MANAGED CARE ORGANIZATIONS

AN OVERVIEW OF OREGON'S MANAGED CARE FRAMEWORK

HISTORY: REBALANCING A STRUGGLING SYSTEM

1986: Oregon ranked 6th highest in the nation for premium rates, with a system straining to meet the needs of Oregon Injured Workers and Employers, prompting reform.

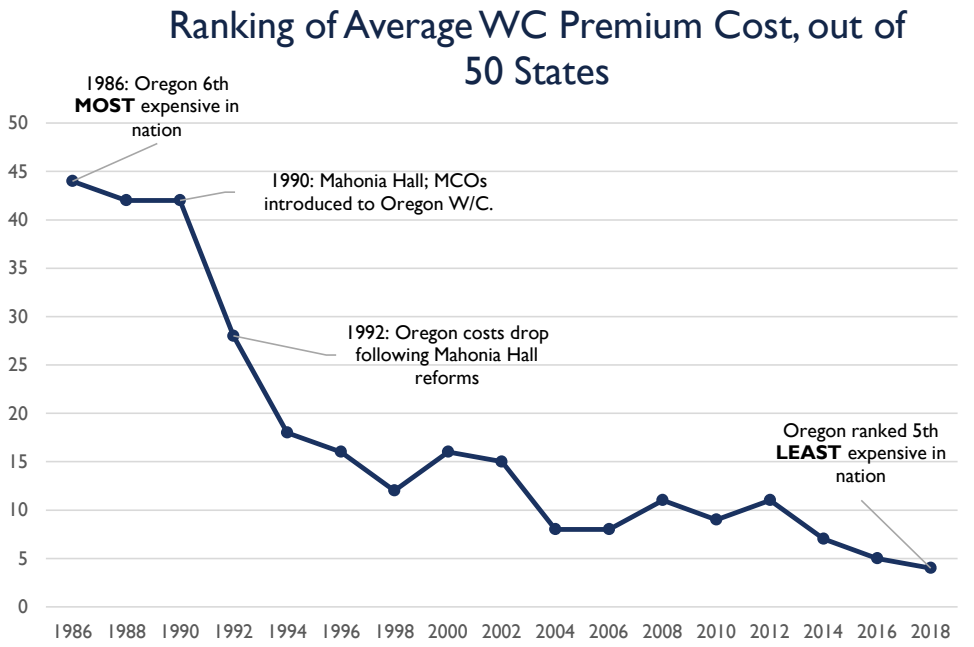
1990: Mahonia Hall delivers series of recommendations to deliver to the Oregon Workers' Compensation System:

- balance
- adequate benefits
- affordability
- efficiency
- stability & flexibility

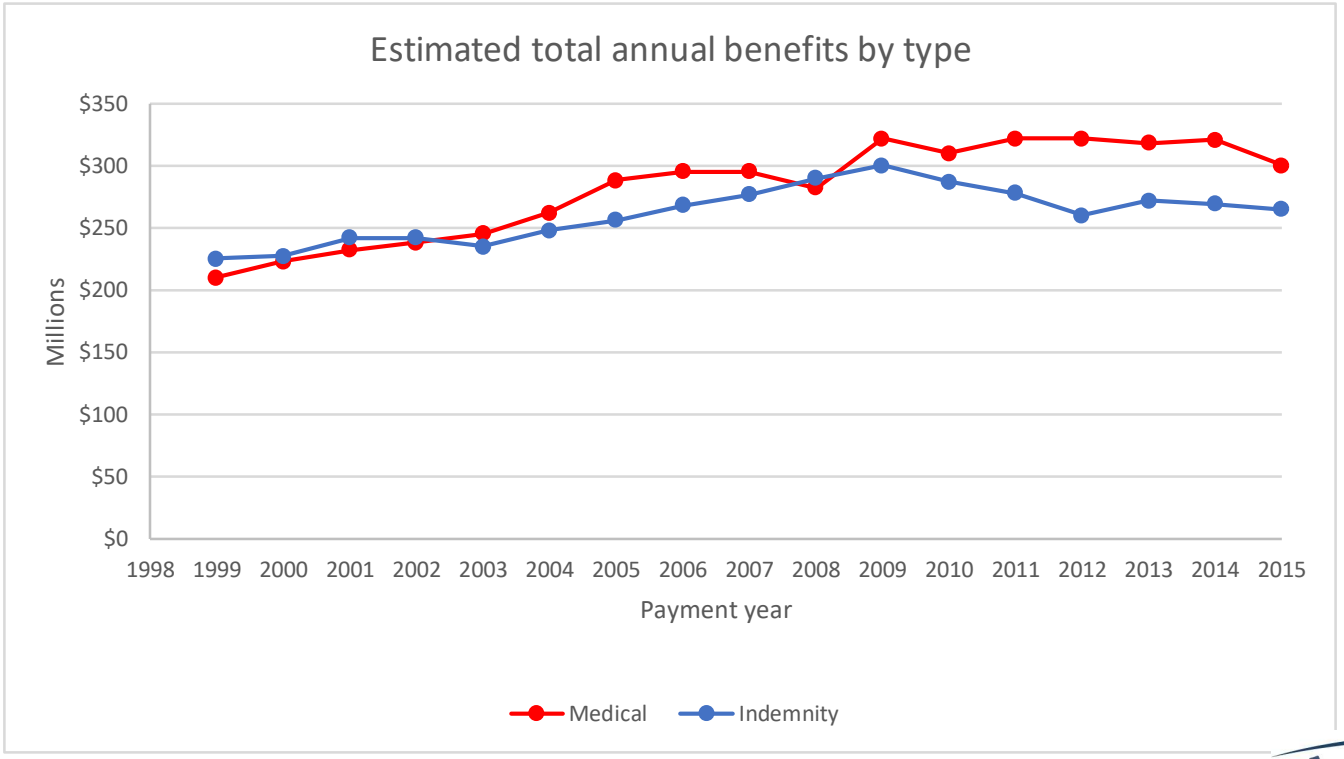
This results in a sweeping set of reforms, including introducing MCOs as a key pillar of the new system

1991+: MCOs are formed, each working to design a model that meets the goal of delivering high quality & consistent care while controlling costs and preventing inappropriate care.

2018: Oregon identified as having the 5th lowest pure premium rate in the nation.



BENEFIT COSTS HOLD DESPITE ENHANCEMENTS & INFLATION



MAJORIS™

THE GOAL: WORKER CARE & RECOVERY

Shared Objectives for all Stakeholders

Workers treating with high quality providers who understand the nuances of the workers' compensation system

Workers provided appropriate care driven by evidenced based medicine & supported by objective data; unnecessary care is avoided

All stakeholders provided the information needed to fulfill their obligations in the system

Ultimately: An efficient, effective system delivering robust medical benefits to today's injured workers without becoming overtaxed, ensuring future workers receive the same level of high-quality care

MAJORIS™

MCO CONCEPT: BASE MEDICAL DECISION-MAKING WITHIN THE MEDICAL FORUM

Peer Review	Evaluation or review of the performance of colleagues by a panel with similar types and degrees of expertise
Utilization Review	MCOs review requests based on medical necessity and are positioned to work with treating providers to ensure workers receive appropriate, evidence- based care and are returned to work timely
Quality Assurance	Activities to safeguard or improve the quality of medical care by assessing the quality of care or service and taking action to improve it
Dispute Resolution	MCOs must have a process to resolve disputes arising under peer review, service utilization and quality assurance activities
Contract Review	Methods and processes for MCOs to monitor and enforce participating provider contracts

MAJORIS™

MEDICAL CASE MANAGEMENT & UTILIZATION REVIEW

MCO Initiative

Support timely injury resolution by ensuring care provided to injured workers is necessary, appropriate and recovery focused.

Each MCO will have their own specific model on how they deliver these services

Medical Case Management

- Treatment & Disability status is monitored to identify and resolve barriers
- Appropriate level of care & assistance facilitating appointments
- Education of treating providers regarding return-to-work options, maximum medical improvement definitions, and/or claim closure

Utilization Review

- Performed by medical providers
- Supported by evidence based, peer reviewed guidelines & objective findings

Ongoing Quality Assurance

- Identify trends in care & develop mechanisms to improve
  - Case Study: opioid treatment
- Improve access to care without undermining quality
  - Case Study: rural communities
  - Case Study: specialized care

MAJORIS™

PROVIDER NETWORK

MCO Initiative

Maintain a network of providers for workers' compensation patients that meet defined quality standards

Each MCO will have their own specific model on how they deliver these services

Network Makeup

- MCO contracts with providers based on patient population needs and MCO defined quality standards
- Statute outlines minimums for provider count and specialty to ensure appropriate coverage

Credentialing

- MCOs have the knowledge, tools and authority to review medical practitioners and confirm they meet quality standards
- Majoris specific: Includes review of malpractice history, board action, workers' compensation treatment patterns

Provider Accountability & Support

- Providers are expected to comply with MCO protocols developed specifically to ensure best practices in the treatment of injured workers
- Engaged partnership positioned to provide education and intervention

MAJORIS™

DISPUTE RESOLUTION

MCO Initiative

Resolve disputes efficiently utilizing objective medical data, evidence-based medicine and peer-based oversight

Each MCO will have their own specific model on how they deliver these services

Dispute Resolution

- Regulated by statute and rule
- All parties have the right to appeal any decision made by the MCO
- Appeals must be made within 30 days of the decision
- MCO must respond to an appeal within 60 days of receipt
- Appeals related to medical treatment are heard by a Medical Review Committee, appeals related to administrative matters are heard by an Administrative Review Committee

MAJORIS™

ENROLLMENT

Notice of Enrollment

- Written notice must be sent to worker, including appeal rights and is effective 3 days from date of mailing
- All known parties to the claim are copied
- Enrollment timing is determined by each insurer to best align with their processes

Directing in Network

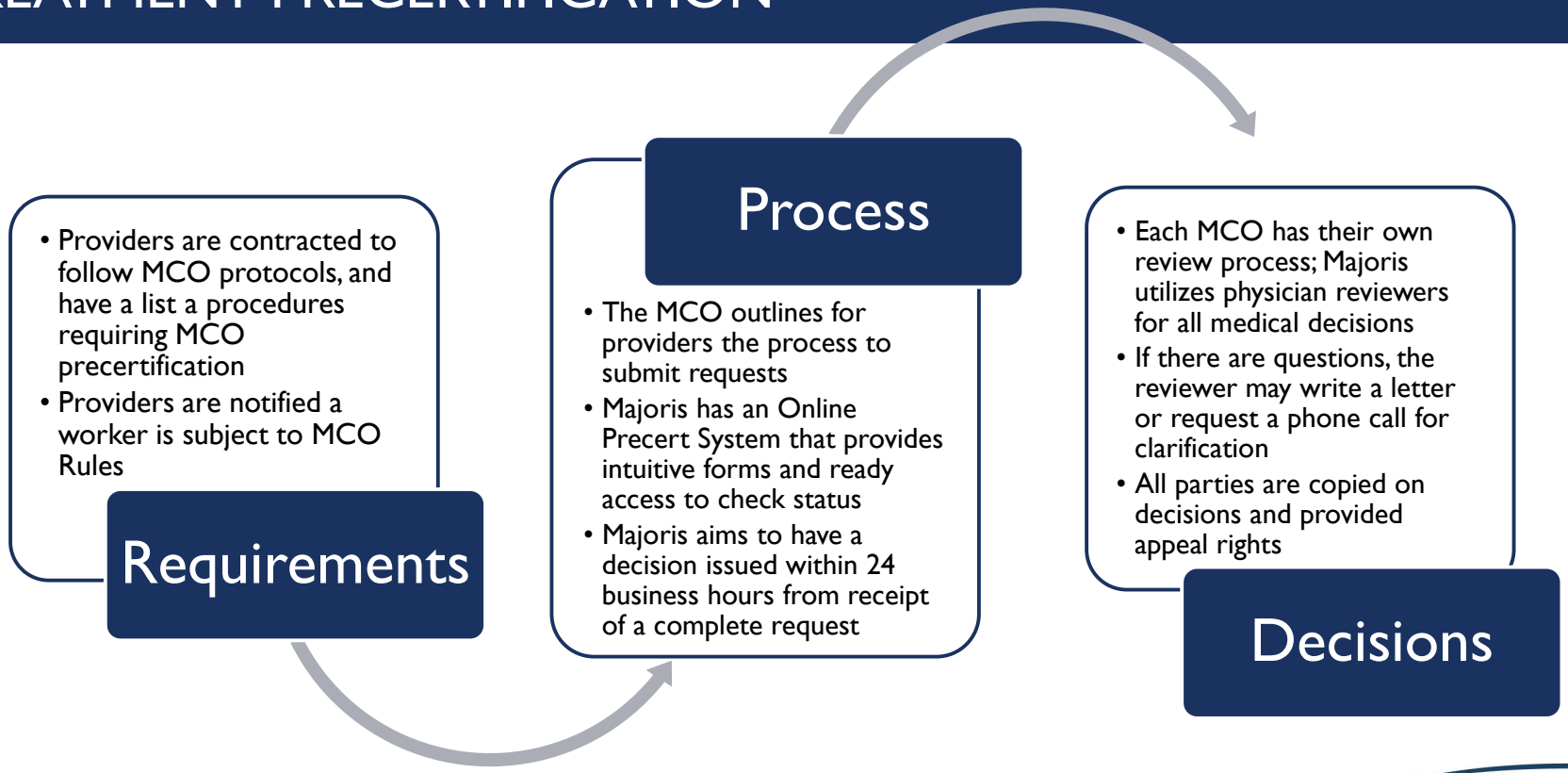
- Worker is informed if they are currently treating in-network or not
- If they are not, worker is provided instructions on how to find a network provider and the MCO is available to assist

Non-Network Care

- Workers have 14 days from date of enrollment notice where they can continue to treat off-panel to provide time to establish with a network provider.
- Certain providers qualify for come-along privileges, allowing the worker to continue treating with a non-network provider; the MCO handles identifying and facilitating this process.
- If the worker is within a global surgery period or treatment has already been approved by the adjuster, such as physical therapy, that course of treatment is generally allowed to complete

MAJORIS™

TREATMENT PRECERTIFICATION



MAJORIS™

MCO VALUE ALIGNED TO MAHONIA HALL GOALS

- **Balanced:** MCOs by nature are neutral, they partner with both medical providers and insurers to provide care to injured workers. Insurers, self-insured employers and third-party administrators cannot be a certified MCO.
- **Adequacy of Benefits:** MCOs are regulated by the Oregon Statutes and Administrative Rules to guarantee MCO design supports worker medical care. MCOs are subject to oversight by DCBS, including having all MCO provider and insurer contracts approved and filed with the Department.
- **Affordability:** Treatment is reviewed for medical necessity and appropriateness, with focus on delivery of care that will provide timely worker recovery. This helps keep overall medical costs controlled while maintaining high quality benefits.
- **Efficiency:** Close partnerships with treating medical providers and contracted insurers/self-insured employers provide the MCO a unique position to understanding the barriers and needs of the system and identifying effective solutions. The defined dispute process keeps disputes on a tight timeline and addressed from a medical standpoint.
- **Stability & Flexibility:** The regulated framework supports stability, with the MCOs close partnerships with other stakeholders providing insight into the evolving needs for the injured workers in the areas they serve; quality assurance activities inform MCOs of new possibilities to improve or enhance medical care.

MAJORIS™