June 18, 2026

Marie Rogers
Policy Analyst / Rules Coordinator
Workers' Compensation Division
350 Winter Street NE
Salem, OR 97301

Re: June 9, 2026 MCO Advisory Committee Meeting

Dear Ms. Rogers,

Thank you for providing the opportunity to submit input on the proposed change to the Oregon Administrative Rules relating to Managed Care Organizations (MCOs).

In addition to the public comment Majoris provided during the advisory meeting held on June 9, 2026, Majoris also submits the following for consideration.

Majoris does not act as an instrument of insurer interest. As an MCO, we operate within a system that creates an interplay between medical care and claims processing. One informs the other. Effective management of the medical component requires reference to how the medical treatment and clinical findings fit within the broader system structure. Characterizing this dynamic as collusion misunderstands both the structural role of MCOs and medical treatment of injured workers.

Majoris agrees separation between the insurer and the managed care organization is important. It is a critical component to the successful, balanced system Oregon has benefited from since managed care was introduced. This is not under debate. Instead, it appears the debate centers on what quality managed care includes.

The issue presented to the Workers' Compensation Division rests on the assertion MCOs are operating outside scope and engaging in claims processing activities. This argument artificially limits managed care to a narrow, superficial definition that contradicts both the statutory design and established clinical standards governing injured worker care. At the same time, it expands what is considered claims processing beyond what an insurer is permitted to do. The proposal does not reflect a well-founded concern that MCOs are operating outside their scope. It reflects an effort to weaken MCOs and inhibit their proper role within the Oregon workers' compensation system.

Public comment submitted in support of the change did not demonstrate that MCOs are engaging in claims processing. Rather, the complaints reflected disagreement with MCOs engaging with the attending physician regarding the use of medical resources and patient outcomes. That is not overreach, it is what the MCO certification is designed to deliver: ensuring enrolled workers receive care that is medically reasonable, necessary, and appropriate. The MCO's responsibility to ensure those standards are met is not suddenly dissolved if the attending physician or worker attorney disagrees with the MCO's standards or medical assessment.

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When submitting the issue, the stakeholder asserted that the stated purpose of MCOs is to 'deliver medical services' within the workers' compensation system. The statute's stated purpose of MCOs is to provide managed care to injured workers.

> **ORS 656.260 (1) Any health care provider or group of medical service providers may make written application to the Director of the Department of Consumer and Business Services to become certified to provide managed care to injured workers for injuries and diseases compensable under this chapter.**

Managed care is present in all healthcare settings as a concept that includes care coordination, medical case management, and treatment utilization management across the continuum of care. This breadth is established within the statute, which lists out a range of activities related to safeguarding worker medical care.

> **ORS 656.260 (4)(d)(D) "Quality assurance" means activities to safeguard or improve the quality of medical care by assessing the quality of care or service and taking action to improve it.**

> **ORS 656.260 (4)(d)(E) "Service utilization review" means evaluation and determination of the reasonableness, necessity and appropriateness of a worker's use of medical care resources and the provision of any needed assistance to clinician or member, or both, to ensure appropriate use of resources. "Service utilization review" includes prior authorization, concurrent review, retrospective review, discharge planning and case management activities.**

As Majoris presented during the meeting, attempting to remove MCO involvement in medical care assessments, decision making, and documentation merely because they may also inform non-medical decisions or actions contradicts both statute and medical care standards. In addition, medical services cover much more than what OTLA asserts. The arguments presented now are not substantively different than those presented when the rules were opened in 2023, when the Division rightly chose not to pursue any changes. The information Majoris presented at that time remains relevant and should be included in the Division's review of the current issue. Both then and now, the proposals are clear attempts to replace medical oversight with legal oversight on the care delivered to Oregon injured workers.

Worker attorney testimony reveals two consistent and troubling patterns. First, the inference that attorneys representing injured workers are better equipped than licensed medical professionals, medical associations, and evidence-based medical guidelines to define and determine medically appropriate care. Second, the examples presented describe MCOs facilitating functional advancement, pursuing curative care options before accepting permanent conclusions, and ensuring clinical findings are clearly and comprehensively documented. Those are activities the MCO should be engaged in. That they are being characterized as harmful to workers reveals more about the interests driving this proposal than about the conduct itself. This is alarming and should be addressed accordingly.

Attorneys are professionals, and an important resource for the Oregon workers' compensation system. However, they are not medical professionals and should not be granted authority or

influence in determining medical appropriateness, reasonableness, or necessity. This includes defining what is and is not medically related. Attorney convenience and worker medical outcomes are not the same measure of system quality. Any rulemaking should be evaluated against the latter.

Majoris addressed the statutory and clinical grounding for MCO engagement on medically stationary status, return-to-work, impairment findings, and functional capacity documentation during the June 9th advisory meeting. Those explanations are reflected in the meeting record and are incorporated here by reference. The following addresses assertions made during public comment that inverted the facts to characterize appropriate MCO conduct as misconduct and warrant direct correction.

Jovanna Patrick claimed an MCO informing a worker of a potential consequence under the system's rules, specifically, that treatment not authorized by the MCO risks being deemed non-compensable by the insurer, as engaging in compensability decision-making. It is not. Informing a worker of a structural consequence is not making a compensability determination. It is fulfilling the MCO's duty to the worker. Withholding that information would be the actual failure of the MCO's responsibility.

Ms. Patrick also presented an MCO's facilitation of additional evaluation and potential treatment following an attending physician's finding of permanent total disability as evidence of improper MCO interference with worker benefits. This framing fundamentally misunderstands the MCO's role, and more importantly, what permanent total disability represents for a worker. A finding of permanent total disability is not a victory for the worker, it is a determination that their injury has taken everything it can from them and medicine has nothing left to offer. An MCO that pursues additional evaluation before accepting that conclusion is not standing between a worker and their benefits. It is refusing to concede the worst possible outcome until it is certain no other path to recovery exists. That is exactly what the system should demand of an MCO.

Steven Schoenfeld claims Majoris has adopted "disability standards" clearly outside MCO scope because we reference "Official Disability Guidelines." Those are nationally recognized, evidence-based guidelines covering a range of topics relevant to work injury care, including the treatment guidelines Majoris references when reviewing treatment plans. They are not Majoris established "disability standards" as Mr. Schoenfeld attempts to frame them. They are treatment guidelines a third-party entity chose to name "Official Disability Guidelines". These evidence-based guidelines are widely used across the workers' compensation industry as a standard work injury clinical tool.

Julene Quinn asserted that asking if a worker has work restrictions has zero relation to medical services or a care plan. This is categorically false. One goal of medical treatment is to return the individual to full function. A worker's ability to work as they could before the injury is a measure of the effects of that care and how much more care may be needed to reach the final goal. Additionally, incorporation of stay-at-work and return-to-work is clinically proven to improve patient outcomes. Efforts that impact patient outcomes are medical.

Majoris has a window into several of the cases presented as examples demonstrating alleged MCO misconduct. With those, facts were misrepresented or omitted, resulting in an incomplete or inaccurate representation. Expansion and clarification on the timelines of those specific cases is provided as an addendum to this written submission. Due to the presence of claim-specific and confidential information, this is being provided separately to the Division. Majoris leaves it to the Division's discretion whether any portion of the supplemental materials may appropriately be

included in the public rulemaking record. Additionally, Majoris is aware of further examples submitted by Ted Heus via written comment. We cannot comment definitively on the examples because they lack context to support any effective assessment of MCO wrongdoing. They do appear to continue the same thread of reframing MCO intent by inference and assumption rather than any factual evidence of improper action.

For example, the first case presented highlights a call between the MCO and attending physician because the attending physician asserted in their chart note that the worker should receive vocational benefits.

There is no indication the MCO was attempting to help the insurer avoid liability for vocational services. Based on our experience, MCO engagement in this scenario likely reflects education to the attending physician that vocational rehabilitation services are not medical, and therefore outside their statutory role to advocate for, or include in their treatment planning. The MCO subsequently reporting "it was not a great call" and that they did not have anything further to help likely reflects that the education did not change the attending physician's decision to continue non-medical benefit advocacy and the MCO understood education to be the boundary for engagement.

Without full context, any characterization of the MCO's intent remains supposition.

We recognize MCO engagement can feel burdensome to providers whose documentation or care plan execution does not align with MCO standards. That friction should not be mistaken for MCO overreach. Instead, it is evidence the MCO is doing its job of ensuring care plans are well documented, meet the standards the MCO is obligated to uphold, and delivered efficiently. Where a provider, worker, or insurer disagrees with an MCO determination, the system provides established avenues for appeal and complaint. The MCO's responsibility is not to defer to another party's preference. It is to ensure the care provided to enrolled workers meets established standards of quality, appropriateness, and necessity.

Majoris concurs with several assertions. Majoris agrees it is beyond the authority of an MCO to assign a worker to a specific medical provider. MCOs should only be determining appropriate level of care. And it would be irresponsible to insist a worker must treat with a provider after that provider declines to assume care. These examples should be reviewed in depth by the Division, alongside any other examples available for submission. We endorse Connie Whelchel's call for comprehensive data review before rulemaking is considered. Any such investigation should be grounded in the established statutory and regulatory framework of what constitutes MCO authority and should include the MCO's account before conclusions are drawn. Anecdotal allegations alone are not a sufficient basis for rulemaking.

Majoris does not claim perfection. The line between medical management and claims administration is genuinely nuanced, and no organization operating at this volume and complexity will navigate every interaction flawlessly. Where errors occur, correction is the appropriate response. That mechanism already exists, both internally and through the regulatory oversight the Division has maintained over Majoris for more than thirty years. Lack of sanctions does not mean there has been lack of correction or guidance. In reality, the Division has consistently provided correction and guidance, resulting in refinements to MCO practice throughout MCOs existence within the system. That is what good-faith operation within a regulated system looks like. What the record does not

show, and what should be the threshold for rulemaking that fundamentally alters MCO operating authority, is willful or systemic misconduct. The evidence presented does not meet that threshold.

The proposed changes would prevent MCOs from fulfilling obligations the statute explicitly assigns to them and would create a gap, since insurers are categorically prohibited from managing medical care under Oregon law.

The people most harmed by that gap are injured workers. Reduced clinical coordination means reduced support for providers navigating a complex system. Reduced support for providers means slower, less complete recoveries. Removal of medical oversight translates to more frequent litigation of medical decisions and increased cost, as the system experienced prior to the Mahonia Hall reforms. Slower recoveries and increased litigation contradict the legislature's own declared purpose for this entire system, which is: to restore the injured worker physically and economically to a self-sufficient status, in an expeditious manner, and to the greatest extent practicable.

Sincerely,

Ann Klein, President

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