22	14	**75**
Residential rehabilitation	7	4	11	5	**27**
Emergency room	4	6	3	12	**25**
Alcohol and drug/SUD	4	1	5	6	**16**
Total	**53**	**72**	**76**	**62**	**263**

The Ombuds Program's recommendations in this report are rooted in understanding of member experiences through Ombuds work in five key areas of concern brought by members: 1) mental health, 2) hospital, 3) residential rehabilitation, 4) emergency room, and 5) alcohol and drug/SUD. These total 263 concerns, representing 11.8 percent of all total Medicaid-related concerns brought to the program in 2022 by OHP members and providers acting on member's behalf.

Mental health and SUD residential capacity for OHP members

The Ombuds Program is concerned about timely access to SUD residential treatment and residential mental health treatment for OHP members. Those seeking services are often turned away due to lack of beds available at a facility, lack of facilities accepting OHP members, or lack of providers enrolled to accept OHP members.

OHP Member Experience: No SUD beds available for OHP members

An OHP member and their father called all SUD residential programs on their CCO's website seeking withdrawal management and residential placement. Member also had co-occurring mental health needs. No programs were available, but the member was placed on a six-week wait list at one. The member sought care in an emergency department outside their CCO's service area. The emergency department referred the member to a non-OHP facility that was immediately available. The facility asked OHA Provider Enrollment questions to better understand rate setting and other aspects of being an OHP provider before they enrolled, particularly to understand payment for co-occurring SUD and mental health treatment in a residential setting. Since OHA did not answer these questions, the facility never enrolled. Ultimately the member's family paid the non-OHP facility out-of-pocket so that their child could get treatment immediately. Despite the intense efforts of the member, their family, the facility, and the Ombuds Program, the member could not get the care they needed through OHP.

The case study above illustrates several common barriers frequently seen in Ombuds case work when OHP members seek to access residential treatment:

- OHP provider directories are often not updated in real time, creating "ghost networks" that presume provider availability, when in fact the system is at its maximum capacity, providers are no longer accepting OHP, or providers are no longer open for business[1].
- Need for network standards for SUD residential care.
- OHA administrative barriers for provider enrollment and lack of transparency around residential rate setting may discourage residential providers from becoming OHP providers.

A 2022 Health Affairs study found that 67.4 percent of network directory listings for mental health prescribers in Oregon, were "phantom" providers who did not see Medicaid patient and that significant discrepancies between the providers listed in directories and those whom enrollees can access suggest that provider network monitoring and enforcement may fall short if based on directory information. Although this study utilized 2018 data, Ombuds case work with members indicates that this reality continues.

- Although OHA and CCOs are now responsible for covering integrated co-occurring disorder treatment, SUD treatment and mental health treatment are not fully integrated system--wide at this time, making it hard for people who have co-occurring disorders to find the appropriate treatment placement.
- Lack of care coordination can also be a barrier. This can happen when a member does not know what facilities are available, how to set up treatment, or how to ask for CCO care coordination support.
- Lack of overall system capacity for withdrawal management (detox). Withdrawal management allows people to withdraw from drugs in a safe environment with medical care. Some people need this type of stabilization before they enter a residential program. Finding a detox program that can coordinate timely transition to a residential program is difficult. Those who leave detox without a plan to continue treatment often end up back in detox programs. They are more vulnerable to overdose if they do not have a treatment plan or Medication Assisted Treatment (MAT).

OHP members experiencing mental health or substance use disorders visited Oregon EDs an average of two times during 2022.

[1] Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid. Health Affairs. Zhu, Jane; Charlesworth, Christina; Polsky, Daniel; and McConnell, K. Health July 2022 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00052

Connecting data to Ombuds cases: Impact of CCO SUD networks as a potential barrier to timely member access to SUD care.

47
Number of SUD residential facilities statewide

36
Number of SUD residential facilities statewide who are contracted to be OHP providers

9
Average number of residential facilities that individual CCOs contract with

A review of SUD residential facilities and CCO networks indicates that individual CCOs do not contract with the majority of residential facilities in the state. This may reduce timely entry into treatment for some members. Of Oregon's 47 licensed SUD residential facilities, 36 are enrolled as OHP providers. On average, each CCO contracts with 9 of these providers. **Six CCOs contract with five or fewer residential facilities.**

In their case work, the Ombuds Program has observed that CCOs are willing to establish a single-case agreement when a residential treatment facility outside their network has a bed available. However, the process to establish a single-case agreement takes more time than if an agreement was already in place. This creates additional administrative burdens on providers and delays member access to care. **For SUD residential treatment particularly, this delay can lead to the individual simply not getting care.**

Hospital discharge planning for OHP members who need behavioral health residential and supported community settings

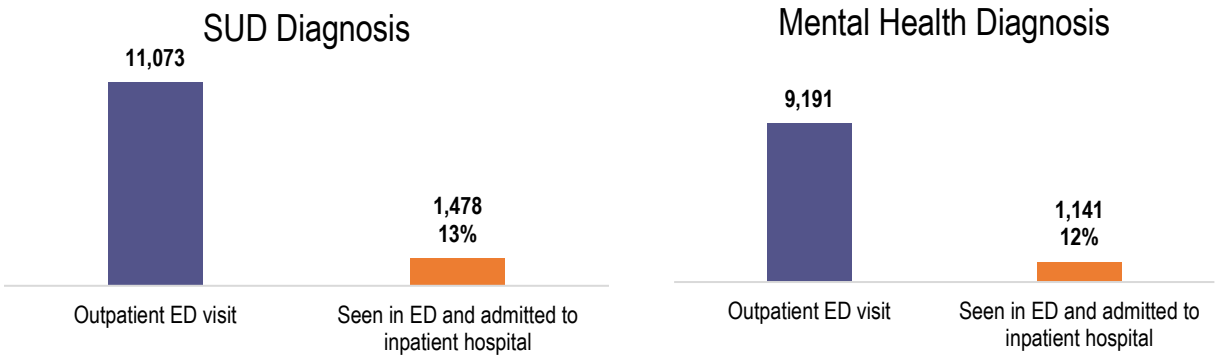
Given many of the above constraints and overall lack of capacity for HCBS and residential treatment, the Ombuds Program is concerned about unhoused OHP members living with mental illness who seek emergency department (ED) care. These members are likely to miss opportunities to get care coordination and community-based supports, and frequently use EDs to access care. Oregon ED data indicates that OHP members experiencing mental health or substance use disorders visited EDs an average of two times during 2022.[2]

OHP Member Experience: Unhoused member experiences EDs and lack of supportive services on the basis of mental health disability

An OHP member with schizophrenia sought care at two hospital EDs for back pain. At both hospitals, security escorted the member out of the ED to a public transit stop where the member curled in a fetal position in pain. A homeless advocate confronted the security guards, who said there was nothing the hospital could do. After these delays in care, the advocate drove the member to a third hospital. The third hospital admitted the member and found a spinal infection that required surgery. Because of this infection and surgery, the member was left permanently disabled and must now use a wheelchair. While this member likely would have qualified for HCBS 1915(i) services and mental health residential treatment through OHA, the **member did not access these services until after they were diagnosed with a physical disability through the Oregon Department of Human Services (ODHS).** ODHS Aging and People with Disabilities worked with the member's CCO to identify needed Durable Medical Equipment (DME), HCBS and secure placement in a residential home within a week of the surgery.

[2] Oregon Emergency Department Information Exchange (EDIE) data, 2022. https://orhealthleadershipcouncil.org/edie-utility-data-and-reports/

Chart 1: 2022 hospital claims data for OHP member ED visits to treat a behavioral health diagnosis (ages 18 and older)



In 2022, Oregon hospitals reported 11,073 ED visits for an SUD diagnosis, and 9,191 visits for a mental health diagnosis. Because discharge planning is only required for hospital discharge, most individuals seeking ED care for an SUD or mental health diagnosis were not fully connected to care.

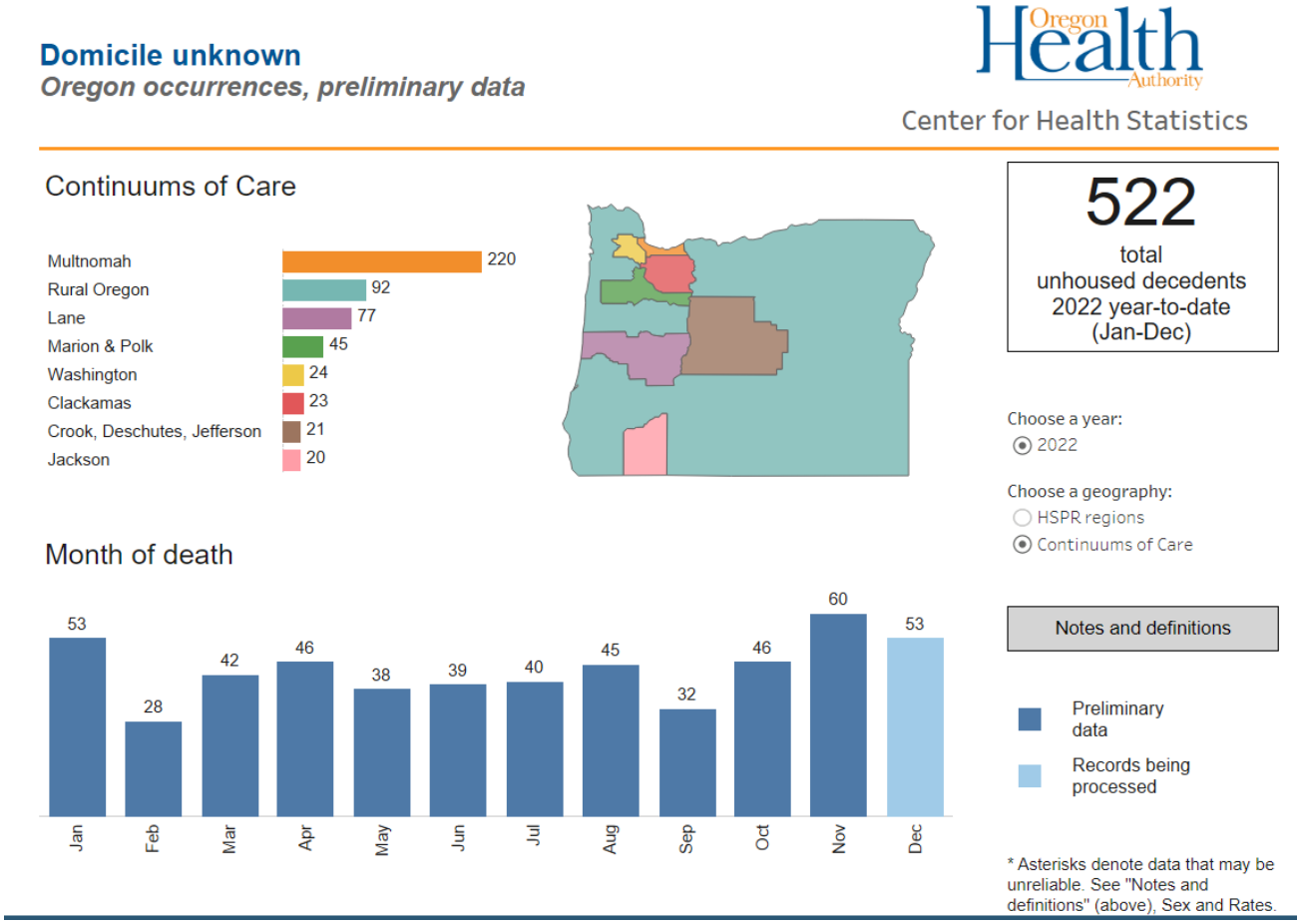
Only ED visits resulting in hospital admission would get connected through discharge planning:

- 13 percent (1,478) of the SUD visits required inpatient hospitalization.
- 12 percent (1,141) of the mental health visits required inpatient hospitalization.

The OHP member experience case study and ED claims data illustrate several common barriers and missed opportunities observed by the Ombuds Program in their work with unhoused members living with mental illness.

- ED visits and hospital admissions have the potential to connect individuals to CCO care coordination, community-based services and evaluation for residential treatment. However, members who visit the ED during a behavioral health crisis often do not know the name of their CCO.
- Unhoused members may have physical health conditions caused by a lack of access to adequate nutrition or hygiene opportunities. ED visits and hospital admissions can be effective, evidence-based times to intervene and offer additional supports.
- Hospital admissions require extensive discharge planning; ED visits do not. This often makes ED visits a missed opportunity to connect members to CCO coordination and other supports.
- Each year, the Ombuds Program has cases where unhoused OHP members visit EDs, get discharged without further connection to care, and are later found dead or face other significant adverse outcomes such the member case study above.

OHA Center for Health Statistics data show that 522 people with no known domicile died in 2022. The Ombuds Program suggests that future reports also indicate how many of these individuals visited an ED in the 30 and 60 days preceding their death.



Funding streams and rate setting in behavioral health as barriers to accessing care

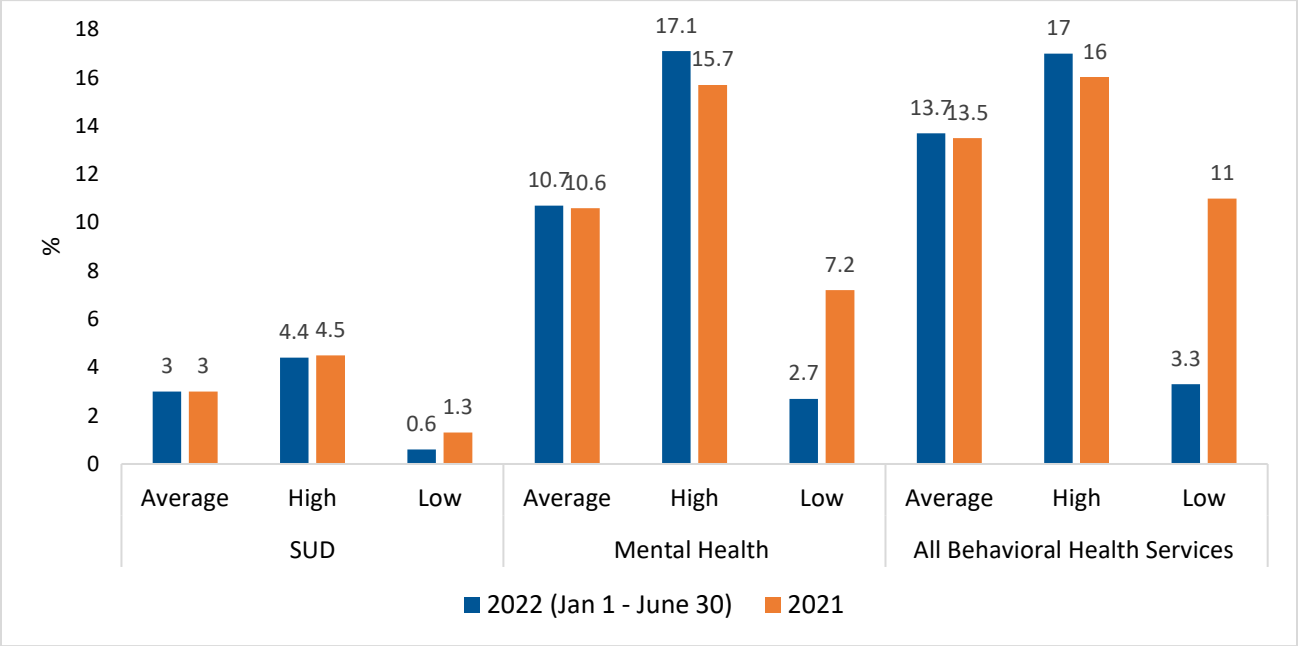
CCO Exhibit L reporting includes the overall amount of CCO Medicaid expenses for mental health care and SUD treatment in the report balance sheet. Limited spending on behavioral health services may help inform some of the barriers to accessing care illustrated by the member stories in this report.

On all behavioral health services, the combined average of net premiums spent by all CCOs in Q2 2022 (Jan. 1 – June 30, 2022) was 13.7 percent with a CCO-specific calculation ranging from a low of 3.3 percent for one CCO and a high of 20.8 percent for another CCO. These percentages do not indicate the number of members served, since the costs of services can differ by region.

- On all SUD services, the consolidated average percent of net premiums spent by CCOs was 3.0 percent, with a CCO-specific calculation ranging from a low of 0.6 percent for one CCO and a high of 4.4 percent for another CCO.
- On all mental health services, the consolidated average percent of net premiums spent by CCO was 10.7 percent, with a CCO-specific calculation ranging from a low of 2.7 percent for one CCO and a high of 17.1 percent for another CCO.

These low rates of spending are one indicator, among others, indicate that OHP members lack adequate access to behavioral health care. Review of services per 1,000 members from claims data would likely provide a stronger understanding of OHP member access to these services. The OHA Ombuds Program recommends that this review be completed.

Chart 2: Percent of capitated rate CCOs spent on behavioral health 2021-2022



	(Jan. 1 – June 30, 2022)			2021		
	Average	**High**	**Low**	**Average**	**High**	**Low**
SUD	3.0%	4.4%	0.6%	3.0%	4.5%	1.3%
Mental health	10.7%	17.1%	2.7%	10.6%	15.7%	7.2%
All behavioral health services	13.7%	17.0%	3.3%	13.5%	16.0%	11.0%

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Home and Community-Based Services (HCBS) 1915(i)

Accessing 1915(i) services on the basis of mental health disability

Home and Community-Based Services (HCBS) are Medicaid services provided to qualifying individuals to support their ability to maintain independence in home- and community-based settings and reduce the need for institutional services. This is designed to support individuals' access to care in the least restrictive community setting as an alternative to inpatient psychiatric hospitalization or nursing facility care.

- ODHS manages and provides HCBS for people with physical, intellectual, and developmental disabilities through HCBS 1915(c) and 1915(k) Medicaid authorities.
- OHA manages and provides HCBS for people who are diagnosed with chronic mental illness, over age 21 and need assistance in two or more instrumental activities of daily living though HCBS 1915(i).

Provision of HCBS 1915(i) in Oregon recognizes that many individuals with mental health conditions do not receive ongoing services through a community mental health partner. Many need ongoing, in-home, personal care to maintain their independence, health, and housing stability within their chosen communities.
The Centers for Medicare & Medicaid Services (CMS) first approved Oregon's 1915(i) HCBS state plan option in 2012. Since then, as updated CMS regulations have allowed, Oregon has developed rules, guidance, and contractual obligations to include:

- Community-based integrated services,
- HCBS residential habilitation,
- HCBS psychosocial rehabilitation services for individuals with Chronic Mental Illness (CMI), and
- HCBS in-home personal care services.

In 2021, CMS approved updated Special Terms and Conditions in Oregon's Medicaid State Plan to allow Oregon to administer five additional 1915(i) services beginning January 1, 2022. These five additional services are:

- Community transportation,
- Transition services,
- Housing support services,
- Home-delivered meals, and
- Pest eradication.

OHA projected serving 2,323 individuals with these expanded benefits in 2022. However, program data provided to the Ombuds Program was for the first six months of 2022 only and showed that 655 individuals received some level of HCBS 1915(i) services in Oregon. It is unknown how many individuals received any 1915(i) services during the second half of 2022 and these data have not been tracked by OHA as part of monthly program reporting and monitoring.[3] Some of the reasons for low number of individuals receiving services may include:

- OHA has not set up processes to track the number of individuals receiving expanded services.
- OHA and most Oregon counties do not keep a list of 1915(i) in-home providers. This means that it is currently difficult to understand who receives these services, exact services, amount of time, appropriateness/quality of care/treatment.
- Shortage of 1915(i) in-home providers.

OHP Member Experience:
Oregon's Public Guardian and other advocates sought Ombuds Program assistance throughout 2022 for unhoused clients with serious and persistent mental illness who seek care in EDs. The Public Guardian and advocates reported homes and beds once open to OHA members are no longer available, in part due to residential providers' poor perceptions of the processes OHA uses to provide HCBS.

Advocates frequently reported that they seek for their clients to qualify for HCBS due to a physical disability through ODHS because services are perceived to be more easily and immediately obtained. Residential providers also seem more willing to open their homes and are more confident in the stability of ODHS rates.

Oregon's administration of these services has resulted in inequitable access for individuals with mental health disabilities.

In work helping individuals seeking HCBS 1915(i) services through OHA, the Ombuds Program has encountered significant gaps and barriers in:

- Referring members for screening,
- Screening members for services,
- Members qualifying for services, and
- Providers being able to adequately provide approved services.

Person-centered administration of HCBS regardless of the type of disability (mental or physical) has the potential to allow Oregon to:

- Leverage additional federal Medicaid funding to provide HCBS to members who are likely eligible, but not currently accessing HCBS on the basis of mental health disability.
- Support housing stability, reduce houselessness and support individuals' ability to maintain independent living.
- Support Oregon's obligations under the Americans with Disabilities Act and the Olmstead Decision to provide services to individuals with disabilities in the most integrated setting appropriate to their needs.

[3] Amendment: Agency reporting to CMS provided to Ombuds Program after this report publication indicate that 2,201 individuals received services some sort of HCBS 1915(i) in 2022.

- Reduce Aid and Assist population at the Oregon State Hospital by
    - Connecting individuals with HCBS early. This could help more individuals find stability within their own communities, avoid Aid and Assist development, and avoid the related risk of losing community, home, family, jobs, relationships, and assets.
    - Connecting individuals with HCBS after release from OSH for Aid and Assist to reduce likelihood of recidivism.

Experience in Ombuds Advocacy: Agency created barriers to accessing HCBS 1915(i) services

The Ombuds Program works frequently with individuals who first seek HCBS through ODHS or who had been receiving HCBS through ODHS and go through re-assessment. At entry or re-assessment, if the individual does not have a qualifying physical disability, ODHS denies HCBS services. A Community Mental Health Program (CMHP) must then assess the individual for 1915(i) service eligibility. OHA's external contractor completes the assessment and determines eligibility. Although, in theory a referral process from ODHS to CMHPs is in place, this does not occur consistently with all offices or with all members. **Individuals with whom the OHA Ombuds Program has worked, have often faced an additional 4-6 month delay in ultimately receiving services when first entering through ODHS and then being referred to OHA's external contractor. As implemented, this system screens people out, operates in silos, significantly increase service gaps, increase health inequities and creates a system in which physical and mental health disabilities are treated differently.**

Often those who work with populations who could benefit from HCBS 1915(i) services, such as community mental health programs, CCOs, ODHS offices, and other social service providers do not know about these services. They also do not know how to refer individuals to see if they qualify for HCBS services through OHA.

Advocates, guardians and others working with individuals in need of HCBS often share that, whenever possible, they try to obtain HCBS through ODHS on the basis of physical disability because the assessment and determination process is 1) more timely; 2) provides stronger, more holistic person-centered supports' 3) provides stronger supports to HCBS providers and residential treatment settings; and 4) provides more timely access to services.

Equity impacts

Additionally, even when qualifying for HCBS 1915(i) services through OHA:

- Members cannot find a provider certified to provide the care they need, particularly when seeking HCBS and care in a residential setting due to a mental health disability.
- Members are not informed that they can receive support from persons with lived experience such as a certified Peer Support Specialist (PSS).
- Individuals receiving HCBS services need to be determined financially eligible for Medicaid benefits separate from HCBS.
- ODHS provides additional mental health supports for individuals who qualify for OHDS HCBS services and also need mental health supports. It is unclear if OHA does the same for individuals who qualify for 1915(i) services and also need physical HCBS supports.

The following groups of HCBS 1915(i)-eligible individuals are disproportionately impacted:

- Members transitioning to Medicare who need to an HCBS 1915(i) reassessment,
- Members accessing HCBS 1915(i) services due to a mental health disability; or
- Members whose primary language is not English and other priority populations.

OHA Ombuds Program recommendations

OHA should take concrete actions to ensure OHP members have timely access to appropriate SUD treatment:

OHA Member Experience: **Working with the Ombuds Program**
I just want to thank you for everything you have done behind the scenes. I was able to connect with a care coordinator today. She is recommending that I work with a Nurse Care Manager and will be arranging a time to meet sometime next week.

- Require CCOs and OHA FFS program to contract with all willing residential SUD providers in the state. Current SUD residential contracting practices and single-case agreement approaches taken by CCOs do not meet member needs.
- Establish standards for minimum spending benchmarks on SUD treatment. Until standards are established, conduct additional review of member utilization based on claims data for inpatient and outpatient SUD treatment with CCOs who spend lower than the average of 3 percent spent across all CCOs on SUD treatment.
- Establish network adequacy standards for SUD treatment based on national standards and estimated need in Oregon. Possible areas to this work could include review of CCO SUD claims data including the number of members per 1,000 who receive inpatient and outpatient SUD care, bed capacity within CCO networks, access to available beds and estimated and actual wait times to obtain a residential bed.
- When distributing stabilization funds for behavioral health providers, prioritize regions with lower number of SUD services in the population overall identified through FFS and CCO claims data and regional capacity and need. This should be a dual approach with OHA and CCOs sharing responsibility to increase capacity.
- Ensure integrated SUD and mental health residential programs are equipped to treat both needs simultaneously in a residential setting.
- Regularly audit CCO and FFS denials of SUD residential provider claims and evaluate member impact and member outcomes.
- Expand statewide service capacity for all residential providers, particularly SUD providers and mental health certified home care agencies who provide some residential habilitation 1915Ii) services.
    - Expand service providers statewide: OHA and counties should prioritize recruitment and support of additional mental health certified home care agencies to serve clients receiving residential habilitation HCBS 1915(i).
    - Provide operational support to providers in navigating OHA administrative processes. Strengthen provider recruitment, retention, onboarding and credentialing. Train providers on how to evaluate and refer members for HCBS 1915(i) service eligibility.
    - Prioritize outreach, education and communication to OHP members potentially eligible for HCBS and the people who serve these members. Material should clearly explain what HCBS is, how to access it and what benefits are provided through the service.
    - Increase member understanding about how to access Peer Support Specialists (PSS) and Peer Wellness Specialists (PWS) for help with CCO/mental health system navigation for adults, families, and children.

Utilize member voice and experience in ongoing evaluation and quality assurance monitoring

- Set clear expectations and standards for coordinating access to Medicaid-funded services and ODHS benefits. This includes:
    - Ensure care coordination connects members to Medicaid-funded services carved out of CCO contract: children's Wraparound services; HCBS 1915(i) and State Plan Personal Care Support Services.
    - As part of the discharge plan, hospitals should connect any OHP member admitted due to a mental health or SUD diagnosis with the following people prior to discharge:
        - A CCO or FFS care coordinator.

        - If the member also has HCBS through ODHS, the member's APD or developmental disability case manager.
        - If the member has a guardian, the guardian, prior to discharge and at a minimum as part of the discharge plan.
    - Offering all members seeking HCBS an opportunity to be evaluated for all HCBS benefits offered through both ODHS and OHA.
- Leverage opportunities in Oregon's new Centers for Medicare and Medicaid Services (CMS) 1115 Demonstration Waiver to improve coordination and access to appropriate services and supports for justice involved individuals upon release, such as health navigators, medication-assisted treatment (MAT), CCO care coordinators, peer support specialists, personal support workers, SUD treatment, HCBS 1915(i) evaluation and referral.
- Reduce inequitable access to HCBS 1915(i) for individuals with mental health disabilities. OHA and ODHS should have a "no wrong door" policy for all Medicaid-funded HCBS evaluations and referrals. This means:
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    - People are screened for all available HCBS at one time. They would not need to go through multiple doors depending on their specific needs.

Reduce inequitable access for individuals with mental health disabilities to HCBS.

- Expand and clarify definition for HCBS 1915(i) and services available through 1915(i). Current language is unclear and seems to exclude some diagnoses. Expand language to Any Mental Illness (AMI) in order to support individuals with re-occurring mental health needs who are at risk of homelessness and other significant impacts during their periodic acute mental illness.
- Provide education on how to access HCBS 1915(i) services. Staff of ODHS, OHA, mental health crisis lines, and community mental health providers need training about referral processes, warm hand-offs and program eligibility.
- Require use of evidence-based processes, assessment tools and procedures for implementing and administering HCBS 1915(i) benefits.
    - Conduct in-depth review of current assessment tools and research other evidence-based assessment tools.
    - Ensure any stop, denial or reduction of HCBS 1915(i) services allows members full notice of this action and their appeal and hearing rights. Only provide this notice through a formal Notice of Adverse Benefit Determination.
    - Establish a quality assurance, monitoring and improvement strategy centered on outcomes for individuals accessing these services. Use member voice and experience in ongoing evaluation and quality assurance monitoring.

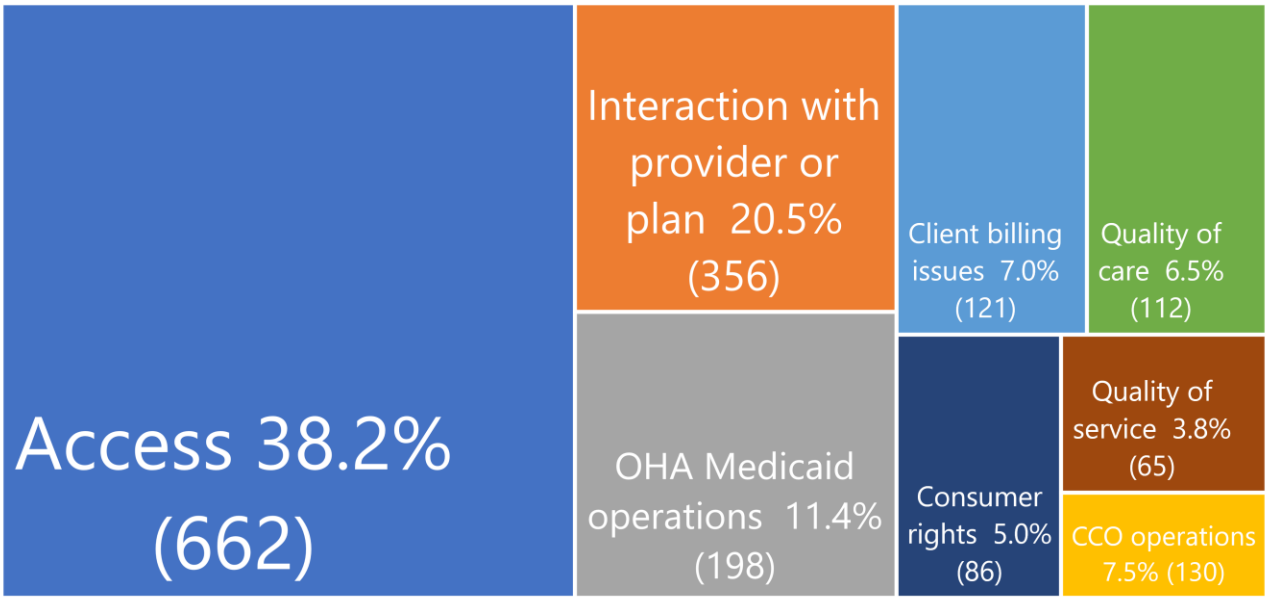
Ombuds Program Medicaid data: January 1 – December 31, 2022

Medicaid concerns by complaint category

The Ombuds Program's data tracking categories for Medicaid concerns align in most part with the member complaints categories that CCOs must report to OHA. This allows for comparison of complaints and concerns that OHP members make to their CCOs. The CCO complaint reports can be found in Appendix B of the OHP quarterly reports to the Centers for Medicare & Medicaid Services (CCO Complaints Summary). In addition, the Ombuds Program tracks concerns that are a result of OHA Medicaid operations, policies or programs.

Data included in the body of this report reflects all Ombuds cases during calendar year 2022. Appendix A breaks down data by quarter. All Medicaid-related concerns fall into one of eight categories highlighted below. Access to care concerns make up almost half of all Medicaid concerns at 45 percent (366).

Chart 3: All 2022 Medicaid concerns, January 1 – December 31, 2022 (1,732 total)



Interaction with provider or plan: 20.5 percent (356)

The concern most frequently brought by OHP members was inadequate or incomplete instructions from their plan. Members often did not know what to do or whom to turn to if receiving a denial for the care that was prescribed by their provider. Any members reported lack of communication and coordination from providers. Examples include lack of coordination for non-emergent medical transportation (NEMT) resulting in missed appointments, and incidents where a referral is made, but the member is not contacted to make an appointment with the referred provider. Ombuds general approach in these situations is to request CCO or FFS care coordination to support member's understanding of internal CCO/FFS processes and support coordination with CCO/FFS-contracted providers. **Ombuds work speaks to the value of care coordination and that members often do not know to ask for care coordination support or how care coordinators can support them.**

OHA Medicaid operations: 11.4 percent (198)

The Ombuds Program tracks concerns related to OHA's implementation and operation of Medicaid policies and programs as OHA Medicaid operation concerns. In 2022 these included concerns related to the Traditional Health Worker (THW) Program and THW certifications, including delayed program response to inquiries and assistance; OHP/Medicaid policies that often do not lead to member-centered outcomes; provider billing questions for services not covered by CCOs; requests for continuity of care to maintain established provider relationships because the member's CCO would not contract with the provider; changing from one CCO to another; queries to OHA about policies around use of flexible funds (particularly air conditioning units during summer 2022), and issues surrounding OHP enrollment/disenrollment.

CCO operations: 7.5 percent (130)

Concerns about CCO operations included questions about social determinants of health (SDOH), Asking CCOs for health-related services (spending for non-medical expenses to support health, such as air conditioners for heat events and air filtration devices), and help to stabilize housing through rental assistance funds. Other concerns included questions about Community Advisory Councils, use of correct gender pronouns and OHP member care coordination including lack of awareness of care coordination supports.

Client billing issues: 7.0 percent (121)

These included both in-state and out-of-state billing concerns. Before bililng any OHP member for services, all Oregon providers must have a signed client agreement to pay form from the member. Concerns included being billed but not having agreement in place or on file; and being charged for copayments in pharmacy settings. Billed services included emergency room, dental care and outpatient clinic visits. Providers also sent bills to Citizenship Waived Medical (CWM) members who thought their service was considered an emergency but OHA did not cover the service because it did not meet policy guidelines qualifying it as an emergency visit. **The Ombuds Program 2022 six-month report highlights significant billing concerns impacting OHP members including their ability to maintain stable housing and urges the Oregon Legislature to consider additional statewide approaches to ensure medical debt does not contribute to Oregon's unhoused crisis or housing instability.**

Quality of care: 6.5 percent (112)

These concerns included problems with a prosthesis, lack of appropriate individualized treatment for dentures, and concerns about unsanitary office conditions, particularly in dental offices. In addition, many issues revolved around hospital care concerns and members feeling they were discharged prematurely.

Consumer rights: 5.0 percent (86)

Almost half of these concerns related to dissatisfaction with treatment plan and denials for services prescribed by the member's provider.

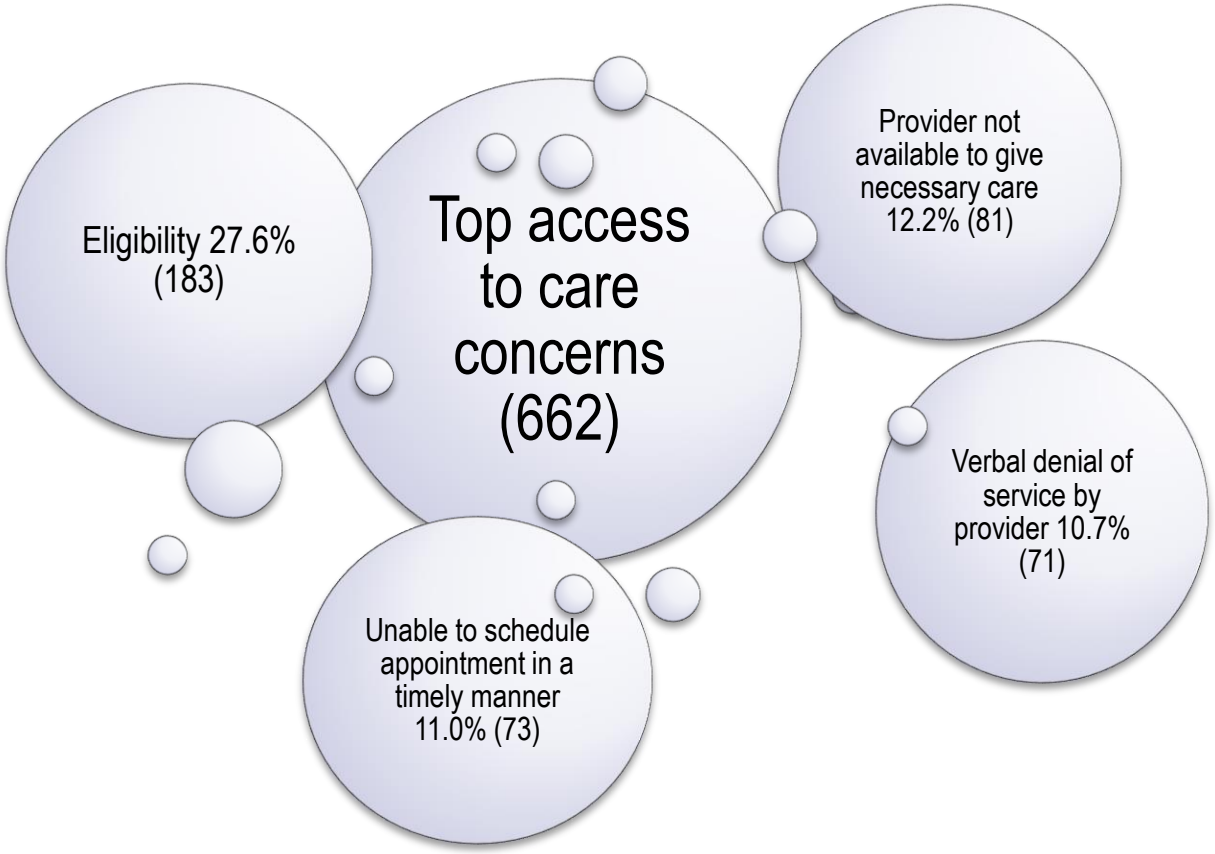
Quality of services: 3.8 percent (65)

These included concerns related to quality of dentures and delays in obtaining dentures, gender-affirming care including facial feminization, and dental implants not covered. Many concerns revolved around benefits not being covered including prescription medications and surgical procedures.

Top access to care concerns 38.2 percent (662)

Because access to care concerns make up almost a third of all Ombuds Medicaid concerns, this category is discussed in further detail to better understand OHP member's access to care needs. Top access to care concerns brought to the Ombuds Program in 2022 were eligibility concerns, provider not avaiable to give necessary care, unable to schedule appointment in a timely manner, and verbal denial of services by a provider. Top access concerns by quarter are included in Appendix A.

Chart 4: Top 2022 access to care concerns to Ombuds Program (662 Total)



Eligibility concerns 27.6 percent (183)

When individuals have concerns about eligibility they often do not seek care; addressing eligibility concerns is a critical first step to accessing OHP and whole health wellness. This area was discussed in-depth in the Ombuds 2021 Year-End Report.

Provider not available to give necessary care 12.2 percent (81)

The Ombuds Program saw the most complaints in the area surrounding mental health and dental care.

Unable to schedule appointment in a timely manner 11.0 percent (73)

This reflects OHP members' need for urgent access to care that is unavailable due to shortage of available providers particularly within mental health, co-occuring residential treatment and primary care providers.

Verbal denial of service by provider 10.7 percent (71)

OHP members have the right to appeal or request a hearing when they receive a written denial. Verbal denials do not offer this right and occur for OHP members across a variety of services.

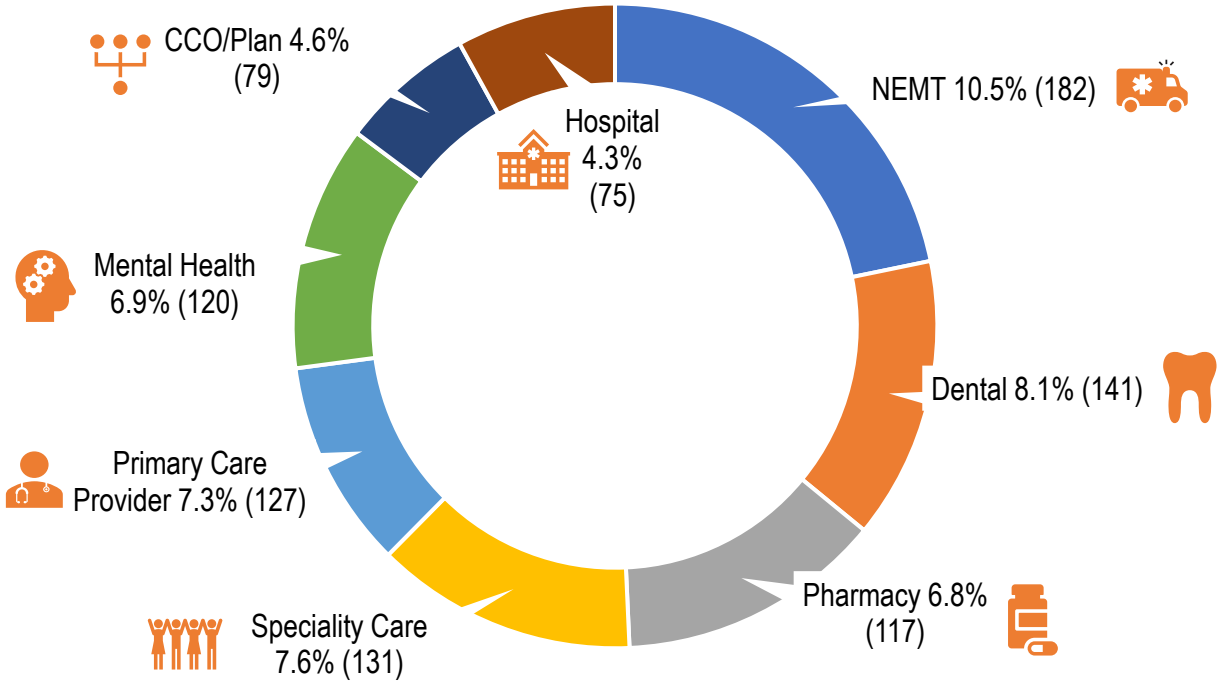
Unable to be seen in a timely manner for urgent/emergent care 5.6 percent (37)

This reflects OHP members' need for urgent access to care that is unavailable due to shortage of available providers.

Top Medicaid concerns by service type

An individual may have access to care concerns related to mental health or any other service type. Vice versa, a mental health service concern may be about any complaint category. This allows CCOs and the Ombuds Program to track the types of service of concerns that members present. In 2022, the OHP services most frequently involved brought to the Ombuds Program by memberswere NEMT, dental care, speciality care, access to primary care providers, mental health care and pharmcy concerns. All other Medicaid (majority eligibility and OHP Operations) concerns are not in the graph below. They make up 24.4 percent (423) of all service delivery concerns and are discussed in the Medicaid concerns by complaint category section.

Chart 5: Top 2022 Medicaid concerns by service type (1,732 Total)



NEMT 10.5 percent (182)

Many concerns regarding NEMT include rides not showing up at scheduled times, rides being cancelled last minute and issues with mileage reimbursement. NEMT concerns have been and continue to be one of the top concerns brought by OHP members to the Ombuds Program significantly impacting OHP member access to care.

Ombuds Advocacy at Work: Using member experience to revise Medicaid policies

Part of the NEMT benefit includes mileage reimbursement for OHP members who drive themselves to and from their medical appointments. These reimbursement rates had not been reviewed or increased since December 2001 and are currently set at 25 cents per mile, $40 per night for lodging, and $12 total per day for food. During summer 2022, while gas prices were at their highest, several OHP members working with the Ombuds Program articulated that mileage reimbursement rates were so low that they could not afford to travel to medical appointments even when receiving this reimbursement. The Ombuds Program elevated this need, worked with an internal OHA workgroup and advocated for OHA to prioritize increasing mileage reimbursement. As a result, OHA is requesting CMS approval to amend the Medicaid State Plan to increase the mileage reimbursement to 75% of the IRS Standard Rate, with plans to have this completed by fall 2023.

Dental 8.1 percent (141)

Many concerns included difficulty with getting an appointment with a dental provider indicating the need for more in network providers. There were several issues revolving around coverage of a prescribed treatment and what to do if a prior authorization was denied.

Specialty Care 7.6 percent (131)

Specialty care includes surgeries and medical treatment beyond seeing a primary care provider. Most of these concerns include not being able to be seen in a timely manner or being notified by the provider that the member cannot be seen.

Primary Care Provider 7.3 percent (127)

The concerns surrounding the primary care provider mostly comprise the member being unable to schedule with the provider in a timely manner, either due to lack of appointment spots or due to lack of providers available in the network area.

Mental Health 6.9 percent (120)

The concerns surrounding mental health care providers includes members being unable to schedule with a provider. Reasons for this include unavailability of providers, lack of providers and long wait times for an appointment. Particularly concerning were concerns where no Oregon facilities were available to treat youth with both physical and mental health needs; and concerns where youth in foster care could not access meaningful mental health supports due to a lack of care coordination.

Pharmacy 6.8 percent (117)

Most concerns include a member being asked to pay out of pocket for a prescription medication that should be covered by OHP.

Durable Medical Equipment (DME) 2.5 percent (43)

DME concerns highlighted the barriers for people with disabilities who need DME. Often, members were denied medical equipment they have needed and used for years. Members report that these experiences impact their mental health and cause trauma as they are forced to fight for services that allow them to be mobile in their community.

Ombuds Program data: 2020-2023 comparison

Concerns coming to the Ombuds Program increased between 2021-2022 and remained fairly stable from 2022 to 2023.

Chart 6: Ombuds Program Concerns received from 2020 - 2022

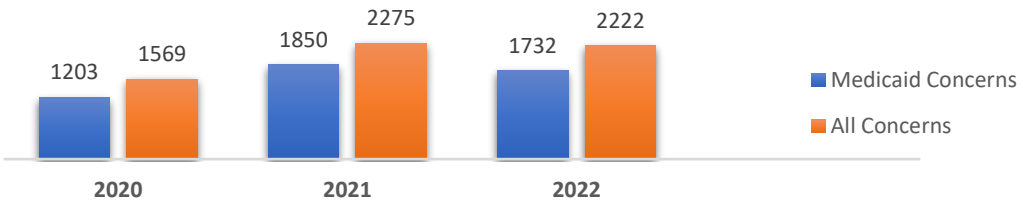
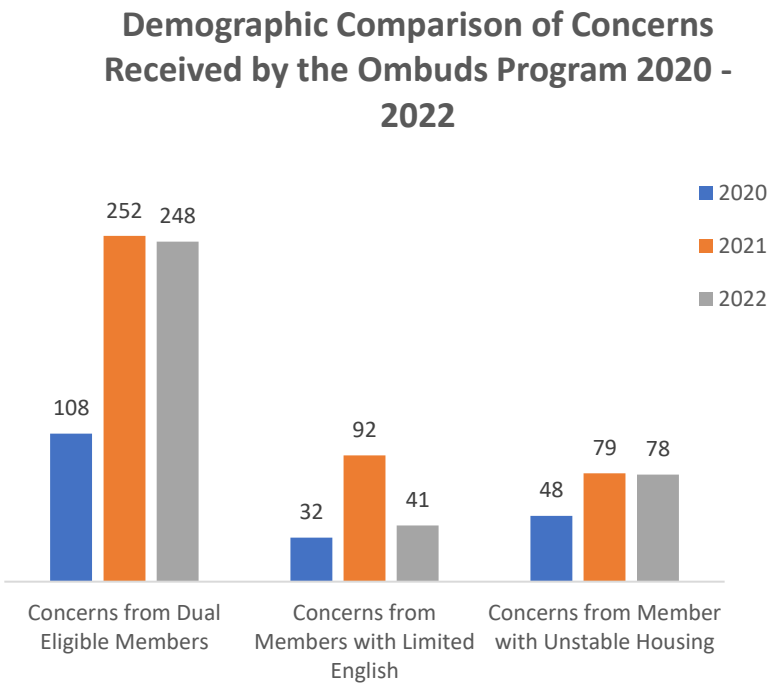


Chart 7: Demographic overview of concerns received from 2020 – 2022

To advance OHA's goal to eliminate health inequities by 2030, the Ombuds Program tracks areas where the program can better prioritize populations impacted by health inequities. From 2020 to 2021, the Ombuds Program increased case work and concerns with dual eligible, limited English proficiency members and members who prefer a language other than English and members with housing instability. In 2022, the numbers of individuals served in these areas remained fairly stable. Additionally, the Ombuds Program tracks issues centered on health equity and raises these concerns to OHA leadership.



Appendix A lists race and language data for OHP/Medicaid-related case work.

OHA Response to Formal Ombuds Recommendations from 2021

Appendix C reviews recommendations made in previous reports and highlights key successes, progress forward, and gaps in resolving the finding/problem identified in previous Ombuds reports. OHA provides a separate formal response and updates on progress forward. OHA's response to the 2021 report and update on activities within the six month Ombuds 2022 report indicate forward progress in many areas. However, many areas identified in previous reports still need action. Continued action is critical to improving OHP member access.

To obtain OHA responses to Ombuds communications so far, the Ombuds Program practiced diligent project management and follow-up with staff. Going forward, timely response from OHA should help the Ombuds Program meet member needs and support systems' changes for member-centered care. While formal response to date has been helpful, OHA still needs to take practical steps to integrate feedback from OHP members into Medicaid operations and policies.

OHA needs continued agency leadership to prioritize centering member voice and experience in internal operational, programmatic and policy work.

The Ombuds Program recommends that OHA agency leadership, the Oregon Health Policy Board, the governor and the Oregon Legislature use the recommendations and needs identified in Ombuds reports to drive action centered on improving access and quality of care for OHP members.

Ombuds Program Overview

OHA Member Experiences: **Working with the OHA Ombuds team**
Being heard, and understood, are so important to me that it's hard to explain how much of a relief it is for me to make a connection with someone with the time and skill to listen, obvious understanding of how the system optimally works, and authority to offer assurance of delivery to a safe harbor.

Ombuds Program enabling legislation required the Ombuds Program to also report on areas for Ombuds Program improvement. Ombuds Program improvement recommendations include:

- Continue OHA's formal annual audit response to Ombuds Program's reports and ensure adequate project management and subject matter expert (SME) support to operationalize changes.
- Increase receptiveness and understanding of OHP member experience through Ombuds casework and learning by other OHA Programs and Divisions
- Strengthen responsiveness of OHA staff for members; prioritize across the agency the same level of responsiveness to Ombuds concerns and those raised by members and those advocating for members as that shown for concerns by legislators and media. Ensure agency leadership supports agency statutory requirements to respond to Ombuds communications.
- Strengthen Ombuds Advisory Committee with a formal governance structure for the Ombuds Program.
- Increase and strengthen Ombuds Program community reach to populations impacted by health inequities and less likely to proactively reach out to the Ombuds Program for support

Success story: Integrating Member experience through Ombuds Feedback in HERC

OHA's Health Evidence Review Committee (HERC) organizes and hosts quarterly meetings with the Ombuds Program to hear emerging OHP member concerns and integrates into future HERC reviews needs that are identified through collaboration with the Ombuds Program and understanding of how HERC guidelines impact member access to care. Ombuds was able to highlight member need and experience to HERC and help an organ transplant rule revision move forward that increased member access to care for all members. Other upcoming HERC reviews informed by Ombuds case work include gender-affirming care and smoking cessation guidelines prior to surgery.

Conclusion

Each person who seeks Ombuds Program assistance deserves nurturing and support. The stories they share often illustrate challenges many others experience . Each story brings lessons for ways to improve Oregon's Medicaid delivery system and to understand the impact of health inequities on people who receive or seek access to Oregon Health Plan benefits.

It is an honor to work within an agency that embraces Oregon Health Plan member experience as essential to successful transformation. The OHA Ombuds Program is privileged to support Oregon's efforts to ensure health equity through advancing better health, lower costs, and improved patient experience for all people in Oregon, particularly populations experiencing health inequities.

Appendix A: Ombuds data tables

All concerns received

	Q1	Q2	Q3	Q4	2022 YTD
Total concerns	565	511	637	508	2221

Medicaid vs. Non-Medicaid concerns

	Q1	Q2	Q3	Q4	2022 YTD	
					%	N
Medicaid	417	405	520	390	78.0%	1732
Non-Medicaid	148	106	117	118	22. 0%	489

Event

	Q1	Q2	Q3	Q4	2022 YTD	
					%	N
COVID	30	18	16	10	3. 3%	74
COVID Medicaid	18	12	11	3	2.5%	44
COVID non-Medicaid	12	6	5	7	6.1%	30
Extreme weather: Fire, heat event, other extreme weather	NA*	74	58	0	5. 9%	132

*The Ombuds Program began tracking Extreme weather as an event during the second quarter of 2022.

Medicaid concerns

Total work by complaint category

	Q1	Q2	Q3	Q4	2022 YTD	
					% of Medicaid Concerns	N
Total Medicaid concerns	417	405	520	390		1732
Access	189	179	156	138	38.2%	662
Interaction with provider or plan	55	60	142	99	20.5%	356
OHA Medicaid operations	51	61	51	35	11.4%	198
CCO operations	12	12	92	14	7.5%	130
Client billing issues	35	26	25	35	7.0%	121
Quality of care	33	25	28	26	6.5%	112
Consumer rights	24	33	7	22	5.0%	86
Quality of service	18	10	15	22	3.8%	65

	Q1	Q2	Q3	Q4	2022 YTD	
					% of all Access Concerns (662)	N
Top access concerns	189	179	156	138	38.2%	662
Eligibility issues	56	46	38	43	27.6%	183

	Q1	Q2	Q3	Q4	2022 YTD % of all Access Concerns (662)	N
Provider not available to give necessary care	17	16	34	14	12.2%	81
Unable to schedule appointment in a timely manner	16	15	19	23	11.0%	73
Verbal denial of service by provider	13	22	15	21	10.7%	71
Unable to be seen in a timely manner for urgent/emergent care	9	10	12	6	5.6%	37
Plan unresponsive, not available, difficult to contact for appointment or information	7	8	6	4	3.8%	25
Provider's office unresponsive, not available, difficult to contact for appointment or information	5	12	5	3	3.8%	25
Verbal denial of service by plan	4	10	3	6	3.5%	23
Referral or 2nd opinion denied/refused by plan	4	2	1	4	1.7%	11

Total concerns by service type

Medicaid complaint categories and service types are independent of each other. An individual may have access to care complaints related to Mental Health or any other service type. Vice versa, a mental health service concern may be about any complaint category.

	Q1	Q2	Q3	Q4	2022 YTD % of Medicaid Concerns	N
Total service type concerns	417	405	520	390		1732
All other Medicaid (majority eligibility and OHP Operations concerns)	120	108	95	100	24.4%	423
NEMT	61	45	61	15	10.5%	182
Dental	33	36	35	37	8.1%	141
Specialty care	31	33	29	38	7.6%	131
Primary care provider	28	23	43	33	7.3%	127
Mental health	25	35	35	25	6.9%	120
Pharmacy	33	32	19	33	6.8%	117
Other	5	6	76	10	5.6%	97
CCO/plan	22	11	31	15	4.6%	79
Hospital	13	26	22	14	4.3%	75
Durable medical equipment	6	9	13	15	2.5%	43
Long term care	6	3	11	11	1.8%	31
Residential Rehabilitation	7	4	11	5	1.6%	27
Pain management	6	8	6	5	1.4%	25
Emergency room	4	6	3	12	1.4%	25
Vision	0	9	4	3	0.9%	16
Alcohol and drug/substance use disorder	4	1	5	6	0.9%	16

Diagnostic studies	3	2	4	3	0.7%	12
Outpatient	3	1	5	1	0.6%	10
Ambulance/medical transportation	2	1	5	2	0.6%	10
Imaging	0	4	3	2	0.5%	9
Acupuncture	1	0	3	1	0.3%	5
Physical therapy	2	0	1	2	0.3%	5
Chiropractic	1	0	1	2	0.2%	4
Occupational therapy	1	0	1	1	0.2%	3

Demographics and populations served

					2022 YTD	
	Q1	Q2	Q3	Q4	% % of Medicaid Concerns	N
Total Medicaid concerns	417	405	520	390		1732
Age: Over 64	61	61	90	74	16.7%	286
Dual eligible members	57	51	69	42	12.6%	219
Provider concerns	42	43	44	31	9.2%	160
Age: Under 19	22	27	30	34	6.5%	113
Individuals with identified unstable housing	12	18	23	10	3.6%	63
Limited English proficiency	12	5	10	9	2.1%	36
Tribal	1	5	0	3	0.5%	9

Language spoken by OHP members served by Ombuds Program

Primary Language*	Q1	Q2	Q3	Q4	%	N
Grand Total**	253	277	134	101	100	765
Farsi	1	-	-	-	>1%	1
Cambodian	-	-	-	-	-	-
Korean	-	-	-	-	-	-
Romanian	-	-	-	-	-	-
Vietnamese	-	-	1	-	>1%	1
Arabic	1	1	-	-	>1%	2
Afghan, Pashto, Pashtu	-	-	-	-	-	-
Hearing Loss, Sign Languages	-	-	-	-	-	-
Russian	1	-	-	-	>1%	1
Other, Undetermined	-	3	-	-	>1%	3
Spanish, Mexican	13	8	4	5	3.9%	30
English	237	266	129	96	95.1%	728

* For OHP members served by the Ombuds Program, 5 percent have an identified primary language other than English.

** This total of 765 unique OHP members for whom the Ombuds Program has identifying information as identified through the Medicaid Management Information System (MMSI). This is in contrast to Ombuds Program which tracks by unique concerns.

Race/ethnicity of OHP members served by the Ombuds Program

Race/Ethnicity	Q1	Q2	Q3	Q4	%	(N)
Total*	253	277	134	101	100%	765
Asian or Pacific Islander	-	-	-	-	-	-
Chinese	-	1	-	-	>1%	1
Caribbean	-	-	-	-	-	-
Slavic	1	-	-	-	>1%	1
Indigenous Mexican, Central American or South American	1	1	-	-	>1%	2
Micronesian	-	-	1	-	-	1
Black	4	3	2	-	1.2%	9
Hispanic or Latino Central American	-	-	-	-	-	-
African	-	1	-	-	>1%	1
Eastern European	1	10	2	1	1.8%	14
Other Hispanic, Latino	2	1	4	4	>1%	11
Other Race or Ethnicity	4	4	2	1	1.4%	11
African American	3	5	1	3	1.6%	12
Other Asian	2	1	1	1	>1%	5
African/African American/Black - Other Black	-	-	-	2	>1%	2
American Indian	4	5	1	3	1.7%	13
Western European	16	10	5	6	4.8%	37
Hispanic or Latino Mexican	11	12	4	3	3.9%	30
Decline to Answer	28	34	19	10	11.9%	91
Did Not Answer	21	23	3	3	6.5%	50
Unknown	18	24	7	4	6.9%	53
Other White	133	146	76	56	53.7%	411
Multiple Racial or Ethnic Identity	-	-	2	3	>1%	5
Biracial or Multiracial	-	-	1	1	>1%	2

*This total of 765 unique OHP members for whom the Ombuds Program has identifying information as identified through the Medicaid Management Information System (MMSI). This is in contrast to Ombuds Program which tracks by unique concerns.

Non-Medicaid concerns

OHA concerns

	Q1	Q2	Q3	Q4	2022 YTD % of all OHA non-Medicaid concerns	2022 YTD N
Total OHA Non-Medicaid Concerns	148	106	117	118		489
Public Health Division concerns	23	9	11	10	10.8%	53
Other OHA general concerns	9	7	7	13	7.4%	36
Licensing: Other	6	5	3	3	3.5%	17

	Q1	Q2	Q3	Q4	2022 YTD % of all OHA non-Medicaid concerns	2022 YTD N
Licensing: Public Health (hospital air, water food, pool, lodging, etc.)	8	3	1	0	2.5%	12
Oregon State Hospital concerns	2	5	3	1	2.2%	11
Licensing: Behavioral Health (DUI, outpatient, etc.)	2	5	1	3	2.2%	11
Civil rights or ADA violation	3	1	0	0	0.8%	4
Public records request	0	1	2	1	0.8%	4
Marketplace	0	1	1	2	0.8%	4
OEI - interpreter and translation (non-member access)	1	0	1	0	0.4%	2
Human resources	0	1	0	0	0.2%	1
PEBBS/PERS	0	0	1	0	0.2%	1

Other government agencies concern

	Q1	Q2	Q3	Q4	2022 YTD %	2022 YTD N
Total non-OHA concerns	148	106	117	118	22.0%	489
Other (included housing and medical licensing board complaints)	37	16	25	19	19.8%	97
Oregon Department of Human Services (ODHS)	24	18	22	16	16.3%	80
Department of Consumer and Business Services (DCBS) (private insurance concerns)	8	12	10	14	11.9%	58
Local government issue (includes social determinants of health concerns such as food, water quality , wildfire impacts, public space access for local parks all best suited to local governmental supports)	11	17	13	11	10.6%	52
Medicare	13	8	9	13	8.8%	43
Veterans' Affairs	0	4	1	2	1.4%	7
HIPAA violation – Health and Human Services (HHS)	0	1	0	2	0.6%	3

Appendix B: Findings and recommendations from previous reports

Ombuds Program Report Recommendation Date	Topic	Finding/ Problem	OHA Ombuds Recommendation	2022 Status Updates
OHA Ombuds Report – 1st and 2nd Quarters 2019	Care Coordination	Member Care Coordination experience is not consistent and does not occur for all members who would benefit. Ombuds cases consistently reflect gaps in: a) Care coordination access for members; b) Member awareness of this service, and c) OHA's lack of definition and standards for member care coordination. Specific populations facing additional care coordination needs are: a) OHP members who, for various reasons, are not tied to one geographic area of the state. These reasons include college attendance, houselessness and housing instability, child welfare involvement, and residential mental health or substance use	OHA should update care coordination rules and contracts to close gaps and set definitions and standards. OHA should work with CCOs to identify challenges and opportunities for implementing care coordination and Intensive Care Coordination (ICC) requirements. OHA should ensure clear guidance in contract and rule and through technical assistance to ensure CCO and FFS care coordination links members to Medicaid-funded services carved out of CCO contract including: children's Wraparound services; 1915(i) and State Plan Personal Care Support Services for members with behavioral, developmental or physical disabilities and other services not covered by Medicaid including housing supporting and other social determinants of health-related services. Ensuring this fundamental element of Oregon's Coordinated Care Model is implemented equitably for all members, both FFS and CCO enrolled, is a	**Successes** Transformation Center learning collaborative with CCOs held throughout 2022 on Care Coordination brought technical assistance and further identification of gaps where clear internal OHA guidance is needed. **Progress forward** OHA began in late 2022 an internal workgroup to revise Care Coordination rules. This workgroup plans to continue working closely with CCOs and incorporate member experiences in 2023. FFS program expensing work to review and strengthen FFS member care coordination through KEPRO contract including data that reflect member experience and include warm transfers for FFS members.

Ombuds Program Report Recommendation Date	Topic	Finding/ Problem	OHA Ombuds Recommendation	2022 Status Updates
		disorder treatment. b) OHA identified priority populations and c) Other populations facing health inequities. Ensuring this fundamental element of Oregon's Coordinated Care Model is implemented equitably for all members, both FFS and CCO enrolled, is a significant area where both OHA and CCOs have opportunity to improve.	significant area where both OHA and CCOs have opportunity to improve.	**Gaps** Updated consistent rules have not been implemented despite long identified need. OHA has consistently failed to dedicate sufficient Subject Matter Expert staff to lead in this critical work area. Lack of HSD care coordinator subject matter expert; lack of alignment between contracts and rules on priority populations for care coordination. Need to prioritize care coordination within OHA compliance team from a member center-centered perspective. OHA provision of Care Coordination to FFS members does not currently apply the same expectations and level of support that OHA expects of CCO care coordination through existing contract obligations.
OHA Ombuds Report – 1st and 2nd Quarters 2021	Care Coordination	Ombuds cases reflect OHP members with physical and mental health needs seen in hospital emergency departments who are not admitted but whom have	OHA and CCOs should leverage ways to ensure appropriate care, treatment and coordinated discharge planning for individuals who present in emergency departments in physical and/or mental	**Successes** **Progress forward** Beginning work at OHA has begun to support coordinated discharges from the

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		significant needs that care coordination could support.	health crisis even when OHP members are not admitted to a hospital.	Oregon State Hospital in coordination with CCOs. **Gaps** Similar attention and processes are needed for other hospitals and health systems throughout Oregon. In 2022, 522 unhoused individuals passed away.
OHA Ombuds Report – 1st and 2nd Quarters 2021	Care Coordination	OHA Quality Assurance Team has many areas of the CCO contract to provide oversight of. Care Coordination would benefit from additional oversight and guidance around Care Coordination by OHA. Additionally, current compliance actions do not include FFS nor does it integrate member experiences as part of the compliance review.	OHA should prioritize care coordination as a compliance action within CCO and FFS reviews. This must center member experience accessing care coordination through review of individual cases and complaints, from secret shopper surveys, member satisfaction surveys, and other methods within compliance review.	**Successes** **Progress Forward** FFS working to implement an overall metrics framework and align with CCO metrics. FFS program plans to implement a CAC. CAC has potential to build member voice into OHA compliance framework. This is not yet implemented or operational. Work to center member experience and feedback in Care Coordination rules guidelines began in late 2021 and will engage members and CCOs to address areas of concerns and challenges with the current system.

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				The Oregon Health Authority (OHA) has contracted with HSAG to conduct a review of Coordinated Care Organizations' (CCOs') compliance with federal (42 CFR 438) and state regulations that address standards related to access, structure and operations, and quality measurement and improvement. Within each three-year compliance cycle, the EQRO will review a full set of standards, with follow-up being conducted during subsequent years to assess corrective actions taken to address deficiencies. One of the standards reviewed by the EQRO is "Coordination and Continuity of Care," which includes a review of all federal and state requirements for care coordination. The standard was reviewed in 2020 and is being reviewed again in 2023. Results from the 2020 review can be found here. In 2023, the EQRO will conduct a secret shopper survey to assess timeliness to appointments.
				Gaps

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OHA Ombuds Report – Calendar Year 2020	Enrollment and transitions	Delayed newborn enrollment into the Oregon Health Plan. In 2020, approximately 36% (7,200) infants were not enrolled into OHP at 10 days after birth and 10% (2,000) infants were not enrolled at 20 days after birth. Federal Medicaid law (Social Security Act, Section 1902(e)(4)) requires states to ensure that all infants born to Medicaid-members have automatic Medicaid eligibility beginning at birth and continuing for 12 months. The gap experienced by Oregon's Medicaid newborns can delay medical care in the critical days after birth.	Prioritize agency resources to ensure same-day enrollment into OHP for infants born to OHP mothers: utilize the mother's Medicaid ID for billing purposes until the infant has their own Medicaid ID. This allows time for an OHP identification to be created for the infant and is allowable under Social Security Act, Section 1902(e)(4)) and 42 CFR 435.117 (c)6 -generate separate Medicaid ID for infants and provide them to expectant mothers during pregnancy, or institute Oklahoma's model of an electronic system where hospitals enter newborn's information into an electronic software interface prior to release that allows for a Medicaid ID to be issued in real time.	**Successes** Oregon's new 1115 Demonstration Waiver includes continuous OHP eligibility from birth until age six. Once enrolled into OHP children's continuous coverage on Medicaid/PHP will be protected for six years. **Progress forward:** Planned change request in beginning 2024 to have next-day CCO enrollment after enrollment into OHP. **Gaps** Continue to explore barriers to OHP enrollment and notification challenges. As redeterminations begin for all 1.4 million OHP members in April 2023, timely enrollment of newborns into OHP is likely to face additional strains and barriers due to increased overall workload to conduct OHP member redeterminations.

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OHA Ombuds Report – 1st and 2nd Quarters 2021	Enrollment and transitions	Eligibility and enrollment transition concerns to the Ombuds Program have increased, rather than decreased, over time. • In 2019, 12 percent of Medicaid concerns were related to enrollment and eligibility. • In 2020, the percentage increased to 14 percent. • In 2021, the percentage was 24.34 percent. These concerns range from confusion around eligibility notices, inability to reach the Oregon Eligibility (ONE) call center for timely assistance , and delays in CCO enrollment when transitions of any kind (such as leaving a justice setting, moving from one part of the state to another, household changes) occur.	Ensure same or next-day enrollment into CCOs for new members and from one CCO to another when transitions occur.	**Progress forward** Planned change request in beginning of 2024 to have next-day CCO enrollment after enrollment into OHP. The Medicaid Management Information System (MMIS) technical team started meeting January 2023 to review and begin designing this technology change. Based on technology limitations within MMIS and CCO systems, the technical team is preparing to design the initial change to enroll member on "next [business] day" of OHP effective date. The team is beginning to engage CCOs to better understand their automated notification processes.

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OHA Ombuds Report – 1st and 2nd Quarters 2021	Language Access & Equity	Ombuds concerns when working with members with Limited English Proficiency (LEP) indicate both OHA and CCO lack of understanding that LEP members are often less likely to complain in the same way or use the established complaint mechanisms that English-speaking members may use, such as filing a formal complaint with their CCO. This is due to many reasons including language barriers and different cultural practices of voicing complaints within medical settings. This can also disproportionally impact members' interest in appealing or requesting a hearing on a denial.	OHA and CCOs should: • Use feedback from, and the voice of, trusted community partners as a proxy for CCO complaints. • Review member appeals in response to a CCO- or FFS-generated Notice of Adverse Benefit Decision (NOABD) by language, race and ethnicity, to determine if LEP members or other populations are less likely to appeal NOABDs. • Develop auditing strategies to ensure language access services are active and accessible across all medical provider offices. For example, secret shopper pilot projects. • Build member experience and voice into OHA's compliance framework for CCO and FFS language access.	**Successes** As part of OHA's efforts to identify and eliminate health equities, The Equity and Inclusion Division led efforts to develop and approve an agency-wide health equity metric focused on providing quality and meaningful language access for CCO members with LEP or who are Deaf and hard of hearing. This upstream metric has two components: (1) a CCO language access self-assessment and (2) a quantitative language access utilization documenting the percent of CCO member visits with interpreter needs in which OHA credentialed interpreter services were provided. Results from the first two measurement years show that CCOs have made measurable improvements in offering meaningful language access to CCO members **Progress forward:** CCOs have made progress but still fall short of quality targets for language access metric. FFS program is conducting initial work to implement FFS metrics and align to CCO metrics. Future work to develop a CAC could support incorporating member voice into FFS work.

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				In 2024, CCO QA unit will launch a second round of secret shopper surveys (another round will be launched in 2023) and we will assess access to language access services at appointments. Currently, the CCO QA unit is building out a process to engage members more directly in providing feedback to compliance related issues (e.g., Network Adequacy member survey and video, member engagement through Ombuds Council and MAC). The CCO QA team will be working with Ombuds and our HSD Complaints team to understand trends and patterns in member complaints that might be helpful in identifying compliance issues. **Gaps**

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OHA Ombuds Report – 1st and 2nd Quarters 2021	Mental health & SUD	Adequate access to mental health and SUD providers, and thus all behavioral health services, is a significant challenge for OHP members. Specific Ombuds concerns in this area include: a) The need for timely and accessible mental health and SUD care at all levels of care; b) Inadequate mental health residential treatment and system capacity, for both children and adults; c) Underutilization of Traditional Health Workers, particularly Peer Support Specialists (PSS) and Peer Wellness Specialists (PWS); and d) Insufficient statewide capacity for inpatient services, with member access further limited by CCO provider networks that may not work with	Report behavioral health capacity annually to support understanding the extent of Oregon's behavioral health capacity crisis and monitoring for its resolution and evaluate adequacy of provider networks for OHP members statewide by CCO. Specifically: Number of adult / child ED visits driven by mental health and SUD by region and by CCO; Number of adults and children held in EDs for more than one day as a result of mental health and SUD health issues; For FFS and each CCO: ▪ Number and types of mental health and SUD providers enrolled in OHP; ▪ Number and types of mental health providers open to receiving new patients; ▪ Average waiting time for first new mental health/SUD patient appointment.	**Successes** SUD inventory and gap analysis report conducts analysis by county but does not review by CCO capacity. https://www.oregon.gov/adpc/Pages/gap-analysis.aspx **Progress Forward** OHA Quality Assurance team conducting enforcement of contractual requirements for Intensive-Home Behavioral Health Treatment and are putting three CCOS that are not in implementing on corrective action plans. Plans to incorporate program quality review of IHBH services in 2023. Quality Assurance team conducted Network Adequacy review, found here, based off of existing time and distance standards and has begun work in 2022 to develop further network adequacy standards that may be able to support additional network adequacy gaps in a more detailed way.

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		all inpatient facilities willing to accept OHP members.	Average and per CCO percentage of capitation that is spent on mental health.	**Gaps** Signiant gaps are highlighted in the body of this report
OHA Ombuds Report – Calendar Year 2020	Mental health & SUD	Inequities in access based on mental health disability is a significant equity concern within Oregon's Medicaid program. OHP members can have in-home supports for mental health disabilities, just like people can have in-home supports for physical, intellectual and developmental disabilities (I/DD). The Oregon Department of Human Services (ODHS) determines eligibility for physical and I/DD in-home supports. OHA determines eligibility for mental health supports. The Ombuds Program worked with individuals who first sought services and supports based on	Strengthen and ensure equitable whole-health, trauma informed services and supports provided by both OHA and ODHS are coordinated and equally available to Oregonians with disabilities regardless of whether the disability is rooted in mental or physical health.	**Gaps** This recommendation is the focus of the 2022 report with additional recommendations and findings of significant gaps. Bed capacity for in-home residential supports. Placements are easier to find on basis of physical disability.

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		physical disability. When ODHS determined that the individual needed support based on a mental health disability, the individual had to go through a new and separate evaluation process with OHA. This delayed the individual's access to services they qualified for. The Ombuds Program also encountered confusion among agency staff, CCO care coordinators, and family members of those seeking services about the process to get approval for mental health in-home services and supports		
OHA Ombuds Report – 1st and 2nd Quarters 2021	Mental health & SUD	Requests to be able to continue therapeutic relationships with mental health providers not part of a CCO network for both inpatient and outpatient services.	Where adequate networks do not exist for outpatient and inpatient mental health and SUD services, allow network access for any licensed providers within the state.	**Gaps** This recommendation has not been implemented. Network adequacy and capacity is a significant barrier faced by CCO and FFS members. This recommendation would need a CCO contractual change.
OHA Ombuds Report – 1st and 2nd Quarters 2021	Mental health & SUD	Underutilization of Traditional Health Workers, particularly Peer Support Specialist and	Increase member understanding about how to access Peer Support Specialist and Peer Wellness Specialists (PSS and PWS) for help with CCO/mental health	**Successes** Rate increases for all behavioral health providers including THWs.

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		Peer Wellness Specialists (PSS and PWS).	system navigation for adults, families and children.	OHA Quality Assurance team model member handbook provides information about CCO PSS and PWS and how CCO members can access them. https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx **Progress Forward** OHA has increased behavioral health payment rates, including for THW. **Gaps** Work is needed regarding 1915i rates, so THW rates are paired with basic H0038 PSS rates and then in addition add optional travel and off-site modifiers for the provider.
2021 Report Ombuds Annual Report	NEMT	Fewer than 10 percent of OHP members use NEMT services, and even then NEMT made up approximately 6 percent (99) of all Medicaid concerns. Most were about late or "no show" rides for members. This often results in members being unable to access their medical care and in some cases being fired by their providers for too many missed or late appointments		**Successes** OHA established an internal NEMT workgroup on February 22, 2022, to explore NEMT challenges and how it impacts access to health care including review of systems, processes, member-specific complaints, examining NEMT rules and contracts. **Progress Forward** Working towards implementing engagement plans through a Technical Advisory Committee structure, to include OHP members. The goal is to develop strategies to change state rules and contracts in a way that centers and

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				advances equity, and improves access, compliance, and efficiency.
				Gaps Existing OHA process improvement is foundational but has not yet resulted in overall systems improvement for OHP members access to and quality of NEMT services.
	NEMT	Part of NEMT benefit includes mileage reimbursement for members who are travelling for medical and use their own vehicle. It also includes food and lodging reimbursement for medical treatment requiring overnight trips (such as accessing specialty care in a region outside of the home CCO region). These reimbursement rates had not been reviewed or increased since December 2001 and are currently set at .25 cents per miles, $40 per night for lodging, and $12 food cost total per day.	Increase mileage, food and lodging rates for NEMT benefit to align with present-day cost of living.	**Progress Forward** The OHA internal NEMT workgroup, with Ombuds Program advocacy, elevated and prioritized mileage rate reimbursement. OHA staff are working on requesting CMS approval to increase the mileage reimbursement to 75% of the IRS Standard Rate, with plans to have this completed by Fall of 2023.

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2022 Ombuds Report, 2nd Quarter	Billing	OHP member billing concerns are one of the top reasons why individuals come to the Ombuds Program. Between 2019-2022, they made up between 7 to 12 percent of OHA Ombuds Medicaid concerns annually and 7 percent (3,638) of all member complaints to CCOs annually. Member billing concerns represent systematic barriers at the provider, CCO, and OHA level.	Strengthen OHP member education and communications about member billing rights with a focus on culturally and linguistically accessible communication, including videos and other alternative communication formats.	**Successes** **Progress forward** Updated member webpage about what to do if bill received. This is available in top languages spoken by OHP members, Spanish and English social media posts and communication to providers about member billing rules. Plans in place to develop FFS clinical advisory committee; this can serve as a forum to elevate and support FFS providers. FFS work to become compliant with federal regulations so that FFS members receive a denial notice for services. This will provide clear information on appeals process and a path to discover if provider billed for services.
			Prioritize training and support of enrolled providers. OHA's Health Systems Division (HSD) should enhance OHP Provider Services to strengthen provider recruitment and retention and offer education and training about member billing, starting with providers serving FFS members. Currently, HSD provides very minimal education and training to providers. To leverage resources, best practices and equity-centered community engagement and communication with providers any new HSD initiatives should work in partnership with the Community Partner Outreach Program (CPOP) which supports and educates providers who are part of the Community Partner application	
			Ensure strong oversight of member billing practices with enrolled FFS providers and work with CCOs to ensure	**Gaps**

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			strong oversight of member billing practices with CCO-contracted providers.	No current plan to provide videos or alternative communication format about billing. No budgeted positions or staff resources at OHA currently exist for Provider education and outreach. Previous positions for provider training were re-allocated for other agency Medicaid administration needs. HSD FFS legislative requests for staff for provider training and outreach have not been approved for the previous four legislative sessions while need to support FFS providers to ensure payment best practices has increased.
			Oregon's new OHP 1115 Medicaid Demonstration Waiver includes housing. CCOs and OHA should ensure that work to remedy members' credit scores when damaged by medical debt is part of program implementation	