

Connecticut Hospital Regulation

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Issue

This report briefly summarizes how Connecticut's acute care hospitals are regulated. It also describes actions nonprofit acute care hospitals must take to maintain their 501(c)(3) tax-exempt status. It updates OLR Report [2013-R-0266](#).

Summary

Several state agencies provide oversight of Connecticut's acute care hospitals, including the departments of Public Health (DPH), Social Services (DSS), Consumer Protection, Energy and Environmental Protection, Labor, and Insurance. Hospitals are primarily regulated by DPH and DSS through licensure, the certificate of need (CON) process, data collection, and the disproportionate share hospital (DSH) program. (State psychiatric hospitals are exempt from DPH regulation and instead regulated by the Department of Mental Health and Addiction Services.)

Hospitals are also regulated by various federal agencies, including the Centers for Medicare and Medicaid Services (CMS), Occupational Safety and Health Administration, Centers for Disease Control and Prevention (CDC), and the Internal Revenue Service (IRS), among others. Most hospitals also comply with accreditation rules from private organizations, such as the [Joint Commission](#), to receive Medicare and Medicaid certification (i.e., deemed status).

In Connecticut and most other northeastern states, the vast majority of hospitals are nonprofit. To qualify for tax-exempt status, nonprofit hospitals must meet various requirements under federal law, including, among other things, (1) being organized and operated exclusively for charitable or other specified purposes, (2) having no net earnings benefitting any private shareholder or individual, (3) restricting political activity, and (4) providing community benefits sufficient to justify their tax-exempt status.

The 2010 federal Patient Protection and Affordable Care Act (ACA) added to the requirements for nonprofit hospitals to maintain their nonprofit status. Specifically, it requires nonprofit hospitals to conduct community health needs assessments at least once every three years and make the assessments widely available to the public. It also adds requirements regarding financial assistance policies and billing and collection practices.

State Regulation

Licensure

DPH licenses the state's 27 acute care hospitals every two years. Because all of these hospitals are deemed Medicare- and Medicaid-certified through either CMS or the Joint Commission, they are inspected every four years, instead of biennially. Hospitals are also inspected when the department (1) receives a complaint against a facility or (2) is following-up to ensure compliance with a corrective action plan. Hospitals must comply with DPH regulations regarding, among other things, physical plant, maintenance, medical staff, safety, equipment, medical records, emergency planning, service provision, and infection control ([Conn. Agencies Regs., § 19-13-D1 et. seq.](#)).

Certificate of Need

CON programs are intended to reduce health care costs, ensure health care access, and coordinate and prioritize the development of new health care services and facility construction. The 1974 federal Health Planning Resources Development Act required all 50 states to have a CON program, but this mandate was repealed in 1987. According to the National Conference of State Legislatures, Connecticut is one of 34 states that currently operate a CON program (<http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>).

Generally, Connecticut law requires health care facilities, including hospitals, to apply for and receive a CON from DPH's Office of Health Care Access (OHCA) when it proposes to (1) establish a new facility or provide new services, (2) change ownership, (3) purchase or acquire certain equipment, or (4) terminate certain services. Table 1 lists the activities pertaining to acute care hospitals that require or are exempt from a CON determination.

Table 1: CON Requirements and Exemptions for Acute Care Hospitals

CON Required	CON Not Required
<ul style="list-style-type: none"> Establishing a new facility, including (1) an outpatient surgical facility or (2) a free-standing emergency department not located on the hospital's main campus 	<ul style="list-style-type: none"> Establishing or expanding a hospital's inpatient or outpatient services, excluding cardiac services
<ul style="list-style-type: none"> Transferring ownership 	<ul style="list-style-type: none"> Replacing existing imaging equipment that received a CON or a CON determination
<ul style="list-style-type: none"> Terminating inpatient or outpatient services, including mental health and substance abuse services 	<ul style="list-style-type: none"> Adding one operating room in a hospital-owned outpatient surgical facility within a three-year period
<ul style="list-style-type: none"> Increasing licensed bed capacity 	
<ul style="list-style-type: none"> Terminating an emergency department 	
<ul style="list-style-type: none"> Acquiring certain imaging equipment or equipment utilizing technology not previously used in the state 	
<ul style="list-style-type: none"> Establishing inpatient or outpatient cardiac services 	
<ul style="list-style-type: none"> Adding two or more operating rooms in a hospital-owned outpatient surgical facility in a three-year period 	

Source: [CGS § 19a-638](#) and DPH website, <http://www.ct.gov/dph/cwp/view.asp?a=3902&q=564018&dphNav=1>

Data Collection

The law requires acute care hospitals to report extensive financial information to OHCA, including, among other things, audited financial statements, a current schedule of charges (i.e., pricemaster), and uncompensated care policies and procedures (CGS §§ [19a-644](#) & [19a-681](#)). DPH regulations require hospitals to file (1) annual reports due by February 28 and (2) 12 month actual filings due by March 31 of each year ([Conn. Agencies Regs., §§ 19a-643-201 to -206](#)). Table 2 lists OHCA's hospital reporting requirements.

Table 2: OHCA's Acute Care Hospital Reporting Requirements

Annual Reporting Requirements	12 Month Actual Filings Required
<ul style="list-style-type: none"> Audited financial statements of the hospital and its parent corporation and affiliates 	<ul style="list-style-type: none"> Hospital balance sheet and statement of operations information
<ul style="list-style-type: none"> Medicare cost report 	<ul style="list-style-type: none"> Hospital gross revenue, net revenue, and statistics by payer
<ul style="list-style-type: none"> Most recent legal chart of corporate structure 	<ul style="list-style-type: none"> Hospital operating expenses by expense category and department
<ul style="list-style-type: none"> Current list of officers and directors 	<ul style="list-style-type: none"> Hospital financial and statistical data analysis
<ul style="list-style-type: none"> CHIME (Connecticut Hospital Association database) hospital utilization reports 	<ul style="list-style-type: none"> Hospital Medicare and Medicaid managed care activity

Table 2 (continued)

Annual Reporting Requirements	12 Month Actual Filings Required
<ul style="list-style-type: none"> Uncompensated care policies and procedures 	<ul style="list-style-type: none"> Parent corporation consolidated balance sheet and statement of operations information
<ul style="list-style-type: none"> Hospital, affiliate, and related corporation net assets 	<ul style="list-style-type: none"> Parent corporation consolidated financial data analysis
<ul style="list-style-type: none"> Transactions between hospital affiliates or related corporations 	<ul style="list-style-type: none"> Hospital inpatient bed utilization by department
<ul style="list-style-type: none"> Expenditures by affiliates or related corporations for the benefit of the hospital 	<ul style="list-style-type: none"> Hospital inpatient and outpatient service utilization and full-time employees
<ul style="list-style-type: none"> Hospital commitments and endorsements for the benefit of affiliates or related corporations 	<ul style="list-style-type: none"> Hospital outpatient, surgical, outpatient endoscopy, and outpatient emergency room services by location
<ul style="list-style-type: none"> Donations and funds restricted for indigent care and free beds 	<ul style="list-style-type: none"> Calculation and summary of DSH upper payment limit and baseline underpayment data
<ul style="list-style-type: none"> Hospital bed funds held or administered by the hospital 	<ul style="list-style-type: none"> Hospital uncompensated care
<ul style="list-style-type: none"> Hospital collection placement policies and collection agent information 	<ul style="list-style-type: none"> Hospital non-government gross revenue, contractual allowances, accrued payments, and discount percentages
<ul style="list-style-type: none"> Salaries and fringe benefits of the ten highest paid hospital positions 	<ul style="list-style-type: none"> Statistical analysis of hospital revenue and expenses
<ul style="list-style-type: none"> Report of each joint venture, partnership, and corporation related to the hospital 	<ul style="list-style-type: none"> Report of independent accountants on applying agreed upon procedures
<ul style="list-style-type: none"> Hospital salaries and fringe benefits paid by joint ventures, affiliates, and related corporations 	<ul style="list-style-type: none"> Nonprofit hospital and parent corporation IRS Form 990
<ul style="list-style-type: none"> Transfer of assets, operations, or control from the hospital to a for-profit entity 	
<ul style="list-style-type: none"> Charity care and reduced cost services provided by the hospital 	

Source: OHCA website, <http://www.ct.gov/dph/cwp/view.asp?a=3902&q=276986>

Additionally, nonprofit hospitals must annually submit to OHCA (1) a complete copy of the hospital’s most recent Form 990 (the “Return of Organization Exempt From Income Tax” form) and (2) data compiled to prepare the hospital’s community health needs assessment required by federal law.

DSH

Under federal and state law, Medicaid provides additional reimbursement to acute care hospitals that serve a disproportionate share (DSH) of Medicaid and other low-income patients. (By state law, Connecticut Children’s Medical Center and UConn Health Center are ineligible for such payments.) DSS administers the state’s DSH program and issues payments to hospitals based on information they report to the department, including, among other things, Medicaid and low-income patient utilization rates, Medicaid payments, and uncompensated care rates ([CGS § 17b-239c](#)).

The federal ACA required the federal Department of Health and Human Services to incrementally reduce DSH payments to hospitals starting in fiscal year 2014. This was due to the expectation that the ACA's expanded health insurance coverage requirements would significantly lower hospitals' uncompensated care costs. But federal legislation delayed the DSH reductions until FY 18 and CMS recently issued a [proposed rule](#) that would reduce these payments by \$43 billion from FYs 18 to 25.

Federal Regulation

Acute care hospitals are regulated by several federal agencies, including the Health Care Financing Administration, Occupational Safety and Health Administration, Environmental Protection Agency, Food and Drug Administration, CDC, IRS, and CMS. For hospitals to participate in Medicare and Medicaid, they must meet CMS' health and safety standards (["Conditions of Participation"](#)). The conditions cover a range of topics, such as the hospital's governing body; patient rights; quality assessment; medical staff; nursing services; pharmaceutical, radiologic, and laboratory services; infection control; and discharge planning.

Most Connecticut acute care hospitals are deemed Medicare- and Medicaid-certified through the Joint Commission, a national accrediting body, instead of directly through CMS. As part of its [accreditation process](#), the Joint Commission inspects each hospital's compliance with its standards at least once every three years.

Maintaining Nonprofit Status

According to data from the American Hospital Association's [2017 annual survey](#), about 59% of community hospitals in the U.S. are nonprofit, 21% are for-profit, and 20% are owned by state or local governments. For this purpose, community hospitals include nonfederal, short-term general, and other special hospitals. Certain hospitals are excluded, such as psychiatric hospitals or hospitals not accessible to the general public (e.g., prison hospitals or college infirmaries). In Connecticut and most other northeastern states, the vast majority of hospitals are nonprofit (Connecticut currently has three for-profit acute care hospitals).

To qualify for tax-exempt status, nonprofit hospitals must meet various requirements under federal law. In general, to qualify for Sec. 501(c)(3) tax-exempt status under the Internal Revenue Code, an organization must (1) be organized and operated exclusively for charitable or other specified purposes, (2) not have net earnings benefitting any private shareholder or individual, and (3) meet certain restrictions on political activity.

In addition, nonprofit hospitals must show that they provide community benefits sufficient to justify their tax-exempt status. In 1969, IRS Revenue Ruling [69-545](#) established the community benefit standard, and noted five factors that are relevant in assessing whether a hospital meets this standard. The factors include whether the hospital:

1. operates a full-time emergency room (ER) open to all patients, regardless of ability to pay (a later ruling ([83-157](#)) revised this factor to outline circumstances where a hospital can be exempt even without an ER, including (a) when a government agency has determined that an ER would unnecessarily duplicate emergency services that are adequately provided by another medical institution in the community or (b) specialized hospitals that treat conditions unlikely to need emergency treatment);
2. otherwise accepts patients able to pay for care, either directly or through third party reimbursement;
3. is governed by a board composed of independent community members;
4. makes medical staff privileges available to all qualified physicians in the area; and
5. uses excess funds to improve the quality of patient care, expand facilities, and advance its training, education, and research programs.

The ruling and related case law indicate that the absence of any particular factor is not necessarily determinative.

The ACA added to the requirements for nonprofit hospitals to maintain their nonprofit status. It requires nonprofit hospitals to conduct community health needs assessments at least once every three years and make the assessments widely available to the public. The act also adds requirements regarding financial assistance policies and billing and collection practices.

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