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**SECOND SUBSTITUTE HOUSE BILL 1272**

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**State of Washington 67th Legislature 2021 Regular Session**

**By** House Appropriations (originally sponsored by Representatives Macri, Cody, Fitzgibbon, Davis, Hackney, Thai, Kloba, Rule, Simmons, Pollet, Dolan, Slatter, Riccelli, and Harris-Talley)

AN ACT Relating to health system transparency; amending RCW 43.70.052, 70.01.040, and 70.41.470; adding a new section to chapter 43.70 RCW; adding a new section to chapter 70.41 RCW; creating a new section; and providing an effective date.

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

**Sec.**  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, including any applicable information reported pursuant to section 2 of this act, 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. 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 other financial and employee compensation information reasonably necessary to fulfill the purposes of this section.

(b) 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.

(c) The department must revise the uniform reporting system to further delineate hospital expenses reported in the other direct expense category in the statement of revenue and expense. The department must include the following additional categories of expenses within the other direct expenses category:

(i) Blood supplies;

(ii) Contract staffing;

(iii) Information technology, including licenses and maintenance;

(iv) Insurance and professional liability;

(v) Laundry services;

(vi) Legal, audit, and tax professional services;

(vii) Purchased laboratory services;

(viii) Repairs and maintenance;

(ix) Shared services or system office allocation;

(x) Staff recruitment;

(xi) Training costs;

(xii) Taxes;

(xiii) Utilities; and

(xiv) Other noncategorized expenses.

(d) The department must revise the uniform reporting system to further delineate hospital revenues reported in the other operating revenue category in the statement of revenue and expense. The department must include the following additional categories of revenues within the other operating revenues category:

(i) Donations;

(ii) Grants;

(iii) Joint venture revenue;

(iv) Local taxes;

(v) Outpatient pharmacy;

(vi) Parking;

(vii) Quality incentive payments;

(viii) Reference laboratories;

(ix) Rental income;

(x) Retail cafeteria; and

(xi) Other noncategorized revenues.

(e)(i) A hospital, other than a hospital designated by medicare as a critical access hospital or sole community hospital, must report line items and amounts for any expenses or revenues in the other noncategorized expenses category in (c)(xiv) of this subsection or the other noncategorized revenues category in (d)(xi) of this subsection that either have a value: (A) Of $1,000,000 or more; or (B) representing one percent or more of the total expenses or total revenues; or

(ii) A hospital designated by medicare as a critical access hospital or sole community hospital must report line items and amounts for any expenses or revenues in the other noncategorized expenses category in (c)(xiv) of this subsection or the other noncategorized revenues category in (d)(xi) of this subsection that represent the greater of: (A) $1,000,000; or (B) one percent or more of the total expenses or total revenues.

(f) A hospital must report any money, including loans, received by the hospital or a health system to which it belongs from a federal, state, or local government entity in response to a national or state-declared emergency, including a pandemic. Hospitals must report this information as it relates to federal, state, or local money received after January 1, 2020, in association with the COVID-19 pandemic. The department shall provide guidance on reporting pursuant to this subsection.

(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)~~)) (8) 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) Patient discharge information reported by hospitals to the department must identify patients by race, ethnicity, gender identity, preferred language, any disability, zip code of primary residence, whether the patient applied for charity care, whether the patient received charity care, and whether the patient reported an income of 400 percent of the federal poverty level or less. The department shall provide guidance on reporting pursuant to this subsection. When requesting demographic information under this subsection, a hospital must inform patients that providing the information is voluntary. If a hospital fails to report demographic information under this subsection because a patient refused to provide the information, the department may not take any action against the hospital for failure to comply with reporting requirements or other licensing standards on that basis.

(7) 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)~~)) (8) 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)~~)) (9)(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)~~)) (9) Recipients of data under subsection ((~~(7)~~)) (8)(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)~~)) (10) Recipients of data under subsection ((~~(7)~~)) (8)(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)~~)) (11) For the purposes of this section:

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

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

((~~(11)~~)) (12) The department must adopt rules necessary to carry out its responsibilities under this section. The department must consider national standards when adopting rules.

NEW SECTION. **Sec.**  A new section is added to chapter 43.70 RCW to read as follows:

(1)(a) For a health system operating a hospital licensed under chapter 70.41 RCW, the health system must annually submit to the department a consolidated annual income statement and balance sheet, 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 that are operated in Washington.

(b) The state auditor's office shall provide the department with audited financial statements for all hospitals owned or operated by a public hospital district under chapter 70.44 RCW. Public hospital districts are not required to submit additional information to the department under this subsection.

(2) The department must make information submitted under this section available in the same manner as hospital financial data.

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

(1) Each hospital must report the following information to the department each month:

(a) The number of days of critical staffing, by job class. Critical staffing job classes include environmental services, nurses, other health care personnel, other licensed independent practitioners, pharmacy and pharmacy technicians, physicians, respiratory therapists, temporary physicians, temporary nurses, temporary respiratory therapists, temporary pharmacists, and other job classes identified by the department; and

(b) Mortality rates, including race and ethnicity mortality rates among labor and delivery patients.

(2) The department must adopt rules to implement the reporting requirements under this section.

**Sec.**  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 website, 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 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.**  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)(i) A hospital, other than a hospital designated by medicare as a critical access hospital or sole community hospital, that is subject to the requirements under subsection (1) of this section must submit 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 the activity addresses the identified needs of the community, how each activity may correspond to follow-up services offered by the hospital, the cost of providing each type of activity with the methodology used to determine the hospital's costs written in plain English, and any materials provided to activity participants. In addition, the information must identify participants by race, ethnicity, gender identity, preferred language, any disability, zip code of primary residence, and whether the participant has an income of 200 percent of the federal poverty level or less. 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.

(ii) A hospital designated by medicare as a critical access hospital or sole community hospital that is subject to the requirements under subsection (1) of this section must submit an addendum which details information about the 10 highest cost 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 the activity addresses the identified needs of the community, how each activity may correspond to follow-up services offered by the hospital, the cost of providing each type of activity with the methodology used to determine the hospital's costs written in plain English, and any materials provided to activity participants. In addition, the information must identify participants by race, ethnicity, gender identity, preferred language, any disability, zip code of primary residence, and whether the participant has an income of 200 percent of the federal poverty level or less. 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.

(iii) The department shall provide guidance on participant data collection and the reporting requirements under this subsection (2)(b). The department must develop the guidelines in consultation with stakeholders, including an association representing hospitals in Washington, labor unions representing workers who work in hospital settings, and community health board associations.

(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) When requesting demographic information under subsection (2)(b) of this section, a hospital must inform participants that providing the information is voluntary. If a hospital fails to report demographic information under subsection (2)(b) of this section because a participant refused to provide the information, the department may not take any action against the hospital for failure to comply with reporting requirements or other licensing standards on that basis.

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

NEW SECTION. **Sec.**  This act takes effect July 1, 2022.

NEW SECTION. **Sec.**  If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2021, in the omnibus appropriations act, this act is null and void.

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