S-1223.1

SENATE BILL 5625

State of Washington 55th Legislature 1997 Regular Session

By Senators Franklin, Deccio, Fairley, Winsley, Wood and Patterson

Read first time 02/04/97. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to health care quality protection; amending RCW 43.70.075; adding new sections to chapter 48.43 RCW; adding a new section to chapter 70.41 RCW; adding a new section to chapter 18.79 RCW; and adding a new section to chapter 70.44 RCW.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The legislature recognizes the role of health care providers as the appropriate authority to determine and establish the delivery of quality health care services. It is the intent of the legislature to recognize patient preference and the clinical sovereignty of providers as they make determinations regarding the nature and duration of services to individual patients. It is not the intent of the legislature to diminish a carrier's ability to utilize managed care strategies but to ensure the clinical judgment of the provider is not undermined by restrictive carrier contracts or utilization review criteria that fail to recognize individual patient needs.

(2) The definitions in this subsection (2) apply throughout this section unless the context clearly requires otherwise.

(a) "Treating provider" means a provider who: (i) Is included in a provider network of the carrier that is providing coverage; and (ii) is a health care professional licensed or certified under chapter 18.130 RCW.

(b) "Health carrier" or "carrier" means disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under this chapter.

(3)(a) Every health carrier and health care facility must permit the treating provider, in consultation with the patient, to make all decisions on patient care, rather than making the decisions through contracts or agreements between providers, health care facilities, and carriers. These decisions must be based on accepted health care practice, as determined by the clinical guidelines established by the treating provider’s health profession.

(b) Covered eligible services may not be denied for health care services as ordered by the treating provider, in consultation with the patient, including inpatient care, in-person follow-up care after discharge from a health care facility, and outpatient care. These services must be based on accepted health care practice, as determined by the clinical guidelines established by the treating provider’s health profession.

(c) At the time of discharge from a health care facility, determination of the type and location of follow-up care, including in-person follow-up care, must be made by the treating provider in consultation with the patient rather than by contract or agreement between providers, the health care facility, and the insurer. These decisions must be based on accepted health care practice, as determined by the clinical guidelines established by the treating provider’s health profession.

(d) Coverage for providers of in-person follow-up care after discharge from a health care facility must include, but need not be limited to, treating providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(e) Nothing in this section shall be construed to require treating providers to authorize care they believe to be medically unnecessary.

(4) No carrier or health care facility may deselect, restrict, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any treating provider or health care facility as a result of the treating provider or health care facility ordering care consistent with accepted health care practice. Nothing in this section shall be construed to prevent an insurer from reimbursing a treating provider or health care facility on a capitated, case rate, or other financial incentive basis. However, the reimbursement must be appropriate and adequate for the services ordered by the treating provider, consistent with accepted health care practice.

(5) Every carrier must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the following occurrences: (a) The next mailing to the policyholder; (b) the yearly summary of benefits sent to the policyholder; or (c) January 1st of the year following the effective date of this act.

(6) This section is not intended to establish a standard of health care.

(7) This section applies to coverage for services under a contract issued or renewed by a health carrier after the effective date of this act, and applies to plans operating under the health care authority, under chapter 41.05 RCW, beginning January 1, 1998.

NEW SECTION. **Sec. 2.** A new section is added to chapter 70.41 RCW to read as follows:

(1) All hospitals shall, as a condition for licensure, file with the department information regarding facility operations and patient outcomes as specified by the department. The information must include, but is not limited to:

(a) All health care quality indicators, criteria, data, or studies used to evaluate, assess, or determine the nature, scope, quality, and staffing of health care services, or to reduce or modify the provision of health care services, including but not limited to staffing, and including but not limited to information on:

(i) Total number and ratio of each type of health care professional. This information must be aggregated for the total facility staff, for each unit, and for each shift;

(ii) Average number of patients per each type of health care professional. This information must be aggregated for the total facility staff, for each unit, and for each shift;

(iii) Annual mortality and morbidity rates of cases based on a defined set of procedures performed or diagnoses treated in the hospital, as designated by the department by rule, adjusted to fairly consider variable factors such as patient demographics and case severity;

(iv) The average total cost and average length of treatment by the hospital for the defined set of procedures designated by the department under (a)(iii) of this subsection;

(v) The total number of the defined set of procedures designated by the department under (a)(iii) of this subsection performed at the hospital within the previous twelve months;

(vi) Hospital solvency and fiscal performance for the preceding fiscal year, including but not limited to:

(A) Total number of full-time equivalent employees employed under each job classification;

(B) Total compensation, including salaries, stock options, and all fringe benefits for the chief executive officer, chief operations officer, and chief financial officer;

(C) The name of each corporation related to the hospital;

(D) A breakdown of facility and subfacility budgets by category including, but not limited to capital, administrative, supervisory, and direct service categories; and

(E) All financial reports and returns required by federal and state tax and securities laws, and statements of any financial interest greater than five percent or five thousand dollars, whichever is lower, in any other health care facility, business, or ancillary health care service supplier;

(b) Incidence of adverse patient care incidents, including but not limited to:

(i) Nosocomial infections, including nosocomial urinary tract infections;

(ii) Decubitus ulcers;

(iii) Medication errors; and

(iv) Patient injury rate;

(c) Patient satisfaction;

(d) Geographic accessibility;

(e) A description of the subject and outcome of all complaints, lawsuits, arbitrations, or other legal proceedings brought against the hospital or any affiliated enterprise, unless disclosure is prohibited by court order or applicable law; and

(f) Results of all regulatory and accreditation surveys or evaluations by public or private agencies or organizations.

(2) All data filed under this section must indicate the source and currency of the data provided.

(3) The department may waive or reduce reporting requirements under this section in the case of a small hospital, as defined by the department, for whom the completion of the requirements would be inapplicable or unduly burdensome.

(4) By July 1st of each calendar year, the department shall publish a summary public report that may include, but is not limited to, the information filed under this section. This report shall include summary relative ratings or rankings of all hospitals based upon this information, in a format established by the department.

(5) Prior to publication of the department report, a qualified, independent consultant contracted by the department shall conduct an audit of the report for completeness and accuracy.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

(1) All health carriers and health plans as defined in RCW 48.43.005 shall, as a condition for licensure, file with the insurance commissioner information regarding plan operations and patient outcomes as specified by the commissioner. Such information must include, but is not limited to, all health care quality indicators, criteria, data, or studies used to evaluate, assess, or determine the nature, scope, and quality of health care services, or to reduce or modify the provision of health care services, including, but not limited to, information on:

(a) Annual mortality and morbidity rates of cases based on a defined set of procedures performed or diagnoses treated for the health carrier or plan’s enrollees by the health carrier or plan’s contracting health care facilities and providers, as designated by the department,

adjusted to fairly consider variable factors such as patient demographics and case severity;

(b) The average total cost and average length of enrollees' hospital stay for a set of procedures and diagnoses designated by the department of health under section 2 of this act;

(c) The total number of the defined set of procedures designated by the department of health under section 2 of this act, by specialty, performed upon the health carrier or plan's enrollees by contracting providers within the previous twelve months;

(d) Health carrier or plan solvency and fiscal performance for the preceding fiscal year, including but not limited to:

(i) Total number of full-time equivalent employees employed under each job classification;

(ii) total compensation including salaries, stock options, and all fringe benefits for the chief executive officer, chief operations officer, and chief financial officer, or their equivalents;

(iii) The name of each corporation related to the health carrier or plan;

(iv) A breakdown of budgets by category, including but not limited to capital, administrative, and direct service categories; and

(v) All financial reports and returns required by federal and state tax and securities laws, and statements of any financial interest greater than five percent or five thousand dollars, whichever is lower, in any other health carrier or plan, health care facility, business, or ancillary health care service supplier;

(e) Incidence of adverse patient care incidents for carrier or plan enrollees, including but not limited to:

(i) Nosocomial infections, including nosocomial urinary tract infections;

(ii) Decubitus ulcers;

(iii) Medication errors; and

(iv) Patient injury rate;

(f) Patient satisfaction;

(g) Geographic accessibility;

(h) A description of the subject and outcome of all complaints, lawsuits, arbitrations, or other legal proceedings brought against the health carrier or plan or any affiliated enterprise, unless disclosure is prohibited by court order or applicable law;

(i) Results of all regulatory and accreditation surveys or evaluations by public or private agencies or organizations.

(j) The proportion of claims in whole or in part denied from the number of claims received or, where appropriate, the proportion of requests for treatment from a health care provider or enrollee that were denied from the number of requests received;

(k) The number of claims or requests for treatment denied on the grounds that such claim or treatment was experimental, investigative, or not medically necessary;

(l) The number of claims or requests for treatment denied and later reversed in whole or in part by a health carrier or plan;

(m) The amount of premiums collected by the health carrier or plan during the preceding fiscal year and the percentage of such premium paid out in claims or medical payments;

(n) Where applicable, the ratio of the number of primary care providers contracted by the health carrier or plan to the number of health carrier or plan enrollees;

(o) Where applicable, the ratio of the number of specialty care providers contracted by the health carrier or plan to the number of health carrier or plan enrollees;

(p) The average length of time that passes between the request for routine care, specialty care, medical tests, or hospital services by an enrollee or enrollee's provider and when such care is rendered;

(q) Complaint data required under section 3(1)(h) of this act;

(r) The number, types, and settlement amounts of all arbitration, malpractice, and bad faith legal cases;

(s) Information regarding whether the carrier or plan is for-profit or not-for-profit and current phone numbers and addresses to obtain additional information regarding the carrier or plan; and

(t) The results of the health carrier or plan's health promotion and disease prevention activities, including:

(i) The number and percent of infants whose birth weight is less than two thousand five hundred grams;

(ii) The number and percent of pregnant women who (A) were enrolled for twelve months prior to delivery; (B) had a live birth; and (C) received prenatal care in the first trimester of pregnancy;

(iii) A summary of screening and preventive health care activities utilized by the health carrier or plan, including but not limited to:

(A) The number and percent of enrolled women aged fifty-two to sixty-four years who received a mammogram during the previous two calendar years;

(B) The number and percent of enrolled women aged twenty-one to sixty-four years continuously enrolled for the past three years who received a pap test;

(C) The number and percent of enrolled adults aged eighteen and above who received colon examinations; and

(D) The number and percent of enrolled children who receive the schedule of immunizations and preventive screenings as recommended by the American academy of pediatrics.

(2) All data filed under this section must indicate the source and currency of the data provided.

(3) The insurance commissioner may waive or reduce reporting requirements under this section in the case of a small health carrier or plan, as defined by the commissioner, for whom the completion of the requirements would be inapplicable or unduly burdensome.

(4) By July 1st of each calendar year, the insurance commissioner shall publish a summary public report that may include, but is not limited to, the information filed under section 3 of this act. This report shall include summary ratings or rankings of all health carriers and plans, based upon this information, in a format established by the commissioner.

(5) Prior to publication of the insurance commissioner's report, a qualified, independent consultant contracted by the commissioner shall conduct an audit of the report for completeness and accuracy.

Sec. 4. RCW 43.70.075 and 1995 c 265 s 19 are each amended to read as follows:

(1) The identity of a whistleblower who complains, in good faith, to ((~~the department of health~~)) an appropriate state agency about the improper quality of care by a health carrier, health care provider, or in a health care facility, as defined in RCW ((~~43.72.010~~)) 48.43.005, shall remain confidential. The provisions of RCW 4.24.500 through 4.24.520, providing certain protections to persons who communicate to government agencies, shall apply to complaints filed under this section. The identity of the whistleblower shall remain confidential unless the department determines that the complaint was not made in good faith. An employee who is a whistleblower, as defined in this

section, and who as a result of being a whistleblower has been subjected to workplace reprisal or retaliatory action has the remedies provided under chapter 49.60 RCW.

(2)(a) "Improper quality of care" means any practice, procedure, action, or failure to act that violates any state law or rule of the applicable state health licensing authority under Title 18 ((~~or~~)) RCW, chapters 18.20, 18.51, 70.05, 70.08, 70.46, 70.41, 70.96A, 70.127, 70.128, 70.175, 71.05, 71.12, ((~~and~~)) 71.24, and 72.36 RCW, or RCW 74.39A.010 or violates any state law or rule adopted under Title 48 RCW or chapter 265, Laws of 1995, regulating health carriers, and which is enforced by the department of health, the state board of health, the department of social and health services, the department of labor and industries, the health care authority, or the insurance commissioner. Each health disciplinary authority as defined in RCW 18.130.040 may, with consultation and interdisciplinary coordination provided by the state department of health, adopt rules defining accepted standards of practice for their profession that shall further define improper quality of care. Improper quality of care shall not include good faith personnel actions related to employee performance or actions taken according to established terms and conditions of employment.

(b) "Reprisal or retaliatory action" means but is not limited to: Denial of adequate staff to perform duties; frequent staff changes; frequent and undesirable office changes; refusal to assign meaningful work; unwarranted and unsubstantiated report of misconduct pursuant to Title 18 RCW; letters of reprimand or unsatisfactory performance evaluations; demotion; reduction in pay; denial of promotion; suspension; dismissal; denial of employment; and a supervisor or superior encouraging coworkers to behave in a hostile manner toward the whistleblower.

(c) "Whistleblower" means a consumer, employee, ((~~or~~)) health care professional, or any other person who in good faith reports alleged quality of care concerns to ((~~the department of health~~)) an appropriate state agency.

(3) Nothing in this section prohibits a health care facility from making any decision exercising its authority to terminate, suspend, or discipline an employee who engages in workplace reprisal or retaliatory action against a whistleblower.

(4) The department shall adopt rules jointly with other appropriate state agencies to implement procedures for filing, investigation, and

resolution of whistleblower complaints that are integrated with complaint procedures under Title 18 RCW for health professionals or health care facilities.

(5) The office of the insurance commissioner shall adopt rules to implement procedures for filing, investigation, and resolution of whistleblower complaints that are integrated with complaint procedures under Title 48 RCW and chapter 265, Laws of 1995, for health carriers.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43 RCW to read as follows:

No health carrier, health plan, or health care facility shall discharge, demote, terminate a contract with, deny privileges to, or otherwise sanction a physician, nurse, or other health care professional for providing safe, adequate, and appropriate care, for advocating in private or in public on behalf of patients, or for reporting in good faith any improper quality of care or alleged violation of law to appropriate authorities.

NEW SECTION. **Sec. 6.** A new section is added to chapter 18.79 RCW to read as follows:

Administration of nursing care services in any health care facility as defined in RCW 70.37.020 must be performed by a registered nurse licensed under this chapter, whose scope of practice includes the health care services or health care related services being provided.

NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Any health carrier regulated under this title or hospital licensed under chapter 70.41 RCW that files with the United States department of justice and the federal trade commission notification of a transaction that is required to be reported pursuant to section 7A of the Clayton Act (15 U.S.C. 18a) shall, on the same date as the notification is submitted, provide the department of health with a written report that includes the overall impact of the transaction on the health services available and readily accessible to the community and that includes the impact of the transaction on each of the following, where applicable:

(a) The availability and accessibility of primary care, acute care, and emergency services;

(b) The availability and accessibility of services for mothers and children;

(c) The availability and accessibility of services to the elderly;

(d) The availability and accessibility of services to other specific populations, including persons whose income is less than two hundred percent of the federal poverty level, or who are uninsured, ethnic minorities, women, or disabled;

(e) The availability and accessibility of specialized services, including services for the prevention, detection, and treatment of the human immunodeficiency virus and related illnesses, mental health services, and substance abuse services;

(f) The safety and quality of health care services to be provided, including anticipated changes in numbers and mix of nursing and other patient care staff and on other factors related to patient outcomes;

(g) The availability and accessibility of social services and other services within the community;

(h) The overall employment within the community;

(i) The health carrier or hospital's work force, including:

(i) The status of existing collective bargaining contracts, if any; and

(ii) Plans for retraining and redeployment of employees who are displaced as a result of the contemplated transaction;

(j) The financial stability of the merged entity, taking into account at least projected acquisition costs, related expenses, and planned marketing or advertising campaigns for the new entity; and

(k) Other factors to be specified in rules to be adopted by the health care policy board.

The report is in addition to any documentation required by any other federal or state agency.

A report under this subsection must be made publicly available by the health carrier or hospital and by the department of health upon request. In addition, the health carrier or hospital shall make publicly available any documentation submitted to the United States department of justice, the federal trade commission, or other federal or state agency regarding the contemplated transaction.

(2) The department shall conduct, or arrange for, public hearings on the elements of each report submitted under subsection (1) of this section and any other factors related to the health, safety, and welfare of patients served by the health carrier or hospital and the

community involved, including the health carrier or hospital's work force. The hearings must be held at a time or times and location or locations readily accessible to the public and may be conducted jointly with relevant federal, state, and local agencies.

(3) The department of health shall review each proposed transaction. The review must be based on the written report submitted under subsection (1) of this section, a transcript of testimony at the public hearing under subsection (2) of this section, and any other factors that the department of health finds are relevant to the health, safety, and welfare of the patients served by the health carrier or hospital and the community, including the health carrier or hospital's work force.

(4) The department of health shall, within forty-five days of completion of a hearing under subsection (2) of this section, issue written findings on the likely impact of the contemplated transaction on the health and safety of the patients and communities served by the health carrier or hospital, including the health carrier or hospital's work force.

(5) If the department of health determines that the overall impact of the transaction on the health and safety of patients and the community is a negative one, the department of health shall issue, as part of the findings, a finding of negative impact on health and safety.

(6) In issuing findings under this section, the department of health may confer with other federal, state, and local agencies that may have an interest in the impact on the public of the proposed transaction.

(7) A health carrier or hospital that executes a transaction that is the subject of a finding of negative impact on health and safety under subsection (5) of this section, or a health carrier or hospital that fails to file a report with the department of health pursuant to subsection (1) of this section, is deemed not to be in compliance with the conditions of participation under the state-purchased health care programs. Such a determination is subject to procedures and appeal as provided in rules adopted by the department of health.

(a) For a hospital licensed under chapter 70.41 RCW, if the department of health determines that conditions effected by the transaction in question pose immediate jeopardy or irreparable harm to patient health, safety, and welfare, the department of health shall, if

such transaction is completed, immediately suspend the entity's license. Such suspension continues in force during any administrative or judicial review for the transaction sought by the entity.

(b) For a health carrier regulated under this title, if the department of health determines that conditions effected by the transaction in question pose immediate jeopardy or irreparable harm to patient health, safety, and welfare, the insurance commissioner shall, if such transaction is completed, immediately suspend the carrier's license. Such suspension continues in force during any administrative or judicial review for the transaction sought by the entity.

NEW SECTION. **Sec. 8.** A new section is added to chapter 70.44 RCW to read as follows:

Nothing in this chapter prohibits any person employed by, contracting with, volunteering with, or working in a public hospital or public hospital district from seeking to serve or serving as a hospital commissioner.

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