
The Attorney General's Community Benefits Guidelines for Non Profit Hospitals



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INTRODUCTION

Charitable Role of Hospitals and Health Maintenance Organizations

Hospitals and health maintenance organizations (HMOs) have critical roles in the delivery of health care in communities across the Commonwealth. As nonprofit institutions, hospitals and HMOs also have important fiduciary obligations to provide benefits to their communities commensurate with their tax-exempt status. The provision of Community Benefits is an important component of a hospital and HMO's charitable activity. *The Attorney General's Community Benefits Guidelines for Non Profit Acute Care Hospitals* and *The Attorney General's Community Benefits Guidelines for Health Maintenance Organizations* outline principles for developing, implementing and reporting on these activities.

The Attorney General's Community Benefits Guidelines set forth voluntary principles encouraging Massachusetts hospitals and HMOs to continue to build upon their commitment to address health and social needs in the communities they serve. The *Guidelines* seek to continue to encourage charitable activities on the part of hospitals and HMOs as well as the spirit of cooperation and partnership between hospitals and HMOs and their communities that promote meaningful and effective community benefit programs. The *Guidelines* represent a unique, non-regulatory approach that calls upon hospitals and HMOs to identify and respond to unmet community health needs by formalizing their approach to community benefits planning, collaborating with community representatives to identify and create programs that address those needs, and issuing annual reports on their efforts. The *Guidelines* do not dictate the specific types of programs that hospitals and HMOs must provide; rather, they encourage hospitals and HMOs to use their expertise and resources, as well as the expertise of their communities, to target the particular needs of underserved and at-risk populations. In addition, by providing a mechanism to report on community benefit initiatives and expenditures, the *Guidelines* allow for public recognition of hospitals and HMOs' activities in support of their charitable mission.

Revision of Guidelines

The Attorney General's Office originally issued the *Community Benefits Guidelines for Non-Profit Acute Care Hospitals* in June 1994. They were followed by the *Attorney General's Community Benefits Guidelines for Health Maintenance Organizations* in February 1996, in recognition of the increased role played by HMOs in the health care system.¹ The evolution of these Guidelines is summarized in

¹ The Attorney General's Office developed the Guidelines consistent with its oversight of numerous aspects of the health care system. Through the Non-Profit Organizations/Public Charities Division, the Attorney General oversees hospitals and health plans as non-profit and

Appendix V.

In the 14 years of the Community Benefits Program, hospitals and HMOs have demonstrated their commitment to the principles underlying the Program. The Program has succeeded in encouraging and demonstrating cooperation between health care institutions and the communities they serve. Health plans and hospitals have used innovative approaches to address difficult public health issues and significant unmet community health needs. In addition, the annual reports, now available on-line, serve the important purpose of providing the public with access to useful information about these programs and initiatives. The availability of such information has enabled hospitals, health plans and communities to work together to identify and address critical unmet community needs, and has facilitated replication of best practices.

However, significant changes in health care since the *Guidelines* were first published underscore both the continued value of the Program and the need to reevaluate and update them. Access to affordable, quality health care is a challenge for many consumers and a formidable state financing burden. Massachusetts' ground-breaking health care reform law, Chapter 58, was enacted to reduce the number of uninsured and change the way providers are reimbursed for uncompensated care. While the law has enabled many to obtain health insurance coverage, affordability is still an issue, especially for those who are ineligible for subsidies and who may be uninsured. At the same time, providers, the state and third party payers all recognize the need to contain escalating health care costs. Increased costs and cost sharing have made medical debt a concern for both consumers and providers. In addition, state data show troubling health disparities for racial and ethnic minorities and increased incidence of chronic diseases, particularly among vulnerable populations. The role of effective community benefits programs addressing such unmet public health needs has never been more critical.

The changes brought by health care reform and growing awareness of systemic unmet health needs provide a unique opportunity to assess the

charitable organizations. The Division assists the Attorney General in carrying out her responsibilities to ensure the "due application of funds given or appropriated to public charities" (M.G.L. C.12 s.8). The Attorney General's authority with respect to non-profit organizations and charities includes ensuring that a charity's trustees meet their fiduciary duties to the organization, and that they operate the organization in accordance with its mission. The Division also plays an important role in hospital and HMO for-profit conversions ensuring the protection of charitable assets. In addition, the Attorney General created the Health Care Division to (1) investigate and litigate consumer protection cases involving health insurers, health providers, and pharmaceutical companies; (2) address consumer complaints relating to health insurance and health care; and (3) assist the Attorney General with her health policy and health reform responsibilities, including improving quality, restraining costs, promoting public health, improving the economy, and protecting consumers.

effectiveness of the Community Benefits Program, especially in the context of a widespread recognition of the importance of transparency and accountability in community benefit reporting. National attention has been focused on the charitable role of health care institutions. For example, recent congressional hearings have examined the tax-exempt status of non-profit hospitals and their obligations to provide charity care and measurable community benefits in furtherance of their charitable purpose. Similarly, the Internal Revenue Service's recent updates to Form 990 for non-profit organizations highlight the importance of transparency and accountability in community benefit reporting, including hospital policies and practices for charity care and debt collection.

Advisory Task Force

In January, 2008, Attorney General Martha Coakley convened a new Advisory Task Force to assist her in reviewing the *Guidelines* in the context of this changing health care landscape. The Advisory Task Force, which included representatives from hospitals, health maintenance organizations and consumer groups, participated in a thoughtful, focused and productive review process that concluded in December, 2008. Members listed in Appendix VI. Attorney General Coakley asked the Task Force to consider how the Guidelines could be improved to help hospitals and HMOs most effectively assess the needs of their communities; design programs to meet these needs, and measure the success of their programs.

In particular, the Task Force considered the following:

- 1) Pre-Planning/Measurement - How to encourage pre-planning and communication with community leaders at the beginning of the year to set benchmarks for what each program hopes to accomplish and ways of evaluating success over time.
- 2) Statewide Priorities - How to develop ways that the Community Benefits Program can be used to encourage hospitals and HMOs to address identified statewide health challenges with a particular focus on reducing healthcare disparities and improving the health of vulnerable populations.
- 3) Improved Reporting - How to streamline reporting requirements that support community benefit initiatives and that produce reports that are useful for evaluation purposes.
- 4) Training/ Acknowledging Success - How to design an appropriate training plan to ensure that hospital and HMO staff understand the Guidelines and reporting requirements and can implement them effectively.

Statewide Priorities

It is appropriate to view the Community Benefits Program in the context of

coordinated health care initiatives across state government.² Accordingly, the *Guidelines* identify certain state-wide health care priorities which we ask all HMOs and hospitals to consider as they conduct their community needs assessments and prepare their community benefit plans. These priorities, which are based on state-wide needs identified by the Executive Office of Health and Human Services in 2007, are intended to be used to focus the community benefit work of hospitals and HMOs in areas of demonstrated need:

Supporting Health Care Reform

In the community benefits context, the Attorney General recommends that hospitals and health plans consider ways in which their community benefit programs can address the needs of individuals who remain uninsured, such as those who are not eligible for existing subsidized programs but still cannot afford available insurance products, as well as those who are burdened with medical debt.

Chronic Disease Management in Disadvantaged Population

The Attorney General recommends that hospitals and HMOs consider developing programs that improve the management of chronic diseases (e.g., diabetes, obesity, and asthma) in vulnerable populations to improve health care quality outcomes and reduce costs.

Reducing Health Disparities

The Attorney General recommends that hospitals and HMOs consider the ways in which their Community Benefits programs can help reduce racial and ethnic health disparities. For example, according to the Massachusetts Department of Public Health, people of color are more likely to suffer from Diabetes, hypertension, colon, breast, lung, and prostate cancers, cardiovascular disease, infant mortality and low birth weight, and HIV/AIDS.

Promoting Wellness of Vulnerable Populations

The Attorney General recommends that hospitals and HMOs consider

² The Attorney General also has a role in numerous state-wide health care initiatives. She has three appointees on the Board of the Health Insurance Connector Authority, which is charged with implementing the health care mandate under Chapter 58, the health care reform law. The Attorney General is also a member of the Health Care Quality and Cost Council which is charged with identifying and implementing statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care. She is also a member of the Health Disparities Council which is also dedicated to reducing health disparities. Finally, the Attorney General is a signatory to the Healthy Mass compact, an initiative designed to develop a coordinated approach on health across state government. The thrust of all of these efforts is to support health care reform, reduce barriers to access, improve quality and reduce cost in health care for all citizens of the Commonwealth.

supporting programs that promote the health and wellness of particular vulnerable populations with unmet needs in their service areas.

These priority areas are identified as ways to encourage hospitals and health plans to work in concert on issues of particular concern and to achieve collective improvements in these areas. However, we recognize that hospitals and HMOs must also assess the needs of their particular service areas and get direct input from their community about which programs to include in their Community Benefits Plans. Programs that otherwise meet the community benefits criteria but do not address these areas may continue to be reported as such. In reviewing the Community Benefits Reports, the Attorney General's Office will pay special attention to programs that address these issues for purposes of public recognition and dissemination of best practices.

Medical Debt/Hospital Collection Practices

Given the concerns about growing costs throughout the health care system and the changed reimbursement for uncompensated care under Chapter 58 of the Acts of 2006, the Attorney General recognizes that hospitals may increasingly face bad debt as a result of providing services for which they have not been paid. At the same time, patients, whether insured or uninsured, who have problems paying their medical bills should be treated fairly and be given information about financial assistance and an opportunity to manage their medical debt. Although bad debt is not considered reportable as a community benefit expenditure, the revised Guidelines allow for the optional reporting of bad debt if the hospital adopts the set of recommended medical debt collection practices outlined in Appendix II.

Scope of this Document

This document applies to nonprofit acute care hospitals throughout the Commonwealth (hereinafter referred to as "hospitals"), defined by Chapter 118G of the Massachusetts General Laws and the teaching hospital of the University of Massachusetts Medical School and any hospital licensed under Section 51 of Chapter 111 that contains a majority of medical, surgical, pediatric, obstetrics and maternity beds as defined by the Department of Public Health. Although for-profit hospitals may find this document helpful in organizing their own community benefit programs, such hospitals are not explicitly covered by these Guidelines. Finally, while these guidelines are effective starting in Hospital fiscal year 2010, the Attorney General recognizes that many hospitals were engaged in highly valuable Community Benefits initiatives prior to these Guidelines, and hopes that these principles inspire even greater efforts.

COMMUNITY BENEFITS PRINCIPLES

- A. The governing body of each non-profit acute care hospital should affirm and make public a Community Benefits Mission Statement, setting forth its formal commitment to provide resources to and support the implementation of its annual Community Benefits Plan.
- B. The hospital should demonstrate its support for its Community Benefits Plan at the highest levels of the organization. The hospital's governing board and senior management should be responsible for overseeing the development and implementation of the Community Benefits Plan including designating the programs or activities to be included in the plan, allocating the resources, and ensuring its regular evaluation.
- C. The hospital should ensure regular involvement of the community, including that of the representatives of the targeted underserved populations, in the planning and implementation of the Community Benefits Plan.
- D. To develop its Mission Statement and Community Benefits Plan, the hospital should conduct a Community Health Needs Assessment, a comprehensive review of unmet health needs of the community by analyzing community input, available public health data and an inventory of existing programs.
- E. The hospital should include in its Community Benefits Plan the Target Populations it wishes to support, specific programs or activities that attend to the needs identified in the Community Health Needs Assessment and, measurable short and long-term goals for each program or activity.
- F. Each hospital should submit an annual Community Benefits Report to the Attorney General's Office which details 1) the process of developing its Community Benefit Plan; 2) information on community benefit programs, including program goals and measured outcomes; and 3) Community Benefits Expenditures. The hospital shall make the report available to the public.

COMMUNITY BENEFITS MISSION STATEMENT

The governing body of each non-profit acute care hospital should affirm and make public a Community Benefits Mission Statement, setting forth its formal commitment to provide resources to and support the implementation of its annual Community Benefits Plan.

A Community Benefits Mission Statement is a public declaration by a hospital or HMO that states the hospital or HMO commits to provide support to address unmet health needs and improve the health of disadvantaged populations through the development and implementation of a Community Benefits Plan. The Mission Statement should explicitly recognize the hospital's traditional partnership with the community, the value of productive collaboration, and the hospital's willingness to allocate resources to address the community's unmet health needs.

The Community Benefits Mission Statement should outline the general goals of the hospital's Community Benefits Programs for a given period, to be addressed in more detail in the Community Benefits Plan. The hospital should develop the Mission Statement in collaboration with its community. It is recommended that this Mission Statement be reviewed and amended by the Governing Board as necessary.

The Community Benefits Mission Statement should be made available to the public. For example, the hospital could post the Community Benefits Mission Statement on its website.

EXAMPLE
COMMUNITY BENEFITS MISSION STATEMENT

"Helpful Hospital in Hopeful Massachusetts is committed to collaborating with community partners to improve the health status of community residents, address root causes of health disparities, and educate community members around prevention and self-care"

LEADERSHIP

The hospital should demonstrate its support for the Community Benefits Plan at the highest levels of the organization. The hospital's governing board and senior management should be responsible for overseeing the development and implementation of the Community Benefits Plan and designating the method to be followed, the resources to be allocated, and the mechanism for its regular evaluation.

The hospital should demonstrate high level support for its Community Benefits Plan. One way to demonstrate this support is to designate a Community Benefits Team within the hospital that is comprised of hospital leaders and staff from a number of different operational groups. Social workers and health educators can bring a great deal of expertise to the Team with regard to the most successful way to reach community members in need as can staff who will implement and report on the program. It is recommended that the hospital designate a Community Benefits manager who will implement the directions of hospital leadership on Community Benefits.

Hospital leadership should meet as often as necessary to oversee the development of the Community Benefits Plan, including to conduct a needs assessment, articulate the institution's mission statement, dedicate resources to implement the plan, and evaluate both individual projects and the program as a whole. For example, a Community Benefits Leadership Team could meet initially to coordinate the needs assessment process and community outreach, again to analyze the results, develop the mission statement and plan, and as necessary thereafter to monitor and evaluate the programs.

In order to form a bridge to community leaders and representatives of the medically underserved, hospitals should establish a Community Benefits Advisory Group, or other similar mechanism, that includes members of the population to be served and which reflects the racial, cultural, and ethnic diversity of the community. Such group could provide invaluable input to hospital leadership when designing the Community Benefits Health Needs Assessment, Mission Statement, and Plan.

COMMUNITY INVOLVEMENT

The hospital should ensure regular involvement of the community, including that of the representatives of the targeted underserved populations, in the planning and implementation of the Community

The hospital should actively seek and encourage collaboration, information, and input from the broad community and representative organizations that use and do not use the hospital's services. The hospital should seek this participation from various populations and groups within the hospital's geographic service area. The hospital should institute effective community outreach to contact populations which may have been historically under-represented within its member population.

The hospital should work with members of the community, including, whenever feasible, the populations the hospital plans to target with its programs and activities, and from those organizations and social service providers that are closest to the targeted populations, such as health care providers, community health centers, Regional Centers for Healthy Communities (RCHCs), public health coalitions, neighborhood associations and community organizations, local boards of health, local health planning networks, social service agencies, community action agencies, private charitable organizations, schools, churches and clergy, police, housing authorities, and ambulance services.

Many of the more than 50 community health centers operating in 184 sites statewide serve primarily disadvantaged populations. In addition, community health centers are addressing the statewide priorities as leaders in implementing health care reform, designing chronic disease management programs and addressing health care disparities. Collaboration among hospitals and community health centers is one important way to identify target populations, set goals, plan and implement programs, assess success, and continue to improve community benefits programs.

COMMUNITY HEALTH NEEDS ASSESSMENT

To develop its Mission Statement and Community Benefits Plan, the hospital should conduct a Community Health Needs Assessment, a comprehensive review of unmet health needs of the community by analyzing community input, available public health data and an inventory of existing programs.

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). 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.

Who is considered part of your community?

While the geographic hospital service area is the natural definition of "community" for purposes of the needs assessment, the hospital service area should be the hospital's starting point for assessing health needs. The community examined may differ from the patient care population. Consider whether there are populations within that geographic area with particular unmet health needs.

1. 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.

2. 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.
- 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.

3. Review Existing Programs

- The hospitals should review all of the community service and community benefits programs currently provided by the hospital, as well as by other health care providers and social service agencies in the service area that are aimed at addressing community health needs. This review should include information about which health indicators are being addressed and which populations are being served in order to avoid duplication and support cooperation.
- After evaluating all of the assessment data, the hospital should evaluate the existing community benefits programs to determine whether it makes sense

for the hospital to continue with programs in light of the community's changing needs.

Collecting as much quantifiable information as possible during the assessment process will support the development of an appropriate measurement methodology for each community benefit program.

COMMUNITY BENEFITS PLAN

The hospital should include in its Community Benefits Plan the Target Populations it wishes to support, specific programs or activities that attend to the needs identified in the Community Health Needs Assessment, and measurable short and long-term goals for each program or activity.

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

Identification of Target Populations/Prioritization of Needs

The hospital should rely on its analysis of its Community Health Needs Assessment data to determine the issues and populations it chooses to make the focus of its Community Benefits Plan. By analyzing this data, the hospital can identify populations that are most underserved or health indicators that are particularly problematic and rank areas of need in order of priority. In prioritizing the needs of its community, the hospital should take into account the health care problems of medically underserved and disadvantaged populations, and should aim to reduce racial and ethnic disparities in health status. Attention should be given to the special needs of 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.

Analysis of Needs Assessment data should include an evaluation of the following criteria:

1. Income level of the affected populations
2. Presence of other significant barriers that hinder access to appropriate health care programs or contribute to poor health outcomes (e.g legal status, poor housing conditions, lack of access to affordable healthy foods, lack of safe recreational opportunities, etc.)
3. Absence of relevant and accessible resources and programs
4. Specific primary, acute, or chronic health care needs
5. Assessment of the hospital's capability of responding to the identified needs
6. Availability of other service providers, both public and private

When evaluating which needs to prioritize, the Attorney General’s Office recommends that each hospital consider how it may address health care disparities, improve chronic disease management, promote the wellness of an identified vulnerable population, and address the needs of the uninsured.

Target Populations

Target Populations are specific populations or communities of need to which the hospital will allocate resources through its Community Benefits Plan. Target populations must be disadvantaged populations. Some examples of disadvantaged populations are 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.

Hospitals are encouraged to be creative in defining specific Targeted Populations it will focus on, so long as there is a clear definition of a community, based on the needs assessment, and for which programs can be developed and outcomes can be measured. For example, the hospital may use the following approaches for defining a population or community:

- a) **Geographic boundary**, e.g., a city, town, county or several contiguous municipalities, not necessarily limited by the hospital’s direct service area;
- b) **Demographic**, e.g., a community may be defined by (i) the low or moderate income persons who are uninsured; (ii) the elderly; or (iii) pregnant women of low or moderate income;
- c) **Health status**, e.g., focusing on the prevalence of a particular disease, such as HIV, STD, diabetes, or cardio-vascular disease, within disadvantaged populations in the service area. This approach may involve contiguous neighborhoods, municipalities or whole counties.

A hospital may choose to focus its community benefit initiatives on more than one issue or population within its community. Hospitals may choose to collaborate with each other and with health plans in order to determine each hospital’s Community Benefits Target Populations and to develop a coordinated Community Benefits plan for the region.

Publication

The hospital should make public its list of Target Populations it plans to address through its Community Benefits Plan publicly available at the beginning of the fiscal year. For example, the hospital could publish the list on its website as well

as in other printed material or media widely disseminated to its service area and patient communities.

Amending the Community Benefits Plan: The Attorney General recognizes that circumstances arise during the year that may result in a change to the Community Benefits Plan. Change in circumstances, new opportunities, requests from community organizations, community and public health emergencies, and other issues could require the hospital to revise the Plan to include programs to address newly identified needs, additional issues or populations. In this situation, the Attorney General recommends that hospitals adopt and follow a transparent process for revising the Community Benefits Plan. At a minimum, that process should include:

1. Community involvement,
2. Hospital leadership approval, and
3. Publication the new list of programs to address the needs of each of the Target Populations.

Expenditures for programs spent after the date of the Plan amendment that support the new Target Populations will be considered Community Benefits Expenditures.

Community Benefits Programs

Only those Programs that address the needs of the Target Populations identified in the Community Benefits Plan can be reported as Community Benefits Programs.

The hospital should demonstrate that each of the community benefits programs in its Community Benefits Plan supports a Target Population. For each program in its Plan, the hospital should set goals, both short-term and long-term, and should identify a means of measuring whether the goals have been accomplished. The hospital should establish a budget sufficient to support its Community Benefits Plan and should ensure community involvement in program design, implementation, and evaluation.

Population Served and Needs Met

The hospital should clearly define who the **beneficiaries of each program** are and the **specific services** that the hospital plans to provide to meet identified needs. It is important to keep in mind that the beneficiaries and the services need to be clearly defined as to make measurement feasible.

Community Involvement

The hospital should demonstrate that it has involved the community in the design of the programs that comprise its Community Benefits Plan. It should also show how community representatives and members are involved in the implementation and evaluation of its programs and Plan as a whole.

Examples of Community Benefits Programs

The following is a list of types of activities that may be considered Community Benefits Programs. It is important to note that all of these Programs are Community Benefits Programs only when they meet needs of disadvantaged communities that were identified by the Community Health Needs Assessment and support your Community Benefits Mission Statement. This list is by no means exhaustive.

1. Outreach health education through Community Health Workers to disadvantaged populations
2. Free preventive care or health screening services to disadvantaged populations
3. Mobile health vans that provide direct services or screening services to disadvantaged populations
4. Support for and participation in community oriented training programs that benefit disadvantaged populations
5. Low or negative-margin services which are offered in response to an identified community need. Such services include immunization programs, services to persons with AIDS, psychiatric care for deinstitutionalized and homeless persons, and outpatient mental health services for disadvantaged populations
6. Violence-reduction education, counseling, and other related measures for disadvantaged populations
7. Anti-smoking education and related activities for disadvantaged populations
8. Substance abuse education and related preventive and acute treatment services for disadvantaged populations
9. Domestic violence and/or child abuse and neglect prevention or intervention services
10. Early childhood wellness programs for disadvantaged populations
11. Expanded prescription drug programs for disadvantaged populations
12. Volunteer services to benefit disadvantaged populations organized by the hospital and performed on hospital time
13. Net financial assistance to independently licensed and hospital licensed community health centers and community mental health centers that provide services to disadvantaged populations
14. Unfunded services that are ancillary to Medicaid or Medicare service, if part of a community benefits program, such as certain kinds of personal

care/home care services for which Medicaid or Medicare does not provide any reimbursement

15. Free legal services that improve the health of disadvantaged population
16. Medical and clinical education and research conducted in response to a previously assessed community need where such need and the education and research are specifically parts of the Community Benefits Plan. For example, in some areas there is a lack of providers of color that may contribute to racial health disparities and a program designed to attract providers of color could help address this issue

The common denominator among all community benefit activities is that they are part of a Community Benefits Plan that responds to specific health needs identified through a needs assessment process with the active collaboration of the population to be served.

See Appendix III for a suggested timeline for developing the plan.

Goals and Measurement

The hospital should articulate measurable goals for each Community Benefits Program. Hospitals should consider establishing quantifiable goals that are appropriate to the nature of the program or activity. For example, if the purpose of a program is to increase parenting skills in teen mothers, a measurable goal could be ensuring that program participants will have 5 new parenting skills at the end of the class. This would be measured by skills testing at the beginning and conclusion of the class.

Hospitals may choose to set either operational or outcome goals depending on the nature of the program. Since no single goal or measure will be applicable to every program, hospitals are encouraged to be creative in setting goals to make their programs a success. Likewise, hospitals are encouraged to apply the objective measures most appropriate for each program.

- **Operational Goals:** A goal associated with the process of the Community Benefits Program like the number of patients treated in a particular area for a given condition (example: number of immunizations, number of pregnant teenagers served, number of adolescents tested and counseled for AIDS)
- **Outcome Goals:** The reduction of or improvement in a particular health status indicator (example: the reduction in incidence of tuberculosis, the reduction in teen pregnancies, the reduction in numbers of adolescents with AIDS, the improvement from pre-testing to post-testing)

It is important to establish a time frame within which the goal should be

realized. Hospitals are encouraged to consider developing both **short-term** (1 year) and **long-term** (3-5 years) goals for each project. Long-term measures of success should be the improvement in health status outcomes of the community or population(s) set forth in the hospital's Community Benefits Target Populations. Community health status outcomes can be determined by consulting the Health Status Indicators of the Department of Public Health and the data on Preventable Hospitalizations in Massachusetts maintained by the Division of Health Care Finance and Policy.

The ultimate measure of the success of the programs and activities comprising a Community Benefits Plan should be the improvement in health status outcomes of the hospital's Target Population(s). Hospitals are encouraged to use existing health status indicators to determine **baseline measures** for purposes of setting measurable goals for Community Benefits Programs and to assess the programs effectiveness in improving health status outcomes.

The Attorney General recommends that hospitals, in determining how to measure the success of their programs, consider assessing the impact of their interventions on the state-wide health priorities (i.e.; health disparities; chronic disease management; promoting wellness of disadvantaged populations; and reaching the uninsured).

Budget

Hospitals are strongly encouraged to incorporate their Community Benefits Budget planning into their hospital-wide budget and fiscal planning processes. This ensures both that funds and resources will be available for Community Benefits Programs and demonstrates the hospital's commitment to the Program and its community. The hospital should commit sufficient resources to fulfill its Community Benefits Mission Statement and implement its Community Benefits Plan. Hospitals are encouraged to establish an overall Community Benefits budget and to make a good faith effort to measure expenditures and administrative costs associated with the process. It is important for the overall budget to plan for contingencies and emergencies that may arise throughout the year.

The Attorney General acknowledges that hospitals vary greatly in size, structure and available resources. Hospitals should set the level of resource allocation for community benefits appropriate for its institution. However, to promote accountability, it is important to establish a framework for evaluating comparative levels of community benefit expenditures that is flexible but also provides transparency.

Accordingly, to determine its annual level of gross community benefit expenditures, the hospital should identify, in collaboration with its community, a

reasonable amount of gross community benefits to be provided by taking into consideration various financial indicators, including the following factors:

- a. Audited total patient operating expenses and audited total operating revenues;
- b. Accumulated hospital operating margins (positive or negative) and compensation structures and levels relative to industry norms; and
- c. The net value of the hospital's tax exempt benefits, if that figure is available.

As with all community benefits activities, hospitals should consult actively and openly with and cooperate with community groups and representatives in establishing a reasonable expenditure level.

It is expected that each hospital will commit sufficient funds to continue the development of a robust and responsive community benefits program. While the Attorney General is not recommending a specific target level of annual gross community benefit expenditures at this time, each hospital should provide information on both its community benefit expenditures and its financial status and resources so that the Attorney General can analyze the relationship between its level of community benefits expenditures and its ability to pay. The Attorney General will annually review each hospital's community benefits expenditures in relation to its operating expenditures, revenues and surplus, and may from time to time conduct audits or publish specific reports based on its analysis.

The Attorney General's Office has previously considered adopting target expenditure levels that would take into account the size of the institution, from small community institutions to large urban medical centers, to suggest appropriate levels of resource allocation to community benefits programs. Under this approach, the target goal for gross community benefits would be accomplished consistent with the financial values associated with achieving the various health care priorities chosen for the Community Benefits Plan. Once priorities are chosen, values would be attached and additional priorities would be included as may be necessary to reach a particular target level of gross community benefits expenditure. The target goals that would be envisioned in this approach are: (a) for hospitals with audited total patient operating expenses under \$200 million, up to 3% of such expenses (although there would be significant flexibility within this alternative, target levels at the lower part of this range would be anticipated only for hospitals with financial circumstances that warrant such a target level); and (b) for hospitals with audited total patient operating expenses over \$200 million, 3% to 6% of such expenses. Hospitals may choose to consider these target levels in developing their community benefit budgets.

REPORT

Each hospital should submit an annual Community Benefits Report to the Attorney General's Office that details 1) the process of developing its Community Benefits Plan; 2) information on its Community Benefits Programs including program goals and measured outcomes; and 3) Community Benefits Expenditures. The hospital should make the report available to the public.

The Community Benefits Report filed annually by each hospital gives the Attorney General's Office and the public important information about how hospitals are working with their communities to identify and address unmet health needs of disadvantaged populations. With this in mind, the AGO Reporting forms have been updated so that hospitals can provide detailed information in a streamlined format on the *goals and outcomes* for its Community Benefit Programs; the *process* by which hospitals create and deliver these programs, and *Community Benefit Expenditures*.

Please see Appendix I for a complete and detailed description of reporting requirements.

Report Content

Information submitted to the AGO in a standardized format has proved to be more useful to the Office and the public than the Full-Text Report. Therefore the AGO no longer *requires* hospitals to submit a full-text report. **Hospitals may choose to submit an optional narrative report as long as the hospital also completes the on-line standard Attorney General Community Benefits On-line Report Form.** There will be a place on the On-line Report Form where hospitals can provide an HTML link to their full text report.

Community Services Reporting The Online Report Form allows hospitals to report on Community Service Programs and charitable activities that do not meet the definition of community benefits programs. This portion of the report is *optional* and the Attorney General Office will not count community service spending toward the community benefits expenditure total, nor will the office report on this data.

1. Community Benefits Process Reporting

In order to capture information on how the hospital works with community partners and determines which needs to address, the report should provide the following information.

- **Leadership** – Hospital governing board members, management and staff involved in the development and implementation of the Community Benefits Plan
- **Community Health Needs Assessment** – The date of last needs assessment, sources of information reviewed and community members involved
- **Community Benefits Plan** – The Community Benefits Mission Statement, plan, programs, and goals that have been adopted and published by the hospital
- **Community Involvement** – The members of the community involved in the process of developing Community Benefits Mission Statement, plan and programs
- **Community Benefits Plan Amendment**– The process the hospital engaged in to amend the Plan due to a need arising during the Plan year.

2. Community Benefits Program Reporting

Hospitals are asked to report detailed information about the Community Benefits Programs included in the Plan. By providing this information, the hospitals will be able to demonstrate how these programs are advancing the hospital’s overall Community Benefits goals.

- **Program Specifics** – The services offered, populations served, goals, budget, responsible parties, community partners and progress indicators; including details about the populations served and the health indicators addressed is critical as these are the items that the public will search for when looking for services.
 - Population Served
 - Goals
 - Outcomes
 - Responsible parties
 - Community partners
 - Budget
- **Statewide Health Priorities** – Hospitals are asked to report whether the community benefits program addresses a state-wide health priority as described in the introduction to the Guidelines.

3. Community Benefits Expenditure reporting

Hospitals are asked to provide information on its estimated total expenditures for Community Benefits for the prior hospital fiscal year. The Attorney General

realizes that some hospitals have more resources to devote to community benefit activities than others and wants to ensure that the efforts of all hospitals are quantified in a fair and useful way and reported along with other hospital financial information.

- **Community Benefits Expenditures:** Funds that are allocated to Programs that support the hospital's Community Benefits Plan and address the needs of the Target Populations are considered Community Benefits Expenditures. These funds can be identified as direct expenses, associated expenses, Determination of Need expenditures, employee volunteerism, and other leveraged resources. (Expenditures that correspond with a Plan amendment may be reported as Community Benefits Expenditures from the time of the amendment onwards).
- **Community Service Expenditures:** Optional reporting of community services expenditures. **Community service expenditures will not count towards the community benefits total.**
- **Bad Debt:** Optional reporting of hospital bad debt if it certifies that, in the prior fiscal year, it has adopted and followed the Attorney General's Recommended Debt Collection Practices for hospitals, outlined in Appendix II.
- **Total Patient Care-related Expenses**
- **Total Revenues**
- **IRS Form 990 information (for comparison purposes only)**

What is the difference between a community service program and a Community Benefits Program?

A hospital may conduct community service programs as well as community benefit programs that provide health services to the community at low or no cost. The difference is that a Community Benefits Program addresses the specific needs of a Target Population the hospital has identified through its Community Health Needs Assessment and outlined in its Community Benefits Plan.

Programming that falls outside the scope of the Community Benefits Plan (or amended plan) CANNOT be counted as a Community Benefit Program. Instead, these services are Community Service Programs which may be reported separately in an optional portion of the report.

Appendix I

Reporting

The AGO asks that each hospital and HMO report annually on its Community Benefits Programs via the AGO [website](#). Information on the website informs filers how to obtain a user name and password that will allow staff to access and complete the on-line reporting form.

Once the Report has been submitted to the website, AGO staff will review the report to ensure it is accurate and complete. If there is a question or problem with the on-line report, the Office will contact the hospital or HMO with this information and ask that the hospital or HMO correct the report. Once the correction has been made the report will be published on the AGO website.

The annual report covers the period of the previous fiscal year.

Timeline for Reporting

<p style="text-align: center;"><u>Due Dates*</u></p> <p style="text-align: center;">Hospital Community Benefit Reports are due on April 1 Date of Publication by the AGO – June 1</p> <p style="text-align: center;">HMO Community Benefit Reports are due on June 1 Date of Publication by the AGO – July 1</p> <p style="text-align: center;">*The Attorney General’s Office does not grant extensions on these dates.</p>

- Any organization that does not submit its report by the due date or that does not address the feedback provided to the organization by the AGO in a timely manner cannot expect to be published on time and may be excluded from the AGO’s press release about the Community Benefits Annual Reports.
- Annual community benefits reports should cover the 12-month period of the hospital or HMO’s fiscal year.
- Not-for-profit HMOs should not delay the filing of their community benefits reports in response to extensions received in connection with tax or public charities filings.

Hospital and HMOs should refer to the definitions set forth in **the Glossary**, as well as to the Attorney General’s Community Benefits Guidelines. Hospitals and HMO’s should also refer to the Community Benefits section of the Attorney General’s web site (www.mass.gov/ago) for other supporting materials that will be added

from time to time.

Reporting Requirements

The following is the list of information requested in the Community Benefits Report:

Organization Address and Contact Information

- Organization Name
- Address
- City, State, Zip
- Website
- Contact Name (specifically the person who is responsible for completing the report)
- Contact Title
- Contact Department
- Telephone Num
- Fax Num
- E-Mail Address
- Contact Address (If different from above)
- Contact City, State, Zip
- Organization Type
- For-Profit Status
- DHCFP ID
- Health System (If part of a Health System)
- Community Health Network Area (CHNA)
- Regional Center for Healthy Communities (RCHC)
- Regions Served

Leadership

- Board Members/Senior Management Members
 - Name
 - Department
 - Title
- Meetings
 - Dates

Community Health Needs Assessment

- Date of Completion of Last Assessment
- Sources of Information
- Needs Identified

Community Benefits Plan

- Community Benefits Mission Statement
- Community Benefits Target Populations and Corresponding Health Assessment Data

Community Benefits Programs List

Community Benefits Programs (for each)

Target Population

Services Offered

Program goals -please provide at least one short term (1 year) and long term (3 to 5 year) goal for each program

Baseline Measurement

Outcome Timeline

Operational Timeline

Budget

Responsible Parties

Implementation Staff

 Name

 Department

 Title

Community Partners

Does this program address a State-Wide Priority? If so, how?

Expenditure Reporting

Community Benefits Programs

 Estimated Expenditures

 Direct Expenses

 Associated Expenses

 Determination of Need Expenditures

 Employee Volunteerism

 Other Leveraged Resources

Total Expenditures

Approved Program Budget

(*Excluding expenditures that cannot be projected at the time of the report.)

Community Service Programs) (OPTIONAL)

 Estimated Expenditures

 Direct Expenses

 Associated Expenses

 Determination of Need Expenditures

 Employee Volunteerism

 Other Leveraged Resources

Charity Care

Bad Debt (OPTIONAL and allowed only if hospital certifies that in the prior fiscal year it has adopted and followed the AGO's recommended debt collection practices for hospitals outlined in Appendix II)

Corporate Sponsorships

Total Patient Care-related expenses for the year (for Hospitals)

Total Revenues (for Hospitals)

Massachusetts Plan Members (for HMOs)
Total Revenues (HMOs)
Total Hospital, Medical, and other Health Care Costs (for HMOs)
Total Administrative Expenses (for HMOs)
Comments

Community Response

The Attorney General encourages community response to hospital or HMO community benefits annual reports, and encourages hospitals and HMOs to solicit such feedback. The Attorney General recommends that community groups or members provide comments, both positive and negative, directly to the hospital or HMO whenever possible. Community groups or members are always welcome, however, to communicate any thoughts or concerns to the Attorney General's Office.

At the request of a community group, the Attorney General's Office will publish on its website written comments related to a hospital or HMO's community benefits annual report. The purpose of this policy is to encourage community participation by offering community members an opportunity for thoughtful and constructive feedback on the community benefits processes and activities described in their local hospitals and HMOs' annual reports. The Attorney General's web site is not intended as a forum for airing grievances that are best resolved through direct communication.

For publication on the Attorney General's web site community submissions should meet the following standards:

Content

1. The submission should relate directly to the hospital or HMO's most recent community benefits report and programs. The tone of the submission should be consistent with the spirit of the Attorney General's Community Benefits Guidelines, which envision cooperation and partnership between hospitals, HMOs and their communities.
2. Appropriate discussion points include, but are not limited to: (1) the hospital or HMO's methods of community engagement or its mechanisms for community participation, including suggestions for improving community engagement; (2) the hospital or HMO's needs assessment process, including information related to unmet community needs that a hospital or HMO should consider in its community benefits planning; (3) other aspects of the community benefits planning process or the results of that process, including comments on how the hospital or HMO's actual programs target identified community needs or recommendations for a shift in priorities; (4) the level of resources a hospital or HMO has allocated to community benefits; (5) recommendations as to how a hospital or HMO could improve a particular community benefits program; and (6) identification of community benefits programs through which a hospital or HMO successfully has addressed identified community needs (i.e., best practices).

3. Submissions aimed primarily at criticizing a hospital or HMO's decision to fund or not fund a particular program will not meet the standards for publication on the web site. Likewise, submissions aimed primarily at praising or thanking a hospital or HMO for supporting a particular community benefits program or community organization will not meet these standards.
4. The submitting party should identify him or herself and any group that he or she represents. The submission also should provide information about the submitting party's relationship with the hospital or HMO, and identify any "stakeholder" interest in the community benefits process (e.g., as a current or potential recipient of community benefit funds). Anonymous submissions are not eligible for posting on the Attorney General's web site; the Attorney General will post contact information for the submitting party.

Process

1. At least thirty days prior to filing a submission for publication on the Attorney General's web site, the submitting party should provide a copy to the hospital or HMO that is the subject of the comments. The submission should be addressed to the hospital or HMO CEO, with a copy to the community benefits manager.
2. At the time that it provides the copy of its submission to the hospital or HMO, the submitting party should notify the hospital or HMO of its intent to ask the Attorney General to publish the submission, and should indicate its willingness to meet with representatives of the hospital or HMO to participate in a good faith discussion of any issues raised in its submission.
3. Any community submission subsequently made to the Attorney General should be filed in both hard copy and on a CD. It should be accompanied by a statement certifying that the submitting party has properly notified the hospital or HMO of its intent to submit its comments for publication on the Attorney General's web site, and summarizing the results of its offer to meet with the hospital or HMO.
4. At the request of the hospital or HMO, the Attorney General will post a single response to a public comment on its community benefits report or program. Any hospital or HMO response should refer directly to the issues raised in the community submission. Any further correspondence will be kept on file at the Attorney General's Office.

Appendix II

Recommended Hospital Debt Collection Practices

Medical debt can adversely impact the health and financial well-being of individuals and their families. Uninsured and insured individuals may need medical services and products that they cannot afford and that are not covered by a third party payer and, as a result, incur medical debt. Unlike some other types of debt, medical debt is generally the consequence of non-discretionary expenditures. The burden of medical debt may discourage an individual from seeking necessary health care, which can ultimately result in worse health outcomes. In addition to becoming a possible barrier to care, medical debt can also affect a person's credit rating and undermine his or her overall financial stability. In turn, this has a negative effect on the financial stability of the community.

At the same time, the Attorney General acknowledges that a hospital must seek reimbursement for services it has provided to individuals who are able to pay. In addition, individuals must also provide appropriate information so the hospital seeking to collect debt can assist them. For these reasons, the Attorney General recommends that hospitals follow fair debt collection practices that take into account the unique nature of medical debt by providing reasonable protections for patients while allowing providers to seek appropriate reimbursement.

Consistent with federal and state regulations, hospitals should develop a written "Credit and Collection Policy" that includes the description of any program through which the hospital offers discounts from charges for the uninsured or medically indigent. Hospitals should also make available to the public information about their charity care policies and other known financial assistance programs.

The Attorney General recommends that hospitals adopt and implement fair debt collection practices for collecting debt for services provided to a patient with limited ability to pay, whether insured or uninsured. The following recommended Hospital Debt Collection Practices are not intended to supersede or in any way limit rights and protections provided under federal or state laws or regulations such as Health Safety Net Eligible Services, 114.6 CMR 13.00. Recommended Hospital Debt Collection Practices include, but are not limited to, the following:

- 1) The hospital should provide sufficient billing information in order for the patient to ascertain the accuracy of his or her bill;

- 2) The hospital should provide the patient with clear information (including on all bills) on how to contact the hospital to inquire or to dispute a bill and should respond to patients' inquiries within 30 days. The hospital should make this information available in all of the languages for which the hospital provides on site interpreter services;
- 3) The hospital should provide the patient with information about all available financial assistance programs including information on how to apply for them during the intake and registration process prior to the provision of any health care services or procedures or as soon thereafter as possible while in the hospital as well as on all bills. Additionally, the hospital should make this information available in all of the languages for which the hospital provides on site interpreter services;
- 4) The hospital and its agents should not begin collection activities, other than billing, without first providing the patient with a written statement of the availability of financial counseling services and giving the patient facing financial hardship the opportunity to avail him or herself of a reasonable payment plan;
- 5) The hospital should not assign patient accounts for collection to a third party collection agency prior to 120 days after the first bill has been sent to the patient (unless the patient did not receive the bill due to a bad address or the patient is deceased) and should continue to work with patients and negotiate patient bills during and after the 120 day period, allowing patients to make payments directly to the hospital at all times;
- 6) If a hospital plans to delegate collection activity to an outside collection agency, it should do so by means of an explicit authorization or contract to do so and should require that the third party agree to abide by the hospital's credit and collection policies;
- 7) Third party collection agents should provide the patient with an opportunity to file a grievance or complaint and should forward all grievances or complaints to the hospital regarding the bill or the conduct of the collection agent;
- 8) The hospital and its agents should not report a patient's debt to a credit reporting agency unless specifically approved by the hospital's board of directors. The hospital and its agents should seek removal of these items from the patient's credit report once the debt is paid in full;
- 9) The hospital and its agents should not sell a patient's debt unless specifically approved by the hospital's board of directors;

- 10) The hospital and its agents should not seek to garnish a patient's or a patient's guarantor's income or wages or seek a lien on a patient's or a patient's guarantor's personal residence or motor vehicle to collect patient debt unless specifically approved by the hospital's board of directors;
- 11) Third party collection agents should first obtain the hospital's written consent prior to commencing any legal action; and
- 12) The hospitals and its agents should not charge interest on patient debt.

Appendix III

Plan Timeline

The development and implementation of a hospital or HMO's Community Benefits Plan necessarily occurs in phases. The following is a suggested sequence for implementing a Community Benefits Plan over the course of a year.

Phase 1: Identify Community Benefits Team

- Designate a Community Benefits Team that includes senior management that will be responsible for the Community Benefits Plan
- Identify meeting dates for the year
- Determine who will be responsible for carrying out the day-to-day responsibilities of implementing the community benefits programs

Phase 2: Completion of Community Health Needs Assessment

- Assess community need, taking into account all data and information already available, and avoiding duplication wherever possible and giving special attention to statewide priorities
- Partner with as many community groups as possible to ensure the information collected is complete
- Identify community health needs
- Review all the community service and community benefit programs currently provided by the hospital, as well as by other health care providers, or social service agencies

Phase 3: Adopt Community Benefits Mission Statement

- Work with community groups to prioritize which needs uncovered in the Community Benefits Needs Assessment and underserved communities the hospital or HMO plans to address in coming plan year
- Formalize and make public a Community Benefits Mission Statement

Phase 4: Develop and Adopt Community Benefits Plan

- Prioritize identified needs and design programs to address those needs
- For each program identify who each program will serve, what services it will provide, and what is the timeframe for reaching these goals as well as who is responsible for each program's success
- Set short-term (one year) and long-term (three to five year) goals for each

program, whether operational or outcome goals

- Determine the need for resources for each program, such as paid and volunteer staff, as well as for additional physical facilities, mobile health units, and other resources
- Prepare a budget for the Community Benefits Plan, indicating expenses, expected revenues, and outside sources of funding

Phase 5: Implement Community Benefits Plan

- Determine time frames for implementing each aspect of the Plan
- Monitor programs and measure according to short and long-term goals
- Retain flexibility to respond to unanticipated community health emergencies

Phase 6: Prepare Annual Community Benefits Report

- Work with program managers or grantees to complete the Community Benefits Report and file with Attorney General's Office
- Review the Report with a focus on opportunities for improvement in next year's Plan

Appendix IV

Community Health Needs Assessment Resources

There are many data sources readily available to hospitals and HMOs for use in the Community Health Needs Assessment. In addition to the sources listed below, local community organizations are good sources of community data.

Mass.gov

The Massachusetts state website is a good resource for health statistics for Massachusetts residents.

Website: <http://www.mass.gov/dph/pubstats.htm>

Massachusetts Department of Public Health

[Regional Health Status Indicators Report](#): The Regional Health Status Indicators Reports use current data to provide information about health care access, births, deaths, major chronic and infectious disease rates, substance abuse, injury, and violence for each region in Massachusetts. This information is organized by race, ethnicity, and age, which will help you to identify vulnerable populations in your catchment area to focus on for your community benefit plan.

Website:

http://www.mass.gov/?pageID=eohhs2terminal&L=4&LO=Home&L1=Consumer&L2=Community+Health+and+Safety&L3=Population+Health+Statistics&sid=Eeohhs2&b=terminalcontent&f=dph_research_epi_c_regional_health&csid=Eeohhs2

[Massachusetts Community Health Information Profile \(MassCHIP\)](#): The Massachusetts Community Health Information Profile (MassCHIP) is a free, online health information service that provides access to customized data reports that will help you to complete a health needs assessment of your community.

Website: <http://masschip.state.ma.us/>

How to use it: Community-level health data can be accessed through MassCHIP in two ways:

- 1) Generating **Instant Topics** (formerly known as standard reports), which are predefined reports using MassCHIP's most recent data. This function is available on-line.
- 2) For an even more in-depth view of your data source and particular selectors, create a user-defined **Custom Report**. Custom reports are not yet available on-line. Follow the directions on the website and download MassCHIP onto your computer.

Department of Public Health, Publications and Statistics: The Department of Public Health has a webpage with links to publications and statistics that cover a broad range of Massachusetts-specific health information, including: communicable diseases, chronic diseases, environmental health, and domestic violence, among others.

Website: <http://www.mass.gov/dph/pubstats.htm>

Academic Institutions

There are a number of prominent schools of medicine, nursing, dentistry and public health throughout the Commonwealth that are involved in community-based research. As part of your community needs assessment and planning process, you might consider reaching out to academic health-related institutions in your area to inquire about research on the unmet health needs of vulnerable populations in your community.

Kaiser Family Foundation

State Health Facts: Massachusetts: The Kaiser Family Foundation makes state-specific health information available for a broad range of health indicators. Some of the information is a few years old, but it might be useful for you to look at this website during the early stages of your planning because it shows the prevalence of various health issues that you might choose to focus on for your community benefit plan.

Website: www.statehealthfacts.org

Boston Public Health Commission

Health of Boston annual report: This resource is useful to hospitals or HMOs whose catchment area is primarily or exclusively in Boston. The annual Health of Boston report provides current information about prevalence and incidence rates of disease and health status indicators for people living in Boston.

Website: <http://www.bphc.org/news/report.asp?id=224>

MetroBoston Data Common: DataCommon is an on-line mapping tool that allows you to create your own community maps using public health data.

Website: <http://www.metrobostondatacommon.org>

Centers for Disease Control, National Center for Health Statistics

Faststats: Provides health trend data for health indicators and behaviors that suggest areas for programming and outreach, such as: binge drinking, diabetes awareness, and no mammogram within 2 years.

Click on “Massachusetts” on the Faststats map to get access to state trends data, state prevalence data, and United States-states data.

Website: http://www.cdc.gov/nchs/fastats/map_page.htm or
http://www.cdc.gov/nchs/fastats/popup_ma.htm

SMART: Selected Metropolitan/Micropolitan Area Risk Trends- allows you to view results to questions about different health risks by geographic areas in Massachusetts.

Website: <http://apps.nccd.cdc.gov/brfss-smart/index.asp>

Massachusetts Department of Public Health

Cancer Registry: The Cancer Registry contains data about the incidence of different types of cancer diagnoses by city/town in Massachusetts.

Website:

http://www.mass.gov/?pageID=eohhs2terminal&&L=5&Lo=Home&L1=Government&L2=Departments+and+Divisions&L3=Department+of+Public+Health&L4=Programs+and+Services+K+-+S&sid=Eeohhs2&b=terminalcontent&f=dph_cancer_g_program_cancer_registry&csid=Eeohhs2

Health Status Indicators by Race and Ethnicity: These reports provide comparative information about health status indicators by racial and ethnic groups in Massachusetts, including: maternal and infant health, risk behaviors, and AIDS incidence.

Website:

http://www.mass.gov/?pageID=eohhs2terminal&&L=4&Lo=Home&L1=Consumer&L2=Community+Health+and+Safety&L3=Population+Health+Statistics&sid=Eeohhs2&b=terminalcontent&f=dph_research_epi_race_ethnicity&csid=Eeohhs2

Appendix V

History of the Guidelines

The Attorney General's Office originally issued the Community Benefits Guidelines in June 1994. They were followed by the *Attorney General's Community Benefits Guidelines for Health Maintenance Organizations* in February 1996, in recognition of the increased role played by HMOs in the health care system. Attorney General Tom Reilly adopted and reissued both the hospital and the HMO Guidelines in their original form in January 2000 and made some technical and editorial changes in 2002.

In 2008, Martha Coakley created a task force to reexamine the process and the guidelines. As part of the Attorney General's Community Benefits Advisory Task Force, hospital and HMO representatives, community advocates and other state agencies worked closely together to recommend updates to the guidelines that would improve and strengthen the Community Benefits Program.

June 1994- The first version of *The Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals* is published by the office

February 1996- The first version of *Attorney General's Community Benefits Guidelines for Health Maintenance Organizations* is published by the office

1996- The first Community Benefits Hospital and HMO reports are filed with the AGO

January 2000- Attorney General Tom Reilly adopts and reissues both the hospital and the HMO Guidelines in their original form

January 2002- Attorney General Tom Reilly revises and re-issues both the hospital and the HMO Guidelines

January 2008- Attorney General Martha Coakley convenes a Community Benefits Task Force to examine the current Community Benefits Report Requirements

February 2009- Attorney General Martha Coakley issues the new versions of the *The Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals and Health Maintenance Organizations*

Please see the link on our website for more information about the origins of the guidelines.

Appendix VI

Community Benefits Task Force Members

Task Force members met once a month for a year on the creation of these new Guidelines. Their efforts and input were invaluable to the process.

Barbara Anthony

Health Law Advocates

Ellen Banach/Kerry Mello

Southcoast Hospital Group

Lori Abrams Berry

Lynn Community Health Center

Dr. Marylou Buyse

Massachusetts Association of Health Plans

John Erwin

Conference of Boston Teaching Hospitals

Zoila Torres Feldman

Kit Clark Senior Center

Matt Fishman

Partners HealthCare

Brian Gibbs

Program to Eliminate Health Disparities
Harvard School of Public Health

Charles Joffe-Halpern

Ecu-Health Care, Inc

Grace Moreno/Fawn Phelps

Health Care for All

Lynn Nicholas

Massachusetts Hospital Association

Dr. Lauren Smith

Department of Public Health

Glossary

Bad debt: (As defined in section 1 of 118G) An account receivable based on services furnished to any patient which (i) is regarded as uncollectable, following reasonable collection efforts consistent with regulations; (ii) is charged as a credit loss; (iii) is not the obligation of any governmental unit or of the federal government or any agency thereof; and (iv) is not a reimbursable health care service by the Health Safety Net or its successor program.

Baseline Measurement: A quantifiable indicator of the current situation the hospital trying to address.

Charity Care:

1. The hospital or HMOs annual assessment to the Health Safety Net Trust Fund (HSN) pursuant to Chapter 118G and the amount, if any, of payment reductions subject to the shortfall allocation pursuant to 114.6CMR14.03 and the hospital's assessment pursuant to section 5 of Chapter 118G;
2. For acute hospitals, the cost of acute hospital services provided to low income patients billed to the HSN which have been denied payment pursuant to the HSN claims adjudication process. Cost of services shall be determined as follows:
 - The total amount net charges billed to the HSN for the denied claims;
 - Multiplied by the ratio of costs to charges calculated as the ratio of total patient care costs (*Schedule II, Line 116 Column 5*) to gross patient service revenue (*Schedule II, Line 116 Column 11*) as reported in the hospital's most recent filing of the DHCFP- 403 Hospital Statement for Reimbursement.
3. For hospitals, free or discounted health care provided to patients in accordance with a hospital's criteria for financial assistance and who are thereby deemed unable to pay for all or a portion of the services, calculated as follows:
 - The total amount of gross patient service revenue written off to the hospital's charity care program less payments received pursuant to the hospital's charity care program;
 - Multiplied by the ratio of costs to charges calculated as the ratio of total patient care costs (*Schedule II, Line 116 Column 5*) to gross patient service revenue (*Schedule II, Line 116 Column 11*) as reported in the hospital's most recent filing of the DHCFP- 403 Hospital Statement for Reimbursement.

Charity care does **not** include:

- Hospital bad debt
- The difference between the cost of care provided under Medicare or any means-tested government programs or to individuals eligible for the HSN, and the revenue derived there from;
- The cost of services that are non-chargeable pursuant to federal or state regulations or policies, including but not limited to Serious Reportable Events as defined by the National Quality Forum and other conditions that may be non-chargeable pursuant to other patient safety or quality improvement initiatives; or
- Contractual adjustments with any third party payers.

Note that the components of charity care in this definition differ from those that may be reported as charity care in the IRS Form 990.

Community Benefits Manager: A hospital or HMO employee responsible for carrying out the directives of hospital or HMO leadership in the development and management of a Community Benefits Program.

Community Benefits Mission Statement: A public declaration by a hospital or HMO that states the hospital or HMO commits to provide support for resources to improve the health of disadvantaged populations and address unmet health needs through the development and implementation of a Community Benefits Plan.

Community Benefits Plan: The description of how the hospital or HMO will address unmet health needs. The plan includes the 1) Mission Statement; 2) Target Population(s); 3) Budget for Plan; and 4) Community Benefits Programs designed to address the needs of each of the Target Populations and goals associated with the Programs.

Community Benefits Program: A program, initiative, or activity developed in collaboration with community representatives that serves the needs of a Target Population identified in the hospital or HMO's Community Benefits Plan.

Community Health Needs Assessment: The process of identifying the unmet health needs of disadvantaged populations in the community through a comprehensive review of unmet health needs by analyzing community input, available public health data, and an inventory of existing programs.

Community Service Program: A program, grant or other initiative that advances the health care or social needs of Massachusetts communities, but does not address the needs of the Target Populations identified in the hospital or HMO's formal Community Benefits Plan. Community Service Program Expenditures are not counted toward the Total Community Benefits Expenditures.

Expenditure Definitions

Corporate Sponsorships: Cash or in-kind contributions that support the charitable activities of other organizations, and are related to the Community Benefits Plan.

Direct Expenses: May include

1. The salary and fringe benefits (or a portion thereof) of a Community Benefits Manager and his or her staff;
2. The value of employee time devoted to a Community Benefits Program during paid work hours or leave time (calculated either at the rate of the employees' pay or using the averages set forth below in the definition of Employee Volunteerism);
3. Any purchased services or supplies directly attributable to the Community Benefits Programs, including contractual and non-contractual agreements with other organizations or individuals to develop, manage or provide the benefit or service, including leases/rentals of equipment or building space;
4. The costs associated with generating Other Leveraged Resources;
5. Dues subsidies and other financial assistance aimed at making health coverage more affordable for the uninsured or those at risk of losing health coverage, and
6. Grants to third parties in furtherance of a community benefit objective.

Associated Expenses: May include:

1. Depreciation or amortization related to the use of major movable equipment purchased or leased directly for the Community Benefits Program, and
2. A share of any fixed depreciation on a building or space therein used solely or in major part for a community benefit.

Determination of Need Expenditures: Direct or Associated Expenses related to Community Benefits Programs provided by a hospital in fulfillment of a specific determination of need condition established by the Massachusetts Department of Public Health pursuant to 105 CMR 100.

Employee Volunteerism: An employee's voluntary activities in connection with a hospital or HMO Community Benefits Program that take place during unpaid time as the result of a formal hospital or HMO initiative to organize or promote voluntary participation in the particular activity among its employees. The value of free or reduced-fee direct health care or public health services volunteered by health care providers employed by the hospital or HMO should be calculated using either (a) the rate of the employee's pay,

or (b) the average hourly rate for Massachusetts health care workers as calculated by the Centers for Medicare and Medicaid Services for purpose of the Medicare Area Wage Index during the reported fiscal year (\$36.74 in 2008 for Boston). The value of non-health care services volunteered by any employee should be calculated using the standard hourly rate set by the Independent Sector, a Washington, D.C.-based coalition of voluntary organizations, foundations and corporate giving programs, during the reported fiscal year (\$19.51 in 2007).

Other Leveraged Resources: Funds and services contributed by third parties for the express purpose of supporting a hospital or HMO's Community Benefits Programs. These include:

1. Services provided by non-salaried physicians or other individual providers free of charge to free-care eligible patients in connection with a hospital's free care program, or at no charge or reduced fee to low-income patients in connection with other hospital or HMO programs (calculated using a standard cost-to-charge ratio of .60);
2. Grants received from private foundations, government agencies or other third parties for the specific purpose of supporting a hospital or HMO Community Benefits Program; and
3. Money raised from or collected by third parties as the result of a fund-raising activity sponsored by a hospital or HMO in connection with a Community Benefits or Community Service Program.

Note: These definitions identify the range of costs that hospitals and HMOs might appropriately include when calculating expenses related to their Community Benefits Programs. They are not intended to impose an obligation on hospitals and HMOs to account for costs that they otherwise would not track. In those instances where costs are difficult to quantify, hospitals and HMOs should develop a reasonable estimate of their costs within the spirit of these guidelines. Hospitals and HMOs also should use discretion in categorizing costs that are not specified in the examples provided above.

Total Community Benefits Expenditures =
Community Benefits Expenditures (direct and associated) +
Determination of Need Expenditures +
Employee Volunteerism +
Other Leveraged Resources +
Corporate Sponsorships +
Charity Care

HMO: As defined by Chapter 176G of the Massachusetts General Laws, means a company organized under the laws of the Commonwealth, or organized under the laws of another state and qualified to do business in the Commonwealth, which

provides or arranges for the provision of health services to voluntarily enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum.

HMO Administrative Expenses: Expenses of the plan not related to hospital and medical benefits, including product development and marketing, Information Technology, customer service, claims administration, medical administration and case management, community benefit and other general expenses, excluding community benefit expenses. (*Line 21 on the NAIC Health Form Statement of Revenue and Expenses minus community benefit expenditures*).

HMO Hospital, Medical and Other Health Care Costs: Include hospital and medical benefits, professional medical services, outside referrals, emergency room and out-of-area services, prescription drugs, other medical costs less net reinsurance recoveries plus claims adjustment expense. (*Lines 18 + 20 on the NAIC Health Form Statement of Revenue and Expenses*)

HMO Total Revenue: The combined amount of premium income and other revenue collected related to the delivery of health care benefits. (*Line 8 on the NAIC Health Form Statement of Revenue and Expenses*)

Hospital: A non-profit acute care hospital, as defined by Chapter 118G of the Massachusetts General Laws to include the teaching hospital of the University of Massachusetts Medical School and any hospital licensed under Section 51 of Chapter 111 and which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the Department of Public Health.

IRS Community Benefits Expenditures: Community Benefits Expenditures as reported to the IRS in schedule H of the Form 990. Please note that the IRS allows hospitals to include the following expenditures as community benefit expenditures: Medicaid/Medicare “shortfalls”; all health professional education; and all cash and in-kind donations to community groups.

Medical Debt: Medical debt is money owed for medical services or products, such as hospital or physician services, prescription drugs, or ambulance services. It may be money owed directly to the provider of the service, to an agent of the provider, or to another source (such as a credit card or other lender) that may have been used to pay the bill.

Operational Goals: A goal associated with the process of the Community Benefits Program. (Example: number of immunizations, number of pregnant teenagers served, and number of adolescents tested and counseled for AIDS)

Outcome Goals: The reduction of or improvement in a particular health status indicator. (Example: the reduction in incidence of tuberculosis, the reduction in teen

pregnancies, the reduction in numbers of adolescents with AIDS, the improvement from pre to post testing)

Plan Members: The average of the total number of members, as defined in Chapter 176G of the Massachusetts General Laws, enrolled in an HMO's health plans, as reported to the Division of Insurance in the four quarterly reports for the periods of time occurring during the reported fiscal year.

Statewide Priorities: State-wide health care priorities identified by the Department of Public Health which the Attorney General recommends all hospitals and HMOs to consider as they conduct their community needs assessments and prepare their community benefits plans. These priorities are: supporting Health Care Reform by assisting those disadvantaged consumers who still do not have health insurance, chronic disease management of disadvantaged populations, reducing health care disparities, and promoting wellness of disadvantaged populations.

Target Population: The specific community or communities that are the focus of the hospital or HMO's Community Benefits Plan. A Target Population can be defined (1) geographically (e.g., low or moderate income residents of a municipality, county or other defined region); (2) demographically (e.g., the uninsured, children or elders, an immigrant group); or (3) by health status (e.g., persons with HIV, victims of domestic violence, pregnant teens). These must be disadvantaged populations such as 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.

Total Patient Care-Related Expenses (for hospitals): Expenses, including capital, related to the care of patients as reported by hospitals to the Division of Health Care Finance and Policy on Schedule 18 of the 403 Cost Report for the reported fiscal year.

Total Revenues (for hospitals): Gross patient service revenues from Schedule 5A of the hospital cost report.