Oregon Health Authority Ombuds
2021 Year End Report

EXTERNAL RELATIONS DIVISION
Ombuds Program

June 2022

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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 systems improvement.

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

Almost 1.4 million Oregonians are enrolled in OHP[1], close to one-third of the state's population of 4.3 million. Close to 90 percent of OHP members are enrolled in OHA-contracted coordinated care organizations (CCOs) for coordinated mental, dental and physical health services. Roughly 1 in 10 OHP members are not enrolled in CCOs. Instead, they are in the fee-for-service (FFS) program coordinated by OHA's Health Systems Division (HSD). Some specific populations can be, or always are enrolled into FFS.[2]

Ombuds complaints and concerns data are unique in several ways:

- **Individuals come to the Ombuds Program because they realize others also experience their concerns.** Many individuals want to ensure that OHA is aware of these systems concerns. Ombuds callers say specifically, "I want to prevent this from happening to anyone else." *As part of OHA's commitment to eliminating health inequities and co-creating with community, it is essential for OHA as an agency to hear and listen to these individual concerns.*
- **Prioritizing equity requires that OHA act on some concerns even without larger amounts of data.** For systems improvement, particularly where internal OHA systems and processes are not receptive to individual needs, OHA should investigate and act upon *even one concern brought from any population experiencing health inequities.* Examples include concerns around language access for Limited English Proficiency (LEP) members and concerns from individuals seeking to access substance use disorder (SUD) treatment.
- **Ombuds capture and articulate each unique need brought by OHP members.** Under federal Medicaid regulations (42 C.F.R. § 438.00), a grievance is defined as "an expression of dissatisfaction." The Ombuds Program logs each concern, resolved or not, as a unique concern to track.

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[1] Monthly Medicaid Reports, Total Medicaid population by county (page 1), https://www.oregon.gov/oha/hsd/ohp/pages/reports.aspx, last visited 4/4/2022.

[2] OHP members who have FFS coverage include

- All Tribal members have the option of choosing FFS coverage. Roughly half of Oregon's Tribal members choose FFS.
- OHP members who have private insurance receive FFS OHP as secondary coverage. OHP members in this group include children with disabilities whose parents have family coverage through employer-sponsored insurance.
- Medicaid members who also have Medicare coverage ("dually eligible" or "Medicare-Medicaid" members) can choose FFS for their physical health care.
- Members who have been approved for a CCO enrollment exemption that allows them to continue care with an FFS provider. Most often this is to allow providers who do not contract with the member's CCO to continue serving the member due to their understanding of the member's specific health history and needs.

- **OHP members come to the Ombuds Program when they cannot get the support they need elsewhere.** The Ombuds Program is designed to support members after other avenues for resolution have been explored — for example, through filing a complaint with an individual CCO. In many instances these concerns represent areas for systems improvement.

Ombuds Recommendations

The Ombuds Program's 2019, 2020, and the six-month 2021 reports make a variety of recommendations based on the program's case work. This year-end 2021 report:

- Summarizes from these previous reports four areas of significant member concern that need systems improvement. Appendix C identifies the recommendations made in previous reports for these areas of concern.
- Makes no new recommendations but rather redraws attention to these four areas where OHA should take further action to improve member access to and quality of care.

These four areas are:

1. OHP member enrollment and transitions
2. Care coordination
3. Language access and equity-centered approaches
4. Mental health and substance use disorder (SUD)

This report also provides an additional issues spotlight around enrollment and transitions with key member stories and experiences highlighting equity-centered areas for concern. In the past three years of reporting, enrollment and transitions concerns are the top concerns consistently shared with the Ombuds Program.

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[3], 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.

Although these concerns affect many populations, newborns are disproportionately impacted by delays into what should be automatic OHP enrollment. Although delays remain for timely enrollment, 2022 data indicate that the percentage of newborns experiencing enrollment gaps greater than 10 and 20 days is decreasing. Appendix D provides additional details around this concern.

[3] The Oregon Department of Human Services maintains a public dashboard of ONE operations data reports and eligibility backlog dashboard at https://www.oregon.gov/dhs/Benefits/Pages/index.aspx.

Eligibility concerns spotlight: Centering equity and OHP priority populations within eligibility processes

Although this report focuses on Medicaid-related concerns, approximately 22 percent (505) of OHA Ombuds concerns were related to other OHA programs and other state agencies. Many of these concerns are related to Marketplace, private insurance and Medicare. This often occurs as individuals transition from OHP to other health insurance or vice versa. Appendix A gives additional details of these concerns and **highlights the importance of prioritizing care transitions across insurance types and throughout individuals' lifetimes.**

These concerns become urgent as we near the end of the federal COVID-19 Public Health Emergency, when eligibility redeterminations and renewals for OHP will begin again[4]. Some OHP members may transition to other insurers. Because renewal processes depend on members having a stable mailing address to receive notices, renewals for OHP members who are unhoused or housing unstable will be at risk. These members may lose health coverage if they need to receive and respond to a notice to renew their coverage. OHA|ODHS should adapt strategies and approaches to support members who do not have reliable mailing addresses.

Confusing notices from ONE system: Hearing directly from members

The Ombuds Program answers calls that come into OHA's Office of Civil Rights because the vast majority relate to OHP and OHP eligibility. Callers reach out to the Office of Civil Rights because the office's phone number is easily visible in the paperwork they receive and does not have a hold time; callers can in fact leave a message. No identifying information below is real. But the transcripts are otherwise verbatim.

In this first case, it was clearly very hard for the caller to speak English. The member spoke very slowly.

> *"My name is Guadalupe. My phone number is x. My question? I don't understand your papers. I get papers from you guys. So I need speak to my case worker about questions and answers. Maybe you have question for me. So I live with my daughter. It looks like two peoples in my apartment. We have mail from you guys. I don't understand. Um. Probably I need to talk to you. If you have questions, please call x."*

In the second case, the call was from that of a self-identified, 90-year-old individual. Here is what the caller spoke.

> *"This is Frances Jones. Out here in MyTown, Oregon. Case number (many numbers). Frances Jones. I'm just wanting to ask some questions. I've had these papers that was sent me from Salem and I'm trying to figure out how to fill it all out. I'm not complaining. I'm just trying to get some help with filling out this thing. I've been workin' on it, I've had it for quite a while and I'm trying to work on it.*

[4] Since March 18, 2020, as a result of the Families First Coronavirus Response Act , OHP and CWM coverage was made continuous. OHP members can only be disenrolled from OHP upon death, incarceration or permanent move out of state; if their medical benefits are approved in error; if they request to get off the OHP because they have an increase in income and another form of health insurance or as a result of a court decision. Once the federal COVID-19 Public Health Emergency ends, OHP renewals will begin again.

I did call before, and I talked to a lady and a caseworker. I talked plain to her. She said she would send me papers. And I thought I was going to receive them from her in Pendleton. But I just received this from Salem. And a whole bunch of stuff there that don't even apply to me. I don't have anyone or a person living with me. I'm just a 90-year-old woman. And I just want to know what I am supposed to send in. All this stuff wouldn't go in that envelope if I did try to send it. If someone would explain to me what I should do I would greatly appreciate it very much. My phone number is x. Thank you. Bye."

Care coordination

OHA must ensure all OHP members have equitable, accessible, and member-centered care coordination. The Ombuds Program, through casework, sees excellent care coordination service across multiple CCOs when members are meaningfully able to connect with a care coordinator. However, this is not consistent across all CCOs, or within OHA's FFS program, meaning it does not occur for all members equitably and for all 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 within Oregon's coordinated care model and FFS program.

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 disorder treatment.
b) OHA-identified priority populations[5]; and
c) Other populations facing health inequities.

Appendix C includes specific Ombuds recommendations from previous reports to improve equity-centered care coordination for OHP members. 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.

Language access and equity-centered approaches

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 thus creating an inequitable health barrier.

Mental health and SUD

[5] House Bill 4052 (2022) defines "Priority Populations" as groups that disproportionately experience avoidable illness, death or other poor health or social outcomes attributable directly or indirectly to racism, including: Communities of color, Oregon's nine federally recognized Tribes and the descendants of the members of the Tribes, immigrants, refugees, migrant and seasonal farmworkers, low-income individuals and families, persons with disabilities, and individuals who identify as lesbian, gay bisexual, transgender or queer or who question their sexual or gender identity.

Adequate access to mental health and SUD providers, and all supporting behavioral health services, is a significant challenge for OHP members. This is an area that requires both Medicaid and behavioral health programs within OHA to coordinate and identify shared solutions for OHP members and for all Oregonians. Specific Ombuds concerns in this area include:

a) The need for timely and accessible mental health and SUD services 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 and residential services, with member access further limited by CCO provider networks that may either be lacking availability by specialty, or that may not work with all inpatient facilities willing to accept OHP members.

Equity spotlight: Inequities in access based on mental health disability is a significant equity concern within Oregon's Medicaid program encountered through Ombuds Program case work. 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. When ODHS determines that individuals need supports based on a mental health disability, the individuals have to go through a new and separate evaluation process with OHA. This delays the individual's access to services they qualify for, and in some cases impacting the eligibility of the individuals for services and benefits they had prior to these processes. The Ombuds Program also encountered confusion among state agencies and their staff, CCO care coordinators, community mental health partners and family members of those seeking services about the process to get approval for mental health in-home services and supports .

Ombuds Program Data: Jan. 1 through Dec. 31, 2021

Data and trends: Medicaid themes in Ombuds service data

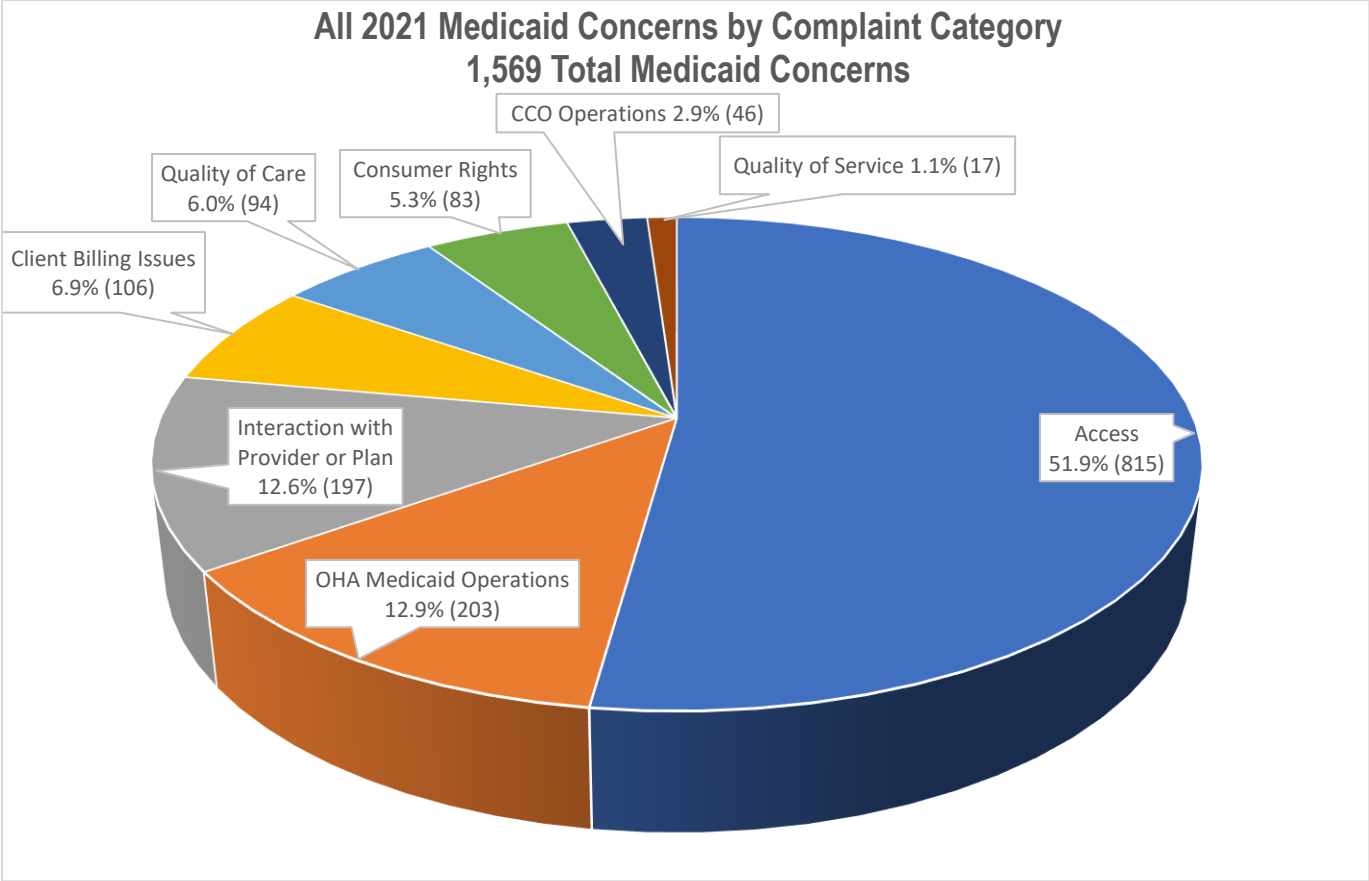
The Ombuds Program's data tracking categories for Medicaid concerns align[6] in most part with the member complaints categories that CCOs must report to OHA. This allows for comparison of complaints and concerns that OHP members make to their CCO. The CCO complaint reports can be found in the OHP quarterly reports to the Centers for Medicare & Medicaid Services under Appendix B of the report (CCO Complaints Summary).

Total Medicaid/OHP concerns to Ombuds Program by complaint categories during 2021

During 2021, the top five OHP complaints to the Ombuds Program were:

1) Access to Care: 51.9% (815);
2) Medicaid Operations: 12.9% (203);
3) Interaction with Provider or Plan: 12.6% (197);
4) Client Billing Concerns: 6.9% (106); and
5) Quality of Care: 6.0% (94).

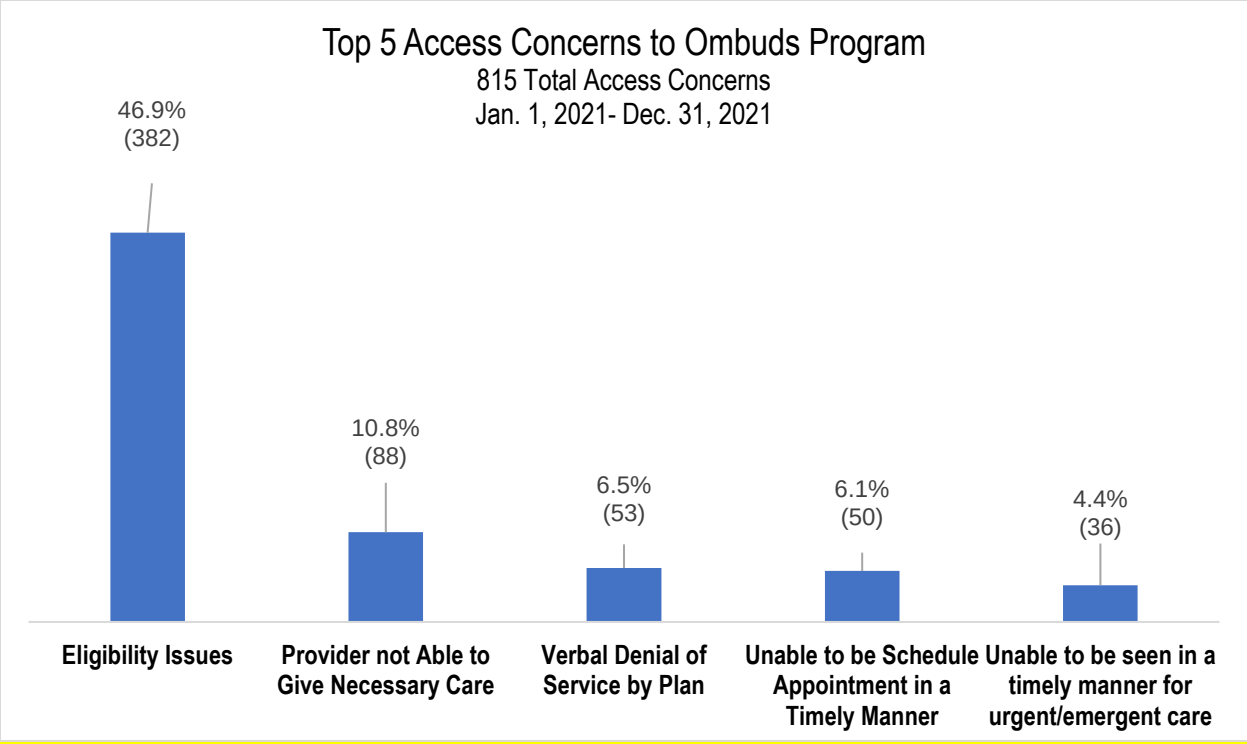
[6] The OHA Ombuds Program also tracks "Oregon Health Authority Medicaid Operations" (a non-CCO complaint category) to identify complaints and concerns that are a result of OHA Medicaid operations, policies or programs.



Access

Access to OHP-related care made up 51.94 percent (815) of all 1,569 Medicaid concerns with OHP eligibility concerns making up over half of those concerns. The graph below has the top five access sub-complaints while all access sub-complaints are included in Appendix A: Top Access Sub-Complaints**.** Eligibility and enrollment concerns were the top access sub-complaint category. Most of these eligibility and enrollment sub-concerns were related to member confusion stemming from OHP enrollment communications. Several highlight significant equity-related eligibility and enrollment sub-complaint concerns:

- **Dual-eligible members:** Of the 219 dual-eligible members who came to the Ombuds Program with OHP-related concerns, approximately 32 percent (70) were about their OHP eligibility status such as losing benefits, reduction, and enrolling. When OHP members enroll in Medicare, they may lose OHP. However, income, disability or eligibility for long-term care services and supports may qualify them for continued full OHP coverage or Medicaid support for out-of-pocket Medicare expenses. Challenges understanding eligibility and enrollment notices during this life transition cause additional confusion for these members and, in some Ombuds cases, result in reduced and/or interrupted care.



OHA Medicaid Operations

OHA Medicaid Operations concerns relate to implementation and operation of Medicaid policies and programs. These concerns made up approximately 13 percent (203) of all 2021 Medicaid concerns and included:

- Being enrolled in the wrong CCO resulting in continuity of care issues;
- Long delays between a member's report of an address change and enrollment into the local CCO;
- Lack of knowledge about or confusion related to the availability of and how to access care coordination services provided by the FFS program;
- Lack of CCO knowledge or care coordination for CCO members accessing carved-out Medicaid services paid for directly by OHA or ODHS;
- Accessibility and user-friendliness of a public-facing provider directory for FFS members to help identify providers accepting OHP FFS program[7]; and
- CCO disenrollment requests to support continued access to medical providers outside of the CCO network, as in the following member story.

[7] Maintaining a current provider directory has been a federal requirement for Medicaid managed care entities since 2018. OHP members enrolled in the fee for service (FFS program) did not have access to a comprehensive public-facing provider directory until 2020.

Interaction with Provider or Plan

Interaction with Provider or Plan concerns made up approximately 13 percent (197) of all Medicaid concerns. These concerns included:

- Language access for members who have limited English proficiency;
- Lack of timely access to dental and mental health care; and
- Concern about inappropriate emergency department (ED) discharges for individuals with significant mental health and/or SUD challenges.

Client Billing

Client Billing concerns made up about 7 percent (106) of all Medicaid concerns. Most concerns were from members billed for out-of-state ED services. Although OHP covers out-of-state ED services, some out-of-state providers refuse to bill the member's CCO or OHA. Often this results in sending OHP members to collections, lowering credit their scores, raising their interest rates, and making it harder to for members to obtain housing, credit, employment, and/or insurance of choice. The Ombuds Program has seen significant improvement within OHA and within CCOs to streamline the resolution process for out-of-state billing cases and ensure each case is resolved. However, OHA should pursue larger solutions at a national or federal level, as recommended in the OHA Ombuds Report – Calendar Year 2020.[8]

Quality of Care

Quality of Care concerns made up about 6 percent (94) of all Medicaid concerns. These concerns included:

- Experienced an adverse outcome, complications, misdiagnosis or other concern related to received care;
- Member neglect or physical, mental or psychological abuse; and
- Lack of appropriate individualized setting in treatment.

Services for which OHP members brought concerns to the OHA Ombuds Program: Total Medicaid work 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. This allows CCOs and the Ombuds Program to track the types of service that members bring concerns about.

The OHP services most frequently involved in Ombuds Program concerns (excluding All Other Medicaid) were:

[8] Support national strategies to ensure Medicaid members are not billed for out-of-state emergency services. Oregon should consider requesting congressional support for federal approaches to this concern. Possible federal solutions may include prohibiting Medicaid providers in all states from billing any other state's Medicaid-enrolled patients for emergency services and allowing every state Medicaid program to receive and pay claims for emergency services from any Medicaid-enrolled provider. This should be done without requiring those providers to go through a state-specific provider credentialing or enrollment process.

1) Mental health: 7.97% (125),
2) Dental care: 7.58% (119),
3) Specialty care: 7.01% (110),
4) Non-emergency medical transportation (NEMT): 6.31% (99), and
5) Pharmacy: 4.14% (65).

Appendix A includes all Service Type concerns.

Mental Health

Mental health services made up approximately 8 percent (125) of all Medicaid concerns. Significant areas included:

- Timely access to any mental health provider; lack of access to experienced, licensed mental health providers at all, or by speciality; inability to connect with a provider who can continue a provider-patient relationship for a reasonable length of time; length of time between appointments in cases where more regular appointments are recommended; and general inability to find mental health providers open to accepting new patients without very long wait times within CCO networks.
- Lack of mental health residential treatment services, for adults and children, has been and continues to be an issue that impacts OHP members,their providers and all levels of need for tranisition of care
- Among members whose CCOs contract only with community mental health programs or have narrow mental health provider networks, requests for greater choice of licensed and experienced mental health providers, as well as traditional health workers such as Peer Support Specialits (PSS) and Peer Wellness Specailists (PWS).
- The lack of bed availability at the Oregon State Hospital for members under civil commitment who are not involved in the state corrections system.
- Processes and supports that lack a trauma-informed approach, such as requiring a brand new assessment and treatment plan every time the member engages an additional mental health or SUD support or changes providers. An individual encountering mental health or SUD services in Oregon through an ED approach has the potential for multiple simultaneous and often times conflicting treatment plans.

Dental Care

Dental care services made up approximately 8 percent (119) of all Medicaid concerns. Denture access and quality has and continues to be a frequent concern brought to the Ombuds Program. Other dental concerns during this period highlighted lack of access to dental care, particularly in rural areas, and quality concerns regarding the dental work members received.

In March 2021, Oregon's Health Evidence Review Commission (HERC) approved an edit to the hernia guideline to allow repair of inguinal hernias that are painful, affect function or prevent employment. It also allows repairs of all inguinal and femoral hernias in women. This change was made effective Jan. 1, 2022. This recommendation was made by the OHA Ombuds Program to HERC and prioritized in the OHA Ombuds 2020 report.

Specialty Care

Specialty care made up approximately 7 percent (110) of all Medicaid concerns. About 50% of specialty care concerns came from members who received a denial for surgeries they requested from their CCO. Transgender-related services and hernia surgeries[9] were most commonly cited by members who came to the Ombuds Program with this type of concern. '

NEMT

NEMT made up approximately 6 percent (99) of all Medicaid concerns. Compared to the 2020 OHA Ombuds Report, this represents a reduction, in part attritbutable to a Corrective Action Plan (CAP) to address many of these concerns. Despite low utilization by OHP members (fewer than 10 percent of members use NEMT services), NEMT remains among the top five Medicaid service concerns received by the Ombuds Program.

- 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.
- One emerging issue was limited access to bariatric NEMT services statewide, which in turn specifically limits access to medical care for bariatric people if they have no other means of transportation.
- Additionally, towards the end of 2021, NEMT concerns increased as hospitals started reaching out to the Ombuds Program to report the lack of NEMT service for patient discharges. This issue results in reduced bed capacity in hospitals. Hospitals must also incur increased costs to keep patients in hospitals for an extended period due to NEMT being unavailable for timely discharges.

HOW NEMT AFFECTS HEALTH EQUITY

Delayed or no-show rides hinder access to life-sustaining care such as dialysis and chemotherapy.

Access to care is disproportionately affected for those who most rely on NEMT:

- Members with disabilities and/or mobility needs.
- Members in assisted living who need access to services outside their residence.

Potentially reduces inequities by:

- Supporting social determinants of health
- Supporting emergency response (e.g., CCOs used NEMT to support wildfire evacuation).

Member Story

Our member self-identified as a 78-year old individual with physical disability. They use an electric scooter to get around. When coming to the Ombuds Program, they shared that in the previous four months they had over ten rides that were either late or never showed to transport them to their medical appointments.

During September 2021, the member was stranded outside the provider's office from 4 p.m. to 2:30 a.m. The member waited for over 9 hours and called the NEMT line almost every hour. During each call, NEMT staff told the member a ride would be coming within an hour, but no ride came.

The member ended up calling the police out of desperation. The police called the NEMT line, which said a ride would be there shortly after midnight. Unfortunately, no ride showed up. The member ended up calling their caregivers. One of them agreed to drive to pick the member up around 2:30 a.m.

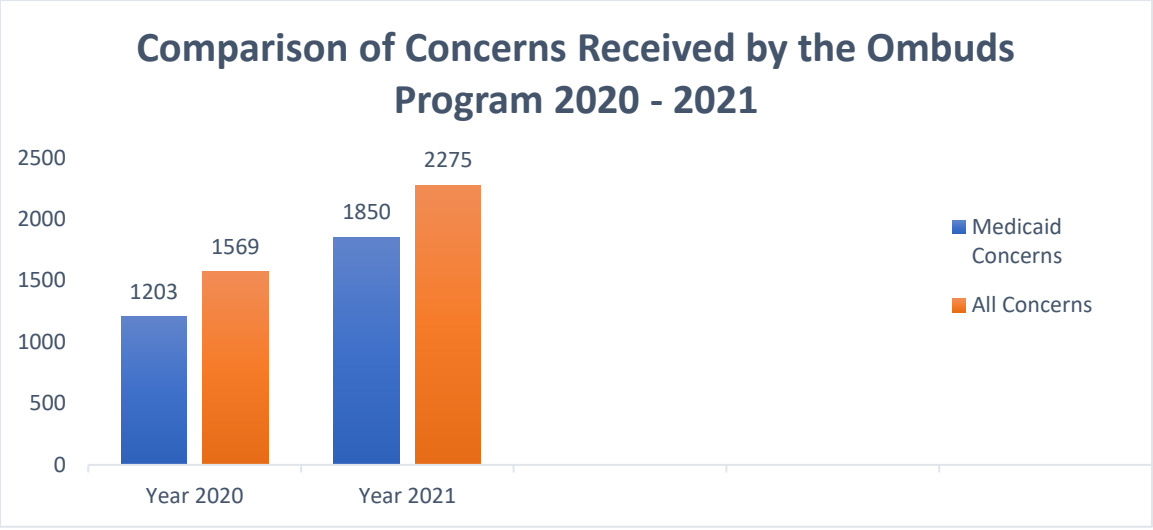
A few weeks later, a similar incident took place. The member waited for three hours and called multiple times for a ride. At 8 p.m. (after approximately four hours), they called the NEMT line again to ask them to send a cab. The member had to leave their scooter in the provider's office. This was the only way to secure a timely ride due to the limited availability of non-ambulatory vehicles that support wheelchair, electric scooters, or bariatric transportation. This case presents the urgent need to address this serious health inequity for some of our most vulnerable populations in Oregon.

Pharmacy

Pharmacy concerns made up approximately 4 percent (65) of all Medicaid concerns. Several concerns were related to pharmacy closures statewide and members' inability to refill medications timely due to this closure. Another common theme was denial of medications at pharmacies for issues related to eligibility, prior authorization (PA) denials, or medications being not covered.

Ombuds Program data: 2020-2022 comparison

All concerns coming to the Ombuds Program increased by 23 percent (from 1,850 in 2020 to 2,275 in 2021). Likewise, Medicaid concerns proportionately increased by approximately 30% (from 1,203 in 2020 to 1,569 in 2021).

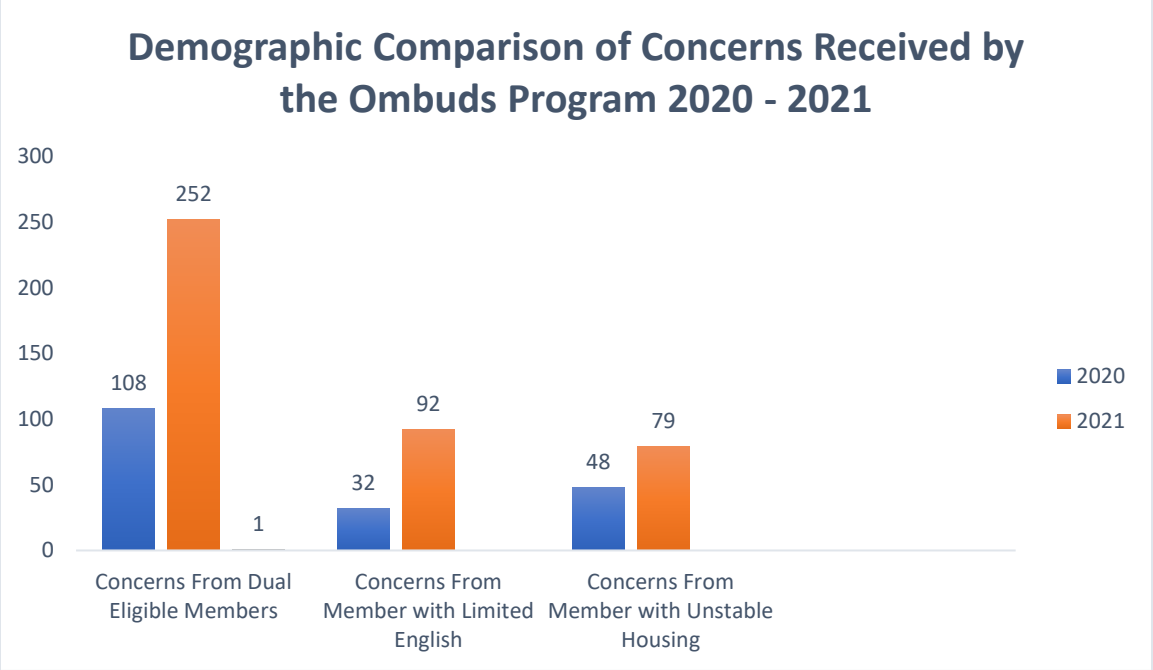


To advance OHA's goal to eliminate health inequities by 2030, the Ombuds Program tracks areas where the program can better prioritize populations impacted by health inequities. From 2020 to 2021, the Ombuds Program increased case work and concerns with:

- Dual eligible OHP members by approximately 133 percent (108 to 252)
- Limited English Proficiency members by approximately 188 percent (32 to 92)
- Members with unstable housing by approximately 65 percent (48 to 79)

Additionally, the Ombuds Program tracks issues centered on health equity and raises these concerns to OHA leadership.

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



Non-Medicaid data

Although this report focuses on Medicaid-related concerns, approximately 22 percent (505) of concerns brought to the Ombuds Program were related to other OHA programs and state agencies. Many of these concerns are related to Marketplace, private insurance and Medicare. This often occurs as individuals transition from OHP to other health insurance or vice versa. Appendix A gives additional details of these concerns.

During 2021, approximately 13 percent (290) of these concerns were related to COVID-19, mostly non-OHP related. However, during the first half of 2021, 55 percent (228) of non-Medicaid concerns were COVID-19-related. This illustrates how the Ombuds Program, like other teams and programs throughout OHA, received COVID-19-related concerns without a strong pathway for resolution. In March 2021, over 12 months into Oregon's pandemic response, OHA developed a customer service and feedback management system to support COVID-19 response. Ombuds Program work and infrastructure were the key drivers of this change, which led to the development of the COVID Feedback Team.

The Ombuds Program recommends that all future Incident Management Teams and emergency work touching OHA include a customer service feedback management process that prioritizes:

- Customer service to address individual concerns.
- System changes and systems responsiveness.
- Data tracking and reporting.
- Prioritization of concerns impacting health inequities.

Conclusion

Each person who makes it to the Ombuds Program 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 and their 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.

Appendices

Appendix A: Ombuds Program data (Jan. 1, 2021 – Dec 31, 2021)

All concerns and complaints received

	Q1	Q2	Q3	Q4	2021 Total
Total Ombuds Complaints and Complaints	673	581	537	484	2275

Medicaid vs. Non-Medicaid concerns

	Q1	Q2	Q3	Q4	Total Concerns and Percentage
Medicaid Complaints	416	408	390	355	1569 (68.97%)
Non-Medicaid Complaints	257	173	147	129	706 (31.03%)
COVID-19 290 total 5.4% (13) OHP/Medicaid Related/ 94.6% (228) Non-OHP	183	60	22	25	290 (12.75%)

Total Medicaid work by complaint category

	Q1	Q2	Q3	Q4	Total % (N)
Total Concerns	416	408	390	355	1569 (100%)
Access	201	224	211	179	815 (51.94%)
Oregon Health Authority Medicaid Operations	66	50	50	37	203 (12.94%)
Interaction with Provider or Plan	58	49	46	44	197 (12.56%)
Client Billing Issues	29	33	22	22	106 (6.76%)
Quality of Care	23	19	31	21	94 (5.99%)
Consumer rights	21	21	18	23	83 (5.29%)
CCO Operations	13	8	10	15	46 (2.93%)
Quality of Service	4	4	2	7	17 (1.08%)

Top Medicaid complaints in the "Access" category

	Q1	Q2	Q3	Q4	Total % (N)
Total Concerns	167	197	190	155	817
Eligibility Issues	76	116	119	71	382 (46.87%)
Provider not Able to Give Necessary Care	17	25	21	25	88 (10.80%)
Verbal denial of service by Plan	17	18	8	10	53 (6.50%)
Unable to Schedule Appointment in a Timely Manner	7	11	17	15	50 (6.13%)
Unable to be Seen in a Timely Manner for Urgent/Emergent Care	13	10	5	8	36 (4.42%)
Provider not Available to Give Necessary Care	15	3	9	9	36 (4.42%)
Verbal Denial of Service by Provider	9	8	10	7	34 (4.17%)
Referral or 2nd Opinion Denied/Refused by Plan	13	6	1	10	30 (3.68%)

Total Medicaid 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	Total % (N)
Total Concerns	416	408	390	355	1569 (100%)
All Other Medicaid (Majority eligibility and OHP Operations concerns)	156	189	183	113	641 (40.85%)
Mental Health	40	34	21	30	125 (7.97%)
Dental	34	27	26	32	119 (7.58%)
Specialty Care	33	27	27	23	110 (7.01%)
NEMT	31	24	17	27	99 (6.31%)
Pharmacy	16	9	16	24	65 (4.14%)
Primary Care Provider	16	11	20	12	59 (3.76%)
CCO/Plan	17	10	6	16	49 (3.12%)
Hospital	17	7	10	14	48 (3.06%)
Other	11	12	11	13	47 (3.00%)
Emergency Room	11	14	5	5	35 (2.23%)
Durable Medical Equipment	7	9	7	11	34 (2.17%)
Long Term Care	5	8	9	5	27 (1.72%)
Pain Management	7	8	6	0	21 (1.34%)
Alcohol & Drug/Substance Use Disorder	0	2	7	6	15 (0.96%)
Outpatient	1	3	3	5	12 (0.76%)
Residential Rehabilitation	3	3	4	1	11 (0.70%)
Vision	3	2	2	4	11 (0.70%)
Diagnostic Studies	0	2	5	2	9 (0.57%)
Ambulance/Medical Transportation	1	0	0	4	5 (0.32%)
Physical Therapy	1	0	3	1	5 (0.32%)
Occupational Therapy	0	2	0	2	4 (0.25%)
Chiropractic	1	1	0	1	3 (0.19%)

Non-Medicaid OHA general complaints

	Q1	Q2	Q3	Q4	Total % (N)
Total Concerns	162	76	47	56	341 (48.30%)
Public Health Non-Medicaid and Non-Licensing	136	39	18	35	228 (32.29%)
Other	16	26	17	13	72 (10.20%)
Licensing: Other	3	2	2	2	9 (1.27%)
Civil Rights or ADA Violation	3	3	1	1	8 (1.13%)
Licensing: Public Health Licensing (air, water food, pool, lodging, etc.)	0	0	3	4	7 (0.99%)
State Hospital	2	0	3	1	6 (0.85%)
OEI - Interpreter and Translation (Non-Member Access)	0	2	2	0	4 (0.57%)
Human Resources	2	1	0	0	3 (0.42%)
Public Records Request	0	2	1	0	3 (0.42%)

	Q1	Q2	Q3	Q4	Total % (N)
Behavioral Health Licensing (DUI, outpatient, etc.)	0	1	0	0	1 (0.14%)

Other government agencies complaints

	Q1	Q2	Q3	Q4	Total % (N)
Total Concerns	82	82	100	77	164
Oregon Department of Human Services (ODHS)	23	22	40	28	113 (16.01%)
Other	31	28	20	25	104 (14.73%)
Department of Consumer and Business Services (DCBS)	15	6	15	9	45 (6.37%)
Local Government Issue	4	18	15	6	43 (6.09%)
Medicare	7	4	9	8	28 (3.97%)
Veterans' Affairs	0	4	0	1	5 (0.71%)
HIPAA Violation – Health and Human Services (HHS)	2	0	1	0	3 (0.42%)

Demographics and populations served for all concerns received

	Q1	Q2	Q3	Q4	Total % (N)
Total Concerns	143	161	120	105	
Dual Eligible Members	57	75	58	59	249 (10.94%)
Limited English Proficiency	28	27	20	17	92 (4.04%)
Provider Concerns	32	31	22	11	96 (4.21%)
Tribal	6	4	4	2	16 (0.70%)
Individuals with Identified Unstable Housing	20	24	16	16	76 (3.34%)

Appendix B: Demographics

Language spoken by OHP members served by Ombuds Program

Primary Language*	N	%
Grand Total**	954	
Farsi	1	0.1%
Cambodian	1	0.1%
Korean	1	0.1%
Romanian	1	0.1%
Vietnamese	1	0.1%
Arabic	2	0.2%
Afghan, Pashto, Pashtu	2	0.2%
Hearing Loss, Sign Languages	3	0.3%
Russian	4	0.4%
Other, Undetermined	8	0.8%
Spanish, Mexican	62	6.5%
English	868	91.0%

* For OHP members served by the Ombuds Program, 9.0% have an identified primary language other than English.

** This total of 954 is unique OHP members for whom the OHA Ombuds Program has identifying information. This is in contrast to Appendix A which tracks by unique concerns, as individuals may have more than one concern.

Race of OHP members served by the Ombuds Program

	N	%
Total*	954	100.0%
Asian or Pacific Islander	1	0.1%
Caribbean	1	0.1%
Slavic	1	0.1%
Indigenous Mexican, Central American or South American	1	0.1%
Micronesian	1	0.1%
Black	2	0.2%
Hispanic or Latino Central American	2	0.2%
African	3	0.3%
Eastern European	3	0.3%
Other Hispanic, Latino	3	0.3%
Other Race or Ethnicity	4	0.4%
African American	7	0.7%
Other Asian	13	1.4%
African/African American/Black - Other Black	17	1.8%
American Indian	17	1.8%
WHITE	21	2.2%
Western European	27	2.8%
Hispanic or Latino Mexican	55	5.8%
Decline to Answer	81	8.5%
Did Not Answer	86	9.0%
Unknown	153	16.0%
Other White	455	47.7%

* This total of 954 is unique OHP members for whom the OHA Ombuds Program has identifying information. This is in contrast to Appendix A which tracks by unique concerns, as individuals may have more than one concern.

Appendix C: Findings and recommendations from previous reports

Ombuds Program Report Recommendation Date	Topic	Finding/ Problem	OHA Ombuds Recommendation
OHA Ombuds Report – 1st and 2nd Quarters 2019	Care Coordination	OHA must ensure all OHP members have equitable, accessible and member-centered care coordination. The Ombuds Program, through casework, sees excellent care coordination service across multiple CCOs when members meaningfully connect with a care coordinator. However, this is not consistent across all CCOs, within OHA's FFS program 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 within Oregon's Coordinated Care Model. 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	OHA should update care coordination rules and contract to address identified gaps and rectify OHA's lack of definition and standards. OHA should work collaboratively 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.

Ombuds Program Report Recommendation Date	Topic	Finding/ Problem	OHA Ombuds Recommendation
		health or substance use disorder treatment. b) OHA identified priority populations (define) 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.	
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 significant needs that care coordination could support.	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 health crisis even when OHP members are not admitted to a hospital.
OHA Ombuds Report – 1st and 2nd Quarters 2021	Care Coordination	OHA Compliance 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 secrete shopper surveys, member satisfaction surveys, and other methods within compliance review.

Ombuds Program Report Recommendation Date	Topic	Finding/ Problem	OHA Ombuds Recommendation
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.
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	Ensure same or next-day enrollment into CCOs for new members and from one CCO to another when transitions occur.

Ombuds Program Report Recommendation Date	Topic	Finding/ Problem	OHA Ombuds Recommendation
		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.	
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.
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	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

Ombuds Program Report Recommendation Date	Topic	Finding/ Problem	OHA Ombuds Recommendation
		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 all inpatient facilities willing to accept OHP members.	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. Average and per CCO percentage of capitation that is spent on mental health.
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	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.

Ombuds Program Report Recommendation Date	Topic	Finding/ Problem	OHA Ombuds Recommendation
		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 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.
OHA Ombuds Report – 1st and 2nd Quarters 2021	Mental health & SUD	Underutilization of Traditional Health Workers, particularly Peer Support Specialist and Peer Wellness Specialists (PSS and PWS).	Increase member understanding about how to access Peer Support Specialist and Peer Wellness Specialists (PSS and PWS) for help with

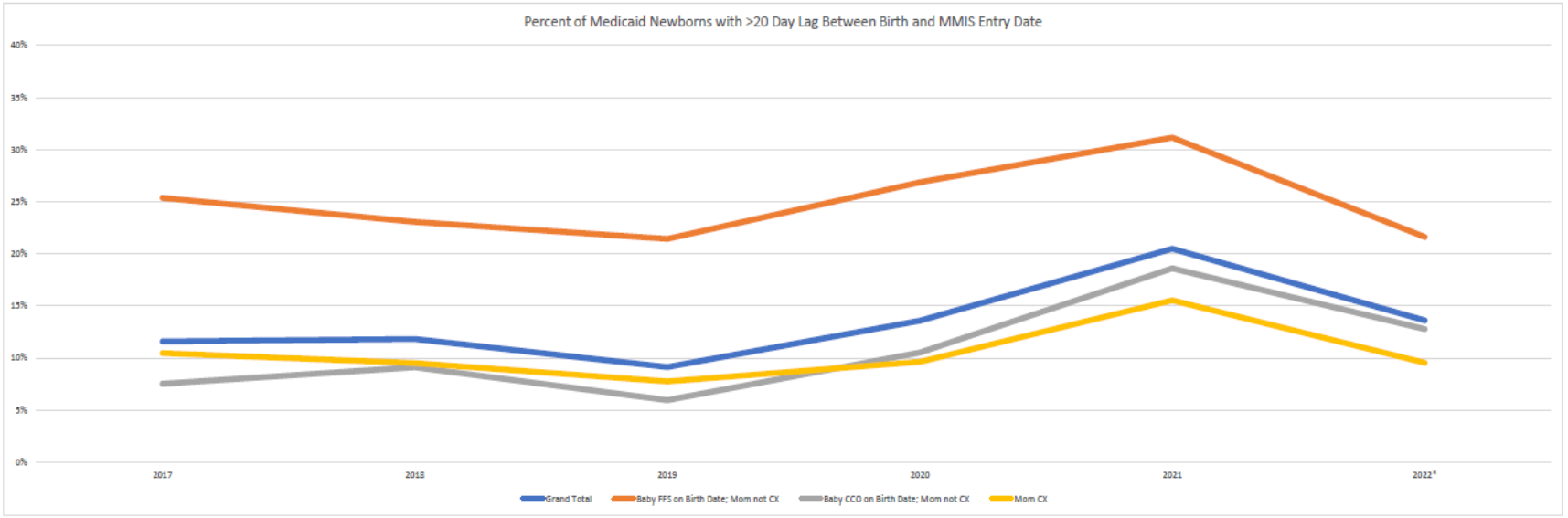
Ombuds Program Report Recommendation Date	Topic	Finding/ Problem	OHA Ombuds Recommendation
			CCO/mental health system navigation for adults, families and children.

Appendix D: Newborn enrollment data

Medicaid Newborns Days between Birth and MMIS Entry Date
2017-2022

	# of Births						>= 3 Day Lag						>= 10 Day Lag						>= 20 Day Lag					
	2017	2018	2019	2020	2021	2022*	2017	2018	2019	2020	2021	2022*	2017	2018	2019	2020	2021	2022*	2017	2018	2019	2020	2021	2022*
Baby FFS on Birth Date; Mom not CX	4,566	3,964	3,879	3,717	3,368	662	92.5%	91.4%	90.8%	90.6%	92.5%	88.4%	51.6%	58.8%	47.0%	50.4%	62.6%	45.0%	25.4%	23.1%	21.4%	26.8%	31.1%	21.6%
Baby CCO on Birth Date; Mom not CX	14,793	14,315	13,936	13,472	14,072	3,663	92.1%	92.7%	92.2%	90.4%	92.4%	87.0%	38.6%	54.9%	37.4%	39.1%	58.8%	40.9%	7.5%	9.1%	5.9%	10.5%	18.6%	12.7%
Mom CX	2,907	2,494	2,483	2,141	1,907	546	90.9%	90.5%	90.9%	88.3%	91.2%	89.2%	39.3%	51.2%	39.1%	35.5%	56.6%	37.0%	10.5%	9.5%	7.7%	9.6%	15.5%	9.5%
Grand Total	22,266	20,773	20,298	19,330	19,347	4,871	92.1%	92.2%	91.8%	90.2%	92.3%	87.5%	41.4%	55.2%	39.5%	40.9%	59.2%	41.0%	11.6%	11.8%	9.1%	13.6%	20.5%	13.6%

* Through April-2022



Appendix E: Letter included in report to Governor

June 6, 2022

The Honorable Kate Brown
Office of the Governor
160 State Capitol
900 Court Street
Salem, OR 97301

Dr. David Bangsberg, Chair
Oregon Health Policy Board
500 Summer Street NE
Salem, OR 97301

Re: 2021 Year-End Oregon Health Authority Ombuds Report

Dear Governor Brown and Chair Bangsberg:

Pursuant to Oregon Revised Statute (ORS) 414.712, the Oregon Health Authority (OHA) provides Ombuds services to individuals who receive medical assistance in Oregon. The Ombudsperson is directed to serve as the recipient's advocate on issues concerning access to and quality of care.

The OHA Ombuds position is a formal, internal voice for process and system improvements responsive to identified trends impacting services for the more than 1.4 million Oregonians served by the Oregon Health Plan (Oregon's Medicaid and Children's Health Insurance Program).

As required by ORS 182.500, the Ombuds Program provides a quarterly report to both the Governor and the Oregon Health Policy Board that includes:

1. A summary of the services that the Ombuds provided during the quarter;
2. Recommendations for improving access to or quality of care provided to Oregon Health Plan members; and
3. Recommendations for improving Ombuds services.

OHA recruited its first Ombuds in 2010. In 2019, with legislative and OHA leadership support, the Ombuds Program expanded to include seven Ombuds.

We are pleased to share that beginning with this 2021 year-end report formal processes are being established in OHA to ensure the process and systems improvements recommended by the Ombuds Program are reviewed and acted upon. The OHA Health Systems Division, which administers the Oregon Health Plan, will treat Ombuds recommendations in the year-end report as formal audit finding. They will provide a formal response and action plan. For the 2021 report, this response and action plan will be forthcoming and will be shared publicly.

Please find the OHA 2021 year-end Ombuds report attached.

Sincerely,

Sarah Dobra
Manager, Member and Stakeholder Support Unit
OHA External Relations

CC:
Tony Lapiz, Governor's Office
Patrick Allen, Director, Oregon Health Authority
Dawn Jagger, Director, OHA External Relations
Lavinia Goto, Medicaid Advisory Committee
Dr. Leslee Huggins, Medicaid Advisory Committee
Margie Stanton, Director, OHA Health Systems Division
Dana Hittle, Interim State Medicaid Director, OHA Health Systems Division
Ellen Pinney, Principal Ombuds