Date: April 30, 2024

From: Steven Ranzoni, Hospital Policy Adviser

Subject: Report on Rulemaking Hearing and Public Comments

Hearing Date: April 17, 2024, 2 p.m.
Hearing Location: Remote, Microsoft Teams
Hearing Officer: Pete Edlund, HPA Rules Coordinator
Public Comment Period: April 1, 2024 to April 22, 2024
Title of Proposed Rules: Changes to hospital financial assistance.
Repeal: none
Amend: OAR 409-023-0100, 409-023-0105
Adopt: OAR 409-023-0110, 409-023-0115

Meeting recording at: https://www.youtube.com/watch?v=J87N653Tk8I

Rules Hearing Attendance Record:
Steven Ranzoni, OHA
Sarah Grabe, OHA
Rachel Higgins, OHA
Piper Block, OHA
Lisa Wilson, OHA
Tiffany Goetz, OHA
Pete Edlund, OHA
Cassie Enderle, Salem Health
Erica Puopolo, Salem Health
Eli Rushbanks, Dollar For
Jason Friend, PeaceHealth
Cheryl Mallory, PeaceHealth
Kara Kaefring, Sky Lakes Medical Center
Karli Tatum, Grande Ronde Hospital
Laura Johnson, SEIU Local 49
Melody Jackson, Legacy Health
Terrie Handy, Legacy Health
Jeremy Brossart, Legacy Health
Diamond Roberts, St Charles Health System
Jackie Fabrick, Providence Health and Services

Public Participants:
Cassondra
Laura Nolasco
Mmb02
Laura

Summary of Oral Comments presented during the April 17, 2024 Rules Hearing.

Testimony by Laura Johnson, SEIU

General Comments: SEIU appreciates all the work OHA has done to engage partners in the rules process and supports the rules as written. SEIU is grateful for all OHA's work and will follow up with brief written comments.

Response 1: OHA is grateful for SEIU's support and recognition of our efforts.

Summary of Written Comments received during the public comment period April 1, 2024, through April 22, 2024.
Chronological order of received.

Comments from SEIU Local 49 (Exhibit 1)

Comment 1: **SEIU is pleased to see the changes OHA made to the proposed rules after the RAC:**

1. Addition of 409-023-0120 (10)(f) and 11(c) that mandate hospitals consult one additional source of data if their initial screen yields inconclusive results.
2. Requirement that hospitals document how patients are screened and how presumptive eligibility determinations are made.
3. Addition of 409-023-1020(6) the discrete requirement that hospitals determine if the patient has already been qualified for financial assistance in the last 9 months before taking other screening actions.
4. Change to 409-023-0125(5) that better aligns appeals process to federal regulations to allow 240 days from the date the patient was notified of the financial assistance determination to correct deficiencies in the application or request an appeal.

Response 1: OHA is grateful that SEIU recognizes and approves these changes.

Comment 2: SEIU suggests OHA consider minor changes:

1. 14(b)(D) Replace "a distinct notice on the billing statement" with "a prominent notice" and use an existing definition of "prominence"; or if none exists, specify that this information must appear in, for example, bold and all caps, and in at least one font size larger than surrounding text.
2. 14(c) Rewrite statements in plainer language at more accessible reading levels. The words "presumptively eligible" and even "financial assistance" are not necessarily clear to those not familiar with industry jargon. Suggest language similar to the following:
   - "Based on our initial screening, you qualify to have your bill forgiven."
   - "Based on our initial screening, you qualify for a discount on your bill. "

- "Our initial screening found that you do not currently qualify for financial assistance."
- "Based on our initial screening, we were unable to tell if you qualify for a discount on your bill."

Response 2: OHA appreciates these language suggestions. However, we intend to use administrative rules to set minimum expectations, rather than specific language, and provide further detailed language guidance as sub-regulatory guidance. OHA will make the following changes:

(D) A *[distinct]* **prominently displayed** notice on the billing statement;

OHA will adopt the term prominently displayed to more clearly articulate expectations around notice on the billing statement.

(c) Clearly state the outcome of the prescreening **using plain language** *[as one]* **for each of** the following **outcomes**:

(A) *[prescreening process has found you are presumptively eligible for full financial assistance*] **Presumptively eligible for full financial assistance**;

(B) *["prescreening process has found you are presumptively eligible for partial financial assistance"]* **Presumptively eligible for partial financial assistance**;

(C) *["prescreening process has found you are not presumptively eligible for financial assistance"]* **Not presumptively eligible for financial assistance**; or

(D) *["prescreening process was unable to determine if you are presumptively eligible for financial assistance"]* **Unable to determine presumptive eligibility status.**

OHA recognizes that there are risks with placing specifically required statements into rules that prevent flexibility in meeting patient and specific population needs. This rule, as written, is meant to set the expectation that hospitals clearly communicate the outcome of the prescreening process with patients.

OHA will issue further sub-regulatory guidance, best practices, and example language for hospitals to use.

Comments from Chris Coughlin, Oregon Consumer Justice (Exhibit 2)

Comment 3: Oregon Consumer Justice (OCJ) is very supportive of the proposed rule and how the rules align with the intent of the legislation to make hospitals responsible for ensuring that patients have timely and appropriate access to financial assistance they are eligible for. OCJ especially supports the following elements of the proposed rule:

- Thorough requirements around prescreening that will ensure hospitals are making a reasonable efforts to determine each patient's eligibility before sending them a bill.

- Provision that a patient's credit score cannot be negatively impacted by use of third-party software tools.
- Extension of the time frame for appeals to align with the federal 240 days requirement.
- Provision requiring hospitals suspend debt collection activities and tell debt collection agencies to pause their debt collections during the appeals process.

Response 3: OHA is grateful Oregon Consumer Justice recognizes and approves these changes.

Comments from Andrea Seykora, Hospital Association of Oregon (Exhibit 3)

Comment 4: 409-023-0115(5) Prior to making the data public, hospitals should have the option to redact confidential business or patient privacy data.

Response 4: OHA will not allow hospitals to redact their own data forms. However, OHA will suppress potentially identifiable data. We will add the following language:

(5) Data collected on form HFCR and form HFAR shall be made publicly available on the Hospital Reporting Program of the Authority's website. **Prior to posting on its website, the Authority shall suppress information as necessary to protect patient confidentiality in accordance with applicable laws and regulations, as well as with the Authority's policies regarding small number reporting.**

OHA is always subject to requirements under federal HIPAA regulations and must always ensure we protect the confidentiality of patients in any reporting which may disclose their identity.

Comment 5: 409-023-0120(6) Suggest small language change specifying patients who have applied for and been determined eligible for financial assistance based on provided documentation.

Response 5: OHA will adopt this suggestion.

(6) Prior to taking any other prescreening actions, the hospital must determine if *[the patient has already qualified for financial assistance based on the hospital qualifying the patient]* during the previous nine (9) month period**, the patient has applied for financial assistance and the hospital has determined that the patient is eligible for financial assistance based on documentation provided by the patient**. *[Patients determined to have already qualified for financial assistance during the previous nine (9) months, fulfills the prescreening requirement and]* **If yes,** the patient must receive a patient cost adjustment in accordance with ORS 442.614, prior to receiving a billing statement.

Comment 6: 409-023-0120(10)(f) Request modifying language related to hospitals' requirement to use additional methods to screen patients if the initial method does not contain any information on the patient.

Response 6: OHA will adopt this suggestion. The goal of this language was to ensure hospitals do not ignore or fail to use readily available information, particularly information they may already have, in favor of a singular source of data about the patient. Since the rules do not require a specific method be used, the recommended language change makes sense.

(f) If a **hospital's initial prescreening** method *[described in this subsection]* fails to return information about the patient, the hospital must *[consult at least one additional method specified in (10) or (11) and]* make a good faith effort to determine the patient's presumptive eligibility status **based on other information available to the hospital.**

Comment 7: 409-023-0120(11)(c) Consistent with comment 6 above, change wording in third party-software requirement to be based on information available to the hospital.

Response 7: OHA will adopt this suggestion.

(c) If a third-party service or software tool fails to return information about the patient, or specifies the patient's income is unknown, the hospital must *[consult one or more of the data sources specified in (10) and]* make a good faith effort to determine the patient's presumptive eligibility status **based on information available to the hospital.**

Comment 8: 409-023-0120(14)(c) Request that the required four outcomes of prescreening that are to be included in the screening notification (found presumptively eligible for full financial assistance, partial financial assistance, no financial assistance, or screening was unable to determine eligibility for financial assistance) be reduced to one single statement that informs the patient they have been screened and any financial assistance they are presumed eligible for has been applied to their bill. This is based on the goal of simplicity for patients.

Response 8: See response 2. OHA will not adopt this suggestion; however, OHA is modifying the section as discussed before.

Simplicity and clarity for the patient is certainly a priority. However, providing the patient with specific statements regarding their presumptive eligibility status is the simplest and clearest way to achieve that goal. The lack of a definitive statement on the status of a patient could result in more work and confusion for the patient to understand what their options are. Deferring the patient to the billing statement requires the patient to read and interpret an itemized bill to understand if financial assistance has been applied, without a clear understanding of how much financial assistance should be applied. This could also lead to a situation where a patient who was denied presumptive eligibility thinks they did receive an adjustment by misinterpreting insurance adjustment statements commonly found on bills.

Furthermore, bill advocates are in strong support of clear indications of the outcome, as captured during comments made in the RAC and noted in the comments from SEIU.

OHA recognizes that this creates administrative challenges and will continue to partner with hospitals to provide assistance and issue further sub-regulatory guidance as necessary.

Comment 9: 409-023-0125(4)(d) Relating to patient appeals, HAO requests swapping out the option for patients to submit appeals "through email" to "electronically" to give hospitals the flexibility to accept appeals through email or secure online portal, as some hospitals said they could do one and not the other, for both email and secure online portal.

Response 9: OHA will change the wording to say:

(d) The notification must include a clear description of how the patient may submit corrections or additional documentation and how the patient may request an appeal. At a minimum, a patient must be able to submit corrections or additional documentations and request an appeal *[through email,]* **electronically, by either email or through a secure online portal, by** mail, and **by** in-person delivery.

Comment 10: 409-023-0125(4)(e) The bill does not require hospitals to offer a meeting with their chief financial officer (CFO) as part of the appeals process but rather allows the patient to "request a review" so HAO recommends changing the wording to better reflect the bill language.

Response 10: OHA will adopt this suggestion.

(e) The notification must inform the patient that if the patient chooses to appeal, the patient may request *[a meeting, virtual or in person, with]* **review by** the hospital's Chief Financial Officer or a designee of the hospital's Chief Financial Officer who has been delegated decision-making authority over the appeal.

Additionally, OHA will add the following language as a new subsection:

(g) The notification must provide contact information to an appropriate hospital representative that may answer questions about the appeals process or the patient's financial assistance application.

Comment 11: 409-023-0125(5) Request a change in the language around allowed time for patients to correct financial assistance application deficiencies to be more specific. Introduce language clarifying a hospital may continue billing practices during this time.

Response 11: OHA will partially adopt the suggested edits; however, OHA will further expand the section to read:

(5) A hospital must allow a patient *[a]* the **remaining** duration of the 240-day application period **after the date of the first post-discharge billing statement for the care provided, as** specified in 26 CFR 1.501(r)-1(b)(3), **or 45-days** from the date the patient was notified of the financial assistance determination to correct deficiencies in the application or request an appeal, **whichever is greater**. **A hospital may conduct standard billing practices during the application period if there is not a pending appeal. However, this does not remove the hospital's obligation to reimburse a patient if found to be eligible for financial assistance, in accordance with ORS 442.615.**

OHA has added the "or 45-days whichever is greater" criteria for two reasons. First, this is meant to avoid a potential situation where a patient is denied the right to appeal a decision because they turned in an application towards the end of the application period and a hospital did not respond until after the period has ended or the remaining period was too short to allow a chance to respond. There is no provision of HB 3320 that allows a hospital to deny the right to an appeal based on the application period if an application was received in the appropriate window of time.

Second, HB3320 introduced an expanded period under which a patient may apply for financial assistance from the 240-day window to 12 months after the patient pays for the services provided. This language avoids an unintended prohibition on appeals for applications received after 240 days.

It is important for timelines to be clear so a hospital may continue its allowable practices and patients know what is expected of them. OHA added the statement to clarify that hospitals may conduct their standard practices during these application windows, if there is not a pending appeal, but also a reminder of the provisions of HB3320 that require reimbursement of any money collected that is later found to be eligible for financial assistance. This is meant to provide clarity around what ORS 442.615 requires.

Comment 12: 409-023-0125(6)(c) Suggest changes to notification sent to patients during the pendency of an appeal allow hospitals to use any of the methods permitted in (4)(b) regardless of what method(s) the hospital used previously, unless a method is request by the patient. Further suggests conforming edits around requesting a review by the CFO (See comment 10).

Response 12: OHA will adopt this suggestion.

(c) Provide the patient with a written statement, delivered *[by the same method used under]* **in accordance** OAR 409-023-0125(4)(b), *[unless the patient has requested a different]* **and any request by the patient to use a specific permitted** delivery method, that contains:

And

(C) Information on *[how to schedule a meeting, including information for both in-person and virtual meetings,]* **any actions the patient may take** if a patient has requested a *[meeting with]* **review by** the hospital's Chief Financial Officer or a designee.

Comment 13: 409-023-0125(7) Hospitals should not be required to offer an in-person meeting for patient appeals review.

Response 13: OHA will delete this section.

Comment 14: Notes a copy error.

Response 14: OHA corrected the error.

Comment 15: Requests a conforming edit to the suggestions made in comment 12.

Response 15: OHA will adopt this suggestion.

(11) A hospital must issue a written determination on the appeal within 30 days of either the date of the final appeals meeting or the date of receipt of corrections related to application deficiencies, whichever is later. The hospital must communicate its determination in accordance with plain language and preferred language requirements established in OAR *[2]***4**09-023-0125(4)(a) and it must be delivered *[through the same method used under*] **in accordance with** OAR 409-023-0125(4)(b), *[unless the patient has requested a different]* **and any request by the patient to use a specific permitted** delivery method.

Jeremy Brossart, Legacy Health (Exhibit 4)

Legacy Health supports the comments provided by HAO and would like to provide experience-based information to reinforce three specifically.

Comment 16: Regarding notifications. Allowing the billing statement to serve as the communication of outcome from the presumptive prescreening requirements will greatly improve the patient experience and reduce unnecessary cost increases. We support the inclusion of this option in the proposed rules and would like to reiterate the comments provided by HAO in which a single outcome statement, with necessary translations, be included in the billing statement and be specific to all outcomes that were not found to be eligible for full FA award presumptively. We care for many patients in our community that receive services multiple times per week for extended periods of time. Envisioning a future in which a cancer patient receives dozens of presumptive prescreening denial letters for being over income while undergoing treatment is not an outcome anyone desires.

Response 16: **See response 8.**

OHA agrees that there is a lack of clarity around the frequency of notifications, particularly with episodes of care situations, or multiple repeated visits in a short period of time. OHA will work with hospitals to issue sub-regulatory guidance that specifies that notifications must be associated with the relevant bill. The intent is that any eligible financial assistance is applied to the patient's owed amount prior to the patient receiving a bill.

Comment 17: Given the equation for approval of financial assistance is a basic mathematical formula of household size and income, there is no apparent benefit to a meeting to review a denial. Envisioning a future in which a patient has an in-person meeting to discuss a single financial document that the patient submitted as proof of income does not seem likely to impact the outcome. Offering a meeting as part of the re-review process should be optional for hospitals.

Response 17: See response 10. OHA will further note that in instances in which patient's income or household size have recently changed compared to available documentation, or they have new information to provide, a review with a written appeal in which the patient explains their situation would likely impact the outcome.

Comment 18: It is important that the corrections and appeals timeline be clearly described and aligned with federal regulation, and we are encouraged to see this in the rules. Patients should be allowed the required time to make corrections or appeals as entitled in established law. It is equally important that the rules clearly describe the expectation that regular billing processes are allowed to continue in the absence of a corrected application or appeal request. This ensures a singular experience across the state for patients and hospitals.

Response 18: See response 11.

Public Comments

In chronological order of receipt

Public Comment on HB3320 Rules

April 17, 2024 | SEIU Local 49

SEIU has long been interested the topic of nonprofit hospital financial assistance because too-often our members tell us how being sent to collections for medical bills has made it hard to manage day-to-day essentials like housing, food and childcare. We are proud to have advocated for the passage of HB3320, which will shift some of this burden from patients -- who are often dealing with a stressful and overwhelming time in their lives due to illness or injury -- onto hospitals who have a duty to provide discounted medical care to low-income individuals.

However, even the best law must have strong administrative rules to ensure its success in implementation. We believe these rules are clearly aligned with the legislative intent as drafted. While we were supportive of the previous version of the rules, the changes in the most recent round of edits strengthen them further.

We are particularly pleased to see the following changes:

1. **Addition of 409-023-0120 (10)(f) and 11(c).** We are fully in support of these additions that mandate hospitals consult one additional source of data if their initial screen yields inconclusive results and to make "a good faith effort" to determine the patient's presumptive eligibility status. Given that most presumptive screening tools rely on tax filing data, the addition of 11(c) will be particularly important for people who do not yet have a documented tax history, such as young adults or college students who have yet to file income taxes. These additions to the rules ensure these groups aren't overlooked in hospitals' obligation to prescreen and apply discounts before billing.

2. **Addition of 409-023-0120 (13).** We also support the addition of a requirement for hospitals to document how patients are screened and how presumptive eligibility determinations are made. We believe this is a reasonable addition given that the agency has removed the requirement in the previous draft rules that hospitals customize patient communication to inform each person how the prescreening determination was made. Hospitals indicated that this would be too burdensome, so we are firmly in support of at the very least having a record so that patients can contact the facility and learn why they were presumptively approved or denied.

3. **Addition of 409-023-0120 (6).** We were pleased to see that the agency added in a discrete requirement to determine if the patient has already qualified for financial assistance in the last 9 months before taking other prescreening actions.

4. **Change to 409-023-0125 (5).** We are in support of this change to the appeals process that better aligns state rules with federal regulations outlined in 26 CFR 1.501(r)-1(b)(3). This change will appropriately allow 240 days from the date the patient was notified of the financial assistance determination to correct deficiencies in the application or

request an appeal.

While we are supportive of the important additions outlined above, we do have a few minor suggestions in 409-023-0120 we urge the agency to consider:

1. **14(b)(D)** – Instead of "a distinct notice on the billing statement," we recommend the agency strengthen this to indicate that the notice must also be "prominent." OHA could use an existing standard definition for "prominence;" or, if none exists, specify that this information must appear in, for example, bold and all caps, and in at least one font size larger than the surrounding text.
2. **14(c)** – We believe these statements could be written in plainer language that is more accessible to all reading levels. In particular, the words "presumptively eligible" (and even "financial assistance") are not necessarily clear to those who aren't already familiar with industry jargon. We suggest language more similar to the following:
   - "Based on our initial screening, you qualify to have your bill forgiven."
   - "Based on our initial screening, you qualify for a discount on your bill."
   - "Our initial screening found that you do not currently qualify for financial assistance."
   - "Based on our initial screening, we were unable to tell if you qualify for a discount on your bill."

With these changes, we believe the rules will be that much more consumer-friendly. We appreciate the agency's diligence throughout this rulemaking process and applaud its efforts to align these rules with their legislative intent.

Oregon Consumer Justice
3055 NW Yeon Avenue, #1336
Portland, OR 97210
(503) 406-3311

April 19, 2024

To: HDD.Admin@odhsoha.oregon.gov

Oregon Consumer Justice (OCJ) is grateful for the opportunity to comment on the proposed new administration rules for hospital financial assistance based on House Bill 3320, passed in 2023.

Oregon Consumer Justice (OCJ) is a nonprofit consumer advocacy organization committed to advancing a justice movement that puts people first through policy, community engagement, and the law. We believe all should be free to thrive and equitably share in our abundance of resources. For too long, flawed systems and economic policies that favor profits over people have stood in the way of this reality, with communities of color most often experiencing the most significant harm. Strengthened through responsive and reciprocal community relationships, OCJ is building a future where financial and business transactions can be relied upon as safe and where all Oregonians know and have recourse to exercise their consumer rights.

OCJ is very supportive of the proposed rule. These rules align with the intent of the legislation to have hospitals be responsible for ensuring that patients have timely and appropriate access to the financial assistance for which they are eligible. Too many Oregonians currently have medical debt in collections, and many of these consumers should have received financial assistance. These rules will help ensure that those who are ill or facing a medical crisis don't have to experience a financial crisis.

In particular, OCJ would like to highlight the following as important elements we strongly support in the proposed rule:

- Thorough requirements around prescreening that will ensure hospitals are truly making a reasonable effort to determine each patient's eligibility before sending them a bill.
- Provision that a patient's credit score cannot be negatively impacted by the use of third-party income verification software tools or services, or if a hospital contracts with a third party to conduct the prescreening.
- Extension of the timeframe for appeals to 240 days to align with federal requirements.
- Provision requiring hospitals to suspend any debt collection activities and to tell collection agencies to pause debt collections if the hospital has sold the debt or authorized a collection agency to collect debts on behalf of the hospital until the appeal process is complete and the patient has been notified of the final determination.

The proposed rule aligns with HB 3320's intention and will provide strong protections for Oregon consumers.

Thank you for your consideration of these comments.

Regards,

Chris Coughlin
Policy Director

Hospital Association of Oregon

April 19, 2024

Steven Ranzoni, Hospital Policy Advisor
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301

Delivered electronically to HDD.Admin@OHA.Oregon.gov.

Mr. Ranzoni:

On behalf of our 61 member hospitals, the Hospital Association of Oregon offers the following comments regarding the Notice of Proposed Rulemaking filed on March 11, 2024, to update hospital financial assistance rules in response to House Bill 3320 (2023).

We appreciate that the proposed rules reflect much of the feedback received through the Rules Advisory Committee (RAC) process. These changes will help hospitals implement the new requirements in ways that improve the patient's experience, minimize administrative costs, and harmonize with existing processes. Below, we outline our requests for additional revision.

OAR 409-023-0115: Annual reports of financial assistance policies and nonprofit status

(5) Data collected on form HFCR and form HFAR shall be made publicly available on the Hospital Reporting Program of the Authority's website.

> **Comment:** We reiterate that prior to making the data public, hospitals should have the option to redact any data that may reveal confidential business information or that contain small cell sizes that may compromise patient privacy. Oregon Health Authority (OHA) staff suggested during the RAC meeting on January 30, 2024 that OHA could apply the standard it uses in public health regarding small cell sizes.[1] We support this approach and request that the rule be revised accordingly.

OAR 409-023-0120: Requirements for prescreening patients for presumptive eligibility for financial assistance

(6) Prior to taking any other prescreening actions, the hospital must determine if the patient has already qualified for financial assistance based on the hospital qualifying the patient during the previous nine (9) month period. Patients determined to have already qualified for financial assistance during the previous nine (9) months, fulfills the prescreening requirement and the patient must receive a patient cost adjustment in accordance with ORS 442.614, prior to receiving a billing statement.

[1] Oregon Health Authority, HB 3320 Rules Advisory Committee meeting #2, January 30, 2024, recording starting at 1:57:52.

4000 Kruse Way Place
Building 2, Suite 100
Lake Oswego, Oregon, 97035

Phone: 503.636.2204
Email: info@oregonhospitals.org
Web: oregonhospitals.org

Comment: HB 3320 provides for nine months of eligibility for financial assistance following a determination based on a patient application.[2] We request the following revision to align with the law:

(6) Prior to taking any other prescreening actions, the hospital must determine if**,** [*the patient has already qualified for financial assistance based on the hospital qualifying the patient*] during the previous nine (9) month period**, the patient has applied for financial assistance and the hospital has determined that the patient is eligible for financial assistance based on documentation provided by the patient**. [*Patients determined to have already qualified for financial assistance during the previous nine (9) months, fulfills the prescreening requirement and*] **If yes,** the patient must receive a patient cost adjustment in accordance with ORS 442.614, prior to receiving a billing statement.

(10) Hospitals may use existing patient data in the prescreening process, including but not limited to:

* * *

(f) If a method described in this subsection fails to return information about the patient, the hospital must consult at least one additional method specified in (10) or (11) and make a good faith effort to determine the patient's presumptive eligibility status.

Comment – (10)(f): We request that this provision be revised for consistency with the language in (10), which refers to data that hospitals "may" use. HB 3320 does not require hospitals to use any specific screening method or information, including when a patient's eligibility is indeterminate. Suggested revision:

(f) If a **hospital's initial prescreening** method [*described in this subsection*] fails to return information about the patient, the hospital must [*consult at least one additional method specified in (10) or (11) and*] make a good faith effort to determine the patient's presumptive eligibility status **based on other information available to the hospital**.

(11) A hospital may use third party income verification software tools or services or contract with a third party to conduct the prescreening if:

* * *

(c) If a third-party service or software tool fails to return information about the patient, or specifies the patient's income is unknown, the hospital must consult one or more of the data sources specified in (10) and make a good faith effort to determine the patient's presumptive eligibility status.

Comment – (11)(c): Consistent with our comments on (10)(f) above, we request the following revision to this provision:

[2] *See* HB 3320, Section 1 (7), which reads, "If a patient applies for financial assistance and the hospital determines that the patient is eligible for financial assistance based on documentation provided by the patient, the patient's eligibility for financial assistance continues for nine months following the hospital's determination, and the patient may not be required to reapply for financial assistance for services provided during that nine-month period."

(c) If a third-party service or software tool fails to return information about the patient, or specifies the patient's income is unknown, the hospital must [*consult one or more of the data sources specified in (10) and*] make a good faith effort to determine the patient's presumptive eligibility status **based on other information available to the hospital**.

(14) A hospital must notify the patient in writing of the results of the prescreening process, regardless of outcome. The notification must meet the following standards:

* * *

(c) Clearly state the outcome of the prescreening as one of the following:

(A) "prescreening process has found you are presumptively eligible for full financial assistance";

(B) "prescreening process has found you are presumptively eligible for partial financial assistance";

(C) "prescreening process has found you are not presumptively eligible for financial assistance; or

(D) "prescreening process was unable to determine if you are presumptively eligible for financial assistance".

Comment: This provision should provide clarity for patients regarding their eligibility while allowing hospitals flexibility in how they communicate with patients. The existing language in (14), "A hospital must notify the patient in writing of the results of the prescreening process, regardless of the outcome," is sufficient to meet these objectives and the requirement in the law that the hospital "notify a patient if the patient has been screened."[3] As such, we request that (14)(c) be deleted. Some hospitals report that incorporating the four different statements under (c) would be difficult given the limitations of their billing software. Hospitals should have the option to meet the law's requirement by developing a single statement that applies to all patients who have been prescreened. For example, "As required by law, you have been prescreened for financial assistance. Any financial assistance for which you are presumptively eligible based on our records has been applied to your bill."

Our collective goal should be simplicity for patients during this process. With that in mind, we support the proposed rule language in (14)(d), which specifies how the notice must also inform the patient of potential next steps.

OAR 409-023-0125: Requirements for a Process for Patient Appeals of Financial Assistance Determinations

(4) If a hospital denies an application for financial assistance, finds the application to be incomplete or missing documentation, or provides a patient cost adjustment for less than 100% of the patient costs, the hospital must, within ten (10) business days, notify the patient of their ability to take corrective action or appeal the determination. The notification must meet the following criteria:

* * *

[3] HB 3320, Section 1 (3)(d).

(d) The notification must include a clear description of how the patient may submit corrections or additional documentation and how the patient may request an appeal. At a minimum, a patient must be able to submit corrections or additional documentations and request an appeal through email, mail, and in-person delivery.

(e) The notification must inform the patient that if the patient chooses to appeal, the patient may request a meeting, virtual or in person, with the hospital's Chief Financial Officer or a designee of the hospital's Chief Financial Officer who has been delegated decision-making authority over the appeal.

Comment – (4)(d): We appreciate the removal of the requirement for hospitals to accept corrections, additional documentation, and appeal requests via an online portal, and we recognize the importance of offering an electronic option. However, restricting the electronic option to the use of email is also problematic for some hospitals. Instead, we request that hospitals be required to accept these materials "electronically," which will allow hospitals to choose whether to use email or a secure online portal.

Comment – (4)(e): HB 3320 does not require that hospitals offer a meeting with the hospital's Chief Financial Officer (CFO) or designee as part of the appeal process; rather, hospitals must allow the patient to "request a review" by the CFO or designee.[4] We recommend the following revision to align with the law:

(e) The notification must inform the patient that if the patient chooses to appeal, the patient may request a [*meeting, virtual or in person, with*] **review by** the hospital's Chief Financial Officer or a designee of the hospital's Chief Financial Officer who has been delegated decision-making authority over the appeal.

(5) A hospital must allow a patient the duration of the 240-day application period, specified in 26 CFR 1.501(r)-1(b)(3), from the date the patient was notified of the financial assistance determination to correct deficiencies in the application or request an appeal.

Comment: We request the following revision for clarity and to align with the applicable federal regulation:

(5) A hospital must allow a patient the **remaining** duration of the 240-day application period **after the date that the first post-discharge billing statement for the care is provided, as** specified in 26 CFR 1.501(r)-1(b)(3), [*from the date the patient was notified of the financial assistance determination*] to correct deficiencies in the application or request an appeal.

Additionally, consistent with the discussion at the January 30, 2024 RAC meeting,[5] we request that language be added to clarify that this provision does not prohibit hospitals from continuing their normal billing processes during the application period.

(6) During the pendency of an appeal a hospital must:

[4] HB 3320, Section 1 (8)(a).
[5] Oregon Health Authority, HB 3320 Rules Advisory Committee meeting #2, January 30, 2024, recording starting at 59:11.

* * *

(c) Provide the patient with a written statement, delivered by the same method used under OAR 409-023-0125(4)(b), unless the patient has requested a different delivery method, that contains:

* * *

(C) Information on how to schedule a meeting, including information for both in-person and virtual meetings, if a patient has requested a meeting with the hospital's Chief Financial Officer or a designee.

Comment – (6)(c): In the absence of a request by the patient, hospitals should be able to use any of the methods permitted in (4)(b) regardless of what method(s) the hospital used previously. We request the following revision:

(c) Provide the patient with a written statement, delivered [*by the same method used under*] **in accordance with** OAR 409-023-0125(4)(b)[*, unless the patient has requested a different*] **and any request by the patient to use a specific permitted** delivery method, that contains:

Comment – (6)(c)(C): HB 3320 does not require that hospitals offer a meeting with the hospital's CFO or designee as part of the appeal process; rather, hospitals must allow the patient to "request a review" by the CFO or designee.[6] We request the following revision:

(C) Information on [*how to schedule a meeting, including information for both in-person and virtual meetings,*] **any actions the patient may take** if a patient has requested a [*meeting with*] **review by** the hospital's Chief Financial Officer or a designee.

(7) A hospital may deny a request for an in-person meeting with the hospital's Chief Financial Officer or a designee as part of an appeal if the patient has a documented history of violence or has made threats against the hospital or staff. In this circumstance, the hospital must document its records accordingly and the patient must be provided with an opportunity for a virtual meeting or to submit appeal documentation via mail or electronic means.

Comment: We appreciate the inclusion of this provision in response to some RAC members' concerns about the safety of in-person meetings. However, this provision could be read to require a hospital to offer an in-person meeting unless the patient has a documented history of violence or has made threats against the hospital or staff. Per our comments above, hospitals should not be required to offer in-person meetings. We ask that this provision be limited to hospitals that routinely offer an in-person meeting if a patient requests a review of a denial by the hospital's CFO or designee.

(11) A hospital must issue a written determination on the appeal within 30 days of either the date of the final appeals meeting or the date of receipt of corrections related to application deficiencies, whichever is later. The hospital must communicate its determination in accordance with plain language and preferred language requirements established in OAR 209-023-0125(4)(a) and it must be delivered through the same method used under OAR 409-023-0125(4)(b), unless the patient has requested a different delivery method.

[6] HB 3320, Section 1 (8)(a).

Comment: It appears that the reference to OAR 209-023-0125(4)(a) should instead reference OAR 409-023-0125(4)(a).

Comment: As we stated regarding (6)(c) above, in the absence of a request by the patient, hospitals should be able to use any of the methods permitted in (4)(b) regardless of what method(s) the hospital used previously. We request the following revision to the second sentence:

The hospital must communicate its determination in accordance with plain language and preferred language requirements established in OAR [*2*]**4**09-023-0125(4)(a) and it must be delivered [*through the same method used under*] **in accordance with** OAR 409-023-0125(4)(b)[*, unless the patient has requested a different*] **and any request by the patient to use a specific permitted** delivery method.

Thank you for facilitating a robust discussion with stakeholders through the RAC process. We look forward to seeing the final rules.

Thank you,

Andrea Seykora
Director of Public Policy and Legal Affairs
Hospital Association of Oregon

About the Hospital Association of Oregon

Founded in 1934, the Hospital Association of Oregon (HAO) is a mission-driven, nonprofit trade association representing Oregon's 61 hospitals. Together, hospitals are the sixth largest private employer statewide, employing more than 70,000 employees. Committed to fostering a stronger, safer, more equitable Oregon where all people have access to the high-quality care they need, the hospital association supports Oregon's hospitals so they can support their communities; educates government officials and the public on the state's health landscape and works collaboratively with policymakers, community based organizations and the health care community to build consensus on and advance health care policy benefiting the state's 4 million residents.

Legacy Health

1919 N.W. Lovejoy St.
Portland, OR 97209

503.415.5600 *phone*
50.415.5777 *fax*

April 22, 2024

Steven Ranzoni
Hospital Policy Advisor
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301

Delivered electronically to HDD.Admin@OHA.Oregon.gov.

Re: HB 3320 Proposed Rules

Mr. Ranzoni:

We appreciated the opportunity to participate in the Rules Advisory Committee for HB 3320.

Legacy Health is a nonprofit health system that includes six-hospitals, a full-service children's hospital, a 24-hour mental and behavioral health services center, and more than 70 primary care, specialty, and urgent care clinics, 14,000 employees and nearly 3,000 health care providers. We provide comprehensive health care services across the Portland and Vancouver metro area and mid-Willamette Valley.

Legacy supports the comments provided by HAO and would like to provide experience-based information to reinforce three specifically.

Notifications: Allowing the billing statement to serve as the communication of outcome from the presumptive prescreening requirements will greatly improve the patient experience and reduce unnecessary cost increases. We support the inclusion of this option in the proposed rules and would like to reiterate the comments provided by HAO in which a single outcome statement, with necessary translations, be included in the billing statement and be specific to all outcomes that were not found to be eligible for full FA award presumptively. We care for many patients in our community that receive services multiple times per week for extended periods of time. Envisioning a future in which a cancer patient receives dozens of presumptive prescreening denial letters for being over income while undergoing treatment is not an outcome anyone desires.

Appeals: It is an important portion of the legislation to include a consistent appeals process and we are encouraged to see its inclusion. We agree that as part of the appeals process, patients should be able to request a re-review of a denial and this re-review should be conducted by an additional level of authority or responsibility. However, given the equation for approval is a basic mathematical formula of household size and income, there is no apparent benefit to a meeting. Envisioning a future in which a patient has an in-person meeting to discuss a single financial

document that the patient submitted as proof of income does not seem likely to impact the outcome. Offering a meeting as part of the re-review process should be optional for hospitals.

Corrections or Appeals: It is important that the corrections and appeals timeline be clearly described and aligned with federal regulation, and we are encouraged to see this in the rules. Patients should be allowed the required time to make corrections or appeals as entitled in established law. It is equally important that the rules clearly describe the expectation that regular billing processes are allowed to continue in the absence of a corrected application or appeal request. This ensures a singular experience across the state for patients and hospitals.

Again, we appreciate the opportunity to participate and your consideration of our comments.

Sincerely,

Jeremy Brossart
Jeremy Brossart (Apr 22, 2024 11:26 PDT)

Jeremy Brossart
Director
Patient Access, Financial Counseling & Customer Services