OREGON INDEPENDENT MENTAL HEALTH PROFESSIONALS

To: House Committee on Behavioral Health

From: Melissa Todd, PhD, representing OIMHP

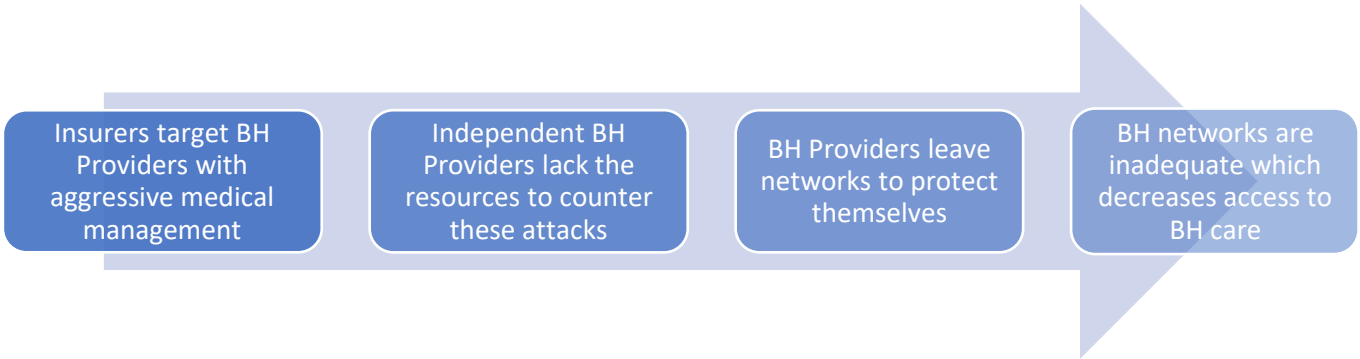
Date: February 5, 2026

Re: Testimony in support of HB 4054

Dear Chair Pham, Co-Chairs Edwards and Javadi, and Members of the Committee,

My name is Melissa Todd. I am a licensed psychologist in solo private practice in Eugene. I am also the President of the Western Oregon Mental Health Alliance (WOMHA) and member of the Oregon Independent Mental Health Professionals (OIMHP). OIMHP is a legislative advocacy committee of practicing behavioral health professionals supported by WOMHA. We advocate for increased public access to behavioral health care, insurer compliance with state and federal Mental Health Parity laws, and improved working conditions for behavioral health providers who contract with health insurance carriers.

I am testifying in support of HB 4028, which we have named *The Behavioral Health Protection Bill* because it advances several strategies designed to safeguard the integrity of care delivered primarily by independent practitioners and small group practices. Unlike large medical and hospital systems, these providers lack the resources to withstand aggressive audits, large clawbacks, and other medical management tactics. These non-quantitative treatment limitations (NQTLs) are in fact being applied more aggressively to behavioral health services according to the last four years of the Oregon DCBS Annual Behavioral Health Parity Reports. In other words, insurers are squeezing providers as a permitted way to control costs creating downstream negative effects on access to care, which ultimately harms patients who have no idea they are being discriminated against.



HB 4028's strategies are designed to address real, systemic problems in Oregon that create barriers to consumer access to behavioral health care by: (1) reducing power imbalances by giving providers more rights in the auditing process, (2) lowering the financial risk of delivering behavioral health care within insurance networks by *effectively* reducing the clawback window to 12 months and allowing providers who owe insurers more control over the repayment process, and (3) increasing transparency by requiring insurers to disclose their medical management tactics in real-time as they apply them to providers and in annual Behavioral Health Parity reporting to state regulators.

Some will claim these protections give behavioral health providers special treatment. In reality, medical management practices — especially audits and clawbacks — disproportionately burden behavioral health providers, who are far more likely to be independent or small-group practices than medical/surgical providers. Addressing this imbalance aligns directly with the intent of mental health parity: achieving parity in practice, not just on paper.

You may hear that this bill contains new concepts and thus should be delayed. **The truth is that nothing in this bill is revolutionary**. 20 states have clawback windows of 12 months or less. HB 3046 (2021) already contains more detailed parity reporting requirements specific to Oregon, which have yielded positive and measurable benefits as shown in DCBS the annual reports. The term "medical management" occurs 31 times in the 2024 Federal Register Preamble and Mental Health Parity Final Rule, which states "medical management techniques are non-quantitative treatment limitations if they limit the scope or duration of treatment" (p. 77597) and therefore must satisfy parity standards.

Lastly, there is legal precedence for prohibiting clawbacks based on clerical errors. In Papa v. Wisconsin Department of Health Services (DHS) (2020), the Wisconsin Supreme Court ruled that DHS cannot recoup Medicaid payments from providers based on "imperfections" in provider records, otherwise known as clerical errors. The Court held that the DHS recoupment policy, which required perfect documentation in the Medicaid Provider Handbook, was unenforceable because it exceeded statutory authority. The Court ruled that DHS may only recoup Medicaid payments when they cannot verify the actual provision of services, not merely because of minor clerical errors or documentation shortcomings.

If HB 4028 is enacted, insurers and CCOs will still hold substantial power and will continue to make coverage and management decisions. What changes is that behavioral health providers will gain reasonable protections they currently lack—and that shift will make a meaningful difference in access to care for consumers without disrupting existing systems. For these reasons, I respectfully urge the Committee to support HB 4028. Thank you for your time and consideration.

Sincerely,

Melissa Todd, PhD
Licensed Psychologist