H-4177.1

SUBSTITUTE HOUSE BILL 2036

State of Washington 66th Legislature 2020 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Macri, Ormsby, Riccelli, and Pollet)

AN ACT Relating to health system transparency; amending RCW 43.70.052, 70.01.040, 70.41.470, and 70.170.060; adding a new section to chapter 70.230 RCW; and providing an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 43.70.052 and 2014 c 220 s 2 are each amended to read as follows:

(1)(a) To promote the public interest consistent with the purposes of chapter 492, Laws of 1993 as amended by chapter 267, Laws of 1995, the department shall ((~~continue to~~)) require hospitals to submit hospital financial and patient discharge information, which shall be collected, maintained, analyzed, and disseminated by the department. The department shall, if deemed cost-effective and efficient, contract with a private entity for any or all parts of data collection.

(b)(i) Data elements shall be reported in conformance with a uniform reporting system established by the department. ((~~This includes data elements identifying each hospital's revenues, expenses, contractual allowances, charity care, bad debt, other income, total units of inpatient and outpatient services, and~~)) Data elements relating to use of hospital services by patients must be the same as those currently compiled by hospitals through inpatient

discharge abstracts. The department shall encourage and permit reporting by electronic transmission or hard copy as is practical and economical to reporters.

(ii) Data elements must identify each hospital's:

(A) Revenues. When reporting revenues, the hospital must include an addendum with a description of the services provided in exchange for the income or revenue and, for any service that generates more than fifty thousand dollars cumulatively during the reporting period, the amount for that service must be listed;

(B) Expenses. When reporting expenses, the hospital must report those expenses defined by the department and, for any expenses that do not meet a defined category, the hospital must include an addendum report with a description of the expenses and for any expense that costs more than fifty thousand dollars cumulatively during the reporting period, the amount for that expense must be listed;

(C) Contractual allowances;

(D) Charity care;

(E) Bad debt;

(F) Total units of inpatient and outpatient services; and

(G) Other financial and employee compensation information reasonably necessary to fulfill the purposes of this section. ((~~Data elements relating to use of hospital services by patients shall be the same as those currently compiled by hospitals through inpatient discharge abstracts. The department shall encourage and permit reporting by electronic transmission or hard copy as is practical and economical to reporters.~~))

(iii) A health system, or entity providing or directing health care services, must report to the department data related to the data elements identified in (b)(ii) of this subsection for each health care facility component or service that comprises the entity. In addition, the entity must report: (A) Any financial exchanges between the entity and each health care facility component or service, or between health care facility components and services, with an explanation of the nature of each exchange over fifty thousand dollars; and (B) the total number of full-time equivalents at each health care facility component or service.

(2) In identifying financial reporting requirements, the department may require both annual reports and condensed quarterly reports from hospitals, so as to achieve both accuracy and timeliness

in reporting, but shall craft such requirements with due regard of the data reporting burdens of hospitals.

(3)(a) Beginning with compensation information for 2012, unless a hospital is operated on a for-profit basis, the department shall require a hospital licensed under chapter 70.41 RCW to annually submit employee compensation information. To satisfy employee compensation reporting requirements to the department, a hospital shall submit information as directed in (a)(i) or (ii) of this subsection. A hospital may determine whether to report under (a)(i) or (ii) of this subsection for purposes of reporting.

(i) Within one hundred thirty-five days following the end of each hospital's fiscal year, a nonprofit hospital shall file the appropriate schedule of the federal internal revenue service form 990 that identifies the employee compensation information with the department. If the lead administrator responsible for the hospital or the lead administrator's compensation is not identified on the schedule of form 990 that identifies the employee compensation information, the hospital shall also submit the compensation information for the lead administrator as directed by the department's form required in (b) of this subsection.

(ii) Within one hundred thirty-five days following the end of each hospital's calendar year, a hospital shall submit the names and compensation of the five highest compensated employees of the hospital who do not have any direct patient responsibilities. Compensation information shall be reported on a calendar year basis for the calendar year immediately preceding the reporting date. If those five highest compensated employees do not include the lead administrator for the hospital, compensation information for the lead administrator shall also be submitted. Compensation information shall include base compensation, bonus and incentive compensation, other payments that qualify as reportable compensation, retirement and other deferred compensation, and nontaxable benefits.

(b) To satisfy the reporting requirements of this subsection (3), the department shall create a form and make it available no later than August 1, 2012. To the greatest extent possible, the form shall follow the format and reporting requirements of the portion of the internal revenue service form 990 schedule relating to compensation information. If the internal revenue service substantially revises its schedule, the department shall update its form.

(4) The health care data collected, maintained, and studied by the department shall only be available for retrieval in original or processed form to public and private requestors pursuant to subsection (7) of this section and shall be available within a reasonable period of time after the date of request. The cost of retrieving data for state officials and agencies shall be funded through the state general appropriation. The cost of retrieving data for individuals and organizations engaged in research or private use of data or studies shall be funded by a fee schedule developed by the department that reflects the direct cost of retrieving the data or study in the requested form.

(5) The department shall, in consultation and collaboration with the federally recognized tribes, urban or other Indian health service organizations, and the federal area Indian health service, design, develop, and maintain an American Indian-specific health data, statistics information system.

(6) All persons subject to the data collection requirements of this section shall comply with departmental requirements established by rule in the acquisition of data.

(7) The department must maintain the confidentiality of patient discharge data it collects under subsection (1) of this section. Patient discharge data that includes direct and indirect identifiers is not subject to public inspection and the department may only release such data as allowed for in this section. Any agency that receives patient discharge data under (a) or (b) of this subsection must also maintain the confidentiality of the data and may not release the data except as consistent with subsection (8)(b) of this section. The department may release the data as follows:

(a) Data that includes direct and indirect patient identifiers, as specifically defined in rule, may be released to:

(i) Federal, state, and local government agencies upon receipt of a signed data use agreement with the department; and

(ii) Researchers with approval of the Washington state institutional review board upon receipt of a signed confidentiality agreement with the department.

(b) Data that does not contain direct patient identifiers but may contain indirect patient identifiers may be released to agencies, researchers, and other persons upon receipt of a signed data use agreement with the department.

(c) Data that does not contain direct or indirect patient identifiers may be released on request.

(8) Recipients of data under subsection (7)(a) and (b) of this section must agree in a written data use agreement, at a minimum, to:

(a) Take steps to protect direct and indirect patient identifying information as described in the data use agreement; and

(b) Not redisclose the data except as authorized in their data use agreement consistent with the purpose of the agreement.

(9) Recipients of data under subsection (7)(b) and (c) of this section must not attempt to determine the identity of persons whose information is included in the data set or use the data in any manner that identifies individuals or their families.

(10) For the purposes of this section:

(a) "Direct patient identifier" means information that identifies a patient; ((~~and~~))

(b) "Health system" means an entity that owns, operates, is in common control of, or provides financial support to at least one hospital as well as other health care facility components and services that may be independent of any hospital or hospitals, including ambulatory surgical facilities, health clinics, urgent care clinics, health-related laboratories, long-term care facilities, home health agencies, dialysis facilities, ambulance services, behavioral health settings, and virtual care entities including, but not limited to, electronic applications and telehealth portals; and

(c) "Indirect patient identifier" means information that may identify a patient when combined with other information.

(11) The department must adopt rules necessary to carry out its responsibilities under this section. The department must consider national standards when adopting rules.

Sec. 2. RCW 70.01.040 and 2012 c 184 s 1 are each amended to read as follows:

(1) Prior to the delivery of nonemergency services, a provider-based clinic that charges a facility fee shall provide a notice to any patient that the clinic is licensed as part of the hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense.

(2) Each health care facility must post prominently in locations easily accessible to and visible by patients, including its web site, a statement that the provider-based clinic is licensed as part of the

hospital and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense.

(3) Nothing in this section applies to laboratory services, imaging services, or other ancillary health services not provided by staff employed by the health care facility.

(4) As part of the year-end financial reports submitted to the department of health pursuant to RCW 43.70.052, all hospitals with provider-based clinics that bill a separate facility fee shall report:

(a) The number of provider-based clinics owned or operated by the hospital that charge or bill a separate facility fee;

(b) The number of patient visits at each provider-based clinic for which a facility fee was charged or billed for the year;

(c) The revenue received by the hospital for the year by means of facility fees at each provider-based clinic; and

(d) The range of allowable facility fees paid by public or private payers at each provider-based clinic.

(5) For the purposes of this section:

(a) "Facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses.

(b) "Provider-based clinic" means the site of an off-campus clinic or provider office ((~~located at least two hundred fifty yards from the main hospital buildings or as determined by the centers for medicare and medicaid services,~~)) that is owned or operated by a hospital licensed under chapter 70.41 RCW or a health system that operates one or more hospitals licensed under chapter 70.41 RCW, is licensed as part of the hospital, and is primarily engaged in providing diagnostic and therapeutic care including medical history, physical examinations, assessment of health status, and treatment monitoring. This does not include clinics exclusively designed for and providing laboratory, X-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

Sec. 3. RCW 70.41.470 and 2012 c 103 s 1 are each amended to read as follows:

(1) As of January 1, 2013, each hospital that is recognized by the internal revenue service as a 501(c)(3) nonprofit entity must make its federally required community health needs assessment widely available to the public within fifteen days of submission to the internal revenue service. Following completion of the initial community health needs assessment, each hospital in accordance with the internal revenue service((~~,~~)) shall complete and make widely available to the public an assessment once every three years.

(2)(a) Unless contained in the community health needs assessment under subsection (1) of this section, a hospital subject to the requirements under subsection (1) of this section shall make public a description of the community served by the hospital, including both a geographic description and a description of the general population served by the hospital; and demographic information such as leading causes of death, levels of chronic illness, and descriptions of the medically underserved, low-income, and minority, or chronically ill populations in the community.

(b) Each hospital subject to the requirements under subsection (1) of this section must make public an addendum which details information about activities identified as community health improvement services. The information must specify the type of activity, the method in which each type of activity was provided, the resources used to provide the activity, how each activity may correspond to follow-up services offered by the hospital, the cost of providing each type of activity, and any materials provided to activity participants. Information related to the resources used to provide the activity includes, but is not limited to, labor provided and whether the location was rented or provided by the hospital.

(3)(a) Each hospital subject to the requirements of subsection (1) of this section shall make widely available to the public a community benefit implementation strategy within one year of completing its community health needs assessment. In developing the implementation strategy, hospitals shall consult with community-based organizations and stakeholders, and local public health jurisdictions, as well as any additional consultations the hospital decides to undertake. Unless contained in the implementation strategy under this subsection (3)(a), the hospital must provide a brief explanation for not accepting recommendations for community benefit proposals identified in the assessment through the stakeholder

consultation process, such as excessive expense to implement or infeasibility of implementation of the proposal.

(b) Implementation strategies must be evidence-based, when available; or development and implementation of innovative programs and practices should be supported by evaluation measures.

(4) For the purposes of this section, the term "widely available to the public" has the same meaning as in the internal revenue service guidelines.

Sec. 4. RCW 70.170.060 and 2018 c 263 s 2 are each amended to read as follows:

(1) No hospital or its medical staff shall adopt or maintain admission practices or policies which result in:

(a) A significant reduction in the proportion of patients who have no third-party coverage and who are unable to pay for hospital services;

(b) A significant reduction in the proportion of individuals admitted for inpatient hospital services for which payment is, or is likely to be, less than the anticipated charges for or costs of such services; or

(c) The refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital.

(2) No hospital shall adopt or maintain practices or policies which would deny access to emergency care based on ability to pay. No hospital which maintains an emergency department shall transfer a patient with an emergency medical condition or who is in active labor unless the transfer is performed at the request of the patient or is due to the limited medical resources of the transferring hospital. Hospitals must follow reasonable procedures in making transfers to other hospitals including confirmation of acceptance of the transfer by the receiving hospital.

(3) The department shall develop definitions by rule, as appropriate, for subsection (1) of this section and, with reference to federal requirements, subsection (2) of this section. The department shall monitor hospital compliance with subsections (1) and (2) of this section. The department shall report individual instances of possible noncompliance to the state attorney general or the appropriate federal agency.

(4) The department shall establish and maintain by rule, consistent with the definition of charity care in RCW 70.170.020, the following:

(a) Uniform procedures, data requirements, and criteria for identifying patients receiving charity care;

(b) A definition of residual bad debt including reasonable and uniform standards for collection procedures to be used in efforts to collect the unpaid portions of hospital charges that are the patient's responsibility.

(5) For the purpose of providing charity care, each hospital shall develop, implement, and maintain a charity care policy which, consistent with subsection (1) of this section, shall enable people below the federal poverty level access to appropriate hospital-based medical services, and a sliding fee schedule for determination of discounts from charges for persons who qualify for such discounts by January 1, 1990. The department shall develop specific guidelines to assist hospitals in setting sliding fee schedules required by this section. All persons with family income below one hundred percent of the federal poverty standard shall be deemed charity care patients for the full amount of hospital charges, except to the extent the patient has third-party coverage for those charges.

(6) Each hospital shall post and prominently display notice of charity care availability. Notice must be posted in all languages spoken by more than ten percent of the population of the hospital service area. Notice must be displayed in at least the following locations:

(a) Areas where patients are admitted or registered;

(b) Emergency departments, if any; and

(c) Financial service or billing areas where accessible to patients.

(7) Current versions of the hospital's charity care policy, a plain language summary of the hospital's charity care policy, ((~~and~~)) the hospital's debt collection practices, the hospital's charity care application form, and the statement specified in subsection (8)(a) of this section must be available on the hospital's web site. The description of the hospital's debt collection practices must identify all entities under contract with the hospital to collect debt and any revenue generating agreement between the hospital and any of the contracted debt collection entities. The summary and application form

must be available in all languages spoken by more than ten percent of the population of the hospital service area.

(8)(a) All hospital billing statements and other written communications concerning billing or collection of a hospital bill by a hospital must include the following or a substantially similar statement prominently displayed on the first page of the statement in both English and the second most spoken language in the hospital's service area:

You may qualify for free care or a discount on your hospital bill, whether or not you have insurance. Please contact our financial assistance office at [web site] and [phone number]. Washington state law gives you the right to an itemized bill and requires that hospitals delay collections actions until a decision about your application for free care has been made. This hospital [does or does not] have a financial interest in one or more of the debt collection agencies that your bill may be referred to if you fail to pay your bill.

(b) Nothing in (a) of this subsection requires any hospital to alter any preprinted hospital billing statements existing as of October 1, ((~~2018~~)) 2019.

(9) Hospital obligations under federal and state laws to provide meaningful access for limited English proficiency and non-English-speaking patients apply to information regarding billing and charity care. Hospitals shall develop standardized training programs on the hospital's charity care policy and use of interpreter services, and provide regular training for appropriate staff, including the relevant and appropriate staff who perform functions relating to registration, admissions, or billing.

(10) Each hospital shall make every reasonable effort to determine:

(a) The existence or nonexistence of private or public sponsorship which might cover in full or part the charges for care rendered by the hospital to a patient;

(b) The annual family income of the patient as classified under federal poverty income guidelines as of the time the health care services were provided, or at the time of application for charity care if the application is made within two years of the time of service, the patient has been making good faith efforts towards payment of health care services rendered, and the patient demonstrates eligibility for charity care; and

(c) The eligibility of the patient for charity care as defined in this chapter and in accordance with hospital policy. An initial determination of sponsorship status shall precede collection efforts directed at the patient.

(11) At the hospital's discretion, a hospital may consider applications for charity care at any time, including any time there is a change in a patient's financial circumstances.

(12) The department shall monitor the distribution of charity care among hospitals, with reference to factors such as relative need for charity care in hospital service areas and trends in private and public health coverage. The department shall prepare reports that identify any problems in distribution which are in contradiction of the intent of this chapter. The report shall include an assessment of the effects of the provisions of this chapter on access to hospital and health care services, as well as an evaluation of the contribution of all purchasers of care to hospital charity care.

(13) The department shall issue a report on the subjects addressed in this section at least annually, with the first report due on July 1, 1990.

NEW SECTION. **Sec. 5.** A new section is added to chapter 70.230 RCW to read as follows:

The department shall require ambulatory surgical facilities to annually report the following information in a format established by the department:

(1) The number of patient encounters;

(2) Utilization data by service provided, including the following categories: Primary care, specialty care, urgent care, or surgery, as well as virtual care appointments by medium;

(3) Acquisitions of diagnostic or therapeutic equipment during the reporting period with a value in excess of five hundred thousand dollars; and

(4) Commencement of projects during the reporting period that require a capital expenditure for the facility in excess of one million dollars.

NEW SECTION. **Sec. 6.** This act takes effect January 1, 2021.

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