

The Attorney General's

Community Benefits Guidelines for Health Maintenance Organizations



COMMONWEALTH OF MASSACHUSETTS
OFFICE OF ATTORNEY GENERAL
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**THE ATTORNEY GENERAL'S COMMUNITY BENEFITS
GUIDELINES FOR HEALTH MAINTENANCE ORGANIZATIONS**

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THE ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR HEALTH MAINTENANCE ORGANIZATIONS

I. INTRODUCTION

A. Background and History

The Attorney General's Community Benefits Guidelines for Health Maintenance Organizations set forth voluntary principles encouraging all Massachusetts HMOs to continue to build upon their commitment to address health and social needs in communities throughout the Commonwealth. The Guidelines represent a unique non-regulatory approach that calls upon HMOs to identify and respond to unmet community needs by formalizing their approach to community benefits planning, collaborating with community representatives to identify and create programs that address those needs, and issuing annual reports on their efforts. The Guidelines do not dictate the types of community benefits programs that HMOs should provide; rather, they suggest that HMOs 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 HMO Community Benefits Guidelines are the product of an extensive process of consultation and partnership between the Attorney General and representatives of the HMO industry, particularly the Massachusetts Association of Health Plans (formerly the Massachusetts Association of HMOs), as well as community advocacy groups. These discussions took place following the issuance of the *Attorney General's Community Benefits Guidelines for Non-Profit Acute Care Hospitals* in June 1994, prompted by a recognition of the increased role that HMOs were playing in the health care system. HMOs, irrespective of their model type or organizational status, have acknowledged their responsibility to do all that they can to improve and maintain the health status of members of the communities they serve. The resulting HMO Community Benefits Guidelines, originally published by the Attorney General's Office in February 1996, are similar to the hospital Guidelines and were the first of their kind to be issued by an Attorney General. 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:

- Top-down support within the hospital or HMO for the principles of the Community Benefits Guidelines;
- 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
- 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 in advocating for lower rates for non-group and Medigap policies. Along with the Insurance Division, the Consumer Protection and Antitrust Division prosecutes unfair trade practices in the health care marketplace. The Consumer Protection and Antitrust Division also 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 plays an important role in hospital and HMO for-profit conversions ensuring the protection of charitable assets. Finally, the Medicaid Fraud Control Unit prosecutes those who commit Medicaid fraud.

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 Massachusetts General Laws, Chapter 176G, Section 1. The Guidelines were developed in consultation with providers, community groups, and HMOs to serve as a set of formal principles to support the development of community benefits plans by HMOs operating in the Commonwealth. These Guidelines may be used by HMOs to help focus their role in helping

to meet the growing and pressing health care needs of underserved or underinsured populations. The Attorney General recognizes the existing community benefits programs sponsored by many HMOs and hopes that these principles inspire even greater efforts.

II. HMO COMMUNITY BENEFITS PRINCIPLES

HMOs are encouraged to develop community benefits intended to promote preventive care and to improve the health status and quality of life for working families and populations at risk, whether or not those individuals are currently HMO members. The Attorney General expects that the public health focus of the following principles will support HMOs in serving the needs of the communities within their geographic service areas and particularly the needs of the medically underserved:

- A. The governing body of each HMO should adopt and make public a Community Benefits Policy Statement setting forth its commitment to a formal Community Benefits Program.**
- B. The governing body and senior management of the HMO should be responsible for overseeing the development and implementation of the Community Benefits Program, the resources to be allocated, and the administrative mechanisms for the regular evaluation of the Program.**
- C. The governing body and senior management of the HMO should seek assistance and participation from HMO members and the community in developing and implementing the HMO's Community Benefits Program, and in defining the targeted population and the specific health care needs to be addressed by the Community Benefits Program.**
- D. Each HMO should develop its Community Benefits Program based upon an assessment of the health care needs and resources of the identified populations, particularly lower- and moderate-income communities. The Program should consider the health care needs of a broad spectrum of age groups and health conditions.**
- E. The HMO should develop and market products which would attract all segments of the population.**
- F. The HMO should strive to offer and promote, consistent with existing laws and regulations, direct enrollment for non-group coverage and continue to work toward insurance market reform so that managed care will be an option for all working families and individuals.**

- G. The HMO should take steps to reduce cultural, linguistic, and physical barriers to accessible health care at key points of patient contact.**
- H. The HMO should strive to help Massachusetts consumers who are about to lose coverage or who are uninsured, to maintain or obtain, as applicable, health care coverage, at least for limited periods of time, at reduced or subsidized rates.**
- I. The HMO should make an Annual Community Benefits Report available to the public. The Report should describe the HMO's community benefits plan, including the HMO's level of community benefits expenditures and its approach to establishing those expenditures.**

III. THE GUIDELINES

- A. The governing body of each HMO should adopt and make public a Community Benefits Policy Statement setting forth its commitment to a formal Community Benefits Program.**

Each HMO should establish a process to develop and update the Community Benefits Policy Statement approved by its governing body. This Policy Statement should address the HMO's commitment to developing, adopting, and implementing a Community Benefits Program intended to facilitate, encourage, or provide for the delivery of health care services and educational and preventive programs and services to underserved populations in the HMO's service area.

The Policy Statement should recognize the value of productive collaboration with the communities within the HMO's geographic service area. The Policy Statement should publicly acknowledge the HMO's commitment to its community. The Policy Statement for each HMO 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.

- B. The governing body and senior management of the HMO should be responsible for overseeing the development and implementation of the Community Benefits Program, the resources to be allocated, and the administrative mechanisms for the regular evaluation of the Program.**

The governing body and senior management of the HMO should be responsible for ensuring that the goals and intent of the Community Benefits Policy Statement are carried out by the HMO. The values embodied in this Statement should be reflected in the HMO Community Benefits Program. The HMO should ensure that the goals and objectives of the Policy Statement

are shared with individuals at every level of the organization so that these goals are reinforced and widely accepted.

Although the governing body and senior management of the HMO should ultimately be responsible for developing and adopting the Policy Statement and ensuring the resource allocation necessary to support the Policy Statement and Community Benefits Program, all employees should be encouraged to take responsibility for the Program's implementation. The HMO should periodically evaluate its Policy Statement and the Community Benefits Program to be sure they complement the HMO's strategic vision and accurately reflect the HMO's community benefits objectives and the managed care focus on preventive care and health promotion.

- C. The governing body and senior management of the HMO should seek assistance and participation from HMO members and the community in developing and implementing the HMO's Community Benefits Program, and in defining the targeted population and the specific health care needs to be addressed by the Community Benefits Program.**

The HMO should actively seek and encourage collaboration, information, and input from the community and representative organizations. This input or participation should be drawn from various populations and groups within the HMO's geographic service area. The HMO should institute effective community outreach to contact populations which may have been historically under-represented within its member population. The HMO may explore different aspects of "community," as a community may be defined in many ways: territorially, geographically, demographically, or epidemiologically.

- D. Each HMO should develop its Community Benefits Program based upon an assessment of the health care needs and resources of the identified populations, particularly lower- and moderate-income communities. The Program should consider the health care needs of a broad spectrum of age groups and health conditions.**

The HMO should develop its Community Benefits Program in consultation with the communities it serves. In general, the Program should include goals, needs assessment, implementation time frames, and budget preparation. The HMO may wish to assess community needs and resources in collaboration with area service provider organizations, such as hospitals, other HMOs, community health centers, and social service agencies, taking into account health status data already available. If an HMO is part of an integrated health care system, the system may develop a coordinated Community Benefits Program.

Finally, the HMO should establish a set of priorities of community health care needs and

resources. In assessing community needs, the HMO should consider public health data and other health status indicators and consult with representatives of the designated community to identify perceived needs. Using existing data and information will avoid wasteful duplication in assessing community needs. Much information is already collected by hospitals, other HMOs, various public and private entities, and local public health departments, as well as the Department of Public Health, the Department of Mental Health, the Rate Setting Commission, and the Division of Medical Assistance.

Attention should be given to the needs of underserved or at-risk populations, including but not limited to: the working poor; poor children; victims of domestic violence; low-to moderate income elderly; racial, linguistic, and ethnic minorities; and people with physical and cognitive difficulties.

The long-term measure of the success of an HMO's Community Benefits Program will be improvement in the health status, quality of life and outcomes of the HMO's target population.

E. The HMO should develop and market products which would attract all segments of the population.

The HMO's Community Benefits Program should allow the HMO to develop product-market strategies which would result in market expansion or diversification in the delivery and financing of health care. The HMO may decide to expand its market by delivering its present products to new populations within its targeted community. Alternatively, the HMO may decide to develop new products to focus on the designated community. In the course of its creating marketing and advertising strategies to implement new or diversified product development strategies, the HMO should avoid marketing and advertising practices which might discourage certain market segments from selecting the HMO as their health plan.

F. The HMO should strive to offer and promote, consistent with existing laws and regulations, direct enrollment for non-group coverage and continue to work toward insurance market reform so that managed care will be an option for all working families and individuals.

The HMO should offer, within applicable laws and regulations, direct enrollment for health care coverage for individuals and families who are not part of any group plan. In addition to providing direct non-group enrollment to the extent currently possible, the HMO should undertake or continue to assert leadership to bring about reform of the health insurance marketplace. HMOs are encouraged to support a fiscally responsible approach to universal coverage, including development of a guaranteed-issue non-group product with no medical underwriting which provides portability of coverage. Such legislation would result in a significant benefit to all citizens of the Commonwealth including communities identified by the

HMO in its Community Benefits Program.

G. 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 are encouraged to commit to increasing the number of bilingual providers. To the extent possible, within their model types, HMOs should make multilingual staff available and provide qualified professional interpreters at service delivery points and in member services. Member brochures and plan benefits summaries should be printed in languages relevant to significant numbers of consumers in the HMO's service area so as to ensure that disclosure about significant information is appropriately communicated to diverse markets. All HMOs should strive to make telecommunications devices (TTY/TDD) available so that hearing impaired persons can have access to services.

H. The HMO should strive to help Massachusetts consumers who are about to lose coverage or who are uninsured, to maintain or obtain, as applicable, health care coverage, at least for limited periods of time, at reduced or subsidized rates.

A major goal of the HMO's Community Benefits Program should be the HMO's commitment to providing preventive care or subsidized coverage to those who are uninsured and unable to pay for health care services. An HMO may choose to offer its existing products to the designated community or offer newly developed products. For example, the provision of flu shots to the medically underserved community in anticipation of the flu season would be the provision of a new service which would benefit the community at large by enhancing health status and ultimately reducing health care costs.

The HMO could make a premium subsidy program available to its members. Subsidies could be provided to group members who become eligible for COBRA coverage with the group through which they were members and whose annual household income is less than a certain percentage of the federal poverty level and who are not eligible for Medicare or Medicaid. In this way, the HMO would be helping its own enrollees to maintain health care coverage for some limited period of time at reduced rates. The HMO could also make this program available to some segment of non-members.

- I. The HMO should make an Annual Community Benefits Report available to the public. The Report should describe the HMO's community benefits plan, including the HMO's level of community benefits expenditures and its approach to establishing those expenditures.**

Each year, the HMO should file with the Attorney General's Office a report on its Community Benefits Plan. In preparing and submitting its annual report, the HMO should follow the process and format set forth in the Appendix to these Guidelines.

Community response to the HMO Community Benefits Program and Reports is encouraged. HMOs are encouraged to solicit and make publicly available comments generated in response to the HMO Community Benefits Program.

IV. CONCLUSION

These Guidelines embody the recommendations of the Attorney General to assist HMOs in the development of community benefits programs to help meet the health and social needs of the communities they serve. Ongoing changes and economic pressures in the health care marketplace will constantly challenge Massachusetts HMOs and their communities to work together to ensure that the needs of vulnerable and at-risk populations are not neglected. The Attorney General expects the process outlined in these Guidelines to undergo continued evolution and refinement. Constructive suggestions from all sources are welcome.

APPENDIX

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.

I. COMPONENTS

Each community benefits annual report consists of two parts:

(A) 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.

(B) 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.

I. 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

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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&W prog1.doc/pdf,
Brockton Hospital	BrocktonText.doc	BrocktonFull.pdf	BrocktonSumm.doc	BrocktonProg1.doc/pdf
Cambridge Health Alliance	CHAtext.doc	CHAfull.pdf	CHAsumm.doc	CHAprg1.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
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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	HarringtonSumm.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
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Massachusetts Eye & Ear Infirmary	ME&EItxt.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
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New England Medical Center	NEMCtext.doc	NEMCfull.pdf	NEMCsumm.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
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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
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BlueCross BlueShield of Massachusetts	BCBStext.doc	BCBSfull.pdf	BCBSsum m.doc	BCBSProg1.doc/pdf
Cigna HealthCare of Massachusetts	CignaText.doc	CignaFull.pdf	CignaSumm.doc	CignaProg1.doc/pdf
Connecticare of Massachusetts	ConnCareText.doc	ConnCareFull.pdf	ConnCareSum m.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	HealthNESum m.doc	HealthNEprog1.doc/pdf
Neighborhood Health Plan	NHPtext.doc	NHPfull.pdf	NHPsum m.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