Maryland Hospital Community Benefit Report
2005

Final Report

Health Services Cost Review Commission
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This is a final document and ready for Commission action.

Maryland Hospital Community Benefit Report
(Fiscal Year 2004)

Introduction

In response to the growing interest in the types and scope of community benefit services provided by Maryland hospitals, the Maryland General Assembly passed House Bill 15 during the 2001 Legislative Session, which created a new responsibility under the Health Services Cost Review Commission ("Commission" or "HSCRC"). (*See* Health General §19-303, Maryland Annotated Code).

Under the law, the Commission is responsible for collecting hospital community benefit information from individual hospitals to compile into a publicly-available statewide Community Benefit Report (CBR). This larger statewide document contains summary information as well as the individual hospital reports; individual hospital community benefit reports and additional documents are also available in written form at the Commission's offices. Individual community benefit report data spreadsheets will be available on the Commission's website in July 2005.

While many Maryland hospitals and health systems already prepare a report to the community describing the services and benefits they provide, there were no statewide guidelines outlining what information is collected until the passage of HB 15. Use of the guidelines permit hospitals and health systems to:

- Present a comprehensive picture of the organization's community benefits;
- Share models of successful community benefit activities;
- Participate in a statewide report on community benefits; and
- Strengthen grant applications and other funding requests.

The community benefit report is an opportunity for each Maryland hospital to critically examine, evaluate, and report the nature, impact, long term sustainability, and success of those activities. The HSCRC has viewed the CBR as a work-in-progress, in part to its start-up nature in first years, but evolving in future years to both keep pace with the changing environment of community benefits and to improve the report's effectiveness as a public policy tool. Given other states' and organizations experience, it is expected that Maryland's initiative will take several years to mature. For this first community benefit report, Maryland hospitals and the Commission worked collaboratively with one another and many interested parties, including local health departments and other State and national organizations. The HSCRC commits to continuing this work to further improve the report and to refine definitions as needed.

What are Community Benefits?

As defined under current Maryland law, community benefit means an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:

- health services provided to vulnerable or underserved populations;
- 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; and
- health education, screening, and prevention services.

As evidenced in this first report, Maryland hospitals provide a broad range of health services to meet the needs of their communities, often receiving partial or no compensation. Only those programs that result in a financial loss are considered reportable in the data submitted by Maryland hospitals to the HSCRC for this report. These activities are expected from Maryland's 46 not-for-profit hospitals, however, as a result of the tax exemptions they receive.

First Year CBR - Highlights

For FY 2004, Maryland hospitals reported providing a total of over $580 million in benefits to their communities. Of this, $252 million was provided in medical education activities, nearly $150 million in charity care, $73 million for mission driven health services, $43 million in community services, $13 million for donations, $9 million in community building efforts, $6 million in foundation community benefit initiatives, $3.7 million in research efforts, and nearly $28 million in "Other Mission Driven Services," (or areas which are difficult to neatly account for in any one community benefit service category).

For additional detail, please see the chart under Attachment I - Aggregated Hospital CBR Data. For technical definitions of each community benefit category and additional examples of the types of services found within a community benefit category, please see Attachment III - Description and Overview of CBR Data Inventory Worksheet.

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit
Community Services	636,291	2,453,595	$43,956,421
Medical Education	4,034,386	348,111	$252,894,290
Mission Driven Health Services	1,143,968	383,400	$73,734,075
Other Mission Driven Health Services	23,972	420,329	$27,940,125
Research	36,152	19,226	$3,665,531
Donations	24,543	87,146	$13,174,402
Community Building	100,503	16,761	$9,183,412
Charity Care	n/a	n/a	$149,691,655
Foundation	15,040	91,772	$6,308,124
Total	**6,014,855**	**3,820,340**	**$580,684,097**

Community Services

In the Community Services category, hospitals provided 636,291 staff hours[1] to enable 2,453,595

1 Staff hours means the total amount of staff hours associated with a given community benefit category.

encounters[2], with a net community benefit[3] of $43,956,421.

Medical Education
For medical education community benefit activities, Maryland hospitals reported 4,034,386 staff hours to provide 348,111 encounters, with a net community benefit of $252,894,290.

Research
Maryland hospitals reported 36,152 staff hours to provide 19,226 encounters, with a net community benefit of $3,665,531.

Mission Driven Health Services
In the Mission Driven Health Services category, hospitals provided 1,143,968 staff hours to enable 383,400 encounters with a net community benefit of $73,734,075.

Other Mission Driven Health Services
Maryland hospitals reported 23,972 staff hours to provide 420,329 encounters, with a net community benefit of $27,940,125.

Donations
In the Donations category, hospitals provided 24,543 staff hours to enable 87,146 encounters, with a net community benefit of $13,174,402.

Community Building
For community building community benefit activities, Maryland hospitals reported 100,503 staff hours to provide 16,761 encounters, with a net community benefit of $9,183,412.

Charity Care
Maryland hospitals reported providing $149,691,655 in charity care community benefits.[4]

Foundation Community Benefit
In the Foundation community benefit category, hospitals provided 15,040 staff hours to enable 91,772 encounters, with a net community benefit of $6,308,124.

Background for Maryland Initiative

The Commission worked with the Maryland Hospital Association and interested hospitals and local health departments on the details and format of the community benefit report for more than twelve months after the passage of HB 15. This work included the data spreadsheet and instructions, which were distributed in January 2003 for public comments.

2 Number of encounters is the number of visits associated with a community benefit category. Note that "encounters" is different than number of people served, that is, one person may have several different encounters in a given hospital's community benefit category.
3 Net community benefit means hospital direct costs plus indirect costs, less any offsetting revenue received by the reporting hospital.
4 Due to the difficulty with tracking staff hours and encounters for charity care visits across a hospital or health system's range of services, charity care was reported by total only.

Comments were received and incorporated into both the spreadsheet and instructions through June 2003, the beginning of the first Community Benefit Report reporting period (Fiscal Year 2004).

The first reporting period for Maryland's Community Benefit Report is July 1, 2003 - June 30, 2004. Hospitals submitted their individual community benefit reports on January 1, 2005 to the HSCRC, using audited financial statements as the source for calculating costs in each of the care categories.

The Maryland data reporting spreadsheet and instructions draw heavily on the VHA community benefits initiative, which offers over ten years of voluntary hospital community benefit reporting experience across many states and individual community benefit reporting efforts. The VHA developed a standardized approach to community benefit definitions and reporting practices, which was then tailored with help from the Maryland Hospital Association and participating members of the Community Benefit Workgroup to fit Maryland's unique regulated environment.

Maryland had to make special accommodations to reflect the benefits of hospital rate setting on community benefits. In other states, the majority of hospital community benefits are reported in three areas - shortfalls from governmental payers, charity care, and medical education costs. In Maryland, however, the HSCRC rate setting system builds the costs of uncompensated care (both charity care and bad debt) and teaching into the rates hospitals are reimbursed, and all payers (including Medicare and Medicaid) pay the same rates for hospital care. To this end, the HSCRC provides data in this report on the revenue provided for the Nurse Support Program, uncompensated care, and graduate medical education which are funded through hospital rates by all payers (*see* Attachment IV). In their individual community benefit reports, hospitals were asked not to include revenue provided from hospitals rates as offsetting revenue. While it would be impossible for the HSCRC to provide a one-for-one match with the data reported by hospitals in the individual CBRs, the Commission believed it was necessary for readers to understand that Maryland hospitals receive offsetting revenue through hospital rates for programs identified within the individual community benefit reports.

Issues

The common reporting format for community benefits will not result in identical reports from Maryland hospitals. As most hospitals address community needs in the most appropriate manner and setting, reporting of the community benefit may not be allocated in exactly the same category or result in the same amount of reportable costs. For example, one hospital may conduct childhood immunizations at its local Head Start facility, while another hospital may find that an on-campus hospital facility is more centrally located to the community. Additionally, due to the start-up nature of the first Maryland CBR, reporting inconsistencies did occur for some Maryland hospitals (most common area occurred under "Other" in Section A. Community Services, C. Mission Driven Health Services, and G. Other Mission Driven Health Services. For further description of these Sections, *see* Attachment III. Community Benefit Categories and Reporting Guidelines**).**

Physician Subsidization Costs

Many hospitals identified physician subsidy costs in the FY 2004 community benefit reports. Physician subsidies varied by hospital service (obstetrics, pediatrics, psychiatric, neonatal, emergency, and anesthesiology) and by type (on call, charity care provided by facility-owned physician groups, and general subsidy costs). For FY 2004, hospitals reported over $37 million in physician subsidies in their community benefit reports, most often within the Mission Driven Health Services or Other Mission Driven Health Services categories. For more detailed information regarding individual hospital physician subsidies, the HSCRC would direct readers to the individual hospital community benefit report of interest under Attachment II.

The Commission and hospitals continue to explore the subject of physician subsidies, with the hope that the greater use of locally directed community needs assessments will assist hospitals in determining when these subsidies should be allocated as community benefits.

Indirect Cost Ratio

Hospitals report the direct costs of offering specific community benefits initiatives in their CBR inventory worksheet. To eliminate the probability that hospitals would uniquely account for indirect costs (overhead, accounting, and personnel costs, etc.), the HSCRC directed hospitals to calculate a specific indirect cost ratio from the hospital's Annual Cost Report data that is used throughout the hospital's CBR inventory worksheet. The model for calculation can be found within the HSCRC's CBR instructions.

While hospitals were directed to use the annual audited cost report data to calculate the ratio, ratios varied widely between hospitals (from 46% to 89%, with a mean of 61% and median of 60%). Additionally, the VHA guidelines did not incorporate until April 2004 (nearly the end of the first Maryland CBR reporting cycle) which categories indirect costs should be applied.[5] In this first report, therefore, the HSCRC permitted indirect costs to be applied to all community benefit categories. For future reports, the Commission will adopt the VHA changes (modified, if necessary to meet Maryland's regulated environment) to the FY 2005 CBR worksheet, which will be an important step in clarifying the appropriate community benefit categories to which indirect costs may be applied.

For the FY 2004 report, however, a straight-forward example of the indirect cost ratio issue can be seen when comparing two disparate categories where an identical indirect cost ratio is applied. This report includes standardized indirect costs for such items as cash donations, physical and environmental improvements, etc. and medical education, community services, and charity care. If a hospital with a 50% indirect cost ratio contributes a $100,000 donation to its local United Way organization, the HSCRC CBR worksheet applies a commensurate indirect cost (that is, $50,000 indirect is applied to the hospital's total CBR activity). While some hospitals expressed concern that individual hospital community benefit reports may be less

[5] In April 2004, the VHA issued updated national guidelines that permit indirect costs to be routinely applied to Community Services, Community Building, and Community Benefit Operations only. Indirect costs may be added to additional categories if a hospital believes that its reported direct costs do not appropriately account for the total costs of a community benefits initiative or program.

consistent between hospitals if the indirect cost ratio is not a set percentage calculated from the hospitals' audited data, other hospitals suggested that having the option of overriding the standard percentage within further categories may provide a more accurate accounting of community benefit activities. To that end, the HSCRC will work with hospitals to explore the option of providing hospitals the ability to override the standard indirect cost ratio within the CBR worksheet.

Community Benefits Evaluation and Community Needs Assessments

Many hospitals had difficulty reporting on community benefit evaluation efforts. Most hospitals have undertaken a community benefits evaluation, but efforts range from patient satisfaction surveys to evaluations of the effectiveness of a targeted community benefit initiative. As the community benefit law is broad with regard to evaluation efforts, the Commission asked hospitals to provide information on the steps taken to evaluate the effectiveness of its community benefit initiatives and chose not to prescribe the type of evaluation effort Maryland hospitals should employ. Additionally, the Commission believed it was necessary to focus first year reporting efforts on implementing the new community benefit reporting requirements and achieving as much data consistency between hospitals as possible.

To help hospitals better understand what types of evaluation efforts may have more value, the Commission is currently working with interested parties to develop an evaluation framework for hospitals to use in determining appropriate information to submit along with the community benefit data spreadsheet. The HSCRC envisions the framework will include a list of succinct questions hospitals will answer (and pose internally) to give the public a better understanding of how a hospital's community benefit are evaluated, if they are incorporated into the facility's overall strategic plan, the sustainability of initiatives, and other related information. It is hoped that this framework will encourage the types of dialogue that are necessary to begin, continue, and refine hospital evaluation efforts.

Hospital Rate Support for Community Benefit Programs

In Maryland, the costs of uncompensated care (both charity care and bad debt) and graduate medical education are built into the rates that hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC also includes amounts in rates for hospital nurse support programs provided at Maryland hospitals. To avoid accounting confusion between programs that are funded in part or in whole through hospital rate funds (regulated) or programs that are not funded by hospital rate funds (unregulated), the HSCRC asked hospitals not to include revenue provided in rates as offsetting revenue on the CBR worksheet. The following section details the amounts of Nurse Support Program, uncompensated care, and graduate medical education (both direct and indirect), costs that are included in rates for Maryland hospitals in Fiscal Year 2004 funded by all payers.

Nurse Support Program

The Nurse Support Program provides hospitals with grants to increase the recruitment and retention of nurses in Maryland hospitals. In FY 2004, $6,697,229 was provided to Maryland hospitals to increase the recruitment and retention of nurses in Maryland hospitals. Hospitals also contributed $5.1 million in in-kind funds to NSP programs in FY 2004. Several

hospitals did include NSP rate money as offsetting revenue in their individual community benefit reports. The majority of hospitals did not (again, to avoid confusion between programs that are funded through hospital rate funds and programs that are not funded by hospital rate funds, the HSCRC asked hospitals not to include revenue provided in rates as offsetting revenue on the CBR worksheet).

For further information about funding provided to specific hospitals, please see Attachment IV.

Uncompensated Care

The HSCRC includes an amount in hospital rates for uncompensated care; this includes both charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). In FY 2004, $545,484,502 million was provided in Maryland hospital rates for the provision of both charity care and hospital bad debt funded by all payers. Hospitals were asked not to include revenue provided through hospital rate as offsetting revenue on the CBR worksheet.

For further information about funding provided to specific hospitals, please see Attachment IV.

Graduate Medical Education

Another social cost funded in Maryland's rate-setting system is the cost of graduate medical education (GME), generally for interns and residents trained in Maryland hospitals. Graduate medical education costs are divided into direct and indirect medical education components for identification and reimbursement purposes. Direct medical education costs are those directly incurred in the operation of teaching activities and consist of salaries and fringe benefits of residents and interns, faculty supervisory expenses, and allocated overhead. By contrast, indirect medical education expenses are generally described as those additional costs incurred as a result of the teaching program (e.g., increase patient severity associated with teaching programs and inefficiencies, such as extra tests ordered by interns/residents or the extra costs of supervision). The Commission utilizes an annual hospital intern and resident count to assist in quantifying the direct and indirect costs of medical education in physician training programs, and recognizes only the interns and residents included on the survey up the hospital's cap. Any resident and intern costs above the hospital's recognized cap, therefore, would not be funded through hospital rates. For FY 2004, $353,106,814 was provided to Maryland hospitals to train residents and interns.

For further information about funding provided to specific hospitals, please see Attachment IV.

Conclusion

As stated earlier in this report, the HSCRC views Maryland's Community Benefit Report as an evolving work-in-progress, where the Commission hopes to build upon the success of the first year's report and add to the value of the report in future CBRs. In many instances, individual CBRs represent the first exhaustive inventory of a hospital's community benefits

initiatives, one that required hard work and diligence by many Maryland hospital employees. The Commission would like to thank the Maryland Hospital Association, the Institute for Community Health, Local Health Departments, the VHA, Maryland hospitals, and many others whose contributions culminated with the production of this first report. Finally, we would ask for the continued assistance of these and other groups as the Commission works to refine and improve the public policy value of Maryland's Community Benefit Report.

Attachment I
Aggregated Hospital CBR Data

FY 2004 MARYLAND HOSPITAL COMMUNITY BENEFIT TOTALS

COMMUNITY BENEFIT ACTIVITES	Number of Staff Hours	Number of Encounters	Net Community Benefit W/Indirect Costs	Net Community Benefit W/O Indirect Costs
A. COMMUNITY SERVICES				
A1 Community Education & Outreach	245,235	877,492	18,991,364	11,313,957
A2 Screenings	41,040	240,651	2,690,967	1,254,311
A3 Support Groups	13,013	45,149	880,659	533,798
A4 Counseling	53,738	37,084	3,879,180	2,198,167
A5 Self-Help/Wellnes	40,414	903,277	2,346,975	1,218,426
A6 Immunizations	5,345	48,639	584,021	309,182
A7 Community Clinics	56,549	18,341	5,271,935	2,911,685
A8 Other	0	0	0	0
TOTAL	636,291	2,453,595	43,956,421	24,432,712
B. MEDICAL EDUCATION				
B1 Physicians/Medical Students	3,724,385	222,899	230,097,891	142,687,109
B2 Scholarships/Funding for Professional Education	490	143	1,005,912	605,752
B3 Nurses	147,943	42,687	10,059,568	6,251,143
B4 Technicians	31,156	30,099	1,645,528	1,057,713
B5 Other Health Professionals	106,129	30,291	4,754,964	3,084,375
B6 Other	24,283	21,992	5,330,428	5,330,082
TOTAL	$ 4,034,386	$ 348,111	$ 252,894,290	157,039,783
C. MISSION DRIVEN HEALTH SERVICES				
TOTAL	1,143,968	383,400	73,734,075	18,566,296
D. RESEARCH				
TOTAL	36,152	19,226	3,665,531	1,387,102
E. DONATIONS				
E1 Cash	665	290	10,148,318	6,404,802
E2 In-Kind Donations	23,878	86,856	3,026,084	1,777,054
TOTAL	24,543	87,146	13,174,402	8,181,856

COMMUNITY BENEFIT ACTIVITES	Number of Staff Hours	Number of Encounters	Net Community Benefit W/Indirect Costs	Net Community Benefit W/O Indirect Costs
F. COMMUNITY BUILDING				
F1 Physical and Environmental Improvements	7,851	2,563	2,030,240	1,297,478
F2 Economic Development	16,939	1,243	676,824	338,581
F3 Support System Enhancements	9,926	9,013	1,075,439	679,795
F4 Leadership Development and Skills Training	12,977	2,339	555,627	350,433
F5 Disaster Preparedness	52,810	1,603	4,845,282	2,026,431
TOTAL	100,503	16,761	9,183,412	4,692,718
G. OTHER MISSION DRIVEN HEALTH SERVICES				
TOTAL	23,972	420,329	27,940,125	17,612,064
H. CHARITY CARE				
TOTAL	$ 149,691,655			
K. FOUNDATION COMMUNITY BENEFIT				
K1 Community Services	15,040	91,232	953,861	590,469
K2 Community Building	30,867	8,026	922,241	613,924
K3 Other	0	540	4,568,085	4,568,085
TOTAL FOUNDATION COMMUNITY BENEFIT	$45,907	$99,798	$6,444,186	$3,804,305
TOTAL HOSPITAL COMMUNITY BENEFIT			$ 580,684,097	$ 235,716,836
Total Operating Expenses	$ 8,527,134,075			
% of Operating Expenses			6.89%	2.76%

Attachment II
Individual Hospital Community Benefit Inventory Worksheets

Available on HSCRC Website 7/6/2005
Hard Copy by Request

Attachment III
Description and Overview of CBR Data Inventory Worksheet

I. Accounting for Community Benefits

In terms of financial accounting practices, the HSCRC directed hospitals to use audited financial statements as the source in calculating costs in care categories.

A. Staff Hours and Number of Encounters

This column includes the number of staff hours associated with and the number of encounters served by the reported community benefit activity[6].

B. Net Community Benefit

The Net Community Benefit column subtracts the sum of the hospital's reported direct and indirect costs from any reported offsetting revenue for each individual community benefit.

Direct costs include salaries, employee benefits, supplies, interest on financing, travel, and other costs that are directly attributable to the specific service and that would not exist if the service or effort did not exist.

Indirect costs are costs not attributed to products and/or services that are included in the calculation of costs for community benefit. These could include, but are not limited to, salaries for human resource and finance departments, insurance, and overhead expenses. Hospitals can currently calculate an indirect cost ratio from their HSCRC Annual Cost Report data.

Offsetting revenue includes funds received from external sources (grants, etc.) to provide the individual community benefit reported. Offsetting revenue provided in the form of HSCRC-approved rates to the hospital is not reported in this column.

II. Community Benefit Categories and Reporting Guidelines

As defined under current Maryland law, community benefit means an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:

- health services provided to vulnerable or underserved populations;
- 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; and
- health education, screening, and prevention services.

[6] Note that number of encounters is different than number of people served.

A. Community Services
Community services include activities carried out for the express purpose of improving community health. They typically extend beyond patient care activities.
To determine whether community services should be included in a community benefit inventory, and in addition to considering the current Maryland definition of "community benefit," hospitals are directed to ask a series of questions, including:

- Does the activity address a community need?
- Does the activity support an organization's community-based mission?
- Is the activity designed to improve health?
- Does the activity produce a measurable community benefit?
- Does the activity attempt to constrain future health care costs, i.e., preventative nature of services?
- Does the activity support other public health programs?
- Is the activity able to be quantified in terms of dollars spent, number of people served, and number of staff hours provided?

The following categories outline the specific areas included within Community Services and a brief description of each.

A1. Community Education and Outreach
Community health education and outreach are programs and activities that are provided to groups and open to the public, without providing clinical or diagnostic services.

Patient education is education provided for current patients in an outpatient or inpatient setting. Hospitals are directed to exclude data on patient education costs, which is considered a component of delivering inpatient or outpatient health care.

A2. Screenings
Screenings are health tests that are conducted in the community as a public clinical service, such as blood pressure measurements, cholesterol checks, and school physicals. They are a secondary prevention activity designed to detect the early onset of illness and disease and can result in a referral to another community medical resource.

A3. Support Groups
Support groups usually meet to address a specific diagnosis or occurrence.

A4. Counseling
Counseling is support given on a one-on-one basis to assist a community member in various areas, including referral to community services, public assistance, and crisis intervention.

A5. Self-help/Wellness
Self-help refers to wellness and health promotion programs, such as exercise classes.

A6. Immunizations
Immunization services include the cost of personnel, equipment, and supplies in providing immunizations. An example would be the provision of flu shot clinics for older adults and at-risk populations.

A7. Community Clinics
Community clinics are staff and resource costs that support non-healthcare organization sponsored community health centers and clinics, such as federally qualified community health centers. Hospital sponsored clinics, are reported in C. Mission Driven Health Services. Medical residency clinic costs are reported under Medical Education, B1.

A8. Other Areas
Other areas include community benefit initiatives and programs where the recipient is not billed. In this area, hospitals include varied types of community service initiatives, including:

- Prescription drug vouchers for the uninsured or underinsured
- Cab, bus or other transportation vouchers
- Personal response systems for seniors
- Senior day treatment programs
- Public Service Announcements with health messages (non-marketing)
- Sign language interpreters
- Adolescent psychiatric programs and education costs
- Costs for assisting local health departments with infection control plans
- Meals on Wheels
- Lab services provided to community clinics
- Home visits, classes, and other resources for new parents, seniors, and other populations
- United Way campaigns

B. Medical Education
For all categories of medical education, hospitals are directed to exclude the costs of orientation programs, in-service training, teaching/delivering papers at professional meetings, and other required education.

B1. Physicians/Medical Students
Hospitals report expenses to provide a clinical setting for undergraduate training, internships/clerkships/residencies, residency education, including clinic costs, continuing medical education program, and access and use of medical library by physicians and medical students.

B2. Scholarships/Funding for Professional Education
Hospitals report negative margins for funding, including registrations, fees, travel, and incidental expenses for staff education that is linked to community services and health improvement.

B3. Nurses
Hospitals report costs to provide a clinical setting for undergraduate training, training of nurse practitioners in special settings (emergency department, etc.), and access and use of medical library by nurses.

B4. Technicians
Hospitals report costs to provide a clinical setting for undergraduate training for lab and other technicians when it produced a negative margin.

B5. Other Health Professionals
Hospitals report negative margin to conduct a clinical setting for undergraduate training for dietitians, physical therapists, and other health professionals, training of health professionals in special settings (occupational health, outpatient facilities, etc.), and access and use of medical library by other health professionals

B6. Other
Hospitals report negative margin for scholarships to community members (not employees), phlebotomy training, foreign nurse recruitment, and physicians assistants.

C. Mission Driven Health Services
Mission driven health services are services provided to the community that were never expected to result in cash inflows but: 1) which the hospital undertakes as a direct result of its community or mission driven initiatives; or 2) would otherwise not be provided in the community if the hospital did not perform these services. Bad debt is not considered an allowable cost. Costs were reported for a broad range of health care initiatives, including:

- Organizationally owned health care clinics and urgent care centers
- Outpatient mental health services
- Medications for uninsured/underinsured patients (hospitals also included this cost under Section A8 - Community Services, Other)
- MedBank subsidy
- Physician on-call costs (psychiatric, pediatric, emergency room), physician charity care (hospital owned provider groups), physician recruitment costs to underserved areas
- Hospice
- Adult day center
- School clinics
- Post-discharge, unreimbursed home visits (Medicaid, high risk patients for OB, home bound patients)
- Disease management programs

D. Research
Research includes studies on health care delivery, unreimbursed studies on therapeutic protocols, evaluation of innovative treatments, and research papers prepared by staff for professional journals.

E. Donations
This category defines funds and in-kind services donated to the community-at-large. In-kind services include hours donated by staff to the community <u>while on hospital work time</u>, as well as overhead expenses of space donated to non-profit community groups for meetings, etc.

E1. Cash
This category includes contributions and/or matching funds provided to non-profit community organizations and contributions to local governments.
E2. In-kind Donations
In-kind donations includes costs for coordinating community events, sponsorship of health related activities, employee costs associated with board and community involvement on work time, food donations, public service announcements for community events (not promotional or marketing driven), supplies, equipment, and meeting room overhead/space

F. Community Building
Community building includes cash, in-kind donations, and budgeted expenditures for the development of community health partnerships and healthier communities initiatives.

F1. Physical and Environmental Improvements
This category includes costs for:
- Public works, lighting, tree planting, graffiti removal
- Neighborhood improvement projects
- Residential improvements (lead, radon, smoke detector programs)
- Projects geared to clean air, water, etc.

F2. Economic Development
Economic development costs include:
- Commercial services, such as providing financial services to a local business
- Household goods
- Small business development
- Community development corporations
- Housing projects
- Transportation initiatives
- Adopt-a-school efforts

F3. Support System Enhancements
This category includes expenses such as:
- Family systems/childcare cooperatives
- Community health assessment
- Healthy communities initiative
- Neighborhood systems; watch groups
- Community gardens
- Mentoring programs
- Youth asset building programs

F4. Leadership Development and Skills Training
Leadership development and skills training includes costs to provide:
- Language skills/development
- Medical translator training
- Cultural skills training
- Conflict resolution
- Communication skills training
- Other related programs

F5. Disaster Preparedness
Since September 11, 2001, hospitals and health systems have stepped up efforts to plan and implement a coordinated, community-wide disaster response system. While disaster readiness, including planning and implementing drills and staff training, have consistently been part of hospital operating practices, new standards of hospital readiness have emerged, many of them quantifiable in terms of community benefit. In including these costs, hospitals were to include disaster readiness expenses that would be considered *expanded, additional* expenditures

subsequent to September 11, 2001.

G. Other Mission Driven Health Services

Other Mission Driven Health Services, or "Gray areas," are areas that are sometimes difficult to determine whether or not they "count" and, if so, where they should be counted. This section lists a few or more common gray areas, along with reporting recommendations on items that should be considered eligible for inclusion and those that should not be included.

Activities considered a community benefit include:

- Employee costs associated with board and community involvement on *work time*
- Donation of food for community events
- Public service announcement production costs
- Offering community use of health care organization fitness facility
- On-site day care center subsidization for community-wide members
- Hospital tours with a community health education component
- Emergency medical care at a community event

In addition to the suggested list provided, Maryland hospitals also identified an additional number of activities, including:

- Physician on-call coverage (OB, surgical house, pediatric house)
- Over-55 targeted wellness activities, including pharmacist review of medications service, health seminars/education/screenings, discounts on over-the-counter medications, & assistance with living wills, advance directives, etc.
- Charity pharmacy

Activities considered ineligible for inclusion include:

- Nurse call lines paid for by payers or physicians
- Promotional and marketing information about health care organization services and programs
- Health promotion activities specifically geared to increase market share
- Social services for inpatients
- Pastoral care and in-house ministry projects
- Free meals and meal discounts for volunteers
- Free parking for clergy, volunteers
- Pharmacy discounts for employees and volunteers
- Tuition reimbursement program costs
- Economic impact of employee payroll and purchasing dollars
- Employee contributions such as United Way, or Adopt a Family at Christmas
- Physician referral if it is more of an internal marketing effort (include if it refers to many community organizations or to physicians from across an area, without regard to admitting practices)
- Standard hospital tours
- Amenities for visitors such as coffee in the waiting rooms, etc.
- Costs associated with provision of day care services for employees

H. Charity Care

Charity care is considered:

- Free or discounted health and health-related services provided to persons who cannot

afford to pay

- Care provided to uninsured, low-income patients who are not expected to pay all or part of a bill, or who are able to pay only a portion using an income-related fee schedule
- Health care services that were never expected to result in cash inflows
- The un-reimbursed cost to the health system for providing free or discounted care to persons whom cannot afford to pay and who are not eligible for public programs

Charity care results from a provider's policy to provide health care services free of charge or at reduced charges to individuals who meet certain financial criteria. A bill or patient encounter record must be generated and recorded and the patient must meet the organization's criteria for charity care, and demonstrate an inability to pay. For the purposes of the Community Benefit Report, charity care does not include bad debt. Bad debt is uncollectible charges arising from the failure to pay by patients whose health care has not been classified as charity care.

Attachment IV – Hospital Rate Support for Community Benefit Programs

Nurse Support Program (NSP)

The following chart details awards granted to Maryland hospitals to fund Nursing Support Program to for initiatives to increase the recruitment and retention of nurses in Maryland hospitals in FY 2004:

Hospital	Grant Awarded
Anne Arundel Medical Center	$194,626
Atlantic General Hospital	$32,309
Bon Secours Hospital (a)	$83,291
Calvert Memorial Hospital (a)	$53,651
Carroll County General Hospital	$95,502
Chester River Hospital Center	$34,685
Civista Medical Center	$55,883
Doctors Community Hospital	$109,195
Dorchester General Hospital	$33,541
Franklin Square Hospital	$222,649
Frederick Memorial Hospital	$145,804
Garrett Memorial Hospital (a)	$23,057
Greater Baltimore Medical Center	$249,747
Good Samaritan Hospital	$152,808
Harbor Hospital	$111,306
Harford Memorial Hospital	$47,079
Holy Cross Hospital (a)	$109,440
Howard County General Hospital	$111,786
Johns Hopkins Bayview Medical Center	$288,850
Johns Hopkins Medical Center	$905,932
Kernan Hospital	$45,770
Laurel Regional Hospital (a)	$72,484
Maryland General Hospital	$108,935
Memorial at Easton	$83,666
Memorial of Cumberland	$78,556

Mercy Medical Center	$169,075
Montgomery General Hospital	$80,213
North Arundel Hospital (a)	$153,452
Northwest Hospital	$122,419
Peninsula Regional Medical Center	$206,171
Prince George's Medical Center (a)	$177,603
Sacred Heart Hospital (a)	$78,651
Saint Agnes Hospital (a)	$196,023
Saint Mary's Hospital (a)	$57,596
Saint Joseph's Hospital	$222,506
Sinai Hospital	$327,337
University of Maryland Medical Center	$494,259
University of Maryland Cancer Center	$47,190
University of Maryland Shock Trauma	$118,953
Union Memorial Hospital	$251,705
Union Hospital of Cecil	$70,580
Upper Chesapeake Medical Center	$81,477
Washington Adventist Hospital (a)	$128,990
Washington County Hospital	$139,437
Total Grants Awarded	$6,697,229

a) Denotes hospitals awarded grants on a calendar year basis. Award amounts shown represent an allocation of funds between two calendar years to approximate fiscal year funding.

Uncompensated Care

The HSCRC includes amount in hospital rates for uncompensated care; this includes both charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). This chart, therefore, illustrates the total amount a hospital received for both charity care and bad debt in FY 2004.

Hospital Name	Uncompensated Care in Rates
Anne Arundel General Hospital	$10,944,925
Atlantic General Hospital	$1,773,525
Bon Secours Hospital	$12,222,255
Calvert Memorial Hospital	$3,531,026
Carroll County General Hospital	$4,340,066
Chester River Hospital Center	$2,109,515

Civista Medical Center	$4,093,675
Doctors Community Hospital	$6,627,405
Dorchester General Hospital	$2,612,948
Fort Washington Medical Center	$1,989,434
Franklin Square Hospital	$15,021,891
Frederick Memorial Hospital	$8,168,922
Garrett County Memorial Hospital	$1,636,693
Good Samaritan Hospital	$7,654,318
Greater Baltimore Medical Center	$5,821,366
Harbor Hospital Center	$8,461,333
Harford Memorial Hospital	$3,393,469
Holy Cross Hospital	$13,748,150
Howard County General Hospital	$5,719,659
James Lawrence Kernan Hospital	$4,682,179
Johns Hopkins Bayview Med. Center	$31,973,176
Johns Hopkins Hospital	$78,172,507
Laurel Regional Hospital	$5,009,348
Maryland General Hospital	$13,308,317
McCready Hospital	$914,806
Memorial Hospital at Easton	$5,242,654
Mercy Medical Center	$20,744,336
Montgomery General Hospital	$4,875,822
North Arundel General Hospital	$9,786,119
Northwest Hospital Center, Inc.	$7,478,059
Peninsula Regional Medical Center	$13,539,475
Prince Georges Hospital	$32,369,999
Sacred Heart Hospital	$4,659,222
Shady Grove Adventist Hospital	$11,451,382
Sinai Hospital	$29,602,381
St. Agnes Hospital	$15,247,763
St. Josephs Hospital	$7,270,755
St. Marys Hospital	$3,257,377
Suburban Hospital	$7,783,624
The Memorial Hospital – Cumberland	$3,854,097
Union Hospital of Cecil County	$5,287,386
Union Memorial Hospital	$17,963,317
Univ. of Maryland Medical System	$55,041,411
Upper Chesepeake Medical Center	$4,720,263
Washington Adventist Hospital	$14,243,540
Washington County Hospital	$8,405,965
TOTAL	**$545,484,502**

Graduate Medical Education

The Commission utilizes an annual hospital intern and resident count to assist in quantifying the direct and indirect costs of medical education in physician training programs, and recognizes only the interns and residents included on the survey up the hospital's cap. Any resident and intern costs above the hospital's recognized cap, therefore, would not be funded through hospital rates. Further, the amounts are differentiated by direct and indirect costs. Direct medical education costs are those directly incurred in the operation of teaching activities and consist of salaries and fringe benefits of residents and interns, faculty supervisory expenses, and allocated overhead. Indirect medical education costs, by contrast, are generally descried as those additional costs incurred as a result of the teaching program (e.g., increased patient severity associated with teaching programs and inefficiencies, such as ordering extra tests or the extra costs of supervision).

The following chart illustrates the amount in hospital rates for graduate medical education for FY 2004:

HOSPITAL NAME	IME	DME	TOTAL
Anne Arundel Medical Center	$0	$0	$0
Atlantic General Hospital	$0	$0	$0
Bon Secours Hospital	$0	$0	$0
Calvert Memorial Hospital	$0	$0	$0
Carroll County General Hospital	$0	$0	$0
Chester River Hospital Center	$0	$0	$0
Civista Medical Center	$0	$0	$0
Doctors Community Hospital	$0	$0	$0
Dorchester General Hospital	$0	$0	$0
Fort Washington Medical Center	$0	$0	$0
Franklin Square Hospital Center	$18,482,477	$3,012,204	$21,494,681
Frederick Memorial Hospital	$0	$0	$0
Garrett County Memorial Hospital	$0	$0	$0
GBMC	$12,562,811	$1,713,877	$14,276,687
Good Samaritan Hospital	$6,978,809	$1,475,848	$8,454,657
Harbor Hospital Center	$8,569,226	$1,496,566	$10,065,792
Harford Memorial Hospital	$0	$0	$0
Holy Cross Hospital	$7,194,903	$1,432,273	$8,627,175
Howard County General Hospital	$0	$0	$0
James Lawrence Kernan Hospital	$961,631	$391,763	$1,353,394
Johns Hopkins Bayview Medical	$22,600,730	$3,481,680	$26,082,410
Johns Hopkins Hospital	$82,880,634	$14,276,109	$97,156,744
Laurel Regional Hospital	$0	$0	$0
Maryland General Hospital	$7,557,284	$1,979,786	$9,537,070
McCready Memorial Hospital	$0	$0	$0
Memorial Hospital at Easton	$0	$0	$0
Memorial of Cumberland	$0	$0	$0
Mercy Medical Center	$12,156,296	$2,194,223	$14,350,519

Montgomery General Hospital	$0	$0	$0
North Arundel Hospital	$894,192	$123,082	$1,017,274
Northwest Hospital Center	$0	$0	$0
Peninsula Regional Medical Center	$0	$0	$0
Prince Georges Hospital Center	$8,018,238	$1,785,162	$9,803,400
Sacred Heart Hospital	$0	$0	$0
Shady Grove Adventist Hospital	$0	$0	$0
Sinai Hospital	$24,366,526	$4,291,081	$28,657,607
St. Agnes Hospital	$14,946,342	$2,745,290	$17,691,632
St. Joseph Medical Center	$0	$0	$0
St. Mary's Hospital	$0	$0	$0
Suburban Hospital	$402,126	$78,895	$481,020
Union Memorial Hospital	$12,802,701	$2,140,625	$14,943,326
Union of Cecil	$0	$0	$0
University of Maryland Hospital	$56,304,079	$12,809,347	$69,113,426
Upper Chesapeake Medical Center	$0	$0	$0
Washington Adventist Hospital	$0	$0	$0
Washington County Hospital	$0	$0	$0
TOTAL	**$297,679,002**	**$55,427,812**	**$353,106,814**

Attachment V - Additional Available Items for Individual Hospitals Not Included in Statewide CBR

(Available in hard copy at HSCRC offices)

- Charity care policies
- Dated list of community service activities (Section A from the CBR inventory worksheet)
- Mission statements
- Evaluation descriptions
- Community needs assessments used, if applicable