HOUSE BILL REPORT
ESHB 2036

As Passed House:
February 17, 2020

Title: An act relating to health system transparency.

Brief Description: Concerning health system transparency.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Macri, Ormsby, Riccelli and Pollet).

Brief History:
Committee Activity:
Health Care & Wellness: 1/15/20, 1/28/20 [DPS];
Appropriations: 2/8/20, 2/10/20 [DPS(HCW)].
Floor Activity:
Passed House: 2/17/20, 56-42.

Brief Summary of Engrossed Substitute Bill

- Requires that hospitals provide additional detail regarding expenses and revenues in financial reports to the Department of Health.
- Eliminates the exemption from reporting information about facility fees for off-campus clinics or providers that are located within 250 yards from the main hospital building.
- Requires that community needs assessments made public by hospitals include an addendum containing certain information about activities identified as community health improvement services.
- Requires hospitals to post information on their websites if they have an ownership interest in a debt collection agency or have certain exchanges of revenue with debt collection agencies.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Cody, Chair; Macri, Vice Chair; Chopp, Davis, Riccelli, Robinson, Stonier, Thai and Tharinger.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Minority Report: Do not pass. Signed by 6 members: Representatives Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers, DeBolt, Harris and Maycumber.

Staff: Chris Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill by Committee on Health Care & Wellness be substituted therefor and the substitute bill do pass. Signed by 19 members: Representatives Ormsby, Chair; Robinson, 1st Vice Chair; Bergquist, 2nd Vice Chair; Chopp, Cody, Dolan, Fitzgibbon, Hansen, Hudgins, Kilduff, Macri, Pettigrew, Pollet, Ryu, Senn, Springer, Sullivan, Tarleton and Tharinger.

Minority Report: Do not pass. Signed by 12 members: Representatives Stokesbary, Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Chandler, Corry, Dye, Hoff, Kraft, Mosbrucker, Steele, Sutherland and Ybarra.

Minority Report: Without recommendation. Signed by 1 member: Representative Schmick.

Staff: Linda Merelle (786-7092).

Background:

Hospital Financial and Patient Discharge Reporting.
Hospitals must submit financial and patient discharge data to the Department of Health (Department). Each hospital must report data elements identifying its revenues, expenses, contractual allowances, charity care, bad debt, other income, total units of inpatient and outpatient services, and other financial and employee compensation information. With respect to compensation information, public and nonprofit hospitals must either provide employee compensation information submitted to the federal Internal Revenue Service or provide the compensation information for the five highest compensated employees of the hospital who do not have direct patient responsibilities.

Facility Fees.
Provider-based clinics that charge facility fees must provide a notice to patients receiving nonemergency services. The notice must inform the patient that the clinic is licensed as part of a hospital, and the patient may receive a separate billing for the facility component of a health care visit which may result in a higher out-of-pocket expense. Hospitals with provider-based clinics that bill a separate facility fee must report specific information to the Department each year. The reportable information relates to the number of provider-based clinics that bill a separate fee, the number of patient visits at each of those provider-based clinics, the revenue received by the hospital through the facility fees billed at each of those provider-based clinics, and the range of allowable facility fees paid by public or private payers at each of those provider-based clinics.

A "provider-based clinic" is defined as the site of an off-campus clinic or provider office that is licensed as part of a hospital and is at least 250 yards from the main hospital buildings, or as determined by the federal Centers for Medicare and Medicaid Services, and is owned by a hospital or a health system that operates one or more hospitals. The clinic or provider must be primarily engaged in providing diagnostic and therapeutic care. A "facility fee" is any separate charge or billing by a provider-based clinic that is in addition to the professional fee for physician's services and is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses.

Community Health Needs Assessments.
To qualify as a nonprofit organization, federal law requires that hospitals complete a community health needs assessment every three years and adopt an implementation strategy to meet the identified community health needs. The community health needs assessment must consider input from people who represent broad interests in the community served by the hospital, including those with special knowledge or expertise in public health.

State law requires that hospitals that are federally recognized as nonprofit entities make their community health needs assessments available to the public. In addition, hospitals must include a description of the community served by the hospital and demographic information related to the community's health. Within one year of completing their community health needs assessments, hospitals must make public a community benefit implementation strategy.

Notice of Charity Care Policies.
Washington hospitals may not deny patients access to emergency care because of the inability to pay. Hospitals are required to develop, implement, and maintain a charity care policy and a sliding fee schedule and submit them, along with data regarding the annual use of charity care, to the Department. Hospitals must also submit bad debt policies to the Department, including standards for collecting the unpaid portions of hospital charges that are the patient's responsibility. "Charity care" is defined as necessary hospital health care rendered to indigent persons to the extent they are unable to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer.

Hospitals must notify a person who may be eligible for charity care in several ways. Hospitals must display notices about the availability of charity care prominently in certain hospital areas, including areas where patients are admitted or registered, emergency departments, and financial services or billing areas. The hospital must also make the current version of the hospital's charity care policy and application form available on its website. In addition, all hospital billing statements and other written statements about billing must include a prescribed message about the potential availability of charity care.

Summary of Engrossed Substitute Bill:

Financial and Patient Discharge Reporting.
The Department of Health (Department) must revise the financial and patient discharge data that hospitals must report to provide additional detail about specific categories of expenses and revenues. The additional categories of expenses include: blood supplies; contract staffing; information technology; insurance and professional liability; laundry services; legal, audit, and tax professional services; purchased laboratory services; repairs and maintenance;

shared services or system office allocation; staff recruitment; training costs; taxes; utilities; and other noncategorized expenses. The additional categories of revenues include: donations; grants; joint ventures; local taxes; outpatient pharmacy; parking; quality incentive payments; reference laboratories; rental income; retail cafeteria; and other noncategorized revenue.

Hospitals, other than those designated as critical access hospitals and sole community hospitals, must report line items and amounts for any expenses or revenues that are noncategorized expenses or revenues that either have a value of $1 million or more, or represent 1 percent or more of the total expenses or revenues. Hospitals that are designated as critical access hospitals or sole community hospitals must report line items and amounts for any expenses or revenues that are noncategorized expenses or revenues that represent the greater of either $1 million, or 1 percent of total expenses or revenues.

Health systems that operate a hospital must annually submit a consolidated income statement and balance sheet to the Department regarding the facilities that they operate in Washington including hospitals, ambulatory surgical facilities, health clinics, urgent care clinics, physician groups, health-related laboratories, long-term care facilities, home health agencies, dialysis facilities, ambulance services, behavioral health settings, and virtual care entities. The Washington State Auditor's Office must provide the Department with audited financial statements for all hospitals owned or operated by a public hospital district. The Department must make the income statements and balance sheets, as well as the audited financial statements, publicly available.

Each ambulatory surgical facility must submit an annual report to the Department with the following information:

- the number of patient encounters;
- utilization data by services provided, including primary care, specialty care, urgent care, surgery, and virtual care;
- acquisitions of diagnostic and therapeutic equipment during the reporting period with a value over $500,000; and
- projects that were commenced during the reporting period that require a capital expenditure for the facility over $1 million.

Facility Fees.
The exemption for off-campus clinics or providers that are located within 250 yards from the main hospital buildings or as determined by the federal Centers for Medicare and Medicaid Services is eliminated from the definition of "provider-based clinic," as the term relates to providing notice of facility fees and reporting facility fee information.

Community Health Needs Assessments.
Hospitals that must make their community health needs assessments available to the public must also make public an addendum with details about the activities that they identify as community health improvement services. Hospitals that are designated as critical access hospitals or sole community hospitals must report the 10 community benefits and community building activities with the highest costs. All other hospitals must report the 20 highest cost community benefits and community building activities. The addendum must describe each activity and its cost, the community health needs assessment implementation strategy that is

the basis for the activity, the zip codes in the hospital's service area, and how medically underserved, low-income, and minority, or chronically ill populations were served.

Hospital Debt Collection Practices.
In addition to posting the current version of the hospital's charity care policy and application form on its website, each hospital must also post information about any ownership interest in a debt collection agency or exchange of revenue with a debt collection agency that exceeds the amount a consumer owed related to medical debt for services provided and administrative costs and fees related to collecting the debt.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect on January 1, 2021.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) Hospital care has the fastest rate of growth in health care expenses, and this bill attempts to get better clarity on the reasons for that. Health care costs are rising, and this raises questions for all purchasers about how to maintain spending over time. Health care purchasers are interested in the success of the health care system; however, it is not clear how resources are being used. Rising health care costs make it difficult for patients to access needed care.

As there is more integration in the health care delivery system, it is important to understand how all of the players in the system interact. The health care system is growing increasingly complex and consolidated which makes it hard to assess the right way to cut costs and assure accountability. People have questions about the financial and care relationships that exist in the health system. It is essential to modernize the oversight of the health care system to follow where the health care delivery is going. Other states have standards that allow them to understand hospital revenues and spending and how money is exchanged between affiliated organizations. It is difficult to maintain a stable provider network with so many rapid changes in the market. The health care system is increasingly clinic-based which is primarily staffed by communities of color and women, and it is not fair to them to not have oversight for the work that is happening there.

Current end-of-year financial reports include a statement related to other revenue or expenses which may have millions of dollars that are not further detailed. When "other expenses" is the largest category of expenses for a hospital, this raises concerns about how the hospitals are spending the community's money. Hospitals report on the financial aspects of their operations in many ways, but the reports do not present a complete picture. One hospital system lists $700 million in "other expenses," but there is no information about what those expenses are. One hospital reported $40 million in facility fees in one year, and it is not known what this money is or where it is going.

There have been lawsuits based on charity care lately that have led some to ask what the financial relationship is between the hospital and the debt collection agency. This bill will

help patients get the care that they need without having to worry about financial stability. The public needs information about hospitals' financial practices to help patients make better decisions about where to seek care.

Some hospitals use community health needs assessments as a marketing campaign rather than funding needs identified through the community health needs assessments, which are supposed to be the basis for spending on community benefits. The behaviors at the large health systems bleed into the behaviors and costs at the rural level as well.

(Opposed) Hospitals currently report a great deal of information, and it would be helpful to discuss what necessary information is not available. It is not clear what kinds of items would be under the $50,000 threshold regarding uncategorized revenues and expenses. The language about reporting between hospital systems and components is not clear. It is not clear what the definition of a provider-based clinic would be. Community health needs assessment information is already publicly available. The reporting requirement about debt collection practices is not clear. This bill imposes substantial burdens on all hospitals without clear purpose or definitions. This bill requires reporting hospital revenue and expenses at the patient level, but hospitals capture that information in the aggregate. The way the bill is written would not allow for context for the data, such as where some services support other unsubsidized services. There is already a gold standard available to the public that will show all of the requested information, including audited financial statements and reports.

While there is a need for more transparency with regard to hospitals and their debt collection practices, it is not clear what must be disclosed under the general financial agreement. It would be problematic to have to release proprietary information like commission rates. It is becoming difficult for collection agencies in Washington to be competitive with agencies across the country. There are parts of legislation from last year that address the itemization concerns expressed by some.

Procedures at ambulatory surgical facilities cost about half of what they would cost in a hospital, so they are not as big a part of the spending problem as hospitals and should not be included in the bill. Many of the reporting requirements do not apply to ambulatory surgical facilities.

Staff Summary of Public Testimony (Appropriations):

(In support) This bill represents an effort to expand access to health care and to better understand the costs. Health care spending is growing and increasingly consolidated and complex. Implementation of this bill would shed light on health care organizations and their finances.

(Opposed) Health care systems are already required to provide a tremendous amount of data, and the requirements under this bill would add more complexity. A better understanding is needed regarding why this information is being required and what purpose it serves.

Persons Testifying (Health Care & Wellness): (In support) Representative Macri, prime sponsor; Sybill Hyppolite, Washington State Labor Council; Brenda Wiest, Teamsters 117;

Jennifer Muhm, Washington State Nurses Association; David Rojas, United Food and Commercial Workers 21; and Rachel Erstad and Lindsey Grad, Service Employees International Union Healthcare 1199 Northwest.

(Opposed) Zosia Stanley, Washington State Hospital Association; Will Callicoat, Mary Bridge Children's Hospital; Kelsi Hamilton, Washington Collectors Association; and Susie Tracy, Washington Ambulatory Surgery Center Association.

Persons Testifying (Appropriations): (In support) Representative Macri, prime sponsor; and Sybill Hyppolite, Washington State Labor Council.

(Opposed) Lisa Thatcher, Washington State Hospital Association; and Chester Baldwin, Washington Collectors Association.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.