Agency Legislative Proposal - 2020 Session

Document Name: 11/01/2019, Office of Health Strategy, Facility Fee Statute (19a-508c) Revisions

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Office of Health Strategy
Liaison: Demian Fontanella **Phone:** 860-418-7056 **E-mail:** demian.fontanella@ct.gov
Lead agency division requesting this proposal: Health Systems Planning
Agency Analyst/Drafter of Proposal: Karen Roberts

Title of Proposal: An Act Concerning Various Revisions to Facility Fee Statute
Statutory Reference: Section 19a-508c of the Connecticut General Statutes
Proposal Summary: The proposed changes will clarify and further strengthen the intent and enforcement of the existing statutory requirements mandating the transparency, patient notification and required annual filings to the Office of Health Strategy by hospitals and health systems which charge or bill Facility Fees.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?

(3) Have certain constituencies called for this action?

(4) What would happen if this was not enacted in law this session?

The proposed changes will clarify and further strengthen the intent and enforcement of the existing statutory requirements mandating the transparency, patient notification and required annual filings to the Office of Health Strategy by hospitals and health systems which charge or bill Facility Fees.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: **Agency Contact (*name, title, phone*):** **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)*
State – The proposed language imposes no additional fiscal liability for state entities subject to this section beyond what is currently in statute.
Federal
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

The proposed language enhances the granularity of the data hospitals, hospital systems and hospital-based facility must already report to the Health Systems Planning Unit concerning the utilization of

facility fees. The additional data will provide deeper insight into the impact of such fees on consumers, with detail by insurance status, the impact of and difference between gross charges and net revenue, by payer source.

◊ **EVIDENCE BASE**

Section 1

Sec. 19a-508c. Hospital and health system facility fees charged for outpatient services at hospital-based facilities. Notice re establishment of hospital-based facility at which facility fees billed. (a) As used in this section:

(1) "Affiliated provider" means a provider that is: (A) Employed by a hospital or health system, (B) under a professional services agreement with a hospital or health system that permits such hospital or health system to bill on behalf of such provider, or (C) a clinical faculty member of a medical school, as defined in section 33-182aa, that is affiliated with a hospital or health system in a manner that permits such hospital or health system to bill on behalf of such clinical faculty member;

(2) "Campus" means: (A) The physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within two hundred fifty yards of the main buildings, or (B) any other area that has been determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus;

(3) "Facility fee" means any fee charged or billed by a hospital or health system for outpatient services provided in a hospital-based facility that is: (A) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee;

(4) "Health system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or (B) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means;

(5) "Hospital" has the same meaning as provided in section 19a-490;

(6) "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided;

(7) "Payer mix" means the proportion of different payer categories from which a hospital receives payment. This includes, but is not limited to, Medicare, Medicaid, commercial insurers, other government insurance, uninsured and self-pay patients.

(8) "Professional fee" means any fee charged or billed by a provider for professional medical services provided in a hospital-based facility; and

[(8)] (9) "Provider" means an individual, entity, corporation or health care provider, whether for profit or nonprofit, whose primary purpose is to provide professional medical services.

(b) If a hospital or health system charges a facility fee utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that is in addition to and separate from the professional fee charged by the provider;

(2) (A) The amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility, and (D) a telephone number the patient may call for additional information regarding such patient's potential financial liability, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(c) If a hospital or health system charges a facility fee without utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility, located outside the hospital campus, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that may be in addition to and separate from the professional fee charged by a provider;

(2) (A) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, (B) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility was not hospital-based, and (C) a telephone number the patient may call for additional information regarding such patient's potential financial liability, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(d) On and after January 1, 2016, each initial billing statement that includes a facility fee shall: (1) Clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider; (2) provide the corresponding Medicare facility fee reimbursement rate for the same service as a comparison or, if there is no corresponding Medicare facility fee for such service, (A) the approximate amount Medicare would have paid the hospital for the facility fee on the billing statement, or (B) the percentage of the hospital's charges that Medicare would have paid the hospital for the facility fee; (3) include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses; (4) inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and (5) include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction without regard to whether such patient qualifies for, or is likely to be granted, any reduction. The hospital, health system or hospital-based facility shall report by July 1st, 2020 and annually thereafter, to the Health Systems Planning Unit of the Office of Health Strategy, the number and total proportion of patients for each payer mix category who have contacted the hospital, health system or hospital-based facility to request a reduction in a facility fee and the number of patients who were granted such a reduction or waiver. The report shall include, by payer mix category, the total aggregated amount of original facility fees charged for all patients who requested a reduction, and the total aggregated amount said facility fees were reduced to. The reported information shall be for the previous calendar year. The hospital, health system or hospital-based facility shall also submit by July 1, 2020, and annually thereafter, to the Health Systems Planning Unit of the Office of Health Strategy, an example of a billing statement in accordance with subsection (d). The billing statement shall not contain patient identifying information but must represent the billing statement format that patients receive pursuant to subsection (d).

(e) The written notices described in subsections (b) to (d), inclusive, and (h) to (j), inclusive, of this section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges. Such notices shall include a statement, in the most prevalent languages spoken in the hospital, health system or hospital-based facility's Primary Service Area, that patients may request the notice in their primary language.

(f) (1) For nonemergency care, if a patient's appointment is scheduled to occur ten or more days after the appointment is made, such written notice shall be sent to the patient by first class mail, encrypted electronic mail or a secure patient Internet portal not less than three days after the appointment is made. If an appointment is scheduled to occur less than ten days after the appointment is made or if the patient arrives without an appointment, such notice shall be hand-delivered to the patient when the patient arrives at the hospital-based facility.

(2) For emergency care, such written notice shall be provided to the patient as soon as practicable after the patient is stabilized in accordance with the federal Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, as amended from time to time, or is determined not to have an emergency medical condition and before the patient leaves the hospital-based facility. If the patient is unconscious, under great duress or for any other reason unable to read the notice and understand and act on his or her rights, the notice shall be provided to the patient's representative as soon as practicable.

(g) Subsections (b) to (f), inclusive, and (l) of this section shall not apply if a patient is insured by Medicare or Medicaid or is receiving services under a workers' compensation plan established to provide medical services pursuant to chapter 568.

(h) A hospital-based facility shall prominently display written notices in locations that are readily accessible to and visible by patients, including the patient appointment check-in area and patient waiting areas. A written notice shall state [, stating]: (1) that the hospital-based facility is part of a hospital or health system, (2) the name of the hospital or health system, [and] (3) that if the hospital-based facility charges a facility fee, the patient may incur a financial liability greater than the patient would incur if the hospital-based facility was not hospital-based, and shall (4) include a statement, in the most prevalent languages spoken in the hospital, health system or hospital-based facility's Primary Service Area, that patients may request the notice in their primary language. The hospital-based facility shall submit by July 1, 2020 and annually thereafter, to the Health Systems Planning unit of the Office of Health Strategy, a copy of the public notice displayed in accordance with this subsection.

(i) A hospital-based facility shall clearly hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage, marketing materials, Internet web sites and stationery.

(j) A hospital-based facility shall, when scheduling services for which a facility fee may be charged, inform the patient (1) that the hospital-based facility is part of a hospital or health system, (2) of the name of the hospital or health system, (3) that the hospital or health system may charge a facility fee in addition to and separate from the professional fee charged by the provider, and (4) of the telephone number the patient may call for additional information regarding such patient's potential financial liability.

(k) (1) On and after January 1, [2016] 2021, if any transaction, as described in subsection (c) of section 19a-486i, results in the establishment of a hospital-based facility at which facility fees [will likely] may be billed, the hospital or health system, that is the purchaser in such transaction shall, not later than thirty days after such transaction, provide direct written notice, by first class mail or by other reasonable method, of the transaction to each patient served within the previous three years by the health care facility that has been purchased as part of such transaction.

(2) Such notice shall include the following information:

(A) A statement [that] indicating the full legal and business name of the health care facility, the date of acquisition, and that it is now a hospital-based facility and is part of a hospital or health system;

(B) The name, business address and phone number of the hospital or health system that is the purchaser of the health care facility;

(C) A statement that the hospital-based facility bills, or is [able] likely to bill, patients a facility fee that may be in addition to, and separate from, any professional fee billed by a health care provider at the hospital-based facility;

(D) (i) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (ii) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility;

(E) The estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility fee billed at such hospital-based facility for the most common services provided at such hospital-based facility; and

(F) A statement that, prior to seeking services at such hospital-based facility, a patient covered by a health insurance policy should contact the patient's health insurer for additional information

regarding the hospital-based facility fees, including the patient's potential financial liability, if any, for such fees.

(3) A copy of the written notice provided to patients in accordance with this subsection shall be filed with the Health Systems Planning Unit of the Office of Health Strategy, established under section 19a-612. Said unit shall post a link to such notice on its Internet web site.

(4) A hospital, health system or hospital-based facility shall not collect a facility fee for services provided at a hospital-based facility that is subject to the provisions of this subsection from the date of the transaction until at least thirty days after the written notice required pursuant to this subsection is mailed to the patient or a copy of such notice is filed with the Health Systems Planning Unit, whichever is later. A violation of this subsection shall be considered an unfair trade practice pursuant to section 42-110b.

(5) By July 1, 2021, and annually thereafter, the hospital-based facility that is the subject of a transaction described in subsection (c) of section 19a-486i during the past calendar year, shall report to the Health Systems Planning Unit, the number of patients the hospital-based facility served for the preceding three years, the number of patients notified in accordance with this subsection by which delivery methods such patients were notified, how many patients were notified by which delivery methods, and the date or dates such notifications were sent. Within this annual filing, the hospital-based facility shall attest that the date or dates of notification to patients was within the 30 days from the completion date of the transaction, as required by subsection (k)(1).

(l) Notwithstanding the provisions of this section, no hospital, health system or hospital-based facility shall collect a facility fee for (1) outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) or assessment and management (CPT A/M) code and are provided at a hospital-based facility located off-site from a hospital campus, or (2) outpatient health care services provided at a hospital-based facility located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate. Notwithstanding the provisions of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of this section, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the date of expiration of such contract, except that an amendment to any such contract extending the expiration date of said contract will not exempt said hospital, health system or hospital-based facility from complying with this subsection. A violation of this subsection shall be considered an unfair trade practice pursuant to chapter 735a. The provisions of this subsection shall not apply to a freestanding emergency department. As used in this subsection, “freestanding emergency department” means a freestanding facility that (A) is structurally separate and distinct from a hospital, (B) provides emergency care, (C) is a department of a hospital licensed under chapter 368v, and (D) has been issued a certificate of need to operate as a freestanding emergency department pursuant to chapter 368z.

(m) (1) Each hospital and health system shall report not later than July 1, 2016, and annually thereafter to the executive director of the Office of Health Strategy concerning facility fees charged or billed during the preceding calendar year. The report shall be in such form as the Health Systems Planning Unit of the Office of Health Strategy may require. Such report shall include (A) the name and [location] full address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility by [Medicare, Medicaid, or under private insurance] payer mix policies, (D) for each facility, the total amount of revenue charged or billed by the hospital or health system, as well as the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of revenue charged or billed by the hospital or health system, as well as the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description, which includes a current procedural terminology, category I code for each of the ten procedures or services provided by the hospital or health system overall that generated the greatest amount of facility fee gross revenue, including volume, for each of these ten procedures or services and gross and net revenue totals, for each such procedure or service, and, for each such procedure or service, the total net amount of revenue received by the hospital or health system derived from facility fees, and (G) the top ten procedures or services, based on patient volume, provided by the hospital or health system overall for which facility fees are billed or charged [based on patient volume], including the gross and net revenue totals received for each such procedure or service. For purposes of this subsection, "facility" means a hospital-based facility that is located outside a hospital campus.

(2) The executive director shall publish the information reported pursuant to subdivision (1) of this subsection, or post a link to such information, on the Internet web site of the Office of Health Strategy.

Agency Legislative Proposal - 2020 Session

Document Name: 11/01/19, Office of Health Strategy, Community Benefits Programs Statute (19a-127k) Revisions

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: **Office of Health Strategy**
Liaison: Demian Fontanella **Phone: 860-418-7056** **E-mail: demian.fontanella@ct.gov**
Lead agency division requesting this proposal: **Health Systems Planning**
Agency Analyst/Drafter of Proposal: **Karen Roberts**

Title of Proposal: An Act Concerning Various Revisions to Community Benefits Programs Statute
Statutory Reference: Section 19a-127k of the Connecticut General Statutes
Proposal Summary: The proposed changes will transfer the community benefits guidelines and reporting requirements outlined in §19a-127k from the Office of Healthcare Advocate to the Office of Health Strategy (OHS). The proposal will remove the references to Managed Care Organizations from this statute and be applied only to Connecticut's hospitals. The proposal will make other changes to the existing statute language to strengthen and improve the timing, content, regularity and uniformity of submissions from the hospitals including how community benefits are addressing the health care needs of populations served by the hospitals. The proposal will require OHS to make the hospital submissions available to the public on the OHS website and will require OHS to annually develop a summary and analysis of such reports received. Further, the proposal will change the civil penalty reference to be aligned with the existing civil penalty statute under Chapter 368z.

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* No

(2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?* N/A This proposal merely shifts existing requirements from one agency to another. However, OHS' mission and focus on "promoting effective health planning and the provision of quality health care in the state" incorporates the community benefit into many of its decisions, and more clearly and directly links these activities with the

community health needs assessments (CHNA), which must be reported to OHS by Connecticut hospitals. This trend to link community benefits with CHNAs is mirrored in at least 10 other states.

(3) *Have certain constituencies called for this action?* No

(4) What would happen if this was not enacted in law this session?

Failure to enact the proposed changes simply maintains the current statutory scheme, with reporting required in this statute remaining under the authority of the Office of Healthcare Advocate and not be transferred to the Office of Health Strategy.

◊ **Origin of Proposal** ☒ **New Proposal** ☐ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Office of Healthcare Advocate
Agency Contact (*name, title, phone*): Sean T. King, Staff Attorney 3, (860) 331-2463
Date Contacted: August 13, 2019 and September 24, 2019.

Approve of Proposal ☒ **YES** ☐ **NO** ☐ Talks Ongoing

Summary of Affected Agency's Comments
OHA has not published any reports on hospital community benefit programs since 2010. OHA has communicated to OHS that they are not opposed to the transfer of this statute to OHS.

Will there need to be further negotiation? ☐ **YES** ☒**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)*
N/A

State: In the event that hospitals required to report under this provision fail to do so, OHS may impose civil penalties in the amount of up to $1,000/day.

Federal N/A
Additional notes on fiscal impact N/A

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

This proposal's shift of the currently required community benefit reporting from OHA to OHS, promotes more consistent hospital reporting and data analysis, which is with OHS' statutory mandate. Indeed, OHA's current guidance to hospitals regarding its enforcement of this statute allows hospitals to submit specified data to OHS, as part of the routine OHS data requirements, as satisfying the reporting requirement. OHS' mission and focus on "promoting effective health planning and the provision of quality health care in the state" incorporates the community benefit into many of its decisions, and more clearly and directly links these activities with the community health needs assessments (CHNA), which must be reported to OHS by Connecticut hospitals.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Data from hospital reporting, aggregated with additional hospital data provided to OHS will facilitate greater detail and granularity of analysis of hospital engagement with their communities, and better inform OHS oversight of the impact of transactions within its oversight authority.

Is that data currently available or must it be developed? All data required to be reported under this proposal is already required and being reported. No new methods, data or processes need to be developed.

Sec. 19a-127k. Community benefits programs. Penalty. (a) As used in this section:

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

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

(3)] "Hospital" has the same meaning as provided in section 19a-490[.];

(3) "Fiscal Year" has the same meaning as provided in section 19a-646.

(b) On or before [January 1, 2005] September 15, 2020, and [biennially] annually thereafter, each [managed care organization and each] tax-exempt, privately-owned hospital shall submit to the [Healthcare Advocate, or the Healthcare Advocate's designee] Health Systems Planning Unit of the Office of Health Strategy, a report on [whether the managed care organization or hospital has in place a community benefits program. If a managed care organization or hospital elects to develop a community benefits program, the report required by this subsection shall comply with the reporting requirements of subsection (d) of this section.] the hospital's community benefits program and the hospital's community benefits and community building investments for the most recently completed fiscal year. The report shall be in a format determined by the Office of Health Strategy.

(c) A [managed care organization or] hospital [may] shall develop community benefit guidelines intended to promote preventive care and to improve the health status for [working families and populations at risk] all populations residing in the communities within the geographic service area of the hospital, 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:

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

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

(3) Seeking assistance and meaningful participation from the communities within the [organization's or] hospital's geographic service areas in developing and implementing the program, as well as the plan for meaningful community benefit and community building investments, 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 each hospital's triennial community health needs assessment and implementation strategy; 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. The program shall consider the health care needs of a broad spectrum of age groups and health conditions.

(d) Each [managed care organization and each] hospital [that chooses to participate in developing a community benefits program] shall include in the [biennial] 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 and the hospital's community benefit and community building investments; (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.] The Office of Health Strategy shall make a copy of each report available to the public via its website.

(e) The [Healthcare Advocate, or the Healthcare Advocate's designee,] Office of Health Strategy shall, within available appropriations, develop a summary and analysis of the community benefits program reports submitted by [managed care organizations and] hospitals under this section and shall review such reports for adherence to the guidelines set forth in subsection (c) of this section. Not later than [October 1, 2005] December 31, 2020, and [biennially] annually thereafter, the [Healthcare Advocate, or the Healthcare Advocate's designee,] Office of Health Strategy shall make such summary and analysis available [to the public upon request] on its website.

(f) The [Healthcare Advocate] Office of Health Strategy may, after notice and opportunity for a hearing, in accordance with chapter 54, impose a civil penalty on any [managed care organization or] hospital that fails to submit the report required pursuant to this section by the date specified in subsection (b) of this section. Such penalty shall be not more than fifty dollars a day for each day after the required submittal date that such report is not submitted.