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6/18/2026

RE: Testimony regarding MCOs

To the Workers' Compensation Division,

I am a physician practicing within the Oregon workers' compensation system. I am writing in support of increased transparency, objective measurement, and oversight of Managed Care Organizations.

MCOs appear to exercise substantial authority within Oregon's workers' compensation system, but the publicly available information does not appear sufficient to determine whether that authority produces measurable improvements in access, care quality, return-to-work outcomes, provider participation, or overall system efficiency. It is not clear that MCOs are being evaluated with objective standards proportional to the authority they exercise.

Clinicians in the workers' compensation system are expected to support their opinions with documentation. We document diagnoses, treatment plans, medical necessity, work restrictions, medically stationary status, impairment findings, disability opinions, and return-to-work recommendations. Those opinions can be challenged, audited, appealed, and rejected if they are not adequately supported. This standard is reasonable, though it should not apply only to clinicians.

MCOs are authorized to perform significant functions, including provider network management, utilization review, case management, quality assurance, peer review, physician profiling, treatment guideline development, care coordination, dispute resolution, and reporting. These are not minor administrative functions. They can affect which providers are available, how quickly care is initiated, how treatment is reviewed, how guidelines are applied, and how disputes are managed.

If MCOs perform these functions well, that should be demonstrable. If their benefits are mixed, limited, or outweighed by added burden in some areas, this should also be visible. The same basic principle should apply throughout the system: the more

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authority a participant has, the more transparent and measurable their performance should be.

Based on the materials I have reviewed, Majoris appears to publish some access-related metrics, including measures such as days to first visit, days to first encounter, network utilization, three-provider search statistics, and utilization of nurse practitioners and physician assistants. These are primarily process metrics. They may show that a worker entered the system or made contact with a provider, however they do not indicate the worker improved because of the MCO system.

Access is important, but access is not the same as outcome. A faster first appointment is valuable only if the system then supports appropriate treatment, timely referrals, recovery, return to function, and durable return to work. The relevant question is not whether the worker had an encounter. The relevant question is whether the MCO structure improves the worker's outcome enough to justify the additional administrative layer.

Our clinic has had limited direct experience with MCOs, so I cannot speak broadly to all of their operations. But the limited experience we have had is consistent with the broader concern about transparency and administrative burden.

Our clinic has received records requests from MCOs before a worker has even been seen. In those situations, there are no records to provide. Even so, the request creates a task that has to be reviewed and addressed by clinic staff. In isolation, this may seem minor. Across a system, these tasks are not minor. They represent staff time, physician time, administrative cost, and workflow disruption.

When interacting with Majoris, they require physicians to sign a non-disclosure agreement before even gaining access to Majoris' guidelines. From a clinical standpoint, that is difficult to square with transparency. If these guidelines are used within Oregon's workers' compensation system to shape care, utilization review, or provider expectations, then they should be available to review and discuss in a meaningful way, without restriction and potential for legal repercussions. This is even more necessary when public funds are involved in any part of the system, such as with SAIF.

There may be a legitimate reason for the NDA. If so, that reason should be explained. But as it stands, the requirement creates an appearance of opacity. If the guidelines are meant to improve care in a public workers' compensation system, why should physicians be required to sign a confidentiality agreement before seeing them?

During the June 9 meeting, it was stated that no complaint had been filed against Majoris in nearly 30 years. If accurate, that is a notable statistic. But in a complex

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system involving injured workers, physicians, attorneys, employers, insurers, care coordinators, and MCOs, it also raises questions.

How is a complaint defined?

How are complaints tracked?

Who is told how to file a complaint?

Are injured workers told?

Are providers told?

Are informal disputes or concerns tracked anywhere?

Are issues resolved in ways that are not counted as complaints?

Do contractual or confidentiality requirements affect whether concerns are raised?

The point is not to assume that complaints have been suppressed. The point is that a statistic like "zero complaints" should come with enough explanation to understand what it means. A system cannot rely on the absence of complaints as proof of success unless the complaint process itself is transparent, accessible, and well understood.

MCOs are authorized to perform quality assurance, quality improvement, peer review, physician profiling, utilization review, and care coordination. These functions are often described as adding value to the system. But from the outside, it is difficult to determine how success in those areas is measured.

If an MCO conducts peer review, what is reviewed and what changes as a result? If it performs physician profiling, what methodology is used? If it applies treatment guidelines, how are those guidelines developed and updated? If it performs care coordination, does that coordination reduce delays, improve referral completion, shorten disability duration, improve function, or improve return-to-work outcomes? These should be answerable questions. They should not depend on anecdote, reassurance, or internal data that workers and providers cannot meaningfully review. If MCOs claim to improve quality, coordination, and return-to-work outcomes, those claims should be evaluated with public, objective measures.

The workers' compensation system routinely accepts that costs matter for employers, insurers, MCOs, and third-party administrators. Cost containment, administrative efficiency, and system sustainability are legitimate concerns. At the June 9 meeting, employers and insurers expressed concern that added oversight could increase cost or administrative burden. The same considerations should apply to clinicians.

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Administrative requirements, uncompensated work, record requests, phone calls, forms, reviews, and compliance tasks all matter and have associated, measurable opportunity costs for clinics. Cost containment should not mean shifting uncompensated administrative work onto treating providers and then ignoring that cost. Clinician time is not a free system resource.

As I understand, the value added by MCOs is considered to be worth a 25% reduction to the posted Oregon Fee Schedule for clinicians. It is unclear how a reduction in reimbursement is offset by value added in any area of clinical operations. The only justification I am aware of, is that it will increase referrals. There may be additional benefits of which I am unaware. While increase referrals can be helpful, each added patient is associated with the added, unpaid, administrative costs, and additional time required by the clinician. It is not clear that the 25% reduced fee schedule can be outweighed by volume alone. For smaller clinics, scaling and adding volume is not an easy or even a possible option, particularly if there are not enough clinicians from the start.

Clinics are typically for-profit, and carefully consider cost containment and efficiency as well. If there is no clear and significant value added from a system or process, then it does not make financial sense to engage with it. A sustainable system has to be transparent and equitable for employers, insurers, injured workers, and the medical professionals expected to provide the care. If MCO participation requires lower reimbursement and no clear economic benefit, no reduction in administrative time, and no obvious other value-added services, policymakers should ask what effect that has on clinician participation.

This creates an important contradiction. MCOs often argue that they improve access. But if the structure discourages participating, then the access benefit may be undermined by the same system claiming to provide it. This is not an argument for simply increasing reimbursement to clinicians. This is to highlight the unequal power dynamics, and the opacity of the current systems, preventing clinicians from being able to weigh the risks and benefits for their businesses before entering a legally binding contract. A system cannot reasonably claim that access is a central goal while downplaying the economic and administrative conditions that determine participation.

This is especially important in specialty care and psychiatric care, where access is already severely limited. Injured workers with complex psychiatric, neurologic, functional, or chronic conditions need timely access to qualified clinicians with the appropriate expertise. If reimbursement reduction and administrative complexity limit participation, injured workers will be harmed regardless of whether the system appears efficient on paper.

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The recent expansion of attending-provider eligibility to include additional provider types may improve access in some cases. It may also raise questions about training, experience, scope, complexity, and outcome measurement. If the argument for expansion is improved access, then that claim should be evaluated with outcome data, not solely appointment availability. A workers' compensation system should be measured by their effects on quality, recovery, functional outcome, disability duration, and return to work.

This type of reporting would not prejudge the value of MCOs. It would allow the value to be calculated. If MCOs improve access, reduce delays, improve return-to-work outcomes, reduce disputes, and improve system efficiency, transparent data should demonstrate that. If the benefits are more limited, or if the burdens fall disproportionately on workers and providers, that should also be known.

There was a suggestion that MCO concerns should be addressed case by case. Case-by-case review is important, as cases and circumstances can be unique. Case-by-case review is not sufficient if the same types of concerns are being raised repeatedly by workers, physicians, attorneys, and families. It cannot substitute for system-level transparency. If a problem is isolated, broader reporting will show that. If a problem is structural, case-by-case review may never reveal the full pattern.

MCOs should be held to accountability standards proportional to their authority. Oregon's workers' compensation system has changed significantly since MCOs were first deployed. The system may have needed one set of tools in the 1990s; it likely needs different oversight, different measurement, and different transparency now. The core issue is whether cost control, access, quality, care coordination, complaints, provider participation, and injured-worker outcomes are being measured in a balanced and transparent way. It is also critical to understand what the data reveals if we are to make any substantive improvements. This should also be a requirement whenever there are public funds involved.

At present, I do not believe there is enough publicly available information to answer these questions with confidence.

Sincerely,

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