House of Representatives

General Assembly

File No. 231

January Session, 2021

Substitute House Bill No. 6550

House of Representatives, March 31, 2021

The Committee on Public Health reported through REP. STEINBERG of the 136th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING THE OFFICE OF HEALTH STRATEGY'S RECOMMENDATIONS REGARDING VARIOUS REVISIONS TO COMMUNITY BENEFITS PROGRAMS ADMINISTERED BY HOSPITALS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-127k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Community benefits program" means any **[**voluntary**]** program to promote preventive care, to reduce racial ethnic, linguistic and cultural disparities in health and to improve the health status for **[**working families and**]** all populations **[**at risk in the communities**]** within the geographic service areas of **[**a managed care organization or**]** a hospital in accordance with guidelines established pursuant to subsection (c) of this section;

[(2) "Managed care organization" has the same meaning as provided

in section 38a-478;**]**

(2) "Community building" means activity that protects or improves a community's health or safety and is eligible to be reported on the Internal Revenue Service form 990;

(3) "Community health needs assessment" means a written assessment, as described in 26 CFR 1.501(r)-(3) conducted by a hospital that defines the community it serves, assesses the health needs of such community, and solicits and takes into account persons that represent the broad interests of the community;

[(3)**]** (4) "Hospital" **[**has the same meaning as provided in section 19a-490.**]** means a nonprofit entity licensed as a hospital pursuant to chapter 368v that is required to annually file Internal Revenue Service form 990; and

(5) "Implementation strategy" means a written plan required by 26 CFR 1.501(r)-(3) that addresses community health needs identified through a community health needs assessment that (A) describes the actions a hospital intends to take to address the health need and impact of these actions, (B) identifies resources that the hospital plans to commit to address such need, and (C) describes the planned collaboration between the hospital and other facilities and organizations to address such health need.

(b) On or before January 1, **[**2005**]** 2022, and **[**biennially**]** annually thereafter, **[**each managed care organization and**]** each hospital shall submit to the **[**Healthcare Advocate, or the Healthcare Advocate's**]** Health Systems Planning Unit of the Office of Health Strategy, or to a designee selected by the executive director of the Office of Health Strategy, a report on **[**whether the managed care organization or hospital has in place a**]** such hospital's community benefits program. **[**If a managed care organization or hospital elects to develop a community benefits program, the**]** The report required by this subsection shall comply with the reporting requirements of subsection (d) of this section.

(c) [A managed care organization or] Each hospital [may] shall develop community benefit guidelines intended to promote preventive care, reduce racial, ethnic, linguistic and cultural disparities in health and [to] improve the health status for [working families and] all populations [at risk] within the geographic service areas of such hospital, whether or not those individuals are [enrollees of the managed care plan or] patients of the hospital. The guidelines shall focus on the following principles:

(1) Adoption and publication of a community benefits policy statement setting forth [the organization's or] such hospital's commitment to a formal community benefits program;

(2) The responsibility for overseeing the development and implementation of the community benefits program, the resources to be allocated and the administrative mechanisms for the regular evaluation of the program;

(3) Seeking assistance and meaningful participation from the communities within [the organization's or] such hospital's geographic service areas in developing and implementing the community benefits program and a plan for meaningful community benefit and community building investments, and in defining the targeted populations and the specific health care needs [it] such hospital should address. In doing so, the governing body or management of [the organization or] such hospital shall give priority to (A) the public health needs outlined in the most recent version of the state health plan prepared by the Department of Public Health pursuant to section 19a-7, and (B) such hospital's triennial community health needs assessment and implementation strategy; and

(4) Developing its [program] implementation strategy based upon an assessment of (A) the health care needs and resources of the targeted populations, particularly a broad spectrum of age, racial and ethnic groups, low and middle-income populations, and medically underserved populations, and (B) barriers to accessing health care, including, but not limited to, cultural, linguistic and physical barriers to

accessible health care, lack of information on available sources of health care coverage and services, and the benefits of preventive health care. [The program shall consider the health care needs of a broad spectrum of age groups and health conditions] Each hospital shall solicit commentary on its implementation strategy from the communities within such hospital's geographic service area and consider revisions to such strategy based on such commentary.

(d) Each [managed care organization and each] hospital [that chooses to participate in developing a community benefits program] shall include in the [biennial] annual report required by subsection (b) of this section [the status of the program, if any, that the organization or hospital established. If the managed care organization or hospital has chosen to participate in a community benefits program, the report shall include] the following components: (1) The community benefits policy statement of [the managed care organization or] such hospital; (2) the [mechanism] process by which community input and participation is solicited and incorporated in the community benefits program; (3) identification of community health needs that were [considered] prioritized in developing [and implementing] the [community benefits program] implementation strategy; (4) a narrative description of the community benefits, community services, and preventive health education provided or proposed, which may include measurements related to the number of people served and health status outcomes; (5) outcome measures [taken] used to evaluate the [results] impact of the community benefits program and proposed revisions to the program; (6) to the extent feasible, a community benefits budget and a good faith effort to measure expenditures and administrative costs associated with the community benefits program, including both cash and in-kind commitments; [and] (7) a summary of the extent to which [the managed care organization or] such hospital has developed and met the guidelines listed in subsection (c) of this section; [. Each managed care organization and each hospital] (8) for the prior taxable year, the demographics of the population within the geographic service area of such hospital; (9) the cost and description of each investment included in the "Financial Assistance and Certain Other Community Benefits at

Cost", and the "Community Building Activities", sections of such hospital's Internal Revenue Service form 990; (10) an explanation of how each investment described in subdivision (9) of this subsection addresses the needs identified in the hospital's triennial community health needs assessment and implementation strategy; and (11) a description of available evidence that shows how each investment described in subdivision (9) of this subsection improves community health outcomes. The Office of Health Strategy shall **[**make a copy of**]** post the annual report **[**available, upon request, to any member of the public**]** required by subsection (b) of this section on its Internet web site.

(e) (1) Not later than January 1, 2023, and biennially thereafter, the Office of Health Strategy, or a designee selected by the executive director of the Office of Health Strategy, shall establish a minimum community benefit and community building spending threshold that hospitals shall meet or exceed during the biennium. Such threshold shall be based on objective data and criteria, including, but not limited to, the following: (A) Historical and current expenditures on community benefits by the hospital; (B) the community needs identified in the hospital's triennial community health needs assessment; (C) the overall financial position of the hospital based on audited financial statements and other objective data; and (D) taxes and payments in lieu of taxes paid by the hospital.

(2) The Office of Health Strategy shall consult with hospital representatives, solicit and consider comments from the public and consult with one or more individuals with expertise in health care economics when establishing a community benefit and community building spending threshold.

(3) The community benefit and community building spending threshold established pursuant to this subsection shall include the minimum proportion of community benefit spending that shall be directed to addressing health disparities and social determinants of health identified in the community health needs assessment during the next biennium.

[(e)**]** (f) The **[**Healthcare Advocate, or the Healthcare Advocate's**]** Office of Health Strategy, or a designee selected by the executive director of the Office of Health Strategy, shall, within available appropriations, develop a summary and analysis of the community benefits program reports submitted by **[**managed care organizations and**]** hospitals under this section and shall review such reports for adherence to the guidelines set forth in subsection (c) of this section. Not later than October 1, **[**2005**]** 2022, and **[**biennially**]** annually thereafter, the **[**Healthcare Advocate, or the Healthcare Advocate's**]** Office of Health Strategy, or a designee selected by the executive director of the Office of Health Strategy, shall **[**make such summary and analysis available to the public upon request**]** post such summary and analysis on its Internet web site.

[(f)**]** (g) The **[**Healthcare Advocate**]** executive director of the Office of Health Strategy, or the executive director's designee, may, after notice and opportunity for a hearing, in accordance with chapter 54, impose a civil penalty on any **[**managed care organization or**]** hospital that fails to submit the report required pursuant to this section by the date specified in subsection (b) of this section. Such penalty shall be not more than fifty dollars a day for each day after the required submittal date that such report is not submitted.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-127k

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill, which requires that the Office of Health Strategy (OHS) set thresholds for certain hospital community benefits programs' spending, is not anticipated to result in a fiscal impact to the agency as it has the necessary expertise to fulfill this task. The shifting of the responsibility for the gathering and publishing of reports on these programs from the Office of the Healthcare Advocate (OHA) to OHS codifies current practice. OHS has already assumed these responsibilities pursuant to a Memorandum of Agreement with OHA. There is also no fiscal impact to the University of Connecticut Health Center anticipated because, as a state entity and a nonprofit hospital, the bill's requirements do not apply to it.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB 6550

AN ACT CONCERNING THE OFFICE OF HEALTH STRATEGY'S RECOMMENDATIONS REGARDING VARIOUS REVISIONS TO COMMUNITY BENEFITS PROGRAMS ADMINISTERED BY HOSPITALS.

SUMMARY

This bill makes various changes to the law on hospital community benefit programs. Among other things, it:

1. conforms to existing practice by shifting oversight of this law from the Office of Healthcare Advocate (OHA) to the Office of Health Strategy (OHS);

2. aligns with federal tax law by excluding for-profit hospitals from state law on community benefit programs;

3. requires OHS, by January 1, 2023, and every two years after that, to establish a minimum community benefit and community building spending threshold for each nonprofit hospital;

4. requires, rather than allows, nonprofit hospitals to develop community benefit guidelines and changes their necessary components (e.g. specifically requiring that they be intended to reduce racial, ethnic, linguistic, and cultural disparities in health);

5. requires nonprofit hospitals' annual reports on community benefits to describe certain investments they made and explain how those investments addressed the needs identified in the hospital's triennial community health needs assessment (which is required by federal law); and

6. removes managed care organizations (MCOs) from this law.

The bill also makes several minor, technical, and conforming changes.

EFFECTIVE DATE: Upon passage

HOSPITAL COMMUNITY BENEFIT PROGRAMS

Scope

Under current law, a "community benefits program" is a voluntary program to promote preventive care and improve the health status of working families and at-risk populations in the communities within a hospital's or MCO's geographic service area.

The bill makes these programs mandatory for nonprofit hospitals, in line with federal law (see BACKGROUND). It removes other hospitals and MCOs from this law. It also adds to the programs' objectives the (1) reduction of racial, ethnic, linguistic, and cultural disparities in health and (2) improvement in the health of all populations in the service area, not just working families and at-risk populations.

Reporting

Under current law, each hospital and MCO must submit a biennial report on whether it has a community benefits program. If the hospital or MCO has such a program, the report must describe its status and address various components set forth in law.

The bill instead requires nonprofit hospitals to report annually on their community benefit programs. They must report to OHS's Health Systems Planning Unit or a designee selected by OHS's executive director, rather than to the Healthcare Advocate or his designee as under current law. (In practice, oversight of the community benefits law has already shifted from OHA to OHS under a memorandum of agreement.)

The bill makes related conforming changes to codify the transfer of authority over this law to OHS. This includes authorizing OHS, rather than OHA, to impose civil penalties of up to $50 per day on hospitals that fail to report as required. As under current law, these penalties may

only be imposed after notice and an opportunity for a hearing.

Report Components. The bill makes several changes to these reports' required components, including several minor and conforming changes. For example, the bill specifies that the reports must identify community health needs that were prioritized, not just considered, in the process.

The bill also adds the following to the list of required report components:

1. the demographics of the hospital's geographic service area for the prior taxable year;

2. the cost and description of each investment included in the "Financial Assistance and Certain Other Community Benefits at Cost" and "Community Building Activities" sections of the hospital's IRS form 990 (see BACKGROUND);

3. an explanation of how each such investment addresses the identified needs in the hospital's triennial community health needs assessment and implementation strategy (see below); and

4. a description of available evidence showing how each such investment improves community health outcomes.

Under the bill, a "community health needs assessment" is a hospital's written assessment, as described in federal regulations, that (1) defines the community it serves, (2) assesses that community's health needs, and (3) solicits and considers people that represent the community's broad interests. An "implementation strategy" is a written plan required by the federal regulations that addresses community health needs identified through the assessment and that (1) describes the hospital's intended actions to address the health need and impact of these actions, (2) identifies resources that the hospital plans to commit to address the need, and (3) describes the planned collaboration between the hospital and other facilities and organizations to address the need (see BACKGROUND).

Required Posting and Analysis. Current law requires hospitals and MCOs to make copies of their community benefits program reports available to the public upon request. The bill instead requires OHS to post nonprofit hospitals' reports on its website.

The bill transfers from OHA to OHS the duty to summarize and analyze the submitted reports, including for adherence to the community benefit guidelines (see below), and within available appropriations. It requires OHS, by October 1, 2022, and annually after that, to post the summary and analysis online. Under current law, OHA must biennially make the summary and analysis available to the public.

Community Benefit Guidelines (§ 1(c))

Current law allows hospitals and MCOs to develop community benefit guidelines and requires any such guidelines to focus on certain principles. The bill instead requires nonprofit hospitals to develop these guidelines. It also modifies some of the principles that must inform the guidelines.

Under existing law, the guidelines must focus on seeking assistance and meaningful participation from the communities in the hospital's service area in (1) developing and implementing its community benefit program and (2) defining the targeted population and specific health needs to be addressed. The hospital must give priority to the needs outlined in the Department of Public Health's most recent state health plan.

The bill extends this community participation focus to include the hospital's developing and implementing a plan for meaningful community benefit and community building investments (see below). It also requires the hospital to give priority to its triennial community health needs assessment and implementation strategy.

The bill requires each nonprofit hospital to solicit commentary on its implementation strategy from the communities in its geographic service area, and consider revisions based on it.

The bill makes other revisions to the required guidelines conforming to the bill's other changes, such as specifically requiring a focus on the health care needs and resources of a broad spectrum of racial and ethnic groups.

MINIMUM COMMUNITY BENEFIT SPENDING THRESHOLD

The bill requires the OHS executive director or her designee, by January 1, 2023, and biennially after that, to establish a minimum community benefit and community building spending threshold that nonprofit hospitals must meet or exceed during the biennium. Under the bill, "community building" is activity that protects or improves a community's health or safety and may be reported on IRS Form 990.

The bill requires the threshold to be based on objective data and criteria, including:

1. the hospital's historical and current expenditures on community benefits;

2. the community needs identified in the hospital's triennial community health needs assessment;

3. the hospital's overall financial position based on audited financial statements and other objective data; and

4. the hospital's taxes paid and payments in lieu of taxes.

Under the bill, when establishing a spending threshold, OHS must (1) consult with hospital representatives and at least one expert in health care economics and (2) solicit and consider public comments.

The spending threshold must include the minimum proportion of community benefit spending to be directed to addressing health disparities and social health determinants identified in the community health needs assessment during the next biennium.

BACKGROUND

Nonprofit Hospitals and Federal Requirements for Community Health Needs Assessments

To maintain tax-exempt status under federal law, a nonprofit hospital must, among other things, (1) conduct a community health needs assessment at least once every three years and (2) adopt an implementation strategy to meet the needs identified in the assessment. Federal regulations set forth various steps that hospitals must take in completing these requirements (26 C.F.R. § 1.501(r)-3).

In addition, a nonprofit hospital must include certain related information in its IRS Form 990 filing (the tax return for organizations exempt from the income tax). Along with the standard form, there is a specific attachment (Schedule H) that these hospitals must complete which addresses, among other things, the hospital's community benefits, community building activities, and financial assistance policy.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 22 Nay 11 (03/12/2021)