The Role of the Attorney General in Community Benefits Reform:
The Success of Voluntary Reporting for Nonprofit Hospitals in Massachusetts

Introduction

Many of America’s hospitals have long enjoyed tax-exempt status as charitable, nonprofit organizations. In theory, the activities of a charitable organization – such as a nonprofit hospital -- benefit the community, offsetting the loss of public revenue represented by the tax exemption. However, over the last 15 years, consumer advocates and policy makers have begun to question whether nominally nonprofit hospitals provide sufficient benefits to their communities -- “community benefits” -- to justify their exemptions. Rising healthcare costs, economic and racial disparities in healthcare outcomes, and the large number of Americans without health insurance lend urgency to the issue:

There has been little federal response to growing concern about the behavior of nonprofit hospitals. Instead, a small number of states and municipalities have developed, with varying degrees of success, their own strategies for encouraging or forcing nonprofit hospitals to meet new standards for community benefits. This paper addresses the role of the attorney general in initiating community benefits reform at the state level, focusing on the innovative regulatory approach developed by the Massachusetts Attorney General in the mid-1990s. Although the community benefits debate has included some discussion of whether and how community benefit requirements should be applied to health maintenance organizations (HMOs), and the Massachusetts program does, in fact, include a separate set of guidelines for HMOs, this paper focuses on community benefit reform as applied to nonprofit hospitals.

Section One of this paper describes the background of community benefits reform, and discusses the origin and definitions of the term “community benefit.” Section Two discusses some of the various reform efforts initiated by different government and
private actors, including the strategies pursued by different attorneys general. Section Three describes the Massachusetts Attorney General’s community benefits initiative in greater detail. Finally, Section Four analyzes the successes and failures of the Massachusetts program, and discusses its viability as a template for other state attorneys general to use in initiating reform.

**Section One: The Movement for Community Benefits Reform**

In the past 15 years, concerns about the accessibility and affordability of health care, as well as the perception that nonprofit hospitals behave no differently than their for-profit counterparts, have given rise to the movement for community benefits reform. The term “community benefit” originated as part of the legal standard for federal tax exemption for nonprofit hospitals. However, the term has since taken on a broader meaning, and is widely used to describe hospital behavior outside of the narrow context of tax law. Different agencies and organizations have defined community benefits differently, and proposed or implemented community benefits standards take varying approaches to measuring nonprofit hospitals’ behavior.

**A: The Argument for Community Benefits Reform**

Most American hospitals are nonprofit organizations, exempted from paying federal, state, and local taxes. Historically, the unambiguously charitable nature of these hospitals provided ample justification for tax exemption. America’s early nonprofit hospitals, formed in the 19th and early 20th centuries, provided medical care exclusively to the poor. Many were affiliated with religious orders, and the doctors and nurses who

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2 Hanson, Jack, *Are We Getting Our Money’s Worth? Charity Care, Community Benefits, and Tax Exemption at Nonprofit Hospitals*, 17 Loy. Consumer L. Rev. 395, 396 (2005) (stating that approximately 85 percent of private American hospitals are nonprofit); Walker, David M., Comptroller General for the U.S. Gov’t Accountability Office, Congressional Testimony Before the House Committee on Ways and Means, May 26, 2005 (stating that 62% of all American nonfederal acute-care hospitals are nonprofit).
3 Noble, Alice A., Andrew L. Hyams, & Nancy M. Kane, *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J.L. Med. & Ethics 116, 116 (1998); Hanson, supra note 1, at 396.
4 *Id.*
staffed them often worked on a volunteer basis.\textsuperscript{5} They were financed with public funds and private donations.\textsuperscript{6} However, changes in health care industry and hospital behavior have sparked concerns that nonprofit hospitals are no longer fulfilling their charitable missions.

Over the last 20 years, the growth of the for-profit health care industry, along with increasing pressure from public and private payers to reduce patient-care costs, have forced nonprofit hospitals to place a heavy emphasis on financial security and competitiveness.\textsuperscript{7} This new focus on financial competitiveness has come at the expense of community benefit expenditures, including charity care, or free or reduced-cost health care services for the uninsured poor.\textsuperscript{8} As nonprofit hospitals engage in price competition -- with each other and with for-profits -- to win the business of insured patients, available financing for non-profitable services decreases.\textsuperscript{9} In 2005, the Government Accountability Office found that private nonprofit hospitals devote only a slightly higher percentage of their patient operating expenses to uncompensated care than do for-profit hospitals, while public hospitals devote a much greater share of their resources to uncompensated care.\textsuperscript{10}

Nonprofit hospitals also began to emulate their for-profit counterparts in a variety of other ways. For example, starting in the 1980s, compensation for executives at nonprofit hospitals skyrocketed.\textsuperscript{11} While hospital executive pay increases had little actual effect on consumer healthcare costs or community benefit expenditures, they drew public attention and criticism. Also, many nonprofit hospitals have begun operating subsidiary for-profit healthcare businesses, which provide financial benefits for their tax-exempt parent entities.\textsuperscript{12}

\begin{thebibliography}{9}
\bibitem{5} Noble et al., \textit{supra} note 3, at 116.
\bibitem{6} \textit{Id}.
\bibitem{8} Noble, \textit{supra} note 3, at 117.
\bibitem{9} Madden et al., \textit{supra} note 7, at 6.
\bibitem{11} Barringer, Felicity, \textit{Hospital Executives’ Pay Rose Sharply in Decade}, N.Y. Times, Sept, 30, 1992, at A14; Rowland, Christopher, \textit{Partners CEO Got $1.9m Last Year; Compensation for Other Hospital Chiefs Closing in on $1m}, The Boston Glove, August 16, 2005.
\bibitem{12} Noble et al., \textit{supra} note 3, at 117
\end{thebibliography}
Furthermore, nonprofit hospitals’ billing practices suggest a lack of commitment to providing affordable care to the uninsured and the poor. Third party payers -- private insurance companies and public programs like Medicaid – use their size to negotiate significant discounts from the ‘sticker’ prices of health care services. As a result, uninsured patients – those who are least able to pay -- are frequently charged the highest rates of all, by for-profit and nonprofit hospitals alike. A series of class-action lawsuits against nonprofit hospitals further allege that hospitals use overly aggressive debt-collection tactics to recover the inflated fees from uninsured patients, suing those who cannot pay their bills. These practices are particularly alarming in light of the fact that close to 45 million Americans – approximately 15% of the population – lack health insurance.

In other words, nonprofit hospitals, while still enjoying tax exemption, have begun to look and act like for-profit hospitals. Under the pressure of market competition, they have shifted resources away from traditional charitable services such as reduced-cost care for the uninsured poor. The goal of community benefits reform is to reverse this trend by encouraging or forcing nonprofit hospitals to meet specific standards for providing benefits to their communities.

B: Tax Law and the Community Benefits Standard

The Internal Revenue Service (IRS) already requires that nonprofit hospitals, in order to maintain their federal tax-exempt status under 26 U.S.C. § 501(c)(3), meet a community benefit standard. However, the IRS standard is, at least in practice, considerably looser than the community benefits standards that have been proposed and implemented as part of state-level reform attempts.

The IRS community benefit standard is the product of a 1969 decision, Revenue Ruling 69-545, that relaxed standards of charitable behavior for nonprofit hospitals.
Prior to the 1969 ruling, a nonprofit hospital was required to be “operated to the extent of its financial ability for those not able to pay for the services rendered”\textsuperscript{18} – in other words, to provide charity care. In contrast, the IRS community benefits standard articulated in Ruling 69-545 contains only a very limited charity care requirement: that hospitals operate emergency rooms that provide charity care in medical emergencies.\textsuperscript{19} Under this broad standard, “promotion of health” is, in and of itself, a community benefit.\textsuperscript{20} While later IRS opinions have stressed the importance of charity care as a core component of community benefits, charity care is no longer the determining factor of federal tax exemption.\textsuperscript{21}

Because the IRS community benefit standard is so broad and easily met, and because the IRS has not made enforcement of its community benefits standard a priority,\textsuperscript{22} federal tax exemption of nonprofit hospitals has never seriously been threatened. Thus, despite the fact that the term “community benefits” has its roots in an IRS ruling, the debate over community benefits is not primarily a debate over whether hospitals are meeting their community benefit obligations under federal tax law. While some lawsuits brought against nonprofit hospitals allege violations of federal tax-exemption standards, most comprehensive efforts to effect community benefits reform have primarily been focused on creating new community benefit standards – and holding hospitals accountable to them – at the state and local level.

C: Defining Community Benefits

Different agencies and organizations have come up with widely varying formulations of what constitutes a community benefit. Charity care – medical care offered to uninsured, poor patients with no expectation that the patient will provide compensation -- is a core community benefit under nearly any definition of the term.


\textsuperscript{19} Noble et al., supra note 3, at 18; see Rev. Rule. 69-545, 1969-2 C.B. 117. This limited charity care requirement was further watered down by Revenue Ruling 83-157, 1983-2 C.B. 94, which held that a hospital need not have an emergency room at all in order to maintain nonprofit status, as long it could demonstrate that the community already had access to emergency medical care from another source.

\textsuperscript{20} Noble et al., supra note 3, at 118; see Rev. Rule. 69-545, 1969-2 C.B. 117.

\textsuperscript{21} Hanson, supra note 1, at 34-37-.

\textsuperscript{22} See Noble et al., supra note 3, at 118-19.
However, other forms of uncompensated care – such as patient care that goes un-
reimbursed as a result of Medicaid or Medicare shortfalls – are often, but not always
excluded.\textsuperscript{23} Most definitions of community benefit exclude “bad debt,” or expenditures
for care that is charged to patients who ultimately do not pay, but many hospitals include
these costs as part of reported community benefits.\textsuperscript{24} There is general agreement that
uncompensated care should be calculated by the cost, not the charge, associated with
providing the care.\textsuperscript{25}

Most definitions of community benefit also include a variety of activities and
services other than direct provision of uncompensated care. These activities may include,
among other things, conducting health education or outreach campaigns in the
community, creating an official community benefits department within the hospital,
creating a formal process for consulting with community leaders to assess community
health needs, hiring from within the community, and even health-promoting volunteer
activities undertaken by hospital staff on their own time. Usually, community benefit
standards are open-ended about which activities and services count, leaving room for the
creation of new kinds of benefits.

There is also some disagreement over how to define community. The question is,
who must benefit from an activity or service in order for it to be a \textit{community} benefit? A
community may be defined either by geographic area or by demographic category.\textsuperscript{26}
However, even within a community defined by either of these criteria, a given service or
activity may tend to benefit a particular sub-category of individuals, giving rise to the
question of whether free, health-promoting services must actually benefit the poor or
uninsured in order to count as community benefits. Most definitions of community
benefit do not distinguish between activities that actually benefit underserved populations
and those that actually benefit the already-insured. Nevertheless, some commentators
argue that community benefits standards should distinguish between those services that
fill an existing need and those – such as free cholesterol screening targeted at wealthy

\textsuperscript{23} Coalition for Nonprofit Health Care, \textit{Redefining the Community Benefit Standard: State Law Approaches
to Ensuring the Social Accountability of Nonprofit Health Care Organizations}, 1999, at 4, available at
mBeneReport.pdf.
\textsuperscript{24} Hanson, \textit{supra} note 2, app. II; Baskin, \textit{supra} note 10.
\textsuperscript{25} Hanson, \textit{supra} note 2, app. II.
\textsuperscript{26} Coalition for Nonprofit Health Care, \textit{supra} note 22, at 3.
community members – that might more accurately be described as hospital or practice-group marketing tools.\textsuperscript{27}

In addition to a definition of community benefits, any comprehensive program for community benefits reform must adopt some kind of community benefits standard that nonprofit hospitals will be expected to meet. There are two basic categories of community benefit standards: process-oriented standards and outcome-oriented standards.\textsuperscript{28} Process-oriented standards require hospitals to implement internal and public-reporting procedures designed to promote the provision of community benefits.\textsuperscript{29} Typically, these procedures include writing a mission statement that includes a commitment to community benefits, performing assessments of community needs, creating a community benefits plan, and reporting community benefits activities and expenditures to a government agency and to the public. Outcome-oriented standards, on the other hand, require hospitals to meet specific benchmarks for community benefits expenditures.\textsuperscript{30} Benchmarks are typically set as a specific percentage of the hospital’s total patient-care costs, or as the value of the taxes that the hospital would have to pay were it not exempted.

Community benefit is a flexible concept, open to a range of interpretations. Any effective program aimed at community benefit reform must include its own definition of the term, clarifying which types of uncompensated care and other hospital activities may or may not be counted as community benefits. Perhaps more importantly, any comprehensive community benefits reform program must also include a determination of which type of community benefit standard will best ensure hospital compliance. State and local attempts at community benefits reform have taken varying approaches.

Section Two: Overview of Community Benefits Reform Efforts

So far, attempts at community benefits reform have included a variety of government and private actions. Some of these actions directly challenge hospitals’ state

\textsuperscript{27} Hanson, \textit{supra} note 1, app. II; Baskin, \textit{supra} note 10.
\textsuperscript{28} See Coalition for Nonprofit Health Care, \textit{supra} note 22.
\textsuperscript{29} See Id at 3-4.
\textsuperscript{30} See Id. at 17-18.
and local tax exemptions; others seek to influence nonprofit hospital behavior with threats of monetary sanctions or revocation of state licensing, or without mandating any specific consequences for hospital noncompliance. In several states, recently implemented community benefit statutes designate the state attorney general as the government officer charged with overseeing compliance. However, in a number of states, state attorneys general have taken steps to enact community benefit reform on their own initiatives. State attorney general-sponsored reform efforts range from litigation to voluntary community benefits reporting guidelines, and have met with varying degrees of success.

A: Private Actions, Legislation, and Challenges to State and Local Tax-Exemption

A variety of private and government actors have taken steps to hold nonprofit hospitals accountable for providing charity care and other community benefits. Private efforts include class action lawsuits and voluntary community benefit guidelines adopted and recommended by hospital associations. Public efforts include lawsuits by tax authorities to challenge individual hospitals’ exemptions from state and local taxes, as well as legislation requiring that nonprofit hospitals file annual community benefit reports or that they meet minimum benchmarks for community benefits expenditure.

1: Private Actions

Class action lawsuits brought against individual nonprofit hospitals in at least 23 states allege that failures to provide charity care to qualified patients, inflated charges billed to uninsured patients, and aggressive debt-collection tactics against the poor and the uninsured violate federal and state law. 31 Specifically, the lawsuits assert third-party claims for breach of contract, arguing that the billing and collection practices of the targeted nonprofit hospitals constitute breach of the “contract” between the hospitals and

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31 Bilimoria, Neville M., Patients Challenging Nonprofit Hospitals’ Charitable-Care Practices, 93 Ill. B.J. 134-135 (2005); Hanson, supra note 1, at 400-401.
the federal government that is inherent in tax-exemption under 26 U.S.C. 501(c)(3). The lawsuits also allege violations of various state laws, such as state consumer protection acts. Many of these lawsuits are part of a coordinated effort orchestrated by Richard Scruggs, the attorney made famous by his role in the lawsuits against tobacco companies in the 1990s. At least one of these lawsuits has settled, while many others are still pending.

Some hospital associations and other private foundations have also developed suggested community benefits guidelines, which may be viewed as either attempts at community benefits reform or as attempts to garner positive publicity and fend off actual reform. For example, the Voluntary Hospitals of America, the Catholic Health Association, and the American Hospital Association have developed their own definitions of community benefit. The Kellogg Foundation has also created a Community Benefit Standards Program. In at least one state, Missouri, public officials -- the Missouri Department of Health -- collaborated with the state hospital association -- the Missouri Hospital Association -- to create and administer a voluntary community benefits reporting program. However, that program has been criticized as defining community benefits too broadly and as lacking mechanisms for verification and auditing of submitted reports.

2: Government Actions

Government-sponsored community benefit action sometimes takes the form of challenges to nonprofit hospitals’ tax exemption by local tax authorities. Although the majority of states and localities adhere to the IRS’ flexible federal community benefit

33 Id. at 22.
34 Bilimoria, supra note 31, at 134-35; Hanson, supra note 1, at 400-401; see Not-for-Profit Litigation website, at www.nfplitigation.com.
36 Noble et al., supra note 3, at 123.
38 Id.
39 Id. at 127-128,
40 Id. at 128-129.
standard for state and local tax exemption, they are not legally required to do so.\footnote{Lagnado, Lucette,  
_A Nonprofit Hospital Fights Back_, the Wall St. J., June 29, 2004, at B1; Noble et al.,  
_supra_ note 3, at 119.} There have been a number of successes by tax authorities seeking to revoke exemption. One recent and highly publicized example is the Provena case. In 2004, in Champaign County, Illinois, the county Board of Review successfully challenged the property tax exemption of Provena County Medical Center on the basis that the hospital undertook inappropriate collection efforts against poor and uninsured patients, and that the nonprofit hospital’s arrangements with for-profit physician groups were impermissible.\footnote{Bilimoria, _supra_ note 31, at 136-37.} Provena has since appealed the decision of the Revenue Board, and that appeal was still pending as of 2005. Meanwhile, the Champaign County Board of Review initiated and won challenge to the property tax exemption of the Carle Foundation Hospital, now also on appeal\footnote{Hanson, _supra_ note 1, at 402; Carvlin, Elizabeth,  
_Cook County Official to Offer Bill Ensuring Hospitals Meet Tax-Exempt Standards_, The Bond Buyer, June 6, 2005 at 6.}.

However, some of these successes have been limited by subsequent political developments. For example, in a 1985 Utah case, _Utah County v. Intermountain Health Care_, the state Supreme Court set out a demanding interpretation of the statutory requirements for state tax exemption of nonprofit hospitals.\footnote{Utah v. Intermountain Health Care, 709 P.2d 265 (Utah 1985).} But, shortly thereafter, the promulgation of new guidelines for tax exemption analysis by the Tax Commission -- ostensibly based on the _Intermountain_ decision -- and the Supreme Court’s affirmation of those guidelines, significantly undermined the strength of the decision.\footnote{Noble et al., _supra_ note 3, at 120-21.} In Pennsylvania, a 1985 decision -- _Hospital Utilization Project v. Commonwealth_\footnote{Hospital Utilization v. Commonwealth, 487 A.2d 1306 (Pa. 1985).} -- articulated a stringent test for hospital tax exemption, helping to spawn a flurry of municipal challenges to hospital exemptions over the next 10 years.\footnote{Noble et al., _supra_ note 3, at 121.} The decision was later superseded by a 1997 law, the Institutions of Public Charity Act,\footnote{10 Pa. Cons. Stat. Ann. §§371-85 (West 2005).} which explicitly allows hospitals to make relatively small voluntary payments to local government in lieu of fulfilling the tax-exemption requirements.\footnote{Noble et al., _supra_ note 3, at 121-22.}
In a number of other states – at least 11\textsuperscript{50} -- legislatures have imposed new statutory requirements on nonprofit hospitals. In at least two states, Texas and Pennsylvania, statutory provisions implemented in the 1990s require hospitals to meet minimum benchmarks for community benefits expenditures, and condition a hospital’s state tax-exempt status on compliance.\textsuperscript{51} The Utah State Tax Commission’s current standards for tax exemption, although not legislative, take a similar approach: a nonprofit hospital must “provide gifts to the community in excess of its annual property tax liability” in order to maintain its tax exemption.\textsuperscript{52}

While those three legislative/regulatory schemes take an outcome-oriented approach, other state community benefit statutes take a process-oriented approach, requiring nonprofit hospitals to perform such tasks as assessing community healthcare needs, creating community benefits plans tailored to those needs, and filing periodic reports with government agencies detailing their community benefit activities.\textsuperscript{53} Most of these state statutes also require that hospitals’ community benefit reports be made available to the public.\textsuperscript{54} States with statutory reporting requirements include California, Idaho, Indiana, New York, Texas (in addition to its minimum expenditure requirement), Connecticut, New Hampshire, Maryland, Rhode Island, and Illinois.\textsuperscript{55} In some states, such as Maryland, fulfillment of the reporting requirements is a condition of state hospital licensing.\textsuperscript{56} In other states, such as Indiana, fines are assessed for failure to file a report.\textsuperscript{57} However, in several states, including California, there is no specified penalty for noncompliance.\textsuperscript{58}

\textsuperscript{50} Hanson, \textit{supra} note 1, at 399.
\textsuperscript{52} Coalition for Nonprofit Health Care, \textit{supra} note 23, at 21; see Utah State Tax Commission, Nonprofit Hospital and Nursing Home Charitable Property Tax Standards, eff. 1990.
\textsuperscript{53} Coalition for Nonprofit Health Care, \textit{supra} note 23, at 3.
\textsuperscript{54} Id. at 5-12, addendum.
\textsuperscript{57} Coalition for Nonprofit Health Care, \textit{supra} note 23, at 8; see Ind. Code. Ann. § 16-21-9-1—9-9 (West 2005)
Although most of these reporting statutes charge the state Departments of Health or equivalent state agency with monitoring compliance, some of these statutes require that hospitals file reports with the state attorney general. However, even without specific statutory authority to oversee community benefits requirements for hospitals, state attorneys general – who are, traditionally, charged with representing the public interest -- can and should take a role in community benefits reform. A number of attorneys general have already done so, taking several different approaches.

### B: Strategies Pursued by State Attorneys General

Without specific statutory authority to monitor compliance with legislative requirements, it is unclear what legal authority a state attorney general may have to require hospitals to provide increased community benefits. So far, state attorneys general have adopted several approaches to community benefits reform, including initiating litigation to challenge a nonprofit hospital’s tax exemption, pressing for state community benefits legislation, participating in third-party litigation as *amicus*, and entering into voluntary pacts with individual hospitals to *FILL IN RE MN*. However, the most comprehensive and effective option available to state attorneys general seems to be the voluntary regulatory approach implemented by the Massachusetts attorney general in the mid 1990s.

Attorney general litigation has not been an effective approach. In states without community benefit statutes mandating attorney general oversight, there is little legal support for the attorney general to bring lawsuits alleging insufficient provision of community benefits. In 1990, the Texas Attorney General brought a legal challenge to the tax exemption of Methodist Hospital, arguing that the hospital did not provide sufficient charity care to justify its exemption. This case was the first attempt by a non-tax authority to challenge a nonprofit hospital’s tax exemption in court, and appears to

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59 Coalition for Nonprofit Health Care, *supra* note 23, at 5-12, addendum.
60 See, *e.g.*, Ill. Community Benefits Act, *supra* note 55.
61 Interview with Barbara Fain, former Massachusetts Assistant Attorney General (until September 2005) responsible for oversight of community benefits program, January 2, 2006.
63 Noble et al., *supra* note 3, at 123.
be the last such suit brought by a state attorney general. A Texas district court judge promptly dismissed the claim on the basis that the attorney general did not have the authority to direct charitable organizations’ allocation of resources.  

Although the Texas Attorney General appealed the dismissal of the lawsuit against Methodist hospital, the appeal was eventually mooted by the passage of a state community benefits statute in 1993. The new law was, in part, the result of the Attorney General’s own efforts to push for legislation. Thus, at least one attorney general has been successful in helping to initiate legislative community benefits reform. However, this approach is limiting for an attorney general in that the legislature – not the attorney general – ultimately determines whether legislation is passed, and what the legislation requires.  

Illinois Attorney General Lisa Madigan took a new approach in 2004, filing amicus briefs in three community benefit lawsuits. Madigan filed briefs on behalf of the Champaign County Board of Review in two as-of-yet successful tax-exemption challenges brought against nonprofit hospitals. In June 2004, she also filed an amicus brief in support of a private lawsuit brought by former patients against Advocate Health Systems Care Network and Advocate Health and Hospitals Corporation, The brief in the Advocate case, filed in opposition of defendants’ motion to dismiss, argues that the plaintiffs correctly stated a claim of action under Illinois’ Consumer Fraud Act. While two of the lawsuits in which Madigan filed briefs have gained victories in Illinois’ lower courts, it is difficult to assess the effectiveness of Madigan’s strategy, since the outcomes of the cases are not likely the result of amicus briefs alone. Still, Madigan has successfully conveyed her support for community benefits reform without requiring any large investment of time or resources by the Attorney General’s office.

64 Lutz, supra note 62.  
65 Noble et al., supra note 3, n.110.  
66 Id. at 123.  
67 Carvlin, supra note 43. Appeals are pending in both cases.  
In Minnesota, Attorney General Mike Hatch has taken another unique approach in negotiating “voluntary” agreements with hospitals regarding billing practices with regard to uninsured patients. Under the agreements, which were negotiated and signed in 2005, each hospital commits to charging uninsured patients the same rate for services as it charges its largest insurer. At least one of these agreements was negotiated under heavy pressure: Fairview Health Services, the first healthcare organization to enter into an agreement with the Attorney General’s office, did so only after Hatch undertook an extensive audit of its billing and collection practices. Four other healthcare organizations, representing 18 Minnesota hospitals, signed the agreements only after being served with subpoenas by the Attorney General’s office, and after Hatch had threatened to bring lawsuits against hospitals that continued to charge higher rates to uninsured patients than to insurers. Finally, in June 2005, 35 new hospitals signed the “voluntary” agreements.

While Hatch’s voluntary program has so far been successful, the success is limited in two key ways. First, the agreements, by their terms, phase out after two years. Second, the agreements are limited to ending a particular practice: excessive billing of uninsured patients. While inflating charges for the uninsured may be particularly reprehensible behavior, the prohibition of one practice falls short of comprehensive community benefit reform. In contrast, the voluntary community benefits program initiated by the Massachusetts Attorney General in the 1990s creates a regulatory framework that provides for reporting and public oversight of all community benefits claimed by nonprofit hospitals. The Massachusetts program, described in Section Three below, represents perhaps the most comprehensive and effective strategy available for state attorneys general to implement community benefits reform on their own initiatives.

Section Three: The Massachusetts Reporting Guidelines

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71 Id.
72 Forster, Julie, Hospitals to Offer Uninsured Patients, Insurance Companies Same Discounts, Pioneer Press (St. Paul, Minn.), May 6, 2005.
73 Id.
74 Evans, supra note 70.
75 Id.
In June 1994, the then-Attorney General of Massachusetts, Scott Harshbarger, released a set of voluntary community benefit reporting guidelines for nonprofit hospitals.\textsuperscript{76} The original guidelines are still in force, although significant revisions became effective in 2002.\textsuperscript{77} This Section begins with a discussion of how the original guidelines were developed. Then, it describes the current guidelines, and identifies the changes that were adopted in 2002. Finally, it discusses how the guidelines work—in other words, how they actually influence hospital behavior.

A: Development of the Massachusetts Guidelines

Nearly all of Massachusetts hospitals are nonprofit.\textsuperscript{78} By the time the Attorney General’s office first released its Community Benefits Reporting Guidelines for nonprofit hospitals, in June 1994, community benefits had already become a hot topic for public debate in Massachusetts. Several Massachusetts hospitals had already adopted the Kellogg Foundation’s community benefits model,\textsuperscript{79} most likely in an effort to publicize their existing community benefit programs and discourage government-sponsored community benefits reform, and the Attorney General’s office itself had already spent several years working on the development of its community benefits reform initiative.\textsuperscript{80}

The Attorney General’s concern about community benefits arose from the perception that many Massachusetts hospitals were “rolling” in cash, but not re-investing those funds into the community.\textsuperscript{81} The provision of charity care per se was not a central issue, as an existing Massachusetts program already required hospitals to make mandatory contributions to a free-care fund used to compensate care for the poor.\textsuperscript{82} Nor did the Attorney General view the size of nonprofit hospitals’ financial reserves and

\textsuperscript{76} Reilly, Tom, Attorney General of the Commonwealth of Mass., \textit{The Attorney General’s Community Benefits Guidelines for Nonprofit Acute Care Hospitals}, January 2002, at 1, available at \url{http://www.cbsys.ago.state.ma.us/pubs/hccbnpguide.pdf}. A second set of guidelines, applicable to HMOs, was issued in 1996, but this paper focuses on the guidelines as applied to hospitals.

\textsuperscript{77} Id. at 2.


\textsuperscript{79} Id.

\textsuperscript{80} Interview with Barbara Anthony, former Massachusetts Assistant Attorney General responsible for initial development of community benefits program, Dec. 27, 2005.

\textsuperscript{81} Fain Interview, supra note 61.

\textsuperscript{82} Anthony Interview, supra note 80.
operating surpluses, per se, as a problem. Instead, the Attorney General hoped that a community benefits program would help meet “unmet healthcare needs” by redirecting resources toward providing new services to “underserved” populations. There were glaring inequities in Massachusetts’ healthcare system: for example, high infant mortality rates, particularly among racial minorities, existed “in the shadow” of well-funded and “first-class” medical institutions. In other words, the Attorney General hoped to use its community benefits plan to address what the *Boston Globe* termed “the growing gap between the institutional wealth of downtown hospitals and the neighborhoods’ unmet health needs.”

Although Harshbarger publicly stated that he would consider challenging the tax-exempt status of hospitals that chose not to comply with the proposed voluntary program, the reality was that the Attorney General did not have any strong legal basis for litigation against nonprofit hospitals under state or federal law. Legislation mandating community benefits was unlikely to garner sufficient support in the legislature of a state where hospitals were such a powerful political force. Nor was legislation necessarily the ideal way to implement community benefits reform: the Attorney General sought to shift the way nonprofit hospital executives viewed community benefits, and realized that “you can’t mandate an attitude.”

The Attorney General therefore settled on the option of issuing its own community benefits reporting guidelines. However, since the Attorney General lacked the legal authority to promulgate enforceable community benefits guidelines, the program could only be voluntary. Hospitals’ consent to the form and content of the guidelines

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83 *Id.*
84 *Id.*
85 Interview with Susan Sherry, current Deputy Director of Community Catalyst and former staff member of Health Care for All, participant in negotiations for initial development of Massachusetts community benefits guidelines as a representative of Health Care for All, January 3, 2006.
88 Fain Interview, *supra* note 61.
89 *Id.*
90 *Id.*
91 *Id.*
was therefore essential to the program’s success. The guidelines were destined to be a “heavily negotiated contract” with Massachusetts hospitals.

In May 1993, the release of a report commissioned by the Boston Department of Health and authored by Nancy M. Kane, a Harvard professor, provided a “political opening” for the implementation of the Attorney General’s plan. The Kane report exposed the surprisingly large financial reserves, holdings, and operating surpluses of Boston’s major nonprofit hospitals, generating public outrage. While the report was released long after the Attorney General had begun planning for its community benefit initiative, and did not directly address the issue of community benefits, it significantly increased the bargaining power of the Attorney General in negotiations with hospitals over the future guidelines. Public reaction to the Kane report “created an atmosphere where [the hospitals’] simply doing nothing would not have looked good.”

The implicit threats that the Attorney General might file legislation, or that local tax authorities in Massachusetts might follow the lead of Pennsylvania municipalities and challenge nonprofit hospitals’ exemptions – both of which seemed more feasible in the wake of the Kane report – also weighed in the Attorney General’s favor. Still, between January 1994 and June 1994, the Attorney General was forced to back off from some of the stronger provisions contained in early drafts of the guidelines. For example, in the face of hospital resistance, proposed required minimum benchmarks for community benefits expenditures were dropped. Ultimately, the negotiations – which included representatives of Health Care for All Massachusetts, a health access advocacy group, as well the Attorney General’s office and hospital representatives – resulted in a set of process-oriented guidelines that all parties agreed were acceptable.

**B: Overview of the Massachusetts Program’s Requirements**

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92 Id.
93 Knox, supra note 88.
94 Sherry Interview, supra note 85.
95 Knox, supra note 88.
96 Anthony Interview, supra note 80.
97 Id.
98 Fain interview, supra note 61.
The current guidelines for hospitals are relatively flexible as well as process-oriented. As summarized in the introduction to the guidelines, “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 guidelines apply specifically to nonprofit acute care hospitals, and not to municipal hospitals, which, as the guidelines recognize, “by and large already provide needed health care services to disadvantaged populations.” The guidelines are currently overseen by the Attorney General’s Division of Public Charities, and the introduction to the guidelines suggests that the Attorney General’s authority to issue the guidelines derives from the office’s “statutory oversight responsibilities to ensure that all charitable organizations in the Commonwealth … conduct themselves in a manner consistent with their benevolent mission.”

The guidelines themselves consist of six “principles” that participating hospitals are expected to adopt. The first principle is that each participating hospital should formulate and make public a Community Benefits Mission Statement, which should be formally affirmed by the hospital’s Governing Board. The second principle is that the Governing Board and senior management of each participating hospital should oversee the development and implementation of the hospital’s Community Benefits Plan, as well as decisions regarding resource allocation and periodic evaluations of the Plan.

The third principle is that each hospital should determine which community is to be the focus of its Plan, and should involve members of that community in developing and implementing its Plan. A community may be defined by the geographic area, demographic category, and/or health status of its members. Community members or representatives should be viewed “as full partners in the process of identifying health care
needs,” and the guidelines suggest that hospitals create a formal process for community input.107

The fourth principle is that each participating hospital’s Community Benefit Plan should include both a “comprehensive assessment” of the designated community’s health needs and a “statement of priorities consistent with the hospital’s resources.”108 In developing its Plan, a hospital should assess community needs and establish hospital priorities; re-evaluate whether existing community benefit programs are consistent with the identified needs and priorities; formulate short- and long-term goals; and prepare a community benefits budget.109 The guidelines stress that “priority should be accorded to the health care needs of disadvantaged and vulnerable populations.”110

The hospital should budget for a “reasonable” level of community benefits expenditures, which should be calculated by “taking various financial indicators” – such as the hospital’s total patient operating expenses and accumulated operating surpluses or deficits – “into consideration.”111 The guidelines also describe a different approach for calculating and appropriate level of community benefits expenditures, using specific percentages of total patient operating expenditures as benchmarks: up to three percent for hospitals with audited total patient operating expenditures under $200 million, and three to six percent for those with expenditures over $200 million.112 However, the Attorney General stops short of recommending this less-flexible standard for expenditures.113 The guidelines also provide a non-exhaustive list of possible community benefits, including community health education, free preventive and screening health services, violence-reduction and substance-abuse education programs, and participation in “community-oriented training programs.”114

The fifth principle is that each hospital should develop and implement its Plan in a timely manner, and the sixth principle is that an annual Community Benefits Report should be submitted to the Attorney General each year and made available for public

107 Id. at 6.
108 Id.
109 Id. at 7-8.
110 Id. at 8.
111 Id. at 9.
112 Id. at 9-10.
113 Id. at 10.
114 Id. at 10-11.
Currently, the Attorney General posts each hospital’s annual report for public review on its own website, and provides a forum for the posting of relevant community comments regarding each plan.

The guidelines also mandate a format for annual hospital reports, each of which is to include both full-text report and a standardized summary. An attached glossary clarifies which expenses may and may not be calculated as community benefits expenditures, specifying, for example, that mandatory free care pool contributions should be calculated separately from community benefits expenditures.

Although the Attorney General’s office reviews the reports, it does not generate any comprehensive analysis. Its oversight is generally limited to checking reported numbers for expenditures that appear to be misrepresented or miscalculated, and calling hospitals’ attention to those mistakes. Ideally, comprehensive review is to be undertaken by community members or organizations with personal stake in hospitals’ community benefits expenditures. Community members who feel that a hospital’s web-posted report is inaccurate or that its community benefit plan is insufficient are encouraged to communicate concerns directly with the hospital, or submit comments to the Attorney General.

1: The 2002 Revisions

The current guidelines are a combination of the original guidelines issued in 1994 and the revisions that took effect in January of 2002. The 2002 revisions are the product of the Attorney General’s Community Benefits Advisory Task Force, a group consisting of representatives from various hospitals, HMOs, community organizations, and government agencies, which first convened in 1998. These revisions included three...

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115 Id. at 11-12.
118 Fain Interview, supra note 61.
119 Id.
120 Id.
121 Id.
major changes: implementation of web-posting of reports; more specific definitional and reporting requirements; and changes to suggested expenditure standards.\textsuperscript{123}

Under the web-posting program that took effect in 2002 (when fiscal year 2001 reports were filed), all hospital community benefits reports are posted for public review on the Attorney General’s website, with a space for the posting of community comments approved as relevant by the Attorney General’s office. Prior to 2002, hospital community benefit reports were only available to the public by request.\textsuperscript{124} Although the Attorney General issued its own reports analyzing the hospital reports it had received, those reports were limited; the Attorney General could not offer candid criticism of hospitals’ self-reporting without risking angering the hospitals and jeopardizing future compliance.\textsuperscript{125} The goal of web-posting is to make hospitals directly accountable to their communities by providing a forum for community members to review hospitals’ reports, and to publicly register their own comments.\textsuperscript{126}

The newer, more specific definitional and reporting requirements appear in Appendix II of the current guidelines, entitled “The Community Benefits Annual Report—Format and Process.” These requirements include the relatively detailed description of which expenses may and may not be counted as community benefits expenditures, as well as the requirement that each hospitals submit both a full-text report and a standardized summary.\textsuperscript{127} The goal of these changes was to facilitate comparison between hospitals by ensuring consistency in expenditure calculations and by generating similarly formatted, standardized “snapshots” of each hospital’s community benefits activities.\textsuperscript{128}

The current recommended expenditure standard – i.e., the “reasonableness” standard – represents the third major change that took effect in 2002. The original 1994 guidelines had suggested that the percentage-of-operating-expenses benchmarks – originally set slightly higher than the percentages now noted in the guidelines – might

\textsuperscript{123} Fain Interview, \textit{supra} note 61.
\textsuperscript{124} \textit{Id.}
\textsuperscript{125} \textit{Id.}
\textsuperscript{126} \textit{Id.}
\textsuperscript{127} Guidelines, \textit{supra} note 76, app. II, attachment 3.
\textsuperscript{128} \textit{Id.}
eventually be implemented as the required standard for participating hospitals. Two other standards were originally suggested in the guidelines: the current “reasonableness” standard and a tax-exemption-value standard, under which a hospital would provide a level of community benefits equivalent to the financial value of its tax exemption. In other words, between 1994 and 2002, the Attorney General eliminated the tax-exemption-value standard, decided not to impose a percentage-of-operating-expenses benchmark, and opted to recommend the highly flexible “reasonableness” standard as the appropriate level of hospital community benefits expenditures.

Ultimately, the revisions represented a victory for the hospitals on the issue of expenditure standards, but a major concession on the issue of public access to reports and a lesser concession on the issue of stricter definitional and reporting requirements. These concessions were not, however, freely given. By 1999, Health Care for All of Massachusetts – a consumer health access group and a member of the Advisory Task Force – had became frustrated with the slow progress of negotiations with hospitals over the proposed changes. Health Care for All drafted and filed state community benefits legislation, with the support of politically powerful sponsors in the state legislature. Fearing that Health Care for All’s proposed legislation might actually passed, the hospitals agreed to both the website-posting provision and the tighter reporting requirements.

While the decision not to implement strict minimum-expenditure standards was indisputable a victory for hospitals, neither the Attorney General’s office nor participating health access advocates were particularly invested in implementing the percentage-of-operating-expenses or tax-exemption-value benchmarks. The Attorney General’s office was satisfied that Massachusetts hospitals were already complying with the spirit of the guidelines, and took the position that there was no need to impose stricter – and potentially inflammatory – requirements. Health access advocates largely agreed with this position, and were aware that “floors can become ceilings”: if hospitals were

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129 Guidelines, supra note 76, app. I, p. 4.
130 Id.
131 Fain Interview, supra note 61.
132 Id.
133 Anthony Interview, supra note 80.
required to fulfill specific expenditure requirements, they might focus on meeting those benchmarks and nothing more.\textsuperscript{134}

\textbf{C: How the Guidelines Work}

A primary goal of the guidelines was to encourage redirection of hospital resources via the implementation of internal hospital procedures that would “change the way [hospitals] do business.”\textsuperscript{135} By requiring top-level hospital directors to affirm Community Benefits Mission Statements and oversee development and implementation of Community Benefit Plans, the Attorney General’s office hoped to encourage a “buy-in from the top.”\textsuperscript{136} In other words, the guidelines were designed to encourage hospital executives and management to become personally invested in the provision of community benefits.\textsuperscript{137} Similarly, by strongly recommending that needs assessments be conducted in partnership with members of the community, the Attorney General’s office sought to change the way hospitals relate to their communities and foster an attitude of responsiveness to community needs.\textsuperscript{138}

Of course, a voluntary program – particularly a process-oriented program that seeks to shift the attitudes and business practices of large, well-funded institutions – requires the consent and compliance of the institutions themselves. The Attorney General’s program works only because the hospitals are willing to make it work. However, with no realistic threat of litigation by the Attorney General, it is not immediately clear what drives hospital participation.

The most significant motivator of hospital compliance seems to be the implicit threats of state legislation or local litigation that might impose more stringent requirements or jeopardize hospitals’ tax-exempt status.\textsuperscript{139} After the Kane report, the political climate in Massachusetts became more conducive to state legislation regarding nonprofit hospital behavior. In 1999, the filing of proposed legislation by Health Care for

\begin{itemize}
  \item \textsuperscript{134} Sherry Interview, \textit{supra} note 85.
  \item \textsuperscript{135} Fain Interview, \textit{supra} note 61.
  \item \textsuperscript{136} \textit{Id}.
  \item \textsuperscript{137} \textit{Id}.
  \item \textsuperscript{138} \textit{Id}.
  \item \textsuperscript{139} Fain Interview, \textit{supra} note 61; Anthony Interview, \textit{supra} note 80.
\end{itemize}
All was sufficiently threatening to nonprofit hospitals to force the acceptance of unfavorable new provisions of the reporting guidelines.\textsuperscript{140} In addition, during the 1990s, local tax authorities in neighboring states -- such as Pennsylvania and New Hampshire -- were threatening the property tax exemptions of nonprofit hospitals, with at least some success.\textsuperscript{141} Hospitals were aware that local governments in Massachusetts could take similar steps. Compliance with the guidelines provided nonprofit hospitals with a significant degree of protection from either type of threat.\textsuperscript{142}

Other motivators include concerns about public image and an existing philosophy of public service. While hospitals are not particularly worried that unfavorable public opinion could decrease fundraising ability or philanthropic donations,\textsuperscript{143} low public opinion of nonprofit hospitals in general could decrease the hospital industry’s political clout, and low public opinion of individual hospitals could negatively impact recruitment of insured patients. In addition, Massachusetts’ nonprofit hospitals have a long history of public service, and generally the institutions remain committed to an ideal of providing benefits to the community.\textsuperscript{144}

\textbf{Section Four: Effectiveness of the Massachusetts Program}

The Massachusetts program is obviously unique; no other state attorney general has yet implemented a similar initiative. In theory, though, the Massachusetts program could serve as a model for other state attorney generals wishing to take a role in community benefits reform. This Section discusses the successes and weaknesses of the Massachusetts program, with the goal of exploring the question of whether the program should be adopted in other states.

\textbf{A: Successes of the Massachusetts Program}

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    \item \textsuperscript{140} Fain Interview, \textit{supra} note 61; \textit{see} discussion at footnotes 128-130, \textit{supra}.
    \item \textsuperscript{142} Fain Interview, \textit{supra} note 61; Pham, \textit{supra} 139.
    \item \textsuperscript{143} Anthony Interview, \textit{supra} note 80.
    \item \textsuperscript{144} Id.; Fain Interview, \textit{supra} note 61.
\end{itemize}
The architects of the Massachusetts program all seem relatively satisfied with the guidelines and reporting system as they were ultimately implemented. One former Assistant Attorney General, who played a major role in developing the 1994 guidelines, opined that “anybody would say the program has been a success.” Hospital compliance rates are high, and nearly every hospital in Massachusetts has now developed a community benefits program and hired of designated a community benefits coordinator. Health access advocates are “generally pleased” with the final guidelines.

The process-oriented approach and flexible definition of community benefits encourage hospitals to be innovative in designing new community benefit programs and to cooperate with community members in assessing needs, rather than to focus on meeting particular expenditure requirements. Arguably, the program has succeeded in changing the terms of the community benefits debate in Massachusetts; hospital leaders now view community benefits as a core hospital function. Furthermore, they appear to recognize accountability to community members as a priority. A 2000 survey of HMOs and hospitals, conducted by the Attorney General’s Community Benefits Advisory Task Force, found that, even before the web-posting provision was implemented to increase community involvement, 97.3% of hospital and HMO representatives charged with preparing community benefits reports agreed that “accountability to the community” was an appropriate focus of community benefits reporting. By 1997, 82% of nonprofit hospitals in Massachusetts had already implemented formal programs for community involvement in needs assessment.

Without benchmarks, it is difficult to define program “success.” However, available data from hospital reports filed for fiscal year 2004 is encouraging: an analysis of web-posted reports shows that those hospitals who reported the relevant financial data

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145 Anthony Interview, supra note 80.
146 Id.
147 Sherry Interview, supra note 85.
148 Fain Interview, supra note 61.
149 Results of 2000 Hospital and HMO Reporting Survey, available at http://www.cbsys.ago.state.ma.us/healthcare/hccbsurv2r.pdf
dedicated an average of 4.0\% of their total patient-care related expenses to community benefits, on top of an average 2.7\% contribution to the free-care pool.\textsuperscript{151}

**B: Weaknesses of the Massachusetts Program**

Despite the apparent successes of the Massachusetts program, there are several key weaknesses in its strategy. One major weakness is the lack of an explicit mechanism to hold hospitals accountable to providing any particular level or type of community benefits. Without benchmarks or sanctions, hospitals do not necessarily have an incentive to increase the benefits they provide to the community. Under a flexible definition of community benefits, they may count “questionable” activities – such as free health screenings actually calculated to get new, insured patients – as benefits.\textsuperscript{152} The lack of accountability is compounded by the fact that, because there is no statutory requirement for the program, the Attorney General has no real obligation to monitor compliance. A new Attorney General is free to ignore the program, decreasing hospitals’ incentive to seriously comply and undermining the effectiveness of the program. There is some speculation that the program has already lost some of its force, and that hospitals have begun to take the guidelines less seriously, under the leadership of Attorney General Tom Reilly, who took office in 1999.

Another major weakness is that the program depends heavily on community involvement. If community members do not take the initiative to participate in hospitals’ assessments of community needs, or to comment on reported community benefits plans and expenditures, hospitals will not become responsive to their communities. Community involvement so far has been somewhat disappointing.\textsuperscript{153} No community comments are posted on the Attorney General’s website in response to hospital’s reports for fiscal year

\textsuperscript{151} Data taken from *Hospital and HMO Annual Reports: FY2004*, available at http://www.cbsys.ago.state.ma.us/healthcare/hccbar.asp?section=15&head2=Community+Benefits&head3=Hospital+and+HMO+Reports. Data used in analysis was taken from 40 hospitals that reported all relevant figures (one additional hospital posted all figures, but figures were clearly erroneous – this hospital was not included).


\textsuperscript{153} Fain Interview, supra note 61.
2004. By one health access advocate’s estimate, community involvement has been strong at 1/3 of the hospitals, weaker at another 1/3, and nonexistent at the others.

An additional weakness is the difficulty inherent in measuring the program’s success. High rates of hospital compliance with reporting guidelines are a good sign, but do not necessarily demonstrate that the program is having the desired effect of increasing access to healthcare. However, this is a problem faced by community benefits programs in general -- even where minimum benchmark expenditures are imposed -- and it is not unique to the Massachusetts program.

**Conclusion**

Overall, the Massachusetts program is probably the best model for state attorneys general who want to become involved in community benefits reform. In the absence of state community benefits legislation, attorneys general have few viable options to influence hospital behavior. In most states, there is no established legal basis upon which an attorney general could bring a community benefits lawsuit against a nonprofit hospital, and, besides, litigation is costly and divisive. New legislation requires the cooperation of the state legislature, and may not be politically feasible. A voluntary reporting program, on the other hand, does not require statutory support, and may be implemented on the attorney general’s initiative alone, as long as the attorney general can negotiate hospitals’ compliance. The Massachusetts model of a voluntary agreement with hospitals is particularly interesting because, unlike the pacts signed by Attorney General Hatch and various hospitals in Minnesota, it addresses community benefits provision as a whole.

Of course, the Massachusetts approach may not work in every state. Hospitals are unlikely to cooperate with a voluntary reporting program unless there is a realistic threat of state legislation or local tax exemption litigation. Hospitals in states with greater numbers of for-profit hospitals might be unwilling to submit to voluntary agreements that could hurt their financial competitiveness. It is also worth noting that the Massachusetts program did not try to force hospitals to provide charity care, which was already

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155 Sherry Interview, *supra* note 85.
mandatory under the Massachusetts free-care pool system. It may be more difficult to implement a voluntary program that specifically directs hospitals to provide more free care.

Ultimately, Congress – or even a state legislature – is probably in a better position than a state attorney general to implement reforms that will increase the affordability and accessibility of health care. However, in the absence of legislative action, attorneys general can and should consider using their influence to monitor the behavior of nonprofit hospitals. So far, the Massachusetts program represents the most effective strategy implemented by an attorney general to address concerns about community benefits, and it is certainly worth considering whether similar attorney general initiatives could be equally effective in other states.