maryland
health services
cost review commission

November 19, 2020

The Honorable Bill Ferguson
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

The Honorable Shane E. Pendergrass
Chair, House Health and Government Operations Committee
Room 241, House Office Building
Annapolis, MD 21401

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401

Re: Maryland Hospital Community Benefit Report required by Health General Article §19–303 (MSAR #2349)

Dear President Ferguson, Speaker Jones, Chair Pendergrass, and Chair Kelley:

Each year, the Health Services Cost Review Commission ("HSCRC") collects community benefit information from individual hospitals to compile into a publicly available statewide Community Benefit Report ("CBR"). This summary report provides background information on hospital community benefits and the history of CBRs in Maryland, and summarizes the community benefit narrative and financial reports for fiscal year (FY) 2019. Individual hospital reports can be found at https://hscrc.maryland.gov/Pages/init_cb.aspx

Legislation was passed during the recent 2020 legislative session requiring the HSCRC to update the community benefit reporting process. A report on steps taken to update this process for FY 2019 and on will be submitted later this year.

If you have any questions regarding this report or the community benefit reporting process, please contact me at tequila.terry1@maryland.gov.

Sincerely,

Tequila Terry
Principal Deputy Director

CC:
The Honorable Robert R. Neall
The Honorable Joseline A. Pena-Melynyk
The Honorable Brian J. Feldman
Sarah Albert, Department of Legislative Services

Maryland Hospital Community Benefit Report: FY 2019

June 23, 2020

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
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LIST OF ABREVIATIONS

ACA	Affordable Care Act
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
DME	Direct Medical Education
ED	Emergency Department
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
IRS	Internal Revenue Service
MHA	Maryland Hospital Association
NSPI	Nurse Support Program I
PSA	Primary Service Area
SHIP	State Health Improvement Process
UCC	Uncompensated Care

INTRODUCTION

The term community benefit refers to initiatives, activities, and investments undertaken by tax-exempt hospitals to improve the health of the communities they serve. Maryland law defines community benefit as an activity that intends to address community needs and priorities primarily through disease prevention and improvement of health status.[1] Examples of community benefit activities can include the following:

- Health services provided to vulnerable or underserved populations such as Medicaid, Medicare, or Maryland Children's Health Program participants
- Financial or in-kind support of public health programs
- Donations of funds, property, or other resources that contribute to a community priority
- Health care cost containment activities
- Health education, screening, and prevention services
- Financial or in-kind support of the Maryland Behavioral Health Crisis Response System

In 2001, the Maryland General Assembly passed House Bill 15,[2] which required the Maryland Health Services Cost Review Commission (HSCRC) to collect community benefit information from individual hospitals and compile it into a statewide, publicly available Community Benefit Report (CBR). In response to this legislative mandate, the HSCRC initiated a community benefit reporting system for Maryland's nonprofit hospitals that included two components. The first component, the *Community Benefit Collection Tool*, is a spreadsheet that inventories community benefit expenses in specific categories defined by the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of the Internal Revenue Service (IRS) Form 990, Schedule H.[3] The second component of Maryland's reporting system is the CBR narrative report. The HSCRC developed the *Community Benefit Narrative Reporting Instructions* to guide hospitals' preparation of these reports, which strengthen and supplement the quantitative community benefit data that hospitals report in their inventory spreadsheets.

This summary report provides background information on hospital community benefits and the history of CBRs in Maryland, and summarizes the community benefit narrative and financial reports for fiscal year (FY) 2019. It concludes with a summary of data reports from the past 10 years.

[1] MD. CODE. ANN., Health-Gen. § 19-303(a)(3).
[2] H.D. 15, 2001 Gen. Assem., 415th Sess. (Md. 2001).
[3] https://www.irs.gov/pub/irs-pdf/f990sh.pdf

BACKGROUND

Federal Requirements

The Internal Revenue Code defines tax-exempt organizations as those that are organized and operated exclusively for specific religious, charitable, scientific, and educational purposes.[4] Nonprofit hospitals are generally exempt from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, nonprofit hospitals may raise funds through tax-deductible donations and tax-exempt bond financing.

Originally, the IRS considered hospitals to be "charitable" if they provided charity care to the extent that they were financially able to do so.[5] However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the "charitable" standard to focus on "community benefits" rather than "charity care."[6] Under this IRS ruling, nonprofit hospitals must provide benefits to the community in order to be considered charitable. This ruling created the "community benefit standard," which is necessary for hospitals to satisfy in order to qualify for tax-exemption.

The Affordable Care Act (ACA) created additional requirements for hospitals in order to maintain tax-exempt status. Every §501(c)(3) hospital—whether independent or part of a hospital system— must conduct a community health needs assessment (CHNA) at least once every three years to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[7] A CHNA is a written document developed for a hospital facility that includes a description of the community served, the process used to conduct the assessment, identification of any persons with whom the hospital collaborated on the assessment, and the health needs identified through the assessment process. CHNAs must incorporate input from individuals who represent the broad interests of the communities served, and hospitals must make them widely available to the public.[8] CHNAs must include an implementation strategy that describes how the hospital plans to meet the community's health needs, as well as a description of what the hospital has historically done to address its community's needs.[9] Further, the hospital must identify any needs that have not been met and explain why they were not addressed. Tax-exempt hospitals must report this information on Schedule H of IRS Form 990.

Maryland Requirements

The Maryland General Assembly adopted the Maryland CBR process in 2001,[10] and the first data collection period was FY 2004. Maryland law requires hospitals to include the following information in their CBRs:

- The hospital's mission statement

[4] 26 U.S.C. § 501(c)(3).
[5] Rev. Ruling 56-185, 1956-1 C.B. 202.
[6] Rev. Ruling 69-545, 1969-2 C.B. 117.
[7] 26 U.S.C. § 501(r)(3); 26 U.S.C. § 4959.
[8] 26 U.S.C. § 501(r)(3)(B).
[9] 26 U.S.C. § 501(r)(3)(A).
[10] MD. CODE. ANN., Health-Gen. § 19-303.

- A list of the hospital's initiatives
- The costs and objectives of each initiative
- A description of efforts taken to evaluate the effectiveness of initiatives
- A description of gaps in the availability of specialist providers
- A description of the hospital's efforts to track and reduce health disparities in the community[11]

The HSCRC worked with the Maryland Hospital Association (MHA), hospitals, local health departments, and health policy organizations and associations to establish the initial details and format of the CBR. In developing the format for data collection, the group relied heavily on the experience of the Voluntary Hospitals of America community benefit process. Maryland hospitals used the resulting data reporting spreadsheet and instructions to submit their FY 2004 data to the HSCRC in January 2005, and the HSCRC published the first CBR in July 2005. The HSCRC continues to work with stakeholders to further improve the reporting process and refine the definitions and periodically convenes a Community Benefit Work Group. The data collection process offers an opportunity for each Maryland nonprofit hospital to critically review and report the activities it has designed to benefit the community. This FY 2019 report represents the HSCRC's 16th year of reporting on Maryland hospital community benefit data.

In March 2020, the Maryland General Assembly passed Senate Bill 774, which amends the statutory requirements for hospital community benefit reporting.[12] This bill requires the HSCRC to establish a Community Benefit Reporting Workgroup and adopt regulations recommended by the Workgroup regarding community benefit reporting. The bill also modifies the definition of community benefit and expands the list of items that hospitals must include in their CBR.

NARRATIVE REPORTS

This section of the document summarizes the findings of the narrative reports by major report section.

Hospitals Submitting Reports

The HSCRC received 47 CBR narratives from 50 hospitals in FY 2019. Please note that the University of Maryland Medical System submits a single CBR for three of its hospitals on the Eastern Shore and another CBR for two of its hospitals in Harford County. These reports sometimes break out individual metrics for each hospital and sometimes combine responses. Therefore, the denominator for hospital response rates varies between 47 and 50 throughout the remainder of this document. Table 1 summarizes the hospitals submitting CBRs by hospital system.

[11] MD. CODE. ANN., Health-Gen. § 19-303(c)(2).
[12] S. 774, 2020 Leg., 441st Sess. (Md. 2020).

Table 1. Maryland Hospitals that Submitted CBRs in FY 2019, by System

Independent Hospitals	**Johns Hopkins Medicine:**
1. Anne Arundel Medical Center	24. Howard County General Hospital
2. Atlantic General Hospital	25. Johns Hopkins Bayview Medical Center
3. Bon Secours Baltimore Health System*	26. Johns Hopkins Hospital
4. CalvertHealth Medical Center	27. Suburban Hospital
5. Doctors Community Hospital	**Lifebridge Health:**
6. Fort Washington Medical Center**	28. Carroll Hospital Center
7. Frederick Memorial Hospital	29. Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.
8. Garrett Regional Medical Center	
9. Greater Baltimore Medical Center	30. Northwest Hospital Center, Inc.
10. McCready Health Foundation, Inc.	31. Sinai Hospital of Baltimore, Inc.
11. Mercy Medical Center	**MedStar Health:**
12. Meritus Medical Center	32. MedStar Franklin Square Medical Center
13. Peninsula Regional Medical Center	33. MedStar Good Samaritan Hospital
14. Saint Agnes Hospital	34. MedStar Harbor Hospital
15. Sheppard Pratt Health System	35. MedStar Montgomery Medical Center
16. Union Hospital of Cecil County	36. MedStar Southern Maryland Hospital Center
17. Western Maryland Health System	37. MedStar St. Mary's Hospital
Jointly Owned Hospitals:	38. MedStar Union Memorial Hospital
18. Mt. Washington Pediatric Hospital***	**University of Maryland:**
Adventist HealthCare:	39. UM Baltimore Washington Medical Center
19. Adventist Healthcare Rehabilitation	40. UM Charles Regional Medical Center
20. Adventist HealthCare Shady Grove Medical Center	41. University of Maryland Medical Center
	42. UMMC Midtown Campus
21. Washington Adventist Hospital	43. UM Capital Region Health****
Holy Cross Health	44. UM Rehabilitation & Orthopaedic Institute
22. Holy Cross Germantown Hospital	45. UM Shore Regional Health*****
23. Holy Cross Hospital	46. UM St. Joseph Medical Center
	47.UM Upper Chesapeake Health******

*Became part of Lifebridge system in December 2019
**Became part of Adventist system in October 2019
***Mt. Washington Pediatric is jointly owned by the University of Maryland Medical System and Johns Hopkins Medicine
****Prince George's and Laurel Regional hospitals combined this year.
*****One narrative report includes three hospitals: Easton, Chester River, and Dorchester
*******One narrative report includes two hospitals: Upper Chesapeake Medical Center and Harford Memorial Hospital

Section I. General Hospital Demographics and Characteristics

Section I of the report collects demographic and other characteristics of the hospital and its service area.

Hospital-Specific Demographics

The first section of the CBR narrative collects information on hospital demographic and utilization statistics, as summarized in Table 2 below. Overall, there were 10,052 beds and 596,410 inpatient admissions. The percentage of admissions by insurance status ranged from 0.0 to 6.1 percent for charity care/self-pay, 1.9 to 80.6 percent for Medicaid, and 14.1 to 91.1 percent for Medicare-among hospitals accepting Medicare clients. These percentages were largely similar to those for FY 2018.

Table 2. Hospital Bed Designation, Inpatient Admissions, and Patient Insurance Status, FY 2019

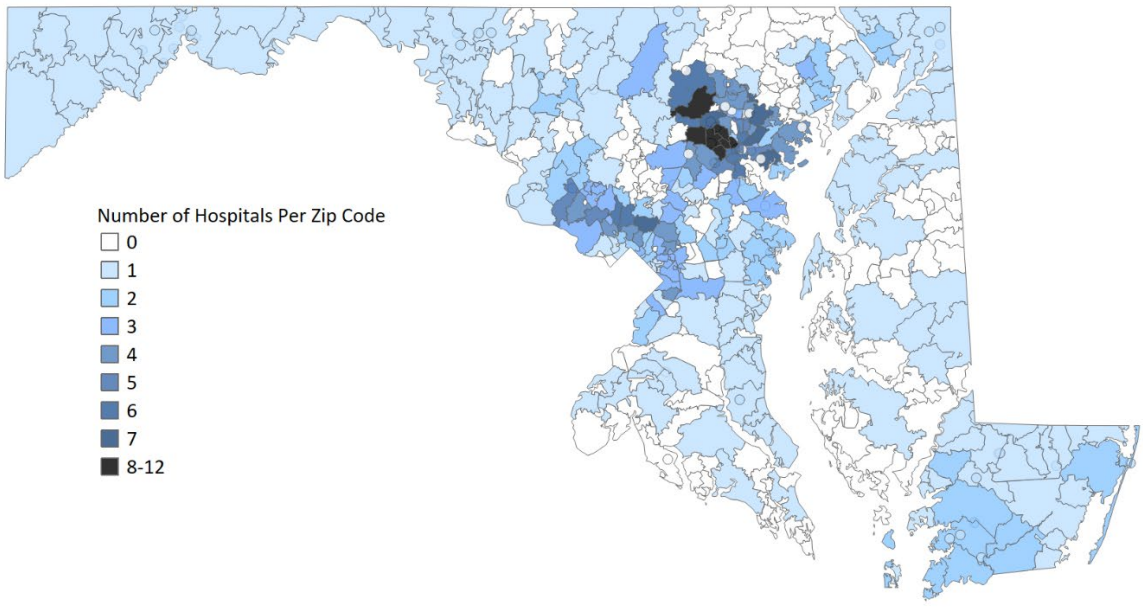
Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
Independent Hospitals					
Anne Arundel Medical Center	349	30,503	1.2	14.3	36.2
Atlantic General Hospital	40	3,084	1.7	12.0	67.0
Bon Secours Baltimore Health System	71	3,030	0.5	64.8	29.6
CalvertHealth Medical Center	73	5,942	0.9	20.3	46.4
Doctors Community Hospital	206	10,257	2.6	17.0	48.6
Fort Washington Medical Center	28	2,042	3.3	15.3	58.2
Frederick Memorial Hospital	269	18,136	2.7	8.2	39.3
Garrett Regional Medical Center	26	1,995	2.5	19.2	51.1
Greater Baltimore Medical Center	257	21,752	0.6	15.5	33.6
McCready Health	3	171	2.9	14.0	78.4
Mercy Medical Center	182	16,094	6.0	30.9	30.7
Meritus Medical Center	237	17,319	2.1	22.4	45.2
Peninsula Regional Medical Center	266	17,475	0.9	24.5	46.9
Saint Agnes Hospital	247	15,674	2.0	29.6	40.5
Sheppard Pratt Health System	414	7,941	2.5	42.8	14.1
Union Hospital of Cecil County	75	5,476	1.5	31.4	45.0
Western Maryland Regional Medical Center	191	11,928	1.5	19.0	54.5
Jointly Owned Hospitals					
Mt. Washington Pediatric Hospital	16	577	-	80.6	-
Adventist HealthCare					
Adventist Rehabilitation	87	1,884	0.4	7.3	61.0
Adventist Shady Grove Medical Ctr.	329	22,991	2.9	22.7	26.3
Washington Adventist Hospital	178	11,978	2.4	50.8	31.0
Holy Cross Health					
Holy Cross Germantown Hospital	70	6,212	3.3	24.1	35.1

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
Holy Cross Hospital	377	34,722	3.4	29.4	22.2
Johns Hopkins Medicine					
Howard County General Hospital	225	17,559	0.6	14.7	37.7
Johns Hopkins Bayview Medical Center	349	20,413	2.4	34.1	39.5
Suburban Hospital	228	13,454	2.0	9.8	57.5
The Johns Hopkins Hospital	1,095	44,617	0.5	28.6	28.0
Lifebridge Health					
Carroll Hospital	161	11,643	0.6	17.0	51.2
Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	100	1,287	0.9	1.9	91.1
Northwest Hospital	190	9,482	0.6	23.9	56.0
Sinai Hospital	347	18,006	0.4	29.9	41.7
MedStar Health					
Franklin Square Medical Center	338	22,527	1.0	31.6	43.3
Good Samaritan Hospital	143	8,470	1.2	21.7	62.3
Harbor Hospital	131	8,818	1.2	44.6	32.4
Montgomery Medical Center	104	6,668	0.8	17.9	52.1
Southern Maryland Hospital Ctr.	182	11,564	1.5	27.9	40.6
St. Mary's Hospital	93	7,485	1.5	22.6	37.8
Union Memorial Hospital	185	10,769	0.9	19.3	58.8
University of Maryland					
Baltimore Washington Medical Center	285	18,582	0.6	23.5	46.6
Charles Regional Medical Center	98	6,715	0.3	20.8	48.3
Laurel Regional Medical Center	43	1,681	6.1	27.1	44.9
University of Maryland Medical Center	806	27,790	0.4	37.2	32.7
UMMC Midtown Campus	100	4,376	0.7	49.2	39.4
Prince George's Hospital Center	254	12,488	5.3	41.2	33.1
UM Rehabilitation & Orthopaedic Institute	2	2,238	0.1	19.9	48.6
Shore Regional Health – Easton	97	7,549	0.7	27.6	49.1
Shore Regional Health – Dorchester	34	1,565	0.6	34.6	50.2
Shore Regional Health – Chester River	12	706	0.3	13.5	76.8
St. Joseph Medical Center	219	16,360	1.5	15.8	42.4
Upper Chesapeake Medical Center	159	12,223	0.3	15.2	46.1
Upper Chesapeake Harford Memorial	81	4,192	0.3	21.4	48.4
Total	**10,052**	**596,410**			

Primary Service Area

Each hospital has a primary service area (PSA), as defined in its global budget revenue (GBR) agreement.[13] Figure 1 displays a map of Maryland's ZIP codes. Each ZIP code has a color indicating how many hospitals claim that area in their PSAs.

Figure 1. Number of Hospitals Claiming the ZIP Code in Their PSAs, FY 2019



Community Benefit Service Area

The CBR also collects the ZIP codes included in each hospital's community benefit service area (CBSA). Each hospital defines its own CBSA and must disclose the methodology behind this definition in both their CBRs and federally mandated CHNAs.[14] Table 3 summarizes the methods reported by Maryland hospitals. The most common method was based on patterns of service utilization, such as percentages of hospital discharges and emergency department (ED) visits. In general, the other methods that hospitals reported were based on proximity to the facility, social determinants of health indicators, and the proportion of residents who were medically underserved or uninsured/underinsured. Eleven hospitals based their CBSAs on the PSAs described above. These definitions remained largely the same as those reported for FY 2018.

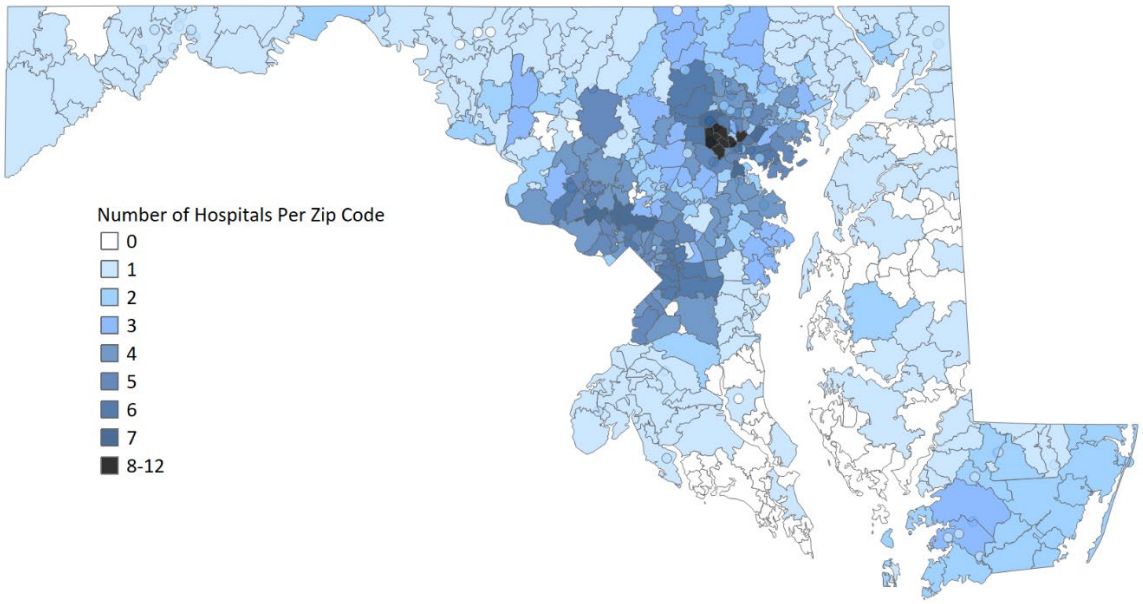
[13] The exception is the specialty hospitals that do not have GBRs. For these hospitals, the ZIP codes that account for 60 percent of discharges are reported.
[14] 26 CFR § 1.501(r)-3(b).

Table 3. Methods Used by Hospitals to Identify Their CBSAs, FY 2019

CBSA Identification Method	Number of Hospitals
Based on ZIP Codes in Financial Assistance Policy	7
Based on ZIP Codes in their PSA	11
Based on Patterns of Utilization	24
Other Method	27

Figure 2 displays the number of hospitals claiming each ZIP code in their CBSAs. A total of 89 ZIP codes—those that appear white on the map—are not a part of any hospital's CBSA. This is a slight increase over FY 2018, which identified 79 ZIP codes that were not covered. Six ZIP codes in Baltimore City/County—those that appear black on the map—are part of eight or more hospitals' CBSAs. Although hospital CBSAs and PSAs overlap to some degree, there are differences in the footprint of the CBSAs and PSAs. Please note that there is no requirement for CBSAs and PSAs to overlap. Please also note that hospitals may include out-of-state ZIP codes in their CBSA, but these are not displayed below.

Figure 2. Number of Hospitals Claiming the ZIP Code in Their CBSAs, FY 2019



Other Demographic Characteristics of Service Areas

Hospitals report details about the communities located in their CBSAs. Because most of the required measures in this section of the report are not available at the ZIP code level, they are reported at the county level. Table 4 displays examples of the county-level demographic measures required in the CBR. Because hospitals vary in their approaches to describing their service areas, the data in Table 4 were retrieved independently. See Appendix A for other community health data sources reported by hospitals.

The following measures were derived from the five-year (2014-2018) average estimates of the U.S. Census Bureau's American Community Survey: median household income, percentage of families below the federal poverty level (FPL), percentage uninsured, percentage with public health insurance, mean travel time to work, percentage that speak a language other than English at home, percentage by racial categories, and percentage by ethnicity categories. The life expectancy three-year average (2016-2018) and the crude death rate (2018) measures were derived from the Maryland Department of Health's Vital Statistics Administration.

Table 4. Community Statistics by County

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Maryland		**81,868**	**6.4**	**6.5**	**31.7**	**23.2**	**32.9**	**18.4**	**58.9**	**31.6**	**9.8**	**79.2**	**838.5**
Allegany	1	44,065	10.7	4.8	45.9	31.0	21.3	4.0	90.0	9.6	1.8	76.3	1223.0
Anne Arundel	7	97,810	4.0	4.7	27.9	16.7	30.7	11.1	76.7	18.5	7.5	79.2	805.0
Baltimore	12	74,127	6.0	5.6	32.5	24.2	29.6	14.4	63.7	29.9	5.3	78.1	1032.2
Baltimore City	17	48,840	16.6	7.2	45.5	43.0	31.0	9.6	32.3	64.1	5.1	72.8	1120.8
Calvert	1	104,301	3.0	4.2	27.6	15.7	41.7	4.5	85.0	14.2	3.8	79.3	734.8
Caroline	1	54,956	10.4	6.4	44.2	36.2	32.9	7.7	82.6	15.5	7.0	76.1	1074.9
Carroll	3	93,363	3.4	3.0	26.9	13.9	35.9	4.9	93.5	4.5	3.4	78.6	996.9
Cecil	2	72,845	6.5	4.5	35.5	25.8	29.6	5.3	90.5	8.2	4.3	76.3	980.3
Charles	1	95,924	4.7	3.6	27.6	20.0	44.4	7.5	49.6	48.6	5.6	78.5	712.1
Dorchester	1	52,145	11.9	5.5	50.4	40.6	27.0	5.9	68.7	30.0	5.3	75.9	1275.1
Frederick	4	91,999	4.4	4.8	26.2	16.2	35.2	13.7	84.0	11.1	9.2	80.1	734.2
Garrett	1	49,619	6.2	7.3	43.1	29.6	24.5	2.7	98.4	1.5	1.1	78.6	1196.7
Harford	2	85,942	5.3	3.7	29.4	17.9	31.8	7.3	81.5	15.2	4.4	78.8	887.9
Howard	4	117,730	3.9	4.0	22.6	14.3	31.3	25.5	61.3	20.7	6.7	83.3	549.5
Kent	1	56,009	7.7	5.4	45.1	25.8	26.4	6.0	83.3	16.0	4.3	78.9	1449.7
Montgomery	8	106,287	4.6	7.4	26.0	17.9	34.6	40.6	57.2	20.1	19.3	85.1	585.9
Prince George's	9	81,969	6.2	10.8	31.1	25.1	37.0	25.6	19.9	64.9	17.9	79.0	703.2
Queen Anne's	2	92,167	3.1	4.4	31.0	16.8	37.0	5.3	90.9	7.8	3.8	79.5	905.5
Saint Mary's	1	90,438	6.0	5.8	26.3	20.3	30.9	7.3	81.8	16.2	5.0	78.7	780.2
Somerset	3	42,165	15.9	6.8	46.5	34.6	24.8	9.0	54.6	43.6	3.5	75.2	1090.6
Talbot	2	67,204	6.7	4.8	43.6	23.1	28.1	7.4	85.7	13.6	6.5	81.4	1257.8

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Washington	1	59,719	9.5	6.2	40.6	29.5	29.7	7.2	85.9	13.1	4.8	77.1	1132.3
Wicomico	2	56,608	9.3	6.9	42.1	33.7	22.0	11.3	69.4	27.8	5.1	76.2	1011.7
Worcester	2	61,145	6.4	5.9	45.7	25.9	25.1	4.8	84.7	14.4	3.4	78.5	1252.3
Source	[15]	[16]	[17]	[18]	[19]	[20]	[21]	[22]	[23]	[24]	[25]	[26]	[27]

[15] As reported by hospitals in their FY 2019 Community Benefit Narrative Reports.
[16] American Community Survey 5-Year Estimates 2014 – 2018, Selected Economic Characteristics, Median Household Income (Dollars), https://data.census.gov/cedsci/.
[17] American Community Survey 5-Year Estimates 2014 – 2018, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families.
[18] American Community Survey 5-Year Estimates 2014 – 2018, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.
[19] American Community Survey 5-Year Estimates 2014 – 2018, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.
[20] American Community Survey 1-Year Estimate, 2018 (denominator) and The Hilltop Institute (numerator).
[21] American Community Survey 5-Year Estimates 2014 – 2018, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes).
[22] American Community Survey 5-Year Estimates 2014 – 2018, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.
[23] American Community Survey 5-Year Estimates 2014 – 2018, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population – White.
[24] American Community Survey 5-Year Estimates 2014 – 2018, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population – Black or African American.
[25] American Community Survey 5-Year Estimates 2014 – 2018, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race).
[26] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2018, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2016 – 2018.
[27] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2018, Table 39A. Crude Death Rates by Race, Hispanic Origin of Mother, Region, and Political Subdivision, Maryland, 2018.

Section II. Community Health Needs Assessment

Section II of the CBR narrative asks hospitals whether they conducted a CHNA, when they last conducted it, and whether they adopted an implementation strategy. All hospitals reported conducting CHNAs that conform to the IRS definition within the past three fiscal years, and all but one hospital reported adopting an implementation strategy.[28] See Appendix B for the dates in which hospitals conducted their last CHNAs. These dates ranged from October 2016 to October 2019.

This section also asks the hospitals to report on the internal and external participants involved in the CHNA process, including their corresponding roles. Just over half of all hospitals reported collaborating with other hospitals or community/neighborhood organizations to identify community health needs. More than half partnered with local health improvement collaboratives in data collection, prioritization, and resource linking. These distributions were similar to what was reported in FY 2018. Additionally, 41 hospitals worked with local health departments to identify community health needs, which is an increase over 38 hospitals in FY 2018. See Appendix C for more detail on the internal and external participants in development of the hospitals' CHNAs.

Section III. Community Benefit Administration

This section of the narrative CBR requires hospitals to report on the process of determining which needs in the community would be addressed through community benefit activities. Hospitals also must report on the internal and external participants involved in community benefit activities and their corresponding roles. Tables 5 and 6 present some highlights, and Appendix D provides full detail. Of note, nearly 90 percent of hospitals employed population health staff and staff dedicated to community benefit. Additionally, the majority of hospitals collaborated with local health departments to administer community benefit activities. Just over half of all hospitals worked with other hospitals and behavioral health organizations. These figures are very similar to what was reported in FY 2018.

Table 5. Number of Hospital Reporting Staff in the Following Categories

Staff Category	Number of Hospitals	% of Hospitals
Population Health Staff	42	89%
Community Benefit Staff	41	87%
CB/Pop Health Director	43	91%

Table 6. Number of Hospitals that Collaborated with Selected Types of External Organizations

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Organizations	13	28%
Local Health Departments	38	81%
Other Hospitals	27	57%
Behavioral Health Organizations	25	53%

[28] This hospital reported a delay due to change in ownership, but expected it to be complete prior to the publication of this report.

Internal Audit and Board Review

This part of the report addresses whether the hospital conducted an internal audit of the CBR financial spreadsheet and narrative. Table 7 shows that 45 out of 47 hospitals conducted an internal audit of the financial spreadsheet. Audits were most frequently performed by hospital or system staff. These figures were very similar to what was reported in FY 2018.

Table 7. Hospital Audits of CBR Financial Spreadsheet

	Number of Hospitals	
Audit Type	**Yes**	**No**
Hospital Staff	37	10
System Staff	28	19
Third-Party	9	38
No Audit	2	45
Two or More Audit Types	27	20
Three or More Audit Types	2	45

This section also addresses whether the hospital board reviews and approves the CBR spreadsheet and narrative. Table 8 shows that most hospital boards review and approve the CBR. Of the hospitals that reported that they did not submit their reports for board review, their rationale was largely related to timing issues or because the board had delegated this authority to executive staff. For example, several hospitals reported that their board meets only twice per year and did not have the opportunity to review before the report deadline. These responses were very similar to what was reported in FY 2018.

Table 8. Hospital Board Review of the CBR

	Number of Hospitals	
Board Review	**Yes**	**No**
Spreadsheet	40	7
Narrative	39	8

This section also asks if community benefit investments were incorporated into the major strategies of the Hospital Strategic Transformation Plan. Table 9 shows that nearly all hospitals indicated that community benefit investments were a part of their Strategic Transformation Plan.

Table 9. Community Benefit Investments in Hospital Strategic Transformation Plan

Community Benefit Investments in Strategic Transformation Plan	Number of Hospitals
Yes	46
No	1

Section IV. Hospital Community Benefit Program and Initiatives

The CBR asks hospitals to describe three, ongoing community benefit initiatives undertaken to address needs in the community. Additionally, hospitals must indicate whether the reported initiatives address a CHNA identified need. Table 10 summarizes the types of initiatives reported. Hospital community benefit initiatives are more likely to target chronic conditions than acute conditions. Of 141 total initiatives reported across all hospitals, 81 addressed the prevention of chronic conditions. Hospitals could report more than one category of intervention for each initiative. This distribution was similar to what was reported in FY 2018.

Table 10. Types of Community Benefit Initiatives

Category	Number of Hospitals with Intervention	Number of Interventions in Each Category	Percentage of Interventions that Fall within Category
Chronic condition-based intervention: treatment intervention	33	58	41%
Chronic condition-based intervention: prevention intervention	43	81	57%
Acute condition-based intervention: treatment intervention	28	43	30%
Acute condition-based intervention: prevention intervention	28	45	32%
Condition-agnostic treatment intervention	8	8	6%
Social determinants of health intervention	38	73	52%
Community engagement intervention	37	73	52%
Other	10	12	9%

Table 11 presents the types of evidence that hospitals used to evaluate the effectiveness of their community benefit initiatives. By far, the most common category of evidence used for this purpose was the count of participants, followed by surveys of participants. Hospitals could report more than one type of evaluative criteria for each initiative.

Table 11. Types of Evidence Used to Evaluate Effectiveness of Initiatives

Evaluation Criteria	Number of Interventions Using each Type of Evaluation Criteria	Percentage of Interventions that Use each Type of Evaluation Criteria
Count of Participants	130	92%
Other Process Measures	49	35%
Surveys of Participants	55	39%
Biophysical Health Indicators	42	30%
Assessment of Environmental Change	6	4%
Impact on Policy Change	4	3%
Effects on Healthcare Utilization or Cost	29	21%
Assessment of Workforce Development	4	3%
Other	21	15%

Table 12 summarizes the top ten community health needs addressed by these initiatives, as identified in the hospitals' CHNAs. Diabetes and educational/community-based programs were the top two community health needs. Hospitals could select multiple community health needs per initiative. In FY 2018, diabetes and heart disease were the top two community health needs.

Table 12. Community Health Needs Addressed by Selected Hospital Community Benefit Initiatives, FY 2019

Community Health Needs	Number of Hospitals	Number of Initiatives	Percentage of Initiatives
Educational and Community-Based Programs	32	62	44%
Diabetes	33	48	34%
Oral Health	33	46	33%
Health-Related Quality of Life & Well-Being	23	45	32%
Behavioral Health, including Mental Health and/or Substance Abuse	32	44	31%
Other Social Determinants of Health	26	42	30%
Nutrition and Weight Status	29	39	28%
Heart Disease and Stroke	30	37	26%
Physical Activity	21	26	18%
Older Adults	16	23	16%

The CBR also asks about community health needs identified through the CHNA process that were not addressed by the hospitals. Overall, 24 hospitals reported that one or more primary community health needs were not addressed, and 23 responded that all needs were addressed. At least one hospital identified environmental health and global health as community health needs,

but no hospital reported initiatives to address them. Some hospitals listed the following reasons for not addressing all of the needs identified in their CHNAs: lack of resources, lack of expertise, and the fact that other local organizations, hospitals, or partnerships were addressing the needs.

Community Benefit Operations/Activities Related to State Initiatives

Hospitals were asked how their community benefit operations/activities worked toward the state's initiatives for improvement in population health, as identified by the State Health Improvement Process (SHIP). The SHIP provides a framework for accountability, local action, and public engagement to advance the health of Maryland residents. In the context of the state's Total Cost of Care Model, hospitals are tasked with improving quality, including decreasing readmissions and hospital-acquired conditions. Of the 47 hospitals, 39 reported that their community benefit activities addressed at least one SHIP goal. Table 13 presents the number of hospitals that addressed at least one goal under each SHIP category. Because hospitals targeted their community benefit initiatives to address community health needs identified in their CHNAs, the SHIP goals selected tended to be those that were in alignment with hospital CHNAs.

Table 13. Number of Hospitals with CB Activities Addressing SHIP Goals, by Category, FY 2019

	Number of Hospitals in Alignment
Healthy Beginnings	24
Healthy Living	37
Healthy Communities	32
Access to Health Care	35
Quality Preventive Care	36

Section V. Physician Gaps in Availability

Maryland law requires hospitals to provide a written description of gaps in the availability of specialist providers to serve their uninsured populations.[29] Each hospital uses its own criteria to determine what constitutes a physician gap. Table 14 shows the gaps in availability that were identified by the hospitals and the number of hospitals that reported each gap. The most frequently reported gap was mental health (reported by 33 hospitals), followed by substance abuse and detoxification. Four hospitals reported no gaps this year, compared with three hospitals in FY 2018. See the mission-driven services section of the financial report summary for a related discussion.

[29] MD. CODE. ANN., Health-Gen. § 19-303(c)(2)(vi).

Table 14. Gaps in Availability

Physician Specialty Gap	Number of Hospitals
No Gaps	4
Mental Health	33
Substance Abuse/Detoxification	24
Obstetrics	18
Primary Care	17
Dental	17
Neurosurgery	17
General surgery	15
Internal medicine	14
Dermatology	11
Orthopedic Specialties	11
Otolaryngology (ENT)	10
Infectious Diseases	4
Oncology	4
Pulmonology	3
Vascular	3
Cardiology	3
Hematology	3
Laboratory	3
Urology	3
Rheumatology	2
Emergency Department	2
Medical Imaging	3
Allergy/Immunology	2
Gastroenterology	2
Outpatient Specialty Care	2
Anesthesiology	1
Physiatry	1
Critical Care	1
Nephrology	1
Ophthalmology	1
Other	3

Section VI. Financial Assistance Policies

Finally, the narrative section of the CBR requires hospitals to submit information about their financial assistance policies. Maryland law established the requirements for hospitals to provide free or reduced cost care as part of their financial assistance policies as follows:[30]

- State statute sets the family income threshold for free, medically necessary care at or below 150 percent of the FPL; however, the statute allows the HSCRC to create higher income thresholds through regulation.[31] HSCRC regulations require hospitals to provide free, medically necessary care to patients with family income at or below 200 percent of the FPL.[32] Sixteen hospitals reported a more generous threshold.
- Hospitals must provide reduced-cost, medically necessary care to patients with family income between 200 and 300 percent of the FPL.[33] Thirty-seven hospitals reported a more generous threshold.
- Hospitals must provide reduced-cost, medically necessary care to patients with family income below 500 percent of the FPL who have a financial hardship, which is referred to as the financial hardship policy.[34] In order to qualify as having a financial hardship, the medical debt incurred by a family over a 12-month period must exceed 25 percent of the family's income.[35] Sixteen hospitals reported a more generous threshold.

Staff noted variation among the hospitals in the content and format of their financial assistance policy documents.

[30] MD. CODE. ANN., Health-Gen. § 19-214.1; COMAR 10.37.10.26.
[31] MD. CODE. ANN., Health-Gen. § 19-214.1(b).
[32] COMAR 10.37.10.26(A-2)(2)(a)(i).
[33] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[34] COMAR 10.37.10.26(A-2)(3).
[35] COMAR 10.37.10.26(A-2)(1)(b)(i).

FINANCIAL REPORTS

The CBR financial reports collect information about staff hours, the number of encounters, and direct and indirect costs of community benefits, categorized by type of community benefit activity. The reporting period for these financial data is July 1, 2018, through June 30, 2019. Audited financial statements were used to calculate the cost of each of the community benefit categories contained in the data reports. Fifty hospitals submitted individual financial reports.

FY 2019 Financial Reporting Highlights

Table 15 presents a statewide summary of community benefit expenditures for FY 2019. Maryland hospitals provided roughly $1.89 billion in total community benefit activities in FY 2019—a total that is slightly higher than FY 2018 ($1.75 billion). The FY 2019 total includes: net community benefit expenses of $694 million in mission-driven health care services (subsidized health services), $593 million in health professions education, $325 million in charity care, $131 million in community health services, $56 million in Medicaid deficit assessment costs, $35 million in community building activities, $14 million in community benefit operations, $17 million in financial contributions, $14 million in research activities, and $6 million in foundation-funded community benefits. These totals include hospital-reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

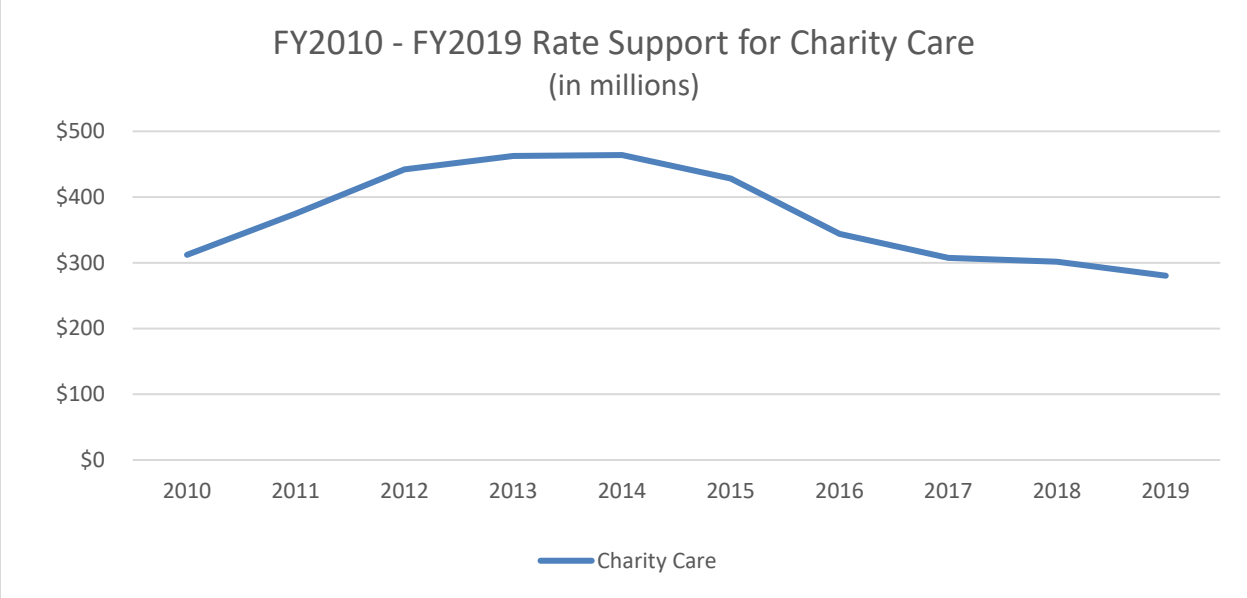
Table 15. Total Community Benefits, FY 2019

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	% of Total Community Benefit Expenditures	Net Community Benefit Expense Less: Rate Support	% of Total Community Benefit Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	0	0	$56,150,071	2.98%	$56,150,071	4.54%
Community Health Services	1,183,102	5,243,238	$130,955,559	6.94%	$130,955,559	10.59%
Health Professions Education	5,070,205	218,943	$593,043,188	31.45%	$223,436,234	18.08%
Mission Driven Health Services	4,504,892	1,725,502	$694,383,923	36.82%	$694,383,923	56.18%
Research	154,382	6,797	$13,862,885	0.74%	$13,862,885	1.12%
Financial Contributions	39,672	145,593	$17,382,089	0.92%	$17,382,089	1.41%
Community Building	316,287	1,485,222	$35,081,193	1.86%	$35,081,193	2.84%
Community Benefit Operations	110,988	127,267	$14,157,914	0.75%	$14,157,914	1.15%
Foundation	85,080	38,395	$5,526,523	0.29%	$5,526,523	0.45%
Charity Care	0	0	$325,409,261	17.25%	$45,088,720	3.65%
Total	**11,464,608**	**8,990,956**	**$1,885,952,606**	**100%**	**$1,236,025,111**	**100%**

In Maryland, the costs of uncompensated care (including charity care and bad debt) and graduate medical education are built into the rates for which hospitals are reimbursed by all payers. Additionally, the rates include amounts for nurse support programs provided at Maryland hospitals. These costs are essentially "passed through" to the payers of hospital care. To comply with IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting, the HSCRC requests that hospitals exclude from their reports all revenue that is included in rates as offsetting revenue on the CBR worksheet. Appendix E details the amounts that were included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2019.

As noted above, the HSCRC includes a provision in hospital rates for uncompensated care—which includes charity care—because it is considered a community benefit. It also includes bad debt, which is not considered a community benefit. Figure 3 shows the rate support for charity care from FY 2010 through FY 2019, which continuously increased from FY 2010 through FY 2014 and then has decreased each subsequent year due to implementation of the ACA. See Appendix F for more details on the charity care methodology.

Figure 3. Rate Support for Charity Care, FY 2010-FY 2019



Another social cost funded through Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (i.e., direct medical education, or DME), which include the residents' and interns' wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC's annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2019, DME costs totaled $353 million.

The HSCRC's Nurse Support Program I (NSP I) is aimed at addressing the short- and long-term nursing shortage affecting Maryland hospitals. In FY 2019, $17 million was provided in hospital rate adjustments for the NSPI. See Appendix E for detailed information about funding provided to specific hospitals.

When the reported community benefit costs for Maryland hospitals were offset by rate support, the net community benefits provided in FY 2019 totaled $1.2 billion, or 7.4 percent of total hospital operating expenses. This is an increase over the $1.1 billion in net benefits provided in FY 2018, which totaled 6.7 percent of hospital operating expenses.

Table 16 presents staff hours, the number of encounters, and expenditures for health professional education by activity. As with prior years, the education of physicians and medical students made up the majority of expenses, totaling $517.7 million. The second highest category was the education of nurses and nursing students, totaling $36.9 million. The education of other health professionals totaled $27.8 million.

Table 16. Health Professions Education Activities and Costs, FY 2019

Health Professions Education	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Physicians and Medical Students	3,959,000	111,902	$517,697,946
Nurses and Nursing Students	580,454	58,327	$36,857,574
Other Health Professionals	441,501	40,148	$27,813,478
Scholarships and Funding for Professional Education	5,400	345	$5,280,149
Other	83,851	8,221	$5,394,041
Total	**5,070,205**	**218,943**	**$593,043,188**

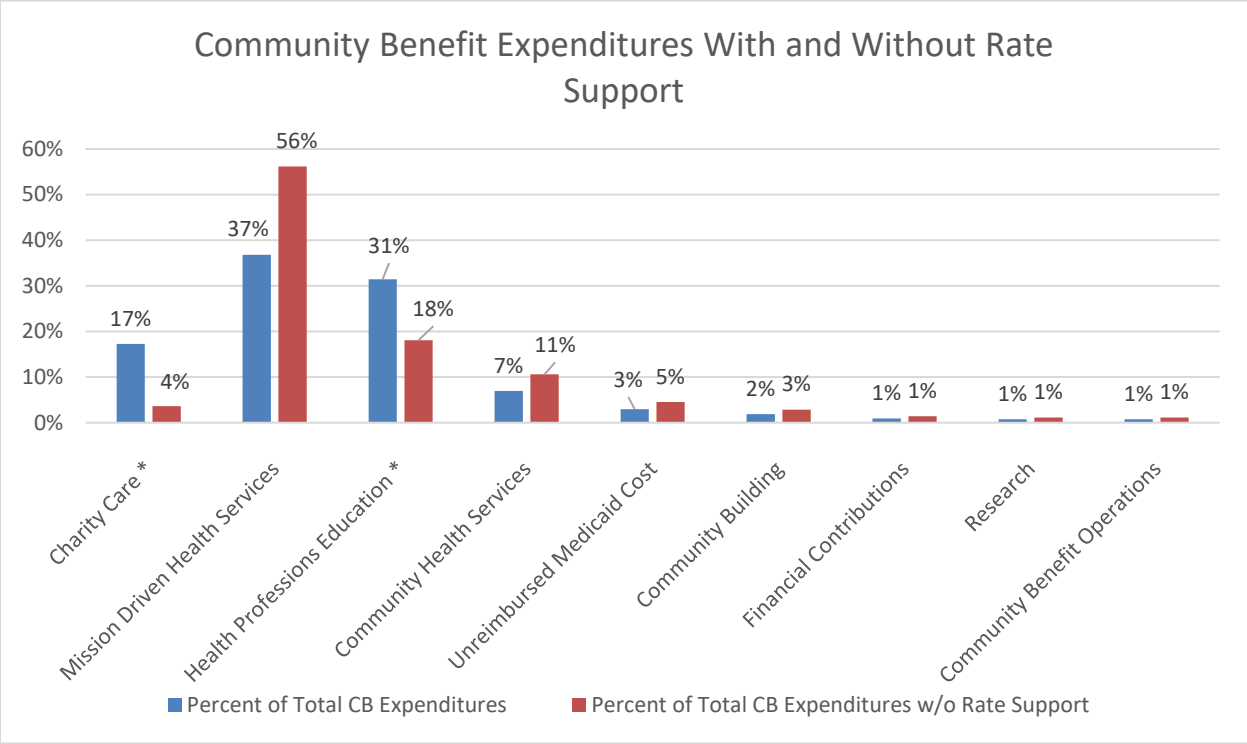
Table 17 presents staff hours, the number of encounters, and expenditures for community health services by activity. As with prior years, health care support services comprised the largest portion of expenses in the category of community health services, totaling $59.1 million. Community health education was the second highest category, totaling $24.5 million, and community-based clinical services were the third highest, totaling $16.1 million. For additional detail, see Appendix G.

Table 17. Community Health Services Activities and Costs, FY 2019

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Health Care Support Services	439,858	399,264	$59,089,585
Community Health Education	248,441	3,708,945	$24,451,873
Community-Based Clinical Services	290,400	551,554	$16,105,508
Free Clinics	4,670	44,919	$6,335,006
Screenings	52,937	236,739	$5,134,026
Support Groups	17,932	38,509	$3,653,670
Mobile Units	34,662	12,883	$1,009,498
Self-Help	16,684	111,704	$999,626
One-Time/Occasionally Held Clinics	1,255	7,199	$286,352
Other	76,263	131,522	$13,890,416
Total	**1,183,102**	**5,243,238**	**$130,955,559**

Accounting for rate support significantly affects the distribution of expenses by category. Figure 4 shows expenditures for each community benefit category as a percentage of total expenditures. Mission-driven health services, health professions education, and charity care represented the majority of the expenses, at 37 percent, 31 percent, and 17 percent, respectively. Figure 4 also shows the percentage of expenditures by category without rate support, which changed the distribution: mission-driven health services remained the category with the highest percentage of expenditures, at 56 percent. Health professions education followed, with 18 percent of expenditures, and community health services accounted for 11 percent of expenditures.

Figure 4. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2019



Appendix H compares hospitals in terms of the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support) or as revenue from billable services, and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2019, 2,220 staff hours were dedicated to community benefit operations, nearly identical to FY 2018. Three hospitals reported zero staff hours dedicated to community benefit operations, which is the same as FY 2018. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

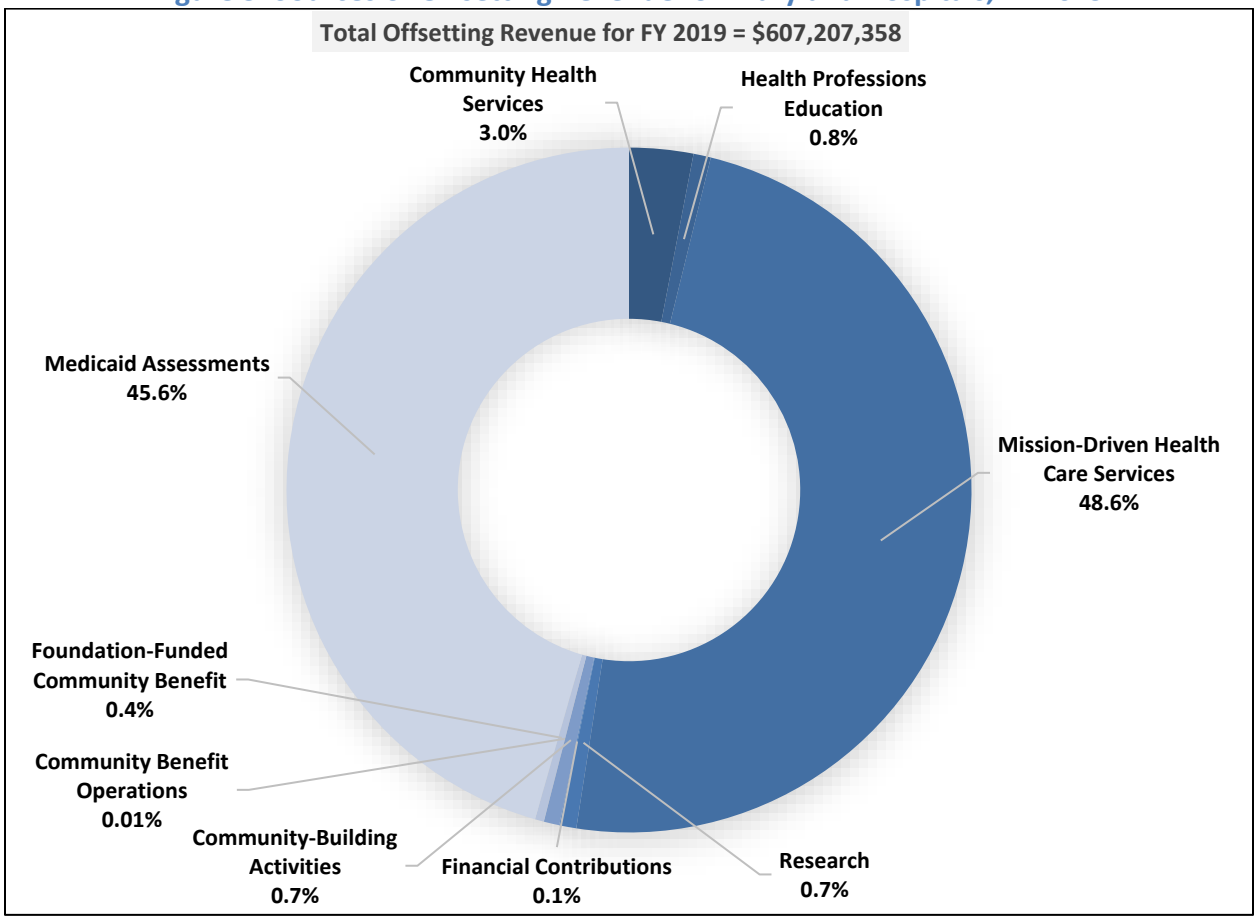
The total amount of net community benefit expenditures without rate support as a percentage of total operating expenses ranged from 1.41 percent to 31.09 percent, with an average of 8.37 percent, which was slightly higher than in FY 2018. Twelve hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with ten hospitals in FY 2018.

Mission-Driven Services and Offsetting Revenue

The instructions for the financial report require hospitals to report offsetting revenue for their community benefit activities, which is defined as any revenue generated by the activity or program, such as payment for services provided to program patients, restricted grants, or contributions used to provide a community benefit. Figure 5 presents the total FY 2019 offsetting revenue by community benefit category. The largest components of offsetting revenue were mission-driven health care services (48.6 percent) and the Medicaid deficit assessment (45.6 percent). Other categories had minimal offsetting revenue. Please note that the Medicaid deficit

assessment is a broad-based uniform assessment to hospital rates that is set by the Maryland General Assembly. The hospitals pay this assessment, but a portion of it is reimbursed back to the hospital through all-payer rates, which is then reported as offsetting revenue. Therefore, the offsetting revenue reported for the Medicaid deficit assessment is different from the offsetting revenue reported for other community benefit categories.

Figure 5. Sources of Offsetting Revenue for Maryland Hospitals, FY 2019



Excluding the Medicaid deficit assessment, mission-driven health services accounted for the majority of offsetting revenues. By definition, mission-driven services are intended to be services provided to the community that are not expected to result in revenue. Rather, hospitals undertake these services as a direct result of their community or mission driven initiatives, or because the services would otherwise not be provided in the community. Table 18 presents offsetting revenue for mission-driven services by hospital. The hospitals are sorted in increasing order of the proportion of reported expenditures offset by revenue. Thirteen hospitals did not report any offsetting revenue from mission-driven health services. Seven hospitals reported offsetting revenue for 50 percent or more of their mission-driven expenditures.

Table 18. Mission-Driven Health Services Expenditure and Offsetting Revenue among Maryland Hospitals, FY 2019

Hospital Name	Total Expenditures	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Net Community Benefit
Garrett Regional Medical Center	$0	$0	-	$0
Doctors Community Hospital	$0	$0	-	$0
Adventist Healthcare Rehabilitation	$384,729	$0	0.0%	$384,729
Bon Secours	$641,966	$0	0.0%	$641,966
Holy Cross Germantown	$2,271,830	$0	0.0%	$2,271,830
MedStar Southern Maryland Hospital	$7,661,991	$0	0.0%	$7,661,991
UM Charles Regional Medical Center	$9,008,627	$0	0.0%	$9,008,627
Carroll Hospital	$10,773,016	$0	0.0%	$10,773,016
Atlantic General Hospital	$12,360,092	$0	0.0%	$12,360,092
Howard County General Hospital	$14,029,918	$0	0.0%	$14,029,918
Washington Adventist	$20,377,404	$0	0.0%	$20,377,404
UM Medical Center Midtown Campus	$27,833,254	$0	0.0%	$27,833,254
UM Shore Regional Health Easton	$29,410,274	$0	0.0%	$29,410,273
Frederick Memorial Hospital	$17,631,302	$13,578	0.1%	$17,617,724
UM Shore Regional Health Dorchester	$10,290,617	$21,340	0.2%	$10,269,277
UM St. Joseph Medical Center	$35,017,956	$122,192	0.3%	$34,895,763
Levindale Hospital	$583,042	$9,575	1.6%	$573,467
McCready Foundation Hospital	$54,048	$985	1.8%	$53,063
Anne Arundel Medical Center	$32,552,406	$621,864	1.9%	$31,930,542
Shady Grove Medical Center	$17,307,110	$367,631	2.1%	$16,939,479
Mercy Hospital	$19,573,600	$474,354	2.4%	$19,099,245
UM Baltimore Washington Medical Center	$12,716,343	$356,993	2.8%	$12,359,350
Johns Hopkins	$21,885,460	$781,979	3.6%	$21,103,481
Holy Cross Hospital	$8,179,303	$414,597	5.1%	$7,764,706
Suburban Hospital	$14,211,709	$878,351	6.2%	$13,333,358
UM Shore Regional Health Chester River	$16,797,522	$1,315,111	7.8%	$15,482,412
Sinai Hospital	$24,555,318	$2,550,364	10.4%	$22,004,953
Johns Hopkins Bayview	$7,148,599	$999,212	14.0%	$6,149,387
Sheppard Pratt Health System	$14,324,285	$2,054,107	14.3%	$12,270,178
Fort Washington Medical Center	$1,601,566	$229,823	14.3%	$1,371,743
MedStar St. Mary's Hospital	$10,002,821	$1,597,641	16.0%	$8,405,180
UM Upper Chesapeake Medical Center	$8,463,140	$1,545,370	18.3%	$6,917,770
Prince George's Hospital	$55,311,304	$10,163,000	18.4%	$45,148,304
UM Harford Memorial	$3,523,259	$662,302	18.8%	$2,860,957
Calvert Memorial Hospital	$16,009,134	$4,088,406	25.5%	$11,920,728

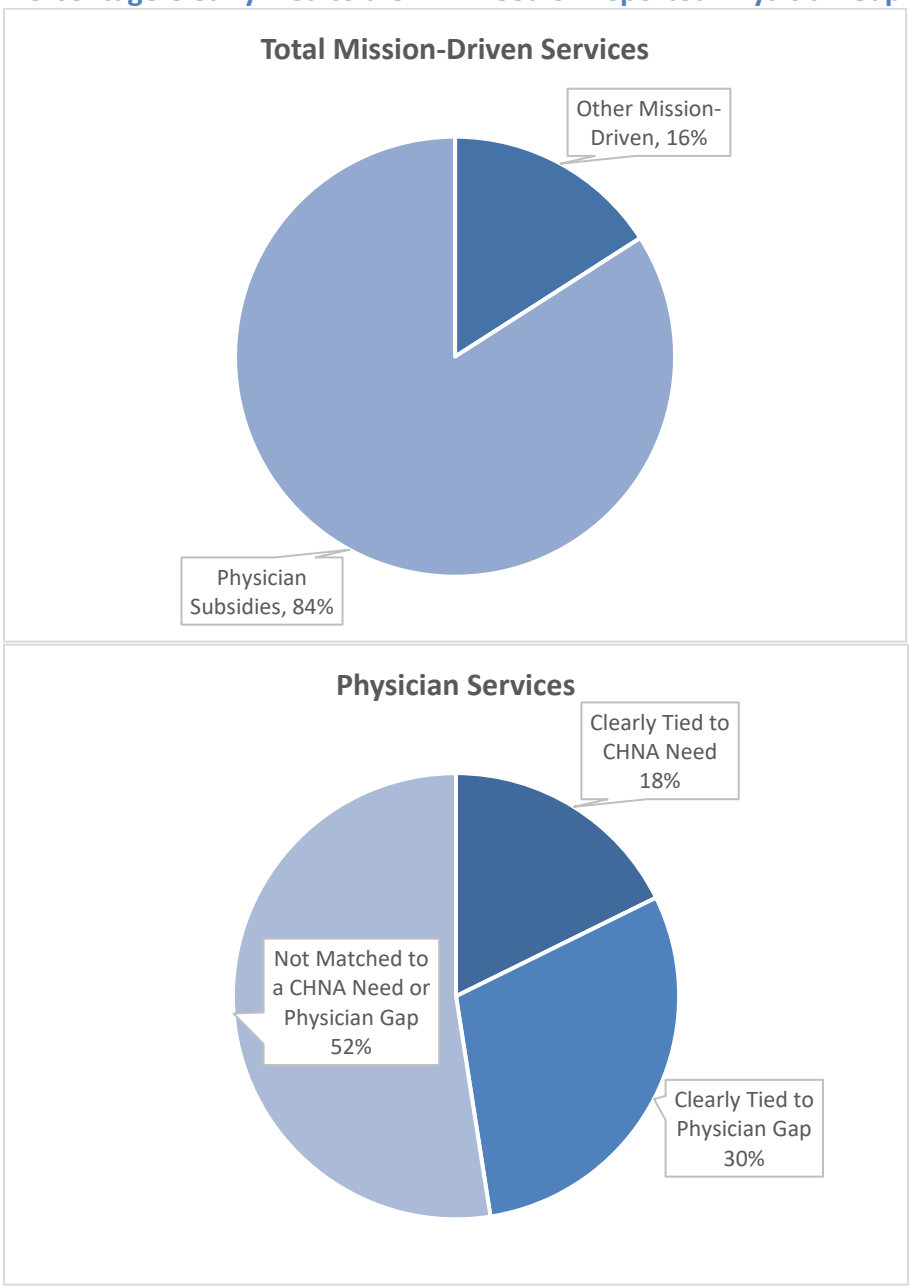
Hospital Name	Total Expenditures	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Net Community Benefit
Northwest Hospital Center	$9,855,460	$3,245,642	32.9%	$6,609,818
Mt. Washington Pediatric Hospital	$1,009,686	$366,769	36.3%	$642,917
UM Rehabilitation & Orthopedic Institute	$2,738,847	$1,023,000	37.4%	$1,715,847
University of Maryland Medical Center	$27,444,460	$11,152,099	40.6%	$16,292,361
Peninsula Regional Medical Center	$76,579,288	$31,257,311	40.8%	$45,321,974
St Agnes Hospital	$29,167,134	$13,478,581	46.2%	$15,688,553
Union Hospital of Cecil County	$17,813,720	$8,528,297	47.9%	$9,285,422
Western Maryland Health System	$86,004,384	$42,166,524	49.0%	$43,837,861
Meritus Medical Center	$71,508,912	$37,888,262	53.0%	$33,620,648
MedStar Harbor Hospital	$15,604,819	$8,490,296	54.4%	$7,114,523
MedStar Good Samaritan	$4,622,764	$2,837,593	61.4%	$1,785,171
MedStar Union Memorial Hospital	$6,449,568	$4,025,030	62.4%	$2,424,538
MedStar Franklin Square	$35,186,768	$22,193,568	63.1%	$12,993,200
Greater Baltimore Medical Center	$112,683,096	$71,382,500	63.3%	$41,300,598
MedStar Montgomery Medical Center	$10,426,219	$7,899,893	75.8%	$2,526,326
Total	**$989,588,064**	**$295,204,140**	**29.8%**	**$694,383,923**

One category of mission-driven services is physician subsidies. Hospitals that reported physician subsidies as a community benefit category are required to further explain why the services would not otherwise be available to meet patient demand. Physician subsidy categories include the following:

- Hospital-based physicians with whom the hospital has an exclusive contract
- Non-resident house staff and hospitalists
- Coverage of ED call
- Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies
- Physician recruitment to meet community need
- Other subsidies

New to this year's report, staff attempted to analyze the physician subsidies reported on hospitals' financial reports and to link these subsidies with needs identified on the hospitals' CHNAs and the gaps in physician availability described in Section V above. Due to varying levels of detail and some ambiguous responses provided by the hospitals in this area, please consider the data in Figure 6 as preliminary. Staff intend to update the report instructions to better collect this information in subsequent years. Staff classified 84 percent of mission-driven service costs as physician subsidies. Within these subsidies, staff were able to link about half of these costs to a CHNA need or reported physician gap.

Figure 6. Preliminary Percentage of Mission-Driven Expenditures for Physician Subsidies and Percentage Clearly Tied to a CHNA Need or Reported Physician Gap



FY 2004 – FY 2019 16-Year Summary

FY 2019 marks the 16th year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9 percent of hospitals' operating expenses. In FY 2019, these expenses represented roughly $1.89 billion, or 11.2 percent of operating expenses. As Maryland hospitals increasingly focused on implementing cost-reduction and quality

improvement strategies, an increasing percentage of operating expenses were directed toward community benefit initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CBR in FY 2004. For consistency purposes, the following figures illustrate community benefit expenses from FY 2010 through FY 2019. Figures 7 and 8 show the trend of community benefit expenses with and without rate support. On average, approximately 50 percent of expenses were reimbursed through the rate-setting system, though that figure fell below 40 percent in FY 2018.

Figure 7. FY 2010 – FY 2019 Community Benefit Expenses with and without Rate Support

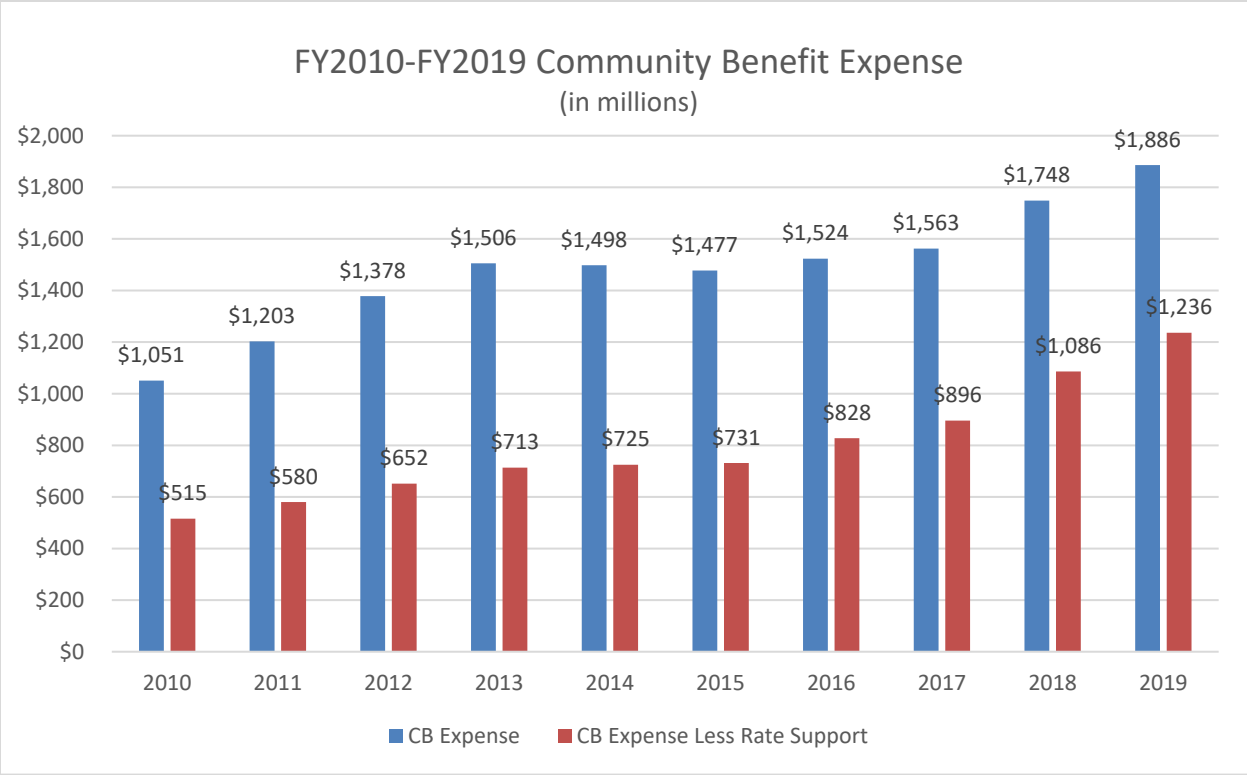
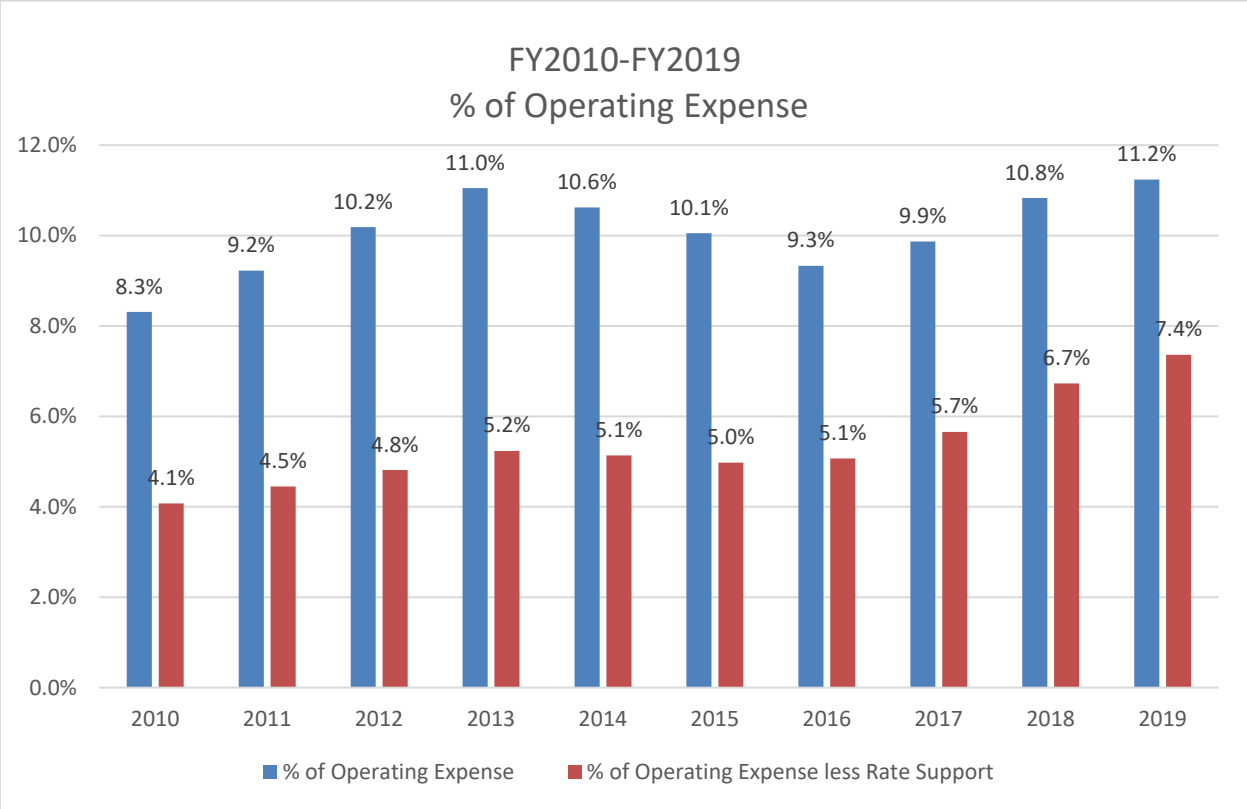


Figure 8. FY 2010 – FY 2019 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



CONCLUSION

In summary, all 50 Maryland hospitals submitted FY 2019 CBRs, showing a total of $1.9 billion in community benefit expenditures, which is a slight increase over FY 2018 ($1.7 billion). The distribution of expenditures across community benefit categories remained similar to prior years, with mission-driven services accounting for the majority of expenditures. Expenditures as a percentage of operating expenses also slightly increased from FY 2018 (6.7 percent) to FY 2019 (7.4 percent).

The narrative portion of the CBR provides the HSCRC with richer detail on hospital community benefit and CHNA activities beyond what is included in the financial report. The hospitals continued to be very responsive to using the new reporting tool, and all hospitals successfully submitted their reports online. Encouraging findings of the review include a senior-level commitment to community benefit activities and community engagement. For example, 91 percent of hospitals employed a population health director, and most reported that these staff members were involved in selecting the community health needs to target and in developing community benefit initiatives. Eighty-seven percent of hospitals employ staff dedicated to community benefit. Community benefit initiatives frequently targeted diabetes treatment/prevention, which is consistent with needs identified in hospital CHNAs and the goals of the state's new Diabetes Action Plan.

The review also identified the following areas for improvement:

- Most, but not all, hospitals reported working with their local health department during the CHNA process. All hospitals are encouraged to include the local health departments in this process. Hospitals are also encouraged to improve visibility and reporting on CHNA activities.
- Staff noted variation in the format and content of the hospitals' financial assistance policy documents. Standardization of these documents could provide greater clarity for consumers.
- Only 13 hospitals reported collaborating with post-acute facilities in their community benefit initiatives. Greater collaboration with such facilities may help the state to achieve the new goals within the Total Cost of Care Model, which emphasizes collaboration with community-based providers to address population needs.
- Inconsistencies and ambiguity in reporting on physician subsidies makes it difficult to tie these expenditures to needs specifically identified in the CHNA or gaps in physician availability. Revisions to the reporting instructions will allow for more precise analyses in subsequent years.

With the passage of Senate Bill 774 during the 2020 legislative session, the HSCRC staff will work with stakeholders in the coming months to address these improvement areas, as well as the changes outlined in the bill. Corresponding changes will be made to next year's reporting tool.

APPENDIX A. COMMUNITY HEALTH MEASURES REPORTED BY HOSPITALS

In addition to the measures reported in Table 4 of the main body of this report, hospitals reported using a number of other sources of community health data, including the following:

- 2017 Cigarette Restitution Fund Program's Cancer in Maryland Report
- Baltimore City Comptroller's Office
- Baltimore City Health Department
- Baltimore City Housing Department
- Baltimore City Liquor Board
- Baltimore City Planning Department
- Baltimore City Public Schools System
- Baltimore City Real Property Management Database
- CDC National Center for Health Statistics
- CDC Chronic Disease Calculator
- CDC Community Health Status Indicators
- Center for a Livable Future
- Conduent - Healthy Communities Institute
- County Health Rankings
- Chesapeake Regional Information System for our Patients
- Healthy People 2020
- HRSA - Health Professional Shortage Areas
- Injuries in Maryland Report
- Johns Hopkins Bloomberg School of Public Health - Healthy Food Priorities Map
- Local Health Departments' Community Health Statistics
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Department of Planning
- Maryland Department of the Environment
- Maryland Physician Workforce Study
- Maryland Report Card
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- Mayor's Office of Information Technology
- Truven/IBM Market Expert
- U.S. Census Bureau - American Community Survey
- University of Maryland School of Public Health

APPENDIX B. CHNA SCHEDULES

Hospital	Date Most Recent CHNA was Completed
Holy Cross Germantown	Oct-16
Holy Cross Hospital	Oct-16
Garrett Regional Medical Center	Nov-16
Western Maryland Health System	Jun-17
CalvertHealth	Nov-17
McCready Health	Dec-17
Lifebridge Levindale	Mar-18
Lifebridge Northwest	Mar-18
Lifebridge Sinai	Mar-18
Carroll Hospital Center	May-18
Johns Hopkins Bayview Medical Center	May-18
UM Upper Chesapeake	May-18
UM Rehab & Ortho	May-18
Mt Washington Pediatric Hospital	Jun-18
UMMC Midtown	Jun-18
University of Maryland Medical Center	Jun-18
Mercy Medical Center	Jun-18
Saint Agnes Hospital	Jun-18
The Johns Hopkins Hospital	Jun-18
MedStar Franklin Square	Jun-18
MedStar Good Samaritan	Jun-18
MedStar Harbor Hospital	Jun-18
MedStar Montgomery Medical Center	Jun-18
MedStar Southern Maryland	Jun-18
MedStar Union Memorial	Jun-18
MedStar St Mary's	Jun-18
UM Charles Regional	Jun-18
Anne Arundel Medical Center	Feb-19
Doctors Community Hospital	Apr-19
Frederick Memorial Hospital	May-19
Meritus Medical Center	May-19
Sheppard Pratt Health System	May-19
Atlantic General	May-19
Fort Washington Medical Center	May-19
UM Shore Regional Health	May-19
Greater Baltimore Medical Center	Jun-19

Hospital	Date Most Recent CHNA was Completed
UM Capitol Region	Jun-19
Peninsula Regional Medical Center	Jun-19
UM BWMC	Jun-19
Suburban Hospital	Jun-19
UM St Joseph Medical Center	Jun-19
Union Hospital of Cecil County	Jun-19
Howard County General Hospital	Jun-19
Bon Secours	Jul-19
Adventist Rehab	Oct-19
Adventist Shady Grove	Oct-19
Washington Adventist Hospital	Oct-19

*Data Source: As reported by hospitals on their FY 2019 CBRs and edited according to hospital websites

APPENDIX C. CHNA INTERNAL AND EXTERNAL PARTICIPANTS AND THEIR ROLES

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
Internal Participants										
CB/ Community Health/Population Health Director (facility level)	4	11	32	31	29	29	33	31	19	5
CB/ Community Health/ Population Health Director (system level)	10	11	17	23	22	20	23	23	17	4
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	1	32	31	19	14	32	23	2	9
Senior Executives (CEO, CFO, VP, etc.) (system level)	6	7	12	24	17	4	21	10	1	6
Board of Directors or Board Committee (facility level)	7	3	17	15	14	4	24	15	3	12
Board of Directors or Board Committee (system level)	13	8	6	10	14	1	11	6	1	8
Clinical Leadership (facility level)	2	0	31	25	27	18	39	33	8	2
Clinical Leadership (system level)	17	8	15	15	15	4	19	14	5	0
Population Health Staff (facility level)	3	10	28	24	21	23	33	33	20	1
Population Health Staff (system level)	14	10	14	19	15	14	20	16	12	3
Community Benefit staff (facility level)	0	13	31	31	31	29	32	30	25	1
Community Benefit staff (system level)	8	12	17	19	23	16	18	17	12	5
Physician(s)	8	0	23	18	17	16	34	27	4	1
Nurse(s)	8	0	25	23	19	20	34	32	10	1
Social Workers	10	1	20	16	14	17	31	30	7	1
Community Benefit Task Force	7	11	18	22	17	22	26	24	9	7
Hospital Advisory Board	6	22	11	12	12	6	17	16	3	1
Other (specify)	4	0	2	1	4	8	6	5	3	1

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
External Participants										
Other Hospitals	17		13	21	17	24	25	19	13	3
Local Health Department	0		25	32	33	42	41	40	36	6
Local Health Improvement Coalition	12		17	19	20	26	30	29	17	1
Maryland Department of Health	20		4	3	6	7	5	7	20	4
Maryland Department of Human Resources	43		0	0	0	1	0	0	3	0
Maryland Department of Natural Resources	46		0	0	0	0	0	0	1	0
Maryland Department of the Environment	41		0	0	0	1	1	0	6	0
Maryland Department of Transportation	39		1	0	0	1	1	1	7	0
Maryland Department of Education	38		1	0	0	1	0	1	8	0
Area Agency on Aging	15		5	7	6	15	19	19	12	1
Local Govt. Organizations	19		9	10	10	13	21	20	7	0
Faith-Based Organizations	9		7	5	1	19	27	27	3	0
School - K-12	15		6	6	9	15	22	23	15	3
School - Colleges and/or Universities	20		7	8	13	16	22	22	11	3
School of Public Health	33		1	2	5	10	10	7	7	3
School - Medical School	40		0	2	1	4	5	5	4	0
School - Nursing School	35		0	3	3	6	8	7	3	0
School - Dental School	45		0	0	0	0	0	2	0	0
School - Pharmacy School	45		0	0	0	0	1	2	0	0
Behavioral Health Organizations	15		12	12	10	13	28	27	7	0
Social Service Organizations	17		8	9	9	17	27	26	5	0
Post-Acute Care Facilities	35		1	1	1	5	7	9	3	1

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
Community/Neighborhood Organizations	17		8	8	4	15	26	24	5	1
Consumer/Public Advocacy Organizations	20		8	7	5	17	23	23	6	0
Other	8		6	5	8	20	26	22	7	3

APPENDIX D. COMMUNITY BENEFIT INTERNAL AND EXTERNAL PARTICIPANTS AND THEIR ROLES

	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing Funding for CB Activities	Allocating budgets for individual initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other (explain)
Internal Participants										
CB/ Community Health/Population Health Director (facility level)	3	10	33	32	33	25	29	31	31	3
CB/ Community Health/ Population Health Director (system level)	12	9	25	24	24	10	16	17	20	1
Senior Executives (CEO, CFO, VP, etc.) (facility level)	3	1	32	35	23	33	33	10	21	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	9	9	23	22	18	14	15	5	13	1
Board of Directors or Board Committee (facility level)	9	3	22	18	13	5	3	2	13	7
Board of Directors or Board Committee (system level)	19	9	14	11	6	0	1	0	3	1
Clinical Leadership (facility level)	4	0	32	29	26	9	14	31	28	1
Clinical Leadership (system level)	20	9	13	13	9	4	6	8	10	0
Population Health Staff (facility level)	1	10	29	27	27	10	14	29	29	0
Population Health Staff (system level)	17	9	15	17	17	6	11	16	17	0
Community Benefit staff (facility level)	4	14	25	25	22	11	12	24	27	2
Community Benefit staff (system level)	9	16	14	14	17	3	4	14	17	1
Physician(s)	6	0	28	26	18	2	3	33	16	3
Nurse(s)	6	0	25	24	19	6	6	38	18	1
Social Workers	14	1	19	19	14	3	3	32	16	0
Community Benefit Task Force	8	12	22	21	20	4	4	11	21	3
Hospital Advisory Board	16	19	9	8	5	2	3	3	6	2
Other (specify)	5	1	2	3	3	1	1	4	3	0
External Participants										

	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing Funding for CB Activities	Allocating budgets for individual initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other (explain)
Other Hospitals	19		16	14	18	10	11	21	18	4
Local Health Department	9		22	17	25	18	7	30	25	5
Local Health Improvement Coalition	14		24	14	16	1	2	13	16	2
Maryland Department of Health	33		4	4	4	5	1	5	5	0
Maryland Department of Human Resources	46		0	0	0	0	0	0	0	0
Maryland Department of Natural Resources	46		0	0	0	0	0	0	0	0
Maryland Department of the Environment	45		0	0	0	0	0	0	0	1
Maryland Department of Transportation	44		1	1	0	0	0	1	0	1
Maryland Department of Education	42		1	2	0	1	0	1	0	1
Area Agency on Aging	21		11	8	12	6	3	16	14	3
Local Govt. Organizations	18		8	8	3	4	2	18	7	3
Faith-Based Organizations	13		17	7	3	0	0	22	6	6
School - K-12	15		12	9	6	2	1	22	11	5
School - Colleges and/or Universities	26		7	5	4	0	0	14	5	4
School of Public Health	37		3	3	4	1	0	7	5	0
School - Medical School	37		3	1	3	3	1	7	4	1
School - Nursing School	30		4	2	4	1	0	12	4	2
School - Dental School	44		0	0	0	0	0	2	0	0
School - Pharmacy School	42		1	1	1	0	0	3	1	1
Behavioral Health Organizations	21		13	9	8	2	2	22	10	2
Social Service Organizations	20		10	13	6	5	1	20	11	2
Post-Acute Care Facilities	33		5	1	3	0	0	9	3	2
Community/Neighborhood Organizations	19		14	10	9	4	1	23	12	2
Consumer/Public Advocacy Organizations	30		6	5	3	2	0	14	10	1
Other	9		9	10	5	5	1	14	12	3

APPENDIX E. FY 2019 FUNDING FOR NURSE SUPPORT PROGRAM I, DIRECT MEDICAL EDUCATION, AND CHARITY CARE

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
Adventist Rehab of Maryland	0	59,478	0	59,478
Adventist Shady Grove Hospital	66,671	401,328	4,995,875	5,463,874
Adventist Washington Adventist	0	271,148	5,728,796	5,999,944
Anne Arundel Medical Center	1,295,673	601,775	4,691,160	6,588,607
Atlantic General	0	107,265	2,550,944	2,658,209
Bon Secours	0	109,890	495,978	605,868
Calvert Hospital	0	149,192	4,318,080	4,467,272
Carroll Hospital Center	0	235,036	289,902	524,938
Doctors Community	0	232,582	5,568,577	5,801,159
Fort Washington Medical Center	0	48,728	915,508	964,236
Frederick Memorial	0	346,113	6,317,028	6,663,141
Garrett County Hospital	0	55,258	2,837,753	2,893,011
GBMC	7,731,237	462,643	1,526,879	9,720,759
Holy Cross Germantown Hospital	0	96,340	4,391,043	4,487,383
Holy Cross Hospital	0	504,633	22,228,197	22,732,830
Howard County Hospital	0	303,037	4,307,426	4,610,463
Johns Hopkins Bayview Medical Center	25,126,324	645,220	16,653,222	42,424,765
Johns Hopkins Hospital	119,235,430	2,352,719	27,205,236	148,793,385
Lifebridge Levindale	0	59,432	0	59,432
Lifebridge Northwest Hospital	0	258,801	1,828,064	2,086,865
LifeBridge Sinai	17,345,063	769,857	4,914,751	23,029,670
McCready	0	16,897	352,315	369,212
MedStar Franklin Square	8,779,317	518,002	10,912,749	20,210,067
MedStar Good Samaritan	4,725,287	297,578	5,531,743	10,554,608
MedStar Harbor Hospital	3,866,851	193,638	4,986,576	9,047,065
MedStar Montgomery General	0	178,461	2,424,194	2,602,655
MedStar Southern Maryland	0	270,323	4,938,308	5,208,631
MedStar St. Mary's Hospital	0	190,011	3,969,758	4,159,769
MedStar Union Memorial	13,134,515	434,442	8,806,075	22,375,032
Mercy Medical Center	5,222,206	524,091	14,645,515	20,391,812
Meritus Medical Center	0	325,953	4,081,165	4,407,118
Mt. Washington Pediatrics	0	59,447	0	59,447
Peninsula Regional	0	437,069	10,845,207	11,282,277
Sheppard Pratt	2,692,100	150,869	0	2,842,969

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
St. Agnes	8,822,979	431,097	17,628,511	26,882,587
Suburban Hospital	598,256	310,897	4,356,540	5,265,693
UM Baltimore Washington	650,488	416,534	5,595,369	6,662,391
UM Capital Region	4,654,172	394,015	11,319,765	16,367,952
UM Charles Regional Medical Center	0	148,862	936,410	1,085,272
UM Harford Memorial	0	105,315	1,600,565	1,705,879
UM Midtown	4,875,719	239,136	4,202,058	9,316,913
UM Rehabilitation and Ortho Institute	4,059,878	124,287	0	4,184,165
UM Shore Medical Chestertown	0	59,207	364,502	423,709
UM Shore Medical Dorchester	0	49,851	402,745	452,596
UM Shore Medical Easton	0	203,068	1,966,084	2,169,152
UM St. Joseph	$0	408,177	8,350,882	8,759,059
UM Upper Chesapeake	0	408,177	8,350,882	8,759,059
UMMC & Shock Trauma	119,732,582	1,603,188	16,640,790	137,976,560
Union Hospital of Cecil County	0	160,871	1,505,630	1,666,501
Western Maryland Health System	0	329,029	8,739,580	9,068,609
Total	**$352,614,747**	**$16,992,206**	**$280,320,541**	**$649,927,494**

APPENDIX F. CHARITY CARE METHODOLOGY

The purpose of this appendix is to explain why the charity care amounts reported by hospitals in their community benefit reports may not match the charity care amounts applied in their global budgets for the same year. The charity care amounts in rates are part of the HSCRC's uncompensated care (UCC) policy, which is a prospective policy applied at the beginning of the rate year. In contrast, the amounts reported by hospitals in their community benefit report retrospective.

The HSCRC applies the following procedures to calculate the charity care dollar amount to subtract from total dollars provided by hospitals in the statewide Community Benefit Report.

Step 1

Determine the amount of uncompensated care that was projected for each hospital for the fiscal year being reported (in this case, the FY 2019 Community Benefit Report) based on the policy approved by the Commission for the beginning of the rate year (also FY 2019).

- The HSCRC uses a logistic regression to predict actual hospital uncompensated care costs in a given year (FY 2019).
- The uncompensated care logistic regression model predicts a patient's likelihood of having UCC based on payer type, the location of service (i.e., inpatient, ED, and other outpatient), and the Area Deprivation Index.[36]
    - An expected UCC dollar amount is calculated for every patient encounter.
    - These UCC dollars are then summarized at the hospital level.
    - These summarized UCC dollars are then divided by the hospital's total charges to estimate the hospital's UCC level.
- The hospital's most current fiscal year financially audited UCC levels (FY 2019) are averaged with the hospital's estimated UCC levels from the prior FY (FY18) to determine hospital-specific adjustments. These are predicted amounts provided to hospitals to fund the next year's UCC.

Step 2

Retrospectively, determine the actual ratio of charity care to total UCC from the hospital's audited financial statements to determine the rate of charity expense to apply to the predicted UCC amount from the rate year 2019 policy. The resulting charity care amount is the estimated amount provided in rates that will be subtracted from the hospital's community benefit.

[36] The Area Deprivation Index represents a geographic area-based measure of the socioeconomic deprivation experienced by a neighborhood.

Example Johns Hopkins Hospital:

Predicted Value from FY 2016 Estimated UCC Levels 3.60%

FY 2017 Audited Financial UCC Level 2.25%

Predicted 50/50 Average 3.02%

Split between Bad Debt and Charity Care Amounts – FY 2017 Audited Financials

Regulated Gross Patient Revenue	Regulated Total UCC	Regulated Bad Debt	Regulated Charity	Bad Debt	Charity Chare
$2,352,718,900	$61,819,012	$40,121,239	$21,697,773	64.90%	35.10%

Estimate amount of UCC $ provided in rates at the beginning of FY 2017:

FY17 Regulated Gross Patient Revenue ($2,352,718,900) * 3.02% (3.02192482223646%) = $ 71,097,396

Estimate of Charity $ provided in rates at the beginning of FY 2017:
35.10% (35.0988673193289%) * $71,097,396 = $24,954,381.

APPENDIX G. FY 2018 COMMUNITY BENEFIT ANALYSIS

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense ($)	Total Community Benefit Expense ($)	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI* ($)	Net CB minus Charity Care, DME, NSPI in Rates ($)	Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care ($)
Adventist Rehab*	573	700	48,735,998	2,850,174	5.85%	59,478	2,790,696	5.73%	298,167
Anne Arundel	4,926	1,368	557,932,000	53,331,203	9.56%	6,588,607	46,742,596	8.38%	4,024,300
Atlantic General	925	102	134,838,095	16,647,351	12.35%	2,658,209	13,989,142	10.37%	2,388,460
Bon Secours	566	17,073	114,971,612	24,681,805	21.47%	605,868	24,075,936	20.94%	491,056
Calvert Hospital	1,150	172	135,516,353	19,718,889	14.55%	4,467,272	15,251,617	11.25%	4,881,836
Carroll Hospital Center	1,745	2,080	203,344,125	17,107,868	8.41%	524,938	16,582,930	8.16%	376,223
Doctors Community	1,609	4,112	200,232,626	14,223,843	7.10%	5,801,159	8,422,684	4.21%	8,425,301
Fort Washington	410	232	44,440,761	2,857,941	6.43%	964,236	1,893,705	4.26%	1,042,403
Frederick Memorial	2,247	361	340,006,000	29,876,984	8.79%	6,663,141	23,213,842	6.83%	7,002,000
Garrett County Hospital	449	42	49,273,773	3,844,371	7.80%	2,893,011	951,360	1.93%	2,924,970
GBMC	0	4,520	524,072,000	52,326,649	9.98%	9,720,759	42,605,890	8.13%	1,264,000
Holy Cross	2,875	6,349	437,129,013	49,023,796	11.21%	22,732,830	26,290,966	6.01%	31,098,161
Holy Cross Germantown	681	354	108,725,994	7,674,729	7.06%	4,487,383	3,187,346	2.93%	4,282,298
Howard County General	1,658	2,913	266,793,000	27,852,189	10.44%	4,610,463	23,241,726	8.71%	5,237,664
Johns Hopkins	0	6,651	2,476,117,000	277,233,977	11.20%	148,793,385	128,440,593	5.19%	25,938,000
Johns Hopkins Bayview	3,479	3,387	652,464,000	87,565,399	13.42%	42,424,765	45,140,634	6.92%	19,238,000
Lifebridge Levindale	860	182	77,338,000	2,393,573	3.09%	59,432	2,334,141	3.02%	1,142,100
Lifebridge Northwest	1,690	1,048	246,006,000	13,611,438	5.53%	2,086,865	11,524,573	4.68%	1,936,100
LifeBridge Sinai	5,109	3,325	784,881,000	64,320,383	8.19%	23,029,670	41,290,713	5.26%	5,247,000
McCready	263	0	17,725,100	619,069	3.49%	369,212	249,857	1.41%	378,616
MedStar Franklin Square	3,045	2,733	538,458,852	44,603,346	8.28%	20,210,067	24,393,278	4.53%	10,276,998

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense ($)	Total Community Benefit Expense ($)	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI* ($)	Net CB minus Charity Care, DME, NSPI in Rates ($)	Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care ($)
MedStar Good Samaritan	1,710	1,520	261,186,698	21,291,048	8.15%	10,554,608	10,736,440	4.11%	6,085,945
MedStar Harbor	1,161	2,080	190,590,189	23,048,579	12.09%	9,047,065	14,001,514	7.35%	5,016,378
MedStar Montgomery General	1,111	0	164,980,014	6,636,813	4.02%	2,602,655	4,034,158	2.45%	2,495,104
MedStar Southern Maryland	1,169	41	247,304,491	16,665,330	6.74%	5,208,631	11,456,699	4.63%	5,863,574
MedStar St. Mary's	1,200	6,240	160,019,685	17,045,901	10.65%	4,159,769	12,886,132	8.05%	4,627,204
MedStar Union Memorial	2,113	20	447,659,408	37,771,783	8.44%	22,375,032	15,396,751	3.44%	7,793,317
Mercy Medical Center	3,551	2,619	493,862,600	69,422,978	14.06%	20,391,812	49,031,165	9.93%	18,604,182
Meritus Medical Center	2,718	140	402,886,829	41,440,328	10.29%	4,407,118	37,033,210	9.19%	4,286,507
Mt. Washington Pediatrics	667	2,232	62,496,501	2,281,040	3.65%	59,447	2,221,593	3.55%	101,000
Peninsula Regional	2,774	445	451,254,859	65,491,801	14.51%	11,282,277	54,209,524	12.01%	10,436,200
Shady Grove*	3,037	5,600	388,910,383	35,994,402	9.26%	5,463,874	30,530,528	7.85%	5,786,233
Sheppard Pratt	2,800	728	239,576,824	23,283,055	9.72%	2,842,969	20,440,086	8.53%	5,435,243
St. Agnes	2,491	0	448,522,000	52,747,629	11.76%	26,882,587	25,865,043	5.77%	23,179,252
Suburban Hospital	1,786	2,174	300,567,000	28,999,485	9.65%	5,265,693	23,733,792	7.90%	4,484,000
UM Baltimore Washington	3,200	4,789	384,744,000	23,463,182	6.10%	6,662,391	16,800,791	4.37%	6,285,000
UM Capital Region	2,500	4,848	350,398,857	62,958,758	17.97%	16,367,952	46,590,806	13.30%	11,417,000
UM Charles Regional	0	394	124,218,000	11,355,994	9.14%	1,085,272	10,270,722	8.27%	966,929
UM Harford Memorial	1,022	992	89,425,000	7,476,206	8.36%	1,705,879	5,770,326	6.45%	1,862,000
UM Medical Center	9,010	2,853	1,639,396,000	235,150,570	14.34%	137,976,560	97,174,010	5.93%	23,193,000
UM Midtown	1,412	832	228,130,000	40,856,366	17.91%	9,316,913	31,539,452	13.83%	3,819,000
UM Rehab and Ortho	660	750	109,077,000	12,615,071	11.57%	4,184,165	8,430,906	7.73%	1,668,000

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense ($)	Total Community Benefit Expense ($)	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI* ($)	Net CB minus Charity Care, DME, NSPI in Rates ($)	Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care ($)
UM Shore Chestertown	185	1,460	51,275,000	16,362,810	31.91%	423,709	15,939,101	31.09%	464,000
UM Shore Dorchester	269	2,160	40,190,863	11,260,927	28.02%	452,596	10,808,331	26.89%	446,565
UM Shore Easton	1,316	2,000	210,627,325	34,690,481	16.47%	2,169,152	32,521,329	15.44%	2,265,611
UM St. Joseph	2,631	249	335,424,000	47,999,642	14.31%	8,759,059	39,240,583	11.70%	8,081,000
UM Upper Chesapeake	2,285	2,314	251,520,000	17,409,231	6.92%	3,794,504	13,614,727	5.41%	4,041,000
Union Hospital of Cecil County	1,200	2,082	162,448,177	12,135,655	7.47%	1,666,501	10,469,154	6.44%	1,836,442
Washington Adventist*	1,600	3,463	252,683,556	36,707,214	14.53%	5,999,944	30,707,270	12.15%	6,114,949
Western Maryland	2,268	260	330,368,433	61,025,350	18.47%	9,068,609	51,956,741	15.73%	10,860,972
All Hospitals	**91,394**	**110,988**	**$16,778,744,994**	**$1,885,952,606**	**11.24%**	**$649,927,494**	**$1,236,025,112**	**7.37%**	**$325,409,261**

* The Adventist Hospital System requested and received permission to report its community benefit activities on a calendar year basis to more accurately reflect true activities during the community benefit cycle. The numbers listed in the "Total in Rates for Charity Care, DME, and NSPI*" column reflect the HSCRC's activities for FY 2018 and therefore are different from the numbers reported by the Adventist Hospitals.

APPENDIX H. FY 2018 HOSPITAL COMMUNITY BENEFIT AGGREGATE DATA

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Unreimbursed Medicaid Costs								
T99	**Medicaid Assessments**	-	-	**$332,893,374**	**$-**	**$276,743,303**	**$56,150,071**	**$56,150,071**
Community Health Services								
A10	Community Health Education	248,441	3,708,945	16,356,775	9,543,010	1,447,912	24,451,873	14,908,863
A11	Support Groups	17,932	38,509	2,236,524	1,480,611	63,465	3,653,670	2,173,059
A12	Self-Help	16,684	111,704	836,509	500,527	337,410	999,626	499,099
A20	Community-Based Clinical Services	290,400	551,554	13,480,074	12,005,591	9,380,157	16,105,508	4,099,917
A21	Screenings	52,937	236,739	3,739,939	2,026,600	632,513	5,134,026	3,107,425
A22	One-Time/Occasionally Held Clinics	1,255	7,199	211,750	75,153	551	286,352	211,199
A23	Free Clinics	4,670	44,919	5,597,868	1,032,509	295,372	6,335,006	5,302,497
A24	Mobile Units	34,662	12,883	1,702,254	811,287	1,504,044	1,009,498	198,210
A30	Health Care Support Services	439,858	399,264	42,109,853	21,228,159	4,248,427	59,089,585	37,861,426
A40	Other	76,263	131,522	9,736,321	4,588,564	434,469	13,890,416	9,301,852
A99	**Total**	**1,183,102**	**5,243,238**	**$96,007,867**	**$53,292,012**	**$18,344,320**	**$130,955,559**	**$77,663,547**
Health Professions Education								
B1	Physicians/Medical Students	3,959,000	111,902	353,723,300	166,950,878	2,976,232	517,697,946	350,747,068
B2	Nurses/Nursing Students	580,454	58,327	26,337,735	10,521,247	1,409	36,857,574	26,336,326
B3	Other Health Professionals	441,501	40,148	19,178,695	8,913,122	278,338	27,813,478	18,900,357
B4	Scholarships/Funding for Professional Education	5,400	345	3,505,285	1,797,673	22,809	5,280,149	3,482,476
B50	Other	83,851	8,221	4,431,396	2,660,363	1,697,717	5,394,041	2,733,678
B99	**Total**	**5,070,205**	**218,943**	**$407,176,411**	**$190,843,283**	**$4,976,506**	**$593,043,188**	**$402,199,905**
Mission-Driven Health Services								
	Mission-Driven Health Services Total	**4,504,892**	**1,725,502**	**$860,187,564**	**$129,400,500**	**$295,204,140**	**$694,383,923**	**$564,983,424**
Research								
D1	Clinical Research	95,598	2,001	10,874,407	2,686,096	4,343,038	9,217,464	6,531,368

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
D2	Community Health Research	36,965	4,796	2,353,248	836,129	204,339	2,985,038	2,148,909
D3	Other	21,819	0	1,376,381	284,001	0	1,660,383	1,376,381
D99	**Total**	**154,382**	**6,797**	**$14,604,036**	**$3,806,226**	**$4,547,377**	**$13,862,885**	**$10,056,659**
	Financial Contributions							
E1	Cash Donations	954	4,059	11,207,502	290,040	86,105	11,411,437	11,121,397
E2	Grants	4,065	3,816	332,615	26,253	33,746	325,122	298,869
E3	In-Kind Donations	33,976	137,708	3,917,299	537,756	231,970	4,223,086	3,685,329
E4	Cost of Fund Raising for Community Programs	677	10	1,256,940	165,504	0	1,422,444	1,256,940
E99	**Total**	**39,672**	**145,593**	**$16,714,357**	**$1,019,553**	**$351,821**	**$17,382,089**	**$16,362,536**
	Community-Building Activities							
F1	Physical Improvements/Housing	19,890	11,339	6,268,893	5,260,455	2,871,258	8,658,090	3,397,635
F2	Economic Development	12,988	5,382	1,461,206	571,107	255,892	1,776,421	1,205,315
F3	Support System Enhancements	137,591	13,041	5,844,636	3,441,249	808,407	8,477,478	5,036,229
F4	Environmental Improvements	15,184	13,316	721,978	384,539	11,113	1,095,404	710,865
F5	Leadership Development/Training for Community Members	8,780	788	316,834	219,644	0	536,478	316,834
F6	Coalition Building	26,605	159,973	3,124,031	1,813,310	141,975	4,795,365	2,982,056
F7	Community Health Improvement Advocacy	8,519	1,005,200	1,949,604	1,123,456	3,400	3,069,660	1,946,204
F8	Workforce Enhancement	73,935	96,242	3,971,568	2,581,141	359,243	6,193,466	3,612,325
F9	Other	12,795	179,941	331,587	154,806	7,565	478,829	324,022
	Total	**316,287**	**1,485,222**	**$23,990,338**	**$15,549,707**	**$4,458,852**	**$35,081,193**	**$19,531,486**
	Community Benefit Operations							
G1	Dedicated Staff	89,408	27,076	6,522,402	4,393,597	54,159	10,861,840	6,468,243
G2	Community health/health assets assessments	15,800	100,191	959,608	569,930	18,091	1,511,447	941,517
G3	Other Resources	5,780	0	1,181,023	604,974	1,370	1,784,627	1,179,653
G99	**Total**	**110,988**	**127,267**	**$8,663,033**	**$5,568,500**	**$73,620**	**$14,157,914**	**$8,589,414**

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Charity Care								
	Total Charity Care	**$325,409,261**						
Foundation-Funded Community Benefits								
J1	Community Services	7,691	6,689	609,753	191,296	75,102	725,947	534,651
J2	Community Building	77,389	31,706	3,850,469	3,371,993	2,432,316	4,790,146	1,418,153
J3	Other	0	0	10,430	0	0	10,430	10,430
J99	**Total**	**85,080**	**38,395**	**$4,470,652**	**$3,563,289**	**$2,507,418**	**$5,526,523**	**$1,963,234**
Total Hospital Community Benefits								
A	Community Health Services	1,183,102	5,243,238	$96,007,867	$53,292,012	$18,344,320	$130,955,559	$77,663,547
B	Health Professions Education	5,070,205	218,943	$407,176,411	$190,843,283	$4,976,506	$593,043,188	$402,199,905
C	Mission Driven Health Care Services	4,504,892	1,725,502	$860,187,564	$129,400,500	$295,204,140	$694,383,923	$564,983,424
D	Research	154,382	6,797	$14,604,036	$3,806,226	$4,547,377	$13,862,885	$10,056,659
E	Financial Contributions	39,672	145,593	$16,714,357	$1,019,553	$351,821	$17,382,089	$16,362,536
F	Community Building Activities	316,287	1,485,222	$23,990,338	$15,549,707	$4,458,852	$35,081,193	$19,531,485
G	Community Benefit Operations	110,988	127,267	$8,663,033	$5,568,500	$73,620	$14,157,914	$8,589,414
H	Charity Care	0	0	$325,409,261	$ -	$ -	$325,409,261	$325,409,261
J	Foundation Funded Community Benefit	85,080	38,395	$4,470,652	$3,563,289	$2,507,418	$5,526,523	$1,963,234
T99	Medicaid Assessments	0	0	$332,893,374	$ -	$276,743,303	$56,150,071	$56,150,071
K99	**Total Hospital Community Benefit**	**11,464,608**	**8,990,956**	**$2,090,116,893**	**$403,043,071**	**$607,207,358**	**$1,885,952,606**	**$1,482,909,535**

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
	Total Operating Expenses	**$16,778,744,994**						
	% Operating Expenses w/ Indirect Costs	**11.24%**						
	% Operating Expenses w/ o Indirect Costs	**8.84%**						