FINAL BILL REPORT
E2SHB 1272

C 162 L 21
Synopsis as Enacted

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).

House Committee on Health Care & Wellness
House Committee on Appropriations
Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means

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;

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- 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.

A hospital's chief executive officer who does not approve the nurse staffing committee's plan 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:

Financial and Patient Discharge Reporting.
By January 1, 2023, 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 or 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.

Beginning January 1, 2023, hospitals 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 in association with the COVID-19 pandemic after January 1, 2020. The Department must provide guidance on reporting this information.

Beginning July 1, 2022, 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.

Beginning January 1, 2023, patient discharge information reported by hospitals must identify the patient's race, ethnicity, gender identity, sexual orientation, preferred language, any disability, and zip code of primary residence. Patients must be informed that providing the information is voluntary. The Department must provide guidance on reporting and may not take any action against a hospital that fails to report demographic information because a patient refused to provide the information. The Department must develop a waiver process for critical access hospitals, sole community hospitals, and Medicare dependent hospitals to opt out of the demographic information reporting requirement due to economic hardship, technological limitations, or other exceptional circumstances. Waivers are limited to no more than one year or another time frame established by the Department, and hospitals may apply for an extension of the waiver.

By October 1, 2022, the Department must establish a grant program to support upgrades to electronic health records systems to comply with demographic data reporting requirements for critical access hospitals, sole community hospitals, and Medicare-dependent hospitals. Hospitals owned or operated by a health system that owns or operates two or more hospitals are not eligible for the grants. In considering a grant application, the Department may consider information about the hospital’s need for financial support and vary the size of the grants accordingly. Hospitals that receive a grant must update their electronic health records systems to comply with demographic information reporting requirements before making any other changes to their electronic health records systems, except for changes related to security, compliance, or privacy. A hospital that receives a grant must comply with demographic information reporting requirements by July 1, 2023.

Hospital Staffing Study.
The Department must contract with the University of Washington School of Nursing to work with other schools in the University of Washington's health sciences administration 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 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.
Beginning July 1, 2022, 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.

Votes on Final Passage:

House	58	40	
Senate	27	21	(Senate amended)
House	57	41	(House concurred)

Effective: July 25, 2021