OLR Bill Analysis

sSB 476

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. Principally, it:

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

2. requires hospitals to submit, on a specified schedule, their community health needs assessments, related implementation strategies, and community benefit status reports, and specifies several matters that hospitals must include in this reporting;

3. requires for-profit acute care hospitals to submit community benefit program reporting consistent with the bill's reporting schedules and reasonably similar to what they would report to the IRS, where applicable;

4. requires OHS to make data from the state's all-payer claims database available to hospitals for the purposes of fulfilling these requirements; and

5. requires OHS to annually summarize and analyze community benefit program reporting data and solicit stakeholder input through a public comment period.

The bill also removes managed care organizations (MCOs) from this law and makes several minor, technical, and conforming changes.

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 various steps that hospitals must take in completing these requirements (26 C.F.R. § 1.501(r)-3).

EFFECTIVE DATE: January 1, 2023

COMMUNITY BENEFIT PROGRAM REPORTING

Program Applicability (§ 1(a), (i))

Current law's community benefit provisions apply to hospitals and MCOs. The bill removes MCOs from this law and instead applies the law to (1) nonprofit hospitals that are required to annually file IRS form 990 (see BACKGROUND) and (2) for-profit acute care general hospitals.

The bill requires these for-profit hospitals to submit community benefit program reporting consistent with the bill's requirements (see below), and reasonably similar to what the hospital would include in its federal tax filing, where applicable.

Program 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 adds to the program purposes (1) protecting health and safety, (2) improving health equity (see below), (3) reducing health disparities, and (4) reducing the cost and burden of poor health. It broadens the scope of these programs to address all populations within the hospital's geographic service area, not just working families and at-risk populations as under current law. It removes references to MCOs.

Under the bill, "health equity" means that everyone has a fair and just opportunity to be as healthy as possible. This includes removing obstacles to health, such as poverty, racism, and their adverse consequences, including a lack of equitable opportunities, access to

good jobs with fair pay, quality education and housing, safe environments, and health care.

"Health disparities" are health differences that are closely linked with social or economic disadvantages that adversely affect groups who have experienced greater systemic social or economic obstacles to health or a safe environment based on race or ethnicity; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Community Benefit Program Reporting

Under current law, each hospital and MCO must submit a biennial report on whether it has a community benefits program. If the entity has that program, the report must describe its status and discuss certain parts of it. Current law also allows hospitals or MCOs to develop community benefit guidelines focused on specified principles.

The bill replaces these provisions, instead requiring hospitals, starting January 1, 2023, to submit community benefit program reporting to OHS or a designee selected by the OHS executive director. This reporting includes three components: the hospital's community health needs assessment (CHNA), implementation strategy, and annual status report on its community benefit program.

The bill outlines the required matters to be included with these submissions (see below). In certain respects, the required topics are similar to topics under current law's provisions for community benefit programs and related guidelines. For example, similar to the current guidelines, the bill requires a hospital's community benefit reporting to address meaningful participation from the community, as described below.

Under the bill, a hospital generally must submit these documents on the following schedule:

1. CHNA: within 30 days after the hospital makes it available to the public as required by federal regulations;

2. implementation strategy: within 30 days after the hospital adopts it as required by federal regulations; and

3. status report: annually, starting by October 1, 2023.

In each case, the OHS executive director, or her designee, may grant an extension.

Current law allows OHA, after notice and the opportunity for a hearing, to assess civil penalties (up to $50 a day) on hospitals or MCOs that fail to submit community benefit reports as required. The bill repeals these provisions and does not transfer similar authority to OHS.

Community Health Needs Assessment (§ 1(c))

The bill requires a hospital's CHNA submission to include the following information, consistent with requirements in federal regulations and as included in the hospital's federal tax filing:

1. a definition of the community the hospital serves and a description of how the hospital determined that community;

2. a description of how the hospital conducted the CHNA;

3. a description of how the hospital solicited and took into account input from people representing the community's broad interests;

4. a prioritized description of the community's significant health needs identified through the CHNA, and a description of the process and criteria used in identifying and prioritizing certain needs as significant;

5. a description of the resources potentially available to address these significant health needs; and

6. an evaluation of the impact of any of the hospital's actions to address the significant health needs identified in its prior CHNA.

The bill also requires hospitals, as part of the CHNA, to submit the following information:

1. the names of the people responsible for developing the CHNA;

2. the population demographics for the hospital's geographic service area and, to the extent feasible, a detailed description of the health disparities, health risks, insurance status, service utilization patterns, and health care costs in this area;

3. a description of the health status and health disparities affecting this service area's population, including those affecting a representative range of age, racial, and ethnic groups; incomes; and medically underserved populations;

4. a description of meaningful participation for community benefit partners (see below) and diverse community members in assessing community health needs, priorities, and target populations;

5. a description of the barriers to achieving or maintaining health and accessing health care, including social, economic, and environmental barriers; lack of access to, or availability of, sources of health care coverage and services; and a lack of access to, and availability of, prevention and health promotion services and support;

6. recommendations on what role the state and other community benefit partners could play in removing these barriers and enabling effective solutions; and

7. any more information, data, or disclosures that the hospital voluntarily includes that may be relevant to its community benefit program.

Under the bill, "community benefit partners" are entities that, in partnership with hospitals, play an essential role in the policy, system, program, and financing solutions needed to achieve community benefit program goals. These partners include federal, state, and municipal government entities and private sector entities, such as faith-based organizations; businesses; educational and academic organizations;

health care organizations or health departments; philanthropic organizations; housing justice or planning and land use organizations; public safety or transportation organizations; and tribal organizations.

"Meaningful participation" means that (1) residents of a hospital's community, including those experiencing the greatest health disparities, have an appropriate opportunity to participate in the hospital's planning and decisions; (2) this participation influences a hospital's planning; and (3) the hospital gives participants information summarizing how the hospital did or did not use their input.

Implementation Strategy (§ 1(d))

The bill requires the hospital's implementation strategy submission, consistent with requirements in federal regulations and as included in the hospital's federal tax filing, to address each significant need identified through the CHNA.

For those needs the hospital intends to address, the submission must (1) describe how the hospital plans to do so, including the hospital's intended actions and their anticipated impact; (2) list the resources the hospital plans to commit to address the need; and (3) describe any planned collaboration with other entities in this process. The submission must also explain why the hospital does not plan to address any identified significant need.

Under the bill, a hospital's implementation strategy submission must also include the following information:

1. the names of the people responsible for developing the strategy;

2. a description of meaningful participation for community benefit partners and diverse community members;

3. a description of the community health needs and health disparities that were prioritized in developing the strategy, considering the Department of Public Health's (DPH) most recent state health plan;

4. if available, evidence (with references) showing how the strategy is intended to address the corresponding need or disparity;

5. planned methods and measures for the ongoing evaluation of the proposed actions' progress or impact;

6. a description of how the hospital solicited community commentary on the strategy and revisions based on that commentary; and

7. any other information that the hospital voluntarily includes as may be relevant, including data, disclosures, expected or planned resource allocation, investments, or commitments, including staff, financial, or in-kind commitments.

Status Report (§ 1(e))

The bill requires hospital status reports on their community benefit programs to describe the following:

1. any major updates on community health needs, priorities, and target populations;

2. progress in the hospital's actions supporting its implementation strategy;

3. any major changes to the proposed implementation strategy and associated hospital actions; and

4. financial and other resources allocated or spent to support the implementation strategy and related actions.

All-Payer Claims Database (APCD) (§ 1(f), (g))

The bill requires OHS to make data in the state's APCD available to hospitals for specified purposes (see below) related to their community benefit programs and activities. OHS must do so (1) regardless of existing state law on uses of APCD data and (2) to the full extent permitted by specified regulations under the federal Health Insurance Portability and Accountability Act (HIPAA). Generally, those regulations allow covered entities, under specified conditions, to use or

disclose a limited data set (i.e., protected health information that excludes various personal identifiers) for purposes of research, public health, or health care operations. The covered entity must enter into a data use agreement with the recipient (45 C.F.R. § 164.514(e)).

Under the bill, OHS must make APCD available to hospitals solely for the purposes of (1) preparing their CHNAs, (2) preparing and executing their implementation strategies, and (3) meeting the bill's community benefit program reporting requirements. Any OHS disclosures of non-health information must be done in a way to protect its confidentiality as may be required by state or federal law.

The bill excuses hospitals from limitations in meeting their community benefit program reporting requirements if they are not provided the APCD data as required.

Office of Health Strategy Reporting and Solicitation of Stakeholder Input (§ 1(h))

The bill (1) transfers from OHA to OHS the duty to summarize and analyze submitted community benefit program reports and (2) removes the current condition that this must occur only within available appropriations. It requires OHS to do so annually, starting by April 1, 2024, and post the summary and analysis online. Under current law, OHA must biennially make the summary and analysis available to the public.

The bill also requires OHS to annually solicit stakeholder input through a public comment period. OHS must use the reporting and stakeholder input to do the following:

1. identify more stakeholders to help address identified community health needs, including (a) federal, state, and municipal entities; (b) non-hospital private sector health care providers; and (c) private sector entities other than health care providers, including community-based organizations, insurers, and charities;

2. determine how these stakeholders could help address identified community health needs or supplement solutions or approaches

reported in implementation strategies;

3. determine whether to make recommendations to DPH in its development of the state health plan; and

4. inform OHS's statewide health care facilities and services plan.

BACKGROUND

IRS Form 990

A nonprofit hospital must include certain information related to the CHNA process 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 30 Nay 0 (03/30/2022)