

**Oregon Health Authority Ombuds  
2022 Quarter 2 and 3 Report  
April 1 – Sept. 30, 2022**



EXTERNAL RELATIONS DIVISION  
Ombuds Program

November 2022

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## Introduction

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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.

The program uses Ombuds data and member experiences to identify trends and make recommendations that are founded in the understanding that:

- One client and their experience give voice to many others who do not know how to reach the Ombuds program, feel overwhelmed by the system or are too exhausted to seek support. Many Ombuds clients 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.
- OHA should at times act on concerns even without larger amounts of data, particularly for concerns impacting health equity.

Top Ombuds concerns remain the same as those in the 2021 annual report. Each concern disproportionately impacts people whose primary language is not English, people with disabilities and other priority populations.

- Capacity and access issues at every level of the behavioral health system. These issues affect anyone who qualifies for, but is unable to access, appropriate in-home or residential care, including children, adults, and people with Serious and Persistent Mental Illness (SPMI).
- Challenges with non-emergency medical transportation (NEMT).
- Program rules and policies for dental and durable medical equipment services do not keep pace with best practice or ensure quality of care.



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

This six-month report includes:

- An issues spotlight on OHP member billing and data analysis of the first six months of 2022 Ombuds case work,
- Second and third quarter data reporting, found in [Appendix A](#), and
- OHA's Health Systems Division progress report, found in [Appendix B](#). This report provides status updates regarding the responses and action plans the division formed to address issues raised in the 2021 annual Ombuds report. These [responses](#) can be found on the Ombuds [web page](#). Health Systems Division will continue to treat the annual reports as formal audits and report status updates in future six-month reports.

## Issues spotlight: OHP members billed for Medicaid-covered services



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<sup>1</sup>, as shown in Table 1. Billing Medicaid members for health services can and often does result in significant harm. OHP members are sent to collections, lowering their credit scores, raising their interest rates, and making it harder for members to obtain housing, credit, employment, and/or insurance of choice. Several member stories spotlight systemic barriers that OHP members face. The effects of improper provider billing on OHP members are highlighted throughout this section.

*Table 1: Total billing concerns received by Ombuds Program per year (2019-2022)*

Year	Total	% of Medicaid Concerns
2019 <sup>2</sup>	82	11%
2020	144	12%
2021 <sup>3</sup>	106	7%
2022	77	6%
<b>Grand Total</b>	<b>418</b>	<b>8%</b>

### *Out-of-state member billing concerns*

From July 2019 through September 2022, 21 percent (89) of Ombuds billing concerns were for out-of-state billing, including for:

- Emergency services (e.g., appendectomy, broken leg);
- Ambulance transport;
- Hospital care;
- Pharmacy services, in some cases for critical medications to avoid emergency situations, and
- Specialty care, sometimes sought because services were not available in Oregon.

<sup>1</sup> CCOs are required to report complaints from OHP members. From 2019-2021, member complaints to CCOs about billing totaled 3,638 complaints or 7 percent of all member complaints.

<sup>2</sup> 2019 reflects six months of data with the forming of a full Ombuds team.

<sup>3</sup> The Ombuds Program's work with multiple CCOs to improve their practices for resolving out of state and in-state member bills resulted in a significant decrease in member billing issues from 2020 to 2021. This work included establishing full CCO responsibility for working with members to resolve member bills.

OHP covers out-of-state emergency department services. However, some out-of-state providers refuse to bill members' CCOs or OHA and are unwilling to enroll with the Oregon Medicaid program. The [2021](#) and [2020](#) Ombuds Annual Reports discuss this in further detail.

### Member Story

A provider collection agency pursued an OHP member for medical debt incurred for OHP-covered services. Before sending the member to collections, the provider had not billed Medicaid nor verified OHP eligibility, as required by OHA. After Ombuds involvement, the provider billed Medicaid. After the provider billed OHP, OHP paid the bill, erasing the member's debt and removing them from collections. The providers did not check the member's OHP status at the time of service or even after the service had been provided.

### *In-state member billing concerns*

From July 2019 through September 2022, 79 percent (329) of Ombuds billing concerns were for in-state services. In most cases, significant federal and state laws<sup>4</sup> prohibit Oregon providers contracted with OHA from billing OHP members. Exceptions include when a provider has an [Agreement to Pay](#) form on file signed by the member. Oregon Medicaid providers must check OHP eligibility before providing non-emergency services, and before billing for emergency services.

This billing spotlight section focuses primarily on in-state billing concerns. Significant areas of in-state billing concerns seen through Ombuds case work include:

- Dental
- Hospital
- Emergency room. 65 percent (44) of these cases were out-of-state, but 35 percent (24) were in-state
- Pharmacy
- Specialty care
- Substance use disorder (SUD) treatment. Not all SUD providers contract with, or are willing to contract with, Medicaid. Even in the case where providers are contracted, they may not be contracted with the member's CCO.

### *Additional billing concerns*

Additional billing concerns highlighted in previous OHA Ombuds reports include:

- **No signed client [agreement to pay form](#).** Before billing an OHP member, all Oregon providers must have a signed client agreement to pay form from the member; concerns included lack of this agreement on file. [2022 1<sup>st</sup> Quarter Ombuds Report](#)

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<sup>4</sup> Oregon Administrative Rule 410-120-1280(1) states, "[a] provider enrolled with the Authority or providing services to a client in an MCE under the Oregon Health Plan (OHP) may not seek payment from the client for any services covered by Medicaid fee-for-service or through contracted health care plans, except as authorized by the Authority under this rule." Under federal law (42 CFR § 447.15), "[a] State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. The provider may only deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with § 447.52(e). The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge."

- **Request for copays within pharmacy settings.** [2022 1<sup>st</sup> Quarter Ombuds Report](#)

## Member Story

The family of a medically fragile child had private insurance with OHP as secondary insurance. Due to several other complex billing interactions, the family spent several years working to undo past and ongoing billing concerns. The Ombuds Program and OHP Provider Services billing team developed a billing instructions letter for the family to provide at every medical visit, planned hospitalization and emergency department visit. Provider Services spent significant time providing verbal and written billing instructions to the family's providers. Despite this, providers continued a pattern of inappropriately billing this member. This occurred with multiple health systems, durable medical equipment suppliers and pharmacies. This meant that the child's family would spend their 30-minute lunch breaks to follow up and resolve medical billing.

### *Equity spotlight*

Both national research<sup>5</sup> and Ombuds casework indicate that medical debt collection disproportionately harms populations already facing health inequities.

- From July 2019 through September 2022, 20 percent (80) of Ombuds member billing concerns came from Fee-for-Service (FFS) program, also known as Open Card. FFS members make up approximately 10 percent of all OHP members, indicating FFS members may be disproportionately affected. FFS members are more likely to be Tribal members and dual-eligible (Medicare-Medicaid) members.
- Other populations likely disproportionately impacted include:
  - Unhoused and housing-unstable members who frequently move. These individuals often do not receive the medical billing notices due to frequent moves or houselessness.
  - Citizenship Waived Medical (CWM) members billed for emergency services.

### *Ombuds recommendations to center OHP members in OHA Medicaid billing actions*

**The Ombuds Program's case work demonstrates that member billing concerns represent systematic barriers at the provider, CCO, and OHA level. While Ombuds work for individual members is beneficial, it has not led to broader system changes that protect members from in-state billing for OHP-covered services. The following recommendations are system approaches to address member billing barriers seen in Ombuds case work.**

**The Ombuds Program urges OHA, CCOs, providers and the Oregon Legislature to ensure that OHP members:**

- **Are not subject to in-state billing for OHP-covered services and**
- **Can expect oversight and regulator action from OHA if and when they are.**

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### OHA should:

- 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.
- 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 assisters' network.
- Ensure strong oversight of member billing practices with enrolled FFS providers and work with CCOs to ensure strong oversight of member billing practices with CCO-contracted providers.
- 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.

### Member Story

An OHP member found a residential SUD center that had space available and would accept them. However, the facility was not an enrolled Medicaid facility. The facility was willing to and had sought to become an OHA-enrolled facility but could not get clear information or support from OHA on how to do this.

Other Ombuds cases have reflected the difficulty that providers, particularly residential treatment providers, have understanding reimbursement rates or how to become an enrolled provider. Providers unable to enroll with OHP, even when willing and able, can lead to members accruing medical debt.

The Oregon Legislature should consider statewide approaches to reduce the burden of medical debt and debt collection for medical bills for all Oregonians, particularly for OHP members.

- Strengthen HB 3076 financial assistance and medical debt provisions with oversight mechanisms to ensure people in Oregon receive hospital financial assistance that they are entitled to.
- Oregon should consider requesting congressional delegation support for federal approaches to ensure no Medicaid members are billed for out-of-state emergency services. Possible federal solutions may include prohibiting all Medicaid providers from billing members in any state's Medicaid program for emergency services; and requiring all state Medicaid programs to receive and pay claims for emergency services from any Medicaid provider, without requiring those providers to go through a state-specific credentialing or enrollment process.

## Ombuds Program Medicaid data: Jan. 1 through June 30, 2022

### *Medicaid concerns by complaint category*

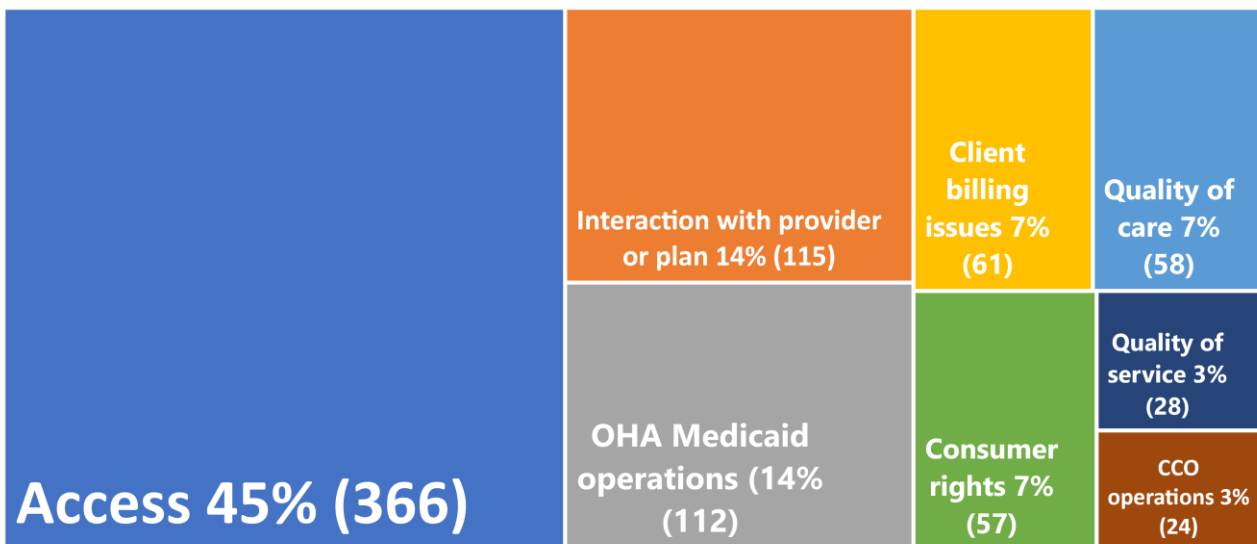
The Ombuds Program's data tracking categories for Medicaid concerns align<sup>6</sup> in most part with the member complaints categories that CCOs must report to OHA. This allows for comparison of complaints and

<sup>6</sup> The Ombuds Program also tracks "OHA Medicaid Operations" (a non-CCO complaint category) to identify complaints and concerns that are a result of OHA Medicaid operations, policies or programs.

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).

Data included in the body of this report is part of the Ombuds Program’s six-month report and includes analysis of data from Jan. 1 through June 30, 2022. Third quarter data from July 1 through Sept. 30, 2022, is in [Appendix A](#) but is not part of the six-month analysis below. 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).

**All Ombuds Medicaid Concerns**  
Jan. 1 through June 30, 2022 (822 Total)



**Interaction with provider or plan: 14 percent (115)**

These included lack of communication and coordination among providers (often resolved with the engagement of a care coordinator); provider or plan explanations inadequate or incomplete, and dismissal by provider or clinic.

**OHA Medicaid operations: 14 percent (112)**

These concerns are about implementation and operation of Medicaid policies and programs. These included concerns related to the Traditional Health Worker (THW) Program and THW certifications including delayed program response, OHP/Medicaid policies, provider billing questions, requests for continuity of care and changing CCOs, queries about flex funds, OHA data, Medicaid questions about the COVID-19 Public Health Emergency and accessing 1915(i) in-home supports for individuals experiencing mental health disability.

**Client billing issues: 7 percent (61)**

These included both in-state and out-of-state billing concerns. All Oregon providers must have a signed client agreement to pay form from an OHP-enrolled member who is billed for provider services; concerns included lack of this agreement on file and request for copays within pharmacy settings.

### Quality of care: 7 percent (58)

These included problems with a prosthesis, lack of appropriate individualized treatment for dentures, and concerns about unsanitary office conditions.

### Consumer rights: 7 percent (57)

Almost half of these concerns related to dissatisfaction with treatment plan.

### Quality of services: 3 percent (28)

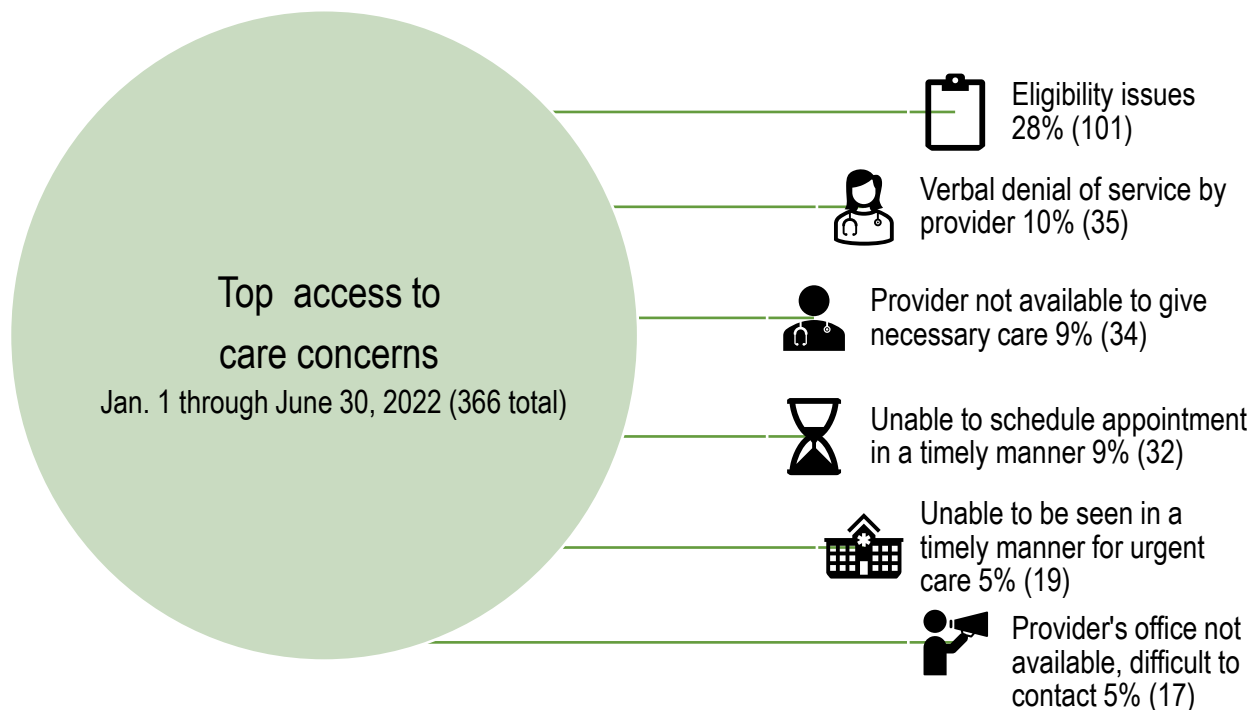
This included concerns related to quality of dentures and delays in obtaining dentures, gender-affirming care including facial feminization, and dental implants not covered.

### CCO operations: 3 percent (24)

These included questions about Social Determinants of Health (SDOH), health-related services spending for non-medical expenses to support health (such as air conditioners for heat events and air filtration devices), Community Advisory Councils, use of correct gender pronouns and questions and needs for OHP member care coordination including lack of awareness of care coordination supports.

### Top access to care concerns: 45 percent (366)

Because access to care concerns make up almost half of all Ombuds concerns, this category is discussed in further detail below in order to better understand OHP members' access to care needs.



### **Eligibility: 28 percent (101).**

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.

**Verbal denial of service by provider: 10 percent (35).**

OHP members have the right to appeal or request a hearing when they receive a written denial. Verbal denials do not offer this right.

**Provider not available to give necessary care: 9 percent (34).**

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

**Unable to schedule appointment in a timely manner: 9 percent (32).**

This included specialty care (neurologists and cardiologists), primary care providers, diagnostic studies, dental and mental health.

**Unable to be seen in a timely manner for urgent/emergent care: 5 percent (19).**

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

**Provider's office unresponsive, not available, difficult to contact for appointment or information : 5 percent (17)**

Regularly updated network provider lists help reduce the amount of time members spend trying to connect with all types of care.

**Plan unresponsive, not available, difficult to contact for appointment or information: 4 percent (15).**

Care coordination is an essential benefit for OHP members' path to whole health wellness.

**Verbal denial of service by plan: 4 percent (14).**

OHP members have the right to appeal or request a hearing when they receive a written denial. Verbal denials do not offer this right.

**Referral or second opinion denied/refused by plan: 2 percent (7).**

This was experienced by members needing access to specialty care.

**Other access concerns**

Other access concerns that made up less than 2 percent of overall access to care concerns include:

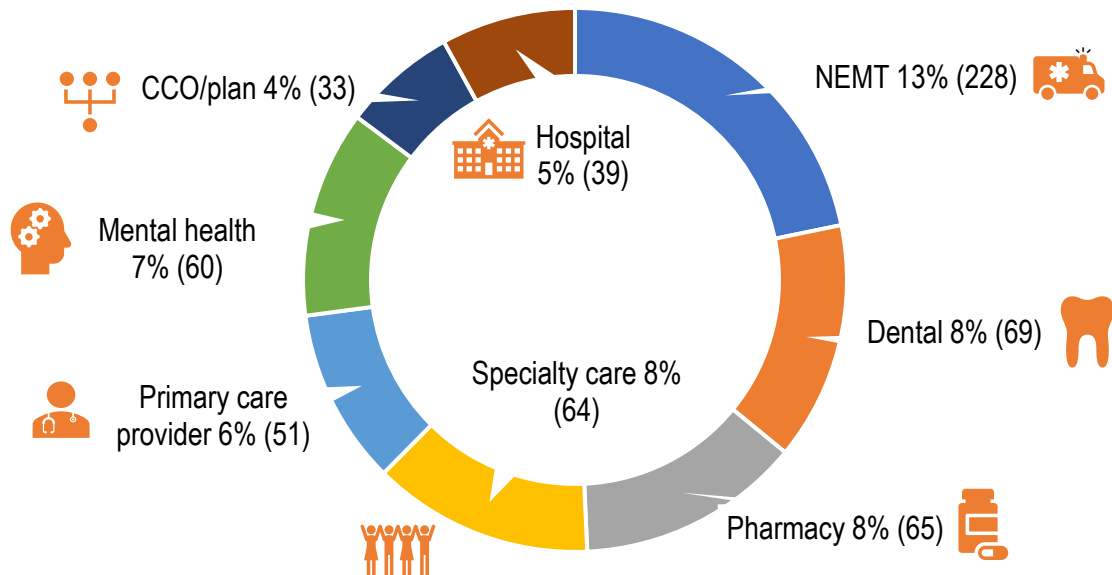
- Provider's office closed to new patients. Member's ability to connect with providers stated by CCOs and Plans as in network, is essential to member's access and continuity of care.
- Provider's office too far away, not convenient. Network inadequacy or lack of local providers may result in members having to travel long distances to receive basic services such as mental health supports, dental, and some types of specialty care.
- Received care, experienced an adverse outcome, complications, misdiagnosis or concern related to provider care. For the 2<sup>nd</sup> quarter of 2022 this single complaint was related to dental services.
- No choice of clinical or clinician choice not available. Members that find lack of network choice for providers interrupts their continuity of care.

*Top Medicaid concerns by service type*

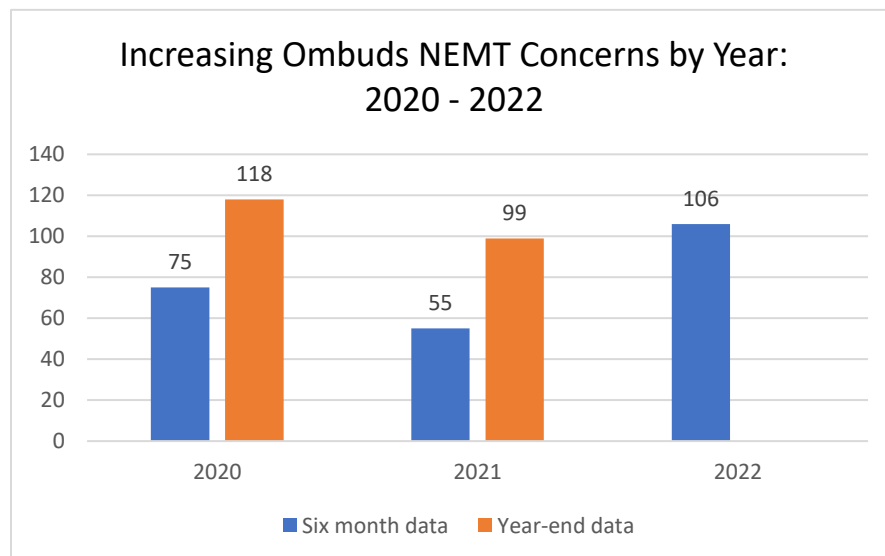
An individual may have access to care concerns related to mental health or any other service type. Vice versa, a mental health service concern may be about any complaint category. This allows CCOs and the

Ombuds Program to track the types of service of concerns that members present. The OHP services most frequently involved in Ombuds Program concerns during the first and second quarters of 2022 were<sup>7</sup>:

### Top Ombuds Medicaid Concerns by Service Type Jan. 1 through June 30, 2022 (822 Total)



All Medicaid service types are in [Appendix A](#); however, this six-month report draws attention to the increase in NEMT concerns to the Ombuds Program.



#### **NEMT: 13 percent (228).**

Members need to be able to rely upon timely, scheduled, and appropriate types of transportation. Without this support, they can experience missed appointments, delays in receiving prescription medications, and disruption to coordination of services. NEMT cases to the Ombuds Program continue to increase.

<sup>7</sup> All other Medicaid (majority eligibility and OHP Operations) concerns are not in the graph below. They make up 28 percent (228) of all service delivery concerns and are discussed in the [Medicaid concerns by complaint category](#) section.

### *Tracking events affecting Oregonians: Extreme weather*

Ombuds data supports a nimble response to emerging concerns. In 2019 the Ombuds Program added a COVID-19 event category (reported in [Appendix A](#)). In 2022, the Ombuds Program added an extreme weather category to track events from heat, fire and other extreme weather events that affect OHP members' health and well-being. During the second quarter of 2022, the Ombuds Program saw significant volume (74 concerns) in this new category, related to the rise in outdoor heat temperatures and smoke from fires resulting in high demand for air-conditions and filters/purifiers.



### Conclusion

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Each person served by Ombuds Program deserves nurturing and support. The stories members 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 OHP. It is essential that OHA continue centering OHP members in the solutions and design of Medicaid programs, services and delivery systems. Member voice to OHA through the Ombuds Program is essential to this work.

It is an honor to work within an agency that embraces OHP 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.

## Appendices

### Appendix A: Ombuds Data Tables

#### All concerns received

	Q1	Q2	Q3	Q4	2022 YTD	
<b>Total concerns</b>	564	511	639		1714	

#### Medicaid vs. Non-Medicaid concerns

	Q1	Q2	Q3	Q4	2022 YTD	
					%	N
Medicaid	417	405	522		78.4%	1344
Non-Medicaid	147	107	116		21.6%	370

#### Event

	Q1	Q2	Q3	Q4	2022 YTD	
					%	N
COVID	30	18	16		3.7%	64
COVID Medicaid	18	12	11		2.4%	41
COVID non-Medicaid	12	6	5		1.3%	23
Extreme weather: Fire, heat event, other extreme weather	NA*	74	58		7.7%	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	
					%	N
<b>Total Medicaid concerns</b>	417	405	522		100%	1344
Access	188	178	156		38.8%	522
Interaction with provider or plan	55	60	142		19.1%	257
OHA Medicaid operations	51	61	51		12.1%	163
CCO operations	12	12	92		8.6%	116
Client billing issues	35	26	25		6.4%	86
Quality of care	33	25	28		6.4%	86
Consumer rights	24	33	7		4.8%	64
Quality of service	18	10	15		3.2%	43

	Q1	Q2	Q3	Q4	2022 YTD	
					%	N
<b>Top access concerns</b>	188	178	156		100%	522
Eligibility issues	55	46	38		26.6%	139
Provider not available to give necessary care	18	16	34		13.0%	68

	Q1	Q2	Q3	Q4	2022 YTD %	N
Unable to schedule appointment in a timely manner	17	15	19		9.8%	51
Verbal denial of service by provider	13	22	15		9.6%	50
Unable to be seen in a timely manner for urgent/emergent care	9	10	12		5.9%	31
Plan unresponsive, not available, difficult to contact for appointment or information	7	8	8		4.4%	23
Provider's office unresponsive, not available, difficult to contact for appointment or information	5	12	5		4.2%	22
Verbal denial of service by plan	4	10	3		3.3%	17
Referral or 2 <sup>nd</sup> opinion denied/refused by plan	4	3	3		1.9%	10

**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 %	N
<b>Total service type concerns</b>	417	405	522		100%	1344
All other Medicaid (majority eligibility and OHP Operations concerns)	120	108	95		24.0%	323
NEMT	61	45	61		12.4%	167
Dental	33	36	35		7.7%	104
Mental health	25	35	35		7.1%	95
Primary care provider	28	23	43		7.0%	94
Specialty care	31	33	29		6.9%	93
Other	5	6	76		6.5%	87
Pharmacy	33	32	19		6.3%	84
CCO/plan	22	11	31		4.8%	64
Hospital	13	26	22		4.5%	61
Durable medical equipment	6	9	13		2.1%	28
Residential Rehabilitation	7	4	11		1.6%	22
Long term care	6	3	11		1.5%	20
Pain management	6	8	6		1.5%	20
Emergency room	4	6	3		1.0%	13
Vision	0	9	4		1.0%	13
Alcohol and drug/substance use disorder	4	1	5		0.7%	10
Outpatient	3	1	5		0.7%	9
Diagnostic studies	3	2	4		0.7%	9
Ambulance/medical transportation	2	1	5		0.6%	8
Imaging	0	4	3		0.5%	7
Acupuncture	1	0	3		0.3%	4

	Q1	Q2	Q3	Q4	2022 YTD %	N
Physical therapy	2	0	1		0.2%	3
Occupational therapy	1	0	1		0.1%	2
Chiropractic	1	0	1		0.1%	2

### Demographics and populations served

	Q1	Q2	Q3	Q4	2022 YTD %	N
<b>Total Medicaid concerns</b>	417	405	522		100.0%	1344
Dual eligible members	57	51	69		13.2%	177
Limited English proficiency	12	5	10		2.0%	27
Provider concerns	42	43	44		9.6%	129
Tribal	1	5	0		0.4%	6
Individuals with identified unstable housing	12	18	23		3.9%	53
Age: Under 19	22	27	30		5.9%	79
Age: Over 64	61	61	90		15.8%	212

### Demographics

#### Language spoken by OHP members served by Ombuds Program

Primary Language*	Q1	Q2	Q3	Q4	%	N
Grand Total**	-	-	-	-	-	-
Farsi	1	-	-	-	>1%	1
Cambodian	-	-	-	-	-	-
Korean	-	-	-	-	-	-
Romanian	-	-	-	-	-	-
Vietnamese	-	-	-	-	-	-
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	-	-	4.0%	21
English	237	266	-	-	94.9%	503

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

#### Race/ethnicity of OHP members served by the Ombuds Program

Race/Ethnicity	Q1	Q2	Q3	Q4	%	(N)
Total*	253	277	-	-	10%	530
Asian or Pacific Islander	-	-	-	-	-	-
Chinese	-	1	-	-	>1%	1
Caribbean	-	-	-	-	-	-
Slavic	1	-	-	-	>1%	1

Race/Ethnicity	Q1	Q2	Q3	Q4	%	(N)
Indigenous Mexican, Central American or South American	1	1			>1%	2
Micronesian	-	-			-	-
Black	4	3			0.013	7
Hispanic or Latino Central American	-	-			-	-
African	-	1			>1%	1
Eastern European	1	10			0.02	11
Other Hispanic, Latino	2	1			>1%	3
Other Race or Ethnicity	4	4			0.015	8
African American	3	5			0.015	8
Other Asian	2	1			>1%	3
African/African American/Black - Other Black	-	-			-	-
American Indian	4	5			0.017	9
Western European	16	10			0.049	26
Hispanic or Latino Mexican	11	12			0.043	23
Decline to Answer	28	34			0.117	62
Did Not Answer	21	23			0.083	44
Unknown	18	24			0.079	42
Other White	133	146			0.526	279

\*\* This total of 530 unique OHP members for whom the 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. 3<sup>rd</sup> quarter data will be reported in the year-end report.

## Non-Medicaid concerns

### OHA concerns

	Q1	Q2	Q3	Q4	2022 YTD	
					%	N
<b>Total OHA concerns (Non-Medicaid)</b>	54	32	32		100.0%	118
Public Health Division concerns	23	9	11		36.4%	43
Other OHA general concerns	9	7	7		19.5%	23
Licensing: Other	6	5	3		11.9%	14
Licensing: Public Health (hospital air, water food, pool, lodging, etc.)	8	3	1		10.2%	12
Oregon State Hospital concerns	2	5	3		8.5%	10
Licensing: Behavioral Health (DUI, outpatient, etc.)	2	5	1		6.8%	8
Civil rights or ADA violation	3	1	0		3.4%	4
Public records request	0	1	2		2.5%	3
OEI - interpreter and translation (non-member access)	1	0	1		1.7%	2
Marketplace	0	1	1		1.7%	2
Human resources	0	1	0		0.8%	1

	Q1	Q2	Q3	Q4	2022 YTD	
					%	N
PEBBS/PERS	0	0	1		0.8%	1

**Other government agencies concern**

	Q1	Q2	Q3	Q4	2022 YTD	
					%	N
<b>Total concerns</b>	93	74	80		100%	247
Other (included housing and medical licensing board complaints)	37	16	25		31.6%	78
Oregon Department of Human Services (ODHS)	24	18	22		25.9%	64
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		16.6%	41
Medicare	13	8	9		12.1%	30
Department of Consumer and Business Services (DCBS) (private insurance concerns)	8	12	10		12.1%	30
Veterans' Affairs	0	4	1		2.0%	5
HIPAA violation – Health and Human Services (HHS)	0	1	0		0.4%	1

*Appendix B: Health Systems Division July 2022 OHA Ombuds Report Response*

Begins on following page

**Date:** October 20, 2022

**To:** Sarah Dobra, Manager  
Ombuds Program  
External Relations Division  
Oregon Health Authority

**From:** Dana Hittle  
Interim State Medicaid Director  
Health Systems Division  
Oregon Health Authority

**Subject:** Update to Oregon Health (OHA) Authority Ombuds Reports, June 2022

The Health Systems Division (HSD) respectfully provides an update to the July 21, 2022, response to the OHA Ombuds Report. Please see below the activities that were conducted to address the needs outlined in the most recent OHA Ombuds Report.

**Equity Need:** Advancing language access for all OHP members

**Status:** Ongoing Implementation Planning

**Related HSD Issue Work:**

- a. 21-021 Provider Access to Interpreter Information
- b. 21-030 CAK Members Accessing Fewer Services

**July-September 2022 Activities:** We are advancing language access for all OHP members through two issue resolution projects: 1) REAL+D Value and Mapping Change Request (CR), and 2) Cover all Kids (CAK) Program utilization evaluation; we've completed the following activities over the last few months to help us reach this goal:

- The CR was tested and the CCOs tested the 834 data file process
- The tests went well, and the CR was implemented in the ONE and MMIS platforms on 9/25/22; OHA continues to monitor this CR, ensuring MMIS and CCOs are receiving REAL+D data as designed
- The CAK workgroup continues to meet to discuss the potential to integrate language and service access metrics into CCO health equity plans
- DOJ reviewed non-Medicaid contracts for language services access and provided recommendations for CCO deliverables

**Equity Need: Identifying person-centered provider access for OHP members facing transitions**

**Status:** Ongoing Implementation Planning

**Related HSD Issue Work:**

- a. 21-008 Incarceration Medicaid Process
- b. 22-003 CCO Disenrollment Needs Outside of Clinical Review Process
- c. 22-012 Delayed Newborn Enrollment
- d. 2022-2027 1115 Medicaid Waiver

**July-September 2022 Activities:** Our first step to ensuring that those OHP members experiencing transitions receive the care they need is prioritizing resources to begin planning and designing a CR for the Medicaid Management Information System (MMIS) that allows for next-day CCO assignments for new or transitioning OHP members. We've completed the following activities over the last few months to help us reach this goal:

- Prioritized and scheduled CR design, to occur within the first quarter of 2023
- Assigned a facilitator to inform and advance the improvement process
- Met with over 30 individuals from varying backgrounds to discuss the CR project, identifying scope of problem, potential impacts, and solidifying communication plan

We are also continuing the 1115 Medicaid Waiver work, conducting implementation planning activities to ensure:

- Continuous enrollment for children through age 6 and two-years of continuous enrollment for everyone age six and up
- Providing housing and nutrition services for those experiencing critical life transitions
- Next steps are to: 1) engage CCOs, 2) conduct a gap analysis of enrollment and transition impacts 3) meet with our subcontractor to finalize requirements, expectations, and Statement of Understanding for the next-day auto-assignment CR needs, and 4) begin to identify those processes that can be resolved through process improvements and guidance.

**Equity Needs:**

- a) Prioritizing care coordination within OHA and CCOs
- b) Focusing on member-centered access to mental health, SUD services, and overall systems capacity improvement

**Status:** Ongoing Implementation Planning

**Related HSD Issue Work:**

- 21-022 Community Based Care
- 21-029 Discharge Planning Challenges for Youth with Acute BH Needs
- 22-002 BH Services FFS Request
- 22-009 BH Provider Network

**July-September 2022 Activities:** The mental health and substance use disorder (SUD) treatment access issue is very complex and the recommendations Ombuds provided will help us prioritize our efforts. Currently, we are evaluating the challenges within OHA's adult residential treatment facilities, as well as emergency departments. Meeting with Ombuds Program staff we identified the following system and process challenges: 1) care coordination 2) rates and reimbursements 3) billing 4) prior authorizations 5) access to medical and clinical data 6) SUD services wait times 7) discharge planning 8) in-home supports 9) complex physical and psychiatric needs of individuals 10) co-occurring needs of individuals 11) emergency department evaluations 12) administrative burden for providers and counties, and 13) OHA contractors lack of clarity surrounding care coordination roles and responsibilities.

These challenges will need to be reviewed by Medicaid and Behavioral Health Subject Matter Experts (SMEs), facilitating discussions that target systemic issues that provide the greatest access impacts to our OHP Members. Additionally, HSD is implementing a Care Coordination Workgroup, in response to the needs identified during the Care Coordination Learning Collaborative.

Next steps are to: 1) identify SMEs for each of the 13 challenges 2) schedule meetings to facilitate discussions, identifying and documenting the cause and effects of these challenges 3) determine next steps, which will result in prioritizing those system and process challenges that have the largest impacts on our members, and 4) identify and allocate appropriate resources to complete this work.

As other care coordination and MH/SUD access challenges arise, OHA will begin to fold them into this work, when appropriate, so that we may effectively utilize resources and promote more strategic planning and implementation activities.

We would like to close by focusing on the good work OHA staff, with the commitment and dedication of their partners, have accomplished over the last few months in an effort to close the access gap for mental health and SUD services by referencing the most recent "Key Behavioral Health Investments Report".<sup>1</sup> These investments made it possible to ensure our partners were able to:

- Receive behavioral health (BH) rate increases to existing fee-for-service (FFS) schedules as of 7/1/22, and CCO rate increases (effective 1/1/23), so that our partners are better able to improve their BH provider networks
- Operationalize Mobile Response and Crisis Stabilization Services (MRSS) in all counties, and continue to evaluate and provide training to further expand these services
- Establish 988 call centers, helping implement around-the-clock mobile crisis services

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<sup>1</sup> Oregon Health Authority. *Key Behavioral Health Investments (21-23 biennium) Expected to Increase Resources and Improve Outcomes for the Population Needing Intensive Services*. <https://www.oregon.gov/oha/HSD/AMH/docs/1e4247.pdf>

- Establish Behavioral Health Resource Networks within every county and tribal area, a big step towards creating a statewide substance use recovery system

Thank you and please feel free to contact me with any questions or concerns.

Sincerely,



Dana Hittle  
Interim State Medicaid Director  
Health Systems Division  
Oregon Health Authority

Cc: Patrick Allen, Director, Oregon Health Authority (OHA)  
Dawn Jagger, Director, OHA External Relations  
Margie Stanton, Director, OHA Health Systems Division (HSD)  
April Gillette, Director, OHA HSD Governance & Process Improvement

## *Appendix C: Letter to the Governor*

November 22, 2022

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

Mr. Oscar Arana, Chair  
Oregon Health Policy Board  
500 Summer Street NE  
Salem, OR 97301

Re: Second and Third Quarter 2022 Ombuds Report (April 1 – September 30, 2022)

Dear Governor Brown and Chair Arana,

Pursuant to Oregon Revised Statute (ORS) 414.712, the Oregon Health Authority (OHA) provides Ombuds services to individuals who receive medical assistance through the Oregon Health Plan (OHP - Oregon's Medicaid and Children's Health Insurance Program). 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 OHP.

As required by ORS 182.500, the OHA Ombuds Program provides quarterly reports to both the Governor and the Oregon Health Policy Board that include:

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 OHP members;  
and
3. Recommendations for improving Ombuds services.

Please find attached the OHA Ombuds report for April through September, the Second and Third Quarters of 2022.

Sincerely,



Sarah Dobra

Ombuds Program Manager, on behalf of the entire OHA Ombuds Program

CC:

Ryan Diebert, Health Policy Advisor, Governor's Office.

Patrick Allen, Director, Oregon Health Authority

Dawn Jagger, Director, External Relations

Dr. Lavinia Goto, Co-Chair, Medicaid Advisory Committee

Adrienne Daniels, Co-Chair, Medicaid Advisory Committee

Margie Stanton, Director, OHA Health Systems Division

Dana Hittle, Interim State Medicaid Director, OHA Health Systems Division

Ellen Pinney, Principal Ombuds