

## **Survey of State Laws/Oversight related to Community Health Needs Assessments and Implementation Strategies**

A provision in the March 2010 Patient Protection and Affordable Care Act requires tax-exempt hospitals to conduct a community health needs assessment every three years and to adopt an implementation strategy. The Catholic Health Association (CHA) surveyed state laws, regulations or guidance to identify states that already mandate similar provisions. CHA identified states which mandate in differing levels of specificity community health needs assessments and subsequent implementation strategies.

The table below describes the state provisions based on the following questions:

### Community Health Needs Assessments

- Is the hospital required to have a process in place to assess community needs?
- How often is the hospital required to conduct the needs assessments?
- Does the hospital have the option to conduct the assessment on its own?
- Does the hospital have the option to conduct the assessment with other organizations?
- Is the hospital required to include community input in the assessment?
- Does the assessment have to focus on vulnerable populations?
- Is the hospital required to give priority to public health needs identified by the state?
- Is the hospital required to publicize the results of the assessment?

### Implementation Strategies

- Does the plan need to identify target populations?
- Does the plan need to list activities and their objectives?
- Is the hospital required to give a budget for community benefit?
- Does the plan need to include mechanisms for evaluating effectiveness?
- Is there a requirement for public input or involvement?
- Does the plan need to be available to the public and/or state?
- Is organizational board approval required?

This information is what is currently known as of August 2010 and subject to change. It is advised that hospitals speak directly with the oversight authority in their respective states during the course of community benefit planning and implementation to assure accurate interpretation of the state mandated or voluntary reporting requirements.

STATE/ Provisions	CA	CT	ID	IL	IN	MA	MD	NH	NY	RI	TX	UT
<b>Community Needs Assessment</b>												
Have a process in place	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Timeline	@ 3 yrs					@ 3 yrs.		@ 5 yrs.	@ 3 yrs.			
Option to do alone	✓						✓	✓				
Option to do with others	✓						✓	✓	✓			
Requires community input	✓	✓				✓		✓	✓		✓	
Focus on vulnerable populations		✓				✓	✓					
Give priority to public health needs		✓				✓	✓		✓	✓		
Must publicize results		✓		✓			✓					
<b>Implementation Strategy</b>			na									na
Identify target populations	✓	✓		✓	✓	✓				✓		
List activities & objectives	✓	✓		✓	✓	✓		✓	✓	✓	✓	
Give budget	✓	✓			✓	✓		✓	✓	✓	✓	
Mechanisms to evaluate plan's effectiveness	✓	✓			✓		✓	✓	✓	✓	✓	
Opportunity for public input or involvement	✓	✓			✓			✓				
Make available to public and/or state annually	✓	✓		✓				✓	✓			
Org. board oversight									✓	✓		

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**California SB 697 (Chapter 812, Statutes of 1994)**Section 127345

(a) “Community benefits plan” means the written document prepared for annual submission to the Office of Statewide Health Planning and Development that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken in order to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community.

(d) “Community needs assessment” means the process by which the hospital identifies, for its primary service area as determined by the hospital, unmet community needs.

(e) “Community needs” means those requisites for improvement or maintenance of health status in the community.

Section 127350 Each hospital shall do all of the following:

(b) By January 1, 1996, complete, either alone, in conjunction with other health care providers, or through other organizational arrangements, a community needs assessment evaluating the health needs of the community serviced by the hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement. The community needs assessment shall be updated at least once every three years.

(c) By April 1, 1996, and annually thereafter adopt and update a community benefits plan for providing community benefits either alone, in conjunction with other health care providers, or through other organizational arrangements.

(d) Annually submit its community benefits plan, including, but not limited to, the activities that the hospital has undertaken in order to address community needs within its mission and financial capacity to the Office of Statewide Health Planning and Development. The hospital shall, to the extent practicable, assign and report the economic value of community benefits provided in furtherance of its plan. Effective with hospital fiscal years, beginning on or after January 1, 1996, each hospital shall file a copy of the plan with the office not later than 150 days after the hospital’s fiscal year ends. The reports filed by the hospitals shall be made available to the public by the office. Hospitals under the common control of a single corporation or another entity may file a consolidated report.

Section 127355 The hospital shall include all of the following elements in its community benefits plan:

(a) Mechanisms to evaluate the plan’s effectiveness including, but not limited to, a method for soliciting the views of the community served by the hospital and identification of community groups and local government officials consulted during the development of the plan.

(b) Measurable objectives to be achieved within specified timeframes.

(c) Community benefits categorized into the following framework:

- (1) Medical care services.
- (2) Other benefits for vulnerable populations.
- (3) Other benefits for the broader community.
- (4) Health research, education, and training programs.
- (5) Nonquantifiable benefits.

**Connecticut General Statute, Section 19a-127k, *The Reporting of Community Benefit Programs by Managed Care Organizations and Hospitals.***

(a)(4)(c) A managed care organization or hospital may develop community benefit guidelines intended to promote preventive care and to improve the health status for working families and populations at risk, whether or not those individuals are enrollees of the managed care plan or patients of the hospital. The guidelines shall focus on the following principles:

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

(4) Developing its program based upon an assessment of the health care needs and resources of the targeted populations, particularly low and middle-income, medically underserved populations and barriers to accessing health care, including, but not limited to, cultural, linguistic and physical barriers to accessible health care, lack of information on available sources of health care coverage and services, and the benefits of preventive health care.

(d) Each managed care organization and each hospital that chooses to participate in developing a community benefits program shall include in the annual report required by subsection (b) of this section the status of the program, if any, that the organization or hospital established. If the managed care organization or hospital has chosen to participate in a community benefits program, the report shall include the following components: (1) The community benefits policy statement of the managed care organization or hospital; (2) the mechanism by which community participation is solicited and incorporated in the community benefits program; (3) identification of community health needs that were considered in developing and implementing the community benefits program; (4) a narrative description of the community benefits, community services, and preventive health education provided or proposed, which may include measurements related to the number of people served and health status outcomes; (5) measures taken to evaluate the results of the community benefits program and proposed revisions to the program; (6) to the extent feasible, a community benefits budget and a good faith effort to measure expenditures and administrative costs associated with the community benefits program, including both cash and in-kind commitments; and (7) a summary of the extent to which the managed care organization or hospital has developed and met the guidelines listed in subsection (c) of this section. Each managed care organization and each hospital shall make a copy of the report available, upon request, to any member of the public.

**Idaho 63-602D.PROPERTY EXEMPT FROM TAXATION -- CERTAIN HOSPITALS.**

(7) A hospital corporation issued an exemption from property taxation pursuant to this section and operating a hospital having one hundred fifty (150) or more patient beds shall prepare a community benefits report to be filed with the board of equalization by December 31 of each year. The report shall itemize the hospital's amount of unreimbursed services for the prior year (including charity care, bad debt, and under reimbursed care covered through government programs); special services and programs the hospital provides below its actual cost; donated time, funds, subsidies and in-kind services; additions to capital such as physical plant and equipment; and *indication of the process the hospital has used to determine general community needs which coincide with the hospital's mission.* The report shall be provided as a matter of community information. Neither the submission of the report nor the contents shall be a basis for the approval or denial of a corporation's property tax exemption.

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**Illinois Public Act 94-0480 Effective 8/8/2003**

Section 15 Organizational mission statement; community benefits plan.

A nonprofit hospital shall develop:

(2.) a community benefits plan defined as an operational plan for serving the community's health care needs that:

- (A) sets out goals and objectives for providing community benefits that include charity care and government sponsored indigent health care; and
- (B) identifies the populations and communities served by the hospital.

Section 20 Annual report for community benefits plan.

(a) Each nonprofit hospital shall prepare an annual report of the community benefits plan. The report must include in addition to the community benefits plan itself, all of the following background information:

(2) A disclosure of the health care needs of the community that were considered in developing the hospital's community benefits plan.

(b) Each nonprofit hospital shall annually file a report of the community benefits plan with the Attorney General. The report must be filed not later than the last day of the sixth month after the close of the hospital's fiscal year, beginning with the hospital fiscal year that ends in 2004.

(c) Each nonprofit hospital shall prepare a statement that notifies the public that the annual report of the community benefits plan is:

- (1) public information;
- (2) filed with the Attorney General; and
- (3) available to the public on request from the Attorney General.

This statement shall be made available to the public.

Section 25. Failure to file annual report. The Attorney General may assess a late filing fee against a nonprofit hospital that fails to make a report of the community benefits plan as required under this Act in an amount not to exceed \$100. The Attorney General may grant extensions for good cause. No penalty may be assessed against a hospital under this Section until 30 business days have elapsed after written notification to the hospital of its failure to file a report.

**Indiana IC 16-21-9 Provision of Charitable Care by Nonprofit Hospitals**

IC 16-21-9-4

Organizational mission statement; community benefits plan

Sec. 4. A nonprofit hospital shall develop:

(1) an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community; and

(2) a community benefits plan defined as an operational plan for serving the community's health care needs that:

- (A) sets out goals and objectives for providing community benefits that include charity care and government sponsored indigent health care; and
- (B) identifies the populations and communities served by the hospital.

*As added by P.L.94-1994, SEC.17.*

IC 16-21-9-5 Health care needs of community

Sec. 5. When developing the community benefits plan, the hospital shall consider the health care needs of the community as determined by communitywide needs assessments. *As added by P.L.94-1994, SEC.17.*

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**(Indiana continued)****IC 16-21-9-6**

## Elements of community benefits plan

Sec. 6. The hospital shall include at least the following elements in the community benefits plan:

- (1) Mechanisms to evaluate the plan's effectiveness, including a method for soliciting the views of the communities served by the hospital.
- (2) Measurable objectives to be achieved within a specified time frame.
- (3) A budget for the plan.

**Maryland Health General §19-303, Maryland Annotated Code 2001**

## Narrative reporting requirements:

2. Describe the community your organization serves. The narrative should address the following topics:

- Describe the geographic community or communities the organization serves;
- Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet. (e.g., population, average income, percentages of community households with incomes below the federal poverty guidelines, percentage of the hospital's patients who are uninsured or Medicaid recipients, [concentrations of vulnerable populations] and life expectancy or mortality rates);

3. Identification of Community Needs:

a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done

*The following are examples of how community health needs might have been identified:*

- Used formal needs assessment developed by the state or local health department. If so, indicate the most recent year;
- Formal needs assessment was done by the hospital. If so, indicate the most recent year and the methods used;
- Did formal collaborative needs assessment involving the hospital. If so, indicate the most recent year, the collaborating organizations, and methods used;
- Analyzed utilization patterns in the hospital to identify unmet needs;
- Surveyed community residents, and if so, indicate the date of the survey;
- Used data or statistics compiled by county, state, or federal government;
- Consulted with leaders, community members, nonprofit organizations, local health officers, or local health care providers (indicate who was consulted, when, and how many meetings occurred, etc.);

b. In seeking information about community health needs, did you consult with the local health department?

4. Please list the major needs identified through the process explained question #3.

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major Community Benefit program initiatives.

8. Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

9. If you list Physician Subsidies in your data, please provide detail.

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**Massachusetts Attorney General Guidelines - revised 2009**

The hospital should collect data to determine unmet health care needs in the hospital's community from a variety of sources and inventory programs currently available to address those needs. The hospital should collect information from publicly available sources such as the Department of Public Health, local cities and towns other state and federal agencies, private foundations and universities (see Appendix IV- Community Health Needs Assessment Resources- sources of data). The hospital should gather information from a wide array of community members.

Since the Needs Assessment process should strive to uncover the unmet health care needs of community members, it is important that the hospital make every effort to make members of the community feel safe and comfortable providing feedback about their needs.

Health Needs

In reviewing the health needs of its community, the hospital should pay special attention to disadvantaged populations as these populations should be the targets of all community benefits programs. For example, disadvantaged populations include the medically underserved, the uninsured, those burdened with medical debt, the elderly, poor, racial, linguistic, ethnic minorities, refugees and immigrants, the gay, lesbian, bisexual, and transgender population, and victims of domestic violence.

In consideration of state-wide health priorities, the Attorney General recommends that hospitals also consider the needs of people in their communities who suffer from chronic diseases and face health disparities.

Collection Methods/Community Input

The hospital should collect information directly from the Target Population whenever possible. The Assessment process should include community representatives from outside the hospital, including community leaders, representatives from other health care and service providers, and members of the disadvantaged population(s).

The process for identifying these needs should be as open and inclusive as possible. Hospitals should encourage feedback from their communities by providing a safe and accessible way for community organizations and members to offer feedback on community benefits programs.

The needs assessment should be based in part on public health data and other existing health status indicators from the hospital's service area. These data are available from public and private entities, such as the Department of Public Health, the Department of Mental Health, and the Division of Health Care Finance and Policy. Additionally, the hospital should look internally at its own data when examining community needs. Please see Appendix IV Community Health Needs Assessment Resources for more information. (sources of data)

A Community Health Needs Assessment should take place at least once every three years.

In addition, the hospital is encouraged to initiate a formal process, such as an annual public hearing or other mechanism, to solicit the views of community members. At such public events, the hospital might wish to invite the participation of local and state public health departments or other public and private agencies that provide information or that coordinate resources to achieve public health objectives.

**(Massachusetts continued)**

The Community Benefits Plan is a blueprint for how the hospital plans to accomplish its Mission. The three key elements of a Community Benefits Plan are:

1. Target Population(s)
2. Programs to address the needs of each of the Target Populations and goals associated with each of the Programs
3. Budget for Plan

**New Hampshire Title 1 Chapter 7 Community Benefits**

7:32-c Community involvement in the development of community benefits plans is necessary to make the health care charitable trusts more responsive to the true needs of the community. State oversight of the planning process and public access to the community benefits plans will assure appropriate use of the resources of health care charitable trusts.

7:32-d IV. "'Community benefits plan" means a written document prepared by a health care charitable trust which identifies health care needs in the area served by the trust and describes the activities the trust has undertaken and will undertake to address the identified needs.

7:32-e Community Benefits Plans. 1999, 312:1, eff. Jan. 1, 2000.

Within 90 days of the start of its fiscal year every health care charitable trust shall develop a community benefits plan. The plan shall be developed in accordance with the following criteria on forms supplied by the attorney general:

I. The trust shall adopt a mission statement which shall be included in its plan and which shall be reaffirmed by the trust on an annual basis.

II. The plan shall take into consideration a community needs assessment conducted in accordance with RSA 7:32-f and shall identify the health care needs that were considered in development of the plan.

III. The plan shall identify the activities the trust expects to undertake or support which address the needs determined through the community needs assessment process or which otherwise qualify as community benefits and shall include all charity care in a discrete category.

IV. The plan shall include a report on the community benefit activities undertaken by the trust in the preceding year and information describing the results or outcomes of the trust's community benefit activities. The report shall also include the means used to solicit the views of the community served by the trust, identification of community groups, members of the public, and local government officials consulted on the development of the plan, and an evaluation of the plan's effectiveness.

V. (a) To the extent practicable, the plan shall include:

- (1) An estimate of the cost of each activity expected to be undertaken or supported in the ensuing year; and
  - (2) A report on the unreimbursed cost of each activity undertaken in the preceding year.
- (b) For reporting purposes, the cost of contributed services shall be determined in accordance with the rates, costs, units of service, or other statistical measures used for general accounting purposes by the health care charitable trust. In addition, each charitable trust shall include in its report the ratio of its gross receipts from operations to its net operating costs, as shown in its final statement of accounts for the preceding fiscal year.

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**(New Hampshire continued)**

VI. 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 into development of the plan and comment upon the trust's proposed plan.

7:32-f Community Needs Assessments 1999, 312:1, eff. Jan. 1, 2000. 2004, 213:2, eff. Aug. 10, 2004.

Every health care charitable trust shall, either alone or in conjunction with other health care charitable trusts in its community, conduct a community needs assessment to assist in determining the activities to be included in its community benefits plan. The needs assessment process shall include consultation with members of the public, community organizations, service providers, and local government officials in the trust's service area, in the identification and prioritization of community needs that the health care charitable trust can address directly, or in collaboration with others. The community needs assessment shall be updated at least every 5 years.

7:32-g Notice to Director of Charitable Trusts and Public; Administrative Fine. 1999, 312:1. 2001, 205:1, eff. July 11, 2001.

I. Every health care charitable trust shall submit its community benefits plan to the director of charitable trusts on an annual basis no later than 90 days after the start of the trust's fiscal year. The trust and the director of charitable trusts shall make all community benefits plans available to the public and, where practicable, shall place the reports on an internet site or web page. Every health care charitable trust shall at least annually provide notice to the public of the availability and process for obtaining a copy of its community benefits plan and shall prominently display such notice in its lobby, waiting rooms, or other area of public access.

II. An extension of time for filing the community benefits plan may be granted by the director, for a period of time not to exceed 12 months.

III. The director may impose an administrative fine upon a charitable organization that violates any provision of RSA 7:32-g, I, in an amount not to exceed \$1,000 plus attorneys fees and costs for each such violation.

7:32-l Combined Needs Assessments, Planning, Reporting. 1999, 312:1, eff. Jan. 1, 2000.

Health care charitable trusts may satisfy the requirements of RSA 7:32-e, RSA 7:32-f, and RSA 7:32-g, individually or in a combination with other health care charitable trusts, provided that information required to be reported under RSA 7:32-e, V(a) and (b) shall be specifically reported for each health care charitable trust participating in a combined plan or report.

**New York NYS Public Health Law Section 2803-1 § 2803-l. Community Service Plans.**

1. The governing body of a voluntary non-profit general hospital must issue an organizational mission statement identifying at a minimum the populations and communities served by the hospital and the hospital's commitment to meeting the health care needs of the community
2. The governing body must at least every three years:
  - (i) review and amend as necessary the hospital mission statement;
  - (ii) solicit the views of the communities served by the hospital on such issues as the hospital's performance and service priorities;

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**(New York continued)**

- (iii) demonstrate the hospital's operational and financial commitment to meeting community health care needs, to provide charity care services and to improve access to health care services by the underserved; and
  - (iv) prepare and make available to the public a statement showing on a combined basis 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.
3. The governing body must at least annually prepare and make available to the public an 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 by the underserved.
4. The governing body shall file with the commissioner its mission statement, its annual implementation report, and at least every three years a report detailing amendments to the statement and reflecting changes in the hospital's operational and financial commitment to meeting the health care needs of the community, providing charity care services, and improving access to health care services by the underserved.

**Rhode Island Statewide Standards for the Provision of Community Benefit Rhode Island General Laws 42-35-4.1****11.5 Provision of Community Benefit**

b) On and after January 2001, each licensed hospital shall have a formal, Board-approved plan for the provision of community benefits. This plan shall be updated and Board-approved, at a minimum, every three (3) years. This plan shall incorporate, at a minimum, the following principles:

- 1) The governing body shall adopt/affirm and make public a community benefits mission statement setting forth the hospital's commitment to a formal community benefits plan;
- 2) The governing body, the chief executive officer, and senior management shall be responsible for the oversight of the development and implementation of the community benefits plan, the methods to be followed, the resources to be allocated, and the mechanism for regular evaluation of the plan on no less than an annual basis;
- 3) The governing body shall 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;
- 4) The community benefits plan shall include a comprehensive assessment of the health care needs of the identified community or communities, which shall include, but not be limited to, needs related to the goals articulated in *A Healthier Rhode Island by 2010: A Plan for Action* of reference 2, as well as a statement of priorities consistent with the hospital's resources; and
- 5) The community benefits plan shall specify the actual or planned dates for implementation of the activities and/or proposals included therein.

**Texas Sec. 311.044. COMMUNITY BENEFITS PLANNING BY NONPROFIT HOSPITALS.**

- (a) A nonprofit hospital shall develop:
- (1) an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community; and
  - (2) a community benefits plan defined as an operational plan for serving the community's health care needs that sets out goals and objectives for providing community benefits that include charity care and government-sponsored indigent health care, as the terms community benefits, charity care, and government-sponsored indigent health care are defined by Sections 311.031 and 311.042, and that identifies the populations and communities served by the hospital.
- (b) When developing the community benefits plan, the hospital shall consider the health care needs of the community as determined by community-wide needs assessments. For purposes of this subsection, "community" means the primary geographic area and patient categories for which the hospital provides health care services; provided, however, that the primary geographic area shall at least encompass the entire county in which the hospital is located.
- (c) The hospital shall include at least the following elements in the community benefits plan:
- (1) mechanisms to evaluate the plan's effectiveness, including but not limited to method for soliciting the views of the communities served by the hospital;
  - (2) measurable objectives to be achieved within a specified time frame; and
  - (3) a budget for the plan.
- (d) In determining the community-wide needs assessment required by Subsection (b), a nonprofit hospital shall consider consulting with and seeking input from representatives of the following entities or organizations located in the community as defined by Subsection (b):
- (1) the local health department;
  - (2) the public health region under Chapter 121;
  - (3) the public health district;
  - (4) health-related organizations, including a health professional association or hospital association;
  - (5) health science centers;
  - (6) private business;
  - (7) consumers;
  - (8) local governments; and
  - (9) insurance companies and managed care organizations with an active market presence in the community.
- (e) Representatives of a nonprofit hospital shall consider meeting with representatives of the entities and organizations listed in Subsection (d) to assess the health care needs of the community and population served by the nonprofit hospital.

**Utah Nonprofit Hospital and Nursing Home Charitable Property Tax Standards**

Effective: 1990 Issued by: The Utah State Tax Commission

**NEEDS ASSESSMENT:** Each nonprofit hospital and nursing home must annually consult with county officials to assess community needs that may be addressed.

**CHARITY PLAN:** Each nonprofit hospital and nursing home must develop a charity plan that addresses its open access policy and procedure for integrating the public interest in its policies.

**PENALTY FOR NONCOMPLIANCE:** A nonprofit hospital or nursing home that does not comply with the requirements of the statute is not eligible for state property tax exemption.

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