The Attorney General's Community Benefits Guidelines for Health Maintenance Organizations

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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 unmet health needs in the communities they serve. The *Guidelines* seek 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 promotes meaningful and effective programs. The *Guidelines* represent a unique, non-regulatory approach that calls upon hospitals and HMOs to identify and respond to unmet community 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 charitable organizations. The Division assists the Attorney General in carrying out her

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 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 effectiveness of the Community Benefits Program, especially in the context of a

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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.

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 to consider as they conduct their community needs assessments and prepare their community benefit plans. These priorities, which are based on state-wide needs indentified by the Department of Public Health 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 or those 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.

Scope of Document

Consistent with the broad oversight and specific responsibilities of the office of the Attorney General, these Community Benefits Guidelines for HMO's are recommended for all HMO's licensed under MGL, chapter 1766, section 1. These guidelines are effective as of HMO fiscal year 2010.

HMO COMMUNITY BENEFITS PRINCIPLES

A. The governing body of each HMO should affirm and make public a Community Benefits Mission Statement, setting forth its commitment to provide resources for and support the implementation of its annual Community Benefits Plan.

B. The HMO should demonstrate support for its Community Benefits Plan at the highest levels of the organization. The HMO'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 HMO should ensure regular involvement of the community, including that of the representatives of the targeted populations, in all stages of planning and implementation of the Community Benefits Plan.

D. The HMO should take steps to reduce cultural, linguistic, and physical barriers to accessible health care at key points of patient contact.

E. Each HMO should develop its annual Community Benefits Plan based upon a Community Health Needs Assessment that identifies the health care needs and resources of its community. This assessment should take into account information from the community, available public health data, and a review of existing programs.

F. The HMO should include in its Community Benefits Plan specific programs or activities that address needs identified in the Community Health Needs Assessment and support the HMO's Community Benefits Mission Statement, requiring for each program or activity measurable short and long-term goals.

G. The HMO should strive to address the unmet health needs of consumers who continue to lack health care coverage.

H. Each HMO 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) Community Benefit programs and activities, including program goals and measured outcomes; and 3) Community Benefits Expenditures.

THE GUIDELINES

A. The governing body of each HMO should affirm and make public a Community Benefits Mission Statement, setting forth its commitment to provide resources for and support the implementation of its annual Community Benefits Plan.

Each HMO should establish a process to develop and update the Community Benefits Mission Statement approved by its governing body. The Mission Statement should set forth the HMO's commitment to developing, adopting, and implementing a Community Benefits Plan intended to facilitate, encourage, or provide for the delivery of health care services and educational and preventive programs and services to underserved populations in the HMO's service area. The HMO should develop the Mission Statement in collaboration with its community.

Once the statement is finalized, the HMO should make its Community Benefits Mission Statement publicly available. For example, the HMO could publish it on its website as well as in other printed material or media widely disseminated to its service area communities.

B. The HMO should demonstrate support for its Community Benefits Plan at the highest levels of the organization. The HMO'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.

The governing body and senior management of the HMO should be responsible for ensuring that the goals and objectives of its Community Benefits Plan are carried out by the HMO. The HMO should ensure that these goals and objectives are shared with individuals at every level of the organization so they are reinforced and widely accepted.

The Attorney General recognizes that the charitable foundations of HMOs in Massachusetts provide valuable services to those in need. If the HMO has established a foundation to conduct is charitable work, the HMO board may charge the foundation with developing and implementing the Community Benefits Plan pursuant to the Guidelines. The HMO should cooperate with its foundation to ensure that the efforts of the foundation that are to be reported as community benefit activities are developed and implemented in accordance with the Guidelines.

C. The HMO should ensure regular involvement of the community, including that of the representatives of the targeted populations, in the planning and implementation of the Community Benefits Plan.

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

The HMO should work with members of the community, including, whenever feasible, the populations the HMO plans to target with its programs and activities, and those organizations and social service providers that are closest to the targeted populations, such as health care providers, community health centers, neighborhood associations and community organizations, local boards of health, local health planning networks, Regional Centers for Healthy Communities (RCHCs), 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 benefit programs.

D. The HMO should take steps to reduce cultural, linguistic, and physical barriers to accessible health care at key points of patient contact.

HMOs should ensure that linguistic and cultural differences and physical disabilities do not present barriers to accessible health care. HMOs should provide translation and interpreter services in a timely and culturally competent manner. HMOs should seek to increase cultural competencies across their organization. To the extent feasible HMOs are encouraged to commit to increasing the number of bilingual providers in their service areas. All HMOs should strive to make telecommunications devices (TTY/TDD) available so that hearing impaired persons can have access to services.

E. Each HMO should develop its annual Community Benefits Plan based upon a Community Health Needs Assessment that identifies the health care needs and resources of its community. This assessment should take into account information from the community, available public health data, and a review of existing programs.

In reviewing the health needs of its community, the HMO should pay special attention to disadvantaged populations in the assessment as these populations should be the targets of all community benefits programs. 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. The HMO should also consider the state-wide health priorities identified by the Attorney General in conducting this assessment.

The needs assessment should be based in part on public health data and other existing health status indicators. These data are available from public and private entities, such as the Department of Public Health, the Department of Mental Health, the Health Care Quality and Cost Council, and the Division of Health Care Finance and Policy. Additionally, the HMO should look internally at its own data when examining community needs. Please see Appendix IV for more information.

Conducting a Needs Assessment should also include community representatives from outside the HMO, including community leaders, representatives from other health care and service providers, and members of the disadvantaged population(s). The HMO should consider community representatives as full partners in the process of identifying needs and in developing the subsequent Community Benefits Plan to address these needs. The process for identifying unmet health needs should be as open and inclusive as possible. HMOs 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.

One way the HMO could encourage feedback from the community is to hold a public hearing or community forum to solicit the views of community members. At such public events, the HMO might wish to invite the participation of the state public health departments or other public and private agencies that provide information or that coordinate resources to achieve public health objectives. Alternatively, the HMO could participate in the regional public health meetings about community needs.

Additionally, as part of the assessment, HMOs should review all of the health related community service and community benefit programs currently provided by the HMO as well as by other health care providers and social service agencies in the

service area. This review should include information about which health issues are being addressed and which populations are being served in order to avoid duplication and support cooperation. After evaluating all of the community needs assessment data, providers should evaluate their existing community benefits programs in light of this new information. Providers should consider whether it make sense for the provider to continue with these existing programs in light of the community's changing needs.

A Community Health Needs Assessment should take place at least once every three years.

F. The HMO should include in its Community Benefits Plan specific programs or activities that address needs identified in the Community Health Needs Assessment and support the HMO's Community Benefits Mission Statement, requiring for each program or activity measurable short and long-term goals.

Once the HMO has completed a Community Health Needs Assessment, the HMO should prioritize the needs identified in the assessment. The HMO should then define the Target Population(s) the Community Benefits Plan will support. Finally, the HMO should design Community Benefits Programs with measurable goals that address the needs of the Target Population(s) and adopt a budget to support these programs.

The Community Benefits Plan should be written with input from the community and should be tailored to be compatible with the HMO's organizational structure and model type, as well as the HMO's corporate culture and strategic vision.

1. <u>Needs Prioritization</u>

In prioritizing community needs, the HMO should consider the following:

1. Income level of the affected populations
2. Presence of other significant barriers that hinder access to appropriate health care 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 HMO's capability of responding to the identified needs
6. Availability of other service providers, both public and private

When evaluating which needs to prioritize in its annual Community Benefits Plan, the Attorney General's Office recommends that the HMO consider how it may address identified statewide health care priorities: supporting health care reform by addressing the needs of the uninsured, reducing racial and ethnic health disparities, chronic disease management, promoting wellness of an identified vulnerable population. An HMO may choose to focus its community benefit initiatives on more than one issue or population within its community. HMOs may choose to collaborate with each other or hospitals in order to develop a coordinated community benefit plan for the region.

2. Target Populations

The Target Population(s) should be identified through the Community Benefits Health Needs Assessment and should focus on disadvantaged populations including 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. HMOs are encouraged to be creative in defining the population or community or issue on which it will focus, so long as there is a clear definition of a targeted community, based on the needs assessment, and for which programs can be developed and outcomes can be measured. The following are some examples of how a population or community may be defined for purposes of choosing a Targeted Population:

A. Geographic boundary approach, e.g., a city, town, county or several contiguous municipalities, not necessarily limited by the HMO's direct service area;
B. Demographic approach, 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 approach focusing on the prevalence of a particular disease, such as HIV, STD, obesity, diabetes, or cardio-vascular disease, within disadvantaged populations in the service area. This approach may involve contiguous neighborhoods, municipalities or whole counties.

The HMO may define its target population and beneficiaries using other criteria based on the issues identified in the community needs assessment as long as those beneficiaries are part of a disadvantaged population.

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

The AGO 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 HMOs to revise the Plan to include additional populations or projects. In this situation, the Office recommends that HMOs adopt and follow a transparent process for revising the Community Benefits Plan. At a minimum, that process should include:

1. Community involvement;
2. HMO leadership approval; and
3. Publication of an amended Community Benefits Plan.

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

3. Programs

The HMO should demonstrate that each of the Community Benefits Programs in its Community Benefits Plan addresses a need identified in a Community Health Needs Assessment. It should clearly identify the beneficiaries of the program and the specific services offered. The HMO should also show that it has involved the community in the design and the development of each program. Programs should have defined goals, both short-term and long-term, and should identify a means of measuring whether the goals have been accomplished.

4. Goals and Measurement

HMOs should establish quantifiable goals that are appropriate to the nature of the program or activity. Health plans may choose to set either operational or outcome goals depending on the nature of the program. Time frames should be established for the accomplishment of each goal. Long-term (1-3 years) measures of success should be the improvement in health status outcomes of the Target Populations. If the program is ongoing, please consider interim measures that support improvement in attendance and outreach methods for a continuous process of improvement such as participant satisfaction.

It may be the case that the timing of grant reporting may not coincide with the Community Benefits reporting cycle. In these cases, the HMO should provide the most recent reporting available in its Community Benefits report and make a note of it.

HMOs are encouraged to use existing health status indicators to determine baseline measures for purposes of setting measurable goals for Community Benefits Programs. 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 HMO's community.

5. <u>Budget</u>

It is expected that each HMO should commit sufficient resources to fulfill its Community Benefits Mission Statement and implement its Community Benefits Plan. HMOs 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.

The Attorney General acknowledges that HMOs vary greatly in size, structure and available resources. HMOs 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 HMO 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 revenues and expenses;
b. Accumulated operating surpluses or deficits and compensation structures and levels relative to industry norms; and
c. The net value of the HMO's tax exempt benefits, if that figure is available.

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

The Attorney General considered but does not recommend a specific target level of annual gross community benefit expenditures at this time.[3] However, HMOs

[3] The Attorney General's Office has previously considered adopting target expenditure levels for non-profit acute care hospitals 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

are asked to provide detailed 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 HMO'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.

6. Publication

HMOs should make their 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 HMO could publish it on its website as well as in other printed material or media widely disseminated to its service area and patient communities.

G. The HMO should strive to address the unmet health needs of consumers who continue to lack health care coverage.

HMOs are uniquely situated to help address the unmet health needs of individuals who are not able to access insurance coverage despite the expansions of Chapter 58 and remain without coverage. Consistent with the Commonwealth's health care reform initiative, health plans should consider supporting programs that provide services to improve the health status of this population or that address the needs of those who cannot afford co-pays. For example, the HMO could fund programs that provide lower cost care to disadvantaged patients who are in a time of transition and without health insurance. Other examples include providing grant funds to lower cost providers to serve a Target Population without insurance. The provision of flu shots to the Targeted Population in anticipation of the flu season would be the provision of a new service which would benefit the community at large by enhancing health status and ultimately reducing health care costs.

H. Each HMO 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) Community Benefit programs and activities, including program goals and measured outcomes; and 3) Community Benefits Expenditures.

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.

The Community Benefits Report filed annually by each HMOs gives the Attorney General's Office and the public important information about how HMOs are working with their communities to identify and address unmet health needs of disadvantaged populations. The HMOs should include in their reports 1) the process of developing its Community Benefits Plan; 2) information on Community Benefits Programs, including program goals and measured outcomes; and 3) Community Benefits Expenditures. In preparing and submitting its annual report, the HMO should follow the process and format set forth in the Appendix I to these Guidelines.

The HMO does not need to submit a narrative (full-text) report. HMOs may choose to submit an optional narrative report as long as the HMO also completes the on-line standard Attorney General Community Benefits On-line Report Form. The HMO may report on community service programs in the on-line report. However, this portion of the report is optional and the Office will not report on this data.

Community response to the HMO Community Benefits Program and Reports is encouraged. HMOs are encouraged to solicit and make publicly available comments generated in response to the HMO Community Benefits Program. Please see Appendix IV for specific guidelines regarding the community response process.

Appendix I

Reporting

The AGO asks that each hospital and HMO report annually on its Community Benefit 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

Due Dates*
Hospital Community Benefit Reports are due on April 1
Date of Publication by the AGO – June 1
HMO Community Benefit Reports are due on **June 1**
Date of Publication by the AGO – July 1
***The Attorney General's Office does not grant extensions on these dates.

- 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&L0=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 Health and Human Services

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&L0=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&L0=Home&L1=Consumer&L2=Community+Health+and+Safety&L3=Population+Health+Statistics&sid=Eeohhs2&b=terminalcontent&f=dph_research_epi_c_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 Programs 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.