maryland
health services
cost review commission

612th Meeting of the Health Services Cost Review Commission
October 11, 2023

(The Commission will begin in public session at 11:00 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

CLOSED SESSION
11:00 am

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on September 13, 2023
2. Docket Status – Cases Closed
3. Docket Status – Cases Open
   - 2631N Tidal Health Peninsula
   - 2632A University of Maryland Medical Center
   - 2633A University of Maryland Medical Center
   - 2634A University of Maryland Medical Center
   - 2635A Johns Hopkins Health System
   - 2636N Adventist Shady Grove Medical Center
   - 2600A University of Maryland Medical Center - Request for Extension
4. Community Benefits - FY 2022 Activities
5. Policy Update and Discussion
   a. Model Monitoring
   b. ED Wait Times Update
   c. EQIP and CTI Performance Update
6. Hearing and Meeting Schedule

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MINUTES OF THE
611th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
September 13, 2023

Chairman Adam Kane called the public meeting to order at 11:37 a.m. In addition to Chairman Kane, in attendance were Commissioners Joseph Antos, PhD, James Elliott, M.D., Ricardo Johnson, Maulik Joshi, Nickki McCann, and Dr. Josh Sharfstein. Upon motion made by Commissioner Joshi and seconded by Commissioner Elliot the public meeting began at 1:29 p.m.

STAFF UPDATE

John Kromm, Executive Director introduced Damaria Smith as a new member of the staff. Ms. Smith will work as a Fellow with Quality Based Methodologies.

REPORT OF SEPTEMBER 13, 2023, CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the September 13, 2023, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE JULY 12 , 2023, PUBLIC MEETING, AND CLOSED SESSION

Commissioner McCann requested that the following comment be added to the July 12, 2023, Public Meeting minutes.

"Commissioner McCann stated that she has concerns about the data volatility but is willing to support the Staff recommendation. She hopes that Staff revisit the methodology in the future when more stable data can be used to assess if the Staff's outcome was accurate."

The Commission voted unanimously to approve the amended minutes of the July 12, 2023, Public Meeting and Closed Session.

ITEM II
CLOSED CASES
N/A

ITEM IV
OPEN CASES

2626R- Encompass Health Rehabilitation Hospital of Southern Maryland

On July 3, 2023, Encompass Health Corporation ("Encompass Health") filed an application with the Health Services Cost Review Commission ("HSCRC") to establish a permanent rate structure for a new 60 bed rehabilitation hospital, Encompass Health Rehabilitation Hospital of Southern Maryland (Encompass Bowie), to be effective June 13, 2023. Effective July 1, 2023, University of Maryland Rehabilitation Institute of Southern Maryland, LLC, a wholly owned subsidiary of University of Maryland Medical System, acquired a 50 percent ownership interest in Encompass Bowie. Encompass Bowie began admitting patients on June 13, 2023.

In addition, Encompass Health also applied for a rate setting exemption pursuant to COMAR 10.37.03.10 (the "Regulation"). Under the Regulation, the HSCRC may on its own or a hospital may file an application to request that rates for services to be exempt from HSCRC jurisdiction rate setting, if all of following conditions are met:

- More than 66 ⅔ percent of annual gross patient revenue is derived from Medicare, Medicaid, or both, who are not required by State law, the Model, or the Medicare waiver to pay Commission approved rates for those services;
- The annual gross revenue for non-physician services is not more than $20 million (in 1996 dollars adjusted by the appropriate index of inflation);
- The gross revenue subject to HSCRC jurisdiction is not more than $5 million (in 1996 dollars adjusted by the appropriate index of inflation); and
- The terms of the Regulation have been met for a minimum of 12 months before the application is filed.

In support of its request, Encompass Health seeks a waiver of the requirement that the conditions of the Regulation must be met for a minimum period of 12 months immediately preceding the request for exemption from rate setting. According to Encompass Health, Encompass Bowie will provide similar services that should result in a similar payer mix as its Encompass Salisbury hospital. The payer-mix for calendar year 2022 at Encompass Salisbury was as follows: Medicare 91.9%, Medicaid 0.6%, Commercial 6.3%, and Self-Pay/Other 1.2%.

Based on the experience of the other two Maryland rehabilitation hospitals, Encompass Health Rehabilitation Hospital of Salisbury and Adventist HealthCare Rehabilitation Hospital, Staff believes that Encompass Bowie will be able to meet the conditions of the Regulation in its first year.

The staff recommends that the Commission approve the following:

1. The rates be approved as requested, effective June 13, 2023.
2. Encompass Health be exempt from rate setting, effective June 13, 2023.

3. Encompass Health file with the HSCRC a copy of its audited financial statements 140 days after the end of its fiscal year.
4. Encompass Health files the required monthly case mix data, as described on the HSCRC website.
5. Encompass Health files a report 30 days after the end of each calendar quarter affirming that the payer-mix meets the Regulation criteria.
6. That the continuation of the rate setting exemption be contingent on the results of the Hospital's financial and case mix reporting.

The Commissioners voted unanimously in favor of the Staff's recommendation.

ITEM IV
FINAL RECOMMENDATION ON PROPOSED FINANCIAL ASSISTANCE AND MEDICAL DEBT COLLECTION REGULATIONS, COMAR 10:37.10.26

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Ms. Megan Renfrew, Associate Director, External Affairs, presented an overview of the Financial Assistance and Medical Debt proposed regulations (see "Overview of Financial Assistance and Medical Debt Proposed Regulation" available on the HSCRC website)

Md. Code Health General §19-214 requires that hospitals provide financial assistance to low-income patients and follow rules around medical debt collection that are designed to protect patients. In 2021, the legislature changed the medical debt requirements, including a requirement that HSCRC develop guidelines for hospitals that requiring that payment plans be income based (Chapter 770, 2021).

Chapter 770 required that the HSCRC seek input from stakeholders in drafting these guidelines. Accordingly, the HSCRC formed a Workgroup on Hospital Payment Plan Guidelines, which met three times between January and February of 2022 to review guidelines originally drafted by HSCRC staff, in collaboration with staff from the Office of the Commissioner of Financial Regulation (OCFR). Workgroup members and members of the public were also invited to submit written comments on the draft guidelines. In April, staff presented draft guidelines to the Commission and solicited public comments. HSCRC and OCFR staff revised the draft guidelines presented based on the comments received in April and the discussion in the April Commission meeting.

HSCRC staff is working on additional documents to provide further guidance for hospitals on implementation of Chapter 770, including a Frequently Asked Questions document, which is being developed in conjunction with OCFR. In addition, HSCRC staff plan to update the Special Audit Procedures to reflect the new requirements in Chapter 770.

Chapter 770 required that these guidelines include:

1. The amount of medical debt owed to the hospital.
2. The duration of the payment plan is based on a patient's annual gross income.
3. Guidelines for requiring appropriate documentation of income level.
4. Guidelines for the payment amount, that:

a) may not exceed 5% of the individual patient's federal or State adjusted gross monthly income.
b) shall consider financial hardship, as defined in § 19–214.1(a) of the Health – General Article

5. Guidelines for:

a) the determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 180 days past the due date of the first payment.
b) a prohibition on interest payments for patients who qualify for free or reduced– cost care.

6. Guidelines for modification of a repayment plan that does not create a greater financial burden on the patient.
7. A prohibition on penalties or fees for prepayment or early payment

In developing these guidelines, HSCRC staff balanced several different policy goals. In general, HSCRC sought to focus on the requirements of Health General §19-214.2, as amended by Chapter 770 (2021). This contained the potential scope of the guidelines.

Under the law, income-based payment plans are now required to be offered to all patients, regardless of income. In developing these guidelines, HSCRC staff sought to balance providing protections to the low- and moderate-income patients who will most benefit from these protections, while trying to minimize the burden on other patients.

HSCRC staff also worked to ensure that the guidelines provide patients with all the protections required by law while continuing to require that hospitals seek payment from patients who can pay their bills. This balance is intended to avoid unnecessary increases in uncompensated care costs.

At the May 2022 Commission Public Meeting the Commissioners voted unanimously to forward the proposed amended COMAR 10.37.10.26 to the AELR Committee for review and publication in the Maryland Register, which will also allow for written public comments.

Based on public comments and substantial feedback received, Staff is requesting that the Commissioners vote to approve publication of the revised regulations in the Maryland Register as proposed regulations and that a new public comment period be open. Once comment period closes, Staff will review comments received and will come back with a recommendation to either approve regulations as final or to amend them.

Based on public feedback received the following changes have been made to the COMAR 10.37.10.26 Staff's draft regulations:

- Both income-based and non-income-based payment plans are allowed
- Clarified calculation of income for income-based payment plans.
- Clarification of treatment of missed payments under income-based payment plans.
- Clarified treatment of prepayments before services are provided.

- Free care can not be limited to hospital service area residents.
- Financial assistance cannot be limited to urgent and emergent care.
- Allows use of the uniform financial assistance application or a similar application.

Commissioner Johnson asked whether the proposed statute would apply to Maryland residents only or if it would apply to all patients treated at a Maryland hospital.

Ms. Renfrew clarified that the statute would apply to Maryland residents only.

Commissioner McCann stated that the income calculation is a challenge. In addition, she encouraged all stakeholders to come together and figure out how hospitals can make patients more aware of the availability of financial assistance.

Commissioner Sharfstein noted that Maryland has a relatively low percentage of residents with medical debt compared to the nation. Additionally, Commissioner Sharfstein stated that the legislature should consider that hospitals are only one type of provider in the healthcare delivery system and that medical debt can be incurred from other types of providers as well.

The Commission voted unanimously to forward the proposed amendments to the AELR Committee for review and publication in the Maryland Register, which will also allow for written public comments.

ITEM V
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Deon Joyce Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 5 months ending May 2023. Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce noted that Medicare Nonhospital spending per-capita was trending close to the nation. Ms. Joyce noted that Medicare Total Cost of Care (TCOC) spending per-capita was favorable when compared to the nation. Ms. Joyce noted that the Medicare TCOC guardrail position is 3.15% below the nation through May. Ms. Joyce noted that Maryland Medicare hospital and non-hospital growth through May shows a savings of $155,458,000.

ED Wait Times Update

Dr Geoff Dougherty, Deputy Director, Population-Based Methodologies, Analytics, and Modeling presented an update on strategies to address Emergency Department performance (see "Emergency Department Dramatic Improvement Effort" available on the HSCRC website).

At the June Public Meeting Staff stated that the State legislature has asked Staff and MHA to convene a workgroup to identify solutions to improve hospital Emergency Department (ED) performance.

Maryland has underperformed on ED measures since before the start of the All-Payor model.

The workgroup task will address:

- ED challenges due to significant lack of statewide Emergency Medical Services units.
- Developing payment policies for ED wait times and avoidable ED for CY 24
- Identifying short-term policies that could spur rapid city improvement.

To help improve the ED performance the workgroup developed the Emergency Department Dramatic Improvement Effort (EDDIE) project.

Staff implemented the EDDIE project in August.

EDDIE is a short-term reporting project which will be used for conversation and input. The areas to be address are as follows:

Monthly, public reporting of three measures:

- ED1 Inpatient arrival to admission time
- OP18 Outpatient ED arrival to discharge time.
- EMS turnaround time (data from Maryland Institute for Emergency Systems)

Staff received August reports from all Hospitals (except Garrett Memorial). Data received may be preliminary and sone hospitals have resubmitted previous months as hospitals work through the process.

Garrett Memorial submitted alternative metrics but is working to report requested metrics.

EDDIE results are as follows:

- ED1a- ED Arrival to Inpatient Admission Time
- OP18a- ED Arrival to Discharge Time
- EMS Turnaround Time

EDDIE's August results reports the following:

- ED1a- ED Arrival to Inpatient Admission Time

Data results show no dramatic movement from arrival to Inpatient admission. Staff were not surprised with the results considering that EDDIE is a new program. Staff believes that results will improve over the next several months.

- OP18a- ED Arrival to Discharge Time

Again, data results show no dramatic movement from arrival to discharge time. Staff are not surprised with results considering that EDDIE is a new program. Staff feel that results will improve over the m=next several months.

- EMS Turnaround Time (ambulance to hospital)

    - 25 Hospitals turnaround time is under 35 minutes.
    - 8 Hospitals turnaround time is greater than 60 minutes.

Dr Dougherty stated that the next steps are as follows:

- Continue monthly data collection from hospitals and MIEMSS.
- Address reporting questions and concerns with hospitals.
- Present results at monthly Commission meeting.
- Add visualizations suggested by Commissioners and other stakeholders.
- Collect and present all hospital improvement goals collected by MHA at October Commission meeting.
    - Goals should be short term, specific, and measurable.
- Collaborate with MHA on legislative request and EDDIE quality improvement initiative.

Commissioner McCann asked if the ED 1a results were based on ED volumes or hospital volumes?

Dr Doughtery stated that the results were based on hospital volumes.

Chairman Kane asked about the integrity of the data.

Dr. Dougherty noted that Staff worked with the hospitals on a compressed time scale to come up with the data. He noted that there were no issues with how the data looked versus other data sources.

Commissioner McCann stated that it was critical to identify the differences between Maryland EDs and other states. She stated that it is hard to believe that Maryland hospitals are so much worse than other states. She stated that before the Staff puts forward a payment policy that they identify the root causes and make sure those root causes can be addressed and improved on.

ITEM VI
REVENUE FOR REFORM

Mr. Kromm presented an overview on Revenue for Reform ("R4R") (see "Revenue for Reform Criteria" available on the HSCRC website).

The core objective for the R4R policy is as follows:

Hospitals are key drivers of community health improvement in their communities. R4R provides the opportunity for hospitals facing reductions in their Annual Update Factor under the Integrated Efficiency

policy to make population health investments in place of their efficiency cuts. The parameters for approving qualified population health investments ensure that R4R initiatives are aligned with statewide population health efforts, evidence-based, and accountable for delivering population health impact.

Policy overview is as follows:

Through the Integrated Efficiency Policy, hospitals that significantly reduce volume are subject to an inflationary reduction because of the reduced variable costs associated with the drop in volume. However, within the TCOC Model, retained revenue should be reinvested toward population health.

R4R allows these hospitals to offset reductions in the Annual Update Factor with approved population health investments.

For approval population health investments must meet certain criteria to qualify for R4R. The quality investments.

- Must be made outside the hospital;
- Must be for non-physician costs except primary care (as defined by the Maryland Primary Care Program), mental health, or dental providers costs;
- Must principally serve the people in the hospital's primary service area;
- Must be related to an unmet need identified in a CHNA, CDC's Healthy People 2030, or other population health planning document identified by MDH (e.g., the SHIP);
- Must be evidence-based; and
- May leverage a Regional Partnership.

Maryland Department of Health must also approve R4R proposals.

MDH and HSCRC staff are developing a process for:

- Submitting and reviewing proposals.
- Establishing a framework for measuring population health impact and tracking key performance indicators.
- Working with hospitals to revise/refine proposals that do not align with approval criteria, and
- Rejecting proposals that cannot meet approval criteria after revision.

For future years, MDH (with support from HSCRC staff) is working to clearly define additional criteria for approval of R4R proposals. The criteria will:

- Identify key, statewide priorities for population health and community health investment.
- Establish a framework for measuring population health impact and tracking key performance indicators.
- Outline a process for repurposing R4R investments if the intervention no longer aligns with statewide priorities and/or proves to be unsuccessful.

Proposed criteria and processes will be reviewed with Commissioners and stakeholders for feedback and comment.

R4R proposals are tentatively due in December with Commissioner approval in January.

Commissioner McCann asked whether the population health investments incentivized through Revenue for Reform are intended to be retrospective or prospective.

Mr. Kromm stated that this would depend on the hospital's proposal, but that existing and net new investments could qualify.

Commissioner Sharfstein expressed concern that allowing existing investments to qualify would not advance population health if that was the policy's intention.

Mr. Pack explained that Staff does not wish to force hospitals to increase spending if they are making effective investments already.

Mr. Kromm added that the Revenue for Reform Policy will allow the HSCRC to assess the effectiveness and ROI of existing investments, which has not been possible historically.

ITEM VIII
HEARING AND MEETING SCHEDULE

October 11, 2023,	Times to be determined- 4160 Patterson Ave HSCRC Conference Room
November 9, 2023,	Times to be determined- 4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:44 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

September 13, 2023

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

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

4. Consultation with Legal Counsel-Authority General Provisions Article, Section §3-305

The Closed Session was called to order by motion at 11:37 a.m.

In attendance via conference call in addition to Chairman Kane were Commissioners Antos, Elliott, Johnson, Joshi, McCann, and Sharfstein.

In attendance representing Staff were Jon Kromm, Jerry Schmith, Allan Pack, William Henderson, Claudine Williams, Geoff Dougherty, Megan Renfrew, Erin Schurmann, Cait Cooksey, Bob Gallion, and Dennis Phelps.

Also attending were:
Eric Lindemann, Commission Consultant, and Stan Lustman and Ari Elbaum Commission Counsel.

Item One

The Commission was updated by Executive Director Jon Kromm on the status of transition in the office resulting from recent changes in the staff's composition.

Item Two

Legal Counsel advised the Commission on recent litigation.

Item Three

Executive Director Kromm summarized the agenda for the Commission's retreat.

Item Four

Executive Director Kromm updated the Commission on the progress of the AHEAD model.

Item Five

Eric Lindemann updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Six

William Henderson, Director, Medical Economics & Data Analytics, updated the Commission on the hospitals' final FY 2023 unaudited financial performance.

The Closed Session was adjourned at 1:22 p.m.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2023**
MEDICAL CENTER	*	**FOLIO: 2442**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2632A**

Staff Recommendation

October 11, 2023

I. INTRODUCTION

University of Maryland Medical Center (“Hospital”) filed an application with the HSCRC on August 30, 2023, for an alternative method of rate determination under COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant and blood and bone marrow transplants for one year with Aetna Health Inc. and Coventry Health Plan beginning October 1, 2023.

II. OVERVIEW OF THE APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. ("FPI"), which is a subsidiary of the University of Maryland Medical System. FPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating recent historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to FPI for all contracted and covered services. FPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between FPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement for the last year and found it to be unfavorable. This is the fourth year that the experience under this arrangement has been unfavorable. The Hospital has provided documentation that the losses were the result of extreme outlier cases. The Hospital has again renegotiated the arrangement. Staff recommends approval of this arrangement. However, if the experience under the renegotiated arrangement during the next year continues to be unfavorable, staff will not recommend further approval.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, and blood and bone marrow transplant services, for a year beginning October 1, 2023. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
UNIVERSITY OF MARYLAND	*	**DOCKET: 2023**
MEDICAL CENTER	*	**FOLIO: 2443**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2633A**

Staff Recommendation

October 11, 2023

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on August 30, 2023, requesting approval to continue its participation in a global rate arrangement with BlueCross and BlueShield Association Blue Distinction Centers for solid organ and blood and bone marrow transplant services for a period of one year beginning October 1, 2023.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. (FPI), which is a subsidiary of the University of Maryland Medical System. FPI will continue to manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to FPI for all contracted and covered services. FPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between FPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff found that the experience under this arrangement for the prior year has been

unfavorable. According to the Hospital, the losses under this arrangement can attributed to several extraordinary outlier cases. Staff believes that absent these cases, the Hospital can again achieve favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for blood and bone marrow transplant services, for a one-year period commencing October 1, 2023. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2023**
MEDICAL CENTER	*	**FOLIO:**	**2444**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2634A**

Staff Recommendation

October 11, 2023

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on August 30, 2023, for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ, blood and bone marrow transplants and ventricular assist device (VAD) services for a period of one year with Cigna Health Corporation beginning October 1, 2023.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. ("FPI"), which is a subsidiary of the University of Maryland Medical System. FPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital's portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to FPI for all contracted and covered services. FPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between FPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff found that the Hospital's experience under this arrangement for the previous year was favorable. Staff believes that the Hospital can continue to achieve a favorable performance.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ, blood and bone marrow transplants and VAD services, for a one-year period commencing October 1, 2023. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2023**
SYSTEM	*	**FOLIO: 2445**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2635A**

Staff Recommendation

October 11, 2023

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on August 31, 2023, on behalf of its member Hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for joint replacement and joint replacement consult services, hip and knee replacement, Cardiovascular, CART-T, and Spine surgery with Carrum Health, Inc. The System requests that the approval be for a period of one year beginning October 1, 2023.

II. OVERVIEW OF THE APPLICATION

The contract will be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the activity under this arrangement has been positive and believes that the arrangement can continue to be successful.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement, joint replacement consult services, bariatric, cardiovascular and spine surgery services for a one-year period commencing October 1, 2023.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

2636N - Shady Grove Medical Center Partial Rate Application

Teneshia J. Richards-Brooks
Analyst, Rate Setting
Revenue & Regulation Compliance
Email Address: Teneshia.Richards-Brooks@maryland.gov

Staff Recommendation:

Introduction

On August 31, 2023, Shady Grove Medical Center ("SGMC" or "the Hospital") submitted a partial rate application requesting a rebundled rate for Radiation Therapy (RAT) services.

The purpose of this rate application is to establish a rebundled rate for inpatients who need radiation therapy services. SGMC will no longer provide this service at the Hospital. The patient will be transported for treatment to Shady Grove Adventist Aquilino Cancer Center, an unregulated facility as recently determined by HSCRC staff and located on the Shady Grove Medical Center Campus. The charge for this service for inpatients can only be billed by the Hospital.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, Shady Grove requested a RAT service rate of $8.82 per RVU, while the statewide median rate for RAT service is $14.29 per RVU.

Recommendation

After reviewing the Shady Grove Medical Center application, the staff recommends:

1. That the RAT rate of $8.82 per RVU be approved effective October 1, 2023;
2. That the RAT rate center not be rate realigned because it is a rebundled rate; and
3. A reduction be made to the FY24 GBR based on the deregulation activity.

Questions?

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
SHADY GROVE	*	**DOCKET:**	**2023**
MEDICAL CENTER	*	**FOLIO:**	**2446**
SALISBURY, MARYLAND	*	**PROCEEDING:**	**2636N**

Staff Recommendation
October 11, 2023

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UNIVERSITY of MARYLAND
MEDICAL SYSTEM
FINANCE SHARED SERVICES CENTER
900 Elkridge Landing, 4th Floor East
Linthicum, Maryland 21090

September 13, 2023

Dennis Phelps
Associate Director, Audit & Compliance
Health Service Cost Review Commission
4201 Patterson Avenue
Baltimore, MD 21215

Re: University of Maryland Medical Center, OptumHealth Care Solutions, Inc. (formerly URN) for solid organ transplant and blood and marrow transplant services

Dear Dennis:

We are requesting a second extension for a period of two months for the UMMC-OptumHealth Care Solutions, Inc. (formerly URN) arrangement for renewal. It is our understanding that our current extension would be set to end October 31, 2023, and this extension would push that date out to December 31, 2023.

We would like to provide some background as to why we now need to request an additional extension. While we did enter into negotiations with OptumHealth with what should have been plenty of time to meet our original filing deadline, four different sets of analyses had to occur between both parties (2-Optum & 2-UMMS). This has taken longer than expected due to the complexity of the analyses required. Additionally, parties being out-of-office delayed data & rate analysis review by nearly six weeks. There is a commitment on both sides to complete these negotiations as expeditiously as possible.

Please let us know if anything else is required or will be needed at the time of our renewal submission.

Sincerely,

X 

Tim Spring
Manager of Reimbursement
& Revenue Advisory Services

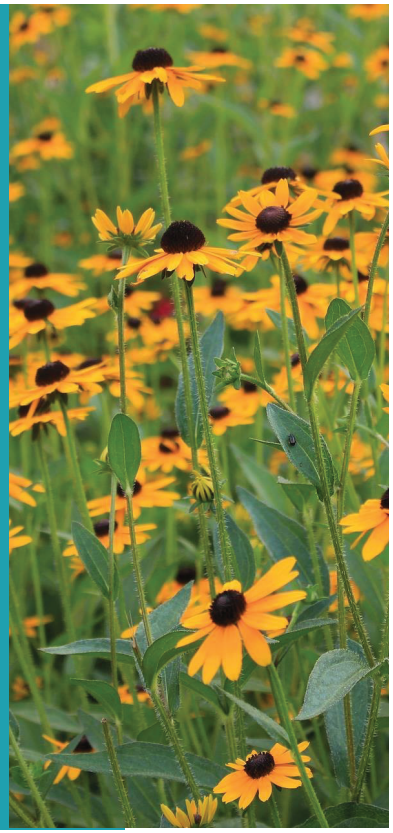
The Hilltop Institute

FY 2022 Hospital Community Benefit Report

Laura Spicer

Presentation to the Maryland Health Services Cost Review Commission

October 11, 2023



UMBC

Introduction

- The HSCRC is required to collect hospital community benefit(CB) information and compile into a statewide, publicly available report
- Two components:
  - Financial Report
  - Narrative Report
- FY 2022 marks the 19th year of reporting

Maryland Reporting Requirements

- MD law defines community benefit as a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.
- Examples include:
  - Community health services
  - Health professional education
  - Research
  - Financial contributions
  - Community-building activities, including partnerships with community-based organizations
  - Community benefit operations
  - Charity care
  - Mission-driven health services

Maryland-Recent Legislation

- HB1169/SB0774 of the 2020 Legislative Session updated §19-303 of the Health General Article
- It updated CB reporting requirements:
  - Updated the definition of CB
  - More closely tied initiatives back to the community health needs assessment (CHNA)
  - Required listing of tax exemptions the hospital claimed during the preceding year

Working Groups

- To implement the new requirements in the 2020 legislation, HSCRC convened the Consumer Standing Advisory Community and a Technical Subgroup in the summer and fall of 2020
- Submitted a legislative report with recommendations in December 2020
- All changes were required from FY 2022 forward

Community Health Needs Assessment

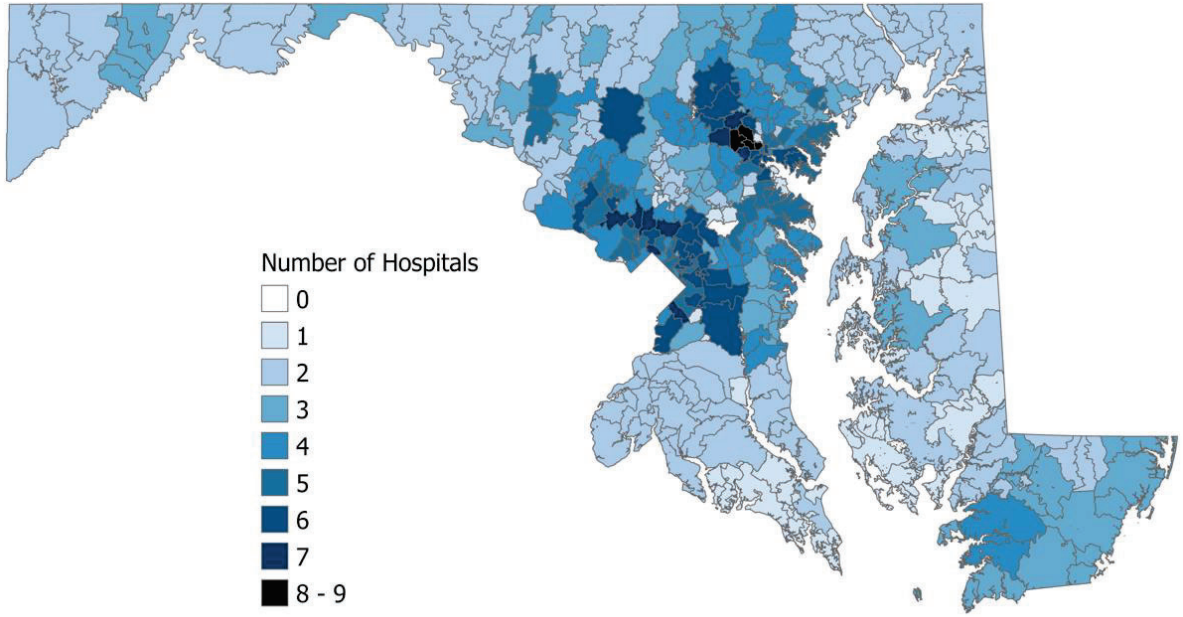
- IRS requirement
- Must be conducted every 3 years
- Publicly available assessment of the most important health needs for residents of a hospital's service area
- Must include input from persons who represent the broad interests of the community served by the hospital facility
- Must develop an implementation strategy to meet the community health needs identified through the CHNA

Key Changes for FY 2022: Reporting

- Provided a list of Itemized HCB expenditures that address CHNA priority areas
- Collected data on physician subsidies in line-item detail

Community Benefit Service Areas Cover all Populated ZIP Codes

- Improvement over FY 2021, when 93 ZIP codes were not covered.



FY 2022 Financial Report Highlights

- 51 hospitals submitted
- $2.06 billion in gross community benefit expenditures, compared to $1.95 billion in FY 2021
  - Represents 10.6% of statewide hospital operating expenses compared to 10.7% in FY 2021
  - Among individual hospitals, this percentage ranges from 3.2% to 25.5%
- After accounting for rate support, net community benefit expenses totaled $1.21 billion, compared with $1.20 billion in FY 2021
  - Represents 6.2% of statewide hospital operating expenses, compared to 6.6% in FY 2021
  - Among individual hospitals, this percentage ranges from 2.0% to 24.7%

FY 2022 Hospital Community Benefit Expenditures by Category

Community Benefit Category	Gross Community Benefit Expense	% Gross Total CB Expenditures	Net Community Benefit Expense Less Hospital-reported Rate Support	% Net Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	$55,621,777	2.69%	$55,621,777	4.58%
Community Health Services	$156,476,493	7.58%	$129,452,584	10.66%
Health Professions Education	$661,694,610	32.05%	$214,685,520	17.67%
Mission Driven Health Services	$724,532,073	35.09%	$724,532,073	59.64%
Research	$12,155,232	0.59%	$12,155,232	1.00%
Financial Contributions	$20,867,653	1.01%	$20,867,653	1.72%
Community Building	$30,678,428	1.49%	$30,678,428	2.53%
Community Benefit Operations	$14,062,045	0.68%	$14,062,045	1.16%
Foundation	$1,839,390	0.09%	$1,839,390	0.15%
Charity Care	$386,716,607	18.73%	$10,985,064	0.90%
Total	**$2,064,644,308**	**100%**	**$1,214,879,766**	**100%**

Community Health Needs Assessment Priority Areas

- Wide variation across hospitals in % spend on CHNA priority areas
  - Overall, 37.2%
  - Ranged from 0.0% to 81.4%
- Top CHNA priority area categories addressed by initiatives:

1. Social Determinants of Health - Health Care Access and Quality
2. Health Conditions - Mental Health and Mental Disorders
3. Health Conditions – Diabetes
4. Settings and Systems – Community
5. Health Conditions – Cancer

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
- Most frequently reported gaps:
  1. Obstetrics & Gynecology
  2. Psychiatry
  3. Emergency Medicine

Narrative Report Highlights

- 98% of hospitals address at least one Statewide Integrated Health Improvement Strategy goal in their initiatives
- 96% of hospitals employ population health directors/staff
- 85% of hospitals employ staff dedicated to community benefit
- 94% of hospitals incorporate community benefit investments in their strategic transformation plans

Questions??

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.

www.hilltopinstitute.org

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UMBC

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stitute

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Maryland Hospital Community Benefit Report: FY 2022

September 27, 2023

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

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List of Abbreviations

ACA	Affordable Care Act
BMI	Body Mass Index
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
DME	Direct Medical Education
ED	Emergency Department
FUTA	Federal Unemployment Tax
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
IRS	Internal Revenue Service
LHIC	Local Health Improvement Collaboratives
NSP	Nurse Support Program
PSA	Primary Service Area
SIHIS	Statewide Integrated Health Improvement Strategy
UCC	Uncompensated Care

Introduction

Community benefit refers to initiatives, activities, and investments undertaken by tax-exempt hospitals to improve the health of the communities they serve. Maryland law defines community benefit as a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.[1] Examples of community benefit activities include the following:

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

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

In 2020, the Maryland General Assembly passed Chapter 437, which required the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments (CHNAs).[4] This bill required the HSCRC to establish a Community Benefit Reporting Workgroup and adopt regulations recommended by the Workgroup regarding community benefit reporting. The bill also modified the definition of community benefit and expanded the list of items that hospitals must include in their CBRs.

[1] MD. CODE. ANN., Health-Gen. § 19-303(a)(3).
[2] H.D. 15, 2001 Gen. Assem., 415th Sess. (Md. 2001).
[3] https://www.irs.gov/pub/irs-pdf/f990sh.pdf
[4] S. 774, 2020 Leg., 441st Sess. (Md. 2020).

This summary report provides background information on hospital community benefit and the history of CBRs in Maryland, summarizes the community benefit narrative and financial reports for fiscal year (FY) 2022, and concludes with a summary of data reports.

Background

Federal Requirements

The Internal Revenue Code defines tax-exempt organizations as those that are organized and operated exclusively for specific religious, charitable, scientific, and educational purposes.[5] Nonprofit hospitals are generally exempt from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, nonprofit hospitals may raise funds through tax-deductible donations and tax-exempt bond financing.

Originally, the IRS considered hospitals to be "charitable" if they provided charity care to the extent that they were financially able to do so.[6] However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the "charitable" standard to focus on "community benefits" rather than "charity care."[7] Under this IRS ruling, nonprofit hospitals must provide benefits to the community in order to be considered charitable. This ruling created the "community benefit standard," which hospitals must meet to qualify for tax-exemption.

The Affordable Care Act (ACA) created additional requirements for hospitals to maintain tax-exempt status. Every §501(c)(3) hospital—whether independent or part of a hospital system—must conduct a CHNA at least once every three years to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[8] A CHNA is a written document developed for a hospital facility that includes a description of the community served, the process used to conduct the assessment, identification of any persons with whom the hospital collaborated on the assessment, and the health needs identified through the assessment process. CHNAs must incorporate input from individuals who represent the broad interests of the communities served, and hospitals must make them widely available to the public.[9] CHNAs must include an implementation strategy that describes how the hospital plans to meet the community's health needs, as well as a description of what the hospital has historically done to address its community's needs.[10] Further, the hospital must identify any needs that have not been met and explain why they were not addressed. Tax-exempt hospitals must report this information on Schedule H of IRS Form 990.

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

Maryland Requirements

The Maryland General Assembly adopted the Maryland CBR process in 2001,[11] and the first data collection period was FY 2004. Maryland law requires hospitals to include the following information in their CBRs:

- The hospital's mission statement
- A list of the hospital's activities to address the identified community health needs
- The costs of each community benefit activity
- A description of how each of the listed activities addresses the health needs of the hospital's community
- A description of efforts to evaluate the effectiveness of each community benefit activity
- A description of gaps in the availability of providers to serve the community
- A description of the hospital's efforts to track and reduce health disparities in the community
- A list of the unmet community health needs identified in the most recent CHNA
- A list of tax exemptions the hospital claimed during the immediately preceding taxable year[12]

This FY 2022 report represents the HSCRC's 19th year of reporting on Maryland hospital community benefit data.

Updates to Maryland's Reporting Instructions

In response to Chapter 437 (2020), the HSCRC made changes to the reporting instructions, requiring hospitals to:

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

Understanding that hospitals needed time to implement these changes, items 1 and 4 above were optional for FY 2021 but were mandatory for this FY 2022 report. Staff did not make substantive changes for the upcoming FY 2023 reporting period.

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

Narrative Reports

Hospitals Submitting Reports

The HSCRC received 48 CBR narratives from all 51 hospitals in FY 2022. This is because the University of Maryland Medical System submits a single CBR for three of its hospitals on the Eastern Shore[13] and another CBR for two of its hospitals in Harford County. Table 1 summarizes the hospitals submitting CBRs by hospital system.

Table 1. Maryland Hospitals that Submitted CBRs in FY 2022, by System

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

*Jointly owned by the University of Maryland Medical System and Johns Hopkins.
**No longer a designated hospital, instead a Freestanding Medical Facility that is a department of Peninsula Regional.

[13] One of these three hospitals, Shore Regional Health Dorchester General Hospital, closed in September of 2021.

Section I. General Hospital Demographics and Characteristics

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

Hospital-Specific Demographics

Table 2 displays statistics on hospital utilization statistics for each of the hospital being reported on. Overall, there were 527,887 inpatient admissions in FY 2022.

Table 2. Hospital Inpatient Admission, FY 2022

Hospital Name	Inpatient Admissions
Adventist HealthCare	
Adventist HealthCare Fort Washington Medical Center	1,764
Adventist HealthCare Rehabilitation	1,123
Adventist HealthCare Shady Grove Medical Center	21,011
Adventist HealthCare White Oak Medical Center	12,619
Ascension	
Saint Agnes Healthcare, Inc.	11,369
Christiana Care Health Services, Inc.	
Christiana Care, Union Hospital	6,379
Independent Hospitals	
Atlantic General Hospital	2,576
CalvertHealth Medical Center	5,901
Frederick Health Hospital	16,986
Greater Baltimore Medical Center	18,151
Mercy Medical Center	11,915
Meritus Medical Center	16,099
Sheppard Pratt	7,791
Johns Hopkins Health System	
Howard County General Hospital	16,692
Johns Hopkins Bayview Medical Center	17,060
Johns Hopkins Hospital	40,370
Suburban Hospital	10,894
Jointly Owned Hospitals	
Mt. Washington Pediatric Hospital	412
LifeBridge Health	
Carroll Hospital	9,839
Grace Medical Center	0
Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	967
Northwest Hospital Center, Inc.	7,319
Sinai Hospital of Baltimore, Inc.	17,622
Luminis Health	
Anne Arundel Medical Center	29,002
Doctors Community Hospital	8,994

Hospital Name	Inpatient Admissions
McNew Family Health Center	773
MedStar Health	
MedStar Franklin Square Medical Center	19,053
Medstar Good Samaritan Hospital	7,973
Medstar Harbor Hospital	7,618
MedStar Montgomery Medical Center	5,545
MedStar Southern Maryland Hospital Center	10,520
MedStar St. Mary's Hospital	8,049
MedStar Union Memorial Hospital	9,207
TidalHealth	
TidalHealth McCready Pavilion	0
TidalHealth Peninsula Regional	16,819
Trinity Health	
Holy Cross Germantown Hospital	7,216
Holy Cross Hospital	29,739
University of Maryland	
UM Baltimore Washington Medical Center	16,852
UM Capital Region Health	12,230
UM Charles Regional Medical Center	6,083
UM Rehabilitation & Orthopaedic Institute	1,660
UM Shore Regional Health – Chestertown	540
UM Shore Regional Health – Dorchester	106
UM Shore Regional Health – Easton	5,155
UM St. Joseph Medical Center	13,443
UM Upper Chesapeake Health – Harford Memorial Hospital	3,837
UM Upper Chesapeake Health – Upper Chesapeake Medical Center	12,177
UMMC Midtown Campus	4,196
University of Maryland Medical Center	24,619
UPMC	
UPMC Western Maryland	9,899
WVU Medical System	
GRMC, Inc., DBA Garrett Regional Medical Ctr.	1,723
Total	**527,887**

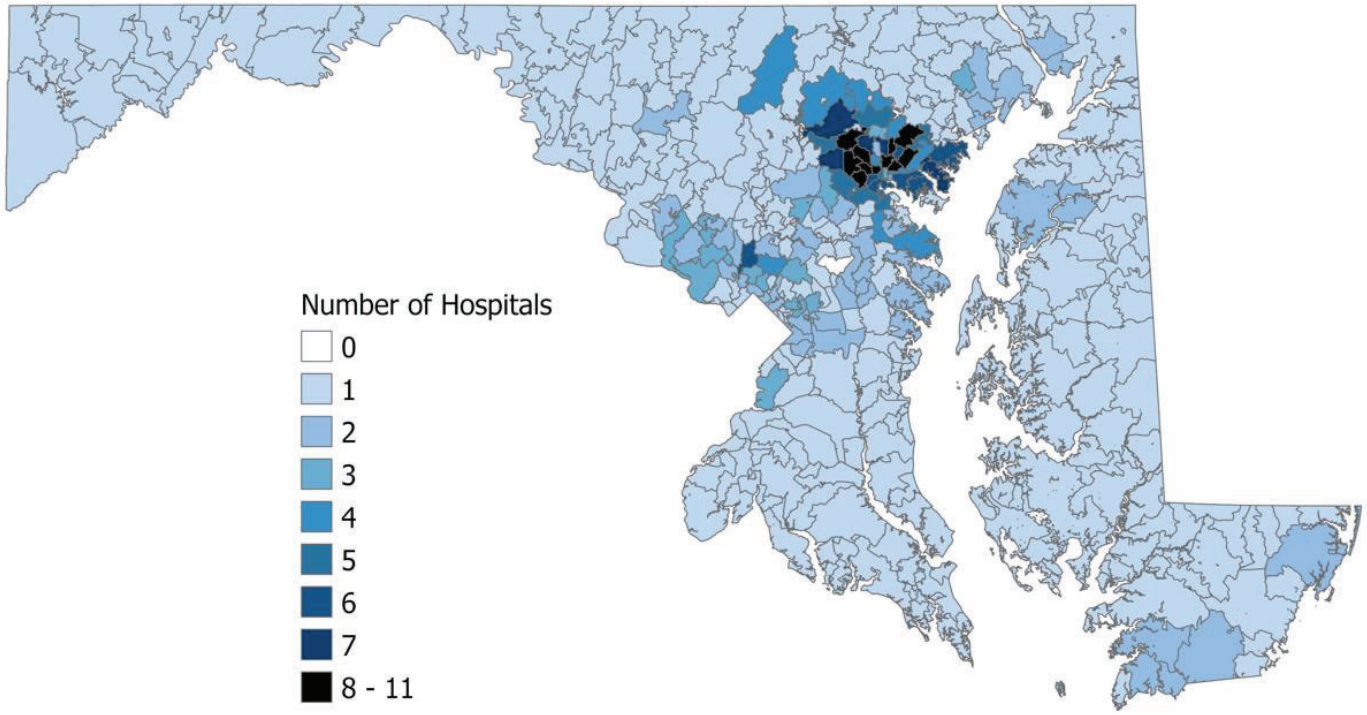
Primary Service Area

Each hospital has a primary service area (PSA), as defined in its global budget revenue (GBR) agreement.[14] Figure 1 displays a map of Maryland's ZIP codes. Each ZIP code has a color

[14] The exception is the specialty hospitals that do not have GBRs. For these hospitals, the ZIP codes that account for 60% of discharges are reported.

indicating how many hospitals claim that area in their PSAs. For FY 2022, every ZIP code in the state was part of the PSA of at least one hospital, which the exception of a single ZIP in central Maryland that does not have a residential population. Other than the areas in and around Baltimore City/County and some of the areas around Washington, D.C., most ZIP codes are claimed by only one hospital.

Figure 1. Number of Hospitals Claiming the ZIP Code in Their PSAs, FY 2022*



* Does not include McNew Family Medical Center.

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.[15] 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, the regions reached by the hospital's community benefit programming, and the proportion of residents who were medically underserved or

[15] 26 CFR § 1.501(r)-3(b).

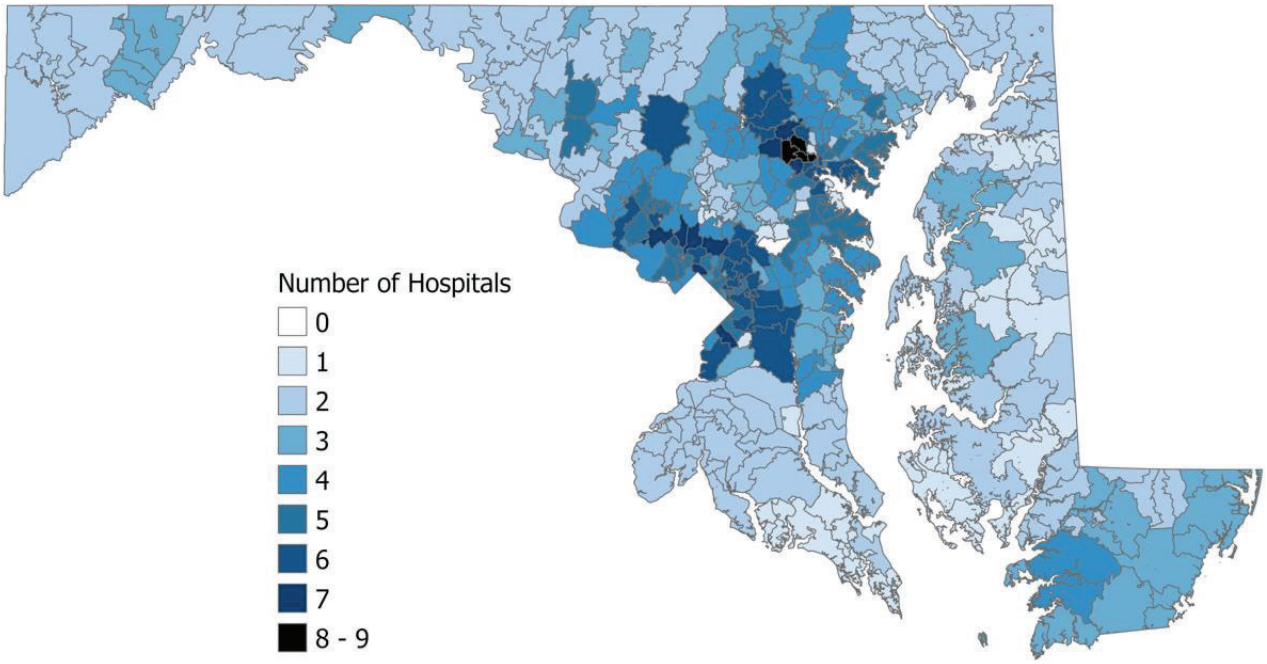
uninsured/underinsured, including multiple reports that cited a lack of other hospitals in the area. Eleven hospitals based their CBSAs on the PSAs described above.

Table 3. Methods Used by Hospitals to Identify their CBSAs, FY 2022

CBSA Identification Method	Number of Hospitals
Based on ZIP Codes in Financial Assistance Policy	7
Based on ZIP Codes in their Global Budget Revenue Agreement	11
Based on Patterns of Utilization	35
Other Method	25

Figure 2 displays the number of hospitals claiming each ZIP code in their CBSAs. Only one ZIP code, which appears as a white space just northeast of Washington, D.C., was not a part of any hospital's CBSA. This ZIP is a protected wildlife area and does not have a residential population. Just one unclaimed ZIP code marks a large decrease from FY 2021, in which 93 ZIP codes were not covered. Many of these newly covered ZIPs are located in the eastern and western parts of the state. Four 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 2022



Other Demographic Characteristics of Service Areas

Hospitals report details about the communities located in their CBSAs/CHNAs. These data help inform decisions about HCB activities. Because most of the 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 used by the hospitals. Table 4 is not exhaustive; see Appendix A for other community health data sources reported by hospitals.

The following measures were derived from the five-year (2017-2021) 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 (2018-2020) and the crude death rate (2020) measures were derived from the Maryland Department of Health's Vital Statistics Administration.

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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		91,431	6.2	6.0	33.2	27.1	32.5	19.5	57.2	32.3	10.6	78.6	992.0
Allegany	3	51,090	9.3	4.2	47.5	36.8	23.0	3.6	90.0	9.8	2.0	75.5	1664.4
Anne Arundel	8	108,048	3.9	4.5	28.3	19.8	30.5	12.0	74.8	19.7	8.3	79.0	862.8
Baltimore	11	81,846	6.2	5.2	34.6	28.7	29.1	14.9	61.1	31.6	5.8	77.5	1199.9
Baltimore City	17	54,124	15.3	5.9	45.9	49.8	30.7	10.3	32.3	63.7	5.6	71.8	1330.1
Calvert	2	120,295	2.8	2.9	26.4	18.4	40.7	4.6	84.4	14.8	4.3	79.4	881.0
Caroline	2	63,027	9.5	6.7	48.3	43.2*	32.8	8.4	81.4	15.9	7.7	76.2	1218.2
Carroll	4	104,708	3.5	3.1	27.3	16.1	35.7	5.4	92.7	4.8	3.9	78.4	1089.3
Cecil	2	81,817	6.9	4.1	36.6	29.5	29.8	6.5	90.0	9.0	4.7	75.1	1179.7
Charles	2	107,808	4.2	4.5	28.3	24.0	44.6	9.4	45.1	52.3	6.4	77.9	873.3
Dorchester	2	55,652	9.4	5.3	53.8	47.1*	26.8	5.7	68.3	30.6	5.9	75.7	1400.2
Frederick	6	106,129	4.5	4.6	27.7	18.5	34.8	14.3	83.0	12.1	10.4	80.1	836.9
Garrett	2	58,011	5.5	5.5	46.2	35.1*	24.2	2.8	97.5	1.6	1.2	77.7	1528.5
Harford	3	98,495	4.2	3.5	29.9	21.0	32.4	7.6	80.7	16.1	4.8	78.5	1002.7
Howard	4	129,549	4.0	3.9	24.7	17.1	30.4	26.2	58.3	21.8	7.2	82.7	632.8
Kent	2	64,451	6.9	4.0	45.2	30.0*	28.4	5.4	81.5	15.7	4.7	78.0	1683.0
Montgomery	10	117,345	4.8	6.7	28.3	21.7	33.8	41.5	55.1	20.7	19.7	84.2	728.9
Prince George's	8	91,124	6.0	10.3	33.3	29.6	36.5	28.2	18.3	64.4	19.4	78.4	925.1
Queen Anne's	3	99,597	4.1	4.5	34.4	20.3*	34.5	5.1	90.8	7.2	4.3	79.8	901.0
Saint Mary's	2	102,859	6.7	4.3	29.2	23.0	30.5	6.9	81.6	16.5	5.5	78.2	882.4
Somerset	4	48,661	15.3	5.0	51.6	42.6*	23.5	5.7	56.5	44.0	3.8	75.7	1379.0

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Talbot	3	79,349	5.6	4.3	46.3	27.0*	27.2	8.0	85.6	13.6	7.1	79.4	1490.3
Washington	2	67,349	9.9	4.9	41.9	33.9	29.5	7.7	85.5	14.3	5.8	75.9	1302.1
Wicomico	3	63,610	8.4	6.7	43.8	39.7	22.6	11.4	68.0	28.5	5.5	76.1	1154.9
Worcester	3	71,262	6.2	6.3	48.0	31.0*	23.7	6.3	85.0	14.1	3.7	79.9	1414.0
Source	[16]	[17]	[18]	[19]	[20]	[21]*	[22]	[23]	[24]	[25]	[26]	[27]	[28]

[16] As reported by hospitals in their FY 2022 Community Benefit Narrative Reports.
[17] American Community Survey 5-Year Estimates 2017 – 2021, Selected Economic Characteristics, Median Household Income (Dollars), https://data.census.gov/cedsci/.
[18] American Community Survey 5-Year Estimates 2017 – 2021, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families.
[19] American Community Survey 5-Year Estimates 2017 – 2021, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.
[20] American Community Survey 5-Year Estimates 2017 – 2021, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.
[21] American Community Survey 1-Year Estimates 2021, ACS Demographic and Housing Estimates, Total Population (denominator) and The Maryland Medicaid DataPort – Eligibility Exploratory Dashboards Standard Report, December 2021 enrollment, the Hilltop Institute (numerator). Starred values used 2020 Census population estimates for the denominator because 2021 ACS 1-Year Estimates were unavailable for these counties.
[22] American Community Survey 5-Year Estimates 2017 – 2021, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes).
[23] American Community Survey 5-Year Estimates 2017 – 2021, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.
[24] American Community Survey 5-Year Estimates 2017 – 2021, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – White.
[25] American Community Survey 5-Year Estimates 2017 – 2021, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – Black or African American.
[26] American Community Survey 5-Year Estimates 2017 – 2021, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race).
[27] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2020, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2018 – 2020. An updated 2021 Vital Statistics Report was unavailable at the time of publication.
[28] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2020, Table 39A. Crude Death Rates by Race, Hispanic Origin of Mother, Region, and Political Subdivision, Maryland, 2020. An updated 2021 Vital Statistics Report was unavailable at the time of publication.

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 as well as adopting an implementation strategy. See Appendix B for the dates in which hospitals conducted their last CHNAs. These dates ranged from April 2019 to August 2022.

This section also asks the hospitals to report on the internal and external participants involved in the CHNA process, including their corresponding roles. Table 5 shows the number of hospitals that reported collaborating with various external organizations. 47 hospitals partnered with local health departments. See Appendices C, D, and E for more detail on the internal and external participants in development of the hospitals' CHNAs.

Table 5. Number of Hospitals that Collaborated with Selected Types of External Organizations for Their Most Recent CHNA, FY 2022

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Facilities	19	40%
Local Health Departments	47	98%
Local Health Improvement Coalitions	46	96%
Other Hospitals	38	79%
Behavioral Health Organizations	41	85%

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 must also report on the internal participants involved in community benefit activities and their corresponding roles. Table 6 presents some highlights, and Appendices C and F provide full detail. Of note, around 96% of hospitals employed population health staff.

Table 6. Number of Hospitals Reporting Staff in the Following Categories

Staff Category	Number of Hospitals	% of Hospitals
Population Health Staff	46	96%
Community Benefit Staff	44	85%
Community Benefit/Pop Health Director	46	96%

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 all hospitals conducted some kind of audit of the financial spreadsheet, an increase of one hospital from FY 2021. Audits were most frequently performed by hospital or system staff.

Table 7. Hospital Audits of CBR Financial Spreadsheet

	Number of Hospitals	
Audit Type	**Yes**	**No**
Hospital Staff	43	5
System Staff	39	9
Third-Party	13	35
No Audit	0	48
Two or More Audit Types	38	10
Three or More Audit Types	9	39

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 or financial staff or an external firm. For example, several hospitals reported that their board meets only twice per year and did not have the opportunity to review before the report deadline. These responses were very similar to what was reported in FY 2021.

Table 8. Hospital Board Review of the CBR

	Number of Hospitals	
Board Review	**Yes**	**No**
Spreadsheet	37	11
Narrative	38	10

This section also asks if community benefit investments were incorporated into the major strategies of the Hospital Strategic Transformation Plan. Table 9 shows that most 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	45
No	3

Section IV. Hospital Community Benefit Program and Initiatives

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 Statewide Integrated Health Improvement Strategy (SIHIS). The SIHIS provides a framework for accountability, local action, and public engagement to advance the health of Maryland residents. SIHIS has four population health goals, in addition to goals related to hospital quality and care transformation. The four population health goals are: 1) reducing the mean body mass index (BMI) for Maryland residents, related to diabetes; 2) decreasing asthma-related ED visits for children; 3) improving opioid overdose mortality; and 4) reducing the severe maternal morbidity rate.

Of the 48 hospitals, 47 reported that their community benefit activities addressed at least one SIHIS goal. Table 10 presents the number of hospitals that addressed at least one goal under each SIHIS category. Reducing the mean BMI for Maryland residents, related to diabetes, was the SIHIS goal most frequently addressed by hospitals' community benefit activities. Decreasing asthma-related ED visits for children was the SIHIS goal that was least commonly addressed. In addition to the hospitals that report community benefit activities related to the SIHIS goals on opioid use disorder and maternal and child health, two hospitals indicated activities that support those SIHIS goals through their population health programs that did not qualify as community benefit activities.

Table 10. Number of Hospitals with Community Benefit Activities Addressing SIHIS Goals, FY 2022

SIHIS Goal	Number of Hospitals
Diabetes – Reduce the mean BMI for Maryland residents	43
Opioid Use Disorder – Improve overdose mortality	33
Maternal and Child Health – Reduce severe maternal morbidity rate	21
Maternal and Child Health – Decrease asthma-related emergency department visit rates for children aged 2-17	11

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 11 shows the gaps in availability that were identified by the hospitals. The most frequently reported gaps were Obstetrics & Gynecology

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

(reported by 29 hospitals), followed by Psychiatry, Emergency Medicine, and other specialties. Six hospitals reported no gaps. Due to incomplete or unclear responses to the physician subsidy reporting item, staff made corrections to physician subsidies reported by five hospitals based on inferences drawn from their financial reports. These edits included selecting physician specialties or subsidy types that most closely resembled the physician subsidy line items reported on the financials sheet for a hospital that failed to select these items on the narrative survey and correcting discrepancies between the financials and the narrative. Additionally, the justifications that four hospitals provided for their reported subsidies failed to fully explain the need for each subsidy. In order to minimize these types of discrepancies moving forward, staff will update the reporting instructions for FY 2023 to collect information on physician subsidies in one place in the financial spreadsheet portion of the report.

Table 11. Gaps in Physician Availability

Physician Specialty Gap	Number of Hospitals
No gaps	6
Obstetrics & Gynecology	29
Psychiatry	26
Emergency Medicine	25
Other	25
Internal Medicine	24
Pediatrics	19
Cardiology	18
Neurology	17
Surgery	16
Oncology-Cancer	13
Orthopedics	13
Anesthesiology	12
Endocrinology, Diabetes & Metabolism	11
Radiology	11
Ophthalmology	10
Family Practice/General Practice	9
Urology	9
Neurological Surgery	6
Otolaryngology	5
Plastic Surgery	5
Physical Medicine & Rehabilitation	4
Pathology	3
Preventive Medicine	3
Dermatology	2
Medical Genetics	1
Allergy & Immunology	0
Geriatrics	0

Section VI. Financial Assistance Policies

Hospitals are required to submit information about their financial assistance policies. Maryland law established the requirements for acute care and chronic care hospitals to provide free or reduced cost care as part of their financial assistance policies as follows:[30]

- Hospitals must provide free, medically necessary care to patients with family income at or below 200% of the FPL.[31] Twenty hospitals reported a more generous threshold.
- Hospitals must provide reduced-cost, medically necessary care to patients with family income between 200 and 300% of the FPL.[32] Forty-three hospitals reported a more generous threshold.[33]
- Hospitals must provide reduced-cost, medically necessary care to patients with family income below 500% 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% of the family's income.[35] Five hospitals reported a more generous threshold.

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

Section VII. Tax Exemptions

Newly required under HB 1169/SB 774 of 2020, hospitals reported on the types of tax exemptions claimed. Table 12 shows the number of hospitals that reported claiming each type of tax exemption. Hospitals that selected "Other" indicated that they also claimed an exemption from the federal unemployment insurance tax (FUTA). One hospital reported claiming some exemptions from some property taxes depending on usage but not from all local property taxes, and another hospital did not file taxes due to their status as an entity of county government.

Table 12. Tax Exemptions

Tax Exemption	Number of Hospitals
Federal corporate income tax	47
State corporate income tax	47
State sales tax	46
Local property tax (real and personal)	45
Other (describe)	7

[30] MD. CODE. ANN., Health-Gen. § 19-214.1; COMAR 10.37.10.26.
[31] MD. CODE. ANN., Health-Gen. § 19-214.1(b)(2)(i); COMAR 10.37.10.26(A-2)(2)(a)(i).
[32] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[33] For this analysis, the FAPs of hospitals at which patients receive free care up to 300% FPL, making the guidelines for reduced-cost care without financial hardship inapplicable, were counted as more generous than Maryland law requires for both the "free care" and "reduced-cost care" (without financial hardship) items.
[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 direct and indirect costs of community benefits, categorized by type of community benefit activity. The reporting period for these financial data is July 1, 2021, through June 30, 2022.[36] Hospitals were instructed to use data from audited financial statements to calculate the cost of each of the community benefit categories contained in the CBR financial reports and to limit reporting to only those hospital services reported on the IRS 990 schedule H. Fifty-one hospitals submitted individual financial reports.

FY 2022 Financial Reporting Highlights

Table 13 presents a statewide summary of community benefit expenditures for FY 2022. Maryland hospitals provided roughly $2.06 billion in total community benefit activities (before adjusting for rate support) in FY 2022—a total that is slightly higher than FY 2021 ($1.95 billion). The FY 2022 total includes: net community benefit expenses of $725 million in mission-driven health care services (subsidized health services), $662 million in health professions education, $387 million in charity care, $156 million in community health services, $56 million in Medicaid deficit assessment costs, $31 million in community building activities, $21 million in financial contributions, $12 million in research activities, $14 million in community benefit operations, and $2 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 13. Total Community Benefit Expenditures, FY 2022

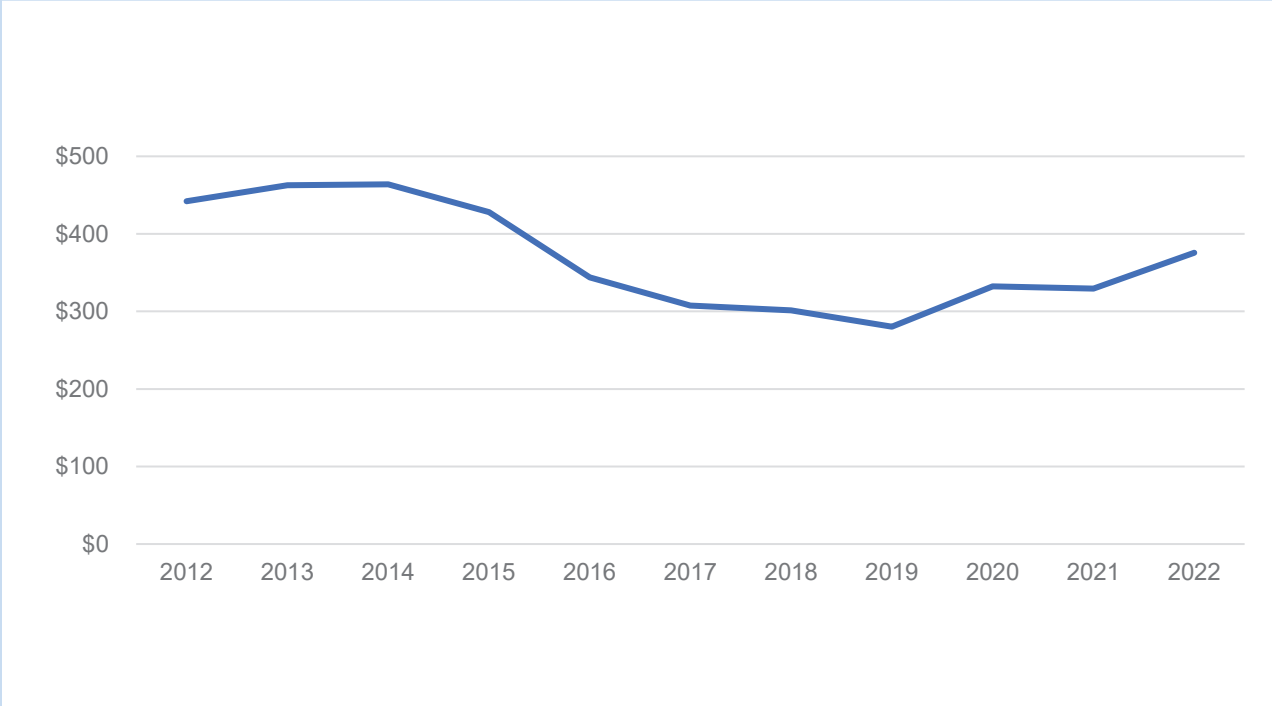
Community Benefit Category	Net Community Benefit Expense	Percent of Total CB Expenditures	Net Community Benefit Expense Less Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	$55,621,777	2.69%	$55,621,777	4.58%
Community Health Services	$156,476,493	7.58%	$129,452,584	10.66%
Health Professions Education	$661,694,610	32.05%	$214,685,520	17.67%
Mission Driven Health Services	$724,532,073	35.09%	$724,532,073	59.64%
Research	$12,155,232	0.59%	$12,155,232	1.00%
Financial Contributions	$20,867,653	1.01%	$20,867,653	1.72%
Community Building	$30,678,428	1.49%	$30,678,428	2.53%
Community Benefit Operations	$14,062,045	0.68%	$14,062,045	1.16%
Foundation	$1,839,390	0.09%	$1,839,390	0.15%
Charity Care	$386,716,607	18.73%	$10,985,064	0.90%
Total	**$2,064,644,308**	**100%**	**$1,214,879,766**	**100%**

[36] Several hospitals are on a calendar financial year. These hospitals report their most recent calendar year's data on the HCB report.

In Maryland, some activities that are considered community benefit are built into the rates for which all hospitals are reimbursed by all payers, including the costs of charity care, graduate medical education, the nurse support programs, population health workforce funding, and the regional partnership catalyst special funding program. 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 I details the amounts that were included in rates and funded by all payers for FY 2022. *New to this year's report, please note that the population health workforce funding is counted as rate support, so the rate support adjustments are higher in FY 2022 compared with prior years.*

Figure 3 shows the rate support for charity care from FY 2012 through FY 2022. This increased in FY 2022 after a decrease in FY 2021, before which an increase in FY 2020 followed several years of decreases in the wake of ACA implementation. See Appendix H for more details on the charity care methodology.

Figure 3. Rate Support for Charity Care (in millions), FY 2012-FY 2022



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. Graduate medical education costs include the direct costs (i.e., direct medical education, or DME) of 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 2022, DME costs totaled $412 million.

The HSCRC's Nurse Support Program I (NSP I) and NSP II are aimed at addressing the short- and long-term nursing shortage affecting Maryland hospitals. In FY 2022, the HSCRC provided $17 million in hospital rate adjustments for the NSP I and $17 million for the NSP II. See Appendix I 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 2022 were about $1.2 billion, or 7.0% of total hospital operating expenses. This is similar to the $1.2 billion in net benefits provided in FY 2021, which totaled 7.4% of hospital operating expenses.

Table 14 presents 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 $578 million, including the DME expenses described above. The second highest category was the education of nurses and nursing students, totaling $41 million, including the NSP program expenses described above. The education of other health professionals totaled $32 million.

Table 14. Health Professions Education Activities and Costs, FY 2022

Health Professions Education	Net Community Benefit with Indirect Cost
Physicians and Medical Students	$578,361,413
Nurses and Nursing Students	$41,069,267
Other Health Professionals	$32,350,709
Scholarships and Funding for Professional Education	$5,245,517
Other	$360,081
Total	**$657,386,988**

Table 15 presents 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 $69 million. Community-based clinical services were the second highest category, totaling $22 million, and community health education was the third highest, totaling $21 million. For additional detail, see Appendix K.

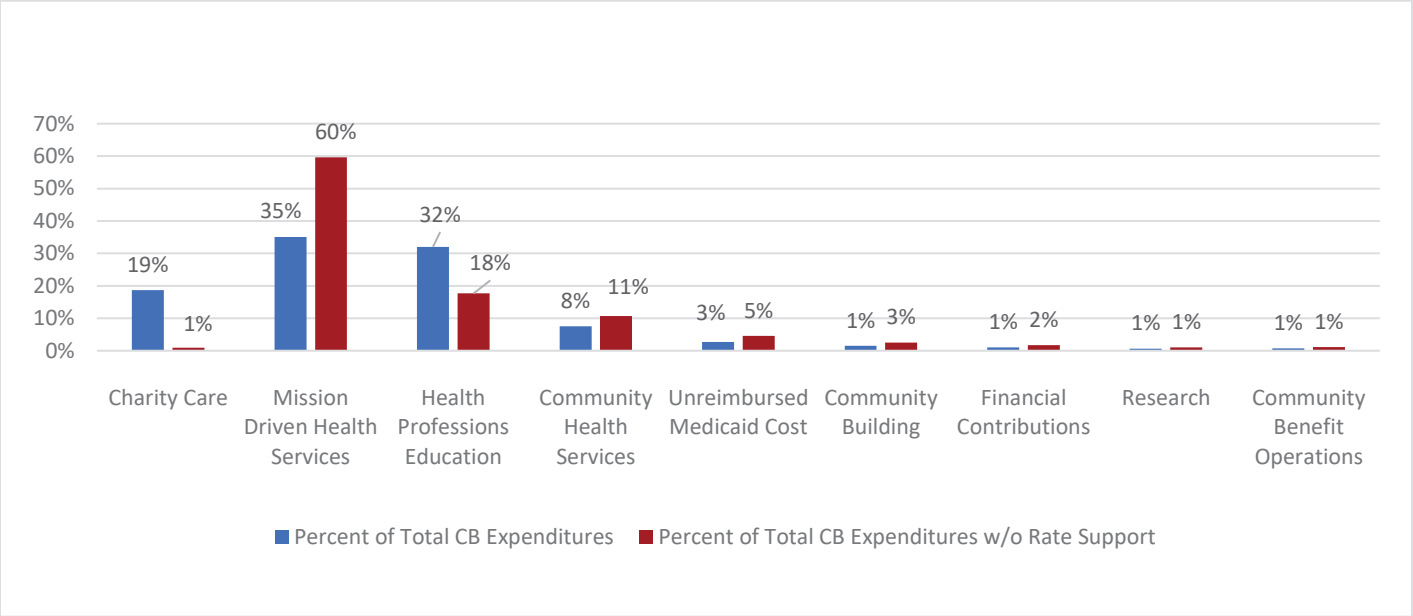
Table 15. Community Health Services Activities and Costs, FY 2022

Community Health Services	Net Community Benefit with Indirect Cost
Community Health Education	$20,710,456
Support Groups	$4,135,881
Self-Help	$1,423,493
Community-Based Clinical Services	$22,023,153
Screenings	$4,620,821
One-Time/Occasionally Held Clinics	$1,438,259
Clinics for Underinsured and Uninsured	$9,477,188

Community Health Services	Net Community Benefit with Indirect Cost
Mobile Units	$2,180,743
Health Care Support Services	$68,968,785
Other	$9,773,930
Total	**$144,752,709**

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 with rate support, at 35%, 32%, and 19%, 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 60%, followed by health professions education at 18% and community health services at 11%.

Figure 4. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2022



Appendix J compares hospitals in terms of the total amount of community benefits reported and the amount of community benefits recovered through HSCRC-approved rate support or as revenue from billable services. The total amount of net community benefit expenditures without rate support as a percentage of total operating expenses ranged from 2.0% to 24.7%, with an average of 7.0%, which was slightly higher than the average of 6.6% in FY 2021. Nine hospitals reported providing benefits in excess of 10% of their operating expenses, the same number as in FY 2021. The wide variation present in the percentage of hospitals' respective budgets dedicated to

community benefit expenditures is likely due in part to the lack of a defined amount that hospitals must spend on community benefit according to state or federal law.

New to the FY 2022 report, hospitals were required to report the costs of community benefit activities that were directly tied to needs identified in the hospitals' CHNAs. Table 16 presents each hospital's net total community benefit spending, the net total spent on CHNA-related activities, and the percentage of total spending on CHNA-related activities. Overall, the hospitals reporting spending 37% of their net community benefit spending on CHNA-related activities, with individual hospitals' ratios ranging from 0 to 81%. Please note that the reporting instructions left flexibility for the hospitals to make their own determinations as to whether their activities were tied to their CHNAs. HSCRC staff intend to debrief with the hospitals on how they made these determinations to see if the reporting instructions could be improved in future years to ensure consistency in reporting among hospitals.

Table 16. CHNA Spending as a Percentage of Net Community Benefit, FY 2022

Hospital	Reported Net CB on CHNA Priority Area Programs	Reported Total Net CB	CHNA as Percent of Net CB
Johns Hopkins Hospital	$269,595,954	$331,053,361	81.4%
UPMC Western Maryland Hospital	$54,112,595	$69,376,372	78.0%
MedStar Union Memorial Hospital	$29,089,027	$38,264,449	76.0%
Howard County General Hospital	$24,272,843	$32,365,979	75.0%
MedStar St. Mary's Hospital	$12,659,537	$17,166,801	73.7%
Johns Hopkins Bayview Med. Center	$75,248,909	$102,988,357	73.1%
MedStar Franklin Square Hospital	$38,960,161	$54,299,495	71.8%
MedStar Harbor Hospital	$17,400,914	$24,340,077	71.5%
Suburban Hospital	$25,383,089	$35,851,044	70.8%
MedStar Good Samaritan Hospital	$16,845,083	$24,857,973	67.8%
Grace Medical Hospital	$2,490,838	$3,965,483	62.8%
GRMC, Inc., DBA Garrett Regional Medical Ctr.	$5,068,847	$8,138,226	62.3%
MedStar Southern Maryland Hospital Center	$14,271,459	$23,252,596	61.4%
Mercy Medical Center	$43,864,573	$73,520,594	59.7%
Doctors Community Hospital	$12,565,445	$23,959,117	52.4%
MedStar Montgomery Medical Center	$5,657,023	$11,545,813	49.0%
Holy Cross Germantown Hospital	$3,546,018	$7,311,368	48.5%
Meritus Medical Center	$21,437,057	$53,181,374	40.3%
Adventist HealthCare Rehabilitation	$1,247,642	$3,323,589	37.5%
Univ. of Maryland Harford Memorial Hospital	$2,189,969	$5,846,434	37.5%
Mt. Washington Pediatric Hospital	$911,606	$2,523,069	36.1%

Hospital	Reported Net CB on CHNA Priority Area Programs	Reported Total Net CB	CHNA as Percent of Net CB
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	$930,681	$2,696,665	34.5%
Univ. of Maryland Upper Chesapeake Health	$4,545,791	$15,481,651	29.4%
Anne Arundel Medical Center	$18,628,910	$70,326,215	26.5%
Holy Cross Hospital	$13,246,155	$51,585,684	25.7%
Northwest Hospital Center, Inc.	$4,341,481	$25,188,533	17.2%
Carroll Hospital Center	$3,690,391	$21,778,511	16.9%
Sinai Hospital of Baltimore, Inc.	$14,506,466	$91,908,449	15.8%
Sheppard Pratt	$4,927,715	$33,085,290	14.9%
Adventist HealthCare Shady Grove Medical Center	$3,840,779	$33,407,654	11.5%
McNew Family Health Center	$247,820	$2,372,787	10.4%
Univ. of Maryland Baltimore Washington Medical Center	$2,400,501	$24,679,564	9.7%
Univ. of Maryland St. Joseph Medical Center	$4,697,502	$53,404,569	8.8%
Adventist HealthCare Fort Washington Medical Center	$330,607	$3,929,364	8.4%
Univ. of Maryland Charles Regional Medical Center	$1,096,668	$14,585,256	7.5%
Saint Agnes Healthcare, Inc.	$3,145,793	$45,950,554	6.8%
Univ. of Maryland Shore Medical Center at Chestertown	$576,290	$10,525,125	5.5%
Univ. of Maryland Shore Medical Center at Easton	$1,341,828	$30,779,779	4.4%
Adventist HealthCare White Oak Medical Center	$1,126,531	$33,884,822	3.3%
Univ. of Maryland Capital Region Health	$1,608,519	$58,344,610	2.8%
Frederick Health Hospital	$1,109,686	$52,789,456	2.1%
TidalHealth McCready Pavilion	$9,953	$582,789	1.7%
CalvertHealth Medical Center	$122,622	$8,480,244	1.4%
Univ. of Maryland Medical Center Midtown Campus	$505,369	$37,051,103	1.4%
Univ. of Maryland Medical Center	$2,892,009	$268,056,170	1.1%
Atlantic General Hospital	$53,319	$6,329,065	0.8%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$52,057	$8,362,550	0.6%
TidalHealth Peninsula Regional	$173,926	$29,157,396	0.6%
Greater Baltimore Medical Center	$328,372	$63,840,913	0.5%
Univ. of Maryland Shore Medical Center at Dorchester	$11,948	$3,840,192	0.3%
ChristianaCare, Union Hospital	$5,084	$15,107,774	0.0%
Total	**$767,313,361**	**$2,064,644,308**	**37.2%**

The CBR asks hospitals to describe the community benefit initiatives undertaken to address CHNA-identified needs in the community. Table 17 summarizes the CHNA priority area categories most commonly addressed by a hospital initiative in FY 2022. Appendix G shows the number of hospitals reporting initiatives to address all CHNA-identified community health needs.

Table 17. Top 5 CHNA Priority Area Categories Addressed

CHNA Priority Area Category	Number of Hospitals with an Initiative Addressing the Category
Social Determinants of Health - Health Care Access and Quality	38
Health Conditions - Mental Health and Mental Disorders	36
Health Conditions - Diabetes	34
Settings and Systems - Community	32
Health Conditions - Cancer	29

Indirect Cost Ratios

The reporting instructions include guidance on calculating indirect cost ratios, which represent the proportion of costs that are not attributed to products and/or services, including such costs as salaries for human resources and finance departments, insurance, and overhead expenses. The HSCRC specifies the methodology that hospitals should use to calculate their indirect cost ratio using their hospital's HSCRC Annual Cost Report. Hospitals have the option to report two ratios: one for hospital/facility-based activities and one for activities in the community that would have less overhead and lower indirect costs. Table 18 presents the indirect cost ratios reported by each hospital. Staff noticed wide variation across hospitals, with many reporting very high indirect costs. Staff intend to work with the hospitals in the coming year to refine the reporting requirements/instructions in this area.

Table 18. Hospital-Reported Indirect Cost Ratios, FY 2022

Hospital Name	Indirect Cost Ratio	
	Hospital-Based	Community-Based
Univ. of Maryland Shore Medical Center at Dorchester	163.2%	9.0%
Univ. of Maryland Shore Medical Center at Chestertown	137.5%	15.4%
Univ. of Maryland Shore Medical Center at Easton	103.9%	10.7%
Adventist HealthCare Rehabilitation	103.8%	15.0%
Sheppard Pratt	97.1%	
Univ. of Maryland Charles Regional Medical Center	95.0%	17.8%
Northwest Hospital Center, Inc.	91.4%	12.0%
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	90.0%	
MedStar Southern Maryland Hospital Center	89.7%	
Univ. of Maryland Medical Center Midtown Campus	88.4%	14.7%
Greater Baltimore Medical Center	87.5%	
Doctors Community Hospital	86.8%	
McNew Family Health Center	86.2%	
Frederick Health Hospital	85.8%	85.8%

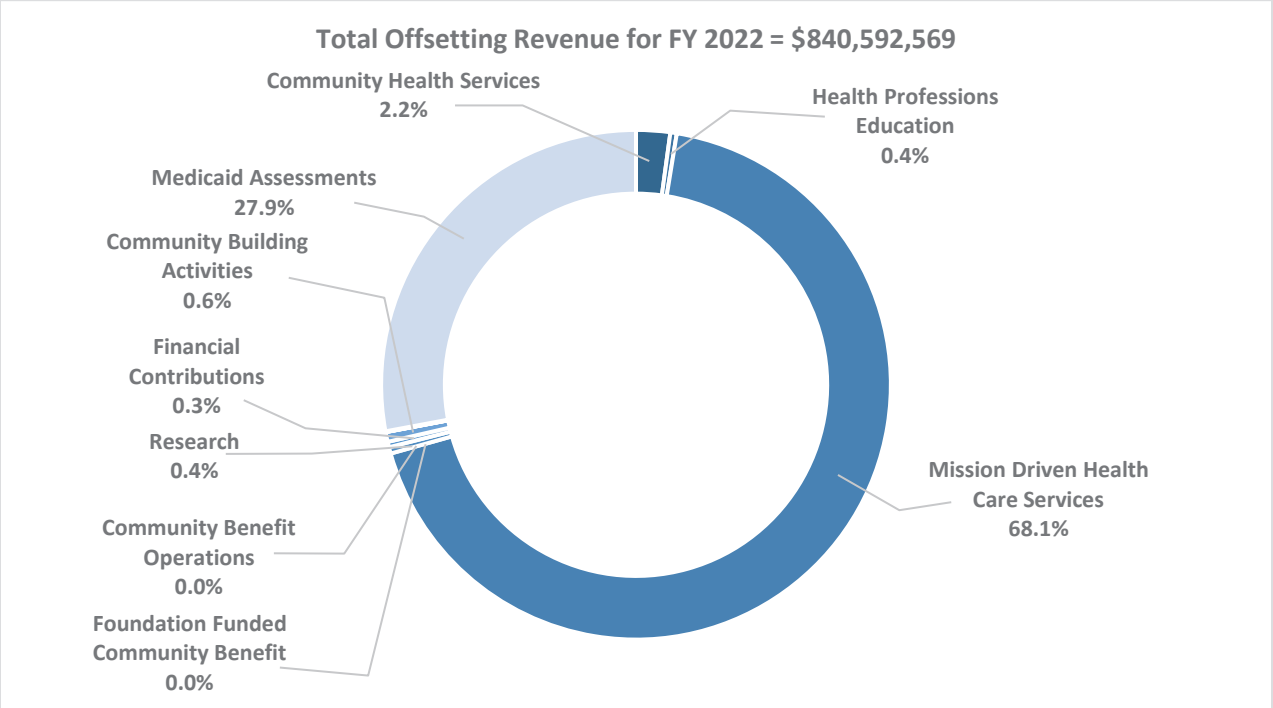
Hospital Name	Indirect Cost Ratio	
	Hospital-Based	Community-Based
Howard County General Hospital	85.7%	19.5%
Saint Agnes Healthcare, Inc.	85.3%	10.0%
Univ. of Maryland St. Joseph Medical Center	82.7%	15.4%
Univ. of Maryland Baltimore Washington Medical Center	82.0%	13.3%
MedStar Harbor Hospital	80.9%	
Univ. of Maryland Capital Region Health	80.3%	13.7%
Adventist HealthCare Shady Grove Medical Center	79.9%	
Mercy Medical Center	78.4%	10.0%
Sinai Hospital of Baltimore, Inc.	78.3%	12.0%
Grace Medical Center	78.0%	12.0%
MedStar Good Samaritan Hospital	77.4%	
Suburban Hospital	75.8%	28.1%
Univ. of Maryland Harford Memorial Hospital	74.4%	11.0%
CalvertHealth Medical Center	74.4%	33.0%
Mt. Washington Pediatric Hospital	73.0%	11.4%
MedStar St. Mary's Hospital	72.3%	
TidalHealth McCready Pavilion	72.1%	
Anne Arundel Medical Center	71.2%	
Meritus Medical Center	70.0%	13.1%
MedStar Montgomery Medical Center	68.7%	0.0%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	66.9%	
UPMC Western Maryland	65.5%	54.9%
Johns Hopkins Bayview Medical Center	64.6%	17.1%
Adventist HealthCare White Oak Medical Center	60.7%	
Adventist HealthCare Fort Washington Medical Center	59.9%	
GRMC, Inc., DBA Garrett Regional Medical Ctr.	59.5%	
Univ. of Maryland Medical Center	59.2%	9.8%
TidalHealth Peninsula Regional	57.0%	
MedStar Franklin Square Medical Center	56.5%	
Univ. of Maryland Upper Chesapeake Health	53.0%	8.0%
Carroll Hospital Center	50.0%	12.0%
Johns Hopkins Hospital	46.9%	15.4%
MedStar Union Memorial Hospital	46.5%	
Atlantic General Hospital	35.3%	
Holy Cross Germantown Hospital	31.1%	
Holy Cross Hospital	28.8%	
ChristianaCare, Union Hospital	0.4%	

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 2022 offsetting revenue by community benefit category. The largest components of offsetting revenue were mission-driven health care services (68.1%) and the Medicaid deficit assessment (27.9%). 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 2022



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.[37] 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 19 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. Fifteen hospitals did not report any offsetting revenue from mission-driven health services. Fourteen hospitals reported offsetting revenue for 50 percent or more of their mission-driven expenditures.

[37] See the HSCRC's FY 2022 Community Benefit Reporting Guidelines and Standard Definitions.

Table 19. Mission-Driven Health Services Expenditure and Offsetting Revenue among Maryland Hospitals, FY 2022

Hospital Name	Total Expenditure	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Net Community Benefit
Adventist HealthCare White Oak Medical Center	$153,401,787	$137,926,854	89.9%	$15,474,933
Adventist HealthCare Rehabilitation	$4,832,356	$3,490,024	72.2%	$1,342,332
MedStar Montgomery Medical Center	$14,016,358	$9,954,862	71.0%	$4,061,496
Atlantic General Hospital	$11,896,279	$8,300,543	69.8%	$3,595,736
MedStar Union Memorial Hospital	$19,973,627	$13,051,785	65.3%	$6,921,842
MedStar Franklin Square Medical Center	$50,090,143	$32,190,580	64.3%	$17,899,563
Greater Baltimore Medical Center	$133,410,917	$83,556,401	62.6%	$49,854,516
Meritus Medical Center	$100,761,353	$62,350,481	61.9%	$38,410,872
Univ. of Maryland Baltimore Washington Medical Center	$35,644,404	$21,010,070	58.9%	$14,634,334
MedStar Good Samaritan Hospital	$20,124,951	$11,820,478	58.7%	$8,304,473
Saint Agnes Healthcare, Inc.	$39,195,002	$22,158,168	56.5%	$17,036,834
MedStar Southern Maryland Hospital Center	$29,392,554	$16,556,959	56.3%	$12,835,595
MedStar Harbor Hospital	$18,692,816	$9,749,461	52.2%	$8,943,355
UPMC Western Maryland	$105,576,782	$52,739,776	50.0%	$52,837,006
ChristianaCare, Union Hospital	$22,349,504	$10,567,749	47.3%	$11,781,755
GRMC, Inc., DBA Garrett Regional Medical Ctr.	$7,348,287	$3,337,187	45.4%	$4,011,100
Univ. of Maryland Medical Center	$25,311,789	$10,081,487	39.8%	$15,230,302
Sinai Hospital of Baltimore, Inc.	$40,187,723	$15,639,484	38.9%	$24,548,239
MedStar St. Mary's Hospital	$15,349,364	$5,601,547	36.5%	$9,747,817
CalvertHealth Medical Center	$6,622,420	$2,412,901	36.4%	$4,209,519
Mt. Washington Pediatric Hospital	$772,310	$251,778	32.6%	$520,533
Northwest Hospital Center, Inc.	$16,406,193	$4,628,617	28.2%	$11,777,576
Univ. of Maryland Charles Regional Medical Center	$14,281,365	$3,957,102	27.7%	$10,324,264
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$3,121,036	$861,511	27.6%	$2,259,525
Univ. of Maryland Capital Region Health	$54,549,650	$14,820,600	27.2%	$39,729,050

Hospital Name	Total Expenditure	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Net Community Benefit
TidalHealth Peninsula Regional	$6,323,675	$1,560,544	24.7%	$4,763,131
Adventist Shady Grove Medical Center	$18,848,046	$4,581,401	24.3%	$14,266,645
Holy Cross Hospital	$10,410,158	$1,825,015	17.5%	$8,585,143
Univ. of Maryland Medical Center Midtown Campus	$21,423,210	$3,304,437	15.4%	$18,118,773
Adventist HealthCare Shady Grove Medical Center	$2,381,168	$301,778	12.7%	$2,079,389
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	$589,185	$63,993	10.9%	$525,192
Johns Hopkins Bayview Medical Center	$9,806,263	$999,713	10.2%	$8,806,550
Suburban Hospital	$16,685,001	$822,154	4.9%	$15,862,847
Sheppard Pratt	$24,075,906	$776,795	3.2%	$23,299,110
Johns Hopkins Hospital	$16,249,639	$498,731	3.1%	$15,750,908
Mercy Medical Center.	$24,820,283	$598,336	2.4%	$24,221,947
Frederick Health Hospital	$34,824,128	$15,292	0.0%	$34,808,836
Univ. of Maryland Harford Memorial Hospital	$1,987,613	$0	0.0%	$1,987,613
Univ. of Maryland Shore Medical Center at Dorchester	$3,238,029	$0	0.0%	$3,238,029
Grace Medical Center	$854,769	$0	0.0%	$854,769
Anne Arundel Medical Center	$38,634,939	$0	0.0%	$38,634,939
Univ. of Maryland Shore Medical Center at Chestertown	$8,674,572	$0	0.0%	$8,674,572
Carroll Hospital Center	$11,755,500	$0	0.0%	$11,755,500
Univ. of Maryland Shore Medical Center at Easton	$23,704,107	$0	0.0%	$23,704,107
TidalHealth McCready Pavilion	$47,973	$0	0.0%	$47,973
Howard County General Hospital	$16,140,216	$0	0.0%	$16,140,216
Univ. of Maryland Upper Chesapeake Health	$5,439,770	$0	0.0%	$5,439,770
Doctors Community Hospital	$9,888,960	$0	0.0%	$9,888,960
Univ. of Maryland St. Joseph Medical Center	$42,258,757	$0	0.0%	$42,258,757
Holy Cross Germantown Hospital	$3,233,534	$0	0.0%	$3,233,534
McNew Family Health Center	$1,251,896	$0	0.0%	$1,251,896
Total	**$1,296,856,268**	**$572,364,595**	**44.1%**	**$724,491,673**

FY 2004 – FY 2022 19-Year Summary

FY 2022 marks the 19th year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9% of hospitals' operating expenses. In FY 2022, these expenses represented roughly $2.06 billion, or 10.6% of operating expenses. When reduced to account for rate support, FY 2022 expenses represented roughly $1.21 billion, or 6.2% of operating expenses. Figures 6 and 7 show the trend of community benefit expenses with and without rate support. On average, approximately 50% of expenses were reimbursed through the rate-setting system.

Figure 6. FY 2012 – FY 2022 Community Benefit Expenses with and without Rate Support (in millions)

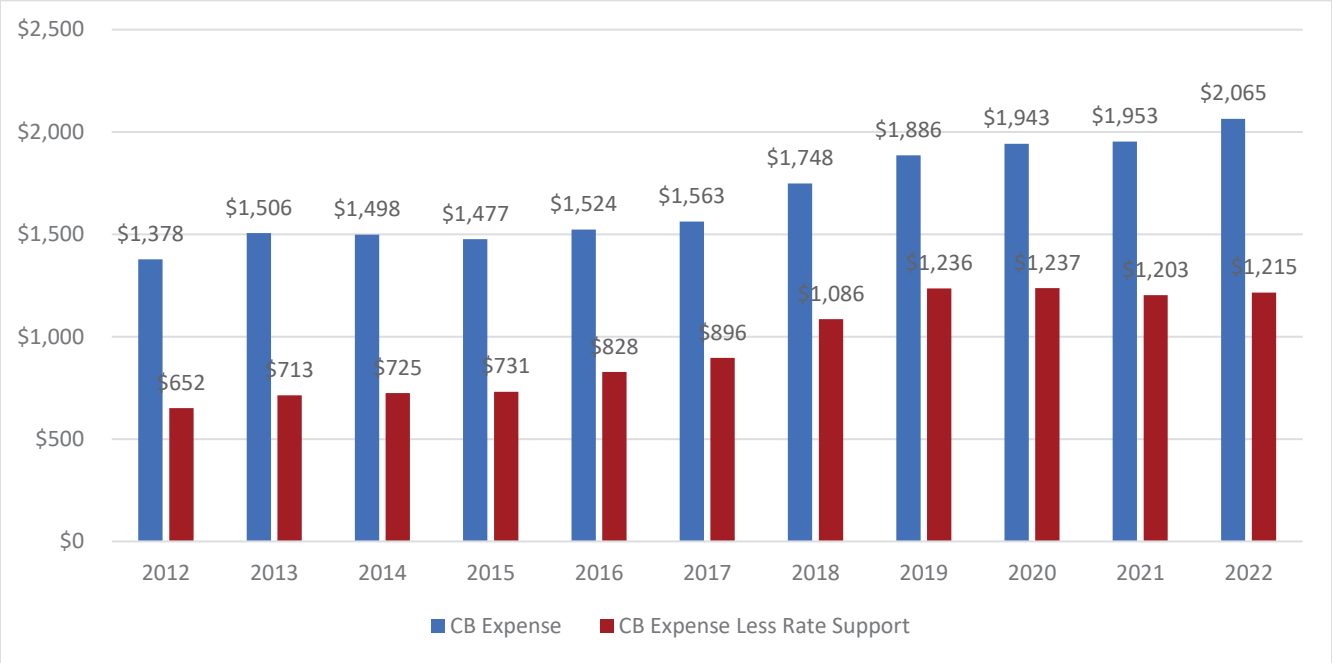
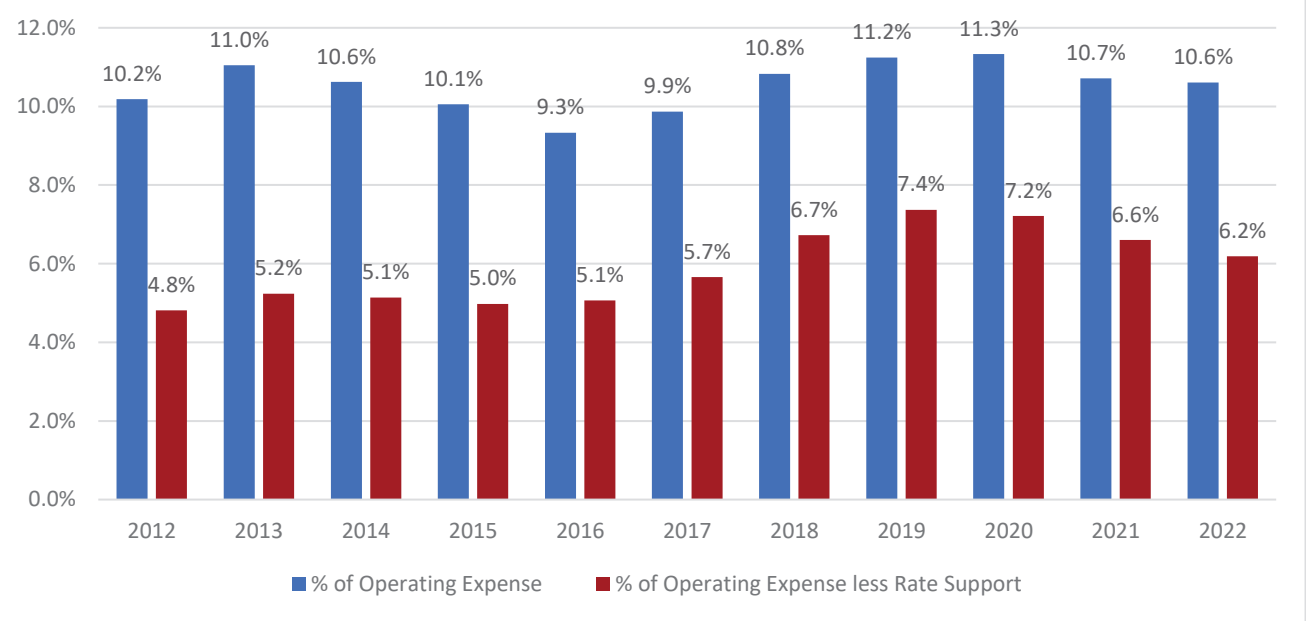


Figure 7. FY 2012 – FY 2022 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



Conclusion

In summary, FY 2022 CBRs were submitted for all 51 Maryland hospitals, showing nearly $2.1 billion in community benefit expenditures, slightly higher than in FY 2021. The distribution of expenditures across community benefit categories remained similar to prior years, with mission-driven services accounting for the majority of expenditures. Overall, expenditures as a percentage of operating expenses slightly decreased from 10.7% in FY 2021 to 10.6% in FY 2022. After accounting for rate support, expenditures as a percentage of operating expenses decreased from 6.6% to 6.2% (partially driven by accounting for additional types of rate support this year). Staff appreciates hospital efforts to meet the new reporting requirement for itemizing CHNA-related community benefit expenditures.

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. Encouraging findings of the review include a senior-level commitment to community benefit activities and community engagement. For example, most 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. Most hospitals employ staff dedicated to community benefit, and most report having initiatives targeting the SIHIS goals.

Staff also identified the following areas for further engaging the hospitals:

- Hospitals historically took inconsistent approaches to reporting offsetting revenue and physician subsidies within mission-driven health services. While hospitals demonstrated

improvement in reporting physician subsidies in the new line-item format, discussion with hospitals indicated that more clarity and guidance is needed to ensure consistent reporting across hospitals. Staff have updated the FY 2023 reporting instructions to collect physician subsidy information in one place in the financials sheet, and additional language was added to clarify that hospitals must report their costs and offsetting revenue separately rather than doing the calculations themselves to determine their net costs and reporting only those values.

- There is wide variation in indirect cost ratios, and many hospitals report very high ratios. Staff acknowledge that this is due to the reporting instructions and intend to engage the hospitals on how to improve the instructions in the future.
- The hospitals did an excellent job on the new requirement to report CHNA-related expenditures. However, staff noted wide variation in the percentage spend on CHNA-related activities and acknowledge that this may be due to the subjectivity in the new reporting instructions. Staff intend to engage the hospitals to determine whether additional clarity in the instructions is needed.

Appendix A. Sources of Community Health Measures Reported by Hospitals

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

- Baltimore City Office of Epidemiology
- Baltimore Neighborhood Indicators Alliance
- CareFirst Community Health and Social Impact
- CDC Behavioral Risk Factor Surveillance System
- CDC Chronic Disease Calculator
- CDC Interactive Atlas of Heart Disease and Stroke
- CDC Wonder Database
- CDC/U.S. Census Bridged Population Files
- Community surveys, focus groups, and interviews
- Conduent - Healthy Communities Institute
- County and local health departments' community health statistics
- County comptroller's offices
- County housing departments
- Chesapeake Regional Information System for our Patients (CRISP)
- Cigarette Restitution Fund Program – Cancer in Maryland Report
- Feeding America
- Findings from health and human services needs assessments completed by contracted entities
- IBM Watson Health
- Internal emergency department and health services quality data
- Local community foundations
- Local health improvement coalitions
- Local police and public school systems data
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Department of Health
- Maryland Health Services Cost Review Commission
- Maryland Hospital Association
- Maryland Medicaid DataPort
- Maryland Office of Minority Health and Health Disparities

- Maryland Physician Workforce Study
- Maryland Sexually Transmitted Infections Program
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- Meritus Health Cancer Registry Report
- National Cancer Institute
- National Center for Health Statistics
- National Survey on Drug Use and Health
- Nielsen/Claritas
- Performance data from community health improvement initiatives
- Robert Wood Johnson Foundation – County Health Rankings
- Robert Wood Johnson Foundation – City Health Dashboard
- United Way – United for ALICE (Asset-Limited, Income Constrained, Employed)
- University of Wisconsin School of Medicine and Public Health – Neighborhood Atlas
- U.S. Census Bureau – American Community Survey
- U.S. Census Bureau – Current Population Survey
- U.S. Census Bureau – Decennial Census population estimates
- U.S. Department of Health and Human Services – Healthy People 2030
- Virginia Commonwealth University (VCU) Center on Society and Health *Uneven Opportunities: How Conditions for Wellness Vary Across the Metropolitan Washington Region* Report

Appendix B. Dates of Most Recent CHNAs

Hospital	Date Most Recent CHNA was Completed
Doctors Community Hospital	Apr-19
Adventist HealthCare Fort Washington Medical Center	May-19
Frederick Health Hospital	May-19
Anne Arundel Medical Center	Jun-19
McNew Family Health Center	Jun-19
Holy Cross Germantown Hospital	Oct-19
Holy Cross Hospital	Oct-19
Adventist HealthCare Rehabilitation	Dec-19
Adventist HealthCare Shady Grove Medical Center	Dec-19
Adventist HealthCare White Oak Medical Center	Dec-19
Grace Medical Center	Jun-20
CalvertHealth Medical Center	Jul-20
Mt. Washington Pediatric Hospital	May-21
Johns Hopkins Bayview Medical Center	May-21
Greater Baltimore Medical Center	Jun-21
Mercy Medical Center	Jun-21
Johns Hopkins Hospital	Jun-21
UM St. Joseph Medical Center	Jun-21
UM Upper Chesapeake Health	Jun-21
Carroll Hospital Center	Jun-21
MedStar Franklin Square Medical Center	Jun-21
MedStar Good Samaritan Hospital	Jun-21
MedStar Harbor Hospital	Jun-21
MedStar Montgomery Medical Center	Jun-21
MedStar Southern Maryland Hospital Center	Jun-21
MedStar St. Mary's Hospital	Jun-21
MedStar Union Memorial Hospital	Jun-21
Northwest Hospital Center, Inc.	Jun-21
Saint Agnes Healthcare, Inc	Jun-21
Sinai Hospital of Baltimore, Inc.	Jun-21
UM Charles Regional Medical Center	Jun-21
UMMC Midtown Campus	Jun-21
University of Maryland Medical Center	Jun-21
UPMC Western Maryland	Jun-21
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	Jun-21

Hospital	Date Most Recent CHNA was Completed
Meritus Medical Center	Mar-22
Atlantic General Hospital	May-22
ChristianaCare Union Hospital	May-22
TidalHealth McCready Pavilion	May-22
TidalHealth Peninsula Regional	May-22
Sheppard Pratt	May-22
UM Shore Regional Health	May-22
UM Capital Region Health	Jun-22
Howard County General Hospital	Jun-22
UM Rehabilitation & Orthopaedic Institute	Jun-22
UM BWMC	Jun-22
Suburban Hospital	Jun-22
GRMC, Inc., DBA Garrett Regional Medical Ctr.	Aug-22

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

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

CHNA Participant Category	Level of Community Engagement					
	Informed - To provide the community with balanced & objective info to assist in understanding the problem, alternatives, opportunities and/or solutions	**Consulted -** To obtain community feedback on analysis, alternatives and/or solutions	**Involved -** To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	**Collaborated -** To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	**Delegated -** To place the decision- making in the hands of the community	**Community Driven/Led -** To support the actions of community initiated, driven and/or led processes
Other Hospitals	18	27	21	24	9	10
Local Health Department	26	29	24	29	8	13
Local Health Improvement Coalition	23	28	17	24	7	13
Maryland Department of Health	19	16	4	11	2	2
Other State Agencies	5	6	3	5	0	0
Local Govt. Organizations	19	25	12	17	2	3
Faith-Based Organizations	19	23	19	21	1	5
School - K-12	18	21	14	15	2	2
School - Colleges, Universities, Professional Schools	19	20	14	16	2	2
Behavioral Health Organizations	22	27	15	19	3	9
Social Service Organizations	20	21	11	17	1	6
Post-Acute Care Facilities	8	11	4	6	0	4
Community/Neighborhood Organizations	20	27	15	16	1	4
Consumer/Public Advocacy Organizations	8	7	3	7	0	2
Other	17	23	12	8	1	3

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

CHNA Participant Category	Recommended Practices							
	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals	32	32	27	34	22	26	16	17
Local Health Department	34	33	30	41	28	26	19	22
Local Health Improvement Coalition	35	23	16	39	20	25	17	22
Maryland Department of Health	10	8	13	15	7	12	2	12
Other State Agencies	7	5	6	6	2	6	3	6
Local Govt. Organizations	25	20	8	29	8	16	18	14
Faith-Based Organizations	28	20	7	30	11	24	19	13
School - K-12	21	18	10	24	13	15	17	13
School - Colleges, Universities, Professional Schools	19	18	11	22	8	15	15	9
Behavioral Health Organizations	28	22	13	31	15	24	17	19
Social Service Organizations	26	18	10	30	12	21	16	16
Post-Acute Care Facilities	5	7	2	11	1	3	8	3
Community/Neighborhood Organizations	23	22	6	30	11	17	17	14
Consumer/Public Advocacy Organizations	10	10	5	12	4	8	3	9
Other	7	12	7	18	8	10	10	4

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Appendix F. Community Benefit Internal Participants and Their Roles

Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting Health Needs That Will Be Targeted	Selecting the Initiatives That Will Be Supported	Determining How to Evaluate the Impact of Initiatives	Providing Funding for CB Activities	Allocating Budgets for Individual Initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other
CB/ Community Health/Population Health Director (facility level)	5	11	32	33	32	20	31	31	32	2
CB/ Community Health/ Population Health Director (system level)	11	7	29	28	29	16	21	17	28	3
Senior Executives (CEO, CFO, VP, etc.) (facility level)	3	0	41	41	25	39	35	9	20	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	12	6	21	23	19	22	22	9	17	2
Board of Directors or Board Committee (facility level)	9	3	15	19	6	8	5	2	13	3
Board of Directors or Board Committee (system level)	15	6	14	13	2	3	2	0	6	2
Clinical Leadership (facility level)	4	0	36	28	25	8	9	25	25	0
Clinical Leadership (system level)	11	8	22	22	11	6	8	4	11	0
Population Health Staff (facility level)	4	11	24	23	31	12	13	32	33	1
Population Health Staff (system level)	19	8	20	20	20	7	12	19	20	0
Community Benefit staff (facility level)	5	14	23	23	24	10	14	28	30	0
Community Benefit staff (system level)	7	12	16	17	26	3	6	15	24	3
Physician(s)	9	0	25	23	15	4	3	24	19	4
Nurse(s)	9	0	26	25	19	6	6	29	23	0
Social Workers	17	0	19	18	12	4	4	26	18	1
Hospital Advisory Board	11	20	16	8	4	2	3	4	11	2
Other (specify)	9	2	4	4	6	2	2	7	7	0

Appendix G. FY 2022 CHNA Priority Area Categories Addressed through CB Initiatives

CHNA Priority Area Category	Number of Hospitals with an Initiative Addressing the Category
Social Determinants of Health - Health Care Access and Quality	38
Health Conditions - Mental Health and Mental Disorders	36
Health Conditions - Diabetes	34
Settings and Systems - Community	32
Health Conditions – Cancer	29
Health Behaviors - Preventive Care	28
Health Conditions - Heart Disease and Stroke	27
Health Behaviors - Drug and Alcohol Use	24
Health Behaviors - Nutrition and Healthy Eating	22
Social Determinants of Health - Economic Stability	19
Social Determinants of Health - Education Access and Quality	19
Social Determinants of Health - Social and Community Context	19
Settings and Systems - Health Care	18
Settings and Systems - Transportation	18
Health Conditions - Addiction	17
Health Conditions - Pregnancy and Childbirth	17
Health Behaviors - Health Communication	17
Health Behaviors - Physical Activity	14
Health Behaviors - Vaccination	14
Health Conditions - Overweight and Obesity	13
Health Behaviors - Violence Prevention	13
Populations - Workforce	13
Health Conditions - Infectious Disease	12
Populations – Adolescents	11
Settings and Systems - Housing and Homes	11
Social Determinants of Health - Neighborhood and Built Environment	11
Health Behaviors - Injury Prevention	10
Populations – Children	10
Populations - Older Adults	10
Settings and Systems - Health Insurance	10

CHNA Priority Area Category	Number of Hospitals with an Initiative Addressing the Category
Health Behaviors - Emergency Preparedness	8
Populations - Parents or Caregivers	8
Populations - People with Disabilities	8
Settings and Systems - Workplace	8
Health Conditions - Chronic Pain	7
Populations – Women	7
Settings and Systems - Hospital and Emergency Services	7
Settings and Systems - Schools	7
Health Conditions - Respiratory Disease	6
Settings and Systems - Public Health Infrastructure	6
Health Behaviors - Child and Adolescent Development	5
Populations – Infants	5
Health Conditions - Chronic Kidney Disease	4
Health Conditions - Sexually Transmitted Infections	4
Health Behaviors - Tobacco Use	4
Health Conditions – Arthritis	2
Health Conditions - Health Care-Associated Infections	2
Health Behaviors - Family Planning	2
Health Behaviors – Sleep	2
Populations – Men	2
Settings and Systems - Environmental Health	2
Health Conditions - Blood Disorders	1
Health Conditions - Dementias	1
Health Conditions - Osteoporosis	1
Health Conditions - Sensory or Communication Disorders	1
Settings and Systems - Health IT	1
Settings and Systems - Health Policy	1
Other (Health Conditions - Colorectal)	1

*Data Source: As reported by hospitals on their FY 2022 financial reports.

Appendix H. 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 are 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 2022 Community Benefit Report) based on the policy approved by the Commission for the beginning of the rate year (also FY 2022).

- The HSCRC uses a logistic regression to predict actual hospital uncompensated care costs in a given year.
- 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.[38]
    - 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 FY financially audited UCC levels (FY 2022) are averaged with the hospital's estimated UCC levels from the prior FY (FY 2021) 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 2022 policy. The resulting charity care amount is the estimated amount provided in rates that will be subtracted from the hospital's community benefit.

[38] 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.

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Appendix I. FY 2022 Funding through Rates for CB Activities Reported by Hospitals

Hospital Name	DME	NSP I	NSP II	Population Health Workforce Support for Disadvantaged Areas Program	Regional Partnership Catalyst Grant Program	Charity Care	Total Rate Support
Adventist HealthCare Fort Washington Medical Center	$0	$53,627	$53,628	$0	$373,565	$657,109	$1,137,929
Adventist HealthCare Rehabilitation	$0	$41,538	$0	$0	$0	$0	$41,538
Adventist HealthCare Shady Grove Medical Center	$0	$474,519	$474,516	$0	$687,415	$12,924,520	$14,560,970
Adventist HealthCare White Oak Medical Center	$0	$328,725	$328,728	$0	$444,953	$9,643,669	$10,746,075
Anne Arundel Medical Center	$5,968,635	$640,391	$640,392	$0	$0	$4,976,327	$12,225,746
Atlantic General Hospital	$0	$107,158	$107,160	$0	$587,838	$1,461,213	$2,263,370
CalvertHealth Medical Center	$0	$157,018	$157,020	$0	$0	$2,799,761	$3,113,799
Carroll Hospital Center	$0	$231,744	$231,744	$0	$117,314	$3,120,446	$3,701,248
ChristianaCare, Union Hospital	$0	$163,369	$163,368	$0	$0	$2,395,905	$2,722,642
Doctors Community Hospital	$0	$256,642	$256,644	$0	$240,776	$8,470,778	$9,224,840
Frederick Health Hospital	$0	$358,754	$358,752	$0	$861,949	$7,323,740	$8,903,195
Grace Medical Center	$0	$39,284	$39,288	$0	$0	$166,170	$244,742
Greater Baltimore Medical Center	$7,585,182	$472,544	$472,548	$0	$240,072	$2,324,394	$11,094,740
GRMC, Inc., DBA Garrett Regional Medical Ctr.	$0	$59,968	$59,964	$0	$0	$2,844,439	$2,964,371
Holy Cross Germantown Hospital*	$0	$119,447	$119,448	$0	$169,723	$3,242,781	$3,651,399
Holy Cross Hospital*	$2,445,270	$512,631	$512,628	$0	$758,471	$26,508,263	$30,737,263
Howard County General Hospital	$0	$300,729	$300,732	$0	$730,090	$5,553,000	$6,884,551
Johns Hopkins Bayview Medical Center	$27,599,517	$666,316	$666,312	$17,998	$1,158,024	$23,211,000	$53,319,167
Johns Hopkins Hospital	$126,582,418	$2,468,450	$2,468,448	$66,884	$3,994,470	$43,951,600	$179,532,270

Hospital Name	DME	NSP I	NSP II	Population Health Workforce Support for Disadvantaged Areas Program	Regional Partnership Catalyst Grant Program	Charity Care	Total Rate Support
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	$0	$63,226	$63,228	$0	$0	$876,784	$1,003,238
McNew Family Health Center	$0	$0	$0	$0	$0	$70,300	$70,300
MedStar Franklin Square Medical Center	$10,939,284	$590,598	$590,604	$11,292	$281,098	$13,546,067	$25,958,943
MedStar Good Samaritan Hospital	$2,972,699	$269,020	$269,016	$9,555	$134,072	$7,206,551	$10,860,914
MedStar Harbor Hospital	$2,578,338	$183,866	$183,864	$8,686	$92,907	$6,380,276	$9,427,938
MedStar Montgomery Medical Center	$0	$183,547	$183,552	$0	$0	$5,332,559	$5,699,658
MedStar Southern Maryland Hospital Center	$0	$281,382	$281,388	$0	$1,985,576	$8,131,773	$10,680,118
MedStar St. Mary's Hospital	$0	$199,026	$199,032	$0	$175,372	$3,720,620	$4,294,050
MedStar Union Memorial Hospital	$12,353,292	$431,563	$431,568	$8,686	$211,206	$7,871,609	$21,307,924
Mercy Medical Center	$5,003,208	$548,690	$548,688	$0	$275,563	$20,692,798	$27,068,947
Meritus Medical Center	$5,067,300	$362,959	$362,964	$0	$1,165,167	$9,872,100	$16,830,490
Mt. Washington Pediatric Hospital	$0	$63,083	$0	$0	$0	$5,413	$68,496
Northwest Hospital Center, Inc.	$0	$268,079	$268,080	$0	$134,977	$4,603,315	$5,274,451
Saint Agnes Healthcare, Inc.	$5,944,162	$420,145	$420,144	$0	$634,035	$14,976,631	$22,395,116
Sheppard Pratt	$2,789,578	$153,498	$0	$0	$0	$6,720,914	$9,663,991
Sinai Hospital of Baltimore, Inc.	$20,400,776	$824,394	$824,400	$6,428	$1,104,029	$11,468,052	$34,628,079
Suburban Hospital	$448,869	$323,439	$323,436	$0	$696,192	$6,501,013	$8,292,949
TidalHealth McCready Pavilion *	$0	$11,740	$11,736	$0	$0	$144,000	$167,476
TidalHealth Peninsula Regional*	$0	$460,021	$460,020	$0	$1,763,515	$11,866,700	$14,550,256
UM Capital Region Health	$5,899,614	$371,258	$371,256	$0	$2,652,849	$11,259,442	$20,554,419
UM Rehabilitation & Orthopaedic Institute	$1,773,068	$114,262	$114,264	$0	$0	$1,023,000	$3,024,594
Univ. of Maryland Baltimore Washington Medical Center	$751,420	$438,784	$438,780	$0	$0	$6,170,000	$7,798,984
Univ. of Maryland Charles Regional Medical Center	$0	$155,189	$155,184	$0	$411,357	$1,850,000	$2,571,730
Univ. of Maryland Harford Memorial Hospital	$0	$100,311	$100,308	$0	$0	$1,298,000	$1,498,619

Hospital Name	DME	NSP I	NSP II	Population Health Workforce Support for Disadvantaged Areas Program	Regional Partnership Catalyst Grant Program	Charity Care	Total Rate Support
Univ. of Maryland Medical Center	$161,545,931	$1,602,322	$1,602,324	$20,847	$2,066,012	$22,001,000	$188,838,436
Univ. of Maryland Medical Center Midtown Campus	$3,792,656	$216,538	$216,540	$19,211	$1,378,774	$3,907,000	$9,530,718
Univ. of Maryland Shore Medical Center at Chestertown	$0	$44,652	$44,652	$0	$0	$1,034,000	$1,123,304
Univ. of Maryland Shore Medical Center at Dorchester	$0	$38,595	$38,592	$0	$0	$323,000	$400,187
Univ. of Maryland Shore Medical Center at Easton	$0	$237,514	$237,516	$0	$0	$3,390,650	$3,865,680
Univ. of Maryland St. Joseph Medical Center	$0	$372,898	$372,900	$0	$194,932	$4,433,161	$5,373,890
Univ. of Maryland Upper Chesapeake Health	$0	$312,241	$312,240	$0	$0	$4,448,000	$5,072,481
UPMC Western Maryland	$0	$317,292	$317,292	$0	$1,132,031	$13,031,700	$14,798,314
Total	**$412,441,216**	**$17,412,986**	**$17,154,888**	**$169,586**	**$26,854,323**	**$375,731,543**	**$849,764,542**

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Appendix J. FY 2022 Community Benefit Analysis

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2022 Amount in Rates for Charity Care, DME, NSPI, NSPII, Population Health Workforce, & Regional Partnership Catalyst Funding*	Total Net CB[39]	Total Net CB as % of Operating Expense	Charity Care Amount Reported in Financial Report Submission
Adventist HealthCare Fort Washington Medical Center	$61,599,333	$3,929,364	6.38%	$1,137,929	$2,791,434	4.53%	$613,543
Adventist HealthCare Rehabilitation	$57,545,302	$3,323,589	5.78%	$41,538	$3,282,052	5.70%	$989,760
Adventist HealthCare Shady Grove Medical Center	$429,916,114	$33,407,654	7.77%	$14,560,970	$18,846,685	4.38%	$9,523,791
Adventist HealthCare White Oak Medical Center	$316,057,692	$33,884,822	10.72%	$10,746,075	$23,138,747	7.32%	$11,912,201
Anne Arundel Medical Center	$672,800,000	$70,326,215	10.45%	$12,225,746	$58,100,469	8.64%	$4,976,327
Atlantic General Hospital	$154,127,092	$6,329,065	4.11%	$2,263,370	$4,065,695	2.64%	$1,620,972
CalvertHealth Medical Center	$146,404,724	$8,480,244	5.79%	$3,113,799	$5,366,445	3.67%	$2,799,501

[39] The values in this column have been calculated by subtracting the total rate support each hospital received for charity care and the DME, NSPI, NSPII, Population Health Workforce, & Regional Partnership Catalyst funding programs from the hospital's total community benefit expense. Hospitals' offsetting revenue has already been subtracted from their total community benefit expense value.

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2022 Amount in Rates for Charity Care, DME, NSPI, NSPII, Population Health Workforce, & Regional Partnership Catalyst Funding*	Total Net CB[39]	Total Net CB as % of Operating Expense	Charity Care Amount Reported in Financial Report Submission
Carroll Hospital Center	$269,285,583	$21,778,511	8.09%	$3,701,248	$18,077,263	6.71%	$3,120,445
ChristianaCare, Union Hospital	$201,277,425	$15,107,774	7.51%	$2,722,642	$12,385,132	6.15%	$2,395,905
Doctors Community Hospital	$243,435,000	$23,959,117	9.84%	$9,224,840	$14,734,278	6.05%	$8,470,800
Frederick Health Hospital	$408,396,000	$52,789,456	12.93%	$8,903,195	$43,886,261	10.75%	$8,370,062
Grace Medical Center	$43,098,140	$3,965,483	9.20%	$244,742	$3,720,740	8.63%	$166,170
Greater Baltimore Medical Center	$605,730,943	$63,840,913	10.54%	$11,094,740	$52,746,172	8.71%	$2,773,030
GRMC, Inc., DBA Garrett Regional Medical Ctr.	$63,270,654	$8,138,226	12.86%	$2,964,371	$5,173,855	8.18%	$2,860,842
Holy Cross Germantown Hospital	$134,492,223	$7,311,368	5.44%	$3,651,399	$3,659,969	2.72%	$3,275,651
Holy Cross Hospital	$523,163,323	$51,585,684	9.86%	$30,737,263	$20,848,422	3.99%	$32,744,408
Howard County General Hospital	$323,918,000	$32,365,979	9.99%	$6,884,551	$25,481,428	7.87%	$5,553,000
Johns Hopkins Bayview Medical Center	$773,596,000	$102,988,357	13.31%	$53,319,167	$49,669,191	6.42%	$23,211,000
Johns Hopkins Hospital	$2,920,138,000	$331,053,361	11.34%	$179,532,270	$151,521,092	5.19%	$43,952,000

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2022 Amount in Rates for Charity Care, DME, NSPI, NSPII, Population Health Workforce, & Regional Partnership Catalyst Funding*	Total Net CB[39]	Total Net CB as % of Operating Expense	Charity Care Amount Reported in Financial Report Submission
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	$85,146,042	$2,696,665	3.17%	$1,003,238	$1,693,427	1.99%	$876,784
McNew Family Health Center	$9,323,321	$2,372,787	25.45%	$70,300	$2,302,487	24.70%	$70,341
MedStar Franklin Square Medical Center	$669,486,011	$54,299,495	8.11%	$25,958,943	$28,340,552	4.23%	$13,546,067
MedStar Good Samaritan Hospital	$311,646,463	$24,857,973	7.98%	$10,860,914	$13,997,059	4.49%	$7,212,228
MedStar Harbor Hospital	$218,397,738	$24,340,077	11.14%	$9,427,938	$14,912,139	6.83%	$6,380,276
MedStar Montgomery Medical Center	$205,575,926	$11,545,813	5.62%	$5,699,658	$5,846,155	2.84%	$5,332,559
MedStar Southern Maryland Hospital Center	$297,984,021	$23,252,596	7.80%	$10,680,118	$12,572,477	4.22%	$8,131,773
MedStar St. Mary's Hospital	$189,706,615	$17,166,801	9.05%	$4,294,050	$12,872,751	6.79%	$3,911,833
MedStar Union Memorial Hospital	$500,756,162	$38,264,449	7.64%	$21,307,924	$16,956,526	3.39%	$7,871,609
Mercy Medical Center	$549,134,673	$73,520,594	13.39%	$27,068,947	$46,451,648	8.46%	$20,692,798
Meritus Medical Center	$478,452,262	$53,181,374	11.12%	$16,830,490	$36,350,884	7.60%	$10,003,851

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2022 Amount in Rates for Charity Care, DME, NSPI, NSPII, Population Health Workforce, & Regional Partnership Catalyst Funding*	Total Net CB[39]	Total Net CB as % of Operating Expense	Charity Care Amount Reported in Financial Report Submission
Mt. Washington Pediatric Hospital	$64,585,597	$2,523,069	3.91%	$68,496	$2,454,573	3.80%	$5,413
Northwest Hospital Center, Inc.	$305,327,335	$25,188,533	8.25%	$5,274,451	$19,914,083	6.52%	$4,603,315
Saint Agnes Healthcare, Inc.	$506,146,000	$45,950,554	9.08%	$22,395,116	$23,555,438	4.65%	$16,175,690
Sheppard Pratt	$254,683,598	$33,085,290	12.99%	$9,663,991	$23,421,300	9.20%	$6,720,914
Sinai Hospital of Baltimore, Inc.	$912,336,095	$91,908,449	10.07%	$34,628,079	$57,280,370	6.28%	$11,488,577
Suburban Hospital	$359,685,000	$35,851,044	9.97%	$8,292,949	$27,558,095	7.66%	$6,501,000
TidalHealth McCready Pavilion	$8,749,900	$582,789	6.66%	$167,476	$415,313	4.75%	$144,000
TidalHealth Peninsula Regional	$445,496,000	$29,157,396	6.54%	$14,550,256	$14,607,140	3.28%	$11,921,900
Univ. of Maryland Baltimore Washington Medical Center	$445,181,000	$24,679,564	5.54%	$7,798,984	$16,880,580	3.79%	$6,170,000
Univ. of Maryland Capital Region Health	$365,558,000	$58,344,610	15.96%	$20,554,419	$37,790,191	10.34%	$10,414,000
Univ. of Maryland Charles Regional Medical Center	$153,803,523	$14,585,256	9.48%	$2,571,730	$12,013,526	7.81%	$1,849,670

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2022 Amount in Rates for Charity Care, DME, NSPI, NSPII, Population Health Workforce, & Regional Partnership Catalyst Funding*	Total Net CB[39]	Total Net CB as % of Operating Expense	Charity Care Amount Reported in Financial Report Submission
Univ. of Maryland Harford Memorial Hospital	$105,601,000	$5,846,434	5.54%	$1,498,619	$4,347,815	4.12%	$1,298,000
Univ. of Maryland Medical Center	$1,954,590,000	$268,056,170	13.71%	$188,838,436	$79,217,734	4.05%	$22,001,000
Univ. of Maryland Medical Center Midtown Campus	$267,139,000	$37,051,103	13.87%	$9,530,718	$27,520,385	10.30%	$3,907,000
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$115,219,000	$8,362,550	7.26%	$3,024,594	$5,337,956	4.63%	$1,023,000
Univ. of Maryland Shore Medical Center at Chestertown	$44,681,000	$10,525,125	23.56%	$1,123,304	$9,401,821	21.04%	$1,084,000
Univ. of Maryland Shore Medical Center at Dorchester	$28,191,000	$3,840,192	13.62%	$400,187	$3,440,005	12.20%	$386,000
Univ. of Maryland Shore Medical Center at Easton	$231,740,000	$30,779,779	13.28%	$3,865,680	$26,914,099	11.61%	$4,379,000
Univ. of Maryland St. Joseph Medical Center	$383,026,000	$53,404,569	13.94%	$5,373,890	$48,030,679	12.54%	$4,848,000
Univ. of Maryland Upper Chesapeake Medical Center	$300,645,000	$15,481,651	5.15%	$5,072,481	$10,409,170	3.46%	$4,448,000

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2022 Amount in Rates for Charity Care, DME, NSPI, NSPII, Population Health Workforce, & Regional Partnership Catalyst Funding*	Total Net CB[39]	Total Net CB as % of Operating Expense	Charity Care Amount Reported in Financial Report Submission
UPMC Western Maryland	$346,075,327	$69,376,372	20.05%	$14,798,314	$54,578,058	15.77%	$13,988,602
All Hospitals	**$19,462,320,156**	**$2,064,644,308**	**10.61%**	**$849,764,542**	**$1,214,879,766**	**6.24%**	**$386,716,607**
Averages, All Hospitals	**$381,614,121**	**$40,483,222**	**10.02%**	**$16,662,050**	**$23,821,172**	**7.09%**	**$7,582,679**

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Appendix K. FY 2022 Hospital Community Benefit Aggregate Data

	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Net Community Benefit[40] with Indirect Cost	Net Community Benefit without Indirect Cost
Unreimbursed Medicaid Costs							
T99	**Medicaid Assessments**	**$290,366,246**	[41]		**$234,744,469**	**$55,621,777**	**$55,621,777**
Community Health Services							
A10	Community Health Education	$14,297,207	$7,904,346	$399,600	$1,091,497	$20,710,456	$12,806,110
A11	Support Groups	$2,488,662	$1,650,631		$3,412	$4,135,881	$2,485,250
A12	Self-Help	$1,052,642	$537,017		$166,166	$1,423,493	$886,476
A20	Community-Based Clinical Services	$20,663,544	$6,295,352	$1,145,629	$3,790,114	$22,023,153	
A21	Screenings	$3,035,649	$1,901,011		$315,839	$4,620,821	$2,719,810
A22	One-Time/Occasionally Held Clinics	$1,355,451	$83,653		$845	$1,438,259	$1,354,606
A23	Clinics for Underinsured and Uninsured	$6,422,981	$3,108,798		$54,591	$9,477,188	$6,368,390
A24	Mobile Units	$2,615,567	$938,963		$1,373,787	$2,180,743	$1,241,780
A30	Health Care Support Services	$64,999,991	$23,049,393	$8,120,740	$10,959,859	$68,968,785	$45,919,392
A40	Other	$8,044,106	$4,181,290	$2,057,815	$393,651	$9,773,930	$5,592,640
A99	**Total**	**$124,975,800**	**$49,650,455**	**$11,723,784**	**$18,149,762**	**$144,752,709**	**$95,102,254**
Health Professions Education							
B10	Physicians/Medical Students	$376,429,674	$205,114,909	$548,688	$2,634,482	$578,361,413	$373,246,504
B20	Nurses/Nursing Students	$28,174,342	$16,355,630	$3,458,205	$2,500	$41,069,267	$24,713,637
B30	Other Health Professionals	$20,467,538	$12,051,639		$168,468	$32,350,709	$20,299,070
B40	Scholarships/Funding for Professional Education	$3,544,728	$2,001,518	$300,729		$5,245,517	$3,243,999

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

	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Net Community Benefit[40] with Indirect Cost	Net Community Benefit without Indirect Cost
B50	Other	$487,545	$465,887		$593,351	$360,081	($105,806)
B99	**Total**	**$429,103,827**	**$235,989,583**	**$4,307,622**	**$3,398,801**	**$657,386,988**	**$421,397,405**
	Mission-Driven Health Services						
C99	**Mission-Driven Health Services Total**	**$1,154,054,339**	**$142,801,930**	**$40,400**	**$572,324,195**	**$724,491,673**	**$581,689,744**
	Research						
D10	Clinical Research	$7,718,605	$4,654,632		$3,247,059	$9,126,178	$4,471,546
D20	Community Health Research	$1,703,202	$649,116		$21,755	$2,330,562	$1,681,447
D30	Other	$559,157	$305,368		166033	$698,491	$393,124
D99	**Total**	**$9,980,964**	**$5,609,116**		**$3,434,847**	**$12,155,232**	**$6,546,117**
	Financial Contributions						
E10	Cash Donations	$11,109,204				$11,109,204	$11,109,204
E20	Grants	$6,234,736			$2,836,705	$3,398,031	$3,398,031
E30	In-Kind Donations	$2,375,783	$6,188		$48,523	$2,333,448	$2,327,260
E40	Cost of Fund Raising for Community Programs	$4,026,969				$4,026,969	$4,026,969
E99	**Total**	**$23,746,693**	**$6,188**		**$2,885,228**	**$20,867,653**	**$20,861,465**
	Community-Building Activities						
F10	Physical Improvements/Housing	$993,118	$167,055		$132,569	$1,027,604	$860,549
F20	Economic Development	$766,973	$34,090			$801,063	$766,973
F30	Community Support	$11,523,192	$4,612,209	$626,414	$2,449,135	$13,059,852	$8,447,643
F40	Environmental Improvements	$592,237	$295,810			$888,047	$592,237
F50	Leadership Development/Training for Community Members	$560,384	$412,505			$972,889	$560,384
F60	Coalition Building	$3,745,025	$2,064,332		$2,167,159	$3,642,198	$1,577,866
F70	Advocacy for Community Health Improvements	$1,103,661	$259,429		$4,990	$1,358,100	$1,098,671

	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Net Community Benefit[40] with Indirect Cost	Net Community Benefit without Indirect Cost
F80	Workforce Development	$3,390,946	$1,595,963		$474,512	$4,512,397	$2,916,434
F90	Other	$2,642,130	$1,147,733			$3,789,863	$2,642,130
F99	**Total**	**$25,317,666**	**$10,589,127**	**$626,414**	**$5,228,365**	**$30,052,014**	**$19,462,887**
	Community Benefit Operations						
G10	Assigned Staff	$6,944,281	$4,060,493		$11,474	$10,993,299	$6,932,807
G20	Community health/health assets assessments	$1,075,217	$837,742		$57,370	$1,855,589	$1,017,847
G30	Other Resources	$1,005,453	$207,703			$1,213,156	$1,005,453
G99	**Total**	**$9,024,951**	**$5,105,938**		**$68,844**	**$14,062,045**	**$8,956,107**
	Charity Care						
H00	**Total Charity Care**						**$386,716,607**
	Foundation-Funded Community Benefits						
J10	Community Services	$1,416,490	$130,272		$107,809	$1,438,953	$1,308,681
J20	Community Building	$371,825	$278,862		$250,250	$400,437	$121,575
J30	Other						
J99	**Total**	**$1,788,315**	**$409,134**		**$358,059**	**$1,839,390**	**$1,430,256**
	Total Hospital Community Benefits						
A99	Community Health Services	$124,975,800	$49,650,455	$11,723,784	$18,149,762	$144,752,709	$95,102,254
B99	Health Professions Education	$429,103,827	$235,989,583	$4,307,622	$3,398,801	$657,386,988	$421,397,405
C99	Mission Driven Health Care Services	$1,154,054,339	$142,801,930	$40,400	$572,324,195	$724,491,673	$581,689,744
D99	Research	$9,980,964	$5,609,116		$3,434,847	$12,155,232	$6,546,117
E99	Financial Contributions	$23,746,693	$6,188		$2,885,228	$20,867,653	$20,861,465
F99	Community Building Activities	$25,317,666	$10,589,127	$626,414	$5,228,365	$30,052,014	$19,462,887
G99	Community Benefit Operations	$9,024,951	$5,105,938		$68,844	$14,062,045	$8,956,107
H99	Charity Care					$386,716,607	$386,716,607

	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Net Community Benefit[40] with Indirect Cost	Net Community Benefit without Indirect Cost
J99	Foundation Funded Community Benefit	$1,788,315	$409,134		$358,059	$1,839,390	$1,430,256
T99	Medicaid Assessments	$290,366,246			$234,744,469	$55,621,777	$55,621,777
K99	**Total Hospital Community Benefit**	**$2,068,358,800**	**$450,161,471**	**$16,698,220**	**$840,592,569**	**$2,047,946,088**	**$1,597,784,617**

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Update on Medicare FFS Data & Analysis

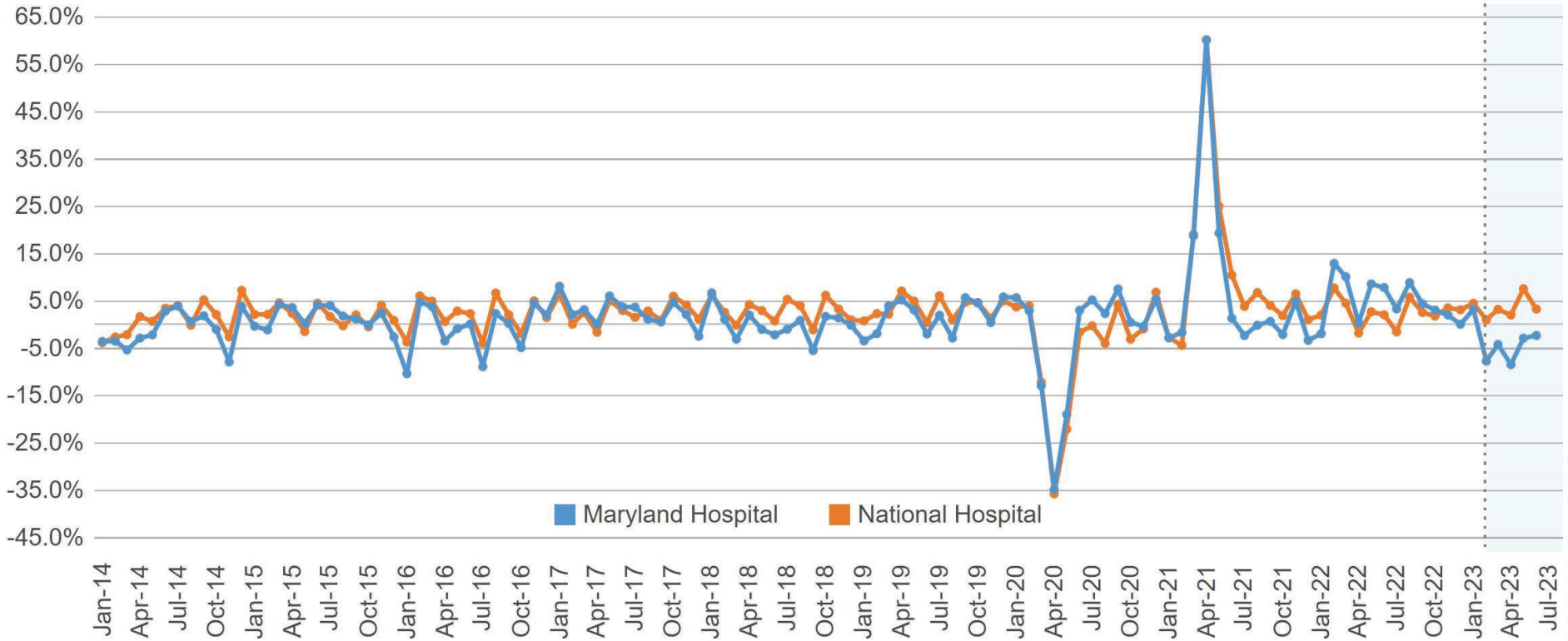
October 2023 Update

Data through June 2023, Claims paid through August 2023

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

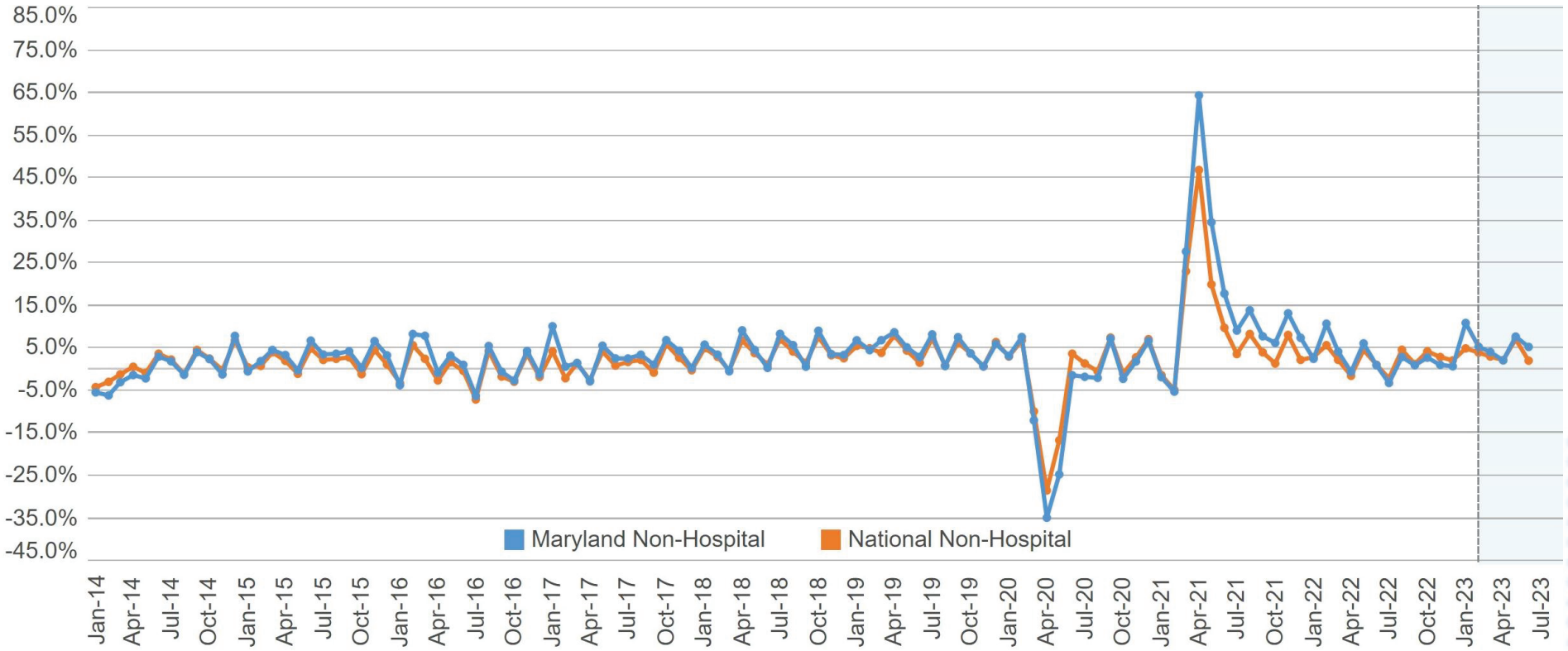
Actual Growth Trend (CY month vs. Prior CY month)



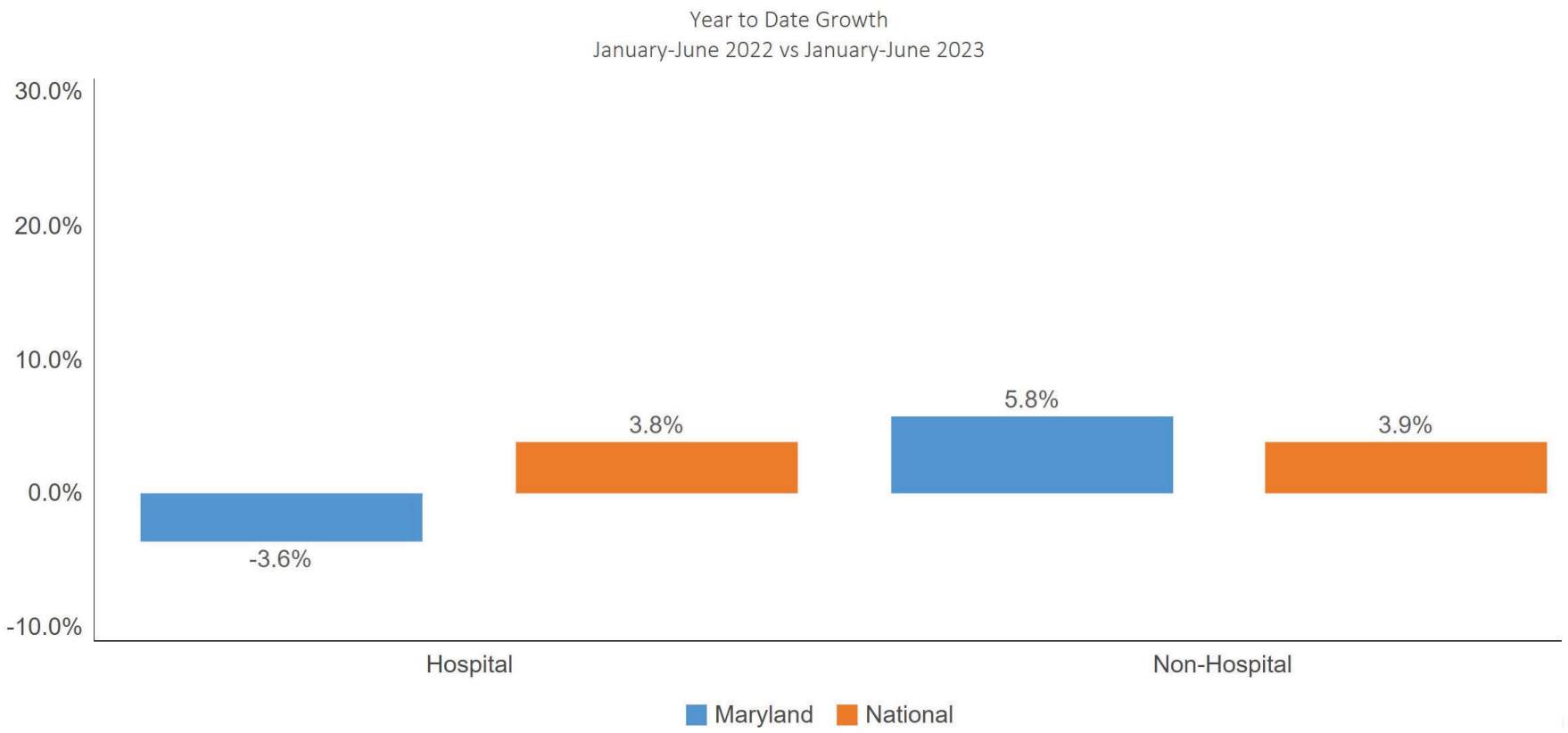
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

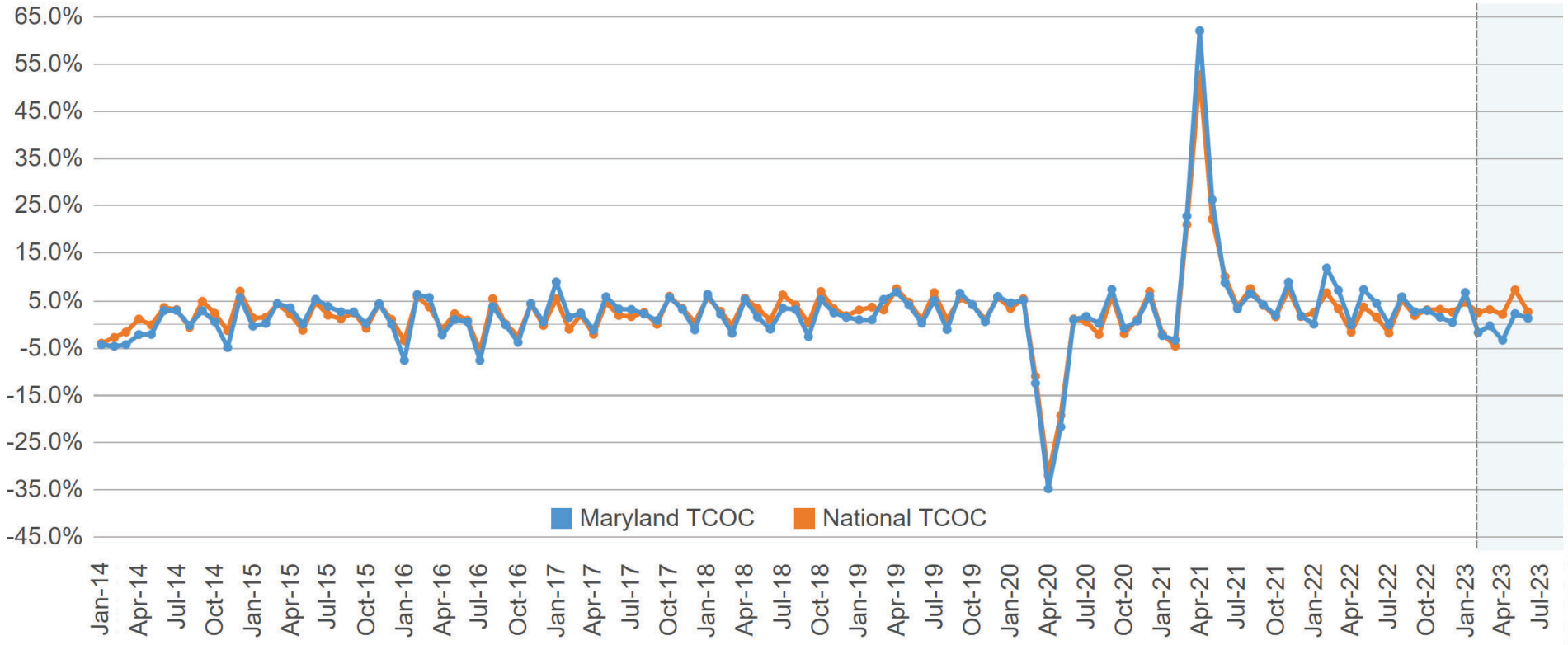


Medicare Hospital and Non-Hospital Payments per Capita



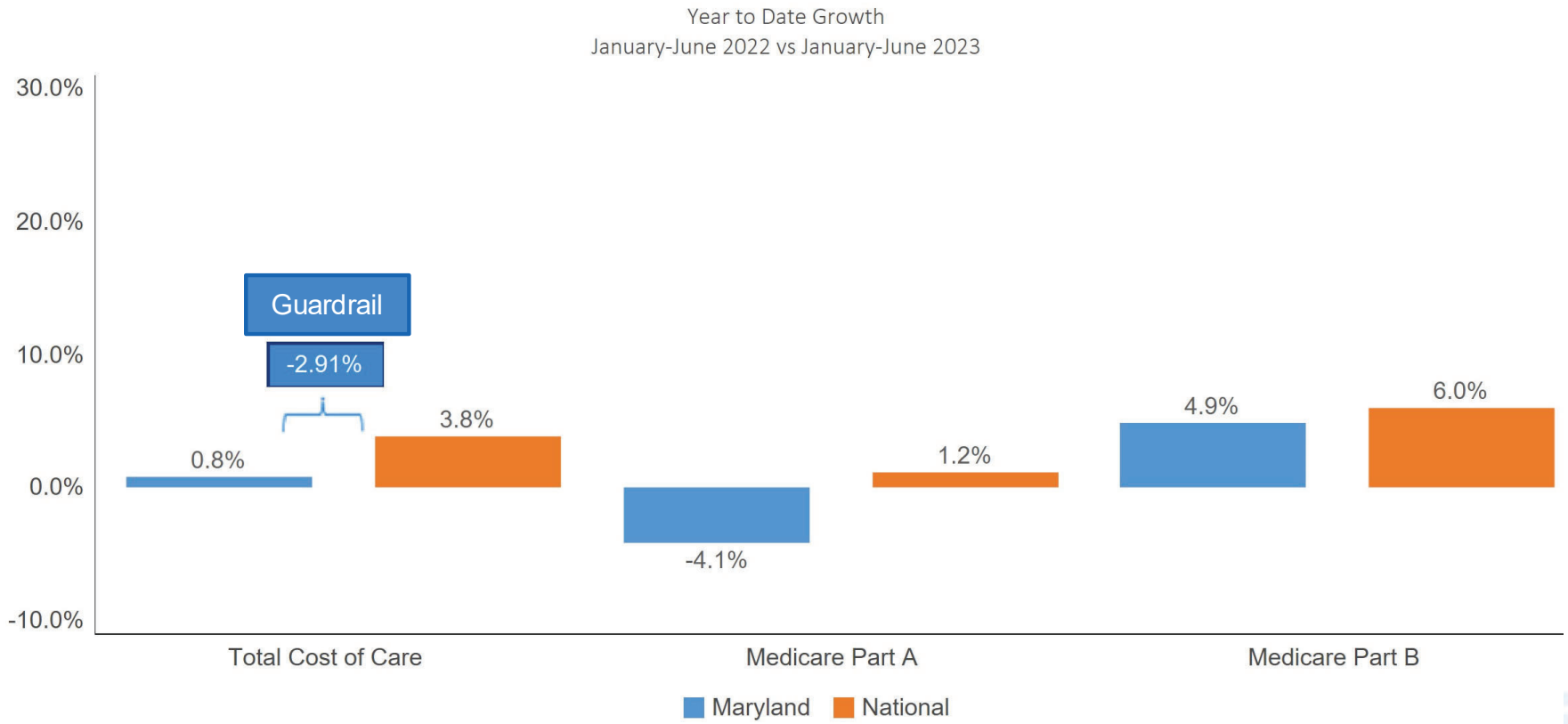
Medicare Total Cost of Care Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)



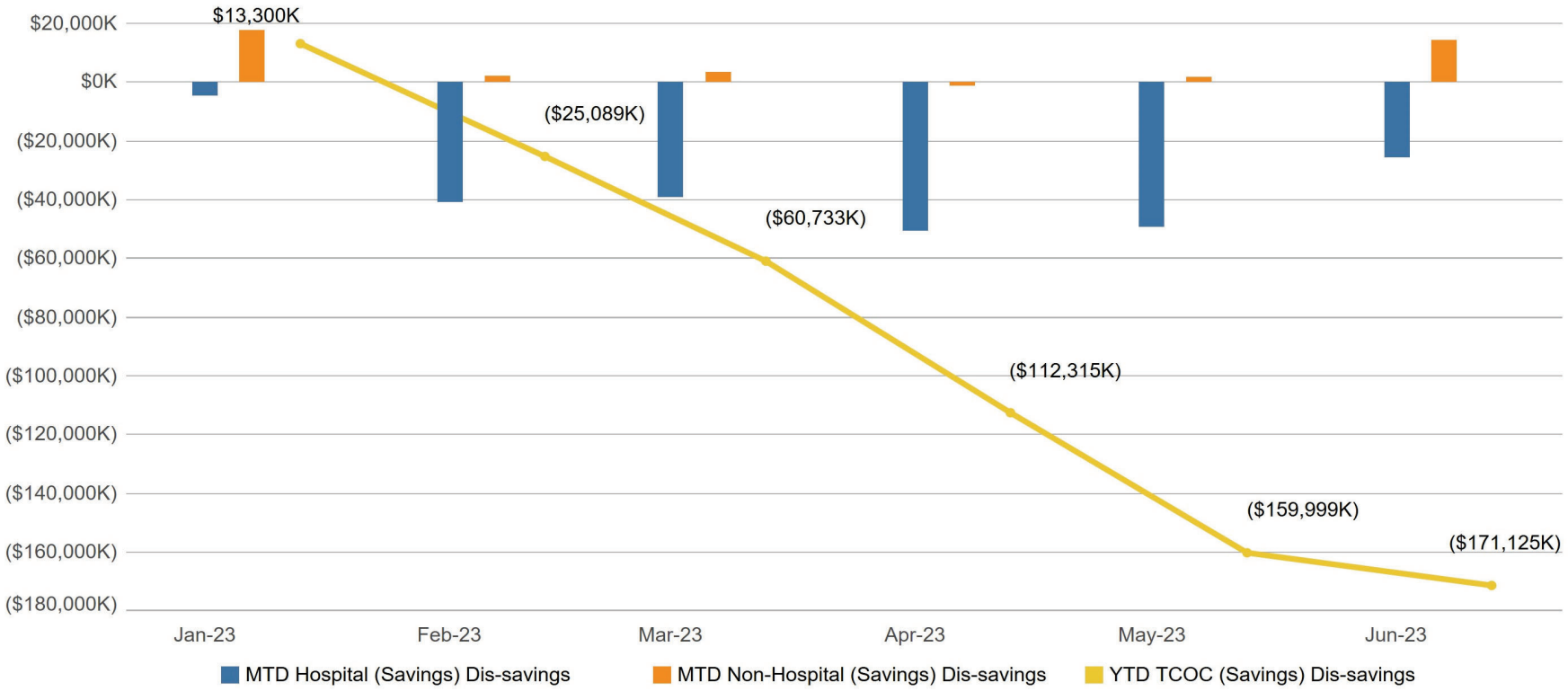
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through June 2023



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Emergency Department Dramatic Improvement Effort (EDDIE)

October Commission Meeting

Geoff Dougherty and Alyson Schuster

EDDIE Overview

- Maryland has underperformed most other states on ED throughput measures since before the start of the All-Payer model
- EDDIE is a Commission-developed quality improvement initiative with two components:

EDDIE: Improved ED Experience for Patients

Quality Improvement

- Rapid cycle QI initiatives to meet hospital set goals related to ED throughput/length of stay
- Learning collaborative
- Convened by MHA

Commission Reporting

- Public reporting of monthly data for three measures
- Led by HSCRC and MIEMSS

MHA Quality Improvement Initiative: Aim Statements

- All hospitals submitted an initial aim statement to MHA as part of the rapid-cycle QI initiative
  - Submitting initial aim statements represents an important first step
  - The intent for the EDDIE Project is to engage in a multi-cycle improvement process to bring Maryland ED length of stay (i.e., wait times) towards the national average within an agreed upon time frame
  - Ongoing monthly progress updates will be critical for executing the intended multi-cycle improvement process.
- When reviewing these aim statements, the HSCRC looked for the following elements:

HSCRC believes some hospitals may need to clarify their aim statements so that they are specific enough to be monitored

Hospital (listed in alphabetical order)	AIM statement
Adventist Fort Wash	By 1/1/24, Adventist Healthcare Ft Washington Medical Center will implement process improvements to decrease EMS turnaround times by 10%.
Adventist Shady Grove	Shady Grove Medical Center Emergency Department is committed to the reduction of LWOBS (left without being seen) by 50% by January 1, 2024. (The national benchmark threshold is 2% and we are currently at 1.31% for the month of September as compared to this time last year of up to 7.95 July 2022, 6.73 August 2022 and 5.80 September 2022) This reduction is in direct correlation with the re-implementation of Supertrack and RPA (results pending area).
Adventist White Oak	By March 31, 2024, the Hospitalist Medicine, Nursing, and Care Navigation leadership teams will redesign the patient discharge process to promptly identify next day discharges and increase discharges by 11A from 11% to 15%
Atlantic General	1) Achieve a LWBS (Left Without Being Seen) rate of 1% or less by 3/1/24. 2)Achieve a median length of stay of 120 minutes or less for ER patients being discharged to home by 3/1/24.
CalvertHealth	1) The CalvertHealth Nursing Division will Decrease admit to floor time from 73 minutes(July 2023) to 45 minutes by June 30, 2024. 2) The CalvertHealth Nursing Division will increase the percent of discharges by 2pm from 41% (July 2023) to 45% by June 2024.
Carroll Hospital	1) Carroll Hospital will utilize Standard Work to increase the percent of discharges by noon from 13% to 25% by July of 2024. 2) Carroll Hospital will utilize Standard Work to increase the percent of discharges by 3pm from 48% to 60% by July 2024. 3) Carroll Hospital will establish a process to track interval data points for patient flow and utilize Standard Work to achieve goal of “Patient in bed within 60 mins from start of room clean” by March of 2024
ChristianaCare	ChristianaCare, Union Hospital will reduce ED arrival to inpatient admission (ED-1a measure) from FY23 median of 422 minutes to median of 410 minutes for the timeframe July 1, 2023 to December 31, 2023.
Frederick Health	By June 30, the Length of Stay Committee, in collaboration with the Stroke Committee, will implement targeted strategies to achieve our expected LOS for stroke patients. (O/E = 1.0)
Garrett Regional	By March 1st, 2024 GRMC will decrease the total average turnaround time for Emergency Department visits by 20 minutes to increase the overall throughput in the Emergency Department.
GBMC	GBMC will decrease Ready to Move (RTM) to Off the Floor (OTF) from 61 minutes to a goal of 45 minutes by June 30, 2024.

Hospital	AIM statement
Grace	Sinai Hospital of Baltimore aims to create a more positive care experience for our patients by reducing length of stay, improving patient flow, and discharging patients safely and timely while maintaining the highest quality of healthcare available for our community throughout our current FY.
Holy Cross	1) By January 2, 2024, the ED Team will increase utilization of the Nurse Handoff tool and identify reasons for Delayed Transfers from the ED to the units to decrease ED median turnaround time from Admit Order to ED Depart by 10%. 2) By January 2, 2024, the Med-Surg Floors will standardize the Interdisciplinary Round Checklist to increase percentage of discharges by 4pm by 5%.
Holy Cross Germantown	1) By January 2, 2024, the ED Team will increase utilization of the Nurse Handoff tool and identify reasons for Delayed Transfers from the ED to the units to decrease ED median turnaround time from Admit
JH Bayview	Johns Hopkins Bayview Medical Center will reduce the time between when a patient is assigned to a unit/bed on selected services and the time the patient departs the Emergency Department by 10% by March 30, 2024.
JH Howard	Johns Hopkins Howard County Medical Center will reduce the time between when a patient is assigned to a unit/bed on selected services and the time the patient departs the Emergency Department by 10% by March 30, 2024.
JH Suburban	Johns Hopkins Suburban Hospital will reduce the time between when a patient is assigned to a unit/bed on selected services and the time the patient departs the Emergency Department by 10% by March 30, 2024.
JHH	Johns Hopkins Hospital will reduce the time between when a patient is assigned to a unit/bed on selected services and the time the patient departs the Emergency Department by 10% by March 30, 2024
Luminis AAMC	1) Luminis Health Anne Arundel Medical Center will reduce ED arrival to discharge home (OP-18a measure) from FY23 median of 258 minutes to median of 245 minutes for the timeframe July 1, 2023 to December 31, 2023 2) Luminis Health Anne Arundel Medical Center will reduce the average inpatient admission to SNF referral by 0.50 days from 6.36 days to 5.86 days by January 31st, 2024.
Luminis DCMC	1) Luminis Health Doctor's Community Medical Center will reduce ED arrival to discharge home (OP18a measure) from FY23 median of 289 minutes to median of 275 minutes for the timeframe July 1, 2023 to December 31, 2023. 2)Luminis Health Doctors Community Medical Center will reduce average inpatient admission to skilled nursing facility referral by 1.0 days from 8.04 days to 7.04 days by January 31, 2024.
Mercy	Mercy Medical Center will reduce overall ED arrival to ED departure time from median 277 minutes in FY23 to median 269 minutes for the timeframe July 1, 2023 to December 31, 2023.

Hospital	AIM statement
Meritus	Meritus Health will reduce ED arrival to discharge home from median 219 minutes in FY23 to 209 minutes (median) from July 1, 2023 to December 31, 2023.
MS Franklin Square	By December of 2023, we will reduce ED waiting room wait times for ESI level 3V, 4, and 5 patients by 10% through the full implementation of a recently piloted LPN-provider team-based model of care.
MS Good Sam	The inpatient/observation units will improve the utilization of the Discharge Hospitality Center (Discharge Lounge or DHC) by; 1) increasing the volume of patients sent to the DHC by 20% per week. 2) Improving the average DHC arrival time by 30 minutes by January 2024.
MS Harbor	Over the next six months, MHH will implement an early discharge stratification program, bedside medication delivery day prior to discharge, and optimization of patient throughput software to impact the reduction of ED1 by 25 minutes (5%) and OP18 by 10 minutes (3%) compared to FY23.
MS Montgomery	By December 2023, the Inpatient team will improve Hospitalist discharge efficiency by 40% and decrease inpatient LOS from 5.3 days to < 4.9 days. The decrease in average LOS will lead to more available beds for ED patients with admission orders and improve overall ED throughput.
MS Southern	By March 31, 2024, MSMHC will decrease the ED2B time by at least 10% compared to median FY23 by restructuring the admission and discharge process.
MS St. Mary's	1) Revise inpatient admission process to expedite bed assignment to improve ED-2B performance. Goal is to decrease ED-2B by 2.5% in FY24. 2) Implement Emergency Department Patient Throughput RN to improve OP-18 performance. Goal is to decrease OP-18 by 2.5% in FY24.
MS Union	The inpatient/observation units will improve the utilization of the Discharge Hospitality Center (Discharge Lounge or DHC) by; 1) increasing the volume of patients sent to the DHC by 20% per week. 2) Improving the average DHC arrival time by 30 minutes by January 2024.
Northwest	1) By end of FY24 the ED will reduce their LOS for admitted patients by 10%. Resulting in an average LOS for admitted patients of 630 minutes. 2) By end of FY24 NW Hospital will increase monthly offloading by 10% over baseline. Achieving goal of 80% of all EMS arrivals offloaded in 30 min or less. 3) By end of FY24 NW hospital will note a 4 % reduction in ALOS. Resulting in a 0.3 reduction from baseline of 6.8 days and a goal of 6.5.
Sinai	Sinai Hospital of Baltimore aims to create a more positive care experience for our patients by reducing length of stay, improving patient flow, and discharging patients safely and timely while maintaining the highest quality of healthcare available for our community throughout our current fiscal year.

Hospital	AIM statement
St Agnes	By March 31,2024 Ascension Saint Agnes med-surg/telemetry units will deploy an improved model of multidisciplinary rounds to increase the following day's discharges before noon to 35% from 25.7% and by June 30, 2024 decrease the percentage of observation stays exceeding 48 hours to 20.5% from 22%
Tidal Health	By January 31, 2024, the Emergency Department and inpatient units will collaborate to decrease the time from the admission order is placed to the time the patient is bedded on the admission unit by 30 minutes.
UM BWMC	By December 31st, the Patient Flow Council will further build out the Expediting Team to increase the number of Departure Lounge patients to 15/day.
UM Cap Region	The Throughput Change Council will implement the Expeditor Role by January 1, 2024 to improve inpatient med-surg discharges by noon by 25% by April 1, 2024.
UM Charles Regional	August 21st CRMC ED implemented a new split flow design triage process to improve “arrival to bed” time, by 15% over the next 60 days.
UM Medical Center	By November 1, 2023, to improve ED throughput and move discharges earlier in the day by 10% over FY23 baseline: Analyze ICU-acute bed ratio and staffing constraints, Analyze hospital system delays, Expand ED vertical 3s and tele-triage, Optimize hospitalist services embedded in ED, Collaborate with lab and radiology on turnaround times
UM Midtown	The Admissions Work Group and Discharge Efficiency Group will merge into Throughput Improvement Council beginning November 1st to achieve 3 of the ADT efficiency goals by end of FY24. ADT Efficiency Goals: ED Boarders < 120 minutes Increase DBN by 4% above FY23 ED Offload time <10% above target Admissions w/out orders 0% Admissions orders written within 60 minutes of decision to admit
UM Shore(Chestertown & Easton)	By January 3, 2024 UM Shore Regional will move discharge order median time written before 12 noon. The current median time for discharge orders written is 14:15. This will be accomplished by implementing our Triad Rounding (11/3/2023) on all units and Care Transition Rounds reorganization (by 11/15/2023) to focus on discharge needs.

Hospital	AIM statement
UM St Joes	1) By January 5th, the ED will create a trial vertical care space in the front end of the ED to decrease arrival to depart times for discharged patients by 10%. 2) By January 5th, SJMC will fully operationalize an AI Capacity Management tool to decrease Inpatient Admission wait time by 10%. 3) By December 15th, the ED will implement a Flow Coordinator Role to ensure 80% of patients are offloaded within 30 minutes of arrival by ambulance.
UM Upper Chesapeake (UC & Harford)	By June 30, 2024 Upper Chesapeake Health will: 1) reduce the LOS of Observation patients by 20% from 1.9 days to 1.52 days; and 2) reduce average total weekly patients boarding hours by 10% from 2143.2 to 1714.6.
UPMC Western MD	By May 31, 2024, UPMC Western Maryland's Emergency Department team will redesign its vertical care model to reduce Total ED Length of Stay for discharged patients excluding psychiatric patients (ED 18b) by 8% (reduction of 19.5 mins for a time of 224.5) over a median baseline of 244 minutes from Sep22-Aug23.

Next steps:

- Decide on statewide long-term goals and timeframe for achievement
- Monitor progress on incremental QI sprints to ensure achievement of long-term goals

September Data 2023 Reporting

Monthly, public reporting of three measures:

- ED1 Inpatient arrival to admission time
- OP18 Outpatient ED arrival to discharge time
- EMS turnaround time (data from MIEMSS)

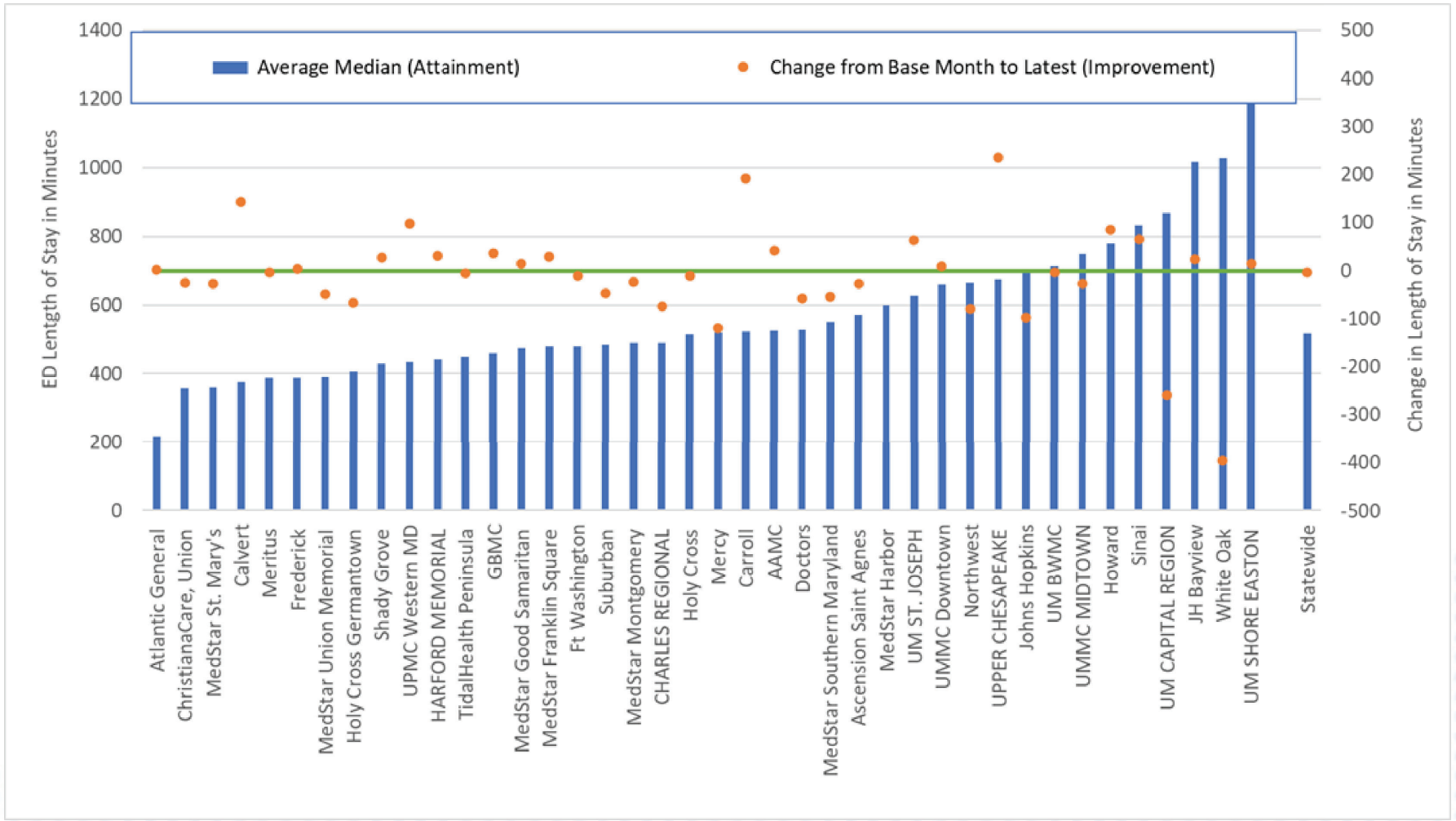
September data received for all hospitals

- Some hospitals have resubmitted previous months as they work through the process of providing the metrics shortly after end of the month
- Garrett reported alternative metrics but is actively working to report requested metrics

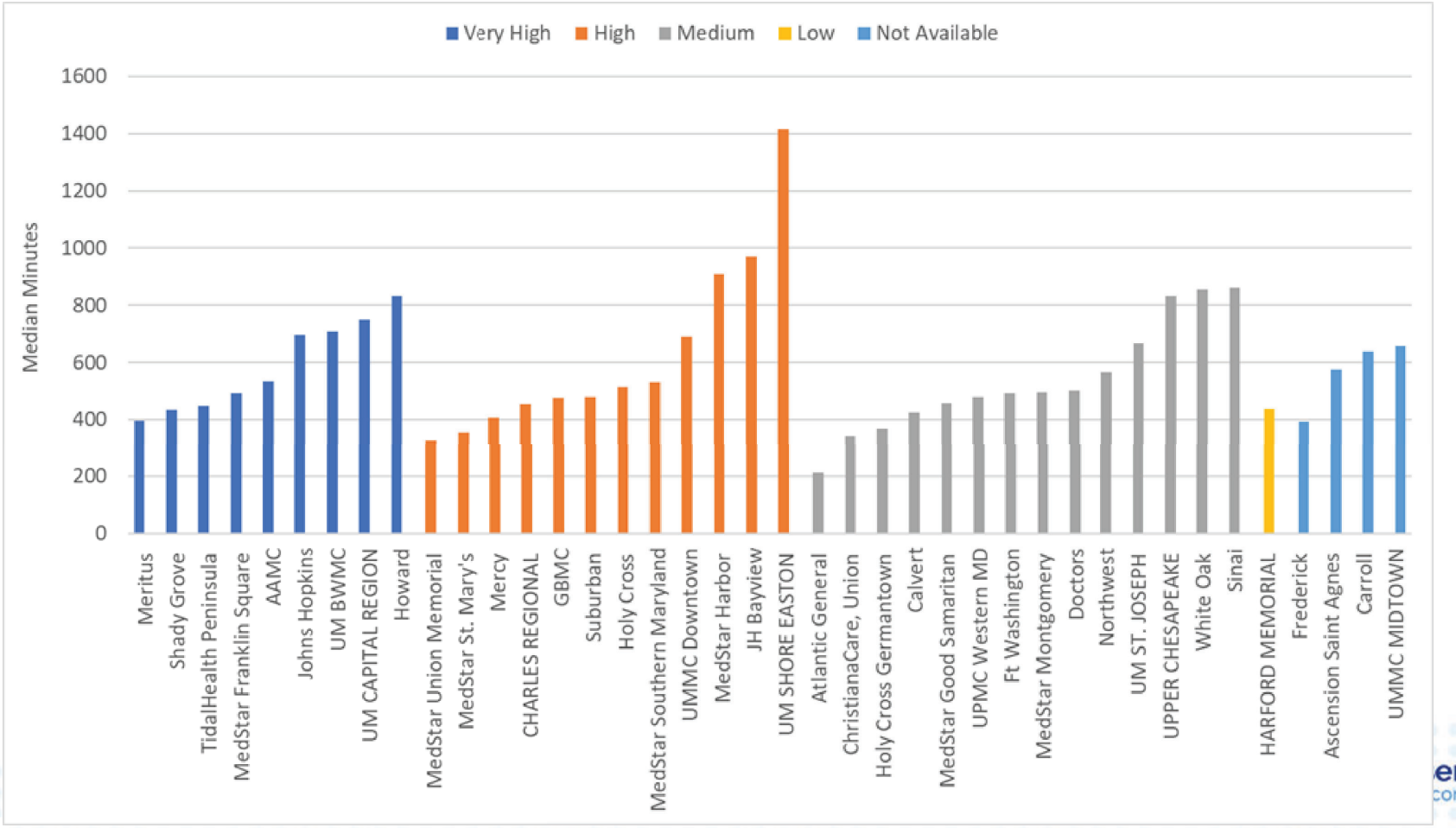
Graphs for ED1a,b,c and OP18a,b,c:

- Rolling median (June-Latest Month) and change from June
- Latest month grouped by CMS ED volume category (volume data is from CMS Care Compare)

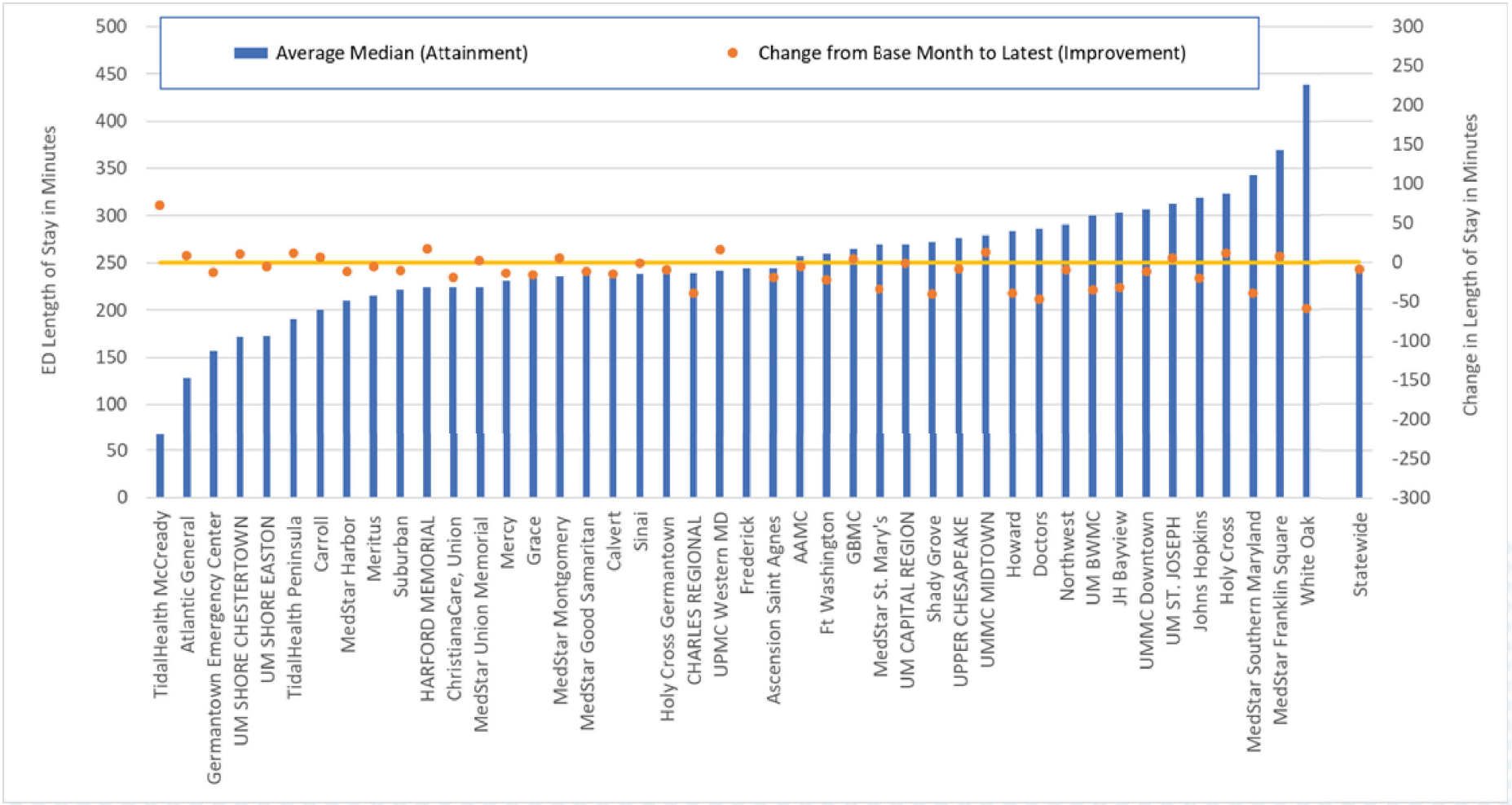
ED 1a: ED Arrival to Inpatient Admission



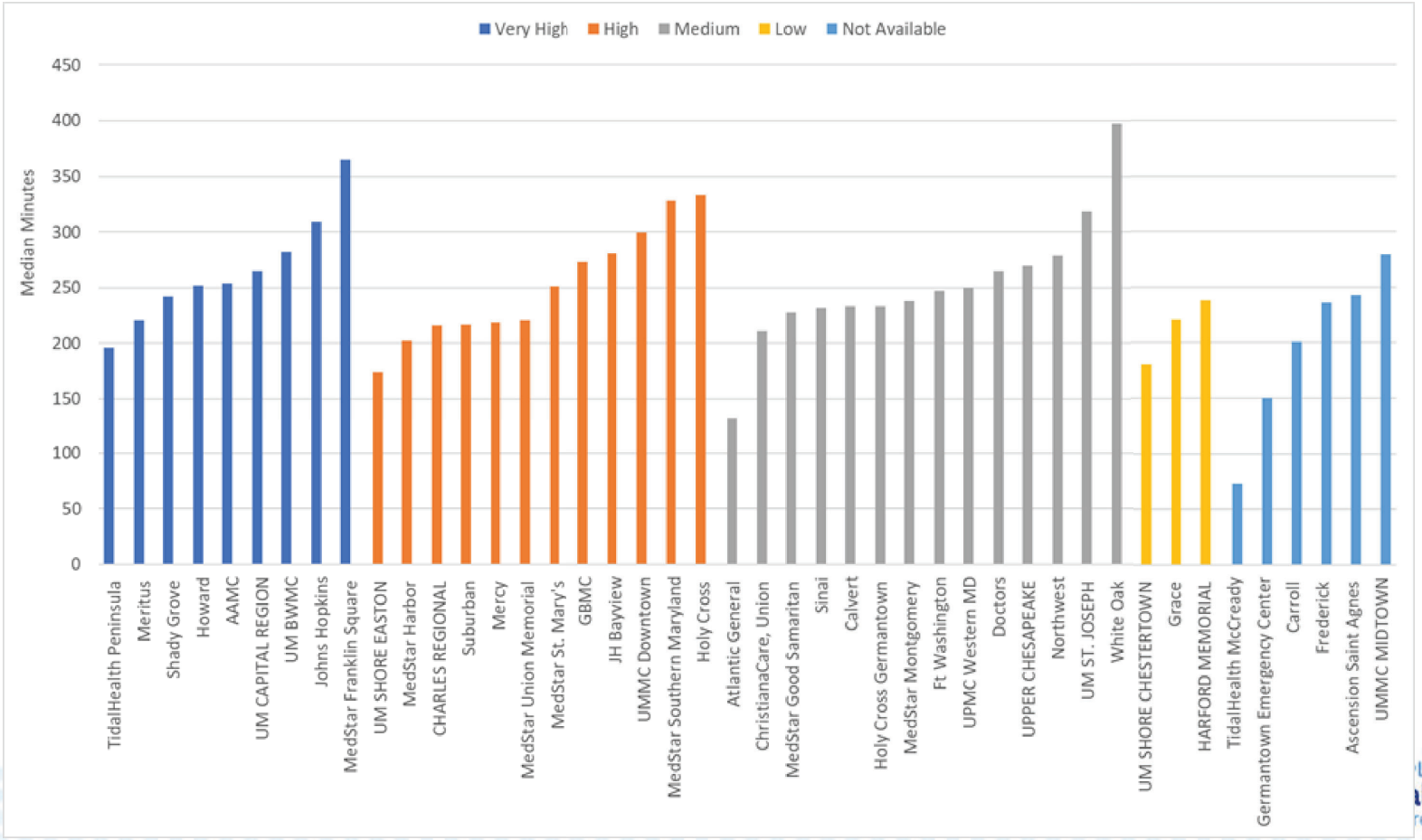
ED 1a: ED Arrival to Inpatient Admission Time
Latest Month Median By Volume



OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time
Latest Month Median By Volume



EMS Turnaround Times: September Performance

90th Percentile: 0-35 Minutes

Atlantic General Hospital
CalvertHealth Medical Center (+)
Cambridge Free-Standing ED
Frederick Health Hospital
Garrett Regional Medical Center
Germantown Emergency Center
Good Samaritan Hospital
Harford Memorial Hospital
Holy Cross Germantown Hospital
Holy Cross Hospital (+)
Johns Hopkins Hospital PEDIATRIC
McCready Health Pavilion
Meritus Medical Center
Montgomery Medical Center
Peninsula Regional
Queenstown Emergency Center
R Adams Cowley Shock Trauma Center
Shady Grove Medical Center
St. Mary's Hospital
Union Hospital
Union Memorial Hospital
Western Maryland

>35 Minutes

Bowie Health Center
Carroll Hospital Center (-)
Charles Regional
Chestertown
Easton
Franklin Square
Grace Medical Center (-)
Greater Baltimore Medical Center
Harbor Hospital
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Northwest Hospital
Sinai Hospital
Southern Maryland Hospital (+)
St. Agnes Hospital
St. Joseph Medical Center (-)
Suburban Hospital
University of Maryland Medical Center
Upper Chesapeake Medical Center

>60 Minutes

Anne Arundel Medical Center
Baltimore Washington Medical Center
Capital Region Medical Center
Doctors Community Medical Center
Fort Washington Medical Center
Howard County General Hospital
White Oak Medical Center

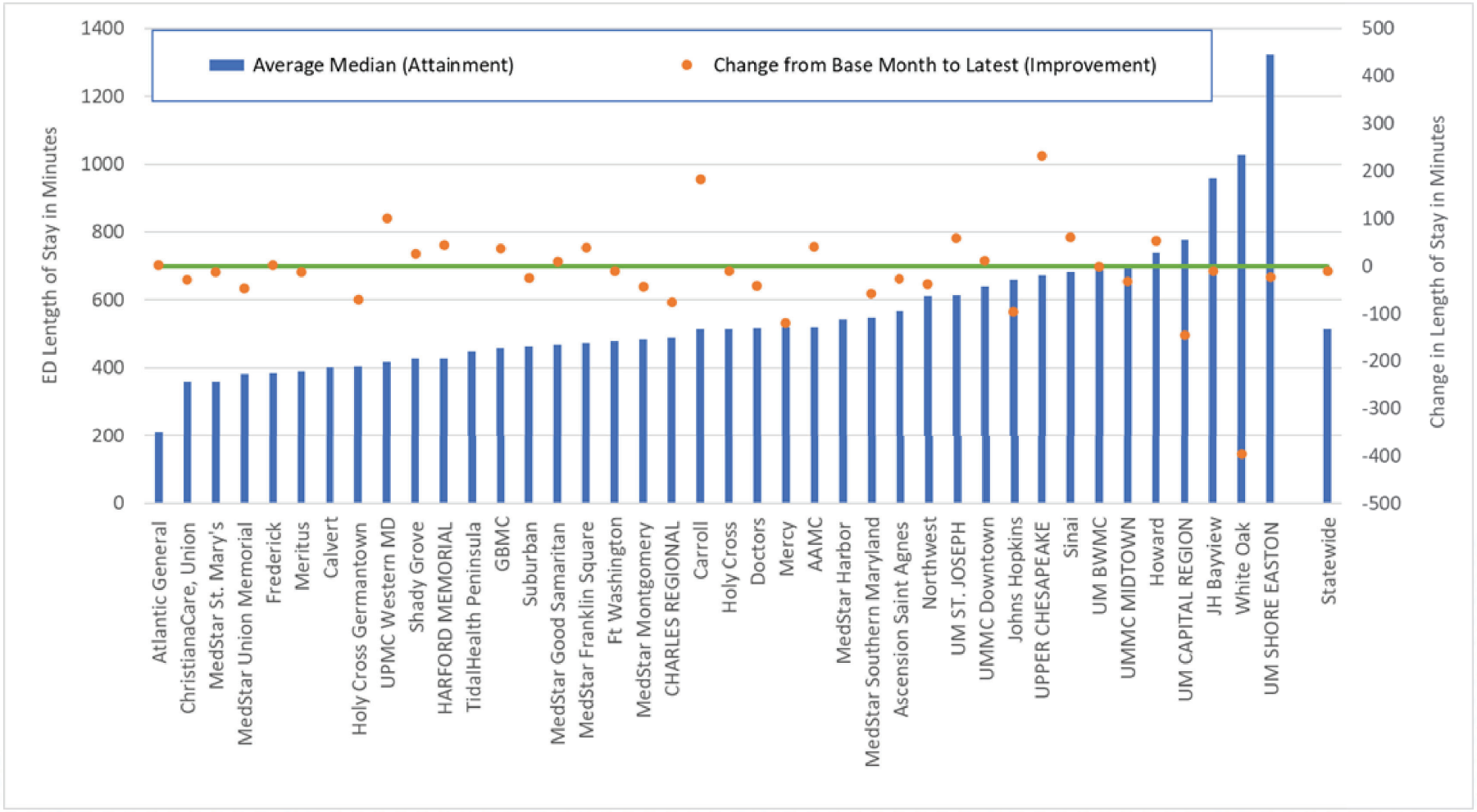
(+): Hospital improved by one or more categories; **(-)**: Hospital declined by one or more categories

Next Steps

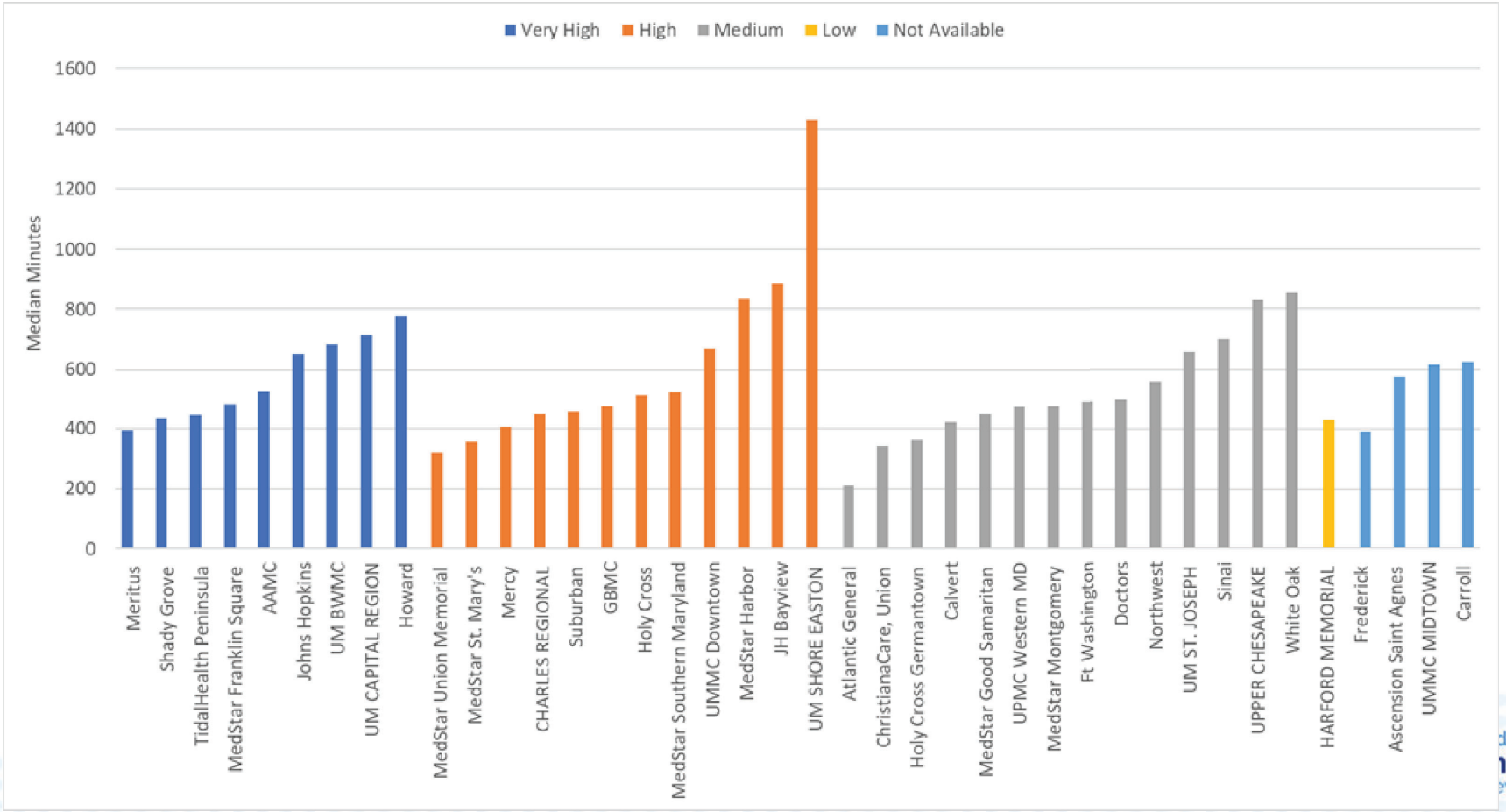
- Provide Commissioners with draft recommendation for inclusion of ED related measures in RY26 (CY24) Quality Based Reimbursement
- Continue monthly data collection from hospitals and MIEMSS
  - Address reporting questions and concerns with hospitals
  - Present results at monthly Commission meeting
  - Add visualizations suggested by Commissioners and other stakeholders
- Collect and present **progress on** hospital improvement goals from MHA at monthly Commission meeting
- Collaborate with MHA on legislative request and EDDIE quality improvement initiative

Appendix

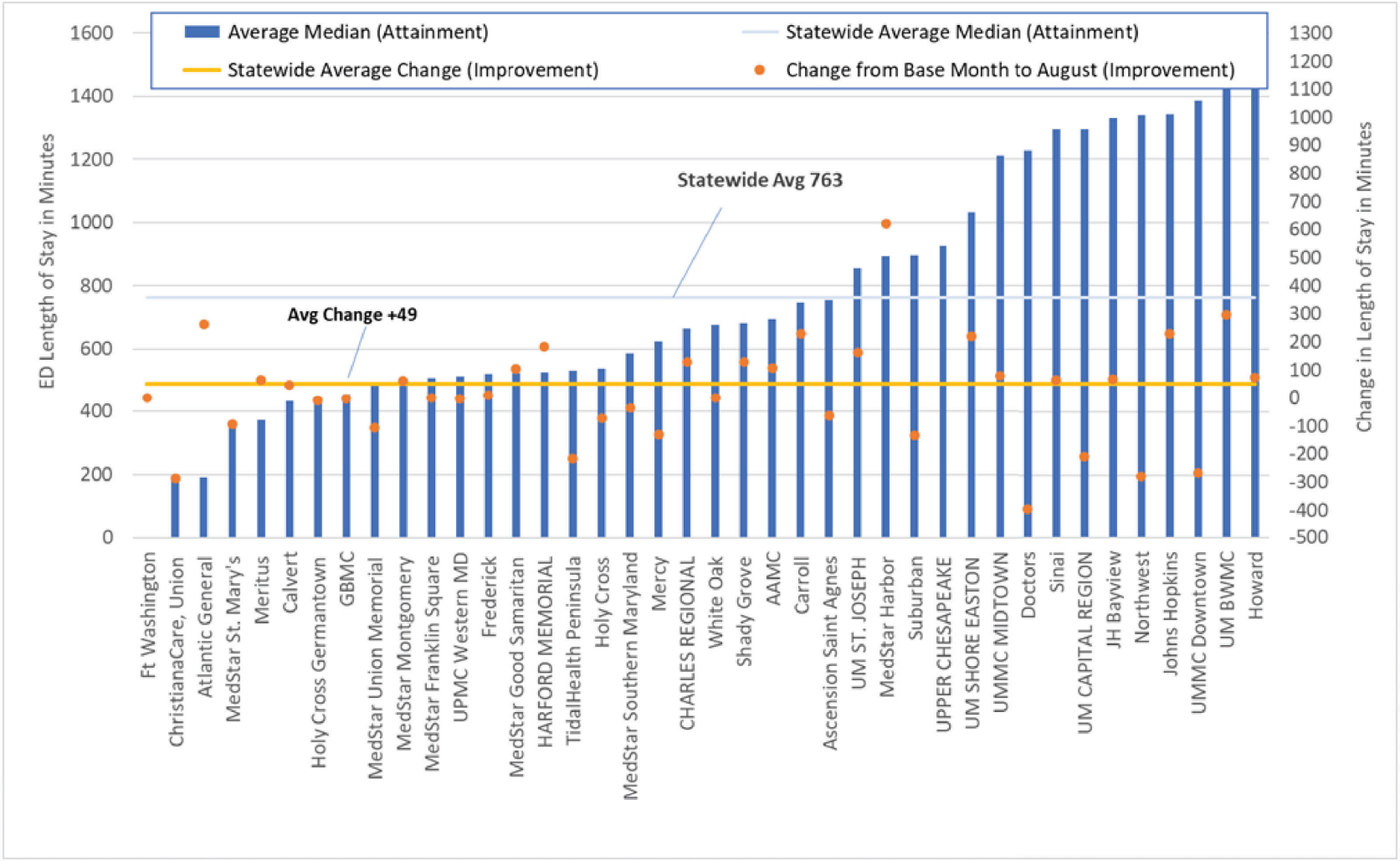
ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



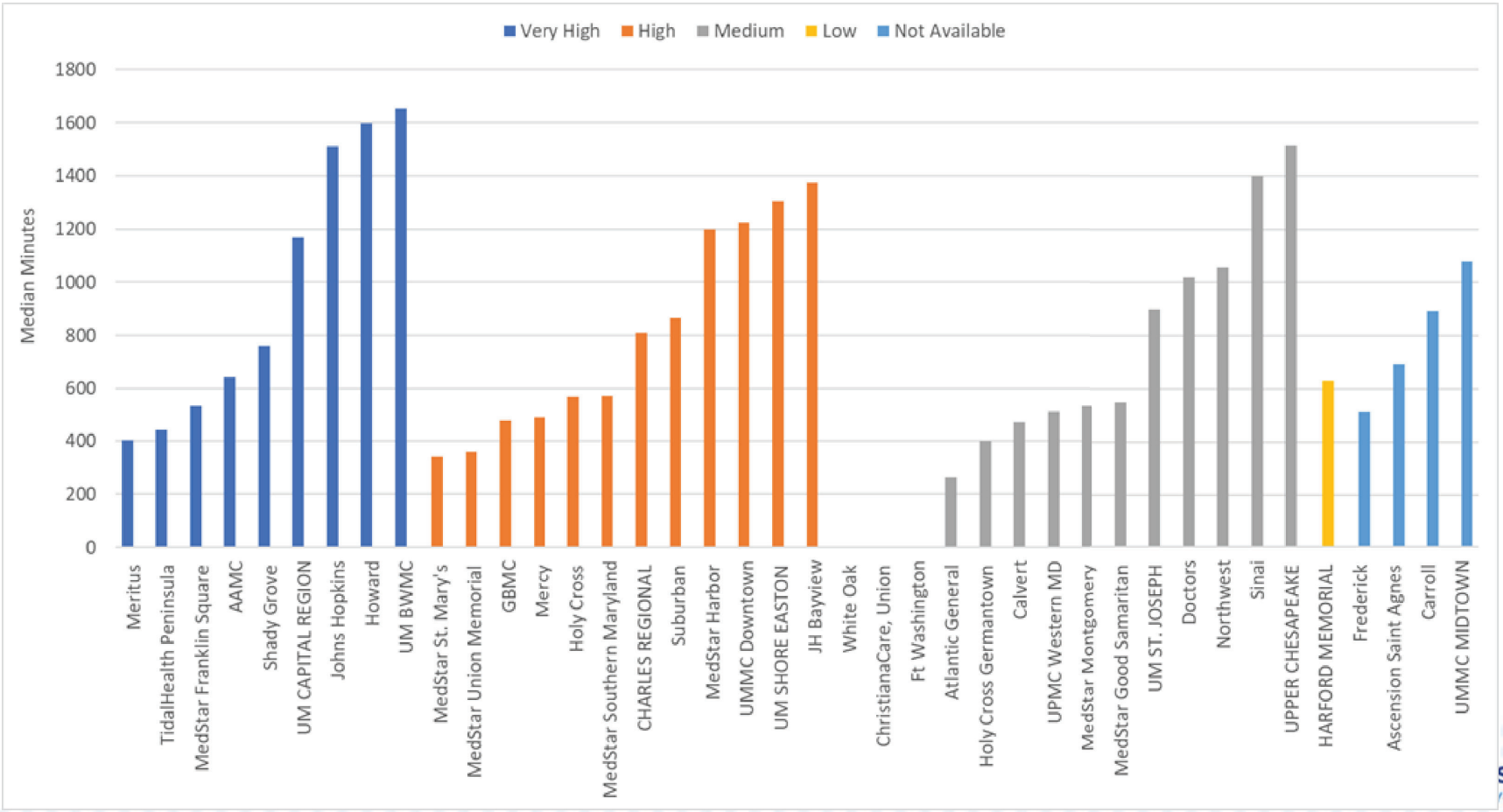
ED 1b: ED Arrival to Inpatient Admission Time by Volume Non-Psychiatric ED Visits



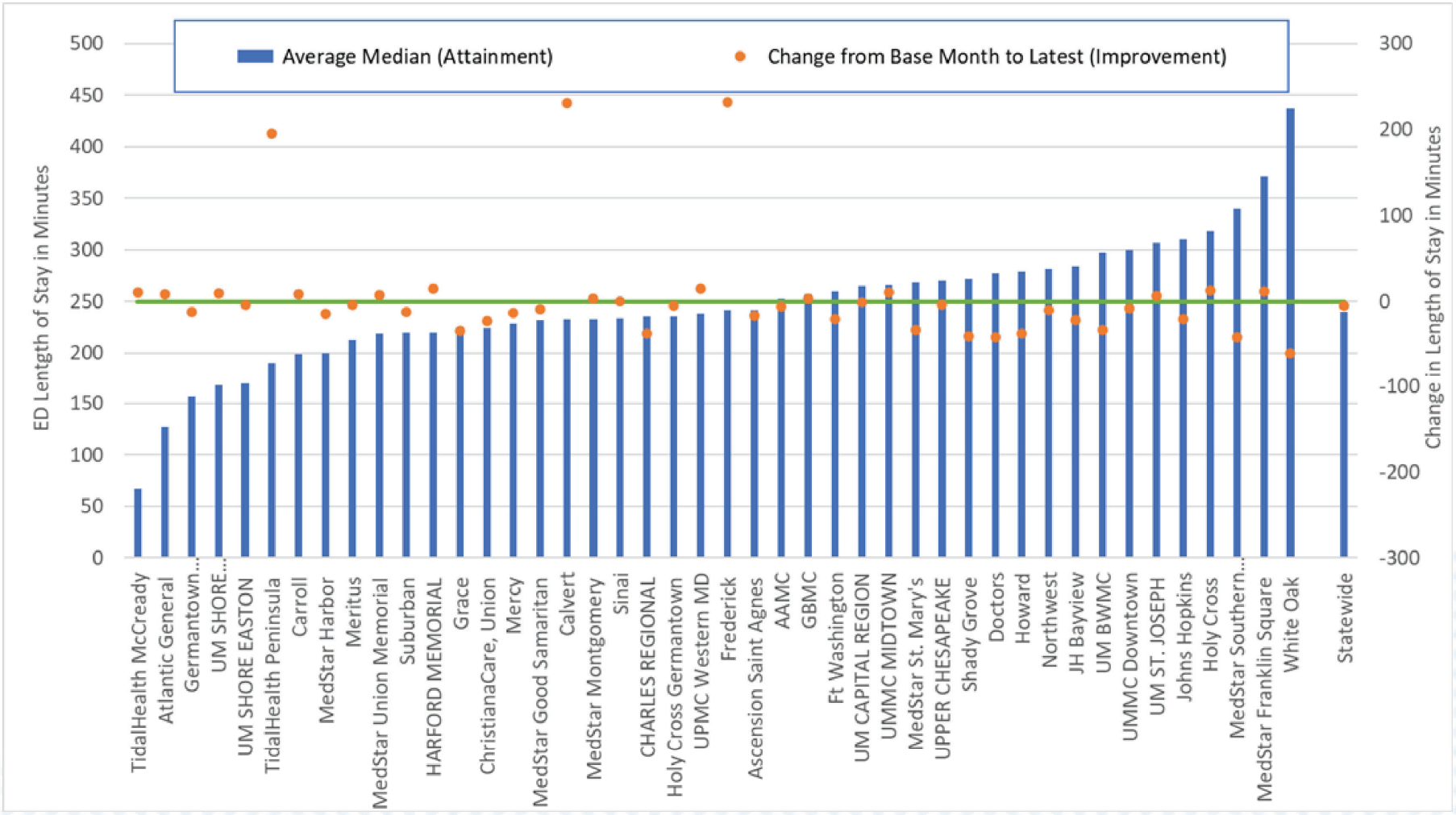
ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



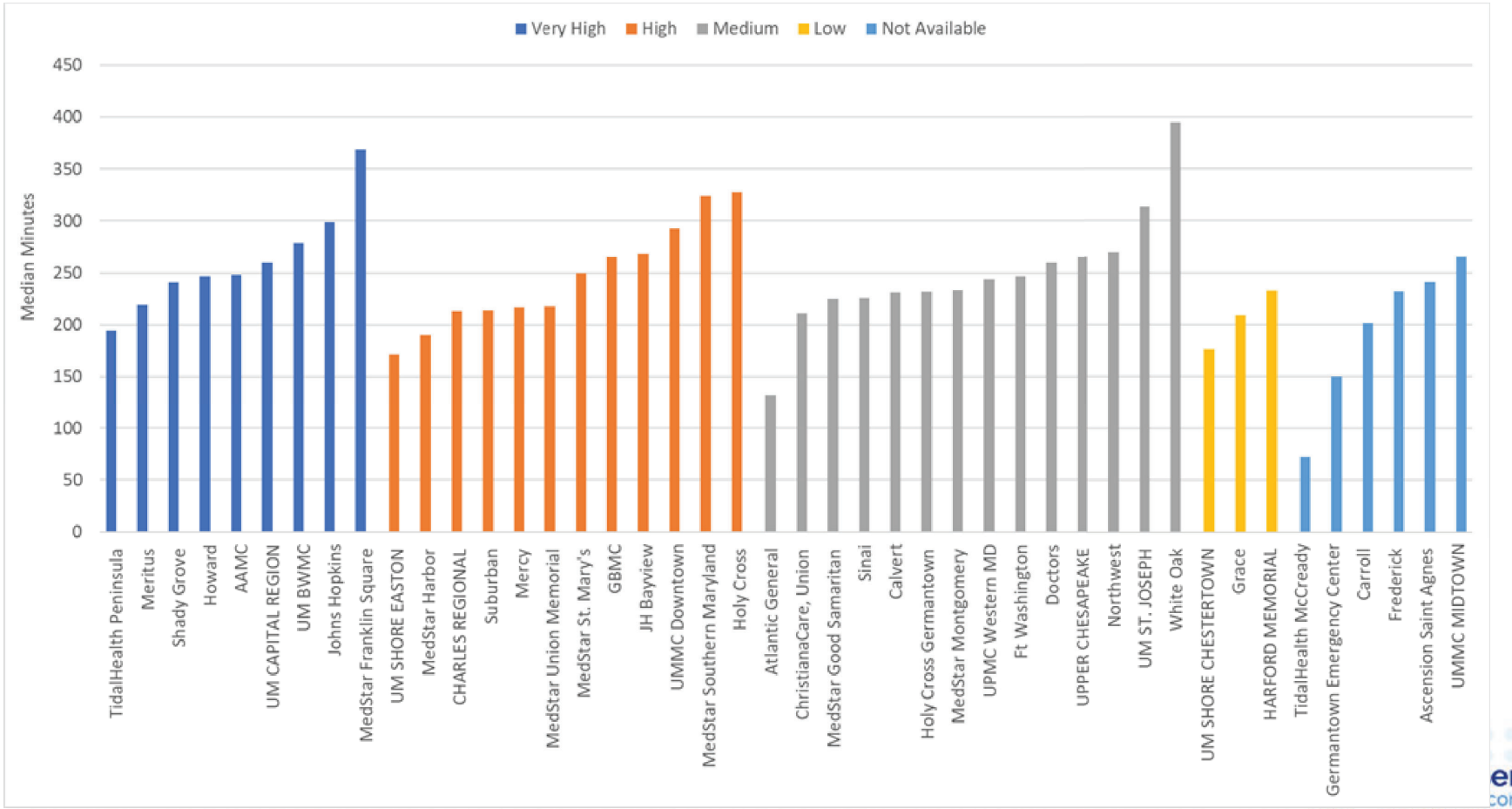
ED 1c: ED Arrival to Inpatient Admission Time by Volume Psychiatric ED Visits



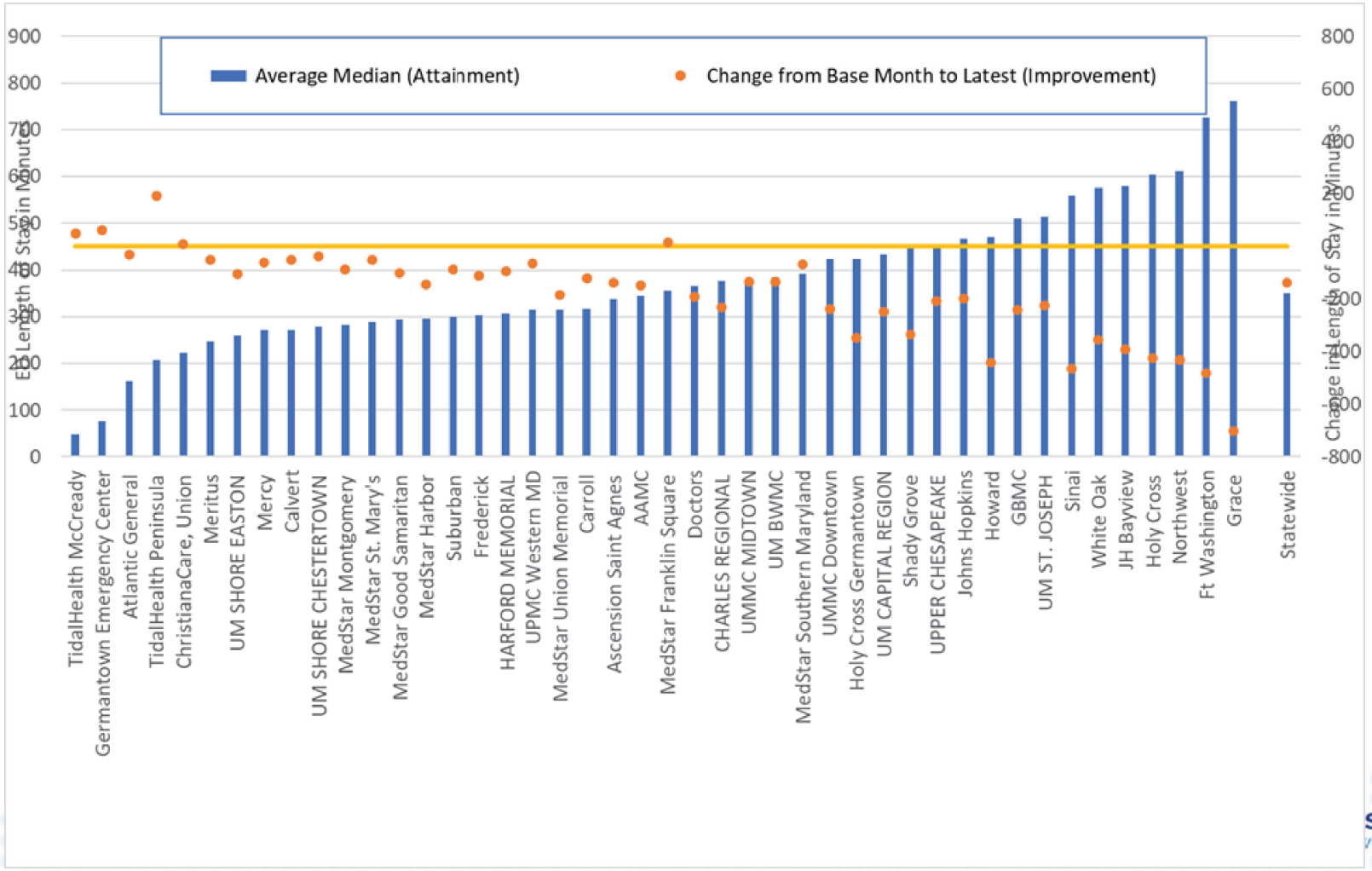
OP18b: ED Arrival to Discharge Time - Non-Psychiatric



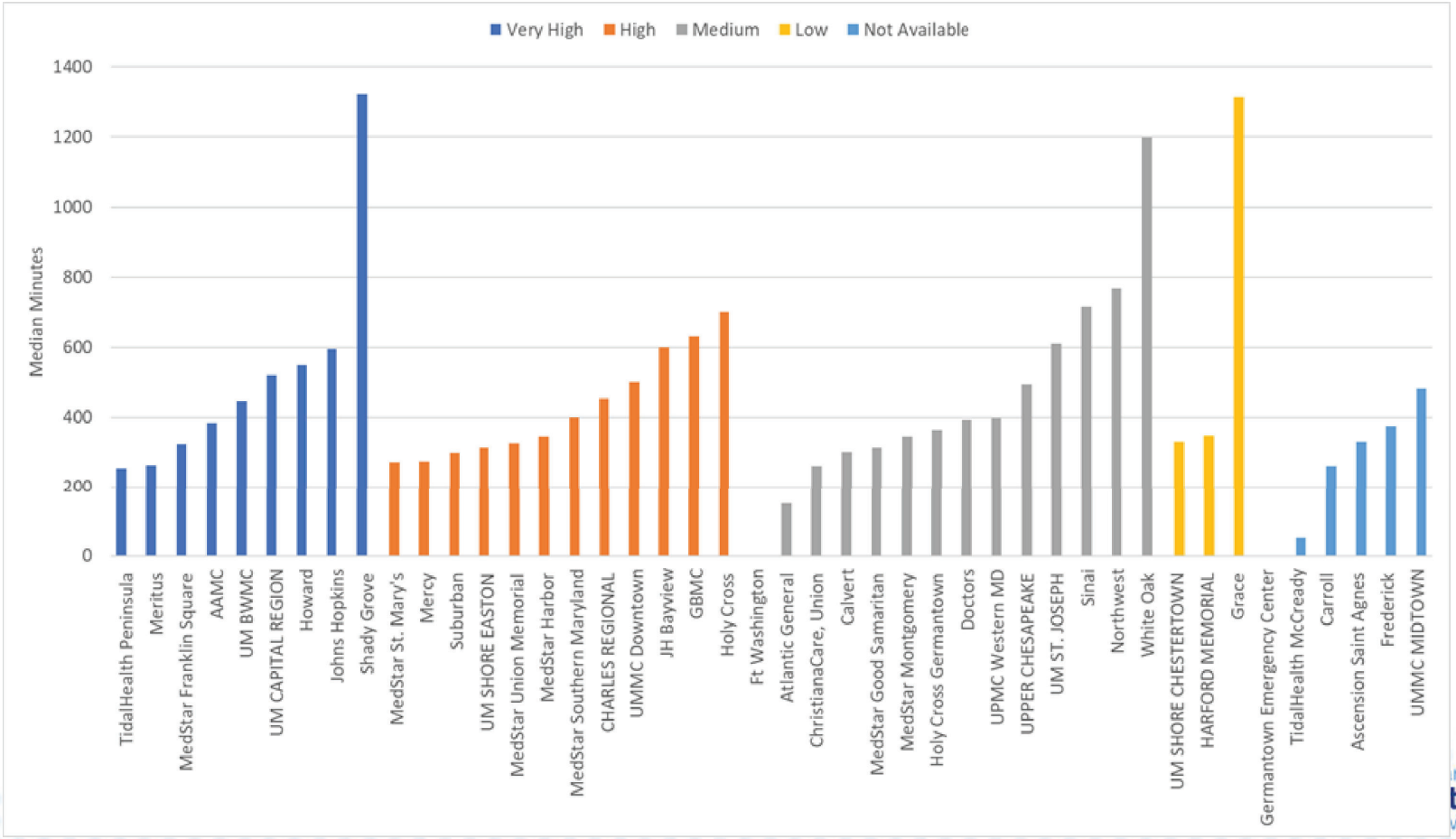
OP18b: ED Arrival to Discharge Time by Volume Non-Psychiatric ED Visits



OP18c: ED Arrival to Discharge Time by Month Psychiatric



OP18 c: ED Arrival to Discharge Time by Volume Psychiatric ED Visits



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The Episode Quality Improvement Program

Review of Year 1 (CY2022) Results, October 2023

The Episode Quality Improvement Program (EQIP)

After approval of the TCOC Model, HSCRC staff began exploring opportunities to **align with hospital efforts to control costs across the healthcare system.**

Maryland **physicians largely remain on fee-for-service** reimbursement incentives and, as a result of the TCOC Model, are left out of national, **Medicare** value-based payment programs.

Therefore, it is imperative that the State **creates new value-based reimbursement** opportunities to **ensure cost containment in non-hospital settings.**

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The Episode Quality Improvement Program – EQIP

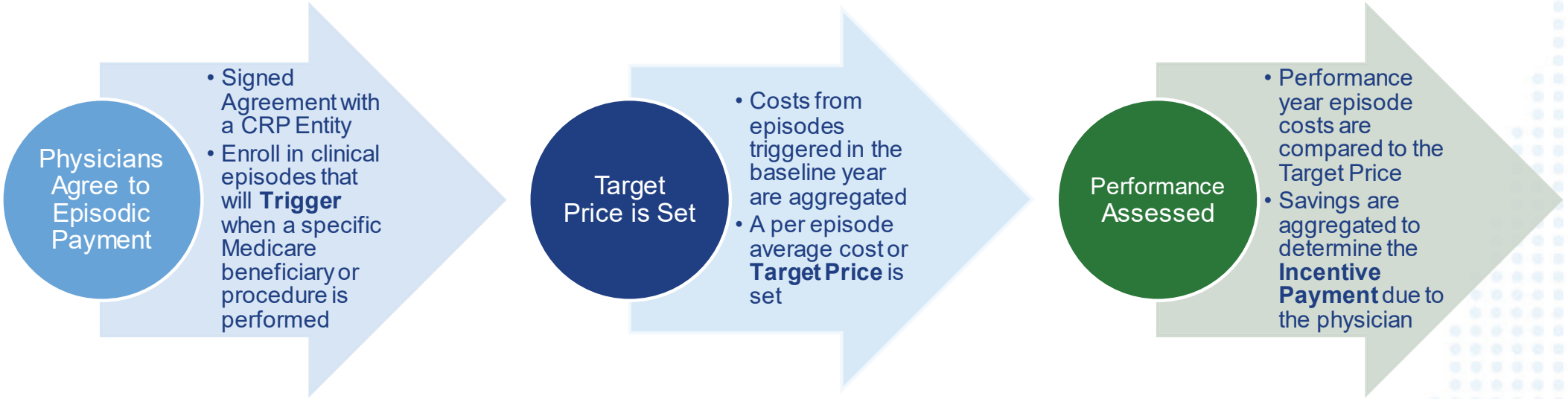
- The HSCRC created a voluntary, episodic incentive payment program for specialist physicians in Medicare, EQIP, in 2022.

Physician ownership of performance	Upside-only risk with dissavings accountability	Alignment with CareFirst's episode payment program	AAPM/value-based payment participation opportunities for MD physicians

- EQIP uses the Prometheus Episode Grouper & episodes that are created by Maryland physicians.
- This approach has allowed Maryland physicians to define their own value-based payment models.

Episodic Value-Based Payment

- EQIP works directly with physicians and allows them to earn a portion of the savings they create through better care management.
- EQIP helps to align physicians with the hospitals and the TCOC Model. By succeeding in EQIP, physicians will help the state meet its savings target and reduce potentially avoidable hospitalizations.



EQIP Interventions and Performance Improvement Opportunities

In addition to electing episodes, each EQIP Entity will need to indicate how they intend to produce savings in their episodes.

Intervention Category	Example Intervention
Clinical Care Redesign and Quality Improvement	Standardized, evidence-based protocols are implemented, for example for discharge planning and follow-up care.
	Performance of medication reconciliation.
	Elimination of duplicative, potentially avoidable complications or low value services
Beneficiary/Caregiver Engagement	Patient education/shared decision making is provided pre-admission and addresses post-discharge options.
	Implementation of "health literacy" practices for patient/family education
Care Coordination and Care Transitions	Assignment of a care manager and enhanced coordination to follow patient across care settings
	Interdisciplinary team meetings address patients' needs and progress.
	Selection of most cost efficient, high-quality settings of care

EQIP Methodology

- Each episode has a Target Price that is based on the EQIP Entities costs in 2019.
  - The baseline period costs are trended forward based on inflation.
  - The Target Price is set regardless of the setting of care (Hospital, Outpatient Facility, ASC) where the episode is initiated. This creates an incentive for participants to move episodes to the most cost-efficient setting of care.
- EQIP Entities earn savings based on whether the actual performance period costs are less than or equal to the Target Price.
  - Each Care Partner's Target will be compared to the statewide experience and annually ranked based on relative efficiency. Lower cost providers will be in a higher tier and vice versa.
  - This ensures that expensive entities are brought down to their peers while efficient entities still have an incentive to participate.

Target Price Rank	% of Savings to due Care Partner
Up to 33rd percentile	50 percent
34th – 66th percentile	65 percent
66th + percentile	80 percent

Episodes for PY1, Episode Type, Length

Cardiology	Gastroenterology and General Surgery	Orthopedics and Neurosurgery
Pacemaker / Defibrillator – Procedure, 30	Colonoscopy – Procedure, 14	Hip Replacement & Hip Revision – Procedure, 90
Acute Myocardial Infarction – Acute, 30	Colorectal Resection – Procedure, 90	Hip/Pelvic Fracture – Acute, 30
CABG &/or Valve Procedures – Procedure, 90	Gall Bladder Surgery – Procedure, 90	Knee Arthroscopy – Procedure, 90
Coronary Angioplasty – Procedure, 90	Upper GI Endoscopy – Procedure, 14	Knee Replacement & Knee Revision – Procedure, 90
		Lumbar Laminectomy – Procedure, 90
		Lumbar Spine Fusion – Procedure, 180
		Shoulder Replacement – Procedure, 90

Enrollment Summary

EQIP entities enrolled:	50
Total Care Partners:	1,981
Specialties represented:	32
Smallest Entity:	1 CP
Largest Entity:	994 CPs
Entities participating in more than 2 episodes:	19

Clinical Episode Categories	Number of EQIP Entities	Number of Care Partners
Cardiology	20	1,317
Gastroenterology	17	1,245
Orthopedics	25	1,745

EQIP Year 1 Results

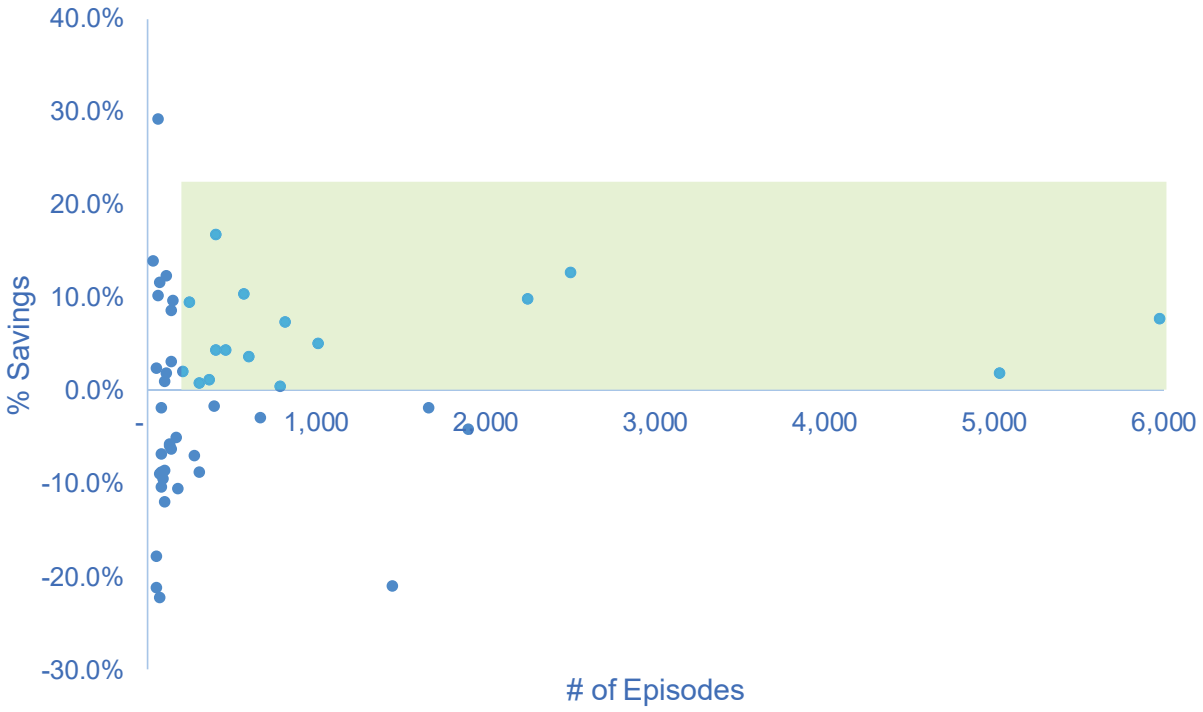
- EQIP saved $20 million in total cost of care in 2021. Overall, EQIP episodes accounted for ~$400 million in costs so the savings rate was approximately 5%.
  - Savings were only counted if the entity exceeded a 3% minimum savings rate, which was created to ensure that savings and payouts from EQIP would be statistically significant.
  - 19 EQIP entities earned savings out of a total of 50. However, the majority of the smaller practices had difficulty earning savings.
- Based on the savings, we expect to pay out $13 million in incentive payments to physicians (i.e., 60% of the total earned savings).

Size Matters!

- The amount of savings earned by the practices was partially determined by the number of episodes the practice had.
  - On average the top quintile in terms of volume saved about $1 mil. The lower quintiles had very little impact.
  - Similarly, the average percent savings per episode was correlated with the number of episodes.
  - Note because there is substantial variation within the lower quartiles. For instance, Q5 varies from +29% to -22% episode savings.
- This could be because larger practices had more resources to use in the program.
- It could also be because the statistical noise from the small sample size has washed out the signal from the program.

Quintile based on number of Episodes	Average $ Savings by Quintile	Average Savings % by Quintile
1 (>687 Episodes)	$992,459	2%
2 (127-287 Episodes)	$309,631	3%
3 (76-127 Episodes)	$(3,136)	0%
4 (35-76 Episodes)	$ (116,642)	-3%
5 (<35 Episodes)	$ (16,068)	-2%

Distribution of Savings by EQIP Entity



- If EQIP had no effect, we would expect to see a random distribution, with equal numbers of episodes above and below $0.
- Instead, we see a skewed distribution towards savings among larger practices (green shaded area)
- This makes intuitive sense as there is little reason to expect costs to increase because of EQIP.
- Most smaller EQIP entities did not see significant savings, whereas large practice with significant economies of small earn most of the savings.

Note: EQIP Entity shown at approximately 6,000 episodes actually had over 12,000 episodes but is shown at this lower number to allow for a narrower axis.

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Analysis by Episode Type

Episode	% of Total Baseline Spend	% Savings
Acute Myocardial Infarction	3.7%	-1.7%
CABG &/or Valve Procedures	10.8%	-4.6%
Pacemaker / Defibrillator	9.8%	3.9%
Coronary Angioplasty	8.0%	1.0%
Total Cardiology	**32.3%**	**0.0%**
Colonoscopy	4.5%	1.8%
Colorectal Resection	2.4%	-13.2%
Gall Bladder Surgery	1.8%	-6.3%
Upper GI Endoscopy	3.5%	3.6%
Total Gastroenterology	**12.2%**	**-1.8%**
Hip Replacement & Hip Revision	12.2%	7.9%
Hip/Pelvic Fracture	5.8%	-8.6%
Knee Arthroscopy	0.7%	8.5%
Knee Replacement & Knee Revision	21.6%	9.4%
Lumbar Laminectomy	1.7%	0.6%
Lumbar Spine Fusion	10.4%	8.9%
Shoulder Replacement	3.2%	-6.9%
Total Orthopedics	**55.5%**	**5.9%**

- Savings do no reflect exclusion of episodes below MSR, as that is applied at an entity level, so % savings is lower.
- Orthopedics represents both the largest share of episodes and the best savings.

Overall Assessment & Next Steps

- HSCRC is conducting a post-episode monitoring analysis, to be completed prior to payment
- CRISP Learning Collaborative has commissioned a formal evaluation study, expect to release it in the next 3-6 months.
- CRISP/MedChi to host Learning Collaborative highlighting practices earning incentive payments
- The Year 1 results are favorable and exceeded our expectations.
  - The program savings exceeds that from CMMI's bundled payment programs and other programs nationally.
  - While the dollar value of the savings is small in the context of MD TCOC, EQIP could have a substantial impact on the savings test if the savings rate can be maintained as the program grows.
- Years 2 and 3 will substantially expand the program.
  - We are added new episodes. 25 new episodes in Year 2 and 5 new episodes in Year 3.
  - The number of participants is also increasing substantially. We expect to have around 4 thousand participants in Year 3, about 2 times the size of the program in Year 1.
- Support for smaller practices
  - In Year 3 Medchi assisted smaller practices in grouping together into single entities
  - In Year 4+, we are considered providing practices with some practice transformation supports.
    - Currently, EQIP has been very low touch with practices, meaning limited engagement between HSCRC / CRISP staff and the practices.
    - This has ensured that the administrative burden on the program on participants remains small. However, it is clear small practices may not have the resources to identify and deploy interventions that will lead to their success.
    - Practice transformation support could help raise the smaller practices to the level of success of the best performing practices.

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Care Transformation Initiatives

Review of Year 1 (FY2022) Results, October 2023

Overview of the Care Transformation Initiatives (CTI)

- Since early in the All-Payer Model, the HSCRC attempted to develop 'alignment programs' which encourage hospitals to partner with non-hospital providers to reduce TCOC.
- These early programs did not work for a variety of reasons:
  - There was a disconnect between hospital's clinical efforts and programs developed by the HSCRC.
  - Hospitals had to earn substantial savings before they receive a reward and it is costly for hospitals to manage TCOC effectively.
  - Thus the ROI for participation was highly uncertain.
- The CTI program overcomes these problems by:
  - Allowing hospitals to define their own populations to focus on.
  - Providing all hospitals with 'first dollar' savings.
  - Distributing savings in a net neutral manner, so hospitals that do not participate (or do not make a successful effort) in care transformation are penalized.

CTI Methodology

- CTI are grouped into “thematic areas” which share a common attribution methodology and parameters that hospitals can use to select their population.
  - For example: in the Care Transitions Thematic Area beneficiaries are attributed to the hospital where they are discharged from. The hospital can limit the CTI population based on DRGs, chronic conditions, number of prior hospitalizations, etc.
  - There are five thematic areas: Care Transitions, Palliative Care, Primary Care, Geographic, and ED Care.
- Each CTI has a target price that is based on the TCOC of the beneficiaries attributed to the CTI in the baseline period.
  - Baseline period costs are updated for inflation and risk adjusted.
  - This compares hospitals to their own historical performance. In other words, this is an improvement only program.
  - Baseline periods can be set back as far as FY17 to try and recognize early adopters.
- Hospitals earn savings if their performance period costs are less than the target price.
  - Hospitals earn 100% of the savings they achieve that exceed a Minimum Savings Rate. This ensures that all payments are made for savings that are statistically significant.
  - All shared savings payments are offset on a statewide basis. Hospitals that are less successful in the CTI will pay for the savings of those hospitals that were successful in the CTI.
  - This ensures that Medicare continues to benefit from care transformation and also that hospitals which are not engaged in successful care transformation pay their fair share of meeting the statewide savings target.

Year 1 CTI Results

- All hospitals participated in the CTI program and nearly 25% of the State's Medicare population was attributed to a hospital's clinical care transformation program.
- Overall, the CTI program accounted for nearly $130 mil. of the State's overall run rate.
  - The range of savings varied from -3% to +7% of the hospital's Medicare FFS revenue.
  - The CTI program redistributed about $56 mil. in revenues. This is the amount that is moved from one hospital to another.
  - If a hospital earns its share of the Statewide savings, then its shared savings is equal to its share of the statewide offset.
  - For example, if a hospital earned $15 mil. and was 10% of the Statewide savings, then the net adjustment for that hospital would be $0 (+$15 mil. in savings - $15 mil. in statewide offset).

CTI Analysis

- Stakeholders asked staff to examine the CTI results and identify what was driving success in CTIs.
  - Size of the Hospital
  - Section of the Baseline Year
  - Specific CTI Criteria
- Overall, success in the CTI does not appear to be driven by the CTI definitions.
  - Some hospitals succeeded and other failed using very similar CTI definitions.
  - Success in the CTI is driven by operational not definitional factors.
  - The HSCRC is committed to developing a learning system so that hospitals can learn from one another's successes.
- However, there are some lessons learned…
  - Participation in primary care CTIs is important because it has leverage over more TCOC than hospital-based CTI.
  - Simpler definitions are better.
  - Hospitals that focused on high-utilizers at the hospital or chronic condition management were more likely to be successful.

Overview of CTI Results

Thematic Area	Number of CTI	Number Exceeding Target Price	Percent Exceeding Target Price	Number Exceeding MSR	Percent Exceeding MSR	Average Savings
Care Transitions	55	36	65%	28	51%	1.6%
Palliative Care	5	3	60%	3	60%	2.9%
Primary Care	23	14	61%	11	48%	2.2%
Geographic	10	5	50%	5	50%	3.2%
ED	14	8	57%	7	50%	1.0%
Total	107	66	62%	54	50%	1.9%

CTI reward / penalty vs size of hospital

Selection of Baseline Period

- The selection of the CTI baseline was not correlated with savings.
- All primary care CTI share the same baseline (2019) and therefore differences in primary care performance cannot be explained by the baseline.

Baseline	Number of CTI	CTI with Savings	Win Rate	Savings as a Percent of Target Price	Percent of MPA Revenue
July 2016 - June 2017	25	15	60%	7.5%	1.0%
July 2017 - June 2018	13	9	69%	7.3%	0.7%
July 2018 - June 2019	20	12	60%	7.1%	1.2%

Precision does not equal success

- The CTI allow hospitals to target their populations very precisely.
  - Each criteria restricts the CTI more narrowly. For example, hospital discharges with 1+ chronic conditions & 2 or more prior hospitalizations.
  - This is an 'intent to treat' estimate of the impact that a clinical intervention has on TCOC.
- More precision did not lead to a higher win rate. But the magnitude of savings decreased.
  - More criteria means fewer episodes, not a higher probability of success.
  - Hospitals did simple things well were most successful.
  - Note: we conducted this analysis only for the care transitions thematic area because the other areas did not have sufficient sample size.

Number of Criteria	Number of CTI	Number with Savings	Winning Percentage	Savings as a Percent of MPA Dollars
0	2	1	50%	1.46%
1	26	11	42%	1.27%
2	15	9	60%	1.10%
3	9	5	56%	0.43%
4	5	4	80%	0.16%
5	1	0	0%	0.08%

Some criteria were associated with more success

- Hospitals that used geographic, chronic conditions, or prior utilization criteria where more successful.
- The role of geography is interesting. We are not sure what clinical processes are driving this result.
- Hospitals focusing on which DRGs patients had or discharge setting were less successful.

Criteria	Number of CTI	Number with Criteria	Number with Savings	Ratio
Geographic Service Area	58	19	15	79%
Diagnosis Codes	58	19	11	58%
# Chronic Conditions	58	31	21	68%
Prior Hosp or ED Use / Look Back	58	25	18	72%
Look Forward	58	14	8	57%

What types of CTI are Working?

- CTIs targeting heart failure, COPD, diabetes, and cancers were more successful than average.
- We are not sure what is driving those clinically, but suspect that for cancer and heart failure specifically, medication management is likely a key driver.

Chronic Conditions	Number of CTI	Number with Savings	Ratio
Heart Failure	22	16	73%
Chronic Obstructive Pulmonary Disease	24	17	71%
Diabetes	20	13	65%
Cancer	11	9	82%

No Clear Pattern in Primary Care CTI

- Most hospitals chose primary care CTI that were based on their MDPCP populations, with no restrictions.
- Some hospitals chose to limit their MDPCP populations to those living in certain areas.
- These hospitals were more successful, although we are not sure what is driving that difference.

Baseline	Number of CTI	CTI with Savings	Win Rate	Savings	Percent of Revenue
All CTI	19	10	53%	6.7%	4.2%
CTI with Geographic Restriction	5	4	80%	9%	6%
CTI with Geographic & Chronic Conditions	4	3	75%	9%	5%

What's next?

- We will continue analyzing the CTI to try and identify what is driving success.
  - Some additional discussion in CTI evaluation reports sponsored by CRISP Learning Collaborative.
  - Most of the drivers of success are likely to be operational drivers, that we cannot identify through claims analysis.
  - We plan to work with CRISP and MHA to try and create some lessons learned that could be exported to other hospitals.
  - We will continue to analyze the CTI definitions, including NPI composition, and report out to the CT Steering Committee.
- Staff are asking for industry comments on revision by October 11, 2023. Revisions will be incorporated, as needed, in the upcoming MPA proposal. Planned adjustments:
  - Cap downside risk
  - Request to restore CTI buy out in MPA policy

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TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: October 11, 2023

RE: Hearing and Meeting Schedule

November 8, 2023 To be determined - GoTo Webinar

December 13, 2023 To be determined - GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday 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.