Ombuds Program

Progress Report







Findings and recommendations from previous reports: 2019 – 2022

Oregon Health Authority

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INTRODUCTION

Oregon Health Authority (OHA) responds to Ombuds reports as an audit with a formal response and implements an action plan to address findings. This document:

- Reviews formal recommendations made in previous OHA Ombuds reports.
- Highlights key successes, progress forward and gaps in resolving each finding/problem.

OHA's response to the 2021 report and update on activities since the six-month Ombuds 2022 report highlighted positive actions in many areas. However, OHA still needs to act on many critical needs to improve OHP member access to care.

Regular updates and all current and previous Ombuds reports can be found on the OHA Ombuds Program Reports page.

STATUS UPDATES BY TOPIC

Care coordination

1st and 2nd Quarter 2019

Finding	Recommendation	Status
Member Care Coordination experience is not consistent and does not occur for all members who would benefit. Ombuds cases consistently reflect gaps in: a) Care coordination access for members; b) Member awareness of this service, and	OHA should: • Update care coordination rules and contracts to close gaps and set definitions and standards. • Work with CCOs to identify challenges and opportunities for implementing care coordination and	**Successes** Transformation Center learning collaborative with CCOs held throughout 2022 on Care Coordination brought technical assistance and further identification of gaps where clear internal OHA guidance is needed.

Finding	Recommendation	Status
c) OHA's lack of definition and standards for member care coordination. Specific populations facing additional care coordination needs are: a) OHP members who, for various reasons, are not tied to one geographic area of the state. These reasons include college attendance, houselessness and housing instability, child welfare involvement, and residential mental health or substance use disorder treatment. b) OHA identified priority populations and c) Other populations facing health inequities. Ensuring this fundamental element of Oregon's Coordinated Care Model is implemented equitably for all members, both FFS and CCO enrolled, is a significant area where both OHA and CCOs have opportunity to improve.	Intensive Care Coordination (ICC) requirements. • Ensure clear guidance in contract and rule and through technical assistance to ensure CCO and FFS care coordination links members to Medicaid-funded services carved out of CCO contract including: children's Wraparound services; 1915(i) and State Plan Personal Care Support Services for members with behavioral, developmental or physical disabilities and other services not covered by Medicaid including housing supporting and other social determinants of health-related services.	**Progress forward** OHA began in late 2022 an internal workgroup to revise Care Coordination rules. This workgroup plans to continue working closely with CCOs and incorporate member experiences in 2023. FFS program expensing work to review and strengthen FFS member care coordination through KEPRO contract including data that reflect member experience and include warm transfers for FFS members. **Gaps** Updated consistent rules have not been implemented despite long identified need. OHA has consistently failed to dedicate sufficient Subject Matter Expert staff to lead in this critical work area. Lack of HSD care coordinator subject matter expert; lack of alignment between contracts and rules on priority populations for care coordination. Need to prioritize care coordination within OHA compliance team from a member center-centered perspective. OHA provision of Care Coordination to FFS members does not currently apply the same expectations and level of support that OHA expects of CCO care coordination through existing contract obligations.

1st and 2nd Quarter 2021

Finding	Recommendation	Status
Ombuds cases reflect OHP members with physical and mental health needs seen in hospital emergency departments who are not admitted but whom have significant needs that care coordination could support.	OHA and CCOs should leverage ways to ensure appropriate care, treatment and coordinated discharge planning for individuals who present in emergency departments in physical and/or mental health crisis even when OHP members are not admitted to a hospital.	**Successes** **Progress forward** Beginning work at OHA has begun to support coordinated discharges from the Oregon State Hospital in coordination with CCOs. **Gaps** Similar attention and processes are needed for other hospitals and health systems throughout Oregon. In 2022, 522 unhoused individuals passed away.
OHA Quality Assurance Team has many areas of the CCO contract to provide oversight of. Care Coordination would benefit from additional oversight and guidance around Care Coordination by OHA. Additionally, current compliance actions do not include FFS nor does it integrate member experiences as part of the compliance review.	OHA should prioritize care coordination as a compliance action within CCO and FFS reviews. This must center member experience accessing care coordination through review of individual cases and complaints, from secret shopper surveys, member satisfaction surveys, and other methods within compliance review.	**Successes** **Progress forward** FFS working to implement an overall metrics framework and align with CCO metrics. FFS program plans to implement a CAC. CAC has potential to build member voice into OHA compliance framework. This is not yet implemented or operational. Work to center member experience and feedback in Care Coordination rules guidelines began in late 2021 and will engage members and CCOs to address areas of concerns and challenges with the current system. OHA has contracted with HSAG to conduct a review of CCOs' compliance with federal (42 CFR 438) and state regulations that address standards related to access, structure and operations,

Finding	Recommendation	Status
		and quality measurement and improvement. Within each three-year compliance cycle, the EQRO will review a full set of standards, with follow-up being conducted during subsequent years to assess corrective actions taken to address deficiencies. One of the standards reviewed by the EQRO is "Coordination and Continuity of Care," which includes a review of all federal and state requirements for care coordination. The standard was reviewed in 2020 and is being reviewed again in 2023. Results from the 2020 review can be found here. In 2023, the EQRO will conduct a secret shopper survey to assess timeliness to appointments.
		Gaps

Enrollment and transitions

Calendar Year 2020

Finding	Recommendation	Status
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	Prioritize agency resources to ensure same-day enrollment into OHP for infants born to OHP mothers: • Utilize the mother's Medicaid ID for billing purposes until the infant has their own Medicaid	**Successes** Oregon's new 1115 Demonstration Waiver includes continuous OHP eligibility from birth until age six. Once enrolled into OHP children's continuous coverage on Medicaid/PHP will be protected for six years.

Finding	Recommendation	Status
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.	ID. This allows time for an OHP identification to be created for the infant and is allowable under Social Security Act, Section 1902(e)(4)) and 42 CFR 435.117 (c)6 • Generate separate Medicaid ID for infants and provide them to expectant mothers during pregnancy, or • Institute Oklahoma's model of an electronic system where hospitals enter newborn's information into an electronic software interface prior to release that allows for a Medicaid ID to be issued in real time.	**Progress forward:** Planned change request in beginning 2024 to have next-day CCO enrollment after enrollment into OHP. **Gaps** Continue to explore barriers to OHP enrollment and notification challenges. As redeterminations begin for all 1.4 million OHP members in April 2023, timely enrollment of newborns into OHP is likely to face additional strains and barriers due to increased overall workload to conduct OHP member redeterminations.

1st and 2nd Quarter 2021

Finding	Recommendation	Status
Eligibility and enrollment transition concerns to the Ombuds Program have increased, rather than decreased, over time. • In 2019, 12% of Medicaid concerns were related to enrollment and eligibility. • In 2020, the percentage increased to 14%. • In 2021, the percentage was 24.34%. These concerns range from confusion around eligibility notices, inability to reach	Ensure same or next-day enrollment into CCOs for new members and from one CCO to another when transitions occur.	**Progress forward** Planned change request in beginning of 2024 to have next-day CCO enrollment after enrollment into OHP. The Medicaid Management Information System (MMIS) technical team started meeting January 2023 to review and begin designing this technology change. Based on technology limitations within MMIS and CCO systems, the technical team is preparing to design the initial change to enroll member on "next [business] day" of OHP effective date. The team is

Finding	Recommendation	Status
the Oregon Eligibility (ONE) call center for timely assistance, and delays in CCO enrollment when transitions of any kind (such as leaving a justice setting, moving from one part of the state to another, household changes) occur.		beginning to engage CCOs to better understand their automated notification processes.

Language access and equity

1st and 2nd Quarter 2021

Finding	Recommendation	Status
Ombuds concerns when working with members with Limited English Proficiency (LEP) indicate both OHA and CCO lack of understanding that LEP members are often less likely to complain in the same way or use the established complaint mechanisms that English-speaking members may use, such as filing a formal complaint with their CCO. This is due to many reasons including language barriers and different cultural practices of voicing complaints within medical settings. This can also disproportionally impact members' interest in appealing or requesting a hearing on a denial.	OHA and CCOs should: • Use feedback from, and the voice of, trusted community partners as a proxy for CCO complaints. • Review member appeals in response to a CCO- or FFS-generated Notice of Adverse Benefit Decision (NOABD) by language, race and ethnicity, to determine if LEP members or other populations are less likely to appeal NOABDs. • Develop auditing strategies to ensure language access services are active and accessible across all medical provider offices. For example, secret shopper pilot projects.	**Successes** As part of OHA's efforts to identify and eliminate health equities, The Equity and Inclusion Division led efforts to develop and approve an agency-wide health equity metric focused on providing quality and meaningful language access for CCO members with LEP or who are Deaf and hard of hearing. This upstream metric has two components: (1) CCO language access self-assessment and (2) Quantitative language access utilization documenting the percent of CCO member visits with interpreter needs in which OHA credentialed interpreter services were provided. Results from the first two measurement years show that CCOs have made measurable improvements in offering

Finding	Recommendation	Status
	• Build member experience and voice into OHA's compliance framework for CCO and FFS language access.	meaningful language access to CCO members **Progress forward:** CCOs have made progress but still fall short of quality targets for language access metric. FFS program is conducting initial work to implement FFS metrics and align to CCO metrics. Future work to develop a CAC could support incorporating member voice into FFS work. In 2024, CCO QA unit will launch a second round of secret shopper surveys (another round will be launched in 2023) and we will assess access to language access services at appointments. Currently, the CCO QA unit is building out a process to engage members more directly in providing feedback to compliance related issues (e.g., Network Adequacy member survey and video, member engagement through Ombuds Council and MAC). The CCO QA team will be working with Ombuds and our HSD Complaints team to understand trends and patterns in member complaints that might be helpful in identifying compliance issues. **Gaps**

Mental health and substance use disorder

Calendar Year 2020

Finding	Recommendation	2022 Status
Inequities in access based on mental health disability is a significant equity concern within Oregon's Medicaid program. OHP members can have in-home supports for mental health disabilities, just like people can have in-home supports for physical, intellectual and developmental disabilities (I/DD). The Oregon Department of Human Services (ODHS) determines eligibility for physical and I/DD in-home supports. OHA determines eligibility for mental health supports. The Ombuds Program worked with individuals who first sought services and supports based on physical disability. When ODHS determined that the individual needed support based on a mental health disability, the individual had to go through a new and separate evaluation process with OHA. This delayed the individual's access to services they qualified for. The Ombuds Program also encountered confusion among agency staff, CCO care coordinators, and family members of those seeking services about the process to get approval for mental health in-home services and supports	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.	**Gaps** This recommendation is the focus of the 2022 report with additional recommendations and findings of significant gaps. Bed capacity for in-home residential supports. Placements are easier to find on basis of physical disability.

1st and 2nd Quarter 2021

Finding	Recommendation	Status
Adequate access to mental health and SUD providers, and thus all behavioral health services, is a significant challenge for OHP members. Specific Ombuds concerns in this area include: a) The need for timely and accessible mental health and SUD care at all levels of care; b) Inadequate mental health residential treatment and system capacity, for both children and adults; c) Underutilization of Traditional Health Workers, particularly Peer Support Specialists (PSS) and Peer Wellness Specialists (PWS); and d) Insufficient statewide capacity for inpatient services, with member access further limited by CCO provider networks that may not work with all inpatient facilities willing to accept OHP members.	Report behavioral health capacity annually to support understanding the extent of Oregon's behavioral health capacity crisis and monitoring for its resolution and evaluate adequacy of provider networks for OHP members statewide by CCO. Specifically: • Number of adult / child ED visits driven by mental health and SUD by region and by CCO; • Number of adults and children held in EDs for more than one day as a result of mental health and SUD health issues; For FFS and each CCO: • Number and types of mental health and SUD providers enrolled in OHP; • Number and types of mental health providers open to receiving new patients; • Average waiting time for first new mental health/SUD patient appointment. • Average and per CCO percentage of capitation that is spent on mental health.	**Successes** SUD inventory and gap analysis report conducts analysis by county but does not review by CCO capacity. https://www.oregon.gov/adpc/Pages/gap-analysis.aspx **Progress forward** OHA Quality Assurance team conducting enforcement of contractual requirements for Intensive-Home Behavioral Health Treatment and are putting three CCOS that are not in implementing on corrective action plans. Plans to incorporate program quality review of IHBH services in 2023. Quality Assurance team conducted Network Adequacy review, found here, based off of existing time and distance standards and has begun work in 2022 to develop further network adequacy standards that may be able to support additional network adequacy gaps in a more detailed way. **Gaps** Significant gaps are highlighted in the body of this report.

Finding	Recommendation	Status
Requests to be able to continue therapeutic relationships with mental health providers not part of a CCO network for both inpatient and outpatient services.	Where adequate networks do not exist for outpatient and inpatient mental health and SUD services, allow network access for any licensed providers within the state.	**Gaps** This recommendation has not been implemented. Network adequacy and capacity is a significant barrier faced by CCO and FFS members. This recommendation would need a CCO contractual change.
Underutilization of Traditional Health Workers, particularly Peer Support Specialist and Peer Wellness Specialists (PSS and PWS).	Increase member understanding about how to access Peer Support Specialist and Peer Wellness Specialists (PSS and PWS) for help with CCO/mental health system navigation for adults, families and children.	**Successes** Rate increases for all behavioral health providers including THWs. OHA Quality Assurance team model member handbook provides information about CCO PSS and PWS and how CCO members can access them. https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-QA-Materials.aspx **Progress forward** OHA has increased behavioral health payment rates, including for THW. **Gaps** Work is needed regarding 1915i rates, so THW rates are paired with basic H0038 PSS rates and then in addition add optional travel and off-site modifiers for the provider.

Non-emergent medical transportation (NEMT)

Calendar Year 2021

Finding	Recommendation	Status
Fewer than 10 percent of OHP members use NEMT services, and even then NEMT made up approximately 6 percent (99) of all Medicaid concerns. Most were about late or "no show" rides for members. This often results in members being unable to access their medical care and in some cases being fired by their providers for too many missed or late appointments		**Successes** OHA established an internal NEMT workgroup on February 22, 2022, to explore NEMT challenges and how it impacts access to health care including review of systems, processes, member-specific complaints, examining NEMT rules and contracts. **Progress forward** Working towards implementing engagement plans through a Technical Advisory Committee structure, to include OHP members. The goal is to develop strategies to change state rules and contracts in a way that centers and advances equity, and improves access, compliance, and efficiency. **Gaps** Existing OHA process improvement is foundational but has not yet resulted in overall systems improvement for OHP members access to and quality of NEMT services.

Finding	Recommendation	Status
Part of NEMT benefit includes mileage reimbursement for members who are travelling for medical and use their own vehicle. It also includes food and lodging reimbursement for medical treatment requiring overnight trips (such as accessing specialty care in a region outside of the home CCO region). These reimbursement rates had not been reviewed or increased since December 2001 and are currently set at 25 cents per mile, $40 per night for lodging, and $12 food cost total per day.	Increase mileage, food and lodging rates for NEMT benefit to align with present-day cost of living.	**Progress forward** The OHA internal NEMT workgroup, with Ombuds Program advocacy, elevated and prioritized mileage rate reimbursement. OHA staff are working on requesting CMS approval to increase the mileage reimbursement to 75% of the IRS Standard Rate, with plans to have this completed by Fall 2023.

Member billing

2nd Quarter 2022

Finding	Recommendation	Status
OHP member billing concerns are one of the top reasons why individuals come to the Ombuds Program. Between 2019-2022, they made up between 7 to 12 percent of OHA Ombuds Medicaid concerns annually and 7 percent (3,638) of all member complaints to CCOs annually. Member billing concerns represent systematic barriers at the provider, CCO, and OHA level.	Strengthen OHP member education and communications about member billing rights with a focus on culturally and linguistically accessible communication, including videos and other alternative communication formats. Prioritize training and support of enrolled providers. OHA's Health Systems Division (HSD) should enhance OHP Provider Services to strengthen provider recruitment and retention and offer education and	**Successes** **Progress forward** Updated member web page about what to do if bill received. This is available in top languages spoken by OHP members, Spanish and English social media posts and communication to providers about member billing rules. Plans in place to develop FFS clinical advisory committee; this can serve as a forum to elevate and support FFS providers. FFS work to become compliant with federal regulations so that

Finding	Recommendation	Status
	training about member billing, starting with providers serving FFS members. Currently, HSD provides very minimal education and training to providers. To leverage resources, best practices and equity-centered community engagement and communication with providers any new HSD initiatives should work in partnership with the Community Partner Outreach Program (CPOP) which supports and educates providers who are part of the Community Partner application Ensure strong oversight of member billing practices with enrolled FFS providers and work with CCOs to ensure strong oversight of member billing practices with CCO-contracted providers. Oregon's new OHP 1115 Medicaid Demonstration Waiver includes housing. CCOs and OHA should ensure that work to remedy members' credit scores when damaged by medical debt is part of program implementation	FFS members receive a denial notice for services. This will provide clear information on appeals process and a path to discover if provider billed for services. **Gaps** No current plan to provide videos or alternative communication format about billing. No budgeted positions or staff resources at OHA currently exist for provider education and outreach. Previous positions for provider training were re-allocated for other agency Medicaid administration needs. HSD FFS legislative requests for staff for provider training and outreach have not been approved for the previous four legislative sessions while need to support FFS providers to ensure payment best practices has increased.