

Network Adequacy Requirements: Oregon vs. Federal

Requirement	CMS QHP Standard	Oregon Draft Rule	Alignment/Divergence
Authority	45 CFR 156.230(a), annual Letters to Issuers, e.g., 2023/2025/2026 Letter	Oregon Revised Statutes (ORS) 743B.505, implemented by Oregon Administrative Rules (OAR) 836-053-0300 to 836-053-XXXX	NA
Foundation	Federal network adequacy standard for QHPs (45 C.F.R 156.230)	Explicitly adopts the federal standard as the Nationally Recognized Standard.	Alignment
Time and Distance Standard	Sets specific maximum travel time/distance standards (45 C.F.R. § 156.230).	Directly adopts the federal time and distance standards and county classifications.	Alignment
Appointment Wait Times	Sets numerical standards in business days (2025 Letter): Primary Care: 15 business days; Behavioral Health: 10 business days; Specialty Care: 30 business days.	Establishes specific, mandatory maximum wait times: Primary care: 15 business days; Behavioral health care: 10 business days; Specialty care: 30 business days. Oregon requires reproductive health care providers to meet the 10 business day appointment wait time standard, placing them into the same quantitative metric as Behavioral Health (BH) providers.	Partial Alignment: While the wait times for primary and specialty care are the same, Oregon has a specific requirement for reproductive health care, aligning it with the behavioral health standard.
Required Provider Scope	Requires adequate access to all provider specialties and facility types identified by CMS.	Oregon includes five specific licensed behavioral health professionals (LPC, LMFT, LCSW, Psychologists,	Divergence: Oregon's requirements are more specific regarding the types of behavioral health providers that

		Psychiatrists) to meet quantitative standards (mandated by SB 822).	must be included to meet network adequacy standards.
Telemedicine Counting	Telehealth does not count toward meeting Time and Distance standards. However, for Appointment Wait Time standards, the 90% compliance rate is calculated using whichever appointment is available sooner, whether in-person or via telehealth.	Telehealth is allowed, as permitted by Department rules. Rules specify that telehealth can be used to satisfy up to 10% of access requirements for primary care and 30% for BH care.	Divergence: The federal standard uses telehealth as a factor in measuring appointment availability, while Oregon's rule sets specific percentage caps on how much telehealth can be used to meet quantitative access standards
Continuity of Care	Requires a good faith effort to provide written notice of provider discontinuation 30 days prior to the change. In cases of termination without cause, enrollees in an active course of treatment can continue for up to 90 days at in-network rates.	Oregon requires a carrier to have a plan for continuity of care in the event of contract termination with a provider, insolvency, or other inability to continue operations, as required by ORS 743B.225. The plan must detail how enrollees will be notified and transitioned to other providers in a timely manner.	Partial Alignment: While both have continuity of care provisions, Oregon's rule is more detailed, requiring carriers to submit a proactive plan for various scenarios, whereas the federal rule focuses on enrollee protections after a provider has already left the network.
Provider Directory Requirements	QHP issuers must make their provider directory available online and in hard copy upon request. The directory must identify providers not accepting new patients and be up-to-date, accurate, and complete.	Carriers must post a current, accurate, and complete provider directory electronically for each network plan, with specific search functions. The directory must be updated at least monthly. A print copy must be available upon request.	Alignment: Oregon's provider directory requirements align with and expand upon the federal standards by specifying update frequency and required search functionalities.

Unmet Standards	Issuers that do not meet all elements of the NA standards are issued a correction notice and a partially populated NA Justification Form to complete and submit.	Carriers must submit a written justification for any unmet quantitative standards in HPSAs or low-income ZIP codes. The justification must explain the reason for the inadequacy, document good-faith contracting efforts, and describe mitigating measures to ensure access to care.	Partial Alignment: Both require a justification for unmet standards, but Oregon's process is more detailed, requiring documentation of specific contracting efforts and mitigating measures.
Reporting Requirements	Issuers submit network data via the ECP/NA template. If standards are not met, a Justification Form is required. For 2025, issuers must also report results from third-party "secret shopper" surveys to verify appointment wait times.	Carriers must submit a comprehensive annual report by March 31. This report must include the carrier's own geospatial analysis, detailed provider data, and plans for continuity of care. A detailed written justification is required for any unmet standards in HPSAs or low-income ZIP codes	Partial Alignment: While Oregon's reporting requirements incorporate federal standards, its mandate for a comprehensive annual report with specific state-required elements diverges from the federal template-based submission process.