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633rd Meeting of the Health Services Cost Review Commission

July 30, 2025

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

CLOSED SESSION
12:00 pm

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on June 11, 2025

Specific Matters

For the purpose of public notice, here is the docket status.

Docket Status – Cases Closed

2668R Johns Hopkins Howard County Medical Center - Application Withdrawn
2681N Luminis Health Doctors Community Medical Center
2672A Johns Hopkins Health System
2673A Johns Hopkins Health System
2674A Johns Hopkins Health System

2. Docket Status – Cases Open

2675A Johns Hopkins Health System
2676A Johns Hopkins Health System
2677A Johns Hopkins Health System
2678A Johns Hopkins Health System

Informational Subjects

3. Presentation: Revolutionizing Heart Failure Care

Subjects of General Applicability

4. Report from the Executive Director
    a. Summary of GME RFI Submissions
    b. Update on Stakeholder Feedback Process (John Colmers)

5. Recommendation: Release of HSCRC Confidential Patient-Level Data
6. Recommendation: Additional Funding Considerations for FY 2026
7. Recommendation: Updates to the Consumer Financial Assistance and Medical Debt Regulations
8. Materials Only: Community Benefits Report - FY 2023 Activities
9. Hearing and Meeting Schedule

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

July 30, 2025

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2485
BALTIMORE, MARYLAND	*	PROCEEDING:	2675A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on May 28, 2025, on behalf of its member hospitals, 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 price arrangement for bariatric surgery, joint replacement, oncology surgical procedures and neurosurgery with BridgeHealth Medical Inc. The System requests approval of the arrangement for a period of one year beginning July 1, 2025.

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 new global rates for solid organ transplants 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 it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bariatric surgery, joint replacement, oncology surgical procedures and neurosurgery for a one-year period commencing July 1, 2025, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). 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.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

July 30, 2025

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2486
BALTIMORE, MARYLAND	*	PROCEEDING:	2676A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on June 27, 2025, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for Executive Health Services with Under Armour, Inc. for a period of one year beginning August 1, 2025.

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 new global rates for solid organ transplants 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 it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Executive Health Services with Under Armour for a one-year period commencing August 1, 2025. 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.

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DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2487
BALTIMORE, MARYLAND	*	PROCEEDING:	2677A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on June 27, 2025, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement with Accarent Health for bariatric surgery, oncology surgical procedures, anal rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, Craniotomy, Ventricular Assist Devices (VAD) procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, Cochlear implants, gall bladder surgery, CAR-T, ankle repairs, hernia and nephrectomy for a period of one year beginning August 1, 2025.

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 new global rates for solid organ transplants 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.

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Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for bariatric surgery, oncology surgical procedures, anal rectal surgery, spine surgery, thyroid parathyroid, joint replacement, neurosurgery procedures, Craniotomy, VAD procedures, pancreas surgery, cardiovascular services, musculoskeletal surgical procedures, solid organ and bone marrow transplants, Executive Health services, Cochlear implants, gall bladder surgery, CAR-T, ankle repairs, hernia and nephrectomy with Accarent Health for a one-year period commencing August 1, 2025. 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.

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Johns Hopkins Health System

July 30, 2025

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2488
BALTIMORE, MARYLAND	*	PROCEEDING:	2678A

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on June 10, 2025, on behalf of its member hospitals, 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 price arrangement for cardiovascular, joint replacement procedures, bypass, cardiac cath, defribillators, Percutaneous Coronary Intervention (PCI) cardiac valves, Transcatheter Aortic Valve Replacement (TAVRs) and oncology evaluation services with Health Design Plus, Inc. The System requests approval of the arrangement for a period of one year beginning August 1, 2025.

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.

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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 risk of potential losses.

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Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

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The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for cardiovascular, joint replacement procedures, bypass, cardiac cath, defibrillators, PCI, cardiac valves, TAVRs and oncology evaluation services for a one-year period commencing August 1, 2025, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

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Commentary on Public Comments on Financial Assistance and Medical Debt Regulations

July 2025

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Introduction

This document contains comments received from the public on draft changes to the current COMAR 10.37.10.26, the Health Services Cost Review Commission's regulations on "Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies" and HSCRC staff responses to those comments. This document includes the following:

1. Direct quotes from written comments received by June 26 on the first draft shared with stakeholders by June 12 ("formal comments").
2. Direct quotes from written comments received by July 17 on the second draft shared with stakeholders on July 3 ("formal comments").
3. Summary of comments received during HSCRC's workgroup meeting on July 23, 2024 ("informal comments").

This document is grouped by topic area, with areas discussed most heavily listed first. The final section includes two groups of comments:

1. **Comments pertaining to previously considered areas of regulations.** Previous stakeholder workgroup meetings and public comment periods resulted in a version of the regulations that was published on the HSCRC website, voted on by HSCRC Commissioners, and sent to AELR in September 2023 (see "Commentary on Public Comments on Financial Assistance and Medical Debt Regulations" section). As stated in written outreach to workgroup members, HSCRC did not intend to return to sections of the regulations that had already been edited and remained untouched by statute since September 2023. To help stakeholders track the different changes to regulations, HSCRC even provided a marked-up version of the different drafts of the regulations when providing the second draft of the regulations on July 3.
2. **Comments on language pulled directly from statute.** HSCRC regulations are intended to clarify and provide details on how to implement language in statute, but the statute is the ultimate source of legal requirements and authority. The comments in this section are on language in the proposed regulations that comes directly from statute. Language in regulations should mirror the language in statute, whenever possible.

Documentation of Income

Formal Comment: *University of Maryland Medical System*

Hospitals should not be required to obtain tax returns to verify income or household size.

Formal Comment: *Maryland Hospital Association*

We recommend allowing attestation for both financial assistance and payment plan determinations.

Response: Attestation is now explicitly allowed for financial assistance under 10.37.10.06A.(4) and thus for payment plan determinations as well through 10.37.10.05D(2).

Formal Comment: *MidAtlantic Collectors Association*

Seeking clarification if, in the absence of documentation, a hospital and/or its third party vendor may use a reliable external third party database to independently obtain information to confirm data about a patient's household, household income, or similar to make a preliminary financial assistance determination.

Response: Information obtained through a reliable external third party database should be covered by "available information" under 10.37.13.06A.(4)(b).

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

These regulations should minimize placing the onus of working through the payment plans and financial assistance processes on patients. Requiring hospitals to use the same process for establishing eligibility for financial assistance as they do to establish the 5% monthly payment threshold for payment was not contemplated as part of statute.

Formal Comment: *University of Maryland Medical System*

HSCRC should clarify what using the same process for establishing eligibility for financial assistance as they do to establish the 5% monthly payment threshold for payment means.

Informal Comment: *University of Maryland Medical System*

Hospitals may have separate teams, including teams that are constituted of third-party partners, for managing financial assistance applications and engaging patients on payment plans. Requiring consideration of the same information may therefore be challenging.

Response: The General Assembly has consistently linked the sections of statute that pertain to medical debt and financial assistance together. HSCRC is aligning the definitions of income across 10.37.13 (in Section 10.37.13.15B(7)) and requiring hospitals to use information collected for financial assistance to determine the 5% monthly payment threshold for income-based payment plans (in Section 10.37.13.05D(2)). In doing so, HSCRC is harmonizing Health-General Article, §19-214.1, which pertains to medical debt, and Health-General Article, §19-214.2, which pertains to financial assistance. Additionally, HSCRC believes that this requirement simplifies the financial assistance and payment plan processes, and

that this benefit outweighs the challenges some hospitals may face in increasing coordination between their teams.

Formal Comment: *Health Education and Advocacy Unit*

Language should be added to 10.37.13.06(I) making clear that hospitals cannot require documentation that presents an undue barrier to the patient's receipt of financial assistance. As written, the language suggests that hospitals can require consumers to validate any information provided in the application, which could be onerous.

Response: This language is from previous updates to regulations, as reflected in September 2023 Public Pre-Meeting Materials. Hospitals may require documentation that verifies income.

Formal Comment: *University of Maryland Medical System*

Suggest including a definition of "monetary assets" that hospitals should apply for the purposes of asset testing.

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

The definition of Monetary Assets should directly reflect the "including but not limited to deferred compensation plans, or nonqualified deferred compensation plan" language in statute. Monetary assets should not include pre-paid higher education funds in a Maryland 529 program account.

Formal Comment: *Health Education and Advocacy Unit*

To provide clarity and uniformity, we recommend defining monetary assets. We recommend this definition: *"Monetary assets" include cash and cash equivalents, such as cash on hand, bank deposits, investment accounts, accounts receivable (AR), and notes receivable, all of which can readily be converted into a fixed or precisely determinable amount of money. "Monetary assets" does not include equity in a primary residence, or retirement assets that the IRS has granted preferential tax treatment as a retirement count, including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans.*

Response: The definition of monetary assets in these regulations under 10.37.13.01B.(11) directly reflects language in statute, with clarifying language added that reflects HEAU's recommendation.

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Scope of Regulations

Formal Comment: *University of Maryland Medical System*

(10.37.13.06 A.(1)(f)) instructs that free and reduced cost medically necessary care shall be provided to all qualified Maryland residents. This would still allow hospitals to establish exclusions for financial assistance for non-urgent or elective services for non-Maryland residents.

Response: HSCRC has added language to 10.37.13.06 A.(1)(g) to clarify that hospitals may not exclude non-urgent or elective, but medically necessary, care from their financial assistance policy. People that do not meet the definition of "Qualified Maryland resident" under 10.37.13.01B.(13) are not covered by this regulation.

Formal Comment: *University of Maryland Medical System*

HB 268 removes language that would limit medical debt to costs billed by a hospital, thereby expanding the definition without providing any limits for what types of care constitute medical debt. Is a hospital expected to assess medical debt incurred from other healthcare providers? If yes, how are hospitals expected to validate medical debt from other healthcare providers? Requiring and reviewing documentation of medical debt from third parties creates an undue burden on patients and hospitals

Formal Comment: *Health Education and Advocacy Unit*

Chapter 498, Laws of Maryland 2025, prohibits the placement of a lien on a patient's primary residence for medical debt. Medical debt is broadly defined in Chapter 498 and not limited to hospital services regulated by the HSCRC. As drafted, this regulation suggests a limitation on the scope of the lien protection.

Response: Under sections 10.37.13.01B. (5) and (9), medical debt is limited to HSCRC-regulated hospital services, for the purpose of these regulations.

Formal Comment: *University of Maryland Medical System*

HB 328 removes language that limits the provision of reduced-cost medically necessary care and payment plans to the service area of the hospital. Does this preclude a hospital's ability to limit the application of free and reduced-cost medically necessary care to Maryland residents?

Response: The hospital shall provide free and reduced cost medically necessary care to all qualified Maryland residents, regardless of their citizenship or immigration status, as stated in section .06A.(e). People that do not meet the definition of "Qualified Maryland resident" under 10.37.13.01B.(13) are not covered by this regulation.

Formal Comment: *MidAtlantic Collectors Association*

The definition of “hospital services” should clarify that they do not include services independent clinicians provide at hospital facilities more or less seamlessly with a hospital’s own employed staff. Seeking further clarification on what “(e)” means in regard to “identified physician services.”

Response: HSCRC has included language in Section 10.37.13.01B(6)(g) to now explicitly state that hospital services do not include physician services that are billed separately.

Formal Comment: *MidAtlantic Collectors Association*

These regulations should confirm how “medically necessary care” aligns with the Emergency Medical Treatment and Labor Act of 1986 (“EMTALA”). “Medically necessary care” should include any care provided that is subject to EMTALA.

Response: HSCRC has included language in Section .01B.(10) to now state "(10) “Medically necessary care”, including care provided in accordance with the Emergency Medical Treatment and Labor Act of 1986 (“EMTALA”), means care that is...".

Formal Comment: *University of Maryland Medical System*

A definition of “qualified Maryland resident” should be provided.

Formal Comment: *Health Education and Advocacy Unit*

The regulations provide that consumers that work or go to school in Maryland are eligible for income-based payment plans. The HEAU believes those same consumers should be eligible for financial assistance. Adding a definition for “qualified Maryland residents” to include those here for school or work would address this.

Informal comment: *Representatives from Johns Hopkins Health System, London Eligibility and London Disability, Health Education and Advocacy Unit, MidAtlantic Collectors Association*

The definition of "qualified Maryland residents” should be flexible enough to account for patients without housing and should not be interpreted to require hospitals to verify addresses, including through documentation.

Response: HSCRC has added a definition of "qualified Maryland residents" based on stakeholder input and feedback.

Application of Asset Tests

Formal Comment: *University of Maryland Medical System*

We do not support a change that would require hospitals to include assets in a patient's income for the purposes of determining eligibility for financial assistance or payment plans. Asset testing creates an administrative burden for patients and hospitals and could discourage patients from requesting a payment plan.

Formal Comment: *Maryland Hospital Association*

Current law allows asset tests to be used for financial assistance but is silent for payment plans. We recommend the asset test for both. Assets should be included in the eligibility determination so that hospitals can ensure that free or reduced cost care is available to the patients who need it.

The regulations should be revised to clarify how the asset test may be applied in coordination with the income threshold requirements for free or reduced-cost care. We recommend that the HSCRC create a formula to include assets in the definition of income.

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

HSCRC seems to suggest that if it is not expressly prohibited, asset tests may be used for payment plans. HSCRC is suggesting that even though clear limits have been placed on the use of these tests in statute, HSCRC chooses to expand beyond the law in its interpretation.

Informal Comment: *Representative of Economic Action Maryland Fund*

10.37.10.06J should include a reference to the definition of monetary assets to ensure that it is clear that asset tests are limited to monetary assets.

Response: The statute as currently written does not ban the use of asset test for payment plans. HSCRC has clarified its expectations of how the asset tests are applied using the definition of "income" and "monetary assets" in section 10.37.10.01B.(7) and (11), as well as adjusting the existing language in section 10.37.10.06J.

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

As drafted, HSCRC's regulations go far beyond the legislative intent of the law passed by the General Assembly in 2024. As passed, hospitals may choose to either use an asset test or to use income-based eligibility–not both. The term "ONLY" limits the option to one not both.

Response: HSCRC does not agree with this interpretation of the law. HSCRC believes that income is central to both financial assistance and income-based payment plan determinations. For example, under section .06A.(1)(c), hospitals must use 'family income" to determine eligibility for financial assistance, so hospitals must include consideration of "income" in their determination. Furthermore, this interpretation would increase variation between hospitals - a concern expressed by consumer advocates previously - and make navigating the financial assistance and payment plan processes even more complicated for those involved. HSCRC believes our definition of income under 10.37.10.01B.(7), which allows for but does not require consideration of assets, both aligns with language of the law and maximizes simplicity.

Definition of Income

Formal Comment: *Health Education and Advocacy Unit*

In .05G generally, the term "adjusted" should be added before "gross monthly income" and "tax household" should be added where currently missing. The regulations should contain a provision allowing for Reasonably Predictable Changes in income, as allowed by federal Medicaid regulations, to account for consumers with varying monthly income. 10.37.13.05(G)(1)(d) should allow for the division of yearly income by 12, even in instances where the consumer's monthly income is a higher amount.

Only the income of those in the tax household should be included in the calculation of income, and only the members of the tax household are counted when determining the patient's share of the income-based payment responsibility.

Formal Comment: *Maryland Hospital Association*

The definition of "household" should apply to both financial assistance and payment plan determinations.

Response: HSCRC has added a definition of household and family under section 10.37.13.01B.(6), which is explicitly limited to those living in the same dwelling. HSCRC has also added a definition of income under section 10.37.13.01B.(7) that incorporates the meaning of "adjusted" ("If a hospital uses state or federal tax returns to verify income, hospitals shall take into consideration adjustments listed on Schedule 1 of Form 1040" and "gross" ("before taxes"). This definition applies across the whole chapter 10.37.13 of regulations, including for determining financial assistance eligibility and payment plans payment amounts.

Impact on UCC

Formal Comment: *University of Maryland Medical System*

HB 765 allows a hospital to sell medical debt to a non-profit for the purposes of debt cancellation. How would this impact a hospital's uncompensated care?

Response: HSCRC has ensured our Uncompensated Care (UCC) policy subject matter experts are aware of these changes. Impacts on UCC were considered as part of statute changes during legislative session. HSCRC cannot change what is in statute.

Updates to Maryland Uniform Financial Assistance Application

Formal Comment: *MidAtlantic Collectors Association*

Request for the workgroup to consider updates to Maryland's uniform financial assistance application to align with Maryland's updated financial assistance and medical debt collections laws, to include consumer friendly explanations and frequently asked questions and making application available electronically to assist consumers in reviewing, completing, and gathering information about the hardship and application processes. A form that offers clear explanations of the categories may also facilitate a smoother process for all to understand what a hardship is, what options are available, and what supporting documentation would be helpful for a hospital and/or its vendors to review to truly be of assistance to patients.

Response: HSCRC will update the Uniform Financial Assistance Application to align with regulations when they are enacted.

Standard Attestation Form

Formal Comment: *London Eligibility and London Disability*

Consider developing a "standard" Attestation form and explain which income and assets and tax returns can be attested to and signature requirements (Ex: minor, incapacitation). Anecdotally, many hospitals are not making patients aware that Attestation is an option and some hospitals may be requiring witnessed signatures, notaries, and other administrative burdens not required by the statute.

Response: There is no requirement for or prohibition against use of attestation in place of documentation from the patient, and for that reason, the HSCRC does not feel that it is urgent to develop a distinct uniform attestation sheet. Instead, the HSCRC will focus its resources over the next year on refining the existing

Uniform Financial Assistance Application. Prohibitions against certain actions, such as requiring witnessed signatures, notaries, etc., should be enumerated under statute rather than created under regulations.

Alignment with Federal Law

Formal Comment: *Maryland Hospital Association*

To the extent possible, we recommend that the state financial assistance sheet not duplicate and be consistent any federal requirements (IRS 501r) related to patient disclosures.

Informal comment: *MidAtlantic Collectors Association*

HSCRC should consider, reference, incorporate, and/or dovetail existing pertinent legal standards under both Internal Revenue Code 501 and EMTALA specifications that may already speak to some of the compliance expectations related to activities regulated by Maryland's medical debt protection laws and regulations.

Response: HSCRC confirmed the State financial assistance sheet is consistent with federal requirements. Our regulations are intended to reflect and clarify implementation and fulfillment of Maryland law and statutory requirements. Furthermore, we think it could be confusing to incorporate federal law rather than spelling out requirements applicable to Maryland. This is because federal law is not entirely applicable to Maryland -- for example, federal law refers to hospital charges that may not exceed the "amounts generally billed" to insured patients. In Maryland, what is billed are the charges that are set by the HSCRC.

Alignment with Relevant Legal Case(s)

Informal comment: *MidAtlantic Collectors Association*

These regulations may need to note the recent court decision suggesting that the Fair Credit Reporting Act may preempt any state law restricting the ability to credit report medical debt. Specifically, the July 11, 2025, decision in the Cornerstone Credit Union League case stated, among other things, that "any state law purporting to prohibit a CRA from furnishing a credit report with coded medical information would be inconsistent with the FCRA and therefore preempted." Concerned particularly about section 10.37.13.04B.(3)(c).

Informal comment: *Representative from Economic Action Maryland Fund*

This case is likely to be contested, should allow for the legal process to play out.

Response: The federal case referenced deals primarily with CRA's furnishing of credit reports, and not the relationship between hospitals and CRAs, so it is HSCRC's position that this area of regulations may not be the right place to address these changes. It would also be prudent to wait to see how the case plays out over the next few months, so HSCRC believes it is not the right time to address this concern regardless.

Additional Comments

Addressed Previously by the HSCRC

Formal Comment: *Health Education and Advocacy Unit*

It is unclear why hospitals would consider expenses when calculating income-based payment plans because expenses are not a component of the calculation. For the same reason, unless the expenses are medical in nature and could be considered for determining reduced-cost care based on financial hardship, expenses should not be considered when modifying income-based payment plans. See 10.37.13.05(P)(2).

Response: As noted in HSCRC's September 2023 Public Pre-Meeting Materials, "Ability to pay is a cornerstone of credit. In the development of the payment plan guidelines, stakeholders noted that household expenses may affect a patient's ability to pay back medical debt under a payment plan. The only expense implicitly addressed in the law was medical debt that meets the definition of financial hardship (this topic is addressed in guideline (5)(a)). HSCRC staff included this language to encourage hospitals to consider patient circumstances." HSCRC has added language to clarify the intent behind section 10.37.13.05.G.

Formal Comment: *MidAtlantic Collectors Association*

There are numerous types of vendors who work by and on behalf of hospitals in regard to patient registration, access management, assisting patients in applying for and following the processes to obtain various forms of governmental assistance for medical bills, and who handle typical customer service, billing and coding functions. We recommend clearly "excepting" companies who perform these and other "non-collections" revenue cycle and patient eligibility and access management services from the broad definitions of "debt collector."

Response: As reflected on page 17 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, this concept was brought to

the attention of, and considered by, HSCRC previously. In this round of regulations updates, HSCRC did not intend to return to the sections of the regulations that were discussed previously.

Formal Comment: *Health Education and Advocacy Unit*

It is important for consumers to understand and appreciate that the payment plans available to them are accessible and offer them a fair and reasonable payment amount and timeline for repayment. Suggest adding language in 10.37.13.03(A)(2)(d) – "of the availability of an income-based payment plan with monthly payments capped at 5% of the patient's household's adjusted gross monthly income" – to 10.37.13.05(A)(2)(b)(iv), 10.37.13.04(I)(6)(f)(ii), .05(C)(1)(b) and (d), and .05(W)(3)(c).

Response: As reflected on page 24-25 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, the content and requirements of the payment plan notice was considered by HSCRC previously. In this round of regulations updates, HSCRC did not intend to return to the sections of the regulations that were discussed previously.

Formal Comment: *Health Education and Advocacy Unit*

10.37.13.04(D) could be read to eviscerate the clear statutory requirement that before filing a debt collection action or delegating collection activity to a debt collector, a hospital "shall demonstrate that it attempted in good faith to meet the requirements of" the debt collection statute and the guidelines. Md. Code Ann., Health-Gen. § 19-214.2(d). The regulation appears to bless some hospitals' current practice of providing simple notice about consumer protections; this amounts to minimum efforts and do not by themselves establish that the hospital has acted in good faith. It is contrary to the statute as passed by the General Assembly and constrains the statutory requirement of good faith. A hospital that does not seek to facilitate a consumer's access to payment plans is not acting in good faith.

Formal Comment: *Economic Action Maryland Fund, 1199 SEIU, High Note Consulting, LLC, Maryland Center on Economic Policy, Community Development Network of Maryland Greater Baltimore Democratic Socialists of America, Maryland Legal Aid, CASH Campaign of Maryland, and Progressive Maryland*

As drafted, 10.37.13.04(D) undermines the clear statutory requirement that before filing a debt collection action or delegating a collection activity to a debt collector, a hospital "shall demonstrate that it attempted in good faith to meet the requirements of" the debt collection statute and guidelines. It seems to accept some hospitals' current practice of providing notice and developing a process as sufficient despite clear barriers that remain in accessing financial assistance let alone payment plans. This regulatory interpretation is inconsistent with clear legislative intent of the General Assembly. The language is also weak because it

does not state that the information sheet be provided with each hospital bill, upon request, and in each written communication regarding the collection of medical debt.

Response: As reflected on pages 16-17 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, HSCRC considered this concept previously. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Formal Comment: *Health Education and Advocacy Unit*

Reiterate objection to the interpretation that income-based payment plans do not have to be provided to patients if they make payments in advance of services; urge the HSCRC to add another condition to .05(A)(2) requiring that hospitals comply with any provider-carrier contract terms and conditions regarding the collection of amounts in advance of claims processing procedures.

Response: As reflected on page 32 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, HSCRC considered comments on the Early Payment section of regulations previously. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Formal Comment: *Health Education and Advocacy Unit*

Reiterate objection to non-income-based payment plans being offered in lieu of the statutorily required plans. That said, hospitals should be required to comply with the partial payments stipulations in these regulations when offering non-income-based payment plans.

Response: As reflected on pages 36-37 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, HSCRC considered this comment previously. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Formal Comment: *University of Maryland Medical System*

Hospitals are required to amend their information sheet to include instructions for how to apply for a payment plan. This information is already readily available in the financial assistance policy and on the hospital bill.

Updates to the information sheet will require hospitals to make changes to Epic workflows and incur translation fees. Changing the font size will increase the size of the document, which will increase print and mailing fees associated with providing the information sheet with hospital bills.

Response: The changes addressed in these comments were part of the updates to regulations included in the September 2023 Public Pre-Meeting Materials. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Formal Comment: *MidAtlantic Collectors Association*

Could communications that are, delivered via other electronic means like chat, texting, messaging, or other method be added to the list – potentially with a proviso, subject to applicable laws?

Suggest reference to Regulation F, 12 CFR Part 1006, which establishes ground rules for debt collectors communicating electronically. Request that in the event a patient who has opted into electronic communications wishes to opt out, any expression or change of communication preferences be provided in writing, including electronic form, not orally, to assure that the patient's communication preferences are understood, documented, and recorded. Companies maintaining online resources are expected to take steps to assure those resources are ADA compliant and accessible. Many also host "IVR" or "interactive voice response" resources that can convert text-to-speech or speech-to-text to accommodate individuals with visual challenges.

Final regulations should be flexible enough to allow hospitals and their debt collectors to harness artificial intelligence and other emerging technologies to accommodate all consumers regardless of how they prefer to communicate (while creating and maintaining documentation of consumers' preferences).

Response: As reflected on page 11 of the Commentary on Public Comments on Financial Assistance and Medical Debt Regulations in the September 2023 Public Pre-Meeting Materials, HSCRC considered similar comments on written communications previously. HSCRC did not intend to return to the sections of the regulations that were discussed previously in the current round of regulations updates.

Directly from statute

Formal Comment: *Health Education and Advocacy Unit*

We request removal of the word "immediately" in .06(A)(1)(b)(iii) because it is unnecessary and suggests an urgency that isn't consistent with the consumer's right to seek financial assistance within 240 days from the initial bill.

Formal Comment: *University of Maryland Medical System*

HB 268 prohibits a hospital from filing a civil action to collect a debt at or below $500. This limits a hospital's ability to collect debt.

Hospitals are required to include a mechanism for patients to request the hospital to reconsider the denial of free or reduced-cost care in their credit and collection policy. This information is already readily available in the financial assistance policy and on the financial assistance application.

Hospitals are required to establish a process for making payment plans available to all patients in the credit and collection policy. This information is already readily available in the financial assistance policy and payment plan policy.

Hospitals are prohibited from making a claim against the estate of a deceased patient if the patient was known by the hospital to be eligible for free medically necessary care and hospitals may offer the family of a deceased patient the ability to apply for financial assistance. UMMS would like to understand how other hospitals interpret this language.

Hospitals are required to describe the payment plans required under Health-General Article, §19-214 and 10.37.13.05. This information is already readily available in the payment plan policy

Response: We believe an MHA workgroup would be the best forum for hospitals to share strategies and best practices delated to implementation of these regulations.

TITLE 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207 and 19-214.1 Annotated Code of Maryland

Notice of Proposed Action

.26 [Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies] Working Capital Differentials — Payment of Charges.

[A. Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(a) Describes the hospital's financial assistance policy;

(b) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;

(c) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

(i) The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced-cost, medically necessary care due to a financial hardship;

(iii) How to apply for free and reduced-cost care; and

(iv) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill;

(d) Provides contact information for the Maryland Medical Assistance Program;

(e) Includes a statement that physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately;

(f) Informs patients that the hospital is permitted to bill outpatients a fee, commonly referred to as a "facility fee", for their use of hospital facilities, clinics, supplies and equipment, and nonphysician services, including but not limited to the services of nonphysician clinicians, in addition to physician fees billed for professional services provided in the hospital;

(g) Informs patients of their right to request and receive a written estimate of the total charges for the hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided and billed for by the hospital;

(h) Informs a patient or a patient's authorized representative of the right to file a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland, which relate to financial assistance and debt collection; and

(i) Provides the patient with the contact information for filing the complaint.

(2) The information sheet shall be in:

(a) Simplified language in at least 10-point type; and

(b) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(3) The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(a) Before the patient receives scheduled medical services;

(b) Before discharge;

(c) With the hospital bill;

(d) On request; and

(e) In each written communication to the patient regarding collection of the hospital bill.

(4) The hospital bill shall include a reference to the information sheet.

(5) The Commission shall:

(a) Establish uniform requirements for the information sheet; and

(b) Review each hospital's implementation of and compliance with the requirements of this section.

A-1. Hospital Credit and Collection Policies.

(1) Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's policy on the collection of debts owed by patients.

(2) The policy shall:

(a) Prohibit the charging of interest on bills incurred by self-pay patients before a court judgment is obtained;

(b) Describe in detail the consideration by the hospital of patient income, assets, and other criteria;

(c) Describe the hospital's procedures for collecting any debt;

(d) Describe the circumstances in which the hospital will seek a judgment against a patient;

(e) Provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care on the date of service, in accordance §A-1(3) of this regulation;

(f) If the hospital, has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free care on the date of the service for which the judgment was awarded or the adverse information was reported, require the hospital to seek to vacated the judgment or strike the adverse information;

(g) Provide a mechanism for a patient to file with the hospital a complaint against the hospital or an outside collection agency used by the hospital regarding the handling of the patient’s bill;

(h) Provide detailed procedures for the following actions:

(i) When a patient debt may be reported to a credit reporting agency;

(ii) When legal action may commence regarding a patient debt;

(iii) When garnishments may be applied to a patient’s or patient guarantor’s income; and

(iv) When a lien on a patient’s or patient guarantor’s personal residence or motor vehicle may be placed.

(3) Beginning October 1, 2010, as provided by Health-General Article, §19-214.2(c):

(a) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2-year period after the date of service, was found to be eligible for free care on the date of service;

(b) A hospital may reduce the 2-year period under §A-1(3)(a) of this regulation to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient’s eligibility for free care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the required information; and

(c) If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital service, a hospital shall have a refund policy that complies with the terms of the patient's plan.

(4) For at least 120 days after issuing an initial patient bill, a hospital may not report adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment unless the hospital documents the lack of cooperation of the patient or the guarantor of the patient in providing information needed to determine the patient's obligation with regard to the hospital bill.

(5) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(6) A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.

(7) If a hospital delegates collection activity to an outside collection agency, the hospital shall:

(a) Specify the collection activity to be performed by the outside collection agency through an explicit authorization or contract;

(b) Specify procedures the outside collection agency must follow if a patient appears to qualify for financial assistance; and

(c) Require the outside collection agency to:

(i) In accordance with the hospital's policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the outside collection agency regarding the handing of patient's bill; and

(ii) If a patient files a complaint with the collection agency, forward the complaint to the hospital.

(8) The Board of Directors of each hospital shall review and approve the financial assistance and debt collection policies of the hospital every 2 years. A hospital may not alter its financial assistance or debt collection policies without approval by the Board of Directors.

(9) The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of §A-1(2) of this regulation.

A-2. Hospital Financial Assistance Responsibilities.

(1) Definitions.

(a) In this regulation, the following terms have the meanings indicated.

(b) Terms Defined.

(i) "Financial hardship" means medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

(ii) "Medical debt" means out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital.

(2) Financial Assistance Policy.

(a) On or before June 1, 2009, each hospital and, on or before October 1, 2010, each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill. A hospital shall provide notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill. The financial assistance policy shall provide at a minimum:

(i) Free medically necessary care to patients with family income at or below 200 percent of the federal poverty level;

(ii) Reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital;

(iii) A maximum patient payment for reduced-cost care not to exceed the charges minus the hospital mark-up;

(iv) A payment plan available to patients irrespective of their insurance status with family income between 200 and 500 percent of the federal poverty level who request assistance; and

(v) A mechanism for a patient, irrespective of that patient's insurance status, to request the hospital to reconsider the denial of free or reduced care, including the address, phone number, facsimile number, email address, mailing address, and website of the Health Education and Advocacy Unit, which can assist the patient or patient's authorized representative in filing and mediating a reconsideration request.

(b) A hospital whose financial assistance policy as of May 8, 2009, provides for free or reduced-cost medical care to a patient at an income threshold higher than those set forth above may not reduce that income threshold.

(c) Presumptive Eligibility for Free Care. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free care, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days:

(i) Households with children in the free or reduced lunch program;

(ii) Supplemental Nutritional Assistance Program (SNAP);

(iii) Low-income-household energy assistance program;

(iv) Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package;

(v) Women, Infants and Children (WIC); or

(vi) Other means-tested social services programs deemed eligible for hospital free care policies by the Maryland Department of Health and the HSCRC, consistent with HSCRC regulation COMAR 10.37.10.26.

(d) A hospital that believes that an increase to the income thresholds as set forth above may result in undue financial hardship to it may file a written request with the Commission that it be exempted from the increased threshold. In evaluating the hospital's request for exemption, the Commission shall consider the hospital's:

(i) Patient mix;

(ii) Financial condition;

(iii) Level of bad debt experienced;

(iv) Amount of charity care provided; and

(v) Other relevant factors.

(e) Based on staff's evaluation of the written request for an exemption, the Executive Director shall respond in writing within a reasonable period of time approving or disapproving the hospital's exemption request.

(f) A hospital denied an exemption request shall be afforded an opportunity to address the Commission at a public meeting on its request. Based on arguments made at the public meeting, the Commission may approve, disapprove, or modify the Executive Director's decision on the exemption request.

(3) Each hospital shall submit to the Commission within 60 days after the end of each hospital's fiscal year:

(a) The hospital's financial assistance policy developed under this section; and

(b) An annual report on the hospital's financial assistance policy that includes:

(i) The total number of patients who completed or partially completed an application for financial assistance during the prior year;

(ii) The total number of inpatients and outpatients who received free care during the immediately preceding year and reduced-cost care for the prior year;

(iii) The total number of patients who received financial assistance during the immediately preceding year, by race or ethnicity and gender;

(iv) The total number of patients who were denied financial assistance during the immediately preceding year, by race or ethnicity and gender;

(v) The total cost of hospital services provided to patients who received free care; and

(vi) The total cost of hospital services provided to patients who received reduced-cost care that was covered by the hospital as financial assistance or that the hospital charged to the patient.

(4) Financial Hardship Policy.

(a) Subject to §A-2(3)(b) and (c) of this regulation, the financial assistance policy required under this regulation shall provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship.

(b) A hospital may seek and the Commission may approve a family income threshold that is different than the family income threshold under §A-2(C)(1) of this regulation.

(c) In evaluating a hospital's request to establish a different family income threshold, the Commission shall take into account:

(i) The median family income in the hospital's service area;

(ii) The patient mix of the hospital;

(iii) The financial condition of the hospital;

(iv) The level of bad debt experienced by the hospital;

(v) The amount of the charity care provided by the hospital; and

(vi) Other relevant factors.

(d) If a patient has received reduced-cost, medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced-cost, medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost, medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost, medically necessary care.

(5) If a patient is eligible for reduced-cost medical care under a hospital's financial assistance policy or financial hardship policy, the hospital shall apply the reduction in charges that is most favorable to the patient.

(6) A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(7) The notice required under §A-2(6) of this regulation shall be in:

(a) Simplified language in at least 10-point type; and

(b) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(8) Each hospital shall use a Uniform Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost care.

(9) Each hospital shall establish a mechanism to provide the Uniform Financial Assistance Application to patients regardless of their insurance status. A hospital may require from patients or their guardians only those documents required to validate the information provided on the application.

(10) Asset Test Requirements. A hospital may, in its discretion, consider household monetary assets in determining eligibility for financial assistance in addition to the income-based criteria, or it may choose to use only income-based criteria. If a hospital chooses to utilize an asset test, the following types of monetary assets, which are those assets that are convertible to cash, shall be excluded:

(a) At a minimum, the first $10,000 of monetary assets;

(b) A "safe harbor" equity of $150,000 in a primary residence;

(c) Retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including, but not limited to, deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans;

(d) One motor vehicle used for the transportation needs of the patient or any family member of the patient;

(e) Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and

(f) Prepaid higher education funds in a Maryland 529 Program account.

(11) Monetary assets excluded from the determination of eligibility for free and reduced-cost care under these provisions shall be adjusted annually for inflation in accordance with the Consumer Price Index.

(12) In determining the family income of a patient, a hospital shall apply a definition of household size that consists of the patient and, at a minimum, the following individuals:

(a) A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;

(b) Biological children, adopted children, or stepchildren; and

(c) Anyone for whom the patient claims a personal exemption in a federal or State tax return.

(13) For a patient who is a child, the household size shall consist of the child and the following individuals:

(a) Biological parents, adoptive parents, stepparents, or guardians;

(b) Biological siblings, adopted siblings, or step siblings; and

(c) Anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

A-3. Patient Complaints. The Commission shall post a process on its website for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of Health-General Article, §19-214.1 or 19-214.2, Annotated Code of Maryland. The process established shall include the option for a patient or a patient's authorized representative to file the complaint jointly with the Commission and the Health Education and Advocacy Unit. The process shall conform to the requirements of Health-General Article, §19-214.3, Annotated Code of Maryland.

B. Working Capital Differentials — Payment of Charges.**]**

A. For purposes of this regulation, the terms "debt collector", "hospital", "income-based payment plan", and "payment plan" have the meaning given such terms in COMAR 10.37.13.01.

[(1)**]** *B.* A third-party payer may obtain a discount in rates established by the Commission if it provides current financing monies in accordance with the following terms.

[(a)**]** *(1)* A third-party payer that provides current financing equal to the average amount of outstanding charges for bills from the end of each regular billing period and for discharged patients shall be entitled to a 2-percent discount. For purposes of this regulation, a regular billing period shall be based on a 30-day billing cycle. The current financing provided **[**in here**]** *to hospitals* corresponds to a third party's paying on discharge.

[(b)**]** *(2)* A third-party payer that provides current financing equal to the average amount of outstanding charges for discharged patients plus the average daily charges times the average length of stay, shall be entitled to a 2.25-percent discount. The current financing provided **[**in here**]** *to hospitals* corresponds to a third party's paying on admission.

[(c)**]** *(3)* Outstanding charges shall be calculated by an amount equal to the hospital's current average daily payment by the payer, multiplied by the hospital's and third party payer's processing and payment time. The precise calculation shall be made in accordance with the guidelines specified by Commission staff.

[(d)**]** *(4)* Upon request from an applicant, the Commission may approve an alternative method of calculating current financing monies.

[(e)**]** *(5)* The third-party payer shall adjust the current financing advance to reflect Commission rate orders and changes in volume associated with the particular payer and hospital. This adjustment shall be made within 45 days of a rate order or at such other time as circumstances warrant. In the absence of a rate order, the adjustment shall be made at least annually.

[(2)**]** *C.* The third-party payer shall promptly provide the Commission with a verified record of the detailed calculation of the current financing and of each recalculated balance as adjustments are made. The detailed calculations shall become a part of the public record. The Commission may, at any time, evaluate the amount of current financing monies provided to a hospital to assure that it meets the discount of requirements specified in §B**[**(1)**]** *of this regulation.* If the Commission finds that the amount of current financing is inconsistent with the requirements of §B**[**(1)**]** of this regulation, the Commission may, at its sole discretion, require an adjustment to the working capital advance or to the discount.

[(3)**]** *D.* A payer or self-paying patient, who does not provide current financing under §B**[**(1)(a)—(e)**]** of this regulation, shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount. For those payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at a simple rate of 1 percent per month. The interest or late payment charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that. *For patients that have entered into a hospital income-based payment plan under COMAR 10.37.13.05 , the interest rate shall be established in accordance with the Guidelines.*

[(4)**]** *E.* Hospital Billing Responsibilities.

(1) A patient shall be given a bill for services at the earlier of the end of each regular billing period or upon discharge or dismissal (when dismissal for outpatients is analogous to discharge for inpatients).

(2) This bill shall cover substantially all care rendered and should, except for some last day ancillary services and, excepting arithmetic errors, represent the full charge for the patient's care.

(3) A notice shall be posted prominently at the billing office of the hospital clearly notifying all patients of the availability of the discounts referred to in D. of this regulation.

(4) The bill and the notice shall state that the patient shall receive a 2-percent discount by paying upon discharge or a 1-percent discount by paying within 30 days.

[(a) A patient shall be given a bill for services at the earlier of the end of each regular billing period or upon discharge or dismissal (when dismissal for outpatients is analogous to discharge for inpatients).

(b) This bill shall cover substantially all care rendered and should, except for some last day ancillary services and excepting arithmetic errors, represent the full charge for the patient's care. In addition, a notice shall be posted prominently at the billing office of the hospital clearly notifying all patients of the availability of the discounts mentioned above.

(c) The bill and the notice shall state that the:

(i) Charge is due within 60 days of discharge or dismissal;

(ii) Patient shall receive a 2-percent discount by paying upon discharge or a 1-percent discount by paying within 30 days; and

(iii) Payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, may be subject to interest or late payment charges at a rate of 1 percent per month beginning on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.

(5) Hospital Written Estimate.

(a) On request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.

(b) The written estimate shall state clearly that it is only an estimate and actual charges could vary.

(c) A hospital may restrict the availability of a written estimate to normal business office hours.

(d) The provisions set forth in §B(5)(a)—(c) of this regulation do not apply to emergency services.**]**

C.**]** *F.* GME Discounts. In those instances where a teaching hospital is reimbursed separately for the costs associated with the provision of graduate medical education (GME), the Commission shall calculate the percentage of the hospital's rates that these GME payments represent and provide notice of the amounts that may be credited toward the payment for services rendered. At all times, total payment received by the teaching hospital shall be in accordance with Commission-approved rates.

TITLE 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.13 Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies

Authority: Health-General Article, §§19-214.2, 19-214.3, 19-207 and 19-219 Annotated Code of Maryland

Notice of Proposed Action

.01 Definitions

A. Definitions. In this chapter, the following terms have the meanings indicated.

B. Terms Defined:

(1) "Credit and collection policy" means a hospital's policy on the collection of medical debt.

(2) Debt Collector.

(a) "Debt collector" means a person who engages directly or indirectly in the business of:

(i) Collecting for, or soliciting from another, medical debt;

(ii) Giving, selling, attempting to give or sell to another, or using, for collection of medical debt, a series or system of forms or letters that indicates directly or indirectly that a person other than the hospital is asserting the medical debt; or

(iii) Employing the services of an individual or business to solicit or sell a collection system to be used for collection of medical debt.

(b) "Debt collector" includes a 'collection agency,' as defined in Business Regulation Article, §7-101, Annotated Code of Maryland.

(3) "Financial hardship" means medical debt, incurred by a family over a 12-month period, that exceeds 25 percent of family income.

(4) "Hospital" means a facility defined in Md. Code Ann., Health-Gen. §19- 301(f).

(5) "Hospital services" means:

(a) Inpatient hospital services as enumerated in Medicare Regulation 42 C.F.R. § 409.10, as amended;

(b) Emergency services, including services provided at a freestanding medical facility licensed under Subtitle 3A of title 19 of Md. Code Ann., Health-Gen. ;

(c) Outpatient services provided at a hospital (as defined in COMAR 10.37.10.07-01);

(d) Outpatient services, as specified by the Commission in COMAR 10.37.10.07-02, provided at a freestanding medical facility licensed under Subtitle 3A of title 19 of Md. Code Ann., Health-Gen. that has received:

(i) A certificate of need under Md. Code Ann., Health-Gen § 19–120(o)(1); or

(ii) An exemption from obtaining a certificate of need under Md. Code Ann., Health-Gen §19–120(o)(3); and

(e) Identified physician services for which a facility has Commission–approved rates on June 30, 1985.

(f) "Hospital services" includes a hospital outpatient service:

(i) Of a hospital that, on or before June 1, 2015, is under a merged asset hospital system;

(ii) That is designated as a part of another hospital under the same merged asset hospital system to make it possible for the hospital outpatient service to participate in the 340B Program under the federal Public Health Service Act; and

(iii) That complies with all federal requirements for the 340B Program and applicable provisions of 42 C.F.R. § 413.65.

(g) "Hospital services" does not include:

(i) Outpatient renal dialysis services; or

(ii) Outpatient services provided at a limited service hospital as defined in Md. Code Ann., Health-Gen § 19–301, except for emergency services; or

(iii) Physician services that are billed separately.

(6) Household.

(a)"Household" means, at a minimum:

(1) For an adult patient, the patient and the following individuals that live in the same dwelling:

(i) A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;

(ii) Biological children, adopted children, or stepchildren; and

(iii) All individuals on the same federal or State tax return, including anyone for whom the patient claims a personal exemption in a federal or State tax return.

(2) For a patient who is a child, the patient and the following individuals that live in the same dwelling:

(i) Biological parents, adoptive parents, stepparents, or guardians;

(ii) Biological siblings, adopted siblings, or step siblings; and

(iii) All individuals on the same federal or State tax return, including anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

(b) The terms "household" and "family" are synonymous for the purposes of this regulation.

(7) "Income" means total taxable income, before taxes.

(a) If a hospital uses state or federal tax returns to verify income, hospitals shall take into consideration adjustments listed on Schedule 1 of Form 1040.

(b) If a hospital utilizes an asset test, "income" includes the value of household monetary assets, consistent with section .06J of this regulation.

(8) "Initial bill" means the first billing statement provided to an individual by a hospital after the care, whether inpatient or outpatient, is provided and the individual has left the hospital.

(9) "Medical debt" means out-of-pocket expenses, including co-payments, coinsurance, and deductibles, for hospital services that are regulated by HSCRC that are billed to a patient or a co-signer for the patient, excluding amounts contractually paid by another payer (e.g. insurers, Medicare, Medicaid, or CHIP).

(10) "Medically necessary care", including care provided in accordance with the Emergency Medical Treatment and Labor Act of 1986 ("EMTALA"), means care that is:

(a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition;

(b) Consistent with current accepted standards of good medical practice; and

(c) Not primarily for the convenience of the patient, the patient's family, or the provider.

(11) "Monetary assets" means assets in excess of $100,000 that can readily be converted into a fixed or precisely determinable amount of money, including cash and cash equivalents, such as cash on hand, bank deposits, investment accounts, accounts receivable (AR), and notes receivable. Monetary assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment, including deferred–compensation plans qualified under the Internal Revenue Code or nonqualified deferred–compensation plans.

(12) "Payment plan" means an agreement between a patient (or a guarantor) to pay for a hospital service over a period of time, including an "income-based payment plan" under regulation .05 of this chapter and a "non-income-based payment plan" under §W of regulation .05 of this chapter.

(13) "Qualified Maryland resident" means someone who lives in Maryland for more than 6 months of the year or whose primary residence is in Maryland, including those in Maryland for school or work.

(14) "Written" Communications.

(a) "Written" means communications in paper form and communications delivered electronically, including through electronic mail, a secure web, or mobile based application such as a patient portal.

(b) "Written" does not include oral communications, including communications delivered by phone.

.02 Electronic Delivery of Written Communications

A. A patient may opt out of receiving written communications required by regulations .03 through .08 of this chapter through electronic delivery methods (such as through email or a patient portal).

B. A hospital or debt collector who communicates with a patient electronically must include in such communication, or attempt to communicate, a clear and conspicuous statement describing a reasonable and simple method by which the patient can opt out of further electronic communications by the hospital or debt collector.

C. A hospital or debt collector may not require, directly or indirectly, that the patient, in order to opt out of electronic communication, pay any fee or provide any information other than the patient's opt out preferences and the email address, telephone number for text messages, or other electronic-medium address subject to the opt-out request.

D. If a hospital or debt collector receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, the hospital or the debt collector:

(1) may not provide the written communications required by regulations .03 through .08 of this chapter through electronic delivery methods; and

(2) must deliver the written communications through non-electronic delivery methods.

E.

(1) If a hospital receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, and the hospital uses a debt collector with respect to that patient, the hospital must immediately inform the debt collector that the patient is opting out of electronic delivery methods.

(2) If a debt collector receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, the debt collector must immediately inform the hospital that controls that patient account that the patient is opting out of electronic delivery methods.

.03 Hospital Information Sheet

A. Each hospital shall develop an information sheet that:

(1) Describes clearly:

(a) the hospital's financial assistance policy as required in regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland; and

(b) a patient's legal rights and obligations with regard to hospital billing and collection.

(2) Informs the patient, the patient's family, the patient's authorized representative, or the patient's legal guardian:

(a) that the hospital is permitted to bill outpatients a fee, commonly referred to as a "facility fee", for their use of hospital facilities, clinics, supplies and equipment, and nonphysician services, including but not limited to the services of nonphysician clinicians, in addition to physician fees billed for professional services provided in the hospital;

(b) of the patient's right to request and receive a written estimate of the total charges for the hospital non-emergency services, procedures, and supplies that reasonably are expected to be provided and billed for by

the hospital, in addition to the good faith estimate requirements in the Public Health Service Act § 2799B-6, the No Surprises Act;

(c) of the patient's right to file a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland;

(d) of the availability of an income-based payment plan;

(e) that physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately;

(3) Provides contact information for:

(a) the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

(i)The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced-cost, medically necessary care due to a financial hardship;

(iii) How to apply for financial assistance;

(iv) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill; and

(v) How to apply for a payment plan;

(b) the Maryland Medical Assistance Program;

(c) filing a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland;

(4) Includes a section that allows the patient to initial that the patient has been made aware of the financial assistance policy.

B. The information sheet shall be in:

(1) Simplified language in at least 12-point type; and

(2) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

C. The information sheet shall conform with Health-General Article, §19–342(d)(7) and (10), Annotated Code of Maryland.

D. The information sheet shall be provided in writing to the patient, the patient's family, the patient's authorized representative, or the patient's legal guardian:

(1) Before the patient receives scheduled medical services;

(2) Before discharge;

(3) With the hospital bill;

(4) On request; and

(5) In each written communication to the patient regarding collection of the hospital bill.

E. The hospital bill shall include a reference to the information sheet.

F. The Commission shall:

(1) Establish uniform requirements for the information sheet; and

(2) Review each hospital's implementation of and compliance with the requirements of this regulation.

.04 Hospital Credit and Collection Responsibilities.

A. Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's credit and collection policy.

B. The policy shall:

(1) Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital;

(2) Prohibit the hospital from selling any debt, except as permitted by Health-General Article, §19–214.2(m) and §O of this regulation, Annotated Code of Maryland;

(3) Prohibit the hospital from:

(a) Engaging in collection activities on 100 percent of the outstanding amount of the Commission-set charge for debt sold under §O of this regulation and Health-General Article, §19-214.2(m); and

(b) Collecting on judgments entered into on patient debt that was sold under §O of this regulation and Health-General Article, §19-214.2(m).

(c) Reporting adverse information to a consumer reporting agency;

(d) Filing a civil action to collect a debt against a patient within 240 days after the initial bill is provided;

(e) Filing a civil action to collect a debt against a patient whose outstanding hospital medical debt is at or below $500;

(f) Forcing the sale or foreclosure of a patient's primary residence to collect medical debt;
(g) Requesting a lien against a patient's primary residence in an action to collect medical debt;
(h) Requesting the issuance of or otherwise knowingly taking action that would cause a court to issue a body attachment against a patient or an arrest warrant against a patient, if the hospital files an action to collect medical debt; and
(i) Requesting a writ of garnishment of wages or filing an action that would result in an attachment of wages against a patient to collect medical debt if the patient is eligible for free or reduced-cost medically necessary care, in accordance with regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland.

(4) In accordance with Health-General Article, §19-214.2(c) and section G. of this regulation, Annotated Code of Maryland, provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free medically necessary care within 240 days after the initial bill was provided under Health General 19-214.1 and §G of this regulation;

(5) If the hospital has obtained a judgment against or had reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free medically necessary care, in accordance with regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland, within 240 days after the initial bill was provided, require the hospital to seek to vacate the judgment or strike the adverse information;

(6) Provide a mechanism for a patient to:

(a) Request the hospital to reconsider the denial of free or reduced–cost care;

(b) File with the hospital a complaint against the hospital or a debt collector used by the hospital regarding the handling of the patient's bill; and

(7) For a patient who is eligible for free or reduced cost-care under the hospital's financial assistance policy, prohibit the hospital from:

(a) charging interest on the debt owed on a bill for the patient before a court judgement is obtained; or

(b) collecting fees or any other amount that exceeds the approved charge for the hospital service as established by the Commission.

(8) Establish a process for making payment plans available to all patients in accordance with regulation .05 of this chapter and Health-General Article, §19-214.2(e)(3), Annotated Code of Maryland.

(9) Provide detailed procedures for the following actions:

(a) When garnishments may be applied to a patient's or patient guarantor's income in accordance with section .04I of this regulation and Health-General Article, §19-214.2(f)(4), Annotated Code of Maryland;

(b) When a lien on a patient's or patient guarantor's personal residence, excluding a primary resident in accordance with section .04I. of this regulation and Health-General Article, §19-214.2(g)(2), Annotated Code of Maryland, or motor vehicle may be placed;

(c) the hospital's procedures for collecting any medical debt, consistent with section .04 of this regulation;

(d) the circumstances in which the hospital will seek a judgment against a patient for the patient's medical debt, subject to §.04 I. of this regulation and Health-General Article, §19–214.2, Annotated Code of Maryland;

(e) the consideration by the hospital of patient income, assets, and other criteria under section .04 of this regulation;

(10) Comply with Health-General Article, §24-2502, Annotated Code of Maryland.

C. Consistent with Health-General Article, §19-214.2(e)(5), Annotated Code of Maryland, a hospital shall demonstrate that it attempted in good faith to meet the requirements of Health-General Article, §19-214.2(e), Annotated Code of Maryland and the Guidelines with regulation .05 of this chapter before the hospital:

(1) Files an action to collect the patient's medical debt; or

(2) Delegates collection activity to a debt collector for a patient's medical debt.

D. The hospital shall be deemed to have demonstrated that it attempted to act in good faith under Health-General Article, §19-214.2(e)(5)(i)(2), Annotated Code of Maryland and §C(2) of this regulation if, before delegating collection of a patient's medical debt to a debt collector, the hospital:

(1) Provides the information sheet before the patient receives scheduled medical services and before discharge in accordance with Health-General Article, §19-214.2(e)(1) and (2), Annotated Code of Maryland, and in §D(1) and (2) of regulation .03 of this chapter-; and

(2) Establishes a process for making payment plans available to all patients in accordance with Health-General Article, §19-214.2(e)(3), Annotated Code of Maryland, and regulation .05 of this chapter;

E. In delegating any or all collection to a debt collector for a patient's medical debt, the hospital may rely on a debt collector to engage in various activities, including:

(1) Facilitating and servicing payment plans in accordance with the Guidelines, including receiving and forwarding any payments received under a payment plan approved by the hospital; and

(2) Such other activities as the hospital may direct in collecting and forwarding payments under a payment plan.

F. A hospital may not seek legal action to collect a patient's medical debt until the hospital has established and implemented a payment plan policy that complies with the Guidelines.

G. As provided by Health-General Article, §19-214.2(c):

(1)(a) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who was found to be eligible for free medically necessary care within 240 days after the initial bill is provided to the patient;

(b) The hospital shall provide the refund to the patient not later than 30 days after determining that the patient was eligible for free medically necessary care.

(2) If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital service, a hospital shall have a refund policy that complies with the terms of the patient's plan.

H. Consumer Reporting.

(1) A hospital may not commence civil action against a patient for nonpayment or delegate collection activity to a debt collector, if the hospital:

(a) Was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days;

(b) Is processing a requested reconsideration of the denial of free or reduced-cost medically necessary care under §A(1)(c)(v) of regulation .06 of this chapter and Health-General Article, §19-214.1(b)(2)(iv), Annotated Code of Maryland, that was appropriately completed by the patient or has completed the reconsideration within the immediately preceding 60 days; or

(c) If the hospital sold the debt under §O of this regulation and Health-General Article, §19-214.2(m).

(2) A hospital shall comply with Health-General Article, §24-2502, Annotated Code of Maryland;

(3) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient, including if the debt was sold under §O of this regulation and Health-General Article, §19-214.2(m)

(4) Not later than November 1, 2025, a hospital that had reported adverse information about a patient to a consumer reporting agency shall instruct the consumer reporting agency to delete the adverse information about the patient.

I. Civil Action

(1) Deceased patients.

(a) A hospital may not make a claim against the estate of a deceased patient to collect medical debt if the deceased patient was known by the hospital to be eligible for free medically necessary care, in accordance with regulation .06 of this chapter and Health-General article, §19-214.1, Annotated Code of Maryland, or if the value of the estate after tax obligations are fulfilled is less than half of the medical debt owed.

(b) A hospital may offer the family of the deceased patient the ability to apply for financial assistance.

(2) A hospital may not file an action to collect medical debt until the hospital determines whether the patient is eligible for free or reduced-cost medically necessary care under regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland.

(3) At least 45 days before filing an action against a patient to collect medical debt, but not within 240 days after the initial bill is provided, a hospital shall send written notice of the intent to file an action to the patient. The notice shall:

(a) Be sent to the patient by certified mail and first class mail;

(b) Be in simplified language and in at least 12-point type;

(c) Include:

(i) The name and telephone number of the hospital, the debt collector (if applicable), and an agent of the hospital authorized to modify the terms of the payment plan (if any);

(ii) The amount required to cure the nonpayment of medical debt, including past due payments, interest, penalties, and fees;

(iii) A statement recommending that the patient seek debt counseling services;

(iv) Telephone numbers and internet addresses of the Health Education Advocacy Unit of the Office of the Attorney General, available to assist patients experiencing medical debt; and

(v) An explanation of the hospital's financial assistance policy;

(d) Be provided in the patient's preferred language or, if no preferred language is specified, English and each language spoken by a limited English proficient population that constitutes at least 5 percent of the population within the jurisdiction in which the hospital is located as measured by the most recent federal census; and

(e) Be accompanied by:

(i) An application for financial assistance under the hospital's financial assistance policy, along with instructions for completing the application for financial assistance, specific instructions about where to send the application, and the telephone number to call to confirm receipt of the application;

(ii) Language explaining the availability of an income-based payment plan to satisfy the medical debt that is the subject of the hospital debt collection action; and

(ii) The information sheet required under regulation .03 of this chapter and Health-General Article, §19-214.1(f), Annotated Code of Maryland.

J. If a hospital delegates collection activity to a debt collector, the hospital shall:

(1) Specify the collection activity to be performed by the debt collector through an explicit authorization or contract;

(2) Require the debt collector to abide by the hospital's credit and collection policy;

(3) Specify procedures the debt collector must follow if a patient appears to qualify for financial assistance under regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland; and

(4) Require the debt collector to:

(a) In accordance with the hospital's credit and collection policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the debt collector regarding the handling of patient's bill;

(b) If a patient files a complaint with the debt collector, forward the complaint to the hospital; and

(c) Along with the hospital, be jointly and severally responsible for meeting the requirements of this regulation and regulation .06 of this chapter and Health-General Article, §19-214.2, Annotated Code of Maryland.

K. A spouse or another individual may not be held liable for the medical debt of an individual 18 years old or older unless the individual voluntarily consents to assume liability for the patient's medical debt. The consent shall be:

(1) Made on a separate document signed by the individual;

(2) Not solicited in an emergency room or during an emergency situation; and

(3) Not required as a condition of providing emergency or non-emergency health care services.

L. The Board of Directors of each hospital shall review and approve the hospital's financial assistance policy required under regulation .06 of this chapter and Health-General Article, §19-214.1, Annotated Code of Maryland and debt collection policy required under regulation .04 of this chapter and Health-General Article, §19-214.2, Annotated Code of Maryland at least every 2 years. A hospital may not alter its financial assistance or credit and collection policies without approval by the Board of Directors.

M. The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of §B of this regulation.

N. Reporting Requirements.

(1) Each hospital shall annually submit to the Commission within 120 days after the end of each hospital's fiscal year a report including:

(a) The total number of patients by race or ethnicity, gender, and zip code of residence against whom the hospital or a debt collector used by the hospital, filed an action to collect medical debt;

(b) The total number of patients by race or ethnicity, gender, and zip code of residence with respect to whom the hospital has and has not reported or classified a bad debt;

(c) The total dollar amount of charges for hospital services provided to patients but not collected by the hospital for patients covered by insurance, including the out-of-pocket costs for patients covered by insurance, and patients without insurance; and

(d) For hospital debts owed by patients of the hospital that the hospital sold to a governmental unit, contractor, or nonprofit organization under Health-General Article, §19-214.2(m), Annotated Code of Maryland and §O:

(i) The total dollar amount of the debt sold by the hospital for the reporting year;

(ii) The total dollar amount paid by the hospital to the unit, contractor, or nonprofit organization who purchased the debt; and

(iii) The total number of patients whose debt was sold, in full or in part, to the unit, contractor, or nonprofit organization who purchased the debt.

(2) The Commission shall post the information submitted under §N(1) of this regulation on its website.

O. Selling Medical Debt.

(1) Consistent with Health-General Article, §19-214.2(m), Annotated Code of Maryland, a hospital may sell debt owed to the hospital by a patient for hospital services to a governmental unit, an entity that is under contract with the governmental unit, or to a nonprofit organization that is exempt from taxation under §501(c)(3) of the Internal Revenue Code for the sole purpose of canceling the debt.

(2) The contract between the hospital and the governmental unit, entity that is under contract with the governmental unit, or nonprofit organization purchasing the debt shall state that the sole purpose of the sale of the debt is to cancel the debt.

(3) The patient is not responsible to the hospital, the governmental unit, the entity that is under contract with the governmental unit, or the nonprofit organization for any amount of the debt that is sold, or any interest, fees, or costs associated with the debt or the sale.

(4) Debt sold under this regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland:

(a) Must be for hospital services provided at least 2 years before the date of the sale;

(b) May not be expected to yield additional reimbursements from a third-party payor;

(c) May not be subject to an open appeal with an insurance company; and

(d) Must be for an individual whose family income is at or below 500 percent of the federal poverty level or who has medical debt exceeding 5 percent of the patient's family income, as determined by the governmental unit, contractor, or nonprofit organization purchasing the debt.

(5) Debt sold under this Regulation and Health-General Article, §19-214.2(m), Annotated Code of Maryland may be sold with a reduction of Commission charges.

(6) The Commission shall treat the amount of payments to hospitals under this subsection as an offset to uncompensated care amounts reported by hospitals.

(7) The purchaser of the debt shall:

(a) Notify the patient that the debt has been canceled; and

(b) If the hospital obtained a judgment against the patient or reported adverse information to a consumer reporting agency about the patient, seek to vacate the judgment or strike the adverse information.

(8) If a hospital sells hospital medical debt under this regulation and Health-General Article, §19-214.2(m), the hospital must immediately dismiss actions pending against a patient for collection of that debt.

.05 Guidelines for Hospital Payment Plans.

A. Scope.

(1) As described in this regulation, the Guidelines for Hospital Payment Plans apply to any income-based payment plan offered by a hospital to a patient to pay for medically necessary hospital services after the services are provided.

(2) "Income" in this section means household monthly income.

(3) Prepayment Plans. Nothing in the Guidelines prevents a hospital from offering patients arrangements to make payments prior to service, provided that:

(a) A hospital may not require or steer a patient to enter into such an arrangement solely to avoid the application of these Guidelines;

(b) Before a hospital requests pre-payment for a hospital service, the hospital shall:

(i) Comply with the notice provisions of Health General 19-214.1 and regulation .03 and .06 of this chapter;

(ii) Advise the patient about the availability of financial assistance;

(iii) Process any request for financial assistance; and

(iv) Advise the patient about the availability of income-based payment plans, including information about the 5 percent cap on monthly payment amounts under §F(1) of this regulation; and

(c) Such an arrangement terminates once the hospital service is rendered.

(4) Unregulated Services. These Guidelines apply only to hospital services that are regulated by the HSCRC. These Guidelines do not apply to services that are not regulated by the HSCRC, including physician services.

(5) Limitation of the Guidelines. These Guidelines do not prevent hospitals from extending payment plans for services (such as physician services) or at times that are outside the parameters of the Guidelines. Except as otherwise required by law or regulation, payment plans that are outside the parameters of these Guidelines are not subject to the Guidelines.

B. Access to Income-Based Payment Plans.

(1) Availability of Income-Based Payment Plans. Maryland hospitals shall make income-based payment plans available to all patients who are Maryland residents, including individuals temporarily residing in Maryland due to work or school, irrespective of their:

(a) Insurance status;

(b) Citizenship status;

(c) Immigration status; or

(d) Eligibility for reduced-cost medically necessary care, including reduced-cost medically necessary care due to financial hardship, under regulation .06 of this chapter.

(2) Treatment of Nonresidents and Unregulated Services.

(a) These Guidelines do not prevent a hospital from extending payment plans to patients who are not described in §B(1) of this regulation.

(b) These Guidelines do not prevent a hospital from extending payment plans to patients for services that are not regulated by the HSCRC.

(c) Except as required by §U of this regulation or by other law or regulation, payment plans for patients who are not described in §B(1) of this regulation and payment plans for services that are not regulated by the HSCRC are not subject to the Guidelines under this regulation.

C. Notice Requirements.

(1) Notice of Availability of an Income-Based Payment Plan.

(a) Posted Notice.

(i) A notice shall be posted in conspicuous places throughout the hospital, including the billing office, informing Maryland residents of the availability of an income-based payment plan and whom to contact at the hospital for additional information.

(ii) If the hospital uses a vendor to assist with financial assistance eligibility, billing, or debt collection (such as a debt collector or eligibility vendor), the hospital shall ensure that the vendor posts a notice in a conspicuous place on their website or online payment portal, informing Maryland residents of the availability of an income-based payment plan and whom to contact at the hospital or debt collector for additional information. Placement on the website or online payment portal should be based on the best interest of the patient.

(b) Information Sheet. A written notice of the availability of an income-based payment plan shall be contained in the information sheet required under regulation .03 of this chapter, including clarity on the availability of income-based payment plans for Maryland residents, and, if payment plans for non-residents are included in the hospital's credit and collection policy, the availability of such plans for non-residents.

(c) Before a Prepayment Plan. Before a patient enters into a prepayment plan as described in §A(2) of this regulation for a medically necessary hospital service, a hospital shall provide a written notice of the availability of an income-based payment plan to a patient.

(d) On a Bill. On the same page of the bill that includes the amount due and due date, the hospital shall provide notice that a lower monthly payment amount may be possible through an income-based plan, in the same font and style as the total amount due notification.

(e) Online Payment Portal. On both the page of the online payment portal that states the amount due, and where the consumer enters the amount being paid by the consumer, the hospital shall provide, in the same font and style as the amount due notification, notice informing Maryland residents of the availability of an income-based monthly payment plan and information, including a telephone number and email address, in order to contact the hospital for additional information.

(2) Notice of Terms Before Execution. A hospital shall provide written notice of the terms of an income-based payment plan to a patient before the patient agrees to enter the income-based payment plan. The terms of the income-based payment plan shall include:

(a) The amount of medical debt owed to the hospital;

(b) The interest rate applied to the income-based payment plan and the total amount of interest expected to be paid by the patient under the income-based payment plan;

(c) The amount of each periodic payment expected from the patient under the income-based payment plan;

(d) The number of periodic payments expected from the patient under the income-based payment plan;

(e) The expected due dates for each payment from the patient;

(f) The expected date by which the account will be paid off in full;

(g) The treatment of any missed payments, including missed payments and default as described in §P and T of this regulation;

(h) That there are no penalties for early payments; and

(i) Whether the hospital plans to apply a periodic recalculation of monthly payment amounts as described in §N of this regulation and the process for such recalculation;

(3) Notice of Plan After Execution. A hospital shall promptly provide a written income-based payment plan, including items listed in §C(2) of this regulation, to the patient following execution by all parties. The income-based payment plan shall be provided to the patient at least 20 days before the due date of the patient's first payment under the income-based payment plan.

D. Financial Assistance. Before entering into an income-based payment plan with a patient, hospitals shall evaluate if the patient is eligible for financial assistance, including free and reduced-cost medically necessary care, including reduced-cost medically necessary care due to financial hardship, in accordance with regulation .06 of this chapter. Hospitals shall:

(1) Apply the financial assistance reduction before entering into an income-based payment plan with a patient; and

(2) Use any information collected for determining financial assistance under section .06 under this regulation to establish the 5% monthly payment threshold for payment plans under section .05F. of this regulation.

E. Offer Required. Hospitals must offer income-based payment plans that meet the requirements of these Guidelines.

F. Monthly Payment Amounts.

(1) Under an income-based payment plan subject to these Guidelines, a hospital may not require a patient to make total payments in a month that exceed 5 percent of the lesser of the patient's household income.

(2) §F(1) applies to total amounts due under the plan, including both principal and interest, but does not apply to any catch-up payments, such as payments described under §P(1) of this regulation.

(3) A hospital shall calculate the monthly payment amount threshold under §F(1) of this regulation by dividing income level by household size and multiplying by .05 percent.

(4) Determining the Household Size. The hospital shall determine the size of the patient's household using the number reported on tax returns, if provided the number of tax filers and dependents listed on the tax return provided by the patient. For example, if a married couple files jointly and has three dependents, the number of tax filers and dependents would equal five. If a patient files as an individual and the patient is not a dependent and has no dependents, the number of tax filers would equal one. If the patient has not provided a tax return, the hospital shall ask the patient to provide the number of individuals in the household.

G. Expenses. A hospital may reduce the amount of the monthly payment due under an income-based payment plan upon consideration of household expense information provided by a patient.

H. Application to Multiple Income-based Payment Plans.

(1) Hospitals. A hospital shall ensure that the total monthly payment amount for all income-based payment plans provided to a patient by the hospital, when added up collectively, does not exceed the income limitation under §F(1) of this regulation.

(2) Hospital System. A hospital system shall ensure that the total monthly payment amount for all income-based payment plans provided to a patient by all hospitals in the hospital system, when added up collectively, does not exceed the income limitation under §F(1) of this regulation.

I. Duration of Income-Based Payment Plan. The duration of an income-based payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation that no monthly payment may exceed 5 percent of the patient's income as calculated under §F(1)of this regulation.

J. Solicitation of Early Payments Prohibited. Hospitals may not solicit, steer, or mandate patients to pay an amount in excess of the monthly payment amount provided for in an income-based payment plan.

K. Application of Partial Payments. A hospital shall apply partial payments in a manner most favorable to the patient.

L. Interest and Fees.

(1) No Interest for Patients Eligible for Financial Assistance. For a patient who is eligible for free or reduced-cost medically necessary care under the hospital's financial assistance policy under regulation .06 of this chapter and Health-General Article, §19–214.1 Annotated Code of Maryland, the hospital may not charge interest or fees on any medical debt amount owed under an income-based payment plan;

(2) Interest Allowed. A hospital may charge interest under an income-based payment plan for a patient who is not eligible for free or reduced-cost medically necessary care, as described in §L of this regulation. A hospital is not required to charge interest for a payment plan.

(3) Interest Rate. An income-based payment plan may not provide for interest in excess of an effective rate of simple interest of 6 percent per annum on the unpaid principal balance of the payment plan. A hospital may not set an interest rate that results in negative amortization. Payers subject to Insurance Article, §15-1005, Annotated Code of Maryland, shall comply with its provisions.

(4) Timing. Interest may not begin before 240 days after the initial bill is provided.

(5) Late payments. A hospital may not charge additional fees or interest for late payments.

M. Early Payment.

(1) Prepayment Allowed.

(a) Patients may, on a voluntary basis, pre-pay, in whole or in part, any amounts owed under an income-based payment plan.

(b) Any prepayment made under §M(1) of this regulation is not subject to the monthly income payment limitations of §F(1) of this regulation.

(2) No Fees or Penalties. A hospital may not assess fees or otherwise penalize early payment of an income-based payment plan.

N. Limited Modifications of Income-based Payment Plans.

(1) Change in Income. If a patient with an income-based payment plan notifies a hospital that the patient's income has changed then the hospital shall offer to modify the income-based payment plan to meet the requirement of §N(6) of this regulation.

(2) Expenses. Before modifying an income-based payment plan, a hospital shall consider information provided by a patient about changes in household expenses in considering a patient request to modify a payment plan.

(3) No Increase in Interest Rate. A hospital may not increase the interest rate on an income-based payment plan when making a modification to an income-based payment plan under this guideline.

(4) Limitation on Payment Amount. A hospital may not modify an income-based payment plan in a way that requires a patient to make a monthly payment that exceeds the percent of the patient's income used to set the monthly payment amount under the initial income-based payment plan as provided for in §F of this regulation.

(5) Change in Duration. The duration of a modified income-based payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation under §F of this regulation.

(6) Process for Modifying an Income-Based Payment Plan.

(a) Prompt Response to Patient Request. If a patient requests a modification to the terms of the payment plan, the hospital shall respond in a timely manner and may not refer the outstanding balance owed to a collection agency or for legal action until 30 days after providing a written response to the patient's request for a modification of the payment plan.

(b) Reconsideration for Financial Assistance. If a patient makes a request for modification of a payment plan, the hospital shall consider if such patient is eligible for financial assistance, including free medically necessary care, reduced-cost medically necessary care, and reduced-cost care due to financial hardship under regulation .06 of this chapter. The hospital will apply the financial assistance reduction in its modification of the payment plan.

(c) Mutual Agreement. A hospital may not modify a payment plan without mutual agreement between the hospital and the patient before the changes are made.

(d) Notice of Terms. The hospital shall provide the patient with a written notice of all payment plan terms, consistent with the requirements of §C of this regulation, upon modifying a payment plan under this guideline.

O. Hospital-Initiated Changes to Income-Based Payment Plans Based on Changes to Patient Income.

(1) Recalculation Allowed. A hospital may, in the terms of an initial income-based payment plan under §C(2) of this regulation that exceeds 3 years in length, provide for periodic recalculations to the amount of the monthly payments and the duration of the payment plan based on changes in the patient's income as subject to and calculated under §N(5) of this regulation.

(2) Notice Included in Initial Income-Based Payment Plan. The hospital may only recalculate payment amounts under an income-based payment plan if the hospital included the process for such recalculation in the notice provided to the patient before they entered into the income-based payment plan, in accordance with §C(2) of this regulation. The patient's agreement to enter into the income-based payment plan after receiving that notice constitutes consent to the payment recalculations allowed under §P of this regulation.

(3) Limitations on Modification Apply. The provisions of §N of this regulation relating to limitations of payment plan modifications apply to payment recalculations for income-based payment plans under §O of this regulation.

(4) Frequency of Recalculation. A hospital may not seek a recalculation of the monthly payment amount under an income-based payment plan, as provided for under §O(1) of this regulation more often than once every 3 years.

(5) Treatment of Missing Information. If a patient does not provide income information on the request of the hospital seeking to make a change to an income-based payment plan under §O of this regulation and the patient is in good standing on the patient's payments under the income-based payment plan, the hospital may not change the monthly payment amounts under the income-based payment plan.

P. Treatment of Missed Payments.

(1) First Missed Payment.

(a) A hospital may not deem a patient to be noncompliant with an income-based payment plan if the patient makes at least 11 scheduled monthly payments within a 12-month period.

(b) Subject to §P(1)(c) of this regulation, the hospital shall permit the patient to repay the missed payment amount at any time, as determined by the patient, including through a set of partial payments.

(c) No later than 30 days after the first missed payment in a 12-month period, the hospital shall notify the patient of the missed payment and inform the patient that the patient may be in default if they do not pay the amount of the missed payment within 12 months or if they miss additional payments within the 12-month period. The notice will give the patient the option to pay the missed payment by paying the amount of the missed payments in one of the following ways:

(i) 11 increments over the subsequent 11 months;

(ii) a single payment; or

(iii) Another approach, as specified by the patient.

(d) With respect to a patient that has missed a single monthly payment in a 12-month period, the hospital shall provide the patient with a method to designate whether any amount of a payment paid in the subsequent 12-month period is to be applied to the amount of missed payment or applied in a different manner.

(e) With respect to a patient that has missed a single monthly payment in a 12-month period, if the hospital receives a payment and the patient has not designated how that payment is to be applied, the hospital shall first apply the amount to any payment that is due in the 31-day period following the date the payment is received. If there is no payment due in the next month, the hospital shall apply the amount of the payment to the missed payment. If the amount of the payment exceeds the amount of any payment that is due in the 31-day period following the date the payment is received, the excess amount shall be applied to the missed payment.

(f) The hospital may consider a patient to be in default on the income-based payment plan if the missed payment is not repaid in full by the end of the 12-month period that begins on the date of the missed payment under §P(1) of this regulation.

(2) Additional Missed Payments.

(a) A hospital may forbear the amount of any additional missed payments that occur in a 12-month period.

(b) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital shall allow the patient to continue to participate in the income-based payment plan.

(c) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital may not refer the outstanding balance owed to a collection agency or for legal action.

(d) The hospital shall recapitalize the amount of any missed payments that were subject to forbearance under this §P of this regulation as additional payments at the end of the income-based payment plan, thereby extending the length of the income-based payment plan.

(e) The hospital shall provide written notice to the patient of the treatment of the missed payments, including any extension of the length of the income-based payment plan.

Q. Treatment of Loans and Extension of Credit. After a hospital service is provided to the patient, a hospital, hospital affiliate, or third-party in partnership with a hospital may not make any loan or extension of credit to the patient in connection with a medically necessary hospital service that is inconsistent with the guidelines for payment plans in this regulation resulting from that service.

R. Application of Credit Provisions of Maryland Commercial Law Article and Licensing Provisions of Financial Institutions Article. An income-based payment plan is an extension of credit subject to Maryland credit regulations under Commercial Law

Article, Title 12, Annotated Code of Maryland and any applicable licensing provisions of Financial Institutions Article, Title 11, Annotated Code of Maryland.

S. Books and Records. A hospital shall retain books and records on income-based payment plans for at least 3 years after the income-based payment plan is closed.

T. Default.

(1)If a patient defaults on an income-based payment plan and the parties are not able to agree to a modification, then the hospital shall follow the provisions of its credit and collection policy established in accordance with regulation .04 of this chapter, before a hospital may write this medical debt off as bad debt.

(2) With respect to the amounts covered by the income-based payment plans, a patient who is on an income-based payment plan and is not in default on that payment plan may not be considered in arrears on their debt to the hospital when the hospital is making decisions about scheduling health care services.

U. Non-Income-Based Payment Plans.

(1) Other Payment Plans Allowed. A hospital may offer a non-income-based payment plan under these guidelines, but must first offer the patient an income-based payment plan.

(2) Application of Guidelines: Consistent with the guidelines for hospital payment plans and consistent with the intent of Health General 19-214.2, the following provisions of this regulation apply to non-income-based payment plans in the same manner such provisions apply to income-based payment plans:

(a) §A of this regulation, regarding scope;

(b) §B of this regulation , regarding access to payment plans;

(c) §C(2) of this regulation, regarding notice of payment plan terms before execution;

(d) §C(3) of this regulation, regarding notice of plan after execution;

(e) §D of this regulation, regarding financial assistance;

(f) §L of this regulation, regarding interest and fees;

(g) §M(1)(a) and (2) of this regulation, regarding early payments;

(h) §N(6) of this regulation, regarding modifications of payment plans;

(i) §Q of this regulation, relating to treatment of loans and extensions of credit;

(j) §R of this regulation, relating to the application of credit provisions of Maryland Commercial Law Article and the licensing provisions of Financial Institutions Article;

(k) §S of this regulation, relating to books and records; and

(l) §T of this regulation, relating to default.

(3) Notice

(a) Notice of Terms Before Execution: In addition to complying with the terms of §C(2) of this regulation, the hospital must include notice that the patient may apply for an income-based payment plan at any time in the notice of terms before execution of a non-income-based payment plan.

(b) Notice of Plan After Execution: The hospital must include the notice required in §U(3)(a) of this regulation in the notice of the payment plan after execution that is required by §C(3) of this regulation.

(c) Notice with Bills: Each bill for a non-income-based payment plan shall include a notice that informs the patient that income-based payment plans are available, which could result in lower monthly payments and provides information on how to apply for such plans.

(4) Consent. Before entering into a non-income-based repayment plan with a patient, the hospital must obtain consent from the patient that records that the patient agrees to the following:

(a) The hospital offered the patient an income-based payment plan.

(b) The income-based payment plan limits monthly payment amounts to 5 percent of the patient's monthly income.

(c) The income-based payment plan may result in lower monthly payment amounts than the monthly payment amounts under the non-income-based repayment plan.

(d) The patient has the opportunity to disclose their income and determine the payment amount under the income-based payment plan.

(e) The patient is declining to enter an income-based payment plan and is consenting to enter a non-income-based repayment plan.

(5) Modification of a Non-Income-Based Payment Plan: In addition to complying with the terms of §N(6) of this regulation, before modifying a non-income-based payment plan-

(a) the hospital shall offer the patient an income-based payment plan; and,

(b) if the patient declines the income-based payment plan, obtain the consent required under §U(4) of this regulation.

(6) Default.

(a) If the patient defaults on a non-income-based payment plan, the hospital must offer an income-based payment plan to the patient before the hospital follows the provisions of its credit and collection policy to collect the debt.

(b) The offer under §U(6)(a) must be sent separately from a bill.

V. Steering:

(1) A hospital may not steer patients to non-income-based payment plans, or third-party credit providers, in such a manner that discourages patients from entering into income-based payment plans.

(2) A hospital may not steer patients to revolving credit products in such a manner that discourages patients from entering into either income-based payment plans or non-income based payment plans under this regulation.

.06 Hospital Financial Assistance Responsibilities.

A. Financial Assistance Policy.

(1)(a) Each hospital and each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost medically necessary care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill.

(b) A hospital shall provide written notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill.

(i) The required notice shall state that the patient has up to 240 days after the day the patient receives the initial hospital bill to apply for financial assistance from the hospital

(ii) The hospital shall obtain documentation ensuring that the patient or the patient's authorized representative acknowledges the patient's receipt of the notice before discharging the patient.

(iii) If a patient chooses not to apply for financial assistance, the patient's documented acknowledgement shall indicate that the patient is not applying for financial assistance on the day of the acknowledgment but may apply within 240 days immediately following the patient's receipt of the initial hospital bill

(c) The financial assistance policy shall provide at a minimum:

(i) Free medically necessary care to patients with family income at or below 200 percent of the federal poverty level, consistent with the provisions of section (a)(2) below;

(ii) Reduced-cost medically necessary care to patients with family income between 200 and 300 percent of the federal poverty level, consistent with the provisions of section (a)(2) below;

(iv) A description of the payment plan required under Health-General Article, §19-214.2(d), Annotated Code of Maryland, and regulation .05 of this chapter; and

(v) A mechanism for a patient, irrespective of that patient's insurance status, to request the hospital to reconsider the denial of free or reduced-cost medically necessary care, including the address, phone number, facsimile number, email address, mailing address, and website of the Health Education and Advocacy Unit, which can assist the patient or patient's authorized representative in filing and mediating a reconsideration request.

(d) If a patient is eligible for reduced–cost medically necessary care under paragraph (c)(ii) of this regulation, the hospital shall, at a minimum, reduce the patient's out-of-pocket expenses for the hospital services:

(i) For a patient with family income of at least 201% but not more than 250% of the federal poverty level, by 75%; and

(ii) For a patient with family income of more than 250% but not more than 300% of the federal poverty level, by 60%.

(e) The hospital shall provide free and reduced cost medically necessary care to all qualified Maryland residents, regardless of their citizenship or immigration status.

(f) The hospital shall provide free and reduced cost medically necessary care under §A(1)(c)) of this regulation to all qualified Maryland residents, regardless of whether the patient resides in the hospital's service area.

(g) The financial assistance policy applies to all medically necessary hospital services provided to qualified Maryland residents. Hospitals may not exclude non-urgent or elective, but medically necessary, care from their financial assistance policy.

(2) The financial assistance policy shall calculate a patient's eligibility for free medically necessary care under §A(1)(c)(i)of this regulation and Health-General Article, §19-214.1(b)(2)(i), Annotated Code of Maryland or reduced-cost medically necessary care under §A(1)(c)(ii) of this regulation and Health-General Article, §19-214.1(b)(2)(ii), Annotated Code of Maryland at the date of service or updated, as appropriate, to account for any change in the financial circumstances of the patient that occurs within 240 days after the initial bill is provided.

(3) The hospital shall consider any change in the patient's financial circumstance in accordance with Health-General Article, §19-214.1(b)(11).

(4) Income Documentation.

(a) Hospitals shall accept generally acceptable forms of documentation that verify income, such as tax returns, pay stubs, and W2s to evaluate if the patient is eligible for financial assistance, including free and reduced-cost medically necessary care, including reduced-cost medically necessary care due to financial hardship, in accordance with regulation .06 of this chapter;

(b) Hospitals shall use available information, including information provided by the patient, to approximate the patient's income if the patient has not provided their tax returns, pay stubs, W2s, or another form of documentation; and

(c) Hospitals may accept patient attestation of the patient's monthly or annual income and the number of filers and dependents on their tax return without documentation. Such an attestation shall include the patient's income and the number of filers and dependents on their tax return. If the patient provides an attestation of income the hospital is not required to conduct any additional income verification.

(d) A hospital's inability to obtain complete income information does not preclude the hospital's ability to reasonably predict a patient's income for the purposes of providing financial assistance. For example, a hospital may multiply income reported at the monthly level by 12 to determine income at the annual level, allowing for reasonably predictable changes in income throughout the year.

(5) Presumptive Eligibility for Free Medically Necessary Care. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free medically necessary care:

(a) Households with a child in the free or reduced lunch program and is eligible for the program based on the household's income;

(b) Supplemental Nutritional Assistance Program (SNAP);

(c)Low-income-household energy assistance program;

(d)Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package;

(e)Women, Infants and Children (WIC); or

(f) Other means-tested social services programs deemed eligible for hospital free medically necessary care policies by the Maryland Department of Health and the HSCRC, consistent with this regulation.

B. Hospital Reports. Each hospital shall submit to the Commission within 120 days after the end of each hospital's fiscal year:

(1) The hospital's financial assistance policy developed under this section; and

(2) An annual report on the hospital's financial assistance policy that includes:

(a) The total number of patients who completed or partially completed an application for financial assistance during the prior year;

(b) The total number of inpatients and outpatients who received free medically necessary care during the immediately preceding year and reduced-cost medically necessary care for the prior year;

(c) The total number of patients who received financial assistance during the immediately preceding year, by race or ethnicity and gender;

(d) The total number of patients who were denied financial assistance during the immediately preceding year, by race or ethnicity and gender;

(e) The total cost of hospital services provided to patients who received free medically necessary care; and

(f)The total cost of hospital services provided to patients who received reduced-cost medically necessary care that was covered by the hospital as financial assistance or that the hospital charged to the patient.

C. Financial Hardship Policy.

(1) Subject to §D of regulation .05 of this chapter, the financial assistance policy required under §A of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland, shall provide reduced-cost medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship.

(2) If a patient has received reduced-cost medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

- *(a) Shall remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost medically necessary care was initially received; and*
- *(b) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost medically necessary care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost medically necessary care.*

(3) If a patient is eligible for reduced-cost medically necessary care under a hospital's financial hardship policy, the hospital shall, at a minimum, reduce the patient's out-of-pocket expenses for hospital services:

- *(a) For a patient with family income of at least 201 percent but not more than 250 percent of the federal poverty level, by 75 percent;*
- *(b) For a patient with family income of more than 250 percent but not more than 300 percent of the federal poverty level, by 60 percent;*
- *(c) For a patient with family income of more than 300 percent but not more than 350 percent of the federal poverty level, by 50 percent;*
- *(d) For a patient with family income of more than 350 percent but not more than 400 percent of the federal poverty level, by 45 percent;*
- *(e) For a patient with family income of more than 400 percent but not more than 450 percent of the federal poverty level, by 40 percent;*
- *(f) For a patient with family income of more than 450 percent but not more than 500 percent of the federal poverty level, by 35.*

D. The Commission may, by regulation, establish income thresholds higher than those in section .06 of this chapter, taking into account the hospital's:

(a) Patient mix;

(b)Financial condition;

(c)Level of bad debt experienced;

(d) Amount of financial assistance provided; and

(e) Other relevant factors.

E.

(1) A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(2) If the hospital uses a vendor to assist with financial assistance eligibility, billing, or debt collection (such as a debt collector or eligibility vendor), that vendor shall post a notice in a conspicuous place on their website or online payment portal, informing patients of their right to apply for financial assistance, providing a link to the financial assistance application, and providing information on how to submit the application. Placement on the website or online payment portal should be based on the best interest of the patient.

F. The notice required under §E of this regulation shall be in:

(1) Simplified language in at least 10-point type; and

(2) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes at least 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

G. Each hospital shall use a Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost medically necessary care.

H. Each hospital shall use a Financial Assistance Application that meets the requirements of this regulation and is consistent with the Uniform Financial Assistance Application.

I. Each hospital shall establish a mechanism to provide a Financial Assistance Application to patients regardless of their insurance status. A hospital may require from patients or their guardians only those documents required to validate the information provided on the application.

J. Asset Test Requirements. A hospital may utilize a monetary asset test when determining eligibility for financial assistance, using the definition of monetary assets as defined in section .01B.(11) of this regulation.

.07 Patient Complaints.

The Commission shall post a process on its website for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of Health-General Article, §19-214.1 or 19-214.2, Annotated Code of Maryland. The process established shall include the option for a patient or a patient's authorized representative to file the complaint jointly with the Commission and the Health Education and Advocacy Unit. The process shall conform to the requirements of Health-General Article, §19-214.3, Annotated Code of Maryland.

.08 Hospital Written Estimate.

A. In addition to the good faith estimate requirements in PHS Act Sec. 2799B-6, the No Surprises Act, on request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.

B. The written estimate shall state clearly that it is only an estimate and actual charges could vary.

C. A hospital may restrict the availability of a written estimate to normal business office hours.

D. The provisions set forth in §A—C of this section do not apply to emergency services.

.09 Other Obligations.

This chapter does not diminish any obligations of a debt collector, as defined by under COMAR 10.37.13.01, under other applicable laws or regulations, including, without limitation, any requirement for the debt collector to obtain a collection agency license from the State Collection Agency Licensing Board in accordance with Business Regulation Article, Title 7, subtitle 3 Annotated Code of Maryland.

JOSHUA SHARFSTEIN

Chair

maryland
health services
cost review commission

Maryland Hospital Community Benefit Report: FY 2023

May 29, 2025

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Table of Contents

List of Abbreviations

ACA	Affordable Care Act
BMI	Body Mass Index
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
CMMI	Center for Medicare and Medicaid Innovation
DME	Direct Medical Education
ED	Emergency Department
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
GME	Graduate Medical Education
HCB	Hospital Community Benefit
HSCRC	Health Services Cost Review Commission
IRS	Internal Revenue Service
NSP	Nurse Support Program
PSA	Primary Service Area
SIHIS	Statewide Integrated Health Improvement Strategy
UCC	Uncompensated Care

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cost review commission

Executive Summary

Tax-exempt hospitals are required to provide "community benefit" as a condition of their federal tax-exemption. The term "community benefit" refers to initiatives, activities, and investments undertaken by hospitals to improve the health of the communities they serve. Hospitals submit information on their community benefit activities to the federal government each year. In addition, Maryland law[1] requires Maryland's nonprofit hospitals to report annual community benefit information to the Health Services Cost Review Commission (HSCRC). Maryland law builds on the federal requirements, providing the State with more information than is available through the federal reports.

In this report, the HSCRC summarizes fiscal year (FY) 2023 information submitted by hospitals, representing the HSCRC's 20th year reporting on Maryland hospital community benefit (HCB) data. The report describes how the State's reporting requirements differ from federal requirements, provides an overview of recent updates made to the reporting instructions, and highlights HSCRC programs that impact hospitals' community benefit spending. To better serve our community partners, staff reorganized this year's report to highlight key data points and make the information easier to use.

Key Highlights

- **Reporting Compliance:** All 49 nonprofit Maryland hospitals submitted their required FY 2023 community benefit reports.[2]
- **Community Benefit Expenditures:** Maryland hospitals reported $2.28 billion in total community benefit in FY 2023, an increase of around 11% from FY 2022.
    - **Rate Support for Hospital Community Benefits:** About 41% of the total HCB expenses are built into hospital rates, which are reimbursed by health care payers, including Medicare, Medicaid, commercial insurance, and patients. Roughly 59% ($1.3 billion) of the total hospital HCB spending comes directly from the hospitals without any rate support.
    - **Indirect Costs:** Hospital community benefit spending includes both direct and indirect costs (i.e., overhead costs). There is significant variation between hospitals in the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 21 to 145% for hospital-based community benefit activities. Three hospitals reported that indirect costs of hospital-based community benefit activities exceeded the direct costs of providing those activities. Due to concerns about the variation in indirect costs and the high amount of indirect costs reported by some

[1] MD. CODE. ANN., Health-Gen. § 19-303.
[2] There are 49 hospitals but only 47 narrative reports (45 reports from single hospitals and 2 reports that each cover 2 hospitals).

hospitals, the HSCRC has updated the community benefit reporting instructions for FY 2024.

- **Community Health Needs Assessments (CHNAs):** Under federal law, hospitals are required to conduct CHNAs every three years. CHNAs identify priority health needs and include implementation strategies to address them. All Maryland hospitals reported complying with this requirement. Hospitals reported spending 37.2% of their net community benefit on CHNA-related activities. Hospitals identified “Social Determinants of Health - Health Care Access and Quality” as the most frequently addressed CHNA priority area. Hospitals continued to show wide variation in the percentage of net community benefit spent on CHNA-related activities. To address this, staff updated reporting instructions for FY 2024.

Introduction

This report presents the results of an annual assessment of community benefit investments and activities of Maryland's nonprofit hospitals. Maryland law requires the Health Services Cost Review Commission (HSCRC) to submit this report annually.[3] This report is based on hospital community benefit (HCB) data submitted to the HSCRC by each hospital. The reports submitted by individual hospitals are posted on the HSCRC's website.[4]

This report explains the HCB reporting requirements and provides a summary of the fiscal year (FY) 2023 data that hospitals submitted to the HSCRC. This report also describes how the State's reporting requirements differ from federal requirements, provides an overview of recent updates made to Maryland's reporting instructions, and highlights HSCRC programs that impact hospitals' community benefit spending. To better serve our community partners, staff reorganized this year's report to highlight key data points and make the information easier to use.

Federal and State Authority over Community Benefits

Federal Tax Exemption and Reporting Requirements

Maryland's hospitals are nonprofit tax-exempt organizations. The federal Internal Revenue Code defines tax-exempt organizations as those that are organized and operated exclusively for specific religious, charitable, scientific, and educational purposes.[5] In order to maintain federal tax-exempt status, a hospital must provide "community benefits"[6] and report their community benefit activities to the Internal Revenue Service (IRS) annually. The IRS has no requirement for the minimum amount of community benefit that a hospital must provide to qualify for federal tax-exempt status.[7] In addition, every tax-exempt hospital, whether independent or part of a hospital system, must conduct a community health needs assessment

[3] MD. CODE. ANN., Health-Gen. § 19-303.
[4] https://hscrc.maryland.gov/Pages/init_cb.aspx
[5] 26 U.S.C. § 501(c)(3). Nonprofit hospitals have been required to demonstrate community benefits to qualify for federal tax-exempt status since 1969. The Internal Revenue Service (IRS) specifies categories of activities that qualify as community benefits in Schedule H of form 990. Under federal tax law, hospitals are required to: conduct a CHNA, including an implementation strategy; have a written financial assistance policy for medically necessary and emergency care; limit hospital charges for those eligible for financial assistance; and comply with billing and collections requirements. Source: James, J. (2016, February 25). Nonprofit hospitals' community benefit requirements, Health Affairs Health Policy Brief. DOI: 10.1377/hpb20160225.954803. Maryland law requires additional reporting of community benefit information. MD. CODE. ANN., Health-Gen. § 19-303. Maryland law adds requirements that exceed the federal requirements related to financial assistance and medical debt collection. MD. CODE. ANN., Health-Gen. §§ 19-214.1 and 19-214.2.
[6] A hospital must report community benefits to demonstrate to the IRS that they are a "charitable" organization, and thus eligible for tax exempt status. Historically, the IRS considered hospitals to be "charitable" if they provided charity care to the extent that they were financially able to do so. Ruling 56-185, 1956-1 C.B. 202. However, in 1969, the IRS modified the "charitable" standard to focus on "community benefits" rather than "charity care." Rev. Ruling 69-545, 1969-2 C.B. 117. "Charity care," now referred to as "financial assistance," is a category of community benefit.
[7] Congressional Research Service. (2024, April 15). Legal requirements for Section 501(c)(3) hospitals, page 4. https://crsreports.congress.gov/product/pdf/R/R48027

(CHNA) at least once every three years.[8] CHNAs are discussed in more detail later in this report. Hospitals must also report information about their CHNAs to the IRS.

Tax-exempt hospitals (also referred to as 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. Table 1 shows the number of Maryland hospitals that reported claiming each type of tax exemption in their FY 2023 HCB report.

Table 1. Tax Exemptions

Tax Exemption	Number of Hospitals
Federal corporate income tax	47
State corporate income tax	47
State sales tax	44
Local property tax (real and personal)	42
Other	5

The five hospitals that selected "Other" indicated that they also claimed an exemption from the federal unemployment insurance tax. One hospital reported claiming exemptions from some property taxes—depending on usage—but not from all local property taxes. The HSCRC conducted a tax benefit assessment of Maryland hospitals in 2020, calculating an overall net tax benefit of about $704 million for the year ending June 30, 2019.[9]

Overview of Maryland Reporting Requirements

Maryland law requires hospitals to report their HCB activities to the HSCRC annually, and the HSCRC is required to submit an annual statewide summary report to the General Assembly. This report contains the community benefit data for FY 2023,[10] marking the HSCRC's 20th year reporting on Maryland HCB.

Maryland's HCB reporting requirements are more extensive than the federal requirements. Maryland law defines "community benefit" as a planned, organized, and measured activity that is intended to meet

[8] Hospitals that do not conduct a CHNA every three years are subject to an annual penalty of up to $50,000 and loss of their tax-exempt status. 26 U.S.C. § 501(r)(3); 26 U.S.C. § 4959. Tax-exempt hospitals must report information on their CHNA on Schedule H of IRS Form 990. This reporting requirement was added by the Affordable Care Act.
[9] The HSCRC study is available here: https://hscrc.maryland.gov/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY19/HSCRC%20Hospital%20Tax%20Benefit%20Report%20July%202020.pdf. Other researchers have published articles and reports on the national scale of the benefit of hospital tax exempt status. "There is debate in the literature regarding the calculation of tax exemption value, particularly concerning federal and state corporate income taxes." Zare, H. & Anderson, G. (2024). Beyond the bottom line: Assessing charity care, community benefits, and tax exemptions in nonprofit hospitals. *Journal of Healthcare Management 69*(6), 439-454. DOI: 10.1097/JHM-D-24-00080. This results in different estimates by different researchers.
[10] The reporting period for these financial data is July 1, 2022, through June 30, 2023. Several hospitals are on a calendar financial year and report their most recent calendar year's data instead.

identified community health needs within a service area.[11] Hospitals must report their community benefit activities in categories that are specified by the HSCRC, including community health services; health professions education; research; financial contributions to other organizations; community-building activities, including partnerships with community-based organizations; financial assistance (i.e., free and reduced cost care); and mission-driven health services.[12] These categories are generally aligned with federal reporting categories (see Appendix A for a comparison of the federal and state reporting categories). The HSCRC also requires hospitals to report on health disparities and the types of tax exemptions claimed by the hospital in the preceding year.

Hospitals are also required to report information about their CHNA, including the amount of community benefit activities that are connected to community needs identified in the hospital's CHNA. The CHNA should influence the hospital's community benefit activities so that the hospital is serving identified community needs.

Maryland law requires hospitals to include the following information in their community benefit reports (CBRs):

- The hospital's mission statement
- A list of the hospital's activities to address the identified community health needs
- The costs of each community benefit activity
- A description of how each of the listed activities addresses the health needs of the hospital's community
- A description of efforts to evaluate the effectiveness of each community benefit activity
- A description of gaps in the availability of providers to serve the community
- A description of the hospital's efforts to track and reduce health disparities in the community
- A description of the process the hospital used to develop their CHNA
- A list of the unmet community health needs identified in the most recent CHNA
- A list of tax exemptions the hospital claimed during the preceding taxable year[13]

Hospitals submit a narrative report that contains descriptive information on their community benefit activities and a financial report on community benefit expenditures. The financial reports collect information about direct and indirect costs of community benefits, categorized by type of community benefit activity. Hospitals should use data from audited financial statements to calculate the cost of each community benefit category

[11] MD. CODE. ANN., Health-Gen. § 19-303(a)(3); COMAR 10.37.01.03.
[12] The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. The FY 2023 version of this document is available here: https://hscrc.maryland.gov/Documents/CommBen/FY%202023/FY%202023%20Community%20Benefit%20Guidelines%20and%20Definitions%20FINAL.pdf. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. https://www.irs.gov/pub/irs-pdf/f990sh.pdf.
[13] MD. CODE. ANN., Health-Gen. § 19-303(c)(4). Each hospital also reports to the HSCRC on the geographic region where the hospital offers its community benefit programs. This is referred to as the hospital's community benefit service area (CBSA). More information on how hospitals determined their CBSAs is in Appendix G.

contained in the financial reports and to limit reporting to only those hospital services reported on the IRS Form 990 Schedule H. Hospitals also submit their financial assistance policies. Each hospital's narrative and financial reports and financial assistance policies are posted on the HSCRC's website.[14]

Updates to Maryland's Reporting Instructions

In response to legislation, the HSCRC updated the reporting instructions in FY 2022, requiring hospitals to:

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

After reviewing the results of the FY 2022 HCB reports, the HSCRC identified potential reporting issues with data related to indirect costs and CHNA-aligned spending. The HSCRC's Commissioners directed staff to convene a short-term technical workgroup[15] to review the reporting instructions. As a result of workgroup deliberations, staff made technical corrections to the reporting instructions for the FY 2024 reports, including adjustments to directions for reporting physician subsidies, CHNA-identified community needs, and justifications for certain indirect costs. Those changes will be reflected in next year's report.

State Authority over Hospital Community Investments

State law requires hospitals to submit community benefit data to the HSCRC. The HSCRC has the authority to fine hospitals for failing to report accurate and timely information in their annual CBRs. All hospitals were compliant with the State community benefit reporting requirement for FY 2023.[16] Appendix B lists the hospitals submitting CBRs by hospital system. Maryland law does not provide regulatory authority over the quantity or quality of the community benefit activities or the CHNA. Maryland's HCB reporting requirements have no bearing on a nonprofit hospital's exemption from state income taxes; state tax exemption is based on the federal determination of the hospital's tax-exempt status.

Hospital Investments in Community Health and Rate Setting

Maryland has a unique statewide all-payer hospital rate-setting system. In contrast to the HSCRC's limited authority over community benefits, Maryland's hospital rate-setting system is a powerful tool for directing hospital investment in community health. The HSCRC uses the rate-setting system to direct hospital

[14] https://hscrc.maryland.gov/Pages/init_cb.aspx; https://hscrc.maryland.gov/Pages/hsp-fap.aspx.
[15] https://hscrc.maryland.gov/Pages/Community-Benefit-Workgroup.aspx.
[16] The HSCRC received 49 financial reports and 47 narrative reports. The University of Maryland Medical System submits one narrative report for its two hospitals on the Eastern Shore and another report for its two hospitals in Harford County.

investment in activities that align with state and community priorities. The following are current HSCRC programs that use the hospital rate-setting system to direct hospital spending on community health.

- **Revenue for Reform:** Hospitals the HSCRC identifies as inefficient are required to invest in community health activities or return funds to payers. These hospitals may only use the funds for community health activities that are approved by the HSCRC and the Maryland Department of Health (the Department). This funding remains in a hospital's global budget revenue (GBR) year after year, creating sustainable long-term funding for population health activities. Revenue for Reform is a new program and was not in place in FY 2023, the year covered by this report.
- **Behavioral Health Regional Partnership Catalyst Program:** The HSCRC approved $79.1 million in cumulative funding over a five-year period (FY 2021–FY 2025) for three behavioral health programs that are focused on expanding access to crisis services. Hospitals applied for this funding and had to demonstrate that they developed meaningful community partnerships and would maintain those partnerships throughout the program. This program has funded new behavioral health crisis centers and other services on the Eastern Shore, in Prince George's County, and in the greater Baltimore metropolitan region.
- **Maternal and Child Health Initiative:** The HSCRC assessed $40 million in funding over four years (FY 2022–FY 2025) to support maternal and child health interventions led by Medicaid managed care organizations and the Department's Prevention and Health Promotion Administration (PHPA). This funding supports new services not previously offered to Medicaid participants and continued efforts to reduce health care disparities. The Department has until the end of CY 2027 to spend the available funds.
- **Nurse Support Programs (NSP):** The HSCRC maintains two programs to develop and maintain the nursing workforce in Maryland. All Maryland hospitals receive funding through NSP I to support recruitment and retention of clinical nurses. In FY 2023, $19.1 million was included in hospital rates for NSP I activities. NSP II is funded through an $18.8 million hospital assessment aimed at expanding faculty and educational capacity at Maryland nursing schools. The Maryland Higher Education Commission (MHEC) administers NSP II on behalf of the HSCRC. Both programs have been implemented for over 20 years.

The HSCRC plans to continue to work with the Department in future years to develop programs that invest in the health of Maryland communities. The HSCRC increases hospital rates to fund these programs (or, in the case of Revenue for Reform, does not lower rates). Health care payers (including Medicare, Medicaid, private insurers, and patients) fund these activities through their payment of hospital claims.

To the extent these hospital investments fit the definition of "community benefit," hospitals may include them in their CBRs. Hospitals identify expenditures on these and other programs that the HSCRC includes in the annual calculation of each hospital's rates so that the HSCRC can determine the percentage of each hospital's community benefit that is funded through rates. These data are discussed later in this report.

Alignment of Hospital Community Benefit Activities with State/Federal Models

Maryland and the federal Center for Medicare and Medicaid Innovation (CMMI) have entered several agreements that support Maryland's all-payer hospital rate setting system, enhanced primary care, population health investments, and other aspects of the health care delivery system. Under the current Total Cost of Care Model agreement, Maryland agreed to four population health goals: 1) reducing the mean body mass index (BMI) for Maryland residents as it pertains to diabetes; 2) improving opioid overdose mortality; 3) decreasing asthma-related emergency department (ED) visits for children; and 4) reducing the severe maternal morbidity rate. All 49 hospitals reported that their community benefit activities addressed at least one of these goals, and most hospitals addressed more than one goal (Table 2). Reducing the mean BMI was the goal most frequently addressed by community benefit activities. Please note that hospitals may have other initiatives addressing these goals that do not count as community benefit.

Table 2. Number of Hospitals with Community Benefit Activities Addressing Population Health Goals under the Total Cost of Care Model, FY 2023

Goal	Number of Hospitals
Diabetes – Reduce the mean BMI for Maryland residents	43
Opioid Use Disorder – Improve overdose mortality	32
Maternal and Child Health – Reduce severe maternal morbidity rate	26
Maternal and Child Health – Decrease asthma-related ED visit rates for children aged 2-17	9

Maryland recently entered the AHEAD Model with CMMI, which will replace the Total Cost of Care Model in 2026. The State is working with stakeholders to develop the population health goals that will be used under the AHEAD Model. The HSCRC will adjust the hospital community benefit reporting instructions to collect information on the alignment between hospital community benefit investments and the AHEAD Model population health goals after those goals are established.

Spending on Community Benefits

Maryland hospitals provided approximately $2.28 billion in total community benefit activities in FY 2023.[17] This is an increase of approximately 11% over FY 2022. Hospital spending on community benefit grew faster than hospital revenue between FY 2022 and FY 2023.[18] In inflation-adjusted (real) dollars, Maryland community benefit expenditures were $943.3 million in FY 2004 (6.9% of operating expenses),[19] which is a significant increase in community benefit investment over the past 20 years.

Rate Support for Community Benefit Activities

As described earlier in this report, the HSCRC ensures that hospitals have funding for community benefit activities that are State priorities. The HSCRC increases hospital GBRs (and, relatedly, hospital rates) to fund these activities.[20] **Approximately $945 million of the $2.3 billion in community benefit reported in FY 2023, or 42% of HCB activities, was funded by health care payers through hospital rates. Approximately $1.3 billion of HCB activities was not funded through rates.** This equates to 6.6% of total hospital operating expenses. This is similar to the $1.22 billion in community benefit that was not rate-supported in FY 2022 (approximately 6.2% of operating expenses). Figures 1 and 2 show the trend of community benefit expenses with and without rate support. Appendix C details the amounts that were included in rates and funded by all payers for FY 2023.

Appendix D presents the total amount of community benefit reported and the amount of community benefit recovered through HSCRC-approved rate support.[21] Hospitals differ in their amount of community benefit not supported by rates compared to their total operating expenses. The total amount of community benefit expenditures without rate support as a percentage of total operating expenses ranged from 1.8% (Mt. Washington Pediatric Hospital) to 31.2% (McNew Family Medical Center), with an average of 7.6%. This is slightly higher than the average of 7.1% in FY 2022. Nine hospitals reported providing community benefit that exceeded 10% of their operating expenses, the same number as in FYs 2021 and 2022.

[17] This amount excludes expenditures on community benefit activities that are offset by revenue.
[18] The HSCRC approved a 3.25% increase in revenue for hospital global budgets for FY 2023. See https://hscrc.maryland.gov/Documents/RY23%20Final%20UF%20Recommendation.docx.pdf.
[19] FY 2004 community benefit expenses were $586.5 million. Inflated by CPI to FY 2023, this equals $943.3 million.
[20] The HSCRC sets the rates that most hospitals can charge payers for hospital services. For general acute care and chronic care hospitals, these rates are paid by Medicare, Medicaid, commercial insurance, and individuals who pay all or a portion of their hospital bill out of their own pocket. For pediatric and psychiatric hospitals, the HSCRC only sets rates for commercial insurers.
[21] Some hospital community benefits activities, such as clinics, generate revenue that offsets the amount of community benefit. Hospitals report the full amount of community benefit that they provide and any offsetting revenue that is not funded through rates. The HSCRC calculates the amount of hospital community benefit from rates using data that is separate from the hospital CBRs. This is intended to align HSCRC reporting with hospital reporting on the IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting.

Figure 1. FY 2013–FY 2023 Community Benefit Expenses with and without Rate Support (in Millions, Inflation Adjusted)

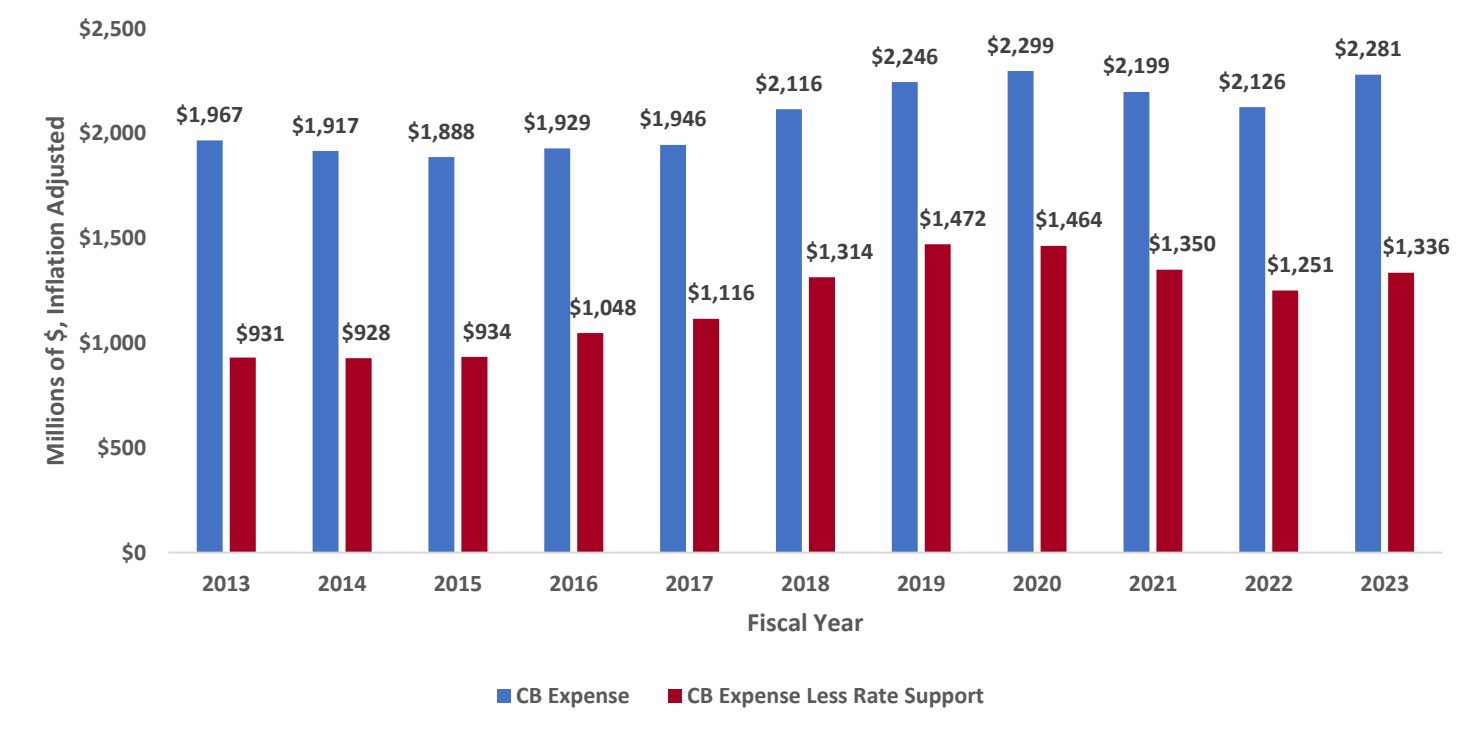


Figure 2. FY 2012–FY 2023 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support

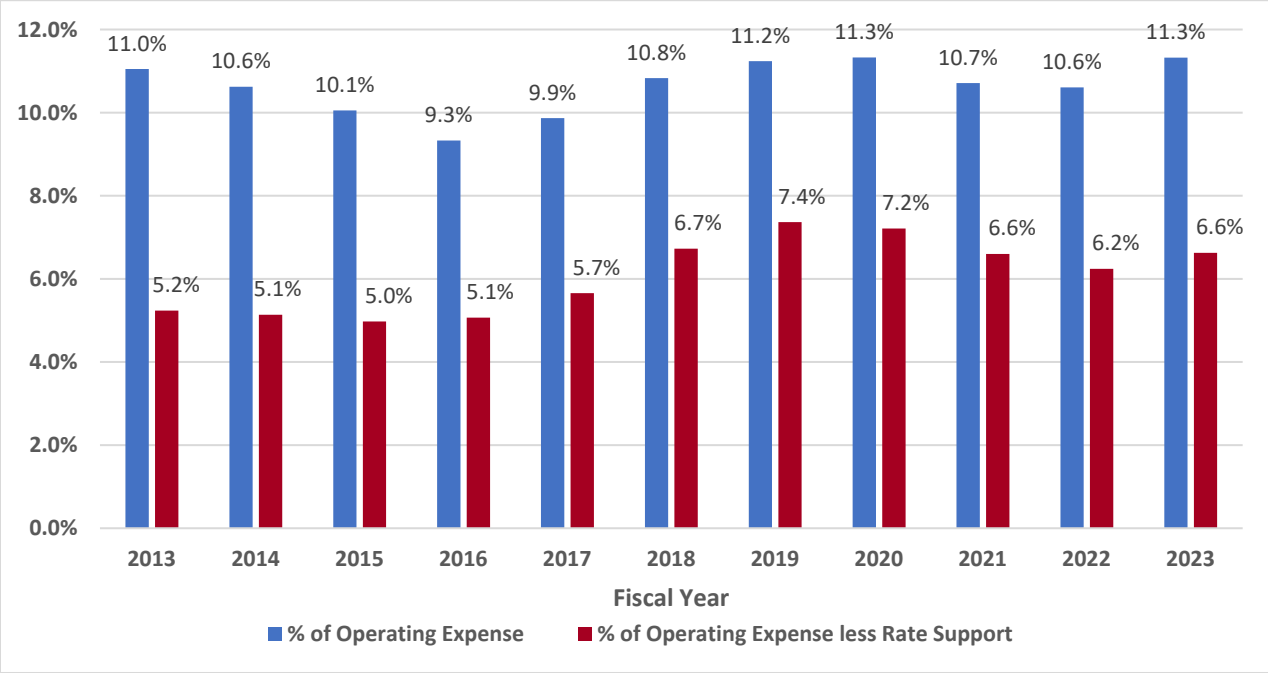
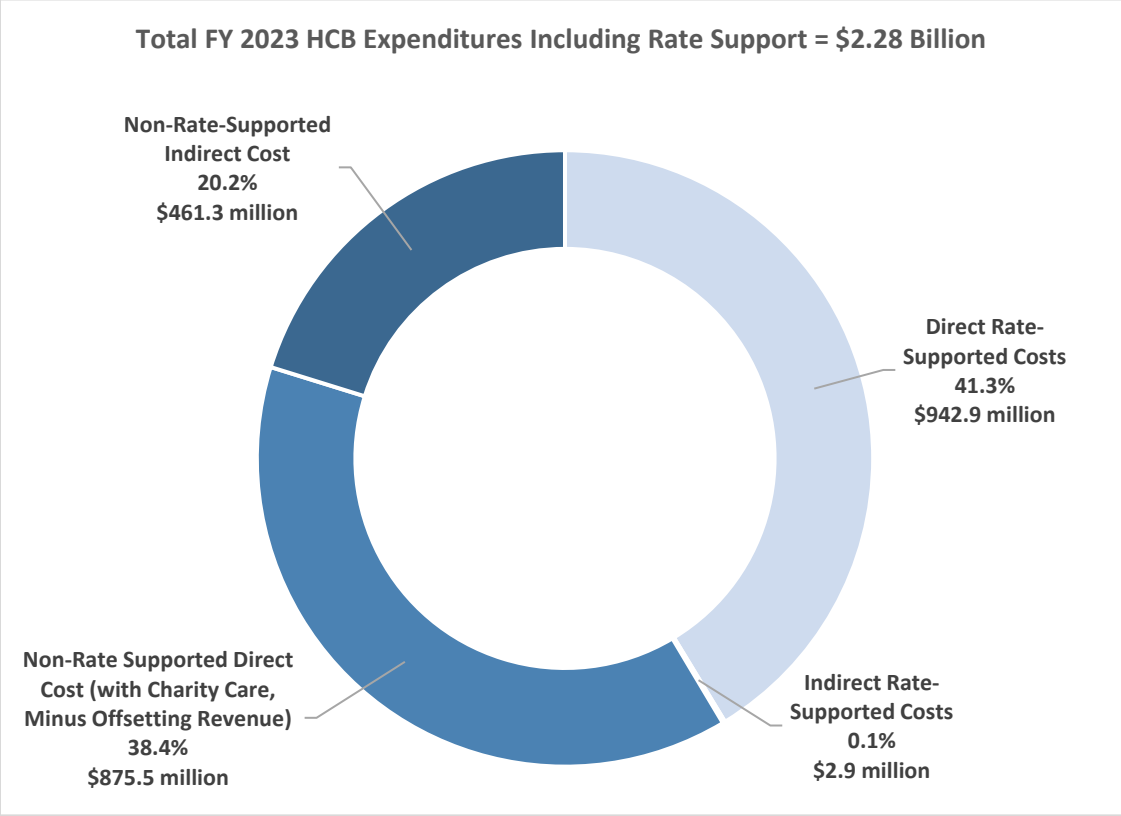


Figure 3 shows hospitals' total rate-supported and non-rate-supported direct and indirect costs in FY 2023 as a percentage of total HCB expenditures. Rate-supported direct and indirect costs accounted for roughly 41% of total expenditures.

Figure 3. Total Direct and Indirect Costs by Rate Support Status for All Hospitals, FY 2023



Examples of the community benefit costs that the HSCRC builds into hospital rates include the following:

- Financial assistance for low-income patients (free and reduced cost care)
- Graduate medical education (GME)
- The HSCRC's Nurse Support Programs, which support nursing education, recruitment, and retention programs in the State
- The Regional Partnership Catalyst Program for behavioral health crisis services

The following sections provide additional information on financial assistance, GME, and nurse support programs.

Financial Assistance

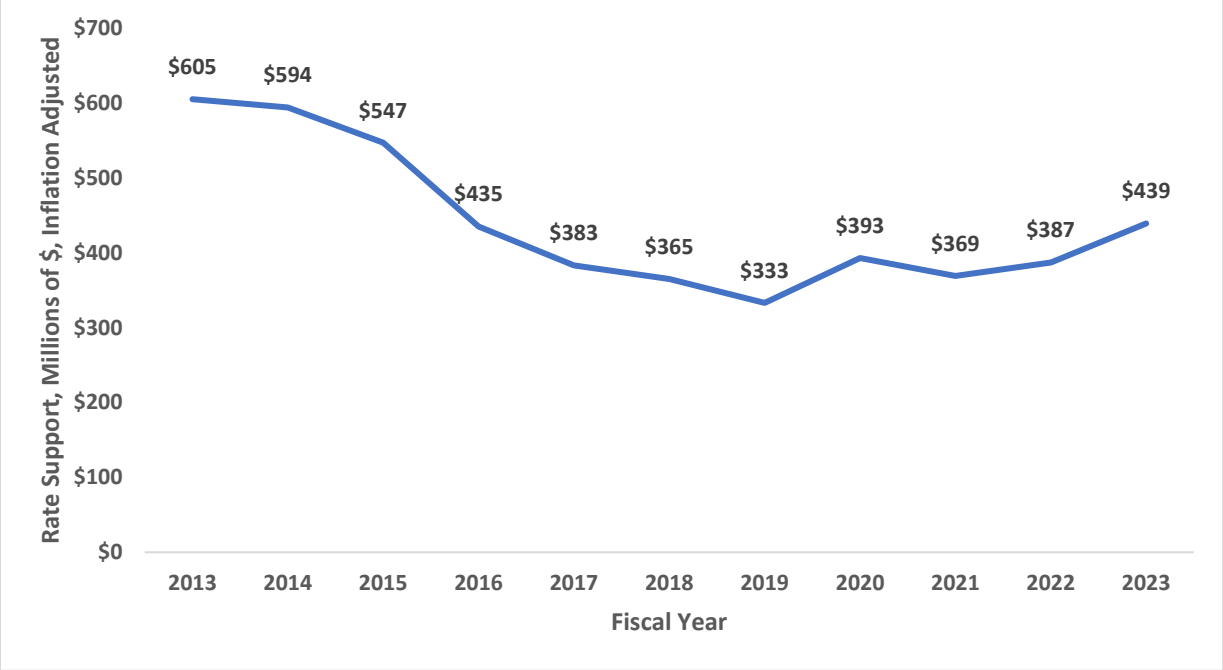
Maryland law requires general acute care and chronic care hospitals to provide financial assistance to patients with low income.[22] This is the third largest category of HCB spending, representing approximately 20% of total HCB spending ($452 million) in FY 2023. Almost all of this spending is accounted for in rates.

Figure 4 shows the amount built into hospital rates for financial assistance provided to low-income patients from FY 2013 through FY 2023. The amounts built into hospital rates for financial assistance are based on the amount of financial assistance that the hospitals provided to patients two years prior to the fiscal year. For example, the amount of rate support provided to hospitals for financial assistance in FY 2023 is based on the amount of financial assistance the hospitals provided to patients in FY 2021.[23]

As insurance coverage expanded under the Affordable Care Act (ACA) in 2014 and subsequent years, hospital patients needed less financial assistance. However, the need for financial assistance has increased since FY 2019, resulting in larger amounts of funding being included in hospital rates for financial assistance. Rate support for financial assistance continued to increase in FY 2023. See Appendix E for more details on the financial assistance methodology.

[22] MD. CODE. ANN., Health-Gen. § 19-214.1and COMAR 10.37.10.26(A-2).
[23] The HSCRC calculates this amount as a percentage of total statewide hospital revenue, adjusted for inflation.

Figure 4. Rate Support for Financial Assistance (in Millions, Inflation-Adjusted), FY 2013–FY 2023



Maryland law sets minimum eligibility standards for patient income based on family income. Hospitals must provide free care to patients under 200% of the federal poverty level (FPL), reduced cost care to patients under 300% of the FPL, and reduced cost care to patients under 500% of the FPL with medical debt that exceeds 25% of their annual income.[24] Hospitals may provide financial assistance to other patients. If a hospital is more generous in either the eligibility criteria in their financial assistance policy or in the amount of assistance they provide to patients who qualify, that could increase their spending on financial assistance.

Staff reviewed hospital financial assistance policies and compared the income thresholds for patient eligibility for free and reduced cost care in the policies with the eligibility requirements in law (Table 3). As with prior years, staff noted variation in the content and format of the financial assistance policy documents.

[24] MD. CODE. ANN., Health-Gen. § 19-214.1(b)(2)(i); COMAR 10.37.10.26(A-2)(2)(a) and COMAR 10.37.10.26(A-2)(3).

Table 3. Number of Hospitals with Expanded Financial Assistance Eligibility Criteria

Type of Financial Assistance	Statutory Eligibility Criteria	# of Hospitals That Provide Financial Assistance to a Higher Income Level
Free Care	Family income at or below 200% FPL	19
Reduced Cost Care	Family income between 201% and 300% FPL[25]	41
Reduced Cost Care due to Financial Hardship	Family income between 301% and 500% FPL, and the medical debt incurred by the family over a 12-month period exceeds 25% of the family's income[26]	22

Workforce: Graduate Medical Education and Nurse Support Programs

The HSCRC builds the cost of GME into hospital rates, as well as the cost of nursing workforce education and retention programs. GME is the cost of educating physician residents and interns. GME costs include the direct costs (i.e., direct medical education, or DME) of wages and benefits for residents and interns, faculty supervisory expenses, and allocated overhead. In FY 2023, DME costs in Maryland totaled $437 million.[27]

The HSCRC's Nurse Support Program I (NSP I) and NSP II are aimed at addressing the short- and long-term nursing shortages affecting Maryland hospitals. In FY 2023, the HSCRC provided just over $19 million in hospital rate adjustments for NSP I and just under $19 million for NSP II. See Appendix C for detailed information about the funding provided to specific hospitals through these programs.

Table 4 presents HCB expenditures for health professions education by activity. As with prior years, the education of physicians and medical students (including the DME expenses described above) made up most expenses in this category. The second highest category was the education of nurses and nursing students, totaling $53 million, including the NSP expenses described above.

[25] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[26] MD. CODE. ANN., Health-Gen. § 19-214.1
[27] The HSCRC's annual cost report.

Table 4. Health Professions Education Activities and Costs, FY 2023

Health Professions Education	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Physicians and Medical Students	$596,228,227	$393,768,365
Nurses and Nursing Students	$52,949,989	$32,144,499
Other Health Professionals	$30,640,738	$20,477,282
Scholarships and Funding for Professional Education	$4,603,458	$2,963,417
Other	$2,434,818	$1,262,268
Total	**$686,857,230**	**$450,615,831**

Categories of Community Benefit Activities

Hospitals must report on their community benefit activities in the following categories[28] defined by the HSCRC:

- **Medicaid Costs:** The cost of the Medicaid Deficit Assessment.
- **Community Health Improvement Services:** Activities that are carried out to improve community health (such as community health education, health screenings, and clinics for uninsured people).
- **Health Professionals Education:** Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional or continuing education that is necessary to retain state license or certification by a professional board.
- **Mission-Driven/Subsidized Health Services:** Services provided to the community that were never expected to result in cash inflows that the hospital undertakes as a direct result of its community or mission-driven initiatives—or which would otherwise not be provided in the community if the hospital did not perform these services, including physician subsidies that address gaps in physician availability.
- **Research**: Clinical research and community and health services research.
- **Cash Donations and In-Kind Contributions:** Resources donated by the hospital to organizations outside the hospital.
- **Community-Building Activities:** Activities that address the underlying causes of health problems and improve health status and quality of life services.
- **Community Benefit Operations:** Costs associated with staff, community health needs and/or assets assessment, and other costs associated with community benefit strategy and operations.

[28] The categories of community benefits are described in detail in the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. The FY 2023 version of this document is available here: https://hscrc.maryland.gov/Documents/CommBen/FY%202023/FY%202023%20Community%20Benefit%20Guidelines%20and%20Definitions%20FINAL.pdf. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of IRS Form 990, Schedule H. https://www.irs.gov/pub/irs-pdf/f990sh.pdf

See Appendix F for a detailed combined spreadsheet showing all hospitals' costs, rate support, and offsetting revenue across all categories.

As in FY 2022, hospitals spent the highest amount of their community benefit investments on mission-driven health services, health professions education, and financial assistance (Table 5).[29]

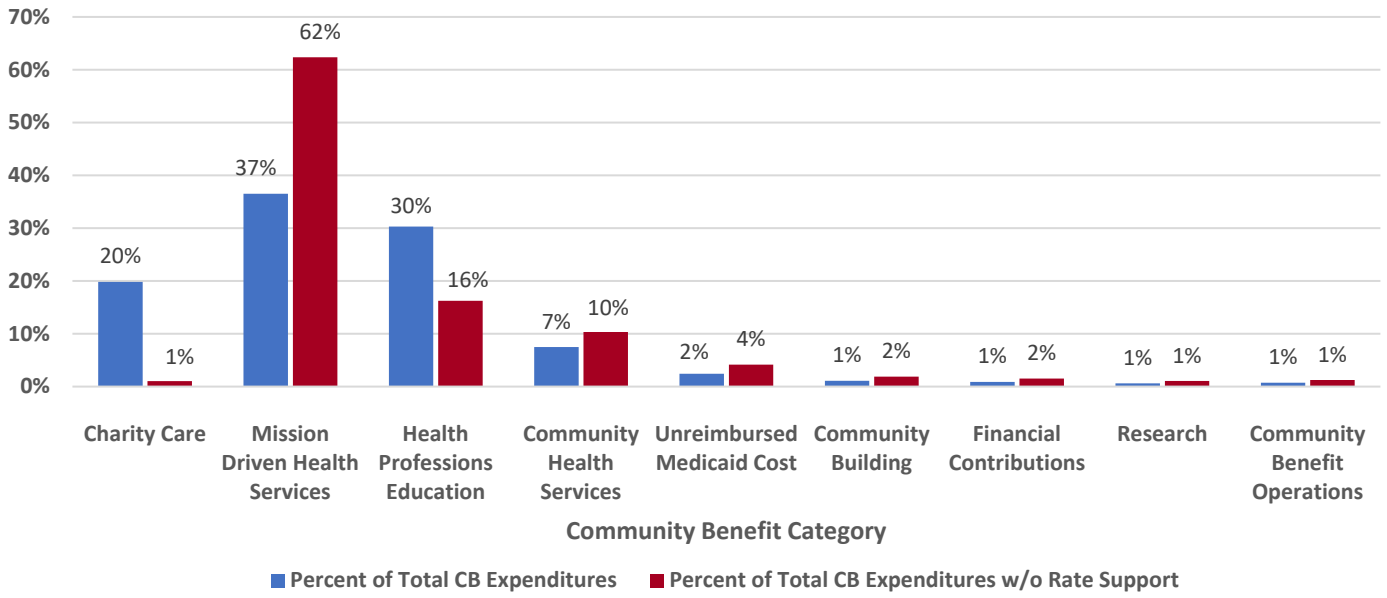
Table 5. Total Community Benefit Expenditures, FY 2023

Community Benefit Category	Total Community Benefit Expense[30]	Category as % of Total CB Expenditures	Total Community Benefit Expense Less Rate Support	Category as % of Total CB Expenditures Less Rate Support
Medicaid Deficit Assessment	$55,466,167	2.43%	$55,466,167	4.15%
Community Health Improvement Services	$170,611,890	7.48%	$138,016,988	10.33%
Health Professions Education	$691,682,793	30.32%	$217,089,010	16.25%
Mission-Driven Health Services	$832,747,261	36.50%	$832,747,261	62.35%
Research	$14,178,301	0.62%	$14,178,301	1.06%
Financial Contributions	$20,126,907	0.88%	$20,126,907	1.51%
Community Building	$25,226,682	1.11%	$25,226,682	1.89%
Community Benefit Operations	$16,801,859	0.74%	$16,801,859	1.26%
Foundation	$2,251,660	0.10%	$2,251,660	0.17%
Financial assistance	$452,369,804	19.83%	$13,692,246	1.03%
Total	**$2,281,463,324**	**100%**	**$1,335,597,081**	**100%**

Accounting for rate support significantly affects the distribution of expenses by category. Figure 5 shows expenditures for each community benefit reporting category as a percentage of total community benefit expenditures in FY 2023. Figure 5 also shows the percentage of expenditures by category for FY 2023 less the amount supported through rates.

[29] The FY 2023 total includes: net community benefit expenses of $833 million in mission-driven health care services (subsidized health services), $692 million in health professions education, $452 million in charity care, $170 million in community health services, $56 million in Medicaid deficit assessment costs, $25 million in community-building activities, $20 million in financial contributions, $14 million in research activities, $17 million in community benefit operations, and $2 million in foundation-funded community benefits.
[30] This amount excludes expenditures on community benefit activities that are offset by revenue.

Figure 5. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2023



Direct and Indirect Costs

Total hospital community benefit spending includes both the direct cost of the activity provided in the community and indirect costs. Indirect costs represent the proportion of total community benefit costs that are not attributed to products and/or services but are necessary for general operations, including salaries for human resources and finance departments, insurance, and overhead expenses.[31] The HSCRC's reporting instructions allow hospitals to report two indirect cost ratios: one for hospital/facility-based activities and one for activities in the community.[32] The "community-based" rate should be lower than the hospital-based rate and should exclude the costs of hospital buildings, the billing office, laundry, and other cost centers that should apply only to hospital-based programs. Table 6 presents the indirect cost ratios reported by each hospital for each community benefit category.

[31] The HSCRC specifies the methodology for calculating the indirect cost ratio. The cost ratio that hospitals report for community benefit should align with the cost ratio that they report on Schedule M of their annual cost report to the HSCRC. Staff followed up with hospitals whose indirect costs did not align with Schedule M. Many hospitals reported manually reducing their indirect cost ratio for community benefits, as they felt the ratio derived from their Schedule M was inappropriately high for community benefits activities.
[32] Some indirect costs are reported as a fixed dollar amount while others are a calculated percentage of the hospital's reported direct costs.

There is significant variation between hospitals regarding the indirect cost ratios associated with hospital-based community benefit activities. Indirect costs, as a percentage of total direct costs, ranged from 21 to 145% for hospital-based community benefit activities. Three hospitals reported that indirect costs of hospital-based community benefit activities exceeded the direct costs of providing those activities to the communities they serve (see the "Hospital-Based CB Activities" column in Table 6). There is less variation between hospitals in their reported indirect cost ratios for community-based services, but there are a few outliers. Three hospitals report indirect cost ratios greater than 25% for community-based services.

Due to concerns about the variation in indirect costs and the high amount of indirect costs reported by some hospitals, the HSCRC convened a workgroup in 2024 to discuss changes to hospital reporting. As a result of that workgroup, the HSCRC has updated the community benefit reporting instructions for FY 2024. The FY 2024 report will include additional analysis on indirect costs.

Table 6. Hospital-Reported Indirect Cost Ratios, FY 2023 (Indirect Costs as a Percentage of Direct Costs)

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
Univ. of Maryland Shore Medical Center at Chestertown	144.8%	19.4%
Adventist Rehabilitation	109.4%	15.0%
Univ. of Maryland Shore Medical Center at Easton	104.9%	11.0%
Univ. of Maryland Charles Regional Medical Center	91.8%	20.2%
Univ. of Maryland Capital Region Medical Center	90.7%	12.9%
Ascension Saint Agnes Hospital	89.5%	10.0%
Mercy Medical Center, Inc.	84.4%	10.0%
MedStar Harbor Hospital Center	84.3%	
J. Kent McNew Family Medical Center	83.3%	
Univ. of Maryland Medical Center Midtown Campus	82.7%	13.1%
MedStar Southern Maryland Hospital	82.5%	
Frederick Memorial Hospital	81.1%	81.1%
Greater Baltimore Medical Center	80.6%	
MedStar Montgomery General Hospital	77.4%	
CalvertHealth Medical Center	76.5%	31.9%
MedStar St. Mary's Hospital	76.4%	
Univ. of Maryland Baltimore Washington Medical Center	74.0%	12.2%
Univ. of Maryland St. Joseph's Medical Center	72.8%	15.4%
Adventist Fort Washington Medical Center	71.5%	15.0%

Hospital Name	Indirect Cost Ratio	
	Hospital-Based CB Activities	Community-Based CB Activities
Univ. of Maryland Rehabilitation & Orthopaedic Institute	71.1%	13.3%
Sheppard & Enoch Pratt Hospital	70.6%	
MedStar Good Samaritan Hospital	70.1%	
Howard County General Hospital	69.8%	18.2%
Doctors Community Hospital	68.4%	
Meritus Medical Center	66.2%	15.0%
MedStar Franklin Square Hospital	66.1%	
Adventist Shady Grove Medical Center	64.9%	15.0%
Mt. Washington Peds	64.2%	10.3%
Suburban Hospital	64.2%	24.2%
Adventist White Oak Hospital	63.7%	15.0%
TidalHealth McCready Pavilion	63.3%	
UPMC Western Maryland Hospital	63.1%	55.9%
MedStar Union Memorial Hospital	62.8%	
Sinai Hospital of Baltimore	60.0%	12.0%
Carroll Hospital Center	60.0%	12.0%
Northwest Hospital	60.0%	12.0%
Levindale Hebrew Geriatric Center & Hospital	60.0%	
Garrett Regional Hospital	58.3%	
Univ. of Maryland Medical Center	57.7%	
Univ. of Maryland Upper Chesapeake Medical Center	53.6%	9.4%
Anne Arundel General Hospital	53.0%	
TidalHealth Peninsula Regional Medical Center	52.7%	
Johns Hopkins Bayview Med. Center	51.6%	16.8%
The Johns Hopkins Hospital	45.1%	15.1%
ChristianaCare, Union Hospital	41.0%	
Atlantic General Hospital	35.3%	
Holy Cross Germantown Hospital	31.3%	10.0%
Holy Cross Hospital	28.9%	10.0%
Univ. of Maryland Harford Memorial Hospital	21.4%	3.8%

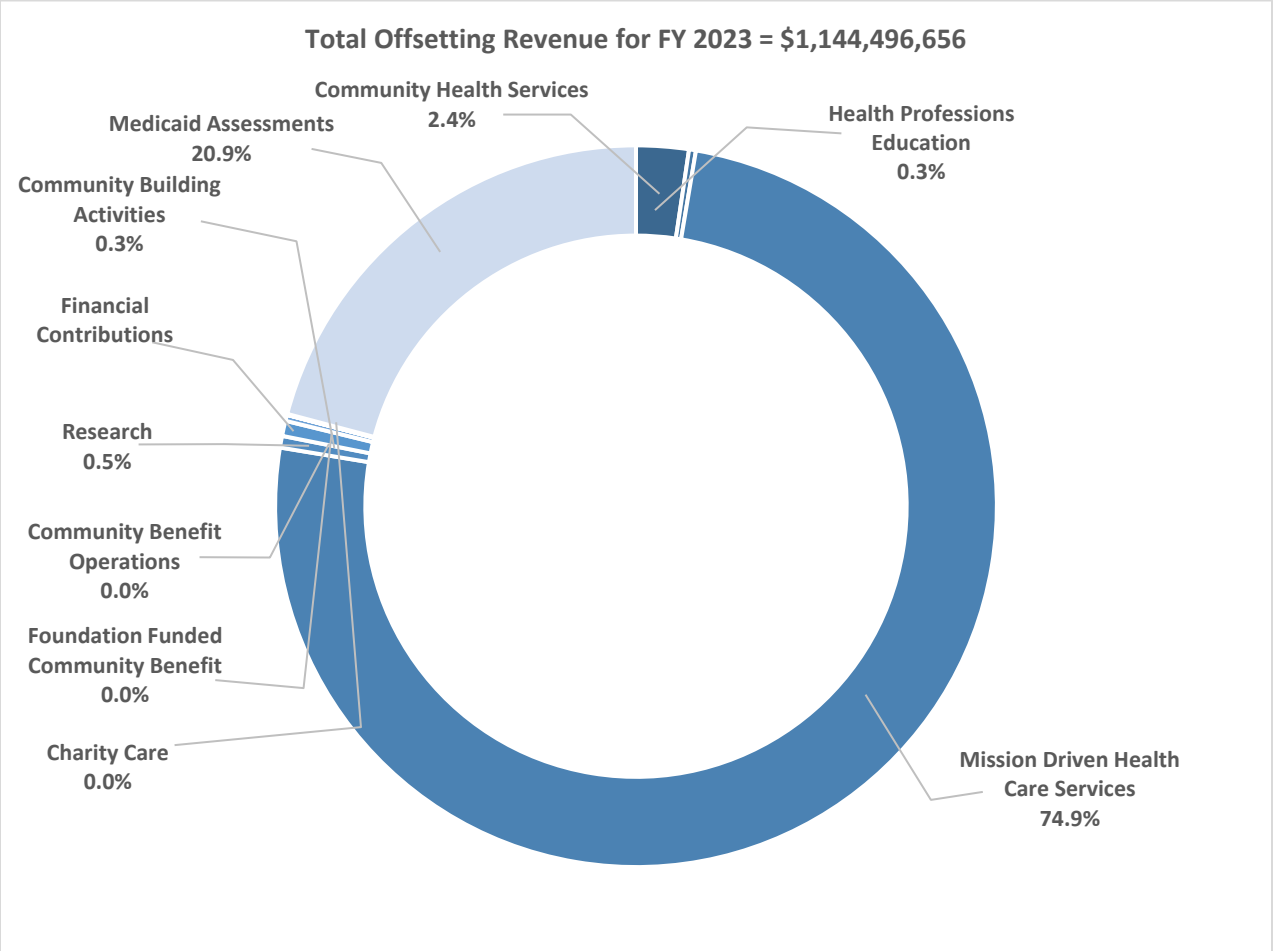
Offsetting Revenue and Mission-Driven Health Services

This report removes offsetting revenue from reported total community benefits. Offsetting revenue is defined as any revenue generated by the activity or program. For example. any payment by patients for services provided to those patients in a sliding-scale clinic would offset the total reported community benefit expenditures reported by the hospital for that clinic. Other examples include restricted grants or

contributions to the hospital that are used to fund a portion of the hospital's community benefit. Hospitals report offsetting revenue to the HSCRC in their annual community benefit reports.

Hospitals reported over $1.1 billion in offsetting revenue for community benefit activities—the majority for mission-driven health services, which are, by definition, intended to be services provided to the community that are not expected to result in revenue.[33] Figure 6 presents the total FY 2023 offsetting revenue by community benefit category.

Figure 6. Offsetting Revenue by Category of Community Benefit Activity for Maryland Hospitals, FY 2023



Offsetting revenue is different from rate-supported activities (described above). In general, hospitals do not report rate support as offsetting revenue. The Medicaid Deficit Assessment is the exception. The Medicaid

[33] See the HSCRC's FY 2023 Community Benefit Reporting Guidelines and Standard Definitions.

deficit assessment (shown as “Medicaid assessments” in Figure 6, above) is a broad-based uniform assessment to hospital rates that is set by the Maryland General Assembly. The hospitals pay this assessment, but a portion of it is reimbursed back to the hospital through all-payer rates, which is then reported as offsetting revenue.

Table 7 presents offsetting revenue for mission-driven health services by hospital. As noted above, mission-driven health services is the community benefit category that generates the most offsetting revenue. However, mission-driven health services are not intended to create revenue. Instead, mission-driven health services are intended to be services that hospitals undertake as a direct result of their community or mission-driven initiatives, or because the services would otherwise not be provided in the community. The hospitals are sorted by the proportion of total expenditures for mission-driven health services that are offset by revenue. Nine hospitals did not report any offsetting revenue from mission-driven health services. Sixteen hospitals reported offsetting revenue for 50% or more of their mission-driven expenditures. After removing offsetting revenue, mission-driven health services remain the largest category of community benefit activities, as shown in Table 5, above.

Table 7. Mission-Driven Health Services Expenditure and Offsetting Revenue among Maryland Hospitals, FY 2023

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
Adventist White Oak Hospital	$165,575,734	$150,707,818	91.0%	$14,867,916
Adventist Rehabilitation	$4,508,647	$3,617,646	80.2%	$891,001
Univ. of Maryland Shore Medical Center at Easton	$141,706,998	$111,222,862	78.5%	$30,484,136
Univ. of Maryland Shore Medical Center at Chestertown	$30,469,877	$22,244,572	73.0%	$8,225,304
Greater Baltimore Medical Center	$170,562,741	$116,052,850	68.0%	$54,509,891
MedStar Montgomery General Hospital	$17,894,531	$11,811,733	66.0%	$6,082,798
MedStar Franklin Square Hospital	$64,397,866	$41,868,138	65.0%	$22,529,728
Univ. of Maryland Baltimore Washington Medical Center	$41,875,612	$26,950,303	64.4%	$14,925,309
Atlantic General Hospital	$17,116,247	$10,991,416	64.2%	$6,124,831
Meritus Medical Center	$137,757,697	$88,293,942	64.1%	$49,463,755
MedStar Union Memorial Hospital	$25,746,992	$15,425,365	59.9%	$10,321,627
MedStar Harbor Hospital Center	$24,784,837	$14,786,099	59.7%	$9,998,738
MedStar Good Samaritan Hospital	$18,669,793	$10,935,530	58.6%	$7,734,263
MedStar Southern Maryland Hospital	$33,622,261	$18,793,989	55.9%	$14,828,272
Adventist Shady Grove Medical Center	$39,210,469	$21,787,060	55.6%	$17,423,408
Ascension Saint Agnes Hospital	$42,726,363	$23,579,043	55.2%	$19,147,320
MedStar St. Mary's Hospital	$21,270,308	$9,740,190	45.8%	$11,530,118
Mt. Washington Pediatric Hospital	$536,688	$235,885	44.0%	$300,803
UPMC Western Maryland Hospital	$103,990,266	$45,525,798	43.8%	$58,464,468

Hospital Name	Total Expenditure on Mission Driven Services	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Community Benefit for Mission Driven Services
Univ. of Maryland Medical Center	$25,483,164	$11,155,391	43.8%	$14,327,773
TidalHealth Peninsula Regional Medical Center	$68,538,838	$29,797,432	43.5%	$38,741,406
Sinai Hospital of Baltimore	$42,779,529	$17,513,782	40.9%	$25,265,747
Lifebridge Northwest Hospital Center	$13,627,318	$4,963,145	36.4%	$8,664,173
ChristianaCare, Union Hospital	$31,700,752	$10,753,067	33.9%	$20,947,685
CalvertHealth Medical Center	$7,029,192	$2,260,287	32.2%	$4,768,905
Garrett Regional Hospital	$9,833,353	$2,957,668	30.1%	$6,875,685
Adventist Fort Washington Medical Center	$7,136,290	$2,087,722	29.3%	$5,048,568
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$3,215,838	$888,976	27.6%	$2,326,862
Univ. of Maryland Charles Regional Medical Center	$13,593,313	$3,686,898	27.1%	$9,906,415
Univ. of Maryland Capital Region Medical Center	$40,524,900	$10,616,400	26.2%	$29,908,500
Univ. of Maryland Medical Center Midtown Campus	$20,198,907	$3,973,133	19.7%	$16,225,774
Holy Cross Hospital	$10,742,646	$1,813,349	16.9%	$8,929,297
Anne Arundel General Hospital	$45,832,486	$6,303,566	13.8%	$39,528,920
Johns Hopkins Bayview Med. Center	$11,011,509	$1,095,942	10.0%	$9,915,567
Suburban Hospital	$16,577,683	$1,155,059	7.0%	$15,422,624
Sheppard & Enoch Pratt Hospital	$23,294,284	$1,038,876	4.5%	$22,255,407
Mercy Medical Center	$22,054,316	$771,483	3.5%	$21,282,833
The Johns Hopkins Hospital	$19,196,912	$339,222	1.8%	$18,857,690
Levindale Hebrew Geriatric Center & Hospital	$1,050,671	$17,957	1.7%	$1,032,714
Doctors Community Hospital	$13,929,205	$2,591	0.0%	$13,926,614
Frederick Memorial Hospital	$43,063,214	$0	0.0%	$43,063,214
Univ. of Maryland Harford Memorial Hospital	$5,733,481	$0	0.0%	$5,733,481
Carroll Hospital Center	$11,159,707	$0	0.0%	$11,159,707
TidalHealth McCready Pavillion	$39,305	$0	0.0%	$39,305
Howard County General Hospital	$18,013,817	$0	0.0%	$18,013,817
Univ. of Maryland Upper Chesapeake Medical Center	$12,526,680	$0	0.0%	$12,526,680
Univ. of Maryland St. Joseph's Medical Center	$45,307,943	$0	0.0%	$45,307,943
Holy Cross Germantown Hospital	$3,599,269	$0	0.0%	$3,599,269
J. Kent McNew Family Medical Center	$1,224,310	$0	0.0%	$1,224,310
Total	**$1,690,442,758**	**$857,762,187**	**50.7%**	**$832,680,571**

Mission-Driven Health Services: Physician Gaps in Availability

As noted above, the mission-driven health services category is the largest category of community benefits reported by Maryland hospitals. The mission-driven health services category includes subsidies that

hospitals provide to physicians to address gaps in physician availability to serve the hospital's uninsured population. Maryland law requires hospitals to justify the reporting of spending on physician subsides as a community benefit.[34] Hospitals must provide a written description of gaps in the availability of providers to serve their uninsured populations by specialty. Since FY 2021, hospitals have been required to separately itemize all physician subsidies claimed by type and specialty. The most frequently reported gaps were obstetrics and gynecology (reported by 31 hospitals), followed by psychiatry, other specialties, and internal medicine. Five hospitals reported no gaps in the availability of physicians to serve their uninsured population. See Table 8.

Table 8. Number of Hospitals Reporting Gaps in Physician Availability by Specialty

Gap in Physician Availability, by Specialty	Number of Hospitals
No gaps reported	5
Obstetrics & Gynecology	31
Psychiatry	30
Other	29
Internal Medicine	26
Emergency Medicine	24
Surgery	21
Pediatrics	19
Neurology	19
Cardiology	14
Oncology-Cancer	14
Anesthesiology	13
Endocrinology, Diabetes & Metabolism	10
Ophthalmology	10
Family Practice/General Practice	10
Orthopedics	9
Urology	9
Radiology	8
Otolaryngology	7
Neurological Surgery	6
Physical Medicine & Rehabilitation	5
Pathology	5
Plastic Surgery	4
Preventive Medicine	3
Geriatrics	2
Medical Genetics	1

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

Community Health Needs Assessments

Federal law requires hospitals to conduct a CHNA every three years and develop an implementation plan for addressing the community needs identified in the CHNA.[35] The CHNA evaluates the health needs of the community the hospital serves and identifies needs, gaps, assets, and resources as they relate to the health of the community. CHNAs are supposed to be developed with robust community input. CHNAs help the hospital set priorities for community benefits expenditures.

Appendix G shows maps indicating the coverage of hospitals' primary service areas and community benefit service areas (CBSAs), two ways of defining the community each hospital serves, as well as describing the ways hospitals reported identifying their CBSAs. Hospitals report details about these communities, which help inform decisions about HCB activities. Appendix H contains demographic statistics on each Maryland county, similar to the measures hospitals may use. See Appendix I for a list of the data sources hospitals reported on their FY 2024 narrative survey that they use in their HCB efforts.

Maryland requires hospitals to include information about their CHNA in their annual CBRs. The goal of this reporting is to provide transparency about 1) the extent to which the hospital's community benefit activities are aligned with their CHNA and 2) the level of community involvement in the development of the CHNA.

Spending on CHNA-Related Activities

Hospitals reported spending 37.2% of their net community benefit spending on CHNA-related activities. Note that not all community benefit activities are expected to align with the CHNA. While CHNAs help identify community health needs and priorities, some community benefit activities may address broader community well-being, even if they do not directly relate to those specific identified needs. Further, because CHNAs are conducted every three years, community benefit activities may address emerging community health needs, e.g., the COVID-19 pandemic.

There was wide variation between individual hospitals, ranging from -0.3% to 81.2% of total community benefit spent on CHNA related activities. This wide variation was similar to what was reported in FY 2022, the first year that hospitals reported this information. It is unclear whether this variation reflects true differences across hospitals or whether hospitals are using different criteria to determine whether activities are CHNA-related. To address this concern, staff convened a workgroup in the summer of 2024 and updated the instructions for FY 2024 reporting to provide additional clarification around what activities may count as CHNA-related, with the goal of having more comparable reporting across hospitals. Table 9

[35] Loyola University Chicago. (2024). *Background on community health needs assessment*. https://hsd.luc.edu/ipath/communityhealthneedsassessment/backgroundoncommunityhealthneedsassessment/#:~:text=The%20CHNA%20process%20helps%20not,the%20basis%20of%20tax%20exemption

presents each hospital's net total community benefit spending, the net total spent on CHNA-related activities, and the percentage of total spending on CHNA-related activities.

Table 9. CHNA Spending[36] as a Percentage of Net Community Benefit, FY 2023

Hospital	Total CB Spent on CHNA Priority Area Programs	Total CB Spending	Spending on CHNA as Percentage of Total CB
TidalHealth McCready Pavillion	$463,026	$569,926	81.2%
The Johns Hopkins Hospital	$294,673,159	$366,842,384	80.3%
MedStar Union Memorial Hospital	$36,524,578	$49,500,236	73.8%
UPMC Western Maryland Hospital	$55,526,483	$76,846,674	72.3%
MedStar Franklin Square Hospital	$45,645,923	$64,715,265	70.5%
Howard County General Hospital	$25,528,880	$36,557,318	69.8%
MedStar St. Mary's Hospital	$14,075,779	$20,644,933	68.2%
Johns Hopkins Bayview Med. Center	$71,781,220	$107,131,629	67.0%
Garrett Regional Hospital	$7,742,302	$11,567,923	66.9%
Suburban Hospital	$24,798,448	$37,663,565	65.8%
MedStar Harbor Hospital Center	$16,919,600	$25,891,745	65.3%
MedStar Southern Maryland Hospital	$17,529,085	$28,203,383	62.2%
MedStar Good Samaritan Hospital	$15,435,506	$26,431,968	58.4%
Mercy Medical Center	$41,474,355	$73,752,855	56.2%
MedStar Montgomery General Hospital	$8,211,584	$14,867,749	55.2%
Holy Cross Germantown Hospital	$3,734,771	$7,783,802	48.0%
Meritus Medical Center	$31,496,141	$66,551,271	47.3%
TidalHealth Peninsula Regional Medical Center	$23,943,154	$68,944,409	34.7%
Doctors Community Hospital	$11,483,619	$34,995,799	32.8%
Levindale Hebrew Geriatric Center & Hospital	$1,731,058	$5,536,488	31.3%
Sinai Hospital of Baltimore	$28,028,248	$92,712,551	30.2%
Mt. Washington Pediatric Hospital	$467,315	$1,574,578	29.7%
Holy Cross Hospital	$14,067,533	$50,599,565	27.8%
Carroll Hospital Center	$5,667,650	$22,533,952	25.2%
Adventist Rehabilitation	$437,533	$1,829,981	23.9%
Univ. of Maryland Upper Chesapeake Medical Center	$4,636,897	$22,452,379	20.7%
Lifebridge Northwest Hospital	$4,287,078	$24,425,906	17.6%
Univ. of Maryland Harford Memorial Hospital	$1,646,469	$9,837,007	16.7%
Anne Arundel General Hospital	$10,907,404	$70,148,046	15.5%
Sheppard & Enoch Pratt Hospital	$5,615,391	$36,721,183	15.3%
J. Kent McNew Family Medical Center	$357,001	$2,733,218	13.1%
Univ. of Maryland Baltimore Washington Medical Center	$3,212,874	$27,931,663	11.5%
Adventist Shady Grove Medical Center	$3,593,163	$40,032,662	9.0%

[36] Offsetting revenue has been removed.

Hospital	Total CB Spent on CHNA Priority Area Programs	Total CB Spending	Spending on CHNA as Percentage of Total CB
Univ. of Maryland Charles Regional Medical Center	$1,285,244	$14,618,252	8.8%
Univ. of Maryland St. Joseph's Medical Center	$4,817,340	$58,245,151	8.3%
Univ. of Maryland Shore Medical Center at Chestertown	$638,545	$10,087,696	6.3%
Adventist White Oak Hospital	$1,444,947	$31,922,588	4.5%
Frederick Memorial Hospital	$2,483,434	$56,892,363	4.4%
Ascension Saint Agnes Hospital	$1,993,893	$52,882,154	3.8%
Univ. of Maryland Shore Medical Center at Easton	$1,372,541	$38,023,876	3.6%
Adventist Fort Washington Medical Center	$198,654	$7,102,621	2.8%
Univ. of Maryland Capital Region Medical Center	$1,175,691	$45,637,576	2.6%
Univ. of Maryland Medical Center Midtown Campus	$687,688	$34,323,489	2.0%
CalvertHealth Medical Center	$169,709	$8,942,397	1.9%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$138,810	$9,020,727	1.5%
Atlantic General Hospital	$70,452	$8,415,352	0.8%
Univ. of Maryland Medical Center	$1,506,692	$282,975,200	0.5%
ChristianaCare, Union Hospital	$120,720	$23,264,049	0.5%
Greater Baltimore Medical Center[37]	-$232,104	$70,577,819	-0.3%
Total	**$849,515,484**	**$2,281,463,324**	**37.2%**

Hospitals also described the community benefit initiatives undertaken to address CHNA-identified needs in the community. Table 10 summarizes the CHNA priority area categories most commonly addressed by hospital initiatives in FY 2023. Appendix J shows the number of hospitals reporting initiatives to address each of the full list of CHNA-identified community health needs.

Table 10. Top 5 CHNA Priority Area Categories Addressed by Hospitals

CHNA Priority Area	Number of Hospitals
Social Determinants of Health - Health Care Access and Quality	35
Settings and Systems - Community	32
Health Conditions - Diabetes	31
Health Conditions - Mental Health and Mental Disorders	31
Health Behaviors - Preventive Care	31

[37] Staff followed up with Greater Baltimore Medical Center to confirm that this net negative amount was correct. Because the value is negative, it indicates that the CHNA priority area programs generated more offsetting revenue than their cost to the hospital.

CHNA Development Process

All Maryland nonprofit hospitals reported conducting CHNAs within the past three fiscal years, as required by federal law. See Appendix K for the dates on which hospitals completed their last CHNAs.

Federal law requires hospitals to use input from individuals who represent the broad interests of the community served by the hospital in their CHNA. Each hospital records the process for assessing community needs and the findings from that process in a CHNA document that is made available to the public. Hospitals also produce a plan for implementing activities to address the identified community needs,[38] which some include directly in the CHNA document and others provide separately. All Maryland nonprofit hospitals reported adopting an implementation strategy. The CHNA document must also note any community needs that were identified in prior CHNAs that have not been met and explain why they were not addressed.

The CHNA document includes descriptions of the people and organizations with whom the hospital collaborated on the assessment of community health needs. Hospitals reported collaborating with a broad set of community organizations when developing their CHNAs. Table 11 shows the number of hospitals that reported collaborating with various external organizations. See Appendices L and M for more detail on these external participants.

[38] 26 U.S.C. § 501(r)(3)(A)-(B).

Table 11. Number of Hospitals that Collaborated with Selected Types of External Organizations for Their Most Recent CHNA, FY 2023

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Facilities	19	40%
Local Health Departments	45	96%
Local Health Improvement Coalitions	42	89%
Other Hospitals	35	74%
Behavioral Health Organizations	40	85%

Community Benefit Administration

Hospitals report information on how they staff CHNA and HCB activities, whether they audit their community benefit data, the role of the hospital board in their community benefit report, and whether community benefit is included in the hospital's strategic planning process.

Conducting CHNAs, developing implementation plans, and reporting HCB takes time and resources. Hospitals have different approaches to staffing the administration of their community benefit activities and reporting responsibilities. Most hospitals have invested in staff who are dedicated to community benefit and/or population health. These staff play a key role in hospital CHNAs and community benefit activities, as shown in Table 12.

Table 12. Number of Hospitals Reporting Staff in the Following Categories Contributing to CB or CHNA Operations

Staff Category	Number of Hospitals	Percentage of Hospitals
Population Health Staff	45	96%
Community Benefit Staff	43	91%
Community Benefit/Pop Health Director	45	96%

Appendix N details the types of staff involved in hospital CHNAs. Appendix O details the types of staff involved in HCB activities.

All hospitals conducted some form of audit on the financial data they submitted to the HSCRC (Table 13). These audits were mostly performed by hospital or hospital system staff, but 12 hospitals used third-party auditors.

Table 13. Hospital Audits of CBR Financial Spreadsheet

Staff or Entity Conducting Audit	Number of Hospitals Completing Audit	
	Yes	No
Hospital Staff	42	5
System Staff	38	9
Third-Party	12	35
No Audit	0	47
Two or More Audit Types	37	10
Three or More Audit Types	8	39

Each nonprofit hospital is governed by a board. The majority (37) of the CBRs were reviewed by the hospital boards (Table 14). Of the 10 CBRs that were not reviewed by the board, common reasons were timing or because the board had delegated this authority to executive or financial staff or an external firm. For example, several hospitals reported that their board meets only twice per year and did not have the opportunity to review before the report deadline. These responses were very similar to what was reported in FY 2022.

Table 14. Hospital Board Review of the CBR

Board Review/Approval	Number of Hospitals	
	Yes	No
Financial Report (Spreadsheet)	37	10
Narrative Report	37	10

Conclusion

Maryland's community benefit reporting requirements are more extensive than the federal requirements. All 49 nonprofit hospitals in Maryland submitted the required information for FY 2023. Maryland hospitals' FY 2023 community benefit expenditures totaled almost $2.3 billion, or $1.3 billion after accounting for activities that are funded through hospital rates set by the HSCRC. Total community benefit expenditures as a percentage of hospital operating expenses increased from 10.6% in FY 2022 to 11.3% in FY 2023. When the rate-supported activities are removed, community benefit expenses grew from 6.2% to 6.6% of operating expenses over the same period. All hospitals reported claiming exemption from federal and state income taxes.

All hospitals submitted a CHNA and CHNA implementation strategy. Most hospitals reported collaborating with local health departments and health improvement coalitions, other hospitals, and behavioral health

organizations on their CHNAs. Encouragingly, most hospitals have dedicated staff for community benefit and/or population health. Most reported that both hospital and system staff audit community benefit financial report data, the hospital board reviews the financial spreadsheet and the narrative report, and they have incorporated community benefit investments into their strategic plan.

Staff identified the following areas for continued review:

- There continues to be a wide variation in the percentage of net community benefit hospitals spent on CHNA-related activities. Staff convened a workgroup in the summer of 2024 to gather feedback for improving the consistency and comparability of reporting in this area, made corresponding clarifications to the FY 2024 reporting instructions, and convened a hospital training webinar. FY 2024 submissions were due in January 2025, and staff will review the results to determine whether further reporting clarifications are needed.
- There continues to be a wide variation in indirect cost ratios. Staff completed an additional validation step for the FY 2023 report, comparing the indirect cost ratio reported on the CBR with the ratio reported on the HSCRC's Annual Cost Report Schedule M. As a result of this step, several hospitals made corrections to their initial submission, while other hospitals provided explanations for the variation. This issue was also discussed in the workgroup, and technical corrections were made to the FY 2024 reporting instructions. While the additional validation step resulted in some improvements for the FY 2023 report, staff will review the results of the upcoming FY 2024 report to determine whether further clarifications are needed. In the FY 2024 report, staff also intend to conduct additional analyses showing what expenditures would be if a consistent indirect cost ratio was applied across hospitals.

Appendix A. Comparison of Federal and State Community Benefit Categories

Activities the Federal Government Defines as HCB (Schedule H)	Activities Maryland Includes as HCB (this list is not exclusive)
Net, unreimbursed costs of financial assistance (free or reduced cost care)**	Financial assistance
Participation in means-tested government programs, such as Medicaid**	Hospital contribution to the Medicaid Deficit Assessment
Health professions education	Health professions education
Health services research	Research
Subsidized health services	Mission-driven health service
Community health improvement activities	A community health service An operation related to a planned, organized, and measured activity that is intended to meet identified community health needs within a service area A planned, organized, and measured activity that is intended to meet identified community health needs within a service area is funded by a foundation
Cash or in-kind contributions to other community groups.	A financial contribution Financial or in-kind support of the Maryland Behavioral Health Crisis Response System.
Community-building activities. Example: Investments in housing	A community-building activity, including partnerships with community-based organizations

Appendix B. Hospitals Submitting Community Benefit Reports

Maryland Hospitals that Submitted CBRs in FY 2023, by System

Adventist HealthCare	**Luminis Health**
Adventist HealthCare Fort Washington Medical Center	Anne Arundel Medical Center
Adventist HealthCare Rehabilitation	Doctors Community Hospital
Adventist HealthCare Shady Grove Medical Center	McNew Family Health Center
Adventist HealthCare White Oak Medical Center	**MedStar Health**
Ascension	MedStar Franklin Square Medical Center
Saint Agnes Healthcare, Inc.	MedStar Good Samaritan Hospital
Christiana Care Health System, Inc.	MedStar Harbor Hospital
Christiana Care, Union Hospital	MedStar Montgomery Medical Center
Independent Hospitals	MedStar Southern Maryland Hospital Center
Atlantic General Hospital	MedStar St. Mary's Hospital
CalvertHealth Medical Center	MedStar Union Memorial Hospital
Frederick Health Hospital	**TidalHealth**
Greater Baltimore Medical Center	TidalHealth McCready Pavilion[39]
Mercy Medical Center	TidalHealth Peninsula Regional
Meritus Medical Center	**Trinity Health**
Sheppard Pratt	Holy Cross Germantown Hospital
Johns Hopkins Health System	Holy Cross Hospital
Howard County General Hospital	**University of Maryland Medical System**
Johns Hopkins Bayview Medical Center	UM Baltimore Washington Medical Center
Johns Hopkins Hospital	UM Capital Region Health
Suburban Hospital	UM Charles Regional Medical Center
Jointly Owned Hospitals	UM Rehabilitation & Orthopaedic Institute
Mt. Washington Pediatric Hospital[40]	UM Shore Regional Health
LifeBridge Health	UM St. Joseph Medical Center
Carroll Hospital Center	UM Upper Chesapeake Health
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	UMMC Midtown Campus
Northwest Hospital Center, Inc.	University of Maryland Medical Center
Sinai Hospital of Baltimore, Inc.	**UPMC**
	UPMC Western Maryland
	West Virginia University Health System
	GRMC, Inc., DBA Garrett Regional Medical Ctr.

[39] The TidalHealth McCready Pavilion is a Freestanding Medical Facility associated with Peninsula Regional.
[40] Jointly owned by the University of Maryland Medical System and Johns Hopkins.

maryland health services cost review commission

Appendix C. FY 2023 Funding through Rates for HCB Activities

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Total Rate-Supported Community Benefit Activities
Adventist Fort Washington Medical Center	$0	$63,872	$63,872	$454,879	$2,245,578	$2,828,202
Adventist Rehabilitation	$0	$45,203	$0	$0	$0	$45,203
Adventist Shady Grove Medical Center	$0	$495,127	$495,127	$732,276	$12,323,361	$14,045,891
Adventist White Oak Hospital	$0	$331,339	$331,339	$473,991	$10,097,266	$11,233,936
Anne Arundel General Hospital	$7,146,295	$699,722	$699,722	$0	$5,004,158	$13,549,898
Atlantic General Hospital	$0	$122,135	$122,135	$561,465	$1,122,610	$1,928,344
CalvertHealth Medical Center	$0	$163,995	$163,995	$0	$2,757,010	$3,085,000
Carroll Hospital Center	$0	$199,007	$199,007	$208,923	$2,902,386	$3,509,323
ChristianaCare, Union Hospital	$0	$251,514	$251,514	$0	$1,587,375	$2,090,403
Doctors Community Hospital	$0	$253,009	$253,009	$288,379	$14,399,742	$15,194,139
Frederick Memorial Hospital	$0	$388,588	$388,588	$832,321	$5,891,400	$7,500,897
Garrett County Memorial Hospital	$0	$66,256	$66,256	$0	$2,677,588	$2,810,100
Greater Baltimore Medical Center	$6,614,075	$526,376	$526,376	$427,540	$3,709,101	$11,803,468
Holy Cross Germantown Hospital	$0	$131,583	$131,583	$180,799	$3,428,100	$3,872,065
Holy Cross Hospital	$2,692,852	$554,475	$554,475	$807,969	$20,676,698	$25,286,469
Howard County General Hospital	$0	$320,588	$320,588	$871,180	$7,973,000	$9,485,356
J Kent McNew Family Medical Center	$0	$9,364	$0	$0	$0	$9,364
Johns Hopkins Bayview Med. Center	$29,014,221	$754,929	$754,929	$1,511,135	$30,503,000	$62,538,214
Levindale Hebrew Geriatric Center & Hospital	$0	$55,385	$55,385	$0	$2,494,444	$2,605,214
Lifebridge Northwest Hospital Center	$0	$274,312	$274,312	$240,378	$6,124,376	$6,913,378
MedStar Franklin Square Hospital	$10,902,334	$604,526	$604,526	$500,602	$17,362,008	$29,973,997
MedStar Good Samaritan Hospital	$2,648,628	$287,494	$287,494	$238,767	$10,187,092	$13,649,475
MedStar Harbor Hospital Center	$1,732,317	$169,385	$169,385	$165,457	$8,406,708	$10,643,252
MedStar Montgomery General Hospital	$0	$189,414	$189,414	$0	$6,094,996	$6,473,824
MedStar Southern Maryland Hospital	$0	$296,310	$296,310	$2,417,778	$9,816,141	$12,826,539
MedStar St. Mary's Hospital	$0	$246,867	$246,867	$210,044	$5,866,438	$6,570,216

Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Financial Assistance	Total Rate-Supported Community Benefit Activities
MedStar Union Memorial Hospital	$12,558,450	$453,671	$453,671	$376,133	$11,690,948	$25,532,873
Mercy Medical Center	$4,685,348	$619,895	$619,895	$490,746	$21,995,243	$28,411,126
Meritus Medical Center	$5,024,792	$429,741	$429,741	$1,178,916	$12,015,919	$19,079,109
Mt. Washington Pediatric Hospital	$0	$63,655	$0	$0	$264,092	$327,747
Sheppard Pratt	$2,990,329	$152,435	$0	$0	$8,741,514	$11,884,279
Sinai Hospital of Baltimore	$19,586,748	$897,075	$897,075	$1,552,902	$15,116,995	$38,050,795
St. Agnes Hospital	$6,826,946	$434,080	$434,080	$478,434	$15,382,432	$23,555,972
Suburban Hospital	$607,064	$370,255	$370,255	$696,192	$7,067,394	$9,111,160
The Johns Hopkins Hospital	$138,125,253	$2,759,868	$2,759,868	$5,231,027	$55,925,900	$204,801,916
TidalHealth McCready Pavillion	$0	$5,296	$5,296	$0	$106,900	$117,492
TidalHealth Peninsula Regional Medical Center	$5,502,090	$508,153	$508,153	$1,684,395	$10,293,900	$18,496,691
UM Capital Region	$5,547,887	$376,230	$376,230	$3,230,297	$7,790,313	$17,320,957
Univ. of Maryland Baltimore Washington Medical Center	$773,097	$475,475	$475,475	$0	$8,287,000	$10,011,047
Univ. of Maryland Charles Regional Medical Center	$0	$169,385	$169,385	$408,173	$2,498,000	$3,244,943
Univ. of Maryland Harford Memorial Hospital	$0	$109,164	$109,164	$0	$2,167,000	$2,385,328
Univ. of Maryland Medical Center	$168,321,811	$1,980,238	$1,980,238	$2,947,123	$29,197,000	$204,426,410
Univ. of Maryland Medical Center Midtown Campus	$3,674,217	$238,163	$238,163	$1,723,233	$4,254,000	$10,127,776
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$1,587,928	$128,091	$128,091	$0	$1,726,000	$3,570,110
Univ. of Maryland Shore Medical Center at Chestertown	$0	$44,183	$44,183	$0	$1,026,000	$1,114,366
Univ. of Maryland Shore Medical Center at Easton	$150,000	$238,163	$238,163	$0	$4,294,758	$4,921,084
Univ. of Maryland St. Joseph's Medical Center	$0	$416,739	$416,739	$347,151	$7,208,373	$8,389,002
Univ. of Maryland Upper Chesapeake Medical Center	$0	$347,850	$347,850	$0	$4,258,000	$4,953,700
UPMC Western Maryland Hospital	$0	$357,297	$357,297	$1,126,299	$13,719,300	$15,560,193
Total	**$436,712,683**	**$19,075,878**	**$18,805,221**	**$32,594,902**	**$438,677,558**	**$945,866,242**

Appendix D. FY 2023 Community Benefit Analysis

Table D1. Hospital Operating Expenses and Community Benefit Expenses

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense
Adventist Fort Washington Medical Center	$63,947,008	$7,102,621	11.11%
Adventist Rehabilitation	$63,524,116	$1,829,981	2.88%
Adventist Shady Grove Medical Center	$450,979,711	$40,032,662	8.88%
Adventist White Oak Hospital	$329,144,866	$31,922,588	9.70%
Anne Arundel General Hospital	$647,110,000	$70,148,046	10.84%
Ascension Saint Agnes Hospital	$537,591,223	$52,882,154	9.84%
Atlantic General Hospital	$166,422,837	$8,415,352	5.06%
CalvertHealth Medical Center	$160,772,982	$8,942,397	5.56%
Carroll Hospital Center	$279,472,729	$22,533,952	8.06%
ChristianaCare, Union Hospital	$192,302,239	$23,264,049	12.10%
Doctors Community Hospital	$247,220,000	$34,995,799	14.16%
Frederick Memorial Hospital	$413,459,000	$56,892,363	13.76%
Garrett Regional Hospital	$63,327,026	$11,567,923	18.27%
Greater Baltimore Medical Center	$624,194,000	$70,577,819	11.31%
Holy Cross Germantown Hospital	$139,664,351	$7,783,802	5.57%
Holy Cross Hospital	$526,196,350	$50,599,565	9.62%
Howard County General Hospital	$331,650,000	$36,557,318	11.02%
J. Kent McNew Family Medical Center	$8,727,322	$2,733,218	31.32%
Johns Hopkins Bayview Med. Center	$760,312,000	$107,131,629	14.09%
Levindale Hebrew Geriatric Center & Hospital	$81,606,195	$5,536,488	6.78%
Lifebridge Northwest Hospital Center	$317,819,933	$24,425,906	7.69%
MedStar Franklin Square Hospital	$682,540,830	$64,715,265	9.48%
MedStar Good Samaritan Hospital	$317,400,224	$26,431,968	8.33%
MedStar Harbor Hospital Center	$230,578,957	$25,891,745	11.23%
MedStar Montgomery General Hospital	$228,602,542	$14,867,749	6.50%
MedStar Southern Maryland Hospital	$306,906,165	$28,203,383	9.19%
MedStar St. Mary's Hospital	$201,299,285	$20,644,933	10.26%
MedStar Union Memorial Hospital	$516,967,157	$49,500,236	9.58%
Mercy Medical Center	$579,752,405	$73,752,855	12.72%
Meritus Medical Center	$517,495,595	$66,551,271	12.86%
Mt. Washington Pediatric Hospital	$68,508,229	$1,574,578	2.30%
Sheppard & Enoch Pratt Hospital	$275,498,276	$36,721,183	13.33%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense
Sinai Hospital of Baltimore	$954,434,934	$92,712,551	9.71%
Suburban Hospital	$374,467,000	$37,663,565	10.06%
The Johns Hopkins Hospital	$3,060,451,000	$366,842,384	11.99%
TidalHealth McCready Pavillion	$9,044,100	$569,926	6.30%
TidalHealth Peninsula Regional Medical Center	$480,411,000	$68,944,409	14.35%
Univ. of Maryland Baltimore Washington Medical Center	$474,046,000	$27,931,663	5.89%
Univ. of Maryland Capital Region Medical Center	$379,857,000	$45,637,576	12.01%
Univ. of Maryland Charles Regional Medical Center	$149,018,616	$14,618,252	9.81%
Univ. of Maryland Harford Memorial Hospital	$99,813,000	$9,837,007	9.86%
Univ. of Maryland Medical Center	$2,022,919,000	$282,975,200	13.99%
Univ. of Maryland Medical Center Midtown Campus	$268,702,000	$34,323,489	12.77%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$124,385,000	$9,020,727	7.25%
Univ. of Maryland Shore Medical Center at Chestertown	$45,865,000	$10,087,696	21.99%
Univ. of Maryland Shore Medical Center at Easton	$298,925,000	$38,023,876	12.72%
Univ. of Maryland St. Joseph's Medical Center	$409,862,000	$58,245,151	14.21%
Univ. of Maryland Upper Chesapeake Medical Center	$314,183,000	$22,452,379	7.15%
UPMC Western Maryland Hospital	$353,692,553	$76,846,674	21.73%
Total, All Hospitals	**$20,151,069,758**	**$2,281,463,324**	**11.32%**

Table D2. Rate-Supported Community Benefit, Including Financial Assistance

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
	A	B	C	D=B-C	E=D/A	F	G=F/A
Adventist Fort Washington Medical Center	$63,947,008	$7,102,621	$2,828,202	$4,274,419	6.68%	$657,109	1.03%
Adventist Rehabilitation	$63,524,116	$1,829,981	$45,203	$1,784,778	2.81%	$108,409	0.17%
Adventist Shady Grove Medical Center	$450,979,711	$40,032,662	$14,045,891	$25,986,771	5.76%	$15,449,975	3.43%
Adventist White Oak Hospital	$329,144,866	$31,922,588	$11,233,936	$20,688,652	6.29%	$12,021,241	3.65%
Anne Arundel General Hospital	$647,110,000	$70,148,046	$13,549,898	$56,598,149	8.75%	$5,004,158	0.77%
Ascension Saint Agnes Hospital	$537,591,223	$52,882,154	$23,555,972	$29,326,182	5.46%	$19,737,929	3.67%
Atlantic General Hospital	$166,422,837	$8,415,352	$1,928,344	$6,487,008	3.90%	$737,899	0.44%
CalvertHealth Medical Center	$160,772,982	$8,942,397	$3,085,000	$5,857,396	3.64%	$2,757,101	1.71%
Carroll Hospital Center	$279,472,729	$22,533,952	$3,509,323	$19,024,629	6.81%	$2,902,386	1.04%
ChristianaCare, Union Hospital	$192,302,239	$23,264,049	$2,090,403	$21,173,646	11.01%	$1,370,679	0.71%
Doctors Community Hospital	$247,220,000	$34,995,799	$15,194,139	$19,801,660	8.01%	$14,399,742	5.82%

[41] Excludes expenditures on community benefit activities that are offset by revenue.
[42] Includes funding for financial assistance, DME, NSPI, NSPII, & Regional Partnership Catalyst Grant.
[43] The values in this column have been calculated by subtracting the total rate support each hospital received for charity care and the DME, NSPI, NSPII, & Regional Partnership Catalyst funding programs from the hospital's total community benefit expense. Hospitals' offsetting revenue has already been subtracted from the total community benefit expense value.

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Frederick Memorial Hospital	$413,459,000	$56,892,363	$7,500,897	$49,391,466	11.95%	$1,283,823	0.31%
Garrett Regional Hospital	$63,327,026	$11,567,923	$2,810,100	$8,757,823	13.83%	$3,646,138	5.76%
Greater Baltimore Medical Center	$624,194,000	$70,577,819	$11,803,468	$58,774,352	9.42%	$3,709,101	0.59%
Holy Cross Germantown Hospital	$139,664,351	$7,783,802	$3,872,065	$3,911,737	2.80%	$3,618,340	2.59%
Holy Cross Hospital	$526,196,350	$50,599,565	$25,286,469	$25,313,096	4.81%	$29,603,040	5.63%
Howard County General Hospital	$331,650,000	$36,557,318	$9,485,356	$27,071,962	8.16%	$7,972,509	2.40%
J. Kent McNew Family Medical Center	$8,727,322	$2,733,218	$9,364	$2,723,854	31.21%	$101,407	1.16%
Johns Hopkins Bayview Med. Center	$760,312,000	$107,131,629	$62,538,214	$44,593,415	5.87%	$30,503,000	4.01%
Levindale Hebrew Geriatric Center & Hospital	$81,606,195	$5,536,488	$2,605,214	$2,931,274	3.59%	$2,494,444	3.06%
Lifebridge Northwest Hospital Center	$317,819,933	$24,425,906	$6,913,378	$17,512,528	5.51%	$6,124,376	1.93%
MedStar Franklin Square Hospital	$682,540,830	$64,715,265	$29,973,997	$34,741,268	5.09%	$17,362,008	2.54%
MedStar Good Samaritan Hospital	$317,400,224	$26,431,968	$13,649,475	$12,782,493	4.03%	$10,187,092	3.21%
MedStar Harbor Hospital Center	$230,578,957	$25,891,745	$10,643,252	$15,248,493	6.61%	$8,406,708	3.65%
MedStar Montgomery General Hospital	$228,602,542	$14,867,749	$6,473,824	$8,393,925	3.67%	$6,094,996	2.67%
MedStar Southern Maryland Hospital	$306,906,165	$28,203,383	$12,826,539	$15,376,844	5.01%	$9,816,141	3.20%
MedStar St. Mary's Hospital	$201,299,285	$20,644,933	$6,570,216	$14,074,716	6.99%	$5,967,196	2.96%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
MedStar Union Memorial Hospital	$516,967,157	$49,500,236	$25,532,873	$23,967,363	4.64%	$11,690,948	2.26%
Mercy Medical Center	$579,752,405	$73,752,855	$28,411,126	$45,341,729	7.82%	$21,995,243	3.79%
Meritus Medical Center	$517,495,595	$66,551,271	$19,079,109	$47,472,161	9.17%	$12,269,867	2.37%
Mt. Washington Pediatric Hospital	$68,508,229	$1,574,578	$327,747	$1,246,830	1.82%	$264,092	0.39%
Sheppard & Enoch Pratt Hospital	$275,498,276	$36,721,183	$11,884,279	$24,836,905	9.02%	$8,741,514	3.17%
Sinai Hospital of Baltimore	$954,434,934	$92,712,551	$38,050,795	$54,661,756	5.73%	$15,116,994	1.58%
Suburban Hospital	$374,467,000	$37,663,565	$9,111,160	$28,552,405	7.62%	$7,067,000	1.89%
The Johns Hopkins Hospital	$3,060,451,000	$366,842,384	$204,801,916	$162,040,468	5.29%	$55,926,000	1.83%
TidalHealth McCready Pavillion	$9,044,100	$569,926	$117,492	$452,434	5.00%	$106,900	1.18%
TidalHealth Peninsula Regional Medical Center	$480,411,000	$68,944,409	$18,496,691	$50,447,718	10.50%	$10,358,300	2.16%
Univ. of Maryland Baltimore Washington Medical Center	$474,046,000	$27,931,663	$10,011,047	$17,920,616	3.78%	$8,287,000	1.75%
Univ. of Maryland Capital Region Medical Center	$379,857,000	$45,637,576	$17,320,957	$28,316,619	7.45%	$6,996,000	1.84%
Univ. of Maryland Charles Regional Medical Center	$149,018,616	$14,618,252	$3,244,943	$11,373,310	7.63%	$2,497,665	1.68%
Univ. of Maryland Harford Memorial Hospital	$99,813,000	$9,837,007	$2,385,328	$7,451,679	7.47%	$2,167,000	2.17%
Univ. of Maryland Medical Center	$2,022,919,000	$282,975,200	$204,426,410	$78,548,790	3.88%	$29,197,000	1.44%

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense[41]	Amount of Community Benefit Amount included in Rates[42]	Total CB not included in hospital rates[43]	Total CB not included in hospital rates as % of Operating Expense	Financial Assistance Amount Reported in Financial Report Submission	Financial Assistance as a % of Operating Expense
Univ. of Maryland Medical Center Midtown Campus	$268,702,000	$34,323,489	$10,127,776	$24,195,713	9.00%	$4,254,000	1.58%
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$124,385,000	$9,020,727	$3,570,110	$5,450,617	4.38%	$1,726,000	1.39%
Univ. of Maryland Shore Medical Center at Chestertown	$45,865,000	$10,087,696	$1,114,366	$8,973,330	19.56%	$1,026,000	2.24%
Univ. of Maryland Shore Medical Center at Easton	$298,925,000	$38,023,876	$4,921,084	$33,102,793	11.07%	$4,670,000	1.56%
Univ. of Maryland St. Joseph's Medical Center	$409,862,000	$58,245,151	$8,389,002	$49,856,149	12.16%	$6,812,000	1.66%
Univ. of Maryland Upper Chesapeake Medical Center	$314,183,000	$22,452,379	$4,953,700	$17,498,679	5.57%	$4,258,000	1.36%
UPMC Western Maryland Hospital	$353,692,553	$76,846,674	$15,560,193	$61,286,481	17.33%	$14,905,333	4.21%
Total, All Hospitals	**$20,151,069,758**	**$2,281,463,324**	**$945,866,242**	**$1,335,597,082**	**6.63%**	**$452,369,804**	**2.24%**

Appendix E. Methodology for Rate Support for Uncompensated Care, including Financial Assistance

Financial assistance amounts reported by hospitals in their community benefit reports (CBRs) may not match the financial assistance amounts applied in their global budgets for the same year. The financial assistance amounts in rates are part of the HSCRC's uncompensated care (UCC) policy, which is a prospective policy applied at the beginning of the rate year. In contrast, the amounts reported by hospitals in their CBRs are retrospective.

The HSCRC calculates the amount of UCC provided in hospital rates at each regulated Maryland hospital using a multi-step process:

1. **Statewide Actual UCC in All-Payer Hospital Rates:** The HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported on all acute hospitals' RE Schedules for the previous year. The change in hospital rates based on statewide actual UCC, as a percent of gross patient revenue, is applied uniformly to acute care hospital rates statewide.
2. **Hospital Payments or Contributions to the UCC Fund** The UCC Fund is then used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.
    i. **Hospital-Specific Actual UCC:** The HSCRC uses gross patient revenue as reported on the hospitals' RE Schedules for the previous year to determine the hospital-specific actual UCC for each hospital.
    ii. **Hospital-Specific Predicted UCC:** The HSCRC uses a mathematical model to predict a hospital's expected amount of UCC. This model takes into account Area Deprivation Index (ADI), payer type, and site of care.
    iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized such that the statewide 50/50 blend equals the prior year actual UCC rate that was built into statewide hospital rates (step 1 for the prior year). This ensures that the UCC fund is redistributive in nature.
    iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how

much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which the HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

Table E1. UCC Methodology Example ($ Millions)

		Statewide actual UCC in all-payer hospital rates		**Hospital Payments or Contributions to the UCC fund.**			
		Step 1		Step 2(i)	Step 2(ii)	Step 2(iii)	Step 2(iv)
	A	**B**	**C = A X B**	**D**	**E**	**F = Avg D & E**	**G = (F-B) X A**
	GBR	**Prior Year Statewide UCC Rate**	**UCC Funding Provided in Rates**	**Prior Year Hospital-Specific UCC Rate**	**Predicted Hospital-specific UCC Rate**	**Hospital-Specific 50/50 Blend**	**(Payment) or Withdrawal from UCC Fund**
Hospital A	$300	5%	$15	3%	4%	3.50%	($4.50)
Hospital B	$300	5%	$15	7%	6%	6.50%	$4.50

The use of blended actual and predicted UCC to determine the amount of hospital contributions and withdrawals from the UCC funds serves to balance the policy goals of reimbursing hospitals for UCC provided to low-income patients while also incentivizing hospitals to minimize bad debt by encouraging them to use reasonable means to collect debt from patients who can afford to pay. Incorporating predicted UCC into this methodology provides hospitals with a financial incentive to collect payments (rather than writing debt off as bad debt without attempting to collect) so that UCC costs do not rise too quickly. This approach is critical to supporting Maryland's unique UCC system and ensuring access to care for low-income patients in the long run.

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Appendix F. FY 2023 Hospital Community Benefit Aggregate Data

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
Unreimbursed Medicaid Costs							
T99	**Medicaid Assessments**	**$295,626,867**	[45]		**$238,997,382**	**$55,466,167**	**$55,466,167**
Community Health Services							
A10	Community Health Education	$16,586,183	$8,318,251	$1,168,901	$2,720,697	$21,014,836	$12,696,586
A11	Support Groups	$2,313,576	$1,767,865	$860	$4,915	$4,075,666	$2,307,801
A12	Self-Help	$1,476,507	$662,923		$226,850	$1,912,581	$1,249,657
A20	Community-Based Clinical Services	$24,494,852	$6,700,082		$10,143,430	$21,051,504	
A21	Screenings	$3,008,461	$2,069,624		$1,028,063	$4,050,023	$1,980,399
A22	One-Time/Occasionally Held Clinics	$972,719	$83,166		$27	$1,055,858	$972,692
A23	Clinics for Underinsured and Uninsured	$7,507,569	$3,384,861		$1,736,399	$9,156,032	$5,771,171
A24	Mobile Units	$1,609,452	$553,326		$1,471,904	$690,874	$137,548
A30	Health Care Support Services	$75,038,638	$27,107,234	$9,023,985	$7,838,474	$85,283,412	$58,176,179
A40	Other	$9,635,784	$4,243,382	$685,510	$1,751,807	$11,441,849	$7,198,467
A99	**Total**	**$142,643,741**	**$54,890,714**	**$10,879,256**	**$26,922,565**	**$159,732,634**	**$104,841,920**
Health Professions Education							
B10	Physicians/Medical Students	$397,318,606	$202,459,862	$619,923	$2,930,318	$596,228,227	$393,768,365
B20	Nurses/Nursing Students	$36,029,551	$20,805,489	$3,885,052		$52,949,989	$32,144,499
B30	Other Health Professionals	$20,620,925	$10,163,456		$143,643	$30,640,738	$20,477,282

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

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
B40	Scholarships/Funding for Professional Education	$3,284,005	$1,640,041	$320,588		$4,603,458	$2,963,417
B50	Other	$1,709,214	$1,172,550		$446,946	$2,434,818	$1,262,268
B99	**Total**	**$458,962,301**	**$236,241,399**	**$4,825,563**	**$3,520,907**	**$686,857,230**	**$450,615,831**
	Mission-Driven Health Services						
C99	**Mission-Driven Health Services Total**	**$1,537,041,477**	**$153,401,280**	**$66,690**	**$857,695,497**	**$832,680,571**	**$679,279,291**
	Research						
D10	Clinical Research	$13,313,308	$4,383,266		$5,751,402	$11,945,173	$7,561,907
D20	Community Health Research	$1,142,112	$380,425		$34,937	$1,487,600	$1,107,175
D30	Other	$663,270	$279,573		$197,315	$745,528	$465,955
D99	**Total**	**$15,118,691**	**$5,043,264**		**$5,983,654**	**$14,178,301**	**$9,135,037**
	Financial Contributions						
E10	Cash Donations	$12,975,236	$4,734		$1,500	$12,978,470	$12,973,736
E20	Grants	$5,898,467			$3,384,457	$2,514,010	$2,514,010
E30	In-Kind Donations	$2,427,066	$29,500		$74,215	$2,382,351	$2,352,851
E40	Cost of Fund Raising for Community Programs	$6,578,376			$4,326,301	$2,252,075	$2,252,075
E99	**Total**	**$27,879,146**	**$34,234**		**$7,786,473**	**$20,126,907**	**$20,092,673**
	Community-Building Activities						
F10	Physical Improvements and Housing	$1,234,790	$295,018		$134,362	$1,395,446	$1,100,428
F20	Economic Development	$1,468,921	$443,861		$12,500	$1,900,282	$1,456,421
F30	Community Support	$6,990,614	$2,720,876	$878,623	$2,374,570	$6,458,297	$3,737,421
F40	Environmental Improvements	$678,749	$341,310		$1,000	$1,019,059	$677,749
F50	Leadership Development/Training for Community Members	$411,572	$315,612			$727,185	$411,572
F60	Coalition Building	$3,931,888	$2,133,076		$82,121	$5,982,843	$3,849,767

Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
F70	Advocacy for Community Health Improvements	$1,197,008	$230,622			$1,427,631	$1,197,008
F80	Workforce Development	$3,314,487	$1,337,859		$491,189	$4,161,156	$2,823,298
F90	Other	$718,577	$557,584			$1,276,161	$718,577
F99	**Total**	**$19,946,606**	**$8,375,819**	**$878,623**	**$3,095,742**	**$24,348,059**	**$15,972,241**
Community Benefit Operations							
G10	Assigned Staff	$9,094,011	$4,674,055		$6,558	$13,761,508	$9,087,453
G20	Community Health/Health Assets Assessments	$483,350	$365,026		$11,085	$837,291	$472,265
G30	Other	$1,741,784	$475,132		$13,856	$2,203,060	$1,727,928
G99	**Total**	**$11,319,145**	**$5,514,213**		**$31,499**	**$16,801,859**	**$11,287,646**
Financial Assistance							
H00	**Total Financial assistance**	**$452,369,804**					
Foundation-Funded Community Benefits							
J10	Community Services	$1,273,727	$458,484		$83,082	$1,649,128	$1,190,644
J20	Community Building	$687,718	$282,822		$379,855	$590,685	$307,863
J30	Other		$11,846			$11,846	
J99	**Total**	**$1,961,445**	**$753,152**		**$462,937**	**$2,251,660**	**$1,498,507**
Total Hospital Community Benefits							
A99	Community Health Services	$142,643,741	$54,890,714	$10,879,256	$26,922,565	$159,732,634	$104,841,920
B99	Health Professions Education	$458,962,301	$236,241,399	$4,825,563	$3,520,907	$686,857,230	$450,615,831
C99	Mission Driven Health Care Services	$1,537,041,477	$153,401,280	$66,690	$857,695,497	$832,680,571	$679,279,291
D99	Research	$15,118,691	$5,043,264		$5,983,654	$14,178,301	$9,135,037
E99	Financial Contributions	$27,879,146	$34,234		$7,786,473	$20,126,907	$20,092,673
F99	Community-Building Activities	$19,946,606	$8,375,819	$878,623	$3,095,742	$24,348,059	$15,972,241

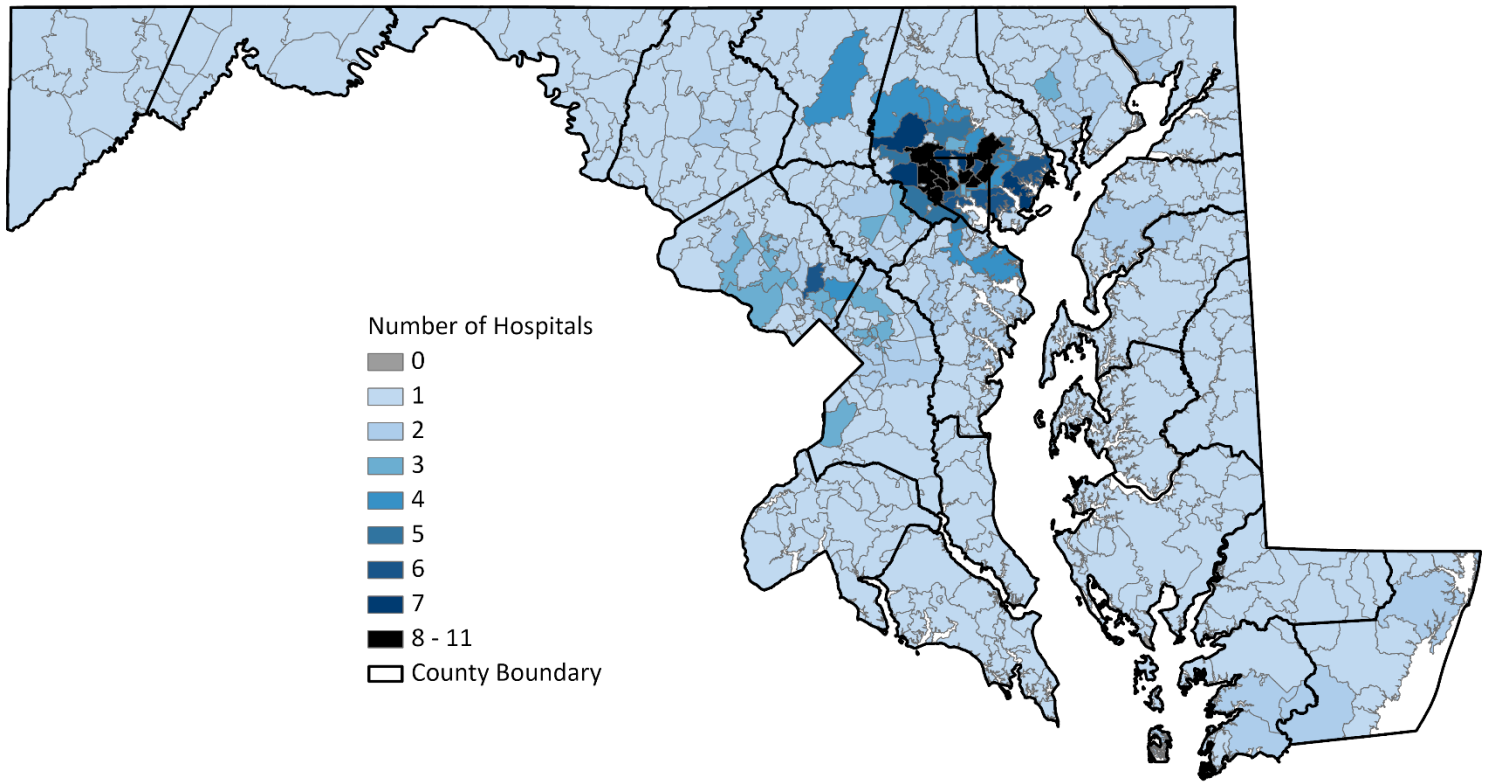
Line Item	Type of Activity	Direct Cost	Indirect Cost	HSCRC Rate Support	Offsetting Revenue	Community Benefit[44] less rate support, including Indirect Cost	Community Benefit less rate support, without Indirect Cost
G99	Community Benefit Operations	$11,319,145	$5,514,213		$31,499	$16,801,859	$11,287,646
H99	Financial assistance					$452,369,804	$452,369,804
J99	Foundation Funded Community Benefit	$1,961,445	$753,152		$462,937	$2,251,660	$1,498,507
T99	Medicaid Assessments	$295,626,867			$238,997,382	$55,466,167	$55,466,167
K99	**Total Hospital Community Benefit**	**$2,510,499,419**	**$464,254,075**	**$16,650,132**	**$1,144,496,656**	**$2,264,813,192**	**$1,800,559,117**

Appendix G. Primary Service Areas and Community Benefit Service Areas

A primary service area (PSA) is the geographical region from which a hospital primarily draws its patients. The HSCRC determines a PSA for each hospital. Figure 1 shows how many hospitals claim each ZIP code in Maryland in their PSAs.[46] Other than the areas in and around Baltimore City/County and some areas around Washington, D.C., most ZIP codes are claimed by only one hospital.

[46] For FY 2023, only three ZIP codes were not claimed to be in the PSA of at least one hospital: 20892 in southern Montgomery County (the National Institutes of Health), 21241 in western Baltimore City (the Social Security Administration), and 21627 in southern Dorchester County (Crocheron, MD, which had a population of 27 in 2020). Note that each of these ZIP codes is very small and therefore difficult to see on this map.

Figure G1: Hospitals Claiming the ZIP Code in Their PSAs, FY 2023*



Hospitals also report the methodology used to determine their community benefit service area (CBSA),[47] which may differ from their PSA. Maryland hospitals considered multiple factors when defining their CBSAs, with the most common factors being patient utilization patterns, such as ZIP codes with the highest percentages of hospital discharges and emergency department (ED) visits. Nine hospitals based their CBSAs on their PSAs, shown above.[48] Other hospitals defined their CBSAs by geographic proximity to the hospital, regions served by the hospital's community benefit programs, and demographic factors, including areas with high needs indicated by social determinants of health and areas with higher proportions of medically underserved or uninsured/underinsured residents. Table G1 summarizes the methods used by hospitals to determine their CBSAs.

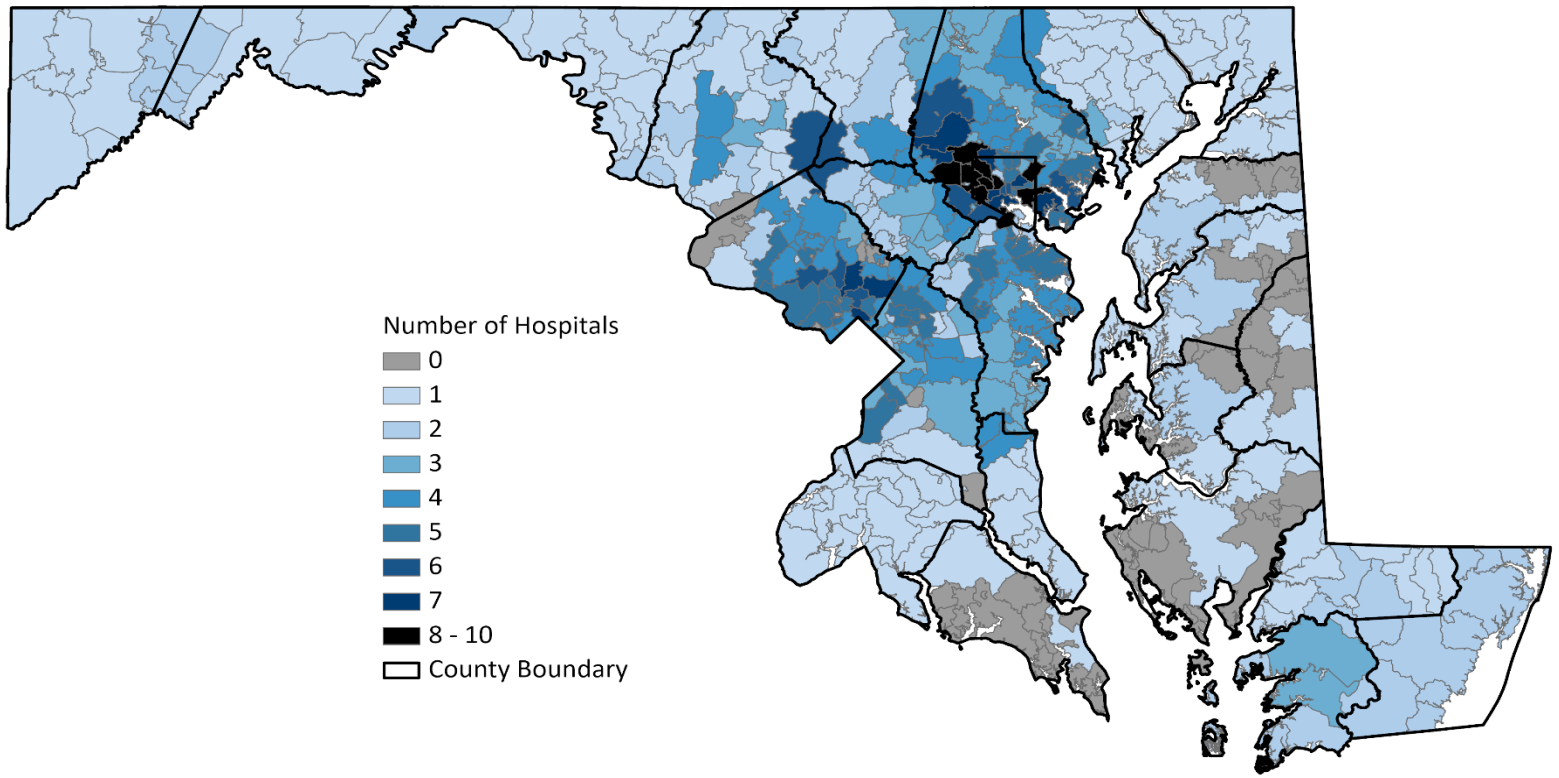
Table G1. Methods Used by Hospitals to Identify Their CBSAs, FY 2023

CBSA Identification Factor	Number of Hospitals[49]
Patterns of Hospital Utilization by Patients	36
ZIP Codes in Their Global Budget Revenue Agreement (Primary Service Area)	9
ZIP Codes in Financial Assistance Policy	7
Other Method	25

Figure G2 displays the number of hospitals that claim each ZIP code as part of their CBSA. Most zip codes in Maryland were included in at least one hospital's CBSA.[50] Most ZIP codes in Baltimore City, Baltimore County, Montgomery County, Prince George's County, Anne Arundel County, and Howard County were claimed by three or more hospitals, with numerous ZIP codes in Baltimore City were claimed by eight or more hospitals. This is a marked change from the CBSAs reported in FY 2022, when only one uninhabited ZIP code in central Maryland was not claimed by a hospital. This difference likely stems at least in part from the fact that the University of Maryland Rehabilitation and Orthopaedic Institute claimed every ZIP code in the State as part of its CBSA in FY 2022 but did not do so in FY 2023.

[47] Hospitals report the CBSA zip codes and selection methodology to the HSCRC and include that information in their federally mandated CHNAs (26 CFR § 1.501(r)-3(b)).
[48] The PSA is the geographic region where the hospital draws most of its patients. The PSA for each general acute care and chronic care hospital is defined in the hospital's Global Budget Agreement with the HSCRC. For specialty hospitals, the PSA is defined as the ZIP codes in which 60% of discharges are reported.
[49] Hospitals used multiple factors to determine their CBSA. As a result, the numbers in this column do not sum to 47.

Figure G2. Number of Hospitals Claiming the ZIP Code in Their CBSAs, FY 2023



Appendix H. Community Statistics by County

Hospitals report details about the communities located in their CBSAs/CHNAs, which help inform decisions about HCB activities. Table 1 displays examples of the county-level demographic measures used by the hospitals.

The following measures in Table 1 were derived from the five-year (2018-2022) 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. Total population was derived from the 1-year and 5-year average American Community Survey estimates. The life expectancy three-year average (2019-2021) and the crude death rate (2021) were derived from the Department's Vital Statistics Administration, and the numerator for the percentage of the population enrolled in Medicaid was pulled from the Maryland Medicaid DataPort.

Table H1. 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		98,461	6.2	5.9	34.0	28.7	32.0	19.8	56.6	32.5	10.9	78.2	941.4
Allegany	2	55,248	9.6	4.0	49.5	38.8	22.6	3.3	91.2	9.3	2.0	74.2	1394.0
Anne Arundel	8	116,009	4.1	4.5	28.7	21.0	30.3	12.6	73.7	20.3	8.7	79.1	849.1
Baltimore	12	88,157	7.0	5.3	35.8	30.7	28.7	14.9	60.1	32.4	6.1	77.2	1119.0
Baltimore City	16	58,349	14.5	5.5	46.8	52.0	30.1	10.3	31.9	63.6	5.9	71.0	1296.0
Calvert	1	128,078	2.8	3.2	27.4	19.4	40.9	4.9	83.9	15.2	4.6	78.6	911.6
Caroline	1	65,326	9.8	6.8	49.7	42.3*	31.6	8.3	80.5	16.0	8.2	75.7	1302.0
Carroll	3	111,672	3.5	2.9	27.7	17.2	35.4	5.9	92.3	5.1	4.1	78.5	1082.0
Cecil	1	86,869	7.2	3.9	37.1	31.0	29.1	6.6	89.0	9.2	4.9	74.2	1206.0
Charles	1	116,882	3.7	4.0	29.3	25.6	44.2	9.8	43.1	53.8	6.7	77.2	877.6
Dorchester	1	57,490	8.7	5.2	54.9	46.0*	26.5	5.9	67.5	30.7	6.1	75.0	1511.0
Frederick	5	115,724	4.6	4.5	27.4	19.4	33.7	15.5	82.0	12.5	11.0	80.2	789.6
Garrett	1	64,447	7.3	5.8	46.2	32.6*	25.0	3.1	97.5	1.4	1.3	76.6	1394.0

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Harford	2	106,417	4.7	3.5	31.0	22.3	32.3	7.5	80.5	16.8	5.0	78.2	989.8
Howard	4	140,971	3.7	3.9	24.8	18.2	29.5	26.5	57.0	22.3	7.5	82.8	595.6
Kent	1	71, 635	5.1	4.3	44.6	28.7*	25.8	5.4	81.2	15.4	4.7	76.4	1641.0
Montgomery	9	125,583	4.9	6.7	29.2	23.0	33.0	41.9	54.1	21.0	20.0	83.5	660.3
Prince George's	7	97,935	6.2	10.5	34.4	31.8	36.0	28.9	17.9	64.3	20.0	78.4	801.0
Queen Anne's	2	108,332	3.7	5.0	35.0	19.7*	34.9	5.4	90.1	7.1	4.6	79.3	1035.0
Saint Mary's	1	113,668	6.6	4.0	29.4	24.2	30.1	7.0	80.8	16.9	5.7	77.3	920.1
Somerset	3	52,149	15.6	3.9	53.2	42.5*	24.0	5.5	57.6	43.4	4.0	74.5	1276.0
Talbot	2	81,667	6.3	4.4	48.0	25.9*	26.4	8.7	83.8	13.6	7.3	79.0	1474.0
Washington	1	73,017	8.6	5.5	42.7	36.0	29.7	8.2	85.1	14.7	6.2	75.3	1307.0
Wicomico	2	69,421	8.0	6.5	43.7	41.9	23.1	11.4	67.9	29.1	5.7	75.0	1207.0
Worcester	2	76,689	5.1	5.8	48.1	29.6*	23.8	6.6	84.2	14.3	3.8	79.2	1392.0
Source	[51]	[52]	[53]	[54]	[55]	[56]*	[57]	[58]	[59]	[60]	[61]	[62]	[63]

[51] As reported by hospitals in their FY 2023 Community Benefit Narrative Reports.
[52] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Median Household Income (Dollars), https://data.census.gov/cedsci/.
[53] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families.
[54] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.
[55] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.
[56] American Community Survey 1-Year Estimates 2022, ACS Demographic and Housing Estimates, Total Population (denominator) and The Maryland Medicaid DataPort – Eligibility Exploratory Dashboards Standard Report, December 2022 enrollment, the Hilltop Institute (numerator). Starred values used American Community Survey 5-Year Estimates 2022, ACS Demographic and Housing Estimates, Total Population for the denominator because 2022 ACS 1-Year Estimates were unavailable for these counties.
[57] American Community Survey 5-Year Estimates 2018 – 2022, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes).
[58] American Community Survey 5-Year Estimates 2018 – 2022, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.
[59] American Community Survey 5-Year Estimates 2018 – 2022, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – White.
[60] American Community Survey 5-Year Estimates 2018 – 2022, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – Black or African American.
[61] American Community Survey 5-Year Estimates 2018 – 2022, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race).
[62] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2021, Table 7. Life Expectancy at Birth by Race, Hispanic Origin, Region, and Political Subdivision, Maryland, 2019 – 2021. An updated 2022 Vital Statistics Report was unavailable at the time of publication.
[63] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2021, Table 32B. Crude Death Rates by Race and Hispanic Origin, Region and Political Subdivision, Maryland, 2021. An updated 2022 Vital Statistics Report was unavailable at the time of publication.

Appendix I. Sources of Community Health Measures Reported by Hospitals

Other community health data sources reported by hospitals include the following:

- Baltimore Neighborhood Indicators Alliance
- CDC Behavioral Risk Factor Surveillance System
- CDC Chronic Disease Calculator
- CDC Interactive Atlas of Heart Disease and Stroke
- CDC Mental Health Surveillance and PRC Survey
- CDC National Center for Health Statistics
- CDC Wonder Database
- Center for Applied Research and Engagement Systems
- Commission on Cancer
- Community surveys, focus groups, and interviews
- Conduent - Healthy Communities Institute
- County and local health departments' community health statistics
- Cigarette Restitution Fund Program – Cancer in Maryland Report
- Feeding America
- Findings from health and human services needs assessments completed by contracted entities
- Health Resources and Services Administration
- Healthy Communities Institute
- Internal emergency department and health services quality data
- Kaiser Family Foundation analyses
- Local community foundations
- Local health improvement coalitions
- Local police and public school systems data
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Center on Economic Progress
- Maryland Chronic Disease Burden

- Maryland Department of Health
- Maryland Department of Planning
- Maryland Hospital Association
- Maryland Office of Minority Health and Health Disparities
- Maryland Physician Workforce Study
- Maryland Sexually Transmitted Infections Program
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- Measure of America Opportunity Index by County
- Meritus Health Cancer Registry Report
- National Cancer Institute
- National Institutes of Health
- Nielsen/Claritas
- Performance data from community health improvement initiatives
- Robert Wood Johnson Foundation – County Health Rankings
- Robert Wood Johnson Foundation – City Health Dashboard
- State of Maryland's Health Care Workforce Report
- United Way – United for ALICE (Asset-Limited, Income Constrained, Employed)
- University of Maryland School of Social Work
- University of Wisconsin School of Medicine and Public Health – Neighborhood Atlas
- U.S. Census Bureau – American Community Survey
- U.S. Census Bureau – Decennial Census population estimates
- U.S. Department of Health and Human Services – Healthy People 2030
- Washington Co. Public Schools Youth Risk Behavior and High School Trend Reports

Appendix J. FY 2023 CHNA Priority Area Categories Addressed through CB Initiatives

CHNA Priority Area	Number of Hospitals
Social Determinants of Health - Health Care Access and Quality	35
Settings and Systems - Community	32
Health Conditions - Diabetes	31
Health Conditions - Mental Health and Mental Disorders	31
Health Behaviors - Preventive Care	31
Health Conditions - Cancer	26
Health Conditions - Heart Disease and Stroke	25
Health Behaviors - Drug and Alcohol Use	25
Health Behaviors - Nutrition and Healthy Eating	23
Settings and Systems - Transportation	22
Social Determinants of Health - Economic Stability	21
Health Conditions - Pregnancy and Childbirth	20
Social Determinants of Health - Social and Community Context	20
Health Conditions - Addiction	19
Settings and Systems - Health Care	17
Social Determinants of Health - Education Access and Quality	17
Health Behaviors - Health Communication	16
Health Behaviors - Physical Activity	16
Health Behaviors - Violence Prevention	14
Populations - Children	14
Populations - Workforce	14
Health Conditions - Overweight and Obesity	11
Populations - Older Adults	11
Settings and Systems - Housing and Homes	11
Social Determinants of Health - Neighborhood and Built Environment	11
Health Conditions - Infectious Disease	10
Health Behaviors - Injury Prevention	10
Populations - Infants	10
Health Behaviors - Vaccination	9
Populations - Parents or Caregivers	9
Settings and Systems - Workplace	9
Populations - Adolescents	8

CHNA Priority Area	Number of Hospitals
Populations - People with Disabilities	8
Populations - Women	8
Health Behaviors - Emergency Preparedness	7
Settings and Systems - Hospital and Emergency Services	7
Settings and Systems - Schools	7
Settings and Systems - Public Health Infrastructure	6
Health Conditions - Chronic Kidney Disease	5
Health Conditions - Chronic Pain	5
Settings and Systems - Environmental Health	5
Settings and Systems - Health Insurance	5
Health Conditions - Respiratory Disease	4
Health Behaviors - Child and Adolescent Development	4
Health Behaviors - Family Planning	4
Health Conditions - Arthritis	3
Health Conditions - Sexually Transmitted Infections	3
Health Conditions - Health Care-Associated Infections	2
Health Conditions - Sensory or Communication Disorders	2
Health Behaviors - Sleep	2
Health Behaviors - Tobacco Use	2
Populations - Men	2
Settings and Systems - Global Health	2
Settings and Systems - Health IT	2
Settings and Systems - Health Policy	2
Health Conditions - Blood Disorders	1
Health Conditions - Osteoporosis	1
Populations - LGBT	1
Health Conditions - Dementias	0
Health Conditions - Foodborne Illness	0
Health Conditions - Oral Conditions	0
Health Behaviors - Safe Food Handling	0

*Data Source: As reported by hospitals on their FY 2023 financial reports.

Appendix K. Dates of Most Recent CHNAs

Hospital	Date Most Recent CHNA was Completed
CalvertHealth	Nov-23
Holy Cross Germantown	Oct-22
Holy Cross Hospital	Oct-22
Adventist HealthCare Fort Washington Medical Center	Oct-22
Adventist HealthCare Rehab	Oct-22
Adventist Shady Grove	Oct-22
Adventist White Oak	Oct-22
Garrett Regional Medical Center	Aug-22
UPMC Western MD	Jun-22
Suburban Hospital	Jun-22
UM BWMC	Jun-22
Howard County General Hospital	Jun-22
UM Capital Region Health	Jun-22
UM Shore Regional Medical Center	May-22
Sheppard Pratt	May-22
TidalHealth McCready Pavilion	May-22
TidalHealth Peninsula Regional	May-22
ChristianaCare Union Hospital	May-22
Meritus Medical Center	May-22
Atlantic General	May-22
Frederick Health Hospital	May-22
Anne Arundel Medical Center	Dec-21
Doctors Community Medical Center	Dec-21
McNew Family Health Center	Dec-21
Carroll Hospital Center	Jun-21
LifeBridge Levindale	Jun-21
MedStar Franklin Square	Jun-21
MedStar Good Samaritan	Jun-21
MedStar Harbor Hospital	Jun-21
MedStar Montgomery	Jun-21
MedStar Southern MD	Jun-21
MedStar St. Mary's	Jun-21

Hospital	Date Most Recent CHNA was Completed
MedStar Union Memorial	Jun-21
Northwest Hospital Center	Jun-21
Sinai Hospital of Baltimore, Inc.	Jun-21
St. Agnes HealthCare	Jun-21
UM Charles Regional	Jun-21
UMMC Midtown	Jun-21
University of Maryland Medical Center	Jun-21
UM Rehab & Ortho	Jun-21
UM Upper Chesapeake Health	Jun-21
UM St. Joseph Medical Center	Jun-21
Johns Hopkins Hospital	Jun-21
Greater Baltimore Medical Center	Jun-21
Mercy Medical Center	Jun-21
Johns Hopkins Bayview Medical Center	May-21
Mt Washington Pediatric Hospital	May-21

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

CHNA Participant Category	Level of Community Engagement					
	Informed - To provide the community with balanced & objective info to assist in understanding the problem, alternatives, opportunities and/or solutions	**Consulted -** To obtain community feedback on analysis, alternatives and/or solutions	**Involved -** To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	**Collaborated -** To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	**Delegated -** To place the decision-making in the hands of the community	**Community Driven/Led -** To support the actions of community initiated, driven and/or led processes
Other Hospitals	16	25	18	25	8	10
Local Health Department	25	30	25	28	8	14
Local Health Improvement Coalition	22	26	18	25	8	15
Maryland Department of Health	18	16	5	12	3	3
Other State Agencies	7	8	4	10	0	0
Local Govt. Organizations	17	24	13	18	3	4
Faith-Based Organizations	19	22	21	21	2	7
School - K-12	18	20	15	17	3	2
School - Colleges, Universities, Professional Schools	19	19	16	17	3	3
Behavioral Health Organizations	21	26	15	20	3	9
Social Service Organizations	17	21	12	19	1	7
Post-Acute Care Facilities	8	12	5	6	0	0
Community/Neighborhood Organizations	19	24	15	18	2	5
Consumer/Public Advocacy Organizations	8	10	4	7	0	1
Other	16	22	11	7	1	4

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

CHNA Participant Category	Recommended Practices							
	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals	30	30	25	33	20	27	17	18
Local Health Department	33	33	34	40	28	28	19	22
Local Health Improvement Coalition	34	24	16	40	21	26	18	21
Maryland Department of Health	11	11	19	15	8	12	3	13
Other State Agencies	14	9	4	11	2	11	4	9
Local Govt. Organizations	27	21	8	28	10	17	18	14
Faith-Based Organizations	29	20	7	30	11	24	18	12
School - K-12	24	19	11	26	15	16	18	13
School - Colleges, Universities, Professional Schools	21	19	12	24	9	17	16	10
Behavioral Health Organizations	29	22	13	32	15	24	17	19
Social Service Organizations	25	19	10	29	13	20	15	15
Post-Acute Care Facilities	11	12	2	15	0	7	3	7
Community/Neighborhood Organizations	25	22	9	31	14	17	17	13
Consumer/Public Advocacy Organizations	13	11	5	11	3	8	7	7
Other	7	11	8	19	8	11	9	4

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Appendix N. Hospitals Involving Staff/Departments in CHNA Efforts

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
CB/Community Health/Population Health Director (facility level)	1	12	32	31	28	27	32	33	15	3
CB/Community Health/Population Health Director (system level)	8	6	26	29	30	26	29	27	19	5
Senior Executives (CEO, CFO, VP, etc.) (facility level)	1	1	37	33	28	21	37	28	6	5
Senior Executives (CEO, CFO, VP, etc.) (system level)	5	6	13	23	26	12	21	11	1	4
Board of Directors or Board Committee (facility level)	8	2	13	15	16	9	26	13	3	11
Board of Directors or Board Committee (system level)	13	6	3	10	12	3	13	6	1	9
Clinical Leadership (facility level)	2	0	31	25	26	23	41	33	11	2
Clinical Leadership (system level)	15	7	16	17	19	10	24	19	4	2
Population Health Staff (facility level)	5	9	31	24	22	19	30	31	16	2
Population Health Staff (system level)	14	7	21	23	23	19	23	22	15	3
Community Benefit staff (facility level)	1	11	34	33	29	29	34	33	23	2
Community Benefit staff (system level)	5	11	20	26	27	21	22	21	17	8
Physician(s)	4	0	24	19	19	17	36	27	7	2
Nurse(s)	7	0	29	23	19	21	37	34	7	0
Social Workers	10	0	23	16	18	20	33	34	6	0
Hospital Advisory Board	3	19	11	13	13	11	19	18	3	3
Other (specify)	12	1	6	6	6	7	7	7	3	2

Appendix O. Hospitals Reporting Community Benefit Internal Participants and Their Roles

Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting Health Needs That Will Be Targeted	Selecting the Initiatives That Will Be Supported	Determining How to Evaluate the Impact of Initiatives	Providing Funding for CB Activities	Allocating Budgets for Individual Initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other
CB/Community Health/Population Health Director (facility level)	2	11	32	33	32	19	31	31	33	3
CB/Community Health/Population Health Director (system level)	8	7	30	28	29	16	20	17	27	3
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	0	41	41	25	38	38	10	21	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	14	7	20	20	18	20	20	9	15	2
Board of Directors or Board Committee (facility level)	7	3	18	22	9	12	7	5	15	3
Board of Directors or Board Committee (system level)	12	8	15	15	4	7	4	3	7	2
Clinical Leadership (facility level)	3	0	34	32	22	9	10	25	21	0
Clinical Leadership (system level)	10	7	24	21	12	5	7	10	12	0
Population Health Staff (facility level)	4	10	25	26	29	11	12	29	30	1
Population Health Staff (system level)	13	7	19	19	25	7	13	18	24	0
Community Benefit staff (facility level)	3	10	26	26	28	13	17	31	32	1
Community Benefit staff (system level)	5	11	17	18	24	4	7	16	24	3
Physician(s)	10	0	24	22	17	4	4	24	21	4
Nurse(s)	9	0	25	24	20	7	8	29	24	0
Social Workers	16	1	20	20	13	5	5	25	19	0
Hospital Advisory Board	8	17	16	14	4	5	3	2	11	2
Other (specify)	13	1	6	5	6	3	2	8	7	0

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TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
July 30, 2025

RE:
Hearing and Meeting Schedule

August 2025 No Meeting

September 10, 2025 In person at HSCRC office and Zoom webinar

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

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