maryland
health services
cost review commission

Maryland Hospital Community Benefit Report: FY 2020

December 8, 2021

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

maryland
health services
cost review commission

Table of Contents

maryland
health services
cost review commission

List of Abbreviations

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
LHIC	Local Health Improvement Collaboratives
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 a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.[1] Examples of community benefit activities can include the following:

- Community health services
- Health professional education
- Research
- Financial contributions
- Community–building activity, including partnerships with community–based organizations
- Charity care
- Mission-driven health services

In 2001, the Maryland General Assembly passed House Bill 15,[2] which required the Maryland Health Services Cost Review Commission (HSCRC or Commission) 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.

In 2020, the Maryland General Assembly passed HB 1169/SB 774 which required the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments (CHNAs).[4] This bill required the HSCRC to establish a Community Benefit Reporting Workgroup and adopt regulations recommended by the Workgroup regarding community benefit reporting. The bill also modified the definition of community benefit and expanded the list of items that hospitals must include in their CBRs.

[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
[4] S. 774, 2020 Leg., 441st Sess. (Md. 2020).

This summary report provides background information on hospital community benefits and the history of CBRs in Maryland, summarizes the community benefit narrative and financial reports for fiscal year (FY) 2020, and concludes with a summary of data reports from the past 10 years.

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.[5] 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.[6] However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the "charitable" standard to focus on "community benefits" rather than "charity care."[7] 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 qualify for tax-exemption.

The Affordable Care Act (ACA) created additional requirements for hospitals to maintain tax-exempt status. Every §501(c)(3) hospital—whether independent or part of a hospital system—must conduct a CHNA at least once every three years to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[8] 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.[9] 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.[10] 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.

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

Maryland Requirements

The Maryland General Assembly adopted the Maryland CBR process in 2001,[11] 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
- A list of the hospital's activities to address the identified community health needs
- The costs of each community benefit activity
- A description of how each of the listed activities addresses the community health needs of the hospital's community
- A description of efforts taken to evaluate the effectiveness of each community benefit activity
- A description of gaps in the availability of providers to serve the community
- A description of the hospital's efforts to track and reduce health disparities in the community
- A list of the unmet community health needs identified in the most recent community health needs assessment
- A list of tax exemptions the hospital claimed during the immediately preceding taxable year[12]

This FY 2020 report represents the HSCRC's 17th year of reporting on Maryland hospital community benefit data.

Updates to Maryland's Reporting Instructions

In response to HB 1169/SB 774 passed during the 2020 legislative session, the HSCRC made changes to reporting instructions. Among other items, hospitals will be required to:

1. Report all initiatives that tie to the CHNA
2. Within the financial report, separately itemize all physician subsidies claimed by type and specialty
3. List the types of tax exemptions claimed
4. Self-assess the level of community engagement in the CHNA process

Understanding that hospitals needed enough lead time to implement these changes, items 1 and 4 above were made optional for FY 2021 reporting, but will be mandatory for FY 2022.

[11] MD. CODE. ANN., Health-Gen. § 19-303.
[12] MD. CODE. ANN., Health-Gen. § 19-303(c)(4).

Narrative Reports

This section of the document summarizes the findings of the FY 2020 narrative reports by major report section.

Hospitals Submitting Reports

The HSCRC received 47 CBR narratives from all 50 hospitals in FY 2020. This is because 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. Table 1 summarizes the hospitals submitting CBRs by hospital system.

Table 1. Maryland Hospitals that Submitted CBRs in FY 2020, by System

Adventist HealthCare	**Luminis Health**
Adventist HealthCare Fort Washington Medical Center	Anne Arundel Medical Center
Adventist HealthCare Rehabilitation	Doctors Community Hospital
Adventist HealthCare Shady Grove Medical Center	**MedStar Health**
Adventist HealthCare White Oak Medical Center	MedStar Franklin Square Medical Center
Ascension	MedStar Good Samaritan Hospital
Saint Agnes Hospital	MedStar Harbor Hospital
Christiana Care Health Services, Inc.	MedStar Montgomery Medical Center
Christiana Care, Union Hospital	MedStar Southern Maryland Hospital Center
Independent Hospitals	MedStar St. Mary's Hospital
Atlantic General Hospital	MedStar Union Memorial Hospital
CalvertHealth Medical Center	**TidalHealth**
Frederick Health Hospital	TidalHealth McCready Pavilion
Greater Baltimore Medical Center	TidalHealth Peninsula Regional
Mercy Medical Center	**Trinity Health**
Meritus Medical Center	Holy Cross Germantown Hospital
Sheppard Pratt	Holy Cross Hospital
Johns Hopkins Heath System	**University of Maryland Medical System**
Howard County General Hospital	UM Baltimore Washington Medical Center
Johns Hopkins Bayview Medical Center	UM Capital Region Health
Suburban Hospital	UM Charles Regional Medical Center
The Johns Hopkins Hospital	UM Rehabilitation & Orthopaedic Institute
Jointly Owned Hospitals	UM Shore Regional Health
Mt. Washington Pediatric Hospital*	UM St. Joseph Medical Center
LifeBridge Health	UM Upper Chesapeake Health
Carroll Hospital Center	UMMC Midtown Campus
Grace Medical Center	University of Maryland Medical Center
Levindale Hebrew Geriatric Center and Hospital	**UPMC**
Northwest Hospital Center, Inc.	UPMC Western Maryland
Sinai Hospital of Baltimore, Inc.	**WVU Medical System**
	Garrett Regional Medical Center

*Mt. Washington Pediatric is jointly owned by the University of Maryland Medical System and Johns Hopkins

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 (Table 2). Overall, there were 10,052 beds and 545,514 inpatient admissions. The percentage of admissions by insurance status ranged from 0.3 to 8.4 percent for charity care/self-pay, 2.5 to 80.1 percent for Medicaid, and 14.0 to 90.8 percent for Medicare-among hospitals accepting Medicare clients. These percentages were largely similar to those for FY 2019.

Table 2. Hospital Bed Designation, Inpatient Admissions, and Patient Insurance Status, FY 2020

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
Adventist HealthCare					
Adventist HealthCare Fort Washington Medical Center	28	1,538	4.4	13.9	54.1
Adventist HealthCare Rehabilitation	87	316	0.6	13.9	53.8
Adventist HealthCare Shady Grove Medical Center	329	22,248	4.4	21.9	25.5
Adventist HealthCare White Oak Medical Center	178	11,096	1.6	48.3	34.8
Ascension					
Saint Agnes Hospital	247	13,327	2.2	30.8	43.6
Christiana Care Health Services, Inc.					
Christiana Care, Union Hospital	75	4,846	1.7	32.5	43.6
Independent Hospitals					
Atlantic General Hospital	40	2,652	1.7	9.6	68.1
CalvertHealth Medical Center	73	6,128	0.8	19.0	45.1
Frederick Health Hospital	269	16,669	2.3	9.7	38.7
Greater Baltimore Medical Center	257	19,988	0.8	16.3	31.7
Mercy Medical Center	182	14,470	5.8	33.2	28.5
Meritus Medical Center	237	15,813	2.4	23.2	44.4
Sheppard Pratt	414	7,357	2.7	22.8	14.0
Johns Hopkins Health System					

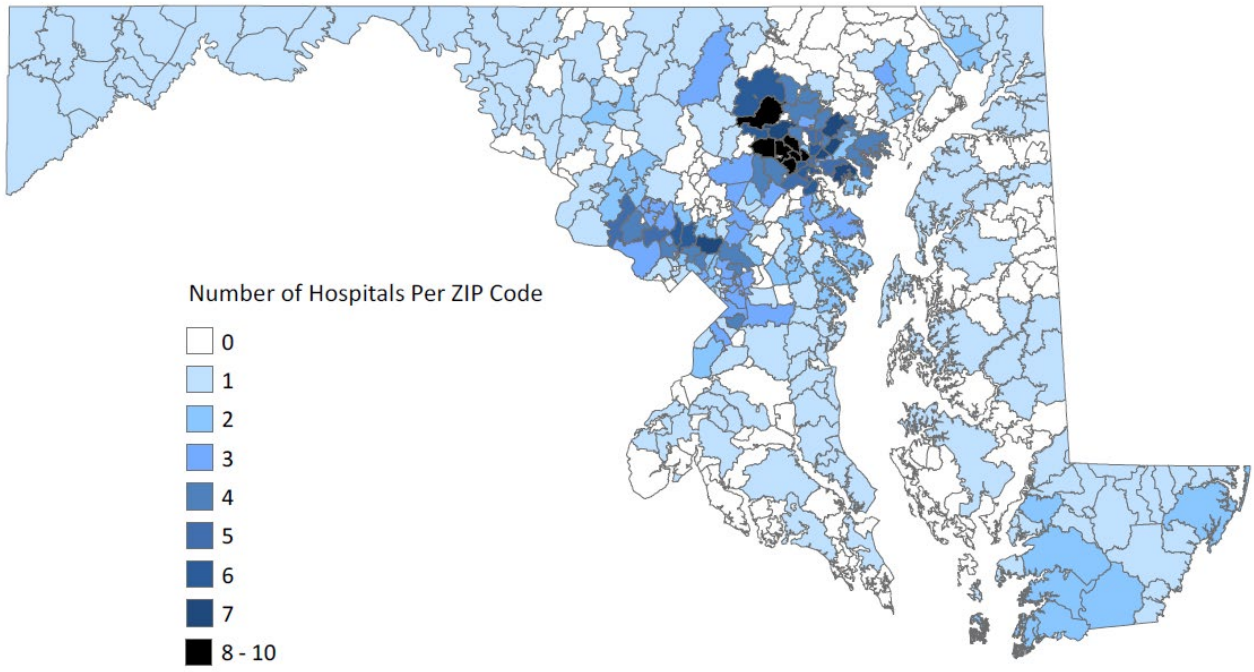
Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
Howard County General Hospital	225	17,039	0.9	14.7	36.5
Johns Hopkins Bayview Medical Center	349	19,049	2.8	34.1	39.6
Suburban Hospital	228	11,858	2.1	10.1	58.0
The Johns Hopkins Hospital	1,095	41,445	1.1	28.8	27.6
Jointly Owned Hospitals					
Mt. Washington Pediatric Hospital	16	513	-	80.1	-
LifeBridge Health					
Carroll Hospital	161	10,335	0.5	16.1	49.5
Grace Medical Center	71	1,720	0.6	48.0	27.6
Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	100	1,060	1.4	2.5	90.8
Northwest Hospital, Inc.	190	7,752	0.5	26.3	54.4
Sinai Hospital of Baltimore, Inc.	347	16,993	0.5	30.1	41.9
Luminis Health					
Anne Arundel Medical Center	349	28,216	1.1	14.6	36.7
Doctors Community Hospital	206	10,340	2.8	17.9	50.6
MedStar Health					
MedStar Franklin Square Medical Center	338	20,049	1.3	34.1	40.8
Medstar Good Samaritan Hospital	143	7,753	1.5	21.9	60.9
Medstar Harbor Hospital	131	8,014	1.0	48.6	29.5
MedStar Montgomery Medical Center	104	5,978	0.7	19.3	51.5
MedStar Southern Maryland Hospital Center	182	10,907	1.8	27.6	38.6
MedStar St. Mary's Hospital	93	7,802	1.9	22.6	37.4
MedStar Union Memorial Hospital	185	9,361	1.0	21.0	58.2
TidalHealth					
TidalHealth McCready Pavilion	3	97	1.0	12.4	78.4
TidalHealth Peninsula Regional	266	16,152	0.8	24.1	46.5
Trinity Health					
Holy Cross Germantown Hospital	70	6,346	3.3	24.9	29.0
Holy Cross Hospital	377	33,050	4.2	31.6	20.2
University of Maryland					
UM Baltimore Washington Medical Center	285	18,691	0.7	24.2	44.3
UM Capital Region Health	297	11,861	8.4	35.6	31.9

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
UM Charles Regional Medical Center	98	6,536	1.1	19.5	52.0
UM Rehabilitation & Orthopaedic Institute	2	1,977	0.4	22.5	46.9
UM Shore Regional Health – Easton	97	6,684	0.3	29.8	46.7
UM Shore Regional Health – Dorchester	34	1,046	0.5	34.0	50.4
UM Shore Regional Health – Chester River	12	579	0.9	14.9	72.7
UM St. Joseph Medical Center	219	14,722	1.0	16.9	42.1
UM Upper Chesapeake Health – Harford Memorial Hospital	81	3,745	0.5	23.1	49.6
UM Upper Chesapeake Health – Upper Chesapeake Medical Center	159	11,826	0.3	16.9	49.3
UMMC Midtown Campus	100	4,677	0.9	49.1	39.3
University of Maryland Medical Center	806	22,460	0.4	38.1	32.0
UPMC					
UPMC Western Maryland	191	10,810	1.4	19.3	53.2
WVU Medical System					
Garrett Regional Medical Center	26	1,623	1.9	21.3	44.2
Total	**10,052**	**545,514**	**1.9**	**25.4**	**38.6**

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 2020



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

[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).

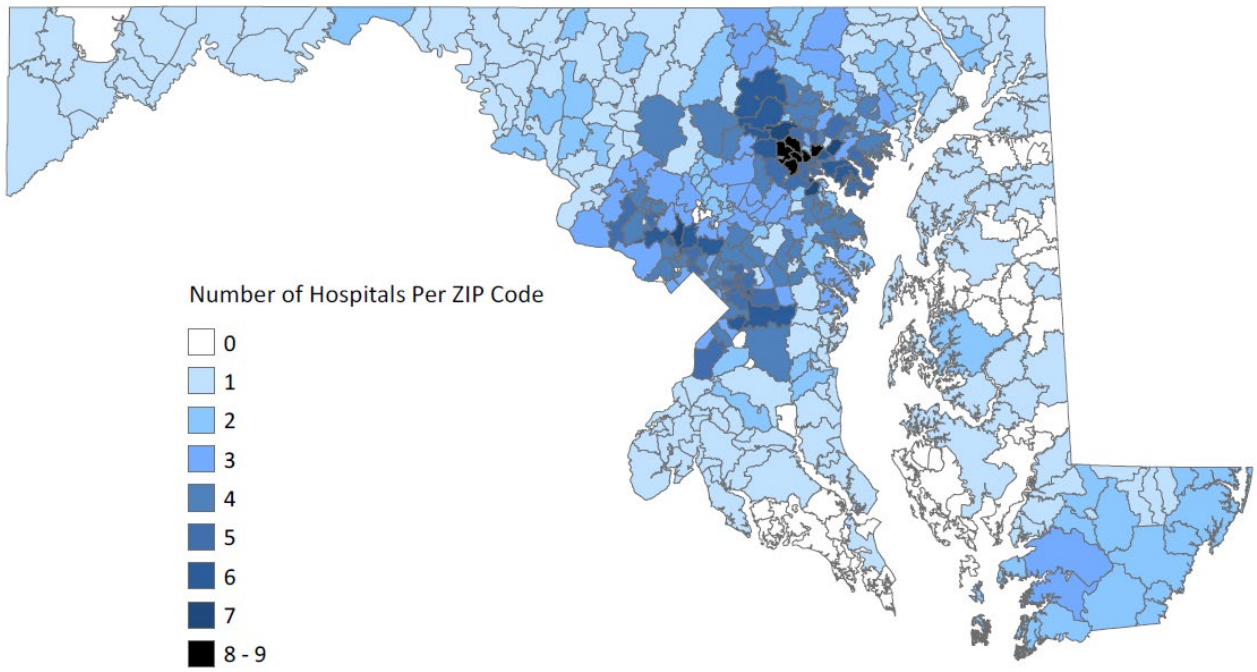
determinants of health indicators, and the proportion of residents who were medically underserved or uninsured/underinsured. Ten hospitals based their CBSAs on the PSAs described above.

Table 3. Methods Used by Hospitals to Identify their CBSAs, FY 2020

CBSA Identification Method	Number of Hospitals
Based on ZIP Codes in Financial Assistance Policy	8
Based on ZIP Codes in their PSA	10
Based on Patterns of Utilization	25
Other Method	27

Figure 2 displays the number of hospitals claiming each ZIP code in their CBSAs. A total of 91 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 2019, which identified 89 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 2020



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 (2015-2019) 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 (2017-2019) and the crude death rate (2019) measures were derived from the Maryland Department of Health's Vital Statistics Administration.

maryland health services cost review commission

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		**84,805**	**6.1**	**6.1**	**32.3**	**23.6**	**33.2**	**19.0**	**58.3**	**31.8**	**10.1**	**79.2**	**841.5**
Allegany	1	45,893	10.5	4.8	46.8	31.6	21.8	4.0	90.3	9.7	1.8	76.7	1,298.0
Anne Arundel	7	100,798	3.9	4.4	27.8	17.0	31.4	11.4	76.4	18.9	7.8	79.3	784.3
Baltimore	12	76,866	5.8	5.2	33.1	25.0	29.8	14.8	62.9	30.5	5.4	78.1	1,030.5
Baltimore City	17	50,379	16.0	6.6	46.0	43.6	31.4	9.9	32.3	64.0	5.3	72.8	1,119.5
Calvert	1	109,313	3.1	3.9	26.4	16.0	42.5	4.2	85.3	14.2	4.0	79.4	843.0
Caroline	1	58,638	9.4	5.6	45.7	36.4	32.7	8.3	82.3	15.8	7.3	76.8	942.9
Carroll	3	96,769	3.2	2.9	27.7	14.1	36.2	5.0	93.3	4.7	3.5	78.6	981.9
Cecil	2	76,887	6.4	4.1	36.0	25.9	29.9	5.5	90.4	8.5	4.4	75.7	1,067.5
Charles	1	100,003	4.7	3.8	27.9	20.4	45.0	8.2	48.1	50.1	5.8	78.6	751.6
Dorchester	1	52,917	10.7	5.4	51.1	41.1	27.6	6.3	69.5	30.1	5.6	75.6	1,299.8
Frederick	4	97,730	4.1	4.5	26.4	16.6	35.4	14.6	83.5	11.4	9.6	80.5	753.6
Garrett	1	52,617	6.8	7.0	42.6	29.7	24.8	3.1	98.3	1.4	1.1	78.3	1,244.2
Harford	2	89,147	4.7	3.4	29.9	18.3	32.0	7.4	81.5	15.6	4.6	79.0	864.8
Howard	4	121,160	3.6	3.9	23.4	14.5	31.2	25.4	60.7	21.2	6.9	83.2	559.1
Kent	1	58,598	6.4	5.2	44.3	25.9	27.2	6.2	83.0	15.9	4.4	79.0	1,349.0
Montgomery	8	108,820	4.7	7.1	26.8	18.2	34.7	41.2	56.5	20.3	19.5	85.1	589.2
Prince George's	9	84,920	5.8	10.1	31.9	25.6	37.3	27.3	18.6	64.8	18.4	79.1	709.3
Queen Anne's	2	97,034	3.1	4.8	31.7	16.9	37.3	5.6	90.8	7.7	3.9	79.8	940.8
Saint Mary's	1	89,845	6.2	5.1	28.1	20.3	31.5	7.3	81.7	16.4	5.2	78.5	767.3
Somerset	3	37,803	17.0	5.8	49.5	35.0	24.4	5.9	55.1	44.4	3.6	75.5	1,034.5

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)
Talbot	2	73,547	5.6	4.3	43.7	23.0	28.1	7.8	86.5	13.8	6.8	80.4	1,385.1
Washington	1	60,860	9.1	5.7	40.6	30.0	30.1	7.5	85.8	13.6	5.1	76.8	1,120.8
Wicomico	2	56,956	8.6	6.6	43.2	34.1	21.9	11.2	68.9	28.1	5.2	76.6	1,023.1
Worcester	2	63,499	6.3	4.9	46.4	25.6	24.8	5.5	85.2	14.2	3.5	79.6	1,203.2
Source	[15]	[16]	[17]	[18]	[19]	[20]	[21]	[22]	[23]	[24]	[25]	[26]	[27]

[15] As reported by hospitals in their FY 2020 Community Benefit Narrative Reports.
[16] American Community Survey 5-Year Estimates 2015 – 2019, Selected Economic Characteristics, Median Household Income (Dollars), https://data.census.gov/cedsci/.
[17] American Community Survey 5-Year Estimates 2015 – 2019, 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 2015 – 2019, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.
[19] American Community Survey 5-Year Estimates 2015 – 2019, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.
[20] American Community Survey 1-Year Estimate, 2019 (denominator) and The Hilltop Institute (numerator).
[21] American Community Survey 5-Year Estimates 2015 – 2019, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes).
[22] American Community Survey 5-Year Estimates 2015 – 2019, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.
[23] American Community Survey 5-Year Estimates 2015 – 2019, 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 2015 – 2019, 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 2015 – 2019, 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: 2019, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2017 – 2019.
[27] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2019, Table 39A. Crude Death Rates by Race, Hispanic Origin of Mother, Region, and Political Subdivision, Maryland, 2019.

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 two hospitals reported adopting an implementation strategy.[28] See Appendix B for the dates in which hospitals conducted their last CHNAs. These dates ranged from November 2017 to June 2020.

This section also asks the hospitals to report on the internal and external participants involved in the CHNA process, including their corresponding roles. More than half of all hospitals reported collaborating with other hospitals or community/neighborhood organizations to identify priority health needs. Only 12 hospitals did not partner with local health improvement collaboratives (LHICs) in their most recent CHNA efforts. These distributions were similar to what was reported in FY 2019. 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, around 90 percent of hospitals employed population health staff and staff dedicated to community benefit. Additionally, nearly all hospitals collaborated with local health departments to administer community benefit activities. Large majorities of hospitals worked with other hospitals and behavioral health organizations. These figures have increased greatly since FY 2019.

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

Staff Category	Number of Hospitals	% of Hospitals
Population Health Staff	44	94%
Community Benefit Staff	42	89%
CB/Pop Health Director	45	96%

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

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Organizations	15	32%
Local Health Departments	44	94%
Other Hospitals	34	72%
Behavioral Health Organizations	30	64%

[28] One hospital changed ownership during the reporting period, making a strategic plan unavailable. The other hospital was creating its strategic plan at the time of reporting.

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 46 out of 47 hospitals conducted some kind of audit of the financial spreadsheet. Audits were most frequently performed by hospital or system staff. These figures are slightly higher than what was reported in FY 2019.

Table 7. Hospital Audits of CBR Financial Spreadsheet

	Number of Hospitals	
Audit Type	**Yes**	**No**
Hospital Staff	40	7
System Staff	31	16
Third-Party	7	40
No Audit	1	46
Two or More Audit Types	29	18
Three or More Audit Types	3	44

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 2019.

Table 8. Hospital Board Review of the CBR

	Number of Hospitals	
Board Review	**Yes**	**No**
Spreadsheet	38	9
Narrative	38	9

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	44
No	3

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, 82 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 2019.

Table 10. Types of Community Benefit Initiatives

Category	Number of Interventions in Each Category	Percentage of Interventions that Fall within Category
Chronic condition-based intervention: treatment intervention	65	46%
Chronic condition-based intervention: prevention intervention	82	58%
Acute condition-based intervention: treatment intervention	47	33%
Acute condition-based intervention: prevention intervention	48	34%
Condition-agnostic treatment intervention	13	9%
Social determinants of health intervention	75	53%
Community engagement intervention	65	46%
Other	8	6%

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	42	30%
Surveys of Participants	47	33%
Biophysical Health Indicators	41	29%
Assessment of Environmental Change	2	1%
Impact on Policy Change	5	4%
Effects on Healthcare Utilization or Cost	29	21%
Assessment of Workforce Development	3	2%
Other	32	23%

Table 12 summarizes the top ten community health needs addressed by these initiatives, as identified in the hospitals' CHNAs. Educational/community-based programs were the top community health needs addressed by the selected initiatives. Hospitals could select multiple community health needs per initiative. In FY 2019, the top community health needs were largely the same.

Table 12. Community Health Needs Addressed by Selected Hospital Community Benefit Initiatives, FY 2020

Community Health Needs	Number of Initiatives	Percentage of Initiatives
Educational and Community-Based Programs	61	43%
Diabetes	50	35%
Oral Health	49	35%
Health-Related Quality of Life & Well-Being	48	34%
Behavioral Health, including Mental Health and/or Substance Abuse	46	33%
Other Social Determinants of Health	45	32%
Nutrition and Weight Status	43	30%
Heart Disease and Stroke	42	30%
Physical Activity	37	26%
Older Adults	34	24%

The CBR also asks about community health needs identified through the CHNA process that were not addressed by the hospitals. Overall, 23 hospitals reported that one or more primary community health needs were not addressed, and 24 responded that all needs were addressed. 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, 45 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 2020

	Number of Hospitals in Alignment
Healthy Beginnings	27
Healthy Living	41
Healthy Communities	39
Access to Health Care	38
Quality Preventive Care	42

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 34 hospitals), followed by primary care and substance abuse and detoxification. Four hospitals reported no gaps. See the mission-driven services section of the financial report summary for a related discussion.

[29] MD. CODE. ANN., Health-Gen. § 19-303(c)(4)(vi).

Table 14. Gaps in Availability

Physician Specialty Gap	Number of Hospitals
No Gaps	***4***
Mental Health	34
Primary Care	22
Substance abuse/detoxification	22
Neurosurgery/neurology	17
Dental	16
Internal Medicine	16
General Surgery	14
Obstetrics	13
Dermatology	12
Orthopedic Specialties	11
Otolaryngology	10
Other	27

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]

- Hospitals must provide free, medically necessary care to patients with family income at or below 200 percent of the FPL.[31] 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.[32] Thirty-five 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.[33] 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.[34] Five 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)(2)(i); COMAR 10.37.10.26(A-2)(2)(a)(i).
[32] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[33] COMAR 10.37.10.26(A-2)(3).
[34] 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, 2019, through June 30, 2020. Hospitals were instructed to use data from audited financial statements to calculate the cost of each of the community benefit categories contained in the CBR financial reports and to limit reporting to only those hospital services reported on the IRS 990 schedule H. Fifty hospitals submitted individual financial reports.

FY 2020 Financial Reporting Highlights

Table 15 presents a statewide summary of community benefit expenditures for FY 2020. Maryland hospitals provided roughly $1.94 billion in total community benefit activities in FY 2020—a total that is slightly higher than FY 2019 ($1.89 billion). The FY 2020 total includes: net community benefit expenses of $717 million in mission-driven health care services (subsidized health services), $610 million in health professions education, $349 million in charity care, $129 million in community health services, $56 million in Medicaid deficit assessment costs, $38 million in community building activities, $15 million in financial contributions, $15 million in research activities, $13 million in community benefit operations, and $1 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.

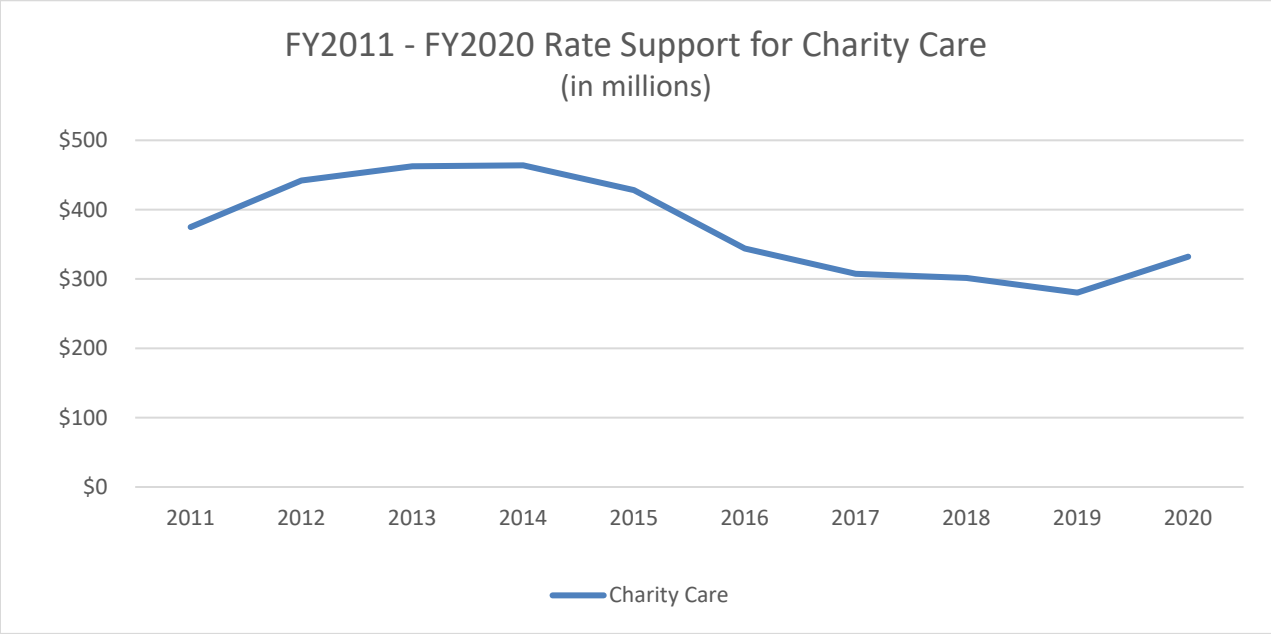
Table 15. Total Community Benefits, FY 2020

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	Percent of Total CB Expenditures	Net Community Benefit Expense Less: Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid	0	0	$56,475,884	2.91%	$56,475,884	4.57%
Community Health Services	934,443	4,453,676	$128,725,778	6.63%	$128,725,778	10.41%
Health Professions Education *	6,968,311	191,808	$609,639,789	31.38%	$236,125,334	19.09%
Mission Driven Health Services	4,153,090	1,785,749	$717,069,936	36.91%	$717,069,936	57.98%
Research	115,676	21,284	$15,459,334	0.80%	$15,459,334	1.25%
Financial Contributions	25,710	144,373	$14,821,576	0.76%	$14,821,576	1.20%
Community Building	379,825	68,848	$37,626,055	1.94%	$37,626,055	3.04%
Community Benefit Operations	99,211	94,153	$12,928,699	0.67%	$12,928,699	1.05%
Foundation	3,452	11,163	$1,165,182	0.06%	$1,165,182	0.09%
Charity Care*	0	0	$348,683,332	17.95%	$16,455,798	1.33%
Total	**12,679,719**	**6,771,054**	**$1,942,595,565**	**100%**	**$1,236,853,576**	**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 2020.

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 2011 through FY 2020, which ticked up in 2020 after continuously decreasing in the wake of ACA implementation. See Appendix F for more details on the charity care methodology.

Figure 3. Rate Support for Charity Care, FY 2011-FY 2020



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 2020, DME costs totaled $355 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 2020, the HSCRC provided $19 million 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 2020 totaled over $1.2 billion, or 7.8 percent of total hospital operating expenses. This is nearly equivalent to the over $1.2 billion in net benefits provided in FY 2019, which totaled 7.4 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 $546.6 million. The second highest category was the education of nurses and nursing students, totaling $34.4 million. The education of other health professionals totaled $19.1 million.

Table 16. Health Professions Education Activities and Costs, FY 2020

Health Professions Education	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Physicians and Medical Students	6,112,327	101,768	$546,627,005
Nurses and Nursing Students	543,359	49,027	$34,374,750
Other Health Professionals	248,203	33,811	$19,061,170
Scholarships and Funding for Professional Education	1,233	220	$5,057,990
Other	63,188	6,982	$4,518,874
Total	**6,968,311**	**191,808**	**$609,639,789**

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 $65.3 million. Community health education was the second highest category, totaling $22.7 million, and community-based clinical services were the third highest, totaling $10.9 million. For additional detail, see Appendix G.

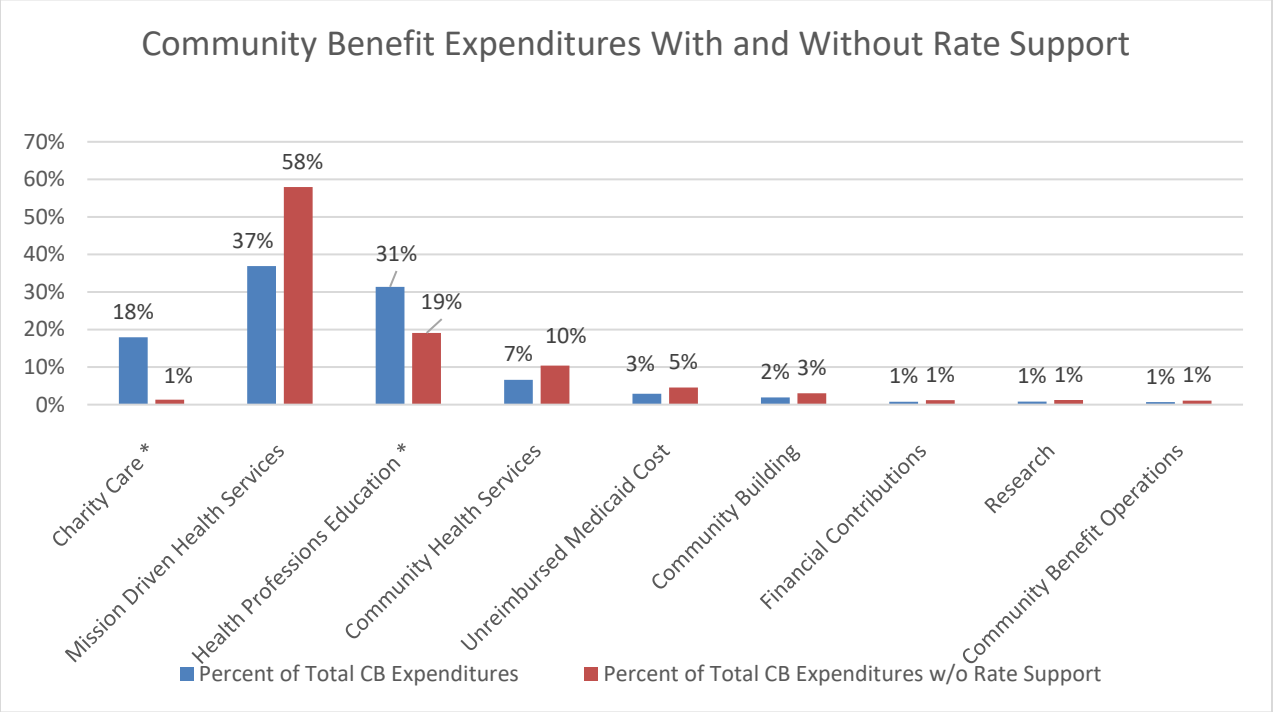
Table 17. Community Health Services Activities and Costs, FY 2020

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Health Care Support Services	367,620.97	434,912.65	$65,318,211.18
Community Health Education	262,440.67	3,364,056.68	$22,670,380.06
Community-Based Clinical Services	117,778.32	100,541.78	$10,936,430.39
Free Clinics	15,828.50	32,449.00	$9,944,362.28
Screenings	13,856.44	23,684.00	$3,946,919.23

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Support Groups	36,123.95	215,310.00	$2,932,221.85
Mobile Units	13,020.80	74,871.00	$882,147.03
Self-Help	33,855.30	13,884.00	$746,945.57
One-Time/Occasionally Held Clinics	1,040.00	3,978.00	$186,905.42
Other	72,878.18	189,989.00	$11,161,254.96
Total	**934,443.12**	**4,453,676.10**	**$128,725,777.97**

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 18 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 58 percent. Health professions education followed, with 19 percent of expenditures, and community health services accounted for 10 percent of expenditures.

Figure 4. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2020



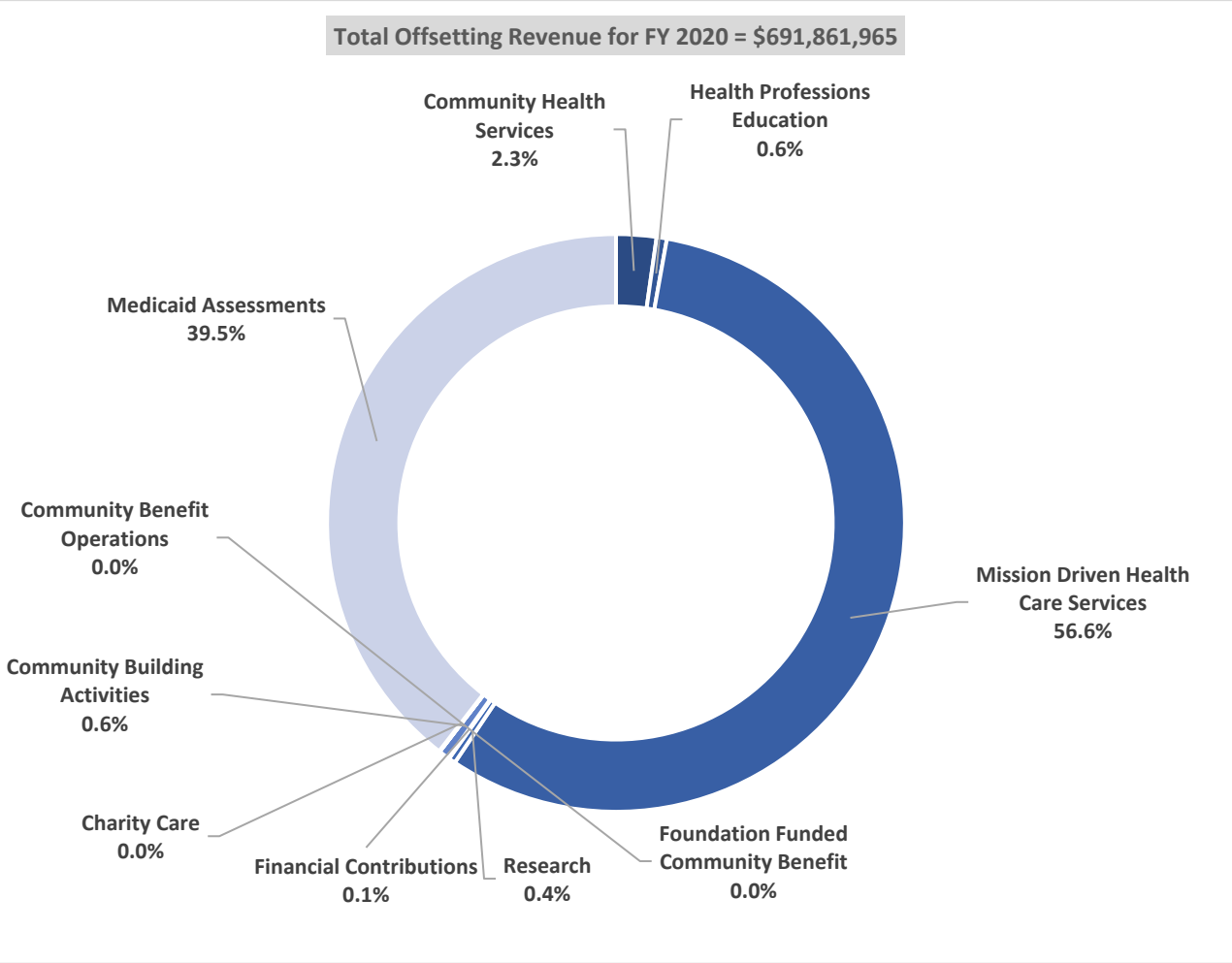
Appendix H compares hospitals in terms of the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support) or as revenue from billable services, and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2020, 1,984 staff hours were dedicated to community benefit operations, lower than FY 2019's figure of 2,220. Three hospitals reported zero staff hours dedicated to community benefit operations, which is the same as FY 2019. 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 1.21 to 31.38 percent, with an average of 7.84 percent, which was slightly lower than in FY 2019. Eleven hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with twelve hospitals in FY 2019.

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 2020 offsetting revenue by community benefit category. The largest components of offsetting revenue were mission-driven health care services (56.6 percent) and the Medicaid deficit assessment (39.5 percent). Last year, these two categories accounted for 48.6 percent and 45.6 percent of offsetting revenue, respectively. 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 2020



Excluding the Medicaid deficit assessment, mission-driven health services accounted for the vast 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 2020

Hospital Name	Total Expenditure	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Net Community Benefit
Garrett Regional Medical Center	$0	$0	-	$0
Adventist Healthcare Rehabilitation	$858,137	$0	0.0%	$858,137
Carroll Hospital	$11,711,013	$0	0.0%	$11,711,013
Doctors Community Hospital	$5,374,267	$0	0.0%	$5,374,267
Holy Cross Germantown	$2,575,182	$0	0.0%	$2,575,182
Howard County General Hospital	$16,100,121	$0	0.0%	$16,100,121
McCready Foundation Hospital	$43,165	$0	0.0%	$43,165
UM Charles Regional Medical Center	$9,487,756	$0	0.0%	$9,487,756
UM Shore Regional Health Chester River	$9,783,568	$0	0.0%	$9,783,568
UM Shore Regional Health Dorchester	$10,457,600	$0	0.0%	$10,457,600
UM Shore Regional Health Easton	$26,058,335	$0	0.0%	$26,058,335
UM St. Joseph Medical Center	$35,068,368	$0	0.0%	$35,068,368
Washington Adventist	$19,214,966	$0	0.0%	$19,214,966
Frederick Memorial Hospital	$17,751,759	$8,527	0.0%	$17,743,232
Shady Grove Medical Center	$17,876,133	$428,117	2.4%	$17,448,016
Johns Hopkins	$23,763,218	$627,183	2.6%	$23,136,035
Mercy Hospital	$22,256,668	$782,885	3.5%	$21,473,784
Suburban Hospital	$14,860,683	$867,526	5.8%	$13,993,157
Anne Arundel Medical Center	$41,021,480	$3,275,356	8.0%	$37,746,124
Levindale Hospital	$666,637	$58,028	8.7%	$608,609
Atlantic General Hospital	$209,718	$19,055	9.1%	$190,663
Sheppard Pratt Health System	$19,629,913	$1,803,931	9.2%	$17,825,981
Johns Hopkins Bayview	$11,764,809	$1,114,078	9.5%	$10,650,731
UM Medical Center Midtown Campus	$20,444,548	$2,656,789	13.0%	$17,787,760
Calvert Memorial Hospital	$15,408,115	$2,061,380	13.4%	$13,346,735
MedStar St. Mary's Hospital	$11,367,520	$1,830,953	16.1%	$9,536,567
Holy Cross Hospital	$8,776,706	$1,679,154	19.1%	$7,097,552
Prince George's Hospital	$49,692,000	$10,414,000	21.0%	$39,278,000
Sinai Hospital	$33,038,115	$8,184,510	24.8%	$24,853,605
MedStar Southern Maryland Hospital	$11,728,652	$3,017,105	25.7%	$8,711,547
UM Harford Memorial	$4,293,053	$1,118,844	26.1%	$3,174,209
Northwest Hospital Center	$11,114,509	$2,945,400	26.5%	$8,169,109
UM Rehabilitation & Orthopedic Institute	$3,304,315	$912,000	27.6%	$2,392,315

Hospital Name	Total Expenditure	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Net Community Benefit
UM Upper Chesapeake Medical Center	$8,998,096	$2,610,635	29.0%	$6,387,461
Mt. Washington Pediatric Hospital	$795,046	$263,890	33.2%	$531,156
University of Maryland Medical Center	$24,433,233	$9,897,507	40.5%	$14,535,726
Bon Secours	$13,060,126	$5,607,915	42.9%	$7,452,211
Union Hospital of Cecil County	$15,697,981	$6,887,031	43.9%	$8,810,950
St Agnes Hospital	$30,550,033	$13,533,465	44.3%	$17,016,568
Meritus Medical Center	$82,349,231	$37,524,481	45.6%	$44,824,750
MedStar Union Memorial Hospital	$6,648,613	$3,067,948	46.1%	$3,580,665
MedStar Harbor Hospital	$16,652,797	$7,801,071	46.8%	$8,851,726
Western Maryland Health System	$87,961,493	$42,389,383	48.2%	$45,572,110
Peninsula Regional Medical Center	$104,657,378	$55,896,290	53.4%	$48,761,088
MedStar Good Samaritan	$6,612,267	$3,589,799	54.3%	$3,022,468
MedStar Franklin Square	$40,723,836	$24,802,331	60.9%	$15,921,505
Greater Baltimore Medical Center	$109,843,505	$67,978,196	61.9%	$41,865,309
MedStar Montgomery Medical Center	$11,160,083	$7,654,608	68.6%	$3,505,475
UM Baltimore Washington Medical Center	$62,525,288	$58,008,335	92.8%	$4,516,953
Fort Washington Medical Center	$274,877	$257,271	93.6%	$17,606
Total	**$1,108,644,913**	**$391,574,977**	**35.3%**	**$717,069,936**

FY 2004 – FY 2020 17-Year Summary

FY 2020 marks the 17th 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 2020, these expenses represented roughly $1.94 billion, or 11.3 percent of operating expenses. 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 2011 through FY 2020. Figures 6 and 7 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 6. FY 2011 – FY 2020 Community Benefit Expenses with and without Rate Support

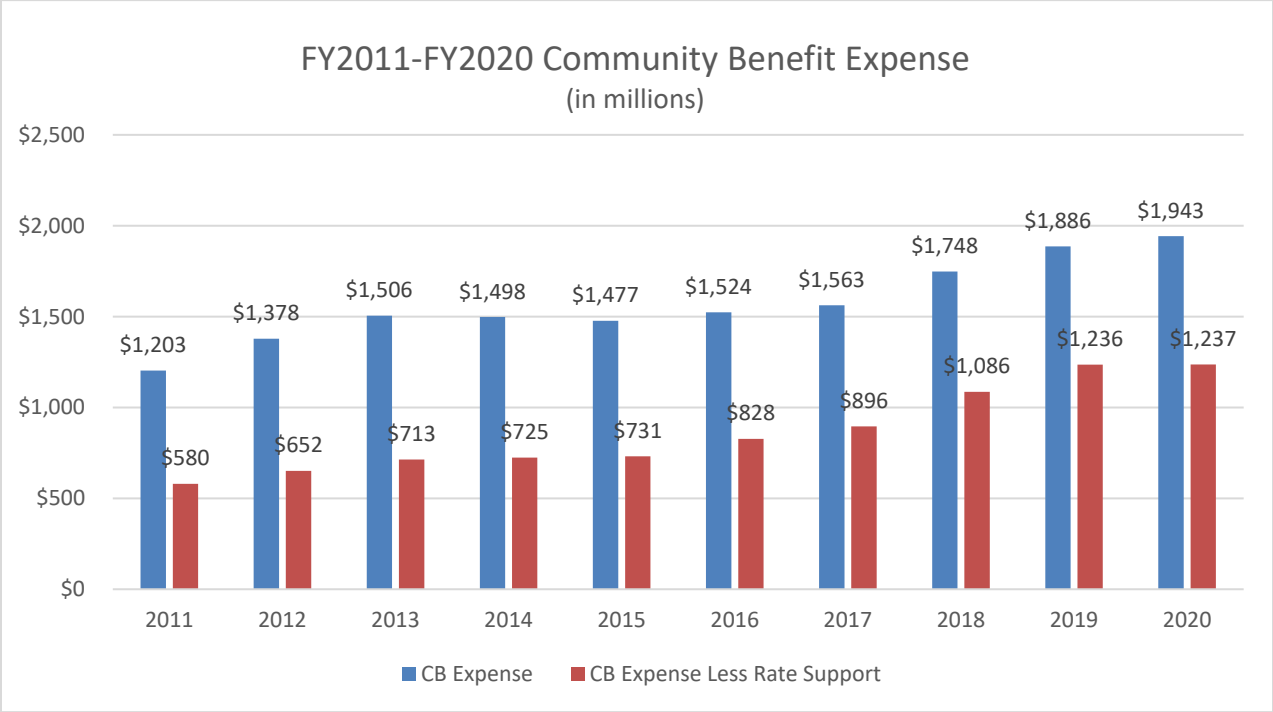
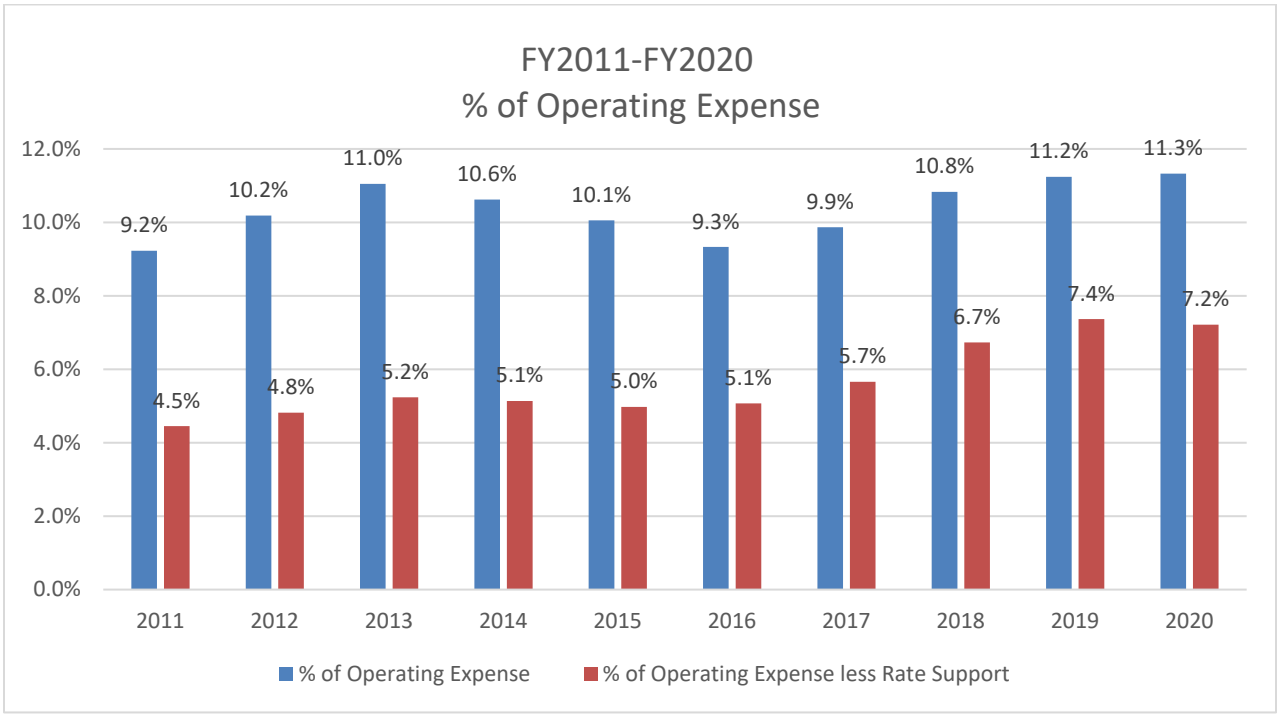


Figure 7. FY 2011 – FY 2020 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



Conclusion

In summary, all 50 Maryland hospitals submitted FY 2020 CBRs, showing a total of $1.9 billion in community benefit expenditures, approximately the same as in FY 2019. The distribution of expenditures across community benefit categories remained similar to prior years, with mission-driven services accounting for the majority of expenditures. Overall, expenditures as a percentage of operating expenses increased from 11.2 percent to 11.3 percent from FY 2019 to FY 2020. After accounting for rate support, expenditures as a percentage of operating expenses slightly decreased from 7.4 percent to 7.2 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 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, 96 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:

- 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.
- 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 provide clarification on what counts as physician subsidy and allow for more precise analyses in subsequent years.
- Hospitals are taking inconsistent approaches to reporting offsetting revenue within mission-driven health services and also including line items that appear inappropriate. In general, mission-driven health services are meant to represent services with no expectation of reimbursement or other revenue; nonetheless, several hospitals have reported multi-million-dollar line items with a significant portion of the total offset by revenue. Given that this category accounts for such a large amount of reported community benefits, priority will be given towards working with hospitals to ensure consistency.

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:

- 2019 Cigarette Restitution Fund Program's Cancer in Maryland Report
- Baltimore Neighborhood Indicators Alliance
- CDC National Center for Health Statistics
- CDC National Center on Birth Defects and Developmental Disabilities
- CDC National Center for Chronic Disease Prevention and Health Promotion
- Conduent - Healthy Communities Institute
- Chesapeake Regional Information System for our Patients (CRISP)
- Healthy People 2020
- 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 Physician Workforce Study
- Maryland Sexually Transmitted Infections Program
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- National Cancer Institute
- Nielsen/Claritas
- Robert Wood Johnson Foundation – City Health Dashboard
- Robert Wood Johnson Foundation – County Health Rankings
- Substance Abuse and Mental Health Services Administration (SAMHSA) – National Survey on Drug Use and Health (NSDUH)
- Truven/IBM Market Expert
- U.S. Census Bureau - American Community Survey
- United Way – United for ALICE (Asset-Limited, Income Constrained, Employed)
- University of Wisconsin School of Medicine and Public Health – Neighborhood Atlas

Appendix B. CHNA Schedules

Hospital	Date Most Recent CHNA was Completed
CalvertHealth Medical Center	Nov-17
TidalHealth McCready Pavilion	Dec-17
Lifebridge Levindale	Mar-18
Lifebridge Northwest	Mar-18
Lifebridge Sinai	Mar-18
Lifebridge Carroll Hospital Center	May-18
Johns Hopkins Bayview	May-18
UM Upper Chesapeake	May-18
UM Rehab & Ortho	May-18
Mt. Washington Pediatric	Jun-18
UMMC	Jun-18
UMMC Midtown	Jun-18
Mercy Medical Center	Jun-18
Johns Hopkins Hospital	Jun-18
St. Agnes Hospital	Jun-18
MedStar Harbor	Jun-18
MedStar Good Samaritan	Jun-18
UM Charles Regional	Jun-18
MedStar Franklin Square	Jun-18
MedStar Union Memorial	Jun-18
MedStar St. Mary's	Jun-18
MedStar Southern Maryland	Jun-18
MedStar Montgomery	Jun-18
Anne Arundel Medical Center	Feb-19
Doctors Community Hospital	Apr-19
Frederick Health Hospital	May-19
Sheppard Pratt	May-19
Meritus Medical Center	May-19
Atlantic General	May-19
Adventist Ft Washington	May-19
UM Shore Regional	May-19
GBMC	Jun-19
UM Capitol Region	Jun-19
TidalHealth Peninsula Regional	Jun-19
UM BWMC	Jun-19

Hospital	Date Most Recent CHNA was Completed
Suburban	Jun-19
UM St. Joseph	Jun-19
ChristianaCare Union Hospital	Jun-19
Howard County General	Jun-19
Grace Medical Center	Jul-19
Holy Cross Germantown	Oct-19
Holy Cross Hospital	Oct-19
Adventist HealthCare Rehabilitation	Dec-19
Adventist HealthCare Shady Grove	Dec-19
Adventist White Oak	Dec-19
Garrett Regional	Jan-20
UPMC Western Maryland	Jun-20

*Data Source: As reported by hospitals on their FY 2020 CBRs.

maryland health services cost review commission

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	9	33	31	31	28	34	34	18	6
CB/ Community Health/ Population Health Director (system level)	12	7	18	23	21	18	23	22	16	5
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	1	35	30	17	15	31	23	2	8
Senior Executives (CEO, CFO, VP, etc.) (system level)	5	5	19	25	17	6	22	10	1	7
Board of Directors or Board Committee (facility level)	10	3	16	15	14	5	22	16	3	13
Board of Directors or Board Committee (system level)	14	5	5	10	14	1	11	6	1	10
Clinical Leadership (facility level)	3	0	33	27	27	19	40	33	10	2
Clinical Leadership (system level)	15	5	20	19	17	5	23	18	6	3
Population Health Staff (facility level)	3	10	29	25	21	21	33	33	21	2
Population Health Staff (system level)	15	6	19	21	17	17	22	18	13	4
Community Benefit staff (facility level)	0	13	31	31	31	28	32	30	26	2
Community Benefit staff (system level)	10	9	18	19	23	17	19	18	12	5
Physician(s)	5	0	23	21	16	20	38	26	4	1
Nurse(s)	6	0	28	26	20	21	39	34	12	1
Social Workers	11	1	21	16	14	16	32	32	8	1
Community Benefit Task Force	6	13	23	21	20	23	25	23	9	5

maryland health services cost review commission

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
Hospital Advisory Board	6	22	10	12	11	8	19	16	3	0
Other (specify)	3	1	2	1	2	6	4	3	1	1
External Participants										
Other Hospitals	17		14	0	18	23	24	20	13	3
Local Health Department	0		26	0	33	43	40	39	35	7
Local Health Improvement Coalition	12		18	0	19	27	30	29	17	3
Maryland Department of Health	19		3	0	6	7	5	8	20	2
Maryland Department of Human Resources	43		0	0	0	1	0	1	2	0
Maryland Department of Natural Resources	45		0	0	0	0	0	0	2	0
Maryland Department of the Environment	40		0	0	0	1	1	0	7	0
Maryland Department of Transportation	39		1	0	0	1	1	1	7	0
Maryland Department of Education	36		1	0	0	1	1	1	9	0
Area Agency on Aging	15		9	0	6	17	19	17	12	2
Local Govt. Organizations	16		9	0	9	17	24	21	10	3
Faith-Based Organizations	6		10	0	3	21	33	32	3	1
School - K-12	14		9	0	6	16	22	24	11	1
School - Colleges and/or Universities	20		9	0	11	16	24	23	8	1
School of Public Health	35		2	0	2	8	8	6	4	1
School - Medical School	40		0	0	1	5	5	6	5	0
School - Nursing School	35		1	0	3	7	8	9	4	0
School - Dental School	46		0	0	0	0	0	1	0	0
School - Pharmacy School	45		0	0	0	0	1	2	0	0
Behavioral Health Organizations	12		13	0	11	16	29	29	10	0

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
Social Service Organizations	12		9	0	8	20	31	31	7	1
Post-Acute Care Facilities	31		1	0	1	7	9	12	4	1
Community/Neighborhood Organizations	13		11	0	4	18	31	27	5	3
Consumer/Public Advocacy Organizations	20		10	0	5	16	24	23	7	0
Other	6		7	0	5	20	28	24	5	3

maryland
health services
cost review commission

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)	1	8	38	38	37	29	34	37	34	3
CB/ Community Health/ Population Health Director (system level)	9	10	24	23	25	14	17	18	18	4
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	0	37	37	25	34	36	9	21	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	6	6	25	24	17	20	19	5	18	4
Board of Directors or Board Committee (facility level)	7	2	24	19	12	7	6	2	16	5
Board of Directors or Board Committee (system level)	19	6	18	9	7	5	0	0	6	2
Clinical Leadership (facility level)	3	0	35	32	27	7	16	29	25	1
Clinical Leadership (system level)	18	8	18	16	12	5	9	6	12	0
Population Health Staff (facility level)	0	9	31	28	29	13	15	30	32	0
Population Health Staff (system level)	13	8	20	20	18	6	11	19	21	2
Community Benefit staff (facility level)	2	12	27	27	30	11	14	28	29	1
Community Benefit staff (system level)	6	14	19	18	21	4	4	17	20	5
Physician(s)	4	0	29	28	16	2	5	32	19	3
Nurse(s)	3	1	25	25	20	6	9	38	23	1
Social Workers	13	0	20	22	18	3	5	32	18	1
Community Benefit Task Force	6	13	25	22	24	2	4	13	24	2

	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)
Hospital Advisory Board	15	17	12	9	5	1	2	2	10	1
Other (specify)	5	2	3	4	4	2	2	4	4	1
External Participants										
Other Hospitals	13		18	15	19	10	11	22	19	5
Local Health Department	3		26	23	27	14	12	32	25	6
Local Health Improvement Coalition	10		27	18	19	2	4	19	20	2
Maryland Department of Health	27		6	10	6	8	2	4	5	2
Maryland Department of Human Resources	45		0	0	0	1	0	1	0	0
Maryland Department of Natural Resources	45		0	0	0	0	0	1	0	1
Maryland Department of the Environment	46		0	0	0	0	0	0	0	1
Maryland Department of Transportation	45		0	0	0	0	0	0	0	2
Maryland Department of Education	41		1	2	2	1	0	3	1	2
Area Agency on Aging	19		12	11	12	4	4	21	13	2
Local Govt. Organizations	20		9	10	5	6	2	17	3	4
Faith-Based Organizations	11		13	9	4	0	0	26	5	8
School - K-12	15		9	8	5	1	1	24	8	5
School - Colleges and/or Universities	22		5	6	4	2	1	18	5	4
School of Public Health	38		2	1	2	0	0	8	3	0
School - Medical School	36		2	0	2	2	2	8	2	1
School - Nursing School	32		2	3	4	1	0	12	4	1
School - Dental School	46		1	0	0	0	0	0	0	0
School - Pharmacy School	42		1	0	0	0	0	3	0	0
Behavioral Health Organizations	17		11	10	7	0	1	26	14	2
Social Service Organizations	18		13	13	8	5	3	21	13	2

	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)
Post-Acute Care Facilities	32		8	5	5	3	0	10	7	2
Community/Neighborhood Organizations	15		17	13	8	3	1	24	14	3
Consumer/Public Advocacy Organizations	25		9	8	4	0	0	15	9	0
Other	20		9	9	4	4	1	15	12	2

Appendix E. FY 2020 Funding for Nurse Support Program I, Direct Medical Education, and Charity Care

Hospital Name	DME	NSP I	Charity Care	Total Rate Support
Adventist Rehabilitation	$0	$0	$0	$0
Anne Arundel General Hospital	$1,295,673	$696,466	$4,665,000	$6,657,140
Atlantic General Hospital	$0	$48,776	$2,080,700	$2,129,476
Bon Secours Hospital	$0	$123,744	$213,345	$337,089
Calvert Memorial Hospital	$0	$165,427	$2,092,026	$2,257,453
Carroll County General Hospital	$0	$260,680	$503,782	$764,462
Doctors Community Hospital	$0	$274,648	$9,425,649	$9,700,297
Fort Washington Medical Center	$0	$48,776	$400,374	$449,150
Frederick Memorial Hospital	$0	$393,815	$5,822,311	$6,216,126
Garrett County Memorial Hospital	$0	$64,222	$3,088,077	$3,152,299
Greater Baltimore Medical Center	$7,731,237	$510,520	$2,193,000	$10,434,757
Holy Cross	$2,300,163	$568,651	$25,216,478	$28,085,292
Holy Cross German Town	$0	$457,635	$4,804,910	$5,262,545
Howard County General Hospital	$0	$344,313	$4,679,000	$5,023,313
Johns Hopkins	$119,235,430	$2,657,027	$35,066,500	$156,958,957
Johns Hopkins Bayview Med. Center	$25,126,324	$745,887	$21,680,000	$47,552,211
Levindale	$0	$67,583	$936,020	$1,003,603
McCready Foundation, Inc.	$0	$19,140	$0	$19,140
MedStar Franklin Square Hospital	$8,779,317	$596,421	$12,318,684	$21,694,422
MedStar Good Samaritan Hospital	$4,725,287	$0	$7,178,703	$11,903,990
MedStar Harbor Hospital Center	$3,866,851	$217,001	$5,448,214	$9,532,066
MedStar Montgomery General Hospital	$0	$202,905	$3,193,638	$3,396,544
MedStar Southern Maryland Hospital	$0	$293,107	$5,442,147	$5,735,253
MedStar St. Mary's Hospital	$0	$217,835	$4,539,656	$4,757,491
MedStar Union Memorial Hospital	$13,134,515	$489,843	$9,977,661	$23,602,019
Mercy Medical Center, Inc.	$5,222,206	$594,951	$17,767,062	$23,584,219
Meritus Medical Center	$0	$371,947	$5,280,200	$5,652,147
Mt. Washington Peds	$0	$67,837	$43,123	$110,960
Northwest Hospital Center, Inc.	$0	$296,207	$1,929,688	$2,225,895
Peninsula Regional Medical Center	$0	$501,914	$13,045,900	$13,547,814
Shady Grove Adventist Hospital	$0	$67,583	$11,221,259	$11,288,842
Sheppard Pratt	$2,692,100	$167,184	$4,391,731	$7,251,015
Sinai Hospital	$17,345,063	$870,729	$5,349,000	$23,564,792
St. Agnes Hospital	$8,822,979	$488,207	$12,957,524	$22,268,710
Suburban Hospital Association, Inc	$598,256	$363,619	$4,768,896	$5,730,772

Hospital Name	DME	NSP I	Charity Care	Total Rate Support
UM Capital Region	$4,654,172	$440,819	$10,373,355	$15,468,345
UMROI	$4,059,878	$0	$1,382,000	$5,441,878
Union Hospital of Cecil County	$0	$184,880	$1,429,900	$1,614,780
UM BWMC	$650,488	$474,915	$6,375,000	$7,500,403
UM Charles Regional	$0	$172,930	$1,088,000	$1,260,930
UM Harford	$0	$117,515	$1,819,000	$1,936,515
Univ. of Maryland Medical Center	$119,732,582	$1,876,955	$21,239,000	$142,848,537
UM Midtown Campus	$4,875,719	$265,141	$3,763,000	$8,903,860
UM Shore Chestertown	$0	$66,388	$624,742	$691,129
UM Shore Dorchester	$0	$57,159	$425,237	$482,396
UM Shore Easton	$0	$235,287	$2,913,105	$3,148,392
UM St. Josephs	$0	$457,635	$7,456,792	$7,914,427
UM Upper Chesapeake	$0	$379,634	$3,918,000	$4,297,634
Washington Adventist Hospital	$0	$311,221	$9,248,445	$9,559,667
Western Maryland Hospital	$0	$371,134	$12,451,700	$12,822,834
Total	**$354,848,240**	**$18,666,216**	**$332,227,534**	**$705,741,989**

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 2020 Community Benefit Report) based on the policy approved by the Commission for the beginning of the rate year (also FY 2020).

- The HSCRC uses a logistic regression to predict actual hospital uncompensated care costs in a given year (FY 2020).
- 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.[35]
  - 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 2020) are averaged with the hospital's estimated UCC levels from the prior FY (FY 2019) 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 2020 policy. The resulting charity care amount is the estimated amount provided in rates that will be subtracted from the hospital's community benefit.

Example Johns Hopkins Hospital:

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

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.

maryland
health services
cost review commission

APPENDIX G. FY 2020 Community Benefit Analysis

Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2020 Amount in Rates for Charity Care, DME, and NSPI*	Total 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 Rehabilitation	476	392	$50,824,294	$3,005,220	5.91%	$0	$3,005,220	5.91%	$551,776
Anne Arundel	4,926	875	$585,311,000	$61,575,726	10.52%	$6,657,140	$54,918,587	9.38%	$4,665,050
Atlantic General	985	84	$134,967,041	$3,764,790	2.79%	$2,129,476	$1,635,314	1.21%	$2,158,110
Grace	567	0	$66,479,100	$8,777,659	13.20%	$337,089	$8,440,570	12.70%	$213,345
Calvert Hospital	0	2,520	$137,396,210	$17,969,884	13.08%	$2,257,453	$15,712,431	11.44%	$2,087,095
Carroll	1,875	2,080	$201,484,375	$17,714,787	8.79%	$764,462	$16,950,325	8.41%	$503,783
Doctors Community	1,577	1,540	$215,413,138	$18,108,642	8.41%	$9,700,297	$8,408,346	3.90%	$9,528,010
Fort Washington	375	88	$46,221,264	$1,314,343	2.84%	$449,150	$865,193	1.87%	$981,260
Frederick	2,390	192	$356,515,000	$30,593,551	8.58%	$6,216,126	$24,377,425	6.84%	$7,159,000
Garrett County	508	127	$49,847,123	$4,100,015	8.23%	$3,152,299	$947,716	1.90%	$3,074,822
GBMC	2,617	4,560	$514,005,000	$54,792,557	10.66%	$10,434,757	$44,357,799	8.63%	$2,329,000
Holy Cross	3,333	6,259	$453,889,368	$46,698,333	10.29%	$28,085,292	$18,613,041	4.10%	$30,178,692
Holy Cross German Town	735	353	$108,611,245	$8,115,922	7.47%	$5,262,545	$2,853,376	2.63%	$4,811,636
Howard County General	1,747	2,955	$262,623,000	$29,341,719	11.17%	$5,023,313	$24,318,406	9.26%	$4,678,771
Johns Hopkins	0	6,334	$2,658,945,000	$311,170,744	11.70%	$156,958,957	$154,211,786	5.80%	$35,067,000
Johns Hopkins Bayview	3,410	538	$671,878,000	$93,408,687	13.90%	$47,552,211	$45,856,476	6.83%	$21,680,000
Levindale	816	815	$80,197,000	$2,795,618	3.49%	$1,003,603	$1,792,015	2.23%	$1,597,300
McCready	263	0	$10,283,006	$308,083	3.00%	$19,140	$288,942	2.81%	$198,594

maryland health services cost review commission

Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2020 Amount in Rates for Charity Care, DME, and NSPI*	Total 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 Franklin Square	2,905	2,636	$549,838,800	$48,273,948	8.78%	$21,694,422	$26,579,526	4.83%	$12,318,684
MedStar Good Samaritan	1,710	1,148	$263,976,142	$23,374,331	8.85%	$11,903,990	$11,470,341	4.35%	$7,178,703
MedStar Harbor	1,127	3,054	$191,182,619	$23,766,596	12.43%	$9,532,066	$14,234,531	7.45%	$5,448,214
MedStar Montgomery	1,016	0	$171,486,283	$8,727,049	5.09%	$3,396,544	$5,330,505	3.11%	$3,193,638
MedStar Southern Maryland	1,149	1,360	$240,415,418	$17,056,467	7.09%	$5,735,253	$11,321,214	4.71%	$5,442,147
MedStar St. Mary's	1,184	5,053	$162,834,942	$18,390,288	11.29%	$4,757,491	$13,632,797	8.37%	$4,735,612
MedStar Union Memorial	2,113	1,413	$430,645,261	$45,660,746	10.60%	$23,602,019	$22,058,727	5.12%	$9,977,661
Mercy	3,539	2,723	$492,374,189	$71,666,597	14.56%	$23,584,219	$48,082,378	9.77%	$17,767,062
Meritus	2,826	319	$399,338,982	$57,109,549	14.30%	$5,652,147	$51,457,401	12.89%	$5,453,564
Mt. Washington	752	2,658	$62,631,697	$1,861,658	2.97%	$110,960	$1,750,697	2.80%	$65,146
Northwest Hospital	1,623	4,687	$249,673,000	$15,601,890	6.25%	$2,225,895	$13,375,995	5.36%	$1,929,700
Peninsula Regional	2,895	430	$493,289,357	$70,601,728	14.31%	$13,547,814	$57,053,914	11.57%	$14,451,000
Shady Grove Adventist	2,556	879	$395,307,320	$39,045,441	9.88%	$11,288,842	$27,756,599	7.02%	$9,670,999
Sheppard Pratt	2,500	378	$232,824,428	$26,672,620	11.46%	$7,251,015	$19,421,605	8.34%	$4,443,367
Sinai Hospital	5,258	14,877	$791,568,000	$73,675,916	9.31%	$23,564,792	$50,111,125	6.33%	$6,345,767
St. Agnes Hospital	2,450	0	$460,174,000	$45,328,937	9.85%	$22,268,710	$23,060,227	5.01%	$16,137,703
Suburban Hospital	1,896	1,652	$311,199,000	$30,311,893	9.74%	$5,730,772	$24,581,121	7.90%	$4,769,000
UM Capital Region	2,500	4,160	$322,178,000	$54,771,320	17.00%	$15,468,345	$39,302,974	12.20%	$9,170,000
UMROI	624	750	$108,289,000	$11,885,649	10.98%	$5,441,878	$6,443,771	5.95%	$1,382,000
Union of Cecil	1,185	893	$159,947,807	$11,110,606	6.95%	$1,614,780	$9,495,825	5.94%	$1,432,729
UM BWMC	3,215	4,576	$398,520,000	$14,436,003	3.62%	$7,500,403	$6,935,600	1.74%	$6,375,000

maryland
health services
cost review commission

Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2020 Amount in Rates for Charity Care, DME, and NSPI*	Total 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 Charles Regional	872	1,249	$133,537,960	$12,815,037	9.60%	$1,260,930	$11,554,108	8.65%	$1,088,212
UM Harford	787	930	$88,580,314	$9,172,043	10.35%	$1,936,515	$7,235,529	8.17%	$1,818,538
UMMC	9,010	2,749	$1,692,179,000	$235,720,079	13.93%	$142,848,537	$92,871,542	5.49%	$21,239,000
UM Midtown Campus	1456	738	$232,223,000	$29,646,890	12.77%	$8,903,860	$20,743,030	8.93%	$3,763,000
UM Shore Chestertown	185	1,460	$43,821,000	$10,778,269	24.60%	$691,129	$10,087,140	23.02%	$635,000
UM Shore Dorchester	269	2,160	$34,558,000	$11,326,735	32.78%	$482,396	$10,844,339	31.38%	$501,000
UM Shore Easton	1,316	2,000	$218,075,000	$32,081,030	14.71%	$3,148,392	$28,932,637	13.27%	$3,090,000
UM St. Josephs	2,041	529	$340,304,000	$48,903,007	14.37%	$7,914,427	$40,988,581	12.04%	$7,921,000
UM Upper Chesapeake	2,477	2,170	$272,962,267	$24,344,308	8.92%	$4,297,634	$20,046,674	7.34%	$3,917,727
Washington Adventist	1,273	1,553	$265,481,640	$37,330,187	14.06%	$9,559,667	$27,770,520	10.46%	$9,664,081
Western Maryland	2,096	316	$333,791,774	$67,592,470	20.25%	$12,822,834	$54,769,636	16.41%	$15,894,834
All Hospitals	**85,022**	**99,211**	**$17,148,098,364**	**$1,942,595,565**	**11.33%**	**$705,741,989**	**$1,236,853,576**	**7.21%**	**$348,683,332**

maryland health services cost review commission

APPENDIX H. FY 2020 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**			**$329,825,000**	-	**$273,349,116**	**$56,475,884**	**$56,475,884**
Community Health Services								
A10	Community Health Education	262,441	3,364,057	$15,467,367	$8,630,185	$1,427,171	$22,670,380	$14,040,195
A11	Support Groups	13,856	23,684	$2,337,396	$1,641,442	$31,919	$3,946,919	$2,305,477
A12	Self-Help	13,021	74,871	$664,095	$380,052	$162,000	$882,147	$502,095
A20	Community-Based Clinical Services	117,778	100,542	$8,798,168	$5,526,513	$3,388,250	$10,936,430	$5,409,918
A21	Screenings	36,124	215,310	$2,170,372	$1,471,826	$709,976	$2,932,222	$1,460,396
A22	One-Time/Occasionally Held Clinics	1,040	3,978	$124,701	$62,760	$556	$186,905	$124,145
A23	Free Clinics	15,829	32,449	$6,675,902	$3,282,319	$13,859	$9,944,362	$6,662,043
A24	Mobile Units	33,855	13,884	$1,649,695	$816,513	$1,719,262	$746,946	$(69,568)
A30	Health Care Support Services	367,621	434,913	$48,321,472	$21,701,489	$4,704,749	$65,318,211	$43,616,723
A40	Other	72,878	189,989	$10,910,692	$3,667,751	$3,417,189	$11,161,255	$7,493,504
A99	**Total**	**934,443**	**4,453,676**	**$97,119,859**	**$47,180,850**	**$15,574,931**	**$128,725,778**	**$81,544,928**
Health Professions Education								
B1	Physicians/Medical Students	6,112,327	101,768	$368,029,289	$181,563,634	$2,965,918	$546,627,005	$365,063,371
B2	Nurses/Nursing Students	543,359	49,027	$23,281,121	$11,094,930	$1,301	$34,374,750	$23,279,820
B3	Other Health Professionals	248,203	33,811	$13,247,968	$5,980,056	$166,854	$19,061,170	$13,081,114

	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
B4	Scholarships/Funding for Professional Education	1,233	220	$3,423,624	$1,680,448	$46,082	$5,057,990	$3,377,542
B50	Other	63,188	6,982	$3,329,596	$1,972,651	$783,373	$4,518,874	$2,546,223
B99	**Total**	**6,968,311**	**191,808**	**$411,311,598**	**$202,291,719**	**$3,963,528**	**$609,639,789**	**$407,348,070**
	Mission-Driven Health Services							
	Mission-Driven Health Services Total	**4,153,090**	**1,785,749**	**$965,405,337**	**$143,239,576**	**$391,574,977**	**$717,069,936**	**$573,830,360**
	Research							
D1	Clinical Research	75,839	19,452	$9,941,889	$3,274,828	$2,632,353	$10,584,364	$7,309,536
D2	Community Health Research	39,837	1,832	$2,791,247	$1,468,733	$0	$4,259,980	$2,791,247
D3	Other	0	0	$378,247	$261,018	$24,276	$614,989	$353,971
D99	**Total**	**115,676**	**21,284**	**$13,111,383**	**$5,004,580**	**$2,656,629**	**$15,459,334**	**$10,454,754**
	Financial Contributions							
E1	Cash Donations	3,108	27,163	$7,640,728	$303,167	$119,574	$7,824,320	$7,521,154
E2	Grants	2,690	307	$501,141	$41,270	$40,505	$501,905	$460,636
E3	In-Kind Donations	19,599	116,140	$3,541,343	$140,655	$187,434	$3,494,563	$3,353,909
E4	Cost of Fund Raising for Community Programs	313	763	$2,872,058	$128,729	$0	$3,000,787	$2,872,058
E99	**Total**	**25,710**	**144,373**	**$14,555,269**	**$613,820**	**$347,513**	**$14,821,576**	**$14,207,756**
	Community-Building Activities							
F1	Physical Improvements/Housing	3,590	19,956	$1,284,478	$405,089	$69,227	$1,620,341	$1,215,251
F2	Economic Development	4,555	3,323	$1,335,029	$516,190	$162,307	$1,688,912	$1,172,722

maryland health services cost review commission

	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
F3	Support System Enhancements	263,382	17,865	$14,306,947	$8,632,115	$2,562,800	$20,376,262	$11,744,147
F4	Environmental Improvements	5,140	20	$616,615	$216,731	$0	$833,346	$616,615
F5	Leadership Development/Training for Community Members	7,470	721	$332,217	$241,386	$25,000	$548,603	$307,217
F6	Coalition Building	19,964	6,794	$3,190,771	$2,054,114	$1,017,691	$4,227,194	$2,173,080
F7	Community Health Improvement Advocacy	10,355	3,211	$1,249,101	$556,955	$0	$1,806,056	$1,249,101
F8	Workforce Enhancement	63,438	15,728	$4,016,449	$2,519,256	$284,952	$6,250,753	$3,731,497
F9	Other	1,932	1,230	$192,993	$81,595	$0	$274,588	$192,993
	Total	**379,825**	**68,848**	**$26,524,600**	**$15,223,432**	**$4,121,977**	**$37,626,055**	**$22,402,623**
Community Benefit Operations								
G1	Dedicated Staff	78,831	1,334	$5,553,313	$3,151,687	$23,010	$8,681,990	$5,530,303
G2	Community health/health assets assessments	19,486	92,769	$1,181,525	$862,246	$13,575	$2,030,196	$1,167,950
G3	Other Resources	894	50	$1,749,289	$467,225	$0	$2,216,514	$1,749,289
G99	**Total**	**99,211**	**94,153**	**$8,484,127**	**$4,481,157**	**$36,585**	**$12,928,699**	**$8,447,542**
Charity Care								
	Total Charity Care	**$348,683,332**						
Foundation-Funded Community Benefits								
J1	Community Services	3,397	10,570	$494,134	$122,857	$105,099	$511,892	$389,035
J2	Community Building	55	593	$378,849	$406,052	$131,610	$653,291	$247,239
J3	Other	0	0	$0	$0	$0	$0	$0

	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
J99	**Total**	**3,452**	**11,163**	**$872,982**	**$528,909**	**$236,709**	**$1,165,182**	**$636,273**
Total Hospital Community Benefits								
A	Community Health Services	934,443	4,453,676	$97,119,859	$47,180,850	$15,574,931	$128,725,778	$81,544,928
B	Health Professions Education	6,968,311	191,808	$411,311,598	$202,291,719	$3,963,528	$609,639,789	$407,348,070
C	Mission Driven Health Care Services	4,153,090	1,785,749	$965,405,337	$143,239,576	$391,574,977	$717,069,936	$573,830,360
D	Research	115,676	21,284	$13,111,383	$5,004,580	$2,656,629	$15,459,334	$10,454,754
E	Financial Contributions	25,710	144,373	$14,555,269	$613,820	$347,513	$14,821,576	$14,207,756
F	Community Building Activities	379,825	68,848	$26,524,600	$15,223,432	$4,121,977	$37,626,055	$22,402,623
G	Community Benefit Operations	99,211	94,153	$8,484,127	$4,481,157	$36,585	$12,928,699	$8,447,542
H	Charity Care	0	0	$348,683,332	$0	$0	$348,683,332	$348,683,332
J	Foundation Funded Community Benefit	3,452	11,163	$872,982	$528,909	$236,709	$1,165,182	$636,273
T99	Medicaid Assessments	0	0	$329,825,000	$0	$273,349,116	$56,475,884	$56,475,884
K99	**Total Hospital Community Benefit**	**12,679,719**	**6,771,054**	**$2,215,893,488**	**$418,564,042**	**$691,861,965**	**$1,942,595,565**	**$1,524,031,523**

	Total Operating Expenses	**$17,148,098,364**
	% Operating Expenses w/ Indirect Costs	**11.33%**
	% Operating Expenses w/ o Indirect Costs	**8.89%**