AN MCOS PERSPECTIVE ON ACCESS TO CARE IN THE STATE OF OREGON

ACCESS TO CARE FOR OREGON

Oregon is facing a medical provider shortage regardless of payer. The presumption that the solution to improving worker access to medical care is to make treating workers' compensation patients more enticing is no longer sufficient – Provider **capacity** is now just as important as provider **willingness** when addressing worker access to care.

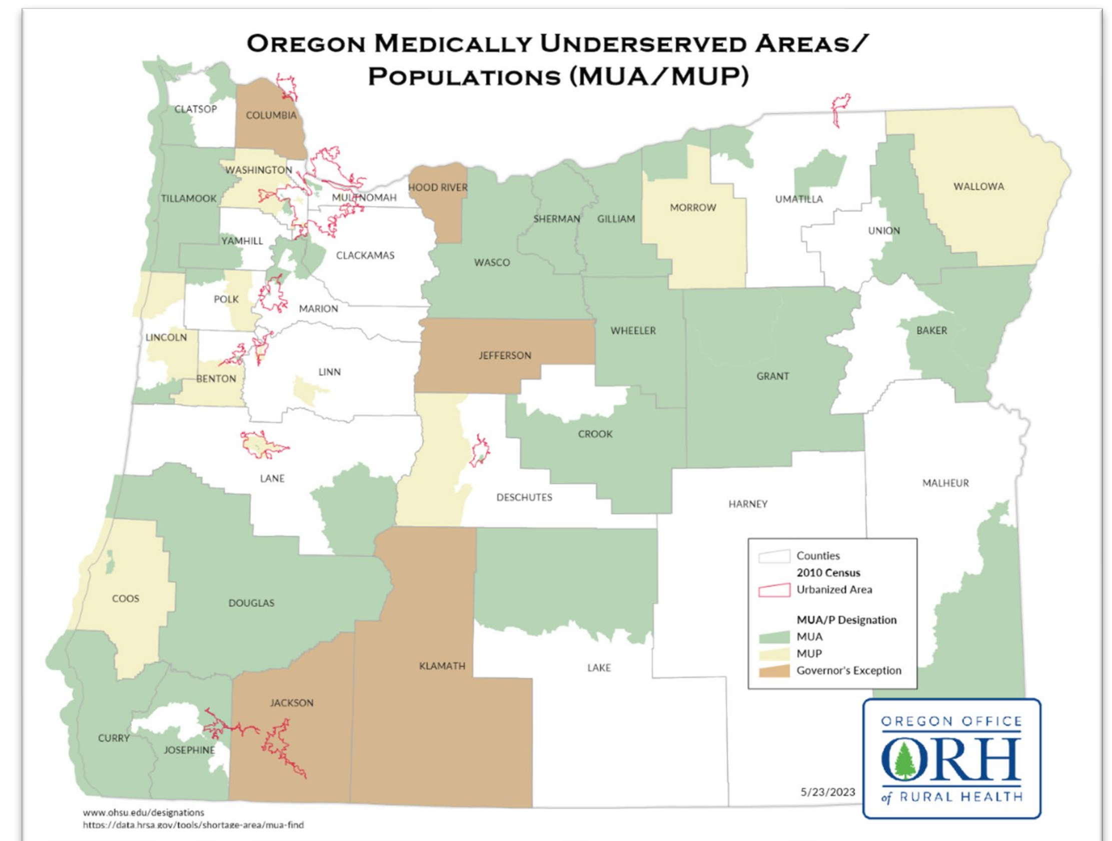
The provider shortage is not unique to Oregon and the national shortage is forecasted to increase in the next 10 years. Which means **efficiency** is as important as **volume**, especially in the short term.

The shortages and drivers of those shortages vary depending on the area of the state, the licensure specialty, and individual patient care needs. The multi-faceted nature of the problem means there is no single solution likely to solve all the components.

The Oregon workers' compensation system remains one of the highest performing in the nation and many workers are accessing the care they need, when they need it. We have strong tools and a history of success to inform next steps.

OVERALL HEALTHCARE RESOURCE REALITIES

- The Health Resources and Service Administration and the Oregon Office of Rural Health show that the state has on average a ratio of 0.98 for primary care providers, representing an exact balance of supply to estimated general population demands. The Association of American Medical Colleges forecasts a national shortfall range of 13,500 to 86,000 physicians by 2036.
- The breakdown across the state also demonstrates an imbalanced distribution between urban and rural communities.
- A survey of physician wait times conducted by Merritt Hawkins' found that the average wait times nationally was 22 days; in the Portland metro area it averaged 45.6 days in 2022. Comparatively, claims enrolled into the Majoris MCO averaged 22.8 days for the Portland area in 2022.



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ADDENDUM: OVERALL HEALTHCARE RESOURCE REALITIES

Major changes since the Addendum

- Providence announced permanent closure of its remaining occupational medicine clinics in the Portland metro area.
- Legacy announced closure of multiple urgent care and specialty clinics:
  - Devers Eye Institute,
  - Outpatient Neuro-Rehabilitation program
  - Salmon Creek Pain Clinic
  - Good Samaritan Cardiac & Pulmonary Rehabilitation
  - 5 Washington 2 Oregon Urgent Care clinics
- Kaiser health care workers organized a five-day strike

Reasons Cited

- Providence:
  - Difficulty recruiting and retaining occupational medicine clinicians
  - Changing needs in the community.
- Legacy:
  - Rising labor & supply costs
  - Insufficient coverage from Medicare and Medicaid (2/3rd of their patient base)
  - State mandated nurse-to-patient ratios and presumptive eligibility
- Kaiser health care workers:
  - Staffing levels
  - Compensation

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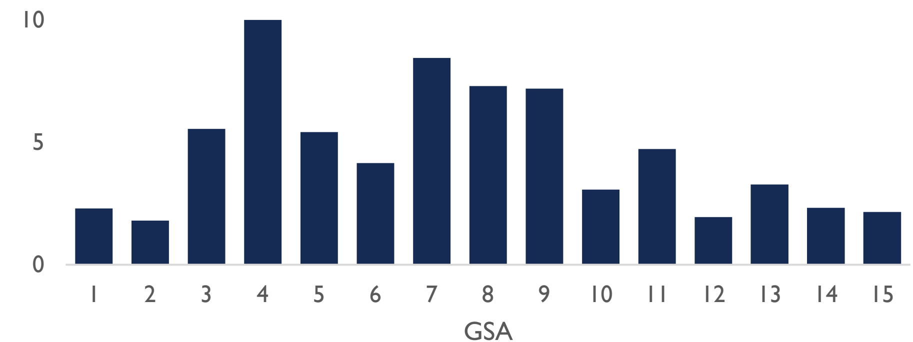
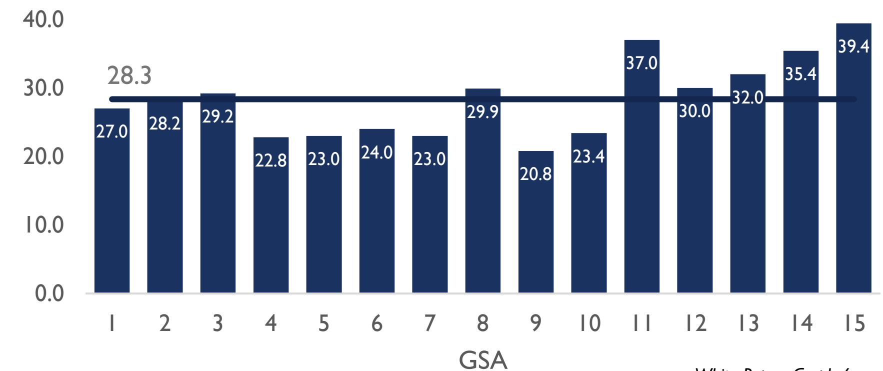
PROVIDER RATIOS: NOT A GUARANTEE

- Time to care is a measure of accessibility. Utilizing the average number of days from enrollment to first office visit offers insight into the ease of worker access.
- GSAs for more populated areas of the state have a lower average number of days. Yet several of those GSAs also have a higher ratio of workers to network providers. Conversely, many of the rural GSAs have a low ratio of enrolled claims to network providers but often higher average days to first visit.
- This demonstrates how the volume of providers in a particular area does not consistently indicate accessibility. Instead, concentration can increase efficiencies and deliver stronger capacity.



White Paper - Graph 5



White Paper: Graph 6

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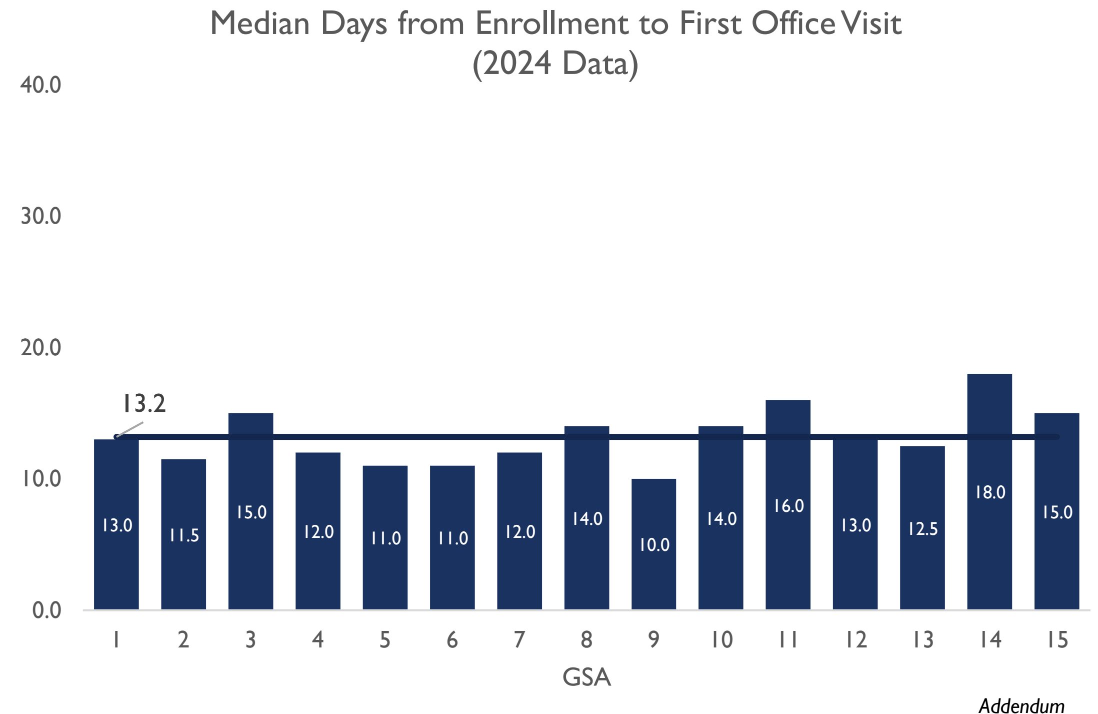
ADDENDUM: MEDIAN DAYS FROM ENROLLMENT TO FIRST VISIT

- A stakeholder requested the same data looking at median days – as they posited, the median days from enrollment to first office visit show that outliers skew the average beyond what most workers experience.
- This demonstrates that while there are challenges within the system, the challenges do not impact all, or even most, workers.



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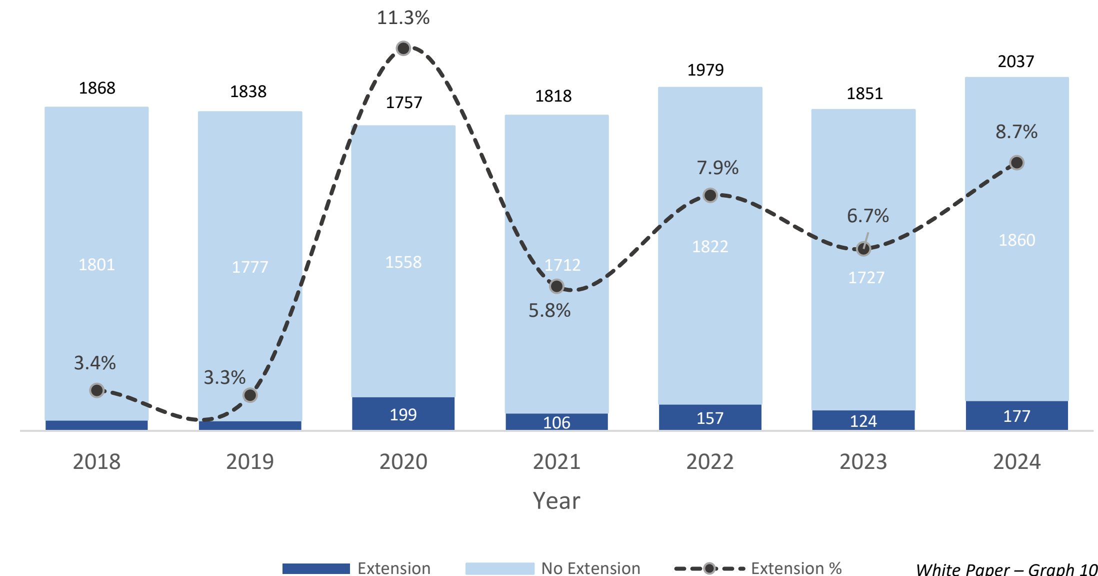
COVID IMPACT & LASTING EFFECTS

The COVID 19 impact had lasting impacts on the healthcare system, and the workers' compensation system mirrors the challenges seen across the general healthcare system.

- Availability of supporting resources, such as anesthesiology, drive increases in surgery extensions.
  - Delayed surgical intervention can translate into higher physical therapy utilization and lengthened recovery timelines.
- COVID significantly increased demand for pulmonology, cardiology and neurology.
  - This is particularly acute in neurology, already under strain due to an increased demand driven by advances in medicine and an aging population.
- Behavioral Health demand continues to increase and outpace available resources. Per the Kaiser Family Foundation, in 2022, 23% of adults received mental health treatment. Up from 19% in 2019.



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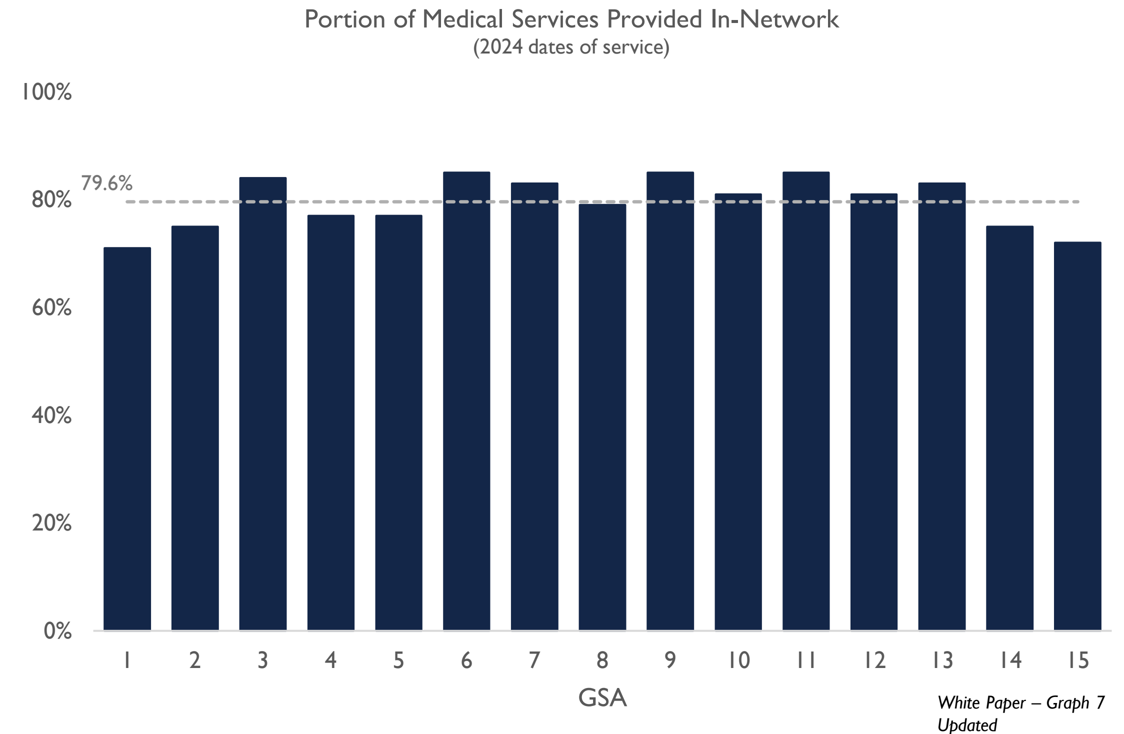
NETWORK VS NON-NETWORK

- If MCO resources are insufficient, the system is designed to safeguard the worker by allowing non-MCO treatment.
- Injured workers are also allowed to treat with their non-network primary care physician, even if there are sufficient MCO options.
- In 2022, on average 77.1% of care provided to enrolled workers was provided via network options. In 2024, that increased to 79.6%. Demonstrating that Majoris network coverage meets most worker needs.



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ADDENDUM: NETWORK VS NON-NETWORK

- Upon request, an MCO is required to provide an enrolled worker a list of 3 providers who confirmed willingness to schedule an appointment with that individual. In 2024, rule updates established a 14-day requirement for the MCO to provide the list, or the worker is allowed to select a non-network provider if they choose to do so.
- Majoris tracked those instances for insight into
  - The MCO's ability to provide a list of 3 willing providers with a two-week time frame,
  - The impact on accessibility to care when a worker was allowed to treat outside the network, and
  - The reasons prompting a worker to request a list of 3.
- Because the list must be providers who have confirmed they will schedule that specific patient, most providers require a records review before indicating yes or no.
  - That creates an additional resource ask of providers to take time to review records for a patient they may never see. Unfortunately, some providers choose not to take the time, and for those that do, they are not always able to complete their review prior to the deadline,.

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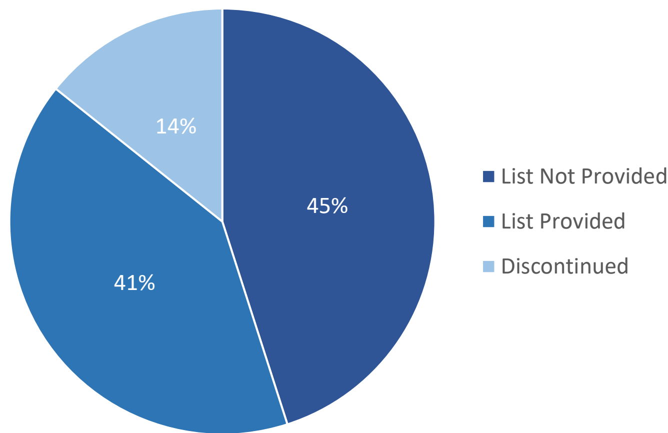
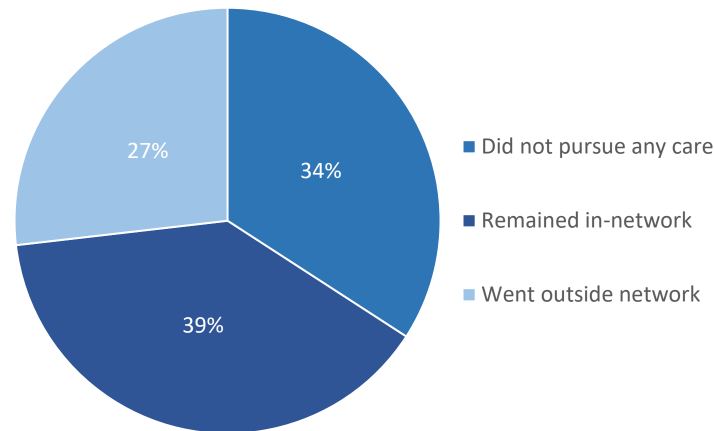
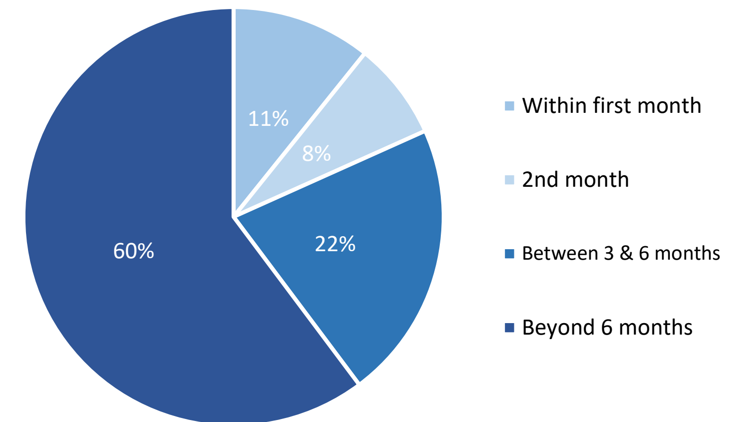
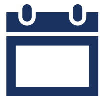
14-DAY RULE STATISTICS

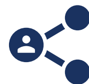








On average, days to treat was 33.6 days when a list was provided and 49.3 days when one was not provided.



25% of requests were when the worker had no provider or needed to establish with a network provider.

13% came after a medically stationary determination.

7% of cases included context of worker behavior challenges, such as harassment of medical staff or frequent cancellations/no-shows.

MOVING FORWARD