

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



COMMONWEALTH OF MASSACHUSETTS
OFFICE OF ATTORNEY GENERAL
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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 non-profit 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’s 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 build upon their commitment to address health and social needs in the communities they serve. The *Guidelines* 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 develop and implement programs that address those needs, and issuing annual reports on their efforts. The *Guidelines* do not dictate the specific 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 missions.

Updates to Guidelines

The Attorney General’s Office (“AGO”) 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

¹ The *Guidelines* were developed consistent with the AGO’s oversight of numerous aspects of the health care system. For example, through the Non-Profit Organizations/Public Charities Division, the AGO oversees hospitals and health plans as non-profit charitable organizations. The Division is responsible for carrying out the AGO’s responsibilities to ensure the “due application of funds given or appropriated to public charities” (M.G.L. C.12 s.8). The AGO’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. Concurrently, the AGO’s Health Care Division (1) investigates and litigates consumer protection cases involving health insurers, health providers, and pharmaceutical companies; (2) addresses consumer complaints relating to health insurance and health care; and (3) leads the office’s health policy and health reform responsibilities, including improving quality, restraining costs, promoting public health, improving the economy, and protecting consumers

The evolution of these *Guidelines* is summarized in Appendix IV. In the 24 years since the first *Guidelines* were published, hospitals and HMOs have demonstrated their commitment to the principles underlying the Community Benefits Program and have invested substantially in the unmet health and social needs of their communities.

Since the *Guidelines* were last updated in 2009, there have been important federal and state developments affecting the Community Benefits Program. The Patient Protection and Affordable Care Act (the “ACA”)² passed in 2010 included federal requirements for how non-profit hospitals approach Community Benefits, including standards for Community Health Needs Assessments (“CHNAs”) and Implementation Strategies, and public reporting on Community Benefits programs.³ In Massachusetts, the Department of Public Health (“DPH”) updated its Determination of Need (“DoN”) regulations in 2017⁴ and included new guidelines on statewide health priorities and community engagement for the DoN Community Health Initiative program.⁵

Significant changes in health care also underscore the continued value of the Community Benefits Program and the need to update the *Guidelines*. In the last decade, evidence has become even more clear that the utilization of medical services is not the primary determinant of community health. Rather, the social conditions in which people are born, grow, live, work, and age play a key role in determining health outcomes and health disparities.⁶ As the health care system shifts to a “population health” framework for payment and delivery system reform, hospitals and HMOs are working hard to engage in new opportunities to keep patients healthy by addressing social and environmental factors. The role of effective Community Benefits programs in addressing such unmet public health needs and promoting health equity has never been more critical.

With the passage of a groundbreaking health care reform law in Massachusetts in 2006⁷ and the ACA in 2010, health insurance coverage rates in Massachusetts remain high relative to other states. Affordability, however, remains an issue for many in Massachusetts, where measures of income inequality are among the highest in the nation.⁸ In addition, state data show troubling health disparities across categories of race, ethnicity, gender, gender identity, sexual orientation, disability, and other groups, as well as increased incidence of chronic diseases, particularly among vulnerable populations.⁹ Updates to the *Guidelines* reflect the continued importance of Community Benefits programs in addressing health disparities and

2 42 U.S.C. § 18001 et seq. (2010).

3 26 C.F.R. § 1.501(r) (2017).

4 105 Mass. Code Regs. 100.000 (2017).

5 DoN Guidelines and Policy Advisories, available at: <https://www.mass.gov/service-details/don-guidelines-and-policy-advisories>.

6 See, e.g., Frieden T. American Journal of Public Health, April 2010, Volume 100 No. 4 (identifying efforts to address socioeconomic determinants of health as having the greatest potential impact among public health interventions).

7 Chapter 58 of the Acts of 2006.

8 See Posey K.G. “American Community Survey Briefs, Household Income: 2015,” Issued September 2016; U.S. Department of Commerce Economics and Statistics Administration.

9 Determination of Need Health Priorities Guideline, available at: <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-health-priority.pdf>.

the needs of those without meaningful access to health care.

Advisory Task Force

In April 2017, Attorney General Maura Healey convened an Advisory Task Force to assist her in reviewing the *Guidelines* in the context of updated statewide health priorities, new IRS requirements associated with the ACA, and accelerating delivery system transformation. The Advisory Task Force, which included representatives of hospitals, health maintenance organizations, and community groups, and public health experts, participated in a thoughtful, focused, and productive review process that concluded in December 2017.¹⁰ Attorney General Healey asked the Advisory 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. These *Guidelines* were directly shaped by the recommendations of the Advisory Task Force but do not represent the views of all Advisory Task Force members on every topic.

In particular, the Advisory Task Force considered:

- 1) Improved Reporting: How to reduce unnecessary administrative burden by harmonizing the *Guidelines* with overlapping federal and state requirements and increase transparency into key aspects of the Community Benefits process and expenditures;
- 2) Statewide Priorities: How to encourage hospitals and HMOs to leverage their Community Benefits programs to address statewide health challenges;
- 3) Community Engagement: How to improve engagement with community partners in the planning, implementation, and evaluation of Community Benefits programs;
- 4) Regional Collaboration: How to encourage regional collaboration on needs assessments, Implementation Strategies, and sharing of best practices; and
- 5) Evaluation: How to offer focused guidance on setting, reporting, and learning from goals and benchmarks.

Concurrent with the Advisory Task Force, the AGO conducted a series of listening sessions to engage directly with the public on the *Guidelines* and to gather feedback on how they could be improved.

¹⁰ Members of the Advisory Task Force are listed in Appendix V.

Statewide Priorities

The Community Benefits Program should be viewed in the context of coordinated initiatives across state government to build long-term capacity to improve outcomes and reduce disparities around common health priorities.¹¹ Accordingly, these *Guidelines* recognize as statewide priorities the same four focus issues identified by the Executive Office of Health and Human Services and DPH in 2017 as significant statewide needs that drive mortality, morbidity, and health care costs. We ask that all hospitals and HMOs closely consider these four focus issues, along with identified local needs, as they conduct their Community Health Needs Assessments and prepare their Implementation Strategies:

Chronic Disease with a Focus on Cancer, Heart Disease and Diabetes
Housing Stability/Homelessness
Mental Illness and Mental Health
Substance Use Disorders

In addition to these four focus issues, in 2017 DPH adopted six health priorities to guide the Community Health Initiative investments funded by the Determination of Need process. These health priorities underscore the relevance of investing in the social determinants of health, and the AGO encourages hospitals and HMOs to consider these six priorities in their Community Benefits planning:

Built Environment

The built environment encompasses the physical parts of where we live, work, travel and play, including transportation, buildings, streets, and open spaces.

Social Environment

The social environment consists of a community's social conditions and cultural dynamics.

Housing

Housing includes the development and maintenance of safe, quality, affordable living accommodations for all people.

Violence

Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, with the behavior likely to cause physical or psychological harm.

¹¹ The AGO works closely with sister agencies and plays a central role across a number of coordinated initiatives to improve health care in the Commonwealth. For example, the Attorney General appoints three members to the Health Policy Commission, which is charged with developing policy to reduce health care cost growth and improve the quality of patient care. Mass. Gen. Laws ch. 6D, § 2. She appoints three members of the Board of the Health Insurance Connector Authority, which is charged with promoting access to affordable health insurance for the Commonwealth's residents and small businesses. Mass. Gen. Laws ch. 176Q, § 2. She also appoints two members to the Oversight Council of the Center for Health Information and Analysis, the agency of record for Massachusetts health care information. Mass. Gen. Laws ch. 12C, § 2A. The Attorney General also serves on the board of the Betsy Lehman Center for Patient Safety and Medical Error Reduction, which is charged with catalyzing efforts of stakeholders working toward safer health care in Massachusetts. Mass. Gen. Laws ch. 12C, § 15. 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.

Education

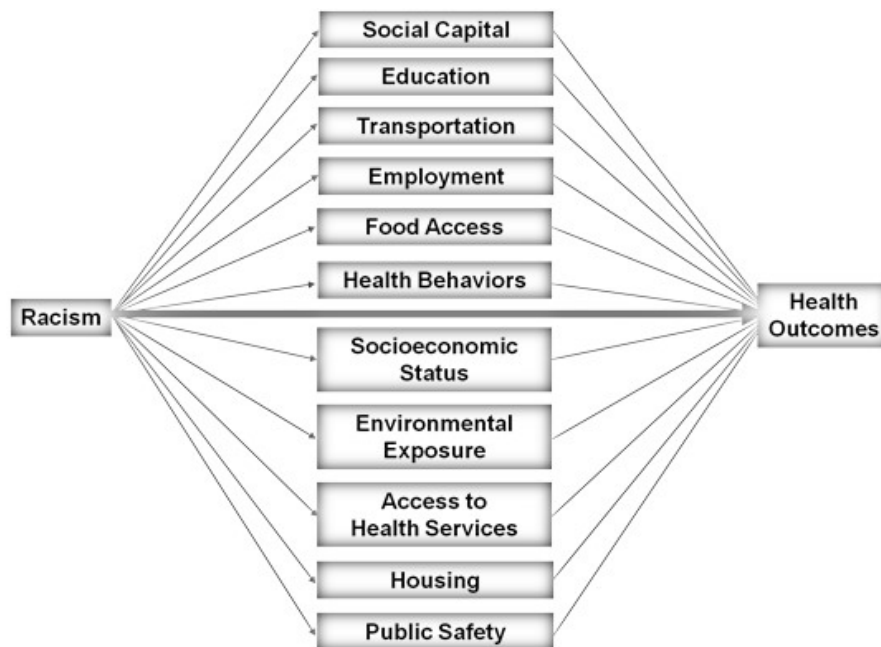
Education refers to a person's educational attainment – the years or level of overall schooling a person has.

Employment

Employment refers to the availability of safe, stable, quality, well-compensated work for all people.

A lengthier description of the six health priorities is available on the DPH website at <https://www.mass.gov/files/documents/2017/01/tr/guidelines-health-priority.pdf>.

The theme of health equity is strongly reflected throughout these health priorities. It is well understood that racism – in all of its forms¹² – and institutional bias impact health outcomes, both through their influence on the social determinants of health and also as an independent factor affecting health. The health equity framework below illustrates how racism has an independent influence on all the social determinants of health and that racism in and of itself has a harmful impact on health. The AGO recommends that hospitals and HMOs consider this framework and continue to recognize and address the role that racism and institutional bias play in impacting health outcomes in their communities.



From the Boston Public Health Commission's Racial Justice and Health Equity Initiative; available at: <http://www.bphc.org/whatwedo/health-equity-social-justice/racial-justice-health-equity-initiative/Documents/RJHEI%202015%20Overview%20FINAL.pdf>.

These *Guidelines* identify the four focus issues and six health priorities to encourage hospitals and HMOs to work in concert on issues of particular concern and to achieve collective improvements in these areas. However, hospitals and HMOs must also assess the needs of their particular service areas and get direct input from their communities about

¹² See YW Boston Stand Against Racism Resources, available at: <http://www.ywboston.org/our-work/stand-against-racism/resources/> (describing the "4I's" of racism, including interpersonal racism, institutional racism, ideological racism, and internalized racism); see also Glossary page 36.

which programs to include in their Implementation Strategies, including programs that may not address these issues. In reviewing the Community Benefits Reports, the AGO will pay special attention to programs that address the focus issues and priorities described above for purposes of public recognition and dissemination of best practices. The AGO may update these issues and priorities over time to continue to align with the health goals identified by sister agencies.

Medical Debt/Hospital Collection Practices

Medical debt continues to be a significant issue for many residents in Massachusetts. In 2015, 1 in 5 adults with health insurance in Massachusetts reported having an unmet health need in the past year due to costs, 1 in 6 reported having difficulty paying their medical bills, and 1 in 5 reported having medical debt.¹³ As these *Guidelines* are being published, the future of federal health policy is uncertain and numerous proposals from 2017 could have decreased coverage for health care services, thereby increasing medical debt. 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 *Guidelines* allow for the optional reporting of bad debt if the hospital adopts the set of recommended medical debt collection practices outlined in Appendix I.

Scope of this Document

This document applies to non-profit acute care hospitals throughout the Commonwealth (hereinafter referred to as “hospitals”), defined by Chapter 111 of the Massachusetts General Laws as any hospital licensed under Section 51 of Chapter 111 that contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by DPH and the teaching hospital of the University of Massachusetts Medical School. 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*. These *Guidelines* are fully effective starting in Hospital fiscal year 2019, with a transition period to include an interim launch in fiscal year 2018 for those elements that can be appropriately introduced at that time. The AGO anticipates working closely with filers throughout the transition.

¹³ Sharon K. Long et al., Massachusetts Health Reform at Ten Years: Great Progress, But Coverage Gaps Remain, 35(9) Health Affairs 1633, 1634-35 (Sept. 2016).

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 its annual Implementation Strategy.
- B. The hospital should demonstrate its support for its Implementation Strategy 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 Implementation Strategy including designating the programs or activities to be included, allocating resources, and ensuring its regular evaluation.
- C. The hospital should make community engagement a regular part of each stage of Community Benefits planning, implementation, and evaluation, with particular attention to engaging diverse perspectives.
- D. To develop its Mission Statement and Implementation Strategy, the hospital should conduct a Community Health Needs Assessment, a comprehensive review of unmet health needs of the community, including negative health impacts of social and environmental conditions, by analyzing community input, available public health data, and an inventory of existing programs, which should facilitate regional collaboration.
- E. The hospital should include in its annual Implementation Strategy the Target Populations it wishes to support, specific programs or activities that attend to significant 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 AGO for publication that includes: 1) its CHNA; 2) its Implementation Strategy; 3) the Self-Assessment Form; 4) information on its Community Benefits programs including program goals and measured outcomes; 5) information on its Community Benefits Expenditures; and 6) the optional supplement (if desired).

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 its annual Implementation Strategy.

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 execution of an Implementation Strategy. 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 Implementation Strategy. 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 on the hospital's 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 its Implementation Strategy 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 Implementation Strategy including designating the programs or activities to be included, allocating resources, and ensuring its regular evaluation.

The hospital should demonstrate high level support for its Implementation Strategy. One way to demonstrate this support is to designate a Community Benefits Leadership Team within the hospital that is composed 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 Community Benefits Leadership 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 Implementation Strategy, including to conduct a needs assessment, articulate the institution's Mission Statement, dedicate resources to fulfill the Implementation Strategy, 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 and develop the Mission Statement and Implementation Strategy, and as necessary thereafter to monitor and evaluate the investments.

In order to form a bridge to community leaders and representatives of the medically underserved, hospitals should establish a Community Benefits Advisory Committee ("CBAC"), or similar mechanism, that includes members of the population to be served and which reflects the racial, cultural, and ethnic diversity of the community with additional attention to diversity in age, sex, gender identity, sexual orientation, disability status, socioeconomic status, and health status. That group should provide input to hospital leadership when designing the Community Health Needs Assessment, Mission Statement, and Implementation Strategy.

COMMUNITY ENGAGEMENT

The hospital should make community engagement a regular part of each stage of Community Benefits planning, implementation, and evaluation, with particular attention to engaging diverse perspectives.

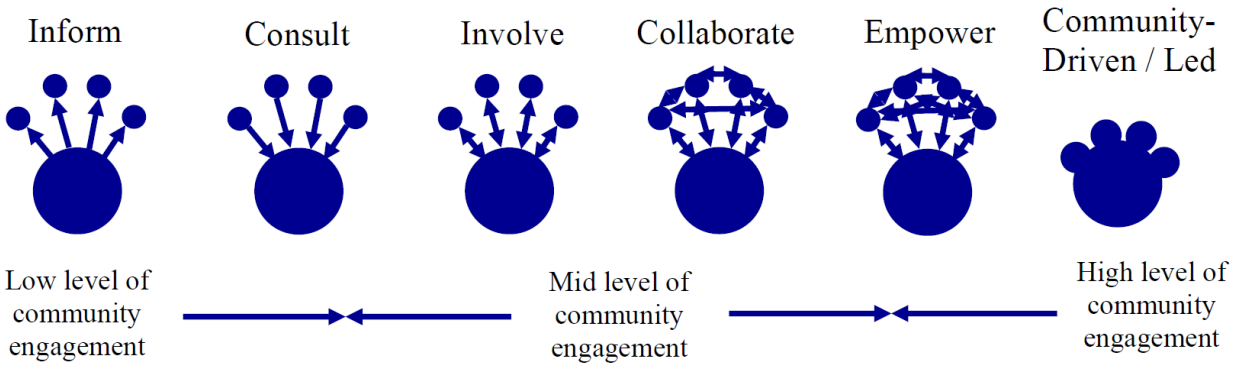
Individuals and Organizations with Whom to Engage

While effective community engagement strategies may vary, hospitals should strive to achieve a transparent decision making process that includes diverse community representation including a process that engages perspectives beyond those represented on the CBAC (described in the previous section). The hospital should engage on an ongoing basis with populations and groups within and beyond the hospital's geographic service area, including those who use and do not use the hospital's services. This engagement should include, whenever feasible, the populations the hospital plans to target with its programs and activities, and those organizations and social service providers that are closest to the targeted populations, such as community health centers, public health coalitions, neighborhood associations, local boards of health, social service agencies, community action agencies, housing authorities, charities, schools, law enforcement, and churches and clergy. As one component of the community engagement process, the hospital is encouraged to initiate a formal process, such as holding a meeting open to the public (either independently or in conjunction with a community partner) at least once per year to solicit community feedback on its Community Benefits programs.

Many of the more than 50 community health centers operating in over 300 access sites statewide serve primarily disadvantaged populations. As leaders in addressing some of the most vexing problems of our health care system, community health centers are actively engaged in statewide priorities, including coordinating care for patients facing social as well as medical needs, designing and implementing chronic disease management programs, addressing health care disparities, and advancing health care reform. 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. Moreover, as frontline providers in their communities, community health centers are well positioned to be effective partners with hospitals and HMOs in implementing Community Benefits programs.

Community Engagement Spectrum

The community engagement spectrum below, designed by the International Association of Public Participation and adapted by DPH,¹⁴ represents a continuum of engagement ranging from low (informing the community) to high (having a community driven or led process). Additional resources on how to use this tool, including examples of engagement strategies that correspond to each level on the spectrum, will be available on the AGO’s Community Benefits website.



Hospitals are encouraged to engage their community at the highest level feasible at each stage of Community Benefits program planning, implementation, and evaluation and to make continual improvement in community engagement an institutional priority. The AGO recommends that filers review this framework as it will be referenced in the hospital self-assessment in the annual Community Benefits Report and in community partners’ assessment of their engagement in the Community Benefits process.

¹⁴ “Community Engagement Standards for Community Health Planning Guideline,” Massachusetts Department of Public Health, available at: <http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf>.

COMMUNITY HEALTH NEEDS ASSESSMENT

To develop its Mission Statement and Implementation Strategy, the hospital should conduct a Community Health Needs Assessment, a comprehensive review of unmet health needs of the community, including negative health impacts of social and environmental conditions, by analyzing community input, available public health data, and an inventory of existing programs, which should facilitate regional collaboration.

A hospital must complete a CHNA at least once every three years. The CHNA process begins with the hospital defining its community. The hospital should collect primary and secondary data (both quantitative and qualitative) to identify unmet health needs in its community from a variety of sources and inventory programs currently available to address those needs (the AGO Community Benefits website will include links to additional data sources). The hospital is encouraged to consider health needs broadly and to include in its needs assessment data and analysis on social, behavioral, and environmental factors that impact health in the community, with particular attention to the six health priorities (see pages 4-5). For example, a hospital may consider a dedicated section of the CHNA to report on data related to social determinants of health in its community.

The CHNA process is complete once the CHNA is documented in a written report, adopted by an authorized body of the hospital, and made widely accessible (including on the hospital's website and as part of the hospital's Community Benefits Report to the AGO).

Elements of a Community Health Needs Assessment

1. A definition of the community served by the hospital and a description of how that definition was derived;
2. A description of the process and methods used to conduct the CHNA;
3. A description of how the hospital solicited and took into account input received from persons who represent the broad interests of the community it serves and how populations experiencing inequities were specifically engaged;
4. A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant needs;
5. A description of the resources potentially available to address the significant health needs identified through the CHNA (such as organizations, facilities, and programs in the community, including those of the hospital);
6. An evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital's prior CHNA(s); and
7. A review of relevant programs and reports (including the CHNA, Implementation Strategy, and Community Benefits Report) of other filers in the region to avoid duplication, improve coordination, and assess whether it make sense to continue with these existing programs in light of the community's changing needs.

Defining the Community Served

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 all of the relevant facts and circumstances, including the geographic area served by the hospital facility, target populations served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease), as well as whether there are populations within the service area with particular unmet health needs.

Joint Community Health Needs Assessments

The AGO encourages hospitals to collaborate with other hospitals and other organizations (such as health plans and local public health departments) in conducting their CHNAs to the extent they serve the same communities. A joint CHNA must comply with all CHNA requirements for each participating hospital and must clearly identify the hospitals to which it applies. The Community Benefits Report includes questions about participation in regional health planning initiatives, such as a joint CHNA.

Identifying Health Disparities

A critical component of assessing community health needs is identifying health disparities, or particular types of health differences that are closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion.¹⁵ Wherever possible, the hospital should include data stratified by vulnerable groups or populations in its CHNA to identify and monitor health disparities.

¹⁵ Healthy People 2020, “Disparities,” available at: <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>.

IMPLEMENTATION STRATEGY

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

The Implementation Strategy is a blueprint, updated annually, for how the hospital plans to accomplish its Community Benefits Mission. This is a critical document in facilitating community engagement and collaboration across institutions. As such, the Implementation Strategy is a core component of the hospital's annual Community Benefits Report.

An Implementation Strategy should include a list of significant needs and Target Populations based upon the triennial Community Health Needs Assessment, along with a description of the hospital's plan to address (or reasons why it does not plan to address) each significant need. The plan contained in the Implementation Strategy should include the specific programs or activities the hospital intends to undertake, including resource commitments and measurable goals, and any planned collaborations between the hospital and other organizations, including other filers, in addressing these needs. The hospital should demonstrate that it has involved the community in the design, execution, and evaluation of the programs set forth in its Implementation Strategy, as well as in the development of the Implementation Strategy itself.

The Implementation Strategy should be updated annually to reflect the hospital's updated plans and resource commitments for the next fiscal year. Given the triennial CHNA cycle and the long term planning required to address certain health needs, a hospital's Implementation Strategy may reflect more significant changes in the year following a CHNA than in the two subsequent years.

Identification of Significant Needs/Target Populations

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 Implementation Strategy. 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.

The hospital should consider the following criteria when prioritizing community needs:

1. Income level and race/ethnicity (or other characteristics historically linked to discrimination or exclusion) 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

"Target Populations" are specific populations or communities of need to which the hospital will allocate resources through its Implementation Strategy. Target populations must be disadvantaged populations. Some examples of disadvantaged populations are the medically underserved, the uninsured, those burdened with medical debt, the elderly, the poor, people of color, non-native English speakers, refugees and immigrants, gay, lesbian, bisexual, and transgender populations, and victims of domestic violence.

Hospitals are encouraged to be creative in defining specific Target Populations to 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 Benefits programs on one or more issues or Target Populations.

Hospital Plan to Address Significant Health Needs

1. Community Benefits Programs

The hospital should describe how it plans to address the significant needs identified in the CHNA. If there are significant needs identified in the CHNA that the hospital does not intend to address, the hospital should explain why it does not intend to address the identified need.

The Implementation Strategy should include a description of the hospital's planned

Community Benefits programs that will address each significant health need. For each program in its Implementation Strategy, 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 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 so as to make measurement feasible.

Examples of Community Benefits Programs

The following is a list of examples 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 address health needs that were identified by the Community Health Needs Assessment and support the filer's Community Benefits Mission Statement. This list is by no means exhaustive.

1. Funding to repair dwellings in order to remove health hazards
2. Neighborhood improvement in low-income area to address public safety issues and environmental hazards
3. Participation in a community coalition to increase jobs with health insurance
4. Support groups for managing chronic disease in underserved populations
5. Programs to prevent emotional, physical, and sexual abuse in adolescent dating relationships
6. Providing at-risk students with specific social and educational supports such as mentoring, vocational or social-emotional skills training, college preparation, supplemental academic services, or case management
7. Mobile units that deliver primary care to underserved populations on an occasional or one-time basis
8. Outreach health education through Community Health Workers to disadvantaged populations
9. Free preventive care or health screening services to disadvantaged populations
10. Substance use disorder education and related preventive and acute treatment services for disadvantaged populations
11. Expanded prescription drug programs for disadvantaged populations
12. Net financial assistance to independently licensed and hospital licensed community health centers and community mental health centers that provide services to disadvantaged populations
13. Free legal services that improve the health of disadvantaged populations
14. 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 Implementation Strategy. 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 programs is that they are part of an Implementation Strategy 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 Implementation Strategy.

Goals and Measurement

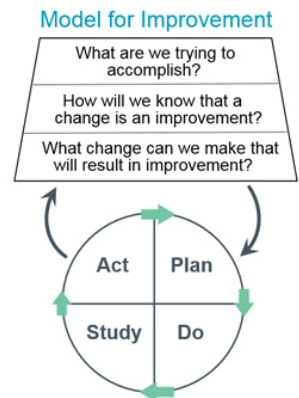
The hospital should articulate measurable goals for each Community Benefits program. Hospitals should consider establishing quantifiable goals that are appropriate to the nature of the program or activity. For example, if a program is aimed at removing asthma triggers from the homes of children in a subsidized housing community, one goal could be an increase in the number of homes in the target community that are newly fitted with clean heating and air conditioning filters. An additional goal could be a reduction in the rate of asthma-related ER admissions among this population as compared to the rate statewide.

To assist in program-level goal setting, hospitals are encouraged to use the Model for Improvement tool (see graphic) developed by Associates in Process Improvement. This tool directs hospitals to select measures that will show whether a Community Benefits program is having its intended effect and helps to guide the hospital to improvements in the program that will enhance its impact.

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 and/or reduction in health disparities. The AGO Community Benefits website will include resources on how to identify benchmarks and track improvement in health outcomes.



The ultimate measures of the success of the programs and activities set forth in an Implementation Strategy should be the improvement in health status outcomes of the hospital's Target Populations and reduction in health disparities. 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 and reducing health disparities.

2. Resources Committed

The Implementation Strategy should include a description of the resources a hospital plans to commit to its Community Benefits program to address the significant needs identified in its CHNA. 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 the plan documented in its Implementation Strategy. 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.

The AGO acknowledges that hospitals vary greatly in size, structure and available resources. A hospital 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. 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 AGO is not recommending a specific target level of annual gross Community Benefits Expenditures at this time, each hospital should provide information on both its Community Benefits Expenditures and its financial status and resources so that the AGO can analyze the relationship between its level of Community Benefits Expenditures and its ability to pay.¹⁶ The AGO will annually review each hospital's Community Benefits Expenditures in relation to its Net Patient Service Revenue, operating expenditures, and surplus, and may from time to time conduct audits or publish specific reports based on its analysis.

In recognition of the fact that the target Community Benefits budget will vary based on institution size, the public Community Benefits Report will display the hospital's total Community Benefits Expenditures as a percentage of its Net Patient Service Revenue.

¹⁶ Hospitals may consider the target level of Community Benefits spending that the AGO previously published of up to 3% of total patient care expenses (for hospitals with total patient care expenses under \$200 million), and 3-6% of total patient care expenses (for hospitals with total patient care expenses over \$200 million).

3. Planned Collaborations

Finally, the Implementation Strategy should include a description of any planned collaborations between the hospital and other organizations, including other filers, in addressing the identified health needs.

Joint Implementation Strategies

The AGO encourages hospitals to collaborate with other hospitals and other organizations (such as health plans and local public health departments) in developing their Implementation Strategies. In general, a hospital that collaborates with other organizations in developing its Implementation Strategy must still document its Implementation Strategy in a separate written report tailored to the specific hospital and its resources.

However, if the hospital adopted a joint CHNA with another organization, the organizations may submit a joint Implementation Strategy that describes how the organizations intend to collaborate together to address the identified needs in their community. A joint Implementation Strategy must be clearly identified as applying to the hospital, clearly identify the hospital's role and responsibility in taking the actions described in the Implementation Strategy, identify the resources the hospital plans to commit to such actions, and include a summary that helps readers identify the portion of the Implementation Strategy relating to the hospital.

Amending the Implementation Strategy

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

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

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

Shared Learning and Dynamic Improvement of Community Benefits Programs

With the benefit of public Implementation Strategies outlining for each hospital the significant needs they have identified in their communities, how they plan to address those needs through Community Benefits programs, and the resources available to support their plan, Massachusetts is positioned to be a collaborative laboratory for the improvement of Community Benefits programs – to help filers identify strategies that deliver meaningful improvements in community health and to revise or end programs that are proven to be less effective. To support shared learning and program improvement, the AGO anticipates introducing a new section to the Community Benefits website that will include resources on program evaluation and regional collaboration to serve as an online Community Benefits Improvement portal. The AGO is also committed to an aligned approach across government to advance dynamic learning and share subject matter expertise. To that end, the office is working closely with sister agencies to explore a collaborative infrastructure for learning, such as an annual forum for participants across common community investment programs to share best practices, coordinate common investments, and learn from one another about approaches to addressing specific community health challenges.

REPORT

Each hospital should submit an annual Community Benefits Report to the AGO for publication that includes: 1) its CHNA; 2) its Implementation Strategy; 3) the Self-Assessment Form; 4) information on its Community Benefits programs including program goals and measured outcomes; 5) information on its Community Benefits Expenditures; and 6) the optional supplement (if desired).

The Community Benefits Report filed annually by each hospital gives the AGO 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 Community Benefits Report has been updated to focus on a robust self-assessment, improved reporting on Community Benefits program expenses, inclusion of the CHNA and Implementation Strategy – critical planning documents hospitals rely upon in the development and implementation of their Community Benefits efforts – and a new optional supplement. Communities also have the ability to comment on hospital Community Benefits Reports.

Please see Appendix II for a timeline for reporting.

Report Content

1. Community Health Needs Assessment

Hospitals are asked to include a copy of their most recent CHNA as part of their Community Benefits Report.

2. Implementation Strategy

Hospitals are asked to include a copy of their Implementation Strategy for the reporting fiscal year as part of their Community Benefits Report.

3. Self-Assessment Form

The Self-Assessment Form is an opportunity for the hospital to reflect on successes and challenges in engaging with its community to assess community health needs and develop responsive programs. This form is also a way to increase transparency so that individuals and organizations that are affected by hospital Community Benefits investments can better understand how to participate in this process. Lastly, the Self-Assessment Form is intended to encourage hospitals to set goals to engage different constituencies in more meaningful ways.

The Self-Assessment Form includes questions on the following topics:

- **Leadership** – Hospital governing board members, management and staff involved in decision making and review of the CHNA, Implementation Strategy, and Community Benefits Report

- **Engagement with Community Groups** – Types of community groups engaged in the Community Benefits process and what efforts were employed to ensure effective, broad engagement
- **Community Health Needs Assessment and Implementation Strategy** – Hospital’s assessment of its level of engagement with the community in developing and implementing its CHNA and Implementation Strategy
- **Regional Collaboration** – Collaboration with regional partners (who and what organizations were involved and in what capacity)

4. Community Benefits Program Report

Hospitals are asked to report detailed information about the Community Benefits programs they implemented in the last year. By providing this information, hospitals will be able to demonstrate how these programs are advancing their overall Community Benefits goals. Program reports include a narrative description of each program, as well as information about the populations served, health need addressed, goals and outcomes, and community partners. The program reports also include program-level tags that allow filers to identify if the program addresses an EOHHS statewide focus issue or DoN health priority, as well as the type of program (i.e., direct clinical services, community-clinical linkages, total population or community-wide intervention, or access/coverage supports).

5. Community Benefits Expenditure Report

Hospitals are asked to provide information on their total expenditures for Community Benefits for the prior hospital fiscal year. The AGO 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.

- **Community Benefits Program Expenditures (Community Benefits Programs and Operations + Cash and In-Kind Contributions):** Funds that are allocated to Community Benefits programs that address a need identified in the CHNA and a Target Population set forth in the Implementation Strategy are considered Community Benefits Program Expenditures. Contextually, these expenses should correspond to many of the expenses reported to the IRS as Community Health Improvement Services and Community Benefits Operations, Community Building, and Cash and In-Kind Contributions for Community Benefit on the Form 990, Schedule H, so long as the programs address a need identified in advance in the CHNA and a Target Population set forth in the Implementation Strategy.

To promote transparency, facilitate community engagement, and enable cross-filer collaboration, hospitals should break out their Community Benefits Program Expenditures in two ways:

1. *By program type*¹⁷ (for each category, provide the total program expenditures as well as a subtotal indicating how much – if any – of the total is paid by the hospital as grants and/or other funding provided to outside organizations):
 - Direct Clinical Services
 - Community-Clinical Linkages
 - Total Population or Community-Wide Interventions
 - Access/Coverage Supports
 - Infrastructure to support Community Benefits collaborations across institutions
2. *By health need addressed*¹⁸:
 - Chronic Disease:
 - Cancer
 - Heart Disease
 - Diabetes
 - Housing Stability/Homelessness
 - Mental Health/Mental Illness
 - Substance Use Disorder
 - Additional Health Needs Identified by the Community¹⁹

Both program expenditure breakouts should equal the same total.

- **Other Leveraged Resources**
- **Charity Care**
- **Bad Debt:** Optional reporting of hospital bad debt if the hospital 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 I.

6. Optional Supplement

The AGO acknowledges and supports the efforts of many Massachusetts hospitals to make their Community Benefits mission a core part of their operations, beyond the Community Benefits programs they offer or the charity care they provide. This optional supplement allows for hospitals to provide a brief narrative on how they are leveraging their role as employers, purchasers, investors, and anchor institutions in their communities to advance health equity, reduce disparities, provide support for the social determinants of health in their communities, or advance other elements of their Community Benefits mission.

17 These categories are based upon the “3 Buckets of Prevention” framework from the Centers for Disease Control and Prevention (see Auerbach J., The 3 Buckets of Prevention, J Public Health Management Practice, 2016, 22(3), 215-218), with additional categories added for programs addressing health care access/coverage and for infrastructure expenditures to support collaboration.

18 These categories correspond to the statewide focus issues identified by the Executive Office of Health and Human Services/DPH in 2017.

19 This list of health needs will be developed in consultation with filers.

Community Feedback

To help engage community representatives in assessing the Community Benefits process and to facilitate productive dialogue between community representatives and the hospital, each hospital should provide a copy of the AGO's annual Community Representative Feedback form to the community representatives on its Community Benefits Advisory Committee and direct each representative to complete the form and submit a copy to both the hospital and the AGO by the due date for the annual Community Benefits Reports. The CBAC may also share the form widely with community partners included in the hospital's self-assessment form, and let those community partners know they are welcome to complete the form (which should be submitted to both the hospital and the AGO).

For other matters related to Community Benefits but not captured in the AGO's annual Community Representative Feedback Form, at the request of a community group, the AGO will publish on its website written comments related to a hospital's or HMO's Community Benefits annual report. The AGO recommends that community groups or members provide comments, both positive and negative, directly to the hospital or HMO whenever possible. The AGO's website is not intended as a forum for airing grievances that are best resolved through direct communication or for submissions aimed primarily at criticizing or thanking a filer for a particular funding decision.

For publication on the AGO's website, community submissions should relate directly to the hospital's or HMO's most recent Community Benefits Report and programs. 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 AGO's website; the AGO will post contact information for the submitting party.

Process

1. At least thirty days prior to filing a submission for publication on the AGO's website, the submitting party should provide a copy to the hospital or HMO that is the subject of the comments, including notice of its intent to submit the comment for publication on the AGO's Community Benefits website. The submission should be addressed to the hospital's or HMO's Community Benefits manager (contact information is available in the Community Benefits Report) and reflect the submitting party's willingness to meet with the hospital or HMO to participate in a good faith discussion of any issues raised in its submission.
2. Any community submission subsequently made to the AGO should be submitted via the AGO Community Benefits website. 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 AGO's website, and summarizing the results of its offer to meet with the hospital or HMO.
3. At the request of the hospital or HMO, the AGO will post a single response to a public comment on the filer's Community Benefits program.

APPENDIX I - 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 AGO 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 AGO 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 AGO 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 limit the rights and protections provided under any federal or state law, including the Health Safety Net Eligible Services, 101 CMR 613.00; the AGO's Debt Collection Regulations, 940 CMR 7.00; and I.R.C. § 501(r). As used below, the term "hospital" includes all employees and agents of the hospital. Recommended Hospital Debt Collection Practices include, but are not limited to, the following:

- 1) The hospital should provide the patient with sufficient billing information in order for the patient to ascertain the accuracy of his or her bill. The hospital should maintain records of all communications with a patient regarding a bill, including both oral and written communications;
- 2) The hospital should provide the patient with clear information (including on all bills) on how to contact the hospital to inquire about or to dispute a bill and should respond to a patient's inquiry or dispute about a bill 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 against a patient, other than billing, without first (1) making reasonable efforts to determine whether the patient is eligible for financial assistance, (2) providing the patient with a written statement of the availability of financial counseling services, and (3) giving the patient facing financial hardship the opportunity to avail him or herself of a reasonable payment plan;
- 5) The hospital should not delegate collection activity 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 the patient and negotiate a reasonable payment plan during and after the 120 day period, allowing the patient 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 should have reasonable procedures to ensure that any information reported to a consumer reporting agency is accurate and complete. The hospital should seek removal of such information from the patient's credit report once the debt is paid in full;
- 9) The hospital should not sell a patient's debt unless specifically approved by the hospital's board of directors;
- 10) The hospital 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) An attorney hired by the hospital or a third party collection agency to collect a debt should not commence legal action against a patient unless the attorney has obtained the hospital's written consent to commence the legal action and has reviewed all documentation necessary to establish the validity of the debt at issue; and
- 12) The hospitals should not charge interest on patient debt;
- 13) The hospital should not deny or delay the delivery of medically necessary services based on the existence of a patient's unpaid medical debt.

APPENDIX II - TIMELINE FOR 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 online reporting form.

Once the report has been submitted to the website, AGO staff will review the report to ensure it is complete. If there is a question or problem with the report, the AGO 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.

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.
- Non-profit hospitals and 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 HMOs should also refer to the Community Benefits section of the AGO's website (<https://www.mass.gov/nonprofit-hospital-and-hmo-community-benefits>) for other supporting materials that will be added from time to time.

APPENDIX III - TIMELINE FOR DEVELOPMENT OF COMMUNITY BENEFITS PROGRAMS

The development and implementation of a hospital or HMO's Implementation Strategy necessarily occurs in phases. The following is a suggested sequence for developing and executing an Implementation Strategy over the course of a year.

Phase 1: Identify Community Benefits Leadership Team

- Designate a Community Benefits Leadership Team that includes senior management that will be responsible for the Implementation Strategy
- 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 (at least once every three years)

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

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 Implementation Strategy

- 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 time frame 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 Implementation Strategy, indicating expenses, expected revenues, and outside sources of funding

Phase 5: Execute Implementation Strategy

- Determine time frames for executing each aspect of the Implementation Strategy
- Monitor programs and measure according to short and long-term goals

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 Implementation Strategy

APPENDIX IV - HISTORY OF THE GUIDELINES

The Attorney General's Office originally issued the Community Benefits Guidelines in June 1994 under Attorney General Scott Harshbarger. Attorney General Harshbarger then issued 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 with updates in 2002. In 2009 Attorney General Martha Coakley updated the Guidelines to improve and strengthen the Community Benefits Program.

In 2017 Attorney General Maura Healey convened an Advisory Task Force to reexamine the process and the *Guidelines*. As part of the Advisory Task Force, hospital and HMO representatives, community advocates and other state agencies worked closely together to recommend updates to the *Guidelines* to further improve and strengthen the Community Benefits Program.

June 1994 - The first version of *The Attorney General's Community Benefits Guidelines for Non-profit 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 Reilly adopts and reissues both the hospital and the HMO Guidelines in their original form

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

February 2009 - Attorney General Coakley revises and re-issues both the hospital and the HMO *Guidelines*

April 2017 - Attorney General Healey convenes a Community Benefits Advisory Task Force to examine the current Community Benefits *Guidelines*

February 2018 - Attorney General Healey issues the new versions of *The Attorney General's Community Benefits Guidelines for Non-profit Acute Care Hospitals* and *Health Maintenance Organizations*

APPENDIX V - COMMUNITY BENEFITS ADVISORY TASK FORCE MEMBERS

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

Audrey Shelto

Blue Cross Blue Shield of Massachusetts
Foundation

Margaret Reid

Boston Public Health Commission

Frank Robinson

Coalition of Western MA Hospitals

Susan Sherry

Community Catalyst

Joan Quinlan

Conference of Boston Teaching Hospitals

Paul Hattis

Greater Boston Interfaith Organization

Joe Kriesberg

MA Association of Community Development
Corporations

Eric Linzer

MA Association of Health Plans

Jody White

MA Council of Community Hospitals

Ben Wood

MA Department of Public Health

Doug Brown

MA Health & Hospital Association

Myechia Minter-Jordan

MA League of Community Health Centers

Maddie Ribble/Enid Eckstein

MA Public Health Association

Don Berwick

Institute for Healthcare Improvement

Michael Botticelli

Grayken Center for Addiction Medicine

Nancy Kane

Harvard T.H. Chan School of Public Health

GLOSSARY

Access/Coverage Supports: Programs designed to increase access to health insurance and health care services for individuals, especially persons living in poverty and other vulnerable populations.

Bad Debt: *(As defined in Mass. Gen. Laws ch. 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.

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

Charity Care:

1. The hospital or HMO's 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 101 CMR 614.03 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 and which have been written off by the hospital. Cost of services shall be determined as follows:
 - o The total amount net charges billed to the HSN for the denied claims;
 - o Multiplied by the ratio of costs to charges calculated as the ratio of total patient care costs to gross patient service revenue as reported in the hospital's most recent Massachusetts Hospital Cost Report filed with the Center for Health Information and Analysis.
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:
 - o 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;
 - o Multiplied by the ratio of costs to charges calculated as the ratio of total patient care costs to gross patient service revenue as reported in the hospital's most recent Massachusetts Hospital Cost Report filed with the Center for Health Information and Analysis.

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 Advisory Committee (“CBAC”): An advisory committee that includes members of the population to be served and which reflects the racial, cultural, and ethnic diversity of the community with additional attention to diversity in age, sex, gender identity, sexual orientation, disability status, socioeconomic status, and health status. The purpose of the CBAC is to provide input to hospital leadership when designing the Community Health Needs Assessment, Community Benefits Mission Statement, and Implementation Strategy.

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 an Implementation Strategy.

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 execution of an Implementation Strategy.

Community Benefits Program: A program, initiative, or activity developed in collaboration with community representatives that addresses a need identified in the hospital or HMO’s Community Health Needs Assessment and serves the needs of a Target Population identified in the hospital or HMO’s Implementation Strategy.

Community Benefits Leadership Team: An internal committee of hospital leadership and staff who oversee the development of the institution’s Community Health Needs Assessment, Community Benefits Mission Statement, and Implementation Strategy, dedicate resources to fulfill the Implementation Strategy, and evaluate Community Benefits programs both individually and holistically.

Community-Clinical Linkages: Interventions that occur in community settings and that impact clinical outcomes. Community-clinical linkage strategies can include coordinating services at a given location, establishing new evidence based programs at non-clinical organizations, coordinating services between different locations, and/or establishing referral protocols to connect patients with resources outside the health care system.

Community Health Needs Assessment (“CHNA”): 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. “CHNA” also refers to the report created through this needs assessment process.

Expenditure Definitions:

Note: All expenditures reported to the AGO as Community Benefits must address a need documented in the CHNA and a Target Population identified in the Implementation Strategy.

Cash and In-Kind Contributions: Contributions made by the filer to health care organizations and other community groups restricted in writing to one or more Community Benefits activities that address a need documented in the Community Health Needs Assessment and a target population identified in the Implementation Strategy, plus the cost of staff hours donated by the organization to the community while on the organization's payroll, indirect cost of space donated to tax-exempt community groups, and the financial value of donated food, equipment, and supplies.

Community Benefits Programs and Operations: Activities or programs, subsidized by the hospital or HMO, carried out or supported for the express purpose of improving community health, including social determinants of health, that address a need documented in the Community Health Needs Assessment and a target population identified in the Implementation Strategy, with any offsetting revenue subtracted; plus activities associated with conducting Community Health Needs Assessments, Community Benefits Program administration, and the organization's activities associated with fundraising or grant-writing for Community Benefits programs. Contextually, these expenses should correspond to those reported on IRS Form 990, Schedule H as Community Health Improvement Services and Community Benefits Operations, and Community Building that address a documented community health need and Target Population identified in advance in the filer's Community Health Needs Assessment and Implementation Strategy. This can include programs currently characterized by the IRS as Community Building such as physical improvements and housing, economic development, and environmental improvements.

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 Programs and Operations +
Cash and In-Kind Contributions +
Other Leveraged Resources +
Charity Care

Health Disparities: Health disparities are particular types of health differences that are closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion.²⁰

Health Equity: The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.²¹

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 Total Revenue: The combined amount of premium income and other revenue collected related to the delivery of health care benefits.

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

Implementation Strategy: A written plan adopted by the hospital or HMO, updated annually, that includes a list of significant needs and Target Populations based upon the Community Health Needs Assessment, along with a description of the hospital's plan to address (or reasons why it does not plan to address) each need.

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.

Net Patient Service Revenues (for hospitals): Net patient service revenues reported to the Center for Health Information and Analysis.

20 Healthy People 2020, "Disparities", <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>.

21 *Id.*

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.

Racism: Interpersonal racism refers to bias and discriminatory behaviors and attitudes that occur among individuals often informed by racial stereotypes. Institutional racism refers to bias and discriminatory policies and practices that result in inequitable distribution of resources and opportunities. Ideological racism refers to assumptions, beliefs, messages, and symbols that reinforce systems of inequity and drive social injustices. Internalized racism refers to bias and prejudice that manifests within oneself giving rise to thoughts and feelings about one's racial superiority or inferiority, influenced by messages from the dominant culture.²²

Target Population: The specific community or communities that are the focus of the hospital or HMO's Implementation Strategy. 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 Population or Community-Wide Interventions: Total population or community-wide prevention strategies include those that are not oriented to a single patient or even to all those within a practice or covered by a given insurer. Rather, the target is an entire population or subpopulation often identified by a geographic area such as a neighborhood, city, or county. Interventions and strategies can occur in settings such as the community, school, or workplace and are policy, systems or environmental changes that alter the context of the social determinants of health for the target populations.

22 YW Boston Stand Against Racism Resources, available at: <http://www.ywboston.org/our-work/stand-against-racism/resources/>.



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