

Health Care Community Benefits

A Compendium of State Laws

November 2007



This report was written with support from the W.K. Kellogg Foundation, the Surdna Foundation, the Jesse B. Cox Charitable Trust and the Public Welfare Foundation.

Community Catalyst, Inc.
30 Winter St. 10th Floor
Boston, MA 02108
617.338.6035
Fax: 617.451.5838
www.communitycatalyst.org

FORWARD

Community Catalyst has compiled this overview of Community Benefit laws as an update to a compendium originally published in September 2003. It reflects any new laws enacted or amendments made since 2003 and is meant to assist advocates in understanding the array of approaches taken on the state level. Health care is a changing environment, however, and laws and regulations are continually affected by the dominance of local issues and interests. Therefore, we welcome your input on the information provided so that we can ensure the accuracy and timeliness of this compendium. Please send your comments to: hap@communitycatalyst.org.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

For more information about Community Catalyst projects and publications, please visit www.communitycatalyst.org.

COMMUNITY BENEFITS STATES

1. CALIFORNIA.....	7
2. CONNECTICUT.....	10
3. GEORGIA.....	12
4. IDAHO.....	14
5. ILLINOIS.....	16
6. INDIANA.....	18
7. MARYLAND.....	20
8A. MASSACHUSETTS (HOSPITALS).....	22
8B. MASSACHUSETTS (HMOs).....	25
9. MINNESOTA.....	27
10. NEVADA.....	29
11. NEW HAMPSHIRE.....	31
12. NEW YORK.....	33
13. OREGON.....	35
14. PENNSYLVANIA.....	37
15. RHODE ISLAND.....	39
16. TEXAS.....	41
17. UTAH.....	43
18. WEST VIRGINIA.....	45

DEFINITIONS AND EXPLANATIONS

- CITATION:** The statute or official administrative regulation pertaining to community benefits.
- TERMINOLOGY:** The language used in the statute to refer to services generally regarded as community benefits.
- REGULATORY OVERSIGHT:** The state official or administrative agency responsible for ensuring compliance with the legislation and enforcing penalties for noncompliance, where applicable.
- INSTITUTIONS REGULATED:** The business entities to which this legislation applies. Note that some states limit applicability of their community benefits statute to nonprofit hospitals, whereas other states apply their statute to HMOs, all hospitals, or public charities.
- BINDING EFFECT:** Whether adherence to the community benefits statute is required by law. Note that in some states, compliance is voluntary.
- DEFINITIONS:** The specific, codified definitions for “community,” “community benefit,” and “community benefits plan” that may be included in a community benefits statute. Not all statutes provide definitions; they have been included as appropriate.
- PUBLIC RECORD:** The record of the community benefits plan that is accessible to the public. Where a statute explains how a copy of the public record can be obtained, that information has been included.
- PUBLIC INPUT:** Whether the statute requires that the public be involved in the creation or administration of the community benefits plan.
- EXAMPLES OF COMMUNITY BENEFITS:** Examples of what may be considered community benefits, according to the statute.
- REQUIRED FREE CARE:** Whether or not an institution is required to provide free care or charity care as a component of their community benefits plan. Note that most states have separate free care statutes. Where appropriate, those statutes have been cross-referenced.

**REQUIRED ELEMENTS
OF COMMUNITY**

BENEFITS PLAN:

The components that must be included in an entity's community benefits plan or a community benefits plan report.

REPORTING:

The manner in which an entity must report on its community benefits plan.

**COMMUNITY HEALTH
NEEDS ASSESSMENT:**

Whether the entity must attempt to gather information regarding actual community needs, and if so, how that information will be gathered.

**HOSPITAL MISSION
STATEMENT:**

Whether an entity is required to have a mission statement and if so, whether the mission statement must mention community benefits. Alternately, whether an entity must draft a specific mission statement for a community benefits program and if so, what that statement must entail.

**PENALTIES FOR
NONCOMPLIANCE:**

Whether or not the statute provides any penalties for failure to comply with the terms of the statute.

COMMUNITY BENEFITS AND FREE CARE LEGISLATION

Exactly what should be included in the term “community benefits” is interpreted differently by every state with a community benefits statute. In some states, “community benefit” is synonymous with free care. In other states, the term “community benefits” encompasses a wide variety of services, including medical education, immunization programs, and social outreach initiatives.

Therefore, to fully analyze requirements regarding provision of community health care services, it may be worthwhile to cross-reference a state’s free care legislation in the Community Catalyst Free Care Compendium.

(http://www.communitycatalyst.org/doc_store/publications/free_care_a_compendium_of_state_laws_sep03.pdf)

The following states have legislation mandating the provision of free care:

- | | |
|-------------------------|--------------------|
| 1. Alabama | 26. Missouri |
| 2. Alaska | 27. Montana |
| 3. Arizona | 28. Nebraska |
| 4. Arkansas | 29. Nevada |
| 5. California | 30. New Hampshire |
| 6. Colorado | 31. New Jersey |
| 7. Connecticut | 32. New Mexico |
| 8. Delaware | 33. New York |
| 9. District of Columbia | 34. North Carolina |
| 10. Florida | 35. North Dakota |
| 11. Georgia | 36. Ohio |
| 12. Hawaii | 37. Oklahoma |
| 13. Idaho | 38. Pennsylvania |
| 14. Illinois | 39. Rhode Island |
| 15. Indiana | 40. South Carolina |
| 16. Iowa | 41. South Dakota |
| 17. Kansas | 42. Tennessee |
| 18. Kentucky | 43. Texas |
| 19. Louisiana | 44. Utah |
| 20. Maine | 45. Vermont |
| 21. Maryland | 46. Virginia |
| 22. Massachusetts | 47. Washington |
| 23. Michigan | 48. West Virginia |
| 24. Minnesota | 49. Wisconsin |
| 25. Mississippi | |

COMMUNITY BENEFITS AND CONVERSION LEGISLATION

Over the past two decades, many states have enacted hospital conversion legislation that controls how a non-profit hospital either sells itself to or becomes a for-profit hospital. Conversion legislation often addresses the impact the transaction has on community benefits, and what happens to any community benefits assets.

Therefore, to fully analyze requirements regarding provision of community health care services, it may be worthwhile to cross-reference a state's free care legislation in the Community Catalyst Conversion Compendium.

(http://www.communitycatalyst.org/doc_store/publications/a_compendium_of_state_laws_sep03.pdf)

The following states have legislation regulating non-profit hospital conversions:

1. Arizona
2. California
3. Colorado
4. Connecticut
5. District of Columbia
6. Georgia
7. Hawaii
8. Idaho
9. Louisiana
10. Maine
11. Maryland
12. Massachusetts
13. Nebraska
14. New Hampshire
15. New Jersey
16. New Mexico
17. New York
18. North Carolina
19. North Dakota
20. Ohio
21. Oregon
22. Rhode Island
23. South Dakota
24. Texas
25. Vermont
26. Virginia
27. Washington
28. Wisconsin

1. CALIFORNIA

CITATION: CAL. HEALTH & SAFETY CODE §§ 127340 -- 127365 (2004).¹

TERMINOLOGY: Community Benefits.

REGULATORY OVERSIGHT: Office of Statewide Health Planning and Development, California Health and Welfare Agency (OSHPD) (<http://www.oshpd.state.ca.us/index.htm>). OSHPD reports to the State Department of Health Services (<http://www.dhs.ca.gov/>).

INSTITUTIONS REGULATED: Private nonprofit acute hospitals.

This statute excludes: (1) hospitals dedicated to serving children that do not receive direct payment for services to any patient, and (2) small and rural hospitals. To qualify as a small or rural hospital, a facility must meet specific criteria established by the state. For instance, the facility can not exceed 76 acute care beds and must be located within a community of no more than 15,000 people, as determined by census.

BINDING EFFECT: Compliance with the community benefits statute is required.

DEFINITIONS:

COMMUNITY:

The service areas or patient populations for which the hospital provides health care services.

COMMUNITY BENEFIT:

An activity that addresses community needs primarily through disease prevention and improvement of health status.

COMMUNITY BENEFITS PLAN: The written document prepared for annual submission to the OSHPD.

PUBLIC RECORD: The community benefits plan must be submitted annually to OSHPD and must be made available to the public by OSHPD.

OSHPD was required to submit a report to the legislature by October 1, 1997 that identified hospitals failing to file timely community benefits plans. This report, which analyzes the plans that were submitted, was published in 1998 and is available on the OSHPD website.²

PUBLIC INPUT: The statute contains no requirements for soliciting public input on the community benefits plan; however, it requires that the community benefits plan contain a method for identifying community groups and soliciting community feedback. The purpose of this requirement is to evaluate the plan's effectiveness in meeting community needs.

¹ Effective September 29, 1996.

² <http://www.oshpd.ca.gov/hid/hospital/hcpb/notforprofitlegislation.pdf>

EXAMPLES OF COMMUNITY BENEFITS: The statute lists a number of services that may be considered community benefits. They include:

- Financial support of public health programs;
- Donation of funds, property, or other resources that contribute to a priority of the community;
- Health care cost containment;
- Enhancement of access to health care or related services;
- Provision of charity care and unreimbursed services, such as:
 - community-oriented wellness and health promotion programs;
 - prevention services (such as health screenings, immunizations, school examinations, and disease counseling and education);
 - adult day care;
 - child care;
 - medical research and education;
 - nursing and other professional training;
 - home-delivered meals to the homebound;
 - sponsorship of free food, shelter, and clothing to the homeless;
 - outreach clinics in socio-economically depressed areas.

REQUIRED FREE CARE:³ There is no requirement to provide free care as a component of a community benefits program.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN:

- Measurable objectives to be achieved within a specific timeframe, with an emphasis on direct provision of goods and services;
- Mechanisms to evaluate the plan's effectiveness, including a method for soliciting the views of the community.

REPORTING: Each hospital must file a copy of its community benefits plan with OSHPD no later than 150 days after the hospital's fiscal year has ended. In this report, the hospital should attempt to assign an economic value to the community benefits provided. Hospitals under the common control of a single corporation or another entity may file a consolidated report.

COMMUNITY HEALTH NEEDS ASSESSMENT: Each hospital must complete a community health needs assessment which must be updated at least once every three years. The community health needs assessment must evaluate the health needs of the community serviced by the hospital and include a process for consulting with community groups and local government officials. This health needs assessment may be conducted alone or in conjunction with other health care providers.

³ For information on California's free care law, see: CAL. WELFARE & INSTITUTIONS CODE § 16900 et. seq. California allows hospitals to set their own free care policies within the guidelines of the free care statute. Free care in California is referred to as indigent care.

HOSPITAL MISSION STATEMENT: Although a nonprofit hospital's mission statement does not need to specifically mention community benefits, the mission statement must reflect the public's interest in ensuring the hospital fulfills its charitable obligations.

PENALTIES FOR NONCOMPLIANCE: None specified.

2. CONNECTICUT

CITATION: CONN. GEN. STAT. § 19a-127k (2003).

TERMINOLOGY: Community Benefits.

REGULATORY OVERSIGHT: Commissioner of Public Health (www.dph.state.ct.us).

INSTITUTIONS REGULATED: Hospitals and Managed Care Organizations.

BINDING EFFECT: Voluntary.

DEFINITIONS:

COMMUNITY:

Not defined.

COMMUNITY BENEFITS PROGRAM: Any voluntary program to promote preventive care and to improve the health status for working families and populations at risk in the communities within the geographic service areas of a regulated entity.

PUBLIC RECORD: Each participating institution must make a copy of the biennial community benefits report available to the public upon request. The Commissioner will compile all of the reports and a summary will be available to the public by October 1, 2005.

PUBLIC INPUT: There is no requirement to solicit public input on the community benefits plan. However, hospitals and managed care organizations that choose to develop a community benefits program must seek “meaningful participation” from the communities within the organization’s or hospital’s service area in developing and implementing the program. The hospital must seek community participation in defining the target populations to be served by the community benefits plan, as well as information about the specific health care needs of the target populations.

EXAMPLES OF COMMUNITY BENEFITS: None.

REQUIRED FREE CARE:⁴ There is no requirement to provide free care as a component of a community benefits program.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: No required elements.

⁴ For more information about Connecticut’s free and uncompensated care requirements, see Connecticut General Statutes §§ 12-263a et. seq.

REPORTING: Beginning January 1, 2005 each hospital and managed care organization with a community benefits program in place must submit a biennial report to the Commissioner of Public Health. The biennial report must include: a community benefits policy statement; details on how community participation is solicited and used in the program; identification of the community health needs considered during the program development; a narrative description of the program; evaluation mechanisms and ideas for improving the program; the budget for the program and; a summary of the extent to which the guidelines of this law have been met.

COMMUNITY HEALTH NEEDS ASSESSMENT: There are no requirements for conducting the assessment but the community benefits program must be based on the health care needs of the targeted populations.

HOSPITAL MISSION STATEMENT: N/A

PENALTIES FOR NONCOMPLIANCE: Because filing a community benefits report is voluntary, there are no penalties for failing to develop a plan. However, an organization that does not submit a report by January 1, 2005 indicating whether or not they have a community benefits program may be fined no more than fifty dollars for each day that the report is late.

3. GEORGIA

CITATION: GA. CODE ANN. § 14-3-305 (2002), § 31-7-90.1 (2004).

TERMINOLOGY: Community benefits.

REGULATORY OVERSIGHT: Superior Court in the county in which the hospital is located.

INSTITUTIONS REGULATED: Nonprofit Hospitals.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFIT: No definition of community benefit is provided, however, the facility is required to provide information in an annual report regarding the indigent and charity care provided by the facility.

PUBLIC RECORD: N/A

PUBLIC INPUT: N/A

EXAMPLES OF COMMUNITY BENEFITS: None given.

REQUIRED FREE CARE:⁵ There are no other forms of community benefits listed besides free care.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: There are no required elements of the community benefits plan.

REPORTING: An annual report must be filed no later than 90 days after the close of the fiscal or calendar year with the clerk of Superior Court in the county in which the hospital is located.

This report must include:

- The cost and type of indigent and charity care provided in the preceding year;
- Number of indigent persons served;
- Categorization of those persons by county of residence; and
- The cost of indigent and charity care.

⁵ Official Code of Georgia § 31-8-1 et. seq. Hospital Care for the Indigent Program.

COMMUNITY HEALTH NEEDS ASSESSMENT: Not required.

HOSPITAL MISSION STATEMENT: N/A.

PENALTIES FOR NONCOMPLIANCE: None specified.

4. IDAHO

CITATION: IDAHO CODE § 63-602D (2006).⁶

TERMINOLOGY: Community benefits.

REGULATORY OVERSIGHT: State Board of Equalization (<http://tax.idaho.gov>)

INSTITUTIONS REGULATED: Nonprofit hospitals with more than 150 beds and that are exempt from state property taxes.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFITS: Not defined.

PUBLIC RECORD: The annual report is to be provided “as a matter of community information.”

PUBLIC INPUT: No requirement to solicit public input.

EXAMPLES OF COMMUNITY BENEFITS: None given.

REQUIRED FREE CARE:⁷ Not required as a component of a community benefits program.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: Although there are no requirements for the community benefits plan, hospitals must prepare an annual report that must include information regarding:

- The amount of charity care provided;
- The hospital’s amount of bad debt for the reporting period;
- The cost of administrating unreimbursed government-sponsored health programs;
- Summary information about services and programs the hospital provides below its actual cost; and
- Donated time, funds, subsidies, and in-kind services.

REPORTING: Hospitals must prepare an annual report to be filed with the Board of Equalization by December 31 of each year.

⁶ Effective January 1, 1999.

⁷ See Idaho Code §§ 31-3501 et. seq. Idaho Hospitals for Indigent Sick.

COMMUNITY HEALTH NEEDS ASSESSMENT: A community health needs assessment is not required, but hospitals must report how community needs were determined as a component of the annual report.

HOSPITAL MISSION STATEMENT: N/A

PENALTIES FOR NONCOMPLIANCE: None specified.

5. ILLINOIS

CITATION: 210 ILL. COMP. STAT. ANN. 76/1-99 (West 2003).

TERMINOLOGY: Community Benefits.

REGULATORY OVERSIGHT: Attorney General.

INSTITUTIONS REGULATED: The law applies to all non-profit hospitals other than government hospitals, rural hospitals, or hospitals with 100 beds or fewer. Hospitals that are part of a group are compliant if the whole group is compliant.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY BENEFITS: The unreimbursed cost “of providing charity care, language assistant services, government-sponsored indigent health care, donations, volunteer services, education, government-sponsored program services, research, and subsidized health services, and collecting bad debts.”

PUBLIC RECORD: Annual reports on the community benefits plan must be submitted to the Attorney General by six months after the close of the hospital’s fiscal year. The reports are public. The hospital must also notify the public that the annual report of the community benefits plan is available.

PUBLIC INPUT: There is no requirement to solicit public input on the community benefits plan.

EXAMPLES OF COMMUNITY BENEFITS: See definition of Community Benefits, above.

REQUIRED FREE CARE: Charity care, defined as care for which the provider does not expect to receive payment, is considered as a form of community benefit. See definition of Community Benefits, above. Illinois does not have a separate charity care requirement under law.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: Each hospital must develop a community benefit plan that sets out goals and objectives for providing community benefits and identifies the populations and communities served by the hospital.

REPORTING: Beginning in the hospital's fiscal year ending in 2004, each hospital must make an annual community benefits report to the Attorney General. The report must include:

- The hospital's mission statement;
- A disclosure of the health care needs of the community that were considered in developing the community benefits plan;
- A disclosure of the amount of charity care provided;
- A disclosure of the types and amounts of any community benefits other than charity care provided; and
- Audited annual financial reports.

COMMUNITY HEALTH NEEDS ASSESSMENT: There are no requirements for conducting an assessment, but the community benefits program must be based on the health care needs of the targeted populations.

HOSPITAL MISSION STATEMENT: Hospitals are required to develop a mission statement that "identifies the hospital's commitment to serving the health needs of the community," but there is no explicit requirement that the mission statement reference community benefits.

PENALTIES FOR NONCOMPLIANCE: There is a \$100 dollar late filing fee that the Attorney General can assess 30 days after a written notice is sent to the hospital.

6. INDIANA

CITATION: IND. CODE § 16-21-9-1 – 16-21-9-8 (1994).

TERMINOLOGY: Charitable Care and Community Benefit

REGULATORY OVERSIGHT: Department of Health (www.in.gov/isdh/regsvcs/index.htm).

INSTITUTIONS REGULATED: Nonprofit hospitals.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFIT: Unreimbursed cost of providing charity care, government sponsored indigent health care, donations, education, government sponsored program services, research, and subsidized health services.

PUBLIC RECORD: The annual report will be made available to the public. Each nonprofit hospital must prepare a statement notifying the public that the report is public information, filed with the state department, and available to the public. This statement must be posted in prominent places throughout the hospital, including the emergency room waiting area and the admission office waiting area. It must also be printed in the hospital patient guide or other material that provides the patient with information about the admissions criteria of the hospital.

PUBLIC INPUT: There are no requirements for soliciting public input.

EXAMPLES OF COMMUNITY BENEFITS: See definition of community benefit, above.

REQUIRED FREE CARE:⁸ A community benefits plan must include charity care and government sponsored indigent health care. Charity care must be listed separately from other community benefits. Each hospital is required to develop a written notice about any charity care program it operates and how to apply for charity care. The notice must be in appropriate languages and conspicuously posted.

⁸ For the state free care law, see IND. CODE § 12-16-2.5-1, et. seq.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN:

- Goals and objectives for providing community benefits that include charity care and government sponsored indigent health care;
- Identification of the populations and communities the hospital serves;
- Mechanisms to evaluate the plan's effectiveness, including a method for soliciting the views of the communities served by the hospital;
- Measurable objectives to be achieved within a specified time frame; and
- A budget for the plan.

REPORTING: Each nonprofit hospital must prepare an annual report that, in addition to the community benefits plan, must include: (1) the mission statement of the hospital; (2) a statement of the health care needs of the community that were considered in developing the plan; and (3) a disclosure of the amounts and types of community benefits actually provided, including charity care. The report must be filed no later than 120 days after the close of the hospital's fiscal year.

COMMUNITY HEALTH NEEDS ASSESSMENT: The nonprofit hospital must conduct a community wide needs assessment when developing the community benefits plan in order to determine the health care needs of the community.

HOSPITAL MISSION STATEMENT: Nonprofit hospitals must develop a mission statement that identifies their commitment to serving the health care needs of the community.

PENALTIES FOR NONCOMPLIANCE: The state department may assess a civil penalty against a nonprofit hospital, not to exceed \$1,000 for each day the hospital fails to file the report. No penalty may be assessed until 30 business days after written notification to the hospital of failure to file a report.

7. MARYLAND

CITATION: MD. CODE ANN., HEALTH GEN §19-303 (2005).⁹

TERMINOLOGY: Community Benefits.

REGULATORY OVERSIGHT: Health Services Cost Review Commission (HSCRC) The HSCRC is authorized to adopt regulations regarding community benefits in conjunction with hospital representatives. (<http://www.hsrc.state.md.us/>)

INSTITUTIONS REGULATED: Nonprofit Hospitals.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFIT: An activity intended to address community needs and priorities primarily through disease prevention and improvement of health status.

PUBLIC RECORD: No requirement for public records.

PUBLIC INPUT: A nonprofit hospital may consult with community leaders or any appropriate people that can assist in identifying community health needs, but is not required to do so. However, in developing the community benefits plan, a hospital must consider the most recent community needs assessment developed by HSCRC or the local health department, as long as such a report is available.

EXAMPLES OF COMMUNITY BENEFITS:

- Health services provided to “vulnerable or underserved populations such as medical, Medicare or Maryland Children’s Health Program Enrollees”;
- Financial support of public health programs;
- Donations of funds;
- Health care cost containment activities; and
- Health education, screening and prevention services.

REQUIRED FREE CARE:¹⁰ There is no requirement that free care be provided as a component of a community benefits program.

⁹ Originally effective on October 1, 2001.

¹⁰ See Code of Maryland Regulations 10.37.09.01 et. seq. (Fee Assessment for Financing Hospital Uncompensated Care).

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: None.

REPORTING: By October 1, 2002 each nonprofit hospital was required to submit an annual community benefits report detailing the community benefits provided in the preceding year. The report must include:

- The mission statement of the hospital;
- A list of initiatives undertaken by the hospital;
- The cost to the hospital of each community benefit provided;
- The objectives of each community benefit;
- A description of efforts taken to evaluate the effectiveness of each community benefit initiative; and
- A description of gaps in the availability of specialist providers to serve the uninsured in the hospital.

The HSCRC must compile all reports into a Nonprofit Hospital Community Health Benefit Report which will be submitted annually to the House Health and Government Operations Committee and the Senate Finance Committee. This report must be made available to the public free of charge.

COMMUNITY HEALTH NEEDS ASSESSMENT: Defined as the process by which unmet community health care needs and priorities are identified. Hospitals are instructed to use the most recent community needs assessment developed by the local health department for the county in which the hospital is located.

HOSPITAL MISSION STATEMENT: No criteria to aid hospitals in developing a mission statement is listed in this statute, but the mission statement must be included in the community benefits report.

PENALTIES FOR NONCOMPLIANCE: None specified.

8A. MASSACHUSETTS (HOSPITALS)

CITATION: M.G.L.A. 111 § 51G (2003). See also: Attorney General’s Guidelines for Nonprofit Acute Care Hospitals, revised January 2002.

TERMINOLOGY: Community Benefits.

REGULATORY OVERSIGHT: The Attorney General has established a comprehensive guidebook to help hospitals create a community benefits plan.
(<http://www.cbsys.ago.state.ma.us/pubs/hccbnpguide.pdf>)

INSTITUTIONS REGULATED: Nonprofit acute care hospitals.

BINDING EFFECT: Community benefit plan must be submitted to receive a license to open an acute care hospital.

DEFINITIONS:

COMMUNITY: Communities can be defined in different ways. Some hospitals may define their community as the immediate geographic area that surrounds the hospital. Alternately, a “community” might be a defined subgroup within a population with a traditional relationship to the hospital. A hospital may design a community benefits plan to focus on more than one community, however the community benefits plan should be a collaborative process with the target community.

COMMUNITY BENEFITS: See examples of community benefits, below.

PUBLIC RECORD: The annual community benefits report will be made a matter of public record on file at the Attorney General’s Office. Copies can be obtained through the Attorney General’s website.

PUBLIC INPUT: Hospitals are “encouraged to initiate a formal process, such as an annual public hearing, to solicit the views of community members.” Hospitals should establish a Community Benefits Advisory Group which includes members of the population to be served and which reflects the racial, cultural, and ethnic diversity of the community. In the event that a community, community group or an individual disagrees with a hospital’s choice of a Community Benefits Plan, or any material aspect thereof, they have the right to file a separate report.

EXAMPLES OF COMMUNITY BENEFITS:

- Community health education;
- Free preventive care or health screening services;
- Mobile health vans;
- Home care;
- Medical and clinical education and research;
- Community oriented training programs;
- Low or negative-margin services (e.g. immunization programs);
- Violence-reduction education;
- Anti-smoking education and related activities;
- Substance abuse education and related preventive and acute treatment services;
- Domestic violence reduction education and training services;
- Early childhood wellness programs;
- Expanded prescription drug programs;
- Volunteer services;
- Net financial assistance to community health centers; and
- Unfunded services ancillary to Medicaid and Medicare.

REQUIRED FREE CARE:¹¹ Not required as a component of a community benefits program.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: A community benefits plan should include a comprehensive assessment of the health care needs of the identified community as well as a statement of priorities consistent with the hospital's resources.

In creating the plan, the hospital should take into account the health care problems of medically underserved and disadvantaged populations, and should aim to reduce racial and ethnic disparities in health status. Attention should be given to the special needs of the poor, of the elderly, of racial, linguistic, and ethnic minorities, and of refugees and immigrants. For example, where it is appropriate, hospitals should establish interpreter services.¹²

REPORTING: An annual report should be submitted to the Office of the Attorney General. Each community benefits annual report consists of a full-text report and an executive summary.

¹¹ See Free Care Pool statute, MASS. GEN. LAWS § 118G §18.

¹² In developing its Community Benefits Plan, the hospital should:

- 1) Establish a set of priorities of community health care needs;
- 2) Prepare an inventory of all the community service and community benefit programs currently provided;
- 3) Re-examine existing community benefit commitments and priorities;
- 4) Identify short-term (one-year) and long-term (three- to five-year) goals;
- 5) Determine the need for additional resources;
- 6) Prepare a budget for the Community Benefits Plan, indicating expenses, expected revenues, and outside sources of funding;
- 7) Determine time frames for implementing each aspect of the Plan;
- 8) Take a leadership role in coordinating community benefit projects, taking into account existing community-based programs;
- 9) Encourage hospital-wide and community-wide involvement in the planning and implementation of the Community Benefits program; and
- 10) Retain the flexibility to respond to unanticipated emergencies.

The report must include:

- Mission Statement;
- Management structure of community benefits program;
- Community Health Needs Assessment;
- Community Participation: Process and mechanism; Identification of community participants; and Community role;
- Community Benefits Plan: Process of development; target population(s)/ identification of priorities; Short-term and long-term strategies and goals;
- Progress Report and;
- Approved budget and projected expenditures.

COMMUNITY HEALTH NEEDS ASSESSMENT: A comprehensive needs assessment of the defined population should be considered at least every three years. In deciding which benefits to provide, the hospital should take into account the health care problems of medically underserved and disadvantaged populations, and should aim to reduce racial and ethnic disparities in health status.

HOSPITAL MISSION STATEMENT: The hospital should develop a community benefits mission statement affirming its commitment to serve a designated community or patient population. The community benefits mission statement should be reviewed and amended as necessary.

PENALTIES FOR NONCOMPLIANCE: Because the guidelines are voluntary, there are no penalties for noncompliance, but a plan must be submitted in order to receive a license to open a new hospital.

8B. MASSACHUSETTS (HMOs)

CITATION: Massachusetts has issued guidelines for HMOs in providing community benefits. These guidelines are voluntary. See: Attorney General's Community Benefit Guidelines for Health Maintenance Organizations, Revised January 2002

TERMINOLOGY: Community Benefits.

REGULATORY OVERSIGHT: Attorney General.
(<http://www.cbsys.ago.state.ma.us/pubs/hccbhmoguide.pdf>)

INSTITUTIONS REGULATED: Health Maintenance Organizations.

BINDING EFFECT: Voluntary.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFITS: Not defined.

COMMUNITY BENEFITS PROGRAM: A program, grant or initiative developed in collaboration with community representatives that serves the needs of the target population.

PUBLIC RECORD: Annual reports should be made public and will be available on the Attorney General's website.

PUBLIC INPUT: HMOs should actively solicit input to encourage collaboration with the community, particularly among populations that have been "historically under-represented" within its membership.

EXAMPLES OF COMMUNITY BENEFITS:

- Developing and marketing products to attract all segments of the population. Community benefits should result in market expansion or diversification in delivery and financing of health care. The HMO should avoid marketing and advertising practices that might discourage certain market segments from choosing the HMO;
- Offering and promoting direct enrollment for non-group coverage;
- Reducing cultural, linguistic, and physical barriers to accessible health care including making telecommunications devices available; and
- Helping consumers who are about to lose coverage or who are uninsured to maintain or obtain health care coverage at reduced costs.

REQUIRED FREE CARE: N/A

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN:

- Statement of goals;
- A needs assessment;
- Implementation time frames; and
- Budget preparations and Plan Priorities

REPORTING: The HMO should submit an annual community benefits report to the Attorney General’s office no later than five months after the end of its fiscal year.

The annual report should include the following:

- Management structure of CB program;
- Community Health Needs Assessment Process;
- Community Participation: Process and mechanism, Identification of community participants, and Community role;
- Community Benefits Plan: Process of development, Choice of target population(s), identification of priorities, Short-term and long-term strategies and goals;
- Progress Report: Expenditures, Major programs and initiatives, Efforts to reduce barriers to health care; and
- Approved budget/ projected expenditures, anticipated goals and program initiatives, and
- Projected outcomes.

COMMUNITY HEALTH NEEDS ASSESSMENT: The HMO may assess community needs and resources in collaboration with hospitals, other HMOs, community health centers, and social service agencies in the area taking into account health status data already available.

HOSPITAL MISSION STATEMENT: N/A

Each HMO should adopt and make public a “community benefits policy statement” setting forth its commitment to a formal community benefits program. The statement should also publicly acknowledge the HMO’s commitment to its community.

PENALTIES FOR NONCOMPLIANCE: Since the guidelines are voluntary, there are no penalties for noncompliance.

9. MINNESOTA

CITATION: MINN. STAT. §144.698-9 (2007).

TERMINOLOGY: Community Benefit and Community Care.

REGULATORY OVERSIGHT: Commissioner of Health. (www.health.state.mn.us/index.html)

INSTITUTIONS REGULATED: Hospitals and outpatient surgical centers.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFITS: “[C]ommunity benefit’ means the costs of community care, underpayment for services provided under state health care programs, research costs, community health services costs, financial and in-kind contributions, costs of community building activities, costs of community benefit operations, education costs, and the cost of operating subsidized services. The cost of bad debts and underpayment for Medicare services are not included in the calculation of community benefit.”

“Community care’ means the costs for medical care that a hospital has determined is charity care... or for which the hospital determines after billing for the services that there is a demonstrated inability to pay. Any costs forgiven under a hospital's community care plan ... may be counted in the hospital's calculation of community care. Bad debt expenses and discounted charges available to the uninsured shall not be included in the calculation of community care. The amount of community care is the value of costs incurred and not the charges made for services.”

PUBLIC RECORD: Community Benefits records are open to public inspection.

PUBLIC INPUT: No requirements for soliciting community input.

EXAMPLES OF COMMUNITY BENEFITS: See the definition of “Community Benefit” above.

REQUIRED FREE CARE:¹³ Not required.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: No required elements.

REPORTING: After the close of the fiscal year, a hospital must file an annual report which must include information on services provided to benefit the community, including:

- Services provided at no cost or for a reduced fee to patients unable to pay;

¹³ See Minn. Rule 4650.0102, et. seq., Minn. Rule 4651.0100, et. seq.

- Teaching and research activities; and
- Other charitable activities.

The Commissioner must report annually on each hospital's community benefit and community care in terms of dollars and as a percentage of the total operating cost for each hospital. The report must contain details of each component of these costs.

COMMUNITY HEALTH NEEDS ASSESSMENT: Not required.

HOSPITAL MISSION STATEMENT: N/A

PENALTIES FOR NONCOMPLIANCE: None listed. The Commissioner must make all requested information available to the Attorney General, who could investigate violations of the law and prosecute those in violation.

10. NEVADA

CITATION: NEV. REV. STAT. ANN. § 449.450-530 (West 2005).

TERMINOLOGY: Community benefits

REGULATORY OVERSIGHT: Department of Health and Human Services (<http://dhhs.nv.gov/>).

INSTITUTIONS REGULATED: Each hospital with 100 or more beds.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY BENEFITS: Includes the “goods, services and resources provided by a hospital to a community to address the specific needs and concerns of that community, services provided by a hospital to the uninsured and underserved persons in that community, training programs for employees in a community and health care services provided in areas of a community that have a critical shortage of such services, for which the hospital does not receive full reimbursement.”

PUBLIC RECORD: An annual report of expenses incurred for providing community benefits must be provided to the Department of Health and Human Services, and the reports “are open to public inspection and must be available for examination at the office of the Department during regular business hours.”

PUBLIC INPUT: There is no requirement to solicit public input on the community benefits plan.

EXAMPLES OF COMMUNITY BENEFITS: See definition of community benefits, above.

REQUIRED FREE CARE: In addition to the report on expenses for community benefits, each hospital must provide a statement of its policies on reduced cost services for people without insurance.¹⁴

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: None

REPORTING: Each hospital must make an annual report to the Attorney General. The report must include:

- A balance sheet with assets, liabilities, and net worth, as well as a statement of income and expenses for the fiscal year;
- A capital improvement report;
- The hospital’s expenses incurred providing community benefits;

¹⁴ For more information on reduced cost care in Nevada, *see* Nev. Rev. Stat Ann § 439B.260.

- A statement of the hospital's discounted care policy;
- A statement of the hospital's accounts receivable policy, including how they collect or make payment arrangements for patients' accounts; and
- Certification by a CPA that all financial statements are accurate

COMMUNITY HEALTH NEEDS ASSESSMENT: There are no requirements for conducting an assessment but the community benefits program must address the needs and concerns of the community.

HOSPITAL MISSION STATEMENT: N/A

PENALTIES FOR NONCOMPLIANCE: The Department of Health and Human Services may impose an administrative fine of \$500 per day for each violation of the law.

11. NEW HAMPSHIRE

CITATION: N.H. REV. STAT. ANN. § 7:32-c – § 7:32-1 (2004).¹⁵

TERMINOLOGY: Community Benefits/Charity Care.

REGULATORY OVERSIGHT: Attorney General (www.state.nh.us/nhdoj/agpage.html).

INSTITUTIONS REGULATED: Health Care Charitable Trusts (HCCTs)¹⁶ with fund balances greater than \$100,000.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: The service area or patient population for which a health care charitable trust provides services.

COMMUNITY BENEFIT: Activities that are intended to address community health care needs. Charity care is “health care services provided by a health care charitable trust for which the trust does not expect...payment.”

PUBLIC RECORD: All community benefits plans are to be available, when practicable, to the public on an internet site or web page. Every HCCT must annually provide public notice of the availability and process for obtaining a copy of its community benefits plan. Notices must be prominently displayed in the lobby, waiting rooms, and other areas of public access at the HCCT.

PUBLIC INPUT: “The process for development of the plan shall include an opportunity for members of the public in the trust’s service area to provide input.”

EXAMPLES OF COMMUNITY BENEFITS: Activities intended to address community health care needs, include, but are not limited to, the following:

- Charity care;
- Financial or in-kind support of public health programs;
- Allocation of funds, property, services or other resources that contribute to identified community health care needs;
- Donation of funds, property, services or other resources to promote or support a healthier community, enhanced access to health care or related services, health education & prevention activities, or services to a vulnerable population; and
- Support of medical research and education and training of health care practitioners.

¹⁵ Effective January 1, 2000.

¹⁶ A Health Care Charitable Trust is “a charitable trust organized to directly provide health care services, including, but not limited to, hospitals, nursing homes, community health services, and medical-surgical or other diagnostic or therapeutic facilities or services.”

REQUIRED FREE CARE:¹⁷ The provision of charity care may be included in a community benefits plan by a health care charitable trust only to the extent that it:

- Does not include any sums identified as bad debt, a receivable, or revenue by the trust in accordance with generally accepted accounting principles;
- Is provided in accordance with a written policy;
- The written policy is available to the public, and it allows any individual to make application and receive a prompt decision on eligibility for and the amount of charity care; and
- Notice of the availability of free care is prominently displayed in the trust's lobby, waiting rooms, or other area of public access or otherwise is provided to service applicants and recipients who are served in their own homes or in locations other than a facility of the trust.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: Within 90 days of the start of the fiscal year, each HCCT must develop a community benefits plan. The plan must:

- Contain a mission statement;
- Take into consideration those needs identified in the community needs assessment;
- Identify the activities taken and planned to address those needs (charity care must be listed as a separate category);
- Contain a report of community benefit activities undertaken in the prior year including results or outcomes;
- Describe the means used to solicit the views of the community;
- Identify community groups, members of the public, and local government officials consulted in the development of the plan; and
- Contain an evaluation of the plan's effectiveness.

REPORTING: An annual community benefits report must be filed with director of charitable trusts within 90 days of the start of HCCT's fiscal year.

COMMUNITY HEALTH NEEDS ASSESSMENT: Each HCCT must conduct a community needs assessment, either alone or in conjunction with other HCCTs in the community. The process should include consultation with members of the public, community organizations, service providers, and local government officials in order to identify and prioritize community needs. The assessment must be updated at least every five years

HOSPITAL MISSION STATEMENT: The hospital mission statement must be included in community benefits plan and reaffirmed by the trust on an annual basis.

PENALTIES FOR NONCOMPLIANCE: A civil fine, not to exceed \$1,000 plus attorneys fees and costs will be imposed for failure to file a community benefits plan.

¹⁷ New Hampshire's provisions for free care are part of the community benefits statute.

12. NEW YORK

CITATION: N.Y. PUB. HEALTH LAW § 2803-1 (1996).

TERMINOLOGY: Community Service Plan.

REGULATORY OVERSIGHT: Commissioner of Health
(www.health.state.ny.us/nysdoh/commish/commish.htm).

INSTITUTIONS REGULATED: Voluntary nonprofit general hospitals.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFIT: Not defined.

PUBLIC RECORD: The hospital's annual implementation report, regarding the hospital's performance in meeting community health care needs, improving access to health care for the underserved, and in providing free care services, must be made available to the public.

PUBLIC INPUT: No requirement for public input.

EXAMPLES OF COMMUNITY BENEFITS: Not provided.

REQUIRED FREE CARE:¹⁸ There are no free care provisions in the community benefits law. New York operates an uncompensated care pool. In order to qualify for funds from the pool, hospitals must establish financial aid policies and provide reduced charge or free services to uninsured patients at lower income levels.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: None.

REPORTING: The governing body of the hospital must prepare an annual implementation report regarding the hospital's performance in meeting the health care needs of the community, providing charity care services, and improving access to health care services for the underserved.

COMMUNITY HEALTH NEEDS ASSESSMENT: Not required.

¹⁸ N.Y. Pub. Health Law §2807-k.

HOSPITAL MISSION STATEMENT: The organizational mission statement must identify the populations and communities the hospital serves, and the hospital's commitment to meeting the health care needs of the community. Every three years the hospital must review its mission statement and solicit the views of the communities the hospital serves.

The mission statement should demonstrate the hospital's commitment (operational and financial) to meeting community health care needs, to providing charity care services and to improving access to health care services for the underserved. Additionally, the hospital must prepare a statement showing a summary of the financial resources of the hospital and related corporations and the allocation of available resources to hospital purposes including the provision of free or reduced charge services.

PENALTIES FOR NONCOMPLIANCE: None.

13. OREGON

CITATION: House Bill 3290¹⁹

TERMINOLOGY: Community benefit.

REGULATORY OVERSIGHT: Office for Oregon Health Policy and Research (<http://egov.oregon.gov/DAS/OHPPR/>)

INSTITUTIONS REGULATED: Hospitals.

BINDING EFFECT: Required (Reporting only).

DEFINITIONS:

COMMUNITY BENEFIT: “A program or activity that provides treatment or promotes health and healing in response to an identified community need.”

PUBLIC RECORD: The Office will produce an annual report based on filings received by all hospitals, and present this report to the Governor, President of the Senate, Speaker of the House of Representatives, and the Legislative Assembly. The report must also “be made available to the public.”

PUBLIC INPUT: None specified.

EXAMPLES OF COMMUNITY BENEFITS: Charity care; shortfalls in Medicare, Medicaid, SCHIP and other publicly funded health programs; community health improvement services; research; financial or in-kind contributions to the community; and community building activities affecting health in the community.

REQUIRED FREE CARE: None.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: None specified, except that the community benefit reporting system must be “cost-based.”

REPORTING: Within 90 days of filing a Medicare cost report, a hospital must file a community benefit report to the Office. Hospitals are to complete a form to be developed by the Office.

COMMUNITY HEALTH NEEDS ASSESSMENT: None specified.

HOSPITAL MISSION STATEMENT: None specified.

¹⁹ Effective January 1, 2008. To be added to Oregon Revised Statutes Ch. 442.

PENALTIES FOR NONCOMPLIANCE: The Office may impose a civil penalty of up to \$500 per day for a violation of this law. The Office may mitigate this penalty under the proper conditions and consistent with public health and safety.

14. PENNSYLVANIA

CITATION: PA. STAT. ANN. TIT. 10 §371 (2002).²⁰

TERMINOLOGY: Community Service.

REGULATORY OVERSIGHT: Department of State, Bureau of Charitable Organizations (www.dos.state.pa.us/char/site/default.asp).

INSTITUTIONS REGULATED: Institutions of Purely Public Charity (“IPPC”).²¹

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFITS: Not defined.

PUBLIC RECORD: An IPPC’s annual report, as described in the section “Reporting” below, is available for public inspection.

PUBLIC INPUT: No provisions for soliciting community input.

EXAMPLES OF COMMUNITY BENEFITS: Pennsylvania law allows for a variety of ways in which an IPPC can fulfill its community service obligation. Generally, these requirements call on the IPPC hospital to provide a certain percentage of its revenues or costs on “uncompensated goods or services,” and/or to demonstrate that a significant percentage of patients are treated without cost or at a significant discount. Uncompensated goods or services include the following:

- The cost of all goods or services provided by the institution for which it has not received compensation, or the difference between the full cost for goods or services and any lesser fee received for the goods or services;
- The difference between the cost of education and research programs provided by or participated in by the institution and any payment made to the institution to support the education and research programs;

²⁰ Effective December 1997.

²¹ In order to qualify as an IPPC, an organization must have a charitable purpose, must operate entirely free from a private profit motive, must engage in an appropriate level of community service, must benefit a substantial and indefinite class of persons who are legitimate subjects of charity, and must relieve the government of some of its burden. An IPPC must be organized as a 501(c)(3), (4), (5), (6), (7), (8), or (9) organization. If the IPPC is not a 501(c)(3) organization, it cannot be either an association of employees, a labor organization, an agricultural organization, a business league, a club, or a fraternal benefit organization.

- The difference between the full cost of any goods or services provided by the institution and payments to the institution from a government program such as Medicaid or Medicare for those goods or services;
- The difference between the full cost of community services provided by the institution and any payments made to the institution for those community services;
- The net value of donations made to other IPPCs or government agencies;
- The reasonable value of volunteer assistance donated by individuals who are involved in providing goods or services by the institution; and
- The cost of goods or services provided by an institution to individuals who are unable to pay, after reasonable and customary collection efforts have been attempted by the institution.

REQUIRED FREE CARE:²² Free care is required.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: None specified.

REPORTING: If an IPPC does not register with the Department of State under the Solicitation of Funds for Charitable Purposes Act, it must file an annual report with the Bureau of Charitable Organizations of the Department of State.²³ This provision does not require hospitals to report their community service activities, although hospitals are required to submit a copy of IRS Form 990 and other federal tax return documents with the report.

COMMUNITY HEALTH NEEDS ASSESSMENT: No.

HOSPITAL MISSION STATEMENT: N/A

PENALTIES FOR NONCOMPLIANCE: An administrative penalty up to \$500 may be imposed if an IPPC fails to file a report or knowingly makes a false statement in the report.

²² See 35 Penn. Stat. § 5701.1101 et. seq. for more information about how charity care is provided.

²³ The annual report must contain detailed tax information.

15. RHODE ISLAND

CITATION: R.I. GEN. LAWS § 23-17.14- to § 23-17.34 (2000); “Rules and Regulations Pertaining to Hospital Conversions,” R23-17.14-HCA. (2006).

TERMINOLOGY: Charity and Uncompensated Care; Community Benefits.

REGULATORY OVERSIGHT: Director of the Rhode Island Department of Health (www.health.state.ri.us).

INSTITUTIONS REGULATED: Hospitals.

BINDING EFFECT: The provision of community benefits is required to obtain or renew a hospital license.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFIT: Community benefit means “the provision of hospital services that meet the ongoing needs of the community for primary and emergency care in a manner that enables families and members of the community to maintain relationships with persons who are hospitalized or are receiving hospital services.” It also includes charity care and uncompensated care.

PUBLIC RECORD: The hospital must make public its community benefits mission statement.

PUBLIC INPUT: The governing body of the hospital must “delineate the specific community or communities, including racial or ethnic minority populations, that will be the focus of its community benefits plan and shall involve representatives of that designated community or communities in the planning and implementation process.”

EXAMPLES OF COMMUNITY BENEFITS: Examples of community benefits include the following:

- Programs that meet the needs of the medically indigent;
- Linkages with community partners that focus on the health needs of community residents;
- Non-revenue producing services made available to the community;
- Public advocacy on behalf of community health needs; and
- Scientific, educational, and medical research activities.

REQUIRED FREE CARE: Free care requirements are included in the regulation governing community benefits.²⁴

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: As of January 1, 2001, each licensed hospital must have a formal plan for the provision of community benefits, to be updated every three years. The plan must include a community benefits mission statement, involvement of representatives of the specifically delineated community or communities in the development of the plan, and a comprehensive health care needs assessment. The hospital's board, chief executive officer, and senior management are responsible for developing a mechanism of the evaluation of the plan on an annual basis.

REPORTING:

Before March 1st of each calendar year, all hospitals must file a detailed description with supporting documentation of: (1) cost of charity care; (2) bad debt; (3) contracted Medicaid shortfalls; and (4) any other information demonstrating compliance with the hospital's legal charity care requirements. The Department's 2004 Hospital Community Benefit Report can be found at <http://www.health.ri.gov/chic/performance/communitybenefits04.pdf>.

COMMUNITY HEALTH NEEDS ASSESSMENT: The community benefit plan must include a comprehensive assessment of the health care needs of the community or communities identified by the governing body of the hospital.

MISSION STATEMENT: N/A

PENALTIES FOR NONCOMPLIANCE: If any person knowingly violates or fails to comply with any provision of the law, or willingly or knowingly gives false or incorrect information, the Director may, after notice and opportunity for a prompt and fair hearing to the applicant or licensee, deny, suspend, or revoke a license, prohibit any new admissions to a facility, prohibit the treatment of any additional persons, or take corrective action necessary to secure compliance with the law. The Superior Court may, after notice and opportunity for a prompt and fair hearing, impose a fine of not more than \$1,000,000 or impose a prison term of not more than 5 years.

²⁴ A 2007 amendment to the regulation governing community benefits requires that hospitals provide free care or reduced cost care to uninsured persons with income and assets below set levels. R23-17.14-HCA. (<http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4378.pdf>). An earlier statute states that the standard level of charity care and community benefits that must be provided for a hospital to obtain or renew a license depends upon guidelines established by the legislature in the charters of existing hospitals. R.I. GEN. LAWS § 23-17-43.

16. TEXAS

CITATION: TEX. HEALTH & SAFETY CODE ANN. § 311.041-311.048 (2003)

TERMINOLOGY: Community Benefits.

REGULATORY OVERSIGHT: Department of State Health Services, Bureau of State Health Data and Policy Analysis.

INSTITUTIONS REGULATED: Nonprofit hospitals, excluding hospitals in counties with populations less than 50,000 that have been designated as Health Professionals Shortage Areas.

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: The primary geographic area and patient categories for which the hospital provides health care services.

COMMUNITY BENEFIT: Unreimbursed cost of providing charity care, government-sponsored indigent health care, donations, education, government-sponsored program services, research, and subsidized health services. Community benefits do not include the cost of paying taxes or other governmental assessment.

COMMUNITY BENEFITS PLAN: An operational plan for serving the community's health care needs, including charity care.

PUBLIC RECORD: The Department will make the hospital's annual report available to the public.

PUBLIC INPUT: The community benefits plan must contain a method of soliciting community views. Hospitals should consider seeking input from government, health-related organizations, and consumers.

EXAMPLES OF COMMUNITY BENEFITS:

No specific examples of community benefits are given. See definition of community benefits for general types of services that would qualify. The hospital may provide community benefits according to any of the following standards:

- Charity care and government-sponsored indigent health care at a level reasonably related to community needs (as determined by the community needs assessment), the available resources of the hospital, and the tax-exempt benefits received by the hospital; or
- Charity care and government-sponsored indigent health care in an amount equal to at least 100% of the hospital's tax-exempt benefits, excluding federal income tax; or

- Charity care and community benefits are provided in a combined amount equal to at least 5% of the hospital's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least 4% of the net patient revenue.

REQUIRED FREE CARE:²⁵ Free care is required. Additionally, each hospital must provide notice of the charity care program and how to apply for charity care must be conspicuously posted in the general waiting area, the waiting area for emergency services, in the business office, and in such other locations as the hospital deems appropriate. The notice must also be posted in appropriate languages.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN:

- Identification of the populations and communities served by the hospital;
- Mechanisms to evaluate the plan's effectiveness, including a method of soliciting the views of the communities served by the hospital;
- Measurable objectives to be achieved within a specified time frame; and
- A budget.

REPORTING: Within 120 days of the end of the hospital's fiscal year, the hospital must file a statement with the Bureau of State Health Data and Policy Analysis stating which of the community benefits standards it has satisfied.

At a minimum, the report must contain:

- The hospital's mission statement;
- The health care needs of the community that were considered in developing the community benefits plan;
- The amount and types of community benefits, including charity care, actually provided;
- The total operating expenses; and
- A completed worksheet that computes the ratio of cost to charge for the fiscal year

The amount of charity care provided must be reported separately from other community benefits.

COMMUNITY HEALTH NEEDS ASSESSMENT: Prior to developing a community benefits plan, a hospital must conduct a community-wide needs assessment.

HOSPITAL MISSION STATEMENT: Each nonprofit hospital must develop an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community. The annual report must contain the hospital's mission statement.

PENALTIES FOR NONCOMPLIANCE: If a hospital fails to file an annual report, Department of State Health Services may fine the hospital up to \$1,000 for each day the report is not filed.

²⁵ See also TX Health and Safety Code §311.031 et. seq.; TX Health and Safety Code §61.001, et. seq.

17. UTAH

CITATION: Property Tax Exemptions Standards of Practice, Appendix 2D, “Nonprofit Hospital and Nursing Home: Charitable Property Tax Exemption Standards,” Utah State Tax Commission, revised June 2007.

Also see UTAH CODE ANN. § 59-2-1101 (2002)²⁶

TERMINOLOGY: Gifts to the Community.

REGULATORY OVERSIGHT: State Tax Commission. (www.tax.utah.gov).

INSTITUTIONS REGULATED: Nonprofit hospitals and nursing homes.

BINDING EFFECT: Adherence to the Standards is required in order for a hospital to be classified as tax exempt.

The health care entity must establish that: (1) It admits and treats members of the public without regard to race, religion, or gender; (2) admission is based on the clinical judgment of the physician and not on ability to pay; (3) indigent persons receive services at no charge or for a reduced charge, in accordance with their ability to pay; and (4) it has informed the public of the open access policy and services for the indigent. The entity must also show that its policies reflect the public interest.

DEFINITIONS:

COMMUNITY: No definition is given, but the Standards provide that “the term community may well be narrower or broader than an individual county’s geographic boundaries.”

COMMUNITY BENEFIT: The term “community benefits” is not used; the term used is “gift(s) exchanged between the charity and the recipient of services or in the lessening of a government burden through the charity’s operation.”

PUBLIC RECORD: No provision

PUBLIC INPUT: No provision.

²⁶ Utah Code Ann § 59-2-1101 (2002) is a statute exempting certain property from property taxes. Included in this statute are “nonprofit entit[ies]...used exclusively for religious, charitable, or educational purposes. The Nonprofit and Nursing Home Charitable Tax Exemption Standards (“Standards”) require that a tax-exempt entity provide substantial “gifts to the community.”

EXAMPLES OF COMMUNITY BENEFITS:

- Indigent care - unreimbursed care to those unable to pay;
- community education and service - such as volunteer and community service not including in-house training for employees;
- medical discounts - value of unreimbursed care for patients covered by Medicare, Medicaid, or other similar programs; and
- continued operation of hospitals where revenues are insufficient to cover costs.

REQUIRED FREE CARE:²⁷ According to the Standards, the institution must show that indigent persons who require services generally available at the hospital will be provided with services regardless of their ability to pay. The entity must “affirmatively inform” the public of its open access policy and the availability of services for indigent persons.

REQUIRED ELEMENTS OF THE COMMUNITY BENEFITS PLAN: No requirements.

REPORTING: Institutions seeking tax-exempt status are required to report:

- Accounting data that shows the amount and value of unreimbursed care to indigent and subsidized patients;
- Accounting data that shows the unreimbursed value of community education and service programs;
- Accounting data that shows the amount and uses of volunteer time and donated funds;
- A description of intangible or unquantifiable community gifts.

COMMUNITY HEALTH NEEDS ASSESSMENT: The hospital’s governing body must meet at least once a year with the county Board of Equalization to discuss the community’s needs.

HOSPITAL MISSION STATEMENT: N/A.

PENALTIES FOR NONCOMPLIANCE: If the hospital does not comply with the Standards, the entity’s tax-exempt status will be revoked.

²⁷ See also Utah Code § 26-18-301 et seq.

18. WEST VIRGINIA

CITATION: W.VA. CODE STATE R. § 110-3-24 (2007)

Also see W.VA. STAT. § 11-3-9

TERMINOLOGY: Charitable Use; Volunteer and Community Services.

REGULATORY OVERSIGHT: Tax Department. (www.state.wv.us/taxdiv/)

INSTITUTIONS REGULATED: Nonprofit hospitals.

A nonprofit hospital is not automatically immune from property taxes. Under West Virginia law, the exemption of property from taxation is based on its primary and immediate use. Therefore, only the nature of the activities conducted by the hospital can qualify it as an organization “used for charitable purposes.”

Key determinants of charitable use include (1) the provision of health services to individuals who cannot afford to pay; (2) the provision of activities which promote the health of the community served by the hospitals.

Any hospital seeking to qualify for charitable status must develop a charity care plan to be approved by the board of trustees at least every two years. The charity care plan must include provision of a specific appropriate level of free care to be determined by the board of trustees of the hospital. (Bad debt should not be included in a calculation of the amount of charity care provided.)

BINDING EFFECT: Required.

DEFINITIONS:

COMMUNITY: Not defined.

COMMUNITY BENEFITS: Charity care or volunteer and community service that assists in relieving the burdens of government to provide health services to individuals who cannot afford to pay.

PUBLIC RECORD: There is no requirement to publicly report community benefits. However, data on charity care must be made available to the public. This data must include a summary of the number of requests for charity care, the dispositions of these requests, and the dollar amount of charity care that was provided.

PUBLIC INPUT: No requirements for public input in development of community benefits program.

EXAMPLES OF COMMUNITY BENEFITS:

- Public education programs;
- Donations of medical supplies;
- Social services;
- Operation of poison control centers;
- Disaster planning;
- Unreimbursed cost for education and training of health professionals and;
- Free or reduced cost health screenings, medical clinics, blood banking, or EMS assistance.

REQUIRED FREE CARE: Free care (referred to as “charity care”) is required. Hospitals must “plainly post” notice of their obligation to provide free and below cost care and of the criteria for receiving such care in the emergency room and admitting areas. Each person the hospital treats who does not have private insurance or does not qualify for a governmental program must also be notified in writing of this obligation.²⁸

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: No required elements.

REPORTING: No annual report is required.

COMMUNITY HEALTH NEEDS ASSESSMENT: Not required.

HOSPITAL MISSION STATEMENT: N/A

PENALTIES FOR NONCOMPLIANCE: Hospitals are at risk of losing nonprofit status if it is determined that they are not operating for solely “charitable” purposes. Hospitals can prove “charitable” status by demonstrating that they provide community benefits and charity care.

²⁸ The hospital may not arbitrarily restrict provision of services to certain individuals or groups; restrictions may only be based on a rationale that reflects a definite benefit to the general public interest; and no hospital may insist that patients provide assurance that all of their bills be paid as a condition for obtaining emergency treatment or the treatment of a life threatening condition.