HOUSE BILL REPORT
E2SHB 1272

As Passed House:
February 25, 2021

Title: An act relating to health system transparency.

Brief Description: Concerning health system transparency.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Macri, Cody, Fitzgibbon, Davis, Hackney, Thai, Kloba, Rule, Simmons, Pollet, Dolan, Slatter, Riccelli and Harris-Talley).

Brief History:
Committee Activity:
Health Care & Wellness: 2/4/21, 2/10/21 [DPS];
Appropriations: 2/18/21, 2/19/21 [DP2S(w/o sub HWC)].
Floor Activity:
Passed House: 2/25/21, 58-40.

Brief Summary of Engrossed Second Substitute Bill

- Requires that hospitals provide detailed information regarding several identified categories of 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 health needs assessments made public by hospitals include an addendum containing certain information about activities identified as community health improvement services.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

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

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 10 members: Representatives Cody, Chair; Bateman, Vice Chair; Caldier, Assistant Ranking Minority Member; Bronoske, Davis, Macri, Riccelli, Simmons, Stonier and Tharinger.

Minority Report: Without recommendation. Signed by 5 members: Representatives Schmick, Ranking Minority Member; Harris, Maycumber, Rude and Ybarra.

Staff: Christopher Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on . Signed by 20 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Caldier, Chopp, Cody, Dolan, Fitzgibbon, Frame, Hansen, Johnson, J., Lekanoff, Pollet, Ryu, Senn, Springer, Stonier, Sullivan and Tharinger.

Minority Report: Do not pass. Signed by 11 members: Representatives Stokesbary, Ranking Minority Member; Corry, Assistant Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Boehnke, Chandler, Dye, Hoff, Jacobsen, Rude, Schmick and Steele.

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

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.

Hospital Staffing.
Hospitals must establish nurse staffing committees to develop and oversee an annual patient care unit and shift-based nurse staffing plan (nurse staffing plan), conduct a semiannual review of the nurse staffing plan, and review, assess, and respond to staffing concerns. Nurse staffing plans must consider such factors as:

- patient census, including total patients by unit and shift;
- level of intensity of patients and the nature of the care to be delivered on each shift;
- skill mix;
- level of experience of nurses providing care;
- the need for specialized or intensive equipment;
- the physical design of the patient care unit;
- staffing guidelines adopted by national nursing associations, specialty associations, and other health professional associations;
- the availability of other personnel supporting nursing services; and
- strategies to enable registered nurses to take meal and rest breaks.

If the chief executive officer of the hospital does not approve the nurse staffing committee's plan, they must provide a written explanation to the committee and either identify elements of the nurse staffing plan to be changed or prepare an alternate nurse staffing plan. The hospital may not retaliate against employees performing duties in connection with the nurse staffing committee or an individual who notifies the nurse staffing committee or the hospital administration about concerns on nurse staffing.

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 a community benefit implementation strategy publicly available.

Summary of Engrossed Second Substitute Bill:

Financial and Patient Discharge Reporting.
The Department of Health (Department) must revise the financial and patient discharge data that hospitals 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 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 noncategorized expenses or revenues that represent the greater of either $1 million or 1 percent of total expenses or revenues.

Hospital must submit quarterly reports to the Department regarding the number of submitted and completed charity care applications that they received and the number of approved applications.

Hospitals must report any money they or their health systems receive from federal, state, or local governments in response to a national or state-declared emergency, including money received after January 1, 2020, in association with the COVID-19 pandemic. The Department must provide guidance on reporting this information.

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.

Patient discharge information reported by hospitals must identify the patient's race, ethnicity, gender identity, preferred language, any disability, and zip code of primary residence. The Department must provide guidance on reporting and develop a waiver process to allow hospitals to adopt an alternative reporting method due to economic hardship, technological limitations, or other exceptional circumstances. Patients must be informed that providing the information is voluntary. The Department may not take any action against a hospital that fails to report demographic information because a patient refused to provide the information.

Hospital Staffing Study.
The Department must select a research entity to analyze the impact of the number, type, education, training, and experience of acute care hospital staffing personnel on patient mortality and patient outcomes. The study should control for other contributing factors, including access to equipment, patients' underlying conditions and diagnoses, patients' demographic information, the trauma level designation of the hospital, transfers from other hospitals, and external factors impacting hospital volume. The study must be completed by September 1, 2022, and submitted to the appropriate committees of the Legislature by October 1, 2022.

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. The addendum must describe the type of activity and how it was provided, how the activity addresses an identified community need in the community health needs assessment, the target population for the activity, strategies to reach the target population, identified outcome metrics, the cost to the hospital to provide the activity, the methodology used to calculate the hospital's costs, and the number of people served by the activity. Hospitals, other than those designated as critical access hospitals or sole community hospitals, are only required to report community health improvement services activities with a cost of $5,000 or more. Hospitals that are designated as critical access hospitals or sole community hospitals are only required to report the information for the 10 highest cost activities identified as community health improvement

services.

Hospitals must also report demographic information about the participants' race, ethnicity, gender identity, preferred language, any disability, zip code of primary residence. The Department, in consultation with interested entities, may revise the demographic information reporting requirements every six years. Participants must be informed that providing the information is voluntary. The Department may not take any action against a hospital that fails to report demographic information because a participant refused to provide the information.

The Department must provide guidance on the community health improvement services data reporting. The Department must develop the guidance in consultation with interested entities, including an association representing hospitals, labor unions representing hospital workers, and community health board associations.

In addition to making the information publicly available, hospitals must submit community health needs assessments and community health improvement services activities information to the Department which must post the information on its website.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect on July 1, 2022. However, the bill is null and void unless funded in the budget.

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

(In support) As health systems grow and become increasingly complex and consolidated, it becomes more difficult to ensure financial accountability. Washington's transparency systems are outdated and do not match how care is delivered today. Without a full picture of the finances, the state cannot act in the best interests of patients, purchasers, or policymakers. Some hospitals have large amounts of cash that they are investing and generating profits from, and this bill will provide policymakers and stakeholders with the information they need to make sound decisions in the face of a rapidly changing health care industry. This bill has the opportunity to create more predictability for purchasers, individuals, and families. Transparency can help show where financial decisions supersede patient safety decisions. When a hospital makes financial decisions that impact front line staffing, then the public has a right to know about the hospital's financial information. Many of Washington's hospitals are owned by multi-state systems and it is unclear if the money spent on health care in Washington is helping Washington.

Understanding the revenues and expenses of hospital systems is paramount in achieving equity and economic sustainability for the state, small businesses, individuals and their

families, and diverse communities. It is important to understand how state dollars are being spent on the health needs of rural and underserved Washingtonians. The data in this bill are important to solving racial inequities in health settings. Black people in Washington continue to experience racism and inequities in health care which is evidenced by health outcomes. There needs to be a proactive health system with a systematic approach to transparency if the state is going to make a difference in addressing systemic racism.

Washingtonians do not know if hospitals have earned their tax-exempt status by serving those most impacted. Nonprofit hospitals need to be accountable to the communities that they serve in a way that is more transparent and results in reflecting and responding to the voices of the communities that they are serving. The transparency and accountability that reporting data provides is vital to ensuring that hospitals are caring for members of the community who are most in need.

(Opposed) Data collection needs focus, context, and analysis to have meaning and drive action, and this bill does not do that. The bill requires reporting of granular demographic information which is difficult and challenging to collect. The critical staffing reporting requirement does not drive action or improvement because of a lack of standard definitions and the information does not lend itself to solutions. This reporting will be a burden to staff at small hospitals and will require costly changes to hospitals' electronic medical records. There is no ability to compile the data required by the bill at the sites where community benefit services are frequently provided. It is unclear what the community benefit data will be used for and whether it is worth the investment.

There is a reluctance in communities of color to share demographic information without a reason and this bill does not provide the reason. The reporting requirements could result in people not seeking needed care. Currently, up to 30 percent of race and ethnicity data are marked as unknown. The extensive demographic data reporting will offend some patients, make them suspicious, and will be harmful to the community and erode trust. This bill will not move the state forward in the direction of increased equity, care delivery, or access. There is a need to identify and address health equity, but the bill puts a significant burden on hospital community benefit activities. The state already has a panel that reviews maternal mortality and it is redundant to require hospitals to submit additional maternal mortality data in a separate process.

Staff Summary of Public Testimony (Appropriations):

(In support) The state is the largest purchaser of health care. Health care systems have consolidated and expanded at rapid rates. It is important to ensure that rural and underserved Washingtonians get the health care that they need. The additional data will help policy makers better understand how to direct state dollars. A lack of transparency does not serve citizens well. This bill will provide data to allow an assessment of sustainability, affordability and equity, particularly in mortality rates.

(Opposed) The new data reporting requirements under this bill will impose substantial costs, including changes to the electronic health records. Small and rural hospitals are currently being supported by federal funding as a result of the pandemic and cannot use those dollars for other purposes.

Persons Testifying (Health Care & Wellness): (In support) Representative Macri, prime sponsor; Bevin McLeod, Alliance for a Healthy Washington; Joyce Sinakhone and Steven Higgs, Service Employees International Union Healthcare 1199 Northwest; Jiquanda Nelson, African American Health Board; Kathleen Bourg-Glasgow, United Food and Commercial Workers International Union 21; Laura Kate Zaichkin, Service Employees International Union 775 Benefits Trust; Danielle O'Toole, Washington State Nurses Association; Sybill Hyppolite, Washington State Labor Council, American Federation of Labor and Congress of Industrial Organizations; Ben Danielson; and Kay Funk, Yakima City Council.

(Opposed) Ramona Hicks, Coulee Medical Center; Mary Quinlan, MultiCare; and Darcy Jaffe and Lisa Thatcher, Washington State Hospital Association.

Persons Testifying (Appropriations): (In support) Representative Macri, prime sponsor; and Sybill Hyppolite, Washington State Labor Council, American Federation of Labor and Congress of Industrial Organizations.

(Opposed) Zosia Stanley, Washington State Hospital Association.

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

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