September 3, 2025

Oregon Division of Financial Regulation
350 Winter Street NE
Salem, OR 97301
Submitted via email

Re: Comments on Network Access draft rules

Dear Ms. Hall,

Kaiser Foundation Health Plan of the Northwest appreciates the opportunity to provide feedback to the Oregon Division of Financial Regulation (DFR) on the network access draft regulation. Kaiser Permanente Northwest is an integrated health care system that covers and cares for Oregonians. We are committed to delivering affordable, coordinated, and high-quality care and coverage that supports not only our members but also the communities we serve.

Thank you for holding the Rulemaking Advisory Committee (RAC) on August 20th. We appreciated the robust discussion on how Oregon will implement the federal network access standards into state regulation. We recognize this is a complex topic, and we appreciate the time devoted to the discussion to ensure alignment with the underlying statute and federal standards. We are providing feedback on health professional shortage areas and the section OAR 836-053-XXX Quantitative Network Adequacy Standards (page 4 of the draft regulation PDF).

**Use of health professional shortage areas for a ZIP code list**

ORS 743B.505 references health professional shortage areas. We agree with the definition added to the draft regulation. We note that The Centers for Medicare and Medicaid Services (CMS) maintains a list of health professional shortage areas on its website. https://www.cms.gov/medicare/payment/fee-for-service-providers/physician-bonuses-health-professional-shortage-areas-hpsas. It would be helpful for the regulation to point to this CMS list. ORS 743B.505 also mentions a low-income ZIP code list, which can be found on the QHP certification page here: https://www.qhpcertification.cms.gov/QHPvforcesite/apex/FileDownload?file=LowIncomeZIPsPY2026-v1. While the underlying statute allows the use of either source, we believe that the health professional shortage area list is a better indicator of provider scarcity and access to services than the low-income ZIP code list.

**Align terminology with federal terminology**

During the RAC, the DFR noted that the terminology used in the regulation was based on the network access work done by the Oregon Health Authority (OHA) for the Medicaid population. While we understand the intent to harmonize with the OHA regulation, we are concerned that this creates confusion. ORS 743B.505 (4)(a)(A) sets the quantitative access standard as the CMS Network Adequacy standard. We believe the regulation should use the same terminology as the CMS standard for alignment and clarity. For example, the county size labels in the regulation should be “large metro,” “metro,” “micro,” etc. instead of the “urban” / “rural” labels that are used by the OHA.

**Provide clarity on the data elements to track to demonstrate network adequacy**

We understand that the DFR plans to have reporting templates and instructions that are outside of the regulation draft and instead are part of the regulations for annual reporting. The regulation draft,

however, is not clear about which data elements the DFR would like carriers to monitor to demonstrate access. When developing the regulation and reporting instructions, we would like the DFR to consider the following questions/topics.

- It is not clear if the measurement standard for appointment access is the number of days between the patient request and the first available appointment or the number of days between the request date and the appointment date the patient selects (which may be further in the future). For provider access outside of an integrated care delivery system, it isn't clear if carriers should be looking at claims data to count the days or if there is another way of tracking that the DFR has in mind.
- What methodology will be used to calculate driving distance for network adequacy access standards? Estimated driving distance (as used by CMS from PY 2022-2025) or geographic distance (used by CMS for PY 2026 onward)?
- Will Oregon use the Alternative Standards published by CMS in 2025 that revised the access metrics for select specialties in select counties?
- What is the time frame that appointment wait time access should be measured by carriers prior to the submission of appointment wait time reporting in the annual report? How many months of time should be used for the sample, and what percentage of oversampling should be used?

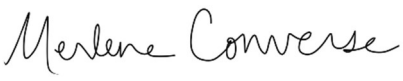
Providing expectations in the regulation or the reporting instructions would help with consistency across health carriers in tracking the data elements and reporting the information.

**Inclusion of telemedicine when measuring network adequacy**

We support the inclusion of telemedicine in meeting the quantitative network adequacy standards. We note that CMS has incorporated telemedicine into the measurement of appointment wait times in the federally facilitated exchange. Given the substantial role that telemedicine plays in the provision of primary care and mental/behavioral health, we recommend that Oregon adopt the identical approach to incorporating telemedicine into the measurement of appointment wait time access.

We thank you for the opportunity to provide comments on this stakeholder draft. We look forward to our continued collaboration throughout this rulemaking process. Please do not hesitate to contact us with questions.

Sincerely,



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