maryland
health services
cost review commission

Hospital Community Benefit Reporting Instructions Workgroup

May 15, 2024

Agenda

- Welcome and Introductions
- Timeline Reminder
- Review Proposed Changes to Reporting Instructions
- Regulations Update

Welcome and Introductions

Timeline Reminder

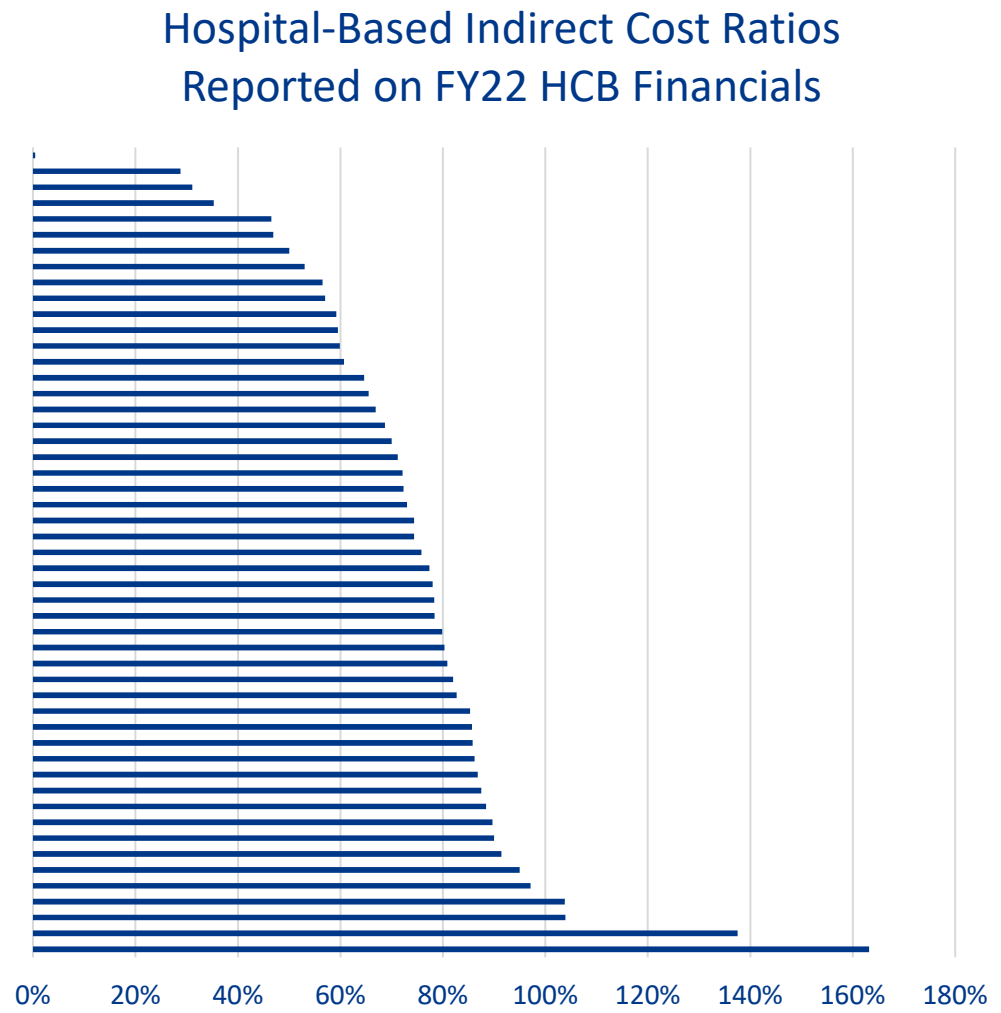
Timeline

Activity	Timeline
Meeting 1	April 17, 2:30-4:30
Meeting 2	May 1, 10:00-12:00
Meeting 3	May 15, 1:00-3:00
Final Workgroup Comments	May 31
Release Final FY 2024 Reporting Instructions	July 1

Indirect Costs

Indirect Costs: Current Definition and Issues

- Definition: Costs not attributed to products and/or services that are included in the calculation of costs for community benefit, including but not limited to, salaries for human resources and finance departments, insurance, and overhead expenses.
- Current instructions refer to HSCRC's Annual Cost Report Schedule M.
- Current instructions lead to wide variation and some hospitals with very high indirect rates.
- Some hospitals' indirect costs do not align between HCB report and schedule M.



Options/Potential Changes Discussed

Option 1: Clarify current instructions for deriving indirect costs from Schedule M to remove categories that are inappropriate for HCB.

Option 2: Move to a set indirect cost threshold not to exceed a specified amount, such as 25%, with exceptions for:

- Research to remain at federally-approved rate.
- Medicaid deficit assessment, charity care, and cash/in-kind to remain at 0%.

Options/Potential Changes Discussed continued

Option 3: Combination of the above:

- Hospitals submit their individual reports based on Schedule M, as updated to remove inappropriate costs.
- For the statewide summary report, HSCRC replaces hospital-reported rates with the set threshold.

Consideration for all options: Apply no indirect costs for physician subsidies.

Draft Edits to the Instructions/Reporting: Option 3

Instructions

- Hospitals will continue to report indirect costs based on Schedule M.
- Staff will correct the outdated Schedule M column references in the instructions.
- Staff will validate the indirect rates in the HCB report against Schedule M filings and will follow up with hospitals as needed.
- Hospitals may continue to report indirect costs for physician subsidies but will be asked to provide an explanation.

Public Reporting

- Staff may create additional tables in the statewide summary report that cap indirect costs at a set threshold, such as 25%.
- Individual hospital reports will still show their Schedule M-based reported rates.

Community Health Needs Assessment (CHNA)-Aligned Spending

CHNA-Aligned Spending: Current Instructions & Issues

- Newly required in the FY 2022 HCB financial reports.
- Separate worksheet that lists initiatives and expenditures that address CHNA-identified needs.
- Instructions intentionally left flexibility for hospitals.
- This resulted in wide variation across hospitals, with % spend on CHNA priority areas ranging from 0.0% to 81.4%.

Issues Discussed during Previous Meeting

- Goal: to revise reporting instructions to better allow comparability between hospitals
- Process
  - Staff effort
  - Software
  - Data collection to connect the activity to the CHNA
  - Challenges
- CHNA
  - Addressing reporting discrepancies due to breadth of CHNAs
- Priority Areas/Categories on the Spreadsheet
  - Based on HealthyPeople 2030

Draft Edits to the Instructions/Reporting

Instructions

- Replace term “priority area” with “CHNA-identified need.”
- Add clarification that physician subsidies may count if access to care is an identified need in the CHNA and there is an objective measure, such as a primary care shortage area.
- Add clarification that charity care may count.
- Continue discussion today as to whether changes should be made to the HealthyPeople 2030 categories.

Public Reporting

- Staff will conduct analyses to adjust for rate support, e.g., charity care.

Other Minor Edits to Reporting Instructions

Other Minor Edits

- Community Health Improvement Services – Community-Based Clinics Subcategory
  - Clarification to the “Do Not Count” list: *Services* within clinics for which a fee is billed/charge do not count.
- Conforming Change with Recent IRS 990 Clarification
  - Allowing hospitals to report activities or programs that are required for licensure or accreditation if they respond to a community need, enhance public health, or relieve government burden to improve health.
  - See page 19 here.

Proposed Minor Regulations Updates

Proposing Minor Edits to Conform with Current Practice

- Draft edits to COMAR 10.37.01.03

(1) Beginning on December 15, 2009, each nonprofit hospital shall submit the Annual Nonprofit Hospital Community Benefit Report to the Commission by *the date prescribed by the Commission* ~~December 15 of every calendar year~~ in the format prescribed by the Commission. ¶

(2) Hospitals shall complete the report on the basis of actual data covering the reporting period of the previous July 1 through June 30 *or other time period as specified by the Commission.* ¶

(3) The Commission shall provide instructions for completing the report *on its public website.* ~~in its "Accounting and Budget Manual for Fiscal and Operating Management.~~ ¶

- Tentative timeline- present to Commission in July
- Comments or concerns?

Written Comments Encouraged

- Submit to lspicer@hilltop.umbc.edu
- All comments due by May 31