State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

John M. Colmers

James N. Elliott, M.D.

Adam Kane

Jack C. Keane

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Payment Reform &
Provider Alignment

Gerard J. Schmith, Director
Revenue & Regulation
Compliance

William Henderson, Director
Medical Economics &
Data Analytics

560th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
April 10, 2019

EXECUTIVE SESSION
11:30 a.m.
(The Commission will begin in public session at 11:30 a.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

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. **Legal Consultation - Authority General Provisions Article, §3-305 (b) (7)**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on March 13, 2019**

2. **New Model Monitoring**

3. **Docket Status – Cases Closed**

4. **Docket Status – Cases Open**

   2475R - Calvert Health Medical Center 2476A – Johns Hopkins Health System
   2477A – Johns Hopkins Health System

5. **2018 Community Benefit Report**

6. **Report on Disclosure of Hospital Financial and Statistical Data**

7. **Nursing Support Program II - Draft Recommendations**

8. **Legal Report**

9. **Policy Update and Discussion**
   a. **Capital funding discussion**

b. **Legislative Update**

10. **CRISP Update**

11. **Hearing and Meeting Schedule**

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF APRIL 4, 2019

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2475R	Calvert Health Medical Center	3/4/2019	4/3/2019	9/2/2019	MSG/DEF	WH	OPEN
2476A	Johns Hopins Health System	3/25/2019	N/A	N/A	ARM	DNP	OPEN
2477A	Johns Hopins Health System	3/28/2019	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*****	**COST REVIEW COMMISSION**	
CALVERT HEALTH	*****	**DOCKET:**	**2019**
MEDICAL CENTER	*****	**FOLIO:**	**2285**
PRINCE FREDERICK, MARYLAND	*****	**PROCEEDING:**	**2475R**

Staff Recommendation

April 10, 2019

Introduction

On March 1, 2019, Calvert Health Medical Center ("the Hospital") submitted a partial rate application to the Commission requesting that its July 1, 2018 Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective July 1, 2019.

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital. The Hospital wishes to combine these two centers, because the patients in both units are cared for in the same area and have similar nurse staffing ratios. The Hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Acute	$1,226.80	5,487	$ 6,731,435
Definitive Observation	$ 928.84	7,564	$ 7,026,093
Combined Rate Proposed	$1,054.13	13,051	$13,757,528

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;
2. That a MSG rate of $1,054.13 per day be approved effective July 1, 2019; and
3. That no change be made to the Hospital's Global Budget Revenue for MSG services.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2019**
SYSTEM	*	**FOLIO:**	**2286**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2476A**

Staff Recommendation

April 10, 2019

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on March 25, 2019 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC for continued participation in a global rate arrangement for solid organ and bone marrow transplants with Preferred Health Care LLC. The Hospitals request that the Commission approve the arrangement for one year beginning May 1, 2019.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Johns Hopkins HealthCare, LLC ("JHHC"), which is a subsidiary of the System. JHHC will continue to 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 continue to 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 that 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

Although there was no activity under this arrangement in the last year, staff believes that the Hospitals can achieve favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing May 1, 2019. The Hospitals 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 Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will 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 HEALTHCARE, LLC	*	**DOCKET:**	**2019**
	*	**FOLIO:**	**2287**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2477A**

Staff Recommendation

April 10, 2019

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on March 28, 2019 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (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 solid organ and bone marrow transplants services with 6 Degrees Health, Inc. The System requests approval for a period of one year beginning May 1, 2019.

II. OVERVIEW OF APPLICATION

The contract will continue to 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 continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer and 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

Although there has been no activity under this arrangement, staff believes that the

Hospitals can achieve a favorable experience under this arrangement.

.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing May 1, 2019. The Hospitals 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 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, 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.

Maryland Hospital Community Benefit Report: FY 2018

April 10, 2019

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

Table of Contents

LIST OF ABREVIATIONS

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

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 an activity that intends to address community needs and priorities primarily through disease prevention and improvement of health status.[1] Activities can include the following:

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

In 2001, the Maryland General Assembly passed House Bill 15,[2] which required the Maryland Health Services Cost Review Commission (HSCRC) to collect community benefit information from individual hospitals to compile 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 is the *Community Benefit Collection Tool*, 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 IRS Form 990, Schedule H.[3] The second component of Maryland's reporting system is the CBR narrative report. The HSCRC developed the *Community Benefit Narrative Reporting Instructions* to guide hospitals' preparation of these reports, which strengthen and supplement the quantitative community benefit data that hospitals report in their inventory spreadsheets. *New to this year's report, the HSCRC rolled out an online reporting tool for the narrative section to collect information that is more consistent across hospitals and to better allow for trending analysis going forward*.

This summary report provides background information on hospital community benefits, the history of CBRs in Maryland, and summaries of the community benefit narrative and financial reports for fiscal year (FY) 2018. It concludes with a summary of data reports from the past 15 years.

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

BACKGROUND

Federal Requirements

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

Originally, the Internal Revenue Service (IRS) considered hospitals to be "charitable" if they provided charity care to the extent of their financial ability to do so.[5] However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the "charitable" standard to focus on "community benefits" rather than "charity care."[6] Under this IRS ruling, nonprofit hospitals must provide benefits to the community in order to be considered charitable. This created the "community benefit standard," which is necessary for hospitals to satisfy in order to qualify for tax-exempt status.

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

Maryland Requirements

The Maryland General Assembly adopted the Maryland CBR process in 2001,[10] and the first data collection period was FY 2004. Maryland law requires hospitals to include the following in their CBRs: the hospital's mission statement, a list of the hospital's initiatives, the costs and objectives

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

of each community benefit initiative, a description of efforts taken to evaluate the effectiveness of initiatives, a description of gaps in the availability of specialist providers, and a description of the hospital's efforts to track and reduce health disparities in the community.[11]

The HSCRC worked with the Maryland Hospital Association (MHA), interested hospitals, local health departments, and health policy organizations and associations to establish the initial details and format of the CBR. In developing the format for data collection, the group relied heavily on the experience of the Voluntary Hospitals of America (VHA) community benefit process. Maryland hospitals used the resulting data reporting spreadsheet and instructions to submit their FY 2004 data to the HSCRC in January 2005, and the HSCRC published the first CBR in July 2005. The HSCRC continues to work with MHA, public health officials, individual hospitals, and other stakeholders to further improve the reporting process and refine the definitions and periodically convenes a Community Benefit Work Group. The data collection process offers an opportunity for each Maryland nonprofit hospital to critically review and report the activities it has designed to benefit the community. This FY 2018 report represents the HSCRC's 15th year of reporting on Maryland hospital community benefit data.

NARRATIVE REPORTS

This section of the document summarizes the findings of the narrative reports.

Hospitals Submitting Reports

The HSCRC received a total of 48 CBR narratives from 51 hospitals in FY 2018. Please note that the University of Maryland Health System submits a single CBR for three of its hospitals on the Eastern Shore and another CBR for two of its hospitals in Harford County. These reports sometimes break out individual metrics for each hospital and sometimes combine responses. Therefore, the denominator for hospital response rates varies between 48 and 51 throughout the remainder of this document. Table 1 summarizes the hospitals submitting CBRs by hospital system. New to this year's report, University of Maryland Prince George's and Laurel Regional hospitals have merged into University of Maryland Capital Region Health.

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

Table 1. List of Hospitals Submitting CBRs in FY 2018, by System

Independent Hospitals	**Johns Hopkins Medicine:**
1. Anne Arundel Medical Center	25. Howard County General Hospital
2. Atlantic General Hospital	26. Johns Hopkins Bayview Medical Center
3. Bon Secours Baltimore Health System	27. Johns Hopkins Hospital
4. CalvertHealth Medical Center	28. Suburban Hospital
5. Doctors Community Hospital	**Lifebridge Health:**
6. Fort Washington Medical Center	29. Carroll Hospital Center
7. Frederick Memorial Hospital	30. Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.
8. Garrett Regional Medical Center	
9. Greater Baltimore Medical Center	31. Northwest Hospital Center, Inc.
10. McCready Health Foundation, Inc.	32. Sinai Hospital of Baltimore, Inc.
11. Mercy Medical Center	**MedStar Health:**
12. Meritus Medical Center	33. MedStar Franklin Square Medical Center
13. Peninsula Regional Medical Center	34. MedStar Good Samaritan Hospital
14. Saint Agnes Hospital	35. MedStar Harbor Hospital
15. Sheppard Pratt Health System	36. MedStar Montgomery Medical Center
16. Union Hospital of Cecil County	37. MedStar Southern Maryland Hospital Center
17 Western Maryland Health System	38. MedStar St. Mary's Hospital
Jointly Owned Hospitals:	39. MedStar Union Memorial Hospital
18. Mt. Washington Pediatric Hospital*	**University of Maryland:**
Adventist HealthCare:	40. UM Baltimore Washington Medical Center
19. Adventist HealthCare Behavioral Health & Wellness Services	41. UM Charles Regional Medical Center
	42. University of Maryland Medical Center
20. Adventist Healthcare Rehabilitation	43. UMMC Midtown Campus
21 Adventist HealthCare Shady Grove Medical Center	44. UM Capital Region Health**
	45. UM Rehabilitation & Orthopaedic Institute
22. Washington Adventist Hospital	46. UM Shore Regional Health***
Holy Cross Health	47. UM St. Joseph Medical Center
23. Holy Cross Germantown Hospital	
24. Holy Cross Hospital	48.UM Upper Chesapeake Health****

*Mt. Washington Pediatric is jointly owned by the University of Maryland Medical System and Johns Hopkins Medicine
**Previously Prince George's and Laurel Regional hospitals
***One narrative report includes three hospitals: Easton, Chester River, and Dorchester
****One narrative report includes two hospitals: Upper Chesapeake Medical Center and Harford Memorial Hospital

Section I. General Hospital Demographics and Characteristics

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

Hospital-Specific Demographics

The first section of the CBR narrative collects information on hospital demographic and utilization statistics, as summarized in Table 2 below. Overall, there were 10,164 beds and 612,361 inpatient admissions. The percentage of admissions ranged from 0.1 to 6.5 percent for

charity care/self-pay patients, 2.0 to 78.6 percent for Medicaid, and 14.2 to 92.2 percent for Medicare. New to this year's report, the information in this table was derived from HSCRC data to ensure consistency in reporting and measurement across hospitals.

Table 2. Hospital Bed Designation, Inpatient Admissions, and Patient Insurance Status, FY 2018

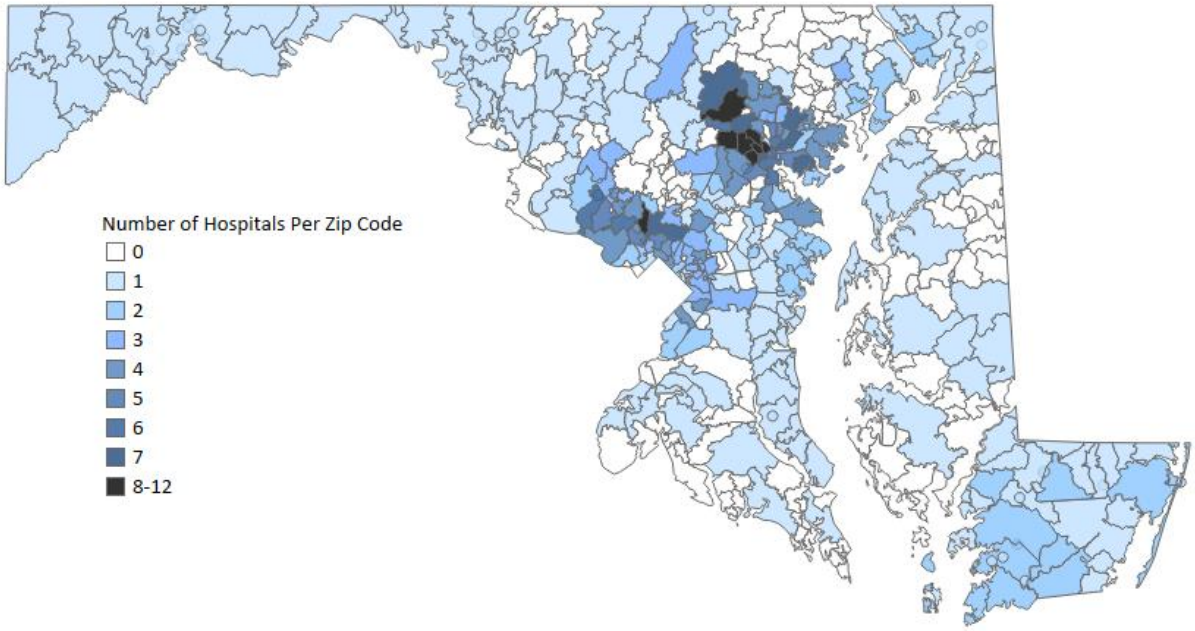
Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
Independent Hospitals					
Anne Arundel Medical Center	381	30,487	0.9	14.3	34.9
Atlantic General Hospital	44	3,188	1.7	13.6	67.8
Bon Secours Baltimore Health System	69	3,356	0.6	64.2	28.8
CalvertHealth Medical Center	72	6,039	0.9	21.3	42.0
Doctors Community Hospital	209	9,326	1.8	17.9	52.1
Fort Washington Medical Center	31	2,052	3.5	16.5	58.3
Frederick Memorial Hospital	262	18,698	1.7	8.7	41.2
Garrett Regional Medical Center	28	2,376	1.7	18.5	49.3
Greater Baltimore Medical Center	232	21,298	0.8	15.2	32.5
McCready Health	3	228	2.2	10.1	74.6
Mercy Medical Center	176	16,127	6.5	32.6	28.8
Meritus Medical Center	238	17,143	1.9	24.5	45.8
Peninsula Regional Medical Center	290	18,950	1.3	23.5	47.8
Saint Agnes Hospital	249	17,222	1.8	28.9	40.3
Sheppard Pratt Health System	414	8,336	2.1	41.3	14.2
Union Hospital of Cecil County	79	5,762	1.7	31.6	43.6
Western Maryland Regional Medical Center	202	12,164	1.3	18.7	55.0
Jointly Owned Hospitals					
Mt. Washington Pediatric Hospital	20	597	0.2	78.6	-
Adventist HealthCare					
Adventist HealthCare Behavioral Health & Wellness Services	36	3,723	2.6	39.6	15.5
Adventist HealthCare Rehabilitation	97	1,906	0.1	6.7	61.3
Adventist HealthCare Shady Grove Medical Center	259	20,982	2.5	20.5	27.6
Washington Adventist Hospital	203	12,368	3.4	48.4	30.9
Holy Cross Health					
Holy Cross Germantown Hospital	71	5,489	2.7	27.1	31.7
Holy Cross Hospital	403	35,532	2.5	29.6	21.9
Johns Hopkins Medicine					

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
Howard County General Hospital	263	18,776	0.6	16.7	36.1
Johns Hopkins Bayview Medical Center	341	20,891	2.0	34.0	39.3
Suburban Hospital	234	14,164	2.3	9.6	56.6
The Johns Hopkins Hospital	1,099	46,559	0.4	29.2	28.2
Lifebridge Health					
Carroll Hospital	147	11,089	0.5	17.0	50.1
Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	210	1,310	1.6	2.0	92.2
Northwest Hospital	194	10,244	0.8	24.4	56.1
Sinai Hospital	358	19,083	0.7	29.6	41.3
MedStar Health					
MedStar Franklin Square Medical Center	347	24,125	1.1	32.1	42.3
Medstar Good Samaritan Hospital	134	8,524	1.3	21.6	61.2
Medstar Harbor Hospital	118	8,694	1.0	45.5	32.9
MedStar Montgomery Medical Center	118	7,572	1.0	20.0	50.9
MedStar Southern Maryland Hospital Center	180	11,168	1.6	27.4	40.7
MedStar St. Mary's Hospital	105	7,916	1.5	22.7	40.1
MedStar Union Memorial Hospital	186	10,923	0.9	20.0	56.0
University of Maryland					
Baltimore Washington Medical Center	281	16,699	0.5	22.7	49.3
Charles Regional Medical Center	107	7,414	0.1	20.7	43.7
Laurel Regional Medical Center	58	3,621	4.7	24.5	47.6
University of Maryland Medical Center	634	25,037	0.5	38.4	32.3
UMMC Midtown Campus	93	4,667	0.7	47.6	42.3
Prince George's Hospital Center	226	13,581	5.8	43.5	32.7
UM Rehabilitation & Orthopaedic Institute	3	2,490	0.1	21.9	46.1
Shore Regional Health – Easton	117	8,293	0.6	25.2	50.1
Shore Regional Health – Dorchester	48	1,995	0.4	30.9	54.2
Shore Regional Health – Chester River	26	1,262	0.6	13.3	74.1
St. Joseph Medical Center	220	16,961	1.5	15.9	42.3
Upper Chesapeake Health – Upper Chesapeake Medical Center	165	11,557	0.5	16.0	47.2
Upper Chesapeake Health – Harford Memorial Hospital	84	4,397	1.0	22.7	49.0
Total	**10,164**	**612,361**	**1.6**	**25.6**	**39.3**

Primary Service Area

In prior years, the CBR requested hospitals to report the ZIP codes in their primary service areas (PSAs), which were defined based on volume. For consistency with the Total Cost of Care Model, the CBR now collects the ZIP codes in hospital PSAs as defined in their global budget revenue (GBR) agreements.[12] Figure 1 displays a map of Maryland's ZIP codes. Each ZIP code has a color indicating how many hospitals claim that area in their PSAs.

Figure 1. Number of Hospitals Claiming the ZIP Code in Their PSAs, FY 2018



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 their federally mandated CHNAs.[13] Table 3 summarizes the methods reported by Maryland hospitals. The most common method was based on patterns of service utilization, such as percentages of hospital discharges and emergency department (ED) visits. In general, the other methods that hospitals reported were based on proximity to the facility, social determinants of health indicators, and the proportion of residents medically

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

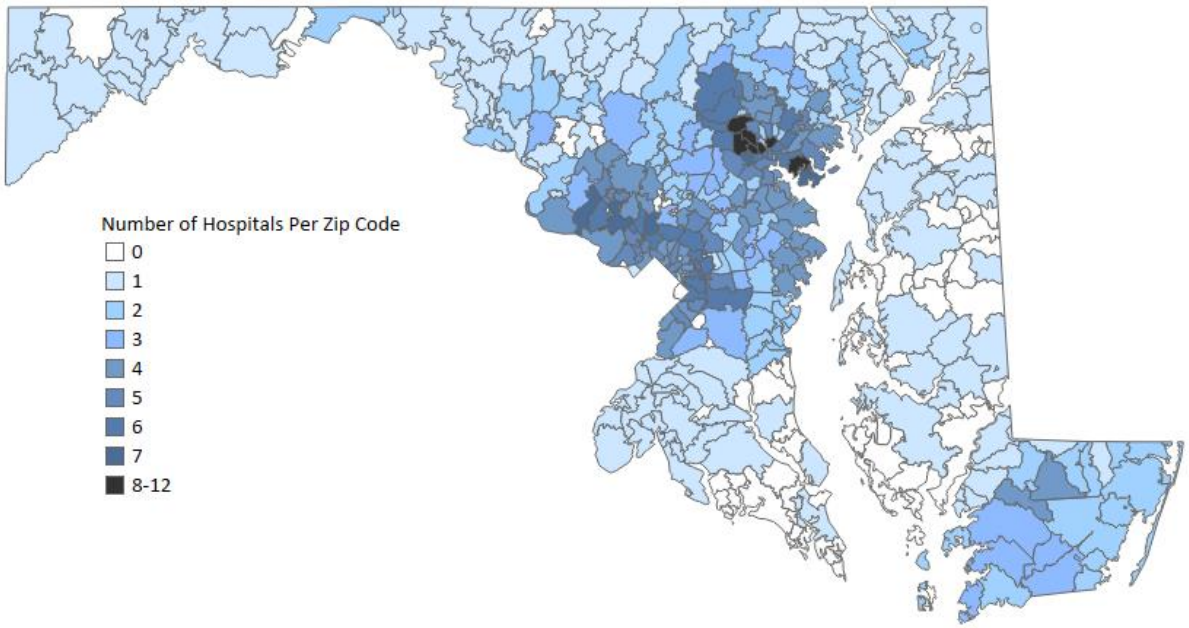
underserved or uninsured/underinsured. Eleven hospitals base their CBSAs on the PSAs described above.

Table 3. Methods Used by Hospitals to Identify Their CBSAs, FY 2018

CBSA Identification Method	Number of Hospitals
Based on ZIP Codes in Financial Assistance Policy	6
Based on ZIP Codes in their PSA	11
Based on Patterns of Utilization	26
Other Method	26

Figure 2 displays the number of hospitals claiming each ZIP code in their CBSAs. A total of 79 ZIP codes—those that appear white on the map—are not a part of any hospital's CBSA. This shows an improvement over FY 2017, which identified 106 ZIP codes that were not covered. Seven 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, the PSAs (displayed in Figure 1 above) cast a wider net within the state. 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 2018



Other Demographic Characteristics of Service Areas

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

The following measures were derived from the five-year (2013-2017) 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 (2015-2017) and the crude death rate (2017) measures are from the Maryland Department of Health's Vital Statistics Administration.

Table 4. Community Statistics by County

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Maryland		**78,916**	**6.6**	**7.3**	**30.7**	**23.5**	**32.7**	**18.0**	**59.1**	**31.5**	**9.6**	**79.2**	**826.3**
Allegany	1	42,771	10.6	5.9	44.4	30.6	20.9	4.3	90.3	9.2	1.7	76.0	1304.2
Anne Arundel	6	94,502	3.9	5.4	26.8	16.9	30.2	11.0	77.0	18.1	7.3	79.5	778.2
Baltimore	12	71,810	6.0	6.7	31.2	24.0	29.5	14.0	64.3	29.5	5.1	78.3	1019.6
Baltimore City	18	46,641	17.2	8.0	45.1	42.5	30.7	9.5	32.0	64.3	5.0	72.8	1086.6
Calvert	1	100,350	3.3	5.3	26.5	16.0	41.9	4.5	85.2	14.3	3.6	79.3	790.1
Caroline	1	52,469	12.1	8.3	44.6	36.5	32.1	7.0	83.3	15.3	6.9	76.2	1069.5
Carroll	3	90,510	3.4	3.7	25.8	14.1	35.6	5.0	93.8	4.3	3.2	79.0	965.5
Cecil	2	70,516	6.5	5.5	32.8	26.4	29.3	4.9	90.3	8.1	4.1	76.1	1005.4
Charles	1	93,973	5.2	4.1	26.5	20.6	43.9	7.7	50.8	47.3	5.4	78.9	683.8
Dorchester	1	50,532	11.9	5.6	49.7	40.4	26.3	5.9	68.9	29.8	5.0	76.1	1355.6
Frederick	4	88,502	4.5	5.3	24.9	16.6	35.0	13.1	84.0	10.9	8.8	80.0	736.0
Garrett	1	48,174	7.6	7.5	43.5	29.8	24.2	2.2	98.6	1.5	1.1	78.2	1173.3
Harford	2	83,445	5.4	3.9	28.4	18.1	32.1	7.0	81.9	15.0	4.2	79.0	865.7
Howard	4	115,576	3.6	4.8	21.8	14.7	30.9	25.2	62.0	20.5	6.5	83.5	515.4
Kent	1	56,638	7.8	6.3	44.1	25.8	26.7	5.5	83.7	15.9	4.3	79.1	1382.6
Montgomery	9	103,178	4.8	8.4	25.2	18.1	34.7	40.5	57.5	19.9	19.0	84.8	575.3
Prince George's	9	78,607	6.5	11.9	30.2	25.2	36.9	24.3	20.6	65.1	17.4	79.1	717.2
Queen Anne's	2	89,241	3.8	5.0	30.8	17.6	36.2	4.9	90.6	8.0	3.7	79.8	870.0
Saint Mary's	1	86,508	5.8	5.8	26.6	20.8	30.9	6.9	81.9	16.1	4.8	79.2	775.7
Somerset	3	39,239	18.0	8.7	46.4	34.4	24.9	8.5	54.9	43.5	3.5	75.0	1207.7
Talbot	1	65,595	6.7	6.2	42.2	23.0	26.6	7.5	85.0	13.5	6.5	81.3	1183.2

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Washington	1	58,260	9.7	7.0	38.3	29.9	29.3	7.2	86.0	13.0	4.5	77.5	1048.6
Wicomico	2	54,493	10.2	8.3	39.5	34.2	21.2	11.4	70.0	27.1	5.0	76.7	967.7
Worcester	2	59,458	7.8	7.4	43.8	26.6	24.3	5.2	84.3	14.6	3.4	77.9	1249.8
Source	[14]	[15]	[16]	[17]	[18]	[19]	[20]	[21]	[22]	[23]	[24]	[25]	[26]

[14] As reported by hospitals in their FY 2018 Community Benefit Narrative Reports
[15] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Median Household Income (Dollars), https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t
[16] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families
[17] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage
[18] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage
[19] American Community Survey 5-Year Estimates, 2013–2017 (denominator) and The Hilltop Institute (numerator)
[20] American Community Survey 5-Year Estimates 2013 – 2017, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes)
[21] American Community Survey 5-Year Estimates 2013 – 2017, Language Spoken at Home, Speak a Language Other Than English
[22] American Community Survey 5-Year Estimates 2013 – 2017, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population - White
[23] American Community Survey 5-Year Estimates 2013 – 2017, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population – Black or African American
[24] American Community Survey 5-Year Estimates 2013 – 2017, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race)
[25] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2017, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2015 – 2017.
[26] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2017, Table 39A. Crude Death Rates by Race, Hispanic Origin of Mother, Region, and Political Subdivision, Maryland, 2017.

Section II. Community Health Needs Assessment

Section II of the narrative CBR asks hospitals whether they conducted a CHNA, when they last conducted it, and whether they adopted an implementation strategy. All hospitals reported conducting a CHNA that conforms to the IRS definition within the past three fiscal years, and all but one reported adopting an implementation strategy.[27] See Appendix B for the dates in which hospitals conducted their last CHNAs. These dates ranged from June 2015 to June 2018.

This section also asks the hospitals to report on internal and external participants involved in the CHNA process and their corresponding roles. Just over half of all hospitals reported collaborating with other hospitals or community/neighborhood organizations to identify community health needs. Over half partner with local health improvement collaboratives in data collection, prioritization, and resource linking. Additionally, 38 hospitals worked with local health departments to identify community health needs. See Appendix C for more detail.

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 benefits activities. This section asks the hospitals to report on internal and external participants involved in community benefit activities and their corresponding roles. Tables 5 and 6 present some highlights; see Appendix D for full detail. Of note, the vast majority of hospitals now employ population health staff, and over 80 percent employ staff dedicated to community benefit. Additionally, the majority of hospitals collaborated with local health departments to administer community benefit activities. Just over half of all hospitals worked with community/neighborhood organizations to deliver community benefit initiatives, while just under half of all hospitals collaborated with other hospitals specifically for community benefit delivery.

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

Staff Category	Number of Hospitals	% of Hospitals
Population Health Staff	45	93.8%
Community Benefit Staff	39	81.3%
CB/Pop Health Director	44	91.7%

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

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Organizations	13	27.1%
Local Health Departments	39	81.2%
Other Hospitals	29	60.4%
Behavioral Health Organizations	22	45.8%

[27] This hospital did not respond to the question asking to explain why the implementation strategy was not adopted and did not respond to a follow-up request for clarification/

Internal Audit and Board Review

This section asks whether the hospital conducts an internal audit of the CBR financial spreadsheet and narrative. All hospitals responded to this question. Table 7 shows that 46 out of 48 hospitals conduct an internal audit of the financial spreadsheet. Audits are most frequently performed by staff.

Table 7. Hospital Audits of CBR Financial Spreadsheet

	Number of Hospitals	
Audit Type	**Yes**	**No**
Hospital Staff	37 (77.1%)	11 (22.9%)
System Staff	31 (64.6%)	17 (35.4%)
Third-Party	8 (16.7%)	40 (83.3%)
No Audit	2 (4.2%)	46 (95.8%)
Two or More Audit Types	29 (60.4%)	19 (39.6%)
Three or More Audit Types	1 (2.1%)	47 (97.9%)

This section also asks 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 reasons were largely related to timing issues or because the board had delegated this authority to executive staff. For example, several hospitals reported that their board meets only twice per year and did not have the opportunity to review before the report deadline.

Table 8. Hospital Board Review of the CBR

	Number of Hospitals	
Board Review	**Yes**	**No**
Spreadsheet	40 (83.3%)	8 (16.7%)
Narrative	38 (79.2%)	10 (20.8%)

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

Table 9. Community Benefit Investments in Hospital Strategic Transformation Plan

Community Benefit Investments in Strategic Transformation Plan	Number of Hospitals
Yes	46 (95.8%)
No	1 (2.1%)
No response	1 (2.1%)

Section IV. Hospital Community Benefit Program and Initiatives

The CBR asks hospitals to describe three, ongoing community benefit initiatives undertaken to address needs in the community. Table 10 summarizes the types of initiatives reported. Hospital community benefit initiatives were much more likely to target chronic conditions than acute conditions. Of 144 total initiatives reported across all hospitals, 97 addressed either the treatment or prevention of chronic conditions, or both. The most common types of interventions were chronic condition (prevention), social determinants of health, and community engagement (addressed by 55.6 percent, 47.2 percent, and 45.1 percent of all initiatives, respectively). Hospitals could report more than one category of intervention for each initiative.

Table 10. Types of Community Benefit Initiatives

	Number of Interventions in Each Category	Percentage of Interventions that Fall within Category
Chronic condition-based intervention: treatment intervention	50	34.7%
Chronic condition-based intervention: prevention intervention	80	55.6%
Acute condition-based intervention: treatment intervention	38	26.4%
Acute condition-based intervention: prevention intervention	40	27.8%
Condition-agnostic treatment intervention	9	6.3%
Social determinants of health intervention	68	47.2%
Community engagement intervention	65	45.1%
Other	15	10.4%

Table 11 presents the types of evidence that hospitals use to evaluate the effectiveness of their community benefit initiatives. By far, the most common category of evidence used to evaluate the effectiveness of community benefit initiatives was the count of participants, which was used in all but 13 initiatives reported. The next most common criteria reported were surveys of participants and biophysical health indicators, which were used in 35.4 percent and 29.2 percent of initiatives, respectively. Hospitals could report more than one type of evaluative criteria for each initiative.

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

	Number of Interventions Using each Type of Evaluation Criteria	Percentage of Interventions that Use each Type of Evaluation Criteria
Count of Participants	131	91.0%
Other Process Measures	34	23.6%
Surveys of Participants	51	35.4%
Biophysical Health Indicators	42	29.2%
Assessment of Environmental Change	7	4.9%
Impact on Policy Change	4	2.8%
Effects on Healthcare Utilization or Cost	26	18.1%
Assessment of Workforce Development	6	4.2%
Other	28	19.4%

Table 12 summarizes the community health needs addressed by these initiatives, as identified in hospitals' CHNAs. Diabetes and heart disease were the top two community health needs.

Table 12. Community Health Needs Addressed by Selected Hospital Community Benefit Initiatives, FY 2018

Community Health Needs	Number of Hospitals	Percentage of Hospitals
Diabetes	34	70.8%
Heart Disease and Stroke	33	68.8%
Educational and Community-Based Programs	30	62.5%
Nutrition and Weight Status	29	60.4%
Social Determinants of Health	24	50.0%
Substance Abuse	23	47.9%
Mental Health and Mental Disorders	22	45.8%
Physical Activity	22	45.8%
Health-Related Quality of Life and Well-Being	21	43.8%
Cancer	17	35.4%
Tobacco Use	17	35.4%

Community Health Needs	Number of Hospitals	Percentage of Hospitals
Other	17	35.4%
Older Adults	16	33.3%
Access to Health Services: Health Insurance	12	25.0%
Access to Health Services: Practicing PCPs	10	20.8%
Access to Health Services: Regular PCP Visits	10	20.8%
Maternal and Infant Health	8	16.7%
Violence Prevention	8	16.7%
Adolescent Health	7	14.6%
Injury Prevention	7	14.6%
Access to Health Services: ED Wait Times	6	12.5%
HIV	6	12.5%
Sexually Transmitted Diseases	6	12.5%
Community Unity	5	10.4%
Chronic Kidney Disease	4	8.3%
Disability and Health	4	8.3%
Immunization and Infectious Diseases	4	8.3%
Respiratory Diseases	4	8.3%
Telehealth	3	6.3%
Health Communication and Health Information Technology	2	4.2%
Oral Health	2	4.2%
Arthritis, Osteoporosis, and Chronic Back Conditions	1	2.1%
Dementias, Including Alzheimer's Disease	1	2.1%
Food Safety	1	2.1%
Lesbian, Gay, Bisexual, and Transgender Health	1	2.1%
Sleep Health	1	2.1%

The CBR also asks hospitals about community health needs identified through the CHNA process that were not addressed. Overall, 29 hospitals reported that one or more primary community health needs were not addressed; 17 responded that all needs were addressed; and 2 did not respond to the question. At least one hospital identified the following community health needs, but no hospital reported initiatives to address them: environmental health, vision, and wound care. Some hospitals listed the following reasons for not addressing all of the needs identified in their CHNAs: lack of resources, lack of expertise, or that the needs are being addressed by other local organizations, hospitals, or partnerships

Community Benefit Operations/Activities Related to State Initiatives

Hospitals were asked how their community benefit operations/activities work toward the state's initiatives for improvement in population health, as identified by the State Health Improvement Process (SHIP). The SHIP seeks to provide a framework for accountability, local action, and public engagement to advance the health of Maryland residents. In the context of the state's All-Payer Model, hospitals are tasked with improving quality, including decreasing readmissions and

hospital-acquired conditions. Of the 48 hospitals, 44 reported that their community benefit activities addressed at least one SHIP goal. Table 13 presents the SHIP goals that hospitals most and least commonly addressed. Because hospitals target their community benefit initiatives to address community health needs identified in their CHNAs, the SHIP goals selected tended to be those that were in alignment with hospital CHNAs.

Table 13. SHIP Goals Most- and Least- Commonly Addressed by Hospitals in FY 2018

SHIP Goal	Number of Hospitals	Percentage of Hospitals
Most-Commonly Addressed SHIP Goals		
Increase the % of adults who are at a healthy weight	36	75.0%
Reduce diabetes-related ED visit rate (per 100,000)	36	75.0%
Reduce hypertension-related ED visit rate (per 100,000)	36	75.0%
Least-Commonly Addressed SHIP Goals		
Reduce the teen birth rate (ages 15-19)	3	6.3%
Increase the % of students entering kindergarten ready to learn	3	6.3%
Reduce Chlamydia infection rate	3	6.3%
Reduce the % of young children with high blood lead levels	3	6.3%

Section V. Physicians

Gaps in Availability

Maryland law requires hospital to provide a written description of gaps in the availability of specialist providers to serve the uninsured cared for by the hospital.[28] Table 14 shows the gaps in availability that were submitted and the number of hospitals reporting each gap. The most frequently reported gap was mental health (reported by 37 hospitals), followed by substance abuse and detoxification. The least frequently reported gaps, each reported by one hospital, were allergy and immunology, anesthesiology, gastroenterology, GYN oncology, nephrology, pain, physiatry, thoracic, and wound care. Three hospitals reported no gaps this year, compared with 13 hospitals in FY 2017.

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

Table 14. Gaps in Availability

Physician Specialty Gap	Number of Hospitals
No Gaps	3
Mental Health	37
Substance Abuse/Detoxification	22
Primary Care	20
Dental	19
Neurosurgery	18
General surgery	16
Obstetrics	14
Dermatology	11
Internal medicine	11
Orthopedic Specialties	11
Otolaryngology (ENT)	10
Pulmonology	6
Infectious Diseases	5
Vascular	5
Oncology	4
Endocrinology	3
Rheumatology	3
Cardiology	2
Emergency Department	2
Hematology	2
Laboratory	2
Medical Imaging	2
Urology	2
Allergy/Immunology	1
Anesthesiology	1
Gastroenterology	1
Gyn Oncology	1
Nephrology	1
Pain	1
Physiatry	1
Thoracic	1
Wound Care	1
Other	3

Physician Subsidies

Hospitals that report physician subsidies as a community benefit category are required to further explain why the services would not otherwise be available to meet patient demand. The physician subsidy categories include the following: hospital-based physicians with whom the

hospital has an exclusive contract; non-resident house staff and hospitalists; coverage of ED call; physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; physician recruitment to meet community need; and other subsidies. The most frequently reported categories were "other," and hospital-based physicians. Subsidies described in the "other" category tended to be outpatient services and specialty services. Overall, 43 hospitals reported at least one category of subsidy.

Table 15. Physician Subsidies

Physician Specialty Gap	Number of Hospitals
Hospital-Based Physicians	33
Non-Resident House Staff and Hospitalists	31
Coverage of ED Call	27
Physician Recruitment to Meet Community Need	24
Physician Provision of Financial Assistance	11
Other	33

Section VI. Financial Assistance Policies

Finally, the narrative section of the CBR requires hospitals to submit information about their financial assistance policies. Maryland law established the requirements for hospitals to provide free or reduced cost care as part of their financial assistance policies as follows:[29]

- State statute sets the family income threshold for free, medically necessary care at or below 150 percent of the FPL; however, the statute allows the HSCRC to create higher income thresholds through regulation.[30] HSCRC regulations require hospitals to provide free, medically necessary care to patients with family income at or below 200 percent of the FPL.[31]
- Hospitals must provide reduced-cost, medically necessary care to patients with family income between 200 and 300 percent of the FPL.[32]
- Hospitals must provide reduced-cost, medically necessary care to patients with family income below 500 percent of the FPL who have a financial hardship; this is referred to as the financial hardship policy.[33] In order to qualify as having a financial hardship, the medical debt incurred by a family over a 12-month period must exceed 25 percent of the family's income.[34]

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

Table 16 summarizes hospital compliance with these thresholds. Overall, 15 hospitals had free care policies that were more generous to patients than required; 36 had sliding scale policies that were more generous; and 15 had financial hardship policies that were more generous. Two hospitals reported policies that fell below the regulatory requirement in at least one category.

Table 16. Summary of Hospital Compliance with Financial Assistance Policy Income Requirements, FY 2018

Income Threshold	Falls Below Requirement	Meets Requirement	Exceeds Requirement	Insufficient Data[35]
Threshold for Free Care	1	32	15	0
Threshold for Sliding Scale Care	2	9	36	1
Threshold for Medical Hardship	0	29	15	4

[35] Several hospitals did not provide a complete enough response to the question to determine the income threshold for the policy and had not yet responded to follow-up requests for more information as of the publication date of this report.

FINANCIAL REPORTS

The financial reports collect information about staff hours, the number of encounters, and direct and indirect costs for community benefits, categorized by type of community benefit activity. The reporting period for these financial data is July 1, 2017, through June 30, 2018. Hospitals submitted their individual CBRs to the HSCRC in December 2018. Audited financial statements were used to calculate the cost of each of the community benefit categories contained in the data reports. Fifty-one hospitals submitted individual data reports.

FY 2018 Financial Reporting Highlights

Table 17 presents a statewide summary of community benefit staff hours, encounters, and expenditures for FY 2018. Maryland hospitals provided roughly $1.75 billion in total community benefit activities in FY 2018—a total that is slightly higher than the $1.56 billion in FY 2017. As with FY 2017, the top three categories in FY 2018 were: $615 million in mission-driven health care services (subsidized health services), $561 million in health professions education, and $311 million in charity care. 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 17. Total Community Benefits, FY 2018

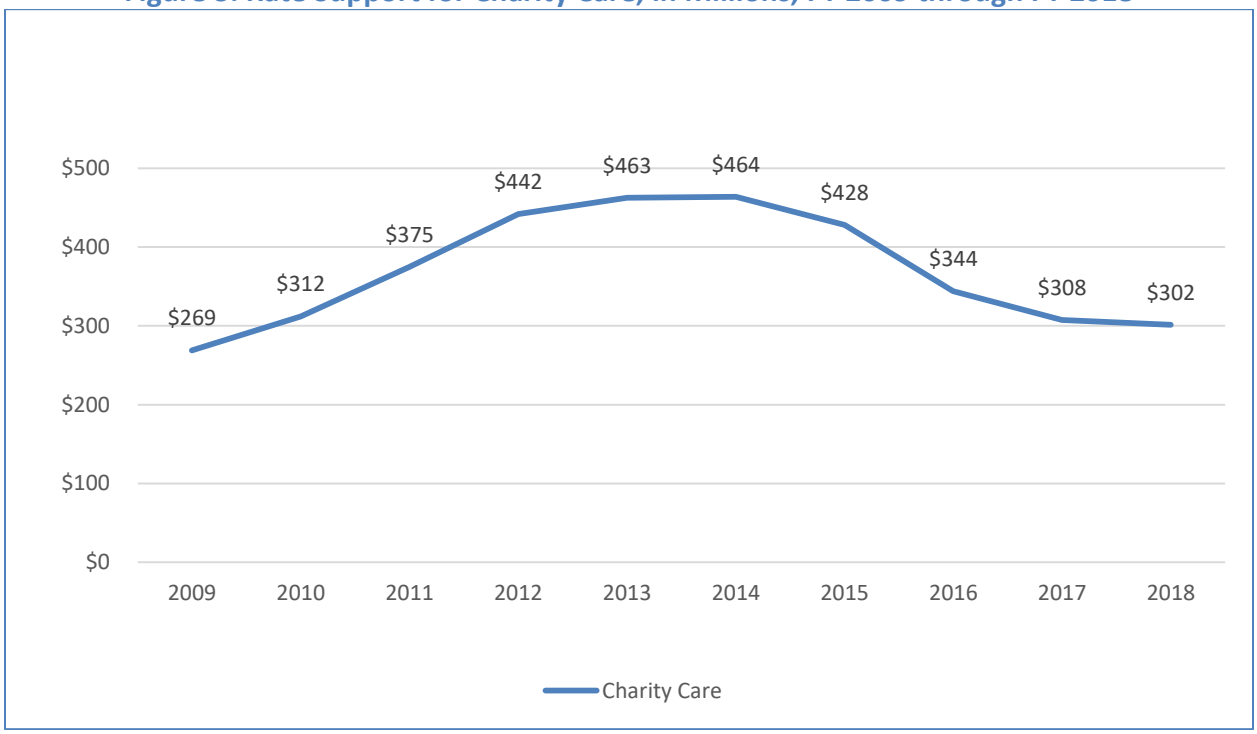
Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	% of Total Community Benefit Expenditures	Net Community Benefit Expense Less: Rate Support	% of Total Community Benefit Expenditures w/o Rate Support
Mission Driven Health Services	4,175,634	1,643,854	$615,041,958	35.18%	$615,041,958	56.63%
Health Professions Education	4,897,638	121,082	$560,999,545	32.09%	$200,280,755	18.44%
Community Health Services	1,977,412	3,051,383	$127,419,231	7.29%	$127,419,231	11.73%
Unreimbursed Medicaid Cost	0	0	$56,475,885	3.23%	$56,475,885	5.20%
Community Building	275,707	295,964	$31,911,655	1.83%	$31,911,655	2.94%
Community Benefit Operations	113,545	2,694	$14,544,083	0.83%	$14,544,083	1.34%
Financial Contributions	29,671	119,941	$14,339,667	0.82%	$14,339,667	1.32%
Research	148,741	6,532	$11,605,193	0.66%	$11,605,193	1.07%
Charity Care	0	0	$310,740,130	17.77%	$9,198,753	0.85%
Foundation	67,248	35,524	$5,334,341	0.31%	$5,334,341	0.49%
Total	**11,685,595**	**5,276,973**	**$1,748,411,689**	**100%**	**$1,086,151,522**	**100%**

In Maryland, the costs of uncompensated care (including charity care and bad debt) and graduate medical education are built into the rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC rates include amounts for nurse support programs provided at Maryland hospitals. These costs are essentially "passed-through" to the purchasers and payers of hospital care and are referred to as "rate support." To comply

with IRS Form 990 and avoid accounting confusion, hospitals include rate support in their CBR worksheets. HSCRC staff then separately account for rate-supported activities, as presented in the last two columns of Table 17 above. Appendix E details the amounts that were included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2018.

As noted above, the HSCRC includes a provision in hospital rates for uncompensated care, which includes both charity care (which is a community benefit) and bad debt (which is not a community benefit). Figure 3 shows the rate support for charity care from FY 2009 through FY 2018. The rate support for charity care continuously increased from FY 2009 through FY 2014; it has decreased each year since FY 2014 due to implementation of the ACA. See Appendix F for more information about the HSCRC's methodology for determining the amount of charity care that is built into rates.

Figure 3. Rate Support for Charity Care, in Millions, FY 2009 through FY 2018



Another social cost funded through Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents who are trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (i.e., direct medical education, or DME), which include the residents' and interns' wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC's annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2018, DME costs totaled $344 million. The HSCRC's Nurse Support Program I (NSP I) is aimed at addressing the short- and long-term nursing shortage affecting Maryland hospitals. In FY 2018, $16.6 million was provided in hospital rate adjustments for the NSPI.

When the reported community benefit costs for Maryland hospitals were offset by rate support, the net community benefits provided in FY 2018 totaled $1.09 billion, or 6.7 percent of total hospital operating expenses. This is an increase from the $896 million in net benefits provided in FY 2017, which totaled 5.7 percent of hospital operating expenses. See Appendix G for additional detail.

Table 18 presents staff hours, the number of encounters, and expenditures for health professional education by activity. The education of physicians and medical students makes up the majority of expenses in the category of health professions education, totaling $493 million. The second highest category is the education of nurses and nursing students, totaling $34 million. The education of other health professionals totaled $23 million.

Table 18. Health Professions Education Activities and Costs, FY 2018

Health Professions Education	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Physicians and Medical Students	3,922,546	55,008	493,039,660
Nurses and Nursing Students	508,674	21,900	34,425,775
Other Health Professionals	349,670	30,913	22,926,720
Scholarships and Funding for Professional Education	5,310	599	5,262,277
Other	111,437	12,661	5,345,113
Total	**4,897,638**	**121,082**	**$560,999,545**

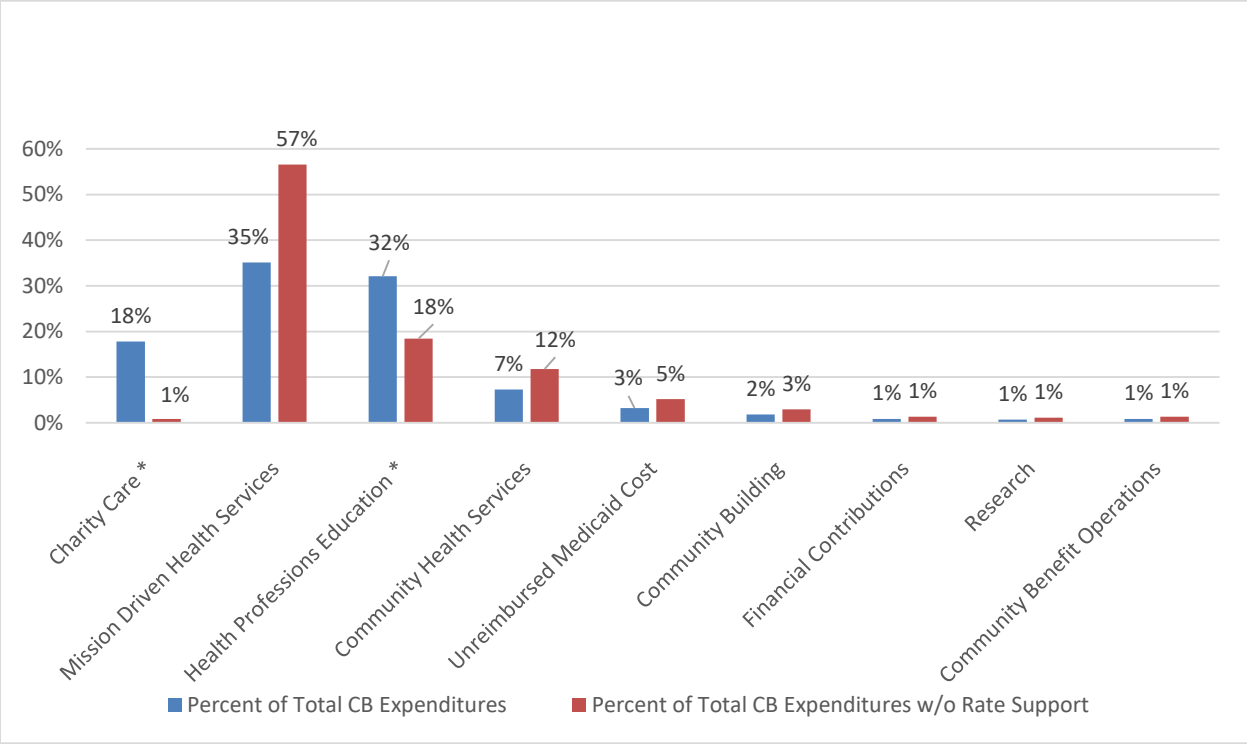
Table 19 presents the number of staff hours and encounters, as well as expenditures for community health services by activity. Health care support services comprise the largest portion of expenses in the category of community health services, totaling $57 million. Community health education is the second highest category, totaling $24 million, and community-based clinical services is the third highest, totaling $18 million. For additional detail, see Appendix H.

Table 19. Community Health Services Activities and Costs, FY 2018

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Health Care Support Services	382,989	345,885	$56,944,842
Community Health Education	1,077,956	1,918,221	24,236,625
Community-Based Clinical Services	302,783	297,981	18,200,984
Other	78,732	136,260	11,959,791
Free Clinics	3,998	9,243	5,075,739
Support Groups	27,742	38,293	4,208,124
Screenings	46,014	204,178	3,107,728
Self-Help	24,410	83,271	1,920,594
Mobile Units	31,283	9,806	1,530,004
One-Time/Occasionally Held Clinics	1,505	8,245	234,800
Total	**1,977,412**	**3,051,383**	**$127,419,231**

Rate offsetting significantly affects the distribution of expenses by category. Figure 4 shows expenditures in each community benefit category as a percentage of total expenditures. Mission-driven health services, health professions education, and charity care represent the majority of the expenses, at 35 percent, 32 percent, and 18 percent, respectively. Figure 4 also shows the percentage of expenditures by category without rate support, which changes the configuration: Mission-driven health services remains the category with the highest percentage of expenditures, at 57 percent. Health professions education follows, with 18 percent of expenditures, and community health services accounts for 12 percent of expenditures.

Figure 4. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2018



Appendix H compares hospitals on the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support), and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2018, 2,226 staff hours were dedicated to community benefit operations, a decrease of 9.9 percent over FY 2017. As with FY 2017, three hospitals did not report any staff hours dedicated to community benefit operations in FY 2018. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

The total amount of FY 2018 community benefit expenditures as a percentage of total operating expenses ranged from 1.30 percent to 25.76 percent, with an average of 7.71 percent, slightly higher than FY 2017 (6.81 percent). Ten hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with eleven hospitals in FY 2017.

FY 2004 – FY 2018 15-Year Summary

FY 2018 marks the 15th year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9 percent of operating expenses. In FY 2018, these expenses represented roughly $1.75 billion, or 10.8 percent of operating expenses. As Maryland hospitals have increasingly focused on implementation of cost- and quality-improvement strategies, an increasing percentage of operating expenses is being directed toward community benefit initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CBR in FY 2004. For consistency purposes, the following figures illustrate community benefit expenses from FY 2009 through FY 2018. Figures 5 and 6 show the trend of community benefit expenses with and without rate support. Historically, roughly 50 percent of expenses were reimbursed through the rate-setting system, though that figure fell to below 40 percent in FY 2018.

Figure 5. FY 2009 – FY 2018 Community Benefit Expenses with and without Rate Support, in Millions

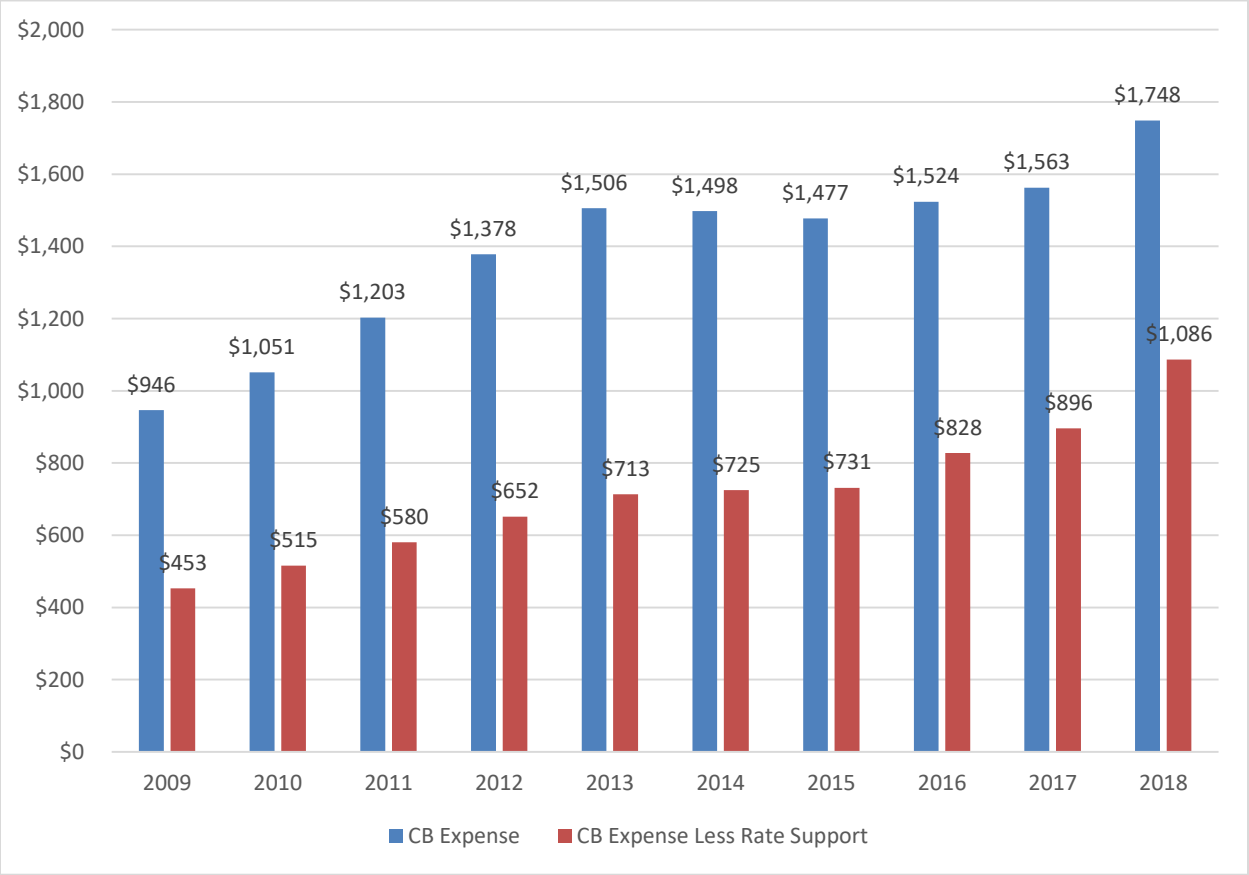
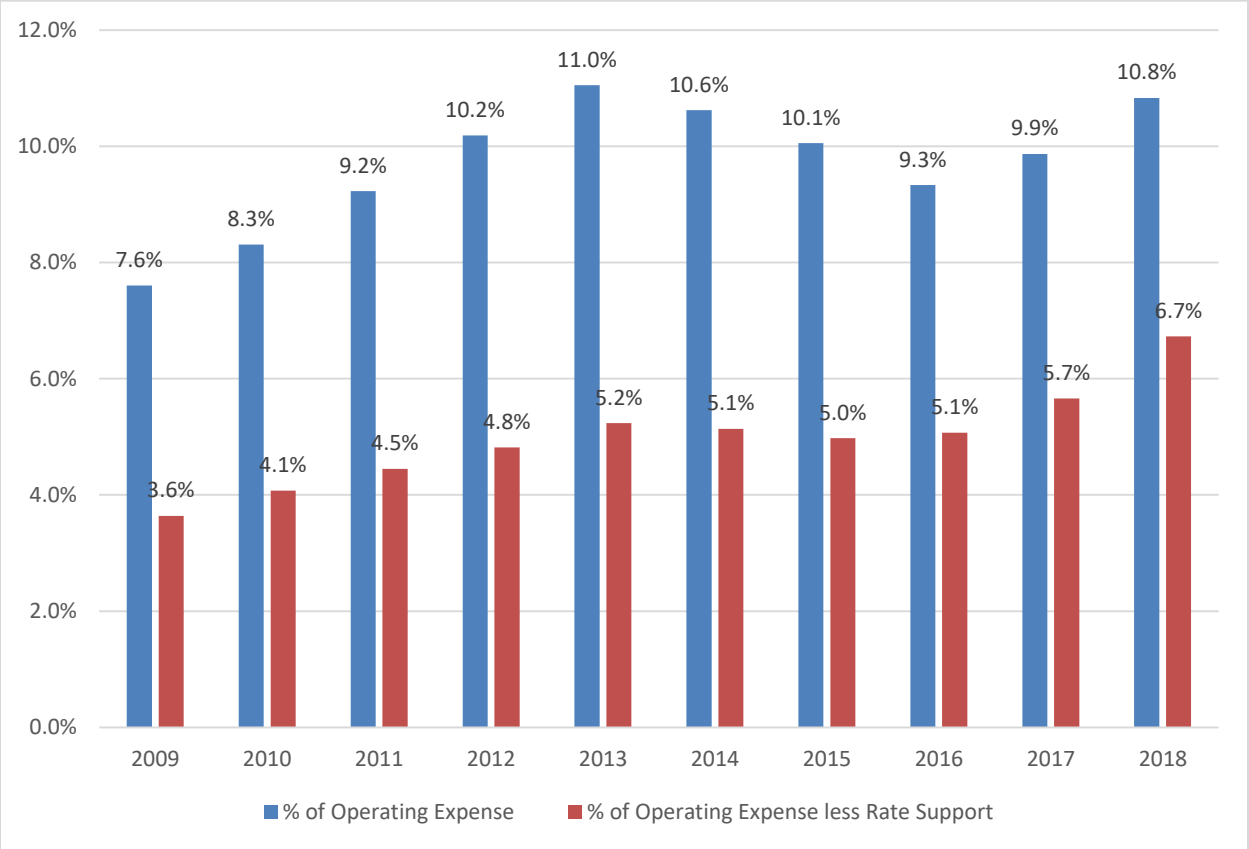


Figure 6. FY 2009 – FY 2018 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



CONCLUSION

In summary, all 51 hospital submitted their FY 2018 CBRs, showing a total of $1.7 billion in community benefit expenditures, which is a slight increase over FY 2017. The distribution of expenditures across community benefit categories remained similar to prior years, with mission-driven services accounting for the majority of expenditures. Expenditures as a percentage of operating expenses also slightly increased from FY 2017 (6.81 percent) to FY 2018(7.71 percent).

The narrative portion provides the HSCRC with richer detail on hospital community benefit beyond what is included in the financial report. The hospitals were very responsive to using the new reporting tool, and all hospitals successfully submitted their reports online. Encouraging findings of the review include senior-level commitment to community benefit activities and community engagement. For example, most hospitals now employ population health staff, and most report that these staff are involved in selecting the community health needs to target and in developing community benefit initiatives. Over 80 percent of hospitals employ staff dedicated to community benefit. Further, hospitals expanded their CBSAs in FY 2018 over FY 2017, covering more ZIP codes within the state.

The review also identified areas for further policy consideration. Consistent with previous reports, access to and partnerships with behavioral health and post-acute providers are a potential area for policy development. The most frequently reported gaps in provider availability were mental health and substance use disorders services. Only 13 hospitals reported collaborating with post-acute facilities in their community benefit initiatives. Hospital community benefit initiatives most frequently targeted chronic conditions, and diabetes and heart disease were identified as top community health needs. With the new Total Cost of Care Model, there is greater emphasis on population health and collaboration with community-based providers to address population health needs. Finally, the review found that two hospitals' reported financial assistance policies were inconsistent with the requirements in regulations. The HSCRC intends to follow up to ensure compliance.

In last year's statewide summary report, staff identified a number of areas for improving the CBR reporting tool. In consultation with the Community Benefit Workgroup, these changes were implemented and will allow for better trending analyses for reports going forward.

APPENDIX A. COMMUNITY HEALTH MEASURES REPORTED BY HOSPITALS

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

- 2017 Cigarette Restitution Fund Program
- Baltimore City Health Department 2017 Neighborhood Health Profiles
- CDC Community Health Indicators
- Comprehensive Health Services, Inc. (CHSI)
- Healthy Communities Institute
- Healthy People 2020
- HRSA
- Johns Hopkins Bloomberg School of Public Health - 2018 Healthy Food Priority Areas Map
- Johns Hopkins Center for a Livable Future - Maryland Food System Map
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Hospital Association
- Maryland Physician Workforce Study
- Maryland Report Card
- Maryland State Health Improvement Process (SHIP)
- Maryland Youth Risk Behavior Survey
- National Cancer Institute
- RWJF County Health Rankings
- Truven/IBM Market Expert
- United Way ALICE
- University of Maryland School of Public Health

APPENDIX B. CHNA SCHEDULES

Hospital	Date Most Recent CHNA was Completed as Reported on FY 2018 CBR
MedStar Franklin Square Medical Center	Jun 2015
MedStar Good Samaritan	Jun 2015
MedStar Harbor Hospital Medical Center	Jun 2015
MedStar Montgomery Medical Center	Jun 2015
MedStar Southern Maryland Hospital Center	Jun 2015
MedStar St. Mary's Hospital	Jun 2015
MedStar Union Memorial Hospital	Jun 2015
UM Charles Regional Medical Center	Jun 2015
Anne Arundel Medical Center	Feb 2016
Atlantic General Hospital	May 2016
Fort Washington Medical Center	May 2016
Meritus Medical Center	May 2016
Sheppard Pratt Health System	May 2016
UM Shore Health at Dorchester	May 2016
UM Shore Health at Easton	May 2016
UM Shore Regional Health at Chestertown	May 2016
Doctors Community Hospital	Jun 2016
Frederick Memorial Hospital	Jun 2016
Greater Baltimore Medical Center	Jun 2016
Johns Hopkins – Howard County General Hospital	Jun 2016
Peninsula Regional Medical Center	Jun 2016
Suburban Hospital	Jun 2016
UM Baltimore Washington Medical Center	Jun 2016
UM Laurel Regional Hospital	Jun 2016
UM St. Joseph Medical Center	Jun 2016
Union Hospital of Cecil County	Jun 2016
Bon Secours Baltimore Health System	Sep 2016
Holy Cross Germantown Hospital	Oct 2016
Holy Cross Hospital	Oct 2016
Garrett Regional Medical Center	Nov 2016
Adventist HealthCare Behavioral Health & Wellness Services	Dec 2016
Adventist HealthCare Rehabilitation	Dec 2016
Adventist HealthCare Shady Grove Medical Center	Dec 2016

Hospital	Date Most Recent CHNA was Completed as Reported on FY 2018 CBR
Adventist HealthCare – Washington Adventist Hospital	Dec 2016
Western Maryland Regional Medical Center	Jun 2017
CalvertHealth Medical Center	Nov 2017
McCready Health	Dec 2017
Lifebridge Carroll Hospital	Mar 2018
Lifebridge Levindale Hebrew Geriatric Center and Hospital of Baltimore	Mar 2018
Lifebridge Northwest Hospital	Mar 2018
Lifebridge Sinai Hospital	Mar 2018
Johns Hopkins Bayview Medical Center	May 2018
UM Upper Chesapeake Health	May 2018
UM Harford Memorial Hospital	May 2018
UM Rehabilitation & Orthopaedic Institute	May 2018
Johns Hopkins Hospital	Jun 2018
Mercy Medical Center	Jun 2018
Mt. Washington Pediatric Hospital	Jun 2018
St. Agnes Hospital	Jun 2018
UMMC Midtown Campus	Jun 2018
UMMC	Jun 2018

*Data Source: As reported by hospitals on their FY 2018 CBRs and edited according to hospital websites

APPENDIX C. CHNA INTERNAL AND EXTERNAL PARTICIPANTS AND THEIR ROLES

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
Internal Participants										
CB/ Community Health/Population Health Director (facility level)	3	13	32	31	28	21	32	29	19	4
CB/ Community Health/ Population Health Director (system level)	9	13	15	23	22	14	25	24	9	4
Senior Executives (CEO, CFO, VP, etc.) (facility level)	1	1	34	31	14	14	32	24	3	11
Senior Executives (CEO, CFO, VP, etc.) (system level)	5	7	18	26	14	5	23	12	2	8
Board of Directors or Board Committee (facility level)	7	4	14	17	9	4	21	16	4	11
Board of Directors or Board Committee (system level)	15	6	9	9	9	1	11	6	1	9
Clinical Leadership (facility level)	1	0	32	25	26	16	40	33	7	2
Clinical Leadership (system level)	18	6	15	14	15	4	21	15	4	0
Population Health Staff (facility level)	4	12	27	21	19	21	31	31	18	1
Population Health Staff (system level)	14	9	16	19	14	14	22	19	12	4
Community Benefit staff (facility level)	0	14	30	31	32	30	32	31	25	1
Community Benefit staff (system level)	7	13	17	19	23	16	18	18	13	6
Physician(s)	8	0	24	18	18	15	32	25	4	1
Nurse(s)	9	0	25	21	18	18	34	31	10	1
Social Workers	10	1	20	15	14	18	30	28	7	1
Community Benefit Task Force	5	11	18	23	16	22	27	25	15	9
Hospital Advisory Board	6	21	12	14	13	6	18	16	3	1
Other (specify)	7	1	2	1	5	8	7	7	5	1

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
External Participants										
Other Hospitals	15		14	20	15	24	25	19	13	4
Local Health Department	3		24	29	28	40	38	38	32	7
Local Health Improvement Coalition	9		16	19	20	27	30	30	19	1
Maryland Department of Health	21		5	4	6	7	4	6	17	3
Maryland Department of Human Resources	41		0	0	0	2	0	0	3	0
Maryland Department of Natural Resources	44		0	0	0	0	0	0	1	0
Maryland Department of the Environment	39		0	0	0	1	1	0	6	0
Maryland Department of Transportation	36		1	1	1	1	1	1	7	1
Maryland Department of Education	35		1	1	1	1	1	1	8	0
Area Agency on Aging	16		5	6	6	14	19	20	11	1
Local Govt. Organizations	20		9	10	9	12	22	20	7	1
Faith-Based Organizations	11		6	5	2	17	24	25	2	1
School - K-12	16		6	5	10	15	22	22	15	5
School - Colleges and/or Universities	19		5	6	13	17	21	23	11	5
School of Public Health	30		2	2	7	12	12	10	7	5
School - Medical School	39		0	1	1	4	4	5	3	0
School - Nursing School	33		0	3	4	6	9	8	3	0
School - Dental School	43		0	0	0	0	0	2	0	0
School - Pharmacy School	42		0	0	0	0	1	2	0	0
Behavioral Health Organizations	19		9	7	7	11	22	24	6	1
Social Service Organizations	16		8	8	9	20	25	26	4	1
Post-Acute Care Facilities	34		1	0	2	5	5	8	2	0

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
Community/Neighborhood Organizations	14		8	7	4	17	26	26	5	1
Consumer/Public Advocacy Organizations	21		6	3	3	14	20	20	6	0
Other	10		4	3	7	19	25	22	8	5

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

	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing Funding for CB Activities	Allocating budgets for individual initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other (explain)
Internal Participants										
CB/ Community Health/Population Health Director (facility level)	3	11	32	31	30	23	28	29	28	3
CB/ Community Health/ Population Health Director (system level)	13	8	23	23	23	8	14	18	20	1
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	1	32	35	21	32	35	7	17	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	7	8	26	24	19	15	16	3	14	2
Board of Directors or Board Committee (facility level)	7	4	23	19	11	8	5	3	13	8
Board of Directors or Board Committee (system level)	20	8	15	11	5	2	2	0	2	2
Clinical Leadership (facility level)	3	0	34	30	26	11	15	31	28	1
Clinical Leadership (system level)	19	8	14	14	10	6	7	10	10	0
Population Health Staff (facility level)	2	10	27	25	25	10	11	29	29	0
Population Health Staff (system level)	16	8	16	19	18	6	12	18	18	0
Community Benefit staff (facility level)	4	15	26	25	22	11	12	23	28	2
Community Benefit staff (system level)	8	16	15	15	16	4	6	15	18	2
Physician(s)	5	0	27	25	18	3	5	34	15	3
Nurse(s)	5	0	24	23	19	7	7	40	18	1
Social Workers	13	2	18	17	14	3	3	33	15	0
Community Benefit Task Force	7	11	25	23	23	3	4	12	21	2
Hospital Advisory Board	15	19	12	11	6	3	5	4	6	2
Other (specify)	37	1	5	6	6	1	1	7	2	0
External Participants										
Other Hospitals	19		18	16	20	11	0	23	19	4

	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing Funding for CB Activities	Allocating budgets for individual initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other (explain)
Local Health Department	9		23	18	24	19	0	28	22	6
Local Health Improvement Coalition	15		25	15	15	1	0	12	13	2
Maryland Department of Health	35		4	5	4	5	0	5	6	0
Maryland Department of Human Resources	48		0	0	0	0	0	0	0	0
Maryland Department of Natural Resources	48		0	0	0	0	0	0	0	0
Maryland Department of the Environment	47		0	0	0	0	0	0	0	1
Maryland Department of Transportation	45		1	1	0	0	0	2	0	1
Maryland Department of Education	42		0	1	0	1	0	3	0	1
Area Agency on Aging	26		10	7	11	5	0	15	13	2
Local Govt. Organizations	23		8	6	3	6	0	15	6	3
Faith-Based Organizations	16		17	5	2	0	0	23	5	6
School - K-12	20		11	7	6	2	0	21	10	5
School - Colleges and/or Universities	27		6	3	3	1	0	16	3	4
School of Public Health	37		3	3	4	1	0	9	5	0
School - Medical School	39		3	1	3	3	0	7	4	1
School - Nursing School	32		4	2	4	1	0	13	4	2
School - Dental School	45		0	0	0	0	0	3	0	0
School - Pharmacy School	44		1	1	1	0	0	3	1	1
Behavioral Health Organizations	26		12	8	7	2	0	20	10	2
Social Service Organizations	23		10	13	6	6	0	19	11	2
Post-Acute Care Facilities	35		3	0	3	0	0	10	3	2
Community/Neighborhood Organizations	19		15	12	9	5	0	25	13	2
Consumer/Public Advocacy Organizations	35		5	5	2	1	0	12	9	1

	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing Funding for CB Activities	Allocating budgets for individual initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other (explain)
Other	25		9	10	5	8	0	17	11	3

APPENDIX E. FY 2018 FUNDING FOR NURSE SUPPORT PROGRAM I, DIRECT MEDICAL EDUCATION, AND CHARITY CARE

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
Adventist Behavioral Health Rockville	$0	$0	$0	$0
Adventist Rehab of Maryland	$0	$59,505	$0	$59,505
Adventist Shady Grove Hospital	$0	$388,714	$3,058,879	$3,447,593
Adventist Washington Adventist	$0	$263,178	$7,371,752	$7,634,930
Anne Arundel Medical Center	$581,746	$576,313	$4,083,657	$5,241,716
Atlantic General	$0	$105,462	$2,722,729	$2,828,191
Bon Secours	$0	$106,732	$624,232	$730,964
Calvert Hospital	$0	$146,699	$4,279,044	$4,425,743
Carroll Hospital Center	$0	$254,065	$802,579	$1,056,643
Doctors Community	$0	$234,046	$8,723,983	$8,958,029
Fort Washington Medical Center	$0	$48,728	$1,087,072	$1,135,799
Frederick Memorial	$0	$363,796	$6,315,042	$6,678,838
Garrett County Hospital	$0	$48,480	$2,457,098	$2,505,578
GBMC	$8,348,758	$439,684	$2,188,897	$10,977,339
Holy Cross Germantown Hospital	$0	$80,883	$5,384,741	$5,465,624
Holy Cross Hospital	$2,663,635	$505,712	$29,480,773	$32,650,121
Howard County Hospital	$0	$297,946	$4,684,589	$4,982,536
Johns Hopkins Bayview Medical Center	$22,133,583	$643,455	$18,323,641	$41,100,679
Johns Hopkins Hospital	$115,134,967	$2,282,683	$29,663,925	$147,081,575
Lifebridge Levindale	$0	$60,313	$0	$60,313
Lifebridge Northwest Hospital	$0	$257,945	$2,599,234	$2,857,179
LifeBridge Sinai	$15,700,811	$732,672	$6,268,158	$22,701,641
McCready	$0	$16,309	$228,989	$245,299
MedStar Franklin Square	$8,972,942	$505,736	$8,190,971	$17,669,649
MedStar Good Samaritan	$4,379,485	$289,109	$5,908,644	$10,577,237
MedStar Harbor Hospital	$5,191,474	$194,369	$5,065,512	$10,451,356
MedStar Montgomery General	$0	$175,828	$2,407,213	$2,583,041
MedStar Southern Maryland	$0	$271,939	$5,084,691	$5,356,630
MedStar St. Mary's Hospital	$0	$178,044	$4,335,334	$4,513,378
MedStar Union Memorial	$13,391,966	$426,344	$7,578,927	$21,397,237
Mercy Medical Center	$5,047,339	$513,600	$15,544,958	$21,105,897
Meritus Medical Center	$0	$321,749	$4,736,137	$5,057,885
Mt. Washington Pediatrics	$0	$58,586	$0	$58,586
Peninsula Regional	$0	$430,071	$8,185,920	$8,615,991
Sheppard Pratt	$2,525,139	$145,349	$0	$2,670,488

Hospital Name	Direct Medical Education (DME)	Nurse Support Program I (NSPI)	Charity Care in Rates	Total Rate Support
St. Agnes	$8,121,090	$432,204	$23,124,503	$31,677,797
Suburban Hospital	$498,336	$301,899	$3,772,662	$4,572,896
UM Baltimore Washington	$631,517	$413,064	$6,023,617	$7,068,198
UM Capital Region	$5,392,004	$391,800	$12,710,685	$18,494,489
UM Charles Regional Medical Center	$0	$148,693	$966,136	$1,114,829
UM Harford Memorial	$0	$104,106	$1,476,120	$1,580,226
UM Midtown	$4,365,083	$226,817	$4,573,587	$9,165,486
UM Rehabilitation and Ortho Institute	$3,818,820	$118,767	$0	$3,937,587
UM Shore Medical Chestertown	$0	$60,065	$412,474	$472,539
UM Shore Medical Dorchester	$0	$51,453	$636,456	$687,909
UM Shore Medical Easton	$0	$199,614	$2,394,487	$2,594,101
UM St. Joseph	$0	$402,083	$5,363,890	$5,765,973
UM Upper Chesapeake	$0	$330,967	$5,252,700	$5,583,667
UMMC & Shock Trauma	$117,180,824	$1,547,784	$16,505,857	$135,234,465
Union Hospital of Cecil County	$0	$160,304	$1,497,839	$1,658,143
Western Maryland Health System	$0	$325,608	$9,443,042	$9,768,650
Total	**$344,079,520**	**$16,639,270**	**$301,541,377**	**$662,260,166**

APPENDIX F. CHARITY CARE METHODOLOGY

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

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

Step 1

Determine the amount of uncompensated care that was projected for each hospital for the fiscal year being reported (in this case, we are referring to the FY 2017 Community Benefit Report) based on the policy approved by the Commission for the beginning of the rate year (also FY 2017).

- The HSCRC uses a logistic regression to predict actual hospital uncompensated care costs in a given year (FY 2017).
- The uncompensated care logistic regression model predicts a patient's likelihood of having UCC based on payer type, the location of service (inpatient, ED, and other outpatient), and the Area Deprivation Index.[36]
    - An expected UCC dollar amount is calculated for every patient encounter.
    - These UCC dollars are then summed at the hospital level.
    - These summed UCC dollars are then divided by the hospital's total charges to estimate the hospital's UCC level.
- The hospital's most current fiscal year financial audited UCC levels (FY 2017) are averaged with the hospital's estimated UCC levels from the prior FY (FY16) to determine hospital-specific adjustments. These are predicted amounts provided to hospitals to fund the coming year's UCC.
- The rate year 2017 statewide UCC amount is set at 4.69 percent.

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 2017 policy. The resulting charity care amount is the estimated amount provided in rates that will be subtracted from the hospital's community benefit.

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

Example Johns Hopkins:

Predicted Value from FY 2016 Estimated UCC Levels 3.60%

FY 2017 Audited Financial UCC Level 2.25%

Predicted 50/50 Average 3.02%

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

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

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

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

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

APPENDIX G. FY 2018 COMMUNITY BENEFIT ANALYSIS

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
Adventist Behavioral Health Rockville*	397	752	$49,561,380	$5,299,339	10.69%	$0	$5,299,339	10.69%	$1,415,734
Adventist Rehab of Maryland*	499	841	$46,858,266	$2,710,713	5.78%	$59,505	$2,651,207	5.66%	$252,630
Adventist Washington Adventist*	1,342	5,914	$243,708,768	$35,087,712	14.40%	$7,634,930	$27,452,781	11.26%	$6,640,537
Anne Arundel Medical Center	4,746	3,277	$558,534,000	$50,281,740	9.00%	$5,241,716	$45,040,023	8.06%	$3,923,800
Atlantic General	950	95	$127,458,282	$13,401,211	10.51%	$2,828,191	$10,573,020	8.30%	$2,567,553
Bon Secours	589	17,917	$109,675,296	$24,668,422	22.49%	$730,964	$23,937,457	21.83%	$488,596
Calvert Hospital	1,300	376	$131,906,976	$18,375,823	13.93%	$4,425,743	$13,950,080	10.58%	$5,547,029
Carroll Hospital Center	1,793	2,080	$195,292,000	$15,781,944	8.08%	$1,056,643	$14,725,301	7.54%	$546,974
Doctors Community	1,604	1,444	$195,871,667	$13,508,198	6.90%	$8,958,029	$4,550,169	2.32%	$8,862,484
Frederick Memorial	1964	134	$340,036,000	$30,721,235	9.03%	$6,678,838	$24,042,397	7.07%	$6,785,000
Ft. Washington	408	416	$42,237,402	$2,368,122	5.61%	$1,135,799	$1,232,323	2.92%	$928,769
Garrett County Hospital	439	10	$51,150,258	$3,169,409	6.20%	$2,505,578	$663,831	1.30%	$2,550,792
GBMC	0	4,380	$504,347,676	$42,577,897	8.44%	$10,977,339	$31,600,558	6.27%	$1,710,711
Holy Cross Germantown	674	356	$100,707,482	$9,403,754	9.34%	$5,465,624	$3,938,129	3.91%	$4,839,365
Holy Cross Hospital	3,461	4,696	$413,981,550	$51,218,319	12.37%	$32,650,121	$18,568,199	4.49%	$31,485,836
Howard County Hospital	1,752	2,580	$265,393,000	$26,930,941	10.15%	$4,982,536	$21,948,406	8.27%	$4,598,000
Johns Hopkins Bayview Medical Center	3,446	3,421	$632,548,000	$83,958,769	13.27%	$41,100,679	$42,858,090	6.78%	$18,957,000
Johns Hopkins Hospital	0	7,079	$2,396,322,000	$272,875,357	11.39%	$147,081,575	$125,793,781	5.25%	$26,475,000

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
Levindale	884	126	$77,169,000	$3,327,824	4.31%	$60,313	$3,267,511	4.23%	$1,018,600
Lifebridge Northwest Hospital	1,767	723	$244,796,678	$13,729,621	5.61%	$2,857,179	$10,872,442	4.44%	$2,067,000
LifeBridge Sinai	4,992	2,295	$752,831,000	$58,913,086	7.83%	$22,701,641	$36,211,445	4.81%	$6,360,600
McCready	273	8	$18,107,925	$652,490	3.60%	$245,299	$407,192	2.25%	$326,004
MedStar Franklin Square	3,013	2,616	$518,888,097	$41,489,808	8.00%	$17,669,649	$23,820,159	4.59%	$7,344,175
MedStar Good Samaritan	1,722	1,594	$259,072,976	$18,360,426	7.09%	$10,577,237	$7,783,188	3.00%	$4,954,141
MedStar Harbor Hospital	1,125	682	$183,508,480	$22,870,652	12.46%	$10,451,356	$12,419,296	6.77%	$3,820,520
MedStar Montgomery General	1,721	60	$165,450,371	$6,332,705	3.83%	$2,583,041	$3,749,664	2.27%	$1,847,698
MedStar Southern Maryland	1,221	8,212	$247,677,692	$18,050,703	7.29%	$5,356,630	$12,694,073	5.13%	$4,843,585
MedStar St. Mary's Hospital	1,200	5,000	$162,218,677	$17,492,296	10.78%	$4,513,378	$12,978,918	8.00%	$3,983,754
MedStar Union Memorial	2,263	664	$449,182,066	$37,410,521	8.33%	$21,397,237	$16,013,284	3.56%	$6,610,504
Mercy Medical Center	3,551	2,489	$483,817,200	$57,442,772	11.87%	$21,105,897	$36,336,875	7.51%	$14,621,887
Meritus Medical Center	2,707	312	$314,735,209	$23,564,918	7.49%	$5,057,885	$18,507,033	5.88%	$4,718,533
Mt. Washington Pediatrics	672	3,151	$58,944,476	$1,476,802	2.51%	$58,586	$1,418,216	2.41%	$86,541
Peninsula Regional	2,794	349	$427,360,744	$50,423,375	11.80%	$8,615,991	$41,807,384	9.78%	$7,604,900
Shady Grove*	1,994	6,324	$337,019,361	$28,444,407	8.44%	$3,447,593	$24,996,814	7.42%	$2,979,569
Sheppard Pratt	2,782	724	$234,132,619	$16,611,638	7.09%	$2,670,488	$13,941,150	5.95%	$4,605,738
St. Agnes	0	0	$452,096,000	$51,743,113	11.45%	$31,677,797	$20,065,315	4.44%	$23,954,876
Suburban Hospital	1,786	0	$295,311,000	$25,543,204	8.65%	$4,572,896	$20,970,308	4.10%	$4,386,000

Hospital Name	Number of Employees	Number of Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	Total in Rates for Charity Care, DME, and NSPI*	Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus Charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
UM Baltimore Washington	2,200	2,936	$344,997,000	$23,691,460	6.87%	$7,068,198	$16,623,262	4.82%	$6,845,000
UM Capital Region	2,603	4,160	$285,839,000	$78,564,066	27.49%	$18,494,489	$60,069,577	21.02%	$12,147,000
UM Charles Regional Medical Center	0	1,868	$120,993,920	$11,528,332	9.53%	$1,114,829	$10,413,503	8.61%	$971,260
UM Harford Memorial	994	936	$87,719,000	$7,721,886	8.80%	$1,580,226	$6,141,660	7.00%	$1,903,000
UM Midtown	1,423	250	$223,093,000	$37,972,794	17.02%	$9,165,486	$28,807,308	12.91%	$3,962,000
UM Rehabilitation and Ortho Institute	667	0	$109,216,000	$9,418,991	8.62%	$3,937,587	$5,481,404	5.02%	$2,258,000
UM Shore Medical Chestertown	241	1,260	$46,259,300	$12,388,833	26.78%	$472,539	$11,916,295	25.76%	$475,000
UM Shore Medical Dorchester	284	1,460	$40,094,943	$10,346,219	25.80%	$687,909	$9,658,310	24.09%	$704,387
UM Shore Medical Easton	1,143	1,060	$187,273,586	$31,622,263	16.89%	$2,594,101	$29,028,162	15.50%	$2,800,988
UM St. Joseph	2,378	25	$337,972,000	$38,134,583	11.28%	$5,765,973	$32,368,610	9.58%	$5,281,000
UM Upper Chesapeake	2,156	2,183	$262,553,000	$15,439,651	5.88%	$5,583,667	$9,855,984	3.75%	$4,313,000
UMMC	8,899	3,919	$1,522,227,000	$212,918,463	13.99%	$135,234,465	$77,683,998	5.10%	$22,057,000
Union Hospital of Cecil County	1,372	2,140	$164,054,488	$8,693,334	5.30%	$1,658,143	$7,035,191	4.29%	$1,822,394
Western Maryland Health System	1,979	252	$323,338,357	$53,781,549	16.63%	$9,768,650	$44,012,899	13.61%	$10,489,666
All Hospitals	**85,808**	**112,793**	**$16,093,978,788**	**$1,743,142,350**	**10.83%**	**$1,111,625,421**	**$631,516,928**	**3.92%**	**$309,324,396**

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

APPENDIX H. FY 2018 HOSPITAL COMMUNITY BENEFIT AGGREGATE DATA

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Unreimbursed Medicaid Costs								
T99	Medicaid Assessments	$-	$-	$364,825,001	$-	$308,349,116	$56,475,885	$56,475,885
Community Health Services								
A10	Community Health Education	1,077,976	1,918,721	16,861,383	9,407,327	2,032,085	24,236,625	$14,829,298
A11	Support Groups	27,742	38,293	2,828,315	1,740,066	360,257	4,208,124	$2,468,058
A12	Self-Help	24,410	83,271	1,420,823	864,678	364,907	1,920,594	$1,055,916
A20	Community-Based Clinical Services	302,783	297,981	15,494,510	13,763,579	11,057,105	18,200,984	$4,437,405
A21	Screenings	46,014	204,178	2,000,791	1,328,912	221,976	3,107,728	$1,778,816
A22	One-Time/Occasionally Held Clinics	1,505	8,245	179,644	72,965	17,809	234,800	$161,835
A23	Free Clinics	3,998	9,243	4,393,521	963,129	280,911	5,075,739	$4,112,611
A24	Mobile Units	31,283	9,806	2,478,558	840,018	1,788,572	1,530,004	$689,986
A30	Health Care Support Services	382,989	345,885	39,875,757	20,716,454	3,647,369	56,944,842	$36,228,388
A40	Other	49,032	113,811	9,489,166	3,231,508	3,334,406	9,386,268	$6,154,760
A41	Other	20,698	8,155	1,261,637	718,364	0	1,980,002	$1,261,637
A42	Other	5,809	12,225	362,031	127,558	10	489,579	$362,021
A43	Other	3,193	2,069	122,758	61,184	80,000	103,943	$42,758
A44	Other	0	0	0	0	0	0	$-
A99	**Total**	**1,977,412**	**3,051,383**	**$96,768,898**	**$53,835,742**	**$23,185,408**	**$127,419,231**	**$73,583,489**
Health Professions Education								
B1	Physicians/Medical Students	3,922,546	55,008	343,365,436	150,027,991	353,767	493,039,660	$343,011,669
B2	Nurses/Nursing Students	508,674	21,900	25,464,327	9,116,006	154,558	34,425,775	$25,309,769
B3	Other Health Professionals	349,670	30,913	16,711,696	6,526,753	311,729	22,926,720	$16,399,967

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
B4	Scholarships/Funding for Professional Education	5,310	599	3,592,392	1,719,435	49,550	5,262,277	$3,542,842
B50	Other	66,223	4,936	3,702,493	1,474,545	36,938	5,140,100	$3,665,555
B51	Other	44,962	6,725	2,426,537	52,240	2,283,877	194,901	$142,661
B52	Other	252	1,000	43,034	30,318	63,239	10,113	$(20,205)
B99	**Total**	**4,897,638**	**121,082**	**$395,305,915**	**$168,947,287**	**$3,253,658**	**$560,999,545**	**$392,052,258**
	Mission-Driven Health Services							
	Mission-Driven Health Services Total	**4,175,634**	**1,643,854**	**$750,879,444**	**$113,537,965**	**$249,375,451**	**$615,041,958**	**$501,503,993**
	Research							
D1	Clinical Research	102,647	2,716	11,008,169	1,469,686	4,553,423	7,924,432	$6,454,746
D2	Community Health Research	23,147	3,816	1,309,029	360,093	153,809	1,515,312	$1,155,220
D3	Other	22,947	0	1,789,316	376,132	0	2,165,448	$1,789,316
D99	**Total**	**148,741**	**6,532**	**$14,106,514**	**$2,205,911**	**$4,707,232**	**$11,605,193**	**$9,399,282**
	Financial Contributions							
E1	Cash Donations	661	5,587	9,087,468	107,049	74,886	9,119,631	$9,012,582
E2	Grants	3,692	456	452,486	20,201	158,457	314,230	$294,029
E3	In-Kind Donations	22,240	108,894	4,012,084	379,434	188,397	4,203,120	$3,823,687
E4	Cost of Fund Raising for Community Programs	3,078	5,004	446,192	256,493	0	702,686	$446,192
E99	**Total**	**29,671**	**119,941**	**$13,998,230**	**$763,177**	**$421,740**	**$14,339,667**	**$13,576,490**
	Community-Building Activities							
F1	Physical Improvements/Housing	29,486	7,517	6,429,677	5,884,273	4,652,100	7,661,850	$1,777,577
F2	Economic Development	3,451	3,944	2,451,588	193,626	13,186	2,632,027	$2,438,402
F3	Support System Enhancements	105,083	30,883	3,432,732	1,752,443	777,998	4,407,177	$2,654,734
F4	Environmental Improvements	13,917	3,382	1,360,049	592,437	29,000	1,923,486	$1,331,049

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
F5	Leadership Development/Training for Community Members	3,149	839	117,074	65,641	0	182,716	$117,074
F6	Coalition Building	23,610	7,349	3,233,505	1,889,268	110,532	5,012,240	$3,122,973
F7	Community Health Improvement Advocacy	7,709	22,966	1,914,329	1,083,724	0	2,998,054	$1,914,329
F8	Workforce Enhancement	62,747	98,490	3,864,338	2,223,322	190,015	5,896,645	$3,674,323
F9	Other	24,241	120,433	525,781	300,396	12,878	813,299	$512,903
F10	Other	1,750	161	92,362	61,974	0	154,336	$92,362
F11	Other	564	0	135,480	93,346	0	228,826	$135,480
	Total	**275,722**	**295,964**	**$23,685,790**	**$14,252,263**	**$5,785,709**	**$32,152,344**	**$17,900,082**
Community Benefit Operations								
G1	Dedicated Staff	100,126	1,565	7,165,049	4,675,414	44,422	11,796,041	$7,120,627
G2	Community health/health assets assessments	5,909	629	605,455	265,791	15,488	855,798	$590,007
G3	Other Resources	7,511	500	1,188,872	578,884	0	1,767,756	$1,188,872
G4	Other	0	0	70,000	54,488	0	124,488	$70,000
G99	**Total**	**113,545**	**2,694**	**$9,029,376**	**$5,574,577**	**$59,870**	**14,544,083**	**$8,969,506**
Charity Care								
	Total Charity Care	**$310,740,130**						
Foundation-Funded Community Benefits								
J1	Community Services	3,888	9,404	1,188,297	135,367	220,107	1,103,557	$968,190
J2	Community Building	63,360	26,120	3,476,181	2,936,824	2,182,222	4,230,783	$1,293,959
J3	Other	0	0	0	0	0	0	$-
J99	**Total**	**67,248**	**35,524**	**$4,664,478**	**$3,072,192**	**$2,402,329**	**$5,334,341**	**$2,262,149**
Total Hospital Community Benefits								
A	Community Health Services	1,977,412	3,051,383	$96,768,898	$53,835,742	$23,185,408	$127,419,231	$73,583,489

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
B	Health Professions Education	4,897,638	121,082	$395,305,915	$168,947,287	$3,253,658	$560,999,545	$392,052,258
C	Mission Driven Health Care Services	4,175,634	1,643,854	$750,879,444	$113,537,965	$249,375,451	$615,041,958	$501,503,993
D	Research	148,741	6,532	$14,106,514	$2,205,911	$4,707,232	$11,605,193	$9,399,282
E	Financial Contributions	29,671	119,941	$13,998,230	$763,177	$421,740	$14,339,667	$13,576,490
F	Community Building Activities	275,707	295,964	$23,556,914	$14,140,451	$5,785,709	$31,911,655	$17,771,205
G	Community Benefit Operations	113,545	2,694	$9,029,376	$5,574,577	$59,870	$14,544,083	$8,969,506
H	Charity Care	0	0	$310,740,130	$0	$-	$310,740,130	$310,740,130
J	Foundation Funded Community Benefit	67,248	35,524	$4,664,478	$3,072,192	$2,402,329	$5,334,341	$2,262,149
T99	Medicaid Assessments	0	0	$364,825,001	$-	$308,349,116	$56,475,885	$56,475,885
K99	**Total Hospital Community Benefit**	**11,685,595**	**5,276,973**	**$1,983,874,900**	**$362,077,302**	**$597,540,513**	**$1,748,441,689**	**$1,386,334,387**
	Total Operating Expenses	**$16,143,540,168**						
	% Operating Expenses w/ Indirect Costs	**10.83%**						
	% Operating Expenses w/ o Indirect Costs	**8.59%**						

Nurse Support Program II
FY 2020 Draft Recommendation

April 10, 2019

Oscar Ibarra
HSCRC

HSCRC
Health Services Cost Review Commission

NSP II Initiatives & Focus Areas

Initiatives for implementation grants in the following five categories:

- Increase Nursing Pre-Licensure Enrollments and Graduates
- Advance the Education of Students and RNs to BSN, MSN & Doctoral
- Increase the Number of Doctoral Prepared Nursing Faculty
- Build Collaborations between Education and Practice
- Develop Statewide Resources and Models

Focus Areas:

- Resource grants: For unmet needs or MD Board of Nursing action plan support
- Planning grants: For new areas of interest or developing proposal
- Statewide faculty focused programs: For recruitment and retention of nurse faculty

Goal: BSN 80 percent by 2020

Over 15 years, have seen increase in the overall education of nurses. Total BSN degrees awarded surpassing ADN degrees related to:

1. Hospitals aware better outcomes with BSN-prepared RNs
2. Economic incentives rewarded hospitals for improved quality
3. Magnet Recognition Program® requires hospitals to have a higher proportion of BSN-educated RNs
4. 2010 IOM report that set a goal of the nursing workforce composed of 80% BSN-prepared RNs by 2020[1]

[1]Buerhaus, Auerbach, Skinner & Staiger (2017). State of the registered nurse workforce in a new era of health reform emerges, *Nursing Economics*, 35(5), 229-237.

NSP II Progress Report

- Met goal of doubling doctoral degree nurses [2]
- NEDG awarded 18 percent of full time faculty to expedite doctoral completions
- Making good progress on goal for 80 percent of nurse workforce with a BSN or higher by 2020
  - Maryland is outpacing the nation at 60.2 percent compared to 56 percent for the nation
- Increased the number of certified nurse educators (CNE) by 21 percent
  - Goal to double # of full time nurse faculty with CNE credential
- National Academies of Sciences, Engineering and Medicine, Committee on the Future of Nursing 2020-2030 study will add to earlier guidance from Future of Nursing (2010) and Future of Nursing Progress Report (2015)

[2] The Future of Nursing 2020-2030, https://nam.edu/the-future-of-nursing-2020-2030/

Staff Recommendations For Funding FY 2020

Grant #	Institution	Grant Title	Proposed Funding
20-102	Allegany College	LPN- RN Online	$150,000
20-104	Coppin State University	Cognitive Reflective CARE	$50,000
20-105	Coppin State University	Planning BSN to DNP	$148,100
20-106	Coppin State University	ATB with CCBC & Howard	$143,951
20-108	Johns Hopkins University	PRIME Model for DNP-NP	$1,001,596
20-109	Johns Hopkins University	Supporting Advance Practice	$150,000
20-110	Johns Hopkins University	Planning CRNA	$150,000
20-112	Montgomery College	ASEL Resources	$50,000
20-116	Morgan State University	Student Resources	$47,897
20-117	Notre Dame of Maryland University	B-Line Software Resources	$50,000
20-118	Salisbury University	Planning MA-FAMI	$149,998
20-120	Towson University	Entry Level MS in Nursing	$149,556
20-121	University of Maryland	AGPCNP Certification	$121,972
20-122	University of Maryland	SA and Addictions Program	$137,408
20-123	University of Maryland	Clinical Faculty Competency	$264,677
20-125	University of Maryland	Maryland Nursing Workforce Center Continuation	$1,912,767
20-126	Montgomery College	MCSRC Group Resource Continuation	$1,475,525
		TOTAL	$6,153,447

Nurse Support Program II

Competitive Institutional Grants Program

Review Panel Recommendations for FY 2020

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, Maryland 21215

(410) 764-2605

FAX: (410) 358-6217

DRAFT

April 10, 2019

This is a draft recommendation for Commission consideration at the April 10, 2019 Public Commission Meeting. Please submit comments on this draft to the Commission by Wednesday, May 1, 2019, via hard copy mail or email to Oscar.Ibarra@maryland.gov.

INTRODUCTION

This report presents recommendations of the Review Panel for funding of the Nurse Support Program II (NSP II) Competitive Institutional Grant for Fiscal Year (FY) 2020. This report and recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the Maryland Health Services Cost Review Commission (HSCRC or Commission).

BACKGROUND

The HSCRC has funded programs to address the cyclical nursing workforce shortages since 1985. In July 2001, the HSCRC implemented the hospital-based Nurse Support Program I (NSP I) to address the nursing shortage impacting Maryland hospitals. Since that time, the NSP I completed three, five-year program evaluation cycles. The most recent renewal was approved on July 12, 2017 to extend the funding until June 30, 2022. The HSCRC implemented the NSP II program in May 2005 to respond to the faculty shortage and other limitations in nursing educational capacity underlying the nursing shortage. The Commission approved an increase of up to 0.1 percent of regulated gross hospital revenue to increase the number of nurses in the state by increasing the capacity of nursing programs through institutional and nursing faculty interventions. MHEC was selected by the HSCRC to administer the NSP II programs, as the coordinating board for all Maryland institutions of higher education. At the conclusion of the first ten years of funding on January 14, 2015, the HSCRC renewed funding for FY 2016 through June 30, 2020. In 2016, the Maryland General Assembly revised the NSP II statute to meet Maryland's changing health care delivery models to recognize all registered nurses (RNs) are needed to ensure a strong nursing workforce. The NSP II program evaluation is in progress and the final report will be submitted to the Commission in December 2019 for approval for FY 2021-2025 funding cycle.

REVIEW OF NSP II GRANT FUNDING RESULTS

The following sections detail the progress made on key initiatives. NSP II has four key areas of focus to strengthen capacity across the state's nursing programs: increasing pre-licensure graduates while making progress toward the "80 percent BSN by 2020"; doubling the doctoral prepared nurses for more highly qualified nurse faculty; advancing lifelong learning for the pipeline for future nurses; and providing for stronger data infrastructure for the nursing workforce.

CERTIFICATION FOR ACADEMIC NURSE EDUCATORS

One indicator of nursing education excellence is certification. NSP II supports nursing education as a specialty area of practice. As clinical nurses are recognized through certification by the American Nurse Credentialing Center (ANCC), nurse educators have a comparable certification process for academic educators through the National League for Nursing (NLN). The CNE credential communicates to academic and health care communities, students, colleagues, and the public that the highest standard of excellence is being met. Faculty serve as role models and leaders with this mark of distinction.

Since January 8, 2018, four NLN Certified Nurse Educator (CNE) Workshops have been sponsored by NSP II. There were approximately 185 nurse faculty attendees seeking to prepare for the examination and complete the credential of CNE. In 2017, a review of data submitted with proposals and annual reports revealed that approximately 12 percent of faculty in Maryland colleges and universities held the CNE credential. By 2020, the goal across the State's nursing programs is to double the number of full-time faculty with this specialty certification for nurse educators. As of March 29, 2019 an additional 26 nurse faculty across 15 nursing programs have achieved the CNE credential. Of the 26 nurses credentialed, 12 nurse faculty represented 6 community colleges (Anne Arundel Community College, Chesapeake College, Community College of Baltimore County, Harford Community College, Howard Community College and Montgomery College) and the remaining 14 nurse faculty represented 9 universities (Frostburg State University, Johns Hopkins University, Hood College, Notre Dame of Maryland University, Salisbury University, Towson University, University of Maryland, Washington Adventist University, and University of Maryland University College). This is a 21% increase and a clear demonstration of excellence in education with nurse faculty committed to the highest standards.

This past February, the Maryland Council of Deans and Directors of Nursing Programs fully endorsed the new NSP II Academic Nurse Educator Certification Award which supports the preparation, CNE examination fees and ongoing professional development each faculty needs to achieve and renew this valued credential every 5 years. This will provide incentives for current full time faculty to demonstrate expertise in pedagogy, curriculum development, teaching and student learning.

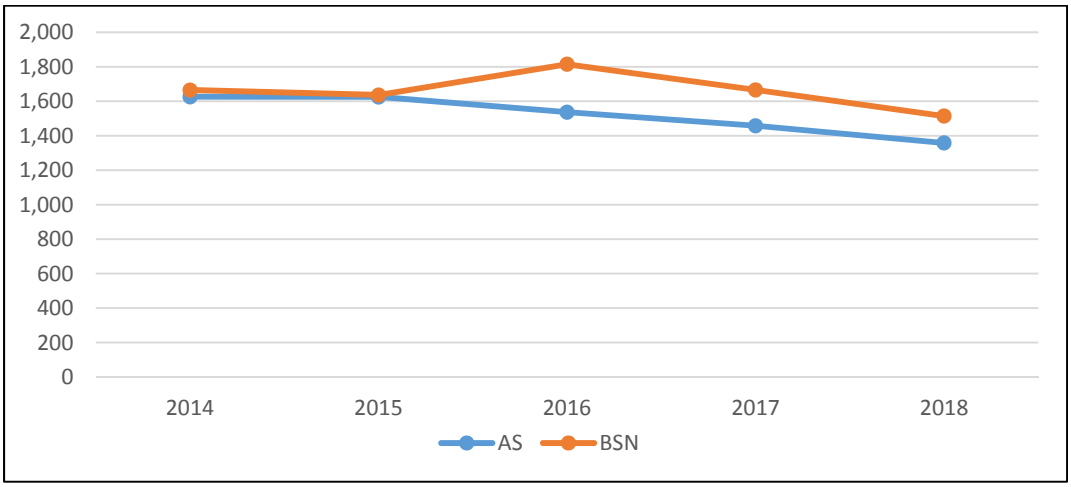
ASSOCIATE TO BACHELORS IN NURSING MODEL

Over the last 5 years, Maryland's nursing graduate data reflects an increase in the overall education of the nursing workforce. According to leading nursing researchers, the total number of Bachelor of Science in Nursing (BSN) degrees awarded have surpassed the Associate of Science in Nursing (AS) degrees. There are several factors behind this movement in registered nurse (RN) education:

- Hospitals are aware of better patient outcomes associated with BSN-prepared RNs;
- Economic incentives reward hospitals for improved quality;
- Requirements for hospitals to have a higher proportion of BSN-educated RNs for the Magnet Recognition Program® , and
- The Institute of Medicine's (2010) report recommending that 80 percent of nurses be BSN-prepared by 2020 (Buerhaus, et al., 2017).

Maryland's nursing programs, both community colleges and universities, have partnered together to promote the BSN with Associate to Bachelors (ATB) agreements for seamless academic progression. We are working with the Maryland Longitudinal Data Center at MHEC to measure ATB completions and determine time and cost savings to the individual nursing student. We expect this seamless transition to result in cost savings to hospitals as fewer courses will need to be completed for the BSN; thereby reducing the amount of tuition reimbursement.

Table 1. Trends in Associate of Science in Nursing (AS) and Bachelor of Science Degrees in Nursing (BSN), 2014 – 2018



Source: Maryland Higher Education Commission Nursing Graduate Data

PROGRESS ON GOALS

The following sections provide an update on the two goals adopted from the IOM *The Future of Nursing* report: 80 percent BSN by 2020 and double the number of doctoral nurses.

80 percent BSN BY 2020

Across the country, progress has been made on the Institute of Medicine's (2010) *The Future of Nursing* report recommendation to increase the number of nurses with a BSN or higher to 80 percent by 2020. The Campaign for Action Maps, funded through the AARP Foundation and Robert Wood Johnson Foundation, used American Community Survey data to display national trends in BSN-prepared nurses. As shown in Table 2, the national average for BSN was 55.9 percent, while Maryland outpaced the national average at 60.2 percent (Courville & Green, 2019). Maryland is making steady progress when compared to other neighboring states in our geographic region, as well.

Table 2. Progress on 80 percent BSN by 2020: A Comparison of Maryland and Neighboring States

	2010	2017	Percent Change
Maryland	55.4%	60.2%	4.8%
Delaware	42.1%	62.8%	20.7%
Pennsylvania	45.9%	57.5%	11.5%
Virginia	51.1%	51.7%	0.6%
West Virginia	37.4%	50.1%	12.7%
US	48.8%	55.9%	7.1%

Source: Campaign for Action Maps Show Nurses' Progress in Earning BSN Degree, 2019

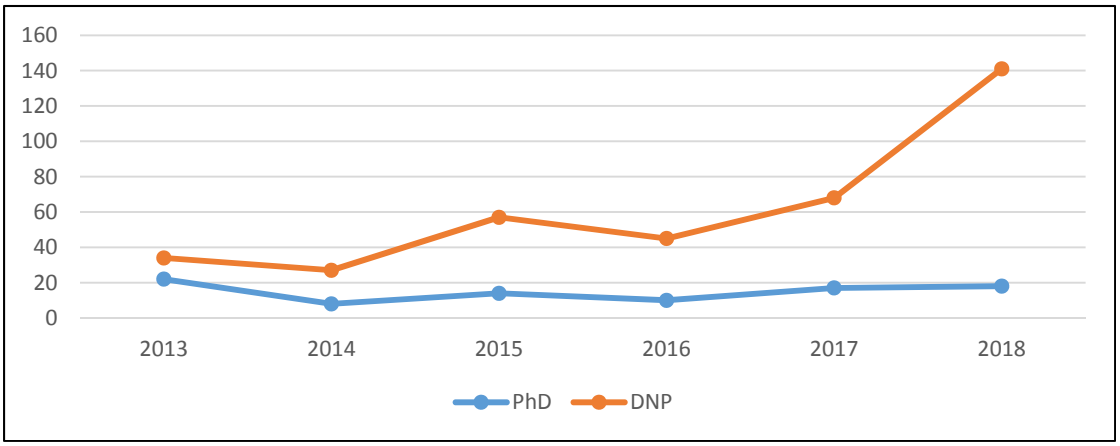
Last year, NSP II funded the Maryland Nursing Workforce Center (MNWC) to compile and report on nursing workforce data. The state level data collected from this initiative will be instrumental in future reports on trends in the state's nursing workforce. The MNWC was recognized by the National Forum of State Nursing Workforce Centers in 2019 to represent Maryland. The Center will serve as a nexus to collect, analyze and manage data, streamline research access and ensure state-level minimum data sets are available at the state and national level. These resources will be available to nursing programs, educators, employers, hospitals, nurses and the public to inform policy development.

DOUBLE THE NURSES WITH DOCTORAL DEGREES

The planning committee for the National Academy of Medicine (formerly IOM) convened a public session on March 22, 2019 for the upcoming study, *The Future of Nursing 2020-2030.* During the meeting, national researchers reported the 2010 goal of doubling the number of nurses with a doctoral degree has been achieved. Maryland data supports this increase in doctoral degrees, for both Doctor of Philosophy in Nursing (PhD) and Doctor of Nursing Practice (DNP). Consistent with national trends, the NSP II Nurse Educator Doctoral Grants for Practice and Dissertation Research (NEDG) was awarded to 114 faculty in 2019; 49 faculty for DNP degrees, 42 faculty for PhD in Nursing degrees, 13 faculty for Doctor of Education (EdD) degrees, and the remaining 10 faculty for PhD degrees in other fields.

The DNP education focuses on preparation of nurses for advanced practice roles. A study by Fang and Bednash (2017) found that 56.8 percent of DNP students who planned to work in academia were already full-time or part-time faculty members. Nurse faculty with dual clinical and academic appointments as advanced practice registered nurses (APRNs) maintain clinical credentials; providing primary care while preparing the next generation of new pre-licensure nurses or serving as preceptors for new APRNs at hospitals and clinical sites. Previous NSP II grants have funded APRN preceptor online training modules that are available to all nursing programs.

Table 3. Trends in PhD and DNP Graduates, 2013 – 2018



Source: Maryland Higher Education Commission Nursing Graduate Data

FISCAL YEAR 2020 COMPETITIVE GRANT PROCESS

In response to the FY 2020 request for applications (RFA), the NSP II Competitive Institutional Grant Review Panel received a total of 26 requests for funding, including 21 new competitive grant proposals, 3 resource grant requests and 2 continuation grant recommendations. The nine-member panel, comprised of former NSP II grant project directors, retired nurse deans, hospital educators, licensure and policy leaders, MHEC and HSCRC staff, reviewed the proposals. All competitive grant proposals received by the deadline were scored by the panel according to the rubric outlined in the FY 2020 RFA. The review panel convened and developed consensus around the most highly recommended proposals. For non-funded proposals, the panel provided feedback to the institutions for future proposal development and encouraged them to resubmit next year. As a result, the review panel recommends funding for 17 of the 26 total proposals.

The recommended proposals include grants for planning, full implementation of programs, continuation of programs, as well as, nursing program resource grants; totaling just over $6 million. The proposals that received the highest ratings for funding focused on nursing graduate outcomes with partnerships across community colleges, universities and hospital health systems. Table 4 lists the recommended proposals for FY 2020 funding.

Table 4. Final Recommendations for Funding for FY 2020

Grant #	Institution	Grant Title	Proposed Funding
20-102	Allegany College	LPN- RN Online	$150,000
20-104	Coppin State University	Cognitive Reflective CARE	$50,000
20-105	Coppin State University	Planning BSN to DNP	$148,100
20-106	Coppin State University	ATB with CCBC & Howard	$143,951
20-108	Johns Hopkins University	PRIME Model for DNP-NP	$1,001,596
20-109	Johns Hopkins University	Supporting Advance Practice	$150,000
20-110	Johns Hopkins University	Planning CRNA	$150,000
20-112	Montgomery College	ASEL Resources	$50,000
20-116	Morgan State University	Student Resources	$47,897
20-117	Notre Dame of Maryland University	B-Line Software Resources	$50,000
20-118	Salisbury University	Planning MA-FAMI	$149,998
20-120	Towson University	Entry Level MS in Nursing	$149,556
20-121	University of Maryland	AGPCNP Certification	$121,972
20-122	University of Maryland	SA and Addictions Program	$137,408
20-123	University of Maryland	Clinical Faculty Competency	$264,677
20-125	University of Maryland	Maryland Nursing Workforce Center Continuation	$1,912,767
20-126	Montgomery College	MCSRC Group Resource Continuation	$1,475,525
		TOTAL	$6,153,447

RECOMMENDATIONS

HSCRC and MHEC staff recommend the 17 proposals presented above in Table 4 for the FY 2020 NSP II Competitive Institutional Grants Program. The recommended proposals represent

the NSP II's commitment to increasing nursing degree completions and academic practice partnerships across Maryland. The most highly recommended proposals include:

- Planning an advanced Faculty Academy and Mentoring Initiative on the Eastern Shore;
- Providing for the continuation of the Maryland Nursing Workforce Center for improved data infrastructure;
- Planning a new Masters entry nursing program at Towson University;
- Implementing the PRIME model for DNP nurse practitioner education at Johns Hopkins University;
- Developing an academic progression partnership for increased diversity with pre-licensure graduates in dual enrollment ATB programs at Community College of Baltimore County and Howard Community College with Coppin State University;
- Continuing the Maryland Clinical Simulation Resource Consortium resources for 26 nursing programs;
- Planning a Certified Registered Nurse Anesthetist (CRNA) program in partnership with Johns Hopkins Healthcare System; and
- Supporting a seamless online educational pathway from LPN to RN in Western Maryland.

REFERENCES

1. Buerhaus, P., Auerbach, Skinner & Staiger (2017). State of the Registered Nurse Workforce as a New Era of Health Reform Emerges. *Nursing Economics*, 35(5), 229-237.
2. Courville, M. & Green, J. (2019). Campaign for Action Maps Show Nurses' Progress in Earning BSN Degree, AARP and Robert Wood Johnson Foundation. Accessed at https://campaignforaction.org/resource/campaign-map-show-nurses-progress-earning-bsn-degree/
3. Institute of Medicine of the National Academies. (2010, October 5). The future of nursing: Leading change, advancing health. Retrieved from http://www.nationalacademies.org/hmd/Reports/2010/The-Future-of-Nursing-LeadingChange-Advancing-Health.aspx
4. The Future of Nursing 2020-2030, accessed at https://nam.edu/the-future-of-nursing-2020-2030/
5. Fang, D. & Bednash, G.D. (2017). Identifying barriers and facilitators to future nurse faculty careers for DNP students. *Journal of Professional Nursing*, 33(1), 56-67.
6. Maryland Higher Education Commission.(2019, March 15). Maryland Nursing Graduate Data Report provided by Alexia Van Orden, Research and Policy Analyst.
7. Maryland General Assembly, Chapter 159, 2016 Laws of Maryland
8. National League for Nursing, Certified Nurse Educator, accessed at http://www.nln.org/Certification-for-Nurse-Educators/cne
9. Nurse Support Program I and II, www.nursesupport.org

BRIAN E. FROSH
Attorney General

ELIZABETH F. HARRIS
Chief Deputy Attorney General

CAROLYN QUATTROCKI
Deputy Attorney General

Writer's Direct Fax No.
(410) 576-6571

Writer's Direct Email:
poconnor@oag.state.md.us

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

WILLIAM D. GRUHN
Chief
Consumer Protection Division

Writer's Direct Dial No.
(410) 576-6515

March 4, 2019

Via email: Diana.Kemp@maryland.gov

Diana Kemp
Regulations Manager
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Proposed Regulation Amendment COMAR 10.37.10.26.A Hospital Information Sheet

Dear Ms. Kemp,

The Health Education and Advocacy Unit of the Office of the Attorney General's Consumer Protection Division (the HEAU) submits the following comments on the Commission's proposed amendment to Regulation 26.A (Hospital Information Sheet) under COMAR 10.37.10 (Rate Application and Approval Procedures). The HEAU opposes the amendment and urges the Commission not to adopt it. We have previously communicated to Commission staff that we do not believe hospitals may mislead patients about material fee information, or withhold that information, under Maryland law. We believe the current regulations and the proposed amendment are inconsistent with Maryland law and do not protect patients from financial harm caused by nondisclosure of material outpatient facility fee information. Accordingly, the HEAU initiated a legislative effort resulting in House Bill 849/Senate Bill 803, the Facility Fee Right to Know Act.[1]

The disclosure and notice provisions in the Right to Know Act were suggested by the patients who have complained to the HEAU about being blind-sided by excessive outpatient facility fees charged by hospitals for services that did not need to be provided "at the hospital," and were unexpected due to lack of meaningful notice about hospital fees at the time of making their appointments.

[1] The HEAU filed letters of support and attachments for the cross filed bills. Attached are Senate Bill 803's letter of support and packet of information.

Here are some examples of the fees complaining consumers encountered:

Doctor Fee	Hospital Outpatient Facility Fee
$454	$1,729
$425	$1,141
$475	$ 627
$297	$ 577
$345	$ 553
$425	$ 296

Before the amendment was proposed, the HEAU discussed its patient complaints with Commission staff in an effort to find a regulatory mechanism to provide notice to the hospitals that their current practices fail to adequately and fairly inform patients in advance of receiving health care services at the hospitals' outpatient facilities that such health care services would be billed as outpatient hospital services which may result in different, and potentially higher, patient cost-sharing responsibility than would be applicable for the same health care services provided at a physician office, and failed to adequately and fairly inform patients when they could be seen by the same provider in a fee-free location.

We advised staff that patients consistently said they should have been told, at the time of making their appointments, that they would be charged a fee by the hospital and what that fee or fee-range would be. Patients say they would have seen their doctors at alternative fee-free locations, if possible, or, if not possible, price shopped for more affordable physicians and locations. Other patients say they would have made the appointments nevertheless but would have done so with full knowledge of their financial responsibility. We expected that a regulatory change, if proposed, would provide patients the protections they have asked for and are legally entitled to.

The proposed amendment does *not* require that notice of the fee or range of fees, and alternative fee-free locations for a visit with their doctor, if available, be given at the time patients make their appointments. Hospitals would merely be required to insert, into a lengthy hospital information sheet intended for inpatients - given to patients when they present to the hospital, not before - a provision stating that outpatients may ask for an estimate of outpatient facility fees, among other things. We note that the hospital information sheet contains information not relevant to patients going to office visits with their doctors, and conspicuously omits the material fee information.

Patients often wait months, take unpaid time off from work (or use sick leave), travel long distances, and pay to park for their appointments. Patients have a right to know about fees they would not otherwise expect, before doing so. Giving patients an inpatient hospital information sheet, along with multiple pages of other documents, when they appear at the registration desk for their appointment, does not provide patients with fair and adequate notice, and even if it did, it would be untimely because patients would already have been harmed.

The proposed amendment would not mitigate or prevent the serious financial harm documented in the attached extract from the HEAU's 2018 Annual Report.[2] The extract contains the following statements representative of consumers' distress about current practices:

> "I object to the bill since (1) the fee was NOT disclosed to me & had I been given the choice, & made aware, I would have gone elsewhere with no fee (2) the fee seems EXCESSIVE & UNUSUALLY HIGH above what is usual & customary charge for a visit (3) It presents a financial hardship to me that could have been avoided had it been disclosed (4) I have repeatedly asked the [hospital] to either forgive or reduce the remaining balance due to something more reasonable (more like $200-350 which is still charging me twice for the same appointment!)….I think if a fee is so large, the patient should be warned there could be [a] fee, and how much the fee will be so they can make an informed decision if they want to pursue the treatment. Most people would only expect a doctor's office visit fee, not a fee to pay the hospital to use their space!"

> "…, my complaint centers on the [hospital's] practice of charging a substantial hospital user fee for patients who have routine doctor office visits two blocks away from the hospital in an entirely separate building - an office building. Moreover and in my case, the assignment of these fees were done without any prior notice to me, the patient. Finally, the amount of the fee, again - at least in my case, was more than eight times the amount of the charge for the office visit itself!"

> "... [My doctor] keeps appointment hours at suburban locations; if I had been aware of the usage fee policy in advance, I could have chosen (as I have in the past) to see him at these alternate venues. The absence of proper notification of patients both at the time of scheduling and at the appointment itself also smacks of abuse of the patient/consumer."

Patients have the right to know material information about outpatient facility fees in order to make informed and affordable health care choices. Patients have told us the information they need, and when they need it, and those requirements are set forth in the HEAU's legislative initiative, House Bill 849/Senate Bill 803, the Facility Fee Right to Know Act. We oppose the proposed amendment because it lacks the basic, common sense protections patients have asked for and would perpetuate, not prevent or mitigate, the serious financial harm being caused by unexpected outpatient facility fees.

[2] See pages 27 through 30 of the attached packet of information.

The HEAU thanks the Commission for considering our comments about the proposed amendment to Regulation 26.A (Hospital Information Sheet) under COMAR 10.37.10 (Rate Application and Approval Procedures).

Sincerely,

/s/

Patricia F. O'Connor
Assistant Attorney General
Deputy Director
Health Education and Advocacy Unit

Maryland
Hospital Association

March 4, 2019

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's (MHA) 62 member hospitals and health systems, we are submitting comments in response to the proposed modification of COMAR 10.37.10.26 – Rate Application and Approval Procedures - Patient Rights and Obligations.

Since this regulation was published for draft comment, a bill was introduced in the Maryland General Assembly to address facility fee billing notification. Maryland's hospitals believe that the Health Services Cost Review Commission (HSCRC) has the statutory authority to address this issue, and the draft regulations are an important first step. We suggest the HSCRC convene several stakeholders, including hospitals, health plans, the Maryland Insurance Administration (MIA), and the Health Education and Advocacy Unit (HEAU) of the Office of the Attorney General to craft a regulatory solution.

Maryland's hospitals support the proposed language disclosing hospital facility fees for outpatients and informing patients of their right to request and receive a written estimate of charges before non-emergent services. Health General 19-350 codifies that hospitals must provide a written estimate of total charges for non-emergency services. Most, if not all, of Maryland's hospitals routinely disclose outpatient facility billing in pre-service literature for patients. We agree that hospitals can continue to improve patient eduction about hospital charges for hospital-based physicians office visits.

Hospital-based clinics provide patients access to physician office services that otherwise may not be available. Governmental and non-governmental payers do not include amounts in private physician office payments to subsidize the cost of charity care. In Maryland, hospital rates include amounts for patients who cannot afford to pay, ensuring access to health care services. Hospital rates also include amounts that contribute to operating hospitals 24 hours a day, seven days per week.

As health plans shift a greater share of financial responsibility to patients, all stakeholders must improve consumer understanding of health plan benefits to avoid surprise, out-of-pocket expenses. Revised regulations should address consumer concerns and recognize the feasibility of implementing appropriate solutions. Facility-based fees will vary based on the type of clinic, the type of service received and the normal fluctuation in hospital charges.

Hospitals, health plans, and the State of Maryland must work together for all patients to have reasonable, affordable, and understandable health benefits. We look forward to working with Commission staff and all stakeholders to address this important issue. If you have any questions, please do not hesitate to contact me.

Sincerely,

Brett McCone
Vice President

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James N. Elliott, M.D.
Adam Kane
Jack Keane
Katie Wunderlich, Executive Director
Erin Schurmann, Project Manager
Judy Wang, Health Policy Analyst

Update on CRISP and ICN

7160 Columbia Gateway Drive, Suite. 230
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

CRISP Services - 2015

1. **POINT OF CARE: Clinical Query Portal & In-context Information**
   - Search for your patients' prior hospital records (e.g., labs, radiology reports, etc.)
   - Monitor the prescribing and dispensing of PDMP drugs
   - Determine other members of your patient's care team
   - Be alerted to important conditions or treatment information

2. **CARE COORDINATION: Encounter Notification Service (ENS)**
   - Be notified when your patient is hospitalized in any regional hospital
   - Receive special notification about ED visits that are potential readmissions
   - Know when your MCO member is in the ED

3. **POPULATION HEALTH: CRISP Reporting Services (CRS)**
   - Use Case Mix data and Medicare claims data to:
     - Identify patients who could benefit from services
     - Measure performance of initiatives for QI and program reporting
     - Coordinate with peers on behalf of patients who see multiple providers

4. **PUBLIC HEALTH SUPPORT:**
   - Deploying services in partnership with Maryland Department of Health
   - Pursuing projects with the District of Columbia Department of Health Care Finance
   - Supporting West Virginia priorities through the WVHIN

5. **PROGRAM ADMINISTRATION:**
   - Making policy discussions more transparent and informed
   - Supporting Care Redesign Programs

CRISP Services - 2019

1. **POINT OF CARE: Clinical Query Portal & In-context Information**
   - Search for your patients' prior hospital records (e.g., labs, radiology reports, etc.)
   - Monitor the prescribing and dispensing of PDMP drugs
   - Determine other members of your patient's care team
   - Be alerted to important conditions or treatment information
2. **CARE COORDINATION: Encounter Notification Service (ENS)**
   - Be notified when your patient is hospitalized in any regional hospital
   - Receive special notification about ED visits that are potential readmissions
   - Know when your MCO member is in the ED
3. **POPULATION HEALTH: CRISP Reporting Services (CRS)**
   - Use Case Mix data and Medicare claims data to:
     - Identify patients who could benefit from services
     - Measure performance of initiatives for QI and program reporting
     - Coordinate with peers on behalf of patients who see multiple providers
4. **PUBLIC HEALTH SUPPORT:**
   - Deploying services in partnership with Maryland Department of Health
   - Pursuing projects with the District of Columbia Department of Health Care Finance
   - Supporting West Virginia priorities through the WVHIN
5. **PROGRAM ADMINISTRATION:**
   - Making policy discussions more transparent and informed
   - Supporting Care Redesign Programs

Service	Typical Week
Positive InContext Requests	525,000
Data Delivered into EMRs	1,400,000
Patients Searched in Portal	62,000
Patients Searched from EMR	65,000
ENS Messages Sent	760,000
Clinical Documents Processed	350,000
Portal Users	40,000
Live ENS Practices	1,400
Reports Accessed	500
Report Users	600

CRISP ICN Spending: Budget versus Actual

- Infrastructure to support statewide care coordination was originally projected to cost $75M over 3 years
- CRISP spent $50M while achieving stakeholder aims
  - $36.6M were state funds while $13.4M were federal funds
- Upon completion, operations was estimated to cost between $8M and $28M
- Total FY2020 ICN spend is estimated at $10M
  - Core HIE operations are shifting to CRISP user fees paid primarily by hospitals ($3.1M in FY19 and FY20)
  - Due to MHIP changes, FY20 assessments are an increase over FY19; HSCRC assessments for this infrastructure will decrease next year

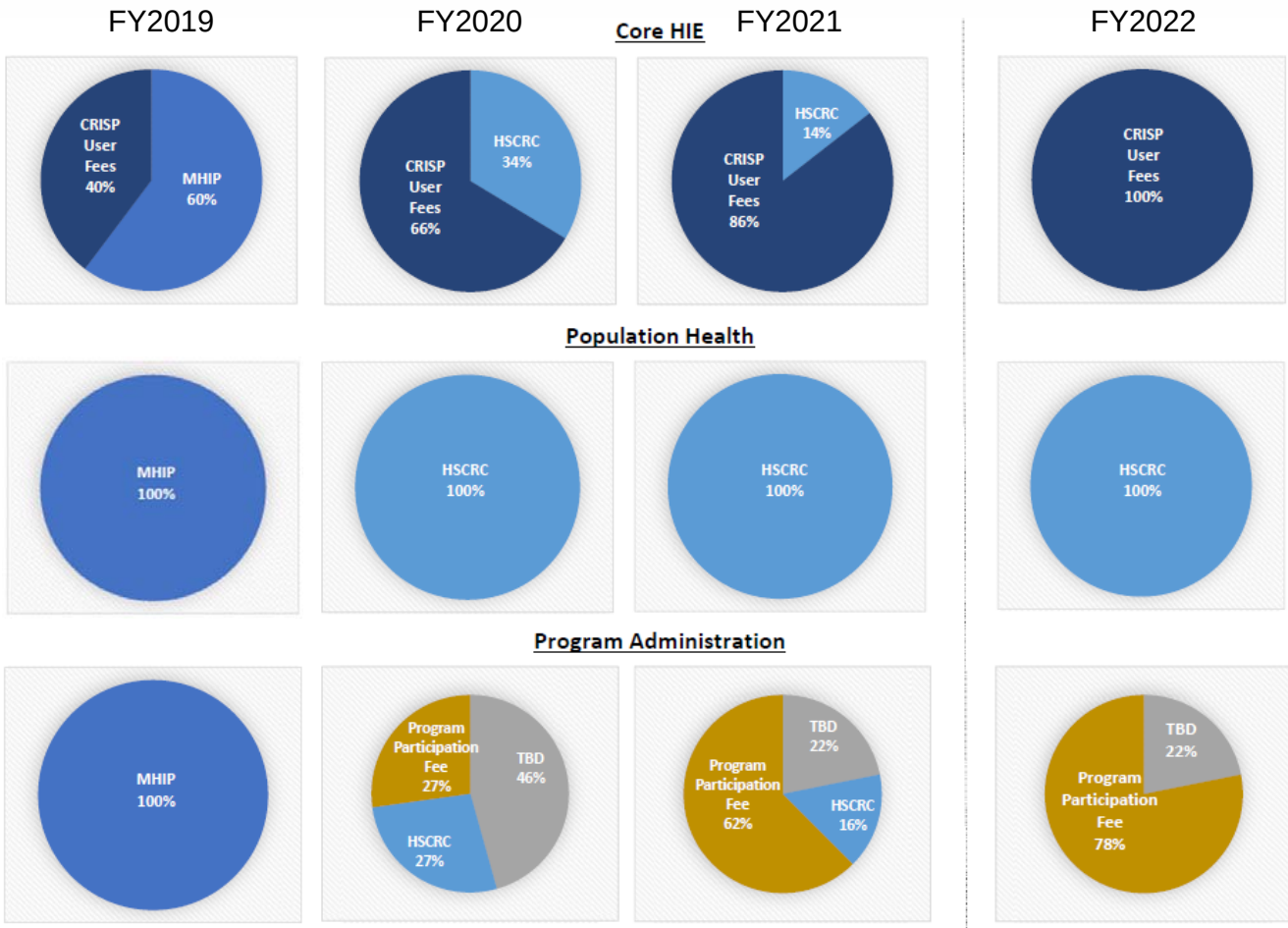
ICN Three Year Budget & Spending Summary

Workstream	Original Full Project "Planning Budget"	Actual Spend 3-Year State & Federal Total
Point of Care	$31,465,723	$25,466,697
Care Managers & Coordinators	$7,887,863	$8,503,299
Population Health Teams	$12,205,684	$7,338,402
Sub-Total	$51,559,270	$41,308,398
Program Administration	$23,737,353	$8,679,588
TOTAL	**$75,296,623**	**$49,987,986**

Original estimate by HMA:
Annual operating cost: **$8M (low) to $28M (high)**

FY2020 ICN Operating Cost (estimated):
Total: **$10M**
HSCRC CRISP Assessment: **$4.5M**
CRISP User Fees: **$2.5M**
MDPCP: **$3.0M** (funding source TBD)

ICN Spending by Source Over Time



As Core HIE activities and Program Administration transition to participant fees, the annual HSCRC assessment will decrease in these categories

= CRISP User Fees
= MHIP Funds
= HSCRC Assessment
= Program Participation Fees
= To Be Determined

Draft HIE Funding Request for FY2020

	HSCRC	CRISP Fees
ICN Activities		
Core HIE Services	$667,000	$1,194,000
Population Health	$2,342,000	$0
Program Administration	$1,441,000	$1,310,000
MDPCP PMO	*$3,000,000*	*$0*
ICN Total	**$7,450,000**	**$2,504,000**
ICN Total HSCRC and Fees	**$9,954,000**	
HIE and Regulatory Activities		
Regulatory Casemix Reporting	$850,000	$0
HIE Operations and IAPD Match	$2,500,000	$3,772,000
HIE and Regulatory Total	**$3,350,000**	**$3,772,000**
Total	**$10,800,000**	**$6,276,000**
MDPCP - Not funded by HSCRC	*($3,000,000)*	
Draft ICN and HIE Request	**$7,800,000**	

Note: Point of Care, Population Health, and Program Administration were paid for with MHIP funds in prior years; MDPCP Program Management funds are to be determined

Core HIE: Point of Care and Care Coordination

- Projects to enhance data and make it more accessible in providers' workflows; part of CRISP's core HIE services and will be absorbed into operations covered by user fees by FY22

Population Health

- Casemix and Medicare claims reports that increase transparency between policymakers and hospital finance departments, and are used for supporting population health initiatives; paid for by hospital assessments

Program Administration

- Support for Care Redesign Programs by being a central source for document submission, facilitating reports for participants, and helping in the protocol design for new programs as requested by stakeholders; CRISP's focus is on efficiency in providing these services
- Primarily includes operations for ECIP and potential new program development

Regulatory Casemix Reporting

- CRISP provides reports to hospitals and policymakers that support transparency and consistency in reimbursement methodology and payment policy

HIE Operations and IAPD Match

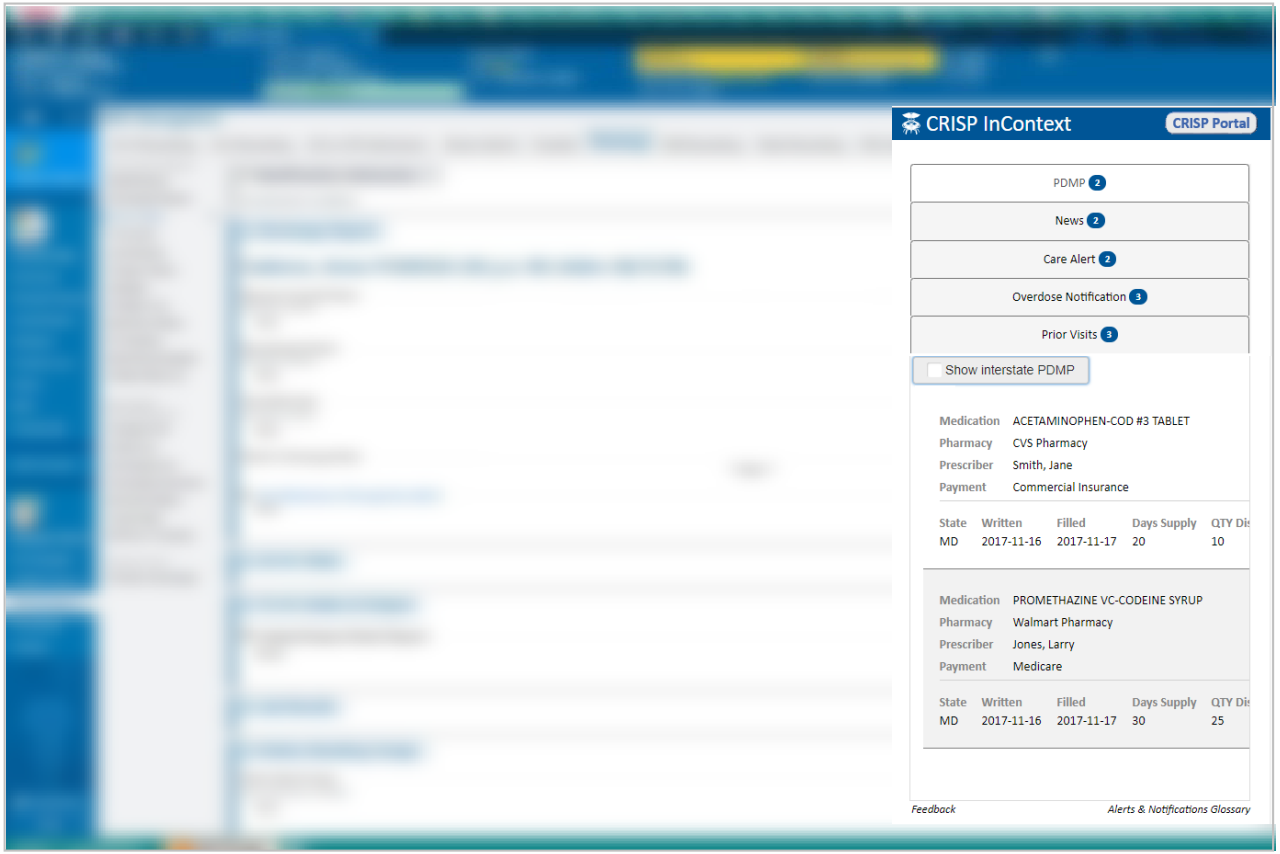
- Funding certain HIE operations such as the support team and the source for the required 10% match for IAPD projects

Maximizing Federal Funds

- Certain activities for the Total Cost of Care Model also support Medicaid initiatives, for example:
  - Casemix reporting on a all-payer basis, particularly with indicators for Medicaid and dually-eligible beneficiaries
  - CCLF total cost of care reports that include dually-eligible beneficiaries
- Medicaid, CRISP, and the HSCRC will work together to submit a funding request through the Medicaid Management Information System
  - Preliminary estimates show approximately $3M in eligible Medicaid funding, making the HSCRC assessment approximately $5M

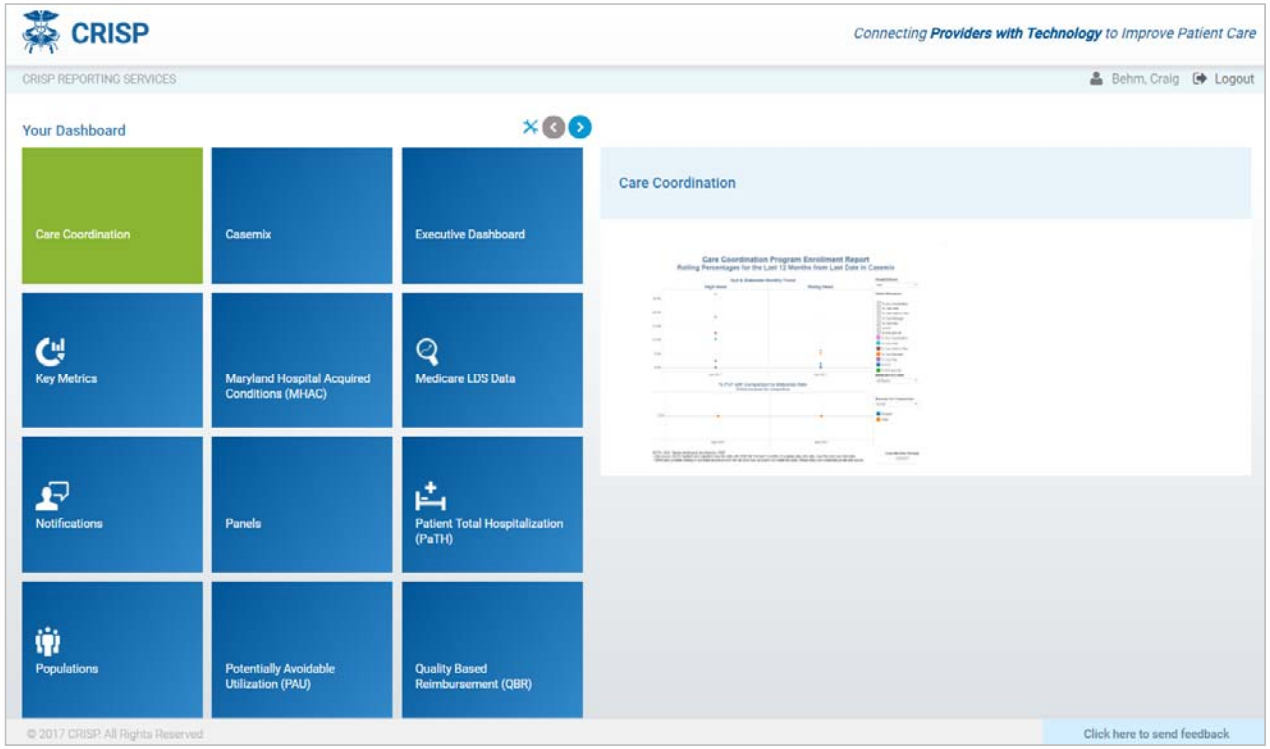
Sample New Service: InContext Data Delivery

- View of critical patient data, pulled from multiple repositories and embedded in the end user's EHR
- Integrations can occur in EHR native app stores or through API queries
- CRISP delivers nearly **1.5M** pieces of data per week through this method (and rising)



Sample New Service: Population Health Reports

- Dashboards from administrative data to support high-needs patient identification, care coordination, and progress reporting
- Primary data sets are hospital casemix and Medicare claims and claim line feed (CCLF)
- Different levels of patient data available for hospitals based on HSCRC payment requirements and Total Cost of Care Model participation
- There are over **600 active users** viewing **85 reports** over **2,000 times per month**



CRISP ICN Spending: Budget versus Actual

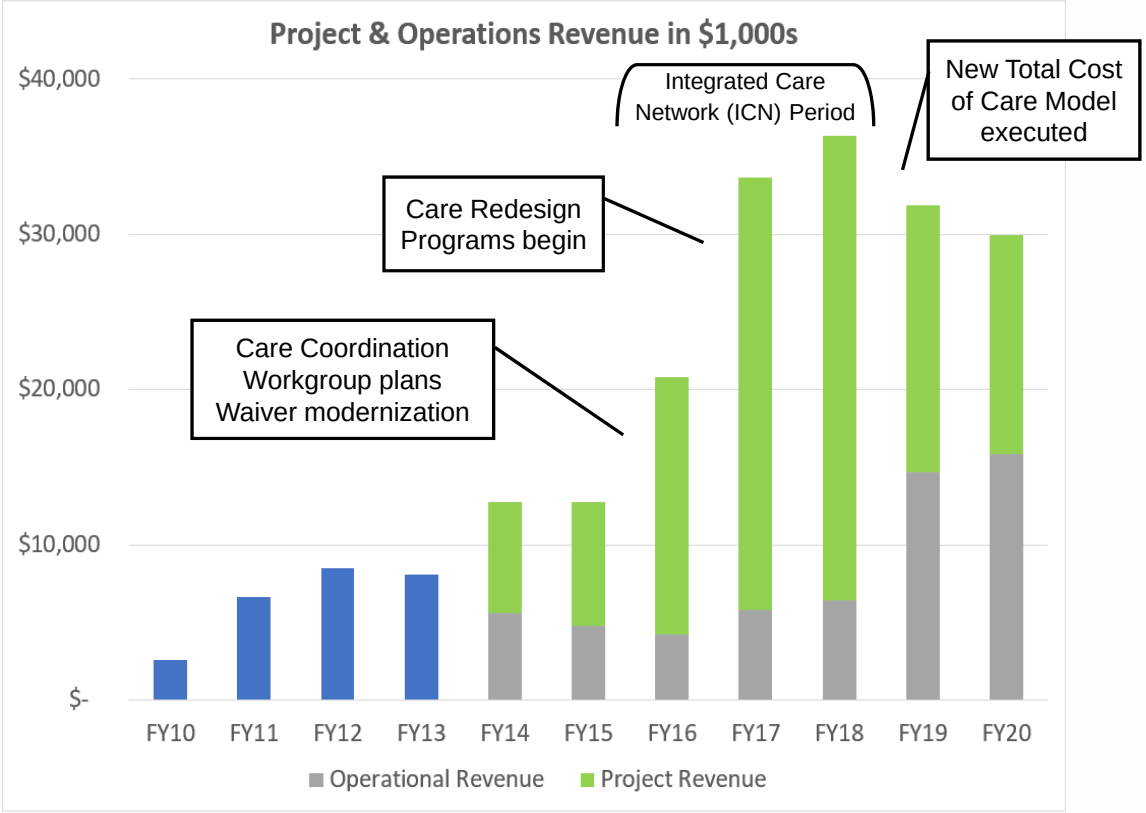
ICN Three Year Budget & Spending Summary

Workstream	Original Full Project "Planning Budget"	Actual Spend 3-Year State & Federal Total
Point of Care	$31,465,723	$25,466,697
Care Managers & Coordinators	$7,887,863	$8,503,299
Population Health Teams	$12,205,684	$7,338,402
Sub-Total	$51,559,270	$41,308,398
Program Administration	$23,737,353	$8,679,588
TOTAL	**$75,296,623**	**$49,987,986**

Key Differences Between "Planning Budget" and Actual Performance

- CRISP worked with the State to leverage Federal funds at a 90/10 match rate as much as possible
  - **Of the $50M total spending, $36.6M was State dollars and $13.4M was Federal dollars**
- The reporting and analytics work for Population Health and Program Administration vendor was efficient and re-used data as much as possible
- Ambulatory Connectivity focused on priority practices and slowed down to leverage national trends
- Investments in infrastructure allowed for core HIE services to scale, thereby lowering the cost per transaction

Statewide Investment in HIE Infrastructure



The chart reflects all HIE funding, including:

- Federal funds
- MHIP funds
- HSCRC assessments
- User fees
- State grants

Starting in FY19, many of the tools and services developed through the ICN project are converting to core operations to transition to sustainable funding sources:

- MHIP funds end 6/30/19
- IAPD funds end 9/30/21

State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

John M. Colmers

James N. Elliott, M.D.

Adam Kane

Jack C. Keane

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Payment Reform &
Provider Alignment

Gerard J. Schmith, Director
Revenue & Regulation
Compliance

William Henderson, Director
Medical Economics &
Data Analytics

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **April 10, 2019**

RE: **Hearing and Meeting Schedule**

May 8, 2019	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
June 12, 2019	To be determined – 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:15 a.m.

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

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