HOUSE BILL NO. 1071

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health, Welfare and Institutions

on _____)

(Patron Prior to Substitute--Delegate Tran)

A BILL to amend and reenact § 32.1-276.5 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 5 of Title 32.1 a section numbered 32.1-137.09, relating to hospitals; financial assistance; payment plans.

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-276.5 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 5 of Title 32.1 a section numbered 32.1-137.09 as follows:

§ 32.1-137.09. Financial assistance; payment plans.

A. As used in this section:

"Patient" means any adult who receives medical services from a hospital or, in the case of a minor who receives medical services from a hospital, the financially responsible party for such minor.

"Uninsured patient" means a patient who does not have any health insurance, third-party assistance, medical savings account, or claims against third parties covered by insurance, is not covered under workers' compensation, a health benefit plan as defined in § 38.2-3438, an employee welfare benefit plan as defined in § 3(1) of the Employee Retirement Income Security Act of 1974, or a health care sharing ministry as defined in § 38.2-6300, or does not receive benefits under Title XVIII or XIX of the Social Security Act or 10 U.S.C. § 1071 et seq. or any other form of coverage from private insurance or federal, state, or local government medical assistance programs.

B. Every hospital shall make reasonable efforts to screen every uninsured patient to determine whether the individual is eligible for medical assistance pursuant to the state plan for medical assistance or for financial assistance under the hospital's financial assistance policy.

C. Every hospital shall make a payment plan available to every uninsured patient who receives services at the hospital and who is determined to be eligible for assistance under the hospital's financial assistance policy if requested by the patient. Such payment plan shall be provided to the patient electronically or in writing, and shall provide for repayment of the cumulative amount owed to the hospital. The amount of monthly payments and the term of the payment plan shall be determined based upon the ability of the patient to pay. Any interest on amounts owed under the payment plan shall not exceed the maximum judgment rate of interest pursuant to § 6.2-302. The hospital shall not charge any fees related to the payment plan. The plan shall allow prepayment of amounts owed without penalty.

D. Every hospital shall develop a process by which an uninsured patient who agrees to a payment plan pursuant to subsection C may request and shall be granted or the hospital may request and shall be granted the opportunity to renegotiate such payment plan. Such renegotiation shall include opportunity for a new screening in accordance with subdivision B. No hospital shall charge any fees for renegotiation of a payment plan pursuant to this subsection.

E. Notwithstanding any other provision of law, no hospital shall engage in garnishment of wages, liens on a primary residence or vehicle, adverse credit reporting, filing of a lawsuit, or any similar action against a patient under its billing and collection policy unless the hospital has made reasonable efforts to determine whether the individual qualifies for medical assistance pursuant to the state plan for medical assistance or is eligible for financial assistance under the hospital's financial assistance policy in accordance with § 501(r)(6)of the Internal Revenue Code as it was in effect on January 1, 2020.

F. Every hospital shall include in written information required pursuant to § 32.1-137.01 information about the availability of a payment plan for the payment of debt owed to the hospital pursuant to subsection C and the renegotiation process described in subsection D.

G. Nothing in this section shall be construed to:

1. Prohibit a hospital, as part of its financial assistance policy, from requiring a patient to (i) provide necessary information needed to determine eligibility for financial assistance under the hospital's financial assistance policy, medical assistance pursuant to Title XVIII or XIX of the Social Security Act or 10 U.S.C. § 1071 et seq., or other programs of insurance or (ii) undertake good faith efforts to apply for and

enroll in such programs of insurance for which the patient may be eligible as a condition of awarding financial assistance;

2. Require a hospital to grant or continue to grant any financial assistance or payment plan pursuant to this section when (i) a patient has provided false, inaccurate, or incomplete information required for determining eligibility for such hospital's financial assistance policy or (ii) a patient has not undertaken good faith efforts to comply with any payment plan pursuant to this section; or

3. Prohibit the coordination of benefits as required by state or federal law.

§ 32.1-276.5. Providers to submit data; civil penalty.

A. Every health care provider shall submit data as required pursuant to regulations of the Board, consistent with the recommendations of the nonprofit organization in its strategic plans submitted and approved pursuant to § 32.1-276.4, and as required by this section. Such data shall include relevant data and information for any parent or subsidiary company of the health care provider that operates in the Commonwealth. Notwithstanding the provisions of Chapter 38 (§ 2.2-3800 et seq.) of Title 2.2, it shall be lawful to provide information in compliance with the provisions of this chapter.

B. In addition, health maintenance organizations shall annually submit to the Commissioner, to make available to consumers who make health benefit enrollment decisions, audited data consistent with the latest version of the Health Employer Data and Information Set (HEDIS), as required by the National Committee for Quality Assurance, or any other quality of care or performance information set as approved by the Board. The Commissioner, at his discretion, may grant a waiver of the HEDIS or other approved quality of care or performance information set upon a determination by the Commissioner that the health maintenance organization has met Board-approved exemption criteria. The Board shall promulgate regulations to implement the provisions of this section.

The Commissioner shall also negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 for compiling, storing, and making available to consumers the data submitted by health maintenance organizations pursuant to this section. The nonprofit organization shall assist the Board in developing a quality of care or performance information set for such health maintenance organizations and shall, at the Commissioner's discretion, periodically review this information set for its effectiveness.

C. Every medical care facility as that term is defined in § 32.1-3 that furnishes, conducts, operates, or offers any reviewable service shall report data on utilization of such service to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data. For purposes of this section, "reviewable service" shall mean inpatient beds, operating rooms, nursing home services, cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging, medical rehabilitation, neonatal special care, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, psychiatric services, organ and tissue transplant services, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging except for the purpose of nuclear cardiac imaging, and substance abuse treatment.

Every medical care facility for which a certificate of public need with conditions imposed pursuant to § 32.1-102.4 is issued shall report to the Commissioner data on charity care, as that term is defined in § 32.1-102.1, provided to satisfy a condition of a certificate of public need, including (i) the total amount of such charity care the facility provided to indigent persons; (ii) the number of patients to whom such charity care was provided; (iii) the specific services delivered to patients that are reported as charity care recipients; and (iv) the portion of the total amount of such charity care provided that each service represents. The value of charity care reported shall be based on the medical care facility's submission of applicable Diagnosis Related Group codes and Current Procedural Terminology codes aligned with methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. Notwithstanding the foregoing, every nursing home as defined in § 32.1-123 for which a certificate of public need with conditions imposed pursuant to § 32.1-102.4 is issued shall report data on utilization and other data in accordance with regulations of the Board.

A medical care facility that fails to report data required by this subsection shall be subject to a civil penalty of up to $100 per day per violation, which shall be collected by the Commissioner and paid into the Literary Fund.

D. Every continuing care retirement community established pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 that includes nursing home beds shall report data on utilization of such nursing home beds to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data.

E. Every hospital that receives a disproportionate share hospital adjustment pursuant to § 1886(d)(5)(F) of the Social Security Act shall report, in accordance with regulations of the Board consistent with recommendations of the nonprofit organization in its strategic plan submitted and provided pursuant to § 32.1-276.4, the number of inpatient days attributed to patients eligible for Medicaid but not Medicare Part A and the total amount of the disproportionate share hospital adjustment received.

F. Every hospital shall report, in accordance with regulations of the Board consistent with recommendations of the nonprofit organization in its strategic plan submitted and provided pursuant to § 32.1-276.4, data and information regarding (i) the amount of charity care, discounted care, or other financial assistance provided by the hospital under its financial assistance policy pursuant to § 32.1-137.09 and (ii) the amount of uncollected bad debt, including any uncollected bad debt from payment plans entered into in accordance with subsection C of § 32.1-137.09.

G. The Board shall evaluate biennially the impact and effectiveness of such data collection.

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