



To: Division of Financial Regulation, Department of Consumer and Business Services

From: Melissa Todd, PhD, representing OIMHP

Date: October 28, 2025

Re: SB 822 Rulemaking Advisory Committee

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OIMHP is a committee of practicing behavioral health professionals supported by the Western Oregon Mental Health Alliance (WOMHA). We advocate for increased public access to behavioral health care, insurer compliance with state and federal Behavioral Health Parity laws, and improved working conditions for behavioral health providers who contract with health insurance carriers. We appreciate this opportunity to advise the department on the SB 822 rulemaking process and respectfully offer our feedback in response to the draft rule and discussion from the October 14<sup>th</sup>, 2025 committee meeting.

### **Telemedicine**

OIMHP supports the current percentage caps for telemedicine in OAR 836-053-XXX Quantitative Network Adequacy Standards Section 3(a-b) as written in the draft rule. We agree with the 9/24/2025 comment by Providence Health Plan that telemedicine “must remain a companion to in-person care” and oppose Kaiser’s 9/23/2025 recommendation to increase telemedicine percentage caps.

Allowing greater percentages of telemedicine providers to meet network adequacy access standards could have the unintended effect of disincentivizing insurers from contracting with local, Oregon-based providers. It opens the door for insurers to meet standards by contracting with large, corporate-owned telehealth companies that are more likely to employ providers based out-of-state. OIMHP supports keeping the health care of Oregonians in the hands of Oregon-based providers and practices.

### **“Safe Harbor” Provisions for Insurers**

OIMHP opposes expanding “safe harbor” provisions for insurers beyond designated health provider shortage areas (HPSAs) and low-income zip codes. We support the written justification requirements insurers must submit for each unmet quantitative time and distance or appointment wait time standard in OAR 836-053-XXXX Network Adequacy Reporting Requirements Section 2(d)(A-D) as written in the draft rule. However, we would like to see additional mandatory elements directing insurers to identify internal administrative barriers to

meeting the standards and steps insurers are taking to remedy these barriers. The listed explanations focus exclusively on barriers from the provider side without acknowledging the barriers to network admission from the insurer side such as staffing shortages, cumbersome credentialing requirements, delays beyond the 90-day credentialing period mandated by Oregon law, delays in contracting, and closing networks to new providers. As practicing behavioral health providers who belong to an association that holds two insurance contracts, we have personally experienced inexplicable barriers to network admission and would like DCBS to have a line of sight on this issue. Note that “barriers to network admission” is considered a non-quantitative treatment limitation subject to behavioral health parity laws.

While HB 3242 (2025) does require insurers to pay “medical claims” for providers joining in-network provider groups, it is unclear whether the new law applies to behavioral health claims and independent providers who are not joining provider groups.

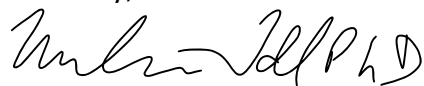
### **Culturally and Linguistically Responsive Care**

OIMHP supports DCBS’s efforts to use the network adequacy reporting requirements as an avenue to gather information about culturally and linguistically responsive care within insurance networks. However, the requirement for insurers to report the number or percentage of providers that self-report cultural competency training or continuing education may be redundant; all Oregon licensed behavioral health providers are required to receive cultural competency continuing education each licensing cycle. If the other types of Oregon licensed providers have the same requirement, it is safe to assume all licensed network providers have received cultural competency training and must receive ongoing continuing education.

It would be more meaningful to ask providers to self-report specialties in categories derived from the omitted bill language: “diverse cultural and ethnic backgrounds, varying sexual orientations and gender identities, disabilities or physical or mental health conditions.” This information could be included in provider directories to guide consumers seeking providers who can meet their needs.

Thank you the opportunity to offer comments to inform the SB 822 rulemaking process.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Todd, PhD'.

Melissa Todd, PhD  
Licensed Psychologist

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Oregon Independent Mental Health Professionals (OIMHP)