Ombuds Program

2023 Year-End Report







Oregon Health Authority

Contents

EXECUTIVE SUMMARY

This 2023 year-end report presents no new concerns about Oregon Health Plan (OHP) access and quality of care. Instead, it elevates previous concerns and recommendations from past Ombuds reports in two specific areas:

- Meaningful language access and culturally responsive services, and
- Behavioral health network adequacy.

Through the 2025 coordinated care organization (CCO) procurement, Oregon Health Authority (OHA) can take meaningful action to address both statewide.

Program data

During 2023, the OHP service concerns most frequently brought to the Ombuds Program by members involved:

1. Specialty care (8.7%);
2. Mental health care (8.3%);
3. Dental care (7.4%);
4. Primary care (7.1%);
5. Non-Emergency Medical Transportation (5.2%).
6. Pharmacy (4.6%)

Recommendations

In addition to continuing work on previous recommendations, the Ombuds Program recommends that OHA establish:

- Enhanced Culturally and Linguistically Specific Services payments for dental and physical health providers.
- A new fee-for-service add-on fee to account for longer health care visits due to interpreter time.

OHA should also increase Ombuds Program capacity to allow the team to:

- Respond to the complexity of current multi-system casework that reflect statewide gaps in mental health and substance use disorder care for OHP members throughout Oregon, and
- Better channel member experience into advocacy for systems improvement.

BACKGROUND

Purpose

Oregon Revised Statute (ORS) 414.712 directs OHA to provide ombuds services for people who receive publicly funded health services. To do this, OHA's Ombuds Program advocates on behalf of OHP members for:

- Access to care,
- Quality of care, and
- Channeling member experience into recommendations for systems, policy, and program improvement.

The Ombuds Program is independent of Medicaid program implementation, operations, or compliance.

Work

The Ombuds Program does it's work by:

- Engaging with OHP members to resolve their challenges.
- Identifying trends and possible solutions.
- Quarterly reports to the Governor, the OHA Director, and the Oregon Health Policy Board. The year-end and six-month reports provide recommendations for improving equity and access for OHP members.

Since 2019, the Ombuds Program has:

- Grown in volume and work scope.
- Made over 40 specific and measurable recommendations to improve OHP member access to care and quality of care.

Recommendations cover nine areas:

1. Adult mental health and substance use disorder (2022)
2. OHP member billing (2020)
3. Care coordination (2019)
4. Children's mental health (2023 six-month report)
5. Eligibility, enrollment, and transitions (2020)
6. Home and Community-Based Services (1915(i) and 1915 (k) (2022, 2023)
7. Meaningful language access and culturally responsive services (2020, 2023)
8. Non-emergency medical transportation (NEMT) (2021)
9. Network adequacy (2022, 2023)

OHA's health equity definition states:

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.

Findings and recommendations

To address Ombuds Program findings, OHA:

- Provides a written response to Ombuds reports and
- Implements an action plan.

The Ombuds Program tracks all recommendations and OHA's progress in addressing concerns. Ombuds reports and a dashboard with previous and current recommendations since 2020 are available on the OHA website.

OHA has acted on several Ombuds Program recommendations. Other recommendations need further support and prioritization. Several are essential if OHA is to operationalize its commitment to eliminating health inequities by 2030.

Member concerns addressed by the Ombuds Program represent challenges experienced by others. One member's experience gives voice to others. To create health with community, OHA must:

- Listen and learn from individual concerns.
- Recognize each concern as an opportunity to identify system improvements.

OHA also has an obligation to be most attentive to concerns impacting health equity. The Ombuds Program's member-centered advocacy helps state agencies be responsive, transparent, accountable and center equity.

RECOMMENDATIONS

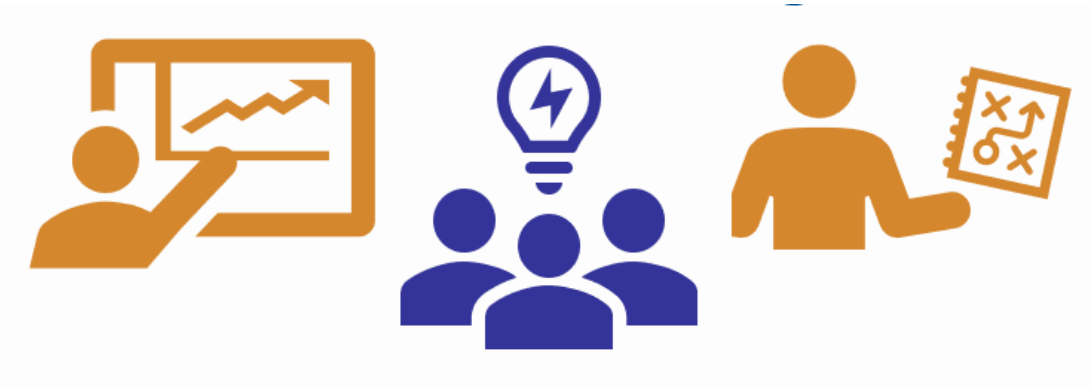
This 2023 year-end report presents no new concerns. Instead, it elevates previous years' report concerns and recommendations in two specific areas:

- Meaningful language access and culturally responsive services and
- Behavioral health network adequacy.

OHA must further prioritize both areas to focus on eliminating health inequities for OHP members most harmed by historical and contemporary injustices. Success requires significant coordination, including programmatic prioritization and funding between

- OHA Medicaid and Behavioral Health divisions,
- CCOs and other state contractors and
- The Oregon Legislature.

Oregon should prioritize culturally and linguistically responsive services and behavioral health network adequacy as part of CCO procurement in 2025.



Ombuds listen and learn from OHP members. Ombuds then make recommendations that focus on health equity.

Culturally and linguistically responsive services

Successes

During the past four years, OHA has worked to support meaningful language access and culturally responsive services. Some successes include:

- A $60 add-on fee to providers for the cost of providing interpreter services at health ca re visits with fee-for-service (open card) OHP members.

- A CCO Incentive Metric to track progress providing meaningful language access to culturally responsive health care services.
- Enhanced provider payments for OHA-approved Culturally and Linguistically Specific Services (CLSS) behavioral health providers.
- Race, Ethnicity, and Language Disability (REALD) tracking to help understand who is most impacted by health inequities.
- Healthier Oregon Program began July 1, 2023. It provides full OHP benefits to people of all ages who meet income and other criteria, no matter their immigration status.
- Redeterminations and improved eligibility letters. The Ombuds Program received a large percentage of its 2019-2021 caseload from members who did not understand eligibility letters. This was particularly critical among members who preferred a language other than English. Language in letters has improved.

Member story: Healthier Oregon Program meets critical need

An individual came to the Ombuds Program for help with accessing medication. They met financial eligibility for OHP but were ineligible due to their immigration status. They were seen in an Emergency Department (ED) during the early part of 2023. They got critical medication and a prescription for a refill but could not use OHP to fill the prescription.

Thanks to full Healthier Oregon Program implementation, this problem should no longer occur as of July 1, 2023.

These successes lay a foundation for additional focused, intentional work.

Concerns

OHP members who prefer a language other than English or seek culturally responsive care still experience many gaps. They often:

- Experience more barriers to access,
- Are overwhelmed by a system that is too often impossible to understand and
- Sometimes receive poorer quality of care.

Ombuds see ongoing concerns when advocating for members who prefer a language other than English or seek other culturally and linguistically responsive services:

- No interpreter provided.
- Deaf and hard of hearing OHP members have trouble accessing accessible services.
- Barriers to requesting Health-Related Services (HRS) or Health Related Social Needs (HRSN) services.
- Canceled dental appointments because the client did not bring an interpreter with them and the clinic did not schedule one.
- Lack of providers that serve the member's specific culture or speak the member's language.

- Members who prefer a language other than English access specialty care services at a lower rate than English-speaking members.
- Neither OHA nor CCOs review appeals or hearings data by REALD data to identify inequities.
- Providers are unaware of resources and tools available to support language access for OHP patients.

The top language access and cultural responsiveness concerns addressed by the Ombuds Program from 2019-2023 were related to:

- Dental care,
- Primary care providers,
- Non-emergent medical transportation (NEMT),
- Specialty care and
- Emergency Department (ED) concerns.

The Ombuds Program continues to find gaps in OHP culturally and linguistically responsive care.

Complaints, appeals and hearings

Members who prefer a language other than English are often less likely to:

- Use available formal complaint processes or
- Contest decisions when a service is denied.

This is for many reasons, including inadequate language access. CCOs and OHA do not review complaints, appeals or contested case hearing requests by language or other REALD measures. This means CCOs and OHA may miss health inequities that prevent member who prefer a language other than English from asserting foundational member rights.

- **OHA and CCO review of member complaints, appeals and hearings using REALD data is critical.** OHA and CCOs should use this data to address identified inequities in access to care and quality of care.

Member story: Gaps in language and disability access

Ombuds received a call from an Intellectual and Developmental Disabilities (IDD) case worker. They called on behalf of a young adult OHP member in a mobility wheelchair. He relied on caregivers and support from his mother for communication and care.

His mother is an immigrant and does not speak English. The member is nonverbal due to his disabilities.

His mother took time off work to attend many monthly appointments with her son. They would rely on NEMT for pick up. NEMT was often late or did not show up. At the end of one ride, the driver dropped the member and his mom off in the pouring rain several blocks from the appointment.

When the mother called the NEMT company to file a complaint, the company would not accept the complaint. They said they must have a release of information from the member to take the complaint. This invalidated the member's experience, failed to elevate his voice, and did not account for language or disability accommodations.

Ombuds advocacy has focused on making sure all clients and their caregivers can have their concerns heard and resolved. It has also elevated the review of requirements for having access to an interpreter during NEMT.

- **Community partners and advocates' feedback is essential.** It is a proxy for member complaints. Community partners often hear first from members who are unlikely to formally complain or appeal due to language or cultural barriers.

OHA has begun work on both areas, but neither are fully operational.

Provider availability

Individuals impacted by health inequities in Oregon face more gaps in accessing OHP covered services. This is particularly true for mental health services. Finding a local provider is often difficult. Finding providers that offer culturally and linguistically aligned care is often impossible.

- **Network adequacy:** OHA should conduct a CCO network adequacy review for culturally and linguistically responsive providers.

ED boarding for youth in mental health crisis

Black or African American youth in mental health crisis often stay for longer than other youth in Oregon hospital emergency departments.

- **Prioritize development and implementation of culturally specific services** to eliminate racial and linguistic inequities in accessing mental health services, follow-ups from EDs, and overrepresentation of youth of color in ED boarding.

OHP member education

OHA does not strongly support or prioritize OHP member communication and education. This gap is even greater for members who need culturally and linguistically responsive services.

Strengthen OHP member education and communications with a focus on culturally and linguistically accessible communication, including videos and other alternative communication formats.

- Develop specific outreach and education for behavioral health literacy and stigma reduction. This will encourage earlier connection with behavioral health services for Healthier Oregon population and other populations experiencing barriers in accessing services.

  Increase member understanding of their right and how to access culturally and linguistically responsive services through their CCO or OHA[1].

OHP provider outreach and education:

The agency has significant gaps in organized, strategic provider outreach, recruitment

[1] OHA manages care for OHP members who are not enrolled in a CCO. Also known as fee-for-service or "open card" members, this group includes Tribal members, Medicare dual eligible members and some others.

and education.

- **Strengthen fee-for-service (open card) provider recruitment and retention.** OHA should enhance OHP Provider Services' engagement, outreach, education and communication. This includes training and support of enrolled providers. Currently, OHA provides very minimal education and training to providers. Medicaid work must be done in partnership with the Community Partner Outreach Program (CPOP). CPOP supports and educates providers who are part of the Community Partner application assisters' network. This will leverage resources, existing best practices and build upon equity-centered community engagement and communication with providers.

Interpreter availability

OHP members experience canceled appointments when interpreters are not available.

Enhance language access that supports all OHA members who may prefer a language other than English.

New recommendations

Enact enhanced CLSS payments for dental and physical health providers.

OHA pays approved Culturally and Linguistically Specific Services (CLSS)providers an enhanced fee-for-service rate. CCOs provide a similar increase through a qualified behavioral health directed payment. Since 2022, 104 providers have qualified as CLSS providers. OHA is working to expand this to substance use disorder treatment providers and Traditional Health Workers. OHA should study the feasibility of expanding upon work to further include physical and dental providers.

New fee-for-service add-on fee to account for longer office visits due to interpreter time

In addition to the $60 fee for the cost of hiring an interpreter, OHA should create an add-on fee for the cost of longer office visits when providers have interpreters.

Behavioral health network adequacy

Successes

OHA, CCOs and the Oregon Legislature have also worked to expand access to behavioral health care. These improvements include:

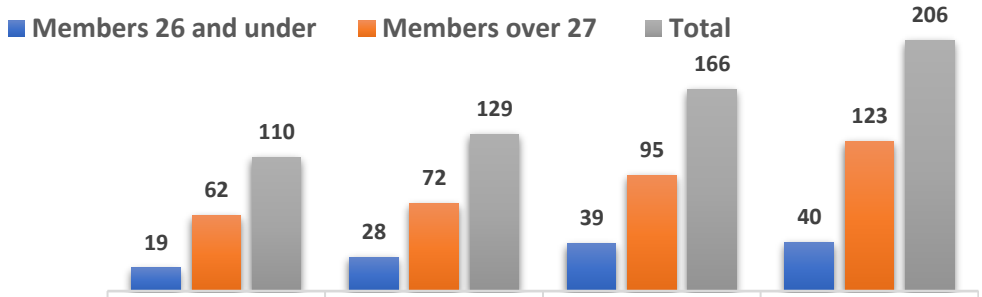
- Legislative funding and investment, primarily focused on adult behavioral health.
- OHA improving 1915(i) Home and Community-Based Services.

- Mobile Response and Stabilization Services program implementation. This program provides developmentally appropriate crisis response services for children, youth and young adults and their families or caregivers.
- Intensive In-Home Behavioral Health Treatment program implementation. This program is a community-based alternative to residential treatment and inpatient hospitalization for children.

Concerns

Even with these investments, OHP members still have gaps in access to care, often because of insufficient CCO and fee-for-service (open card) network adequacy.

Chart 1: Behavioral health concerns received (2020-2023)



	2020	2021	2022	2023
Members 26 and under	19	28	39	40
Members over 27	62	72	95	123
Total	110	129	166	206

Ombuds case work and advocacy for OHP member with substance use disorder and mental health concerns has increased 87 percent over the last four years.

The complexity of these concerns has proportionately increased. Adequate access to providers, and all supporting behavioral health services, is a significant challenge for OHP members. It is particularly true for members most harmed by health inequities. **OHA Medicaid and Behavioral Divisions must coordinate and identify shared solutions for OHP members and for all people in Oregon.** Children's mental health has had significantly fewer investments than adult mental health. Ombuds cases reflects critical care gaps in children's mental health.

OHP member story: Closed CCO network panel disrupts mental health care

An OHP member struggled to find a therapist. She finally found a therapeutic relationship that met her needs. This provider was in network for several CCOs, but not member's CCO. Her CCO provided out of network (OON) authorization for her to see that provider. But the CCO did not make this provider an in-network provider. Eventually the CCO refused to authorize more services with this provider and would not continue an OON authorization. This meant the member would no longer be able to see her provider. The member asked the CCO for support finding a new therapist. The Ombuds Program asked the CCO to provide care coordination to help the member find a new provider. CCO sent the member a 90-page list with 772 providers. The therapist and member called the providers on this list. They could not find a new provider. This caused member to become distressed, anxious, and sleepless. One provider was deceased, several no longer worked in Oregon, many were no longer in practice, some were SUD specialist (not member's needs) and others specialized in children's behavioral health. Member found eight clinicians appropriate for her needs. Of these eight, some were not in the client's area, others were not open to new patients, and most had no appointments for long periods. The member appealed and eventually had an administrative hearing. After seeing the list the CCO had given member and learning what member and her therapist had done, the judge ordered the CCO to continue the authorization with the therapist. The judge stated that for the CCO to terminate the authorization, the CCO needed to offer a list of specific therapists appropriate for member's needs and available to a new patient appointment within a reasonable time.

Specific Ombuds concerns in this area include:

Network adequacy

Oregon has insufficient statewide capacity for inpatient and residential mental health and substance use disorder services. OHP members often struggle to find mental health professionals within their CCO network who are available.

- Member access is further limited by CCO provider networks that either lack availability by specialty or may not work with all inpatient facilities willing to accept OHP members.
- OHP provider directories are often not updated in real time, creating "ghost networks" that presume provider availability, when in fact the system is at its maximum capacity, providers are no longer accepting OHP, or providers are no longer open for business.
- SUD network adequacy: Individual CCOs do not contract with most of Oregon's 47 licensed SUD facilities, even if they have available treatment placements. These limited SUD residential contracts and single-case agreement approaches fail members. Members experience delayed or denied care.

Require statewide networks. Put in place statewide networks. Enact statewide network for both inpatient and outpatient mental health services. Require CCOs and OHA to contract with all willing and licensed behavioral health providers. Specifically, require them to contract with:

- All willing residential substance use disorder treatment providers in the state for youth and adults and
- All willing residential mental health providers in the state for youth.
- Do not allow CCOs to have closed panel mental health programs and services. All OHP members must have the ability to work with any licensed mental health provider who meets their needs.

Children's mental health

Children's residential capacity: Hospital ED boarding data for children indicate children and youth are not timely connected to neither residential, or inpatient setting, nor community-based services.

Low funding for children's mental health: The Oregon Legislature, OHA, and CCOs do not prioritize children's mental health resources. This is particularly true of intensive community-based services that can help keep children and youth from needing residential care.

- **Prioritize funding for children's mental health at a rate proportionate to the percentage of this population covered by OHP.** 34% of OHP members are age 18 or under. The Oregon Legislature, OHA and CCOs should prioritize investments in community-based child and youth mental health services. This includes investing in the workforce serving children and youth at amounts equal to or greater than investments in adult mental health and at least proportional to the number of young people in Oregon.

Member story: Youth behavioral health residential and community-based treatment barriers

At discharge, a hospitalized youth needed a rehab facility, but no Oregon facilities would accept the youth due to their complex mental and physical health needs. The youth needed specific, intensive in-home supports for safe discharge to their family. The youth's family were immigrants and preferred a language other than English. The CCO struggled to find in-network culturally and linguistically responsive in-home providers for the family.

Ombuds worked with the CCO and identified out-of-network providers who could provide culturally and linguistically capable therapists and traditional health workers to help ensure safe transition of the youth back home. The CCO created single-case agreements to work with these providers.

The youth returned home with this network of supports in place. But the youth never received the originally recommended level of care — placement in a rehab facility.

Underutilization of Traditional Health Workers

Leverage Traditional Health Workers (THWs) and peer workforce. Leverage THW peer-delivered services through the employment of state-certified Peer Support and Peer Wellness Specialists including Youth Support Specialists, Family Support Specialists, Recovery Peers, and Mental Health Peers.to expand Oregon's workforce and support network adequacy. Focus specific attention on supporting a robust peer workforce for children's mental health.

Home and Community-Based Services (HCBS)

Gaps between OHA and Oregon Department of Human Services (ODHS) in HCBS coordination and administration. Ongoing underutilization and poor coordination across 1915(i) and (k) services.

Inadequate OHA support of 1915(i) provider recruitment, education, and technical assistance. Provider recruitment and support and support improved network adequacy for this service. **Improve Home and Community Based Services.** Reduce inequitable access to HCBS 1915(i) for individuals with mental health disabilities. Implement a no wrong door policy across OHA and ODHS for all Medicaid-funded HCBS evaluations and referrals. Ensure mental health services are provided under 1915(k) waiver in compliance with federal Medicaid requirements.

Member story: Gaps in Home and Community-Based Services

An OHP member was discharged from an Oregon hospital to the streets. The member had complex health concerns. This included severe mental health, problematic substance use, physical disability, and health needs. This member should have qualified for residential care.

The hospital had created a discharge plan with no coordination from other parties. The local Community Mental Health Program had not returned the hospital's calls. The hospital did not trust the state or county programs to be able to find any residential option. Instead, the hospital found room at a local shelter.

Due to complex health needs, the member needed to get kidney dialysis at a dialysis center. Hospital and CCO staff coordinated NEMT for the member to receive dialysis at the center three times a week. The member had to travel long distances to get to the center.

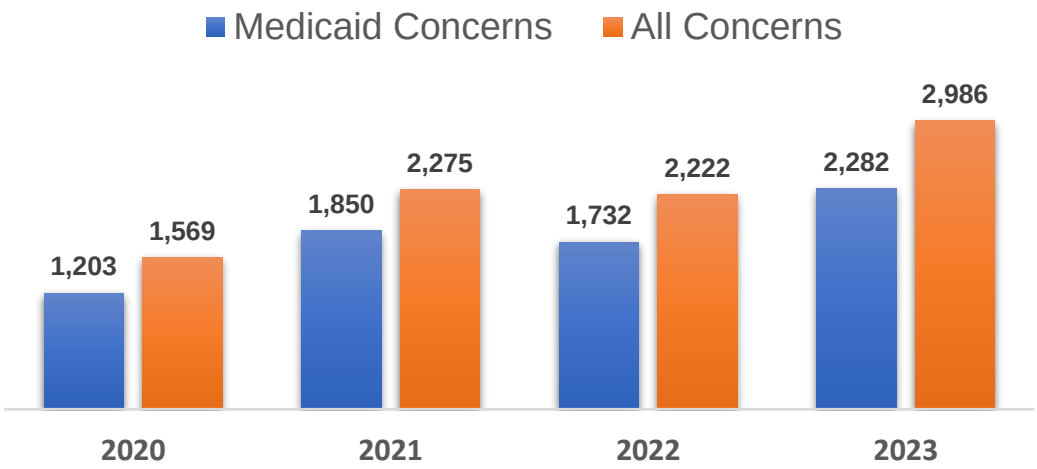
Ombuds worked with all parties involved to readmit the member to the hospital. All parties worked together to qualify the member to obtain residential care in a place close to the dialysis center.

Ombuds Program capacity

Since formation as a full Ombuds Program in 2019, the Ombuds Program has had a **90%** increase in Medicaid cases. The cases represent increasingly complex gaps in care and need for system improvement, many rooted in mental health needs across the state, such as:

- Access to treatment for substance use and mental health disorders,
- Redeterminations and disruptions to care for priority populations, and
- Housing and social determinants of health including additional health related social concerns brought to the Ombuds Program through Oregon's 1115 Medicaid waiver. **As Oregon expands weather and housing-related benefits under the new waiver, these concerns reflect additional workload for which the Ombuds Program is not staffed.**

Chart 2: Ombuds Program concerns received (2020-2023)



This increase is due to a variety of reasons including:

- Increased agency commitment to community engagement,
- Focus on agency responsiveness to concerns impacting health equity,
- Ombuds Program's strategic outreach to populations who face historical and contemporary health inequities and lack of access to care,
- Increased agency attention to centering OHP member voice in policy work.

This has led to increased workload for the Ombuds Program **without additional staffing or support**. The Ombuds Program's essential role as a member-centered catalyst for Medicaid systems improvements is at risk.

Based on agency need and Ombuds workloads exceeding existing resources, OHA should expand Ombuds Program staffing. This would allow the program to:

- Respond to complex, multi-system child and adult cases that reflect statewide gaps in access to care for mental health and substance use disorders for OHP members.
- Ensure adequate project management and subject matter expert support to advocate for and operationalize recommended changes.
- Increase receptiveness and understanding of the Ombuds Program and OHP member experience by other OHA programs and divisions.
- Strengthen responsiveness to members across the agency regardless of how the member or their story came to our attention.

2023 PROGRAM DATA

The data in this section reflect quarterly and cumulative 2023 data. First, second and third quarter data published in previous reports may differ from the data in this final report. This is because of updated case work, coding and a new case management system for Ombuds Program data established in June 2023.

In 2023 the Ombuds Program addressed **2,986** concerns and served **2,487** individuals.

2,282 (76%) of these concerns were Medicaid related.

379 Medicaid concerns were from Dual Medicaid-Medicare eligible individuals.

96 individuals had identified housing instability.

157 individuals served were age 19 or under.

415 individuals served were age 65 or older.

Total concerns

Table 1: Total Medicaid and non-Medicaid concerns

Concerns	Q1	Q2	Q3	Q4	Total (%)	Total (N)
Medicaid	602	625	549	506	76.4%	2282
Non-Medicaid	197	187	168	152	23.6%	704
All	**799**	**812**	**717**	**658**	**100%**	**2986**

OHP members often have health-related needs not related to their covered benefits. These can include:

- Housing, food and nutrition.
- Needs due to climate change including smoke and extreme weather.

Often called social determinants of health, these needs are not always OHP concerns. CCOs can choose to support these needs through care coordination, health-related services, and coordination with other state and local government services.

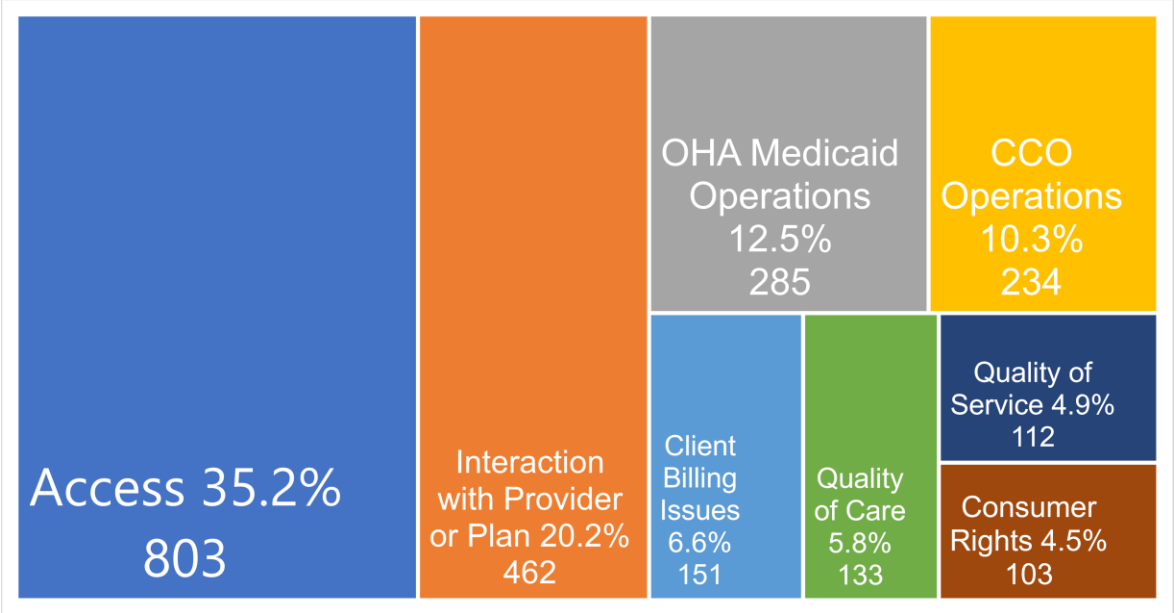
The Ombuds Program provides advocacy and systems elevation for improvement for Medicaid-related concerns; for non-Medicaid related cases, the Ombuds Program ensures a person-centered approach and serves as the right door to the right program.

Medicaid concerns

Total concerns received by Ombuds Program

Chart 2: Total concerns received (2,282)

Appendix A provides additional detail about these concerns by quarter.



Access to care concerns: 35.2 percent (803)

Access to care concerns comprise over one-third of Medicaid concerns. These involved:

- **Eligibility (257):** When individuals are confused or have concerns about eligibility, they often do not seek care. The Ombuds Program had significant eligibility concerns brought by Oregon Supplemental Income Program Medical (OSIPM) members. ODHS and OHA paused benefits redetermination for this group to avoid

further harm. As redeterminations for these members begin again in 2024, this is an area for OHA and advocates to monitor closely.

- **Unable to schedule appointment in a timely manner (128):** This included specialty care (neurologists and cardiologists), primary care providers, diagnostic studies, dental and mental health.
- **Provider not available to give necessary care (93):** Most complaints in this area surrounded mental health and dental care.
- **Verbal denial of service by provider (82):** OHP members have the right to appeal or request a hearing when they receive a written denial. When clients receive a 'verbal' denial, they have no ability to access this right.

Appendix A provides additional detail about these concerns by quarter.

Interaction with provider or plan: 20.2 percent (462)

These concerns included difficulty navigating the CCO complaint/ grievance process, finding a new provider and requesting health-related services through providers. These concerns were often resolved with the engagement of a CCO care coordinator.

OHA Medicaid operations: 12.5 percent (285)

These concerns are about implementation and operation of Medicaid policies and programs. These included requests for air conditioners, CCO enrollment challenges, and requests to OHA asking to maintain fee-for-service (open card) OHP to see providers outside the CCO's network.

CCO operations: 10.3 percent (234)

Most concerns about were about health-related services including requests for air conditioners and housing/rental assistance.

Client billing issues: 6.6 percent (151)

OHP members continue these concerns in and out of state. This includes billing by dentists, ambulance, emergency department providers, and for pharmacy copayments.

Quality of care: 5.8 percent (133)

These included member concerns about adverse outcomes from medical care, dental treatments and inadequate care from hospitals, including early discharges and lack of discharge planning.

Quality of service: 4.9 percent (112)

These concerns included denial of services, particularly of durable medical equipment such as wheelchairs.

Consumer rights: 4.5 percent (103)

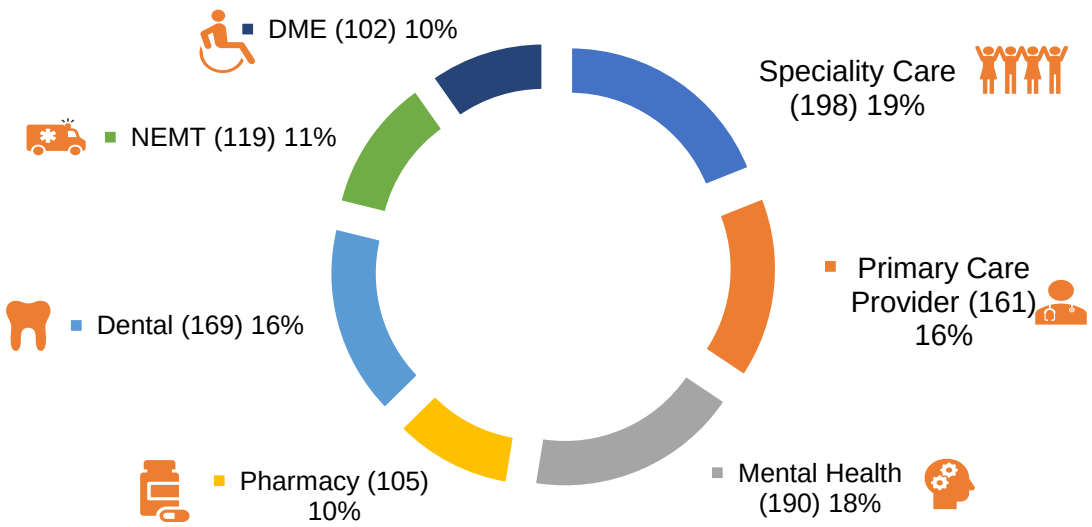
Concerns included interpreters not provided at health care visits and chairside denials. Chairside denials occur when members receive verbal denials from their provider instead of a written denial from the CCO or OHA. This often occurs when the provider assumes the OHP does not cover service and does not ask the CCO or OHA to confirm this belief.

Top concerns by service type

Complaint categories and service types are independent of each other. An individual may have access to care concerns related to any service type. Vice versa, a mental health service concern may in any complaint category, such as interaction with provider or plan. The services most frequently involved in Ombuds Program concerns were:

1. Specialty care (8.7%)
2. Mental health care (8.3%)
3. Dental care (7.4%)
4. Primary care (7.1%)
7. Other (7.1%)
5. Non-emergent medical transportation (5.2%)
6. Pharmacy (4.6%)

Chart 3: Top concerns by service type (of 2,282 total concerns)



Specialty care: 8.7 percent (198)

Many concerns included difficulty with accessing surgery care. There were some chairside denials.

Primary care provider: 7.1 percent (161)

These concerns included being unable to schedule with the provider in a timely manner, either due to lack of appointment spots or due to lack of covered providers available in the area.

Other: 7.1 percent (162)

These concerns include reporting abuse, and questions about HRS and HRSN requests.

Mental health: 8.3 percent (190)

A recurring concern included difficulty finding an available provider, long wait times for an appointment, and lack of available services for children and youth.

Dental: 7.4 percent (169)

Concerns included difficulty getting an appointment with a dental provider for both regular checkups and urgent conditions. This may indicate the need for both CCOs and OHA to monitor and build adequate capacity for this service. There were several issues about coverage of a prescribed treatment and what to do if a CCO or OHA denies a prior authorization request.

NEMT: 5.2 percent (119)

Recurring issues include members not being picked up or the member receiving the ride too early or too late. Missed rides cause member harm that cannot be undone.

Pharmacy: 4.6 percent (105)

Most concerns include pharmacies asking a member to pay out of pocket for a prescription medication that OHP should cover.

Durable Medical Equipment (DME): 4.5 percent (102)

Often, members received denials for DME they have needed and used for years, including wheelchairs and wheelchair accessories. Members report that these denials force them to fight for services that give them mobility, causing trauma and impacting their mental health.

Race and ethnicity of OHP members served (if known)

This table shows the data on file for members who contacted the Ombuds Program in 2023. This information is not known for all members who contacted the Ombuds Program and does not reflect the entire population served by the Ombuds program.

Table 2: 2023 demographics

Race/Ethnicity	%	N
Other White	51.0%	766
African American	2.6%	39
American Indian	3.1%	46
Asian Indian	0.2%	3
Biracial or Multiracial	1%	14
Black	0.1%	2
Communities of the Micronesian Region	0.1%	2
Decline to Answer	12.4%	186
Did Not Answer	4.0%	60
Eastern European	0.7%	11
Filipino/a	0.2%	3
Hispanic or Latino/a/x/e Central American	0.2%	3
Hispanic or Latino/a/x/e Mexican	2.5%	37
Hispanic or Latino/a/x/e South American	0.1%	2
Middle Eastern	0.3%	5
Multiple racial or ethnic identity	1.6%	24
Other African (Black)	0.3%	4
Other Asian	1.1%	17
Other Black	1.4%	21
Other Hispanic or Latino/a/x/e	3.5%	52
Other Pacific Islander	0.3%	4
Other Race or Ethnicity	0.3%	4
Samoan	0.1%	2
Slavic	0.1%	2
Somali	0.1%	1
South Asian	0.1%	2
Unknown	5.2%	78
Vietnamese	0.3%	5
Western European	5.2%	78
White	1.3%	19
Total	**100**	**1502**

Non-Medicaid concerns

Table 3: OHA concerns

Type of concern	Q1	Q2	Q3	Q4	Total (N)
Civil rights or ADA violation	0	0	1	0	1
Equity and Inclusion: Interpreter and translation (non-member access)	0	1	2	0	3
Human resources	0	2	0	0	2
Licensing: Behavioral health (DUI, outpatient, etc.)	5	3	0	1	9
Licensing: Other	5	12	9	3	29
Licensing: Public Health (hospitals, air, water, food, pools, lodging, etc.)	7	4	0	1	12
Marketplace	3	0	2	1	6
Oregon State Hospital concerns	4	7	5	8	24
Other OHA concerns	33	40	58	45	176
Other Public Health Division concerns	21	20	22	11	74
Public records request	2	1	1	1	5
Total	**54**	**63**	**71**	**61**	**249**

Table 4: Other government agencies' concerns

Type of concern	Q1	Q2	Q3	Q4	Total (N)
Department of Consumer and Business Services (private insurance)	22	14	0	2	38
HIPAA violation – Health and Human Services	3	3	2	0	8
Local government issue	8	15	6	3	32
Medicare	32	18	18	22	90
Oregon Department of Human Services	30	42	24	29	125
Oregon Housing & Community Services	0	1	2	0	3
Other (includes housing and medical licensing board complaints)	46	26	43	33	138
Veterans' Affairs	1	2	2	0	5
Total	**143**	**124**	**97**	**91**	**455**

CONCLUSION

Each person who seeks Ombuds Program advocacy deserves nurturing and support. Their stories often illustrate challenges many others experience. Each brings ways to:

- Improve the OHP delivery system and
- Understand the impact of health inequities on OHP members.

The Ombuds Program is honored to work in an agency that embraces OHP member experience. Responding to member experience is essential to successful transformation.

The Ombuds Program supports Oregon's efforts to advance better health, lower costs, and better care for everyone in Oregon. To advance health equity, the Ombuds Program commits to:

- Identifying opportunities to address social and structural racism.
- Advocating for Oregon to reprioritize resources and power to address health inequities.

APPENDICES

Appendix A: 2023 data by quarter

Table 5: Total Medicaid concerns (2,282)

Type of concern	Q1	Q2	Q3	Q4	%	N
Access	201	208	214	180	35.2%	803
CCO operations	56	65	50	63	10.3%	234
Client billing issues	41	37	25	48	6.6%	151
Consumer rights	23	31	27	22	4.5%	103
Interaction with provider or plan	146	144	95	77	20.2%	462
OHA Medicaid operations	65	90	82	48	12.5%	285
Quality of care	41	28	28	36	5.8%	133
Quality of service	30	22	28	32	4.9%	112
Total	**603**	**626**	**549**	**506**	**100.0%**	**2282**

Table 6: Top access to care subcategories

Type of access concern	Q1	Q2	Q3	Q4	N
Eligibility issues	53	51	80	73	257
Unable to schedule appointment in a timely manner	33	46	25	24	128
Provider not available to give necessary care	25	24	29	15	93
Verbal denial of service by provider	20	18	18	26	82

Table 7: All Medicaid concerns by service type

Service type	Q1	Q2	Q3	Q4	%	N
Acupuncture	1	0	1	2	0.2%	4
Alcohol and drug/ substance use disorder	6	3	3	4	0.7%	16
Ambulance/ medical transportation	6	0	1	1	0.4%	8
CCO plan	20	16	13	30	3.5%	79
Chiropractic	4	3	4	0	0.5%	11
Dental	45	43	40	41	7.4%	169
Diagnostic studies	7	8	4	8	1.2%	27
DME	15	32	33	22	4.5%	102
Emergency room	9	14	8	5	1.6%	36
Hospital	16	29	13	21	3.5%	79
Imaging	2	1	3	4	0.4%	10
Long-term care	14	10	8	7	1.7%	39

Service type	Q1	Q2	Q3	Q4	%	N
Mental Health	57	53	42	38	8.3%	190
NEMT	44	34	24	17	5.2%	119
Occupational therapy	0	3	0	0	0.2%	3
Other OHP services	36	61	16	49	7.1%	162
All Other Medicaid (eligibility)	147	159	221	138	29.1%	665
Outpatient	3	2	1	3	0.4%	9
Pain management	7	12	6	10	1.5%	35
Pharmacy	28	26	23	28	4.6%	105
Physical Therapy	3	2	2	0	0.3%	7
Primary Care Provider	54	47	33	27	7.1%	161
Residential rehabilitation	11	6	7	5	1.3%	29
Specialty Care	61	54	41	42	8.7%	198
Vision	6	7	2	3	0.8%	18
Total	**602**	**625**	**549**	**506**	**100.0%**	**2282**

Table 8: Additional member demographic information

Ombuds does not have these data for all members, but for those whom identifying information was provided.

Demographic	Q1	Q2	Q3	Q4	N
Age 0-19	47	35	45	30	157
Age 19-64	108	120	92	79	399
Age 65 and older	111	124	98	82	415
Dual eligible members	93	101	90	95	379
Individuals with identified unstable housing	22	35	24	15	96
Individuals who prefer a language other than English	24	18	16	28	86