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Maryland Hospital Community Benefit Report: FY 2023

May 29, 2025

Required by Health-General §19-303

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List of Abbreviations

ACA	Affordable Care Act
BMI	Body Mass Index
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
CMMI	Center for Medicare and Medicaid Innovation
DME	Direct Medical Education
ED	Emergency Department
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
GME	Graduate Medical Education
HCB	Hospital Community Benefit
HSCRC	Health Services Cost Review Commission
IRS	Internal Revenue Service
NSP	Nurse Support Program
PSA	Primary Service Area
SIHIS	Statewide Integrated Health Improvement Strategy
UCC	Uncompensated Care

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Executive Summary

Tax-exempt hospitals are required to provide "community benefit" as a condition of their federal tax-exemption. The term "community benefit" refers to initiatives, activities, and investments undertaken by hospitals to improve the health of the communities they serve. Hospitals submit information on their community benefit activities to the federal government each year. In addition, Maryland law[1] requires Maryland's nonprofit hospitals to report annual community benefit information to the Health Services Cost Review Commission (HSCRC). Maryland law builds on the federal requirements, providing the State with more information than is available through the federal reports.

In this report, the HSCRC summarizes fiscal year (FY) 2023 information submitted by hospitals, representing the HSCRC's 20th year reporting on Maryland hospital community benefit (HCB) data. The report describes how the State's reporting requirements differ from federal requirements, provides an overview of recent updates made to the reporting instructions, and highlights HSCRC programs that impact hospitals' community benefit spending. To better serve our community partners, staff reorganized this year's report to highlight key data points and make the information easier to use.

Key Highlights

- **Reporting Compliance:** All 49 nonprofit Maryland hospitals submitted their required FY 2023 community benefit reports.[2]
- **Community Benefit Expenditures:** Maryland hospitals reported $2.28 billion in total community benefit in FY 2023, an increase of around 11% from FY 2022.
    - **Rate Support for Hospital Community Benefits:** About 41% of the total HCB expenses are built into hospital rates, which are reimbursed by health care payers, including Medicare, Medicaid, commercial insurance, and patients. Roughly 59% ($1.3 billion) of the total hospital HCB spending comes directly from the hospitals without any rate support.
    - **Indirect Costs:** Hospital community benefit spending includes both direct and indirect costs (i.e., overhead costs). There is significant variation between hospitals in the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 21 to 145% for hospital-based community benefit activities. Three hospitals reported that indirect costs of hospital-based community benefit activities exceeded the direct costs of providing those activities. Due to concerns about the variation in indirect costs and the high amount of indirect costs reported by some

[1] MD. CODE. ANN., Health-Gen. § 19-303.
[2] There are 49 hospitals but only 47 narrative reports (45 reports from single hospitals and 2 reports that each cover 2 hospitals).

hospitals, the HSCRC has updated the community benefit reporting instructions for FY 2024.

- **Community Health Needs Assessments (CHNAs):** Under federal law, hospitals are required to conduct CHNAs every three years. CHNAs identify priority health needs and include implementation strategies to address them. All Maryland hospitals reported complying with this requirement. Hospitals reported spending 37.2% of their net community benefit on CHNA-related activities. Hospitals identified “Social Determinants of Health - Health Care Access and Quality” as the most frequently addressed CHNA priority area. Hospitals continued to show wide variation in the percentage of net community benefit spent on CHNA-related activities. To address this, staff updated reporting instructions for FY 2024.

Introduction

This report presents the results of an annual assessment of community benefit investments and activities of Maryland's nonprofit hospitals. Maryland law requires the Health Services Cost Review Commission (HSCRC) to submit this report annually.[3] This report is based on hospital community benefit (HCB) data submitted to the HSCRC by each hospital. The reports submitted by individual hospitals are posted on the HSCRC's website.[4]

This report explains the HCB reporting requirements and provides a summary of the fiscal year (FY) 2023 data that hospitals submitted to the HSCRC. This report also describes how the State's reporting requirements differ from federal requirements, provides an overview of recent updates made to Maryland's reporting instructions, and highlights HSCRC programs that impact hospitals' community benefit spending. To better serve our community partners, staff reorganized this year's report to highlight key data points and make the information easier to use.

Federal and State Authority over Community Benefits

Federal Tax Exemption and Reporting Requirements

Maryland's hospitals are nonprofit tax-exempt organizations. The federal Internal Revenue Code defines tax-exempt organizations as those that are organized and operated exclusively for specific religious, charitable, scientific, and educational purposes.[5] In order to maintain federal tax-exempt status, a hospital must provide "community benefits"[6] and report their community benefit activities to the Internal Revenue Service (IRS) annually. The IRS has no requirement for the minimum amount of community benefit that a hospital must provide to qualify for federal tax-exempt status.[7] In addition, every tax-exempt hospital, whether independent or part of a hospital system, must conduct a community health needs assessment

[3] MD. CODE. ANN., Health-Gen. § 19-303.
[4] https://hscrc.maryland.gov/Pages/init_cb.aspx
[5] 26 U.S.C. § 501(c)(3). Nonprofit hospitals have been required to demonstrate community benefits to qualify for federal tax-exempt status since 1969. The Internal Revenue Service (IRS) specifies categories of activities that qualify as community benefits in Schedule H of form 990. Under federal tax law, hospitals are required to: conduct a CHNA, including an implementation strategy; have a written financial assistance policy for medically necessary and emergency care; limit hospital charges for those eligible for financial assistance; and comply with billing and collections requirements. Source: James, J. (2016, February 25). Nonprofit hospitals' community benefit requirements, Health Affairs Health Policy Brief. DOI: 10.1377/hpb20160225.954803. Maryland law requires additional reporting of community benefit information. MD. CODE. ANN., Health-Gen. § 19-303. Maryland law adds requirements that exceed the federal requirements related to financial assistance and medical debt collection. MD. CODE. ANN., Health-Gen. §§ 19-214.1 and 19-214.2.
[6] A hospital must report community benefits to demonstrate to the IRS that they are a "charitable" organization, and thus eligible for tax exempt status. Historically, the IRS considered hospitals to be "charitable" if they provided charity care to the extent that they were financially able to do so. Ruling 56-185, 1956-1 C.B. 202. However, in 1969, the IRS modified the "charitable" standard to focus on "community benefits" rather than "charity care." Rev. Ruling 69-545, 1969-2 C.B. 117. "Charity care," now referred to as "financial assistance," is a category of community benefit.
[7] Congressional Research Service. (2024, April 15). Legal requirements for Section 501(c)(3) hospitals, page 4. https://crsreports.congress.gov/product/pdf/R/R48027

(CHNA) at least once every three years.[8] CHNAs are discussed in more detail later in this report. Hospitals must also report information about their CHNAs to the IRS.

Tax-exempt hospitals (also referred to as 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. Table 1 shows the number of Maryland hospitals that reported claiming each type of tax exemption in their FY 2023 HCB report.

Table 1. Tax Exemptions

Tax Exemption	Number of Hospitals
Federal corporate income tax	47
State corporate income tax	47
State sales tax	44
Local property tax (real and personal)	42
Other	5

The five hospitals that selected "Other" indicated that they also claimed an exemption from the federal unemployment insurance tax. One hospital reported claiming exemptions from some property taxes—depending on usage—but not from all local property taxes. The HSCRC conducted a tax benefit assessment of Maryland hospitals in 2020, calculating an overall net tax benefit of about $704 million for the year ending June 30, 2019.[9]

Overview of Maryland Reporting Requirements

Maryland law requires hospitals to report their HCB activities to the HSCRC annually, and the HSCRC is required to submit an annual statewide summary report to the General Assembly. This report contains the community benefit data for FY 2023,[10] marking the HSCRC's 20th year reporting on Maryland HCB.

Maryland's HCB reporting requirements are more extensive than the federal requirements. Maryland law defines "community benefit" as a planned, organized, and measured activity that is intended to meet

[8] Hospitals that do not conduct a CHNA every three years are subject to an annual penalty of up to $50,000 and loss of their tax-exempt status. 26 U.S.C. § 501(r)(3); 26 U.S.C. § 4959. Tax-exempt hospitals must report information on their CHNA on Schedule H of IRS Form 990. This reporting requirement was added by the Affordable Care Act.
[9] The HSCRC study is available here: https://hscrc.maryland.gov/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY19/HSCRC%20Hospital%20Tax%20Benefit%20Report%20July%202020.pdf. Other researchers have published articles and reports on the national scale of the benefit of hospital tax exempt status. "There is debate in the literature regarding the calculation of tax exemption value, particularly concerning federal and state corporate income taxes." Zare, H. & Anderson, G. (2024). Beyond the bottom line: Assessing charity care, community benefits, and tax exemptions in nonprofit hospitals. *Journal of Healthcare Management 69*(6), 439-454. DOI: 10.1097/JHM-D-24-00080. This results in different estimates by different researchers.
[10] The reporting period for these financial data is July 1, 2022, through June 30, 2023. Several hospitals are on a calendar financial year and report their most recent calendar year's data instead.

identified community health needs within a service area.[11] Hospitals must report their community benefit activities in categories that are specified by the HSCRC, including community health services; health professions education; research; financial contributions to other organizations; community-building activities, including partnerships with community-based organizations; financial assistance (i.e., free and reduced cost care); and mission-driven health services.[12] These categories are generally aligned with federal reporting categories (see Appendix A for a comparison of the federal and state reporting categories). The HSCRC also requires hospitals to report on health disparities and the types of tax exemptions claimed by the hospital in the preceding year.

Hospitals are also required to report information about their CHNA, including the amount of community benefit activities that are connected to community needs identified in the hospital's CHNA. The CHNA should influence the hospital's community benefit activities so that the hospital is serving identified community needs.

Maryland law requires hospitals to include the following information in their community benefit reports (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 health needs of the hospital's community
- A description of efforts 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 description of the process the hospital used to develop their CHNA
- A list of the unmet community health needs identified in the most recent CHNA
- A list of tax exemptions the hospital claimed during the preceding taxable year[13]

Hospitals submit a narrative report that contains descriptive information on their community benefit activities and a financial report on community benefit expenditures. The financial reports collect information about direct and indirect costs of community benefits, categorized by type of community benefit activity. Hospitals should use data from audited financial statements to calculate the cost of each community benefit category

[11] MD. CODE. ANN., Health-Gen. § 19-303(a)(3); COMAR 10.37.01.03.
[12] The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. The FY 2023 version of this document is available here: https://hscrc.maryland.gov/Documents/CommBen/FY%202023/FY%202023%20Community%20Benefit%20Guidelines%20and%20Definitions%20FINAL.pdf. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. https://www.irs.gov/pub/irs-pdf/f990sh.pdf.
[13] MD. CODE. ANN., Health-Gen. § 19-303(c)(4). Each hospital also reports to the HSCRC on the geographic region where the hospital offers its community benefit programs. This is referred to as the hospital's community benefit service area (CBSA). More information on how hospitals determined their CBSAs is in Appendix G.

contained in the financial reports and to limit reporting to only those hospital services reported on the IRS Form 990 Schedule H. Hospitals also submit their financial assistance policies. Each hospital's narrative and financial reports and financial assistance policies are posted on the HSCRC's website.[14]

Updates to Maryland's Reporting Instructions

In response to legislation, the HSCRC updated the reporting instructions in FY 2022, requiring hospitals to:

1. Report on initiatives that directly address needs identified in the CHNA
2. Within the financial report, 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

After reviewing the results of the FY 2022 HCB reports, the HSCRC identified potential reporting issues with data related to indirect costs and CHNA-aligned spending. The HSCRC's Commissioners directed staff to convene a short-term technical workgroup[15] to review the reporting instructions. As a result of workgroup deliberations, staff made technical corrections to the reporting instructions for the FY 2024 reports, including adjustments to directions for reporting physician subsidies, CHNA-identified community needs, and justifications for certain indirect costs. Those changes will be reflected in next year's report.

State Authority over Hospital Community Investments

State law requires hospitals to submit community benefit data to the HSCRC. The HSCRC has the authority to fine hospitals for failing to report accurate and timely information in their annual CBRs. All hospitals were compliant with the State community benefit reporting requirement for FY 2023.[16] Appendix B lists the hospitals submitting CBRs by hospital system. Maryland law does not provide regulatory authority over the quantity or quality of the community benefit activities or the CHNA. Maryland's HCB reporting requirements have no bearing on a nonprofit hospital's exemption from state income taxes; state tax exemption is based on the federal determination of the hospital's tax-exempt status.

Hospital Investments in Community Health and Rate Setting

Maryland has a unique statewide all-payer hospital rate-setting system. In contrast to the HSCRC's limited authority over community benefits, Maryland's hospital rate-setting system is a powerful tool for directing hospital investment in community health. The HSCRC uses the rate-setting system to direct hospital

[14] https://hscrc.maryland.gov/Pages/init_cb.aspx; https://hscrc.maryland.gov/Pages/hsp-fap.aspx.
[15] https://hscrc.maryland.gov/Pages/Community-Benefit-Workgroup.aspx.
[16] The HSCRC received 49 financial reports and 47 narrative reports. The University of Maryland Medical System submits one narrative report for its two hospitals on the Eastern Shore and another report for its two hospitals in Harford County.

investment in activities that align with state and community priorities. The following are current HSCRC programs that use the hospital rate-setting system to direct hospital spending on community health.

- **Revenue for Reform:** Hospitals the HSCRC identifies as inefficient are required to invest in community health activities or return funds to payers. These hospitals may only use the funds for community health activities that are approved by the HSCRC and the Maryland Department of Health (the Department). This funding remains in a hospital's global budget revenue (GBR) year after year, creating sustainable long-term funding for population health activities. Revenue for Reform is a new program and was not in place in FY 2023, the year covered by this report.
- **Behavioral Health Regional Partnership Catalyst Program:** The HSCRC approved $79.1 million in cumulative funding over a five-year period (FY 2021–FY 2025) for three behavioral health programs that are focused on expanding access to crisis services. Hospitals applied for this funding and had to demonstrate that they developed meaningful community partnerships and would maintain those partnerships throughout the program. This program has funded new behavioral health crisis centers and other services on the Eastern Shore, in Prince George's County, and in the greater Baltimore metropolitan region.
- **Maternal and Child Health Initiative:** The HSCRC assessed $40 million in funding over four years (FY 2022–FY 2025) to support maternal and child health interventions led by Medicaid managed care organizations and the Department's Prevention and Health Promotion Administration (PHPA). This funding supports new services not previously offered to Medicaid participants and continued efforts to reduce health care disparities. The Department has until the end of CY 2027 to spend the available funds.
- **Nurse Support Programs (NSP):** The HSCRC maintains two programs to develop and maintain the nursing workforce in Maryland. All Maryland hospitals receive funding through NSP I to support recruitment and retention of clinical nurses. In FY 2023, $19.1 million was included in hospital rates for NSP I activities. NSP II is funded through an $18.8 million hospital assessment aimed at expanding faculty and educational capacity at Maryland nursing schools. The Maryland Higher Education Commission (MHEC) administers NSP II on behalf of the HSCRC. Both programs have been implemented for over 20 years.

The HSCRC plans to continue to work with the Department in future years to develop programs that invest in the health of Maryland communities. The HSCRC increases hospital rates to fund these programs (or, in the case of Revenue for Reform, does not lower rates). Health care payers (including Medicare, Medicaid, private insurers, and patients) fund these activities through their payment of hospital claims.

To the extent these hospital investments fit the definition of "community benefit," hospitals may include them in their CBRs. Hospitals identify expenditures on these and other programs that the HSCRC includes in the annual calculation of each hospital's rates so that the HSCRC can determine the percentage of each hospital's community benefit that is funded through rates. These data are discussed later in this report.

Alignment of Hospital Community Benefit Activities with State/Federal Models

Maryland and the federal Center for Medicare and Medicaid Innovation (CMMI) have entered several agreements that support Maryland's all-payer hospital rate setting system, enhanced primary care, population health investments, and other aspects of the health care delivery system. Under the current Total Cost of Care Model agreement, Maryland agreed to four population health goals: 1) reducing the mean body mass index (BMI) for Maryland residents as it pertains to diabetes; 2) improving opioid overdose mortality; 3) decreasing asthma-related emergency department (ED) visits for children; and 4) reducing the severe maternal morbidity rate. All 49 hospitals reported that their community benefit activities addressed at least one of these goals, and most hospitals addressed more than one goal (Table 2). Reducing the mean BMI was the goal most frequently addressed by community benefit activities. Please note that hospitals may have other initiatives addressing these goals that do not count as community benefit.

Table 2. Number of Hospitals with Community Benefit Activities Addressing Population Health Goals under the Total Cost of Care Model, FY 2023

Goal	Number of Hospitals
Diabetes – Reduce the mean BMI for Maryland residents	43
Opioid Use Disorder – Improve overdose mortality	32
Maternal and Child Health – Reduce severe maternal morbidity rate	26
Maternal and Child Health – Decrease asthma-related ED visit rates for children aged 2-17	9

Maryland recently entered the AHEAD Model with CMMI, which will replace the Total Cost of Care Model in 2026. The State is working with stakeholders to develop the population health goals that will be used under the AHEAD Model. The HSCRC will adjust the hospital community benefit reporting instructions to collect information on the alignment between hospital community benefit investments and the AHEAD Model population health goals after those goals are established.

Spending on Community Benefits

Maryland hospitals provided approximately $2.28 billion in total community benefit activities in FY 2023.[17] This is an increase of approximately 11% over FY 2022. Hospital spending on community benefit grew faster than hospital revenue between FY 2022 and FY 2023.[18] In inflation-adjusted (real) dollars, Maryland community benefit expenditures were $943.3 million in FY 2004 (6.9% of operating expenses),[19] which is a significant increase in community benefit investment over the past 20 years.

Rate Support for Community Benefit Activities

As described earlier in this report, the HSCRC ensures that hospitals have funding for community benefit activities that are State priorities. The HSCRC increases hospital GBRs (and, relatedly, hospital rates) to fund these activities.[20] **Approximately $945 million of the $2.3 billion in community benefit reported in FY 2023, or 42% of HCB activities, was funded by health care payers through hospital rates. Approximately $1.3 billion of HCB activities was not funded through rates.** This equates to 6.6% of total hospital operating expenses. This is similar to the $1.22 billion in community benefit that was not rate-supported in FY 2022 (approximately 6.2% of operating expenses). Figures 1 and 2 show the trend of community benefit expenses with and without rate support. Appendix C details the amounts that were included in rates and funded by all payers for FY 2023.

Appendix D presents the total amount of community benefit reported and the amount of community benefit recovered through HSCRC-approved rate support.[21] Hospitals differ in their amount of community benefit not supported by rates compared to their total operating expenses. The total amount of community benefit expenditures without rate support as a percentage of total operating expenses ranged from 1.8% (Mt. Washington Pediatric Hospital) to 31.2% (McNew Family Medical Center), with an average of 7.6%. This is slightly higher than the average of 7.1% in FY 2022. Nine hospitals reported providing community benefit that exceeded 10% of their operating expenses, the same number as in FYs 2021 and 2022.

[17] This amount excludes expenditures on community benefit activities that are offset by revenue.
[18] The HSCRC approved a 3.25% increase in revenue for hospital global budgets for FY 2023. See https://hscrc.maryland.gov/Documents/RY23%20Final%20UF%20Recommendation.docx.pdf.
[19] FY 2004 community benefit expenses were $586.5 million. Inflated by CPI to FY 2023, this equals $943.3 million.
[20] The HSCRC sets the rates that most hospitals can charge payers for hospital services. For general acute care and chronic care hospitals, these rates are paid by Medicare, Medicaid, commercial insurance, and individuals who pay all or a portion of their hospital bill out of their own pocket. For pediatric and psychiatric hospitals, the HSCRC only sets rates for commercial insurers.
[21] Some hospital community benefits activities, such as clinics, generate revenue that offsets the amount of community benefit. Hospitals report the full amount of community benefit that they provide and any offsetting revenue that is not funded through rates. The HSCRC calculates the amount of hospital community benefit from rates using data that is separate from the hospital CBRs. This is intended to align HSCRC reporting with hospital reporting on the IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting.

Figure 1. FY 2013–FY 2023 Community Benefit Expenses with and without Rate Support (in Millions, Inflation Adjusted)

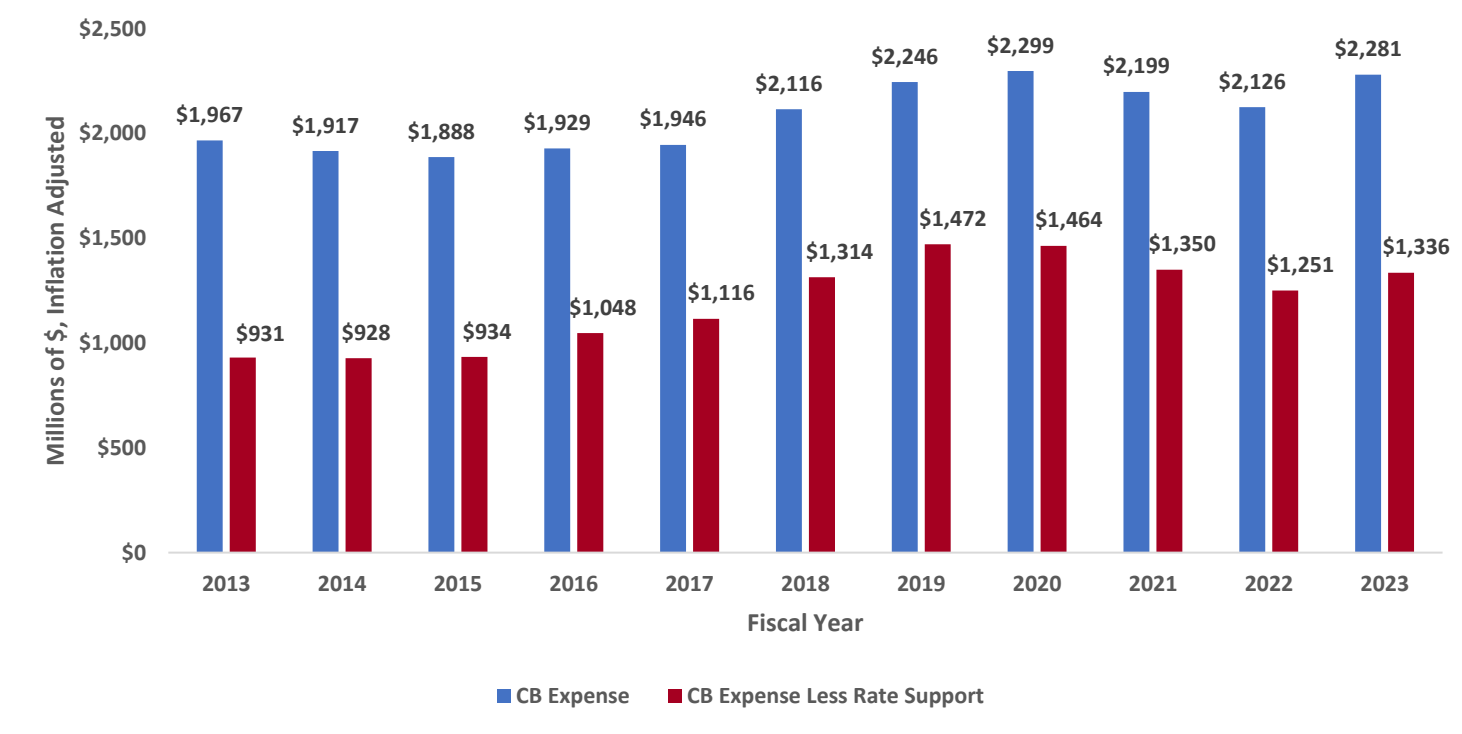


Figure 2. FY 2012–FY 2023 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support

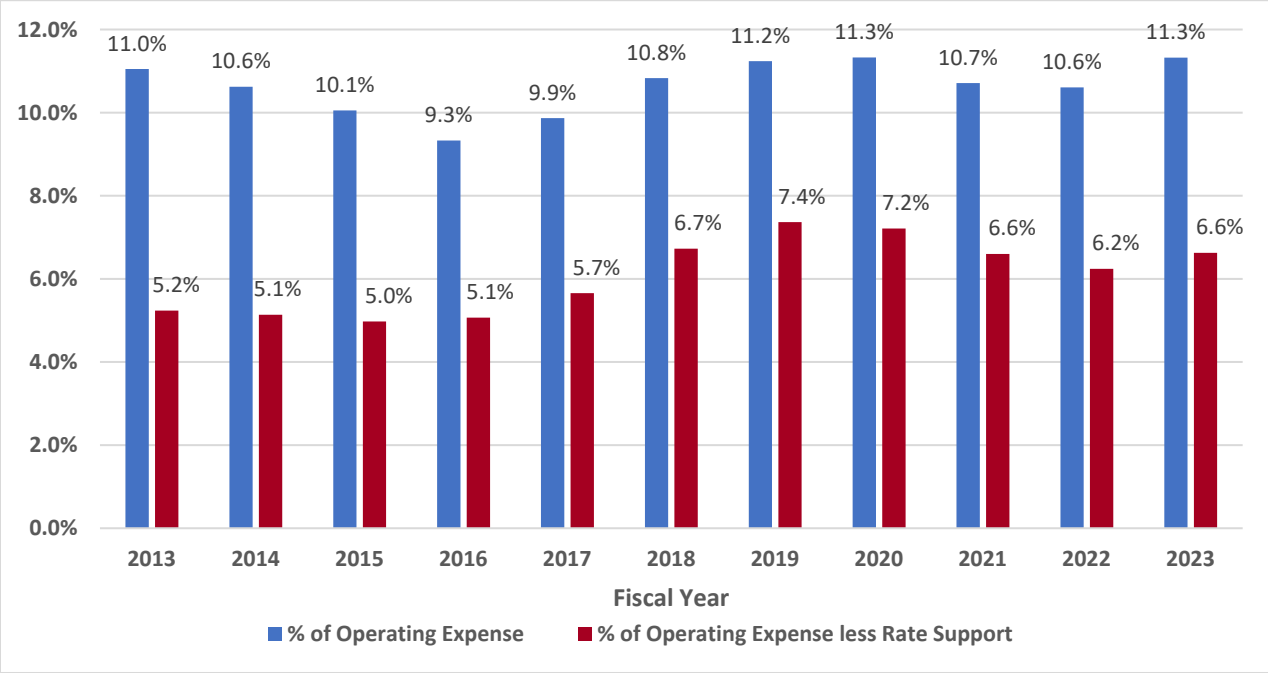
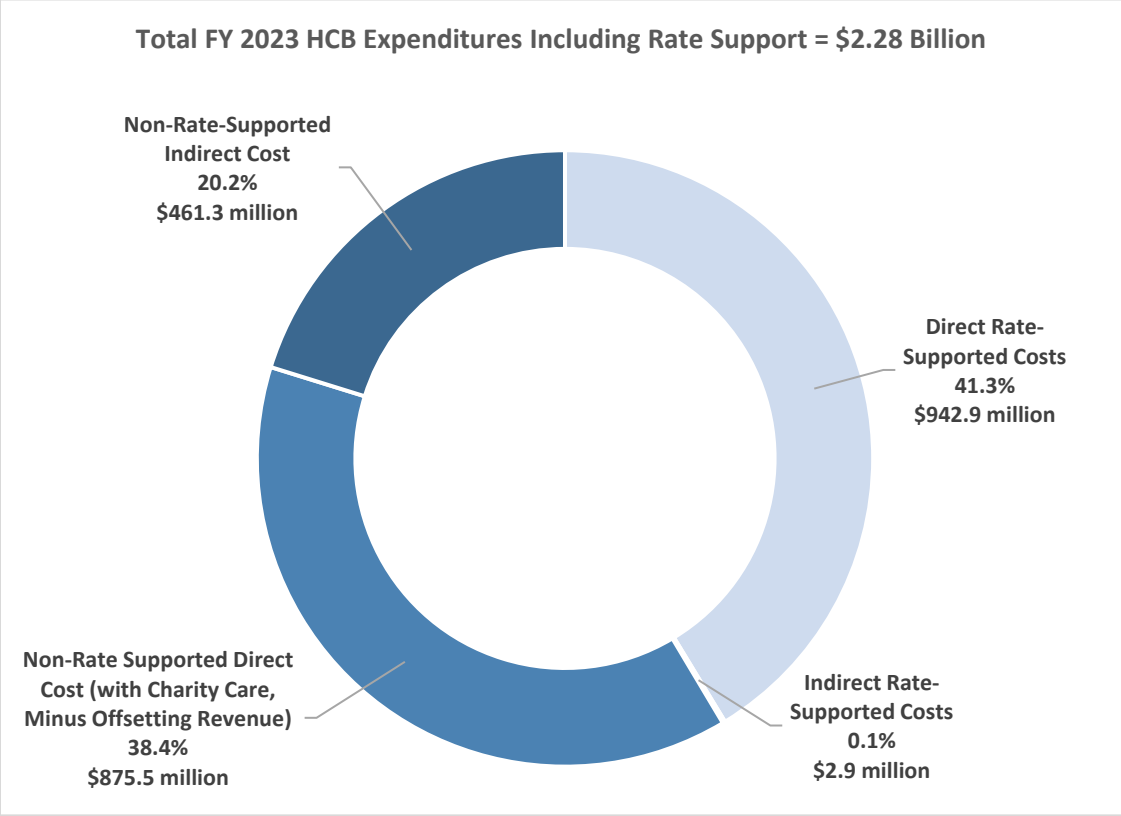


Figure 3 shows hospitals' total rate-supported and non-rate-supported direct and indirect costs in FY 2023 as a percentage of total HCB expenditures. Rate-supported direct and indirect costs accounted for roughly 41% of total expenditures.

Figure 3. Total Direct and Indirect Costs by Rate Support Status for All Hospitals, FY 2023



Examples of the community benefit costs that the HSCRC builds into hospital rates include the following:

- Financial assistance for low-income patients (free and reduced cost care)
- Graduate medical education (GME)
- The HSCRC's Nurse Support Programs, which support nursing education, recruitment, and retention programs in the State
- The Regional Partnership Catalyst Program for behavioral health crisis services

The following sections provide additional information on financial assistance, GME, and nurse support programs.

Financial Assistance

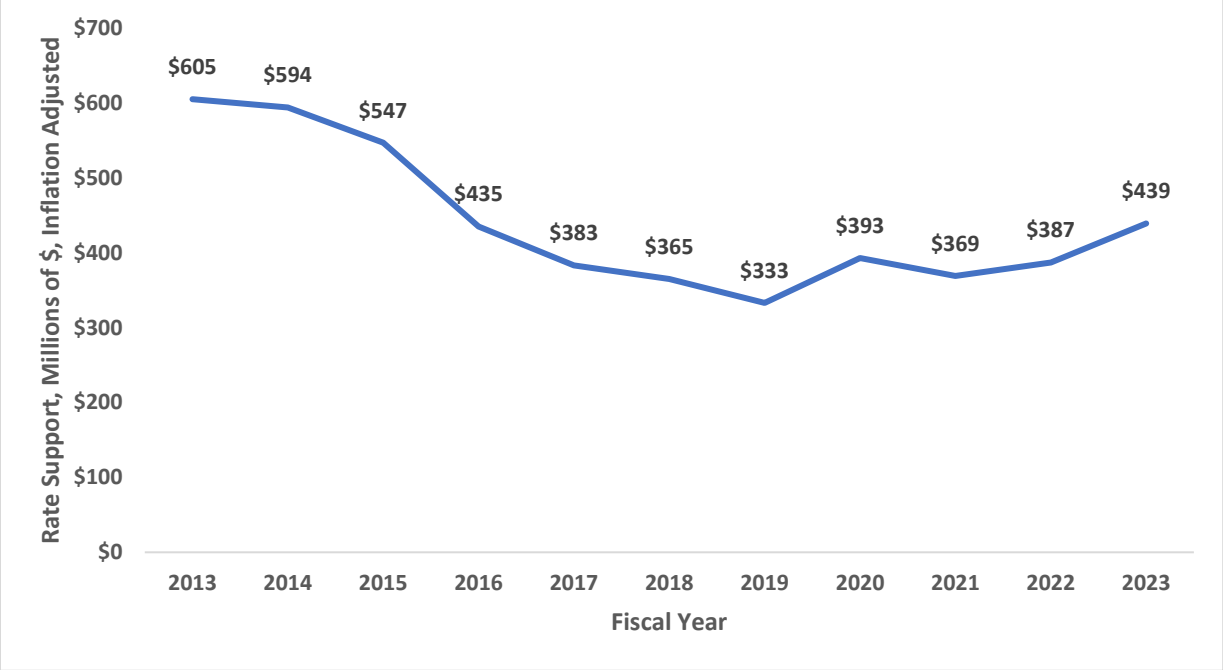
Maryland law requires general acute care and chronic care hospitals to provide financial assistance to patients with low income.[22] This is the third largest category of HCB spending, representing approximately 20% of total HCB spending ($452 million) in FY 2023. Almost all of this spending is accounted for in rates.

Figure 4 shows the amount built into hospital rates for financial assistance provided to low-income patients from FY 2013 through FY 2023. The amounts built into hospital rates for financial assistance are based on the amount of financial assistance that the hospitals provided to patients two years prior to the fiscal year. For example, the amount of rate support provided to hospitals for financial assistance in FY 2023 is based on the amount of financial assistance the hospitals provided to patients in FY 2021.[23]

As insurance coverage expanded under the Affordable Care Act (ACA) in 2014 and subsequent years, hospital patients needed less financial assistance. However, the need for financial assistance has increased since FY 2019, resulting in larger amounts of funding being included in hospital rates for financial assistance. Rate support for financial assistance continued to increase in FY 2023. See Appendix E for more details on the financial assistance methodology.

[22] MD. CODE. ANN., Health-Gen. § 19-214.1and COMAR 10.37.10.26(A-2).
[23] The HSCRC calculates this amount as a percentage of total statewide hospital revenue, adjusted for inflation.

Figure 4. Rate Support for Financial Assistance (in Millions, Inflation-Adjusted), FY 2013–FY 2023



Maryland law sets minimum eligibility standards for patient income based on family income. Hospitals must provide free care to patients under 200% of the federal poverty level (FPL), reduced cost care to patients under 300% of the FPL, and reduced cost care to patients under 500% of the FPL with medical debt that exceeds 25% of their annual income.[24] Hospitals may provide financial assistance to other patients. If a hospital is more generous in either the eligibility criteria in their financial assistance policy or in the amount of assistance they provide to patients who qualify, that could increase their spending on financial assistance.

Staff reviewed hospital financial assistance policies and compared the income thresholds for patient eligibility for free and reduced cost care in the policies with the eligibility requirements in law (Table 3). As with prior years, staff noted variation in the content and format of the financial assistance policy documents.

[24] MD. CODE. ANN., Health-Gen. § 19-214.1(b)(2)(i); COMAR 10.37.10.26(A-2)(2)(a) and COMAR 10.37.10.26(A-2)(3).

Table 3. Number of Hospitals with Expanded Financial Assistance Eligibility Criteria

Type of Financial Assistance	Statutory Eligibility Criteria	# of Hospitals That Provide Financial Assistance to a Higher Income Level
Free Care	Family income at or below 200% FPL	19
Reduced Cost Care	Family income between 201% and 300% FPL[25]	41
Reduced Cost Care due to Financial Hardship	Family income between 301% and 500% FPL, and the medical debt incurred by the family over a 12-month period exceeds 25% of the family's income[26]	22

Workforce: Graduate Medical Education and Nurse Support Programs

The HSCRC builds the cost of GME into hospital rates, as well as the cost of nursing workforce education and retention programs. GME is the cost of educating physician residents and interns. GME costs include the direct costs (i.e., direct medical education, or DME) of wages and benefits for residents and interns, faculty supervisory expenses, and allocated overhead. In FY 2023, DME costs in Maryland totaled $437 million.[27]

The HSCRC's Nurse Support Program I (NSP I) and NSP II are aimed at addressing the short- and long-term nursing shortages affecting Maryland hospitals. In FY 2023, the HSCRC provided just over $19 million in hospital rate adjustments for NSP I and just under $19 million for NSP II. See Appendix C for detailed information about the funding provided to specific hospitals through these programs.

Table 4 presents HCB expenditures for health professions education by activity. As with prior years, the education of physicians and medical students (including the DME expenses described above) made up most expenses in this category. The second highest category was the education of nurses and nursing students, totaling $53 million, including the NSP expenses described above.

[25] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[26] MD. CODE. ANN., Health-Gen. § 19-214.1
[27] The HSCRC's annual cost report.

Table 4. Health Professions Education Activities and Costs, FY 2023

Health Professions Education	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Physicians and Medical Students	$596,228,227	$393,768,365
Nurses and Nursing Students	$52,949,989	$32,144,499
Other Health Professionals	$30,640,738	$20,477,282
Scholarships and Funding for Professional Education	$4,603,458	$2,963,417
Other	$2,434,818	$1,262,268
Total	**$686,857,230**	**$450,615,831**

Categories of Community Benefit Activities

Hospitals must report on their community benefit activities in the following categories[28] defined by the HSCRC:

- **Medicaid Costs:** The cost of the Medicaid Deficit Assessment.
- **Community Health Improvement Services:** Activities that are carried out to improve community health (such as community health education, health screenings, and clinics for uninsured people).
- **Health Professionals Education:** Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional or continuing education that is necessary to retain state license or certification by a professional board.
- **Mission-Driven/Subsidized Health Services:** Services provided to the community that were never expected to result in cash inflows that the hospital undertakes as a direct result of its community or mission-driven initiatives—or which would otherwise not be provided in the community if the hospital did not perform these services, including physician subsidies that address gaps in physician availability.
- **Research**: Clinical research and community and health services research.
- **Cash Donations and In-Kind Contributions:** Resources donated by the hospital to organizations outside the hospital.
- **Community-Building Activities:** Activities that address the underlying causes of health problems and improve health status and quality of life services.
- **Community Benefit Operations:** Costs associated with staff, community health needs and/or assets assessment, and other costs associated with community benefit strategy and operations.

[28] The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. The FY 2023 version of this document is available here: https://hscrc.maryland.gov/Documents/CommBen/FY%202023/FY%202023%20Community%20Benefit%20Guidelines%20and%20Definitions%20FINAL.pdf. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. https://www.irs.gov/pub/irs-pdf/f990sh.pdf

See Appendix F for a detailed combined spreadsheet showing all hospitals' costs, rate support, and offsetting revenue across all categories.

As in FY 2022, hospitals spent the highest amount of their community benefit investments on mission-driven health services, health professions education, and financial assistance (Table 5).[29]

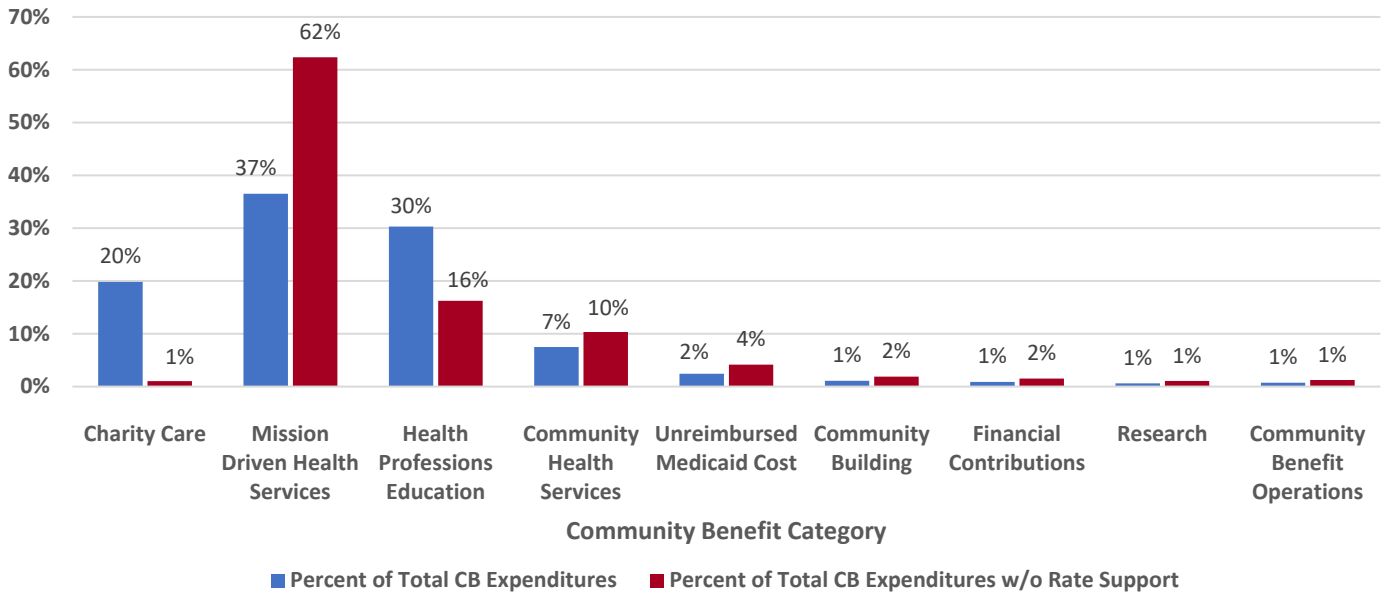
Table 5. Total Community Benefit Expenditures, FY 2023

Community Benefit Category	Total Community Benefit Expense[30]	Category as % of Total CB Expenditures	Total Community Benefit Expense Less Rate Support	Category as % of Total CB Expenditures Less Rate Support
Medicaid Deficit Assessment	$55,466,167	2.43%	$55,466,167	4.15%
Community Health Improvement Services	$170,611,890	7.48%	$138,016,988	10.33%
Health Professions Education	$691,682,793	30.32%	$217,089,010	16.25%
Mission-Driven Health Services	$832,747,261	36.50%	$832,747,261	62.35%
Research	$14,178,301	0.62%	$14,178,301	1.06%
Financial Contributions	$20,126,907	0.88%	$20,126,907	1.51%
Community Building	$25,226,682	1.11%	$25,226,682	1.89%
Community Benefit Operations	$16,801,859	0.74%	$16,801,859	1.26%
Foundation	$2,251,660	0.10%	$2,251,660	0.17%
Financial assistance	$452,369,804	19.83%	$13,692,246	1.03%
Total	**$2,281,463,324**	**100%**	**$1,335,597,081**	**100%**

Accounting for rate support significantly affects the distribution of expenses by category. Figure 5 shows expenditures for each community benefit reporting category as a percentage of total community benefit expenditures in FY 2023. Figure 5 also shows the percentage of expenditures by category for FY 2023 less the amount supported through rates.

[29] The FY 2023 total includes: net community benefit expenses of $833 million in mission-driven health care services (subsidized health services), $692 million in health professions education, $452 million in charity care, $170 million in community health services, $56 million in Medicaid deficit assessment costs, $25 million in community-building activities, $20 million in financial contributions, $14 million in research activities, $17 million in community benefit operations, and $2 million in foundation-funded community benefits.
[30] This amount excludes expenditures on community benefit activities that are offset by revenue.

Figure 5. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2023



Direct and Indirect Costs

Total hospital community benefit spending includes both the direct cost of the activity provided in the community and indirect costs. Indirect costs represent the proportion of total community benefit costs that are not attributed to products and/or services but are necessary for general operations, including salaries for human resources and finance departments, insurance, and overhead expenses.[31] The HSCRC's reporting instructions allow hospitals to report two indirect cost ratios: one for hospital/facility-based activities and one for activities in the community.[32] The "community-based" rate should be lower than the hospital-based rate and should exclude the costs of hospital buildings, the billing office, laundry, and other cost centers that should apply only to hospital-based programs. Table 6 presents the indirect cost ratios reported by each hospital for each community benefit category.

[31] The HSCRC specifies the methodology for calculating the indirect cost ratio. The cost ratio that hospitals report for community benefit should align with the cost ratio that they report on Schedule M of their annual cost report to the HSCRC. Staff followed up with hospitals whose indirect costs did not align with Schedule M. Many hospitals reported manually reducing their indirect cost ratio for community benefits, as they felt the ratio derived from their Schedule M was inappropriately high for community benefits activities.
[32] Some indirect costs are reported as a fixed dollar amount while others are a calculated percentage of the hospital's reported direct costs.

There is significant variation between hospitals regarding the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 21 to 145% for hospital-based community benefit activities. Three hospitals reported that indirect costs of hospital-based community benefit activities exceeded the direct costs of providing those activities to the communities they serve (see the "Hospital-Based CB Activities" column in Table 6). There is less variation between hospitals in their reported indirect cost ratios for community-based services, but there are a few outliers. Three hospitals report indirect cost ratios greater than 25% for community-based services.

Due to concerns about the variation in indirect costs and the high amount of indirect costs reported by some hospitals, the HSCRC convened a workgroup in 2024 to discuss changes to hospital reporting. As a result of that workgroup, the HSCRC has updated the community benefit reporting instructions for FY 2024. The FY 2024 report will include additional analysis on indirect costs.

Table 6. Hospital-Reported Indirect Cost Ratios, FY 2023 (Indirect Costs as a Percentage of Direct Costs)

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
Univ. of Maryland Shore Medical Center at Chestertown	144.8%	19.4%
Adventist Rehabilitation	109.4%	15.0%
Univ. of Maryland Shore Medical Center at Easton	104.9%	11.0%
Univ. of Maryland Charles Regional Medical Center	91.8%	20.2%
Univ. of Maryland Capital Region Medical Center	90.7%	12.9%
Ascension Saint Agnes Hospital	89.5%	10.0%
Mercy Medical Center, Inc.	84.4%	10.0%
MedStar Harbor Hospital Center	84.3%	
J. Kent McNew Family Medical Center	83.3%	
Univ. of Maryland Medical Center Midtown Campus	82.7%	13.1%
MedStar Southern Maryland Hospital	82.5%	
Frederick Memorial Hospital	81.1%	81.1%
Greater Baltimore Medical Center	80.6%	
MedStar Montgomery General Hospital	77.4%	
CalvertHealth Medical Center	76.5%	31.9%
MedStar St. Mary's Hospital	76.4%	
Univ. of Maryland Baltimore Washington Medical Center	74.0%	12.2%
Univ. of Maryland St. Joseph's Medical Center	72.8%	15.4%
Adventist Fort Washington Medical Center	71.5%	15.0%

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
Univ. of Maryland Rehabilitation & Orthopaedic Institute	71.1%	13.3%
Sheppard & Enoch Pratt Hospital	70.6%	
MedStar Good Samaritan Hospital	70.1%	
Howard County General Hospital	69.8%	18.2%
Doctors Community Hospital	68.4%	
Meritus Medical Center	66.2%	15.0%
MedStar Franklin Square Hospital	66.1%	
Adventist Shady Grove Medical Center	64.9%	15.0%
Mt. Washington Peds	64.2%	10.3%
Suburban Hospital	64.2%	24.2%
Adventist White Oak Hospital	63.7%	15.0%
TidalHealth McCready Pavilion	63.3%	
UPMC Western Maryland Hospital	63.1%	55.9%
MedStar Union Memorial Hospital	62.8%	
Sinai Hospital of Baltimore	60.0%	12.0%
Carroll Hospital Center	60.0%	12.0%
Northwest Hospital	60.0%	12.0%
Levindale Hebrew Geriatric Center & Hospital	60.0%	
Garrett Regional Hospital	58.3%	
Univ. of Maryland Medical Center	57.7%	
Univ. of Maryland Upper Chesapeake Medical Center	53.6%	9.4%
Anne Arundel General Hospital	53.0%	
TidalHealth Peninsula Regional Medical Center	52.7%	
Johns Hopkins Bayview Med. Center	51.6%	16.8%
The Johns Hopkins Hospital	45.1%	15.1%
ChristianaCare, Union Hospital	41.0%	
Atlantic General Hospital	35.3%	
Holy Cross Germantown Hospital	31.3%	10.0%
Holy Cross Hospital	28.9%	10.0%
Univ. of Maryland Harford Memorial Hospital	21.4%	3.8%

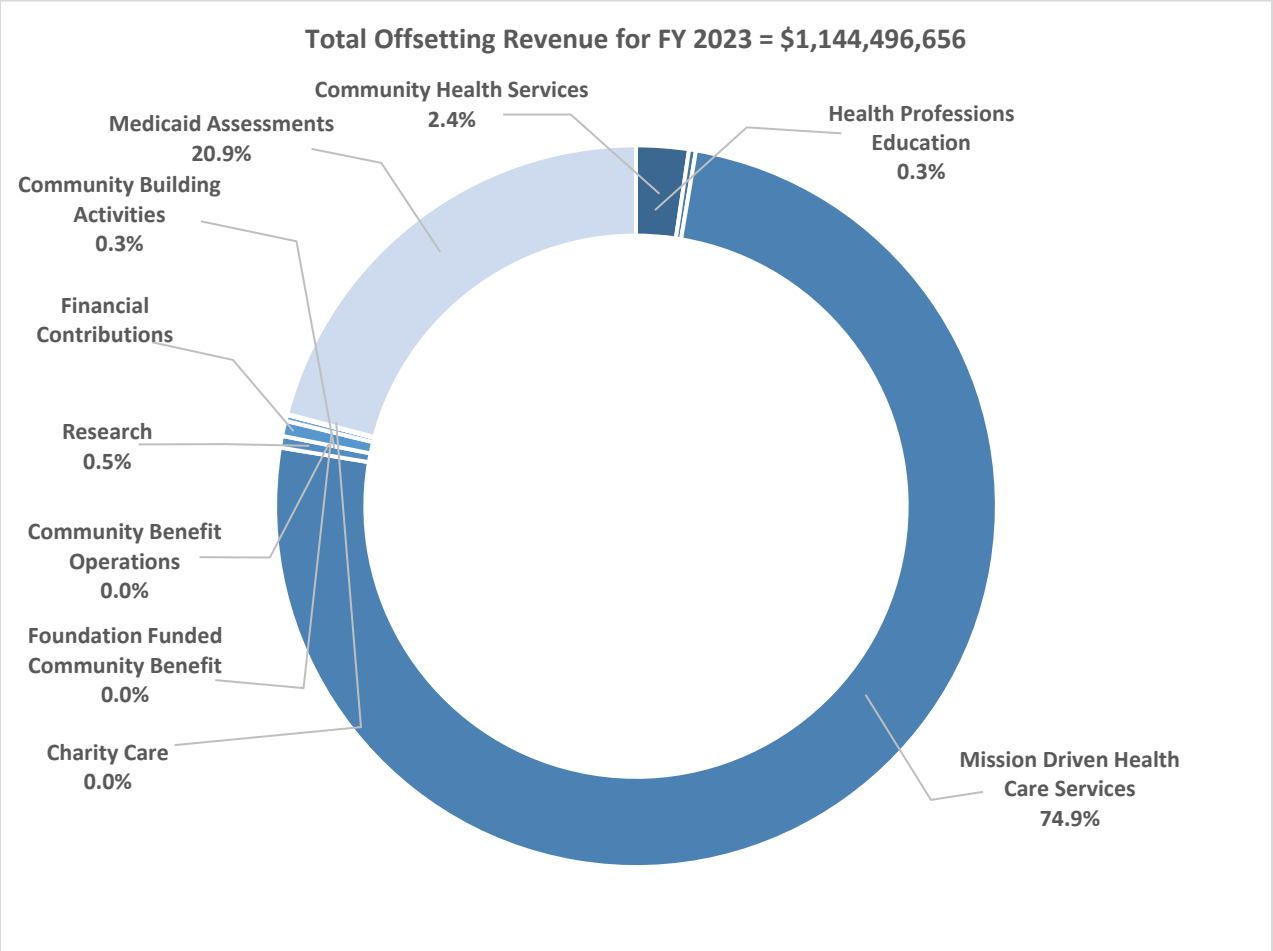
Offsetting Revenue and Mission-Driven Health Services

This report removes offsetting revenue from reported total community benefits. Offsetting revenue is defined as any revenue generated by the activity or program. For example. any payment by patients for services provided to those patients in a sliding-scale clinic would offset the total reported community benefit expenditures reported by the hospital for that clinic. Other examples include restricted grants or

contributions to the hospital that are used to fund a portion of the hospital's community benefit. Hospitals report offsetting revenue to the HSCRC in their annual community benefit reports.

Hospitals reported over $1.1 billion in offsetting revenue for community benefit activities—the majority for mission-driven health services, which are, by definition, intended to be services provided to the community that are not expected to result in revenue.[33] Figure 6 presents the total FY 2023 offsetting revenue by community benefit category.

Figure 6. Offsetting Revenue by Category of Community Benefit Activity for Maryland Hospitals, FY 2023



Offsetting revenue is different from rate-supported activities (described above). In general, hospitals do not report rate support as offsetting revenue. The Medicaid Deficit Assessment is the exception. The Medicaid

[33] See the HSCRC's FY 2023 Community Benefit Reporting Guidelines and Standard Definitions.

deficit assessment (shown as “Medicaid assessments” in Figure 6, above) 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.

Table 7 presents offsetting revenue for mission-driven health services by hospital. As noted above, mission-driven health services is the community benefit category that generates the most offsetting revenue. However, mission-driven health services are not intended to create revenue. Instead, mission-driven health services are intended to be services that hospitals undertake as a direct result of their community or mission-driven initiatives, or because the services would otherwise not be provided in the community. The hospitals are sorted by the proportion of total expenditures for mission-driven health services that are offset by revenue. Nine hospitals did not report any offsetting revenue from mission-driven health services. Sixteen hospitals reported offsetting revenue for 50% or more of their mission-driven expenditures. After removing offsetting revenue, mission-driven health services remain the largest category of community benefit activities, as shown in Table 5, above.

Table 7. Mission-Driven Health Services Expenditure and Offsetting Revenue among Maryland Hospitals, FY 2023

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
Adventist White Oak Hospital	$165,575,734	$150,707,818	91.0%	$14,867,916
Adventist Rehabilitation	$4,508,647	$3,617,646	80.2%	$891,001
Univ. of Maryland Shore Medical Center at Easton	$141,706,998	$111,222,862	78.5%	$30,484,136
Univ. of Maryland Shore Medical Center at Chestertown	$30,469,877	$22,244,572	73.0%	$8,225,304
Greater Baltimore Medical Center	$170,562,741	$116,052,850	68.0%	$54,509,891
MedStar Montgomery General Hospital	$17,894,531	$11,811,733	66.0%	$6,082,798
MedStar Franklin Square Hospital	$64,397,866	$41,868,138	65.0%	$22,529,728
Univ. of Maryland Baltimore Washington Medical Center	$41,875,612	$26,950,303	64.4%	$14,925,309
Atlantic General Hospital	$17,116,247	$10,991,416	64.2%	$6,124,831
Meritus Medical Center	$137,757,697	$88,293,942	64.1%	$49,463,755
MedStar Union Memorial Hospital	$25,746,992	$15,425,365	59.9%	$10,321,627
MedStar Harbor Hospital Center	$24,784,837	$14,786,099	59.7%	$9,998,738
MedStar Good Samaritan Hospital	$18,669,793	$10,935,530	58.6%	$7,734,263
MedStar Southern Maryland Hospital	$33,622,261	$18,793,989	55.9%	$14,828,272
Adventist Shady Grove Medical Center	$39,210,469	$21,787,060	55.6%	$17,423,408
Ascension Saint Agnes Hospital	$42,726,363	$23,579,043	55.2%	$19,147,320
MedStar St. Mary's Hospital	$21,270,308	$9,740,190	45.8%	$11,530,118
Mt. Washington Pediatric Hospital	$536,688	$235,885	44.0%	$300,803
UPMC Western Maryland Hospital	$103,990,266	$45,525,798	43.8%	$58,464,468

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
Univ. of Maryland Medical Center	$25,483,164	$11,155,391	43.8%	$14,327,773
TidalHealth Peninsula Regional Medical Center	$68,538,838	$29,797,432	43.5%	$38,741,406
Sinai Hospital of Baltimore	$42,779,529	$17,513,782	40.9%	$25,265,747
Lifebridge Northwest Hospital Center	$13,627,318	$4,963,145	36.4%	$8,664,173
ChristianaCare, Union Hospital	$31,700,752	$10,753,067	33.9%	$20,947,685
CalvertHealth Medical Center	$7,029,192	$2,260,287	32.2%	$4,768,905
Garrett Regional Hospital	$9,833,353	$2,957,668	30.1%	$6,875,685
Adventist Fort Washington Medical Center	$7,136,290	$2,087,722	29.3%	$5,048,568
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$3,215,838	$888,976	27.6%	$2,326,862
Univ. of Maryland Charles Regional Medical Center	$13,593,313	$3,686,898	27.1%	$9,906,415
Univ. of Maryland Capital Region Medical Center	$40,524,900	$10,616,400	26.2%	$29,908,500
Univ. of Maryland Medical Center Midtown Campus	$20,198,907	$3,973,133	19.7%	$16,225,774
Holy Cross Hospital	$10,742,646	$1,813,349	16.9%	$8,929,297
Anne Arundel General Hospital	$45,832,486	$6,303,566	13.8%	$39,528,920
Johns Hopkins Bayview Med. Center	$11,011,509	$1,095,942	10.0%	$9,915,567
Suburban Hospital	$16,577,683	$1,155,059	7.0%	$15,422,624
Sheppard & Enoch Pratt Hospital	$23,294,284	$1,038,876	4.5%	$22,255,407
Mercy Medical Center	$22,054,316	$771,483	3.5%	$21,282,833
The Johns Hopkins Hospital	$19,196,912	$339,222	1.8%	$18,857,690
Levindale Hebrew Geriatric Center & Hospital	$1,050,671	$17,957	1.7%	$1,032,714
Doctors Community Hospital	$13,929,205	$2,591	0.0%	$13,926,614
Frederick Memorial Hospital	$43,063,214	$0	0.0%	$43,063,214
Univ. of Maryland Harford Memorial Hospital	$5,733,481	$0	0.0%	$5,733,481
Carroll Hospital Center	$11,159,707	$0	0.0%	$11,159,707
TidalHealth McCready Pavillion	$39,305	$0	0.0%	$39,305
Howard County General Hospital	$18,013,817	$0	0.0%	$18,013,817
Univ. of Maryland Upper Chesapeake Medical Center	$12,526,680	$0	0.0%	$12,526,680
Univ. of Maryland St. Joseph's Medical Center	$45,307,943	$0	0.0%	$45,307,943
Holy Cross Germantown Hospital	$3,599,269	$0	0.0%	$3,599,269
J. Kent McNew Family Medical Center	$1,224,310	$0	0.0%	$1,224,310
Total	**$1,690,442,758**	**$857,762,187**	**50.7%**	**$832,680,571**

Mission-Driven Health Services: Physician Gaps in Availability

As noted above, the mission-driven health services category is the largest category of community benefits reported by Maryland hospitals. The mission-driven health services category includes subsidies that

hospitals provide to physicians to address gaps in physician availability to serve the hospital's uninsured population. Maryland law requires hospitals to justify the reporting of spending on physician subsides as a community benefit.[34] Hospitals must provide a written description of gaps in the availability of providers to serve their uninsured populations by specialty. Since FY 2021, hospitals have been required to separately itemize all physician subsidies claimed by type and specialty. The most frequently reported gaps were obstetrics and gynecology (reported by 31 hospitals), followed by psychiatry, other specialties, and internal medicine. Five hospitals reported no gaps in the availability of physicians to serve their uninsured population. See Table 8.

Table 8. Number of Hospitals Reporting Gaps in Physician Availability by Specialty

Gap in Physician Availability, by Specialty	Number of Hospitals
No gaps reported	5
Obstetrics & Gynecology	31
Psychiatry	30
Other	29
Internal Medicine	26
Emergency Medicine	24
Surgery	21
Pediatrics	19
Neurology	19
Cardiology	14
Oncology-Cancer	14
Anesthesiology	13
Endocrinology, Diabetes & Metabolism	10
Ophthalmology	10
Family Practice/General Practice	10
Orthopedics	9
Urology	9
Radiology	8
Otolaryngology	7
Neurological Surgery	6
Physical Medicine & Rehabilitation	5
Pathology	5
Plastic Surgery	4
Preventive Medicine	3
Geriatrics	2
Medical Genetics	1

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

Community Health Needs Assessments

Federal law requires hospitals to conduct a CHNA every three years and develop an implementation plan for addressing the community needs identified in the CHNA.[35] The CHNA evaluates the health needs of the community the hospital serves and identifies needs, gaps, assets, and resources as they relate to the health of the community. CHNAs are supposed to be developed with robust community input. CHNAs help the hospital set priorities for community benefits expenditures.

Appendix G shows maps indicating the coverage of hospitals' primary service areas and community benefit service areas (CBSAs), two ways of defining the community each hospital serves, as well as describing the ways hospitals reported identifying their CBSAs. Hospitals report details about these communities, which help inform decisions about HCB activities. Appendix H contains demographic statistics on each Maryland county, similar to the measures hospitals may use. See Appendix I for a list of the data sources hospitals reported on their FY 2024 narrative survey that they use in their HCB efforts.

Maryland requires hospitals to include information about their CHNA in their annual CBRs. The goal of this reporting is to provide transparency about 1) the extent to which the hospital's community benefit activities are aligned with their CHNA and 2) the level of community involvement in the development of the CHNA.

Spending on CHNA-Related Activities

Hospitals reported spending 37.2% of their net community benefit spending on CHNA-related activities. Note that not all community benefit activities are expected to align with the CHNA. While CHNAs help identify community health needs and priorities, some community benefit activities may address broader community well-being, even if they do not directly relate to those specific identified needs. Further, because CHNAs are conducted every three years, community benefit activities may address emerging community health needs, e.g., the COVID-19 pandemic.

There was wide variation between individual hospitals, ranging from -0.3% to 81.2% of total community benefit spent on CHNA related activities. This wide variation was similar to what was reported in FY 2022, the first year that hospitals reported this information. It is unclear whether this variation reflects true differences across hospitals or whether hospitals are using different criteria to determine whether activities are CHNA-related. To address this concern, staff convened a workgroup in the summer of 2024 and updated the instructions for FY 2024 reporting to provide additional clarification around what activities may count as CHNA-related, with the goal of having more comparable reporting across hospitals. Table 9

[35] Loyola University Chicago. (2024). *Background on community health needs assessment*. https://hsd.luc.edu/ipath/communityhealthneedsassessment/backgroundoncommunityhealthneedsassessment/#:~:text=The%20CHNA%20process%20helps%20not,the%20basis%20of%20tax%20exemption

presents each hospital's net total community benefit spending, the net total spent on CHNA-related activities, and the percentage of total spending on CHNA-related activities.

Table 9. CHNA Spending[36] as a Percentage of Net Community Benefit, FY 2023

Hospital	Total CB Spent on CHNA Priority Area Programs	Total CB Spending	Spending on CHNA as Percentage of Total CB
TidalHealth McCready Pavillion	$463,026	$569,926	81.2%
The Johns Hopkins Hospital	$294,673,159	$366,842,384	80.3%
MedStar Union Memorial Hospital	$36,524,578	$49,500,236	73.8%
UPMC Western Maryland Hospital	$55,526,483	$76,846,674	72.3%
MedStar Franklin Square Hospital	$45,645,923	$64,715,265	70.5%
Howard County General Hospital	$25,528,880	$36,557,318	69.8%
MedStar St. Mary's Hospital	$14,075,779	$20,644,933	68.2%
Johns Hopkins Bayview Med. Center	$71,781,220	$107,131,629	67.0%
Garrett Regional Hospital	$7,742,302	$11,567,923	66.9%
Suburban Hospital	$24,798,448	$37,663,565	65.8%
MedStar Harbor Hospital Center	$16,919,600	$25,891,745	65.3%
MedStar Southern Maryland Hospital	$17,529,085	$28,203,383	62.2%
MedStar Good Samaritan Hospital	$15,435,506	$26,431,968	58.4%
Mercy Medical Center	$41,474,355	$73,752,855	56.2%
MedStar Montgomery General Hospital	$8,211,584	$14,867,749	55.2%
Holy Cross Germantown Hospital	$3,734,771	$7,783,802	48.0%
Meritus Medical Center	$31,496,141	$66,551,271	47.3%
TidalHealth Peninsula Regional Medical Center	$23,943,154	$68,944,409	34.7%
Doctors Community Hospital	$11,483,619	$34,995,799	32.8%
Levindale Hebrew Geriatric Center & Hospital	$1,731,058	$5,536,488	31.3%
Sinai Hospital of Baltimore	$28,028,248	$92,712,551	30.2%
Mt. Washington Pediatric Hospital	$467,315	$1,574,578	29.7%
Holy Cross Hospital	$14,067,533	$50,599,565	27.8%
Carroll Hospital Center	$5,667,650	$22,533,952	25.2%
Adventist Rehabilitation	$437,533	$1,829,981	23.9%
Univ. of Maryland Upper Chesapeake Medical Center	$4,636,897	$22,452,379	20.7%
Lifebridge Northwest Hospital	$4,287,078	$24,425,906	17.6%
Univ. of Maryland Harford Memorial Hospital	$1,646,469	$9,837,007	16.7%
Anne Arundel General Hospital	$10,907,404	$70,148,046	15.5%
Sheppard & Enoch Pratt Hospital	$5,615,391	$36,721,183	15.3%
J. Kent McNew Family Medical Center	$357,001	$2,733,218	13.1%
Univ. of Maryland Baltimore Washington Medical Center	$3,212,874	$27,931,663	11.5%
Adventist Shady Grove Medical Center	$3,593,163	$40,032,662	9.0%

[36] Offsetting revenue has been removed.

Hospital	Total CB Spent on CHNA Priority Area Programs	Total CB Spending	Spending on CHNA as Percentage of Total CB
Univ. of Maryland Charles Regional Medical Center	$1,285,244	$14,618,252	8.8%
Univ. of Maryland St. Joseph's Medical Center	$4,817,340	$58,245,151	8.3%
Univ. of Maryland Shore Medical Center at Chestertown	$638,545	$10,087,696	6.3%
Adventist White Oak Hospital	$1,444,947	$31,922,588	4.5%
Frederick Memorial Hospital	$2,483,434	$56,892,363	4.4%
Ascension Saint Agnes Hospital	$1,993,893	$52,882,154	3.8%
Univ. of Maryland Shore Medical Center at Easton	$1,372,541	$38,023,876	3.6%
Adventist Fort Washington Medical Center	$198,654	$7,102,621	2.8%
Univ. of Maryland Capital Region Medical Center	$1,175,691	$45,637,576	2.6%
Univ. of Maryland Medical Center Midtown Campus	$687,688	$34,323,489	2.0%
CalvertHealth Medical Center	$169,709	$8,942,397	1.9%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$138,810	$9,020,727	1.5%
Atlantic General Hospital	$70,452	$8,415,352	0.8%
Univ. of Maryland Medical Center	$1,506,692	$282,975,200	0.5%
ChristianaCare, Union Hospital	$120,720	$23,264,049	0.5%
Greater Baltimore Medical Center[37]	-$232,104	$70,577,819	-0.3%
Total	**$849,515,484**	**$2,281,463,324**	**37.2%**

Hospitals also described the community benefit initiatives undertaken to address CHNA-identified needs in the community. Table 10 summarizes the CHNA priority area categories most commonly addressed by hospital initiatives in FY 2023. Appendix J shows the number of hospitals reporting initiatives to address each of the full list of CHNA-identified community health needs.

Table 10. Top 5 CHNA Priority Area Categories Addressed by Hospitals

CHNA Priority Area	Number of Hospitals
Social Determinants of Health - Health Care Access and Quality	35
Settings and Systems - Community	32
Health Conditions - Diabetes	31
Health Conditions - Mental Health and Mental Disorders	31
Health Behaviors - Preventive Care	31

[37] Staff followed up with Greater Baltimore Medical Center to confirm that this net negative amount was correct. Because the value is negative, it indicates that the CHNA priority area programs generated more offsetting revenue than their cost to the hospital.

CHNA Development Process

All Maryland nonprofit hospitals reported conducting CHNAs within the past three fiscal years, as required by federal law. See Appendix K for the dates on which hospitals completed their last CHNAs.

Federal law requires hospitals to use input from individuals who represent the broad interests of the community served by the hospital in their CHNA. Each hospital records the process for assessing community needs and the findings from that process in a CHNA document that is made available to the public. Hospitals also produce a plan for implementing activities to address the identified community needs,[38] which some include directly in the CHNA document and others provide separately. All Maryland nonprofit hospitals reported adopting an implementation strategy. The CHNA document must also note any community needs that were identified in prior CHNAs that have not been met and explain why they were not addressed.

The CHNA document includes descriptions of the people and organizations with whom the hospital collaborated on the assessment of community health needs. Hospitals reported collaborating with a broad set of community organizations when developing their CHNAs. Table 11 shows the number of hospitals that reported collaborating with various external organizations. See Appendices L and M for more detail on these external participants.

[38] 26 U.S.C. § 501(r)(3)(A)-(B).

Table 11. Number of Hospitals that Collaborated with Selected Types of External Organizations for Their Most Recent CHNA, FY 2023

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Facilities	19	40%
Local Health Departments	45	96%
Local Health Improvement Coalitions	42	89%
Other Hospitals	35	74%
Behavioral Health Organizations	40	85%

Community Benefit Administration

Hospitals report information on how they staff CHNA and HCB activities, whether they audit their community benefit data, the role of the hospital board in their community benefit report, and whether community benefit is included in the hospital's strategic planning process.

Conducting CHNAs, developing implementation plans, and reporting HCB takes time and resources. Hospitals have different approaches to staffing the administration of their community benefit activities and reporting responsibilities. Most hospitals have invested in staff who are dedicated to community benefit and/or population health. These staff play a key role in hospital CHNAs and community benefit activities, as shown in Table 12.

Table 12. Number of Hospitals Reporting Staff in the Following Categories Contributing to CB or CHNA Operations

Staff Category	Number of Hospitals	Percentage of Hospitals
Population Health Staff	45	96%
Community Benefit Staff	43	91%
Community Benefit/Pop Health Director	45	96%

Appendix N details the types of staff involved in hospital CHNAs. Appendix O details the types of staff involved in HCB activities.

All hospitals conducted some form of audit on the financial data they submitted to the HSCRC (Table 13). These audits were mostly performed by hospital or hospital system staff, but 12 hospitals used third-party auditors.

Table 13. Hospital Audits of CBR Financial Spreadsheet

Staff or Entity Conducting Audit	Number of Hospitals Completing Audit	
	Yes	No
Hospital Staff	42	5
System Staff	38	9
Third-Party	12	35
No Audit	0	47
Two or More Audit Types	37	10
Three or More Audit Types	8	39

Each nonprofit hospital is governed by a board. The majority (37) of the CBRs were reviewed by the hospital boards (Table 14). Of the 10 CBRs that were not reviewed by the board, common reasons were timing or because the board had delegated this authority to executive or financial staff or an external firm. 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 2022.

Table 14. Hospital Board Review of the CBR

Board Review/Approval	Number of Hospitals	
	Yes	No
Financial Report (Spreadsheet)	37	10
Narrative Report	37	10

Conclusion

Maryland's community benefit reporting requirements are more extensive than the federal requirements. All 49 nonprofit hospitals in Maryland submitted the required information for FY 2023. Maryland hospitals' FY 2023 community benefit expenditures totaled almost $2.3 billion, or $1.3 billion after accounting for activities that are funded through hospital rates set by the HSCRC. Total community benefit expenditures as a percentage of hospital operating expenses increased from 10.6% in FY 2022 to 11.3% in FY 2023. When the rate-supported activities are removed, community benefit expenses grew from 6.2% to 6.6% of operating expenses over the same period. All hospitals reported claiming exemption from federal and state income taxes.

All hospitals submitted a CHNA and CHNA implementation strategy. Most hospitals reported collaborating with local health departments and health improvement coalitions, other hospitals, and behavioral health

organizations on their CHNAs. Encouragingly, most hospitals have dedicated staff for community benefit and/or population health. Most reported that both hospital and system staff audit community benefit financial report data, the hospital board reviews the financial spreadsheet and the narrative report, and they have incorporated community benefit investments into their strategic plan.

Staff identified the following areas for continued review:

- There continues to be a wide variation in the percentage of net community benefit hospitals spent on CHNA-related activities. Staff convened a workgroup in the summer of 2024 to gather feedback for improving the consistency and comparability of reporting in this area, made corresponding clarifications to the FY 2024 reporting instructions, and convened a hospital training webinar. FY 2024 submissions were due in January 2025, and staff will review the results to determine whether further reporting clarifications are needed.
- There continues to be a wide variation in indirect cost ratios. Staff completed an additional validation step for the FY 2023 report, comparing the indirect cost ratio reported on the CBR with the ratio reported on the HSCRC's Annual Cost Report Schedule M. As a result of this step, several hospitals made corrections to their initial submission, while other hospitals provided explanations for the variation. This issue was also discussed in the workgroup, and technical corrections were made to the FY 2024 reporting instructions. While the additional validation step resulted in some improvements for the FY 2023 report, staff will review the results of the upcoming FY 2024 report to determine whether further clarifications are needed. In the FY 2024 report, staff also intend to conduct additional analyses showing what expenditures would be if a consistent indirect cost ratio was applied across hospitals.

Appendix A. Comparison of Federal and State Community Benefit Categories

Activities the Federal Government Defines as HCB (Schedule H)	Activities Maryland Includes as HCB (this list is not exclusive)
Net, unreimbursed costs of financial assistance (free or reduced cost care)**	Financial assistance
Participation in means-tested government programs, such as Medicaid**	Hospital contribution to the Medicaid Deficit Assessment
Health professions education	Health professions education
Health services research	Research
Subsidized health services	Mission-driven health service
Community health improvement activities	A community health service An operation related to a planned, organized, and measured activity that is intended to meet identified community health needs within a service area A planned, organized, and measured activity that is intended to meet identified community health needs within a service area is funded by a foundation
Cash or in-kind contributions to other community groups.	A financial contribution Financial or in-kind support of the Maryland Behavioral Health Crisis Response System.
Community-building activities. Example: Investments in housing	A community-building activity, including partnerships with community-based organizations

Appendix B. Hospitals Submitting Community Benefit Reports

Maryland Hospitals that Submitted CBRs in FY 2023, 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	McNew Family Health Center
Adventist HealthCare White Oak Medical Center	**MedStar Health**
Ascension	MedStar Franklin Square Medical Center
Saint Agnes Healthcare, Inc.	MedStar Good Samaritan Hospital
Christiana Care Health System, Inc.	MedStar Harbor Hospital
Christiana Care, Union Hospital	MedStar Montgomery Medical Center
Independent Hospitals	MedStar Southern Maryland Hospital Center
Atlantic General Hospital	MedStar St. Mary's Hospital
CalvertHealth Medical Center	MedStar Union Memorial Hospital
Frederick Health Hospital	**TidalHealth**
Greater Baltimore Medical Center	TidalHealth McCready Pavilion[39]
Mercy Medical Center	TidalHealth Peninsula Regional
Meritus Medical Center	**Trinity Health**
Sheppard Pratt	Holy Cross Germantown Hospital
Johns Hopkins Health System	Holy Cross Hospital
Howard County General Hospital	**University of Maryland Medical System**
Johns Hopkins Bayview Medical Center	UM Baltimore Washington Medical Center
Johns Hopkins Hospital	UM Capital Region Health
Suburban Hospital	UM Charles Regional Medical Center
Jointly Owned Hospitals	UM Rehabilitation & Orthopaedic Institute
Mt. Washington Pediatric Hospital[40]	UM Shore Regional Health
LifeBridge Health	UM St. Joseph Medical Center
Carroll Hospital Center	UM Upper Chesapeake Health
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	UMMC Midtown Campus
Northwest Hospital Center, Inc.	University of Maryland Medical Center
Sinai Hospital of Baltimore, Inc.	**UPMC**
	UPMC Western Maryland
	West Virginia University Health System
	GRMC, Inc., DBA Garrett Regional Medical Ctr.

[39] The TidalHealth McCready Pavilion is a Freestanding Medical Facility associated with Peninsula Regional.
[40] Jointly owned by the University of Maryland Medical System and Johns Hopkins.

maryland health services cost review commission

Appendix C. FY 2023 Funding through Rates for HCB Activities

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Total Rate-Supported Community Benefit Activities
Adventist Fort Washington Medical Center	$0	$63,872	$63,872	$454,879	$2,245,578	$2,828,202
Adventist Rehabilitation	$0	$45,203	$0	$0	$0	$45,203
Adventist Shady Grove Medical Center	$0	$495,127	$495,127	$732,276	$12,323,361	$14,045,891
Adventist White Oak Hospital	$0	$331,339	$331,339	$473,991	$10,097,266	$11,233,936
Anne Arundel General Hospital	$7,146,295	$699,722	$699,722	$0	$5,004,158	$13,549,898
Atlantic General Hospital	$0	$122,135	$122,135	$561,465	$1,122,610	$1,928,344
CalvertHealth Medical Center	$0	$163,995	$163,995	$0	$2,757,010	$3,085,000
Carroll Hospital Center	$0	$199,007	$199,007	$208,923	$2,902,386	$3,509,323
ChristianaCare, Union Hospital	$0	$251,514	$251,514	$0	$1,587,375	$2,090,403
Doctors Community Hospital	$0	$253,009	$253,009	$288,379	$14,399,742	$15,194,139
Frederick Memorial Hospital	$0	$388,588	$388,588	$832,321	$5,891,400	$7,500,897
Garrett County Memorial Hospital	$0	$66,256	$66,256	$0	$2,677,588	$2,810,100
Greater Baltimore Medical Center	$6,614,075	$526,376	$526,376	$427,540	$3,709,101	$11,803,468
Holy Cross Germantown Hospital	$0	$131,583	$131,583	$180,799	$3,428,100	$3,872,065
Holy Cross Hospital	$2,692,852	$554,475	$554,475	$807,969	$20,676,698	$25,286,469
Howard County General Hospital	$0	$320,588	$320,588	$871,180	$7,973,000	$9,485,356
J Kent McNew Family Medical Center	$0	$9,364	$0	$0	$0	$9,364
Johns Hopkins Bayview Med. Center	$29,014,221	$754,929	$754,929	$1,511,135	$30,503,000	$62,538,214
Levindale Hebrew Geriatric Center & Hospital	$0	$55,385	$55,385	$0	$2,494,444	$2,605,214
Lifebridge Northwest Hospital Center	$0	$274,312	$274,312	$240,378	$6,124,376	$6,913,378
MedStar Franklin Square Hospital	$10,902,334	$604,526	$604,526	$500,602	$17,362,008	$29,973,997
MedStar Good Samaritan Hospital	$2,648,628	$287,494	$287,494	$238,767	$10,187,092	$13,649,475
MedStar Harbor Hospital Center	$1,732,317	$169,385	$169,385	$165,457	$8,406,708	$10,643,252
MedStar Montgomery General Hospital	$0	$189,414	$189,414	$0	$6,094,996	$6,473,824
MedStar Southern Maryland Hospital	$0	$296,310	$296,310	$2,417,778	$9,816,141	$12,826,539
MedStar St. Mary's Hospital	$0	$246,867	$246,867	$210,044	$5,866,438	$6,570,216

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Total Rate-Supported Community Benefit Activities
MedStar Union Memorial Hospital	$12,558,450	$453,671	$453,671	$376,133	$11,690,948	$25,532,873
Mercy Medical Center	$4,685,348	$619,895	$619,895	$490,746	$21,995,243	$28,411,126
Meritus Medical Center	$5,024,792	$429,741	$429,741	$1,178,916	$12,015,919	$19,079,109
Mt. Washington Pediatric Hospital	$0	$63,655	$0	$0	$264,092	$327,747
Sheppard Pratt	$2,990,329	$152,435	$0	$0	$8,741,514	$11,884,279
Sinai Hospital of Baltimore	$19,586,748	$897,075	$897,075	$1,552,902	$15,116,995	$38,050,795
St. Agnes Hospital	$6,826,946	$434,080	$434,080	$478,434	$15,382,432	$23,555,972
Suburban Hospital	$607,064	$370,255	$370,255	$696,192	$7,067,394	$9,111,160
The Johns Hopkins Hospital	$138,125,253	$2,759,868	$2,759,868	$5,231,027	$55,925,900	$204,801,916
TidalHealth McCready Pavillion	$0	$5,296	$5,296	$0	$106,900	$117,492
TidalHealth Peninsula Regional Medical Center	$5,502,090	$508,153	$508,153	$1,684,395	$10,293,900	$18,496,691
UM Capital Region	$5,547,887	$376,230	$376,230	$3,230,297	$7,790,313	$17,320,957
Univ. of Maryland Baltimore Washington Medical Center	$773,097	$475,475	$475,475	$0	$8,287,000	$10,011,047
Univ. of Maryland Charles Regional Medical Center	$0	$169,385	$169,385	$408,173	$2,498,000	$3,244,943
Univ. of Maryland Harford Memorial Hospital	$0	$109,164	$109,164	$0	$2,167,000	$2,385,328
Univ. of Maryland Medical Center	$168,321,811	$1,980,238	$1,980,238	$2,947,123	$29,197,000	$204,426,410
Univ. of Maryland Medical Center Midtown Campus	$3,674,217	$238,163	$238,163	$1,723,233	$4,254,000	$10,127,776
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$1,587,928	$128,091	$128,091	$0	$1,726,000	$3,570,110
Univ. of Maryland Shore Medical Center at Chestertown	$0	$44,183	$44,183	$0	$1,026,000	$1,114,366
Univ. of Maryland Shore Medical Center at Easton	$150,000	$238,163	$238,163	$0	$4,294,758	$4,921,084
Univ. of Maryland St. Joseph's Medical Center	$0	$416,739	$416,739	$347,151	$7,208,373	$8,389,002
Univ. of Maryland Upper Chesapeake Medical Center	$0	$347,850	$347,850	$0	$4,258,000	$4,953,700
UPMC Western Maryland Hospital	$0	$357,297	$357,297	$1,126,299	$13,719,300	$15,560,193
Total	**$436,712,683**	**$19,075,878**	**$18,805,221**	**$32,594,902**	**$438,677,558**	**$945,866,242**

Appendix D. FY 2023 Community Benefit Analysis

Table D1. Hospital Operating Expenses and Community Benefit Expenses

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense
Adventist Fort Washington Medical Center	$63,947,008	$7,102,621	11.11%
Adventist Rehabilitation	$63,524,116	$1,829,981	2.88%
Adventist Shady Grove Medical Center	$450,979,711	$40,032,662	8.88%
Adventist White Oak Hospital	$329,144,866	$31,922,588	9.70%
Anne Arundel General Hospital	$647,110,000	$70,148,046	10.84%
Ascension Saint Agnes Hospital	$537,591,223	$52,882,154	9.84%
Atlantic General Hospital	$166,422,837	$8,415,352	5.06%
CalvertHealth Medical Center	$160,772,982	$8,942,397	5.56%
Carroll Hospital Center	$279,472,729	$22,533,952	8.06%
ChristianaCare, Union Hospital	$192,302,239	$23,264,049	12.10%
Doctors Community Hospital	$247,220,000	$34,995,799	14.16%
Frederick Memorial Hospital	$413,459,000	$56,892,363	13.76%
Garrett Regional Hospital	$63,327,026	$11,567,923	18.27%
Greater Baltimore Medical Center	$624,194,000	$70,577,819	11.31%
Holy Cross Germantown Hospital	$139,664,351	$7,783,802	5.57%
Holy Cross Hospital	$526,196,350	$50,599,565	9.62%
Howard County General Hospital	$331,650,000	$36,557,318	11.02%
J. Kent McNew Family Medical Center	$8,727,322	$2,733,218	31.32%
Johns Hopkins Bayview Med. Center	$760,312,000	$107,131,629	14.09%
Levindale Hebrew Geriatric Center & Hospital	$81,606,195	$5,536,488	6.78%
Lifebridge Northwest Hospital Center	$317,819,933	$24,425,906	7.69%
MedStar Franklin Square Hospital	$682,540,830	$64,715,265	9.48%
MedStar Good Samaritan Hospital	$317,400,224	$26,431,968	8.33%
MedStar Harbor Hospital Center	$230,578,957	$25,891,745	11.23%
MedStar Montgomery General Hospital	$228,602,542	$14,867,749	6.50%
MedStar Southern Maryland Hospital	$306,906,165	$28,203,383	9.19%
MedStar St. Mary's Hospital	$201,299,285	$20,644,933	10.26%
MedStar Union Memorial Hospital	$516,967,157	$49,500,236	9.58%
Mercy Medical Center	$579,752,405	$73,752,855	12.72%
Meritus Medical Center	$517,495,595	$66,551,271	12.86%
Mt. Washington Pediatric Hospital	$68,508,229	$1,574,578	2.30%
Sheppard & Enoch Pratt Hospital	$275,498,276	$36,721,183	13.33%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense
Sinai Hospital of Baltimore	$954,434,934	$92,712,551	9.71%
Suburban Hospital	$374,467,000	$37,663,565	10.06%
The Johns Hopkins Hospital	$3,060,451,000	$366,842,384	11.99%
TidalHealth McCready Pavillion	$9,044,100	$569,926	6.30%
TidalHealth Peninsula Regional Medical Center	$480,411,000	$68,944,409	14.35%
Univ. of Maryland Baltimore Washington Medical Center	$474,046,000	$27,931,663	5.89%
Univ. of Maryland Capital Region Medical Center	$379,857,000	$45,637,576	12.01%
Univ. of Maryland Charles Regional Medical Center	$149,018,616	$14,618,252	9.81%
Univ. of Maryland Harford Memorial Hospital	$99,813,000	$9,837,007	9.86%
Univ. of Maryland Medical Center	$2,022,919,000	$282,975,200	13.99%
Univ. of Maryland Medical Center Midtown Campus	$268,702,000	$34,323,489	12.77%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$124,385,000	$9,020,727	7.25%
Univ. of Maryland Shore Medical Center at Chestertown	$45,865,000	$10,087,696	21.99%
Univ. of Maryland Shore Medical Center at Easton	$298,925,000	$38,023,876	12.72%
Univ. of Maryland St. Joseph's Medical Center	$409,862,000	$58,245,151	14.21%
Univ. of Maryland Upper Chesapeake Medical Center	$314,183,000	$22,452,379	7.15%
UPMC Western Maryland Hospital	$353,692,553	$76,846,674	21.73%
Total, All Hospitals	**$20,151,069,758**	**$2,281,463,324**	**11.32%**

Table D2. Rate-Supported Community Benefit, Including Financial Assistance

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
	A	B	C	D=B-C	E=D/A	F	G=F/A
Adventist Fort Washington Medical Center	$63,947,008	$7,102,621	$2,828,202	$4,274,419	6.68%	$657,109	1.03%
Adventist Rehabilitation	$63,524,116	$1,829,981	$45,203	$1,784,778	2.81%	$108,409	0.17%
Adventist Shady Grove Medical Center	$450,979,711	$40,032,662	$14,045,891	$25,986,771	5.76%	$15,449,975	3.43%
Adventist White Oak Hospital	$329,144,866	$31,922,588	$11,233,936	$20,688,652	6.29%	$12,021,241	3.65%
Anne Arundel General Hospital	$647,110,000	$70,148,046	$13,549,898	$56,598,149	8.75%	$5,004,158	0.77%
Ascension Saint Agnes Hospital	$537,591,223	$52,882,154	$23,555,972	$29,326,182	5.46%	$19,737,929	3.67%
Atlantic General Hospital	$166,422,837	$8,415,352	$1,928,344	$6,487,008	3.90%	$737,899	0.44%
CalvertHealth Medical Center	$160,772,982	$8,942,397	$3,085,000	$5,857,396	3.64%	$2,757,101	1.71%
Carroll Hospital Center	$279,472,729	$22,533,952	$3,509,323	$19,024,629	6.81%	$2,902,386	1.04%
ChristianaCare, Union Hospital	$192,302,239	$23,264,049	$2,090,403	$21,173,646	11.01%	$1,370,679	0.71%
Doctors Community Hospital	$247,220,000	$34,995,799	$15,194,139	$19,801,660	8.01%	$14,399,742	5.82%

[41] Excludes expenditures on community benefit activities that are offset by revenue.
[42] Includes funding for financial assistance, DME, NSPI, NSPII, & Regional Partnership Catalyst Grant.
[43] The values in this column have been calculated by subtracting the total rate support each hospital received for charity care and the DME, NSPI, NSPII, & Regional Partnership Catalyst funding programs from the hospital's total community benefit expense. Hospitals' offsetting revenue has already been subtracted from the total community benefit expense value.

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Frederick Memorial Hospital	$413,459,000	$56,892,363	$7,500,897	$49,391,466	11.95%	$1,283,823	0.31%
Garrett Regional Hospital	$63,327,026	$11,567,923	$2,810,100	$8,757,823	13.83%	$3,646,138	5.76%
Greater Baltimore Medical Center	$624,194,000	$70,577,819	$11,803,468	$58,774,352	9.42%	$3,709,101	0.59%
Holy Cross Germantown Hospital	$139,664,351	$7,783,802	$3,872,065	$3,911,737	2.80%	$3,618,340	2.59%
Holy Cross Hospital	$526,196,350	$50,599,565	$25,286,469	$25,313,096	4.81%	$29,603,040	5.63%
Howard County General Hospital	$331,650,000	$36,557,318	$9,485,356	$27,071,962	8.16%	$7,972,509	2.40%
J. Kent McNew Family Medical Center	$8,727,322	$2,733,218	$9,364	$2,723,854	31.21%	$101,407	1.16%
Johns Hopkins Bayview Med. Center	$760,312,000	$107,131,629	$62,538,214	$44,593,415	5.87%	$30,503,000	4.01%
Levindale Hebrew Geriatric Center & Hospital	$81,606,195	$5,536,488	$2,605,214	$2,931,274	3.59%	$2,494,444	3.06%
Lifebridge Northwest Hospital Center	$317,819,933	$24,425,906	$6,913,378	$17,512,528	5.51%	$6,124,376	1.93%
MedStar Franklin Square Hospital	$682,540,830	$64,715,265	$29,973,997	$34,741,268	5.09%	$17,362,008	2.54%
MedStar Good Samaritan Hospital	$317,400,224	$26,431,968	$13,649,475	$12,782,493	4.03%	$10,187,092	3.21%
MedStar Harbor Hospital Center	$230,578,957	$25,891,745	$10,643,252	$15,248,493	6.61%	$8,406,708	3.65%
MedStar Montgomery General Hospital	$228,602,542	$14,867,749	$6,473,824	$8,393,925	3.67%	$6,094,996	2.67%
MedStar Southern Maryland Hospital	$306,906,165	$28,203,383	$12,826,539	$15,376,844	5.01%	$9,816,141	3.20%
MedStar St. Mary's Hospital	$201,299,285	$20,644,933	$6,570,216	$14,074,716	6.99%	$5,967,196	2.96%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
MedStar Union Memorial Hospital	$516,967,157	$49,500,236	$25,532,873	$23,967,363	4.64%	$11,690,948	2.26%
Mercy Medical Center	$579,752,405	$73,752,855	$28,411,126	$45,341,729	7.82%	$21,995,243	3.79%
Meritus Medical Center	$517,495,595	$66,551,271	$19,079,109	$47,472,161	9.17%	$12,269,867	2.37%
Mt. Washington Pediatric Hospital	$68,508,229	$1,574,578	$327,747	$1,246,830	1.82%	$264,092	0.39%
Sheppard & Enoch Pratt Hospital	$275,498,276	$36,721,183	$11,884,279	$24,836,905	9.02%	$8,741,514	3.17%
Sinai Hospital of Baltimore	$954,434,934	$92,712,551	$38,050,795	$54,661,756	5.73%	$15,116,994	1.58%
Suburban Hospital	$374,467,000	$37,663,565	$9,111,160	$28,552,405	7.62%	$7,067,000	1.89%
The Johns Hopkins Hospital	$3,060,451,000	$366,842,384	$204,801,916	$162,040,468	5.29%	$55,926,000	1.83%
TidalHealth McCready Pavillion	$9,044,100	$569,926	$117,492	$452,434	5.00%	$106,900	1.18%
TidalHealth Peninsula Regional Medical Center	$480,411,000	$68,944,409	$18,496,691	$50,447,718	10.50%	$10,358,300	2.16%
Univ. of Maryland Baltimore Washington Medical Center	$474,046,000	$27,931,663	$10,011,047	$17,920,616	3.78%	$8,287,000	1.75%
Univ. of Maryland Capital Region Medical Center	$379,857,000	$45,637,576	$17,320,957	$28,316,619	7.45%	$6,996,000	1.84%
Univ. of Maryland Charles Regional Medical Center	$149,018,616	$14,618,252	$3,244,943	$11,373,310	7.63%	$2,497,665	1.68%
Univ. of Maryland Harford Memorial Hospital	$99,813,000	$9,837,007	$2,385,328	$7,451,679	7.47%	$2,167,000	2.17%
Univ. of Maryland Medical Center	$2,022,919,000	$282,975,200	$204,426,410	$78,548,790	3.88%	$29,197,000	1.44%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Univ. of Maryland Medical Center Midtown Campus	$268,702,000	$34,323,489	$10,127,776	$24,195,713	9.00%	$4,254,000	1.58%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$124,385,000	$9,020,727	$3,570,110	$5,450,617	4.38%	$1,726,000	1.39%
Univ. of Maryland Shore Medical Center at Chestertown	$45,865,000	$10,087,696	$1,114,366	$8,973,330	19.56%	$1,026,000	2.24%
Univ. of Maryland Shore Medical Center at Easton	$298,925,000	$38,023,876	$4,921,084	$33,102,793	11.07%	$4,670,000	1.56%
Univ. of Maryland St. Joseph's Medical Center	$409,862,000	$58,245,151	$8,389,002	$49,856,149	12.16%	$6,812,000	1.66%
Univ. of Maryland Upper Chesapeake Medical Center	$314,183,000	$22,452,379	$4,953,700	$17,498,679	5.57%	$4,258,000	1.36%
UPMC Western Maryland Hospital	$353,692,553	$76,846,674	$15,560,193	$61,286,481	17.33%	$14,905,333	4.21%
Total, All Hospitals	**$20,151,069,758**	**$2,281,463,324**	**$945,866,242**	**$1,335,597,082**	**6.63%**	**$452,369,804**	**2.24%**

Appendix E. Methodology for Rate Support for Uncompensated Care, including Financial Assistance

Financial assistance amounts reported by hospitals in their community benefit reports (CBRs) may not match the financial assistance amounts applied in their global budgets for the same year. The financial assistance 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 CBRs are retrospective.

The HSCRC calculates the amount of UCC provided in hospital rates at each regulated Maryland hospital using a multi-step process:

1. **Statewide Actual UCC in All-Payer Hospital Rates:** The HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported on all acute hospitals' RE Schedules for the previous year. The change in hospital rates based on statewide actual UCC, as a percent of gross patient revenue, is applied uniformly to acute care hospital rates statewide.
2. **Hospital Payments or Contributions to the UCC Fund** The UCC Fund is then used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.
    i. **Hospital-Specific Actual UCC:** The HSCRC uses gross patient revenue as reported on the hospitals' RE Schedules for the previous year to determine the hospital-specific actual UCC for each hospital.
    ii. **Hospital-Specific Predicted UCC:** The HSCRC uses a mathematical model to predict a hospital's expected amount of UCC. This model takes into account Area Deprivation Index (ADI), payer type, and site of care.
    iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized such that the statewide 50/50 blend equals the prior year actual UCC rate that was built into statewide hospital rates (step 1 for the prior year). This ensures that the UCC fund is redistributive in nature.
    iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how

much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which the HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

Table E1. UCC Methodology Example ($ Millions)

		Statewide actual UCC in all-payer hospital rates		**Hospital Payments or Contributions to the UCC fund.**			
		Step 1		Step 2(i)	Step 2(ii)	Step 2(iii)	Step 2(iv)
	A	**B**	**C = A X B**	**D**	**E**	**F = Avg D & E**	**G = (F-B) X A**
	GBR	**Prior Year Statewide UCC Rate**	**UCC Funding Provided in Rates**	**Prior Year Hospital-Specific UCC Rate**	**Predicted Hospital-specific UCC Rate**	**Hospital-Specific 50/50 Blend**	**(Payment) or Withdrawal from UCC Fund**
Hospital A	$300	5%	$15	3%	4%	3.50%	($4.50)
Hospital B	$300	5%	$15	7%	6%	6.50%	$4.50

The use of blended actual and predicted UCC to determine the amount of hospital contributions and withdrawals from the UCC funds serves to balance the policy goals of reimbursing hospitals for UCC provided to low-income patients while also incentivizing hospitals to minimize bad debt by encouraging them to use reasonable means to collect debt from patients who can afford to pay. Incorporating predicted UCC into this methodology provides hospitals with a financial incentive to collect payments (rather than writing debt off as bad debt without attempting to collect) so that UCC costs do not rise too quickly. This approach is critical to supporting Maryland's unique UCC system and ensuring access to care for low-income patients in the long run.

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Appendix F. FY 2023 Hospital Community Benefit Aggregate Data

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
Unreimbursed Medicaid Costs							
T99	**Medicaid Assessments**	**$295,626,867**	[45]		**$238,997,382**	**$55,466,167**	**$55,466,167**
Community Health Services							
A10	Community Health Education	$16,586,183	$8,318,251	$1,168,901	$2,720,697	$21,014,836	$12,696,586
A11	Support Groups	$2,313,576	$1,767,865	$860	$4,915	$4,075,666	$2,307,801
A12	Self-Help	$1,476,507	$662,923		$226,850	$1,912,581	$1,249,657
A20	Community-Based Clinical Services	$24,494,852	$6,700,082		$10,143,430	$21,051,504	
A21	Screenings	$3,008,461	$2,069,624		$1,028,063	$4,050,023	$1,980,399
A22	One-Time/Occasionally Held Clinics	$972,719	$83,166		$27	$1,055,858	$972,692
A23	Clinics for Underinsured and Uninsured	$7,507,569	$3,384,861		$1,736,399	$9,156,032	$5,771,171
A24	Mobile Units	$1,609,452	$553,326		$1,471,904	$690,874	$137,548
A30	Health Care Support Services	$75,038,638	$27,107,234	$9,023,985	$7,838,474	$85,283,412	$58,176,179
A40	Other	$9,635,784	$4,243,382	$685,510	$1,751,807	$11,441,849	$7,198,467
A99	**Total**	**$142,643,741**	**$54,890,714**	**$10,879,256**	**$26,922,565**	**$159,732,634**	**$104,841,920**
Health Professions Education							
B10	Physicians/Medical Students	$397,318,606	$202,459,862	$619,923	$2,930,318	$596,228,227	$393,768,365
B20	Nurses/Nursing Students	$36,029,551	$20,805,489	$3,885,052		$52,949,989	$32,144,499
B30	Other Health Professionals	$20,620,925	$10,163,456		$143,643	$30,640,738	$20,477,282

[44] "Net Community Benefit" refers to hospitals' costs minus their offsetting revenue and rate support totals.
[45] Blank cells indicate a value of 0.

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
B40	Scholarships/Funding for Professional Education	$3,284,005	$1,640,041	$320,588		$4,603,458	$2,963,417
B50	Other	$1,709,214	$1,172,550		$446,946	$2,434,818	$1,262,268
B99	**Total**	**$458,962,301**	**$236,241,399**	**$4,825,563**	**$3,520,907**	**$686,857,230**	**$450,615,831**
	Mission-Driven Health Services						
C99	**Mission-Driven Health Services Total**	**$1,537,041,477**	**$153,401,280**	**$66,690**	**$857,695,497**	**$832,680,571**	**$679,279,291**
	Research						
D10	Clinical Research	$13,313,308	$4,383,266		$5,751,402	$11,945,173	$7,561,907
D20	Community Health Research	$1,142,112	$380,425		$34,937	$1,487,600	$1,107,175
D30	Other	$663,270	$279,573		$197,315	$745,528	$465,955
D99	**Total**	**$15,118,691**	**$5,043,264**		**$5,983,654**	**$14,178,301**	**$9,135,037**
	Financial Contributions						
E10	Cash Donations	$12,975,236	$4,734		$1,500	$12,978,470	$12,973,736
E20	Grants	$5,898,467			$3,384,457	$2,514,010	$2,514,010
E30	In-Kind Donations	$2,427,066	$29,500		$74,215	$2,382,351	$2,352,851
E40	Cost of Fund Raising for Community Programs	$6,578,376			$4,326,301	$2,252,075	$2,252,075
E99	**Total**	**$27,879,146**	**$34,234**		**$7,786,473**	**$20,126,907**	**$20,092,673**
	Community-Building Activities						
F10	Physical Improvements and Housing	$1,234,790	$295,018		$134,362	$1,395,446	$1,100,428
F20	Economic Development	$1,468,921	$443,861		$12,500	$1,900,282	$1,456,421
F30	Community Support	$6,990,614	$2,720,876	$878,623	$2,374,570	$6,458,297	$3,737,421
F40	Environmental Improvements	$678,749	$341,310		$1,000	$1,019,059	$677,749
F50	Leadership Development/Training for Community Members	$411,572	$315,612			$727,185	$411,572
F60	Coalition Building	$3,931,888	$2,133,076		$82,121	$5,982,843	$3,849,767

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
F70	Advocacy for Community Health Improvements	$1,197,008	$230,622			$1,427,631	$1,197,008
F80	Workforce Development	$3,314,487	$1,337,859		$491,189	$4,161,156	$2,823,298
F90	Other	$718,577	$557,584			$1,276,161	$718,577
F99	**Total**	**$19,946,606**	**$8,375,819**	**$878,623**	**$3,095,742**	**$24,348,059**	**$15,972,241**
Community Benefit Operations							
G10	Assigned Staff	$9,094,011	$4,674,055		$6,558	$13,761,508	$9,087,453
G20	Community Health/Health Assets Assessments	$483,350	$365,026		$11,085	$837,291	$472,265
G30	Other	$1,741,784	$475,132		$13,856	$2,203,060	$1,727,928
G99	**Total**	**$11,319,145**	**$5,514,213**		**$31,499**	**$16,801,859**	**$11,287,646**
Financial Assistance							
H00	**Total Financial assistance**	**$452,369,804**					
Foundation-Funded Community Benefits							
J10	Community Services	$1,273,727	$458,484		$83,082	$1,649,128	$1,190,644
J20	Community Building	$687,718	$282,822		$379,855	$590,685	$307,863
J30	Other		$11,846			$11,846	
J99	**Total**	**$1,961,445**	**$753,152**		**$462,937**	**$2,251,660**	**$1,498,507**
Total Hospital Community Benefits							
A99	Community Health Services	$142,643,741	$54,890,714	$10,879,256	$26,922,565	$159,732,634	$104,841,920
B99	Health Professions Education	$458,962,301	$236,241,399	$4,825,563	$3,520,907	$686,857,230	$450,615,831
C99	Mission Driven Health Care Services	$1,537,041,477	$153,401,280	$66,690	$857,695,497	$832,680,571	$679,279,291
D99	Research	$15,118,691	$5,043,264		$5,983,654	$14,178,301	$9,135,037
E99	Financial Contributions	$27,879,146	$34,234		$7,786,473	$20,126,907	$20,092,673
F99	Community-Building Activities	$19,946,606	$8,375,819	$878,623	$3,095,742	$24,348,059	$15,972,241

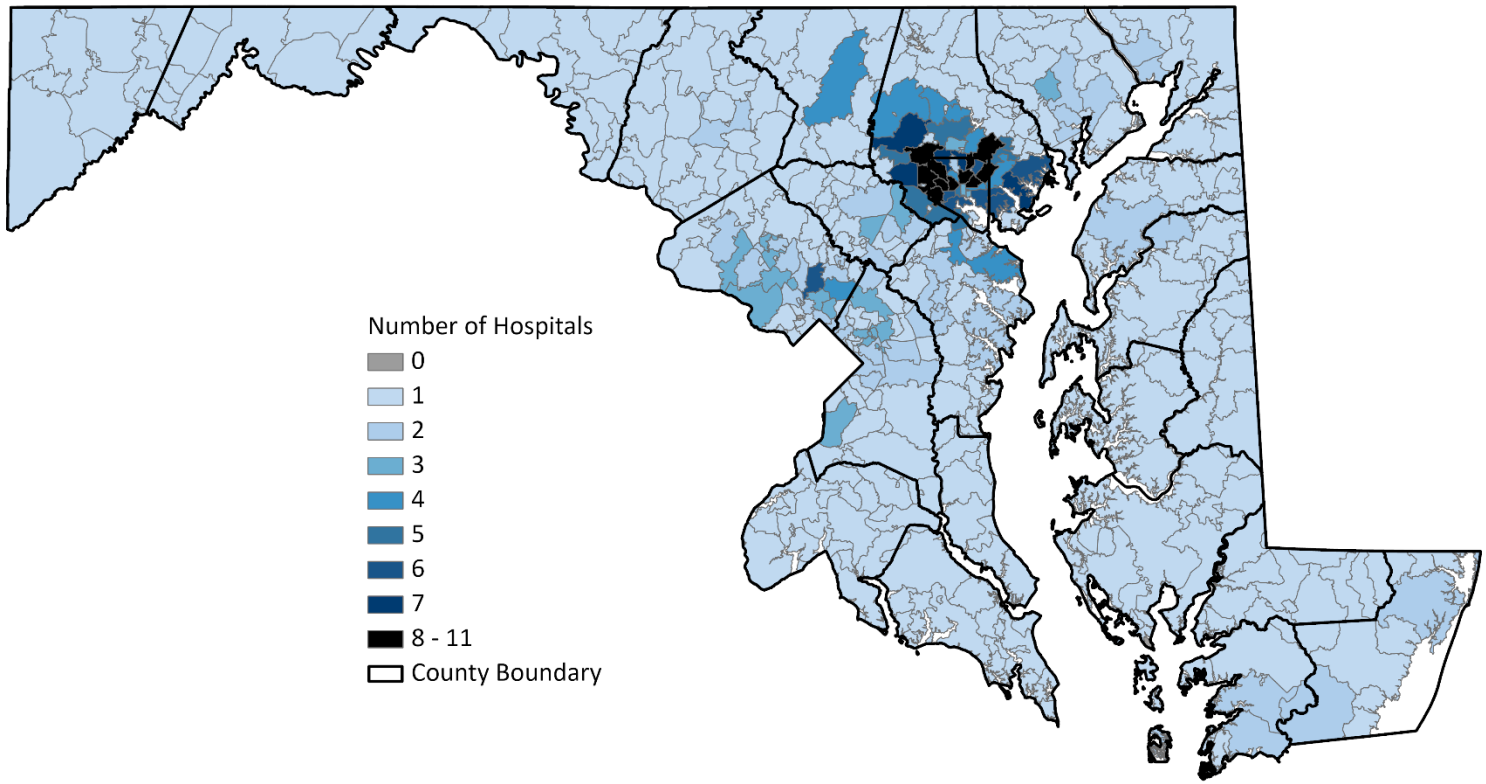
Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
G99	Community Benefit Operations	$11,319,145	$5,514,213		$31,499	$16,801,859	$11,287,646
H99	Financial assistance					$452,369,804	$452,369,804
J99	Foundation Funded Community Benefit	$1,961,445	$753,152		$462,937	$2,251,660	$1,498,507
T99	Medicaid Assessments	$295,626,867			$238,997,382	$55,466,167	$55,466,167
K99	**Total Hospital Community Benefit**	**$2,510,499,419**	**$464,254,075**	**$16,650,132**	**$1,144,496,656**	**$2,264,813,192**	**$1,800,559,117**

Appendix G. Primary Service Areas and Community Benefit Service Areas

A primary service area (PSA) is the geographical region from which a hospital primarily draws its patients. The HSCRC determines a PSA for each hospital. Figure 1 shows how many hospitals claim each ZIP code in Maryland in their PSAs.[46] Other than the areas in and around Baltimore City/County and some areas around Washington, D.C., most ZIP codes are claimed by only one hospital.

[46] For FY 2023, only three ZIP codes were not claimed to be in the PSA of at least one hospital: 20892 in southern Montgomery County (the National Institutes of Health), 21241 in western Baltimore City (the Social Security Administration), and 21627 in southern Dorchester County (Crocheron, MD, which had a population of 27 in 2020). Note that each of these ZIP codes is very small and therefore difficult to see on this map.

Figure G1: Hospitals Claiming the ZIP Code in Their PSAs, FY 2023*



Hospitals also report the methodology used to determine their community benefit service area (CBSA),[47] which may differ from their PSA. Maryland hospitals considered multiple factors when defining their CBSAs, with the most common factors being patient utilization patterns, such as ZIP codes with the highest percentages of hospital discharges and emergency department (ED) visits. Nine hospitals based their CBSAs on their PSAs, shown above.[48] Other hospitals defined their CBSAs by geographic proximity to the hospital, regions served by the hospital's community benefit programs, and demographic factors, including areas with high needs indicated by social determinants of health and areas with higher proportions of medically underserved or uninsured/underinsured residents. Table G1 summarizes the methods used by hospitals to determine their CBSAs.

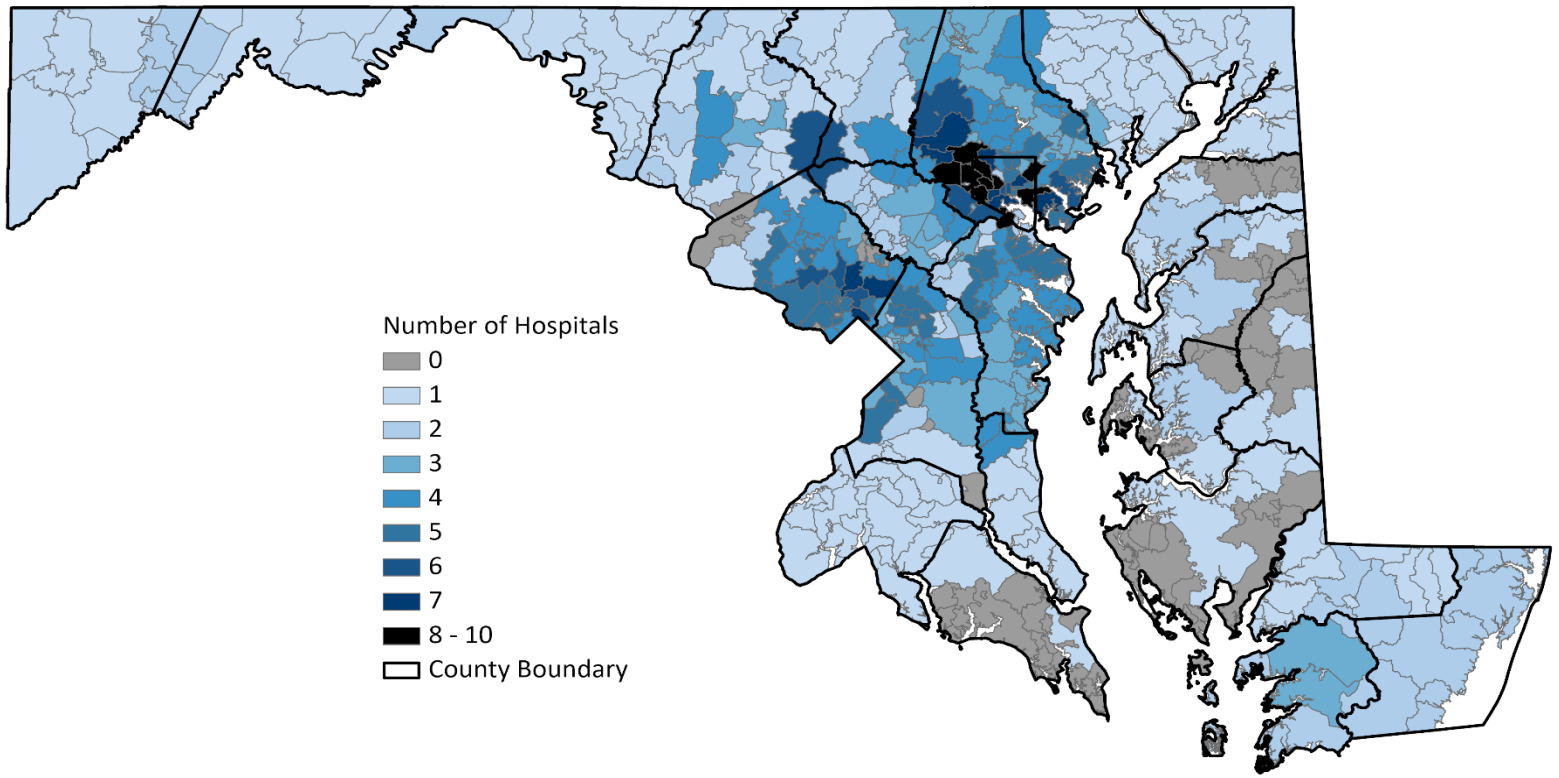
Table G1. Methods Used by Hospitals to Identify Their CBSAs, FY 2023

CBSA Identification Factor	Number of Hospitals[49]
Patterns of Hospital Utilization by Patients	36
ZIP Codes in Their Global Budget Revenue Agreement (Primary Service Area)	9
ZIP Codes in Financial Assistance Policy	7
Other Method	25

Figure G2 displays the number of hospitals that claim each ZIP code as part of their CBSA. Most zip codes in Maryland were included in at least one hospital's CBSA.[50] Most ZIP codes in Baltimore City, Baltimore County, Montgomery County, Prince George's County, Anne Arundel County, and Howard County were claimed by three or more hospitals, with numerous ZIP codes in Baltimore City were claimed by eight or more hospitals. This is a marked change from the CBSAs reported in FY 2022, when only one uninhabited ZIP code in central Maryland was not claimed by a hospital. This difference likely stems at least in part from the fact that the University of Maryland Rehabilitation and Orthopaedic Institute claimed every ZIP code in the State as part of its CBSA in FY 2022 but did not do so in FY 2023.

[47] Hospitals report the CBSA zip codes and selection methodology to the HSCRC and include that information in their federally mandated CHNAs (26 CFR § 1.501(r)-3(b)).
[48] The PSA is the geographic region where the hospital draws most of its patients. The PSA for each general acute care and chronic care hospital is defined in the hospital's Global Budget Agreement with the HSCRC. For specialty hospitals, the PSA is defined as the ZIP codes in which 60% of discharges are reported.
[49] Hospitals used multiple factors to determine their CBSA. As a result, the numbers in this column do not sum to 47.

Figure G2. Number of Hospitals Claiming the ZIP Code in Their CBSAs, FY 2023



Appendix H. Community Statistics by County

Hospitals report details about the communities located in their CBSAs/CHNAs, which help inform decisions about HCB activities. Table 1 displays examples of the county-level demographic measures used by the hospitals.

The following measures in Table 1 were derived from the five-year (2018-2022) 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. Total population was derived from the 1-year and 5-year average American Community Survey estimates. The life expectancy three-year average (2019-2021) and the crude death rate (2021) were derived from the Department's Vital Statistics Administration, and the numerator for the percentage of the population enrolled in Medicaid was pulled from the Maryland Medicaid DataPort.

Table H1. 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		98,461	6.2	5.9	34.0	28.7	32.0	19.8	56.6	32.5	10.9	78.2	941.4
Allegany	2	55,248	9.6	4.0	49.5	38.8	22.6	3.3	91.2	9.3	2.0	74.2	1394.0
Anne Arundel	8	116,009	4.1	4.5	28.7	21.0	30.3	12.6	73.7	20.3	8.7	79.1	849.1
Baltimore	12	88,157	7.0	5.3	35.8	30.7	28.7	14.9	60.1	32.4	6.1	77.2	1119.0
Baltimore City	16	58,349	14.5	5.5	46.8	52.0	30.1	10.3	31.9	63.6	5.9	71.0	1296.0
Calvert	1	128,078	2.8	3.2	27.4	19.4	40.9	4.9	83.9	15.2	4.6	78.6	911.6
Caroline	1	65,326	9.8	6.8	49.7	42.3*	31.6	8.3	80.5	16.0	8.2	75.7	1302.0
Carroll	3	111,672	3.5	2.9	27.7	17.2	35.4	5.9	92.3	5.1	4.1	78.5	1082.0
Cecil	1	86,869	7.2	3.9	37.1	31.0	29.1	6.6	89.0	9.2	4.9	74.2	1206.0
Charles	1	116,882	3.7	4.0	29.3	25.6	44.2	9.8	43.1	53.8	6.7	77.2	877.6
Dorchester	1	57,490	8.7	5.2	54.9	46.0*	26.5	5.9	67.5	30.7	6.1	75.0	1511.0
Frederick	5	115,724	4.6	4.5	27.4	19.4	33.7	15.5	82.0	12.5	11.0	80.2	789.6
Garrett	1	64,447	7.3	5.8	46.2	32.6*	25.0	3.1	97.5	1.4	1.3	76.6	1394.0

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)
Harford	2	106,417	4.7	3.5	31.0	22.3	32.3	7.5	80.5	16.8	5.0	78.2	989.8
Howard	4	140,971	3.7	3.9	24.8	18.2	29.5	26.5	57.0	22.3	7.5	82.8	595.6
Kent	1	71, 635	5.1	4.3	44.6	28.7*	25.8	5.4	81.2	15.4	4.7	76.4	1641.0
Montgomery	9	125,583	4.9	6.7	29.2	23.0	33.0	41.9	54.1	21.0	20.0	83.5	660.3
Prince George's	7	97,935	6.2	10.5	34.4	31.8	36.0	28.9	17.9	64.3	20.0	78.4	801.0
Queen Anne's	2	108,332	3.7	5.0	35.0	19.7*	34.9	5.4	90.1	7.1	4.6	79.3	1035.0
Saint Mary's	1	113,668	6.6	4.0	29.4	24.2	30.1	7.0	80.8	16.9	5.7	77.3	920.1
Somerset	3	52,149	15.6	3.9	53.2	42.5*	24.0	5.5	57.6	43.4	4.0	74.5	1276.0
Talbot	2	81,667	6.3	4.4	48.0	25.9*	26.4	8.7	83.8	13.6	7.3	79.0	1474.0
Washington	1	73,017	8.6	5.5	42.7	36.0	29.7	8.2	85.1	14.7	6.2	75.3	1307.0
Wicomico	2	69,421	8.0	6.5	43.7	41.9	23.1	11.4	67.9	29.1	5.7	75.0	1207.0
Worcester	2	76,689	5.1	5.8	48.1	29.6*	23.8	6.6	84.2	14.3	3.8	79.2	1392.0
Source	[51]	[52]	[53]	[54]	[55]	[56]*	[57]	[58]	[59]	[60]	[61]	[62]	[63]

[51] As reported by hospitals in their FY 2023 Community Benefit Narrative Reports.
[52] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Median Household Income (Dollars), https://data.census.gov/cedsci/.
[53] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families.
[54] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.
[55] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.
[56] American Community Survey 1-Year Estimates 2022, ACS Demographic and Housing Estimates, Total Population (denominator) and The Maryland Medicaid DataPort – Eligibility Exploratory Dashboards Standard Report, December 2022 enrollment, the Hilltop Institute (numerator). Starred values used American Community Survey 5-Year Estimates 2022, ACS Demographic and Housing Estimates, Total Population for the denominator because 2022 ACS 1-Year Estimates were unavailable for these counties.
[57] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes).
[58] American Community Survey 5-Year Estimates 2018 – 2022, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.
[59] American Community Survey 5-Year Estimates 2018 – 2022, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – White.
[60] American Community Survey 5-Year Estimates 2018 – 2022, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – Black or African American.
[61] American Community Survey 5-Year Estimates 2018 – 2022, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race).
[62] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2021, Table 7. Life Expectancy at Birth by Race, Hispanic Origin, Region, and Political Subdivision, Maryland, 2019 – 2021. An updated 2022 Vital Statistics Report was unavailable at the time of publication.
[63] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2021, Table 32B. Crude Death Rates by Race and Hispanic Origin, Region and Political Subdivision, Maryland, 2021. An updated 2022 Vital Statistics Report was unavailable at the time of publication.

Appendix I. Sources of Community Health Measures Reported by Hospitals

Other community health data sources reported by hospitals include the following:

- Baltimore Neighborhood Indicators Alliance
- CDC Behavioral Risk Factor Surveillance System
- CDC Chronic Disease Calculator
- CDC Interactive Atlas of Heart Disease and Stroke
- CDC Mental Health Surveillance and PRC Survey
- CDC National Center for Health Statistics
- CDC Wonder Database
- Center for Applied Research and Engagement Systems
- Commission on Cancer
- Community surveys, focus groups, and interviews
- Conduent - Healthy Communities Institute
- County and local health departments' community health statistics
- Cigarette Restitution Fund Program – Cancer in Maryland Report
- Feeding America
- Findings from health and human services needs assessments completed by contracted entities
- Health Resources and Services Administration
- Healthy Communities Institute
- Internal emergency department and health services quality data
- Kaiser Family Foundation analyses
- Local community foundations
- Local health improvement coalitions
- Local police and public school systems data
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Center on Economic Progress
- Maryland Chronic Disease Burden

- Maryland Department of Health
- Maryland Department of Planning
- Maryland Hospital Association
- Maryland Office of Minority Health and Health Disparities
- Maryland Physician Workforce Study
- Maryland Sexually Transmitted Infections Program
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- Measure of America Opportunity Index by County
- Meritus Health Cancer Registry Report
- National Cancer Institute
- National Institutes of Health
- Nielsen/Claritas
- Performance data from community health improvement initiatives
- Robert Wood Johnson Foundation – County Health Rankings
- Robert Wood Johnson Foundation – City Health Dashboard
- State of Maryland's Health Care Workforce Report
- United Way – United for ALICE (Asset-Limited, Income Constrained, Employed)
- University of Maryland School of Social Work
- University of Wisconsin School of Medicine and Public Health – Neighborhood Atlas
- U.S. Census Bureau – American Community Survey
- U.S. Census Bureau – Decennial Census population estimates
- U.S. Department of Health and Human Services – Healthy People 2030
- Washington Co. Public Schools Youth Risk Behavior and High School Trend Reports

Appendix J. FY 2023 CHNA Priority Area Categories Addressed through CB Initiatives

CHNA Priority Area	Number of Hospitals
Social Determinants of Health - Health Care Access and Quality	35
Settings and Systems - Community	32
Health Conditions - Diabetes	31
Health Conditions - Mental Health and Mental Disorders	31
Health Behaviors - Preventive Care	31
Health Conditions - Cancer	26
Health Conditions - Heart Disease and Stroke	25
Health Behaviors - Drug and Alcohol Use	25
Health Behaviors - Nutrition and Healthy Eating	23
Settings and Systems - Transportation	22
Social Determinants of Health - Economic Stability	21
Health Conditions - Pregnancy and Childbirth	20
Social Determinants of Health - Social and Community Context	20
Health Conditions - Addiction	19
Settings and Systems - Health Care	17
Social Determinants of Health - Education Access and Quality	17
Health Behaviors - Health Communication	16
Health Behaviors - Physical Activity	16
Health Behaviors - Violence Prevention	14
Populations - Children	14
Populations - Workforce	14
Health Conditions - Overweight and Obesity	11
Populations - Older Adults	11
Settings and Systems - Housing and Homes	11
Social Determinants of Health - Neighborhood and Built Environment	11
Health Conditions - Infectious Disease	10
Health Behaviors - Injury Prevention	10
Populations - Infants	10
Health Behaviors - Vaccination	9
Populations - Parents or Caregivers	9
Settings and Systems - Workplace	9
Populations - Adolescents	8

CHNA Priority Area	Number of Hospitals
Populations - People with Disabilities	8
Populations - Women	8
Health Behaviors - Emergency Preparedness	7
Settings and Systems - Hospital and Emergency Services	7
Settings and Systems - Schools	7
Settings and Systems - Public Health Infrastructure	6
Health Conditions - Chronic Kidney Disease	5
Health Conditions - Chronic Pain	5
Settings and Systems - Environmental Health	5
Settings and Systems - Health Insurance	5
Health Conditions - Respiratory Disease	4
Health Behaviors - Child and Adolescent Development	4
Health Behaviors - Family Planning	4
Health Conditions - Arthritis	3
Health Conditions - Sexually Transmitted Infections	3
Health Conditions - Health Care-Associated Infections	2
Health Conditions - Sensory or Communication Disorders	2
Health Behaviors - Sleep	2
Health Behaviors - Tobacco Use	2
Populations - Men	2
Settings and Systems - Global Health	2
Settings and Systems - Health IT	2
Settings and Systems - Health Policy	2
Health Conditions - Blood Disorders	1
Health Conditions - Osteoporosis	1
Populations - LGBT	1
Health Conditions - Dementias	0
Health Conditions - Foodborne Illness	0
Health Conditions - Oral Conditions	0
Health Behaviors - Safe Food Handling	0

*Data Source: As reported by hospitals on their FY 2023 financial reports.

Appendix K. Dates of Most Recent CHNAs

Hospital	Date Most Recent CHNA was Completed
CalvertHealth	Nov-23
Holy Cross Germantown	Oct-22
Holy Cross Hospital	Oct-22
Adventist HealthCare Fort Washington Medical Center	Oct-22
Adventist HealthCare Rehab	Oct-22
Adventist Shady Grove	Oct-22
Adventist White Oak	Oct-22
Garrett Regional Medical Center	Aug-22
UPMC Western MD	Jun-22
Suburban Hospital	Jun-22
UM BWMC	Jun-22
Howard County General Hospital	Jun-22
UM Capital Region Health	Jun-22
UM Shore Regional Medical Center	May-22
Sheppard Pratt	May-22
TidalHealth McCready Pavilion	May-22
TidalHealth Peninsula Regional	May-22
ChristianaCare Union Hospital	May-22
Meritus Medical Center	May-22
Atlantic General	May-22
Frederick Health Hospital	May-22
Anne Arundel Medical Center	Dec-21
Doctors Community Medical Center	Dec-21
McNew Family Health Center	Dec-21
Carroll Hospital Center	Jun-21
LifeBridge Levindale	Jun-21
MedStar Franklin Square	Jun-21
MedStar Good Samaritan	Jun-21
MedStar Harbor Hospital	Jun-21
MedStar Montgomery	Jun-21
MedStar Southern MD	Jun-21
MedStar St. Mary's	Jun-21

Hospital	Date Most Recent CHNA was Completed
MedStar Union Memorial	Jun-21
Northwest Hospital Center	Jun-21
Sinai Hospital of Baltimore, Inc.	Jun-21
St. Agnes HealthCare	Jun-21
UM Charles Regional	Jun-21
UMMC Midtown	Jun-21
University of Maryland Medical Center	Jun-21
UM Rehab & Ortho	Jun-21
UM Upper Chesapeake Health	Jun-21
UM St. Joseph Medical Center	Jun-21
Johns Hopkins Hospital	Jun-21
Greater Baltimore Medical Center	Jun-21
Mercy Medical Center	Jun-21
Johns Hopkins Bayview Medical Center	May-21
Mt Washington Pediatric Hospital	May-21

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Appendix L. CHNA External Participants and Their Level of Community Engagement During the CHNA Process

CHNA Participant Category	Level of Community Engagement					
	Informed - To provide the community with balanced & objective info to assist in understanding the problem, alternatives, opportunities and/or solutions	**Consulted -** To obtain community feedback on analysis, alternatives and/or solutions	**Involved -** To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	**Collaborated -** To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	**Delegated -** To place the decision-making in the hands of the community	**Community Driven/Led -** To support the actions of community initiated, driven and/or led processes
Other Hospitals	16	25	18	25	8	10
Local Health Department	25	30	25	28	8	14
Local Health Improvement Coalition	22	26	18	25	8	15
Maryland Department of Health	18	16	5	12	3	3
Other State Agencies	7	8	4	10	0	0
Local Govt. Organizations	17	24	13	18	3	4
Faith-Based Organizations	19	22	21	21	2	7
School - K-12	18	20	15	17	3	2
School - Colleges, Universities, Professional Schools	19	19	16	17	3	3
Behavioral Health Organizations	21	26	15	20	3	9
Social Service Organizations	17	21	12	19	1	7
Post-Acute Care Facilities	8	12	5	6	0	0
Community/Neighborhood Organizations	19	24	15	18	2	5
Consumer/Public Advocacy Organizations	8	10	4	7	0	1
Other	16	22	11	7	1	4

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Appendix M. CHNA External Participants and the Recommended CHNA Practices They Engaged in

CHNA Participant Category	Recommended Practices							
	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals	30	30	25	33	20	27	17	18
Local Health Department	33	33	34	40	28	28	19	22
Local Health Improvement Coalition	34	24	16	40	21	26	18	21
Maryland Department of Health	11	11	19	15	8	12	3	13
Other State Agencies	14	9	4	11	2	11	4	9
Local Govt. Organizations	27	21	8	28	10	17	18	14
Faith-Based Organizations	29	20	7	30	11	24	18	12
School - K-12	24	19	11	26	15	16	18	13
School - Colleges, Universities, Professional Schools	21	19	12	24	9	17	16	10
Behavioral Health Organizations	29	22	13	32	15	24	17	19
Social Service Organizations	25	19	10	29	13	20	15	15
Post-Acute Care Facilities	11	12	2	15	0	7	3	7
Community/Neighborhood Organizations	25	22	9	31	14	17	17	13
Consumer/Public Advocacy Organizations	13	11	5	11	3	8	7	7
Other	7	11	8	19	8	11	9	4

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Appendix N. Hospitals Involving Staff/Departments in CHNA Efforts

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
CB/Community Health/Population Health Director (facility level)	1	12	32	31	28	27	32	33	15	3
CB/Community Health/Population Health Director (system level)	8	6	26	29	30	26	29	27	19	5
Senior Executives (CEO, CFO, VP, etc.) (facility level)	1	1	37	33	28	21	37	28	6	5
Senior Executives (CEO, CFO, VP, etc.) (system level)	5	6	13	23	26	12	21	11	1	4
Board of Directors or Board Committee (facility level)	8	2	13	15	16	9	26	13	3	11
Board of Directors or Board Committee (system level)	13	6	3	10	12	3	13	6	1	9
Clinical Leadership (facility level)	2	0	31	25	26	23	41	33	11	2
Clinical Leadership (system level)	15	7	16	17	19	10	24	19	4	2
Population Health Staff (facility level)	5	9	31	24	22	19	30	31	16	2
Population Health Staff (system level)	14	7	21	23	23	19	23	22	15	3
Community Benefit staff (facility level)	1	11	34	33	29	29	34	33	23	2
Community Benefit staff (system level)	5	11	20	26	27	21	22	21	17	8
Physician(s)	4	0	24	19	19	17	36	27	7	2
Nurse(s)	7	0	29	23	19	21	37	34	7	0
Social Workers	10	0	23	16	18	20	33	34	6	0
Hospital Advisory Board	3	19	11	13	13	11	19	18	3	3
Other (specify)	12	1	6	6	6	7	7	7	3	2

Appendix O. Hospitals Reporting Community Benefit Internal Participants and Their Roles

Participant Category	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
CB/Community Health/Population Health Director (facility level)	2	11	32	33	32	19	31	31	33	3
CB/Community Health/Population Health Director (system level)	8	7	30	28	29	16	20	17	27	3
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	0	41	41	25	38	38	10	21	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	14	7	20	20	18	20	20	9	15	2
Board of Directors or Board Committee (facility level)	7	3	18	22	9	12	7	5	15	3
Board of Directors or Board Committee (system level)	12	8	15	15	4	7	4	3	7	2
Clinical Leadership (facility level)	3	0	34	32	22	9	10	25	21	0
Clinical Leadership (system level)	10	7	24	21	12	5	7	10	12	0
Population Health Staff (facility level)	4	10	25	26	29	11	12	29	30	1
Population Health Staff (system level)	13	7	19	19	25	7	13	18	24	0
Community Benefit staff (facility level)	3	10	26	26	28	13	17	31	32	1
Community Benefit staff (system level)	5	11	17	18	24	4	7	16	24	3
Physician(s)	10	0	24	22	17	4	4	24	21	4
Nurse(s)	9	0	25	24	20	7	8	29	24	0
Social Workers	16	1	20	20	13	5	5	25	19	0
Hospital Advisory Board	8	17	16	14	4	5	3	2	11	2
Other (specify)	13	1	6	5	6	3	2	8	7	0