Health Care Community Benefits:
A Compendium of State Laws

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FORWARD

Community Catalyst has compiled this overview of Community laws 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: Touzin@communitycatalyst.org

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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. Usually, an annual report is required, but note that these requirements and what information must be included in the report differ among states.

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 synonomous 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.

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

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

District of Columbia

1. CALIFORNIA

CITATION: CAL. HEALTH & SAFETY CODE §§ 127340 -- 12765 (2003).

TERMINOLOGY: Community Benefits.

REGULATORY OVERSIGHT: Office of Statewide Health Planning and Development, California Health and Welfare Agency (OSHPD) (www.oshpd.state.ca.us/search.htm). OSHPD reports to the State Department of Health Services (www.dhs.cahwnet.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 including that 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 population 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.

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.

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.

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;
- Outreach clinics in socio-economically depressed areas;
- 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.

REQUIRED FREE CARE[1]: 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

[1] 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.

officials. This health needs assessment may be conducted alone or in conjunction with other health care providers.

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 (this is an amendment to the statute; earlier versions required an annual report). 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[2]: 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.

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[2] 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[3]

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] N/A means that the statute did not directly address this issue.

3. GEORGIA

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

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 RECORDS: N/A

PUBLIC INPUT: N/A

EXAMPLES OF COMMUNITY BENEFITS: None given.

REQUIRED FREE CARE[4]: 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.

[4] 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 (2003).[5]

TERMINOLOGY: Community benefits.

REGULATORY OVERSIGHT: State Board of Equalization (www2.state.ed.us/tax/index.html).

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[6]: 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.

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[5] Effective January 1, 1999.
[6] See Idaho Code §§ 31-5501 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. INDIANA

CITATION: IND. CODE § 16-21-9-1 – 16-21-9-8 (2003).

TERMINOLOGY:

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, above.

REQUIRED FREE CARE[7]: 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.

[7] For free care legislation, see IND. CODE § 12-16-2-1, 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;
- 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.

6. MARYLAND

CITATION: MD. CODE ANN., HEALTH GEN-I (2003).

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.

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 RECORDS: 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. 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 Heath 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[8]: There is no requirement that free care be provided as a component of a community benefits program.

[8] 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 and;
- A description of efforts taken to evaluate the effectiveness of each community benefit initiative.

The HSCRC must compile all reports into a Nonprofit Hospital Community Health Benefits Report which will be submitted annually to the House Economic Matters Committee and the Senate Finance Committee. This report shall 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.

7A. MASSACHUSETTS

COMMUNITY BENEFITS CITATION: Massachusetts has not codified their community benefits program as law. See: Attorney General's Guidelines for Nonprofit Acute Care Hospitals, revised January 2003.

COMMUNITY BENEFITS TERMINOLOGY: Community Benefits.

OVERSIGHT: The Attorney General has established a comprehensive guidebook to help hospitals create a community benefits plan. (www.ago.state.ma.us/healthcare)

INSTITUTIONS REGULATED: Nonprofit acute care hospitals.

BINDING EFFECT: Voluntary.

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 shall 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 ;
- Unfunded services ancillary to Medicaid and Medicare.

REQUIRED FREE CARE[9]: 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 undeserved 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.

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.

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;

[9] See Free Care Pool statute, MASS. GEN. LAWS § 118G § 18

- 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 undeserved and disadvantaged populations, and should aim to reduce racial and ethnic disparities in health status.[10]

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.

[10] 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) preparing a budget for the Community Benefits Plan, indicating expenses, expected revenues and outside sources of funding;
7) Determining time frames for implementing each aspect of the Plan;
8) Taking a leadership role in coordinating community benefit projects, taking into account existing community-based programs;
9) Encouraging hospital-wide and community-wide involvement in the planning and implementation of the Community Benefits program;
10) Retaining the flexibility to respond to unanticipated emergencies.

7B. MASSACHUSETTS

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 2003

REGULATORY OVERSIGHT: Attorney General. (www.ago.state.ma.us/healthcare)

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 underrepresented 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;
- 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:

- 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
- Approved budget/ projected expenditures; anticipated goals and program initiatives; 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.

8. MINNESOTA

CITATION: MINN. STAT. § 144.698 (2003).[11]

TERMINOLOGY: Charity Care, Community and Charitable Activities.

REGULATORY OVERSIGHT: Commissioner of Health. (A hospital may engage the services of a nonprofit reporting agency that will compile a report to be sent to the 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: Not defined.

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

PUBLIC INPUT: No requirements for soliciting community input.

EXAMPLES OF COMMUNITY BENEFITS: Although the statute does not use the language "Community Benefit", services provided to benefit the community include **charity care** or care at a reduced fee, teaching and research activities, and other community or charitable activities.

REQUIRED FREE CARE[12]: 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;
- Teaching and research activities; and
- Other charitable activities.

COMMUNITY HEALTH NEEDS ASSESSMENT: Not required.

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[11] Effective July 1, 1994.
[12] See Minn. Ad. Code 4650.0102, et. Seq., Minn. Ad. Code 4651.0100, et. seq.

HOSPITAL MISSION STATEMENT: N/A

PENALTIES FOR NONCOMPLIANCE: None.

9. NEW HAMPSHIRE

CITATION: N.H. REV. STAT. ANN. § 7:32-c – § 7:32-l (2003).[13]

TERMINOLOGY: Community Benefits/Charity Care.

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

INSTITUTIONS REGULATED: Health Care Charitable Trusts (HCCT) 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 available to the public on the Web. 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: No requirements for soliciting public input.

EXAMPLES OF COMMUNITY BENEFITS: Activities intended to address community health care needs, including but not limited to:

- 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.

[13] Effective January 1, 2000.

REQUIRED FREE CARE[14]: 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 three 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 & costs will by imposed for failure to file a community benefits plan.

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

10. NEW YORK

CITATION: N.Y. PUB. HEALTH LAW § 2803-l (2003).[15]

TERMINOLOGY: Free or reduced charge services.

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

INSTITUTIONS REGULATED: Nonprofit general hospitals.

BINDING EFFECT: Required.

DEFINITIONS:

> **COMMUNITY:** Not defined.
>
> **COMMUNITY BENEFIT:** Not defined.

PUBLIC RECORD: The hospital's annual implementation report and a summary of financial resources devoted to free or reduced charge services must be made available to the public.

PUBLIC INPUT: No requirement for public input.

EXAMPLES OF COMMUNITY BENEFITS: Not provided.

REQUIRED FREE CARE[16]: No provision for free care.

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.

HOSPITAL MISSION STATEMENT: The organizational mission statement must identify the populations and communities the hospital serves, and the hospital's commitment to meeting the

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[15] The New York community benefits law was originally enacted in 1991 but it underwent many amendments in 1996.

[16] New York free care law:

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.

11. Pennsylvania

CITATION: PA. STAT. ANN. TIT. 10 § 371 (2002).[17]

TERMINOLOGY: Community Services.

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"). [18]

BINDING EFFECT: Required.

DEFINITIONS:

> **COMMUNITY:** Not defined.
>
> **COMMUNITY BENEFITS**: See 'Examples of Community Benefits,' below.

PUBLIC RECORD: The annual report is available for public inspection.

PUBLIC INPUT: No provisions for soliciting community input.

EXAMPLES OF COMMUNITY BENEFITS:

- Provision of goods or services to all who seek without regard to ability to pay, as long as the IPPC has a written and published policy so stating and at least 75% of the IPPC's income, but no more than 3% of its total operating expenses, is spent on uncompensated goods and services;
- Provision of goods or services for fees based on the patient's ability to pay;
- Provision of wholly gratuitous goods or services to at least 5% of those receiving goods or services from the institution;
- Provision of financial assistance or uncompensated goods or services to at least 20% of those receiving goods or services. At least 10% of the individuals must pay no fees or fees which are 90% or less the cost of the goods or services;

[17] Effective December 1997

[18] 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. Section 5(e)(5). Presumably, the various Blue Cross Blue Shield plans of Pennsylvania would not be considered an IPPC as they do not fit into any of these categories. § 375(e)(5).

- Provision of uncompensated goods or services that are equal to at least 5% of the institution's costs of providing goods or services;
- Provision of goods or services at no fee or reduced fees to government agencies or individuals eligible for government programs and;
- Fundraising on behalf of or providing grants to an IPPC.

REQUIRED FREE CARE[19]: Free care is required.

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: Free care in accordance with guidelines explained in 'Examples of Community Benefits,' above.

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.[20]

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.

[19] See 35 Penn. Stat. § 5701.1101 et. seq. for more information about how charity care is provided.
[20] The annual report must contain detailed tax information.

12. RHODE ISLAND

CITATION: R.I. GEN. LAWS § 23-17.14 – 19; 23-17-43

TERMINOLOGY: Charity and uncompensated care.

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:** Not defined.

PUBLIC RECORDS: No requirement.

PUBLIC INPUT: No requirement.

EXAMPLES OF COMMUNITY BENEFITS: No examples.

REQUIRED FREE CARE: Not required.[21]

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: A community benefits plan is not required.

REPORTING:
Before March 1st of each calendar year, all hospitals must file a detailed description with supporting documentation of: (1) charity and uncompensated care provided; (2) hospital bad debt; (3) contracted Medicaid shortfalls.

[21] 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 state hospitals. See R.I. GEN. LAWS § 23-17-43.

COMMUNITY HEALTH NEEDS ASSESSMENT: Not required.

MISSION STATEMENT: N/A

PENALTIES FOR NONCOMPLIANCE: A license may be suspended or revoked if the annual report is not submitted.

13. TEXAS

COMMUNITY BENEFITS CITATION: TEX. HEALTH & SAFETY CODE ANN. § 311.042, et. seq.

COMMUNITY BENEFITS TERMINOLOGY: Community Benefits.

REGULATORY OVERSIGHT: Department of Health, Bureau of State Health Data and Policy Analysis (www.tdh.texas.gov/data.htm).

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…include[ing] 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[22]: 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;
- 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 CB plan;
- The amount and types of CB, 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: Required. 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, DOH may fine the hospital $1,000 for each day the report is not filed.

[22] See TX Health and Safety Code §311.031m et. seq.; TX tax Code § 11.801, et. seq.; TX Health and Safety Code §61.001, et. seq.

14. Utah

CITATION: Nonprofit Hospital and Nursing Home Charitable Property Tax Exemption Standards Utah State Tax Commission
Also see UTAH CODE ANN. § 59-2-1101 (2002)

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. A hospital will only be exempt from taxation is if it satisfies the "charitable purposes test." William Budge Mem. Hosp. v. Maughan, 3 P. 2d 258 (Utah 1932). This test is codified in Utah State Tax Commission Nonprofit and Nursing Home Charitable Tax Exemption Standards ("Standards"), which explains the requirement that a tax-exempt entity provide substantial "gifts to the community."

TERMINOLOGY: Gifts to the Community.

REGULATORY OVERSIGHT: State Tax Commission. (www.tax.ex.state.ut.us/)

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 statute provides 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." Utah County v. Intermountain Health Care, Inc. 709 P. 2d 265, 269 (Utah 1985)

PUBLIC RECORD: No provision

PUBLIC INPUT: No provision.

EXAMPLES OF "GIFTS TO THE COMMUNITY":

- 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[23]: 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: An annual report is required.
The Annual report should include:

- 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.

[23] See Utah Code § 63-55-226.

15. WEST VIRGINIA

CITATION: W.VA. CODE STATE R. § 110-3-24 (2003)[24]
Also see W.VA. STAT. § 11-3-9 (2003)

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 RECORDS: 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.

[24] West Virginia's community benefits law first became effective July 1, 1990.

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.[25]

REQUIRED ELEMENTS OF COMMUNITY BENEFITS PLAN: No required elements.

ANNUAL REPORT: 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.

[25] 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;
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.

ARIZONA

Arizona does not have a statute governing the provision of community benefits but defines community benefits in the state's hospital conversion statute as follows:

"Community benefit activity means any activity furthering community benefit purposes including any health care activity that includes education, prevention, promotion of community health, indigent care or any other charitable purpose." Az. Rev. Stat. § 10-11251.

For more information about the provision of free care in Arizona, see Az. Rev. Stat. § 11-291 et. seq.

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 synonomous 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 hospital services, it may be worthwhile to cross-reference a state's free care legislation in the Community Catalyst Free Care Compendium.

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

47. Alabama
48. Alaska
49. Arizona
50. Arkansas
51. California
52. Colorado
53. Connecticut
54. Delaware
55. Florida
56. Georgia
57. Hawaii
58. Idaho
59. Illinois
60. Indiana
61. Iowa
62. Kansas
63. Kentucky
64. Louisiana
65. Maine
66. Maryland
67. Massachusetts
68. Michigan
69. Minnesota
70. Mississippi
71. Missouri
72. Montana
73. Nebraska
74. Nevada
75. New Hampshire
76. New Jersey
77. New Mexico
78. New York
79. North Carolina
80. North Dakota
81. Ohio
82. Oklahoma
83. Pennsylvania
84. Rhode Island
85. South Carolina
86. South Dakota
87. Tennessee
88. Texas
89. Utah
90. Washington
91. West Virginia
92. Wisconsin

District of Columbia