Oregon Health Authority Ombuds Report

EXTERNAL RELATIONS DIVISION
Oregon Health Authority Ombuds Program

October 2021

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Executive summary

The Oregon Health Authority (OHA) Ombuds Program provides this report in two sections.

1) Recommendations for member-centered improvement and
2) Ombuds Medicaid data highlighting key trends. Oregon Health Plan (OHP) member experience which speaks to the need for system improvements and opportunities to eliminate health inequities are prioritized throughout.

The OHA 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.

Recommendations

Advance language access for all OHP members.

- Ensure OHA's Medicaid Management Information System (MMIS) has current, accurate and complete information about members' preferred language.
- Understand that differences in language and cultural practices may make Limited English Proficiency (LEP) members less likely to submit complaints or appeal OHP coverage decisions in the frequency or manner that English-speaking members do and take program steps to address this inequity. Specifically:
    - Use feedback from and the voice of trusted community partners as a proxy for CCO complaints.
    - Review member appeals by language, race and ethnicity, to determine if LEP members are less likely to appeal OHP coverage decisions.

Prioritize care coordination within OHA and CCOs.

- Work with CCOs to identify challenges and opportunities for implementing care coordination and Intensive Care Coordination (ICC) requirements.
- Include member experience accessing care coordination within compliance review through review of individual cases and complaints.
- Ensure 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
    - services not covered by Medicaid including housing supporting and other social determinants of health-related services.
- Explore 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 those patients are not admitted to a hospital.

Focus on member centered access to mental health, SUD services and overall system improvement.

- Increase member understanding about how to access Peer Support and Peer Wellness Specialists (PSS and PWS) for help with CCO/mental health system navigation for adults, families and children.
- Evaluate adequacy of provider networks for OHP members statewide by CCO.
- Consider the possibility of requiring CCOs to include the following providers in their networks regardless of CCO region to increase member access to timely care:
    - All licensed mental health and SUD inpatient facilities.
    - All outpatient mental health providers willing, enrolled and available in Oregon.

Person-centered provider access for OHP members facing transitions.

To address gaps in services that arise due to the regional, geographically confined operation of CCOs, especially for members not tied to one area or facing transitions:

- Ensure same or next-day enrollment from one CCO to another when transitions occur.
- Evaluate OHA and CCO provider contracting and credentialing practices to identify areas of opportunity for OHA to reduce administrative burden on providers and CCOs.
- Explore alternative cost and quality mechanisms that support broader geographic, or preferably statewide, network access for more OHP members.
- Implement and utilize an integrated state-wide health information exchange.

Ombuds data: January 1 – June 30, 2021

Medicaid data

During the first half of 2021, the top five types of OHP complaints to the Ombuds Program were:

1) Access to Care 52% (423),
2) Medicaid Operations 14% (117),
3) Interaction with Provider or Plan 13% (105),
4) Client Billing Concerns 7% (59), and
5) Consumer Rights 5% (41).

This break down is similar to 2020 data.

CCO and Ombuds Program complaint data capture the type of complaint and the type of service the complaint is about. The OHP services most frequently involved in Ombuds Program concerns were:

1) Mental Health 9% (74),
2) Dental Care 8% (61),
3) Specialty Care 7% (60),
4) Non-Emergency Medical Transportation (NEMT) 7% (54), and
5) CCO/Plan 3% (27).

Non-Medicaid data

During the first two quarters of 2021, 20% (241) of all concerns to the Ombuds Program were related to COVID-19, wth the majority of these being non-OHP related.

Background

Oregon Revised Statute (ORS) 414.712 directs the 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 OHA 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.

Although this report focuses on Medicaid-related concerns, 33.6% (411) 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.**

During the first half of 2021, COVID-19 concerns made up 20% (241) of all (Medicaid and non-Medicaid) concerns reported to the Ombuds Program. Over half, 55% (228), of the Ombuds Program non-Medicaid related concerns were COVID-19-related. It was not until March 2021, over 12 months into OHA's pandemic response efforts, that a customer service and complaints management system was developed to support COVID-19 response. As a result, the Ombuds Program, and other teams and programs throughout OHA, received COVID-19-related concerns without a strong pathway for resolution. Ombuds Program work and infrastructure were the key drivers in the development of the now established COVID Feedback Team. Appendix B includes data from the COVID Feedback Team. **The OHA Ombuds Program recommends that all future Incident Management Teams and emergency work touching OHA include a customer service complaints management process that prioritizes and enables system changes and prioritizes complaints and responsiveness impacting health inequities.**

55% (228) of Ombuds Program non-Medicaid related concerns were COVID-19 related.

OHA Ombuds Program work and infrastructure were the key drivers in the development of the now established COVID Feedback Team.

The remainder of this report focuses on the 817 Medicaid concerns that came into the OHA Ombuds Program from January 1, 2020 – June 30, 2020.

1.33 million Oregonians are enrolled in OHP, close to one third of the state's population of 4.2 million. Because CCO enrollment is mandatory for most, close to 90% of OHP members are enrolled in CCOs with which OHA contracts to coordinate 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 which OHA's Health Systems Division (HSD) coordinates. Providers enrolled in FFS are paid directly by OHA. Members have access to any FFS provider accepting new patients. FFS OHP members also have access to a 24/7 nurse advice line and care coordination through OHP contractor KEPRO. Some specific populations can be, or always are enrolled into FFS.[1]

Recommendations

Advance language access for all OHP members

[1] 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.
- Pregnant members with CAWEM Plus coverage must remain in FFS.
- OHP members who have private insurance receive FFS 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.

OHA has made gains in increasing language access by ensuring interpreter reimbursement for FFS providers and continuing to emphasize CCO and provider obligations to provide interpretation through communications such as OHA's May 2020 announcement about providing culturally and linguistically appropriate services during the COVID-19 emergency. However, Ombuds OHP member language access cases indicate that significant gaps remain, which may increase rather than decrease health inequities. To increase language access, the OHA Ombuds Program recommends that OHA Medicaid Operations:

- Provide communication and technical assistance to FFS providers about using interpreter services for their patients. CCOs should offer similar communication and technical assistance for their providers.
- Ensure OHA's Medicaid Management Information System (MMIS) which tracks OHP member enrollment, preferred written and spoken language, race and ethnicity, has current, accurate and complete information about members' preferred language.
- Understand that Limited English Proficiency (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 langauge 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 of 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.
- Understand when language-access complaints are raised that even a single complaint is typically representative of systemic issues that must be closely examined through a root-cause analysis.
- Understand that the absence of complaints may indicate a customer service and complaints system that is not linguistically or culturally acessible. OHA should specifically monitor CCO complaints and lack of complaints in the following three complaint subcategories:
    - Member has difficulty understanding provider due to language or cultural barriers.
    - Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity.
    - Provider's office or/and provider exhibits language or cultural barriers/lack of cultural sensitivity/interpreters.

Prioritize care coordination within OHA and CCOs

When care coordination occurs, Oregon's Medicaid model has the potential to significantly decrease health inequities, improve overall health and reduce costs. The OHA Ombuds Program, through Ombuds case work, sees daily the transformative role of CCO and FFS care coordination when members are connected to a care coordinator.

However, the Ombuds Program also sees significant gaps in CCOs' proactive early identification of and outreach to members whose medical records or emergency department admits indicate the need for care coordination. The Ombuds Program recommends that:

- OHA work with CCOs to identify challenges and opportunities for implementing care coordination and Intensive Care Coordination requirements for populations called out in contract and others in need;
- OHA include member experience from complaints made to OHA, from secrete shopper surveys, member satisfaction surveys, and other methods within compliance review;

- OHA monitor and support culturally and linguistically appropriate care coordination;
- CCOs use care coordination to link 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.
- CCOs, hospitals, OHA and ODHS explore 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 those patients are not admitted to the hospital.

Focus on member centered access to mental health, SUD services and overall systems capacity improvement

Inadequate access to mental health providers, and thus mental health services, is a significant challenge for OHP members identified through OHA Ombuds Program case work. Timely and accessible mental health and SUD care at all levels of service is arguably a public health crisis that impacts every Oregonian. The Oregon Legislature approved significant mental health and SUD funding during the 2021 legislative session. OHP member-centered recommendations based on Ombuds case work include that OHA should:

- Strengthen work with the Public Employment Benefits Board (PEBB) and the Department of Consumer and Business Servies to identify statewide, cross-system approaches for increasing mental health provider capacity across all insurance types with an eye to nurturing the expansion of a culturally and linguistically diverse mental health workforce.
- Increase member understanding about how to access Peer Support and Peer Wellness Specialists (PSS and PWS) for CCO/mental health system navigation as part of the system of care for adults, families and children.
- Ensure all OHP-contracted mental health and SUD providers receive technical support to fully use telehealth with OHP members who choose that option.
- Report behavioral health capacity annually to support understanding the extent of Oregon's behavioral health capacity crisis and monitoring for its resolution. 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.
- Evaluate adequacy of provider networks for OHP members statewide by CCO. Include in this evaluation provider specialties and wait time for first appointment by specialty and by CCO; crisis and ED services, MH and SUD programs, service technologies, and statewide demographic population of all regions to determine what is needed to increase member access and decrease existing inequities to accessing both inpatient and outpatient MH and SUD services.
    - Specifically evaluate if requiring CCOs to provide a statewide network of all licensed inpatient facilities would support increased member access and decrease existing inequities, particularly for accessing timely SUD care, and
    - For outpatient providers, explore a statewide mental health provider network regardless of CCO regions as a tool for CCO ability to expand capacity utilizing willing, enrolled and available providers in every part of the state.

Identify person-centered provider access for OHP members not tied to a specific geographic region and facing transitions

Each CCO serves a specific part of the State but is contractually obligated to provide emergency services and coordinate care for their members who have traveled outside of the home CCO region for OHP covered care not available within the CCOs region or who are receiving in-patient residential treatment[1]. For many CCO members this provides local, community-centered and based care.

However, for some of Oregon's most vulnerable OHP members, particularly those not tied to a specific geographic region, geographically limited care is a significant barrier to access that furthers health inequities, particularly when CCO responsibility for care coordination does not occur. The OHA Ombuds Program consistently works with OHP members who are not able to access timely care, or any care, for this reason. For example, individuals in residential treatment outside of their CCO's service region, despite CCO requirements to ensure care, sometimes cannot access preventive care (e.g., dental cleaning, primary care for their diabetes management) during their residential stay. For many individuals, this may be the first time and opportunity to access primary medical care.

Some of the populations most impacted by such situations include:

- Homeless and unhoused individuals;
- Children and youth involved with Oregon's child welfare system moving for available foster placements;
- Individuals displaced due to wildfires and other natural events;
- Individuals in treatment outside their home CCO area;
- Children living with parents are in residential SUD residential treatment facilities for pregnant or parenting members. Simply gaining access to such a facility is a barrier and often requires going outside the CCO's service area;
- Individuals moving in and out of the justice system; and
- Young adults still connected with their parents' OHP coverage but residing in a different geographic region.

The following member story illustrates the critical gaps in health care that can occur for these populations.

Member Story

An Oregon Health Plan member who identified as unhoused and with learning disabilities had a constant need for oxygen, provided through oxygen tanks. The member kept their home base in the Portland-metro areas and valued their established health care providers, but also traveled throughout other regions of the state fairly regularly. While outside of the Portland-metro areas they went to a local ODHS office to renew other state benefits. This resulted in an updated address change to the region where the individual renewed benefits and auto-enrollment into a new CCO. As a result, the member lost their established providers, had to go through a new prior authorization for oxygen, and ultimately was unable to obtain a portable oxygen tank through their new CCO. The new CCO only offered oxygen concentrators which require an electrical outlet to operate and, per manufacture speciation's, only can be used indoors. Regular access to electricity and an electrical outlet and an indoor setting is not something this unhoused member had access to. This was a critical interruption in the member's access to life sustaining care. The Ombuds Program worked with the member to re-establish their address in the Portland-metro areas and worked with both CCOs to ensure a smooth transition back to the original CCO and the providers and care they needed.

[1] 410-141-3815 *CCO Enrollment for Temporary Out-of-Area Behavioral Health Treatment Services* states, 5) For new and existing temporary residential placements, CCOs shall coordinate all behavioral health care and needs including, but not limited to, medication assisted treatment, routine non-emergent physical health care, oral, and transportation when within the scope of the CCO's contract, including when member's temporary placements are outside the CCO service area. CCO's shall coordinate care for members receiving behavioral health treatment while in temporary placement and discharge planning for the return to the Home CCO. Additionally, CCO's shall coordinate all care for accompanying dependent members.

OHA should ensure that CCO contract and Medicaid operations process address gaps in service that arise due to the regional, geographically confined operation of CCOs. Specific areas which would support this include, but are not limited to:

- Changing enrollment processes to have next-day enrollment from one CCO to another after address changes or when other transitions occur;
- Evaluation of CCO contract requirements allowing geographically limited care and service networks;
- Evaluation of CCO provider contracting and credentialing practices to identify areas of opportunity for OHA to reduce administrative burden on providers and CCOs;
- Exploration of alternative cost and quality mechanisms that support broader geographic, or preferably, statewide network access for more OHP members; and
- Implement and utilize an integrated state-wide health information exchange.

Data and trends: Medicaid themes in Ombuds service data

Top Medicaid complaints and concerns to Ombuds Program

The OHA Ombuds Programs aligns most[2] data tracking categories for Medicaid concerns with what CCOs are obligated to 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 here under CMS *Quarterly Report*.

OHA Ombuds complaints and concerns data are unique in several ways:

- **They capture and articulate any concern from OHP members.** Per Centers for Medicare & Medicaid Services (CMS) requirements, a complaint is defined as 'an expression of dissatisfaction. Each CCO collects and reports to OHA OHP member concerns which reflect dissatisfaction as measured by the CCO staff receiving the member concern. The Ombuds program logs all client calls and emails as concerns/ complaints regardless of whether the call is rooted in confusion, a query, or a concern. Indeed, many OHP members do not want to be labeled as a "complainant."
- **OHP members come to the OHA Ombuds Program because they know their concern is a system's issue experienced by other members.** OHP members come to the OHA Ombuds most appropriately and ideally after all other avenues for addressing their concerns have been explored. Their voice is understood to speak for many others. Indeed, sometimes Ombuds callers say specifically, "I want to prevent this from happening to anyone else."
- **Ombuds cases serve as "the canary in the coalmine."** The number of complaints per category is not always the best proxy for the urgency of the need to address systemic issues and often represent a need impacting many OHP members or particularly vulnerable OHP members.

[2] 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.

Total Medicaid/OHP concerns to OHA Ombuds by complaint categories (Jan. 1, 2020 - June 30, 2021)

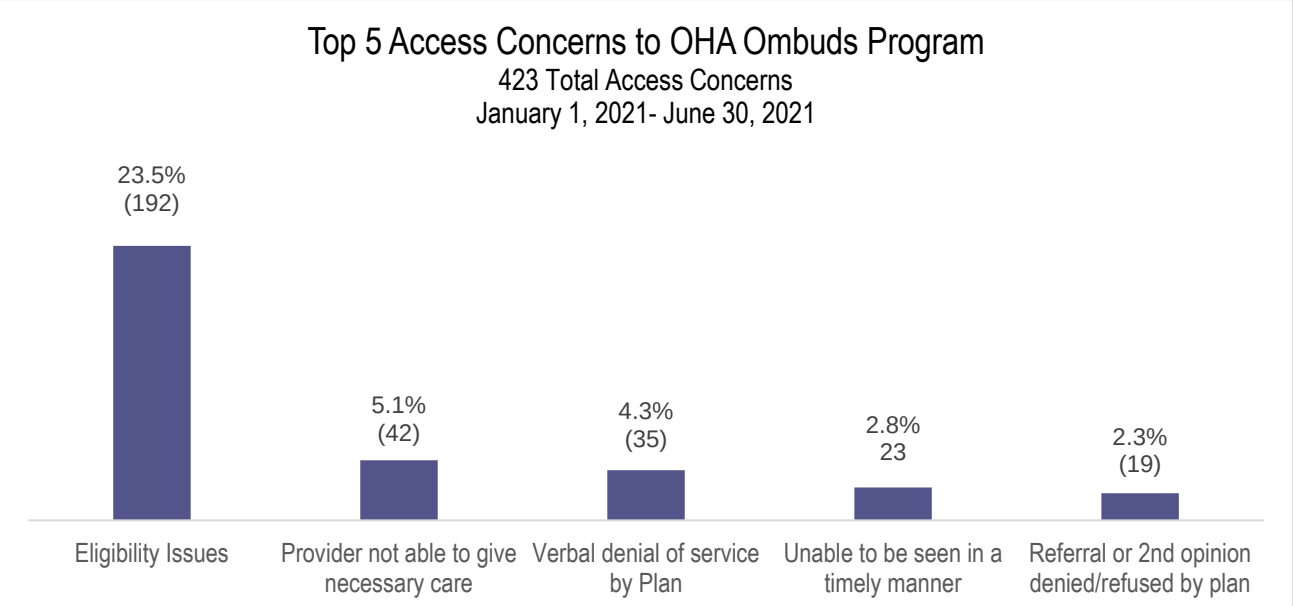
	Q1	Q2	Q1 and Q2 % of Medicaid Complaints
Total Medicaid Concerns	412	405	817
Access	200	223	51.8%
OHA Medicaid Operations	65	52	14.3%
Interaction with Provider or Plan	59	46	12.9%
Client Billing Issues	28	31	7.2%
Consumer Rights	21	21	5.1%
Quality of Care	22	19	5.0%
CCO Operations	13	8	2.6%
Quality of Service	4	5	1.1%

During the first two quarters of 2021, the top five OHP complaints to the OHA Ombuds Program were:

1) Access to Care 52% (423);
2) Medicaid Operations 14% (117);
3) Interaction with Provider or Plan 13% (103);
4) Client Billing Concerns 7% (58); and
5) Consumer Rights 5% (42).

Access

Access to OHP related care made up 52% (423) of all OHA Ombuds Medicaid concerns, as shown below.



Focus on eligibility issues and equity:
Since March 18, 2020, and for the remainder of the COVID-19 Public Health emergency, OHP and CAWEM coverage continues for all members and individuals are disenrolled only for specific reasons[3]. However, even with this protection in place, the number and percentage of OHP eligibility calls coming to the OHA Ombuds Program increased.

- In 2019, 12% of Medicaid concerns were Enrollment and Eligibility related.
- In 2020, the percentage increased to 14%.

During the first half of 2021, Enrollment and Eligibility concerns made up over 23% of total Medicaid concerns. Most were related to member confusion stemming from OHP enrollment communications. Several highlight significant equity related concerns.

- **CAWEM Plus coverage:** CAWEM Plus coverage is almost identical to full OHP coverage. It covers pregnant women who would otherwise have access only to emergency services. An eligibility system error resulted in an abrupt and incorrect reduction of Reproductive Health Equity Fund (RHEF) benefits for many CAWEM Plus members, who experienced this change by receiving health care bills or/and notices of canceled provider appointments. Collaboration across Ombuds, the Community Partner Outreach Program (CPOP), Medicaid eligibility policy teams and operations resulted in this concern being addressed through a ONE system code fix, case corrections, and updated eligibility notices to impacted Oregonians.
- Dual Eligible members: Of the 123 dual-eligible members who came to the Ombuds Program 36% (44) were concerned about losing OHP. When OHP-enrolled individuals 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 among some of our most vulnerable Oregonians and, in some Ombuds cases, resulted in reduced and/or interrupted care.

OHA Medicaid Operations

OHA Medicaid Operations concerns relate to OHA implementation and operation of Medicaid policies and program. These concerns made up 14 % (117) of all OHA Ombuds Program Medicaid concerns and included:

- OHP members being enrolled in the wrong CCO resulting in interruption of care;
- Long delays between a client'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 enrolled members accessing carved-out Medicaid services paid for directly by OHA or ODHS;
- Lack of a public-facing provider directory for FFS members to help identify providers accepting OHP FFS program[4]; and
- CCO disenrollment requests to support continued access to medical providers outside of the CCO network, as in the following member story.

[3] During this time of COVID related emergency declaration, 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.
[4] Maintaining a current provider directory is a CCO requirement. Until June of this year, OHP members enrolled in the fee for service (FFS program) did not have access to a public-facing member directory.

Member Story

A FFS OHP member with complex health conditions had previously established care with a team of providers in different parts of the state due to having private insurance. During the pandemic the member lost access to their private insurance and was enrolled in a CCO. The member's long-term relationship with their care team was at risk because their providers were not in the CCO's network and the provider was unwilling to work with the CCO. To ensure the member's continuity of care, the Ombuds Program walked the member through the process of requesting CCO disenrollment so that they could maintain access to their team of specialty providers.

Interaction with Provider or Plan

Interaction with Provider or Plan made up 13% (103) of all OHA Ombuds 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 ED discharges for individuals with significant mental health and/or SUD challenges.

Member Stories

An OHP member who identified as a refugee shared with the OHA Ombuds Program that they had three canceled appointments in three months due to a lack of interpreter availability. The Ombuds Program collaborated with the CCO, provider and member to elevate the member's voice and experience with this equity concern. The member had their appointments rescheduled with interpreters timely and consistently available during their later appointments.

A Spanish-speaking member called a clinic and was told the clinic did not have an interpreter. When an English-speaking public health nurse called on the member's behalf, the clinic said that an interpreter could be provided. Rather than follow-up on lack of provision of language access from the member's experience, the clinic said that the Spanish-speaking member would need to document the time, date, and who they talked to when being told there was no interpreter available. This problematically placed the burden on the LEP member to further document the inequity that they had already reported.

The Ombuds Program has encountered perceptions within OHA and among CCOs that the lack of language access complaints means language access is not an issue. But the public health nurse noted that like this Spanish-speaking member, members are often very hesitant to make formal complaints related to language access, due some negative experiences doing so in other state agencies. And, even when they do, their experience is discounted.

Client Billing

Client Billing concerns made up over 7% (59) of all OHA Ombuds Medicaid concerns. The majority were for out-of-state ED utilization and later being directly billed for the emergency 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 OHA 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 larger specific federal recommendations made by the OHA Ombuds Program in the Ombuds 2020 Annual Report[5] are needed.

Member Story

An OHP member received emergency services out of state two years ago. The out of state provider initially refused to work with OHP to resolve the issue and instead sent the bills directly to the member and then sent the member to collections. After over a year of ongoing communication and negotiations between the OHA Ombuds, the CCO and the out of state provider, the provider agreed to bill and be paid by OHP and to withdraw their collections claim.

Consumer Rights

Consumer Rights concerns made up over 5% (42) of all OHA Ombuds Medicaid concerns. These concerns included:

- Provider offices' lack of Americans with Disabilities (ADA) compliance;
- Member dissatisfaction with treatment plan;
- Complaints/appeals process not explained; and
- Not understanding the language used in a Notice of Adverse Benefits Determination (NOABD).[6].

Services for which OHP members brought concerns to the OHA Ombuds Program

In addition to the types of complaints and concerns dicussed above, CCOs and the OHA Ombuds Program also capture type of service impacted. The OHP services most frequently involved in OHA Ombuds Program concerns were"

1) Mental health 9% (72),
2) Dental Care 8% (61),
3) Specialty Care 7% (60),

[5] Support national strategies to ensure Medicaid members are not billed for out of state emergency services. Oregon should consider requesting congressional delegation support for federal approaches to this concern. Possible federal solutions may include prohibiting Medicaid providers in all states from billing any 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.

[6] By federal law, any time there is a Medicaid denial, a member is entitled to receive plain language explanation of the reasons for the denial and their rights to an appeal and hearing process if they disagree with the plan's decision. The requirement for a denial notice and appeal process is not unique to Medicaid; Medicare and private insurance policies have similar obligations

4) Non-Emergency Medical Transportation (NEMT) 7% (54), and
5) CCO/Plan 3% (27).

Mental Health

Mental health service made up 9% (72) of all OHA Ombuds Medicaid concerns. Significant areas included:

- Timely access to any mental health provider; lack of access to experienced, licensed mental health providers; 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, especially for children, has been and continues to be an issue that impacts OHP members and their providers.
- 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.
- The lack of bed availability at the Oregon State Hospital for members under civil commitment and not involved in the state corrections system.
- Processes and supports that lack trauma informed approach including the need for a brand new assessment and treatment plan every time a provider change is needed.

Member Story

An unhoused member experiencing mental health needs went to an ED for treatment of severe foot and leg pain. The hospital left the member in a wheelchair at the bus stop even though he could not walk. A "Good Samaritan" picked the member up and took him back to the ED but was escorted off of the property by security. The next day the individual was found with a brain injury and admitted to the hospital.

Dental Care

Dental care services made up 8% (61) of all OHA Ombuds Medicaid concerns. Denture access and quality has and continues to be a frequent OHP member 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.

Specialty Care

Specialty care made up 7% (60) of all OHA Ombuds Medicaid concerns. Over 50% (36) of specialty care concerns came from members who received a denial for these services from their CCO. Transgender-related services and hernia surgeries[7] were among the most common cited by members who came to the OHA Ombuds Program for this service type.

[7] In March 2021, the OHA Health Evidence Review Committee (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 repair of all inguinal and

Non-Emergency Medical Transportation (NEMT)

NEMT made up 7% (54) of all OHA Ombuds Medicaid concerns. Compared to the 2020 OHA Ombuds Report, this represents a reduction, in part attritbutable to a Corrective Action Plan (CAP) where many of these concerns originated from. Despite low utilization by OHP members (fewer than 10% of members use NEMT services), NEMT remains among the top five Medicaid service concerns received by the OHA Ombuds Program. Most were about late or "no show" rides. This often results in members unable to access their medical care and in some cases being fired by their provider for too many missed or late appointments. During the first half of 2021, one of the emerging NEMT related issues was limited access to bariatric NEMT services statewide. This causes a direct impact on our vulnerable population unable to access medical care without bariatric transportation.

CCO/Plan

CCO/Plan made up 3% (27) of all OHA Ombuds Medicaid concerns. Most concerns were related to CCO care coordination needs. Timely referral of vulnerable OHP members to care coordination or intensive care coordination can quickly address health inequities, improve health and lower costs. Populations where the OHA Ombuds Program saw an increased need for timely proactive care coordination and where health inequities have the potential to be worsened include:

- Medicaid-Medicare dual-eligible members
- individuals needing referrals and coordination with Medicaid services *not* covered by CCOs such as in- home services and supports for people with mental health and/or SUD health challenges;
- homeless individuals in mental or physical health crisis visiting ER departments;
- immigrant and refugee populations new to Oregon's OHP services and
- individuals who prefer health care and commuication in a langauge other than English.

Timely referral of vulnerable OHP members to care coordination or intensive care coordination can quickly address health inequities improve health and lower costs.

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 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 our most vulnerable.

femoral hernias in women. This change will be effective January 1, 2022. This recommendation was made by the OHA Ombuds Program to HERC and prioritized in the OHA Ombuds 2020 Report.

Appendices

Appendix A: OHA Ombuds Program Data (Jan. 1, 2021 – June 30, 2021)

All concerns and complaints to the OHA Ombuds Program

	Q1	Q2	Q1 and Q2 Total
Total Ombuds Complaints and Complaints	658	572	1,230

Medicaid vs. Non-Medicaid

	Q1	Q2	% of Complaints (Q1 and Q2 combined)
Medicaid Complaints	412	405	66.4% (817)
Non-Medicaid Complaints	246	166	33.5% (412)
COVID-19 247 total 5.4% (13) OHP/Medicaid Related/ 94.6% (228) Non-OHP	182	58	19.5% (240)

Total Medicaid work by complaint category

	Q1	Q2	Total % (N)
Total	412	405	817
Access	200	223	51.8% (423)
Oregon Health Authority Medicaid Operations	65	52	14.3% (117)
Interaction with Provider or Plan	59	46	12.9% (105)
Client Billing Issues	28	31	7.2% (59)
Consumer rights	21	21	5.1% (42)
Quality of Care	22	19	5.0% (41)
CCO Operations	13	8	2.6% (21)
Quality of Service	4	5	1.1% (9)

Top Access Sub-Complaints

	Q1	Q2	Total % (N)
Total	412	405	817
Eligibility Issues	76	116	23.5% (192)
Provider not able to give necessary care	17	25	5.1% (42)
Verbal denial of service by Plan	17	18	4.3% (35)
Unable to be seen in a timely manner for urgent/emergent care	13	10	2.8% (23)
Referral or 2nd opinion denied/refused by plan	13	6	2.3% (19)
Unable to be seen in a timely manner for urgent/emergent care	15	3	2.2% (18)
Unable to schedule appointment in a timely manner.	7	11	2.2% (18)
Verbal denial of service by Provider	9	8	2.1% (17)

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 from Access to Quality of Care.

	Q1	Q2	Total % (N)
Total	412	405	817
Mental Health	40	34	9.1% (74)
Dental	34	27	7.5% (61)
Specialty Care	33	27	7.3% (60)
NEMT	31	24	6.7% (55)
CCO/Plan	17	10	3.3% (27)
Primary Care Provider	16	11	3.3% (27)
Pharmacy	16	9	3.1% (25)
Emergency Room	11	14	3.1% (25)
Hospital	17	7	2.9% (24)
Other	11	12	2.8% (23)
Durable Medical Equipment	7	9	2.0% (16)
Pain Management	7	8	1.8% (15)
Long Term Care	5	8	1.6% (13)
Residential Rehabilitation	3	3	0.7% (6)
Vision	3	2	0.6% (5)
Outpatient	1	3	0.5% (4)
Chiropractic	1	1	0.2% (2)
Occupational Therapy	0	2	0.2% (2)
Diagnostic Studies	0	2	0.2% (2)
Ambulance/Medical Transportation	1	0	0.1% (1)
Physical Therapy	1	0	0.1% (1)
Alcohol & Drug/Substance Use Disorder	0	2	0.2% (2)
All other Medicaid (Majority eligibility and OHP Operations concerns)	156	189	42.2% (345)

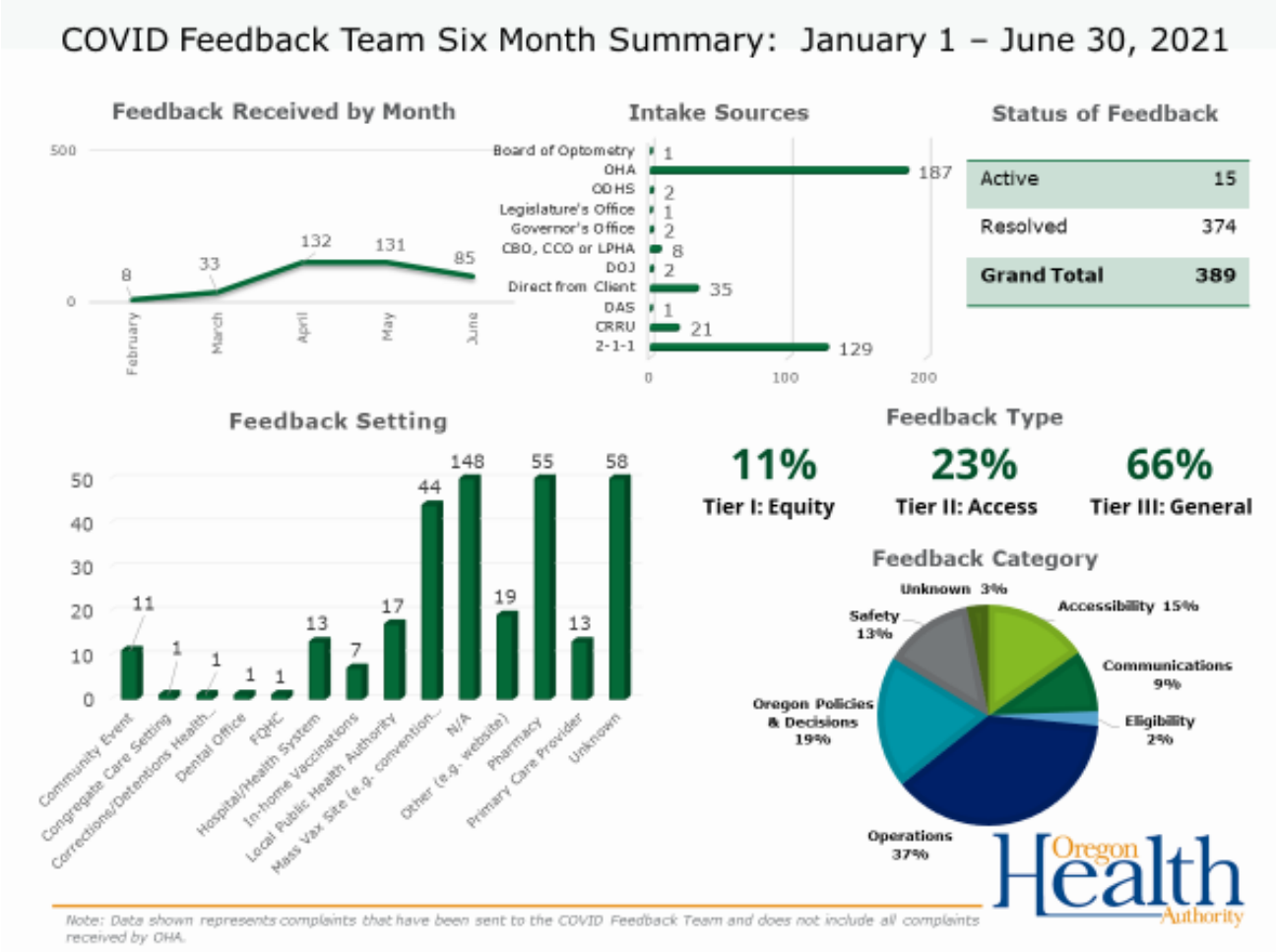
Non-Medicaid OHA general complaints

	Q1	Q2	Total % (N)
Total	159	73	232
Public Health Non-Medicaid and Non-Licensing	136	39	75.4% (175)
Other	16	26	18.1% (42)
Civil Rights or ADA Violation	3	3	2.6% (6)
OEI - Interpreter and Translation (Non-Member Access)	0	2	0.9% (2)
State Hospital	2	0	0.9% (2)
Human Resources	2	1	1.3%(3)
Public Records Request	0	2	0.9% (2)
Licensing: Public Health Licensing (air, water food, pool, lodging, etc.)	0	0	0.0% (0)
Licensing: Other	3	2	2.2% (5)
Behavioral Health Licensing (DUI, outpatient, etc.)	0	1	0.4% (1)

Other government agencies complaints

	Q1	Q2	Total % (N)
Total	82	82	164
Other	31	28	36.0% (59)
ODHS	23	22	27.4% (45)
DCBS	15	6	12.8% (21)
Local Government Issue	4	18	13.4% (22)
Medicare	7	4	6.7% (11)
Veterans' Affairs	0	4	2.4% (4)
HIPAA Violation - HHS	2	0	1.2% (2)

Appendix B: COVID-19 Feedback Team (Jan. 1, 2021 – June 30, 2021)



Appendix C: Letter included in submission to the governor

October 21, 2021

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: Jan. 1 – June 30, 2021 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 served by Oregon's Medicaid program. The Ombudsperson is directed to serve as the member'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 1.3 million Oregonians served by the Oregon Health Plan (OHP - Oregon's Medicaid and Children's Health Insurance Program).

As required by ORS 182.500, the OHA Ombuds Program provides a 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 OHP-eligible persons; and
3. Recommendations for improving Ombuds services.

Please find attached the OHA Ombuds report for the first half of 2021.

Sincerely,

Sarah Dobra
Ombuds Program Manager

CC:
Tony Lapiz, Oregon Health Authority Advisor, Governor's Office.
Patrick Allen, Director, Oregon Health Authority
Dawn Jagger, Director, External Relations
Dr. David Bangsberg. Oregon Health Policy Board Chair
Dr. Leslee Huggins, Medicaid Advisory Committee
Jeremiah Rigsby, Medicaid Advisory Committee
Margie Stanton, Director, Health Systems Division
Dana Hittle, Medicaid Director
Ellen Pinney, Lead Ombudsperson