The Attorney General's

Community Benefits Guidelines for Non-Profit Acute Care Hospitals

Commonwealth of Massachusetts

Office of Attorney General
Martha Coakley

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One Ashburton Place
Boston, MA 02108

(617) 727-2200
www.mass.gov/ago

THE ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR NONPROFIT ACUTE CARE HOSPITALS

TABLE OF CONTENTS

THE ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR NONPROFIT ACUTE CARE HOSPITALS

I. INTRODUCTION

A. Background and History

The Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals set forth voluntary principles encouraging Massachusetts hospitals to continue to build upon their commitment to address health and social needs in the communities they serve. The Guidelines represent a unique non-regulatory approach that calls upon hospitals to identify and respond to unmet community needs by formalizing their approach to community benefits planning, collaborating with community representatives to identify and create programs that address those needs, and issuing annual reports on their efforts. The Guidelines do not dictate the types of community benefits programs that hospitals should provide; rather, they suggest that hospitals tap into their own particular resources and areas of expertise, as well as the expertise of their communities, to target the needs of underserved and at-risk populations.

The hospital Community Benefits Guidelines are the product of an extensive process of consultation and partnership between the Attorney General and representatives of the hospital industry, particularly the Massachusetts Hospital Association, as well as community advocacy groups. The evolution of these Guidelines is summarized in Appendix I. Through the Guidelines, Massachusetts hospitals formally acknowledge their responsibility to do all that they can to improve and maintain the health status of members of the communities they serve.

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

Since the issuance of the Community Benefits Guidelines, the Attorney General's Office, hospital and HMO representatives, community advocates and other state agencies have worked closely together and devoted substantial efforts toward their implementation through the Attorney General's Community Benefits Advisory Task Force. The Advisory Task Force accomplishes much of its work through working groups chaired by the Attorney General's Office. The role of these working groups is to conceive of, implement and disseminate strategies or tools to encourage and support community benefits program development consistent with the principles of the Community Benefits Guidelines. The working groups recently have focused on promoting what the Advisory Task Force has identified as three ingredients essential to the success of any community benefits program:

1. Top-down support within the hospital or HMO for the principles of the Community

Benefits Guidelines;

2. Opportunities for active community participation in the development and implementation of hospital and HMO community benefits programs and plans, and community groups organized to avail themselves of those opportunities; and

3. Public access to useful, reliable information about hospital and HMO community benefits programs.

In order to ensure that the Community Benefits Guidelines remain current, the Attorney General's Office revised and re-issued both the hospital and the HMO Guidelines effective January 2002. Most of the revisions are editorial or technical in nature; they do not alter the underlying principles of the original Guidelines. The most notable substantive addition is a set of detailed guidelines, developed with the participation of the Advisory Task Force, that strengthen and partially standardize the format and process for the hospital and HMO community benefits annual reports.

B. Role of the Attorney General

The impact of problems in the health care system is felt virtually everywhere in the Office of the Attorney General. One of the priorities of the Attorney General has been to use the powers of this Office to address a broad range of health care issues.

The Attorney General's Insurance Division represents the interests of consumers by prosecuting unfair trade practices in the health care marketplace, advocating for lower rates for Medigap policies and working on legislative and regulatory changes that promote access to quality health coverage. The Consumer Protection and Antitrust Division applies antitrust laws to hospitals, HMOs and other providers in mergers and joint ventures and investigates health care markets when necessary to protect the public from anti-competitive practices. Through the Division of Public Charities, the Attorney General has broad statutory oversight responsibilities to ensure that all charitable organizations in the Commonwealth, including not-for-profit HMOs and hospitals, account for their funds and conduct themselves in a manner consistent with their benevolent mission. The Public Charities Division also plays an important role in hospital and HMO for-profit conversions ensuring the protection of charitable assets. The Administrative Law Division provides representation to state health care agencies. Finally, the Medicaid Fraud Control Unit prosecutes those who commit Medicaid fraud.

II. SCOPE OF THIS DOCUMENT

This document applies to nonprofit acute care hospitals throughout the Commonwealth (hereinafter referred to as "hospitals"), defined by Chapter 118G of the Massachusetts General Laws as the teaching hospital of the University of Massachusetts Medical School and any

hospital licensed under Section 51 of Chapter 111 that contains a majority of medical, surgical, pediatric, obstetrics and maternity beds as defined by the Department of Public Health. Although municipal hospitals and hospitals which charge no fee for any of their patient care services may find this document helpful in organizing their own community benefit programs, such hospitals are not explicitly covered by these Guidelines. Finally, the Attorney General recognizes that many hospitals were engaged in community benefits initiatives prior to these Guidelines, and hopes that these principles inspire even greater efforts.

III. COMMUNITY BENEFITS PRINCIPLES

Hospitals are encouraged to be innovative in developing community benefit programs so as to use institutional strengths and available resources in the most effective way.

These Guidelines offer a flexible framework of the components of a Community Benefits Program and what can be considered a community benefit, as well as a choice of accountability measures. The Attorney General anticipates that these recommendations will facilitate dialogue between the hospitals and the communities they serve:

A. The governing body of each acute care hospital should affirm and make public a Community Benefits Mission Statement, setting forth its commitment to a formal Community Benefits Plan.

B. The Governing Board and senior management should be responsible for overseeing the development and implementation of the Community Benefits Plan, the method to be followed, the resources to be allocated, and the mechanism for its regular evaluation.

C. A hospital should delineate a specific community or communities that will be the focus of its Community Benefits Plan and should involve representatives of that designated community in the planning and implementation process.

D. A Community Benefits Plan should include a comprehensive assessment of the health care needs of the identified community as well as a statement of priorities consistent with the hospital's resources.

E. The hospital should develop and implement its Plan in a timely fashion.

F. Each hospital should submit an annual Community Benefits Report to the Attorney General's Office which discloses its level of community benefits expenditures and describes the hospital's approach to establishing such expenditures. The hospital should make the Report available to the public.

IV. THE GUIDELINES

A. The governing body of each hospital should affirm and make public a Community Benefits Mission Statement, setting forth its commitment to a formal Community Benefits Plan.

In a special Community Benefits Mission Statement, the Governing Board of each hospital should formally affirm its commitment to serve a designated community or patient population. 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 broadly defined health care needs.

It is recommended that this Mission Statement be reviewed and amended by the Governing Board as necessary.

B. The Governing Board and senior management should be responsible for overseeing the development and implementation of the Community Benefits Plan, the method to be followed, the resources to be allocated, and the mechanism for regular evaluation.

Crucial to the effectiveness of a Community Benefits Plan is the active participation, of the hospital's Governing Board and senior management. While the Governing Board should place responsibility for the Plan's implementation at the highest organizational level, it is equally important that the hospital create a shared sense of purpose and commitment among all members of the hospital staff.

For example, the hospital could designate an individual or group, under the direction of a senior level manager, responsible for planning, organizing and evaluating the hospital's Community Benefits program. That planning group would be an integral part of the general policy development and budgeting process of the hospital and would be accountable directly to the Governing Board.

Regular evaluations of the Plan and its implementation should be reviewed by the Governing Board. Where necessary, appropriate amendments to the Plan should be made by the Board.

Copies of the Plan should be provided to all those involved in its development and should be made widely available for comment. Following the comment phase, the Governing Board should formally review, revise, and adopt the Community Benefits Plan.

C. A hospital should delineate a specific community or communities that will be the focus of its Community Benefits Plan and should involve representatives of that designated community in the planning and implementation process.

In order to form a bridge to community leaders and representatives of the medically underserved, hospitals should establish a Community Benefits Advisory Group, or other similar mechanism, which includes members of the population to be served and which reflects the racial, cultural, and ethnic diversity of the community.

1. Defining Community

The first step which a hospital should take in formulating a Community Benefits Plan is to define its relevant community for those purposes, a definition which may differ from that used for its patient care population. The step should be accomplished in collaboration with the community in which the hospital is located and, if different, the community which the hospital historically has served.

Hospitals are encouraged to be creative in defining their community, so long as there is a definition that is clear and for which outcomes can be measured.

It is possible that more than one community may be chosen as the focus of a hospital's Community Benefits Plan. For some hospitals located in the same geographic area, it may be desirable to collaborate with each other in order to establish each hospital's "community" and to develop a coordinated plan.

The following are some examples of how a community may be defined:

a. The geographic boundary approach, e.g. a city, town, or county, or several contiguous municipalities;

b. The demographic approach, e.g. a community may be defined by (i) the low or moderate income persons who are uninsured or underinsured; (ii) the elderly; or (iii) pregnant women of low or moderate income;

c. The outreach approach would involve a hospital's reaching beyond the geographic boundaries of its service area in order to apply its community benefits resources to undeserved populations and neighborhoods elsewhere as long as the community parameters are drawn to permit ease of access to the hospital or to its mobile facilities;

d. The health status approach focusing on the prevalence of a particular disease, such as HIV, STD, diabetes, cardio-vascular. This approach may involve contiguous neighborhoods, municipalities or whole counties.

2. Community Process and Input

The goal is to identify the health care needs, especially the needs of unserved and undeserved populations, within the designated community through a process as open and inclusive as possible. Hospitals should consider community representatives as full partners in the process of identifying health care needs.

Whenever feasible, information should be collected directly from the population at risk and from those organizations and social service providers which are closest to the designated populations, such as: health care providers, community health centers, neighborhood associations and community organizations, local boards of health, local health planning networks, community action agencies, private charitable organizations, schools, churches and clergy, police, housing authorities, and ambulance services.

In addition, the hospital is encouraged to initiate a formal process, such as an annual public hearing, to solicit the views of community members. At such public events, the hospital might wish to invite the participation of local and state public health departments or other public and private agencies that provide information or that coordinate resources to achieve public health objectives.

D. A Community Benefits Plan should include a comprehensive assessment of the health care needs of the identified community as well as a statement of priorities consistent with the hospital's resources.

1. Developing the Plan

In developing its Community Benefits Plan, the hospital, in partnership with its community, should consider carrying out the following steps:

a. Assess community needs, taking into account all data and information already available, and avoiding duplication wherever possible;

b. Establish a set of priorities of community health care needs that are the primary candidates for the resources of a Community Benefits Plan;

c. Prepare an inventory of all the community service and community benefit programs currently provided by the hospital, as well as by other health care providers, or social service agencies, that correspond to identified community health care needs. For purposes of reporting and quantification, health care programs can be broadly defined, and essential community service programs already in existence can be incorporated into the hospital's Community Benefit Plan, so long as that Plan is the result of a hospital-community dialogue;

d. Re-examine existing community benefit commitments and priorities in light of formally identified community needs and hospital resources;

e. Identify short-term (one year) and long-term (three to five year) goals, described with as much specificity as possible;

f. Determine the need for additional resources such as paid and volunteer staff, as well as for additional physical facilities, mobile health units, and other resources;

g. Using the priorities established in item (b), as well as the information developed in items (c), (d), (e), and (f) of this section, prepare a budget for the Community Benefits Plan, indicating expenses, expected revenues and outside sources of funding;

h. Determine time frames for implementing each aspect of the Plan;

i. Take a leadership role in coordinating community benefit projects, taking into account existing community-based programs that may already be providing important health-related services;

j. Encourage hospital-wide and community-wide involvement in the planning and implementation of the Community Benefits program;

k. Retain the flexibility to respond to unanticipated emergencies and continue to respond rapidly to provide appropriate aid in critical time of need.

2. The Needs Assessment Process

The needs assessment should be based on public health data and other health status indicators, as well as consultations with representatives of the designated community. Efforts should be made to make use of existing data and information and to avoid "reinventing the wheel" by duplicating information that is already available. In order to avoid wasteful duplication when assessing needs, hospitals should begin by looking at existing health status information already collected by public and private entities, most particularly the Department of Public Health, the Department of Mental Health, and the Division of Health Care Finance and Policy.

In deciding which benefits to provide, the hospital should take into account the health care problems of medically undeserved and disadvantaged populations, and should aim to reduce racial and ethnic disparities in health status. While the hospital should take cognizance of special health-related problems in a particular community, even if such problems may not be unique to the disadvantaged, priority should be accorded to the health care needs of disadvantaged and vulnerable populations within the hospital's designated community.

There are several different approaches to conducting a needs assessment. At a minimum, the hospital's needs assessment process should involve members of the staff who are most knowledgeable about the needs and available resources in the community. Invited members from outside the hospital should include community leaders, representatives from the other health care and service providers, and members of the population(s) at risk. The Community Benefits Plan should focus on projects that enhance the health status of the designated community.

Attention should be given to the special needs of the poor, of the elderly, of racial, linguistic, and ethnic minorities, and of refugees and immigrants. It is recommended that, where appropriate, hospitals establish interpreter services so that linguistic differences do not present a barrier to accessible health care.

Data compiled from all sources should be evaluated, with areas of need ranked in order of priority, using at least the following criteria:(1) income level of the affected population; (2) presence of significant barriers that hinder access to appropriate health care delivery programs; (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.

A comprehensive needs assessment of the defined population should be considered at least every three years.

3. Options for Measurable Objectives and Outcomes

The long term measure of the success of a Community Benefits Plan should be the improvement in health status outcomes of the hospital's defined community. Both short and long term measurements could be quantified in the following ways:

a. The number of patients treated in a particular area for a given condition, i.e. number of immunizations, number of pregnant teenagers served, number of adolescents tested and counseled for AIDS;

b. The reduction or improvement in a particular health status indicator, i.e. the reduction in incidence of tuberculosis, the reduction in teen pregnancies, the reduction in numbers of adolescents with AIDS.

Community health status outcomes can be determined by consulting the Health Status Indicators of the Department of Public health and the data on Preventable Hospitalizations in Massachusetts maintained by the Division of Health Care Finance and Policy.

4. Establishing the Level of Community Benefits Expenditures

Hospitals are encouraged to establish a Community Benefits budget and to make a good faith effort to measure expenditures and administrative costs associated with the process. Recognizing that some community benefits are not subject to a good faith estimate of value, the Attorney General asks hospitals that provide benefits not easily quantified to report a full and accurate description of such benefits.

These Guidelines encourage hospitals to adopt the approach set forth below in determining the level of gross community benefits expenditures. This flexible approach reflects the fact that hospitals vary greatly in size, structure and available resources.

In collaboration with its community, the hospital could identify a reasonable amount of gross community benefits to be provided by taking various financial indicators, including the following factors, into consideration:

a. The total unreimbursed cost to the hospital of providing health care services in accordance with the Massachusetts free care pool, M.G.L. c. 118G, §1.

b. Audited total patient operating expenses and audited total operating revenues;

c. Accumulated operating surpluses or deficits; compensation structures and levels relative to industry norms;

d. The net value of the hospital's tax exempt benefits, if that figure is available.

Hospitals should be aware that the successful implementation of this approach is directly related to the quality of the collaboration with the community that takes place. It is incumbent upon hospitals choosing this approach to consult actively and openly with and cooperate with community groups and representatives in establishing a reasonable expenditure level.

The Attorney General also considered recommending an alternative approach that would take into account the size of the institution, from small community institutions to large urban medical centers, to suggest appropriate levels of resource allocation to Community Benefits Programs. Under this approach, the target goal for gross community benefits would be accomplished consistent with the financial values associated with achieving the various health care priorities chosen for the Community Benefits Plan as discussed in Section D and E of this document. Once priorities had been chosen, values could be attached and additional priorities could be included as may be necessary to reach a particular target level of gross community benefits expenditure. The target goals that would be envisioned in this approach are:

a. For hospitals with audited total patient operating expenses under $200 million, up to 3% of such expenses (although there would be significant flexibility within this

alternative, target levels at the lower part of this range would be anticipated only for hospitals whose financial circumstances warrant such a target level).

b. For hospitals with audited total patient operating expenses over $200 million, 3% to 6% of such expenses.

In order to provide hospitals an opportunity to implement their commitment to work collaboratively and systematically with their communities to meet health needs and improve community health status, the Attorney General deferred recommendation of this approach until such time that, after consultation with hospitals and community advocates, it becomes appropriate to adopt this or another approach.

5. Community Benefits Programs

Community benefits projects may include, but certainly are not limited to:

a. Community health education through informational programs, publications and outreach activities in response to a formally adopted Community Benefits Plan;

b. Free preventive care or health screening services;

c. Mobile health vans;

d. Home care consistent with the definition of net charity care;

e. Medical and clinical education and research conducted in response to a previously assessed community need where such need and the education and research are specifically parts of the Community Benefits Plan;

f. Support for and participation in community oriented training programs;

g. Low or negative-margin services which are offered in response to an identified community need. Such services include immunization programs, services to persons with AIDS, psychiatric care for deinstitutionalized and homeless persons, and outpatient mental health services for vulnerable populations;

h. Violence-reduction education, counseling, and other related measures;

i. Anti-smoking education and related activities;

j. Substance abuse education and related preventive and acute treatment services;

k. Domestic violence reduction education and training services;

l. Early childhood wellness programs;

m. Expanded prescription drug programs;

n. Volunteer services (if part of the community benefit Plan);

o. Net financial assistance to independently licensed and hospital licensed community health centers and community mental health centers;

p. Unfunded services that are ancillary to Medicaid or Medicare service, if part of a community benefits program, such as certain kinds of personal care/home care services for which Medicaid or Medicare does not provide any reimbursement.

The common denominator among all community benefits is that they be part of a Community Benefits Plan that responds to a specific health care need identified through a formal assessment process with the active collaboration of the population to be served. Community benefits that a hospital has provided previously are included within this definition so long as such on-going programs and services are consistent with, and become a part of, the hospital's formal Community Benefits Plan.

E. The hospital should develop and implement its Plan in a timely fashion.

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

Phase 1: Adoption by the Governing Board of the Community Benefits Mission Statement.

Phase 2: Formation of the hospital's Community Benefits planning mechanism for developing the operational Plan.

Phase 3: Completion of Community Benefits Needs Assessment.

Phase 4: Development and adoption of the Community Benefits Plan.

Phase 5: Implementation of the Community Benefits Plan.

Phase 6: Annual review of Community Benefits Plan.

F. Each hospital should submit an annual Community Benefits Report to the Attorney General's Office which discloses its level of community benefits expenditures and describes the hospital's approach to establishing such expenditures. The hospital should make the Report available to the public.

The hospital should file with the Attorney General's Office an annual report on its Community Benefits Plan consistent with the process and format set forth in Appendix II to these Guidelines.

The hospital may decide to circulate a draft of its annual Report and Community Benefits Plan before submitting that Report and Plan to the Office of the Attorney General. Community response to the Community Benefits Plan or Report is encouraged and should also reflect the positive aspects of the Plan and/or Report. Hospitals are encouraged to solicit and make publicly available comments generated in response to the Community Benefits Plan. In the event that a community, community group or an individual disagrees with a hospital's choice of a Community Benefits Plan, or disagrees with any material aspect of the program or process used to create a Community Benefits Plan, said community, community group or individual shall have the right to file a separate report, and the report will be made a public record on file at the Attorney General's Office.

V. CONCLUSION

These Guidelines embody the recommendations of the Attorney General in key areas of process and substance. They have been developed in order to provide the Governing Board and senior management of nonprofit acute care hospitals with helpful assistance in the fulfillment of their charitable purpose. The current changes in health care delivery carry a clear challenge to Massachusetts hospitals and to their communities. In the face of increasing competition and economic pressure to curtail unnecessary health care costs, extra vigilance is required to ensure that the needs of vulnerable and at-risk populations are not neglected.

With institutional change on the horizon and already underway, the Attorney General anticipates continued evolution and refinement of the process outlined in these Guidelines and welcomes constructive suggestions from all sources.

APPENDIX I

DEVELOPMENT OF THE ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR NONPROFIT ACUTE CARE HOSPITALS

[Note: A version of this document was published in 1994 as the executive summary to the original hospital Community Benefits Guidelines, and is included here for historical purposes.]

Thank you for your interest in the Attorney General's Community Benefits Guidelines. It is our hope that Massachusetts nonprofit acute care hospitals, working with their communities, will begin to adopt and implement these voluntary Guidelines. For those which may have already begun to implement other community benefits guidelines, including but not limited to those of the Kellogg Foundation, the Catholic Health Association, and the Voluntary Hospitals of America, these Guidelines are sufficiently flexible to enable hospitals to adapt such on-going processes to fit these Guidelines.

The Attorney General wishes to extend his personal appreciation to everyone who provided assistance to this office during the development and refinement of these Guidelines. The many thoughtful comments and suggestions have been carefully considered and, where consistent with the goals of our initiative, have been incorporated into the final draft.

We continue to welcome feedback from hospital trustees, administrators, health care advocates, community representatives, and others, as the Guidelines are put into practice. Future editions of the Guidelines will benefit from your continued assistance and constructive criticism.

Attorney General Perspective

As you are aware, one of the Attorney General's priorities has been to use the law enforcement and statutory oversight powers of this office to address a broad range of health care cases and policy issues. This is because the impact of the problems generated by an inefficient and inequitable health care system are felt virtually everywhere in this office, including the areas of consumer protection, public charities, insurance, antitrust, and Medicaid fraud control. On the basis of our experience, we believe that many populations -- the working poor, the elderly, at-risk women and children, and others who are without adequate health insurance or access to health care now -- may continue to lack elementary primary and preventive medical care even with national or state health care reform.

Based on our casework and issues that are brought to our attention by the public, we are concerned that a more competitive and cost conscious health care system, one that is evolving and changing rapidly, may prompt some nonprofit acute care hospitals to curtail or eliminate services needed by disadvantaged patient populations, or to simply grow apart from their communities. Thus, we have developed these voluntary Guidelines in an effort to create a level playing field with respect to the expectation that all such hospitals will make or continue to make

community benefits an integral part of their institutional missions.

Although these Guidelines are intended for use by hospital providers, we expect to work with other nonprofit institutions, such as health maintenance organizations, to adapt these Guidelines to serve their charitable purposes as well.

Approach Taken in the Guidelines

As you will note, we have retained the general approach of our earlier draft. The governing board of each nonprofit acute care hospital, in partnership with its community, is asked to identify that community's health care needs and to develop and implement a responsive coordinated plan. The specific details of how the hospital defines its community and develops its plan are left to the discretion of the institution, within the broad parameters described by the Guidelines. Each hospital is then requested to report to this office on an annual basis the status of its plan, including resources committed and benefits provided.

While the general approach of the earlier draft is retained, numerous modifications and clarifications were made in response to comments and suggestions. For example, in areas of special concern to those who commented, refinements were made as explained below:

Standards of Accountability

This section of the Guidelines received the most attention and was clearly the most controversial. On the one hand, some hospital representatives warned that any quantitative attempt to measure community benefits expenditures would prove counter-productive, distracting attention from the task of providing necessary health care services. The Attorney General was urged to eliminate any suggestion that hospitals quantify community benefits and to adopt instead one of the hospital-generated community benefit standards, such as the Kellogg Program, that do not include suggested spending levels or principles of quantification. Some commenters argued that the inclusion of suggested benchmarks would give some community groups "leverage" to extract unreasonable demands from financially strapped hospitals. Others asserted that if hospitals devoted resources to community benefits programs, it would result in job losses and financial hardship.

On the other hand, some community health care advocates and public health analysts, inspired by recent state legislation enacted or pending in other jurisdictions, requiring minimum levels of hospital charity care expenditure, urged the Attorney General to turn the Guidelines into regulations. Many also expressed concern that, in the absence of regulations, hospitals would make merely formal gestures of compliance. Some commenters recommended that the benchmarks be increased, while others argued that the "reasonable amount" standard be dropped entirely and that hospitals be given only the option of a benchmark percentage.

In addition, some advocates argued that the Guidelines should, in general, be less flexible

and more prescriptive and that only a narrow category of health care services be eligible to be counted as community benefits in arriving at a target benchmark. Further, some community representation advocated that only true uncompensated charity care be counted as a community benefit, and that hospitals not be allowed to use donated funds, grants, or any research funds in the measurement of community benefits.

A few commenters, rejecting extreme positions by some hospitals and community advocates, urged that the Attorney General consider deferring recommended benchmarks until at least one cycle of community benefits data could be reported in accordance with the remainder of the Guidelines. These commenters, who acknowledged the desirability of quantification, argued in favor of collecting community benefit spending levels from all hospitals before final recommendations on any target levels are made.

We reviewed all the comments which we received and met on several occasions with both hospital and community representatives over the issue of accountability by objective standards. We tried to reconcile what appeared to be the polar positions of some of the advocates and some of the hospital representatives. We pointed out that for providers, the pressures to consolidate, to eliminate excess capacity and drive down costs are taking place with or without these Guidelines. Powerful and irresistible forces are at work to make our health care system more economical. Our Guidelines seek to ensure that as we move toward a leaner system, the unserved and underserved health care needs of vulnerable and disadvantaged populations are not overlooked and neglected.

We also recognize that each hospital must have the flexibility to adapt to a changing health care marketplace and implement a community benefits program that best fits its particular circumstances and community. Rigid and inflexible regulation would be counterproductive toward achieving that objective. At this stage in the development of these Guidelines, we have made decisions on the issue of objective measurements consistent with our best assessment of what is reasonable, fair and consistent with our goals to promote and encourage the adoption of community benefits programs in a way that facilitates accountability, ease of monitoring, and credibility in the process.

In furtherance of these goals, but still attentive to the concerns expressed by the commenters, we made the following modifications to the language and concepts in this Section of the Guidelines. First, the order of the standards of accountability was re-arranged so that the reasonable-amount standard, which had been in last position, was placed first. This change was made not only because it appeared that several commenters had either overlooked or had not been aware of this option, but also because we want to emphasize that it <u>is</u> an option, and a very flexible one, that hospitals and communities should actively embrace.

We also added specific language recommending that the hospital's expenditure level and its reasonableness be determined in collaboration with the community to be served. This is a deliberate attempt to prompt hospitals to consult and cooperate more actively with community

groups and representatives in establishing a Community Benefits program.

In our first draft, the second standard of accountability utilized target goals based on total patient operating expenses. With respect to this alternative, while we continue to describe it in the Guidelines, we have deferred recommending this approach for the first two years following the issuance of these Guidelines. We have done so in order to give hospitals an opportunity to implement their stated commitments to work with their communities to develop or expand upon community benefits programs that will meet unserved health care needs and improve community health status.

The deferral is also consistent with the request of many commenters, that this office collect data during the immediate future and make target goal recommendations, if any, after such information has been collected. At the end of two years, we will review the data, and, in consultation with hospitals and community advocates, recommend appropriate adjustments, if any, in this approach.

Although the Guidelines defer recommending this approach, hospitals that wish to consider it, or be better prepared for its possible recommendation at the end of two years, may find the following information useful. The reason for choosing patient operating expenses as a yardstick is to facilitate a comparative review of resources allocated to community benefits programs. While this deferred approach retains the concept of two target levels linked to hospital size, the target percentages themselves would have been adjusted downward from the earlier draft. The range of percentages for hospitals whose total patient operating expenses are under $200 million would have been changed from 2-4% to "up to 3%." For hospitals over $200 million, we would have changed the range, at this point in time, from 4-7% to "3-6%."

The changes in the deferred target goals were made to reflect statistical data, not available at the time of the first draft, showing that in fiscal year 1992, most Massachusetts acute care hospitals spent an average of 1.5% of total patient costs on unreimbursed free care alone, an item which is only one of many significant programs that could be counted in the broad measure of community benefits defined in the new draft of the Guidelines.

We have decided to eliminate the third approach, which was to determine community benefits expenditures based on the net value of the hospital's tax-exempt benefit. Our first draft indicated that if this calculation was available, some hospitals and communities would find it a useful measure of the appropriate level of community benefits a hospital should provide. Many hospitals, however, indicated that it was difficult if not impossible to calculate the figure and community advocates were also not in a position to determine the value of the benefit. Some other commenters felt that it signaled some unstated, broader objective to examine the tax exempt status of all types of nonprofit institutions; no such objective exists. Given that it appears that the tax exempt benefits figure is not one which hospitals can readily calculate and given the potential for misunderstanding across a broad range of nonprofit corporations, it made sense to use to delete that approach from the Guidelines. Notwithstanding, however, if there are hospitals

that wish to look at this factor, it is still mentioned in the list of factors that a hospital may take into account under the "reasonable amount" approach.

We have added the concept that hospitals should make a "good faith" effort to measure expenditures. Administrative costs associated with the organization of a Community Benefits Plan -- which we believe would be nominal -- are also a recognized part of Community Benefits expenditures.

The recommendation that hospitals should report the dollar value of both Gross and Net Community Benefits has been retained, although the measurement of community benefits expenditure levels is based only on the value of Gross Community Benefits.

In response to several comments received, we have explicitly acknowledged that there are some community benefits that are not easily quantifiable, but they are important and should be reported. Therefore, we have added language which makes it clear that community benefits that cannot be easily quantified, should be described fully and publicly reported.

Definition of Community Benefits

We clarified and expanded the definition of Gross Community Benefits to emphasize that it includes health-related community services if such services are incorporated into a formally adopted plan. For example, domestic violence reduction, education and training services, net financial support of community health centers and community mental health centers, and unfunded programs ancillary to Medicaid or Medicare services, such as certain personal care/home care services for AIDS patients, are just a few of the examples listed in the Glossary.

We also made it clear that existing community benefits or community services that target the designated community are included within the definition so long as such programs have been incorporated into the Plan.

In addition, programs developed to comply with regulatory requirements, such as the Determination of Need, may be counted as Gross Community Benefits if such programs have been formalized into a Plan according to the Community Benefits process outlined in the Guidelines. As stated above, those community benefits which cannot be quantified may, nonetheless, be described in the annual report to the Attorney General's Division of Public Charities.

In the Glossary, we have clarified that Net Charity Care means the actual costs, and not the hospital charge, of providing free care to patients.

Time Frame

In response to concerns expressed as to the adequacy of a twelve month period for

completion of the community benefits process, the Guidelines have been modified to increase the suggested time for completion to fifteen months. This change was made in recognition of the different relationships that hospitals have with their communities and the differing needs of those communities. While many hospitals in Massachusetts are already providing extensive community based services in response to assessed community needs, others will need more time to develop a productive dialogue with their communities.

Flexibility

In response to comments and concerns that the earlier draft Guidelines appeared to be too prescriptive, the language throughout has been modified so as to make clear that the Guidelines encourage the development of individualized solutions to community health care needs, although hospitals are still encouraged to give priority to the health care needs of unserved and underserved populations within their respective communities.

In addition to the changes explained above, many other modifications have been made in the terms and provisions of the Guidelines. A section-by-section description of those changes is set forth below. Although some of these changes may appear technical in nature, viewed in their entirety, these changes help to make clear the ultimate responsibility of the Board of Trustees and, at the same time, to provide necessary flexibility for trustees and administrators in the development and implementation of a Community Benefits Plan.

The **SCOPE OF THIS DOCUMENT** has been changed to clarify the type of acute care hospitals covered by the Guidelines. We excluded municipal hospitals because those hospitals, directly supported by tax dollars, by and large already provide needed health care services to disadvantaged populations.

Under **Principle A** of the Guidelines, in our recommendation pertaining to the Special Mission Statement, we changed this to emphasize the importance of the hospital-community partnership by asking that the Mission Statement formally affirm the hospital's commitment to the Community.

Under **Principle B**, in keeping with the ultimate legal responsibility of the hospital governing board, we emphasized that the final decisions regarding the development and implementation of the Community Benefits Plan lie with that board. We gave recognition to the fact that hospitals differ in management structure by making our recommendations regarding internal planning for Community Benefits more flexible.

Under **Principle C Section 1 (Defining Community)**, the definition of the target patient population has been broadened to embrace all ethnic, cultural, racial, and economic groups, so long as the identification of the tartget patient population is the result of a collaborative hospital-community planning process.

In **Principle C Section 2 (Community Process and Input),** we eliminated detail in favor of general guidance so as to emphasize the flexibility the Guidelines afford and to recognize the unique situations of certain hospitals. We retained the focus of meeting the needs of unserved and underserved populations and of considering community representatives as partners in the process of identifying health care needs. In order to facilitate coordination of already existing data and expertise, we encouraged the participation of local and state public health departments and other public agencies during any formal needs assessment process.

Under **Principle D (Needs Assessment and Setting Priorities),** we deleted some of the detailed recommendations regarding the Needs Assessment procedure in further recognition of the difference among hospitals and their communities and the fact that a number of hospitals currently are performing needs assessment in their communities. We moved the steps which we suggest be taken in formulating a Community Benefits Plan from Principle B (Overseeing the Development of the Plan) to Principle D (Needs Assessment and Setting Priorities).

The language of **Principle F, (Report and Accountability)** has been changed to read as follows: "Each hospital should submit an annual Community Benefits Report to the Attorney General's Office which discloses its benefits expenditures and describes the hospital's approach to establishing such expenditures. The hospital should make the Report available to the public."

Under **Principle F**, the February 15 deadline for filing the annual Community Benefits Report has been removed. Instead, hospitals will be expected to file community benefits reports at the same time as they file their Form PC with the Division of Public Charities. This change should reduce confusion about filing requirements and also eliminate duplicative paperwork.

We added the recommendation that the draft of the annual Report be circulated before submitting it to the Office of the Attorney General. To this end, the hospital has been asked to solicit and make publicly available any comments generated in response to the Community Benefits Plan.

The 15 month start-up time envisioned in the Guidelines means that most hospitals will not file their first annual report until sometime after the Spring of 1996 which will coincide with the filing of the annual Form PC. Because of this lengthy delay between the issuance of the Guidelines and the filing of the first annual report, we are asking hospitals to submit a one-time "status report" by February 15, 1995, indicating the status of the hospital's Community Benefits efforts to date and including a copy of the Community Benefits Mission Statement and a description of the Community Benefits planning mechanism. For those hospitals who may find it helpful, an optional form for this status report is attached to the Guidelines. Thereafter, hospitals may file the annual report at the time of the filing of the Form PC.

Under **Principle F, Section 2 (Measurement)**, we clarified the recommendation that short

and long term measurements may actually be quantified in a similar fashion, while retaining the concept that long term measurement means improvement in health status outcomes.

***

As indicated previously, it is our hope that these Guidelines will encourage nonprofit hospitals, in partnership with their communities, to make resource commitments consistent with their individual institutional strengths and with the formally assessed needs of their community. In order to provide assistance to hospitals, particularly smaller community hospitals, in their efforts to accomplish these goals, our Office will offer an educational and training program in the near future.

Thank you again for your valuable contribution to the development of these important Community Benefit Guidelines.

APPENDIX II

THE COMMUNITY BENEFITS ANNUAL REPORT: FORMAT AND PROCESS

The Attorney General's Community Benefits Guidelines call upon health maintenance organizations (HMOs) and non-profit acute care hospitals (hospitals) to prepare annual reports documenting the status of their community benefits programs and initiatives. These annual reports serve the important purpose of providing the public with access to useful information about these programs and initiatives. The availability of such information enables hospitals, HMOs and communities to work together to identify and address critical unmet community needs, and facilitates replication of best practices.

The Attorney General recognizes the significant efforts that hospitals and HMOs devote to the reporting process, but notes that the information generated through these labors previously has been inconsistent and accessible to a very limited audience. In response, the Attorney General, in partnership with members of the Attorney General's Community Benefits Advisory Task Force, has developed a plan to use information technology not widely available when the Guidelines were first issued to improve public access to useful information about hospital and HMO community benefits. Under this plan, the Attorney General's Office will add a community benefits section to its web site containing a wide range of information about community benefits, including the full text of each hospital and HMO annual report. An important element of this plan is the development of a new community benefits reporting format and process that reflects what we have learned from five years of reporting experience, provides a common basis for interpreting the reporting elements of the Community Benefits Guidelines and is designed to allow hospitals, HMOs and communities to take full advantage of the web environment to transmit and receive useful information about community benefits activities.

The following community benefits reporting guidelines become effective with the annual reports for fiscal year 2001 (due in the spring of 2002), and replace all reporting templates and related materials in effect through fiscal year 2000.

1. COMPONENTS

Each community benefits annual report consists of two parts:

1. Full-Text Report

The full-text report should address the topics identified in **Attachment 1**. The full-text component offers the opportunity for a detailed description of information about a hospital or HMO's community benefits plan and programs. Its format is flexible, allowing hospitals and HMOs to convey the unique character of their community benefits initiatives.

2. Standardized Summary

The standardized summary should conform to the outline and templates in **Attachment 2**. The summary component is a standardized, condensed version of the information contained in the full-text report. It offers a "snapshot" of each hospital or HMO community benefits report and facilitates analysis. It also provides information about specific programs in a format from which the Attorney General's Office can produce a searchable statewide community benefits program database for use by those looking for information about specific types of programs. The standardized summary form can be downloaded from **Attachment 2**.

Note: In preparing the two parts of its annual report, a hospital or HMO should refer to the definitions set forth in **Attachment 3**, as well as to the Attorney General's Community Benefits Guidelines. Hospitals and HMOs should also refer to the community benefits section of the Attorney General's web site **(www.ago.state.ma.us)** for other supporting materials that will be added from time to time.

II. PROCESS

A. Reporting Period and Filing Deadline

Annual community benefits reports should cover the 12-month period of the hospital or HMO's fiscal year. A hospital or HMO should file its community benefits report no later than **5** (five) months after the end of its fiscal year. Not-for-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. **[Note: For FY 2001 only, the due date for all hospital and HMO reports is May 31, 2002.]**

B. Form of Submission

Each hospital or HMO should deliver to the Attorney General's Office both a hard copy and a diskette containing electronic copies of its annual report. The Attorney General's Office will use the electronic copy to make each hospital and HMO report available through its web site.

The Attorney General's web site presently cannot accept direct electronic filing of community benefits annual reports. To facilitate the posting of reports on the web site, hospitals and HMOs should provide diskettes containing two versions of the annual report: (1) a file that is retrievable using commonly-available word processing software, and (2) an Adobe Acrobat .pdf or similar file. A hospital or HMO whose report contains photographs, charts or other advanced graphics also should submit an alternative "text-only" version that the public will more likely be able to view or download without difficulty.

C. Additional Materials

The Attorney General discourages the submission of additional materials related to a hospital or HMO's community benefits programs, including brochures, videotapes and other products. Such materials **cannot** be included in the Attorney General's web site. At the request of the reporting institution, the Attorney General's site will offer direct links to a hospital or HMO web site through which the hospital or HMO can make these types of materials available.

D. Amended Reports

At any time during the year, a hospital or HMO may file an amended report, or section thereof, with the Attorney General. The Attorney General's Office will post such amended reports on its web site and, if indicated, update its own statewide program database.

III. COMMUNITY RESPONSE

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

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

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

A. Content

1. The submission should relate directly to the hospital or HMO's most recent community benefits report and programs. The tone of the submission should be consistent with the spirit of the Attorney General's Community Benefits Guidelines, which envision cooperation and partnership between hospitals, HMOs

and their communities.

2. Appropriate discussion points include, but are not limited to: (1) the hospital or HMO's methods of community engagement or its mechanisms for community participation, including suggestions for improving community engagement; (2) the hospital or HMO's needs assessment process, including information related to unmet community needs that a hospital or HMO should consider in its community benefits planning; (3) other aspects of the community benefits planning process or the results of that process, including comments on how the hospital or HMOs' actual programs target identified community needs or recommendations for a shift in priorities; (4) the level of resources a hospital or HMO has allocated to community benefits; (5) recommendations as to how a hospital or HMO could improve a particular community benefits program; and (6) identification of community benefits programs through which a hospital or HMO successfully has addressed identified community needs (i.e., best practices).

3. Submissions aimed primarily at criticizing a hospital or HMO's decision to fund or not fund a particular program will not meet the standards for publication on the web site. Likewise, submissions aimed primarily at praising or thanking a hospital or HMO for supporting a particular community benefits program or community organization will not meet these standards.

4. The submitting party should identify him or herself and any group that he or she represents. The submission also should provide information about the submitting party's relationship with the hospital or HMO, and identify any "stakeholder" interest in the community benefits process (e.g., as a current or potential recipient of community benefit funds). Anonymous submissions are not eligible for posting on the Attorney General's web site; the Attorney General will post contact information for the submitting party.

B. Process

1. At least thirty days prior to filing a submission for publication on the Attorney General's web site, the submitting party should provide a copy to the hospital or HMO that is the subject of the comments. The submission should be addressed to the hospital or HMO CEO, with a copy to the community benefits manager.

2. At the time that it provides the copy of its submission to the hospital or HMO, the submitting party should notify the hospital or HMO of its intent to ask the Attorney General to publish the submission, and should indicate its willingness to meet with representatives of the hospital or HMO to participate in a good faith discussion of any issues raised in its submission.

3. Any community submission subsequently made to the Attorney General should be filed in both hard copy and on a diskette. It should be accompanied by a statement certifying that the submitting party has properly notified the hospital or HMO of its intent to submit its comments for publication on the Attorney General's web site, and summarizing the results of its offer to meet with the hospital or HMO.

4. Community submissions should be delivered to the Attorney General's Office within four months of the posting of the relevant hospital or HMO annual report on the Attorney General's web site.

5. At the request of the hospital or HMO, the Attorney General will post a single response to a public comment on its community benefits report or program. Any hospital or HMO response should refer directly to the issues raised in the community submission. Any further correspondence will be kept on file at the Attorney General's Office.

MAILING ADDRESS

All community benefits reports and submissions should be sent to:

Office of the Attorney General
200 Portland Street, 4th Floor
Boston, MA 02114
Attn: Community Benefits Administrator

ATTACHMENT 1

SUGGESTED OUTLINE OF FULL-TEXT ANNUAL REPORT

The full-text component of the community benefits annual report should provide detailed information about each of the topics set forth below. The focus of this narrative should be both retrospective (reporting on the past fiscal year) and prospective (identifying next steps for the current fiscal year and planning ahead for the years to come). The Attorney General suggests the following outline, but recognizes that individual hospitals and HMOs should determine the organization, format and length that best represent the unique qualities of their programs. In addition to the following outline, hospitals and HMOs should refer to the relevant Attorney General's Community Benefits Guidelines and to the definitions set forth in **Attachment 3** when preparing their narratives.

A hospital or HMO that has developed and maintained as a separate document a comprehensive Community Benefits Plan addressing the issues identified below has the option of attaching that Plan to its narrative report, and focusing the narrative more narrowly on a progress report for the reporting year and proposed next steps for subsequent years.

The Attorney General will post each hospital and HMO's full narrative report on the Community Benefits section of the Attorney General's Office web site as an Adobe Acrobat document. Because Adobe Acrobat documents containing significant graphic material are difficult for many web users to view, the Attorney General recommends that hospitals and HMOs either minimize the use of photographs, charts and other advanced graphics in their reports, or submit alternative "text-only" versions.

a. Mission Statement

A. Summary

B. Approval of governing body

II. Internal Oversight and Management of Community Benefits Program

A. Management structure (i.e., the role of senior management, is there a community benefits advisory group and where does it fit in the general policy-making structure of the institution?)

B. Method for sharing information about community benefits mission/programs with staff at all levels of the institution

III. Community Health Needs Assessment

A. Process, including participants

B. Information sources

C. Summary of findings

IV. Community Participation

A. Process and mechanism

B. Identification of community participants

C. Community role in development, implementation and review of community benefits plan and annual reports

V. Community Benefits Plan

A. Process of development of the Plan, including how the community was involved (if not previously described)

B. Choice of target population(s)/identification of priorities, including an explanation of how these relate to the results of the community health needs assessment

C. Short-term (one-year) and long-term (three to five years) strategies and goals

D. Process for measuring outcomes and evaluating effectiveness of programs

E. Process and considerations for determining a budget

F. Process for reviewing, evaluating and updating the Plan

VI. Progress Report: Activity During Reporting Year

A. Expenditures

- Should include "Expenditures" chart (see **Attachment 2**) in text or as appendix

- May include discussion of the financial environment/status of the hospital or HMO, including deficits and shortfalls

B. Major programs and initiatives

- Formatted either as a detailed narrative description or a table (such as an expanded version of the "Selected Community Benefits Program" table in **Attachment 2**)

- Should include information regarding expenditures/budget for each major program/initiative

C. HMOs: Efforts to reduce cultural, linguistic and physical barriers to health care, market products that attract all segments of the population, and to help consumers obtain or maintain affordable health coverage

D. Notable challenges, accomplishments and outcomes

VII. Next Reporting Year

A. Approved budget/projected expenditures

B. Anticipated goals and program initiatives

C. Projected outcomes

VIII. Contact Information

(Name, title, department, address, phone number, e-mail address)

ATTACHMENT 2
ANNUAL REPORT STANDARDIZED SUMMARY

[HOSPITAL/HMO]
[Health System]
[City/Town]
[Optional: include web address for a direct link to hospital/HMO site]
Region Served: [ ]

Report for Fiscal Year [200x]

COMMUNITY BENEFITS MISSION

[<50 word description of mission]

PROGRAM ORGANIZATION AND MANAGEMENT

[<100 word description of organizational, management structure of Community Benefits Program, identifying those responsible for developing and approving the Community Benefits Plan]

KEY COLLABORATIONS AND PARTNERSHIPS

[List of key community and institutional partners who played significant roles in developing the Community Benefits Plan or are involved in specific programs or initiatives]

COMMUNITY HEALTH NEEDS ASSESSMENT

[<100 word description of the needs assessment process used to develop the Community Benefits Plan, including the needs identified through that process]

COMMUNITY BENEFITS PLAN

[<100 word summary that includes: target population/priorities, process for measuring outcomes or evaluating the effectiveness of programs, long-term strategic plans]

KEY ACCOMPLISHMENTS OF REPORTING YEAR

[<100-word description of major accomplishments during reporting period, and how those accomplishments address previously-identified needs and further the Community Benefits Plan]

PLANS FOR NEXT REPORTING YEAR

[<100 word description or list of "next steps" or specific initiatives designed to further mission during next reporting period**]**

CONTACT

[Community Benefits Manager's name, title, department, address, phone number and e-mail address]

SELECTED COMMUNITY BENEFITS PROGRAMS

PROGRAM OR INITIATIVE	TARGET POPULATION/OBJECTIVE	PARTNER(S)	HOSPITAL/HMO CONTACT
[List up to five. Optional: to enable users to see a detailed program description by clicking on the program name, provide that description in a separate word processing or .pdf file]		[Name, address, phone number of community or institutional partners that have played key roles in program development or implementation; provide web address for direct link]	[Name, address, phone; provide e-mail address for direct link]

EXPENDITURES

TYPE	ESTIMATED TOTAL EXPENDITURES FOR [REPORTED FISCAL YEAR]	APPROVED PROGRAM BUDGET FOR [NEXT FISCAL YEAR]*
COMMUNITY BENEFITS PROGRAMS	**(1) Direct Expenses [$]** **(2) Associated Expenses [$]** **(3) Determination of Need Expenditures [$]** **(4) Employee Volunteerism [$]** **(5) Other Leveraged Resources [$]**	**[$]** ***Excluding expenditures that cannot be projected at the time of the report.**
COMMUNITY SERVICE PROGRAMS	**(1) Direct Expenses [$]** **(2) Associated Expenses [$]** **(3) Determination of Need Expenditures [$]** **(4) Employee Volunteerism [$]** **(5) Other Leveraged Resources [$]**	
NET CHARITY CARE or UNCOMPENSATED CARE POOL CONTRIBUTION	**[$ Insert figure supplied by DHCFP]**	
CORPORATE SPONSORSHIPS	**[$]**	
	TOTAL [$]	

[Hospitals]:
TOTAL PATIENT CARE-RELATED EXPENSES FOR [Reported Fiscal Year]: [$]

[HMOs]:
MASSACHUSETTS PLAN MEMBERS [#]
[FOR PROFIT/NOT-FOR-PROFIT]

ATTACHMENT 3

GLOSSARY

Community Benefits Guidelines: *The Attorney General's Community Benefits Guidelines for Nonprofit Acute-Care Hospitals* and *The Attorney General's Community Benefits Guidelines for Health Maintenance Organizations*.

Community Benefits Manager: A hospital or HMO employee directly responsible for the development and management of a *Community Benefits Program* or *Community Service Program.*

Community Benefits Plan: A formal plan to address the health needs of an identified community, developed in accordance with the principles of the *Community Benefits Guidelines*, with appropriate community participation, and approved by the hospital or HMO's governing board.

Community Benefits Program: A program, grant or initiative developed in collaboration with community representatives or based upon a *Community Health Needs Assessment* that serves the needs of a *Target Population* identified in the hospital or HMO's *Community Benefits Plan*.

Community Health Needs Assessment: A process through which a hospital or HMO, in partnership or consultation with representatives of its community, identifies community health needs using public health data, community surveys, focus groups and other community-initiated information and data gathering activities, and/or other relevant health status indicators and data.

Community Service Program: A program, grant or other initiative that advances the health care or social needs of Massachusetts communities, but is not related to the priorities or *Target Population* identified in the hospital or HMO's formal *Community Benefits Plan.*

Corporate Sponsorships: Cash or in-kind contributions that support the charitable activities of other organizations, and are *not* related to a *Community Benefits Plan.*

Expenditures:

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

(6) grants to third parties in furtherance of a community benefit or community service objective.

Associated Expenses: May include (1) depreciation or amortization related to the use of major movable equipment purchased or leased directly for the *Community Benefits* or *Community Service Program*, and (2) a share of any fixed depreciation on a building or space therein used solely or in major part for a community benefit or service.

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

Employee Volunteerism: An employee's voluntary activities in connection with a hospital or HMO *Community Benefits Program* or *Community Service Program* that take place during *unpaid* time as the result of a formal hospital or HMO initiative to organize or promote voluntary participation in the particular activity among its employees. The value of free or reduced-fee *direct health care or public health services* volunteered by *health care providers* employed by the hospital or HMO should be calculated using either (a) the rate of the employee's pay, or (b) the average hourly rate for Massachusetts health care workers as calculated by the Centers for Medicare and Medicaid Services for purpose of the Medicare Area Wage Index during the reported fiscal year ($25.00 in 2001). The value of *non-health care services* volunteered by *any employee* should be calculated using the standard hourly rate set by the Independent Sector, a Washington, D.C.-based coalition of voluntary organizations, foundations and corporate giving programs, during the reported fiscal year ($15.39 in 2001).

Other Leveraged Resources: Funds and services contributed by third parties for the express purpose of supporting a hospital or HMO's *Community Benefits* or *Community Service 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* or *Community Service Program;* and (3) monies 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* and *Community Service 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.

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.

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

Net Charity Care/Uncompensated Care Pool Contribution: As defined under Section 1 of Chapter 118G of the Massachusetts General Laws, the amount of "free care" provided by a hospital as determined by its annual assessment plus any shortfall allocation in connection with administering the Uncompensated Care Pool Trust Fund, or an HMO's annual contribution to the Uncompensated Care Pool, as listed by the Massachusetts Division of Health Care Finance and Policy in its most current settlement for the reported fiscal year. *Net Charity Care* does not include hospital bad debt related to patients not eligible for free care, "shortfalls" related to Medicaid, Medicare or other health plan reimbursements that do not cover the full costs of a hospital's services or "shortfalls" related to an HMO's coverage of *Plan Members* enrolled through a Medicaid or Medicare program.

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.

Target Population: The specific community or communities that are the focus of the hospital or HMO's *Community Benefits Plan*. A target population can be defined (1) geographically (e.g., low or moderate income residents of a municipality, county or other defined region); (2) demographically (e.g., the uninsured, children or elders, an immigrant group); (3) by health status (e.g., persons with HIV, victims of domestic violence, pregnant teens) or (4) by an issue consistent with the *Community Benefits Guidelines* (e.g., community building, reducing disparities in access to quality health care).

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

Attachment 4

DIRECTIONS FOR SUBMITTING ELECTRONIC FILES

To facilitate the posting of the annual reports on the Attorney General's web site, and to comply with the Americans with Disabilities Act, and other accessibility requirements, please observe the following guidelines when formatting and naming the electronic files on the diskette that you submit with your annual report.

- The **Full Report** should be submitted as a text-only file (Microsoft Word or another commonly-available word-processing program). You also are free to submit an Adobe Acrobat version of the full report that will allow most users to see the report as it actually appears in hard copy.
- The **Standardized Summary** form (Attachment 2) was created with Microsoft Word and should be submitted in that format.
- The optional **Program Descriptions** (detailed descriptions of programs identified on the "Selected Community Benefits Programs"chart in the Standardized Summary) should be submitted as individual text-only files; Adobe Acrobat files are acceptable if they are accompanied by a text-only version.

Please assign the following names to the electronic files. This will allow our webmaster to identify and keep track of the reports and ensure accuracy. The public will not see these file codes, so please do not be concerned about our abbreviations.

Finally, remember to label the diskette itself with the name of your hospital/HMO and the fiscal year of the report.

HOSPITAL	Full Report (Text-Only)	Full Report (Adobe Acrobat)	Standardized Summary	Program Descriptions
Anna Jaques Hospital	AJHospText.doc	AJHospFull.pdf	AJHospSumm.doc	AJHospProg1.doc/pdf, AJHospProg2.doc/pdf, etc.
Athol Memorial Hospital	AtholText.doc	AtholFull.pdf	AtholSumm.doc	AtholProg1.doc/pdf
Baystate Medical Center	BaystateText.doc	BaystateFull.pdf	BaystateSumm.doc	BaystateProg1.doc/pdf
Berkshire Medical Center	BerkshireText.doc	BerkshireFull.pdf	BerkshireSumm.doc	BerkshireProg1.doc/pdf
Beth Israel Deaconess Medical Center	BIDeaconText.doc	BIDeaconFull.pdf	BIDeaconSumm.doc	BIDeaconProg1.doc/pdf

HOSPITAL	Full Report (Text-Only)	Full Report (Adobe Acrobat)	Standardized Summary	Program Descriptions
Beverly Hospital	BeverlyText.doc	BeverlyFull.pdf	BeverlySumm.doc	BeverlyProg1.doc/pdf
Boston Medical Center	BMCtext.doc	BMCfull.pdf	BMCsumm.doc	BMCprog1.doc/pdf
Brigham and Women's Hospital	B&Wtext.doc	B&Wfull.pdf	B&Wsumm.doc	B&Wprog1.doc/pdf,
Brockton Hospital	BrocktonText.doc	BrocktonFull.pdf	BrocktonSumm.doc	BrocktonProg1.doc/pdf
Cambridge Health Alliance	CHAtext.doc	CHAfull.pdf	CHAsumm.doc	CHAprog1.doc/pdf
Cape Cod Hospital	CapeText.doc	CapeFull.pdf	CapeSumm.doc	CapeProg1.doc/pdf
Caritas Good Samaritan Medical Center	GoodSamText.doc	GoodSamFull.pdf	GoodSamSumm.doc	GoodSamProg1.doc/pdf
Caritas Norwood Hospital	NorwoodText.doc	NorwoodFull.pdf	NorwoodSumm.doc	NorwoodProg1.doc/pdf
Carney Hospital	CarneyText.doc	CarneyFull.pdf	CarneySumm.doc	CarneyProg1.doc/pdf
Children's Hospital	ChildrensText.doc	ChildrensFull.pdf	ChildrensSumm.doc	ChildrensProg1.doc/pdf
Cooley Dickinson Hospital, Inc.	CooleyText.doc	CooleyFull.pdf	CooleySumm.doc	CooleyProg1.doc/pdf
Dana-Farber Cancer Institute	DanaFarbText.doc	DanaFarbFull.pdf	DanaFarbSumm.doc	DanaFarbProg1.doc/pdf
Deaconess-Glover Hospital Corporation	DGloverText.doc	DGloverfull.pdf	DGloverSumm.doc	DGloverProg1.doc/pdf
Deaconess-Nashoba Hospital	DNashobaText.doc	DNashobaFull.pdf	DNashobaSumm.doc	DNashobaProg1.doc/pdf
Emerson Hospital	EmersonText.doc	EmersonFull.pdf	EmersonSumm.doc	EmersonProg1.doc/pdf

HOSPITAL	Full Report (Text-Only)	Full Report (Adobe Acrobat)	Standardized Summary	Program Descriptions
Fairview Hospital	FairviewText.doc	FairviewFull.pdf	FairviewSumm.doc	FairviewProg1.doc/pdf
Faulkner Hospital	FaulknerText.doc	FaulknerFull.pdf	FaulknerSumm.doc	FaulknerProg1.doc/pdf
Franklin Medical Center	FranklinText.doc	FranklinFull.pdf	FranklinSumm.doc	FranklinProg1.doc/pdf
Hallmark Health Corporation	HallmarkText.doc	HallmarkFull.pdf	HallmarkSumm.doc	HallmarkProg1.doc/pdf,
Harrington Memorial Hospital	HarringtonText.doc	HarringtonFull.pdf	HarrringtonSumm.doc	HarringtonProg1.doc/pdf
HealthAlliance Hospitals, Inc.	HlthAllText.doc	HlthAllFull.pdf	HlthAllSumm.doc	HlthAllProg1.doc/pdf
Heywood Hospital	HeywoodText.doc	HeywoodFull.pdf	HeywoodSumm.doc	HeywoodProg1.doc/pdf
Holy Family Hospital and Medical Center	HolyFamText.doc	HolyFamFull.pdf	HolyFamSumm.doc	HolyFamProg1.doc/pdf
Holyoke Hospital, Inc.	HolyokeText.doc	HolyokeFull.pdf	HolyokeSumm.doc	HolyokeProg1.doc.pdf
Hubbard Regional Hospital	HubbardText.doc	HubbardFull.pdf	HubbardSumm.doc	HubbardProg1.doc/pdf
Jordan Hospital, Inc.	JordonText.doc	JordonFull.pdf	JordonSumm.doc	JordonProg1.doc/pdf
Lahey Clinic Hospital, Inc.	LaheyText.doc	LaheyFull.pdf	LaheySumm.doc	LaheyProg1.doc/pdf
Lawrence General Hospital	LawrGHtext.doc	LawrGHfull.pdf	LawrGHsumm.doc	LawrGHprog1.doc/pdf
Lowell General Hospital	LowellText.doc	LowellFull.pdf	LowellSumm.doc	LowellProg1.doc/pdf
Marlborough Hospital	MarlborText.doc	MarlborFull.pdf	MarlborSumm.doc	MarlborProg1.doc/pdf

HOSPITAL	Full Report (Text-Only)	Full Report (Adobe Acrobat)	Standardized Summary	Program Descriptions
Martha's Vineyard Hospital	MVHospText.doc	MVHospFull.pdf	MVHospSumm.doc	MVHospProg1.doc/pdf
Mary Lane Hospital	MaryLaneText.doc	MaryLaneFull.pdf	MaryLaneSumm.doc	MaryLaneProg1.doc/pdf
Massachusetts Eye & Ear Infirmary	ME&EItext.doc	ME&EIfull.pdf	ME&EIsumm.doc	ME&Eprog1.doc/pdf
Massachusetts General Hospital	MGHtext.doc	MGHfull.pdf	MGHsumm.doc	MGHprog1.doc/pdf,
Mercy Medical Center	MercyText.doc	MercyFull.pdf	MercySumm.doc	MercyProg1.doc/pdf
Merrimack Valley Hospital	MerrimackText.doc	MerrimackFull.pdf	MerrimackSumm.doc	MerrimackProg1.doc/pdf
MetroWest Medical Center	MetroWestText.doc	MetroWestFull.pdf	MetroWestSumm.doc	MetroWestProg1.doc/pdf
Milford-Whitinsville Regional Hospital	MWRHtext.doc	MWRHfull.pdf	MWRHsumm.doc	MWRHprog1.doc/pdf
Milton Hospital	MiltonText.doc	MiltonFull.pdf	MiltonSumm.doc	MiltonProg1.doc/pdf
Morton Hospital and Medical Center, Inc.	MortonText.doc	MortonFull.pdf	MortonSumm.doc	MortonProg1.doc/pdf
Mount Auburn Hospital	MtAuburnText.doc	MtAuburnFull.pdf	MtAuburnSumm.doc	MtAuburnProg1.doc/pdf

HOSPITAL	Full Report (Text-Only)	Full Report (Adobe Acrobat)	Standardized Summary	Program Descriptions
Nantucket Cottage Hospital	NantucketText.doc	NantucketFull.pdf	NantucketSumm.doc	NantucketProg1.doc/pdf
New England Baptist Hospital	NEBaptistText.doc	NEBaptistFull.pdf	NEBaptistSumm.doc	NEBaptistProg1.doc/pdf
New England Medical Center	NEMC text.doc	NEMCfull.pdf	NEMC summ.doc	NEMCprog1.doc/pdf
Newton-Wellesley Hospital	NewWellText.doc	NewWellFull.pdf	NewWellSumm.doc	NewWellProg1.doc/pdf
Noble Hospital	NobleText.doc	NobleFull.pdf	NobleSumm.doc	NobleProg1.doc/pdf
North Adams Regional Hospital	NAdamsText.doc	NAdamsFull.pdf	NAdamsSumm.doc	NAdamsProg1.doc/pdf
Quincy Medical Center	QuincyText.doc	QuincyFull.pdf	QuincySumm.doc	QuincyProg1.doc/pdf
Saint Anne's Hospital Corporation	StAnneText.doc	StAnneFull.pdf	StAnneSumm.doc	StAnneProg1.doc/pdf,
Saint Vincent Hospital At Worcester Medical Center	StVincentText.doc	StVincentFull.pdf	StVincentSumm.doc	StVincentProg1.doc/pdf
Saints Memorial Medical Center Inc.	StsMemText.doc	StsMemFull.pdf	StsMemSumm.doc	StsMemProg1.doc/pdf
South Shore Hospital	SShoreText.doc	SShoreFull.pdf	SShoreSumm.doc	SShoreProg1.doc/pdf
Southcoast Hospitals Group	SCoastText.doc	SCoastFull.pdf	SCoastSumm.doc	SCoastProg1.doc/pdf
St. Elizabeth's Medical Center of Boston	StElizText.doc	StElizFull.pdf	StElizSumm.doc	StElizProg1.doc/pdf

HOSPITAL	Full Report (Text-Only)	Full Report (Adobe Acrobat)	Standardized Summary	Program Descriptions
Sturdy Memorial Hospital	SturdyText.doc	SturdyFull.pdf	SturdySumm.doc	SturdyProg1.doc/pdf
The Salem Hospital	SalemText.doc	SalemFull.pdf	SalemSumm.doc	SalemProg1.doc/pdf
UMass Memorial - Clinton Hospital	UMassClinText.doc	UMassClinFull.pdf	UMassClinSumm.doc	UMassClinProg1.doc/pdf
UMass Memorial Medical Center	UMassMemText.doc	UMassMemFull.pdf	UMassMemSumm.doc	UMassMemProg1.doc/pdf
Union Hospital	UnionText.doc	UnionFull.pdf	UnionSumm.doc	UnionProg1.doc/pdf
Winchester Hospital	WinchstrText.doc	WinchstrFull.pdf	WinchstrSumm.doc	WinchstrProg1.doc/pdf
Wing Memorial Hospital & Medical Centers	WingText.doc	WingFull.pdf	WingSumm.doc	WingProg1.doc/pdf

HMO	Full Report (Text-Only)	Full Report (Adobe Acrobat)	Standardized Summary	Program Descriptions
Aetna U.S. Healthcare	AetnaText.doc	AetnaFull.pdf	AetnaSumm.doc	AetnaProg1.doc/pdf, AetnaProg2.doc/pdf, etc.
BlueCross BlueShield of Massachusetts	BCBStext.doc	BCBSfull.pdf	BCBSsumm.doc	BCBSProg1.doc/pdf
Cigna HealthCare of Massachusetts	CignaText.doc	CignaFull.pdf	CignaSumm.doc	CignaProg1.doc/pdf
Connecticare of Massachusetts	ConnCareText.doc	ConnCareFull.pdf	ConnCareSumm.doc	ConnCareProg1.doc/pdf
Fallon Community Health Plan	FallonText.doc	FallonFull.pdf	FallonSumm.doc	FallonProg1.doc/pdf
Harvard Pilgrim Health Care	HPHCtext.doc	HPHCfull.pdf	HPHC Summ.doc	HPHCprog1.doc/pdf
Health New England	HealthNEtext.doc	HealthNEfull.pdf	HealthNESumm.doc	HealthNEprog1.doc/pdf
Neighborhood Health Plan	NHPtext.doc	NHPfull.pdf	NHPsumm.doc	NHPprog1.doc/pdf
One Health Plan of Massachusetts	OneHealthText.pdf	OneHealthFull.pdf	OneHealthSumm.doc	OneHealthProg1.doc/pdf
Tufts Health Plan	TuftsText.doc	TuftsFull.pdf	TuftsSumm.doc	TuftsProg1.doc/pdf
United Health Care of New England	UnitedText.doc	UnitedFull.pdf	UnitedSumm.doc	UnitedProg1.doc/pdf