

MEDICAID ADVISORY COMMITTEE

April 28, 2021, 9:00am-12:00pm

Microsoft Teams meeting: **Join on your computer or mobile app** [Click here to join the meeting](#)

Or call in (audio only): [+1 971-277-2343, 308346243#](#) United States, Portland, Phone Conference ID: 308 346 243#

Item #	When	What	Who	Materials
1	9:00	Welcome, roll call, and approve February minutes	Leslee Huggins and Jeremiah Rigsby, MAC Co-Chairs	1. MAC Agenda 4.28.21 1a. February Meeting Minutes
2	9:10	Ombuds Program 2020 Report Review	Ellen Pinney, Principal Ombudsperson, OHA Sarah Dobra, Ombuds Program and Innovator Agents Manager, OHA	2. Ombuds 2020 Annual Report
3	9:45	1115 Waiver Renewal	Lori Coyner, OHA Medicaid Director	3. Wavier Vision and Goals_APRIL_Final
4	10:20	Legislative Update – ODDS and APD	Brooke Hall, Sr. Legislative Policy Analyst, DHS	4. ODHS.ODDS.Bills 4a. MAC_Bills of Interest
	10:35	Break		
5	10:40	OHA Agency Update	David Inbody, CCO Operations Manager (OHA)	
6	10:55	OHA Legislative Update	Mackenzie Carroll, Legislative Lead, Health Policy and Analytics, OHA	
7	11:20	OHA Medicaid Quality Strategy	Lisa Bui, Director of Quality Improvement, OHA	7. 2021 OHA Medicaid Quality Strategy-DRAFT-MAC-4-20-21
8	11:35	Advancing Consumer Experience – Subcommittee Status	Lavinia Goto, Subcommittee Chair	
	11:50	Meeting adjournment		

Note: Time for public comment will take place immediately after each agenda item.

Next Meeting: May 26, 2021. 9:00 am -12:00

May Agenda (tentative):

1115 Waiver Update

Notice of Adverse Benefit Determination (Follow up discussion)

Health Equity Plan Findings



OREGON MEDICAID ADVISORY COMMITTEE (MAC)

February 24, 2021

9:00 AM – 12:00 PM

MEMBERS IN ATTENDANCE: Adrienne Daniels, Daniel Alrick, Dave Inbody, Jeremiah Rigsby, Kärün Virtue, Lavinia Goto, Leslee Huggins, Tamara Bakewell, Divya Sharma, Miguel Angel-Herrada

MEMBERS ABSENT: Brandy Charlan, Anna Lansky

Quorum? Yes

PRESENTERS: Amanda Peden, Veronica Guerra, Lisa Bui, Kweku Wilson

STAFF: Tom Cogswell, Margie Fernando, Jackie Wetzel

MAC PRIORITIES for 2020-2021			Deliverable/Timing
1.	CCO 2.0	Monitor 2.0 implementation from a consumer and community perspective	Annual report with committee observations re 2.0 implementation and consumers – Q1, 2022
2.	Advancing Consumer Experience Subcommittee	Lavinia Goto, MAC member, is Chairing a subcommittee focused on improving OHP consumer experience. The workgroup includes MAC members (Karun Virtue and Tamara Bakewell) as well as consumers and advocates.	Draft report with recommendations to be delivered to the MAC in June 2021; next steps TBD based on MAC input
3	1115 Waiver	(for discussion on 4/28/21) Support the OHPB role in waiver by: - reviewing the 1115 waiver renewal application from a consumer perspective - serving as a public comment forum for the waiver	TBD Public comment log

TOPIC	Key Discussion Points
Welcome and Introductions	Jeremiah Rigsby welcomed everyone to the meeting. <i>There was a motion to approve the minutes of 1/27/21, with a request to include the date of the OHPB retreat in the minutes. With that correction, all votes were in favor of approval of the 1/27/21 minutes.</i>

TOPIC	Key Discussion Points
DHS Updates /OHA Updates	Anna Lanksy was not available. Dave Inbody updated the committee with recent OHA developments including • CCO Enrollment • \$5.2M E-Board funding & Oregon State Hospital • 2022 CCO Contract Restatement • COVID vaccinations • CCO Data Reporting • Health Equity Plan Reporting
Healthcare Interpreter Report Findings	Kweku Wilson shared findings from the initial healthcare interpreter report, which is related to the equity measure for meaningful language access to culturally responsive healthcare services. Findings from the healthcare interpreter report are important to the MAC's role in monitoring CCO 2.0 implementation from a consumer perspective in that the report provides visibility into how OHP members are receiving culturally and linguistically appropriate care. Overall, access to interpreters is not adequate; as part of CCO 2.0, CCOs will submit healthcare interpreter reports quarterly.
Telehealth Workgroup Update	Amanda Peden, Senior Policy Analyst, OHA and Telehealth Lead for OHA's workgroup focused on current and future policies of Telehealth. Today's presentation focused on the rise of telehealth use and three key themes of where telehealth is heading in terms of equity, data, and cross-agency coordination and alignment. Telehealth services spiked when COVID hit and rapid policy change was required to meet the increased use. It peaked in April 2020 and remains high. Question: Does OHP cover remote patient monitoring? In terms of what is covered, do any of the codes cover rental of equipment for a patient to access services? Answer: Remote patient monitoring (e.g., 99453, 99457, 99458) services are covered for new and established patients. Prioritized List Ancillary Guideline Note A5 delineates coverage indications for RPM.

TOPIC	Key Discussion Points
	Question: has OHA done any analysis of behavioral health access prior to and after the pandemic and the impact telehealth may have had on access? For example, we've heard feedback from providers that with the rise of telehealth, different and new patients are accessing telehealth as opposed to those who access in-person services. We don't have an answer to this question (more data and analysis are needed).
Quality Strategy Discussion	Veronica Guerra, Quality Assurance and Contract Oversight Manager, OHA Lisa Bui, Director of Quality Improvement, OHA Lisa Bui shared the latest updates to the Quality Strategy. The changes include: • Inclusion of OHA's 10-year goal to eliminate health inequities by 2030. • Alignment of strategies to include CCO 2.0 priorities/current CCO contracts • Alignment of strategies to 2020 -2024 State Health Improvement Plan (SHIP) • Alignment to November 2021 code of federal regulations (CFR) updates • Alignment to quality payment programs Lisa asked for MAC's input on: What additional information from the Quality Strategy would the MAC want a deeper dive on? • Metrics reports; impacts on OHP members • Complaints and Grievance data and interventions to address problems • Delivery System Network that gets to access discussions • CCO Transformation Quality Strategy outcomes and policy directions How does the MAC want be engaged on future developments and changes to the Quality Strategy? Veronica Guerra added information about the Notices of Adverse Benefit Determination. CCO's and DCOs must submit documentation for a sample selected by OHA from the Grievance and Appeal log. MAC members were concerned that the language in the NOABD's was not plain and understandable. Veronica said that when the workgroup is convened, they will be looking at this issue to make sure that the language is modified to make it more consumer friendly. They will engage MEOC to help with this work. Member Engagement and Outreach Committee (MEOC) is a workgroup and forum for Health Systems Division to work with directly with coordinated care organizations (CCOs) and managed care entities

TOPIC	<i>Key Discussion Points</i>
	(MCEs), to share input on policies and to resolve issues that arise related to communication and outreach to Oregon Health Plan members. The workgroup is also a forum for CCOs to work together to share information and resources related to operations and best practices. MEOC meets monthly, and meeting information and materials can be found here: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Member-Engagement-Outreach.aspx.
OHPB Retreat - Discussion	Leslee Huggins provided a recap of the OHPB retreat on February 17th, during which all committees of the board shared details about past work products, current work focus, and future needs for board guidance and input. Some highlights of the discussion include: • The policy board along with the eight committees of the board have a vast list of accomplishments in Oregon's health system transformation (HST) history • There was a lot of discussion about the need for cross-committee collaboration to advance collective goals and the board's role in synthesizing and aligning work across the committees • Consistent with OHA's goal to eliminate health inequities by 2030, there is an equity focus throughout all committee work; data challenges continue to pose a significant barrier to this work The MAC's role in elevating consumer voice is important, including: • CCO 2.0 progress monitoring regarding health system transformation objectives • Contributing to 1115 waiver development – which we will hear more about in April • Achieving OHA agency goal of eliminating health inequities by 2030
Public Comment	There was no Public Comment.
Closing Comments	The next meeting is April 28, 2021 via Microsoft Teams

Next Meeting
Wed April 28, 2021, 9am-noon
Via Microsoft Teams



EXTERNAL RELATIONS DIVISION

Kate Brown, Governor



500 Summer St. NE, E-20

Salem, OR 97301

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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 transportation (NEMT) (7.6%).

Coordinated care organization (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 involvement or the program was unable to contact the individuals again.

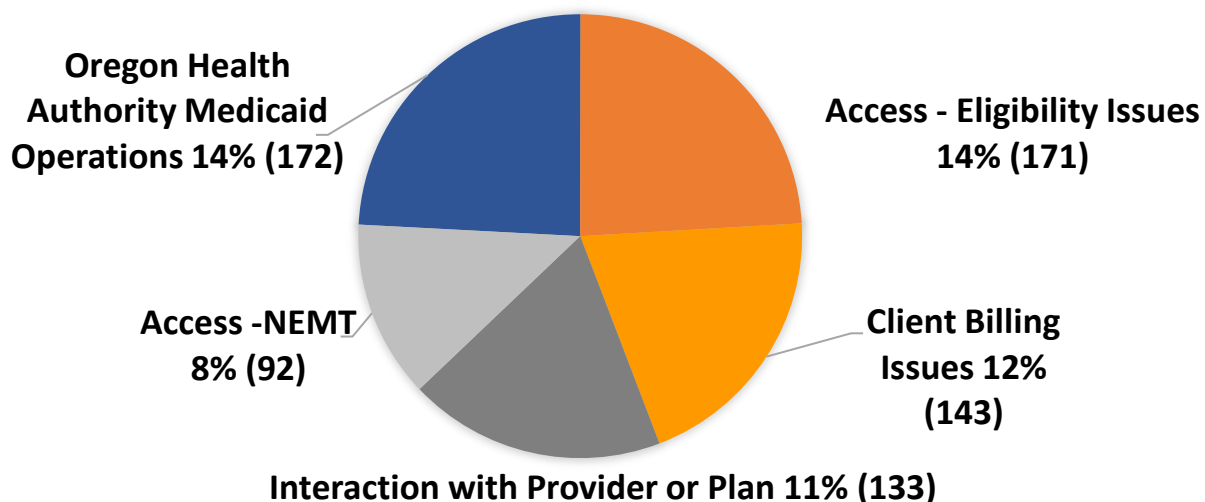
Prior to bringing on a full OHA Ombuds Program, the Ombuds Program could only address the most critical concerns, with response times that could take up to several weeks. Now that the program has a full team of Ombudspersons:

- The program responds 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 transportation (NEMT) (7.6%).

TOP 5 OHP/MEDICAID COMPLAINTS TO OMBUDS PROGRAM FOR 2020; 1,203 TOTAL CONCERNS



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.

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.

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.

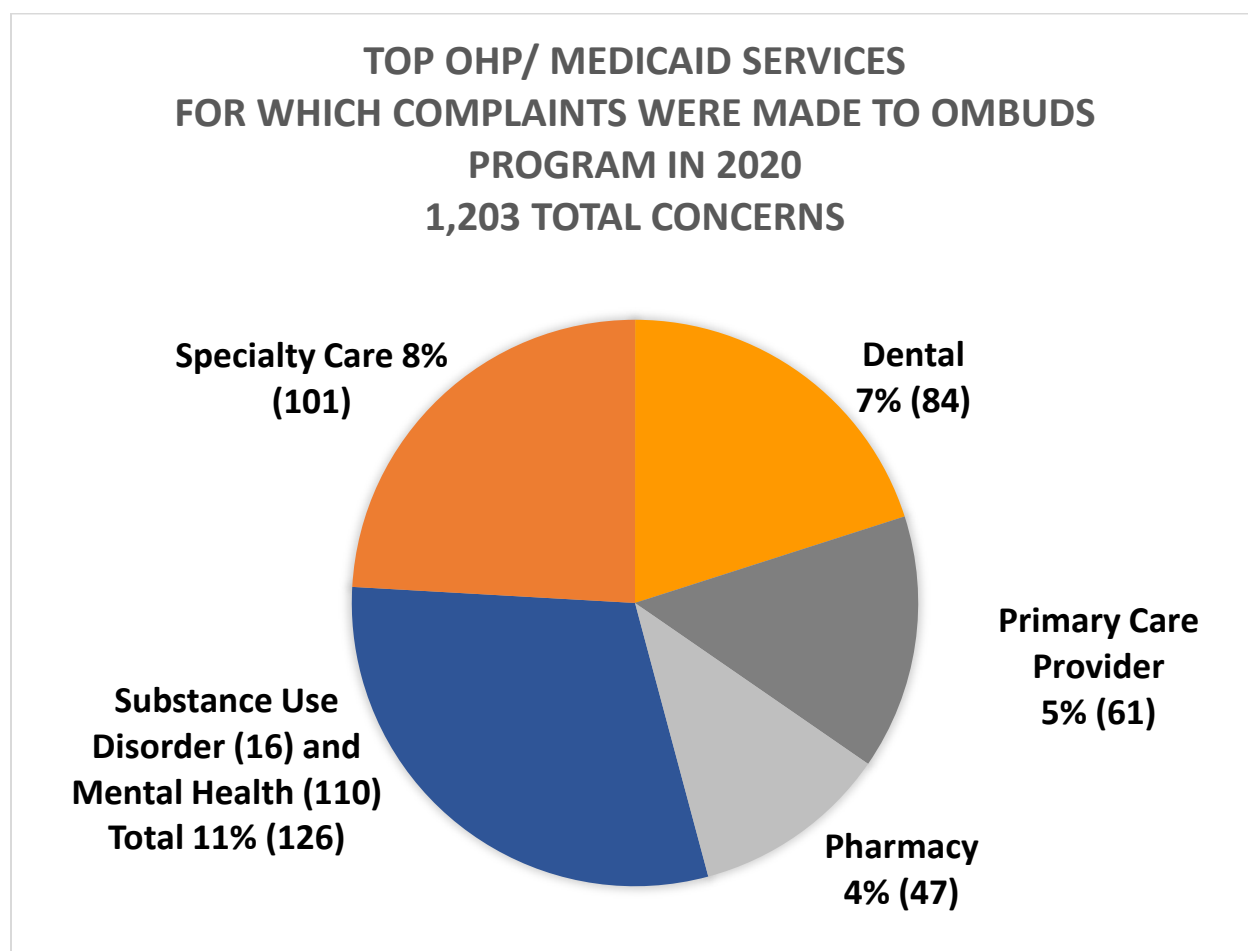
Notably, Jimmy's CCO, which is required to provide integrated care coordination, was unaware of the severity of Jimmy's needs and had not taken steps to address any of these concerns prior to Ombuds involvement.

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 copayments 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		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

<i>Elected official</i>	68	8%	19	5	19	25
<i>Unknown</i>	47	4%	21	18	3	5
<i>Directors Office</i>	57	6%	20	4	14	19
<i>CCO</i>	10	1%	2	2	3	3
<i>Other</i>	2	0%	1	1	0	0
<i>CPOP</i>	15	2%	0	5	5	5
<i>HSD</i>	14	1%	5	2	2	5
<i>In Person</i>	1	0%	1	0	0	0
<i>Missing data</i>	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

Overall goal		Progress towards elimination of health inequities		
What are the drivers of health inequities?	Despite progress, people who often face the greatest challenges, including discrimination and historic oppression in accessing care, are often least likely to have the supports needed to successfully navigate our complex health and social service sectors	A much higher uninsured rate for communities of color can result in disrupted or delayed care, additional stress, and greater costs for the individual and the system	The current system is designed to pay most when people get sick . Little funding is left to invest in preventive or social services, and the communities most impacted by those investments often don't have a seat at the table .	Large-scale funding isn't dedicated upstream to cross-system drivers of health inequities that often have long timelines for cost-savings
Key goals	Create an equity-centered system of health	Ensure access to coverage for all people in Oregon	Encourage smart, flexible spending that supports health equity	Reinvest government savings across systems to achieve health equity
What would the system look like if we achieved these goals?	➤ No language, cultural, or economic barriers to care ➤ Enrollment is preserved in OHP as patients transition between systems ➤ People experience streamlined, coordinated, and integrated care across health and social systems ➤ Easier to access and have Medicaid cover housing supports, social supports, and pre-treatment services	➤ Enrolling a higher % of folks who are eligible ➤ Reducing churn and providing better continuity of coverage ➤ Reducing/eliminating the inequity in the uninsured rate	➤ See a shift in investments on the ground that focus on prevention and equity ➤ Provide a predictable rate of growth ➤ Financial power and decision-making on community investments are held by the community itself ➤ Patients would get the care and supports they need, regardless of whether it's a covered benefit	➤ Oregon enters into a shared savings agreement with the federal gov't ➤ Savings are reinvested into targeted areas to address health inequities ➤ Resources are invested to improve cross-system coordination
What are the potential strategies to achieve these goals?	- Improve care and capacity across the behavioral health system - Housing and SDOH supports - Incentives focused on health equity in care delivery - Coverage and enhanced coordination for justice-involved populations	- Coverage for all people, regardless of immigration status - Increased outreach to ensure eligible individuals are enrolled - Preserved enrollment in OHP	- True "global budget" for enhanced CCO flexibility - Community-managed funds for investment in equity and SDOH - Cost-control mechanisms for high-cost, low-value care and services - Increased CCO accountability to health equity	- Commitment to statewide Cost Growth Target across all markets - Equity-focused investments with statewide impacts

The Office of Developmental Disabilities Services 2021 Bills

Bill #	Office/ Title	Bill Overview
SB 86	ODDS: Statute Alignment for Settings Supporting Individuals with Developmental Disabilities and Licensing Consideration of Provider Performance in Other States	SB 86 will give ODDS authority to consider the performance of a provider or provider agency operating a program or setting in another state outside of Oregon by aligning the statutory language for residential training homes and facilities to be consistent with the statute for adult foster homes.
SB 88	ODDS: Housekeeping	Senate Bill 20 was passed during the 2019 legislative session. The legislation moved certain Community Developmental Disability Programs (CDDP) functions from ORS 430.664 to ORS 430.662. This move made references to 430.664 elsewhere in statute inaccurate. SB 88 corrects these references.
SB 89	ODDS: Child in Care	During the 2017 session, Senate Bill 243 expanded the definition of “Child in Care” to include children residing in a certified foster home or developmental disabilities residential facility. This legislation defined “developmental disabilities residential facility” as a residential facility or foster home for children who are 18 years of age or younger and receiving developmental disability services. SB 89 clarifies that developmental disability residential facilities refers to children who are 17 years of age or under.
SB 90	ODDS: Client Privacy for Vulnerable Population	SB 90 would protect client privacy by adding residential names and addresses of adults with intellectual and developmental disabilities (I/DD) who reside in adult foster homes, residential training facilities and residential training homes to the “public records exempt from disclosure list” in ORS 192.345.
Bill #	Office/ Title	Bill Overview
HB 2151	ODDS: State as Model Employer Program for Employment of People with Intellectual and Developmental Disabilities	HB 2151 establishes the Task Force on the State as a Model Employer Program for the employment of people with developmental and intellectual disabilities and codifies the State as a Model Employer Program within the Oregon Department of Human Services.
HB 2105	ODDS and APD: Supported Decision-Making: Promoting Greater Self-Determination in the Area of Decision-Making Supports	HB 2105 ensures youth with disabilities receive information, training, and resources regarding supported decision-making during their IEP meetings.

Medicaid Advisory Council – Possible Bills of Interest

Bill Number	Description	Link
House Bills		
HB 2327	Emergency response plan and PPO for facilities in public health emergencies	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2327
HB 2394	Communication for residents in isolation in a facility	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2394
HB 2397	Senior Medical Emergency Innovations program	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2397
HB 2595	ODHS/APD workload analysis before developing biennial budget	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2595
HB 2822	Provides a person receiving 1915(i) services can continue receiving them when	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2822

	they begin getting 1915(k) services	
HB 2952	Allocates funds to assist seniors with behavioral health needs and address disproportionate burdens from the COVID-19 pandemic	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2952
HB 3039	Health Information Technology Oversight Council convenes one or more groups of stakeholders and experts to study and make recommendations regarding explore specified issues related to adoption of secure, statewide, integrated health information and community information exchanges.	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB3039

HB 3352	Expands Health Care for All Children to also include adults	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB3352
Senate Bills		
SB 584	Removes income and resource requirements for the EPD program	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB584
SB 700	Establishes Oregon Brain Injury Trust Fund.	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB700
SB 703	Evaluate cost of care in facilities and add a direct care worker representative to the Quality Measurement Council	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB703
SB 714	Requires acuity-based staffing tool, and compliance for staffing once a facility adopts an acuity-based staffing tool, and provides for ODHS to provide a pilot acuity-	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB714

	based staffing tool for facilities	
SB 800	Oregon Essential Workforce Health Care Program	https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB800

Oregon's Medicaid Quality Strategy

I. Introduction

To monitor how well Oregon's coordinated care model is achieving its goals of access, equity, quality and outcome improvement, and to help determine whether health system transformation efforts have improved or worsened quality and access in the state, Oregon must have robust performance monitoring strategies and mechanisms to monitor and assess all Medicaid delivery systems (including coordinated care organizations [CCOs] and fee-for-service [FFS]).

As required by CFR 438.330, Oregon assesses how well the CCOs and managed care organizations are meeting requirements through the robust performance measurement process and ongoing analysis of the quality and appropriateness of care and services delivered to enrollees, and member satisfaction. Oregon's evaluation plans, described in Attachment X, will also inform the quality and appropriateness of care provided to Medicaid beneficiaries. Information on how Oregon will report to CMS on elements of the demonstration can be found in Attachment X.

Oregon has developed a comprehensive program to assess all aspects of the delivery system and the CCO and MCO activities to determine quality improvement and contract compliance. This Quality Strategy describes the components of that program.

II. Overview

Framework for quality

To monitor quality, the Oregon Health Authority will build upon the eight currently implemented focus areas across Oregon's health care delivery system. Continuing the progress in the focus areas, the Oregon Health Authority will intensify key focus areas, such as adding oral health to the existing primary care and behavioral health integration. Working collaboratively across the system, CCOs, MCOs and the Oregon Health Authority will support the framework through quality improvement in these focus areas. Focus areas are detailed in the following "Improvement Strategies" section.

Continuing on the pathway to achieve the triple aim, the Oregon Health Authority recognizes the need for alignment across all health delivery systems for quality. Increased focus on alignment will include programs in Medicare, Medicaid (CCO and FFS systems) and federal improvement programs (for example, value-based payment). Working with a regional quality improvement organization (QIO), OHA's External Quality Review Organization and health delivery systems (CCOs, MCOs), the Oregon Health Authority will look for opportunities to align state efforts with federal direction in quality and transformation activities. While maintaining the state's program integrity related to gains in health transformation, the Oregon Health Authority will develop strategic alignment for quality programs to increase organizations' efficiency and decrease burden on the health systems for reporting and communicating common-thread goals that will continue Oregon's work towards the triple aim of better health, better care and decreasing costs.

Improvement strategies

- [Driver diagram]

Accountability summary

To drive innovation, improve health outcomes and maintain compliance with regulatory agencies, the Oregon Health Authority is managing the substantial work through clear lines of responsibilities. Aligning programmatic expertise and skills with the appropriate quality activity supports the necessary detail needed to move health care transformation forward. Specific delineation occurs for functions relating to quality and performance improvement, as well as quality assurance and compliance. Key attributes of accountability of this quality structure include, but are not limited to, the following:

- Oregon Health Authority
 - Oregon Health Policy Board – develops strategic direction of health systems
 - OHA Quality Council – monitors clinical quality performance, health transformation and quality improvement
 - Managed Care and CCO Collaborative – monitors the client experience through enrollment trends, complaints and grievances, appeals, and utilization trends
 - Quality management/contract compliance – monitors managed care organizations and CCOs for contract compliance, external quality review and quality assurance elements (complaints, fraud, waste, abuse)
- Health delivery system (partnership committees with delivery system and OHA)
 - Quality and Health Outcomes Committee – monitors clinical quality performance with improvement strategy development and implementation
 - Health Evidence Review Committee – reviews and develops evidence-based practices for all managed care entities (including FFS)

Methods and resources for monitoring

Across the Oregon Health Authority's quality programs, the agency utilizes multiple quality strategies as tools for improvement. Continuous quality improvement, Plan-Do-Study-Act models, and LEAN principles are examples of proven methods of improvement. Ongoing use of these methods across the agency supports the transformation in the health care delivery system through train-the-trainer models with CCOs and contractual relationships with FFS. An additional resource for monitoring includes robust data systems to drive a data-decision culture. Key agency data systems include, but are not limited to, the all payer all claims database, performance monitoring through measures reporting, and CCO data dashboards from claims reporting. See Attachment X, Part III: Measurement Strategy for more detailed description of data sources.

Standards for managed care contracts

As required by CFR 438.204(g), Oregon must establish standards for all managed care contracts regarding access to care, structure and operations, and quality measurement and improvement. [Appendix X] outlines each required component of the federal regulations and identifies the section of the model coordinated care organization, dental care organization, fully capitated health plan, and provider service organization contracts, and/or Operational Protocol where this requirement is addressed.

Compliance

[content]

Expectations for CCOs

As Oregon's health transformation journey continues to meet the triple aim, how systems of care are delivered are becoming part of day-to-day functions. The ongoing performance management, while creating a culture of innovation, will be the foundation to move CCOs forward. Goals for coming years will include maintaining the gains in health transformation while increasing alignment of quality activities at the federal and state level, decreasing the burden of reporting and ensuring compliance with federal regulations will be achieved through the CCO Quality Strategy. CCOs are annually submitting a Transformation Quality Strategy (TQS).

The CCO Quality and Transformation Strategy will reflect an analysis of quality and transformation activities of the full prior calendar year. This analysis will provide CCOs the necessary picture to further determine gaps in health delivery, health improvement and cost containment. As gaps are defined, CCOs will determine interventions in alignment with the CCO's strategic plan to improve the quality of members care for their region. When developing interventions, CCOs will consider areas of transformation for the development of activities.

CCOs will define in their annual work plan the interventions, measures of success and accountability for implementation of the identified interventions. The contract requirements (deliverables) will be updated annually for clear lines of understanding of format, due date, and the accountable review structure at Oregon Health Authority.

Health priority alignment

CCO 2.0 priorities

The next phase of Oregon's health care transformation, called CCO 2.0, is focused on four key areas identified by the Governor:

1. Improve the behavioral health system and address barriers to access to and integration of care.
Integrate behavioral, physical and oral health to allow patients to receive the right care at the right time and in the right place. Focus on behavioral health (mental health and substance use disorder) services. Assure that children with serious behavioral health care needs are addressed as a priority.
2. Increase value and pay for performance.
Reward providers' delivery of patient-centered and high-quality care. Reward health plan and system performance. Ensure consideration of health disparities and members with complex needs. Align payment reforms with other state and federal efforts.
3. Focus on social determinants of health and health equity.
Build stronger relationships between CCOs and other sectors. In addition, align outcomes between health care and other social systems to improve health equity. Encourage a greater investment in prevention and the factors that affect our health outside the doctor's office
4. Maintain sustainable cost growth and ensure financial transparency.
Continue to operate within a sustainable budget and address the major cost drivers in the system. Ensure ongoing financial transparency and accountability.

These focus areas and the associated policies are the foundation of the CCO contracts awarded for 2020–2024.

State Health Improvement Plan

OHA provides backbone support for implementation of the State Health Improvement Plan, Healthier Together Oregon (HTO). Oregon's 2020–2024 HTO identifies efforts needed to advance health equity for priority populations through collective action in five priority areas: institutional bias; adversity, trauma and toxic stress; access to equitable preventive health care; behavioral health; and economic drivers of health, such as housing, food security and living wage jobs. HTO is intended to be an alignment tool for anyone working to improve health, including other state agencies and partners who develop and implement community health improvement plans (CHPs). CCO CHPs are required to align with at least two HTO priorities and strategies. Finally, OHA convenes the PartnerSHIP, a community-based steering committee, to provide oversight and governance of the plan. The PartnerSHIP is made up of representatives of priority populations and implementers of the plan, including CCOs and their community advisory councils.

Equity

To improve health outcomes, there must be a focus on health equity. Oregon will have achieved health equity when all people have the opportunity to attain their full health potential, but there is no easy solution for eliminating health disparities. In fact, there are often many causes for the adverse health outcomes experienced by certain disadvantaged communities. Some communities are less likely to live in quality housing, less likely to live in neighborhoods with easy access to fresh produce, less likely to be tobacco-free, less likely to have health insurance, and less likely to receive culturally and linguistically appropriate care when seeing a health care provider.

OHA utilizes several levers to improve health equity. The coordination of these levers and the monitoring and accountability are essential actions to have the greatest impact. Levers include, but not limited to, measurement monitoring and reporting across racial and ethnic disparities, health equity pay for performance incentive metric, CCO health equity plans, equity components of the CCO Transformation and Quality Strategy, and connections to the community health improvement plans and regional health equity coalitions.

To reinforce Oregon Health Authority's commitment to improve health and equity, OHA adopted a 10-year goal and an equity definition as a foundation for the agency's work. The strategic goal was informed by an extensive community engagement process throughout the state to ensure the agency was especially responsive to people in Oregon most impacted by health inequities stemming from long-standing and contemporary racism and oppression. The process also allowed for understanding where work needs to focus, robust internal and external coordination, and impacts around how to think about and work towards achieving health equity.

OHA 10-year goal: To end health inequities in the state of Oregon by 2030.

10-year goal key questions:

- How do we address the equitable distribution and redistribution of resources and power?
- How does this impact our policy, practice and decision making?
- What do we need to do differently?

Health equity definition

In October 2019 the Oregon Health Policy Board (OHPB) and the Oregon Health Authority (OHA) adopted the health equity definition developed by the Health Equity Committee (a subcommittee of OHPB). The definition states that:

Oregon will have established 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, age, 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:

- *The equitable distribution or redistribution of resources and power; and*
- *Recognizing, reconciling and rectifying historical and contemporary injustices.*

Quality payment programs
[content]

III. Methods

Accountability methods

Oregon has developed a comprehensive program to assess all aspects of the delivery system. This program involves routine analysis and monitoring of delivery system performance and consumer satisfaction data, comprehensive on-site operational reviews, and other focused reviews and surveys designed to monitor areas of particular concern (such as provider availability, marketing activities, and other issues identified through routine monitoring). In addition to these activities, OHA conducts ongoing accountability and compliance reviews (described below).

Ongoing focused reviews

Focused reviews, which may or may not be on-site, are conducted in response to suspected deficiencies that are identified through routine monitoring processes and grievance and appeal reporting. These reviews will also provide more detailed information on areas of particular interest to the state such as emergency department visits, behavioral health, utilization management, and data collection problems. Another example of a focused review is an on-going review of plans' provider networks to determine if physicians are being listed as practicing in a plan's network when they have had their medical license suspended or revoked.

Appointment and availability studies

The purpose of these studies is to review managed care and FFS provider availability/ accessibility and to determine compliance with contractually defined performance standards. To conduct these studies, state and External Quality Review Organization (EQRO) staff attempt to schedule appointments under defined scenarios, such as a pregnant woman requesting an initial prenatal appointment.

Marketing and materials review

Managed care contractors are contractually required to submit all marketing materials, marketing plans, and certain member notices to the state for approval prior to use. This process ensures the accuracy of the information presented to members and potential members.

Performance monitoring [content]

On-site operational reviews

On-site reviews will be conducted periodically as a result of, gaps in performance, requested by CCO, or requested by the EQRO for example. Reviews will include, but not limited to, validating reports and data previously submitted by the CCO, an assessment of supporting documentation, and/or conducting a more in-depth review of the CCO's quality assurance activities. Reviews will also serve as an opportunity for in-person, one-on-one technical assistance in identified gap area. For example, a site visit relating to performance improvement projects will include a refresher in CCO deliverable, applicable state and federal requirements and provide technical assistance in root cause development and aim statement objectives.

Furthermore, on-site review(s) supplements the state monitoring program of CCOs with direct and focused areas of improvement.

Accountability team reviews

The OHA accountability teams meet monthly to review contract compliance issues across all delivery systems in aggregate and quarterly to review performance metrics.

On an annual basis, OHA prepares a compendium of plan-specific descriptive data reflecting their performance metrics. This analysis includes information on trends in plan enrollment, provider network characteristics, performance measures, complaints and grievances, identification of special needs populations, trends in utilization using encounter data, statements of deficiencies, and other on-site survey findings, focused clinical study findings, and financial data. Each of the data files helps prepare a profile for each plan, including a summary of plan strengths and weaknesses. These reports also provide a concise summary of critical quality performance data for each plan, as well as the EQRO's assessment of strengths and opportunities for improvement.

Each year, the state reassesses each plan's progress in addressing and improving identified problem areas. If any deficiencies are identified through the operational review, the plan will be issued a Statement of Deficiency (SOD), which specifically identifies areas of non-compliance. The plan will be required to submit a Plan of Correction (POC), which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Follow-up visits may be conducted as appropriate to assess the plan's progress in implementing its POC. Performance improvement

As per STC 24b.ii, OHA will contractually require each CCO to address four of the quality improvement focus areas, using rapid cycle improvement methods to:

- Study the extent and unique characteristics of the issue within the population served,
- Plan an intervention that addresses the specific program identified,
- Implement the action plan,
- Study its events, and
- Refine the intervention.

Performance improvement

Advancing PIPs

Moving forward, the PIP strategies are maturing into use of technology around care coordination and expanding into integrated practices. Allowing for the CCOs who have developed data monitoring systems, case management programs, and measurement alignment to develop initiatives in the space of social determinants of health will be key continuing to push health transformation. Additionally, lessons learned from the 2012–2017 demonstration for PIP implementation have led to the development of SMART (specific, measurable, attainable, relevant, timely) objectives with a corresponding measurement for monitoring progress. Future technical assistance and monitoring will continue to focus on these quality improvement foundations.

PIP focus areas

To move forward in testing and implementing improvement strategies, the CCOs will be required to conduct four performance improvement projects. Two of the four will be selected from the focus area list by the CCO, the third will be a statewide PIP under the “integration of health” focus area, and the fourth PIP will be a statewide substance use disorder PIP. The quality improvement focus areas, as referenced in Oregon’s 2017–2022 1115 Waiver Attachment X are:

1. Reducing preventable re-hospitalizations;
2. Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, aligned federal and state programs;
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers;
4. Integration of health: physical health, oral health and/or behavioral health;
5. Ensuring appropriate care is delivered in appropriate settings;
6. Improving perinatal and maternity care;
7. Improving primary care for all populations through increased adoption of the Patient- Centered Primary Care Home (PCPCH) model of care, and
8. Social determinants of health

In addition, CCOs are required by contract to demonstrate improvement in care coordination for members with serious and persistent mental illness. PIP focus areas are subject to change as CCOs mature.

External Quality Review Organization (EQRO) activities

OHA has contracted with an EQRO to support monitoring of quality in the CCO delivery system. In compliance with federal regulations, the scope of work includes all mandatory activities: compliance reviews every three years, validating health plan PIPs; and performance measure validation including information system capability assessment (ISCA), and preparing an EQRO technical report for each Medicaid managed care plan.

The contract also ensures the ability to negotiate optional activities, including encounter data validation, the conduct of focused studies and/or PIPs, PM calculations described above and beyond what the state and/or plans calculate, and administration and/or validation of consumer and provider satisfaction surveys.

Surveys

OHA conducts an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of approximately 45,000 members, asking them to report on and evaluate their experiences with health care. The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

Seventeen CAHPS measures (ten for adults and seven for children) are included as state quality measures under the current (2017–2022) waiver and are reported annually in the CCO Performance Report. Comprehensive CCO-level and OHP-level CAHPS survey results are also reported annually in separate reports.

IV. Quality components

Quality management plans

Managed care plans are required to have internal quality management plans to participate in the Medicaid managed care program. Plans must document structures and processes in place to assure quality performance.

Transformation and quality strategy

The transformation and quality strategy (TQS), developed in 2017, incorporates all components of the Quality Assessment and Performance Improvement (QAPI) program. The QAPI has been incorporated into the CCO's TQS and will address health transformation, quality and performance management while ensuring compliance with state and federal regulations. The TQS specifically focuses on CCO documentation of key efforts across the following components, as well as documentation of the CCO's overall quality program within the CCO's larger strategic plan:

- Access: quality and adequacy of services
- Access: cultural considerations
- Access: timely
- Behavioral health integration
- CLAS standards
- Grievance and appeal system
- Health equity: data
- Health equity: cultural responsiveness
- Oral health integration
- Patient-centered primary care home: member enrollment
- Patient-centered primary care home: tier advancement
- Serious and persistent mental illness
- Social determinants of health & health equity
- Special health care needs
- Utilization review

CCO TQS documentation will be monitored to ensure a robust CCO quality and transformation program, in accordance with best practices and CFR. This includes a formal OHA assessment and scoring of each CCO TQS submission with actionable feedback to support continuous quality improvement. The TQS will also be used as a basis for peer sharing of evidence-based and emerging best practices to further health transformation across CCOs. See “Expectations of CCOs” section above for further details.

Health equity plan

As a CCO 2.0 contract deliverable, CCOs are required to develop and submit a yearly health equity plan. The health equity plan aims to provide the CCO and its stakeholders a clear framework to becoming an organization that values and prioritizes health equity. The framework includes an action plan detailing where the CCO is headed, what it plans to achieve, the methods it will use, and milestones to monitor progress. A successful health equity plan is built on a thorough analysis of the existing CCO structure, governance, staff, program or service mix, collaborations and resources, including financial, human, technical and material. This analysis is vital because it allows an organization to understand which components it must change to achieve its goals related to health equity.

OHA requires all CCOs to develop a health equity plan that:

- Acts as a catalyst to initiate the deep organizational changes needed to build equity and diversity into service planning and delivery in the organization, community and provider network;
- Creates the foundation to build equity into ongoing accountability, resource allocation and performance management relationships between OHA, the CCO and the provider network;
- Provides a visible and concrete context for widespread discussion of health equity – within individual organizations, within sectors, across sectors, and in the wider community; and
- Incorporates and operationalizes the health equity definition.

Performance improvement projects

Statewide PIP

[content]

Statewide PIP – SUD

[content]

Overview of CCO PIPs

Under Oregon’s 1115 2012–2017 demonstration waiver, CCOs developed performance improvement projects (PIPs) in a few key areas: high utilizers, maternal care, increased patient assignment within PCPCH medical homes, and diabetes care for individuals with serious and persistent mental illness. Development of effective coordination strategies across health systems, primary care, specialty care and hospital systems for high utilizers and reducing rehospitalizations is an ongoing effort. The PIPs initially focused on breaking down the silos of care and expanding care delivery to team-based approaches. A few key lessons learned from adolescent well-care visits and maternal health have been helpful in providing for patients’ social determinants of health (food insecurity, stable transitions, supportive services); therefore, an additional focus area has been added for CCOs to test new models in the area of social determinants of health.

Access

Network adequacy

Monitoring access to care includes, but is not limited to, review of access to networks of providers and provider access for members across the diverse regions of Oregon. Access standards will be developed in accordance with the 2016 CMS Medicaid and Children's Health Insurance Program (CHIP) rules.

Monitoring will be through analysis that includes, but is not limited to: CCOs assessment of whether they are meeting State time and distance standards (primary care provider and patient-centered primary care home); wait time and time to appointment standards (Oregon Administrative Rules); and demonstration with MOU and wraparound services plans that the CCO is aware of gaps in access and is actively coordinating with community partners to provide access to all elements of integrated care required in Oregon.

DSN

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Provider Oversight

Provider contract

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Credentialing

CCOs and MCO plans must institute a credentialing process for their providers that includes, at a minimum, obtaining and verifying information such as valid licenses; professional misconduct or malpractice actions; confirming that providers have not been sanctioned by Medicaid, Medicare or other state agencies; and the provider's National Practitioner Data Bank profile. FFS providers are also enrolled through the state's Provider Enrollment Unit, which confirms that Medicaid, Medicare or other state agencies have not sanctioned providers. ~~The Provider Enrollment Unit also checks providers' National Practitioner Data Bank Profile.~~ Additionally, all credentialed providers must verify regularly through the Office of Inspector General and SAMHSA for compliance with conflict of interest standards.

Policy requirements include standards on credentialing, privileging, conflict of interest compliance including time and interval of credentialing functions. CCOs must also work with OHA to assure proper credentialing of mental health programs, associated providers and traditional health care workers. See Appendix X for a list of contractual elements and associated OARs.

Licensing

CCOs and MCOs must ensure all licensed or certified providers maintain active licenses or certifications. The CCOs and MCOs must monitor provider licenses and certifications for any adverse action from a licensing or certifying entity and develop a process for reviewing a provider's contractual status due to any adverse action. All actions against a provider's license, certification or contractual status with a CCO or MCO must be immediately reported to the Provider Enrollment Unit through the OHA.Provider.Review@dhsosha.state.or.us email address. Adverse action reports must include the provider information, the action taken by the CCO or MCO and all supporting documents.

Member Satisfaction

Ombuds team

[content]

Medicaid Advisory Committee

The Medicaid Advisory Committee (MAC) is a federally mandated body that advises OHA and DHS leadership, the Oregon Health Policy Board, the Legislature and the Governor's office about the operation and administration of the Oregon Health Plan from a consumer and community perspective. The MAC's role includes reviewing Oregon's Medicaid Quality Strategy, changes to OHA's quality rating strategy for managed care organizations, managed care marketing materials, and the access monitoring plan for OHP members enrolled in the Open Card plan (FFS Medicaid). Additionally, the MAC receives information about CAHPS survey findings, Ombuds Program updates, grievance and complaint data trends, and CCO deliverables that provide visibility into Oregon's health transformation from a consumer experience lens.

Grievances and appeals

On a quarterly basis, plans must submit a summary of all complaints registered during that quarter, along with a more detailed record of all complaints that have been unresolved for more than 45 days. A uniform report format has been developed to ensure that complaint data is consistent and comparable. OHA uses complaint data to identify developing trends that may indicate a problem in access, quality of care, and/or education. Grievance and appeals reports also identify FFS provider trends.

Improving upon the uniformed report will be the next step with administrative simplification through technology updates to the report, which will lead to deeper analysis for trend reporting. Analysis through the updated automated report will provide greater detail for health system (oral health, behavioral health, physical health) delineation of complaints origin and tracking of topic issues (e.g. non-emergency medical transportation) across the CCOs simpler. Potential changes also include developing systems for details regarding dual eligible client complaint tracking to ensure a smooth transition from passive enrollment.

Surveys

Seventeen CAHPS measures (ten for adults and seven for children) are included as state quality measures under the current (2017–2022) waiver and are reported annually in the CCO Performance Report. Comprehensive CCO-level and OHP-level CAHPS survey results are also reported annually in separate reports.

Quality payment programs

Medicaid Efficiency and Performance Program

Performance Based Reward (PBR) is a financial incentive program under CCO 2.0 designed to incentivize spending on health-related services, while controlling costs, maintaining quality and improving efficiency. One component of PBR is the Medicaid Efficiency and Performance Program (MEPP); CCOs must participate in MEPP work to be eligible for PBR. MEPP is based on an efficiency and quality algorithm that reviews claims data and identifies adverse actionable events (AAE) — downstream medical complications that could potentially be avoided with better upstream care. CCOs are asked to

design interventions for three different types of episodes (such as diabetes, SUD, and asthma) with the goal of improving outcomes as measured by AAE.

Qualified directed payments

CCOs are required by contract to administer qualified directed payments (QDPs) as directed by OHA, and as approved by CMS. OHA will continue to follow federal guidance on how to reference this quality strategy to support the quality improvement goals of each QDP.

Fiscal monitoring

Fraud, waste and abuse

The plan must submit complaints of fraud or abuse that are made to or identified by the plan and warrant preliminary investigation. The plan must also submit the following information on an ongoing basis for each confirmed case of fraud and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees, or any other source:

- The name of the individual or entity that committed the fraud or abuse;
- The source that identified the fraud or abuse;
- The type of provider, entity, or organization that committed the fraud or abuse;
- A description of the fraud or abuse;
- The approximate dollar amount of the fraud or abuse;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and
- Other data or information as requested.

Concerns related to FFS provider networks are identified through ongoing provider services and client services reviews.

Surveys

CAHPS

OHA conducts an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of approximately 45,000 members, asking them to report on and evaluate their experiences with health care. The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

MIPs

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V. Quality measurement

Performance measures

[content]

Quarterly and annual financial statements

[content]

Work plan

[content]

VI. Quality Strategy governance

Quality structure

The Oregon Health Authority (OHA) is comprised of subject matter experts in evidence-based care, contract compliance, quality assurance, population health management, performance management, and quality improvement across the agency to support the monitoring and improvement of the health delivery system. Quality and health transformation elements are monitored at the programmatic level with key agency-wide committees responsible for oversight and planning. Underpinned across the quality and health transformation elements are health equity and social determinants of health with key contributions at the leadership committee level.

Oregon Health Authority structure to support quality and access monitoring:

- Oregon Health Authority
 - Oregon Health Policy Board
 - OHA Quality Council
 - Managed Care and CCO Collaborative
 - Quality Management Program and contract compliance
- Health delivery systems
 - Quality and Health Outcomes Committee
 - Health Evidence Review Committee

Review of Quality Strategy

The OHA Quality Strategy shall be reviewed annually by OHA. The OHA Quality Strategy review and update will be completed by December of each year and submitted to CMS, upon significant changes, in the subsequent quarterly report update.

The OHA Quality Council shall have overall responsibility to guide the annual review and update of the Quality Strategy. The review and update shall include an opportunity for both internal and external stakeholders to provide input and comment on the Quality Strategy. Key stakeholders shall include, but are not limited to:

- Addictions and Mental Health Planning and Advisory Council*
- Medicaid Advisory Committee*
- Health Systems Division Executive Team
- Health Policy and Analytics Management Team
- OHA Executive Team
- CCO Medical Directors
- FFS Contractors
- CCO Quality Management Coordinators
- Local Government Advisory Committee*

- DHS Internal Stakeholders
- OHA Internal Stakeholders
- Health Equity Committee*

* Committees including consumer representatives.

The Quality Strategy and subsequent updates will be posted online for a two-week public comment period before they are submitted to CMS for approval. Final versions will be posted on the OHA website.

Enforcement

The OHA managed care program has an enforcement policy for data reporting, which also applies to reporting for quality and appropriateness of care, contract compliance and reports for monitoring. If a plan cannot meet a reporting deadline, a request for an extension must be submitted in writing to the division. The division will reply in writing as well, within one week of receiving the request. Plans that have not submitted mandated data (or requested an extension) are notified within one week of non-receipt that they must: (1) contact the division within one week with an acceptable extension plan; or (2) submit the information within one week.

Enforcement options for plans that are out of compliance are progressive in nature, beginning with collaborative efforts between OHA and the plans to provide technical assistance and to increase shared accountability through informal reviews and visits to plans, or increased frequency of monitoring efforts. If these efforts are not producing results, a corrective action plan may be jointly developed and the plan monitored for improvement. More aggressive enforcement options that OHA may apply include restricting enrollment, financial penalties and ultimately, non-renewal of contracts.

Conditions that may result in sanctions:

1. Fails substantially to provide medically appropriate services that the contractor is required to provide, under law or under its contract with OHA, to a member covered under this contract;
2. Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medical Assistance Program;
3. Acts to discriminate among members on the basis of their health status or need for health care services. This includes, but is not limited to, termination of enrollment or refusal to reenroll a member, except as permitted under the Medical Assistance Program, or any practice that would reasonably be expected to discourage enrollment by individuals whose medical condition or history indicates probable need for substantial future medical services;
4. Misrepresents or falsifies any information that it furnishes to CMS or to the state, or its designees, including but not limited to the assurances submitted with its application or Enrollment, any certification, any report required to be submitted under this contract, encounter data or other information related to care of services provided to a member;
5. Misrepresents or falsifies information that it furnishes to a member, potential member, or health care provider;
6. Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210 and this contract;
7. Fails to comply with the operational and financial reporting requirements specified in this contract;

8. Fails to maintain a participating provider panel sufficient to ensure adequate capacity to provide covered services under this contract;
9. Fails to maintain an internal quality improvement program, or fraud and abuse prevention program, or to provide timely reports and data required under Exhibit B, Part 1 through Part 9 and Exhibit L, of the model contract;
10. Fails to comply with grievance and appeal requirements, including required notices, continuation or reinstatement of benefits, expedited procedures, compliance with requirements for processing and disposition of grievances and appeals, and record keeping and reporting requirements;
11. Fails to pay for emergency services and post-emergency stabilization services or Urgent care services required under this contract;
12. Fails to follow accounting principles or accounting standards or cost principles required by federal or state laws, rule or regulation, or this contract;
13. Fails to make timely claims payment to providers or fails to provide timely approval of authorization requests;
14. Fails to disclose required ownership information or fails to supply requested information to OHA on subcontractors and suppliers of goods and services;
15. Fails to submit accurate, complete, and truthful encounter data in the time and manner required by Exhibit B, Part 8, Section 7;
16. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the state or that contain false or materially misleading information;
17. Fails to comply with a term or condition of this contract, whether by default or breach of this contract. Imposition of a sanction for default or breach of this contract does not limit OHA's other available remedies;
18. Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations;
19. Fails to submit accurate, complete and truthful pharmacy data in the time and manner required by Exhibit B, Part 8, Section 7; or
20. Violates any of the other applicable requirements of 42 USC §1396b(m) or 1396u-2 and any implementing regulations.

Technical report

The technical report provides a feedback loop for ongoing quality strategy directions and development of any technical assistance training plans. In addition to the statement of deficiencies and resulting plans of correction, findings from the operational reviews may be used in future qualification processes as indicators of the capacity to provide high-quality and cost-effective services, and to identify priority areas for program improvement and refinement.

Appendix A: CCO Contract

Appendix B: Quality definitions

Disability in adults

The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) that can be expected to result in death or that have lasted or can be expected to last for a continuous period of not less than 12 months.

Disability in children

Under title XVI, a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Source: <https://www.ssa.gov/disability/professionals/bluebook/general-info.htm>

Sections to add:

Care coordination

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Dual eligible

CCO contractors must be an affiliate of, or contract with, one or more entities that provide services as a Medicare Advantage Plan, and they must ensure their provider network is adequate to provide both the Medicare and the Medicaid Covered Services to its dually eligible members. CCOs must have a Coordination of Benefits Agreement (COBA) with CMS. These requirements are found in the CCO contract, Exhibit B – Statement of Work – Part 8. Dual eligible individuals will generally be auto enrolled into a CCO with an option for them to opt out of managed care to FFS. The requirements for enrollment of dually eligible individuals into CCOs are according to OAR 410-141-3805.