

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



COMMONWEALTH OF MASSACHUSETTS  
OFFICE OF ATTORNEY GENERAL  
MAURA HEALEY

FEBRUARY 2018



# TABLE OF CONTENTS

<b>Introduction .....</b>	<b>1</b>
Charitable Role of Hospitals and Health Maintenance Organizations .....	1
Updates to Guidelines .....	1
Advisory Task Force.....	3
Statewide Priorities .....	4
Scope of this Document .....	6
<b>HMO Community Benefits Principles.....</b>	<b>7</b>
<b>Guidelines.....</b>	<b>8</b>
<b>Appendix I - Timeline for Reporting.....</b>	<b>20</b>
<b>Appendix II - Timeline for Development of Community Benefits Programs.....</b>	<b>21</b>
<b>Appendix III - History of the Guidelines .....</b>	<b>23</b>
<b>Appendix IV - Community Benefits Advisory Task Force Members.....</b>	<b>24</b>
<b>Glossary .....</b>	<b>25</b>



# 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.<sup>1</sup> The

---

<sup>1</sup> 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

evolution of these *Guidelines* is summarized in Appendix III. 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”)<sup>2</sup> 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.<sup>3</sup> In Massachusetts, the Department of Public Health (“DPH”) updated its Determination of Need (“DoN”) regulations in 2017<sup>4</sup> and included new guidelines on statewide health priorities and community engagement for the DoN Community Health Initiative program.<sup>5</sup>

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.<sup>6</sup> 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 2006<sup>7</sup> 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.<sup>8</sup> 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.<sup>9</sup> Updates to the *Guidelines* reflect the continued importance of Community Benefits programs in addressing health disparities and the needs of those without meaningful access to health care.

---

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>.

## **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.<sup>10</sup> 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.

---

<sup>10</sup> Members of the Advisory Task Force are listed in Appendix IV.

## **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.<sup>11</sup> 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.

---

<sup>11</sup> 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

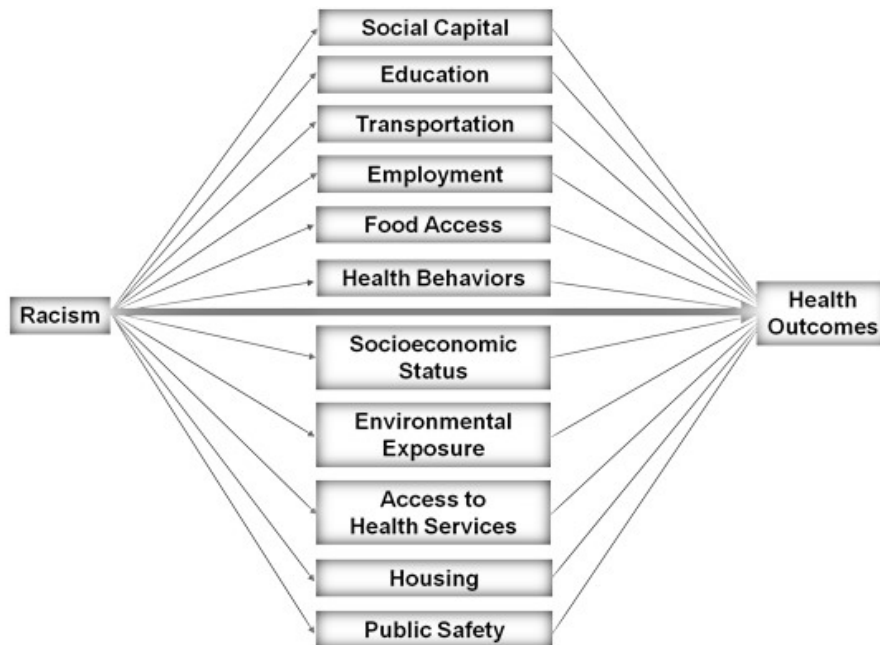
Education refers to a person’s educational attainment – the years or level of overall schooling a person has.

## 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 forms<sup>12</sup> – 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

<sup>12</sup> 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.

### **Scope of this Document**

Consistent with the broad oversight and specific responsibilities of the office of the Attorney General, these Community Benefits *Guidelines* for HMOs are recommended for all HMOs licensed under chapter 176 of the Massachusetts General Laws. These *Guidelines* are fully effective starting in HMO 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.

# 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 Implementation Strategy.
- B. The HMO should demonstrate its support for its Implementation Strategy 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 Implementation Strategy including designating the programs or activities to be included, allocating resources, and ensuring its regular evaluation.
- C. The HMO 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. 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 Implementation Strategy based upon a Community Health Needs Assessment that identifies the health care needs and resources of its community, including negative health impacts of social and environmental conditions. This assessment should take into account information from the community, available public health data, and a review of existing programs, which should facilitate collaboration.
- F. The HMO should include in its 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.
- 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 that details: 1) its key planning document(s); 2) the Self-Assessment Form; 3) information on its Community Benefits programs including program goals and measured outcomes; 4) information on its Community Benefits Expenditures; and 5) the optional supplement (if desired).

## 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 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 articulate the HMO's commitment to allocating resources to address the community's unmet health needs and the value of productive collaboration in that process.

The Community Benefits Mission Statement should outline the general goals of the HMO's Community Benefits programs for a given period, to be addressed in more detail in the Implementation Strategy. The HMO 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 HMO's website.

**B. The HMO should demonstrate its support for its Implementation Strategy 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 Implementation Strategy including designating the programs or activities to be included, allocating 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 Implementation Strategy 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 its charitable work, the HMO board may charge the foundation with developing and executing the Implementation Strategy 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 Benefits activities are developed and implemented in accordance with the Guidelines.

**C. The HMO 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, HMOs should strive to achieve a transparent decision making process that includes diverse community representation. 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 service area.

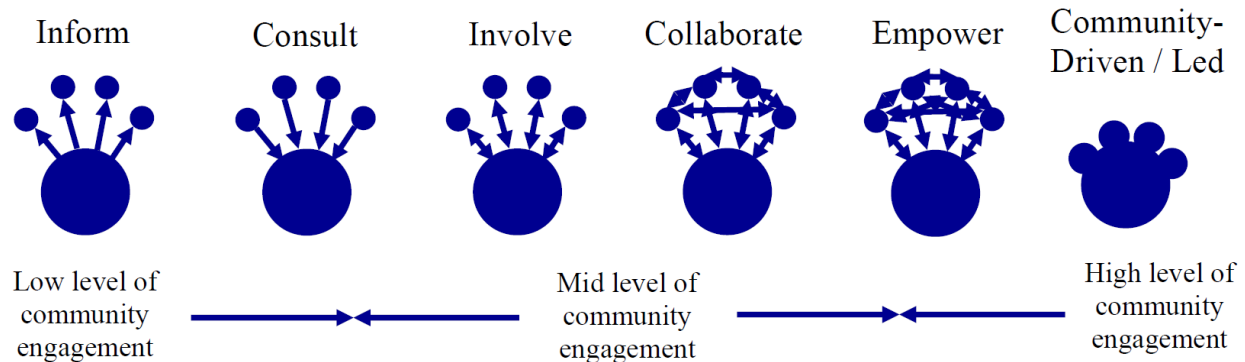
This engagement should include, whenever feasible, the populations the HMO plans to target with its programs and activities, and those organizations and social service providers that are closest to the targeted populations, such as community health centers, neighborhood associations, public health coalitions, 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 HMO 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 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 HMOs 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,<sup>13</sup> 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.



HMOs 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 HMO self-assessment in the annual Community Benefits Report and in community partners' assessment of their engagement in the Community Benefits process.

### **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 accommodations available so that people with disabilities can have full access to the HMO's services.

<sup>13</sup> "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>.

**E. Each HMO should develop its annual Implementation Strategy based upon a Community Health Needs Assessment that identifies the health care needs and resources of its community, including negative health impacts of social and environmental conditions. This assessment should take into account information from the community, available public health data, and a review of existing programs, which should facilitate collaboration.**

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. The HMO should also consider the state-wide health focus issues identified by EOHHS in conducting this assessment (see page 4). The HMO 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 populations they serve, with particular attention to the six health priorities (see pages 4-5). The needs assessment should be based in part on public health data and other existing health status indicators. The AGO Community Benefits website will include links to needs assessment resources.

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 disadvantaged populations. The HMO should consider community representatives as full partners in the process of identifying needs and in developing the subsequent Implementation Strategy to address these needs. The process for identifying unmet health needs should be as open and inclusive as possible.

Additionally, as part of the assessment, HMOs should review their Community Benefits programs as well as related programs provided by other organizations in their service area(s). 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 this information, HMOs should consider whether there are any existing Community Benefits programs that do not make sense to continue in the light of the changing needs in the community.

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.<sup>14</sup> Wherever possible, the HMO should include data stratified by vulnerable groups or populations in its CHNA to identify and monitor health disparities.

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

---

<sup>14</sup> Healthy People 2020. "Disparities." Available from: <http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx>



## Joint Community Health Needs Assessments

The AGO encourages HMOs to collaborate with hospitals, local public health departments, and other organizations in conducting their CHNAs to the extent they serve overlapping/related communities.

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

Once the HMO has completed a Community Health Needs Assessment, the HMO should create an Implementation Strategy. The Implementation Strategy should include a list of significant needs and Target Populations based upon the Community Health Needs Assessment, along with a description of the HMO's plan to address these needs. The plan contained in the Implementation Strategy should include the specific programs or activities the HMO intends to undertake, including resource commitments and measurable goals, and any planned collaborations between the HMO and other organizations, including other filers, in addressing these needs.

The Implementation Strategy 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.

### Identification of Significant Health Needs/Target Populations

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

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 HMO'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 HMO 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, poor, people of color, non-native English speakers, refugees and immigrants, gay, lesbian, bisexual, and transgender populations, and victims of domestic violence.

HMOs are encouraged to be creative in defining specific Target Populations to



will focus on, so long as there is a clear definition of a community, based on the needs assessment, and for which programs can be developed and outcomes can be measured. For example, the HMO 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 HMO'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.

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. The HMO may choose to focus its Community Benefits programs on one or more issues or Target Populations.

#### HMO Plan to Address Significant Health Needs

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

#### 1. Community Benefits Programs

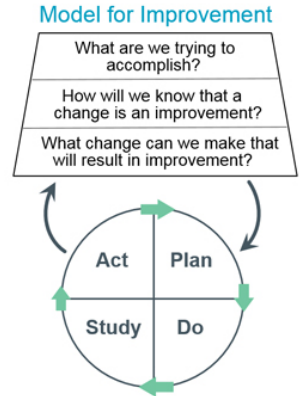
The HMO should describe how it plans to address the significant needs identified in the CHNA. The HMO should demonstrate that each of the Community Benefits programs in its Implementation Strategy addresses a need identified in a Community Health Needs Assessment. It should clearly identify the beneficiaries 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.

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.

## 2. 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 measures of success should be the improvement in health status outcomes of the Target Populations and/or reduction in health disparities. 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.

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



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

## 3. Resources Committed

It is expected that each HMO should commit sufficient resources to fulfill its Community Benefits Mission Statement and Implementation Strategy. 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 HMO should commit sufficient resources to fulfill its Community Benefits Mission Statement and implement the plan documented in its Implementation Strategy.

The Attorney General acknowledges that HMOs vary greatly in size, structure and available resources. Each HMO should set the level of resource allocation for community benefits appropriate for its institution, taking into account 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 exemption benefits, if that figure is available.

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. HMOs should consult actively and openly with and cooperate with community groups and representatives in establishing a reasonable expenditure level.

While the AGO is not recommending a specific target level of annual gross Community Benefits Expenditures at this time, each HMO 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. The AGO 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

### Joint Implementation Strategies

The AGO encourages HMOs to collaborate with hospitals, local public health departments, and other organizations in developing their Implementation Strategies.

### 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 HMO to revise the Implementation Strategy to include programs to address newly identified needs, additional issues or populations. In this situation, the AGO recommends that HMOs adopt and follow a transparent process for revising the Implementation Strategy. At a minimum, that process should include:

1. Community involvement,
2. HMO 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 planning documents outlining for each hospital and HMO 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.

**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 remain uninsured or who cannot afford to access health care due to co-pays or deductibles. 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 cost sharing. For example, an 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.

**H. Each HMO should submit an annual Community Benefits Report to the Attorney General's Office that details 1) its key planning documents; 2) the Self-Assessment Form; 3) information on its Community Benefits programs including program goals and measured outcomes; 4) information on its Community Benefits Expenditures; and 5) the optional supplement (if desired).**

The Community Benefits Report filed annually by each HMO gives the AGO and the public important information about how HMOs 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 key planning documents HMOs 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 HMO Community Benefits Reports

Please see Appendix I for a timeline for reporting.

Report Content

**1. Key Planning Document(s) Reflecting Needs Assessment and Strategy for Implementation**

HMOs are asked to include a copy of their primary planning document(s) as part of their Community Benefits Reports.

## 2. Self-Assessment Form

The Self-Assessment Form is an opportunity for the HMO 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 HMO Community Benefits investments can better understand how to participate in this process. Lastly, the Self-Assessment Form is intended to encourage HMOs to set goals to engage different constituencies in more meaningful ways.

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

- **Leadership** – 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
- **Assessing and Addressing Community Needs** – HMO’s assessment of its level of engagement with the community in assessing community health needs and developing its Implementation Strategy
- **Collaboration** – Collaboration with regional partners (who and what organizations were involved and in what capacity)

## 3. Community Benefits Program Report

HMOs are asked to report detailed information about the Community Benefits programs they implemented in the last year. By providing this information, HMOs 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).

## 4. Community Benefits Expenditure Report

HMOs are asked to provide information on their total expenditures for Community Benefits for the prior HMO fiscal year. The AGO realizes that some HMOs have more resources to devote to Community Benefit activities than others and wants to ensure that the efforts of all HMOs 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.

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

- 1) *By program type<sup>15</sup> (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 HMO 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<sup>16</sup>:*
  - Chronic Disease:
    - Cancer
    - Heart Disease
    - Diabetes
  - Housing Stability/Homelessness
  - Mental Health/Mental Illness
  - Substance Use Disorder
  - Additional Health Needs Identified by the Community<sup>17</sup>

Both program expenditure breakouts should equal the same total.

- **Other Leveraged Resources**
- **Charity Care**

## 5. Optional Supplement

The AGO acknowledges and supports the efforts of many Massachusetts HMOs to make their Community Benefits mission a core part of their operations, beyond the Community Benefits they provide. This optional supplement allows for HMOs 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.

---

15 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.

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

17 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 HMO, each HMO may provide a copy of the AGO's annual Community Representative Feedback form to the community representatives on its committee that oversees Community Benefits for submission to both the HMO 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'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 - 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 II - 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 with special attention to identifying health disparities
- 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 III - 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 IV - 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.<sup>18</sup>

**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.<sup>19</sup>

**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.

---

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

19 *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.<sup>20</sup>

**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.

---

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



**Office of Attorney General  
Maura Healey**

One Ashburton Place  
Boston, MA 02108  
(617) 727-8400