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HOUSE BILL NO. 248

Offered January 12, 2022

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A BILL to amend and reenact §§ 32.1-276.2 through 32.1-276.5, 32.1-276.7, and 32.1-276.8 of the Code of Virginia, relating to health care data report; carriers; civil penalty.

Patron—Davis

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-276.2 through 32.1-276.5, 32.1-276.7, and 32.1-276.8 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-276.2. Health care data reporting; purpose.

The General Assembly finds that the establishment of effective health care data analysis and reporting initiatives is essential to improving the quality and efficiency of health care, fostering competition among health care providers, *fostering competition among carriers and health plans,* and increasing consumer choice with regard to health care services *and coverage offered by carriers and health plans* in the Commonwealth, and that accurate and valuable health care data can best be identified by representatives of state government and the consumer, provider, insurance, and business communities. For this reason, the State Board of Health and the State Health Commissioner, assisted by the ~~State~~ Department of Health and the Bureau of Insurance, shall administer the health care data reporting initiatives established by this chapter.

§ 32.1-276.3. Definitions.

As used in this chapter:

"Actual reimbursement amount" means reimbursement information included in the claims data submitted by data suppliers to the Virginia All-Payer Claims Database, whether such information is referred to in the claims data as "paid amounts," "allowed amounts," or another term having the same or similar meaning and whether in reference to the payer who paid the actual reimbursement amount or the provider who received the actual reimbursement amount.

"Board" means the Board of Health.

"Carrier" has the same meaning as provided in § 38.2-3407.10; however, carrier also includes any person required to be licensed under Title 38.2 that offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) of Title 38.2 or that provides or arranges for the provision of health care services, health plans, networks, or provider panels that are subject to regulation as the business of insurance in accordance with Title 38.2.

"Common data layout" means the national data collection standard adopted and maintained by the APCD Council.

"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.

"Cost-sharing payment" means any amount a covered person is required to pay for health care services.

"Covered lives" means subscribers, policyholders, members, enrollees, or dependents, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a *carrier or health plan,* managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"ERISA plan" means any self-funded employee welfare benefit plan governed by the requirements of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1).

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title; (ii) a mental or psychiatric hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2; (iii) a hospital operated by the Department of Behavioral Health and Developmental Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.),

Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2; or (vii) any person licensed to practice dentistry pursuant to Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 who is registered with the Board of Dentistry as an oral and maxillofacial surgeon and certified by the Board of Dentistry to perform certain procedures pursuant to § 54.1-2709.1. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health maintenance organization" means any person who undertakes to provide or to arrange for one or more health care plans pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, that is subject to state regulation and that is required to be offered, arranged, or issued in the Commonwealth by a carrier licensed under Title 38.2. "Health plan" does not include (i) coverages issued pursuant to Title XVIII (42 U.S.C. § 1395 et seq.), Title XIX (42 U.S.C. § 1396 et seq.), or Title XXI (42 U.S.C. § 1397aa et seq.) of the Social Security Act, 5 U.S.C. § 8901 et seq., or 10 U.S.C. § 1071 et seq. or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5, a hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2, a hospital operated by the Department of Behavioral Health and Developmental Services for the care and treatment of individuals with mental illness, or a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority.

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.

"Oral and maxillofacial surgeon" means, for the purposes of this chapter, a person who is licensed to practice dentistry in Virginia, registered with the Board of Dentistry as an oral and maxillofacial surgeon, and certified to perform certain procedures pursuant to § 54.1-2709.1.

"Oral and maxillofacial surgeon's office" means a place (i) owned or operated by a licensed and registered oral and maxillofacial surgeon who is certified to perform certain procedures pursuant to § 54.1-2709.1 or by a group of oral and maxillofacial surgeons, at least one of whom is so certified, practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages at least one oral and maxillofacial surgeon who is so certified, and (ii) designed and equipped for the provision of oral and maxillofacial surgery services to ambulatory patients.

"Outpatient surgery" means all surgical procedures performed on an outpatient basis in a general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title or in a physician's office or oral and maxillofacial surgeon's office, as defined above. Outpatient surgery refers only to those surgical procedure groups on which data are collected by the nonprofit organization as a part of a pilot study.

"Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

"Physician's office" means a place (i) owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages physicians and (ii) designed and equipped solely for the provision of fundamental medical care, whether diagnostic, therapeutic, rehabilitative, preventive or palliative, to ambulatory patients.

"Surgical procedure group" means at least five procedure groups, identified by the nonprofit organization designated pursuant to § 32.1-276.4 in compliance with regulations adopted by the Board, based on criteria that include, but are not limited to, the frequency with which the procedure is performed, the clinical severity or intensity, and the perception or probability of risk. The nonprofit organization shall form a technical advisory group consisting of members nominated by its Board of Directors' nominating organizations to assist in selecting surgical procedure groups to recommend to the Board for adoption.

"System" means the Virginia Patient Level Data System.

§ 32.1-276.4. Agreements for certain data services.

A. The Commissioner shall negotiate and enter into contracts or agreements with a nonprofit

organization for the compilation, storage, analysis, and evaluation of data submitted by health care providers, *carriers, and health plans* pursuant to this chapter; for the operation of the All-Payer Claims Database pursuant to § 32.1-276.7:1; and for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers, *carriers, and health plans*. Such nonprofit organization shall be governed by a board of directors composed of representatives of state government, including the Commissioner, representatives of the Department of Medical Assistance Services and the Bureau of Insurance, *carriers,* health plans and health insurance issuers, and the consumer, health care provider, and business communities. Of the health care provider representatives, there shall be an equal number of hospital, nursing home, physician, and health plan representatives. The articles of incorporation of such nonprofit organization shall require the nomination of such board members by organizations and associations representing those categories of persons specified for representation on the board of directors.

B. In addition to providing for the compilation, storage, analysis, and evaluation services described in subsection A, any contract or agreement with a nonprofit, tax-exempt health data organization made pursuant to this section shall require the board of directors of such organization to:

1. Develop and disseminate other health care quality and efficiency information designed to assist businesses and consumers in purchasing health care and long-term care services;

2. Prepare and make public summaries, compilations, or other supplementary reports based on the data provided pursuant to this chapter;

3. Collect, compile, and publish Health Employer Data and Information Set (HEDIS) information or reports or other quality of care or performance information sets approved by the Board, pursuant to § 32.1-276.5, and submitted by health maintenance organizations or other health care plans;

4. Jointly determine with the Board of Medicine any data concerning safety services and quality health care services rendered by physicians to Medicaid recipients that should be identified, collected, and disseminated. The board of directors shall further determine jointly with the Board of Medicine the costs of requiring physicians to identify, submit, or collect such information and identify sufficient funding sources to appropriate to physicians for the collection of the same. No physician shall be required to collect or submit safety and quality of health care services information that is already identified, collected, or submitted under this chapter; or for which funds for collection are not appropriated;

5. Maintain the confidentiality and security of data as set forth in §§ 32.1-276.7:1 and 32.1-276.9;

6. Submit a report to the Board, the Governor, and the General Assembly no later than October 1 of each year for the preceding fiscal year. Such report shall include a certified audit, including an analysis of the efficacy and value of the All-Payer Claims Database, and provide information on the accomplishments, priorities, and current and planned activities of the nonprofit organization;

7. Submit, as appropriate, strategic plans to the Board, the Governor, and the General Assembly recommending specific data projects to be undertaken and specifying data elements for collection under this chapter. In developing strategic plans, the nonprofit organization shall incorporate similar activities of other public and private entities to maximize the quality of data projects and to minimize the cost and duplication of data projects. In its strategic plans, the nonprofit organization shall also evaluate the continued need for and efficacy of current data initiatives, including the use of patient level data for public health purposes. The approval of the General Assembly shall be required prior to the implementation of any recommendations set forth in a strategic plan submitted pursuant to this section;

8. Competitively bid or competitively negotiate all aspects of all data projects, if feasible; and

9. Fulfill all funded requirements set forth for the nonprofit organization in this chapter.

C. The Department shall take steps to increase public awareness of the data and information available through the nonprofit organization's website and how consumers can use the data and information when making decisions about health care providers and services *and coverage offered by carriers and health plans*.

D. Except as provided in subdivision A 2 of § 2.2-4345, the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the activities of the Commissioner authorized by this section. Funding for services provided pursuant to any such contract or agreement shall come from general appropriations and from fees determined pursuant to § 32.1-276.8 and from such fees and other public and private funding sources as may be authorized by this chapter.

§ 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 carrier 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, for each health plan type offered, arranged, or issued by a carrier, (i) all data required to be reported to the Centers for Medicaid and Medicare Services pursuant to medical loss ratio reporting requirements; (ii) data regarding preauthorization requests, including the average and median times for processing preauthorization requests and preauthorization request approval and denial rates; (iii) data regarding denials of claims and appeals of such denials, including (a) the number of claims and payment amounts denied by category, including inpatient hospital services, outpatient hospital services, emergency services, physician services, and pharmaceuticals, (b) the number of claims and payment amounts appealed and overturned or denied by category, including inpatient hospital services, outpatient hospital services, emergency services, physician services, and pharmaceuticals, and (c) the 30 most frequently stated reasons for denial of claims and frequency of each denial reason; and (iv) the average and*

median times to pay clean claims, by provider type. Such data shall include relevant data and information for any parent or subsidiary company of the carrier 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.

Each carrier shall submit an annual historical filing of revenues, expenses, other income, other outlays, assets and liabilities, units of service, and related statistics as prescribed by the Board on forms provided by the Board, together with unconsolidated certified audited financial statements that include its total assets, liabilities, revenues, expense, and reserves. If the carrier is part of a publicly held company, the individual institution may submit unconsolidated unaudited financial statements. Each carrier shall submit audited consolidated financial statements and consolidating financial schedules to the Commissioner.

Any carrier that fails to report data or information 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.

The Board shall make available to the public such data and information as may allow consumers to compare the cost and performance of carriers and health plans and shall annually publish a summary of the data and information submitted by carriers pursuant to this section, by health plan type.

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

§ 32.1-276.7. Methodology to review and measure the efficiency and productivity of health care providers and carriers.

A. Pursuant to the contract identified in § 32.1-276.4, and consistent with recommendations set forth in strategic plans submitted and approved pursuant to § 32.1-276.4, the nonprofit organization shall administer and modify, as appropriate, the methodology to review and measure the efficiency and productivity of health care providers *and carriers*. The methodology shall provide for, but not be limited to, comparisons of a health care provider's *and carrier's* performance to national and regional data, where available, and may include different methodologies and reporting requirements for the assessment of the various types of health care providers ~~which~~, *carriers, and health plans that* report to it. Health care providers *and carriers* shall submit the data necessary for implementation of the requirements of this section pursuant to regulations of the Board. Individual health care provider *and carrier* filings shall be open to public inspection once they have been received pursuant to the methodology adopted by the Board as required by this section.

B. The data reporting requirements of this section shall not apply to those health care providers enumerated in (iv) and (v) of the definition of health care providers set forth in § 32.1-276.3 until a strategic plan submitted pursuant to § 32.1-276.4 is approved requiring such reporting and any implementing laws and regulations take effect.

§ 32.1-276.8. Fees for processing, verification, and dissemination of data.

A. The Board shall prescribe a reasonable fee for each affected health care provider *and carrier* to cover the costs of the reasonable expenses of establishing and administering the methodology developed pursuant to § 32.1-276.7. The payment of such fees shall be at such time as the Board designates. The Board may assess a late charge on any fees paid after their due date.

~~In addition, the Board shall prescribe a tiered-fee structure based on the number of enrollees for each health maintenance organization to cover the costs of collecting and making available such data. Such fees shall not exceed $3,000 for each health maintenance organization required to provide information pursuant to this chapter. The payment of such fees shall also be at such time as the Board designates. The Board may also assess a late charge on any fees paid by health maintenance organizations after their due dates.~~

B. Except for the fees assessed pursuant to subsection A, the nonprofit organization providing services pursuant to an agreement or contract as provided in § 32.1-276.4 shall not assess any fee against any health care provider *or carrier* that submits data under this chapter that is processed, verified, and timely in accordance with standards established by the Board. The Board shall establish penalties for submission of data in a manner that is inconsistent with such standards.

C. State agencies shall not be assessed fees for the submission of patient level data required by subsection C of § 32.1-276.6. Individual employers~~, insurers,~~ and other organizations may voluntarily provide the nonprofit organization with outpatient data for processing, storage, and comparative analysis and shall be subject to fees negotiated with and charged by the nonprofit organization for services provided.

D. The nonprofit organization providing services pursuant to an agreement or contract with the Commissioner of Health shall be authorized to charge and collect reasonable fees for the dissemination of patient level data and Health Employer Data and Information Set (HEDIS) data or other approved quality of care or performance information set data; however, the Commissioner of Health, the State Corporation Commission, and the Commissioner of Behavioral Health and Developmental Services shall

be entitled to receive relevant and appropriate data from the nonprofit organization at no charge.

E. The Board shall (i) maintain records of its activities; (ii) collect and account for all fees and deposit the moneys so collected into a special fund from which the expenses attributed to this chapter shall be paid; and (iii) enforce all regulations promulgated by it pursuant to this chapter.

2. That the Board of Health shall adopt regulations to implement the provisions of this act.