



AN ACT CONCERNING COMMUNITY BENEFIT PROGRAMS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 19a-127k of the general statutes is repealed and
2 the following is substituted in lieu thereof (*Effective October 1, 2003*):

3 (a) As used in this section:

4 (1) "Community benefits program" means any voluntary program to
5 promote preventive care and to improve the health status for working
6 families and populations at risk in the communities within the
7 geographic service areas of a managed care organization or a hospital
8 in accordance with guidelines established pursuant to subsection (c) of
9 this section;

10 (2) "Managed care organization" has the same meaning as provided
11 in section 38a-478;

12 (3) "Hospital" has the same meaning as provided in section 19a-490;
13 and

14 (4) "Commissioner" means the Commissioner of Public Health.

15 (b) On or before January 1, [2001, and annually] 2005, and biennially
16 thereafter, each managed care organization and each hospital shall
17 submit to the commissioner, or the commissioner's designee, a report

18 on whether the managed care organization or hospital has in place a
19 community benefits program. If a managed care organization or
20 hospital elects to develop a community benefits program, the report
21 required by this subsection shall comply with the reporting
22 requirements of subsection (d) of this section.

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

29 (1) Adoption and publication of a community benefits policy
30 statement setting forth the organization's or hospital's commitment to
31 a formal community benefits program;

32 (2) The responsibility for overseeing the development and
33 implementation of the community benefits program, the resources to
34 be allocated and the administrative mechanisms for the regular
35 evaluation of the program;

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

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

50 and the benefits of preventive health care. The program shall consider
51 the health care needs of a broad spectrum of age groups and health
52 conditions.

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

78 (e) The commissioner, or the commissioner's designee, shall develop
79 a summary and analysis of the community benefits program reports
80 submitted by managed care organizations and hospitals under this
81 section and shall review such reports for adherence to the guidelines
82 set forth in subsection (c) of this section. Not later than October 1,
83 [2001, and annually] 2005, and biennially thereafter, the commissioner,

