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Kaiser Foundation Health Plan of the Northwest

February 23, 2026

Oregon Division of Financial Regulation
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97301

**Re: Feedback on Draft Network Adequacy Reporting Template**

Dear Oregon Division of Financial Regulation Team,

Thank you for the opportunity to provide feedback on the draft Network Adequacy reporting template. We appreciate the Division of Financial Regulation's (DFR) collaborative approach and willingness to engage carriers as you refine both the template and the associated reporting expectations. We offer the following comments and questions for your consideration, with the goal of supporting accurate, consistent, and feasible reporting across carriers.

**Data Availability and Reporting Burden**
Several data elements requested in the draft template are not consistently captured in existing carrier systems or are only available through complex or manual processes. In particular, some requirements would necessitate new, recurring provider surveys across the carrier market, resulting in significant operational burden for providers and duplicative outreach across health plans. While we recognize that some elements stem directly from statutory language, flexibility, phased implementation, or clearer methodological guidance would help ensure accurate and sustainable compliance. As outlined in this letter, the template reporting instructions could benefit from further clarification.

**Appointment Wait Time Standards**
We request additional consideration and clarification regarding the proposed appointment wait time reporting, particularly for behavioral health providers. As drafted, these requirements raise both methodological and operational concerns, as outlined below:

- **Inpatient Behavioral Health Facilities**
  We are not aware of any CMS-defined appointment wait time standards for inpatient admissions. In practice, inpatient access is binary—either a bed is available or it is not. Surveying inpatient facilities would yield only a point-in-time snapshot of open beds, which, when compared to total plan membership, would result in percentages that are not meaningful for access evaluation. Additionally, we believe the State of Oregon has implemented a psychiatric bed monitoring system and is aware of the persistent lack of available beds, particularly for inpatient and residential substance use disorder treatment. Existing state policies, including prioritization requirements for pregnant individuals and individuals using substances intravenously, further underscore that these shortages are well-documented and systemic rather than carrier-specific.
- **Outpatient Behavioral Health Providers**
  For outpatient clinical behavioral health providers, it is unclear how appointment availability should be measured or interpreted. If providers are surveyed for the number of available new-patient appointments at a single point in time, dividing those appointments by total plan membership does not appear to yield a meaningful or comparable access metric. Additional clarification is needed regarding sampling expectations, weighting methodologies (e.g., if only a subset of the network is surveyed), and how DFR intends to ensure apples-to-apples comparisons across carriers.
- **Operational Feasibility**
  Not all carriers routinely collect appointment availability data in this manner today. Implementing these requirements would require the development of new provider outreach processes, staffing resources, and data collection timelines. Advance clarity regarding expectations and measurement periods will be critical to ensure that any future reporting can be operationalized prospectively rather than retrospectively.

**Definitions and Clarifications Needed**
Clear and standardized definitions will be critical to ensure consistent reporting across carriers. We request additional clarification on the following terms and concepts:

- **Facility**, particularly in light of facilities that may have multiple NPIs.
- **Network affiliation** and **network tier level**, including how these fields should be populated for multi-tier arrangements.
- **Reproductive health**, including how this category relates to existing specialties such as OB/GYN, endocrinology, and other related services.
- **"Assigned or attributed" enrollees**, particularly for behavioral health providers.

**Providers Tab**
We also request clarification on several elements within the Providers tab to support consistent and accurate reporting. First, it is unclear whether the "accepting new patients" field is intended to apply to facilities. We note that this concept is typically meaningful for individual practitioners rather than facility-based providers who do not have a panel of patients and serve the patients that are in the hospital or other facility. Second, additional guidance is needed on how Oregon counties served should be determined, particularly for providers and facilities that serve members statewide or virtually, and whether selecting "all" counties is an acceptable and intended response in those circumstances. Finally, clarification would be helpful regarding whether the template expects multiple rows per provider or facility by specialty and/or location.

**Behavioral Health Tab**
We appreciate the focus on behavioral health access and note the following areas where additional clarification would improve consistency and reduce ambiguity:

- **Chronic or Complex Behavioral Health Conditions**: It is unclear how carriers should identify or report whether providers treat "chronic or complex" behavioral health conditions. If this designation is diagnostic in nature, carriers are unlikely to have reliable or standardized data, as most behavioral health providers treat a wide range of complex conditions (e.g., eating disorders, autism, treatment-resistant depression, bipolar disorder).
- **Unique Members Seen**: Additional guidance is needed regarding the reporting period for "unique members seen". Clarification would also be helpful regarding how members should be counted when they receive care from multiple providers, to avoid duplication unless explicitly intended.
- **County and ZIP Code Fields**: Because most behavioral health providers may treat members statewide—particularly through telehealth—it is unclear what value these fields add beyond identifying a provider's brick-and-mortar or business location. Clarification would be helpful regarding whether these fields are duplicative of the Time and Distance Reporting tab and how DFR intends to use this information analytically.

**Provider Self-Identified Attributes**

- The template includes fields requiring carriers to report on how providers have self-identified their ability to serve certain populations (e.g., cultural or linguistic attributes). In practice, not all providers respond to such requests from carriers, and these data are not consistently captured today. We recommend that reporting for these fields be clearly framed as optional and reported only if available, and that missing data not be interpreted as a deficiency or non-compliance. Consistency across carriers will depend on standardized definitions and expectations.

**Telehealth Providers**
We request further guidance on reporting expectations for telehealth-only providers, including:

- How to report addresses without inadvertently publishing personal or home addresses. Is a null value acceptable?
- How to treat telehealth providers located out of state who are used to meet Oregon network adequacy standards. (e.g., Kaiser contracts with some large behavioral health telehealth providers outside of Oregon that would support meeting network adequacy requirements).

Some current address and location fields may not align well with how telemedicine is operationally used to meet access requirements.

**HPSA and Low-Income ZIP Code Reporting**
Mapping county-level adequacy results to specific Health Professional Shortage Areas (HPSAs) and low-income ZIP codes introduces additional analytical complexity. On the Provider tab, clarification would be helpful on the interpretation of "is in or serves," particularly for telehealth providers, and on expectations where county-level and ZIP-level geographies do not align cleanly.

**Mitigation Measures for Network Gaps**
The draft template appears to limit carriers to selecting a single mitigation strategy, even though multiple mitigation approaches (e.g., telehealth, adjacent counties, transportation supports) are often used simultaneously. Allowing multiple selections or more flexible responses would more accurately reflect how carriers address access gaps in practice.

**Use of Reported Data**
Finally, we would welcome additional transparency regarding how DFR intends to analyze and use the submitted data. Understanding how specific fields support network adequacy assessment would help carriers focus efforts on the most meaningful and actionable data elements.

Thank you again for the opportunity to provide input. We appreciate DFR's continued engagement with carriers and look forward to ongoing collaboration as the template and guidance are refined.

Sincerely,

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