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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 409
OREGON HEALTH AUTHORITY
HEALTH POLICY AND ANALYTICS

FILED
03/11/2024 3:33 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: New rules to screen patients for financial assistance, provide for appeals, and report new data.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 04/22/2024 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
Pete Edlund
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HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 04/17/2024
TIME: 2:00 PM - 3:00 PM
OFFICER: Pete Edlund

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NEED FOR THE RULE(S)

HB 3320 created new prescreening, appeals and data reporting requirements for the existing hospital financial assistance program created by HB 3076 (2019). Hospitals will now be required to screen certain patients for presumptive eligibility for financial assistance before they receive a bill, determine and award financial assistance based on said presumptive eligibility, establish an appeals process for financial assistance denials, and report data to OHA on financial assistance applications and determinations. The new bill will be incorporated into the existing community benefit reporting program rules. OHA will write new rules that will focus on technical specifications for processes and reporting.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

ORS Chapter 442 information is available at https://www.oregonlegislature.gov/bills_laws/ors/ors442.html. Proposed changes to OAR 409-023 will be available on the agency's website at https://www.oregon.gov/OHA/HPA/Pages/Rulemaking.aspx.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

1. Identify Affected Communities, including Tribal Governments to form the RAC

A. The populations affected from a racial equity perspective are those whose socioeconomic status fall into the 400% FPL or below. This could include all races, genders and sexual orientations, but Oregonians who identify as Black or African American, American Indian or Alaskan Native, or Hispanic or Latino have disproportionately lower median household incomes than those who identify as Asian or White (source). Additionally, the bill has the potential to impact undocumented workers in Oregon, a population that is sometimes self-excluded from other healthcare programs, meaning their bills could be impacted the same as all other Oregonians. The bill specifically targets the low-income population and may have a positive economic impact through reduced hospital bills and medical debt. There is potential to impact those in rural areas more as Oregon's rural areas are lower income than the urban areas. The expected long-term impact includes increased compliance and more efficient processes on the hospital side, which should result in a more positive experience for low-income hospital patients.

B. Racially/ethnically specific communities are affected by this rule in that if they meet certain criteria, they will receive an automatic financial assistance reduction of their bill. All Oregonians, regardless of race/ethnicity, will be able to apply for financial assistance and have an easier process of receiving reductions to their bill.

C. To determine the impacts described here, this statement uses census data on median household income by race/ethnicity. This bill builds on the existing HB 3076 which established hospital financial assistance processes. To prepare for the rulemaking process, OHA conducted key informant interviews with partners who explained the way the bill and rules may impact undocumented individuals and outlined potential ways to ensure that financial assistance would be accessible to that population.
D. This rule has been identified as a Tier 3 per the tribal consultation policy, so no Dear Tribal Leader Letter was sent and no consultation meeting with tribal partners was held as the bill builds on existing processes targeting existing populations.

2. Community Engagement and Communication Strategy
The HB 3320 Implementation Team plans to engage the populations described in section (1) that are impacted by the rules to raise awareness of the proposed changes and allow them to provide feedback and suggestions through partnership with community-based organizations that directly work with and represent the impacted populations. Our partners are vocal proponents for the new bill and have provided invaluable information and support in developing these changes. We invited our community partners to the RAC and will work with them to communicate the changes to the public once the rules are final. We will issue a public invite to the RAC which the public to attend.
We alerted the Tribes as a Tier 3 project.

All communications about the changes to financial assistance that impact the public are mandated by law to be plain language, translated into multiple languages, and easily accessible.

3. Communication Plan, Address Feedback.
To communicate the permanent rule change language with partners and impacted communities, we have a multiple step plan. During rule development, we interviewed all interested parties including hospitals, rule sponsor, and non-profit organizations that work with our impacted population. These interviews heavily informed the rules we drafted. These partners are also invited to participate in the RAC. Once the rules have been drafted, we will engage our non-profit and community partners to communicate about the rule changes and ensure uptake of the new law. This communication plan will involve at least one press release and potential other small and targeted communications.

4. Remediation Plan
To mitigate any potential negative impacts to racial equity or racially/ethnically specific communities, OHA is dedicated to working towards an equitable solution. The draft rules intentionally set boundaries which hospitals can act within and do not set a specific process, which could allow for changes in the future if necessary. During the rule drafting process, OHA reinforced strong relationships with partners and will continue to leverage these relationships if negotiations and changes are necessary.

FISCAL AND ECONOMIC IMPACT:

There may be increased administrative burden and costs for professional services for hospitals to implement and run the additions to financial assistance specified in this bill. The bill is likely to result in an increase in unreimbursed care costs (charity care) to hospitals.
OHA will have a minor increase in administrative burden as the bill adds new reporting which will need to be processed and reported on.

There is a positive financial impact on the general population of Oregon as the low-income populations targeted in this bill will likely have lower hospital bills and medical debt.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

1: Current staff will develop and launch the program so there will not be an increase in staff and payroll in order to write and implement these rules.
These rules are expected to lead to decreases in hospital bills and overall medical debt for members of the public.

2: Though Oregon does have some small, rural hospitals, they do not qualify as small businesses as defined by ORS 183.310(10)(a). However, Oregon's smaller, independent hospitals may face greater implementation costs and challenges compared with larger urban hospitals.

2a: None. Rule amendments apply to hospitals.

2b: Hospitals may experience increased administrative burden to comply with the new screening, appeals and data reporting requirements above current requirements to report community benefit activities. Hospitals will need to set up a program, involving staff time to run these processes. OHA does not expect additional reporting requirements will require facilities expand staff.

2c: Cost estimates vary from no additional costs to upwards of $100,000 depending on the status of the hospital and how the hospital chooses to implement the requirements. New rules will provide flexibility for hospitals in implementation, allowing hospitals to choose processes or services that work best for them. There are no set costs associated with these rules and hospitals will have options to minimize their financial impact.

The most likely source of additional costs identified in rule making is payments to professional services for providing credit/income analysis for patients. These costs are typically billed per service, and thus will vary across all hospitals based on their volume. Hospitals are not required to use a professional service to conform to rules and many hospitals are already utilizing and paying for the services.

The second most likely source of costs is hiring additional staff to administer the prescreening and appeals processes if the hospital determines their existing admissions or financial assistance staff are insufficient to handle the increased work. An estimated cost of an additional FTE, with benefits, to support this work is approximately $100,000, an amount that will vary based on location and prevailing wages in the area.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

All Oregon hospitals, the Hospital Association of Oregon, along with other interested parties were invited to participate in the RAC. Small businesses are not involved in this process; rather hospitals that exceed the FTE to qualify as a small business, and local nonprofits are involved.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
409-023-0100, 409-023-0115, 409-023-0120, 409-023-0125

AMEND: 409-023-0100

RULE SUMMARY: Definitions section updated to include new definitions required in adopted rule 409-023-0120 and 409-023-0125. Minor housekeeping edits for grammar.

CHANGES TO RULE:

409-023-0100
Definitions ¶

The following definitions apply to OAR 409-023-0100 to 409-023-01~~1~~25:¶
(1) "Affiliated ~~C~~clinic" or "hospital affiliated clinic" mean an outpatient clinic located in Oregon that is operating under the common control or ownership of a hospital.¶
(2) "Authority" means the Oregon Health Authority.¶
(3) "Charity care" means free or discounted health services provided to persons who cannot afford to pay and from whom a hospital has no expectation of payment. Charity care does not include bad debt, governmentally set fees, contractual allowances, or discounts for quick payment. ¶
(4) "Community" means the geographic service area and patient population that the health care institution serves as defined by the hospital.¶
(5) "Community benefits" mean programs or activities that provide treatment or promote health and healing, address health disparities or address the social determinants of health in a response to identified community needs. They are not provided primarily for marketing purposes or to increase market share. Community benefit must generate a negative margin and meet at least one of the following criteria:¶
(a) Improve access to health services;¶
(b) Enhance population health or improve health disparities;¶
(c) Advance generalizable knowledge;¶
(d) Demonstrate charitable purpose; or¶
(e) Address social determinants of health.¶
(6) "Health System" means an organization that delivers health care services through hospitals, facilities, clinics, medical groups and other entities that are under common ownership or control.¶
(7) "Hospital" has the meaning provided in ORS 442.612.¶
(8) "Patient cost" has the meaning provided in ORS 442.612.¶
(9) "Prescreen" or "Prescreening" means the process a hospital uses to proactively screen a patient for presumptive eligibility for financial assistance in accordance with ORS 442.615.¶
(10) "Presumptive eligibility" refers to a decision by the hospital that, based upon the hospital's prescreening, the patient qualifies for financial assistance. ¶
(11) "Net ~~C~~cost" means the total expense incurred by the hospital minus any offsetting revenue such as grants, donations, or payments for service. Net costs may be provided using either a cost-to-charge ratio methodology or a cost accounting methodology.¶
~~(9~~(12) "Social Determinants of Health" has the meaning provided in ORS 442.612.¶
(13) "State medical assistance program" means a program for payment of health services provided to eligible Oregonians, including Medicaid and CHIP services under the OHP Medicaid Demonstration Project and Medicaid and CHIP services under the State Plan, or Healthier Oregon, or Bridge Program, or any other programs that may be prescribed by the Authority from time to time, in accordance with ORS 414.025(17).
Statutory/Other Authority: ORS 442.602, 442.618, 442.624
Statutes/Other Implemented: ORS 442.602, ORS 442.601, 442.612

AMEND: 409-023-0115

RULE SUMMARY: Amended to include new data reporting requirements specified by HB 3320 (2023).

CHANGES TO RULE:

409-023-0115
Annual reports of financial assistance policies and nonprofit status
(1) For purposes of this rule: ¶
(a) "Health care facility" means:¶
(A) A hospital;¶
(B) An ambulatory surgical center;¶
(C) A freestanding birthing center;¶
(D) An outpatient renal dialysis facility; or¶
(E) An extended stay center.¶
(b) "Reportable affiliated clinic" means an outpatient clinic located in Oregon that:¶
(A) Is operating under the common control of a hospital; or¶
(B) Is owned in whole or part by the hospital; or¶
(C) Is operating under the same brand of the hospital.¶
(2) A hospital or health system designee must submit a health care facility and reportable affiliated clinic report using the Hospital Facility and Clinic Report form (form HFCR) to the Authority, annually, by June 30 of each calendar year. The report shall identify its health care facilities and reportable affiliated clinics on form HFCR and provide the following:¶
(a) The health care facility name and street address for the facility location;¶
(b) The reportable affiliated clinic name and street address for the clinic location;¶
(c) The non-profit status of each health care facility or reportable affiliated clinic; and¶
(d) An attestation, signed by an officer of the hospital, that the hospital's financial assistance policy as developed under ORS 442.614 has been posted in the health care facilities and reportable affiliated clinics, and has been made available to patients of the facility and reportable affiliated clinic.¶
(3) Effective for hospital fiscal years that begin on or after January 1, 2025, hospitals must submit the Hospital Financial Assistance Report form (form HFAR) no later than 150 days after the end of the hospital's fiscal year, for certain financial assistance data from the most recently completed fiscal year. Data on form HFAR must include:¶
(a) Total number of financial assistance applications received in the fiscal year, and of the received applications, the number approved and denied by the following payer types: ¶
(A) Uninsured; ¶
(B) Medicare and Medicare Advantage; ¶
(C) State medical assistance programs including out-of-state Medicaid; ¶
(D) Commercial or private health insurance; and ¶
(E) All other payers. ¶
(b) Total number of patients that received cost adjustments based on: ¶
(A) Completing a hospital's financial assistance application; and ¶
(B) Without completing a hospital's financial assistance application, but instead as a result of the hospital's presumptive eligibility process as specified in OAR 409-023-0120. ¶
(c) Total number of patient accounts referred to a debt collector or collection agency. ¶
(d) Total number of patient accounts in which extraordinary collection activities (ECA) occurred, listed by the following categories, as described in 26 C.F.R. 1.501(r)-6(b): ¶
(A) Selling of an individual's debt to another party (except for those sales not considered an ECA as described in 26 C.F.R. 1.501(r)-6(b)(2)); ¶
(B) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus; ¶
(C) Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the hospital's financial assistance policy, as described in 26 C.F.R. 1.501(r)-6(b)(iii); and¶
(D) Taking actions that require aa legal or judicial process including, but not limited to, liens, judgements, garnishments, foreclosures, or other action related to collection of a debt owed to the hospital as described in 26 CFR 1.501(r)-6(b)(iv)(A)-(G). ¶
(e) The average and median per person debt, as well as the total amount of debt owed to the hospital by patients whose accounts were either placed in collections or referred to a collection agency during the reporting period. ¶
(4) The Authority shall provide the necessary data reporting templates and make them available on its website no later than September 30th of each year for the upcoming fiscal year reporting. ¶
(5) Data collected on form HFCR and form HFAR shall be made publicly available on the Hospital Reporting

Program of the Authority's website. ¶
(6) A hospital that fails to report as required in OAR 409-023-0115 may be subject to a civil penalty not to exceed $500 per day.
Statutory/Other Authority: ORS 442.618
Statutes/Other Implemented: ORS 442.618

ADOPT: 409-023-0120

RULE SUMMARY: Adopt new rules specifying procedures for prescreening patients for presumptive eligibility of financial assistance as specified by HB 3320 (2023).

CHANGES TO RULE:

409-023-0120
Requirements for prescreening patients for presumptive eligibility for financial assistance
(1) Prescreening and presumptive eligibility rules are effective July 1, 2024. ¶
(2) Hospitals must document their prescreening process in their financial assistance policy. Process documentation must disclose the software products and all other third-party services used to evaluate patient household income for prescreening. ¶
(3) The prescreening process and presumptive eligibility determination is not considered an application for financial assistance and does not disqualify a patient from seeking financial assistance. ¶
(4) The prescreening process must use the financial assistance eligibility standards published in the hospital's financial assistance policy and in accordance with the minimum standards specified in ORS 442.614. Any adjustment to patient cost due to the prescreening process must meet the minimum standards specified in ORS 442.614.¶
(5) Hospitals must complete prescreening for financial assistance and make any resulting adjustments to patient cost prior to sending the patient a billing statement. ¶
(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. ¶
(7) Hospitals must prescreen for presumptive eligibility for financial assistance whenever the patient meets any of the following criteria: ¶
(a) Is uninsured; or ¶
(b) Is enrolled in a state medical assistance program; or ¶
(c) Will owe the hospital $500 or more after all adjustments from insurance or third-party payers, if applicable, have been made. ¶
(8) Hospitals may prescreen patients who do not meet any of the criteria in (7) above at the hospital's discretion or as established in the hospital's financial assistance policy.¶
(9) A hospital must not require a patient to present documentation or other verification related to any eligibility criteria as a condition of prescreening or a requirement for adjustment to the patient costs as a result of prescreening. A hospital may accept voluntary submission of information or documentation that would assist the hospital in the prescreening process provided the hospital does not compel the patient to provide the information. ¶
(10) Hospitals may use existing patient data in the prescreening process, including but not limited to: ¶
(a) Existing patient records; ¶
(b) Information routinely collected during patient registration or admission; ¶
(c) Information voluntarily supplied by the patient; ¶
(d) Previous financial assistance adjustments; and ¶
(e) Existing eligibility for assistance programs. Examples include, but are not limited to: Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), free lunch or breakfast programs, low income home energy assistance programs, or any other program which are means tested and would reasonably reflect the approximate patient household income.¶
(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.¶
(11) A hospital may use third party income verification software tools or services or contract with a third party to conduct the prescreening if: ¶
(a) The process does not cause any negative impact on the patient's credit score; ¶
(b) Evaluations must be based on eligibility criteria established in the hospital's written financial assistance policy. Evaluations by non-profit hospitals must be based on household income only, and cannot consider household assets or any assessment, evaluation or score that predicts the patient's propensity or ability to pay; and ¶
(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. ¶

(13) Hospitals must document methods utilized under (10) and (11) they took to prescreen the patient. ¶
(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: ¶
(a) Be written in plain language and either the preferred language of the patient or otherwise in alignment with the translation standards specified in ORS 442.614; ¶
(b) Delivered by a minimum of one of the following means: ¶
(A) Letter; ¶
(B) Email, if agreed to by the patient as an acceptable form of communication; ¶
(C) Message or notification on an online patient portal if the patient is a registered user of the patient portal; ¶
(D) A distinct notice on the billing statement; ¶
(E) An insert accompanying a billing statement; or ¶
(F) In-person acknowledgement signed by the patient.¶
(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".¶
(d) If the prescreening process determines that the patient is not presumptively eligible, or their eligibility cannot be determined, or the patient cost adjustment was less than 100% of the patient cost amount, the hospital must further state the following information: ¶
(A) That the patient may still apply for financial assistance, or additional financial assistance, by using the standard hospital financial assistance application; ¶
(B) How a patient may request and receive a physical application or access an online application; ¶
(C) How a patient may request assistance in completing the financial assistance application; and ¶
(D) That the patient is eligible to apply for financial assistance for at least 240 days following the first billing statement for the services provided or at least 12 months after the patient pays for the services provided, or for any additional time period beyond these minimums as specified in the hospital's financial assistance policies.
Statutory/Other Authority: ORS 442.615
Statutes/Other Implemented: ORS 442.615, ORS 442.614

ADOPT: 409-023-0125

RULE SUMMARY: Adopt new rules specifying procedures for appealing a financial assistance determination as specified by HB 3320 (2023).

CHANGES TO RULE:

409-023-0125
Requirements for a Process for Patient Appeals of Financial Assistance Determinations
(1) Requirements for patient appeals of financial assistance determination are effective January 1, 2025. ¶
(2) Hospitals must document their financial assistance appeals process in their financial assistance policy. ¶
(3) A patient may only appeal determinations based on applications for financial assistance. ¶
(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: ¶
(a) The notification must be written in plain language and either the preferred language of the patient or otherwise in alignment with the translation standards specified in ORS 442.614. ¶
(b) The notification may be delivered by mail, email, in person, or through an online portal, if the patient is a registered user of the hospital's portal. The notification must be delivered separately and in addition to any financial assistance statements included on billing statements. ¶
(c) The notification must clearly specify whether the application was incomplete or if the patient was denied due to not meeting eligibility criteria.¶
(A) If the application is found to be incomplete, missing documentation, or containing errors, the notification must designate the application as incomplete and requiring further action by the patient. The notice must further clearly describe the deficiencies and the actions the patient can take to complete the application by correcting the deficiencies. ¶
(B) If the application was denied based on a failure to meet eligibility criteria, the notification must specify the relevant eligibility criteria and provide contact information so that the patient can request further information about the relevant eligibility criteria and the information that was used by the hospital to reach its determination.¶
(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. ¶
(f) The notification must inform the patient that the patient may also submit an appeal through a written statement or other supporting documentation.¶
(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. ¶
(6) During the pendency of an appeal a hospital must: ¶
(a) Suspend all collection activities if the hospital has initiated collection activities; and ¶
(b) If the hospital has sold the debt under appeal to a collection agency or has authorized a collection agency to collect debts on behalf of the hospital, the hospital must notify the collection agency to suspend collection activities; and¶
(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: ¶
(A) Confirmation of receipt of the patient's appeal request; ¶
(B) Notice that:¶
(i) The hospital has suspended all collection activities that they have initiated; and¶
(ii) If the hospital has sold debt to a collection agency or authorized a collection agency to collect debts on behalf of the hospital, that the hospitals has notified the collection agency to suspend collection activities. ¶
(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.¶
(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.¶

(8) If it is determined by the hospital officer with the authority to determine the appeal that the patient must provide additional information, the patient must be allowed an additional 45 days, minimum, to provide the requested information. This additional time period runs from the date the hospital officer with the authority to determine the appeal informs the patient that they must supply additional information.¶
(9) A hospital may allow for multiple meetings to make a decision about the appeal. ¶
(10) A hospital must allow for a third party acting with consent and on behalf of the patient to take action on a patient's application and/or represent the patient on appeal. A hospital may require documentation of consent to representation from the patient.¶
(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.¶
(a) If the final determination results in a denial of financial assistance, the hospital must also notify the patient of the date on which suspended collection activities, if any, will resume. ¶
(b) A hospital may not resume suspended collection activities until a patient is notified of the final determination. ¶
(12) A patient who has taken corrective action on an application that was determined to have deficiencies may request an appeal if the application is subsequently denied based on a failure to meet the hospital's eligibility criteria.
Statutory/Other Authority: ORS 442.615
Statutes/Other Implemented: ORS 442.615, ORS 442.614