EXTERNAL RELATIONS DIVISION
Kate Brown, Governor

Oregon Health Authority
500 Summer St. NE, E-20
Salem, OR 97301
Voice: 503-947-2340
Fax: 503-947-2341

March 11, 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: 2020 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 through Oregon's Medicaid 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 1.2 million Oregonians served by the Oregon Health Plan (Oregon's Medicaid and Children's Health Insurance Program).

As required by ORS 182.500, the OHA 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 (OHP) eligible persons; and
3. Recommendations for improving Ombuds services.

Please find attached the OHA Ombuds report for 2020.

Sincerely,

Ellen Pinney
Lead Ombudsperson

CC:
Berri Leslie, Oregon Health Authority Advisor, Governor's Office.
Patrick Allen, Director, Oregon Health Authority
Dawn Jagger, Director, External Relations
Jeremiah Rigsby, Medicaid Advisory Committee
Margie Stanton, Director, Health Systems Division
Lori Coyner, Medicaid Director
Sarah Dobra, Manager, Member and Stakeholder Support Unit

Oregon Health Authority Ombuds Program Report:

January 1 through December 31, 2020

Executive Summary

Oregon Revised Statute (ORS) 414.712 directs the Oregon Health Authority (OHA) to provide Ombuds services to individuals who receive medical assistance in Oregon. The Ombudsperson serves as the advocate for Oregon Health Plan (Medicaid and Children's Health Insurance Program) recipients in these areas:

- Access to care;
- Quality of care; and
- Channeling member experience into recommendations for system improvement.

This report is divided into 3 key sections. (1) Medicaid themes in Ombuds service data; (2) Ombuds Program and agency successes in response to client needs; and (3) Recommendations for improvement.

Ombuds Data

During 2020, the Ombuds Program responded to 1,850 contacts, queries, and complaints; 1,203, or 65% of all concerns were regarding OHP. The top five OHP complaints to the Ombuds Program were Medicaid operations (14.3%), access - enrollment and eligibility (14.2%), client billing concerns (12%), interaction with provider or plan (11%), and access - non-emergency medical transporation (NEMT) (7.6%).

Coordinated care organiztion (CCO) and Ombuds Program complaint data captures the type of complaint (e.g., access, quality of care) and the type of service the complaint is about. The OHP services most frequently involved in Ombuds Program concerns were 1) mental health alcohol/ substance use disorder (10.5 %), 2) speciality care (8.4 %) 3) dental care (7%); 4) primary care provider (5.1%), and 5) pharmacy (4%).

During 2020, 13.8% (285) of all concerns to the Ombuds Program were related to COVID-19.

Successes

Ombuds Program and agency successes in response to OHP member voice and experiences include:

1. **Increased access to interpreters for limited English Speaking (LEP) OHP members/ Medicaid beneficiaries** by authorizing reimbursement to Fee for Service Medicaid Providers for interpreter services effective January 1, 2021. Memo available here.
2. **Improved access to NEMT transport** for disabled OHP members/ Medicaid beneficiaries.
3. **Established pathways for OHP member voice within OHA.** The Medicaid Advisory Committee (MAC) and Ombuds Program collaborated to elevate MAC's role as key to channeling OHP member voice within OHA. The Ombuds Program supported the move of the Medicaid Advisory Committee to become a sub-committee of the Oregon Health Policy Board (OHPB). The Ombuds Program, at OHPB's request, reports quarterly to

MAC. In addition, the Ombuds Program serves on a newly created MAC Member Voice Sub-committee.

4. **Elevated OHP member voice and experience** to the Health Evidence Review Commission (HERC).
5. **Engaged with CCO Community Advisory Councils** to increase understanding of the respective roles of OHA member-serving teams.
6. **Onboarded a full team of six Ombuds** to the program.
7. **Implemented Ombuds database** for real time identification of repeated concerns and emergent themes coming to the Ombuds Program from OHP members.

Recommendations

- Strengthen and ensure equitable whole-health, trauma informed services and supports provided by both OHA and Oregon Department of Human Services (ODHS) are coordinated and equally available to Oregonians with disabilities regardless of whether the disability is rooted in mental or physical health.
- Prioritize agency resources to ensure same-day enrollment into OHP for infants born to OHP mothers.
- Support national strategies to ensure Medicaid members are not billed for out-of-state emergency services.
- Increase Ombuds Program focus on health equity and eliminating health inequalities.

Oregon Health Authority Ombuds Program Report:

January 1 through December 31, 2020

Service Data and Trends

Oregon Revised Statutes (ORS) 414.712 directs the Oregon Health Authority (OHA) to provide Ombuds services to individuals who receive medical assistance through Oregon's Medicaid program. The Ombudsperson is directed to serve as the Oregon Health Plan (OHP)/ Medicaid recipient's advocate on issues concerning access to and quality of care and to channel member experience into recommendations for system improvement.

The Ombuds Program listens to, documents and identifies trends in the experiences shared by the 1.2 million Oregonians served by the OHP. This work is essential for health care transformation that is grounded in the needs of Oregonians and informs the Ombuds Programs recommendations for client-focused process and system improvements with OHA and ODHS.

This report is divided into 3 key sections. (1) Medicaid themes in Ombuds service data; (2) Ombuds Program and agency successes in response to client needs; and (3) Recommendations for improvement.

Top Medicaid Themes in Ombuds Service Data

During 2020, the Ombuds Program responded to 1,850 contacts, queries, and complaints; 1,203, or 65% of all concerns were regarding OHP.

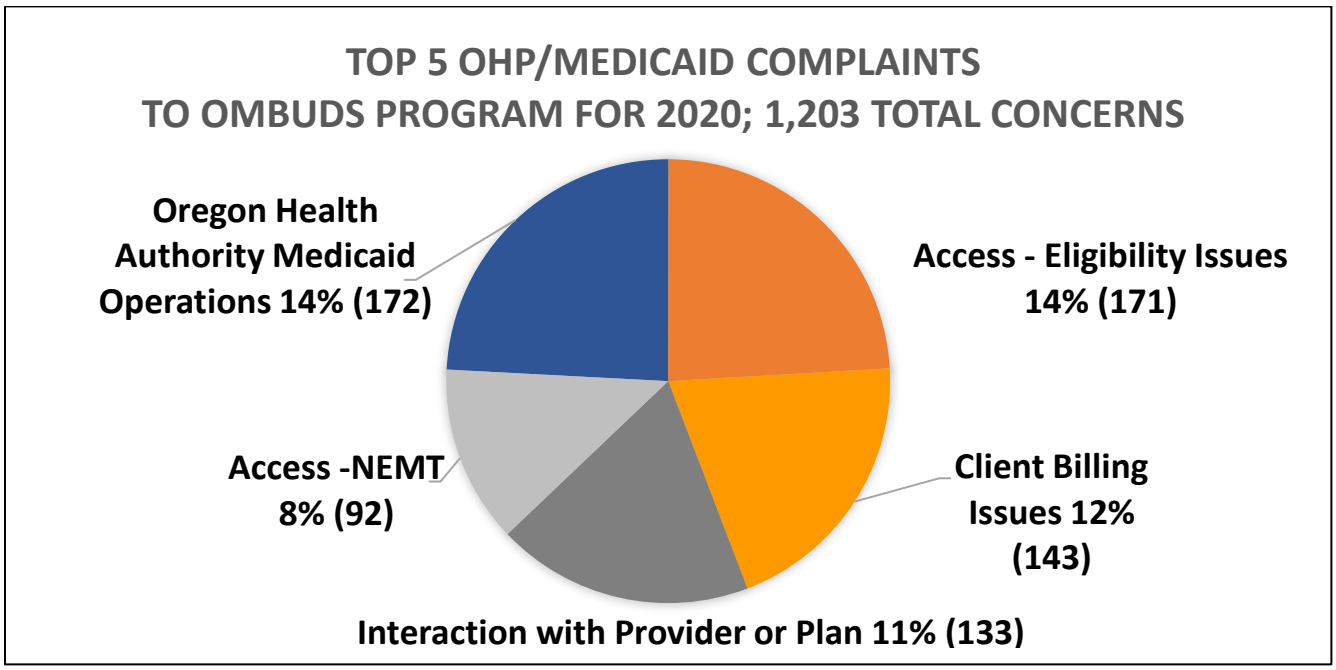
- The Ombuds Program responded to 92% of all inquiries to the program.
- 8% of initial inquiries to the Ombuds Program did not involve further work either because individuals solved their concern without Ombuds inovlvment or the program was unable to contact the individuals again.

Prior to brining on a full OHA Ombuds Program, the Ombuds Program could only address the most critical concerns, with response times that could take up to several weeks. Now that the program has a full team of Ombudspersons:

- The program respons to all individuals who contact the program. Member concerns are addressed by the Ombuds program or given a warm handoff to the appropriate division or program that can address their concerns.
- Response time is now less than four days (including weekends). During 2021, Ombuds program response time goal is to respond within one business day.

In 2020, the top five OHP complaints to the OHA Ombuds Program were related to:

1. Medicaid operations (14.3%),
2. Access – enrollment and eligibility (14.2%),
3. Client billing concerns (12%),
4. Interaction with provider or plan (11%), and
5. Access - non-emergency medical transporation (NEMT) (7.6%).



OHA Medicaid Operations

OHA Medicaid operations made up 14.3 % (171) of OHP complaints to the Ombuds Program. Concerns in this category highlight the value OHP members place on established relationships with trusted providers. These included:

- 28 concerns related to continuity of care. The continuity of care process enables members to request fee-for-service OHP so that they can continue seeing a provider with whom their CCO is not contracted.
- CCO 2.0 member transitions during the first quarter of 2020.
- COVID-19-related changes to services, such as telehealth and NEMT, during the second and third quarters of 2020.

Access to Care: Eligibility and Enrollment

Access to care issues related to eligibility and enrollment made up 14.2% (171) of OHP complaints to the Ombuds Program. Significantly, dual Medicaid-Medicare members made up 11.7% (20) of all eligibility related cases. Eligibility concerns came from, among others:

- OHP members moving from OHP to Medicare;
- OHP members with both Medicare and full Medicaid who experienced sudden change of plan and wanted to keep relationships with their providers; and
- OHP members confused about eligibility-related notices.

Client Billing

Client billing concerns made up 12% (143) of OHP complaints to the Ombuds Program.

These cases were disproportionately related to out-of-state emergency department (ED) bills for emergency services (e.g., appendectomy, broken leg).

- Although OHP covers out-of-state emergency services, out-of-state providers sometimes refuse to bill the member's CCO or OHA.
- Instead, these providers send OHP clients to collections which, unless action is taken, can result in lower credit scores, higher interest rates, and inability to get housing of choice.

Although addressing these concerns is a CCO responsibility, the Ombuds Program found great variation in CCOs' understanding of how best to resolve these cases. In some cases, out-of-state providers were unwilling to bill or accept payment from CCOs until the Ombuds Program intervened, as illustrated in this Member Story.

MEMBER STORY

An OHP member traveling to California had an accident that resulted in two broken legs and several other health issues requiring ED services.

Within a month of returning to Oregon, this member started receiving direct bills for the ED services she had received. These services totaled over $200,000.00.

The Ombuds Program worked for 12 months on behalf of the member by coordinating with the CCO, providers and OHA subject matter expert to ensure the bills were eventually paid.

Interaction with Provider or Plan

Concerns related to interactions with a provider or plan made up 11% (133) of OHP complaints to the Ombuds Program. These concerns included lack of communication and coordination among providers and inadequate or incomplete explanation by CCOs to members.

While CCOs are required to provide coordinated physical, mental, and dental care, many of the concerns identified by OHP members in 2020 stemmed from a lack of integrated coordination across these services.

For members with complex care needs, transportation needs and language access needs, this lack of coordination can lead to severe barriers to service access, as this Member Story shows.

MEMBER STORY

Kris is a humanitarian immigrant who made Oregon their new home. They came from a conflict zone where they lost family members and suffered violence that left them with permanent disabilities. Kris does not speak English and uses a wheelchair. Due to Kris's complex care needs, they require ongoing provider appointments. Kris also does not have access to a car, so they rely solely on NEMT to access medical care.

To communicate at health care visits, Kris relies on interpreters, who can wait for a patient for only 15 minutes after the scheduled appointment time. Kris was always diligent, persistent, and clear with NEMT providers about the need to arrive at appointments on time in order to access their providers and interpreters. Yet Kris's rides were consistently late or they never showed, causing Kris to miss many important appointments and in turn, get terminated from providers because of the missed appointments. Most NEMT providers did not speak Kris's language, making it more challenging for Kris to communicate their frustration and need for timely service.

The Ombuds Program gave Kris culturally and linguistically appropriate services. After ongoing corrections, advocacy, and some more unfortunate last-minute appointment cancellations, the program, in collaboration with the CCO and OHA's Civil Rights investigator, was able to put three major changes in place:

- Access to effective care coordination,
- Ensuring language access in all settings, and most significantly,
- A meeting between Kris and the CCO staff that allowed Kris to share their story, experience, and concerns.

Kris now gets the support they need to access the health care they need without the barriers they have experienced before.

Access to Care: NEMT

These concerns made up 7.6 % (92) of OHP complaints to the Ombuds Program.

- NEMT is an OHP benefit that helps members get to and from non-emergency medical appointments.
- Although approximately only four percent of OHP members use NEMT, those who use it are among the most vulnerable. For example, many members on dialysis depend on NEMT for access to this life-saving treatment.

Despite the relatively low number of NEMT users, complaints to the Ombuds Program regarding NEMT represent significant disruptions in access to care, as shown in this Member Story.

Complaints in 2020 included:

- Providers failing to pick members up for appointments or after appointments to return home,
- Late arrivals
- Cancellation of rides with short notice,
- Providers terminating patients for missing appointments that were the result of NEMT issues,
- Long NEMT call center wait times, and
- Lack of appropriate equipment in vehicles to support member needs.

MEMBER STORY

Jimmy is a 11-year-old who lives in a remote, rural part of Oregon 45 minutes away from any health care providers. After getting major reconstructive surgery to allow him to walk, Jimmy was denied access to the physical therapist most geographically convenient for the family.

As Jimmy's mother said, "Jimmy must learn to walk properly again or at least part of this surgery will be for naught."

Through Ombuds involvement:

- Jimmy's CCO assigned him a pediatric care coordinator,
- The family received mileage reimbursement through the NEMT program, and
- Jimmy was able to see the family's preferred physical therapist.

Notably, Jimmy's CCO, which is required to provide integrated care coordination, was unaware of the severity of Jimmy's needs and had not taken steps to address any of these concerns prior to Ombuds involvement.

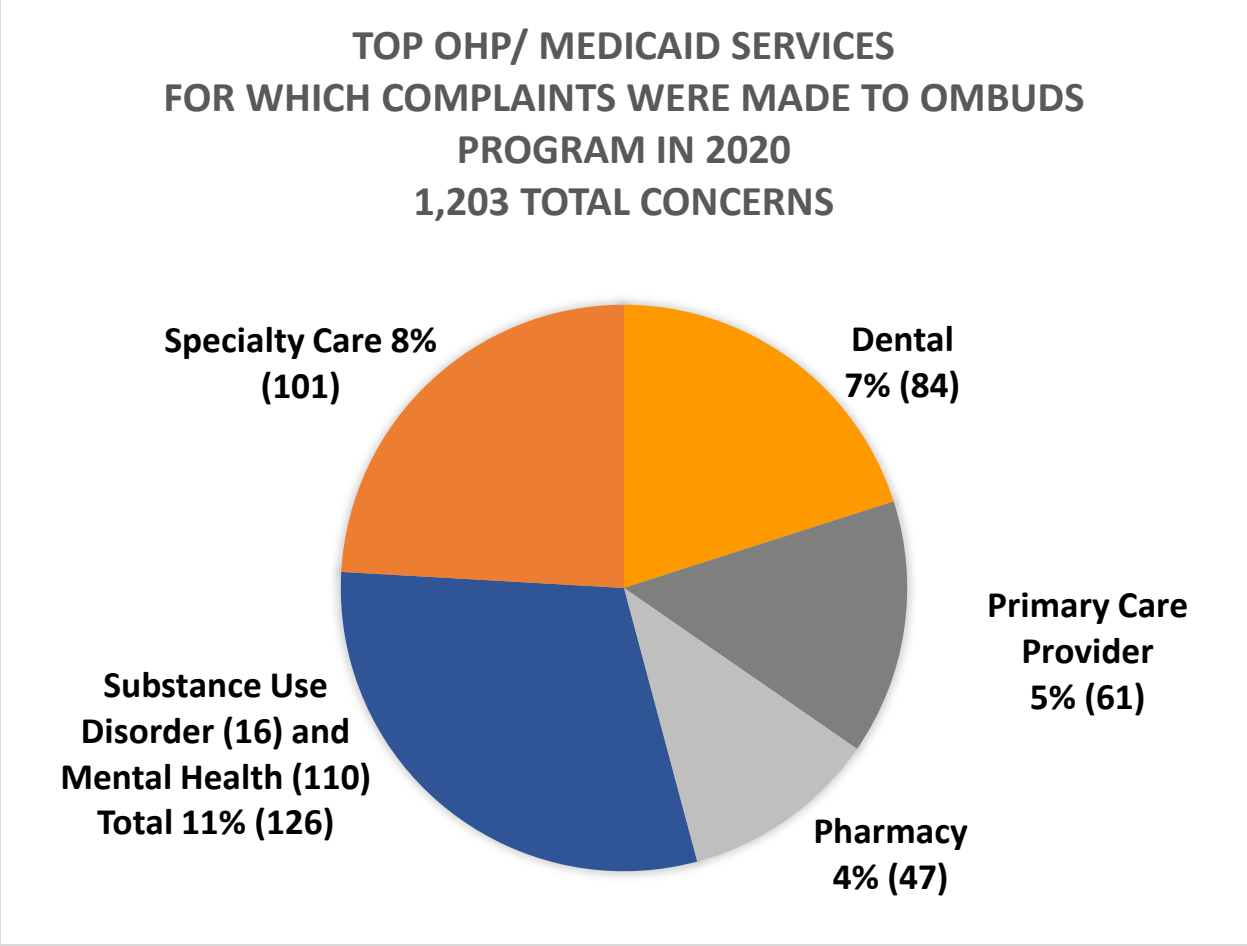
Notably, as COVID decreased the number of in-person medical appointments, NEMT usage also decreased and complaints regarding NEMT to the Ombuds Program also decreased.

Additional Themes

CCO and Ombuds Program complaint data captures the type of complaint (access, quality of care, etc.) and the type of service the complaint is about. The OHP services most frequently involved in Ombuds Program concerns were:

- Mental health and alcohol/ substance use disorder (10.5 %),
- Speciality care (8.4 %),
- Dental care (7%);
- Primary care provider (5.1%), and
- Pharmacy (4%).

Several other areas where client concerns indicate systemic issues include pain management, durable medical equipment, and delayed newborn enrollment into the Oregon Health Plan.



Mental Health and Substance Use Disorder Services

Mental health and substance use disorder (alcohol/drug) concerns included complaints about access to and quality of mental health services; inability to get timely outpatient or residential treatment; and requests to be able to continue therapeutic relationships with mental health providers not part of a CCO network. Significant areas of concern include:

- **Children in need of mental health support:** The Ombuds Program received urgent, compelling concerns about children in mental health crisis in hospital emergency

departments, instead of receiving appropriate, timely care. They underscore the importance of OHA's Children Behavioral Health Unit's work to ensure that behavioral health services for children, youth, young adults and their families, are responsive to their needs so that youth and families have access to the right services at the right time and for the right duration. Oregon's Secretary of State Audit further details the importance of this work and the unit's Policy Vision Paper lays out a children and family centered approach. Importantly, OHA's Children's Behavioral Health Unit is involving children and families in this work and actively seeking their feedback; opportunities are available on the team's website.[1]

- **Inequitable access to in-home supports for individuals with disabilities***:* Medicaid provides in-home supports for qualified individuals based on disability. However, Oregon creates siloed entries for these services depending on whether the need is based on physical or mental health disability. The Oregon Department of Human Services (ODHS) determines eligibility for individuals with physical or developmental disabilities, while OHA determines eligibility based on mental health disability. The Ombuds Program worked with individuals who first sought services and supports based on physical disability. When mental health was determined to be the primary cause of disability these individuals had to go through a new and separate evaluation process, thus delaying timely access to services they qualified for. The Ombuds Program also encountered confusion among agency staff, CCO care coordinators, and family members of those seeking in-home services and supports about how to navigate the process. Additional information about these services can be found here[2].
- **Alcohol & Drug/ Substance Use Disorder** (SUD) concerns included access to inpatient SUD facilities and complaints about lack of care coordination from a residential facility that closed due to COVID-19 concerns in March 2020.

Specialty Care

Specialty care concerns include barriers accessing specialty services and need for care coordination to support access to specialty care. In particular, the Ombuds Program received complaints from OHP members experiencing barriers to and inequity in ability to access transgender services.

- Not all CCOs share similar practices in access to transgender and gender-affirming care, particularly in their interpretation of HERC Guideline Note 127[3].
- Transgender members who have contacted the Ombuds Program experience barriers to accessing these services because of CCO policies, varied application of HERC guidelines and lack of qualified in-state providers.

Dental Care

Dental issues most frequently cited were related to dentures that did not fit, cut into gums, or could not be used. Current Oregon Administrative Rules only allow for replacement of partial dentures once every 5 years or a complete set of dentures once every 10 years without taking into consideration how the product was made or if it works appropriately. Other dental concerns included the quality of dental care and timely access to providers.

1 https://www.oregon.gov/oha/HSD/BH-Child-Family/pages/index.aspx

2 https://www.oregon.gov/oha/HSD/OHP/Tools/BH-In-Home-Comparison-Chart.pdf

3 https://www.oregon.gov/oha/HPA/DSI-HERC/SearchablePLdocuments//Prioritized-List-GN-127.docx

Primary Care Providers

Primary Care Provider (PCP) concerns included access to naturopathic providers as PCPs, access to flu vaccines at PCPs, and care coordination to support establishing services with a PCP.

Pharmacy

Pharmacy concerns included bills and copyaments at pharmacies.

Other concerns not significantly reflected in total numbers

The top reasons for OHP-related calls to the Ombuds Program are not always the best indicator of the urgency of the need. Several other areas are noteworthy for comment.

- **Pain management** concerns included inability of clients to get the pain management treatments they were seeking and/or their providers were prescribing.
- **Durable medical equipment (DME)** concerns included challenges with timely access and confusion about the reasons for denial. Specific DME involved included wheelchairs (approval of purchases or repair) and continuous glucose monitoring devices.
- **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.

CCO-Reported Complaints

CCOs are likewise required to report on complaints received by their members. Information reflecting OHP member complaints by CCO can be found at 2017-2022 Quarterly and Annual Reports to CMS.[4] In some cases Ombuds data and CCO complaint data reflect similar trends; in other cases, Ombuds Program data calls out issues and concerns not identified in CCO complaints.

Reviewing the data from CCO-reported complaints in a collaborative manner is an essential process that supports OHA's commitment to hearing from, being responsive to, and partnering with those served by OHA programs to ensure the elevation of OHP member voice and experience within OHA. This requires the continued collaboration of the Ombuds Program and the teams within OHA that implement operations for Medicaid services, receive and review general member complaints, or interact and work directly with OHP members.

Non-Medicaid Complaints and Other Government Agency Referrals

The Ombuds Program is set in statute as an advocate for OHP members, but in function serves as the Ombuds Program for all Oregonians served by OHA programs.

[4] https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/2017-2022-Quarterly-Annual-Reports.aspx

Non-Medicaid Complaints

20% (371) of all concerns to the Ombuds Program were general complaints about OHA with the majority of these (232) being referred to OHA's Public Health Division.

Other Government Agency Referrals

For these concerns, the Ombuds Program seeks to serve as a no-wrong-door and works to connect with the federal, state, or local agency best able to address client concerns.

During 2020, 13.8% (285) of all concerns were related to COVID-19.

These concerns made up 14.9% (272) of all concerns in 2020 and related to:

- Public benefits administered by ODHS;
- Private insurance, Marketplace, and Medicare concerns addressed by the Department of Consumer and Business Services (DCBS)[5]; and
- COVID-19, workplace concerns and access to vaccines. During 2020, 13.8% (285) of all concerns to the Ombuds Program were COVID related.

The program referred COVID-19 workplace concerns to Oregon's Bureau of Labor and Industries (BOLI) and Oregon Occupational Safety and Health (Oregon OSHA). As 2020 rolled to a close, the Ombuds Program fielded calls related to vaccine rollout and priority populations.

Successes: Client Centered Care Related Progress in 2020

The Ombuds Program is committed to partnering directly with Oregonians receiving or eligible for OHA services, particularly those most impacted by health inequities. This helps ensure that OHA programs are:

- Responsive to all people served and
- Centered on both ensuring health equity and eliminating health inequalities.

In 2020, the Ombuds Program and OHA worked on policy, program and organizational advancements rooted in, driven by, or opening the door to, member voice and experience.

OHA Health Equity Definition:
Oregon will establish a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:
(1) The equitable distribution or redistribution of resources and power; and
(2) recognizing, reconciling and rectifying historical and contemporary injustices.

[5] Please see Appendix C for additional information on OHA General Complaints and Other Government Agency referrals.

Improving Member Experience

Increased Access to Interpreter Services

OHA's Equity and Inclusion Division, Health Systems Division, Fiscal Division, , Community Partner and Outreach Program and Ombuds Program collaborated to implement fee-for-service reimbursement to OHP providers for interpreter services effective January 1, 2021. Memo available here.

Improved NEMT Access

Limitations on use of stretcher vans for NEMT transport in the Portland-metro area caused significant gaps in accessing essential health care including dialysis, hospital discharges to acute care facilities, and specialty care. OHA released guidance to support statewide access to NEMT stretcher transport. In addition, the Ombuds Program, Health Systems Division, and OHA Government Relations worked collaboratively with local county government and CCOs for local policy changes.

Stronger CCO Processes to Resolve Member Billing Concerns

The Ombuds Program worked collaboratively with several CCOs to strengthen member-centered processes to better respond and resolve out-of-state emergency department bills.

Elevating Member Voice

OHA Pathways for OHP Member Voice

The Medicaid Advisory Committee (MAC) and Ombuds Program collaborated to elevate the MAC's role as a key entity to channel OHP member voice within OHA.

- The MAC is now a subcommittee of the Oregon Health Policy Board (OHPB), the policy-making oversight body for OHA and its divisions.
- At OHPB's request, the Ombuds Program now reports quarterly to the MAC and serves on the new MAC Member Voice Subcommittee.

Health Evidence Review Commission (HERC) Engagement

HERC and Ombuds Program established quarterly meetings to elevate OHP member experiences related to the Prioritized List of Health Services diagnosis and treatment pairings to HERC leadership.

In 2020, the Ombuds Program worked with ten OHP members seeking advocacy for hernia repair surgeries, which are not currently covered by OHP. Often these hernias were disabling to the extent that OHP members were not able to work or go about daily activities.

The Ombuds Program shared these member experiences with HERC, resulting in a review of HERC's criteria for hernia repair surgeries.

CCO Pathways for Members with Complex Needs

The Ombuds Program developed pathways with each CCO to ensure timely connections for individuals with complex needs to CCO care coordination teams.

Other Successes

- Engaged CCO Community Advisory Councils to connect with and understand the respective roles of OHA member-serving teams. This was done in partnership with OHA's Community Partner and Outreach Program, Ombuds Program, and Innovator Agents.
- Expanded Ombuds Program capacity by on boarding a full team of six Ombuds; and establishing an internship program and VISTA volunteer for continued program building and strengthening in 2020 and 2021.
- Implemented Ombuds database for real time understanding and identification of repeated concerns and emergent themes coming to the Ombuds Program from OHP members.

Recommendations

For OHP Member Experience

- 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. Prioritize eliminating silos and service disparities based on disability type.
- 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.
- Prioritize agency resources to ensure same day enrollment into OHP of infants born to OHP mothers. Several options, based on national best practices, could support automatic and continuous coverage for all babies born to OHP enrolled mothers in Oregon. These include:
  1) 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];
  2) generate separate Medicaid ID for infants and provide them to expectant mothers during pregnancy, or

[6] 42 CFR 435.117 (c) *Medicaid identification number.* (1) The Medicaid identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the State issues the child a separate identification number.

3) 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.[7]

For Ombuds Program Improvement:

Increase Ombuds Program focus on health equity and eliminating health inequalities by promoting the Ombuds Program to non-English-speaking members.

- Develop Ombuds Program outreach materials in the top 10 primary languages spoken by OHP members.
- By the end of 2021, have 10% of Ombuds concerns from OHP members who speak languages other than English.

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.

It is an honor to work within an agency that embraces client experience as part of ensuring successful transformation. The Ombuds Program is privileged to support Oregon's efforts to achieve better health, lower costs, and improved patient experience.

[7] Electronic Enrollment of Newborns into Medicaid: Insights from Oklahoma. State Health Policy, June 2010, https://nashp.org/wp-content/uploads/sites/default/files/Newborns_Brief_0.pdf

APPENDIX A: Data from Chart 1

Top 5 OHP Complaints to Ombuds Program for 2020

	Number	Percent (of all Medicaid Concerns)
OHA Medicaid Operations	172	14.3%
Access to Care: Eligibility and Enrollment	171	14.2%
Client Billing	143	12%
Interaction with Provider or Plan	133	11%
Access to Care: NEMT	92	7.6%

APPENDIX B: Data from Chart 2

Top OHP Services Related to Complaints Received in 2020

	Number	Percent (of all Medicaid Service Types)
Substance Use Disorder (16) and Mental Health (110)	126	10.50%
Specialty Care	101	8.40%
Dental	84	7.00%
Primary Care Provider	61	5.10%
Pharmacy	47	3.90%

APPENDIX C: 2020 OHA Ombuds Program Data

Oregon Health Authority Ombuds Program 2020 Data

	Total	Percent	Q1	Q2	Q3	Q4
All Ombuds queries, concerns and complaints	2018		552	488	431	547
Complaints responded to	1850	91.67%	511	418	405	516
Complaints with no further Ombuds Work (excluded from % of overall work)	168	8.33%	41	70	26	31
Medicaid Complaints	1203	65.03%	347	255	263	338
Non-Medicaid Complaints	647	34.97%	164	163	142	178
COVID-19 Concerns	285	13.75%	92	56	47	90
Total Medicaid Work	**Total**	**Percent**				
	1203	%	Q1	Q2	Q3	Q4
Access	535	44%	**167**	**94**	**123**	**151**
Eligibility issues	171	32%	55	20	49	47
NEMT not provided, late pick up w/missed appointment, no coordination of services	92	17%	45	11	16	20
Provider not available to give necessary care	68	13%	14	25	10	19
Plan unresponsive, not available, difficult to contact for appointment or information.	50	9%	16	15	8	11
Unable to be seen in a timely manner for urgent/emergent care	30	6%	5	5	13	7
Unable to schedule appointment in a timely manner.	23	4%	1	3	6	13
Referral or 2nd opinion denied/refused by plan.	23	4%	6	2	5	10
Verbal denial of service by Plan	20	4%	5	4	2	9
Verbal denial of service by Provider	16	3%	6	0	6	4
Provider's office unresponsive, not available, difficult to contact for appointment or information.	15	3%	8	4	0	3
Provider's office too far away, not convenient	7	1%	0	3	2	2
Missing data	5	1%	2	0	0	3
Referral or 2nd opinion denied/refused by provider	5	1%	0	0	2	3
Dismissed by clinic as a result of past due billing issues	3	1%	1	1	1	0
Provider's office closed to new patients.	2	0%	2	0	0	0
OHA Medicaid Operations	172	14%	**62**	**38**	**37**	**35**
Other	88	51%	37	16	16	19
Continuity of Care Request	28	16%	10	7	7	4
Provider Billing Questions	18	10%	5	8	2	3
FFS Policies & RACS	11	6%	2	2	3	4
OEI - Traditional Health Workers	9	5%	3	2	3	1
HERC	7	4%	1	0	4	2
Pharmacy Policies	5	3%	3	2	0	0
1915i and DHS Waivers	4	2%	0	1	2	1
Client Billing Issues	143	12%	**33**	**37**	**27**	**29**
Member complaint about OHP clients receiving a bill, without signing a waiver	126	88%	33	37	27	29
Co-pays	13	9%	3	0	4	6
Premiums	3	2%	0	1	1	1
Plan explanation/instruction inadequate/incomplete	1	1%	0	0	0	1
Interaction with Provider or Plan	133	11%	**30**	**41**	**29**	**33**
Lack of communication and coordination among providers	23	17%	3	9	5	6
Plan explanation/instruction inadequate/incomplete	20	15%	3	9	5	6
Member not treated with respect and due consideration for his/her dignity and privacy	16	12%	3	6	4	3
Dismissed by clinic (member misbehavior, missed appts. Etc.)	15	11%	4	4	3	4
Provider explanation/instruction inadequate/incomplete	13	10%	2	1	4	6
Provider rude or inappropriate comments or behavior	12	9%	4	2	2	4
Wants to change providers; provider not a good fit.	8	6%	2	1	1	1
Plan rude or inappropriate comments or behavior	8	6%	3	3	1	6
Dismissed by provider (member misbehavior, missed appts. etc.)	7	5%	2	5	0	0
Wait too long in office before receiving care	4	3%	1	2	0	1
Provider's office or/and provider exhibits language or cultural barriers/lack of cultural sensitivity/interpreters	4	3%	2	0	1	1
Member has difficulty understanding provider due to language or cultural barriers.	3	2%	2	0	1	0
Quality of Care	64	5%	**18**	**18**	**10**	**18**
Received care, experienced an adverse outcome, complications, misdiagnosis or concern related to provider care	23	36%	6	7	3	7
Lack of appropriate individualized setting in treatment	15	23%	5	5	2	3
Member neglect or physical, mental or psychological abuse	12	19%	4	2	4	2
Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommended by Provider or Plan)	6	9%	1	2	1	2
Testing / assessment insufficient, inadequate or omitted	5	8%	1	1	0	3
Provider office unsafe/unsanitary environment or equipment	3	5%	1	1	0	1
CCO Operations	46	4%	**17**	**8**	**10**	**11**
Other	45	98%	17	8	10	10
CAC	1	2%	0	0	0	1
Consumer Rights	64	5%	**9**	**16**	**16**	**23**

Complaint/appeal process not explained, lack of adequate or understandable NOA	26	41%	2	5	9	10
Member dissatisfaction with treatment plan	9	14%	1	3	3	2
Concern over confidentiality.	6	9%	2	2	1	1
Not informed of consumer (Member) rights	4	6%	0	1	2	1
Fraud and financial abuse	3	5%	1	0	0	2
Provider/Plan bias barrier	3	5%	0	2	0	1
Provider's office has a physical barrier/not ADA compliant	3	5%	1	2	0	0
No response to members request to amend inaccurate or incomplete info in the medical record	3	5%	0	0	0	3
Member denied access to medical records (other than as restricted by law)	2	3%	1	0	0	1
Education, unable to get prescription filled or therapeutic alternative recommended by Provider or Plan.	2	3%	0	0	0	2
Quality of Service	24	2%	**6**	**1**	**6**	**11**
Delay in receiving or concern regarding quality of materials and supplies (DME) or dental	19	79%	4	1	**6**	9
Benefits not covered	3	13%	1	0	**6**	1
Lack of access to medical records or unable to make changes	2	8%	1	0	**6**	1
Missing data	22	2%	2	1	**0**	19
Medicaid Service Types	**Total Number**	**Types**	**Q1**	**Q2**	**Q3**	**Q4**
All other Medicaid (includes eligibly related concerns)	387	32.0%	122	83	86	96
NEMT	118	10.0%	58	17	18	25
Mental Health	110	9.0%	27	21	34	28
Specialty Care	101	8.0%	25	17	23	36
Dental	84	7.0%	18	17	28	21
Primary Care Provider	61	5.0%	20	14	9	18
CCO Plan	58	5.0%	14	21	10	13
Pharmacy	47	4.0%	13	10	10	14
Emergency Room	40	3.0%	9	13	8	10
Durable Medical Equipment	33	3.0%	6	3	7	17
Pain Management	30	3.0%	10	2	8	10
Hospital	27	2.0%	5	9	2	11
Other	22	2.0%	2	3	8	9
Long Term Care	18	2.0%	8	4	2	4
Alcohol & Drug/Substance Use Disorder	16	1.0%	1	9	4	2
Diagnostic Studies	10	1.0%	2	3	1	4
Residential Rehabilitation	9	1.0%	2	2	1	4
Physical Therapy	8	1.0%	2	1	3	2
Ambulance/Medical Transportation	4	0.0%	1	2	0	1
Vision	3	0.0%	0	1	0	2
Missing data	3	0.0%	0	1	0	2
Outpatient	3	0.0%	1	1	0	1
Occupational Therapy	2	0.0%	1	0	1	0
Acupuncture	1	0.0%	0	1	0	0
Chiropractic	1	0.0%	0	0	0	1
Process Metrics	Total Number	% Process Metrics	Q1	Q2	Q3	Q4
Average Days To Ombuds First Response (includes weekends)	5		34	4	5	4
Average Days to Complaint Closure (includes weekends)	20		26	17	15	5
Tribal	13	0.70%	4	3	1	5
Provider Complaints	113	6.11%	49	20	23	21
Limited English Proficiency	16	0.86%	3	4	4	5
Unstable Housing	48	2.59%	11	12	15	10
Dual Eligible	108	5.84%	31	17	25	35
Age categories	Average Age	47	**46**	**49**	**45**	46
Average Age at Intake (excluding data with no age reported)	Number	% of Medicaid	Q1	Q2	Q3	Q4
Age 0-9	37	4.42%	15	7	10	5
Age 10-19	50	5.97%	12	7	18	13
Age 20-29	68	8.11%	15	15	15	15
Age 30-39	133	15.87%	36	35	34	28
Age 40-49	139	16.59%	21	45	31	42
Age 50-59	166	19.81%	46	46	36	40
Age 60-69	175	20.88%	45	55	38	45
Age 70-79	51	6.09%	11	17	13	10
Age 80+	19	2.27%	5	7	4	3
Referral Sources	1094	100%	**279**	**186**	**205**	**264**
Ombuds Line	395	41%	126	80	85	104
Ombuds Email	49	5%	10	19	8	12
Ombuds Staff Direct Contact	104	12%	25	22	20	37
GAO	75	8%	21	18	18	18
OHA_DHS Staff	87	9%	28	10	24	25

Elected official	68	8%	19	5	19	25
Unknown	47	4%	21	18	3	5
Directors Office	57	6%	20	4	14	19
CCO	10	1%	2	2	3	3
Other	2	0%	1	1	0	0
CPOP	15	2%	0	5	5	5
HSD	14	1%	5	2	2	5
In Person	1	0%	1	0	0	0
Missing data	10	1%	0	0	4	6
Total Non-Medicaid OHA General Complaints	342	18.49%	92	98	66	86
Public Health Non-Medicaid and Non-Licensing	232	68%	75	60	43	54
Other	75	22%	14	23	16	22
State Hospital	12	4%	1	7	2	2
HR	4	1%	1	2	0	1
Office of Equity and Inclusion (OEI) - Interpreter and Translation (Non-OHP Access)	5	1%	1	1	1	2
Civil Rights or ADA Violation	4	1%	0	1	0	3
Public Records Request	5	1%	0	3	1	1
Licensing OHA General Complaints	29	1.57%	4	14	6	5
Behavioral Health Licensing (DUI, outpatient, etc.)	12	41%	6	3	3	6
Other	9	31%	14	23	16	22
Public Health Licensing (air, water, food, pool, lodging, etc.)	8	28%	3	0	0	5
Other Government Agencies	276	14.92%	58	61	70	87
Other	113	40.94%	23	26	32	32
DHS	61	22.10%	17	12	16	16
DCBS – Marketplace, Private, SHIBA, and other	60	21.60%	12	13	16	19
Medicare	11	3.99%	1	5	1	4
Local Government Issue	19	6.88%	4	0	4	11
HIPPA Violation - HHS	8	2.90%	1	4	1	2
No Ombuds Work	3	1.09%	0	0	0	3
Missing data	1	0.36%	0	1	0	0