COMMUNITY CATALYST

The Health Care Institution Responsibility Model Act[1]

Digest

100. **Legislative Findings; Intent**

100.1 The legislature finds that access to health care services is of vital concern to the people of this State.

100.2 The legislature further finds that health care services providers play an important role in providing essential health care services in the communities they serve. In addition, insurers have become a dominant force affecting the provision of health care based on their ability to control reimbursement rates and make purchasing decisions on behalf of large patient populations. The legislature therefore also finds that insurers play an important role in providing essential health care services in the communities they serve.

100.3 Notwithstanding public and private efforts to increase access to health care, the people of this State continue to have tremendous unmet health needs. Studies suggest that as many as [number] or [percent] of the State's residents are uninsured or underinsured.

100.4 The legislature further concludes that licensing privileges conveyed by this state to health care institutions for the right to conduct intrastate business should be accompanied by concomitant obligations to address unmet health care needs. These obligations should be clearly delineated.

100.5 The State has a substantial interest in assuring that the unmet health needs of its residents are addressed. Health care institutions can help address these needs by providing community benefits to the uninsured and underinsured members of their communities.

100.6 Community benefits should become a recognized and accepted obligation of all health care institutions in this State. Accordingly, every health care services provider that receives a license under section [cross reference with the health care services provider licensing section of the code] and every insurer that receives a certificate of authority under section [cross reference with the insurance certificate of authority section of the code] must provide community benefits in a manner set forth in this Act.

[1] Wherever an asterisk (*****) appears, readers are advised to consult the accompanying commentary for further discussion.

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101. Definitions

101.1 As used in this Act, the following terms have the following meanings:

(a) "Administration" means the [state] Insurance Administration. *****

(b) "Bad debt" means the unpaid accounts of any individual who has received medical care or is financially responsible for the cost of care rendered to another, where such individual has the ability to pay, and has refused to pay. *****

(c) "Community" means the geographic service area(s) and patient population(s) that the health care institution serves. *****

(d) "Community benefits" means the unreimbursed goods, services and resources provided by health care institutions that address community-identified health needs and concerns, particularly of those who are uninsured or underserved. Community benefits include but are not limited to the following:

1. Free care; *****
2. Public education and other programs relating to preventive medicine or the public health of the community;
3. Health or disease screening programs;
4. Free or below-cost prescription drugs;
5. Transportation services;
6. Poison control centers;
7. Donated medical supplies and equipment;
8. Unreimbursed costs of providing services to persons participating in any government-subsidized health care program; *****
9. Free or below-cost blood banking services;
10. Free or below-cost assistance, material, equipment, and training to EMS and ambulance services;
11. The costs to implement a basic enrollment program that provides a package of primary care services to uninsured members of the community; and
12. Health research, education and training programs, provided that they are related to identified community health needs. *****

(e) "Department" means the [state] Department of Health. *****

(f) "Free Care" means care provided by a health care services provider to patients unable to pay and for which the provider has no expectation of payment from the patient or from any third-party payer, and as further defined in §106 of this Act. *****

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(g) "Health Care Institution" means health care services providers and insurers jointly, as defined by this Act. *****

(h) "Health Care Services Provider" has the meaning stated in section [ ] of the [state health code]. *****

(i) "Insurer" means an entity [under state code section] that pays for or arranges for the purchase of health care services provided by acute health care services providers. The term "insurer" shall not include [the state Medicaid program], other governmental programs of public assistance and their beneficiaries or recipients, and the workers compensation program established pursuant to [state code section or chapter]. *****

(j) "Person" means any individual, partnership, corporation, association, joint venture, insurance company, or other organization.

102. Community Benefits; Basic Requirements

102.1 Each health care services provider that receives a license from this State shall provide community benefits to the community or communities it serves.

102.2 Each insurer that receives a certificate of authority from this State shall provide community benefits to the community or communities it serves.

102.3 Within eighteen months from the day this Act is signed into law, each health care institution shall develop in collaboration with the community:

(a) An organizational mission statement that identifies the institution's commitment to developing, adopting, and implementing a community benefits program; *****
(b) A description of the process for approval of the mission statement by the health care institution's governing board;
(c) A declaration that senior management of the health care institution will be responsible for oversight and implementation of the community benefits plan;
(d) A community health assessment that evaluates the health needs and resources of the community it serves;
(e) A community benefits plan designed to achieve the following outcomes:
  (1) increase access to health care for members of the target community or communities;
  (2) address critical health care needs of members of the target community or communities; and
  (3) foster measurable improvements in health for members of the target community or communities.

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103. The Community Health Assessment *

103.1 Prior to adopting a community benefits plan every health care institution subject to this Act shall identify and prioritize the health needs of the community it serves. It shall also identify health resources within the community. As part of the assessment, the health care institution shall solicit comment from and meet with community groups, local government officials, health related organizations, and health care providers, with particular attention given to those persons who are themselves underserved and those who work with underserved populations.

103.2 The Department shall compile available public health data, including statistics on the state's unmet health care needs. In preparing its community health assessment, a health care institution shall use available public health data.

103.3 Health care institutions are encouraged to collaborate with other health care institutions in conducting community health assessments and may make use of existing studies and plans in completing their own community health assessments.

103.4 Prior to finalizing the community health assessment, each health care institution shall make available to the public a copy of the community health assessment for review and comment.

103.5 Once finalized, the community health assessment shall be updated at least every three years.

104. The Community Benefits Plan *

104.1 Every health care institution shall adopt, annually, a plan for providing community benefits.

104.2 The community benefits plan shall be drafted with input from the community as provided for in Section 103.1 of this Act.

104.3 The community benefits plan shall include, at a minimum:

(a) a list of the services the health care institution intends to provide in the following year to address community health needs identified in the community health assessment. The list of services shall be categorized under:

1. Free care;
2. Other services for vulnerable populations;
3. Health research, education and training programs;

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4. Community benefits that address public health needs; and
5. Nonquantifiable services, such as local governance and preferential hiring policies that benefit those who are uninsured or underserved.

(b) a description of the target community or communities that the plan is intended to benefit;
(c) an estimate of the economic value of the community benefits that the health care entity intends to provide under the plan;
(d) a report summarizing the process used to elicit community participation in the community health assessment and community benefits plan design, and ongoing implementation and oversight;
(e) a list of individuals, organizations, and government officials consulted during development of the plan and a description of any provisions made for the promotion of ongoing participation by community members in the implementation of the plan;
(f) a statement identifying the health care needs of the communities that were considered in developing the plan;
(g) a statement describing the intended impact on health outcomes attributable to the plan, including short and long-term measurable goals and objectives;
(h) mechanisms to evaluate the plan's effectiveness, including a method for soliciting comments by community members; and
(i) the name and title of the person who shall be responsible for implementing the community benefits plan.

104.4 Each health care services provider shall submit its community benefits plan to the Department prior to implementation.

104.5 Each health care services provider shall make its community benefits plan available to the public for review and comment prior to implementation.

104.6 Each insurer shall submit its community benefits plan to the Administration prior to implementation.

104.7 Each insurer shall make its community benefits plan available to the public for review and comment prior to implementation.

104. Annual Report *

105.1 Within 120 days of the end of the health care services provider's fiscal year, each health care services provider shall submit to the Department an annual report detailing its community benefits efforts in the preceding calendar year. The annual report shall include:

(a) the health care services provider's mission statement;

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(b) the amounts and types of community benefits provided, listed in categories provided in §104.3(a), provided on a form to be developed by the Department;
(c) a statement of the health care services provider's impact on health outcomes attributable to the plan, including a description of the health care services provider's progress toward meeting its short and long-term goals and objectives;
(d) an evaluation of the plan's effectiveness, including a description of the method by which community members' comments have been solicited; and
(e) the health care services provider's audited financial statement.

105.2 Each health care services provider shall prepare a statement announcing that its annual community benefits report is available to the public. The statement shall be posted in prominent locations throughout the health care services provider, including the emergency room waiting area, the admissions waiting area, and the business office. The statement shall also be included in any written material that discusses the admissions or free care criteria of the health care services provider. A copy of the report shall be given free of charge to anyone who requests it. *****

105.3 Information provided in accordance with §105.1(b) shall be calculated in accordance with generally accepted accounting standards. This information shall be calculated for each individual health care services provider within a system and not on an aggregate basis, though both calculations may be submitted. Each health services provider shall also file a calculation of its cost-to-charge ratio with its annual report.*****

105.4 Within 120 days of the end of the insurer's fiscal year, each insurer shall submit to the Administration an annual report detailing its community benefits efforts in the preceding calendar year. The annual report shall include:

(a) the insurer's mission statement;
(b) the amounts and types of community benefits provided, listed in categories provided in §104.3(a), provided on a form to be developed by the Administration;
(c) a statement of the insurer's impact on health outcomes attributable to the plan, including a description of the insurer's progress toward meeting its short and long-term goals and objectives;
(d) an evaluation of the plan's effectiveness, including a description of the method by which community members' comments have been solicited; and
(e) the insurer's audited financial statement.

105.5 Each insurer shall prepare a statement announcing that its annual community benefits report is available to the public. The statement shall be posted in the

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insurer's business offices. The statement shall also be mailed to each subscriber. A copy of the report shall be given free of charge to anyone who requests it. *****

105.6 Information provided in accordance with §105.4(b) shall be calculated in accordance with generally accepted accounting standards. This information shall be calculated for each individual insurer within a system and not on an aggregate basis, though both calculations may be submitted. Each insurer shall also file a calculation of its cost-to-charge ratio with its annual report. *****

105.7 Any person who disagrees with a community benefits report may file a dissenting report with the Department or with the Administration, as appropriate. Dissenting reports shall be filed within sixty (60) days of the filing of the community benefits report and shall become public records. *****

105. Free Care *

106.1 Every health care services provider that provides free care in full or partial fulfillment of its community benefits obligation shall develop a written notice describing its free care program and explaining how to apply for free care. The notice shall be in appropriate languages and conspicuously posted throughout the health care services provider facility, including the general waiting area, the emergency room waiting area, and the business office.

106.2 Every health care services provider that provides free care in full or partial fulfillment of its community benefits obligation shall report the value of such care, provided that the value of such care does not include any bad debt costs.

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106. Subsidized Care; Sliding Scale Fees *

107.1 In determining sliding scale fees or other payment schedules for uninsured persons, health care services providers should base such fees on the income of the uninsured person.

107.2 Where the sliding scale fee is below actual costs, the health care services provider may include the difference in its community benefits computation.

107. Monitoring and Enforcement of Health Care Services Provider Community Benefits *

108.1 The Department shall assess a penalty of not less than $1000/day against any health care services provider that fails to file a community benefits plan or a timely annual community benefits report.

108.2 The Department shall revoke or decline to renew the license of any health care services provider that fails to provide community benefits as required by this Act. The Department may issue a provisional license for a period of up to one year to any health care services provider that has had its license revoked or nonrenewed.

108.3 Before taking any punitive action, the Department must hold an adjudicative hearing, giving the affected parties at least fourteen (14) days notice. Any person who filed a dissenting report has standing to testify at the hearing. ***** Any punitive measures taken by the Department following the hearing shall be considered final action for purposes of appeal.

108.4 Any final action by the Department shall be subject to judicial review by the state superior court at the initiation of any person who participated in the adjudicative hearing.

108.5 The Department shall submit a report to the Legislature on September 1 of each year that contains the following:

(a) The name of each health care services provider, if any, that did not file a community benefits report in the preceding year;
(b) The name of each person who filed a dissenting report, and the substance of the complaint;
(c) A list of the most common activities performed by health care services providers in fulfillment of their community benefits obligation;
(d) The dollar value of the community benefits activities performed by health care services providers, expressed in both aggregate and individual terms; and
(e) The amount of net patient revenue for each health care services provider.

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108.6 The report referred to in section 108.5 of this Act shall be available to the public.

108.7 The Department shall promulgate rules and regulations necessary to effectuate this Act.

108. Monitoring and Enforcement of Insurer Community Benefits *

109.1 The Administration shall assess a penalty of not less than $1000/day against any insurer that fails to file a community benefits plan or a timely annual community benefits report.

109.2 The Administration shall revoke or decline to renew the certificate of authority of any insurer that fails to provide community benefits as required by this Act. The Administration may issue a provisional certificate of authority for a period of up to one year to any insurer that has had its certificate of authority revoked or nonrenewed.

109.3 Before taking any punitive action, the Administration must hold an adjudicative hearing, giving the affected parties at least fourteen (14) days notice. Any person who filed a dissenting report has standing to testify at the hearing. ***** Any punitive measures taken by the Administration following the hearing shall be considered final action for purposes of appeal.

109.4 Any final action by the Administration shall be subject to judicial review by the state superior court at the initiation of any person who participated in the adjudicative hearing.

109.5 The Administration shall submit a report to the Legislature on September 1 of each year that contains the following:

(a) The name of each insurer, if any, that did not file a community benefits report in the preceding year;
(b) The name of each person who filed a dissenting report, and the substance of the complaint;
(c) A list of the most common activities performed by insurers in fulfillment of their community benefits obligation;
(d) The dollar value of the community benefits performed by insurers, expressed in both aggregate and individual terms; and
(e) The amount of net premium revenue for each insurer.

109.6 The report referred to in section 109.5 of this Act shall be available to the public.

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109.7 The Administration shall promulgate rules and regulations necessary to effectuate this Act.

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