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SENATE BILL NO. 201

Offered January 12, 2022

Prefiled January 10, 2022

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.

Patrons—Favola and Hashmi

Referred to Committee on Education and Health

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 is (i) 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 Employer Retirement Income Security Act of 1974, or a health sharing ministry as defined in § 38.2-6300 or (ii) not eligible for benefits under Title XVIII or XIX of the Social Security Act or 10 U.S.C. § 1071 et seq.

B. Every hospital shall screen every uninsured patient to determine the patient's household income and whether the individual is eligible for financial assistance under the hospital's financial assistance policy.

C. No hospital shall require any uninsured patient who is eligible for assistance under the hospital's financial assistance policy and determined to have a household income that is less than or equal to 200 percent of the federal poverty level for a household of such size to pay any amount for emergency services as defined in § 38.2-3438 provided by the hospital.

D. 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. Such payment plan shall be provided to the patient in writing and shall provide for repayment of the cumulative amount owed to the hospital for medical services by all members of the patient's household. Monthly payments made pursuant to such payment plan shall not exceed an amount that is equal to four percent of the household's total monthly income. Interest on amounts owed shall not exceed the maximum judgement 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.

E. Every hospital shall develop a process by which an uninsured patient who agrees to a payment plan pursuant to subsection D 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.

F. Notwithstanding any other provision of law, no hospital shall engage in extraordinary collection actions to recover a debt for medical services against (i) any uninsured patient who agrees to a payment plan pursuant to subsection D at the time medical services were provided and makes a good faith effort to comply with such payment plan (ii) the estate of a deceased patient.

G. Every hospital shall, in accordance with the provisions of subsection F of § 32.1-276.5, report 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; (ii) the amount of such financial assistance that is subject to a payment plan entered into in accordance with subsection D; (iii) the amount of such financial assistance that is subject to a payment plan entered into in accordance with subsection D for which payments are delinquent; and (iv) the value of emergency medical services provided without charge pursuant to subsection C.

H. Every hospital shall notify each uninsured patient to whom medical services are provided, in writing or by electronic means, of the availability of a payment plan for the payment of debt owed to the hospital for such medical services pursuant to subsection D and the renegotiation process pursuant to subsection E at the time medical services are provided or the patient is discharged, whichever is

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later. Such written information shall also be included together with any billing statement provided to the patient and each written communication regarding collection of the debt provided to the patient.

I. 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 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; (ii) the amount of such financial assistance that is subject to a payment plan entered into in accordance with § 32.1-137.09; (iii) the amount of such financial assistance that is subject to a payment plan entered into in accordance with § 32.1-137.09 for which payments are delinquent; and (iv) the value of emergency medical services provided without charge pursuant to subsection C of § 32.1-137.09.*

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