Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2036

Brief Description: Concerning health system transparency.

Sponsors: Representatives Macri, Ormsby, Riccelli and Pollet.

Brief Summary of Bill

- Adds ambulatory surgical facilities to hospital reporting requirements regarding financial and patient discharge data.
- Requires entities that operate health systems to report financial and patient discharge data related to components and services that comprise the health system, as well as data regarding certain financial exchanges and the number of employees.
- 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 submitted by hospitals include an addendum containing certain information about activities identified as community health improvement services.
- Requires hospitals to make their debt collection practices available on their web sites.

Hearing Date: 1/15/20

Staff: Chris Blake (786-7392).

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

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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 non-emergency 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 web site. 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 Bill:

Financial and Patient Discharge Reporting.
Ambulatory surgical facilities are added to hospital reporting requirements and must submit financial and patient discharge data to the Department of Health (Department).

Any entity that operates a health system must report financial and patient discharge data to the Department for each health care facility component or service within the entity. The entity must also report:

- any financial exchanges between the entity and each health care facility component or service, or between health care facility components and services, including an explanation of the nature of each exchange over $50,000; and
- the total number of full-time equivalent employees at each health care facility component or service.

A "health system" is defined as an entity that is financially responsible for at least one hospital as well as other health care components and services that may be independent of the hospital. These may include ambulatory surgical facilities, health clinics, urgent care clinics, health-related laboratories, long-term care facilities, home health agencies, dialysis facilities, ambulance services, behavioral health settings, and virtual care entities, including electronic applications and telehealth portals.

When reporting data related to revenue, ambulatory surgical facilities, hospitals, and entities operating health systems must include a description of the services provided in exchange for the income or revenue. If a service generates more than $50,000 during the reporting period, the amount for that service must be listed.

In addition to reporting expense data defined by the Department, ambulatory surgical facilities, hospitals, and entities operating health systems must provide a description of any expenses that do not meet a defined category of expenses. If an expense costs more than $50,000 during the reporting period, the amount for that expense must be listed.

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

- a current inventory of beds and services;
- utilization data by bed type and service;
- 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 submit an addendum with details about the activities that they identify as community health improvement services. The addendum must specify the type of activity, the method in which the type of activity was provided, the resources used to provide the activity, how the activity may correspond to follow up services offered by the hospital, the cost of providing each type of activity, and any materials provided to activity participants.

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 make available its debt collection practices. The description of the debt collection practices must identify all entities that are under contract with the hospital to collect debt and the general financial arrangements between the hospital and the debt collection agency.

Appropriation: None.

Fiscal Note: Requested on January 7, 2020.

Effective Date: The bill takes effect on January 1, 2020.