BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: Z-0403.7/24 7th draft

ATTY/TYPIST: MW:eab

BRIEF DESCRIPTION: Updating the governor's interagency coordinating council on health disparities.

AN ACT Relating to updating the name, authority, membership, and duties of the governor's interagency coordinating council on health disparities; amending RCW 43.20.270, 43.20.275, 43.20.280, 41.05.840, and 70.41.470; reenacting and amending RCW 43.20.025; and repealing RCW 44.28.810.

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

Sec. 1. RCW 43.20.025 and 2019 c 185 s 1 are each reenacted and amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Commissary" means an approved food establishment where food is stored, prepared, portioned, or packaged for service elsewhere.

(2) ((~~"Commissions" means the Washington state commission on African American affairs established in chapter 43.113 RCW, the Washington state commission on Asian Pacific American affairs established in chapter 43.117 RCW, the Washington state commission on Hispanic affairs established in chapter 43.115 RCW, and the governor's office of Indian affairs.~~

~~(3)~~)) "Consumer representative" means any person who is not an elected official, who has no fiduciary obligation to a health

facility or other health agency, and who has no material financial interest in the rendering of health services.

((~~(4)~~)) (3) "Council" means the governor's ((~~interagency coordinating~~)) council ((~~on~~)) for health ((~~disparities~~)) justice and equity, convened according to this chapter.

((~~(5)~~)) (4) "Department" means the department of health.

((~~(6)~~)) (5) "Health disparities" means the difference in incidence, prevalence, mortality, or burden of disease and other adverse health conditions, including lack of access to proven health care services that exists between specific population groups in Washington state.

((~~(7)~~)) (6) "Health impact review" means a review of a legislative or budgetary proposal completed according to the terms of this chapter that determines the extent to which the proposal improves or exacerbates health disparities.

((~~(8)~~)) (7) "Local health board" means a health board created pursuant to chapter 70.05, 70.08, or 70.46 RCW.

((~~(9)~~)) (8) "Local health officer" means the legally qualified physician appointed as a health officer pursuant to chapter 70.05, 70.08, or 70.46 RCW.

((~~(10)~~)) (9) "Mobile food unit" means a readily movable food establishment.

((~~(11)~~)) (10) "Regulatory authority" means the local, state, or federal enforcement body or authorized representative having jurisdiction over the food establishment. The local board of health, acting through the local health officer, is the regulatory authority for the activity of a food establishment, except as otherwise provided by law.

((~~(12)~~)) (11) "Secretary" means the secretary of health, or the secretary's designee.

((~~(13)~~)) (12) "Servicing area" means an operating base location to which a mobile food unit or transportation vehicle returns regularly for such things as vehicle and equipment cleaning, discharging liquid or solid wastes, refilling water tanks and ice bins, and boarding food.

((~~(14)~~)) (13) "Social determinants of health" means those elements of social structure most closely shown to affect health and illness, including at a minimum, early learning, education, socioeconomic standing, safe housing, gender, incidence of violence,

convenient and affordable access to safe opportunities for physical activity, healthy diet, and appropriate health care services.

((~~(15)~~)) (14) "State board" means the state board of health created under this chapter.

Sec. 2. RCW 43.20.270 and 2006 c 239 s 1 are each amended to read as follows:

The legislature finds that women and people of color experience significant disparities from men and the general population in education, employment, healthful living conditions, access to health care, and other social determinants of health. The legislature finds that these circumstances coupled with lower, slower, and less culturally appropriate and gender appropriate access to needed medical care result in higher rates of morbidity and mortality for women and persons of color than observed in the general population. Health disparities are defined by the national institute[s] of health as the differences in incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States.

It is the intent of the Washington state legislature to create the healthiest state in the nation by striving to eliminate health disparities in people of color and between men and women. In meeting the intent of ((~~chapter 239, Laws of 2006~~)) this chapter, the legislature creates the governor's ((~~interagency coordinating council on health disparities~~)) council for health justice and equity. This council shall create an action plan and statewide policy to include health impact reviews that measure and address other social determinants of health that lead to disparities as well as the contributing factors of health that can have broad impacts on improving status, health literacy, physical activity, and nutrition.

Sec. 3. RCW 43.20.275 and 2018 c 58 s 19 are each amended to read as follows:

(1) In collaboration with staff whom the office of financial management may assign, and within funds made expressly available to the state board for these purposes, the state board shall ((~~assist the governor by convening and providing~~)) convene and provide assistance to the council.

(2) The council shall consist of 22 core members which shall include ((~~one representative from each of~~)) the following ((~~groups: Each of the commissions,~~)) representatives:

(a) One from the commission on African American affairs;

(b) One from the commission on Asian Pacific American affairs;

(c) One from the commission on Hispanic affairs;

(d) One from the governor's office of Indian affairs;

(e) One from the LGBTQ commission;

(f) One from the state board((~~,~~));

(g) One from the department((~~,~~));

(h) One from the department of social and health services((~~,~~));

(i) One from the department of commerce((~~,~~));

(j) One from the health care authority((~~,~~));

(k) One from the department of agriculture((~~,~~));

(l) One from the department of ecology((~~,~~));

(m) One from the office of the superintendent of public instruction((~~,~~));

(n) One from the department of children, youth, and families((~~,~~));

(o) One from the workforce training and education coordinating board((~~,~~)); and ((~~two~~))

(p) Seven members of the public ((~~who will represent the interests of health care consumers. The council is a class one group under RCW 43.03.220. The two public members shall be paid per diem and travel expenses in accordance with RCW 43.03.050 and 43.03.060. The council shall reflect diversity in race, ethnicity, and gender. The governor or the governor's designee shall chair the council.~~

~~(2) The council shall promote and facilitate communication, coordination, and collaboration among relevant state agencies and communities of color, and the private sector and public sector, to address health disparities. The council shall conduct public hearings, inquiries, studies, or other forms of information gathering to understand how the actions of state government ameliorate or contribute to health disparities. All state agencies must cooperate with the council's efforts.~~

~~(3) The council with assistance from the state board, shall assess through public hearings, review of existing data, and other means, and recommend initiatives for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies.~~

~~(4) In order to assist with its work, the council shall establish advisory committees to assist in plan development for specific issues and shall include members of other state agencies and local communities.~~

~~(5) The advisory committee shall reflect diversity in race, ethnicity, and gender~~)), including at least two youth representatives, who have direct lived experience with health inequities and will bring the voices of communities who have been systematically excluded from the power, opportunities, access, and resources needed to attain health and well-being.

(3) The council shall establish its decision making and voting procedures within council bylaws.

(4) Councilmembers must be persons who are committed to and well-informed regarding principles of health justice and equity and who, to the greatest extent practicable, reflect diversity in race, ethnicity, age, disability status, sexual orientation, gender, gender identity, military or military family status, urban and rural areas, and regions of the state.

(a) To promote agency commitment and coordination, each state agency on the council shall identify an executive team level staff person or designee to participate on behalf of the agency.

(b) Nongovernmental members of the council shall be appointed by the governor with guidance from the office of equity.

(c) The youth representatives must be 26 years of age or younger at the time of appointment.

(d) The governor shall appoint cochairs who have expertise or experience with health justice and equity. At least one cochair must be selected from among councilmembers representing the commissions identified in subsection (2)(a) through (e) of this section or members of the public identified in subsection (2)(p) of this section. The governor shall consider cochair nominations or recommendations from the council.

(5) When representing the council, councilmembers may communicate policy recommendations and positions on behalf of the council instead of their respective agency or organization.

(6) The council is a class one group under RCW 43.03.220. Nongovernmental members of the council shall be compensated and reimbursed in accordance with RCW 43.03.050, 43.03.060, and 43.03.220.

Sec. 4. RCW 43.20.280 and 2006 c 239 s 4 are each amended to read as follows:

(1) The council shall ((~~consider in its deliberations and by 2012, create an action plan for eliminating health disparities. The action plan must address, but is not limited to, the following diseases, conditions, and health indicators: Diabetes, asthma, infant mortality, HIV/AIDS, heart disease, strokes, breast cancer, cervical cancer, prostate cancer, chronic kidney disease, sudden infant death syndrome (SIDS), mental health, women's health issues, smoking cessation, oral disease, and immunization rates of children and senior citizens. The council shall prioritize the diseases, conditions, and health indicators according to prevalence and severity of the health disparity. The council shall address these priorities on an incremental basis by adding no more than five of the diseases, conditions, and health indicators to each update or revised version of the action plan. The action plan shall be updated biannually. The council shall meet as often as necessary but not less than two times per calendar year. The council shall report its progress with the action plan to the governor and the legislature no later than January 15, 2008. A second report shall be presented no later than January 15, 2010, and a third report from the council shall be presented to the governor and the legislature no later than January 15, 2012. Thereafter, the governor and legislature shall require progress updates from the council every four years in odd-numbered years. The action plan shall recognize the need for flexibility~~)) work with governmental and nongovernmental partners to create a statewide vision and universal goals for health and well-being as well as policy recommendations to move Washington toward achieving its vision and goals.

(a) The vision, goals, and policy recommendations shall:

(i) Provide an actionable framework to support communities, state agencies, the governor, and the legislature in advancing health justice and equity in Washington state;

(ii) Recognize racism as a public health crisis;

(iii) Recognize how climate change affects us all and exacerbates inequities;

(iv) Incorporate the diversity of communities across the state and recognize the intersecting forms of oppression people may experience as barriers to attaining optimal health and reaching their full potential;

(v) Guide state agencies as they continue to fulfill requirements pursuant to chapters 70A.02 and 43.06D RCW; and

(vi) Work toward resolving the negative structural and social determinants of health and promoting the positive determinants.

(b) In the development of the vision, goals, and policy recommendations, the council shall engage communities and may use participatory methods that promote community-led planning and design, so that communities who are disproportionately impacted by inequities have meaningful opportunity and power to shape narratives, priorities, and policy recommendations.

(2) The council shall promote and facilitate communication, information sharing, coordination, and collaboration among relevant state agencies, organizations that have been established for and by the people most impacted by an issue such as racism and health inequities, communities of color and other marginalized communities, and the private and public sectors to support health justice and equity, well-being, truth and reconciliation, and healing.

(3) The council, with assistance from state agencies and other partners, shall conduct public hearings, research, inquiries, studies, or other forms of information gathering to:

(a) Understand how the actions of state government ameliorate or contribute to health inequities; and

(b) Recommend initiatives for improving the availability of culturally and linguistically appropriate information and services within public and private health-related agencies.

(4) The council shall collaborate with the environmental justice council, the state poverty reduction work group, the state office of equity, and other state agencies, boards, committees, and commissions to propel state government toward actions that are coordinated and rooted in antiracism, access, belonging, and justice so that these efforts benefit all Washingtonians.

(5) The council shall submit an initial report to the governor and relevant committees of the legislature by October 31, 2026, with the statewide vision and universal goals for health and well-being detailed in subsection (1) of this section. Beginning October 31, 2028, and every two years thereafter until 2038, the council shall submit an update to the governor and relevant committees of the legislature with policy recommendations, the status of policy adoption and implementation among relevant state agencies, the governor, and the legislature, as well as any revisions to the

statewide vision and universal goals for health and well-being. The council shall make its reports publicly available on its website to provide convenient access to all state agencies.

(6) Within available resources, all relevant state agencies shall collaborate and be responsive to the council's requests.

(7) The council may:

(a) Use topics and findings from health impact reviews, as authorized by RCW 43.20.285, to inform the council's priorities, strategies, and recommendations;

(b) Use disaggregated data to inform its work;

(c) Develop policy positions; and

(d) Form advisory committees or implement participatory models, such as collaboratives or community assemblies, to support the council in gathering information and developing policy priorities, recommendations, and positions. These groups may include members of the community and state agencies.

Sec. 5. RCW 41.05.840 and 2021 c 309 s 2 are each amended to read as follows:

(1) The universal health care commission is established to create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the necessary federal authority has become available. The authority must begin any necessary federal application process within 60 days of its availability.

(2) The commission includes the following voting members:

(a) One member from each of the two largest caucuses of the house of representatives, appointed by the speaker of the house of representatives;

(b) One member from each of the two largest caucuses of the senate, appointed by the president of the senate;

(c) The secretary of the department of health, or the secretary's designee;

(d) The director of the health care authority, or the director's designee;

(e) The chief executive officer of the Washington health benefit exchange, or the chief executive officer's designee;

(f) The insurance commissioner, or the commissioner's designee;

(g) The director of the office of equity, or the director's designee; and

(h) Six members appointed by the governor, using an equity lens, with knowledge and experience regarding health care coverage, access, and financing, or other relevant expertise, including at least one consumer representative and at least one invitation to an individual representing tribal governments with knowledge of the Indian health care delivery in the state.

(3)(a) The governor must appoint the chair of the commission from any of the members identified in subsection (2) of this section for a term of no more than three years. A majority of the voting members of the commission shall constitute a quorum for any votes of the commission.

(b) The commission's meetings shall be open to the public pursuant to chapter 42.30 RCW. The authority must publish on its website the dates and locations of commission meetings, agendas of prior and upcoming commission meetings, and meeting materials for prior and upcoming commission meetings.

(4) The health care authority shall staff the commission.

(5) Members of the commission shall serve without compensation but must be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

(6) The commission may establish advisory committees that include members of the public with knowledge and experience in health care, in order to support stakeholder engagement and an analytical process by which key design options are developed. A member of an advisory committee need not be a member of the commission.

(7) By November 1, 2022, the commission shall submit a baseline report to the legislature and the governor, and post it on the authority's website. The report must include:

(a) A complete synthesis of analyses done on Washington's existing health care finance and delivery system, including cost, quality, workforce, and provider consolidation trends and how they impact the state's ability to provide all Washingtonians with timely access to high quality, affordable health care;

(b) A strategy for developing implementable changes to the state's health care financing and delivery system to increase access to health care services and health coverage, reduce health care costs, reduce health disparities, improve quality, and prepare for the transition to a unified health care financing system by actively

examining data and reports from sources that are monitoring the health care system. Such sources shall include data or reports from the health care cost transparency board under RCW 70.390.070, the public health advisory board, the governor's ((~~interagency coordinating~~)) council ((~~on~~)) for health ((~~disparities~~)) justice and equity under RCW 43.20.275, the all-payer health care claims database established under chapter 43.371 RCW, prescription drug price data, performance measure data under chapter 70.320 RCW, and other health care cost containment programs;

(c) An inventory of the key design elements of a universal health care system including:

(i) A unified financing system including, but not limited to, a single-payer financing system;

(ii) Eligibility and enrollment processes and requirements;

(iii) Covered benefits and services;

(iv) Provider participation;

(v) Effective and efficient provider payments, including consideration of global budgets and health plan payments;

(vi) Cost containment and savings strategies that are designed to assure that total health care expenditures do not exceed the health care cost growth benchmark established under chapter 70.390 RCW;

(vii) Quality improvement strategies;

(viii) Participant cost sharing, if appropriate;

(ix) Quality monitoring and disparities reduction;

(x) Initiatives for improving culturally appropriate health services within public and private health-related agencies;

(xi) Strategies to reduce health disparities including, but not limited to, mitigating structural racism and other determinants of health as set forth by the office of equity;

(xii) Information technology systems and financial management systems;

(xiii) Data sharing and transparency; and

(xiv) Governance and administration structure, including integration of federal funding sources;

(d) An assessment of the state's current level of preparedness to meet the elements of (c) of this subsection and steps Washington should take to prepare for a just transition to a unified health care financing system, including a single-payer financing system. Recommendations must include, but are not limited to, administrative changes, reorganization of state programs, retraining programs for

displaced workers, federal waivers, and statutory and constitutional changes;

(e) Recommendations for implementing reimbursement rates for health care providers serving medical assistance clients who are enrolled in programs under chapter 74.09 RCW at a rate that is no less than 80 percent of the rate paid by medicare for similar services;

(f) Recommendations for coverage expansions to be implemented prior to and consistent with a universal health care system, including potential funding sources; and

(g) Recommendations for the creation of a finance committee to develop a financially feasible model to implement universal health care coverage using state and federal funds.

(8) Following the submission of the baseline report on November 1, 2022, the commission must structure its work to continue to further identify opportunities to implement reforms consistent with subsection (7)(b) of this section and to implement structural changes to prepare the state for a transition to a unified health care financing system. The commission must submit annual reports to the governor and the legislature each November 1st, beginning in 2023. The reports must detail the work of the commission, the opportunities identified to advance the goals under subsection (7) of this section, which, if any, of the opportunities a state agency is implementing, which, if any, opportunities should be pursued with legislative policy or fiscal authority, and which opportunities have been identified as beneficial, but lack federal authority to implement.

(9) Subject to sufficient existing agency authority, state agencies may implement specific elements of any report issued under this section. This section shall not be construed to authorize the commission to implement a universal health care system through a unified financing system until there is further action by the legislature and the governor.

(10) The commission must hold its first meeting within 90 days of July 25, 2021.

Sec. 6. RCW 70.41.470 and 2021 c 162 s 5 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 and submit it to the department 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 and submit to the department an assessment once every three years. The department must post the information submitted to it pursuant to this subsection on its website.

(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 and submit to the department 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) Beginning July 1, 2022, 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 annually submit to the department an addendum which details information about activities identified as community health improvement services with a cost of $5,000 or more. The addendum must include the type of activity, the method in which the activity was delivered, how the activity relates to 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. If a community health improvement service is administered by an entity other than the hospital, the other entity must be identified in the addendum.

(ii) Beginning July 1, 2022, 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 annually submit to the department an addendum which details information about the 10 highest cost activities identified as community health improvement services. The addendum must include the

type of activity, the method in which the activity was delivered, how the activity relates to 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. If a community health improvement service is administered by an entity other than the hospital, the other entity must be identified in the addendum.

(iii) The department shall require the reporting of demographic information about participant race, ethnicity, any disability, gender identity, preferred language, and zip code of primary residency. The department, in consultation with interested entities, may revise the required demographic information according to an established six-year review cycle about participant race, ethnicity, disabilities, gender identity, preferred language, and zip code of primary residence that must be reported under (b)(i) and (ii) of this subsection (2). At a minimum, the department's consultation process shall include community organizations that provide community health improvement services, communities impacted by health inequities, health care workers, hospitals, and the governor's ((~~interagency coordinating~~)) council ((~~on~~)) for health ((~~disparities~~)) justice and equity. The department shall establish a six-year cycle for the review of the information requested under this subsection (2)(b)(iii).

(iv) The department shall provide guidance on participant data collection and the reporting requirements under this subsection (2)(b). The guidance shall include a standard form for the reporting of information under this subsection (2)(b). The standard form must allow for the reporting of community health improvement services that are repeated within a reporting period to be combined within the addendum as a single project with the number of instances of the services listed. The department must develop the guidelines in consultation with interested entities, including an association representing hospitals in Washington, labor unions representing workers who work in hospital settings, and community health board associations. The department must post the information submitted to it pursuant to this subsection (2)(b) on its website.

(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. 7.** RCW 44.28.810 (Review of governor's interagency coordinating council on health disparities—Report to the legislature) and 2006 c 239 s 7 are each repealed.

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