State of Maryland
Department of Health

Health Services Cost Review Commission
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575th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
July 8, 2020

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

EXECUTIVE SESSION
12:00 pm

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

PUBLIC SESSION
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on June 10, 2020

2. Docket Status – Cases Closed

2520A – University of Maryland Medical Center **2521A - University of Maryland Medical Center**
2322A – Johns Hopkins Health System

3. Docket Status – Cases Open

None

4. Total Cost of Care Model State Activities Update

a. **Statewide Integrated Health Improvement Strategy (SIHIS)**
b. **Maryland Primary Care Program (MDPCP)**
c. **Care Redesign Programs and Care Transformation Initiatives**

5. COVID-19 Long-Term Care Partnership Grant Update

6. **FY 2019 Community Benefits Report**

7. **Policy Update and Discussion**

    a. **CY 2019 Model Performance Overview**
    b. **Model Monitoring**
    c. **COVID-19 Volume and Financial Trends**

8. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

June 10, 2020

Upon motion made in public session, Chairman Kane called for adjournment into closed session to discuss the following items:

1. Discussion on Planning for Model Progression– Authority General Provisions Article, §3-103 and §3-104

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order at 12:03 p.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance via conference call in addition to Chairman Kane were Commissioners Antos, Bayless, Cohen, Colmers, Elliott, and Malhotra.

In attendance via conference call representing Staff were Katie Wunderlich, Chris Peterson, Allan Pack, William Henderson, Alyson Schuster, Tequila Terry, Will Daniel, Joe Delenick, Claudine Williams, Amanda Vaughn, and Dennis Phelps.

Also attending via conference call were Eric Lindemann, Commission Consultant, and Stan Lustman and Tom Werthman, Commission Counsel.

Item One

Eric Lindemann, Commission Consultant, updated the Commission on Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Two

Katie Wunderlich, Executive Director, updated the Commission and the Commission discussed the current state of the COVID-19 pandemic and HSCRC's response.

William Henderson, Director Medical Economics & Data Analytics, presented recent survey data on Maryland hospital volumes overall and the volume of

COVID-19 patients. Mr. Henderson also reported on federal COVID-19 funding to Maryland hospitals.

Ms. Wunderlich updated the Commission and the Commission discussed the status of corridor expansion for hospital undercharges associated with the COVID-19 pandemic.

The Closed Session was adjourned at 1:06 p.m.

MINUTES OF THE
574th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
June 10, 2020

Chairman Adam Kane called the public meeting to order at 12:03 pm. Commissioners Joseph Antos, PhD, Victoria Bayless, Stacia Cohen, John Colmers, James Elliott, M.D., and Sam Malhotra were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Colmers, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:16 p.m.

REPORT OF JUNE 10, 2020 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the June 10, 2020 Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE MAY 13, 2020 CLOSED SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the May 13, 2020 public meeting and Closed Session minutes.

ITEM II
CASES CLOSED

2503R- Johns Hopkins Bayview Medical Center

ITEM III
FINAL RECOMMENDATION ON THE UPDATE FACTOR 2021

Mr. Jerry Schmith, Principal Deputy Director, Revenue and Compliance, and Mr. Allan Pack, Principal Deputy, Population Based Methodologies presented staff's final recommendation for the Update Factors for FY 2021 (See "Final Recommendation for the Update Factors for FY 2021" on the HSCRC website).

Staff updates hospitals' rates and approved revenues on July 1st for inflation as well as settling all adjustments from the prior year. Calculation of the update factors for RY 2021 generally follows approaches established in prior years. Staff recognizes that the COVID-19 pandemic has created significant uncertainty and will likely drive large short and long-term changes in the healthcare industry. However, in order to maintain simplicity and stability during the crisis, the calculation of the RY2021 update factor does not specifically address the COVID-19-specific challenges. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis.

There are two categories of hospital revenue:

- Global Budget Revenues from those hospitals that fall under the HSCRC's full rate-setting authority, and those approved rates paid by all payers

- Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay on the basis of those approve rates. This includes freestanding psychiatric hospitals and Mount

Washington Pediatric Hospital.

For RY2021, staff proposed an update of 3.52 percent per capita for global revenue hospitals and an update of 2.77 percent for non-global revenue hospitals.

HSCRC staff accounted for a number of factors that are central provisions in the update process and are linked to hospital costs and performance. These include:

- Adjustment for Inflation: The inflation factor uses the gross blended statistic of 2.77 percent.

- Rising Cost of New Outpatient Drugs: The rising cost of drugs, particularly of new physician administered outpatient infusion and oncology drugs in the outpatient setting, continues to be a concern among hospitals, payers, and consumers.

- Care Coordination / Population Health: In January 2020, The Commission approved $25.3 million which was 0.25 percent in RY2020 hospital rates for funding streams that focus on Diabetes & Management and Behavioral Health Crisis Programs. The 0.25 percent will be reduced by 0.06 percent from unspent funds from prior rate years reducing the grant funding to 0.19 percent.

- Adjustments for Volume: The Maryland Department of Planning's estimate of population growth for CY 2020 is 0.16 percent. For RY 2021, the staff propose recognizing the full value of the 0.16 percent growth for the Demographic Adjustment to hospitals in keeping with prior year norms.

- Set-Aside for Unforeseen Adjustment: Staff recommends a 0.25 percent set-aside for unforeseen adjustments during RY 2021.

- Capital Funding: Suburban Hospital received approval in 2015 for a Certificate of Need (CON) totaling $200 million to replace and renovate the Hospital facility.

- Complexity and Innovation (previously known as Categorical Cases): Staff concluded that the historical average growth rate was 0.43 percent, which equates to a combined State impact of 0.10 percent for the RY 2021 Update Factor.

- Quality Scaling Adjustments: The RY 2020 adjustments have been restored in the base for the Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement (QBR) adjustment. New adjustments are reflected in staff's recommendation.

- PAU Savings Reduction: The statewide RY 2021 PAU savings adjustment is now calculated based on update factor inflation and demographic adjustment applied to CY 2019 PAU revenue.

Based on the available data and the staff's analyses, the HSCRC staff provides the following final recommendations for the RY 2021 update factors.

- Provide an overall increase of 3.52 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.35 percent per capita revenue increase for hospitals under Global Budgets.
- Provide an overall increase of 2.77 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

- Continue to work with all stakeholders to address specific COVID-19 issues such as anticipated hospital undercharges, the challenge of maintaining affordability in a time of economic crisis and the need to ensure sufficient ongoing health system liquidity.

- The Total Cost of Care (TCOC) Contract and the Commission's mandate both assume that hospital rate increases maintain the affordability of care for all Marylanders. This responsibility has been acknowledged through a cumulative test against a static historic average Gross State Product (GSP) in the TCOC contract, and more recently through a comparison to recent GSP in the FY20 and FY21 Update Factor Recommendations and the acknowledgement of maintaining growth below GSP in the MPA Framework and Capital Policies approved by the Commission. However, none of these policies create an active, defined method for evaluating and enforcing the affordability of hospital rates against GSP, when setting the update factor. In addition there are inconsistencies in the calculations required under the guardrail tests in the Medicare TCOC Contract and the Commission's approach to rate setting. To address these issues the Commission should task staff with:

    - Developing, by December 31, 2020, in conjunction with industry, a recommendation for evaluating future update factors against GSP, over the most recent 1 to 5 years, as a proxy for affordability. The recommendation should include (1) a methodology for identifying the affordability standard and (2) policies for adjusting the update factor should the inflation provided differ from the affordability standard in future years, in order to maintain long-term affordability.

    - Preparing in the same timeframe, in conjunction with industry, a report discussing how Maryland hospital rates relate to the premiums paid for commercial insurance as maintaining the affordability of healthcare for Marylanders also requires that hospital rates are translated into affordable premiums.

    - Working with CMS to assess the feasibility of converting the Medicare guard rails to a Fiscal Year basis and utilizing retrospective Medicare growth rates in Medicare tests in a way that recognizes multiple years of results.

Commissioner Colmers asked if staff has looked back to see historically how well staff's Medicare TCOC projections have compared to actual performance.

Mr. Schmith stated that staff always compares TCOC projections to actual performance, but indicated it is difficult to project national performance accurately.

Mr. Schmith also indicated staff uses a three-year average inflation amount when preparing the update factor recommendation. Mr. Schmith noted that the recommended update for this year is a little higher than the GSP when in prior years it had been a little lower than the GSP. However, the three-year average of the update factors compared to the three-year average of GSP, is about equal.

Commissioner Colmers stated affordability is essential for the Commission to consider. He expressed concern That the Commission was not focusing enough on making hospital services and overall health care affordable for Maryland residents.

Commissioner Colmers also suggested looking at the update factor, not in terms of one single year, but over a

longer time horizon. He also suggested that there might be other ways to measure affordability than to compare relative performance to the GSP.

Commissioner Antos agreed with Commissioner Colmers and expressed concern about moving forward with a fixed GSP standard when it is not yet clear what impact it would have.

Commissioner Bayless stated that the affordability measure should become a reference point for the update factor, but not a standard upon which update factors would be set. Commissioner Bayless added the Commission must also consider many other variable such as insurance premium growth, fluctuations in the economy, changes in the health care industry, pharmacy costs, labor, etc. as these factors do not always move in unison.

Commissioner Cohen added that she is supportive of having an objective reference point and supports staff developing a formulaic approach with less unintended variation.

Brett McCone, Senior Vice President, Healthcare Payment, Maryland Hospital Association (MHA), expressed concern about hospital affordability, stated that MHA opposes the idea of a maximum update factor limit that is based solely on GSP.

Arin Foreman, Senior Director, Regulatory Affairs, CareFirst, expressed concern about affordability as well, but stated CareFirst supports the Staff recommendation.

Chairman Kane asked Mr. Foreman if CareFirst could share their findings on the relationship between insurance premiums and hospital costs with the Commission when research is complete.

Mr. Foreman agreed to do so, and stated that the findings would be compiled and provided to the update factor workgroup.

Commissioner Colmers expressed agreement with the Staff recommendation, but noted that the question of affordability should be addressed by the workgroup as soon as possible.

Commissioners voted unanimously in favor of Staff's recommendation.

ITEM IV
FINAL RECOMMENDATION FOR SUPPORT OF CRISP FOR RY 2021

Mr. William Henderson, Director, Medical Economics & Data Analytics presented the final recommendations for FY 2021 funding to support Health Information Exchange (HIE) Operations and the Chesapeake Regional Information System for our Patients (CRISP) (See "Final Recommendation: Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2021 Funding to Support HIE Operations and CRISP Reporting Services and the ICN Project" on the HSCRC website).

The Commission approved a total of $5.17 million in funding through hospital rates in FY 2021 to support the HIE and Implementation Advanced Planning Document (IAPD), Integrated Care Network (ICN) projects, and Medicaid Management Information System initiative activities for the Commission. This funding represents approximately 24 percent of CRISP's Maryland funding. The remainder of CRISP's Maryland funding assessment request is 14 percent of total CRISP funding for FY 2021, when funding from other states is included.

While this assessment declined slightly, overall CRISP activities will continue to expand because ongoing operating costs for HIE services continue the planned shift to user fees resulting in an overall increase in CRISP operating capacity. CRISP, in partnership with Medicaid, also continues to leverage federal funding through IAPD and MMIS matching grants.

The approved rate funding for HIE and standard reporting functions in FY 2021 including the federal match that will be generated from the IAPD funding are as follows:

Health Information Exchange Assessment	$1,500,000
Implementation Advanced Planning Document	1,000,000
ICN Program Support	1,110,000
MMIS matching funds	1,560,000
Total	5,170,000

Staff recommended that the Commission approve a total of $5,170,000 in funding through hospital rates in FY 2021 to support the HIE and IAPD initiative activities and continue the investments made in the ICN initiative.

Commissioners voted unanimously in favor of Staff's recommendation,

ITEM V
FINAL RECOMMENDATION ON THE MARYLAND PATIENT SAFETY CENTER FOR FY 2021

Ms. Diane Feeney, Associate Director, Quality Initiatives, presented Staff's final recommendation on the funding of the Maryland Patient Safety Center for FY 2021 (see Final Recommendation on Continued Financial Support for The Maryland Patient Center for FY 2021"on the HSCRC Website)

In 2004, the HSCRC adopted recommendations to provide seed funding for the MPSC through hospital rates. The initial recommendations funded 50% of the budgeted costs of the MPSC. In FY 2020, HSCRC-dedicated funds accounted for 20% of its total budget. The proposed support for MPSC in FY 2021 represents 14.5% of its total budget. The HSCRC collaborates with MPSC on projects as appropriate, receives an annual briefing and documentation on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year.

In April 2020, the HSCRC received the MPSC program plan update for FY 2021. The MPSC is requesting a total of $246,056 in funding support from the HSCRC for FY 2021, a 50 percent decrease over the FY 2019 budget, consistent with the Commission's intent to reduce State funds over time and encourage a sustainable business model for the MPSC.

Staff final recommendation is as follows:

- Consistent with the prior Commission recommendations, the HSCRC should reduce the amount of unrestricted funding support for the MPSC in FY 2021 by 25 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $246,056.

- In order to receive future funding from the hospital rate setting system, the MPSC should continue to report twice annually on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.
- Going forward, the HSCRC should decrease the amount of unrestricted support by 25 percent per year from the FY 2019 amount of $492,075 in order to achieve the goal of independent sustainability for MPSC by FY 2023
- MSPC may request annually needed funding from HSCRC that will be restricted for targeted projects that align with statewide TCOC Model and quality and safety goals, which the Commission will consider on a case by case basis.

    - ❖ For FY 2021, HSCRC should fund an additional $275,000 for the Clean Collaborative for Long Term Care project through hospital rates.

- The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs.

Commissioner Antos asked for clarification as to whether the recommendation resulted in a funding increase or decrease. He added the Commission has long been concerned as to whether MPSC's activities are effective in changing practices that can ultimately lead to improved performance.

Ms. Feeney confirmed that the recommendation did result in a funding increase.

Commissioner Kane asked if the recommendation commits an additional $275,000 of funding in the next year.

Ms. Feeney confirmed, and indicated there is a bi-annual reporting requirement to report to the Commission on admissions related to infections and the results in other safety measures. She recommended that the Commission review reports before deciding whether fund the additional $275,000. Ms. Feeney added that the safety center would continue to pursue other sources of revenue.

Ms. Katie Wunderlich, Executive Director, stated that to the extent to which long-term facilities can improve infection control, this could be a benefit to hospitals.

Ms. Feeney added that MPSC is continuing to follow guidance from the Commission on use of funds from hospital rate assessments. The additional project on the Clean Collaborative can be voted on separately, if the Commission prefers.

Commissioner Kane added that he questions whether the Commission is really the right place to fund educational programs for individual providers.

Dr. Blair Eig, President, Maryland Patient Safety Center, supported Staff's recommendation. He alluded to the efficacy and results of Collaborative the MPSC has worked on previously, reducing health care spending and improving safety.

Kevin Heffner, President and CEO of Lifespan Network, supported for the Clean Collaborative and is in favor of the continuation of the Collaborative work. Mr. Heffner explained that Lifespan is primarily online education, providing a variety of educational programs that providers can take asynchronously, and is growing.

Lifespan also has large classroom space in Columbia, MD, but is unsure when in-person trainings will return as a result of COVID.

Joe Dematto, President and CEO of the Health Facilities Association of Maryland (HFAM) expressed support for the MPSC Collaborative. Mr. Dematto lauded the clinical efficacy they provide, and the difference they have made in the cost curve in Maryland. Mr. Dematto explained that Lifespan, like HFAM, provides online education and stand alone in office courses as well as, in-class education at the Beacon Institute at Lifespan.

Traci LaValle, Senior Vice President, Quality & Health, MHA, expressed MHA's support of the staff's recommendation. She stated that the Collaborative is unlike other types of programs in that it uses a quality improvement approach that allows significant results rapidly.

Chairman Kane asked when hands-on improvement can even begin, especially in nursing homes, considering the fragile state of sanitation due to COVID.

Dr. Eig responded that the Patient Safety Center is prepared to start as soon as they can identify ten sites, or more, that will participate in the collaborative. He stated that long-term care facilities need infection control more now than ever, especially during this pandemic, and the Patient Safety Center wants to react now.

David Mayor, Executive Director of MedStar Quality and Safety spoke in support of the Collaborative and of staff recommendation.

Commissioner Colmers stated that he supports the Collaborative, but would like Staff to provide feedback and updates on its performance.

Commissioner Elliot expressed support of the Staff recommendation, but suggested that the Commission should consider utilizing other agencies that provide similar work.

Commissioner Antos stated that his concern is not with the Collaborative project, it is with the idea of unrestricted funding, as this has been an issue for the Commission for a long time, but he agrees that the Collaborative would be great if it has positive result.

Chairman Kane restated his concern as to whether the Commission is authorized to provide educational resources for providers.

Commissioner Colmers responded that the Commission already funds the Nursing Support Program through hospital rate assessments.

Commissioners unanimously voted in favor of Staff's recommendation.

ITEM VI
FINAL RECOMMENDATION CHANGES TO RELATIVE VALUE UNITS FOR CLINIC EVALUATION & MANAGEMENT (E&M)

Mr. William Hoff, Chief Audit & Compliance, presented Staff's final recommendation on changes to the Relative Value Units (RVUs) for Clinic (CL) Evaluation & Management (E&M) (see "Final Recommendation On Changes To The Relative Value Units for Clinic Evaluation & Management (E&M) Effective 7/1/20" on the HSCRC website).

As a result of patient complaints, State legislators have contacted the HSCRC to evaluate the Clinic rate and its underlying components. In light of the concerns raised, the HSCRC has agreed to review and modify the rate structure. In the short term, staff will revise the Relative Value Unit (RVU) scale. In the future, staff will assess overhead allocations to Clinic and other rate centers.

Staff has determined that a significant reason for high Clinic E&M charges is that the rate setting methodology does not fully reflect the less intensive nature of Clinic services versus other hospital services. Additionally, the RVU range of the five E&M Visit Levels is too wide. Modifications to the methodology used to allocated overhead expenses is a long term undertaking; therefore, staff has decided that for Fiscal Year (FY) 2021, narrowing the range of the Visit Level RVUs, similar to Medicare's E&M RVU scale, coupled with a reduction in the amount of overhead allocated to Clinics, would result in a significant lowering of E&M RVUs.

CPT Code	Current RVUs	New RVUs
99201	2	2
99202	4	3
99203	7	4
99204	15	5
99205	18	6
99211	2	2
99212	4	3
99213	7	4
99214	15	5
99215	18	6
G0463		

HCPCs code G0463 can be used for Medicare billing with the above levels assigned RVUs

Staff final recommendation is as follows:

- The HSCRC staff recommends that the Commission approve revisions to the Relative Value Unit (RVU) Scale for Clinic Evaluation & Management Current Procedural Terminology CPT codes. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual

- The RVU scale was updated to reflect linkages of RVUs to the CPT codes and to link national guideline for Clinic E&M Services consistent with the HSCRC's plan to adopt national RVUs where possible. The Commission should adopt these new RVUs, effective July 1, 2020.

- The Clinic E&M reset will be revenue neutral to the overall GBR and will be reallocating approximately $60 million in Clinic revenue to other rate centers.

Commissioner voted unanimously in favor of the Staff's recommendation.

ITEM VII
REPORT ON UNCOMPENSATED CARE

Ms. Prudence Akindo, Analyst, Research and Methodology, presented Staff's report and draft recommendation

on the Uncompensated Care Policy for FY 2021 (See "Rate Year 2021 Uncompensated Care Report" on the HSCRC website).

Uncompensated Care (UCC) is care provided for which no compensation is received, typically a combination of charity care and bad debt. Recognizing the financial burden hospitals take on when providing quality care to patients who cannot readily pay for it, the HSCRC factors in the cost of UCC into the State's hospital rate setting structure. This provision increases access to hospital services in the State for those patients who cannot readily pay for them.

The purpose of Staff's report is to provide background information on the UCC policy and to provide by hospital values for the UCC built into statewide rates as well as the UCC pool for rate year (RY) 2021. The HSCRC determines the total amount of UCC that will be placed in hospital rates for each year and the amount of funding that will be made available for the UCC pool. Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all hospitals within the State. For RY 2021, the determined UCC amount to be built into rates for Maryland hospitals is 4.41 percent.

Based on the Staff's analysis, Staff's will implement the following for RY 2021:

- Increase statewide UCC provision in rates from 4.26% to 4.41 % effective July 1, 2020;
- Continue to use the regression modeling approach approved by the Commission at the June 2016 meeting;
- Continue to do 50/50 blend of FY 2019 audited UCC levels and FY 2021 predicted UCC levels to determine hospital specific adjustments.

ITEM VIII
POLICY UPDATE

Model Monitoring

Ms. Wunderlich stated that Maryland final Medicare TCOC performance from CY19 will be reported publically as soon as the Commission has confirmation from CMS. Based on Maryland performance from January 2020 through March 2020 Maryland has improved its position relative to the nation on the Medicare TCOC test.

Ms. Wunderlich noted that staff surveyed hospitals to gauge the level of federal funding that Maryland hospitals have received thus far. Staff received these surveys on Friday, June 5, 2020, but have not finished compiling the data. Ms. Wunderlich stated that it is important to quantify the amount of funding received and apply this amount against the undercharge for GBR performance in FY20. Staff continues to work on compiling reported data.

ITEM IX
HEARING AND MEETING SCHEDULE

July 8, 2020	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
August 12, 2020	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:17 p.m.

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Cases Closed

The closed cases from last month are listed in the agenda

Statewide Integrated Health Improvement Strategy (SIHIS)

Tequila Terry
Health Services Cost Review Commission

HSCRC
Health Services Cost Review Commission

Background

- In December 2019, Maryland & CMS signed a Memorandum of Understanding (MOU) agreeing to establish a *Statewide Integrated Health Improvement Strategy,*

- This initiative is designed to engage more state agencies and private-sector partners than ever before to collaborate and invest in improving health, addressing disparities, and reducing costs for Marylanders.

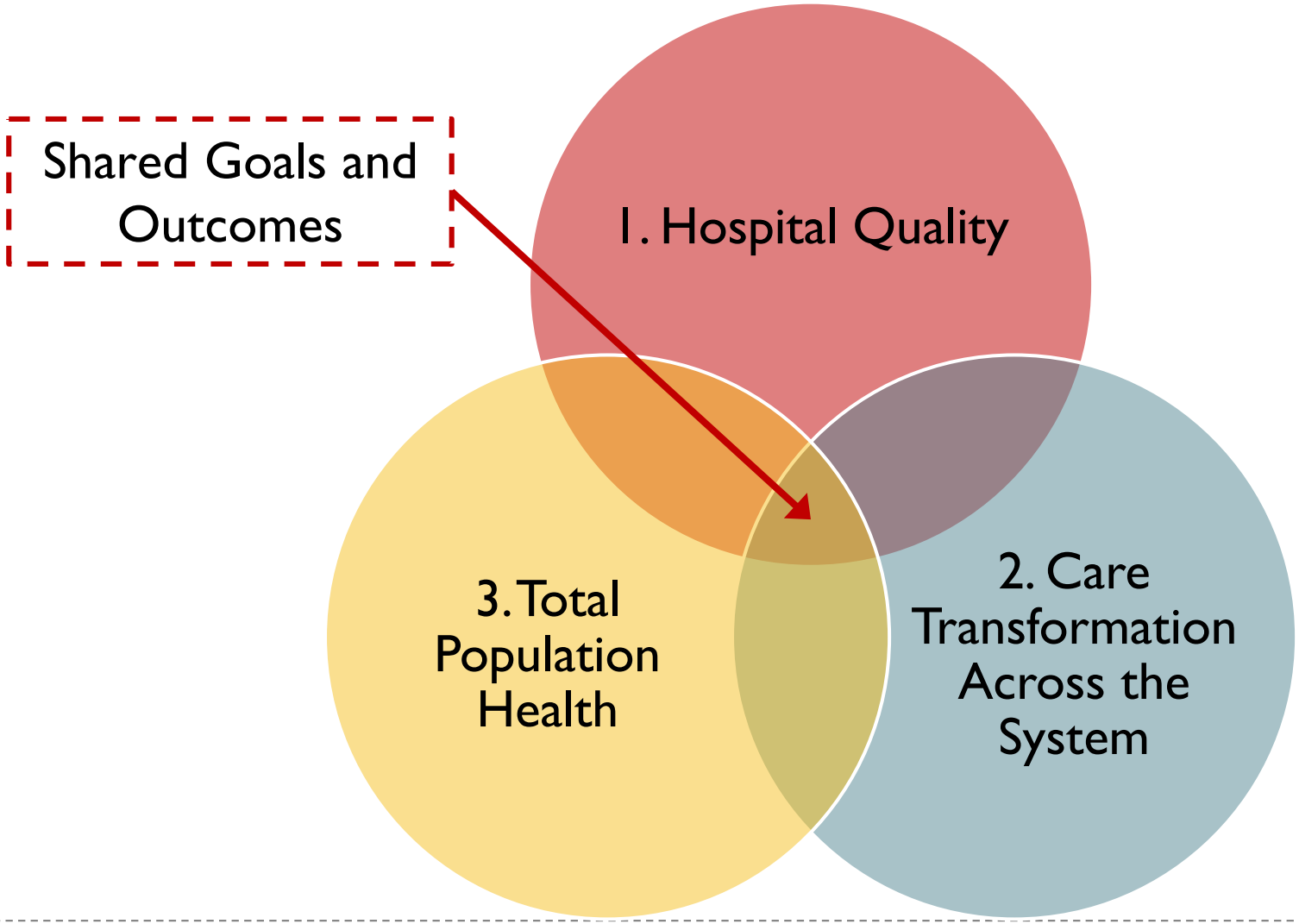
- The MOU requires the State to propose goals, measures, milestone and targets in three domains by the end of 2020.

- CMMI insists that for the Maryland TCOC Model to be made permanent, the State must:
  - Sustain and improve high quality care under the hospital finance model
  - Achieve annual cost saving targets
  - Set targets/milestones and achieve progress on the Statewide Integrated Health Improvement Strategy

Guiding Principles for Maryland's Statewide Integrated Health Improvement Strategy

- Maryland's strategy should fully *maximize the population health improvement opportunities* made possible by the TCOC Model
- Goals, measures, and targets should be *specific to Maryland* and established through a collaborative public process
- Goals, measures and targets should reflect an *all-payer perspective*
- Goals, measures and targets should capture statewide improvements, including *improved health equity*
- Goals for the three domains of the integrated strategy should be *synergistic and mutually reinforcing*
- Measures should be focused on *outcomes whenever possible*; milestones, including process measures, may be used to signal progress toward the targets
- Maryland's strategy must *promote public and private partnerships* with shared resources and infrastructure

Domains of Maryland's Statewide Integrated Health Improvement Strategy (non-financial)



Domain 3: Total Population Health

- Objective: Identify population health focus areas that the State will work to improve as part of the Total Cost of Care Model.

Priority Area 1: Diabetes	• Identified as a statewide priority by Maryland State Secretary of Health • Maryland's statewide ***Diabetes Action Plan*** is now available on MDH website • Initiative being led by the Maryland Department of Health
Priority Area 2: Opioids	• Identified as a statewide priority by Lieutenant Governor through the Maryland Heroin and Opioid Emergency Task Force (2015-2018) and the Commission to Study Mental and Behavioral Health (2019) • State of Emergency declared by Governor Hogan in 2017 • Initiative being led by the Opioid Operational Command Center
Priority Area 3: TBD	• The State has the option to choose a 3rd population health focus area by December 31, 2020.

Setting Targets

- The State must set targets and demonstrate progress in the 3 domains

- CMMI will review data through 2021to make decisions about making the Model permanent
  - Although outcomes are preferred to show success, they are less likely to be obtained in 2021 data
  - Each goal /measure could have, for example, a 2021 milestone, a 2023 interim target, and a 2026 target

Domain	2021 Milestone	2023 Interim Target	2026 Target
1. Hospital Quality			
2. Care Transformation Across the System			
3. Total Population Health a) Diabetes			
b) Opioids			

Broad work plan

- Domain 1
  - HSCRC's Performance Measurement Work Group
- Domain 2
  - HSCRC's Performance Measurement Work Group
  - HSCRC's Total Cost of Care Work Group
- Domain 3
  - Diabetes: Maryland Department of Health (MDH)
  - Opioids: Maryland Opioid Operational Command Center (OOCC)

Next Steps

- Timing
  - July – September – Milestones, Targets, & Measures developed
  - October 14th – Presentation of Milestones & Targets to Commissioners
  - October 15th – December 1st – Drafting of Proposal
  - December 9th – Presentation of Proposal to Commissioners
  - December 31st – SIHIS Proposal is due to CMS

SIHIS Partner Updates

Priority Area 1: Diabetes

Anne Langley

Director

Maryland Department of Health

Center for Population Health Initiatives

Office of the Deputy Secretary for Public Health Services

Priority Area 2: Opioids

Steve Schuh

Executive Director

Maryland Opioid Operational Command Center

Office of the Governor

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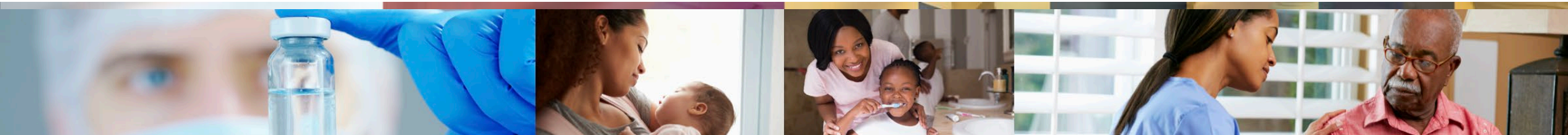
SIHIS: Diabetes

Anne Langley, JD, MPH

Center for Population Health Initiatives

July 8, 2020



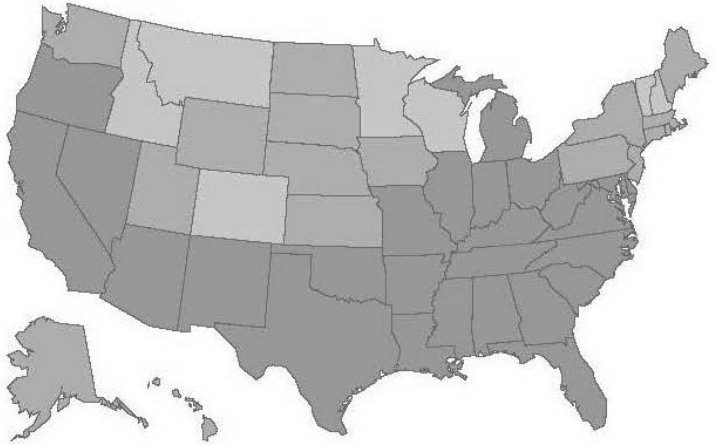
Diabetes by the Numbers

2.1M

Estimated number of adults with diabetes or prediabetes in Maryland.

100M+

Estimated number of US adults with diabetes or prediabetes.



500K

Maryland adults with diabetes. An additional 139K Maryland adults have diabetes and do not know they have it.

1.6M

Maryland adults with prediabetes, 9 out of 10 do not know they have it.

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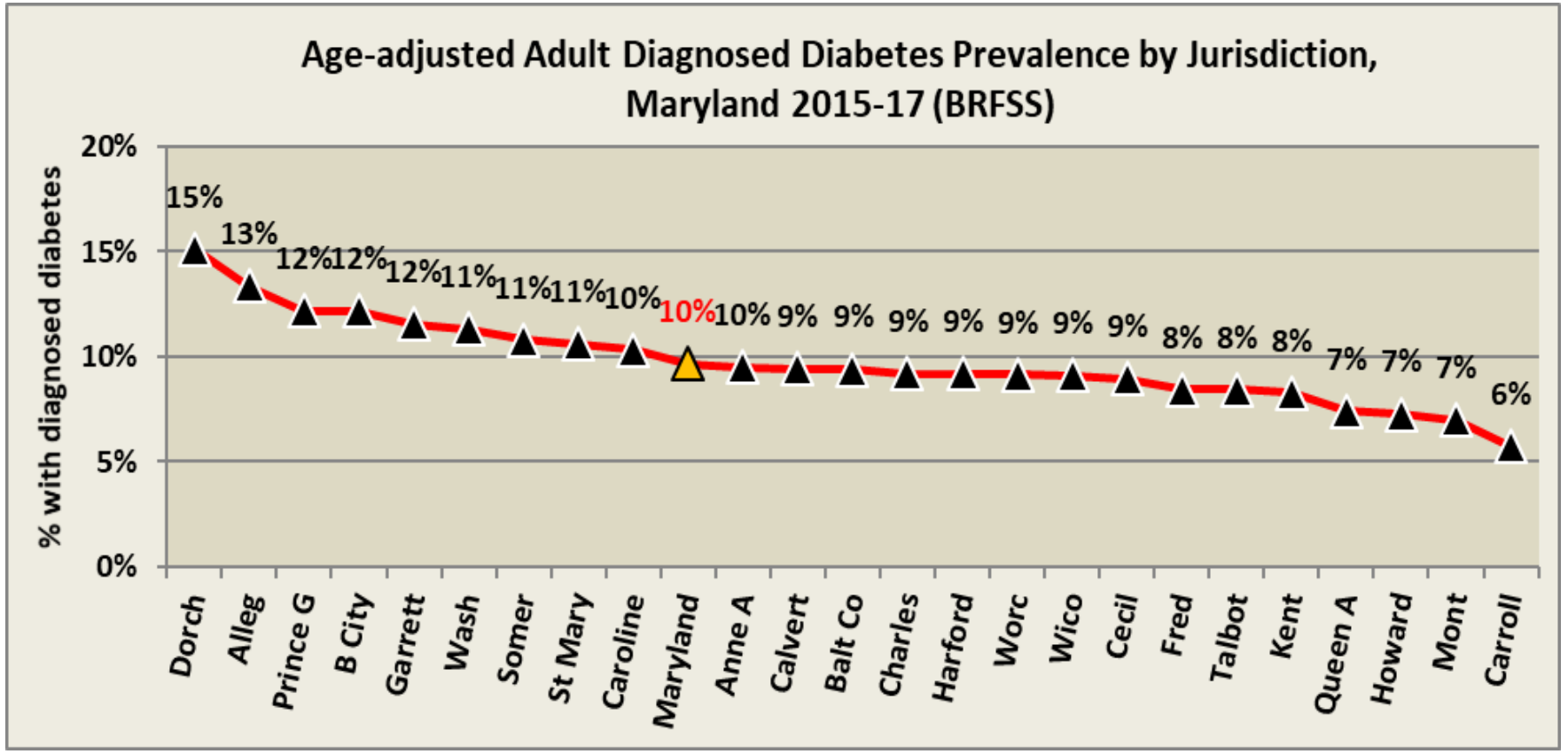
Costs of Diabetes

- Estimated annual cost for Maryland as a result of prediabetes and type 2 diabetes: $7 billion
- Estimated medical expenses for people with diabetes: 2-3 times higher than for people without diabetes
- Estimated annual medical costs for Maryland as a result of diabetes and prediabetes: $4.9 billion
- Annual loss in Maryland economic productivity as a result of prediabetes and diabetes: $2 billion

American Diabetes Association

Maryland DEPARTMENT OF HEALTH

Diabetes Prevalence by Jurisdiction



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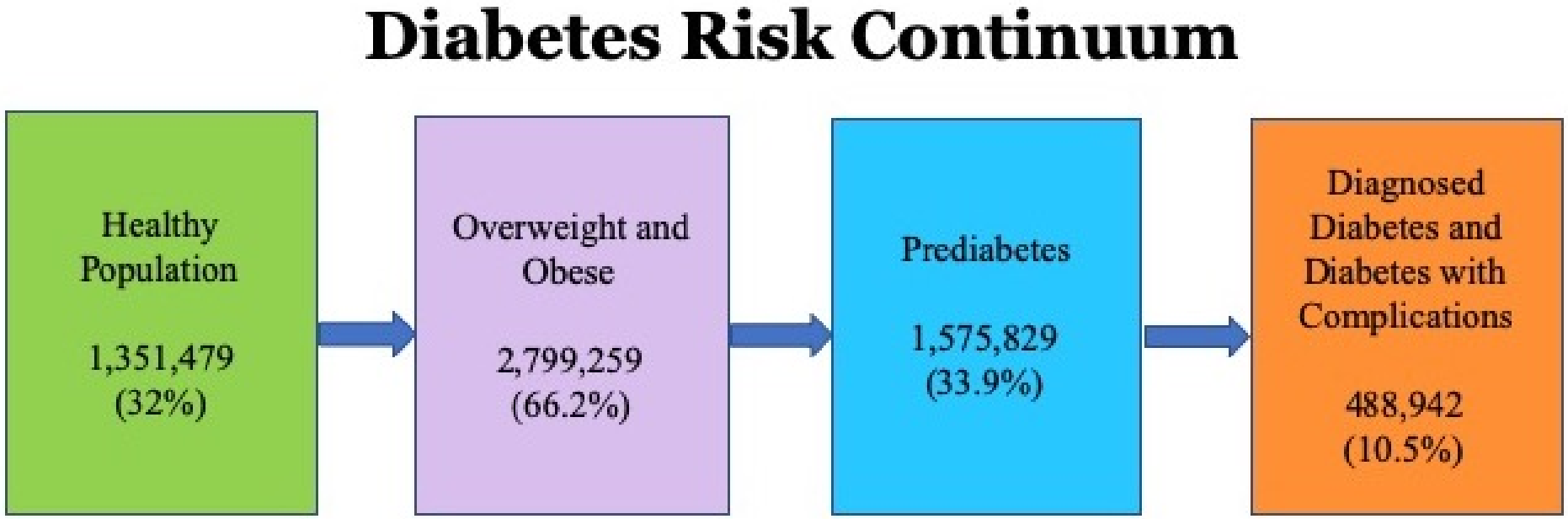
Population Health Targets



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Diabetes Action Plan: Engage All Sectors

- Patients and families
- Clinicians/provider community
- State agencies and local government
- Employers
- Payers
- Philanthropic community
- Professional and advocacy organizations
- Community-based organizations, non-profits
- Schools

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Local Health Improvement Coalitions

- Investments Focusing on Diabetes
  - **MCHRC:** 1M to strengthen LHICs and implement the DAP
  - **MDH:** Technical assistance and health literacy consultations
  - **LHIC partners:** Individual investments and programs
  - **HSCRC Catalyst Grants**: Hospitals required to "work in collaboration with Local Health Improvement Coalitions …"
- Collaboration, aligned resources, local expertise lead to greater impact

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Selecting Total Population Health Measures

- Convene the Diabetes Target Measures Work Group
- Present a panel of potential measures
- Evaluate proposed measures
- Collect and evaluate additional information as requested by the Work Group
- Come to consensus
- Present to commissioners

Convene Diverse Stakeholders and Experts

Multi-sector, multi-disciplinary, collaborative public approach:

- Hospital industry representatives
- HSCRC
- Reps across MDH (MHHD, Medicaid, PHPA, MDPCP)
- CRISP
- American Diabetes Association
- Clinicians/provider community
- Specialists/researchers
- Other service providers with subject matter expertise (e.g., diabetes educators, Diabetes Prevention Program vendors)
- Payer industry

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Criteria for Goals, Measures, and Targets

- Clinically relevant—make a real difference to health outcomes
- Sufficient connection between the interventions and the outcomes we are measuring
- Feasible to achieve a measurable difference in the time period
- Data available to measure interim/final targets with sufficient precision
- Measures capture Improvements in health equity

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Thank you—we look forward to the work ahead

MDH Center for Population Health Initiatives

Office of the Deputy Secretary for Public Health Services

Anne Langley, JD, MPH
Director

Sadie Peters, MD, MHS
Medical Director

Lisa Marr
Project Manager

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Maryland
OPIOID OPERATIONAL COMMAND CENTER

Health Services Cost Review Commission (HSCRC)

July 8, 2020

Opioid Operational Command Center

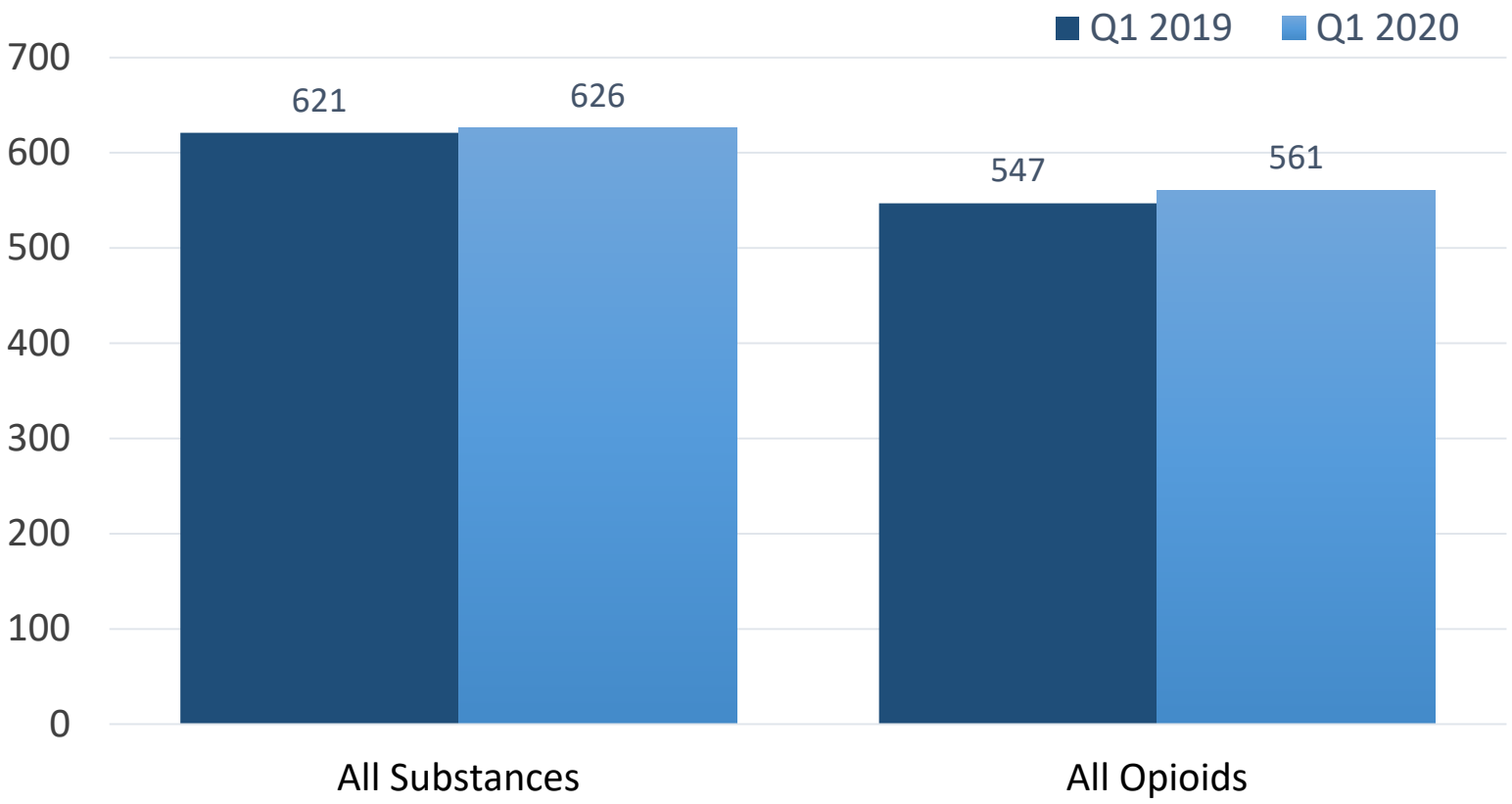
Established in 2017 to:

- Coordinate the statewide response to the opioid crisis.
- Assure that all efforts around the state align with the governor's three major policy priorities: *Prevention & Education*, *Enforcement & Public Safety*, and *Treatment & Recovery*.

Opioid Operational Command Center (cont'd)

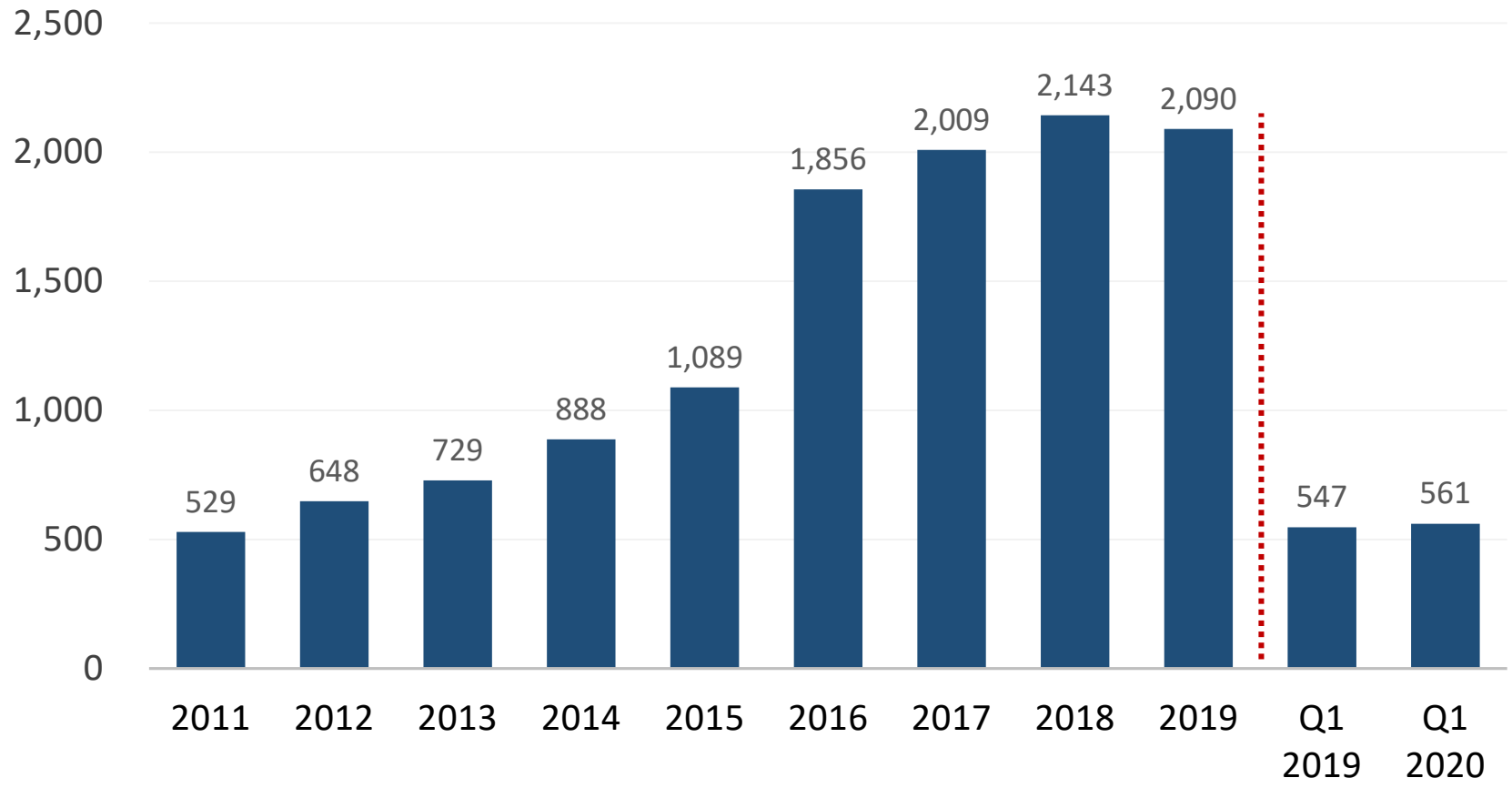
- Prepare strategic plan (entitled *Maryland Inter-Agency Opioid Coordinating Plan*).
- Coordinate efforts of 20 state agencies and 24 local jurisdictions.
- Disseminate best practices.
- Identify gaps and direct state resources to address those gaps.
- Review and approve all opioid-related budget proposals and legislation.

All Substance and All Opioid Intoxication Deaths – Q1 2019 vs. Q1 2020*



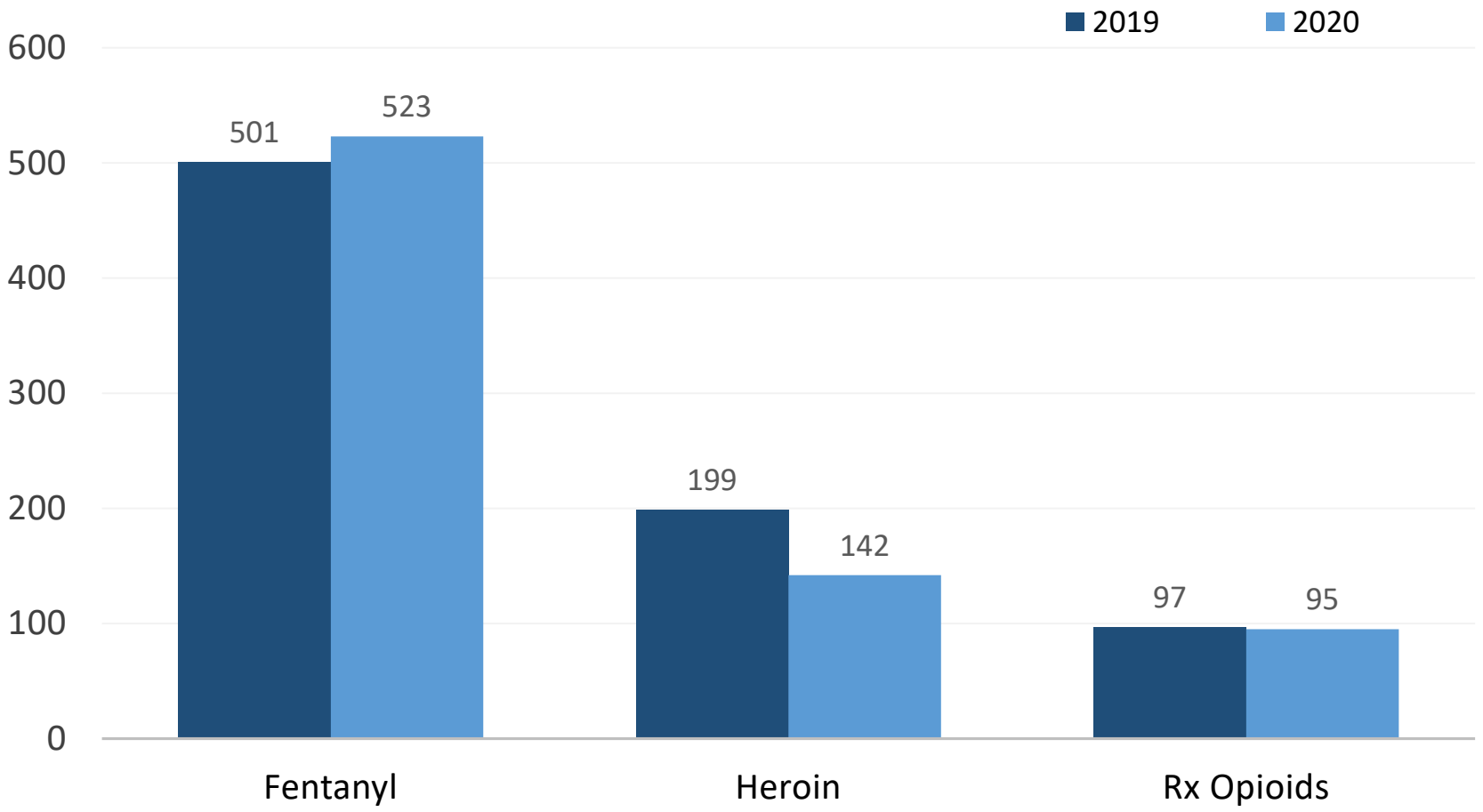
*2019 and 2020 counts are preliminary.

Opioid-Related Fatalities – 2011-Q1 2020*



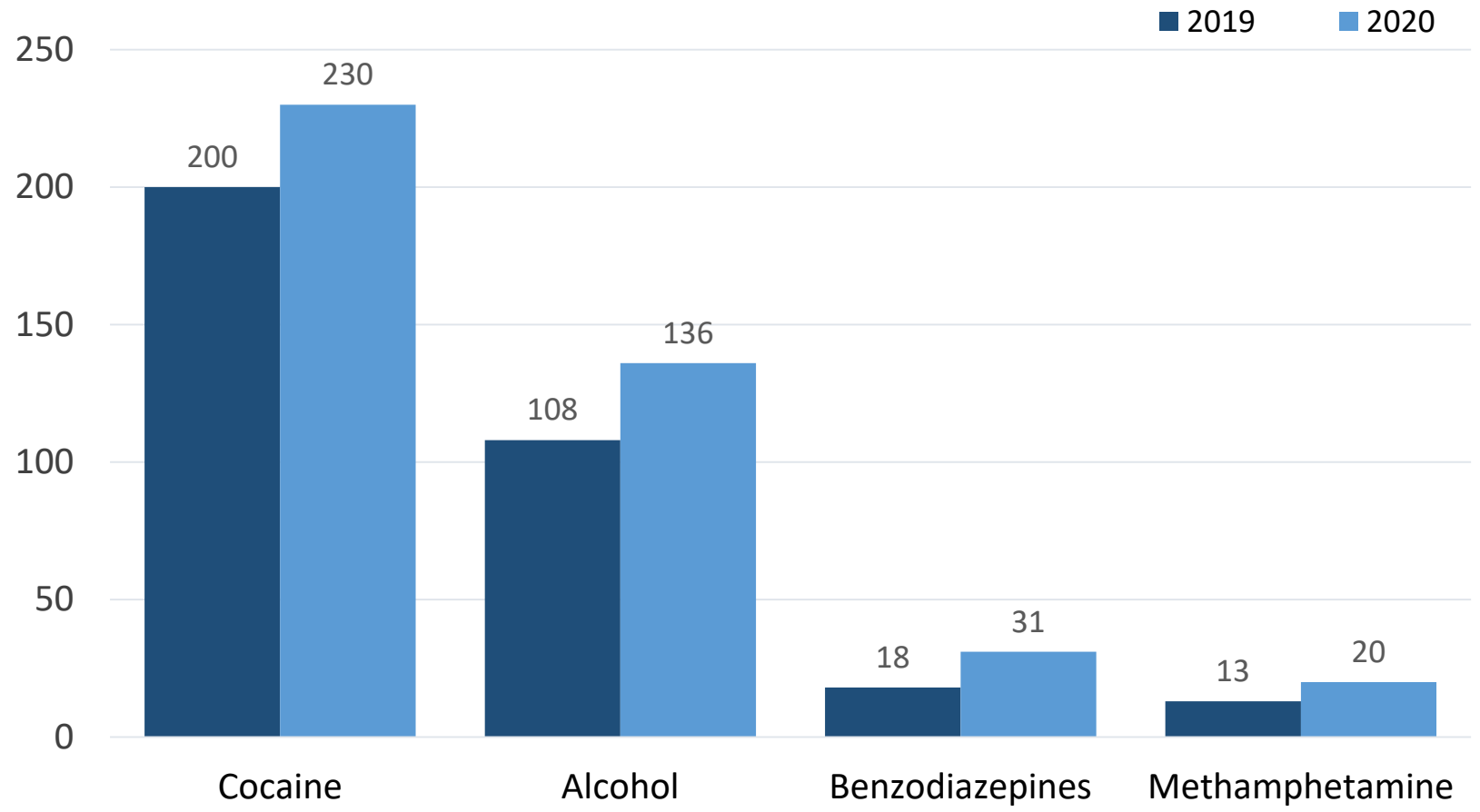
*2019 and 2020 counts are preliminary.

Intoxication Deaths by Opioid Type – Q1 2019 vs. Q1 2020*



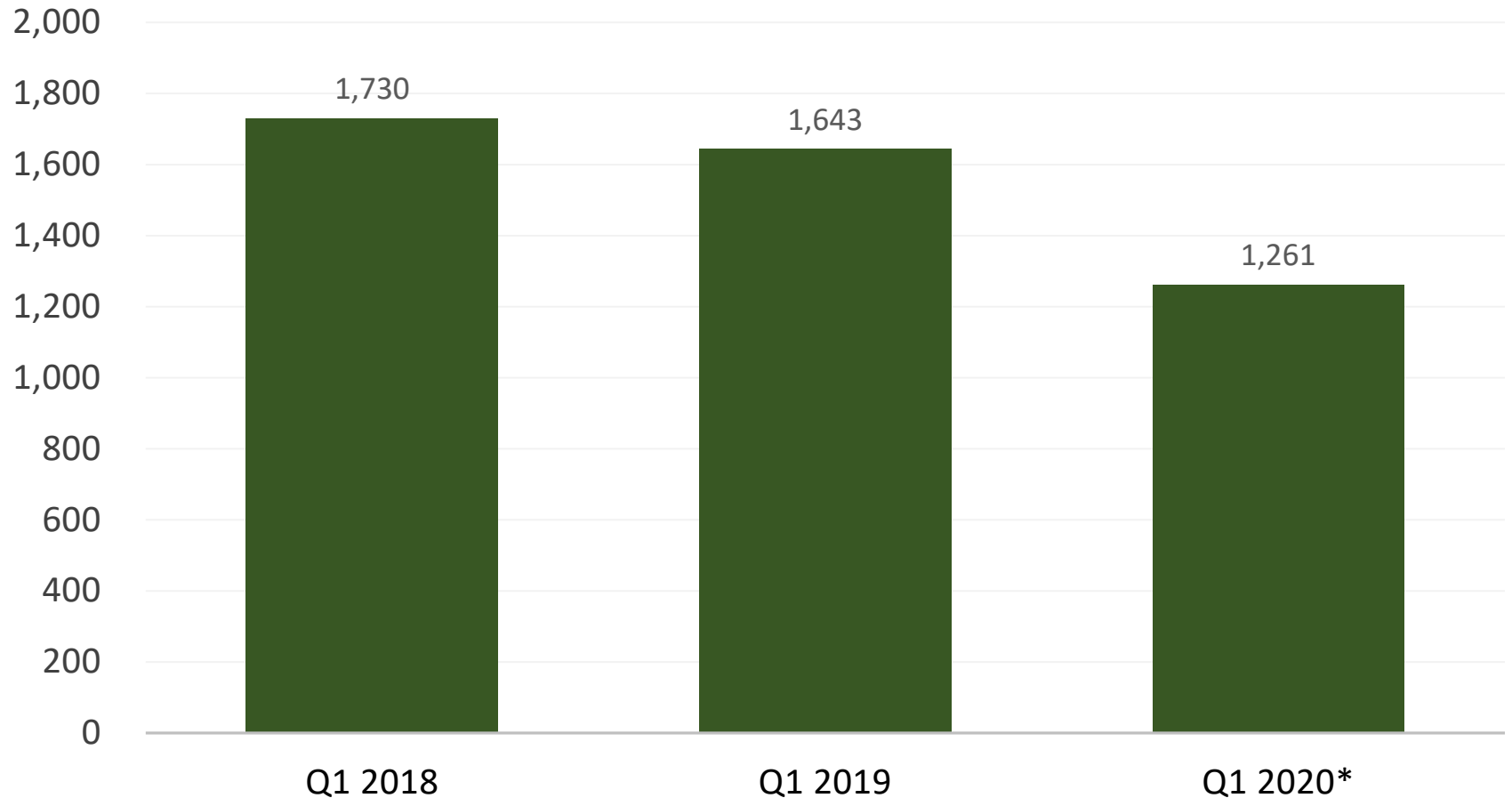
*2019 and 2020 counts are preliminary.

Non-Opioid Intoxication Deaths – Q1 2019 vs. Q1 2020*



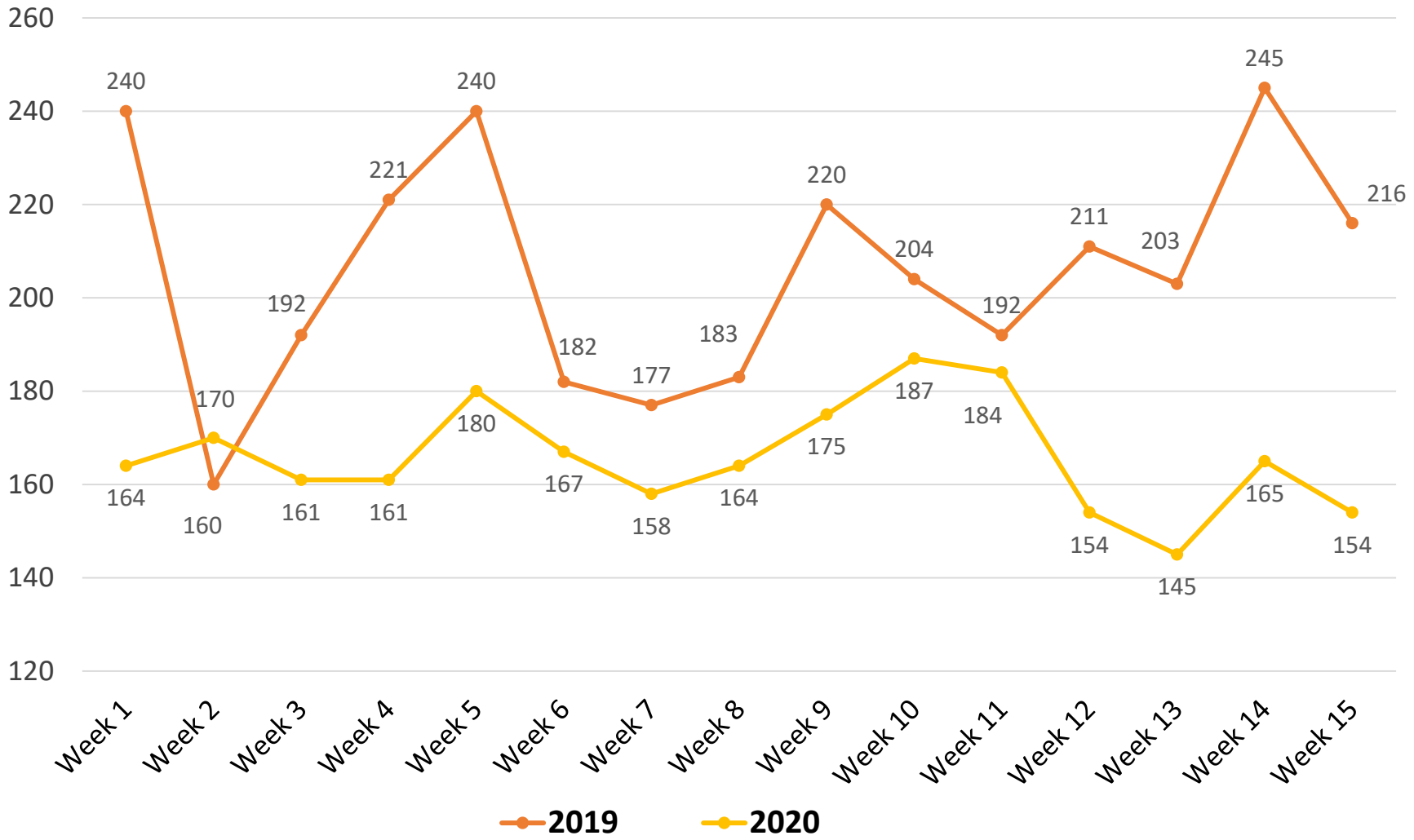
*2019 and 2020 counts are preliminary.

Non-Fatal Opioid Overdose ED Visits – Q1 2020*



*2020 counts are preliminary.

Naloxone Administrations by EMS Personnel – Q1 2020*



*2019 and 2020 counts are preliminary.

Collaboration with HSCRC on SIHIS

- *Opioid Screening, Prevention, and Treatment* was identified as one of two population health priorities for the SIHIS initiative.
- The HSCRC introduced the SIHIS and its planning process to the OOCC and MDH in December 2019.
- The OOCC was identified as the lead office for assisting the HSCRC with identifying goals, targets, and measures for opioid use as an indicator of population health.

Collaboration with HSCRC on SIHIS (cont'd)

- The OOCC met with MDH to identify a list of potential indicators for use in the SIHIS.
- Potential opioid-related population health indicators were presented during our state partner briefing in June 2020.
- Follow-up meetings will be held with additional state partners in the coming weeks and months.
- Finalize opioid targets: the OOCC's goal for September 2020.

The OOCC Is Easy to Reach!

Help.OOCC@Maryland.gov
100 Community Place
Crownsville, MD 21032

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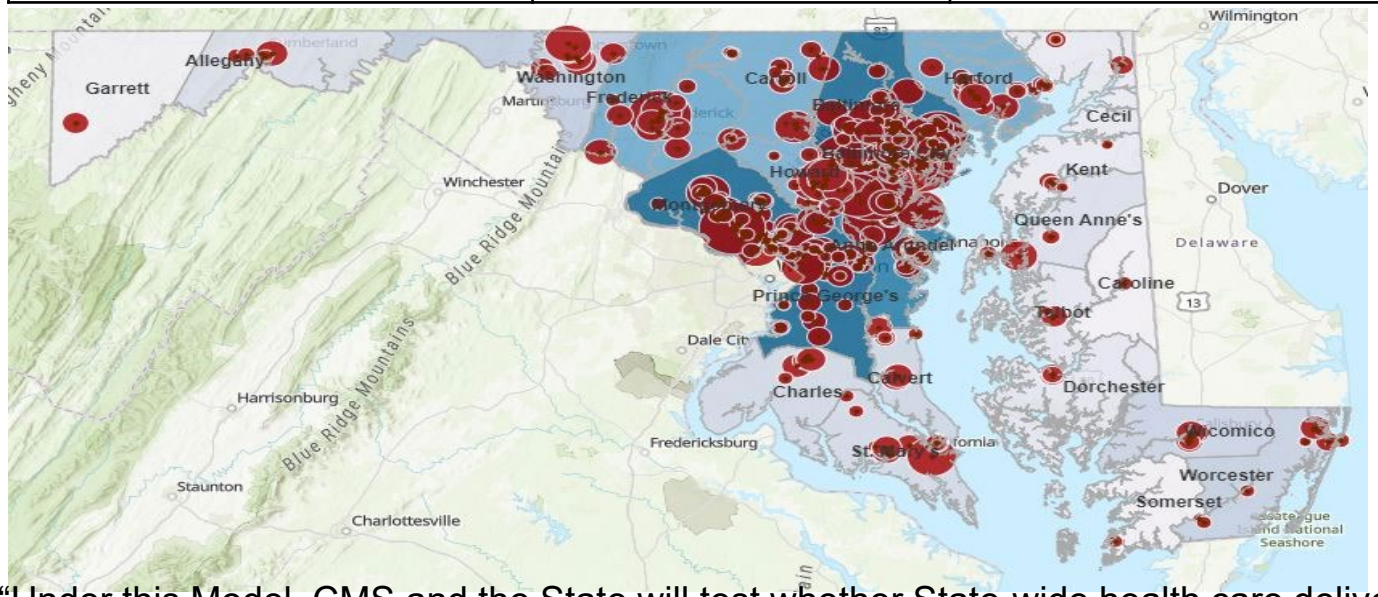
MDPCP 2019-2020 Highlights

Maryland Department of Health
Program Management Office
Howard Haft, MD – Executive Director

8 July 2020

Statewide Health Care Delivery Transformation

PARTICIPANTS	2019	2020 (Q2)
Providers in MDPCP	~1,500	~2,000
FFS Beneficiaries Attributed	220,000	347,000
Marylanders Served	2,000,000 – 3,000,000*	2,700,000 – 3,800,000*



Key Elements of Care Transformation:

- Care Management
- Telehealth
- Behavioral Health Integration
- Data-Driven Care

- "Under this Model, CMS and the State will test whether State-wide health care delivery transformation, in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare Total Cost of Care ("TCOC")."

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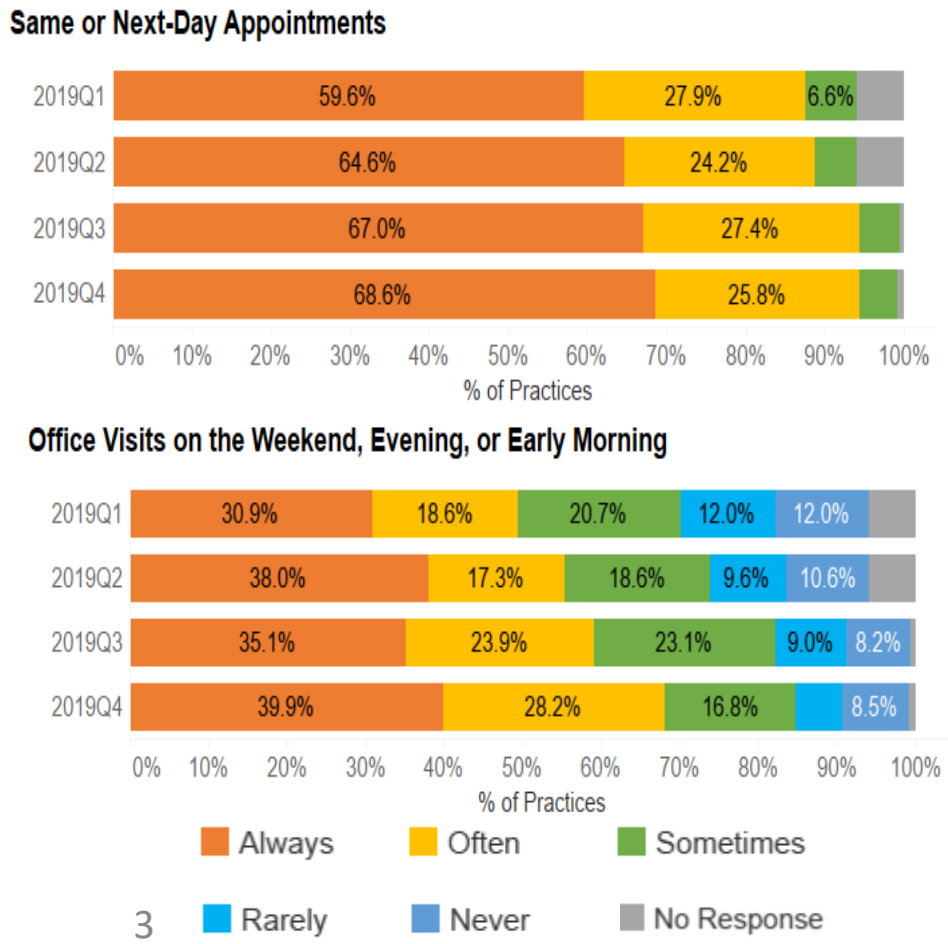
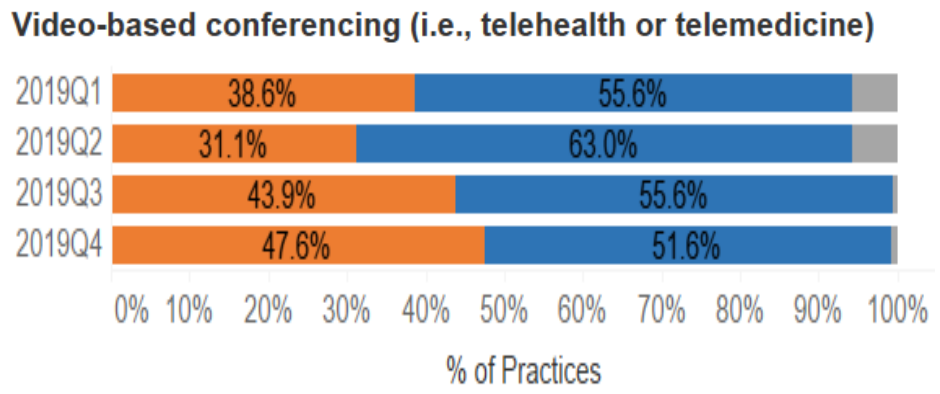
Enhanced Access to Care in the Community

Enhanced Access and Communication



Alternative Approaches to Care



- % of practices where it is unclear if the practice offers this option
- % of practices that do not offer this option
- % of practices that do offer this option

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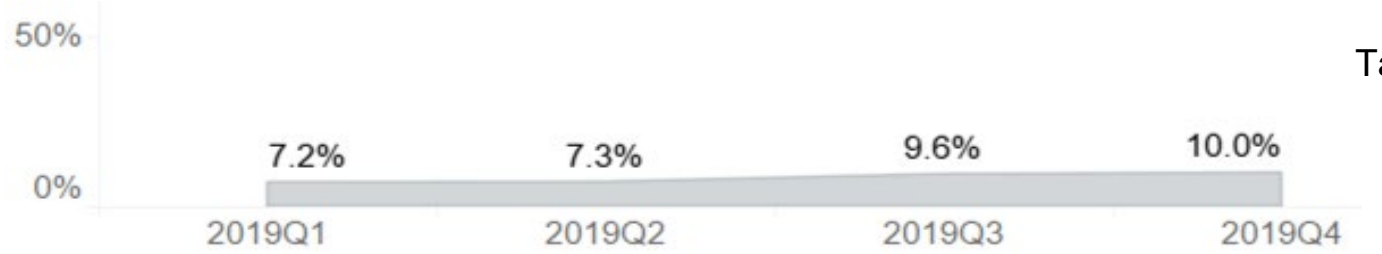
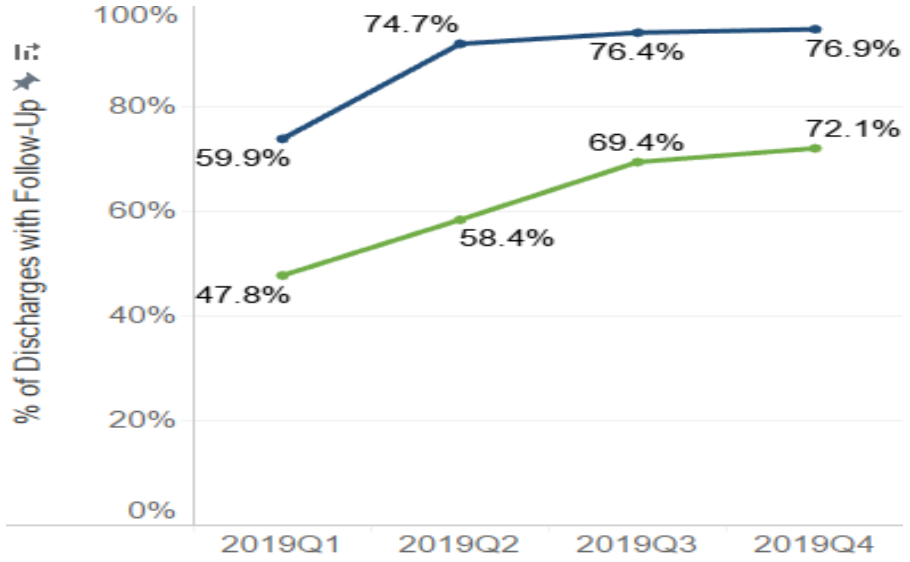
Care Management and Transitions

% of Empaneled Beneficiaries under Longitudinal Care Management



Target is 5%

Beneficiary Follow-up Rate, By Setting and Quarter



Emergency Department (Follow-up Within One Week)
Hospital (Follow-up Within 72 Hours or 2 Business Days)

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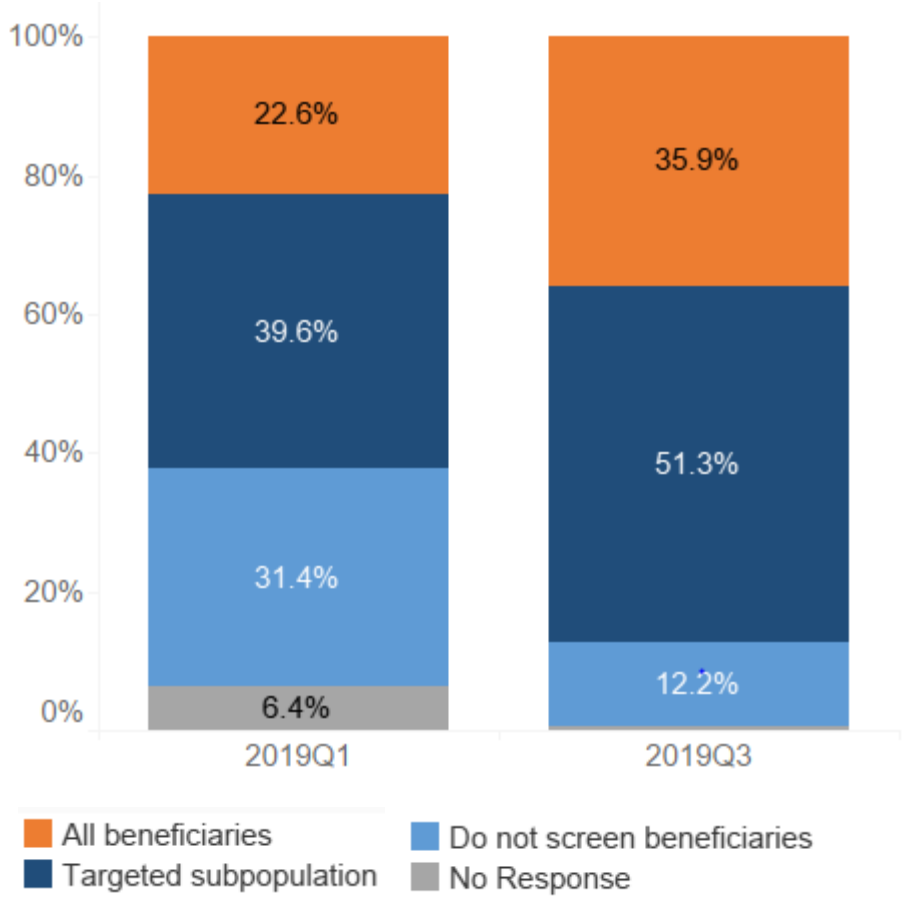
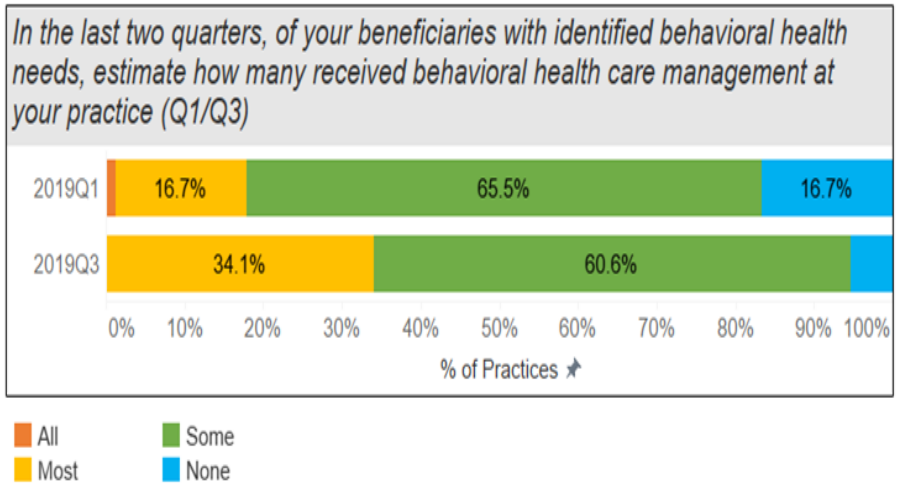
Social Determinants and Behavioral Health

Practices' Response to the Question "Do you routinely screen your beneficiaries for unmet social needs? (Q1/Q3)"



Practices' Integration of Behavioral Health Care Management



126 practices fully implemented SBIRT

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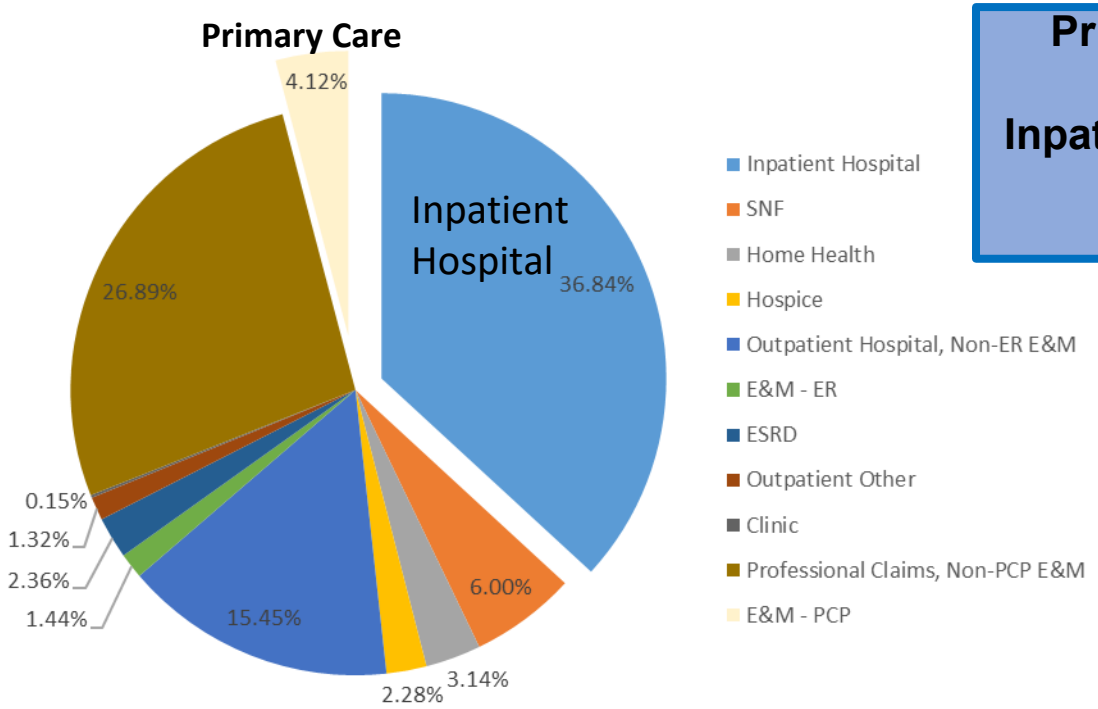
By the numbers- Expenditures

Medicare FFS % of 2019 Expenditures By Provider Type, 2019



Primary Care $0.42B (4.1%)

Inpatient Hospital 3.78B(36.8%)

Total A/B $10.3B

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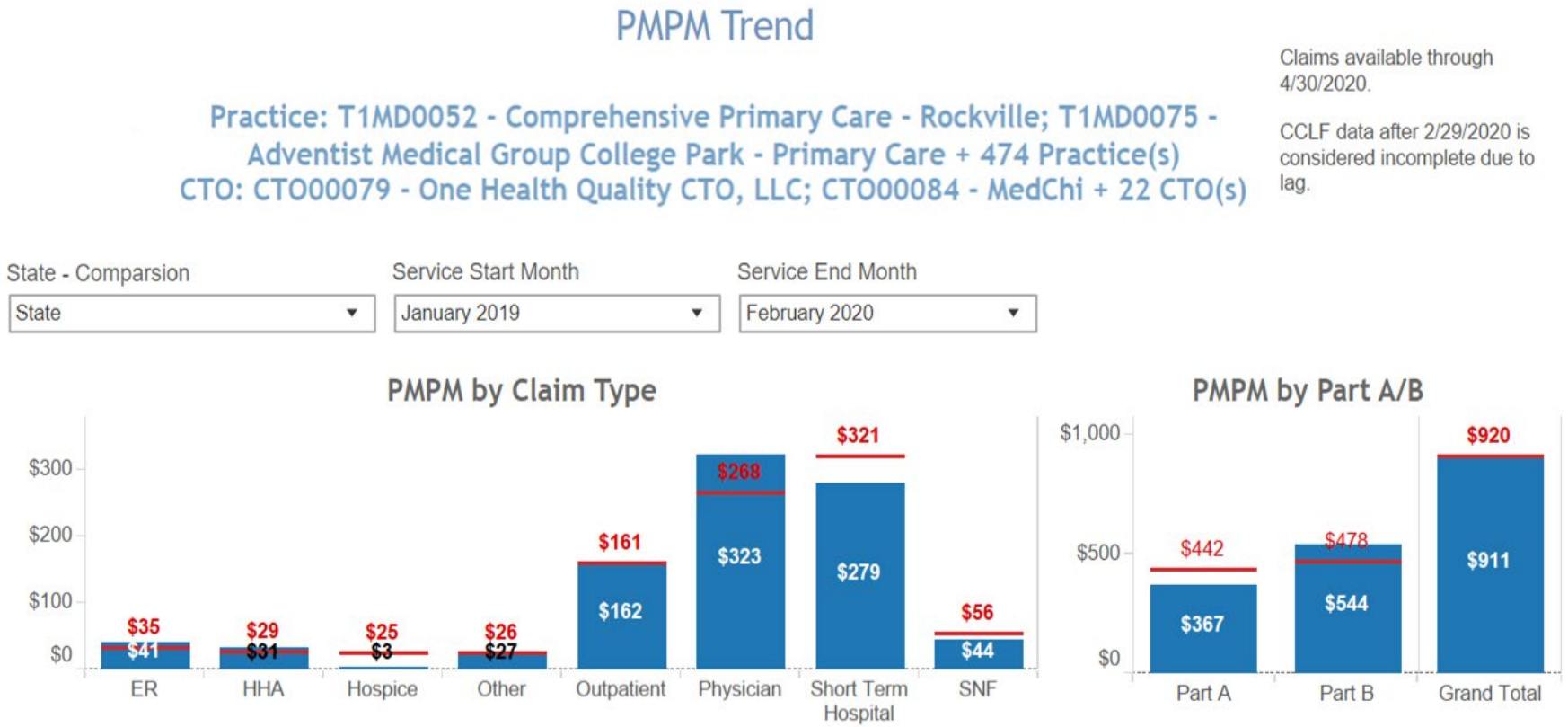
MDPCP PMPM Relative to State



MDPCP Total A/B (0.9%) less than State

MDPCP Part A (20%) less than State

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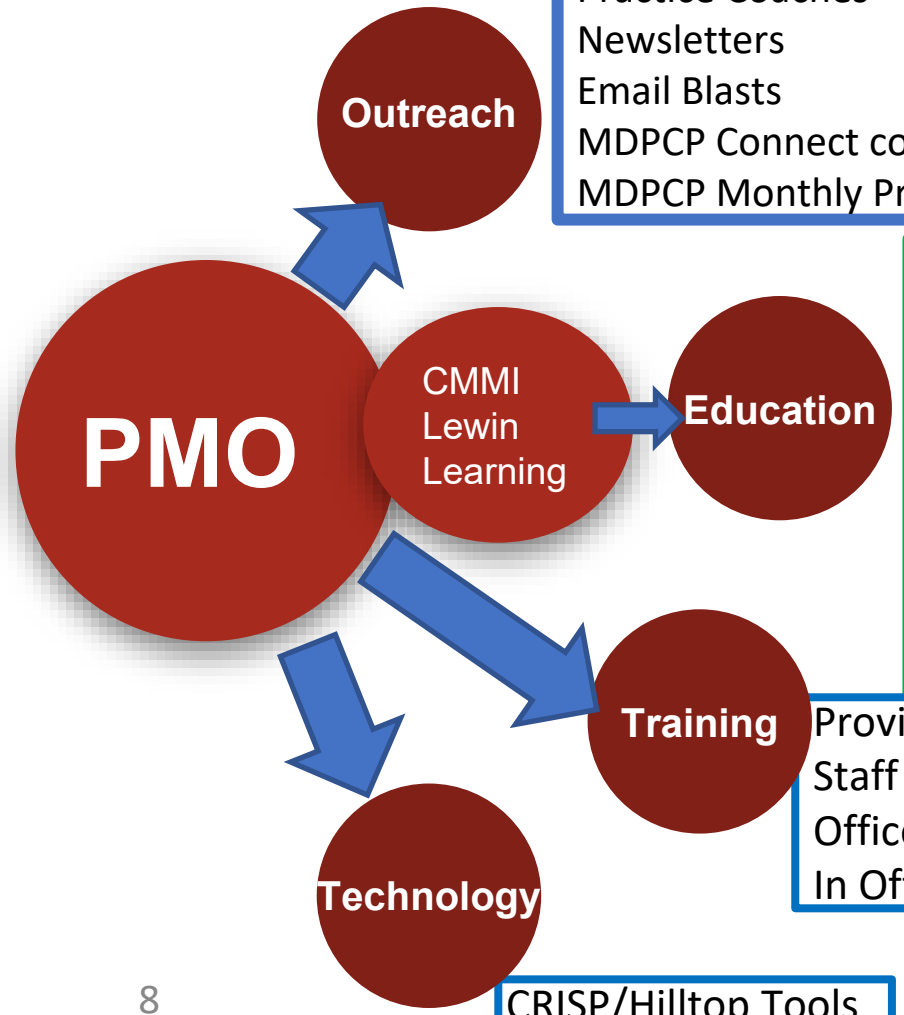
PMO Building a Primary Care Foundation for State



Practice Coaches - Onsite & Virtual Support
Newsletters
Email Blasts
MDPCP Connect communication
MDPCP Monthly Priorities

MDPCP PMO Work
COVID-19 Webinars, ~2,042 unique attendees, ~9,311 total attendees, average attendance of 207
COVID-19 Roadmap to Recovery Guide

Joint MDPCP PMO-The Lewin Group Work
MDPCP Learning Webinars
MDPCP Resource Documents and Summary Guides
Affinity Groups and Office Hours
Learning Sessions (1-3)

Provider Leadership Academies
Staff Training Academies
Office Reopening Training
In Office Covid Testing training

CRISP/Hilltop Tools

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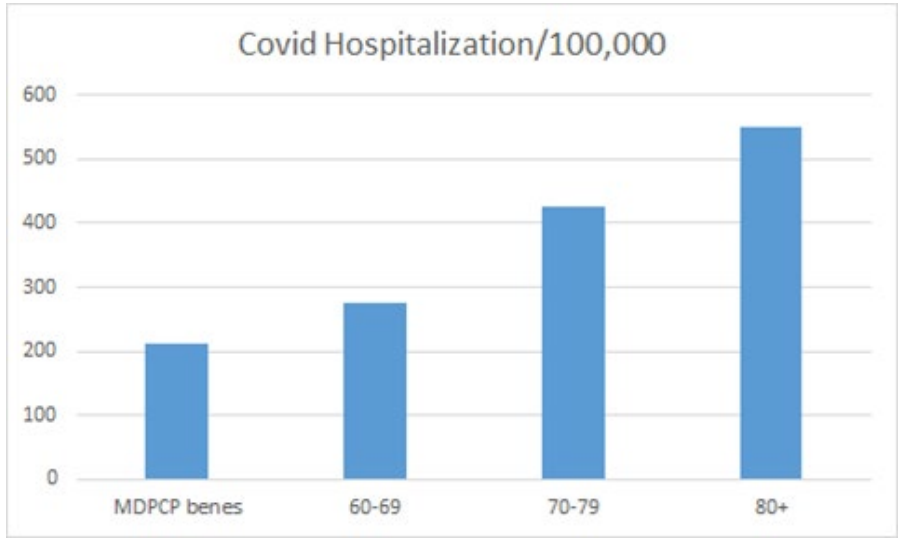
MDPCP Practices COVID-19 Response

- Practices use telemedicine- 99%+ during COVID
- Testing- 64.2% of responding practices committed to conduct on-premises currently
- CVI/Pre-AH tools used to guide interventions to vulnerable patients



Source: CRISP ADT Feeds
March- May 2020

- Surveys suggest (38.9%) with severe financial strain *(Larry Green Center)*

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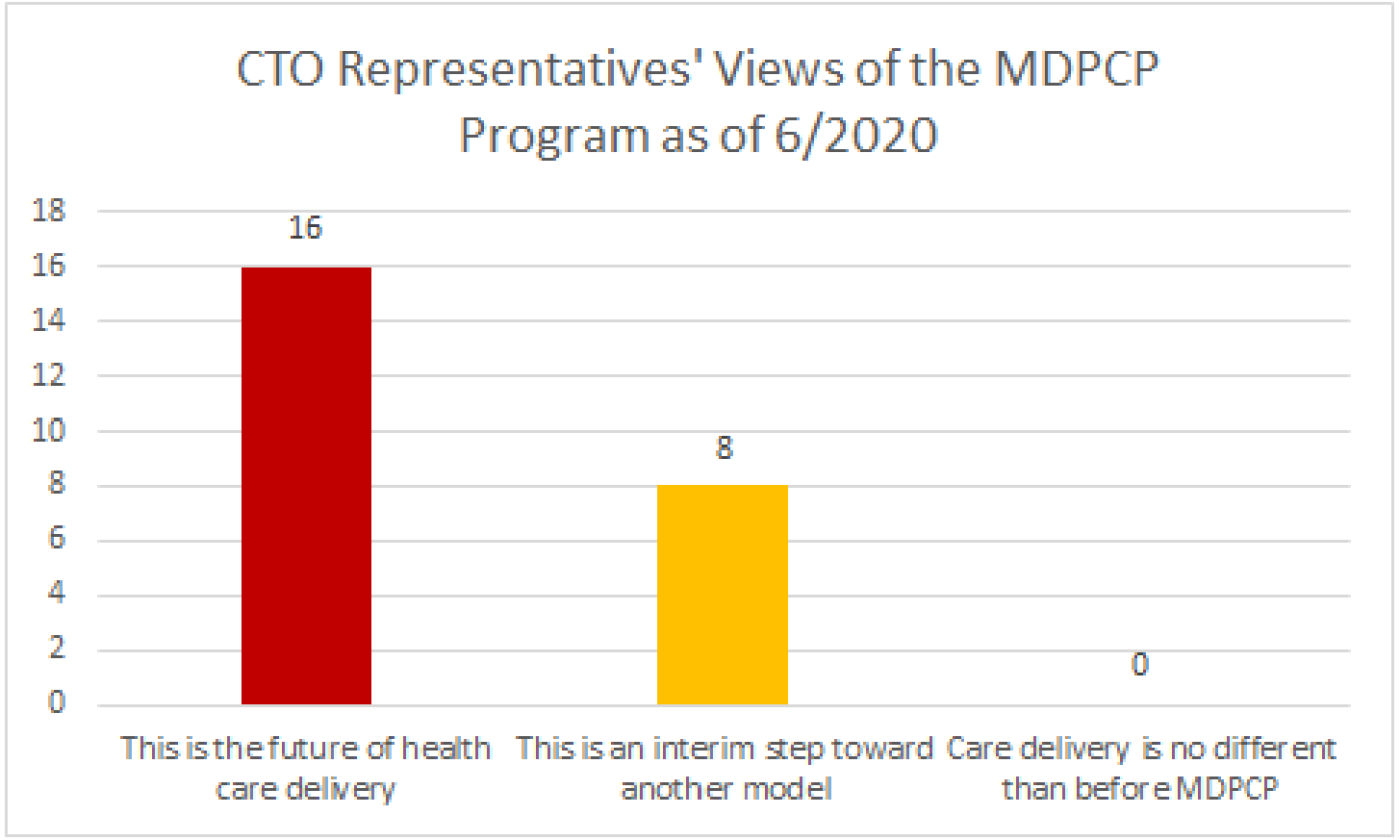
CTO View of MDPCP



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What's Next

- Expanded Population Based payments– PMO is working with the Advisory Council and CMMI to develop an optional Track 3 Proposal modeled after Primary Care First
- Data driven care –
  - Further Enhancements to our unique Avoidable Hospital Events tool that incorporates address level social determinants
  - Recently released a PQI-Like report that provides feedback to practices on unnecessary Hospital and ED use
  - Robust Social Determinants of Health Screening and linkages to CBOs
- Manage population health and provide surveillance under the new normal of COVID-19 including:
  - Statewide testing of primary care patients
  - Modified protocols and workflows
  - Long term focus on telehealth

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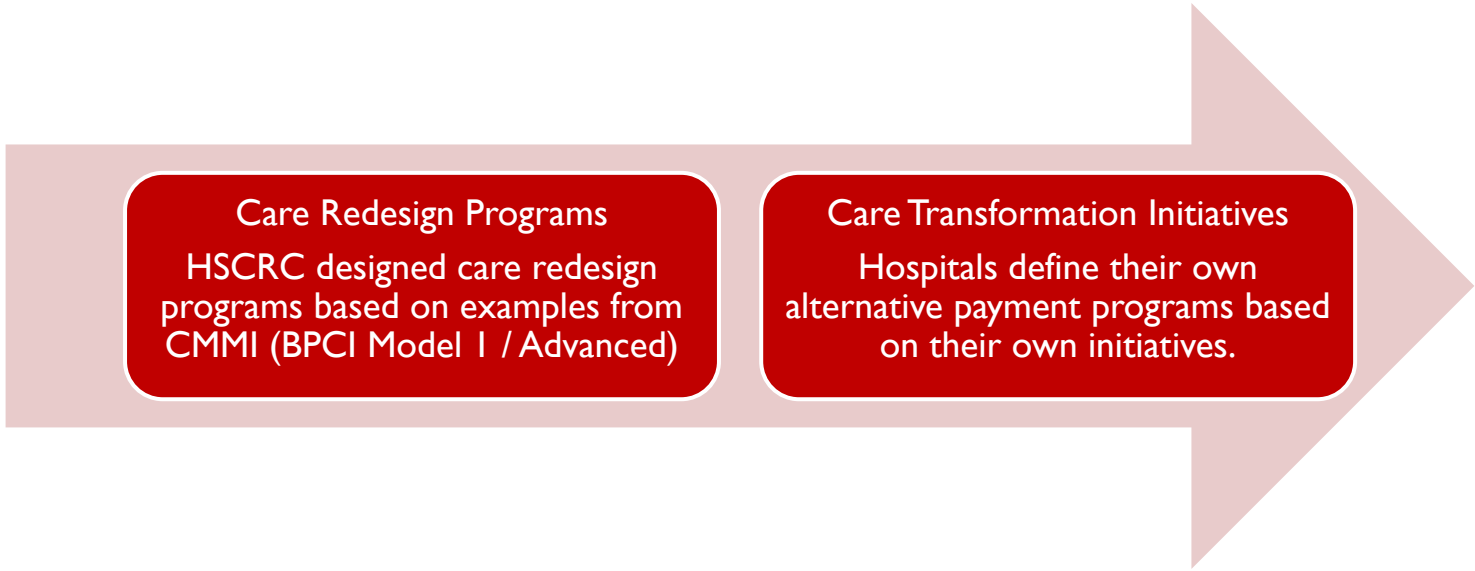
CTI Update

July 8, 2020

Evolution of Care Redesign Efforts



- CRP was created to allow hospitals to make gainsharing payments to non-hospital providers.
- HSCRC and hospitals learned valuable lessons about the creation and implementation of alternative payment models.
- CTIs were created in order to address some of the limitations with the CRP.
- Hospitals can define their own CTI population, rather than following CMS definitions.

Comparison of CRP and CTI

	Care Redesign Programs	Care Transformation Initiatives
Program Design	CRP tracks were designed by HSCRC in collaboration with hospitals.	Hospitals define their own CTI initiatives.
Total Cost of Care Savings	Hospitals in HCIP keep internal cost savings. Hospitals in ECIP share savings with CMS.	Hospitals receive 100 percent of the TCOC savings they produce.
Incentive Payments	Hospitals may make incentive payments.	No incentive payments required.
Program Administration	Large administrative burden is necessary under the fraud and abuse waivers.	Administrative burden is limited. No required reporting beyond defining the CTI population.

Overview of Care Redesign Program

- Hospital Care Improvement Program (HCIP)
  - This program benchmarks physicians to Best Practice Norms based on the length of stay and other measures.
  - Hospitals pay incentive payments to physicians that meet the hospital the best practice norms.
  - 7 hospitals are participating in HCIP. In the first half of 2019, hospitals created $1.3 million in internal cost savings and shared $250 thousand with physicians.
- Episode Care Improvement Program (ECIP)
  - This program pays hospitals that reduce the 90 day post acute care costs in 23 different clinical episodes.
  - Hospitals may choose to make incentive payments to physicians, SNFs, HH, and other providers.
  - 22 hospitals are participating in ECIP. In 2019, participating hospitals (9) earned $500 in shared savings payments.

Overview of the CTI Policy

- The Care Transformation Initiatives (CTI) Policy incentivizes hospitals to manage the TCOC selected populations.
  - Hospitals can define the populations that they manage.
  - As opposed to the MPA, this policy allows the hospital to choose which population is attributed to them.
- Hospitals receive 100 percent of the savings that they achieve on the beneficiaries in their population.
  - Savings are calculated by comparing the TCOC of the included beneficiaries to similar beneficiaries in a prior year.
  - Payments to hospitals are offset across all hospitals in the State in order to incentivize participation by all hospitals.
- The CTI process will create an inventory of interventions that hospitals are engaged in under the Model.
  - This will allow the Commission to calculate the ROI on interventions.
  - This will help illustrate the Model's care transformation impact to CMMI.

Initial CTI Thematic Areas

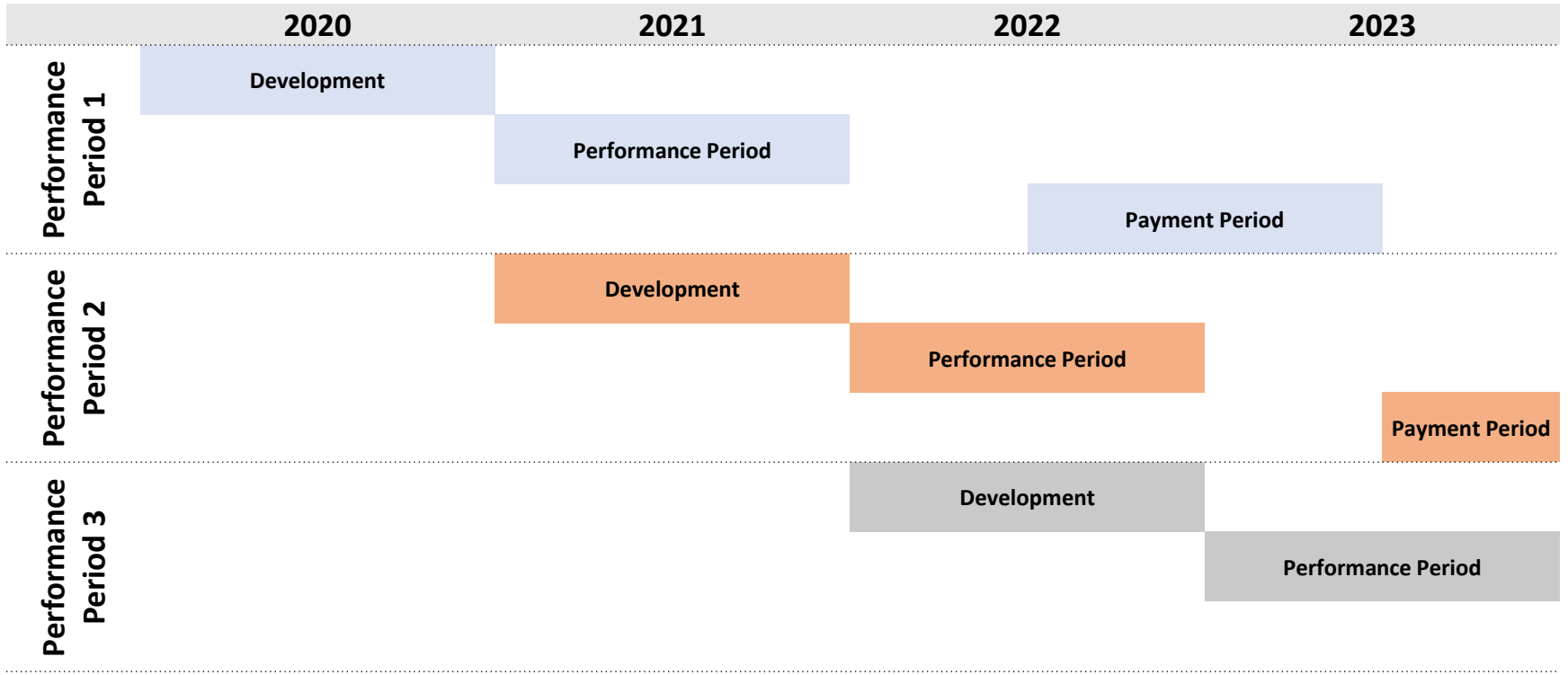
Thematic Area	Target Population	Clinical Interventions
Care Transitions (42 Hospitals)	Patients discharged from the hospital	Post-discharge care management programs include: • Discharge planning in physician's office • Hospital screening and assessment • Home assessment or step-down level of care
Palliative Care (21 Hospitals)	Patients seen at the hospital who have serious illnesses	Palliative care teams are deployed to manage patients with serious illnesses. This includes: • Palliative care consults • Evidence-based pathways of care
Primary Care (20 Hospitals)	Patients seen by primary care practices	Care management teams are integrated with primary care practices or clinics. The care teams: • Develop of individualized plans of care • Deploy tele-monitoring technology
Community Care (11 Hospitals)	Patients residing in SNFs or assisted living facilities	Care management teams are deployed to SNF or assisted living facilities. The care teams: • Conduct standardized assessments for referred residents • Address the unmet clinical and social needs
Emergency Care (TBD)	Patients seen at the ED but not admitted to the hospital	A community-based team partner with paramedics in order and provides care management at the homes of high utilizers and frequent fliers.

* Preliminary participation numbers; final implementation protocols due in October

Update on CTI Process

- The Care Transformation Initiatives (CTI) policy is scheduled to begin on January 1, 2021.
  - The original policy was delayed by 6 months due to COVID.
  - Final implementation protocols will be due in October of 2020.
  - The first performance period will be calendar year 2021 with payments made beginning of July 2022.
- New CTI Thematic Areas can be developed throughout CY 2022.
- Staff will also explore additional methodologies to set a target price like the MA or PACE benchmarks.
  - An actuarial approach could set a target price without comparing a hospital to their previous performance.
  - This will allow more flexibility for hospitals to measures savings on new interventions.

Timing of CTI Implementation



HSCRC
Health Services Cost Review Commission

Next Steps

- Revise the hospital's cost reports in order to collect data on the amount that hospitals spend on their CTIs.
  - These costs can be used to calculate an ROI on their interventions.
  - These costs can be included in the ICC in order to incorporate population health spending into our efficiency policies.
- Development of next CTI Thematic Areas and methodologies will continue through 2021.

July 8, 2020

COVID-19 Long-Term Care Partnership Grant Program

Tequila Terry, Deputy Director
Health Services Cost Review Commission (HSCRC):
Center for Payment Reform and Provider Alignment

HSCRC
Health Services Cost Review Commission

COVID-19 Long-Term Care Partnership Grant Program

- This grant program is intended to foster collaboration between hospitals, long-term care facilities, and other congregate living facilities that serve vulnerable populations during the COVID-19 crisis.

- Under the LTC Grant Program, hospitals and their long-term care/congregate living partners will collaborate on best practices to reduce the spread of COVID-19 in these settings through a focus on:
  - Patient management
  - Infection prevention
  - Infection control

- The grant program is intended to be a one-year program starting July 1, 2020 and ending June 30, 2021

- Rolling Application Deadline: Awards will be issued in order of receipt until the statewide approved funding limit of $10 million has been met

- This grant program is being funded by the previously unallocated 3rd funding stream of the Regional Partnership Catalyst Grant Program

Examples of Collaboration Opportunities

Resource Sharing

- Nursing staff to work with COVID-19 diagnosed patients
- Resource nurses to provide care management/discharge placement functions at the hospital and infection prevention and control at the nursing home
- Physician specialists working with the nursing home onsite nurse to evaluate patients/residents and initiate or change treatments
- Personal protective equipment (PPE) support
- Lab services to enable frequent and expedited COVID-19 testing

Quality Improvement

- Sharing of best practices and provision of training on processes designed to reduce facility risk through protocols established by CDC, CMS, and MDH
  - Prevent symptomatic and pre-symptomatic transmission
  - Provide ongoing testing of patients/residents and staff
  - Isolate symptomatic patients
  - Protect healthcare personnel

Data/Analytics

- Access to data and/or technology that can be used to internally track, monitor, and manage information related to COVID-19 affected patients.

Federal Waivers

- Earlier in 2020, the federal government took steps to remove barriers that have traditionally limited the ability for hospitals and long-term care/congregate living facilities to work together.

- In response to the COVID-19 pandemic, the U.S. Department of Health & Human Services (HHS) Secretary issued Blanket Waivers to ensure that during the COVID-19 emergency period there are sufficient health care services available to meet the needs of individuals in the enrolled in Medicare, Medicaid, and the Children's Health Insurance Program programs.

- As part of these waivers, exemptions were provided to eliminate sanctions for noncompliance penalties that otherwise would apply to collaboration

- The HSCRC believes there are now new opportunities for collaboration between hospitals and long-term care and other congregate living facilities that serve vulnerable populations to curb community spread during the pandemic

- Hospitals will need to evaluate these waivers to determine their applicability to their particular applications and in light of existing federal/state Antitrust and Fraud and Abuse laws

Grant Eligibility Criteria

- Hospitals must partner with at least **one** licensed long-term care and/or congregate living facility that services vulnerable populations and is operating in Maryland

- Hospitals should work with partners that are in the same geographic areas and with whom they have a "911 relationship" with to handle the majority of emergencies.

- As of the application date, hospitals must have a collaboration agreement with the long-term care/congregate living facility that is currently operating in Maryland to be eligible for grant funding.

- Applications must include a list of strategies that will be implemented to address COVID-19 patient management, infection prevention, and infection control.

- Details about arrangements for resource sharing, financial payments, and/or in-kind support must be disclosed in the applications.

Evaluation Criteria

Impact Potential	• The potential for the proposed activities to achieve improvement in the LTC Grant Program goals for COVID-19 patient management and infection prevention/control procedures.
Collaboration Plan	• The extent to which applications articulate plans to establish collaboration with hospitals and long term care/congregate living facilities through meaningful engagement including resource sharing, quality improvement consultation, and/or data sharing.
Evidence-Based Approaches	• Whether the proposed activities are well-conceived, evidence-based/evidence-informed, and appropriately propose how to implement the investments in manner consistent with CDC, CMS, and MDH direction.
Governance & Operational Planning	• Level of detail and feasibility of plan including governance model to enable partners to work together effectively.

COVID-19 Long-Term Care Partnership Grant Program: Staff Recommendation

- Delegate authority to HSCRC Staff to:
  - Evaluate applications submitted for funding
  - Make award determinations up to the approved limit of $10M

- HSCRC Staff should work with one or more Commissioners during the process

Update on Hospital Community Benefit Reporting and Legislative Directives

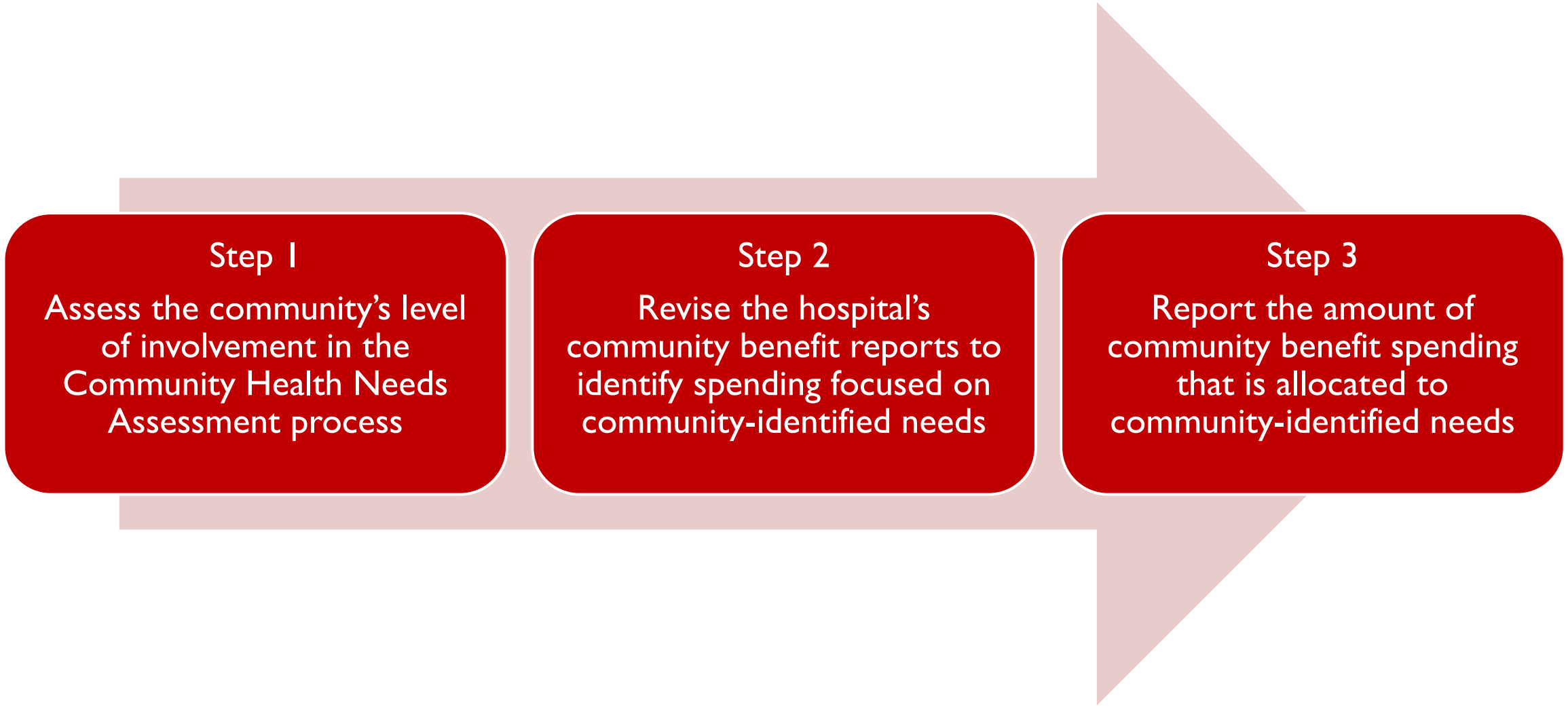
7/08/2020

HSCRC
Health Services Cost Review Commission

2020 Legislative Update – SB0774 and HB1169

- During the 2020 Maryland Legislative Session, Senate Bill 0774 (Chapter 437) and House Bill 1169 (Chapter 436) directed the HSCRC to:
  - Establish a Community Benefits Reporting Workgroup
  - Require hospitals to conduct its community health needs assessment by consulting with members of the community
  - Revise the Community Benefits Report to assess the amount of community benefit spending that is targeted towards community needs as identified on the hospital's community health needs assessment.
- Staff intends to use the Consumer Standing Advisory Committee to review the community benefits reports. This will include:
  - Reviewing a report to the Legislature by December 1, 2020 that assesses the hospitals community engagement and a description of changes to the community benefit reports.
  - We anticipate bringing a draft recommendation on the community benefit reports to the Commission in the fall.

Strategy for Revising Hospital Community Benefit Reporting



Estimated Statewide Tax Benefit

- At the direction of the Commission, Staff commissioned a report by SB & Company to estimate the total value of the tax benefits provided to Maryland not-for-profit hospital's regulated operations through their tax-exempt entity status.
- Full text of the report will be included in meeting follow-up items on the HSCRC website
- The report followed an article that did a national analysis of the tax benefits. The analysis examined six types of tax benefits:
  - Federal Income Taxation
  - State Income Taxation
  - State Sales Taxation
  - Local Property Tax Exemption
  - Tax Exempt Bonds
  - Charitable Contributions
- The analysis showed the hospitals' tax benefit was equal to $700 million, or 5% of operating revenue.
- FY 2019 HCB spending totaled $1.1 billion, after eliminating rate-supported activities.

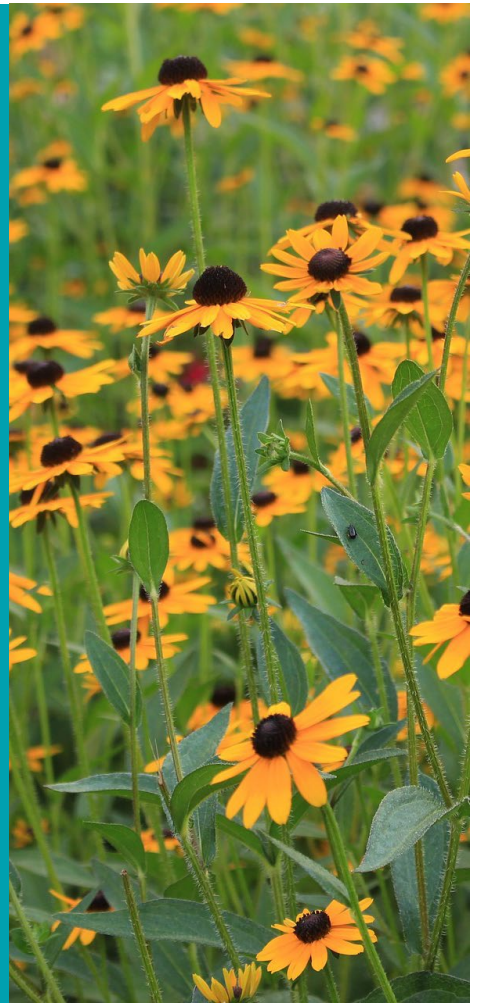
Estimated Tax Benefit

Tax Category	Net Benefit
Federal Income Tax (21%)	$193,133,200
State Income Tax (8.25%)	84,023,498
State Sales Tax Exemption (6%)	38,623,786
Property Tax Exemption	240,463,563
Tax-Exempt Bonds	133,614,252
Charitable Subsidization	13,745,971
Total Value of Tax Benefit	**$703,604,270**
Total FY19 Regulated Operating Revenue per Schedule RE	$15,253,815,000
Tax Benefit as % of Operating Revenue	5%

The Hilltop Institute

FY 2019 Hospital Community Benefits Report

Laura Spicer and Cynthia Woodcock
Maryland Health Services Cost Review Commission
July 8, 2020

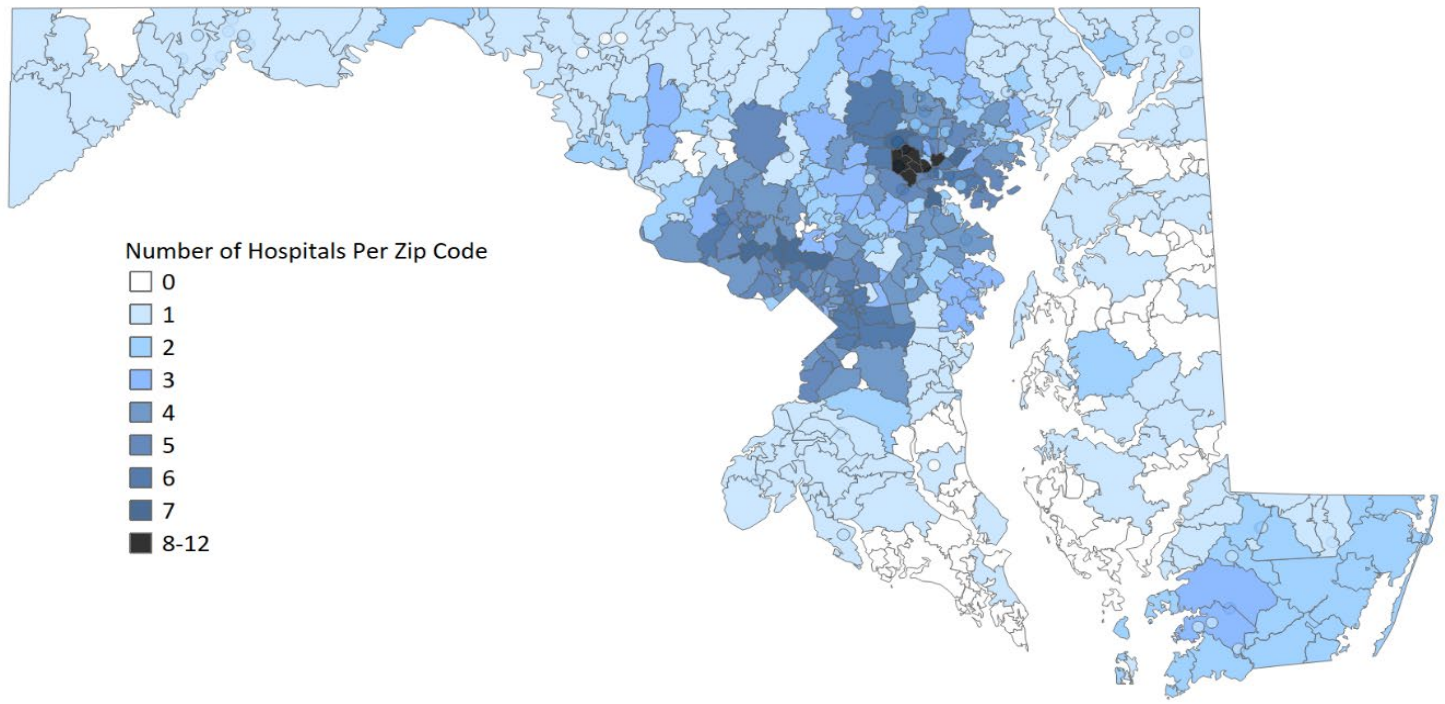


UMBC

Introduction

- The HSCRC is required to collect hospital community benefit information and compile into a statewide, publicly available report
- Two components:
  - Financial Report
  - Narrative Report
- FY 2019 marks the 16th year of reporting

Community Benefit Service Areas Cover all but 89 Maryland ZIP Codes



FY 2019 Financial Report Highlights

- 50 hospitals submitted
- $1.89 billion in community benefit expenditures, compared to $1.75 billion in FY 2018
  - Represents 11.2% of statewide hospital operating expenses compared to 10.8% in FY 2018
  - Ranges from 3.1% to 31.9%
- After accounting for rate support, community benefit expenses totaled $1.2 billion, compared with $1.1 billion in FY 2018
  - Represents 7.4% of statewide hospital operating expenses, compared to 6.7% in FY 2018
  - Ranges from 1.4% to 31.1%

FY 2019 Hospital Community Benefit Expenditures by Category

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

Mission-Driven Services and Off-Setting Revenue

- Hospitals report off-setting revenue for each CB category
- Mission-driven services (48.6%) and the Medicaid deficit assessment (45.6%) account for 94.2% of all off-setting revenue
- Mission-driven services, however, are intended to be services provided to the community that are not expected to result in revenue
  - 13 hospitals reported no offsetting revenue for mission-driven services
  - 7 hospitals reported off-setting revenue for over 50% of their mission-driven expenditures

Physician Subsidies

- A subcategory of mission-driven services
- Include:
  - Hospital-based physicians
  - Non-resident house staff and hospitalists
  - ED call
  - Physician provision of financial assistance
  - Physician recruitment
  - Other subsidies
- Inconsistencies and ambiguity in reporting – difficult to analyze
- Preliminary findings:
  - Physician subsidies account for 84% of mission-driven expenditures
  - About half of the physician subsidy expenditures are tied to a reported CHNA need or gap in physician availability

Narrative Report Highlights

- Top community health needs addressed by initiatives:
  - Educational and Community-Based Programs
  - Diabetes
  - Oral Health
  - Health-Related Quality of Life & Well-Being
  - Behavioral Health
  - Other Social Determinants of Health
  - Nutrition and Weight Status
  - Heart Disease and Stroke
  - Physical Activity
  - Older Adults

- 83 percent of hospitals address at least one State Health Improvement Process goals in their initiatives

Narrative Report Highlights

- 90% of hospitals:
  - Employ population health directors/staff
  - Employ staff dedicated to community benefit
- 98% of hospitals incorporate community benefit investments in their strategic transformation plans

About Hilltop

The Hilltop Institute is a nonpartisan research organization at the University of Maryland, Baltimore County (UMBC) dedicated to improving the health and wellbeing of people and communities. We conduct cutting-edge data analytics and translational research on behalf of government agencies, foundations, and nonprofit organizations to inform public policy at the national, state, and local levels.

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Maryland Hospital Community Benefit Report: FY 2019

June 23, 2020

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LIST OF ABREVIATIONS

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

INTRODUCTION

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

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

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

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

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

BACKGROUND

Federal Requirements

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

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

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

Maryland Requirements

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

- The hospital's mission statement

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

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

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

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

NARRATIVE REPORTS

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

Hospitals Submitting Reports

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

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

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

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

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

Section I. General Hospital Demographics and Characteristics

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

Hospital-Specific Demographics

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

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

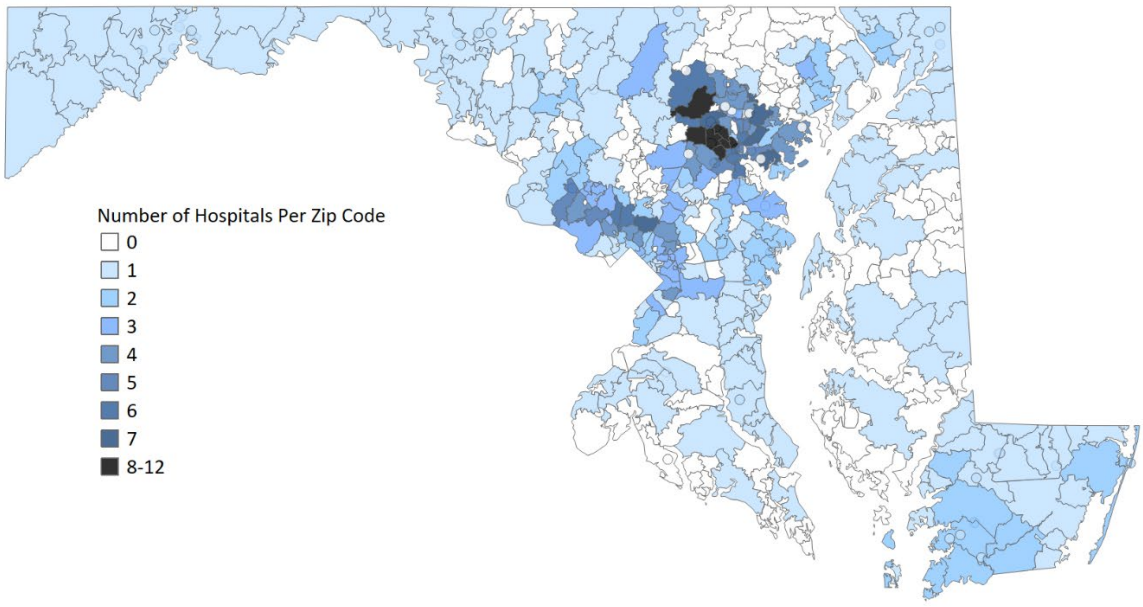
Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
Independent Hospitals					
Anne Arundel Medical Center	349	30,503	1.2	14.3	36.2
Atlantic General Hospital	40	3,084	1.7	12.0	67.0
Bon Secours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

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

Primary Service Area

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

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



Community Benefit Service Area

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

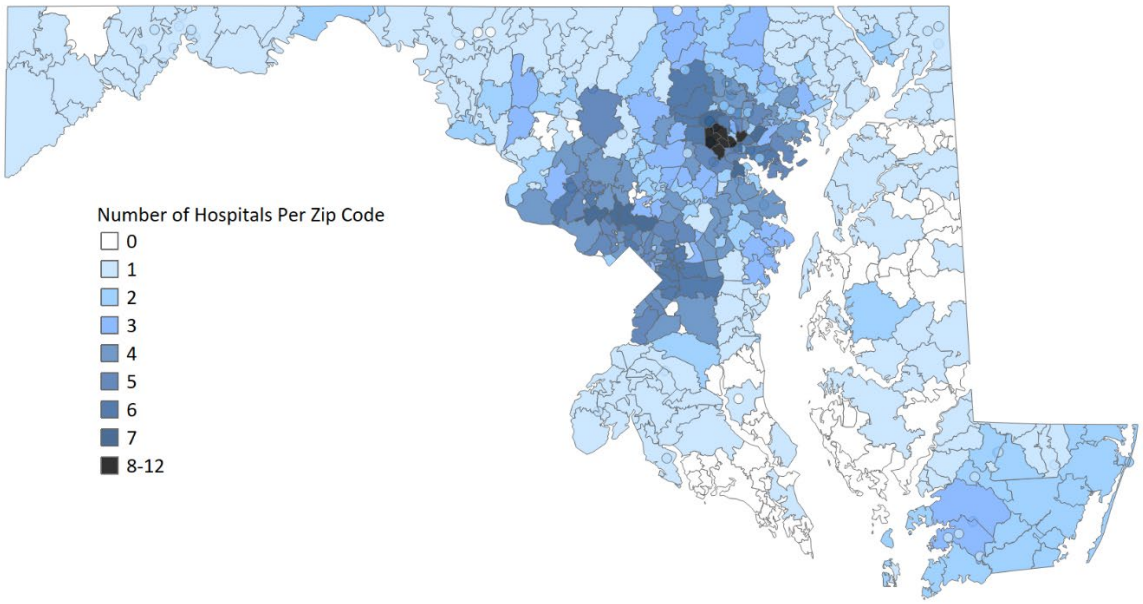
[13] The exception is the specialty hospitals that do not have GBRs. For these hospitals, the ZIP codes that account for 60 percent of discharges are reported.
[14] 26 CFR § 1.501(r)-3(b).

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

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

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

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



Other Demographic Characteristics of Service Areas

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

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

Table 4. Community Statistics by County

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

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

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

Section II. Community Health Needs Assessment

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

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

Section III. Community Benefit Administration

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

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

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

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

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

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

Internal Audit and Board Review

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

Table 7. Hospital Audits of CBR Financial Spreadsheet

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

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

Table 8. Hospital Board Review of the CBR

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

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

Table 9. Community Benefit Investments in Hospital Strategic Transformation Plan

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

Section IV. Hospital Community Benefit Program and Initiatives

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

Table 10. Types of Community Benefit Initiatives

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

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

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

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

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

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

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

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

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

Community Benefit Operations/Activities Related to State Initiatives

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

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

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

Section V. Physician Gaps in Availability

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

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

Table 14. Gaps in Availability

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

Section VI. Financial Assistance Policies

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

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

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

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

FINANCIAL REPORTS

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

FY 2019 Financial Reporting Highlights

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

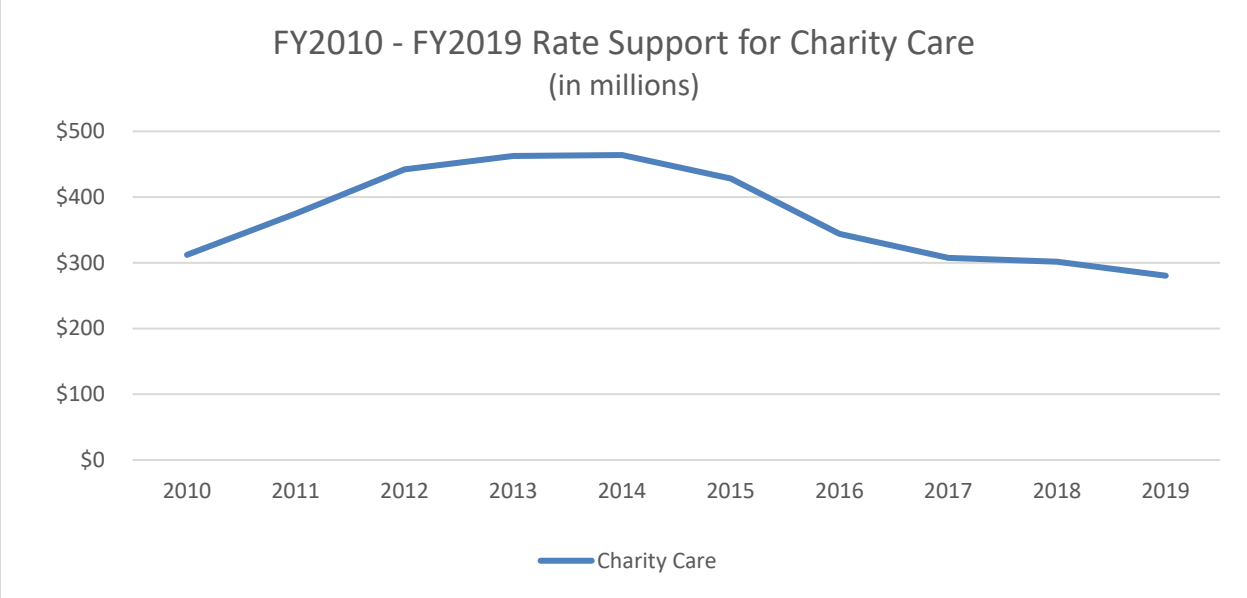
Table 15. Total Community Benefits, FY 2019

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

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

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

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



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

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

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

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

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

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

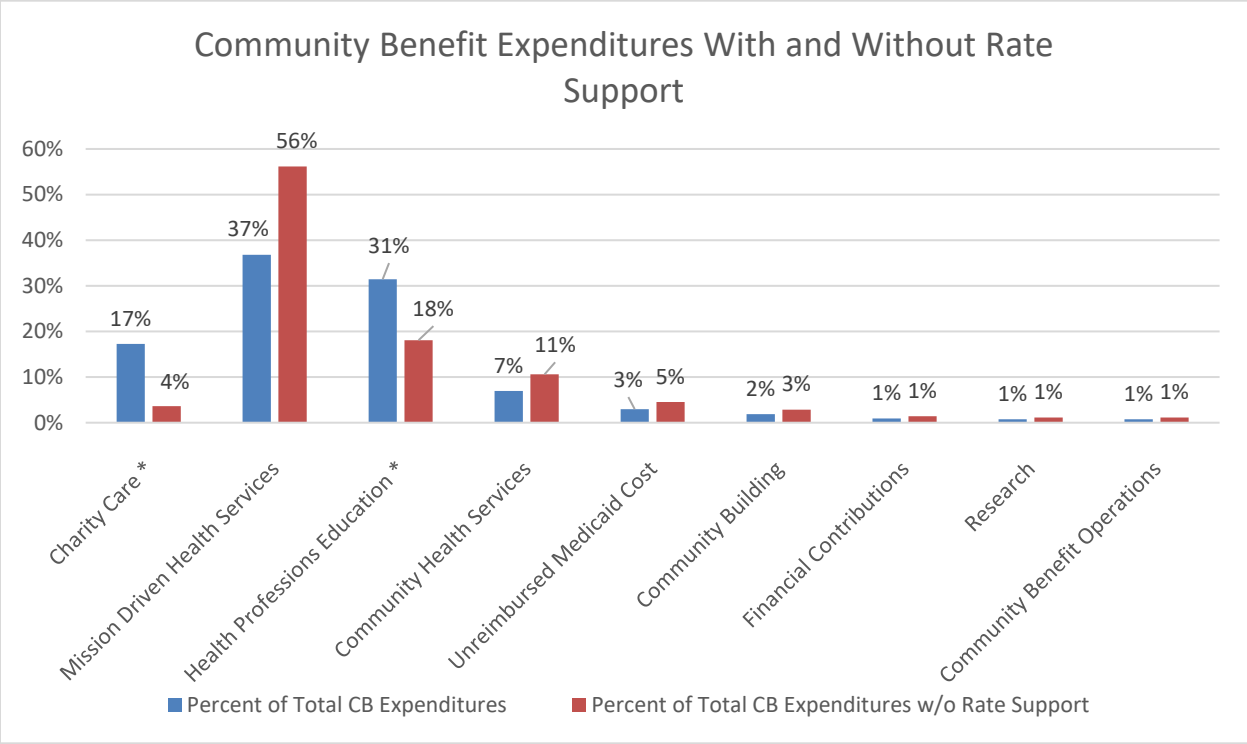
Table 17 presents staff hours, the number of encounters, and expenditures for community health services by activity. As with prior years, health care support services comprised the largest portion of expenses in the category of community health services, totaling $59.1 million. Community health education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

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

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

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

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



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

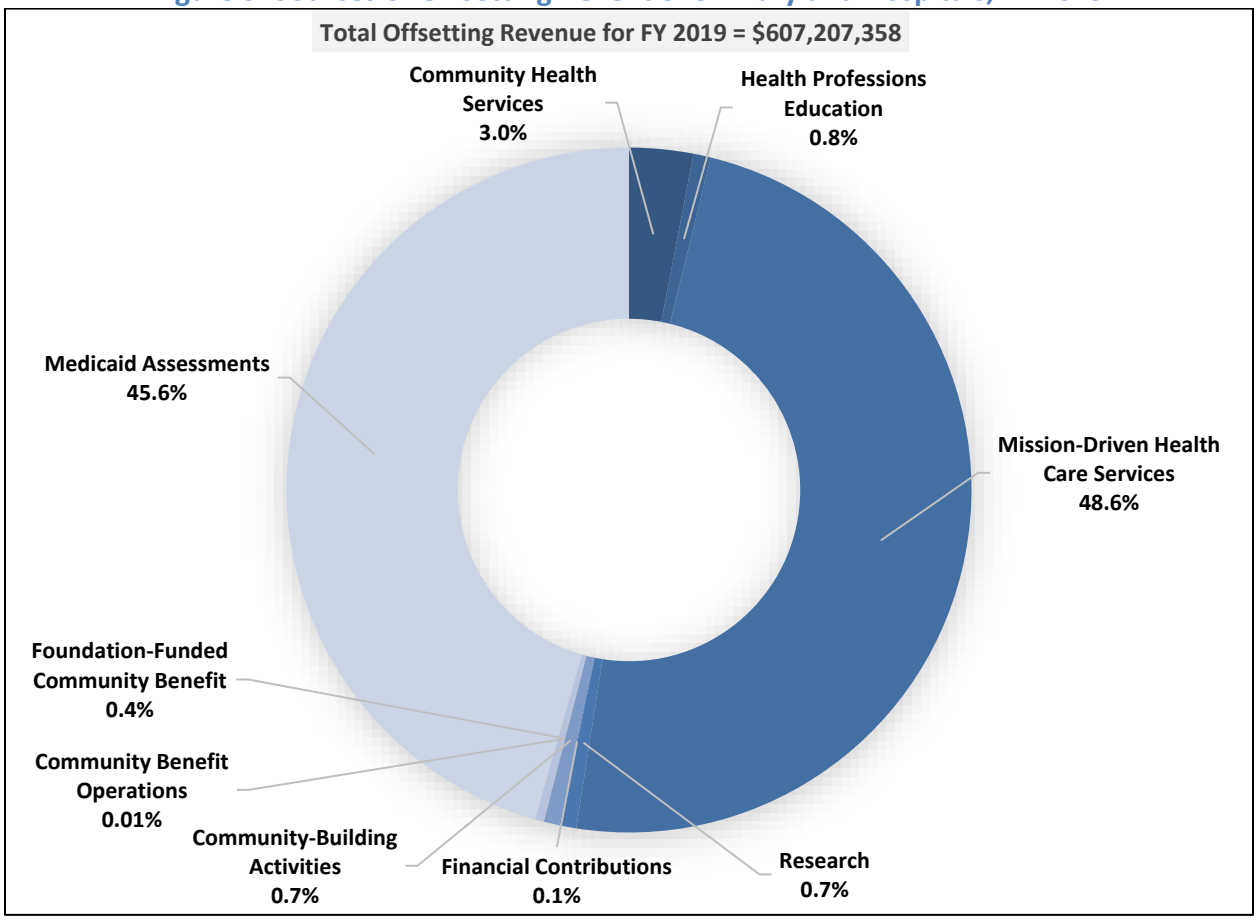
The total amount of net community benefit expenditures without rate support as a percentage of total operating expenses ranged from 1.41 percent to 31.09 percent, with an average of 8.37 percent, which was slightly higher than in FY 2018. Twelve hospitals reported providing benefits in excess of 10 percent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

Mission-Driven Services and Offsetting Revenue

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

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

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



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

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

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

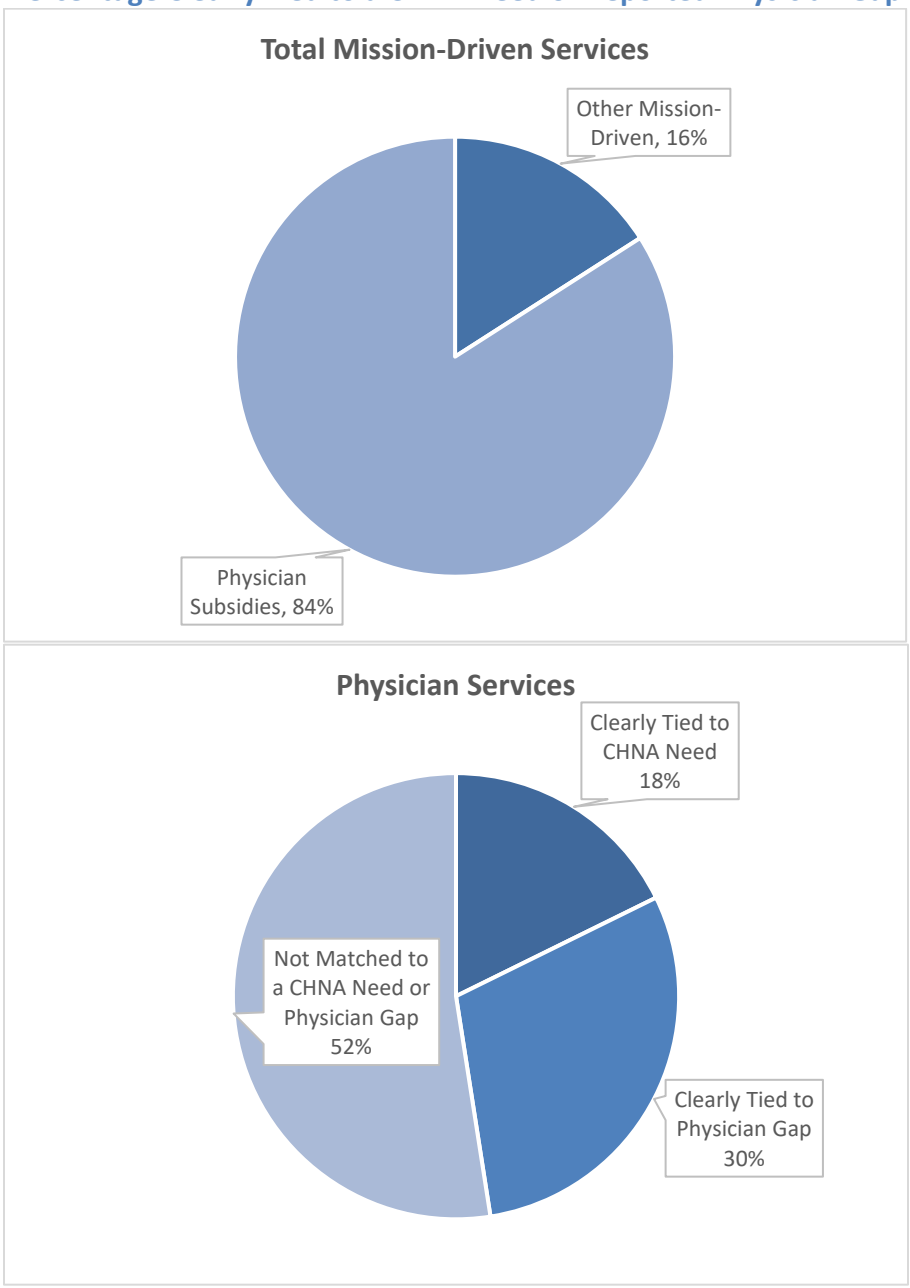
Hospital Name	Total Expenditures	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Net Community Benefit
Northwest Hospital Center	$9,855,460	$3,245,642	32.9%	$6,609,818
Mt. Washington Pediatric Hospital	$1,009,686	$366,769	36.3%	$642,917
UM Rehabilitation & Orthopedic Institute	$2,738,847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

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

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

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

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



FY 2004 – FY 2019 16-Year Summary

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

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

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

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

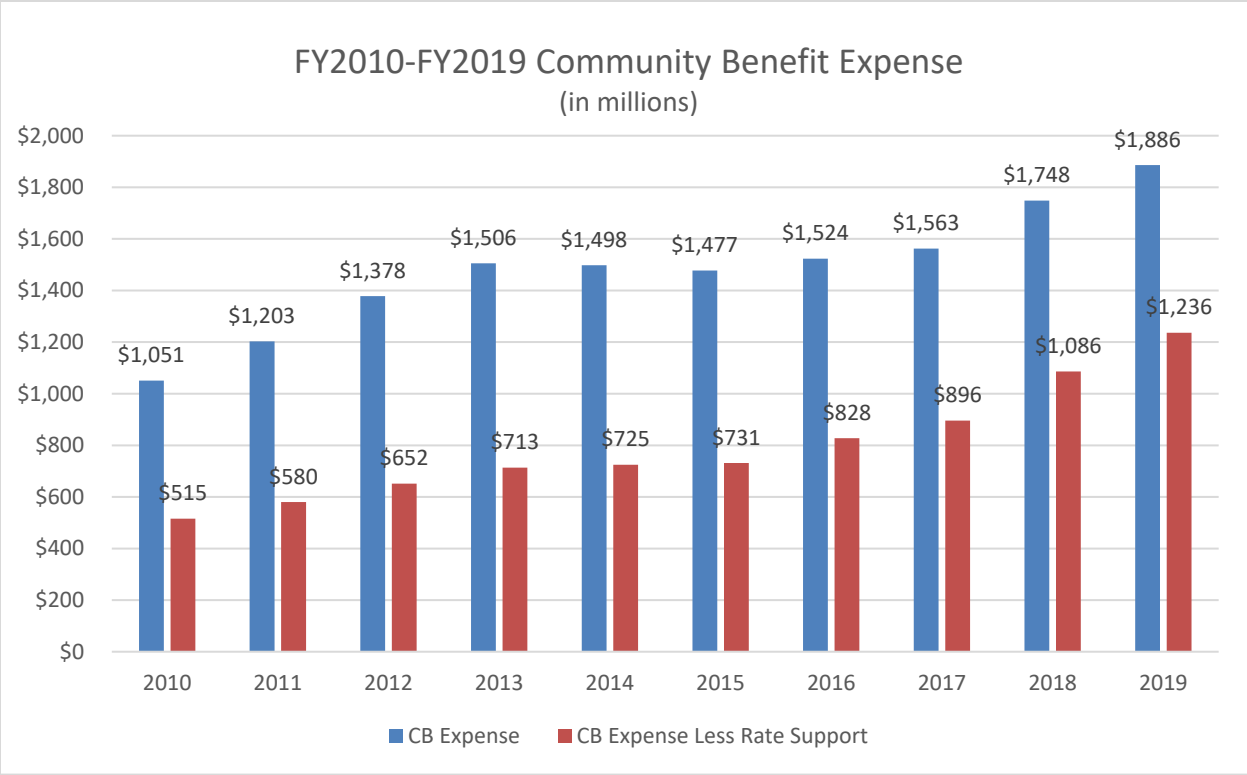
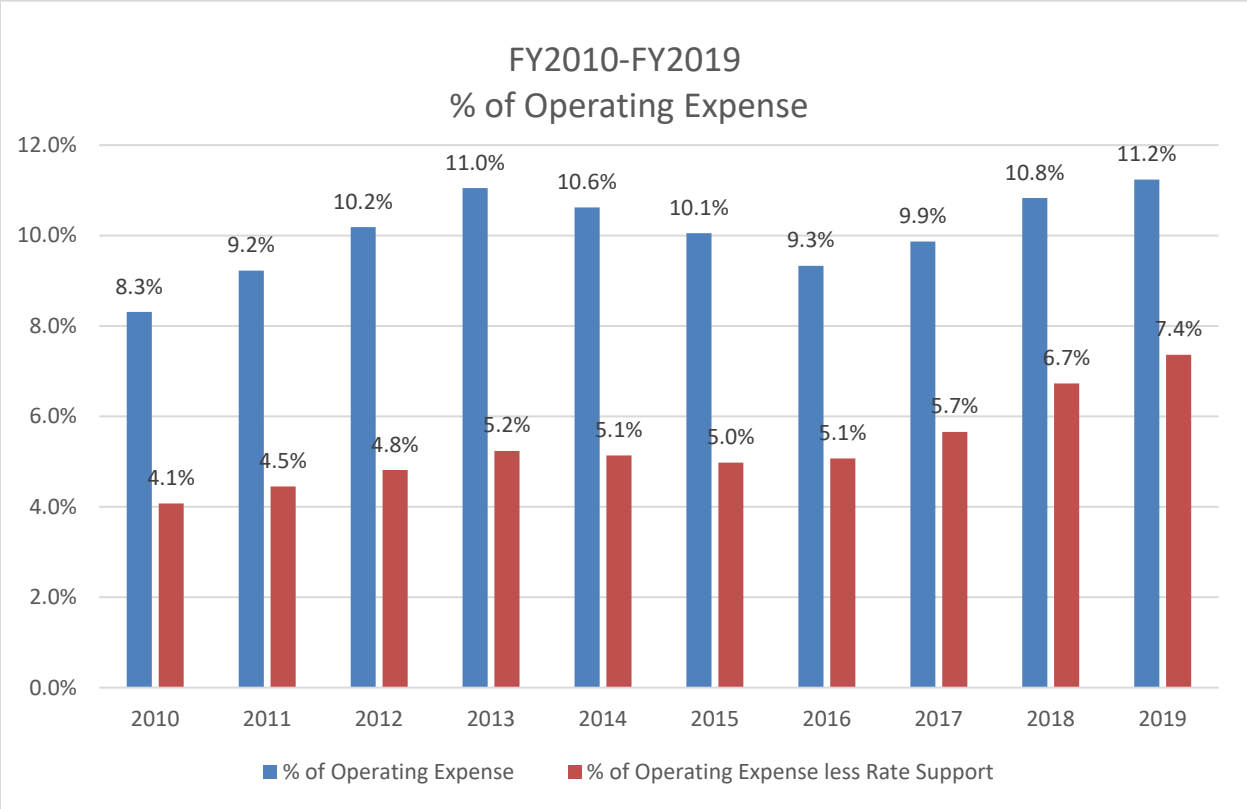


Figure 8. FY 2010 – FY 2019 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



CONCLUSION

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

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

The review also identified the following areas for improvement:

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

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

APPENDIX A. COMMUNITY HEALTH MEASURES REPORTED BY HOSPITALS

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

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

APPENDIX B. CHNA SCHEDULES

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

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

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

APPENDIX C. CHNA INTERNAL AND EXTERNAL PARTICIPANTS AND THEIR ROLES

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

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

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

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

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

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

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

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

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

APPENDIX F. CHARITY CARE METHODOLOGY

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

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

Step 1

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

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

Step 2

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

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

Example Johns Hopkins Hospital:

Predicted Value from FY 2016 Estimated UCC Levels 3.60%

FY 2017 Audited Financial UCC Level 2.25%

Predicted 50/50 Average 3.02%

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

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

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

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

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

APPENDIX G. FY 2018 COMMUNITY BENEFIT ANALYSIS

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

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

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

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

APPENDIX H. FY 2018 HOSPITAL COMMUNITY BENEFIT AGGREGATE DATA

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

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

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

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

COVID-Related Data Update

July 8, 2020

HSCRC
Health Services Cost Review Commission

Update on Bi-Weekly Revenue Reporting Through June 14th, 2020

July 2020

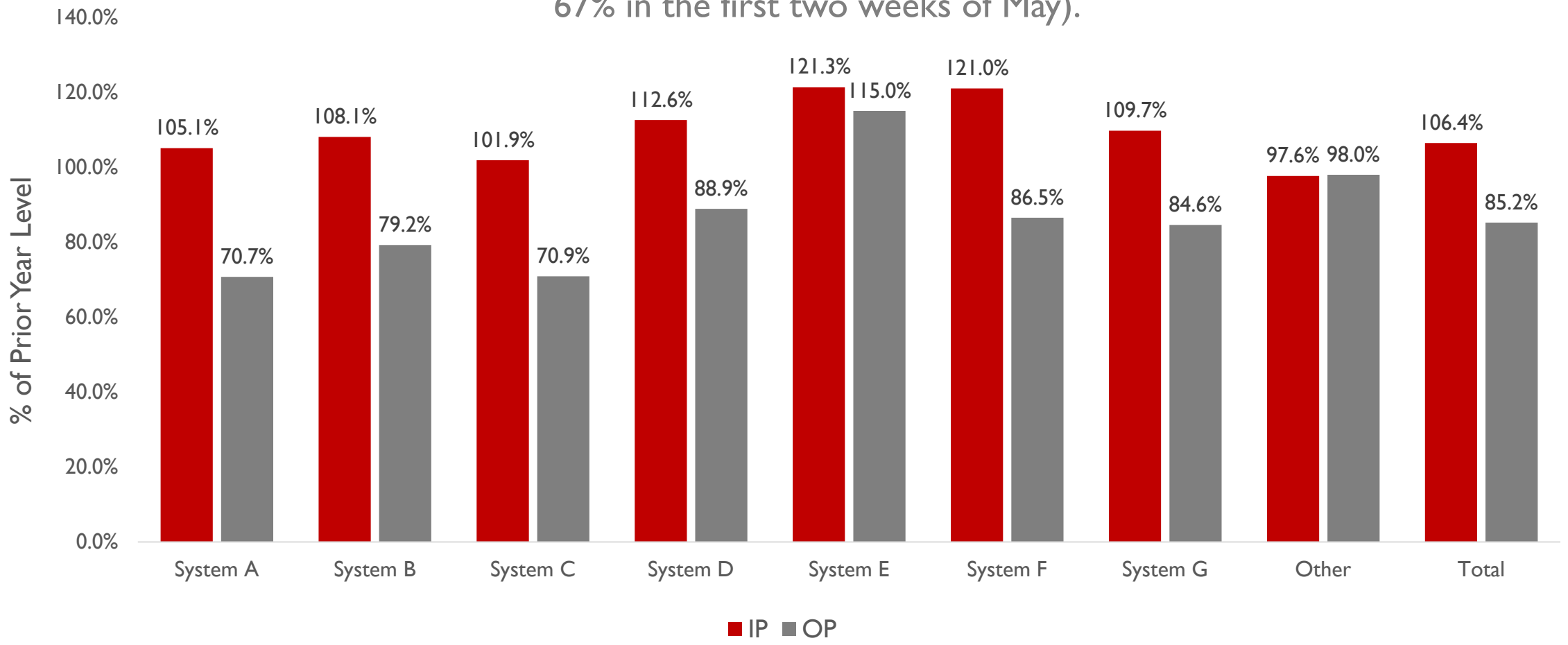
HSCRC
Health Services Cost Review Commission

Bi-weekly data

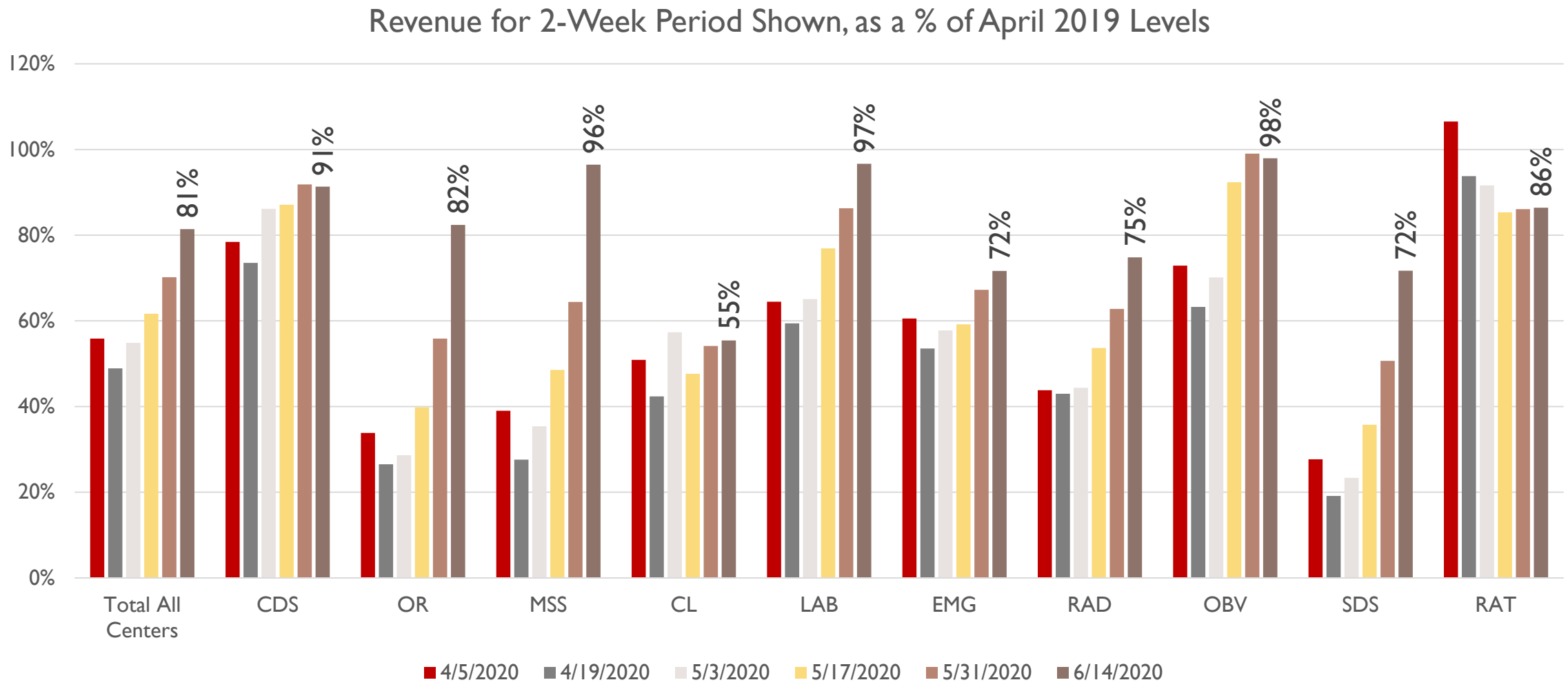
The following slides are based on bi-weekly revenue and volume data the HSCRC has been collecting from hospitals since early April. The data was gathered for reference only and has not been subject to review or audit and is not intended for use in formal policy making

Revenue Levels: 2-Weeks Ending June 14th by System

Statewide IP revenue was above historic levels, OP revenue was at 85% (up from 67% in the first two weeks of May).



OP Revenue Levels for Top 10 Rate Centers by Revenue*



* Excludes System E hospitals as this system does not report bi-weekly data at a revenue center level

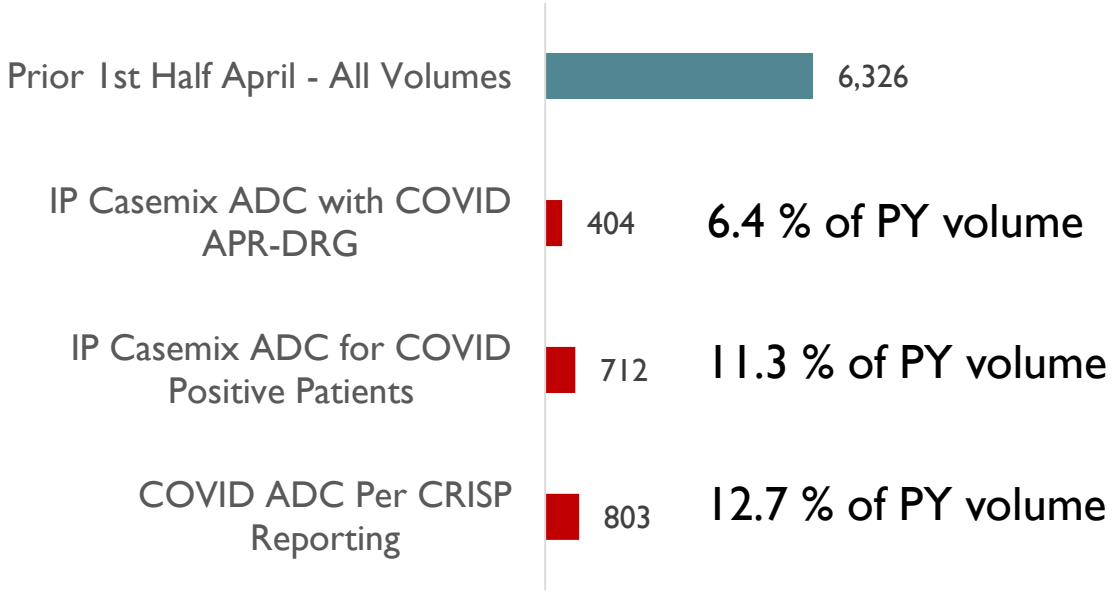
Update on Hospital COVID Volume in April 2020

July 2020

HSCRC
Health Services Cost Review Commission

COVID Statewide ADC – April 1 to April 15

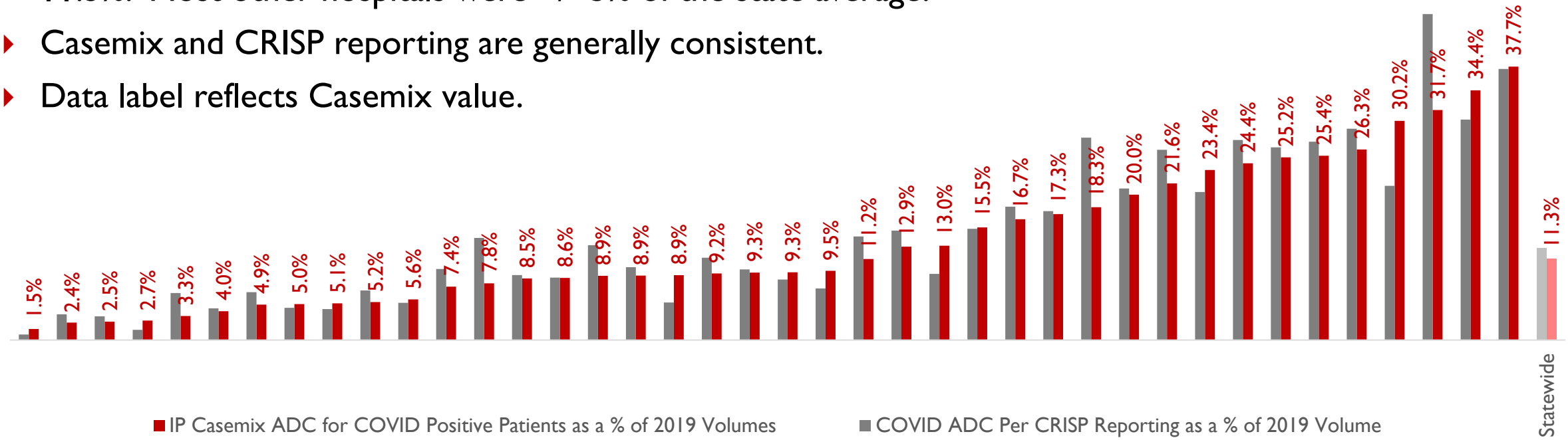
- Chart reflects Statewide ADC for COVID patients in the first half of April.
  - First half of April is used because case mix data reflects discharges only so data for second half is likely understated
  - COVID volumes continued to grow through April. CRISP measured volume increased to 22% of prior year volume in May from 12.7% in the first half of April.



- HSCRC has 3 methods for identifying COVID patient days
  1. From CRISP hospital reporting,
  2. Based on Casemix IP stays for patients flagged as COVID positive in CRISP records
  3. Based on COVID DRG in Casemix.
- Coding to the COVID DRG may not have been effective in early April

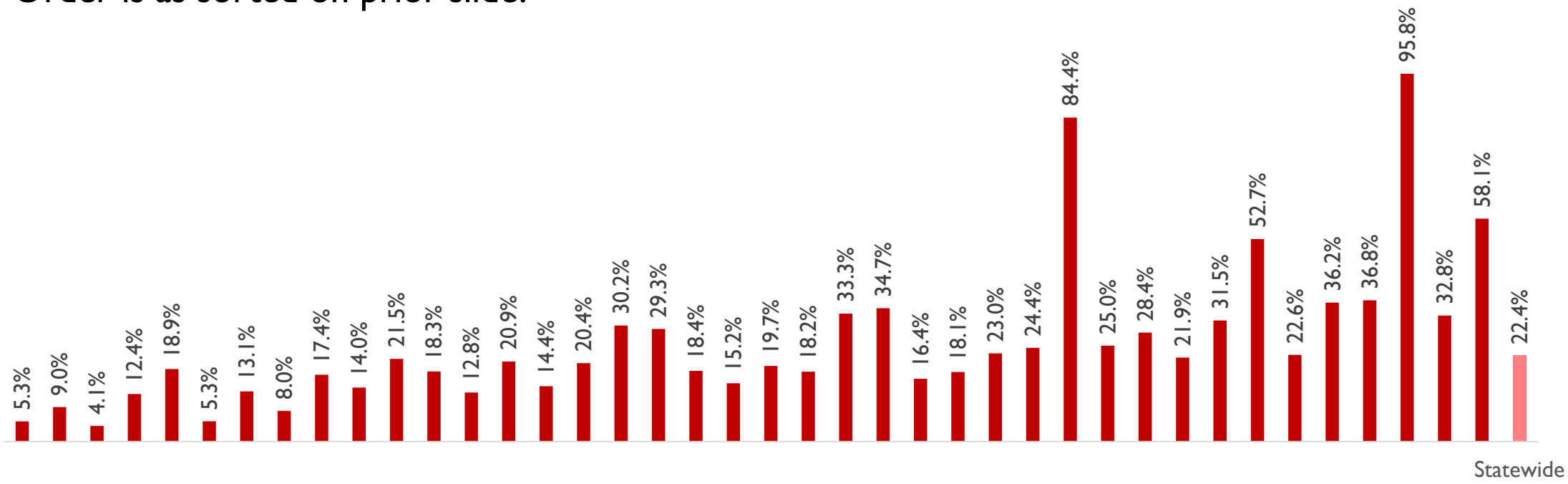
COVID ADC 1st Half of April '20 as a % of Prior Year ADC

- Each group of columns reflects one hospital's COVID inpatient volume for the first half of April 2020 as a % of 2019 April Average ADC. High values to the right all reflect DC area and Southern Maryland hospitals.
- For the first half of April, average Casemix data show COVID volume at an average statewide of 11.3%. Most other hospitals were +/- 5% of the state average.
- Casemix and CRISP reporting are generally consistent.
- Data label reflects Casemix value.

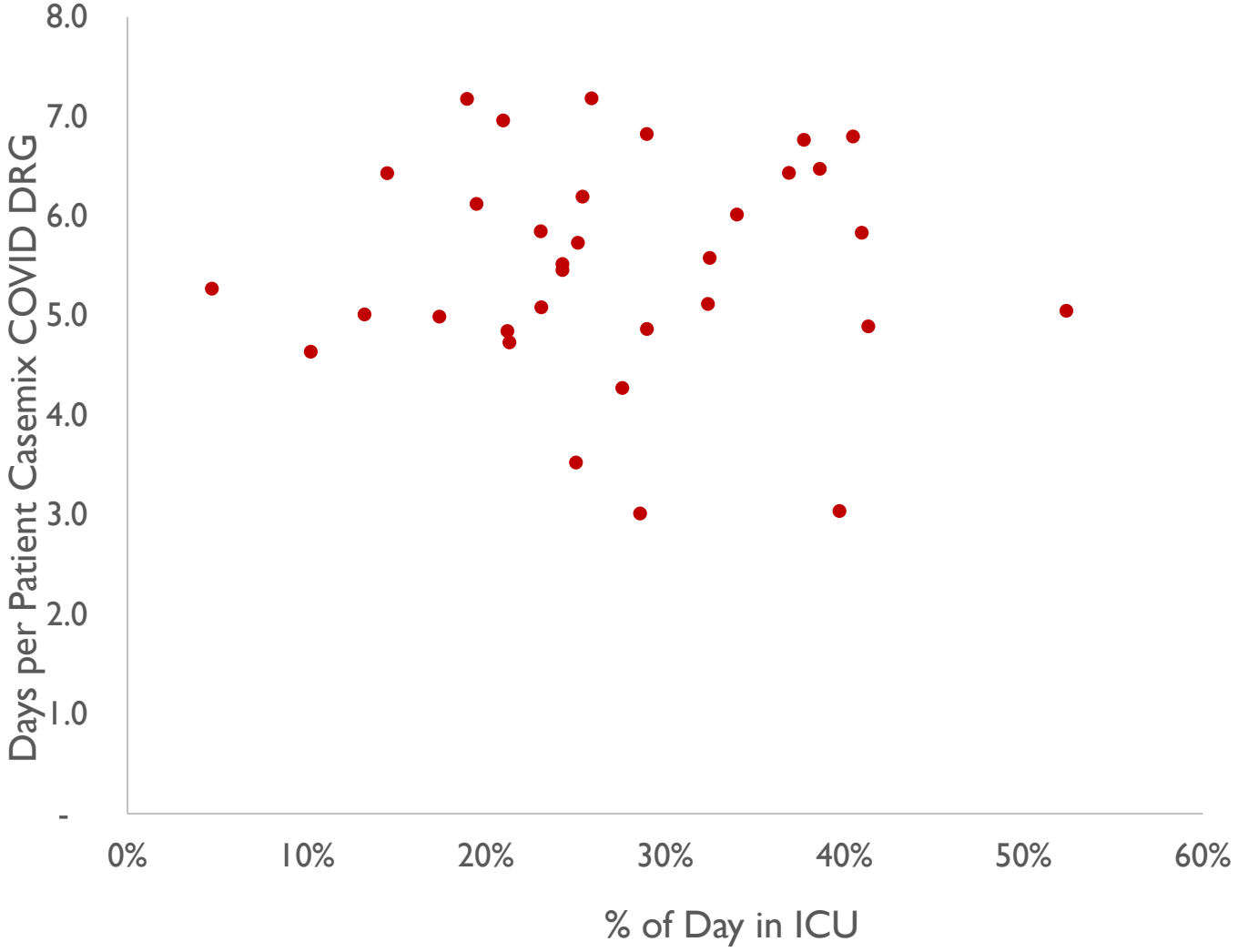


COVID ADC May '20 as a % of Prior Year ADC

- By May the State average increased to 22%. Data reflects CRISP reporting as Casemix is not yet available. Based on the prior slide the data sources will yield similar results.
- While a few DC-area hospitals remained outliers, most had moderated somewhat. Most facilities experienced between 15% and 30% of their typical ADC in COVID cases.
- Order is as sorted on prior slide.



April 1 to 15th, Intensity by Hospital (>10 COVID admts)



- Graph shows two metrics of case intensity – days per patient and % days ICU for the first half of April (both based on all stays in Casemix where COVID flag was positive).
- Length of stay for most hospitals was in the range of 5 to 6.5 days.
- ICU% for the majority was 20% to 35%
- Days per patient is similar to LOS but as this graphic only represents days during the early April window it will somewhat understate ultimate LOS

Update on Projected Under Charge

July 2020

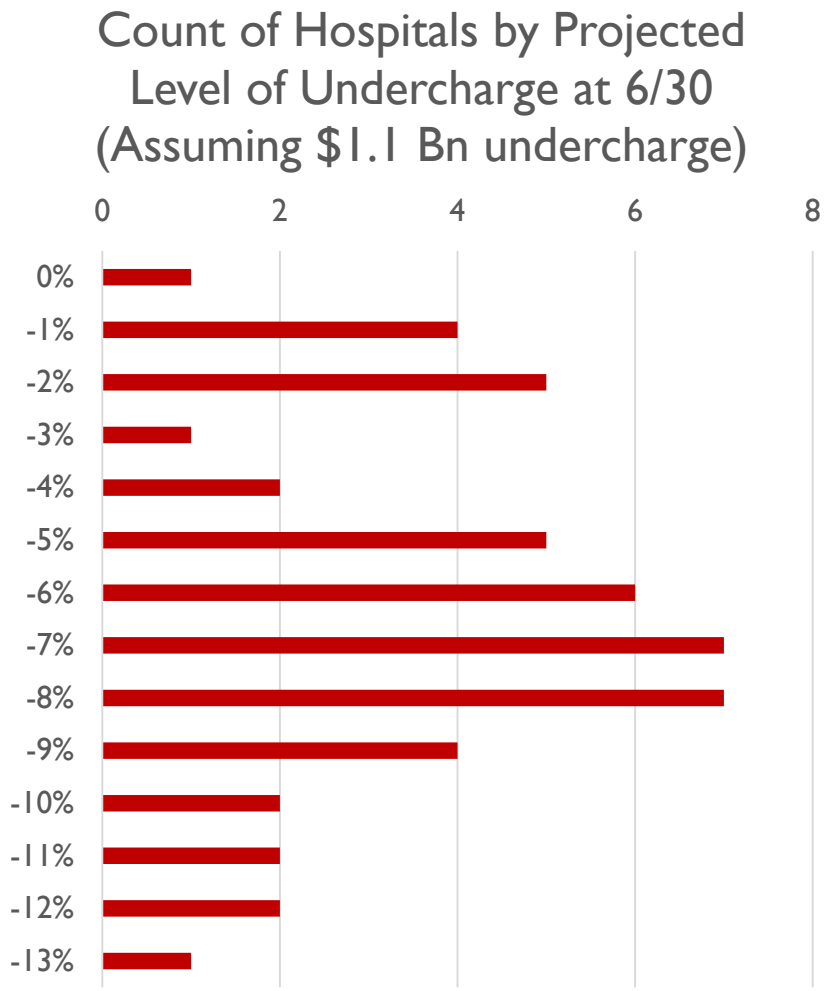
HSCRC
Health Services Cost Review Commission

Projected Undercharge as of 6/30/2020

Staff updated projections for 6/30 undercharge. Estimate ranged from $970 Bn to $1.1 Bn before Federal funding[1].

A $1Bn undercharge represents 5.5% undercharge at full GBRs, 6.9% at 80% of GBR. These amounts should be recoverable in FY21 with moderate corridor relief.

1. IP based on mid-May reporting and COVID volumes from CRISP reporting. Statewide, this results in IP revenue being approximately equal to typical IP revenue for May and June (~0 IP undercharge in May and June).
2. Two scenarios on OP:
   a. OP goes from mid-May reported average of 60% of historic volume to 65% in late-May and 75% in June
   b. 75% in late may and 85% in June



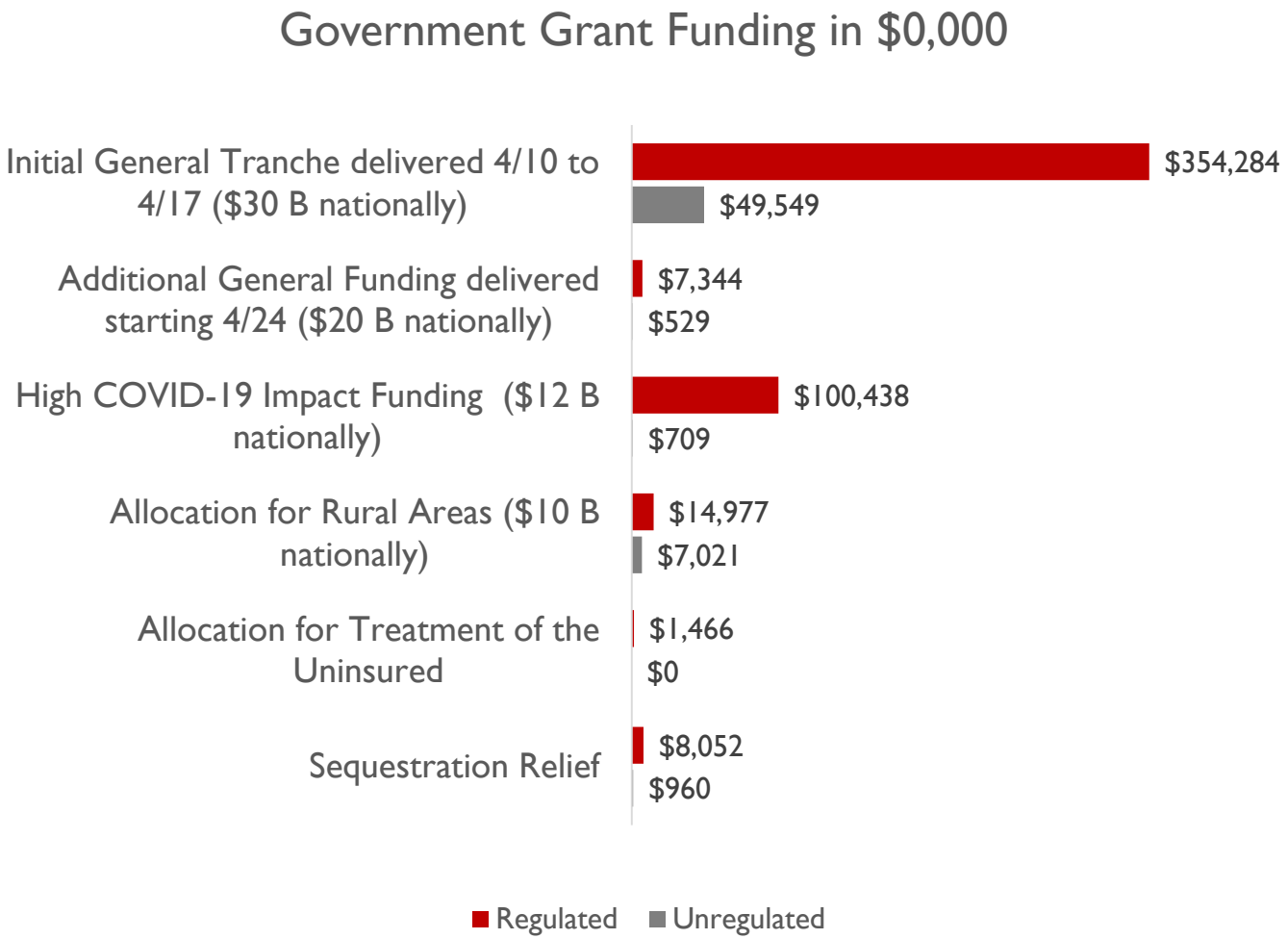
Hospitals projected $960 Bn undercharge in latest reporting but some hospitals projections are fixed to assume zero undercharge.

Government Funding Received by Maryland Hospitals

June 2020

HSCRC
Health Services Cost Review Commission

Government Funding to MD Hospitals through 5/15



- Graph shows grant funding by source. Total amount is $487M for regulated business and $59 M for unregulated business reported on annual filings. No FEMA funds have been received to date.
- In addition Maryland hospitals received $1.397 B in loan funding for regulated entities and $23.5 M for unregulated entities reported on the annual filing. The vast majority through the Medicare Advance Payment Program.

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

State of Maryland
Department of Health

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Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

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Compliance

William Henderson, Director
Medical Economics &
Data Analytics

TO: **HSCRC Commissioners**

FROM: **HSCRC Staff**

DATE: **July 8, 2020**

RE: **Hearing and Meeting Schedule**

September 9, 2020 To be determined - 4160 Patterson Avenue
HSCRC/MHCC Conference Room

October 14, 2020 To be determined – 4160 Patterson Avenue
HSCRC/MHCC Conference Room

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.